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: **"**Reviewer's 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 pressure ulcer, complications and its management in detail.*
- *Nursing home admission from 02/06/YYYY to 02/28/YYYY at Vero Rehabilitation has been summarized in detail including skin care, wound assessments, nursing daily notes, orders and its management.*
- *From 02/28/YYYY to 06/25/YYYY, the details related to the pressure ulcer has been presented briefly to show the progress of the condition.*
- *Daily progress notes have been presented cumulatively.*

Flow of Events

Boston Medical Center

01/29/YYYY-02/06/YYYY: *Mr. Hicks presented to ER for weakness, 3-days ago, he felt unwell and sat himself on the ground, which he remembers about couldn't really say why it happened-Skin assessment showed stage II sacral decubitus ulcer, right knee abrasion, midline thoracic and lumbar spinal tenderness-On 01/30, underwent left knee diagnostic arthroscopy And arthrocentesis, right wrist-ID consulted on 02/01/YYYY, advised to continue antibiotics-Wound care consultation on 02/04/YYYY which revealed sacral/coccyx: DTI (POA) > Unstageable: 6 x 5cm of fixated eschar localize to the left sacral area with deflated blister (From DTI) at the linear cleft and mid right sacral area, Left hip with full thickness opening now with pale pink tissue, blistering resolved, Left heel (lateral) 3 x 3 cm (approx) DTI (POA) unstageable: Resolved dark hue of DTI now with fixated eschar, right heel (posterior) 3 x 3cm DTI > unstageable: Eschar now black and fixated-Assessed with septic arthritis secondary to N. Meningitidis-Advised to off-load affected area, encourage ambulation, optimize nutrition, wound care and wound dressing as needed-Transferred to Vero Rehab on 02/06/YYYY in stable condition*

Vero Health & Rehab Parkway

02/06/YYYY-02/28/YYYY: *Admitted for rehabilitation-Wound assessment showed left heel with 3.5 x 3.5 cm, black color; right heel with purple color 6 x 6 cm, has liquid in coccyx area, 16 x 9 x 0.2 cm, stage III; had yellow, black tissue on wound base, small amount of sero drainage; left hip area with stage II, 8 x 8 x 0.1cm, granulating; right knee with had one scab, dry; left knee with infusion site, dry, clean; continued in IV Ceftriaxone, wound dressings done-Received physical therapy, occupational therapy and speech therapy sessions-Transferred to Beth Israel Deaconess-Needham for stage IV pressure ulcer with 6 cm depth.*

Beth Israel Deaconess-Needham

02/28/YYYY-03/01/YYYY: *Ms. Hicks presented to ER for gluteal pain at site of decubitus ulcer, sacrum with decubitus ulcer with necrotic tissue to the left of gluteal cleft, 10cm x 10 cm, foul smelling, sensate and tender-MRI of pelvis showed large, deep left sacral decubitus ulcer closely abutting the left sacroiliac joint, without convincing findings of septic arthritis or osteomyelitis-On 03/01/YYYY, underwent intraoperative debridement of sacral wound-transferred to BIDMC Boston*

Beth Israel Deaconess Medical Center

03/02/YYYY-03/12/YYYY: *He was admitted for decubitus ulcer, had large sacral wound, bone visible-Antibiotics given, wound care consultation obtained-assessed with right heel right unstageable pressure injury, left lateral heel with unstageable pressure injury, left lateral malleolus with dry crusted scab and left-Plastic surgery consultation obtained-On 03/04/YYYY, underwent debridement of sacral pressure ulcer-Assessed with sacral decubitus ulcer, osteomyelitis, weakness, heel wound, anemia and diabetes-Transferred to Wingate health care for extended care*

Beth Israel Deaconess Medical Center

04/30/YYYY: *He underwent Excision of stage IV sacral pressure ulcer, closure of sacral defect with local fasciocutaneous flaps and debridement of right heel ulcer and placement of VAC for Stage IV sacral pressure ulcer and stage III right heel pressure ulcer*

Wingate at Needham

03/12/YYYY-06/07/YYYY: *Skilled short-term rehab hospitalization for wound infection, sacral decubitus, weakness, diabetes-Multiple weekly skin assessments done*

Boston Medical Center/Aisling Flanagan-Hickey, NP
06/10/YYYY: *He presented for sacral decubitus follow-up; Dressing changed in office warm/dry, see VNA at home for ongoing assist with dressings. Also heel ulcer, DSD applied as patient brought extra dressing.*

PHH Home Health
06/09/YYYY-06/25/YYYY: *Multiple home health nurse visits, occupational therapy session and physical therapy sessions-He was advised to follow-up on requested DME with MD office on 06/26*

Patient History

Past Medical History: Acute blood loss as cause post-op anemia, asthma had for 1 year-only 3 years ago, benign essential hypertension 02/02/2006, elevated cardiac enzymes-Noted during 24-hours admission 12/02/2016, dentures complicating chewing on 12/15/2016-Fronto Parietal, diabetes mellitus, herniated lumbar disc without myelopathy, hyperlipidemia, hypertension, osteoarthritis, seizures-denies seizures in over 6 years, type II diabetes mellitus-05/11/2009

Surgical History: Anterior cervical discectomy with fusion on 11/13/2017-C4-C5-C6-c7, C5 corpectomy, use of anterior cervical plate; back surgery 1999-low back pain, BSARA 2012, cervical spine surgery with TT on 09/2017, carpal tunnel release bilateral 2014, lumbar fusion on 04/26/2018-Lumbar L2-3and L5-S1 anterior spina fusion, posterior spinal arthrodesis L2-S1, bilateral facetectomies L5-S1, left shoulder surgery approx 1970

Family History: Father died of CVA, had stroke. Sister had diabetes mellitus. Brother died from motor vehicle accident. Mother had arthritis. 2 Sisters had no known problems. 1 Sister had diabetes mellitus.

Social History: Former smoker, 0.25 packs per day, quit date 02/27/1970; denies ETOH. Denies illicit.

Allergy: No known allergies.

Detailed Summary

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
01/29/YYYY	Hospital/ Provider Name	**ER visit for weakness:** **Weakness:** This is a new problem. The current episode started in the past 7 days. The problem occurs constantly. The problem has been unchanged. Nothing aggravates the symptoms. **Vitals:** BP 137/67, PR 97 bpm, Temp 96.7 (35.9), RR 18, Spo2 94%. **Review of systems:** Unable to perform-Acuity of condition. **Physical examination:** Mouth/throat: Mucous membranes are dry. Abnormal dentition. Dental caries present. Oropharyngeal exudate present.	600-603

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		ER course: **Medical decision making:** A 74 year-old-male BIBEMS from home. He states he lowered himself to the ground due to feeling weak three days ago. No one heard his calls for help until today. He denies falling or new traumatic injuries. Currently complains of pain all over his body and being very thirsty. Awake, alert, uncomfortable. Lungs clear. Mouth full of purulent secretions, very dry mucous membranes. Right shoulder tender with range of motion, no obvious bony deformities. Large stage II sacral decubitus ulcer over left buttock, smaller stage I area of skin breakdown over left hip. Abrasion to right knee. Midline thoracic and lumbar spinal tenderness, no obvious step-offs or deformities. EKG: Non-ischemic. Chest X-ray: Clear. Labs with multiple metabolic derangements- elevated trap, leukocytosis, hypernatremia, AKI, hyperglycemia, elevated lactate and CK-Consistent with being found down. CT of head/neck, chest/abdomen/pelvis given question of trauma and midline spinal tenderness in the setting of prior instrumentation. Plain films of bilateral shoulders given pain with range of motion. Impression is chronic hypernatremia (Given downtime >48-hours) and hypovolemia, trop elevation due to demand. Initially resuscitated with NS and LR, switched to D5W for free water deficit of 8-liters while in the ER. Plan for admission to medicine for further management.	
01/29/YYYY	Hospital/ Provider Name	**ER attending attestation:** He reports 3-days ago he felt unwell and sat himself on the ground, which he remembers about can't really say why it happened. Denies fall or injury. He then was unable to get himself up off the floor. Has been on the floor calling for help for 3 days. Today his neighbor finally heard him calling and called 911. Patient is on arrival with coughing thick yellow sputum, nursing removed large, very large chunk of sputum. Awake and alert, very thick yellow sputum, dried in mouth. Very dry crusted MM and tongue, Nurse removed very large 4 cm x 2 cm coagulated sputum mass. Vitals reviewed tachycardia. Complains of right shoulder pain, limited range of motion. Right wrist with area of redness and swelling positive tender to palpation. Diffuse back pain. Skin: left hip with pressure sore, 3cm round. Back with large pressure sore midback, skin sloughing.	599

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		MAE throughout but with chronic bilateral shoulder pain. **Assessment/plan:** Downs on ground x extended period. Volume depletion. No apparent direct trauma from fall but diffuse pain and multiple pressure sores. Plan for CT scan for diffuse spine tender to palpation. Labs. CXR, pelvis X-ray. Re-assess 1 p.m.: Patient feeling significantly improved. Able to hold a conversation. Still not clear why he was on the ground. "I felt weak, so I sat on the ground." Denies trauma/fall. Labs: Creat 4, baseline around 1.0. Na 165. Patient was given 2-liter Normal Saline, 1-liter LR, repeated VBG with Cr 3.3 and Na still 164. Appears better volume resuscitated. Will add additional LR 1 liter. And start D5W. Calculated free water deficit as 8L. Continued fluid resuscitation and free water deficit repletion. The patient is also with hyperglycemia initially 500. Still 430 after 3L fluid. Will need sliding scale especially now that he needs free water replacement with D5. Will give Lispro 10U SQ and continue with regular fs and sliding scale. Admit.	
01/29/YYYY	Hospital/ Provider Name	**X-ray of chest:** **History:** Fall. **Findings/impression:** Lines and tubes: None. Heart and mediastinum: Stable. Lungs and pleura: Lungs are clear. No pneumothorax. No pleural effusions. Bones: Degenerative changes present around the left shoulder joint, partially imaged. Cervical spine fixation hardware is noted. I personally reviewed the study and agree with the dictated report.	1712
01/29/YYYY	Hospital/ Provider Name	**X-ray of pelvis:** **History:** Fall. **Findings:** Hardware present in the partially imaged lumbar spine. No acute displaced fracture is visualized. **Impression:** No acute osseous abnormality.	1712
01/29/YYYY	Hospital/ Provider Name	**X-ray of right/left shoulder:** **History:** Trauma.	1712-1713

