BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823
Attending: Clifford Ehmke **Reg Date:** 09/24/18
Reason: UNSPECIFIED PSYCHOSIS

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

SCHIZOPHRENIA, UNSPECIFIED (09/24/18)
BIPOLAR DISORD, CRNT EPISODE MANIC SEVERE W PSYCH FEATURES (09/24/18)
PERSONALITY DISORDER, UNSPECIFIED (09/24/18)
DRUG INDUCED AKATHISIA (09/24/18)
ESSENTIAL (PRIMARY) HYPERTENSION (09/24/18)
RESTLESSNESS AND AGITATION (09/24/18)
ADVERSE EFFECT OF OTH ANTIPSYCHOTICS AND NEUROLEPTICS, INIT (09/24/18)
PATIENT ROOM IN HOSPITAL AS PLACE (09/24/18)

Medications Given

Discontinued Medications

Acetaminophen (Tylenol Tab*) 650 mg PO Q6H PRN
PRN Reason: PAIN
Amlodipine Besylate (Norvasc Tab*) 10 mg PO DAILY SCH

Continued on Page 2

Medications Given - Continued

Last Admin: 10/15/18 09:56 Dose: Not Given
Device (Nicotine Mouth Piece*) 1 each INH .USE WITH NICOTROL PRN
PRN Reason: CRAVING
Lorazepam (Ativan Tab(*)) 0.5 mg PO BID SCH
Stop: 10/16/18 09:01
Last Admin: 10/15/18 09:57 Dose: Not Given
Metoprolol Tartrate (Lopressor Tab*) 25 mg PO BID SCH
Last Admin: 10/15/18 09:57 Dose: Not Given
Nicotine (Nicotine Inhaler*) 10 mg INH Q2H PRN
PRN Reason: CRAVING
Nicotine Polacrilex (Nicotine Gum*) 2 mg PO Q2H PRN
PRN Reason: CRAVING
Paliperidone (Invega Er Tab*) 6 mg PO DAILY SCH
Last Admin: 10/15/18 09:57 Dose: Not Given
Paliperidone Palmitate (Invega Sustenna*) 234 mg IM ONCE ONE
Stop: 10/05/18 15:01
Paliperidone Palmitate (Invega Sustenna*) 234 mg IM ONCE@0900 ONE
Stop: 10/06/18 09:01
Last Admin: 10/08/18 14:14 Dose: 234 mg
Paliperidone Palmitate (Invega Sustenna*) 156 mg IM ONCE ONE
Stop: 10/12/18 10:01
Last Admin: 10/12/18 11:31 Dose: 156 mg
Paliperidone Palmitate (Invega Sustenna*) 234 mg IM ONCE ONE
Stop: 11/09/18 10:26

Nursing Notes

10/15/18 12:30 Social Worker by Bliss,Alison
I met with patient this morning to check in and review her discharge plan. Patient presented as euthymic and was engaged in organized and reality based conversation. Patient's phone arrived in the mail in the last few days and she was able to charge it and get various phone numbers out of it. She confirmed with her neighbor that there is a key for her at her home and she can return there today. She will be taking a Medicaid Taxi directly to her home at time of discharge. She is agreeable with follow up with Dr. Breiman her primary care doctor and is aware that they will be calling her directly to schedule. She has declined outpatient mental health treatment, she has poor insight into the continued need for this saying "I just don't think it's necessary." She was informed we would still be giving her an intake appointment at TCMH and she is encouraged to follow up.

Initialized on 10/15/18 12:30 - END OF NOTE

10/15/18 12:30 Nursing Note by Aether,Shannon Esme
Discharge Note: Patient discharged home via taxi arranged by discharge planner. Patient alert and oriented upon discharge. In behavioral control. Able to make her needs known effectively. Patient verbalized readiness for discharge and denied further need to remain in the hospital for safety. Patient denied lethality towards herself or others. Denied confused thought processes. Patient reviewed discharge instructions and plan, verbalizing understanding and agreement. Patient signed releases of information for

Continued on Page 3

PCP and for TCMHC to coordinate treatment. Patient denied questions regarding discharge plan and has written copy. Escorted to main entrance to meet taxi by writer.

Initialized on 10/15/18 12:30 - END OF NOTE

10/15/18 05:41 Nursing Note by Luxner,Lynne
2300 - 0700

Patient did accept scheduled Ativan at HS medication pass, but still continued to refuse the metoprolol. Patient was seclusive to her room, but pleasant and polite with this RN.

Patient has appeared to have slept 7+ hours during this shift. No complaints/concerns noted at this time. Patient has had unlabored respirations noted while on Q-30 minute observations for safety. Will continue to monitor & support as necessary.

Initialized on 10/15/18 05:41 - END OF NOTE

10/14/18 21:57 Nursing Note by Trapper,Eric
1500-2300 shift. Pt presents as euthymic with congruent affect. Pt stated, "there is no change since yesterday. I need keys for my house and for my car. My car is still at the hotel I was staying at." Pt states readiness for discharge. Pt states not feeling at risk to herself or other people. Pt declined most evening medications. Pt did take Ativan as scheduled. Pt did not go to groups. Pt is meal compliant. Pt lying in bed for most of shift. Pt visualized to be safe on all checks. Will continue to monitor.

Initialized on 10/14/18 21:57 - END OF NOTE

10/14/18 13:29 Nursing Note by Hewitt,Anne
07:00 to 15:00- Pt euthymic with congruent affect. Pt makes needs known to staff. Pt observed walking around the unit and staying seclusive to self. Pt excited to be discharged tomorrow. Pt told writer that she called Hotel Ithaca for a reservation and was told that she was not allowed back on the property. Pt said, "Well, I guess I will just go home then". Pt denies SI/HI, depression, and anxiety. Pt given Ativan last night to help her sleep and she said it was successful. Pt denied medications this morning. Pt medication compliant but not group. Pt did not have any visitors. Pt safe on all checks and in behavioral control. Will continue to monitor.

Initialized on 10/14/18 13:29 - END OF NOTE

10/14/18 06:35 Nursing Note by Welch,Jonathan
2300-0700 Pt slept from 2300 to 0500. Pt appeared safe on all checks. Will continue to monitor.

Initialized on 10/14/18 06:35 - END OF NOTE

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Nursing Notes - Continued

10/13/18 21:24 Nursing Note by Trapper,Eric
1500-2300 shift. Pt presents as dysphoric with congruent affect. Pt stated, "I feel horrible for the situation that I'm in. I feel my restlessness is worse after getting my Invega injection. I think it's akathisia. I know my life will be like hell for months after getting Invega." Pt talked to Dr. Rahman and agreed to take 0.5 mg of Ativan BID for 3 days until being discharged on Monday. Scheduled Ativan administered per provider order for symptoms of akathisia. Pt declined all other evening medications. Pt is not going to groups and lies in bed often. Pt is meal compliant. Pt states not feeling at risk to self or others. Pt states not feeling safe on unit. Pt is looking forward to discharge. Pt visualized to be safe on all checks. Will continue to monitor.

Initialized on 10/13/18 21:24 - END OF NOTE

10/13/18 13:35 Nursing Note by Hewitt,Anne
07:00 to 15:00- Pt euthymic with a congruent affect. Pt still remains irritable at times but is more pleasant towards staff. Pt makes needs known to staff. Pt denies SI/HI, depression, anxiety, AH and VH. Pt slept through the night. Pt declined medications this morning but they weren't part of her TOO. Pt did ask why she was still on oral Invega after getting the initial injection and booster the other day. Writer told Pt to ask the On-call provider when they get in this afternoon. Pt observed walking around the unit but still remaining seclusive to self. Pt shaved today but did not complete any other ADLs. Pt meal compliant but still did not attend weekend groups. Pt safe on all checks and in behavioral control. Will continue to monitor.

Initialized on 10/13/18 13:35 - END OF NOTE

10/13/18 08:23 Vital Signs by Hewitt,Anne
07:00- Pt refused to have vitals taken.

Initialized on 10/13/18 08:23 - END OF NOTE

10/13/18 05:28 Nursing Note by Luxner,Lynne
2300 - 0700

Patient had refused HS metoprolol, but was polite about it. Kept to her room. Appeared to be asleep at the start of the shift. Woke up about 3 am and requested 2 orange juices. Was pleasant and grateful to RN for bringing her the juice. Returned back to sleep.

Patient has appeared to be asleep 6+ hours during the shift. Unlabored respirations noted on Q-30 minute observations for safety. Will continue to monitor & support as needed.

Initialized on 10/13/18 05:28 - END OF NOTE

10/12/18 18:30 Nursing Note by Lister,Barbara
1500-2300 Nursing Note:
Pt was in bed when approached for 1:1. Pt was very angry about getting the Invega Sustena today for she feels that she does not require that medication and stated she would have tried something else. She states that this medication has caused her to stutter, which was heard, and have a dry mouth. She states that

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she would like to go on medical marijuana. She describes her mood as "sucks so bad" due to getting the medication. She feels she is at "square zero" and has lots of anxiety about all that she has to do when discharged. She was worried about her cell phone. Her cell phone was delivered to the hospital where it was added to her belonging list and put into the safe. Pt is aware of this. She is very malodorous and unkempt. She came out of her room for dinner. She did not attend any groups. Pt states that the pain to her left shoulder area is a 2/10 when she is laying down and an 8/10 when she is up and moving around even when it is in a sling. Pt denies hallucinations. She does state that she has some paranoia regarding breaches in cyber security. Pt denies SI and HI. She has been safe on all visualized safety checks and in behavioral control. She will continue to be monitored for safety and for any changes to her mood, thoughts, affect, and behavior.

Initialized on 10/12/18 18:30 - END OF NOTE

10/12/18 14:57 Social Worker by Hoellrich,Cameron
This writer approached the patient about scheduling physical therapy appointments following her discharge. The patient stated, "I don't want you to schedule anything for me. I would prefer to do that myself." This writer informed the patient that an initial follow up scheduled by staff would ease her discharge transition, and was made aware that she could schedule all other appointments. The patient stated, "No, I have to do my research. I want to see the place, see what the parking is like. Those are all things I want to do myself."

This writer also informed that patient that a call was placed to Hotel Ithaca to determine if the patient's phone was sent to the hospital. The patient was made aware that a message was left regarding the cell phone.

Initialized on 10/12/18 14:57 - END OF NOTE

10/12/18 12:35 Nursing Note by Lenetsky,Selina
MEDICATION NOTE:

Dr. Ehmke ordered Invega sustenna 156mg booster for patient, pharmacy scheduled administration of medication for 1000 today. Patient states she will only accept IM administration of medication in right deltoid, as left shoulder is injured. This writer called pharmacy to ask if IM administration of booster in right deltoid is safe, as patient received initial injection of Invega sustenna also in right deltoid (usual practice is to administer booster in opposite deltoid as initial injection). Pharmacist asked to research this question, then called this writer back to confirm it is safe to administer Invega sustenna booster in same deltoid as initial injection site. 1115 this writer approached patient to ask if she is agreeable to Invega sustenna 156mg booster IM administration at this time. Patient states "I don't agree with any of this treatment over objection bullshit, but sure I will take the shot." This writer, charge nurse, and MHT present in patient's room during administration. Patient calm and in control throughout injection (given in right deltoid, per patient's request), patient tolerated well. Patient pleasant and cooperative after administration.

Initialized on 10/12/18 12:35 - END OF NOTE

10/12/18 12:27 MHU Staff by Schlee,Marissa
0700-1500

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Nursing Notes - Continued

Patient presents as dysphoric with congruent affect. Stated that today was the, "Dreaded day of getting shot up by invega, that shit ruins my life." Patient said the shot makes her feel unsafe. She seemed to be in a better mood post shot as evidenced by a smile on her face and she was seen tap dancing in her, "New and improved shoes with soul." Patient showed me signatures on legal papers that she was convinced were not from the same person based on very minute differences in signature. For example, one signature had a dot after the middle initial and the other one did not. Patient was visible in milieu with minimal interactions with staff and peers. She attended groups today. Was visualized safe on all 30 minute checks by staff, will continue to monitor for changes to safety.

Initialized on 10/12/18 12:27 - END OF NOTE

10/12/18 10:24 Social Worker by Bliss,Alison
I met with patient yesterday to check in and discuss discharge planning. Patient is now able to engage with writer in a more respectful manner, she is pleasant and talkative. She does require some redirection as she is hyperverbal and tangential but responded to my request to return to the topics at hand. Patient is looking forward to discharge on Monday. She is waiting for her phone to be mailed to CMC from Hotel Ithaca. She needs to be able to get the phone number for her neighbor out of her phone so that she can get back into her home. She states she lost her keys to both her car and home a little while before admission to CMC. She states she does still have belongings at Hotel Ithaca as well and they are holding them for her. She continues to demonstrate poor insight into her mental illness, she states she has no need to follow up with TCMH or Dr. Babiak. She states she is only willing to see Kevin Field, PhD for therapy as she worked with him in his private practice years ago. I let her know we are recommending she follow up with TCMH and I do not think Kevin has space to see her right now. She is willing to follow up with Dr. Brieman for primary care to continue monitoring healing from her injuries.

Initialized on 10/12/18 10:24 - END OF NOTE

10/12/18 06:16 Nursing Note by Welch,Jonathan
2300-0700 Pt Slept from 2300 to 0330 and then from 0500 to 0600. Pt. presented as safe on all checks. Will continue to monitor.

Initialized on 10/12/18 06:16 - END OF NOTE

10/12/18 05:55 Nursing Note by Luxner,Lynne
2300 - 0700
Patient has appeared to have slept 6+ hours during this shift. Patient has had no complaints or concerns during this time. Did wake up, requested juice, but was polite and soon returned back to sleep. Unlabored respirations have been noted on Q-30 minute observations for patient's safety. Will continue to monitor and support as needed.

Initialized on 10/12/18 05:55 - END OF NOTE

10/11/18 22:56 Nursing Note by Barrington,Matthew
1500-2300

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Nursing Notes - Continued

Patient presents as pleasant and neutral. Anne Rose met her goal today of making a payment to NYSEG to keep her heat on. The patient states "This is a big relief for me." She states that she has concerns about her discharge Monday, including driving with her sling, stating, "I live 5 miles out and I need to drive to the store to get groceries- how will I manage with my arm in this sling? I can't use it anyhow." Patient did not attend groups, but was observed out in the milieu occasionally. Negative for SI and SIB. Patient was observed as safe on all 30 minute safety checks by staff members. Staff will continue to monitor patient for changes in behavior, monitor for safety, and offer ongoing emotional support.

Initialized on 10/11/18 22:56 - END OF NOTE

10/11/18 16:34 Social Worker by Hoellrich,Cameron
Discharge planning group took place from 1520-1610. The group was delayed due to the therapy dog on the unit from 1500-1520. The group discussed identifying red flags for dangerous/unhealthy behavior and green flags for healthy positive behavior. The red and green flags were used in the development of a safety plan. The patient was able to provide responses both with and without prompting. Certain responses were relevant to the group topic, however others were unrelated and delusional in nature. She was able to be redirected without issue.

Initialized on 10/11/18 16:34 - END OF NOTE

10/11/18 10:14 Nursing Note by Powers,Joni Lynn
Patient out of room for breakfast in the common area with prompting. Afterward, patient approached medication window for scheduled medications. Compliant with Invega PO, but declined metoprolol and amlodipine. Cooperative during interactions, but continues to present with irritable edge related to ongoing hospitalization and lack of insight into medication indication and action. Remains seclusive to self in room much of shift.

Initialized on 10/11/18 10:14 - END OF NOTE

10/11/18 05:36 MHU Staff by Welch,Jonathan
2300-0700 Pt slept from 2300 to 0100 and then from 0200 to 0530. Pt presented as as safe on all checks. Will continue to monitor.

Initialized on 10/11/18 05:36 - END OF NOTE

10/10/18 22:20 Nursing Note by Jolly,Kelly
1500-2300

Patient presents as dysphoric, but brightens upon approach. She is pleasant and cooperative. Visible intermittently in the milieu and social with select peers and staff. She attended some groups this evening but not all stating, "I'm just tired from today and I would like to go to bed". She consumed meals and snack. She declined to take cardiac medications: Norvasc and Lopressor. Pt is wearing sling for shoulder injury, endorses pain but declined pain medication or intervention at this time. Visualized to be safe on all 15 minute checks.

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Initialized on 10/10/18 22:20 - END OF NOTE

10/10/18 13:35 Nursing Note by Cohen,Lyle

Addendum entered by Cohen,Lyle, RN 10/10/18 14:38:

Physical therapist came to the unit to examine the patient. Recommended use of sling and passive motion. Sling in place at this time, will continue to monitor.

Original Note:

Patient was seen by Occupational therapist however, patient declined treatment as she was "in too much pain to do anything." Patient would still like to see Physical therapist and was encouraged to follow up with OT if some of the pain is alleviated. Will continue to monitor.

Initialized on 10/10/18 13:35 - END OF NOTE

10/10/18 11:15 Nursing Note by Cohen,Lyle
0700-1500
Patient presents as dysphoric but brightens at times and is pleasant during conversations. Patient has been present in the milieu and attending groups throughout the shift. Patient complained of left shoulder pain, was offered Tylenol but declined. Patient again offered PT consult and was agreeable to seeing them; Dr. Ehmke notified and stated he will reorder the consult. Patient is med and meal compliant, has been visualized to be safe on all checks, will continue to monitor.

Initialized on 10/10/18 11:15 - END OF NOTE

10/10/18 06:11 Nursing Note by Welch,Jonathan
2300 - 0700 Pt slept from 2300 to 2345, and then from 0030 to 0600. Pt. presented as safe on all checks. Will continue to monitor.

Initialized on 10/10/18 06:11 - END OF NOTE

10/09/18 20:20 Nursing Note by Clark,Moriah A
11a-11p Anne presents this shift dysphoric with flat affect, brightening at times. Patient was minimally interactive with others unless approached. Patient continues to express anger regarding Invega Sustenna, stating, "Please just tell them not to give me the second shot of Invega. I am going to sue this hospital and leave here rich." Patient had contacted a lawyers office this AM. Patient participated in some groups during the day shift. Patient did not participate in evening shift groups. Patient remained in behavioral control this shift. Will continue to monitor for safety and thought content.

Initialized on 10/09/18 20:20 - END OF NOTE

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Nursing Notes - Continued

10/09/18 06:27 Nursing Note by Welch,Jonathan
2300-0700 Pt slept from 2300 to 2315 and then from 0000 to 0330 and then from 0400 to 0615. Pt. presented as safe on all checks. Will continue to monitor.

Initialized on 10/09/18 06:27 - END OF NOTE

10/08/18 21:10 Nursing Note by Trapper,Eric
1500-2300 shift. Pt presents as dysphoric with congruent affect. Pt is irritable at times and talks negatively about staff. At one point pt stated, "that nurse can go to hell for sitting next to me." When asked how pt is doing emotionally, pt replied, "I hate that question." Pt states not feeling safe on the unit. Pt states not feeling at risk to self or others. Pt is meal compliant. Pt visualized to be walking in milieu Pt did not go to groups and slept. Pt is not medication compliant. Pt observed while shaving during shift and remained in behavioral control. Pt visualized to be safe on all checks. Will continue to monitor.

Initialized on 10/08/18 21:10 - END OF NOTE

10/08/18 14:35 Nursing Note by Cohen,Lyle
0700-1500
Patient presents as dysphoric, irritable and argumentative. Patient received morning PO Invega (See EMAR) without issue. Patient attended morning groups and was present for breakfast and dinner. Patient met with Dr. Ehmke and became very agitated to learn that she would be given IM Invega Sustenna. Patient approached the nursing station and became argumentative with charge nurse stating that because she is "voluntarily" taking PO Invega she should not be required to receive the IM Invega Sustenna. When told that receiving the injection was not a choice patient stated, "I will sue everyone, you're all fucked" and "I hope enjoy federal prison." She then raised her middle finger to staff and stated, "Sit on it and spin." Dr. Ehmke reiterated the need to administer the medication.

Medication Administration:

Security was called to help facilitate medication administration as patient was extremely agitated. Unit manager present and spoke with the patient. Patient was asked to go to her room to receive the injection. Patient complied and sat on her bed. Patient stated she would not fight but did not want the shot. IM Invega Sustenna 234mg administered at 14:14, right deltoid, without issue (See EMAR). Patient is currently pacing the halls. Patient has been visualized to be safe on all checks, will continue to monitor for safety, thought content, and ill-effects of medication administration.

Initialized on 10/08/18 14:35 - END OF NOTE

10/08/18 05:33 Nursing Note by Luxner,Lynne
2300 - 0700
Patient has appeared to have slept 7+ hours during the night.
Patient has not had any complaints or concerns. Unlabored respirations noted while performing Q-30 minute observations for safety.
Will continue to monitor and support as needed.

Initialized on 10/08/18 05:33 - END OF NOTE

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10/07/18 21:02 MHU Staff by Schlee,Marissa
1500-2300
Pt presents as euthymic with an irritable edge. Pt has been meal compliant, but has declined going to groups this shift, spending some time in the milieu but most of the shift in her room. At the beginning of the shift, pt spent some time on the phone, when asked how the call went, she replied "it's always a shit show; I had to call the FBI". Pt states she is still having "a lot" of "unbearable" pain all through her left side, stating there are still bruises from over a month ago, as well as having two black eyes from the same incident over a month ago, which seemed to concern her. Pt insists that the T.O.O. papers were "not legally signed- the judge's signature is forged", she also shared, "this treatment over objection bullshit is invalid, I am not suffering from bipolar disorder, and they spelled my name wrong on one of the papers, so that should make it invalid automatically". Pt asked TW to send a fax to a mental hygiene lawyer, named Richard Wenig, to "decline the T.O.O", charger notified. Pt states "the invega makes me suicidal, I tried it two years ago and it was horrible". Pt has been safe on all checks and will continue to be monitored.

Initialized on 10/07/18 21:02 - END OF NOTE

10/07/18 12:04 Nursing Note by Smith,Megan L

Addendum entered by Smith,Megan L, RN 10/07/18 15:08:
Per Dr. Rahman; Invega Sustenna does not need to be administered today as patient has taken PO Invega this morning.

Original Note:

Addendum entered by Smith,Megan L, RN 10/07/18 12:39:
Per medication RN, patient presented to nursing station this morning requesting PO Invega without being prompted by staff to do so.

Original Note:

0700-1500 SHIFT NOTE:
Patient alert and oriented to person, place, time, and situation. Patient varies between calm, cooperative, and pleasant to irritable and restless. Patient speech normal in rate, rhythm, and volume; maintains appropriate eye contact. Patient thought process coherent and goal-directed; able to maintain linear conversation. Patient was heard yelling "ouch" from inside room, when this writer entered room to assess patient, patient stated "of course I'm not alright. I'm in fucking pain. I'm being physically abused by the police and psychologically abused by you guys. Have you ever seen Dr. Cliffy look sad?". Patient exited room and began walking hallway before turning around and screaming "30 seconds. That's how long that police officer beat me" while raising fist in the air. Patient offered and declined pain interventions including medication, heat, and ice. Patient intermittently visible in milieu. Patient requested to shave and was assisted by MHT. Patient agreeable to and received Invega ER 6mg PO; remains agitated when attempted to discuss administration of Invega Sustenna. Patient safe on all 15 minute observation checks.

Initialized on 10/07/18 12:04 - END OF NOTE

10/07/18 05:30 Nursing Note by Luxner,Lynne

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2300 - 0700
Patient has appeared to have slept 6+ hours during the night, waking after 5 am. She walked out to the nurse station and pleasantly requested juice. Patient has offered no complaints or concerns, nor did she want to engage in conversation as she had yesterday with her rumminations over the injection. Unlabored respirations while sleeping were noted on Q-30 minute observations for safety. Will continue to monitor and support as needed.

Initialized on 10/07/18 05:30 - END OF NOTE

10/06/18 21:02 Nursing Note by Clark,Moriah A
3-11 Anne presents this shift euthymic with congruent affect. Patient would not engage in 1:1 discussion with this writer and stated, "I don't have any problems." Patient was pleasant when approached other than when taking medication earlier in shift. Patient was present in milieu for a large portion of the shift. Patient did not participate in programming. Remained in behavioral control. Will continue to monitor for safety and thought content.

Initialized on 10/06/18 21:02 - END OF NOTE

10/06/18 10:49 Nursing Note by Smith,Megan L

Addendum entered by Cohen,Lyle, RN 10/06/18 15:29:

15:28
Patient willing to accept PO Paliperidone ER 6mg. Medication administered per Dr. Rahman without issue (See EMAR). Will continue to monitor.

Original Note:

0700-1100 SHIFT NOTE:
Patient alert and oriented to person, place, time, and situation. Patient calm, cooperative and pleasant during majority of interactions; becomes increasingly agitated when discussing current orders and medications. Patient speech normal in rate, rhythm, and volume; maintains appropriate eye contact. Patient thought process coherent and goal-directed; maintains linear conversation without losing train of thought. Patient visible in milieu throughout shift and observed to be writing or interacting with select peers. Patient agreeable to manual blood pressure with BP 142/76. Patient endorsed pain in left shoulder that increases when trying to raise or move arm; declined pain interventions such as medication and heat/ ice pack. Patient reported concern that shoulder "has never been x-rayed" and stated she would be agreeable to having xray.

Patient became agitated when approached for TOO Invega Sustenna; began shouting obscenities and stated "you're not competent enough to practice" while raising finger towards staff and pacing unit. Due to patient's recent injuries (nasal fracture, rib fracture, shoulder fracture) and risk of possible injury if restraint was to occur while administering medication, decision made to wait for further instruction from providers.

Initialized on 10/06/18 10:49 - END OF NOTE

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088571823

Nursing Notes - Continued

10/06/18 06:24 Nursing Note by Welch,Jonathan
2300 - 0700 Pt slept from 2330 to 2345 and then from 0300 to 0615. Paitent presented safe on all checks, will continue to monitor.

Initialized on 10/06/18 06:24 - END OF NOTE

10/06/18 05:49 Nursing Note by Luxner,Lynne
2300 - 0700

Patient was very talkative with this writer while writer was working as medication nurse 1900-2300 as written per evening nurse. Patient was irritable, angry and rumminative over court proceedings and how she was not in any need of mental health, and this hospital is committing atrocities, and many other comments specifically about psychiatrist who ordered the sustenna injection. Patient demanding to know why she is not being allowed to take the oral medication and all nurses should refuse to comply with the doctor's orders for the sustenna. Writer and other staff have attempted to re-direct her complaints after she has had some time to vent her frustrations. She continues to speak of her intelligence, her professional abilities as a computer programmer and how she's "at war".

Patient has slept a total of maybe 2 hours during the night. Unlabored respirations noted on Q-15 minute checks for safety. Will continue to monitor and assist as needed.

Initialized on 10/06/18 05:49 - END OF NOTE

10/05/18 22:17 Nursing Note by Barrington,Matthew
1500-2300
Patient presents as agitated, delusional, and hostile. "Anne Rose" was given the opportunity to appear before the honorable Judge Scott Miller of the County Court of Tompkins County but refused to do so in the matter for an order authorizing treatment over objection. The court ruled that it was in the best interest of the patient to treat the patient over the patient's objection pursuant to Section 33.03 of the Mental Hygiene Law. Anne Rose is observed walking about the milieu for the first time since her arrival. She has stated that she was not physically able to get out of bed, let alone go to court today and when asked about her change in physical status, she stated, "It's the threat of an injection of Invega Sustena- that is what motivates me." She is aware of the court's ruling and becomes angry and raises her voice against IM medications over objection. She states, "I don't want Invega- that's 6 months of hell I'll be going through. I'll take by mouth medications now, but I won't do that (Invega). Give me Seroquel or something." She stated that the "court application" is "invalid because Dr. Emhke lied about me." She is tangential; she talks about "being poisoned in 2014", being engaged in "a cyber warfare, subverted by unknown agents, maybe BlackHats International". The writer redirects her to her feelings and thoughts about the court proceedings, but she continues, " I have a 145 IQ and the Chief of the NSA thinks he can hack me?". Later in the evening she became irate with the medication nurse and requested "Kevin Fields, PhD, a clinical psychologist that will stand up for me- tell him I'll give him $200 cash from my wallet- it's an emergency." Patient has been observed as safe on all 15 minute safety checks by staff. Staff will continue to monitor for safety, for changes in behavior, and offer emotional support.

Initialized on 10/05/18 22:17 - END OF NOTE

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Nursing Notes - Continued

10/05/18 18:21 Nursing Note by Jolly,Kelly
Patient approached T/W at the nursing station with paperwork that she states "is from my doctor for medical marijuana". She appeared agitated, but not aggressive and preservating on her early interactions with provider. Pt recalled her perspective of their interaction stating," I don't agree with taking that injection, I want to take POs". When asked the reason for the preference pt became upset and stated "I went through this in 2012 and that Dr messed me up, he's psychotic. I do not need an anti-psychotic, my mental state is fine. I want you to call the state and verify". After acknowledging pt's feelings she appeared to calm and then stated that she would "like to go to the milieu and find some beverages".

Pt then returned to the nursing station about a half hour later still preservating on interactions with the provider and loss of court case. She stated, "I can't get an injection in my left arm because it is still bruised and messed up, it is not a viable site. I want you to assess it now and verify for the pharmacy. The cops beat me up and I need more medical care". T/W explained that I could assess her arm, but a decision would have to be made by a provider. Upon assessment pt was noted to have pain to the area, could not abduct her arm more than a few inches from her body, appeared to be swollen but no visible bruising noted. Pt continued to make paranoid statements about previous experiences with providers in other areas being "crazy too and I had to investigate them myself because no-one will do it". She then turned and returned to the milieu.

Initialized on 10/05/18 18:21 - END OF NOTE

10/05/18 14:37 MHU Staff by Dart,David
Presents as dysphoric with congruent affect. Has been in his room the whole shift because, "I cannot put clothes on." He states that, "I would feel safe if that crazy bitch [staff] and that freak [Doctor] were not here." Did not attend groups. States that he was abused by the police, brought to the hospital and is now being kept captive by the MHU. He denied anxiety and depression. Was visualized as safe on all checks. Will continue to monitor for changes to safety.

Initialized on 10/05/18 14:37 - END OF NOTE

10/05/18 13:21 Social Worker by Bliss,Alison
Court was held this morning at 10:30 for Treatment Over Objection. Judge Miller granted the TOO at the end of the hearing. Patient refused to attend court so only Dr. Ehmke testified.

After court I received a copy of the signed TOO order and a copy is now in patient's chart

Initialized on 10/05/18 13:21 - END OF NOTE

10/05/18 08:50 Nursing Note by Lenetsky,Selina
MEDICATION NOTE:

When offered her 0900 medications, patient states "no, those are not my medications. You can tell Dr. Ehmke to take them. I hope he chokes on them and dies. He is a fraud, psychopath, and a liar."

Initialized on 10/05/18 08:50 - END OF NOTE

Continued on Page 14

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center Loc:BEHAVIORAL SERVICES UNIT Bed:202-01
62 F 05/01/1956 Med Rec Num:M000597460 Visit:A00088571823

Nursing Notes - Continued

10/05/18 05:39 Nursing Note by Ferraro,Neely
2300-0700
Patient appeared to sleep approximately 5 hours, as evidenced by all routine checks throughout the shift. Pt. was safe on all checks and remains asleep at this time. Will continue to monitor.

Initialized on 10/05/18 05:39 - END OF NOTE

10/04/18 23:24 Nursing Note by Barrington,Matthew
1500-2300
Patient presents as highly agitated and tangential. "Anne Rose" reports that Dr. Emhke is a "sadistic psychopath who deserves to burn in the pit of hell!" She states the doctor is keeping her here against her will. He continues, "This is a cover up of a hate crime by a cop" and "I belong two floors up and deserve to be treated as a medical patient". She reports pain "11 out of fucking 10". Anne Rose exhibits signs of paranoid delusions with political fixations, stating "I have a relationship with the NSA" and "the FBI has me by the balls". Anne Rose has a court date tomorrow for treatment over objection, and states that "there's no way I can go- I'm not physically able; I can't put on clothes let alone walk down the hall". The writer offered the assistance of a wheelchair and skilled staff to assist him to the courthouse and she became highly agitated and yelled "no". At 1635 the SW Allison approached her about court and he burst out screaming at her. She is eating meals and completing ADLs independently. Patient was noted as safe on all 15 minute safety checks my staff. Staff will continue to monitor for changes in behavior, monitor for safety and offer emotional support.

Initialized on 10/04/18 23:24 - END OF NOTE

10/04/18 16:34 Social Worker by Bliss,Alison
I went into patient's room to talk to her about court tomorrow. I reminded her that court is scheduled for tomorrow at 10:30 am and we have a hospital van reserved to take her there and back with staff. Patient immediately became agitated, she told me she is incapable of walking and she is incapacitated. I reflected to her that we have observed her to walk from her bed to the bathroom and she was medically cleared prior to admission on our unit. At this patient became very angry with writer, raising her voice and screaming at me "what is wrong with you?! You're a maniac!! This is torture!!" I then left the room, other staff members responded to assess patient due to her continued agitation and yelling.

Initialized on 10/04/18 16:34 - END OF NOTE

10/04/18 14:29 MHU Staff by Wida,Kristen
Pt presents this shift as neutral, but brightened minimally during interaction. Pt remains seclusive to her room, lying in bed. Pt sits up in bed to consume meals, then lays back down again. Pt has not completed any ADL's this shift. While using the bathroom pt pulls the bathroom for general needs (juice/ food). She has been pleasant and calm during interaction until she mentioned her upcoming court appointment tomorrow, then pt became slightly irritable. Pt continues to refuse participation in unit programming as well as medications. Pt visualized as safe on all checks. Will continue to monitor.

Initialized on 10/04/18 14:29 - END OF NOTE

Continued on Page 15

Nursing Notes - Continued

10/04/18 06:17 Nursing Note by Ferraro,Neely
2300-0700
Patient appeared to sleep approximately 5.5 hours, as evidenced by all routine checks throughout the night. Pt. was safe on all checks and remains asleep at this time. Will continue to monitor.

Initialized on 10/04/18 06:17 - END OF NOTE

10/03/18 22:17 Nursing Note by Jolly,Kelly
1500-2300

Patient is alert and oriented. She continues to remain seclusive to her room laying in bed. Pt sits up in bed to consume meals and then lays back down again. Pt is able to ambulate with steady gait to her bathroom for toileting only, no other ADLS completed. While using the bathroom pt pulls the bathroom alarm to request juice and food items from staff. She is pleasant, calm and appropriate during conversation until asked questions about treatment or medications and then patient becomes irritable and short. Pt is refusing all groups and medications. Denies further needs at this time. Pt visualized as safe on all checks.

Initialized on 10/03/18 22:17 - END OF NOTE

10/03/18 15:45 Social Worker by Bliss,Alison
Correction patient's court is rescheduled for Friday at 10:30am. A van has been reserved to bring patient to court.

Initialized on 10/03/18 15:45 - END OF NOTE

10/03/18 13:54 Nursing Note by Hayes,Briar
Patient presents as neutral with an irritable edge, seclusive to her room lying down in bed all day, demanding of staff. Patient is not group-compliant, has not performed any ADLs this shift, and continues to refuse to put on clothes or come to the milieu for meals. Patient made statements suggesting that she is angry about her upcoming court date for Treatment over Objection status. When approached by this writer for her 1:1, patient called her provider "a creep impostor, a psychopath, he's in way over his head," and repeatedly referred to a passage in the patient handbook as "a contradiction," saying "don't you know what language is?" When this writer attempted to redirect patient to another subject, patient became insulting, cursing at this writer and demanding that I leave. Patient was then observed ambulating independently with steady gait quickly to her bathroom, where she activated the call bell alarm and demanded that staff "go get me some f***ing OJ." Patient has been visualized as safe on all checks, and continues to be monitored for safety and any changes in her mental status.

Initialized on 10/03/18 13:54 - END OF NOTE

10/03/18 09:19 Nursing Note by Hewitt,Anne
08:45- Pt states, "I don't need meds". Pt euthymic with congruent affect. Pt observed laying down in bed with 75% of breakfast eaten at her bedside tray. Will continue to monitor.

Continued on Page 16

Initialized on 10/03/18 09:19 - END OF NOTE

10/03/18 06:11 Nursing Note by Welch,Jonathan
Sleep- Pt. Slept from 2300 to 0215 and then from 0315 to 0600. No distress noted. Pt presented as safe on all checks, will continue to monitor.

Initialized on 10/03/18 06:11 - END OF NOTE

10/02/18 22:09 MHU Staff by McCoy,Andrew
1500-2300

Pt. described as tangential, a bit dysphoric but pleasant upon approach. When speaking with pt. on 1:1 she described her day as a slow day. Pt. was not able to attend groups. Pt. began talking about experiences on the 4th floor and says that the black and blue bruise on her left side of body is from security dealing with her. Also the pt. says that its Dr. "G.E." fault and hopes he "gets a long prison sentence" refers to Dr. as "the sadistic(expletive) and "he's a crook and fraud and wants to see him prosecuted." The pt. says she needs actual medical care. Pt. says she's not depressed but pissed off. Afterwards, pt was talking about history of MH issues, says currently "I'm clear of mind." Pt. cleared on all safety checks and monitors.

Initialized on 10/02/18 22:09 - END OF NOTE

10/02/18 11:35 Nursing Note by Smith,Megan L
0700-1500 SHIFT NOTE:
Patient alert and oriented to person, place, time, and situation. Patient calm, cooperative, and pleasant during majority of interactions; at times becomes slightly irritable when requests are unable to be met (ex: used bathroom call bell to request apple juice and verbalized frustration when informed no apple juice available). Patient speech normal in rate, rhythm, and volume; maintains appropriate eye contact. Patient presents with blunted affect, brightens minimally. Patient thought process coherent and goal-directed; denied lethality. Patient endorsed left sided body pain that increases when moving left arm; reported pain 3/10 on intensity scale, declined pain relief interventions. Patient has remained naked and seclusive to room throughout shift; has been observed ambulating independently with steady gait between bathroom and bed. Patient declined all medications and nursing interventions, including vitals and physical assessment. Patient consumed breakfast and lunch meal while seated on side of bed in room.

Initialized on 10/02/18 11:35 - END OF NOTE

10/02/18 05:40 Nursing Note by Luxner,Lynne
2300 - 0700

Patient has appeared to have slept 6+ hours through the night shift. Offered no complaints or concerns and only rang for staff with her bathroom call bell one time. Unlabored respirations noted on Q-15 minute checks for safety. Will continue to monitor & support

Continued on Page 17

Initialized on 10/02/18 05:40 - END OF NOTE

10/01/18 22:08 Nursing Note by Barrington,Matthew
1500-2300
Anne Rose presents lying in bed, dysphoric, and agitated. She remains secluded to her room and declines help with showering. Meal brought to her room at dinner. Patient reports pain 5/10, but declines prn medication. Patient remains unclothed beneath the sheets and disrobed to display ecchymosis on left dorsal flank. Patient states various legal threats against the Ithaca Police Department for battery. She continued in an elevated voice to state that the hospital would be facing legal challenges from her regarding Treatment Over Objection. She asks, “What gives you the right, I want to know?” Patient denies SI or SIB. Denies AH. Anne Rose used the bathroom call bell while having a movement in order to request being brought dessert. Patient was observed as safe every 15 minutes on safety checks by staff members. Staff will continue to monitor patient for changes in behavior, monitor for safety, and offer emotional support.

Initialized on 10/01/18 22:08 - END OF NOTE

10/01/18 14:06 Social Worker by Bliss,Alison
Court for TOO is scheduled for Friday Oct 5th at 10:00 am.

Copy of petition is in patient's chart.

I served patient a copy of petition, updated legal rights, and letter informing her of TOO. Patient quickly became agitated and questioned writer about my opinion of her safety. Patient refused to take the paperwork from me so I left it on a shelf in her room. I attempted to explain the process for going to court and patient's right to an attorney. I told her Kristin from MHLS would be representing her. Patient became increasingly upset and said "Do you think you belong in hell? This is psychiatric torture." I then left the room.

Initialized on 10/01/18 14:06 - END OF NOTE

10/01/18 12:45 Nursing Note by Aether,Shannon Esme
Patient remains seclusive to her room throughout the day. She continues to decline offers of assistance with ADLs including help with shower or bed bath. Patient continues to decline OT/PT. Patient declined medications this morning, expressing profanity to describe her perception of prescribed medications. Meals brought to patient in her room at both breakfast and lunch, eating each meal and denying complaints. Patient also offered radio in her room per provider order and in response to patient's recent statement that she would enjoy listening to the radio- when radio was brought to patient, she was dismissive and declined offer, explaining that she would not be able to adjust radio stations. Writer offered to assist patient with setting up the radio in a place where she could easily reach the switches herself, and she declined, stating, "I already have music in my head."
Patient denies thoughts of lethality towards herself or others. Denies AH. Patient continues to express paranoid ideation regarding inpatient psychiatric admission, asserting he was inappropriately brought to this unit. Patient unable to tolerate reality based feedback and quickly raises her voice in a dismissive, angry manner when attempts are made to communicate in an interactive manner.
Safe on all visual checks. Will continue to monitor.

