

**EXTENDED CARE CLINICAL  
DIRECTOR OF NURSES MEETING  
AUGUST 25, 2016**

**AGENDA**

<b>MatrixCare Wound Management</b>	<b>Amanda &amp; Janet</b>
<b>MatrixCare Preventative Healthcare</b>	<b>Darria</b>
<b>Hospice</b>	<b>Darria</b>
<b>Dietary Recommendations &amp; Orders</b>	<b>Darria</b>
<b>Discharges related to This Week &amp; Mental Abuse</b>	<b>Kim &amp; Amie</b>
<b>ReHospitalizations Workshop</b>	<b>Stephanie</b>
<b>EHDS – Refresher and Test IDs</b>	<b>Stephanie</b>
<b>OTC List – MACRx</b>	<b>Stephanie</b>

# Matrix - Wound Management

## To add a new wound:

1. **Add New** - Blue button on RIGHT
2. Date/time Identified (put in onset date/time)
3. Present on Admit (Yes/No)
4. Wound Type (only can choose Ulcer)
5. On the body highlight region wound is located. Then select wound location from drop-down menu. For areas that need descriptors (medial, lateral, posterior, sup, dorsal, etc.) use the "additional location details then **"Save & Proceed"**.
6. Now choose type of Ulcer (Arterial, Venous, Pressure, Diabetic)  
**Problem:** can't choose things such as Surgical, cancer lesion, moisture associated dermatitis.  
**Option:** With the location, put the type i.e., R breast cancer lesion
7. Input L x W x D  
**Problem:** Can't put <0.1 – For depth.  
**Option:** Put 0.1 and in comments clarify depth to be <.1 cm.
8. Input Drainage Amount.  
**Problem:** Form has options of "none", "light", "mod", "heavy". Our policy supports the accepted terms of "none", "scant", "small", "mod", "large". There are no parameters for what the Wound Management defines theirs.  
**Option:** Define None = closed/dry  
Light = <25% less of dressing  
Mod = 25-75%  
Heavy = >75% of dressing
9. Choose type of drainage.
10. Choose odor (yes/no). If yes, describe.
11. Choose Stage  
**Problem:** Mucosal pressure ulcers – you do not stage Mucosal ulcers.  
**Option:** This system will let you leave the stage blank so for any Mucosal Pressure Ulcer leave this section blank.
12. Choose undermining (yes/no)
  - a. Input longest.
  - b. Input direction. **Problem:** can't put in range such as 12-3. Can only put in one number.  
**Option:** Clarify in comments.
13. Choose Tunneling (Yes/No)
  - a. input length of tunnel
  - b. input direction
14. Choose Tissue Type. Only able to choose ONE type of tissue. The PUSH tool requires you to code for the worst tissue type. For example, if the wound has 10% granulation, 30% slough and 20% eschar, you would choose 'Necrotic' for tissue type.  
**Problem:** can only choose one type. Can't choose multiple to show there could be eschar, slough, and granulation in the wound.  
**Option:** Code the worst tissue type but put the % of each type observed. For example above, put

10% for granulation, 30% for slough and 20% for eschar even though you only choose 'necrotic' for tissue type.

15. Select wound edges observed.

16. Select Periwound observed

**Problem:** Callous is not an option to choose or OTHER.

**Option:** Code in comments

17. Choose (yes/no) wound vac.

a. if yes, input suction amount

b. input continuous / intermittent

18. Choose wound healing status.

**Problem** only has 'improve, stable, decline'. Doesn't have new.

**Option:** For "new" wound, leave this section Blank.

**NOTE: Problem:** Missing Pain (Yes/No), and anywhere to put presence of structures such as hardware, bone, tendon, muscle, etc.

