Medical Chronology/Summary

Confidential and privileged information

Usage guideline/Instructions

***Verbatim summary:** All the medical details have been included "word by word' or "as it is" from the provided medical records to avoid alteration of the meaning and to maintain the validity of the medical records. The sentence available in the medical record will be taken as it is without any changes to the tense.

***Case synopsis/Flow of events:** For ease of reference and to know the glimpse of the case, we have provided a brief summary including the significant case details.

***Injury report:** Injury report outlining the significant medical events/injuries is provided which will give a general picture of the case.

***Comments:** We have included comments for any noteworthy communications, contradictory information, discrepancies, misinterpretation, missing records, clarifications, etc for your notification and understanding. The comments will appear in red italics as follows:
"****Comments***"

Indecipherable notes/date:** Illegible and missing dates are presented as "00/00/0000" (mm/dd/yyyy format). Illegible handwritten notes are left as a blank space "_____" with a note as ***"Illegible Notes" in heading reference.

***Patient's History:** Pre-existing history of the patient have been included in the history section

***Snapshot inclusion:** If the provider name is not decipherable, then the snapshot of the signature is included. Snapshots of significant examinations and pictorial representation have been included for reference.

***De-Duplication:** Duplicate records and repetitive details have been excluded.

General Instructions:

- *The medical summary focuses on **nursing home fall occurred on 08/12/YYYY** and its management in detail. Fall risk assessments and precautions have been included in detail*
- *From the prior records, only musculoskeletal injuries have been summarized in detail. Unrelated visits for other medical conditions have been included in brief for reference.*
- *Medical records from 08/12/YYYY till death are summarized in detail to show the decline in condition; interim progress notes and therapy records are summarized in brief.*

Flow of Events

Parsons Presbyterian Manor

05/12/YYYY-08/12/YYYY: Ms. Tanner was a nursing home resident-she had cerebrovascular accident, end stage renal disease on dialysis and generalized weakness-On 08/12/YYYY, she fell on to floor from her bed and injured head and noted left eye shut and blurred eye brow swollen-Transferred to Labette Health ER for further evaluation

Labette Health ER & Free Man Health System

05/12/YYYY-08/12/YYYY: She was transferred to Labette Health ER for evaluation-Fall risk score 45 on 08/12/YYYY-CT of head & maxillofacial obtained which revealed Left orbital floor fracture, left periorbital preseptal hematoma; could not exclude hematoma along the left orbital floor; Hemorrhagic opacification left maxillary sinus and transferred to Freeman Health system for an extended care-Multiple consultations obtained- canthotomy and cantholysis was performed at the bedside in ER to reduce intraocular pressure from greater than 70 to approximately 45-subsequently admitted to the intensive care unit for further management-Thoracocentesis performed-Developed pneumonia and C. Diff-Treated and transferred to Landmark on 08/27/YYYY

Landmark Hospital of Joplin

08/27/YYYY-09/23/YYYY: *She was transferred on 08/27/YYYY; course was complicated by E. coli bacteremia and healthcare acquired pneumonia with a large left pleural effusion which is been tapped and not recurrent. She also developed C. Difficile colitis which is been fully treated.*

Elm Haven East

09/23/YYYY-12/07/YYYY: *She was a nursing home resident; on 12/07/YYYY, her health condition was declined due to stopping dialysis post going onto hospice services-At 1200 hrs, nurse was unable to obtain vitals; Resident body left facility at 1320 hrs to Carson Wall Funeral home.*

Patient History

Past Medical History: Cerebrovascular accident with right sided weakness on TPA (2009), End-stage renal disease, hypothyroidism, hyperlipidemia, gastro esophageal reflux disease, acute blood loss anemia, hyponatremia, coronary artery disease with stent placement, deep urinary tract infection, hypertension, dysphagia

Surgical History: Bilateral total hip replacement (2000 and 2004)

Family History: Not known

Social History: There is a distant history of tobacco abuse, but no current tobacco use. No alcohol and ho illicit drug use

Allergy: No known drug allergies

Detailed Summary

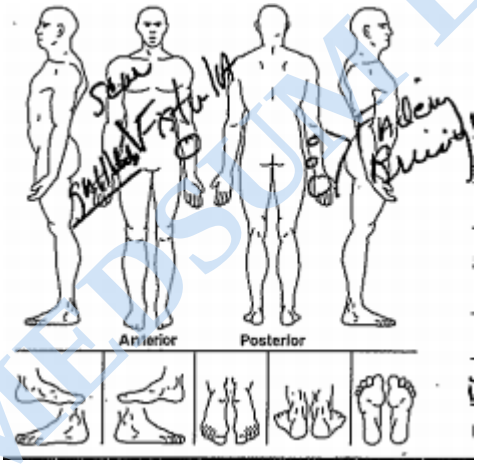
DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
04/19/YYYY	Hospital/ Provider Name	**Occupational therapy initial evaluation report:** **Admitting diagnosis**: Altered mental status, history of intracranial hemorrhage **History of present illness**: Patient admitted 04/17/YYYY. Patient presented to ER with complaints of decreased level of consciousness. The patient was discharged to VCRH the day prior to admit. Family noted the patient was completely aphasic & had altered mental status. She was sporadically moving the right side of her body and was not following any commands. She was recently admitted on 03/26/YYYY with right sided hemorrhagic cerebrovascular accident. CT 04/17/YYYY: Subacute right thalamic hemorrhage, decreasing in size and density compared with 04/06/YYYY. No evidence of rebleed. MRI 04/18/YYYY: There is a right thalamic hemorrhage present with no other abnormality seen. Underlying chronic changes in the deep white matter compatible with chronic ischemic change, similar to the prior study. **Prior living situation**: Home, lives alone **Steps**: 2 from garage **Employment status:** Retired **Prior gait:** Independent without assistive device Comments: Patient has a cane she would use after dialysis. Her daughter reports she would hold onto the cart while shopping or somebody's arm if it was long distances. **Patient owned equipment**: Cane, single point, grab bars, raised toilet seat, reacher **Patient owned equipment comments:** Hand held shower **Prior toileting**: Independent. Uses raised toilet seat, uses grab bar **Prior dressing:** Independent **Prior bathing:** Independent, uses shower chair, has grab bar **Prior bathing comments:** Patient has a shower chair but reports she was able to stand prior to her cerebrovascular accident **Prior driving**: Yes **Prior groceries, cooking, laundry, cleaning**: Independent Comments: Patient's daughter would assist patient with deep cleaning like scrubbing the showers and mowing the yard. Patient was independent with dishes, dusting, etc. Patient independent with bed mobility & managed own medications. **Patient/family goals**: Go to a skilled nursing unit Comment: Patient reports she has been told she cannot go home and they have mentioned the nursing home. Patient states she would prefer to go home is she is able	1-3

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Patient condition: Alert, confused, cooperative **Neuro screen**: Temperature sensation impaired to left upper extremity Comments: Per chart, patient with dysphagia. However, daughter reports patient only has difficulty swallowing when on medication that makes her lethargic. **Feeding assistance**: Dobhoff **Oral hygiene and grooming:** Oral hygiene and grooming position: Edge of Bed (EOB) Oral hygiene and grooming assistance: 2 – Moderate + assistance (patient=25%+) **Dressing:** Dressing position: Edge of Bed (EOB) Dressing assistance upper extremity: 2 – Moderate + assistance (patient=25%+) Dressing assistance lower extremity: 1 – Maximal assistance (patient=1%+) Dressing assistance for sock and shoe: 1 – Maximal assistance (patient=1%+) Toileting transfer: Untested **Bathing:** Bathing transfer: Sponge Bathing transfer assistance: 1. Maximal assistance (patient=1%+), with assistance of 2 Bathing assistance trunk/arms: 2. Moderate + assistance (patient=25%+) Bathing assistance legs/feet: 1. Maximal assistance (patient=1%+) **Bed mobility, gait and balance:** Bed mobility: 1. Maximal assistance (patient=1%+), with assistance of 2 Gait screen: Untested Sitting balance: Poor-Some evidence of postural reactions and/or protective extension but unable to maintain balance without assist/upper extremity support. Standing balance: Poor-Some evidence of postural reactions. Unable to maintain balance without support. Bed mobility, gait, and balance comments: Patient leans to the left while sitting edge of bed **Recommendations and plan of care:** **Problem list:** Decreased range of motion, decreased safety awareness, decreased strength, fall risk, impaired balance, impaired coordination, impaired bed mobility, impaired self-care, impaired transfers **Treatment provided**: Family education, functional activity, patient education **Treatment charged**: Evaluation	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Activity tolerance: Active participant, cognitively impaired **Occupational therapy services indicated**: Yes **Refer to other services**: Speech therapy **Services indicated/refer to other services comments**: Family is concerned about dysphagia Potential to meet goals: Fair Meet goals in time: 2 weeks Hygiene and grooming assistance: 3. Moderate assistance (patient=50%+) Dressing assistance upper extremity: 3. Moderate assistance (patient=50%+) Dressing assistance lower extremity: 2. Moderate + assistance (patient=25%+) Toileting assistance: 2. Moderate + assistance (patient=25%+) Bathing assistance: 2. Moderate + assistance (patient=25%+) **Treatment intervention:** Range of motion exercises, strengthening, functional self-care, functional mobility, balance/coordination, patient/family education, functional activities Frequency: See patient daily Monday-Friday	
04/19/YYYY	Hospital/ Provider Name	**Physical therapy initial evaluation report:** **Admitting diagnosis:** Altered mental status, history of intracranial hemorrhage Patient was admitted on 04/17/YYYY. Presented to ER with complaints of decreased level of consciousness. Patient was discharged to VCRH the day prior to admit. Family noted the patient was completely aphasic prior to admit. Family noted the patient was completely aphasic & had altered mental status. She was sporadically moving the right side of her body and was not following any commands. She was recently admitted on 03/26/YYYY with right sided hemorrhagic cerebrovascular accident. CT 04/17/YYYY: Subacute right thalamic hemorrhage, decreasing in size and density compared with 04/06/YYYY. No evidence of rebleed. MRI 04/18/YYYY: There is a right thalamic hemorrhage present with no other abnormality seen. Underlying chronic changes in the deep white matter compatible with chronic ischemic change, similar to the prior study. **Precautions:** Fall risk **Prior gait**: Independent without assistive device Comments: Patient has a cane she would use after dialysis. Her daughter reports she would hold onto the cart while shopping or somebody's arm if it was long distances. **Patient owned equipment:** Cane, single point. Grab bars, raised toilet seat, reacher	4-6

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Comments: Hand held shower Prior toileting: Independent, uses raised toilet seat, uses grab bar Prior dressing: Independent Prior bathing: Independent, uses shower chair, has grab bar Comments: Patient has a shower chair but reports she was able to stand prior to her cerebrovascular accident Prior driving: Yes Prior groceries, cooking, laundry, cleaning: Independent Comments: Patient's daughter would assist patient with deep cleaning like scrubbing the showers and mowing the yard. Patient was independent with dishes, dusting, etc. Patient independent with bed mobility & managed own meds. Patient condition: Alert, confused, cooperative Pain: No **Neuro screen**: Dysarthria, dysphagia Comments: Mild pushing with extended right upper extremity towards left when seated **Bed mobility, transfers**: Maximal assistance with assist of 2 Gait: Untested **Balance:** Sitting balance: Poor-some evidence of postural reactions and/or protective extension but unable to maintain balance without assist/upper extremity support. Standing balance: Poor-some evidence of postural reactions. Unable to maintain balance without support. **Recommendations and plan of care:** Problem list: Decreased insight to precautions, decreased safety awareness, decreased strength, fall risk, impaired balance, impaired coordination, impaired bed mobility, impaired self-care, impaired speech/language, impaired transfers, visual/auditory deficits **Treatment provided:** Family education, functional mobility, patient education **Treatment charged**: Evaluation, functional activities **Activity tolerance**: Active participant, cognitively impaired, fatigues easily **Refer to other services**: Speech therapy **Potential**: Fair **Plan of care:** Treatment frequency: See patient daily Monday-Friday	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Treatment interventions: Strengthening, functional mobility, balance/ coordination, patient/family education **Discharge recommendations:** Skilled nursing unit	
04/19/YYYY-04/24/YYYY	Hospital/ Provider Name	***Hospitalization records:*** *The patient was admitted to Via Christi Hospitals Wichita, INC on 04/19/YYYY and was there for a week for management of chronic conditions. Patient had uremia, BP fluctuations and had dialysis. Patient was transferred to Parson's Rehab on 04/24/YYYY for rehab and management of debility.*	7-15
04/25/YYYY	Hospital/ Provider Name	**Admission plan of care:** **Activities of daily living problems:** Self-care deficit related to: Disease process & end stage disease process. Other: Recent stroke paralysis to left side. **Goals:** No decline in activities of daily living ability will be experienced over next 30 days. **Approaches:** Bathing: Assist of 1 Personal hygiene & grooming: Assist of 1 Eating: Assist of 1 Ambulation/locomotion: Assist of 2 Toileting: Assist of 2 Transfers: Assist of 2 Total assist of 2 with all activities of daily living Occupational therapy per M.D. orders Physical therapy per M.D. orders Assistive device: Hoyer lift **Fall prevention:** At risk for fall due to disease process, impaired cognition and impaired activities of daily living. **Approaches:** Educated on safety measures to reduce fall risk Orient to room and PMMA common area Low bed Provide appropriate activities of daily living assist Cueing with safety measures Assistive devices in place Ensure appropriate lighting Educated on call light use and function Skilled therapy services	16-17
04/25/YYYY	Hospital/ Provider Name	**Transfer report:** Arrival at referring facility 1501 hrs Departure: 1522 hrs Arrival at receiving facility: 1805 hrs	18

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Origin: Via Christi St. Francis Destination: Parsons Presbyterian Manor **Chief complaint/reason for transport**: Post Cerebrovascular accident	
04/25/YYYY	Hospital/ Provider Name	**Admission nursing assessment:** *(Illegible notes)* Date of admission: 04/25/YYYY Time of admission: 1805 hrs Transported by: Ambulance Accompanied by: EMT's **Vitals**: T 97.1F, PR 69 bpm, RR 20, BP 180/76 **Diagnosis**: CVA (Cerebrovascular Accident), ESRD (End Stage Renal Disease) dialysis **Pain on admission**: No pain **General skin condition**: Dry **Skin condition**:  **Comments**: Bedpan, also wears brief **Special treatments and procedures:** Also Vista to be applied at __ to prevent breakdown, inner rectal slightly red **Functional status:** Transfers – able to transfer: 2 person assist, total assist Ambulation – able to ambulate: 2 person assist, wheelchair only	19-20
04/25/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* Resident arrived approximately 1805 hrs via ambulance to second floor. Taken to room 230 bed B. Daughters here before resident arrived. Resident is alert and verbal with slight confusion. Daughter stated she is at fall risk. Resident has fistula to the mid left arm. Takes medications crushed with apple sauce. Resident	21

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		takes small sips at a time. Resident is on low sodium diet (renal). Tray brought to resident and she ate approximately 25-30%. Resident is to take medications with apple sauce and crushed. Two medications given at bedtime. Medications from _ not received _ of yet. Vital signs today 180/76, PR 69 bpm, RR 20, T 97.1F. Resident has fading bruise to her right hand and mid right forearm. No other bruising noted. There is a scar to section of right quadrant. She states it _ from gallbladder surgery". Resident has upper and lower _. Resident has ability to use call light to make her needs known. Uses bedpan for toileting. Resident has tendency to kick off blankets and sheets and throws her legs off of the bed and does not keep her feet on pillow for comfort. Feet and heels clear. The inner section had slight redness; _ CNA's start applying Aloe Vista with each change.	
04/25/YYYY	Hospital/ Provider Name	**Nursing notes:** May we have order for physical therapy/occupational therapy to evaluate and treat questionable; resident is skilled care.	22
04/26/YYYY	Hospital/ Provider Name	**Physical therapy evaluation:** *(Illegible notes)* **Hospitalization dates**: 03/26/YYYY to 04/25/YYYY **Primary diagnosis**: Cerebrovascular accident with right sided hemorrhagic Unspecified late effects of cerebrovascular accident (438.9) Late effects of cerebrovascular disease, hemiplegia affecting dominant side (438.21) **Treatment diagnosis:** Generalized muscle weakness (728.87) Abnormal gait (719.7) **Onset date**: 03/26/YYYY **Prior level of function:** Patient living independent at home, family _. Dialysis 3 times a week **Reason for referral**: Decreased strength and mobility **Prior physical therapy treatment**: N/A **Precautions/complications:** Fall risk **Functional area:** **Bed mobility:** Supine/sit: Maximum assist x 2 Sit/stand: Total assist x 2 Rolling: Maximal assist x 2 Bridging: Not tested **Weightbearing:** Weightbearing as tolerated	23-24

<table>
<tr><th>DATE</th><th>FACILITY/ PROVIDER</th><th>MEDICAL EVENTS</th><th>PDF REF</th></tr>
<tr><td></td><td></td><td>
Gait: Unable at this time

Transfers:
Bed/chair: Maximal – total/Hoyer
Wheelchair: Maximal assist x 2
Car: Not tested

Balance:
Static sitting: Poor, unable without support
Static standing: Poor, no balance
Dynamic sitting: Poor
Dynamic standing: Not tested
Fall risk: Moderate

Pain: Denies

Wheelchair mobility/management: Dependent
Cognitive status, orientation: Alert and oriented x 2+
Activity tolerance: Poor
Cardiac/pulmonary status: Good
Skin integrity: Intact
Gross motor condition, fine motor condition: Impaired left side

Extremity function:
<table>
<tr><td></td><td>Left lower extremity</td><td>Right lower extremity</td></tr>
<tr><td>Strength</td><td>1+</td><td>3+</td></tr>
<tr><td>Range of motion</td><td>Within normal limits (passive)</td><td>Within functional limits</td></tr>
<tr><td>Sensation</td><td>Fair</td><td>Good</td></tr>
</table>
Treatment plan:
Skilled physical therapy may include: Therapeutic procedures, neuromuscular reeducation, therapeutic activities
Frequency: 5 times a week for 30 days

Discharge plan/location: Long-term care

Rehab potential: Good
</td><td></td></tr>
<tr><td>04/27/YYYY</td><td>Hospital/ Provider Name</td><td>
Transfer form:

To: Labette Health ER.

From: Presb Manor Parsons

Reason for transfer: Fall to floor, hit her head on left upper forehead.

