



### **3.0 RESIDENT ASSESSMENT INSTRUMENT**

#### **MRS. M SIGNIFICANT CHANGE IN STATUS**

#### **CHART REVIEW**

#### **Demographics**

Mrs. Cynthia M is a 90-year-old, Caucasian female, born June 22, 1920 in Germany and immigrated to the United States when she was seven years old. Mrs. M speaks English, but if upset or agitated sometimes speaks in her native language of German. Mrs. M has been a widow for 25 years and prefers to be called Mrs. M related to being address formally as a school teacher for over 40 years. Mrs. M has been high functioning all of her life and has no history of mental illness.

#### **Incident**

On December 15, 2010, Mrs. M was found on the floor next to her bed at 3:30 AM by the nursing home staff. When the CNA asked Mrs. M what happened she stated, "I was trying to go to the bathroom and I fell". The night shift supervisor was summoned and she completed a post fall assessment.

**Assessment findings:** Mrs. M's major complaint was extreme left hip pain, an 8 on a scale of 1-10. Upon examination of her left hip, it was noted that there was external rotation and she complained of extreme pain upon position changes. In addition, there appeared to be some shortening of the left leg. Mrs. M's vital signs were T 98.9, P 96, R 28 and B/P 136/90. Her pupils were equal and reactive and she was able to move all other joints within her previous level of functioning prior to her fall. There was a skin tear on her right forearm measuring 2cm in length. Once Mrs. M was assessed her left leg was immobilized and, she was transferred into bed. The skin tear was cleansed and dressed. Mrs. M's physician was notified and received a summary of the incident. Dr C ordered Mrs. M to be transferred via ambulance to the hospital ER for evaluation and possible admission. Mrs. M's daughter was notified of her mother's fall and that she was being transferred to the hospital. Later that day, Mrs. M's daughter notified the facility that her mother had an ORIF, was stable post op and doing well.

#### **Discharge Assessment**

Mrs. M was admitted to the hospital on December 15, 2010, a discharge assessment return anticipated was completed.

#### **Reentry Tracking Form**

Mrs. M returned on December 20, 2010 therefore a reentry tracking form was completed which was correctly dated December 20, 2010.

#### **Reentry to the Facility**

Mrs. M received left hip surgery Open Reduction Internal Fixation (ORIF) on December 15, 2010. Mrs. M meets the criteria for Medicare Part A skilled level of care and will be placed in a Medicare bed.

## Physical Functioning

Mrs. M's weight bearing status is "toe touch" (TTWB) on the left leg, she was unable to raise her left leg without assistance but she is able to raise her right leg without difficulty. Mrs. M has residual left-sided weakness from her past CVA. Her left arm is weaker than her right arm but she is able to use her left arm as support when ambulating with a walker. She is not able to use her left arm to touch the back of her head which is not a change from her previous level of functioning. Her left leg continues to be weaker than her right but this is only problematic when she is tired or not feeling well. The balance assessment revealed that she requires staff assistance to steady her for each component of the test. Due to her CHF and therapy schedule she becomes fatigued and unsteady thus needing the staff to transport her by wheelchair to all activities, meals, and therapy. Weight-bearing assistance of one person is required for all transfers she can self-propel in a W/C for short distances in her room. Mrs. M receives supervision and verbal cueing for using a trapeze to pull herself up in bed. On four occasions as her arms fatigued she required extensive physical assistance of one person to reposition in bed. Mrs. M is able to help turn herself in bed with the assistance of side rails and one person to manually support and position her left leg. Mrs. M is able to perform upper body activities of daily living but she is very slow. She requires minimal assistance of one person to dress her upper body. She is able to button her clothing using a large handled buttonhook. She requires physical assistance of one person to assist with dressing her lower body daily. She requires weight-bearing assistance of one person for transfers in and out of the bathtub. She requires weight-bearing assistance of one person to transfer on/off the toilet and standby assistance with hygiene (e.g., being handed toilet tissue). Mrs. M has not walked in the hall since her return from the hospital. Mrs. M has fallen two times in the last 14 days and four times in the last six months. The latest fall was five days ago which occurred when she was attempting to go to the bathroom during the night resulting in a left hip fracture.

