LATASHA NAILAH SPEARS WINKFIELD; MARVIN WINKFIELD; SANDRA CHATMAN; and JAHI McMATH, a minor, by and through her Guardian ad Litem, LATASHA NAILAH SPEARS WINKFIELD, Plaintiffs, vs. FREDERICK S. ROSEN, M.D.; UCSF BENIOFF CHILDREN'S HOSPITAL OAKLAND (formerly Children's Hospital & Research Center at Oakland); MILTON McMATH, a nominal defendant, and DOES 1 THROUGH 100, Defendants.

1. Sharleen Bangura, R.N., declare:

1. I am a registered nurse in the State of New Jersey, and in that capacity I have regularly provided nursing care to Jahi McMath in her apartment for the last
three years. I have personal knowledge of the facts stated here, and if called as a witness I could and would testify competently to them.

2. In addition to her parents, Jahi is cared for by nurses who work in three shifts, 24/7. I have been her nurse on the day shift since she was discharged from St. Peter's Medical Center in early 2014.

3. Jahi's nursing care is contemporaneously documented on "Nurse Shift Note & Time Record" forms. The Nurse's Shift Note & Time Record dated 9/9/14 attached as Exhibit 1 documented the following: "Pt. Noted to be on her menstrual cycle as evidenced by a large amount of bright red blood in her diaper."

4. I have observed that Jahi is more alert on some days than she is on other days. On her alert days, if I ask her to squeeze my hand, she does so. If I ask her to move different parts of her body, she will move that part. When I put on meditation music for her to listen to, I watch as her heart rate goes down. Her heart rate increases when she is listening to music that I know she enjoys, like Bobby Brown, who is one of her favorites. Attached to this declaration as Exhibit 2 are true and correct copies of Nurse's Shift Notes & Time Records that I authored between February 18, 2016 and August 7, 2016. In each of these notes, I noted times that I observed Jahi's movements in response to commands from family members.

I declare under penalty of perjury under the laws of the States of New Jersey and California that the foregoing is true and correct.

Executed this 27th day of June, 2017 at Somerset, New Jersey.

[Signature]
Sharleen Bangura, R.N., Declarant
**NURSE'S SHIFT NOTE & TIME RECORD**

**Client's Name:** Janis Newell  
**Client Services Manager:** Lamar Fisher

**DATE** | **DAY (circle day worked)** | **TIME STARTED** | **TIME FINISHED** | **TIME WORKED**
---|---|---|---|---
2/18 | M T W T F Sa Su | 7am | 3pm | 6:00

My signature certifies that I provided service to the client on the date and time listed above, and that the report of client status and care provided are accurate. I understand that I will be paid on the verified time on this time record and that my pay includes compensation for time spent for client care, documentation, and travel between cases. I also agree to the terms on the back of this form.

_Signed: Bhenya Bensama_  
Employee Signature/Title  
_Date_

---

**Temp:** 97  
**Pulse:** 71  
**Resp:** 20  
**O2 Sat:** 98%  
**B/P:** 138/81

- **Mental Status:** Confused  
- **Respiratory Status:** Vent Dependent

- **Skin Integrity:** Warm, Dry, Firm  
- **Nasal Cannula:**  
- **Neurological:** N/A  
- **Seizures**

- **Infection Control:** Standard Precautions  
- **Medication**

**Oxygen:** Continuous  
**ICU/Pron**

- **Urinary Status:** Incontinent

- **Communication needs:** Non-verbal

- **Other:**

**Situation/Lying/Standing**

**Medicaid ID#:**

**Client Signature**  
**(State of PA Only)**

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**Pain Status:** Client reports pain as a problem: Yes  
**Recurrent/New Location:** N/A  
**Exacerbating Factors:**

**Treatment:** Medication  
**Other:**

**If No, intervention/follow-up:**

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**SHIFT NOTES:**

7am: Received report from nighttime RN in bed positioned on her side. Skin warm, dry, intact. Resp 24/min.

12pm: Client is now sitting in bed with assistance. Skilled nurse has been called. Client's daughter is monitoring client's vital signs.

**PROGRESS TOWARD GOALS/OUTCOMES OF THIS SHIFT:**

1. **39m of fluid replacement needed.**
2. **Maintained SAT 98% on RA.**
3. **Irrigated NG tube.**

**HAS A CHANGE IN STATUS OCCURRED THAT REQUIRES REPORTING?**

- **YES**
- **NO**

**COORDINATED WITH/REPORTED TO:**

- **Medication**  
- **DME**  
- **Respiratory Therapist**

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NURSE'S SHIFT NOTE & TIME RECORD

Client's Name: John McMath
Client Services Manager: Lamar Fisher

<table>
<thead>
<tr>
<th>DATE</th>
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<td>10:30 AM</td>
<td>4:00 PM</td>
<td>9 1/2 HRS</td>
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Employee Signature/Title: Drasirgan Bangoa RN 2/17/11

<table>
<thead>
<tr>
<th>Temp</th>
<th>Pulse</th>
<th>Resp</th>
<th>O2 Sat</th>
<th>BIP</th>
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<td>12</td>
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<td>127</td>
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</table>

Mental Status: □ AAO □ Confused □ Disoriented □ Other
Respiratory Status: □ Vent dependent (IVS) □ Other
Trach □ Vent □ CPAP □ Alarms Set □ N/A
Oxygen: □ Continuous □ PRN □ N/A
Cardiac Status: □ HR regular □ Bradycardia □ Tachycardia
Mucous Membrane: □ Pink □ Tan □ Yellow
Skin Integrity: □ Warm □ Cold □ Incontinent
Neurological: □ Absent □ Seizures x

Infection Control: □ Standard Precautions □ Other:

SHIFTS NOTES:
- 8am-12pm Received report from night nurse. John in bed positioned on her back.
- Pt's eyes closed covered with soiled gauze. Shiny, hot; dry; moist; cool, matted. Difficult to suction but not attached to EKG/IV. Suction and humidified nebulizer set and functioning. Bedside monitor on Lash. Abdominal soft on Trendelenburg to full supine._SK_ infusion at 60 cc/hr.
- 12pm-4pm PRN on all extremities. Bed gas flush per NP. Begin clab 4am. No PT recruits
- 4pm-8pm Eye Remedies applied. 9:00 pm CRF to bed.
- 8pm-12am PRN on all extremities. Bed gas flush per RP. Begin clab 4am. No PT recruits
- 12am-4am PRN on all extremities. Bed gas flush per RP. Begin clab 4am. No PT recruits
- 4am-8am PRN on all extremities. Bed gas flush per RP. Begin clab 4am. No PT recruits
- 8am-12pm PRN on all extremities. Bed gas flush per RP. Begin clab 4am. No PT recruits

HAS A CHANGE IN STATUS OCCURRED THAT REQUIRES REPORTING? (Review orders for reporting parameters): □ YES □ NO

Coordinated with/Reported to: O/N/R/Client Serv Mgr/Physician (Addendum completed, if applicable)

HHA Supervision: □ Yes □ No □ N/A
HHA Present: □ Yes □ No □ N/A

Care Plan Update: □ Yes □ No
Client Participated in Care Plan Update: □ Yes □ No
NURSE’S SHIFT NOTE & TIME RECORD

Client’s Name: John McHannah
Client Services Manager: Tamara Fisher

Date: 2/15/16

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<th>TIME</th>
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<tr>
<td>2/15</td>
<td>2/15</td>
<td>10am</td>
<td>11am</td>
<td>1 hour 30 min</td>
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Shelley Sumayra RN 2/15/16

Employee Signature/Title

Temp: 97.7
Pulse: 88
Respiratory Rate/ AP Resp: 12
O2 Sat: 95%
B/P: 126/76
Sitting/Lying/Standing

Mental Status: AAO Confused Disoriented Other
Respiratory Status: Vent dependent
Nasal Trach Vent CPAP Alarms Set
Oxygen: Continuous NPNR N/A
Cardiac Status: N/A Regular
Genitalia
Edema: None
Skin Integrity: Loss of Dry Intact
Musculoskeletal: Pink/Bloody
Nausea/Vomiting: None
Neurological: ADR Seizures
Infection Control: Standard Precautions Other

Equipment checked Back up equipment checked Emergency equipment checked Go Bag checked

Pressure Ulcers: Client reports pain as a problem: Yes No Intensity Level (Circle one) 1 2 3 4 5 6 7 8 9 10

有效或无效: Yes No

Exacerbating Factors: None

Treatment: Medication Rest Other

If no, intervention/follow-up


Progress Toward Goals/Outcomes of This Shift

1) 1900mL of fluid replacement given.
2) Maintained SST 1900 mL. No Trend Change.
3) Interfered feeding. No Personal Care noted.

