

<b>Restorative Nursing Program Exercise Worksheet</b>
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**Restorative Nursing Program Exercise #1a Pepper Mint**

Observation Period 9/9 – 9/15/14 (ARD)

Transmitted Value	Reviewed Value	Answer
O0500A Passive Range of Motion 6 days	O0500A Passive Range of Motion_____days	
O0500B Active Range of Motion 6 days	O0500B Active Range of Motion_____days	

**Restorative Nursing Program Exercise #1b Pepper Mint**

Observation Period 9/9 – 9/15/14 (ARD)

Transmitted Value	Reviewed Value	Answer
O0500A Passive Range of Motion 6 days	O0500A Passive Range of Motion_____days	

**Restorative Nursing Program Exercise #2 Chocolate Almond**

Observation Period 9/9 – 9/15/14 (ARD)

Transmitted Value	Reviewed Value	Answer
O0500F Walking 7 days	O0500F Walking _____ days	

**Restorative Nursing Program Exercise #3 Double Chocolate Almond**

Observation Period 9/9 – 9/15/14 (ARD)

Transmitted Value	Reviewed Value	Answers
H0200C Scheduled Toileting Yes	H0200C Scheduled Toileting _____	
M1200C Turning/Repositioning Yes	M1200C Turning/Repositioning _____	

**Restorative Nursing Program Exercise #4a Lemon Custard**

Observation Period 9/9 – 9/15/14 (ARD)

Transmitted Value	Reviewed Value	Answer
O0500J Communication 6 days	O0500J Communication _____ days	

**Restorative Nursing Program Exercise #4b Lemon Custard**

Observation Period 9/9 – 9/15/14 (ARD)

Transmitted Value	Reviewed Value	Answer
O0500J Communication 7 days	O0500J Communication _____ days	

**Restorative Nursing Program Exercise Worksheet**

**Restorative Nursing Program Exercise #5 Bubble Gum**

Observation Period 9/9 – 9/15/14 (ARD)

<b>Transmitted Values</b>		<b>Reviewed Values</b>	<b>Answers</b>
O0500B	Active Range of Motion      7 days	O0500B Active Range of Motion	____days
O0500D	Bed Mobility      7 days	O0500D Bed Mobility	____days
O0500E	Transfers      7 days	O0500E Transfers	____days
O0500G	Dressing or Grooming      7 days	O0500G Dressing or Grooming	____days
O0500H	Eating      7 days	O0500H Eating	____days
O0500J	Communication      7 days	O0500J Communication	____days

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**Restorative Nursing Program Exercise #6 Raspberry Sherbet**

Observation Period 9/9 – 9/15/14 (ARD)

<b>Transmitted Values</b>		<b>Reviewed Values</b>	<b>Answers</b>
O0500A	Passive Range of Motion      7 days	O0500A Passive Range of Motion	____days
O0500C	Splint/Brace Assistance      7 days	O0500C Splint/Brace Assistance	____days

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**Restorative Nursing Program Exercise #7 Cherry Cordial**

Observation Period 9/9 – 9/15/14 (ARD)

<b>Transmitted Values</b>		<b>Reviewed Values</b>	<b>Answer</b>
O0500B	Active Range of Motion      7 days	O0500B Active Range of Motion	____days

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## Restorative Nursing Care Plan and Flow Record

**Month/Year: September 2014**

**ARD: 9/15/14**

**Directions:** Use one form for each program. Complete and describe program, problem, measurable goals, and interventions. Be specific. Record direct restorative minutes daily in shift box. Be sure to initial when service is provided and sign form (full signature, title). A licensed nurse must evaluate the program within the quarter. Notes must be dated and signed.