Continued on Page 18

Initialized on 10/01/18 12:45 - END OF NOTE

10/01/18 05:42 Nursing Note by Parseghian,Roberta E
The patient was awake most of the night lying in bed. Pt fell asleep about 3am and is still asleep at this time. Safe on all visual safety checks. Will continue to be monitored.

Initialized on 10/01/18 05:42 - END OF NOTE

10/01/18 00:18 Nursing Note by Parseghian,Roberta E
Since the beginning of the 11-7 shift Bonze Anne Rose has complained every time staff opened the door for 15 min safety checks. At 0015 patient pulled the bathroom alarm. This writer found the patient sitting on the toilet and denied any particular needs but rudely stated " Make sure the door is closed every time you guys open it and stop looking at me every fifteen minutes." Pt was informed staff legally were required to monitor every fifteen minutes per MD order. Pt replied "No you don't have to open the door every fifteen minutes." Pt refused to allow the alarm to be turned off stating "I will turn it off when I am ready." Patient turned off the alarm a few minutes later. Safe on all visual safety checks.

Initialized on 10/01/18 00:18 - END OF NOTE

09/30/18 19:07 Nursing Note by Lister,Barbara

Addendum entered by Lister,Barbara, RN 09/30/18 20:05:

Pt did not take her evening meds.

Original Note:

1500-2300 Nursing Noet;
Pt presents as dysphoric and restricted this shift. Pt is pleasant to one to one during interactions in her room. Pt is still seclusive to her room, specifically her bed where she lays on her back, naked. Pt expresses anger towards the police who beat her up and Dr. Ehmke for her being here and her previous admission. Pt is clearly frustrated about being on this unit expressed by her desire to want to be on the medical floor where she can get "real healthcare" and where she can get OT and PT. She expresses wanting to have OT and PT but only on that floor. Writer tried bringing a wedge to pt to help get her off of her back so that she does not get pressure sores but pt declined. She states that the pain is too much to try to lay on either side. Pt does not move her left arm or shoulder. Her pain level is a 2-3 at rest. She denies auditory and visual hallucinations and delusions. She is not suicidal. She has anxiety about not knowing when she is going to get "real healthcare" and states always having some level of depression. Pt declines trying to do ADL's. She ate dinner in her room. She states that she is also "conserving energy" for she is not "getting enough to eat or drink." Pt has been in behavioral control and safe on all visualized safety checks. She will continue to be monitored for safety and for any changes to her mood, thoughts, affect, and behavior.

Initialized on 09/30/18 19:07 - END OF NOTE

Continued on Page 19

Nursing Notes - Continued

09/30/18 09:31 Nursing Note by Aether,Shannon Esme
Patient accepted breakfast in her room per unit routine. Able to make her needs known effectively. Patient denied AH. When asked about lethality, patient denied SI but reported that she hoped harm would come to the individual who forced her to come to the inpatient BSU. Patient described this individual as someone falsely posing as a police officer. Patient denied active thoughts to harm anyone including
Patient was again encouraged to consider showering, getting dressed and entering the milieu. Patient declined in a dismissive, somewhat exasperated manner. Writer offered patient assistance with bed bath/ ADLs, and she declined, stating that this could only occur on the medical floor. Patient states that she can use her left hand minimally but continues to report pain/discomfort in left shoulder (3 out of 10) that she reports hinders full range of motion. Patient continues to accept tylenol and declines scheduled medications. Patient again encouraged to wear sling and/or meet with OT/PT, and she declined; patient asserted that the OT/PT staff who visit on this floor are "imposters". Patient offered call bell and she denied need. Patient did allow writer to change her bedding and was observed walking with steady gait from the bed to her bathroom. Safe on all visual checks. Will continue to monitor.

Initialized on 09/30/18 09:31 - END OF NOTE

09/30/18 05:01 Nursing Note by Hewitt,Anne
23:00 to 07:00- Pt asleep at start of shift. Pt woke up at 04:05 by setting off the alarm in her bathroom. Two psych techs responded to the alarm and Pt said she just wanted an apple juice. Apple juice was provided without incident. Pt went back to sleep after drinking her juice. Pt has remained in behavioral control and is safe on all checks. Will continue to monitor.

Initialized on 09/30/18 05:01 - END OF NOTE

09/29/18 19:24 Nursing Note by Parseghian,Roberta E
Bonze Anne Rose has remained in bed the entire shift. Patient's dinner was served in pt's room and patient only ate the meatloaf and nothing else. Patient complained about not receiving dessert. The patient did not attend groups and refused to take HS medications. Patient continues to request transfer to the medical floor. Safe on all visual safety checks. Will continue to be monitored.

Initialized on 09/29/18 19:24 - END OF NOTE

09/29/18 09:36 Nursing Note by Aether,Shannon Esme
Patient remains seclusive to her room this morning. Breakfast provided at bedside. Patient declined morning medications, asserting, "They're not my medications." Patient declined offer of assistance getting dressed, asserting she would not be able to get her left arm into a garment sleeve. Writer offered assistance and showed patient an open cardigan, offering assistance and suggesting patient apply sling. Patient became increasingly irritable/angry and directed writer to take article of clothing out of her room immediately. Declined need for sling. Patient asserted that the only intervention that would help is transfer to the medical floor. Writer asked patient if she would be interested in meeting with OT or PT, and she again declined, stating that these disciplines "don't have anything to offer". Patient dismissed writer and asked to be left alone. Safe on all visual checks. Will continue to monitor.

Continued on Page 20

Initialized on 09/29/18 09:36 - END OF NOTE

09/29/18 06:13 Nursing Note by Luxner,Lynne
2300 - 0700

Patient was much more pleasant this shift than she was last night. She was not overly demanded. Did request milk at the start of the shift and juice in the morning, otherwise, she was a lot more appropriate. 5.5 hours of sleep notated with unlabored respirations on Q-15 minute observations for volatile behaviors and potential for unpredictable behavior. Will continue to monitor & support.

Initialized on 09/29/18 06:13 - END OF NOTE

09/28/18 19:43 Nursing Note by Lister,Barbara
1500-2300 Nursing Note:
Pt was pleasant to writer during all interactions. She spent the entire shift in her room, naked. During first interaction, pt showed writer her bruising. Her hair is unkempt. She states inability to move her left arm as the reason she is not getting dressed. She stated that she is getting lonely in her room. Pt repeated a few times that she should be on the medical floor getting OT and PT and that she does not have any psychological problems that would warrant an admission to the BSU or require her to take any psychological medications which she is refusing. She denies hallucinations, SI, and HI. She admits to having some level of depression for most of her life and states that the anxiety she is having is due to not "knowing when I will get out of here." Pt ate meals in room. She has been in behavioral control and safe on visualized safety checks. She will continue to be monitored for safety and for any changes to her mood, thoughts, affect, and behavior.

Initialized on 09/28/18 19:43 - END OF NOTE

09/28/18 13:51 Nursing Note by Barton,Nathaniel

0700-1500: Pt presents as calm with a neutral affect, until engaged at which point the Pt quickly becomes irritable. The Pt declined any formal 1:1, stating "you can go now...this is not treatment, this is torture, get out now." The Pt has stayed in their room for the entire shift, and has only gotten out of bed to use the bathroom. Safe on all checks; will continue to monitor for any changes in mood and behavior.

Initialized on 09/28/18 13:51 - END OF NOTE

09/28/18 04:09 Nursing Note by Luxner,Lynne
2300 - 0700

Patient was asleep for a few hours, on and off. She has been demanding of staff, wanting multiple juices throughout the night (3 orange, 6 apple juices) - She stated, "This hospital is a disgrace. I'm so dehydrated and they won't transfer me to medical. Do you see my side? It's so sore, I can't walk down to the nurse's station." She has been naked in her room, walking between her bed and her bathroom, flipping on the help light in the bathroom to call staff to tell them that she wants juice. She states that she can't drink water out of the yellow pitcher, because she can't lay down with the yellow pitcher like she can with the little juices.

Continued on Page 21

Patient would benefit from a behavior modification plan that would help the 3 shifts with setting limits on the kind and number of beverages to give patient during the shift. Patient is on Q-15 minute observations for safety. Will continue to monitor & support.

Initialized on 09/28/18 04:09 - END OF NOTE

09/27/18 22:03 Nursing Note by Vanpetten,Jacqueline
Pt. seclusive to her room in bed majority of the shift, no interaction with peers/staff. Writer offered patient hospital scrubs/gown, writer encouraged patient to ambulate around unit with assistance, pt refused, Pt. yelled at writer. Pt. stated" I feel lonesome, i was in Denny's a guy posing as a cop beat me up because i was doing some pretty weird stuff, i can't put a gown on it hurts. i feel insulted you are not a physical therapist i want go back to the 4th floor." Pt. c/o" Body Pain 8/10" Pt. ate 100% dinner at her bedside, frequently requested apple juice. Pt. also stated" I don't need to be here on this unit." Pt. denies suicidal ideation,anxiety,and depression. Continue to monitor pt safety,mood, behavior. Pt. safe on all visualized checks.

Initialized on 09/27/18 22:03 - END OF NOTE

09/27/18 16:18 Social Worker by Bliss,Alison
I have attempted to meet with patient and engage her in conversations about treatment and discharge planning numerous times since her admission. Patient recalls writer from previous admissions and has been willing to engage in minimal conversation. She does not want to discuss many personal details of her life, when I ask her about her housing she initially would not share any information with me. She then shared that she has about quite a few thousand dollars in the bank, likely from the sale of a property and she has been living off of that. She will not say where she would plan to live after discharge. She is insisting that she needs to go back to the medical floor and that we were not authorized to admit her to the mental health unit. She presents as disheveled and irritable, she stays in her bed with no clothes on wearing only a blanket. She expresses paranoid ideation throughout our meeting. Patient requested that I bring her apple juice and we ended our meeting.

I submitted Treatment Over Objection Petition, 2PC, and clinical record to Tom Smith at Harris Beach as the hospital is pursing TOO due to patient's refusal to take medication

Patient is now on 2PC

Initialized on 09/27/18 16:18 - END OF NOTE

09/27/18 12:44 Nursing Note by Aether,Shannon Esme
Cynthia Perez (607-760-3587) orthopedic PA (associated with Dr. Blake) contacted by writer to convey request from OT/PT that recommendations regarding use of sling are required for their services to be initiated. Cynthia stated that she would enter a note that will be accessible/viewable to facilitate this process.

Initialized on 09/27/18 12:44 - END OF NOTE

Continued on Page 22

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088571823

Nursing Notes - Continued

09/27/18 11:12 Nursing Note by Aether,Shannon Esme
Patient has been seclusive to her room throughout the morning. Breakfast provided to room at bedside table. Patient expressed gratitude for meal. Speech was noted to be less pressured but still tangential as patient emphasized dissatisfaction with on-going inpatient psychiatric admission, stating that she feels her needs would be better met on the medical floor. Patient identified benefit of having access to an electronic nurse/nurse aide call bell where she could specify which need was required (drinking water, bathroom, bedside assistance). Patient declined need for call bell despite encouragement and clarification that nursing staff could easily address whatever request was stated upon response.
Writer asked patient if she would be willing to work with PT or OT to address her report of poor mobility in left shoulder s/p reductive surgery.
Patient declined, asserting that these services will not be able to effectively assist her while she is in the psychiatric unit. Patient rejected feedback that (per OT/PT progess notes) she had also refused to meet with either discipline while on the medial floor, stating that this is a false statement that originated from treating psychiatrist.
Apple juices x 2 brought to patient later in the morning.
Safe on all visual checks. Will continue to monitor.

Initialized on 09/27/18 11:12 - END OF NOTE

09/26/18 20:39 Nursing Note by LeFevre,Mary
1500-2300

Pt has been seclusive to room, lying in bed the entire shift, only getting up to use the restroom. Pt was pleasant upon approach. Pt denied formal 1:1 stating " There's too much to get into in a 1:1, but basically I need to be on a medical floor with medical care, but thank you anyway." Pt further stated "I'm not depressed just angry. Psychiatry has nothing to offer me that I would need." Pt ate meal in bed, and did not attend groups. Pt continues to be visualized as safe on all checks, will continue to monitor.

Initialized on 09/26/18 20:39 - END OF NOTE

09/26/18 11:21 Nursing Note by Aether,Shannon Esme
Patient seclusive to her room throughout the morning. Breakfast provided to patient at her request, 100% of the meal consumed. Patient was initially receptive to meeting with writer when approached, launching into tangential, lengthy and repetitive narrative regarding perceived injustices that she feels she is experiencing: Patient expressed outrage that her medical needs are not being met, and repeatedly demanded she be re-admitted to the medical floor. However, when asked multiple times how her well-being and treatment would be enhanced on the medical floor, patient unable to specify. When patient was asked to identify comfort measures, nursing interventions, and/or alternatives to alleviate her stated discomfort, patient unable to state apart from returning to the medical floor. Patient yelled at writer, "Are you even an RN!?!" as she became increasingly hostile and irritated. Patient intermittently interjected her beliefs that she has been illegally admitted to the psychiatric unit, and appears to suffer from persecutory beliefs regarding involuntary admission- patient identifying treating psychiatric provider as individual responsible for admission.
Patient also discussed her long term involvement working for the NSA as a software developer for classified intelligence. Patient asserts that she would be homicidal if she needed to defend her country, and generalized this statement to protecting/defending this nation. When asked about suicidal ideation, patient replied that she did not want pain medication because her left shoulder pain "keeps me registered". Patient did decline offer of tylenol to alleviate discomfort.

Continued on Page 23

Nursing Notes - Continued

Patient refused to complete all admission paperwork including her treatment plan, asserting content is fraudulent. Patient abruptly ended the conversation by screaming at writer and demanding that apple juice be brought to her room "every hour on the hour". Space provided as conversation was clearly non-productive and appeared to be instigating patient's agitation. Safe on all visual checks. Will continue to monitor.

Initialized on 09/26/18 11:21 - END OF NOTE

09/26/18 08:25 Nursing Note by Hewitt,Anne

Addendum entered by Smith,Megan L, RN 09/26/18 08:49:
Patient initially agreeable to lab work but then declined when phlebotomist explained that she needed to move patient's bed slightly away from wall so that she could access patient's uninjured arm (patient would not have needed to exit bed).

Original Note:

Medication Note: Pt refused all morning meds and said, "Why do I need them? I don't need help with my mental state only my physical". Pt did agree to labwork this morning. Will continue to monitor.

Initialized on 09/26/18 08:25 - END OF NOTE

09/26/18 06:26 Nursing Note by Barton,Nathaniel

2300-0700: Pt slept for the entire shift. Safe on all checks; will continue to monitor for any changes in mood and behavior.

Initialized on 09/26/18 06:26 - END OF NOTE

09/25/18 20:15 Nursing Note by Parseghian,Roberta E
Bonze Anne Rose laid in bed all shift so far only sitting up in bed to eat dinner and snack in her room. She did not attend groups and declined medications including acetaminophen which was offered for pain. Pt reports pain from injuries sustained prior to admission. On skin assessment pt's upper left arm is swollen with redness towards the back of the arm. Her left side is bruised from under the arm to the waist in shades of reds to dark purple.There is bruising under the eyes also. Pt requests transfer to a medical floor claiming her "physical needs are not being met" and "the unit is not conducive to healing from the abuse I suffered". She does not believe she needs mental health treatment and made derogatory comments about her assigned provider. Pt refused to wear clothing and remained naked this shift. Safe on all 15 min safety checks. Will continue to be monitored.

Initialized on 09/25/18 20:15 - END OF NOTE

09/25/18 13:41 Nursing Note by Barton,Nathaniel

Continued on Page 24

0700-1500: Pt has laid in bed for the entire shift. She has refused to get out of bed for anything other than the bathroom. The Pt refused any formal 1:1, and even refused to discuss and basic needs. The Pt requested breakfast in bed, and the requested to be left alone. Pt refused to sign any paperwork. She has been safe on all checks; will continue to monitor for any changes in mood and behavior.

Initialized on 09/25/18 13:41 - END OF NOTE

09/25/18 12:43 Nursing Note by Hewitt,Anne
Medication Note: Writer went to Pt to ask about medications. Pt said, "No, no, no. I am insulted that I am even being prescribed these medications. I am of sound mind and I am not a harm to myself or others. I have noticed an increase in crazy people and that is why I say just 'shoot em' meaning take them to jail or get them off the street." Writer said, "ok, I just need verbal confirmation. Pt replied, "No,no, no ever". Will continue to monitor.

Initialized on 09/25/18 12:43 - END OF NOTE

09/25/18 08:30 Vital Signs by Hewitt,Anne

Addendum entered by Hewitt,Anne 09/25/18 13:46:
13:46- Charge nurse did not refuse to bring Pt her meals in their room but reviewed it with treatment team. Treatment team said that Pt can eat meals in their room. Will continue to monitor.

Original Note:

08:00- Pt refused to have vitals taken but told the psych tech, "I am feeling awful today". Writer let the tech know that getting the Pt's vitals is the only way for us to determine how the Pt is feeling. Pt would refuse vitals being taken on the medical floor as well. Pt then requested to have breakfast in bed but charge nurse refused. Will continue to monitor.

Initialized on 09/25/18 08:30 - END OF NOTE

09/25/18 06:01 Nursing Note by Luxner,Lynne
2300 - 0700

At time of writing, patient appears to have slept ~6 hours. Did wake once during the night & requested a drink. Unlabored respirations noted on Q-15 minute observation status. Will continue to monitor & support as needed.

Initialized on 09/25/18 06:01 - END OF NOTE

Continued on Page 25

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center Loc:BEHAVIORAL SERVICES UNIT Bed:202-01
62 F 05/01/1956 Med Rec Num:M000597460 Visit:A00088571823

Orders

09/25/18 11:00
Acetaminophen TAB* [Tylenol TAB*] 650 mg PO Q6H PRN
Metoprolol Tartrate TAB* [Lopressor TAB*] 25 mg PO BID
Paliperidone ER TAB* [Invega ER TAB*] 6 mg PO DAILY
amLODIPine TAB* [Norvasc TAB*] 10 mg PO DAILY

09/26/18 06:00
Hemoglobin A1c [CHEM] Routine
Comment:
Department: ERI0089
Specimen: Send someone from the department to collect
Lipid Profile [CHEM] Routine
Comment:
Department: ERI0089
Specimen: Send someone from the department to collect

09/26/18 13:09
Nursing Communication Routine
Request: Medical bed please for patient comfort.

09/26/18 13:10
Mouth Piece, Nicotine* [Nicotine Mouth Piece*] 1 each INH .USE WITH NICOTROL PRN
Nicotine GUM* 2 mg PO Q2H PRN
Nicotine Inhaler* 10 mg INH Q2H PRN

09/27/18 10:30
OT [Occupational Therapy] Routine
Comment:
Physician Instructions:
Occupational Therapy Order:: status post separated left shoulder
PT [Physical Therapy] Routine
Comment:
Physician Instructions:
Physical Therapy Order:: status post separated left shoulder

09/27/18 12:16
PT [Physical Therapy] Routine
Comment:
Physician Instructions:
Physical Therapy Order:: NWB, no pushing or pulling, no abd or ff above 90, no external rotation

09/27/18 12:18
OT [Occupational Therapy] Routine
Comment:
Physician Instructions:
Occupational Therapy Order:: NWB, no pushing or pulling, no abd or ff above 90, no external rotation

10/01/18 12:14
Nursing Communication Routine
Request: Patient may have a radio in her room.

Continued on Page 26

Orders - Continued

10/04/18 06:00
Hemoglobin A1c [CHEM] Routine
Department: KRY0002
Lipid Profile [CHEM] Routine
Department: KRY0002

10/05/18 15:00
Paliperidone SUSTENNA* [Invega Sustenna*] 234 mg IM ONCE ONE

10/05/18 15:11
Nursing Communication Routine
Request: Patient must have single room

10/06/18 09:00
Paliperidone SUSTENNA* [Invega Sustenna*] 234 mg IM ONCE@0900 ONE

10/06/18 13:25
SHOULDER LEFT 2+ VWS [DX] Stat
Comment:
Is Patient Pregnant:
Mode Of Transportation: Portable
Physician Instructions:
Reason For Exam: to rule out fracture/dislocation
Treat with highest level priority (Code situation, ABC, etc): No
Type of Isolation: Standard Precautions

10/10/18 11:10
OT [Occupational Therapy] Routine
Comment:
Physician Instructions:
Occupational Therapy Order:: Separated Left Shoulder
PT [Physical Therapy] Routine
Comment:
Physician Instructions:
Physical Therapy Order:: Separated Left Shoulder

10/10/18 14:38
Nursing Communication Routine
Request: Patient may wear sling on left arm

10/11/18 11:00
Observation: q30 minutes QSHIFT
Physician Instructions:
Patient Privileges QSHIFT
Physician Instructions: computer per nursing limits

10/12/18 10:00
Paliperidone SUSTENNA* [Invega Sustenna*] 156 mg IM ONCE ONE

10/13/18 21:00
LORazepam TAB(*) [Ativan TAB(*)] 0.5 mg PO BID

Continued on Page 27

10/15/18
Discharge Patient From System Routine
Comment:
Actual Time of Discharge:: 12:15
Discharge Disposition: HOME

10/15/18 10:32
Discharge Routine
Comment:
Anticipated time of Discharge: 11
Discharge Disposition:: HOME

11/09/18 10:25
Paliperidone SUSTENNA* [Invega Sustenna*] 234 mg IM ONCE ONE

Laboratory Information

	09/28/18 07:34	09/28/18 07:34	10/08/18 07:14
Hemoglobin A1c		5.4	
Triglycerides	173		99
Cholesterol	161		183
LDL Cholesterol	84		108
HDL Cholesterol	42.5		54.9

	10/08/18 07:14
Hemoglobin A1c	5.3
Triglycerides	
Cholesterol	
LDL Cholesterol	
HDL Cholesterol	

ED Visit information

Last Name: BLAYK Status:
First Name: BONZE Priority:
Middle: ANNE ROSE Condition: Improved
Birthdate: 05/01/1956 Arrival Date/Time:

Continued on Page 28

BLAYK,BONZE ANNE ROSE

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

62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

ED Visit information - Continued

Age:	62	Arrival Mode:	
Sex:	F	Triaged At:	
Language:	ENGLISH	Time Seen by Provider:	

Stated Complaint:
Chief Complaint:

ED Location:
Area:
Station:
Group:
ED Provider:
ED Midlevel Provider:
ED Nurse:
Primary Care Provider: No Primary Care Phys,NOPCP

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)

Initial Vital Signs

Continued on Page 29

BLAYK,BONZE ANNE ROSE

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

62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Initial Vital Signs - Continued

	Temp	Pulse	Resp	BP	Pulse Ox
10/15/18 09:33			16		
10/14/18 21:52			16		
10/14/18 19:59			16		
10/14/18 11:34			16		
10/14/18 07:48			16		
10/13/18 22:47			16		
10/13/18 20:01			16		
10/13/18 11:36			16		
10/13/18 08:36			16		
10/12/18 12:06			16		
10/12/18 08:51	97.5 F	90	14	135/82	97
10/11/18 10:11			18		
10/11/18 08:22			16		
10/10/18 09:43			16		
10/10/18 08:04				122/88	
10/10/18 07:22		91			95
10/09/18 16:12			18		
10/08/18 10:38			16		
10/08/18 08:01	97.9 F	98	16		99
10/07/18 10:57			17		
10/07/18 07:45	98.0 F	111	16		98
10/06/18 09:17			16		
10/06/18 08:58				142/76	
10/05/18 12:18			16		
10/05/18 07:57			16		
10/05/18 07:24	97.8 F	85	14		98
10/04/18 08:41			16		
10/04/18 08:19			16		
10/03/18 11:25			16		
10/03/18 07:30		79	16		99
10/02/18 10:48			16		
10/01/18 12:34			16		
10/01/18 07:46			16		
09/30/18 09:17			16		
09/30/18 08:22	98.5 F	88	16		99
09/29/18 09:36			16		
09/29/18 09:20			16		
09/29/18 08:38	99.1 F	80	20		98
09/28/18 13:47			16		
09/28/18 08:44			16		
09/27/18 10:54			16		
09/26/18 10:51			16		
09/26/18 09:03	98.6 F	85	16		
09/25/18 12:37			16		
09/24/18 20:56	98.0 F	108	16	153/90	97

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Last Documented Vital Signs

	Temp	Pulse	Resp	BP	Pulse Ox
10/15/18 09:33			16		
10/14/18 21:52			16		
10/14/18 19:59			16		
10/14/18 11:34			16		
10/14/18 07:48			16		
10/13/18 22:47			16		
10/13/18 20:01			16		
10/13/18 11:36			16		
10/13/18 08:36			16		
10/12/18 12:06			16		
10/12/18 08:51	97.5 F	90	14	135/82	97
10/11/18 10:11			18		
10/11/18 08:22			16		
10/10/18 09:43			16		
10/10/18 08:04				122/88	
10/10/18 07:22		91			95
10/09/18 16:12			18		
10/08/18 10:38			16		
10/08/18 08:01	97.9 F	98	16		99
10/07/18 10:57			17		
10/07/18 07:45	98.0 F	111	16		98
10/06/18 09:17			16		
10/06/18 08:58				142/76	
10/05/18 12:18			16		
10/05/18 07:57			16		
10/05/18 07:24	97.8 F	85	14		98
10/04/18 08:41			16		
10/04/18 08:19			16		
10/03/18 11:25			16		
10/03/18 07:30		79	16		99
10/02/18 10:48			16		
10/01/18 12:34			16		
10/01/18 07:46			16		
09/30/18 09:17			16		
09/30/18 08:22	98.5 F	88	16		99
09/29/18 09:36			16		
09/29/18 09:20			16		
09/29/18 08:38	99.1 F	80	20		98
09/28/18 13:47			16		
09/28/18 08:44			16		
09/27/18 10:54			16		
09/26/18 10:51			16		
09/26/18 09:03	98.6 F	85	16		
09/25/18 12:37			16		
09/24/18 20:56	98.0 F	108	16	153/90	97

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments

Admission 01: General/Advance Directives Start: 09/24/18 18:54
Freq: Status: Complete
Protocol:

Document 09/25/18 00:51 BRA0067 (Rec: 09/25/18 00:53 BRA0067 BSU-C09)

Admission Data

Admission Data

Information Obtained From	Prior Records Pre-Admission Assessment
Swing Patient	No
Patient Wearing Medication Patch	No
Valuables Form Completed	Yes
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
Medical Advanced Directives in Effect	No
Reason Medical Advanced Directives Not in Effect	Refused
Advance Directives Location	No Advance Directives

Psychiatric Advance Directives

Psychiatric Advance Directive in Effect	No
Reason Psychiatric Advanced Directives Not in Effect	Refused
Patient Given Information About Psychiatric Advance Directives	Unable

Height/Weight

Height/Weight

Height	5 ft 6 in
Weight	166 lb
Actual/Estimated Weight	Estimated
Weight Comment	Weight info from medical/ surgical floor admission.
Body Mass Index (BMI)	26.8

Document 09/25/18 12:37 NAT0065 (Rec: 09/25/18 13:05 NAT0065 BSU-C31)

Admission Data

Admission Data

Information Obtained From	Prior Records
Swing Patient	No
Patient Wearing Medication Patch	No
Valuables Form Completed	Yes
Valuables Placed in Safe	Yes
Does Patient Have Own Meds with Them	No
Patient Rights Booklet Given?	Yes

Advance Directives

Medical Advance Directives

Code Status	Full Code
Code Status Requires Follow Up?	N
Medical Advanced Directives in Effect	No
Reason Medical Advanced Directives Not	Refused

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

in Effect	
Advance Directives Location	No Advance Directives
Medical Orders for Life Sustaining Treatment (MOLST)	No
Psychiatric Advance Directives	
Psychiatric Advance Directive in Effect	No
Reason Psychiatric Advanced Directives Not in Effect	Refused
Patient Given Information About Psychiatric Advance Directives	Unable

End of Life Care

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

Height/Weight

Height/Weight	
Height	5 ft 6 in
Weight	166 lb
Actual/Estimated Weight	Estimated
Weight Comment	Pt appears their estimated weight
Body Mass Index (BMI)	26.8

Admission 02: Infection/Isolation Assess — Start: 09/24/18 18:54
Freq: — Status: Complete
Protocol:
Document 09/25/18 12:37 NAT0065 (Rec: 09/25/18 13:05 NAT0065 BSU-C31)

Infectious Disease History

Infectious Disease- History	
Traveled Outside the US in Last 30 Days	No
Infectious Disease History	No

Infectious Disease - Active/Suspected

Infectious Disease - Active/Suspected	
Active/Suspected Infectious Disease	No

Isolation and MRSA Assessment

MRSA Assessment Status	
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

Admission 03: Vaccination Assess — Start: 09/24/18 18:54
Freq: — Status: Complete

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Protocol:
Document 09/25/18 12:37 NAT0065 (Rec: 09/25/18 13:05 NAT0065 BSU-C31)
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.

Admission 04: Pain Assess Start: 09/24/18 18:54
Freq: Status: Complete
Protocol:
Document 09/25/18 12:37 NAT0065 (Rec: 09/25/18 13:05 NAT0065 BSU-C31)
Pain History
Pain History
Hx Chronic Pain: No
Pain Assessment

Continued on Page 34

Assessments and Treatments - Continued

Pain Assessment	
Protocol: C.PNSCALE	
Patient Currently Having Pain	Unable to Determine
Pain Assessment Based Upon	Unable to Obtain-Appears to be Sleeping
Reassessment of Respiratory Rate	
Reassessment of respiratory rate is required for the following:	
Dilaudid	
Fentanyl	
Morphine	
Respiratory Rate	16
Interventions	
Time Follow Up Due	-

Admission 05: Neurological Assess Start: 09/24/18 18:54
Freq: Status: Complete
Protocol:
Document 09/25/18 12:37 NAT0065 (Rec: 09/25/18 13:05 NAT0065 BSU-C31)

Neurological History

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

Neurological

Neurological Assessment	
Neurological Assessment within Normal Limits	Yes
Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.	
Level of Consciousness	Awake Alert Appropriate
Speech/Swallowing Assessment	
Speech Pattern	Clear Appropriate for Age Inappropriate Pressured
Any Evidence of Chewing or Swallowing Difficulties	No
Strength Assessment	
Strength/Range of Motion	Impaired
Strength/Range of Motion Impairment Comment	Pt has sustained injuries and exhibits weakness during ambulation, as evidenced by a slow shuffling gait.

Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Protocol: RASS

Respiratory Rate	16
Agitation/Sedation Score	(-1) Drowsy
Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger to staff (3) VERY AGITATED: Pulls or removes tube (s) or catheter(s); aggressive (2) AGITATED: Frequent non-purposeful movement, fights ventilator (1) RESTLESS: Anxious or apprehensive, but movements not aggressive or vigorous (0) ALERT/CALM (-1) DROWSY: Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds) (-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds) (-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

Admission 06: Sensory Assess — Start: 09/24/18 18:54
Freq: — Status: Complete
Protocol:
Document 09/25/18 12:37 NAT0065 (Rec: 09/25/18 13:05 NAT0065 BSU-C31)
Sensory

Sensory Impairments And Aides

Sensory Impairment	No
Use of Contacts/Glasses	No: UTA
Active Hearing Aide	No: UTA

Admission 07: Cardiovascular Assess — Start: 09/24/18 18:54
Freq: — Status: Complete
Protocol:
Document 09/25/18 12:37 NAT0065 (Rec: 09/25/18 13:05 NAT0065 BSU-C31)
Cardiovascular History

Cardiovascular History

Cardiovascular History	Yes
Hx Hypertension	Yes

Cardiovascular

Cardiovascular Assessment

Cardiovascular Assessment Within Normal Limits	Yes
Query Text:Patient reports no chest pain . Skin color is appropriate for race,	

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

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 90/50-140/80 or is within 20% of stated patient baseline.

Edema Assessment
Edema Present: No

Admission 08: Respiratory Assess — Start: 09/24/18 18:54
Freq: — Status: Complete
Protocol:
Document 09/25/18 12:37 NAT0065 (Rec: 09/25/18 13:05 NAT0065 BSU-C31)

Respiratory History
Respiratory History
Respiratory History: No

Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits: Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.
Oxygen Devices in Use Now: None

Tobacco Use
Tobacco Cessation Assessment
Have you ever used Tobacco?: Yes
Patient Uses Tobacco & Location is BSU: Yes

Admission 09: GI/GU Assess — Start: 09/24/18 18:54
Freq: — Status: Complete
Protocol:
Document 09/25/18 12:37 NAT0065 (Rec: 09/25/18 13:05 NAT0065 BSU-C31)

GI History
GI History
GI History: No

Nutrition History
Nutrition
A nutrition consult must be entered if any of the questions below are "Yes."
Nutrition History: Able to Obtain
Ongoing Unintentional Weight Loss: No
Severe Decrease in Oral Intake Longer than 1 Week: No
Evidence of Difficulty Swallowing: No
Evidence of Difficulty Chewing: No

Oral Assessment
Oral Assessment
Oral Assessment Within Normal Limits: Yes
Query Text:Normal oral moisture with

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

intact teeth. No oral deviations noted.	
Dentures	None
Gastrointestinal Assessment	
Abdominal Assessment	
Gastrointestinal Assessment Within Normal Limits	Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.	
Genitourinary History	
GU History	
GU History	No
Genitourinary Assessment	
GU Assessment	
Genitourinary Assessment Within Normal Limits	Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.	

Admission 10: Skin Assess — Start: 09/24/18 18:54
Freq: — Status: Complete
Protocol: C.SKINBRAD
Document 09/25/18 12:37 NAT0065 (Rec: 09/25/18 13:05 NAT0065 BSU-C31)

Skin Assessment	
Skin Assessment	
4 Eye Skin Assessment Completed by Person #1	Barton,Nathaniel
4 Eye Skin Assessment Completed by Person #2	Smith,Megan L
4 Eye Skin Result	Skin Intact
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	No Impairment
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 Scale	No Apparent Problem
Total Score - Skin Risk Assessment (points)	19
Query Text:** Score and Skin Risk Level **	

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

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).

Admission 12: Mobility/Musculoskeletal Start: 09/24/18 18:54
Freq: Status: Complete
Protocol:
Document 09/25/18 12:37 NAT0065 (Rec: 09/25/18 13:05 NAT0065 BSU-C31)
Musculoskeletal History
Musculoskeletal History

Musculoskeletal History	No

Mobility Assessment
Mobility Assessment

Known Mobility Impairments	Yes
Mobility Impairments/Barriers	Pain Weakness Gait Problems Bedrest

Admission 13: Safety Assess Start: 09/24/18 18:54
Freq: Status: Complete
Protocol: C.FALLINT
Document 09/25/18 12:37 NAT0065 (Rec: 09/25/18 13:05 NAT0065 BSU-C31)
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
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

Query Text:Ask patient: Can you, will you, and are you able to ring for assistance?

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Secondary Diagnosis (2 or More Medical Diagnoses)	Yes
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

Side Rails Up	1 Rail

Document 09/25/18 19:38 ROB0100 (Rec: 09/25/18 19:38 ROB0100 BSU-C27)

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 Diagnoses)	No
Gait/Transferring	Normal
Score	0
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

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Fall Risk - Determined by RN	Low
Query Text:** DO NOT assign a level lower than the calculated Fall Risk. ** This question can be updated based on nursing judgement. If different than calculated fall risk, include reason in comments below (required).	

Admission 14: Endocrine/Hematology — Start: 09/24/18 18:54
Freq: — Status: Complete
Protocol:
Document 09/25/18 12:37 NAT0065 (Rec: 09/25/18 13:05 NAT0065 BSU-C31)
Endocrine

Endocrine/Hematology History	
Endocrine/Hematological Disorders	No
Hx Diabetes	No

Admission 15: Diabetes Assess — Start: 09/24/18 18:54
Freq: — Status: Complete
Protocol:
Document 09/25/18 12:37 NAT0065 (Rec: 09/25/18 13:05 NAT0065 BSU-C31)
Diabetes

Diabetes Education/Care	
Is Patient Diabetic	No

Admission 16: Surgical/Cancer Assess — Start: 09/24/18 18:54
Freq: — Status: Complete
Protocol:
Document 09/25/18 12:37 NAT0065 (Rec: 09/25/18 13:05 NAT0065 BSU-C31)
Surgical/Cancer

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

Admission 17: Psychiatric/Psychosocial — Start: 09/24/18 18:54
Freq: — Status: Complete
Protocol:
Document 09/25/18 12:37 NAT0065 (Rec: 09/25/18 13:05 NAT0065 BSU-C31)
Psychiatric/Psychosocial History

Psychiatric/Psychosocial History	
Psychiatric/Psychosocial History	Yes
Hx Bipolar Disorder	Yes
Hx Post Traumatic Stress Disorder	Yes
Hx Schizophrenia	Yes
Hx of Violent Episodes Against Others	Yes

Psychosocial Assessment

Psychosocial Assessment	
Patient's Psychosocial/Emotional Status	Appropriate to Situation Calm Irritable Uncooperative
Able to Perform Age Appropriate ADL's	Yes
Has Known or Suspected Problems Carrying Out ADLs	No
My Home Has the Following	All

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Alcohol Use	UTA
Recreational/Excessive Substance Use	Other
Substance Use Comment - Amount & Last Used	UTA
Abuse Screening Assessment	None
Alcohol Use Disorders Identification Test	
Blood Alcohol Content	
BAC Greater Than or Equal to 100	No
Query Text:Answer "No" if not tested.	
AUDIT Screening	
How Often Do You Have a Drink Containing Alcohol	Monthly or Less
How Many Drinks Containing Alcohol Do You Have on a Typical Day When You Are Drinking	1 or 2
How Often Do You Have Six or More Drinks on One Occasion	Monthly or Less
How Often During the Last Year Have You Found You Were Not Able to Stop Drinking Once You Had Started	Never
How Often During the Last Year Have You Failed to Do What Was Normally Expected From You Because of Drinking	Never
How Often During the Last Year Have You Needed a First Drink in the Morning to Get Yourself Going After a Heavy Drinking Session	Never
How Often During the Last Year Have You Had a Feeling of Guilt or Remorse After Drinking	Never
How Often During the Last Year Have You Been Unable to Remember What Happened the Night Before Because You Had Been Drinking	Never
Have You/Someone Else Been Injured as a Result of Your Drinking	No
Has a Relative or Friend, or a Doctor or Other Health Worker, Been Concerned About Your Drinking or Suggested You Cut Down	No
AUDIT Total	2
MICA	
MICA	Yes

Admission 18: Spiritual/Cultural Assess Start: 09/24/18 18:54
Freq: Status: Complete
Protocol:

Document 09/25/18 12:37 NAT0065 (Rec: 09/25/18 13:05 NAT0065 BSU-C31)

Spiritual History	
Spiritual History	
Religion	Unknown/Unable to Obtain
Spiritual Assessment	
Spiritual Assessment	
How Important Is It to You to Receive a	Unable to Determine

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Visit from the Hospital Chaplain
Cultural Needs Assessment
Cultural Needs Assessment
Cultural Beliefs to Consider that Would Affect Care: Unable to Obtain/Confirm

Arrival: Assessment/VS — Start: 09/24/18 18:54
Freq: — Status: Discharge
Protocol: C.PNSCALE
Document 09/24/18 20:56 ROW0001 (Rec: 09/24/18 20:58 ROW0001 BSU-C02)
Arrival Assessment: Adult

Arrival Information	
Date of Arrival on Unit	09/24/18
Time of Arrival on Unit	18:15
Arrived From	In House Transfer
Mode of Arrival	Stretcher
Provider Notified	Yes
Diagnosis	UNSPECIFIED PSYCHOSIS
ID Bracelet Applied to Patient	Yes
Allergy Bracelet Applied to Patient	No
Level of Consciousness/Information	
Level of Consciousness	Awake Alert Appropriate
Safety	
Orientation With	Patient

Arrival Assessment: Vital Signs

Vital Signs	
Vital signs MUST be manually entered.	
Temperature	98.0 F
Temperature Source	Temporal Artery Scan
Pulse Rate	108
Respiratory Rate	16
Blood Pressure (mmHg)	153/90
Blood Pressure Source	Manual Cuff/Auscultation
O2 Sat by Pulse Oximetry	97
Oxygen Devices in Use Now	None

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
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	-

Assessment 01: Neurological — Start: 09/24/18 18:54
Freq: — Status: Discharge
Protocol:

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088571823

Assessments and Treatments - Continued

Document 09/25/18 12:37 NAT0065 (Rec: 09/25/18 13:05 NAT0065 BSU-C31)
Assessment/Reassessment: +Neurological

Neurological Assessment	
Neurological Assessment within Normal Limits	Yes
Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.	
Level of Consciousness	Awake Alert Appropriate
Strength Assessment	
Strength/Range of Motion	Impaired
Strength/Range of Motion Impairment Comment	Pt has sustained physical injuries and has a weak gait

Document 09/26/18 10:51 SHA0063 (Rec: 09/26/18 11:20 SHA0063 BSU-C27)
Assessment/Reassessment: +Neurological

Neurological Assessment	
Neurological Assessment within Normal Limits	Yes
Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.	
Level of Consciousness	Awake Alert Appropriate
Patient Orientation	A&O x 4
Query Text:For pediatric patients A&O x 4 as appropriate for age.	
Patient Behavior	Inappropriate
Patient Behavior Comment	refuses to wear clothing/ refuses offer of clothing
Speech/Swallowing Assessment	
Speech Pattern	Clear Inappropriate Pressured
Any Evidence of Chewing or Swallowing Difficulties	No
Speech Comment	angry/hostile and irritable
Strength Assessment	
Strength/Range of Motion	Impaired
Strength/Range of Motion Impairment Comment	Pt has sustained physical injuries, she states that she

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Assessments and Treatments - Continued

	has difficulty raising her left arm; reports that she can ambulate short distances, i.e . from her bed to the bathroom
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	
Agitation/RASS Intervention	No Intervention Required
Other Intervention Detail	alert/calm until writer made attempts to interact- see n.n.
Agitation/RASS Comment	Patient returned to state of calm behavior after writer departed room.
Document 09/27/18 10:54 SHA0063 (Rec: 09/27/18 11:12 SHA0063 BSU-C27)	
Assessment/Reassessment: +Neurological	
Neurological Assessment	
Neurological Assessment within Normal Limits	Yes
Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness,	

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Assessments and Treatments - Continued

tingling, coldness, or dizziness.	
Level of Consciousness	Awake Alert Appropriate
Patient Orientation	A&O x 4
Query Text:For pediatric patients A&O x 4 as appropriate for age.	
Patient Behavior	Inappropriate
Patient Behavior Comment	continues to refuse to wear clothing/ refuse offer of clothing
Speech/Swallowing Assessment	
Speech Pattern	Clear Rambling
Any Evidence of Chewing or Swallowing Difficulties	No
Strength Assessment	
Strength/Range of Motion	Impaired
Strength/Range of Motion Impairment Comment	Pt has sustained physical injuries, she states that she has difficulty raising her left arm; reports that she can ambulate short distances, i.e . from her bed to the bathroom . OT/PT ordered by physician. Earlier in a.m., patient stated that she did not want to meet with either service, explaining that both disciplines will not be able to assist unless she is on the medical floor.
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	

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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	
Agitation/RASS Intervention	No Intervention Required

Document 09/28/18 13:47 NAT0065 (Rec: 09/28/18 13:51 NAT0065 BSU-M01)
Assessment/Reassessment: +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.	Yes
Level of Consciousness	Awake Alert Appropriate
Patient Orientation Query Text:For pediatric patients A&O x 4 as appropriate for age.	A&O x 4
Patient Behavior	Inappropriate
Patient Behavior Comment	continues to refuse to wear clothing/ refuse offer of clothing
Speech/Swallowing Assessment	
Speech Pattern	Clear Rambling
Any Evidence of Chewing or Swallowing Difficulties	No
Strength Assessment	
Strength/Range of Motion	Impaired
Strength/Range of Motion Impairment Comment	Pt has sustained physical injuries, she states that she has difficulty raising her left arm; reports that she can ambulate short distances, i.e . from her bed to the bathroom . OT/PT ordered by physician. Earlier in a.m., patient stated that she did not want to meet with either service, explaining that both disciplines will not be able

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

	to assist unless she is on the medical floor.
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	
Agitation/RASS Intervention	No Intervention Required
Document 09/29/18 09:20 SHA0063 (Rec: 09/29/18 09:36 SHA0063 BSU-C27)	
Assessment/Reassessment: +Neurological	
Neurological Assessment	
Neurological Assessment within Normal Limits	Yes
Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.	
Level of Consciousness	Awake Alert
Patient Behavior	Inappropriate
Patient Behavior Comment	continues to refuse to wear clothing/ refuse offer of clothing

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Speech/Swallowing Assessment	
Speech Pattern	Clear Perseverating Rambling
Any Evidence of Chewing or Swallowing Difficulties	No
Strength Assessment	
Strength/Range of Motion	Impaired
Strength/Range of Motion Impairment Comment	Pt sustained physical injuries prior to admission, she states that she has difficulty raising her left arm; reports that she can ambulate short distances, i.e. from her bed to the bathroom. OT/PT ordered by physician but patient continues to refuse to meet with either discipline.