Has a change in status occurred that requires reporting? [YES/NO] YES

Coordinated with/Reported to: RN IA RN Manager RN Other

2/10
CLINICAL NOTES

Client's Name: Jahi McMath

Week ending Sunday 2/21/16

Time Arrived: __________ Time Left: __________

Temp: __________ Pulse: __________ Resp: __________ B/P: __________ PAIN LEVEL: 0 1 2 3 4 5 6 7 8 9 10

Void 6:00 pm Peri care given, repositioned onto back. Bath & 10s. of feet & hands. Discussed new Peri care plan. 10:00 pm - Meds: Flushing 4 mg. NAP. 6:30 am - PRN 4 on all extremities. 7:00 am - Vent circuits changed. Feeding on back-up vent while circuits changed. Tolerated well NO signs of distress or discomfort.

8:00 am - Meds given PRN NAP. Eye ointment applied. 9:00 am - ABI Vest Kegm. Infused 100 cc's of oral Care. 11:00 am - Diaper Change void. 2 am soft pm Peri Care given. Re-positioned to left side. 11:00 pm - Vas, NAD, SNP Pol Nasal. Trauch as needed. Tolerated all aspects of care. Am noted head to fingers to her mothers Command throughout shift. Report given to Night Nurse.

OUTCOME FOR THIS SHIFT/VISIT (Progress toward goals, including client’s response to pain intervention):

COORDINATED WITH/REPORTED TO: [ ] Physician [ ] Clinical Mgr. [ ] PT [ ] OT [ ] SNP [ ] MSW [ ] RN/LPN [ ] GHNA [ ] Client Serv. Mgr. [ ] N/A

COMMENTS:

PLAN FOR NEXT SHIFT/VISIT: [ ] Continue C.P.C.

CARE PLAN UPDATE: [ ] YES [ ] NO HHA present? [ ] YES [ ] NO
Patient participated in Care Plan Update? [ ] YES [ ] NO HHA SUPERVISION: [ ] YES [ ] NO

Signature/Title: [ ] Date: ___/15/16

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CLINICAL NOTES
**NURSE'S SHIFT NOTE & TIME RECORD**

Client's Name: John Smith

Client Services Manager: Lamar Fisher

<table>
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<th>TIME STARTED</th>
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<td>M W T F Sa Su</td>
<td>7am</td>
<td>8pm</td>
<td>13hrs</td>
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My signature certifies that I received service on the date as listed and that the times and services performed are accurate. I understand that if payment for this service will be from Federal and State funds, any false claims, statements, documents, or concealment of material may be prosecuted under applicable Federal and State laws. I also agree to the terms on the back of this form.

Employee Signature/Title: [Signature] 2/12/16

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**Medical Information**

- **Temp:** 96.5°F
- **Pulse:** 78 BPM
- **Resp:** 12
- **B/P:** 128/78
- **O2 Sat:** 97%
- **BMI:** 23

**Respiratory Status:** Vent dependent

**Sputum:** None

**Mental Status:** Confused

**Nutrition/Diet:** None

**Bowel Status:** Bowel incontinent

**Urinary Status:** Incontinent

**Environment/Safety:** No changes observed

**Blood Pressure:** Stable

**Communication needs:** None

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**Infection Control:** Standard Precautions

**Equipment checked:** Yes

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**Skin Integrity:** Normal, no redness, no infections

**Other:** Other

**Blood pressure:** 128/78

**Sedation:** None

**Seizures:** None

**Medication:** None

**Medication given:** None

**Flushing:** None

**Exacerbating Factors:** None

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**SHIFT NOTES:**

- 7am: Received report from night nurse. Skin was clean and no redness observed. No signs of swelling or bruising.
- 7:30am: Made bed and assessed for any new changes.
- 8am: Meds given: 8am - Antacid, Metoclopramide, and Flaxseed.
- 8:30am: Performed oral care. Meds given: 8am - 2mg Metoclopramide, 8am - Antacid, 8am - Flaxseed.
- 9am: Continued with oral care and hygiene.
- 10am: Performed oral care. Meds given: 9am - 2mg Metoclopramide, 10am - Antacid, 10am - Flaxseed.
- 11am: Performed oral care. Meds given: 10am - 2mg Metoclopramide, 10am - Antacid, 10am - Flaxseed.
- 12pm: Performed oral care. Meds given: 11am - 2mg Metoclopramide, 11am - Antacid, 11am - Flaxseed.

**Progress Toward Goals/Outcomes of This Shift:**

- **1.** Maintained S & O 98% on RA
- **2.** Maintained SAT 99% on RA
- **3.** Induced nausea
- **4.** Personal care needs: None

---

**HAS A CHANGE IN STATUS OCCURRED THAT REQUIRES REPORTING?**

- **YES**
- **NO**

**COORDINATED WITH/REPORTED TO:**

- N/A
- Clin Mgr
- RN/LPN
- Client Svc Mgr
- Physician

---

**HHA Supervision:**

- **YES**
- **NO**
- N/A

**Care Plan Update:**

- **YES**
- **NO**

**HHA Present:**

- **YES**
- **NO**
- N/A

**Client Participated in Care Plan Update:**

- **YES**
- **NO**
Client's Name: John McMath

Week ending Sunday 2/14/16

<table>
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<tr>
<th>Time Arrived:</th>
<th>Time Left:</th>
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</thead>
</table>

Temp: Pulse: Resp: B/P: PAIN LEVEL: 0 1 2 3 4 5 6 7 8 9 10

6pm—Med Flush given Per MD. (10pm—Diaper Change by void (102%))

6pm—Med Flush given Per MD. (11pm—Diaper Change by void (100%))

Med Soft Pen Peri care given. Repositioned onto back. All foot rests on feet. Trent care provided. 745 Evening meds given Per MD. Eye

Ointment applied. 8pm—Visited by son and needed 1 non-med fingers. Head to her mother commands. I tolerated all aspects of care. Report given to mom.

OUTCOME FOR THIS SHIFT/VISIT (Progress toward goals, including client's response to pain intervention):

COORDINATED WITH/REPORTED TO:  
- Physician  
- Clinical Mgr.  
- PT  
- OT  
- SP  
- MSW  
- RN/LPN  
- HHA  
- Client Serv. Mgr.  
- N/A

COMMENTS:

PLAN FOR NEXT SHIFT/VISIT:

CARE PLAN UPDATE:  
- YES  
- NO  
- HHA presen.?  
- YES  
- NO  
- HHA SUPERVISION:  
- YES  
- NO

Signature/Title: Shalene Bangura RN

Date: 2/12/16

CLINICAL NOTES

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NURSE'S SHIFT NOTE & TIME RECORD

Client's Name: John Smith

Client Services Manager: Lamar Fisher

DATE: 3/23

TIME

STARTED

FINISHED

WORKED

M T W Th F Sa Su

12:30

4:30

9 1/2 hrs

Temp: 97.1

Pulse: 75

Resp: 12

Mental Status: □ AAO □ Confused □ Disoriented □ Other

Nutrition/Diet: No solid food/liquid and insensible

Respiratory Status: Vent dependent (4 hrs)

Bowel Status: Incontinent (03许)

Trach □ Vent □ CPAP □ A alarms Set □ N/A

Urinary Status: Incontinent

Oxygen: □ Continuous □ PRN □ N/A

Environment/Safety: Sitting, Hoist, Dolphin Bed

Cardiac Status: No Regular Stop Brisk

Communication needs: Non-Verbal

Edema: None

Infection Control: □ Standard Precautions □ Other: Other: OA/Influenza/Antibiotic

Skin Integrity: Warm, Dry intact

No Equipment checked □ Back up equipment checked

Neurological: ABN □ Seizures x □ NIA

Emergency equipment checked □ Go Bag checked

Pain Status: Client reports pain as a problem: □ Yes □ No

Exacerbating Factors: N/A

Intensity Level (Circle one): 0 1 2 3 4 5 6 7 8 9 10

□ Recurrent □ New (location): N/A

□ Other N/A

Treatment: □ Medication □ Rest □ Other N/A

Effective □ Yes □ No

If no, intervention/follow-up N/A

SHIFT NOTES:

(8) Report received from night nurse, John is indeed lying on her back, eyes closed, Airway 4/0 Trach Patent, intact, suctioned 1/1, iv iso vent vent setting verified, continuous pulse ox monitoring in place, none on. Middle finger Alarms set functioning, auditory response at level 2. Rig between CTA. 2/11 Feeds 12pm, Attent & Intact, Intake 820mLs, Infus HES 3% NS, Q4H, NS 0.9% as ordered. 12pm-3pm Bed bath, VH/R.

(9) HOV intake NS 0.9% as ordered. 12pm-3pm Bed Bath, VH/R.