**Option:** code pain and any underlining structures or observation not mentioned in "comments".

**NOTE: Problem:** Unable to make change to any field once saved.

**Option:** No options here, would have to invalidate it and redo all fields.

**NOTE: Problem:** For DTI just purple in color. The tissue type option doesn't allow for "purple"

**Option:** Choose "closed" and describe in the 'comments' section that this wound is purple in color and intact.

### To input new measurements on same wound.

1. Click on "Wound Management" tab
2. Look for ulcer location and click on blue ACTION button
3. Choose "Update"
4. Input date/time observed for weekly measurements.
5. Input L x W x D
6. Input exudate amount/type
7. Input odor (yes/no)
8. Input stage (leave blank if mucosal)
9. Input undermining / tunneling
10. Input edges / periwound
11. Input vac info if yes
12. Add any info in "comments"

## **Wound Report:**

The wound report gives you the following fields: Name, Unit, Room, Wound Type, Date/time identified, location, present on admit, date/time healed and status.

The Summary Page gives you the following fields: Admit with / Acquired but not by stage.


*Comments – If a wound is coded as unstageable, or unstageable not removable dressing, the stage does not show up on the report. Stages 1-4 do but not any of the other ones.*

*Comments – this report does not give you measurements or current information for the wound.*

*Comments – only way to determine that a wound is anything other than Pressure/Arterial/Diabetic/Venous and not just show up as “ulcer” on Wound Management report is to include type of skin condition in the additional box given for location.*

# Wound Management

## *Adding a New Wound*

1. From your resident's menu, select the Wound Management option.
2. The Wound Management page opens. All active documented wound observations appear on this page.
3. Select the Add New button. The Wound Management page opens.
4. Update the Date/Time Identified for the new wound, as needed. You can use the Calendar  feature to select a date .
5. Select Yes or No for Present on Admission/Re-entry?
6. From the Wound Type drop-down list, select Ulcer.
7. Select an area on the body image to indicate the Wound Location, then select a Wound Location from the drop-down list.
8. The Additional Location Details field opens. You can enter additional details here, as need.
9. Select Save & Back to save and return to the Wound Management page.  
Select Save & Proceed to save and enter additional details about the wound.  
Or, select Cancel if you do not want to save.
10. Select a Sub-type for the ulcer. *Note: This can only be done once and not edited later.*

Wound Management

**Wound Information**

Wound Type: Ulcer  
Wound Location: Abdomen - left lower quadrant  
Date/Time Identified: 06/16/2016 02:59 PM  
Present on Admission/Re-entry? No  
Created By: Paulson, DJ  
Created Date/Time: 06/16/2016 03:01 PM

**The sub-type of this Ulcer has not been set.**  
Pick one of the options below to set the sub-type (this can only be done once):

11. Enter the Length – head to toe direction (centimeters) of the wound.
12. Enter the Width – hip to hip direction (centimeters) of the wound.
13. Select Yes or No for Can Depth be measured?  
If Yes, a text box opens to measure the deepest part of visible wound (centimeters).
14. Select the amount for Exudate Amount. A list of color and consistency opens for selection.

15. Select Yes or No for Wound odor present?  
If Yes, a text box opens to describe the odor.
16. For Pressure ulcer sub-type only: Select the Stage of the ulcer. Note: You are NOT able to  
backstage after you have saved the wound information.  
For all other ulcer sub-types: Select the Depth of tissue injury.
17. Select Yes or No for Undermining present?  
If Yes, a text box opens for measurements and a drop-down opens for direction.
18. Select Yes or No for Sinus tract/tunneling present.  
If Yes, a text box opens for measurements and a drop-down opens for direction.
19. Select the type from Tissue Type.
20. Enter percentage for Percent of wound covered by epithelialization tissue:
21. Enter percentage for Percent of wound covered by granulation tissue:
22. Enter percentage for Percent of wound covered by hypergranulation tissue:
23. Enter percentage for Percent of wound covered by red, friable granulation tissue:
24. Enter percentage for Percent of wound covered by slough tissue:
25. Enter percentage for Percent of wound covered by eschar tissue:
26. Enter percentage for Percent of wound covered by clean, non-granulation tissue:
27. Select one of more responses for Wound edges/margins:
28. Select one of more responses for Skin surrounding wound: Assess within 4cm of wound  
edge:
29. Select Yes or No for Is a wound vac present?:  
If Yes a selection box for Wound vac suction level (mm Hg): opens.
30. Select response for Wound vac suction type:
31. Select response for Wound healing status:
32. For Pressure ulcer sub-type only: As you enter the details of the wound, the PUSH tool table  
reflects the appropriate scoring.
33. Select Save Observation.  
For Pressure ulcer sub-type only: The Pressure Ulcer Healing Chart page opens with the  
Pressure Ulcer Healing Record and Pressure Ulcer Healing Graph.
34. You can select Back to return to the Wound Management page.

