BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428
Attending: Frederick Ryan Caballes **Reg Date:** 09/19/18
Reason: RHABDOMYOLYSIS WITH REACTIVE LEUKOCYTOSIS AND NASA

Allergies

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

Active (Home) Medications

Medication	Instructions	Recorded	Confirmed	Last Taken	Type
Metoprolol Tartrate TAB* [Lopressor TAB*]	25 mg PO BID tab	10/15/18		Unknown	Rx
amLODIPine TAB* [Norvasc 5 mg TAB*]	10 mg PO DAILY tab	10/15/18		Unknown	Rx

Diagnoses

ELEVATED WHITE BLOOD CELL COUNT, UNSPECIFIED (09/19/18)
NICOTINE DEPENDENCE, CIGARETTES, UNCOMPLICATED (09/19/18)
SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE (09/19/18)
SCHIZOAFFECTIVE DISORDER, UNSPECIFIED (09/19/18)
UNSP PSYCHOSIS NOT DUE TO A SUBSTANCE OR KNOWN PHYSIOL COND (09/19/18)
POST-TRAUMATIC STRESS DISORDER, UNSPECIFIED (09/19/18)
PERSONALITY DISORDER, UNSPECIFIED (09/19/18)
ESSENTIAL (PRIMARY) HYPERTENSION (09/19/18)
FRACTURE OF NASAL BONES, INIT ENCNTR FOR CLOSED FRACTURE (09/19/18)
FRACTURE OF ONE RIB, LEFT SIDE, INIT FOR CLOS FX (09/19/18)
ANTERIOR DISLOCATION OF LEFT HUMERUS, INITIAL ENCOUNTER (09/19/18)
TRAUMATIC ISCHEMIA OF MUSCLE, INITIAL ENCOUNTER (09/19/18)
EXPOSURE TO OTHER SPECIFIED FACTORS, INITIAL ENCOUNTER (09/19/18)
RESTAURANT OR CAFE AS PLACE (09/19/18)
FAMILY HX OF ISCHEM HEART DIS AND OTH DIS OF THE CIRC SYS (09/19/18)
PATIENT'S OTHER NONCOMPLIANCE WITH MEDICATION REGIMEN (09/19/18)

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LEGAL RECORD COPY - DO NOT DESTROY

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Medications Given

Discontinued Medications

Acetaminophen (Tylenol Tab*) 650 mg PO ONCE PRN
PRN Reason: PAIN - MILD
Acetaminophen (Tylenol Tab*) 975 mg PO BID SCH
Last Admin: 09/24/18 08:06 Dose: Not Given
Hydrocodone Bitart/Acetaminophen (Norco 5-325 Tab*) 2 tab PO ONCE PRN
PRN Reason: PAIN - MODERATE
Amlodipine Besylate (Norvasc Tab*) 10 mg PO DAILY SCH
Last Admin: 09/24/18 08:06 Dose: Not Given
Dimenhydrinate (Dramamine Iv*) 25 mg IV PUSH ONCE PRN
PRN Reason: NAUSEA/VOMITING
Fentanyl Citrate (Fentanyl*) Confirm Administered Dose 100 mcg .ROUTE .STK-MED ONE
Stop: 09/19/18 18:21
Fentanyl Citrate (Fentanyl*) 25 mcg IV Q2M PRN
PRN Reason: PAIN - MODERATE
Haloperidol Lactate (Haldol Inj Iv/Im*) 5 mg IV SLOW PU Q2H PRN
PRN Reason: AGITATION/ANXIETY/INSOMNIA
Last Admin: 09/19/18 23:51 Dose: 5 mg
Hydralazine HCl (Apresoline Iv*) 10 mg IV SLOW PU Q6H PRN
PRN Reason: BLOOD PRESSURE
Hydromorphone HCl (Dilaudid Inj1s*) 0.5 mg IV SLOW PU Q6H PRN
PRN Reason: PAIN
Last Admin: 09/19/18 12:14 Dose: 0.5 mg
Sodium Chloride (Ns 0.9% 1000 Ml*) 1,000 mls @ 1,000 mls/hr IV ED ONCE ONE
Stop: 09/19/18 07:13
Last Admin: 09/19/18 07:08 Dose: 1,000 mls/hr
Sodium Chloride (Ns 0.9% 1000 Ml*) 1,000 mls @ 125 mls/hr IV PER RATE SCH
Stop: 09/20/18 16:44
Last Admin: 09/19/18 18:19 Dose: 125 mls/hr
Sodium Chloride (Ns 0.9% 1000 Ml*) 1,000 mls @ 75 mls/hr IV PER RATE SCH
Last Admin: 09/19/18 23:50 Dose: 75 mls/hr
Magnesium Sulfate 3 gm/ Sodium (Chloride) 106 mls @ 53 mls/hr IVPB ONCE ONE
Stop: 09/24/18 12:59
Last Admin: 09/24/18 10:31 Dose: Not Given
Iohexol (Omnipaque 300* (Contrast)) 100 ml IV ONCE ONE
Stop: 09/19/18 16:24
Last Admin: 09/19/18 17:04 Dose: 100 ml
Ketamine HCl (Ketamine Hcl*) Confirm Administered Dose 500 mg .ROUTE .STK-MED ONE
Stop: 09/19/18 04:52
Ketamine HCl (Ketamine Hcl*) 300 mg IM ONCE ONE
Stop: 09/19/18 04:57
Last Admin: 09/19/18 04:57 Dose: 300 mg
Levofloxacin (Levaquin Tab*) 500 mg PO Q24H SCH
Last Admin: 09/22/18 11:17 Dose: Not Given
Lorazepam (Ativan Inj*) 2 mg IM ED ONCE ONE
Stop: 09/19/18 05:52
Last Admin: 09/19/18 06:09 Dose: Not Given
Lorazepam (Ativan Inj*) 2 mg IV PUSH ED ONCE ONE

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Medications Given - Continued

Stop: 09/19/18 06:10
Last Admin: 09/19/18 06:09 Dose: 2 mg
Lorazepam (Ativan Inj*) 2 mg IV PUSH Q4H PRN
PRN Reason: AGITATION
Magnesium Oxide (Magox 400 Tab*) 800 mg PO ONCE STA
Stop: 09/24/18 10:31
Last Admin: 09/24/18 11:12 Dose: Not Given
Metoprolol Tartrate (Lopressor Tab*) 25 mg PO BID SCH
Last Admin: 09/24/18 08:06 Dose: Not Given
Midazolam HCl (Versed 2mg/2ml*) Confirm Administered Dose 2 mg .ROUTE .STK-MED ONE
Stop: 09/19/18 18:21
Morphine Sulfate (Morphine Inj ((Syringe))*) 2 mg IV Q10M PRN
PRN Reason: PAIN
Naloxone HCl (Narcan*) 0.08 mg IV Q2M PRN
PRN Reason: severe induced resp depression
Olanzapine (Zyprexa *Odt*) 10 mg PO DAILY SCH
Last Admin: 09/24/18 08:06 Dose: Not Given
Ondansetron HCl (Zofran Inj*) 4 mg IV ONCE PRN
PRN Reason: NAUSEA/VOMITING
Oxycodone/Acetaminophen (Percocet 5/325 Tab*) 1 tab PO Q6H PRN
PRN Reason: PAIN
Propofol (Diprivan*) Confirm Administered Dose 400 mg IV PUSH .STK-MED ONE
Stop: 09/19/18 20:07
Tetanus/Reduced Diphtheria/Acell Pertussis (Boostrix Syr*) 0.5 ml IM .ONCE ONE
Stop: 09/19/18 04:58
Last Admin: 09/19/18 08:44 Dose: 0.5 ml
Ziprasidone (Geodon Im Inj*) 20 mg IM ED ONCE ONE
Stop: 09/19/18 05:48
Last Admin: 09/19/18 06:07 Dose: 20 mg

Nursing Notes

09/24/18 13:53 Nursing Note by Vellake,Joseph A
ADMISSION NOTE:

PATIENT TO BE ADMITTED TO CMC BSU WITH DX OF UNSPECIFIED PSYCHOSIS D/O ON A 9.39 LEGAL STATUS. PATIENT IS A 62YO MALE TO FEMALE TRANSGENDER WHO IS PARANOID (POLICE CONSPIRACY AGAINST HER), AND SHOWING POOR INSIGHT AND JUDGMENT INTO HER OWN BEHAVIORS. SHE IS REFUSING TO TAKE ANY OF HER MEDICATIONS HERE IN THE HOSPITAL. PATIENT HAS BEEN GIVEN PRN HALDOL AND ATIVAN WHEN HER BEHAVIORS ARE OUT OF CONTROL. SHE IS EASILY AGITATED WHEN HER NEEDS OR DEMANDS ARE NOT INSTANTLY MET BY STAFF.

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Nursing Notes - Continued

PATIENT WAS BROUGHT TO ED ON 9/19/18 BY POLICE ON A 9.41 LEGAL STATUS. POLICE RESPONDED TO A 911 CALL AT THE LOCAL DENNY'S RESTAURANT. THE PATIENT WAS LOUD AGITATED AND OUT OF CONTROL. PATIENT RESISTED THE POLICE AND SUFFERED A NASAL FX, LEFT SHOULDER INJURY AND ELEVATED CPK LEVEL DURING THE PHYSICAL ALTERCATION. IN THE ED PATIENT CONTINUED TO BE COMBATIVE AND REQUIRED IM MEDICATIONS AND PHYSICAL RESTRAINTS. PATIENT WAS ADMITTED TO CMC TELEMETRY UNIT 4S, AND IS NOW MEDICALLY CLEARED TO COME TO CMC BSU. PATIENT WILL BE CHANGED INTO PAPER SCRUBS AND GIVEN S&R, AND BROUGHT TO UNIT WHEN BED IS AVAILABLE.

Initialized on 09/24/18 13:53 - END OF NOTE

09/24/18 11:52 Case Manager by Ayers,Lorraine
REVIEWED CHART AGAIN, PATIENT CONTINUES TO WAIT FOR BED IN BSU, SHE DOES NOT ALWAYS ALLOW STAFF TO DO VS ALSO SHE DOES NOT WANT TO TAKE ALL MEDICATIONS ORDERED BY MD, CASE MANAGER WILL CONTINUE TO FOLLOW AS NEEDED, CASE DISCUSSED IN IDR.

Initialized on 09/24/18 11:52 - END OF NOTE

09/24/18 09:13 Nursing Note by Marsh,Mackenzie

Addendum entered by Marsh,Mackenzie, RN 09/24/18 18:13:

Pt being discharged. Security present. Having issues with agreeing to go down but I believe they were able to convince the pt. Pt discharged to mental health.

Original Note:

Addendum entered by Marsh,Mackenzie, RN 09/24/18 15:02:

Pt has a bed to mental health. Pt should be going later today. Awaiting BHU staff.

Original Note:

Addendum entered by Marsh,Mackenzie, RN 09/24/18 10:39:

Mag 1.7, Dr Cabelles ordered mag PO. Pt declined to take meds even when explained risk and benefits. Pt stated," that just a vitamin supplement no thank you."

Original Note:

Pt declined to be assessed and all meds. Did allow the hospital aide to do VS however.Please see VS tab. Pt denies pain. Awaiting bed for mental health.

Initialized on 09/24/18 09:13 - END OF NOTE

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Nursing Notes - Continued

09/24/18 07:13 Nursing Note by Harmon,Rayanna
Report given to Mackenzie RN.

Initialized on 09/24/18 07:13 - END OF NOTE

09/24/18 03:40 (created 09/24/18 05:50) Nursing Note by Harmon,Rayanna
Patient refused 23:15 and 3:15 VS.

Initialized on 09/24/18 05:50 - END OF NOTE

09/23/18 19:18 Nursing Note by Harmon,Rayanna
Assumed patient care at 1900 from Stacy and Taylor RNs. VS and labs reviewed. Physical assessment completed, see worklist for details. Bruising and abrasions noted r/t fight with police before arrival, left arm noted to be edematous. Patient awake. lying in bed, in no apparent distress upon meeting. Patient currently denies pain or dizziness. Patient declines most care, VS and all medications declined, per previous nurse provider aware. Patient left lying in bed, call bell within reach, will continue to monitor.

Initialized on 09/23/18 19:18 - END OF NOTE

09/23/18 18:56 Nursing Note by Shelley,Stacy
Report given to Rayanna, RN.

Initialized on 09/23/18 18:56 - END OF NOTE

09/23/18 13:49 Nursing Note by Shelley,Stacy
Pt is resting in bed with no signs of distress. Pt declines medications and vital signs. Pt is alert and oriented and cooperative as long as you respect her boundaries with her care.

Initialized on 09/23/18 13:49 - END OF NOTE

09/23/18 09:00 (created 09/23/18 10:34) Nursing Note by Shelley,Stacy
Received report from Sophany, RN. Assumed care of pt at 0700. Pt presents sitting up in bed, with multiple facial wounds to forehead, cheeks, and eyes, sustained from fight with law enforcement prior to admission. Pt c/o of pain but denies medication, vs being taken, or pulmonary assessment. Pt. was sitting still and c/o pain in left shoulder arm but refuses to wear sling or receive medication. Physical assessment completed, minus lung assessment. Pt is appears anxious when asking questions, but was willing to let me auscultate heart sounds and check pedal pulses. Pt not on tele. Call bell within reach. Will continue to monitor.

Initialized on 09/23/18 10:34 - END OF NOTE

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09/22/18 22:15 Nursing Note by Soeung,Sophany

Addendum entered by Soeung,Sophany, RN 09/23/18 07:09:

End of shift report given to Stacy, RN and Taylor, RN.

Original Note:

Addendum entered by Soeung,Sophany, RN 09/23/18 03:36:

Pt refused 0300 vitals.

Original Note:

1900 Assumed pt care. Pt resting in bed, minimally interactive and cooperative with staff. Allowed writer to do physical assessment and 1900 vitals but refused 2300 vitals. Pt continues to refuse meds despite education, notified Bahgat Abdelaziz PA of pt's BP of 180/98 and refusal of 2100 meds. Pt becomes quickly agitated when meds and plan of care are discussed. Pt requests to not be bothered and would prefer listen to music. Call bell within reach, will continue to monitor.

Initialized on 09/22/18 22:15 - END OF NOTE

09/22/18 19:07 Nursing Note by Downing,Morgan
Change of shift report given to Sophany, RN. Assessment unchanged from previous documentation.

Initialized on 09/22/18 19:07 - END OF NOTE

09/22/18 12:18 Nursing Note by Downing,Morgan
Received report from Megan Harrington, RN. Assumed pt care at 1030. Labs and vital signs reviewed. Physical assessment consistent with previous documentation. Pt resting in bed. Telemetry montioring discontinued. Pt A&Ox4 but wifty. Pt education complete about the importance of medication management. Pt attentively listened, but declined all medications. MD aware. Pt left resting in bed with call bell within reach and bed alarm armed. Pt verbalized an understanding and compliance of call bell usage. Will continue to monitor.

Initialized on 09/22/18 12:18 - END OF NOTE

09/22/18 10:28 Nursing Note by Harrington,Megan
Pt refused all 0900 medications, Dr. Caballes MD notified, no new orders.

When asked if new IV access could be initiated, pt refused. Will continue to reassess.

Report given to Morgan Downing RN.

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Initialized on 09/22/18 10:28 - END OF NOTE

09/21/18 21:30 (created 09/21/18 23:07) Nursing Note by Harrington,Megan
Pt refused 2100 medications. Nurse educated about importance of prescribed medications, and pt still refused. Pt stated "she believes these medications are unreasonable". Nurse notified by aide that pt also refused manual blood pressure because the automatic would not capture. Pt's blood pressures has been running high, pt notified but still refused metoprolol tartate. Pt became verbally agitated with nurse, and then refused to let nurse remove hand IV access. Provider Josh Hamilton NP notified of refusal of medications, no new orders, will continue to monitor.

Initialized on 09/21/18 23:07 - END OF NOTE

09/21/18 20:00 (created 09/21/18 23:13) Nursing Note by Harrington,Megan
During initial assessment, pt's R hand IV access noted to be infiltrated when flushed. When told she would have this IV site taken out and a new one inserted because this was the only IV access, pt refused. Pt wanted to "speak to a doctor before putting a new one in". Bahgat Abdelaziz PA notified of situation, provider recommended to remove infiltrated IV, and wait until the morning before initiated a new site. Will continue to reassess situation and pt.

Initialized on 09/21/18 23:13 - END OF NOTE

09/21/18 19:45 (created 09/22/18 01:49) Nursing Note by Harrington,Megan
Assumed care at 1900, received report from Connor O'Hare RN. Pt is lying in bed, pt hesitant to pt care. Pt complaining of severe left upper extremity and left flank pain, 9/10. Pt refuses pain medications even though they are ordered. Pt states "they won't do anything anyways". When offered other interventions pt refused. Pt states "if she stays in the same position it doesn't hurt as bad". Pt's right hand IV site appears to have infiltrated upon assessment. See note for details. Pt is on tele monitor, call bell within reach, will continue to monitor.

Initialized on 09/22/18 01:49 - END OF NOTE

09/21/18 18:52 Nursing Note by O'Hare,Connor
Hand-off report given to Megan Harrington, RN.

Initialized on 09/21/18 18:52 - END OF NOTE

09/21/18 12:46 Case Manager by Ayers,Lorraine
PATIENT REQUESTING NO SW OR VISITORS TO TALK ABOUT DISCHARGE, PLAN IS FOR HER TO GO TO BSU AT DC, CM WILL REMAIN AVAILABLE AS NEEDED.

Initialized on 09/21/18 12:46 - END OF NOTE

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Nursing Notes - Continued

09/21/18 08:00 (created 09/21/18 09:11) Nursing Note by O'Hare,Connor
Assumed care of pt @ 0700: Hand-off report received from Jeremy, RN. Labs and vitals reviewed. Pt is A&O X4 but experiences moments of forgetfulness and impulsiveness, BA in place, pain is stated, medications declined, pain managed with positioning and relaxation. Pt on tele, sinus rhythm-sinus tachycardia. No edema noted, skin deviations include bruising and abrasions to the bilateral eye, nose, left hip and leg. 20 gauge to the right wrist, site patent and benign, dressing clean, dry and intact. Pt on room air, denies shortness of breath and cough at the time. Plan of care reviewed with pt, no further questions or concerns at this time.

Physical assessment completed, see EMR for further details.

Pt is laying in bed, call bell within reach, will continue to monitor.

Initialized on 09/21/18 09:11 - END OF NOTE

09/21/18 05:08 Nursing Note by Strichartz,Jeremy
Pt refuses IV flush and IV fluids at this time

Initialized on 09/21/18 05:08 - END OF NOTE

09/21/18 00:16 Nursing Note by Strichartz,Jeremy
Received report and assumed care at 1900. Pt has been a&o and pleasant, but continues to have paranoid ideation and is impulsive. She denies pain. Refused IV line flush but allowed assessment. Elevated BP and HR noted. Assessments completed and documented. See worklist for details. Pt in bed with alarms in place

Initialized on 09/21/18 00:16 - END OF NOTE

09/20/18 19:21 Nursing Note by O'Hare,Connor
Change of shift report given to Jeremy, RN.

Initialized on 09/20/18 19:21 - END OF NOTE

09/20/18 16:55 Nursing Note by Tourville-Knapp,Anita
assumed care of pt at 1500.
answers questions, calm, refuses vital signs and tele.
report called to Conner on 4S. pt with safety sitter. transferred to room 436 with belongings without incident.

Initialized on 09/20/18 16:55 - END OF NOTE

09/20/18 16:30 (created 09/20/18 19:21) Nursing Note by O'Hare,Connor
Arrival vitals reviewed, pt BP elevated, provider notified and ordered PRN medications. Prior to giving medication pt refused treatment, an explanation was provided on the importance of controlling blood

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pressure and the medication to be given. Pt still refused medication, provider notified.

Initialized on 09/20/18 19:21 - END OF NOTE

09/20/18 15:30 (created 09/20/18 19:08) Nursing Note by O'Hare,Connor
SBAR report received from ICU, pt transferred to unit via wheelchair, able to ambulate to bed. Arrival assessment and vitals reviewed, 4 eyed skin check completed. Room orientation completed, safety monitor in place. Pt A&O X4, denies pain at this time. Pt on tele, sinus rhythm-sinus tachycardia, no edema noted, abrasions and bruising to the bilateral eye, nose, forehead, left hip/leg, no dressings applied. 20 gauge to the right wrist, site patent and benign, dressing clean, dry and intact. Pt on room air, denies shortness of breath or cough. Plan of care reviewed with pt, no further questions or concerns.

Physical assessment completed, see EMR for further details.

Pt is laying in bed, safety monitor in place, call bell within reach, will continue to monitor.

Initialized on 09/20/18 19:08 - END OF NOTE

09/20/18 15:11 Social Worker by Forte,Jennifer
Social work met with pt to discuss living situation and community resources. Pt was vague about living situation, stating that she was living on Trumansburg Rd, but that the building may have been sold. Pt stated that her situation is “weird”, and when this writer asked for specifics pt was guarded and then said, “just go to badtriprecords.biz”, which is a website for a record company in Trumansburg which is located at the address where pt states she was residing. Pt refused to give this writer anymore details about her life and asked that this writer leave the room and not send anyone else in to speak with her. Pt states it’s not personal she just “doesn’t like social workers”. SW spoke with Dr, Ehmke who reports that pt can be admitted to BSU once medically stable. SW remains available as needed.

Initialized on 09/20/18 15:11 - END OF NOTE

09/19/18 20:15 Nursing Note by Soeung,Kimberly

Addendum entered by Soeung,Kimberly, RN 09/20/18 06:21:

Patient refuses morning bloodwork x3.

Original Note:

Addendum entered by Soeung,Kimberly, RN 09/20/18 05:05:

As patient moves around in the bed, patient saying "ouch". Writer in to patient's room to offer PRN pain medications and assistance with repositioning. Patient declines.

Original Note:

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Nursing Notes - Continued

Addendum entered by Soeung,Kimberly, RN 09/20/18 04:45:

0015: Patient agrees to do a bedside dysphagia screen. No difficulties swallowing observed.

Original Note:

Addendum entered by Soeung,Kimberly, RN 09/20/18 04:43:

9/19/18 2351: Haldol 5mg PRN given for agitation with positive effect

Original Note:

Addendum entered by Soeung,Kimberly, RN 09/19/18 21:39:

Patient returns to ICU from PACU via bed at 2045. Sling to left arm observed. Patient denies pain to shoulder when asked. Patient allows this writer to put on blood pressure cuff after explaining to the patient what the BP cuff's function is. Patient does not want the EKG leads on, but after a few minutes of explaining the purpose of the monitor leads, the patient agreed to have them on. This writer asked the patient if I could listen to patient's heart and lungs as part of my head to toe assessment. The patient refuses, saying "you aren't doing anything to me". The patient refuses to have this writer perform a complete assessment.

2105: Patient requesting "something to drink and eat". Patient starting to pull at EKG leads and left arm sling. Patient states "this sling is not serving a purpose". This writer explained to the patient that the sling helps has a reminder to not move/lift the left arm, to prevent the shoulder from possibly dislocating again. The patient did not seem to understand that she should leave the sling on and in place as she continued to to try and remove it.
This writer calls Hospitalist, with my concerns with the patient trying to pull off the arm sling and that the patient would like to eat and drink. Dr. Rooth orders bedside dysphagia screening before giving patient anything to drink. Patient refuses to have the bed at sitting position (90 degrees) to start the bedside dysphagia screening. Soft wrist restraint to right wrist obtained.

2130: Pt removes blood pressure cuff, stating "this is not needed".

2150: Patient attempts to remove arm sling to left arm. Staff unable to effectively communicate with the patient, as she continues to pull at the sling and attempts to move the left arm to "exam it herself". Security called to stand by as soft wrist restraint is applied to right wrist.

2200: Right wrist restraint initiated.

Bed in low position. Callbell within reach. Safety monitor at the bedside.

Original Note:

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Nursing Notes - Continued

Assumed care of the patient at 1900. Patient laying in bed, with safety monitor at the bedside. Received report from day shift RN that Dr. Blake was in to see the patient in regards to his Left shoulder. Patient is scheduled to go to the OR for left shoulder procedure. During change of shift and while receiving report, the patient is requesting food and does not want to go to the OR to have the shoulder reduced. Rosika, RN at the bedside at this time. Pt still refusing the procedure. Charge Nurse and House supervisor were made aware that patient is requesting food and is refusing procedure. Anesthesia arrives on the unit, and was also made aware of patient's refusal. Dr. Blake and Dr. Stallone arrive on the unit to speak with the patient. Dr. Blake, Dr. Stallone, and Dr. Robelo felt the patient was not within capacity to make decisions for herself. Patient was taken to OR via bed by OR staff at 1945.

Initialized on 09/19/18 20:15 - END OF NOTE

09/19/18 19:54 Nursing Note by Moore,Kylee
0850- Received patient from ED via bed on telemetry. 4x restraints on and in use. VSS at this time, patient on room air. See admission flow sheet for details. CHG BBD. Patient constant observation at this time. HOB elevated. Patient confused, slurred speech, drowsy. Continue to monitor.
1000- Dr.Cabelles at bedside- x-ray for continued shoulder pain acknowledged and repeat labs.

1100- BLE restraints removed- patient cooperative no attempts to kick staff. Dr.Caballes notified.

1200- Behavioral restraints d/c'd from BUE- patient cooperative. Injury prevention soft restraints initiated BUE r/t patient confusion per order.

1215- Shoulder X-ray read- Dr.Cabelles notifed of results, ortho consult ordered.

1530-Patient transported to CT scan for shoulder scan per ortho order by RN and transport. Results received hmg 7.0 down from 13.7- repeat labs orders to verify results, type and screen collected, patient transported to CT for abd/pelvis r/t bruising and tenderness of left flank.

1600- CT negative- repeat H+H stable at 11.6/34.0

Initialized on 09/19/18 19:54 - END OF NOTE

09/19/18 19:36 Nursing Note by Frank,Rosika
At 1800 pt is alert and oriented x4, not drowsy. Able to state that she was in a Denny's and "some guys pretending to be police officers got into a fight with me". Able to converse, follow commands, however appears paranoid and distrustful of authority figures. At 1800 Dr. Blake came to bedside to consent patient to have her shoulder reduced, however pt now states that she does not want surgery. This writer attempted to ask patient about her concerns about the procedure and evaluate patient's knowledge of her injury. Pt shushed the writer multiple times, stated "I don't want to know anything about the operation or procedure, I don't want it." Patient also stated that "I just want dinner. That doctor is keeping food from me, she is starving me, and I don't want surgery." Pt refused explanation by this writer for NPO status. This writer communicated with Dr. Blake, Dr. Blake explained that this is a serious risk to the neurovasculature of the arm from not having the arm reduced. This writer involved anesthesia, supervisor, and charge nurses to convey concerns that while this patient is oriented, she has questionable capacity to understand her injury & the risk of further injury from refusing treatment. At this time, dual physicians are consenting for procedure based on medical necessity, anesthesia at bedside, plan to take pt to OR to have shoulder reduced.

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Initialized on 09/19/18 19:36 - END OF NOTE

09/19/18 07:50 (created 09/19/18 08:07) ED Nursing Note by Smith,Nathan
admitting provider is at bedside.

Initialized on 09/19/18 08:07 - END OF NOTE

09/19/18 07:30 (created 09/19/18 07:54) ED Nursing Note by Smith,Nathan
pt remains in 4 point soft restraints for pt and staff safety. pt had been medicated for agitation and aggressive behavior and continues to intermittently attempt to reach for the PIV and/or move to the edges of the bed. Sitter remains at bedside.

Initialized on 09/19/18 07:54 - END OF NOTE

09/19/18 07:24 ED Nursing Note by Stelick,Thomas
Straight cath ordered, ~400ml clear yellow urine removed. Report given to oncoming nurse.

Initialized on 09/19/18 07:24 - END OF NOTE

09/19/18 06:37 ED Nursing Note by Stelick,Thomas
pt to ct

Initialized on 09/19/18 06:37 - END OF NOTE

09/19/18 06:32 ED Nursing Note by Stelick,Thomas
Pt became agitated, yelling, screaming, thrashing about in bed. Security called. Medication ordered by Dr. Hinkley. Pt calmed after med administration, continuing to pull against restraints. Constant observation continuing. 4 point soft restraints in place.

Initialized on 09/19/18 06:32 - END OF NOTE

09/19/18 05:50 ED Nursing Note by Stelick,Thomas
Pt arrived via ambulance with police present. Pt taken to ED rm 10, security present. Pt complaining of jaw and arm pain, did not specify which arm. Dr. Hinkley in room. Pt having flight of ideas, appears to be responding to internal stimuli, using some unintelligible words, combative, yelling at staff, not following directions. Unable to perform full assessment due to combative and uncooperative nature. Ketamine ordered by Dr. Hinkley. After administration of ketamine, pt became less combative. Police removed handcuffs and 4 point soft restraints applied. Pt placed on cardiac monitor. Constant observation ordered, safety monitor sitting in room. Iv line established and labs drawn.

Continued on Page 13

Initialized on 09/19/18 05:50 - END OF NOTE

Orders

09/19/18
Social Worker Consult Routine
Comment: UTA patient's living status/needs
Physician Instructions:
FLUOROSCOPY<1 HOUR - OR [XA] Routine
Mode Of Transportation: Bed
Reason For Exam: CLOSED REDUCTION LEFT SHOULDER
PQRS Data Required: PQRS Data Required

09/19/18 03:23
Acetaminophen [CHEM] Stat
Comment:
Department: THO0010
Specimen: Send someone from the department to collect
Alcohol [CHEM] Stat
Comment:
Department: THO0010
Specimen: Send someone from the department to collect
Comprehensive Metabolic Panel [CHEM] Stat
Comment:
Department: THO0010
Specimen: Send someone from the department to collect
Creatine Kinase [CHEM] Stat
Comment:
Department: THO0010
Specimen: Send someone from the department to collect
Lithium [CHEM] Stat
Department: THO0010
Specimen: Send someone from the department to collect
Salicylate [CHEM] Stat
Comment:
Department: THO0010
Specimen: Send someone from the department to collect
TSH (Thyroid Stimulating Horm) [CHEM] Stat
Comment:
Department: THO0010
Specimen: Send someone from the department to collect

09/19/18 04:51
Ketamine HCL* 500 mg .ROUTE .STK-MED ONE

09/19/18 04:55
12 Lead EKG Stat

Continued on Page 14

Reason for EKG (Preop/Surgery NA): MHE
Mental Health Gown ONCE
Observation: Constant (Visual) QSHIFT
Physician Instructions:
Straight Catheterization ONCE
Physician Instructions: for UA specimen if unable to void in 1hr
Restraint: Behavior Mgmt > 17 Q1HR
Restraint Order Status: Initiation
Restraint Reason: Harmful to Others
Type of Restraint: Soft Wrist Bilateral
Soft Ankle Bilateral
Duration of Restraint (Hours):: 1
Stop Date/Time for Restraints: 09/19/18 05:55

09/19/18 04:56
Ketamine HCL* 300 mg IM ONCE ONE
Restraint: Initiation ONCE

09/19/18 04:57
CT BRAIN WO [CT] Stat
Comment:
Is Patient Pregnant:
Mode Of Transportation: Bed
Physician Instructions:
Reason For Exam: head injury
Treat with highest level priority (Code situation, ABC, etc): No
CT MAXILLOFACIAL W/O [CT] Stat
Comment:
Is Patient Pregnant:
Mode Of Transportation: Bed
Physician Instructions:
Reason For Exam: jaw deformity
Treat with highest level priority (Code situation, ABC, etc): No
CT SPINE CERVICAL W/O [CT] Stat
Comment:
Is Patient Pregnant:
Mode Of Transportation: Bed
Physician Instructions:
Reason For Exam: head/face injury
Treat with highest level priority (Code situation, ABC, etc): No
Tetan/Diph/Pertus SYR(Tdap)* [Boostrix SYR*] 0.5 ml IM .ONCE ONE

09/19/18 05:23
CBC Auto Diff Stat
Comment:
Department: THO0010
Specimen: Send someone from the department to collect

09/19/18 05:47
Ziprasidone IM INJ* [Geodon IM INJ*] 20 mg IM ED ONCE ONE

09/19/18 05:51

Continued on Page 15

LORazepam INJ* [Ativan INJ*] 2 mg IM ED ONCE ONE

09/19/18 06:09
LORazepam INJ* [Ativan INJ*] 2 mg IV PUSH ED ONCE ONE

09/19/18 06:13
CHEST AP PORTABLE [DX] Stat
Comment:
Is Patient Pregnant: No
Physician Instructions:
Reason For Exam: injury, psych
Treat with highest level priority (Code situation, ABC, etc): No
Type of Isolation: Standard Precautions

09/19/18 06:14
Ns 0.9% 1000 ml* 1,000 ml IV ED ONCE

09/19/18 07:03
Drug Screen UR ED/Pain Clinic Stat
Comment:
Department: THO0010
Specimen: Send someone from the department to collect
Urinalysis w/Refl Micro/Cult Stat
Department: THO0010
Specimen: Send someone from the department to collect

09/19/18 08:19
MRSA NasalSwab if Criteria Met ONCE
Telemetry Monitor Notification .PRN
Telemetry Monitor: Continuous Q8HR
Comment:
Physician Instructions:

09/19/18 08:20
May Go to Tests off Telemetry .PRN
Physician Instructions:

09/19/18 08:21
Observation: 1:1 (Arms-length) QSHIFT
Physician Instructions:

09/19/18 08:22
Haloperidol INJ IV/IM* [Haldol INJ IV/IM*] 5 mg IV SLOW PU Q2H PRN

09/19/18 08:26
LORazepam INJ* [Ativan INJ*] 2 mg IV PUSH Q4H PRN

09/19/18 08:29
HYDROmorphone INJ1* [Dilaudid INJ1S*] 0.5 mg IV SLOW PU Q6H PRN

09/19/18 08:31
Consult to Provider Routine

Continued on Page 16

Consulting Provider: Ruparelia,Ashu
Was Consulting Physician Contacted?: Yes
Reason For Consult:: Courtesy of Dr. Conner; fracture of left nasal bone
Warning: For Psych consults, please use the CMC PSYCHIATRIST provider group!

09/19/18 08:34
Consult to Provider Routine
Consulting Provider: CMC PSYCHIATRIST
Was Consulting Physician Contacted?: Yes
Reason For Consult:: Left message with Dr. Ehmke's voicemail. 62 male-to-female transgender with hx of unspecified psychotic d/o either due to bipolar or schizoaffective d/o was very argumentative and confrontational with flight of ideas with police officer. Got punched by police and presented to ED, with psychosis and was sedated. Found to have mild rhabdomyolysis, mild nasal fx, and mildly displaced 9th rib fx. Pt is still currently delusional and refuses any medications and/or further evaluations despite explanation and data provided that suggests otherwise.
Warning: For Psych consults, please use the CMC PSYCHIATRIST provider group!

09/19/18 08:45
Ns 0.9% 1000 ml* 1,000 ml IV PER RATE

09/19/18 08:56
Restraint: Behav Mgmt SafetyCk Q15MIN

09/19/18 08:57
SCD [Sequential Compression Device] QSHIFT
Physician Instructions:

09/19/18 09:00
OLANzapine TAB*ODT* [ZyPREXA *ODT*] 10 mg PO DAILY

09/19/18 11:06
SHOULDER LEFT 2+ VWS [DX] Stat
Comment:
Is Patient Pregnant: No
Mode Of Transportation: Bed
Physician Instructions: Please evaluate for dislocation/fracture
Reason For Exam: Pt psychotic and violent; unable to fully examine
Treat with highest level priority (Code situation, ABC, etc): No
Type of Isolation: Standard Precautions

09/19/18 11:28
Point of Care Glucose Routine
Department: INFCE

09/19/18 11:30
Fingerstick Monitoring [Blood Glucose Monitoring POC] ONCE
Comment:

09/19/18 12:02

Continued on Page 17

Restraint: Injury Prevention Q2HR
Restraint Order Status: Initiation
Restraint Reason: Agitated
Purpose for Restraint: Injury Prevention
Type of Restraint: Soft Wrist Bilateral
Duration of Restraint (Hours):: 24
Stop Date/Time for Restraints: 09/20/18 12:02

09/19/18 12:03
Restraint: Initiation ONCE
Restraint: Inj Prev Safety Ck Q30MIN

09/19/18 14:58
CT EXTREMITY UPPER LEFT WO [CT] Stat
Comment:
Is Patient Pregnant: No
Mode Of Transportation: Bed
Physician Instructions:
Reason For Exam: fx-dislocation
Treat with highest level priority (Code situation, ABC, etc): No
Type of Isolation: Standard Precautions

09/19/18 15:03
CBC Auto Diff Routine
Comment:
Department: GRE0012
Specimen: Has been collected
CPK [Creatine Kinase] [CHEM] Routine
Comment:
Department: GRE0012
Specimen: Has been collected

09/19/18 15:54
CT ABD/PEL W [CT] Stat
Comment:
Is Patient Pregnant: No
Mode Of Transportation: Bed
Physician Instructions: Please evaluate for internal bleed
Reason For Exam: Sudden drop in H&H. Please evaluate for internal
Treat with highest level priority (Code situation, ABC, etc): No
Type of Isolation: Standard Precautions
Peripheral IV Insertion Date: 09/19/18
Peripheral IV Gauge: 20

09/19/18 16:05
ABO/RH TYPE Confirmation Stat
BBK Wristband Number:
Department: ORB0002
Type and Screen Stat
Comment:
Department: ORB0002
Specimen: Has been collected

Continued on Page 18

Was the patient pregnant or transfused in the last 90 days?: No
CBC Auto Diff Stat
Comment:
Department: ORB0002
Specimen: Has been collected

09/19/18 16:23
Iohexol 300* (CONTRAST) [Omnipaque 300* (CONTRAST)] 100 ml IV ONCE ONE

09/19/18 17:48
Foley Catheter [Foley Catheter with Urometer] .ONCE
Comment:
Physician Instructions:

09/19/18 17:49
Safety Monitor .PRN
Physician Instructions:

09/19/18 18:20
Midazolam* [Versed 2mg/2ml*] 2 mg .ROUTE .STK-MED ONE
fentaNYL* 100 mcg .ROUTE .STK-MED ONE

09/19/18 18:26
Admit Routine
Comment:
Admit To (Status): Inpatient
Diagnosis:: SI
Admit to Service: Medical
Admission Location: 4 South - Medical/Tele
Estimated Length of Stay: 4-5
Certification Statement: I certify that the inpatient services were ordered in accordance with Medicare regulations governing the order. This includes certification that hospital inpatient services are reasonable and necessary and, in the case of services not specified as inpatient-only under 42 CFR 419.229(n), that they are appropriately provided as inpatient services in accordance with the 2-midnight benchmark under 43 CFR 412.3(e).
Hx VTE: No
VTE - Note: ~~ Use approximate date/time if exact is unknown ~~
Telemetry Monitoring: Yes
May Go to Tests Off Telemetry: Yes
ICU Priority Details: Priority One: Unstable - In need of intensive treatment and monitoring that can not be provided outside of the ICU.
Priority Two: Requires intensive monitoring with a potential need for intervention.
Priority Three: Unstable and critically ill with a reduced likelihood of recovery due to nature of the disease or acute illness.
Priority Four: Exception to above criteria, please document why in comment.
Admission to Intensivist Service: Requires call to Intensivist.
Anticipated Post Hospital Care Needs: See Discharge Plan Notes

09/19/18 20:06

Continued on Page 19

Propofol* [Diprivan*] 400 mg IV PUSH .STK-MED ONE

09/19/18 20:26
Blood Glucose Monitoring POC ONCE
Comment: on all insulin dependent diabetics
Intructions: Glucose Monitoring: Call Anesthesiologist if blood glucose is outside of the range 60-200mg/dL.
Acetaminophen TAB* [Tylenol TAB*] 650 mg PO ONCE PRN
DiMENhydriNATE IV* [DraMAMine IV*] 25 mg IV PUSH ONCE PRN
HYDROcodone/ACETAMIN 5-325 MG* [Norco 5-325 TAB*] 2 tab PO ONCE PRN
Morphine Inj ((Syringe))* 2 mg IV Q10M PRN
Naloxone* [Narcan*] 0.08 mg IV Q2M PRN
Ondansetron INJ* [Zofran INJ*] 4 mg IV ONCE PRN
fentaNYL* 25 mcg IV Q2M PRN
Active Warming to: .PRN
Physician Instructions: for all patients with temp less than 36 degrees C
NSG: Oxygen Q8HR
PACU: Routine Monitoring .PER PROTOCOL
Physician Instructions:
Phase1:Disch When Criteria Met .ONCE
Physician Instructions:
Phase2:Disch When Criteria Met .ONCE
Physician Instructions:
SS Surg Services Only: Oxygen .in PACU
Comment:
Physician Instructions: 4L/M NC PRN for SpO2 < 98% in PACU
*RT: Oxygen .QSHIFT(NO PROT)
Oxygen Therapy Order: O2 At Designated LPM/FIO2
Oxygen Delivery Method: Nasal Cannula
O2 Flow Rate/FIO2: 4
Physician Instructions: Overnight

09/19/18 21:11
Restraint: Injury Prevention Q2HR
Restraint Order Status: Initiation
Restraint Reason: Dislodging Medical Device
Purpose for Restraint: Injury Prevention
Type of Restraint: Soft Wrist Right
Duration of Restraint (Hours):: 12
Stop Date/Time for Restraints: 09/20/18 09:11

09/19/18 21:28
Restraint: Initiation ONCE
Restraint: Inj Prev Safety Ck Q30MIN

09/19/18 23:30
Ns 0.9% 1000 ml* 1,000 ml IV PER RATE

09/19/18 Dinner
NPO Except Meds with Sips of H2O
Comment:
Physician Instructions:

Continued on Page 20

Nutrition Warning Controller: N

09/20/18 09:06
Transfer Routine
Transfer From: INTENSIVE CARE UNIT
Transfer To: 4 SOUTH - MEDICAL/TELEMETRY
Transfer Time: 09:06

09/20/18 09:13
SHOULDER LEFT 2+ VWS [DX] Routine
Comment:
Is Patient Pregnant: No
Mode Of Transportation: Portable
Physician Instructions:
Reason For Exam: s/p closed red left shoulder dislocation
Treat with highest level priority (Code situation, ABC, etc): No
Type of Isolation: Standard Precautions

09/20/18 16:16
OOB [Out of Bed to Chair Activity] Routine
Comment:
Physician Instructions: with assist by staff with safety sitter in room

09/20/18 17:19
hydrALAZINE IV* [Apresoline IV*] 10 mg IV SLOW PU Q6H PRN

09/20/18 Breakfast
Regular Unrestricted Diet
Comment:
Physician Instructions:
Nutrition Warning Controller: N

09/21/18 06:00
CBC Auto Diff Routine
Comment:
Department: ERI0089
Specimen: Send someone from the department to collect
Comprehensive Metabolic Panel [CHEM] Routine
Comment:
Department: ERI0089
Specimen: Send someone from the department to collect
Magnesium [CHEM] Routine
Comment:
Department: ERI0089
Specimen: Send someone from the department to collect
Phosphorus [CHEM] Routine
Comment:
Department: ERI0089
Specimen: Send someone from the department to collect

09/21/18 11:00
Levofloxacin TAB* [Levaquin TAB*] 500 mg PO Q24H

Continued on Page 21

09/21/18 12:19
PT [Physical Therapy] Routine
Comment:
Physician Instructions: ROM due to fx per Ortho; sling as needed

09/21/18 12:20
OT [Occupational Therapy] Routine
Comment:
Physician Instructions: ROM due to fx per Ortho; sling as needed

09/21/18 12:30
oxyCODONE/Acetamin 5/325 MG* [Percocet 5/325 TAB*] 1 tab PO Q6H PRN

09/21/18 12:31
Incentive Spirometry Education ONCE
Comment:
Physician Instructions:
Incentive Spirometry Education ONCE
Comment:
Physician Instructions:
NSG: Incentive Spirometry .10XHR
Physician Instructions:

09/21/18 14:00
amLODIPine TAB* [Norvasc TAB*] 10 mg PO DAILY

09/21/18 21:00
Acetaminophen TAB* [Tylenol TAB*] 975 mg PO BID
Metoprolol Tartrate TAB* [Lopressor TAB*] 25 mg PO BID

09/22/18 10:42
Discontinue Telemetry .ONCE
Comment:
Physician Instructions:

09/22/18 11:59
MD [Provider To Nurse Communicatio] .ONCE
Provider to Nurse Communication: Patient ok to have no IV access.

09/23/18 07:25
Message to Nutrition & Dining [C.DIETMESS] Routine
Diet Message: Please bring up 2 chocolate milks for breakfast please, thank you!
Call Back Number for Questions: 3820

09/24/18
admission [Admit] Routine
Comment:
Admit To (Status): Inpatient
Diagnosis:: unspecified psychosis
Admit to Service: Behav Svcs Unit - Adult
Admission Location: Behavioral Services Unit

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center   Loc:4 SOUTH - MEDICAL/TELEMETRY   Bed:436-01
62 F 05/01/1956   Med Rec Num:M000597460   Visit:A00088518428
Orders - Continued

Estimated Length of Stay: 5-7 days
Certification Statement: I certify that the inpatient services were ordered in accordance with Medicare regulations governing the order. This includes certification that hospital inpatient services are reasonable and necessary and, in the case of services not specified as inpatient-only under 42 CFR 419.229(n), that they are appropriately provided as inpatient services in accordance with the 2-midnight benchmark under 43 CFR 412.3(e).
VTE - Note: ~~ Use approximate date/time if exact is unknown ~~
ICU Priority Details: Priority One: Unstable - In need of intensive treatment and monitoring that can not be provided outside of the ICU.
Priority Two: Requires intensive monitoring with a potential need for intervention.
Priority Three: Unstable and critically ill with a reduced likelihood of recovery due to nature of the disease or acute illness.
Priority Four: Exception to above criteria, please document why in comment.
Admission to Intensivist Service: Requires call to Intensivist.
Legal Status: 9.39 Involuntary
Anticipated Post Hospital Care Needs: See Discharge Plan Notes

09/24/18 05:42
CBC No Diff Routine
Comment:
Department: ERI0089
Specimen: Send someone from the department to collect

09/24/18 05:46
Comprehensive Metabolic Panel [CHEM] Routine
Comment:
Department: ERI0089
Specimen: Send someone from the department to collect
Magnesium [CHEM] Routine
Comment:
Department: ERI0089
Specimen: Send someone from the department to collect
Phosphorus [CHEM] Routine
Comment:
Department: ERI0089
Specimen: Send someone from the department to collect

09/24/18 10:30
Magnesium Oxide TAB* [MagOx 400 TAB*]   800 mg PO ONCE STA

09/24/18 11:00
Magnesium Sulfate IV* 3 gm   Ns 0.9% 100 ml* 100 ml IVPB ONCE

09/24/18 13:25
Discharge Routine
Comment:
Anticipated time of Discharge: Now
Discharge Disposition:: PSYCHIATRIC FACILITY-CMC

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center Loc:4 SOUTH - MEDICAL/TELEMETRY Bed:436-01
62 F 05/01/1956 Med Rec Num:M000597460 Visit:A00088518428

Orders - Continued

09/24/18 18:12
Discharge Patient From System Routine
Comment:
Actual Time of Discharge:: 18:11
Discharge Disposition: PSYCHIATRIC FACILITY-CMC

10/03/18 18:27
MRSA NasalSwab if Criteria Met ONCE
May Go to Tests off Telemetry .PRN
Physician Instructions:
Telemetry Monitor Notification .PRN
Telemetry Monitor: Continuous Q8HR
Comment:
Physician Instructions:
Clinical Screening Routine
Cervical Smear Status: Smear not Indicated
Breast Exam Status: Exam not Indicated
Sickle-Cell Screening Status: Screening Not Indicated

Laboratory Information

	09/19/18 03:23	09/19/18 05:23	09/19/18 06:44
WBC		28.8 H	
RBC		4.46	
Hgb		13.7	
Hct		42	
MCV		93	
MCH		31	
MCHC		33	
RDW		14	
Plt Count		324	
MPV		8.2	
Neut % (Auto)		80.9	
Lymph % (Auto)		12.2 L	
Mono % (Auto)		5.0	
Eos % (Auto)		0.9	
Baso % (Auto)		1.0	
Absolute Neuts (auto)		23.3 H	
Absolute Lymphs (auto)		3.5	
Absolute Monos (auto)		1.4 H	
Absolute Eos (auto)		0.3	
Absolute Basos (auto)		0.3 H	
Absolute Nucleated RBC		0	
Nucleated RBC %		0	

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Laboratory Information - Continued

Sodium	136		
Potassium	TNP		3.9
Chloride	107		
Carbon Dioxide	20 L		
Anion Gap	9		
BUN	21		
Creatinine	0.87		
Est GFR (African Amer)	79.8		
Est GFR (Non-Af Amer)	66.0		
BUN/Creatinine Ratio	24.1 H		
Glucose	212 H		
POC Glucose (mg/dL)			
Calcium	8.9		
Phosphorus			
Magnesium			
Total Bilirubin	0.30		
AST	TNP		33
ALT	27		
Alkaline Phosphatase	116 H		
Total Creatine Kinase	867 H		
Total Protein	6.8		
Albumin	4.1		
Globulin	2.7		
Albumin/Globulin Ratio	1.5		
TSH	1.86		
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			
Lithium	< 0.10 L		
Urine Cocaine Screen			
U Cannabinoids Screen			
Serum Alcohol	< 10		
Blood Type			
Antibody Screen			

Continued on Page 25
LEGAL RECORD COPY - DO NOT DESTROY

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Laboratory Information - Continued

	09/19/18 07:03	09/19/18 07:03	09/19/18 11:28
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			
Potassium			
Chloride			
Carbon Dioxide			
Anion Gap			
BUN			
Creatinine			
Est GFR (African Amer)			
Est GFR (Non-Af Amer)			
BUN/Creatinine Ratio			
Glucose			
POC Glucose (mg/dL)			134 H
Calcium			
Phosphorus			
Magnesium			
Total Bilirubin			
AST			
ALT			
Alkaline Phosphatase			
Total Creatine Kinase			
Total Protein			
Albumin			
Globulin			
Albumin/Globulin Ratio			
TSH			
Urine Color	Yellow		

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center Loc:4 SOUTH - MEDICAL/TELEMETRY Bed:436-01
62 F 05/01/1956 Med Rec Num:M000597460 Visit:A00088518428

Laboratory Information - Continued

Urine Appearance	Clear		
Urine pH	5.0		
Ur Specific Gravity	1.026		
Urine Protein	Negative		
Urine Ketones	Negative		
Urine Blood	Negative		
Urine Nitrate	Negative		
Urine Bilirubin	Negative		
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	
Lithium			
Urine Cocaine Screen		None detected	
U Cannabinoids Screen		Presumptive positive A	
Serum Alcohol			
Blood Type			
Antibody Screen			

	09/19/18 15:03	09/19/18 15:03	09/19/18 16:05
WBC	7.7		13.5 H
RBC	2.17 L		3.72 L
Hgb	7.0 L		11.6 L
Hct	20 L		34 L
MCV	94		92
MCH	32 H		31
MCHC	35		34
RDW	14		14
Plt Count	131 L		245
MPV	7.8		7.6
Neut % (Auto)	74.6		74.8
Lymph % (Auto)	14.9 L		14.6 L
Mono % (Auto)	10.2 H		9.7 H
Eos % (Auto)	0.1		0.3
Baso % (Auto)	0.2		0.6
Absolute Neuts (auto)	5.7		10.1 H
Absolute Lymphs (auto)	1.1		2.0
Absolute Monos (auto)	0.8		1.3 H
Absolute Eos (auto)	0		0
Absolute Basos (auto)	0		0.1
Absolute Nucleated RBC	0.1		0
Nucleated RBC %	1.3		0.1
Sodium			

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BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01

62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Laboratory Information - Continued

Potassium			
Chloride			
Carbon Dioxide			
Anion Gap			
BUN			
Creatinine			
Est GFR (African Amer)			
Est GFR (Non-Af Amer)			
BUN/Creatinine Ratio			
Glucose			
POC Glucose (mg/dL)			
Calcium			
Phosphorus			
Magnesium			
Total Bilirubin			
AST			
ALT			
Alkaline Phosphatase			
Total Creatine Kinase		979 H	
Total Protein			
Albumin			
Globulin			
Albumin/Globulin Ratio			
TSH			
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			
Urine Opiates Screen			
Acetaminophen			
Ur Barbiturates Screen			
Ur Phencyclidine Scrn			
Ur Amphetamines Screen			
U Benzodiazepines Scrn			
Lithium			
Urine Cocaine Screen			
U Cannabinoids Screen			
Serum Alcohol			
Blood Type			
Antibody Screen			

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center   Loc: 4 SOUTH - MEDICAL/TELEMETRY   Bed: 436-01
62 F 05/01/1956   Med Rec Num: M000597460   Visit: A00088518428

Laboratory Information - Continued

	09/19/18 16:05	09/22/18 04:56	09/22/18 04:56
WBC		13.0 H	
RBC		3.94 L	
Hgb		12.2	
Hct		36	
MCV		90	
MCH		31	
MCHC		34	
RDW		13	
Plt Count		281	
MPV		7.9	
Neut % (Auto)		75.9	
Lymph % (Auto)		14.1 L	
Mono % (Auto)		7.8 H	
Eos % (Auto)		1.7	
Baso % (Auto)		0.5	
Absolute Neuts (auto)		9.9 H	
Absolute Lymphs (auto)		1.8	
Absolute Monos (auto)		1.0 H	
Absolute Eos (auto)		0.2	
Absolute Basos (auto)		0.1	
Absolute Nucleated RBC		0	
Nucleated RBC %		0	
Sodium			135
Potassium			3.9
Chloride			103
Carbon Dioxide			27
Anion Gap			5
BUN			10
Creatinine			0.69
Est GFR (African Amer)			104.3
Est GFR (Non-Af Amer)			86.2
BUN/Creatinine Ratio			14.5
Glucose			123 H
POC Glucose (mg/dL)			
Calcium			8.9
Phosphorus			3.2
Magnesium			1.7 L
Total Bilirubin			0.60
AST			41 H
ALT			35
Alkaline Phosphatase			69
Total Creatine Kinase			
Total Protein			6.3 L
Albumin			3.3
Globulin			3.0
Albumin/Globulin Ratio			1.1
TSH			
Urine Color			

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center Loc:4 SOUTH - MEDICAL/TELEMETRY Bed:436-01
62 F 05/01/1956 Med Rec Num:M000597460 Visit:A00088518428

Laboratory Information - Continued

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			
Urine Opiates Screen			
Acetaminophen			
Ur Barbiturates Screen			
Ur Phencyclidine Scrn			
Ur Amphetamines Screen			
U Benzodiazepines Scrn			
Lithium			
Urine Cocaine Screen			
U Cannabinoids Screen			
Serum Alcohol			
Blood Type	O Negative		
Antibody Screen	Negative		

	09/24/18 05:42	09/24/18 05:46
WBC	15.3 H	
RBC	4.27	
Hgb	13.3	
Hct	39	
MCV	90	
MCH	31	
MCHC	35	
RDW	14	
Plt Count	397	
MPV	7.5	
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		135

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center Loc:4 SOUTH - MEDICAL/TELEMETRY Bed:436-01
62 F 05/01/1956 Med Rec Num:M000597460 Visit:A00088518428

Laboratory Information - Continued

Potassium		4.5
Chloride		101
Carbon Dioxide		27
Anion Gap		7
BUN		15
Creatinine		0.63
Est GFR (African Amer)		115.9
Est GFR (Non-Af Amer)		95.8
BUN/Creatinine Ratio		23.8 H
Glucose		113 H
POC Glucose (mg/dL)		
Calcium		9.0
Phosphorus		3.3
Magnesium		1.7 L
Total Bilirubin		0.70
AST		52 H
ALT		78 H
Alkaline Phosphatase		84
Total Creatine Kinase		
Total Protein		6.4
Albumin		3.4
Globulin		3.0
Albumin/Globulin Ratio		1.1
TSH		
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		
Urine Opiates Screen		
Acetaminophen		
Ur Barbiturates Screen		
Ur Phencyclidine Scrn		
Ur Amphetamines Screen		
U Benzodiazepines Scrn		
Lithium		
Urine Cocaine Screen		
U Cannabinoids Screen		
Serum Alcohol		
Blood Type		
Antibody Screen		

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LEGAL RECORD COPY - DO NOT DESTROY

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

ED Visit information

Last Name:	BLAYK	Status:	Rm Ready
First Name:	BONZE	Priority:	3 - Two or more resources
Middle:	ANNE ROSE	Condition:	Good
Birthdate:	05/01/1956	Arrival Date/Time:	09/19/18 04:28
Age:	62	Arrival Mode:	BANGS AMBULANCE
Sex:	F	Triaged At:	09/19/18 04:31
Language:	ENGLISH	Time Seen by Provider:	

Stated Complaint: ASSAULTED
Chief Complaint: EDFacialInjury

ED Location: Emergency Department
Area:
Station:
Group:
ED Provider: Hinkley,Kirk
ED Midlevel Provider:
ED Nurse:
Primary Care Provider: No Primary Care Phys,NOPCP
Other Provider: Ruparelia,Ashu; Mehdi,Askar; Duplan,Auguste; White,Clarence; Ehmke,Clifford; Dauria MD,Colin K; Gerson,Henry; Bezirganian,John; Rahman,Mahfuzur; Novick,Melanie; Mendola,Robert; Mustafa,Syed; Legg,Timothy; Cranston,Tracey; Cotton,Wayne

Status/Phase	DtTm/Value	User/Action
Pend Adm	09/19/18 08:33:02	Feocco,Jacqueline
Attending Provider	Frederick R Caballes MD	New
Admitting Provider	Frederick R Caballes MD	New
Received	09/19/18 04:55:46	Azari,Jade
Referrals (Provider)	No Primary Care Phys,NOPCP	Added
In Room	09/19/18 04:42:43	Azari,Jade
Ed Provider	Kirk Hinkley MD	New
Received	09/19/18 04:42	Stelick,Thomas
Chief Complaint	EDFacialInjury	New
	09/19/18 04:28:31	Truex,Jillian
Stated Complaint	ASSAULTED	New

Procedures

GROUP PSYCHOTHERAPY (09/24/18)
INDIVIDUAL PSYCHOTHERAPY, COGNITIVE-BEHAVIORAL (12/25/16)
OTHER LOCAL DESTRUC SKIN (02/09/94)
REPOSITION LEFT SHOULDER JOINT, EXTERNAL APPROACH (09/19/18)

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BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center   Loc:4 SOUTH - MEDICAL/TELEMETRY   Bed:436-01

62 F 05/01/1956   Med Rec Num:M000597460   Visit:A00088518428

Initial Vital Signs

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Initial Vital Signs - Continued

	Temp	Pulse	Resp	BP	Pulse Ox
09/24/18 15:50					96
09/24/18 15:32	99.1 F	95	12	155/92	96
09/24/18 11:51	97.5 F	90	19	153/94	98
09/24/18 08:21	98.9 F	94	20	166/96	98
09/23/18 19:08			16		
09/23/18 15:40	97.7 F	87	16		96
09/23/18 08:00			16		
09/22/18 20:00			18		
09/22/18 19:16	98.0 F	101	16		97
09/22/18 16:33				180/98	
09/22/18 15:20	98.3 F	89	16		96
09/22/18 11:18	98.9 F	84	20		97
09/22/18 09:33				180/110	
09/22/18 08:14	98.0 F	88	20		96
09/22/18 08:00			20		
09/22/18 05:16	99.7 F	87	18	180/100	95
09/21/18 20:37	98.0 F	95	12		97
09/21/18 19:30			12		
09/21/18 15:48	99.4 F	93	12	173/113	97
09/21/18 11:44		92	18	183/109	99
09/21/18 08:06	98.9 F	91	20		95
09/21/18 08:00			18		
09/21/18 04:00				164/88	
09/21/18 03:37	98.5 F	89	24		95
09/20/18 23:52	99.5 F	105	20		95
09/20/18 20:15	98.7 F	104	20	170/100	96
09/20/18 20:00			20		
09/20/18 17:17	98.6 F	116	20	191/124	96
09/20/18 16:34			18		
09/20/18 10:00	100.8 F				
09/20/18 08:57				167/107	
09/20/18 08:35		106			95
09/20/18 08:30		90			92
09/20/18 08:25		108			93
09/20/18 08:20		101			93
09/20/18 08:15		103			93
09/20/18 08:10		92			94
09/20/18 08:05		107			93
09/20/18 08:00		111			93
09/20/18 07:55		103	30		93
09/20/18 07:50		95	27		94
09/20/18 07:45		106	16		94
09/20/18 07:40		101	25		94
09/20/18 07:35		92	25		94
09/20/18 07:30		110	18		94
09/20/18 07:25		88	24		93
09/20/18 07:20		98	27		94
09/20/18 07:15		87	25		94
09/20/18 07:10		107	36		95
09/20/18 07:05		88	21		94

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center   Loc:4 SOUTH - MEDICAL/TELEMETRY   Bed:436-01
62 F 05/01/1956   Med Rec Num:M000597460   Visit:A00088518428

Initial Vital Signs - Continued

	09/20/18 07:00		101	34		95		
	09/20/18 06:55		96	26		93		
	09/20/18 06:50		102	35		90		
	09/20/18 06:45		103	23		95		
	09/20/18 06:40		109	15		95		
	09/20/18 06:35		105	19		93		
	09/20/18 06:30		104	23		94		
	09/20/18 06:25		90	28		94		
	09/20/18 06:20		104	43		94		
	09/20/18 06:15		109	34		91		
	09/20/18 06:10		108	24		97		
	09/20/18 06:05		106	14		96		
	09/20/18 06:00		99	24		94		
	09/20/18 05:55		90	21		96		
	09/20/18 05:50		108	16		95		
	09/20/18 05:45		96	28		95		
	09/20/18 05:40		89	24		93		
	09/20/18 05:35		105	23		94		
	09/20/18 05:34		107	22		95		
	09/20/18 05:25			24				
	09/20/18 05:20		101	31		95		
	09/20/18 05:15		110	31		96		
	09/20/18 05:10		106	45		95		
	09/20/18 05:05		116	27		95		
	09/20/18 05:01		123	37	100/76	94		
	09/20/18 05:00		106	27		94		
	09/20/18 04:57			18				
	09/20/18 04:55		97	28		94		
	09/20/18 04:50		108	21		95		
	09/20/18 04:45		93	27		94		
	09/20/18 04:40		108	32		93		
	09/20/18 04:35		105	31		94		
	09/20/18 04:30		109	18		95		
	09/20/18 04:25		96	27		95		
	09/20/18 04:20		108	26		93		
	09/20/18 04:15		105	22		95		
	09/20/18 04:10		96	34		94		
	09/20/18 04:05		100	32		94		
	09/20/18 04:01		88	25	161/94	94		
	09/20/18 04:00		95	31		96		
	09/20/18 03:55		94	31		94		
	09/20/18 03:50		100	31		94		
	09/20/18 03:45		88	23		93		
	09/20/18 03:40		96	31		94		
	09/20/18 03:35		99	25		93		
	09/20/18 03:30		94	28		94		
	09/20/18 03:25		110	26		94		
	09/20/18 03:20		106	19		97		
	09/20/18 03:15		87	23		94		
	09/20/18 03:10		91	22		94		
	09/20/18 03:05		87	21		97		
	09/20/18 03:00		86	23		96		

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LEGAL RECORD COPY - DO NOT DESTROY

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01

62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Initial Vital Signs - Continued

09/20/18 02:55		88	24		96	
09/20/18 02:50		106	21		96	
09/20/18 02:45		102	21		95	
09/20/18 02:40		89	22		95	
09/20/18 02:35		104	23		95	
09/20/18 02:31		106	22	160/102	96	
09/20/18 02:30		100	24		96	
09/20/18 02:25		94	21		96	
09/20/18 02:20		95	18		97	
09/20/18 02:15		84	23		95	
09/20/18 02:10		87	21		95	
09/20/18 02:08		106	31		94	
09/20/18 02:00		101	23		95	
09/20/18 01:57					96	
09/20/18 01:55		108	22		97	
09/20/18 01:53			23			
09/20/18 01:50		84	20		96	
09/20/18 01:45		89	23	167/102	96	
09/20/18 01:40		103	19		96	
09/20/18 01:35		89	22		95	
09/20/18 01:30		88	21		95	
09/20/18 01:25		99	25		95	
09/20/18 01:20		96	22		96	
09/20/18 01:15		104	30		95	
09/20/18 01:10		102	23		95	
09/20/18 01:05		97	28		96	
09/20/18 01:01		86	24	176/109	95	
09/20/18 01:00		100	24		95	
09/20/18 00:55		102	27		96	
09/20/18 00:50		101	17		98	
09/20/18 00:45		87	20		94	
09/20/18 00:40		88	25		94	
09/20/18 00:35		87	20		96	
09/20/18 00:30		85	21	178/105	96	
09/20/18 00:25		86	21		95	
09/20/18 00:20		88	21		96	
09/20/18 00:15		109	20		95	
09/20/18 00:10			29			
09/20/18 00:05			21			
09/20/18 00:00			26	150/101	95	
09/19/18 23:55			26			
09/19/18 23:50			25			
09/19/18 23:45			20			
09/19/18 23:40			20			
09/19/18 23:35			21			
09/19/18 23:30			26	163/105		
09/19/18 23:25			25			
09/19/18 23:20		109	28		91	
09/19/18 23:16			16			
09/19/18 23:15		95	16		96	
09/19/18 23:13		92	22		92	
09/19/18 23:10		85	23		96	

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LEGAL RECORD COPY - DO NOT DESTROY

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01

62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Initial Vital Signs - Continued

09/19/18 23:05		93	14		95
09/19/18 23:00		71	23	164/101	95
09/19/18 22:55		98	23		95
09/19/18 22:50		93	26		96
09/19/18 22:45		86	25	167/105	96
09/19/18 22:40		86	21		95
09/19/18 22:35		90	24		96
09/19/18 22:30		85	21	161/99	95
09/19/18 22:25		90	22		96
09/19/18 22:20		89	26		95
09/19/18 22:15		87	21	146/99	95
09/19/18 22:10		96	17		96
09/19/18 22:05		105	22		96
09/19/18 22:00		97	15		96
09/19/18 21:55		86	19		96
09/19/18 21:50		98	25		97
09/19/18 21:45		100	24		95
09/19/18 21:40		90	28		96
09/19/18 21:35		94	17		97
09/19/18 21:30		96	18		96
09/19/18 21:25		93	19		97
09/19/18 21:20		101	32		95
09/19/18 21:15		86	20	165/98	95
09/19/18 21:10		88	22		96
09/19/18 21:05		95	30		96
09/19/18 21:00		96	16	152/114	96
09/19/18 20:55		85	17		96
09/19/18 20:51		92	11		97
09/19/18 20:49		103		169/103	96
09/19/18 20:48		97			96
09/19/18 20:45			18		
09/19/18 20:40			18		
09/19/18 20:36		97	20	164/106	96
09/19/18 20:35		97	22		95
09/19/18 20:31		92	27	169/118	96
09/19/18 20:30		97	13	184/111	96
09/19/18 20:25		89		169/107	96
09/19/18 20:23		92			95
09/19/18 20:21		94		150/98	96
09/19/18 20:20		96		163/114	96
09/19/18 20:19	98.1 F	96	16	172/104	97
09/19/18 19:45	100.1 F				
09/19/18 19:40		108			95
09/19/18 19:35		113			96
09/19/18 19:30		112	20	154/105	97
09/19/18 19:25		91	23		96
09/19/18 19:20		90	21		96
09/19/18 19:15		99	18		96
09/19/18 19:10		92	29		96
09/19/18 19:05		98	15		96
09/19/18 19:00		88	19	126/89	96
09/19/18 18:55		88	21		95

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Initial Vital Signs - Continued

09/19/18 18:50		92	23		95	
09/19/18 18:45		87	23		96	
09/19/18 18:40		91	25		97	
09/19/18 18:35		88	22		96	
09/19/18 18:30		95	27	154/86	95	
09/19/18 18:25		93	28		95	
09/19/18 18:21		104	22	147/96	95	
09/19/18 18:20		102	30		96	
09/19/18 18:15		85	18		95	
09/19/18 18:10		89	23		95	
09/19/18 18:05		93	18		96	
09/19/18 18:00		100	23		96	
09/19/18 17:55		92	24		96	
09/19/18 17:50		94	21		96	
09/19/18 17:45		88	21		96	
09/19/18 17:40		89	17		95	
09/19/18 17:35		86	18		96	
09/19/18 17:30		92	24		96	
09/19/18 17:25		97	23		96	
09/19/18 17:20		102	27		95	
09/19/18 17:15		95	22		95	
09/19/18 17:10		94	22		96	
09/19/18 17:06		87			96	
09/19/18 17:00			22			
09/19/18 16:30			14			
09/19/18 16:25			16			
09/19/18 16:20		91	13		95	
09/19/18 16:15		92	23		95	
09/19/18 16:10		84	19		95	
09/19/18 16:08		81	18	129/88	95	
09/19/18 16:05		83	17		95	
09/19/18 16:00	99.9 F	91	28		95	
09/19/18 15:55		89	24		95	
09/19/18 15:50		93	19		95	
09/19/18 15:45		89	20		95	
09/19/18 15:40		91	27		95	
09/19/18 15:35		88	25		95	
09/19/18 15:34		80	10		96	
09/19/18 15:10		93	20		95	
09/19/18 15:05		84	16		95	
09/19/18 15:04		90	19	137/94	95	
09/19/18 15:00		86	23		95	
09/19/18 14:55		87	11		95	
09/19/18 14:50		100	17		96	
09/19/18 14:45		86	22		96	
09/19/18 14:40		97	22		96	
09/19/18 14:35		116	18		94	
09/19/18 14:30		79	18		94	
09/19/18 14:25		78	16		93	
09/19/18 14:20		79	16		93	
09/19/18 14:15		78	16		93	
09/19/18 14:10		78	16		93	

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LEGAL RECORD COPY - DO NOT DESTROY

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01

62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Initial Vital Signs - Continued

09/19/18 14:05		78	15		93
09/19/18 14:00		78	15	122/78	93
09/19/18 13:55		79	15		93
09/19/18 13:50		81	16		93
09/19/18 13:45		79	15		93
09/19/18 13:40		79	17		94
09/19/18 13:35		81	16		94
09/19/18 13:30		84	18		94
09/19/18 13:25		83	21		94
09/19/18 13:20		83	13		95
09/19/18 13:15		83	17		96
09/19/18 13:10		92	20		94
09/19/18 13:05		82	19		93
09/19/18 13:00		90	17	144/101	95
09/19/18 12:55		83	16		94
09/19/18 12:50		80	17		92
09/19/18 12:45		81	16		92
09/19/18 12:40		82	16		92
09/19/18 12:35		82	15		93
09/19/18 12:30		81	11		94
09/19/18 12:25		84	18		94
09/19/18 12:20		80	18		93
09/19/18 12:15		86	12		94
09/19/18 12:14			20		
09/19/18 12:10		98	12		94
09/19/18 12:05		76	22		97
09/19/18 12:00	98.5 F	88	14	147/104	96
09/19/18 11:55		80	19		95
09/19/18 11:50		75	19		95
09/19/18 11:45		78	24		96
09/19/18 11:40		83	18		95
09/19/18 11:35		95	15		95
09/19/18 11:30		83	26	143/95	95
09/19/18 11:25		81	18		96
09/19/18 11:20		88	31		94
09/19/18 11:15		85	22	149/95	94
09/19/18 11:10		89	18		94
09/19/18 11:05		87	24		95
09/19/18 11:00		80	16	151/91	95
09/19/18 10:55		81	6		94
09/19/18 10:50		79	22		95
09/19/18 10:45		80	9	144/89	95
09/19/18 10:40		81	9		94
09/19/18 10:35		93	28		93
09/19/18 10:31		90	21	141/115	92
09/19/18 10:30		95	20		94
09/19/18 10:25		90	23		94
09/19/18 10:20		76	18		94
09/19/18 10:15		104	18	130/88	95
09/19/18 10:10		77	20		94
09/19/18 10:05		77	20		95
09/19/18 10:00		78	14	147/98	95