Send to ER for evaluation of head and check left elbow/shoulder.
</td><td>25</td></tr>
</table>

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Code status: DNR (Do Not Resuscitate).	
04/28/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* When I want to be in chair place me in left than recliner with call light within reach.	26
05/07/YYYY	Hospital/ Provider Name	**Progress notes:** *(Illegible notes)* The patient is hospitalized 04/17/YYYY-04/25/YYYY for acute encephalopathy secondary to Kleb urinary tract infection. Prior, she had hemorrhagic cerebrovascular accident with left side weakness. **Meds:** Miralax 17g daily as needed constipation Ativan 0.5mg at night for insomnia Tucks pads as needed for hemorrhoids	27
05/14/YYYY	Hospital/ Provider Name	**Transfer form:** *(Illegible notes)* **Transferred to facility:** Labette Health Via Christ-St. Francis. **Transferring facility:** Presb Manor Parsons. **Diagnosis:** Cerebrovascular accident Endstage renal disease Dialysis **Reason for transfer:** Dyspnea, shortness of breath. **Disabilities:** Paralysis left side. **Activity tolerance limitations:** Severe. **Weight bearing:** Partial. **Transportation:** Ambulance.	28-29
05/15/YYYY	Hospital/ Provider Name	**Echocardiogram:** **Impression:** Severe left ventricular systolic dysfunction. Moderate pulmonary hypertension. EF visually around 35%.	30
05/16/YYYY	Hospital/ Provider Name	**Speech therapy functional measurements:** **Admitting diagnosis:** Pulmonary edema. **History of present illness:** She presented with multiple recent hospital admissions, end state renal disease and recent history of hemorrhagic	31

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		cerebrovascular accident with residual left sided weakness. Chest X-ray dated 05/15/YYYY noted "five lobed infiltrates" and infiltrates cleared by 05/16/YYYY. **Prior living situation:** Skilled nursing. **Oral-peripheral exam:** **Facial symmetry:** Left side weakness. **Bedside dysphagia evaluation:** **Prior diet:** Regular, thin/regular consistency liquids **Current diet:** Nil per oral **Evaluation position:** 90 degrees angle in bed **Swallow initiation:** Mildly delayed. **Swallow function comments:** Patient reported eating a regular diet without difficulty prior to admission. Patient was presented with ice, water, and applesauce. Mild swallow delay with inconsistent cough/throat clear and gurgly vocal quality with all consistencies. 2-3 swallows for every bolus indicating pharyngeal weakness. Laryngeal excursion appears adequate. Patient reported pain when swallowing. Recommended sips and chips and modified barium swallow to visualize structures and rule gut aspiration.	
05/14/YYYY-05/21/YYYY	Hospital/ Provider Name	***Hospitalization related records:*** *Assessment, progress notes, therapy records* ***Ref:*** *32-48*	
05/21/YYYY	Hospital/ Provider Name	**Discharge summary:** **Date of admission:** 05/14/YYYY. **Final diagnoses:** 1. Acute respiratory failure secondary to a combination of pulmonary edema, pneumonia, and possible aspiration. 2. Pneumonia, bilateral, which has resolved prior to the dismissal likely secondary to aspiration versus community-acquired pneumonia. 3. End-stage renal disease, on chronic dialysis treatment. 4. Atrial fibrillation, which has reverted to normal sinus rhythm since admission. 5. History of hemorrhagic cerebrovascular accident in 03/YYYY. 6. Type 2 Non-ST elevation myocardial infarction. 7. Congestive heart failure with an ejection fraction of 35%. 8. Anemia of chronic kidney disease and .acute disease. 9. Hypokalemia. 10. Hypophosphatemia. 11. Hypothyroidism. 12. Hyperlipidemia. 13. Urinary urgency without evidence of urinary infection. **Consultations:**	49-51

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		1. Wasim Shaheen, MD, Cardiology. 2. Janel Harting, MD, Pulmonology. 3. Richard Steinberger, MD, Urology. **Procedures:** Hemodialysis treatment. **Hospital course:** She was admitted from Parsons, Kansas due to worsening shortness of breath and markedly elevated white count. The patient normally follows with Dr. Linda Francisco at Parson s Dialysis Center. Prior to admission, she was complaining of significant shortness of breath and further evaluation was consistent with acute respiratory failure with pulmonary edema and question of infection as well. White count was elevated. Her clinical symptoms and chest X-ray have improved progressively over the next few days of admission. Pulmonologist, Dr. Harting and her parents did assist with management of respiratory failure and pneumonia. The patient initially was in atrial fibrillation. The rhythm subsequently did convert to normal sinus rhythm. Dr. Shaheen was consulted. The patient was felt to have non-ST elevation myocardial infarction type 2 with congestive heart failure with an ejection fraction of 35%. Her electrolyte imbalance was corrected as best as possible during this admission. Her TSH was high and her thyroid supplementation was adjusted. The patient also complained of severe urgency of urination since her stroke in 03/YYYY. Dr. Steinberger, urologist was consulted. Urine cultures were negative, but there was suspicion for infection. She was treated with Neosporin installation into the bladder and was instructed to follow up with local urologist, Dr. Pai. The patient was dismissed in a stable and improved condition to return to the nursing home. **Physical limitations:** As tolerated with ongoing physical therapy as needed. She will continue her dialysis as scheduled on Monday, Wednesday and Friday at Parsons Dialysis Center. She will follow up with Dr. Linda Francisco at dialysis center and with the nursing home physician for non-renal diagnosis.	
06/27/YYYY	Hospital/ Provider Name	**Nursing notes:** Resident is requesting Lortab daily for pain, is not controlling for pain. May we increase this to twice daily routinely to help with pain questionable. Also we have an order for Miralax routinely instead of as needed questionable. Please advise	52
10/16/YYYY	Hospital/ Provider Name	**Restorative care program:** *(Illegible notes)* Patient is discharged from: Occupational therapy. **Goals for restorative program:** Participate with group RA _ daily Single body assist with wheelchair propulsion RM <-> _	53

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Min _ to self-correct posture seated in wheelchair Single body assist-moderate assist with hemi-technique with upper body dressing **Approach/recommendations for implementation of above goals:** Provider the patient her shirt/jacket/seater with morning dressing tasks. Remind her to sit up fall during wheelchair prop from room <-> DR. **Precautions or comments to this program:** Fall risk. Left neglect.	
12/29/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)*	54
01/08/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* May we have an order for physical therapy and occupational therapy evaluation and treatment for resident. Recent fall and muscle weakness. Resident is ok with physical therapy and occupational therapy.	55
02/06/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* Resident fell in room out of wheel chair slid out onto floor, denied hurting self or any pain. Denied hitting her head, no nurse initiated. Vitals stable. Once in chair noted abrasion 1cm length right side, no bleeding left OTA. Noted with 2 skin tears left forearm above wrist top 1.3cm bottom 1.4cm applied _ duodenum change every 3-7 days as needed until resolved left elbow 0.2 circular some treatment for other skin tears. Also bruise to right wrist 2 x 1 cm, monitor until resolved. Vitals every shift x 72 hours.	56
02/20/YYYY	Hospital/ Provider Name	**Progress notes:** Evaluation of bilateral total hip replacements and left hemiplegia.	57
02/20/YYYY	Hospital/ Provider Name	**Follow-up visit:** She is currently residing at Presbyterian Manor. She is being seen for evaluation of concerns about control of internal rotation of her left leg. Therapists at the Manor have talked to her about obtaining a brace to control the rotation of the leg and also the possibility of a wedge between the legs. The patient is non-ambulatory. She is bed-to-chair activities. She has poor balance. Much of this relates to a stroke with resulting left hemiplegia from March of 2012. The patient has been on renal dialysis since February of 2009. She has had previous bilateral total hip replacements for treatment of rheumatoid arthritis with the left total hip replacement in April of 2000 and the right total hip replacement in March of 2007. The patient has seen Dr. Davis in the past. The patient states that the left hemiplegia from the stroke has left her with very little use of the left upper and left lower extremities. A daughter was with her today. **Physical examination:** The patient's exam showed her to be alert and appropriately oriented. She was in a wheelchair. She had the ability to release the fingers of her left hand, but could not actively make a fist. She had fair active range of motion of the left elbow with 3/5 strength and no contractures. She had comfortable range of motion of both hips and knees and ankles passively with no crepitation or pain. Left ankle	58-59

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		had dorsiflexion to neutral. The left knee had 2/5 strength with a 30-degree extension lag. There was full range of motion to the left knee without pain or crepitation. The left hip had 20 degrees of internal and external rotation and 20 degrees of abduction. While seated, the patient had the tendency to let the left hip rotate in 10 degrees. Both hips and knees appeared stable on exam. No ankle swelling. Her shunt was in the left upper extremity. X-rays were ordered, performed, and interpreted of the pelvis and left hip and showed bilateral total hip replacements. There was a cemented CPT prosthesis with no evidence of loosening or osteolysis. Significant osteopenia of the pelvis. No evidence of acute fractures. There were vessel calcifications. Both hips were appropriately located with no evidence of any polyethylene wear. **Assessment:** 1. Bilateral total hip replacements, doing well. 2. Chronic renal failure on dialysis. 3. Left hemiplegia. **Plan:** 1. I advised against any type of lower extremity bracing; this will be uncomfortable, prone to skin breakdown issues, difficult to apply, and is not appropriate for the situation. 2. If internal rotation positioning of the left lower extremity is a problem, then a simple wedge between the legs or custom podium seating is more appropriate. 3. I explained to the patient and family this falls within the area of rehabilitation medicine and would be more appropriately addressed with Dr. Davis.	
02/27/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* Lowered to floor 1605 hrs, weakness complaint after returning from dialysis. NO injuries noted. Will monitor.	60
03/05/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* She visited your office on 02/20/YYYY regarding her left leg turning inward and hurting daughter, Sandy, attended with her and stated that X-rays were taken of both hips and they showed to be in perfect alignment. She said that she could use a wedge between her knees and or a soft pillow. Could we please have a copy of X-ray report and documentation of what to use questionable.	61
03/26/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* Has been requesting more pain meds, states they don't help. Had one at 0900 this morning et is requesting one at 1100. She is hurting in mid back at neck. May we give Lortab 5/500mg more often questionable. Gets one at night then can have 1 every 6 hours as needed. Please advise	62

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Are you wanting more frequent as needed order every 4 hours or more routine, not sure what note is asking. I think he is wanting Lortab routinely more often change as needed order to _.	
06/11/YYYY	Hospital/ Provider Name	**Rehab screening:** The patient is having difficulty getting out of recliner. Recommended platform under chair to increase mobility and ease of transfers.	63
06/17/YYYY	Hospital/ Provider Name	**History and physical examination report:** **Chief complaint:** Right basal ganglia hemorrhage. **History of present illness:** She resides at a nursing home. Her family noticed that she just was "lethargic" since last Thursday. The daughter, who is present at the bedside, states that the patient just had a slow decline and was not "acting like herself." She was taken to the Parsons ER on the date of admission. A CT scan of the brain was obtained. It showed a right basal ganglia hemorrhage and this was in the same location as the patient's prior right basal ganglia hemorrhage approximately a year ago. She was then transferred to Via Christi Hospital on North St. Francis Neuro Critical Care Unit for work-up of a hemorrhagic stroke. **Social history:** The patient resides in a nursing home. The daughter reports that she is able to sit up in a wheelchair and converse normally. She just requires a tremendous amount of activities of daily living. She has deficit.in the left upper and lower extremities that are residual from the right basal ganglia bleed that the patient experienced a year ago. **Review of systems:** The daughter states that patient just does not "seem as sharp as she usually is." **Physical examination:** HEENT: The patient does have a bit of a right gaze preference. This is easily overcome. No facial lesions or pigmentations that is inconsistent with age. Extremities: The patient does have a left upper extremity AV fistula that has a palpable thrill. Neurological: The patient is alert and oriented to person, place, and time. She is able to-perform multistep commands mostly with her right side. She has residual left side deficit from her bleed in the right basal ganglia a year ago. She is unable to perform serial sevens. She is unable to spells the word world forwards and backwards. She has fairly good memory recall at 1 arid 5 minutes. Speech is normal with good comprehension. She is able to repeat and name objects. Cranial nerves: I not tested. II: Pupils are 2 mm, equal, round, ' and reactive. Visual fields are full to confrontation. Once again, the patient does have a bit of a right gaze preference but this is easily overcome. Funduscopy not performed. Cranial nerves III, IV, and VI: Full extraocular movements. Eyes open, no nystagmus. No saccadic eye movements. Cranial nerve V: Normal facial sensation, positive corneal reflex. Cranial nerve VII: Able to close eyes. Cranial nerve VIII: Normal	64-69

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		hearing to gross testing finger rubs bilaterally. Cranial nerves IX, X, XI and XII: Normal gag Tongue is midline. Good strength to the sternocleidomastoid muscles trapezius muscle bilaterally. Motor strength is 4/5 on the right upper and lower extremities and 3 out of 5 on the left upper and lower extremities. **Cerebellar:** Able to perform finger-nose-finger with the right upper extremity and unable on the left secondary to weakness. **Radiology:** The patient was sent with the CT scan that was unable to be opened on this system. The reports read a 7 x 11 mm fight basal ganglia bleed. A CT scan without contrast was obtained after admission to this facility and their report shows a 12 mm hyperdensity within the right thalamus which may represent calcification related to the old hemorrhage, an underlying cavernoma is also possible, but less likely that this could represent an acute hemorrhage. **Impression:** 1. ICH, right basal ganglia versus calcification related to the old hemorrhage. 2. End-stage renal disease. 3. Hypertension. 4. Urinary tract infection. 5. Previous stroke, acute ischemic 2009. 6. Hypothyroidism. 7. Hypercholesterolemia. 8. Rheumatoid arthritis. 9. Coronary artery disease, status post stents 10. Status post inferior vena cava placement 2009 related to a history of deep vein thrombosis. **Plan:** Intracerebral hemorrhage right basal ganglia, acute versus calcification related.to the old hemorrhage 1 year ago. We will monitor the patient's clinical status closely and we will institute neuro checks every 1 hour for the next 24 hours for change in mentation or level of consciousness, or pupillary changes. We will also keep the head of the bed up 30-degrees. If we do have any decline in neuro status we will repeat CT scan of the head without contrast. End-stage renal disease. The patient is on chronic hemodialysis 3 times a week. Her last dialysis was the day of admission Monday 06/17/YYYY. We will consider nephrology consult and hemo-dialyzed the patient as necessary. Hypertension. We will maintain strict blood pressure control and demanding a systolic pressure of less than 140. We will- institute nicardipine and titrate to keep the blood pressure within the desired goal. Because the patient is end-stage renal disease and she is able to take per oral, no IV fluids will be started at this time. Urinary tract infection. The patient has a history of chronic urinary tract	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		infection. UA obtained at the outlying facility was positive for leukocyte esterase and a culture is in progress. She was given Levaquin 500mg at the outlying hospital on day of admission. We will follow the patient closely, and attempt to obtain culture results as they become known at the outlying facility. We will continue her on her Levaquin 500mg daily for a regimen of 7 days. The patient is largely oliguric, so it is very difficult to obtain a sample, but the outlying hospital was successful, so we will not repeat that culture. We will follow the one that has already been obtained. Hyperthyroidism. We will continue the patient on her home medication. Hypercholesterolemia. We will continue the patient on her home medication. Rheumatoid arthritis. We will continue the patient on her prednisone. She is on chronic Prednisone therapy, and we will medicate for pain above and beyond if necessary. Coronary artery disease, status post stent placement. We will continue to treat the patient's coronary artery disease medically. History of deep vein thrombosis status post inferior vena cava placement in 2009. The patient is not a candidate for anti-coagulation at this point especially in light of the possible right basal ganglia bleed. She was not on any chronic anti-coagulation prior to admission.	
06/18/YYYY	Hospital/ Provider Name	**CT of head without contrast:** **Indication:** History of infarct and hemorrhage. **Impression:** Focal hematoma in the fight thalamus previously noted has apparently resolved now- with some regional blush-like hyperdensity, at that site probably some developing calcifications. Mild petechial hemorrhage could not be excluded but less likely given the absence of identifiable regional edema. Short-term followup suggested: Superimposed chronic senescent changes were otherwise stable with no new site of focal abnormality.	70
06/21/YYYY	Hospital/ Provider Name	**Nursing notes:** Gave routine Lortab this morning, pulled from wrong card, received 10/500mg dose instead of 5/500mg. No adverse reaction noted. Out to dialysis at this time. Please advise No new orders.	71
07/18/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* Reposition patient every 1-2 hours using draw sheet and pillow to help keep spine aligned and prevent ulcer formation. Physical therapy evaluation and treatment. Repeat urine culture in 1-week.	72
07/26/YYYY	Hospital/ Provider Name	**Plan of care:** **Diagnosis:** Strength/weakness.	73-90

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Impaired physical function related to cerebrovascular accident: I use a wheelchair for locomotion with an assist of one as needed Please explain each procedure to me so I can participate in my activities of daily living care to the maximum of my ability Allow/encourage to propel wheel chair to and from dining room for meals. Morning exercise 2-5 x a week, 30mins as tolerated Nursing restorative assessment yearly and as needed Nursing restorative monthly notes to monitor programs and appropriateness. Regarding left hemiparesis. Please reposition me often for comfort and to prevent skin breakdown. Use positioning devices to assist me to maintain good body alignment. I prefer my medications to be given to me in the dining room. Per my preference, I like my Renvela given a few minutes (10-15) before my meal. **At risk for falls due to cerebrovascular accident:** Fall risk screen quarterly and as needed. Ensure call light is within reach and remind me to use it to call for assistance. Ensure my bed is in the low position at night as needed. Ensure my environment is hazard and clutter free with adequate lighting. Flat pad call light due to am unable to press regular call light. After dialysis please assist resident to use bedside commode and not the bathroom due to resident feeling weak after dialysis Re-educate staff to watch placement of resident when turned on side. Make sure resident is not too close to the edge. Occupational therapy/physical therapy evaluation and treatment. Place a pillow case on wheelchair cushion to prevent resident from sliding.	
08/03/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* Resident is refusing witch hazel hemorrhoids pads that are ordered daily at night, can we change this to daily at night as needed questionable.	91
08/19/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* BP taken this morning before dialysis, 223/100, rechecked 209/81; these were close around 0700 hrs. Rechecked again at 1100 hrs before it got 199/78. Please advise; if remains > 180/90, ER.	92
08/20/YYYY	Hospital/ Provider Name	**Nurses communication:** *(Illegible notes)* **Reason for visit:** Increase BP at dialysis at Nursing Home. Drooling at face, drooping to one side at dialysis. **New treatment orders:** Daily BPs, call if not improving with increase Norvasc, systolic BP > 160. Please follow previous orders to witch hazel pads each night. Also reported patient frequently 1-2 hours even while in _ to help prevent pressure ulcer.	93
09/01/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* Resident was found with bruises to her right arm today, on below right forearm	94