## Diagnoses

Mrs. M has the following diagnoses:

- Fractured left hip with ORIF
- CVA in 1997 requiring extensive rehabilitation
- Anterior wall MI in 1988
- CHF related to damage from her MI
- Arteriosclerotic heart disease (ASHD)
- Osteoarthritis and Rheumatoid Arthritis
- GI bleed and ulcer related to steroid and NSAID use
- Anemia
- Hypothyroidism for 10 years
- Depression diagnosed post CVA 1997
- Stress incontinence
- Macular Degeneration
- Hard of Hearing

## Current Condition

Mrs. M's BIM score was an 11 which was completed on December 24, 2010 her previous score was 13 November 5, 2010. When the CAM was completed, new fluctuating behaviors of inattention and altered

levels of consciousness since returning from the hospital were noted. She is experiencing left hip pain in addition to pain at the incision site. She describes the pain as a 7 on a scale of 1 to 10. Ultracet is being given every 6 hours around the clock with Mrs. M expressing acceptable pain control. In addition, she has difficulty with joint pain and stiffness in the early AM which resolves once she receives a daily dose of Relafen. She sleeps at a 45-degree angle due to orthopnea. Mrs. M is currently afebrile but since surgery she has a late-afternoon low grade fever. Her vital signs upon readmission are: T 97.4 (oral), P 70 (irregular), RR 20 (even and unlabored) and B/P 142/80. She has a grade III systolic murmur, no jugular venous distention, and 2+ pitting pedal edema. She wears bilateral lower extremity Jobst stockings for edema. Her abdomen is soft with active bowel sounds in all four quadrants. She has no complaints of nausea or recent episodes of vomiting. The left hip incision site is dry with no signs or symptoms of infection. Her left lower extremity is pink in color warm to the touch, bilateral pedal pulses are strong. She weighs 135 pounds and is 70 inches tall. Historically reviewing the past 6 months of weight there has been no changes with the exception of a 5 pound loss since her fall and hospitalization. Her diet is regular with No-Added-Salt. She doesn't always eat well at meals. Mrs. M states that she ate even less when she was in the hospital and complained that "the food was just awful". She receives snacks throughout the day to supplement her diet. She is independent with feeding herself after tray setup and uses a dycem plate and a rocker knife to eat her meals. Mrs. M received D5 ½ Normal saline per IV at 100 cc an hour for hydration for three days while hospitalized, which was discontinued December 18, 2010.

Mrs. M has a healing surgical wound outer left thigh and a healing skin tear on her right forearm. Her skin is thin related to steroid medications and tears easily. She also has a non-blanchable 3 cm reddened area on her coccyx, the skin is intact. Her left heel has a blood-filled blister approximately 2.5 cm the skin around it is intact there is no boggy in the surrounding tissue. The Braden Scale score indicates that there is no impairment with sensory perception; she is able to respond appropriately and can voice discomfort (score 3). Since the Foley catheter was removed she occasionally has incontinent episodes several times a week (score 3). Her ability to walk is limited. She cannot bear full weight on the left leg and must be assisted into a chair or wheelchair (score 2). Her mobility is limited. She is able to slightly change body or extremity position(s) but is unable to make significant changes independently (score 2). Her nutritional intake is fair she leaves 25% of food 2 out of 3 meals and has had a recent weight loss (score 3). She occasionally slides down in her chair and doesn't always raise her buttocks to sit back up which increases her risk of shearing/friction (score 2). Her total Braden score is 15 out of 23 total points. Mrs. M is receiving PT and OT evaluations per physician orders.