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Initial Vital Signs - Continued

09/19/18 09:55		78	22		93
09/19/18 09:50		77	20		93
09/19/18 09:45		74	20	131/88	94
09/19/18 09:40		89	20		97
09/19/18 09:35		79	21		94
09/19/18 09:30		77	20	129/94	95
09/19/18 09:25		79	19		96
09/19/18 09:20		81	21		95
09/19/18 09:15		80	18	131/98	96
09/19/18 09:11		82	22	143/97	96
09/19/18 09:10		90	25		97
09/19/18 09:06		82	23		97
09/19/18 09:04		84	19	148/106	98
09/19/18 09:01		89			98
09/19/18 09:00			19		
09/19/18 08:50	98.3 F	82	22	148/78	96
09/19/18 08:45		81	23		98
09/19/18 08:40		78	21		98
09/19/18 08:39	97 F	83	22	146/78	96
09/19/18 08:35		76	24		99
09/19/18 08:32		79	27	146/78	94
09/19/18 08:30		78	23		99
09/19/18 08:25		79	23		98
09/19/18 08:20		76	23		99
09/19/18 08:15		75	23		99
09/19/18 08:10		76	23		98
09/19/18 08:01		74	24	139/75	100
09/19/18 08:00		76	27		96
09/19/18 07:31		81	29	114/74	94
09/19/18 07:30		83	27		96
09/19/18 07:05		77	28	94/65	94
09/19/18 07:03		77	32	79/60	96
09/19/18 07:00		80	33		96
09/19/18 06:41		75	32		96
09/19/18 06:13		83	26	133/80	98
09/19/18 06:09			26		
09/19/18 06:00		116	57		98
09/19/18 05:57		114	34	200/131	100
09/19/18 05:31		96	42		98
09/19/18 05:30		106	38	185/127	98
09/19/18 05:28		101	42	210/110	98
09/19/18 05:27		103	38	219/112	
09/19/18 05:25		113			98
09/19/18 04:39		117		176/113	96
09/19/18 04:31	96 F	116	22	176/113	98

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Last Documented Vital Signs

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center   Loc:4 SOUTH - MEDICAL/TELEMETRY   Bed:436-01
62 F 05/01/1956   Med Rec Num:M000597460   Visit:A00088518428

Last Documented Vital Signs - Continued

	Temp	Pulse	Resp	BP	Pulse Ox
09/24/18 15:50					96
09/24/18 15:32	99.1 F	95	12	155/92	96
09/24/18 11:51	97.5 F	90	19	153/94	98
09/24/18 08:21	98.9 F	94	20	166/96	98
09/23/18 19:08			16		
09/23/18 15:40	97.7 F	87	16		96
09/23/18 08:00			16		
09/22/18 20:00			18		
09/22/18 19:16	98.0 F	101	16		97
09/22/18 16:33				180/98	
09/22/18 15:20	98.3 F	89	16		96
09/22/18 11:18	98.9 F	84	20		97
09/22/18 09:33				180/110	
09/22/18 08:14	98.0 F	88	20		96
09/22/18 08:00			20		
09/22/18 05:16	99.7 F	87	18	180/100	95
09/21/18 20:37	98.0 F	95	12		97
09/21/18 19:30			12		
09/21/18 15:48	99.4 F	93	12	173/113	97
09/21/18 11:44		92	18	183/109	99
09/21/18 08:06	98.9 F	91	20		95
09/21/18 08:00			18		
09/21/18 04:00				164/88	
09/21/18 03:37	98.5 F	89	24		95
09/20/18 23:52	99.5 F	105	20		95
09/20/18 20:15	98.7 F	104	20	170/100	96
09/20/18 20:00			20		
09/20/18 17:17	98.6 F	116	20	191/124	96
09/20/18 16:34			18		
09/20/18 10:00	100.8 F				
09/20/18 08:57				167/107	
09/20/18 08:35		106			95
09/20/18 08:30		90			92
09/20/18 08:25		108			93
09/20/18 08:20		101			93
09/20/18 08:15		103			93
09/20/18 08:10		92			94
09/20/18 08:05		107			93
09/20/18 08:00		111			93
09/20/18 07:55		103	30		93
09/20/18 07:50		95	27		94
09/20/18 07:45		106	16		94
09/20/18 07:40		101	25		94
09/20/18 07:35		92	25		94
09/20/18 07:30		110	18		94
09/20/18 07:25		88	24		93
09/20/18 07:20		98	27		94
09/20/18 07:15		87	25		94
09/20/18 07:10		107	36		95
09/20/18 07:05		88	21		94

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BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01

62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Last Documented Vital Signs - Continued

	09/20/18 07:00		101	34		95	
	09/20/18 06:55		96	26		93	
	09/20/18 06:50		102	35		90	
	09/20/18 06:45		103	23		95	
	09/20/18 06:40		109	15		95	
	09/20/18 06:35		105	19		93	
	09/20/18 06:30		104	23		94	
	09/20/18 06:25		90	28		94	
	09/20/18 06:20		104	43		94	
	09/20/18 06:15		109	34		91	
	09/20/18 06:10		108	24		97	
	09/20/18 06:05		106	14		96	
	09/20/18 06:00		99	24		94	
	09/20/18 05:55		90	21		96	
	09/20/18 05:50		108	16		95	
	09/20/18 05:45		96	28		95	
	09/20/18 05:40		89	24		93	
	09/20/18 05:35		105	23		94	
	09/20/18 05:34		107	22		95	
	09/20/18 05:25			24			
	09/20/18 05:20		101	31		95	
	09/20/18 05:15		110	31		96	
	09/20/18 05:10		106	45		95	
	09/20/18 05:05		116	27		95	
	09/20/18 05:01		123	37	100/76	94	
	09/20/18 05:00		106	27		94	
	09/20/18 04:57			18			
	09/20/18 04:55		97	28		94	
	09/20/18 04:50		108	21		95	
	09/20/18 04:45		93	27		94	
	09/20/18 04:40		108	32		93	
	09/20/18 04:35		105	31		94	
	09/20/18 04:30		109	18		95	
	09/20/18 04:25		96	27		95	
	09/20/18 04:20		108	26		93	
	09/20/18 04:15		105	22		95	
	09/20/18 04:10		96	34		94	
	09/20/18 04:05		100	32		94	
	09/20/18 04:01		88	25	161/94	94	
	09/20/18 04:00		95	31		96	
	09/20/18 03:55		94	31		94	
	09/20/18 03:50		100	31		94	
	09/20/18 03:45		88	23		93	
	09/20/18 03:40		96	31		94	
	09/20/18 03:35		99	25		93	
	09/20/18 03:30		94	28		94	
	09/20/18 03:25		110	26		94	
	09/20/18 03:20		106	19		97	
	09/20/18 03:15		87	23		94	
	09/20/18 03:10		91	22		94	
	09/20/18 03:05		87	21		97	
	09/20/18 03:00		86	23		96	

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Last Documented Vital Signs - Continued

	09/20/18 02:55		88	24		96
	09/20/18 02:50		106	21		96
	09/20/18 02:45		102	21		95
	09/20/18 02:40		89	22		95
	09/20/18 02:35		104	23		95
	09/20/18 02:31		106	22	160/102	96
	09/20/18 02:30		100	24		96
	09/20/18 02:25		94	21		96
	09/20/18 02:20		95	18		97
	09/20/18 02:15		84	23		95
	09/20/18 02:10		87	21		95
	09/20/18 02:08		106	31		94
	09/20/18 02:00		101	23		95
	09/20/18 01:57					96
	09/20/18 01:55		108	22		97
	09/20/18 01:53			23		
	09/20/18 01:50		84	20		96
	09/20/18 01:45		89	23	167/102	96
	09/20/18 01:40		103	19		96
	09/20/18 01:35		89	22		95
	09/20/18 01:30		88	21		95
	09/20/18 01:25		99	25		95
	09/20/18 01:20		96	22		96
	09/20/18 01:15		104	30		95
	09/20/18 01:10		102	23		95
	09/20/18 01:05		97	28		96
	09/20/18 01:01		86	24	176/109	95
	09/20/18 01:00		100	24		95
	09/20/18 00:55		102	27		96
	09/20/18 00:50		101	17		98
	09/20/18 00:45		87	20		94
	09/20/18 00:40		88	25		94
	09/20/18 00:35		87	20		96
	09/20/18 00:30		85	21	178/105	96
	09/20/18 00:25		86	21		95
	09/20/18 00:20		88	21		96
	09/20/18 00:15		109	20		95
	09/20/18 00:10			29		
	09/20/18 00:05			21		
	09/20/18 00:00			26	150/101	95
	09/19/18 23:55			26		
	09/19/18 23:50			25		
	09/19/18 23:45			20		
	09/19/18 23:40			20		
	09/19/18 23:35			21		
	09/19/18 23:30			26	163/105	
	09/19/18 23:25			25		
	09/19/18 23:20		109	28		91
	09/19/18 23:16			16		
	09/19/18 23:15		95	16		96
	09/19/18 23:13		92	22		92
	09/19/18 23:10		85	23		96

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Last Documented Vital Signs - Continued

09/19/18 23:05		93	14		95
09/19/18 23:00		71	23	164/101	95
09/19/18 22:55		98	23		95
09/19/18 22:50		93	26		96
09/19/18 22:45		86	25	167/105	96
09/19/18 22:40		86	21		95
09/19/18 22:35		90	24		96
09/19/18 22:30		85	21	161/99	95
09/19/18 22:25		90	22		96
09/19/18 22:20		89	26		95
09/19/18 22:15		87	21	146/99	95
09/19/18 22:10		96	17		96
09/19/18 22:05		105	22		96
09/19/18 22:00		97	15		96
09/19/18 21:55		86	19		96
09/19/18 21:50		98	25		97
09/19/18 21:45		100	24		95
09/19/18 21:40		90	28		96
09/19/18 21:35		94	17		97
09/19/18 21:30		96	18		96
09/19/18 21:25		93	19		97
09/19/18 21:20		101	32		95
09/19/18 21:15		86	20	165/98	95
09/19/18 21:10		88	22		96
09/19/18 21:05		95	30		96
09/19/18 21:00		96	16	152/114	96
09/19/18 20:55		85	17		96
09/19/18 20:51		92	11		97
09/19/18 20:49		103		169/103	96
09/19/18 20:48		97			96
09/19/18 20:45			18		
09/19/18 20:40			18		
09/19/18 20:36		97	20	164/106	96
09/19/18 20:35		97	22		95
09/19/18 20:31		92	27	169/118	96
09/19/18 20:30		97	13	184/111	96
09/19/18 20:25		89		169/107	96
09/19/18 20:23		92			95
09/19/18 20:21		94		150/98	96
09/19/18 20:20		96		163/114	96
09/19/18 20:19	98.1 F	96	16	172/104	97
09/19/18 19:45	100.1 F				
09/19/18 19:40		108			95
09/19/18 19:35		113			96
09/19/18 19:30		112	20	154/105	97
09/19/18 19:25		91	23		96
09/19/18 19:20		90	21		96
09/19/18 19:15		99	18		96
09/19/18 19:10		92	29		96
09/19/18 19:05		98	15		96
09/19/18 19:00		88	19	126/89	96
09/19/18 18:55		88	21		95

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center Loc:4 SOUTH - MEDICAL/TELEMETRY Bed:436-01
62 F 05/01/1956 Med Rec Num:M000597460 Visit:A00088518428

Last Documented Vital Signs - Continued

	09/19/18 18:50		92	23		95	
	09/19/18 18:45		87	23		96	
	09/19/18 18:40		91	25		97	
	09/19/18 18:35		88	22		96	
	09/19/18 18:30		95	27	154/86	95	
	09/19/18 18:25		93	28		95	
	09/19/18 18:21		104	22	147/96	95	
	09/19/18 18:20		102	30		96	
	09/19/18 18:15		85	18		95	
	09/19/18 18:10		89	23		95	
	09/19/18 18:05		93	18		96	
	09/19/18 18:00		100	23		96	
	09/19/18 17:55		92	24		96	
	09/19/18 17:50		94	21		96	
	09/19/18 17:45		88	21		96	
	09/19/18 17:40		89	17		95	
	09/19/18 17:35		86	18		96	
	09/19/18 17:30		92	24		96	
	09/19/18 17:25		97	23		96	
	09/19/18 17:20		102	27		95	
	09/19/18 17:15		95	22		95	
	09/19/18 17:10		94	22		96	
	09/19/18 17:06		87			96	
	09/19/18 17:00			22			
	09/19/18 16:30			14			
	09/19/18 16:25			16			
	09/19/18 16:20		91	13		95	
	09/19/18 16:15		92	23		95	
	09/19/18 16:10		84	19		95	
	09/19/18 16:08		81	18	129/88	95	
	09/19/18 16:05		83	17		95	
	09/19/18 16:00	99.9 F	91	28		95	
	09/19/18 15:55		89	24		95	
	09/19/18 15:50		93	19		95	
	09/19/18 15:45		89	20		95	
	09/19/18 15:40		91	27		95	
	09/19/18 15:35		88	25		95	
	09/19/18 15:34		80	10		96	
	09/19/18 15:10		93	20		95	
	09/19/18 15:05		84	16		95	
	09/19/18 15:04		90	19	137/94	95	
	09/19/18 15:00		86	23		95	
	09/19/18 14:55		87	11		95	
	09/19/18 14:50		100	17		96	
	09/19/18 14:45		86	22		96	
	09/19/18 14:40		97	22		96	
	09/19/18 14:35		116	18		94	
	09/19/18 14:30		79	18		94	
	09/19/18 14:25		78	16		93	
	09/19/18 14:20		79	16		93	
	09/19/18 14:15		78	16		93	
	09/19/18 14:10		78	16		93	

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BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01

62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Last Documented Vital Signs - Continued

	09/19/18 14:05		78	15		93	
	09/19/18 14:00		78	15	122/78	93	
	09/19/18 13:55		79	15		93	
	09/19/18 13:50		81	16		93	
	09/19/18 13:45		79	15		93	
	09/19/18 13:40		79	17		94	
	09/19/18 13:35		81	16		94	
	09/19/18 13:30		84	18		94	
	09/19/18 13:25		83	21		94	
	09/19/18 13:20		83	13		95	
	09/19/18 13:15		83	17		96	
	09/19/18 13:10		92	20		94	
	09/19/18 13:05		82	19		93	
	09/19/18 13:00		90	17	144/101	95	
	09/19/18 12:55		83	16		94	
	09/19/18 12:50		80	17		92	
	09/19/18 12:45		81	16		92	
	09/19/18 12:40		82	16		92	
	09/19/18 12:35		82	15		93	
	09/19/18 12:30		81	11		94	
	09/19/18 12:25		84	18		94	
	09/19/18 12:20		80	18		93	
	09/19/18 12:15		86	12		94	
	09/19/18 12:14			20			
	09/19/18 12:10		98	12		94	
	09/19/18 12:05		76	22		97	
	09/19/18 12:00	98.5 F	88	14	147/104	96	
	09/19/18 11:55		80	19		95	
	09/19/18 11:50		75	19		95	
	09/19/18 11:45		78	24		96	
	09/19/18 11:40		83	18		95	
	09/19/18 11:35		95	15		95	
	09/19/18 11:30		83	26	143/95	95	
	09/19/18 11:25		81	18		96	
	09/19/18 11:20		88	31		94	
	09/19/18 11:15		85	22	149/95	94	
	09/19/18 11:10		89	18		94	
	09/19/18 11:05		87	24		95	
	09/19/18 11:00		80	16	151/91	95	
	09/19/18 10:55		81	6		94	
	09/19/18 10:50		79	22		95	
	09/19/18 10:45		80	9	144/89	95	
	09/19/18 10:40		81	9		94	
	09/19/18 10:35		93	28		93	
	09/19/18 10:31		90	21	141/115	92	
	09/19/18 10:30		95	20		94	
	09/19/18 10:25		90	23		94	
	09/19/18 10:20		76	18		94	
	09/19/18 10:15		104	18	130/88	95	
	09/19/18 10:10		77	20		94	
	09/19/18 10:05		77	20		95	
	09/19/18 10:00		78	14	147/98	95	

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BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01

62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Last Documented Vital Signs - Continued

09/19/18 09:55		78	22		93
09/19/18 09:50		77	20		93
09/19/18 09:45		74	20	131/88	94
09/19/18 09:40		89	20		97
09/19/18 09:35		79	21		94
09/19/18 09:30		77	20	129/94	95
09/19/18 09:25		79	19		96
09/19/18 09:20		81	21		95
09/19/18 09:15		80	18	131/98	96
09/19/18 09:11		82	22	143/97	96
09/19/18 09:10		90	25		97
09/19/18 09:06		82	23		97
09/19/18 09:04		84	19	148/106	98
09/19/18 09:01		89			98
09/19/18 09:00			19		
09/19/18 08:50	98.3 F	82	22	148/78	96
09/19/18 08:45		81	23		98
09/19/18 08:40		78	21		98
09/19/18 08:39	97 F	83	22	146/78	96
09/19/18 08:35		76	24		99
09/19/18 08:32		79	27	146/78	94
09/19/18 08:30		78	23		99
09/19/18 08:25		79	23		98
09/19/18 08:20		76	23		99
09/19/18 08:15		75	23		99
09/19/18 08:10		76	23		98
09/19/18 08:01		74	24	139/75	100
09/19/18 08:00		76	27		96
09/19/18 07:31		81	29	114/74	94
09/19/18 07:30		83	27		96
09/19/18 07:05		77	28	94/65	94
09/19/18 07:03		77	32	79/60	96
09/19/18 07:00		80	33		96
09/19/18 06:41		75	32		96
09/19/18 06:13		83	26	133/80	98
09/19/18 06:09			26		
09/19/18 06:00		116	57		98
09/19/18 05:57		114	34	200/131	100
09/19/18 05:31		96	42		98
09/19/18 05:30		106	38	185/127	98
09/19/18 05:28		101	42	210/110	98
09/19/18 05:27		103	38	219/112	
09/19/18 05:25		113			98
09/19/18 04:39		117		176/113	96
09/19/18 04:31	96 F	116	22	176/113	98

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments

4-Eyed Skin Assessment Start: 09/20/18 17:19
Freq: ONCE Status: Discharge
Protocol:
Document 09/20/18 17:19 CON0001 (Rec: 09/20/18 18:03 CON0001 TELE-M07)
Skin Assessment
Skin Assessment
4 Eye Skin Assessment Completed by Person #1 — Lehman,Briann
4 Eye Skin Assessment Completed by Person #2 — O'Hare,Connor
4 Eye Skin Result — Skin Intact Except for Deviations Noted Below
Skin Deviation
Skin Deviation-
bilateral inner eye
Skin Deviations — Bruise
Dressing Status — None
Drainage Amount — None
left flank
Skin Deviations — Bruise
Dressing Status — None
Drainage Amount — None
Nose
Skin Deviations — Bruise
Dressing Status — None
Drainage Amount — None
Forehead
Skin Deviations — Bruise
Dressing Status — None
Drainage Amount — None
left hip
Skin Deviations — Bruise
Dressing Status — None
Drainage Amount — None
Left Leg
Skin Deviations — Bruise
Dressing Status — None
Drainage Amount — None

ADLs: Activity Start: 09/19/18 08:47
Freq: Q4HR Status: Inactive
Protocol:
Document 09/19/18 12:00 KYL0009 (Rec: 09/19/18 12:48 KYL0009 ICU-C12)
Activity
Bed Rest
Bed Rest Ordered — No
Chair
Was Patient Up to Chair — No
Reason Patient Not Up to Chair — patient drowsy lethargic
Ambulation
Did Patient Ambulate — No
Ambulation Assistive Device — None

Continued on Page 49

Assessments and Treatments - Continued

```
Document     09/19/18 16:00  KYL0009  (Rec: 09/19/18 17:53  KYL0009  ICU-C12)
Activity
    Bed Rest
      Bed Rest Ordered                        No
    Chair
      Was Patient Up to Chair                 No
      Reason Patient Not Up to Chair          patient drowsy lethargic
    Ambulation
      Did Patient Ambulate                    No
      Ambulation Assistive Device             None
Not Done     09/19/18 20:00  KIM0006  (Rec: 09/19/18 22:36  KIM0006  ICU-C12)
    Patient Off Unit
Document     09/20/18 00:00  KIM0006  (Rec: 09/20/18 01:08  KIM0006  ICU-C12)
Activity
    Bed Rest
      Bed Rest Ordered                        No
Document     09/20/18 04:00  KIM0006  (Rec: 09/20/18 04:33  KIM0006  ICU-C12)
Activity
    Bed Rest
      Bed Rest Ordered                        No
Document     09/20/18 09:00  JOA0063  (Rec: 09/20/18 10:06  JOA0063  ICU-C25)
Activity
    Bed Rest
      Bed Rest Ordered                        No
    Chair
      Was Patient Up to Chair                 Yes
      Chair Transfer Assistance               Supervision
    Ambulation
      Did Patient Ambulate                    Yes
      Number of Feet Patient Ambulated this   15
       Shift
      Ambulation Assistive Device             None
      Ambulation Assistance                   Supervision
Document     09/20/18 12:00  JOA0063  (Rec: 09/20/18 15:46  JOA0063  ICU-C25)
Activity
    Bed Rest
      Bed Rest Ordered                        No
    Chair
      Was Patient Up to Chair                 Yes
      Chair Transfer Assistance               Supervision
Document     09/20/18 16:21  ANI0051  (Rec: 09/20/18 16:22  ANI0051  ICU-C25)
Activity
    Bed Rest
      Bed Rest Ordered                        No
```

```
ADLs: Activity                                       Start:  09/21/18 08:26
Freq:   DAILY@0600,1400,2200                         Status: Discharge
Protocol:
Document     09/21/18 14:00  SUE0004  (Rec: 09/21/18 14:37  SUE0004  TELE-C11)
Activity
    Bed Rest
      Bed Rest Ordered                        No
    Chair
      Was Patient Up to Chair                 No
```

Continued on Page 50

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

```
      Reason Patient Not Up to Chair          Pt confused
      Number of Times/Duration Up to Chair    0
       this Shift
      Chair Transfer Assistance               Supervision
    Ambulation
      Did Patient Ambulate                    Yes
      Number of Feet Patient Ambulated this   16
       Shift
      Ambulation Assistive Device             None
      Ambulation Assistance                   Supervision
Document     09/21/18 22:00  SAR0138  (Rec: 09/21/18 22:47  SAR0138  TELE-C11)
Activity
    Bed Rest
      Bed Rest Ordered                        No
    Chair
      Was Patient Up to Chair                 No
      Reason Patient Not Up to Chair          pt was resting in bed
    Ambulation
      Did Patient Ambulate                    Yes
      Number of Feet Patient Ambulated this   80
       Shift
      Ambulation Assistive Device             None
      Ambulation Assistance                   Supervision
Not Done     09/22/18 06:00  BOB0001  (Rec: 09/22/18 10:06  BOB0001  TELE-C11)
    Unable to Determine if Done
Document     09/22/18 14:00  BOB0001  (Rec: 09/22/18 15:15  BOB0001  TELE-C11)
Activity
    Bed Rest
      Bed Rest Ordered                        No
    Chair
      Was Patient Up to Chair                 Yes
      Number of Times/Duration Up to Chair    1
       this Shift
      Chair Transfer Assistance               Independent
                                              Supervision
    Ambulation
      Did Patient Ambulate                    Yes
      Number of Feet Patient Ambulated this   40
       Shift
      Ambulation Assistance                   Independent
Document     09/22/18 21:18  ELI0141  (Rec: 09/22/18 21:19  ELI0141  TELE-C01)
Activity
    Bed Rest
      Bed Rest Ordered                        No
    Chair
      Was Patient Up to Chair                 No
      Reason Patient Not Up to Chair          Pt. was resting in bed.
    Ambulation
      Did Patient Ambulate                    Yes
      Number of Feet Patient Ambulated this   60 feet
       Shift
      Ambulation Assistive Device             None
      Ambulation Assistance                   Supervision
```

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Document 09/23/18 06:00 FRA0018 (Rec: 09/23/18 07:44 FRA0018 TELE-C01)
Activity
- Bed Rest
  - Bed Rest Ordered: No
- Chair
  - Was Patient Up to Chair: No
  - Reason Patient Not Up to Chair: pt resting in bed
  - Chair Transfer Assistance: Independent; Contact Guard Assist
- Ambulation
  - Did Patient Ambulate: Yes
  - Number of Feet Patient Ambulated this Shift: 30
  - Ambulation Assistance: Contact Guard Assist

Document 09/23/18 14:00 BOB0001 (Rec: 09/23/18 14:56 BOB0001 TELE-C07)
Activity
- Bed Rest
  - Bed Rest Ordered: No
- Chair
  - Was Patient Up to Chair: No
  - Reason Patient Not Up to Chair: pt.wants rest in bed
  - Chair Transfer Assistance: Min Assist
- Ambulation
  - Did Patient Ambulate: No

Document 09/23/18 21:36 ELI0141 (Rec: 09/23/18 21:37 ELI0141 TELE-C01)
Activity
- Bed Rest
  - Bed Rest Ordered: No
- Chair
  - Was Patient Up to Chair: No
  - Reason Patient Not Up to Chair: Pt. was resting in bed.
- Ambulation
  - Did Patient Ambulate: No

Not Done 09/24/18 06:00 MAC0003 (Rec: 09/24/18 08:05 MAC0003 TELE-M12)
- Unable to Determine if Done

Document 09/24/18 12:59 MAC0003 (Rec: 09/24/18 12:59 MAC0003 TELE-M12)
Activity
- Bed Rest
  - Bed Rest Ordered: No

ADLs: Bathing Care Start: 09/19/18 08:47
Freq: 09 Status: Inactive
Protocol:

Document 09/19/18 09:00 KYL0009 (Rec: 09/19/18 09:40 KYL0009 ICU-M27)
Bathing Care
- Assistance
  - Assistance Required: Total
  - Bathing Completed: Bed Bath
  - Telemetry Lead Stickers Changed: Yes
  - Oral Care Completed: Oral Cavity Moisturizer; Suction Toothbrush
  - Peri Care Completed: Yes
  - Back Care Completed: Yes
  - Urinary Catheter Care Completed: Not Applicable

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

```
      Catheter Securing Device Applied to       No
       Thigh
      Assistive Devices Care                    None
      Complete Bed Change                       Yes
Not Done     09/20/18 09:00  JOA0063  (Rec: 09/20/18 15:43  JOA0063  ICU-C25)
    Declined by Patient
```

```
ADLs: Bathing Care                                        Start:  09/21/18 08:26
Freq:   DAILY@0800                                        Status: Discharge
Protocol:
 Document     09/22/18 08:00  BOB0001  (Rec: 09/22/18 10:04  BOB0001  TELE-C11)
 Bathing Care
    Assistance
      Assistance Required                       Total
      Bathing Completed                         Bed Bath
      Oral Care Completed                       Independent
                                                Teeth Brushed
      Peri Care Completed                       Yes
      Back Care Completed                       Yes
      Urinary Catheter Care Completed           Not Applicable
      Catheter Securing Device Applied to       No
       Thigh
      Complete Bed Change                       Yes
 Not Done     09/23/18 08:00  RAY0005  (Rec: 09/23/18 19:17  RAY0005  TELE-C11)
    Unable to Determine if Done
 Document     09/24/18 08:00  JEF0031  (Rec: 09/24/18 10:40  JEF0031  TELE-C11)
 Bathing Care
    Assistance
      Assistance Required                       Independent with All ADLs
      Complete Bed Change                       Yes
```

```
ADLs: Chlorhexidine Bathing                               Start:  09/19/18 08:47
Freq:   09                                                Status: Inactive
Protocol:
 Document     09/19/18 09:00  KYL0009  (Rec: 09/19/18 09:40  KYL0009  ICU-M27)
 Chlorhexidine Bathing
    Description
     All ICU admitted patients will receive a daily bath with 2% chlorhexidine
     washcloths for the first 5 days of their ICU stay. (This includes
     telemetry and medical overflow patients.)

     ***Discontinue chlorhexidine bathing after at least 5 days and at least 5
     baths.***

    Chlorhexidine Bathing Care Initiated
      Date of First Bathing                     09/19/18
    Chlorhexidine Bathing
      Bathing Complete                          Yes
      Number of Chlorhexidine Baths Completed   1
 Not Done     09/20/18 09:00  JOA0063  (Rec: 09/20/18 15:43  JOA0063  ICU-C25)
    Declined by Patient
```

```
ADLs: HS Care                                             Start:  09/19/18 08:47
Freq:   2100                                              Status: Inactive
Protocol:
 Not Done     09/19/18 21:00  KIM0006  (Rec: 09/19/18 23:06  KIM0006  ICU-C12)
```

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

patient refused

ADLs: HS Care Start: 09/21/18 08:26
Freq: DAILY@2100 Status: Discharge
Protocol:

Document 09/21/18 21:00 SAR0138 (Rec: 09/21/18 22:46 SAR0138 TELE-C11)
HS Care
HS Care

Assistance Required	Supervision
HS Care Completed	Declined
Face Washed	Declined
Hands Washed	Declined
Hearing Aides Removed	N/A
Oral Care Completed	Declined
Back Care/Rub	Declined
Bed Refreshed	Declined
HS Care Comments	pt declined HS care nurse Megan Notified

Document 09/22/18 20:52 ELI0141 (Rec: 09/22/18 20:52 ELI0141 TELE-C01)
HS Care
HS Care

Assistance Required	Set Up
HS Care Completed	Yes
Face Washed	Yes
Hands Washed	Yes
Hearing Aides Removed	N/A
Oral Care Completed	Teeth Brushed
Back Care/Rub	No
Urinary Catheter Care Completed	Not Applicable
Catheter Securing Device Applied to Thigh	No
Bed Refreshed	No

Document 09/23/18 20:57 ELI0141 (Rec: 09/23/18 20:57 ELI0141 TELE-C01)
HS Care
HS Care

Assistance Required	Set Up
HS Care Completed	Declined
Face Washed	Declined
Hands Washed	Declined
Hearing Aides Removed	N/A
Oral Care Completed	Declined
Back Care/Rub	No
Urinary Catheter Care Completed	Not Applicable
Bed Refreshed	No

ADLs: Meal Record Start: 09/19/18 08:47
Freq: 09,13,18 Status: Inactive
Protocol:

Document 09/19/18 09:00 KYL0009 (Rec: 09/19/18 09:40 KYL0009 ICU-M27)
ADLs: Meal Record
General Information

Is Patient NPO?	Yes
Does the Patient Require Assistance to Eat?	drowsy/ lethargic

Meal

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center Loc:4 SOUTH - MEDICAL/TELEMETRY Bed:436-01
62 F 05/01/1956 Med Rec Num:M000597460 Visit:A00088518428

Assessments and Treatments - Continued

Meal Breakfast
Meal Comments NPO at this time
Document 09/19/18 09:54 EMI0007 (Rec: 09/19/18 09:55 EMI0007 ICU-C24)
ADLs: Meal Record
General Information
Is Patient NPO? No
Does the Patient Require Assistance to Eat? No
Meal
Meal Breakfast
Percent of Meal Consumed 100
Liquids
Protocol: C.INTAKE
Intake, Oral Amount 240
Document 09/19/18 13:00 KYL0009 (Rec: 09/19/18 13:28 KYL0009 ICU-C12)
ADLs: Meal Record
General Information
Is Patient NPO? Yes
Does the Patient Require Assistance to Eat? No: NPO
Liquids
Protocol: C.INTAKE
Intake, Oral Amount 0
Document 09/19/18 18:00 KYL0009 (Rec: 09/19/18 18:27 KYL0009 ICU-C12)
ADLs: Meal Record
General Information
Is Patient NPO? Yes
Does the Patient Require Assistance to Eat? No: NPO
Liquids
Protocol: C.INTAKE
Intake, Oral Amount 0
Document 09/20/18 11:00 JOA0063 (Rec: 09/20/18 15:44 JOA0063 ICU-C25)
ADLs: Meal Record
General Information
Is Patient NPO? No
Does the Patient Require Assistance to Eat? No
Meal
Meal Breakfast
Percent of Meal Consumed 20
Liquids
Protocol: C.INTAKE
Intake, Oral Amount 450
Document 09/20/18 14:00 JOA0063 (Rec: 09/20/18 15:45 JOA0063 ICU-C25)
ADLs: Meal Record
General Information
Is Patient NPO? No
Does the Patient Require Assistance to Eat? No
Meal
Meal Lunch
Percent of Meal Consumed 75

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Assessments and Treatments - Continued

Liquids
Protocol: C.INTAKE
Intake, Oral Amount 500

ADLs: Meal Record Start: 09/20/18 18:18
Freq: Status: Inactive
Protocol:
Document 09/20/18 18:18 ELI0141 (Rec: 09/20/18 18:18 ELI0141 TELE-C11)
ADLs: Meal Record
General Information
Is Patient NPO? No
Does the Patient Require Assistance to Eat? No
Meal
Meal Dinner
Percent of Meal Consumed 75
Liquids
Protocol: C.INTAKE
Intake, Oral Amount 360

ADLs: Meal Record Start: 09/21/18 08:26
Freq: DAILY@0900,1400,1800 Status: Discharge
Protocol:
Document 09/21/18 09:00 SUE0004 (Rec: 09/21/18 10:48 SUE0004 TELE-C09)
ADLs: Meal Record
General Information
Is Patient NPO? No
Does the Patient Require Assistance to Eat? No
Meal
Meal Breakfast
Percent of Meal Consumed 100
Liquids
Protocol: C.INTAKE
Intake, Oral Amount 240
Document 09/21/18 14:00 SUE0004 (Rec: 09/21/18 14:05 SUE0004 TELE-C11)
ADLs: Meal Record
General Information
Is Patient NPO? No
Does the Patient Require Assistance to Eat? No
Meal
Meal Lunch
Percent of Meal Consumed 75
Liquids
Protocol: C.INTAKE
Intake, Oral Amount 720
Document 09/21/18 18:00 SAR0138 (Rec: 09/21/18 21:16 SAR0138 TELE-C11)
ADLs: Meal Record
General Information
Is Patient NPO? No
Does the Patient Require Assistance to Eat? No
Meal
Meal Dinner

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BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01

62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

```
Assessments and Treatments - Continued
      Percent of Meal Consumed                  100
    Liquids
    Protocol:  C.INTAKE
      Intake, Oral Amount                       480
Document     09/22/18 09:00  BOB0001  (Rec: 09/22/18 10:22  BOB0001  TELE-C11)
ADLs: Meal Record
    General Information
      Is Patient NPO?                           No
      Does the Patient Require Assistance to    No
       Eat?
    Meal
      Meal                                      Breakfast
      Percent of Meal Consumed                  100
    Liquids
    Protocol:  C.INTAKE
      Intake, Oral Amount                       360
Document     09/22/18 14:00  BOB0001  (Rec: 09/22/18 15:15  BOB0001  TELE-C11)
ADLs: Meal Record
    General Information
      Is Patient NPO?                           No
      Does the Patient Require Assistance to    No
       Eat?
    Meal
      Meal                                      Lunch
      Percent of Meal Consumed                  100
    Liquids
    Protocol:  C.INTAKE
      Intake, Oral Amount                       360
Document     09/22/18 18:54  ELI0141  (Rec: 09/22/18 18:54  ELI0141  TELE-C01)
ADLs: Meal Record
    General Information
      Is Patient NPO?                           No
      Does the Patient Require Assistance to    No
       Eat?
    Meal
      Meal                                      Dinner
      Percent of Meal Consumed                  100
Not Done     09/23/18 09:00  RAY0005  (Rec: 09/23/18 19:18  RAY0005  TELE-C11)
    Unable to Determine if Done
Not Done     09/23/18 14:00  RAY0005  (Rec: 09/23/18 19:18  RAY0005  TELE-C11)
    Unable to Determine if Done
Not Done     09/23/18 18:00  RAY0005  (Rec: 09/23/18 23:29  RAY0005  TELE-C11)
    Unable to Determine if Done
Document     09/24/18 09:00  MAC0003  (Rec: 09/24/18 10:11  MAC0003  TELE-M12)
ADLs: Meal Record
    General Information
      Is Patient NPO?                           No
      Does the Patient Require Assistance to    No
       Eat?
    Meal
      Meal                                      Breakfast
      Percent of Meal Consumed                  100
Document     09/24/18 10:40  JEF0031  (Rec: 09/24/18 10:40  JEF0031  TELE-C11)
```

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

ADLs: Meal Record
    General Information
      Is Patient NPO? No
      Does the Patient Require Assistance to Eat? No
    Meal
      Meal Breakfast
      Percent of Meal Consumed 100
    Liquids
    Protocol: C.INTAKE
      Intake, Oral Amount 420
Not Done 09/24/18 14:00 MAC0003 (Rec: 09/24/18 14:04 MAC0003 TELE-C09)
    Unable to Determine if Done

ADLs: Stool Record Start: 09/21/18 08:26
Freq: DAILY@0600,1400,2200 Status: Discharge
Protocol:
Document 09/21/18 09:19 CON0001 (Rec: 09/21/18 09:19 CON0001 TELE-M11)
Date of Last Bowel Movement
    Date of Last Bowel Movement
      Date of Last Bowel Movement 9/21/18
Record: Stool
    Stool Record
      Stool Characteristics Soft
      Formed
      Incontinent No
Document 09/21/18 14:00 SUE0004 (Rec: 09/21/18 14:37 SUE0004 TELE-C11)
Date of Last Bowel Movement
    Date of Last Bowel Movement
      Date of Last Bowel Movement 9/21/18
Document 09/21/18 22:00 SAR0138 (Rec: 09/21/18 22:47 SAR0138 TELE-C11)
Date of Last Bowel Movement
    Date of Last Bowel Movement
      Date of Last Bowel Movement 9/21/18
Record: Stool
    Output, Stool
      Number of Bowel Movements 0
Not Done 09/22/18 06:00 BOB0001 (Rec: 09/22/18 10:06 BOB0001 TELE-C11)
    Unable to Determine if Done
Document 09/22/18 14:00 BOB0001 (Rec: 09/22/18 15:14 BOB0001 TELE-C11)
Date of Last Bowel Movement
    Date of Last Bowel Movement
      Date of Last Bowel Movement 9/21/18
Document 09/22/18 21:18 ELI0141 (Rec: 09/22/18 21:19 ELI0141 TELE-C01)
Date of Last Bowel Movement
    Date of Last Bowel Movement
      Date of Last Bowel Movement 9/21/18
Document 09/23/18 06:00 FRA0018 (Rec: 09/23/18 07:44 FRA0018 TELE-C01)
Date of Last Bowel Movement
    Date of Last Bowel Movement
      Date of Last Bowel Movement 9/21/18
Record: Stool
    Stool Record
      Number of Bowel Movements Since Last 0

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```
      Documentation
    Output, Stool
      Number of Bowel Movements                   0
Document     09/23/18 14:00  BOB0001  (Rec: 09/23/18 14:56  BOB0001  TELE-C07)
Date of Last Bowel Movement
    Date of Last Bowel Movement
      Date of Last Bowel Movement                 9/21/18
Document     09/23/18 21:36  ELI0141  (Rec: 09/23/18 21:37  ELI0141  TELE-C01)
Date of Last Bowel Movement
    Date of Last Bowel Movement
      Date of Last Bowel Movement                 9/21/18
Not Done     09/24/18 06:00  MAC0003  (Rec: 09/24/18 08:05  MAC0003  TELE-M12)
    Unable to Determine if Done
Document     09/24/18 14:00  MAC0003  (Rec: 09/24/18 14:04  MAC0003  TELE-C09)
Date of Last Bowel Movement
    Date of Last Bowel Movement
      Date of Last Bowel Movement                 9/21/18
```

```
ADLs: Urine Record                                  Start:  09/21/18 08:26
Freq:   DAILY@0600,1400,2200                        Status: Discharge
Protocol:
Document     09/21/18 14:00  SUE0004  (Rec: 09/21/18 14:37  SUE0004  TELE-C11)
ADLs: Urine Record
    Urine Record
      Does Patient Void                           Yes
      Voiding Description                         Continent
      Toileting Methods                           Toilet
      Urine Concentration                         Not Observed
      Urine Color                                 Not Observed
      Urine Character                             Not Observed
    Output, Urine
      Output, Urine Amount                        0
Document     09/21/18 15:15  SAR0138  (Rec: 09/21/18 16:39  SAR0138  TELE-C01)
ADLs: Urine Record
    Urine Record
      Does Patient Void                           Yes
      Voiding Description                         Continent
      Toileting Methods                           Toilet
      Urine Concentration                         Pale/Diluted
      Urine Color                                 Yellow
      Urine Character                             Clear
      Urinary Diversions/Devices                  None
      Catheter Care Completed                     Not Applicable
    Output, Urine
      Number of Voids                             1
      Output, Estimated Void Amount               Medium
Document     09/21/18 22:00  SAR0138  (Rec: 09/21/18 22:47  SAR0138  TELE-C11)
ADLs: Urine Record
    Urine Record
      Does Patient Void                           Yes
      Voiding Description                         Continent
      Toileting Methods                           Toilet
      Urine Concentration                         Not Observed
      Urine Color                                 Not Observed
```

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued
Urine Character Not Observed
Urinary Diversions/Devices None
Catheter Care Completed Not Applicable
Output, Urine
Number of Voids 4
Document 09/22/18 06:00 BOB0001 (Rec: 09/22/18 10:05 BOB0001 TELE-C11)
ADLs: Urine Record
Urine Record
Does Patient Void Yes
Voiding Description Continent
Toileting Methods Toilet
Urine Concentration Medium
Urine Color Yellow
Urine Character Clear
Urinary Diversions/Devices None
Catheter Care Completed Not Applicable
Catheter Securing Device Applied to Thigh No
Output, Urine
Number of Voids 1
Output, Estimated Void Amount Large
Document 09/22/18 14:00 BOB0001 (Rec: 09/22/18 15:15 BOB0001 TELE-C11)
ADLs: Urine Record
Urine Record
Does Patient Void Yes
Voiding Description Continent
Toileting Methods Toilet
Urine Concentration Medium
Urine Color Yellow
Urine Character Clear
Urinary Diversions/Devices None
Catheter Care Completed Not Applicable
Catheter Securing Device Applied to Thigh No
Output, Urine
Number of Voids 2
Output, Estimated Void Amount Large
Document 09/22/18 21:18 ELI0141 (Rec: 09/22/18 21:19 ELI0141 TELE-C01)
ADLs: Urine Record
Urine Record
Does Patient Void Yes
Voiding Description Continent
Toileting Methods Toilet
Urine Concentration Not Observed
Urine Color Not Observed
Urine Character Not Observed
Urinary Diversions/Devices None
Catheter Care Completed Not Applicable
Catheter Securing Device Applied to Thigh No
Document 09/23/18 06:00 FRA0018 (Rec: 09/23/18 07:44 FRA0018 TELE-C01)
ADLs: Urine Record
Urine Record

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BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01

62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

```
      Does Patient Void                         Yes
      Voiding Description                       Continent
      Toileting Methods                         Toilet
      Urine Concentration                       Not Observed
      Urine Color                               Not Observed
      Urine Character                           Not Observed
      Urinary Diversions/Devices                None
      Catheter Care Completed                   Not Applicable
    Output, Urine
      Number of Voids                           1
Document     09/23/18 14:00  BOB0001  (Rec: 09/23/18 14:56  BOB0001  TELE-C07)
ADLs: Urine Record
    Urine Record
      Urine Concentration                       Not Observed
      Urine Color                               Not Observed
      Urine Character                           Not Observed
Document     09/23/18 21:36  ELI0141  (Rec: 09/23/18 21:37  ELI0141  TELE-C01)
ADLs: Urine Record
    Urine Record
      Does Patient Void                         Yes
      Voiding Description                       Continent
      Toileting Methods                         Toilet
      Urine Concentration                       Not Observed
      Urine Color                               Not Observed
      Urine Character                           Not Observed
      Urinary Diversions/Devices                None
      Catheter Care Completed                   Not Applicable
Not Done     09/24/18 06:00  MAC0003  (Rec: 09/24/18 08:05  MAC0003  TELE-M12)
    Unable to Determine if Done
Document     09/24/18 14:00  MAC0003  (Rec: 09/24/18 14:04  MAC0003  TELE-C09)
ADLs: Urine Record
    Urine Record
      Does Patient Void                         Yes
      Voiding Description                       Continent
    Output, Urine
      Number of Voids                           1
      Output, Estimated Void Amount             Medium
```

```
Arrival: Assessment/VS                                    Start:  09/19/18 08:47
Freq:   ONCE                                              Status: Inactive
Protocol:  C.PNSCALE
Document     09/19/18 08:50  KYL0009  (Rec: 09/19/18 09:21  KYL0009  ICU-M27)
Arrival Assessment: Adult
    Arrival Information
      Date of Arrival on Unit                   09/19/18
      Time of Arrival on Unit                   08:50
      Arrived From                              Emergency Department
      Mode of Arrival                           Stretcher
      Provider Notified                         Yes
      Diagnosis                                 RHABDOMYOLYSIS WITH REACTIVE
                                                LEUKOCYTOSIS AND NASA
      ID Bracelet Applied to Patient            Yes
      Allergy Bracelet Applied to Patient       N/A
    Level of Consciousness/Information
```

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BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01

62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

```
      Level of Consciousness                    Arousable
                                                Drowsy
                                                Lethargic
                                                Responds to Voice
      Patient Orientation                       Unable to Determine
       Query Text:For pediatric patients A&O x
       4 as appropriate for age.
    Safety
      Call Bell within Reach                    Yes
      Room Orientation Complete                 Yes
      Orientation With                          Patient
      Immediate Safety Risks                    Yes
Arrival Assessment: Vital Signs
    Vital Signs
     Vital signs MUST be manually entered.
      Temperature                               98.3 F
      Temperature Source                        Tympanic
      Pulse Rate                                82
      Respiratory Rate                          22
      Blood Pressure (mmHg)                     148/78
      Blood Pressure Source                     Automatic Cuff
      O2 Sat by Pulse Oximetry                  96
      Oxygen Devices in Use Now                 None
Pain Assessment/Reassessment
    Pain Assessment
    Protocol:  C.PNSCALE
      Patient Currently Having Pain             Yes
      Pain Assessment Based Upon                Nursing Observation
      Pain Intensity                            5
       Query Text:0-10
      Pain Scale Used                           CPOT
      Stated Pain Consistent with Observed      N/A
       Level of Pain
    Pain Location/Description
      left shoulder
       Pain Description                         Unable to Verbalize
    Interventions
     Please document those interventions you are currently providing.
      Interventions Provided for Current Pain   Positioning
       Level
      Follow Up Evaluation Needed               No
      Time Follow Up Due                        -
Edit Result  09/19/18 08:50  KYL0009  (Rec: 09/19/18 19:54  KYL0009  ICU-C21)
Arrival Assessment: Adult
    Level of Consciousness/Information
      Level of Consciousness                    Arousable
                                                Drowsy
                                                Responds to Voice
Document     09/20/18 17:17  CON0001  (Rec: 09/20/18 17:19  CON0001  TELE-M07)
Arrival Assessment: Adult
    Arrival Information
      Date of Arrival on Unit                   09/20/18
      Time of Arrival on Unit                   17:05
```

Continued on Page 62

Assessments and Treatments - Continued

Arrived From	In House Transfer
Mode of Arrival	Wheelchair
Diagnosis	RHABDOMYOLYSIS WITH REACTIVE LEUKOCYTOSIS AND NASA
ID Bracelet Applied to Patient	Yes
Allergy Bracelet Applied to Patient	N/A
Level of Consciousness/Information	
Level of Consciousness	Awake Alert
Patient Orientation	Person
Query Text:For pediatric patients A&O x 4 as appropriate for age.	
Safety	
Call Bell within Reach	Yes
Room Orientation Complete	Yes
Orientation With	Patient
Immediate Safety Risks	No
Arrival Assessment: Vital Signs	
Vital Signs	
Vital signs MUST be manually entered.	
Temperature	98.6 F
Temperature Source	Temporal Artery Scan
Pulse Rate	116
Respiratory Rate	20
Blood Pressure (mmHg)	191/124
Blood Pressure Source	Automatic Cuff
O2 Sat by Pulse Oximetry	96
Oxygen Devices in Use Now	None
Pain Assessment/Reassessment	
Pain Assessment	
Protocol: C.PNSCALE	
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	-

Arrival: Assessment/VS Start: 09/21/18 08:26
Freq: Q1MX1,T.PRN Status: Discharge
Protocol: C.PNSCALE
Not Done 09/21/18 08:26 CON0001 (Rec: 09/21/18 09:01 CON0001 TELE-M11)
See past vitals

Blood Glucose Monitoring POC Start: 09/19/18 11:30
Freq: ONCE Status: Complete
Protocol:
Document 09/19/18 11:30 KYL0009 (Rec: 09/19/18 11:40 KYL0009 ICU-M27)

Blood Glucose Monitoring	
Blood Glucose Monitoring Record	
POC Glucose Obtained	Yes
Source of Specimen	Capillary
Glucose Result Being Addressed/Treated (mg/dL)	134
Blood Glucose Method	POC Glucose (bedside)

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BLAYK,BONZE ANNE ROSE
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62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

```
Blood Glucose Monitoring POC                                Start:  09/19/18 20:26
Freq:   ONCE                                                Status: Inactive
Protocol:
 Not Done     09/19/18 20:26  KIM0006  (Rec: 09/20/18 00:06  KIM0006  ICU-C12)
     Patient Off Unit
```

```
CARE Act Assessment                                         Start:  09/19/18 08:47
Freq:   Q1HX1,T.PRN                                         Status: Inactive
Protocol:
 Document     09/19/18 09:15  KYL0009  (Rec: 09/19/18 09:43  KYL0009  ICU-M27)
 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
     Caregiver Needed at Discharge
       Caregiver Needed at Discharge             No
```

```
CARE Act Reassessment                                       Start:  09/19/18 09:43
Freq:   04,16                                               Status: Discharge
Protocol:
 Document     09/19/18 16:00  KYL0009  (Rec: 09/19/18 17:53  KYL0009  ICU-C12)
 CARE Act Reassessment Status
     CARE Act Reassessment
       Reassessment Status                       Continue to Reassess
 Document     09/20/18 04:00  KIM0006  (Rec: 09/20/18 04:27  KIM0006  ICU-C12)
 CARE Act Reassessment Status
     CARE Act Reassessment
       Reassessment Status                       Continue to Reassess
 Document     09/20/18 16:21  ANI0051  (Rec: 09/20/18 16:22  ANI0051  ICU-C25)
 CARE Act Reassessment Status
     CARE Act Reassessment
       Reassessment Status                       Continue to Reassess
 Document     09/21/18 04:00  JER0049  (Rec: 09/21/18 05:04  JER0049  TELE-C09)
 CARE Act Reassessment Status
     CARE Act Reassessment
       Reassessment Status                       Continue to Reassess
 Document     09/21/18 15:34  CON0001  (Rec: 09/21/18 15:34  CON0001  TELE-M11)
 CARE Act Reassessment Status
     CARE Act Reassessment
       Reassessment Status                       Continue to Reassess
 Document     09/22/18 04:00  MEG0025  (Rec: 09/22/18 07:48  MEG0025  TELE-C09)
 CARE Act Reassessment Status
     CARE Act Reassessment
       Reassessment Status                       Continue to Reassess
 Document     09/23/18 04:00  SOP0051  (Rec: 09/23/18 04:45  SOP0051  TELE-C11)
 CARE Act Reassessment Status
     CARE Act Reassessment
       Reassessment Status                       Continue to Reassess
```

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Document 09/23/18 16:00 STA0017 (Rec: 09/23/18 18:34 STA0017 TELE-C03)
CARE Act Reassessment Status
CARE Act Reassessment
Reassessment Status Continue to Reassess

Document 09/23/18 22:34 RAY0005 (Rec: 09/23/18 22:36 RAY0005 TELE-C11)
CARE Act Reassessment Status
CARE Act Reassessment
Reassessment Status Continue to Reassess

Document 09/24/18 15:50 MAC0003 (Rec: 09/24/18 15:50 MAC0003 TELE-C09)
CARE Act Reassessment Status
CARE Act Reassessment
Reassessment Status Continue to Reassess

Care Plan Initiated Start: 09/19/18 08:47
Freq: ONCE Status: Inactive
Protocol:
Document 09/19/18 08:47 KYL0009 (Rec: 09/19/18 09:44 KYL0009 ICU-M27)

Care Plan Initiated Start: 09/21/18 08:26
Freq: ONCE Status: Discharge
Protocol:
Document 09/21/18 08:26 CON0001 (Rec: 09/21/18 09:00 CON0001 TELE-M11)

Collect Specimen: CBC Auto Diff Start: 09/19/18 15:00
Freq: ONCE Status: Complete
Protocol:
Document 09/19/18 15:00 ROS0014 (Rec: 09/19/18 15:05 ROS0014 ISDEMO-M05)

Collect Specimen: CBC Auto Diff Start: 09/19/18 16:00
Freq: ONCE Status: Complete
Protocol:
Document 09/19/18 16:00 ROS0014 (Rec: 09/19/18 16:08 ROS0014 ISDEMO-M05)

Collect Specimen: Creatine Kinase Start: 09/19/18 15:00
Freq: ONCE Status: Complete
Protocol:
Document 09/19/18 15:00 ROS0014 (Rec: 09/19/18 15:05 ROS0014 ISDEMO-M05)

Collect Specimen: Type and Screen Start: 09/19/18 16:00
Freq: ONCE Status: Complete
Protocol:
Document 09/19/18 16:00 ROS0014 (Rec: 09/19/18 16:08 ROS0014 ISDEMO-M05)

Complete Home Medications/Reconciliation Start: 09/21/18 08:26
Text: Check that all drugs have been entered/confirmed in the Home Medications routine in the Summary Tab. Status: Discharge
Freq: ONCE
Protocol:
Document 09/21/18 11:37 ANN0068 (Rec: 09/21/18 11:37 ANN0068 HOSP-C11)

Complete Vaccine Admin Record (#12007) Start: 09/20/18 18:12
Freq: ONCE Status: Discharge
Protocol: C.VACC
Document 09/20/18 18:12 CON0001 (Rec: 09/20/18 18:12 CON0001 TELE-M07)

ED Discharge Assessment Start: 09/19/18 04:28
Freq: Status: Discharge
Protocol:
Document 09/19/18 08:39 NAT0019 (Rec: 09/19/18 08:41 NAT0019 ED-C19)
ED Discharge Assessment
Discharge Information
Protocol: C.PNSCALE

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BLAYK,BONZE ANNE ROSE
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Assessments and Treatments - Continued

IV Stop Times Documented on eMAR	Non-Applicable
Method to Door	Stretcher
Patient To	CMC Admit
Pain Scale Used	unable to assess due to pt status
Admission to CMC	
Time Report Initiated	08:40
Time Report Given	08:40
Report To	Moore,Kylee
Provider Type	Registered Nurse
Name of Person Transporting Patient	Smith,Nathan
Discharge Vital Signs	
Temperature	97 F
Temperature Source	Temporal Artery Scan
Pulse Rate	83
Respiratory Rate	22
Blood Pressure (mmHg)	146/78
Patient on Room Air	Yes
O2 Saturation	96

ED Quick Triage — Start: 09/19/18 04:28
Freq: — Status: Discharge
Protocol:
Document 09/19/18 04:31 THO0010 (Rec: 09/19/18 04:42 THO0010 EDRM-C10)

ED Quick Triage

Arrival	
Arrival Area	Back
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
Infectious Disease	
Infectious Disease History	Unable to Obtain/Confirm
Chief Complaint	
Associated Signs & Symptoms, Duration, and Frequency Query Text:*i.e. constant or intermittent, how long have symptoms been happening (minutes, hours, days, months, years), how often	pt brought in after fight with police. Bloody face. complaining of arm and jaw pain.
Date of Onset Query Text:*Meaningful Use	09/19/18
Time of Onset Query Text:*Meaningful Use	04:15
Allergy Assessment	
Allergy Information	Allergy Details Documented/ Verified
Vital Signs	
Actual/Estimated Weight	Stated
Temperature	96 F

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BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01

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Assessments and Treatments - Continued

Temperature Source	Temporal Artery Scan
Pulse Rate	116
Respiratory Rate	22
Blood Pressure (mmHg)	176/113
Patient on Room Air	Yes
O2 Saturation	98
Pain Intensity	0
Query Text:0-10	
MEWS Scoring Tool	
Protocol: C.EDEWS	
Systolic BP	111 - 219
Temperature	95.1 - 96.8
Pulse	111 - 130
Respiratory Rate	21 - 24
Oxygen Saturation	Greater Than or Equal To 96
Inspired O2	Room Air
Alertness Scale	New Agitation or Confusion
Suspicion For Infection	No
Early Warning Score	6
Modified Early Warning Level	Med
Initial Suspicion For Infection	No
Initial Modified Early Warning Score	6
Initial Modified Early Warning Level	Med
Provider Notified	Kirk Hinkley
Time Provider Notified	04:41
SIRS Scoring Tool	
Tachycardia	Yes
Query Text:>90 bpm	
Tachypnea	Yes
Query Text:RR>20 or PaCO2 <32	
Hypo/Hyperthermic	Yes
Query Text:Hyperthermic > 38.3C or 101.0F Hypothermic <36.0C or 96.8F	
SIRS Criteria Present	3
Query Text:If 2 or more SIRS criteria are present, the patient may be septic.	
Initial SIRS Criteria Present	3
Triage Status & Disposition	
Are You Having Thoughts of Hurting Yourself Or Others	Unable To Obtain
Priority/Triage Level	3 - Two or more resources
Primary Chief Complaint	EDFacialInjury
Triage Disposition	ED Room
ESI Reassessment Due Time	
Time Next Reassessment Due	N/A

Edit Result 09/19/18 04:31 THO0010 (Rec: 09/19/18 05:43 THO0010 ED-C19)

ED Quick Triage

Chief Complaint	
Associated Signs & Symptoms, Duration, and Frequency	Pt brought by police. Bloody face. Complaining of arm and jaw pain.
Query Text:*i.e. constant or intermittent, how long have symptoms	

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been happening (minutes, hours, days,
months, years), how often

ED RN Assessment Start: 09/19/18 04:42
Freq: Status: Discharge
Protocol:
Document 09/19/18 05:43 THO0010 (Rec: 09/19/18 05:48 THO0010 ED-C19)

Onset/Description of Symptoms
Chief Complaint
Associated Signs & Symptoms, Duration, and Frequency — Pt brought by police. Bloody face. Complaining of arm and jaw pain.
Query Text:*i.e. constant or intermittent, how long have symptoms been happening (minutes, hours, days, months, years), how often
Date Of Onset — 09/19/18
Query Text:*Meaningful Use
Time Of Onset — 04:15
Query Text:*Meaningful Use

ED Chief Complaint Detail RN
Complaint/Symptoms Details
What Makes the Pain/Condition Better/ Worse — -
Treatment Of This Condition Prior To Arrival In The ED — -
Query Text:*i.e. medications, ice, heat, elevation, rest, other

Allergies Documented/Verified
Allergy Assessment
Allergy Information — Allergy Details Documented/ Verified

Isolation and MRSA Assessment
MRSA Assessment Status
Protocol: C.MRSACHAR
MRSA Assessment — Unable to Assess/Obtain
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
Protocol: C.ISOLCHA2
Reason for Isolation — None
Type of Isolation — Standard Precautions
Isolation Summary
Does Patient Require Isolation — No

Pertinent PMH
Pertinent Past Medical History
ED:Past Medical History — PTSD/Gender dysphonia/Temporal lobe epilepsy
Query Text:Please be sure to review

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BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01

62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

History under Patient Care for potential additional histories.	
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
Advance Directives	
Medical Advance Directives	
Code Status	Full Code
Code Status Requires Follow Up?	N
Advance Directives Location	unable to assess
ED Physical and Psychosocial	
Currently Having Pain	
Currently Having Pain	No
Respiratory Assessment	
Airway Assessment	Clear
Chest Expansion	Symmetrical
Circulation	
Bilateral Radial Pulse Present	Yes
Neurologic Assessment	
Level Of Consciousness	Awake Alert Inappropriate Disoriented Combative Restless
Coma Scale Eye Opening	Spontaneous
Coma Scale Verbal Response	Inappropriate
Coma Scale Motor Response	Obeys Commands
Coma Scale Total	13
Skin Assessment	
Skin Temperature	Warm
Skin Color	Skin Color Reflects Adequate Perfusion
Extremities	
Extremities	Normal
Home Environment	
Do You Feel Emotionally and Physically Safe	No
Can You Tell Me More	Unable to assess at this time
Lethality Risk Screen	
Are You Having Thoughts of Hurting Yourself Or Others	Unable To Obtain
Thoughts of Hurting Yourself/Others Comment	unable to assess at this time
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
Self-Referred Testing	

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
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Assessments and Treatments - Continued

Consent
Is Patient Able to Consent for Self Referred Testing — No
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 Testing Consent Comments — unable to assess at this time.

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 — 09/19/18
Does Patient Consent to Hepatitis C Testing — N/A - Already Offered This Visit or Prior Visit
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

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 .**
Tobacco Cessation Information Provided — N/A Due to Patient Condition

Alcohol/Substance Use
Alcohol Use
Alcohol Use — None
Alcohol Amount — unable to assess
Substance Use
Substance Use Type — None
Substance Use Comment - Amount & Last Used — unable to assess

ED Priority/Triage Level
ED Priority Information
Priority/Triage Level — 3 - Two or more resources

Edit Result 09/19/18 05:43 THO0010 (Rec: 09/19/18 07:24 THO0010 EDL-C01)

ED Physical and Psychosocial
Head/Face
Head/Face — Abnormal
Head/Face Comment — laceration to bridge of nose,

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Assessments and Treatments - Continued

laceration over left eye, swelling of right jaw.

Skin Deviations
Hand
Skin Problem — Abrasion
Skin Comment — abrasion to both wrists from police handcuffs.

Enter/Update Patient Pharmacy — Start: 09/19/18 04:28
Freq: — Status: Discharge
Protocol:
Document 09/19/18 04:31 THO0010 (Rec: 09/19/18 04:42 THO0010 EDRM-C10)

Enter/Update Patient Pharmacy — Start: 09/21/18 08:26
Freq: ONCE — Status: Discharge
Protocol:
Document 09/21/18 08:26 CON0001 (Rec: 09/21/18 09:27 CON0001 TELE-M11)

Foley Catheter: Removal — Start: 09/19/18 20:48
Freq: ONCE — Status: Discharge
Protocol:
Not Done 09/19/18 20:48 KIM0006 (Rec: 09/20/18 00:05 KIM0006 ICU-C12)
patient does not have foley cath

Height and Weight — Start: 09/19/18 05:41
Freq: — Status: Discharge
Protocol:
Document 09/19/18 05:41 THO0010 (Rec: 09/19/18 05:42 THO0010 ED-C19)
Height/Weight
Height/Weight

Height	5 ft 6 in
Weight	161 lb
Date of Weight	09/19/18
Time of Weight	05:00
Actual/Estimated Weight	Actual
Body Mass Index (BMI)	25.9
Scale Used	Bed Scale

Query Text:To ensure accurate weights, be sure to always weigh your patient with the same scale.

Hourly Rounding — Start: 09/19/18 08:47
Freq: Q1HR — Status: Inactive
Protocol:
Document 09/19/18 09:00 KYL0009 (Rec: 09/19/18 09:40 KYL0009 ICU-M27)
Document 09/19/18 10:00 KYL0009 (Rec: 09/19/18 11:33 KYL0009 ICU-M27)
Document 09/19/18 11:00 KYL0009 (Rec: 09/19/18 11:39 KYL0009 ICU-M27)
Document 09/19/18 12:00 KYL0009 (Rec: 09/19/18 12:48 KYL0009 ICU-C12)
Document 09/19/18 13:00 KYL0009 (Rec: 09/19/18 13:28 KYL0009 ICU-C12)
Document 09/19/18 14:00 CHA0032 (Rec: 09/19/18 14:01 CHA0032 ICU-M27)
Document 09/19/18 15:00 ROS0014 (Rec: 09/19/18 15:05 ROS0014 ISDEMO-M05)
Document 09/19/18 16:00 ROS0014 (Rec: 09/19/18 16:08 ROS0014 ISDEMO-M05)
Document 09/19/18 17:00 KYL0009 (Rec: 09/19/18 17:39 KYL0009 ICU-C12)
Document 09/19/18 18:00 KYL0009 (Rec: 09/19/18 18:27 KYL0009 ICU-C12)
Document 09/19/18 19:00 KIM0006 (Rec: 09/19/18 20:53 KIM0006 ICU-M27)
Not Done 09/19/18 20:00 KIM0006 (Rec: 09/19/18 22:36 KIM0006 ICU-C12)
Patient Off Unit
Document 09/19/18 21:00 KIM0006 (Rec: 09/19/18 22:43 KIM0006 ICU-C12)

Continued on Page 71

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01

62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Document 09/19/18 22:00 KIM0006 (Rec: 09/19/18 23:06 KIM0006 ICU-C12)
Document 09/19/18 23:00 KIM0006 (Rec: 09/19/18 23:13 KIM0006 ICU-C12)
Document 09/20/18 00:00 KIM0006 (Rec: 09/20/18 01:08 KIM0006 ICU-C12)
Document 09/20/18 01:00 KIM0006 (Rec: 09/20/18 01:08 KIM0006 ICU-C12)
Document 09/20/18 01:53 KIM0006 (Rec: 09/20/18 01:53 KIM0006 ICU-C12)
Document 09/20/18 03:00 KIM0006 (Rec: 09/20/18 04:25 KIM0006 ICU-C12)
Document 09/20/18 04:00 KIM0006 (Rec: 09/20/18 04:25 KIM0006 ICU-C12)
Document 09/20/18 04:56 KIM0006 (Rec: 09/20/18 04:56 KIM0006 ICU-C12)
Document 09/20/18 05:40 KIM0006 (Rec: 09/20/18 05:40 KIM0006 ICU-M35)
Document 09/20/18 06:53 JOA0063 (Rec: 09/20/18 06:53 JOA0063 ICU-C25)
Document 09/20/18 08:00 JOA0063 (Rec: 09/20/18 09:12 JOA0063 ICU-M23)
Document 09/20/18 09:00 JOA0063 (Rec: 09/20/18 10:48 JOA0063 ICU-C25)
Document 09/20/18 10:00 JOA0063 (Rec: 09/20/18 10:48 JOA0063 ICU-C25)
Document 09/20/18 13:00 JOA0063 (Rec: 09/20/18 15:45 JOA0063 ICU-C25)
Document 09/20/18 14:00 JOA0063 (Rec: 09/20/18 15:45 JOA0063 ICU-C25)
Document 09/20/18 15:00 JOA0063 (Rec: 09/20/18 15:45 JOA0063 ICU-C25)
Document 09/20/18 16:21 ANI0051 (Rec: 09/20/18 16:22 ANI0051 ICU-C25)

ICCU 01: Neurological Assessment Start: 09/19/18 08:47
Freq: DAILY@0000,0400,0800,1200,1600,2000 Status: Inactive
Protocol:

Document 09/19/18 12:00 KYL0009 (Rec: 09/19/18 12:48 KYL0009 ICU-C12)

ICCU: Neurological Assessment

Neurological Assessment

Level of Consciousness	Arousable Drowsy Sedated Lethargic Responds to Pain Responds to Voice
Patient Orientation	Confused
Query Text:For pediatric patients A&O x 4 as appropriate for age.	
Patient Behavior	Cooperative
Facial Droop	No
Arm Drift	No
Speech	Garbled Slurred

Pupils

Right Pupil Reaction	Brisk
Right Pupil Size	2 mm
Left Pupil Reaction	Brisk
Left Pupil Size	2 mm

Glasgow Coma Scale

Glasgow Coma Scale

Best Eye Response	3 - To Speech
Best Motor Response	6 - Obeys Commands
Best Verbal Response	4 - Confused
Glasgow Coma Scale Total	13
Glascow Coma Scale Comments	speech garbled and slurred

Strength Assessment

Strength Assessment

Left Hand Grasp Ability	Normal Performance
Right Hand Grasp Ability	Normal Performance

Continued on Page 72

Assessments and Treatments - Continued