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Findings: Left shoulder: Degenerative changes present with large marginal osteophytes and joint space narrowing/subchondral sclerosis and cystic changes seen in the left shoulder joint. There is evidence of chronic calcific tendinosis around the left shoulder joint. Right shoulder: Degenerative changes seen at the right acromioclavicular joint. No acute fracture.	
01/29/YYYY	Hospital/ Provider Name	**CT of trauma head and cervical spine without contrast:** **History:** Trauma A 72 year-old-male reports 3-days ago, he felt unwell and sat himself on the ground, which he remembers about can't really say why it happened. Denies fall or injury. Midline spinal tenderness. **Findings:** **CT brain:** No infra- or extra-axial mass, hemorrhage or acute large territorial infarct is detected. There is mild prominence of the sulci consistent with global cerebral volume loss. The ventricles and cisterns are within normal limits. Nonspecific scattered periventricular and subcortical white matter hypodensities which are nonspecific but may be seen in setting of chronic small vessel ischemic disease. There is chronic medial bowing of the left lamina papyracea fracture similar compared to prior exam likely related to prior trauma. Right orbit is unremarkable. There is mild mucosal thickening of the right frontal and sphenoid sinus and ethmoid air cells. Maxillary sinuses are clear. Calcification of the carotid siphons bilaterally. CT of cervical spine: Status post anterior plate and screw fusion and discectomy of C4-C7. No peri-hardware fracture or lucencies. Cervical lordosis is mildly straightened No acute fracture, subluxation or pre-vertebral soft tissue swelling is noted. There are multilevel degenerative changes of the cervical spine with prominent sclerosis of the dens similar compared to prior exam. The Atlantodental interval is symmetric. Atherosclerotic calcification at the common carotid bifurcation **Impression:** 1. No acute intracranial abnormality or skull fracture.	1713-1715

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		2. Post-surgical changes from fusion and discectomy at the C4-C7. No acute fracture or subluxation of the cervical spine.	
01/29/YYYY	Hospital/ Provider Name	**CT of chest/abdomen/pelvis without contrast:** **Clinical information:** Found down. **Findings:** Lung nodules: Evaluation for pulmonary nodules is limited by mild respiratory motion, particularly at the bases. Within this limitation, scattered pulmonary nodules measuring up to 4 mm in size are again seen and unchanged from June 3, 2010. Vessels: Thoracic aorta is normal in caliber and course with minimal scattered atherosclerotic calcifications. Main pulmonary artery is normal in size. Bones: There are severe degenerative changes of the left glenohumeral joint with bone-on-bone articulation. Post-surgical changes from partial fusion of the lower cervical spine. There are flowing anterior osteophytes crossing more than 4 thoracic body levels, which is consistent with diffuse idiopathic skeletal hyperostosis. Abdomen: Evaluation of the abdomen and pelvis is limited by lack of intravenous contrast, within these limitations. Kidneys: Mildly tabulated and mildly atrophic. Bladder: Mostly decompressed and otherwise unremarkable. Bowel: Large and small bowel are normal in caliber. Vessels: Atherosclerotic changes. Abdominal wall: Tiny fat-containing umbilical hernia. Small right inguinal fat-containing hernia. Bones: No suspicious bony lesions. Multilevel degenerative changes of the lumbar spine. There is a posterior fusion from L2 through S1 with no evidence of hardware fracture or loosening. **Impression:** 1. No acute process in the chest, abdomen, or pelvis. 2. High density material within the gallbladder, which may represent sludge. No discrete gallstones are identified. No signs of acute cholecystitis.	1715-1716
01/29/YYYY	Hospital/ Provider Name	**X-ray of right wrist:** **History:** Found down, right wrist pain.	1716-1717

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Findings/impression: No acute fracture. There is severe narrowing of the radiocarpal joint and subchondral cystic changes. There is significant soft tissue swelling surrounding the wrist joint and distal hand.	
01/29/YYYY	Hospital/ Provider Name	**EKG:** **Result:** Ventricular rate 101 bpm. Pre-mature ventricular contractions.	1722
01/29/YYYY	Hospital/ Provider Name	**Medicine history and physical examination report:** **Chief complaint:** Weakness. **History of present illness:** He presented with back pain, displacement of lumbar discs and disc degeneration, cervical spondylitis, rotator cuff injury, hypertension, epilepsy, DM2 (Questionable diet controlled), BIBEMS from home after being found down. He states three days ago he lowered himself to the ground due to feeling weak and unable to keep himself up. No one heard his calls for help until today. He denies falling or new traumatic injuries. Currently complains of pain all over his body, especially of his wrists, and thirst. **ER course:** Vitals: Temp max 97.8, HR 75-111, RR 18-20, BP 92-155/63-89, Spo2 94-100. Exam: Mouth full of purulent secretions, very dry mucous membranes, stage II sacral decubitus ulcer, right knee abrasion, midline thoracic and lumbar spinal tenderness. Labs: BMP 162/5.1/123/18/166/4.09/502. CBC: 23/14.5/44/436 VBG: 7.3/37/49 Trop: 1.0 Lipase: 328 Lactate: 3.93 Culture: None **Imaging:** CXR clear lungs, pelvis X-ray no acute abnormality, right shoulder X-ray degenerative changes, no fracture, left shoulder X-ray degenerative disease, no fracture, Lumbar X-ray in process questionable, CT of trauma head and neck no acute changes, CT chest/abdomen/pelvis showed no acute process, high density material in gallbladder. EKG: Nonischemic Consults: None Fluids: 2-Liter NS, 2-Liter LR **Meds:** Morphine 2mg, ASA 325, Keppra 500mg, Lispro 10U, insulin gtt. **Response:** Somewhat improved mental status, reportedly able to hold a conversation. Concern for severe dehydration in the setting of being down.	715-727

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Physical examination: Mouth/throat: Extremely dry mucous membranes and chapped lips Abdominal: Soft. Bowel sounds are normal. He exhibits no distension. There is tenderness. Left lower quadrant tenderness Musculoskeletal: He exhibits edema and deformity. Right wrist swollen, tender to palpation, radial pulse intact. Skin: Skin is warm and dry. Rash noted. He is not diaphoretic. Multiple pressure ulcers, sacral decubitus. *Labs and radiological studies reviewed.* **Synthesis:** He presented with back pain, displacement of lumbar discs and disc degeneration, cervical spondylitis, rotator cuff injury, hypertension, epilepsy, DM2 (Questionable diet controlled), BIBEMS from home after being found down severely dehydrated and hyperglycemic, admitted to the MICU for management. **Assessment/plan:** **Neuro:** Altered mental status: Difficult to assess mental status in the setting of dysphonia due to secretions and dry mouth. Unclear etiology of his initial collapse however based on his description, non-focal neurologic exam, and negative CTH, most suspect toxic metabolic etiology, though difficult to r/o seizure disorder in this setting. Follow up ID as below Electrolytes as below No further specific neurologic workup at this time History of epilepsy on 2x AEDs: Restart home Phenytoin Restart home Keppra History of pain: Holding Gabapentin 100mg twice daily Holding Cyclobenzaprine Holding Oxycodone **Respiratory:** No acute issues **Cardiovascular:** Hypertension: Holding home Lisinopril and Hydrochlorothiazide in setting of severe dehydration. **CV risk:** Continue ASA Continue pravastatin	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		GI: Dysphagia on sips of water per RN SLP evaluation **GU/renal:** Severe dehydration Hypernatremia Both in the setting of being down x3 days without per oral intake. Now s/p 6-liters total with approx 10 liters total water deficit Have given 4L isotonic solution (LR) and 2 liters D5 to this point. Some concern for overly rapid correction, however recent Na back to 156. Every 4 hours BMPs Continue 1/2 NS and D5 at 75cc/hour Repeat 1-liter LR now **AKI:** Cr 4.0 on presentation, pre-renal in setting of severe hypovolemia. Already significantly down trending with volume resuscitation. CK elevation Likely due to crush injury, less likely compartment syndrome given strong radial pulses and intact cap refill. Optimally would continue aggressive fluids, but some c/f overcorrection of hypernatremia. As patient nears euvolemia, would increase fluids. **MSK:** Right wrist swelling Consider orthopedics consult in morning **ID:** No active concerns, follow up 1 bacterial culture and 1 urine culture in progress **Endocrine:** Hyperglycemia Favoring hyperosmotic syndrome (though not clearly HHS) over DKA given no ketones. Continue ICU insulin protocol **Heme:** DVT prophylaxis: HSQ **MICU bundle:** Access: PIV Tubes: None Skin: Wound consult for multiple pressure wounds Fluids: Aggressively Electrolytes: Replete as needed Nutrition:	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Prophylaxis: DVT-HSQ GI-Not indicated Consults: None PCP: Mitchell Medow, M.D. Advance directives: Full code presumed **Future appts:** Ryan Kelaghan, PA-C on 03/11/YYYY Gloria Shih, NP on 03/18//YYYY Mitchell Meadow, M.D. on 04/01/YYYY Maria Stefanidou, M.D. on 10/07/YYYY	
01/30/YYYY	Hospital/ Provider Name	**MICU attending admit note:** The patient was seen and examined with Dr. Downs, exam and history confirmed by my exam, agree with plan as documented. A 74-year-old man with history of lumbar disc disorder, rotator cuff injury, HTN, epilepsy, DM2 was on the floor of his home, unable to get up for 3 days before found by neighbor who called BEMS to take patient to BMC ER and is admitted to MICU for sepsis from severe left lower extremity cellulitis. In MICU, the patient is awake and responsive difficulty speaking clearly. BP 129/62 (BP cuff location: Left upper arm, Patient position: Lying), Pulse 85, Temp 98.8 (37.1) (Axillary), RR 20, Spo2 99%. Abdomen with good bowel sounds, tender to moderate palpation in left lower quadrant. Ext: Swollen right wrist Skin: Multiple pressure related wounds **Impression/plan:** He was admitted with severe sepsis from severe left cellulitis who is critically ill with the following problems: 1. Dehydration-Has had good response to IVF from ER will continue to replete volume and free water as needed 2. Left lower extremity cellulitis-no evidence of gas formation or involvement suggestive of necrotizing fasciitis on imaging or exam. Continue with Cefepime and Vanco while awaiting results of micro exams 3. AKI-In setting of dehydration, mild rhabdo and prior history; appears to be responding to IVF 4. Hyperglycemia-DM without ketosis but not likely to absorb well, ICU insulin protocol 5. MICU-SC Heparin, nutrition consult, wound nurse consult, analgesia for multiple skin and joint pain, PIVs, condom catheter, full code, questionable HCP	727-728
01/30/YYYY	Hospital/ Provider Name	**Wound care nurse consultation report:** Consult for pressure injuries after being found down (3-days). Briefly, 74 year-old-male with back pain, displacement of lumbar discs and	753-754