## *Updating a Wound*

1. From your resident's menu, select the Wound Management option.
2. The Wound Management page opens. All active documented wound observations appear on this page.
3. Select the Action drop-down for the wound you want to update.
4. Select Update.
5. The Wound Information and Observation History display the current information.
6. Enter the wound updated information, including Date/Time Observed.
7. Select Save Observation.

## *Marking a Wound Healed*

To mark a wound healed:

1. From your resident's menu, select the Wound Management option.
2. The Wound Management page opens.
3. Select Mark Healed from the Action drop-down list.
4. You can enter an optional Comment.
5. Select Mark Healed.
6. When you mark a wound as healed, it appears in wound history rather than on the Wound Management page.

## *Marking a Wound Invalid*

To mark a wound invalid:

1. From your resident's menu, select the Wound Management option.
2. The Wound Management page opens.
3. Select Mark Invalid from the Action drop-down list.
4. Select the red Mark Wound and All Observations Invalid button to mark the entire wound and all observations invalid.

Or

Select the red Mark Observation Invalid button for a single observation to mark that observation of the wound invalid.

5. Select Incorrect Data or Wrong Resident from the Reason drop-down list.
6. Enter a Comment (optional).
7. Select a user from the Requested By drop-down list.
8. Select Mark Invalid.

## *Viewing the PUSH Tool Pressure Ulcer Healing Chart*

1. From your resident's menu, select the Wound Management option.
2. The Wound Management page opens.
3. Select PUSH Tool from the Action drop-down list.

*Note: This is only available for a subtype= Pressure wound.*

4. The PUSH Tool Pressure Ulcer Healing Record and the Pressure Ulcer Healing Graph for the wound appear.
5. The 10 most recent, valid wound observations are shown on this page.
  - For wounds with more than 10 previous observations, you can select the Previous and Next buttons to view the additional documentation.

*Note: Selecting the Previous or Next buttons shifts the view of both the Pressure Ulcer Healing Record and Pressure Ulcer Healing Graph.*

## *Viewing Wound History*

When a wound is marked as healed or marked invalid, it no longer appears on the Wound Management page, but it has been moved to wound history.

To view wound history:

1. Select Wound History from the Wound Management page.
2. Enter a Start Date and End Date to search wound observations in that date range.
3. You can select one or more wound type(s) to include in the search results.
4. You can select one or more wound status(es) to include in the search results.
5. Select Search.
6. The wound observations that meet the search criteria appear below.
7. From the Action buttons in the Search Results, you can select View, Mark Invalid, and PUSH Tool (For pressure ulcers only).

# Facility Wound Summary Report

Description
This report is used to track and trend wound healing by facility.
Parameters
You can run the Facility Wound Summary Report by: <ul style="list-style-type: none"> <li>• Start Date</li> <li>• End Date</li> <li>• Residents</li> <li>• Units</li> <li>• Wound Types and Sub-types</li> <li>• Last documented wound healing status</li> <li>• Present on admission or re-entry</li> <li>• Include only wounds identified during the date range</li> <li>• Exclude wounds that were marked healed during the date range</li> <li>• Sort By</li> <li>• Report Output Type</li> </ul>
Purpose
You can use this report to follow wounds being healed at your facility.

