51

DOC # 0800661
04/12/2012 01:14 PM Deputy: KE
OFFICIAL RECORD
Requested By:
GEORGE M KEELE

Douglas County - NV
Karen Ellison - Recorder

Page: 1 Of 13 Fee: 51.00
BK-0412 PG-3314 RPTT: 0.00

The undersigned hereby affirms
that there is no
Social Security number
contained in this document.

When recorded, mail to:
George M. Keele
1692 County Road, #A
Minden, NV 89423

CERTIFICATE OF SOLE SUCCESSOR TRUSTEE

I, MARY K. URRUTIA, hereby swear (or affirm), under penalty of perjury, that the following assertions are true of my own personal knowledge:

1. I am over the age of twenty-one (21) years and competent to be a witness as to the matters hereinafter stated.

2. By instrument dated June 7, 2001, MARY E. KELLY, the settlor and the trustee, executed the MARY E. KELLY REVOCABLE TRUST ("the Trust").

3. Article Six (Trustee), paragraph 6.1 (Successor Trustees) of the Trust provides as follows:

> If the office of trustee becomes vacant, by reason of death, incapacity, or any other reason, the following, in the order of priority indicated, shall be trustee:
>
> First, MARY K. URRUTIA, my daughter;
> Second, JOHN M. KELLY, my son;
> Third, ANN M. KELLY-WRIGHT, my daughter.
>
> If all those named above are unwilling or unable to serve as successor trustee, a new trustee or cotrustees shall be appointed by the court.

4. On December 9, 2011, MARY E. KELLY, settlor and trustee of the Trust, was discharged from Sonora Regional Medical Center with a diagnosis of

"Left Acetabular fracture, Alzheimers [sic], Dementia, Osteoporosis, Hypertension."

5. On December 9, 2011, MARY E. KELLY, settlor and trustee of the Trust, was also evaluated by Barbara L. Bammann, M.D., in Physician's Report for Residential Care Facilities for the Elderly (RCFE) as NOT "Able to Manage Own Cash Resources." (Copies of the 3-page Discharge Summary from the Sonora Regional Medical Center Skilled Nursing Transitional Care Unit containing the above-quoted diagnosis and of the 6-page Physician's Report for RCFE are attached hereto, respectively, as Exhibits A and B and are made a part hereof by this reference.)

6. Therefore, pursuant to the terms of Article Six, paragraph 6.1, of the Trust, and as the "First" designated successor trustee of the Trust if the office of trustee "becomes vacant, by reason of incapacity, or any other reason," I have assumed the responsibilities of sole Successor Trustee of the Trust.