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		disc degeneration, cervical spondylitis, rotator cuff injury, hypertension, epilepsy, DM2 (Questionable diet controlled), BIBEMS from home after being found down. Admit to MICU for management. Per chart review, nursing covered deep tissue injury with adhesive foam dressings after CHG bath when admit to MICU. Bilateral knees noted for full thickness scabbed areas, no surrounding erythema. Can continue to leave open to air. Left lateral heel: DTI (Deep Tissue Injury) 3 x 3cm Darken hue area with blanchable erythema, no open areas. Right heel posterior: DTI 4 x 4cm posterior aspect of heel, darken hue, nom blanchable, erythema. Left lateral hip: DTI evolving to Stage 3, 5x5cm with blistering tissue edges, no surrounding erythema, pale red wound base. Sacral/coccyx: DTI evolving to unstageable: 10 x 10cm. Blacken eschar noted to be forming at the left upper sacral aspect with remainder of area noted for blistering darken hue tissue. Peri wound soft with mild reactive erythema. Deep tissue injuries can evolve to full or partial thickness openings. Bilateral heels likely evolve to eschar more quickly as well as the left mid upper sacrum. Bilateral left heel sheets open to air and elevate up on pillows off sheets at all times. Left hip/sacral/coccyx, continue to use adhesive foam dressings (Sacral dressing will fit at both sites) Change dressings daily, cleans with saline. Continue to monitor all sites, will need to change treatment POC as areas evolve. Patient is seen with Nursing and flowsheets revised. Will continue to follow along.	
01/30/YYYY	Hospital/ Provider Name	**Orthopedic surgery consultation report:** **Chief complaint:** Right wrist and left knee pain, concern for septic joint.	750-753

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		History of present illness: He presented with septic right wrist and septic left knee. The patient found down by neighbors, reporting unable to ambulate or stand for past 3 of days. On presentation found to be complaining of pain everywhere. Found to have acute kidney injury, CK elevation, hypernatremia, dehydration, sacral pressure wound, AMS (Altered Mental Status). **Physical examination:** Right upper extremity: Erythema and effusion to right wrist. Tender wrist Pain with rom of wrist Intact deltoid / biceps/ triceps Sensation present to light touch in median/ ulnar/ radial distributions Palpable radial pulse, hand and fingers WWP (Warm, Well-perfused) Left lower extremity: Left knee effused without erythema Tender Left knee globally Pain with PROM (Passive Range of Motion) Intact Gastroc-soleus complex/A/EHL/FHL Sensation present to light touch in deep peroneal/ superficial peroneal/tibia distributions Palpable dorsalis pedis pulse, foot WWP **Assessment/plan:** He presented with septic right wrist and septic left knee. Right wrist aspirated at the bedside for 1cc purulent fluid Left wrist aspirated at the bedside for 15cc purulent fluid Follow-up aspiration cell count and cultures Please keep NPO (Nil Per Oral) Plan for OR tonight for I & D right wrist Plan for OR tonight for I & D left knee **Attending attestation note:** I saw and evaluated the patient. I reviewed the findings and assessment with the resident, and I agree with the plan as documented in the resident's note, with no changes. I have seen the patient, examined the patient, and agree with above. Synovial cell count from left knee arthrocentesis was approx 97,000 cells-Concerning for septic left knee, indicated for left knee I & D and also indicated for right wrist I & D. All questions answered. Patient elects to proceed.	
01/30/YYYY	Hospital/ Provider Name	**Operative report:** **Pre-operative diagnosis:** Acute septic left knee and possible septic right wrist. **Post-operative diagnosis:** Acute septic left knee.	711-715, 1562-1564

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Procedure: 1. Left knee diagnostic arthroscopy. 2. Arthrocentesis, right wrist. **IV fluids:** 800ml of crystalloid IV. **Estimated blood loss:** Minimal. **Indication for the operation:** A 74-year-old gentleman with a history of seizure disorder was found down by neighbors. He was brought to the hospital. He was admitted to the ICU. He was resuscitated and stabilized. He had acute pain and swelling of his left knee and also some erythema and swelling and pain in the right wrist. Left knee arthrocentesis was performed. Synovial cell count was approximately 97,000 cells, clearly concerning for a septic process. Attempted arthrocentesis of the right wrist was done, but no fluid was obtained. Clinically, the patient had tenderness on palpation over the dorsal and palmar aspect of the right wrist, but more isolated erythema and swelling over the dorsal ulnar forearm and wrist, but no palpable effusion of his right wrist on exam. Radiographs of left knee reveal a moderate arthrosis of the left knee joint. Radiographs of the right wrist demonstrate a moderate arthrosis of right wrist, with no acute fractures on left knee x-rays or right wrist X-rays. Given the constellation of findings, the patient had inflammatory serology to include sed rate and CRP levels as well. Given the constellation of findings, the patient was diagnosed with acute septic left knee and a possible acute septic right wrist. The patient was indicated for left knee diagnostic arthroscopy with arthroscopic left knee irrigation and debridement, and possible right wrist arthrocentesis, and possible right wrist open irrigation and debridement. The goals, risks, benefits and nature of the proposed surgery were explained to the patient, and the patient elected to undergo this operative procedure. **Operative findings:** 1. Examination under anesthesia of left knee performed. Left knee range of motion is 0-130 degrees of flexion. Left knee is ligamentously stable on exam. 2. Left knee diagnostic arthroscopy was performed. Out superior medial outflow portal was inserted to aid with fluid egress. Inspection of the patellofemoral joint demonstrated a grade IV chondral lesion of the trochlea with exposed subchondral bone. Medial articular cartilage was intact, medial facet and lateral facet of the patella. There was extensive angry erythematous synovitis present in the retro patella fat pad area as well as the medial gutter, lateral gutter, and suprapatellar pouch. Aggressive synovectomy performed with arthroscopic shaver of the medial gutter, lateral gutter, suprapatellar pouch as well as the retro patellar fat pad. Diagnostic arthroscopy performed.	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Probing medial meniscus demonstrated some fraying, but no obvious tear. ACL taut to probing. Lateral meniscus stable. There were grade III chondral changes of the medial femoral condyle and lateral femoral condyle. We irrigated approximately 12 liters of crystalloid solution through the knee for arthroscopic irrigation and debridement. I did obtain a sample of the left knee joint fluid upon entry of the cannula into the knee joint, and thick yellow purulent fluid was obtained and sent to the lab for cultures including aerobic, anaerobic, AFB, P. acnes and fungal specimens. We also attempted an arthrocentesis of the right wrist. We prepped out the right wrist in preparation for possible open I&D. We took an 18-gauge needle and attempted to perform arthrocentesis dorsally into the wrist joint. No fluid was encountered on multiple aspiration attempts. We therefore decided that this was not an acute septic right wrist and we would follow this clinically. Clinically, it appeared to be more cellulitis of the wrist and forearm area of the right upper extremity. **Specimens:** Left knee joint fluid sent for aerobic, anaerobic, P. Acnes and fungal and AFB cultures.	
01/30/YYYY	Hospital/ Provider Name	**X-ray of left tibia, fibula femur and knee:** **History:** Fracture. **Findings/impression:** Left femur: Single AP view of the left femur demonstrates no displaced fracture. Alignment anatomic. Mild joint space narrowing and marginal osteophyte formation involving the left hip joint. Atherosclerotic vascular calcifications. Left knee: There is no fracture. Bony alignment is anatomic. Chondrocalcinosis within the medial and lateral tibiofemoral compartments. Tricompartmental osteophyte formation. Small joint effusion. Left tibia and fibula: No fracture. Bony alignment is anatomic. Soft tissues are unremarkable.	1717-1719
01/30/YYYY	Hospital/ Provider Name	**Speech language pathology evaluation (FEES) report:** **Medical diagnosis:** Hypernatremia. **SLP diagnosis:** Oropharyngeal dysphagia. **Assessment:** He as BIBEMS from home after being found down. He states three days ago he lowered himself to the ground due to feeling weak and unable to keep himself up. No one heard his calls for help until today (1/29). He denies falling or new traumatic injuries. Currently complains of pain all over his body, especially of his wrists, and thirst. Pt underwent ACDF in Nov 2017. Had a clinical swallow evaluation on 11/15/2017 with recommendations for puree diet with thin liquids. Was also seen on a subsequent admission for a clinical swallow evaluation, also with recommendation for puree diet with thin liquids.	1594-1602

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Impressions: Patient with history of oropharyngeal dysphagia, currently presenting with overt clinical signs/symptoms of aspiration with thin liquids and inconsistently with nectar-thick liquids. Patient would benefit from instrumental swallow assessment to characterize swallow function and guide care planning/recommendations. **Treatment frequency:** Will follow 1-3x/week for dysphagia management. **Recommendations** **Further assessment via:** Flexible endoscopic evaluation of swallowing **Administer medications:** Crushed, with puree **Diet:** Nil per oral **Other recommendations:** Good oral care Nil per oral except ice chips, sips of water and meds crushed in puree.	
01/31/YYYY	Hospital/ Provider Name	**Procedure report:** **Indications:** Inadequate peripheral access. **Comments:** Order for midline in Epic. Procedure explained and verbal consent obtained. Using sterile technique, left brachial vein accessed and 14cm midline inserted without complications. Vigorous blood return and easy flush noted. Patient is educated of care of line. Line ready for immediate use.	685-687
01/31/YYYY	Hospital/ Provider Name	**X-ray of abdomen/KUB:** **History:** Dobhoff placement. **Findings and impression:** **Tubes:** Dobhoff catheter coursing below the diaphragm with tip terminating in the expected region of the stomach in the left upper quadrant. Bowel gas pattern: Nonobstructive. Free air: No gross evidence of free air, but evaluation is significantly limited due to supine positioning. Abnormal calcifications: None. Bones: Partially visualized lower lumbar spine hardware with intervertebral disc spacers.	1719
02/01/YYYY	Hospital/ Provider Name	**Physical therapy missed visit:** Attempted to visit patient for therapy but was unable for the following reasons: Patient is not medically appropriate for therapy intervention and patient with other team members. **Additional comments:** Attempted x2 - on first attempt, patient with increased pain; on second attempt, RN preparing patient for transfer to floor. Physical	3016-3017