## Medications

Medications as listed on the MAR:

- Lanoxin 0.25 mg daily PO
- Prilosec 25 mg daily PO
- Relafen 1000 mg daily PO
- Calan 80 mg TID PO
- Prednisone 5 mg daily PO
- Synthroid 0.1 mg daily PO
- Bumex 1 mg daily PO
- Prozac 10 mg daily PO
- Ultracet every 6 hours PO
- Pericolace 100 mg BID PO
- Lovenox 40 mg SQ once daily. D/C after 14<sup>th</sup> dose

- Nitroglycerin (NTG) 0.4 mg SL spray PRN for chest pain

## **Treatments and Procedures**

While in the hospital, Mrs. M had a Foley catheter, was on I&O, received one blood transfusion on December 16, 2010, and received IV medications and IV fluids for hydration for three days post op.

Admission orders included:

- Remove Foley catheter on 12/21/10
- I&O
- Dry dressing daily to left hip surgical incision
- Elevate both heels off bed
- Duoderm to coccyx, change q 3-4 days
- Hgb and Hct on day 2, then in 30 days
- PT and OT to evaluate and treat

Speech eval and treat orders were obtained after results of BIM were noted.

Therapy evaluations were completed and treatment plans were developed to include:

- PT – 30 min bid for gait training, TTWB; parallel bars progressing to walker; TTWB transfer training; therapeutic exercise; and pain management
- OT – 30 min daily for LE dressing; bed/WC positioning; bed mobility; and functional transfers.
- ST – 30 min daily times one week to focus on cognitive skills

Therapy minutes provided since admission:

- |                 |             |                   |
|-----------------|-------------|-------------------|
| • PT evaluation | 30 minutes  | 12/20/10          |
| • PT treatments | 180 minutes | 6 days of therapy |
| • OT evaluation | 30 minutes  | 12/21/10          |
| • OT treatments | 120 minutes | 5 days of therapy |
| • ST evaluation | 45 minutes  | 12/27/10          |
| • ST treatment  | 30 minutes  | 1 day of therapy  |

## **Immunizations**

- Influenza vaccine given at the facility November 16, 2010
- Pneumococcal vaccine given at physician's office November 2003

## **ARD**

- December 27, 2010

**INTERDISCIPLINARY NOTES**  
**(SAMPLE ENTRIES)**

**12/20/10 Significant change** in status triggered due to recent Left Hip Fx secondary to a fall; ORIF performed on 12/15/10. Return to facility with admit to Medicare status this date for rehab; physician's orders include daily PT and OT. Overall functional decline noted with bed mobility, transferring, ambulation and LE ADLs; recent increase in incontinence and increased pain are also concerns. Assessment reference date has not been determined..... *S. Coordinate, RN*

**12/21/10 Activities note:** Attempted to complete the Interview for Daily and Activity Preference without success. Mrs. M could not stay focused on the questions and gave nonsensical answers. Will complete the assessment by reviewing with daughter, and staff. In the interim will review previous history and put in place some of the activities she use to participate in and then update as needed with daughter's information..... *R. Gaye, AD*

**12/22/10 Dietary note:** Mrs. M returned to the facility on 12/20/10 after a brief hospital stay at which time she lost 5 pounds, current wt 135#. Her wt had been stable the past several months even though she continued to leave 25% or more of her meals. 12/15/10 albumin of 3.5 indicates mild protein depletion, but is an overall improvement from 11/12/10 alb of 3.2. She received a transfusion of I unit PRBCs post op; Mrs. M. did have IV fluids for hydration for 3 days following her hip surgery. Will monitor to ensure she does not need additional fluids. 12/18/10 Hgb 8.3 and stable. Will recommend Fe Supp TID with follow up lab in 2-4 wks, hx of constipation will require close monitoring. Mrs. M has maintained the ability to eat independently with set up assistance and adaptive equipment. Swallowing difficulties post CVA remain a concern, but are minimized with cueing and proper positioning. She would like to continue her between meal snacks of fresh fruit, specifically grapes, oranges, and peaches. Canned fruit is suitable if fresh is not available. She prefers Carnation Instant Breakfast as a protein snack, but would like cold cereal offered occasionally. According to nursing staff, Mrs. M has an increased risk of skin breakdown with areas of concern on her coccyx and heel so will plan to assess intake weekly and offer choices to meet her increased needs. Mrs. M is aware of her changing dietary needs and is willing to work toward improved intake to regain the few pounds she lost and to improve protein intake. She is agreeable to eating meals in the dining room..... *Joan Diet, RD*