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		and another on right elbow. Resident stated her hand and arm slipped when she pulls on lower of recliner. Bruise right forearm 3.4 length x 1.5 width, right elbow 1.7 x 1.6 cm wider long. Will monitor.	
10/22/YYYY	Hospital/ Provider Name	**Active range of motion program report:** **Program name:** Active range of motion program. **Start date:** 10/15/YYYY. **Frequency:** Day shift only/every 1 day, shifts, 2 **Program text:** Invite to morning exercise daily, 30mins as tolerated , Increase/maintain range of motion, co-ordination, gross motor skills **Program name:** Transfer program **Program text:** Stand 2-5 min using grab bar. Sit to Stand with grab bar 2 times 5 reps. Nustep Level 5, times 15 minutes. Rings bilateral 5 times each side. Purple putty with left hand 10 min. Pulleys 10 min. **Program help text:** To maintain single body assist-contact guard assist with wheelchair to toilet transfers, minimal assist wheelchair to bed transfers with grab bar, moderate assist wheelchair to recliner transfers; to avoid using lift et commode (Pick 1 exercise out of choices 4, 5 & 6. Switch off; not all have to be done every day) **Program name:** Wheelchair mobility training program **Frequency:** Every day (Day & amp; evening shift only)/every 1 day/shifts, 2, 3. **Program text:** Allow/encourage to propel wheel chair to and from dining room for meals. Increase/Maintain upper body strength.	95
11/15/YYYY	Hospital/ Provider Name	**Orders:** *(Illegible notes)* Home to nursing home. Keep dressing in place surgery, but not too tight. Dressing change every 1-2 hours for increase in severity of bleeding. Follow-up with dialysis in the morning as early as possible for evaluation. ER if bleeding accelerates/_ in severity.	96
11/21/YYYY	Hospital/ Provider Name	**Nursing notes:** I talked with all three of the patient's daughter tonight about if they wanted a surgical consult of follow-up with Hgb related to her posture, blood in stool. They stated since it's not an emergency; they well wait to make decisions when Dr. Riddle takes over she gets routine Hgb at dialysis now.	97
11/23/YYYY	Hospital/ Provider Name	**Nursing notes:** Returned form hospital after receiving blood transfusion. There over night, did not have meds since yesterday in morning. BP when she was 219/96. Gave her	98

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		morning after rechecked it after 2 hours. BP 182/76. Please advice No signs/symptoms of hypertension noted.	
11/28/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* Resident has witch hazel pad ordered to hemorrhoids every night, but is refusing a lot of times. Can we change this order to as needed questionable	99
01/07/YYYY	Hospital/ Provider Name	**Rehabilitation screening:** **Reason for screen:** Other referral. **Findings/observations:** Change in mobility status. **Comments:** Patient and nursing staff states patient was having difficulty with mobility post her colonoscopy, but both state she is back to prior level of function when discharged form therapy the last time.	100
01/23/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* Resident refuses with hazel pads every evening. She requests them during the day may we change order to daily and as needed questionable.	101
02/27/YYYY	Hospital/ Provider Name	**Nurse communication:** Start preparation maximum strength. Topical cream daily. Schedule podiatry visit as soon as possible.	102
04/24/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* She was lowered to the floor related to her physical decline. She was screened by therapies and they feel she would benefit with some daily therapies. May we have an order for: Physical therapy/occupational therapy evaluate and treat	103
04/29/YYYY	Hospital/ Provider Name	**Nursing notes:** She is continuing to complain of left knee pain after being lowered to the floor on 04/23. There is no swelling, bruising or redness to the joint. We have been applying an ice pak off and on and she has been taking her as needed Norco more often. Any concerns questionable. Would like to evaluate in office.	104
05/13/YYYY	Hospital/ Provider Name	**Doctor's communication:** **Diagnosis:** Generalized debility and weakness. High risk pressure sore, buttock. Position change every 2 hours (alternative is to use foam wedges). Ligament strain right knee: RICE (Rest, ice, ACE bandage compression,	105

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		elevation) for 1 more week, the start physical therapy for debility/strengthening bilateral lower extremity 3 times per week for 8 weeks. Hypertension. Discuss with nephrology.	
06/26/YYYY	Hospital/ Provider Name	**Doctor's communication:** Stable removal. Call ortho to schedule for left knee pain. Ordered labs 1 weeks prior to next appt.	106
06/26/YYYY	Hospital/ Provider Name	**Nursing communication:** 2-months check-up. She complains of left knee pain. Would like to staples taken out today left arm. Physical therapy/occupational therapy are discharging due to refusals. Will possible pick back up at a later date	107
07/14/YYYY	Hospital/ Provider Name	**Doctor's communication:** *(Illegible notes)* Healing left distal femur fracture, lower extremity hemi-plegia. **New treatment orders:** Cycling. 25% partial weight bearing left lower extremity. Left quad isometrics, assisted SLR's **Return visit date:** 4-weeks.	108
08/20/YYYY	Hospital/ Provider Name	**Doctor's communication:** Healed left femur fractures. Ok to advance to full weight bear as tolerated and gait training with therapy.	109
09/16/YYYY	Hospital/ Provider Name	**Plan of care:** **Risk for fall due to cerebrovascular accident:** I use a flat pad call light. Ensure my bed is in the low position at night. I have trouble with foot positioning during transfer, ensure I understand which direction to transfer.	110-120
09/17/YYYY	Hospital/ Provider Name	**Care conference summary:** **Diagnosis:** Arthritis, chronic renal failure, GERD, HTN, CVD, hyper parathyroidism, pain, hemiparesis. **Activities:** She prefers self-directed and one on one activities due to the length of time that she is at dialysis. She enjoys watching TV, reading, and visits with her family. She also enjoys getting her nails and hair done. Participates in group exercise occasionally. **Psychosocial:** She is social and enjoys conversing with other residents in the community. She is able to make her needs and feelings known. She has great family support.	121-123

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Rehab/restorative: Medicare B physical therapy. **Summary of care conference discussion:** Procel changed back to 2 scoops daily on 06/23/YYYY, no other medication changes. Medicare B Therapy recertified through 09/26/YYYY.	
09/17/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* She would like her Zyrtec 5mg to be daily in the morning instead of as needed.	124
09/24/YYYY	Hospital/ Provider Name	**Restorative care program:** Patient is discharged from physical therapy. **Goal for restorative program:** Maintain moderate assist with transfers. **Approach/recommendations for implementation of above goals:** NU-Step x 15 mins, LS 2-3 times per week Sit to sand at 11 bars x 5, 2-3 times per week Seated lower extremity exercises with 3# right, 0#left, red TB right Yellow TB left, group exercises **Precautions or comments to this program:** Place blue rubber ball between knees when standing at 11 bars to decrease hip adduction and increase weight bearing to left lower extremity.	125
12/17/YYYY	Hospital/ Provider Name	**Plan of care:** **Risk for fall due to cerebrovascular accident:** I use a flat pad call light. Ensure my bed is in the low position at night. I have trouble with foot positioning during transfer, ensure I understand which direction to transfer. I require extensive assist of one-two staff during transfers.	126-142
12/17/YYYY	Hospital/ Provider Name	**Care conference summary:** **Summary of care conference discussion:** The patient's daughters Sandy and Diane were present at the care plan meeting. She would like to be woke-up at 6:30 a.m. She reported that she is satisfied with activities that are offered. The patient and her family requested that Joyce be given her medication at meal time to take herself. The patient stated that she has to have a little something on her stomach before she takes it. She also would like to take her Rolaids between meals.	143-145
01/27/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* She had 2 nose bleeds tonight. #1 was just little bit and over quickly around 1.00 a.m. #2 was around 0530 hrs and was for almost 10 mints, both times there was clotted and dried blood. Possible a humidifier might help.	146

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Agree with trial of warm humidifier.	
02/02/YYYY	Hospital/ Provider Name	**Rehabilitation screening:** Resident with complains of 8-9/10 neck and shoulder pain which affects her sleeping and functional mobility with wheelchair and social activities. **Recommendations:** **Evaluation indicated:** Occupational therapy.	147
02/10/YYYY	Hospital/ Provider Name	**Physician subsequent visit:** Seen for general checkup and for followup on wound care issues. Boils now nearly resolved. Renal notes: Hgb stable at 9.4. BP 98/60-145/85. **Assessment:** CRF (Chronic Renal Failure) stage-ESRD (End Stage Renal Disease) Iron deficiency anemia, unspecified Chronic obstructive pulmonary disease Hypertension Hypothyroidism, acquired Osteoarthrosis Boil of buttock **Plan:** **Orders:** Nursing facility care subsequent. **Instructions**: See scanned nursing orders document for written plan. **Disposition:** Call or return if symptoms worsen or persist. Return visit request in/on 2 months +/- 2 days.	148-151
03/18/YYYY	Hospital/ Provider Name	**Plan of care:** **At risk for falls due to cerebrovascular accident:** Poor standing balance. I use a flat pad call light. Ensure my bed is in the low position, east to get in and out safety. I have trouble with foot positioning during transfer, ensure I understand which direction to transfer. Sit to stand used for safe transfers. I require extensive assist of one two staff during transfers I am weaker on my dialysis days	152-176
03/18/YYYY	Hospital/ Provider Name	**Care conference summary:** **Diagnosis:** Cerebrovascular accident latent effects, ESRD (End-Stage Renal Disease), renal dialysis, hypertension, anemia, hypoparathyroidism, chronic kidney disease, hyperlipidemia, arthropathy, seizure, GERD, CVD (Cardiovascular Disease), debility, nutritional deficiency, pain angina, allergies.	177-178

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Nursing: Medication administration, activities of daily living and mobility assistance, monitoring and dressing change to dialysis shunt. **Nutrition:** Resident chooses to continue with regular diet options with renal precautions, dialysis three times per week with sack lunch provided. Weight is stable, current weight 153 lbs. **Activities:** She prefers self-directed activities due to the length of time she is at dialysis. She does participate in morning exercise when she feels up to it and enjoys entertainment and social activities. She also participates in resident council. **Psychosocial:** She is cognitively intact and can make her needs known. She is friendly and enjoys socializing with others. She has good family support. **Rehab/restorative:** Restorative therapy active range of motion, physical therapy screen completed 03/10/YYYY and no therapy was recommended at this time, resident transfers with staff assistance without difficulty. **Summary of care conference discussion:** The patient and her two daughters. Sandy and Diane were present for care plan. Discussed pain control with Joyce's boils on her bottom and that she gets relief from lying down and family suggested that maybe using the recliner for relief might help as well. Joyce stated that her pain is being managed well. Discussed her follow up on April 17th for her lower partial denture. Joyce also discussed food issues of not wanting to eat the enchiladas due to being in a casserole form and not individually rolled as well as there being too much spicy food. CDM stated that she would take care of that and reminded resident of alternative menu. Resident stated that she does order off that often. No other concerns at this time.	
04/12/YYYY	Hospital/ Provider Name	**Nursing notes:** Resident noted to have bruise under chin 0.75 cm. Doesn't know how it happened. Will monitor until healed.	179
04/30/YYYY	Hospital/ Provider Name	**Ophthalmology follow-up visit:** Check cataract progress, check glaucoma progress, and check macular degeneration progress. Patient is here to have ocular health checked. Reports no trouble with visual acuity. Has been having broken blood vessels in both eyes, dialysis nurse told she needed an eye exam. **Assessment:** Cataract, both eyes Glaucoma suspect left eye	180-184

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Non-exudative macular degeneration of retina both eyes **Plan:** Continue Ocuvite 50+ daily. No change in spec prescription needed. Will send a report to kidney doctor.	
05/11/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* Bruise noted to right forearm. Measures 5 cm x 2.5 cm. Dark purple in color. No complaints of pain. Resident stated she hit her arm on bedrail.	185
06/01/YYYY	Hospital/ Provider Name	**Rehab screening:** *(Illegible notes)* Resident will benefit from physical therapy to improve transfers and increase bilateral lower extremity strength and functional activity tolerance. Nursing report a decline with resident and resident progress. **Evaluation indicated:** Physical therapy.	186
06/01/YYYY	Hospital/ Provider Name	**Nursing notes:** Resident is having lower extremity weakness and difficulty assisting staff during transfers. Requesting order for physical therapy to evaluate and treat for strengthening and activity tolerance. Ok as above. Physical therapy-Evaluate and treat.	187
06/02/YYYY	Hospital/ Provider Name	**Functional limitations assessment:** **Current value:** **G8978:** (CM - 80% - 99% impaired) Mobility: Walking & moving around functional limitation, current status, at therapy episode outset and at reporting intervals. **Note:** Mobility: Current G-Code functional limitation category and modifier selected is based on the Transfers FOM Score of 2.0. **Goal value:** G8979: (CJ-20%-39% impaired) Mobility: Walking & moving around functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting.	188
06/02/YYYY	Hospital/ Provider Name	**Berg balance scale:** **Total score:** 5/56.	189-190
06/16/YYYY	Hospital/ Provider Name	**Plan of care:** **At risk for falls due to CVA, poor standing balance:** I use a flat pad call light. Ensure my bed is in low position that is easy to get in and out of safely. I have trouble with foot positioning during transfer, ensure I understand which	191-216

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		direction to transfer. I require extensive assist of one two staff during transfers I am weaker on my dialysis days Sit to stand use for safe transfers	
04/26/YYYY-06/22/YYYY	Hospital/ Provider Name	***Nursing home stay from 04/26/YYYY to 06/22/YYYY:*** *Patient was a long-term resident from 04/26/YYYY to 06/22/YYYY for management and rehab of chronic conditions including cerebrovascular accident, end-stage renal disease on dialysis, general weakness and debility. She had regular dialysis treatments.* *Ref: 416-1110* **Reviewer's Comment: The patient was a long-term nursing home resident. Fall-related assessments and prevention measures (wherever available) are included in the summary. These records appear less significant to the case focus. Hence these records are not elaborated.*	217-415
06/30/YYYY	Hospital/ Provider Name	**Nursing notes:** She has area to left inner buttock from possible hair follicle/boil opening. Had moderate amount bleeding that was on brief and had serous drainage on gauze when pressure applied to area when cleansing. Foam dressing with silver applied for absorption/protection. Will monitor. Anything else questionable. Would patient be amenable to evaluate by Dr. Bolt to rule out pilonidal sinuses due to recurrent nature of boils questionable.	1111
07/01/YYYY	Hospital/ Provider Name	**@07:51:40: Nursing notes:** This nurse assessed the "boils" on resident right inner buttocks. She had two areas that were sore to touch. Resident has had this issue for a while Dr Riddel did assess the areas the last time she was here on 6-16 and gave prescription for Bactroban cream staff have been applying that since ordered. No redness or warmth noted. Both areas draining bloody drainage. It appears it maybe a hair follicle that has become inflamed. Charge Nurse Allison was instructed to contact physician with recommendations of removing the pubic hair from that area and keeping a foam dressing on the area to assist with collection of the drainage. We will await those orders.	1112
07/01/YYYY	Hospital/ Provider Name	**@21:29:08: Nursing notes:** Received a fax back from an earlier inquiry by staff to Dr Riddel, she asked that we approach t with the possibility of having a consultation with Dr. Bolt for possible pilonidal sinuses due to her recurrent boils, I spoke with patient and she expressed her frustration that Dr Riddel herself had not evaluated the boils", she was unsure about whether or not she wished to have said consultation and wanted to review it with her daughter's who will be in tomorrow night.	1112
07/03/YYYY	Hospital/ Provider Name	**@11:54:45: Nursing notes:** Pharmacist recommendation states that resident is receiving lipid-lowering	1113

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		therapy with Atorvastatin 5mg, but does not have a fasting lipid profile documented in the previous 12 months. Recommendation for fasting lipid panel on the next convenient lab day and annually thereafter. Sent recommendation to Dr. Riddel. Waiting for response at this time.	
07/03/YYYY	Hospital/ Provider Name	**@14:56:40: Nursing notes:** Received wound culture results. Results noted and faxed to Dr. Riddel. Wound to right buttock identified Escherichia Coli.	1113
07/03/YYYY	Hospital/ Provider Name	**@19:06:37: Nursing notes:** Talked with Dr. Riddle regarding the results of the culture from wound on buttocks and she ordered Bactrim DS twice daily x 10 days. Medication ordered from Bowen's.	1113
07/04/YYYY	Hospital/ Provider Name	**@13:26:31: Nursing notes:** As needed Norco given at 1240 hrs for general pain.	1113
07/04/YYYY	Hospital/ Provider Name	**@23:47:47: Nursing notes:** Temp 97.9. Resident started on Bactrim DS this shift. Four tablets taken from E-Kit to get us through until Monday evening dose. Resident has had no drainage noted from area. Received pain medication x 1 this shift for generalized discomfort.	1113
07/05/YYYY	Hospital/ Provider Name	**@05:48:32: Nursing notes:** Continue Bactrim DS for boils on buttock, no signs/symptoms, and adverse reaction noted, Temp 97.0.	1113
07/05/YYYY	Hospital/ Provider Name	**@19:10:25: Nursing notes:** Temp 97.9. Resident continues on oral Bactrim DS for infected boil on buttocks area. She has had no drainage noted from area. Received a Norco x1 this shift for discomfort. No adverse reactions noted to medication.	1113
07/06/YYYY	Hospital/ Provider Name	**@14:19:11: Nursing notes:** Temp 97.3. Resident continues on antibiotic therapy for infective boil on buttocks. Denies any discomfort at this time. No drainage noted to area at this time. No adverse reactions to medication.	1114
07/06/YYYY	Hospital/ Provider Name	**@21:47:27: Nursing notes:** Patient continues on antibiotic therapy for wounds, she has been calm and tolerated oral therapy well and without incidence thus far. She is afebrile. She did go to dialysis today and she had a strong pull of 1.5 liter with a post-weight of 70.0 kgs (154lbs).	1114
07/07/YYYY	Hospital/ Provider Name	**@05:22:00: Nursing notes:** Continue antibiotics for boils on buttock, Temp 96.9, request, given Norco 5/325mg for leg/foot general pain at 0420 hrs with effective results.	1114

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
07/07/YYYY	Hospital/ Provider Name	**@10:48:01: Nursing notes:** Temp 97.4. Resident continues on oral antibiotic for infected boil on buttocks. No complaints of discomfort or drainage. No adverse reaction noted to medication.	1114
07/07/YYYY	Hospital/ Provider Name	**@17:28:16: Nursing notes:** Received returned fax from Dr. Riddel regarding culture wound of buttocks with only statement on abx appointment with Bolt questionable. Resident wants to see Dr. Bouman as she has been to him before. Joe is working on the appointment.	1114
07/07/YYYY	Hospital/ Provider Name	**@19:59:44: Nursing notes:** Patient continues on oral antibiotic therapy for wounds. She states she is tolerating the therapy without occurrence. No observed signs/symptoms of SAE/AE to antibiotics. She is afebrile. Patient refused to have her dressing to her hemodialysis shunt changed by this nurse, citing that she feels it is ok. This is an almost certain response when I approach pt about the change in her dressing. I have only changed dressing once during my tenure of caring for this patient. PMMA Admin is aware of pts regular refusal. The existing dressing is dry and intact. a	1114
07/08/YYYY	Hospital/ Provider Name	**@03:06:41: Nursing notes:** Resident used call light, requested et assisted to bedside commode early in shift, continue antibiotics for boils on buttock, no signs/symptoms, adverse reaction noted, Temp 96.4.	1114
07/08/YYYY	Hospital/ Provider Name	**@15:11:02: Nursing notes:** @1030 hrs, Resident out of facility to dialysis. Noon medications sent with resident with her dialysis sheet.	1114
07/09/YYYY	Hospital/ Provider Name	**@03:46:13: Nursing notes:** Used call light, Norco 5/325mg given at 0045 for complains of general pain with effective results, continue antibiotics for boils, Temp 97.1.	1115
07/09/YYYY	Hospital/ Provider Name	**@13:53:25: Nursing notes:** Spoke with resident regarding seeing Dr. Bouman for her boils. Resident stated that her boils were feeling better and she did not want to see Dr. Bouman, but she wants her daughter's input. Her daughters will be here this evening and she was going to discuss it with them. I told her that I would follow up with her tomorrow about it. Dr. Riddle will be in the facility 07/14 to do rounds and I told her that we could discuss it with her as well.	1115
07/09/YYYY	Hospital/ Provider Name	**@14:07:07: Nursing notes:** Resident has small bump noted to right calf. Area is pink with a whitehead. No complaints of pain or discomfort. Told resident that I would reassess the area on Monday during her shower.	1115
07/09/YYYY	Hospital/	**@19:40:42: Nursing notes:**	1115