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	
Agitation/RASS Intervention	No Intervention Required

Document 09/30/18 09:17 SHA0063 (Rec: 09/30/18 09:30 SHA0063 BSU-C27)
Assessment/Reassessment: +Neurological

Neurological Assessment	

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Neurological Assessment within Normal Limits Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.	Yes
Level of Consciousness	Awake Alert
Patient Behavior	Inappropriate
Patient Behavior Comment	continues to refuse to wear clothing/ refuses offer of clothing
Speech/Swallowing Assessment	
Speech Pattern	Clear Perseverating Rambling
Any Evidence of Chewing or Swallowing Difficulties	No
Strength Assessment	
Strength/Range of Motion	Impaired
Strength/Range of Motion Impairment Comment	Pt sustained physical injuries prior to admission, she states that she has difficulty raising her left arm; reports that she can ambulate short distances, i.e. from her bed to the bathroom. Writer observed patient sitting up and walking into the bathroom this morning; patient able to walk with steady gait. Patient states that she can use her left hand minimally but continues to report pain/ discomfort in left shoulder (3 out of 10) that she reports hinders full range of motion. Declined tylenol per norm. OT/PT ordered by physician but patient continues to refuse to meet with either discipline : Patient reports that OT/PT who visit on this floor are " imposters".
Richmond Agitation Sedation Scale (RASS)	
Sedation / Agitation	
Protocol: RASS	
Respiratory Rate	16
Agitation/Sedation Score	(0) Alert/Calm

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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

Agitation/RASS Intervention	No Intervention Required

Document 10/01/18 12:34 SHA0063 (Rec: 10/01/18 12:45 SHA0063 BSU-C27)
Assessment/Reassessment: +Neurological

Neurological Assessment

Neurological Assessment within Normal Limits	Yes

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

Level of Consciousness	Awake Alert
Patient Behavior	Inappropriate
Patient Behavior Comment	continues to refuse to wear clothing/ refuses offer of clothing

Speech/Swallowing Assessment

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

Strength Assessment

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Strength/Range of Motion	Impaired
Strength/Range of Motion Impairment Comment	Pt sustained physical injuries prior to admission, she states that she has difficulty raising her left arm; reports that she can ambulate short distances, i.e. from her bed to the bathroom. OT/PT ordered by physician but patient continues to refuse to meet with either discipline .

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	
Agitation/RASS Intervention	No Intervention Required

Document 10/02/18 10:48 MEG0009 (Rec: 10/02/18 10:54 MEG0009 BSU-C27)
Assessment/Reassessment: +Neurological
Neurological Assessment

Neurological Assessment within Normal Limits	Yes
Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting.	

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Assessments and Treatments - Continued

Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.	
Level of Consciousness	Awake Alert Appropriate
Patient Orientation	A&O x 4
Query Text:For pediatric patients A&O x 4 as appropriate for age.	
Is Patient Dizzy	No
Speech/Swallowing Assessment	
Speech Pattern	Clear

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 10/03/18 11:25 NAT0065 (Rec: 10/03/18 11:36 NAT0065 BSU-C27)

Assessment/Reassessment: +Neurological

Neurological Assessment	
Neurological Assessment within Normal Limits	Yes
Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting.	

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.	
Level of Consciousness	Awake Alert Appropriate
Patient Orientation	A&O x 4
Query Text:For pediatric patients A&O x 4 as appropriate for age.	
Patient Behavior	Appropriate Cooperative
Is Patient Dizzy	No
Speech/Swallowing Assessment	
Speech Pattern	Clear Appropriate for Age
Any Evidence of Chewing or Swallowing Difficulties	No
Strength Assessment	
Strength/Range of Motion	Impaired
Strength/Range of Motion Impairment Comment	Pt sustained physical injuries prior to admission, she states that she has difficulty raising her left arm; reports that she can ambulate short distances, i.e. from her bed to the bathroom. OT/PT ordered by physician but patient continues to refuse to meet with either discipline .
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	

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

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 10/04/18 08:41 LYL0001 (Rec: 10/04/18 08:46 LYL0001 BSU-M01)
Assessment/Reassessment: +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.	Yes
Level of Consciousness	Awake Alert Appropriate
Patient Orientation Query Text:For pediatric patients A&O x 4 as appropriate for age.	A&O x 4
Patient Behavior	Appropriate Cooperative
Is Patient Dizzy	No
Speech/Swallowing Assessment	
Speech Pattern	Clear Appropriate for Age
Any Evidence of Chewing or Swallowing Difficulties	No
Strength Assessment	
Strength/Range of Motion	Impaired
Strength/Range of Motion Impairment Comment	Pt sustained physical injuries prior to admission, she states that she has difficulty raising her left arm; reports that she can ambulate short distances, i.e. from her bed to the bathroom. OT/PT ordered by physician but patient continues to refuse to meet with either discipline .

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

Continued on Page 55

Assessments and Treatments - Continued

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

Document 10/05/18 12:18 SEL0001 (Rec: 10/05/18 12:25 SEL0001 BSU-M01)
Assessment/Reassessment: +Neurological

Neurological Assessment

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

Speech/Swallowing Assessment

Speech Pattern	Clear Appropriate for Age

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Any Evidence of Chewing or Swallowing Difficulties	No
Strength Assessment	
Strength/Range of Motion	Impaired
Strength/Range of Motion Impairment Comment	Pt sustained physical injuries prior to admission, she states that she has difficulty raising her left arm; reports that she can ambulate short distances, i.e. from her bed to the bathroom. OT/PT ordered by physician but patient continues to refuse to meet with either discipline .

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 10/06/18 09:17 MEG0009 (Rec: 10/06/18 09:21 MEG0009 BSU-C27)
Assessment/Reassessment: +Neurological

Neurological Assessment

Neurological Assessment within Normal Limits	Yes

Query Text:Within normal limits: Patient is awake, alert and oriented to person,

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Assessments and Treatments - Continued

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

Level of Consciousness	Awake Alert Appropriate
Patient Orientation	A&O x 4
Query Text:For pediatric patients A&O x 4 as appropriate for age.	
Patient Behavior	Appropriate Cooperative
Is Patient Dizzy	No

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	(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 10/07/18 10:57 MEG0009 (Rec: 10/07/18 11:10 MEG0009 BSU-C02)

Assessment/Reassessment: +Neurological

Neurological Assessment

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Assessments and Treatments - Continued

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

Richmond Agitation Sedation Scale (RASS)

Sedation / Agitation	
Protocol: RASS	
Respiratory Rate	17
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 10/08/18 10:38 LYL0001 (Rec: 10/08/18 10:43 LYL0001 BSU-M01)

Assessment/Reassessment: +Neurological

Neurological Assessment	
Neurological Assessment within Normal	Yes

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Assessments and Treatments - Continued

Limits Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.	
Level of Consciousness	Awake Alert
Patient Orientation Query Text:For pediatric patients A&O x 4 as appropriate for age.	A&O x 4
Is Patient Dizzy	No
Speech/Swallowing Assessment	
Speech Pattern	Clear
Strength Assessment	
Strength/Range of Motion	Impaired
Strength/Range of Motion Impairment Comment	Pt sustained physical injuries prior to admission, she states that she has difficulty raising her left arm; reports that she can ambulate short distances, i.e. from her bed to the bathroom. OT/PT ordered by physician but patient continues to refuse to meet with either discipline .
Richmond Agitation Sedation Scale (RASS)	
Sedation / Agitation	
Protocol: RASS	
Respiratory Rate	16
Agitation/Sedation Score 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)	(0) Alert/Calm

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088571823

Assessments and Treatments - Continued

(-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 10/09/18 16:12 MOR0051 (Rec: 10/09/18 16:13 MOR0051 BSU-C30)
Assessment/Reassessment: +Neurological
Neurological Assessment
Neurological Assessment within Normal Limits Yes
Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.
Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation
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 10/10/18 09:43 LYL0001 (Rec: 10/10/18 09:47 LYL0001 BSU-M01)

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Assessment/Reassessment: +Neurological	
Neurological Assessment	
Neurological Assessment within Normal Limits	Yes
Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.	
Level of Consciousness	Awake Alert Appropriate
Patient Orientation	A&O x 4
Query Text:For pediatric patients A&O x 4 as appropriate for age.	
Speech/Swallowing Assessment	
Speech Pattern	Clear
Strength Assessment	
Strength/Range of Motion	Impaired
Strength/Range of Motion Impairment Comment	Pt sustained physical injuries prior to admission, she states that she has difficulty raising her left arm; reports that she can ambulate short distances, i.e. from her bed to the bathroom. OT/PT ordered by physician but patient continues to refuse to meet with either discipline .
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)	

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

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

Document 10/11/18 10:11 JON0059 (Rec: 10/11/18 10:14 JON0059 BSU-C26)
Assessment/Reassessment: +Neurological

Neurological Assessment	
Neurological Assessment within Normal Limits	Yes
Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.	
Level of Consciousness	Awake Alert Appropriate
Patient Orientation	A&O x 4
Query Text:For pediatric patients A&O x 4 as appropriate for age.	
Patient Behavior	Appropriate Cooperative
Is Patient Dizzy	No
Pupils Equal and Appropriate for Lighting	Yes
Speech/Swallowing Assessment	
Speech Pattern	Clear
Any Evidence of Chewing or Swallowing Difficulties	No
Strength Assessment	
Strength/Range of Motion	Impaired
Strength/Range of Motion Impairment Comment	Pt sustained physical injuries prior to admission, she states that she has difficulty raising her left arm; reports that she can ambulate short distances, i.e. from her bed to the bathroom. OT/PT ordered by physician but patient continues to refuse to meet with either discipline .

Richmond Agitation Sedation Scale (RASS)

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

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 10/12/18 12:06 SHA0063 (Rec: 10/12/18 12:17 SHA0063 BSU-C27)
Assessment/Reassessment: +Neurological

Neurological Assessment

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

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Pupils Equal and Appropriate for Lighting	Yes
Speech/Swallowing Assessment	
Speech Pattern	Clear
Any Evidence of Chewing or Swallowing Difficulties	No
Strength Assessment	
Assess with Strength Assessment Scale	Yes
Strength/Range of Motion	Impaired
Strength/Range of Motion Impairment Comment	range of motion in left arm impaired secondary to physical injuries sustained prior to admission/ patient is using sling today

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	
Agitation/RASS Intervention	No Intervention Required

Document 10/13/18 11:36 ANN0115 (Rec: 10/13/18 11:39 ANN0115 BSU-M01)

Assessment/Reassessment: +Neurological

Neurological Assessment	
Neurological Assessment within Normal Limits	Yes
Query Text:Within normal limits: Patient is awake, alert and oriented to person,	

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.	
Level of Consciousness	Awake Alert Appropriate
Patient Orientation	A&O x 4
Query Text:For pediatric patients A&O x 4 as appropriate for age.	
Patient Behavior	Appropriate Cooperative
Is Patient Dizzy	No
Pupils Equal and Appropriate for Lighting	Yes
Speech/Swallowing Assessment	
Speech Pattern	Clear
Any Evidence of Chewing or Swallowing Difficulties	No
Strength Assessment	
Assess with Strength Assessment Scale	Yes
Strength/Range of Motion	Impaired
Strength/Range of Motion Impairment Comment	range of motion in left arm impaired secondary to physical injuries sustained prior to admission/ patient is using sling today
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	

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

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 10/14/18 11:34 ANN0115 (Rec: 10/14/18 11:39 ANN0115 BSU-C12)
Assessment/Reassessment: +Neurological

Neurological Assessment	
Neurological Assessment within Normal Limits	Yes
Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.	
Level of Consciousness	Awake Alert Appropriate
Patient Orientation	A&O x 4
Query Text:For pediatric patients A&O x 4 as appropriate for age.	
Patient Behavior	Appropriate Cooperative
Is Patient Dizzy	No
Pupils Equal and Appropriate for Lighting	Yes
Speech/Swallowing Assessment	
Speech Pattern	Clear
Any Evidence of Chewing or Swallowing Difficulties	No
Strength Assessment	
Assess with Strength Assessment Scale	Yes
Strength/Range of Motion	Impaired
Strength/Range of Motion Impairment Comment	range of motion in left arm impaired secondary to physical injuries sustained prior to admission/ patient is using sling today

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	

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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

Assessment 02: Cardiovascular Start: 09/24/18 18:54
Freq: Status: Discharge
Protocol:

Document 09/24/18 20:00 ROW0001 (Rec: 09/24/18 22:38 ROW0001 BSU-C02)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment
Cardiovascular Assessment Within Normal Limits Yes
Query Text:Patient reports no chest pain . Skin color is appropriate for race, warm and dry with normal turgor. Capillary refill is less than 3 seconds. S1 and S2 are present and regular. Heart rate is between 60-100. Blood pressure is within 90/50-140/80 or is within 20% of stated patient baseline.
DVT Assessment
DVT Assessment
DVT / VTE Prophylaxis Application (QM) None
Reason DVT / VTE Prophylaxis Not Applied (QM) Not Needed

Document 09/25/18 13:35 ANN0115 (Rec: 09/25/18 13:35 ANN0115 BSU-M01)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment
Cardiovascular Assessment Within Normal Limits Yes
Query Text:Patient reports no chest pain . Skin color is appropriate for race, warm and dry with normal turgor. Capillary refill is less than 3 seconds. S1 and S2 are present and regular. Heart rate is between 60-100. Blood

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

pressure is within 90/50-140/80 or is within 20% of stated patient baseline.	
Chest/Cardiac Pain	No

DVT Assessment
DVT Assessment

DVT / VTE Prophylaxis Application (QM)	None
Reason DVT / VTE Prophylaxis Not Applied (QM)	Not Needed
Early Ambulation	Patient Declined

Document 09/27/18 10:54 SHA0063 (Rec: 09/27/18 11:12 SHA0063 BSU-C27)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment

Cardiovascular Assessment Within Normal Limits	Yes
Query Text:Patient reports no chest pain . Skin color is appropriate for race, warm and dry with normal turgor. Capillary refill is less than 3 seconds. S1 and S2 are present and regular. Heart rate is between 60-100. Blood pressure is within 90/50-140/80 or is within 20% of stated patient baseline.	
Chest/Cardiac Pain	No
Cardiac Symptoms Comments	patient refusing vital signs

DVT Assessment
DVT Assessment

DVT / VTE Prophylaxis Application (QM)	None
Reason DVT / VTE Prophylaxis Not Applied (QM)	Not Needed
Early Ambulation	Patient Declined

Document 09/28/18 13:47 NAT0065 (Rec: 09/28/18 13:51 NAT0065 BSU-M01)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment

Cardiovascular Assessment Within Normal Limits	Yes
Query Text:Patient reports no chest pain . Skin color is appropriate for race, warm and dry with normal turgor. Capillary refill is less than 3 seconds. S1 and S2 are present and regular. Heart rate is between 60-100. Blood pressure is within 90/50-140/80 or is within 20% of stated patient baseline.	
Chest/Cardiac Pain	No
Cardiac Symptoms Comments	patient refusing vital signs

DVT Assessment
DVT Assessment

DVT / VTE Prophylaxis Application (QM)	None
Reason DVT / VTE Prophylaxis Not Applied (QM)	Not Needed
Early Ambulation	Patient Declined

Document 09/29/18 09:20 SHA0063 (Rec: 09/29/18 09:36 SHA0063 BSU-C27)
Assessment/Reassessment: +Cardiovascular

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Cardiovascular Assessment
Cardiovascular Assessment Within Normal Limits — Yes
Query Text:Patient reports no chest pain . Skin color is appropriate for race, warm and dry with normal turgor. Capillary refill is less than 3 seconds. S1 and S2 are present and regular. Heart rate is between 60-100. Blood pressure is within 90/50-140/80 or is within 20% of stated patient baseline.
Chest/Cardiac Pain — No
Cardiac Symptoms Comments — Patient refused blood pressure but allowed HR assessment- HR = 80.

DVT Assessment
DVT Assessment
DVT / VTE Prophylaxis Application (QM) — None
Reason DVT / VTE Prophylaxis Not Applied (QM) — Not Needed
Early Ambulation — Patient Declined

Document 09/30/18 09:17 SHA0063 (Rec: 09/30/18 09:30 SHA0063 BSU-C27)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment
Cardiovascular Assessment Within Normal Limits — Yes
Query Text:Patient reports no chest pain . Skin color is appropriate for race, warm and dry with normal turgor. Capillary refill is less than 3 seconds. S1 and S2 are present and regular. Heart rate is between 60-100. Blood pressure is within 90/50-140/80 or is within 20% of stated patient baseline.
Chest/Cardiac Pain — No
Cardiac Symptoms Comments — Patient refused blood pressure but allowed HR assessment- HR = 88.

DVT Assessment
DVT Assessment
DVT / VTE Prophylaxis Application (QM) — None
Reason DVT / VTE Prophylaxis Not Applied (QM) — Not Needed
Early Ambulation — Patient Declined

Document 10/01/18 12:34 SHA0063 (Rec: 10/01/18 12:45 SHA0063 BSU-C27)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment
Cardiovascular Assessment Within Normal Limits — Yes
Query Text:Patient reports no chest pain . Skin color is appropriate for race, warm and dry with normal turgor. Capillary refill is less than 3 seconds.

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

S1 and S2 are present and regular. Heart rate is between 60-100. Blood pressure is within 90/50-140/80 or is within 20% of stated patient baseline.	
Chest/Cardiac Pain	No
Cardiac Symptoms Comments	Patient refused blood pressure .

DVT Assessment
DVT Assessment

DVT / VTE Prophylaxis Application (QM)	None
Reason DVT / VTE Prophylaxis Not Applied (QM)	Not Needed
Early Ambulation	Patient Declined

Document 10/02/18 10:48 MEG0009 (Rec: 10/02/18 10:54 MEG0009 BSU-C27)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment

Cardiovascular Assessment Within Normal Limits	Yes
Query Text:Patient reports no chest pain . Skin color is appropriate for race, warm and dry with normal turgor. Capillary refill is less than 3 seconds. S1 and S2 are present and regular. Heart rate is between 60-100. Blood pressure is within 90/50-140/80 or is within 20% of stated patient baseline.	
Skin Perfusion	Skin Color Reflects Adequate Perfusion
Chest/Cardiac Pain	No

Document 10/03/18 11:25 NAT0065 (Rec: 10/03/18 11:36 NAT0065 BSU-C27)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment

Cardiovascular Assessment Within Normal Limits	Yes
Query Text:Patient reports no chest pain . Skin color is appropriate for race, warm and dry with normal turgor. Capillary refill is less than 3 seconds. S1 and S2 are present and regular. Heart rate is between 60-100. Blood pressure is within 90/50-140/80 or is within 20% of stated patient baseline.	
Skin Perfusion	Skin Color Reflects Adequate Perfusion
Chest/Cardiac Pain	No

DVT Assessment
DVT Assessment

DVT / VTE Prophylaxis Application (QM)	None
Reason DVT / VTE Prophylaxis Not Applied (QM)	Not Needed
Early Ambulation	Patient Declined

Document 10/04/18 08:41 LYL0001 (Rec: 10/04/18 08:46 LYL0001 BSU-M01)
Assessment/Reassessment: +Cardiovascular

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Assessments and Treatments - Continued

Cardiovascular Assessment
Cardiovascular Assessment
Cardiovascular Assessment Within Normal Limits — Yes
Query Text:Patient reports no chest pain . Skin color is appropriate for race, warm and dry with normal turgor. Capillary refill is less than 3 seconds. S1 and S2 are present and regular. Heart rate is between 60-100. Blood pressure is within 90/50-140/80 or is within 20% of stated patient baseline.
Skin Perfusion — Skin Color Reflects Adequate Perfusion

DVT Assessment
DVT Assessment
DVT / VTE Prophylaxis Application (QM) — None
Reason DVT / VTE Prophylaxis Not Applied (QM) — Not Needed

Document 10/05/18 12:18 SEL0001 (Rec: 10/05/18 12:25 SEL0001 BSU-M01)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment
Cardiovascular Assessment
Cardiovascular Assessment Within Normal Limits — Yes
Query Text:Patient reports no chest pain . Skin color is appropriate for race, warm and dry with normal turgor. Capillary refill is less than 3 seconds. S1 and S2 are present and regular. Heart rate is between 60-100. Blood pressure is within 90/50-140/80 or is within 20% of stated patient baseline.
Skin Perfusion — Skin Color Reflects Adequate Perfusion

DVT Assessment
DVT Assessment
DVT / VTE Prophylaxis Application (QM) — None
Reason DVT / VTE Prophylaxis Not Applied (QM) — Not Needed

Document 10/06/18 09:17 MEG0009 (Rec: 10/06/18 09:21 MEG0009 BSU-C27)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment
Cardiovascular Assessment
Cardiovascular Assessment Within Normal Limits — Yes
Query Text:Patient reports no chest pain . Skin color is appropriate for race, warm and dry with normal turgor. Capillary refill is less than 3 seconds. S1 and S2 are present and regular. Heart rate is between 60-100. Blood pressure is within 90/50-140/80 or is within 20% of stated patient baseline.
Skin Perfusion — Skin Color Reflects Adequate Perfusion

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088571823

Assessments and Treatments - Continued

Chest/Cardiac Pain	No

Document 10/07/18 10:57 MEG0009 (Rec: 10/07/18 11:10 MEG0009 BSU-C02)
Assessment/Reassessment: +Cardiovascular

Cardiovascular Assessment	
Cardiovascular Assessment Within Normal Limits	Yes
Query Text:Patient reports no chest pain . Skin color is appropriate for race, warm and dry with normal turgor. Capillary refill is less than 3 seconds. S1 and S2 are present and regular. Heart rate is between 60-100. Blood pressure is within 90/50-140/80 or is within 20% of stated patient baseline.	
Skin Perfusion	Skin Color Reflects Adequate Perfusion

Document 10/08/18 10:38 LYL0001 (Rec: 10/08/18 10:43 LYL0001 BSU-M01)
Assessment/Reassessment: +Cardiovascular

Cardiovascular Assessment	
Cardiovascular Assessment Within Normal Limits	Yes
Query Text:Patient reports no chest pain . Skin color is appropriate for race, warm and dry with normal turgor. Capillary refill is less than 3 seconds. S1 and S2 are present and regular. Heart rate is between 60-100. Blood pressure is within 90/50-140/80 or is within 20% of stated patient baseline.	
Skin Perfusion	Skin Color Reflects Adequate Perfusion

DVT Assessment

DVT Assessment	
DVT / VTE Prophylaxis Application (QM)	None
Reason DVT / VTE Prophylaxis Not Applied (QM)	Not Needed

Document 10/09/18 16:12 MOR0051 (Rec: 10/09/18 16:13 MOR0051 BSU-C30)
Assessment/Reassessment: +Cardiovascular

Cardiovascular Assessment	
Cardiovascular Assessment Within Normal Limits	Yes
Query Text:Patient reports no chest pain . Skin color is appropriate for race, warm and dry with normal turgor. Capillary refill is less than 3 seconds. S1 and S2 are present and regular. Heart rate is between 60-100. Blood pressure is within 90/50-140/80 or is within 20% of stated patient baseline.	

DVT Assessment

DVT Assessment	
DVT / VTE Prophylaxis Application (QM)	None
Reason DVT / VTE Prophylaxis Not Applied	Not Needed

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

(QM)
Document 10/10/18 09:43 LYL0001 (Rec: 10/10/18 09:47 LYL0001 BSU-M01)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment
Cardiovascular Assessment Within Normal Limits — Yes
Query Text:Patient reports no chest pain . Skin color is appropriate for race, warm and dry with normal turgor. Capillary refill is less than 3 seconds. S1 and S2 are present and regular. Heart rate is between 60-100. Blood pressure is within 90/50-140/80 or is within 20% of stated patient baseline.
DVT Assessment
DVT Assessment
DVT / VTE Prophylaxis Application (QM) — None
Reason DVT / VTE Prophylaxis Not Applied (QM) — Not Needed
Document 10/11/18 10:11 JON0059 (Rec: 10/11/18 10:14 JON0059 BSU-C26)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment
Cardiovascular Assessment Within Normal Limits — Yes
Query Text:Patient reports no chest pain . Skin color is appropriate for race, warm and dry with normal turgor. Capillary refill is less than 3 seconds. S1 and S2 are present and regular. Heart rate is between 60-100. Blood pressure is within 90/50-140/80 or is within 20% of stated patient baseline.
Cardiac Symptoms Comments — patient declined vital signs, denies cardiac symptoms
DVT Assessment
DVT Assessment
DVT / VTE Prophylaxis Application (QM) — None
Reason DVT / VTE Prophylaxis Not Applied (QM) — Not Needed
Document 10/12/18 12:06 SHA0063 (Rec: 10/12/18 12:17 SHA0063 BSU-C27)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment
Cardiovascular Assessment Within Normal Limits — Yes
Query Text:Patient reports no chest pain . Skin color is appropriate for race, warm and dry with normal turgor. Capillary refill is less than 3 seconds. S1 and S2 are present and regular. Heart rate is between 60-100. Blood pressure is within 90/50-140/80 or is within 20% of stated patient baseline.
Cardiac Symptoms Comments — allowed manual blood pressure

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

	to be taken- wnl- see flow sheet

DVT Assessment
DVT Assessment

DVT / VTE Prophylaxis Application (QM)	None
Reason DVT / VTE Prophylaxis Not Applied (QM)	Not Needed

Document 10/13/18 11:36 ANN0115 (Rec: 10/13/18 11:39 ANN0115 BSU-M01)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment

Cardiovascular Assessment Within Normal Limits Query Text:Patient reports no chest pain . Skin color is appropriate for race, warm and dry with normal turgor. Capillary refill is less than 3 seconds. S1 and S2 are present and regular. Heart rate is between 60-100. Blood pressure is within 90/50-140/80 or is within 20% of stated patient baseline.	Yes
Blood Pressure in Range Query Text:90/50 - 140/80 or 20% of Patient's Stated Baseline For Pediatric Patients, BP is in normal range as appropriate for age and activity level	Pt refused
Chest/Cardiac Pain	No
Cardiac Symptoms Comments	allowed manual blood pressure to be taken- wnl- see flow sheet

DVT Assessment
DVT Assessment

DVT / VTE Prophylaxis Application (QM)	None
Reason DVT / VTE Prophylaxis Not Applied (QM)	Not Needed
Early Ambulation	Yes

Document 10/14/18 11:34 ANN0115 (Rec: 10/14/18 11:39 ANN0115 BSU-C12)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment

Cardiovascular Assessment Within Normal Limits Query Text:Patient reports no chest pain . Skin color is appropriate for race, warm and dry with normal turgor. Capillary refill is less than 3 seconds. S1 and S2 are present and regular. Heart rate is between 60-100. Blood pressure is within 90/50-140/80 or is within 20% of stated patient baseline.	Yes
Blood Pressure in Range Query Text:90/50 - 140/80 or 20% of Patient's Stated Baseline For Pediatric Patients, BP is in normal	Pt refused

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
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Assessments and Treatments - Continued

range as appropriate for age and activity level	
Chest/Cardiac Pain	No
Cardiac Symptoms Comments	allowed manual blood pressure to be taken- wnl- see flow sheet

DVT Assessment
DVT Assessment

DVT / VTE Prophylaxis Application (QM)	None
Reason DVT / VTE Prophylaxis Not Applied (QM)	Not Needed
Early Ambulation	Yes

Assessment 03: Respiratory Start: 09/24/18 18:54
Freq: Status: Discharge
Protocol:

Document 09/25/18 12:37 NAT0065 (Rec: 09/25/18 13:05 NAT0065 BSU-C31)
Assessment/Reassessment: +Respiratory
Respiratory Assessment

Respiratory Assessment Within Normal Limits	Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.	
Oxygen Devices in Use Now	None

Document 09/26/18 10:51 SHA0063 (Rec: 09/26/18 11:20 SHA0063 BSU-C27)
Assessment/Reassessment: +Respiratory
Respiratory Assessment

Respiratory Assessment Within Normal Limits	Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.	

Document 09/27/18 10:54 SHA0063 (Rec: 09/27/18 11:12 SHA0063 BSU-C27)
Assessment/Reassessment: +Respiratory
Respiratory Assessment

Respiratory Assessment Within Normal Limits	Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No	

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

observation or report of shortness of breath, significant cough and/or sputum.

Document 09/28/18 13:47 NAT0065 (Rec: 09/28/18 13:51 NAT0065 BSU-M01)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits: Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.

Document 09/29/18 09:20 SHA0063 (Rec: 09/29/18 09:36 SHA0063 BSU-C27)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits: Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.

Document 09/30/18 09:17 SHA0063 (Rec: 09/30/18 09:30 SHA0063 BSU-C27)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits: Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.

Document 10/01/18 12:34 SHA0063 (Rec: 10/01/18 12:45 SHA0063 BSU-C27)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits: Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

breath, significant cough and/or sputum.
Document 10/02/18 10:48 MEG0009 (Rec: 10/02/18 10:54 MEG0009 BSU-C27)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.
Respiratory Effort Normal
Respiratory Pattern Regular
Cough None
Document 10/03/18 11:25 NAT0065 (Rec: 10/03/18 11:36 NAT0065 BSU-C27)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.
Respiratory Effort Normal
Respiratory Pattern Regular
Cough None
Document 10/04/18 08:41 LYL0001 (Rec: 10/04/18 08:46 LYL0001 BSU-M01)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.
Respiratory Effort Normal
Respiratory Pattern Regular
Cough None
Document 10/05/18 12:18 SEL0001 (Rec: 10/05/18 12:25 SEL0001 BSU-M01)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Yes

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BLAYK,BONZE ANNE ROSE

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

62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

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.

Respiratory Effort — Normal
Respiratory Pattern — Regular
Cough — None

Document 10/06/18 09:17 MEG0009 (Rec: 10/06/18 09:21 MEG0009 BSU-C27)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits — Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.

Respiratory Effort — Normal
Respiratory Pattern — Regular
Cough — None

Document 10/07/18 10:57 MEG0009 (Rec: 10/07/18 11:10 MEG0009 BSU-C02)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits — Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.

Respiratory Effort — Normal
Respiratory Pattern — Regular
Cough — None

Document 10/08/18 10:38 LYL0001 (Rec: 10/08/18 10:43 LYL0001 BSU-M01)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits — Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
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Assessments and Treatments - Continued

patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.

Respiratory Effort	Normal
Respiratory Pattern	Regular
Cough	None

Document 10/09/18 16:12 MOR0051 (Rec: 10/09/18 16:13 MOR0051 BSU-C30)
Assessment/Reassessment: +Respiratory
Respiratory Assessment

Respiratory Assessment Within Normal Limits	Yes

Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.

Document 10/10/18 09:43 LYL0001 (Rec: 10/10/18 09:47 LYL0001 BSU-M01)
Assessment/Reassessment: +Respiratory
Respiratory Assessment

Respiratory Assessment Within Normal Limits	Yes

Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.

Document 10/11/18 10:11 JON0059 (Rec: 10/11/18 10:14 JON0059 BSU-C26)
Assessment/Reassessment: +Respiratory
Respiratory Assessment

Respiratory Assessment Within Normal Limits	Yes

Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.

Document 10/12/18 12:06 SHA0063 (Rec: 10/12/18 12:17 SHA0063 BSU-C27)
Assessment/Reassessment: +Respiratory
Respiratory Assessment

Respiratory Assessment Within Normal Limits	Yes

Query Text:Lung sounds are clear and normal bilaterally. Breathing is

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.

Document 10/13/18 11:36 ANN0115 (Rec: 10/13/18 11:39 ANN0115 BSU-M01)
Assessment/Reassessment: +Respiratory
Respiratory Assessment

Respiratory Assessment Within Normal Limits	Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.	
Oxygen in Use	No
Oxygen Devices in Use Now	None
Respiratory Effort	Normal
Respiratory Pattern	Regular
Cough	None

Document 10/14/18 11:34 ANN0115 (Rec: 10/14/18 11:39 ANN0115 BSU-C12)
Assessment/Reassessment: +Respiratory
Respiratory Assessment

Respiratory Assessment Within Normal Limits	Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.	
Oxygen in Use	No
Oxygen Devices in Use Now	None
Respiratory Effort	Normal
Respiratory Pattern	Regular
Cough	None

Assessment 04: GI Start: 09/24/18 18:54
Freq: Status: Discharge
Protocol:
Document 09/25/18 12:37 NAT0065 (Rec: 09/25/18 13:05 NAT0065 BSU-C31)
Assessment/Reassessment: +GI
Abdominal Assessment

Gastrointestinal Assessment Within Normal Limits	Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel	

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BLAYK,BONZE ANNE ROSE

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

62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088571823

Assessments and Treatments - Continued

movements. Patient reports no nausea or vomiting.

Document 09/26/18 10:51 SHA0063 (Rec: 09/26/18 11:20 SHA0063 BSU-C27)
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.

Document 09/27/18 10:54 SHA0063 (Rec: 09/27/18 11:12 SHA0063 BSU-C27)
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.

Document 09/28/18 13:47 NAT0065 (Rec: 09/28/18 13:51 NAT0065 BSU-M01)
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.

Document 09/29/18 09:20 SHA0063 (Rec: 09/29/18 09:36 SHA0063 BSU-C27)
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.

Document 09/30/18 09:17 SHA0063 (Rec: 09/30/18 09:30 SHA0063 BSU-C27)
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.

Document 10/01/18 12:34 SHA0063 (Rec: 10/01/18 12:45 SHA0063 BSU-C27)

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits — Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.
Document 10/02/18 10:48 MEG0009 (Rec: 10/02/18 10:54 MEG0009 BSU-C27)

Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits — Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.
Gastrointestinal Symptoms — No Symptoms
Document 10/03/18 11:25 NAT0065 (Rec: 10/03/18 11:36 NAT0065 BSU-C27)

Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits — Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.
Gastrointestinal Symptoms — No Symptoms
Document 10/04/18 08:41 LYL0001 (Rec: 10/04/18 08:46 LYL0001 BSU-M01)

Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits — Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.
Gastrointestinal Symptoms — No Symptoms
Document 10/05/18 12:18 SEL0001 (Rec: 10/05/18 12:25 SEL0001 BSU-M01)

Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits — Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.
Gastrointestinal Symptoms — No Symptoms

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Document 10/06/18 09:17 MEG0009 (Rec: 10/06/18 09:21 MEG0009 BSU-C27)
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits: Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.
Gastrointestinal Symptoms: No Symptoms

Document 10/07/18 10:57 MEG0009 (Rec: 10/07/18 11:10 MEG0009 BSU-C02)
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits: Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.
Gastrointestinal Symptoms: No Symptoms

Document 10/08/18 10:38 LYL0001 (Rec: 10/08/18 10:43 LYL0001 BSU-M01)
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits: Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.
Gastrointestinal Symptoms: No Symptoms

Document 10/09/18 16:12 MOR0051 (Rec: 10/09/18 16:13 MOR0051 BSU-C30)
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits: Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.

Document 10/10/18 09:43 LYL0001 (Rec: 10/10/18 09:47 LYL0001 BSU-M01)
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits: Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Document 10/11/18 10:11 JON0059 (Rec: 10/11/18 10:14 JON0059 BSU-C26)
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits — Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.

Document 10/12/18 12:06 SHA0063 (Rec: 10/12/18 12:17 SHA0063 BSU-C27)
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits — Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.

Document 10/13/18 11:36 ANN0115 (Rec: 10/13/18 11:39 ANN0115 BSU-M01)
Date of Last Bowel Movement
Date of Last Bowel Movement
Date of Last Bowel Movement — no complaints
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits — Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.
Gastrointestinal Symptoms — No Symptoms

Document 10/14/18 11:34 ANN0115 (Rec: 10/14/18 11:39 ANN0115 BSU-C12)
Date of Last Bowel Movement
Date of Last Bowel Movement
Date of Last Bowel Movement — no complaints
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits — Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.
Gastrointestinal Symptoms — No Symptoms

Assessment 05: Genitourinary Start: 09/24/18 18:54
Freq: Status: Discharge
Protocol:

Document 09/25/18 12:37 NAT0065 (Rec: 09/25/18 13:05 NAT0065 BSU-C31)
Assessment/Reassessment: +GU

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BLAYK,BONZE ANNE ROSE
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Assessments and Treatments - Continued

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 09/26/18 10:51 SHA0063 (Rec: 09/26/18 11:20 SHA0063 BSU-C27)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.