**12/26/10 Social Service note:** Mrs. M returned to the facility on 12/20/10 after a brief hospital stay. The BIM test was done today with a score of 11. Previous scores have been 13-14 so a decline has been noted. Consistent observations of fluctuating behaviors of inattention and altered levels of consciousness have been noted by the staff and noted on the CAM. The PHQ-9 was also completed on this date. The score was 14 compared to scores of 4-5 in the past. Mrs. M declared that she would be better off dead. Upon further discussion Mrs. M stated she did not have a plan and would not hurt herself but feels she has lived long enough and "God can take her". Nursing was notified of the results of the assessment and in turn called her physician. Dr. G was made aware of the results of the tests. Speech therapy is to see her for a further cognitive evaluation, and a change to her antidepressant..... *Sally Social, MSW*

**12/26/10 Nursing note:** 3 day bladder diary completed. Diary began after foley discontinued on 12/21/10. Results showed increase frequency in the AM to void related to Bumex administration. By mid-afternoon would void, again at mealtime and at bedtime. Incontinence noted only at night with no pattern noted. Will care plan to offer frequently during the AM and to respond to call light promptly..... *S. Coordinate, RN*

**12/30/10 Care Plan note:** Significant change in status MDS and CAAs completed and discussed at the care plan team meeting, resident and daughter in attendance. Care plan goals discussed and agreed upon. Functional ability improving and pain better controlled. Signs of delirium have decreased and her cognitive scores for the BIM have improved. Speech is to be discontinued. Continue with daily PT and OT, plan to review progress in one week on 01/06/06..... *S. Coordinate, RN*

**PHYSICAL THERAPY INITIAL EVALUATION  
12/20/10 S. WALKER PT**

**Reason for evaluation:** Previous resident who fell and is now readmitted following recent L hip fx, s/p ORIF on 12/15/10. Physician's order for 5X Wkly PT for gait training, transfer training, therapeutic exercise and pain assessment/management; TTWB status.

**Baseline function:** Prior to hip fx resident was able to transfer and ambulate 20-30 feet independently with rolling walker; limited endurance due to CHF hx. When fatigued, would transport via wheelchair with staff assist of one. Also, S/P CVA with L-sided weakness UE/LE.

**Initial evaluation:** Required mod assist of one for position change from supine to sit due to pain and leg positioning; maintained sitting balance at side of bed. Mod assist of one for pivot transfers in/out of bed using standard walker for balance and to maintain WB status. Amb 30 feet in parallel bars and required verbal cue x2 to limit WB to toe touch. Independent with W/C mobility in room only. Stated L hip pain 7/10 prior to eval, request for pre-therapy medication effectively reduced pain to 2/10.

**Plan:** PT for 30 min BID 5X weekly X 4 weeks for gait training; transfer training, therapeutic ex, parallel bars progressing to walker. Pain management coordinated with nursing.

**OCCUPATIONAL THERAPY INITIAL EVALUATION  
12/21/10 A.D. LEARN OT**

**Reason for evaluation:** Recent L hip FX, s/p ORIF on 12/15/10. Physician's order for 5X wkly OT for LE dressing, bed/wc positioning, bed mobility and functional transfers.

**Baseline function:** Prior to hip FX, resident had CVA with L-sided weakness (1997) and hx of CHF. She had been independent with ADLs except bathing and toileting, and is slow with task completion on most days. She required min assist of one to don/doff UE garments, but can button garment front independently with the aid of a large handled button hook. Required min assist of one with daily LE dressing to don/doff Jobst stockings, but could place slacks, socks and shoes independently most days. She was independent with bed mobility; required stand by assist to min assist for safety with toileting and transferring in/out of tub.