(10) HOV intake NS 0.9% as ordered. 12pm-3pm Bed Bath, VH/R.

(11) HOV intake NS 0.9% as ordered. 12pm-3pm Bed Bath, VH/R.

(12) HOV intake NS 0.9% as ordered. 12pm-3pm Bed Bath, VH/R.

(13) HOV intake NS 0.9% as ordered. 12pm-3pm Bed Bath, VH/R.

(14) HOV intake NS 0.9% as ordered. 12pm-3pm Bed Bath, VH/R.

(15) HOV intake NS 0.9% as ordered. 12pm-3pm Bed Bath, VH/R.

PROGRESS TOWARD GOALS/OUTCOMES OF THIS SHIFT:

1. Maintained IV.
2. Maintained SAT 99-01% on RA.
3. Tolerated feeding (4) Personal care needs met.
4. All safety precautions maintained, no injury.

HAS A CHANGE IN STATUS OCCURRED THAT REQUIRES REPORTING? (Review orders for reporting parameters) □ Yes □ No

COORDINATED WITH/REPORTED TO:

□ N/A □ Clin Mgr □ RN/LPN □ Client Svcs Mgr □ Physician (Addendum completed, if applicable)

□ DME □ Respiratory Therapist □ Other:

HHA Supervision: □ Yes □ No □ N/A

HHA Present: □ Yes □ No □ N/A

Care Plan Update: □ Yes □ No

Client Participated in Care Plan Update: □ Yes □ No

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NURSE'S SHIFT NOTE & TIME RECORD

Client's Name: JOHN McCARTHY
Client Services Manager: LOMAR FISHER

Client #: 619-27
Week Ending Sunday: 3/20/11
Bayada Home Health Care

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Employee Signature/Title: ANNELESE SCARR Date: 3/21/11

Temp: 99.6 Pulse: 75 BP/ AP Resp: 16 O2 Sat: 98 B/P: 121/81 Sitting LV (State of PA Only)

Medicaid ID: CLIENTS Signature

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<td>3/14</td>
<td>W Th F Sa Su</td>
<td>4am 11pm</td>
<td>7am 11pm</td>
<td>7 hrs</td>
</tr>
</tbody>
</table>

Respiratory Status: Vent dependent (Windsor)

Respiratory Status: Incontinent

Skin Integrity: None

Mucous Membrane: Oral intact

Nasal Intubation: None

NA

Urinary Status: Incontinent

Environment/Safety: Shirred, Hair Clipper, Hand Washes, Hand Rubs

Communication needs: Verbal

Edema: None

Infection Control: Standard Precautions

Respiratory Status: Incontinent

Pain Status: Client reports pain as a problem: Yes No Intensity Level (Circle one) 0 1 2 3 4 5 6 7 8 9 10

If no, intervention/follow-up NA

SHIFT NOTES: 4:00PM - Reassess report from day nurse. Jim in bed position on the right side. Eyes closed, covered. ZNS soaked gauze. Resp unimproved. 130pm wings CTA, double HOXT. Trach intact, intact tubing. Cuff inflated & secured by stretchers & attached to the LVJUS. Vent humidified in room. Vent setting as ordered. 6:12pm. People. T-12518 for RA. Continuous pulse ox monitoring in place.

Alarms set & functioning auditory & T-12517. Pedi caring. Intact. Data intact. Infusing 4ccmin. Abd hoses soft-tender. 6pm - Meds given per PRF. GCS 9. 6pm - Diaper change, need only pam peri care given. Repositioned onto left side. 7pm: 1pm on all extremities. 8pm Oral care. Meds given per PRF. GCS 9. 9pm - Feeding required. 9pm - AFS. West X-rays. 10pm - Diaper change, need only pam peri care given. Trach care.

Repositioned to left side. 11pm - USS. VAD, Sin, Avacol, Trach as needed. Jim tolerated all aspects of care. Jim moved head & left fingers.

Has a change in status occurred that requires reporting? (Review orders for reporting parameters) Yes No

PROGRESS TOWARD GOALS/OUTCOMES OF THIS SHIFT:

I maintained S & O with T & O from

2. Maintained SATURATION on RA to mother's command.

3. Isolated feeding to right nurse.

4. Personal care necessary.

HHA Supervision: Yes No N/A

HHA Present: Yes No N/A

Care Plan Update: Yes No

Client Participated in Care Plan Update: Yes No

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# Nurse's Shift Note & Time Record

## Client's Name: John McCarthy

### Client Services Manager: Lorraine Fisher

<table>
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<tr>
<th>DATE</th>
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<th>TIME STARTED</th>
<th>TIME FINISHED</th>
<th>TIME WORKED</th>
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<td>7am</td>
<td>8pm</td>
<td>13hrs</td>
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### Employee Signature/Title: [Signature] Date: 31/1/11

- **Temp:** 99°F
- **Pulse:** 76 bpm
- **Resp.:** 20/min
- **Nutrition/Diet:** NPO, Senility, Call 40m/Ltr
- **Bowel Status:** Incontinent
- **Urinary Status:** Incontinent
- **Environment/Safety:** SBX, ESL, Hose, Impress
- **Communication Needs:** N/A
- **Infection Control:** Standard Precautions
- **Other:** None
- **Equipment checked**
- **Back up equipment checked**
- **Emergency equipment checked**
- **Go Bag checked**

### Shift Notes:
- 7am: Received report from night nurse. John in bed positioned on her back, eyes closed, general appearance normal. Slimy 4-hp, T 99.4°F, intact T attached to the IVU. SO2 Vent, Humidifier, bed at 30°. Continuous pulse oximetry in place, alarms set. Functioning auditory #20. Antiseptic intact. Senility, Call 40m/Ltr, NPO. Abdominal soft, flat non-tender.
- 7am: Meds given as per N/A, Aramine N/A. Ate, O2 continuous applied. 7am: Neds given
- Oral Care given. 978/19amin, 10% Diaper change, no daily change, non-contaminated. 7pm: Meds given: Pain, 10mg phenformin, 1/4 mg diazepam. 10 pm: Diaper change.
- 2pm: Meds given: Phenformin, 2/3 mg. Diaper change, 1/4 mg diazepam.
- 7pm: Nasal care given, positioned to right side, 7pm: UOG, Sunpatch, Lumbar, arm, left side. 7pm: UOG, Sunpatch, Lumbar, positioning to right side, 7pm: UOG, Sunpatch, Lumbar, positioning to right side.

### Progress Toward Goals/Outcomes of this Shift:
- 1) Maintained 3 to 4 Drip.
- 2) Maintained S/S x 2.
- 3) Inflatorched feeding.
- 4) Personal care needs met.
- 5) All Safety Precautions maintained, no injury.

### Notes:
- Fingers (D) hand to man's command.
- Care Plan Update: Yes
- Client Participated in Care Plan Update: Yes

### Signature:
- Signature: [Signature]
- Date: 31/1/11

---

**Client Signature:** (State of PA Only)

**MVCDAID ID:** [ID]

---

**HHA Supervision:** [Signature]

**HHA Present:** [Signature]

**Care Plan Update:** Yes

**Client Participated in Care Plan Update:** Yes
NURSE'S SHIFT NOTE & TIME RECORD

Client's Name: John Smith
Client Services Manager: Karen Fisher

Date: 24

<table>
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<th>TIME FINISHED</th>
<th>TIME WORKED</th>
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<tbody>
<tr>
<td>M T W Th F Sa Su</td>
<td>7am</td>
<td>11pm</td>
<td>4hr 43min</td>
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Employee Signature/Title: [Signature] Date: 3/10/11

Temp: 97
Pulse: 81
RBP: 02 Sat.
BP: 124/81
Sitting (lying) Standing

Mental Status: Normal
Respiratory Status: Normal

Sitting (lying) Stagnant
Urinary Status: Normal

Skin Integrity: Normal
Mucous Membranes: No
Pain Status: Client reports no pain.