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
	Provider Name	Resident sitting up in wheel chair today. Alert and verbal oriented x 3. BP 141/83, PR 55, Temp 96.9. Remains on antibiotic therapy, for boil. No adverse effects. Monitor site as needed.	
07/11/YYYY	Hospital/ Provider Name	**@00:01:15: Nursing notes:** Resident returned from dialysis this shift, up in wheelchair/chair, alert and verbal voice no complains of pain at that time. Resident remained in with chair and then propelled herself to the D/R for supper meal. Assisted per staff after supper meal with activities of daily living. Around 2030 hrs, CNA reported that resident was complains of nausea. She was lying on her side. Possible symptoms due to the antibiotic of Bactrim she is currently on. Resident did not emesis during the remainder of shift. Her BP today 135/74, PR 89bpm, Temp 97.5. Continue to monitor.	1115
07/11/YYYY	Hospital/ Provider Name	**@09:09:10: Nursing notes:** Temp 97.0. No complains of nausea/vomiting, so far tonight.	1115
07/11/YYYY	Hospital/ Provider Name	**@16:01:35: Nursing notes:** Temp 97.1, resident continues on antibiotic for infected boil on buttocks area. No drainage noted. No complaint of discomfort. No adverse reaction to medication noted.	1116
07/12/YYYY	Hospital/ Provider Name	**@08:34:32: Nursing notes:** Temp 97.0; no adverse reactions, to Bactrim antibiotics noted, or reported.	1116
07/12/YYYY	Hospital/ Provider Name	**@12:10:23: Nursing notes:** Resident continues on antibiotics for infection of boil on buttocks. No drainage or discomfort noted. No adverse reaction noted to medication. Resident stated her shunt started to bleed last evening. Dressing reinforced to the shunt area. No new bleeding noted this shift. Denies any discomfort noted.	1116
07/12/YYYY	Hospital/ Provider Name	**@14:47:09: Nursing notes:** Resident dialysis shunt continues to have active bleeding noted. Have reinforced x 2 this shift. Ask her about going out to ER and she refused to go. I encouraged her if this continues she needs to be seen and will pass on to next shift the day's progress.	1116
07/12/YYYY	Hospital/ Provider Name	**@22:32:34: Nursing notes:** Patient continue ot have moderate bleeding from her left upper extremity shunt for hemodialysis. This began yesterday and has continued at a steady pace. Pt refuses to go to ER for evaluation. She insists on waiting to speak with dialysis center citing previous experience with Doctors who do nothing. I repeatedly offered my advice to have her seen, but she adamantly refuses. The dressing removed had "bleed through" two abd dressings and 6 to 8, 2 x 2s in the last 8 to 9 hours. Again I state empathetically that strongly encouraged patient to seek emergent medical care. I have paged the on call nephrologist, awaiting a call back from a Dr. Challa to inform them of this ongoing concern. Dressing changed.	1116

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
07/13/YYYY	Hospital/ Provider Name	**@08:25:40: Nursing notes:** Received a phone order, from Dr. Challa (Nephrologist); regarding residents left, forearm shunt site. However dressing remained clean/dry/intact. Kept her left arm elevated, and checked frequently, during the night. Last checked at 0635 hrs and dressing was still clean/dry/intact.	1116
07/13/YYYY	Hospital/ Provider Name	**@13:14:59: Nursing notes:** Temp 97.2, PR 78, RR 18, BP 128/66. No bleeding from shunt area this morning. Dressing dry and intact. Went to dialysis this morning. Continues on oral antibiotic for infected boil of buttocks. No adverse reaction noted to medication.	1116
07/13/YYYY	Hospital/ Provider Name	**@16:32:43: Nursing notes:** Nurse assessed area on right inner buttocks, area closed granulation no drainage, skin around the possible inflamed hair follicle is pink no warmth no induration, will continue to monitor. Right posterior leg appears to be a hair follicle that had been inflamed and now has resolved, informed her that we will continue to monitor, suggestion made to get a different cushion for her wheelchair.	1117-1118
07/14/YYYY	Hospital/ Provider Name	**@15:23:08: Nursing notes:** Continue on antibiotics for Boyles. No adverse reactions noted, afebrile, will monitor.	1117
07/14/YYYY	Hospital/ Provider Name	**@19:06:26: Nursing notes:** Dr. Riddwel here today and left following orders: Change to scheduled twice daily Norco and Norco twice daily as needed every 6 hours. Stop daily weights and change to 3-times/week. Nurse changed medication for administration for morning and evening dose.	1117
07/16/YYYY	Hospital/ Provider Name	**Nursing notes:** @1100 hrs, Resident out to dialysis via facility van. Noon medication sent with facility. Vital signs stable and placed on dialysis sheet. Dressing dry and intact to left forearm.	1117
07/17/YYYY	Hospital/ Provider Name	**@0815 hrs: Nursing notes:** *(Illegible notes)* Patient does not want to have consultation appt with Dr. Bouman at this time. Attached to this fax are wound treatment orders for you to sign. We will use Aquacel Foam Ag 2 x 2 daily as needed for comfort. Resident starts Furuncles are feeling much better and the foam helps.	1119
07/17/YYYY	Hospital/ Provider Name	**@11:05:34: Nursing notes:** Spoke with resident regarding consultation appointment with Dr. Bouman. Resident stated that she does not want to go at this time. Her boils are feeling better and she said that staff applying foam helps with her discomfort. Faxed Dr. Riddel for wound treatment orders for Aquacel AG foam 2 x 2 daily PRN for discomfort. Faxed Dr. Riddel that resident wants to cancel consultation at this	1117

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		time. Emailed Joyce's daughter, Sandy, regarding canceling the consultation and the wound treatment orders. Dr Riddel gave diagnosis for skin issues to buttocks: recurrent perirectal furuncles rule out pilonidal cysts. Will cancel appointment with Dr. Bouman.	
07/17/YYYY	Hospital/ Provider Name	**@17:09:10: Nursing notes:** @1100 hrs, Resident out to dialysis via facility van accompanied by van driver. Noon medication sent with resident. Temp 97.1, PR 61, RR 18, BP 128/69.	1117
07/20/YYYY	Hospital/ Provider Name	**Nursing notes:** Resident out to dialysis accompanied by van driver. Temp 97.9, PR 93, RR 18, BP 142/74. Dressing dry and intact when left. Paper work sent.	1117
07/23/YYYY	Hospital/ Provider Name	**@02:34:44: Nursing notes:** Returned to facility on 03-11 shift, no new orders but attached sticky noted, stated ProCel 100 Vanilla Whey Protein Powder 1 scoop=25g- 1/8 cup.	1120
07/23/YYYY	Hospital/ Provider Name	**@05:08:14: Nursing notes:** Requested et gave emesis basin due to dry heaves/nausea from sinus drainage per Resident, request et given Zofran 4mg at 0400 hrs for continued complains of nausea, cream applied to boils on buttocks.	1120
07/23/YYYY	Hospital/ Provider Name	**@17:18:32: Nursing notes:** No irregularities.	1120
07/24/YYYY	Hospital/ Provider Name	**Nursing notes:** @1100 hrs, Temp 97.0, PR 96 bpm, RR 18, BP 143/92. Resident alert and oriented x 3. Out to dialysis via facility van; noon medication sent with resident. Dressing changed twice prior to her leaving due to first one coming off.	1120
07/27/YYYY	Hospital/ Provider Name	**Nursing notes:** @1100 hrs, resident out to dialysis via facility van. Noon meds sent with resident. Vitals stable see care tracker.	1120
07/28/YYYY	Hospital/ Provider Name	**@11:01:02: Nursing notes:** Spoke with daughter, Sandy, via email. Updated her on Wichita appointment 08/04/YYYY. Sandy needed 2 forms of identification for resident. Emailed her the documents.	1120
07/28/YYYY	Hospital/ Provider Name	**@20:30:11: Nursing notes:** Received fax back from Dr. Riddel's office in regard to request to change some other creams being applied on res. daily, which was for her hemorrhoids such as preparation, Anusol at night and Witch hazel pads. Order received to discontinue prep H or change to as needed per patient preference. Discharged the daily Prep H and changed to as needed.	1120
07/31/YYYY	Hospital/ Provider Name	**Nursing notes:** @1100 hrs, Resident out to dialysis accompanied by CNA in facility van. Vitals	1120

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		stable when left. Medications for noon sent with resident.	
08/02/YYYY	Hospital/ Provider Name	**Nursing notes:** Nurse changed dressing to her fistula site of her left arm, note bruising to the upper region of her arm. Resident stated that was caused in dialysis when they stuck her on Friday, she stated that she had some tenderness where fistula was. Nurse noted that resident has been coughing over the week-end and she has been taking Robitussin cough syrup today and yesterday evening. She has congestion in upper chest, continue to monitor, cough is non-productive.	1121-1122
08/04/YYYY	Hospital/ Provider Name	**@17:17:49: Nursing notes:** Resident returns to facility following appointment in Wichita. Resident is alert and oriented x 3. Voices no complain at this time. Orders received from Lifeline Vascular Access related to Dialysis shunt. Will pass on to Dialysis facility here. Will continue to monitor.	1123
08/04/YYYY	Hospital/ Provider Name	**@17:33:17: Nursing notes:** Residents vitals stable and are in care tracker. Dressing to shunt site dry/intact.	1123
08/05/YYYY	Hospital/ Provider Name	**@10:41:55: Nursing notes:** Called Vascular Center in Wichita to verity that sutures to fistula sites should be removed today 08/05/YYYY. They stated that sutures are mainly a pressure dressing and are to be removed today.	1123
08/05/YYYY	Hospital/ Provider Name	**@11:47:11: Nursing notes:** Resident out to dialysis at this time. Resident noted to have dressing dry and intact to left forearm with small amount of dried blood. Sent discharge orders from appointment yesterday to the dialysis center with her today. Resident noted to have more of a cough, states her throat is slightly sore, hoarseness and some wheezing noted in her upper right lung. No shortness of breath noted. New orders for: 1. Airborne may dissolve in water; give one daily until symptoms resolve. 2. Albuterol (Ipratropium) Nebulizer 0.5/3mg-3ml thrice daily as needed shortness of breath. 3. Cepacol Throat Lozenger as directed. Daughter Sandy notified of resident new orders.	1123
08/05/YYYY	Hospital/ Provider Name	**@17:49:59: Nursing notes:** Received notification from Dialysis Center that they want sutures to incision site to be left on Friday and they will remove them while she is at dialysis.	1123
08/05/YYYY	Hospital/ Provider Name	**@21:27:02: Nursing notes:** CNA reports to this nurse that there is red blood coming from the dressing to her Left arm from fistula repair yesterday. There is a large hematoma with a raise area approx, the size of a golf ball. The arm was measured to 20.4 cm around at this site. Talked, to Dr. Shaikh and was instructed to watch area et if it cont. to grow then take to ER. If it doesn't we are to contact the Access Center, where the fistula work was done, in the am. Sandy, daughter was notified et was pleased	1123

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		with what was being done for her mother. I told she would be contacted if anything else happens this night. Will pass measurements on to night nurse for monitoring.	
08/06/YYYY	Hospital/ Provider Name	**Nursing notes:** Spoke with Joyce this morning and listened to lungs which are coarse in upper lobes, also really congested. Voice hoarse. States she has been coughing up some green tinged sputum every now and then, but has not had to blow nose often. This nurse encouraged her to take breathing treatments today, and other staff spoke with her about this as well as she has been reluctant to do this. She has Cepacol as needed that she used this morning and Robitussin. Shunt site has been actively bleeding last night and this morning bled through dressing/gauze placed last night by RN. 3 areas are oozing blood, and nodule noted above site. Contacted Dialysis, and stated she needs to come out to Dialysis center instead of going to ER as instructed the first time. Joe to take this morning around 10 am. Daughter Sandy aware and met her there. Currently has new dressing to site, and Coban lightly wrapped for pressure, and dialysis is aware. The patient came back to facility at 1130 hrs with instructions per dialysis to monitor site/dressing often and hold pressure if bleeding. Change dressing if bleeding and apply pressure for at least 10 minutes. If she continues to bleed w/o getting bleeding to stop, please let Dialysis know. After lunch, at around 12:30, shunt site began bleeding, Applied pressure to site for 15 minutes, then placed new 4 x 4/folded dressing and wrapped with Kerlix lightly. Will monitor.	1124
08/06/YYYY	Hospital/ Provider Name	**Nursing notes:** Resident up to bedside commode early in shift with sit to stand lift, arm measured et nodule assessed, 23cm around arm, small amount red drainage visible to access dressing, up to bed side commode at 0345 hrs, nodule does not appear to be as big as golf ball et arm cont to measure 23cm, moderate amount red drainage noted on access dressing, top layer dressing with tape removed, more 4 x 4 gauze with rolled gauze applied for reinforced pressure dressing applied, will continue to monitor.	1125
08/07/YYYY	Hospital/ Provider Name	**Nursing notes:** Resident returned from dialysis this afternoon, in her wheelchair. Taken to room. Resident assisted into to be per her request today. Nurse into room and found resident covered up with her choice of blankets, Nurse leaned over to speak with resident and she was moaning. Nurse spoke with resident and asked if she was in pain or having chest pain. She told nurse no; no; BP taken 131/81, PR 99, Temp 96.9, RR 21. No perfuse sweating noted but told nurse she was now hot. Nurse removed cover and draped her with just the sheet. Nurse asked res. again if she was hurting with pain and she said no., but kept moaning. Shortly afterwards resident used call light to request door to be closed. Resident was assisted up to sit on the commode per her request; she asked that her meal be given to her in room. She was on the call light several times for assistance and continues for staff to answer questions, she has been intermittently confused. There has been no bleeding from her fistula site. Remains with non-productive coughing and remains with expiratory wheezing in upper lobe, she told nurse she gets cold then	1126

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		hot. Skin coloration ashy and very dry. Nurse asked res. if she felt short of breath and she said no., Told resident could apply O2 on her and she refused, continue to monitor.	
08/08/YYYY	Hospital/ Provider Name	**Nursing notes:** Resident up in wheelchair in her room. CNA comes to this writer ET states that Resident told her the fistula dressing was showing signs of active bleeding. Upon assess the dressing it appeared the Resident was pull of the new dressing et exposing the old dressing underneath which did have some previous bleeding, but, no new bleeding was found. Encouraged Resident to not try to removed bandage as this was for her protection et she stated "you don't need to yell at me. I don't deserve that." I stated "that I was not yelling at her et was sorry if she felt that way" et I apologized for that. I removed the dressing that was coming off from earlier today and put on a new dressing et secured it to the bottom dressing et again encouraged Resident not to remove dressing et it was there for her protection. She complained to CNA that she did not receive her supper et the strawberry shake she ordered et, I had removed the tray from her room et she had eaten 1/2 of sandwich et the rest of the shake was on her over the bed table. Will continue to monitor.	1127
08/09/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* Around 0345 hrs on 08/09/YYYY a broken blood vessel at patient's left cornea sclera of her left eye was noted. We will monitor. Would like any follow-up questionable.	1128
08/09/YYYY	Hospital/ Provider Name	**@07:35:08: Nursing notes:** Around 03:45; staff noted, that resident had a red area, to left eye. Upon closer exam; noted that she had a broken blood vessel, on the inner corner, of her left eye (sclera). We will monitor area until healed. Dr. Riddel, was notified by fax. Left a message, for Sandy Babcock, resident s daughter and D.P.O.A. at 0743 hrs.	1129
08/09/YYYY	Hospital/ Provider Name	**@15:10:17: Nursing notes:** Resident has had no bleeding noted from dialysis shunt area. Dressing intact from last evening shift. Left eye remains blood shot, but denies any pain or vision changes from eye.	1129
08/09/YYYY	Hospital/ Provider Name	**@18:57:19: Nursing notes:** Resident out to Dr for supper ate well ET smiling ET visiting with table mates. Dressing to Right arm remains dry/intact. No bleeding noted so far this shift. Will continue to monitor.	1129
08/10/YYYY	Hospital/ Provider Name	**Nursing notes:** Temp 97.9, PR 93, RR 18, BP 145/83, Resident out of facility to dialysis via facility van. Resident improved today in her red left eye. States she feels better with her congestion. No shortness of breath noted.	1129
04/26/YYYY-08/11/YYYY	Hospital/ Provider Name	***Therapy sessions from 04/26/YYYY to 08/11/YYYY:***	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Patient had various functional impairments including range of motion, balance and gait abnormalities, mobility and transfers, dysphagia, etc secondary to cerebrovascular accident and other chronic conditions. She was evaluated by physical, occupational and speech therapy for generalized weakness, dysphagia. She had regular therapy sessions during this period. *Ref: 1130-1337* **Reviewer's Comment: These records appear less significant to the case focus. Hence these records are not elaborated*	
08/11/YYYY	Hospital/ Provider Name	**Nursing notes:** Resident has blood blister on top of left hand about the size of a pencil eraser. Joyce doesn't recall if her hand was pinched, or if she hit it on anything. When asked if she wanted any padding to her wheelchair for protection, she declined my offer. She said she won't bother it, and that she wasn't worried about it either. Will monitor for changes and until healed. Noticed eyes being blood shot, and blood vessels apparently broke. Dr. Riddel will be here to see her today.	1338
08/12/YYYY	Hospital/ Provider Name	**@08:52:46 hrs: Nursing notes:** @0300 hrs, Labette Health nurse Keri; stated that the patient, had a left, orbital fracture, and was being transferred to Freeman hospital, in Joplin, MO. Daughter, Sandy Babcock, is aware, of the transfer. Nurse on call notified.	1339
08/12/YYYY	Hospital/ Provider Name	**@01:43:14 hrs: Nursing notes:** Around midnight, I heard a thud sound, and found resident, lying on left side, in a fetal- like position, facing the door, and beside her bed. She was barefoot. Noted she had a nose bleed. She was able to speak, and said she was asleep, and tried, to roil over, and fell out of bed. Her call light was still on the bed, and she had not turned it on. Hand rails were, in place, on both sides, of the bed. With assist of 3 staff, we were able to turn, her over, onto a sling, and lift, her onto, her bed. Noted that her left brow, and left eye, was very swollen, and bruised. No other head injury was found, and her nose bleed, had stopped. Noted left elbow, dark bruise about 4cm diameter, and irregularly shaped, with a 2cm by 0.3cm skin tear, and small amount of blood. Cleaned and dressed the left elbow; and placed an ice pack, on her left eye. Found a superficial scrape, to her right knee, about 2.5 cm by 2 cm, area cleansed, and left O.T.A. No other injuries, or abnormal, body alignment noted. She seemed alert and oriented x 3. Started neurological checks, and vitals: Temp 96.7, PR 94, RR 20 and BP 148/85; O2 saturation 95%, on room air. Notified on call nurse: Amber Conrad RN, at 0020 hrs. Called Dr. Riddel, at 0030 hrs; she ordered that resident be taken, to Labette Health ER and be checked, due to head injury. Called and left message with resident's daughter, and D.P.O.A., Sandy Babcock, at 0033 hrs. Gave report, over the phone to ER nurse Annie Elson RN, at 0036 hrs. Joe Ponce notified, about transportation, at 0025 hrs. Resident assisted, with 2 staff, to her own wheelchair; then left facility, with Joe, to be taken, to LH ER, via facility van. Paperwork sent with Joe and resident.	1339
08/12/YYYY	Hospital/	**Resident transfer form:** *(Illegible notes)*	1340-