**Initial evaluation:** Required min-mod assist with bed mobility for leg positioning. Required mod assist of one with all LE dressing due to pain, limited ROM of L-hip, and WB limitation. Also required mod-max assist of one for transferring on/off toilet and in/out of bathtub. Upper extremity dressing and ADLs remain unchanged from baseline; however required staff's assist with set up due to limitations with mobility.

**Plan:** OT 30 min daily 5X per week X 4 weeks for LE dressing, bed/WC positioning, bed mobility, and functional transfers.

**SPEECH THERAPY INITIAL EVALUATION  
12/26/10 A Voice ST**

**Reason for evaluation:** Recent L hip fx, s/p ORIF on 12/15/10. Post op a decrease in cognition function has been noted along with signs of delirium.

**Baseline function:** Prior to hip fx, resident had CVA with L-sided weakness (1997) and hx of CHF. Mrs. M's BIM score had been consistently 13-14 till this recent score of 11. Staff has also noted new fluctuation in behaviors as far as being inattentive and altered levels of consciousness in that she is sleepier and then becomes hyper vigilant. These observations have been since readmission after the fracture. She has macular degeneration making it difficult for her to read any size font. She can see people's faces in good lighting and is able to get around the facility with minimal problems. She is also hard of hearing and chooses not to obtain hearing aids.

**Initial evaluation:** Completed an extensive cognitive evaluation which showed deficits in both short and long term memory. Mrs. M also has delayed responses and poor processing of information. Attention span is noted to be very short.

**Plan:** Speech 30 min. 5x for one week for improvement in cognitive skills especially long and short term memory and problem solving skills.

**MRS. M PPS-SIGNIFICANT CHANGE CAA DOCUMENTATION**

**CAA Summary Note:** #1 Delirium

**Date:** 12/30/10

**MDS items:** #1 Delirium

**Triggers:** BIM score declined from 13-14 to 11

<b>1. DELIRIUM: REVIEW of INDICATORS OF DELIRIUM</b>		
<b>Mark if Area Triggered</b>	<b>Change in Vital Signs</b>	<b>Supporting Documentation: (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</b>
x	Rectal temp above 100°F or below 95°F (38°C/ 35°C)	Has been running a low grade temperature every afternoon
x	Pulse rate <60 or >100 beats/ min	Irregular Grade III systolic murmur
	Respiratory rate >25 breaths/minute or < 16 breaths/minute	
	Hypotension or a significant decrease in blood pressure	
	Systolic b/p < 90mmHg OR	
	Decline of 20 mmHg or greater in systolic b/p from person's usual baseline OR	
	Decline of 10 mmHg or greater in diastolic b/p from person's usual baseline OR	
	Hypertension – systolic b/p above 160 mmHg OR a diastolic b/p above 95 mmHg.	
	<b>Abnormal Laboratory Values</b>	
	Electrolytes, such as sodium	
	Kidney function	
	Liver function	
	Blood sugar	
	Thyroid function	
	Arterial blood gases	
	Other	Anemic
	<b>Pain</b>	
	Pain Care Area triggered (review findings for relationship to delirium)	Yes was triggered
x	Pain frequency, intensity, and characteristics (time of onset, duration, quality) indicate possible relationship to delirium	Defines pain as 7 out of 10. Has impacted ability to participate in therapy.
	Adverse effect of pain on function may be related to delirium	
	<b>Diseases and Conditions</b>	
	Circulatory/Heart: anemia, cardiac dysrhythmias, angina, MI, ASHD, CHF, pulmonary edema, CVA, TIA	History of CHF and a CVA. Irregular pulse and a systolic heart murmur, MI, ASHD
	Respiratory: asthma, emphysema, COPD,	SOB if lies flat