MatrixCare Center						
Facility Wound Summary Report						01/01/2016 - 07/11/2016
Resident Name	Room/Bed	Wound Type	Wound Sub-Type	Date/Time	Location	Healed
<b>Aarnick, Wendy</b>						
SouthEast	SE 2012	Ulcer		5/23/2016 11:20AM	Left shoulder	Yes
SouthEast	SE 2012	Ulcer		5/24/2016 4:05PM	Left shoulder	Yes
SouthEast	SE 2012	Ulcer		5/24/2016 4:15PM	Left shoulder	Yes
SouthEast	SE 2012	Ulcer		5/24/2016 4:20PM	Right palm	Yes
SouthEast	SE 2012	Ulcer		5/24/2016 4:28PM	Right ankle	Yes
<b>Aaron, Darby</b>						
300 Hall	30672	Pressure Ulcer	Stage 8 ***	5/16/2016 4:16PM	Left shoulder	Yes
<b>Aaron, Harold</b>						
300 Hall	3061A	Ulcer		4/19/2016 9:35AM	Left second finger	Yes
300 Hall	3061A	Ulcer		4/19/2016 9:35AM	Left ring finger	Yes
MatrixCare Report      User: 20 Neulson      Run Date: 07/11/2016 10:42:04 AM      Page 1 of 16						

The Facility Activity Report now includes the "Wounds – Active" and "Wounds – Identified" options.

## Report Parameters

### Facility Activity Report

Start Date:	08/24/2016
End Date:	08/24/2016
Choose From the Following to Display in Report:	<div style="border: 1px solid black; padding: 5px;"> <ul style="list-style-type: none"> <li>Clinical Coach - Triggered</li> <li>Events - Open</li> <li>Events - Created</li> <li>Observations - Incomplete</li> <li>Observations - Created</li> <li>Orders</li> <li>Progress Notes</li> <li>Vital Signs Out of Range</li> <li>Vital Signs</li> <li style="background-color: #e0e0e0;">Wounds - Active</li> <li style="background-color: #e0e0e0;">Wounds - Identified</li> <li>Select All</li> </ul> <p>Hold down the 'Ctrl' key to select multiple choices</p> </div>

### Example Output:

Wayne, Bruce		Unit/Room/Bed: NORTH WING/112/B					
<b>Wounds - Active</b>							
Date/Time Identified	Creator	Type	Location	Present on Admission?	Last Documented Wound Healing Status	Date/Time Healed	
08/22/2016 12:37PM	Jeffrey Tolley	Ulcer	Left pinky	No		08/24/2016 11:27AM	
08/22/2016 12:42PM	Jeffrey Tolley	Ulcer	Left thumb	Yes			
08/24/2016 11:27AM	Jeffrey Tolley	Pressure Ulcer	Right shoulder	No	Stable		
<b>Wounds - Identified</b>							
Date/Time Identified	Creator	Type	Location	Present on Admission?	Last Documented Wound Healing Status	Date/Time Healed	
08/24/2016 11:27AM	Jeffrey Tolley	Pressure Ulcer	Right shoulder	No	Stable		

## Running the Preventive Health Care Report

The Preventive Health Care report is available for reporting on preventive health care information entered for residents in the facility with detail and summary view options.

To run the Preventive Health Care Report:

1. From the **Facility** menu, select **Reports**. The **Facility Reports** page appears.
2. From the **Resident Info** section, select **Preventive Health Care Report**. The **Report Parameters** page appears.
3. You can update the **Start Date** and **End Date**, if necessary. The **Start Date** defaults to 30 days prior to the current date and the **End Date** defaults to the current date. You can use the Calendar feature to select a date.
4. Select one or more **Residents**. Press the **Ctrl** key to select one or more residents. If you do not select any residents, all residents are selected when you run the report.
5. Select one or more **Units**. Press the **Ctrl** key to select one or more units. If you do not select any units, all units are selected when you run the report.
6. Select one or more **Care Items**. Press the **Ctrl** key to select one or more care items. If you do not select any care items, all care items are selected when you run the report.
7. Select **Summary Only** or **Detail Only** for the report **Format**. **Summary Only** is selected by default.
8. Check the **Refused Only** box to only report on preventive care items charted as refused.
9. Check **Show Outpatients Only** to only report on residents with a status of outpatient during the report date range.
10. Check **Include Outpatients** to include residents with a status of outpatient during the report date range in addition to in-house residents.
11. Check **Include Discharged** to include residents who are currently discharged from the facility.