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		therapy to follow up as able.	
02/01/YYYY	Hospital/ Provider Name	**Infectious disease initial consultation report:** **Reason for consultation:** N. Meningiditis in right wrist culture. **History of present illness:** He presented with a past medical history of back pain, rotator cuff injury, hypertension, epilepsy, diabetes mellitus type II (Questionable A1c 6.5), BIBEMS from home after being found down severely dehydrated and hyperglycemic, admitted to the MICU for management. The patient was at home and doing well, though complaints of only a sore throat. He does not report remembering falling, and thinks he was maybe down for about a day. Does remember recognizing that he was on the ground and needed to get to his phone but was unable to. Denies preceding symptoms besides the sore throat, though he has told previous interviewers the he had some pre-syncopal symptoms. Denies sick contacts, fever, chills. At baseline, he is able to walk about 1 mile and complete ADL's, though he does have persistent left sided foot drop. Reports that he takes his anti-seizure meds daily and has not had a seizure in approx 6 years. Denies history of gout. In terms of hardware patient has bilateral rods L2-S1, as well as anterior cervical plate. In the ER, the patient was noted to have significantly elevated Na to 162 and multiple other electrolyte abnormalities including hypercalcemia, hyperglycemia, hyperkalemia. Per ICU team patient was given fluids in the ER but no antibiotics and upon arrival to the MICU was alert x oriented, alert, oriented x 3. Due to full body aches and noted erythema of right wrist and effusion of left knee, those sites were aspirated (and arthrocentesis in the case of the left knee). Right wrist cultures growing Neisseria Meningiditis. **Social history:** Employment: Painter, Elderly Affairs with Boston, General Dynamics lives on 5th floor of BHA-elevator building in the North End. Likes to be called "Joe" 8th grade education, worked as meat cutter **Social history:** Previous smoker, started at 19 years old (Approx 1963), stop on 02/27/1970. Smoked 1 pack per 1-2 weeks. **Vitals:** Temp: (97.6 (36.4)-98.9 (37.2)) 97.6 (36.4) Heart rate: (85-92) 88 Resp: (15-29) 20 BP: (96-118)/ (56-68) 117/68	738-749

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Spo2 (%): (92%-98%) 97% **Physical examination:** General: No acute distress, lying in bed, pleasant, conversive, appears comfortable Pulmonary: Bibasilar expiratory wheeze Extremities: Right arm wrapped to forearm, hanging from IV pole. Erythema and tenderness over left 3rd PIP with limited ROM. Right knee with small scabbed scrape, and left knee with small bandages at incision sites, no erythema. Neuro: Grossly normal. CN II-XII intact, normal reflexes, normal strength and sensation except left foot, decreased sensation and strength that is at his baseline. Lines: Clean/dry/intact/NT. **Synthesis:** He presented with past medical history of chronic back pain with cervical and lumbar plates, diabetes mellitus who presented from home found down after 3-days with severe hypernatremia, full body pain, and right wrist and left knee pain concerning for septic arthritis. **Impression and recommendations:** Septic arthritis, right wrist and left knee: Assessment: The patient was found down after 3 days. Preceding sore throat reportedly helped himself to the ground; due to MSK issues was not able to get up. Presented with acute mental status changes is so severe electrolyte abnormalities that improved with fluid resuscitation. Noted to have increased WBC, lactate, hyperglycemia raising concern for sepsis. Uric acid elevated to 12.2. Ortho consulted and arthrocentesis of left knee with 97,000 WBC, 96% poly, no organisms grown. Patient on Cefepime and Vanc. Right wrist with erythema and X-ray concerning for cellulitis but arthrocentesis 01/30 grew N. Meningiditis. Cefepime transitioned to Ceftriaxone. Patient quick recovery with fluids point towards electrolyte abnormalities as etiology of initial altered mental status. No further evidence of meningitis. Cannot rule out that patient was bacteremic with seeding of joints; we feel benefits of higher dose Ceftriaxone outweighs the risk. **Plan:** Continue Ceftriaxone 2g every 12 hours Daily blood cultures if blood culture turn positive It has been > 24-hours of appropriate therapy and patient does not need special precautions for Neisseria Will continue to follow **Attending attestation:** I saw and evaluated the patient. I reviewed the findings and assessment with the resident, and I agree with the plan as documented in the resident's note, except as outlined below. We are asked to assist with management of N. Meningiditis in wrist culture. Briefly, he presented with a history of back pain status post multiple surgeries, seizure d/o	

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		(on daily meds, none for years), left foot drop, DM, HTN, HL who was found on the ground is his apartment. He does not recall events of the evening. Per notes, he sat on the ground because of weakness and could not get up and could not reach phone. Eventually someone heard him calling. He was brought in by ems with acute kidney injury, significant metabolic derangements, right wrist swelling, some confusion. He then developed left knee swelling - aspirated and concerning for septic joint. Mental status improved. Underwent washout and right wrist was aspirated and today culture returned positive for N. Meningiditis today. Blood cultures remain negative. Today left 3rd PIP painful. Electrolyte abnormalities and Cr improved. My exam is consistent with above. Also, able to say days of the week backwards but required prompting x 2. **Impression:** Native joint septic arthritis with meningococcus in the right wrist. This is a rare organism to cause purulent arthritis. It is possible his initial symptoms and weakness and tab abnormalities were due to sepsis from meningococcemia but blood culture negative and he does not remember details. While his presentation seems unusual for meningitis and no evidence of such today, it is difficult to definitively rule out. Suggest narrowing therapy to Ceftriaxone 2g IV every 12 hours. We will follow with you. Duration of treatment to be determined. Does not require precautions.	
02/01/YYYY	Hospital/ Provider Name	**Nutrition brief note:** Please see full initial nutrition assessment by RD from 01/31. Nutrition consult received regarding nil per oral secondary to aspiration. Patient remains in the ICU, noted patient now with NGT. Noted renal labs improving, please see updated tube feed recommendations below. Recommend: 1. TF as Jevity 1.5 goal 75 ml/hour x's 18 hours/day (Hold 1-hour pre/post thrice daily Dilantin) and 1 Prostat packet thrice daily Start at 15 ml/hour, advance by 10ml every 4-hours as tolerated to goal rate. Provides 2265 kcal, 119 grams protein, and 1026 ml free water Additional free water per team Will monitor need for renal formula 2. Will follow for ability to ADAT with texture per SLP Recommend 75gm CHO diet, monitor need for renal diet 3. Recommend oral supplement Ensure Enlive twice daily with full liquids or PO solids (Adjust to Nepro as needed) 4. Follow weight trends 5. Monitor lytes and treat/replete as needed 6. Continue with bowel regimen as needed 7. Goal to maintain glucose to <180 mg/dl 8. Check Copper, Zinc and CRP Suggest MVI/min +250mg, Vitamin C Will follow for discharge planning needs as indicated	749-750

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
02/01/YYYY	Hospital/ Provider Name	**Medicine transfer summary:** He presented with back pain, displacement of lumbar discs and disc degeneration, cervical spondylitis, rotator cuff injury, hypertension, epilepsy, DM2 (Questionable diet controlled), BIBEMS from home after being found down severely dehydrated and hyperglycemic, admitted to the MICU for management. **Outstanding issues on transfer:** N. Meningitidis on cx from synovial fluid (wrist)- as of now likely septic arthritis, please follow up ID recs who were consulted today. Use appropriate precautions, transitioned cefepime -> CTX as prelim recs. Hypernatremia down trending, continue free water per Dobhoff tube, likely ok for BID checks Transitioned off insulin gtt today (was concurrently on D5 at 200/hour)- consider weight based if becoming hyperglycemic Acute kidney injury improving with hydration MSK-Septic arthritis s/p I & D of knee, right wrist also aspirated, ortho continues to follow Not ready for diet per speech and swallow Many skin issues Poor access, midline placed Will likely need lots of PT/OT/Rehab Holding multiple pain meds-Gabapentin, Cyclobenzaprine Holding CV meds in setting of dehydration lisinopril and hydrochlorothiazide, statin in setting of CK elevation Transitioned Dilaudid -> Oxycodone today for pain **Antibiotics course:** Cefepime 1/30-> 2/1/YYYY CTX 2/1/YYYY > Present vancomycin 1/30 -> Present (pending recs from ID) **Exam on day of transfer:** General: Patient is lying in bed, in no acute distress with NG tube placed. Oropharynx: Dry mucous membranes, however improved from admission Respiratory: Breathing comfortably on room air, clear to auscultation bilaterally Extremities: Right upper extremity in ACE wrap / elevation, left knee is wrapped, not undressed for this exam, left upper extremity third digit erythematous Skin: Multiple pressure ulcers, sacral decubitus **Microbiology:** Wound culture (Synovial fluid-wrist) 1/30/YYYY-N. Meningitidis Wound culture (Synovial fluid-left knee) 1/30/YYYY-NGTD Blood culture 1/29-NGTD (Negative to Date) Blood culture 1/31-NGTD (Negative to Date)	1566-1573