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
	Provider Name	**Facility from:** Presbyterian Manor Parsons **Facility to:** Labette Health ER. **Date of stay at facility transferring from:** 05/12/YYYY. **Date of last physical examination:** 08/11/YYYY. **Date of last bowel movement:** 08/11/YYYY. **Diagnosis at the time of transfer:** Unspecified cerebrovascular accident, dysphagia, dialysis. **Vitals at the time of transfer:** PR 105 bpm, RR 20, BP 142/83. **Reason for transfer:** Fell on to floor from her bed. Injured left eye brow, left eye swollen shut and blurred. **Dialysis:** 3 times per week.	1341
08/12/YYYY	Hospital/ Provider Name	**ER nurse notes:** **Arrived by:** Walk-in. **Exact time of arrival:** @0053 hrs. **Diagnosis:** Fall; orbital fracture-left; epistaxis-nose bleed-posterior; end stage renal disease on dialysis. **Presenting complaint:** The patient states she rolled out of her bed at approx mid-night. States she landed on her face on the carpeted floor. Denies loss of consciousness. States she also hit her right knee. Denies any other complaints. Abrasion noted to right knee. Bruising and swelling noted to left eye. Patient is coughing up blood. States it is draining down the back of her throat from her nose. Priority level: III. Care prior to arrival: None. Mechanism of injury: Fall out of bed. Trauma event details: The patient did not lose consciousness. Injury occurred in Labette County, injury occurred on August 12, 2015 at 0000 hrs. Occurred: The injury/incident occurred at an institutional residence, in a nursing home, Presbyterian Manor, in a bedroom. Trauma team: ER RN here prior to patient arrival. The claimant was receiving from another setting of care (long-term care facility). She was not transferred to Labette health from another hospital. **Fall risk:**	1342-1345

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Ambulatory aid- None/bed rest/nurse assists (0 pts). Gait-Impaired (20 pts.). Fall in past 12 months (25 points). IV access (20 points). Mental status-Oriented to own ability (0 pts). Secondary diagnosis (15 pts) impaired mobility. Total Morse fall scale indicates high risk score (45 or more points). Fall prevention measures have been instituted. Side rails up x 2 placed close to nursing station frequent observations/assessments occurring as available patient and family educated on fall prevention program and strategies. **Vitals:** BP 132/61, PR 76 bpm, RR 18, Spo2 95% on room air, pain level 3/10, GCS 15. **Assessment:** Pain: Complains of pain in face. General: Appears uncomfortable, behavior is appropriate for age. **Administered meds:** Zofran 4mg IVP Fentanyl 25mcg IVP Lidocaine-Epinephrine 1% 4ml Outcome: ER care complete, transfer ordered by M.D.	
08/12/YYYY	Hospital/ Provider Name	**ER provider notes:** She presented to ER via walk-in with complains of fall injury. **Details of fall:** The patient fell from a height, off furniture, approximately 2.5 feet, bed. Onset: The symptoms/episode began/occurred suddenly, just prior to arrival. Associated injuries: The patent sustained injury to the head, contusion, hematoma, pain, and swelling. Occurred: The injury/incident occurred at an institutional residence, in a nursing home, Presbyterian Manor, in a bedroom. Associated signs and symptoms: Pertinent positives: headache, epistaxis, Pertinent negatives: Nausea, shortness of breath, vomiting. Loss of consciousness: The patient experienced no loss of consciousness. Severity of symptoms: At their worst the symptoms were moderate; in the emergency department the symptoms are unchanged. The patient has not recently seen a physician. Patient gets hemodialysis Mon-Wed-Fri. **Review of systems:** Eyes: Positive for pain, swelling, ecchymosis. ENT: Positive for nose bleed Abdomen/GI: Positive for coughing up bloody drainage. Musculoskeletal/extremity: Positive for abrasion. Neuro: Positive for headache. **Physical examination:** Head/face: Noted is ecchymosis that is moderate, of the left eye, swelling, that is	1346-1349

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		moderate, of the left eye. Eyes: Large ecchymosis over left eye prevents visualization of the cornea/eye surface ENT: Bleeding, is seen from the left nare, and is minimal, no septal hematoma is appreciated. Extremities: Grossly normal except: noted in the right knee: Abrasion **ER course:** The patient experienced a couple of episodes of coughing up blood clots so a Rhino rocket was placed in left nare, Rhino rocket Infused with 4mL of lidocaine 1% with epinephrine for pain control and hemostasis, no further episodes of coughing up blood. Given patient's facial fractures and coughing of blood, I feel that she needs admitted to hospital for observation. However given her ongoing hemodialysis; will need to transfer her to a place that accomplishes the dialysis. Dr. Grounds in the ER at Freeman was contacted and accepted the patient in transfer. **Disposition:** Transfer ordered to Freeman-Joplin. **Diagnoses:** Fall, orbital fracture-left, epistaxis-nose bleed-posterior, end stage renal disease on dialysis. **Reason for transfer:** Necessary services/specialist not available. Accepting physician is Dr. Grounds. Condition is stable. Problem is new. Symptoms are unchanged.	
08/12/YYYY	Hospital/ Provider Name	**CT of head without IV contrast:** **Clinical history:** External injury/trauma. **Impression:** 1. On axial image 28 in the right medial thalamus there is increased density concerning for hemorrhage though the appearance is atypical, and this could represent an abnormal appearance of calcification. MRI confirmation is recommended. 2. Left orbital floor fracture, left periorbital preseptal hematoma. Cannot exclude hematoma along the left orbital floor. 3. Hemorrhagic opacification left maxillary sinus.	1350-1351
08/12/YYYY	Hospital/ Provider Name	**CT of maxillofacial without IV contrast (Preliminary report):** **Clinical history:** External injury/trauma. **Impression:** The left orbital floor is fractured. No evidence of depression. It does not appear	1352-1353

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		that the inferior rectus is entrapped but there is hematoma along the floor of the left orbit and the left inferior rectus muscle may either be edematous or have hematoma within it. There is large left preseptal hematoma. The eye appears intact.	
08/12/YYYY	Hospital/ Provider Name	**CT of fascial bones:** **Impression:** 1. There is evidence suggesting small fractures of the medial and inferior left orbital wall. No muscle entrapment is evident. 2. The left inferior rectus muscle is enlarged. This could relate to intermuscular hematoma or edema. 3. There is a large amount of hemorrhage in the left maxillary sinus. Some opacification of left sided ethmoid air cells also may represent hemorrhage. 4. No additional fracture is evident. There is a large cephalohematoma superior to the left orbit and involving the eyelids.	1354
08/12/YYYY	Hospital/ Provider Name	**ER visit:** **Time seen**: @ 0420 hrs **Reason for visit**: Orbit fracture, nose bleed **Complaint/presentation:** Fall **Location:** Face, eye **Mechanism:** Accidental **Onset:** Just prior to arrival **History of present illness:** She presents to the ER after falling out of bed and sustaining injury to her orbit. She was seen at another facility and was found to have an orbital fracture and epistaxis. Patient was seen in a different facility and was sent here for further evaluation and higher level of care because she also is a dialysis patient. She is scheduled for dialysis today. Patient complains mostly of facial pain. According to the prior chart from another facility patient had a couple episodes of coughing up blood and a Rhino Rocket was placed in left nares. **Review of systems:** Eyes: Reports: Discharge, vision changes Ears/nose/throat: Reports: Epistaxis Musculoskeletal: Reports: Pain Genitourinary female: Reports: Other (does not make urine) Heme: Reports: Bleeding (nose) **Physical examination**: Head/eyes: Abnormal eyelids (discharge from the left eye). Other (left eye: Erythema around eye, swelling, hard to touch, right pupil is non-reactive to light. Patient cannot see light or shapes. She has minimal movement of EOMI on the	1355-1397

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Left eye). Extremities: Contusion (right shoulder) Skin: Contusion (right shoulder, bruises of various stages of healing on extremities). ERG reviewed: Atrial fibrillation rhythm, prolonged QT interval **Imaging Interpretation**: CT head without contrast: Ischemic microvascular changes in the supratentorial white matter. No hemorrhage or extra axial collection. CT facial bones: Suspicion for subtle fractures involving the anterior left maxillary sinus and orbit floor. Left ethmoid sign of blood/fluid left periorbital maxillary swelling of blood products involving the medial orbit retrobulbar space. Mild bilateral mastoid inflammatory disease. Right maxillary and left Eastpointe sinusitis. **Referral/consultation**: 1. Referral/consultation Name: James Harwell Time of discussion: 0641 Consultant: Agrees with evaluation, agrees with plan, accepts admit 2. Referral/consultation Name: Kent McIntire (Dr Tudor) Consultant: Agrees with evaluation, agrees with plan, accepts admit **Critical care time (minutes) excluding procedures**: 30-74 (I spent approximately 35 minutes of critical care time for the acute management of this patient's traumatic injuries lewd consultations emergently; this does not include procedure or teaching time with Dr. Egbert.) **Matthew Grounds, M.D., notes on 08/12/YYYY @ 0643 hrs:** Patient came in as a transfer from Parsons. She is a dialysis patient. CT brain and face were repeated. Patient has inferior orbital fracture. On examination it appears that she has entrapment. Intraocular pressure was too high to read by the Tono-Pen. Lateral canthotomy performed in the ER. Extension of this procedure was performed by ear nose and throat upon arrival. She still does not have visual acuity or can distinguish light at this point in her left eye. Her pressure is now down to 43. Timolol drops ordered and given. This document has been created with the use of voice recognition software. Case discussed with ENT, who has been by to see patient and performed extension of lateral canthotomy. ENT also notified ophthalmology. Hospitalist has also been contacted about observation for patient as well as nephrology for dialysis. Patient and family updated on plan for admission.	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Impression/diagnosis: Orbital fracture Elevated IOP (Intraocular Pressure) Elevated INR Fall **Procedure and findings:** Eye exam and lateral canthotomy: Intraocular pressure measured in left eye was too high to read. Patient has no visual acuity of the left eye. Eye and skin around eye taught. Patient's lateral canthus was anesthetized with 1% lidocaine, 2 cc. The skin was then clamped at the lateral comer of the eye and hemostat was held for 1-2 minutes. 1-2 mm incision made along the lateral canthus of the eye. The incision was extended laterally out and away from the globe. After this was made, there was some bloody discharge. The patient tissue around the eye was now soft, no longer tight. Patient's pressure was checked again and was still too high to read. At this point, ENT came and performed procedure. After the procedure done by them, patient's pressure 43. **Disposition:** **Condition:** Good. **Disposition:** Observation.	
08/12/YYYY	Hospital/ Provider Name	**History and physical examination report:** **Chief complaint**: Orbit fracture and nose bleed. **History of present illness**: Patient presents as a transfer from outside facility after rolling out of bed and falling at the nursing home where she resides. At the outside facility she was found to have an orbital fracture and epistaxis. She was transferred to our facility for higher level of care. Patient was seen by ENT service of Dr. McIntire, also Dr. Brown of ophthalmology was consulted. Patient also has end-stage renal disease from uncontrolled hypertension and has been on hemodialysis since 2009. The ER physician contacted the on-call nephrologist as she is scheduled for hemodialysis today. She follows with a nephrologist in Wichita Kansas. Patient's primary care physician is Dr. Riddel. Patient's cardiologist is Dr. Nicholas. Patient reportedly has a past medical history positive for atrial fibrillation along with history of intracranial hemorrhage and residual left-sided weakness. The intracranial hemorrhage occurred 3 years ago and at that point in time a Greenfield filter was placed and patient was taken off anticoagulation. Patient has not been sick recently except for a reported mild cough that was nonproductive. Patients intake s daughter both deny history of liver disease, bleeding disorders, family history of bleeding disorders, or anticoagulants use.	1398-1404

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Patient reportedly has mild dementia at baseline. **Physical examination**: General: Mild distress Eyes: Other (significant ecchymosis surrounding left eye) Osteopathic/musculoskeletal: Other (deferred secondary to patient s current condition) **Review of imaging results:** CT of the maxilla reveals subtle fracture of the anterior left maxillary sinus CT of the brain reveals no hemorrhage EKG reveals atrial fibrillation 93 bpm **Assessment & plan**: Atrial fibrillation Elevated INR Elevated IOP (Intraocular Pressure) End stage renal disease Fall HTN (hypertension) Orbital fracture **Impression & plan**: Orbital fracture with elevated IOP ENT and ophthalmology on the case Elevated INR Patient reportedly is not on any coagulation therapy, does not have a known cancer, does not have fiver disease Obtain home and list from Dr. Nichols's office Stat recheck INR DIC panel, mixing studies, Abnormal PT/PTT Hematology consulted Atrial fibrillation Currently rate controlled Continue home medication Telemetry End stage renal disease ER physician contacted nephrology service patient has hemodialysis Monday Wednesday Friday History of seizures Continue home medication Hypothyroidism	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Continue Synthroid DVT prophylaxis IPCs **Addendum:** Radiology called and reported that patient has a 6 mm subdural hematoma. I also discussed case with hematology service of Dr. Brahman day. Neurosurgery service of Dr. Nichols has been consulted.	
08/12/YYYY	Hospital/ Provider Name	**Nephrologist consultation report**: **Reason for consultation**: Fluid status evaluation and possible need of dialysis in patient with history of end-stage renal disease. **History of present illness**: She was seen today at 11:30 a.m. in consultation for above reason. She has history of end-stage renal disease and currently is resting and not answering many questions. She is on pain medications and her daughter is at bedside that provides most of the history. The patient has end-stage renal disease and is on chronic maintenance hemodialysis in Parsons, Kansas. She is under the care of Dr. Shaikh. She is on Monday, Wednesday, Friday dialysis. Yesterday at the nursing home she was trying to roll and reach on the other side when she rolled off the bed and fell on the ground. She was taken to the local Emergency Room. She was found to have coagulopathy and a big orbital swelling on the left side. She was subsequently transferred to Freeman Hospital and renal was consulted for above reason. Patient has been diagnosed with orbital fracture with elevated IOP. ENT and Ophthalmology has seen the patient and she is ultimately seen by Neurosurgery for possible head injury. Currently, patient was breathing at room air as she was in no acute distress from respiratory status. According to the daughter, the patient has not been eating or drinking much anyways the last few days. She had uneventful dialysis per her reports last week. Patient is scheduled for dialysis today but she was admitted because of above reasons. There are no reports of any palpitations, no reports of any nausea, vomiting. Patient has a fistula in her left arm and also is badly bruised with swelling in the shoulder and elbow area from the fall. Patient also has left-sided weakness from a previous stroke and mostly is wheelchair bound per patient's daughter. **Social history**: Patient is a resident of a nursing home for the last 3 years. No history of tobacco smoking. She was a homemaker. No illegal drug use. **Physical examination**: General: She is in very obvious splinting on the left side of her face with a dressing in place. Eyes: The left eye has severe ecchymosis and swelling and unable to open. **Impression**: 1. End-stage renal disease on chronic maintenance hemodialysis Monday,	1405-1408

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Wednesday, Friday, missed treatment today because of her fall and admission but no obvious signs of fluid overload or distress. 2. Coagulopathy, unclear etiology. She is not on Coumadin reportedly. She does have history of atrial fibrillation. 3. Anemia likely from her underlying chronic kidney disease and also is coagulopathy. 4. Atrial fibrillation. 5. Orbital fracture. 6. History of hypertension. **Plan**: 1. There is no acute need of dialysis today. Her volume status and her electrolytes are acceptable. We will closely monitor that. Will schedule for dialysis tomorrow. 2. Her fistula has been left on which has a positive bruit and thrill. It is under the dressing from her injuries on her left arm. Her thrill is weak. Also need to rule out any factor in her left arm prior to accessing her fistula. This was discussed at length with Dr. Blair. Will be getting images of her left upper extremities to further evaluate that. 3. Will check iron profile, B12 and Folate. 4. Repeat labs in the morning. Other recommendations depending upon response to initial treatment.	
08/12/YYYY	Hospital/ Provider Name	**Hematology & oncology consultation report**: **Reason for consultation:** Coagulopathy. **History of present illness**: Please note patient is in mild to moderate distress complaining of pain in the hands and, given her age, she is unable to give any significant history at this time. However, patient is accompanied by her two daughters, Sandy and Diane, who are good historians and are able to give me history. History was also gathered talking to the patient's primary Attending and also reviewing the chart and the EMR. The patient has a history of end-stage renal disease, on dialysis, who lives in a nursing home in Parsons, Kansas. Has been transferred to Freeman Hospital after she was found to have orbital fracture and epistaxis. As per the daughters, patient had been having easy bruising over the past many months and also noted to have epistaxis in the last few days. Patient, unfortunately, had a mechanical fall	1409-1412