**Program:** Active/Passive Range of Motion

**Problem:** Unable to move left side fingers, hand, arm and leg secondary to CVA and left sided hemiplegia

**Goal:** Will remain free of contractures of left fingers, hand, arm and leg through next review/90 days

**Interventions:** Active/Passive ROM to left fingers, hand, arm and leg; 5 reps of each joint bid daily; stop if complains of pain

**Restorative aide note:** 9/12/14, 11:00 am. Out for MD appt this morning. *Edgar Eggplant, CNA*

**Licensed nurse evaluation of resident's response to program (Must be within the quarter):** 9/15/14, 2:00 pm. Resident was out for an appointment one morning during the observation period. Has received ROM to left side fingers, hand, arm and leg, 5 reps each joint, for at least 15 minutes a day for 6 days this observation period. No complaints of pain during exercises, and no contractures. Still unable to move left side extremities. Will continue program. *Olive Oliver, RN*

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
<b>7-3/mins</b>	8	8	X	8	9	8	7	10	10	10	8	0	7	10	7	7	8	9	9	9	10	7	8	8	7	5	8	9	10	8	X
<b>Initials</b>	EE	EE	X	EE	EE	CA	CA	CA	CA	EE	EE	EE	EE	CA	CA	CA	CA	EE	EE	EE	EE	CA	CA	CA	CA	EE	EE	EE	CA	CA	X
<b>3-11/mins</b>	8	8	X	8	8	0	8	5	5	5	8	9	9	7	9	9	8	8	8	X	7	7	7	9	7	12	8	8	8	9	X
<b>Initials</b>	GA	GA	X	OO	OO	OO	GA	GA	PP	PP	PP	PP	PP	GA	GA	OO	OO	OO	OO	X	GA	GA	GA	OO	OO	PP	PP	PP	GA	GA	X

Initials	Full Signature and Title	Initials	Full Signature and Title
EE	<i>Edgar Eggplant, CNA</i>	CA	<i>Carmella Apple, CNA</i>
GA	<i>Gus Asparagus, CNA</i>	OO	<i>Ollie Orange, CNA</i>
PP	<i>Patty Peach, CNA</i>		

*Full signatures required to authenticate initials.*

Resident Name	Medical Record Number	Room Number
<b>Pepper Mint</b>	<b>101010</b>	<b>101</b>

**Example #1a**

## Restorative Nursing Care Plan and Flow Record

**Month/Year: September 2014**

**ARD: 9/15/14**

**Directions:** Use one form for each program. Complete and describe program, problem, measurable goals, and interventions. Be specific. Record direct restorative minutes daily in shift box. Be sure to initial when service is provided and sign form (full signature, title). A licensed nurse must evaluate the program within the quarter. Notes must be dated and signed.

**Program:** Passive Range of Motion

**Problem:** Unable to move left side fingers, hand, arm and leg secondary to CVA and left sided hemiplegia

**Goal:** Will remain free of contractures of left fingers, hand, arm and leg through next review/90 days

**Interventions:** Passive ROM to left fingers, hand, arm and leg; 5 reps of each joint bid daily; stop if complains of pain

**Restorative aide note:** 9/12/14, 11:00 am. Out for MD appt this morning. *Edgar Eggplant, CNA*

**Licensed nurse evaluation of resident's response to program (Must be within the quarter):** 9/15/14, 2:00 pm. Resident was out for an appointment one morning during the observation period. Has received ROM to left side fingers, hand, arm and leg, 5 reps each joint, for at least 15 minutes a day for 6 days this observation period. No complaints of pain during exercises, and no contractures. Still unable to move left side extremities. Will continue program. *Olive Oliver, RN*

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
<b>7-3/mins</b>	8	8	X	8	9	8	7	10	10	10	8	0	7	10	7	7	8	9	9	9	10	7	8	8	7	5	8	9	10	8	X
<b>Initials</b>	EE	EE	X	EE	EE	CA	CA	CA	CA	EE	EE	EE	EE	CA	CA	CA	CA	EE	EE	EE	EE	CA	CA	CA	CA	EE	EE	EE	CA	CA	X
<b>3-11/mins</b>	8	8	X	8	8	0	8	5	5	5	8	9	9	7	9	9	8	8	8	X	7	7	7	9	7	12	8	8	8	9	X
<b>Initials</b>	GA	GA	X	OO	OO	OO	GA	GA	PP	PP	PP	PP	PP	GA	GA	OO	OO	OO	OO	X	GA	GA	GA	OO	OO	PP	PP	PP	GA	GA	X