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Brief hospital course: He presented with 74-year-old male with back pain, displacement of lumbar discs and disc degeneration, cervical spondylitis, rotator cuff injury, hypertension, epilepsy, DM2 (Questionable diet controlled), BIBEMS from home after being found down severely dehydrated and hyperglycemic, admitted to the MICU for management of electrolyte abnormalities. Initially, infection was suspected given leukocytosis and inflammatory markers, of unclear etiology. Exam of right wrist and left knee consistent with possible septic arthritis (Wound culture now growing N. Meningitidis) however no meningismus, no concern for disseminated meningitis picture seems to be limited to joint spaces; ID now following consulted before transfer. Additional issues include ongoing water repletion, limited due to nil per oral status (Has Dobhoff for free water flushes) and hyperglycemia. Has been on insulin gtt until 2/1 a.m., suspect his insulin needs will be low. **Major procedures:** Midline placement 01/31/YYYY Arthroscopic I & D left knee 01/30/YYYY Joint aspiration right wrist 01/30/YYYY **Assessment/plan:** **Arthritis, septic, knee:** Patient found down after 3 days. Preceding sore throat reportedly helped himself to the ground; due to MSK issues was not able to get up. Presented with acute mental status changes iso severe electrolyte abnormalities that improved with fluid resuscitation. Noted to have increased WBC, lactate, hyperglycemia raising concern for sepsis. Uric acid elevated to 12.2. Ortho consulted and arthrocentesis of left knee with 97,000 WBC, 96% poly, no organisms grown. Patient on Cefepime and Vanc. Right wrist with erythema and X-ray concerning for cellulitis but arthrocentesis 1/30 grew N. Meningiditis. Cefepime transitioned to Ceftriaxone. Patient quick recovery with fluids point towards electrolyte abnormalities as etiology of initial altered mental status. No further evidence of meningitis, Cannot rule out that patient was bacteremic with seeding of joints; we feel benefits of higher dose Ceftriaxone outweighs the risk. Continue Ceftriaxone 2g every 12hrs Daily blood cultures if blood culture turn positive It has been >24 hours of appropriate therapy and patient does not need special precautions for Neisseria. **Hyperglycemia** **Hypernatremia:** In the setting of being down x 3 days without per oral intake. True initial Na even higher in setting of severe hyperglycemia status post extensive IVF fluid resuscitation. Na down trended initially after fluid resuscitation, latest Na 150 with repeated titration of D5 free water. BID Na checks, free water flushes every 4 hours.	

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		Altered mental status: Unclear etiology of his initial collapse however based on his description, non-focal neurologic exam, and negative CTH, most suspect toxic metabolic etiology, though difficult to rule out seizure disorder in this setting, especially as Dilantin level non-therapeutic on labs yesterday with increased CK. Also, cannot rule out infectious etiology given leukocytosis and elevated Procal with recent findings of septic joint. However, mental status significantly improved today is improved electrolytes. Follow up ID as below Electrolytes as below No further specific neurologic workup at this time, but will consider neuro consult if any change **Dysphagia** **Evaluated by SLP, moderate-severe dysphagia, nil per oral.** **Elevated CK** **Elevated troponin** **AKI (acute kidney injury)** **Generalized convulsive epilepsy** **Hospital bundle:** Chronic pain: Holding Gabapentin 100mg twice daily, Cyclobenzaprine, Oxycodone. HTN: Holding home lisinopril and hydrochlorothiazide in setting of severe dehydration. CAD: Continue ASA, holding statin iso increased CK FEN: Nil per oral diet, replete lytes pm with goal of K > 4, Mg > 2, no IVF Access: DVT prophylaxis: Lovenox PPI prophylaxis: Not indicated Code status: Full. **Dispo:** Floor.	
02/02/YYYY	Hospital/ Provider Name	**Physical therapy initial evaluation report:** **Assessment:** The patient is admitted with septic knee who is now status post left knee arthroscopic I & D, synovectomy, chondroplasty, right wrist aspiration. The patient is able to initiate standing this date with heavy max assist and transfer to chair via Hoyer lift. Patient also requiring assist for bed mobility. Static sitting balance intact. Recommend sub-acute rehab for return to functional independence at prior level.	3011-3016

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		Problem list: Impaired functional mobility, pain, decreased strength, Impaired activity tolerance, impaired balance Impaired functional mobility: Ambulation, stair negotiation, transfers, bed mobility **Recommendations:** Sub-acute rehab. **Plan:** Balance training; gait training; stair training; bed mobility; strengthening/ROM; functional transfer training; continued evaluation **Frequency:** 3-5 times a week.	
02/03/YYYY	Hospital/ Provider Name	**X-ray of abdomen/KUB:** **History:** Dobhoff advancement after it was pulled out slightly. **Findings and impression:** Tubes: Enteric tube terminates at the level of the distal esophagus/GE junction and should be advanced. Bowel gas pattern: Nonobstructive. Free air: No gross evidence of free air. Abnormal calcifications: None. Bones: No acute osseous abnormality. Partially visualized lumbar fixation hardware.	1719-1720
02/03/YYYY	Hospital/ Provider Name	**Inpatient diabetes consultation report:** **Reason for consultation:** Assistance with management of hyperglycemia and recommendations for outpatient diabetes regimen. **Assessment/plan:** He presented with back pain, displacement of lumbar discs and disc degeneration, cervical spondylitis, rotator cuff injury, hypertension, epilepsy, DM2 (Questionable diet controlled), BIBEMS from home after being found down. He was on insulin drip for hyperglycemia (insulin drip rate was variable approx 3-7 units/hour) and the insulin drip was discontinued on 1/31/YYYY without basal insulin was given. Afterwards, his BG continues to increase The GLUC service has been consulted for diabetes mellitus management in setting. **Inpatient recommendations:** Hold home oral hypoglycemics Increase Glargine 12 -> 16 units once daily Discontinue Nutritional Lispro 6 units thrice daily with meals (hold if not eating) for safety Change LISS to 1:30 for BG >150 every 4 hours	635-642

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		If patient has a diet order, please ensure all diet orders are consistent carb with no concentrated sweets OR Start LISS 1:30 >150 every 4 hours if nil per oral **Outpatient recommendations:** TBD, pending inpatient requirements. Please page GLUC Fellow on call prior to discharge for final recommendations.	
02/04/YYYY	Hospital/ Provider Name	**Nursing notes:** Patient removed right arm splint and dressing; patient refuses it for now. Patient explains that it feels better without it on and that he can move his hand freely. Ortho MD pager 4700 texted. MD pager 6911 also texted.	3002
02/04/YYYY	Hospital/ Provider Name	**Wound care nurse consultation report:** Regarding consult for multiple wounds, septic arthritis. Patient was seen by Wound Care at time of admission in MICU (Patient found down) Multiple areas noted with evolving from DTI (Deep Tissue Injury). Briefly, 74-year-old found down at home. Resuscitated in ICU. Incidentally noted to have swollen right wrist and left knee. Now with 3 days of left 3rd PIP swelling/tender. Culture from right wrist grew N. Meningitidis. Primary ID consult team recommended CTX at a dose of 2gm IV every 12 hours until all BCUL were finalized and meningitis was excluded. Ongoing weakness of unknown etiology. Patient is transferred to 7W off droplet precautions. Sacral/coccyx: DTI (POA) > Unstageable: 6 x 5cm of fixated eschar localize to the left sacral area with deflated blister (From DTI) at the linear cleft and mid right sacral area. Left hip: Full thickness opening now with pale pink tissue, blistering resolved. Left heel (lateral) 3 x 3 cm (approx) DTI (POA) unstageable: Resolved dark hue of DTI now with fixated eschar. No surrounding erythema. Left foot does posture in abducted position, painful for to move due to recent surgery of septic arthritis Right Heel (posterior) 3 x 3cm DTI > unstageable: Eschar now black and fixated, no surrounding erythema. Current treatment plan of care is adhesive foam dressing to sacral/coccyx, (Sacral dressing), left hip, adhesive foam dressing, heels open to air and elevated up off sheets. All deep tissue injuries are now evolving to eschar with L sacral with fixated eschar. Patient has been continent of stool (Asking for bedpan)	737-738

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		No change in treatment plan of care, however, will add "paint with betadine to left sacral and cover with Sacral adhesive foam dressing to continue dryness to act as biologic as best can. Will place orders in EPIC, please sign if agree. Will have UC order waffle cushion and also order Hil-Rom 300ws Patient seen with Nursing. Will continue to follow along as needed	
01/31/YYYY-02/04/YYYY	Hospital/ Provider Name	**Interim speech therapy summary:** **He received speech therapy sessions on the following dates:** *01/31/YYYY & 02/04/YYYY* **Condition of patient as on 02/04/YYYY:** Patient exhibits moderate dysphagia, somewhat improved from prior exam 1/31. Dysphagia is characterized by suspected impaired hyolaryngeal excursion, reduced epiglottic inversion, impaired laryngeal vestibule closure, and reduced pharyngeal contraction. This results in aspiration of liquids and penetration of all tested consistencies. Amount of residue noted to be less than during prior exams. Of note, patient's Dobhoff tube is noted to be curled/coiled in pharynx as depicted above and should be removed as soon as possible. Aspiration avoided using a left head turn + chin tuck, and very small bites & small sips. Patient required high levels of cueing to complete. Given this, there is still a moderate-to-high aspiration risk particularly if patient does not adhere to strategies. Patient appears to be improving but continue to suspect he is below baseline swallow function. Discussed with MD; see resultant recommendations outlined below. Recommendations: Solids: Puree Liquids: Thin Pills: Crushed in puree Strategies: 1. Turn your head to the left and tuck your chin down 2. Take a small sip or bite 3. Swallow 4. Then you can release the turn + tuck position	1585-1602
02/01/YYYY-02/05/YYYY	Hospital/ Provider Name	**Interim physical therapy summary:** **Therapies given:** Balance training; gait training; stair training; bed mobility; strengthening/ROM; functional transfer training; continued evaluation **He received physical therapy sessions on the following dates:** *02/01/YYYY, 02/02/YYYY, 02/05/YYYY* **Condition of patient as on 02/05/YYYY:** Patient is status post septic arthritis of left knee and cellulitis of right hand. Patient required max assist x 2 with increased time and multiple steps for repositioning when transferring chair>bed via squat pivot. Patient reported severe pain in left knee during	1602-1613