No Medication
No Rest
Other: N/A

Exacerbating Factors: N/A

Effective: Yes
No

SHIFT NOTES:

All eyes closed; Toward: Nasal Cannula: No
Mucus Membrane: Pinkish
Resp: Unalarmed
Fahrenheit: 84
Tongue: Clean

Meds given: Per Plan
Nasal Cannula: Yes
Mattress: Bedrest
Pullout: None

Discharge: Yes

Progress Toward Goals/Outcomes of This Shift:

1. Maintained on O2 at 3L/min
2. Maintained SAT 100%
3. Tolerated feeding
4. Personal care needs met.
5. All Safety Precautions Maintained

HHA Supervision: Yes
HHA Present: Yes

Care Plan Update: Yes
Client Participated in Care Plan Update: Yes

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OFFICE

NURSE'S SHIFT NOTE & TIME RECORD
**CLINICAL NOTES**

- Occupational Therapy
- Physical Therapy
- Speech Therapy
- Medical Social Services
- Nursing
- Other

**Client's Name:** Jodi Melanath

**Client #:** [Redacted]

**Date:** 3/14/16

**Week ending Sunday 3/13/16**

<table>
<thead>
<tr>
<th>Time Arrived:</th>
<th>Time Left:</th>
</tr>
</thead>
</table>

**Temp:**

**Pulse:**

**Resp:**

**B/P:**

**PAIN LEVEL:** 0 1 2 3 4 5 6 7 8 9 10

- 4pm: Eye ointment applied. 4pm:Medsk Flush given per MAR. 6:30pm: Diaper change void. 7am: Soft en Peri Care given. Traan Care provided.
- Repositioned on back. All Proct. knots confirmed. 7am: Pressure on all extremities.
- 8am: Meds given per MAR. Eye ointment applied. 9am: Ass. Vest Xhanging.
- 10am: Oral Care. Diaper change void. Only 8am Peri Care given. Repositioned to back side. 11pm: VSS, NA, no pain.
- Traan as needed. Jour to write all aspects of care. Jim moved fingers on both hands to mother's commands. Report given to night nurse.

---

**OUTCOME FOR THIS SHIFT/VISIT (Progress toward goals, including client's response to pain intervention):**

---

**COORDINATED WITH/REPORTED TO:**

- Physician
- Clinical Mgr.
- PT
- OT
- SP
- MSW
- RN/LPN
- HHA
- Client Serv. Mgr.
- N/A

**COMMENTS:**

---

**PLAN FOR NEXT SHIFT/VISIT:**

- Continue T.P.O.C.

**CARE PLAN UPDATE:**

- Question: QYES
- No: QNO

- HHA present? QYES
- QNO

- HHA SUPERVISION:

**Signature/Title:** Shalom Bengna RN

**Date:** 3/14/16

---

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NURSE'S SHIFT NOTE & TIME RECORD

Client's Name: John McMath
Client Services Manager: Diana Hengen

DATE: 4/21
DAY (circle day worked): M
TIME STARTED: 7am
TIME FINISHED: 3pm
TIME WORKED: 8 hrs

My signature certifies that I received service on the date as listed and that the times and services performed are accurate. I understand that all payment for this service will be from Federal and State funds, and that no false claims, statements, or concealment of material may be prosecuted under applicable Federal and State laws. I also agree to the terms on the back of this form.

Employee Signature/Title: [Signature]
Date: [Date]

TEMP: 98
PULSE: 80
RESPIRATORY Rate: 20
RESP: 2
O2 Sat: 100%
B/P: 124/79
SITTING

Nutrition/Diet: NPO
Seizures: 1 Call 911

Bowel Status: Incontinent (as needed)
Urinary Status: YIED, Incontinence

Environment/Safety: Patient in bed
All Procedural Needs: [N/A]

Communication needs: Non-Verbal
Infection Control: Standard Precautions

Edema: None
Skin Integrity: Dry, intact
successfully maintained

Neurological: APOn

Pain Status: Client reports pain as a problem: [ ] Yes [ ] No
Exacerbating Factors: [N/A]

Other: [ ] Recumbent
Treatment: [ ] Medication
Rest [ ] Other [N/A]

If, no intervention/follow-up [ ]

SHIFT NOTES:
7am: Reassessed report from night nurse, John was Braden level 2 on his back.
By eye plans general appearance normal. BP, PRR, and R notes as per track paper.
Upon arrival, visualized humidifier in room, setup verified, continuous pulse ox monitoring in base, alarms set, functioning as desired.
He was on1000 mL stock solution 8mg uvr injectable. 8mg @ 4 am, at 10 am.
20 mg phenobarbital IV over 1 minute. 10 mg Red 600, red 600, white 500.
20 mg Mg Start. Track Care. Assessed, groomed, positioned to left side. 20 mg of insulin given per NNA.
Eye ointment applied. 9am corn care notes. Given flush. 9 pm. ASI noted X stable.
10 pm PRN x ketonomic. 10 mg Red 600, red 600, white 500.

PROGRESS TOWARD GOALS/OUTCOMES OF THIS SHIFT:
[ ] Maintained I & D, [ ] 600 mg
[ ] Maintained STAT 600 P.M.
[ ] Prevented Feeding: [ ] Personal Care needs met.
[ ] All Safety precautions maintained NO injury.

HAS A CHANGE IN STATUS OCCURRED THAT REQUIRES REPORTING? \[ ] Yes [ ] No
COORDINATED WITH/REPORTED TO: [ ] Clin Mgr [ ] RN/LPN [ ] Client Svc Mgr [ ] Physician (Addendum completed if applicable)
[ ] DME [ ] Respiratory Therapist [ ] Other:

302
NURSE'S SHIFT NOTE & TIME RECORD

Client's Name:  
Client Services Manager:  
Client #: 6/21
Week Ending Sunday: 4/10/16
Month/Day/Year

My signature certifies that I provided service to the client on the date and time listed above, and that the report of client status and care provided are accurate. I understand that I will be paid on the verified time on this time record and that my pay includes compensation for time spent for client care, documentation, and travel between cases. I also agree to the terms on the back of this form.

Employee Signature/Title:  
MEDICAID ID#:  
Client Signature:  
(State of PA Only)

Temp: 97.3  Pulse: 80  RP / AP  Resp: 17
O2 Sat: 100% B/P: 149/98  Sitting / Lying / Standing

Mental Status:  
Respiratory Status: Ventilator Dependent
Respiratory Equipment: Vent, CPAP
Oxygen: Continuous PRN N/A
Cardiac Status: Atrial Fibrillation
Edema: None
Cardiovascular medications: Pink sheet
CNS medications: None
Neurological: ABC x Seizures

Pain Status: Client reports pain as a problem: Yes No
Intensity Level (Circle one): 0 1 2 3 4 5 6 7 8 9 10

Recurrent New (location): No N/A
Exacerbating Factors: N/A
Treatment: Medication Rest Other N/A
Effective Yes No
Jennifer Bongara RN 4/14/16
If no, intervention/follow-up N/A

SHIFT NOTES: 4pm - Received report from Day nurse. Jim in bed positioned on his right side, eyes closed covered. IV in left hand. GA 70 HcG18. BMI 34.5. ABG's checked at 4pm, hgb 10.5, hct 36, pla 218, pot 3.8, cal 8, k 4.1, bic 22, paco2 34, hco3 17, ph 7.41, base 0.8. 4pm ADT Tach, Brad, BP 149/98, JVP 4.5, S & R 110/60, Sats 92, Temperature 98.6. 6pm RN gave 42 ml of Morphine. 7pm RN report patient having difficulty sleeping, patient is 225. 8pm RN report patient is 225. 8pm - RN report patient is having trouble sleeping. 9pm RN report patient is having trouble sleeping. 10pm RN report patient is having trouble sleeping. 11pm RN report patient is having trouble sleeping.

PROGRESS TOWARD GOALS/OUTCOMES OF THIS SHIFT:

1. Maintained T x0.4°C x O. S. x x x x
2. Maintained B/P 149/98
3. Throated feeding
4. Personal care mat
5. All safety precautions maintained NO injury

HAS A CHANGE IN STATUS OCCURRED THAT REQUIRES REPORTING?  (Review orders for reporting parameters)  

COORDINATED WITH/REPORTED TO:

Client: 6/19/21

BAYADA® Home Health Care
**CLINICAL NOTES**

Client's Name: John McMath  
Client #: 619-27

<table>
<thead>
<tr>
<th>Week ending Sunday</th>
<th>5/15/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time Arrived:</td>
<td>Time Left:</td>
</tr>
<tr>
<td>PAIN LEVEL:</td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
</tr>
</tbody>
</table>

4:30pm Clindamycin 150mg started for track infection. No adverse reactions. 4:30pm Meds given per NA. 6:00pm Diaper Change. 6:40pm q4h perineal care given. Repositioned onto left side. All Atlo Vesicants on feet. 7pm 90% O2 on all extremities. 8pm Meds given per NA. Eye ointment applied. 9pm ABD vest x30min. 10:30pm Diaper Change. 2:00am q4h perineal care given. Repositioned to left side. 11pm VNS, NAD. Sun pahnagai. Track as needed. Tolerated all aspects of care. Minor head’s fingers and hands when asked. Report given to night nurse.