```
       Range of Motion Left Arm                 5-Full ROM
       Range of Motion Right Arm                5-Full ROM
       Range of Motion Left Leg                 5-Full ROM
       Range of Motion Right Leg                5-Full ROM
Edit Result  09/19/18 12:00  KYL0009  (Rec: 09/19/18 16:48  KYL0009  ICU-C12)
ICCU: Neurological Assessment
    Neurological Assessment
       Level of Consciousness                   Drowsy
                                                Lethargic
                                                Responds to Voice
Document     09/19/18 16:00  KYL0009  (Rec: 09/19/18 17:53  KYL0009  ICU-C12)
ICCU: Neurological Assessment
    Neurological Assessment
       Level of Consciousness                   Appropriate
                                                Drowsy
       Patient Orientation                      Confused
        Query Text:For pediatric patients A&O x
        4 as appropriate for age.
       Patient Behavior                         Cooperative
       Facial Droop                             No
       Arm Drift                                No
       Speech                                   Garbled
                                                Slurred
    Pupils
       Right Pupil Reaction                     Brisk
       Right Pupil Size                         2 mm
       Left Pupil Reaction                      Brisk
       Left Pupil Size                          2 mm
Glasgow Coma Scale
    Glasgow Coma Scale
       Best Eye Response                        3 - To Speech
       Best Motor Response                      6 - Obeys Commands
       Best Verbal Response                     4 - Confused
       Glasgow Coma Scale Total                 13
       Glascow Coma Scale Comments              speech garbled and slurred
Strength Assessment
    Strength Assessment
       Left Hand Grasp Ability                  Normal Performance
       Right Hand Grasp Ability                 Normal Performance
       Range of Motion Left Arm                 5-Full ROM
       Range of Motion Right Arm                5-Full ROM
       Range of Motion Left Leg                 5-Full ROM
       Range of Motion Right Leg                5-Full ROM
Document     09/19/18 17:00  ROS0014  (Rec: 09/19/18 20:03  ROS0014  ICU-C22)
ICCU: Neurological Assessment
    Neurological Assessment
       Level of Consciousness                   Awake
                                                Drowsy
       Patient Orientation                      A&O x 4
        Query Text:For pediatric patients A&O x
        4 as appropriate for age.
       Patient Behavior                         Appropriate
                                                Cooperative
```

Continued on Page 73

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Facial Droop	No
Arm Drift	No
Speech	Slurred
Neurological Comment	pt oriented and able to state that she was "brought to the hospital for getting in a fight with 2 fake police officers in a Denny's" Pt continues to have intermittent flight of ideas, drowsy
Pupils	
Right Pupil Reaction	Brisk
Right Pupil Size	3 mm
Left Pupil Reaction	Brisk
Left Pupil Size	3 mm
Glasgow Coma Scale	
Glasgow Coma Scale	
Best Eye Response	4 - Spontaneous
Best Motor Response	6 - Obeys Commands
Best Verbal Response	5 - Oriented
Glasgow Coma Scale Total	15
Strength Assessment	
Strength Assessment	
Left Hand Grasp Ability	Normal Performance
Right Hand Grasp Ability	Normal Performance
Range of Motion Left Arm	Unable to Assess
Range of Motion Right Arm	5-Full ROM
Range of Motion Left Leg	5-Full ROM
Range of Motion Right Leg	5-Full ROM
Strength/Range of Motion Impairment Comment	Left shoulder fractured and dislocated

Document 09/19/18 18:00 ROS0014 (Rec: 09/19/18 20:05 ROS0014 ICU-C22)

ICCU: Neurological Assessment

Neurological Assessment	
Level of Consciousness	Awake
Patient Orientation	A&O x 4
Query Text:For pediatric patients A&O x 4 as appropriate for age.	
Patient Behavior	Appropriate Cooperative
Facial Droop	No
Arm Drift	No
Speech	Slurred
Neurological Comment	Pt anxious, speaks in rambling sentances but is alert and oriented
Pupils	
Right Pupil Reaction	Brisk
Right Pupil Size	3 mm
Left Pupil Reaction	Brisk
Left Pupil Size	3 mm
Glasgow Coma Scale	
Glasgow Coma Scale	

Continued on Page 74

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Best Eye Response	4 - Spontaneous
Best Motor Response	6 - Obeys Commands
Best Verbal Response	5 - Oriented
Glasgow Coma Scale Total	15

Strength Assessment
Strength Assessment

Left Hand Grasp Ability	Normal Performance
Right Hand Grasp Ability	Normal Performance
Range of Motion Left Arm	Unable to Assess
Range of Motion Right Arm	5-Full ROM
Range of Motion Left Leg	5-Full ROM
Range of Motion Right Leg	5-Full ROM
Strength/Range of Motion Impairment Comment	Left shoulder fractured and dislocated

Document 09/20/18 00:30 KIM0006 (Rec: 09/20/18 01:19 KIM0006 ICU-C12)
ICCU: Neurological Assessment
Neurological Assessment

Level of Consciousness	Awake
Patient Orientation	Unable to Determine
Query Text:For pediatric patients A&O x 4 as appropriate for age.	
Patient Behavior	Other
Facial Droop	No
Arm Drift	No
Speech	Garbled
Neurological Comment	Speech slightly garbled. patient does not wish to answer any orientation questions. Pt uncooperative most the shift

Pupils

Pupil Comments	pt does not want pupils to be checked

Glasgow Coma Scale
Glasgow Coma Scale

Best Eye Response	4 - Spontaneous
Best Motor Response	5 - Purposeful Movement
Best Verbal Response	4 - Confused
Glasgow Coma Scale Total	13

Strength Assessment
Strength Assessment

Range of Motion Left Arm	Unable to Assess
Range of Motion Right Arm	5-Full ROM
Range of Motion Left Leg	5-Full ROM
Range of Motion Right Leg	5-Full ROM
Strength/Range of Motion Impairment Comment	Pt does not participate in strength assessment. Observed pt to have Full ROM to bilat lower extremities and Right arm

Document 09/20/18 04:00 KIM0006 (Rec: 09/20/18 04:33 KIM0006 ICU-C12)
ICCU: Neurological Assessment
Neurological Assessment

Continued on Page 75

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01

62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Level of Consciousness	Awake
Patient Orientation	Person
Query Text:For pediatric patients A&O x 4 as appropriate for age.	Place Time
Patient Behavior	Cooperative
Facial Droop	No
Arm Drift	No
Speech	Patient's Normal

Glasgow Coma Scale

Glasgow Coma Scale

Best Eye Response	4 - Spontaneous
Best Motor Response	5 - Purposeful Movement
Best Verbal Response	5 - Oriented
Glasgow Coma Scale Total	14

Strength Assessment

Strength Assessment

Range of Motion Left Arm	Unable to Assess
Range of Motion Right Arm	5-Full ROM
Range of Motion Left Leg	5-Full ROM
Strength/Range of Motion Impairment Comment	Pt does not participate in strength assessment. Observed pt to have Full ROM to bilat lower extremities and Right arm

Document 09/20/18 08:00 JOA0063 (Rec: 09/20/18 16:02 JOA0063 ICU-C25)

ICCU: Neurological Assessment

Neurological Assessment

Level of Consciousness	Awake Alert
Patient Orientation	Person
Query Text:For pediatric patients A&O x 4 as appropriate for age.	
Patient Behavior	Other
Facial Droop	No
Arm Drift	No
Speech	Patient's Normal
Neurological Comment	DECLINES MOST CARE, FORGETFUL

Pupils

Pupil Comments	pt does not want pupils to be checked

Glasgow Coma Scale

Glasgow Coma Scale

Best Eye Response	4 - Spontaneous
Best Motor Response	5 - Purposeful Movement
Best Verbal Response	5 - Oriented
Glasgow Coma Scale Total	14

Strength Assessment

Strength Assessment

Range of Motion Left Arm	3-Gravity Only
Range of Motion Right Arm	5-Full ROM
Range of Motion Left Leg	5-Full ROM
Strength/Range of Motion Impairment Comment	Pt does not participate in strength assessment. Observed

Continued on Page 76

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

```
                                        pt to have Full ROM to bilat
                                        lower extremities and Right
                                        arm, PARTIAL ROM LT ARM
Not Done     09/20/18 12:00  JOA0063  (Rec: 09/20/18 16:05  JOA0063  ICU-C25)
    AWAITS BED 4N, MED STATUS
Document     09/20/18 16:21  ANI0051  (Rec: 09/20/18 16:22  ANI0051  ICU-C25)
ICCU: Neurological Assessment
    Neurological Assessment
       Level of Consciousness           Awake
                                        Alert
       Patient Orientation              Person
        Query Text:For pediatric patients A&O x
        4 as appropriate for age.
       Patient Behavior                 Other
       Facial Droop                     No
       Arm Drift                        No
       Speech                           Patient's Normal
       Neurological Comment             DECLINES MOST CARE, FORGETFUL
Glasgow Coma Scale
    Glasgow Coma Scale
       Best Eye Response                4 - Spontaneous
       Best Motor Response              5 - Purposeful Movement
       Best Verbal Response             5 - Oriented
       Glasgow Coma Scale Total         14
Strength Assessment
    Strength Assessment
       Range of Motion Left Arm         3-Gravity Only
       Range of Motion Right Arm        5-Full ROM
       Range of Motion Left Leg         5-Full ROM
       Strength/Range of Motion Impairment  Pt does not participate in
        Comment                         strength assessment. Observed
                                        pt to have Full ROM to bilat
                                        lower extremities and Right
                                        arm, PARTIAL ROM LT ARM
```

```
ICCU 02: Cardiovascular Assessment                Start:  09/19/18 08:47
Freq:   DAILY@0000,0400,0800,1200,1600,2000        Status: Inactive
Protocol:
Document     09/19/18 12:00  KYL0009  (Rec: 09/19/18 12:48  KYL0009  ICU-C12)
ICCU: Cardiovascular Assessment
    Alarms/Monitoring
       Alarm Limits Set/Checked         Yes
       Method of Monitoring             Hardwire
    Cardiovascular Assessment
       Heart Rhythm                     Sinus Rhythm
       Heart Sounds/Apical Pulse        S1
                                        S2
                                        Regular
       Skin Perfusion                   Skin Color Reflects Adequate
                                        Perfusion
                                        Cool
       Capillary Refill                 Less than 3 Seconds
       Chest/Cardiac Pain               No
    Peripheral Pulse Assessment
```

Continued on Page 77

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01

62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

```
      Bilateral Radial
       Pulse                                  Present
       Pulse Strength                         2+ Normal
      Bilateral Dorsal Pedal
       Pulse                                  Present
       Pulse Strength                         2+ Normal
    Edema Assessment
      Edema Present                           Yes
    Edema Details
      gen
       Edema Type                             Non-Pitting
       Edema Degree                           1+/Trace
DVT Assessment
    DVT Assessment
      DVT / VTE Prophylaxis Application (QM)  SCD
                                              Bilateral
      Anti-Coagulation Medication             No
      Calf Assessment                         Benign
Document     09/19/18 16:00  KYL0009  (Rec: 09/19/18 17:53  KYL0009  ICU-C12)
ICCU: Cardiovascular Assessment
    Alarms/Monitoring
      Alarm Limits Set/Checked                Yes
      Method of Monitoring                    Hardwire
    Cardiovascular Assessment
      Heart Rhythm                            Sinus Rhythm
      Heart Sounds/Apical Pulse               S1
                                              S2
                                              Regular
      Skin Perfusion                          Skin Color Reflects Adequate
                                              Perfusion
                                              Cool
      Capillary Refill                        Less than 3 Seconds
      Chest/Cardiac Pain                      No
    Peripheral Pulse Assessment
      Bilateral Radial
       Pulse                                  Present
       Pulse Strength                         2+ Normal
      Bilateral Dorsal Pedal
       Pulse                                  Present
       Pulse Strength                         2+ Normal
    Edema Assessment
      Edema Present                           Yes
    Edema Details
      gen
       Edema Type                             Non-Pitting
       Edema Degree                           1+/Trace
DVT Assessment
    DVT Assessment
      DVT / VTE Prophylaxis Application (QM)  SCD
                                              Bilateral
      Anti-Coagulation Medication             No
      Calf Assessment                         Benign
Not Done     09/19/18 20:00  KIM0006  (Rec: 09/19/18 22:42  KIM0006  ICU-C12)
```

Continued on Page 78

Assessments and Treatments - Continued

2050 patient refusing assessment

Document 09/20/18 00:30 KIM0006 (Rec: 09/20/18 01:19 KIM0006 ICU-C12)

ICCU: Cardiovascular Assessment

Alarms/Monitoring

Alarm Limits Set/Checked	Yes
Method of Monitoring	Hardwire

Cardiovascular Assessment

Heart Rhythm	Sinus Rhythm
Heart Sounds/Apical Pulse	S1 S2 Regular
Skin Perfusion	Skin Color Reflects Adequate Perfusion Cool
Capillary Refill	Less than 3 Seconds
Chest/Cardiac Pain	No

Peripheral Pulse Assessment

Bilateral Radial

Pulse	Present
Pulse Strength	2+ Normal

Bilateral Dorsal Pedal

Pulse	Present
Pulse Strength	2+ Normal

Edema Assessment

Edema Present	Yes

Edema Details

right shoulder

Edema Type	Non-Pitting
Edema Degree	2+/Mild

DVT Assessment

DVT Assessment

DVT / VTE Prophylaxis Application (QM)	SCD Bilateral
Anti-Coagulation Medication	No
Calf Assessment	Benign
DVT Prophylaxis Comment	pt declines SCD

Document 09/20/18 04:00 KIM0006 (Rec: 09/20/18 04:33 KIM0006 ICU-C12)

ICCU: Cardiovascular Assessment

Alarms/Monitoring

Alarm Limits Set/Checked	Yes
Method of Monitoring	Hardwire

Cardiovascular Assessment

Heart Rhythm	Sinus Rhythm
Heart Sounds/Apical Pulse	S1 S2 Regular
Skin Perfusion	Skin Color Reflects Adequate Perfusion Cool
Capillary Refill	Less than 3 Seconds
Chest/Cardiac Pain	No

Peripheral Pulse Assessment

Bilateral Radial

Continued on Page 79

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01

62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

```
      Pulse                                   Present
      Pulse Strength                          2+ Normal
     Bilateral Dorsal Pedal
      Pulse                                   Present
      Pulse Strength                          2+ Normal
    Edema Assessment
     Edema Present                            Yes
    Edema Details
     right shoulder
      Edema Type                              Non-Pitting
      Edema Degree                            2+/Mild
DVT Assessment
    DVT Assessment
     DVT / VTE Prophylaxis Application (QM)   SCD
                                              Bilateral
     Anti-Coagulation Medication              No
     Calf Assessment                          Benign
     DVT Prophylaxis Comment                  pt declines SCD
Document     09/20/18 08:00  JOA0063  (Rec: 09/20/18 16:02  JOA0063  ICU-C25)
ICCU: Cardiovascular Assessment
    Alarms/Monitoring
     Alarm Limits Set/Checked                 Yes
     Method of Monitoring                     Hardwire
    Cardiovascular Assessment
     Heart Rhythm                             Sinus Tachycardia
     Heart Sounds/Apical Pulse                S1
                                              S2
                                              Regular
     Skin Perfusion                           Skin Color Reflects Adequate
                                              Perfusion
                                              Dry
                                              Warm
     Capillary Refill                         Less than 3 Seconds
     Chest/Cardiac Pain                       No
    Edema Assessment
     Edema Present                            No
DVT Assessment
    DVT Assessment
     Reason DVT / VTE Prophylaxis Not Applied Refusal of Treatment by
      (QM)                                    Patient
     Anti-Coagulation Medication              No
     Early Ambulation                         Yes
     Calf Assessment                          Benign
Not Done     09/20/18 12:00  JOA0063  (Rec: 09/20/18 16:05  JOA0063  ICU-C25)
    AWAITS BED 4N, MED STATUS
Document     09/20/18 16:22  ANI0051  (Rec: 09/20/18 16:31  ANI0051  ICU-C25)
ICCU: Cardiovascular Assessment
    Alarms/Monitoring
     Alarm Limits Set/Checked                 Yes
     Method of Monitoring                     Hardwire
    Cardiovascular Assessment
     Heart Rhythm                             Sinus Tachycardia
     Heart Sounds/Apical Pulse                S1
```

Continued on Page 80

Assessments and Treatments - Continued

	S2
	Regular
Skin Perfusion	Skin Color Reflects Adequate Perfusion
	Dry
	Warm
Capillary Refill	Less than 3 Seconds
Chest/Cardiac Pain	No
Edema Assessment	
Edema Present	No
DVT Assessment	
DVT Assessment	
Reason DVT / VTE Prophylaxis Not Applied (QM)	Refusal of Treatment by Patient
Anti-Coagulation Medication	No
Early Ambulation	Yes
Calf Assessment	Benign

ICCU 03: Pulmonary Assessment Start: 09/19/18 08:47
Freq: DAILY@0000,0400,0800,1200,1600,2000 Status: Inactive
Protocol:

Document 09/19/18 12:00 KYL0009 (Rec: 09/19/18 12:48 KYL0009 ICU-C12)

ICCU: Pulmonary Assessment	
Lung Sounds Assessment	
Bilateral	
Lung Sound Respiratory Phase	Inspiratory & Expiratory
Breath Sounds	Coarse
Respiratory Effort	Normal
Cough Assessment	
Cough Frequency	None
Oxygen Assessment	
Patient on Room Air	No
Ventilation	
Settings	
Is Patient on a Ventilator	No
Patient Position	
HOB Elevated 30 Degrees	Yes
Patient Position	Supine

Document 09/19/18 16:00 KYL0009 (Rec: 09/19/18 17:53 KYL0009 ICU-C12)

ICCU: Pulmonary Assessment	
Lung Sounds Assessment	
Bilateral	
Lung Sound Respiratory Phase	Inspiratory & Expiratory
Breath Sounds	Coarse
Respiratory Effort	Normal
Cough Assessment	
Cough Frequency	None
Oxygen Assessment	
Patient on Room Air	No
Ventilation	
Settings	
Is Patient on a Ventilator	No
Patient Position	
HOB Elevated 30 Degrees	Yes

Continued on Page 81

```
      Patient Position                          Supine
Not Done     09/19/18 20:00  KIM0006  (Rec: 09/19/18 22:42  KIM0006  ICU-C12)
    2050 patient refusing assessment
Document     09/20/18 00:30  KIM0006  (Rec: 09/20/18 01:19  KIM0006  ICU-C12)
ICCU: Pulmonary Assessment
    Lung Sounds Assessment
      Bilateral
       Lung Sound Respiratory Phase             Inspiratory & Expiratory
       Breath Sounds                            Clear
       Respiratory Effort                       Normal
    Cough Assessment
      Cough Frequency                           None
    Oxygen Assessment
      Patient on Room Air                       Yes
Document     09/20/18 04:00  KIM0006  (Rec: 09/20/18 04:37  KIM0006  ICU-C12)
ICCU: Pulmonary Assessment
    Lung Sounds Assessment
      Bilateral
       Lung Sound Respiratory Phase             Inspiratory & Expiratory
       Breath Sounds                            Clear
       Respiratory Effort                       Normal
    Cough Assessment
      Cough Frequency                           None
    Oxygen Assessment
      Patient on Room Air                       Yes
      Oxygen Devices in Use Now                 None
Ventilation
    Settings
      Is Patient on a Ventilator                No
Document     09/20/18 08:00  JOA0063  (Rec: 09/20/18 16:02  JOA0063  ICU-C25)
ICCU: Pulmonary Assessment
    Lung Sounds Assessment
      Bilateral
       Lung Sound Respiratory Phase             Inspiratory & Expiratory
       Breath Sounds                            Clear
       Respiratory Effort                       Normal
       Lung Sound Comment                       PER MD
    Cough Assessment
      Cough Frequency                           None
    Oxygen Assessment
      Patient on Room Air                       Yes
      Oxygen Devices in Use Now                 None
Ventilation
    Settings
      Is Patient on a Ventilator                No
    Patient Position
      HOB Elevated 30 Degrees                   Yes
      Patient Position                          Supine
Not Done     09/20/18 12:00  JOA0063  (Rec: 09/20/18 16:05  JOA0063  ICU-C25)
    AWAITS BED 4N, MED STATUS
Document     09/20/18 16:22  ANI0051  (Rec: 09/20/18 16:31  ANI0051  ICU-C25)
ICCU: Pulmonary Assessment
    Lung Sounds Assessment
```

Continued on Page 82

Assessments and Treatments - Continued

```
      Bilateral
       Lung Sound Respiratory Phase          Inspiratory & Expiratory
       Breath Sounds                         Clear
       Respiratory Effort                    Normal
       Lung Sound Comment                    PER MD
    Cough Assessment
      Cough Frequency                        None
    Oxygen Assessment
      Patient on Room Air                    Yes
      Oxygen Devices in Use Now              None
ICCU 04: Gastrointestinal Assessment                   Start:  09/19/18 08:47
Freq:   DAILY@0000,0400,0800,1200,1600,2000            Status: Inactive
Protocol:
 Document     09/19/18 12:00  KYL0009  (Rec: 09/19/18 12:48  KYL0009  ICU-C12)
 Date of Last Bowel Movement
    Date of Last Bowel Movement
      Date of Last Bowel Movement            UTA
 ICCU: GI Assessment
    Abdominal Assessment
      All Quadrants
       Bowel Sounds                          Normal/Active
    Abdominal Assessment
      Abdomen Description                    Benign
      Abdominal Tenderness                   Non-Tender
    Gastrointestinal Assessment
      Gastrointestinal Symptoms              No Symptoms
 Document     09/19/18 16:00  KYL0009  (Rec: 09/19/18 17:53  KYL0009  ICU-C12)
 Date of Last Bowel Movement
    Date of Last Bowel Movement
      Date of Last Bowel Movement            UTA
 ICCU: GI Assessment
    Abdominal Assessment
      All Quadrants
       Bowel Sounds                          Normal/Active
    Abdominal Assessment
      Abdomen Description                    Benign
      Abdominal Tenderness                   Non-Tender
    Gastrointestinal Assessment
      Gastrointestinal Symptoms              No Symptoms
 Not Done     09/19/18 20:00  KIM0006  (Rec: 09/19/18 22:42  KIM0006  ICU-C12)
    2050 patient refusing assessment
 Document     09/20/18 00:00  KIM0006  (Rec: 09/20/18 01:20  KIM0006  ICU-C12)
 Date of Last Bowel Movement
    Date of Last Bowel Movement
      Date of Last Bowel Movement            UTA
 ICCU: GI Assessment
    Abdominal Assessment
      All Quadrants
       Bowel Sounds                          Normal/Active
    Abdominal Assessment
      Abdomen Description                    Benign
                                             Soft
      Abdominal Tenderness                   Non-Tender
```

Continued on Page 83

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

```
    Gastrointestinal Assessment
      Bowel Pattern                           No Bowel Movement
Edit Time    09/20/18 00:30  KIM0006  (Rec: 09/20/18 01:21  KIM0006  ICU-C12)
    09/20/18 00:00=>09/20/18 00:30
Document     09/20/18 04:00  KIM0006  (Rec: 09/20/18 04:37  KIM0006  ICU-C12)
Date of Last Bowel Movement
    Date of Last Bowel Movement
      Date of Last Bowel Movement             UTA
ICCU: GI Assessment
    Gastrointestinal Assessment
      Bowel Pattern                           No Bowel Movement
Document     09/20/18 08:00  JOA0063  (Rec: 09/20/18 16:02  JOA0063  ICU-C25)
Date of Last Bowel Movement
    Date of Last Bowel Movement
      Date of Last Bowel Movement             9/20/18
ICCU: GI Assessment
    Abdominal Assessment
      All Quadrants
       Bowel Sounds                           Normal/Active
    Abdominal Assessment
      Abdomen Description                     Benign
                                              Soft
      Abdominal Tenderness                    Non-Tender
    Gastrointestinal Assessment
      Bowel Pattern                           No Bowel Movement
Not Done     09/20/18 12:00  JOA0063  (Rec: 09/20/18 16:05  JOA0063  ICU-C25)
    AWAITS BED 4N, MED STATUS
Document     09/20/18 16:22  ANI0051  (Rec: 09/20/18 16:31  ANI0051  ICU-C25)
Date of Last Bowel Movement
    Date of Last Bowel Movement
      Date of Last Bowel Movement             9/20/18
ICCU: GI Assessment
    Abdominal Assessment
      All Quadrants
       Bowel Sounds                           Normal/Active
    Abdominal Assessment
      Abdomen Description                     Benign
                                              Soft
      Abdominal Tenderness                    Non-Tender
    Gastrointestinal Assessment
      Bowel Pattern                           No Bowel Movement
ICCU 05: Genitourinary Assessment                       Start:  09/19/18 08:47
Freq:   DAILY@0000,0400,0800,1200,1600,2000             Status: Inactive
Protocol:
Document     09/19/18 12:00  KYL0009  (Rec: 09/19/18 12:48  KYL0009  ICU-C12)
ICCU: GU Assessment
    Genitourinary Assessment
      Does Patient Void                       Yes
      Voiding Description                     Has Not Voided This Shift
                                              See Comment
      Catheter Care Completed                 Not Applicable
      Genitourinary Comments                  Straight cath'd in ED PTA to
                                              ICU
```

Continued on Page 84

Assessments and Treatments - Continued

```
Document     09/19/18 16:00  KYL0009  (Rec: 09/19/18 17:53  KYL0009  ICU-C12)
ICCU: GU Assessment
    Genitourinary Assessment
      Does Patient Void                          Yes
      Voiding Description                        Has Not Voided This Shift
                                                 See Comment
      Catheter Care Completed                    Not Applicable
      Genitourinary Comments                     Straight cath'd in ED PTA to
                                                 ICU
Not Done     09/19/18 20:00  KIM0006  (Rec: 09/19/18 22:42  KIM0006  ICU-C12)
    2050 patient refusing assessment
Document     09/20/18 00:00  KIM0006  (Rec: 09/20/18 01:20  KIM0006  ICU-C12)
ICCU: GU Assessment
    Genitourinary Assessment
      Voiding Description                        See Comment
      Genitourinary Comments                     Urinal/bed pan offered, pt
                                                 declines. has not voided
Edit Time    09/20/18 00:30  KIM0006  (Rec: 09/20/18 01:21  KIM0006  ICU-C12)
    09/20/18 00:00=>09/20/18 00:30
Document     09/20/18 04:00  KIM0006  (Rec: 09/20/18 04:37  KIM0006  ICU-C12)
ICCU: GU Assessment
    Genitourinary Assessment
      Voiding Description                        Continent
      Toileting Methods                          Urinal
      Urine Concentration                        Medium
      Urine Character                            Clear
      Urine Color                                Yellow
Document     09/20/18 08:00  JOA0063  (Rec: 09/20/18 16:02  JOA0063  ICU-C25)
ICCU: Urine Volume
    Urine Volume
      Urine Volume                               Quantity Sufficient
ICCU: GU Assessment
    Genitourinary Assessment
      Does Patient Void                          Yes
      Voiding Description                        Continent
      Toileting Methods                          Toilet
      Urine Concentration                        Medium
      Urine Character                            Clear
      Urine Color                                Yellow
      Urinary Diversions/Devices                 None
      Catheter Care Completed                    Not Applicable
      Urinary Symptoms                           None
Not Done     09/20/18 12:00  JOA0063  (Rec: 09/20/18 16:05  JOA0063  ICU-C25)
    AWAITS BED 4N, MED STATUS
Document     09/20/18 16:22  ANI0051  (Rec: 09/20/18 16:31  ANI0051  ICU-C25)
ICCU: Urine Volume
    Urine Volume
      Urine Volume                               Quantity Sufficient
ICCU: GU Assessment
    Genitourinary Assessment
      Does Patient Void                          Yes
      Voiding Description                        Continent
      Toileting Methods                          Toilet
```

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Urine Concentration	Medium
Urine Character	Clear
Urine Color	Yellow
Urinary Diversions/Devices	None
Catheter Care Completed	Not Applicable
Urinary Symptoms	None

ICCU 06: Skin Assessment Start: 09/19/18 08:47
Freq: DAILY@0000,0400,0800,1200,1600,2000 Status: Inactive
Protocol: C.SKINBRAD
Document 09/19/18 12:00 KYL0009 (Rec: 09/19/18 12:48 KYL0009 ICU-C12)
ICCU: Skin Assessment
Skin Deviation

Nose	
Skin Deviations	Abrasion Bruise
Dressing Status	None
Drainage Amount	Scant
Drainage Description	dried blood
Drainage Odor	None/Absent
Forehead	
Skin Deviations	Abrasion Bruise
Skin Deviation Description Query Text:Do not describe pressure ulcers here.	surrounding facial swelling-forehead and jaw
Dressing Status	None
Drainage Amount	None
left hip	
Skin Deviations	Abrasion
Dressing Status	None
Drainage Amount	None
Left Leg	
Skin Deviations	Abrasion
Dressing Status	None
Drainage Amount	None
Hand	
Skin Deviations	Bruise
Skin Deviation Description Query Text:Do not describe pressure ulcers here.	left forearm

Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown

Is There New or Worsening Pressure-Related Skin Breakdown	No

Braden Risk and Strategies
Braden Scale
Protocol: C.BRADGRID

Sensory Perception - Skin Risk Assessment Scale	Slightly Limited
Moisture -Skin Risk Assessment Scale	Occasionally Moist
Activity - Skin Risk Assessment Scale	Bedfast
Mobility - Skin Risk Assessment Scale	Very Limited
Nutrition - Skin Risk Assessment Scale	Adequate

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Friction & Shear - Skin Risk Assessment Scale — No Apparent Problem
Total Score - Skin Risk Assessment (points) — 15
Query Text:** Score and Skin Risk Level **
19-23 = No Risk
15-18 = Mild Risk
13-14 = Moderate Risk
10-12 = High Risk
9 or Less= Very High Risk
Skin Risk Level-Calculated — Mild Risk

Skin Risk Level
Protocol: C.SKINBRA
Skin Risk Level-Determined by RN — Mild Risk
Query Text:** DO NOT assign a level lower than the calculated Skin Risk level. **
This question can be updated based on nursing judgement. If different than calculated skin risk, include reason in comment below (required).

Document 09/19/18 16:00 KYL0009 (Rec: 09/19/18 17:53 KYL0009 ICU-C12)
ICCU: Skin Assessment
Skin Deviation

left flank
Skin Deviations	Abrasion Bruise
Dressing Status	None
Drainage Amount	None

Nose
Skin Deviations	Abrasion Bruise
Dressing Status	None
Drainage Amount	None
Appearance of Tissue Surrounding Wound	Skin Intact

Forehead
Skin Deviations	Abrasion Bruise
Dressing Status	None
Drainage Amount	None
Drain Type	None

left hip
Skin Deviations	Abrasion
Dressing Status	None
Drainage Amount	None

Left Leg
Skin Deviations	Abrasion
Dressing Status	None
Drainage Amount	None

Hand
Skin Deviations	Bruise
Skin Deviation Description	left forearm

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Query Text:Do not describe pressure ulcers here.

Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown
Is There New or Worsening Pressure-Related Skin Breakdown — No

Braden Risk and Strategies
Braden Scale
Protocol: C.BRADGRID
Sensory Perception - Skin Risk Assessment Scale — Very Limited
Moisture -Skin Risk Assessment Scale — Occasionally Moist
Activity - Skin Risk Assessment Scale — Bedfast
Mobility - Skin Risk Assessment Scale — Very Limited
Nutrition - Skin Risk Assessment Scale — Very Poor
Friction & Shear - Skin Risk Assessment Scale — No Apparent Problem
Total Score - Skin Risk Assessment (points) — 12
Query Text:** Score and Skin Risk Level **
19-23 = No Risk
15-18 = Mild Risk
13-14 = Moderate Risk
10-12 = High Risk
9 or Less= Very High Risk
Skin Risk Level-Calculated — High Risk
Skin Risk Level
Protocol: C.SKINBRA
Skin Risk Level-Determined by RN — High Risk
Query Text:** DO NOT assign a level lower than the calculated Skin Risk level. **
This question can be updated based on nursing judgement. If different than calculated skin risk, include reason in comment below (required).

Not Done 09/19/18 20:00 KIM0006 (Rec: 09/19/18 22:42 KIM0006 ICU-C12)
2045 patient refusing assessment

Document 09/20/18 00:30 KIM0006 (Rec: 09/20/18 01:26 KIM0006 ICU-C12)

ICCU: Skin Assessment
Skin Deviation
bilateral inner eye
Skin Deviations — Bruise
Skin Deviation Description — swelling and purple bruise to bilateral inner eyes
Query Text:Do not describe pressure ulcers here.
left flank
Skin Deviations — Abrasion, Bruise
Dressing Status — None
Drainage Amount — None
Nose

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Skin Deviations	Abrasion Bruise
Dressing Status	None
Drainage Amount	None
Forehead	
Skin Deviations	Abrasion Bruise
Dressing Status	None
Drainage Amount	None
left hip	
Skin Deviation Description Query Text:Do not describe pressure ulcers here.	Did not observe. Pt did not want this writer to look at
Left Leg	
Skin Deviations	Abrasion
Dressing Status	None
Drainage Amount	None
Hand	
Skin Deviations	Bruise
Skin Deviation Description Query Text:Do not describe pressure ulcers here.	left forearm
Skin Reassessment Provider Communication	
Provider Notification for Skin Breakdown	
Is There New or Worsening Pressure-Related Skin Breakdown	No
Braden Risk and Strategies	
Braden Scale	
Protocol: C.BRADGRID	
Sensory Perception - Skin Risk Assessment Scale	Slightly Limited
Moisture -Skin Risk Assessment Scale	Occasionally Moist
Activity - Skin Risk Assessment Scale	Bedfast
Mobility - Skin Risk Assessment Scale	Slightly Limited
Nutrition - Skin Risk Assessment Scale	Probably Inadequate
Friction & Shear - Skin Risk Assessment Scale	No Apparent Problem
Total Score - Skin Risk Assessment (points) Query Text:** Score and Skin Risk Level ** 19-23 = No Risk 15-18 = Mild Risk 13-14 = Moderate Risk 10-12 = High Risk 9 or Less= Very High Risk	15
Skin Risk Level-Calculated	Mild Risk
Skin Risk Level	
Protocol: C.SKINBRA	
Skin Risk Level-Determined by RN Query Text:** DO NOT assign a level lower than the calculated Skin Risk level. **	Mild Risk

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This question can be updated based on nursing judgement. If different than calculated skin risk, include reason in comment below (required).

Document 09/20/18 04:00 KIM0006 (Rec: 09/20/18 04:39 KIM0006 ICU-C12)

ICCU: Skin Assessment
Skin Deviation
bilateral inner eye

Skin Deviations	Bruise
Skin Deviation Description Query Text:Do not describe pressure ulcers here.	swelling and purple bruise to bilateral inner eyes

left flank

Skin Deviations	Abrasion Bruise
Dressing Status	None
Drainage Amount	None

Nose

Skin Deviations	Abrasion Bruise
Dressing Status	None
Drainage Amount	None

Forehead

Skin Deviations	Abrasion Bruise
Dressing Status	None
Drainage Amount	None

left hip

Skin Deviations	Abrasion
Dressing Status	None
Drainage Amount	None

Left Leg

Skin Deviations	Abrasion
Dressing Status	None
Drainage Amount	None

Hand

Skin Deviations	Bruise
Skin Deviation Description Query Text:Do not describe pressure ulcers here.	left forearm

Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown

Is There New or Worsening Pressure-Related Skin Breakdown	No

Braden Risk and Strategies
Braden Scale
Protocol: C.BRADGRID

Sensory Perception - Skin Risk Assessment Scale	Slightly Limited
Moisture -Skin Risk Assessment Scale	Occasionally Moist
Activity - Skin Risk Assessment Scale	Bedfast
Mobility - Skin Risk Assessment Scale	Slightly Limited
Nutrition - Skin Risk Assessment Scale	Probably Inadequate

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center Loc:4 SOUTH - MEDICAL/TELEMETRY Bed:436-01
62 F 05/01/1956 Med Rec Num:M000597460 Visit:A00088518428

Assessments and Treatments - Continued

Friction & Shear - Skin Risk Assessment Scale	No Apparent Problem
Total Score - Skin Risk Assessment (points)	15
Query Text:** Score and Skin Risk Level **	
19-23 = No Risk	
15-18 = Mild Risk	
13-14 = Moderate Risk	
10-12 = High Risk	
9 or Less= Very High Risk	
Skin Risk Level-Calculated	Mild Risk
Skin Risk Level	
Protocol: C.SKINBRA	
Skin Risk Level-Determined by RN	Mild Risk
Query Text:** DO NOT assign a level lower than the calculated Skin Risk level. ** This question can be updated based on nursing judgement. If different than calculated skin risk, include reason in comment below (required).	

Document 09/20/18 08:00 JOA0063 (Rec: 09/20/18 16:02 JOA0063 ICU-C25)

ICCU: Skin Assessment

Skin Deviation	
bilateral inner eye	
Skin Deviations	Bruise
Skin Deviation Description	swelling and purple bruise to bilateral inner eyes
Query Text:Do not describe pressure ulcers here.	
left flank	
Skin Deviations	Abrasion Bruise
Dressing Status	None
Drainage Amount	None
Nose	
Skin Deviations	Abrasion Bruise
Dressing Status	None
Drainage Amount	None
Forehead	
Skin Deviations	Abrasion Bruise
Dressing Status	None
Drainage Amount	None
left hip	
Skin Deviations	Abrasion
Dressing Status	None
Drainage Amount	None
Left Leg	
Skin Deviations	Abrasion
Dressing Status	None
Drainage Amount	None

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BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

```
      Hand
       Skin Deviations                           Bruise
       Skin Deviation Description                left forearm
        Query Text:Do not describe pressure
        ulcers here.
Skin Reassessment Provider Communication
    Provider Notification for Skin Breakdown
      Is There New or Worsening Pressure-        No
       Related Skin Breakdown
Braden Risk and Strategies
    Braden Scale
    Protocol:  C.BRADGRID
      Sensory Perception - Skin Risk             Slightly Limited
       Assessment Scale
      Moisture -Skin Risk Assessment Scale       Rarely Moist
      Activity - Skin Risk Assessment Scale      Bedfast
      Mobility - Skin Risk Assessment Scale      Slightly Limited
      Nutrition - Skin Risk Assessment Scale     Probably Inadequate
      Friction & Shear - Skin Risk Assessment    No Apparent Problem
       Scale
      Total Score - Skin Risk Assessment (       16
       points)
       Query Text:** Score and Skin Risk Level
       **
       19-23 = No Risk
       15-18 = Mild Risk
       13-14 = Moderate Risk
       10-12 = High Risk
       9 or Less= Very High Risk
      Skin Risk Level-Calculated                 Mild Risk
    Skin Risk Level
    Protocol:  C.SKINBRA
      Skin Risk Level-Determined by RN           Mild Risk
       Query Text:**  DO NOT assign a level
       lower than the calculated Skin Risk
       level.  **
       This question can be updated based on
       nursing judgement.  If different than
       calculated skin risk, include reason in
       comment below (required).
Not Done     09/20/18 12:00  JOA0063  (Rec: 09/20/18 16:05  JOA0063  ICU-C25)
    AWAITS BED 4N, MED STATUS
Document     09/20/18 16:22  ANI0051  (Rec: 09/20/18 16:31  ANI0051  ICU-C25)
ICCU: Skin Assessment
    Skin Deviation
      bilateral inner eye
       Skin Deviations                           Bruise
       Skin Deviation Description                no change
        Query Text:Do not describe pressure
        ulcers here.
      left flank
       Skin Deviations                           Abrasion
                                                 Bruise
```

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Nose	
Skin Deviations	Abrasion Bruise
Forehead	
Skin Deviations	Abrasion Bruise
left hip	
Skin Deviations	Abrasion
Left Leg	
Skin Deviations	Abrasion
Hand	
Skin Deviations	Bruise
Skin Reassessment Provider Communication	
Provider Notification for Skin Breakdown	
Is There New or Worsening Pressure-Related Skin Breakdown	No
Braden Risk and Strategies	
Braden Scale	
Protocol: C.BRADGRID	
Sensory Perception - Skin Risk Assessment Scale	Slightly Limited
Moisture -Skin Risk Assessment Scale	Rarely Moist
Activity - Skin Risk Assessment Scale	Walks Occasionally
Mobility - Skin Risk Assessment Scale	Slightly Limited
Nutrition - Skin Risk Assessment Scale	Probably Inadequate
Friction & Shear - Skin Risk Assessment Scale	No Apparent Problem
Total Score - Skin Risk Assessment (points)	18
Query Text:** Score and Skin Risk Level ** 19-23 = No Risk 15-18 = Mild Risk 13-14 = Moderate Risk 10-12 = High Risk 9 or Less= Very High Risk	
Skin Risk Level-Calculated	Mild Risk
Skin Risk Level	
Protocol: C.SKINBRA	
Skin Risk Level-Determined by RN	Mild Risk
Query Text:** DO NOT assign a level lower than the calculated Skin Risk level. ** This question can be updated based on nursing judgement. If different than calculated skin risk, include reason in comment below (required).	

ICCU 07: Safety Assessment Start: 09/19/18 08:47
Freq: DAILY@0000,0400,0800,1200,1600,2000 Status: Inactive
Protocol: C.FALLINT
Document 09/19/18 12:00 KYL0009 (Rec: 09/19/18 12:48 KYL0009 ICU-C12)
Hx of Falls During Hospital Visit
Hx of Falls During Hospital Visit

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Assessments and Treatments - Continued

History of Falls During Hospital Visit	No
Safety/Fall Risk Assessment	
Safety/Fall Risk Assessment	
Protocol: C.FALLINT	
Mental Status	Forgets/Disregards Limitations ,Impulsive or Altered Mentation
Patient Is Willing and Able to Assist in Fall Prevention Query Text:Ask patient: Can you, will you, and are you able to ring for assistance?	No
Recent History of Falls (Within the Last 12 Months)	No
Age	Less Than 65 Years
Narcotic/Sedative/Hypnotic Medication Administered	Yes
Bladder/Bowel Incontinence	No
Attached Equipment (Lines/Tubes/Etc)	Yes
Secondary Diagnosis (2 or More Medical Diagnoses)	Yes
Gait/Transferring	Bed Rest/Immobile
Score	125
CVA/TIA or Stroke in past 24 hours Query Text:** If CVA/TIA or Stroke related diagnosis in past 24 hours, patient should be considered High Risk for falls. ** ** If right hemisphere injury, consider using alarm. **	No
Fall Risk - Calculated	Alarm
Fall Risk - Determined by RN 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).	Alarm
Safety Interventions	
Alarm Limits Set/Checked	Yes
Side Rails Up	2 Rails
Call Bell Within Reach	Yes
Method of Monitoring	Bed Alarm Personal Alarm Pulse Oximetry
Safety Interventions Comment	1:1
Additional Precautions	
Additional Precautions	
Additional Precautions	Aspiration
Risk for Entrapment	
Risk for Entrapment	
Is Patient at Risk For Entrapment in Bed Rails	Confusion

Continued on Page 94

Assessments and Treatments - Continued

Query Text:Two or more items place patient at risk for entrapment and will trigger entrapment intervention to your worklist.

Document 09/19/18 16:00 KYL0009 (Rec: 09/19/18 17:53 KYL0009 ICU-C12)

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
- Protocol: C.FALLINT
  - Mental Status: Oriented to Own Ability
  - Patient Is Willing and Able to Assist in Fall Prevention: No
    - 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): Yes
  - Secondary Diagnosis (2 or More Medical Diagnoses): Yes
  - Gait/Transferring: Bed Rest/Immobile
  - Score: 65
  - CVA/TIA or Stroke in past 24 hours: No
    - Query Text:** If CVA/TIA or Stroke related diagnosis in past 24 hours, patient should be considered High Risk for falls. ** ** If right hemisphere injury, consider using alarm. **
  - 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).
- Safety Interventions
  - Alarm Limits Set/Checked: Yes
  - Side Rails Up: 2 Rails
  - Call Bell Within Reach: Yes
  - Method of Monitoring: Personal Alarm

Additional Precautions
- Additional Precautions
  - Additional Precautions: Aspiration

Risk for Entrapment
- Risk for Entrapment

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Assessments and Treatments - Continued

Is Patient at Risk For Entrapment in Bed Rails Query Text:Two or more items place patient at risk for entrapment and will trigger entrapment intervention to your worklist.	Confusion

Document 09/19/18 20:50 KIM0006 (Rec: 09/19/18 23:03 KIM0006 ICU-C12)

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
Protocol: C.FALLINT

Mental Status	Forgets/Disregards Limitations ,Impulsive or Altered Mentation
Patient Is Willing and Able to Assist in Fall Prevention Query Text:Ask patient: Can you, will you, and are you able to ring for assistance?	No
Recent History of Falls (Within the Last 12 Months)	No
Age	Less Than 65 Years
Narcotic/Sedative/Hypnotic Medication Administered	Yes
Bladder/Bowel Incontinence	No
Attached Equipment (Lines/Tubes/Etc)	Yes
Secondary Diagnosis (2 or More Medical Diagnoses)	Yes
Gait/Transferring	Impaired
Score	135
CVA/TIA or Stroke in past 24 hours Query Text:** If CVA/TIA or Stroke related diagnosis in past 24 hours, patient should be considered High Risk for falls. ** ** If right hemisphere injury, consider using alarm. **	No
Fall Risk - Calculated	Alarm
Fall Risk - Determined by RN 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).	Alarm

Safety Interventions

Alarm Limits Set/Checked	Yes
Side Rails Up	2 Rails
Call Bell Within Reach	Yes

Additional Precautions
Additional Precautions

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Additional Precautions — Aspiration

Risk for Entrapment
Risk for Entrapment
Is Patient at Risk For Entrapment in Bed Rails — Confusion
Query Text:Two or more items place patient at risk for entrapment and will trigger entrapment intervention to your worklist.

Document 09/20/18 00:30 KIM0006 (Rec: 09/20/18 01:26 KIM0006 ICU-C12)

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
Protocol: C.FALLINT
Mental Status — Forgets/Disregards Limitations ,Impulsive or Altered Mentation
Patient Is Willing and Able to Assist in Fall Prevention — No
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 — Yes
Bladder/Bowel Incontinence — No
Attached Equipment (Lines/Tubes/Etc) — Yes
Secondary Diagnosis (2 or More Medical Diagnoses) — Yes
Gait/Transferring — Impaired
Score — 135
CVA/TIA or Stroke in past 24 hours — No
Query Text:** If CVA/TIA or Stroke related diagnosis in past 24 hours, patient should be considered High Risk for falls. **
** If right hemisphere injury, consider using alarm. **
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).
Safety Comment — Safety monitor at the bedside

Safety Interventions
Alarm Limits Set/Checked — Yes

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BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01

62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

```
      Side Rails Up                              2 Rails
      Call Bell Within Reach                     Yes
Additional Precautions
    Additional Precautions
      Additional Precautions                     Aspiration
Risk for Entrapment
    Risk for Entrapment
      Is Patient at Risk For Entrapment in Bed  Confusion
       Rails
       Query Text:Two or more items place
       patient at risk for entrapment and will
       trigger entrapment intervention to your
       worklist.
Document     09/20/18 04:00  KIM0006  (Rec: 09/20/18 04:39  KIM0006  ICU-C12)
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
    Protocol:  C.FALLINT
      Mental Status                              Forgets/Disregards Limitations
                                                 ,Impulsive or Altered
                                                 Mentation
      Patient Is Willing and Able to Assist in   No
       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      Yes
       Administered
      Bladder/Bowel Incontinence                 No
      Attached Equipment (Lines/Tubes/Etc)       Yes
      Secondary Diagnosis (2 or More Medical     Yes
       Diagnoses)
      Gait/Transferring                          Impaired
      Score                                      135
      CVA/TIA or Stroke in past 24 hours         No
       Query Text:** If CVA/TIA or Stroke
       related diagnosis in past 24 hours,
       patient should be considered High Risk
       for falls. **
       ** If right hemisphere injury, consider
       using alarm. **
      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
```

Continued on Page 98

Assessments and Treatments - Continued

```
      comments below (required).
     Safety Comment                            Safety monitor at the bedside
   Safety Interventions
     Alarm Limits Set/Checked                  Yes
     Side Rails Up                             2 Rails
     Call Bell Within Reach                    Yes
Additional Precautions
   Additional Precautions
     Additional Precautions                    Aspiration
Risk for Entrapment
   Risk for Entrapment
     Is Patient at Risk For Entrapment in Bed  Confusion
      Rails
      Query Text:Two or more items place
      patient at risk for entrapment and will
      trigger entrapment intervention to your
      worklist.
Document     09/20/18 08:00  JOA0063  (Rec: 09/20/18 16:02  JOA0063  ICU-C25)
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
   Protocol:  C.FALLINT
     Mental Status                             Forgets/Disregards Limitations
                                               ,Impulsive or Altered
                                               Mentation
     Patient Is Willing and Able to Assist in  No
      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     Yes
      Administered
     Bladder/Bowel Incontinence                No
     Attached Equipment (Lines/Tubes/Etc)      Yes
     Secondary Diagnosis (2 or More Medical    Yes
      Diagnoses)
     Gait/Transferring                         Impaired
     Score                                     135
     CVA/TIA or Stroke in past 24 hours        No
      Query Text:** If CVA/TIA or Stroke
      related diagnosis in past 24 hours,
      patient should be considered High Risk
      for falls. **
      ** If right hemisphere injury, consider
      using alarm. **
     Fall Risk - Calculated                    Alarm
     Fall Risk - Determined by RN              Alarm
      Query Text:**  DO NOT assign a level
```

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

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).
      Safety Comment                          Safety monitor at the bedside
    Safety Interventions
      Alarm Limits Set/Checked                Yes
      Side Rails Up                           4 Rails
      Call Bell Within Reach                  Yes
Additional Precautions
    Additional Precautions
      Additional Precautions                  Aspiration
Risk for Entrapment
    Risk for Entrapment
      Is Patient at Risk For Entrapment in Bed  Confusion
       Rails
       Query Text:Two or more items place
       patient at risk for entrapment and will
       trigger entrapment intervention to your
       worklist.
Not Done     09/20/18 12:00  JOA0063  (Rec: 09/20/18 16:05  JOA0063  ICU-C25)
    AWAITS BED 4N, MED STATUS
Document     09/20/18 16:22  ANI0051  (Rec: 09/20/18 16:31  ANI0051  ICU-C25)
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
    Protocol:  C.FALLINT
      Mental Status                           Forgets/Disregards Limitations
                                              ,Impulsive or Altered
                                              Mentation
      Patient Is Willing and Able to Assist in  No
       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     Yes
       Administered
      Bladder/Bowel Incontinence              No
      Attached Equipment (Lines/Tubes/Etc)      Yes
      Secondary Diagnosis (2 or More Medical    Yes
       Diagnoses)
      Gait/Transferring                       Impaired
      Score                                   135
      CVA/TIA or Stroke in past 24 hours        No
       Query Text:** If CVA/TIA or Stroke
       related diagnosis in past 24 hours,
       patient should be considered High Risk
```

Continued on Page 100

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

for falls. **
** If right hemisphere injury, consider using alarm. **

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).

Safety Comment	safety monitor

Safety Interventions

Alarm Limits Set/Checked	Yes
Call Bell Within Reach	Yes

Additional Precautions
Additional Precautions

Additional Precautions	Aspiration

Risk for Entrapment
Risk for Entrapment

Is Patient at Risk For Entrapment in Bed Rails	Confusion

Query Text:Two or more items place patient at risk for entrapment and will trigger entrapment intervention to your worklist.

ICCU 08: Delirium Assessment Start: 09/19/18 08:47
Freq: DAILY@0400,1600 Status: Inactive
Protocol:
Document 09/19/18 16:00 KYL0009 (Rec: 09/19/18 17:53 KYL0009 ICU-C12)
CAM-ICU Worksheet
Richmond Agitation Sedation Scale (RASS)

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)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (

Continued on Page 101

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

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

1: Acute Onset or Fluctuating Course

Is the Patient Different Than His/Her Baseline Mental Status	Yes
Has the Patient Had Any Fluctuation in Mental Status in Past 24 Hrs	Yes

Query Text:As evidenced by fluctuation on a sedation scale (e.g. RASS), GCS, or previous delirium assessment.

Feature 1	Positive

2: Inattention

Attempt the ASE Letters first. If patient is able to perform this test and the score is clear, record this score and continue with evaluation. If patient is unable to perform this test OR the score is unclear, then perform the ASE Pictures.

ASE Letters: Record Score	Not Tested

Query Text:Directions: Say to the patient, "I am going to read you a series of 10 letters. Whenever you hear the letter "A," indicate by squeezing my hand." Read letters from the following letter list in a normal tone:
S A V E A H A A R T
Scoring: Errors are counted when a patient fails to squeeze on the letter "A" and when the patient squeezes on any letter other than "A."

ASE Pictures: Record Score	Not Tested

Query Text:Directions are included on the picture packets.

Feature 2	Not Tested

3: Altered Level of Consciousness

Feature 3	Positive

Query Text:CAM RASS Score

Overall CAM-ICU

Feature 1 plus 2 AND either 3 OR 4 present = CAM-ICU Positive

Overall CAM-ICU	Unable to Determine from Assessment

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Notification

Is Delirium New or Worsening	No

Document 09/20/18 04:00 KIM0006 (Rec: 09/20/18 04:39 KIM0006 ICU-C12)

CAM-ICU Worksheet

Richmond Agitation Sedation Scale (RASS)

Agitation/Sedation Score	(0) Alert/Calm

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

Continued on Page 102

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01

62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

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

1: Acute Onset or Fluctuating Course

Is the Patient Different Than His/Her Baseline Mental Status	No
Has the Patient Had Any Fluctuation in Mental Status in Past 24 Hrs	Yes

Query Text:As evidenced by fluctuation on a sedation scale (e.g. RASS), GCS, or previous delirium assessment.

Feature 1	Positive

2: Inattention

Attempt the ASE Letters first. If patient is able to perform this test and the score is clear, record this score and continue with evaluation. If patient is unable to perform this test OR the score is unclear, then perform the ASE Pictures.

ASE Letters: Record Score	Not Tested

Query Text:Directions: Say to the patient, "I am going to read you a series of 10 letters. Whenever you hear the letter "A," indicate by squeezing my hand." Read letters from the following letter list in a normal tone:
S A V E A H A A R T
Scoring: Errors are counted when a patient fails to squeeze on the letter "A" and when the patient squeezes on any letter other than "A."

ASE Pictures: Record Score	Not Tested

Query Text:Directions are included on the picture packets.

Continued on Page 103

Feature 2 Not Tested
3: Altered Level of Consciousness
Feature 3 Negative
Query Text:CAM RASS Score
Overall CAM-ICU
Feature 1 plus 2 AND either 3 OR 4 present = CAM-ICU Positive
Overall CAM-ICU Unable to Determine from Assessment

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Notification
Is Delirium New or Worsening No

Document 09/20/18 16:22 ANI0051 (Rec: 09/20/18 16:31 ANI0051 ICU-C25)
CAM-ICU Worksheet
Richmond Agitation Sedation Scale (RASS)
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
1: Acute Onset or Fluctuating Course
Is the Patient Different Than His/Her Baseline Mental Status No
Has the Patient Had Any Fluctuation in Mental Status in Past 24 Hrs Yes
Query Text:As evidenced by fluctuation on a sedation scale (e.g. RASS), GCS, or previous delirium assessment.
Feature 1 Positive
2: Inattention
Attempt the ASE Letters first. If patient is able to perform this test and

Continued on Page 104

the score is clear, record this score and continue with evaluation. If patient is unable to perform this test OR the score is unclear, then perform the ASE Pictures.

ASE Letters: Record Score — Not Tested

Query Text:Directions: Say to the patient, "I am going to read you a series of 10 letters. Whenever you hear the letter "A," indicate by squeezing my hand." Read letters from the following letter list in a normal tone:
S A V E A H A A R T
Scoring: Errors are counted when a patient fails to squeeze on the letter " A" and when the patient squeezes on any letter other than "A."

ASE Pictures: Record Score — Not Tested

Query Text:Directions are included on the picture packets.

Feature 2 — Not Tested

3: Altered Level of Consciousness

Feature 3 — Negative

Query Text:CAM RASS Score

Overall CAM-ICU

Feature 1 plus 2 AND either 3 OR 4 present = CAM-ICU Positive

Overall CAM-ICU — Unable to Determine from Assessment

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Notification

Is Delirium New or Worsening — No

ICCU 10: Sepsis Screen — Start: 09/19/18 08:47
Freq: QSHIFT — Status: Inactive
Protocol:

Not Done 09/19/18 20:00 KIM0006 (Rec: 09/19/18 22:42 KIM0006 ICU-C12)
2045 patient refusing assessment

Document 09/20/18 08:00 JOA0063 (Rec: 09/20/18 16:02 JOA0063 ICU-C25)

Sepsis Screen

Initial Score

Initial SIRS Criteria Present	3
Previous Score	
Previous SIRS Criteria Present	2
Part I (SIRS Criteria)	
Tachycardia (Query Text:>90 bpm)	Yes
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
WBC > 12000 or < 4000 OR Bands > 10%	No, or No Lab Data Available for the Last 24 Hour Period
SIRS Criteria Present	1

Continued on Page 105

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01

62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Query Text:If 2 or more SIRS criteria
are present, the patient may be septic.

ICCU Adm 00: Sepsis Screen Start: 09/19/18 08:47
Freq: Status: Complete
Protocol:
Document 09/19/18 09:10 KYL0009 (Rec: 09/19/18 10:20 KYL0009 ICU-M27)

Sepsis Screen
- Initial Score
  - Initial SIRS Criteria Present: 3
- Previous Score
  - Previous SIRS Criteria Present: 3
- Part I (SIRS Criteria)
  - Tachycardia: No
    Query Text:>90 bpm
  - Tachypnea: Yes
    Query Text:RR>20 or PaCO2 <32
  - Hypo/Hyperthermic: No
    Query Text:Hyperthermic > 38.3C or 101.0F
    Hypothermic <36.0C or 96.8F
  - WBC > 12000 or < 4000 OR Bands > 10%: Yes
  - SIRS Criteria Present: 2
    Query Text:If 2 or more SIRS criteria are present, the patient may be septic.
  - Are SIRS Criteria New or Worsening: No

ICCU Adm 01: Gen Admiss/Adv Directives Start: 09/19/18 08:47
Freq: Status: Complete
Protocol:
Document 09/19/18 09:10 KYL0009 (Rec: 09/19/18 10:20 KYL0009 ICU-M27)

Admission Data
- Admission Data
  - Information Obtained From: Unable to Obtain
  - Swing Patient: No
  - Patient Wearing Medication Patch: No
  - Valuables Form Completed: No
  - Valuables Placed in Safe: No
  - Does Patient Have Own Meds with Them: No
  - Patient Rights Booklet Given?: Yes

Advance Directives
- Medical 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
  - Does Patient Have MOLST Section E: No
  - Patient Given Information About Medical Advance Directives: No

End of Life Care
- End of Life Care
  - Is Patient Receiving End of Life Care: No

Continued on Page 106

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Social, Spiritual and Cultural Resources Provided to Patient and Family	Yes
Height/Weight	
Height/Weight	
Height	5 ft 6 in
Weight	166 lb 10.711 oz
Date of Weight	09/19/18
Time of Weight	08:50
Actual/Estimated Weight	Actual
Body Mass Index (BMI)	26.9
Scale Used	Bed Scale
Query Text:To ensure accurate weights, be sure to always weigh your patient with the same scale.	

ICCU Adm 02: Infection/Isolation Start: 09/19/18 08:47
Freq: Status: Complete
Protocol: C.ISOLCHA2
Document 09/19/18 09:10 KYL0009 (Rec: 09/19/18 10:20 KYL0009 ICU-M27)

Infectious Disease History	
Infectious Disease- History	
Traveled Outside the US in Last 30 Days	No
Infectious Disease History	Unable to Obtain/Confirm
Infectious Disease - Active/Suspected	
Infectious Disease - Active/Suspected	
Active/Suspected Infectious Disease	Unable to Obtain/Confirm
Active Clostridium Difficile	Unable to Determine
Active Lice	Unable to Determine
Active Meningitis	Unable to Determine
Active Rotovirus	Unable to Determine
Active RSV	Unable to Determine
Active Scabies	Unable to Determine
Active Shingles	Unable to Determine
Active Tuberculosis	Unable to Determine
Active Varicella	Unable to Determine
Active Other	Unable to Determine
Isolation and MRSA Assessment	
MRSA Assessment Status	
Protocol: C.MRSACHAR	
MRSA Assessment	Unable to Assess/Obtain
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	
Protocol: C.ISOLCHA2	
Reason for Isolation	None
Type of Isolation	Standard Precautions
Isolation Summary	

Continued on Page 107

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Does Patient Require Isolation No

ICCU Adm 03: Vaccinations Start: 09/19/18 08:47
Freq: Status: Complete
Protocol:
Document 09/19/18 09:10 KYL0009 (Rec: 09/19/18 10:20 KYL0009 ICU-M27)
Vaccine Status
Vaccine Status
Is Patient Able to Be Assessed for Vaccine Status No
Query Text:If no, document reason in comment below and click "Save."
Vaccine Status Comment Patient drowsy/lethargic- UTA at this time
Pneumococcal Vaccination Assessment
Last Pneumococcal Vaccination
Most Recent Pneumonia Vaccination Unsure
Influenza Vaccination Assessment
Last Influenza Vaccination
Most Recent Influenza Vaccination Unsure

ICCU Adm 04: Pain Start: 09/19/18 08:47
Freq: Status: Complete
Protocol:
Document 09/19/18 09:10 KYL0009 (Rec: 09/19/18 10:20 KYL0009 ICU-M27)
Pain History
Pain History
Hx Chronic Pain No
Pain Assessment
Pain Assessment
Protocol: C.PNSCALE
Patient Currently Having Pain No
Pain Assessment Based Upon Nursing Observation
Pain Intensity 0
Query Text:0-10
Pain Scale Used CPOT
Pain Intensity Goal 0
Query Text:0-10
Stated Pain Consistent with Observed Level of Pain N/A

ICCU Adm 05: Skin Start: 09/19/18 08:47
Freq: Status: Complete
Protocol: C.SKINBRAD
Document 09/19/18 09:10 KYL0009 (Rec: 09/19/18 10:20 KYL0009 ICU-M27)
Skin
Skin Assessment
4 Eye Skin Assessment Completed by Person #1 Moore,Kylee
4 Eye Skin Assessment Completed by Person #2 rosika
4 Eye Skin Result Skin Intact Except for Deviations Noted Below
Skin Deviation
Nose
Skin Deviations Abrasion

Continued on Page 108

	Bruise
Skin Deviation Description	associated facial swelling
Query Text:Do not describe pressure ulcers here.	
Dressing Status	None
Drainage Amount	Scant
Drainage Description	Serosanguineous
Drainage Odor	None/Absent
Is Skin Deviation a Pressure Ulcer	No
Forehead	
Skin Deviations	Abrasion
	Bruise
Dressing Status	None
Drainage Amount	Scant
Drainage Description	Serosanguineous
Drainage Odor	None/Absent
Drain	No
Is Skin Deviation a Pressure Ulcer	No
Is Patient a Wound Clinic Patient	No
left hip	
Skin Deviations	Abrasion
Dressing Status	None
Drainage Amount	None
Is Patient a Wound Clinic Patient	No
Left Leg	
Skin Deviations	Abrasion
Skin Deviation Description	shin
Query Text:Do not describe pressure ulcers here.	
Dressing Status	Dry & Intact
Drainage Amount	None
Drain	No
Is Skin Deviation a Pressure Ulcer	No
Is Patient a Wound Clinic Patient	No
Hand	
Skin Deviation Description	no injury noted
Query Text:Do not describe pressure ulcers here.	
Skin Assessment Provider Communication	
Provider Notification for Skin Breakdown	
Is there Existing Pressure-Related Skin Breakdown	No
Braden Risk and Strategies	
Braden Scale	
Protocol: C.BRADGRID	
Sensory Perception - Skin Risk Assessment Scale	Very Limited
Moisture -Skin Risk Assessment Scale	Rarely Moist
Activity - Skin Risk Assessment Scale	Bedfast
Mobility - Skin Risk Assessment Scale	Very Limited
Nutrition - Skin Risk Assessment Scale	Adequate
Friction & Shear - Skin Risk Assessment Scale	Potential Problem

Continued on Page 109

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01

62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Total Score - Skin Risk Assessment (points) — 14

Query Text:** Score and Skin Risk Level **
19-23 = No Risk
15-18 = Mild Risk
13-14 = Moderate Risk
10-12 = High Risk
9 or Less= Very High Risk

Skin Risk Level-Calculated — Moderate Risk

Skin Risk Level

Protocol: C.SKINBRA

Skin Risk Level-Determined by RN — Moderate Risk

Query Text:** DO NOT assign a level lower than the calculated Skin Risk level. **
This question can be updated based on nursing judgement. If different than calculated skin risk, include reason in comment below (required).

ICCU Adm 06: Neurological — Start: 09/19/18 08:47

Freq: — Status: Complete

Protocol:

Document 09/19/18 09:10 KYL0009 (Rec: 09/19/18 10:20 KYL0009 ICU-M27)

Neurological History

Neurological History

Neurological History	Unable to Obtain/Confirm
Other Neuro Impairments/Disorders	Yes: States history of temporal lobe epilepsy, no seizures

ICCU: Neurological Assessment

Neurological Assessment

Level of Consciousness	Arousable Drowsy Sedated Lethargic Responds to Pain Responds to Voice
Patient Orientation	Unable to Determine

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

Patient Behavior	Inappropriate
Speech	Garbled Incomprehensible Sounds Slurred

Pupils

Right Pupil Reaction	Brisk
Right Pupil Size	2 mm
Left Pupil Reaction	Brisk
Left Pupil Size	2 mm

CAM-ICU Worksheet

Richmond Agitation Sedation Scale (RASS)

Agitation/Sedation Score — (-2) Light Sedation

Continued on Page 110

Assessments and Treatments - Continued

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

Overall CAM-ICU
Feature 1 plus 2 AND either 3 OR 4 present = CAM-ICU Positive

Overall CAM-ICU	Delirium Assessment Not Indicated

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Notification

Is Delirium New or Worsening	No

Glasgow Coma Scale

Glasgow Coma Scale

Best Eye Response	3 - To Speech
Best Motor Response	6 - Obeys Commands
Best Verbal Response	2 - Incomprehensible Words
Glasgow Coma Scale Total	11

Strength Assessment

Strength Assessment

Left Hand Grasp Ability	Normal Performance
Right Hand Grasp Ability	Normal Performance
Range of Motion Left Arm	5-Full ROM
Range of Motion Right Arm	5-Full ROM
Range of Motion Left Leg	5-Full ROM
Range of Motion Right Leg	5-Full ROM

ICCU Adm 07: Cardiovascular Start: 09/19/18 08:47
Freq: Status: Complete
Protocol:
Document 09/19/18 09:10 KYL0009 (Rec: 09/19/18 10:20 KYL0009 ICU-M27)
Cardiovascular History

Continued on Page 111

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Cardiovascular History	
Cardiovascular History	Unable to Obtain/Confirm
Hx Hypertension	Yes
ICCU: Cardiovascular Assessment	
Alarms/Monitoring	
Alarm Limits Set/Checked	Yes
Method of Monitoring	Hardwire
Cardiovascular Assessment	
Heart Rhythm	Sinus Rhythm
Heart Sounds/Apical Pulse	S1 S2 Regular
Skin Perfusion	Skin Color Reflects Adequate Perfusion Cool
Capillary Refill	Less than 3 Seconds
Edema Assessment	
Edema Present	No
DVT Assessment	
DVT Assessment	
DVT / VTE Prophylaxis Application (QM)	SCD Bilateral
Anti-Coagulation Medication	No
Calf Assessment	Benign

ICCU Adm 08: Pulmonary Start: 09/19/18 08:47
Freq: Status: Complete
Protocol:
Document 09/19/18 09:10 KYL0009 (Rec: 09/19/18 10:20 KYL0009 ICU-M27)

Respiratory History	
Respiratory History	
Respiratory History	Unable to Obtain/Confirm
ICCU Admission: Pulmonary Questions	
Initial Information	
Is Patient on a Ventilator	No
Does Patient Have a Tracheostomy	No
Chest Tube	No
Oxygen Devices Used Prior to Hospitalization	None
Tobacco Use	
Tobacco Cessation Assessment	
Smoking Status (MU)	Unknown if Ever Smoked
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 .**	
Tobacco Cessation Information Provided	N/A Due to Patient Condition
ICCU: Pulmonary Assessment	
Lung Sounds Assessment	
Bilateral	
Lung Sound Respiratory Phase	Inspiratory & Expiratory
Breath Sounds	Coarse
Respiratory Effort	Normal

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Cough Assessment
Cough Frequency: None
Oxygen Assessment
Patient on Room Air: No
Ventilation
Settings
Is Patient on a Ventilator: No

ICCU Adm 09: Gastrointestinal — Start: 09/19/18 08:47
Freq: — Status: Complete
Protocol:
Document 09/19/18 09:10 KYL0009 (Rec: 09/19/18 10:20 KYL0009 ICU-M27)
GI History
GI History
GI History: Unable to Obtain/Confirm
Nutrition History
Nutrition
A nutrition consult must be entered if any of the questions below are "Yes."
Nutrition History: Unable to Obtain/Confirm
Oral Assessment
Oral Assessment
Oral Assessment Within Normal Limits: No
Query Text:Normal oral moisture with intact teeth. No oral deviations noted.
Oral Hygeine: Poor Hygiene
Dentures: None
Teeth: Intact
Oral Assessment Comment: dried blood present
Date of Last Bowel Movement
Date of Last Bowel Movement
Date of Last Bowel Movement: UTA
ICCU: GI Assessment
Abdominal Assessment
All Quadrants
Bowel Sounds: Normal/Active
Abdominal Assessment
Abdomen Description: Benign
Abdominal Tenderness: Non-Tender
Gastrointestinal Assessment
Gastrointestinal Symptoms: No Symptoms

ICCU Adm 10: Genitourinary — Start: 09/19/18 08:47
Freq: — Status: Complete
Protocol:
Document 09/19/18 09:10 KYL0009 (Rec: 09/19/18 10:20 KYL0009 ICU-M27)
Genitourinary History
GU History
GU History: Unable to Obtain/Confirm
ICCU Admission: GU Questions
Urinary Catheter
Catheter Care Completed: Not Applicable
ICCU: GU Assessment
Genitourinary Assessment
Does Patient Void: Yes

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BLAYK,BONZE ANNE ROSE

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62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

```
      Voiding Description                        Has Not Voided This Shift
ICCU Adm 11: Mobility/Musculoskeletal                      Start:  09/19/18 08:47
Freq:                                                      Status: Complete
Protocol:
 Document     09/19/18 09:10  KYL0009  (Rec: 09/19/18 10:20  KYL0009  ICU-M27)
 Musculoskeletal History
     Musculoskeletal History
       Musculoskeletal History                   Unable to Obtain/Confirm
 Mobility Assessment
     Mobility Assessment
       Known Mobility Impairments                Unable to Obtain/Confirm
 Sensory
     Sensory Impairments And Aides
       Sensory Impairment                        Unable to Obtain/Confirm
       Use of Contacts/Glasses                   No: UTA
       Active Hearing Aide                       No: UTA
ICCU Adm 12: Vascular Access                               Start:  09/19/18 08:47
Freq:                                                      Status: Complete
Protocol:
 Document     09/19/18 09:10  KYL0009  (Rec: 09/19/18 10:20  KYL0009  ICU-M27)
 Vascular Access
     Peripheral IV Assessment
       Right Hand
        Peripheral IV Gauge                      20
        Site Appearance                          Benign
        IV Secured With                          Gauze
                                                 Tape
        Peripheral IV Insertion Date             09/19/18
        IV Inserted by Emergency Medical         No
         Services (EMS)
ICCU Adm 13: Safety                                        Start:  09/19/18 08:47
Freq:                                                      Status: Complete
Protocol:  C.FALLINT
 Document     09/19/18 09:10  KYL0009  (Rec: 09/19/18 10:20  KYL0009  ICU-M27)
 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
     Protocol:  C.FALLINT
        Mental Status                            Forgets/Disregards Limitations
                                                 ,Impulsive or Altered
                                                 Mentation
        Patient Is Willing and Able to Assist in No
         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    Yes
         Administered
```

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BLAYK,BONZE ANNE ROSE
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Assessments and Treatments - Continued

Bladder/Bowel Incontinence No
Attached Equipment (Lines/Tubes/Etc) Yes
Secondary Diagnosis (2 or More Medical Diagnoses) Yes
Gait/Transferring Normal
Score 120
CVA/TIA or Stroke in past 24 hours No
Query Text:** If CVA/TIA or Stroke related diagnosis in past 24 hours, patient should be considered High Risk for falls. **
** If right hemisphere injury, consider using alarm. **
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).
Safety Comment Patient 1:1
Safety Interventions
Alarm Limits Set/Checked Yes
Side Rails Up 2 Rails
Call Bell Within Reach Yes
Method of Monitoring Bed Alarm
Pulse Oximetry
Risk for Entrapment
Risk for Entrapment
Is Patient at Risk For Entrapment in Bed Rails Confusion
Query Text:Two or more items place patient at risk for entrapment and will trigger entrapment intervention to your worklist.

