

Resident Face Sheet

David Chapman

Initiation Date
09/09/2025

Physician
Dr George - (646) 666-4545

Move in Date
09/05/2025

Last TB Skin Test
09/04/2025

TB Question
No

Resident Representative
Mia Chapman (Wife) - (469) 115-6666

Emergency Contact
Mia Chapman (Wife) - (469) 115-6666

Important Details

Code Status
DNR

Level of Care
Directed Care (Must renew every 3 months)

Resident Service Plan
Initial Service Plan

Next Service Plan Due
12/09/2025

Advanced Directives on file
Yes

Evacuation Plan
Yes

Allergies
Penicillin, Latex

Vital Signs and Diagnosis

Temperature	98.0
Blood Pressure	114/59
Pulse	80
Pulse Ox	97.9

Height
5 ft 4 in

Weight
99 Lbs

Date of Birth
04/15/1926

Medical Diagnosis and History

Alzheimer's Disease, Hypertension, BPH, History of CVA, Stage 4 Pressure Ulcer on Coccygeal region

Activities of Daily Living and Contracted Services

Activity of Daily Living	Level Of Care Required	Frequency
Eating	Independent	Three times daily and as needed with snacks
Oral Care	Requires assistance	Twice daily and as needed
Nail Care	Requires assistance	Nails checked daily and trimmed as needed
Hair Care	Requires assistance	Daily and as needed
Dressing	Requires total care	Twice daily and as needed
Bathing	Requires total care	Twice weekly and as needed
Toileting	Requires total care	Daily needed

Transferring	Requires total care	Daily and as needed
Transportation to Appointments	Requires total care	As needed
Finances	Requires total care	As needed; resident representative manages
Supplies	Requires total care	As needed; resident representative manages
Laundry	Requires total care	Daily and as needed

Hygiene

Hospice CNA & Caregiver Respectively help with showers 2 time(s) per week

Hospice Services

RD Hospice

- **CNA** Visits for 30 minutes, 2 times per Week and as needed
- **Provider** Visits for 30 minutes, 1 time per Week and as needed
- **Chaplain** Visits for 30 minutes, 1 time per Month and as needed
- **Social Worker** Visits for 30 minutes, 1 time per Month and as needed

Home Health Services

No services rendered at this time

Body Assessment

Vision

Glasses

Comments: Resident has glasses for reading.

Cardiovascular

Cardiac Hx

Comments: Resident has HTN

Mental Status

Awake/Alert, Confused at times, Hallucinates, Oriented, Forgetful at times, Anxious at times, Agitated at times, Advanced dementia

Comments: Confused and forgetful at all times

Speech

Nonsensical Speech

Comments: The patient has advanced dementia with non-sensical speech

Gastrointestinal

BM every 2-3 days, Incontinent

Comments: Resident wears briefs day and night

Pain

Occasional

Location: R Hip

Method of relief: Medication

Hearing

Impaired

Comments: Hard of hearing in right ear

Urinary

Underwear liners, Briefs - Day, Briefs - Night, Catheter, Pull up - Day, Incontinent

Comments:

Daily Care for indwelling catheter:

1. **Hand Hygiene:**
   - Caregivers must wash hands thoroughly with soap and water or use hand sanitizer before and after catheter care. Caregivers must wear gloves during all catheter care activities.
2. **Catheter Site Cleaning:**
   - Clean the catheter insertion site and surrounding genital area daily using mild soap and water.
   - Gently cleanse the area around the catheter where it enters the body. Avoid harsh scrubbing to prevent irritation.
   - Rinse the area well with warm water and pat dry with a clean towel.
   - Do not use powders, lotions, or other products near the catheter site unless specifically prescribed.
3. **Monitoring and Inspection:**
   - Check the catheter tubing and drainage system for kinks, leaks, or disconnections every shift.
   - Inspect the insertion site for signs of infection (e.g., redness, swelling, discharge) and report any concerns to the nursing supervisor or physician.
4. **Drainage Bag Care:**

- Ensure the drainage bag is below the level of the bladder at all times to prevent backflow of urine.
- Empty the drainage bag at least every 4 hours or more frequently if it becomes full. Document the urine output in the patient's chart.
- Avoid touching the drainage spout to any surface when emptying the bag. Clean the spout with an alcohol wipe after emptying.

5. **Catheter Securement:**
   - Ensure the catheter is securely anchored to the patient's thigh or abdomen to minimize movement and reduce irritation at the insertion site.
6. **Encourage Hydration:**
   - If not contraindicated, encourage the patient to maintain adequate fluid intake (e.g., 6-8 glasses of water per day) to promote urine flow.
7. **Catheter Replacement and Maintenance:**
   - Catheter will be replaced regularly using sterile technique by a skilled nurse (home health or hospice) (e.g., every 4-6 weeks) or immediately if there are signs of blockage, leakage, or infection.
8. **Signs of Complications:**
   - Report to the physician immediately if any of the following occur:
     - Fever or chills
     - Cloudy, foul-smelling, or bloody urine
     - Increased pain or discomfort around the catheter site
     - No urine output for 4-6 hours or sudden decrease in urine output

Respiratory

SOB at rest

Comments: Shortness of breath at times

Mobility

Bed Ridden, Wheel Chair, Chair Ridden, Fall Risk
Requires Positioning: Yes, every 2 hours Hour(s)
Transfer Assistance: Yes, 2 Person(s)

Comments: The resident is chair-ridden and bedridden and needs assistance with all ADLs. He had a non-injury fall on 9/7/2025, which was reported to RD Hospice.