Document 09/27/18 10:54 SHA0063 (Rec: 09/27/18 11:12 SHA0063 BSU-C27)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.

Document 09/28/18 13:47 NAT0065 (Rec: 09/28/18 13:51 NAT0065 BSU-M01)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.

Document 09/29/18 09:20 SHA0063 (Rec: 09/29/18 09:36 SHA0063 BSU-C27)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.

Document 09/30/18 09:17 SHA0063 (Rec: 09/30/18 09:30 SHA0063 BSU-C27)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
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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.

Document 10/01/18 12:34 SHA0063 (Rec: 10/01/18 12:45 SHA0063 BSU-C27)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits — Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.

Document 10/02/18 10:48 MEG0009 (Rec: 10/02/18 10:54 MEG0009 BSU-C27)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits — Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.
Voiding — Continent
Urinary Symptoms — None

Document 10/03/18 11:25 NAT0065 (Rec: 10/03/18 11:36 NAT0065 BSU-C27)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits — Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.
Voiding — Continent
Urinary Symptoms — None

Document 10/04/18 08:41 LYL0001 (Rec: 10/04/18 08:46 LYL0001 BSU-M01)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits — Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.
Voiding — Continent
Urinary Symptoms — None

Document 10/05/18 12:18 SEL0001 (Rec: 10/05/18 12:25 SEL0001 BSU-M01)
Assessment/Reassessment: +GU

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088571823

Assessments and Treatments - Continued

GU Assessment
Genitourinary Assessment Within Normal Limits — Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.
Voiding — Continent
Urinary Symptoms — None
Toileting Methods — Toilet

Document 10/06/18 09:17 MEG0009 (Rec: 10/06/18 09:21 MEG0009 BSU-C27)
Assessment/Reassessment: +GU

GU Assessment
Genitourinary Assessment Within Normal Limits — Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.
Voiding — Continent
Urinary Symptoms — None

Document 10/07/18 10:57 MEG0009 (Rec: 10/07/18 11:10 MEG0009 BSU-C02)
Assessment/Reassessment: +GU

GU Assessment
Genitourinary Assessment Within Normal Limits — Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.
Voiding — Continent
Urinary Symptoms — None

Document 10/08/18 10:38 LYL0001 (Rec: 10/08/18 10:43 LYL0001 BSU-M01)
Assessment/Reassessment: +GU

GU Assessment
Genitourinary Assessment Within Normal Limits — Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.
Voiding — Continent
Urinary Symptoms — None

Document 10/09/18 16:12 MOR0051 (Rec: 10/09/18 16:13 MOR0051 BSU-C30)
Assessment/Reassessment: +GU

GU Assessment
Genitourinary Assessment Within Normal Limits — Yes
Query Text:Patient states ability to

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Assessments and Treatments - Continued

urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.

Document 10/10/18 09:43 LYL0001 (Rec: 10/10/18 09:47 LYL0001 BSU-M01)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.

Document 10/11/18 10:11 JON0059 (Rec: 10/11/18 10:14 JON0059 BSU-C26)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.

Document 10/12/18 12:06 SHA0063 (Rec: 10/12/18 12:17 SHA0063 BSU-C27)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.

Document 10/13/18 11:36 ANN0115 (Rec: 10/13/18 11:39 ANN0115 BSU-M01)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.
Voiding Continent
Urinary Symptoms None
Toileting Methods Toilet
Urinary Diversions/Devices None

Document 10/14/18 11:34 ANN0115 (Rec: 10/14/18 11:39 ANN0115 BSU-C12)
Assessment/Reassessment: +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.	
Voiding	Continent
Urinary Symptoms	None
Toileting Methods	Toilet
Urinary Diversions/Devices	None

Assessment 06: Skin Start: 09/24/18 18:54
Freq: Status: Discharge
Protocol: C.SKINBRAD

Document 09/25/18 12:37 NAT0065 (Rec: 09/25/18 13:05 NAT0065 BSU-C31)
Assessment/Reassessment: +Skin

Skin Color	
Skin Color	Skin Color Appropriate for Race
Skin Condition	
Skin Condition	Skin Intact
Skin Reassessment Provider Communication	
Provider Notification for Skin Breakdown	
Is There New or Worsening Pressure-Related Skin Breakdown	No

Document 09/26/18 10:51 SHA0063 (Rec: 09/26/18 11:20 SHA0063 BSU-C27)
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	Excellent
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	

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Assessments and Treatments - Continued

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	
Left Back	
Skin Deviations	Bruise
Skin Deviation Description	extensive bruising in different shades of purple/ dark red on the length of left side from incident in the community from prior to admission
Query Text:Do not describe pressure ulcers here.	
Left Eye	
Skin Deviations	Bruise
Skin Deviation Description	bruising surrounding left eye from incident in the community from prior to admission
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

Document 09/27/18 10:54 SHA0063 (Rec: 09/27/18 11:12 SHA0063 BSU-C27)

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	No Limitations
Nutrition - Skin Risk Assessment Scale	Excellent
Friction & Shear - Skin Risk Assessment Scale	No Apparent Problem
Total Score - Skin Risk Assessment (points)	23
Query Text:** 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	

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Assessments and Treatments - Continued

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	
Left Back	
Skin Deviations	Bruise
Skin Deviation Description	bruising on left side
Query Text:Do not describe pressure ulcers here.	sustained during physical altercation with police prior to admission
Left Eye	
Skin Deviations	Bruise
Skin Deviation Description	bruising surrounding left eye
Query Text:Do not describe pressure ulcers here.	is healing (injury sustained prior to admission during physical altercation with the police)
Skin Reassessment Provider Communication	
Provider Notification for Skin Breakdown	
Is There New or Worsening Pressure-Related Skin Breakdown	No
Document 09/28/18 13:47 NAT0065 (Rec: 09/28/18 13:51 NAT0065 BSU-M01)	
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	
Protocol: C.SKINBRA	

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
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Assessments and Treatments - Continued

Skin Risk Level-Determined by RN 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).	No Risk
Skin Reassessment Provider Communication	
Provider Notification for Skin Breakdown	
Is There New or Worsening Pressure-Related Skin Breakdown	No

Document 09/29/18 09:20 SHA0063 (Rec: 09/29/18 09:36 SHA0063 BSU-C27)

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	Excellent
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	21
Skin Risk Level-Calculated	No 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. ** This question can be updated based on nursing judgement. If different than calculated skin risk, include reason in comment below (required).	No Risk
Assessment/Reassessment: +Skin	
Skin Color	
Skin Color	Skin Color Appropriate for Race
Skin Deviation	
Left Back	
Skin Deviations	Bruise
Skin Deviation Description Query Text:Do not describe pressure	bruise on length of left back sustained prior to admission

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Assessments and Treatments - Continued

ulcers here.	is healing
Left Eye	
Skin Deviation Description	bruise surrounding left eye
Query Text:Do not describe pressure ulcers here.	sustained prior to admission is healing well

Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown

Is There New or Worsening Pressure-Related Skin Breakdown	No

Document 09/30/18 09:17 SHA0063 (Rec: 09/30/18 09:30 SHA0063 BSU-C27)
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	No Limitations
Nutrition - Skin Risk Assessment Scale	Excellent
Friction & Shear - Skin Risk Assessment Scale	No Apparent Problem
Total Score - Skin Risk Assessment (points)	23
Query Text:** 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
Left Back

Skin Deviations	Bruise
Skin Deviation Description	healing bruise on left side
Query Text:Do not describe pressure ulcers here.	from injury sustained prior to admission

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Assessments and Treatments - Continued

Left Eye	
Skin Deviations	Bruise
Skin Deviation Description	healing bruise surround left eye from injury sustained prior to admission
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

Document 10/01/18 12:34 SHA0063 (Rec: 10/01/18 12:45 SHA0063 BSU-C27)

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	No Limitations
Nutrition - Skin Risk Assessment Scale	Excellent
Friction & Shear - Skin Risk Assessment Scale	No Apparent Problem
Total Score - Skin Risk Assessment (points)	23
Query Text:** 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	
Left Back	
Skin Deviations	Bruise
Skin Deviation Description	healing bruise on left side
Query Text:Do not describe pressure ulcers here.	from injury sustained prior to admission

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BLAYK,BONZE ANNE ROSE
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Assessments and Treatments - Continued

Left Eye	
Skin Deviations	Bruise
Skin Deviation Description	healing bruise surround left
Query Text:Do not describe pressure ulcers here.	eye from injury sustained prior to admission

Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown

Is There New or Worsening Pressure-Related Skin Breakdown	No

Document 10/02/18 10:48 MEG0009 (Rec: 10/02/18 10:54 MEG0009 BSU-C27)
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
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).	

Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown

Is There New or Worsening Pressure-Related Skin Breakdown	No

Document 10/03/18 11:25 NAT0065 (Rec: 10/03/18 11:36 NAT0065 BSU-C27)
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	Walks Occasionally

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BLAYK,BONZE ANNE ROSE
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Assessments and Treatments - Continued

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)	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).	

Assessment/Reassessment: +Skin
Skin Color

Skin Color	Skin Color Appropriate for Race

Skin Condition

Skin Condition	Skin Intact

Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown

Is There New or Worsening Pressure-Related Skin Breakdown	No

Document 10/04/18 08:41 LYL0001 (Rec: 10/04/18 08:46 LYL0001 BSU-M01)
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	No Limitations
Nutrition - Skin Risk Assessment Scale	Adequate
Friction & Shear - Skin Risk Assessment Scale	No Apparent Problem
Total Score - Skin Risk Assessment (points)	22
Query Text:** Score and Skin Risk Level ** 19-23 = No Risk 15-18 = Mild Risk 13-14 = Moderate Risk	

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BLAYK,BONZE ANNE ROSE
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Assessments and Treatments - Continued

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 Reassessment Provider Communication	
Provider Notification for Skin Breakdown	
Is There New or Worsening Pressure-Related Skin Breakdown	No
Document 10/05/18 12:18 SEL0001 (Rec: 10/05/18 12:25 SEL0001 BSU-M01)	
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	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) 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	18
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	

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
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Assessments and Treatments - Continued

calculated skin risk, include reason in comment below (required).	
Assessment/Reassessment: +Skin	
Skin Color	
Skin Color	Skin Color Appropriate for Race
Skin Reassessment Provider Communication	
Provider Notification for Skin Breakdown	
Is There New or Worsening Pressure-Related Skin Breakdown	No
Document 10/06/18 09:17 MEG0009 (Rec: 10/06/18 09:21 MEG0009 BSU-C27)	
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	
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).	
Skin Reassessment Provider Communication	
Provider Notification for Skin Breakdown	
Is There New or Worsening Pressure-Related Skin Breakdown	No
Document 10/07/18 10:57 MEG0009 (Rec: 10/07/18 11:10 MEG0009 BSU-C02)	
Braden Risk and Strategies	
Braden Scale	
Protocol: C.BRADGRID	
Sensory Perception - Skin Risk Assessment Scale	No Impairment
Moisture -Skin Risk Assessment Scale	Rarely Moist

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

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
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).	

Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown

Is There New or Worsening Pressure-Related Skin Breakdown	No

Document 10/08/18 10:38 LYL0001 (Rec: 10/08/18 10:43 LYL0001 BSU-M01)
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	No Limitations
Nutrition - Skin Risk Assessment Scale	Adequate
Friction & Shear - Skin Risk Assessment Scale	No Apparent Problem
Total Score - Skin Risk Assessment (points)	22
Query Text:** 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

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BLAYK,BONZE ANNE ROSE
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62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Skin Risk Level-Determined by RN 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).	No Risk
Assessment/Reassessment: +Skin	
Skin Color	
Skin Color	Skin Color Appropriate for Race
Skin Condition	
Skin Condition	Skin Intact
Skin Reassessment Provider Communication	
Provider Notification for Skin Breakdown	
Is There New or Worsening Pressure-Related Skin Breakdown	No
Document 10/09/18 16:12 MOR0051 (Rec: 10/09/18 16:13 MOR0051 BSU-C30)	
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	No Limitations
Nutrition - Skin Risk Assessment Scale	Adequate
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	22
Skin Risk Level-Calculated	No 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. ** This question can be updated based on nursing judgement. If different than calculated skin risk, include reason in comment below (required).	No Risk
Skin Reassessment Provider Communication	
Provider Notification for Skin Breakdown	
Is There New or Worsening Pressure-	No

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Assessments and Treatments - Continued

Related Skin Breakdown	
Document 10/10/18 09:43 LYL0001 (Rec: 10/10/18 09:47 LYL0001 BSU-M01)	
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	No Limitations
Nutrition - Skin Risk Assessment Scale	Adequate
Friction & Shear - Skin Risk Assessment Scale	No Apparent Problem
Total Score - Skin Risk Assessment (points)	22
Query Text:** 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 Reassessment Provider Communication	
Provider Notification for Skin Breakdown	
Is There New or Worsening Pressure-Related Skin Breakdown	No
Document 10/11/18 10:11 JON0059 (Rec: 10/11/18 10:14 JON0059 BSU-C26)	
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	No Limitations
Nutrition - Skin Risk Assessment Scale	Adequate

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Assessments and Treatments - Continued

Friction & Shear - Skin Risk Assessment Scale	No Apparent Problem
Total Score - Skin Risk Assessment (points)	22
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).	

Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown

Is There New or Worsening Pressure-Related Skin Breakdown	No

Document 10/12/18 12:06 SHA0063 (Rec: 10/12/18 12:17 SHA0063 BSU-C27)
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	No Limitations
Nutrition - Skin Risk Assessment Scale	Excellent
Friction & Shear - Skin Risk Assessment Scale	No Apparent Problem
Total Score - Skin Risk Assessment (points)	23
Query Text:** 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	

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62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

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 Reassessment Provider Communication	
Provider Notification for Skin Breakdown	
Is There New or Worsening Pressure-Related Skin Breakdown	No
Document 10/13/18 11:36 ANN0115 (Rec: 10/13/18 11:39 ANN0115 BSU-M01)	
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	
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 Reassessment Provider Communication	
Provider Notification for Skin Breakdown	

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BLAYK,BONZE ANNE ROSE
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Assessments and Treatments - Continued

Is There New or Worsening Pressure-Related Skin Breakdown	No

Document 10/14/18 11:34 ANN0115 (Rec: 10/14/18 11:39 ANN0115 BSU-C12)
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
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 Condition

Skin Condition	Skin Intact Except

Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown

Is There New or Worsening Pressure-Related Skin Breakdown	No

Assessment 07: Safety Start: 09/24/18 18:54
Freq: Status: Discharge
Protocol: C.FALLINT
Document 09/24/18 23:25 ROW0001 (Rec: 09/24/18 23:26 ROW0001 BSU-C02)
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	

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Assessments and Treatments - Continued

-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 Diagnoses)	Yes
Gait/Transferring	Normal
Score	5
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).	

Document 09/24/18 23:51 LYN0010 (Rec: 09/24/18 23:51 LYN0010 BSU-C27)
Isolation and MRSA Assessment
MRSA Assessment Status
Protocol: C.MRSACHAR

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Assessments and Treatments - Continued

MRSA Assessment 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	No Update Needed
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 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)	No
Gait/Transferring	Normal
Score	0
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	Low

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Assessments and Treatments - Continued

comments below (required).
Document 09/25/18 12:37 NAT0065 (Rec: 09/25/18 13:05 NAT0065 BSU-C31)
Assessment/Reassessment: +Safety
Additional Precautions
Additional Precautions — None
New Medications
New Medications this Shift
Was Patient Started on any New Medications this Shift — No
Document 09/26/18 10:51 SHA0063 (Rec: 09/26/18 11:20 SHA0063 BSU-C27)
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 Diagnoses) — No
Gait/Transferring — Normal
Score — 0
CVA/TIA or Stroke in past 24 hours — No

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62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

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).

Assessment/Reassessment: +Safety

Additional Precautions

Additional Precautions	None

New Medications

New Medications this Shift

Was Patient Started on any New Medications this Shift	No

Document 09/26/18 20:34 MIC0258 (Rec: 09/26/18 20:35 MIC0258 BSU-M01)

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?

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Assessments and Treatments - Continued

Recent History of Falls (Within the Last 12 Months)	No
Age	Less Than 65 Years
Narcotic/Sedative/Hypnotic Medication Administered	No
Bladder/Bowel Incontinence	No
Attached Equipment (Lines/Tubes/Etc)	No
Secondary Diagnosis (2 or More Medical Diagnoses)	No
Gait/Transferring	Normal
Score	0
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).	

New Medications

New Medications this Shift

Was Patient Started on any New Medications this Shift	No

Document 09/26/18 22:36 ERI0025 (Rec: 09/26/18 22:37 ERI0025 BSU-C27)

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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Assessments and Treatments - Continued

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 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)	No
Gait/Transferring	Normal
Score	0
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).	Low

Safety Interventions

Side Rails Up	None

Assessment/Reassessment: +Safety
Additional Precautions

Additional Precautions	None

New Medications
New Medications this Shift

Was Patient Started on any New Medications this Shift	No

Document 09/26/18 23:59 GIT0002 (Rec: 09/27/18 00:05 GIT0002 BSU-C09)
Isolation and MRSA Assessment
MRSA Assessment Status
Protocol: C.MRSACHAR

MRSA Assessment Query Text: -No Update Needed: When isolation items have not changed since last documentation	No Update Needed

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62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

-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 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)	No
Gait/Transferring	Normal
Score	0
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).	Low

Document 09/27/18 10:54 SHA0063 (Rec: 09/27/18 11:12 SHA0063 BSU-C27)
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	Oriented to Own Ability
Patient Is Willing and Able to Assist in Fall Prevention	Yes
Query Text:Ask patient: Can you, will you, and are you able to ring for assistance?	
Recent History of Falls (Within the Last 12 Months)	No
Age	Less Than 65 Years
Narcotic/Sedative/Hypnotic Medication Administered	No
Bladder/Bowel Incontinence	No
Attached Equipment (Lines/Tubes/Etc)	No
Secondary Diagnosis (2 or More Medical Diagnoses)	No
Gait/Transferring	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	

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

comments below (required).	
Assessment/Reassessment: +Safety	
Additional Precautions	
Additional Precautions	None
New Medications	
New Medications this Shift	
Was Patient Started on any New Medications this Shift	No
Document 09/28/18 00:11 LYN0010 (Rec: 09/28/18 00:11 LYN0010 BSU-C02)	
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 Diagnoses)	No
Gait/Transferring	Normal
Score	0
CVA/TIA or Stroke in past 24 hours	No
Query Text:** If CVA/TIA or Stroke	

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

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).	

Document 09/28/18 13:47 NAT0065 (Rec: 09/28/18 13:51 NAT0065 BSU-M01)
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	Yes

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Assessments and Treatments - Continued

Diagnoses)	
Gait/Transferring	Impaired
Score	20
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

Side Rails Up	1 Rail

Assessment/Reassessment: +Safety

Additional Precautions

Additional Precautions	None

New Medications

New Medications this Shift

Was Patient Started on any New Medications this Shift	No

Document 09/28/18 20:07 BAR0006 (Rec: 09/28/18 20:07 BAR0006 BSU-M01)

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

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

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).	Low

New Medications

New Medications this Shift

Was Patient Started on any New Medications this Shift	No

Document 09/29/18 00:21 LYN0010 (Rec: 09/29/18 00:30 LYN0010 BSU-C02)
Isolation and MRSA Assessment

MRSA Assessment Status

Protocol: C.MRSACHAR

MRSA Assessment 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	No Update Needed

Isolation Assessment

Protocol: C.ISOLCHA2

Reason for Isolation	None

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

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 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)	No
Gait/Transferring	Normal
Score	0
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).	Low

Document 09/29/18 09:20 SHA0063 (Rec: 09/29/18 09:36 SHA0063 BSU-C27)

Isolation and MRSA Assessment

MRSA Assessment Status	
Protocol: C.MRSACHAR	
MRSA Assessment 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	No Update Needed

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

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 Diagnoses)	Yes
Gait/Transferring	Normal
Score	5
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).	
Assessment/Reassessment: +Safety	
Additional Precautions	
Additional Precautions	None
New Medications	
New Medications this Shift	
Was Patient Started on any New Medications this Shift	No

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Document 09/29/18 19:46 ROB0100 (Rec: 09/29/18 19:47 ROB0100 BSU-C01)

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 Diagnoses)	No
Gait/Transferring	Normal
Score	0
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	

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

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).

Document 09/30/18 00:54 BRA0067 (Rec: 09/30/18 00:54 BRA0067 BSU-C09)

Isolation and MRSA Assessment

MRSA Assessment Status

Protocol: C.MRSACHAR

MRSA Assessment 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	No Update Needed

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 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	Normal
Score	5
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. **	No

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

** 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).	

Document 09/30/18 09:17 SHA0063 (Rec: 09/30/18 09:30 SHA0063 BSU-C27)

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 Diagnoses)	No
Gait/Transferring	Normal
Score	0

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

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).	

Assessment/Reassessment: +Safety

Additional Precautions

Additional Precautions	None

New Medications

New Medications this Shift

Was Patient Started on any New Medications this Shift	No

Document 09/30/18 19:03 BAR0006 (Rec: 09/30/18 19:04 BAR0006 BSU-C30)

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	

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

assistance?	
Recent History of Falls (Within the Last 12 Months)	No
Age	Less Than 65 Years
Narcotic/Sedative/Hypnotic Medication Administered	No
Bladder/Bowel Incontinence	No
Attached Equipment (Lines/Tubes/Etc)	No
Secondary Diagnosis (2 or More Medical Diagnoses)	Yes
Gait/Transferring	Normal
Score	5
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).	

New Medications

New Medications this Shift	
Was Patient Started on any New Medications this Shift	No

Document 09/30/18 23:57 BRA0067 (Rec: 09/30/18 23:57 BRA0067 BSU-C09)

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:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

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 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	Normal
Score	5
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).	Low

Document 10/01/18 12:34 SHA0063 (Rec: 10/01/18 12:45 SHA0063 BSU-C27)

Isolation and MRSA Assessment

MRSA Assessment Status
Protocol: C.MRSACHAR

MRSA Assessment 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	No Update Needed

Isolation Assessment
Protocol: C.ISOLCHA2

Reason for Isolation	None

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

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 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)	No
Gait/Transferring	Normal
Score	0
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).	Low

Assessment/Reassessment: +Safety

Additional Precautions	
Additional Precautions	None

New Medications

New Medications this Shift	
Was Patient Started on any New Medications this Shift	No

Document 10/01/18 21:21 KEL0019 (Rec: 10/01/18 21:21 KEL0019 BSU-C02)

Isolation and MRSA Assessment

MRSA Assessment Status	
Protocol: C.MRSACHAR	
MRSA Assessment	No Update Needed

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Query Text: -No Update Needed: When isolation items have not changed since last documentation -Update Needed: Upon arrival or if isolation items have changed during stay -Unable to Assess/Obtain: Patient's condition is emergent and assessment can not be done	
Isolation Assessment	
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 Diagnoses)	No
Gait/Transferring	Normal
Score	0
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).	

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Assessment/Reassessment: +Safety
Additional Precautions
Additional Precautions — None
New Medications
New Medications this Shift
Was Patient Started on any New Medications this Shift — No
Document 10/01/18 23:43 LYN0010 (Rec: 10/01/18 23:44 LYN0010 BSU-C02)
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 Diagnoses) — No
Gait/Transferring — Normal
Score — 0
CVA/TIA or Stroke in past 24 hours — No
Query Text:** If CVA/TIA or Stroke related diagnosis in past 24 hours,

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

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).	

Document 10/02/18 10:48 MEG0009 (Rec: 10/02/18 10:54 MEG0009 BSU-C27)
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 Diagnoses)	Yes

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Gait/Transferring	Normal
Score	5
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).	

Document 10/02/18 22:09 MIC0258 (Rec: 10/02/18 22:10 MIC0258 BSU-L07)
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	No

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Administered	
Bladder/Bowel Incontinence	No
Attached Equipment (Lines/Tubes/Etc)	No
Secondary Diagnosis (2 or More Medical Diagnoses)	No
Gait/Transferring	Normal
Score	0
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).	

Assessment/Reassessment: +Safety

Additional Precautions	
Additional Precautions	None

New Medications

New Medications this Shift	
Was Patient Started on any New Medications this Shift	No

Document 10/03/18 11:25 NAT0065 (Rec: 10/03/18 11:36 NAT0065 BSU-C27)

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

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

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 Diagnoses)	Yes
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

Side Rails Up	1 Rail

Assessment/Reassessment: +Safety
Additional Precautions

Additional Precautions	None

New Medications
New Medications this Shift

Was Patient Started on any New Medications this Shift	No

Document 10/03/18 22:46 KEL0019 (Rec: 10/03/18 22:47 KEL0019 BSU-C02)
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	

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

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 Diagnoses)	No
Gait/Transferring	Normal
Score	0
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).	
Assessment/Reassessment: +Safety	
Additional Precautions	
Additional Precautions	None
New Medications	
New Medications this Shift	

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Was Patient Started on any New Medications this Shift	No

Document 10/04/18 00:41 BRA0067 (Rec: 10/04/18 00:41 BRA0067 BSU-C09)

Isolation and MRSA Assessment

MRSA Assessment Status

Protocol: C.MRSACHAR

MRSA Assessment 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	No Update Needed

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 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	Yes
Bladder/Bowel Incontinence	No
Attached Equipment (Lines/Tubes/Etc)	No
Secondary Diagnosis (2 or More Medical Diagnoses)	Yes
Gait/Transferring	Weak
Score	30
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	Medium

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Fall Risk - Determined by RN	Medium
Query Text:** DO NOT assign a level lower than the calculated Fall Risk. ** This question can be updated based on nursing judgement. If different than calculated fall risk, include reason in comments below (required).	

Document 10/04/18 08:41 LYL0001 (Rec: 10/04/18 08:46 LYL0001 BSU-M01)

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 Diagnoses)	Yes
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,	

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

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).	
Assessment/Reassessment: +Safety	
Additional Precautions	
Additional Precautions	None
New Medications	
New Medications this Shift	
Was Patient Started on any New Medications this Shift	No
Document 10/04/18 23:53 GIT0002 (Rec: 10/04/18 23:54 GIT0002 BSU-C27)	
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

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Age	Less Than 65 Years
Narcotic/Sedative/Hypnotic Medication Administered	No
Bladder/Bowel Incontinence	No
Attached Equipment (Lines/Tubes/Etc)	No
Secondary Diagnosis (2 or More Medical Diagnoses)	No
Gait/Transferring	Normal
Score	0
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).	Low

Document 10/05/18 12:18 SEL0001 (Rec: 10/05/18 12:25 SEL0001 BSU-M01)

Isolation and MRSA Assessment

MRSA Assessment Status

Protocol: C.MRSACHAR

MRSA Assessment 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	No Update Needed

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

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Query Text:Ask patient: Can you, will you, and are you able to ring for assistance?	
Recent History of Falls (Within the Last 12 Months)	No
Age	Less Than 65 Years
Narcotic/Sedative/Hypnotic Medication Administered	No
Bladder/Bowel Incontinence	No
Attached Equipment (Lines/Tubes/Etc)	No
Secondary Diagnosis (2 or More Medical Diagnoses)	Yes
Gait/Transferring	Normal
Score	5
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).	

Assessment/Reassessment: +Safety

Additional Precautions	
Additional Precautions	None

New Medications

New Medications this Shift	
Was Patient Started on any New Medications this Shift	No

Document 10/05/18 21:21 KEL0019 (Rec: 10/05/18 21:21 KEL0019 BSU-C02)

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

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

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 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)	No
Gait/Transferring	Normal
Score	0
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).	Low

Assessment/Reassessment: +Safety

Additional Precautions	
Additional Precautions	None

New Medications

New Medications this Shift	
Was Patient Started on any New Medications this Shift	No

Document 10/06/18 02:25 LYN0010 (Rec: 10/06/18 02:25 LYN0010 BSU-C02)

Isolation and MRSA Assessment

MRSA Assessment Status	
Protocol: C.MRSACHAR	
MRSA Assessment	No Update Needed

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Query Text: -No Update Needed: When isolation items have not changed since last documentation -Update Needed: Upon arrival or if isolation items have changed during stay -Unable to Assess/Obtain: Patient's condition is emergent and assessment can not be done	
Isolation Assessment	
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 Diagnoses)	No
Gait/Transferring	Normal
Score	0
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).	

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Document 10/06/18 06:00 LYN0010 (Rec: 10/07/18 01:18 LYN0010 BSU-C02)

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 Diagnoses)	No
Gait/Transferring	Normal
Score	0
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	

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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).

Document 10/06/18 09:17 MEG0009 (Rec: 10/06/18 09:21 MEG0009 BSU-C27)

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 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	Normal
Score	5
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. **	No

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Assessments and Treatments - Continued

** 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).	

Document 10/07/18 10:57 MEG0009 (Rec: 10/07/18 11:10 MEG0009 BSU-C02)

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 Diagnoses)	Yes
Gait/Transferring	Normal
Score	5

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

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).	

Document 10/08/18 00:00 LYN0010 (Rec: 10/08/18 00:01 LYN0010 BSU-C02)
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

Continued on Page 144

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Attached Equipment (Lines/Tubes/Etc)	No
Secondary Diagnosis (2 or More Medical Diagnoses)	No
Gait/Transferring	Normal
Score	0
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).	

Document 10/08/18 10:38 LYL0001 (Rec: 10/08/18 10:43 LYL0001 BSU-M01)
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	No

Continued on Page 145

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

12 Months)	
Age	Less Than 65 Years
Narcotic/Sedative/Hypnotic Medication Administered	No
Bladder/Bowel Incontinence	No
Attached Equipment (Lines/Tubes/Etc)	No
Secondary Diagnosis (2 or More Medical Diagnoses)	Yes
Gait/Transferring	Normal
Score	5
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).	

Assessment/Reassessment: +Safety

Additional Precautions	
Additional Precautions	None

New Medications

New Medications this Shift	
Was Patient Started on any New Medications this Shift	No

Document 10/08/18 21:09 ERI0025 (Rec: 10/08/18 21:10 ERI0025 BSU-C31)

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

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Hx of Falls During Hospital Visit	
History of Falls During Hospital Visit	No
Safety/Fall Risk Assessment	
Safety/Fall Risk Assessment	
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 Diagnoses)	No
Gait/Transferring	Normal
Score	0
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	
Side Rails Up	None
Assessment/Reassessment: +Safety	
Additional Precautions	
Additional Precautions	None
New Medications	
New Medications this Shift	
Was Patient Started on any New Medications this Shift	No

Document 10/09/18 16:12 MOR0051 (Rec: 10/09/18 16:13 MOR0051 BSU-C30)

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:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

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 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)	No
Gait/Transferring	Normal
Score	0
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).	Low

Document 10/09/18 19:49 KEL0019 (Rec: 10/09/18 19:49 KEL0019 BSU-C12)
Isolation and MRSA Assessment

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

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 Diagnoses)	Yes
Gait/Transferring	Normal
Score	5
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	

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

nursing judgement. If different than calculated fall risk, include reason in comments below (required).	
Assessment/Reassessment: +Safety	
Additional Precautions	
Additional Precautions	None
New Medications	
New Medications this Shift	
Was Patient Started on any New Medications this Shift	No
Document 10/10/18 03:43 BRA0067 (Rec: 10/10/18 03:44 BRA0067 BSU-C03)	
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 Diagnoses)	Yes
Gait/Transferring	Normal
Score	5

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

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).	

Document 10/10/18 09:43 LYL0001 (Rec: 10/10/18 09:47 LYL0001 BSU-M01)

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)	Yes
Age	Less Than 65 Years
Narcotic/Sedative/Hypnotic Medication Administered	No
Bladder/Bowel Incontinence	No

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Attached Equipment (Lines/Tubes/Etc)	No
Secondary Diagnosis (2 or More Medical Diagnoses)	Yes
Gait/Transferring	Normal
Score	30
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	Medium
Fall Risk - Determined by RN	Medium
Query Text:** DO NOT assign a level lower than the calculated Fall Risk. ** This question can be updated based on nursing judgement. If different than calculated fall risk, include reason in comments below (required).	

Assessment/Reassessment: +Safety

Additional Precautions	
Additional Precautions	None

New Medications

New Medications this Shift	
Was Patient Started on any New Medications this Shift	No

Document 10/10/18 22:19 KEL0019 (Rec: 10/10/18 22:19 KEL0019 BSU-C12)

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	

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

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	Normal
Score	5
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).	Low

Assessment/Reassessment: +Safety

Additional Precautions

Additional Precautions	None

New Medications

New Medications this Shift

Was Patient Started on any New Medications this Shift	No

Document 10/11/18 10:11 JON0059 (Rec: 10/11/18 10:14 JON0059 BSU-C26)

Isolation and MRSA Assessment

MRSA Assessment Status

Protocol: C.MRSACHAR

MRSA Assessment 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	No Update Needed

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

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 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)	Yes
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	30
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	Medium
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).	Medium
Assessment/Reassessment: +Safety	
Additional Precautions	
Additional Precautions	None
New Medications	
New Medications this Shift	
Was Patient Started on any New Medications this Shift	No

Document 10/11/18 22:55 MAT0034 (Rec: 10/11/18 22:56 MAT0034 BSU-C27)
Isolation and MRSA Assessment

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

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)	Yes
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	30
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	Medium
Fall Risk - Determined by RN	Medium
Query Text:** DO NOT assign a level lower than the calculated Fall Risk. ** This question can be updated based on	

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Assessments and Treatments - Continued

nursing judgement. If different than calculated fall risk, include reason in comments below (required).	
Assessment/Reassessment: +Safety	
Additional Precautions	
Additional Precautions	None
New Medications	
New Medications this Shift	
Was Patient Started on any New Medications this Shift	No
Document 10/12/18 00:43 LYN0010 (Rec: 10/12/18 00:43 LYN0010 BSU-C02)	
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 Diagnoses)	No
Gait/Transferring	Normal
Score	0

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

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).	

Document 10/12/18 12:06 SHA0063 (Rec: 10/12/18 12:17 SHA0063 BSU-C27)

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

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Attached Equipment (Lines/Tubes/Etc)	No
Secondary Diagnosis (2 or More Medical Diagnoses)	Yes
Gait/Transferring	Normal
Score	5
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).	

Assessment/Reassessment: +Safety

Additional Precautions

Additional Precautions	None

New Medications

New Medications this Shift

Was Patient Started on any New Medications this Shift	No

Document 10/12/18 18:01 ROB0100 (Rec: 10/12/18 18:02 ROB0100 BSU-C02)

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

Continued on Page 158

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

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)	No
Gait/Transferring	Normal
Score	0
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).	Low

Assessment/Reassessment: +Safety

Additional Precautions	
Additional Precautions	None

Document 10/12/18 23:52 LYN0010 (Rec: 10/12/18 23:52 LYN0010 BSU-C02)
Isolation and MRSA Assessment

MRSA Assessment Status	
Protocol: C.MRSACHAR	
MRSA Assessment 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	No Update Needed
Isolation Assessment	
Protocol: C.ISOLCHA2	
Reason for Isolation	None
Type of Isolation	Standard Precautions

Continued on Page 159

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

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 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)	No
Gait/Transferring	Normal
Score	0
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).	Low

Document 10/13/18 11:36 ANN0115 (Rec: 10/13/18 11:39 ANN0115 BSU-M01)

Isolation and MRSA Assessment	
MRSA Assessment Status	
Protocol: C.MRSACHAR	
MRSA Assessment 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	No Update Needed

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Assessments and Treatments - Continued

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 Diagnoses)	Yes
Gait/Transferring	Impaired
Score	20
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).	
Assessment/Reassessment: +Safety	
Additional Precautions	
Additional Precautions	None
New Medications	
New Medications this Shift	
Was Patient Started on any New Medications this Shift	No

Document 10/13/18 19:05 ROB0100 (Rec: 10/13/18 19:05 ROB0100 BSU-C02)

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

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 Diagnoses)	No
Gait/Transferring	Normal
Score	0
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. **	

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

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

Document 10/13/18 21:22 ERI0025 (Rec: 10/13/18 21:23 ERI0025 BSU-C27)

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
Recent History of Falls (Within the Last 12 Months)	No
Age	Less Than 65 Years
Narcotic/Sedative/Hypnotic Medication Administered	No
Bladder/Bowel Incontinence	No
Attached Equipment (Lines/Tubes/Etc)	No
Secondary Diagnosis (2 or More Medical Diagnoses)	No
Gait/Transferring	Normal
Score	0
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

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088571823

Assessments and Treatments - Continued

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	
Side Rails Up	None
Assessment/Reassessment: +Safety	
Additional Precautions	
Additional Precautions	None
New Medications	
New Medications this Shift	
Was Patient Started on any New Medications this Shift	No

Document 10/13/18 23:46 BRA0067 (Rec: 10/13/18 23:47 BRA0067 BSU-M02)

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

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Narcotic/Sedative/Hypnotic Medication Administered	Yes
Bladder/Bowel Incontinence	No
Attached Equipment (Lines/Tubes/Etc)	No
Secondary Diagnosis (2 or More Medical Diagnoses)	Yes
Gait/Transferring	Normal
Score	20
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).	

Document 10/14/18 11:34 ANN0115 (Rec: 10/14/18 11:39 ANN0115 BSU-C12)
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	

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

you, and are you able to ring for assistance?	
Recent History of Falls (Within the Last 12 Months)	No
Age	Less Than 65 Years
Narcotic/Sedative/Hypnotic Medication Administered	No
Bladder/Bowel Incontinence	No
Attached Equipment (Lines/Tubes/Etc)	No
Secondary Diagnosis (2 or More Medical Diagnoses)	Yes
Gait/Transferring	Impaired
Score	20
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).	