ICCU Adm 14: Endocrine Start: 09/19/18 08:47
Freq: Status: Complete
Protocol:
Document 09/19/18 09:10 KYL0009 (Rec: 09/19/18 10:20 KYL0009 ICU-M27)
Endocrine
Endocrine/Hematology History
Endocrine/Hematological Disorders Unable to Obtain/Confirm

ICCU Adm 15: Diabetes Start: 09/19/18 08:47
Freq: Status: Complete
Protocol:
Document 09/19/18 09:10 KYL0009 (Rec: 09/19/18 10:20 KYL0009 ICU-M27)
Diabetes
Diabetes Education/Care
Is Patient Diabetic No

ICCU Adm 16: Surgical/Cancer Start: 09/19/18 08:47
Freq: Status: Complete
Protocol:

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Assessments and Treatments - Continued

Document 09/19/18 09:10 KYL0009 (Rec: 09/19/18 10:20 KYL0009 ICU-M27)
Surgical/Cancer
    Surgical History
        Surgical History   Unable to Obtain/Confirm
        Surgery Procedure, Year, and Place   Left inguinal hernia repair
    Cancer History
        Hx Cancer   Unable to Obtain/Confirm

ICCU Adm 17: Psychological/Psychosoc   Start: 09/19/18 08:47
Freq: Status: Complete
Protocol:
Document 09/19/18 09:10 KYL0009 (Rec: 09/19/18 10:20 KYL0009 ICU-M27)
Psychiatric/Psychosocial History
    Psychiatric/Psychosocial History
        Hx Bipolar Disorder   Yes
        Hx Post Traumatic Stress Disorder   Yes
        Hx Schizophrenia   Yes
        Hx of Violent Episodes Against Others   Yes
        Other Psychiatric Issues/Disorders   Yes: Transsexualism
Psychosocial Assessment
    Psychosocial Assessment
        Patient's Psychosocial/Emotional Status   Other
        Psychosocial/Emotional Status Comment   lethargic
        Able to Perform Age Appropriate ADL's   No
        Has Known or Suspected Problems Carrying Out ADLs   UTA
        Impacts of This Stay on Stressors   UTA
        Alcohol Use   UTA
        Recreational/Excessive Substance Use   Other
        Substance Use Comment - Amount & Last Used   UTA
        Has the Pattern of Use Changed Recently   UTA
        Abuse Screening Assessment   Inconsistent History
        Are You Having Thoughts of Hurting Yourself Or Others   Unable To Obtain
        Agencies Involved in Patient Care   UTA
Discharge
    Discharge
        Patient Lives with   Other
        Lives with/Residence Comment   UTA
        Does Patient Have to Climb Stairs   UTA
        Services Anticipated at Discharge   Other
        Other Services Comment   UTA
        Is Patient a Veteran   Unable to Determine
        Does Patient Have a DSS or CPS Caseworker   Unable to Determine

ICCU Adm 18: Spiritual/Cultural   Start: 09/19/18 08:47
Freq: Status: Complete
Protocol:
Document 09/19/18 09:10 KYL0009 (Rec: 09/19/18 10:20 KYL0009 ICU-M27)
Spiritual History
    Spiritual History
        Religion   Unknown/Unable to Obtain
Spiritual Assessment

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Assessments and Treatments - Continued

Spiritual Assessment

How Important Is It to You to Receive a Visit from the Hospital Chaplain	Unable to Determine

Cultural Needs Assessment

Cultural Needs Assessment

Cultural Beliefs to Consider that Would Affect Care	Unable to Obtain/Confirm

ICCU Adm 19: Education Start: 09/19/18 08:47
Freq: Status: Complete
Protocol:
Document 09/19/18 09:10 KYL0009 (Rec: 09/19/18 10:20 KYL0009 ICU-M27)
Education

Education Assessment

Patient

Caregiver Name/Relationship	Patient
Barriers to Learning	Confusion Physical Other
Preferred/Primary Language	English
Readiness To Learn	Poor
Learning Style(s) Preferred by Patient	Unable to Determine

IMG: CT Questionnaire Start: 09/19/18 16:21
Freq: Status: Discharge
Protocol:
Document 09/19/18 16:22 MIC0082 (Rec: 09/19/18 16:23 MIC0082 IMG-C76)
Patient Exam Information

Technologist Info

Patient ID verified	Yes
Patient Stated Symptoms	SUDDEN DROP IN H&H, EVALUATE FOR INTERNAL BLEEDING
Procedure(s) explained to:	Patient
Completed by:	JS

Pregnancy/Lactation Status

Pregnant

Pregnant:	No

Surgical/Cancer History

Surgical History

Surgical History	Yes
Surgery Procedure, Year, and Place	Left inguinal hernia repair

Cancer History

Hx Cancer	Unable to Obtain/Confirm

Contrast Screening

Contrast Medical History Screening

Hx Hypertension	Yes
Hx Diabetes	No

Contrast

Contrasted exam	Yes

History Previous Contrast

Has the Patient Received Contrast in the Past 48 hours	No
Has Patient Received ANY Contrast in the Past	No
Any problems with Contrast in the Past	No

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Assessments and Treatments - Continued

CT Contrast
- Lab Results
  - Creatinine Results Within Policy Parameters: Yes
  - Date of Results: 09/19/18
  - BUN Results: 21
  - Creatinine Results: 0.87
  - GFR: 66
- Contrast
- Protocol: C.IMGCONT
  - Is Patient Cleared for Contrast: Yes
    Query Text:If NO Document Reason in Comment
  - Weight: 166 lb
  - Contrast Type: Omnipaque 300

IMG: CT Questionnaire Non Contrast   Start: 09/19/18 05:00
Freq: Status: Discharge
Protocol:

Document 09/19/18 05:00 ALL0007 (Rec: 09/19/18 05:00 ALL0007 IMG-CS07)

Patient Exam Information
- Technologist Info
  - Patient ID verified: Yes
  - Patient Stated Symptoms: pt brought in after fight with police. Bloody face. complaining of arm and jaw pain.
  - Procedure(s) explained to: Patient
  - Completed by: az

Pregnancy/Lactation Status
- Pregnant
  - Pregnant: No

Surgical/Cancer History
- Surgical History
  - Surgical History: Yes
  - Surgery Procedure, Year, and Place: Left inguinal hernia repair
- Cancer History
  - Hx Cancer: None

Document 09/19/18 15:39 JOS0026 (Rec: 09/19/18 15:39 JOS0026 IMG-CS07)

Patient Exam Information
- Technologist Info
  - Patient ID verified: Yes
  - Patient Stated Symptoms: trauma to left shoulder, pain
  - Procedure(s) explained to: Patient
  - Completed by: js

Pregnancy/Lactation Status
- Pregnant
  - Pregnant: No

Surgical/Cancer History
- Surgical History
  - Surgical History: Yes
  - Surgery Procedure, Year, and Place: Left inguinal hernia repair
- Cancer History
  - Hx Cancer: Unable to Obtain/Confirm

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Assessments and Treatments - Continued

IMG: Diagnostic Questionnaire Start: 09/19/18 07:16
Freq: Status: Discharge
Protocol:

Document 09/19/18 07:16 CYN0016 (Rec: 09/19/18 07:16 CYN0016 IMGED-CS01)
Pregnancy Status
Pregnant
Pregnant: No
Technologist Information
Technologist Info
Technologist(s) CE
Patient ID verified Yes
Procedure(s) explained to: Patient
Shielded Yes
Diagnostic Chest Exam
Reason for Exam
Other ASSAULT
Chest Exam History
History
Hx Hypertension Yes
Hx Tobacco Use Yes

Document 09/19/18 12:08 DEV0055 (Rec: 09/19/18 12:09 DEV0055 IMG-CS02)
Pregnancy Status
Pregnant
Pregnant: No
Technologist Information
Technologist Info
Technologist(s) DR/NG/TS
Patient ID verified Yes
Procedure(s) explained to: Patient
Shielded Yes
Diagnostic Pelvis/Extremity Exam
Reason for Exam
Other EVALUATE LEFT SHOULDER FOR DISLOCATION/FRACTURE. IMAGES DONE PORTABLY IN ICU
Pelvis/Extremity Exam History
History
Musculoskeletal History Unable to Obtain/Confirm

Document 09/19/18 20:40 GEM0001 (Rec: 09/19/18 20:41 GEM0001 IMGED-CS01)
Pregnancy Status
Pregnant
Pregnant: No
Technologist Information
Technologist Info
Technologist(s) GP
Patient ID verified Yes
Procedure(s) explained to: Patient
Shielded Yes
Fluoro Time 5s
DAP 0.01918
Diagnostic Pelvis/Extremity Exam
Reason for Exam
Other OPEN REDUCTION LEFT SHOULDER

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Assessments and Treatments - Continued

Pelvis/Extremity Exam History
    History
        Musculoskeletal History   Unable to Obtain/Confirm
Document 09/20/18 09:53 EIL0057 (Rec: 09/20/18 09:59 EIL0057 IMG-CS03)
Pregnancy Status
    Pregnant
        Pregnant: No
Technologist Information
    Technologist Info
        Technologist(s)   EILEEN /KIM N
        Patient ID verified   Yes
        Procedure(s) explained to: Patient
        Shielded   Yes
Diagnostic Pelvis/Extremity Exam
    Reason for Exam
        Pain   Yes
        Other   POST CLOSED REDUCTION / ALL VIEWS OBTAINED BY WAY OF ANGLING AND MANIPULATION OF CAMERA HEAD
PT. UNCOOPERATIVE AND WE WERE INFORMED THAT THE PT. HAD BEEN COMBATIVE EARLIER AND PLEASE DO OUR BEST TO AVOID ANY ELEVATION. WE WERE ABLE TO DO THAT AND THE PT. WAS FINE WHEN WE WERE DONE
Pelvis/Extremity Exam History
    History
        Musculoskeletal History   Unable to Obtain/Confirm
        Hx Orthopedic Surgery   Yes: 9/2018 TOOK PT. TO OR FOR REDUCTION OF SHOULDER DISLOCATION

Incentive Spirometry Education   Start: 09/21/18 12:31
Freq: ONCE   Status: Discharge
Protocol:
Document 09/21/18 12:31 CON0001 (Rec: 09/21/18 12:43 CON0001 TELE-M11)
Incentive Spirometry Education
    Incentive Spirometry
        Patient Educated on Use   Yes
        Teaching Methods   Discussion
                Demonstration
        Response to Teaching   Reinforcement Needed
        Is Patient Compliant   No

Incentive Spirometry Education   Start: 09/21/18 12:31
Freq: ONCE   Status: Discharge
Protocol:
Document 09/21/18 12:31 CON0001 (Rec: 09/21/18 12:43 CON0001 TELE-M11)

Infusion(s) Flowsheet   Start: 09/19/18 08:47
Text: Status: Inactive
Freq: 06,14,22
Protocol:
Document 09/19/18 14:00 KYL0009 (Rec: 09/19/18 15:13 KYL0009 ICU-C12)

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Assessments and Treatments - Continued

IV Fluids/IVPB Intakes
IV Fluids and IVPB
NS
Intake, IV Fluids Volume Infused 690

Not Done 09/19/18 22:00 KIM0006 (Rec: 09/19/18 22:11 KIM0006 ICU-M27)
Nausea

Document 09/20/18 06:00 KIM0006 (Rec: 09/20/18 06:20 KIM0006 ICU-M35)
IV Fluids/IVPB Intakes
IV Fluids and IVPB
NS
Intake, IVPB Volume Infused 497

Document 09/20/18 14:00 JOA0063 (Rec: 09/20/18 16:06 JOA0063 ICU-C25)
IV Fluids/IVPB Intakes
IV Fluids and IVPB
NS
IV Rate (ml/hr) 75
Intake, IV Fluids Volume Infused 608

Document 09/20/18 16:55 ANI0051 (Rec: 09/20/18 16:55 ANI0051 ICU-C25)
IV Fluids/IVPB Intakes
IV Fluids and IVPB
NS
Intake, IV Fluids Volume Infused 175

Inpatient OT: Missed TX Note Start: 09/19/18 08:47
Freq: Status: Discharge
Protocol:

Document 09/21/18 15:48 KAR0031 (Rec: 09/21/18 15:50 KAR0031 PMRU-C09)
OT: Missed Treatment Note
OT Missed Treatment Note
Session Not Completed Comment: Per operative note 9/19/18, pt to be nonweightbearing in sling at all times, however OT order recieved for "ROM due to fx per Ortho, sling as needed" without instructions on ROM limitations or restrictions. Will need further clarification on what pt is cleared for prior to completing OT evaluation. Will follow up as appropriate.
Plan: Continue as Able

Document 09/24/18 11:12 KAR0031 (Rec: 09/24/18 11:15 KAR0031 PMRU-C09)
OT: Missed Treatment Note
OT Missed Treatment Note
Session Not Completed: Patient Declined
Session Not Completed Comment: Pt reports fatigued from being up in bathroom earlier and requesting to rest at this time. Pt does report having difficulty due to LUE pain/ edema/bruising and states currently requiring assistance for bathing. Pt currently

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Assessments and Treatments - Continued

states that putting on clothes "is totally out of the question, not going to happen." Pt educated on OT role, pt agreeable for OT to reattempt next date, however appears questionable whether pt will be agreeable to participate. Pt also reports refusing sling although in bed at time of attempt, pt educated on sling to increase comfort and protect arm, however pt states, "not wearing, not doing it, not gonna' happen." Will reattempt OT evaluation next date as able/appropriate.

Plan — Continue as Able

Inpatient PT: Missed Treatment Note — Start: 09/22/18 15:39
Freq: — Status: Discharge
Protocol:
Document 09/22/18 15:39 MAR0029 (Rec: 09/22/18 15:40 MAR0029 SSU-C18)
PT: Missed Treatment Note
PT Missed Treatment Note
Session Not Completed — Patient Declined
Session Not Completed Comment — Attempted PT eval. Pt declined stating she could get around just fine. ADV pt to use L arm sling when out of room for safety and protection. Pt agreed. No PT eval performed.
Plan — Discontinue Skilled PT Services

Inpatient Physical Therapy Communication — Start: 09/19/18 08:47
Freq: — Status: Discharge
Protocol:
Document 09/21/18 18:00 ALE0017 (Rec: 09/21/18 18:03 ALE0017 SSU-C14)
Inpatient Physical Therapy Communication
Visit Status
Saw Patient for New Evaluation — Attempted to see patient, patient refusing at time of visit
Other
Visit Comment/Additional Information — patietn currently refusing all treatment and medications. patient is currently refusing sling use. at this time, given likelyhood stated for repeat dislocation, will hold evaluation and continue to attempt at later dates when patient is more likely to be compliant with treatment and

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Assessments and Treatments - Continued

precautions. at time of attempt patient is in bed without sling, but arm is appropriately supported by bed and held in proper position by patient.

Intake and Output Start: 09/19/18 08:47
Freq: Q1HR Status: Inactive
Protocol:

Document 09/19/18 09:00 KYL0009 (Rec: 09/19/18 09:40 KYL0009 ICU-M27)
Intake
    Intake, Oral
    Protocol: C.INTAKE
        Intake, Oral Amount 0
Output
    Output, Urine
        Output, Urine Amount 0

Document 09/19/18 10:00 KYL0009 (Rec: 09/19/18 11:33 KYL0009 ICU-M27)
Intake
    Intake, Oral
    Protocol: C.INTAKE
        Intake, Oral Amount 0
Output
    Output, Urine
        Output, Urine Amount 0

Document 09/19/18 11:00 KYL0009 (Rec: 09/19/18 11:39 KYL0009 ICU-M27)
Intake
    Intake, Oral
    Protocol: C.INTAKE
        Intake, Oral Amount 0
Output
    Output, Urine
        Output, Urine Amount 0

Document 09/19/18 12:00 KYL0009 (Rec: 09/19/18 12:48 KYL0009 ICU-C12)
Intake
    Intake, Oral
    Protocol: C.INTAKE
        Intake, Oral Amount 0
Output
    Output, Urine
        Output, Urine Amount 0

Document 09/19/18 13:00 KYL0009 (Rec: 09/19/18 13:28 KYL0009 ICU-C12)
Intake
    Intake, Oral
    Protocol: C.INTAKE
        Intake, Oral Amount 0
Output
    Output, Urine
        Output, Urine Amount 0

Document 09/19/18 14:00 KYL0009 (Rec: 09/19/18 15:13 KYL0009 ICU-C12)
Intake
    Intake, Oral
    Protocol: C.INTAKE

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Assessments and Treatments - Continued

```
       Intake, Oral Amount                      0
Document     09/19/18 15:00  KYL0009  (Rec: 09/19/18 15:55  KYL0009  ICU-C12)
Intake
    Intake, Oral
    Protocol:  C.INTAKE
       Intake, Oral Amount                      0
Document     09/19/18 16:00  KYL0009  (Rec: 09/19/18 17:53  KYL0009  ICU-C12)
Intake
    Intake, Oral
    Protocol:  C.INTAKE
       Intake, Oral Amount                      0
Output
    Output, Urine
       Output, Urine Amount                     0
Document     09/19/18 17:00  KYL0009  (Rec: 09/19/18 17:56  KYL0009  ICU-C12)
Intake
    Intake, Oral
    Protocol:  C.INTAKE
       Intake, Oral Amount                      0
Document     09/19/18 18:00  KYL0009  (Rec: 09/19/18 18:27  KYL0009  ICU-C12)
Intake
    Intake, Oral
    Protocol:  C.INTAKE
       Intake, Oral Amount                      0
Output
    Output, Urine
       Output, Urine Amount                     600
Document     09/19/18 22:00  IBE0050  (Rec: 09/19/18 22:08  IBE0050  ICU-M35)
Output
    Output, Urine
       Output, Urine Amount                     0
Not Done     09/19/18 23:00  KIM0006  (Rec: 09/19/18 23:16  KIM0006  ICU-C12)
    NPO
Document     09/20/18 00:00  KIM0006  (Rec: 09/20/18 01:26  KIM0006  ICU-C12)
Intake
    Intake, Oral
    Protocol:  C.INTAKE
       Intake, Oral Amount                      60
Not Done     09/20/18 01:00  KIM0006  (Rec: 09/20/18 01:26  KIM0006  ICU-C12)
    no out put or intake
Document     09/20/18 01:53  KIM0006  (Rec: 09/20/18 01:53  KIM0006  ICU-C12)
Intake
    Intake, Oral
    Protocol:  C.INTAKE
       Intake, Oral Amount                      120
Document     09/20/18 02:15  KIM0006  (Rec: 09/20/18 04:26  KIM0006  ICU-C12)
Output
    Output, Urine
       Output, Urine Amount                     350
Document     09/20/18 03:00  KIM0006  (Rec: 09/20/18 04:26  KIM0006  ICU-C12)
Intake
    Intake, Oral
    Protocol:  C.INTAKE
```

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Assessments and Treatments - Continued

```
      Intake, Oral Amount                      120
Document     09/20/18 04:00  KIM0006  (Rec: 09/20/18 04:26  KIM0006  ICU-C12)
Intake
    Intake, Oral
    Protocol:  C.INTAKE
      Intake, Oral Amount                      240
Document     09/20/18 05:37  KIM0006  (Rec: 09/20/18 05:37  KIM0006  ICU-M35)
Output
    Output, Urine
      Output, Urine Amount                     100
    Output, Stool
      Date of Last Bowel Movement              9/20/18
      Number of Bowel Movements                1
      Output, Estimated Stool Amount           Medium
Document     09/20/18 06:00  KIM0006  (Rec: 09/20/18 06:20  KIM0006  ICU-M35)
Intake
    Intake, Oral
    Protocol:  C.INTAKE
      Intake, Oral Amount                      60
Document     09/20/18 08:45  JOA0063  (Rec: 09/20/18 09:44  JOA0063  ICU-C25)
Output
    Output, Urine
      Output, Estimated Void Amount            Medium
Document     09/20/18 11:00  JOA0063  (Rec: 09/20/18 15:46  JOA0063  ICU-C25)
Output
    Output, Urine
      Output, Estimated Void Amount            Medium
Document     09/20/18 13:00  JOA0063  (Rec: 09/20/18 15:46  JOA0063  ICU-C25)
Output
    Output, Urine
      Output, Estimated Void Amount            Medium
Document     09/20/18 15:00  JOA0063  (Rec: 09/20/18 16:06  JOA0063  ICU-C25)
Output
    Output, Urine
      Output, Estimated Void Amount            Medium
Document     09/20/18 16:22  ANI0051  (Rec: 09/20/18 16:31  ANI0051  ICU-C25)
Intake
    Intake, Oral
    Protocol:  C.INTAKE
      Intake, Oral Amount                      120
Output
    Output, Urine
      Number of Voids                          1
      Output, Estimated Void Amount            Medium
```

```
Intake and Output                                        Start:  09/21/18 08:26
Freq:   DAILY@0600,1400,2200                             Status: Discharge
Protocol:
Document     09/21/18 14:33  ANN0068  (Rec: 09/21/18 14:33  ANN0068  HOSP-C11)
Intake
    Intake, Oral
    Protocol:  C.INTAKE
      Intake, Oral Amount                      480
Document     09/21/18 22:00  SAR0138  (Rec: 09/21/18 22:47  SAR0138  TELE-C11)
```

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BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01

62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Intake
Intake, Oral
Protocol: C.INTAKE
Intake, Oral Amount 960

Document 09/22/18 06:19 MEG0025 (Rec: 09/22/18 06:21 MEG0025 TELE-M01)
Intake
Intake, Oral
Protocol: C.INTAKE
Intake, Oral Amount 1,560
Output
Output, Urine
Number of Voids 1
Output, Estimated Void Amount Large

Document 09/22/18 14:00 BOB0001 (Rec: 09/22/18 15:15 BOB0001 TELE-C11)
Intake
Intake, Oral
Protocol: C.INTAKE
Intake, Oral Amount 480

Document 09/22/18 21:18 ELI0141 (Rec: 09/22/18 21:19 ELI0141 TELE-C01)
Intake
Intake, Oral
Protocol: C.INTAKE
Intake, Oral Amount 0

Document 09/23/18 00:05 TAY0008 (Rec: 09/23/18 00:05 TAY0008 TELE-C32)
Intake
Intake, Oral
Protocol: C.INTAKE
Intake, Oral Amount 800

Document 09/23/18 06:00 FRA0018 (Rec: 09/23/18 07:44 FRA0018 TELE-C01)
Intake
Intake, Oral
Protocol: C.INTAKE
Intake, Oral Amount 0

Document 09/23/18 14:00 BOB0001 (Rec: 09/23/18 14:56 BOB0001 TELE-C07)
Intake
Intake, Oral
Protocol: C.INTAKE
Intake, Oral Amount 0

Document 09/23/18 21:36 ELI0141 (Rec: 09/23/18 21:37 ELI0141 TELE-C01)
Intake
Intake, Oral
Protocol: C.INTAKE
Intake, Oral Amount 0

Document 09/23/18 21:38 HEI0057 (Rec: 09/23/18 21:39 HEI0057 TELE-M01)
Intake
Intake, Oral
Protocol: C.INTAKE
Intake, Oral Amount 450

Document 09/24/18 03:24 ASH0007 (Rec: 09/24/18 03:24 ASH0007 TELE-C07)
Intake
Intake, Oral
Protocol: C.INTAKE
Intake, Oral Amount 480

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Not Done 09/24/18 06:00 MAC0003 (Rec: 09/24/18 08:05 MAC0003 TELE-M12)
Unable to Determine if Done
Not Done 09/24/18 14:00 MAC0003 (Rec: 09/24/18 14:04 MAC0003 TELE-C09)
Unable to Determine if Done
Document 09/24/18 16:10 SAR0138 (Rec: 09/24/18 16:10 SAR0138 TELE-C11)
Intake
Intake, Oral
Protocol: C.INTAKE
Intake, Oral Amount 400

MHU:Evaluation Part 2 Start: 09/24/18 13:56
Freq: Status: Discharge
Protocol:
Document 09/24/18 13:57 JOS0070 (Rec: 09/24/18 14:02 JOS0070 BSU-C35)
MHU: Evaluation Part 2
Review
Clinical Formulation and Rationale

PATIENT TO BE ADMITTED TO CMC BSU WITH DX OF UNSPECIFIED PSYCHOSIS D/O ON A 9.39 LEGAL STATUS. PATIENT IS A 62YO MALE TO FEMALE TRANSGENDER WHO IS PARANOID (POLICE CONSPIRACY AGAINST HER), AND SHOWING POOR INSIGHT AND JUDGEMENT INTO HER OWN BEHAVIORS. SHE IS REFUSING TO TAKE ANY OF HER MEDICATIONS HERE IN THE HOSPITAL. SHE IS EASILY AGITATED WHEN HER NEEDS OR DEMANDS ARE NOT INSTANTLY MET BY STAFF.
PATIENT WAS BROUGHT TO ED ON 9 /19/18 BY POLICE ON A 9.41 LEGAL STATUS. POLICE RESPONDED TO A 911 CALL AT THE LOCAL DENNEY'S RESTAURANT. THE PATIENT WAS LOUD AGITATED AND OUT OF CONTROL. PATIENT RESISTED THE POLICE AND SUFFERED A NASAL FX, LEFT SHOULDER INJURY AND ELEVATED CPK LEVEL DURING THE PHYSICAL ALTERCATION. IN THE ED PATIENT CONTINUED TO BE COMBATIVE AND REQUIRED IM MEDICATIONS AND PHYSICAL RESTRAINTS. PATIENT WAS ADMITTED TO CMC TELEMETRY UNIT 4S, AND IS NOW MEDICALLY CLEARED TO COME TO CMC BSU. PATIENT WILL BE CHANGED INTO PAPER SCRUBS AND GIVEN S&R, AND BROUGHT TO UNIT WHEN BED IS AVAILABLE.

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Time Reviewed with Provider 11:30
Reviewing Doctor Frederick Ryan Caballes
Time Reviewed with Psychiatrist 12:30
Reviewing Psychiatrist Ehmke,Clifford
Disposition Emergency Admit (9.39)
Admitting Psychiatrist Ehmke,Clifford
Follow Up if Not Admitted admitted to cmc bsu
Patient: Insurance Information
Insurance Information
Copy of Insurance Card Obtained No
Insurance Company medicaid
Insurance Policy Number AN33246W
Time Spent
Time Spent on MHU Evaluation (minutes) 180
Query Text:Record total minutes spent on
MHU Evaluation process for this patient
.

MRSA NasalSwab if Criteria Met Start: 09/19/18 08:19
Freq: ONCE Status: Discharge
Protocol:
Not Done 09/19/18 08:19 JOA0063 (Rec: 09/20/18 16:07 JOA0063 ICU-C25)
Declined by Patient

Mental Health Gown Start: 09/19/18 04:55
Freq: ONCE Status: Inactive
Protocol:
Not Done 09/19/18 04:55 KYL0009 (Rec: 09/19/18 11:44 KYL0009 ICU-M27)
patient admitted to ICU
Not Done 09/19/18 08:00 KYL0009 (Rec: 09/19/18 11:44 KYL0009 ICU-M27)
patient admitted to ICU

NSG: Oxygen Start: 09/19/18 20:26
Freq: Q8HR Status: Discharge
Protocol: RTPROTOCOL
Document 09/20/18 00:00 KIM0006 (Rec: 09/20/18 01:27 KIM0006 ICU-C12)
NSG: Oxygen
Oxygen
Patient on Room Air Yes
Oxygen Devices in Use Now None
O2 Sat by Pulse Oximetry 95
Not Done 09/20/18 08:00 JOA0063 (Rec: 09/20/18 16:02 JOA0063 ICU-C25)
ALREADY DOCUMENTED
Document 09/20/18 16:34 ANI0051 (Rec: 09/20/18 16:35 ANI0051 ICU-C25)
NSG: Oxygen
Oxygen
Patient on Room Air Yes
Oxygen Devices in Use Now None
Not Done 09/21/18 00:00 CON0001 (Rec: 09/21/18 08:07 CON0001 TELE-M11)
Unable to Determine if Done
Document 09/21/18 08:00 CON0001 (Rec: 09/21/18 08:07 CON0001 TELE-M11)
NSG: Oxygen
Oxygen
Patient on Room Air Yes
Oxygen Devices in Use Now None
Document 09/21/18 15:34 CON0001 (Rec: 09/21/18 15:34 CON0001 TELE-M11)

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BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

```
NSG: Oxygen
    Oxygen
       Patient on Room Air                       Yes
       Oxygen Devices in Use Now                 None
Document     09/22/18 00:00  MEG0025  (Rec: 09/22/18 07:48  MEG0025  TELE-C09)
NSG: Oxygen
    Oxygen
       Patient on Room Air                       Yes
       Oxygen Devices in Use Now                 None
Document     09/22/18 08:00  MOR0002  (Rec: 09/22/18 12:27  MOR0002  TELE-C05)
NSG: Oxygen
    Oxygen
       Patient on Room Air                       Yes
       Oxygen Flow Rate (L/min)                  97
       Change Made to Oxygen?                    No
Document     09/22/18 16:00  MOR0002  (Rec: 09/22/18 17:34  MOR0002  TELE-C05)
NSG: Oxygen
    Oxygen
       Patient on Room Air                       Yes
Document     09/23/18 00:00  SOP0051  (Rec: 09/23/18 03:35  SOP0051  TELE-C11)
NSG: Oxygen
    Oxygen
       Patient on Room Air                       Yes
Document     09/23/18 08:00  STA0017  (Rec: 09/23/18 10:33  STA0017  TELE-C03)
NSG: Oxygen
    Oxygen
       Patient on Room Air                       Yes
       Oxygen Devices in Use Now                 None
Document     09/23/18 16:00  STA0017  (Rec: 09/23/18 18:34  STA0017  TELE-C03)
NSG: Oxygen
    Oxygen
       Patient on Room Air                       Yes
       Oxygen Devices in Use Now                 None
Document     09/23/18 22:34  RAY0005  (Rec: 09/23/18 22:34  RAY0005  TELE-C11)
NSG: Oxygen
    Oxygen
       Patient on Room Air                       Yes
Not Done     09/24/18 08:00  MAC0003  (Rec: 09/24/18 08:05  MAC0003  TELE-M12)
    Declined by Patient
Document     09/24/18 15:50  MAC0003  (Rec: 09/24/18 15:50  MAC0003  TELE-C09)
NSG: Oxygen
    Oxygen
       Patient on Room Air                       Yes
       Oxygen Devices in Use Now                 None
       O2 Sat by Pulse Oximetry                  96
```

```
Nutrition: Assessment                               Start:  09/19/18 08:47
Freq:                                               Status: Inactive
Protocol:  C.NUTSUPP
 Document     09/19/18 09:10  ALE0011  (Rec: 09/19/18 09:17  ALE0011  DIET-C13)
 Nutrition Only Assessment
     Diagnosis/History
        Current Medical Diagnosis                rhabdomyolysis with reactive
                                                 leukocytosis
```

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BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

```
      Pertinent Past Medical/Surgical History  male-to-female transgender;
                                               HTN
   BMI
      Height                                   5 ft 6 in
      Last Documented Weight                   161 lb
   Labs/Medications/Supplements/Herbals
      Pertinent Labs/Fingersticks Reviewed     Yes
      Pertinent Labs/Fingersticks Comment      BG 212
                                               total CK elevated
      Pertinent Medications                    Zyprexa
                                               prn opiates
   Skin
      Skin Breakdown                           not avail
      Recent Braden Score per Nursing          not avail
       Assessment
Nutrition: Interventions
   Follow Up
      Proposed Rescreen Date                   09/26/18
      Visit Reason Details                     Initial
                                               Labs
Nutrition Support Assessment
   Nutrition Support Composition @ Target Rate/24 Hours
```

```
OR 01: Position/Safety                                      Start:  09/19/18 20:48
Freq:                                                       Status: Discharge
Protocol:
 Document     09/19/18 20:49  JAM0034  (Rec: 09/19/18 20:55  JAM0034  ORRM-C05A)
 OR Prep 01: Position/Safety Measures
    Operative Preparation
       Pre-Op Handoff and Universal Protocol    Yes
        Checklist Completed
       Operating Room                           1
    Surgical Positioning
       Surgical Position                        Supine
       Right Upper Extremity Placement          Board
       c.stl                                    None
       Positioning Equipment                    Action Pads
                                                Arm Board
                                                Flat-Top Table
                                                Pillow
       Positioning Comment                      PATIENT POSITIONED SUPINE ON
                                                FLAT-TOP TABLE WITH THE
                                                ASSISTANCE OF SURGEON AND
                                                ANESTHESIA. PILLOW UNDER HEAD.
                                                RIGHT ARM ON GEL PADDED ARM
                                                BOARD. ALL BONY PROMINENCES
                                                PROTECTED WITH GEL PADS.
    Safety Measures
       Safety and Comfort Measures Met per      Yes
        Policy
       Safety Belts                             Abdomen
       Safety Comment                           LOWER LEGS SECURED WITH BLACK
                                                SAFETY BELT
```

OR 03: Post-Op Assmt/Discharge Summary Start: 09/19/18 20:48

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

```
Freq:                                                        Status: Discharge
Protocol:
 Document     09/19/18 20:49  JAM0034  (Rec: 09/19/18 20:55  JAM0034  ORRM-C05A)
 OR: Post-Operative Asst/DC Summary
     Vascular Access
        Does Patient Have Vascular Access          Yes
     Vascular Access Assessment
       Peripheral IV 1
        Vascular Access Location                   RIGHT ARM
     Skin Assessment
       Is Skin Warm, Dry, and Intact               Yes
       Tourniquet Site Post-Procedure Skin         N/A
        Condition
       Ground Pad Site Post-Procedure Skin         N/A
        Condition
     Drains
       Does Patient Have Drain(s)                  No
     Dressing/Packing
       Does Patient Have Dressing(s) and/or        Yes
        Packing(s)
     Dressing/Packing Assessment
       Left Shoulder
        Dressing                                   Yes
        Dressing Type                              LARGE SHOULDER SLING
     Respiratory Status
       Respiration Method                          Spontaneous Respirations
       Patient on Room Air                         Yes
```

```
OR Equip: Thermal Regulation                                 Start:  09/19/18 20:48
Freq:                                                        Status: Discharge
Protocol:
 Document     09/19/18 20:49  JAM0034  (Rec: 09/19/18 20:55  JAM0034  ORRM-C05A)
 OR Equipment: Thermal Regulation
     Room Temperature
       Room Temperature                            65.3 F
     Warm Blankets
       Warm Blankets Applied                       Yes
```

```
Observation: Constant (Visualize Pt)                         Start:  09/19/18 04:55
Text: • Patient must be under continuous staff observation Status: Complete
(must be able to see patient at all times).
      • More than one patient can be observed by one
Safety Observer if all patients can be visualized.
      • Document on 15 minute observation form.

Freq:   QSHIFT
Protocol:
 Document     09/19/18 05:36  THO0010  (Rec: 09/19/18 05:36  THO0010  ED-C19)
 Document     09/19/18 09:27  KYL0009  (Rec: 09/19/18 09:27  KYL0009  ICU-M27)
```

```
Pain Assessment/Reassessment                                 Start:  09/19/18 08:47
Freq:   Q1HR                                                 Status: Inactive
Protocol:  C.PNSCALE
 Document     09/19/18 09:00  KYL0009  (Rec: 09/19/18 09:40  KYL0009  ICU-M27)
 Pain Assessment/Reassessment
     Pain Assessment
```

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Protocol: C.PNSCALE
Patient Currently Having Pain — No
Pain Assessment Based Upon — Nursing Observation
Pain Intensity — 0
Query Text:0-10
Pain Scale Used — CPOT
Pain Intensity Goal — 0
Query Text:0-10
Stated Pain Consistent with Observed Level of Pain — N/A

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 — -

Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation
Protocol: RASS
Respiratory Rate — 19
Agitation/Sedation Score — (-2) Light 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 — Patient Safety Interventions

Document 09/19/18 10:00 KYL0009 (Rec: 09/19/18 11:33 KYL0009 ICU-M27)

Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE
Patient Currently Having Pain — Unable to Determine

Continued on Page 132

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Pain Assessment Based Upon	Nursing Observation
Pain Based Upon Comments	with movement
Pain Intensity Query Text:0-10	1
Pain Scale Used	CPOT
Pain Intensity Goal Query Text:0-10	0
Stated Pain Consistent with Observed Level of Pain	Yes

Pain Location/Description
left shoulder

Pain Description Comments	UTA patient speech garbled and slurred

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	-

Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation
Protocol: RASS

Respiratory Rate	14
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)
(-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 09/19/18 11:00 KYL0009 (Rec: 09/19/18 11:39 KYL0009 ICU-M27)
Pain Assessment/Reassessment

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Pain Assessment
Protocol: C.PNSCALE

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 Intensity Goal	0
Query Text:0-10	
Stated Pain Consistent with Observed Level of Pain	Yes

Pain Location/Description
left shoulder

Pain Description	Unable to Verbalize

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	-

Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation
Protocol: RASS

Respiratory Rate	24
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)
(-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 09/19/18 12:00 KYL0009 (Rec: 09/19/18 12:48 KYL0009 ICU-C12)

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BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01

62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Pain Assessment/Reassessment

Pain Assessment

Protocol: C.PNSCALE

Patient Currently Having Pain	Yes
Pain Assessment Based Upon	Patient Report
Pain Intensity	6
Query Text:0-10	
Pain Scale Used	0-10 Numeric
Pain Intensity Goal	0
Query Text:0-10	
Stated Pain Consistent with Observed Level of Pain	Yes

Pain Location/Description

left shoulder

Pain Description	Unable to Verbalize

Reassessment of Respiratory Rate

Reassessment of respiratory rate is required for the following:
Dilaudid
Fentanyl
Morphine

Respiratory Rate	11

Interventions

Please document those interventions you are currently providing.

Interventions Provided for Current Pain Level	Medication Positioning
Follow Up Evaluation Needed	Yes
Time Follow Up Due	1245

Richmond Agitation Sedation Scale (RASS)

Sedation / Agitation

Protocol: RASS

Respiratory Rate	14
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)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (but no eye contact)

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BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01

62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

(-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

Side Effects

Side Effects from Previous Interventions — None

Document 09/19/18 13:00 KYL0009 (Rec: 09/19/18 13:28 KYL0009 ICU-C12)

Pain Assessment/Reassessment

Pain Assessment

Protocol: C.PNSCALE

Patient Currently Having Pain	No
Pain Assessment Based Upon	Patient Report
Pain Intensity Query Text:0-10	0
Pain Scale Used	0-10 Numeric
Pain Intensity Goal Query Text:0-10	0
Stated Pain Consistent with Observed Level of Pain	Yes

Pain Location/Description

left shoulder

Pain Description	See Comment

Reassessment of Respiratory Rate

Reassessment of respiratory rate is required for the following:
Dilaudid
Fentanyl
Morphine

Respiratory Rate	14

Interventions

Please document those interventions you are currently providing.

Interventions Provided for Current Pain Level	Positioning Relaxation
Follow Up Evaluation Needed	No
Time Follow Up Due	-

Richmond Agitation Sedation Scale (RASS)

Sedation / Agitation

Protocol: RASS

Respiratory Rate	14
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

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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

Agitation/RASS Intervention — No Intervention Required

Document 09/19/18 14:00 KYL0009 (Rec: 09/19/18 15:13 KYL0009 ICU-C12)

Pain Assessment/Reassessment
- Pain Assessment
- Protocol: C.PNSCALE
  - Patient Currently Having Pain — Yes
  - Pain Assessment Based Upon — Patient Report
  - Pain Intensity — 4
    - Query Text:0-10
  - Pain Scale Used — 0-10 Numeric
- Pain Location/Description
  - left shoulder
    - Pain Description — Sharp
- Side Effects
  - Please document any side effects from previous interventions here. If no previous interventions were provided, please skip to "Interventions."
  - Side Effects from Previous Interventions — None
- 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 — -

Richmond Agitation Sedation Scale (RASS)
- Sedation / Agitation
- Protocol: RASS
  - Respiratory Rate — 15
  - 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

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

(-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 09/19/18 15:00 KYL0009 (Rec: 09/19/18 15:55 KYL0009 ICU-C12)

Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE

Patient Currently Having Pain	Yes
Pain Assessment Based Upon	Patient Report
Pain Intensity	4
Query Text:0-10	
Pain Scale Used	0-10 Numeric
Stated Pain Consistent with Observed Level of Pain	Yes

Pain Location/Description
left shoulder

Pain Description	Unable to Verbalize

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	-

Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation
Protocol: RASS

Respiratory Rate	23
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

Continued on Page 138

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

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

Agitation/RASS Intervention — No Intervention Required

Document 09/19/18 16:00 KYL0009 (Rec: 09/19/18 17:53 KYL0009 ICU-C12)

Pain Assessment/Reassessment

Pain Assessment

Protocol: C.PNSCALE

Patient Currently Having Pain — No
Pain Assessment Based Upon — Patient Report
Pain Intensity — 0
Query Text:0-10
Pain Scale Used — 0-10 Numeric
Stated Pain Consistent with Observed Level of Pain — Yes

Pain Location/Description

left shoulder
Pain Description — Unable to Verbalize

Reassessment of Respiratory Rate

Reassessment of respiratory rate is required for the following:
Dilaudid
Fentanyl
Morphine
Respiratory Rate — 19

Side Effects

Please document any side effects from previous interventions here. If no previous interventions were provided, please skip to "Interventions."
Side Effects from Previous Interventions — None

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 — -

Richmond Agitation Sedation Scale (RASS)

Sedation / Agitation

Protocol: RASS

Respiratory Rate — 19
Agitation/Sedation Score — (-1) Drowsy
Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger to staff

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

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 09/19/18 17:00 KYL0009 (Rec: 09/19/18 17:56 KYL0009 ICU-C12)

Pain Assessment/Reassessment

Pain Assessment

Protocol: C.PNSCALE

Patient Currently Having Pain	No
Pain Assessment Based Upon	Patient Report
Pain Intensity	0
Query Text:0-10	
Pain Scale Used	0-10 Numeric

Reassessment of Respiratory Rate

Reassessment of respiratory rate is required for the following:
Dilaudid
Fentanyl
Morphine

Respiratory Rate	22

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	-

Richmond Agitation Sedation Scale (RASS)

Sedation / Agitation

Protocol: RASS

Respiratory Rate	22
Agitation/Sedation Score	(-1) Drowsy

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

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

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 09/19/18 18:00 KYL0009 (Rec: 09/19/18 18:27 KYL0009 ICU-C12)

Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE
Patient Currently Having Pain — No
Pain Assessment Based Upon — Patient Report
Pain Intensity — 0
Query Text:0-10
Pain Scale Used — 0-10 Numeric
Pain Location/Description
left shoulder
Pain Description — Unable to Verbalize
Reassessment of Respiratory Rate
Reassessment of respiratory rate is required for the following:
Dilaudid
Fentanyl
Morphine
Respiratory Rate — 22
Side Effects
Please document any side effects from previous interventions here. If no previous interventions were provided, please skip to "Interventions."
Side Effects from Previous Interventions — None
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 — -

Richmond Agitation Sedation Scale (RASS)

Continued on Page 141

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Sedation / Agitation
Protocol: RASS
Respiratory Rate 22
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)
(-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 09/19/18 19:00 KIM0006 (Rec: 09/19/18 23:05 KIM0006 ICU-C12)

Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE
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 -

Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation
Protocol: RASS
Respiratory Rate 19
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

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

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 09/19/18 20:45 KIM0006 (Rec: 09/19/18 23:05 KIM0006 ICU-C12)

Pain Assessment/Reassessment

Pain Assessment

Protocol: C.PNSCALE

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	-

Richmond Agitation Sedation Scale (RASS)

Sedation / Agitation

Protocol: RASS

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)

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BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

(-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 09/19/18 21:00 KIM0006 (Rec: 09/19/18 23:06 KIM0006 ICU-C12)

Pain Assessment/Reassessment

Pain Assessment

Protocol: C.PNSCALE

Patient Currently Having Pain	No
Pain Assessment Based Upon	Patient Report
Pain Based Upon Comments	Patient denies pain

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	-

Richmond Agitation Sedation Scale (RASS)

Sedation / Agitation

Protocol: RASS

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

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

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

Document 09/19/18 22:00 KIM0006 (Rec: 09/19/18 23:15 KIM0006 ICU-C12)

Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE

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	-

Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation
Protocol: RASS

Respiratory Rate	15
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

Document 09/19/18 23:16 KIM0006 (Rec: 09/19/18 23:16 KIM0006 ICU-C12)

Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE

Patient Currently Having Pain	No
Pain Assessment Based Upon	Nursing Observation
Pain Based Upon Comments	pt resting in bed, appears

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

comfortable

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 -

Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation
Protocol: RASS
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 09/20/18 00:15 KIM0006 (Rec: 09/20/18 01:28 KIM0006 ICU-C12)

Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE
Patient Currently Having Pain No
Pain Assessment Based Upon Patient Report
Pain Based Upon Comments pt continues to deny pain

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 -

Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation

Continued on Page 146

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Protocol: RASS
Respiratory Rate 25
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 09/20/18 01:00 KIM0006 (Rec: 09/20/18 01:28 KIM0006 ICU-C12)
Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE
Patient Currently Having Pain No
Pain Assessment Based Upon Patient Report
Pain Based Upon Comments pt continues to deny pain
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 -
Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation
Protocol: RASS
Respiratory Rate 25
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

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Assessments and Treatments - Continued

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 09/20/18 01:53 KIM0006 (Rec: 09/20/18 01:54 KIM0006 ICU-C12)

Pain Assessment/Reassessment

Pain Assessment

Protocol: C.PNSCALE

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	-

Richmond Agitation Sedation Scale (RASS)

Sedation / Agitation

Protocol: RASS

Respiratory Rate	23
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

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Assessments and Treatments - Continued

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 09/20/18 03:00 KIM0006 (Rec: 09/20/18 04:27 KIM0006 ICU-C12)

Pain Assessment/Reassessment

Pain Assessment

Protocol: C.PNSCALE

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	-

Richmond Agitation Sedation Scale (RASS)

Sedation / Agitation

Protocol: RASS

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

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Document 09/20/18 04:00 KIM0006 (Rec: 09/20/18 04:27 KIM0006 ICU-C12)
Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE
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 -
Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation
Protocol: RASS
Respiratory Rate 15
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 09/20/18 04:57 KIM0006 (Rec: 09/20/18 04:57 KIM0006 ICU-C12)
Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE
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

Continued on Page 150

Assessments and Treatments - Continued

Follow Up Evaluation Needed No
Time Follow Up Due -

Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation
Protocol: RASS
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

Document 09/20/18 06:00 KIM0006 (Rec: 09/20/18 06:20 KIM0006 ICU-M35)

Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE
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 -

Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation
Protocol: RASS
Respiratory Rate 25
Agitation/Sedation Score (0) Alert/Calm
Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger to staff

Continued on Page 151

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

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

Not Done 09/20/18 07:00 JOA0063 (Rec: 09/20/18 15:47 JOA0063 ICU-C25)
PT WON'T RATE, REFUSES MED THEN COMPUTER DOWN
Not Done 09/20/18 08:00 JOA0063 (Rec: 09/20/18 15:47 JOA0063 ICU-C25)
PT WON'T RATE, REFUSES MED THEN COMPUTER DOWN
Not Done 09/20/18 09:00 JOA0063 (Rec: 09/20/18 15:47 JOA0063 ICU-C25)
PT WON'T RATE, REFUSES MED THEN COMPUTER DOWN
Not Done 09/20/18 10:00 JOA0063 (Rec: 09/20/18 15:47 JOA0063 ICU-C25)
PT WON'T RATE, REFUSES MED THEN COMPUTER DOWN
Not Done 09/20/18 11:00 JOA0063 (Rec: 09/20/18 15:47 JOA0063 ICU-C25)
PT WON'T RATE, REFUSES MED THEN COMPUTER DOWN
Not Done 09/20/18 12:00 JOA0063 (Rec: 09/20/18 15:47 JOA0063 ICU-C25)
PT WON'T RATE, REFUSES MED THEN COMPUTER DOWN
Not Done 09/20/18 13:00 JOA0063 (Rec: 09/20/18 15:47 JOA0063 ICU-C25)
PT WON'T RATE, REFUSES MED THEN COMPUTER DOWN
Not Done 09/20/18 14:00 JOA0063 (Rec: 09/20/18 15:47 JOA0063 ICU-C25)
PT WON'T RATE, REFUSES MED THEN COMPUTER DOWN
Not Done 09/20/18 15:00 JOA0063 (Rec: 09/20/18 15:47 JOA0063 ICU-C25)
PT WON'T RATE, REFUSES MED THEN COMPUTER DOWN
Document 09/20/18 16:34 ANI0051 (Rec: 09/20/18 16:35 ANI0051 ICU-C25)

Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE

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	-

Continued on Page 152

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation
Protocol: RASS

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

Pain Assessment/Reassessment Start: 09/21/18 08:26
Freq: DAILY@0800,2000 Status: Discharge
Protocol: C.PNSCALE
Document 09/21/18 19:30 MEG0025 (Rec: 09/21/18 23:33 MEG0025 TELE-C09)

Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE

Patient Currently Having Pain	Yes
Pain Assessment Based Upon	Patient Report
Pain Intensity	9

Query Text:0-10

Pain Scale Used	0-10 Numeric

Pain Location/Description
left flank

Pain Description	Acute

left shoulder

Pain Description	Acute

Interventions
Please document those interventions you are currently providing.

Interventions Provided for Current Pain Level	Positioning Relaxation

Continued on Page 153

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01

62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Interventions Provided Comment pt refuses pain medication
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 09/22/18 08:00 MEG0025 (Rec: 09/22/18 10:28 MEG0025 TELE-C13)

Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE
Patient Currently Having Pain Yes
Pain Assessment Based Upon Patient Report
Pain Intensity 9
Query Text:0-10
Pain Scale Used 0-10 Numeric
Pain Location/Description
left flank
Pain Description Acute
left shoulder
Pain Description Acute
Reassessment of Respiratory Rate
Reassessment of respiratory rate is required for the following:
Dilaudid
Fentanyl
Morphine
Respiratory Rate 20
Side Effects
Please document any side effects from previous interventions here. If no previous interventions were provided, please skip to "Interventions."
Side Effects from Previous Interventions None
Interventions
Please document those interventions you are currently providing.
Interventions Provided for Current Pain Level Positioning
Relaxation
Interventions Provided Comment pt refuses pain medication
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 09/22/18 20:00 SOP0051 (Rec: 09/22/18 20:09 SOP0051 TELE-C11)

Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE
Patient Currently Having Pain Yes
Pain Assessment Based Upon Patient Report
Pain Intensity 6
Query Text:0-10
Pain Scale Used 0-10 Numeric
Pain Location/Description
left flank
Pain Description Ache
Acute
left shoulder
Pain Description Ache
Acute
Interventions
Please document those interventions you are currently providing.
Interventions Provided for Current Pain Environmental Control

Continued on Page 154

Assessments and Treatments - Continued

```
      Level                                  Music
                                             Positioning
                                             Relaxation
     Interventions Provided Comment          pt refuses pain medication
     Follow Up Evaluation Needed             No
     Time Follow Up Due                      -
Document     09/23/18 08:00  STA0017  (Rec: 09/23/18 10:33  STA0017  TELE-C03)
Pain Assessment/Reassessment
    Pain Assessment
    Protocol:  C.PNSCALE
     Patient Currently Having Pain           Yes
     Pain Assessment Based Upon              Patient Report
     Pain Intensity                          8
      Query Text:0-10
     Pain Scale Used                         0-10 Numeric
    Pain Location/Description
     left flank
      Pain Description                       Ache
     left shoulder
      Pain Description                       Ache
    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  None
      Level
     Follow Up Evaluation Needed             No
     Time Follow Up Due                      -
Document     09/23/18 19:07  RAY0005  (Rec: 09/23/18 19:07  RAY0005  TELE-C11)
Pain Assessment/Reassessment
    Pain Assessment
    Protocol:  C.PNSCALE
     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                      -
Not Done     09/24/18 08:00  MAC0003  (Rec: 09/24/18 08:05  MAC0003  TELE-M12)
    Declined by Patient
Patient Education                                     Start:  09/19/18 08:47
Freq:  DAILY@0000,0400,0800,1200,1600                  Status: Inactive
Protocol:
Document     09/19/18 12:00  KYL0009  (Rec: 09/19/18 12:48  KYL0009  ICU-C12)
Patient Education
    Patient Education
     Readiness To Learn                      Poor
```

Continued on Page 155

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Barriers to Learning — Physical
Needs Follow Up/Reinforcement — Fall Precautions
Safety

Document 09/19/18 16:00 KYL0009 (Rec: 09/19/18 17:53 KYL0009 ICU-C12)
Patient Education
Patient Education
Readiness To Learn — Poor
Barriers to Learning — Physical
Needs Follow Up/Reinforcement — Fall Precautions
Safety

Document 09/20/18 00:30 KIM0006 (Rec: 09/20/18 01:30 KIM0006 ICU-C12)
Patient Education
Patient Education
Readiness To Learn — Poor
Barriers to Learning — Physical
Needs Follow Up/Reinforcement — Standard (Pain Scale, Shift Plan,POC, Meds, Pt Goals, Safety)
Fall Precautions
Safety

Document 09/20/18 04:00 KIM0006 (Rec: 09/20/18 04:40 KIM0006 ICU-C12)
Patient Education
Patient Education
Readiness To Learn — Poor
Barriers to Learning — Physical
Needs Follow Up/Reinforcement — Standard (Pain Scale, Shift Plan,POC, Meds, Pt Goals, Safety)
Fall Precautions
Safety

Document 09/20/18 08:00 JOA0063 (Rec: 09/20/18 15:49 JOA0063 ICU-C25)
Patient Education
Patient Education
Readiness To Learn — Fair
Barriers to Learning — Motivation
Physical
Needs Follow Up/Reinforcement — Standard (Pain Scale, Shift Plan,POC, Meds, Pt Goals, Safety)
Fall Precautions
Reason for Hospitalization
Safe Ambulation
Safety
Patient Education Comment — CONFUSED, FORGETFUL DELUISIONAL
Patient Education
Teaching Recipient — Patient
Teaching Methods — Discussion

Document 09/20/18 12:00 JOA0063 (Rec: 09/20/18 16:07 JOA0063 ICU-C25)
Patient Education
Patient Education
Readiness To Learn — Fair
Barriers to Learning — Confusion

Continued on Page 156

	Motivation
	Physical
Needs Follow Up/Reinforcement	Standard (Pain Scale, Shift Plan,POC, Meds, Pt Goals, Safety)
	Fall Precautions
	Reason for Hospitalization
	Safe Ambulation
	Safety
Patient Education Comment	CONFUSED, FORGETFUL DELUISIONAL
Patient Education	
Teaching Recipient	Patient
Teaching Methods	Discussion

Document 09/20/18 16:34 ANI0051 (Rec: 09/20/18 16:35 ANI0051 ICU-C25)

Patient Education

Patient Education	
Readiness To Learn	Fair
Barriers to Learning	Confusion
	Motivation
	Physical
Needs Follow Up/Reinforcement	Standard (Pain Scale, Shift Plan,POC, Meds, Pt Goals, Safety)
	Fall Precautions
	Reason for Hospitalization
	Safe Ambulation
	Safety
Patient Education Comment	CONFUSED, FORGETFUL DELUISIONAL
Patient Education	
Teaching Recipient	Patient
Teaching Methods	Discussion

Patient Education Start: 09/21/18 08:26
Freq: DAILY@0400,1600 Status: Discharge
Protocol:

Document 09/21/18 15:34 CON0001 (Rec: 09/21/18 15:34 CON0001 TELE-M11)

Patient Education

Patient Education	
Readiness To Learn	Poor
Barriers to Learning	Confusion
	Motivation
	Physical
Needs Follow Up/Reinforcement	Standard (Pain Scale, Shift Plan,POC, Meds, Pt Goals, Safety)
	Fall Precautions
	Reason for Hospitalization
	Safe Ambulation
	Safety

Incentive Spirometry Education

Incentive Spirometry	
Patient Educated on Use	Yes

Continued on Page 157

Teaching Methods	Discussion Demonstration
Response to Teaching	Reinforcement Needed
Is Patient Compliant	No
Patient Education	
Teaching Recipient	Patient
Teaching Methods	Discussion Demonstration

Document 09/22/18 04:00 MEG0025 (Rec: 09/22/18 04:13 MEG0025 TELE-C09)

Patient Education

Patient Education	
Readiness To Learn	Poor
Barriers to Learning	Confusion Emotional Motivation Physical
Needs Follow Up/Reinforcement	Standard (Pain Scale, Shift Plan,POC, Meds, Pt Goals, Safety) Community Resources Disease Process Fall Precautions Medical Equipment/Devices Medication Management Pain Management Reason for Hospitalization Safe Ambulation Safety
Patient Education	
Teaching Recipient	Patient
Teaching Methods	Discussion

Document 09/22/18 16:00 MOR0002 (Rec: 09/22/18 17:33 MOR0002 TELE-C05)

Patient Education

Patient Education	
Readiness To Learn	Poor
Barriers to Learning	Anxiety Emotional Motivation
Needs Follow Up/Reinforcement	Standard (Pain Scale, Shift Plan,POC, Meds, Pt Goals, Safety) Community Resources Disease Process Medication Management Pain Management Reason for Hospitalization Safe Ambulation Safety Skin Breakdown Prevention Strategies

Document 09/23/18 04:00 SOP0051 (Rec: 09/23/18 04:47 SOP0051 TELE-C11)

Patient Education

Patient Education

Continued on Page 158

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01

62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Readiness To Learn	Poor
Barriers to Learning	Anxiety Emotional Motivation Other
Needs Follow Up/Reinforcement	Standard (Pain Scale, Shift Plan,POC, Meds, Pt Goals, Safety) Community Resources Disease Process Medication Management Pain Management Reason for Hospitalization Safe Ambulation Safety
Patient Education Comment	psychosis
Patient Education	
Teaching Recipient	Patient
Teaching Methods	Discussion

Document 09/23/18 16:00 STA0017 (Rec: 09/23/18 18:34 STA0017 TELE-C03)

Patient Education

Patient Education	
Readiness To Learn	Poor
Barriers to Learning	Emotional Other
Patient Education Comment	Pt declines medical interventions, meds, vs with automatic cuff, tolerated manual cuff for BP once.
Patient Education	
Teaching Recipient	Patient
Education Comments	Pt declines education

Document 09/23/18 22:34 RAY0005 (Rec: 09/23/18 22:36 RAY0005 TELE-C11)

Patient Education

Patient Education	
Readiness To Learn	Poor
Barriers to Learning	Anxiety Emotional Motivation Physical Other
Understood/Returned Demonstration	Standard (Pain Scale, Shift Plan,POC, Meds, Pt Goals, Safety) Pain Management Safe Ambulation
Needs Follow Up/Reinforcement	Standard (Pain Scale, Shift Plan,POC, Meds, Pt Goals, Safety) Community Resources Disease Process Fall Precautions Medical Equipment/Devices

Continued on Page 159

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

```
                                            Medication Management
                                            Pain Management
                                            Reason for Hospitalization
                                            Safe Ambulation
                                            Safe Transfers
                                            Safety
                                            Skin Breakdown Prevention
                                            Strategies
    Patient Education
      Teaching Recipient                    Patient
      Teaching Methods                      Discussion
 Document     09/24/18 15:51  MAC0003  (Rec: 09/24/18 15:51  MAC0003  TELE-C09)
 Patient Education
    Patient Education
      Readiness To Learn                    Poor
      Barriers to Learning                  Anxiety
                                            Emotional
                                            Other
      Needs Follow Up/Reinforcement         Standard (Pain Scale, Shift
                                            Plan,POC, Meds, Pt Goals,
                                            Safety)
                                            Disease Process
                                            Medical Equipment/Devices
                                            Medication Management
                                            Pain Management
                                            Skin Breakdown Prevention
                                            Strategies
    Patient Education
      Teaching Recipient                    Patient
      Teaching Methods                      Discussion
```

```
Peripheral IV: Care                                 Start:  09/19/18 08:47
Freq:   Q4HR                                        Status: Inactive
Protocol:  C.IV
 Document     09/19/18 12:00  KYL0009  (Rec: 09/19/18 12:48  KYL0009  ICU-C12)
 Peripheral IV: Care
    Care
    Protocol:  C.PHLEB
      Right Hand
       IV Inserted by Emergency Medical     No
        Services (EMS)
       Insertion Date                       09/19/18
       Type                                 Saline Lock
       Peripheral IV Gauge                  20
       Dressing Status                      Dry
                                            Intact
 Edit Result 09/19/18 12:00  KYL0009  (Rec: 09/19/18 19:51  KYL0009  ICU-C21)
 Peripheral IV: Care
    Care
    Protocol:  C.PHLEB
      Left Antecubital
       IV Inserted by Emergency Medical     No
        Services (EMS)
       Insertion Date                       09/19/18
```

Continued on Page 160

```
      Type                                  Saline Lock
      Peripheral IV Gauge                   20
      Dressing Status                       Dry
                                            Intact
      Is Site Patent                        Yes
      Is Site Benign                        Yes
     Right Hand
      Is Site Patent                        Yes
      Is Site Benign                        Yes
Document     09/19/18 16:00  KYL0009  (Rec: 09/19/18 17:53  KYL0009  ICU-C12)
Peripheral IV: Care
    Care
    Protocol:  C.PHLEB
     Left Antecubital
      IV Inserted by Emergency Medical      No
       Services (EMS)
      Insertion Date                        09/19/18
      Type                                  Saline Lock
      Peripheral IV Gauge                   20
      Dressing Status                       Dry
                                            Intact
      Is Site Patent                        Yes
      Is Site Benign                        Yes
     Right Hand
      Insertion Date                        09/19/18
      Type                                  Saline Lock
      Peripheral IV Gauge                   20
Edit Result  09/19/18 16:00  KYL0009  (Rec: 09/19/18 19:51  KYL0009  ICU-C21)
Peripheral IV: Care
    Care
    Protocol:  C.PHLEB
     Right Hand
      Dressing Status                       Dry
                                            Intact
      Is Site Patent                        Yes
      Is Site Benign                        Yes
Document     09/19/18 20:50  KIM0006  (Rec: 09/19/18 22:45  KIM0006  ICU-C12)
Peripheral IV: Care
    Care
    Protocol:  C.PHLEB
     Left Antecubital
      IV Inserted by Emergency Medical      No
       Services (EMS)
      Insertion Date                        09/19/18
      Type                                  Saline Lock
      Peripheral IV Gauge                   20
      Dressing Status                       Dry
                                            Intact
      Is Site Patent                        Yes
      Is Site Benign                        Yes
     Right Hand
      Insertion Date                        09/19/18
      Type                                  Saline Lock
```

Continued on Page 161

```
      Peripheral IV Gauge                     20
      Dressing Status                         Dry
                                              Intact
      Is Site Patent                          Yes
      Is Site Benign                          Yes
Document     09/20/18 00:30  KIM0006  (Rec: 09/20/18 01:30  KIM0006  ICU-C12)
Peripheral IV: Care
    Care
    Protocol:  C.PHLEB
      Left Antecubital
      IV Inserted by Emergency Medical        No
       Services (EMS)
      Insertion Date                          09/19/18
      Type                                    Saline Lock
      Peripheral IV Gauge                     20
      Dressing Status                         Dry
                                              Intact
      Is Site Patent                          Yes
      Is Site Benign                          Yes
      Right Hand
      Insertion Date                          09/19/18
      Type                                    Saline Lock
      Peripheral IV Gauge                     20
      Dressing Status                         Dry
                                              Intact
      Is Site Patent                          Yes
      Is Site Benign                          Yes
Document     09/20/18 04:00  KIM0006  (Rec: 09/20/18 04:40  KIM0006  ICU-C12)
Peripheral IV: Care
    Care
    Protocol:  C.PHLEB
      Left Antecubital
      IV Inserted by Emergency Medical        No
       Services (EMS)
      Insertion Date                          09/19/18
      Type                                    Saline Lock
      Peripheral IV Gauge                     20
      Dressing Status                         Dry
                                              Intact
      Is Site Patent                          Yes
      Is Site Benign                          Yes
      Right Hand
      Insertion Date                          09/19/18
      Type                                    Saline Lock
      Peripheral IV Gauge                     20
      Dressing Status                         Dry
                                              Intact
      Is Site Patent                          Yes
      Is Site Benign                          Yes
Document     09/20/18 08:00  JOA0063  (Rec: 09/20/18 15:49  JOA0063  ICU-C25)
Peripheral IV: Care
    Care
    Protocol:  C.PHLEB
```

Continued on Page 162

Left Antecubital

IV Inserted by Emergency Medical Services (EMS)	No
Insertion Date	09/19/18
Type	Saline Lock
Peripheral IV Gauge	20
Dressing Status	Dry Intact
Is Site Patent	Yes
Is Site Benign	Yes

Right Hand

Insertion Date	09/19/18
Type	Continuous IV
Peripheral IV Gauge	20
Dressing Status	Dry Intact
Is Site Patent	Yes
Is Site Benign	Yes

Document 09/20/18 12:00 JOA0063 (Rec: 09/20/18 16:07 JOA0063 ICU-C25)
Peripheral IV: Care
Care
Protocol: C.PHLEB
Left Antecubital

IV Inserted by Emergency Medical Services (EMS)	No
Insertion Date	09/19/18
Type	Saline Lock
Peripheral IV Gauge	20
Dressing Status	Dry Intact
Is Site Patent	Yes
Is Site Benign	Yes

Right Hand

Insertion Date	09/19/18
Type	Continuous IV
Peripheral IV Gauge	20
Dressing Status	Dry Intact
Is Site Patent	Yes
Is Site Benign	Yes

Document 09/20/18 16:34 ANI0051 (Rec: 09/20/18 16:35 ANI0051 ICU-C25)
Peripheral IV: Care
Care
Protocol: C.PHLEB
Right Hand

Insertion Date	09/19/18
Type	Continuous IV
Peripheral IV Gauge	20
Dressing Status	Dry Intact
Is Site Patent	Yes
Is Site Benign	Yes

Peripheral IV: Care Start: 09/21/18 08:26

Continued on Page 163

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01

62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Freq: DAILY@0800,1600,0000 Status: Complete
Protocol: C.IV
Document 09/21/18 15:34 CON0001 (Rec: 09/21/18 15:34 CON0001 TELE-M11)
Peripheral IV: Care
Care
Protocol: C.PHLEB
Right Hand

Insertion Date	09/19/18
Type	Continuous IV
Peripheral IV Gauge	20
Dressing Status	Dry Intact
Is Site Patent	Yes
Is Site Benign	Yes

Document 09/22/18 00:00 MEG0025 (Rec: 09/22/18 01:49 MEG0025 TELE-C09)
Peripheral IV: Care
Care
Protocol: C.PHLEB
Right Hand

Insertion Date	09/19/18
Type	Continuous IV
Peripheral IV Gauge	20
Dressing Status	Dry Intact
Is Site Patent	No: pt refuses to let nurse remove IV or put in new IV access, provider aware
Is Site Benign	No

Document 09/22/18 08:00 MEG0025 (Rec: 09/22/18 10:28 MEG0025 TELE-C13)
Peripheral IV: Care
Care
Protocol: C.PHLEB
Right Hand

Insertion Date	09/19/18
Type	Continuous IV
Peripheral IV Gauge	20
Dressing Status	Dry Intact
Is Site Patent	No: pt refuses to let nurse remove IV or put in new IV access, provider aware
Is Site Benign	No

Peripheral IV: Insertion Start: 09/19/18 04:42
Freq: Status: Discharge
Protocol: C.IV
Document 09/19/18 06:32 THO0010 (Rec: 09/19/18 06:32 THO0010 ED-C19)
Peripheral IV: Insertion
Insertion
Right Hand

Peripheral IV Insertion Date	09/19/18
Peripheral IV Insertion Time	0545
Peripheral IV Type	Saline Lock
Local Anesthesia Used	None

Continued on Page 164

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01

62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Gauge 20
Brisk Blood Return Yes
Site Appearance Benign
Secured With Sterile Occlusive Dressing
Patient Tolerated Well

Peripheral IV: Insertion Start: 09/19/18 08:47
Freq: Status: Inactive
Protocol: C.IV
Document 09/19/18 12:32 KYL0009 (Rec: 09/19/18 12:33 KYL0009 ICU-C12)
Peripheral IV: Insertion
Insertion
Right Hand
Peripheral IV Insertion Date 09/19/18
Peripheral IV Insertion Time n
Peripheral IV Type Saline Lock
Local Anesthesia Used None
Gauge 20
Brisk Blood Return Yes
Site Appearance Benign
Secured With Sterile Occlusive Dressing
Patient Tolerated Well

RT: Oxygen Start: 09/19/18 20:26
Freq: .QSHIFT(NO PROT) Status: Complete
Protocol: RTPROTOCOL
Document 09/20/18 01:57 KEV0015 (Rec: 09/20/18 01:57 KEV0015 RESP-C01)
RT Oxygen
Oxygen
Patient on Room Air Yes
Oxygen Devices in Use Now None
O2 Sat by Pulse Oximetry 96
Time Spent (minutes) 2
Change Made to Oxygen? No

Restraint: Behav Mgmt Safety Check Start: 09/19/18 08:56
Freq: Q15MIN Status: Complete
Protocol:
Document 09/19/18 05:39 THO0010 (Rec: 09/19/18 05:40 THO0010 ED-C19)
Restraint:Behav Mgmt Safety Ck
Restraint
Type of Restraint Soft Wrist Bilateral
Soft Ankle Bilateral
Restraint Secured Appropriately Yes
Query Text:
** Ensure that restraint is applied and secured in accordance with manufacturer's instructions. Do not secure the restraint to the side rails. Ensure that the device will not tighten or loosen as the bed is raised or lowered. **
Care and Management
Call Light Within Reach Yes
Reoriented to Person/Time/Place Yes
Provide Conversation as appropriate Yes
Decrease Auditory Stimulation Yes

Continued on Page 165

CMS Check
CMS Restrained Extremity Check WNL Yes
Query Text:
** The skin surrounding and under restraint is warm, dry, and appropriate for race. It is intact without evidence of friction. No swelling noted. Pulses are present. No tingling, numbness or change in sensation reported. Mobility is unchanged from baseline. **
Nourishment/Hygiene/Toileting
Nourishment pt not answering
Hygiene and Toileting Care Provided
Injury Assessment
Restraint: Injury Evaluation No Injury Noted
Document 09/19/18 05:45 THO0010 (Rec: 09/19/18 05:48 THO0010 ED-C19)
Restraint:Behav Mgmt Safety Ck
Restraint
Type of Restraint Soft Wrist Bilateral
Soft Ankle Bilateral
Restraint Secured Appropriately Yes
Query Text:
** Ensure that restraint is applied and secured in accordance with manufacturer's instructions. Do not secure the restraint to the side rails. Ensure that the device will not tighten or loosen as the bed is raised or lowered. **
Care and Management
Call Light Within Reach Yes
Reoriented to Person/Time/Place Yes
Provide Conversation as appropriate Yes
Decrease Auditory Stimulation Yes
CMS Check
CMS Restrained Extremity Check WNL Yes
Query Text:
** The skin surrounding and under restraint is warm, dry, and appropriate for race. It is intact without evidence of friction. No swelling noted. Pulses are present. No tingling, numbness or change in sensation reported. Mobility is unchanged from baseline. **
Nourishment/Hygiene/Toileting
Nourishment pt not answering
Hygiene and Toileting Care Provided
Injury Assessment
Restraint: Injury Evaluation No Injury Noted
Document 09/19/18 06:00 THO0010 (Rec: 09/19/18 06:16 THO0010 ED-C19)
Restraint:Behav Mgmt Safety Ck
Restraint
Type of Restraint Soft Wrist Bilateral
Soft Ankle Bilateral