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		wherein she injured her left eye. Patient has a dense hemiplegia of the left side of the body after a stroke many years ago. Patient is not on any Coumadin or any blood thinners. In the emergency room, patient had a CT scan of the face that showed a fracture involving the left orbital floor and also the anterior left maxillary sinus, and also significant periorbital and facial soft tissue hematoma. Patient also had a CT of the brain that showed a small left subdural hematoma with acute and chronic component. This measures about 6-7 mm. There is no intracranial bleeding noted. Of note, on further workup, patient was found to have an elevated PT of 40 and a PTT of 97, which when repeated shows PT of 36 and a PTT of 73. We have been consulted with regards to above blood coagulopathy. Of note, patient's hemoglobin was 10 with MCV of 110, platelets of 192, and hemoglobin of 12.1. **Physical examination**: General: Patient is in mild to moderate distress, complaining of pain from her fall/contusion of the left eye. HEENT: Obvious trauma of the left eye with soft tissue contusions noted around the left orbit. Bleeding is noted behind the head. Chest: Decreased breath sounds at the bases bilaterally. Skin: Positive for ecchymosis around the left eye. **Impression:** The patient with a history of end-stage renal disease, on hemodialysis at the nursing home, status post fall, noted to have bleeding of the left eye orbit and small subdural hematoma. Coagulation workup reveals elevated PT, PTT. 1. Coagulopathy with elevation of PT, PTT. The differential diagnoses include acquired hemophilia, which is less likely as the mixing study shows correction of the PT, PTT. The other possible etiologies include Coumadin, which again is unlikely as the patient is not on Coumadin as per the records. The less likely but potential causes could be poor nutrition/use of antibiotics. Very rare etiology, could be presence of super Warfarin. 2. End-stage renal disease, on hemodialysis. 3. History of subdural hematoma with dense left-sided hemiplegia. **Recommendations**: 1. Given the less likelihood of an acquired hemophilia as the mixing study was corrected, I do not recommend NovoSeven. I would recommend fresh frozen plasma 2 units and also cryoprecipitate 1unit stat. I discussed with the blood bank and orders written and also discussed with the nurse. 2. Also recommend vitamin K 10 mg q. day for 5 days IV.	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		3. Await confirmatory testing for PT, PTT workup to exclude acquired hemophilia. The requisition was written and I discussed with Mary in Hematology. This is a send-out test to Esoterix. 4. Given the volume infusion with fresh frozen plasma, Nephrology needs to be onboard for possible need for dialysis in case of fluid overload. 5. I have ordered PT, PTT testing 2 hours posttransfusion of our blood products and have also asked the nurse to inform me about the results.	
08/12/YYYY	Hospital/ Provider Name	**Neurosurgeon initial consultation report**: **Chief complaint**: Head injury. **History of present illness**: Patient fell striking her face. She presented to the Emergency Room with bruising around the left eye. She denied headache. CT scan demonstrated a left orbital floor fracture extending into the anterior left maxillary sinus. CT scan of the brain demonstrated a 6 mm left temporal focal subdural layer of blood with no mass effect. She also had an increased density in the right thalamus which was possibly calcification but could have been a small area of hemorrhage as well. She had small lacunar infarcts. She had a history of a previous hemorrhagic stroke in March 2012 which left her with a hemiparesis. She has a history of atrial fibrillation but is not on anticoagulants; however, her INR is markedly elevated at 4. She has had drainage of a periorbital hematoma which continued to bleed. She denies any new weakness or numbness of her arms or legs. **Review of systems:** High blood pressure, atrial fibrillation, urinary tract infections, thyroid disease, history of left leg fracture, left arm weakness, left leg weakness, bilateral leg pain, joint pain, arthritis. The patient wears glasses. Left eye injury currently, nosebleeds, nasal congestion, sinus problems, sinus headaches, sore throat, history of stroke, blurry vision, poor coordination, history of head injury, anemia, and blood transfusion September 2014. **Physical examination:** Eyes: She has marked left periorbital ecchymoses and edema with continued oozing from the drained area inferior to the left eye. She is unable to open her left eye. The right eye movements are full. Her right pupil is 4 mm and sluggishly reactive. Visual fields full to confrontation. Extremities: She has bruising and some drainage from an injury to the left elbow. She has a dialysis access in the left arm. Neuro: She has a left hemiparesis with strength of 3/5 on the left. She also is weak on the right with strength of 4+/5. There is a bruise over her left shoulder. **Impression**: The patient has a small focal area of subdural blood in the left temporal region with no mass effect. There is also a questionable increased density in the right thalamus which could be a tiny area of hemorrhage. Fortunately, she has no	1413-1416

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		neurologic changes particularly since her INR is markedly elevated. Dr. Brahmanday, (Hematology), has been consulted and is attempting to correct her coagulopathy. She will require close neurologic observation. If her neurologic status changes, her CAT scan will need to be repeated.	
08/12/YYYY	Hospital/ Provider Name	**Dermatologist consultation report**: **Reason for consultation**: I saw on 08/12/YYYY. I was asked by ears, nose and throat to evaluate and had suffered a fall, injured the left side of her face. Upon arrival to the Emergency Room, she was evaluated and the ears, nose and throat team noted via exam and CT scan verification that she had a retrobulbar hemorrhage and proptosis. They did an intraocular pressure measurement which was described to me as being 70 mmHg. They did an emergency canthotomy with cut down and started her on Timolol and called me and asked me to evaluate the patient at which time they said her pressure was already trending down into the 40s mmHg, approximately 49. I made suggestions prior to seeing the patient in terms of additional anti-pressure drops to use. They instituted this. I saw the patient in her room in the presence of her 2 family members. Upon entering the room, she was awake and alert, in somewhat considerable discomfort. I was made aware that she had previously had a stroke and had inability to move much of the left side of her body so the exam was done completely at bedside. Initially, I took her visual acuity. She did not have her glasses with her. She stated no visual change or problems with her right eye; however, she said that since her fall she could see nothing through the left eye. She was indeed no light perception in the left eye. She easily counted fingers in the right eye from across the room. Her extraocular muscle function on the right eye was full and normal. It was severely restricted in the left eye. She had considerable subconjunctival hemorrhage in the left eye. CT scan did verify an intact globe without rupture. Her cornea appeared mildly but diffusely edematous. Her anterior segment appeared intact. I placed a drop of anesthetic onto her left eye and re-measured the pressure with the Tono-Pen. It measured 29 mm of hg. I retested it and measured 28, tested it again and it was 27 mmHg. She had visible and evident bleeding from her canthotomy site that was still actively bleeding. She had been noted to have an INR of 4.5 upon admission and had been admitted to control this. She had a full 4+ afferent pupillary defect on the left eye to pupillary testing. I dilated the left eye with 1% Tropicamide and 2.5% Phenylephrine. Upon viewing the retina of the eye it was intact. There was no retinal detachment. Her optic nerved looked healthy. It was about 0.55 vertical cup x 0.45 horizontal cup, There was no papillitis. Macula and vasculature of retina appeared grossly normal. There was no sign of occlusive process at that time. A long discussion had with patient and family. This is likely either traumatic optic neuropathy or ischemic optic neuropathy or a combination of both. The prognosis for visual recovery was poor. We did discuss some studies involving high-dose intravenous Prednisolone. Given the side effects and the current hemodynamic condition and condition of the patient it was decided that this unproven therapy was likely not warranted or justified in this case. I did ask that	1417-1418

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		the patient visit me on an outpatient basis in order to confirm the integrity of the recovery in the left eye although again I did emphasize that it was unlikely to get any significant visual recovery from this eye. The patient thanked me as did the family.	
08/12/YYYY	Hospital/ Provider Name	**Otolaryngologist consultation report:** **Reason for consultation**: Left eye injury. **History of chief complaint**: Patient was transferred from Parsons, Kansas Emergency Department for her left eye injury and reportedly left epistaxis after suffering a fall at her nursing home at approximately midnight on the day of consultation. Per ER reports, patient was transferred to Freeman Emergency Department at approximately 4:00 or 5:00 a.m. She was evaluated by the Emergency Department attending whom found that the patient had intraocular pressure greater than 70 on Tono-Pen evaluation which was greater than the device was able to read. Patient had a significant amount of proptosis, periorbital ecchymosis and chemosis to the eye. Patient reportedly had no light perception at the time of initial examination by Emergency Department. CT examination from outlying facility reveals a retro-orbital hematoma, a long fracture on the floor of the orbit as well as on the medial wall. Examination by the ENT team revealed similar results on physical examination. The patient had no light perception. Tono-Pen examination was not performed until after a left lateral canthotomy with cantholysis was performed. Performing the Tono-Pen evaluation afterward revealed that the intraocular pressure had gone down to approximately 40. The patient's nasal examination revealed no active epistaxis, a large amount of clot was removed from the patient's posterior oropharynx but no bleeding was present at that time. A pack had been placed into the left nasal cavity previously. This was removed to relieve pressure from the orbit. **Physical examination:** General: Patient is in a mild to moderate amount of distress secondary to a left eye and loss of light sensation. Examination is difficulty secondary to patient's pain. HEENT: The eye is very tender to palpation. Ballottement reveals a firm left global prior to canthotomy and cantholysis. Clot is present in the oropharynx, this is removed, and no active bleeding is examined at the time of our examination. Tonsils are 1+; no lesions are noted in the patient's oral cavity or oropharynx. **Assessment and plan**: Patient has left orbital injury with retrobulbar hematoma, no light perception, minimal extraocular movements on the left eye. A canthotomy and cantholysis is performed at the bedside to reduce the patient's intraocular pressure from greater than 70 to approximately 45. She was then placed on Combigan and Lumigan eye drops twice a day and once a day respectively to help decrease pressure.	1419-1423

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Ophthalmology is consulted for evaluation of patient's globe. The medicine team will be admitting due to the patient's multiple medical comorbidities including history that is requiring hemodialysis and also due to the patient's coagulopathy. Patient is not a good candidate for surgery at this time due to her coagulopathy and due to the fact that she has no light perception in the eye at this time raising a suspicion that the patient has already lost function of the left globe. We will await further consultation with Ophthalmology and we will await patient's coagulopathy correction. Will continue to monitor patient's status closely in concert with Ophthalmology. Dr. Kent McIntire participated in the development of the above tests and plan and is in agreement. I did participate in the evaluation of this patient with the resident. I have reviewed the chart. I have reviewed the films. I have reviewed the report dictated by the resident, and I agree.	
08/12/YYYY	Hospital/ Provider Name	**CT of the brain without contrast**: **History**: Orbit fracture. Nosebleed. **Findings**: There is a small left subdural hematoma measures 6-7 mm, with more acute and probably some chronic component. This collection demonstrates mixed attenuation. There is diffuse underlying cerebral atrophy, white matter small vessel ischemic changes. Significant left periorbital soft tissue swelling and left orbital fracture is seen. Small lacunar infarcts are identified, within the left basal ganglia. **Impression**: 1. Small left subdural hematoma with acute component and some chronic component. Close follow-up should be considered. This was not mentioned on VRC report, and findings called to patient s nurse Andrea at 8:30 a.m. on 08/12/YYYY. 2. Other chronic and incidental findings as above. 3. Please refer to the report of CT of facial bone on the same day for further details. STAT transcription.	1424-1425
08/12/YYYY	Hospital/ Provider Name	**CT of the facial bones without contrast**: **History**: Injury. **Impression:** 1. Fracture involving the inferior left orbital floor and anterior left maxillary sinus, without muscular entrapment. 2. Significant periorbital and facial soft tissue hematoma and contusion on the left.	1426-1427

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		3. Sinus opacification suggests sinus disease and blood products, especially within the left ethmoid sinus. There is mild bilateral mastoid inflammatory disease in right maxillary sinus and left ethmoid sinusitis. VRC report provided upon completion of the exam.	
08/12/YYYY	Hospital/ Provider Name	**X-ray of chest:** **Clinical history**: Lung crackles. **Findings**: The heart is quite large with atherosclerotic calcifications and moderate COPD. Mild to moderate central venous congestion. Mild diffuse interstitial pulmonary edema. Left lung base opacities and effusions should be followed up.	1428
08/12/YYYY	Hospital/ Provider Name	**X-ray of the left forearm**: **Clinical history**: Fall. **Findings**: Severe vascular calcifications. Diffuse osteopenia. Diffuse severe left wrist DJD (Degenerative Joint Disease). The left forearm shows no definite acute fracture or dislocation.	1429
08/12/YYYY	Hospital/ Provider Name	**X-ray of the left humerus**: **History**: Fall. **Impression**: Unremarkable evaluation of the humerus.	1430
08/12/YYYY	Hospital/ Provider Name	**X-ray of the cervical spine**: **Clinical history**: Trauma, fall. **Findings:** Diffuse cervical straightening. Mild cervical dextroscoliosis. Extensive atherosclerotic calcifications. **Impression**: Moderate mid to lower cervical degenerative change with no definite acute fracture.	1431
08/12/YYYY	Hospital/ Provider Name	**EKG:** **Result**: Atrial fibrillation, right bundle branch block, left anterior fascicular block, bifascicular block, abnormal EKG.	1432
08/13/YYYY	Hospital/ Provider Name	**Nursing notes:** Approx 1530 hrs, Dr. Riddel was here and made routine rounds and saw resident. She visited with resident about labs from dialysis and stated they were looking better. She also addressed her cold symptoms and red eyes. Joyce was concerned about her thyroid medication not always given first thing of a morning and Dr. Riddel stated may be could eat breakfast a little later, but resident declined. Joyce let the doctor know her buttocks was sore and doctor told her the options was to have it removed by a surgeon or we would have to keep treating it as the cyst could continue to keep coming back. She encouraged Joyce to let the staff know if she decided to have surgeon consultant.	1433
08/14/YYYY	Hospital/	**CT of the brain without contrast:**	1434

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
	Provider Name	**Clinical history:** Subdural hematoma follow-up. **Findings:** On this exam, a left subdural hematoma is similar in size to the prior exam, measuring up to about 7 mm thick. The ventricles and parenchyma again show moderate to severe age related changes. Right thalamic probable calcifications again seen. Scattered old small lacunes. Moderate left para orbital soft tissue swelling. Severe left maxillary sinus opacities. **Impression**: Stable head CT from two days ago as described.	
08/16/YYYY	Hospital/ Provider Name	**CT of the brain without contrast:** **Clinical history**: Altered mental status. Previous trauma and subdural hematoma. **Findings:** Re-demonstration of stable left temporal convexity subdural hematoma. Stable amorphous foci of high attenuation in right thalamus that may represent calcifications or micro hemorrhage. Re-demonstration of advanced bifrontal and anterior temporal predominant cerebral volume loss. Moderate patchy and focal hypoattenuation in subcortical and periventricular white matter compatible with chronic microvascular ischemia. Chronic bilateral small lacunar infarcts. If there is concern for subtle acute ischemia, MRI with diffusion weighted imaging would be more sensitive. Re-demonstration of left periorbital hematoma with inferior orbital wall fracture, accompanied by left maxillary sinus fractures with hemorrhagic products. Chronic-appearing circumferential mucosal thickening in right maxillary antrum. **Impression:** 1. Stable CT of brain with stable small left temporal convexity subdural hematoma. 2. Follow-up is suggested. 3. Stat transcription.	1435-1436
08/17/YYYY	Hospital/ Provider Name	**X-ray of chest:** **History**: End-stage renal disease. Fluid overload. **Impression:** 1. Element or degree of CHF/fluid overload cannot be excluded. 2. Left lung base atelectasis or infiltrate accompanied by an effusion. 3. Follow-up chest radiograph recommended.	1437
08/17/YYYY	Hospital/ Provider Name	**Nursing notes:** Received a returned fax from Dr. Riddel returned a fax regarding blood vessel redness in her left eye. Only statement from doctor “inpatient.”	1443
08/19/YYYY	Hospital/ Provider Name	**ER faculty note:** The patient presents to the emergency department today as a transfer from health.	1439-1440

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Patient tells me that she was in bed sleeping. She externally rolled out of bed, striking her left orbit. She tells me that she usually rolls out of bed the other way, but tonight some reason she had rolled out of bed to her right striking her left orbit on a bedside table. She reports no loss of consciousness. She reports no other pain aside from orbital and left-sided facial pain. In the emergency department at health. CT scan was obtained and she was sent here for further evaluation of orbital and racial fractures and as she is an end-stage renal dialysis patient. They had no ability to do dialysis at that facility. Upon her arrival here. My exam reveals a proptotic left eye. It was markedly injected with a large amount of subconjunctival hemorrhage and she also had a fixed pupil. She had no ability to see from this eye and she said that this was a new finding, however, had been that way since arriving at health. Her vital signs were stable here. The intraocular pressure was unable to be measured because it was so high. I have reviewed the CAT scan and I am very concerned that she has a retro orbital hematoma and she will require an emergent lateral canthotomy. As of this. I anesthetized the lateral canthus. I did tissue crush for at least 30 seconds and then I aggressively and deeply cat. The lateral canthus. There is immediate blood pouring from the extension of the lateral canthus does report immediate improvement of her symptoms and pressure behind her eye. She was consulted and came in immediately to see the patient. The lateral calculi, cysts were completed by Dr. tutor under supervision by myself. We have repeated intraocular pressures and they were measured at 43. There is still no light reflex or light perception of the patient. **Relevant findings on physical examination/diagnostic studies this visit:** Peri-orbital ecchymosis and swelling with pain and loss of vision with a fixed pupil with IOP undetectable because of high read error on machine. No other associated injuries. Rotation bilaterally. Abdomen soft, non-tender, nondistended, positive bowel sounds. Moves all extremities well without deficit. **Clinical impression:** Orbital fracture, elevated IOP, elevated INR, fall. **Plan of care:** Lab, X-ray, CT scan, procedure, admit.	
08/21/YYYY	Hospital/ Provider Name	**X-ray of chest:** **History**: Decreased breath sounds on the left. **Findings:** Increased atelectasis and/or pneumonia is seen in the left lung. Pleural effusion identified. **Impression:** 1. Worsened left lung density. Underlying infection or neoplasm cannot be excluded. 2. Atelectasis and small left effusion identified. 3. Cardiomegaly identified. Correlation with echocardiography/EKG may be considered.	1441-1442

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		4. Element or degree of CHF/fluid overload cannot be excluded.	
08/21/YYYY	Hospital/ Provider Name	**Nursing notes:** No irregularities noted.	1443
08/22/YYYY	Hospital/ Provider Name	**CT of the chest without contrast**: **History**: Abnormal chest x-ray. Coagulopathy. On dialysis. **Impression**: 1. Cardiomegaly and mildly prominent pulmonary vessels but no overt pulmonary edema. Element or degree of CHF/fluid overload cannot be excluded. 2. Left larger than right pleural effusions. Only trace effusion on the right. 3. Associated atelectasis identified in the left lung accompanied by some soft tissue fullness in the region of the left hilum, raising concern for the possibility of underlying malignancy. 4. Unusually extensive atherosclerotic disease identified as discussed above. Cardiomegaly. Ascites. Induration/stranding in the mesentery for which the differential diagnosis is discussed above. 5. CT scan of the abdomen and pelvis recommended for complete delineation of the abdominal and pelvic findings. At this juncture, abdominal malignancy cannot be excluded.	1444-1445
08/23/YYYY	Hospital/ Provider Name	**Pathology report**: **Specimen**: Thoracentesis body fluid **Clinical note**: Left lung pleural effusion **Diagnosis:** Thoracentesis fluid, side not specified: Mesothelial cells with moderate acute and chronic inflammation.	1446
08/23/YYYY	Hospital/ Provider Name	**X-ray of chest @ 1317:** **History**: Status post thoracentesis. **Impression:** Successful thoracentesis. No pneumothorax.	1447-1448
08/23/YYYY	Hospital/ Provider Name	**Ultra sound of chest:** **History:** Abnormal chest radiograph. Respiratory compromise. Suspected pleural effusion. **Impression**: 1. Left pleural effusion with volume of 405 ml. 2. Please see subsequent thoracentesis report	1449
08/23/YYYY	Hospital/ Provider Name	**Ultra sound guided thoracentesis**:	1450-1452

