Windy Hill VILLAGE

A Tradition of Care. A Heritage of Trust.

17024 Veterans Memorial Hwy, Kingwood, WV 26537
Phone: 304-329-2741 F ax: 304-329-2744

WINDY HILL VILLAGE
ACTIVITIES ASSESSMENT

Activities Assessment For _____ Room _____
(Name of Resident)

Admission Date _____ Attending Physician _____

(Complete: Upon admission, annually, upon room change, or readmission)

ORIENTATION	1st	2nd	3rd	4th	5th	6th	7th	8th
DATES								

Resident was oriented to:								
Call bell								
Siderails								
Bathroom								
Heating System								
House Rules								
Policies								
Fire								
Disaster								
Resident was informed of "Resident Rights" & How to file concern/complaint								

Comments: _____

_____

_____

_____

ORIENTATION	1st	2nd	3rd	4th	5th	6th	7th	8th
DATES								
Participates in Church Activities								
Participates in watching TV								
Participates in playing Bingo								
Participates with other Residents								

Comments: _____

_____

_____

_____

_____

_____

_____

Assessed by:

1._____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

WINDY HILL VILLAGE

SUBJECT: NURSING PRN PROTOCOL **PAGE 1 OF 2**

PROCEDURE: For the below listed patient complaints the nurse may:

1. Perform a nursing assessment of the symptoms;
2. Administer the appropriate PRN medications regimen as outlined; and
3. Appropriately document in the Nursing Notes and on the MAR.
4. If symptoms persist after treatment indicated, contact RN-on-Call and physician.

Constipation – After 3 days	Milk of Magnesia 30ml	B.I.D.
Constipation - After 4 days	Bisacodyl Supp. 10mg	1 dose
Constipation – After 5 days	Fleets Saline or Soap Suds Enema	1 dose
Constipation – After 6 days	CONTACT PHYSICIAN	
Cough (Non-productive)	Robitussin DM 5ml	Q4 hours not to exceed 5 days
Cough (Non-productive) Resident With HTN	Robitussin 5 ml	Q4 hours not to exceed 5 days
Cough – if persists for more one day	CONTACT PHYSICIAN	
Diarrhea - After 1st loose BM	Imodium AD liq 20ml/2 tab	1 dose
Diarrhea - After each subsequent loose BM	Imodium AD liq 10ml/1 tab	NO MORE THAN 40ml/4 tabs per day for 48 hours
Diarrhea – After 2nd day	CONTACT PHYSICIAN	If diarrhea persists
Dry Eyes	Natural Tears 2gtts OU	Q4 hours not to exceed 48 hrs
Ear Wax Build-up	Debrox 3 gtts	T.I.D. For 5 days then irrigate with normal saline to remove wax.
Fever above 100 degrees	Acetaminophen 650mg PO or suppository	Q4 hours not to exceed a 24 hour period
Fever above 100 degrees	CONTACT PHYSICIAN	If two consecutive temps over 100 degrees, contact physician
Flu vaccine	Flu vaccine 0.5ml IM	Annually with consent from resident of legal rep.
Indigestion/Heartburn	Mylanta 30 ml or Tums 2 tabs (for resident with history of renal problems)	Q4 hours not to exceed a 48 hour period.
Itchy, Watery Eyes	Benadryl 25mg	Q6 hours not to exceed 4 doses in 24 hours

Mild Pain or general discomfort	Acetaminophen 650mg or Ibuprofen 400 mg	Q4 hours not to exceed a 24 hour period
Nasal Congestion	Chlortrimeton 4mg	Q6 hours not to exceed 5 days
Nausea / Vomiting	Compazine 25mg rectal supp.	1 dose
Reddened, unbroken skin	Desitin	Apply to affected areas as needed for 3 days
Skin Tear	Cleanse with normal saline, apply opsite dressing. Change as needed.	NOTIFY PHYSICIAN & RN-ON-CALL
Skin Tear with flap	Cleanse with normal saline, reapproximate flap of skin, apply steri-strips, the apply opsite dressing. Change as needed.	NOTIFY PHYSICIAN & RN-ON-CALL
Skin Tears of all types on residents with frail skin	Cleanse with normal saline, apply bacitracin ointment, apply telfa, and wrap with cling. Change every other day.	NOTIFY PHYSICIAN & RN-ON-CALL

AMAPs MUST NOTIFY THE RN BEFORE ADMINISTERING ANY PRN STANDING ORDER MEDICATIONS

_____ _____

PHYSICIAN SIGNATURE **DATE**

WINDY HILL VILLAGE
PHYSICIAN'S CERTIFICATION OF MENTAL CAPACITY/INCAPACITY

Name of Patient: _____

Date of Examination:_____ **Patient's Age:**_____

Name of Physician: _____

*Second physician required for persons with mental illness, mental retardation, or addiction, or if required on the legal document.

I certify I am the Patient's attending physician, duly licenses to practice medicine in the state of West Virginia.

I further certify that I examined the patient indicated above on the dated indicated above.