Continued on Page 166

Assessments and Treatments - Continued

Restraint Secured Appropriately Yes
Query Text:
** Ensure that restraint is applied and secured in accordance with manufacturer's instructions. Do not secure the restraint to the side rails. Ensure that the device will not tighten or loosen as the bed is raised or lowered. **

Care and Management
Call Light Within Reach Yes
Reoriented to Person/Time/Place Yes
Provide Conversation as appropriate Yes
Decrease Auditory Stimulation Yes

CMS Check
CMS Restrained Extremity Check WNL Yes
Query Text:
** The skin surrounding and under restraint is warm, dry, and appropriate for race. It is intact without evidence of friction. No swelling noted. Pulses are present. No tingling, numbness or change in sensation reported. Mobility is unchanged from baseline. **

Nourishment/Hygiene/Toileting
Nourishment pt not answering
Hygiene and Toileting Patient Declined

Injury Assessment
Restraint: Injury Evaluation No Injury Noted

Document 09/19/18 06:15 THO0010 (Rec: 09/19/18 06:16 THO0010 ED-C19)
Restraint:Behav Mgmt Safety Ck

Restraint
Type of Restraint Soft Wrist Bilateral
Soft Ankle Bilateral
Restraint Secured Appropriately Yes
Query Text:
** Ensure that restraint is applied and secured in accordance with manufacturer's instructions. Do not secure the restraint to the side rails. Ensure that the device will not tighten or loosen as the bed is raised or lowered. **

Care and Management
Call Light Within Reach Yes
Reoriented to Person/Time/Place Yes
Provide Conversation as appropriate Yes
Decrease Auditory Stimulation Yes

CMS Check
CMS Restrained Extremity Check WNL Yes
Query Text:
** The skin surrounding and under restraint is warm, dry, and appropriate for race. It is intact without evidence of friction. No swelling noted. Pulses

Continued on Page 167

Assessments and Treatments - Continued

are present. No tingling, numbness or
change in sensation reported. Mobility
is unchanged from baseline. **

Nourishment/Hygiene/Toileting

Nourishment	pt not answering
Hygiene and Toileting	Patient Declined

Injury Assessment

Restraint: Injury Evaluation	No Injury Noted

Document 09/19/18 06:30 MEL0095 (Rec: 09/19/18 07:00 MEL0095 EDL-C01)

Restraint:Behav Mgmt Safety Ck

Restraint

Type of Restraint	Soft Wrist Bilateral Soft Ankle Bilateral
Restraint Secured Appropriately	Yes

Query Text:
** Ensure that restraint is applied and
secured in accordance with manufacturer'
s instructions. Do not secure the
restraint to the side rails. Ensure that
the device will not tighten or loosen
as the bed is raised or lowered. **

Care and Management

Call Light Within Reach	Yes
Reoriented to Person/Time/Place	Yes
Provide Conversation as appropriate	Yes
Decrease Auditory Stimulation	Yes

CMS Check

CMS Restrained Extremity Check WNL	Yes

Query Text:
** The skin surrounding and under
restraint is warm, dry, and appropriate
for race. It is intact without evidence
of friction. No swelling noted. Pulses
are present. No tingling, numbness or
change in sensation reported. Mobility
is unchanged from baseline. **

Nourishment/Hygiene/Toileting

Nourishment	Patient Declined
Hygiene and Toileting	Patient Declined

Injury Assessment

Restraint: Injury Evaluation	No Injury Noted

Document 09/19/18 06:45 MEL0095 (Rec: 09/19/18 07:00 MEL0095 EDL-C01)

Restraint:Behav Mgmt Safety Ck

Restraint

Type of Restraint	Soft Wrist Bilateral Soft Ankle Bilateral
Restraint Secured Appropriately	Yes

Query Text:
** Ensure that restraint is applied and
secured in accordance with manufacturer'
s instructions. Do not secure the
restraint to the side rails. Ensure that
the device will not tighten or loosen

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BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

as the bed is raised or lowered. **

Care and Management
- Call Light Within Reach — Yes
- Reoriented to Person/Time/Place — N/A
- Provide Conversation as appropriate — N/A
- Decrease Auditory Stimulation — Yes

CMS Check
- CMS Restrained Extremity Check WNL — Yes
  Query Text:
  ** The skin surrounding and under restraint is warm, dry, and appropriate for race. It is intact without evidence of friction. No swelling noted. Pulses are present. No tingling, numbness or change in sensation reported. Mobility is unchanged from baseline. **

Nourishment/Hygiene/Toileting
- Nourishment — Patient Declined
- Hygiene and Toileting — Patient Declined

Injury Assessment
- Restraint: Injury Evaluation — No Injury Noted

Document 09/19/18 07:00 KIR0007 (Rec: 09/19/18 07:15 KIR0007 EDRM-C10)

Restraint:Behav Mgmt Safety Ck

Restraint
- Type of Restraint — Soft Wrist Bilateral; Soft Ankle Bilateral
- Restraint Secured Appropriately — Yes
  Query Text:
  ** Ensure that restraint is applied and secured in accordance with manufacturer's instructions. Do not secure the restraint to the side rails. Ensure that the device will not tighten or loosen as the bed is raised or lowered. **

Care and Management
- Call Light Within Reach — Yes
- Reoriented to Person/Time/Place — N/A
- Provide Conversation as appropriate — N/A
- Decrease Auditory Stimulation — Yes

CMS Check
- CMS Restrained Extremity Check WNL — Yes
  Query Text:
  ** The skin surrounding and under restraint is warm, dry, and appropriate for race. It is intact without evidence of friction. No swelling noted. Pulses are present. No tingling, numbness or change in sensation reported. Mobility is unchanged from baseline. **

Nourishment/Hygiene/Toileting
- Nourishment — Patient Declined
- Hygiene and Toileting — Patient Declined

Injury Assessment

Continued on Page 169

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01

62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Restraint: Injury Evaluation No Injury Noted

Document 09/19/18 07:00 NAT0019 (Rec: 09/19/18 07:53 NAT0019 ED-C19)

Restraint:Behav Mgmt Safety Ck

Restraint

Type of Restraint Soft Wrist Bilateral
Soft Ankle Bilateral

Restraint Secured Appropriately Yes

Query Text:
** Ensure that restraint is applied and secured in accordance with manufacturer' s instructions. Do not secure the restraint to the side rails. Ensure that the device will not tighten or loosen as the bed is raised or lowered. **

Care and Management

Call Light Within Reach No

Reoriented to Person/Time/Place No: medicated for agitation/ aggressive behavior

Provide Conversation as appropriate No

Decrease Auditory Stimulation Yes

CMS Check

CMS Restrained Extremity Check WNL Yes

Query Text:
** The skin surrounding and under restraint is warm, dry, and appropriate for race. It is intact without evidence of friction. No swelling noted. Pulses are present. No tingling, numbness or change in sensation reported. Mobility is unchanged from baseline. **

Nourishment/Hygiene/Toileting

Nourishment pt unable to eat at this time

Hygiene and Toileting Urinary Catheter

Nourishment/Hygiene/Toileting Comment pt was recently straight cathed for urine sample

Injury Assessment

Restraint: Injury Evaluation No Injury Noted

Document 09/19/18 07:15 KIR0007 (Rec: 09/19/18 07:16 KIR0007 EDRM-C10)

Restraint:Behav Mgmt Safety Ck

Restraint

Type of Restraint Soft Wrist Bilateral
Soft Ankle Bilateral

Restraint Secured Appropriately Yes

Query Text:
** Ensure that restraint is applied and secured in accordance with manufacturer' s instructions. Do not secure the restraint to the side rails. Ensure that the device will not tighten or loosen as the bed is raised or lowered. **

Care and Management

Call Light Within Reach Yes

Reoriented to Person/Time/Place N/A

Continued on Page 170

Assessments and Treatments - Continued

```
      Provide Conversation as appropriate      N/A
      Decrease Auditory Stimulation            Yes
   CMS Check
      CMS Restrained Extremity Check WNL       Yes
       Query Text:
       ** The skin surrounding and under
       restraint is warm, dry, and appropriate
       for race. It is intact without evidence
       of friction. No swelling noted. Pulses
       are present. No tingling, numbness or
       change in sensation reported. Mobility
       is unchanged from baseline. **
   Nourishment/Hygiene/Toileting
      Nourishment                              Patient Declined
      Hygiene and Toileting                    Patient Declined
   Injury Assessment
      Restraint: Injury Evaluation             No Injury Noted
Document     09/19/18 07:29  KIR0007  (Rec: 09/19/18 07:29  KIR0007  EDRM-C10)
Restraint:Behav Mgmt Safety Ck
   Restraint
      Type of Restraint                        Soft Wrist Bilateral
                                               Soft Ankle Bilateral
      Restraint Secured Appropriately          Yes
       Query Text:
       ** Ensure that restraint is applied and
       secured in accordance with manufacturer'
       s instructions. Do not secure the
       restraint to the side rails. Ensure that
       the device will not tighten or loosen
       as the bed is raised or lowered. **
   Care and Management
      Call Light Within Reach                  Yes
      Reoriented to Person/Time/Place          N/A
      Provide Conversation as appropriate      N/A
      Decrease Auditory Stimulation            Yes
   CMS Check
      CMS Restrained Extremity Check WNL       Yes
       Query Text:
       ** The skin surrounding and under
       restraint is warm, dry, and appropriate
       for race. It is intact without evidence
       of friction. No swelling noted. Pulses
       are present. No tingling, numbness or
       change in sensation reported. Mobility
       is unchanged from baseline. **
   Nourishment/Hygiene/Toileting
      Nourishment                              Patient Declined
      Hygiene and Toileting                    Patient Declined
   Injury Assessment
      Restraint: Injury Evaluation             No Injury Noted
Document     09/19/18 07:45  KIR0007  (Rec: 09/19/18 07:45  KIR0007  EDRM-C10)
Restraint:Behav Mgmt Safety Ck
   Restraint
```

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BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01

62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Type of Restraint   Soft Wrist Bilateral
Soft Ankle Bilateral

Restraint Secured Appropriately   Yes

Query Text:
** Ensure that restraint is applied and secured in accordance with manufacturer's instructions. Do not secure the restraint to the side rails. Ensure that the device will not tighten or loosen as the bed is raised or lowered. **

Care and Management

Call Light Within Reach   Yes

Reoriented to Person/Time/Place   N/A

Provide Conversation as appropriate   N/A

Decrease Auditory Stimulation   Yes

CMS Check

CMS Restrained Extremity Check WNL   Yes

Query Text:
** The skin surrounding and under restraint is warm, dry, and appropriate for race. It is intact without evidence of friction. No swelling noted. Pulses are present. No tingling, numbness or change in sensation reported. Mobility is unchanged from baseline. **

Nourishment/Hygiene/Toileting

Nourishment   Patient Declined

Hygiene and Toileting   Patient Declined

Injury Assessment

Restraint: Injury Evaluation   No Injury Noted

Document 09/19/18 08:00 NAT0019 (Rec: 09/19/18 08:01 NAT0019 ED-C19)

Restraint:Behav Mgmt Safety Ck

Restraint

Type of Restraint   Soft Wrist Bilateral
Soft Ankle Left

Restraint Secured Appropriately   Yes

Query Text:
** Ensure that restraint is applied and secured in accordance with manufacturer's instructions. Do not secure the restraint to the side rails. Ensure that the device will not tighten or loosen as the bed is raised or lowered. **

Care and Management

Call Light Within Reach   No

Reoriented to Person/Time/Place   Yes: attempted but unsuccessful

Provide Conversation as appropriate   No: pt only intermittently yells and reaches for IV line

Decrease Auditory Stimulation   Yes

CMS Check

CMS Restrained Extremity Check WNL   Yes

Query Text:

Continued on Page 172

** The skin surrounding and under restraint is warm, dry, and appropriate for race. It is intact without evidence of friction. No swelling noted. Pulses are present. No tingling, numbness or change in sensation reported. Mobility is unchanged from baseline. **

Nourishment/Hygiene/Toileting
- Nourishment: unable to provide due to pt status
- Hygiene and Toileting: Patient Declined
- Nourishment/Hygiene/Toileting Comment: pt was straight cathed for urine

Injury Assessment
- Restraint: Injury Evaluation: No Injury Noted

Document 09/19/18 08:14 KIR0007 (Rec: 09/19/18 08:16 KIR0007 EDRM-C10)
Restraint:Behav Mgmt Safety Ck

Restraint
- Type of Restraint: Soft Wrist Bilateral; Soft Ankle Left
- Restraint Secured Appropriately: Yes

Query Text:
** Ensure that restraint is applied and secured in accordance with manufacturer's instructions. Do not secure the restraint to the side rails. Ensure that the device will not tighten or loosen as the bed is raised or lowered. **

Care and Management
- Call Light Within Reach: No
- Reoriented to Person/Time/Place: n/a
- Provide Conversation as appropriate: n/a
- Decrease Auditory Stimulation: No

CMS Check
- CMS Restrained Extremity Check WNL: Yes

Query Text:
** The skin surrounding and under restraint is warm, dry, and appropriate for race. It is intact without evidence of friction. No swelling noted. Pulses are present. No tingling, numbness or change in sensation reported. Mobility is unchanged from baseline. **

Nourishment/Hygiene/Toileting
- Nourishment: Patient Declined
- Hygiene and Toileting: Patient Declined

Injury Assessment
- Restraint: Injury Evaluation: No Injury Noted

Document 09/19/18 08:30 KIR0007 (Rec: 09/19/18 08:30 KIR0007 EDRM-C10)
Restraint:Behav Mgmt Safety Ck

Restraint
- Type of Restraint: Soft Wrist Bilateral; Soft Ankle Left

Continued on Page 173

Assessments and Treatments - Continued

```
       Restraint Secured Appropriately          Yes
        Query Text:
        ** Ensure that restraint is applied and
        secured in accordance with manufacturer'
        s instructions. Do not secure the
        restraint to the side rails. Ensure that
        the device will not tighten or loosen
        as the bed is raised or lowered. **
    Care and Management
       Call Light Within Reach                  No
       Reoriented to Person/Time/Place          n/a
       Provide Conversation as appropriate      n/a
       Decrease Auditory Stimulation            No
    CMS Check
       CMS Restrained Extremity Check WNL       Yes
        Query Text:
        ** The skin surrounding and under
        restraint is warm, dry, and appropriate
        for race. It is intact without evidence
        of friction. No swelling noted. Pulses
        are present. No tingling, numbness or
        change in sensation reported. Mobility
        is unchanged from baseline. **
    Nourishment/Hygiene/Toileting
       Nourishment                              Patient Declined
       Hygiene and Toileting                    Patient Declined
    Injury Assessment
       Restraint: Injury Evaluation             No Injury Noted
Document     09/19/18 08:45  KIR0007  (Rec: 09/19/18 08:47  KIR0007  EDRM-C10)
Restraint:Behav Mgmt Safety Ck
    Restraint
       Type of Restraint                        Soft Wrist Bilateral
                                                Soft Ankle Left
       Restraint Secured Appropriately          Yes
        Query Text:
        ** Ensure that restraint is applied and
        secured in accordance with manufacturer'
        s instructions. Do not secure the
        restraint to the side rails. Ensure that
        the device will not tighten or loosen
        as the bed is raised or lowered. **
    Care and Management
       Call Light Within Reach                  No
       Reoriented to Person/Time/Place          n/a
       Provide Conversation as appropriate      n/a
       Decrease Auditory Stimulation            No
    CMS Check
       CMS Restrained Extremity Check WNL       Yes
        Query Text:
        ** The skin surrounding and under
        restraint is warm, dry, and appropriate
        for race. It is intact without evidence
        of friction. No swelling noted. Pulses
```

Continued on Page 174

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01

62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

```
        are present. No tingling, numbness or
        change in sensation reported. Mobility
        is unchanged from baseline. **
    Nourishment/Hygiene/Toileting
       Nourishment                              Patient Declined
       Hygiene and Toileting                    Patient Declined
    Injury Assessment
       Restraint: Injury Evaluation             No Injury Noted
Document     09/19/18 09:00  KYL0009  (Rec: 09/19/18 09:40  KYL0009  ICU-M27)
Restraint:Behav Mgmt Safety Ck
    Restraint
       Type of Restraint                        Soft Wrist Bilateral
                                                Soft Ankle Bilateral
       Restraint Secured Appropriately          Yes
        Query Text:
        ** Ensure that restraint is applied and
        secured in accordance with manufacturer'
        s instructions. Do not secure the
        restraint to the side rails. Ensure that
        the device will not tighten or loosen
        as the bed is raised or lowered. **
    Care and Management
       Call Light Within Reach                  Yes
       Reoriented to Person/Time/Place          Yes
       Provide Conversation as appropriate      Yes
       Decrease Auditory Stimulation            Yes
    CMS Check
       CMS Restrained Extremity Check WNL       No
        Query Text:
        ** The skin surrounding and under
        restraint is warm, dry, and appropriate
        for race. It is intact without evidence
        of friction. No swelling noted. Pulses
        are present. No tingling, numbness or
        change in sensation reported. Mobility
        is unchanged from baseline. **
       CMS Restrained Extremity Check           Skin: Cool to Touch
    Nourishment/Hygiene/Toileting
       Nourishment                              NPO
       Hygiene and Toileting                    Care Provided
    Injury Assessment
       Restraint: Injury Evaluation             No Injury Noted
Document     09/19/18 09:15  KYL0009  (Rec: 09/19/18 09:45  KYL0009  ICU-M27)
Restraint:Behav Mgmt Safety Ck
    Restraint
       Type of Restraint                        Soft Wrist Bilateral
                                                Soft Ankle Bilateral
       Restraint Secured Appropriately          Yes
        Query Text:
        ** Ensure that restraint is applied and
        secured in accordance with manufacturer'
        s instructions. Do not secure the
        restraint to the side rails. Ensure that
```

Continued on Page 175

the device will not tighten or loosen
as the bed is raised or lowered. **

Care and Management

Call Light Within Reach	Yes
Reoriented to Person/Time/Place	Yes
Provide Conversation as appropriate	Yes
Decrease Auditory Stimulation	Yes

CMS Check

CMS Restrained Extremity Check WNL	No

Query Text:
** The skin surrounding and under restraint is warm, dry, and appropriate for race. It is intact without evidence of friction. No swelling noted. Pulses are present. No tingling, numbness or change in sensation reported. Mobility is unchanged from baseline. **

CMS Restrained Extremity Check	Skin: Cool to Touch

Nourishment/Hygiene/Toileting

Nourishment	NPO
Hygiene and Toileting	Care Provided

Injury Assessment

Restraint: Injury Evaluation	No Injury Noted

Document 09/19/18 09:30 KYL0009 (Rec: 09/19/18 09:45 KYL0009 ICU-M27)

Restraint:Behav Mgmt Safety Ck

Restraint

Type of Restraint	Soft Wrist Bilateral Soft Ankle Bilateral
Restraint Secured Appropriately	Yes

Query Text:
** Ensure that restraint is applied and secured in accordance with manufacturer's instructions. Do not secure the restraint to the side rails. Ensure that the device will not tighten or loosen as the bed is raised or lowered. **

Care and Management

Call Light Within Reach	Yes
Reoriented to Person/Time/Place	Yes
Provide Conversation as appropriate	Yes
Decrease Auditory Stimulation	Yes

CMS Check

CMS Restrained Extremity Check WNL	No

Query Text:
** The skin surrounding and under restraint is warm, dry, and appropriate for race. It is intact without evidence of friction. No swelling noted. Pulses are present. No tingling, numbness or change in sensation reported. Mobility is unchanged from baseline. **

CMS Restrained Extremity Check	Skin: Cool to Touch

Nourishment/Hygiene/Toileting

Continued on Page 176

Assessments and Treatments - Continued

```
      Nourishment                              NPO
      Hygiene and Toileting                    Care Provided
   Injury Assessment
      Restraint: Injury Evaluation             No Injury Noted
Document     09/19/18 09:45  KYL0009  (Rec: 09/19/18 09:45  KYL0009  ICU-M27)
Restraint:Behav Mgmt Safety Ck
   Restraint
      Type of Restraint                        Soft Wrist Bilateral
                                               Soft Ankle Bilateral
      Restraint Secured Appropriately          Yes
       Query Text:
       ** Ensure that restraint is applied and
       secured in accordance with manufacturer'
       s instructions. Do not secure the
       restraint to the side rails. Ensure that
       the device will not tighten or loosen
       as the bed is raised or lowered. **
   Care and Management
      Call Light Within Reach                  Yes
      Reoriented to Person/Time/Place          Yes
      Provide Conversation as appropriate      Yes
      Decrease Auditory Stimulation            Yes
   CMS Check
      CMS Restrained Extremity Check WNL       No
       Query Text:
       ** The skin surrounding and under
       restraint is warm, dry, and appropriate
       for race. It is intact without evidence
       of friction. No swelling noted. Pulses
       are present. No tingling, numbness or
       change in sensation reported. Mobility
       is unchanged from baseline. **
      CMS Restrained Extremity Check           Skin: Cool to Touch
   Nourishment/Hygiene/Toileting
      Nourishment                              NPO
      Hygiene and Toileting                    Care Provided
   Injury Assessment
      Restraint: Injury Evaluation             No Injury Noted
Document     09/19/18 10:00  KYL0009  (Rec: 09/19/18 11:33  KYL0009  ICU-M27)
Restraint:Behav Mgmt Safety Ck
   Restraint
      Type of Restraint                        Soft Wrist Bilateral
                                               Soft Ankle Bilateral
      Restraint Secured Appropriately          Yes
       Query Text:
       ** Ensure that restraint is applied and
       secured in accordance with manufacturer'
       s instructions. Do not secure the
       restraint to the side rails. Ensure that
       the device will not tighten or loosen
       as the bed is raised or lowered. **
   Care and Management
      Call Light Within Reach                  Yes
```

Continued on Page 177

Assessments and Treatments - Continued

Reoriented to Person/Time/Place Yes
Provide Conversation as appropriate Yes
Decrease Auditory Stimulation Yes
CMS Check
CMS Restrained Extremity Check WNL No
Query Text:
** The skin surrounding and under restraint is warm, dry, and appropriate for race. It is intact without evidence of friction. No swelling noted. Pulses are present. No tingling, numbness or change in sensation reported. Mobility is unchanged from baseline. **
CMS Restrained Extremity Check Skin: Cool to Touch
Nourishment/Hygiene/Toileting
Nourishment NPO
Hygiene and Toileting Patient Declined
Injury Assessment
Restraint: Injury Evaluation No Injury Noted

Document 09/19/18 10:15 KYL0009 (Rec: 09/19/18 11:35 KYL0009 ICU-M27)
Restraint:Behav Mgmt Safety Ck
Restraint
Type of Restraint Soft Wrist Bilateral
Soft Ankle Bilateral
Restraint Secured Appropriately Yes
Query Text:
** Ensure that restraint is applied and secured in accordance with manufacturer's instructions. Do not secure the restraint to the side rails. Ensure that the device will not tighten or loosen as the bed is raised or lowered. **
Care and Management
Call Light Within Reach Yes
Reoriented to Person/Time/Place Yes
Provide Conversation as appropriate Yes
Decrease Auditory Stimulation Yes
CMS Check
CMS Restrained Extremity Check WNL No
Query Text:
** The skin surrounding and under restraint is warm, dry, and appropriate for race. It is intact without evidence of friction. No swelling noted. Pulses are present. No tingling, numbness or change in sensation reported. Mobility is unchanged from baseline. **
CMS Restrained Extremity Check Skin: Cool to Touch
Nourishment/Hygiene/Toileting
Nourishment NPO
Hygiene and Toileting Patient Declined
Injury Assessment
Restraint: Injury Evaluation No Injury Noted

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Document 09/19/18 10:30 KYL0009 (Rec: 09/19/18 11:35 KYL0009 ICU-M27)
Restraint:Behav Mgmt Safety Ck
Restraint
Type of Restraint — Soft Wrist Bilateral
Soft Ankle Bilateral
Restraint Secured Appropriately — Yes
Query Text:
** Ensure that restraint is applied and secured in accordance with manufacturer's instructions. Do not secure the restraint to the side rails. Ensure that the device will not tighten or loosen as the bed is raised or lowered. **
Care and Management
Call Light Within Reach — Yes
Reoriented to Person/Time/Place — Yes
Provide Conversation as appropriate — Yes
Decrease Auditory Stimulation — Yes
CMS Check
CMS Restrained Extremity Check WNL — No
Query Text:
** The skin surrounding and under restraint is warm, dry, and appropriate for race. It is intact without evidence of friction. No swelling noted. Pulses are present. No tingling, numbness or change in sensation reported. Mobility is unchanged from baseline. **
CMS Restrained Extremity Check — Skin: Cool to Touch
Nourishment/Hygiene/Toileting
Nourishment — NPO
Hygiene and Toileting — Patient Declined
Injury Assessment
Restraint: Injury Evaluation — No Injury Noted

Document 09/19/18 10:45 KYL0009 (Rec: 09/19/18 11:35 KYL0009 ICU-M27)
Restraint:Behav Mgmt Safety Ck
Restraint
Type of Restraint — Soft Wrist Bilateral
Soft Ankle Bilateral
Restraint Secured Appropriately — Yes
Query Text:
** Ensure that restraint is applied and secured in accordance with manufacturer's instructions. Do not secure the restraint to the side rails. Ensure that the device will not tighten or loosen as the bed is raised or lowered. **
Care and Management
Call Light Within Reach — Yes
Reoriented to Person/Time/Place — Yes
Provide Conversation as appropriate — Yes
Decrease Auditory Stimulation — Yes
CMS Check

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Assessments and Treatments - Continued

CMS Restrained Extremity Check WNL No
Query Text:
** The skin surrounding and under restraint is warm, dry, and appropriate for race. It is intact without evidence of friction. No swelling noted. Pulses are present. No tingling, numbness or change in sensation reported. Mobility is unchanged from baseline. **
CMS Restrained Extremity Check Skin: Cool to Touch
Nourishment/Hygiene/Toileting
Nourishment NPO
Hygiene and Toileting Patient Declined
Injury Assessment
Restraint: Injury Evaluation No Injury Noted

Document 09/19/18 11:00 KYL0009 (Rec: 09/19/18 11:39 KYL0009 ICU-M27)
Restraint:Behav Mgmt Safety Ck
Restraint
Type of Restraint Soft Wrist Bilateral
Restraint Secured Appropriately Yes
Query Text:
** Ensure that restraint is applied and secured in accordance with manufacturer's instructions. Do not secure the restraint to the side rails. Ensure that the device will not tighten or loosen as the bed is raised or lowered. **
Care and Management
Call Light Within Reach Yes
Reoriented to Person/Time/Place Yes
Provide Conversation as appropriate Yes
Decrease Auditory Stimulation Yes
CMS Check
CMS Restrained Extremity Check WNL No
Query Text:
** The skin surrounding and under restraint is warm, dry, and appropriate for race. It is intact without evidence of friction. No swelling noted. Pulses are present. No tingling, numbness or change in sensation reported. Mobility is unchanged from baseline. **
CMS Restrained Extremity Check Skin: Cool to Touch
Nourishment/Hygiene/Toileting
Nourishment NPO
Hygiene and Toileting Patient Declined
Injury Assessment
Restraint: Injury Evaluation No Injury Noted

Document 09/19/18 11:15 KYL0009 (Rec: 09/19/18 11:41 KYL0009 ICU-M27)
Restraint:Behav Mgmt Safety Ck
Restraint
Type of Restraint Soft Wrist Bilateral
Restraint Secured Appropriately Yes

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center   Loc:4 SOUTH - MEDICAL/TELEMETRY   Bed:436-01
62 F 05/01/1956   Med Rec Num:M000597460   Visit:A00088518428

Assessments and Treatments - Continued

Query Text:
** Ensure that restraint is applied and secured in accordance with manufacturer's instructions. Do not secure the restraint to the side rails. Ensure that the device will not tighten or loosen as the bed is raised or lowered. **

Care and Management
  Call Light Within Reach   Yes
  Reoriented to Person/Time/Place   Yes
  Provide Conversation as appropriate   Yes
  Decrease Auditory Stimulation   Yes

CMS Check
  CMS Restrained Extremity Check WNL   No
  Query Text:
  ** The skin surrounding and under restraint is warm, dry, and appropriate for race. It is intact without evidence of friction. No swelling noted. Pulses are present. No tingling, numbness or change in sensation reported. Mobility is unchanged from baseline. **
  CMS Restrained Extremity Check   Skin: Cool to Touch

Nourishment/Hygiene/Toileting
  Nourishment   NPO
  Hygiene and Toileting   Patient Declined

Injury Assessment
  Restraint: Injury Evaluation   No Injury Noted

Document   09/19/18 11:30 KYL0009 (Rec: 09/19/18 11:41 KYL0009 ICU-M27)
Restraint:Behav Mgmt Safety Ck

Restraint
  Type of Restraint   Soft Wrist Bilateral
  Restraint Secured Appropriately   Yes
  Query Text:
  ** Ensure that restraint is applied and secured in accordance with manufacturer's instructions. Do not secure the restraint to the side rails. Ensure that the device will not tighten or loosen as the bed is raised or lowered. **

Care and Management
  Call Light Within Reach   Yes
  Reoriented to Person/Time/Place   Yes
  Provide Conversation as appropriate   Yes
  Decrease Auditory Stimulation   Yes

CMS Check
  CMS Restrained Extremity Check WNL   No
  Query Text:
  ** The skin surrounding and under restraint is warm, dry, and appropriate for race. It is intact without evidence of friction. No swelling noted. Pulses are present. No tingling, numbness or

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Assessments and Treatments - Continued

change in sensation reported. Mobility
is unchanged from baseline. **

CMS Restrained Extremity Check — Skin: Cool to Touch

Nourishment/Hygiene/Toileting
- Nourishment — NPO
- Hygiene and Toileting — Patient Declined

Injury Assessment
- Restraint: Injury Evaluation — No Injury Noted

Document 09/19/18 11:45 KYL0009 (Rec: 09/19/18 11:51 KYL0009 ICU-M27)

Restraint:Behav Mgmt Safety Ck

Restraint
- Type of Restraint — Soft Wrist Bilateral
- Restraint Secured Appropriately — Yes

Query Text:
** Ensure that restraint is applied and
secured in accordance with manufacturer'
s instructions. Do not secure the
restraint to the side rails. Ensure that
the device will not tighten or loosen
as the bed is raised or lowered. **

Care and Management
- Call Light Within Reach — Yes
- Reoriented to Person/Time/Place — Yes
- Provide Conversation as appropriate — Yes
- Decrease Auditory Stimulation — Yes

CMS Check
- CMS Restrained Extremity Check WNL — No

Query Text:
** The skin surrounding and under
restraint is warm, dry, and appropriate
for race. It is intact without evidence
of friction. No swelling noted. Pulses
are present. No tingling, numbness or
change in sensation reported. Mobility
is unchanged from baseline. **

- CMS Restrained Extremity Check — Skin: Cool to Touch

Nourishment/Hygiene/Toileting
- Nourishment — NPO
- Hygiene and Toileting — Patient Declined

Injury Assessment
- Restraint: Injury Evaluation — No Injury Noted

Restraint: Behavior Mgmt > 17 Start: 09/19/18 04:55
Freq: Q1HR Status: Complete
Protocol:

Document 09/19/18 06:12 THO0010 (Rec: 09/19/18 06:15 THO0010 ED-C19)

Restraint: Behavior Management

Restraint Status
- Progress Toward Release — Behaviors Continue/Restraints in Place

Restraint
- Behavior Necessitating Restraint Continuation — Harmful to Self, Harmful to Others

Hourly Documentation

Continued on Page 182

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Level of Consciousness Restless
ROM Performed and at Baseline Yes
Query Text:ROM is performed and no change from baseline is noted.
Restraints Released for Care No: pt combative
Participated in ADL's Dependent for Care
Able to Follow Simple Directive No
Activity/Reposition if Appropriate Repositioned
Health Teaching Provided No: pt unable to comprehend
Query Text:Patient provided education onteachings coping skills and managing aggression.

Document 09/19/18 07:00 NAT0019 (Rec: 09/19/18 08:28 NAT0019 ED-C19)
Restraint: Behavior Management
Restraint Status
Progress Toward Release Behaviors Continue/Restraints in Place
Restraint
Behavior Necessitating Restraint Continuation Harmful to Self
Harmful to Others
Other (See Comment)
Behavior Comment intermittently agitated and reaching for PIV and monitor cables
Hourly Documentation
Level of Consciousness Arousable
Restless
ROM Performed and at Baseline No
Query Text:ROM is performed and no change from baseline is noted.
ROM to Restrained Extremity Uncooperative with ROM
Restraints Released for Care No
Participated in ADL's Dependent for Care
Able to Follow Simple Directive No
Activity/Reposition if Appropriate Repositioned
Health Teaching Provided No: unable to teach at this
Query Text:Patient provided education ontime coping skills and managing aggression.

Document 09/19/18 08:00 NAT0019 (Rec: 09/19/18 08:30 NAT0019 ED-C19)
Restraint: Behavior Management
Restraint Status
Progress Toward Release Behaviors Continue/Restraints in Place
Restraint
Behavior Necessitating Restraint Continuation Harmful to Self
Harmful to Others
Other (See Comment)
Behavior Comment interfering with care by reaching for PIV and monitor cables
Hourly Documentation
Level of Consciousness Arousable
Restless
ROM Performed and at Baseline No

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

```
        Query Text:ROM is performed and no
        change from baseline is noted.
       ROM to Restrained Extremity             Uncooperative with ROM
       Restraints Released for Care            No
       Participated in ADL's                   Dependent for Care
       Able to Follow Simple Directive         No
       Activity/Reposition if Appropriate      Repositioned
       Health Teaching Provided                No: pt unable to comprehend
        Query Text:Patient provided education onteaching at this time
        coping skills and managing aggression.
Document     09/19/18 09:00  KYL0009  (Rec: 09/19/18 09:40  KYL0009  ICU-M27)
Restraint: Behavior Management
    Restraint Status
       Progress Toward Release                 Behaviors Continue/Restraints
                                               in Place
    Restraint Removal Documentation
       CMS Restrained Extremity Check WNL      No
        Query Text:
        ** The skin surrounding and under
        restraint is warm, dry, and appropriate
        for race. It is intact without evidence
        of friction. No swelling noted. Pulses
        are present. No tingling, numbness or
        change in sensation reported. Mobility
        is unchanged from baseline. **
       CMS Restrained Extremity Check          Skin: Cool to Touch
       Restraint: Injury Evaluation            No Injury Noted
    Restraint
       Behavior Necessitating Restraint        Harmful to Others
        Continuation
    Hourly Documentation
       Level of Consciousness                  Arousable
                                               Drowsy
                                               Lethargic
                                               Responds to Pain
                                               Responds to Voice
       ROM Performed and at Baseline           No
        Query Text:ROM is performed and no
        change from baseline is noted.
       ROM to Restrained Extremity             ROM changed from baseline
       ROM Comment                             left arm pain
       Restraints Released for Care            Yes
       Participated in ADL's                   Dependent for Care
       Able to Follow Simple Directive         Yes
       Activity/Reposition if Appropriate      Repositioned
       Health Teaching Provided                Yes
        Query Text:Patient provided education on
        coping skills and managing aggression.
Edit Result  09/19/18 09:00  KYL0009  (Rec: 09/19/18 19:42  KYL0009  ICU-C21)
Restraint: Behavior Management
    Hourly Documentation
       Level of Consciousness                  Arousable
                                               Drowsy
```

Continued on Page 184

```
                                              Lethargic
Document     09/19/18 10:00  KYL0009  (Rec: 09/19/18 11:33  KYL0009  ICU-M27)
Restraint: Behavior Management
    Restraint Status
       Progress Toward Release                Release Criteria Achieved/
                                              Restraints Removed
       Stop Date/Time for Restraints          Removed
    Restraint Removal Documentation
       CMS Restrained Extremity Check WNL     No
        Query Text:
        ** The skin surrounding and under
        restraint is warm, dry, and appropriate
        for race. It is intact without evidence
        of friction. No swelling noted. Pulses
        are present. No tingling, numbness or
        change in sensation reported. Mobility
        is unchanged from baseline. **
       CMS Restrained Extremity Check         Skin: Cool to Touch
       Restraint: Injury Evaluation           No Injury Noted
    Restraint
       Behavior Necessitating Restraint       Harmful to Others
        Continuation
    Hourly Documentation
       Level of Consciousness                 Arousable
                                              Drowsy
                                              Sedated
                                              Lethargic
                                              Responds to Voice
       ROM Performed and at Baseline          No
        Query Text:ROM is performed and no
        change from baseline is noted.
       ROM to Restrained Extremity            ROM changed from baseline
       ROM Comment                            left shoulder pain
       Restraints Released for Care           Yes
       Participated in ADL's                  Participated
       Able to Follow Simple Directive        Yes
       Activity/Reposition if Appropriate     Repositioned
       Health Teaching Provided               Yes
        Query Text:Patient provided education on
        coping skills and managing aggression.
Edit Result  09/19/18 10:00  KYL0009  (Rec: 09/19/18 19:40  KYL0009  ICU-C21)
Restraint: Behavior Management
    Restraint Status
       Progress Toward Release                Behaviors Continue/Restraints
                                              in Place
Edit Result  09/19/18 10:00  KYL0009  (Rec: 09/19/18 19:42  KYL0009  ICU-C21)
Restraint: Behavior Management
    Hourly Documentation
       Level of Consciousness                 Arousable
                                              Drowsy
                                              Responds to Voice
Document     09/19/18 11:00  KYL0009  (Rec: 09/19/18 11:39  KYL0009  ICU-M27)
Restraint: Behavior Management
```

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Assessments and Treatments - Continued

Restraint Status
- Progress Toward Release — Release Criteria Achieved/ Restraints Removed
- Stop Date/Time for Restraints — Removed

Restraint Removal Documentation
- CMS Restrained Extremity Check WNL — No
  - Query Text:
    ** The skin surrounding and under restraint is warm, dry, and appropriate for race. It is intact without evidence of friction. No swelling noted. Pulses are present. No tingling, numbness or change in sensation reported. Mobility is unchanged from baseline. **
- CMS Restrained Extremity Check — Skin: Cool to Touch
- Restraint: Injury Evaluation — No Injury Noted

Restraint
- Behavior Necessitating Restraint Continuation — Harmful to Others

Hourly Documentation
- Level of Consciousness — Arousable, Drowsy, Sedated, Lethargic, Responds to Voice
- ROM Performed and at Baseline — No
  - Query Text:ROM is performed and no change from baseline is noted.
- ROM to Restrained Extremity — ROM changed from baseline
- ROM Comment — left shoulder pain
- Restraints Released for Care — Yes
- Participated in ADL's — Participated
- Able to Follow Simple Directive — Yes
- Activity/Reposition if Appropriate — Repositioned
- Health Teaching Provided — Yes
  - Query Text:Patient provided education on coping skills and managing aggression.

Edit Result 09/19/18 11:00 KYL0009 (Rec: 09/19/18 19:40 KYL0009 ICU-C21)

Restraint: Behavior Management

Restraint Removal Documentation
- Details of Injury and Provider/Nurse Notified — Bilateral soft ankle restraints d/c'd- Dr.Caballe notified

Hourly Documentation
- Level of Consciousness — Arousable, Drowsy, Sedated

Edit Result 09/19/18 11:00 KYL0009 (Rec: 09/19/18 19:42 KYL0009 ICU-C21)

Restraint: Behavior Management

Restraint Removal Documentation
- Details of Injury and Provider/Nurse Notified

Edit Result 09/19/18 11:00 KYL0009 (Rec: 09/19/18 19:45 KYL0009 ICU-C21)

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Restraint: Behavior Management
Restraint Removal Documentation
Details of Injury and Provider/Nurse Notified — Bilateral ankle restraints released- Dr.Caballa notified.

Restraint: Initiation — Start: 09/19/18 04:56
Freq: ONCE — Status: Complete
Protocol:
Document 09/19/18 05:30 THO0010 (Rec: 09/19/18 05:39 THO0010 ED-C19)
Restraint: Initiate
Purpose for Restraint
Purpose for Restraint — Injury Prevention
Injury Prevention
Type of Injury Prevention Restraint — Soft Wrist Bilateral
Soft Ankle Bilateral
Behavior Necessitating Injury Prevention Restraint — Agitated
Assaultive/Combative
Restraint Initiation
Restraint Secured Appropriately — Yes
Query Text:
** Ensure that restraint is applied and secured in accordance with manufacturer's instructions. Do not secure the restraint to the side rails. Ensure that the device will not tighten or loosen as the bed is raised or lowered. **
Time Restraint Initiated — 05:00
Alternatives Attempted
Alternatives Used — Communication
Reorient as needed
Explain Tests/Procedures
Allow to Express Feelings
Active Listening
Reassurance
Notification
Name of Provider Notified/Time — hinkley/05:00
Was Family/Guardian Notified of Plan of Care — No
Patient Discussion
Discussed with Patient that Restraints can be Discontinued When the Behavior that Necessitated the Restraints is No Longer Exhibited. — Yes

Restraint: Initiation — Start: 09/19/18 12:03
Freq: ONCE — Status: Complete
Protocol:
Document 09/19/18 12:03 KYL0009 (Rec: 09/19/18 12:36 KYL0009 ICU-C12)
Restraint: Initiate
Purpose for Restraint
Purpose for Restraint — Injury Prevention
Injury Prevention
Type of Injury Prevention Restraint — Soft Wrist Bilateral
Behavior Necessitating Injury Prevention Restraint — Unreliable/Forgetful

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Assessments and Treatments - Continued

Restraint Initiation
Restraint Secured Appropriately — Yes
Query Text:
** Ensure that restraint is applied and secured in accordance with manufacturer's instructions. Do not secure the restraint to the side rails. Ensure that the device will not tighten or loosen as the bed is raised or lowered. **
Time Restraint Initiated — 12:00
Plan of Care Initiated — Yes
Query Text:*** Restraint Problem Should be Added to Plan of Care. ***

Alternatives Attempted
Alternatives Used — Communication
Reorient as needed
Pain Management
Safety Monitor

Notification
Name of Provider Notified/Time — Dr.Cabelles
Was Family/Guardian Notified of Plan of Care — No: unknown family

Patient Discussion
Discussed with Patient that Restraints can be Discontinued When the Behavior that Necessitated the Restraints is No Longer Exhibited. — Yes

Restraint: Initiation Start: 09/19/18 21:28
Freq: ONCE Status: Complete
Protocol:
Document 09/19/18 22:00 KIM0006 (Rec: 09/19/18 22:09 KIM0006 ICU-M27)
Restraint: Initiate

Purpose for Restraint
Purpose for Restraint — Injury Prevention

Injury Prevention
Type of Injury Prevention Restraint — Soft Wrist Right
Behavior Necessitating Injury Prevention Restraint — Dislodging Medical Device
Agitated
Behavior Comment — pulling on Left arm sling wanting to take off, pulling of leads.

Restraint Initiation
Restraint Secured Appropriately — Yes
Query Text:
** Ensure that restraint is applied and secured in accordance with manufacturer's instructions. Do not secure the restraint to the side rails. Ensure that the device will not tighten or loosen as the bed is raised or lowered. **
Time Restraint Initiated — 22:00
Plan of Care Initiated — Yes
Query Text:*** Restraint Problem Should

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

be Added to Plan of Care. ***

Alternatives Attempted

Alternatives Used	Communication Reorient as needed Diversional Activities Pain Management Explain Tests/Procedures Allow to Express Feelings Active Listening One-to-One Staff

Notification

Name of Provider Notified/Time	Dr. Rooth 2105
Was Family/Guardian Notified of Plan of Care	No

Patient Discussion

Discussed with Patient that Restraints can be Discontinued When the Behavior that Necessitated the Restraints is No Longer Exhibited.	Yes

Restraint: Inj Prev Safety Check Start: 09/19/18 12:03
Freq: Q30MIN Status: Complete
Protocol:
Document 09/19/18 12:00 KYL0009 (Rec: 09/19/18 12:37 KYL0009 ICU-C12)
Restraint:Inj Prev SafetyCheck

Restraint

Type of Restraint	Soft Wrist Bilateral
Restraint Secured Appropriately	Yes

Query Text:
** Ensure that restraint is applied and secured in accordance with manufacturer's instructions. Do not secure the restraint to the side rails. Ensure that the device will not tighten or loosen as the bed is raised or lowered. **

Care and Management

Call Light Within Reach	Yes
Reoriented to Person/Time/Place	Yes
Provide Conversation as Appropriate	Yes
Decrease Auditory Stimulation	Yes

CMS Check

CMS Restrained Extremity Check WNL	No

Query Text:
** The skin surrounding and under restraint is warm, dry, and appropriate for race. It is intact without evidence of friction. No swelling noted. Pulses are present. No tingling, numbness or change in sensation reported. Mobility is unchanged from baseline. **

CMS Restrained Extremity Check	Skin: Cool to Touch

Nourishment/Hygiene/Toileting

Nourishment	NPO
Hygiene and Toileting	Patient Declined

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```
    Injury Assessment
       Restraint: Injury Evaluation             No Injury Noted
Document     09/19/18 13:00  KYL0009  (Rec: 09/19/18 13:28  KYL0009  ICU-C12)
Restraint:Inj Prev SafetyCheck
    Restraint
       Type of Restraint                        Soft Wrist Bilateral
       Restraint Secured Appropriately          Yes
        Query Text:
        ** Ensure that restraint is applied and
        secured in accordance with manufacturer'
        s instructions. Do not secure the
        restraint to the side rails. Ensure that
        the device will not tighten or loosen
        as the bed is raised or lowered. **
    Care and Management
       Call Light Within Reach                  Yes
       Reoriented to Person/Time/Place          Yes
       Provide Conversation as Appropriate      Yes
       Decrease Auditory Stimulation            Yes
    CMS Check
       CMS Restrained Extremity Check WNL       No
        Query Text:
        ** The skin surrounding and under
        restraint is warm, dry, and appropriate
        for race. It is intact without evidence
        of friction. No swelling noted. Pulses
        are present. No tingling, numbness or
        change in sensation reported. Mobility
        is unchanged from baseline. **
       CMS Restrained Extremity Check           Skin: Cool to Touch
    Nourishment/Hygiene/Toileting
       Nourishment                              NPO
       Hygiene and Toileting                    Care Provided
                                                Patient Declined
       Nourishment/Hygiene/Toileting Comment    Bed pan provided per pt
                                                request- patient did not
                                                urinate
    Injury Assessment
       Restraint: Injury Evaluation             No Injury Noted
Document     09/19/18 13:30  KYL0009  (Rec: 09/19/18 15:03  KYL0009  ICU-C12)
Restraint:Inj Prev SafetyCheck
    Restraint
       Type of Restraint                        Soft Wrist Bilateral
       Restraint Secured Appropriately          Yes
        Query Text:
        ** Ensure that restraint is applied and
        secured in accordance with manufacturer'
        s instructions. Do not secure the
        restraint to the side rails. Ensure that
        the device will not tighten or loosen
        as the bed is raised or lowered. **
    Care and Management
       Call Light Within Reach                  Yes
```

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Assessments and Treatments - Continued

```
       Reoriented to Person/Time/Place          Yes
       Provide Conversation as Appropriate      Yes
       Decrease Auditory Stimulation            Yes
    CMS Check
       CMS Restrained Extremity Check WNL       No
        Query Text:
        ** The skin surrounding and under
        restraint is warm, dry, and appropriate
        for race. It is intact without evidence
        of friction. No swelling noted. Pulses
        are present. No tingling, numbness or
        change in sensation reported. Mobility
        is unchanged from baseline. **
       CMS Restrained Extremity Check           Skin: Cool to Touch
    Nourishment/Hygiene/Toileting
       Nourishment                              NPO
       Hygiene and Toileting                    Care Provided
                                                Patient Declined
       Nourishment/Hygiene/Toileting Comment    Bed pan provided per pt
                                                request- patient did not
                                                urinate
    Injury Assessment
       Restraint: Injury Evaluation             No Injury Noted
Document    09/19/18 14:00  KYL0009  (Rec: 09/19/18 15:13  KYL0009  ICU-C12)
Restraint:Inj Prev SafetyCheck
    Restraint
       Type of Restraint                        Soft Wrist Bilateral
                                                Soft Wrist Left
       Restraint Secured Appropriately          No
        Query Text:
        ** Ensure that restraint is applied and
        secured in accordance with manufacturer'
        s instructions. Do not secure the
        restraint to the side rails. Ensure that
        the device will not tighten or loosen
        as the bed is raised or lowered. **
    Care and Management
       Call Light Within Reach                  Yes
       Reoriented to Person/Time/Place          Yes
       Provide Conversation as Appropriate      Yes
       Decrease Auditory Stimulation            Yes
    CMS Check
       CMS Restrained Extremity Check WNL       No
        Query Text:
        ** The skin surrounding and under
        restraint is warm, dry, and appropriate
        for race. It is intact without evidence
        of friction. No swelling noted. Pulses
        are present. No tingling, numbness or
        change in sensation reported. Mobility
        is unchanged from baseline. **
       CMS Restrained Extremity Check           Skin: Cool to Touch
    Nourishment/Hygiene/Toileting
```

Continued on Page 191

```
      Nourishment                              NPO
      Hygiene and Toileting                    Patient Declined
   Injury Assessment
      Restraint: Injury Evaluation             No Injury Noted
Edit Result  09/19/18 14:00  KYL0009  (Rec: 09/19/18 19:47  KYL0009  ICU-C21)
Restraint:Inj Prev SafetyCheck
   Restraint
      Type of Restraint                        Soft Wrist Bilateral
      Restraint Secured Appropriately          Yes
       Query Text:
       ** Ensure that restraint is applied and
       secured in accordance with manufacturer'
       s instructions. Do not secure the
       restraint to the side rails. Ensure that
       the device will not tighten or loosen
       as the bed is raised or lowered. **
Document     09/19/18 14:30  KYL0009  (Rec: 09/19/18 15:13  KYL0009  ICU-C12)
Restraint:Inj Prev SafetyCheck
   Restraint
      Type of Restraint                        Soft Wrist Bilateral
                                               Soft Wrist Left
      Restraint Secured Appropriately          No
       Query Text:
       ** Ensure that restraint is applied and
       secured in accordance with manufacturer'
       s instructions. Do not secure the
       restraint to the side rails. Ensure that
       the device will not tighten or loosen
       as the bed is raised or lowered. **
   Care and Management
      Call Light Within Reach                  Yes
      Reoriented to Person/Time/Place          Yes
      Provide Conversation as Appropriate      Yes
      Decrease Auditory Stimulation            Yes
   CMS Check
      CMS Restrained Extremity Check WNL        No
       Query Text:
       ** The skin surrounding and under
       restraint is warm, dry, and appropriate
       for race. It is intact without evidence
       of friction. No swelling noted. Pulses
       are present. No tingling, numbness or
       change in sensation reported. Mobility
       is unchanged from baseline. **
      CMS Restrained Extremity Check           Skin: Cool to Touch
   Nourishment/Hygiene/Toileting
      Nourishment                              NPO
      Hygiene and Toileting                    Patient Declined
   Injury Assessment
      Restraint: Injury Evaluation             No Injury Noted
Edit Result  09/19/18 14:30  KYL0009  (Rec: 09/19/18 19:47  KYL0009  ICU-C21)
Restraint:Inj Prev SafetyCheck
   Restraint
```

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

```
      Type of Restraint                      Soft Wrist Bilateral
      Restraint Secured Appropriately        Yes
       Query Text:
       ** Ensure that restraint is applied and
       secured in accordance with manufacturer'
       s instructions. Do not secure the
       restraint to the side rails. Ensure that
       the device will not tighten or loosen
       as the bed is raised or lowered. **
Document     09/19/18 15:00  KYL0009  (Rec: 09/19/18 15:55  KYL0009  ICU-C12)
Restraint:Inj Prev SafetyCheck
    Restraint
      Type of Restraint                      Soft Wrist Bilateral
                                             Soft Wrist Left
      Restraint Secured Appropriately        No
       Query Text:
       ** Ensure that restraint is applied and
       secured in accordance with manufacturer'
       s instructions. Do not secure the
       restraint to the side rails. Ensure that
       the device will not tighten or loosen
       as the bed is raised or lowered. **
    Care and Management
      Call Light Within Reach                Yes
      Reoriented to Person/Time/Place        Yes
      Provide Conversation as Appropriate    Yes
      Decrease Auditory Stimulation          Yes
    CMS Check
      CMS Restrained Extremity Check WNL     No
       Query Text:
       ** The skin surrounding and under
       restraint is warm, dry, and appropriate
       for race. It is intact without evidence
       of friction. No swelling noted. Pulses
       are present. No tingling, numbness or
       change in sensation reported. Mobility
       is unchanged from baseline. **
      CMS Restrained Extremity Check         Skin: Cool to Touch
    Nourishment/Hygiene/Toileting
      Nourishment                            NPO
      Hygiene and Toileting                  Patient Declined
    Injury Assessment
      Restraint: Injury Evaluation           No Injury Noted
Edit Result  09/19/18 15:00  KYL0009  (Rec: 09/19/18 19:47  KYL0009  ICU-C21)
Restraint:Inj Prev SafetyCheck
    Restraint
      Type of Restraint                      Soft Wrist Bilateral
      Restraint Secured Appropriately        Yes
       Query Text:
       ** Ensure that restraint is applied and
       secured in accordance with manufacturer'
       s instructions. Do not secure the
       restraint to the side rails. Ensure that
```

Continued on Page 193

```
        the device will not tighten or loosen
        as the bed is raised or lowered. **
Restraint: Inj Prev Safety Check                            Start:  09/19/18 21:28
Freq:   Q30MIN                                              Status: Complete
Protocol:
 Not Done     09/19/18 21:30  KIM0006  (Rec: 09/19/18 22:10  KIM0006  ICU-M27)
    restraints not initaited at this time 2130
 Document     09/19/18 22:00  KIM0006  (Rec: 09/19/18 22:11  KIM0006  ICU-M27)
 Restraint:Inj Prev SafetyCheck
    Restraint
       Type of Restraint                        Soft Wrist Right
       Restraint Secured Appropriately          Yes
        Query Text:
        ** Ensure that restraint is applied and
        secured in accordance with manufacturer'
        s instructions. Do not secure the
        restraint to the side rails. Ensure that
        the device will not tighten or loosen
        as the bed is raised or lowered. **
    Care and Management
       Call Light Within Reach                  Yes
       Reoriented to Person/Time/Place          Yes
       Provide Conversation as Appropriate      Yes
       Decrease Auditory Stimulation            Yes
    CMS Check
       CMS Restrained Extremity Check WNL       Yes
        Query Text:
        ** The skin surrounding and under
        restraint is warm, dry, and appropriate
        for race. It is intact without evidence
        of friction. No swelling noted. Pulses
        are present. No tingling, numbness or
        change in sensation reported. Mobility
        is unchanged from baseline. **
    Nourishment/Hygiene/Toileting
       Nourishment                              Patient Declined
       Hygiene and Toileting                    Patient Declined
    Injury Assessment
       Restraint: Injury Evaluation             No Injury Noted
 Document     09/19/18 22:30  KIM0006  (Rec: 09/19/18 23:14  KIM0006  ICU-C12)
 Restraint:Inj Prev SafetyCheck
    Restraint
       Type of Restraint                        Soft Wrist Right
       Restraint Secured Appropriately          Yes
        Query Text:
        ** Ensure that restraint is applied and
        secured in accordance with manufacturer'
        s instructions. Do not secure the
        restraint to the side rails. Ensure that
        the device will not tighten or loosen
        as the bed is raised or lowered. **
    Care and Management
       Call Light Within Reach                  Yes
```

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BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01

62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

```
        Reoriented to Person/Time/Place          Yes
        Provide Conversation as Appropriate      Yes
        Decrease Auditory Stimulation            Yes
     CMS Check
        CMS Restrained Extremity Check WNL       Yes
         Query Text:
         ** The skin surrounding and under
         restraint is warm, dry, and appropriate
         for race. It is intact without evidence
         of friction. No swelling noted. Pulses
         are present. No tingling, numbness or
         change in sensation reported. Mobility
         is unchanged from baseline. **
     Nourishment/Hygiene/Toileting
        Nourishment                              NPO
        Hygiene and Toileting                    Patient Declined
        Nourishment/Hygiene/Toileting Comment    patient refuses to have
                                                 dysphagia screen done
     Injury Assessment
        Restraint: Injury Evaluation             No Injury Noted
Document     09/19/18 23:00  KIM0006  (Rec: 09/19/18 23:14  KIM0006  ICU-C12)
Restraint:Inj Prev SafetyCheck
     Restraint
        Type of Restraint                        Soft Wrist Right
        Restraint Secured Appropriately          Yes
         Query Text:
         ** Ensure that restraint is applied and
         secured in accordance with manufacturer'
         s instructions. Do not secure the
         restraint to the side rails. Ensure that
         the device will not tighten or loosen
         as the bed is raised or lowered. **
     Care and Management
        Call Light Within Reach                  Yes
        Reoriented to Person/Time/Place          Yes
        Provide Conversation as Appropriate      Yes
        Decrease Auditory Stimulation            Yes
     CMS Check
        CMS Restrained Extremity Check WNL       Yes
         Query Text:
         ** The skin surrounding and under
         restraint is warm, dry, and appropriate
         for race. It is intact without evidence
         of friction. No swelling noted. Pulses
         are present. No tingling, numbness or
         change in sensation reported. Mobility
         is unchanged from baseline. **
     Nourishment/Hygiene/Toileting
        Nourishment                              NPO
        Hygiene and Toileting                    Patient Declined
        Nourishment/Hygiene/Toileting Comment    patient refuses to have
                                                 dysphagia screen done
     Injury Assessment
```

Continued on Page 195

Assessments and Treatments - Continued

```
      Restraint: Injury Evaluation              No Injury Noted
Document     09/19/18 23:30  KIM0006  (Rec: 09/19/18 23:42  KIM0006  ICU-M27)
Restraint:Inj Prev SafetyCheck
    Restraint
      Type of Restraint                         Soft Wrist Right
      Restraint Secured Appropriately           Yes
       Query Text:
       ** Ensure that restraint is applied and
       secured in accordance with manufacturer'
       s instructions. Do not secure the
       restraint to the side rails. Ensure that
       the device will not tighten or loosen
       as the bed is raised or lowered. **
    Care and Management
      Call Light Within Reach                   Yes
      Reoriented to Person/Time/Place           Yes
      Provide Conversation as Appropriate       Yes
      Decrease Auditory Stimulation             Yes
    CMS Check
      CMS Restrained Extremity Check WNL        Yes
       Query Text:
       ** The skin surrounding and under
       restraint is warm, dry, and appropriate
       for race. It is intact without evidence
       of friction. No swelling noted. Pulses
       are present. No tingling, numbness or
       change in sensation reported. Mobility
       is unchanged from baseline. **
    Nourishment/Hygiene/Toileting
      Nourishment                               NPO
      Hygiene and Toileting                     Patient Declined
      Nourishment/Hygiene/Toileting Comment     Starting NS at 75mL/HR
    Injury Assessment
      Restraint: Injury Evaluation              No Injury Noted
Edit Result  09/19/18 23:30  KIM0006  (Rec: 09/20/18 01:32  KIM0006  ICU-C12)
Restraint:Inj Prev SafetyCheck
    Nourishment/Hygiene/Toileting
      Nourishment                               Patient Declined
Document     09/20/18 00:00  KIM0006  (Rec: 09/20/18 01:32  KIM0006  ICU-C12)
Restraint:Inj Prev SafetyCheck
    Restraint
      Type of Restraint                         Soft Wrist Right
      Restraint Secured Appropriately           Yes
       Query Text:
       ** Ensure that restraint is applied and
       secured in accordance with manufacturer'
       s instructions. Do not secure the
       restraint to the side rails. Ensure that
       the device will not tighten or loosen
       as the bed is raised or lowered. **
    Care and Management
      Call Light Within Reach                   Yes
      Reoriented to Person/Time/Place           Yes
```

Continued on Page 196

Assessments and Treatments - Continued

```
        Provide Conversation as Appropriate      Yes
        Decrease Auditory Stimulation            Yes
     CMS Check
        CMS Restrained Extremity Check WNL       Yes
         Query Text:
         ** The skin surrounding and under
         restraint is warm, dry, and appropriate
         for race. It is intact without evidence
         of friction. No swelling noted. Pulses
         are present. No tingling, numbness or
         change in sensation reported. Mobility
         is unchanged from baseline. **
     Nourishment/Hygiene/Toileting
        Nourishment                              Accepted
        Hygiene and Toileting                    Patient Declined
        Nourishment/Hygiene/Toileting Comment    passed bedside dysphagia
                                                 screen
     Injury Assessment
        Restraint: Injury Evaluation             No Injury Noted
 Document     09/20/18 00:30  KIM0006  (Rec: 09/20/18 01:32  KIM0006  ICU-C12)
 Restraint:Inj Prev SafetyCheck
     Restraint
        Type of Restraint                        Soft Wrist Right
        Restraint Secured Appropriately          Yes
         Query Text:
         ** Ensure that restraint is applied and
         secured in accordance with manufacturer'
         s instructions. Do not secure the
         restraint to the side rails. Ensure that
         the device will not tighten or loosen
         as the bed is raised or lowered. **
     Care and Management
        Call Light Within Reach                  Yes
        Reoriented to Person/Time/Place          Yes
        Provide Conversation as Appropriate      Yes
        Decrease Auditory Stimulation            Yes
     CMS Check
        CMS Restrained Extremity Check WNL       Yes
         Query Text:
         ** The skin surrounding and under
         restraint is warm, dry, and appropriate
         for race. It is intact without evidence
         of friction. No swelling noted. Pulses
         are present. No tingling, numbness or
         change in sensation reported. Mobility
         is unchanged from baseline. **
     Nourishment/Hygiene/Toileting
        Nourishment                              Patient Declined
        Hygiene and Toileting                    Patient Declined
     Injury Assessment
        Restraint: Injury Evaluation             No Injury Noted
 Document     09/20/18 01:00  KIM0006  (Rec: 09/20/18 01:32  KIM0006  ICU-C12)
 Restraint:Inj Prev SafetyCheck
```

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Restraint
Type of Restraint Soft Wrist Right
Restraint Secured Appropriately Yes
Query Text:
** Ensure that restraint is applied and secured in accordance with manufacturer's instructions. Do not secure the restraint to the side rails. Ensure that the device will not tighten or loosen as the bed is raised or lowered. **
Care and Management
Call Light Within Reach Yes
Reoriented to Person/Time/Place Yes
Provide Conversation as Appropriate Yes
Decrease Auditory Stimulation Yes
CMS Check
CMS Restrained Extremity Check WNL Yes
Query Text:
** The skin surrounding and under restraint is warm, dry, and appropriate for race. It is intact without evidence of friction. No swelling noted. Pulses are present. No tingling, numbness or change in sensation reported. Mobility is unchanged from baseline. **
Nourishment/Hygiene/Toileting
Nourishment Accepted
Hygiene and Toileting Patient Declined
Injury Assessment
Restraint: Injury Evaluation No Injury Noted

Document 09/20/18 01:30 KIM0006 (Rec: 09/20/18 01:33 KIM0006 ICU-C12)
Restraint:Inj Prev SafetyCheck
Restraint
Type of Restraint Soft Wrist Right
Restraint Secured Appropriately Yes
Query Text:
** Ensure that restraint is applied and secured in accordance with manufacturer's instructions. Do not secure the restraint to the side rails. Ensure that the device will not tighten or loosen as the bed is raised or lowered. **
Care and Management
Call Light Within Reach Yes
Reoriented to Person/Time/Place Yes
Provide Conversation as Appropriate Yes
Decrease Auditory Stimulation Yes
CMS Check
CMS Restrained Extremity Check WNL Yes
Query Text:
** The skin surrounding and under restraint is warm, dry, and appropriate for race. It is intact without evidence

Continued on Page 198

of friction. No swelling noted. Pulses
are present. No tingling, numbness or
change in sensation reported. Mobility
is unchanged from baseline. **

Nourishment/Hygiene/Toileting
Nourishment Accepted
Hygiene and Toileting Patient Declined
Injury Assessment
Restraint: Injury Evaluation No Injury Noted

Document 09/20/18 01:54 KIM0006 (Rec: 09/20/18 01:55 KIM0006 ICU-C12)
Restraint:Inj Prev SafetyCheck
Restraint
Type of Restraint Soft Wrist Right
Restraint Secured Appropriately Yes
Query Text:
** Ensure that restraint is applied and
secured in accordance with manufacturer'
s instructions. Do not secure the
restraint to the side rails. Ensure that
the device will not tighten or loosen
as the bed is raised or lowered. **

Care and Management
Call Light Within Reach Yes
Reoriented to Person/Time/Place Yes
Provide Conversation as Appropriate Yes
Decrease Auditory Stimulation Yes
CMS Check
CMS Restrained Extremity Check WNL Yes
Query Text:
** The skin surrounding and under
restraint is warm, dry, and appropriate
for race. It is intact without evidence
of friction. No swelling noted. Pulses
are present. No tingling, numbness or
change in sensation reported. Mobility
is unchanged from baseline. **

Nourishment/Hygiene/Toileting
Nourishment Accepted
Hygiene and Toileting Patient Declined
Injury Assessment
Restraint: Injury Evaluation No Injury Noted

Not Done 09/20/18 02:30 KIM0006 (Rec: 09/20/18 04:25 KIM0006 ICU-C12)
Restraint off at 0210
Not Done 09/20/18 03:00 KIM0006 (Rec: 09/20/18 04:25 KIM0006 ICU-C12)
Restraint off at 0210
Not Done 09/20/18 03:30 KIM0006 (Rec: 09/20/18 04:25 KIM0006 ICU-C12)
Restraint off at 0210
Not Done 09/20/18 04:00 KIM0006 (Rec: 09/20/18 04:25 KIM0006 ICU-C12)
Restraint off at 0210
Not Done 09/20/18 04:30 KIM0006 (Rec: 09/20/18 04:43 KIM0006 ICU-C12)
restrait off at 0210
Not Done 09/20/18 05:00 KIM0006 (Rec: 09/20/18 04:57 KIM0006 ICU-C12)
restraint off

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Assessments and Treatments - Continued

Not Done 09/20/18 05:30 KIM0006 (Rec: 09/20/18 05:13 KIM0006 ICU-M35)
restraint off
Not Done 09/20/18 06:00 KIM0006 (Rec: 09/20/18 05:39 KIM0006 ICU-M35)
restraint off at 0210
Not Done 09/20/18 06:30 KIM0006 (Rec: 09/20/18 05:39 KIM0006 ICU-M35)
restraint off at 0210
Not Done 09/20/18 07:00 JOA0063 (Rec: 09/20/18 10:46 JOA0063 ICU-C25)
RESTRAINTS OFF, NOT NEEDED
Not Done 09/20/18 07:30 JOA0063 (Rec: 09/20/18 10:46 JOA0063 ICU-C25)
RESTRAINTS OFF, NOT NEEDED
Not Done 09/20/18 08:00 JOA0063 (Rec: 09/20/18 10:46 JOA0063 ICU-C25)
RESTRAINTS OFF, NOT NEEDED
Not Done 09/20/18 08:30 JOA0063 (Rec: 09/20/18 10:46 JOA0063 ICU-C25)
RESTRAINTS OFF, NOT NEEDED
Not Done 09/20/18 09:00 JOA0063 (Rec: 09/20/18 10:46 JOA0063 ICU-C25)
RESTRAINTS OFF, NOT NEEDED
Not Done 09/20/18 09:30 JOA0063 (Rec: 09/20/18 10:46 JOA0063 ICU-C25)
RESTRAINTS OFF, NOT NEEDED
Not Done 09/20/18 10:00 JOA0063 (Rec: 09/20/18 10:46 JOA0063 ICU-C25)
RESTRAINTS OFF, NOT NEEDED
Not Done 09/20/18 10:30 JOA0063 (Rec: 09/20/18 10:46 JOA0063 ICU-C25)
RESTRAINTS OFF, NOT NEEDED
Not Done 09/20/18 11:00 JOA0063 (Rec: 09/20/18 10:46 JOA0063 ICU-C25)
RESTRAINTS OFF, NOT NEEDED

Restraint: Injury Prevention Start: 09/19/18 12:02
Freq: Q2HR Status: Complete
Protocol:

Document 09/19/18 14:00 KYL0009 (Rec: 09/19/18 15:13 KYL0009 ICU-C12)
Restraint: Injury Prevention
Restraint Status
Progress Toward Release — Behaviors Continue/Restraints in Place
Restraint Removal Documentation
CMS Restrained Extremity Check WNL — No
Query Text:
** The skin surrounding and under restraint is warm, dry, and appropriate for race. It is intact without evidence of friction. No swelling noted. Pulses are present. No tingling, numbness or change in sensation reported. Mobility is unchanged from baseline. **
CMS Restrained Extremity Check — Skin: Cool to Touch
Restraint: Injury Evaluation — No Injury Noted
Restraint
Behavior Necessitating Restraint Continuation — Unreliable/Forgetful
2 Hour Documentation
Level of Consciousness — Arousable
Drowsy
Lethargic
ROM Performed and at Baseline — No
Query Text:ROM is performed and no

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Assessments and Treatments - Continued