**Note:** If you check **Show Outpatients Only** and **Include Outpatients** or **Include Discharged**, an error message appears when you select the **Report** button.

12. Check **Scheduled Only** to report on only care items scheduled during the date range of the report.
13. From the **Sort By** drop-down list, select **Resident Name** or **Unit/Room/Bed**.
14. From the **Report Output Type** drop-down list, select **PDF** or **EXCEL**.
15. Select **Report**. The report opens in a new window. You can save or print it, as necessary.

## About Preventive Health Care

You can record and track preventive health care information for residents by adding, editing, marking invalid, and reporting on preventive health care information such as vaccines, tests, and x-rays.

## Adding Preventive Health Care Information

To add preventive health care information:

1. Select the **Preventive Health Care** option from the **Resident** menu. The **Preventive Health Care** page appears.
2. Select **Add**. The **Add New** window opens.
3. From the drop-down list, select the appropriate item to add.
4. Select **OK**. The **Preventive Health Care** page updates with a form for entering details about the vaccine or test selected.
5. Enter the details about the vaccine or test, as necessary.
6. Select **Save**. The History section on the left side of the page updates with the vaccine or test added. The details of the most recently added vaccine or test appear on the right side of the page.
7. To view the details of a different vaccine or test, select the Date, Type, or Administered link for that item.

## Editing Preventive Health Care Information

To edit preventive health care information:

1. From the **Preventive Health Care** page, select a link for the vaccine or test you would like to edit. The details of the vaccine or test appear on the right side of the page.
2. Select **Edit**. The page updates, making the details fields editable.
3. Update the information that needs changing.
4. Select **Save**. The page updates and the details fields change to view-only.

## Marking Invalid Preventive Health Care Information

To mark invalid preventive health care information:

1. From the **Preventive Health Care** page, select a link for the vaccine or test you would like to edit. The details of the vaccine or test appear on the right side of the page.
2. Select **Mark Invalid**. The **Preventive Health Care Mark Invalid** page appears.
3. Select the **Invalidation Reason** from the drop-down list.
4. Select the appropriate user from the **Requested By** drop-down list.
5. Enter a **Reason Note**, if necessary.
6. Select **Save**.
7. Preventive Health Care items marked invalid appear in the History list with gray links. You can select the item, then select the **View Invalid** button to view the details.

## Darria Warnock

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**From:** Stephanie Peterson  
**Sent:** Thursday, August 25, 2016 1:39 PM  
**To:** Darria Warnock  
**Subject:** FW: IDPH

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**From:** Ron Nunziato  
**Sent:** Wednesday, August 10, 2016 1:20 PM  
**To:** Stephanie Peterson; Laura Feliciano-Dixon; Karen Hamilton; Nikki Dinsmore; Margie Thompson; Niki Mehta; Amy Skrypkun-Castro; Daniel Elkaim; Michael Stoudt; Stephanie Hunter; Mary Rose Stucker; Eli Mayer; David Taylor; Jackie Gully; Mike Hunter; Stephen Brumer; Mark Steinberg; Wendy Janulis  
**Subject:** IDPH

I understand IDPH may be coming in to look at discharges – in general and some that have been called in as a complaint to “improper discharge.”

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Please review **F201, F202, F203 and F204** and you will pretty much cover what needs to happen. Basically, this information is conveyed but often times we don't have anything supporting the information was conveyed. For instance, we may have 100 conversations about say lack of payment, personal portion, etc. and resulting discharge BUT do we have anything documenting the conversations? Often times not.

