Exhibit I

HEART TO HEART HOME CARE

let our family service your family's needs

60 Day RN Revisit Assessment and Nursing Note

Patient's Name:	Date: 10/27/17	Time Arrived:	Time Left:	Visit Total:

Address:	DOB:	Location: Home

Reason for Visit: ✓ 60 Day Supervision ___ PRN ___ Supervise New Hire ___ Other ________

Other Objective/Subjective Data ________________________________

Vital Signs: BP 150/80 AP 93 RP 60 Resp 18 Temp 98.2 Weight 109 lbs Actual ☐ Stated
Height ____

SpO2 99%

Pain Assessment:

Describe: location, character, frequency, and pain relief measures Denies any pain. Lost wt. 2° to CA; lost of appetite before.

Emergency Plan/ Patient has: ☑ Emergency Contact ________ ☐ Alternate Housing in a Disaster

☑ Plan to obtain food, supplies, medication, DME ☑ Comments Adequate medication

Functional Assessment:

__ Change ✓ No Change in Upper Body dressing ________ Assist c ADL

__ Change ✓ No Change in Lower Body dressing ________

__ Change ✓ No Change in Toileting and Transfer ________

__ Change ✓ No Change in assistance needed for food and meal preparation ________

__ Change ✓ No Change in Medication management Future schedule for possible Chemo Therapy

Fall Risk and Safety Assessment reviewed:

☑ No changes and no additional interventions ☐ Change- describe and actions taken:
____

Plan of Care reviewed with: ☑ Patient ☐ Family ☑ CHHA ☐ LPN ☐ Other ________

Plan of Care meets Patient's needs ☑ Yes ☐ No – Explain ________________

Name of CHHA/Staff Present ________ Skills observed ________________

Review of Systems

Cardiovascular	☐ WNL Circle any that apply: Chest pain, Dyspnea, Cyanosis, Palpitations, Pulses present, Pulses Absent, Irregular pulse, History MI, History CHF Other Comments weak
Respiratory	☐ WNL Circle any that apply: Lungs clear to auscultation, SOB on exertion, SOB at Rest, Orthopnea, Cough, Wheezing, Rhonchi, Rales Oxygen at ____ L/Min Comments mild SOB on this visit
Head/ Neck	☑ WNL Circle any that apply: Masses, Tenderness, Swollen Glands, History Thyroid disease Other Comments
Neurological	☐ WNL Circle any that apply: Headache, History CVA, Tumor, Alzheimers, Dementia, Parkinsons, Syncope, Spinal disc, Mental Status changes, History of seizure disorder, Other Comments
GI	☐ WNL Circle any that apply: Nausea, Vomiting, Acid reflux; Constipation, Diarrhea, history of cancer, appetite loss, tenderness, distention, abnormal bowel sounds Other Comments sluggish
GU	☐ WNL Circle any that apply: Active UTI, History UTI, Foley catheter (size___, balloon___ cc), burning, painful urination, change in color ____, cloudiness, history of BPH, Urostomy Other Comments Anuria 2° to HD
Musculo- Skeletal	☐ WNL Circle any that apply: Arthritis, Broken bone, History of fractures, History of Sprain, History Joint Replacements Other Comments Swollen ankle 2+
Integumentary	☐ WNL Circle any that apply: Color Pale, Color flushed, Color jaundiced, bruising _____, Wound(s) describe ____ Other Comments
Psychosocial	☑ WNL Coping Ability fair Lives with family Environment suitable for therapy ☐ Yes ☐ No Circle any that apply: Depression, Anxiety, Schizophrenia, Psychosis Other Comments
Other	☐ None ☐ Anemia ☐ Autoimmune Disease _____ ☐ Genetic Disorder ____ Comments

Nutritional: ☑ Oral ☐ Enteral ☐ TPN ☐ Other ________

Current Diet Vna ↓ Cholesterol Nutritional Screen done ☐ Yes ☐ No, not needed on this visit

Pump Type ________ ☐ Intermittent ☐ Continuous – Rate and other ________

Patient compliant with Treatment, Therapy ☐ Yes ☐ No

Patient Teaching Comply c continue present regimen

Referrals Made: ☐ No ☐ Yes ________

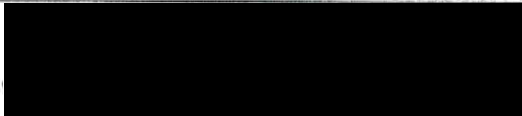
General Assessment comments and comments on Plan of Care meeting patient's needs

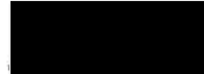
Patient ongoing CHHC c home care follow-up under future assessment for Chemo Therapy. At present patient [illegible] well c no [illegible] discomfort

RN Signature: [redacted] Date: 10/27/17

HEART TO HEART HOME CARE

PARAPROFESSIONAL SUPERVISORY FORM

EMPLOYEE NAME:  DATE: 10/27/17

SKILL LEVEL: CHHA CONTRACT: ______________ PATIENT ID: 

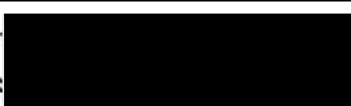
PLEASE BOX

ACTIVITY
FOLLOWS PLAN OF CARE
COMPLETES TASKS AS DIRECTED
MAINTAINS PATIENT'S LIVING AREA/ENVIRONMENT NEAT AND CLEAN
DEVELOPS RELATIONSHIPS WITH PATIENTS AND/OR FAMILY
UNIFORM/I.D. BADGE WORN
VERBALIZES UNDERSTANDING OF OBSERVING CHANGES IN THE PATENT'S CONDITION AND MEANS OF REPORTING CHANGES
VERBALIZES UNDERSTANDING OF STANDARD/UNIVERSAL PRECAUTIONS AND PROCEDURES

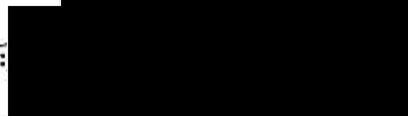
OTHER (SPECIFY): ______________________________

ON THE JOB TRAINING AND/OR OTHER SUPERVISORY OBSERVATIONS: ______________________________

RN SIGNATURE: **DATE:** 10/27/17

LPN SIGNATURE:  **DATE:** ______

COORDINATOR SIGNATURE: **DATE:** 10/27/17
***By phone**

EMPLOYEE SIGNATURE:  **DATE:** 10/27/17

CHECK ONE:

- ☐ CARE PLAN ORIENTED TO NEW EMPLOYEE
- ☑ CARE PLAN REVIEWED WITH PREVIOUSLY ORIENTED EMPLOYEE

☑ IN HOME ☐ IN OFFICE ☐ BY PHONE