In my opinion, said patient **HAS** or **LACKS** (circle one) sufficient mental capacity to appreciate the nature and implications of a health care decision, to make a choice regarding alternatives presented, and to communicate such choice in an unambiguous manner. *The patient has been informed that he/she lacks the mental capacity to make medical decisions, therefore, their legal representative will be making decisions on his/her behalf (Medical Power of Attorney, Health Care Surrogate).*

If patient lacks capacity, state the cause (diagnosis) and nature of the incapacity.

- Cause_____
- Nature _____

What is the extent and probable duration of the capacity? (Example: short term and how long OR long term)

- _____
- _____

Physician Signature: _____

Date: _____

WINDY HILL VILLAGE
RESIDENT'S POSSESSIONS LIST

Resident Name:_____ M/F:_____

CLOTHING:

Slacks/Pants/Jeans_____'

_____

Shirts/Blouses/Sweaters _____

_____

Dresses/suites _____

_____

Jackets/Coats_____

_____

Shoes/Slippers_____

_____

Socks/Undergarments _____

_____

PERSONAL ITEMS: (Pictures/Bed Linens/etc.) _____

_____

_____

_____

_____

_____

HEARING AID(S): L_____ R_____ **DENTURES**: _____

FURNITURE/FIXTURES (include S/N): _____

_____

_____

MISCELLANEOUS: _____

_____

_____

_____

Resident/Representative Date

_____

Facility Representative/Witness Date

WINDY HILL VILLAGE
PHYSICIAN ADMITTING ORDERS

Resident Name:_____ Room Number: _____

DATE	MEDICATION ORDERS
DATE	**TREATMENT ORDERS**

DIET ORDER: _____(Regular, NAS, NCS)

CONSISTENCY ORDER: _____(Regular, Puree, May Grind)

VERBAL ORDERS TAKEN BY: _____ DATE:_____

FAXED TO PHARMACY: _____ DATE:_____

PHYSICIAN SIGNATURE: _____ DATE:_____

WINDY HILL VILLAGE
IMMUNIZATION TRACKING RECORD

Name _____ Physician _____

Initial Tuberculin:

Manufacturer	*Lot Number*	*Date & Site*	*Initials*	*Result*

Annual Tuberculin:

Manufacturer	*Lot Number*	*Date & Site*	*Initials*	*Result*

Flu Vaccine:

Manufacturer	*Lot Number*	*Date & Site*	*Initials*	*Result*

Pneumovax:

Manufacturer	*Lot Number*	*Date & Site*	*Initials*	*Result*

Tetanus Diptheria:

Manufacturer	*Lot Number*	*Date & Site*	*Initials*	*Result*

WINDY HILL VILLAGE
ANNUAL UPDATES

ON ADMISSION & ANNUALLY (DATE)	ASSESSMENT	SERVICE PLAN	T.B.	HEIGHT	WEIGHT
2014					
2015					
2016					
2017					
2018					
2019					
2020					
2021					
2022					
2023					
2024					

ON CHANGE IN CONDITION (DATE)	SERVICE PLAN UPDATED (DATE)

WINDY HILL VILLAGE
NURSES NOTES

FULL DATE	TIME	NURSES' NOTES

WINDY HILL VILLAGE
CARE LEVEL EVALUATION TOOL
ASSESSED QUARTERLY OR WITH CHANGE OF CONDITION

NAME_____ DATE_____

Activities of Daily Living (ADL'S)	Level 1 Ambulate Independent	Level 2 Assist of 1 Aide	Level 3 Assist of 2 Aides	Level 4 Bedfast Nurse Care
Bathing				
Dressing				
Eating				
Toileting				
Ambulation				
Taking Meds				
OTHER CARE				
		Confused Behavior		
			Wound Care	
			Continuous O2	
			Insulin	
			Other Injections	
			Foley Catheter	
			Colostomy	
			Fall Risk/Alarm	
			Inappropriate behavior	

Wandering in Facility/Exit Risk		Level 5

WINDY HILL VILLAGE
FALL ASSESSMENT CHECK LIST

Resident Name: _____

*AGE
50-65_____
66-75_____
76-^_____

*AMBULATORY STATUS
Independent Ambulating_____
Requires Assistance of 1_____
Requires Assistance of 2_____

*MENTAL STATUS
Alert and Oriented____
Confused periodically – MR_____
Confused at all times_____

*DURATION OF STAY _____

*FALL
Within the past 6 months

*ELIMINATION
Independent/Continent_____
Uses catheter, ostomy or both _____

Needs help with elimination_____

*MEDICATIONS
0 _____
2 or more _____
Alcohol _____
Anesthetics _____
Antihypertensive _____
Anti-seizure _____
Anti-diabetics _____
Benzodiazepines _____
Cathartics _____
Diuretics _____
Narcotics _____
Psychotropic _____
Sedative-Hypnotic _____

*VISUALLY IMPAIRED _____

*CONFINED TO CHAIR _____

*ORTHOSTATIC HYPOTENSION_____

Completed By: _____Date:_____

Approved By:_____ Date:_____