7. I am authorized under the terms of the Trust to act in all respects as the sole Successor Trustee of the Trust.

Mary K. Urrutia
MARY K. URRUTIA

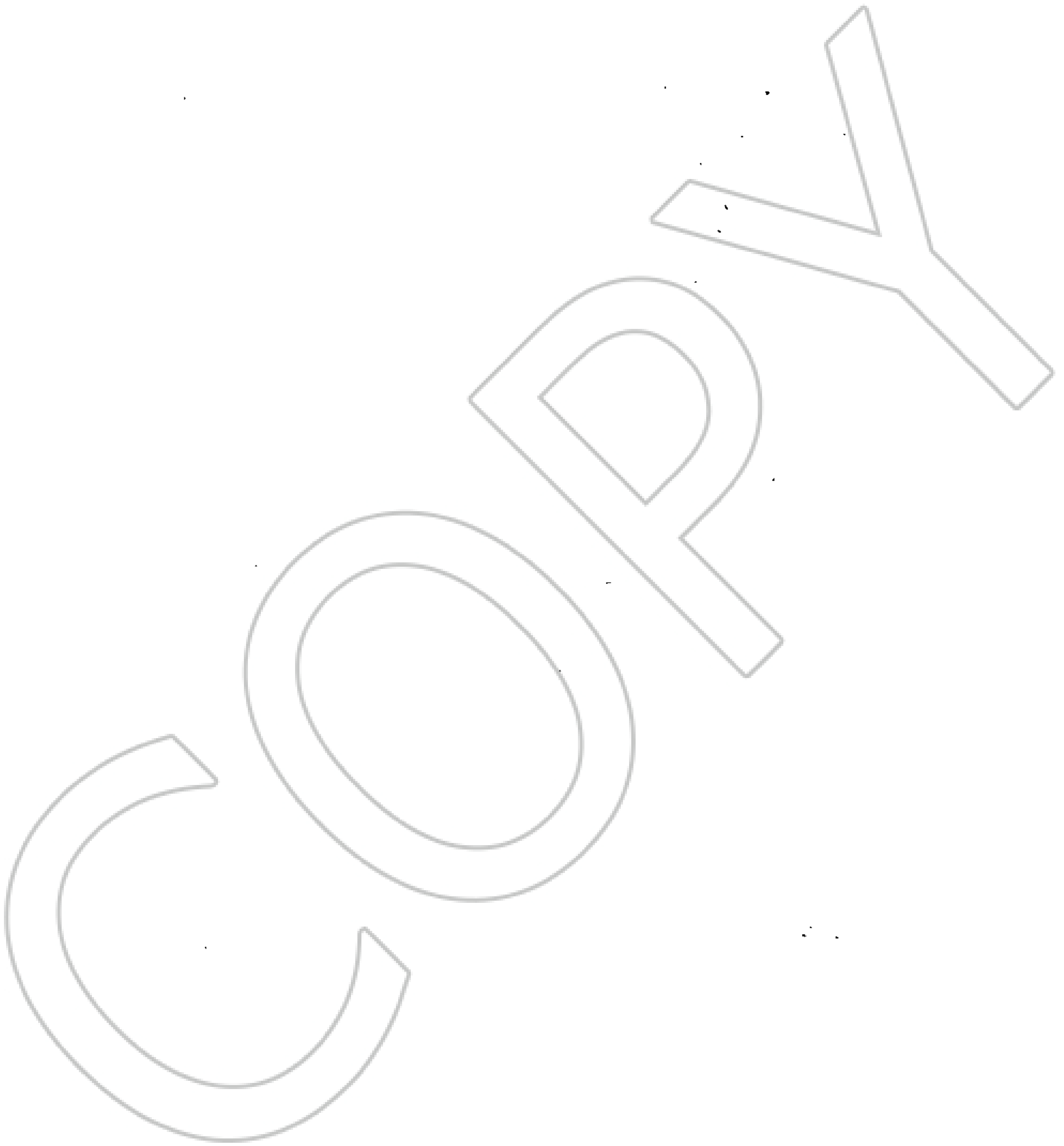
STATE OF NEVADA)
: ss.
COUNTY OF DOUGLAS)

This instrument was acknowledged before me on the 12th day of April, 2012, by MARY K. URRUTIA.

Mary E. Baldecchi
NOTARY PUBLIC

Copy

EXHIBIT A



SONORA REGIONAL MEDICAL CENTER – DP-SNF

DISCHARGE SUMMARY – PAGE 1

For Discharge to Home, Board & Care, Intermediate or Skilled Care
(Completed Form Must Accompany Resident, Place Copy on Chart)

DISCHARGED TO: Oak Terrace 533-4822 **ADDRESS:** 20420 Rafferty Court Jamestown CA 95327

ACCOMPANIED BY: Mary Urrutia **RELATIONSHIP:** Daughter

MODE OF TRANSPORT: private vehicle **DATE:** 12-10-11 **TIME:** 0930

REASON FOR DISCHARGE: (Circle #) (1.) Health improved – no longer needs SNF level of care. (2.) Resident/Family arrangement. (3.) Needs cannot be met in facility. (4.) Safety or health of other individuals endangered by presence. (5.) Failure to meet financial obligation.

NOTIFICATION OF DISCHARGE: Resident ☒ yes ☐ no
Responsible Party Daughter Mary Urrutia ☒ yes ☐ no Time: 12/9/11

RECAPITULATION OF RESIDENT STAY

ADMISSION DATE 12/05/11 **DISCHARGE DATE** 12-10-11 **LENGTH OF STAY** 5 days

REASON FOR ADMISSION (DIAGNOSIS) Left Acetabular fracture, Alzheimers, Dementia, Osteoporosis, hypertension

TREATMENT PROVIDED Physical Therapy, Occupational Therapy, nursing care & medication management