Assessment/Reassessment: +Safety

Additional Precautions	
Additional Precautions	None

New Medications

New Medications this Shift	
Was Patient Started on any New Medications this Shift	No

Document 10/14/18 16:16 ROB0100 (Rec: 10/14/18 16:16 ROB0100 BSU-C02)

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

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

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 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)	No
Gait/Transferring	Normal
Score	0
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).	Low

Document 10/14/18 22:11 ERI0025 (Rec: 10/14/18 22:16 ERI0025 BSU-C27)

Isolation and MRSA Assessment	
MRSA Assessment Status	
Protocol: C.MRSACHAR	
MRSA Assessment 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	No Update Needed

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BLAYK,BONZE ANNE ROSE

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

62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

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 Diagnoses)	No
Gait/Transferring	Normal
Score	0
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	
Side Rails Up	None
Assessment/Reassessment: +Safety	
Additional Precautions	
Additional Precautions	None
New Medications	
New Medications this Shift	
Was Patient Started on any New	No

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Medications this Shift
Document 10/14/18 23:46 LYN0010 (Rec: 10/14/18 23:46 LYN0010 BSU-C02)
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 Diagnoses)	No
Gait/Transferring	Normal
Score	0
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

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

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

Assessment 08: Psychiatric/Psychosocial Start: 09/24/18 18:54
Freq: Status: Discharge
Protocol:
Document 09/25/18 12:37 NAT0065 (Rec: 09/25/18 13:05 NAT0065 BSU-C31)
Assessment/Reassessment: +Psychosocial/Psychiatric

Psychosocial Assessment	
Patient's Psychosocial/Emotional Status	Appropriate to Situation
	Calm
	Irritable
	Uncooperative
Assess: Coping Skills	
Coping Skills Assessment	
Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Usually Understood
Patient Compliant	No
Does Patient Understand Reason for Hospitalization	No
Has Patient Adapted to the Hospital Environment	Yes
Reassessment: MHU Questions	
Mobility Assessment	
Ambulates Independently	Yes
Ambulation Assistive Devices	None
Patient Can Perform Own ADLs	Yes
ADLs Completed	No
Weight Bearing Status	Full Weight Bearing
Patient Instructed to Call for Help if Feeling Weak or Dizzy	Yes
Coping Skills Assessment	
Patient Compliant with Treatment	No
Communication Ability	Fair
Patient Understands Current Problem/ Treatment Plan	Yes
Coping/Decision Making Ability	With Guidance
Coping Strategies	Avoidance
	Minimizing
	Distancing
	Selective Attention
	Defining Problem
	Emotional Support Request
Coping Response Effectiveness	Destructive
Daytime Naps	Yes
Thought Content Assessment	
Ideation	Denies All
Hallucinations	None
Delusions	Bizzare
Eye Contact	Inconsistent

Continued on Page 170

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Self Harm Assessment	
Are You Having Thoughts of Harming Yourself	No
Lethality Assessment	
Suicide Risk Degree	Low
Suicide Plan Description	No Plan
Suicidal Ideation Description	None
Safety Plan	Yes: q 15min checks
Are You Having Thoughts of Hurting Others	No
Are You at Risk of Hurting Yourself If Discharged	No
Are You at Risk of Hurting Others If Discharged	No
Does Patient Need to Be on Increased Safety Precautions	No
Initiate 1:1/Constant Observation	No
Psychiatrist Notified	No

Document 09/26/18 10:51 SHA0063 (Rec: 09/26/18 11:20 SHA0063 BSU-C27)
Assessment/Reassessment: +Psychosocial/Psychiatric

Psychosocial Assessment	
Patient's Psychosocial/Emotional Status	Appropriate to Situation Calm Irritable Uncooperative

Assess: Coping Skills

Coping Skills Assessment	
Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Usually Understood
Patient Compliant	No
Does Patient Understand Reason for Hospitalization	No
Has Patient Adapted to the Hospital Environment	Yes

Reassessment: MHU Questions

Mobility Assessment	
Ambulates Independently	Yes
Ambulation Assistive Devices	None
Patient Can Perform Own ADLs	Yes
ADLs Completed	No
Weight Bearing Status	Full Weight Bearing
Patient Instructed to Call for Help if Feeling Weak or Dizzy	Yes
Coping Skills Assessment	
Patient Compliant with Treatment	No
Communication Ability	Fair
Patient Understands Current Problem/ Treatment Plan	Yes
Coping/Decision Making Ability	With Guidance
Coping Strategies	Avoidance Minimizing Distancing Selective Attention

Continued on Page 171

Assessments and Treatments - Continued

	Defining Problem
	Emotional Support Request
	Internalization
	Blaming
Coping Response Effectiveness	Destructive
Daytime Naps	Yes
Thought Content Assessment	
Ideation	Denies All
	Homicidal
Ideation Response Plan	reports HI in the context of protecting his country- see n. n.
Hallucinations	None
Delusions	Bizzare
Eye Contact	Intense
Self Harm Assessment	
Are You Having Thoughts of Harming Yourself	No
Lethality Assessment	
Suicide Plan Description	No Plan
Suicidal Ideation Description	None
Safety Plan	Yes: q 15min checks
Are You Having Thoughts of Hurting Others	No
Are You at Risk of Hurting Yourself If Discharged	No
Are You at Risk of Hurting Others If Discharged	No
Does Patient Need to Be on Increased Safety Precautions	No

Document 09/27/18 10:54 SHA0063 (Rec: 09/27/18 11:12 SHA0063 BSU-C27)
Assessment/Reassessment: +Psychosocial/Psychiatric

Psychosocial Assessment	
Patient's Psychosocial/Emotional Status	Appropriate to Situation
	Uncooperative
Psychosocial/Emotional Status Comment	less irritable than yesterday, but writer did not bring up tx topics

Assess: Coping Skills

Coping Skills Assessment	
Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Usually Understood
Patient Compliant	No
Does Patient Understand Reason for Hospitalization	No
Has Patient Adapted to the Hospital Environment	Yes

Reassessment: MHU Questions

Mobility Assessment	
Ambulates Independently	Yes
Ambulation Assistive Devices	None
Patient Can Perform Own ADLs	Yes
ADLs Completed	No

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BLAYK,BONZE ANNE ROSE

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

62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Weight Bearing Status	Full Weight Bearing
Patient Instructed to Call for Help if Feeling Weak or Dizzy	Yes
Coping Skills Assessment	
Patient Compliant with Treatment	No
Communication Ability	Fair
Patient Understands Current Problem/ Treatment Plan	Yes
Coping/Decision Making Ability	With Guidance
Coping Strategies	Avoidance Minimizing Distancing Selective Attention Defining Problem Emotional Support Request Internalization Blaming
Coping Response Effectiveness	Destructive
Daytime Naps	Yes
Patient Slept Well at Night	Yes
Thought Content Assessment	
Ideation	Denies All
Hallucinations	None
Delusions	Bizzare
Eye Contact	Fair
Self Harm Assessment	
Are You Having Thoughts of Harming Yourself	No
Lethality Assessment	
Suicide Plan Description	No Plan
Suicidal Ideation Description	None
Safety Plan	Yes: q 15min checks
Are You Having Thoughts of Hurting Others	No
Are You at Risk of Hurting Yourself If Discharged	No
Are You at Risk of Hurting Others If Discharged	No
Does Patient Need to Be on Increased Safety Precautions	No

Document 09/28/18 13:47 NAT0065 (Rec: 09/28/18 13:51 NAT0065 BSU-M01)

Assessment/Reassessment: +Psychosocial/Psychiatric

Psychosocial Assessment	
Patient's Psychosocial/Emotional Status	Appropriate to Situation Calm Uncooperative
Psychosocial/Emotional Status Comment	less irritable than yesterday, but writer did not bring up tx topics

Assess: Coping Skills

Coping Skills Assessment	
Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Usually Understood

Continued on Page 173

Assessments and Treatments - Continued

Patient Compliant	No
Does Patient Understand Reason for Hospitalization	No
Has Patient Adapted to the Hospital Environment	Yes
Reassessment: MHU Questions	
Mobility Assessment	
Ambulates Independently	Yes
Ambulation Assistive Devices	None
Patient Can Perform Own ADLs	Yes
ADLs Completed	No
Weight Bearing Status	Full Weight Bearing
Patient Instructed to Call for Help if Feeling Weak or Dizzy	Yes
Coping Skills Assessment	
Patient Compliant with Treatment	No
Communication Ability	Fair
Patient Understands Current Problem/ Treatment Plan	Yes
Coping/Decision Making Ability	With Guidance
Coping Strategies	Avoidance Minimizing Distancing Selective Attention Defining Problem Emotional Support Request Internalization Blaming
Coping Response Effectiveness	Destructive
Daytime Naps	Yes
Patient Slept Well at Night	Yes
Thought Content Assessment	
Ideation	Denies All
Hallucinations	None
Delusions	Bizzare
Eye Contact	Fair
Self Harm Assessment	
Are You Having Thoughts of Harming Yourself	No
Lethality Assessment	
Suicide Risk Degree	Low
Suicide Plan Description	No Plan
Suicidal Ideation Description	None
Safety Plan	Yes: q 15min checks
Are You Having Thoughts of Hurting Others	No
Are You at Risk of Hurting Yourself If Discharged	No
Are You at Risk of Hurting Others If Discharged	No
Does Patient Need to Be on Increased Safety Precautions	No
Initiate 1:1/Constant Observation	No

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Psychiatrist Notified	No

Document 09/29/18 09:20 SHA0063 (Rec: 09/29/18 09:36 SHA0063 BSU-C27)
Assessment/Reassessment: +Psychosocial/Psychiatric

Psychosocial Assessment

Patient's Psychosocial/Emotional Status	Irritable Uncooperative
Psychosocial/Emotional Status Comment	irritable/delusional/paranoid

Assess: Coping Skills

Coping Skills Assessment

Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Usually Understood
Patient Compliant	No
Does Patient Understand Reason for Hospitalization	No
Has Patient Adapted to the Hospital Environment	Yes

Reassessment: MHU Questions

Mobility Assessment

Ambulates Independently	Yes
Ambulation Assistive Devices	None
Patient Can Perform Own ADLs	refuses to work with OT/PT to assess fully
ADLs Completed	No
Weight Bearing Status	Full Weight Bearing
Patient Instructed to Call for Help if Feeling Weak or Dizzy	Yes

Coping Skills Assessment

Patient Compliant with Treatment	No
Communication Ability	Fair
Patient Understands Current Problem/ Treatment Plan	Yes
Coping/Decision Making Ability	With Guidance
Coping Strategies	Avoidance Minimizing Distancing Selective Attention Defining Problem Emotional Support Request Internalization Blaming
Coping Response Effectiveness	Destructive
Patient Slept Well at Night	Yes

Thought Content Assessment

Ideation	Denies All
Hallucinations	None
Delusions	Bizzare
Eye Contact	Inconsistent

Self Harm Assessment

Are You Having Thoughts of Harming Yourself	No

Lethality Assessment

Suicide Plan Description	No Plan
Suicidal Ideation Description	None

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Safety Plan	Yes: q 15min checks
Are You Having Thoughts of Hurting Others	No
Are You at Risk of Hurting Yourself If Discharged	No
Are You at Risk of Hurting Others If Discharged	No
Does Patient Need to Be on Increased Safety Precautions	No

Document 09/30/18 09:17 SHA0063 (Rec: 09/30/18 09:30 SHA0063 BSU-C27)
Assessment/Reassessment: +Psychosocial/Psychiatric

Psychosocial Assessment

Patient's Psychosocial/Emotional Status	Uncooperative
Psychosocial/Emotional Status Comment	delusional/paranoid

Assess: Coping Skills

Coping Skills Assessment

Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Usually Understood
Patient Compliant	No
Does Patient Understand Reason for Hospitalization	No
Has Patient Adapted to the Hospital Environment	Yes

Reassessment: MHU Questions

Mobility Assessment

Ambulates Independently	Yes
Ambulation Assistive Devices	None
Patient Can Perform Own ADLs	refuses to work with OT/PT to assess fully
ADLs Completed	No: declined assistance
Weight Bearing Status	Full Weight Bearing
Call Bell within Reach	patient declined need
Patient Instructed to Call for Help if Feeling Weak or Dizzy	Yes

Coping Skills Assessment

Patient Compliant with Treatment	No
Communication Ability	Fair
Patient Understands Current Problem/ Treatment Plan	No
Coping/Decision Making Ability	With Guidance
Coping Strategies	Avoidance Minimizing Distancing Selective Attention Defining Problem Emotional Support Request Internalization Blaming
Coping Response Effectiveness	Destructive
Daytime Naps	Yes: lying down/resting throughout the day
Patient Slept Well at Night	Yes

Thought Content Assessment

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Ideation	Denies All
Hallucinations	None
Delusions	Bizzare
Thought Content Comments	appears paranoid
Eye Contact	Inconsistent
Self Harm Assessment	
Are You Having Thoughts of Harming Yourself	No
Lethality Assessment	
Suicide Plan Description	No Plan
Suicidal Ideation Description	None
Safety Plan	Yes: q 15min checks
Are You Having Thoughts of Hurting Others	No
Are You at Risk of Hurting Yourself If Discharged	No
Are You at Risk of Hurting Others If Discharged	No
Does Patient Need to Be on Increased Safety Precautions	No

Document 10/01/18 12:34 SHA0063 (Rec: 10/01/18 12:45 SHA0063 BSU-C27)
Assessment/Reassessment: +Psychosocial/Psychiatric

Psychosocial Assessment	
Patient's Psychosocial/Emotional Status	Uncooperative
Psychosocial/Emotional Status Comment	delusional/paranoid/somewhat irritable

Assess: Coping Skills

Coping Skills Assessment	
Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Usually Understood
Patient Compliant	No
Does Patient Understand Reason for Hospitalization	No
Has Patient Adapted to the Hospital Environment	Yes

Reassessment: MHU Questions

Mobility Assessment	
Ambulates Independently	Yes
Ambulation Assistive Devices	None
Patient Can Perform Own ADLs	refuses to work with OT/PT to assess fully
ADLs Completed	No: declined assistance
Patient's Senses Intact	Yes
Weight Bearing Status	Full Weight Bearing
Call Bell within Reach	patient declines need for call bell
Patient Instructed to Call for Help if Feeling Weak or Dizzy	Yes
Coping Skills Assessment	
Patient Compliant with Treatment	No
Communication Ability	Fair
Patient Understands Current Problem/ Treatment Plan	No

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Coping/Decision Making Ability	With Guidance
Coping Strategies	Avoidance
	Minimizing
	Distancing
	Selective Attention
	Defining Problem
	Emotional Support Request
	Internalization
	Blaming
Coping Response Effectiveness	Destructive
Daytime Naps	Yes: lying down/resting throughout the day
Thought Content Assessment	
Ideation	Denies All
Hallucinations	None
Delusions	Bizzare
Thought Content Comments	paranoid ideation noted
Eye Contact	Fair
Self Harm Assessment	
Are You Having Thoughts of Harming Yourself	No
Lethality Assessment	
Suicide Plan Description	No Plan
Suicidal Ideation Description	None
Safety Plan	Yes: q 15min checks
Are You Having Thoughts of Hurting Others	No
Are You at Risk of Hurting Yourself If Discharged	No
Are You at Risk of Hurting Others If Discharged	No
Does Patient Need to Be on Increased Safety Precautions	No

Document 10/02/18 10:48 MEG0009 (Rec: 10/02/18 10:54 MEG0009 BSU-C27)
Assessment/Reassessment: +Psychosocial/Psychiatric

Psychosocial Assessment	
Patient's Psychosocial/Emotional Status	Appropriate to Situation

Assess: Coping Skills

Coping Skills Assessment	
Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Understood
Patient Compliant	No

Reassessment: MHU Questions

Mobility Assessment	
Ambulates Independently	Yes
Coping Skills Assessment	
Patient Compliant with Treatment	No
Thought Content Assessment	
Ideation	Denies All
Hallucinations	None
Delusions	None
Eye Contact	Normal

Document 10/03/18 11:25 NAT0065 (Rec: 10/03/18 11:36 NAT0065 BSU-C27)

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Assessments and Treatments - Continued

Assessment/Reassessment: +Psychosocial/Psychiatric	
Psychosocial Assessment	
Patient's Psychosocial/Emotional Status	Appropriate to Situation Calm Irritable Uncooperative
Assess: Coping Skills	
Coping Skills Assessment	
Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Understood
Patient Compliant	No
Does Patient Understand Reason for Hospitalization	No
Has Patient Adapted to the Hospital Environment	Yes
Reassessment: MHU Questions	
Mobility Assessment	
Ambulates Independently	Yes
Ambulation Assistive Devices	None
Patient Can Perform Own ADLs	Yes
ADLs Completed	No
Patient's Senses Intact	Yes
Weight Bearing Status	Full Weight Bearing
Patient Instructed to Call for Help if Feeling Weak or Dizzy	Yes
Coping Skills Assessment	
Patient Compliant with Treatment	No
Communication Ability	Fair
Patient Understands Current Problem/ Treatment Plan	No
Coping/Decision Making Ability	With Guidance
Coping Strategies	Avoidance Minimizing Distancing Selective Attention Defining Problem
Coping Response Effectiveness	Destructive
Thought Content Assessment	
Ideation	Denies All
Hallucinations	None
Delusions	None
Eye Contact	Normal
Self Harm Assessment	
Are You Having Thoughts of Harming Yourself	No
Lethality Assessment	
Suicide Risk Degree	Low
Suicide Plan Description	No Plan
Suicidal Ideation Description	None
Safety Plan	Yes: q 15min checks
Are You Having Thoughts of Hurting Others	No
Are You at Risk of Hurting Yourself If	No

Continued on Page 179

Assessments and Treatments - Continued

Discharged	
Are You at Risk of Hurting Others If Discharged	No
Does Patient Need to Be on Increased Safety Precautions	No
Initiate 1:1/Constant Observation	No
Psychiatrist Notified	No

Document 10/04/18 08:41 LYL0001 (Rec: 10/04/18 08:46 LYL0001 BSU-M01)
Assessment/Reassessment: +Psychosocial/Psychiatric

Psychosocial Assessment

Patient's Psychosocial/Emotional Status	Appropriate to Situation Calm

Assess: Coping Skills

Coping Skills Assessment

Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Understood
Patient Compliant	No
Does Patient Understand Reason for Hospitalization	No
Has Patient Adapted to the Hospital Environment	Yes

Reassessment: MHU Questions

Mobility Assessment

Ambulates Independently	Yes
Ambulation Assistive Devices	None
Patient Can Perform Own ADLs	Yes
ADLs Completed	No
Patient's Senses Intact	Yes
Weight Bearing Status	Full Weight Bearing
Patient Instructed to Call for Help if Feeling Weak or Dizzy	Yes

Coping Skills Assessment

Patient Compliant with Treatment	No
Communication Ability	Fair
Patient Understands Current Problem/ Treatment Plan	No
Coping/Decision Making Ability	With Guidance
Coping Strategies	Avoidance Minimizing Distancing Selective Attention Defining Problem
Coping Response Effectiveness	Destructive
Daytime Naps	Yes
Patient Slept Well at Night	Yes

Thought Content Assessment

Ideation	Denies All
Hallucinations	None
Delusions	None
Eye Contact	Normal

Self Harm Assessment

Are You Having Thoughts of Harming Yourself	No

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Lethality Assessment	
Suicide Risk Degree	Low
Suicide Plan Description	No Plan
Suicidal Ideation Description	None
Safety Plan	Yes: q 15min checks
Are You Having Thoughts of Hurting Others	No
Are You at Risk of Hurting Yourself If Discharged	No
Are You at Risk of Hurting Others If Discharged	No
Does Patient Need to Be on Increased Safety Precautions	No
Initiate 1:1/Constant Observation	No
Psychiatrist Notified	No

Document 10/05/18 12:18 SEL0001 (Rec: 10/05/18 12:25 SEL0001 BSU-M01)
Assessment/Reassessment: +Psychosocial/Psychiatric

Psychosocial Assessment	
Patient's Psychosocial/Emotional Status	Appropriate to Situation Irritable

Assess: Coping Skills

Coping Skills Assessment	
Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Understood
Patient Compliant	No: refusing medications
Does Patient Understand Reason for Hospitalization	No
Has Patient Adapted to the Hospital Environment	Yes

Reassessment: MHU Questions

Mobility Assessment	
Ambulates Independently	Yes
Ambulation Assistive Devices	None
Patient Can Perform Own ADLs	Yes
ADLs Completed	No
Patient's Senses Intact	Yes
Weight Bearing Status	Full Weight Bearing
Patient Instructed to Call for Help if Feeling Weak or Dizzy	Yes
Coping Skills Assessment	
Patient Compliant with Treatment	No
Communication Ability	Fair
Patient Understands Current Problem/ Treatment Plan	No
Coping/Decision Making Ability	With Guidance
Coping Strategies	Avoidance Minimizing Distancing Selective Attention Defining Problem Blaming
Coping Response Effectiveness	Destructive
Daytime Naps	Yes

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Patient Slept Well at Night	Yes
Thought Content Assessment	
Ideation	Denies All
Hallucinations	None
Delusions	None
Eye Contact	Normal
Self Harm Assessment	
Are You Having Thoughts of Harming Yourself	No
Lethality Assessment	
Suicide Risk Degree	Low
Suicide Plan Description	No Plan
Suicidal Ideation Description	None
Safety Plan	Yes: q 15min checks
Are You Having Thoughts of Hurting Others	No
Are You at Risk of Hurting Yourself If Discharged	No
Are You at Risk of Hurting Others If Discharged	No
Does Patient Need to Be on Increased Safety Precautions	No
Initiate 1:1/Constant Observation	No
Psychiatrist Notified	No

Document 10/07/18 10:57 MEG0009 (Rec: 10/07/18 11:10 MEG0009 BSU-C02)
Assessment/Reassessment: +Psychosocial/Psychiatric

Psychosocial Assessment	
Patient's Psychosocial/Emotional Status	Irritable

Assess: Coping Skills

Coping Skills Assessment	
Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Understood
Patient Compliant	No

Reassessment: MHU Questions

Mobility Assessment	
Ambulates Independently	Yes
Coping Skills Assessment	
Patient Compliant with Treatment	No
Communication Ability	Good
Thought Content Assessment	
Ideation	Denies All
Hallucinations	None
Delusions	None

Document 10/08/18 10:38 LYL0001 (Rec: 10/08/18 10:43 LYL0001 BSU-M01)
Assessment/Reassessment: +Psychosocial/Psychiatric

Psychosocial Assessment	
Patient's Psychosocial/Emotional Status	Cooperative Irritable

Assess: Coping Skills

Coping Skills Assessment	
Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Understood
Patient Compliant	Yes

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Does Patient Understand Reason for Hospitalization	No
Has Patient Adapted to the Hospital Environment	Yes

Reassessment: MHU Questions

Mobility Assessment

Ambulates Independently	Yes
Ambulation Assistive Devices	None
Patient Can Perform Own ADLs	Yes
ADLs Completed	Yes
Patient's Senses Intact	Yes
Weight Bearing Status	Full Weight Bearing

Coping Skills Assessment

Patient Compliant with Treatment	No
Communication Ability	Good
Patient Understands Current Problem/ Treatment Plan	Yes
Coping/Decision Making Ability	Autonomous
Coping Strategies	Minimizing Selective Attention Finding Alternatives Information Seeking
Coping Response Effectiveness	Constructive
Daytime Naps	No
Patient Slept Well at Night	Yes

Thought Content Assessment

Ideation	Denies All
Hallucinations	None
Delusions	None
Eye Contact	Normal

Self Harm Assessment

Are You Having Thoughts of Harming Yourself	No

Lethality Assessment

Suicide Risk Degree	Low
Suicide Plan Description	No Plan
Suicidal Ideation Description	None
Safety Plan	Yes: Q15min visual checks
Are You Having Thoughts of Hurting Others	No
Are You at Risk of Hurting Yourself If Discharged	No
Are You at Risk of Hurting Others If Discharged	No
Does Patient Need to Be on Increased Safety Precautions	No
Initiate 1:1/Constant Observation	No
Psychiatrist Notified	No

Document 10/10/18 09:43 LYL0001 (Rec: 10/10/18 09:47 LYL0001 BSU-M01)
Assessment/Reassessment: +Psychosocial/Psychiatric

Psychosocial Assessment

Patient's Psychosocial/Emotional Status	Appropriate to Situation Calm

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

	Cooperative
Assess: Coping Skills	
Coping Skills Assessment	
Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Understood
Patient Compliant	Yes
Does Patient Understand Reason for Hospitalization	No
Has Patient Adapted to the Hospital Environment	Yes
Reassessment: MHU Questions	
Mobility Assessment	
Ambulates Independently	Yes
Ambulation Assistive Devices	None
Patient Can Perform Own ADLs	Yes
ADLs Completed	Yes
Patient's Senses Intact	Yes
Weight Bearing Status	Full Weight Bearing
Coping Skills Assessment	
Patient Compliant with Treatment	Yes
Communication Ability	Good
Patient Understands Current Problem/ Treatment Plan	Yes
Coping/Decision Making Ability	Autonomous
Coping Strategies	Minimizing Selective Attention Finding Alternatives Information Seeking
Coping Response Effectiveness	Constructive
Daytime Naps	No
Patient Slept Well at Night	Yes
Thought Content Assessment	
Ideation	Denies All
Hallucinations	None
Delusions	None
Eye Contact	Normal
Self Harm Assessment	
Are You Having Thoughts of Harming Yourself	No
Lethality Assessment	
Suicide Risk Degree	Low
Suicide Plan Description	No Plan
Suicidal Ideation Description	None
Safety Plan	Yes: Q15min visual checks
Are You Having Thoughts of Hurting Others	No
Are You at Risk of Hurting Yourself If Discharged	No
Are You at Risk of Hurting Others If Discharged	No
Does Patient Need to Be on Increased Safety Precautions	No
Initiate 1:1/Constant Observation	No

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Psychiatrist Notified	No

Document 10/11/18 10:11 JON0059 (Rec: 10/11/18 10:14 JON0059 BSU-C26)
Assessment/Reassessment: +Psychosocial/Psychiatric

Psychosocial Assessment

Patient's Psychosocial/Emotional Status	Appropriate to Situation Calm Cooperative

Assess: Coping Skills

Coping Skills Assessment

Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Understood
Patient Compliant	Yes
Does Patient Understand Reason for Hospitalization	No
Has Patient Adapted to the Hospital Environment	Yes

Reassessment: MHU Questions

Mobility Assessment

Ambulates Independently	Yes
Ambulation Assistive Devices	None
Patient Can Perform Own ADLs	Yes
ADLs Completed	Yes
Patient's Senses Intact	Yes
Weight Bearing Status	Full Weight Bearing

Coping Skills Assessment

Patient Compliant with Treatment	Yes: with exception of blood pressure medications
Communication Ability	Good
Patient Understands Current Problem/ Treatment Plan	Yes
Coping/Decision Making Ability	Autonomous
Coping Strategies	Minimizing Selective Attention Finding Alternatives Information Seeking
Coping Response Effectiveness	Constructive
Daytime Naps	No
Patient Slept Well at Night	Yes

Thought Content Assessment

Ideation	Denies All
Hallucinations	None
Delusions	None
Eye Contact	Normal

Self Harm Assessment

Are You Having Thoughts of Harming Yourself	No

Lethality Assessment

Suicide Risk Degree	Low
Suicide Plan Description	No Plan
Suicidal Ideation Description	None
Safety Plan	Yes: Q15min visual checks
Are You Having Thoughts of Hurting Others	No

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Assessments and Treatments - Continued

Are You at Risk of Hurting Yourself If Discharged	No
Are You at Risk of Hurting Others If Discharged	No
Does Patient Need to Be on Increased Safety Precautions	No
Initiate 1:1/Constant Observation	No
Psychiatrist Notified	No

Document 10/12/18 12:06 SHA0063 (Rec: 10/12/18 12:17 SHA0063 BSU-C27)
Assessment/Reassessment: +Psychosocial/Psychiatric

Psychosocial Assessment

Patient's Psychosocial/Emotional Status	Appropriate to Situation Calm Cooperative

Assess: Coping Skills

Coping Skills Assessment

Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Understood
Patient Compliant	Yes
Does Patient Understand Reason for Hospitalization	No
Has Patient Adapted to the Hospital Environment	Yes

Reassessment: MHU Questions

Mobility Assessment

Ambulates Independently	Yes
Ambulation Assistive Devices	None
Patient Can Perform Own ADLs	Yes
ADLs Completed	Yes
Patient's Senses Intact	Yes
Weight Bearing Status	Full Weight Bearing
Call Bell within Reach	patient declines need for call bell

Coping Skills Assessment

Patient Compliant with Treatment	Yes- but declined hypotensives
Communication Ability	Good
Patient Understands Current Problem/ Treatment Plan	Yes
Coping/Decision Making Ability	Autonomous
Coping Strategies	Selective Attention Finding Alternatives Internalization Information Seeking
Coping Response Effectiveness	Constructive
Daytime Naps	No
Patient Slept Well at Night	Yes

Thought Content Assessment

Ideation	Denies All
Hallucinations	None
Eye Contact	Normal

Self Harm Assessment

Are You Having Thoughts of Harming Yourself	No

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Lethality Assessment

Suicide Risk Degree	Low
Suicide Plan Description	No Plan
Suicidal Ideation Description	None
Safety Plan	Yes: Q15min visual checks
Are You Having Thoughts of Hurting Others	No
Are You at Risk of Hurting Yourself If Discharged	No
Are You at Risk of Hurting Others If Discharged	No
Does Patient Need to Be on Increased Safety Precautions	No
Initiate 1:1/Constant Observation	No

Document 10/13/18 11:36 ANN0115 (Rec: 10/13/18 11:39 ANN0115 BSU-M01)
Assessment/Reassessment: +Psychosocial/Psychiatric

Psychosocial Assessment

Patient's Psychosocial/Emotional Status	Appropriate to Situation Calm Cooperative

Assess: Coping Skills

Coping Skills Assessment

Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Understood
Patient Compliant	Yes
Does Patient Understand Reason for Hospitalization	No
Has Patient Adapted to the Hospital Environment	Yes

Reassessment: MHU Questions

Mobility Assessment

Ambulates Independently	Yes
Ambulation Assistive Devices	None
Patient Can Perform Own ADLs	Yes
ADLs Completed	Yes
Patient's Senses Intact	Yes
Weight Bearing Status	Full Weight Bearing
Call Bell within Reach	patient declines need for call bell

Coping Skills Assessment

Patient Compliant with Treatment	Yes- but declined hypotensives
Communication Ability	Good
Patient Understands Current Problem/ Treatment Plan	Yes
Coping/Decision Making Ability	Autonomous
Coping Strategies	Selective Attention Finding Alternatives Internalization Information Seeking
Coping Response Effectiveness	Constructive
Daytime Naps	No
Patient Slept Well at Night	Yes

Thought Content Assessment

Continued on Page 187

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Ideation	Denies All
Hallucinations	None
Eye Contact	Normal
Self Harm Assessment	
Are You Having Thoughts of Harming Yourself	No
Lethality Assessment	
Suicide Risk Degree	Low
Suicide Plan Description	No Plan
Suicidal Ideation Description	None
Safety Plan	Yes: Q15min visual checks
Are You Having Thoughts of Hurting Others	No
Are You at Risk of Hurting Yourself If Discharged	No
Are You at Risk of Hurting Others If Discharged	No
Does Patient Need to Be on Increased Safety Precautions	No
Initiate 1:1/Constant Observation	No

Document 10/14/18 11:34 ANN0115 (Rec: 10/14/18 11:39 ANN0115 BSU-C12)
Assessment/Reassessment: +Psychosocial/Psychiatric

Psychosocial Assessment	
Patient's Psychosocial/Emotional Status	Appropriate to Situation Calm Cooperative

Assess: Coping Skills

Coping Skills Assessment	
Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Understood
Patient Compliant	Yes
Does Patient Understand Reason for Hospitalization	No
Has Patient Adapted to the Hospital Environment	Yes

Reassessment: MHU Questions

Mobility Assessment	
Ambulates Independently	Yes
Ambulation Assistive Devices	None
Patient Can Perform Own ADLs	Yes
ADLs Completed	Yes
Patient's Senses Intact	Yes
Weight Bearing Status	Full Weight Bearing
Call Bell within Reach	patient declines need for call bell
Coping Skills Assessment	
Patient Compliant with Treatment	Yes- but declined hypotensives
Communication Ability	Good
Patient Understands Current Problem/ Treatment Plan	Yes
Coping/Decision Making Ability	Autonomous
Coping Strategies	Selective Attention Finding Alternatives

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

	Internalization
	Information Seeking
Coping Response Effectiveness	Constructive
Daytime Naps	No
Patient Slept Well at Night	Yes
Thought Content Assessment	
Ideation	Denies All
Hallucinations	None
Eye Contact	Normal
Self Harm Assessment	
Are You Having Thoughts of Harming Yourself	No
Lethality Assessment	
Suicide Risk Degree	Low
Suicide Plan Description	No Plan
Suicidal Ideation Description	None
Safety Plan	Yes: Q15min visual checks
Are You Having Thoughts of Hurting Others	No
Are You at Risk of Hurting Yourself If Discharged	No
Are You at Risk of Hurting Others If Discharged	No
Does Patient Need to Be on Increased Safety Precautions	No
Initiate 1:1/Constant Observation	No

Assessment 09: Significant Occurrences Start: 09/24/18 18:54
Freq: Status: Discharge
Protocol:

Document 09/25/18 12:37 NAT0065 (Rec: 09/25/18 13:05 NAT0065 BSU-C31)
Significant Occurences

Significant Occurences	
Significant Occurrences	none this shift
Query Text:	
Please begin each entry with date/time.	
Please do not delete previous entries.	
Include occurrences during this hospital stay, such as:	
In-hospital transfer	
Fall/Injury	
Surgical procedure	
Invasive procedure	
New diagnosis since admission	

Document 09/26/18 10:51 SHA0063 (Rec: 09/26/18 11:20 SHA0063 BSU-C27)
Significant Occurences

Significant Occurences	
Significant Occurrences	none this shift
Query Text:	
Please begin each entry with date/time.	
Please do not delete previous entries.	
Include occurrences during this hospital stay, such as:	
In-hospital transfer	

Continued on Page 189

Assessments and Treatments - Continued

Fall/Injury
Surgical procedure
Invasive procedure
New diagnosis since admission
Document 09/27/18 10:54 SHA0063 (Rec: 09/27/18 11:12 SHA0063 BSU-C27)
Significant Occurences
Significant Occurences
Significant Occurrences none this shift
Query Text:
Please begin each entry with date/time.
Please do not delete previous entries.
Include occurrences during this hospital
stay, such as:
In-hospital transfer
Fall/Injury
Surgical procedure
Invasive procedure
New diagnosis since admission
Document 09/28/18 13:47 NAT0065 (Rec: 09/28/18 13:51 NAT0065 BSU-M01)
Significant Occurences
Significant Occurences
Significant Occurrences none this shift
Query Text:
Please begin each entry with date/time.
Please do not delete previous entries.
Include occurrences during this hospital
stay, such as:
In-hospital transfer
Fall/Injury
Surgical procedure
Invasive procedure
New diagnosis since admission
Document 09/29/18 09:20 SHA0063 (Rec: 09/29/18 09:36 SHA0063 BSU-C27)
Significant Occurences
Significant Occurences
Significant Occurrences none this shift
Query Text:
Please begin each entry with date/time.
Please do not delete previous entries.
Include occurrences during this hospital
stay, such as:
In-hospital transfer
Fall/Injury
Surgical procedure
Invasive procedure
New diagnosis since admission
Document 09/30/18 09:17 SHA0063 (Rec: 09/30/18 09:30 SHA0063 BSU-C27)
Significant Occurences
Significant Occurences
Significant Occurrences none this shift
Query Text:
Please begin each entry with date/time.
Please do not delete previous entries.

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BLAYK,BONZE ANNE ROSE

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

62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Include occurrences during this hospital
stay, such as:
In-hospital transfer
Fall/Injury
Surgical procedure
Invasive procedure
New diagnosis since admission

Document 10/01/18 12:34 SHA0063 (Rec: 10/01/18 12:45 SHA0063 BSU-C27)
Significant Occurences
Significant Occurences
Significant Occurrences none this shift
Query Text:
Please begin each entry with date/time.
Please do not delete previous entries.
Include occurrences during this hospital
stay, such as:
In-hospital transfer
Fall/Injury
Surgical procedure
Invasive procedure
New diagnosis since admission

Document 10/02/18 10:48 MEG0009 (Rec: 10/02/18 10:54 MEG0009 BSU-C27)
Significant Occurences
Significant Occurences
Significant Occurrences none this shift
Query Text:
Please begin each entry with date/time.
Please do not delete previous entries.
Include occurrences during this hospital
stay, such as:
In-hospital transfer
Fall/Injury
Surgical procedure
Invasive procedure
New diagnosis since admission

Document 10/03/18 11:25 NAT0065 (Rec: 10/03/18 11:36 NAT0065 BSU-C27)
Significant Occurences
Significant Occurences
Significant Occurrences none this shift
Query Text:
Please begin each entry with date/time.
Please do not delete previous entries.
Include occurrences during this hospital
stay, such as:
In-hospital transfer
Fall/Injury
Surgical procedure
Invasive procedure
New diagnosis since admission

Document 10/05/18 12:18 SEL0001 (Rec: 10/05/18 12:25 SEL0001 BSU-M01)
Significant Occurences
Significant Occurences
Significant Occurrences none this shift

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Query Text:
Please begin each entry with date/time.
Please do not delete previous entries.
Include occurrences during this hospital
stay, such as:
In-hospital transfer
Fall/Injury
Surgical procedure
Invasive procedure
New diagnosis since admission

Document 10/07/18 10:57 MEG0009 (Rec: 10/07/18 11:10 MEG0009 BSU-C02)
Significant Occurences
Significant Occurences
Significant Occurrences none this shift
Query Text:
Please begin each entry with date/time.
Please do not delete previous entries.
Include occurrences during this hospital
stay, such as:
In-hospital transfer
Fall/Injury
Surgical procedure
Invasive procedure
New diagnosis since admission

Document 10/12/18 12:06 SHA0063 (Rec: 10/12/18 12:17 SHA0063 BSU-C27)
Significant Occurences
Significant Occurences
Significant Occurrences none this shift
Query Text:
Please begin each entry with date/time.
Please do not delete previous entries.
Include occurrences during this hospital
stay, such as:
In-hospital transfer
Fall/Injury
Surgical procedure
Invasive procedure
New diagnosis since admission

Discharge Checklist - Inpatient Start: 09/24/18 18:54
Freq: Status: Discharge
Protocol:

Document 10/15/18 12:29 SHA0063 (Rec: 10/15/18 12:30 SHA0063 BSU-C27)
Discharge Checklist-Inpatient
General Items
Original Copy of MOLST Given to Patient Not Applicable
Medical Devices Removed Not Applicable
Query Text:*vascular access devices,
catheter
Medications Reviewed Yes
Query Text:*discuss purpose,dosage,side
effects
*discuss the time of the last dose for
all medications and when medications

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

should be taken	
Has Belonging	Valuables from Safe Glasses
Plan of Care Reviewed	Explain Diagnosis Condition Changed When to Call 911 Discuss Follow Up Appts Discuss Press Ganey Survey
Care Act Caregiver	
Caregiver Needed at Discharge	No
Quality/Core Measures	
All MU/QM questions are used in reporting payment	information for hospital
Patient Education Provided (MU) Query Text:**select "Yes" if any education was given during the patient's visit; this can include paper department-specific education, patient education videos and instructions, verbal education, etc.	Yes
Problems, Meds and Labs Reviewed for Patient Education (MU) Query Text:**were the documented patient problems, medications, and labs reviewed by the caregiver providing education prior to educating the patient .	Yes
Care Plan Goals Field Completed in Discharge Panel Query Text:*Include the Primary Problem, Goal, and Instructions given to the patient to meet goal **The information entered into the Care Plan Goal field will go to the Patient Portal and be seen by the patient and other providers**	No
Discharge Assessment	
Mental Status (Patient Portal Info)	Oriented to Own Ability
Able to Perform Age Appropriate ADL's (Patient Portal Info)	Yes
Mode of Discharge	Ambulated
Discharge Instructions Review, Understood; Given to Pt/Caregivers	Yes
Discharge Assessment Comment	Patient discharged home via taxi, writer escorted patient to main entrance to wait for ride.