Initials	Full Signature and Title	Initials	Full Signature and Title
EE	<i>Edgar Eggplant, CNA</i>	CA	<i>Carmella Apple, CNA</i>
GA	<i>Gus Asparagus, CNA</i>	OO	<i>Ollie Orange, CNA</i>
PP	<i>Patty Peach, CNA</i>		

*Full signatures required to authenticate initials.*

Resident Name	Medical Record Number	Room Number
<b>Pepper Mint</b>	<b>101010</b>	<b>101</b>

**Example #1b**

## Restorative Nursing Care Plan and Flow Record

**Month/Year:** September 2014

**ARD:** 9/15/14

**Directions:** Use one form for each program. Complete and describe program, problem, measurable goals, and interventions. Be specific. Record direct restorative minutes daily in shift box. Be sure to initial when service is provided and sign form (full signature, title). A licensed nurse must evaluate the program within the quarter. Notes must be dated and signed.

**Program:** Walk to Dine

**Problem:** Ambulation

**Goal:** Walk to dining room at lunch daily

**Interventions:** Remind of meal times and how to get to dining room

**Evaluation:** 9/15/14, Continue. Olive Oliver, RN

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
<b>11-7/mins</b>																															
<b>Initials</b>																															
<b>7-3/mins</b>	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	X
<b>Initials</b>	EE	X																													
<b>3-11/mins</b>																															
<b>Initials</b>																															

Initials	Full Signature and Title	Initials	Full Signature and Title
EE	<i>Edgar Eggplant, CNA</i>		

*Full signatures required to authenticate initials.*

Resident Name	Medical Record Number	Room Number
Chocolate Almond	202020	202

### Example #2

## Restorative Nursing Program Flow Sheet

Day of the Month		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Turn/reposition q 2 hrs when in bed	11-7	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
		EE	EE	EE	EE	EE	CA	CA	CA	CA	CA	EE	EE	EE	EE	EE	CA	CA	CA	CA	CA	CA	EE	EE	EE	EE	EE	CA	CA	CA	CA	CA	CA
	3-11	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
GA		GA	GA	GA	GA	OO	OO	OO	GA	GA	GA	GA	OO	OO	OO	OO	GA	GA	GA	OO	OO	OO	GA	GA	GA	GA	GA	OO	OO	OO	OO	OO	
Reposition q 1 hr when in wheelchair	7-3	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	
		EE	EE	EE	EE	EE	CA	CA	CA	CA	CA	EE	EE	EE	EE	EE	CA	CA	CA	CA	CA	CA	EE	EE	EE	EE	EE	CA	CA	CA	CA	CA	
	3-11	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
GA		GA	GA	GA	GA	OO	OO	OO	GA	GA	GA	GA	OO	OO	OO	OO	GA	GA	GA	OO	OO	OO	GA	GA	GA	GA	GA	OO	OO	OO	OO	OO	
Check on q 2 hrs during night for toileting needs and incontinent care	11-7	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	
		PP	PP	PP	PP	PP	BB	BB	BB	BB	BB	PP	PP	BB	BB	BB	BB	BB	PP	PP	BB	BB	BB	PP	PP	PP	PP	PP	BB	BB	BB	BB	
	7-3	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
EE		EE	EE	EE	EE	CA	CA	CA	CA	CA	EE	EE	EE	EE	EE	CA	CA	CA	CA	CA	CA	EE	EE	EE	EE	EE	CA	CA	CA	CA	CA		
C		C	C	C	C	C	C	C	I	I	C	C	C	C	C	C	C	C	C	I	I	I	C	C	C	C	C	C	C	C	C		
Take to toilet upon awakening, before and after meals and at bedtime	3-11	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	
		GA	GA	GA	GA	GA	OO	OO	OO	GA	GA	GA	GA	OO	OO	OO	OO	GA	GA	GA	OO	OO	OO	GA	GA	GA	GA	GA	OO	OO	OO	OO	
	I	C	C	C	C	I	C	C	C	C	C	C	C	I	I	C	C	C	C	C	C	C	I	C	I	I	C	C	C	C	C		
	7-3																																
	INT.																																
	3-11																																
	INT.																																
Initials	Full Signature and Title										Initials	Full Signature and Title																					
EE	Edgar Eggplant, CNA										CA	Carmella Apple, CNA																					
GA	Gus Asparagus, CNA										OO	Ollie Orange, CNA																					
PP	Patty Peach, CNA										BB	Brock Broccoli, LPN																					