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		History: Abnormal chest radiograph. Respiratory compromise. Known pleural effusion. **Impression**: 1. Successful ultrasound guided left thoracentesis, yielding 550 ml of fluid of which a 60 ml sample was sent to the laboratory for analysis. 2. No complications occurred. No pneumothorax on subsequent chest radiograph.	
08/23/YYYY	Hospital/ Provider Name	**X-ray of chest @1047:** **History**: Abnormal findings on prior chest radiograph. **Impression**: 1. Continued atelectasis in the left lung. Underlying infection or neoplasm cannot be excluded. 2. Radiographs of the left humerus may be considered.	1453-1454
08/24/YYYY	Hospital/ Provider Name	**Infectious disease specialist consultation report:** **Reason for consultation**: Correction of pneumonia in a lady with C. difficile colitis now. **History of present illness**: Patient seemingly a nursing home resident on hemodialysis for end-stage renal disease who was admitted on 08/12/YYYY after falling out of her bed in the nursing home suffering seemingly head trauma with left orbital fracture, some small subdural hematoma and also very high left intraocular pressure with loss of vision. Subsequently she was found to have a left hemiparesis. She also had a coagulopathy. She was in atrial fibrillation seemingly not a new finding. She had initially no fever but a leukocytosis of 11.9 with 82% neutrophils. Blood cultures were obtained which surprisingly grew E. coli which was pan sensitive. The patient on 08/13 was started on Ceftriaxone which was continued until 08/22. Subsequently chest X-ray which was not done on admission but was done on 08/17 revealed fluid overload, marked cardiomegaly and left lower lung infiltrate with effusion versus atelectasis. CAT scan on the chest done on 08/22 showed a large left and a tiny right pleural effusion also left lung atelectasis and there was also some ascites. On 08/23 she underwent left thoracentesis and 550 ml of fluid was obtained which revealed 843 white cells 71% of which were mononuclear cells, 29% lymphocytes, no segmental. The protein was 4.2 gm. LDH was only 264. Follow-up chest x-ray from 08/24 reviewed, persistent marked cardiomegaly and diffuses mild alveolar infiltrate but no obvious consolidation to suspect pneumonia. On 08/22 BNP was 117,000 with a Procalcitonin level of 1.05. On 08/23 stool was tested for C. difficile which came out positive. The patient according to the nurses has watery diarrhea frequently which has the typical smell consistent with	1455-1459

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		C. difficile. On 08/22 the patient's antibiotics were changed from Ceftriaxone to Meropenem plus intravenous Vancomycin; on 08/24 she was started on oral Vancomycin because of the C. difficile infection. The patient's course was basically afebrile except for some minimal temperature elevation of 99.4 degrees Fahrenheit on 08/13. On 08/24 her temperature is maximum of 99 degrees Fahrenheit. The patient initially had leukocytosis which on 08/12 went as high as 17.2, on the 14th 19.4 with 85% neutrophils, then came down, on the 16th it was 10.2 with 83% neutrophils, on the 17th 8.8, since then her white count has been in normal range. On the 24th it is 5.7 with 75% neutrophils. The patient is seemingly anuric and is maintained on hemodialysis via an AV fistula in the left forearm. **Physical examination:** HEENT: She has periorbital hematoma, subconjunctival hemorrhages, left more than on the right side. Left pupil is medium wide and fixed. The right pupil is constricted. Heart: Shows a slightly irregular rhythm but no murmur. **Assessment**: 1. Clostridium difficile colitis. 2. Status post E. coli septicemia with unknown source. Patient's urine could not be tested because the patient reportedly is anuric. 3. Congestive heart failure with fluid overload and atelectasis. I doubt the patient has pneumonia. 4. Exudative left pleural effusion. 5. End-stage renal disease. 6. Left hemiparesis. 7. End-stage renal disease. **Plan**: 1. Meropenem and intravenous Vancomycin will be discontinued. 2. The patient will be continued on oral Vancomycin for her C. difficile colitis. We should try to avoid any systemic antibiotics which would aggravate her colitis unless there is clear cut evidence for pneumonia for example.	
08/24/YYYY	Hospital/ Provider Name	**X-ray of chest:** **History**: Pneumonia. **Findings:** The heart is quite large with atherosclerotic calcifications and moderate COPD. Mild to moderate hazy alveolar-interstitial infiltrates and small effusions again seen. No significant change from the prior day.	1460
08/24/YYYY	Hospital/	**CT of the brain without contrast**:	1461-

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
	Provider Name	**History**: Confusion, altered mental status. **Findings**: The ventricles and parenchyma again show moderate atrophy and moderate probable chronic bi-cerebral white matter ischemic changes. Several old small scattered lacunes. Severe left maxillary sinus disease. **Impression:** 1. No acute intracranial hemorrhage or midline shift. 2. Essentially resolved previously seen small left subdural hematoma. 3. Unchanged age-related changes, small lacunes, and right thalamic probable dystrophic calcification.	1462
08/25/YYYY	Hospital/ Provider Name	**X-ray of chest:** **History**: Pneumonia. **Findings**: The heart remains quite large with atherosclerosis and moderate COPD with mild central venous congestion. No new lung findings, no pneumothorax.	1463
08/25/YYYY	Hospital/ Provider Name	**Echocardiogram report:** **Brief history:** She presented with congestive heart failure. Echocardiographic images revealed the patient to have abnormal left ventricular systolic function with hypokinesis in the mid inferior and inferoseptal wall with an overall ejection fraction of 45-50%.	1464-1465
08/14/YYYY-08/26/YYYY	Hospital/ Provider Name	**Culture reports**: **Blood culture on 08/14/YYYY**: Escherichia coli 1 of 2 bottles. **Blood culture on 08/17/YYYY**: No growth. **Blood culture on 08/21/YYYY**: No growth. **Gram stain on 08/23/YYYY:** Moderate amount of WBC's and no organisms observed. **Aerobic culture on 08/25/YYYY**: No anaerobes isolated. **Blood culture on 08/26/YYYY:** No growth.	1466-1467
08/26/YYYY	Hospital/ Provider Name	**X-ray of chest**: **History**: Pneumonia. **Findings**: The heart is very large with atherosclerotic calcifications and moderate COPD with mild central venous congestion. No focal pneumonia or other change.	1468
08/12/YYYY-	Hospital/	***Hospitalization related records:*** *Patient information, progress notes, labs,*	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
08/27/YYYY	Provider Name	*transfusion record, orders, rhythm strip note, social service note, nutrition record, medication sheet, assessment, image note,* ***Ref:*** *1469-1734*	
08/27/YYYY	Hospital/ Provider Name	**Discharge summary**: **Date of admission**: 08/12/YYYY **Date of discharge**: 08/27/YYYY **Discharge diagnosis:** **Final diagnosis:** Anemia in chronic kidney disease (Acute) Atrial fibrillation (Acute) Bacteremia due to Escherichia coli (Acute) Cerebrovascular accident, old (Acute) Coagulopathy (Acute) Decreased breath sounds (Acute) Elevated INR (Acute) Elevated IOP (Acute) End stage renal disease (Acute) Fall (Acute) Fall at nursing home (Acute) HTN (hypertension) (Acute) History of hyperlipidemia (Acute) History of hypothyroidism (Acute) History of seizure (Acute) Hyperphosphatemia (Acute) Hypophosphatemia (Acute) Macrocytic anemia (Acute) Orbital floor fracture (Acute) Orbital fracture (Acute) Permanent atrial Fibrillation (Acute) Pleural effusion (Acute) Secondary hyperparathyroidism of renal origin (Acute) Subdural hematoma (Acute) **Reason for admission:** Transferred from Parsons with history of fall, left orbital fracture as well as Coumadin coagulopathy. **Procedures performed:** CT brain x2 CT chest Thoracentesis left lung Chest X-ray CT facial bone	1735-1742

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Hospital course: Patient with past medical history significant for hypertension, atrial fibrillation and end-stage renal disease-on hemodialysis every Monday, Wednesday and Friday presented to outside facility with history of rolling out of bed and falling at the nursing home where she resides. Patient was found to have a left periorbital ecchymosis and she also reported coughing up blood a couple of times. The patient was not on Coumadin for atrial fibrillation because of previous history of intracerebral hemorrhage. CT scan revealed left orbital fracture. Patient was subsequently transferred to Freeman for further management. CT brain and face here revealed inferior left orbital fracture as well as a small left subdural hematoma measuring about 6 mm. Patient did not have left visual acuity. She was noted to have very high left intra-articular pressure. Patient was seen by the ENT specialist for orbital fracture. He recommended no surgical intervention because the patient had already lost vision in the left eye. She was noted to have retrobulbar hematoma with very high intraocular pressure and minimal extraocular movements in the left eye and no light perception. A canthotomy and cantholysis was performed at the bedside in ER to reduce intraocular pressure from greater than 70 to approximately 45 and patient was placed on Combigan and Lumigan eyedrops twice a day and once a day respectively to help decrease the pressure. She was subsequently admitted to the intensive care unit for further management. She was seen by Dr. Brahmanday from hematology for coagulopathy. Etiology of coagulopathy was not clear. Per Dr. Brahmanday acquired hemophilia was less likely as mixing study demonstrated correction of elevated PT and PTT. Other considerations were vitamin K deficiency, poor nutrition, recent use of antibiotics etc. He recommended giving vitamin K 10 mg IV daily for 5 days. Her INR was 4.5. She was given cryoprecipitate 5 pack, 4 units of FFP as well vitamin K. She also received 1 unit of PRBC. The next day her INR was 1.3. She received 3 more FFPs over the next couple of days. Her PT and PTT have been stable since then. She was seen by Dr. Nichols from neurosurgery for left subdural hematoma. Patient did not have any mass effect or new neurological deficits. She recommended to closely monitoring her neurologic status and CT surveillance as needed. Follow-up CT done 08/24 showed near complete resolution of SDH. She was seen by Dr. Nagaria from nephrology service for routine hemodialysis and has remained on her normal schedule. The patient did have a blood culture returned positive for Escherichia coli sensitive to cephalosporins on 12th. She was started on Rocephin and completed a 10 day course. Her coagulopathy has completely resolved through treatment by heme/onc. I have repeated blood cultures on the 18th. On 08/21 chest x-ray it looked like patient had infiltrate so PCT was ordered which was elevated so we elected to start patient on HCAP therapy. A CT scan was also ordered at this time to work-up further and it showed a large pleural effusion on the left for which thoracentesis was ordered. After thoracentesis patients overall breathing and mental status did seem to improve.	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		The patient is currently awaiting review by LTAC for placement per family's wishes. She is not a candidate for being placed back to NH from where she came 2/2 not being able to sit in a chair which would be required for transport to HD. She is undergoing physical therapy daily with improvement in strength and endurance. On 08/23 night it was noted that patient had some foul smelling stools so stool was sent for C. Diff and came back positive. She was initiated on PO Vane by Nephro on 08/24 and has only had 1 loose BM today. Today she is looking much more alert and energetic than I've seen her. Patient was seen by Dr. Khan earlier yesterday 08/24 in HD and he thought she seemed altered so CT brain was ordered which came back negative for any acute changes. Actually, it showed the SDH has almost completely resolved. Since patient was being treated for PNA and now has C. Diff I did call Dr. Schmidt ID who has graciously accepted consult. He saw patient yesterday and discontinued her IV Antibiotics since it looked like PNA had resolved clinically. Patient is not currently complains of any headaches, fever, chills, cough, shortness of breath, chest pain. Patient is doing well, there is bed availability at Landmark this Saturday, suspect we can discharge the Saturday. Apparently Landmark has a bed and patient can be discharged today and we will transfer today to Landmark. **Pertinent lab & imaging**: CT brain revealed small left subdural hematoma about 6-7 mm with acute as well as chronic component, diffuse cerebral atrophy and white matter small vessel ischemic changes. It also revealed significant left periorbital soft tissue swelling and left orbital fracture. CT of the facial bones revealed inferior left orbital floor fracture and fracture of the anterior left maxillary sinus without muscular entrapment, left periorbital and facial soft tissue hematoma as well as sinus opacification suggesting sinus disease and blood products airspace usually within the left ethmoid sinus. X-ray of the left forearm revealed diffuse osteopenia, diffuse severe left wrist DJD. No evidence of acute fracture or dislocation. X-ray of the left hip humerus unremarkable. X-ray of the cervical spine revealed moderate mid to lower cervical degenerative changes. No evidence of acute fracture. Chest x-ray revealed moderate COPD, probable mild to moderate venous congestion, left lung base opacity and effusion or atelectasis. **Physical examination**: Constitutional: Positive for: No apparent distress ENT: Positive for: Normal exam Respiratory: Positive for: Clear to auscultation Cardiovascular: Positive for: RRR **Diet on discharge**: Renal-on dialysis	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Activity on discharge: As tolerated **Return to work/school forms:** Portal enrollment **Condition on discharge:** Stable **Discharge disposition**: Acute Long Term Care **Referral & follow-up request:** Lance L Brown, MD (ASSOCIATE)-2 weeks NICHOLE M RIDDEL, MD (Primary Care Provider)-4 weeks **Dietary:** Diet: Renal dialysis Start: Sat, Aug 22, lunch **Discharge medication list**: Tylenol 650mg, every 4 hours as needed Albuterol solution, inhaler three times a day as needed Amiodarone 200mg, daily 0800 Anusol/tucks max strength at 1030, 1830 Aspirin 81mg at 0800 Atorvastatin 5mg, daily night Calcium carbonate 750mg at daily 1030 & 1830 Carvedilol 3.125mg,two times with meals Cetirizine HCL 5mg, daily 0800 Cinacalcet hydrochloride 30mg, Mowefr @ 1700 Docusate sodium 100mg, at 0800 Ergocalciferol 50, 000 units daily @ 1200 Famotidine 20mg, oral at 0800 Gemfibrozil 600mg, daily 1030 & 1830 Guaifenesin 10ml every 4 hours as needed Levetiracetam 500mg, at 0800 Levothyroxine 0.05mg at 0700 Levothyroxine 0.2mg at 0700 Loperamide 30ml every 24 hours as needed Multiple vitamins 1 at 0800 Nitroglycerine 0.4mg, sublingual every 5 minutes x 3 as needed Ondansetron HCL 4mg, three times a day as needed Polyethylene glycol 17gm every morning as needed Sevelamer carbonate 1600mg, at snacks Sevelamer carbonate 3200mg, at three times meals	
08/27/YYYY	Hospital/ Provider Name	**History and physical examination report**: **Reason for admission:** Recent fall with orbital fracture left eye and retro-bulbar hematoma end-stage renal disease.	1743-1745

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		History of present illness: The patient was in a local nursing home in Parsons Kansas when she rolled over in bed and fell out of bed contusing the left side of her face. She was seen in the local emergency room and found to have proptosis and decreased eye movement on the left and a retrobulbar hemorrhage was noted. She was transferred Freeman Hospital where she went an emergency canthotomy and can hemodialysis for elevated intraocular pressure on the left. By the time she arrived the vision in the left eye was completely lost. Her coagulation labs showed a coagulopathy she was not Coumadin because of the previous history of intracranial hemorrhage but she does have chronic atrial fib. This was corrected with fresh frozen plasma and vitamin K. It was felt that this was probably due to vitamin K deficiency from overall malnutrition nutrition. She also received cryoprecipitate. Initial INR was 4.5 on 8/26 it was 1.3. She is admitted here for rehabilitation until such a time she can return to the nursing home in Parsons and be able to sit up in a chair long enough to be dialyzed. She also had an orbital fracture which was not fixed because she had already lost the vision in her eye and she has a very small subdural hematoma which was not operated and is stable. On last CAT scan the subdural hematoma is nearly fully resolved. Her course there was further complicated by E. coli bacteremia which has been fully treated. She was also treated for healthcare acquired pneumonia and was found to have a large left pleural effusion which was tapped. Thoracentesis fluid grew no organisms. She also developed C. difficile colitis while at Freeman. **Social history**: Long-term non-smoker consumes no alcohol living in a nursing home the last 3 years. **Physical examination:** HENT/neck: Right eye has a small subconjunctival hemorrhage. Cardio: Irregular rhythm PMI is non-discernible grade 1-2 systolic ejection murmur heard best at the mid epigastric area. **Impression and plan:** Fall and facial trauma with orbital floor fracture, traumatic glaucoma, retrobulbar hemorrhage, small subdural hematoma End-stage renal disease on dialysis Hypertension hypertensive heart disease and diastolic dysfunction Congestive heart failure volume dependent Valvular heart disease, moderate MR, mild PI, severe TR with PAP pressure 45 mmHg, moderate pulmonary hypertension Hypothyroidism Hyperlipidemia Permanent atrial fibrillation Previous history intracranial hemorrhage Seizure disorder due to above Secondary hyperparathyroidism Vitamin D deficiency Coagulopathy presumably due to vitamin K deficiency, corrected	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		C. difficile colitis Severe debility Anemia presumably of chronic disease Right bundle branch block Presumed recent healthcare associated pneumonia with parapneumonic effusion status post thoracentesis **Plan:** Medications will continue as noted above Nephrology consult continue dialysis 3 times weekly Nutritional evaluation and support Universal decolonization protocol Continue eyedrops as prescribed by ophthalmology Prophylactic Pepcid DVT prophylaxis with SCDs Follow chest x-rays regarding pleural effusion	
08/27/YYYY	Hospital/ Provider Name	**EKG**: **Result:** Atrial fibrillation with premature aberrantly conducted complexes, left axis deviation, right bundle branch block, T wave abnormality, repolarization abnormality, abnormal EKG.	1746
08/28/YYYY	Hospital/ Provider Name	**X-ray of chest**: **Clinical history**: Atelectasis **Findings**: Mild right hemidiaphragm elevation. The heart is very large with atherosclerosis and mild central venous congestion. Perihilar edema mildly decreased. No other change.	1747
08/31/YYYY	Hospital/ Provider Name	**X-ray of chest:** The heart is enlarged with atherosclerotic calcifications and moderate to severe COPD. Mild central venous congestion. Mild diffuse interstitial pulmonary edema. No significant change from three days ago.	1748
09/04/YYYY	Hospital/ Provider Name	**Nursing notes:** Resident daughter and other family members came tonight and went to resident's room. Daughter's stated they were going to remove resident's personal items from room. Nurse place phone call to administrator and left message.	1749
09/08/YYYY	Hospital/ Provider Name	**X-ray of chest:** The heart is very large with atherosclerosis and moderate COPD. Mild diffuse interstitial pulmonary edema again seen. Left lung bass opacities and effusion. No obvious pneumothorax.	1750
09/09/YYYY	Hospital/ Provider Name	**X-ray of chest:** The heart is large with atherosclerotic calcifications. Mild COPD with mild central venous congestion. No focal pneumonia. No other change.	1751
09/11/YYYY	Hospital/	**X-ray of right hip**:	1752

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
	Provider Name	**Findings**: A right total hip replacement appears grossly intact. Extensive arterial vascular calcification is present. The right ischial pubic rami are no adequately visualized on this limited study.	
09/16/YYYY	Hospital/ Provider Name	**X-ray of chest:** The heart is enlarged with mild central venous congestion and mild diffuse interstitial pulmonary edema. No focal pneumonia or significant change.	1753
09/01/YYYY-09/22/YYYY	Hospital/ Provider Name	***Interim physical therapy summary:*** ***Therapies given:*** *Range of motion/therapeutic exercise, gait, balance, stair training, transfers, bed mobility, patient/family education* ***She received physical therapy sessions on the following dates:*** *08/29/YYYY, 09/01/YYYY, 09/02/YYYY, 09/03/YYYY, 09/04/YYYY, 09/08/YYYY, 09/10/YYYY, 09/11/YYYY, 09/14/YYYY, 09/15/YYYY, 09/16/YYYY, 09/17/YYYY, 09/18/YYYY, 09/21/YYYY, 09/22/YYYY*	1754-1761
08/27/YYYY-09/23/YYYY	Hospital/ Provider Name	***Hospitalization related records:*** *Progress notes, orders, medication sheet, flow sheets, MAR, labs, rhythm strip note, assessment, plan of care, respiratory therapy, social service note* *Ref: 1762-2465*	
08/31/YYYY-09/23/YYYY	Hospital/ Provider Name	***Interim occupational therapy summary:*** ***Therapies given****: Patient/family education and training, upper extremity exercise/coordination/range of motion, functional mobility retraining, positioning, activity of daily living retraining, bed mobility, balance retraining, bed sitting, begin wheelchair positioning,* *She received occupational therapy on following dates: 08/31/YYYY; 09/01/YYYY; 09/02/YYYY; 09/03/YYYY; 09/04/YYYY; 09/08/YYYY; 09/10/YYYY; 09/11/YYYY; 09/14/YYYY; 09/15/YYYY; 09/16/YYYY; 09/17/YYYY; 09/18/YYYY; 09/21/YYYY; 09/22/YYYY; 09/23/YYYY* ***No of completed visits****: 15.* ***Condition of patient as on 09/23/YYYY:*** *The patient demonstrated increased strength grossly for ADL. She met her feeding goal, but needing supervision for safety and cues to encourage intake. The patient demonstrated improved trunk control, able to sit edge of bed for up to 10 minutes with minimal assist. She was able to maintain functional wheelchair positioning for 1 hour. The patient is discharged to skilled nursing where she has the potential to continue to improve strength and function. She was discharged on 03/23/YYYY.*	2466-2486
09/23/YYYY	Hospital/ Provider Name	**Discharge summary**: **Date of admission**: 08/27/YYYY **Date of discharge**: 09/23/YYYY	2487-2489