```
        change from baseline is noted.
       ROM to Restrained Extremity            Uncooperative with ROM
       ROM Comment                            left shoulder pain
       Restraints Released for Care           Yes
       Participated in ADL's                  Participated
       Activity/Reposition if appropriate     Repositioned
       Health Teaching Provided               Yes
        Query Text:Patient provided education on
        coping skills and managing aggression.
Edit Result  09/19/18 14:00  KYL0009  (Rec: 09/19/18 19:49  KYL0009  ICU-C21)
Restraint: Injury Prevention
    2 Hour Documentation
       ROM to Restrained Extremity            ROM changed from baseline
Document     09/19/18 15:30  KYL0009  (Rec: 09/19/18 15:59  KYL0009  ICU-C12)
Restraint: Injury Prevention
    Restraint Status
       Progress Toward Release                Release Criteria Achieved/
                                              Restraints Removed
       Stop Date/Time for Restraints          Removed
    Restraint Removal Documentation
       CMS Restrained Extremity Check WNL     No
        Query Text:
        ** The skin surrounding and under
        restraint is warm, dry, and appropriate
        for race. It is intact without evidence
        of friction. No swelling noted. Pulses
        are present. No tingling, numbness or
        change in sensation reported. Mobility
        is unchanged from baseline. **
       CMS Restrained Extremity Check         Skin: Cool to Touch
       Restraint: Injury Evaluation           No Injury Noted
    2 Hour Documentation
       Level of Consciousness                 Appropriate
       ROM Performed and at Baseline          No
        Query Text:ROM is performed and no
        change from baseline is noted.
       ROM to Restrained Extremity            Uncooperative with ROM
       ROM Comment                            left shoulder pain
       Restraints Released for Care           Yes
       Participated in ADL's                  Participated
       Activity/Reposition if appropriate     Repositioned
       Health Teaching Provided               Yes
        Query Text:Patient provided education on
        coping skills and managing aggression.
Edit Result  09/19/18 15:30  KYL0009  (Rec: 09/19/18 19:49  KYL0009  ICU-C21)
Restraint: Injury Prevention
    2 Hour Documentation
       ROM to Restrained Extremity            ROM changed from baseline
Restraint: Injury Prevention                            Start:  09/19/18 21:11
Freq:   Q2HR                                            Status: Complete
Protocol:
Not Done     09/19/18 22:00  KIM0006  (Rec: 09/19/18 22:12  KIM0006  ICU-M27)
    Restraint applied to right wrist at 2200
```

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Document 09/20/18 00:00 KIM0006 (Rec: 09/20/18 01:37 KIM0006 ICU-C12)
Restraint: Injury Prevention
Restraint Status
Progress Toward Release — Behaviors Continue/Restraints in Place
Restraint
Behavior Necessitating Restraint Continuation — Dislodging Medical Device; Agitated
2 Hour Documentation
Level of Consciousness — Awake; Responds to Voice; Other (see Comment)
Comment — Pt appropriate at times but continues to pull at medical devices
ROM Performed and at Baseline — No
Query Text:ROM is performed and no change from baseline is noted.
ROM to Restrained Extremity — Uncooperative with ROM
Restraints Released for Care — Yes
Participated in ADL's — Declined
Activity/Reposition if appropriate — Repositioned
Health Teaching Provided — Yes
Query Text:Patient provided education on coping skills and managing aggression.

Document 09/20/18 01:54 KIM0006 (Rec: 09/20/18 01:55 KIM0006 ICU-C12)
Restraint: Injury Prevention
Restraint Status
Progress Toward Release — Behaviors Continue/Restraints in Place
Restraint
Behavior Necessitating Restraint Continuation — Dislodging Medical Device; Agitated
2 Hour Documentation
Level of Consciousness — Awake; Responds to Voice; Other (see Comment)
Comment — Pt appropriate at times but continues to pull at medical devices
ROM Performed and at Baseline — No
Query Text:ROM is performed and no change from baseline is noted.
ROM to Restrained Extremity — Uncooperative with ROM
Restraints Released for Care — Yes
Participated in ADL's — Declined
Activity/Reposition if appropriate — Repositioned
Health Teaching Provided — Yes
Query Text:Patient provided education on coping skills and managing aggression.

Document 09/20/18 02:10 KIM0006 (Rec: 09/20/18 04:42 KIM0006 ICU-C12)
Restraint: Injury Prevention
Restraint Status

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Progress Toward Release	Release Criteria Achieved/ Restraints Removed
Stop Date/Time for Restraints	Removed
Restraint Removal Documentation	
CMS Restrained Extremity Check WNL	Yes
Query Text: ** The skin surrounding and under restraint is warm, dry, and appropriate for race. It is intact without evidence of friction. No swelling noted. Pulses are present. No tingling, numbness or change in sensation reported. Mobility is unchanged from baseline. **	
Restraint: Injury Evaluation	No Injury Noted
2 Hour Documentation	
Level of Consciousness	Awake Alert Other (see Comment)
Comment	pt agrees to be cooperative with care and not pull on medical equipment

Not Done 09/20/18 06:00 KIM0006 (Rec: 09/20/18 05:39 KIM0006 ICU-M35)
restraints off at 0210

SS 01: Phase I/Phase II Flowsheet Start: 09/19/18 20:14
Freq: Status: Discharge
Protocol:
Document 09/19/18 20:19 SON0056 (Rec: 09/19/18 20:27 SON0056 PACRM-C14)

SS: Post-Anesthesia Initial Information

Received With	
Received From	OR
Anesthesiologist Report Received From (if applicable)	Robelo,Benjamin
Allergies Verified	Yes

SS: Post-Anesthesia Care Record

Vital Signs

Only document vital signs here if NOT captured through vital signs monitor interface or manually documented on a vital signs assessment already.

Temperature	98.1 F
Temperature Source	Temporal Artery Scan
Pulse Rate	91
Blood Pressure (mmHg)	150/98
Respiratory Rate	16
O2 Sat by Pulse Oximetry	95
Patient on Room Air	Yes
Respiration Method	Spontaneous Respirations
Oxygen Devices in Use Now	None
Vital Signs Comment	REP. REC'D. PT DROWSY BUT TALKING. REFUSED MONITOR. L SHOULDER W/SLING INTACT. IV CATH W/O REDNESS, SWELLING OR EXUDATE. PT DENIES PAIN IN HIS SHOULDER. STATES HIS NOSE HURTS.

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Assessments and Treatments - Continued

```
      Currently Having Pain                    No
    White Scoring System
      Activity on Command                      2 = Able to Move All
                                               Extremities on Command
      Respiration                              2 = Able to Breathe Deeply
      Circulation - Systolic Blood Pressure    2 = Within 20% of Pre-Op Level
      Consciousness                            1 = Arousable with Minimal
                                               Stimulation
      Oxygen Saturation                        2 = SpO2 > 90% on Room Air
      Post-Operative Pain Assessment           2 = None or Mild Discomfort
      Post-Operative Emetic Symptoms           2 = None or Mild Nausea with
                                               No Active Vomiting
      White Total Score                        13
       Query Text:Score > 11 = Transition to
       Phase II
    Phase I/Phase II Assessment
      Phase I/Phase II Assessment              Safety Measures Met
SS: Intake and Output
    Surgical Phase
      Surgical Phase                           Phase I
    Intake, IV Drips
     LR
      IV Intake Total Amount                   300
SS: Medications
SS: Mixtures
Document     09/19/18 20:25  SON0056  (Rec: 09/19/18 20:30  SON0056  PACRM-C14)
SS: Post-Anesthesia Initial Information
    Received With
      Received From                            OR
      Anesthesiologist Report Received From (  Robelo,Benjamin
       if applicable)
      Allergies Verified                       Yes
SS: Post-Anesthesia Care Record
    Vital Signs
     Only document vital signs here if NOT captured through vital signs monitor
     interface or manually documented on a vital signs assessment already.
      Patient on Room Air                      Yes
      Respiration Method                       Spontaneous Respirations
      Oxygen Devices in Use Now                None
      Currently Having Pain                    No
    White Scoring System
      Activity on Command                      2 = Able to Move All
                                               Extremities on Command
      Respiration                              2 = Able to Breathe Deeply
      Circulation - Systolic Blood Pressure    2 = Within 20% of Pre-Op Level
      Consciousness                            2 = Awake and Oriented
      Oxygen Saturation                        2 = SpO2 > 90% on Room Air
      Post-Operative Pain Assessment           2 = None or Mild Discomfort
      Post-Operative Emetic Symptoms           2 = None or Mild Nausea with
                                               No Active Vomiting
      White Total Score                        14
       Query Text:Score > 11 = Transition to
       Phase II
```

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

```
SS: Medications
SS: Mixtures
Edit Result  09/19/18 20:25  SON0056  (Rec: 09/19/18 20:30  SON0056  PACRM-C14)
SS: Post-Anesthesia Care Record
    Phase I/Phase II Assessment
       Phase I/Phase II Assessment             Safety Measures Met
Document     09/19/18 20:30  SON0056  (Rec: 09/19/18 20:30  SON0056  PACRM-C14)
SS: Post-Anesthesia Initial Information
    Received With
       Received From                           OR
       Anesthesiologist Report Received From (  Robelo,Benjamin
        if applicable)
       Allergies Verified                      Yes
SS: Post-Anesthesia Care Record
    Vital Signs
     Only document vital signs here if NOT captured through vital signs monitor
     interface or manually documented on a vital signs assessment already.
       Patient on Room Air                     Yes
       Respiration Method                      Spontaneous Respirations
       Oxygen Devices in Use Now               None
       Vital Signs Comment                     ICE CHIPS PROVIDED.
       Currently Having Pain                   No
    White Scoring System
       Activity on Command                     2 = Able to Move All
                                               Extremities on Command
       Respiration                             2 = Able to Breathe Deeply
       Circulation - Systolic Blood Pressure   2 = Within 20% of Pre-Op Level
       Consciousness                           2 = Awake and Oriented
       Oxygen Saturation                       2 = SpO2 > 90% on Room Air
       Post-Operative Pain Assessment          2 = None or Mild Discomfort
       Post-Operative Emetic Symptoms          2 = None or Mild Nausea with
                                               No Active Vomiting
       White Total Score                       14
        Query Text:Score > 11 = Transition to
        Phase II
    Phase I/Phase II Assessment
       Phase I/Phase II Assessment             Safety Measures Met
SS: Medications
SS: Mixtures
Edit Result  09/19/18 20:30  SON0056  (Rec: 09/19/18 20:51  SON0056  PACRM-C14)
SS: Intake and Output
    Surgical Phase
       Surgical Phase                          Phase I
Document     09/19/18 20:35  SON0056  (Rec: 09/19/18 20:51  SON0056  PACRM-C14)
SS: Post-Anesthesia Initial Information
    Received With
       Received From                           OR
       Anesthesiologist Report Received From (  Robelo,Benjamin
        if applicable)
       Allergies Verified                      Yes
SS: Post-Anesthesia Care Record
    Vital Signs
     Only document vital signs here if NOT captured through vital signs monitor
```

Continued on Page 205

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

interface or manually documented on a vital signs assessment already.

Patient on Room Air	Yes
Respiration Method	Spontaneous Respirations
Oxygen Devices in Use Now	None
Vital Signs Comment	PT TOLERATING ICE CHIPS. PT IS TALKING ABOUT ELECTRIC SHOCK THERAPY WHEN ASKED ASSESSMENT QUESTIONS. DOES NOT ANSWER ASSESSMENT QUESTIONS. ICU NOTIFIED PT IS ALERT, VSS.
Currently Having Pain	No

White Scoring System

Activity on Command	2 = Able to Move All Extremities on Command
Respiration	2 = Able to Breathe Deeply
Circulation - Systolic Blood Pressure	2 = Within 20% of Pre-Op Level
Consciousness	2 = Awake and Oriented
Oxygen Saturation	2 = SpO2 > 90% on Room Air
Post-Operative Pain Assessment	2 = None or Mild Discomfort
Post-Operative Emetic Symptoms	2 = None or Mild Nausea with No Active Vomiting
White Total Score	14

Query Text:Score > 11 = Transition to Phase II

Phase I/Phase II Assessment

Phase I/Phase II Assessment	Safety Measures Met Tolerating PO

SS: Intake and Output

Surgical Phase

Surgical Phase	Phase I

SS: Medications

SS: Mixtures

Document 09/19/18 20:45 SON0056 (Rec: 09/19/18 20:51 SON0056 PACRM-C14)

SS: Post-Anesthesia Initial Information

Received With

Received From	OR
Anesthesiologist Report Received From (if applicable)	Robelo,Benjamin
Allergies Verified	Yes

SS: Post-Anesthesia Care Record

Vital Signs

Only document vital signs here if NOT captured through vital signs monitor interface or manually documented on a vital signs assessment already.

Vital Signs Comment	DR. BLAKE AT BEDSIDE. PT TRANSFERRED VIA MONITORED BED TO ICU ON RA
Currently Having Pain	No

White Scoring System

Activity on Command	2 = Able to Move All Extremities on Command
Respiration	2 = Able to Breathe Deeply
Circulation - Systolic Blood Pressure	2 = Within 20% of Pre-Op Level

Continued on Page 206

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01

62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Consciousness 2 = Awake and Oriented
Oxygen Saturation 2 = SpO2 > 90% on Room Air
Post-Operative Pain Assessment 2 = None or Mild Discomfort
Post-Operative Emetic Symptoms 2 = None or Mild Nausea with No Active Vomiting
White Total Score 14
Query Text:Score > 11 = Transition to Phase II
Phase I/Phase II Assessment
Phase I/Phase II Assessment Safety Measures Met
Tolerating PO
SS: Intake and Output
Surgical Phase
Surgical Phase Phase I
SS: Medications
SS: Mixtures
Edit Result 09/19/18 20:45 SON0056 (Rec: 09/19/18 20:52 SON0056 PACRM-C14)
SS: Post-Anesthesia Care Record
Vital Signs
Only document vital signs here if NOT captured through vital signs monitor interface or manually documented on a vital signs assessment already.
Vital Signs Comment UNABLE TO OBTAIN ACCURATE B/P'S. PT IS MOVING HER RIGHT ARM NON-STOP. DR. BLAKE AT BEDSIDE. PT TRANSFERRED VIA MONITORED BED TO ICU ON RA

Self-Referred Testing Start: 09/19/18 08:47
Freq: ONCE Status: Complete
Protocol:
Document 09/19/18 08:47 KYL0009 (Rec: 09/19/18 09:44 KYL0009 ICU-M27)
Self-Referred Testing
Consent
Is Patient Able to Consent for Self Referred Testing No
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 Testing Consent Comments patient drowsy/lethargic UTA at this time
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 09/19/18
Does Patient Consent to Hepatitis C Testing N/A - Already Offered This Visit or Prior Visit
Query Text:A "Hepatitis C - Ab Self

Continued on Page 207

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

```
          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
Sequential Compression Device                               Start:  09/19/18 08:57
Freq:   QSHIFT                                              Status: Discharge
Protocol:
 Not Done     09/19/18 20:00  KIM0006  (Rec: 09/19/18 22:45  KIM0006  ICU-C12)
     2045 patient refusing
 Not Done     09/20/18 08:00  JOA0063  (Rec: 09/20/18 10:06  JOA0063  ICU-C25)
     Declined by Patient
 Not Done     09/20/18 20:00  JER0049  (Rec: 09/20/18 23:45  JER0049  TELE-C07)
     Declined by Patient
 Document     09/21/18 08:00  CON0001  (Rec: 09/21/18 08:08  CON0001  TELE-M11)
 Not Done     09/21/18 20:00  MEG0025  (Rec: 09/21/18 23:33  MEG0025  TELE-C09)
     Pt refused
 Document     09/22/18 08:00  MEG0025  (Rec: 09/22/18 10:28  MEG0025  TELE-C13)
 Document     09/22/18 20:00  SOP0051  (Rec: 09/22/18 20:09  SOP0051  TELE-C11)
 Document     09/23/18 08:00  STA0017  (Rec: 09/23/18 10:33  STA0017  TELE-C03)
 Document     09/23/18 19:07  RAY0005  (Rec: 09/23/18 19:07  RAY0005  TELE-C11)
 Not Done     09/24/18 08:00  MAC0003  (Rec: 09/24/18 08:05  MAC0003  TELE-M12)
     Declined by Patient
Shift Inpt 01: Neurological                                 Start:  09/20/18 18:05
Freq:   DAILY@0800,2000                                     Status: Discharge
Protocol:
 Document     09/20/18 20:00  JER0049  (Rec: 09/20/18 22:03  JER0049  TELE-C07)
 Shift Inpt 01: Neurological
     Neurological Assessment
        Neurological Assessment within Normal     No
         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 Orientation                       Confused
         Query Text:For pediatric patients A&O x
         4 as appropriate for age.
 Richmond Agitation Sedation Scale (RASS)
     Sedation / Agitation
     Protocol:  RASS
        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
```

Continued on Page 208

(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 09/21/18 08:00 CON0001 (Rec: 09/21/18 08:12 CON0001 TELE-M11)

Shift Inpt 01: Neurological

Neurological Assessment

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.	No
Level of Consciousness	Awake Alert
Patient Orientation Query Text:For pediatric patients A&O x 4 as appropriate for age.	Person Place Confused
Patient Behavior	Anxious
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

Richmond Agitation Sedation Scale (RASS)

Sedation / Agitation

Protocol: RASS

Respiratory Rate	18
Agitation/Sedation Score	(0) Alert/Calm

Continued on Page 209

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 09/21/18 19:30 MEG0025 (Rec: 09/21/18 23:33 MEG0025 TELE-C09)

Shift Inpt 01: 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 — Inappropriate

Speech/Swallowing Assessment

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

Richmond Agitation Sedation Scale (RASS)

Sedation / Agitation

Protocol: RASS

Respiratory Rate — 12

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

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

Agitation/RASS Intervention — No Intervention Required

Document 09/22/18 08:00 MEG0025 (Rec: 09/22/18 10:28 MEG0025 TELE-C13)

Shift Inpt 01: 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 — Inappropriate

Speech/Swallowing Assessment

Speech Pattern — Clear

Any Evidence of Chewing or Swallowing Difficulties — No

Richmond Agitation Sedation Scale (RASS)

Sedation / Agitation

Continued on Page 211

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Protocol: RASS

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 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 09/22/18 20:00 SOP0051 (Rec: 09/22/18 20:15 SOP0051 TELE-C11)

Shift Inpt 01: 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 Inappropriate
Other

Patient Behavior Comment pt uncooperative with care

Speech/Swallowing Assessment

Speech Pattern Clear

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Any Evidence of Chewing or Swallowing Difficulties — No

Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation
Protocol: RASS
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 09/23/18 08:00 STA0017 (Rec: 09/23/18 10:33 STA0017 TELE-C03)

Shift Inpt 01: 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

Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation

Continued on Page 213

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Protocol: RASS

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

Agitation/RASS Intervention No Intervention Required

Document 09/23/18 19:08 RAY0005 (Rec: 09/23/18 19:16 RAY0005 TELE-C11)

Shift Inpt 01: 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 Other

Patient Behavior Comment Uncooperative, declines most care

Is Patient Dizzy No

Pupils Equal and Appropriate for Yes

Continued on Page 214

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01

62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Lighting

Speech/Swallowing Assessment

Speech Pattern	Clear
Any Evidence of Chewing or Swallowing Difficulties	No

Richmond Agitation Sedation Scale (RASS)

Sedation / Agitation

Protocol: RASS

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

Agitation/RASS Intervention	No Intervention Required

Not Done 09/24/18 08:00 MAC0003 (Rec: 09/24/18 08:05 MAC0003 TELE-M12)

Declined by Patient

Shift Inpt 02: Cardiovascular Start: 09/20/18 18:05

Freq: DAILY@0800,2000 Status: Discharge

Protocol:

Document 09/20/18 20:00 JER0049 (Rec: 09/20/18 23:35 JER0049 TELE-C07)

Shift Inpt 02: 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

Continued on Page 215

```
        pressure is within patient baseline.
    Cardiovascular Assessment Findings
       Heart Sounds/Apical Pulse                Fast
    Edema Assessment
       Edema Present                            No
    Pulse Assessment
      Bilateral Dorsal Pedal
       Pulse                                    Present
       Pulse Strength                           2+ Normal
Document     09/21/18 08:00  CON0001  (Rec: 09/21/18 08:12  CON0001  TELE-M11)
Shift Inpt 02: 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 patient baseline.
    Cardiovascular Assessment Findings
       Heart Sounds/Apical Pulse                S1
                                                S2
                                                Regular
                                                Fast
       Skin Perfusion                           Skin Color Reflects Adequate
                                                Perfusion
       Skin Turgor                              Tight
       Capillary Refill                         Less than 3 Seconds
       Chest/Cardiac Pain                       No
    Edema Assessment
       Edema Present                            No
    Pulse Assessment
      Bilateral Dorsal Pedal
       Pulse                                    Present
                                                Via Palpation
       Pulse Strength                           2+ Normal
DVT Assessment
    DVT Assessment
      DVT / VTE Prophylaxis Application (QM)    None
      Reason DVT / VTE Prophylaxis Not Applied  Refusal of Treatment by
       (QM)                                     Patient
      Anti-Coagulation Medication               No
      Early Ambulation                          Yes
      Calf Assessment                           Benign
Document     09/21/18 19:30  MEG0025  (Rec: 09/21/18 23:33  MEG0025  TELE-C09)
Shift Inpt 02: Cardiovascular
    Cardiovascular Assessment
      Cardiovascular Assessment Within Normal   Yes
       Limits
       Query Text:Patient reports no chest pain
       . Skin color is appropriate for race,
```

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Assessments and Treatments - Continued

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 patient baseline.

Cardiovascular Assessment Findings

Heart Sounds/Apical Pulse	S1 S2
Heart Sounds/Apical Pulse Comment	90's
Skin Perfusion	Skin Color Reflects Adequate Perfusion
Chest/Cardiac Pain	No
Edema Assessment	
Edema Present	Yes
Edema Details	
Left Shoulder	
Edema Type	Non-Pitting
Edema Degree	1+/Trace
Pulse Assessment	
Bilateral Dorsal Pedal	
Pulse	Present Via Palpation
Pulse Strength	2+ Normal

DVT Assessment

DVT Assessment

DVT / VTE Prophylaxis Application (QM)	SCD
Reason DVT / VTE Prophylaxis Not Applied (QM)	Refusal of Treatment by Patient
Anti-Coagulation Medication	No
Early Ambulation	Patient Declined
Calf Assessment	Benign

Document 09/22/18 08:00 MEG0025 (Rec: 09/22/18 10:28 MEG0025 TELE-C13)

Shift Inpt 02: 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 patient baseline.

Cardiovascular Assessment Findings

Heart Sounds/Apical Pulse	S1 S2
Heart Sounds/Apical Pulse Comment	90's
Skin Perfusion	Skin Color Reflects Adequate Perfusion
Chest/Cardiac Pain	No
Edema Assessment	
Edema Present	Yes
Edema Details	

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```
      Left Shoulder
       Edema Type                                 Non-Pitting
       Edema Degree                               1+/Trace
    Pulse Assessment
      Bilateral Dorsal Pedal
       Pulse                                      Present
                                                  Via Palpation
       Pulse Strength                             2+ Normal
DVT Assessment
    DVT Assessment
      DVT / VTE Prophylaxis Application (QM)      SCD
      Reason DVT / VTE Prophylaxis Not Applied    Refusal of Treatment by
       (QM)                                       Patient
      Anti-Coagulation Medication                 No
      Early Ambulation                            Patient Declined
      Calf Assessment                             Benign
Document     09/22/18 20:00  SOP0051  (Rec: 09/22/18 20:15  SOP0051  TELE-C11)
Shift Inpt 02: 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 patient baseline.
    Cardiovascular Assessment Findings
      Heart Sounds/Apical Pulse                   S1
                                                  S2
                                                  Regular
      Skin Perfusion                              Skin Color Reflects Adequate
                                                  Perfusion
      Chest/Cardiac Pain                          No
    Edema Assessment
      Edema Present                               Yes
    Edema Details
      Left Shoulder
       Edema Type                                 Non-Pitting
       Edema Degree                               1+/Trace
DVT Assessment
    DVT Assessment
      DVT / VTE Prophylaxis Application (QM)      SCD
      Reason DVT / VTE Prophylaxis Not Applied    Refusal of Treatment by
       (QM)                                       Patient
      Anti-Coagulation Medication                 No
      Early Ambulation                            Patient Declined
      Calf Assessment                             Benign
Document     09/23/18 08:00  STA0017  (Rec: 09/23/18 10:33  STA0017  TELE-C03)
Shift Inpt 02: Cardiovascular
    Cardiovascular Assessment
      Cardiovascular Assessment Within Normal     Yes
```

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

```
       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 patient baseline.
    Cardiovascular Assessment Findings
      Heart Sounds/Apical Pulse                 S1
                                                S2
      Skin Perfusion                            Skin Color Reflects Adequate
                                                Perfusion
      Skin Turgor                               Elastic
      Capillary Refill                          Less than 3 Seconds
      Chest/Cardiac Pain                        No
    Edema Assessment
      Edema Present                             Yes
    Edema Details
      Left Shoulder
       Edema Type                               Non-Pitting
       Edema Degree                             3+/Moderate
    Pulse Assessment
      Bilateral Dorsal Pedal
       Pulse                                    Present
                                                Via Palpation
       Pulse Strength                           2+ Normal
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                          Patient Declined
      Calf Assessment                           Benign
Document     09/23/18 19:08  RAY0005  (Rec: 09/23/18 19:16  RAY0005  TELE-C11)
Shift Inpt 02: 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 patient baseline.
    Cardiovascular Assessment Findings
      Heart Sounds/Apical Pulse                 S1
                                                S2
                                                Regular
      Skin Perfusion                            Skin Color Reflects Adequate
                                                Perfusion
```

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BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01

62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

```
      Chest/Cardiac Pain                        No
    Edema Assessment
      Edema Present                             Yes
    Edema Details
      Left Shoulder
        Edema Type                              Non-Pitting
        Edema Degree                            3+/Moderate
DVT Assessment
    DVT Assessment
      DVT / VTE Prophylaxis Application (QM)    SCD
      Reason DVT / VTE Prophylaxis Not Applied  Refusal of Treatment by
        (QM)                                    Patient
      Anti-Coagulation Medication               No
      Early Ambulation                          Patient Declined
Not Done     09/24/18 08:00  MAC0003  (Rec: 09/24/18 08:05  MAC0003  TELE-M12)
    Declined by Patient
```

```
Shift Inpt 03: Respiratory                          Start:  09/20/18 18:05
Freq:   DAILY@0800,2000                             Status: Discharge
Protocol:
Document     09/20/18 20:00  JER0049  (Rec: 09/20/18 23:36  JER0049  TELE-C07)
Shift Inpt 03: Respiratory
    Respiratory Assessment
      Respiratory Assessment Within Normal      Yes
        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.
    Auscultation Assessment
      Bilateral
        Breath Sounds                           Clear
Document     09/21/18 08:00  CON0001  (Rec: 09/21/18 08:12  CON0001  TELE-M11)
Shift Inpt 03: Respiratory
    Respiratory Assessment
        Respiratory Assessment Within Normal    Yes
         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.
    Auscultation Assessment
      Bilateral
        Breath Sounds                           Clear
    Effort/Cough/Sputum
      Respiratory Effort                        Normal
```

Continued on Page 220

Assessments and Treatments - Continued

Respiratory Pattern Regular
Cough None
Sputum Amount (Reported or Observed) None
Oxygen in Use No

Document 09/21/18 19:30 MEG0025 (Rec: 09/21/18 23:33 MEG0025 TELE-C09)
Shift Inpt 03: 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
Effort/Cough/Sputum
Respiratory Effort Normal
Respiratory Pattern Regular
Cough None
Oxygen in Use No

Document 09/22/18 08:00 MEG0025 (Rec: 09/22/18 10:28 MEG0025 TELE-C13)
Shift Inpt 03: 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
Effort/Cough/Sputum
Respiratory Effort Normal
Respiratory Pattern Regular
Cough None
Oxygen in Use No
Oxygen Assessment
Oxygen Devices in Use Now None

Document 09/22/18 20:00 SOP0051 (Rec: 09/22/18 20:15 SOP0051 TELE-C11)
Shift Inpt 03: Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits Yes

Continued on Page 221

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

Effort/Cough/Sputum
- Respiratory Effort: Normal
- Respiratory Pattern: Regular
- Cough: None
- Oxygen in Use: No

Document 09/23/18 08:00 STA0017 (Rec: 09/23/18 10:33 STA0017 TELE-C03)

Shift Inpt 03: Respiratory

Respiratory Assessment
- Respiratory Assessment Within Normal Limits: No

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 Comment: unable to assess...pt declined moving to listen to lungs

Effort/Cough/Sputum
- Respiratory Effort: Normal
- Cough: None

Document 09/23/18 19:08 RAY0005 (Rec: 09/23/18 19:16 RAY0005 TELE-C11)

Shift Inpt 03: 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

Effort/Cough/Sputum

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Assessments and Treatments - Continued

Respiratory Effort Normal
Cough None
Oxygen in Use No
Not Done 09/24/18 08:00 MAC0003 (Rec: 09/24/18 08:05 MAC0003 TELE-M12)
Declined by Patient

Shift Inpt 04: GI/GU Start: 09/20/18 18:05
Freq: DAILY@0800,2000 Status: Discharge
Protocol:
Document 09/20/18 20:00 JER0049 (Rec: 09/20/18 23:46 JER0049 TELE-C07)
Date of Last Bowel Movement
Date of Last Bowel Movement
Date of Last Bowel Movement 9/20/18
Shift Inpt 04: 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.
Bowel Sounds
All Quadrants
Bowel Sound Active
Shift Inpt 04: 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 09/21/18 08:00 CON0001 (Rec: 09/21/18 08:12 CON0001 TELE-M11)
Date of Last Bowel Movement
Date of Last Bowel Movement
Date of Last Bowel Movement 9/20/18
Shift Inpt 04: 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.
Abdomen Description Benign
Soft
Abdominal Tenderness Non-Tender
Gastrointestinal Symptoms No Symptoms
Bowel Sounds
All Quadrants
Bowel Sound Active

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BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

```
Shift Inpt 04: GU
    GU Assessment
      Genitourinary Assessment Within Normal    Yes
       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.
      Voiding                                   Continent
      Urinary Symptoms                          None
      Toileting Methods                         Toilet
      Urinary Diversions/Devices                None
      Urine Concentration                       Not Observed
      Urine Color                               Not Observed
      Urine Character                           Not Observed
Document     09/21/18 19:30  MEG0025  (Rec: 09/21/18 23:33  MEG0025  TELE-C09)
Date of Last Bowel Movement
    Date of Last Bowel Movement
      Date of Last Bowel Movement               9/21/18
Shift Inpt 04: 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.
      Abdomen Description                       Benign
                                                Soft
      Abdominal Tenderness                      Non-Tender
    Bowel Sounds
      All Quadrants
       Bowel Sound                              Active
Shift Inpt 04: GU
    GU Assessment
      Genitourinary Assessment Within Normal    Yes
       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.
      Voiding                                   Continent
      Toileting Methods                         Toilet
      Urine Concentration                       Not Observed
      Urine Color                               Not Observed
      Urine Character                           Not Observed
Document     09/22/18 08:00  MEG0025  (Rec: 09/22/18 10:28  MEG0025  TELE-C13)
Date of Last Bowel Movement
    Date of Last Bowel Movement
      Date of Last Bowel Movement               9/21/18
```

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BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Shift Inpt 04: 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.
      Abdomen Description — Benign, Soft
      Abdominal Tenderness — Non-Tender
    Bowel Sounds
      All Quadrants
        Bowel Sound — Active

Shift Inpt 04: 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
      Toileting Methods — Toilet
      Urinary Diversions/Devices — None
      Urine Concentration — Medium
      Urine Color — Yellow
      Urine Character — Clear

Document 09/22/18 20:00 SOP0051 (Rec: 09/22/18 20:15 SOP0051 TELE-C11)

Date of Last Bowel Movement
    Date of Last Bowel Movement
      Date of Last Bowel Movement — 9/21/18

Shift Inpt 04: 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.
      Abdomen Description — Benign, Soft
      Abdominal Tenderness — Non-Tender
    Bowel Sounds
      All Quadrants
        Bowel Sound — Active

Shift Inpt 04: GU
    GU Assessment
      Genitourinary Assessment Within Normal Limits — Yes

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Assessments and Treatments - Continued
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.
Toileting Methods Toilet
Urinary Diversions/Devices None
Urine Concentration Not Observed
Urine Color Not Observed
Urine Character Not Observed
Document 09/23/18 08:00 STA0017 (Rec: 09/23/18 10:33 STA0017 TELE-C03)
Date of Last Bowel Movement
Date of Last Bowel Movement
Date of Last Bowel Movement 9/21/18
Shift Inpt 04: 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.
Abdomen Description Benign
Abdominal Tenderness Non-Tender
Gastrointestinal Symptoms No Symptoms
Bowel Sounds
All Quadrants
Bowel Sound Active
Shift Inpt 04: 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
Urine Concentration Not Observed
Urine Color Not Observed
Document 09/23/18 19:08 RAY0005 (Rec: 09/23/18 19:16 RAY0005 TELE-C11)
Date of Last Bowel Movement
Date of Last Bowel Movement
Date of Last Bowel Movement 9/21/18
Shift Inpt 04: 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 226

vomiting.
Abdomen Description — Benign
Soft
Non-Distended
Abdominal Tenderness — Non-Tender
Gastrointestinal Symptoms — No Symptoms
Bowel Sounds
All Quadrants
Bowel Sound — Active
Shift Inpt 04: 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
Toileting Methods — Toilet
Urinary Diversions/Devices — None
Urine Concentration — Not Observed
Urine Color — Not Observed
Urine Character — Not Observed
Not Done 09/24/18 08:00 MAC0003 (Rec: 09/24/18 08:05 MAC0003 TELE-M12)
Declined by Patient

Shift Inpt 05: Skin — Start: 09/20/18 18:05
Freq: DAILY@0800,2000 — Status: Discharge
Protocol: C.SKINBRAD
Document 09/20/18 20:00 JER0049 (Rec: 09/20/18 23:45 JER0049 TELE-C07)
Braden Risk and Strategies
Braden Scale
Protocol: C.BRADGRID
Sensory Perception - Skin Risk Assessment Scale — Slightly Limited
Moisture -Skin Risk Assessment Scale — Rarely Moist
Activity - Skin Risk Assessment Scale — Walks Occasionally
Mobility - Skin Risk Assessment Scale — Slightly Limited
Nutrition - Skin Risk Assessment Scale — Adequate
Friction & Shear - Skin Risk Assessment Scale — Potential Problem
Total Score - Skin Risk Assessment (points) — 18
Query Text:** Score and Skin Risk Level **
19-23 = No Risk
15-18 = Mild Risk
13-14 = Moderate Risk
10-12 = High Risk
9 or Less= Very High Risk
Skin Risk Level-Calculated — Mild Risk
Skin Risk Level
Protocol: C.SKINBRA

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Skin Risk Level-Determined by RN — Mild Risk
Query Text:** DO NOT assign a level lower than the calculated Skin Risk level. **
This question can be updated based on nursing judgement. If different than calculated skin risk, include reason in comment below (required).

Skin Provider Communication
Provider Notification for Skin Breakdown
Is There New or Worsening Pressure-Related Skin Breakdown — No

Document 09/21/18 08:00 CON0001 (Rec: 09/21/18 08:12 CON0001 TELE-M11)

Braden Risk and Strategies
Braden Scale
Protocol: C.BRADGRID
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 — Slightly Limited
Nutrition - Skin Risk Assessment Scale — Adequate
Friction & Shear - Skin Risk Assessment Scale — No Apparent Problem
Total Score - Skin Risk Assessment (points) — 21
Query Text:** Score and Skin Risk Level **
19-23 = No Risk
15-18 = Mild Risk
13-14 = Moderate Risk
10-12 = High Risk
9 or Less= Very High Risk
Skin Risk Level-Calculated — No Risk

Skin Risk Level
Protocol: C.SKINBRA
Skin Risk Level-Determined by RN — No Risk
Query Text:** DO NOT assign a level lower than the calculated Skin Risk level. **
This question can be updated based on nursing judgement. If different than calculated skin risk, include reason in comment below (required).

Assessment/Reassessment: +Skin
Skin Color
Skin Color — Skin Color Appropriate for Race
Skin Condition
Skin Condition — Skin Intact Except
Skin Deviation
bilateral inner eye
Skin Deviations — Bruise

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Dressing Status	None
Drainage Amount	None
left flank	
Skin Deviations	Bruise
Dressing Status	None
Drainage Amount	None
Nose	
Skin Deviations	Bruise
Dressing Status	None
Drainage Amount	None
Forehead	
Skin Deviations	Bruise
Dressing Status	None
Drainage Amount	None
left hip	
Skin Deviations	Bruise
Dressing Status	None
Drainage Amount	None
Left Leg	
Skin Deviations	Bruise
Dressing Status	None
Drainage Amount	None
Hand	
Skin Deviations	Bruise
Dressing Status	None
Drainage Amount	None
Skin Provider Communication	
Provider Notification for Skin Breakdown	
Is There New or Worsening Pressure-Related Skin Breakdown	No

Document 09/21/18 19:30 MEG0025 (Rec: 09/21/18 23:33 MEG0025 TELE-C09)

Braden Risk and Strategies

Braden Scale	
Protocol: C.BRADGRID	
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:** Score and Skin Risk Level **
19-23 = No Risk
15-18 = Mild Risk
13-14 = Moderate Risk
10-12 = High Risk
9 or Less= Very High Risk

Skin Risk Level-Calculated	No Risk
Skin Risk Level	

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Assessments and Treatments - Continued

Protocol: C.SKINBRA

Skin Risk Level-Determined by RN	No Risk
Query Text:** DO NOT assign a level lower than the calculated Skin Risk level. ** This question can be updated based on nursing judgement. If different than calculated skin risk, include reason in comment below (required).	

Assessment/Reassessment: +Skin

Skin Color	
Skin Color	Skin Color Appropriate for Race
Skin Condition	
Skin Condition	Skin Intact Except
Skin Deviation	
bilateral inner eye	
Skin Deviations	Bruise
Dressing Status	None
left flank	
Skin Deviations	Bruise
Nose	
Skin Deviations	Abrasion Bruise
Dressing Status	None
Forehead	
Skin Deviations	Abrasion
Dressing Status	None
left hip	
Skin Deviations	Abrasion
Dressing Status	None
Left Leg	
Skin Deviations	Abrasion Bruise
Dressing Status	None
Hand	
Skin Deviations	Abrasion Bruise

Skin Provider Communication

Provider Notification for Skin Breakdown	
Is There New or Worsening Pressure-Related Skin Breakdown	No

Document 09/22/18 08:00 MEG0025 (Rec: 09/22/18 10:28 MEG0025 TELE-C13)

Braden Risk and Strategies

Braden Scale

Protocol: C.BRADGRID

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	Slightly Limited
Nutrition - Skin Risk Assessment Scale	Adequate
Friction & Shear - Skin Risk Assessment	No Apparent Problem

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Scale	
Total Score - Skin Risk Assessment (points)	20
Query Text:** Score and Skin Risk Level ** 19-23 = No Risk 15-18 = Mild Risk 13-14 = Moderate Risk 10-12 = High Risk 9 or Less= Very High Risk	
Skin Risk Level-Calculated	No Risk
Skin Risk Level	
Protocol: C.SKINBRA	
Skin Risk Level-Determined by RN	No Risk
Query Text:** DO NOT assign a level lower than the calculated Skin Risk level. ** This question can be updated based on nursing judgement. If different than calculated skin risk, include reason in comment below (required).	
Assessment/Reassessment: +Skin	
Skin Color	
Skin Color	Skin Color Appropriate for Race
Skin Condition	
Skin Condition	Skin Intact Except
Skin Deviation	
bilateral inner eye	
Skin Deviations	Bruise
left flank	
Skin Deviations	Abrasion Bruise
Dressing Status	None
Nose	
Skin Deviations	Abrasion Bruise
Dressing Status	None
Forehead	
Skin Deviations	Abrasion Bruise
Dressing Status	None
left hip	
Skin Deviations	Abrasion Bruise
Dressing Status	None
Left Leg	
Skin Deviations	Abrasion
Dressing Status	None
Hand	
Skin Deviations	Abrasion
Skin Provider Communication	
Provider Notification for Skin Breakdown	

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BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Is There New or Worsening Pressure-Related Skin Breakdown	No

Document 09/22/18 20:00 SOP0051 (Rec: 09/22/18 20:15 SOP0051 TELE-C11)

Braden Risk and Strategies

Braden Scale

Protocol: C.BRADGRID

Sensory Perception - Skin Risk Assessment Scale	Slightly Limited
Moisture -Skin Risk Assessment Scale	Rarely Moist
Activity - Skin Risk Assessment Scale	Walks Occasionally
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)	19

Query Text:** Score and Skin Risk Level **
19-23 = No Risk
15-18 = Mild Risk
13-14 = Moderate Risk
10-12 = High Risk
9 or Less= Very High Risk

Skin Risk Level-Calculated	No Risk

Skin Risk Level

Protocol: C.SKINBRA

Skin Risk Level-Determined by RN	No Risk

Query Text:** DO NOT assign a level lower than the calculated Skin Risk level. **
This question can be updated based on nursing judgement. If different than calculated skin risk, include reason in comment below (required).

Assessment/Reassessment: +Skin

Skin Color

Skin Color	Skin Color Appropriate for Race

Skin Condition

Skin Condition	Skin Intact Except

Skin Deviation

bilateral inner eye

Skin Deviations	Bruise

left flank

Skin Deviations	Bruise

Nose

Skin Deviations	Bruise Other
Skin Deviation Description	FX Left nasal bone

Query Text:Do not describe pressure ulcers here.

Forehead

Skin Deviations	Bruise

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

```
                                              Wound
      left hip
       Skin Deviations                        Bruise
      Left Leg
       Skin Deviations                        Abrasion
                                              Bruise
      Hand
       Skin Deviations                        Abrasion
                                              Bruise
Skin Provider Communication
    Provider Notification for Skin Breakdown
      Is There New or Worsening Pressure-     No
       Related Skin Breakdown
Document     09/23/18 08:00  STA0017  (Rec: 09/23/18 10:33  STA0017  TELE-C03)
Braden Risk and Strategies
    Braden Scale
    Protocol:  C.BRADGRID
      Sensory Perception - Skin Risk          No Impairment
       Assessment Scale
      Moisture -Skin Risk Assessment Scale    Occasionally Moist
      Activity - Skin Risk Assessment Scale   Walks Occasionally
      Mobility - Skin Risk Assessment Scale   Slightly Limited
      Nutrition - Skin Risk Assessment Scale  Adequate
      Friction & Shear - Skin Risk Assessment No Apparent Problem
       Scale
      Total Score - Skin Risk Assessment (    19
       points)
       Query Text:** Score and Skin Risk Level
       **
       19-23 = No Risk
       15-18 = Mild Risk
       13-14 = Moderate Risk
       10-12 = High Risk
       9 or Less= Very High Risk
      Skin Risk Level-Calculated              No Risk
    Skin Risk Level
    Protocol:  C.SKINBRA
      Skin Risk Level-Determined by RN        No Risk
       Query Text:**  DO NOT assign a level
       lower than the calculated Skin Risk
       level.  **
       This question can be updated based on
       nursing judgement.  If different than
       calculated skin risk, include reason in
       comment below (required).
Assessment/Reassessment: +Skin
    Skin Color
      Skin Color                              Skin Color Appropriate for
                                              Race
    Skin Condition
      Skin Condition                          Skin Intact
    Skin Deviation
      bilateral inner eye
```

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BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01

62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Skin Deviations	Bruise
Dressing Status	None
left flank	
Skin Deviations	Abrasion Bruise
Dressing Status	None
Nose	
Skin Deviations	Abrasion
Dressing Status	None
Drainage Odor	None/Absent
Forehead	
Skin Deviations	Abrasion
Dressing Status	None
left hip	
Skin Deviations	Bruise
Dressing Status	None
Left Leg	
Skin Deviations	Bruise
Dressing Status	None
Drainage Odor	None/Absent
Is Skin Deviation a Pressure Ulcer	No
Skin Deviation Comment	Lots of bruising over left side of body from injuries sustained with law enforcement . No open wounds.
Hand	
Dressing Status	None
Skin Provider Communication	
Provider Notification for Skin Breakdown	
Is There New or Worsening Pressure-Related Skin Breakdown	No

Document 09/23/18 19:08 RAY0005 (Rec: 09/23/18 19:16 RAY0005 TELE-C11)

Braden Risk and Strategies	
Braden Scale	
Protocol: C.BRADGRID	
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	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:** Score and Skin Risk Level ** 19-23 = No Risk 15-18 = Mild Risk 13-14 = Moderate Risk 10-12 = High Risk 9 or Less= Very High Risk	
Skin Risk Level-Calculated	No Risk

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BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01

62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Skin Risk Level
Protocol: C.SKINBRA
Skin Risk Level-Determined by RN — No Risk
Query Text:** DO NOT assign a level lower than the calculated Skin Risk level. **
This question can be updated based on nursing judgement. If different than calculated skin risk, include reason in comment below (required).

Assessment/Reassessment: +Skin
Skin Color
Skin Color — Skin Color Appropriate for Race
Skin Condition
Skin Condition — Skin Intact Except
Skin Deviation
bilateral inner eye
Skin Deviations — Bruise
left flank
Skin Deviations — Bruise
Nose
Skin Deviations — Bruise
Skin Deviation Description — Nasal fracture
Query Text:Do not describe pressure ulcers here.
Forehead
Skin Deviations — Abrasion, Bruise
left hip
Skin Deviations — Bruise
Left Leg
Skin Deviation Description — Unable to assess
Query Text:Do not describe pressure ulcers here.
Hand
Skin Deviations — Abrasion, Bruise

Skin Provider Communication
Provider Notification for Skin Breakdown
Is There New or Worsening Pressure-Related Skin Breakdown — No

Not Done 09/24/18 08:00 MAC0003 (Rec: 09/24/18 08:05 MAC0003 TELE-M12)
Declined by Patient

Shift Inpt 06: Musculoskeletal/Safety — Start: 09/20/18 18:05
Freq: DAILY@0800,2000 — Status: Discharge
Protocol: C.FALLINT

Document 09/20/18 20:00 JER0049 (Rec: 09/21/18 03:04 JER0049 TELE-C09)
Isolation and MRSA Assessment
MRSA Assessment Status
Protocol: C.MRSACHAR
MRSA Assessment — No Update Needed
Query Text:

Continued on Page 235

-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
Protocol: C.ISOLCHA2

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
Protocol: C.FALLINT

Mental Status	Forgets/Disregards Limitations ,Impulsive or Altered Mentation
Patient Is Willing and Able to Assist in Fall Prevention Query Text:Ask patient: Can you, will you, and are you able to ring for assistance?	No
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	Weak
Score	105
CVA/TIA or Stroke in past 24 hours Query Text:** If CVA/TIA or Stroke related diagnosis in past 24 hours, patient should be considered High Risk for falls. ** ** If right hemisphere injury, consider using alarm. **	No
Fall Risk - Calculated	Alarm
Fall Risk - Determined by RN 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	Alarm

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comments below (required).
Assessment/Reassessment: +Safety
Risk for Entrapment
Is Patient at Risk For Entrapment in Bed Rails — None
Query Text:Two or more items place patient at risk for entrapment and will trigger entrapment intervention to your worklist.
Shift Inpt: Musculoskeletal
Musculoskeletal Assessment
Musculoskeletal Assessment Within Normal Limits — Yes
Query Text:Moves all extremities well with full range of motion and strength normal for patient. Gait steady. Patient denies numbness, tingling, weakness, or change in sensation of extremities.
Document 09/21/18 08:00 CON0001 (Rec: 09/21/18 08:12 CON0001 TELE-M11)
Isolation and MRSA Assessment
MRSA Assessment Status
Protocol: C.MRSACHAR
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
Protocol: C.ISOLCHA2
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
Protocol: C.FALLINT
Mental Status — Forgets/Disregards Limitations ,Impulsive or Altered Mentation
Patient Is Willing and Able to Assist in Fall Prevention — No
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 237

```
       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                                      90
      CVA/TIA or Stroke in past 24 hours         No
       Query Text:** If CVA/TIA or Stroke
       related diagnosis in past 24 hours,
       patient should be considered High Risk
       for falls. **
       ** If right hemisphere injury, consider
       using alarm. **
      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).
    Safety Interventions
      Alarm Limits Set/Checked                   Yes
      Side Rails Up                              2 Rails
      Call Bell Within Reach                     Yes
      Method of Monitoring                       Bed Alarm
Assessment/Reassessment: +Safety
    Additional Precautions
      Additional Precautions                     None
    Risk for Entrapment
      Is Patient at Risk For Entrapment in Bed   None
       Rails
       Query Text:Two or more items place
       patient at risk for entrapment and will
       trigger entrapment intervention to your
       worklist.
Shift Inpt: Musculoskeletal
    Musculoskeletal Assessment
      Musculoskeletal Assessment Within Normal   Yes
       Limits
       Query Text:Moves all extremities well
       with full range of motion and strength
       normal for patient. Gait steady. Patient
       denies numbness, tingling, weakness, or
       change in sensation of extremities.
Document     09/21/18 19:30  MEG0025  (Rec: 09/21/18 23:33  MEG0025  TELE-C09)
Isolation and MRSA Assessment
    MRSA Assessment Status
    Protocol:  C.MRSACHAR
```

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Assessments and Treatments - Continued

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	
Protocol: C.ISOLCHA2	
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	
Protocol: C.FALLINT	
Mental Status	Forgets/Disregards Limitations ,Impulsive or Altered Mentation
Patient Is Willing and Able to Assist in Fall Prevention	No
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	90
CVA/TIA or Stroke in past 24 hours	No
Query Text:** If CVA/TIA or Stroke related diagnosis in past 24 hours, patient should be considered High Risk for falls. ** ** If right hemisphere injury, consider using alarm. **	
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	

Continued on Page 239

nursing judgement. If different than calculated fall risk, include reason in comments below (required).

Safety Interventions

Alarm Limits Set/Checked	Yes
Side Rails Up	2 Rails
Call Bell Within Reach	Yes
Method of Monitoring	Bed Alarm

Assessment/Reassessment: +Safety

Additional Precautions

Additional Precautions	None

Risk for Entrapment

Is Patient at Risk For Entrapment in Bed Rails	None

Query Text:Two or more items place patient at risk for entrapment and will trigger entrapment intervention to your worklist.

Shift Inpt: Musculoskeletal

Musculoskeletal Assessment

Musculoskeletal Assessment Within Normal Limits	No

Query Text:Moves all extremities well with full range of motion and strength normal for patient. Gait steady. Patient denies numbness, tingling, weakness, or change in sensation of extremities.

Musculoskeletal

Left Upper Extremity

Extremity Musculoskeletal Condition	Limited Range of Motion
Condition Status	New in Past 1-2 Days

Document 09/22/18 08:00 MEG0025 (Rec: 09/22/18 10:28 MEG0025 TELE-C13)

Isolation and MRSA Assessment

MRSA Assessment Status

Protocol: C.MRSACHAR

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

Protocol: C.ISOLCHA2

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

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

History of Falls During Hospital Visit	No
Safety/Fall Risk Assessment	
Safety/Fall Risk Assessment	
Protocol: C.FALLINT	
Mental Status	Forgets/Disregards Limitations ,Impulsive or Altered Mentation
Patient Is Willing and Able to Assist in Fall Prevention Query Text:Ask patient: Can you, will you, and are you able to ring for assistance?	No
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	95
CVA/TIA or Stroke in past 24 hours Query Text:** If CVA/TIA or Stroke related diagnosis in past 24 hours, patient should be considered High Risk for falls. ** ** If right hemisphere injury, consider using alarm. **	No
Fall Risk - Calculated	Alarm
Fall Risk - Determined by RN 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).	Alarm
Safety Interventions	
Alarm Limits Set/Checked	Yes
Side Rails Up	2 Rails
Call Bell Within Reach	Yes
Method of Monitoring	Bed Alarm
Assessment/Reassessment: +Safety	
Additional Precautions	
Additional Precautions	None
Risk for Entrapment	
Is Patient at Risk For Entrapment in Bed Rails Query Text:Two or more items place patient at risk for entrapment and will trigger entrapment intervention to your worklist.	None

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Assessments and Treatments - Continued

Shift Inpt: Musculoskeletal
    Musculoskeletal Assessment
        Musculoskeletal Assessment Within Normal Limits — No
            Query Text:Moves all extremities well with full range of motion and strength normal for patient. Gait steady. Patient denies numbness, tingling, weakness, or change in sensation of extremities.
    Musculoskeletal
        Left Upper Extremity
            Extremity Musculoskeletal Condition — Limited Range of Motion
            Condition Status — New in Past 1-2 Days

Document 09/22/18 20:00 SOP0051 (Rec: 09/22/18 20:15 SOP0051 TELE-C11)

Isolation and MRSA Assessment
    MRSA Assessment Status
    Protocol: C.MRSACHAR
        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
    Protocol: C.ISOLCHA2
        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
    Protocol: C.FALLINT
        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 — No

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```
        Diagnoses)
       Gait/Transferring                        Weak
       Score                                    10
       CVA/TIA or Stroke in past 24 hours       No
        Query Text:** If CVA/TIA or Stroke
        related diagnosis in past 24 hours,
        patient should be considered High Risk
        for falls. **
        ** If right hemisphere injury, consider
        using alarm. **
       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
       Alarm Limits Set/Checked                 No
       Side Rails Up                            None
       Call Bell Within Reach                   No
       Method of Monitoring                     Monitoring/Alarm not indicated
Assessment/Reassessment: +Safety
    Additional Precautions
       Additional Precautions                   None
    Risk for Entrapment
       Is Patient at Risk For Entrapment in Bed None
        Rails
        Query Text:Two or more items place
        patient at risk for entrapment and will
        trigger entrapment intervention to your
        worklist.
Shift Inpt: Musculoskeletal
    Musculoskeletal Assessment
       Musculoskeletal Assessment Within Normal No
        Limits
        Query Text:Moves all extremities well
        with full range of motion and strength
        normal for patient. Gait steady. Patient
        denies numbness, tingling, weakness, or
        change in sensation of extremities.
    Musculoskeletal
      Left Upper Extremity
       Extremity Musculoskeletal Condition      Limited Range of Motion
       Condition Status                         New in Past 1-2 Days
Document     09/23/18 08:00  STA0017  (Rec: 09/23/18 10:33  STA0017  TELE-C03)
Isolation and MRSA Assessment
    MRSA Assessment Status
    Protocol:  C.MRSACHAR
       MRSA Assessment                          No Update Needed
        Query Text:
        -No Update Needed: When isolation items
```

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

```
        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
    Protocol:  C.ISOLCHA2
       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
    Protocol:  C.FALLINT
       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                        Weak
       Score                                    15
       CVA/TIA or Stroke in past 24 hours       No
        Query Text:** If CVA/TIA or Stroke
        related diagnosis in past 24 hours,
        patient should be considered High Risk
        for falls. **
        ** If right hemisphere injury, consider
        using alarm. **
       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
       Alarm Limits Set/Checked                 Yes
```

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

```
      Side Rails Up                                2 Rails
      Call Bell Within Reach                       Yes
      Method of Monitoring                         Monitoring/Alarm not indicated
Assessment/Reassessment: +Safety
    Additional Precautions
      Additional Precautions                       None
    Risk for Entrapment
      Is Patient at Risk For Entrapment in Bed None
       Rails
       Query Text:Two or more items place
       patient at risk for entrapment and will
       trigger entrapment intervention to your
       worklist.
Shift Inpt: Musculoskeletal
    Musculoskeletal Assessment
      Musculoskeletal Assessment Within Normal No
       Limits
       Query Text:Moves all extremities well
       with full range of motion and strength
       normal for patient. Gait steady. Patient
       denies numbness, tingling, weakness, or
       change in sensation of extremities.
    Musculoskeletal
      Left Upper Extremity
      Extremity Musculoskeletal Condition          Limited Range of Motion
                                                   Other (See Comment)
      Condition Status                             New in Past 3-7 Days
      Condition Comment                            R/t injuries obtained during
                                                   episode c law enforcement
                                                   prior to admission
Document     09/23/18 19:08  RAY0005  (Rec: 09/23/18 19:16  RAY0005  TELE-C11)
Isolation and MRSA Assessment
    MRSA Assessment Status
    Protocol:  C.MRSACHAR
      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
    Protocol:  C.ISOLCHA2
      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
```

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BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01

62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Safety/Fall Risk Assessment

Safety/Fall Risk Assessment

Protocol: C.FALLINT

Item	Value
Mental Status	Oriented to Own Ability
Patient Is Willing and Able to Assist in Fall Prevention Query Text:Ask patient: Can you, will you, and are you able to ring for assistance?	Yes
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	Weak
Score	15
CVA/TIA or Stroke in past 24 hours Query Text:** If CVA/TIA or Stroke related diagnosis in past 24 hours, patient should be considered High Risk for falls. ** ** If right hemisphere injury, consider using alarm. **	No
Fall Risk - Calculated	Low
Fall Risk - Determined by RN 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).	High
Safety Comment	Nursing judgement

Safety Interventions

Item	Value
Alarm Limits Set/Checked	Yes
Side Rails Up	2 Rails
Call Bell Within Reach	Yes
Method of Monitoring	Monitoring/Alarm not indicated

Assessment/Reassessment: +Safety

Additional Precautions

Item	Value
Additional Precautions	None

Risk for Entrapment

Item	Value
Is Patient at Risk For Entrapment in Bed Rails Query Text:Two or more items place patient at risk for entrapment and will trigger entrapment intervention to your worklist.	None

Shift Inpt: Musculoskeletal

Musculoskeletal Assessment

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BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01

62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

```
       Musculoskeletal Assessment Within Normal No
        Limits
        Query Text:Moves all extremities well
        with full range of motion and strength
        normal for patient. Gait steady. Patient
        denies numbness, tingling, weakness, or
        change in sensation of extremities.
    Musculoskeletal
      Left Upper Extremity
       Extremity Musculoskeletal Condition      Limited Range of Motion
       Condition Status                         New in Past 3-7 Days
       Condition Comment                        r/t injuries
Not Done     09/24/18 08:00  MAC0003  (Rec: 09/24/18 08:05  MAC0003  TELE-M12)
    Declined by Patient
```

```
Shift Inpt 07: Sepsis Screen                             Start:  09/20/18 18:05
Freq:   DAILY@0800,2000                                  Status: Discharge
Protocol:
Document     09/20/18 20:00  JER0049  (Rec: 09/20/18 22:55  JER0049  TELE-C07)
Sepsis Screen
    Initial Score
       Initial SIRS Criteria Present            3
    Previous Score
       Previous SIRS Criteria Present           1
    Part I (SIRS Criteria)
       Tachycardia                              Yes
        Query Text:>90 bpm
       Tachypnea                                No
        Query Text:RR>20 or PaCO2 <32
       Hypo/Hyperthermic                        No
        Query Text:Hyperthermic > 38.3C or 101.
        0F
        Hypothermic <36.0C or 96.8F
       WBC > 12000 or < 4000 OR Bands > 10%     No, or No Lab Data Available
                                                for the Last 24 Hour Period
       SIRS Criteria Present                    1
        Query Text:If 2 or more SIRS criteria
        are present, the patient may be septic.
Edit Result  09/20/18 20:00  JER0049  (Rec: 09/20/18 22:56  JER0049  TELE-C07)
Sepsis Screen
    Part I (SIRS Criteria)
       WBC > 12000 or < 4000 OR Bands > 10%     Yes
       SIRS Criteria Present                    2
        Query Text:If 2 or more SIRS criteria
        are present, the patient may be septic.
Document     09/21/18 08:00  CON0001  (Rec: 09/21/18 08:12  CON0001  TELE-M11)
Sepsis Screen
    Initial Score
       Initial SIRS Criteria Present            3
    Previous Score
       Previous SIRS Criteria Present           2
    Part I (SIRS Criteria)
       Tachycardia                              Yes
        Query Text:>90 bpm
```

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

```
       Tachypnea                                No
        Query Text:RR>20 or PaCO2 <32
       Hypo/Hyperthermic                        No
        Query Text:Hyperthermic > 38.3C or 101.
        0F
        Hypothermic <36.0C or 96.8F
       WBC > 12000 or < 4000 OR Bands > 10%     Yes
       SIRS Criteria Present                    2
        Query Text:If 2 or more SIRS criteria
        are present, the patient may be septic.
       Are SIRS Criteria New or Worsening       No
Document     09/21/18 19:30  MEG0025  (Rec: 09/21/18 23:33  MEG0025  TELE-C09)
Sepsis Screen
    Initial Score
       Initial SIRS Criteria Present            3
    Previous Score
       Previous SIRS Criteria Present           2
    Part I (SIRS Criteria)
       Tachycardia                              Yes
        Query Text:>90 bpm
       Tachypnea                                No
        Query Text:RR>20 or PaCO2 <32
       Hypo/Hyperthermic                        No
        Query Text:Hyperthermic > 38.3C or 101.
        0F
        Hypothermic <36.0C or 96.8F
       WBC > 12000 or < 4000 OR Bands > 10%     Yes
       SIRS Criteria Present                    2
        Query Text:If 2 or more SIRS criteria
        are present, the patient may be septic.
       Are SIRS Criteria New or Worsening       No
Document     09/22/18 08:00  MEG0025  (Rec: 09/22/18 10:28  MEG0025  TELE-C13)
Sepsis Screen
    Initial Score
       Initial SIRS Criteria Present            3
    Previous Score
       Previous SIRS Criteria Present           2
    Part I (SIRS Criteria)
       Tachycardia                              No
        Query Text:>90 bpm
       Tachypnea                                No
        Query Text:RR>20 or PaCO2 <32
       Hypo/Hyperthermic                        No
        Query Text:Hyperthermic > 38.3C or 101.
        0F
        Hypothermic <36.0C or 96.8F
       WBC > 12000 or < 4000 OR Bands > 10%     Yes
       SIRS Criteria Present                    1
        Query Text:If 2 or more SIRS criteria
        are present, the patient may be septic.
Document     09/22/18 20:00  SOP0051  (Rec: 09/22/18 20:15  SOP0051  TELE-C11)
Sepsis Screen
    Initial Score
```

Continued on Page 248

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