8 points to make sure discharge was “proper”:

1. Time/ date/ where of discharge notification (supported by d/c notice)
2. Discharge not discussed with resident (supported by progress note)
3. Discussion with resident Ombudsman assistance (include in progress note #2)
4. Notification in writing 30 days (supported by d/c notice)
5. Relocation efforts of facility (include in progress note #2, i.e. met to discussion relocation – resident asked to send admission packet to X,Y,Z)
6. Facility counseling efforts to resolve discharge (again supported by progress note)
7. Explanation of reason for discharge (supported by d/c notice and progress note)
8. No Physician orders

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EFax: 866-570-5619

## **CMS to Focus on Involuntary Discharge**

The Centers for Medicare and Medicaid Services (CMS) has announced there will be increased enforcement on involuntary discharges that are not in compliance with **federal requirements**. CMS is going to immediately begin reaching out to state agencies to discuss enhanced enforcement for these deficiencies. Penalties can include **denial of payment for new admissions, civil money penalties and directed plans of correction**. **For residents who are unable to communicate, CMS has indicated the reasonable person standard and**

**implied psychosocial harm will be used. It is assumed that when someone is evicted from their home they suffer psychosocial harm.**

Beginning sometime in federal Fiscal Year 2017, CMS will also add a surveyor oversight track to insure consistency in how deficiencies are sited. Involuntary discharges will be reviewed by a committee of three people: a representative from CMS's national office, a representative from the state's Regional Office and a representative from another regional office.

Below are critical federal requirements that must be strictly followed to avoid a deficiency:

- When a resident is transferred to the hospital, they must be given a copy of the facility's bed hold policy. If the hospital stay exceeds the bed hold policy, then the resident must be offered the first available bed in a same-sex, semi-private room.
- A resident that can not be transferred back to the facility because they pose a danger to themselves or other residents must be provided with a Notice of Involuntary Discharge as soon as practicable before discharge. If you cannot provide the notice before discharge due to the emergent nature of the situation, provide it as soon afterward as possible. If you intend to discharge a resident who does not meet the criteria for an emergency discharge, then you must take them back from the hospital to allow for the 30 days notice of discharge.
- **A resident can only be involuntarily discharged for the following reasons.**
  - The discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility (requires documentation from the resident's physician).
  - The discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility (requires documentation from the resident's physician).
  - The safety of individuals in the facility is endangered.
  - The health of individuals in the facility would otherwise be endangered (requires documentation from a physician).
  - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Section 300.3300(c) and (j) of the state rules provide additional requirements for discharge due to nonpayment, including that a resident cannot be discharged while the individual is an applicant for Medicaid.
- If an individual has resident at the facility for less than 30 days, you can discharge that resident without providing the notice 30 days in advance, but it must still be for one of the allowable reasons.

Surveyors are likely to scrutinize whether there is an adequate basis for an emergency discharge, especially when the facility holds itself out as being able to handle those types of behaviors. This is particularly true for facilities that care for persons with mental illness. A deficiency will likely be cited if you are basing an emergency discharge on behaviors the facility knew, or should have known about, at the time of admission. It is also very important you have contemporaneous documentation that supports the reasons for any emergency discharge, including alternative approaches that were attempted to address any behaviors.

# CareWatch Webinar Refresher Sessions



**Who:** Facility Administrators, DONs, MDS

**Where:** Chateau, Munster Med-Inn, and Prairie Manor

**Why:** To improve our understanding of the Care Watch system, and to better Quality Measures, Star Ratings, MDS scoring, and more.

**When:**

08/31/2016 at 2pm  
09/07/2016 at 2pm  
09/14/2016 at 2pm  
09/28/2016 at 2pm  
10/05/2016 at 2pm  
10/12/2016 at 2pm  
10/19/2016 at 2pm  
10/26/2016 at 2pm

All sessions are required, as they will cover different topics.