Resident Name: Double Chocolate Almond

Month Sept Year 2014

Example #3

## Care Plans

<u>Date</u>	<u>Program</u>	<u>Problem</u>	<u>Goal</u>	<u>Interventions</u>
6/20/14	Scheduled Toileting	Unable to toilet self due to being unable to find toilet independently and unable to voice toileting needs related to dementia	Will remain dry during waking hours daily x 90 days	<ol style="list-style-type: none"> <li>1. Take to toilet upon awakening, before and after meals, at bedtime</li> <li>2. Visual cue (large, bright picture on toilet room door)</li> <li>3. Staff to provide verbal reminders/directions to use toilet at scheduled times</li> <li>4. Check q 2 hrs during night for toileting needs/ incontinent care</li> </ol>
9/15/14 <u>Evaluation</u>		Has remained dry during day shift on 12 of 14 days and dry during evening shift 11 of 14 days on this toileting schedule. Is unable to tell staff when he needs to toilet, and is unable to find toilet independently. He will use toilet when taken by staff and verbally cued. Continue with current scheduled toileting plan. <i>Tom Tomato, RN 9/15/14</i>		
<hr/>				
6/20/14	Turning/ Repositioning	At risk for additional skin breakdown related to unable to turn/reposition self in bed/chair	Will remain free from additional skin breakdown x 90 days	<ol style="list-style-type: none"> <li>1. Turn/reposition q 2 hrs when in bed</li> <li>2. Reposition q 1 hr when in wheelchair</li> <li>3. Alternating air mattress</li> <li>4. Gel cushion in wheelchair</li> <li>5. Monitor skin for new breakdown q shift</li> </ol>
9/15/14 <u>Evaluation</u>		Has been turned and repositioned per plan daily during this observation period. Alternating air mattress on bed and gel cushion in chair as ordered. Remains free of additional skin breakdown with this schedule. Continue with current turning/repositioning schedule x 90 days. <i>Tom Tomato, RN 9/15/14</i>		

**Resident: Double Chocolate Almond**

**Medical Record # 3003**

**Room #303**

### Example #3

## Restorative Nursing Care Plan and Flow Record

**Month/Year:** September 2014

**ARD:** 9/15/14

**Directions:** Use one form for each program. Complete and describe program, problem, measurable goals, and interventions. Be specific. Record direct restorative minutes daily in shift box. Be sure to initial when service is provided and sign form (full signature, title). A licensed nurse must evaluate the program within the quarter. Notes must be dated and signed.

**Program:** Communication

**Problem:** At risk for decline, requires group involvement/stimulation

**Goal:** Maintain communication abilities

**Interventions:** 1) Assist to group communication 6 days week; 2) May read and discuss newspaper articles; 3) Encourage to discuss past life or family; 4) Sing hymns

**Evaluation:** 9/15/14, 2:00 pm. Enjoys talking about past life and singing hymns.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
<b>7-3 min.</b>	8	9	15		12	15	7	9	10	8		10	9	8	7	12	9		15	13	7	0	8	12		5	14	10	10	6	X
<b>Initials</b>	CA	CA	CA		CA	PP	PP	PP	PP	CA		CA	CA	PP	PP	PP	CA		CA	PP	PP	PP	PP	PP		PP	CA	CA	CA	CA	X
<b>3-11 min.</b>	10	9	7		11	10	10	7	8	8		7	10	7	9	8	8		6	6	10	16	9	7		13	8	8	7	12	X
<b>Initials</b>	EE	EE	EE		EE	GA	GA	GA	GA	EE		EE	GA	GA	GA	EE	EE		EE	GA	GA	GA	GA	EE		EE	GA	GA	EE	EE	X

Initials	Full Signature and Title	Initials	Full Signature and Title
PP	<i>Patty Peach, CNA</i>	CA	<i>Carmella Apple, CNA</i>
EE	<i>Edgar Eggplant, CNA</i>	GA	<i>Gus Asparagus, CNA</i>