OUTCOME FOR THIS SHIFT/VISIT (Progress toward goals, including client’s response to pain intervention):

COORDINATED WITH/REPORTED TO: [ ] Physician [ ] Clinical Mgr. [ ] PT [ ] OT [ ] OT [ ] MSW [ ] RN/LPN [ ] HHA [ ] Client Serv. Mgrs. [ ] N/A

COMMENTS:

PLAN FOR NEXT SHIFT/VISIT:

CARE PLAN UPDATE: QYES QNO  
HHA present? QYES QNO  
Patient participated in Care Plan Update? QYES QNO  
HHA SUPERVISION: QYES QNO

Signature/Title: [Signature]
Date: 5/13/16

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NURSE’S SHIFT NOTE & TIME RECORD

Client’s Name: Jilian McIntosh
Client Services Manager: Diana Moncayo

<table>
<thead>
<tr>
<th>DATE</th>
<th>DAY (circle day worked)</th>
<th>TIME STARTED</th>
<th>TIME FINISHED</th>
<th>TIME WORKED</th>
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</thead>
<tbody>
<tr>
<td>5/20</td>
<td>M T W Th F Sa Su</td>
<td>7am</td>
<td>3pm</td>
<td>8HRS</td>
</tr>
</tbody>
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My signature certifies that I provided service to the client on the date and time listed above, and that the report of client status and care provided are accurate. I understand that I will be paid on the verified time on this time record and that my pay includes compensation for time spent for client care, documentation, and travel between cases. I also agree to the terms on the back of this form.

[Signature]
Employee Signature/Title

Temp: 98
Pulse: 91
BP/PR: 110/70
Respirations: 12

Mental Status: AAO
Confused
Disoriented
Other

Respiratory Status: Vent Dependent
Trach
Vent
COPD
Adams Set
N/A

Urinary Status: Incontinent
Strict Bed

Environment/Safety: Safe

Communication needs: None

Infection Control: Standard Precautions
Other:

Neurological: Seizures

Pain Status: Client reports pain as a problem: Yes

Exacerbating Factors: N/A

SHIFT NOTES: I am receiving report from Night Nurse. Jim in bed positioned on his back, eyes closed. General appearance normal. All fluid intake and output noted. Trach tube in, suctioned. Bed adjusted for high head. Vent settings verified. Continuous pulse ox monitoring in place. Alarms set. Functioning. Time: 1:00 PM. Bedside washout 1:00 PM. Bedside washout. 8:00 AM oral care, had good dentition. 8:30 PM ABG obtained. Girths checked: 36" x 36". 9:00 PM NPH prescribed. 9:30 PM NPH given. 9:45 PM Diaper change and 8 PM Peri given.

HHA Supervision: Yes
HHA Present: Yes

Care Plan Update: Yes
Client Participated in Care Plan Update: Yes

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Client #: 6019-27
Week Ending: 5/22/21
Month/Day/Year

My signature certifies that I received service on the date as listed and that the times and services performed are accurate. I understand that if payment for this service will be from Federal and State funds, any false claims, statements, documents or concealment of material may be prosecuted under applicable Federal and State laws. I also agree to the terms on the back of this form.

[Signature]
Employee Signature/Title

Medicaid ID: [State of PA Only]

Care Plan Update: Yes
HHA Supervision: Yes
HHA Present: Yes
Client Participated in Care Plan Update: Yes
**NURSE'S SHIFT NOTE & TIME RECORD**

**Client's Name:** John McNaught

**Client Services Manager:** Diana Marquez

**DATE** | **DAY (circle day worked)** | **TIME STARTED** | **TIME FINISHED** | **TIME WORKED**
---|---|---|---|---
02/15 | M T W Th F Sa Su | Co 8am | 3pm | 8 1/2 hrs

My signature certifies that I provided service on the client on the date and time listed above, and that the report of client status and care provided are accurate. I understand that I will be paid on the verified time on this time record and that my pay includes compensation for time spent by client care, documentation, and travel between cases. I also agree to the terms on the back of this form.

**Employee Signature/Title:**

---

---|---|---|---|---|---|---|---|---|---|---|---|---|

**Mental Status:** 
- AAO
- Confused
- Disoriented
- Other

**Respiratory Status:** 
- Vent dependent (Continuous) 
- CPAP
- No alarms Set
- N/A

**Oxygen:** 
- Continuous 
- NIPR
- N/A

**Cardiac Status:** 
- HR Regular 
- BP Refill within

**Edema:** 
- None

**Skin Integrity:** 
- Warm, Dry, intact
- Moist
- Other

**Neurological:** 
- AEE
- Seizure x
- Other

**Pain Status:** Client reports pain as a problem: 
- Yes
- No

**Intensity Level (Circle one):** 
- 0 1 2 3 4 5 6 7 8 9 10

**Exacerbating Factors:** NA

**Treatment:** 
- Medication
- Rest
- Other

**Effective** 
- Yes
- No

**If no, Intervention/ follow-up NA**

---

**SHIFT NOTES:**

**03/27** Client asked to right nurse. Client in bed positioned on her left side. Client problems collect. Activity from patient intact & alert to the environment. Client hemodynamically stable. Vent settings verified. Continuous pulse ox monitoring in place. All alarms set. Functioning auditory, visual alarms CT.

- 11pm: 
  - Prescribed admitted medication, Patient intake & output recorded. Bedside pulse ox monitoring in place. All alarms set. Functioning auditory, visual alarms CT.

- 03/28:
  - Bed position adjusted. Client repositioned to right side. Bedside pulse ox monitoring in place. All alarms set. Functioning auditory, visual alarms CT.

- 03/29:
  - Client repositioned to left side. Bedside pulse ox monitoring in place. All alarms set. Functioning auditory, visual alarms CT.

**HAS A CHANGE IN STATUS OCCURRED THAT REQUIRES REPORTING?** (Review orders for reporting parameters) 
- Yes
- No

**PROGRESS TOWARD GOALS/OUTCOMES OF THIS SHIFT:**

1. **Maintained T 3.0°C** & BP 192/98 on RA
2. **Intermittent feeding.**
3. **Personal care 
   - PPD negative**
4. **No injury**
NURSE'S SHIFT NOTE & TIME RECORD

Client's Name: Joni McDade
Client Services Manager: Diana Marcayo

DATE | DAY (circle day worked) | TIME STARTED | TIME FINISHED | TIME WORKED
--- | --- | --- | --- | ---
5/28 | M T W Th F S Sa Su | 7am | 3pm | 8hrs

My signature certifies that I provided service to the client on the date and time listed above, and that the report of client status and care provided are accurate. I understand that I will be paid on the verified time on this time record and that my pay includes compensation for time spent for client care, documentation, and travel between cases. I also agree to the terms on the back of this form.

Employee Signature/Ttitle: [Signature]
Date: 5/28/11

- Temp: 98.4
- Pulse: 77 RP/AP
- Resp: 2
- O2 Sat: 99%, BIP: 10
- Sitting
- Lying
- Standing

Nutrition/Diet: NPO
Bowel Status: Incapable
Urinary Status: Incontinent

Environment/Safety: 68°, No Drapes
Bed: Raised

Communication needs: None

Infection Control: Standard Precautions
Other:

Skin Integrity: Intact

Sensory
- Vision
- Hearing
- Taste
- Touch

Musculoskeletal
- Asymmetrical
- Symmetrical

Neurological
- Absent
- Seizures

- N/A

Pain Status: Client reports pain as a problem: Yes
- Recurrent
- New Location

Intensities Level (Circle one)
1 2 3 4 5 6 7 8 9 10

Treatment: Medication
- Rest
- Other

Exacerbating Factors: N/A

If no, intervention/follow-up

SHIFT NOTES:

2. Performed various tasks: Fingertip pulse, 1L O2, Face mask setting, Ventilator, Continuous pulse ox monitoring in place. Alarms set: Hypoxia.


/AIDS

Progress Toward Goals/Outcomes of This Shift:
1. Maintained I/F: 3.0/4.0. I/F: 3.0/4.0. Monitored all aspects of I/F. Reported to RN.
2. Maintained ABG: 73/29 on RA. Given to RN.
3. Interacted with patient. (1) No injury.

Has a Change in Status Occurred That Requires Reporting? (Review order for reporting parameters)

Coordinated With/Reported To:
- N/A
- Colm Mgr
- RN/LPN
- Client Svcs Mgr
- Physician (Addendum completed, if applicable)
- DME
- Respiratory Therapist

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2104-551-370
CLINICAL NOTES

Client's Name: Jobi Helaft

Month Day Year Mon Tue Wed Thu Fri Sat Sun

Week ending Sunday 6/15/16

Time Arrived: Time Left: ________________

Temp: Pulse: Resp: B/P: PAIN LEVEL: 0 1 2 3 4 5 6 7 8 9 10

6:30pm- Diaper change void=434ml 080m peri care given. Repositioned onto back. All pressure points on feet. 120m Phen on all extremities. 8pm- Oral care. Hands given per NAH eye ointment applied. 9pm- Abscess x-rays. 10pm Diaper change void=326ml Npd 5
cm. 11pm peri care given. Repositioned to right side. 11pm VSS, NAH. 8am phone call as needed. Jm tolerated all aspects of care. Jm moved head + hands left + right to Grandmother request. Report given to RN + night nurse.