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# Locations

## Chateau

7050 S Madison St, Willowbrook, IL 60527  
(630) 323-6380



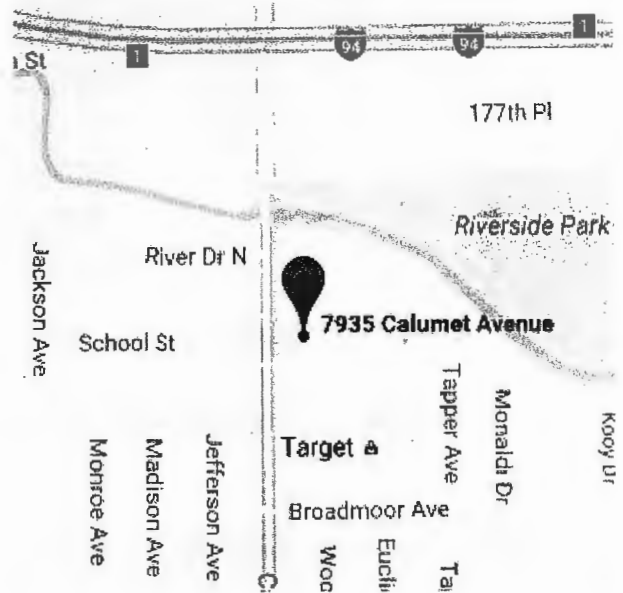
## Prairie Manor

345 Dixie Hwy, Chicago Heights, IL 60411  
(708) 754-5447



## Munster Med-Inn

7935 Calumet Ave, Munster, IN 46321  
(219) 836-8300



CLASS	DRUG	COST	NDC
ANTIFUNGAL	CLOTRIMAZOLE 1% CRM 30GM	1.77	00904--7822-31
	MICONAZOLE 2% CRM 30GM	2.03	00603-7805-50
	MONISTAT 3 4% CRM	12.94	63736-0015-18
ANTITUSSIVE	DEXTROMETHOROPHRAM POLY.89ML	5.04	00904-6312-56
	DAYQUILL 3.54ML	6.57	37000-0565-12
	ROBAFEN 480ML	2.14	00904-0061-16
ARTIFICIAL TEARS	systane ultra 10ml	9.36	00065-0431-05
	TEARS NATURAL BALANCE 15ML	1.94	00904-6493-35
	ARTIFICIAL TEARS 15ML	1.73	00536-1084-94
CALCIUM SUPPLEMENTS	CALCIUM CARB 600MG 150	2.77	00904-3232-92
	calcium carb 1250mg 100's	5.11	00054-4120-25
	CALCIUM LACTATE 648MG 100	2.78	00536-3422-01
	CALCIUM CARB 500/200 100	1.59	00536-7817-08
COUGH&COLD	ROBAFEN DM 480ML	3.19	00904-0053-16
	MUCINEX DM 118ML	7.33	63824-0019-19
LAXATIVES	BISACODYL 5MG 100	0.94	57896-0441-01
	SENNAPLUS 100	3.14	00904-5343-61
	PEG 3350 PWD 8OZ	7.40	45802-0868-02
MOTION SICKNESS	DIMENHYDRINATE 100	1.44	00603-3330-21
	DIPHENHYDRAMINE 25MG 100	1.74	00904-5551-59
	MECLIZINE 12.5MG 100	3.20	00536-1017-01
NASAL DECONGESTANT	OXYMETAZOLINE 0.05% 15ML	0.82	00904-5711-35
	DEEP SEA 45ML	0.82	00904-3865-75
	APHENYLEPHRINE 1% 15ML	3.34	69536-0100-15
OPHTHALMIC ANTI-ALLERGY	VISINE A 15ML	5.16	42002-0200-05
	KETOFEN 0.025% 5ML	6.29	24208-0601-05
	OPTICLEAR 15ML	1.45	00904-6334-35
ACID REFLUX	OMEPRAZOLE 20MG TAB 42	16.93	37205-0837-15
	RANITIDINE 75MG TAB 30	3.49	47981-0026-30
	FAMOTIDINE 20MG TAB 30	4.83	00904-5730-51
ALLERGY			