*Full signatures required to authenticate initials.*

Resident Name	Medical Record Number	Room Number
Lemon Custard	404040	404

### Example #4a

## Restorative Nursing Care Plan and Flow Record

**Month/Year: September 2014**

**ARD: 9/15/14**

**Directions:** Use one form for each program. Complete and describe program, problem, measurable goals, and interventions. Be specific. Record direct restorative minutes daily in shift box. Be sure to initial when service is provided and sign form (full signature, title). A licensed nurse must evaluate the program within the quarter. Notes must be dated and signed.

**Program:** Communication

**Problem:** New CVA with expressive aphasia, unable to consistently communicate wants and needs

**Goal:** Will be able to use communication board to communicate wants and needs in 4 weeks

**Interventions:** Keep communication board within reach; when asking a question, encourage to point to picture or words on board; show family how to use communication board; encourage family to use communication board; add pictures or words as needed; allow time for response

**Evaluation:** 9/15/14, 2:00 pm. Since implementation of communication board 2 weeks ago, Mrs. Custard is able to let staff know if she is hungry, thirsty or in pain. Added "TV" and "newspaper" to board. Will continue program for 2 more weeks, then re-evaluate. *Butter Pecan, RN*

9/30/14, 10:00 am. Resident using communication board without difficulty. Program d/c'd. *Butter Pecan, RN*

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
<b>11-7 min.</b>																															
<b>Initials</b>																															
<b>7-3 min.</b>	18	20	16	23	21	18	17	20	22	19	17	21	18	18	16	19	23	18	20	17	15	18	15	17	18	15	15	15	15	X	X
<b>Initials</b>	CA	CA	CA	PP	CA	PP	PP	PP	PP	CA	CA	CA	CA	PP	PP	PP	CA	CA	CA	PP	PP	PP	PP	PP	CA	PP	CA	CA	CA	X	X
<b>3-11 min.</b>																															
<b>Initials</b>																															

Initials	Full Signature and Title	Initials	Full Signature and Title
PP	<i>Patty Peach, CNA</i>	CA	<i>Carmella Apple, CNA</i>