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		transfer. Required multiple breaks for deep breathing, left leg management, and repositioning once in bed. Patient is operating well below PLOF. Recommend subacute rehab at this time.	
02/05/YYYY	Hospital/ Provider Name	**Occupational therapy initial evaluation report:** Occupational therapy consult received and chart reviewed. Patient seen this date for occupational therapy evaluation and recommendations for disposition. Patient presented supine in bed, agreeable to participate in session. Patient currently presents significantly below functional baseline with deficits as listed below impacting safety and IND with ail ADLs, IADLs, and functional mobility. Patient currently requiring moderate assist for bed mobility and heavy maximal assist to complete sit <> squat. Limited this date secondary to pain. Patient required frequent rest breaks and max increased time for all activities. Patient will continue to benefit from further skilled IP OT services, recommending Sub-acute rehab once medically appropriate for discharge. **Problem list:** Pain, decreased strength, impaired balance, impaired activity tolerance, decreased range of motion, impaired ADLs, impaired functional mobility **Impaired functional mobility:** Bed mobility, transfers, ambulation **Discharge recommendations:** Sub-acute rehab **Discharge DME:** Will continue to assess **Plan:** The patient will continue to benefit from further skilled inpatient occupational therapy services. ADL retraining, functional transfer training, upper extremity strengthening/ROM, endurance training, cognitive orientation, patient/family training, equipment eval/education, neuro muscular reeducation, fine motor coordination activities, compensatory techniques education **Frequency:** 2-4 times a week.	1614-1619
02/06/YYYY	Hospital/ Provider Name	**Telephone conversation:** Patient is scheduled for hospital discharge follow-up on 02/20/YYYY at 9 a.m. with Dr. Ganta, PCP Dr. Medow and NP anchor not available.	2595-2614
02/06/YYYY	Hospital/ Provider Name	**Nursing notes:** Patient ordered for discharge to Vero Rehab this afternoon. Patient with 3-4+ edema to left lower extremity and right hand, team aware. Tolerating IV antibiotics treatment well. Discharged with double lumen midline in place. Dressing clean/dry/intact. Hiccups unrelieved with current regimens. Team aware. Dressing to left lower extremity clean/dry/intact. Sacral dressing changed by this RN before discharge. Lovenox dose given before discharge. Patient is in agreement with transfer to rehab facility, discharged in stable	1541

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		condition at 1625.	
01/29/YYYY-02/06/YYYY	Hospital/ Provider Name	***Cumulative inpatient progress notes:*** *Patient was admitted on 01/29/YYYY status post fall to the ground due to feeling weak and unable to keep himself up. Incidentally noted to have swollen right wrist and left knee. Culture from right wrist grew meningitis. He was treated with Ceftriaxone 2 gm every 12 hours. Discharged on 02/06/YYYY with advice to continue Ceftriaxone until 02/13/YYYY to complete course of 2 weeks for septic arthritis.* ***Hospitalization related records:** Case management notes, progress notes, patient's information, plan of care, flow sheets, MAR, labs, orders, flow sheets, patient education, discharge instructions* ***Ref:** 1521-1562, 1564-1566, 1581-1585, 1619-1711, 1723-2545, 2547-2594, 3000-3001, 3008-3011, 3037-3051, 3057-3058, 586-598, 600, 603-635, 642-685, 687-711, 770-1520, 1573-1580*	
02/06/YYYY	Hospital/ Provider Name	**Medicine physician discharge summary:** **Admit date:** 01/29/YYYY. **Discharge date:** 02/06/YYYY. **Principal diagnosis:** Septic arthritis secondary to N. Meningitidis. **Secondary to diagnosis:** Hypernatremia Hyperglycemia Dysphagia Epilepsy Acute kidney injury secondary to severe hypovolemia Pain CAD (Coronary Artery Disease) HTN (Hypertension) **Outstanding issues at discharge:** **Septic arthritis secondary to N. Meningitidis:** Antibiotics course per ID: Ceftriaxone 2g every 12 hours (02/01-02/06), final dose on 02/06 in evening (Day of discharge to be given at SAR) Ceftriaxone 2g every 24 hours (02/07-02/13) Follow-up appt with ID on 02/20/YYYY While on Ceftriaxone, please check CBC, BMP, LFT, ESR, CRP weekly. Fax results to CID clinic-Attention: Dr. Nelson. **Ortho recommendations:** Continue medical management with antibiotics Follow-up appt with Ortho on 03/11/YYYY **Dysphagia:**	728-736

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		SLP recommendations: Puree diet with thin liquids -> Please continue to evaluate and advance diet as tolerated Patient with nausea/vomiting possibly due to adverse Rx of Oxycodone, resolved with Zofran Nutrition: Ensure supplements thrice daily (Given albumin 2.2) **Hypertension:** Previously prescribed Hydrochlorothiazide and Lisinopril which was held on admission in the setting of severe dehydration Patient's BP normotensive thus BP meds not restarted (as well as iso acute kidney injury) Continue to monitor BP daily and restart medications if indicated and patient becomes hypertensive **Diabetes mellitus (HbA1c 6.5% in 04/2018):** GLUC consulted, suspect hyperglycemia iso infection Regimen: Lantus 15 units at bedtime and metformin 500mg daily on day of discharge Per glucose: Start Metformin 500mg once a day and increase to 1000mg twice daily gradually after 3 days if good tolerance. **Acute kidney injury secondary to severe hypovolemia:** Baseline Creat 0.8-1.0; at admission Creat 4.0, on discharge Creat 1.44; CTM renal function as not yet at previous baseline, possibly due to component of ATN (Avascular Tubular Necrosis) **Sacral decubitus ulcer:** Off-load affected area, encourage ambulation, optimize nutrition Wound care and wound dressing as needed **Reason for inpatient admission/chief complaint:** He presented with back pain, displacement of lumbar discs and disc degeneration, cervical spondylitis, rotator cuff injury, hypertension, epilepsy, diabetes mellitus type II, brought in by EMS from home after being found down. He states 3-days ago he towered himself to the ground due to feeling weak and unable to keep himself up. No one heard his calls for help until today. He denies falling or new traumatic injuries. Currently complains of pain all over his body, especially of his wrists, and thirst. **Vitals:** Temp max 97.8, HR 75-111, RR 18-20, BP 92-155/63-89, Spo2 94-100. **ER course:** Exam: Mouth full of purulent secretions, very dry mucous membranes, stage II sacral decubitus ulcer, right Knee abrasion, midline thoracic and lumbar spinal tenderness.	

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		Labs: BMP 162/ 5.1 / 123 /18 /166/4.09/502 CBC 23 / 14.5 / 44 / 436 VBG 7.3 / 3 7 / 4 9 Trop 1.0 Lipase 328 Lactate 3.93 Culture: None **Imaging:** Chest X-ray showed clear lungs Pelvis X-ray showed no acute abnormality Right shoulder X-ray degenerative changes, no fracture Left shoulder X-ray degenerative disease, no fracture. Lumbar X-ray in process questionable. CT of trauma head and neck no acute changes CT of chest/abdomen/pelvis showed no acute process, high density material in gallbladder. EKG: Non-ischemic **Consults:** None**.** **Fluids:** 2-liter Normal Saline, 2-liter LR (Lactate Ringer). **Meds:** Morphine 2mg, ASA 325, Keppra 500mg, Lispro 10 units, Insulin gtt. **Response:** Somewhat improved mental status, reportedly able to hold a conversation. Concern for severe dehydration in the setting of being down. **Hospital course:** He presented with back pain, displacement of lumbar discs and disc degeneration, cervical spondylitis, rotator cuff injury, hypertension, epilepsy, diabetes mellitus type II (Questionable diet controlled), BIBEMS (Brought in By Emergency Medical Services) from home after being found down severely dehydrated and hyperglycemic, admitted to the MICU for management of electrolyte abnormalities (hyperglycemia and hypernatremia). Initially, infection was suspected given leukocytosis and inflammatory markers, exam of right wrist and left knee consistent with possible septic arthritis, wound culture now grew N. Meningitidis, however no meningismus, no concern for disseminated meningitis picture as seemed to be limited to joint spaces; ID consulted, patient is on CTX (Ceftriaxone) 2g every 12 hours. Additional issues include ongoing water repletion, limited due to nil per oral status (Has Dobhoff for free water flushes) and hyperglycemia. Has been on insulin gtt until 02/01 morning, suspect his insulin needs will be low. **Problem course:** **Septic arthritis secondary to N. Meningitidis:** Patient is found down after 3 days. Preceding sore throat reportedly helped himself to the ground; due to MSK issues was not able to get up. Presented with acute mental status changes iso severe electrolyte abnormalities that improved with fluid resuscitation. Noted to have increased WBC, lactate, hyperglycemia raising concern for	

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		sepsis. Uric acid elevated to 12.2. Ortho consulted and arthrocentesis of left knee with 97,000 WBC, 96% poly, no organisms grown. Patient initially started on Cefepime and Vanc. Right wrist with erythema and X-ray concerning for cellulitis but arthrocentesis 01/30 grew N. Meningitidis. ID consulted. Cefepime transitioned to Ceftriaxone 2g every 12 hours. Patient quick recovery with fluids point towards electrolyte abnormalities as etiology of initial altered mental status (suspect toxic metabolic encephalopathy). No further evidence of meningitis. Per ID recommendations, patient to be treated with CTX 2g every 12 hours (End date 02/06) and then CTX (Ceftriaxone) 2g every 24 hours (02/07-02/13). CDI: Septic arthritis is continued to be treated upon discharge with CTX as above (End date 02/13) **Hyperglycemia:** Patient initially hyperglycemic to >500, controlled well with insulin drip although experiencing periodic increases in glucose, likely due to D5 drip. GLUC was consulted and patient was started on basal/bolus regimen once TFs at goal. Hemoglobin A1c 6.5% in 04/2018, which indicate well-controlled diabetes mellitus. Hyperglycemia thought to be due to tube feed and infection. Once patient transitioned to puree diet, glargine up titrated. Per GLUC, patient is to be discharged on Lantus 15 units at bedtime and start Metformin 500mg daily (To be increased to 1000mg daily after 3-4 days if patient tolerating well). **Severe hypovolemia complicated by acute kidney injury, elevated CK, hypernatremia:** The patient initially presented with acute kidney injury (Cr 4.0) thought to be pre-renal in the setting of severe hypovolemia, which significantly down trended and improved with volume resuscitation. Baseline Creat 0.8-1.0, upon discharge Creat approx 1.3. Additionally, patient with elevated CK (iso being down for 3-4 days) with CK peak 3356 which also down trended with fluids. Patient did not have any signs of compartment syndrome and CK was no longer trended after < 2000. Other metabolic derangements include hypernatremia, hypercalcemia, hyperkalemia, hypercalcemia and hypermagnesemia all of which resolved with volume resuscitation. **Toxic metabolic encephalopathy:** Unclear etiology of his initial collapse however based on his description, non-focal neurologic exam, and negative CT of head, most suspect toxic metabolic etiology, though difficult to rule out seizure disorder in this setting, especially as Dilantin level non-therapeutic on labs yesterday with increased CK. Also, cannot rule out infectious etiology given leukocytosis and elevated Procal with recent findings of septic joint. However, mental status significantly improved L/S/O improved electrolytes. **Dysphagia:** Patient presented with dysphagia, reported to be new. Evaluated by SLP, moderate-severe dysphagia, was made nil per oral and started on TFs. Notably, patient was re-evaluated by SLP on 02/04 and was transitioned to puree diet with thin liquids which he tolerated.	