```
      Initial SIRS Criteria Present           3
   Previous Score
      Previous SIRS Criteria Present          1
   Part I (SIRS Criteria)
      Tachycardia                             Yes
       Query Text:>90 bpm
      Tachypnea                               No
       Query Text:RR>20 or PaCO2 <32
      Hypo/Hyperthermic                       No
       Query Text:Hyperthermic > 38.3C or 101.
       0F
       Hypothermic <36.0C or 96.8F
      WBC > 12000 or < 4000 OR Bands > 10%    Yes
      SIRS Criteria Present                   2
       Query Text:If 2 or more SIRS criteria
       are present, the patient may be septic.
      Are SIRS Criteria New or Worsening      No
Document     09/23/18 08:00  STA0017  (Rec: 09/23/18 10:33  STA0017  TELE-C03)
Sepsis Screen
   Initial Score
      Initial SIRS Criteria Present           3
   Previous Score
      Previous SIRS Criteria Present          2
   Part I (SIRS Criteria)
      Tachycardia                             No
       Query Text:>90 bpm
      Tachypnea                               No
       Query Text:RR>20 or PaCO2 <32
      Hypo/Hyperthermic                       No
       Query Text:Hyperthermic > 38.3C or 101.
       0F
       Hypothermic <36.0C or 96.8F
      WBC > 12000 or < 4000 OR Bands > 10%    Yes
      SIRS Criteria Present                   1
       Query Text:If 2 or more SIRS criteria
       are present, the patient may be septic.
   Comments
      Comments                                Pt declines vital signs.  Pt
                                              feels warm but denies tylenol
                                              to be given or temp to be
                                              taken.
Document     09/23/18 19:16  RAY0005  (Rec: 09/23/18 19:17  RAY0005  TELE-C11)
Sepsis Screen
   Initial Score
      Initial SIRS Criteria Present           3
   Previous Score
      Previous SIRS Criteria Present          1
   Part I (SIRS Criteria)
      Tachycardia                             No
       Query Text:>90 bpm
      Tachypnea                               No
       Query Text:RR>20 or PaCO2 <32
      Hypo/Hyperthermic                       No
```

Continued on Page 249

Assessments and Treatments - Continued

Query Text:Hyperthermic > 38.3C or 101.
0F
Hypothermic <36.0C or 96.8F
WBC > 12000 or < 4000 OR Bands > 10% No, or No Lab Data Available for the Last 24 Hour Period
SIRS Criteria Present 0
Query Text:If 2 or more SIRS criteria
are present, the patient may be septic.
Not Done 09/24/18 08:00 MAC0003 (Rec: 09/24/18 08:05 MAC0003 TELE-M12)
Declined by Patient

Skin Risk:High Interventns In Progress Start: 09/19/18 17:53
Freq: Q2HR Status: Complete
Protocol: C.SKINBRAD
Document 09/19/18 18:00 KYL0009 (Rec: 09/19/18 18:27 KYL0009 ICU-C12)
High Risk Skin Strategies
-
Protocol: C.SKINBRAD
High Risk Skin Strategies Maintained No
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not

Continued on Page 250

limited to heels, elbows, between knees
-Protect skin by using barrier creams if incontinent
-Position in bed/chair every 2 hours with pillows or wedges PRN
-Consider Nutrition consult
** High Risk Strategies (May include the following Interventions, but not limited to):
-Include Mild and Moderate Risk Strategies as appropriate
-Use appropriate pressure relieving devices
-Consider up in chair 1-2 hr maximum at one time
-Use trapeze bar when indicated
-Use lift sheet to prevent friction/ sheering
-Ensure transfer aids are not left under pt
-Encourage pressure relief between turns
-Massage bony prominences which receive direct pressure if no redness or breakdown
-Active/Passive ROM during bathing and transfers
-Assist with feeding and caloric intake as indicated
-Avoid positioning on reddened areas
-Use devices to optimize mobilization/ transfers as indicated
-Consider OT/PT consult for active support in mobilizing patient (OOB, Ambulation, etc.)
-Elevate Head of Bed 30 degrees or less to relieve pressure

Document 09/19/18 20:50 KIM0006 (Rec: 09/19/18 23:12 KIM0006 ICU-C12)
High Risk Skin Strategies
-
Protocol: C.SKINBRAD
High Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT STRATEGIES
** Mild Risk Strategies (May include the following Interventions, but not limited to):
-Encourage change of position every 2 hours or prn if pt independent
-Encourage nutrition/hydration every 2 hours or prn if pt independent
-Use devices to optimize mobilization/ transfers
-Inspect skin when repositioning/

Continued on Page 251

toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult
** High Risk Strategies (May include the
following Interventions, but not
limited to):
-Include Mild and Moderate Risk
Strategies as appropriate
-Use appropriate pressure relieving
devices
-Consider up in chair 1-2 hr maximum at
one time
-Use trapeze bar when indicated
-Use lift sheet to prevent friction/
sheering
-Ensure transfer aids are not left under
pt
-Encourage pressure relief between turns
-Massage bony prominences which receive
direct pressure if no redness or
breakdown
-Active/Passive ROM during bathing and
transfers
-Assist with feeding and caloric intake
as indicated
-Avoid positioning on reddened areas
-Use devices to optimize mobilization/

Continued on Page 252

transfers as indicated
-Consider OT/PT consult for active
support in mobilizing patient (OOB,
Ambulation, etc.)
-Elevate Head of Bed 30 degrees or less
to relieve pressure

Not Done 09/19/18 22:00 KIM0006 (Rec: 09/19/18 23:15 KIM0006 ICU-C12)
Mild skin intervention complete
Not Done 09/20/18 00:00 KIM0006 (Rec: 09/20/18 01:34 KIM0006 ICU-C12)
Moderate skin intervention complete
Not Done 09/20/18 02:00 KIM0006 (Rec: 09/20/18 01:38 KIM0006 ICU-C12)
using moderate skin intervention
Not Done 09/20/18 04:00 KIM0006 (Rec: 09/20/18 04:42 KIM0006 ICU-C12)
documented under moderate skin interventions
Not Done 09/20/18 06:00 KIM0006 (Rec: 09/20/18 05:38 KIM0006 ICU-M35)
documenting moderate skin interventions
Not Done 09/20/18 10:00 JOA0063 (Rec: 09/20/18 16:04 JOA0063 ICU-C25)
MILD RISK
Not Done 09/20/18 12:00 JOA0063 (Rec: 09/20/18 16:04 JOA0063 ICU-C25)
MILD RISK
Not Done 09/20/18 14:00 JOA0063 (Rec: 09/20/18 16:04 JOA0063 ICU-C25)
MILD RISK
Document 09/20/18 16:34 ANI0051 (Rec: 09/20/18 16:35 ANI0051 ICU-C25)
High Risk Skin Strategies
-
Protocol: C.SKINBRAD
High Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):

Continued on Page 253

-Include Mild Risk Strategies
-Consider therapeutic surface (air mattress)
-Consider up in chair 2-3 hr maximum at one time
-Instruct pt to minimize friction and sheering risk
-Instruct pt to remove pressure from bony prominences to include, but not limited to heels, elbows, between knees
-Protect skin by using barrier creams if incontinent
-Position in bed/chair every 2 hours with pillows or wedges PRN
-Consider Nutrition consult
** High Risk Strategies (May include the following Interventions, but not limited to):
-Include Mild and Moderate Risk Strategies as appropriate
-Use appropriate pressure relieving devices
-Consider up in chair 1-2 hr maximum at one time
-Use trapeze bar when indicated
-Use lift sheet to prevent friction/ sheering
-Ensure transfer aids are not left under pt
-Encourage pressure relief between turns
-Massage bony prominences which receive direct pressure if no redness or breakdown
-Active/Passive ROM during bathing and transfers
-Assist with feeding and caloric intake as indicated
-Avoid positioning on reddened areas
-Use devices to optimize mobilization/ transfers as indicated
-Consider OT/PT consult for active support in mobilizing patient (OOB, Ambulation, etc.)
-Elevate Head of Bed 30 degrees or less to relieve pressure

Document 09/20/18 18:00 CON0001 (Rec: 09/20/18 18:04 CON0001 TELE-M07)
High Risk Skin Strategies
-
Protocol: C.SKINBRAD
High Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT STRATEGIES
** Mild Risk Strategies (May include the

Continued on Page 254

following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult
** High Risk Strategies (May include the
following Interventions, but not
limited to):
-Include Mild and Moderate Risk
Strategies as appropriate
-Use appropriate pressure relieving
devices
-Consider up in chair 1-2 hr maximum at
one time
-Use trapeze bar when indicated
-Use lift sheet to prevent friction/
sheering
-Ensure transfer aids are not left under
pt
-Encourage pressure relief between turns

Continued on Page 255

-Massage bony prominences which receive direct pressure if no redness or breakdown
-Active/Passive ROM during bathing and transfers
-Assist with feeding and caloric intake as indicated
-Avoid positioning on reddened areas
-Use devices to optimize mobilization/ transfers as indicated
-Consider OT/PT consult for active support in mobilizing patient (OOB, Ambulation, etc.)
-Elevate Head of Bed 30 degrees or less to relieve pressure

Skin Risk:Mild Interventns In Progress Start: 09/19/18 12:48
Freq: Q2HRWA Status: Complete
Protocol: C.SKINBRAD
Document 09/19/18 14:00 KYL0009 (Rec: 09/19/18 15:13 KYL0009 ICU-C12)
Mild Risk Skin Care Strategies
-
Protocol: C.SKINBRAD
Mild Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT STRATEGIES
** Mild Risk Strategies (May include the following Interventions, but not limited to):
-Encourage change of position every 2 hours or prn if pt independent
-Encourage nutrition/hydration every 2 hours or prn if pt independent
-Use devices to optimize mobilization/ transfers
-Inspect skin when repositioning/ toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to minimize pressure
-Develop plan with pt/family and update PRN
Document 09/19/18 16:00 KYL0009 (Rec: 09/19/18 17:53 KYL0009 ICU-C12)
Mild Risk Skin Care Strategies
-
Protocol: C.SKINBRAD
Mild Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT STRATEGIES

Continued on Page 256

** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN

Document 09/19/18 18:00 KYL0009 (Rec: 09/19/18 18:27 KYL0009 ICU-C12)
Mild Risk Skin Care Strategies
-
Protocol: C.SKINBRAD
Mild Risk Skin Strategies Maintained No
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN

Document 09/19/18 20:50 KIM0006 (Rec: 09/19/18 23:12 KIM0006 ICU-C12)
Mild Risk Skin Care Strategies
-
Protocol: C.SKINBRAD

Continued on Page 257

Assessments and Treatments - Continued

Mild Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN

Not Done 09/19/18 22:00 KIM0006 (Rec: 09/19/18 23:15 KIM0006 ICU-C12)
Mild skin intervention complete

Document 09/20/18 08:00 JOA0063 (Rec: 09/20/18 16:03 JOA0063 ICU-C25)
Mild Risk Skin Care Strategies
-
Protocol: C.SKINBRAD
Mild Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update

Continued on Page 258

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

PRN
Document 09/20/18 10:00 JOA0063 (Rec: 09/20/18 16:04 JOA0063 ICU-C25)
Mild Risk Skin Care Strategies
-
Protocol: C.SKINBRAD
Mild Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
Document 09/20/18 12:00 JOA0063 (Rec: 09/20/18 16:07 JOA0063 ICU-C25)
Mild Risk Skin Care Strategies
-
Protocol: C.SKINBRAD
Mild Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt

Continued on Page 259

Assessments and Treatments - Continued
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
Document 09/20/18 16:21 ANI0051 (Rec: 09/20/18 16:22 ANI0051 ICU-C25)
Mild Risk Skin Care Strategies
-
Protocol: C.SKINBRAD
Mild Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
Document 09/20/18 18:00 CON0001 (Rec: 09/20/18 18:04 CON0001 TELE-M07)
Mild Risk Skin Care Strategies
-
Protocol: C.SKINBRAD
Mild Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
Continued on Page 260

-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN

Document 09/20/18 20:00 JER0049 (Rec: 09/20/18 23:47 JER0049 TELE-C07)
Mild Risk Skin Care Strategies
-
Protocol: C.SKINBRAD
Mild Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN

Document 09/20/18 22:00 JER0049 (Rec: 09/21/18 02:53 JER0049 TELE-C09)
Mild Risk Skin Care Strategies
-
Protocol: C.SKINBRAD
Mild Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting

Continued on Page 261

-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to minimize pressure
-Develop plan with pt/family and update PRN

Skin Risk:Moderate Interventns In Prog Start: 09/19/18 10:22
Freq: Q2HR Status: Discharge
Protocol: C.SKINBRAD
Document 09/19/18 12:00 KYL0009 (Rec: 09/19/18 12:48 KYL0009 ICU-C12)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT STRATEGIES
** Mild Risk Strategies (May include the following Interventions, but not limited to):
-Encourage change of position every 2 hours or prn if pt independent
-Encourage nutrition/hydration every 2 hours or prn if pt independent
-Use devices to optimize mobilization/ transfers
-Inspect skin when repositioning/ toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to minimize pressure
-Develop plan with pt/family and update PRN
** Moderate Skin Strategies (May include the following Interventions, but not limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air mattress)
-Consider up in chair 2-3 hr maximum at one time
-Instruct pt to minimize friction and sheering risk
-Instruct pt to remove pressure from bony prominences to include, but not

Continued on Page 262

limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult
Document 09/19/18 14:00 KYL0009 (Rec: 09/19/18 15:13 KYL0009 ICU-C12)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult
Document 09/19/18 16:00 KYL0009 (Rec: 09/19/18 17:53 KYL0009 ICU-C12)

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Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult

Document 09/19/18 18:00 KYL0009 (Rec: 09/19/18 18:27 KYL0009 ICU-C12)

Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the

Continued on Page 264

following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult
Document 09/19/18 20:00 KIM0006 (Rec: 09/19/18 23:09 KIM0006 ICU-C12)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
Continued on Page 265

Assessments and Treatments - Continued

transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult

Edit Time 09/19/18 20:50 KIM0006 (Rec: 09/19/18 23:09 KIM0006 ICU-C12)
09/19/18 20:00=>09/19/18 20:50
Document 09/19/18 22:00 KIM0006 (Rec: 09/19/18 23:15 KIM0006 ICU-C12)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours

Continued on Page 266

-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult

Document 09/20/18 00:00 KIM0006 (Rec: 09/20/18 01:33 KIM0006 ICU-C12)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update

Continued on Page 267

PRN
** Moderate Skin Strategies (May include the following Interventions, but not limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air mattress)
-Consider up in chair 2-3 hr maximum at one time
-Instruct pt to minimize friction and sheering risk
-Instruct pt to remove pressure from bony prominences to include, but not limited to heels, elbows, between knees
-Protect skin by using barrier creams if incontinent
-Position in bed/chair every 2 hours with pillows or wedges PRN
-Consider Nutrition consult

Document 09/20/18 01:55 KIM0006 (Rec: 09/20/18 01:55 KIM0006 ICU-C12)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT STRATEGIES
** Mild Risk Strategies (May include the following Interventions, but not limited to):
-Encourage change of position every 2 hours or prn if pt independent
-Encourage nutrition/hydration every 2 hours or prn if pt independent
-Use devices to optimize mobilization/ transfers
-Inspect skin when repositioning/ toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to minimize pressure
-Develop plan with pt/family and update PRN
** Moderate Skin Strategies (May include the following Interventions, but not limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air mattress)

Continued on Page 268

-Consider up in chair 2-3 hr maximum at one time
-Instruct pt to minimize friction and sheering risk
-Instruct pt to remove pressure from bony prominences to include, but not limited to heels, elbows, between knees
-Protect skin by using barrier creams if incontinent
-Position in bed/chair every 2 hours with pillows or wedges PRN
-Consider Nutrition consult

Document 09/20/18 04:00 KIM0006 (Rec: 09/20/18 04:43 KIM0006 ICU-C12)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT STRATEGIES
** Mild Risk Strategies (May include the following Interventions, but not limited to):
-Encourage change of position every 2 hours or prn if pt independent
-Encourage nutrition/hydration every 2 hours or prn if pt independent
-Use devices to optimize mobilization/ transfers
-Inspect skin when repositioning/ toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to minimize pressure
-Develop plan with pt/family and update PRN
** Moderate Skin Strategies (May include the following Interventions, but not limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air mattress)
-Consider up in chair 2-3 hr maximum at one time
-Instruct pt to minimize friction and sheering risk
-Instruct pt to remove pressure from bony prominences to include, but not limited to heels, elbows, between knees

Continued on Page 269

-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult

Document 09/20/18 05:38 KIM0006 (Rec: 09/20/18 05:38 KIM0006 ICU-M35)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult

Not Done 09/20/18 10:00 JOA0063 (Rec: 09/20/18 16:04 JOA0063 ICU-C25)
MILD RISK

Continued on Page 270

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01

62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Not Done 09/20/18 12:00 JOA0063 (Rec: 09/20/18 16:04 JOA0063 ICU-C25)
MILD RISK
Not Done 09/20/18 14:00 JOA0063 (Rec: 09/20/18 16:04 JOA0063 ICU-C25)
MILD RISK
Document 09/20/18 16:34 ANI0051 (Rec: 09/20/18 16:35 ANI0051 ICU-C25)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult
Document 09/20/18 18:00 CON0001 (Rec: 09/20/18 18:04 CON0001 TELE-M07)
Moderate Skin Risk Strategies
-

Continued on Page 271

Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult

Document 09/20/18 20:00 JER0049 (Rec: 09/20/18 23:47 JER0049 TELE-C07)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):

Continued on Page 272

-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult

Document 09/20/18 22:00 JER0049 (Rec: 09/21/18 02:53 JER0049 TELE-C09)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/

Continued on Page 273

toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult

Document 09/21/18 00:00 JER0049 (Rec: 09/21/18 07:15 JER0049 TELE-C09)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt

Continued on Page 274

-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult
Document 09/21/18 02:00 JER0049 (Rec: 09/21/18 07:15 JER0049 TELE-C09)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
Continued on Page 275

-Include Mild Risk Strategies
-Consider therapeutic surface (air mattress)
-Consider up in chair 2-3 hr maximum at one time
-Instruct pt to minimize friction and sheering risk
-Instruct pt to remove pressure from bony prominences to include, but not limited to heels, elbows, between knees
-Protect skin by using barrier creams if incontinent
-Position in bed/chair every 2 hours with pillows or wedges PRN
-Consider Nutrition consult

Document 09/21/18 04:00 JER0049 (Rec: 09/21/18 07:15 JER0049 TELE-C09)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT STRATEGIES
** Mild Risk Strategies (May include the following Interventions, but not limited to):
-Encourage change of position every 2 hours or prn if pt independent
-Encourage nutrition/hydration every 2 hours or prn if pt independent
-Use devices to optimize mobilization/ transfers
-Inspect skin when repositioning/ toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to minimize pressure
-Develop plan with pt/family and update PRN
** Moderate Skin Strategies (May include the following Interventions, but not limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air mattress)
-Consider up in chair 2-3 hr maximum at one time
-Instruct pt to minimize friction and sheering risk

Continued on Page 276

-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult

Document 09/21/18 06:00 JER0049 (Rec: 09/21/18 07:15 JER0049 TELE-C09)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN

Continued on Page 277

-Consider Nutrition consult
Document 09/21/18 08:00 CON0001 (Rec: 09/21/18 08:12 CON0001 TELE-M11)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult
Document 09/21/18 09:27 CON0001 (Rec: 09/21/18 09:27 CON0001 TELE-M11)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT

Continued on Page 278

STRATEGIES
** Mild Risk Strategies (May include the following Interventions, but not limited to):
-Encourage change of position every 2 hours or prn if pt independent
-Encourage nutrition/hydration every 2 hours or prn if pt independent
-Use devices to optimize mobilization/ transfers
-Inspect skin when repositioning/ toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to minimize pressure
-Develop plan with pt/family and update PRN
** Moderate Skin Strategies (May include the following Interventions, but not limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air mattress)
-Consider up in chair 2-3 hr maximum at one time
-Instruct pt to minimize friction and sheering risk
-Instruct pt to remove pressure from bony prominences to include, but not limited to heels, elbows, between knees
-Protect skin by using barrier creams if incontinent
-Position in bed/chair every 2 hours with pillows or wedges PRN
-Consider Nutrition consult

Document 09/21/18 12:00 CON0001 (Rec: 09/21/18 12:42 CON0001 TELE-M11)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the following Interventions, but not limited to):
-Encourage change of position every 2 hours or prn if pt independent
-Encourage nutrition/hydration every 2

Continued on Page 279

hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult

Document 09/21/18 13:34 CON0001 (Rec: 09/21/18 13:34 CON0001 TELE-M11)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours

Continued on Page 280

Assessments and Treatments - Continued
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult
Document 09/21/18 15:34 CON0001 (Rec: 09/21/18 15:34 CON0001 TELE-M11)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
Continued on Page 281

PRN
** Moderate Skin Strategies (May include the following Interventions, but not limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air mattress)
-Consider up in chair 2-3 hr maximum at one time
-Instruct pt to minimize friction and sheering risk
-Instruct pt to remove pressure from bony prominences to include, but not limited to heels, elbows, between knees
-Protect skin by using barrier creams if incontinent
-Position in bed/chair every 2 hours with pillows or wedges PRN
-Consider Nutrition consult

Document 09/21/18 18:00 CON0001 (Rec: 09/21/18 18:06 CON0001 TELE-M11)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT STRATEGIES
** Mild Risk Strategies (May include the following Interventions, but not limited to):
-Encourage change of position every 2 hours or prn if pt independent
-Encourage nutrition/hydration every 2 hours or prn if pt independent
-Use devices to optimize mobilization/ transfers
-Inspect skin when repositioning/ toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to minimize pressure
-Develop plan with pt/family and update PRN
** Moderate Skin Strategies (May include the following Interventions, but not limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air mattress)

Continued on Page 282

-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult

Document 09/21/18 19:30 MEG0025 (Rec: 09/21/18 23:33 MEG0025 TELE-C09)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees

Continued on Page 283

-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult

Document 09/21/18 22:00 MEG0025 (Rec: 09/21/18 23:33 MEG0025 TELE-C09)

Moderate Skin Risk Strategies

-

Protocol: C.SKINBRAD

Moderate Risk Skin Strategies Maintained Yes

Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult

Document 09/22/18 00:00 MEG0025 (Rec: 09/22/18 01:49 MEG0025 TELE-C09)

Moderate Skin Risk Strategies

Continued on Page 284

-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult

Document 09/22/18 02:00 MEG0025 (Rec: 09/22/18 04:11 MEG0025 TELE-C09)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not

Continued on Page 285

limited to):
-Encourage change of position every 2 hours or prn if pt independent
-Encourage nutrition/hydration every 2 hours or prn if pt independent
-Use devices to optimize mobilization/ transfers
-Inspect skin when repositioning/ toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to minimize pressure
-Develop plan with pt/family and update PRN
** Moderate Skin Strategies (May include the following Interventions, but not limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air mattress)
-Consider up in chair 2-3 hr maximum at one time
-Instruct pt to minimize friction and sheering risk
-Instruct pt to remove pressure from bony prominences to include, but not limited to heels, elbows, between knees
-Protect skin by using barrier creams if incontinent
-Position in bed/chair every 2 hours with pillows or wedges PRN
-Consider Nutrition consult

Document 09/22/18 04:00 MEG0025 (Rec: 09/22/18 04:13 MEG0025 TELE-C09)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT STRATEGIES
** Mild Risk Strategies (May include the following Interventions, but not limited to):
-Encourage change of position every 2 hours or prn if pt independent
-Encourage nutrition/hydration every 2 hours or prn if pt independent
-Use devices to optimize mobilization/ transfers

Continued on Page 286

-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult

Document 09/22/18 06:00 MEG0025 (Rec: 09/22/18 06:02 MEG0025 TELE-M01)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry

Continued on Page 287

-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to minimize pressure
-Develop plan with pt/family and update PRN
** Moderate Skin Strategies (May include the following Interventions, but not limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air mattress)
-Consider up in chair 2-3 hr maximum at one time
-Instruct pt to minimize friction and sheering risk
-Instruct pt to remove pressure from bony prominences to include, but not limited to heels, elbows, between knees
-Protect skin by using barrier creams if incontinent
-Position in bed/chair every 2 hours with pillows or wedges PRN
-Consider Nutrition consult

Document 09/22/18 08:00 MEG0025 (Rec: 09/22/18 10:28 MEG0025 TELE-C13)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT STRATEGIES
** Mild Risk Strategies (May include the following Interventions, but not limited to):
-Encourage change of position every 2 hours or prn if pt independent
-Encourage nutrition/hydration every 2 hours or prn if pt independent
-Use devices to optimize mobilization/ transfers
-Inspect skin when repositioning/ toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to minimize pressure
-Develop plan with pt/family and update PRN
** Moderate Skin Strategies (May include the following Interventions, but not

Continued on Page 288

limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air mattress)
-Consider up in chair 2-3 hr maximum at one time
-Instruct pt to minimize friction and sheering risk
-Instruct pt to remove pressure from bony prominences to include, but not limited to heels, elbows, between knees
-Protect skin by using barrier creams if incontinent
-Position in bed/chair every 2 hours with pillows or wedges PRN
-Consider Nutrition consult

Document 09/22/18 10:00 MEG0025 (Rec: 09/22/18 10:28 MEG0025 TELE-C13)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT STRATEGIES
** Mild Risk Strategies (May include the following Interventions, but not limited to):
-Encourage change of position every 2 hours or prn if pt independent
-Encourage nutrition/hydration every 2 hours or prn if pt independent
-Use devices to optimize mobilization/ transfers
-Inspect skin when repositioning/ toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to minimize pressure
-Develop plan with pt/family and update PRN
** Moderate Skin Strategies (May include the following Interventions, but not limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air mattress)
-Consider up in chair 2-3 hr maximum at one time
-Instruct pt to minimize friction and

Continued on Page 289

sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult

Document 09/22/18 12:00 MOR0002 (Rec: 09/22/18 12:25 MOR0002 TELE-C05)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours

Continued on Page 290

with pillows or wedges PRN
-Consider Nutrition consult
Document 09/22/18 14:00 MOR0002 (Rec: 09/22/18 14:37 MOR0002 TELE-C05)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult
Document 09/22/18 16:00 MOR0002 (Rec: 09/22/18 17:33 MOR0002 TELE-C05)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes

Continued on Page 291

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center Loc:4 SOUTH - MEDICAL/TELEMETRY Bed:436-01
62 F 05/01/1956 Med Rec Num:M000597460 Visit:A00088518428

Assessments and Treatments - Continued

Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult

Document 09/22/18 20:00 SOP0051 (Rec: 09/22/18 20:09 SOP0051 TELE-C11)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent

Continued on Page 292

-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult

Document 09/22/18 21:48 SOP0051 (Rec: 09/22/18 21:48 SOP0051 TELE-C11)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence

Continued on Page 293

-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to minimize pressure
-Develop plan with pt/family and update PRN
** Moderate Skin Strategies (May include the following Interventions, but not limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air mattress)
-Consider up in chair 2-3 hr maximum at one time
-Instruct pt to minimize friction and sheering risk
-Instruct pt to remove pressure from bony prominences to include, but not limited to heels, elbows, between knees
-Protect skin by using barrier creams if incontinent
-Position in bed/chair every 2 hours with pillows or wedges PRN
-Consider Nutrition consult

Document 09/23/18 00:00 SOP0051 (Rec: 09/23/18 03:35 SOP0051 TELE-C11)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT STRATEGIES
** Mild Risk Strategies (May include the following Interventions, but not limited to):
-Encourage change of position every 2 hours or prn if pt independent
-Encourage nutrition/hydration every 2 hours or prn if pt independent
-Use devices to optimize mobilization/ transfers
-Inspect skin when repositioning/ toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to minimize pressure

Continued on Page 294

-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult

Document 09/23/18 02:00 SOP0051 (Rec: 09/23/18 03:36 SOP0051 TELE-C11)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air

Continued on Page 295

mattress)
-Consider up in chair 2-3 hr maximum at one time
-Instruct pt to minimize friction and sheering risk
-Instruct pt to remove pressure from bony prominences to include, but not limited to heels, elbows, between knees
-Protect skin by using barrier creams if incontinent
-Position in bed/chair every 2 hours with pillows or wedges PRN
-Consider Nutrition consult

Document 09/23/18 04:00 SOP0051 (Rec: 09/23/18 04:47 SOP0051 TELE-C11)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT STRATEGIES
** Mild Risk Strategies (May include the following Interventions, but not limited to):
-Encourage change of position every 2 hours or prn if pt independent
-Encourage nutrition/hydration every 2 hours or prn if pt independent
-Use devices to optimize mobilization/ transfers
-Inspect skin when repositioning/ toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to minimize pressure
-Develop plan with pt/family and update PRN
** Moderate Skin Strategies (May include the following Interventions, but not limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air mattress)
-Consider up in chair 2-3 hr maximum at one time
-Instruct pt to minimize friction and sheering risk
-Instruct pt to remove pressure from bony prominences to include, but not

Continued on Page 296

limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult
Document 09/23/18 06:00 SOP0051 (Rec: 09/23/18 06:32 SOP0051 TELE-C11)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult
Document 09/23/18 08:00 STA0017 (Rec: 09/23/18 10:33 STA0017 TELE-C03)

Continued on Page 297

Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult

Document 09/23/18 10:00 STA0017 (Rec: 09/23/18 10:43 STA0017 TELE-C03)

Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the

Continued on Page 298

following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult
Document 09/23/18 12:00 STA0017 (Rec: 09/23/18 12:14 STA0017 TELE-C03)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
Continued on Page 299

transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult

Document 09/23/18 14:00 STA0017 (Rec: 09/23/18 15:20 STA0017 TELE-C03)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure

Continued on Page 300

Assessments and Treatments - Continued
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to minimize pressure
-Develop plan with pt/family and update PRN
** Moderate Skin Strategies (May include the following Interventions, but not limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air mattress)
-Consider up in chair 2-3 hr maximum at one time
-Instruct pt to minimize friction and sheering risk
-Instruct pt to remove pressure from bony prominences to include, but not limited to heels, elbows, between knees
-Protect skin by using barrier creams if incontinent
-Position in bed/chair every 2 hours with pillows or wedges PRN
-Consider Nutrition consult

Document 09/23/18 18:00 TAY0053 (Rec: 09/23/18 18:20 TAY0053 TELE-C08)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT STRATEGIES
** Mild Risk Strategies (May include the following Interventions, but not limited to):
-Encourage change of position every 2 hours or prn if pt independent
-Encourage nutrition/hydration every 2 hours or prn if pt independent
-Use devices to optimize mobilization/ transfers
-Inspect skin when repositioning/ toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to minimize pressure
-Develop plan with pt/family and update PRN
** Moderate Skin Strategies (May include

Continued on Page 301

the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult

Document 09/23/18 19:07 RAY0005 (Rec: 09/23/18 19:07 RAY0005 TELE-C11)

Moderate Skin Risk Strategies

-

Protocol: C.SKINBRAD

Moderate Risk Skin Strategies Maintained Yes

Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time

Continued on Page 302

-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult

Document 09/23/18 22:00 RAY0005 (Rec: 09/23/18 22:33 RAY0005 TELE-C11)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent

Continued on Page 303

-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult

Document 09/23/18 23:29 RAY0005 (Rec: 09/23/18 23:29 RAY0005 TELE-C11)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult

Document 09/24/18 02:00 RAY0005 (Rec: 09/24/18 02:15 RAY0005 TELE-C11)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD

Continued on Page 304

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult

Document 09/24/18 04:00 RAY0005 (Rec: 09/24/18 04:45 RAY0005 TELE-C11)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2

Continued on Page 305

hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult

Document 09/24/18 05:49 RAY0005 (Rec: 09/24/18 05:49 RAY0005 TELE-C11)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting

Continued on Page 306

-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to minimize pressure
-Develop plan with pt/family and update PRN
** Moderate Skin Strategies (May include the following Interventions, but not limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air mattress)
-Consider up in chair 2-3 hr maximum at one time
-Instruct pt to minimize friction and sheering risk
-Instruct pt to remove pressure from bony prominences to include, but not limited to heels, elbows, between knees
-Protect skin by using barrier creams if incontinent
-Position in bed/chair every 2 hours with pillows or wedges PRN
-Consider Nutrition consult

Not Done 09/24/18 08:00 MAC0003 (Rec: 09/24/18 08:05 MAC0003 TELE-M12)
Declined by Patient
Not Done 09/24/18 10:00 MAC0003 (Rec: 09/24/18 09:21 MAC0003 TELE-M12)
Declined by Patient
Document 09/24/18 12:00 MAC0003 (Rec: 09/24/18 12:59 MAC0003 TELE-M12)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained No
Query Text:SKIN RISK TREATMENT STRATEGIES
** Mild Risk Strategies (May include the following Interventions, but not limited to):
-Encourage change of position every 2 hours or prn if pt independent
-Encourage nutrition/hydration every 2 hours or prn if pt independent
-Use devices to optimize mobilization/ transfers
-Inspect skin when repositioning/ toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care

Continued on Page 307

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01

62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN
** Moderate Skin Strategies (May include
the following Interventions, but not
limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air
mattress)
-Consider up in chair 2-3 hr maximum at
one time
-Instruct pt to minimize friction and
sheering risk
-Instruct pt to remove pressure from
bony prominences to include, but not
limited to heels, elbows, between knees
-Protect skin by using barrier creams if
incontinent
-Position in bed/chair every 2 hours
with pillows or wedges PRN
-Consider Nutrition consult

Document 09/24/18 14:00 MAC0003 (Rec: 09/24/18 14:04 MAC0003 TELE-C09)

Moderate Skin Risk Strategies

-

Protocol: C.SKINBRAD

Moderate Risk Skin Strategies Maintained No

Query Text:SKIN RISK TREATMENT
STRATEGIES
** Mild Risk Strategies (May include the
following Interventions, but not
limited to):
-Encourage change of position every 2
hours or prn if pt independent
-Encourage nutrition/hydration every 2
hours or prn if pt independent
-Use devices to optimize mobilization/
transfers
-Inspect skin when repositioning/
toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to
minimize pressure
-Develop plan with pt/family and update
PRN

Continued on Page 308

** Moderate Skin Strategies (May include the following Interventions, but not limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air mattress)
-Consider up in chair 2-3 hr maximum at one time
-Instruct pt to minimize friction and sheering risk
-Instruct pt to remove pressure from bony prominences to include, but not limited to heels, elbows, between knees
-Protect skin by using barrier creams if incontinent
-Position in bed/chair every 2 hours with pillows or wedges PRN
-Consider Nutrition consult

Not Done 09/24/18 16:00 MAC0003 (Rec: 09/24/18 15:51 MAC0003 TELE-C09)
Declined by Patient

Document 09/24/18 17:23 MAC0003 (Rec: 09/24/18 17:23 MAC0003 TELE-C09)
Moderate Skin Risk Strategies
-
Protocol: C.SKINBRAD
Moderate Risk Skin Strategies Maintained No
Query Text:SKIN RISK TREATMENT STRATEGIES
** Mild Risk Strategies (May include the following Interventions, but not limited to):
-Encourage change of position every 2 hours or prn if pt independent
-Encourage nutrition/hydration every 2 hours or prn if pt independent
-Use devices to optimize mobilization/ transfers
-Inspect skin when repositioning/ toileting
-Offer toileting to maintain continence
-Check for incontinence every 2-4 hours
-Provide routine skin care
-Assess for and minimize pressure
-Keep skin folds clean and dry
-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to minimize pressure
-Develop plan with pt/family and update PRN
** Moderate Skin Strategies (May include the following Interventions, but not limited to):
-Include Mild Risk Strategies
-Consider therapeutic surface (air

Continued on Page 309

Assessments and Treatments - Continued

mattress)
-Consider up in chair 2-3 hr maximum at one time
-Instruct pt to minimize friction and sheering risk
-Instruct pt to remove pressure from bony prominences to include, but not limited to heels, elbows, between knees
-Protect skin by using barrier creams if incontinent
-Position in bed/chair every 2 hours with pillows or wedges PRN
-Consider Nutrition consult

Spiritual Care: Assessment/Intervention Start: 09/21/18 08:26
Freq: Status: Discharge
Protocol:
Document 09/21/18 14:51 TZI0001 (Rec: 09/21/18 14:51 TZI0001 SPIR-C01)
Spiritual Care: Assessment/Intervention Form
Assessment/Intervention
Date of Most Recent Visit 09/21/18
Length of Visit (in Minutes) 10 Minutes
Spiritual Care Interventions Pt. Not Available
Peace Note

Straight Catheterization Start: 09/19/18 04:55
Freq: ONCE Status: Complete
Protocol:
Document 09/19/18 07:00 THO0010 (Rec: 09/19/18 07:26 THO0010 EDL-C01)

Telemetry Monitor: Continuous Start: 09/19/18 08:19
Freq: Q8HR Status: Complete
Protocol:
Document 09/19/18 16:00 KYL0009 (Rec: 09/19/18 17:53 KYL0009 ICU-C12)
EKG Monitoring Assessment
EKG Monitoring Assessment
Is Patient on Telemetry? Yes
EKG Monitoring Hardwire
Alarms On/Call Bell Within Reach/Pt Observed Every Hour Yes
Change in Rhythm Yes
Heart Rhythm Sinus Rhythm
Interventions needed No
Cardiac pacemaker or pacemaker wires? No
Document 09/20/18 00:00 KIM0006 (Rec: 09/20/18 01:33 KIM0006 ICU-C12)
EKG Monitoring Assessment
EKG Monitoring Assessment
Is Patient on Telemetry? Yes
EKG Monitoring Hardwire
Alarms On/Call Bell Within Reach/Pt Observed Every Hour Yes
Change in Rhythm No
Heart Rhythm Sinus Rhythm
Not Done 09/20/18 08:00 JOA0063 (Rec: 09/20/18 10:18 JOA0063 ICU-C25)
ON BEDSIDE MONITOR
Document 09/20/18 16:34 ANI0051 (Rec: 09/20/18 16:35 ANI0051 ICU-C25)

Continued on Page 310

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01

62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

EKG Monitoring Assessment
    EKG Monitoring Assessment
        Is Patient on Telemetry?   No: pt refuses

Document 09/21/18 00:00 JER0049 (Rec: 09/21/18 02:54 JER0049 TELE-C09)

EKG Monitoring Assessment
    EKG Monitoring Assessment
        Is Patient on Telemetry?   Yes
        Heart Rhythm   Sinus Rhythm
            Sinus Tachycardia

Document 09/21/18 08:00 CON0001 (Rec: 09/21/18 09:00 CON0001 TELE-M11)

EKG Monitoring Assessment
    EKG Monitoring Assessment
        Is Patient on Telemetry?   Yes
        EKG Monitoring   Telemetry
        Alarms On/Call Bell Within Reach/Pt Observed Every Hour   Yes
        Heart Rhythm   Sinus Rhythm
            Sinus Tachycardia
        Heart Rate/Rhythm Comment   HR 83

Document 09/21/18 16:00 CON0001 (Rec: 09/21/18 17:44 CON0001 TELE-M11)

EKG Monitoring Assessment
    EKG Monitoring Assessment
        Is Patient on Telemetry?   Yes
        EKG Monitoring   Telemetry
        Alarms On/Call Bell Within Reach/Pt Observed Every Hour   Yes
        Heart Rhythm   Sinus Rhythm
            Sinus Tachycardia
        Heart Rate/Rhythm Comment   HR 94

Document 09/22/18 00:00 MEG0025 (Rec: 09/22/18 04:11 MEG0025 TELE-C09)

EKG Monitoring Assessment
    EKG Monitoring Assessment
        Is Patient on Telemetry?   Yes
        EKG Monitoring   Telemetry
        Alarms On/Call Bell Within Reach/Pt Observed Every Hour   Yes
        Heart Rhythm   Sinus Rhythm
        Rate per Minute   88

Turn and Reposition   Start: 09/19/18 08:47
Freq: Q2HR   Status: Inactive
Protocol:

Document 09/19/18 09:00 KYL0009 (Rec: 09/19/18 09:40 KYL0009 ICU-M27)

Turn and Position
    Turning/Repositioning
        Position   Supine

Document 09/19/18 10:00 KYL0009 (Rec: 09/19/18 11:33 KYL0009 ICU-M27)

Turn and Position
    Turning/Repositioning
        Position   Right Side

Document 09/19/18 12:00 KYL0009 (Rec: 09/19/18 12:48 KYL0009 ICU-C12)

Turn and Position
    Turning/Repositioning
        Position   Supine

Continued on Page 311

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

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Document     09/19/18 14:00  KYL0009  (Rec: 09/19/18 15:13  KYL0009  ICU-C12)
Turn and Position
    Turning/Repositioning
       Position                             Supine
       Reason Patient Not Turned            Patient Repositions Self
Document     09/19/18 16:00  KYL0009  (Rec: 09/19/18 17:53  KYL0009  ICU-C12)
Turn and Position
    Turning/Repositioning
       Position                             Supine
       Reason Patient Not Turned            weight shifting- boosted as
                                            needed
Document     09/19/18 18:00  KYL0009  (Rec: 09/19/18 18:27  KYL0009  ICU-C12)
Turn and Position
    Turning/Repositioning
       Position                             Supine
       Reason Patient Not Turned            weight shifting- boosted as
                                            needed
Not Done     09/19/18 20:00  KIM0006  (Rec: 09/19/18 22:45  KIM0006  ICU-C12)
    2045 patient refusing
Document     09/19/18 22:00  KIM0006  (Rec: 09/19/18 23:13  KIM0006  ICU-C12)
Turn and Position
    Turning/Repositioning
       Position                             Supine
       Reason Patient Not Turned            Patient Repositions Self
Document     09/20/18 00:00  KIM0006  (Rec: 09/20/18 01:33  KIM0006  ICU-C12)
Turn and Position
    Turning/Repositioning
       Position                             Supine
       Reason Patient Not Turned            Patient Repositions Self
Document     09/20/18 01:55  KIM0006  (Rec: 09/20/18 01:55  KIM0006  ICU-C12)
Turn and Position
    Turning/Repositioning
       Position                             Right Side
       Reason Patient Not Turned            Patient Repositions Self
Document     09/20/18 04:00  KIM0006  (Rec: 09/20/18 04:43  KIM0006  ICU-C12)
Turn and Position
    Turning/Repositioning
       Reason Patient Not Turned            Patient Repositions Self
Document     09/20/18 05:38  KIM0006  (Rec: 09/20/18 05:38  KIM0006  ICU-M35)
Turn and Position
    Turning/Repositioning
       Reason Patient Not Turned            Patient Repositions Self
Document     09/20/18 08:00  JOA0063  (Rec: 09/20/18 10:07  JOA0063  ICU-C25)
Turn and Position
    Turning/Repositioning
       Reason Patient Not Turned            Patient Repositions Self
Document     09/20/18 10:00  JOA0063  (Rec: 09/20/18 15:50  JOA0063  ICU-C25)
Turn and Position
    Turning/Repositioning
       Reason Patient Not Turned            Patient Repositions Self
Document     09/20/18 12:00  JOA0063  (Rec: 09/20/18 15:51  JOA0063  ICU-C25)
Turn and Position
    Turning/Repositioning
```

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

```
       Reason Patient Not Turned                Patient Repositions Self
Document     09/20/18 16:21  ANI0051  (Rec: 09/20/18 16:22  ANI0051  ICU-C25)
Turn and Position
    Turning/Repositioning
       Reason Patient Not Turned                Patient Repositions Self
Document     09/20/18 18:00  CON0001  (Rec: 09/20/18 18:04  CON0001  TELE-M07)
Turn and Position
    Turning/Repositioning
       Reason Patient Not Turned                Patient Repositions Self
```

```
Turn and Reposition                                  Start:  09/21/18 08:26
Freq:   Q2HR                                         Status: Complete
Protocol:
Document     09/21/18 09:27  CON0001  (Rec: 09/21/18 09:27  CON0001  TELE-M11)
Turn and Position
    Turning/Repositioning
       Reason Patient Not Turned                Patient Repositions Self
Document     09/21/18 12:00  CON0001  (Rec: 09/21/18 12:42  CON0001  TELE-M11)
Turn and Position
    Turning/Repositioning
       Reason Patient Not Turned                Patient Repositions Self
Document     09/21/18 13:34  CON0001  (Rec: 09/21/18 13:34  CON0001  TELE-M11)
Turn and Position
    Turning/Repositioning
       Reason Patient Not Turned                Patient Repositions Self
Document     09/21/18 15:34  CON0001  (Rec: 09/21/18 15:34  CON0001  TELE-M11)
Turn and Position
    Turning/Repositioning
       Reason Patient Not Turned                Patient Repositions Self
Document     09/21/18 18:00  CON0001  (Rec: 09/21/18 18:06  CON0001  TELE-M11)
Turn and Position
    Turning/Repositioning
       Reason Patient Not Turned                Patient Repositions Self
Document     09/21/18 20:00  SAR0138  (Rec: 09/21/18 21:16  SAR0138  TELE-C11)
Turn and Position
    Turning/Repositioning
       Reason Patient Not Turned                Patient Repositions Self
Document     09/21/18 22:00  SAR0138  (Rec: 09/21/18 22:47  SAR0138  TELE-C11)
Turn and Position
    Turning/Repositioning
       Reason Patient Not Turned                Patient Repositions Self
Document     09/22/18 00:00  TAY0008  (Rec: 09/22/18 00:30  TAY0008  TELE-C32)
Turn and Position
    Turning/Repositioning
       Reason Patient Not Turned                Patient Repositions Self
Document     09/22/18 02:00  TAY0008  (Rec: 09/22/18 03:39  TAY0008  TELE-C07)
Turn and Position
    Turning/Repositioning
       Reason Patient Not Turned                Patient Repositions Self
Document     09/22/18 04:00  MEG0025  (Rec: 09/22/18 04:13  MEG0025  TELE-C09)
Turn and Position
    Turning/Repositioning
       Reason Patient Not Turned                Patient Repositions Self
Document     09/22/18 06:00  MEG0025  (Rec: 09/22/18 06:02  MEG0025  TELE-M01)
```

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Turn and Position
- Turning/Repositioning
  - Reason Patient Not Turned — Patient Repositions Self

Update History Assessment — Start: 09/21/18 08:26
Freq: Q1MX1,T.PRN — Status: Discharge
Protocol:
Document 09/21/18 08:26 CON0001 (Rec: 09/21/18 09:00 CON0001 TELE-M11)

Update Adm History Assessment

Item	Response
Update History	
History Update	No Changes/Additions
Pain History	
Hx Chronic Pain	No
Infectious Disease History	
Traveled Outside the US in Last 30 Days	No
Infectious Disease History	Unable to Obtain/Confirm
Neurological History	
Neurological History	Unable to Obtain/Confirm
Other Neuro Impairments/Disorders	Yes: States history of temporal lobe epilepsy, no seizures
Sensory History	
Sensory Impairment	Unable to Obtain/Confirm
Hx Contacts or Glasses	No: UTA
Hx Hearing Aid	No: UTA
Cardiovascular History	
Hx Hypertension	Yes
Respiratory History	
Respiratory History	Unable to Obtain/Confirm
GI History	
GI History	Unable to Obtain/Confirm
GU History	
GU History	Unable to Obtain/Confirm
Musculoskeletal History	
Musculoskeletal History	Unable to Obtain/Confirm
Safety History	
History of Falls During Hospital Visit	No
Surgical History	
Surgical History	Yes
Surgery Procedure, Year, and Place	Left inguinal hernia repair
Cancer History	
Hx Cancer	Unable to Obtain/Confirm
Psychiatric/Psychosocial History	
Hx Bipolar Disorder	Yes
Hx Post Traumatic Stress Disorder	Yes
Hx Schizophrenia	Yes
Hx of Violent Episodes Against Others	Yes
Other Psychiatric Issues/Disorders	Yes: Transsexualism
Endocrine/Hematology History	
Hx Diabetes	No

Vaccination Eligibility Reassessment — Start: 09/19/18 10:22
Freq: DAILY@0800,2000 — Status: Complete
Protocol:
Not Done 09/19/18 20:00 KIM0006 (Rec: 09/19/18 23:09 KIM0006 ICU-C12)

Continued on Page 314

patient refuses to speak of vaccination
Document 09/20/18 08:00 CON0001 (Rec: 09/20/18 18:12 CON0001 TELE-M07)
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."
Pneumococcal Vaccination Assessment
Last Pneumococcal Vaccination
Most Recent Pneumonia Vaccination — Unknown
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
Last Influenza Vaccination
Most Recent Influenza Vaccination — Unknown
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.

Vital Signs - Manual Entry Start: 09/19/18 08:47
Freq: Q4HR Status: Inactive
Protocol:
Document 09/19/18 12:00 EMI0007 (Rec: 09/19/18 13:33 EMI0007 ICU-C24)
Vital Signs: Manual Entry
Vital Signs
Only document vital signs here if NOT captured through vital signs monitor
Temperature — 98.5 F

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

```
       Temperature Source                        Temporal Artery Scan
 Document     09/19/18 16:00  KYL0009  (Rec: 09/19/18 18:23  KYL0009  ICU-C12)
 Vital Signs: Manual Entry
     Vital Signs
      Only document vital signs here if NOT captured through vital signs monitor
       Temperature                               99.9 F
       Temperature Source                        Tympanic
 Document     09/19/18 19:45  IBE0050  (Rec: 09/19/18 19:45  IBE0050  ICU-M35)
 Vital Signs: Manual Entry
     Vital Signs
      Only document vital signs here if NOT captured through vital signs monitor
       Temperature                               100.1 F
       Temperature Source                        Temporal Artery Scan
 Not Done     09/20/18 00:00  KIM0006  (Rec: 09/20/18 01:32  KIM0006  ICU-C12)
     vitals auto capture
 Not Done     09/20/18 04:00  KIM0006  (Rec: 09/20/18 04:43  KIM0006  ICU-C12)
     vitals auto capture
 Document     09/20/18 10:00  JOA0063  (Rec: 09/20/18 10:07  JOA0063  ICU-C25)
 Vital Signs: Manual Entry
     Vital Signs
      Only document vital signs here if NOT captured through vital signs monitor
       Temperature                               100.8 F
       Temperature Source                        Temporal Artery Scan
 Not Done     09/20/18 12:00  JOA0063  (Rec: 09/20/18 15:52  JOA0063  ICU-C25)
     Patient Asleep
```

```
Vital Signs - Manual Entry                                 Start:  09/20/18 20:15
Freq:   .PRN                                               Status: Inactive
Protocol:
 Document     09/20/18 20:15  ELI0141  (Rec: 09/20/18 20:16  ELI0141  TELE-C01)
 Vital Signs: Manual Entry
     Vital Signs
      Only document vital signs here if NOT captured through vital signs monitor
       Temperature                               98.7 F
       Temperature Source                        Oral
       Pulse Rate                                104
       Respiratory Rate                          20
       Blood Pressure (mmHg)                     170/100
       Blood Pressure Source                     Manual Cuff/Auscultation
       Blood Pressure Mean                       123
       Patient on Room Air                       Yes
       O2 Sat by Pulse Oximetry                  96
 Document     09/21/18 04:00  JAN0023  (Rec: 09/21/18 04:51  JAN0023  2012CITRIX04)
 Vital Signs: Manual Entry
     Vital Signs
      Only document vital signs here if NOT captured through vital signs monitor
       Blood Pressure (mmHg)                     164/88
       Blood Pressure Source                     Manual Cuff/Auscultation
       Blood Pressure Mean                       113
```

```
Vital Signs - Manual Entry                                 Start:  09/21/18 08:26
Freq:   .PRN                                               Status: Discharge
Protocol:
 Document     09/21/18 15:48  SAR0138  (Rec: 09/21/18 15:48  SAR0138  TELE-C01)
 Vital Signs: Manual Entry
```

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Vital Signs
Only document vital signs here if NOT captured through vital signs monitor

Temperature	99.4 F
Temperature Source	Temporal Artery Scan
Pulse Rate	93
Respiratory Rate	12
Blood Pressure (mmHg)	173/113
Blood Pressure Source	Automatic Cuff
Blood Pressure Mean	133
Patient on Room Air	Yes
O2 Sat by Pulse Oximetry	97

Document 09/22/18 05:16 MEG0025 (Rec: 09/22/18 09:33 MEG0025 TELE-M15)
Vital Signs: Manual Entry
Vital Signs
Only document vital signs here if NOT captured through vital signs monitor

Temperature	99.7 F
Temperature Source	Temporal Artery Scan
Pulse Rate	87
Respiratory Rate	18
Blood Pressure (mmHg)	180/100
Blood Pressure Source	Manual Cuff/Auscultation
Blood Pressure Mean	126
Patient on Room Air	Yes

Document 09/22/18 09:33 MEG0025 (Rec: 09/22/18 09:33 MEG0025 TELE-M15)
Vital Signs: Manual Entry
Vital Signs
Only document vital signs here if NOT captured through vital signs monitor

Blood Pressure (mmHg)	180/110
Blood Pressure Source	Manual Cuff/Auscultation
Blood Pressure Mean	133

Document 09/22/18 16:33 ELI0141 (Rec: 09/22/18 16:33 ELI0141 TELE-C03)
Vital Signs: Manual Entry
Vital Signs
Only document vital signs here if NOT captured through vital signs monitor

Blood Pressure (mmHg)	180/98
Blood Pressure Source	Manual Cuff/Auscultation
Blood Pressure Mean	125

Vital Signs-Auto Capture (VS3) Start: 09/21/18 08:26
Text: Status: Discharge
Freq: 0315,0715,1115,1515,1915,2315
Protocol: NEURO.TS

Document 09/20/18 23:52 CON0001 (Rec: 09/21/18 08:27 CON0001 TELE-M11)
Vital Signs-Automatic Capture
Monitor Operator

Monitor Operator	Janelle Nez

Temperature

Temperature	99.5 F
Temperature Source	Temporal Artery Scan

Heart/Pulse Rate

Pulse Rate	105

Respirations

Respiratory Rate	20

Oxygen Saturation

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BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

O2 Sat by Pulse Oximetry 95
Patient on Room Air Yes

Document 09/21/18 03:37 CON0001 (Rec: 09/21/18 08:27 CON0001 TELE-M11)
Vital Signs-Automatic Capture
Monitor Operator
Monitor Operator Janelle Nez
Temperature
Temperature 98.5 F
Temperature Source Temporal Artery Scan
Heart/Pulse Rate
Pulse Rate 89
Respirations
Respiratory Rate 24
Oxygen Saturation
O2 Sat by Pulse Oximetry 95
Patient on Room Air Yes

Document 09/21/18 08:06 CON0001 (Rec: 09/21/18 08:27 CON0001 TELE-M11)
Vital Signs-Automatic Capture
Monitor Operator
Monitor Operator Jeffery Storrs
Temperature
Temperature 98.9 F
Temperature Source Temporal Artery Scan
Heart/Pulse Rate
Pulse Rate 91
Respirations
Respiratory Rate 20
Oxygen Saturation
O2 Sat by Pulse Oximetry 95
Patient on Room Air Yes

Document 09/21/18 11:44 CON0001 (Rec: 09/21/18 12:43 CON0001 TELE-M11)
Vital Signs-Automatic Capture
Monitor Operator
Monitor Operator Jeffery Storrs
Heart/Pulse Rate
Pulse Rate 92
Respirations
Respiratory Rate 18
Blood Pressure
Blood Pressure (mmHg) 183/109
Blood Pressure Mean 125
Oxygen Saturation
O2 Sat by Pulse Oximetry 99
Patient on Room Air Yes

Document 09/21/18 20:37 MEG0025 (Rec: 09/21/18 21:10 MEG0025 TELE-M01)
Vital Signs-Automatic Capture
Monitor Operator
Monitor Operator Sara McKee
Temperature
Temperature 98.0 F
Temperature Source Oral
Heart/Pulse Rate
Pulse Rate 95

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

```
    Respirations
       Respiratory Rate                         12
    Oxygen Saturation
       O2 Sat by Pulse Oximetry                 97
       Patient on Room Air                      Yes
Document     09/22/18 05:16  SOP0051  (Rec: 09/22/18 05:52  SOP0051  TELE-C15)
Vital Signs-Automatic Capture
    Monitor Operator
       Monitor Operator                         Megan Harrington
    Temperature
       Temperature                              99.7 F
       Temperature Source                       Temporal Artery Scan
    Heart/Pulse Rate
       Pulse Rate                               87
    Respirations
       Respiratory Rate                         18
    Oxygen Saturation
       O2 Sat by Pulse Oximetry                 95
       Patient on Room Air                      Yes
Document     09/22/18 08:14  MEG0025  (Rec: 09/22/18 09:27  MEG0025  TELE-C09)
Vital Signs-Automatic Capture
    Monitor Operator
       Monitor Operator                         Boblette Davidson
    Temperature
       Temperature                              98.0 F
       Temperature Source                       Oral
    Heart/Pulse Rate
       Pulse Rate                               88
    Respirations
       Respiratory Rate                         20
    Oxygen Saturation
       O2 Sat by Pulse Oximetry                 96
       Patient on Room Air                      Yes
Document     09/22/18 11:18  MOR0002  (Rec: 09/22/18 12:26  MOR0002  TELE-C05)
Vital Signs-Automatic Capture
    Monitor Operator
       Monitor Operator                         Boblette Davidson
    Temperature
       Temperature                              98.9 F
       Temperature Source                       Oral
    Heart/Pulse Rate
       Pulse Rate                               84
    Respirations
       Respiratory Rate                         20
    Oxygen Saturation
       O2 Sat by Pulse Oximetry                 97
       Patient on Room Air                      Yes
Document     09/22/18 15:20  MOR0002  (Rec: 09/22/18 15:30  MOR0002  TELE-C05)
Vital Signs-Automatic Capture
    Monitor Operator
       Monitor Operator                         Elizabeth Peck
    Temperature
       Temperature                              98.3 F
```

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Assessments and Treatments - Continued

Temperature Source Oral
Heart/Pulse Rate
Pulse Rate 89
Respirations
Respiratory Rate 16
Oxygen Saturation
O2 Sat by Pulse Oximetry 96
Patient on Room Air Yes
Document 09/22/18 19:16 SOP0051 (Rec: 09/22/18 20:07 SOP0051 TELE-C11)
Vital Signs-Automatic Capture
Monitor Operator
Monitor Operator Elizabeth Peck
Temperature
Temperature 98.0 F
Temperature Source Oral
Heart/Pulse Rate
Pulse Rate 101
Respirations
Respiratory Rate 16
Oxygen Saturation
O2 Sat by Pulse Oximetry 97
Patient on Room Air Yes
Document 09/23/18 15:40 TAY0053 (Rec: 09/23/18 18:20 TAY0053 TELE-C08)
Vital Signs-Automatic Capture
Monitor Operator
Monitor Operator Faith Forster
Temperature
Temperature 97.7 F
Temperature Source Oral
Heart/Pulse Rate
Pulse Rate 87
Respirations
Respiratory Rate 16
Oxygen Saturation
O2 Sat by Pulse Oximetry 96
Document 09/24/18 08:21 MAC0003 (Rec: 09/24/18 08:35 MAC0003 TELE-M12)
Vital Signs-Automatic Capture
Monitor Operator
Monitor Operator Jeffery Storrs
Temperature
Temperature 98.9 F
Temperature Source Temporal Artery Scan
Heart/Pulse Rate
Pulse Rate 94
Respirations
Respiratory Rate 20
Blood Pressure
Blood Pressure (mmHg) 166/96
Blood Pressure Mean 112
Oxygen Saturation
O2 Sat by Pulse Oximetry 98
Patient on Room Air Yes
Document 09/24/18 11:51 MAC0003 (Rec: 09/24/18 11:57 MAC0003 TELE-M12)

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BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01

62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Vital Signs-Automatic Capture

Monitor Operator	
Monitor Operator	Jeffery Storrs
Temperature	
Temperature	97.5 F
Temperature Source	Oral
Heart/Pulse Rate	
Pulse Rate	90
Respirations	
Respiratory Rate	19
Blood Pressure	
Blood Pressure (mmHg)	153/94
Blood Pressure Mean	108
Oxygen Saturation	
O2 Sat by Pulse Oximetry	98
Patient on Room Air	Yes

Document 09/24/18 15:32 MAC0003 (Rec: 09/24/18 15:50 MAC0003 TELE-C09)

Vital Signs-Automatic Capture

Monitor Operator	
Monitor Operator	Sara McKee
Temperature	
Temperature	99.1 F
Temperature Source	Temporal Artery Scan
Heart/Pulse Rate	
Pulse Rate	95
Respirations	
Respiratory Rate	12
Blood Pressure	
Blood Pressure (mmHg)	155/92
Blood Pressure Mean	106
Oxygen Saturation	
O2 Sat by Pulse Oximetry	96
Patient on Room Air	Yes

Vital Signs-Bedside Monitor Auto Capture Start: 09/19/18 04:42

Text: Status: Discharge

Freq:

Protocol:

Document 09/19/18 04:39 NAT0019 (Rec: 09/19/18 08:09 NAT0019 ED-C19)

Vital Signs from Bedside Monitors

Vital Signs	
Pulse Rate	117
O2 Sat by Pulse Oximetry	96
Blood Pressure (mmHg)	176/113
Blood Pressure Mean	127

Document 09/19/18 05:25 NAT0019 (Rec: 09/19/18 08:09 NAT0019 ED-C19)

Vital Signs from Bedside Monitors

Vital Signs	
Pulse Rate	113
O2 Sat by Pulse Oximetry	98

Document 09/19/18 05:27 NAT0019 (Rec: 09/19/18 08:09 NAT0019 ED-C19)

Vital Signs from Bedside Monitors

Vital Signs	
Heart Rate	105

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Pulse Rate	103
Respiratory Rate	38
Blood Pressure (mmHg)	219/112
Blood Pressure Mean	131

Document 09/19/18 05:28 NAT0019 (Rec: 09/19/18 08:09 NAT0019 ED-C19)
Vital Signs from Bedside Monitors
Vital Signs

Heart Rate	100
Pulse Rate	101
Respiratory Rate	42
O2 Sat by Pulse Oximetry	98
Blood Pressure (mmHg)	210/110
Blood Pressure Mean	128

Document 09/19/18 05:30 NAT0019 (Rec: 09/19/18 08:09 NAT0019 ED-C19)
Vital Signs from Bedside Monitors
Vital Signs

Heart Rate	105
Pulse Rate	106
Respiratory Rate	38
O2 Sat by Pulse Oximetry	98
Blood Pressure (mmHg)	185/127
Blood Pressure Mean	138

Document 09/19/18 05:31 NAT0019 (Rec: 09/19/18 08:09 NAT0019 ED-C19)
Vital Signs from Bedside Monitors
Vital Signs

Heart Rate	96
Pulse Rate	96
Respiratory Rate	42
O2 Sat by Pulse Oximetry	98

Document 09/19/18 05:57 NAT0019 (Rec: 09/19/18 08:09 NAT0019 ED-C19)
Vital Signs from Bedside Monitors
Vital Signs

Heart Rate	116
Pulse Rate	114
Respiratory Rate	34
O2 Sat by Pulse Oximetry	100
Blood Pressure (mmHg)	200/131
Blood Pressure Mean	160

Document 09/19/18 06:00 NAT0019 (Rec: 09/19/18 08:09 NAT0019 ED-C19)
Vital Signs from Bedside Monitors
Vital Signs

Heart Rate	116
Pulse Rate	116
Respiratory Rate	57
O2 Sat by Pulse Oximetry	98

Document 09/19/18 06:13 NAT0019 (Rec: 09/19/18 08:09 NAT0019 ED-C19)
Vital Signs from Bedside Monitors
Vital Signs

Pulse Rate	83
Respiratory Rate	26
O2 Sat by Pulse Oximetry	98
Blood Pressure (mmHg)	133/80
Blood Pressure Mean	88

Continued on Page 322

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01

62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Document 09/19/18 06:41 NAT0019 (Rec: 09/19/18 08:09 NAT0019 ED-C19)
Vital Signs from Bedside Monitors
Vital Signs

Heart Rate	76
Pulse Rate	75
Respiratory Rate	32
O2 Sat by Pulse Oximetry	96

Document 09/19/18 07:00 NAT0019 (Rec: 09/19/18 08:09 NAT0019 ED-C19)
Vital Signs from Bedside Monitors
Vital Signs

Heart Rate	80
Pulse Rate	80
Respiratory Rate	33
O2 Sat by Pulse Oximetry	96

Document 09/19/18 07:03 NAT0019 (Rec: 09/19/18 08:09 NAT0019 ED-C19)
Vital Signs from Bedside Monitors
Vital Signs

Heart Rate	78
Pulse Rate	77
Respiratory Rate	32
O2 Sat by Pulse Oximetry	96
Blood Pressure (mmHg)	79/60
Blood Pressure Mean	68

Document 09/19/18 07:05 NAT0019 (Rec: 09/19/18 08:09 NAT0019 ED-C19)
Vital Signs from Bedside Monitors
Vital Signs

Heart Rate	76
Pulse Rate	77
Respiratory Rate	28
O2 Sat by Pulse Oximetry	94
Blood Pressure (mmHg)	94/65
Blood Pressure Mean	77

Document 09/19/18 07:30 NAT0019 (Rec: 09/19/18 08:09 NAT0019 ED-C19)
Vital Signs from Bedside Monitors
Vital Signs

Heart Rate	84
Pulse Rate	83
Respiratory Rate	27
O2 Sat by Pulse Oximetry	96

Document 09/19/18 07:31 NAT0019 (Rec: 09/19/18 08:09 NAT0019 ED-C19)
Vital Signs from Bedside Monitors
Vital Signs

Heart Rate	90
Pulse Rate	81
Respiratory Rate	29
O2 Sat by Pulse Oximetry	94
Blood Pressure (mmHg)	114/74
Blood Pressure Mean	83

Document 09/19/18 08:00 NAT0019 (Rec: 09/19/18 08:09 NAT0019 ED-C19)
Vital Signs from Bedside Monitors
Vital Signs

Heart Rate	78
Pulse Rate	76

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Respiratory Rate 27
O2 Sat by Pulse Oximetry 96

Document 09/19/18 08:01 NAT0019 (Rec: 09/19/18 08:09 NAT0019 ED-C19)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 77
Pulse Rate 74
Respiratory Rate 24
O2 Sat by Pulse Oximetry 100
Blood Pressure (mmHg) 139/75
Blood Pressure Mean 83

Vital Signs-Bedside Monitor Auto Capture Start: 09/19/18 08:47
Text: Status: Inactive
Freq: Q1HR
Protocol:

Document 09/19/18 08:10 ROS0014 (Rec: 09/19/18 09:17 ROS0014 ISDEMO-M05)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 74
Pulse Rate 76
Respiratory Rate 23
O2 Sat by Pulse Oximetry 98

Document 09/19/18 08:15 ROS0014 (Rec: 09/19/18 09:17 ROS0014 ISDEMO-M05)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 74
Pulse Rate 75
Respiratory Rate 23
O2 Sat by Pulse Oximetry 99

Document 09/19/18 08:20 ROS0014 (Rec: 09/19/18 09:17 ROS0014 ISDEMO-M05)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 76
Pulse Rate 76
Respiratory Rate 23
O2 Sat by Pulse Oximetry 99

Document 09/19/18 08:25 ROS0014 (Rec: 09/19/18 09:17 ROS0014 ISDEMO-M05)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 79
Pulse Rate 79
Respiratory Rate 23
O2 Sat by Pulse Oximetry 98

Document 09/19/18 08:30 ROS0014 (Rec: 09/19/18 09:17 ROS0014 ISDEMO-M05)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 79
Pulse Rate 78
Respiratory Rate 23
O2 Sat by Pulse Oximetry 99

Document 09/19/18 08:32 ROS0014 (Rec: 09/19/18 09:17 ROS0014 ISDEMO-M05)
Vital Signs from Bedside Monitors
Vital Signs

Continued on Page 324

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Heart Rate 78
Pulse Rate 79
Respiratory Rate 27
O2 Sat by Pulse Oximetry 94
Blood Pressure (mmHg) 146/78
Blood Pressure Mean 101

Document 09/19/18 08:35 ROS0014 (Rec: 09/19/18 09:17 ROS0014 ISDEMO-M05)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 76
Pulse Rate 76
Respiratory Rate 24
O2 Sat by Pulse Oximetry 99

Document 09/19/18 08:40 ROS0014 (Rec: 09/19/18 09:17 ROS0014 ISDEMO-M05)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 79
Pulse Rate 78
Respiratory Rate 21
O2 Sat by Pulse Oximetry 98

Document 09/19/18 08:45 ROS0014 (Rec: 09/19/18 09:17 ROS0014 ISDEMO-M05)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 85
Pulse Rate 81
Respiratory Rate 23
O2 Sat by Pulse Oximetry 98

Document 09/19/18 09:01 ROS0014 (Rec: 09/19/18 09:17 ROS0014 ISDEMO-M05)
Vital Signs from Bedside Monitors
Vital Signs
Pulse Rate 89
O2 Sat by Pulse Oximetry 98

Document 09/19/18 09:04 ROS0014 (Rec: 09/19/18 09:17 ROS0014 ISDEMO-M05)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 84
Pulse Rate 84
Respiratory Rate 19
O2 Sat by Pulse Oximetry 98
Blood Pressure (mmHg) 148/106
Blood Pressure Mean 125

Document 09/19/18 09:06 ROS0014 (Rec: 09/19/18 09:17 ROS0014 ISDEMO-M05)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 83
Pulse Rate 82
Respiratory Rate 23
O2 Sat by Pulse Oximetry 97

Document 09/19/18 09:10 ROS0014 (Rec: 09/19/18 09:17 ROS0014 ISDEMO-M05)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 91
Pulse Rate 90

Continued on Page 325

Assessments and Treatments - Continued

Respiratory Rate 25
O2 Sat by Pulse Oximetry 97

Document 09/19/18 09:11 ROS0014 (Rec: 09/19/18 09:17 ROS0014 ISDEMO-M05)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 82
Pulse Rate 82
Respiratory Rate 22
O2 Sat by Pulse Oximetry 96
Blood Pressure (mmHg) 143/97
Blood Pressure Mean 105

Document 09/19/18 09:15 ROS0014 (Rec: 09/19/18 09:17 ROS0014 ISDEMO-M05)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 80
Pulse Rate 80
Respiratory Rate 18
O2 Sat by Pulse Oximetry 96
Blood Pressure (mmHg) 131/98
Blood Pressure Mean 113

Document 09/19/18 09:20 KYL0009 (Rec: 09/19/18 10:55 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 81
Pulse Rate 81
Respiratory Rate 21
O2 Sat by Pulse Oximetry 95

Document 09/19/18 09:25 KYL0009 (Rec: 09/19/18 10:55 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 78
Pulse Rate 79
Respiratory Rate 19
O2 Sat by Pulse Oximetry 96

Document 09/19/18 09:30 KYL0009 (Rec: 09/19/18 10:55 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 79
Pulse Rate 77
Respiratory Rate 20
O2 Sat by Pulse Oximetry 95
Blood Pressure (mmHg) 129/94
Blood Pressure Mean 110

Document 09/19/18 09:35 KYL0009 (Rec: 09/19/18 10:55 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 79
Pulse Rate 79
Respiratory Rate 21
O2 Sat by Pulse Oximetry 94

Document 09/19/18 09:40 KYL0009 (Rec: 09/19/18 10:55 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs

Continued on Page 326

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Heart Rate 84
Pulse Rate 89
Respiratory Rate 20
O2 Sat by Pulse Oximetry 97

Document 09/19/18 09:45 KYL0009 (Rec: 09/19/18 10:55 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 75
Pulse Rate 74
Respiratory Rate 20
O2 Sat by Pulse Oximetry 94
Blood Pressure (mmHg) 131/88
Blood Pressure Mean 99

Document 09/19/18 09:50 KYL0009 (Rec: 09/19/18 10:55 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 77
Pulse Rate 77
Respiratory Rate 20
O2 Sat by Pulse Oximetry 93

Document 09/19/18 09:55 KYL0009 (Rec: 09/19/18 10:55 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 76
Pulse Rate 78
Respiratory Rate 22
O2 Sat by Pulse Oximetry 93

Document 09/19/18 10:00 KYL0009 (Rec: 09/19/18 10:55 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 77
Pulse Rate 78
Respiratory Rate 14
O2 Sat by Pulse Oximetry 95
Blood Pressure (mmHg) 147/98
Blood Pressure Mean 110

Document 09/19/18 10:05 KYL0009 (Rec: 09/19/18 10:55 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 77
Pulse Rate 77
Respiratory Rate 20
O2 Sat by Pulse Oximetry 95

Document 09/19/18 10:10 KYL0009 (Rec: 09/19/18 10:55 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 77
Pulse Rate 77
Respiratory Rate 20
O2 Sat by Pulse Oximetry 94

Document 09/19/18 10:15 KYL0009 (Rec: 09/19/18 10:55 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs

Continued on Page 327

Assessments and Treatments - Continued

Heart Rate 105
Pulse Rate 104
Respiratory Rate 18
O2 Sat by Pulse Oximetry 95
Blood Pressure (mmHg) 130/88
Blood Pressure Mean 97

Document 09/19/18 10:20 KYL0009 (Rec: 09/19/18 10:55 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 74
Pulse Rate 76
Respiratory Rate 18
O2 Sat by Pulse Oximetry 94

Document 09/19/18 10:25 KYL0009 (Rec: 09/19/18 10:55 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 87
Pulse Rate 90
Respiratory Rate 23
O2 Sat by Pulse Oximetry 94

Document 09/19/18 10:30 KYL0009 (Rec: 09/19/18 10:55 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 95
Pulse Rate 95
Respiratory Rate 20
O2 Sat by Pulse Oximetry 94

Document 09/19/18 10:31 KYL0009 (Rec: 09/19/18 10:55 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 90
Pulse Rate 90
Respiratory Rate 21
O2 Sat by Pulse Oximetry 92
Blood Pressure (mmHg) 141/115
Blood Pressure Mean 131

Document 09/19/18 10:35 KYL0009 (Rec: 09/19/18 10:55 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 92
Pulse Rate 93
Respiratory Rate 28
O2 Sat by Pulse Oximetry 93

Document 09/19/18 10:40 KYL0009 (Rec: 09/19/18 10:55 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 80
Pulse Rate 81
Respiratory Rate 9
O2 Sat by Pulse Oximetry 94

Document 09/19/18 10:45 KYL0009 (Rec: 09/19/18 10:55 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs

Continued on Page 328

Assessments and Treatments - Continued

Heart Rate 80
Pulse Rate 80
Respiratory Rate 9
O2 Sat by Pulse Oximetry 95
Blood Pressure (mmHg) 144/89
Blood Pressure Mean 100

Document 09/19/18 10:50 KYL0009 (Rec: 09/19/18 10:55 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 79
Pulse Rate 79
Respiratory Rate 22
O2 Sat by Pulse Oximetry 95

Document 09/19/18 10:55 KYL0009 (Rec: 09/19/18 11:39 KYL0009 ICU-M27)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 79
Pulse Rate 81
Respiratory Rate 6
O2 Sat by Pulse Oximetry 94

Document 09/19/18 11:00 KYL0009 (Rec: 09/19/18 11:39 KYL0009 ICU-M27)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 80
Pulse Rate 80
Respiratory Rate 16
O2 Sat by Pulse Oximetry 95
Blood Pressure (mmHg) 151/91
Blood Pressure Mean 103

Document 09/19/18 11:05 KYL0009 (Rec: 09/19/18 11:39 KYL0009 ICU-M27)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 90
Pulse Rate 87
Respiratory Rate 24
O2 Sat by Pulse Oximetry 95

Document 09/19/18 11:10 KYL0009 (Rec: 09/19/18 11:39 KYL0009 ICU-M27)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 88
Pulse Rate 89
Respiratory Rate 18
O2 Sat by Pulse Oximetry 94

Document 09/19/18 11:15 KYL0009 (Rec: 09/19/18 11:39 KYL0009 ICU-M27)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 74
Pulse Rate 85
Respiratory Rate 22
O2 Sat by Pulse Oximetry 94
Blood Pressure (mmHg) 149/95
Blood Pressure Mean 108

Document 09/19/18 11:20 KYL0009 (Rec: 09/19/18 11:39 KYL0009 ICU-M27)

Continued on Page 329

Assessments and Treatments - Continued

Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 89
Pulse Rate 88
Respiratory Rate 31
O2 Sat by Pulse Oximetry 94
Document 09/19/18 11:25 KYL0009 (Rec: 09/19/18 11:39 KYL0009 ICU-M27)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 80
Pulse Rate 81
Respiratory Rate 18
O2 Sat by Pulse Oximetry 96
Document 09/19/18 11:30 KYL0009 (Rec: 09/19/18 11:39 KYL0009 ICU-M27)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 84
Pulse Rate 83
Respiratory Rate 26
O2 Sat by Pulse Oximetry 95
Blood Pressure (mmHg) 143/95
Blood Pressure Mean 107
Document 09/19/18 11:35 KYL0009 (Rec: 09/19/18 11:39 KYL0009 ICU-M27)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 97
Pulse Rate 95
Respiratory Rate 15
O2 Sat by Pulse Oximetry 95
Document 09/19/18 11:40 KYL0009 (Rec: 09/19/18 12:32 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 81
Pulse Rate 83
Respiratory Rate 18
O2 Sat by Pulse Oximetry 95
Document 09/19/18 11:45 KYL0009 (Rec: 09/19/18 12:32 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 78
Pulse Rate 78
Respiratory Rate 24
O2 Sat by Pulse Oximetry 96
Document 09/19/18 11:50 KYL0009 (Rec: 09/19/18 12:32 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 75
Pulse Rate 75
Respiratory Rate 19
O2 Sat by Pulse Oximetry 95
Document 09/19/18 11:55 KYL0009 (Rec: 09/19/18 12:32 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs

Continued on Page 330

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01

62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Heart Rate 79
Pulse Rate 80
Respiratory Rate 19
O2 Sat by Pulse Oximetry 95

Document 09/19/18 12:00 KYL0009 (Rec: 09/19/18 12:32 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 88
Pulse Rate 88
Respiratory Rate 14
O2 Sat by Pulse Oximetry 96
Blood Pressure (mmHg) 147/104
Blood Pressure Mean 116

Document 09/19/18 12:05 KYL0009 (Rec: 09/19/18 12:32 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 75
Pulse Rate 76
Respiratory Rate 22
O2 Sat by Pulse Oximetry 97

Document 09/19/18 12:10 KYL0009 (Rec: 09/19/18 12:32 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 100
Pulse Rate 98
Respiratory Rate 12
O2 Sat by Pulse Oximetry 94

Document 09/19/18 12:15 KYL0009 (Rec: 09/19/18 12:32 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 85
Pulse Rate 86
Respiratory Rate 12
O2 Sat by Pulse Oximetry 94

Document 09/19/18 12:20 KYL0009 (Rec: 09/19/18 12:32 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 81
Pulse Rate 80
Respiratory Rate 18
O2 Sat by Pulse Oximetry 93

Document 09/19/18 12:25 KYL0009 (Rec: 09/19/18 12:32 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 84
Pulse Rate 84
Respiratory Rate 18
O2 Sat by Pulse Oximetry 94

Document 09/19/18 12:30 KYL0009 (Rec: 09/19/18 12:32 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 80
Pulse Rate 81

Continued on Page 331

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Respiratory Rate 11
O2 Sat by Pulse Oximetry 94

Document 09/19/18 12:35 KYL0009 (Rec: 09/19/18 13:29 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 83
Pulse Rate 82
Respiratory Rate 15
O2 Sat by Pulse Oximetry 93

Document 09/19/18 12:40 KYL0009 (Rec: 09/19/18 13:29 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 82
Pulse Rate 82
Respiratory Rate 16
O2 Sat by Pulse Oximetry 92

Document 09/19/18 12:45 KYL0009 (Rec: 09/19/18 13:29 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 81
Pulse Rate 81
Respiratory Rate 16
O2 Sat by Pulse Oximetry 92

Document 09/19/18 12:50 KYL0009 (Rec: 09/19/18 13:29 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 80
Pulse Rate 80
Respiratory Rate 17
O2 Sat by Pulse Oximetry 92

Document 09/19/18 12:55 KYL0009 (Rec: 09/19/18 13:29 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 82
Pulse Rate 83
Respiratory Rate 16
O2 Sat by Pulse Oximetry 94

Document 09/19/18 13:00 KYL0009 (Rec: 09/19/18 13:29 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 90
Pulse Rate 90
Respiratory Rate 17
O2 Sat by Pulse Oximetry 95
Blood Pressure (mmHg) 144/101
Blood Pressure Mean 115

Document 09/19/18 13:05 KYL0009 (Rec: 09/19/18 13:29 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 81
Pulse Rate 82
Respiratory Rate 19
O2 Sat by Pulse Oximetry 93

Continued on Page 332

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01

62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Document 09/19/18 13:10 KYL0009 (Rec: 09/19/18 13:29 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 92
Pulse Rate 92
Respiratory Rate 20
O2 Sat by Pulse Oximetry 94

Document 09/19/18 13:15 KYL0009 (Rec: 09/19/18 13:29 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 85
Pulse Rate 83
Respiratory Rate 17
O2 Sat by Pulse Oximetry 96

Document 09/19/18 13:20 KYL0009 (Rec: 09/19/18 13:29 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 83
Pulse Rate 83
Respiratory Rate 13
O2 Sat by Pulse Oximetry 95

Document 09/19/18 13:25 KYL0009 (Rec: 09/19/18 13:29 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 82
Pulse Rate 83
Respiratory Rate 21
O2 Sat by Pulse Oximetry 94

Document 09/19/18 13:30 ROS0014 (Rec: 09/19/18 15:05 ROS0014 ISDEMO-M05)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 83
Pulse Rate 84
Respiratory Rate 18
O2 Sat by Pulse Oximetry 94

Document 09/19/18 13:35 ROS0014 (Rec: 09/19/18 15:05 ROS0014 ISDEMO-M05)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 80
Pulse Rate 81
Respiratory Rate 16
O2 Sat by Pulse Oximetry 94

Document 09/19/18 13:40 ROS0014 (Rec: 09/19/18 15:05 ROS0014 ISDEMO-M05)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 79
Pulse Rate 79
Respiratory Rate 17
O2 Sat by Pulse Oximetry 94

Document 09/19/18 13:45 ROS0014 (Rec: 09/19/18 15:05 ROS0014 ISDEMO-M05)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 79

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Assessments and Treatments - Continued

Pulse Rate 79
Respiratory Rate 15
O2 Sat by Pulse Oximetry 93

Document 09/19/18 13:50 ROS0014 (Rec: 09/19/18 15:05 ROS0014 ISDEMO-M05)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 82
Pulse Rate 81
Respiratory Rate 16
O2 Sat by Pulse Oximetry 93