*Full signatures required to authenticate initials.*

Resident Name	Medical Record Number	Room Number
Lemon Custard	404040	404

**Example #4b**

## Restorative Nursing Program Flow Sheet

Day of the Month		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
<b>Dressing</b> Help dress and undress daily	<b>7-3</b>	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
	<b>INT.</b>	EE	EE	EE	EE	EE	CA	CA	CA	CA	CA	EE	EE	EE	EE	EE	CA	CA	CA	CA	CA	EE	EE	EE	EE	EE	CA	CA	CA	CA	CA	
	<b>3-11</b>	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	
	<b>INT.</b>	GA	GA	GA	GA	GA	OO	OO	OO	GA	GA	GA	GA	OO	OO	OO	OO	GA	GA	GA	OO	OO	OO	GA	GA	GA	GA	GA	OO	OO	OO	
<b>Eating</b> Encourage to eat daily	<b>7-3</b>	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	
	<b>INT.</b>	EE	EE	EE	EE	EE	CA	CA	CA	CA	CA	EE	EE	EE	EE	EE	CA	CA	CA	CA	CA	EE	EE	EE	EE	EE	CA	CA	CA	CA		
	<b>3-11</b>	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	
	<b>INT.</b>	GA	GA	GA	GA	GA	OO	OO	OO	GA	GA	GA	GA	OO	OO	OO	OO	GA	GA	GA	OO	OO	OO	GA	GA	GA	GA	GA	OO	OO	OO	
<b>Communication</b> Talk to resident during care	<b>7-3</b>	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	
	<b>INT.</b>	EE	EE	EE	EE	EE	CA	CA	CA	CA	CA	EE	EE	EE	EE	EE	CA	CA	CA	CA	CA	EE	EE	EE	EE	EE	CA	CA	CA	CA		
	<b>3-11</b>	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	
	<b>INT.</b>	GA	GA	GA	GA	GA	OO	OO	OO	GA	GA	GA	GA	OO	OO	OO	OO	GA	GA	GA	OO	OO	OO	GA	GA	GA	GA	GA	OO	OO	OO	
<b>Bed Mobility</b> Assist to turn in bed	<b>11-7</b>	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15		
	<b>INT.</b>	PP	PP	PP	PP	PP	BB	BB	BB	BB	BB	PP	PP	BB	BB	BB	BB	PP	PP	BB	BB	BB	PP	PP	PP	PP	PP	BB	BB	BB		
<b>Transfers</b> Assist with all transfers	<b>7-3</b>	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	
	<b>INT.</b>	EE	EE	EE	EE	EE	CA	CA	CA	CA	CA	EE	EE	EE	EE	EE	CA	CA	CA	CA	CA	EE	EE	EE	EE	EE	CA	CA	CA	CA		
	<b>3-11</b>	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	
	<b>INT.</b>	GA	GA	GA	GA	GA	OO	OO	OO	GA	GA	GA	GA	OO	OO	OO	OO	GA	GA	GA	OO	OO	OO	GA	GA	GA	GA	GA	OO	OO	OO	
<b>AROM</b>	<b>7-3</b>	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10		
	<b>INT.</b>	EE	EE	EE	EE	EE	CA	CA	CA	CA	CA	EE	EE	EE	EE	EE	CA	CA	CA	CA	CA	EE	EE	EE	EE	EE	CA	CA	CA	CA		
	<b>3-11</b>	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10		
	<b>INT.</b>	GA	GA	GA	GA	GA	OO	OO	OO	GA	GA	GA	GA	OO	OO	OO	OO	GA	GA	GA	OO	OO	OO	GA	GA	GA	GA	GA	OO	OO	OO	
Initials	Full Signature and Title										Initials	Full Signature and Title																				
EE	<i>Edgar Eggplant, CNA</i>										CA	<i>Carmella Apple, CNA</i>																				
GA	<i>Gus Asparagus, CNA</i>										OO	<i>Ollie Orange, CNA</i>																				
PP	<i>Patty Peach, CNA</i>										BB	<i>Brock Broccoli, LPN</i>																				

**Problem:** Needs assist with ADLs.

**Goal:** Will participate with ADLs as able.

**Evaluation:** Continue to assist with ADLs daily as needed. Encourage to do as much for self as possible. 9/15/14 Butter Pecan RN

**Resident:** Bubble Gum

**Example #5**

Month Sept Year 2014

## Treatment Administration Record

Day of the Month		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
PROM 15 - 20 minutes daily	11-7 INT.																															
	7-3 INT.	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	
	3-11 INT.																															
	INT.	TS	TS	TS	TS	TS	ES	ES	ES	ES	ES	TS	TS	TS	TS	TS	ES	ES	ES	ES	ES	TS	TS	TS	TS	ES	ES	ES	ES	TS	TS	TS
Apply right hand splint daily On at 8 am  Off at 8 pm	11-7 INT.																															
	7-3 INT.	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	
	3-11 INT.	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	
	INT.	NB	NB	NB	NB	NB	LB	LB	NB	NB	NB	NB	NB	LB	LB	LB	LB	LB	NB	NB	NB	LB	LB	LB	LB	NB	NB	NB	LB	LB	LB	
	11-7 INT.																															
	7-3 INT.																															
	3-11 INT.																															
	INT.	BB	BB	BB	BB	NS	NS	NS	NS	NS	NS	BB	BB	BB	BB	NS	NS	NS	NS	BB	BB	BB	NS	NS	NS	BB	BB	BB	BB	BB	NS	NS
	11-7 INT.																															
	7-3 INT.																															
	3-11 INT.																															
	INT.																															
Initials	Full Signature and Title										Initials	Full Signature and Title																				
BB	<i>Betty Bones, LPN</i>										LB	<i>Lettie Bones, LPN</i>																				
NB	<i>Nettie Bones, RN</i>										NS	<i>Ned Skeleton, RN</i>																				
TS	<i>Ted Skeleton, CNA</i>										ED	<i>Ed Skeleton, CNA</i>																				