	shortness of breath,	
	Infectious: Infections, wound infection other than foot or lower extremity, Isolation - active	Recent hospital stay with foley catheter that has now been removed
	Metabolic: diabetes, thyroid, hyponatremia	On thyroid replacement
	Gastrointestinal bleed	DX GI Bleed and Ulcer
	Renal disease, dialysis	
	Hospice Care	
	Cancer	
	Dehydration	
	<b>Signs of Infection (from observation, clinical record)</b>	
	Fever	Daily afternoon elevated temperatures
	Cloudy or foul smelling urine	
	Congested lungs or cough	SOB if lies flat
	Dyspnea	
	Diarrhea	
	Abdominal pain	
	Purulent wound drainage	
	Erythema around an incision	
	<b>Indicators of Dehydration</b>	
	Dehydration care area triggered, indicating s/s of dehydration are present	No S/S but did have IV fluids in hospital for hydration after surgery
	Recent decrease in urine volume or more concentrated urine than usual	
	Recent decrease in eating habits - skipping meals or leaving food uneaten, weight loss	Decrease appetite with recent weight loss
	Nausea, vomiting, diarrhea or blood loss	History of GI Bleed. Recent blood transfusion post surgery.
	Receiving IV meds	
	Receiving diuretics or drugs that may cause electrolyte imbalance	Bumex daily
	<b>Functional Status</b>	
	Recent decline in ADL status	Requires more assist since hip fx
	Increased risk for falls	Fell causing fx hip
	<b>Medications (that may contribute to delirium)</b>	
	New med or dosage increase	
	Drugs w/anticholinergic properties (antipsychotics, antidepressants, antiparkinsonian, antihistamines)	Prozac was just increased but symptoms were noted before increase
	Opioids	
	Benzodiazepines, especially long acting	
	Analgesics, cardiac and GI meds, anti-inflammatory drugs	On both cardiac, GI meds, and analgesics
	Recent abrupt discontinuation, omission, or decrease in dose of a short/long acting benzodiazepine	
	Drug interactions	
	Resident taking more than one drug from a particular class of drugs	
	Possible drug toxicity, esp. if the person is dehydrated or has renal insufficiency.	

	Check serum drug levels	
	<b>Associated or Progressive Signs and Symptoms</b>	
	Sleep disturbances (up & awake at noc, asleep during day)	Altered levels of consciousness
	Agitation & inappropriate movements (unsafe climbing out of bed or chair, pulling out tubes)	
	Hypoactivity (low or lack of motor activity, lethargy or sluggish responses)	Sluggish
	Perceptual disturbances such as hallucinations and delusions	
	<b>Other Considerations</b>	
	Psychosocial: - Recent change in mood: sad or anxious, crying, social withdrawal - Recent change in social situation (isolation, recent loss of family or friend)	Fell less than a week ago resulting in a hip fracture which resulted in the hospital stay. Returning now as more depressed DX Depression. Prozac recently increased.
	Physical or environmental factors: - Hearing or vision impairment, may have an impact on ability to process information like directions, reminders, environmental clues - Lack of frequent reorientation, reassurance, reminders to help make sense of things - Recent change in environment (room change, new admission, return from hosp) - Interference w/resident's ability to get enough sleep (light, noise, frequent disruptions) - Noisy or chaotic environment (calling out, loud music, constant commotion, frequent caregiver changes)	Return from hospital. Is having difficulty processing new information at this time.  Dx macular degeneration, Hard of Hearing
	<b>Input from resident and/or family or representative regarding the care area. Questions/comments/concerns Preferences/suggestions</b>	Family has noted a decline since returning from hospital
<b>Analysis of Findings</b>		<b>Care Plan Considerations</b>
Review indicators and supporting documentation, and draw conclusions. Document: <ul style="list-style-type: none"> <li>Description of the problem</li> <li>Causes and contributing factors</li> <li>Risk factors related to the care area</li> </ul>	Care Plan? Yes No	Document reason(s) care plan will or will not be developed.
Problem: Mrs. M's BIM score has decreased from previous assessment. Causes: Low grade fever, multiple medical diagnoses including CHF, CVA, hypothyroid, and anemia. Recent hospitalization with surgery. Risk factors: Increase confusion may interfere with providing care, and put Mrs. M at risk for further	Yes	Care plan to be developed to monitor current level of cognition for further decline. Will incorporate interventions to minimize further loss of cognition