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		Elevated troponin: 1.005 on admission -> down trended to 0.867, stopped trending. Likely due to demand ischemia, EKG with NSR (Normal Sinus Rhythm). **Chronic problems:** **Epilepsy:** Continued home phenytoin and Keppra. **Chronic pain:** Holding Gabapentin 100mg twice daily, Cyclobenzaprine, oxycodone. To be continued upon discharge. **HTN:** Holding home lisinopril and hydrochlorothiazide in setting of severe dehydration. After patient was euvolemic, continued to be normotensive thus. **CAD:** Continue ASA, holding statin iso increased CK. **Consults:** IP consult to social work IP consult wound nurse Clinical swallow evaluation IP consult to orthopedic surgery Anesthesia follow-up Physical therapy evaluation and treatment IP consult to social work IP consult to nutrition services IP consult to infectious diseases IP consult to social work IP consult wound nurse IP consult to endocrinology-Diabetes Occupational therapy evaluation and treatment **Major procedures:** Midline placement 01/31/YYYY Arthroscopic I & D left knee 01/30/YYYY Joint aspiration right wrist 01/30/YYYY **Discharge exam:** Abdomen: Mildly distended abdomen, normoactive bowel sounds. Extremities: Swelling of right hand/wrist (improved since yesterday). **Discharged condition:** Stable. **Disposition:** **Discharge planning** **Living arrangements:** Alone **Support systems:** Friends/Neighbors, Church/Faith Community **Assistance needed:** None **Type of residence/transferring facility:** Assisted living **Care facility name:** Asonium	

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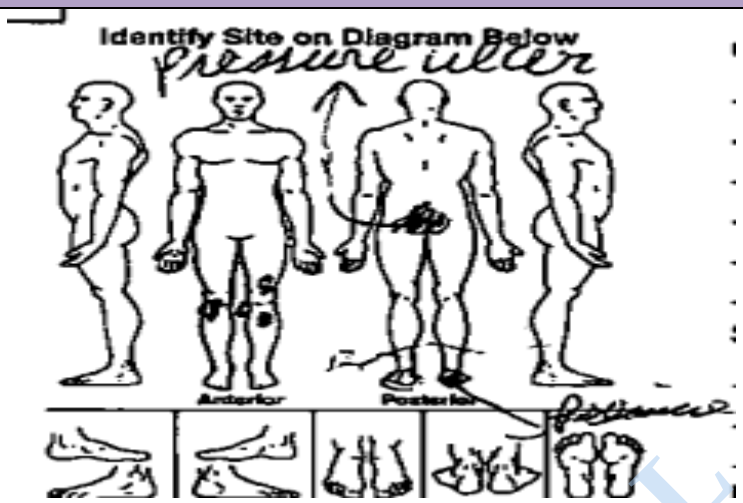
		Home care services: Yes **Type of home care services:** Safety alert **Follow-up appts:** 02/20/YYYY: Hospital discharge with Teja Ganta, M.D. 02/20/YYYY: Established ID with Alison Lynn Nelson, D.O. 03/11/YYYY: Established patient appointment with Ryan Kelaghan, PA-C Orthopedic Surgery) 03/08/YYYY: Established patient appointment with Gloria Shih, NP 04/01/YYYY: Established patient appointment with Mitchell Medow, M.D. **Meds:** Ceftriaxone 2g in NACL 0.9% 100ml IVPB every 12 hours for 1 dose, daily for 6 hours, Lantus 15 units nightly, Metformin 500mg daily. **Continue taking these meds:** Tylenol 500mg three times a day, ASA 81mg daily, Dulcolax 5mg daily as needed for constipation, Vitamin D3 2000 units daily, Flexeril 5mg two times daily as needed for muscle spasm, DME-Custom AFO for drop foot left foot-has old brace, Gabapentin 100mg tow times a day, Keppra 500mg two times a day, Roxicodone 5mg every 4 hours as needed for pain upto 20 doses, Dilantin 100mg ER 2 in morning and 3 in evening, Pravachol 40mg daily, Rollator Walker with chair.	
02/06/YYYY	Hospital/ Provider Name	**Nursing admission evaluation report:** *(Illegible notes)* **Active diagnosis:** Septic knee arthritis secondary to N. Meningitidis, hyperglycemia, epilepsy **Is therapy screen, evaluation and treatment triggered:** Physical therapy, occupational therapy and speech language pathologist **Pain:** Location: generalized pain Intensity: Mild pain Comments: When repositioning or turning in bed or out of bed/pain **Skin conditioned:** Warm, moist. Edema present: Both bilateral (Bilateral lower extremity)	2966-2967

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		 **Comments:** Right heel prressure wound, skin is dry, bruise right heel, blister fill with bleed noted on right arm, one open area in right knee and 3 areas with sutures in left knee, prressure wound in coccyx **Eating:** Diet order: NAS-CCD-Purred texture Diet type/consistency: Purre texture Fluid consistency: Thin liquid **Oral assessment:** Own teeth: Yes Dentures: Partial Do dentures fit: Yes Condition of teeth: Broken	
02/06/YYYY	Hospital/ Provider Name	**Weekly skin evaluation report:** *(Illegible notes)* Bruise: CP Rash: All big joint red swelling Blanchable: No Non-blanchable: No Open area: See left	3067

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		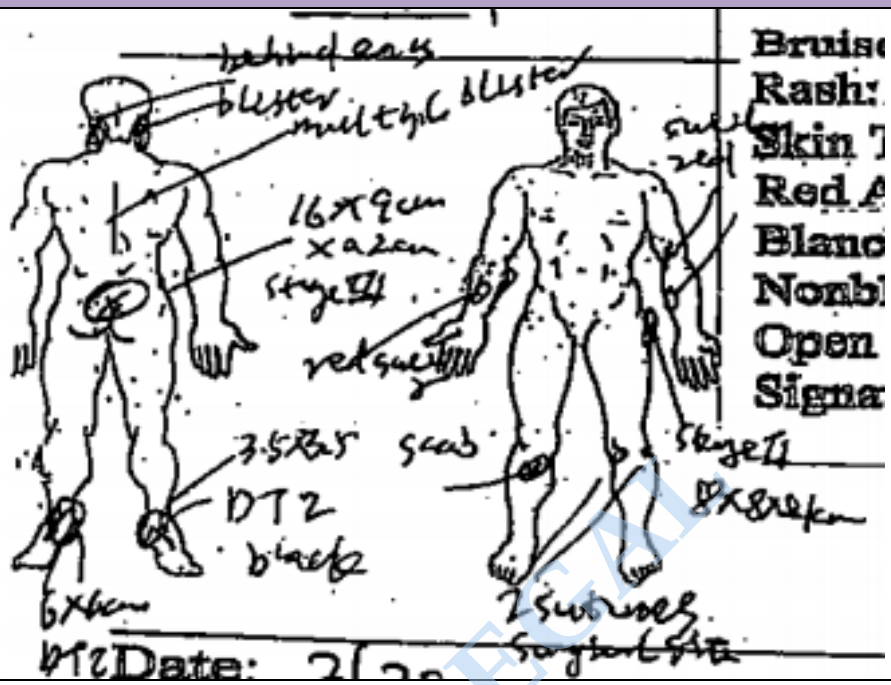	
02/06/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* Resident is a 74 year-old-male, English speaking. Is admit to 22 BB from BMC via ambulance, He was transferred by 2 persons. **Diagnosis:** Septic arthritis secondary to N. Meningitides, hyperglycemia, toxic metabolic encephalopathy. Resident is alert, awake, oriented x 3. Temp 97.6, BP 116/70, Spo2 92% on room air, RR 20. Resident has lots of skin issues; all large joints area: Swelling, red and painful. Both heels: Deep tissue injury. Left heel: Black color. Dry skin. Right heel: Purple. Skin: Intact. Liquid under skin. Coccyx area 16 x 9 x _ 2 cm, pressure ulcer, stage III, yellow, black wound base. Left hip has stage II 8 x 8 x 0.1 cm granulating. Right knee has one scab dry. Left knee: Has 2 effusions site. Suture in place. Dry and clean, skin intact. Left arm midline site dressing is intact, had swelling, palm and left upper arm. Both forearms have multiple red bump or swelling. Both ears behind _. Yellowish blister. Swelling is red. He also has multiple blister on back too. Bowel sounds is positive four quadrants, lung sounds in diminished, no complains of shortness of breath. Resident is _ on pain management with effects. All doctor orders were verified by on call NP. Labs, CBC with diff, CMP, CRP, A1C on 02/08/YYYY, will continue to monitor.	3140-3141