Resident Name: Raspberry Sherbet

Month Sept Year 2014

Example #6

## Restorative Nursing Care Plans

<u>Date</u>		<u>Problem/Program</u>	<u>Goal</u>	<u>Interventions</u>
9/15/14	#1	Unable to move right side related to CVA/ PROM Program	Will remain free of contractures x 90 days (other than right hand)	<ol style="list-style-type: none"> <li>1. PROM exercises per policy /procedures 15 mins/daily</li> <li>2. Stop if complains of pain</li> <li>3. Refer to OT/PT for pain or decrease in ROM</li> </ol>

Evaluation: Remains unable to move right side related to CVA. PROM provided 15 minutes per day, 5 reps per joint. No pain reported with exercises. No contractures other than right hand. Able to move left side independently. *Butter Pecan, RN 9/15/14*

9/15/14	#2	Contractures right hand related to CVA/ Splint program	Will wear right hand splint daily x 90 days	<ol style="list-style-type: none"> <li>1. Right hand splint on q am, off hs</li> <li>2. Assess for red or open areas on hand</li> <li>3. PROM to hand before placing splint on and when removing</li> <li>4. Refer to OT/PT as indicated for increase in contracture, decrease ROM</li> </ol>
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Evaluation: Right hand splint is applied every morning at 8 AM and removed every evening at 8 PM. No red or open areas on hand, no pain reported with wearing of splint. Hand remains contracted. Continue current program. *Butter Pecan, RN 9/15/14*

<b>Resident: Raspberry Sherbet</b>	<b>Medical Record # 6006</b>	<b>Room # 606</b>
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### Example #6

## Restorative Nursing Care Plan and Flow Record

**Month/Year: September 2014**

**ARD: 9/15/14**

**Directions:** Use one form for each program. Complete and describe program, problem, measurable goals, and interventions. Be specific. Record direct restorative minutes daily in shift box. Be sure to initial when service is provided and sign form (full signature, title). A licensed nurse must evaluate the program within the quarter. Notes must be dated and signed.

**Program:** AAROM right hand and fingers

**Problem:** Contractures of right hand and fingers due to CVA, unable to completely open hand and straighten fingers independently

**Goal:** Will be able to open right hand and straighten fingers with assist daily through next review/90 days

**Interventions:** AAROM to right hand and fingers, 8-10 reps each joint before and after splint application; move joints gently; stop if complains of pain; refer to OT if decrease in range of motion

**Evaluation:** 9/15/14, 2:00 pm. Right hand and fingers still contracted but able to move right hand and fingers through AAROM exercises with assistance. No pain with movement and no increase in resistance to movements. AAROM exercises not done 2 days during this observation period, as splint was off due to open area on palm. Continue with AAROM program when splint resumes.  
Olive Oliver, RN

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
6 am Minutes/ AAROM	8	10	8	9	8	8	8	8	8	8	8	8	8	0	0	0	0	0	0	0	8	8	8	8	8	8	8	8	8	8	X
Initials	EE	EE	CA	EE	EE	CA	CA	CA	CA	EE	EE	EE	EE	CA	CA	CA	CA	EE	EE	EE	EE	CA	CA	CA	CA	EE	EE	EE	CA	CA	X
4 pm Minutes/ AAROM	8	8	8	8	8	7	8	8	8	10	8	9	9	0	0	0	0	0	0	0	7	7	7	9	7	12	8	8	8	9	X
Initials	GA	GA	GA	OO	OO	OO	GA	GA	PP	PP	PP	PP	PP	GA	GA	OO	OO	OO	OO	GA	GA	GA	GA	OO	OO	PP	PP	PP	GA	GA	X

*Full signatures required to authenticate initials.*

Initials	Full Signature and Title	Initials	Full Signature and Title	Initials	Full Signature and Title
EE	<i>Edgar Eggplant, LPN</i>	CA	<i>Carmella Apple, LPN</i>	PP	<i>Patty Peach, RN</i>
GA	<i>Gus Asparagus, LPN</i>	OO	<i>Ollie Orange, RN</i>		

Resident Name	Medical Record Number	Room Number
Cherry Cordial	707070	707

**Example #7**