IMG: Diagnostic Questionnaire Start: 10/06/18 13:46
Freq: Status: Discharge
Protocol:
Document 10/06/18 13:46 GEM0001 (Rec: 10/06/18 13:47 GEM0001 IMG-CS03)
Pregnancy Status
Pregnant

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Pregnant:	No
Technologist Information	
Technologist Info	
Technologist(s)	GP/KNO
Patient ID verified	Yes
Procedure(s) explained to:	Patient
Shielded	Yes
Diagnostic Pelvis/Extremity Exam	
Reason for Exam	
Other	R/O FRACTURE OR DISLOCTAION
Pelvis/Extremity Exam History	
History	
Musculoskeletal History	No

Inpatient OT: Evaluation Start: 09/27/18 15:41
Freq: Status: Discharge
Protocol:
Document 10/12/18 14:11 SHA0179 (Rec: 10/12/18 14:27 SHA0179 PMRU-C08)

OT: Treatment Time/Type	
Treatment Info	
Evaluation Type	Acute Care
Treatment Start Date	10/12/18
Treatment Start Time	13:04
Treatment Stop Date	10/12/18
Treatment Stop Time	13:31
Session 1 Time Elapsed	27
Interrupted Treatment Info	
Treatment Start Date 2	10/12/18
Treatment Stop Date 2	10/12/18
Totals	
OT Treatment Total Time (Minutes)	27
Does the Patient Have Medicare Insurance Query Text:Answer "Yes" if Medicare is listed under the patient's insurances (primary, secondary, etc).	Yes
OT: General Evaluation	
Subjective	
Patient's Stated Reason for Admission	altercation at Denny's in Ithaca
Primary Diagnosis	rib fx, L shoulder dislocation s/p reduction
Patient Complaints	Additional PMH: ETOH and drug abuse
Living Situation	Home
Living With	Alone
Housing	Multiple Levels
Total Stairs	0 STE Flight of stairs to 2nd level
Bathroom Set Up	Tub/Shower Combination Walk in Shower with Lip Regular Toilet
Precautions Comment	LUE: NWB LUE, no pushing or pulling, no ABD or FF above 90 degrees, no external rotation

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Prior Status	
Upper Body Dressing	Independent
Lower Body Dressing	Independent
Bathing	Independent
Toileting	Independent
Toilet Transfer	Independent
Shower Transfer	Independent
Grooming	Independent
Eating	Independent
Prior Status Comments	Pt was independent with all IADLs PTA including driving.
Weight Bearing	
Left Upper Extremity	
Weight Bearing Status	Non-Weight Bearing
Cognition	
Mental Status	A&Ox4
Hand Dominance	
Hand Dominance	Right
Upper Extremity Function Assessment	
Bilateral	
Upper Extremity Sensation	WFL
Coordination Comment	RUE WFL LUE impaired 2* L dislocated shoulder
Upper Extremity Tone	Normal
Stength	
Strength Comment	RUE WFL LUE impaired 2* L dislocated shoulder
ROM	
Range of Motion Comment	RUE WFL LUE impaired 2* L dislocated shoulder
Endurance Assessment	
Endurance	Fair
Balance	
Sit Static	Good
Sit Dynamic	Good
Standing Static	Good
Standing Dynamic	Good
Current ADL Status	
Upper Body Dressing	Independent
Lower Body Dressing	Independent
Bathing	Independent
Grooming	Independent
Current Toileting Status	
Toileting	Independent
Current Toilet Transfer Status	
Toilet Transfer	Independent
Current Shower Transfer Status	
Shower Transfer	Independent
Current Eating Status	
Eating	Independent

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Education	
Education Type	Increased Participation/ Tolerance for ADL Tasks Safety Training Energy Conservation Fall Prevention Patient Goals Plan of Care Weight Bearing Patient and/or Family Educated
Patient Goals and Plan of Care Discussed with Patient/Family	Yes
Assessment	
Patient Presents with Decreased Independence for ADLs and IADLs	No
Patient Would Benefit from Skilled OT Services	No
Rehabilitation Potential	good
Assessment Comment	Pt is a 62 y/o female s/p L shoulder dislocation s/p reduction in OR presenting with NWB LUE, no pushing or pulling, no ABD or FF above 90 degrees, no external rotation . Pt compliant with wearing sling while out of bed. Pt educated on AAROM exercises and pendulum exercisess to use with LUE. Pt educated on her current precuations with forward flexion while completing AAROM. Pt edcuated on hemi dressing techinques using RUE. Pt states understanding and reports no further questions or concerns. Pt also educated on home modifications to ensure safe d /c. Pt reports she is okay to drive. Writer states she will check with nsg/SW and have them check with ortho MD. Pt reports no further questions or concerns at this time. Recommend outpatient PT. SW notified. Pt does not present with skilled OT needs at this time. D/C OT
Functional Limitation Assessment	
Self Care	
Self Care Current Status	CI <20% Limited
Self Care Goal Status	CI <20% Limited
Self Care Discharge Status	CI <20% Limited

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Assessment Complete	
Functional Assessment Complete	Yes
OT: Recommendations/Plan	
Recommendations	
Recommendations	No Further OT Needs
OT: Charges	
Untimed Treatments	
Untimed Treatments	Eval - Mod Visit
Provider	
Treatment Rendered by or Reviewed with Query Text:Assistants and Students MUST choose their supervising provider (for billing purposes).	SHA0179

Inpatient OT: Missed TX Note Start: 09/27/18 15:41
Freq: Status: Discharge
Protocol:

Document 09/27/18 15:41 KAR0031 (Rec: 09/27/18 15:41 KAR0031 PMRU-C14)

OT: Missed Treatment Note	
OT Missed Treatment Note	
Session Not Completed Comment	Per discussion with PT, pt currently refusing to participate in therapies and with increased agitation after conversation with PT. Will attempt OT evaluation as appropriate and pt willing to participate next date.
Plan	Continue as Able

Document 09/28/18 11:22 KAR0031 (Rec: 09/28/18 11:24 KAR0031 PMRU-C09)

OT: Missed Treatment Note	
OT Missed Treatment Note	
Session Not Completed Comment	OT consult recieved last date, however evaluation not attempted due to pt agitation and refusal of PT. OT evaluation attempted this date . Pt initially stated, "I don' t need you, I'm retired." When OT explained to patient to increase independence with ADLs, pt stated, "I've been taking care of myself for years, I don't need your help. " Pt also reported limitations in LUE with pain to which this writer explained why OT may be able to help pt find ways to be more independent and pt stated, "I don't need you, goodbye!" and waved this writer away. Staff alerted of pt refusal, psychiatric tech

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

	in agreement to have physician place a new order if pt agreeable to participate in OT in the future. Pt not agreeable to participate at this time.
Plan	Discontinue Skilled OT Service

Document 10/10/18 13:37 KAR0031 (Rec: 10/10/18 13:39 KAR0031 PMRU-C09)
OT: Missed Treatment Note

OT Missed Treatment Note	
Session Not Completed	Patient Declined
Session Not Completed Comment	Pt reporting she is currently unable to care for herself due to left shoulder pain. Pt educated on OT role, ability to teach techniques to attempt for pt to be as independent as possible, however pt denied the need for OT at this time, stating, "That's impossible, it just can't be done right now." Pt stated, "what I really need is PT for my shoulder." Pt agreeable for this writer to reattempt once pt has had the opportunity to work with PT if she feels able to participate in OT. Discussed with RN, Lyle, that OT will follow at this time and attempt to follow up with patient following PT evaluation as able and pt willing to participate.
Plan	Continue as Able

Inpatient PT General Eval - Short Start: 10/10/18 14:19
Freq: Status: Discharge
Protocol:
Document 10/10/18 14:19 JOH0140 (Rec: 10/10/18 14:28 JOH0140 SSU-C15)
PT: Treatment Time/Type

Treatment Info	
Evaluation Type	Acute Care
Treatment Start Date	10/10/18
Treatment Start Time	13:45
Treatment Stop Date	10/10/18
Treatment Stop Time	14:08
Session 1 Time Elapsed	23
Interrupted Treatment Info	
Treatment Start Date 2	10/10/18
Treatment Stop Date 2	10/10/18
Totals	
PT Treatment Total Time (Minutes)	23
Does the Patient Have Medicare Insurance	No

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BLAYK,BONZE ANNE ROSE

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

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Assessments and Treatments - Continued

Query Text:Answer "Yes" if Medicare is listed under the patient's insurances (primary, secondary, etc).	
PT: General Evaluation (SHORT)	
General Information	
Orders Received	Yes
Chart Reviewed/Assessed	Yes
Admitting Diagnosis	UNSPECIFIED PSYCHOSIS
Admission Comment	L shoulder separation s/p reduction; Hx of chronic psychotic and personaility disorders
Precautions	Weight Bearing Precautions
Precaution Comment	L UE non-weightbearing, no pushing/ pulling, no shoulder flexion or abduction >90deg, no external rotation; sling at all times when OOB
Strength	
Strength	LE Impaired
Query Text:Strength WFL: The strength that is adequate for ordinary functional activities amongst individuals of various ages, sizes and both sexes.	
Strength Comment	L shoulder flex and abduction 2-/5, limited due to pain/ weakness; visible L deltoid atrophy noted
Range of Motion	
Range of Motion	LE Impaired
Query Text:ROM WFL: The range that is adequate for ordinary functional activities amongst individuals of various ages, sizes and both sexes.	
Range of Motion Comment	L shoulder limited 2/2 precautions
Patient Education	
Pt Ed to Increase Mobil as Tol & Perform Daily Exercises	Yes
Pt Educated in Fall Prevention/ Mobilizing With Assist Only	Yes
Assessment	
Assessment Comment	Pt seen due to L shoulder pain and decreased function following glenohumeral separation s/p reduction. Pt demonstrates muscle atrophy secondary to disuse and prior non-compliance with medical / orthopedic recommendations. Pt is more receptive to education today of gentle, gravity assisted range of

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

	motion with L shoulder flexion / abduction. Pt also receptive to wearing sling when ambulating to prevent further injury. Pt verbalized good understanding of education topics, recommendation for gentle ROM, use of sling. Pt is independent with this plan at this time and is being discharged from PT. OT plans to follow up to provide additional assistance with performance of ADLs.
Plan	
Plan	Discontinue Skilled PT Services
Inpatient PT Charges	
Provider	
Treatment Rendered by or Reviewed with Query Text:Assistants and Students MUST choose their supervising provider (for billing purposes).	JOH0140

Inpatient PT: Missed Treatment Note Start: 09/27/18 15:37
Freq: Status: Discharge
Protocol:
Document 09/27/18 15:37 MAR0029 (Rec: 09/27/18 15:44 MAR0029 SSU-C14)
PT: Missed Treatment Note

PT Missed Treatment Note	
Session Not Completed	Patient Declined
Session Not Completed Comment	PT eval attempted. PT identified self to pt, as PT had attempted eval prior to reduction. Pt was in bed, refusing to get up. Shared MD/ ortho orders with pt x 2: L UE NWB, no pushing/pulling; no abd or flex > 90 degrees; no ER. ADV using the sling when OOB in order to protect the joint. Pt did not want to hear anything more, refused to use a sling at all, and waved me away, stating 'this conversation is over. Good bye '. I wished her good luck with her recovery.
Plan	Discontinue Skilled PT Services

MHU: Adult Treatment Team Note Start: 09/24/18 18:54
Freq: Status: Discharge
Protocol:
Document 09/25/18 09:17 MAU0059 (Rec: 09/25/18 09:19 MAU0059 BSU-L01)

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

MHU Treatment Team
Observation Level
Level of observation discussed and admission note reviewed by Treatment Team Members

Patient Type	New Admission
Observation Level	Continuation
Observation Level Details	15 minutes
Other Pertinent Treatment Team Information	assess and treat start treatment over objection , possible conversion to a 2PC refusing to eat in meals

Document 09/26/18 09:15 MAU0059 (Rec: 09/26/18 09:16 MAU0059 BSU-L01)
MHU Treatment Team
Observation Level
Level of observation discussed and admission note reviewed by Treatment Team Members

Patient Type	Established Patient
Observation Level	Continuation
Observation Level Details	15 minutes
Other Pertinent Treatment Team Information	order for a medical bed TOO paperwork submitted conversion to 2PC seclusive to her room

Document 09/27/18 09:17 KYL0051 (Rec: 09/27/18 09:20 KYL0051 BSU-L01)
MHU Treatment Team
Observation Level
Level of observation discussed and admission note reviewed by Treatment Team Members

Patient Type	Established Patient
Observation Level	Continuation
Observation Level Details	15 minutes
Other Pertinent Treatment Team Information	Treatment over objection paperwork started Continue to treat

Document 09/28/18 09:12 KYL0051 (Rec: 09/28/18 09:13 KYL0051 BSU-L01)
MHU Treatment Team
Observation Level
Level of observation discussed and admission note reviewed by Treatment Team Members

Patient Type	Established Patient
Observation Level	Continuation
Observation Level Details	15 minutes
Other Pertinent Treatment Team Information	On 2PC legal status treatment over objection paperwork submitted

Document 10/01/18 09:14 KYL0051 (Rec: 10/01/18 09:15 KYL0051 BSU-L01)
MHU Treatment Team
Observation Level
Level of observation discussed and admission note reviewed by Treatment Team Members

Patient Type	Established Patient
Observation Level	Continuation
Observation Level Details	15 minutes

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Comment	agitated at times drinking fluids may use radio in her room
Other Pertinent Treatment Team Information	Treatment over objection paperwork submitted - waiting on court date

Document 10/02/18 09:15 KYL0051 (Rec: 10/02/18 09:17 KYL0051 BSU-L01)
MHU Treatment Team
Observation Level
Level of observation discussed and admission note reviewed by Treatment Team Members

Patient Type	Established Patient
Observation Level	Continuation
Observation Level Details	15 minutes
Other Pertinent Treatment Team Information	treatment over objection court date scheduled for Friday, 10/5 at 10am

Document 10/03/18 09:09 KYL0051 (Rec: 10/03/18 09:10 KYL0051 BSU-L01)
MHU Treatment Team
Observation Level
Level of observation discussed and admission note reviewed by Treatment Team Members

Patient Type	Established Patient
Observation Level	Continuation
Observation Level Details	15 minutes
Other Pertinent Treatment Team Information	court scheduled for Friday, 10/5

Document 10/04/18 09:09 KYL0051 (Rec: 10/04/18 09:11 KYL0051 BSU-L01)
MHU Treatment Team
Observation Level
Level of observation discussed and admission note reviewed by Treatment Team Members

Patient Type	Established Patient
Observation Level	Continuation
Observation Level Details	15 minutes
Other Pertinent Treatment Team Information	court tomorrow at 10:30

Document 10/05/18 09:11 KYL0051 (Rec: 10/05/18 09:11 KYL0051 BSU-L01)
MHU Treatment Team
Observation Level
Level of observation discussed and admission note reviewed by Treatment Team Members

Patient Type	Established Patient
Observation Level	Continuation
Observation Level Details	15 minutes
Other Pertinent Treatment Team Information	court this morning at 10:30am

Document 10/08/18 09:15 MAU0059 (Rec: 10/08/18 09:17 MAU0059 BSU-L01)
MHU Treatment Team
Observation Level
Level of observation discussed and admission note reviewed by Treatment Team Members

Patient Type	Established Patient

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Observation Level	Continuation
Observation Level Details	15 minutes
Other Pertinent Treatment Team Information	lost at court on Friday, court order for medications obtained took PO medications reconsider OT and PT consults if pt. is agreeable con't to treat

Document 10/09/18 09:11 MAU0059 (Rec: 10/09/18 09:13 MAU0059 BSU-L01)
MHU Treatment Team
Observation Level
Level of observation discussed and admission note reviewed by Treatment Team Members

Patient Type	Established Patient
Observation Level	Continuation
Observation Level Details	15 minutes
Other Pertinent Treatment Team Information	con't to treat encourage pt. to agree to OT and PT received injection yesterday

Document 10/10/18 09:13 MAU0059 (Rec: 10/10/18 09:14 MAU0059 BSU-L01)
MHU Treatment Team
Observation Level
Level of observation discussed and admission note reviewed by Treatment Team Members

Patient Type	Established Patient
Observation Level	Continuation
Observation Level Details	15 minutes
Other Pertinent Treatment Team Information	taking medications as per court order agreeable to OT/PT consults

Document 10/11/18 09:09 KYL0051 (Rec: 10/11/18 09:12 KYL0051 BSU-L01)
MHU Treatment Team
Observation Level
Level of observation discussed and admission note reviewed by Treatment Team Members

Patient Type	Established Patient
Observation Level	Continuation
Observation Level Details	15 minutes
Other Pertinent Treatment Team Information	was seen by PT, may wear sling taking Invega

Document 10/12/18 09:11 MAU0059 (Rec: 10/12/18 09:13 MAU0059 BSU-L01)
MHU Treatment Team
Observation Level
Level of observation discussed and admission note reviewed by Treatment Team Members

Patient Type	Established Patient
Observation Level	Continuation
Observation Level Details	30 minutes
Other Pertinent Treatment Team Information	possible d/c Monday set up follow-up care

Document 10/15/18 09:23 MAU0059 (Rec: 10/15/18 09:25 MAU0059 BSU-L01)

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

MHU Treatment Team
Observation Level
Level of observation discussed and admission note reviewed by Treatment Team Members

Patient Type	Established Patient
Observation Level	Continuation
Observation Level Details	30 minutes
Other Pertinent Treatment Team Information	possible d/c today

MHU: Group Compliance — Start: 09/24/18 18:54
Freq: QSHIFT — Status: Complete
Protocol:

Document	09/24/18 20:00	ROW0001	(Rec: 09/24/18 22:38	ROW0001	BSU-C02)

MHU Group Complaince
Group Compliance
Group Compliant: No

Document	09/25/18 13:35	ANN0115	(Rec: 09/25/18 13:35	ANN0115	BSU-M01)

MHU Group Complaince
Group Compliance
Group Compliant: No

Document	09/25/18 20:00	ROB0100	(Rec: 09/25/18 21:02	ROB0100	BSU-C27)

MHU Group Complaince
Group Compliance
Group Compliant: No

Document	09/26/18 10:19	ANN0115	(Rec: 09/26/18 10:19	ANN0115	BSU-M01)

MHU Group Complaince
Group Compliance
Group Compliant: No

MHU: Medication Compliance — Start: 09/24/18 18:54
Freq: QSHIFT — Status: Complete
Protocol:

Document	09/24/18 20:00	ROW0001	(Rec: 09/24/18 22:38	ROW0001	BSU-C02)

MHU Medication Compliance
Medication Compliance
Medication Compliant: No

Document	09/25/18 13:35	ANN0115	(Rec: 09/25/18 13:35	ANN0115	BSU-M01)

MHU Medication Compliance
Medication Compliance
Medication Compliant: No

Document	09/25/18 20:00	ROB0100	(Rec: 09/25/18 21:02	ROB0100	BSU-C27)

MHU Medication Compliance
Medication Compliance
Medication Compliant: No

Document	09/26/18 10:19	ANN0115	(Rec: 09/26/18 10:19	ANN0115	BSU-M01)

MHU Medication Compliance
Medication Compliance
Medication Compliant: No

MHU: Tobacco Use Screening — Start: 09/26/18 15:50
Freq: ONCE — Status: Discharge
Protocol:

Document	09/26/18 15:50	KEL0019	(Rec: 09/26/18 15:51	KEL0019	BSU-C27)

MHU: Tobacco Use Screening
Tobacco Use History

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Smoking Status (MU) 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 .**	Current Every Day Smoker
Used Tobacco in Past 6 Months?	Yes
Used Tobacco in Past 30 Days?	Yes
Used Tobacco in Past 7 Days?	Yes
Types of Tobacco Currently Used	Cigarettes
Description/Frequency of Use	Refused to answer
For How Many Years Have You Been Using Tobacco?	n/a
How Many Minutes After Waking Up Do You First Use Tobacco?	n/a
How Important is it to You to Quit Using Tobacco?	1 (Not)
How Confident Are You That You Can Quit Using Tobacco?	1 (Not)
Counseling	
Provided Personalized Advice to Quit Use of Tobacco	No
Personalized Advice	Pt declined to answer questions
Patient Ready to Quit Use of Tobacco	No
Do you plan to quit in the next 6 months ?	Not ready to quit in the next 6 months
Discussed the 5 R's Query Text:The 5 R's: Relevance, Risk, Rewards, Roadblocks, Repetition	No
Strategic Advice	
Strategic Advice Given	Recommend follow-up
Referrals	
Referred to NYS Smokers' Quitline	Yes, Not Interested
NYS Smokers' Quitline Comment	You have declined referral to the NYS Smoker's quit line at this time. If you decide to access this free service in the future you can contact the quit line toll-free at 866-697-8487.

MHU:Adult Group 01- Community Meeting Start: 09/24/18 18:54
Freq: Status: Discharge
Protocol:

Document 09/26/18 09:31 BRI0130 (Rec: 09/26/18 09:31 BRI0130 BSU-C30)
Adult Group: Community Meeting

Community Meeting	
Treatment Team Goal Completed	No
Community Meeting Comments	DNA

Document 09/27/18 08:45 KRI0028 (Rec: 09/27/18 08:45 KRI0028 BSU-C31)
Adult Group: Community Meeting

Community Meeting	
Treatment Team Goal Completed	No

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
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Assessments and Treatments - Continued

Document 09/28/18 08:51 BRI0130 (Rec: 09/28/18 08:51 BRI0130 BSU-C30)
Adult Group: Community Meeting
Community Meeting
Treatment Team Goal Completed No
Community Meeting Comments DNA
Document 09/29/18 09:14 ILA0001 (Rec: 09/29/18 09:14 ILA0001 BSU-C31)
Adult Group: Community Meeting
Community Meeting
Treatment Team Goal Completed No
Community Meeting Comments Did not attend
Document 09/30/18 09:10 BRI0130 (Rec: 09/30/18 09:10 BRI0130 BSU-C30)
Adult Group: Community Meeting
Community Meeting
Treatment Team Goal Completed No
Community Meeting Comments DNA
Document 09/30/18 09:34 MAR0445 (Rec: 09/30/18 09:35 MAR0445 BSU-C30)
Adult Group: Community Meeting
Community Meeting
Treatment Team Goal Completed No: DNA
Document 10/01/18 08:57 MAT0068 (Rec: 10/01/18 08:57 MAT0068 BSU-C31)
Adult Group: Community Meeting
Community Meeting
Treatment Team Goal Completed No
Document 10/02/18 08:48 MAT0068 (Rec: 10/02/18 08:48 MAT0068 BSU-C31)
Adult Group: Community Meeting
Community Meeting
Treatment Team Goal Completed No
Document 10/03/18 09:41 BRI0130 (Rec: 10/03/18 09:41 BRI0130 BSU-C30)
Adult Group: Community Meeting
Community Meeting
Treatment Team Goal Completed No
Community Meeting Comments DNA
Document 10/04/18 08:48 MAR0445 (Rec: 10/04/18 08:48 MAR0445 BSU-C31)
Adult Group: Community Meeting
Community Meeting
Treatment Team Goal Completed No: DNA
Document 10/05/18 08:52 KRI0028 (Rec: 10/05/18 08:52 KRI0028 BSU-C31)
Adult Group: Community Meeting
Community Meeting
Treatment Team Goal Completed No
Document 10/06/18 08:50 BRI0130 (Rec: 10/06/18 08:51 BRI0130 BSU-C31)
Adult Group: Community Meeting
Community Meeting
Treatment Team Goal Completed Yes
Community Meeting Comments Goal: to not run into things
Document 10/07/18 09:14 MAT0068 (Rec: 10/07/18 09:14 MAT0068 BSU-C31)
Adult Group: Community Meeting
Community Meeting
Treatment Team Goal Completed No
Document 10/08/18 09:04 MAT0068 (Rec: 10/08/18 09:04 MAT0068 BSU-C31)
Adult Group: Community Meeting
Community Meeting
Treatment Team Goal Completed No

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BLAYK,BONZE ANNE ROSE
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Assessments and Treatments - Continued

Document 10/09/18 09:00 MAT0068 (Rec: 10/09/18 09:00 MAT0068 BSU-C31)
Adult Group: Community Meeting
Community Meeting
Treatment Team Goal Completed No
Document 10/10/18 09:58 BRI0130 (Rec: 10/10/18 09:59 BRI0130 BSU-C31)
Adult Group: Community Meeting
Community Meeting
Treatment Team Goal Completed No
Document 10/11/18 09:56 MAR0445 (Rec: 10/11/18 09:56 MAR0445 BSU-C30)
Adult Group: Community Meeting
Community Meeting
Treatment Team Goal Completed No: DNA
Document 10/12/18 09:23 MAR0445 (Rec: 10/12/18 09:23 MAR0445 BSU-C30)
Adult Group: Community Meeting
Community Meeting
Treatment Team Goal Completed No: DNA
Document 10/13/18 09:09 KRI0028 (Rec: 10/13/18 09:09 KRI0028 BSU-C31)
Adult Group: Community Meeting
Community Meeting
Treatment Team Goal Completed No
Document 10/14/18 08:39 KRI0028 (Rec: 10/14/18 08:39 KRI0028 BSU-C31)
Adult Group: Community Meeting
Community Meeting
Treatment Team Goal Completed No
Document 10/15/18 09:28 NAV0003 (Rec: 10/15/18 09:28 NAV0003 BSU-C30)
Adult Group: Community Meeting
Community Meeting
Treatment Team Goal Completed No
Community Meeting Comments Pt. declined to attend community meeting.

MHU:Adult Group 02- Exercise Start: 09/24/18 18:54
Freq: Status: Discharge
Protocol:
Document 09/26/18 09:31 BRI0130 (Rec: 09/26/18 09:31 BRI0130 BSU-C30)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined
Document 09/27/18 09:58 KRI0028 (Rec: 09/27/18 09:58 KRI0028 BSU-C31)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined
Document 09/28/18 08:51 BRI0130 (Rec: 09/28/18 08:51 BRI0130 BSU-C30)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined
Document 09/29/18 09:14 ILA0001 (Rec: 09/29/18 09:14 ILA0001 BSU-C31)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined
Exercise Group Comments Did not attend
Document 09/30/18 09:10 BRI0130 (Rec: 09/30/18 09:10 BRI0130 BSU-C30)
Adult Group: Exercise
Exercise Group

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BLAYK,BONZE ANNE ROSE

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

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Assessments and Treatments - Continued

Exercise Group Participation Declined
Document 09/30/18 09:34 MAR0445 (Rec: 09/30/18 09:35 MAR0445 BSU-C30)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined
Document 10/02/18 09:22 BRI0130 (Rec: 10/02/18 09:22 BRI0130 BSU-C30)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined
Document 10/03/18 09:41 KRI0028 (Rec: 10/03/18 09:41 KRI0028 BSU-C31)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined
Document 10/05/18 09:54 KRI0028 (Rec: 10/05/18 09:54 KRI0028 BSU-C31)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined
Document 10/06/18 09:33 RAC0019 (Rec: 10/06/18 09:33 RAC0019 BSU-C31)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined
Document 10/07/18 09:58 RAC0019 (Rec: 10/07/18 09:58 RAC0019 BSU-C31)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined
Document 10/09/18 09:55 NAV0003 (Rec: 10/09/18 09:55 NAV0003 BSU-C30)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined
Document 10/10/18 09:58 BRI0130 (Rec: 10/10/18 09:59 BRI0130 BSU-C31)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined
Document 10/11/18 09:56 MAR0445 (Rec: 10/11/18 09:56 MAR0445 BSU-C30)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined
Document 10/12/18 09:23 MAR0445 (Rec: 10/12/18 09:23 MAR0445 BSU-C30)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined
Document 10/13/18 10:39 MAR0445 (Rec: 10/13/18 10:40 MAR0445 BSU-C30)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined
Document 10/14/18 09:22 KRI0028 (Rec: 10/14/18 09:22 KRI0028 BSU-C31)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined

MHU:Adult Group 03- Cog Behavior Ther Start: 09/24/18 18:54
Freq: Status: Discharge
Protocol:
Document 09/25/18 11:32 KYL0051 (Rec: 09/25/18 11:32 KYL0051 BSU-C08)

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BLAYK,BONZE ANNE ROSE

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

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Assessments and Treatments - Continued

Adult Group: Cognitive Behavior Therapy
Cognitive Behavior Therapy
CBT Response Declined
Document 09/26/18 11:04 BRI0130 (Rec: 09/26/18 11:04 BRI0130 BSU-C30)
Adult Group: Cognitive Behavior Therapy
Cognitive Behavior Therapy
CBT Participation Declined
Document 09/27/18 10:52 MAT0068 (Rec: 09/27/18 10:52 MAT0068 BSU-C30)
Adult Group: Cognitive Behavior Therapy
Cognitive Behavior Therapy
CBT Response Declined
Document 09/28/18 10:38 MAT0068 (Rec: 09/28/18 10:38 MAT0068 BSU-C31)
Adult Group: Cognitive Behavior Therapy
Cognitive Behavior Therapy
CBT Participation Declined
CBT Response Declined

MHU:Adult Group 04- Focus Start: 09/24/18 18:54
Freq: Status: Discharge
Protocol:
Document 09/25/18 14:43 MAU0059 (Rec: 09/25/18 15:57 MAU0059 BSU-C04)
Adult Group: Focus
Focus Group
Focus Group Response Declined
Document 09/26/18 11:54 KYL0051 (Rec: 09/26/18 11:54 KYL0051 BSU-C08)
Adult Group: Focus
Focus Group
Focus Group Response Declined
Document 09/27/18 12:05 KYL0051 (Rec: 09/27/18 12:05 KYL0051 BSU-C08)
Adult Group: Focus
Focus Group
Focus Group Response Declined
Document 09/28/18 11:57 KYL0051 (Rec: 09/28/18 11:57 KYL0051 BSU-C08)
Adult Group: Focus
Focus Group
Focus Group Topic Leisure Education
Focus Group Response Declined
Document 10/01/18 13:29 KYL0051 (Rec: 10/01/18 13:29 KYL0051 BSU-C08)
Adult Group: Focus
Focus Group
Focus Group Response Declined
Document 10/02/18 12:08 KYL0051 (Rec: 10/02/18 12:08 KYL0051 BSU-C08)
Adult Group: Focus
Focus Group
Focus Group Response Declined
Document 10/03/18 11:49 KYL0051 (Rec: 10/03/18 11:49 KYL0051 BSU-C08)
Adult Group: Focus
Focus Group
Focus Group Response Declined
Document 10/04/18 11:44 KYL0051 (Rec: 10/04/18 11:44 KYL0051 BSU-C08)
Adult Group: Focus
Focus Group
Focus Group Topic Community Resources
Focus Group Response Declined

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BLAYK,BONZE ANNE ROSE
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Assessments and Treatments - Continued

Document 10/05/18 11:56 KYL0051 (Rec: 10/05/18 11:56 KYL0051 BSU-C08)
Adult Group: Focus
Focus Group
Focus Group Topic — Leisure Education
Focus Group Response — Declined

Document 10/08/18 12:53 MAU0059 (Rec: 10/08/18 12:53 MAU0059 BSU-C04)
Adult Group: Focus
Focus Group
Focus Group Topic — Stress Management
Focus Group Affect Behavior — Appropriate
Cooperative
Engaged
Euthymic
Full
Focus Group Interventions — Encourage Participation
Validate
Focus Group Response — Participated
Followed Directions
Improved Mood
Motivated

Document 10/09/18 13:42 MAU0059 (Rec: 10/09/18 13:42 MAU0059 BSU-C04)
Adult Group: Focus
Focus Group
Focus Group Topic — Self Awareness
Focus Group Affect Behavior — Appropriate
Cooperative
Engaged
Euthymic
Full
Focus Group Interventions — Encourage Participation
Validate
Focus Group Response — Participated
Followed Directions

Document 10/10/18 14:36 MAU0059 (Rec: 10/10/18 14:37 MAU0059 BSU-C04)
Adult Group: Focus
Focus Group
Focus Group Response — Declined

Document 10/11/18 13:27 KYL0051 (Rec: 10/11/18 13:27 KYL0051 BSU-C08)
Adult Group: Focus
Focus Group
Focus Group Response — Declined

Document 10/12/18 11:42 MAU0059 (Rec: 10/12/18 11:42 MAU0059 BSU-C04)
Adult Group: Focus
Focus Group
Focus Group Response — Declined

Document 10/15/18 12:16 MAU0059 (Rec: 10/15/18 12:16 MAU0059 BSU-C04)
Adult Group: Focus
Focus Group
Focus Group Response — Declined

MHU:Adult Group 05- Dialectical Behav Start: 09/24/18 18:54
Freq: Status: Discharge
Protocol:

Document 09/25/18 14:20 NAV0003 (Rec: 09/25/18 14:21 NAV0003 BSU-C27)

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BLAYK,BONZE ANNE ROSE
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Assessments and Treatments - Continued

Adult Group: Dialectical Therapy
Dialectical Behavior Therapy
DBT Group Topic — Interpersonal Effectiveness
DBT Group Responses — Declined
Document 09/26/18 14:10 BRI0130 (Rec: 09/26/18 14:10 BRI0130 BSU-C30)

Adult Group: Dialectical Therapy
Dialectical Behavior Therapy
DBT Group Responses — Declined
Document 09/27/18 15:13 KRI0028 (Rec: 09/27/18 15:13 KRI0028 BSU-C31)

Adult Group: Dialectical Therapy
Dialectical Behavior Therapy
DBT Group Topic — Interpersonal Effectiveness: Validation
DBT Group Interventions — Encourage Participation; Validate
DBT Group Responses — Declined
Document 09/28/18 13:50 ALL0023 (Rec: 09/28/18 13:51 ALL0023 BSU-C30)

Adult Group: Dialectical Therapy
Dialectical Behavior Therapy
DBT Group Topic — Assertive Communication
DBT Group Responses — Declined
DBT Group Comments — DNA
Document 09/29/18 13:14 TAH0001 (Rec: 09/29/18 13:14 TAH0001 BSU-C31)

Adult Group: Dialectical Therapy
Dialectical Behavior Therapy
DBT Group Topic — Interpersonal Effectiveness
DBT Group Responses — Declined
Document 10/01/18 13:30 MAT0068 (Rec: 10/01/18 13:30 MAT0068 BSU-C31)

Adult Group: Dialectical Therapy
Dialectical Behavior Therapy
DBT Group Responses — Declined
Document 10/02/18 13:34 MAT0068 (Rec: 10/02/18 13:34 MAT0068 BSU-C31)

Adult Group: Dialectical Therapy
Dialectical Behavior Therapy
DBT Group Responses — Declined
Document 10/03/18 14:31 KRI0028 (Rec: 10/03/18 14:31 KRI0028 BSU-C31)

Adult Group: Dialectical Therapy
Dialectical Behavior Therapy
DBT Group Topic — Mindfulness
DBT Group Interventions — Encourage Participation; Validate
DBT Group Responses — Declined
Document 10/04/18 13:33 KRI0028 (Rec: 10/04/18 13:33 KRI0028 BSU-C30)

Adult Group: Dialectical Therapy
Dialectical Behavior Therapy
DBT Group Topic — MINDFULNESS: HOW Skills
DBT Group Interventions — Encourage Participation; Validate
DBT Group Responses — Declined
Document 10/05/18 15:21 NAV0003 (Rec: 10/05/18 15:21 NAV0003 BSU-C30)

Adult Group: Dialectical Therapy
Dialectical Behavior Therapy
DBT Group Topic — Mindfulness and Mindful Goal

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Assessments and Treatments - Continued

	Setting
DBT Group Responses	Declined

Document 10/06/18 11:09 ALL0023 (Rec: 10/06/18 11:10 ALL0023 BSU-C30)
Adult Group: Dialectical Therapy
Dialectical Behavior Therapy

DBT Group Topic	Mindfulness Recap
DBT Group Responses	Declined
DBT Group Comments	DNA

Document 10/08/18 13:37 KRI0028 (Rec: 10/08/18 13:37 KRI0028 BSU-C31)
Adult Group: Dialectical Therapy
Dialectical Behavior Therapy

DBT Group Topic	Distress Tolerance: Distress Tolerance Skills
DBT Group Affect Behavior	Appropriate Calm Cooperative Flat
DBT Group Interventions	Encourage Participation Validate
DBT Group Responses	Participated

Document 10/09/18 13:40 MAT0068 (Rec: 10/09/18 13:40 MAT0068 BSU-C30)
Adult Group: Dialectical Therapy
Dialectical Behavior Therapy

DBT Group Responses	Declined

Document 10/10/18 13:44 NAV0003 (Rec: 10/10/18 13:44 NAV0003 BSU-C30)
Adult Group: Dialectical Therapy
Dialectical Behavior Therapy

DBT Group Topic	Distress Tolerance - Imagery Relaxation
DBT Group Responses	Declined

Document 10/11/18 13:41 MAR0445 (Rec: 10/11/18 13:41 MAR0445 BSU-C12)
Adult Group: Dialectical Therapy
Dialectical Behavior Therapy

DBT Group Topic	SODAS
DBT Group Responses	Declined

Document 10/12/18 14:12 MAR0445 (Rec: 10/12/18 14:13 MAR0445 BSU-C26)
Adult Group: Dialectical Therapy
Dialectical Behavior Therapy

DBT Group Topic	Radical Acceptance
DBT Group Responses	Declined

Document 10/13/18 11:08 JAC0076 (Rec: 10/13/18 11:09 JAC0076 BSU-C31)
Adult Group: Dialectical Therapy
Dialectical Behavior Therapy

DBT Group Topic	Goals and Priorities in interpersonal Situations
DBT Group Responses	Declined

MHU:Adult Group 06- Recreation Therapy Start: 09/24/18 18:54
Freq: Status: Discharge
Protocol:
Document 09/25/18 15:51 KYL0051 (Rec: 09/25/18 15:51 KYL0051 BSU-C08)
MHU: Attendance-Activity Ther
Activity Attendance Assessment

Activity Therapy Attendance	Refused

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BLAYK,BONZE ANNE ROSE

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

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Assessments and Treatments - Continued

Document 09/26/18 15:11 KYL0051 (Rec: 09/26/18 15:11 KYL0051 BSU-C08)
MHU: Attendance-Activity Ther
Activity Attendance Assessment
Activity Therapy Attendance No

Document 09/27/18 15:20 KYL0051 (Rec: 09/27/18 15:20 KYL0051 BSU-C08)
MHU: Attendance-Activity Ther
Activity Attendance Assessment
Activity Therapy Attendance Refused

Document 09/28/18 15:04 KYL0051 (Rec: 09/28/18 15:04 KYL0051 BSU-C08)
MHU: Attendance-Activity Ther
Activity Attendance Assessment
Activity Therapy Attendance No

Document 09/29/18 14:42 ILA0001 (Rec: 09/29/18 14:42 ILA0001 BSU-C31)
MHU: Attendance-Activity Ther
Activity Attendance Assessment
Activity Group Topic coloring/music
Activity Therapy Attendance No
Activity Attendance Comment did not attend

Document 09/30/18 14:48 MAR0445 (Rec: 09/30/18 14:48 MAR0445 BSU-C30)
MHU: Attendance-Activity Ther
Activity Attendance Assessment
Activity Group Topic BINGO
Activity Therapy Attendance Refused

Document 10/01/18 15:17 KYL0051 (Rec: 10/01/18 15:17 KYL0051 BSU-C08)
MHU: Attendance-Activity Ther
Activity Attendance Assessment
Activity Therapy Attendance Refused

Document 10/02/18 16:23 KYL0051 (Rec: 10/02/18 16:23 KYL0051 BSU-C08)
MHU: Attendance-Activity Ther
Activity Attendance Assessment
Activity Therapy Attendance Refused

Document 10/03/18 14:59 KYL0051 (Rec: 10/03/18 14:59 KYL0051 BSU-C08)
MHU: Attendance-Activity Ther
Activity Attendance Assessment
Activity Therapy Attendance No

Document 10/04/18 16:24 KYL0051 (Rec: 10/04/18 16:24 KYL0051 BSU-C08)
MHU: Attendance-Activity Ther
Activity Attendance Assessment
Activity Therapy Attendance No

Document 10/05/18 15:49 MAU0059 (Rec: 10/05/18 15:49 MAU0059 BSU-C04)
MHU: Attendance-Activity Ther
Activity Attendance Assessment
Activity Therapy Attendance No

Document 10/06/18 17:00 BRI0130 (Rec: 10/06/18 17:01 BRI0130 BSU-C30)
MHU: Attendance-Activity Ther
Activity Attendance Assessment
Activity Group Topic Arts & games
Activity Therapy Attendance No

Document 10/08/18 15:10 KYL0051 (Rec: 10/08/18 15:10 KYL0051 BSU-C08)
MHU: Attendance-Activity Ther
Activity Attendance Assessment
Activity Therapy Attendance No

Document 10/09/18 16:06 KYL0051 (Rec: 10/09/18 16:07 KYL0051 BSU-C08)

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
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Assessments and Treatments - Continued

MHU: Attendance-Activity Ther
Activity Attendance Assessment
Activity Therapy Attendance Yes
Activity Attendance Comment joined pet therapy briefly
Document 10/10/18 15:11 KYL0051 (Rec: 10/10/18 15:11 KYL0051 BSU-C08)
MHU: Attendance-Activity Ther
Activity Attendance Assessment
Activity Therapy Attendance No
Document 10/11/18 15:39 KYL0051 (Rec: 10/11/18 15:39 KYL0051 BSU-C08)
MHU: Attendance-Activity Ther
Activity Attendance Assessment
Activity Therapy Attendance Refused
Document 10/12/18 14:55 KYL0051 (Rec: 10/12/18 14:55 KYL0051 BSU-C08)
MHU: Attendance-Activity Ther
Activity Attendance Assessment
Activity Therapy Attendance No
Document 10/14/18 15:57 MAR0445 (Rec: 10/14/18 15:57 MAR0445 BSU-C30)
MHU: Attendance-Activity Ther
Activity Attendance Assessment
Activity Group Topic BINGO
Activity Therapy Attendance Refused

MHU:Adult Group 07- Education Start: 09/24/18 18:54
Freq: Status: Discharge
Protocol:
Document 09/28/18 17:24 MAR0485 (Rec: 09/28/18 17:24 MAR0485 BSU-C31)
Adult Group: Education
Education
Education Group Topic Settting Goals
Education Group Response Declined
Document 09/29/18 13:06 MAR0445 (Rec: 09/29/18 13:06 MAR0445 BSU-C30)
Adult Group: Education
Education
Education Group Topic Nutrition
Education Group Response Declined
Document 10/01/18 16:03 ILA0001 (Rec: 10/01/18 16:04 ILA0001 BSU-C31)
Adult Group: Education
Education
Education Group Topic 1500-2300
Education Group Response Declined
Education Group Comments Did not attend
Document 10/06/18 12:14 NAT0065 (Rec: 10/06/18 12:15 NAT0065 BSU-C30)
Adult Group: Education
Education
Education Group Topic nutrition
Education Group Response Declined
Document 10/08/18 15:30 MAT0068 (Rec: 10/08/18 15:30 MAT0068 BSU-C30)
Adult Group: Education
Education
Education Group Topic change
Education Group Affect Behavior Appropriate
Calm
Cooperative
Engaged

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
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Assessments and Treatments - Continued

	Full
	Congruent
Education Group Intervevtions	Facilitate Prob Solving
	Validate
	Instruct
Education Group Response	Participated
	Followed Directions
	Improved Mood
	Insightful
	Motivated
	Helpful to Peers

Document 10/13/18 11:32 KRI0028 (Rec: 10/13/18 11:32 KRI0028 BSU-C30)
Adult Group: Education
Education

Education Group Topic	NUTRITION GROUP
Education Group Intervevtions	Encourage Participation
	Validate
Education Group Response	Declined

MHU:Adult Group 09- Evening Start: 09/24/18 18:54
Freq: Status: Discharge
Protocol:

Document 09/24/18 20:25 VOD0001 (Rec: 09/24/18 20:26 VOD0001 BSU-C30)
Adult Group: Evening
Evening

Evening Group Topic	Journal Exercise
Evening Group Participation	Declined

Document 09/25/18 19:50 VOD0001 (Rec: 09/25/18 19:50 VOD0001 BSU-C31)
Adult Group: Evening
Evening

Evening Group Topic	Hope and Recovery with MHA
Evening Group Participation	Declined

Document 09/26/18 20:12 JAC0076 (Rec: 09/26/18 20:14 JAC0076 BSU-C31)
Adult Group: Evening
Evening

Evening Group Topic	How did the problem develop
Evening Group Participation	Declined

Document 09/27/18 19:55 ILA0001 (Rec: 09/27/18 19:55 ILA0001 BSU-C30)
Adult Group: Evening
Evening

Evening Group Topic	Grouding Techniques
Evening Group Participation	Declined
Evening Group Comments	Did not attend

Document 09/28/18 20:27 JAD0003 (Rec: 09/28/18 20:27 JAD0003 BSU-C31)
Adult Group: Evening
Evening

Evening Group Topic	Anger Management
Evening Group Participation	Declined

Document 09/29/18 21:08 VOD0001 (Rec: 09/29/18 21:08 VOD0001 BSU-C31)
Adult Group: Evening
Evening

Evening Group Topic	Writing Journal
Evening Group Participation	Declined

Document 09/30/18 19:39 ILA0001 (Rec: 09/30/18 19:40 ILA0001 BSU-C31)

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Assessments and Treatments - Continued

Adult Group: Evening
Evening
Evening Group Topic — Stress reduction
Evening Group Participation — Declined
Evening Group Comments — Did not attend
Document 10/01/18 19:33 ILA0001 (Rec: 10/01/18 19:33 ILA0001 BSU-C31)

Adult Group: Evening
Evening
Evening Group Topic — Goal Setting
Evening Group Participation — Declined
Evening Group Comments — Did not attend
Document 10/02/18 20:58 JAD0003 (Rec: 10/02/18 20:58 JAD0003 BSU-C30)

Adult Group: Evening
Evening
Evening Group Topic — Hope and Recovery
Evening Group Participation — Declined
Document 10/03/18 20:42 JAC0076 (Rec: 10/03/18 20:42 JAC0076 BSU-C30)

Adult Group: Evening
Evening
Evening Group Topic — Understanding Your Triggers for Anger
Evening Group Participation — Declined
Document 10/04/18 20:12 RYA0008 (Rec: 10/04/18 20:12 RYA0008 BSU-C03)

Adult Group: Evening
Evening
Evening Group Topic — Self-Protection
Evening Group Participation — Declined
Document 10/05/18 20:06 TAH0001 (Rec: 10/05/18 20:06 TAH0001 BSU-C31)

Adult Group: Evening
Evening
Evening Group Topic — Journaling
Evening Group Participation — Declined
Document 10/06/18 20:32 RYA0008 (Rec: 10/06/18 20:32 RYA0008 BSU-C30)

Adult Group: Evening
Evening
Evening Group Topic — Rumination and Reflection
Evening Group Participation — Declined
Document 10/07/18 23:02 RYA0008 (Rec: 10/07/18 23:02 RYA0008 BSU-C31)

Adult Group: Evening
Evening
Evening Group Topic — DNA - Empathy
Evening Group Participation — Declined
Document 10/08/18 20:43 VOD0001 (Rec: 10/08/18 20:44 VOD0001 BSU-C30)

Adult Group: Evening
Evening
Evening Group Topic — Writing Journal
Evening Group Participation — Declined
Document 10/09/18 19:43 JAD0003 (Rec: 10/09/18 19:43 JAD0003 BSU-C31)

Adult Group: Evening
Evening
Evening Group Topic — Hope and Recovery
Evening Group Participation — Declined
Document 10/10/18 20:00 ILA0001 (Rec: 10/10/18 20:00 ILA0001 BSU-C30)

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Assessments and Treatments - Continued

Adult Group: Evening
Evening
Evening Group Topic — Positive Traits and Self-Care
Evening Group Participation — Declined
Evening Group Comments — Did not attend
Document 10/11/18 20:58 JAC0076 (Rec: 10/11/18 20:59 JAC0076 BSU-C31)

Adult Group: Evening
Evening
Evening Group Topic — I Am a Person Who
Evening Group Participation — Declined
Document 10/12/18 19:39 JAD0003 (Rec: 10/12/18 19:39 JAD0003 BSU-C30)

Adult Group: Evening
Evening
Evening Group Topic — Anger Management
Evening Group Participation — Declined
Document 10/12/18 20:28 JAC0076 (Rec: 10/12/18 20:29 JAC0076 BSU-C31)

Adult Group: Evening
Evening
Evening Group Topic — Express your Anger
Evening Group Participation — Declined
Document 10/13/18 21:40 JAC0076 (Rec: 10/13/18 21:41 JAC0076 BSU-C31)

Adult Group: Evening
Evening
Evening Group Topic — Break the Ice
Evening Group Participation — Declined
Document 10/14/18 21:09 JAC0076 (Rec: 10/14/18 21:11 JAC0076 BSU-C31)

Adult Group: Evening
Evening
Evening Group Topic — Mirror Me, Negative Limiting Thought, Positive Enabling Thought.Self Esteem
Evening Group Participation — Declined

MHU:Adult Group 12- Wrap Up — Start: 09/24/18 18:54
Freq: — Status: Discharge
Protocol:

Document 09/25/18 21:30 VOD0001 (Rec: 09/25/18 21:30 VOD0001 BSU-C31)

Adult Group: Wrap Up
Wrap Up
Wrap Up Group Goal — Did Not Meet Goal
Document 09/27/18 21:27 JAC0076 (Rec: 09/27/18 21:27 JAC0076 BSU-C30)

Adult Group: Wrap Up
Wrap Up
Wrap Up Group Goal — no goal
Document 09/28/18 22:15 JAC0076 (Rec: 09/28/18 22:15 JAC0076 BSU-C30)

Adult Group: Wrap Up
Wrap Up
Wrap Up Group Goal — no goal
Document 09/29/18 20:37 JAC0076 (Rec: 09/29/18 20:37 JAC0076 BSU-C30)

Adult Group: Wrap Up
Wrap Up
Wrap Up Group Goal — no goal
Document 10/01/18 21:22 VOD0001 (Rec: 10/01/18 21:22 VOD0001 BSU-C31)

Adult Group: Wrap Up

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Assessments and Treatments - Continued

Wrap Up
Wrap Up Group Goal — Pt has no goal
Document 10/03/18 22:02 VOD0001 (Rec: 10/03/18 22:02 VOD0001 BSU-C31)
Adult Group: Wrap Up

Wrap Up
Wrap Up Group Goal — Did Not Meet Goal
Document 10/04/18 21:39 JAC0076 (Rec: 10/04/18 21:39 JAC0076 BSU-C31)
Adult Group: Wrap Up

Wrap Up
Wrap Up Group Goal — no goal
Document 10/05/18 21:46 JAC0076 (Rec: 10/05/18 21:47 JAC0076 BSU-C31)
Adult Group: Wrap Up

Wrap Up
Wrap Up Group Goal — no goal
Document 10/06/18 22:23 JAD0003 (Rec: 10/06/18 22:24 JAD0003 BSU-C31)
Adult Group: Wrap Up

Wrap Up
Wrap Up Group Goal — Met Goal
Wrap Up Group Comments — Goal: okay
Document 10/07/18 22:53 JAD0003 (Rec: 10/07/18 22:53 JAD0003 BSU-C30)
Adult Group: Wrap Up

Wrap Up
Wrap Up Group Goal — did not set a goal
Document 10/08/18 20:43 VOD0001 (Rec: 10/08/18 20:44 VOD0001 BSU-C30)
Adult Group: Wrap Up

Wrap Up
Wrap Up Group Goal — Did Not Meet Goal
Document 10/10/18 20:44 JAC0076 (Rec: 10/10/18 20:44 JAC0076 BSU-C31)
Adult Group: Wrap Up

Wrap Up
Wrap Up Group Goal — no goal
Document 10/11/18 21:27 JAD0003 (Rec: 10/11/18 21:27 JAD0003 BSU-C30)
Adult Group: Wrap Up

Wrap Up
Wrap Up Group Goal — did not set a goal
Document 10/12/18 20:28 JAC0076 (Rec: 10/12/18 20:29 JAC0076 BSU-C31)
Adult Group: Wrap Up

Wrap Up
Wrap Up Group Goal — no goal
Document 10/14/18 21:09 JAC0076 (Rec: 10/14/18 21:11 JAC0076 BSU-C31)
Adult Group: Wrap Up

Wrap Up
Wrap Up Group Goal — no goal

MHU:Adult- Psychosocial Assessment — Start: 09/24/18 18:54
Freq: — Status: Discharge
Protocol:
Document 09/25/18 10:41 ALI0046 (Rec: 09/25/18 10:42 ALI0046 BSU-C20)
MHU: Adult- Psych Assess
Reason for Admission
History of Current Episode or Illness — Per MHE in ED: "PT BIBA 9.41 FROM SUNOCO STATION DOWNTOWN AFTER PT CALLED 911 REPORTING ALTERCATION W/ ANOTHER PERSON

NEVER HAPPENED AT THE SUNOCO EVER:

FALSE / NO MHL 9.41 3-Day Hold

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Assessments and Treatments - Continued

	AT GAS STATION WHICH LED PT TO FEEL UNSAFE. PT REQUESTED TRANS TO ER FOR MHE. PT CALM/ COOPERATIVE IN ER UNTIL AWOKEN FOR EVAL, AT WHICH TIME PT BECAME VERY AGITATED, YELLING AT STAFF, ACCUSING ER STAFF OF WAKING HIM TO ABUSE HIM. PT WAS DE-ESCALATED AND CALMED JUST ENOUGH TO CONDUCT EVAL INTERVIEW. PT HYPERVERBAL, DISORGANIZED AND TANGENTIAL PERSEVERATING ON BEING "KICKED OUT" OF MOTEL DUE TO BEING LABELED MENTALLY ILL. PT RELATES THAT HE ATTEMPTED TO GET A BED AT THE FRIENDSHIP CENTER, BUT THEY WOULDN'T ALLOW HIM IN. PT DENIES SI, HI ,SIB OR ANY HX OF THESE. PT MAKING DELUSIONAL STATEMENTS ABOUT BEING "AN OFFICER OF THE FEDERAL GOVM'T" AND "BAD GUYS THAT ARE HACKING MY SOFTWARE ARE TRYING TO KILL ME". PT REMAINED HYPERVERBAL AND AGITATED THROUGHOUT EVAL. PT DENIED ANY CURRENT OUTPT MH TRTMT, OTHER THAN SESSIONS W/ DR KEVIN FIELDS - LAST ONE BEING APPROX 2MOS AGO. PT ALSO DENIES ANY CURRENT HOME MEDS. STATES ONLY CURRENT PROVIDER IS PCP - DR BREIMEN. PT VASCILLATES BTWN REQUESTING ADMIT AND STATING DESIRE TO BE D/C'd. "
FALSE: I ran out of money!	
Current Outpatient Providers	
Therapist/Counselor	none
Psychiatrist	Uncertain
Case Manager	Uncertain
Primary Care Physician	NOP2399
General Information	
Patient's County of Residence	Tompkins
Type of Residence FALSE	Homeless 1668 Trumansburg Rd
Religion	Unknown/Unable to Obtain
Insurance Christian Church - Disciples of Christ - in record 8/25/2014	
Insurance	Medicaid
Income	
Employment	Unemployed DATABEAST INC / Secretary
SSD	Yes: Possibly
Family Hx Mental Health/Substance Abuse	
Hx Family Depression	Yes: MOTHERR "ATTEMPTED

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Assessments and Treatments - Continued

	SUICIDE
Current/History of Trauma	
Current Abuse Comment	Unsure
History of Abuse Comment	Unsure and did not elaborate due to agitated manner.
History of Violent/Aggressive Behavior	She denies.
PHYSICAL HEALTH/MEDICAL HISTORY	
Social Resources/External Support System	
Support Person	None
Patient's Identified Strengths/Assests/Potentials	
ID Strengths/Assests/Potentials Comment	Reports positive relationship with her therapist, Dr. Kevin Field, and although she will not sign ROI she does give verbal permission to speak with him.
Patient's Identified Problems/Liabilities	
Identified Problems/Liabilities Comment	Unclear what other providers working with this individual or what her living situation really is due the nature of her agitation and guardedness with staff.
Treatment Precautions	
Treatment Precautions	15 Minute Safety Checks
Housing Options	
Housing Options	Return to Previous Arrangement
Treatment Options	
Treatment Options	Return to Current Outpatient Provider
Group Recommendations	
Group Recommendations	Community Exercise Cognitive Behavior Focus Dialectical Behavior Education Evening
Discharge Plan/Anticipated Needs/Referrals	
Discharge Comments	Discharge planning to include providing group and individual programming as well as milieu and recreational therapies. Patient will be encouraged to mee with social worker and doctor towards meeting treatment goals and discharge planning options. She refuses to sign ROI's but gives verbal permission to speak to her therapist, Dr. Kevin Field. Her personality remains agitative, guarded,

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Assessments and Treatments - Continued

	accusatory and difficult to work with as she feels persecuted by being at the BSU when "I only came to the hospital for a psychiatrist interview and a warm place to spend the night". She has put in a court request for hearing as of 12/25 so SW will likely pursue this process as patient's unwillness to work with staff hinders our moving forward with a proper discharge plan. Patient will show readiness for discharge when she is observed and verbalizing improved mood, decrease in aggresive nature.

Edit Result 09/25/18 10:41 ALI0046 (Rec: 10/04/18 12:37 ALI0046 BSU-C20)
MHU: Adult- Psych Assess

Referral Source	
Police	
Referral Agency/Contact	.
Current Outpatient Providers	
Therapist/Counselor	none, never followed up with

Edit Result 09/25/18 10:41 ALI0046 (Rec: 10/09/18 16:38 ALI0046 BSU-C20)
MHU: Adult- Psych Assess

General Information	
Lives With/Family Composition	Patient will not share information with me about her housing or family situation. From what I gather she is currently living alone, she is married but not with her wife and has not been for years. It seems she likely sold her property and has been staying in hotels with the money she made.
Employment Status/Occupation	unemployed. Based on conversation she likely has SSDI for financial resource but she was not clear about this with SW. hx working at Cornell for 8 years and as a computer programmer for 30+ years.
Cultural Needs	Patient identifies as a transgender woman and has been accomodated with a single room.
Highest Level of Education Completed	Bachelor's Degree
Education Comment	Bachelors degree in Economics

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Assessments and Treatments - Continued

Legal System Involved	Yes
Legal Status	Arrest
Legal Comment	Patient was involved with an altercation with police prior to admission. It was reportedly that she attacked an officer and they responded with force. Possible charges
Previous Inpatient Treatment	
Mental Health	
Facility Name	CMC for almost 2 months in January 2017
Reason for Admission	Psychosis
Current/History of Trauma	
Self Injury/Previous Suicide Attempts	unclear
History of Violent/Aggressive Behavior	Per police report patient attacked a police officer prior to admission
Patient's Identified Strengths/Assests/Potentials	
ID Strengths/Assests/Potentials Comment	Patient is agitated and asked writer to leave room
Patient's Identified Problems/Liabilities	
Identified Problems/Liabilities Comment	Patient is agitated, angry with Dr. Ehmke and the police

Edit Result 09/25/18 10:41 ALI0046 (Rec: 10/09/18 16:38 ALI0046 BSU-C20)
MHU: Adult- Psych Assess

Identified Problems	
Noncompliance	
Identified Problems Comment	with outpatient and medication

MHU:Adult- Rec Therapy Assessment Start: 09/24/18 18:54
Freq: Status: Discharge
Protocol:
Document 09/25/18 12:57 KYL0051 (Rec: 09/25/18 13:06 KYL0051 BSU-C08)
MHU: Adult Recreation Therapy 01- Client Interview

General Information	
Reason for Visit	UNSPECIFIED PSYCHOSIS
Living Situation	Patient reports staying at various hotels prior to her admission. Patient reports recently selling her home in Jacksonville to a neighbor.
Transportation	Public/Bus Own Car Walk
Vocation	Unemployed See Comment
Vocation Comments	Patient sold her home to a neighbor and is using that money hx working at Cornell for 8 years and as a computer programmer for 30+ years.
Leisure Profile	

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Assessments and Treatments - Continued

Constructive	Patient enjoys playing the guitar, listening to music, singing, going to social/music events in the community and going to concerts, hx being in a band
Destructive	denies hx nicotine use
Engagement	Infrequent to no involvement in leisure activities prior to admission for "months"
Perceived Barriers to Leisure	See Comment
Perceived Barriers to Leisure Comment	"lyme disease" "unable to ambulate" "on meds that didn't help"
Strengths	
Strengths	smart
Goals/Areas for Improvement	
Goals/Areas for Improvement	Patient unable to identify treatment goals at this time stating she doesn't believe she needs to be on the unit but stated she wanted to continue to have follow up conversations with writer.

MHU: Adult Recreation Therapy 02- Staff Assessment

Cognitive Assessment	
Ability to Follow Directions	Good
Number of Cues Needed	few
Willingness to Follow Directions	Fair
Group Participation	has yet to attend
Thoughts/Distortions Assessment	
Automatic Thoughts and Distortions	Blaming
Thoughts/Distortions Assessment Comment	blaming doctor numerous times throughout conversation
Emotional Assessment	
Mood	Irritable
Affect	Restricted
Emotional Assessment Comment	slight irritable edge
Social Assessment	
Social	Self-Initiative Responsive
Physical Assessment	
Gross Motor Skills	Fair
Fine Motor Skills	Good
Physical Assessment Comment	stated she can only take a few steps at a time, has difficulty ambulating
Summary of Assessment and Clinical Impression	
Summary of Assessment and Clinical Impression	Patient was open to meeting with writer for an informal conversation about her leisure lifestyle. Patient was

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Assessments and Treatments - Continued

	pleasant towards writer and forthcoming with information, although she presented with disorganized thought content at times.

Edit Result 09/25/18 12:57 KYL0051 (Rec: 09/25/18 14:19 KYL0051 BSU-C08)
MHU: Adult Recreation Therapy 01- Client Interview
General Information

Education	College
Education Comments	Bachelors degree in Economics

MHU: Adult Recreation Therapy 02- Staff Assessment
Summary of Assessment and Clinical Impression

Summary of Assessment and Clinical Impression	Patient was open to meeting with writer about her leisure lifestyle. Patient was pleasant towards writer and forthcoming with information, although she presented with disorganized thought content at times and would often blame the doctor for admission.

Goals

Patient will engage in leisure activities while on the unit	
Goal Status	New
Patient will communicate her needs and feelings appropriately to staff throughout admission	
Goal Status	New
Patient will demonstrate an imrovement in mood symptoms prior to discharge	
Goal Status	New

Interventions

Provide and encourage involvement in leisure activities	
Intervention Status	New
Provide opportunities for patient to express herself	
Intervention Status	New
Meet with patient regularly to maintain rapport	
Intervention Status	New

Edit Result 09/25/18 12:57 KYL0051 (Rec: 09/25/18 14:28 KYL0051 BSU-C08)
MHU: Adult Recreation Therapy 01- Client Interview
General Information

Reason for Visit Additional Information	Per chart - Per MHE in ED: "PT BIBA 9.41 FROM SUNOCO STATION DOWNTOWN AFTER PT CALLED 911 REPORTING ALTERCATION W/ ANOTHER PERSON AT GAS STATION WHICH LED PT TO FEEL UNSAFE. PT REQUESTED TRANS TO ER FOR MHE. PT CALM/COOPERATIVE IN ER UNTIL AWOKEN FOR EVAL, AT WHICH TIME PT BECAME VERY AGITATED, YELLING AT STAFF, ACCUSING ER STAFF OF WAKING HIM TO ABUSE HIM. PT WAS DE-ESCALATED AND CALMED JUST

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Assessments and Treatments - Continued

ENOUGH TO CONDUCT EVAL INTERVIEW. PT HYPERVERBAL, DISORGANIZED AND TANGENTIAL PERSEVERATING ON BEING "KICKED OUT" OF MOTEL DUE TO BEING LABELED MENTALLY ILL. PT RELATES THAT HE ATTEMPTED TO GET A BED AT THE FRIENDSHIP CENTER, BUT THEY WOULDN'T ALLOW HIM IN. PT DENIES SI, HI ,SIB OR ANY HX OF THESE. PT MAKING DELUSIONAL STATEMENTS ABOUT BEING "AN OFFICER OF THE FEDERAL GOVM'T" AND "BAD GUYS THAT ARE HACKING MY SOFTWARE ARE TRYING TO KILL ME". PT REMAINED HYPERVERBAL AND AGITATED THROUGHOUT EVAL. PT DENIED ANY CURRENT OUTPT MH TRTMT, OTHER THAN SESSIONS W/ DR KEVIN FIELDS - LAST ONE BEING APPROX 2MOS AGO. PT ALSO DENIES ANY CURRENT HOME MEDS. STATES ONLY CURRENT PROVIDER IS PCP - DR BREIMEN. PT VASCILLATES BTWN REQUESTING ADMIT AND STATING DESIRE TO BE D/C'd. "

MHU:Adult- Rec Therapy Progress Note Start: 09/24/18 18:54
Freq: Status: Discharge
Protocol:

Document 10/02/18 13:00 KYL0051 (Rec: 10/02/18 13:01 KYL0051 BSU-C08)
MHU: Adult Recreation Therapy Progress Note
Goals
Patient will engage in leisure activities while on the unit
Goal Status In Progress
Patient will communicate her needs and feelings appropriately to staff throughout admission
Goal Status In Progress
Patient will demonstrate an imrovement in mood symptoms prior to discharge
Goal Status In Progress
Interventions
Provide and encourage involvement in leisure activities
Intervention Status In Progress
Provide opportunities for patient to express herself
Intervention Status In Progress
Meet with patient regularly to maintain rapport
Intervention Status In Progress

Edit Result 10/02/18 13:00 KYL0051 (Rec: 10/02/18 14:16 KYL0051 BSU-C08)
MHU: Adult Recreation Therapy Progress Note
Goals
Patient will engage in leisure activities while on the unit
Goals Patient has refused to attend

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Assessments and Treatments - Continued

	recreation group which is offered daily. Is open to listening to music in her room which she now has an order for.
Patient will communicate her needs and feelings appropriately to staff throughout admission	
Goals	Patient continues to be dismissive of staff and presents with an irritable affect when communicating her needs.
Patient will demonstrate an imrovement in mood symptoms prior to discharge	
Goals	Patient has no significant improvement in mood symptoms - has court scheduled for treatment over objection.
Interventions	
Provide and encourage involvement in leisure activities	
Intervention Comments	Will continue to provide encouragement to engage in leisure activities
Provide opportunities for patient to express herself	
Intervention Comments	Will continue to provide opportunities for patient to express herself
Meet with patient regularly to maintain rapport	
Intervention Comments	Will continue to meet with patient to maintain rapport

Document 10/09/18 13:34 KYL0051 (Rec: 10/09/18 13:35 KYL0051 BSU-C08)
MHU: Adult Recreation Therapy Progress Note

Goals	
Patient will engage in leisure activities while on the unit	
Goal Status	In Progress
Goals	Patient has not been engaging in recreational activities that are being offered daily
Patient will communicate her needs and feelings appropriately to staff throughout admission	
Goal Status	In Progress
Goals	Patient is communicating her needs and feelings more appropriately with staff
Patient will demonstrate an imrovement in mood symptoms prior to discharge	
Goal Status	In Progress
Goals	Patient has had an improvement in mood symptoms - is attending more groups throughout the day and is socially interactive with staff and peers.
Interventions	
Provide and encourage involvement in leisure activities	

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Assessments and Treatments - Continued

Intervention Status	In Progress
Intervention Comments	Will continue to provide encouragement to engage in leisure activities
Provide opportunities for patient to express herself	
Intervention Status	In Progress
Intervention Comments	Will continue to provide opportunities for patient to express herself
Meet with patient regularly to maintain rapport	
Intervention Status	In Progress
Intervention Comments	Will continue to meet with patient to maintain rapport

MHU:Attendance- Discharge Planning Group Start: 09/24/18 18:54
Freq: Status: Discharge
Protocol:
Document 09/27/18 16:24 CAM0005 (Rec: 09/27/18 16:24 CAM0005 BSU-C21)
MHU: Attendance-Discharge Planning Group
Discharge Planning Group Attendance

Discharge Planning Group Attendance	No

Edit Result 09/27/18 16:24 CAM0005 (Rec: 10/11/18 16:28 CAM0005 BSU-C21)
MHU: Attendance-Discharge Planning Group
Discharge Planning Group Attendance

Discharge Planning Group Attendance	Yes
Discharge Planning Group Attendance Comment	Discussed red & green flags. Developed safety plan w/ red and green flags.

MHU:Attendance- Pet Therapy Start: 09/24/18 18:54
Freq: .ONCE Status: Discharge
Protocol:
Document 10/09/18 15:13 VOD0001 (Rec: 10/09/18 15:13 VOD0001 BSU-C31)
MHU: Attendance-Pet Therapy
Pet Therapy Attendance Assessment

Pet Therapy Attendance	No

Nutrition: Assessment Start: 09/24/18 18:54
Freq: Status: Discharge
Protocol: C.NUTSUPP
Document 09/30/18 16:50 ALE0011 (Rec: 09/30/18 16:50 ALE0011 DIET-C11)
Nutrition Only Assessment

Diagnosis/History	
Current Medical Diagnosis	unspecified psychosis
Pertinent Past Medical/Surgical History	male-to-female transgender; HTN
Diet	
Diet Order	limited caffeine
BMI	
Height	5 ft 6 in
Last Documented Weight	166 lb
Body Mass Index (BMI)	26.8
Body Mass Index (BMI) Classification	Overweight
Query Text:Underweight: <18.5 Normal Weight: 18.5-24.9 Overweight: 25.0-29.9	

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Assessments and Treatments - Continued

Obesity (Level I): 30-34.9 Obesity (Level II): 35-39.9 Morbid Obesity (Level III): 40.0 or greater	
Skin	
Recent Braden Score per Nursing Assessment	No Risk
Nutrition: Interventions	
Follow Up	
Proposed Rescreen Date	10/01/18
Visit Reason Details	Initial
Nutrition Support Assessment	
Nutrition Support Composition @ Target Rate/24 Hours	
Document 10/01/18 12:57 ALE0011 (Rec: 10/01/18 13:06 ALE0011 DIET-C11)	
Nutrition Only Assessment	
Diagnosis/History	
Current Medical Diagnosis	unspecified psychosis
Pertinent Past Medical/Surgical History	male-to-female transgender; HTN
Diet	
Diet Order	limited caffeine
BMI	
Height	5 ft 6 in
Last Documented Weight	166 lb
Body Mass Index (BMI)	26.8
Body Mass Index (BMI) Classification Query Text:Underweight: <18.5 Normal Weight: 18.5-24.9 Overweight: 25.0-29.9 Obesity (Level I): 30-34.9 Obesity (Level II): 35-39.9 Morbid Obesity (Level III): 40.0 or greater	Overweight
GI Assessment	
Oral Diet Intake Amount	appears to be accepting meals on unit
Meeting Needs	Adequate
Labs/Medications/Supplements/Herbals	
Pertinent Labs/Fingersticks Reviewed	Yes
Pertinent Labs/Fingersticks Comment	no BMP A1c WNL: 5.4% lipids well controlled
Pertinent Medications	Invega
Skin	
Skin Breakdown	No
Recent Braden Score per Nursing Assessment	No Risk/23
Nutrition: Other Pertinent Information	
Assessment Comments	
Assessment Comment	Pt with chronic psychotic and personality disorders, admitted after an altercation with police in the community.

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

	Pt still irritable with poor insight per MD notes, and TOO is being pursued. Reviewed H&P , available labs, meds, and notes. No acute nutrition concerns identified; pt appears to be accepting meals on the unit. Wt stable over past year: 161-175#. No intervention currently indicated; will follow per protocol.
Identified Nutrition Diagnosis/Interventions	
Does Patient Have a Nutrition Diagnosis at This Time	None Identified
Does Patient Have Anticipated Nutrition Interventions	None Identified
Nutrition: Diagnosis	
Nutrition Prescription	
Nutrition Prescription	limited caffeine
Nutrition: Interventions	
Goal	
Intervention Goals	Intake will be adequate to maintain stable wt without unintended wt loss
Follow Up	
Proposed Rescreen Date	11/01/18
Visit Reason Details	Re-Screen
Nutrition Support Assessment	
Nutrition Support Composition @ Target Rate/24 Hours	

Observation: q15 minutes Start: 09/27/18 03:24
Freq: QSHIFT Status: Complete
Protocol:

Document	09/27/18 08:55	JON0059	(Rec: 09/27/18 08:55	JON0059	BSU-C12)	
Document	09/27/18 21:28	KEL0019	(Rec: 09/27/18 21:28	KEL0019	BSU-C02)	
Document	09/28/18 08:10	JON0059	(Rec: 09/28/18 08:10	JON0059	BSU-C27)	
Document	09/28/18 20:08	BAR0006	(Rec: 09/28/18 20:08	BAR0006	BSU-M01)	
Document	09/29/18 08:39	JON0059	(Rec: 09/29/18 08:39	JON0059	BSU-M01)	
Document	09/29/18 19:43	ROB0100	(Rec: 09/29/18 19:44	ROB0100	BSU-C01)	
Document	09/30/18 00:54	BRA0067	(Rec: 09/30/18 00:54	BRA0067	BSU-C09)	
Document	09/30/18 08:12	JON0059	(Rec: 09/30/18 08:12	JON0059	BSU-C12)	
Document	09/30/18 19:38	BAR0006	(Rec: 09/30/18 19:39	BAR0006	BSU-C30)	
Document	09/30/18 23:57	BRA0067	(Rec: 09/30/18 23:57	BRA0067	BSU-C09)	
Document	10/01/18 08:14	SHA0063	(Rec: 10/01/18 08:16	SHA0063	BSU-C27)	
Document	10/01/18 20:00	KEL0019	(Rec: 10/01/18 21:20	KEL0019	BSU-C02)	
Document	10/02/18 08:00	SEL0001	(Rec: 10/02/18 08:35	SEL0001	BSU-M01)	
Document	10/02/18 20:00	MIC0258	(Rec: 10/02/18 22:10	MIC0258	BSU-L07)	
Document	10/02/18 22:10	MIC0258	(Rec: 10/02/18 22:10	MIC0258	BSU-L07)	
Document	10/03/18 08:41	SHA0063	(Rec: 10/03/18 08:41	SHA0063	BSU-C12)	
Document	10/03/18 20:00	KEL0019	(Rec: 10/03/18 20:10	KEL0019	BSU-C02)	
Document	10/04/18 00:41	BRA0067	(Rec: 10/04/18 00:41	BRA0067	BSU-C09)	
Document	10/04/18 07:39	JON0059	(Rec: 10/04/18 07:39	JON0059	BSU-C27)	
Document	10/04/18 20:00	MAT0034	(Rec: 10/04/18 22:20	MAT0034	BSU-M01)	

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Document	10/05/18 04:41	BRA0067	(Rec: 10/05/18 04:41	BRA0067	BSU-C09)
Document	10/05/18 07:57	JON0059	(Rec: 10/05/18 07:57	JON0059	BSU-C02)
Document	10/05/18 20:00	KEL0019	(Rec: 10/05/18 21:21	KEL0019	BSU-C02)
Document	10/06/18 08:00	LYL0001	(Rec: 10/06/18 08:45	LYL0001	BSU-M01)
Document	10/07/18 08:00	LYL0001	(Rec: 10/07/18 08:32	LYL0001	BSU-C27)
Document	10/08/18 08:00	LYN0010	(Rec: 10/08/18 08:23	LYN0010	BSU-M01)
Document	10/08/18 20:00	ERI0025	(Rec: 10/08/18 20:51	ERI0025	BSU-C27)
Document	10/09/18 08:00	NAT0065	(Rec: 10/09/18 08:06	NAT0065	BSU-M01)
Document	10/09/18 20:03	KEL0019	(Rec: 10/09/18 20:03	KEL0019	BSU-C12)
Document	10/10/18 03:43	BRA0067	(Rec: 10/10/18 03:44	BRA0067	BSU-C03)
Document	10/10/18 08:00	LYL0001	(Rec: 10/10/18 08:18	LYL0001	BSU-M01)
Document	10/10/18 22:18	KEL0019	(Rec: 10/10/18 22:19	KEL0019	BSU-C12)
Document	10/11/18 08:20	JON0059	(Rec: 10/11/18 08:20	JON0059	BSU-C26)

Observation: q30 minutes Start: 10/11/18 11:00
Freq: QSHIFT Status: Discharge
Protocol:

Document	10/11/18 20:00	KEL0019	(Rec: 10/11/18 20:05	KEL0019	BSU-C02)
Document	10/12/18 08:00	LYL0001	(Rec: 10/12/18 08:00	LYL0001	BSU-C26)
Document	10/12/18 20:00	ROB0100	(Rec: 10/12/18 20:10	ROB0100	BSU-C02)
Document	10/13/18 07:37	JON0059	(Rec: 10/13/18 07:37	JON0059	BSU-C02)
Document	10/13/18 19:05	ROB0100	(Rec: 10/13/18 19:05	ROB0100	BSU-C02)
Document	10/13/18 19:47	ROB0100	(Rec: 10/13/18 19:47	ROB0100	BSU-C02)
Document	10/13/18 23:46	BRA0067	(Rec: 10/13/18 23:47	BRA0067	BSU-M02)
Document	10/14/18 07:49	JON0059	(Rec: 10/14/18 07:49	JON0059	BSU-C02)
Document	10/14/18 20:00	ROB0100	(Rec: 10/14/18 21:48	ROB0100	BSU-C02)
Document	10/15/18 07:47	JON0059	(Rec: 10/15/18 07:47	JON0059	BSU-C12)

Pain Assessment/Reassessment Start: 09/24/18 18:54
Freq: QSHIFT Status: Discharge
Protocol: C.PNSCALE

Document 09/24/18 20:00 ROW0001 (Rec: 09/24/18 22:38 ROW0001 BSU-C02)
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

Interventions
Please document those interventions you are currently providing.

Interventions Provided for Current Pain Level	None
Follow Up Evaluation Needed	No
Time Follow Up Due	-

Document 09/24/18 23:51 LYN0010 (Rec: 09/24/18 23:51 LYN0010 BSU-C27)
Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE

Patient Currently Having Pain	Unable to Determine
Pain Assessment Based Upon	Unable to Obtain-Appears to be Sleeping

Interventions
Please document those interventions you are currently providing.

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Interventions Provided for Current Pain Level	None
Follow Up Evaluation Needed	No
Time Follow Up Due	-

Document 09/25/18 12:22 ANN0115 (Rec: 09/25/18 12:23 ANN0115 BSU-M01)
Pain Assessment/Reassessment

Pain Assessment
Protocol: C.PNSCALE

Patient Currently Having Pain	Unable to Determine
Pain Assessment Based Upon	Unable to Obtain-Appears to be Sleeping

Interventions
Please document those interventions you are currently providing.

Follow Up Evaluation Needed	No
Time Follow Up Due	-

Document 09/25/18 20:00 ROB0100 (Rec: 09/25/18 21:02 ROB0100 BSU-C27)
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

Interventions
Please document those interventions you are currently providing.

Interventions Provided for Current Pain Level	See Comment
Follow Up Evaluation Needed	No
Time Follow Up Due	`

Document 09/25/18 22:01 LAU0148 (Rec: 09/25/18 22:01 LAU0148 BSU-M01)
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	-

Document 09/26/18 10:19 ANN0115 (Rec: 09/26/18 10:19 ANN0115 BSU-M01)
Pain Assessment/Reassessment

Pain Assessment
Protocol: C.PNSCALE

Patient Currently Having Pain	Unable to Determine
Pain Assessment Based Upon	See Comment
Pain Based Upon Comments	Pt refused to answer

Interventions
Please document those interventions you are currently providing.

Follow Up Evaluation Needed	No
Time Follow Up Due	-

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Document 09/26/18 20:34 MIC0258 (Rec: 09/26/18 20:35 MIC0258 BSU-M01)
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
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed — No
Time Follow Up Due — -

Document 09/26/18 23:59 GIT0002 (Rec: 09/27/18 00:05 GIT0002 BSU-C09)
Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE
Patient Currently Having Pain — Unable to Determine
Pain Assessment Based Upon — Unable to Obtain-Appears to be Sleeping
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed — No
Time Follow Up Due — -

Document 09/27/18 08:00 LYL0001 (Rec: 09/27/18 13:35 LYL0001 BSU-M01)
Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE
Patient Currently Having Pain — Unable to Determine
Pain Assessment Based Upon — Nursing Observation; Unable to Obtain-Appears to be Sleeping
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed — No
Time Follow Up Due — -

Document 09/27/18 21:28 KEL0019 (Rec: 09/27/18 21:28 KEL0019 BSU-C02)
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 — -

Document 09/28/18 00:11 LYN0010 (Rec: 09/28/18 00:11 LYN0010 BSU-C02)
Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE
Patient Currently Having Pain — Unable to Determine
Pain Assessment Based Upon — Unable to Obtain-Appears to be Sleeping

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Interventions
Please document those interventions you are currently providing.
Interventions Provided for Current Pain Level: None
Follow Up Evaluation Needed: No
Time Follow Up Due: -

Document 09/28/18 08:10 JON0059 (Rec: 09/28/18 08:10 JON0059 BSU-C27)
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: -

Document 09/28/18 20:31 KEL0019 (Rec: 09/28/18 20:31 KEL0019 BSU-C02)
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
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed: No
Time Follow Up Due: -

Document 09/29/18 00:21 LYN0010 (Rec: 09/29/18 00:30 LYN0010 BSU-C02)
Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE
Patient Currently Having Pain: Unable to Determine
Pain Assessment Based Upon: Unable to Obtain-Appears to be Sleeping
Interventions
Please document those interventions you are currently providing.
Interventions Provided for Current Pain Level: None
Follow Up Evaluation Needed: No
Time Follow Up Due: -

Document 09/29/18 09:18 SHA0063 (Rec: 09/29/18 09:19 SHA0063 BSU-C27)
Pain Assessment/Reassessment
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
Interventions
Please document those interventions you are currently providing.

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Interventions Provided for Current Pain Level	None
Interventions Provided Comment	patient declines
Follow Up Evaluation Needed	No
Time Follow Up Due	-

Document 09/29/18 19:43 ROB0100 (Rec: 09/29/18 19:44 ROB0100 BSU-C01)
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	-

Document 09/30/18 00:54 BRA0067 (Rec: 09/30/18 00:54 BRA0067 BSU-C09)
Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE

Patient Currently Having Pain	No
Pain Assessment Based Upon	Nursing Observation Unable to Obtain-Appears to be Sleeping

Interventions
Please document those interventions you are currently providing.

Follow Up Evaluation Needed	No
Time Follow Up Due	-

Document 09/30/18 08:23 JON0059 (Rec: 09/30/18 08:23 JON0059 BSU-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.

Follow Up Evaluation Needed	No
Time Follow Up Due	-

Document 09/30/18 19:38 BAR0006 (Rec: 09/30/18 19:39 BAR0006 BSU-C30)
Pain Assessment/Reassessment
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

Interventions
Please document those interventions you are currently providing.

Interventions Provided for Current Pain Level	See Comment
Interventions Provided Comment	offered pain medication but pt declined
Follow Up Evaluation Needed	No

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Time Follow Up Due	-

Document 09/30/18 23:57 BRA0067 (Rec: 09/30/18 23:57 BRA0067 BSU-C09)
Pain Assessment/Reassessment

Pain Assessment	
Protocol: C.PNSCALE	
Patient Currently Having Pain	No
Pain Assessment Based Upon	Nursing Observation Unable to Obtain-Appears to be Sleeping
Interventions	
Please document those interventions you are currently providing.	
Follow Up Evaluation Needed	No
Time Follow Up Due	-

Document 10/01/18 08:14 SHA0063 (Rec: 10/01/18 08:16 SHA0063 BSU-C27)
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
Interventions	
Please document those interventions you are currently providing.	
Interventions Provided for Current Pain Level	None
Interventions Provided Comment	patient declines all interventions including tylenol- see n.n.
Follow Up Evaluation Needed	No
Time Follow Up Due	-

Document 10/01/18 20:00 KEL0019 (Rec: 10/01/18 21:20 KEL0019 BSU-C02)
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
Interventions	
Please document those interventions you are currently providing.	
Follow Up Evaluation Needed	No
Time Follow Up Due	-

Document 10/01/18 23:43 LYN0010 (Rec: 10/01/18 23:44 LYN0010 BSU-C02)
Pain Assessment/Reassessment

Pain Assessment	
Protocol: C.PNSCALE	
Patient Currently Having Pain	Unable to Determine
Pain Assessment Based Upon	Unable to Obtain-Appears to be Sleeping
Interventions	
Please document those interventions you are currently providing.	