Integumentary

Wounds

The following are performed to prevent, & treat bruises, injuries, pressure ulcers, and infections:

- Keep resident's skin clean and dry
- Apply hydrating lotion
- Check resident's skin at every shower, bath, and PRN
- Ensure good hygiene and nutrition
- Communicate weekly with wound care nurse
- If incontinent; check the resident's brief and provide hygiene care as needed to prevent skin breakdown every 4 hours.

Comments: The resident has a stage 4 pressure ulcer in coccygeal region. Hospice RN provides wound care per orders three times weekly. Please see hospice binder for wound care orders.

Memory Care Compliance Interventions

Medical & Admission Compliance

- ✔ **Resident evaluated by a medical practitioner within 30 days prior to admission**
- ✔ **Medical practitioner signed documentation confirming facility can meet resident's needs**
- ✔ **Resident has a documented dementia or related cognitive impairment diagnosis**

Cognitive & Behavioral Interventions

- ✔ **Staff use redirection techniques for agitation or confusion**
- ✔ **Staff use validation therapy (affirming feelings, not correcting facts)**
- ✔ **Staff use calm tone, short sentences, and non-confrontational language**
- ✔ **Staff offer structured daily routines to minimize confusion**
- ✔ **Distractions are used to redirect residents from unsafe behaviors (e.g., exit-seeking)**
- ✔ **Staff provide reassurance during episodes of anxiety or fear**
- ✔ **Staff use life story or memory books to promote familiarity and reduce distress**
- ✔ **Staff avoid known triggers (e.g., mirrors, clutter, loud noise)**

Elopement Prevention Strategies

- ✔ **Resident's elopement risk assessed and documented**
- ✔ **Resident wears a wander management device (e.g., bracelet or pendant)**
- ✔ **Doors equipped with alarms**
- ✔ **Staff visually monitor resident during transitions or outdoor time**
- ✔ **Personal belongings and/or room labeled with photos or names to increase orientation**

✔ **Elopement drill conducted every 6 months per shift (dates documented)**

Environmental Adaptations

✔ **Facility uses clear, contrasting signage for bathrooms, exits, and dining areas**
✔ **Resident room personalized with photos or memory cues**
✔ **Furniture arranged to support safe navigation and reduce confusion**
✔ **Hazardous areas secured (e.g., kitchens, supply closets)**
✔ **Facility minimizes overstimulation (dim lighting, low noise, no mirrors if disorienting)**
✔ **Resting areas available with low-stimulation, calming design**

Social & Engagement Support

✔ **Resident participates in daily memory-stimulating activities (e.g., music, puzzles)**
✔ **Resident encouraged to join small group or 1:1 social interaction**
✔ **Activities tailored to cognitive ability and former interests**
✔ **Staff offer guided reminiscing conversations**
✔ **Sensory activities provided (e.g., textured fabrics, aromatherapy)**
✔ **Outdoor time or nature access integrated safely (e.g., secured garden)**

Nutrition and Medication Administration

Medication Administration

(Please see resident's MAR for current medications)

- **Resident requires total care with medication administration**
- **Medications administered following Doctor’s Orders**
- **Doctor delegation to caregivers to administer medications**
- **Medications are stored in the residential facility**

Diabetes Management

- Insulin inject (staff)
- BS check (staff) 2 time(s) Per Day

Nutrition

Diet: Regular Diet, BS controlled diet

- Resident eats 75% of meals
- Resident drinks 8 cups of water per day

Resident is encouraged to drink 6-8 cups of water per day
Resident is encouraged to eat meals and snacks as tolerated

Additional Information, Notes, and Signatures

Strategies to ensure resident's personal Safety

- Resident has bell at bedside to call for assistance/ safety
- Doors are alarmed
- Resident is checked on every 3-4 hours at night time and as needed during day time to ensure safety
- Facility staff provide daily room cleaning and additional housekeeping services as needed to maintain a safe, sanitary, and comfortable living environment.

Activities (Cognitive stimulation and activities to maximize function)

- Watch TV
- Read
- Socialize with other residents
- Encouraged to participate in group activities

Coordination of communication with resident's representative

- ✔ Daily & as needed through phone calls, visits, text messages and or email
- ✔ **Weekly & as needed through phone calls, visits, text messages and or email**
- ✔ Monthly & as needed through phone calls, visits, text messages and or email
- ✔ As needed only through phone calls, visits, text messages and or email

Assistive Devices

- Hearing aids, Dentures, Hospital bed, Glasses, O2 concentrator, Other: Over the bed Table

Signatures

Provider	Resident/Representative	Manager/Delegate
David Lup **07/29/2025**	**Mia Chapman**	**James Holloway** **09/09/2025**
Service plan was signed by Dr. David Lup, DNP, FNP-C on 07/29/2025 7:59 am MST	Signature	Signature

Notes

Important Notes: Though communication is limited, the resident responds positively to soft touch, soothing tones, and daily routines. Staff provide attentive care and reassurance throughout the day. The resident's loved ones remain involved and deeply supportive, with regular communication from the care team.

Disclaimers

The resident's needs may change at any time and the service plan will be reviewed and changed as required by Arizona Department of Health Services.

R&D Health Services is relying on Facility and Facility's owners,employees,agents,subcontractors, residents, and residents' personal representatives to provide Contractor with complete and accurate information.Facility agrees that Contractor will not be liable for any Claim (defined in Section 8 of contractor agreement) arising out of incomplete or inaccurate information provided to Contractor by Facility or Facility's owners, directors, officers, employees, agents, subcontractors, residents, or residents' personal representative.

Arizona Department of Health Services rules require Assisted Living Facilities to evaluate a resident before acceptance and every 6 months for personal care, every 3 months for directed care, and every 1 year for supervisory care throughout the duration of the resident's stay.