PROGRESS WITH STAY (including any complications) met rehab goals

FINAL SUMMARY OF STAY

COGNITIVE STATUS: ☒ ALERT & ~~ORIENTED~~ ☒ CONFUSED ☒ WANDERS ☒ COOPERATIVE ☐ NON-COOPERATIVE
MEMORY INTACT ☐ Yes ☒ No
ABLE TO MAKE NEEDS KNOWN ☒ Yes ☐ No INDEPENDENT DECISIONS ☐ Yes ☒ No

SENSORY AND PHYSICAL IMPAIRMENT

	GOOD	FAIR	POOR	NONE
VISION	✓			
HEARING	✓			
BLADDER CONTROL	✓			
BOWEL CONTROL	✓			

DATE OF LAST BOWEL MOVEMENT 12-9-11

RESIDENT USES:	YES	NO
GLASSES	✓	
HEARING AID		✓
DENTURES		✓
CATHETER		✓
COLOSTOMY		✓

FUNCTIONAL STATUS

	AMBULATION	TRANSFER	EAT	DRESS	BATHING	GROOMING
INDEPENDENT			✓			✓
NEEDS ASSIST	✓	✓		✓	✓	

(Continued on page 2)

Sonora Regional Medical Center
Adventist Health
1000 Greenley Road
Sonora, California 95370
(209) 532-5000

SKILLED NURSING
TRANSITIONAL CARE

(Patient Identification)

KELLY, MARY E
F 085Y 11/18/1926 ATT 452 BAMMANN HOSP, BARBA
Acct: 84057041 REF
MR # 128-284 CON
ADMIT: 12/05/2011 5023 SWG J

SONORA REGIONAL MEDICAL CENTER – DP-SNF

DISCHARGE SUMMARY – PAGE 2

(Completed Form Must Accompany Resident, Place Copy on Chart)

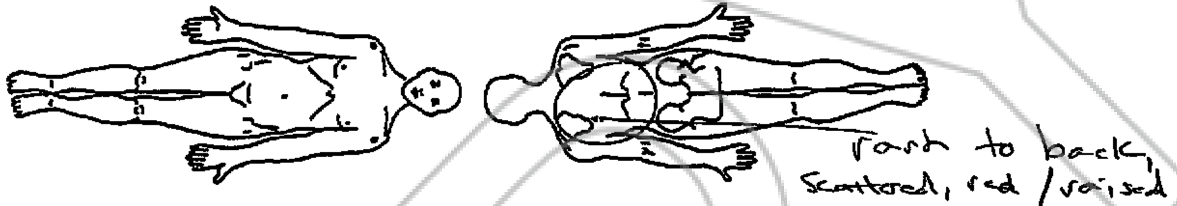
PSYCHO-SOCIAL / MOOD STATUS: INTERACTS ☑ WITHDRAWN ☐ VERBALIZES NEEDS ☑ forgetful, slight confusion
EMOTIONAL ☐ RESISTS CARE/MEDS ☐

LIMITATIONS: Weight bearing as tolerated L-A leg with front wheel walker, up with assist only

NUTRITIONAL STATUS: DIET: Regular, No added salt

SWALLOWING PROBLEMS ______ CHEWING PROBLEMS ______
HEIGHT 5' 6" WEIGHT 142 (lbs) OTHER ______

SKIN CONDITION ON DAY OF TRANSFER: (Depict, Stage and Describe Abnormalities)



DISCHARGE VITAL SIGNS: TEMP 99.4 PULSE 62 RESP. 16 BP 146 / 66

ALLERGIES: NKA

POST DISCHARGE PLAN OF CARE

DISCHARGE DRUG THERAPY: (USE LAY TERMS)

MEDICATION	HOW MUCH	HOW OFTEN	USED FOR	SPECIAL INSTRUCTIONS
Norvasc	2.5mg	every day	(blood pressure)	#30
EC ASA	325mg	every day		#30
Os Cal	1250mg	every day		#30
Vit D3 1000iu	ii TABS	every day		#60
Aricept	5mg	every night		#30
Namenda	10mg	2 times a day		#60
Norco	5/325mg	every 4 hours	as needed pain	#60

(CONTINUED ON PAGE 3)

Sonora Regional Medical Center
Adventist Health

1000 Greenley Road
Sonora, California 95370
(209) 532-5000

SKILLED NURSING
TRANSITIONAL CARE

(Patient Identification)

KELLY, MARY E
F 085Y 11/18/1926 ATT 452 BAMMANN HOSP, BARBA
Acct: 84057041 REF
MR # 128-284 CON 5023 SWG J
ADMIT: 12/05/2011