OUTCOME FOR THIS SHIFT/VISIT (Progress toward goals, including client's response to pain intervention):

COORDINATED WITH/REPORTED TO: ☐ Physician ☐ Clinical Mgr. ☐ PT ☐ OT ☐ SP ☐ MSW ☐ RN/LPN/ ☐ HHA ☐ Client Serv. Mgr. ☐ N/A

COMMENTS:

PLAN FOR NEXT SHIFT/VISIT: Continue C.P.A.

CARE PLAN UPDATE: ☐ YES ☐ NO
Patient participated in Care Plan Update? ☐ YES ☐ NO

Signature/Title: Shaloo Benjuya RN

Date: 5/30/16

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**NURSE'S SHIFT NOTE & TIME RECORD**

**Client's Name:** Shabara Arnous

**Client Services Manager:** Diana Monroyo

**DATE** | **DAY (circle day worked)** | **TIME STARTED** | **TIME FINISHED** | **TIME WORKED**
---|---|---|---|---
143 | M T W Th F | 7am | 8pm | 8HRs

My signature certifies that I provided service to the client on the date and times listed above, and that the report of client status and care provided are accurate. I understand that I will be paid on the verified time on this time record and that my pay includes compensation for time spent for client care, documentation, and travel between cases. I also agree to the terms on the back of this form.

**Employee Signature/Title:** Shabara Arnous RN 143

**Temp:** 98.1°

**Pulse:** 89

**RP / AP:** Resp: 12

**O2 Sat:** 98

**B/P:** 120/79 Sitting (Lying) Standing

**Mental Status:** Confused

**Disoriented**

**Other**

**Respiratory Status:** Vent dependent

**Ventilator Set**

**CPAP**

**Alarms Set**

**N/A**

**Oxygen:** Continuous

**PRN**

**N/A**

**Nasal Cannula**

**N/A**

**Cardiac Status:** HA Regular

**Cap: 92**

**Blood Pressure:** 120/79

**Edema:** None

**Skin Integrity:** Warm, Dry, intact

**Macromunomous, pink & moist**

**Infection Control:** Standard Precautions

**Other:** Other

**Neurological:** Seizures x

**Other:** Other

**Pain Status:** Client reports pain as a problem:

- Yes
- No

**Intensity Level (Circle one):** 0 1 2 3 4 5 6 7 8 9 10

- Recurrent
- New (location) N/A

**Exacerbating Factors:** N/A

**Treatment:**

- Medication
- Rest
- Other

**If no, Intervention/Follow-up:** N/A

**SHIFT NOTES:** Received report from night nurse Janice placed positioned on the right side, eyes closed, O2 rate 25%, head lifted, vent sitting verified, continuous pulse, O2 saturation verified, household setting verified.

- Meds given per chart, eye ointment applied.
- 9am Meds given, 10am O2 rate xdoming 100% bed sitting, 2pm Meds given, 3pm "seated site murmur site pink & dry"

- Traan cor, dressed & seated, repositioned onto back, 12pm meds censored

- 3pm cal

- 4pm Meds: 2pm Meds given per chart, eye ointment applied, 2pm Meds given, 3pm "hearing from x4 extremities, 3/4" bDiaper change, 5pm Meds given, 6pm per cange given, repositioned to left side, 9pm USS, NAP, 10pm cal

**PROGRESS TOWARD GOALS/OUTCOMES OF THIS SHIFT:**

- Maintained I & O (+6oz)

- Report of care, report given to evening nurse

- Personal care meet: No

**HAS A CHANGE IN STATUS OCCURRED THAT REQUIRES REPORTING?**

- Review orders for reporting parameters:
  - Yes
  - No

**COORDINATED WITH/REPORTED TO:**

- N/A
- Clin Mgr
- RN/LPN
- Client Svc Mgr
- Physician

**Additional Notes:**

**HHA Supervision:**

- Yes
- No
- N/A

**HHA Present:**

- Yes
- No
- N/A

**Care Plan Update:**

- Yes
- No

**Client Participated in Care Plan Update:**

- Yes
- No

---

**BAYADA Home Health Care**

**Client #: 9999-87**

**Week Ending Sunday:** 11/15/11

**Month Day Year:** 11/15/11

**Client Signature:**

**MEDICAID ID:**

**State of PA Only:**

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**377**

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Client's Name: Jani McMath

Week ending Sunday 6/5/16

Time Arrived:

Time Left:

Temp: Pulse: Resp: B/P: PAIN LEVEL: 0 1 2 3 4 5 6 7 8 9 10

6:30pm - Diaper Change. Void=31oz. 6:35pm Peri Care given. Repositioned onto back. Blood pressure on feet. 7pm - PROM on all extremities. 9pm - Meds given per N/A. Eye Avritional applied. Oral care. 9pm ABG.


OUTCOME FOR THIS SHIFT/ VISIT (Progress toward goals, including client's response to pain intervention):

COORDINATED WITH/REPORTED TO: Physician Clinical Mgs. PT OT SP MSW RN/LPN HHA Client Serv. Mgs. N/A

COMMENTS:

PLAN FOR NEXT SHIFT/ VISIT: Continue C.R.O.C.

CARE PLAN UPDATE: YES NO
Patient participated in Care Plan Update? YES NO

HHA present? YES NO
HHA SUPERVISION: YES NO

Signature/Title: Sharron Benjamin, RN

Date: 6/4/16

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NURSE'S SHIFT NOTE & TIME RECORD

Client's Name: 
Client Services Manager: Diana Moncayo

DATE: 6/21/2016
TIME: 7am 3pm 8:15

Temp: 97.7
Pulse: 81
Resp: 2
O2 Sat: 97%
B/P: 83/42
Alarm: None

Mental Status: Alert and oriented x 5
Respiratory Status: Ventilated
Nasal Trach, CPAP
Oxygen Status: Continuous
O2 Sat: 97%

Cardiac Status: Regular
Blood Pressure: 83/42
Heart Rate: 83

Skin Integrity: None
Mucous Membranes: Pink
Temperature: 97.7

Neurological: Alert
Seizures: None

Sleep: 8 hours

Treatment: None

Exacerbating Factors: None

Client Signature: 
Client Signature: 
(Medicaid ID: )
(State of PA Only)

Employee Signature/Title: 

- Vent: Ventilator
- CPAP: Continuous Positive Airway Pressure
- Oxygen: Continuous Oxygen
- NPO: Nothing by Mouth
- Regular: Regular
- BP: Blood Pressure
- HR: Heart Rate
- SBP: Systolic Blood Pressure
- DBP: Diastolic Blood Pressure
- O2 Sat: Oxygen Saturation
- B/P: Blood Pressure
- Resp: Respirations

Client Notes:

SHIFT NOTES:

10:30am - Received report from night nurse. Jim is in bed, positioned on his back. 5000 ml of intravenous fluids are in place. Jim is oriented, alert, and talking. He has a history of chronic obstructive pulmonary disease (COPD). He is receiving oxygen via nasal cannula at 4 liters per minute. He has a history of diabetes mellitus Type 2.

Medications:

- Ativan 0.5 mg IM
- Ibuprofen 800 mg PO
- Metformin 500 mg PO
- Omeprazole 20 mg PO

5:00pm - Wet to dry dressing applied to right hand. 100 ml of saline was given PO. Diaper was changed. Jim was placed in a left side position. He was given 100 ml of saline. He was then placed in a left side position

Mood: Calm

Nutritional: Intake of 3000 ml of fluids.

Progress Toward Goals/Outcomes of This Shift:

1. Maintained AT 100% on ABG
2. Maintained AT 99% on O2
3. Tolerated feeding
4. Personal care met
5. No Injury

Additional Observations:

- SVO2: 98%
- Pulse: 81
- Respiration: 12
- O2 Sat: 98%

Medication Administration:

- Ativan 0.5 mg IM
- Ibuprofen 800 mg PO
- Metformin 500 mg PO
- Omeprazole 20 mg PO

HHA Supervision: 
HHA Present: 

Care Plan Update: 
Client Participated in Care Plan Update: 

390
Client's Name: John McMath

<table>
<thead>
<tr>
<th>Time Arrived:</th>
<th>Time Left:</th>
</tr>
</thead>
</table>

Temp: Pulse: Resp: B/P: PAIN LEVEL: 0 1 2 3 4 5 6 7 8 9 10

Lpam-Hydral Flush given per M.D. Lpam: 8pm-Diaper Change Void-792 ml Lq site 8pm Peri Care given, Repositioned onto book, All Probed boots on feet. Lpam-9pm on all extremities, 8pm-Hydral given, eye ointment applied. 9pm-ABT Water 1300mls. 10:30pm-Oral Care, Diaper Change Void-212 ml Q8pm Peri Care given, Repositioned to left side. Lmn-5am. Q12hr Sin polynsal as needed. Im tolerated all aspects of care. Im moved hands fingers to move's request. Report given to night nurse.