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		History: Patient fell out of bed on 08/26 transferred Freeman Hospital with retro-orbital hematoma, facial fracture retrobulbar hemorrhage and traumatic glaucoma. Initially she had a coagulopathy which was corrected with fresh plasma, vitamin is and cryoprecipitate. She also had a very small subdural hematoma which was not operated and is stable. Her course was complicated by E. Coli bacteremia and healthcare acquired pneumonia with a large left pleural effusion which is been tapped and not recurrent. She also developed C. difficile colitis which is been fully treated. **Discharge physical examination**: Patient is awake alert confused left eye is retracted and the globe is sunken. No JVD lungs clear cardiac irregular atrial fib noted grade 2/6 systolic ejection murmur abdomen negative no significant peripheral edema. No vision in the left eye at all including light sensitivity. She has no focal neurological deficits. She is awake and oriented to person only. **Final diagnoses**: Fall and facial trauma with orbital floor fracture, traumatic glaucoma, retrobulbar hemorrhage, small subdural hematoma End-stage renal disease on dialysis Hypertension hypertensive heart disease and diastolic dysfunction Now with hypotension requiring midodrine Congestive heart failure volume dependent, controlled by dialysis Senile dementia probable Alzheimer's type Valvular heart disease, moderate MR, mild PI, severe TR with PA P pressure 45 mmHg, moderate pulmonary hypertension Hypothyroidism Hyperlipidemia Permanent atrial fibrillation Previous history intracranial hemorrhage Seizure disorder due to above History of secondary hyperparathyroidism, recent PTH normal Vitamin D deficiency Coagulopathy presumably due to vitamin K deficiency, corrected prior to admission here C. difficile colitis, resolved Severe debility Anemia presumably of chronic disease Right bundle branch block Presumed recent healthcare associated pneumonia with parapneumonic effusion status post thoracentesis Macrocytosis with normal B12 and folic acid **Outcome of care including treatment, procedures and surgery**: Patient stabilized she is responded well enough from physical therapy to return to the nursing home.	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Hospital course: Patient admitted with an orbital fracture and retrobulbar hemorrhage. She had traumatic glaucoma. She underwent an emergency canthotomy and cantholysis. Her orbital fracture was not repaired as she had already lost sight in the left eye. She was admitted here to continue on her dialysis regimen. She was so debilitated that she could not sit up in a chair long enough for outpatient dialysis. She underwent a course of physical therapy essentially at this point she is bed to chair with moderate to maximum assist and ambulates only a few steps. She has a history of dementia and had some delusional thinking while here related probably to oxycodone which is since been discontinued. She is confused and disoriented but has not been agitated and does not require sedation. Most recent representative labs accompany this dictation. Chest X-ray as of 916 demonstrated cardiomegaly with mild vascular congestion no consolidating infiltrates and no pleural effusion **Condition at discharge:** Stable **Disposition of case/follow-up care**: Discharge to Elm Haven East, Parsons Kansas Dr. Riddel will follow as primary care. The patient should see an ophthalmologist at some point regarding her traumatic glaucoma and see if the eyedrops can be tapered. **Discharge medications**: Amiodarone 200 mg daily. Alphagan eyedrops 0.2% 1 drop left eye twice a day Colace 100 mg daily Pepcid 20 mg daily Renal vitamin 1 daily Xalatan eyedrops 0.005% 1 drop left eye daily at bedtime Keppra 500 mg daily Levothyroxine 250 pg daily Claritin 5 mg daily Megace 40 mg twice a day Midodrine 10 mg twice a day MiraLax 17 g 10 ounces of water daily Nepro supplement on all meal trays Timoptic eyedrops 0.5% 1 drop left eye twice a day Granulex spray to buttocks 4 times a day and when necessary Vitamin D 50,000 units by mouth weekly As needed Tylenol As needed Dulcolax As needed lactulose When necessary melatonin As needed ODT Zofran	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Tramadol 25 mg 4 times a day when necessary pain	
10/06/YYYY	Hospital/ Provider Name	**History and physical examination report:** **Chief complaint**: New admission **History of present illness:** She is here for new admit assessment. Patient had a fall from bed in the middle of the night over 3 weeks ago (08/26. S/15) She was hospitalized with facial fracture to zygomatic arch on left side and large amount of peri and retro orbital swelling and bruising. Also sustained small subdural hematoma and several other areas of soft tissue damage, which have now mostly resolved. Suffered E. Coli bacteremia and pneumonia with simple mild left pleural effusion. Denies any further cough/DOE (Dyspnea on Exertion)/etc. Patient lost a great deal of strength and suffered disruption of mood with poor motivation, poor energy, poor appetite, etc. Lost approximately 12 lbs. Has completed 2 weeks of inpatient rehab and is not continuing physical therapy here at nursing home. Is anticipated to be long term care due to previous health issues prior to her fall. She previously resided at a nursing home before hospitalization. Continues to do very well with HD (Hemodialysis) 3 times per week. Daughters concerned about her inability to sleep, her weight loss, her mood, and issues with drooling from left side of her mouth at times since the accident. No new or other focal neurologic deficits. **Review of systems:** Constitutional: Fatigue **Physical examination**: Motor examination : Right upper extremity strength: Strength 4+/5 (baseline) Left upper extremity strength: 1/5 (baseline) Right lower extremity strength: Strength 4+/5 (baseline) **Assessment:** Subdural hematoma Depression Facial fracture due to fall, sequela **Plan:** Instructions: No signs/symptoms of recurrent infection. Neurologic condition stable but will review with nursing staff monitoring closely for changes No further signs/symptoms of bleeding/bruising/clotting. Encouraged setting small goals for rehab. Counseled for normal mood reaction to serious health event and highlighted the amazing recovery she has made given her initial findings. Just in past 2 days has started participating more and eating better.	2490-2494

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
11/03/YYYY	Hospital/ Provider Name	**Triage report:** **Triage date & time**: 11/03/YYYY at 1752 **Presenting complaint**: Family states: Dr Riddel made rounds today at NH. Took a bad fall August 12, 2015 and lost sight in left eye, had a bleed at Freeman for 3 weeks then landmark, then back to EHE. A month ago was seen by Dr and the speech was different today when she saw her et she wanted her to be seen because there is a definite decline since a month ago. Not able to feed herself as well for about 3 weeks. Stroke in 03/YYYY-left sided weakness, does not ambulate, x2 assist with lift. Last known well unknown. Care prior to arrival: None. Was this an injury questionable no. Transition of care: Patient was received from another setting of care (long-term care facility), Elm haven East. Patient was not transferred to Labette Health from another hospital. **Triage assessment:** General: Appears in no apparent distress, behavior is. Pain: Denies pain. Neuro: Level of consciousness is awake, obeys commands, orientation to parson. Acuity: III **Social history**: Smoking status: Patient/guardian denies using tobacco, ETOH: Patient/Guardian denies using ETOH, No barriers to communication noted. **Diagnosis**: Altered mental status-resolved Discharge ordered by MD. **Disposition:** Discharged to home via wheelchair, with caregiver. Condition: stable	2495-2497
11/03/YYYY	Hospital/ Provider Name	**ER visit**: **Time seen**: 1926 **History of present illness**: Patient presents to ER via walk-in with complaints of altered mental status. Patient with history of possible change in mental status. Sent out by Dr. Riedel for evaluation. Has chronic renal failure. **Physical examination**: Constitutional: The patient appears alert, awake. Neuro: Orientation is normal. **Order**: Comprehensive Metabolic Panel CT head: Negative	2498-2500

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Impression: Altered mental status-resolved. **Disposition**: 11/03/YYYY @ 2012 Discharged to Home. Condition is Stable. **Follow-up:** Nichole Riddel, MD; When: 2 - 3 days; Reason: Continuance of care.	
11/03/YYYY	Hospital/ Provider Name	**Culture report:** **Blood culture:** No growth	2501
11/03/YYYY	Hospital/ Provider Name	**CT of the head without contrast:** **Reason for test**: Altered mental status **Impression:** 1. Marked diffuse cerebral atrophy with periventricular white matter small vessel ischemic change. 2. No intracranial hemorrhage or large cortical infarct is seen. 3. Stable CT head without contrast.	2502
11/04/YYYY	Hospital/ Provider Name	**Culture report:** **Blood culture:** No growth	2503
11/04/YYYY	Hospital/ Provider Name	**Follow-up visit from ER**: **Chief complaint:** Patient here today to follow up from going to the ER 11/03/YYYY Patient came from EHE Patient does have dialysis today at 11:00am **History of present illness:** Patient is here as an established patient for follow-up of neurologic changes, altered mental status, ER follow-up for stroke evaluation, elevated liver enzymes, questions regarding dialysis, weight loss, goals of care. Patient was seen yesterday in nursing home per family request due to decreased responsiveness, new inability to feed herself, subtle decline over past 2 weeks in ability to communicate clearly. Sometimes not making sense. Slumped over in her chair and weak. See neuro exam findings yesterday. Patient seen in ER and workup including CT head was negative-no extension of previous subdural bleed or new signs of hemorrhage. MRI not pursued. Patient had difficulty tolerating and holding still for CT. Travel a likely burden for her and declines neurology referral at this time. Does have pending appointment with cardiology as she has had increase in BNP and small bilateral pleural effusions. Here today for continued workup for other etiologies of fatigue/lethargy and for etiology of elevated liver enzymes.	2504-2507

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Review of systems: Constitutional: weight loss-attributes to not eating Eyes: Poor vision cannot specify quadrant/etc. HEENT: Lightheadedness when stands Musculoskeletal: Joint pain, worsening chronic especially on left side (the side she leans on in wheelchair) **Physical examination**: Neurologic: Mental status examination: Orientation: Grossly oriented to person, place Speech/language: Speech is mumbled but intelligible, Memory: Recall impaired, Attention: Attention is decreased Fund of knowledge: Fund of knowledge within normal limits-mix of very appropriate and insightful responses with inappropriate or unrelated responses. **Assessment:** Lethargy Mental status change Elevated liver enzymes CHF (congestive heart failure), NYHA class II, acute, combined **Plan:** Echocardiogram, chest X-ray PA and Lat. Goals of care: Non-invasive, non-aggressive. **Disposition:** Call or return if symptoms worsen or persist Return visit request in/on 2 weeks +/- 2 days	
11/10/YYYY	Hospital/ Provider Name	**Telephone note**: Patient chose not to take antibiotic and per nursing home staff she has been doing "fine" ie good intake/outputs. Alert and oriented. Clear speech. Interactive. Etc. Chose also to reschedule her echo and chest x-ray for later date. Does not want to travel to Joplin for neurology evaluation.	2508
11/12/YYYY	Hospital/ Provider Name	**Ultra sound of abdomen complete**: **Reason for abdomen test**: Inflammatory liver **Findings**: The examination is limited as the patient was unable to cooperate with breathing instructions. **Impression**: Low grade hepatomegaly. Trace amount of ascites. Obscured polycystic kidneys with chronic renal parenchymal disease.	2509-2510

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Partially visualized bilateral pleural effusions. Cholecystectomy.	
11/12/YYYY	Hospital/ Provider Name	**X-ray of chest:** **Reason**: Renal disease **Findings:** The cardiac silhouette is again enlarged. Calcified aortic atherosclerotic plaque. Coarse interstitial changes of the lungs. **Impression:** Trace pleural effusions with findings suspicious for low grade interstitial pulmonary edema.	2511
11/19/YYYY	Hospital/ Provider Name	**Echocardiogram report:** **Indications for procedure**: CAD (Coronary Artery Disease), CHF (Congestive Heart failure) **Final impression:** 1. Dilated cardiomyopathy with an ejection fraction of 35 percent. 2. Right atrial enlargement with severe mitral and tricuspid insufficiency with marked pulmonary hypertension.	2512
09/23/YYYY-12/07/YYYY	Hospital/ Provider Name	***Cumulative nursing home records:*** ***09/23/YYYY:*** *Report received from Aaron, RN at Land Mark Hospital. The resident is an 80-year-old female of Dr. Riddel. She was previously a resident at Presbyterian Manor, where she sustained a retro-orbital fracture to her left eye and a subdural hematoma. She has NKA and is a full code. She has a history of seizures, stents, atrial fibrillation (which she is currently running), HTN, appendectomy, hysterectomy, bilateral hip surgeries, hypothyroidism, CVA, end stage renal disease, and dementia. She was being treated for C-diff while hospitalized, but is "cleared now." She has "Sun downer's that presents around 4 p.m." She is not combative or aggressive. She is on a renal diet, receives dialysis on M-W-F. She is scheduled for dialysis at DaVita this Friday at 1110 hrs. She had 700ml dialyzed this morning. She has an AV fistula. She is incontinent of bowel/bladder, but has "no urinary output." She is assist x 2. Her last bowel movement was 09-22-2015. Awaiting resident arrival to facility.* *Resident arrived to facility. She was taken to her room, showed how to use bed controls, and call light. Three daughters present with daughter and seem very attentive to resident's needs. Unable to perform skin assessment due to resident wanting to wait until "gets ready for bed." Alert and oriented x 3. Sclera to left eye red in color from previous trauma/injury. Glasses in place. Oral mucosa pink and moist. She has partial dentures in place to the upper and lower gums. HRRR. Lungs CTA. Hand grips equal and strong. Bowel sounds active x 4 quadrants. Unable to assess pedal pulses or bilateral lower extremity edema due to resident previous request to wait until bedtime. Resident wears pull-ups for bowel/bladder*	*2513-3886*

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		incontinence. She voices a familial history of HTN. Resident's family requests that resident have quarter rails placed on resident's bed due to history of resident falling out of bed. Resident currently sitting up in wheelchair with three daughters present. She denies complains of pain or discomfort. She will be skilled for physical therapy/occupational therapy. Will continue to monitor. ***09/24/YYYY:*** *During skin assessment noted to have faint bruising to left eye orbital, 3 bruises that expand topside of right forearm, scabbing to right knee, mid and lower shin, scars to upper right thigh, scarring to abdomen below ribs, scarring to pelvic region, scarring to left hip, bruising to left forearm around dialysis fistula, mole to mid right back, scabs to left ankle and heel with some redness appearing like she had the beginnings of breakdown at some point at those sites, coccyx was reddened with some scarring as if from old pressure ulcer.* ***09/24/YYYY:*** *Call received from Dr. Riddel in response to hospital discharge orders being faxed to her. Stated she was sending back basic orders and stated that she had peri-rectal abscess that caused her intermittent pain. Will see her when she is in the building next week.* *Admin reports that he spoke with dialysis regarding Nepro orders and that we were unable to find it locally. Dialysis stated that they did not have res on it prior to her going to Joplin. Stated they would review her labs in the morning and call with appropriate substitute. Stated we could use what we had in the meantime. Admin discussed this with family and they are agreeable.* ***12/07/YYYY:*** *Continue to monitor pressure areas to left foot 3rd toe, 4th toe, and malleolus. Day nurse performed treatment to areas this day, sites remain bandaged and clean/dry/intact with Kerlix wrap around foot. Wrap is secure and clean and dry. Continues to moan and grunt with cares, but when asked if she is having pain in that foot she doesn't respond. AS needed Roxanol administered this night @2300 hrs due to signs/symptoms of pain/discomfort that may or may not be caused by skin issues, effective. Resident appears more comfortable, not as restless; she is in bed with eyes closed.* *At 0655 went into resident room to check on resident. Resident noted to be very restless moving legs and arms thrashing about. Resident respirations noted to be 10 with approx 5 seconds of apnea noted between each breath. Resident skin ashen in color and very cool to the touch. Resident given as needed Roxinal at 0700, at this time resident noted to have approx 10 seconds of apnea. Sandy daughter notified at 0710 regarding resident condition. At this time Sandy is with resident, all per oral medications held along with treatments held at this time due to condition. Will continue to monitor* *Resident with expected health decline due to stopping dialysis post going onto hospice services, currently resting in bed c daughters Sandy, Diane, and Marcie at her bedside.*	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		At 1200 hrs, called down to resident room by staff, this nurse was unable to obtain vital signs. Resident daughter's at bed side. Asked to have funeral home called. Hospice nurse Andres notified at 1202 hrs, Dr. Riddel office notified at 1205, at 1210 Carson Wall notified. *She passed away shortly post noon today with her daughters' at her bedside, hospice RN Andres here earlier today et made aware by CN that resident was gone, Carson-Wall notified.* *Carson Wall Funeral home. Resident body left facility at 1320, glasses and teeth sent with resident.*	
12/07/YYYY	Hospital/ Provider Name	**Record of death:** **Date of admission:** 09/23/YYYY at 1536 hrs **Date of death:** 12/07/YYYY at 1200 hrs **Nurse present at time of death:** Wanda Francis. **Name of person notified:** Sandy Babcock. **Body released by:** Carson-Wall Funeral Home. **Attending physician notified by:** Phone at 12/07/YYYY at 1205 hrs.	3887
12/07/YYYY	Hospital/ Provider Name	**Discharge & transfer-record of death:** **Facility received from:** Elm Haven East. **Name of mortuary:** Carson-Wall. At 1200 hrs, called down to resident room by staff, this nurse was unable to obtain vital signs. Resident daughter's at bed side. Asked to have funeral home called. Hospice nurse Andros notified at 1202 hrs, Dr. Riddel office notified at 1205 hrs, at 1210 hrs, Carson Wall notified *(Wanda Franks LPN/ADON)* Carson Wall Funeral home. Resident body left facility at 1320 hrs, glasses and teeth sent with resident *(Wanda Franks LPN/ADON)*	3888-3889

***Related records:** Others, blank, patient information, legal records, image note, medication sheet, consent, transfusion record, assessment, orders, labs, MAR, plan of care, nutrition record, immunization record, hemodialysis records, patient education,*

Ref: 3890-5755

***Reviewer's Comments:** All the significant details are included in the chronology. These records have been reviewed and do not contain any significant information. Hence not elaborated.*