SONORA REGIONAL MEDICAL CENTER - DP-SNF
DISCHARGE SUMMARY - PAGE 3
(Completed Form Must Accompany Resident, Place Copy on Chart)

OXYGEN/SPECIAL EQUIPMENT - OBTAINED FROM SONORA OXYGEN SERVICES
(Setup/Discharge instructions provided by Sonora Oxygen Services

SPECIAL TREATMENTS/PROCEDURES/INSTRUCTIONS: (use lay terms) Patient gets out of bed without assist, alarms required

VALUABLES release and signed for: ☑ YES ☐ NO 586-3225
PRESCRIPTIONS called to Twain Harte Pharm **Pharmacy** **Date** 12-9-11 **Time** 0900
Rx Script Given To: ☐ **Patient** ☑ **Family** patient's daughter **Date** 12-10-11 **Time** 0930

REFERRALS
call for an appointment for following care with D Boyd PHONE # 532-0126
within One T (days/weeks) (Nick Dobler PA. - 536-5065) (2-3 weeks)

COMMUNITY RESOURCES

SRMC Social Services	536-3854	(SRMC Home Health - Sonora)	536-5700
SRMC Rehab Services	536-5040	SRMC Home Health - Calaveras	736-9181
SRMC Dietician	536-5046	Community Personal Care	536-3823
Sonora Oxygen & Medical Supply	536-3760	Tuolumne County Behavioral Health	588-9528
Motherlode Ombudsman	532-7632	Calif Dept of Public Health	800-554-0354

Other RN, P.T., O.T. Registered Nurse, physical & Occupational therapist

DISCHARGED BY: ☐ Wheelchair ☐ Ambulation ☐ Stretcher
SIGNATURE/TITLE N. Conway DATE 12/9/11
SIGNATURE/TITLE [signature] DATE 12-10-11
SIGNATURE/TITLE DATE

RESIDENTS AND REPRESENTATIVE(S) REACTION TO DISCHARGE PLAN: Patient eager for discharge

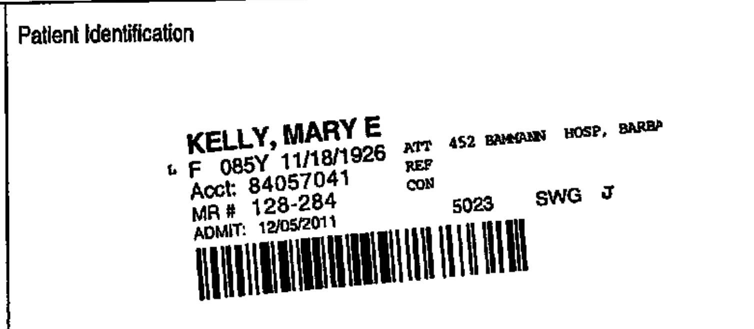
I acknowledge receipt of the medication, belongings, and equipment listed and understand all instructions given. I authorize release of the information in this Discharge Summary to persons and/or agencies involved in the care of person whose identity is stamped on this document.

Mary Urrutia 12-10-11 9:50
RESIDENT/RESPONSIBLE PARTY DATE TIME

Sonora Regional Medical Center
Adventist Health
1000 Greenley Road
Sonora, CA 95370
(209) 532-5000

SKILLED NURSING TRANSITIONAL CARE

Patient Identification


KELLY, MARY E
F 085Y 11/18/1926 ATT 452 BAHMANN HOSP, BARBA
Acct: 84057041 REF
MR # 128-284 CON 5023 SWG J
ADMIT: 12/05/2011

BK- 0412
PG- 3320
0800661 Page: 7 Of 13 04/12/2012

EXHIBIT B

COPY

PHYSICIAN'S REPORT FOR RESIDENTIAL CARE FACILITIES FOR THE ELDERLY (RCFE)

BK- 0412
PG- 3321
04/12/2012
0800661 Page: 8 Of 13

I. FACILITY INFORMATION *(To be completed by the licensee/designee)*

1. NAME OF FACILITY		2. TELEPHONE
Oak Terrace Memory Care		(209) 533-4822
3. ADDRESS	CITY	ZIP CODE
20420 Rafferty Court,	Soulsbyville, Ca. 95372	

4. LICENSEE'S NAME	5. TELEPHONE	6. FACILITY LICENSE NUMBER
Sonora Memory Care Operation LP	(209)533-4822	557003912

II. RESIDENT/PATIENT INFORMATION *(To be completed by the resident/resident's responsible person)*

1. NAME	2. BIRTH DATE	3. AGE
Kelly, Mary E.	11/18/1926	85

III. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
(To be completed by resident/resident's legal representative)

I hereby authorize release of medical information in this report to the facility named above.