injury such as another fall, skin breakdown, weight loss, etc.		
Referral to another discipline is warranted - to whom and why?		Speech to see for compensatory techniques

**CAA Summary Note: #2 Cognitive Loss/Dementia**

**Date:** 12/30/10

**MDS items:** BIM score less than 13 C0500 and inattention and altered level of consciousness C01300

**Analysis:** Mrs. M does show signs of delirium, see Delirium CAA 12/30/10. She does have a history of a CVA with new onset of changes in behavior in inattention and altered levels of consciousness. Her PHQ-9 also shows an increase in depression from her previous assessment. Medically she does have a thyroid disorder, ASHD, Hx of MI and GI Bleed/Ulcer, CHF, SOB with activity and inability to lie flat, and depression. Pain control has also been an issue since readmission but better participation noted in therapy over the last several days. Due to her recent surgery she does require more assistance with her ADL's. In the last week she has also had several environmental changes between the hospital and the nursing home which may also impact her cognition. Speech therapy to see. Will care plan to minimize further decline and to possibly improve her cognitive ability with continuity of care and pain management.

Decision to proceed with care plan - **YES**

**CAA Summary Note: #3 Visual Function; #4 Communication**

**Date:** 12/30/10

**MDS items:** Vision Impaired: B1000 Hearing, B0200 and Ability to understand others: B0800

Mrs. M triggered for these CAA areas due to sensory deficits, resulting in highly impaired vision and hearing. There have been no changes in either area since the original admission. See Visual Function and Communication CAA note dated 1/21/10.

Decision to proceed with care plan - **YES**

**CAA Summary Note: #5 ADLs; #11 Falls**

**Date:** 12/30/10

**MDS items:** #5 ADL's - Requires assistance with ADLs G0110 and has a decline in cognition C0500; #11 Falls - Has balance problems G0300

*See PT eval 12/21/10 and OT eval 12/21/10*

*Vision/Communication CAA 12/30/10 and Urinary incontinence CAA dated 12/30/10*

Mrs. M triggered for the above CAAs due to her need for limited to extensive assistance with ADLs and a recent fall resulting in a fracture. PT and OT have addressed recommendations for Mrs. M's ADL status. In addition to a recent history of falls, Mrs. M is at fall risk due to possible medication side effects, urinary incontinence; weakness requiring limited to extensive staff assist at times because of fatigue, and sensory deficits. Medications that contribute to fall risk include Prozac, Bumex, Calan, NTG (PRN) and Digoxin.

Pharmacy review to be done per facility protocols to determine further recommendations at this time. Urinary incontinence is related to urgency secondary to diuretics and is likely to be exacerbated by recent catheter insertion.

Decision to proceed with care plan - **YES**, to alert staff to multiple risks for falls, and assistance with ADL's

**CAA Summary Note: #6 Urinary Incontinence**

**Date:** 12/30/10

**MDS items:** Incontinence and requires assistance with toileting H0300

Mrs. M triggered for this CAA due to urinary incontinence that has been a problem for her since prior to her admission at home and has continued since her original admission. A bladder diary was done with the first admission and has been repeated during days 3-6 of this stay (See Nursing Note 12/26/10). During the hospitalization a catheter had been inserted but has since been removed on 12/21/10. Since the removal Mrs. M has been incontinent several times a week, which is similar to her voiding pattern prior to hospitalization. This was confirmed by comparing the current diary with the previous admission diary. Mrs. M is unable to ambulate to the BR w/ walker due to fatigue. She requires weight bearing assistance of one person to transfer on/off the commode. She is able to call for assistance, but due to urgency can only hold her urine for about 5 minutes. Urgency is greater in the morning after Bumex administration. Delirium was also a possible incontinence factor as well as her increased need for assistance in toileting.