Document 09/19/18 13:55 ROS0014 (Rec: 09/19/18 15:05 ROS0014 ISDEMO-M05)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 79
Pulse Rate 79
Respiratory Rate 15
O2 Sat by Pulse Oximetry 93

Document 09/19/18 14:00 ROS0014 (Rec: 09/19/18 15:05 ROS0014 ISDEMO-M05)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 78
Pulse Rate 78
Respiratory Rate 15
O2 Sat by Pulse Oximetry 93
Blood Pressure (mmHg) 122/78
Blood Pressure Mean 86

Document 09/19/18 14:05 ROS0014 (Rec: 09/19/18 15:05 ROS0014 ISDEMO-M05)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 78
Pulse Rate 78
Respiratory Rate 15
O2 Sat by Pulse Oximetry 93

Document 09/19/18 14:10 ROS0014 (Rec: 09/19/18 15:05 ROS0014 ISDEMO-M05)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 78
Pulse Rate 78
Respiratory Rate 16
O2 Sat by Pulse Oximetry 93

Document 09/19/18 14:15 ROS0014 (Rec: 09/19/18 15:05 ROS0014 ISDEMO-M05)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 78
Pulse Rate 78
Respiratory Rate 16
O2 Sat by Pulse Oximetry 93

Document 09/19/18 14:20 ROS0014 (Rec: 09/19/18 15:05 ROS0014 ISDEMO-M05)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 78
Pulse Rate 79
Respiratory Rate 16

Continued on Page 334

O2 Sat by Pulse Oximetry 93
Document 09/19/18 14:25 ROS0014 (Rec: 09/19/18 15:05 ROS0014 ISDEMO-M05)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 78
Pulse Rate 78
Respiratory Rate 16
O2 Sat by Pulse Oximetry 93
Document 09/19/18 14:30 ROS0014 (Rec: 09/19/18 15:05 ROS0014 ISDEMO-M05)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 79
Pulse Rate 79
Respiratory Rate 18
O2 Sat by Pulse Oximetry 94
Document 09/19/18 14:35 ROS0014 (Rec: 09/19/18 15:05 ROS0014 ISDEMO-M05)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 118
Pulse Rate 116
Respiratory Rate 18
O2 Sat by Pulse Oximetry 94
Document 09/19/18 14:40 ROS0014 (Rec: 09/19/18 15:05 ROS0014 ISDEMO-M05)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 97
Pulse Rate 97
Respiratory Rate 22
O2 Sat by Pulse Oximetry 96
Document 09/19/18 14:45 ROS0014 (Rec: 09/19/18 15:05 ROS0014 ISDEMO-M05)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 85
Pulse Rate 86
Respiratory Rate 22
O2 Sat by Pulse Oximetry 96
Document 09/19/18 14:50 ROS0014 (Rec: 09/19/18 15:05 ROS0014 ISDEMO-M05)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 99
Pulse Rate 100
Respiratory Rate 17
O2 Sat by Pulse Oximetry 96
Document 09/19/18 14:55 ROS0014 (Rec: 09/19/18 15:05 ROS0014 ISDEMO-M05)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 87
Pulse Rate 87
Respiratory Rate 11
O2 Sat by Pulse Oximetry 95
Document 09/19/18 15:00 ROS0014 (Rec: 09/19/18 15:05 ROS0014 ISDEMO-M05)
Vital Signs from Bedside Monitors
Vital Signs

Continued on Page 335

Assessments and Treatments - Continued

Heart Rate 86
Pulse Rate 86
Respiratory Rate 21
O2 Sat by Pulse Oximetry 95

Document 09/19/18 15:04 ROS0014 (Rec: 09/19/18 15:05 ROS0014 ISDEMO-M05)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 89
Pulse Rate 90
Respiratory Rate 19
O2 Sat by Pulse Oximetry 95
Blood Pressure (mmHg) 137/94
Blood Pressure Mean 107

Document 09/19/18 15:05 KYL0009 (Rec: 09/19/18 16:14 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 82
Pulse Rate 84
Respiratory Rate 16
O2 Sat by Pulse Oximetry 95

Document 09/19/18 15:10 KYL0009 (Rec: 09/19/18 16:14 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 93
Pulse Rate 93
Respiratory Rate 20
O2 Sat by Pulse Oximetry 95

Document 09/19/18 15:34 KYL0009 (Rec: 09/19/18 16:14 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 79
Pulse Rate 80
Respiratory Rate 10
O2 Sat by Pulse Oximetry 96

Document 09/19/18 15:35 KYL0009 (Rec: 09/19/18 16:14 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 89
Pulse Rate 88
Respiratory Rate 25
O2 Sat by Pulse Oximetry 95

Document 09/19/18 15:40 KYL0009 (Rec: 09/19/18 16:14 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 91
Pulse Rate 91
Respiratory Rate 27
O2 Sat by Pulse Oximetry 95

Document 09/19/18 15:45 KYL0009 (Rec: 09/19/18 16:14 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 88
Pulse Rate 89

Continued on Page 336

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Respiratory Rate 20
O2 Sat by Pulse Oximetry 95

Document 09/19/18 15:50 KYL0009 (Rec: 09/19/18 16:14 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 94
Pulse Rate 93
Respiratory Rate 19
O2 Sat by Pulse Oximetry 95

Document 09/19/18 15:55 KYL0009 (Rec: 09/19/18 16:14 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 88
Pulse Rate 89
Respiratory Rate 24
O2 Sat by Pulse Oximetry 95

Document 09/19/18 16:00 KYL0009 (Rec: 09/19/18 16:14 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 94
Pulse Rate 91
Respiratory Rate 28
O2 Sat by Pulse Oximetry 95

Document 09/19/18 16:05 KYL0009 (Rec: 09/19/18 16:14 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 83
Pulse Rate 83
Respiratory Rate 17
O2 Sat by Pulse Oximetry 95

Document 09/19/18 16:08 KYL0009 (Rec: 09/19/18 16:14 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 80
Pulse Rate 81
Respiratory Rate 18
O2 Sat by Pulse Oximetry 95
Blood Pressure (mmHg) 129/88
Blood Pressure Mean 104

Document 09/19/18 16:10 KYL0009 (Rec: 09/19/18 16:14 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 85
Pulse Rate 84
Respiratory Rate 19
O2 Sat by Pulse Oximetry 95

Document 09/19/18 16:15 KYL0009 (Rec: 09/19/18 17:55 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 90
Pulse Rate 92
Respiratory Rate 23
O2 Sat by Pulse Oximetry 95

Continued on Page 337

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Document 09/19/18 16:20 KYL0009 (Rec: 09/19/18 17:55 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 91
Pulse Rate 91
Respiratory Rate 13
O2 Sat by Pulse Oximetry 95

Document 09/19/18 16:25 KYL0009 (Rec: 09/19/18 17:55 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 95
Respiratory Rate 16

Document 09/19/18 16:30 KYL0009 (Rec: 09/19/18 17:55 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 92
Respiratory Rate 14

Document 09/19/18 17:06 KYL0009 (Rec: 09/19/18 17:55 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Pulse Rate 87
O2 Sat by Pulse Oximetry 96

Document 09/19/18 17:10 KYL0009 (Rec: 09/19/18 17:55 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 93
Pulse Rate 94
Respiratory Rate 22
O2 Sat by Pulse Oximetry 96

Document 09/19/18 17:15 KYL0009 (Rec: 09/19/18 17:55 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 96
Pulse Rate 95
Respiratory Rate 22
O2 Sat by Pulse Oximetry 95

Document 09/19/18 17:20 KYL0009 (Rec: 09/19/18 17:55 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 102
Pulse Rate 102
Respiratory Rate 27
O2 Sat by Pulse Oximetry 95

Document 09/19/18 17:25 KYL0009 (Rec: 09/19/18 17:55 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 98
Pulse Rate 97
Respiratory Rate 23
O2 Sat by Pulse Oximetry 96

Document 09/19/18 17:30 KYL0009 (Rec: 09/19/18 17:55 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs

Continued on Page 338

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01

62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

```
        Heart Rate                          93
        Pulse Rate                          92
        Respiratory Rate                    24
        O2 Sat by Pulse Oximetry            96
Document     09/19/18 17:35  KYL0009  (Rec: 09/19/18 17:55  KYL0009  ICU-C12)
Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate                          84
        Pulse Rate                          86
        Respiratory Rate                    18
        O2 Sat by Pulse Oximetry            96
Document     09/19/18 17:40  KYL0009  (Rec: 09/19/18 17:55  KYL0009  ICU-C12)
Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate                          87
        Pulse Rate                          89
        Respiratory Rate                    17
        O2 Sat by Pulse Oximetry            95
Document     09/19/18 17:45  KYL0009  (Rec: 09/19/18 17:55  KYL0009  ICU-C12)
Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate                          88
        Pulse Rate                          88
        Respiratory Rate                    21
        O2 Sat by Pulse Oximetry            96
Document     09/19/18 17:50  KYL0009  (Rec: 09/19/18 17:55  KYL0009  ICU-C12)
Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate                          94
        Pulse Rate                          94
        Respiratory Rate                    21
        O2 Sat by Pulse Oximetry            96
Document     09/19/18 17:55  KYL0009  (Rec: 09/19/18 18:27  KYL0009  ICU-C12)
Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate                          93
        Pulse Rate                          92
        Respiratory Rate                    24
        O2 Sat by Pulse Oximetry            96
Document     09/19/18 18:00  KYL0009  (Rec: 09/19/18 18:27  KYL0009  ICU-C12)
Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate                          100
        Pulse Rate                          100
        Respiratory Rate                    23
        O2 Sat by Pulse Oximetry            96
Document     09/19/18 18:05  KYL0009  (Rec: 09/19/18 18:27  KYL0009  ICU-C12)
Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate                          94
        Pulse Rate                          93
        Respiratory Rate                    18
        O2 Sat by Pulse Oximetry            96
```

Continued on Page 339

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Document 09/19/18 18:10 KYL0009 (Rec: 09/19/18 18:27 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 88
Pulse Rate 89
Respiratory Rate 23
O2 Sat by Pulse Oximetry 95

Document 09/19/18 18:15 KYL0009 (Rec: 09/19/18 18:27 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 85
Pulse Rate 85
Respiratory Rate 18
O2 Sat by Pulse Oximetry 95

Document 09/19/18 18:20 KYL0009 (Rec: 09/19/18 18:27 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 102
Pulse Rate 102
Respiratory Rate 30
O2 Sat by Pulse Oximetry 96

Document 09/19/18 18:21 KYL0009 (Rec: 09/19/18 18:27 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 104
Pulse Rate 104
Respiratory Rate 22
O2 Sat by Pulse Oximetry 95
Blood Pressure (mmHg) 147/96
Blood Pressure Mean 116

Document 09/19/18 18:25 KYL0009 (Rec: 09/19/18 18:27 KYL0009 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 92
Pulse Rate 93
Respiratory Rate 28
O2 Sat by Pulse Oximetry 95

Document 09/19/18 18:30 SON0056 (Rec: 09/19/18 20:40 SON0056 PACRM-C14)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 94
Pulse Rate 95
Respiratory Rate 27
O2 Sat by Pulse Oximetry 95
Blood Pressure (mmHg) 154/86
Blood Pressure Mean 114

Document 09/19/18 18:35 SON0056 (Rec: 09/19/18 20:40 SON0056 PACRM-C14)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 87
Pulse Rate 88
Respiratory Rate 22
O2 Sat by Pulse Oximetry 96

Continued on Page 340

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01

62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Document 09/19/18 18:40 SON0056 (Rec: 09/19/18 20:40 SON0056 PACRM-C14)

Vital Signs from Bedside Monitors

Vital Signs

Heart Rate	91
Pulse Rate	91
Respiratory Rate	25
O2 Sat by Pulse Oximetry	97

Document 09/19/18 18:45 SON0056 (Rec: 09/19/18 20:40 SON0056 PACRM-C14)

Vital Signs from Bedside Monitors

Vital Signs

Heart Rate	88
Pulse Rate	87
Respiratory Rate	23
O2 Sat by Pulse Oximetry	96

Document 09/19/18 18:50 SON0056 (Rec: 09/19/18 20:40 SON0056 PACRM-C14)

Vital Signs from Bedside Monitors

Vital Signs

Heart Rate	92
Pulse Rate	92
Respiratory Rate	23
O2 Sat by Pulse Oximetry	95

Document 09/19/18 18:55 SON0056 (Rec: 09/19/18 20:40 SON0056 PACRM-C14)

Vital Signs from Bedside Monitors

Vital Signs

Heart Rate	89
Pulse Rate	88
Respiratory Rate	21
O2 Sat by Pulse Oximetry	95

Document 09/19/18 19:00 SON0056 (Rec: 09/19/18 20:40 SON0056 PACRM-C14)

Vital Signs from Bedside Monitors

Vital Signs

Heart Rate	89
Pulse Rate	88
Respiratory Rate	19
O2 Sat by Pulse Oximetry	96
Blood Pressure (mmHg)	126/89
Blood Pressure Mean	106

Document 09/19/18 19:05 SON0056 (Rec: 09/19/18 20:40 SON0056 PACRM-C14)

Vital Signs from Bedside Monitors

Vital Signs

Heart Rate	98
Pulse Rate	98
Respiratory Rate	15
O2 Sat by Pulse Oximetry	96

Document 09/19/18 19:10 SON0056 (Rec: 09/19/18 20:40 SON0056 PACRM-C14)

Vital Signs from Bedside Monitors

Vital Signs

Heart Rate	92
Pulse Rate	92
Respiratory Rate	29
O2 Sat by Pulse Oximetry	96

Document 09/19/18 19:15 SON0056 (Rec: 09/19/18 20:40 SON0056 PACRM-C14)

Vital Signs from Bedside Monitors

Continued on Page 341

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01

62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Vital Signs
Heart Rate 99
Pulse Rate 99
Respiratory Rate 18
O2 Sat by Pulse Oximetry 96

Document 09/19/18 19:20 SON0056 (Rec: 09/19/18 20:40 SON0056 PACRM-C14)

Vital Signs from Bedside Monitors

Vital Signs
Heart Rate 92
Pulse Rate 90
Respiratory Rate 21
O2 Sat by Pulse Oximetry 96

Document 09/19/18 19:25 SON0056 (Rec: 09/19/18 20:40 SON0056 PACRM-C14)

Vital Signs from Bedside Monitors

Vital Signs
Heart Rate 92
Pulse Rate 91
Respiratory Rate 23
O2 Sat by Pulse Oximetry 96

Document 09/19/18 19:30 SON0056 (Rec: 09/19/18 20:40 SON0056 PACRM-C14)

Vital Signs from Bedside Monitors

Vital Signs
Heart Rate 111
Pulse Rate 112
Respiratory Rate 20
O2 Sat by Pulse Oximetry 97
Blood Pressure (mmHg) 154/105
Blood Pressure Mean 122

Document 09/19/18 19:35 SON0056 (Rec: 09/19/18 20:40 SON0056 PACRM-C14)

Vital Signs from Bedside Monitors

Vital Signs
Pulse Rate 113
O2 Sat by Pulse Oximetry 96

Document 09/19/18 19:40 SON0056 (Rec: 09/19/18 20:40 SON0056 PACRM-C14)

Vital Signs from Bedside Monitors

Vital Signs
Pulse Rate 108
O2 Sat by Pulse Oximetry 95

Document 09/19/18 20:19 SON0056 (Rec: 09/19/18 20:40 SON0056 PACRM-C14)

Vital Signs from Bedside Monitors

Vital Signs
Pulse Rate 96
O2 Sat by Pulse Oximetry 97
Blood Pressure (mmHg) 172/104
Blood Pressure Mean 117

Document 09/19/18 20:20 SON0056 (Rec: 09/19/18 20:40 SON0056 PACRM-C14)

Vital Signs from Bedside Monitors

Vital Signs
Pulse Rate 96
O2 Sat by Pulse Oximetry 96
Blood Pressure (mmHg) 163/114
Blood Pressure Mean 123

Document 09/19/18 20:21 SON0056 (Rec: 09/19/18 20:40 SON0056 PACRM-C14)

Continued on Page 342

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01

62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Vital Signs from Bedside Monitors
    Vital Signs
        Pulse Rate 94
        O2 Sat by Pulse Oximetry 96
        Blood Pressure (mmHg) 150/98
        Blood Pressure Mean 120

Document 09/19/18 20:23 SON0056 (Rec: 09/19/18 20:40 SON0056 PACRM-C14)

Vital Signs from Bedside Monitors
    Vital Signs
        Pulse Rate 92
        O2 Sat by Pulse Oximetry 95

Document 09/19/18 20:25 SON0056 (Rec: 09/19/18 20:40 SON0056 PACRM-C14)

Vital Signs from Bedside Monitors
    Vital Signs
        Pulse Rate 89
        O2 Sat by Pulse Oximetry 96
        Blood Pressure (mmHg) 169/107
        Blood Pressure Mean 126

Document 09/19/18 20:30 SON0056 (Rec: 09/19/18 20:40 SON0056 PACRM-C14)

Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate 97
        Pulse Rate 97
        Respiratory Rate 13
        O2 Sat by Pulse Oximetry 96
        Blood Pressure (mmHg) 184/111
        Blood Pressure Mean 119

Document 09/19/18 20:31 SON0056 (Rec: 09/19/18 20:40 SON0056 PACRM-C14)

Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate 91
        Pulse Rate 92
        Respiratory Rate 27
        O2 Sat by Pulse Oximetry 96
        Blood Pressure (mmHg) 169/118
        Blood Pressure Mean 131

Document 09/19/18 20:35 SON0056 (Rec: 09/19/18 20:40 SON0056 PACRM-C14)

Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate 98
        Pulse Rate 97
        Respiratory Rate 22
        O2 Sat by Pulse Oximetry 95

Document 09/19/18 20:36 SON0056 (Rec: 09/19/18 20:40 SON0056 PACRM-C14)

Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate 98
        Pulse Rate 97
        Respiratory Rate 20
        O2 Sat by Pulse Oximetry 96
        Blood Pressure (mmHg) 164/106
        Blood Pressure Mean 114

Document 09/19/18 20:40 KIM0006 (Rec: 09/19/18 22:12 KIM0006 ICU-M27)

Continued on Page 343

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate   96
        Respiratory Rate   18

Document   09/19/18 20:48 KIM0006 (Rec: 09/19/18 22:12 KIM0006 ICU-M27)
Vital Signs from Bedside Monitors
    Vital Signs
        Pulse Rate   97
        O2 Sat by Pulse Oximetry   96

Document   09/19/18 20:49 KIM0006 (Rec: 09/19/18 22:12 KIM0006 ICU-M27)
Vital Signs from Bedside Monitors
    Vital Signs
        Pulse Rate   103
        O2 Sat by Pulse Oximetry   96
        Blood Pressure (mmHg)   169/103
        Blood Pressure Mean   125

Document   09/19/18 20:51 KIM0006 (Rec: 09/19/18 22:12 KIM0006 ICU-M27)
Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate   91
        Pulse Rate   92
        Respiratory Rate   11
        O2 Sat by Pulse Oximetry   97

Document   09/19/18 20:55 KIM0006 (Rec: 09/19/18 22:12 KIM0006 ICU-M27)
Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate   85
        Pulse Rate   85
        Respiratory Rate   17
        O2 Sat by Pulse Oximetry   96

Document   09/19/18 21:00 KIM0006 (Rec: 09/19/18 22:12 KIM0006 ICU-M27)
Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate   95
        Pulse Rate   96
        Respiratory Rate   15
        O2 Sat by Pulse Oximetry   96
        Blood Pressure (mmHg)   152/114
        Blood Pressure Mean   131

Document   09/19/18 21:05 KIM0006 (Rec: 09/19/18 22:12 KIM0006 ICU-M27)
Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate   96
        Pulse Rate   95
        Respiratory Rate   30
        O2 Sat by Pulse Oximetry   96

Document   09/19/18 21:10 KIM0006 (Rec: 09/19/18 22:12 KIM0006 ICU-M27)
Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate   88
        Pulse Rate   88
        Respiratory Rate   22
        O2 Sat by Pulse Oximetry   96

Continued on Page 344

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01

62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Document 09/19/18 21:15 KIM0006 (Rec: 09/19/18 22:12 KIM0006 ICU-M27)
Vital Signs from Bedside Monitors
Vital Signs

Heart Rate	86
Pulse Rate	86
Respiratory Rate	20
O2 Sat by Pulse Oximetry	95
Blood Pressure (mmHg)	165/98
Blood Pressure Mean	109

Document 09/19/18 21:20 KIM0006 (Rec: 09/19/18 22:12 KIM0006 ICU-M27)
Vital Signs from Bedside Monitors
Vital Signs

Heart Rate	99
Pulse Rate	101
Respiratory Rate	32
O2 Sat by Pulse Oximetry	95

Document 09/19/18 21:25 KIM0006 (Rec: 09/19/18 22:12 KIM0006 ICU-M27)
Vital Signs from Bedside Monitors
Vital Signs

Heart Rate	94
Pulse Rate	93
Respiratory Rate	19
O2 Sat by Pulse Oximetry	97

Document 09/19/18 21:30 KIM0006 (Rec: 09/19/18 22:12 KIM0006 ICU-M27)
Vital Signs from Bedside Monitors
Vital Signs

Heart Rate	96
Pulse Rate	96
Respiratory Rate	18
O2 Sat by Pulse Oximetry	96

Document 09/19/18 21:35 KIM0006 (Rec: 09/19/18 22:12 KIM0006 ICU-M27)
Vital Signs from Bedside Monitors
Vital Signs

Heart Rate	94
Pulse Rate	94
Respiratory Rate	17
O2 Sat by Pulse Oximetry	97

Document 09/19/18 21:40 KIM0006 (Rec: 09/19/18 22:12 KIM0006 ICU-M27)
Vital Signs from Bedside Monitors
Vital Signs

Heart Rate	91
Pulse Rate	90
Respiratory Rate	28
O2 Sat by Pulse Oximetry	96

Document 09/19/18 21:45 KIM0006 (Rec: 09/19/18 22:12 KIM0006 ICU-M27)
Vital Signs from Bedside Monitors
Vital Signs

Heart Rate	101
Pulse Rate	100
Respiratory Rate	24
O2 Sat by Pulse Oximetry	95

Document 09/19/18 21:50 KIM0006 (Rec: 09/19/18 22:12 KIM0006 ICU-M27)
Vital Signs from Bedside Monitors

Continued on Page 345

Vital Signs
Heart Rate 96
Pulse Rate 98
Respiratory Rate 25
O2 Sat by Pulse Oximetry 97

Document 09/19/18 21:55 KIM0006 (Rec: 09/19/18 22:12 KIM0006 ICU-M27)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 87
Pulse Rate 86
Respiratory Rate 19
O2 Sat by Pulse Oximetry 96

Document 09/19/18 22:00 KIM0006 (Rec: 09/19/18 22:12 KIM0006 ICU-M27)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 96
Pulse Rate 97
Respiratory Rate 24
O2 Sat by Pulse Oximetry 96

Document 09/19/18 22:05 KIM0006 (Rec: 09/19/18 22:12 KIM0006 ICU-M27)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 107
Pulse Rate 105
Respiratory Rate 22
O2 Sat by Pulse Oximetry 96

Document 09/19/18 22:10 KIM0006 (Rec: 09/19/18 22:12 KIM0006 ICU-M27)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 97
Pulse Rate 96
Respiratory Rate 17
O2 Sat by Pulse Oximetry 96

Document 09/19/18 22:15 KIM0006 (Rec: 09/19/18 23:12 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 85
Pulse Rate 87
Respiratory Rate 21
O2 Sat by Pulse Oximetry 95
Blood Pressure (mmHg) 146/99
Blood Pressure Mean 111

Document 09/19/18 22:20 KIM0006 (Rec: 09/19/18 23:12 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 88
Pulse Rate 89
Respiratory Rate 26
O2 Sat by Pulse Oximetry 95

Document 09/19/18 22:25 KIM0006 (Rec: 09/19/18 23:12 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 91

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Pulse Rate 90
Respiratory Rate 22
O2 Sat by Pulse Oximetry 96

Document 09/19/18 22:30 KIM0006 (Rec: 09/19/18 23:12 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 85
Pulse Rate 85
Respiratory Rate 21
O2 Sat by Pulse Oximetry 95
Blood Pressure (mmHg) 161/99
Blood Pressure Mean 113

Document 09/19/18 22:35 KIM0006 (Rec: 09/19/18 23:12 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 92
Pulse Rate 90
Respiratory Rate 24
O2 Sat by Pulse Oximetry 96

Document 09/19/18 22:40 KIM0006 (Rec: 09/19/18 23:12 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 86
Pulse Rate 86
Respiratory Rate 21
O2 Sat by Pulse Oximetry 95

Document 09/19/18 22:45 KIM0006 (Rec: 09/19/18 23:12 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 86
Pulse Rate 86
Respiratory Rate 25
O2 Sat by Pulse Oximetry 96
Blood Pressure (mmHg) 167/105
Blood Pressure Mean 122

Document 09/19/18 22:50 KIM0006 (Rec: 09/19/18 23:12 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 94
Pulse Rate 93
Respiratory Rate 26
O2 Sat by Pulse Oximetry 96

Document 09/19/18 22:55 KIM0006 (Rec: 09/19/18 23:12 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 100
Pulse Rate 98
Respiratory Rate 23
O2 Sat by Pulse Oximetry 95

Document 09/19/18 23:00 KIM0006 (Rec: 09/19/18 23:12 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 73

Continued on Page 347

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

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        Pulse Rate                         71
        Respiratory Rate                   23
        O2 Sat by Pulse Oximetry           95
        Blood Pressure (mmHg)              164/101
        Blood Pressure Mean                127
Document     09/19/18 23:05  KIM0006  (Rec: 09/19/18 23:12  KIM0006  ICU-C12)
Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate                         93
        Pulse Rate                         93
        Respiratory Rate                   14
        O2 Sat by Pulse Oximetry           95
Document     09/19/18 23:10  KIM0006  (Rec: 09/19/18 23:12  KIM0006  ICU-C12)
Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate                         84
        Pulse Rate                         85
        Respiratory Rate                   23
        O2 Sat by Pulse Oximetry           96
Document     09/19/18 23:13  KIM0006  (Rec: 09/20/18 01:32  KIM0006  ICU-C12)
Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate                         96
        Pulse Rate                         92
        Respiratory Rate                   22
        O2 Sat by Pulse Oximetry           92
Document     09/19/18 23:15  KIM0006  (Rec: 09/20/18 01:32  KIM0006  ICU-C12)
Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate                         94
        Pulse Rate                         95
        Respiratory Rate                   16
        O2 Sat by Pulse Oximetry           96
Document     09/19/18 23:20  KIM0006  (Rec: 09/20/18 01:32  KIM0006  ICU-C12)
Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate                         90
        Pulse Rate                         109
        Respiratory Rate                   28
        O2 Sat by Pulse Oximetry           91
Document     09/19/18 23:25  KIM0006  (Rec: 09/20/18 01:32  KIM0006  ICU-C12)
Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate                         107
        Respiratory Rate                   25
Document     09/19/18 23:30  KIM0006  (Rec: 09/20/18 01:32  KIM0006  ICU-C12)
Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate                         94
        Respiratory Rate                   26
        Blood Pressure (mmHg)              163/105
        Blood Pressure Mean                120
Document     09/19/18 23:35  KIM0006  (Rec: 09/20/18 01:32  KIM0006  ICU-C12)
```

Continued on Page 348

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 83
Respiratory Rate 21

Document 09/19/18 23:40 KIM0006 (Rec: 09/20/18 01:32 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 87
Respiratory Rate 20

Document 09/19/18 23:45 KIM0006 (Rec: 09/20/18 01:32 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 107
Respiratory Rate 20

Document 09/19/18 23:50 KIM0006 (Rec: 09/20/18 01:32 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 108
Respiratory Rate 25

Document 09/19/18 23:55 KIM0006 (Rec: 09/20/18 01:32 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 119
Respiratory Rate 26

Document 09/20/18 00:00 KIM0006 (Rec: 09/20/18 01:32 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 100
Respiratory Rate 26
Blood Pressure (mmHg) 150/101
Blood Pressure Mean 120

Document 09/20/18 00:05 KIM0006 (Rec: 09/20/18 01:32 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 96
Respiratory Rate 21

Document 09/20/18 00:10 KIM0006 (Rec: 09/20/18 01:32 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 100
Respiratory Rate 29

Document 09/20/18 00:15 KIM0006 (Rec: 09/20/18 01:32 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 106
Pulse Rate 109
Respiratory Rate 20
O2 Sat by Pulse Oximetry 95

Document 09/20/18 00:20 KIM0006 (Rec: 09/20/18 01:32 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 87
Pulse Rate 88

Continued on Page 349

Assessments and Treatments - Continued

```
      Respiratory Rate                      21
      O2 Sat by Pulse Oximetry              96
Document     09/20/18 00:25  KIM0006  (Rec: 09/20/18 01:32  KIM0006  ICU-C12)
Vital Signs from Bedside Monitors
    Vital Signs
      Heart Rate                            84
      Pulse Rate                            86
      Respiratory Rate                      21
      O2 Sat by Pulse Oximetry              95
Document     09/20/18 00:30  KIM0006  (Rec: 09/20/18 01:32  KIM0006  ICU-C12)
Vital Signs from Bedside Monitors
    Vital Signs
      Heart Rate                            86
      Pulse Rate                            85
      Respiratory Rate                      21
      O2 Sat by Pulse Oximetry              96
      Blood Pressure (mmHg)                 178/105
      Blood Pressure Mean                   119
Document     09/20/18 00:35  KIM0006  (Rec: 09/20/18 01:32  KIM0006  ICU-C12)
Vital Signs from Bedside Monitors
    Vital Signs
      Heart Rate                            87
      Pulse Rate                            87
      Respiratory Rate                      20
      O2 Sat by Pulse Oximetry              96
Document     09/20/18 00:40  KIM0006  (Rec: 09/20/18 01:32  KIM0006  ICU-C12)
Vital Signs from Bedside Monitors
    Vital Signs
      Heart Rate                            87
      Pulse Rate                            88
      Respiratory Rate                      25
      O2 Sat by Pulse Oximetry              94
Document     09/20/18 00:45  KIM0006  (Rec: 09/20/18 01:32  KIM0006  ICU-C12)
Vital Signs from Bedside Monitors
    Vital Signs
      Heart Rate                            86
      Pulse Rate                            87
      Respiratory Rate                      20
      O2 Sat by Pulse Oximetry              94
Document     09/20/18 00:50  KIM0006  (Rec: 09/20/18 01:32  KIM0006  ICU-C12)
Vital Signs from Bedside Monitors
    Vital Signs
      Heart Rate                            101
      Pulse Rate                            101
      Respiratory Rate                      17
      O2 Sat by Pulse Oximetry              98
Document     09/20/18 00:55  KIM0006  (Rec: 09/20/18 01:32  KIM0006  ICU-C12)
Vital Signs from Bedside Monitors
    Vital Signs
      Heart Rate                            102
      Pulse Rate                            102
      Respiratory Rate                      27
      O2 Sat by Pulse Oximetry              96
```

Continued on Page 350

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Document 09/20/18 01:00 KIM0006 (Rec: 09/20/18 01:32 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 100
Pulse Rate 100
Respiratory Rate 24
O2 Sat by Pulse Oximetry 95

Document 09/20/18 01:01 KIM0006 (Rec: 09/20/18 04:24 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 87
Pulse Rate 86
Respiratory Rate 24
O2 Sat by Pulse Oximetry 95
Blood Pressure (mmHg) 176/109
Blood Pressure Mean 124

Document 09/20/18 01:05 KIM0006 (Rec: 09/20/18 01:32 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 97
Pulse Rate 97
Respiratory Rate 28
O2 Sat by Pulse Oximetry 96

Document 09/20/18 01:10 KIM0006 (Rec: 09/20/18 01:32 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 107
Pulse Rate 102
Respiratory Rate 23
O2 Sat by Pulse Oximetry 95

Document 09/20/18 01:15 KIM0006 (Rec: 09/20/18 01:32 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 103
Pulse Rate 104
Respiratory Rate 30
O2 Sat by Pulse Oximetry 95

Document 09/20/18 01:20 KIM0006 (Rec: 09/20/18 01:32 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 97
Pulse Rate 96
Respiratory Rate 22
O2 Sat by Pulse Oximetry 96

Document 09/20/18 01:25 KIM0006 (Rec: 09/20/18 01:32 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 101
Pulse Rate 99
Respiratory Rate 25
O2 Sat by Pulse Oximetry 95

Document 09/20/18 01:30 KIM0006 (Rec: 09/20/18 01:32 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors

Continued on Page 351

Assessments and Treatments - Continued

Vital Signs
Heart Rate 86
Pulse Rate 88
Respiratory Rate 21
O2 Sat by Pulse Oximetry 95

Document 09/20/18 01:35 KIM0006 (Rec: 09/20/18 04:24 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 90
Pulse Rate 89
Respiratory Rate 22
O2 Sat by Pulse Oximetry 95

Document 09/20/18 01:40 KIM0006 (Rec: 09/20/18 04:24 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 103
Pulse Rate 103
Respiratory Rate 19
O2 Sat by Pulse Oximetry 96

Document 09/20/18 01:45 KIM0006 (Rec: 09/20/18 04:24 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 91
Pulse Rate 89
Respiratory Rate 23
O2 Sat by Pulse Oximetry 96
Blood Pressure (mmHg) 167/102
Blood Pressure Mean 113

Document 09/20/18 01:50 KIM0006 (Rec: 09/20/18 04:24 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 83
Pulse Rate 84
Respiratory Rate 20
O2 Sat by Pulse Oximetry 96

Document 09/20/18 01:55 KIM0006 (Rec: 09/20/18 04:24 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 109
Pulse Rate 108
Respiratory Rate 22
O2 Sat by Pulse Oximetry 97

Document 09/20/18 02:00 KIM0006 (Rec: 09/20/18 04:24 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 102
Pulse Rate 101
Respiratory Rate 23
O2 Sat by Pulse Oximetry 95

Document 09/20/18 02:08 KIM0006 (Rec: 09/20/18 04:24 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 99

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Assessments and Treatments - Continued

```
        Pulse Rate                          106
        Respiratory Rate                    31
        O2 Sat by Pulse Oximetry            94
Document     09/20/18 02:10  KIM0006  (Rec: 09/20/18 04:24  KIM0006  ICU-C12)
Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate                          85
        Pulse Rate                          87
        Respiratory Rate                    21
        O2 Sat by Pulse Oximetry            95
Document     09/20/18 02:15  KIM0006  (Rec: 09/20/18 04:24  KIM0006  ICU-C12)
Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate                          82
        Pulse Rate                          84
        Respiratory Rate                    23
        O2 Sat by Pulse Oximetry            95
Document     09/20/18 02:20  KIM0006  (Rec: 09/20/18 04:24  KIM0006  ICU-C12)
Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate                          95
        Pulse Rate                          95
        Respiratory Rate                    18
        O2 Sat by Pulse Oximetry            97
Document     09/20/18 02:25  KIM0006  (Rec: 09/20/18 04:24  KIM0006  ICU-C12)
Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate                          91
        Pulse Rate                          94
        Respiratory Rate                    21
        O2 Sat by Pulse Oximetry            96
Document     09/20/18 02:30  KIM0006  (Rec: 09/20/18 04:24  KIM0006  ICU-C12)
Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate                          102
        Pulse Rate                          100
        Respiratory Rate                    24
        O2 Sat by Pulse Oximetry            96
Document     09/20/18 02:31  KIM0006  (Rec: 09/20/18 04:24  KIM0006  ICU-C12)
Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate                          107
        Pulse Rate                          106
        Respiratory Rate                    22
        O2 Sat by Pulse Oximetry            96
        Blood Pressure (mmHg)               160/102
        Blood Pressure Mean                 124
Document     09/20/18 02:35  KIM0006  (Rec: 09/20/18 04:24  KIM0006  ICU-C12)
Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate                          105
        Pulse Rate                          104
        Respiratory Rate                    23
```

Continued on Page 353

Assessments and Treatments - Continued

O2 Sat by Pulse Oximetry 95

Document 09/20/18 02:40 KIM0006 (Rec: 09/20/18 04:24 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 90
Pulse Rate 89
Respiratory Rate 22
O2 Sat by Pulse Oximetry 95

Document 09/20/18 02:45 KIM0006 (Rec: 09/20/18 04:24 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 105
Pulse Rate 102
Respiratory Rate 21
O2 Sat by Pulse Oximetry 95

Document 09/20/18 02:50 KIM0006 (Rec: 09/20/18 04:24 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 104
Pulse Rate 106
Respiratory Rate 21
O2 Sat by Pulse Oximetry 96

Document 09/20/18 02:55 KIM0006 (Rec: 09/20/18 04:24 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 87
Pulse Rate 88
Respiratory Rate 24
O2 Sat by Pulse Oximetry 96

Document 09/20/18 03:00 KIM0006 (Rec: 09/20/18 04:24 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 85
Pulse Rate 86
Respiratory Rate 23
O2 Sat by Pulse Oximetry 96

Document 09/20/18 03:05 KIM0006 (Rec: 09/20/18 04:24 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 87
Pulse Rate 87
Respiratory Rate 21
O2 Sat by Pulse Oximetry 97

Document 09/20/18 03:10 KIM0006 (Rec: 09/20/18 04:24 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 90
Pulse Rate 91
Respiratory Rate 22
O2 Sat by Pulse Oximetry 94

Document 09/20/18 03:15 KIM0006 (Rec: 09/20/18 04:24 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs

Continued on Page 354

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

```
        Heart Rate                          86
        Pulse Rate                          87
        Respiratory Rate                    23
        O2 Sat by Pulse Oximetry            94
Document     09/20/18 03:20  KIM0006  (Rec: 09/20/18 04:24  KIM0006  ICU-C12)
Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate                          104
        Pulse Rate                          106
        Respiratory Rate                    19
        O2 Sat by Pulse Oximetry            97
Document     09/20/18 03:25  KIM0006  (Rec: 09/20/18 04:24  KIM0006  ICU-C12)
Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate                          109
        Pulse Rate                          110
        Respiratory Rate                    26
        O2 Sat by Pulse Oximetry            94
Document     09/20/18 03:30  KIM0006  (Rec: 09/20/18 04:24  KIM0006  ICU-C12)
Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate                          93
        Pulse Rate                          94
        Respiratory Rate                    28
        O2 Sat by Pulse Oximetry            94
Document     09/20/18 03:35  KIM0006  (Rec: 09/20/18 04:24  KIM0006  ICU-C12)
Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate                          95
        Pulse Rate                          99
        Respiratory Rate                    25
        O2 Sat by Pulse Oximetry            93
Document     09/20/18 03:40  KIM0006  (Rec: 09/20/18 04:24  KIM0006  ICU-C12)
Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate                          96
        Pulse Rate                          96
        Respiratory Rate                    31
        O2 Sat by Pulse Oximetry            94
Document     09/20/18 03:45  KIM0006  (Rec: 09/20/18 04:24  KIM0006  ICU-C12)
Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate                          87
        Pulse Rate                          88
        Respiratory Rate                    23
        O2 Sat by Pulse Oximetry            93
Document     09/20/18 03:50  KIM0006  (Rec: 09/20/18 04:24  KIM0006  ICU-C12)
Vital Signs from Bedside Monitors
    Vital Signs
        Heart Rate                          98
        Pulse Rate                          100
        Respiratory Rate                    31
        O2 Sat by Pulse Oximetry            94
```

Continued on Page 355

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Document 09/20/18 03:55 KIM0006 (Rec: 09/20/18 04:24 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 93
Pulse Rate 94
Respiratory Rate 31
O2 Sat by Pulse Oximetry 94

Document 09/20/18 04:00 KIM0006 (Rec: 09/20/18 04:24 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 92
Pulse Rate 95
Respiratory Rate 31
O2 Sat by Pulse Oximetry 96

Document 09/20/18 04:01 KIM0006 (Rec: 09/20/18 04:24 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 90
Pulse Rate 88
Respiratory Rate 25
O2 Sat by Pulse Oximetry 94
Blood Pressure (mmHg) 161/94
Blood Pressure Mean 125

Document 09/20/18 04:05 KIM0006 (Rec: 09/20/18 04:24 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 102
Pulse Rate 100
Respiratory Rate 32
O2 Sat by Pulse Oximetry 94

Document 09/20/18 04:10 KIM0006 (Rec: 09/20/18 04:24 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 97
Pulse Rate 96
Respiratory Rate 34
O2 Sat by Pulse Oximetry 94

Document 09/20/18 04:15 KIM0006 (Rec: 09/20/18 04:24 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 107
Pulse Rate 105
Respiratory Rate 22
O2 Sat by Pulse Oximetry 95

Document 09/20/18 04:20 KIM0006 (Rec: 09/20/18 04:24 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 107
Pulse Rate 108
Respiratory Rate 26
O2 Sat by Pulse Oximetry 93

Document 09/20/18 04:25 KIM0006 (Rec: 09/20/18 05:05 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors

Continued on Page 356

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Vital Signs
Heart Rate 96
Pulse Rate 96
Respiratory Rate 27
O2 Sat by Pulse Oximetry 95

Document 09/20/18 04:30 KIM0006 (Rec: 09/20/18 05:05 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 107
Pulse Rate 109
Respiratory Rate 18
O2 Sat by Pulse Oximetry 95

Document 09/20/18 04:35 KIM0006 (Rec: 09/20/18 05:05 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 105
Pulse Rate 105
Respiratory Rate 31
O2 Sat by Pulse Oximetry 94

Document 09/20/18 04:40 KIM0006 (Rec: 09/20/18 05:05 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 109
Pulse Rate 108
Respiratory Rate 32
O2 Sat by Pulse Oximetry 93

Document 09/20/18 04:45 KIM0006 (Rec: 09/20/18 05:05 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 92
Pulse Rate 93
Respiratory Rate 27
O2 Sat by Pulse Oximetry 94

Document 09/20/18 04:50 KIM0006 (Rec: 09/20/18 05:05 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 107
Pulse Rate 108
Respiratory Rate 21
O2 Sat by Pulse Oximetry 95

Document 09/20/18 04:55 KIM0006 (Rec: 09/20/18 05:05 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 97
Pulse Rate 97
Respiratory Rate 28
O2 Sat by Pulse Oximetry 94

Document 09/20/18 05:00 KIM0006 (Rec: 09/20/18 05:05 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 109
Pulse Rate 106
Respiratory Rate 27

Continued on Page 357

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

O2 Sat by Pulse Oximetry 94

Document 09/20/18 05:01 KIM0006 (Rec: 09/20/18 05:05 KIM0006 ICU-C12)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 121
Pulse Rate 123
Respiratory Rate 37
O2 Sat by Pulse Oximetry 94
Blood Pressure (mmHg) 100/76
Blood Pressure Mean 81

Document 09/20/18 05:05 KIM0006 (Rec: 09/20/18 06:20 KIM0006 ICU-M35)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 114
Pulse Rate 116
Respiratory Rate 27
O2 Sat by Pulse Oximetry 95

Document 09/20/18 05:10 KIM0006 (Rec: 09/20/18 06:20 KIM0006 ICU-M35)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 107
Pulse Rate 106
Respiratory Rate 45
O2 Sat by Pulse Oximetry 95

Document 09/20/18 05:15 KIM0006 (Rec: 09/20/18 06:20 KIM0006 ICU-M35)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 110
Pulse Rate 110
Respiratory Rate 31
O2 Sat by Pulse Oximetry 96

Document 09/20/18 05:20 KIM0006 (Rec: 09/20/18 06:20 KIM0006 ICU-M35)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 101
Pulse Rate 101
Respiratory Rate 31
O2 Sat by Pulse Oximetry 95

Document 09/20/18 05:25 KIM0006 (Rec: 09/20/18 06:20 KIM0006 ICU-M35)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 111
Respiratory Rate 24

Document 09/20/18 05:34 KIM0006 (Rec: 09/20/18 06:20 KIM0006 ICU-M35)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 109
Pulse Rate 107
Respiratory Rate 22
O2 Sat by Pulse Oximetry 95

Document 09/20/18 05:35 KIM0006 (Rec: 09/20/18 06:20 KIM0006 ICU-M35)
Vital Signs from Bedside Monitors
Vital Signs

Continued on Page 358

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01

62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Heart Rate 103
Pulse Rate 105
Respiratory Rate 23
O2 Sat by Pulse Oximetry 94

Document 09/20/18 05:40 KIM0006 (Rec: 09/20/18 06:20 KIM0006 ICU-M35)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 89
Pulse Rate 89
Respiratory Rate 24
O2 Sat by Pulse Oximetry 93

Document 09/20/18 05:45 KIM0006 (Rec: 09/20/18 06:20 KIM0006 ICU-M35)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 96
Pulse Rate 96
Respiratory Rate 28
O2 Sat by Pulse Oximetry 95

Document 09/20/18 05:50 KIM0006 (Rec: 09/20/18 06:20 KIM0006 ICU-M35)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 109
Pulse Rate 108
Respiratory Rate 16
O2 Sat by Pulse Oximetry 95

Document 09/20/18 05:55 KIM0006 (Rec: 09/20/18 06:20 KIM0006 ICU-M35)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 88
Pulse Rate 90
Respiratory Rate 21
O2 Sat by Pulse Oximetry 96

Document 09/20/18 06:00 KIM0006 (Rec: 09/20/18 06:20 KIM0006 ICU-M35)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 92
Pulse Rate 99
Respiratory Rate 24
O2 Sat by Pulse Oximetry 94

Document 09/20/18 06:05 KIM0006 (Rec: 09/20/18 06:20 KIM0006 ICU-M35)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 105
Pulse Rate 106
Respiratory Rate 14
O2 Sat by Pulse Oximetry 96

Document 09/20/18 06:10 KIM0006 (Rec: 09/20/18 06:20 KIM0006 ICU-M35)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 109
Pulse Rate 108
Respiratory Rate 24
O2 Sat by Pulse Oximetry 97

Continued on Page 359

Assessments and Treatments - Continued

Document 09/20/18 06:15 KIM0006 (Rec: 09/20/18 06:20 KIM0006 ICU-M35)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 111
Pulse Rate 109
Respiratory Rate 34
O2 Sat by Pulse Oximetry 91

Document 09/20/18 06:20 JOA0063 (Rec: 09/20/18 10:07 JOA0063 ICU-C25)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 105
Pulse Rate 104
Respiratory Rate 43
O2 Sat by Pulse Oximetry 94

Document 09/20/18 06:25 JOA0063 (Rec: 09/20/18 10:07 JOA0063 ICU-C25)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 94
Pulse Rate 90
Respiratory Rate 28
O2 Sat by Pulse Oximetry 94

Document 09/20/18 06:30 JOA0063 (Rec: 09/20/18 10:07 JOA0063 ICU-C25)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 104
Pulse Rate 104
Respiratory Rate 23
O2 Sat by Pulse Oximetry 94

Document 09/20/18 06:35 JOA0063 (Rec: 09/20/18 10:07 JOA0063 ICU-C25)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 105
Pulse Rate 105
Respiratory Rate 19
O2 Sat by Pulse Oximetry 93

Document 09/20/18 06:40 JOA0063 (Rec: 09/20/18 10:07 JOA0063 ICU-C25)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 109
Pulse Rate 109
Respiratory Rate 15
O2 Sat by Pulse Oximetry 95

Document 09/20/18 06:45 JOA0063 (Rec: 09/20/18 10:07 JOA0063 ICU-C25)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 105
Pulse Rate 103
Respiratory Rate 23
O2 Sat by Pulse Oximetry 95

Document 09/20/18 06:50 JOA0063 (Rec: 09/20/18 10:07 JOA0063 ICU-C25)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 110

Continued on Page 360

Assessments and Treatments - Continued

```
       Pulse Rate                               102
       Respiratory Rate                         35
       O2 Sat by Pulse Oximetry                 90
Document     09/20/18 06:55  JOA0063  (Rec: 09/20/18 10:07  JOA0063  ICU-C25)
Vital Signs from Bedside Monitors
    Vital Signs
       Heart Rate                               95
       Pulse Rate                               96
       Respiratory Rate                         26
       O2 Sat by Pulse Oximetry                 93
Document     09/20/18 07:00  JOA0063  (Rec: 09/20/18 10:07  JOA0063  ICU-C25)
Vital Signs from Bedside Monitors
    Vital Signs
       Heart Rate                               102
       Pulse Rate                               101
       Respiratory Rate                         34
       O2 Sat by Pulse Oximetry                 95
Document     09/20/18 07:05  JOA0063  (Rec: 09/20/18 10:07  JOA0063  ICU-C25)
Vital Signs from Bedside Monitors
    Vital Signs
       Heart Rate                               88
       Pulse Rate                               88
       Respiratory Rate                         21
       O2 Sat by Pulse Oximetry                 94
Document     09/20/18 07:10  JOA0063  (Rec: 09/20/18 10:07  JOA0063  ICU-C25)
Vital Signs from Bedside Monitors
    Vital Signs
       Heart Rate                               107
       Pulse Rate                               107
       Respiratory Rate                         36
       O2 Sat by Pulse Oximetry                 95
Document     09/20/18 07:15  JOA0063  (Rec: 09/20/18 10:07  JOA0063  ICU-C25)
Vital Signs from Bedside Monitors
    Vital Signs
       Heart Rate                               86
       Pulse Rate                               87
       Respiratory Rate                         25
       O2 Sat by Pulse Oximetry                 94
Document     09/20/18 07:20  JOA0063  (Rec: 09/20/18 10:07  JOA0063  ICU-C25)
Vital Signs from Bedside Monitors
    Vital Signs
       Heart Rate                               98
       Pulse Rate                               98
       Respiratory Rate                         27
       O2 Sat by Pulse Oximetry                 94
Document     09/20/18 07:25  JOA0063  (Rec: 09/20/18 10:07  JOA0063  ICU-C25)
Vital Signs from Bedside Monitors
    Vital Signs
       Heart Rate                               86
       Pulse Rate                               88
       Respiratory Rate                         24
       O2 Sat by Pulse Oximetry                 93
Document     09/20/18 07:30  JOA0063  (Rec: 09/20/18 10:07  JOA0063  ICU-C25)
```

Continued on Page 361

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 110
Pulse Rate 110
Respiratory Rate 18
O2 Sat by Pulse Oximetry 94
Document 09/20/18 07:35 JOA0063 (Rec: 09/20/18 10:07 JOA0063 ICU-C25)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 94
Pulse Rate 92
Respiratory Rate 25
O2 Sat by Pulse Oximetry 94
Document 09/20/18 07:40 JOA0063 (Rec: 09/20/18 10:07 JOA0063 ICU-C25)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 98
Pulse Rate 101
Respiratory Rate 25
O2 Sat by Pulse Oximetry 94
Document 09/20/18 07:45 JOA0063 (Rec: 09/20/18 10:07 JOA0063 ICU-C25)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 107
Pulse Rate 106
Respiratory Rate 16
O2 Sat by Pulse Oximetry 94
Document 09/20/18 07:50 JOA0063 (Rec: 09/20/18 10:07 JOA0063 ICU-C25)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 97
Pulse Rate 95
Respiratory Rate 27
O2 Sat by Pulse Oximetry 94
Document 09/20/18 07:55 JOA0063 (Rec: 09/20/18 10:07 JOA0063 ICU-C25)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 102
Pulse Rate 103
Respiratory Rate 30
O2 Sat by Pulse Oximetry 93
Document 09/20/18 08:00 JOA0063 (Rec: 09/20/18 10:07 JOA0063 ICU-C25)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 108
Pulse Rate 111
O2 Sat by Pulse Oximetry 93
Document 09/20/18 08:05 JOA0063 (Rec: 09/20/18 10:07 JOA0063 ICU-C25)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 106
Pulse Rate 107
O2 Sat by Pulse Oximetry 93

Continued on Page 362

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Assessments and Treatments - Continued

Document 09/20/18 08:10 JOA0063 (Rec: 09/20/18 10:07 JOA0063 ICU-C25)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 91
Pulse Rate 92
O2 Sat by Pulse Oximetry 94

Document 09/20/18 08:15 JOA0063 (Rec: 09/20/18 10:07 JOA0063 ICU-C25)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 103
Pulse Rate 103
O2 Sat by Pulse Oximetry 93

Document 09/20/18 08:20 JOA0063 (Rec: 09/20/18 10:07 JOA0063 ICU-C25)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 102
Pulse Rate 101
O2 Sat by Pulse Oximetry 93

Document 09/20/18 08:25 JOA0063 (Rec: 09/20/18 10:07 JOA0063 ICU-C25)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 114
Pulse Rate 108
O2 Sat by Pulse Oximetry 93

Document 09/20/18 08:30 JOA0063 (Rec: 09/20/18 10:07 JOA0063 ICU-C25)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 91
Pulse Rate 90
O2 Sat by Pulse Oximetry 92

Document 09/20/18 08:35 JOA0063 (Rec: 09/20/18 10:07 JOA0063 ICU-C25)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 106
Pulse Rate 106
O2 Sat by Pulse Oximetry 95

Document 09/20/18 08:40 JOA0063 (Rec: 09/20/18 10:07 JOA0063 ICU-C25)
Vital Signs from Bedside Monitors
Vital Signs
Heart Rate 96

Document 09/20/18 08:57 JOA0063 (Rec: 09/20/18 10:07 JOA0063 ICU-C25)
Vital Signs from Bedside Monitors
Vital Signs
Blood Pressure (mmHg) 167/107
Blood Pressure Mean 120

Weigh Patient Start: 09/19/18 08:47
Freq: DAILY@0600 Status: Inactive
Protocol:

Document 09/20/18 05:37 KIM0006 (Rec: 09/20/18 05:38 KIM0006 ICU-M35)
Weigh Patient
Weight
Weight 166 lb 10.711 oz
Last Documented Weight 166 lb

Continued on Page 363

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Assessments and Treatments - Continued

Weight Change	0.669437 lb
Actual/Estimated Weight	Actual
Scale Used	Bed Scale

Query Text:To ensure accurate weights, be sure to always weigh your patient with the same scale.

POC Problems

Cardiovascular Start: 09/19/18 17:32
Freq: Status: Discharge
Protocol:
Created 09/19/18 17:32 ROS0014 (Rec: 09/19/18 17:32 ROS0014 ISDEMO-M05)
Rank 09/19/18 17:35 KYL0009 (Rec: 09/19/18 17:35 KYL0009 ICU-C12)
2=>1
Rank 09/19/18 17:37 KYL0009 (Rec: 09/19/18 17:37 KYL0009 ICU-C12)
2=>1
Edit Status 09/24/18 18:14 MAC0003 (Rec: 09/24/18 18:14 MAC0003 TELE-C09)
Active=>Discharge

Mobility Start: 09/19/18 17:36
Freq: Status: Discharge
Protocol:
Created 09/19/18 17:36 KYL0009 (Rec: 09/19/18 17:36 KYL0009 ICU-C12)
Edit Status 09/24/18 18:14 MAC0003 (Rec: 09/24/18 18:14 MAC0003 TELE-C09)
Active=>Discharge

Pain/Comfort Start: 09/19/18 17:36
Freq: Status: Discharge
Protocol:
Created 09/19/18 17:36 KYL0009 (Rec: 09/19/18 17:36 KYL0009 ICU-C12)
Edit Status 09/24/18 18:14 MAC0003 (Rec: 09/24/18 18:14 MAC0003 TELE-C09)
Active=>Discharge

Potential Injury from Restraint Start: 09/19/18 12:37
Freq: Status: Complete
Protocol:
Created 09/19/18 12:37 KYL0009 (Rec: 09/19/18 12:37 KYL0009 ICU-C12)
Edit Status 09/19/18 17:35 KYL0009 (Rec: 09/19/18 17:35 KYL0009 ICU-C12)
Active=>Complete

Psychosocial Start: 09/19/18 17:32
Freq: Status: Discharge
Protocol:
Created 09/19/18 17:32 ROS0014 (Rec: 09/19/18 17:32 ROS0014 ISDEMO-M05)
Rank 09/19/18 17:35 KYL0009 (Rec: 09/19/18 17:35 KYL0009 ICU-C12)
2=>1
Rank 09/19/18 17:37 KYL0009 (Rec: 09/19/18 17:37 KYL0009 ICU-C12)
1=>2
Edit Status 09/24/18 18:14 MAC0003 (Rec: 09/24/18 18:14 MAC0003 TELE-C09)
Active=>Discharge

Continued on Page 364

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Outcomes

```
Cardiovascular-Improve/Maintain                Start:  09/19/18 17:32
Freq:   DAILY@0400,1600                        Status: Discharge   Target:
Protocol:
 Created      09/19/18 17:32  ROS0014  (Rec: 09/19/18 17:32  ROS0014  ISDEMO-M05)
 Document     09/19/18 17:38  KYL0009  (Rec: 09/19/18 17:39  KYL0009  ICU-C12)
 Document     09/19/18 23:17  KIM0006  (Rec: 09/19/18 23:21  KIM0006  ICU-C12)
 Document     09/20/18 16:21  ANI0051  (Rec: 09/20/18 16:22  ANI0051  ICU-C25)
 Document     09/21/18 04:00  JER0049  (Rec: 09/21/18 05:04  JER0049  TELE-C09)
 Document     09/21/18 15:34  CON0001  (Rec: 09/21/18 15:34  CON0001  TELE-M11)
 Document     09/22/18 04:00  MEG0025  (Rec: 09/22/18 04:13  MEG0025  TELE-C09)
 Document     09/22/18 16:00  MOR0002  (Rec: 09/22/18 17:33  MOR0002  TELE-C05)
 Document     09/23/18 04:00  SOP0051  (Rec: 09/23/18 04:47  SOP0051  TELE-C11)
 Document     09/23/18 16:00  STA0017  (Rec: 09/23/18 18:34  STA0017  TELE-C03)
 Document     09/23/18 22:34  RAY0005  (Rec: 09/23/18 22:36  RAY0005  TELE-C11)
 Document     09/24/18 15:50  MAC0003  (Rec: 09/24/18 15:50  MAC0003  TELE-C09)
 Edit Status  09/24/18 18:14  MAC0003  (Rec: 09/24/18 18:14  MAC0003  TELE-C09)
     Active=>Discharge
```

```
Mobility-Improve/Maintain                      Start:  09/19/18 17:36
Freq:   DAILY@0400,1600                        Status: Discharge   Target:
Protocol:
 Created      09/19/18 17:36  KYL0009  (Rec: 09/19/18 17:36  KYL0009  ICU-C12)
 Document     09/19/18 17:38  KYL0009  (Rec: 09/19/18 17:39  KYL0009  ICU-C12)
 Document     09/19/18 23:17  KIM0006  (Rec: 09/19/18 23:21  KIM0006  ICU-C12)
 Document     09/20/18 16:34  ANI0051  (Rec: 09/20/18 16:35  ANI0051  ICU-C25)
 Document     09/21/18 04:00  JER0049  (Rec: 09/21/18 05:04  JER0049  TELE-C09)
 Document     09/21/18 15:34  CON0001  (Rec: 09/21/18 15:34  CON0001  TELE-M11)
 Document     09/22/18 04:00  MEG0025  (Rec: 09/22/18 04:13  MEG0025  TELE-C09)
 Document     09/22/18 16:00  MOR0002  (Rec: 09/22/18 17:33  MOR0002  TELE-C05)
 Document     09/23/18 04:00  SOP0051  (Rec: 09/23/18 04:47  SOP0051  TELE-C11)
 Document     09/23/18 16:00  STA0017  (Rec: 09/23/18 18:34  STA0017  TELE-C03)
 Document     09/23/18 22:34  RAY0005  (Rec: 09/23/18 22:36  RAY0005  TELE-C11)
 Document     09/24/18 15:50  MAC0003  (Rec: 09/24/18 15:50  MAC0003  TELE-C09)
 Edit Status  09/24/18 18:14  MAC0003  (Rec: 09/24/18 18:14  MAC0003  TELE-C09)
     Active=>Discharge
```

```
Pain/Comfort-Improve/Maintain                  Start:  09/19/18 17:36
Freq:   DAILY@0400,1600                        Status: Discharge   Target:
Protocol:
 Created      09/19/18 17:36  KYL0009  (Rec: 09/19/18 17:36  KYL0009  ICU-C12)
 Document     09/19/18 17:38  KYL0009  (Rec: 09/19/18 17:39  KYL0009  ICU-C12)
 Document     09/19/18 23:17  KIM0006  (Rec: 09/19/18 23:21  KIM0006  ICU-C12)
 Document     09/20/18 16:34  ANI0051  (Rec: 09/20/18 16:35  ANI0051  ICU-C25)
 Document     09/21/18 04:00  JER0049  (Rec: 09/21/18 05:04  JER0049  TELE-C09)
 Document     09/21/18 15:34  CON0001  (Rec: 09/21/18 15:34  CON0001  TELE-M11)
 Document     09/22/18 04:00  MEG0025  (Rec: 09/22/18 04:13  MEG0025  TELE-C09)
 Document     09/22/18 16:00  MOR0002  (Rec: 09/22/18 17:33  MOR0002  TELE-C05)
 Document     09/23/18 04:00  SOP0051  (Rec: 09/23/18 04:47  SOP0051  TELE-C11)
 Document     09/23/18 16:00  STA0017  (Rec: 09/23/18 18:34  STA0017  TELE-C03)
 Document     09/23/18 22:34  RAY0005  (Rec: 09/23/18 22:36  RAY0005  TELE-C11)
 Document     09/24/18 15:50  MAC0003  (Rec: 09/24/18 15:50  MAC0003  TELE-C09)
 Edit Status  09/24/18 18:14  MAC0003  (Rec: 09/24/18 18:14  MAC0003  TELE-C09)
     Active=>Discharge
```

Continued on Page 365

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Outcomes - Continued

```
Psychosocial-Improve/Maintain                   Start:  09/19/18 17:32
Freq:   DAILY@0400,1600                         Status: Discharge   Target:
Protocol:
 Created      09/19/18 17:32  ROS0014  (Rec: 09/19/18 17:32  ROS0014  ISDEMO-M05)
 Document     09/19/18 17:38  KYL0009  (Rec: 09/19/18 17:39  KYL0009  ICU-C12)
 Document     09/19/18 23:17  KIM0006  (Rec: 09/19/18 23:21  KIM0006  ICU-C12)
 Document     09/20/18 16:34  ANI0051  (Rec: 09/20/18 16:35  ANI0051  ICU-C25)
 Document     09/21/18 04:00  JER0049  (Rec: 09/21/18 05:04  JER0049  TELE-C09)
 Document     09/21/18 15:34  CON0001  (Rec: 09/21/18 15:34  CON0001  TELE-M11)
 Document     09/22/18 04:00  MEG0025  (Rec: 09/22/18 04:13  MEG0025  TELE-C09)
 Document     09/22/18 16:00  MOR0002  (Rec: 09/22/18 17:33  MOR0002  TELE-C05)
 Document     09/23/18 04:00  SOP0051  (Rec: 09/23/18 04:47  SOP0051  TELE-C11)
 Document     09/23/18 16:00  STA0017  (Rec: 09/23/18 18:34  STA0017  TELE-C03)
 Document     09/23/18 22:34  RAY0005  (Rec: 09/23/18 22:36  RAY0005  TELE-C11)
 Document     09/24/18 15:50  MAC0003  (Rec: 09/24/18 15:50  MAC0003  TELE-C09)
 Edit Status  09/24/18 18:14  MAC0003  (Rec: 09/24/18 18:14  MAC0003  TELE-C09)
     Active=>Discharge
Restraint- Improve/Maintain                     Start:  09/19/18 12:37
Freq:   0400,1600                               Status: Complete    Target: 09/20/18
Protocol:
 Created      09/19/18 12:37  KYL0009  (Rec: 09/19/18 12:37  KYL0009  ICU-C12)
 Edit Status  09/19/18 17:35  KYL0009  (Rec: 09/19/18 17:35  KYL0009  ICU-C12)
     Active=>Complete
```

Clinical Data

PREFERRED LANGUAGE (MU) ENGLISH
Height 5 ft 6 in
Weight 166 lb 10.711 oz
Code Status Full Code
Pregnant: No
Type of Isolation Standard Precautions

Condition Good
Visit Reason RHABDOMYOLYSIS WITH REACTIVE LEUKOCYTOSIS AND NASA
Language ENGLISH

Diagnosis Code	Name
S43.015A	ANTERIOR DISLOCATION OF LEFT HUMERUS, INITIAL ENCOUNTER
S22.32XA	FRACTURE OF ONE RIB, LEFT SIDE, INIT FOR CLOS FX
F29	UNSP PSYCHOSIS NOT DUE TO A SUBSTANCE OR KNOWN PHYSIOL COND
S02.2XXA	FRACTURE OF NASAL BONES, INIT ENCNTR FOR CLOSED FRACTURE
T79.6XXA	TRAUMATIC ISCHEMIA OF MUSCLE, INITIAL ENCOUNTER
X58.XXXA	EXPOSURE TO OTHER SPECIFIED FACTORS, INITIAL ENCOUNTER
D72.829	ELEVATED WHITE BLOOD CELL COUNT, UNSPECIFIED
F25.9	SCHIZOAFFECTIVE DISORDER, UNSPECIFIED
F25.0	SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE
F43.10	POST-TRAUMATIC STRESS DISORDER, UNSPECIFIED
F60.9	PERSONALITY DISORDER, UNSPECIFIED
F17.210	NICOTINE DEPENDENCE, CIGARETTES, UNCOMPLICATED
I10	ESSENTIAL (PRIMARY) HYPERTENSION

Continued on Page 366

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**4 SOUTH - MEDICAL/TELEMETRY **Bed:**436-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088518428

Clinical Data - Continued

Y92.511	RESTAURANT OR CAFE AS PLACE
Z91.14	PATIENT'S OTHER NONCOMPLIANCE WITH MEDICATION REGIMEN
Z82.49	FAMILY HX OF ISCHEM HEART DIS AND OTH DIS OF THE CIRC SYS

Discharge Information

ED Provider: Hinkley,Kirk
Status: Rm Ready
Time Seen by Provider:
Condition: Good
Triaged At: 09/19/18 04:31
Other ED Providers: Ruparelia,Ashu
Mehdi,Askar
Duplan,Auguste
White,Clarence
Ehmke,Clifford
Dauria MD,Colin K
Gerson,Henry
Bezirganian,John
Rahman,Mahfuzur
Novick,Melanie
Mendola,Robert
Mustafa,Syed
Legg,Timothy
Cranston,Tracey
Cotton,Wayne

Emergency Discharge Date/Time: 09/19/18 08:39
Emergency Discharge Disposition: ADMITTED TO CAYUGA MEDICAL
Clinical Impression Acute psychosis
Schizophrenia
Contusion of face
Fracture of nasal bone
Rhabdomyolysis
Fracture of rib of left side
Emergency Discharge Comment:

Admit Intervention Last Done
ED Discharge Assessment 09/19/18 08:39

Query	Result
IV Stop Times Documented on eMAR	Non-Applicable
Method to Door	Stretcher
Patient To	CMC Admit
Pain Scale Used	unable to assess due to pt status
Time Report Initiated	08:40
Time Report Given	08:40
Report to	Moore,Kylee
Provider Type	Registered Nurse
Name of Person Transporting Patient	Smith,Nathan
Temperature	97 F

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

Discharge Information - Continued

Temperature Source	Temporal Artery Scan
Pulse Rate	83
Respiratory Rate	22
Blood Pressure (mmHg)	146/78
Patient on Room Air	Yes
O2 Sat by Pulse Oximetry	96

Inpatient Discharge Date/Time: 09/24/18 18:14
Inpatient Discharge Disposition: PSYCHIATRIC FACILITY-CMC
Inpatient Discharge Comment:

Instructions: Pain Management (DC)
Hypertension (DC)
Stand-Alone Forms:
Prescriptions:
Visit Report
- Forms:
- Referrals: No Primary Care Phys,NOPCP (Primary Care Provider)
- Additional text: As tolerated

Important Reminders:
-Follow up and/or call your PCP within 3 days post-discharge from BSU
-Please take your medications as prescribed
-Please follow recommendations and advise of BSU team/Dr. Ehnke

User Key

Monogram	Mnemonic	Name	Credentials	Provider Type
	ALE0011	Clinton,Alexandra M	RD	Registered Dietitian
	ALE0017	Osinski,Alek		Physical Therapist
	ALL0007	Zevotek,Allison M		Radiology Technologist
	ANI0051	Tourville-Knapp,Anita	RN	Registered Nurse
	ANN0068	Reigle,Anna	RN	Registered Nurse
	ASH0007	Thornton,Ashley		Hospital Aide
	BOB0001	Davidson,Boblette		Hospital Aide
	CHA0032	Evener,Charlie		Hospital Aide
	CON0001	O'Hare,Connor	RN	Registered Nurse
	CYN0016	Ellis,Cynthia		Radiology Technologist
	DEV0055	Rogers,Devonne	RT	Radiology Technologist
	EIL0057	Miller,Eileen G		Radiology Technologist
	ELI0141	Peck,Elizabeth		Hospital Aide
	EMI0007	Crumb,Emily		Hospital Aide
	FRA0018	Dallaire,Francis		Hospital Aide
	GEM0001	Bardo,Gemma		Radiology Technologist
	HEI0057	Tremaine,Heidi	RN	Registered Nurse
	IBE0050	Intong,Ibencia		Hospital Aide
	JAM0034	Driver,Jamie	RN	Registered Nurse
	JAN0023	Nez,Janelle		Hospital Aide

Continued on Page 368

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** 4 SOUTH - MEDICAL/TELEMETRY **Bed:** 436-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088518428

User Key - Continued

	JEF0031	Storrs,Jeffery		Hospital Aide
	JER0049	Strichartz,Jeremy	RN	Registered Nurse
	JOA0063	Tregaskis,Joan L	RN	Registered Nurse
	JOS0026	Switzer,Joseph	RT	Radiology Technologist
	JOS0070	Vellake,Joseph A	RN	Registered Nurse
	KAR0031	Henry,Karen	OT	Occupational Therapist
	KEV0015	West,Kevin	RT	Respiratory Therapist
	KIM0006	Soeung,Kimberly	RN	Registered Nurse
	KIR0007	Chase,Kirsten		Hospital Aide
	KYL0009	Moore,Kylee	RN	Registered Nurse
	MAC0003	Marsh,Mackenzie	RN	Registered Nurse
	MAR0029	Carlucci,Mary Lou	PT	Physical Therapist
	MEG0025	Harrington,Megan	RN	Registered Nurse
	MEL0095	Hern,Melissa L	RN	Registered Nurse
	MIC0082	Canger,Michael V II		Registered Nurse
	MOR0002	Downing,Morgan	RN	Registered Nurse
	NAT0019	Smith,Nathan	RN	Registered Nurse
	RAY0005	Harmon,Rayanna	RN	Registered Nurse
	ROS0014	Frank,Rosika	RN	Registered Nurse
	SAR0138	McKee,Sara		Student Nurse
	SON0056	Gross,Sonja	RN	Registered Nurse
	SOP0051	Soeung,Sophany	RN	Registered Nurse
	STA0017	Shelley,Stacy	RN	Registered Nurse
	SUE0004	Lee,Suejin		Hospital Aide
	TAY0008	Butler,Taylor		Student Nurse
	TAY0053	Colbert,Taylor		Registered Nurse
	THO0010	Stelick,Thomas	RN	Registered Nurse
	TZI0001	Szajman,Tziona E		Chaplain