1. SIGNATURE OF RESIDENT AND/OR RESIDENT'S LEGAL REPRESENTATIVE

Mary Urrutia

2. ADDRESS	3. DATE
P.O. Box 122 (62 Desert View) Smith NV89430	12-9-11

IV. PATIENT'S DIAGNOSIS *(To be completed by the physician)*

NOTE TO PHYSICIAN: The person named above is either a resident or prospective resident of a residential care facility for the elderly licensed by the Department of Social Services. The license requires the facility to provide primarily non-medical care and supervision to meet the needs of that person. THESE FACILITIES DO NOT PROVIDE SKILLED NURSING CARE. The information that you provide about this person is required by law to assist in determining whether the person is appropriate for care in this non-medical facility. It is important that all questions be answered.
(Please attach separate pages if needed.)

1. DATE OF EXAM	2. SEX	3. HEIGHT	4. WEIGHT	5. BLOOD PRESSURE
12/9/11	F		142 pds	122/61

6. TUBERCULOSIS (TB) TEST

a. Date TB Test Given	b. Date TB Test Read	c. Type of TB Test	d. Please Check if TB Test is: ☐ Negative ☐ Positive

e. Results: mm ____________ f. Action Taken (if positive): ____________

g. Chest X-ray Results: 11/29/11 - negative

h. Please Check One of the Following:

☐ Active TB Disease ☐ Latent TB Infection ☒ No Evidence of TB Infection or Disease

7. PRIMARY DIAGNOSIS: Left Acetabular Fx

a. Treatment/medication (type and dosage)/equipment:
Tylenol gr X po q4hrs prn mild pain
Norco 5/325 po q4hrs prn mod to severe pain.

b. Can patient manage own treatment/medication/equipment? ☐ Yes ☒ No

c. If not, what type of medical supervision is needed?
Needs supervision to store meds.

8. SECONDARY DIAGNOSIS(ES): Alzheimer's Disease, Osteoporosis, HT

a. Treatment/medication (type and dosage)/equipment:
Aricept 5mg po qhs
Namenda 10 mg po bid
Norvasc 2.5 mg po qday
EC ASA 325 mg po qday
Os-Cal 1250 mg po qday
Vit D_3 1000u ii po qday

b. Can patient manage own treatment/medication/equipment? ☐ Yes ☒ No

c. If not, what type of medical supervision is needed?
Needs sup. to store meds

9. CHECK IF APPLICABLE TO 7 OR 8 ABOVE:

☐ Mild Cognitive Impairment: Refers to people whose cognitive abilities are in a "conditional state" between normal aging and dementia.

☒ Dementia: The loss of intellectual function (such as thinking, remembering, reasoning, exercising judgement and making decisions) and other cognitive functions, sufficient to interfere with an individual's ability to perform activities of daily living or to carry out social or occupational activities.

10. CONTAGIOUS/INFECTIOUS DISEASE: N/A

a. Treatment/medication (type and dosage)/equipment:

b. Can patient manage own treatment/medication/equipment? ☐ Yes ☐ No

c. If not, what type of medical supervision is needed?

BK-0412 PG-3322 04/12/2012
0800661 Page: 9 Of 13

11. ALLERGIES: None Known

a. Treatment/medication (type and dosage)/equipment:

b. Can patient manage own treatment/medication/equipment? ☐ Yes ☐ No

c. If not, what type of medical supervision is needed?

12. OTHER CONDITIONS: N/A

a. Treatment/medication (type and dosage)/equipment:

b. Can patient manage own treatment/medication/equipment? ☐ Yes ☐ No

c. If not, what type of medical supervision is needed?