OUTCOME FOR THIS SHIFT/VISIT (Progress toward goals, including client's response to pain intervention):

COORDINATED WITH/REPORTED TO: Physician Clinical Mgr. PT OT SP MSW RN/LPN HHA Client Serv. Mgr. N/A

COMMENTS:

PLAN FOR NEXT SHIFT/VISIT: Continue T.P.D.C.

CARE PLAN UPDATE: QYES QNO  HHA present: QYES QNO
Patient participated in Care Plan Update? QYES QNO  HHA SUPERVISION: QYES QNO

Signature/Title: Shanna Beanwa ADL  Date: 6/13/16

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# Nurse's Shift Note & Time Record

**Client's Name:** Juke McDonald  
**Client Services Manager:** Diana Macaropoulo  
**Client #:** W-19-27  
**Week Ending:** 11/3/16  
**Medicaid ID:**  

## Signature

My signature certifies that I provided service on the date and time listed above, and that the report of client status and care provided are accurate. I understand that I will be paid on the verified time on this time record and that my pay includes compensation for time spent for client care, documentation, and travel between cases. I also agree to the terms on the back of this form.

**Employee Signature/Title:**  
**Date:**

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### Temp: 97.4  
Pulse: 82  
Respiratory Status: Vent 
Nutrition/Diet: NPO  
Urinary Status: Incontinent  
Communication needs: Nonverbal

### Edema: Knee

### Skin Integrity: Warm, dry, intact

### Musculoskeletal Pain's Location: Back, Hip

### Neurological: Asf, x Seizure

### Pain Status: Client reports pain as a problem: Yes  
Intensity Level (Circle one): 1  
Exacerbating Factors:  
Effective Yes  
No

### Shift Notes:

- **10am:** Received report from night nurse. Jim in bed position and on his back. All staff hands in place. Eyes closed. Shelly Trach attached to the EVS. Humidified nebulizer setting. Continuous pulse oximeter on, alarms set and functioning. Auscultation of lungs. Resp: 20, P: 90, BP: 120/80. Post-tubal patency intact. 
- **2pm:** Bed turned, given diuretic (Midol). 
- **4pm:** Diaper changed. 
- **8pm:** Bedtime, given diuretic (Midol). 
- **9:30pm:** Assistance with bathroom. 
- **10pm:** Bedtime, given diuretic (Midol).

### Progress Toward Goals/Outcomes of This Shift:

1. **Maintained 5 EK**  
2. **Irritated feeding.**  
3. **All safety precautions maintained, no injury.**

**Has a change in status occurred that requires reporting?**  
**Yes**  
**No**

**Coordinated with/reported to:**  

**Medicaid:**  

---

**www.bayada.com**
Client's Name: John McMath

<table>
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<th></th>
<th>Mon</th>
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<th>Thu</th>
<th>Fri</th>
<th>Sat</th>
<th>Sun</th>
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<tr>
<td>Week ending Sunday</td>
<td>7/10/16</td>
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</table>

Time Arrived: ___
Time Left: ___

Temp: ___
Pulse: ___
Resp: ___
B/P: ___
PAIN LEVEL: 0 1 2 3 4 5 6 7 8 9 10

6:30am - Diaper Change Void = 484ml. 8am peri care given. Repositioned onto back. All probiotics as needed. 7am - POM on arms only. 8am - Oral Care. Nodes given. 9am - ABT legs x 20mins
10am - Diaper Change Void = 104ml 8am peri care given. Repositioned to right side. 11am - VS, NAD, Sun polynasal. Track as needed. Sniffed all aspects of care. Report given to night nurse.

OUTCOME FOR THIS SHIFT/VISIT (Progress toward goals, including client's response to pain intervention):

COORDINATED WITH/REPORTED TO: ☐ Physician ☐ Clinical Mgr. ☐ PT ☐ OT ☐ SP ☐ MSW ☐ RN/LPN ☐ HHA ☐ Client Serv. Mgr. ☐ N/A

COMMENTS:

PLAN FOR NEXT SHIFT/VISIT: Continue CPOC.

CARE PLAN UPDATE: ☐ YES ☐ NO
Patient participated in Care Plan Update? ☐ YES ☐ NO
HHA present? ☐ YES ☐ NO
HHA SUPERVISION: ☐ YES ☐ NO

Signature/Title: [Signature]

Date: 7/14/16

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NURSE'S SHIFT NOTE & TIME RECORD

Client's Name: "[Name redacted]"
Client Services Manager: "[Name redacted]"
Client #: 619-27

DATE: 8/1/21
DAY (circle day worked): W Th F Sa Su
TIME STARTED: 3pm
TIME ENDED: 11pm
TIME TRAINED: 8:14

My signature certifies that I received service on the date as listed and that I understand that if payment for this service is from Federal and State funds, any false claims, statements, or concealment of material may be prosecuted under applicable Federal and State laws. I also agree to the terms on the back of this form.

Employee Signature/Title: "[Signature]
Date: [Date]

Temp: 97.5°F Pulse: 80 RP/AP Resp: 12
O2 Sat: 98% BP: 128/73 Sitt (lying)

Mental Status: Alert Confused Disoriented Other: Nutrition/Diet: NPO Feeding 100% 90% 90% 90%
Respiratory Status: Vent Dependent (Ventilator) Bowel Status: Incapable (As active)
Urinary Status: Incontinent

O2 Trach Vent CPAP Alarms Set N/A Environment/Safety: Standard Precautions Hand Rails Bath Equipment

Oxygen: Continuous IV P R N IV Infusion

Cardiac Status: HR Regular Medication:

Edema: None

Infection Control: Standard Precautions Other:

Skin Integrity: Warm, Dry, Intact

Neurological: NRS

Pain Status: Client reports pain as a problem: Yes No Intensity Level (circle one): 1 2 3 4 5 6 7 8 9 10

Recurrent: No (new location) N/A Exacerbating Factors: N/A Effective: Yes No

Treatment: Medication Other N/A If no, Intervention/follow-up N/A

SHIFT NOTES:
- 3pm: Received report from Designated Nurse. Client was positioned on her left side, eyes closed, covered, chin supported, mouth guarded, Resp unobstructed 16bpm Lungs, SpO2 99%. Patient intubated, cuffs inflated with secured by Velcro ties to a ring. Breathing set to 15L/min humidified in a humidifier. Setting the flow at 30L/min. Resp 16Rpm,潮气量 350mL. Continuous pulse oximeter monitoring in place. Alarms set to high mode.
- 8pm: Client changed from left side to right side. Skin intact.
- 8pm: Eye ointment applied. 8pm: Diaper change mid-06/06 8pm Peri urethral. Client positioned to right. Bed left in place. Medications given. 8pm: PAIN Meds given. 8pm: Eye ointment applied. 9am:
- 9am: Client positioned to right side, 9am: PAIN Meds given. 9am: Eye ointment applied. 9am:

PROGRESS TOWARD GOALS/OUTCOMES OF THIS SHIFT:
1) Maintained 100% of care. Client tolerated all aspects as needed. Client tolerated all aspects as needed. Client tolerated all aspects as needed.
2) Maintained SS 1-1.99 on all donor commands. Report given to nurse.
3) Tolerated feeding.
4) Personal care met. N/A

HAS A CHANGE IN STATUS OCCURRED THAT REQUIRES REPORTING? (Review orders for reporting parameters) YES NO

COORDINATED WITH/REPORTED TO: RN WA Clin Mgr RN/LPN Client Svc Mgr Physician (Addendum completed, if applicable)

HHA Supervision: Yes No N/A
HHA Present: Yes No N/A
Care Plan Update: Yes No
Client Participated in Care Plan Update: Yes No

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**NURSE'S SHIFT NOTE & TIME RECORD**

**Client's Name:** John McHale

**Client Services Manager:** Sharon Howey

<table>
<thead>
<tr>
<th>DATE</th>
<th>DAY (daily workday)</th>
<th>TIME STARTED</th>
<th>TIME FINISHED</th>
<th>TIME WORKED</th>
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<tr>
<td>8/2</td>
<td>M CF W Th F Sa Su</td>
<td>7 am</td>
<td>7 pm</td>
<td>9 hours 8 minutes</td>
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My signature certifies that I provided service to the client on the date and time listed above, and that the report of client status and care provided are accurate. I understand that I will be paid on the verified time on the time record and that my pay includes compensation for time spent for the client's care, documentation, and travel between cases. I also agree to the terms on the back of this form.