	LORATIDINE 10MG 300	12.85	458020650-87
	CETIRIZINE 10MG 30	2.63	00904-5842-46
	DIPHENHYDRAMINE 25MG TAB 100	1.74	00904-5551-59
ANALGESICS			
	IBUPROFEN 200MG 100	1.83	00904-7915-80
	MAPAP 500MG 100	1.28	00904-1983-59
	NAPROXEN 220MG 50	3.19	00536-1094-06
ANTACID			
	GERI-LANTA 12OZ	1.60	57896-0629-12
	ANTACID TAB 500MG 150	1.67	00904-6412-92
ANTI-DIARRHEAL			
	LOPERAMIDE 2MG TAB 24	2.13	00904-7725-24
	PINK BISMUTH 30	2.21	00603-0235-16
ANTI-EMETIC			
	MECLIZINE 12.5MG TAB 100	3.20	00536-1017-01
	FORMULA EM	1.91	00904-0049-20
ANTI-FLATUANT		0.00	
	SIMETHICONE CHEW TAB 80MG 100	1.96	00904-5068-60
SKIN MOISTURIZER		0.00	
	HYDROCERIN LOTION 240ML	3.23	54162-0620-08
	HYDR CERIN CREAM 454GM	4.55	54162-0600-01
SLEEP AID		0.00	
	MELATONIN 3MG 60	3.04	51991-0014-16
	DOXYLAMINE 25MG TAB 16	4.76	41167-0060-07
	DIPHENHYDRAMINE 25MG TAB 100	1.74	00904-5551-59
STOOL SOFTENERS		0.00	
	DOCUSATE 50MG 28	7.23	67618-0109-28
	DOCUSATE 100MG 100	1.70	00904-6457-60
TOPICAL ANALGESICS		0.00	
	CAPSACIN 0.025% 60GM	3.09	00603-0648-88
	ICY HOT PATCH 5PATCH	3.88	41167-0084-01
	ANALGESIC BALM 30GM	1.08	54162-0555-01
URINARY ANALGESIC		0.00	
	AZO URINARY PAIN RELIEF 12	4.20	49973-0244-12
VITAMINS		0.00	
	VIT A 8000UNIT 100	2.95	79854-0100-05
	VITAMIN B-1 50MG 100	1.44	00536-4678-01
	VITAMIN B-1 100MG	1.71	00536-4680-01
	VITAMIN B-2 50MG 100	4.14	35046-0001-20
	VITAMIN B-2 100MG 100	3.42	54629-0095-01
	NIACIN 100MG TAB 100	2.74	49805-0228-49
	NIACIN 250MG 100	1.29	00536-+0726-01

NIACIN 500MG 100	4.50	00536-4077-01
PANTOTHENIC ACID B-5 500MG 100	4.22	00536-6717-01
VITAMIN B-6 50MG 100	1.54	00536-4408-01
VITAMIN B-6 100MG 100	1.91	00904-0518-60
BIOTIN 1000MCG 100	4.30	79854-0039-85
BIOTIN 5000MCG 100	4.30	96295-0119-18
FOLIC ACID .4MG 100	1.10	00904-3197-60
FOLIC ACID .8MG 100	1.53	00536-3843-01
VITAMIN B-12 250MCG 100	1.89	00904-4218-13
VITAMIN B-12 500MCG 100	2.18	00536-3551-01
VITAMIN B-12 1000MCG 100	3.82	00536-3556-01
VITAMIN C 250MG 100	1.48	00904-0522-60
VITAMIN C 500MG 300	5.98	00904-0523-72
VITAMIN C 1000MG 100	3.82	00904-5013-60
VITAMIN D 400IU 100	1.28	00904-5823-60
VITAMIN D 2000IU 100	2.49	00904-6157-60
VITAMIN D 5000IU 100	2.12	00904-5986-60
VITAMIN E 100IU 100	1.67	009040270-60
VITAMIN E 200IU 100	2.37	00904-0272-60
VITAMIN E 400IU 100	4.61	00904-0274-60
VITAMIN K 100MCG 100	1.95	11845-0077-91