13. PHYSICAL HEALTH STATUS	YES	NO	ASSISTIVE DEVICE (If applicable)	EXPLAIN
a. Auditory Impairment		X		
b. Visual Impairment	X		eyeglasses	
c. Wears Dentures		X		
d. Wears Prosthesis		X		
e. Special Diet		X		
f. Substance Abuse Problem		X		
g. Use of Alcohol		X		
h. Use of Cigarettes		X		
i. Bowel Impairment		X		
j. Bladder Impairment		X		
k. Motor Impairment/Paralysis		X		
l. Requires Continuous Bed Care		X		
m. History of Skin Condition or Breakdown		X		

BK- 0412 PG- 3323 04/12/2012
0800661 Page: 10 Of 13

COPY

14. MENTAL CONDITION	YES	NO	EXPLAIN
a. Confused/Disoriented	X		
b. Inappropriate Behavior		X	
c. Aggressive Behavior		X	
d. Wandering Behavior		X	
e. Sundowning Behavior		X	
f. Able to Follow Instructions	X		
g. Depressed		X	
h. Suicidal/Self-Abuse		X	
i. Able to Communicate Needs	X		
j. At Risk if Allowed Direct Access to Personal Grooming and Hygiene Items		X	
k. Able to Leave Facility Unassisted	X		

15. CAPACITY FOR SELF-CARE	YES	NO	EXPLAIN
a. Able to Bathe Self	X		with supervision
b. Able to Dress/Groom Self	X		with supervision
c. Able to Feed Self	X		
d. Able to Care for Own Toileting Needs	X		with supervision
e. Able to Manage Own Cash Resources		X	

16. MEDICATION MANAGEMENT	YES	NO	EXPLAIN
a. Able to Administer Own Prescription Medications	X		c̄ sup.
b. Able to Administer Own Injections	N/A		
c. Able to Perform Own Glucose Testing	N/A		
d. Able to Administer Own PRN Medications	X		c̄ sup.
e. Able to Administer Own Oxygen	N/A		
f. Able to Store Own Medications		X	

BK- 0412 PG- 3324 04/12/2012
0800661 Page: 11 Of 13

COPY

17. AMBULATORY STATUS:

a. This person is considered: ☒ Ambulatory ☐ Nonambulatory ☐ Bedridden

Nonambulatory: Means persons unable to leave a building unassisted under emergency conditions. It includes any person who is unable, or likely to be unable, to physically and mentally respond to a sensory signal approved by the State Fire Marshal, or to an oral instruction relating to fire danger, and persons who depend upon mechanical aids such as crutches, walkers, and wheelchairs. (Health & Safety Code Section 13131)

Bedridden: Means either requiring assistance in turning and repositioning in bed, or being unable to independently transfer to and from bed, except in facilities with appropriate and sufficient care staff, mechanical devices if necessary, and safety precautions. No resident shall be admitted or retained in a residential care facility for the elderly if the resident is bedridden, other than for a temporary illness or for recovery from surgery. (Health & Safety Code Section 1569.72)

b. If resident is nonambulatory, this status is based upon:

☐ Physical Condition ☐ Mental Condition ☐ Both Physical and Mental Condition

c. If a resident is bedridden, check one or more of the following and describe the nature of the illness, surgery or other cause:

☐ Illness: ______________________

☐ Recovery from Surgery: ______________________

☐ Other: ______________________

NOTE: An illness or recovery is considered temporary if it will last 14 days or less.

d. If a resident is bedridden, how long is bedridden status expected to persist? N/A

1. ________ (number of days)

2. ______________ (estimated date illness or recovery is expected to end or when resident will no longer be confined to bed)

3. If illness or recovery is permanent, please explain: ______________________

e. Is resident receiving hospice care?

☐ No ☐ Yes If yes, specify the terminal illness: ______________________

BK- 0412 PG- 3325 04/12/2012
0800661 Page: 12 Of 13

18. PHYSICAL HEALTH STATUS: ☒ Good ☐ Fair ☐ Poor

19. COMMENTS:

BK- 0412
PG- 3326
04/12/2012
0800661 Page: 13 Of 13

COPY

20. PHYSICIAN'S NAME AND ADDRESS (PRINT)	
Barbara L. Bammana MD (Nick Dobler PA is 1° Care),	
21. TELEPHONE	22. LENGTH OF TIME RESIDENT HAS BEEN YOUR PATIENT
(209) 536-5047	Since 12/5/11.
23. PHYSICIAN'S SIGNATURE	24. DATE
[signature]	12/9/11