Employee Signature/Titile

Date: 8/11/16

<table>
<thead>
<tr>
<th>Temp:</th>
<th>97.1</th>
<th>Pulse: T9</th>
<th>Resp:</th>
<th>O2 Sat:</th>
<th>B/P:</th>
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<tr>
<td>91</td>
<td>79</td>
<td>16/7</td>
<td>02</td>
<td>100</td>
<td>102</td>
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**Mental Status:** No AAO No Confused No Disoriented Other

**Respiratory Status:** Vent Dependent

**Urinary Status:** Incontinent

**Communication needs:** Non-verbal

**Infection Control:** Standard Precautions

**Neurological:** No Seizures

**Patient Position:** Right Side

**Baseline Blood Pressure:** 100/70

**Pain Status:** Client reports pain as a problem: Yes No

**Intensity Level:** (Circle one) 1 2 3 4 5 6 7 8 9 10

**Recurrence:** No

**New (Location):** N/A

**Exacerbating Factors:** N/A

**Effective:** Yes

**Treatment:** Medication Rest Other

**If no, Intervention/follow-up:** N/A

**SHIFT NOTES:** 7am Received Report from aides. John in bed Positioned on his back with eyes closed. Responded to 10pm, large call. 8am - Meds taken... 11am - Meds taken... 2pm - Meds taken...

**Note:** N/A

**Progress Toward Goals/Outcomes of This Shift:** N/A

**HAS A CHANGE IN STATUS OCCURRED THAT Requires REPORTING?** Yes No

**COORDINATED WITH/REPORTED TO:** DME Respiratory Therapist Other:

**HHA Supervision:** Yes No N/A

**HHA Present:** Yes No N/A

**Care Plan Update:** Yes No

**Client Participated in Care Plan Update:** Yes No

---

**Medicaid ID:** (State of PA Only)

**Client Signature:**

**Month Day Year**

**my signature certifies that I received service on the dates as listed and that times and services performed are accurate. I understand that if payment for this service is not from Federal and State funds, my false claim[s], statement[s], or concealment of material may be prosecuted under applicable Federal and State laws. I also agree to the terms on the back of this form.

---

**Signatures:**

**Employee:**

**Client:**

**Date:** 8/11/16

---

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NURSE'S SHIFT NOTE & TIME RECORD

Client's Name: John Nelson
Client Services Manager: Diana Morcayo

Client #: 018-27
Week Ending Sun: 11/14
Month/Day/Year: 11/14
Client Signature: [Signature]
(Medical ID #: ________ (State of PA Only)

Employee Signature/Title: Shalynn Benninger RN 8/14/16

Temp: 97.6° Pulse: 88 BP/ AP Resp: 12 O2 Sat: [89%] B/P: 130/88 Sitting (Lying) Standing

Mental Status: AAO Confused Disoriented Other: Nutrition/Diet: No Metal (Ag) On Morning

Respiratory Status: Ventilator Dependent Lung Soothes Bowel Status: Incontinent

W/Trach: Vent COPAP B Heat Alarms Set N/A Urinary Status: Incontinent

Oxygen: Continuous PRN N/A Environment/Safety: No known health hazards by Body Lots.

Candie Status: HR Requires Communication needs: Non-Verbal

Edema: None Infusion Control: [Standard Precautions] Other: [Other]

Skin Integrity: Warm, Dry, intact Microbes: [None] Infection Control: [Other]

Microbes: [None] Equipment checked: [Back up equipment checked]

Neurological: Yes Seizures Other: [Other] Emergency equipment checked: [Go Bag checked]

Pain Status: Client reports pain as a problem: Yes No Intensity Level (Circle one): 0 1 2 3 4 5 6 7 8 9 10

No Recurrent New (location): N/A Exacerbating Factors: N/A Effective: Yes No

Treatment: Medication: Resil. Other: N/A If no, intervention/ follow-up: N/A

SHIFT NOTES:Client received report from night nurse. In misfed, positioned on her back. RN: AROs placed. Stethoscope in place. Eyes closed, covered. NS 50 ml

Reposaudor 150 mg. Humidified air. C/O mending in noc.


Skin: oral care. Hards given. Eye ointment applied. 9am Hards given.

10pm: Oral on all three. No pain. 11am Washed. Hydrate.

12pm: Fluid given: Water. No more fluid given. 3pm: Diaper change.

Urinal: 15 ml at 9am. 10am: Bed bath given. RN: AROs placed. Repositioned right side.

3pm: Hards given. 3pm: Ventsil, SV 600. All Trill off.

PROGRESS TOWARDS GOALS/OUTCOMES OF THIS SHIFT: [Handwritten notes]

HAS A CHANGE IN STATUS OCCURRED THAT REQUIRES REPORTING? (Review orders for reporting parameters) Yes No

COORDINATED WITH/REPORTED TO: HHA N/A Clin Mgr RN/LPN N/A Client Svc Mgr N/A Physician (Addendum completed, if applicable)

DME Respiratory Therapist Other

HHA Supervision: Yes No N/A Care Plan Update: Yes No

HHA Present: Yes No N/A Client Participated in Care Plan Update: Yes No

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# Nurse's Shift Note & Time Record

**Client's Name:** John Smith  
**Client Services Manager:** Diana Morgan

<table>
<thead>
<tr>
<th>DATE</th>
<th>Mon</th>
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**Temp:** 97.6  
**Pulse:** 82  
**Resp:** 20  
**B/P:** 116/78  
**Sitting/Lying/Standing:** Lying

**Mental Status:** Confused  
**Respiratory Status:** Vent Dependent

**Oxygen:** Continuous  
**Cardiac Status:** HR Regular

**Skin Integrity:** None  
**Neurological:** Alert  
**Infection Control:** Standard Precautions

**Medication:** N/A  
**Exacerbating Factors:** N/A

**Pain Status:** Client reports pain as a problem. 
**Treatmen:** N/A

**Medical History:**  
**Allergies:** None

**Shift Notes:** I am received report from night nurse, Jim in bed positioned on her back, with feet elevated and legs in place, eyes closed. A new sleeping mat was inserted under the mattress, and a new external monitor was placed on his wrist. The vented humidifier was turned on, and the patient was wearing a comfortable robe. The patient's nutrition needs were assessed, and a new diet plan was implemented. The patient was given a new pain management medication. The patient's current medical condition was discussed with the on-coming nurse.

**Progress Toward Goals/Outcomes of This Shift:** 
- All aspects of care were documented.
- No changes in status were reported.
- No new medications were administered.
- No new allergies were reported.

**HA Supervision:** N/A  
**HHA Present:** N/A

**Care Plan Update:** No

**Client Participated in Care Plan Update:** No

---

**Signature:** 
**Date:** 8/6/16

**Medication:** N/A

**Exacerbating Factors:** N/A

**Effective:** Yes  
**No:** No

---

**Author:** 
**Date:** 8/6/16

**Signature:** 
**State of PA Only:** 

---

**Comments:**
- Maintenance of TPSR 7:00 PM
- Temperature of 97.6 recorded

---

**Follow-up:**
- No

**Signatures:**
- Nurse
- Client
CLINICAL NOTES

Occupational Therapy
Physical Therapy
Speech Therapy
Medical Social Services
Nursing
Other

Client's Name: Jane Nolath
Client#: 01927
Month Day Year: Mon Tue Wed Thu Fri Sat Sun
Week ending Sunday: 8/7/16

Time Arrived: __________ Time Left: __________

Temp: __________ Pulse: __________ Resp: __________ B/P: __________

PAIN LEVEL: 0 1 2 3 4 5 6 7 8 9 10

Gpm - Nodal flush given per Med. 7am-PRAM 6pm-Not given, eye
Antibiotic applied. 9am-ABX 6am O2 6am. 945am Diaper Change
Void - Clothing & perineal care given. Trauch & bed unit provided. Reposition
to right side. 11am-MPSB. Simple Nasal Trach as needed. Im
Nursed food & drinks to mouth's command. Unassisted all aspects
of care. Report given to night nurse.

OUTCOME FOR THIS SHIFT/VISIT (Progress toward goals, including client's response to pain intervention):

COORDINATED WITH/REPORTED TO: 

PHYSICIAN • CLINICAL MGR. • PT • OT • SP • HSW • RN/LPN • HHA • CLINICAL SERV. MGR. • N/A

COMMENTS:

PLAN FOR NEXT SHIFT/VISIT: Continue, T.P.O.C.

CARE PLAN UPDATE: YES • NO
HHA present? YES • NO
Patient participated in Care Plan Update? YES • NO
HHA SUPERVISION: YES • NO

Signature/Title: 

Date: 8/7/16

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