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Interventions Provided for Current Pain Level	None
Follow Up Evaluation Needed	No
Time Follow Up Due	-

Document 10/02/18 08:00 SEL0001 (Rec: 10/02/18 08:35 SEL0001 BSU-M01)
Pain Assessment/Reassessment

Pain Assessment
Protocol: C.PNSCALE

Patient Currently Having Pain	Unable to Determine
Pain Assessment Based Upon	See Comment
Pain Based Upon Comments	Pt declines to report pain level

Interventions
Please document those interventions you are currently providing.

Follow Up Evaluation Needed	No
Time Follow Up Due	-

Document 10/02/18 22:09 MIC0258 (Rec: 10/02/18 22:10 MIC0258 BSU-L07)
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

Interventions
Please document those interventions you are currently providing.

Follow Up Evaluation Needed	No
Time Follow Up Due	-

Document 10/03/18 08:36 ANN0115 (Rec: 10/03/18 08:36 ANN0115 BSU-M01)
Pain Assessment/Reassessment

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

Interventions
Please document those interventions you are currently providing.

Follow Up Evaluation Needed	No
Time Follow Up Due	-

Document 10/03/18 20:00 KEL0019 (Rec: 10/03/18 20:10 KEL0019 BSU-C02)
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	-

Document 10/04/18 00:41 BRA0067 (Rec: 10/04/18 00:41 BRA0067 BSU-C09)

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE
Patient Currently Having Pain — No
Pain Assessment Based Upon — Nursing Observation
Unable to Obtain-Appears to be Sleeping
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed — No
Time Follow Up Due — -

Document 10/04/18 08:00 JON0059 (Rec: 10/04/18 08:56 JON0059 BSU-C27)
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 — -

Document 10/04/18 20:00 MAT0034 (Rec: 10/04/18 22:19 MAT0034 BSU-M01)
Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE
Patient Currently Having Pain — Yes
Pain Assessment Based Upon — Patient Report
Pain Intensity — 10
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 — No
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed — No
Time Follow Up Due — -

Document 10/04/18 23:53 GIT0002 (Rec: 10/04/18 23:54 GIT0002 BSU-C27)
Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE
Patient Currently Having Pain — Unable to Determine
Pain Assessment Based Upon — Unable to Obtain-Appears to be Sleeping
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed — No
Time Follow Up Due — -

Document 10/05/18 08:00 SEL0001 (Rec: 10/05/18 08:02 SEL0001 BSU-M01)
Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Patient Currently Having Pain	Yes
Pain Assessment Based Upon	Patient Report
Pain Intensity	3
Query Text:0-10	
Pain Scale Used	0-10 Numeric

Interventions
Please document those interventions you are currently providing.

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

Document 10/05/18 20:00 KEL0019 (Rec: 10/05/18 21:21 KEL0019 BSU-C02)
Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE

Patient Currently Having Pain	Yes
Pain Assessment Based Upon	Patient Report
Pain Intensity	5
Query Text:0-10	
Pain Scale Used	0-10 Numeric

Interventions
Please document those interventions you are currently providing.

Follow Up Evaluation Needed	No
Time Follow Up Due	-

Document 10/06/18 02:25 LYN0010 (Rec: 10/06/18 02:25 LYN0010 BSU-C02)
Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE

Patient Currently Having Pain	Unable to Determine
Pain Assessment Based Upon	Unable to Obtain-Appears to be Sleeping

Interventions
Please document those interventions you are currently providing.

Interventions Provided for Current Pain	None
Level	
Follow Up Evaluation Needed	No
Time Follow Up Due	-

Document 10/06/18 06:00 LYN0010 (Rec: 10/07/18 01:18 LYN0010 BSU-C02)
Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE

Patient Currently Having Pain	Unable to Determine
Pain Assessment Based Upon	Unable to Obtain-Appears to be Sleeping

Interventions
Please document those interventions you are currently providing.

Interventions Provided for Current Pain	None
Level	
Follow Up Evaluation Needed	No
Time Follow Up Due	-

Document 10/06/18 08:00 LYL0001 (Rec: 10/06/18 08:45 LYL0001 BSU-M01)
Pain Assessment/Reassessment
Pain Assessment

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

```
    Protocol:  C.PNSCALE
       Patient Currently Having Pain            Yes
       Pain Assessment Based Upon               Patient Report
                                                Nursing Observation
       Pain Based Upon Comments                 "Some pain", would not
                                                elaborate further
       Pain Intensity                           2
        Query Text:0-10
       Pain Scale Used                          PAINAD
    Interventions
     Please document those interventions you are currently providing.
       Follow Up Evaluation Needed              No
       Time Follow Up Due                       -
Document     10/07/18 08:00  LYL0001  (Rec: 10/07/18 09:00  LYL0001  BSU-C27)
Pain Assessment/Reassessment
    Pain Assessment
    Protocol:  C.PNSCALE
       Patient Currently Having Pain            Yes
       Pain Assessment Based Upon               Patient Report
       Pain Intensity                           2
        Query Text:0-10
       Pain Scale Used                          0-10 Numeric
    Interventions
     Please document those interventions you are currently providing.
       Follow Up Evaluation Needed              No
       Time Follow Up Due                       -
Document     10/07/18 20:59  MIC0258  (Rec: 10/07/18 20:59  MIC0258  BSU-M01)
Pain Assessment/Reassessment
    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
    Interventions
     Please document those interventions you are currently providing.
       Follow Up Evaluation Needed              No
       Time Follow Up Due                       -
Document     10/08/18 00:00  LYN0010  (Rec: 10/08/18 00:01  LYN0010  BSU-C02)
Pain Assessment/Reassessment
    Pain Assessment
    Protocol:  C.PNSCALE
       Patient Currently Having Pain            Unable to Determine
       Pain Assessment Based Upon               Unable to Obtain-Appears to be
                                                Sleeping
    Interventions
     Please document those interventions you are currently providing.
       Interventions Provided for Current Pain  None
        Level
       Follow Up Evaluation Needed              No
       Time Follow Up Due                       -
Document     10/08/18 08:00  LYN0010  (Rec: 10/08/18 08:23  LYN0010  BSU-M01)
```

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE

Patient Currently Having Pain	Yes
Pain Assessment Based Upon	Patient Report
Pain Based Upon Comments	Left side
Pain Intensity	2
Query Text:0-10	
Pain Scale Used	0-10 Numeric

Interventions
Please document those interventions you are currently providing.

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

Document 10/08/18 20:53 MIC0258 (Rec: 10/08/18 20:53 MIC0258 BSU-M01)
Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE

Patient Currently Having Pain	Unable to Determine
Pain Assessment Based Upon	Unable to Obtain-Appears to be Sleeping

Interventions
Please document those interventions you are currently providing.

Follow Up Evaluation Needed	No
Time Follow Up Due	-

Document 10/09/18 08:00 NAT0065 (Rec: 10/09/18 08:06 NAT0065 BSU-M01)
Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE

Patient Currently Having Pain	Unable to Determine
Pain Assessment Based Upon	See Comment
Pain Based Upon Comments	Pt has sustained recent injuries, but refuses to comment on her pain level
Pain Scale Used	Adult Non Verbal
Stated Pain Consistent with Observed Level of Pain	N/A

Interventions
Please document those interventions you are currently providing.

Follow Up Evaluation Needed	No
Time Follow Up Due	-

Document 10/09/18 20:03 KEL0019 (Rec: 10/09/18 20:03 KEL0019 BSU-C12)
Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE

Patient Currently Having Pain	Yes
Pain Assessment Based Upon	Patient Report
Pain Intensity	5
Query Text:0-10	
Pain Scale Used	0-10 Numeric

Interventions
Please document those interventions you are currently providing.

Continued on Page 240

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Follow Up Evaluation Needed	No
Time Follow Up Due	-

Document 10/10/18 03:43 BRA0067 (Rec: 10/10/18 03:44 BRA0067 BSU-C03)
Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE

Patient Currently Having Pain	No
Pain Assessment Based Upon	Nursing Observation Unable to Obtain-Appears to be Sleeping

Interventions
Please document those interventions you are currently providing.

Follow Up Evaluation Needed	No
Time Follow Up Due	-

Document 10/10/18 08:00 LYL0001 (Rec: 10/10/18 08:32 LYL0001 BSU-M01)
Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE

Patient Currently Having Pain	Yes
Pain Assessment Based Upon	Nursing Observation
Pain Intensity	2
Query Text:0-10	
Pain Scale Used	0-10 Numeric

Interventions
Please document those interventions you are currently providing.

Interventions Provided for Current Pain Level	Positioning
Interventions Provided Comment	Offed PO tylenol, patient declined
Follow Up Evaluation Needed	No
Time Follow Up Due	-

Document 10/10/18 22:18 KEL0019 (Rec: 10/10/18 22:19 KEL0019 BSU-C12)
Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE

Patient Currently Having Pain	Yes
Pain Assessment Based Upon	Patient Report
Pain Intensity	5
Query Text:0-10	
Pain Scale Used	0-10 Numeric

Interventions
Please document those interventions you are currently providing.

Follow Up Evaluation Needed	No
Time Follow Up Due	-

Document 10/11/18 00:02 GIT0002 (Rec: 10/11/18 00:03 GIT0002 BSU-C02)
Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE

Patient Currently Having Pain	No
Pain Assessment Based Upon	Nursing Observation Unable to Obtain-Appears to be Sleeping

Interventions

Continued on Page 241

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088571823

Assessments and Treatments - Continued

Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -
Document 10/11/18 08:22 JON0059 (Rec: 10/11/18 08:22 JON0059 BSU-C26)
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 -
Document 10/11/18 20:00 KEL0019 (Rec: 10/11/18 22:47 KEL0019 BSU-C02)
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 -
Document 10/12/18 00:43 LYN0010 (Rec: 10/12/18 00:43 LYN0010 BSU-C02)
Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE
Patient Currently Having Pain Unable to Determine
Pain Assessment Based Upon Unable to Obtain-Appears to be Sleeping
Interventions
Please document those interventions you are currently providing.
Interventions Provided for Current Pain Level None
Follow Up Evaluation Needed No
Time Follow Up Due -
Document 10/12/18 08:00 LYL0001 (Rec: 10/12/18 09:18 LYL0001 BSU-C12)
Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE
Patient Currently Having Pain Yes
Pain Assessment Based Upon Patient Report
Pain Based Upon Comments Pain 2-8/10 depending on movement
Pain Intensity 2
Query Text:0-10
Pain Scale Used 0-10 Numeric
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 -

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Document 10/12/18 20:00 ROB0100 (Rec: 10/12/18 20:10 ROB0100 BSU-C02)
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: -

Document 10/12/18 23:52 LYN0010 (Rec: 10/12/18 23:52 LYN0010 BSU-C02)
Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE
Patient Currently Having Pain: Unable to Determine
Pain Assessment Based Upon: Unable to Obtain-Appears to be Sleeping
Interventions
Please document those interventions you are currently providing.
Interventions Provided for Current Pain Level: None
Follow Up Evaluation Needed: No
Time Follow Up Due: -

Document 10/13/18 08:21 LAU0148 (Rec: 10/13/18 08:22 LAU0148 BSU-C12)
Pain Assessment/Reassessment
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: Adult Non Verbal
Pain Intensity Goal: 0
Query Text:0-10
Interventions
Please document those interventions you are currently providing.
Interventions Provided for Current Pain Level: None
Follow Up Evaluation Needed: No
Time Follow Up Due: -

Document 10/13/18 19:05 ROB0100 (Rec: 10/13/18 19:05 ROB0100 BSU-C02)
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: -

Document 10/13/18 19:47 ROB0100 (Rec: 10/13/18 19:47 ROB0100 BSU-C02)
Pain Assessment/Reassessment
Pain Assessment

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

```
    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
    Interventions
     Please document those interventions you are currently providing.
       Follow Up Evaluation Needed              No
       Time Follow Up Due                       -
Document     10/13/18 23:46  BRA0067  (Rec: 10/13/18 23:47  BRA0067  BSU-M02)
Pain Assessment/Reassessment
    Pain Assessment
    Protocol:  C.PNSCALE
       Patient Currently Having Pain            No
       Pain Assessment Based Upon               Nursing Observation
                                                Unable to Obtain-Appears to be
                                                Sleeping
    Interventions
     Please document those interventions you are currently providing.
       Follow Up Evaluation Needed              No
       Time Follow Up Due                       -
Document     10/14/18 09:53  LAU0148  (Rec: 10/14/18 09:54  LAU0148  BSU-M01)
Pain Assessment/Reassessment
    Pain Assessment
    Protocol:  C.PNSCALE
       Patient Currently Having Pain            Yes
       Pain Assessment Based Upon               Patient Report
       Pain Intensity                           5
        Query Text:0-10
       Pain Scale Used                          0-10 Numeric
    Pain Location/Description
      Generalized
       Pain Description Comments                Pt unspecific about location
                                                or pain number, number based
                                                on RN observation
    Interventions
     Please document those interventions you are currently providing.
      Interventions Provided for Current Pain   Relaxation
       Level
      Follow Up Evaluation Needed               No
      Time Follow Up Due                        -
Document     10/14/18 20:00  ROB0100  (Rec: 10/14/18 21:48  ROB0100  BSU-C02)
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                        -
Document     10/14/18 23:46  LYN0010  (Rec: 10/14/18 23:46  LYN0010  BSU-C02)
```

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Pain Assessment/Reassessment
Pain Assessment
Protocol: C.PNSCALE

Patient Currently Having Pain	Unable to Determine
Pain Assessment Based Upon	Unable to Obtain-Appears to be Sleeping

Interventions
Please document those interventions you are currently providing.

Interventions Provided for Current Pain Level	None
Follow Up Evaluation Needed	No
Time Follow Up Due	-

Patient Privileges Start: 10/11/18 11:00
Freq: QSHIFT Status: Discharge
Protocol:

Document	10/11/18 20:00	KEL0019	(Rec: 10/11/18 20:05	KEL0019	BSU-C02)		
Document	10/12/18 08:00	LYL0001	(Rec: 10/12/18 08:00	LYL0001	BSU-C26)		
Document	10/12/18 20:00	ROB0100	(Rec: 10/12/18 20:10	ROB0100	BSU-C02)		
Document	10/13/18 07:37	JON0059	(Rec: 10/13/18 07:37	JON0059	BSU-C02)		
Document	10/13/18 19:05	ROB0100	(Rec: 10/13/18 19:05	ROB0100	BSU-C02)		
Document	10/13/18 19:47	ROB0100	(Rec: 10/13/18 19:47	ROB0100	BSU-C02)		
Document	10/13/18 23:46	BRA0067	(Rec: 10/13/18 23:47	BRA0067	BSU-M02)		
Document	10/14/18 07:49	JON0059	(Rec: 10/14/18 07:49	JON0059	BSU-C02)		
Document	10/14/18 20:00	ROB0100	(Rec: 10/14/18 21:48	ROB0100	BSU-C02)		
Document	10/15/18 07:47	JON0059	(Rec: 10/15/18 07:47	JON0059	BSU-C12)		

Skin Risk:Mild Interventns In Progress Start: 10/03/18 11:36
Freq: Q2HRWA Status: Complete
Protocol: C.SKINBRAD

Document	10/03/18 12:00	NAT0065	(Rec: 10/03/18 12:03	NAT0065	BSU-C27)

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

Continued on Page 245

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088571823

Assessments and Treatments - Continued

minimize pressure
-Develop plan with pt/family and update
PRN

Document 10/03/18 14:00 KEL0019 (Rec: 10/03/18 18:09 KEL0019 BSU-C02)
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 10/03/18 16:00 KEL0019 (Rec: 10/03/18 18:09 KEL0019 BSU-C02)
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

Continued on Page 246

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

Document 10/03/18 18:00 KEL0019 (Rec: 10/03/18 18:09 KEL0019 BSU-C02)
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 10/03/18 20:00 KEL0019 (Rec: 10/03/18 20:10 KEL0019 BSU-C02)
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

Continued on Page 247

Assessments and Treatments - Continued

-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 10/03/18 22:00 KEL0019 (Rec: 10/03/18 22:16 KEL0019 BSU-C02)
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 10/04/18 07:39 JON0059 (Rec: 10/04/18 07:39 JON0059 BSU-C27)
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

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Assessments and Treatments - Continued

-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 10/04/18 10:00 LYL0001 (Rec: 10/04/18 11:13 LYL0001 BSU-M01)
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 10/04/18 11:58 LYL0001 (Rec: 10/04/18 11:58 LYL0001 BSU-M01)
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

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

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 10/04/18 14:00 LYL0001 (Rec: 10/04/18 14:03 LYL0001 BSU-M01)
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 10/04/18 16:00 KEL0019 (Rec: 10/04/18 16:45 KEL0019 BSU-C02)
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):

Continued on Page 250

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

-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 10/04/18 18:00 MAT0034 (Rec: 10/04/18 22:20 MAT0034 BSU-M01)
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 10/04/18 20:00 MAT0034 (Rec: 10/04/18 22:20 MAT0034 BSU-M01)
Mild Risk Skin Care Strategies
-
Protocol: C.SKINBRAD
Mild Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT STRATEGIES

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

** 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 10/04/18 22:00 MAT0034 (Rec: 10/04/18 22:20 MAT0034 BSU-M01)
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 10/05/18 07:57 JON0059 (Rec: 10/05/18 07:57 JON0059 BSU-C02)
Mild Risk Skin Care Strategies
-
Protocol: C.SKINBRAD

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

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

Document 10/05/18 10:00 JON0059 (Rec: 10/05/18 10:58 JON0059 BSU-C02)
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 10/05/18 12:00 SEL0001 (Rec: 10/05/18 12:25 SEL0001 BSU-M01)

Continued on Page 253

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088571823

Assessments and Treatments - Continued

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 10/05/18 14:00 JON0059 (Rec: 10/05/18 15:41 JON0059 BSU-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

Continued on Page 254

Assessments and Treatments - Continued

-Develop plan with pt/family and update
PRN

Document 10/05/18 16:00 SEL0001 (Rec: 10/05/18 18:43 SEL0001 BSU-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 10/05/18 18:21 KEL0019 (Rec: 10/05/18 18:21 KEL0019 BSU-C27)
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

Continued on Page 255

Assessments and Treatments - Continued

-Minimize wrinkles or lumps under pt
-Avoid multiple layering of linens to minimize pressure
-Develop plan with pt/family and update PRN

Document 10/05/18 20:00 KEL0019 (Rec: 10/05/18 21:21 KEL0019 BSU-C02)
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 10/05/18 21:21 KEL0019 (Rec: 10/05/18 21:21 KEL0019 BSU-C02)
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

Continued on Page 256

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

Document 10/06/18 08:00 LYL0001 (Rec: 10/06/18 08:45 LYL0001 BSU-M01)
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 10/06/18 10:00 LYL0001 (Rec: 10/06/18 11:01 LYL0001 BSU-M01)
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/

Continued on Page 257

Assessments and Treatments - Continued

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 10/06/18 12:00 LYL0001 (Rec: 10/06/18 13:38 LYL0001 BSU-M01)
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 10/06/18 14:00 LYL0001 (Rec: 10/06/18 14:45 LYL0001 BSU-M01)
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

Continued on Page 258

Assessments and Treatments - Continued

-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 10/07/18 08:00 LYL0001 (Rec: 10/07/18 08:32 LYL0001 BSU-C27)
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 10/07/18 10:00 NAT0065 (Rec: 10/07/18 10:19 NAT0065 BSU-M01)
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

Continued on Page 259

Assessments and Treatments - Continued

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 10/07/18 12:00 LYL0001 (Rec: 10/07/18 13:15 LYL0001 BSU-C27)
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 10/08/18 08:00 LYN0010 (Rec: 10/08/18 08:22 LYN0010 BSU-M01)
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

Continued on Page 260

Assessments and Treatments - Continued

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 10/08/18 09:54 LYL0001 (Rec: 10/08/18 09:54 LYL0001 BSU-M01)
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 10/08/18 12:00 LYL0001 (Rec: 10/08/18 14:58 LYL0001 BSU-M01)
Mild Risk Skin Care Strategies
-
Protocol: C.SKINBRAD
Mild Risk Skin Strategies Maintained Yes

Continued on Page 261

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

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

Document 10/08/18 14:00 LYL0001 (Rec: 10/08/18 14:58 LYL0001 BSU-M01)
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 10/08/18 16:00 KEL0019 (Rec: 10/08/18 17:41 KEL0019 BSU-C02)
Mild Risk Skin Care Strategies

Continued on Page 262

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088571823

Assessments and Treatments - Continued

-
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 10/08/18 20:00 ERI0025 (Rec: 10/08/18 20:51 ERI0025 BSU-C27)
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 263

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088571823

Assessments and Treatments - Continued

PRN
Document 10/08/18 22:00 KEL0019 (Rec: 10/08/18 22:10 KEL0019 BSU-M02)
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 10/09/18 08:00 NAT0065 (Rec: 10/09/18 08:06 NAT0065 BSU-M01)
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 264

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

-Avoid multiple layering of linens to minimize pressure
-Develop plan with pt/family and update PRN

Document 10/09/18 12:00 KEL0019 (Rec: 10/09/18 16:04 KEL0019 BSU-C27)
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 10/09/18 14:00 KEL0019 (Rec: 10/09/18 16:05 KEL0019 BSU-C27)
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 265

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

Document 10/09/18 16:00 KEL0019 (Rec: 10/09/18 16:05 KEL0019 BSU-C27)
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 10/09/18 18:00 KEL0019 (Rec: 10/09/18 18:25 KEL0019 BSU-C27)
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 266

Assessments and Treatments - Continued

-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 10/09/18 20:03 KEL0019 (Rec: 10/09/18 20:03 KEL0019 BSU-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 10/09/18 22:00 KEL0019 (Rec: 10/09/18 23:00 KEL0019 BSU-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/

Continued on Page 267

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088571823

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

Document 10/10/18 08:00 LYL0001 (Rec: 10/10/18 08:19 LYL0001 BSU-M01)
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 10/10/18 10:00 LYL0001 (Rec: 10/10/18 10:53 LYL0001 BSU-M01)
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

Continued on Page 268

Assessments and Treatments - Continued

-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 10/10/18 12:00 LYL0001 (Rec: 10/10/18 12:02 LYL0001 BSU-M01)
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 10/10/18 14:00 LYL0001 (Rec: 10/10/18 14:43 LYL0001 BSU-M01)
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

Continued on Page 269

Assessments and Treatments - Continued

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 10/10/18 16:00 KEL0019 (Rec: 10/10/18 18:15 KEL0019 BSU-C02)
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 10/10/18 18:00 KEL0019 (Rec: 10/10/18 18:15 KEL0019 BSU-C02)
Mild Risk Skin Care Strategies
-
Protocol: C.SKINBRAD
Mild Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT

Continued on Page 270

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088571823

Assessments and Treatments - Continued

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 10/10/18 22:18 KEL0019 (Rec: 10/10/18 22:19 KEL0019 BSU-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 10/11/18 08:20 JON0059 (Rec: 10/11/18 08:20 JON0059 BSU-C26)
Mild Risk Skin Care Strategies
-

Continued on Page 271

Assessments and Treatments - Continued

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 10/11/18 10:00 JON0059 (Rec: 10/11/18 10:02 JON0059 BSU-C26)
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

Continued on Page 272

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Document 10/11/18 11:28 JON0059 (Rec: 10/11/18 11:28 JON0059 BSU-C26)
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 10/11/18 14:00 JON0059 (Rec: 10/11/18 14:12 JON0059 BSU-C26)
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

Continued on Page 273

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
62 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00088571823

Assessments and Treatments - Continued

minimize pressure
-Develop plan with pt/family and update
PRN

Document 10/11/18 16:00 KEL0019 (Rec: 10/11/18 16:02 KEL0019 BSU-C02)
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 10/11/18 18:00 KEL0019 (Rec: 10/11/18 20:05 KEL0019 BSU-C02)
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

Continued on Page 274

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

Document 10/11/18 20:00 KEL0019 (Rec: 10/11/18 20:05 KEL0019 BSU-C02)
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
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-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 10/11/18 22:00 KEL0019 (Rec: 10/11/18 22:47 KEL0019 BSU-C02)
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

Continued on Page 275

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

-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 10/12/18 08:00 LYL0001 (Rec: 10/12/18 08:00 LYL0001 BSU-C26)
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 10/12/18 10:00 SEL0001 (Rec: 10/12/18 11:19 SEL0001 BSU-M01)
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

Continued on Page 276

Assessments and Treatments - Continued

-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 10/12/18 12:05 SHA0063 (Rec: 10/12/18 12:05 SHA0063 BSU-C27)
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 10/12/18 14:00 ROB0100 (Rec: 10/12/18 16:10 ROB0100 BSU-C02)
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

Continued on Page 277

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

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 10/12/18 16:00 ROB0100 (Rec: 10/12/18 16:11 ROB0100 BSU-C02)
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
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-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 10/12/18 18:00 ROB0100 (Rec: 10/12/18 20:10 ROB0100 BSU-C02)
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):

Continued on Page 278

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

-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 10/12/18 20:00 ROB0100 (Rec: 10/12/18 20:10 ROB0100 BSU-C02)
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 10/12/18 21:49 ROB0100 (Rec: 10/12/18 21:49 ROB0100 BSU-C02)
Mild Risk Skin Care Strategies
-
Protocol: C.SKINBRAD
Mild Risk Skin Strategies Maintained Yes
Query Text:SKIN RISK TREATMENT STRATEGIES

Continued on Page 279

Assessments and Treatments - Continued

** 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 10/13/18 07:37 JON0059 (Rec: 10/13/18 07:37 JON0059 BSU-C02)
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
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-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 10/13/18 11:35 ANN0115 (Rec: 10/13/18 11:35 ANN0115 BSU-M01)
Mild Risk Skin Care Strategies
-
Protocol: C.SKINBRAD

Continued on Page 280

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

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
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-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

Vital Signs - Manual Entry Start: 09/24/18 18:54
Freq: .PRN Status: Discharge
Protocol:

Document 09/26/18 09:03 BRI0130 (Rec: 09/26/18 09:03 BRI0130 BSU-C26)
Vital Signs: Manual Entry
Vital Signs
Only document vital signs here if NOT captured through vital signs monitor

Temperature	98.6 F
Temperature Source	Temporal Artery Scan
Pulse Rate	85
Respiratory Rate	16
Patient on Room Air	Yes
Vital Signs Comment	Patient refused blood pressure reading

Document 09/29/18 08:38 JON0059 (Rec: 09/29/18 08:39 JON0059 BSU-M01)
Vital Signs: Manual Entry
Vital Signs
Only document vital signs here if NOT captured through vital signs monitor

Temperature	99.1 F
Temperature Source	Temporal Artery Scan
Pulse Rate	80
Respiratory Rate	20
Patient on Room Air	Yes
O2 Sat by Pulse Oximetry	98
Vital Signs Comment	refused auto BP

Document 09/30/18 08:22 JON0059 (Rec: 09/30/18 08:23 JON0059 BSU-C12)
Vital Signs: Manual Entry
Vital Signs
Only document vital signs here if NOT captured through vital signs monitor

Continued on Page 281

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Temperature	98.5 F
Temperature Source	Temporal Artery Scan
Pulse Rate	88
Respiratory Rate	16
Patient on Room Air	Yes
O2 Sat by Pulse Oximetry	99

Document 10/06/18 08:58 LYL0001 (Rec: 10/06/18 08:59 LYL0001 BSU-M01)
Vital Signs: Manual Entry
Vital Signs
Only document vital signs here if NOT captured through vital signs monitor

Blood Pressure (mmHg)	142/76
Blood Pressure Source	Manual Cuff/Auscultation
Blood Pressure Mean	98

Document 10/10/18 08:04 SEL0001 (Rec: 10/10/18 08:04 SEL0001 BSU-C12)
Vital Signs: Manual Entry
Vital Signs
Only document vital signs here if NOT captured through vital signs monitor

Blood Pressure (mmHg)	122/88
Blood Pressure Source	Manual Cuff/Auscultation
Blood Pressure Mean	99

Document 10/12/18 08:51 SHA0063 (Rec: 10/12/18 08:52 SHA0063 BSU-C27)
Vital Signs: Manual Entry
Vital Signs
Only document vital signs here if NOT captured through vital signs monitor

Temperature	97.5 F
Temperature Source	Temporal Artery Scan
Pulse Rate	90
Respiratory Rate	14
Blood Pressure (mmHg)	135/82
Blood Pressure Source	Manual Cuff/Auscultation
Blood Pressure Mean	99
Patient on Room Air	Yes
O2 Sat by Pulse Oximetry	97

Vital Signs-Auto Capture (VS3) Start: 09/24/18 18:54
Text: Status: Discharge
Freq: DAILY@0600
Protocol: NEURO.TS

Document 09/28/18 08:44 JON0059 (Rec: 09/28/18 08:54 JON0059 BSU-C27)
Vital Signs-Automatic Capture
Respirations

Respiratory Rate	16

Document 09/29/18 09:36 JON0059 (Rec: 09/29/18 10:45 JON0059 BSU-C26)
Vital Signs-Automatic Capture
Respirations

Respiratory Rate	16

Document 09/30/18 08:22 JON0059 (Rec: 09/30/18 08:22 JON0059 BSU-C12)
Vital Signs-Automatic Capture
Respirations

Respiratory Rate	16

Document 10/01/18 07:46 MAT0034 (Rec: 10/01/18 16:06 MAT0034 BSU-C12)
Vital Signs-Automatic Capture
Monitor Operator

Monitor Operator	Marissa Schlee

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Respirations
Respiratory Rate 16
Document 10/03/18 07:30 ANN0115 (Rec: 10/03/18 08:01 ANN0115 BSU-M01)
Vital Signs-Automatic Capture
Monitor Operator
Monitor Operator Kristen Wida
Heart/Pulse Rate
Pulse Rate 79
Respirations
Respiratory Rate 16
Oxygen Saturation
O2 Sat by Pulse Oximetry 99
Patient on Room Air Yes
Document 10/04/18 08:19 JON0059 (Rec: 10/04/18 08:55 JON0059 BSU-C27)
Vital Signs-Automatic Capture
Respirations
Respiratory Rate 16
Document 10/05/18 07:24 JON0059 (Rec: 10/05/18 07:57 JON0059 BSU-C02)
Vital Signs-Automatic Capture
Monitor Operator
Monitor Operator David Dart
Temperature
Temperature 97.8 F
Temperature Source Tympanic
Heart/Pulse Rate
Pulse Rate 85
Respirations
Respiratory Rate 14
Oxygen Saturation
O2 Sat by Pulse Oximetry 98
Document 10/05/18 07:57 JON0059 (Rec: 10/05/18 07:57 JON0059 BSU-C02)
Vital Signs-Automatic Capture
Respirations
Respiratory Rate 16
Document 10/07/18 07:45 LYL0001 (Rec: 10/07/18 08:32 LYL0001 BSU-C27)
Vital Signs-Automatic Capture
Monitor Operator
Monitor Operator Matthew R Youngs
Temperature
Temperature 98.0 F
Temperature Source Temporal Artery Scan
Heart/Pulse Rate
Pulse Rate 111
Respirations
Respiratory Rate 16
Oxygen Saturation
O2 Sat by Pulse Oximetry 98
Document 10/08/18 08:01 LYL0001 (Rec: 10/08/18 09:54 LYL0001 BSU-M01)
Vital Signs-Automatic Capture
Monitor Operator
Monitor Operator Kristen Wida
Temperature
Temperature 97.9 F

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Assessments and Treatments - Continued

Temperature Source	Temporal Artery Scan
Heart/Pulse Rate	
Pulse Rate	98
Respirations	
Respiratory Rate	16
Oxygen Saturation	
O2 Sat by Pulse Oximetry	99
Patient on Room Air	Yes

Document 10/10/18 07:22 LYL0001 (Rec: 10/10/18 07:58 LYL0001 BSU-M01)
Vital Signs-Automatic Capture

Monitor Operator	
Monitor Operator	Navjot Kaur
Heart/Pulse Rate	
Pulse Rate	91
Oxygen Saturation	
O2 Sat by Pulse Oximetry	95

Document 10/11/18 08:22 JON0059 (Rec: 10/11/18 08:22 JON0059 BSU-C26)
Vital Signs-Automatic Capture

Respirations	
Respiratory Rate	16

Document 10/13/18 08:36 JON0059 (Rec: 10/13/18 08:37 JON0059 BSU-C02)
Vital Signs-Automatic Capture

Respirations	
Respiratory Rate	16

Document 10/14/18 07:48 JON0059 (Rec: 10/14/18 07:48 JON0059 BSU-C02)
Vital Signs-Automatic Capture

Respirations	
Respiratory Rate	16

Document 10/15/18 09:33 JON0059 (Rec: 10/15/18 09:53 JON0059 BSU-C12)
Vital Signs-Automatic Capture

Respirations	
Respiratory Rate	16

Weigh Patient Start: 09/24/18 18:54
Freq: We@0600 Status: Discharge
Protocol:

Not Done 10/03/18 06:00 JON0059 (Rec: 10/04/18 07:39 JON0059 BSU-C27)
Unable to Determine if Done

Document 10/10/18 08:18 LYL0001 (Rec: 10/10/18 08:18 LYL0001 BSU-M01)
Weigh Patient

Weight	
Weight	167 lb 8 oz
Last Documented Weight	166 lb
Weight Change	1.500000 lb
Actual/Estimated Weight	Actual
Scale Used	Standing Scale - Mechanical

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

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BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
62 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00088571823

Clinical Data

PREFERRED LANGUAGE (MU) ENGLISH
Height 5 ft 6 in
Weight 167 lb 8 oz
Code Status Full Code
Pregnant: No
Type of Isolation Standard Precautions

Condition Improved
Visit Reason UNSPECIFIED PSYCHOSIS
Language ENGLISH

Diagnosis Code	Name
F20.9	SCHIZOPHRENIA, UNSPECIFIED
G25.71	DRUG INDUCED AKATHISIA
T43.595A	ADVERSE EFFECT OF OTH ANTIPSYCHOTICS AND NEUROLEPTICS, INIT
Y92.230	PATIENT ROOM IN HOSPITAL AS PLACE
I10	ESSENTIAL (PRIMARY) HYPERTENSION
F60.9	PERSONALITY DISORDER, UNSPECIFIED
F31.2	BIPOLAR DISORD, CRNT EPISODE MANIC SEVERE W PSYCH FEATURES

Discharge Information

Inpatient Discharge Date/Time: 10/15/18 12:15
Inpatient Discharge Disposition: HOME
Inpatient Discharge Comment:

Instructions:
Stand-Alone Forms:
Prescriptions:
Visit Report
- Forms:
- Referrals: TOMPKINS CNTY MENTAL HLTH CTR (Outside)
  Breiman,Robert, MD (Medical Doctor)
- Additional text: Additional Information & Instructions

  Reason for Admission: [Psychosis]

  Discharge Diagnosis: [Unspecified Psychotic Disorder]

  Diet Instructions: [regular diet]

  Activity Instructions: [left arm in sling until further directed by primary care physician]

  Safety & In Case of Emergency:
  If you feel like you are going to harm yourself/others, if you are experiencing a crisis or if you or someone you know is thinking about suicide, please refer to the resources listed below. Please go to the emergency room or call 911 if your condition worsens. For safety, spouse/parent/guardian or responsible adult should secure all weapons and

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Discharge Information - Continued

medications.

Cayuga Medical Center Behavioral Services Unit 607-274-4304
Suicide Prevention and Crisis Services 607-272-1616
National Suicide Prevention Lifeline 800-273-8255
Tompkins County Mental Health Clinic 607-274-6200
Alcoholics Anonymous 607-273-1541
Tompkins County Mental Health Association 607-273-9250

Contact Information for Hospital Stay
If you need to contact a healthcare professional or physician related to your hospital stay, please call the Behavioral Services Unit at 607-274-4304. This number is available 24 hours a day/7 days a week.

Contact Information for Obtaining Results of Pending Studies /Tests
For questions about pending results, please contact the Cayuga Medical Center Medical Records Department at 607-274-4314. Staff is available to assist you between the hours of 7:00 AM until 5:00 PM.

Summary of Procedures and Tests Completed Supporting Patient 's Diagnosis, Treatment, and Discharge Plan
[Your hemoglobin A1c and fasting lipid panel were within normal limits. X-ray of your left shoulder showed fracture.]

Pending Labs
[none]

Pending Tests and Procedures
[none]

Advance Directives Information
Code Status: Full Code
Advance Directives Location: No Advance Directives
Given Information About Medical Advance Directives:
Given Information About Psychiatric Advance Directives: Unable

Tobacco Referral Information
NYS Smokers' Quitline: You have declined referral to the NYS Smoker's quit line at this time. If you decide to access this free service in the future you can contact the quit line toll-free at 866-697-8487.
Referred to Primary Care Physician
Referred to Cayuga Center for Healthy Living (CCHL)

Substance Abuse Follow up (select one of following):

[x] N/A
[] Patient was referred to [] for substance abuse treatment.
[] Substance use treatment referrals were offered and patient refused.
[] Patient refused offer of [], an FDA-approved medication for alcohol or substance use disorder.

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Discharge Information - Continued

Substance Use:

[] A prescription for an FDA-approved medication for alcohol or drug disorder was given to the patient at discharge
[] A prescription for an FDA-approved medication for alcohol or drug disorder was offered at discharge and the patient refused
[] The patient's residence is not in the USA
[x] A prescription for an FDA-approved medication for alcohol or drug disorder was not offered at discharge or UTD

User Key

Monogram	Mnemonic	Name	Credentials	Provider Type
	ALE0011	Clinton,Alexandra M	RD	Registered Dietitian
	ALI0046	Bliss,Alison		Social Worker
	ALL0023	Compres,Alleny		Mental Health Technician
	ANN0115	Hewitt,Anne		Registered Nurse
	BAR0006	Lister,Barbara	RN	Registered Nurse
	BRA0067	Niver,Brandy L	RN	Registered Nurse
	BRI0130	Hayes,Briar		Mental Health Technician
	CAM0005	Hoellrich,Cameron		Social Worker
	ERI0025	Trapper,Eric	RN	Registered Nurse
	GEM0001	Bardo,Gemma		Radiology Technologist
	GIT0002	Sidhu,Gitanjali	RN	Registered Nurse
	ILA0001	Winters,Ilana		Mental Health Technician
	JAC0076	Vanpetten,Jacqueline		Mental Health Technician
	JAD0003	Doty,Jade		Mental Health Technician
	JOH0140	Mayer,John		Physical Therapist
	JON0059	Powers,Joni Lynn	RN	Registered Nurse
	KAR0031	Henry,Karen	OT	Occupational Therapist
	KEL0019	Jolly,Kelly	RN	Registered Nurse
	KRI0028	Wida,Kristen		Mental Health Technician
	KYL0051	Jaynes,Kylee K		Cert Ther Recreational Spec
	LAU0148	Kovac,Laura	RN	Registered Nurse
	LYL0001	Cohen,Lyle	RN	Registered Nurse
	LYN0010	Luxner,Lynne	RN	Registered Nurse
	MAR0029	Carlucci,Mary Lou	PT	Physical Therapist
	MAR0445	Schlee,Marissa		Mental Health Technician
	MAR0485	LeFevre,Mary		Mental Health Technician
	MAT0034	Barrington,Matthew	RN	Registered Nurse
	MAT0068	Youngs,Matthew R		Mental Health Technician
	MAU0059	Coats,Maureen		Cert Ther Recreational Spec
	MEG0009	Smith,Megan L	RN	Registered Nurse
	MIC0258	Brown,Michele	RN	Registered Nurse
	MOR0051	Clark,Moriah A	RN	Registered Nurse
	NAT0065	Barton,Nathaniel	RN	Registered Nurse
	NAV0003	Kaur,Navjot		Mental Health Technician
	RAC0019	Bliss,Rachel		Mental Health Technician

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BLAYK,BONZE ANNE ROSE

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User Key - Continued

	ROB0100	Parseghian,Roberta E	RN	Registered Nurse
	ROW0001	Diano,Rowen	RN	Registered Nurse
	RYA0008	Campbell,Ryan		Mental Health Technician
	SEL0001	Lenetsky,Selina	RN	Registered Nurse
	SHA0063	Aether,Shannon Esme	RN	Registered Nurse
	SHA0179	Murray,Shauna	OT	Occupational Therapist
	TAH0001	Hanna-Martinez,Tahlia		Mental Health Technician
	VOD0001	Elemi-Schoenwald,Voda		Mental Health Technician