Decision to proceed with care plan - **YES**

**CAA Summary Note: #10 Activities**

**Date:** 12/30/10

**MDS Items:** Little interest or pleasure in doing things D0200 A

Mrs. M triggered for Activities due to the observation of little interest or pleasure in doing things. She has been a resident here for over a year. Prior to this most recent hospitalization she was an active participant in activities inside the home and occasionally went out with her daughter. She enjoyed small group activities but also enjoyed her time working on crossword puzzles. Currently due to pain, therapy attendance she has been too tired to participate in many activities. There are no other barriers such as environmental or staffing at this time. Review also the Cognitive loss, Delirium and Mood state CAAs 12/30/10.

Decision to proceed with care plan - **YES**

**CAA Summary Note: #12 Nutritional Status; #14 Dehydration/Fluid Maintenance**

**Date:** 12/30/10

**MDS items:** #12 Nutritional Status - Therapeutic diet K0500; #14 Dehydration/Fluid Maintenance - Taking diuretic: N0400

*See current dietary note dated 12/22/10. No change essentially since original admission; see CAA note dated 1/19/10 for Nutritional Status and Dehydration/Fluid Maintenance*

Decision to proceed with care plan - **YES**

**CAA Summary Note:** #8 Mood state; #17 Psychotropic Drugs

**Date:** 12/30/10

**MDS items:** #8 Mood state - Would be better off dead D0200 and increase in PHQ 9 from last assessment to current assessment D0300; #17 Psychotropic Drugs - Antidepressant N0400

Mrs. M was readmitted back to the facility after a fall resulting in hip fracture requiring surgery and a 3 day hospitalization. Mrs. M has a history of depression secondary to CVA and has taken Prozac since 1997. Upon readmission she showed signs of delirium, decline in ADL's with diagnosis of cardiac disease, and post CVA. She is on cardiac and pain medications. She is on thyroid replacement. Will contact Dr. G for a thyroid level as no levels have been drawn in over a year. Dr. G is aware of her wish to die but denied that she had a plan to follow through with those thoughts. She has been on Prozac but it has recently been increased..

Decision to proceed with care plan - **YES**

**CAA Summary Note:** #16 Pressure Ulcers M0300

**Date:** 12/30/10

**MDS items:** Currently has 2 pressure ulcers

Mrs. M. triggered for pressure ulcers due to an intact blister on her left heel that developed during her hospital stay as well as a nonblanchable area on her coccyx. Risk factors include: decreased mobility, friction and shear from sliding in bed, stress incontinence, delirium. She is on an antidepressant but this is a long standing medication and it has been increased recently. She has diagnosis of delirium, post CVA, depression, and edema. She also has the following conditions: recent weight loss, SOB if lies flat, and a recent decline in ADL's. Other factors include recently readmitted, and head of bed elevated for ease in breathing. Will care plan to ensure pressure is reduced to that area and that no further problems develop.

Decision to proceed with care plan - **YES**

**CAA Summary Note:** #19 Pain

**Date:** 12/30/10

**MDS Items:** Pain has limited day to day activities J0500

Diseases: Circulatory, pressure ulcers, post stroke, hip fracture

Characteristics of pain: Left hip, intermittent with an increase with movement, and decrease with rest.

Pain described as throbbing

Frequency: Hurts worst with ambulation and lessens after sitting

Pain effect on function: Does not disturb sleep, but appetite has decreased; more depressed compared to previous admission and impacts ability to complete ADL's

Associated signs and symptoms: delirium

Other considerations: Decrease in mobility due to recent surgery

Decision to proceed with care plan - **YES**