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
02/06/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* 3-11: Both heels have deep tissue injury. Left heel: 3.5 x 3.5 cm, black color, no drainage. Right heel: Purple color 6 x 6 cm, has liquid in coccyx area: 16 x 9 x 0.2 cm, stage III. Has yellow, black tissue on wound base, small amount of sero drainage, no odor. Left hip area: Stage II, 8 x 8 x 0.1cm, granulating Right knee: Has one scab, dry, OTA Left knee: Infusion site, dry, clean, 2 sutures in place, OTA Both forearms have red bump on swelling, all large joints are swelling, red and painful. Left arm midline site: Dressing intact. Left upper arm screening: Redness present.	3137
02/06/YYYY	Hospital/ Provider Name	**Orders:** *(Illegible notes)* May admit resident to room 226 B. may verify _ under from BMC. Labs ordered: CBC with diff, CMP, CRP, A1C on 02/08/YYYY. Added FBS x twice daily, call _.	3098
02/07/YYYY	Hospital/ Provider Name	**Occupational therapy plan of care:** **Reason for referral:** He presented with past medical history of back pain, displacement of lumbar disc and disc degeneration, cervical spondylitis, rotator cuff injury, hypertension, epilepsy, DM II, BIBEMS who was found down (Reporting for 3-days) and admitted to ER for sepsis from severe left lower extremity cellulitis. Exam of right wrist and left knee consistent with possible septic arthritis. Patient is now s/p left knee arthroscopic I and D, synovectomy. chondroplasty, right wrist aspiration. Patient is in an apartment with an elevator with access and its reported is modified Independence with functional mobility using axillary crutches for outdoor ambulation (due to previous back surgery within last year) and rollator for household ambulation/mobility. Patient reported he has a drop foot and has a brace for ambulation but does not use it. Upon occupational therapy evaluation, patient presents with impaired left lower extremity range of motion, impaired lower extremity, right upper extremity decreased strength, question of decreased sensation, impaired activity tolerance for ADLs. Edema and left knee pain reported which is limiting his ability to complete functional mobility independently. The patient will benefit from skilled occupational therapy interventions to address impairments, return to PLOF (Prior Level of Function) and ensure safe discharge to home. More than likely with adaptive equipment to lessen risk of falls. **Precautions:** Fall risk, left lower extremity weight bearing as tolerated, full range of motion, no restrictions, right upper extremity in splint, elevated at all times, left upper extremity PICC, drop foot left lower extremity. **Treatment diagnosis:** Muscle weakness (Generalized). **Requires skilled services to focus on:**	3161-3162

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		Therapeutic exercise Neuromuscular re-education Occupational therapy evaluation-Moderate complexity Therapeutic activities Self-care training. **Frequency/duration:** 5 times a week for 4 weeks.	
02/07/YYYY	Hospital/ Provider Name	**Speech therapy plan of care:** **Treatment diagnosis:** Dysphagia, oral phase. **Medical diagnosis:** Dysphagia, unspecified. **Reason for referral:** He presented with past medical history of back pain, displacement of lumbar discs and disc degeneration, cervical spondylitis, rotator cuff Injury, HTN, epilepsy, DM II, BIBEMs who was found down (reporting for 3 days) and admitted to ER for sepsis from severe left lower extremity cellulitis. Exam of right wrist and left knee consistent with possible septic arthritis. Patient is now s/p left knee arthroscopic I & D, synovectomy, chondroplasty, R wrist aspiration. Patient is now under orders as follows: Left lower extremity weight bearing as tolerated, full range of motion no restriction, right upper extremity in splint and WBAT, elevated at all times. Prior to hospitalization, patient lived home alone tolerating regular solids and thin liquids without difficulty swallowing. The patient presents to Parkway on altered diet of puree solids and thin liquids which is below baseline diet. Speech therapy evaluation and treatment is recommended to assess diet tolerance, determine highest and safest diet, reduce the risk of aspiration, and train compensatory strategies. **Requires skilled services to focus on:** Treatment of swallowing dysfunction and/or oral function for feeding Evaluate swallowing function (bedside) **Frequency/duration:** 5 times a week for 4-weeks	3170-3171
02/07/YYYY	Hospital/ Provider Name	**Physical therapy plan of care:** **Reason for referral:** He presented with past medical history of back pain, displacement of lumbar discs and disc degeneration, cervical spondylitis, rotator cuff injury, HTN, epilepsy, DM II, BIBEMs who was found down (reporting for 3 days) and admitted to ER for sepsis from severe left lower extremity cellulitis. Exam of right wrist and left knee consistent with possible septic arthritis. Patient is now s/p left knee arthroscopic I & D, synovectomy, chondroplasty, R wrist aspiration. Patient is now under orders as follows: Left lower extremity weight bearing as tolerated, full ROM no restriction, RUE in splint and WBAT, elevated at all times. Prior to admission, patient lived alone in an apartment with elevator access and was modified independent with functional mobility using axillary crutches for outdoor ambulation (due to previous back surgery within last year) and rollator for household ambulation. Patient reported he has left drop foot and has a brace for ambulation but does	3177-3179

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		not use it. Upon physical therapy evaluation, patient presents with impaired left lower extremity range of motion, impaired lower extremity strength, impaired standing balance, impaired activity tolerance, edema and left knee pain which is limiting ability to complete functional mobility independently. Patient would benefit from skilled physical therapy intervention to address impairments, return to PLOF (Prior Level of Function) and ensure safe discharge to home. **Requires skilled services to focus on:** Therapeutic exercise Neuromuscular re-education Gait training Manual therapy Physical therapy evaluation-Moderate complexity Therapeutic activities **Frequency/duration:** 5 times a week for 4-weeks.	
02/07/YYYY	Hospital/ Provider Name	**NP visit:** He was transferred from hospital where he was admitted for sepsis with severe lower extremity cellulitis. Tx for hyponatremia, AKI, meningitidis septic arthritis, hyperglycemia, dysphagia Was on IV and per oral antibiotics Had mental status changes, unclear etiology Today, he is vomiting a small amount Will obtain admit labs **Review of systems:** Stiffness, muscle aches, arthralgias/joint, back pain Additionally, reports nausea and left sided pain **Physical examination:** Psychiatric: Anxious. Hesitant speech. Lungs: Decreased breath sounds. Musculoskeletal: Limited range of motion. He is in be PICC line intact, vomiting a small amount, right upper extremity splint, per NSG has multiple open areas on back side, appears to be shivering, cooperative, pleasant 2/4 bilateral pedal edema, DJD changes of all joints. **Assessment/plan:** Cellulitis of lower limb: Complete IV antibiotics, monitor temp and WBC, follow-up wound consult as needed Bacterial arthritis: Has been on IV antibiotics, follow-up Rheum consult as needed Arthritis due to other bacteria, unspecified joint Type II diabetes mellitus with other skin ulcer	3126-3128

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		Diabetic assessment will be done. Will monitor for diabetic complications, plan will be to monitor HgbA1c, FSBS as needed, adjust diabetic agents as needed, dietary consult	
02/07/YYYY	Hospital/ Provider Name	**Admission note:** *(Illegible notes)* Mr. Ezekiel Hicks is a 74-year-old African American male admitted to Parkway Health and Rehab center, for skilled nursing and rehab care. Resident diagnosis is as follows, septic arthritis secondary to hypertension, meningitidis, coronary artery disease, dysphagia, epilepsy, hyperglycemia, hypernatremia, acute kidney injury, pain, weakness, osteoarthritis. His release is protestant. Resident is for short-term rehab. His goal is to return to his home after treatment. Resident is co-operative and seems pleasant. He is an alert, and oriented x 3 and full code status. Resident receives calendar posted in his room, daily sheep plan program. Activity staff with support and encourage during his stay at the facility.	3193
02/07/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* 11-7: Admission of previous shift; patient is alert and verbally responsive, no complains of pain or discomfort. Has a double lumen PICC present in the left upper arm, patent and dressing intact. Both extremities remains swollen.	3142
02/07/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* 1930hrs: Upon resumption of care. Patient is alert and responsive. Denies any respiratory distress or discomfort. Left knee stiches intact. Patient has a midline to LUA, patent and intact. Patient received 2g IV Ceftriaxone at 9.00 a.m. today. Patient is receiving IV Ceftriaxone until 02/13. Right upper extremity splint intact. Temp 98.4, PR 95 bpm, BP 100/51, Spo2 95% on room air. Patient changed and repositioned. Safety precautions. Maintained call bell and personal belongings intact.	3142
02/07/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* 2310hrs: Resident is alert and verbally responsive. Vomited x 3 _ particles. **Vitals:** Temp 99.8, PR 104, BP 104/57, Spo2 98%. Tylenol 650mg _. Continue IV Ceftriaxone via left arm _. Right upper extremity splint in place. FSG at 5 p.m. 266 and Glycemia noted. Ordered labs. Scheduled Tylenol 500mg per oral given. Continue to monitor.	3142
02/07/YYYY	Hospital/ Provider Name	**Orders:** *(Illegible notes)* For Dr. Rohan/_. Occupational therapy evaluation. Occupational therapy 5 times a week for 4 weeks, therapeutic exercise, neuromuscular re-education, moderate complexity, therapeutic activities and self-care training.	3097
02/08/YYYY	Hospital/	**Nursing notes:** *(Illegible notes)*	3142-3143

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	Provider Name	Resident is alert and verbally responsive, totally dependent on activities of daily livings and transfers. Continue on skilled therapy physical therapee/occupational therapy for endurance. Continue on IV antibiotics Ceftriaxone for cellulitis, no ill effect. Midline to be replace secondary out IV team was call awaiting to come to be replace and have blood drawn safety free maintained.	
02/08/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* Resident is alert, awake and oriented x 3 with on pain management with effects. No complains of _ discomfort noted. Wound team nurse replace midline on right arm, left arm old midline site redness, no increasing _. He is not on IV antibiotics for septic arthritis. Continue to monitor.	3143
02/08/YYYY	Hospital/ Provider Name	**Orders:** *(Illegible notes)* May insert midline for IV antibiotics to replace old one. Noted by _.	3097
02/09/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* 3-7: Resident is alert and oriented x 3, med compliant, continued on antibiotics, no adverse reaction. Temp 98.0.	3143
02/10/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* 11-7: Patient is alert and verbally responsive. Has a midline present in right arm. Slept throughout the night.	3143
02/10/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* 7-3: Resident is alert and verbally responsive. No complains of voiced this shift. Continue on pain management as needed. Continue on IV Ceftriaxone secondary to cellulitis. No adverse reactions noted. Midline intact, flushed as ordered. Patient was sitting at the bedside for 2 hours. Dressing changed as ordered. Safety maintained, will continue to monitor.	3143
02/10/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* 2200: Alert, able to make needs known, continue IV antibiotics IV for cellulitis, right arm midline patent. IV site with no infiltrate, bleeding infection. No reactions of antibiotics have noted. 5 p.m. _ was 173 with no change. NO complains of pain/discomfort.	3144
02/11/YYYY	Hospital/ Provider Name	**MD visit:** **Encounter reason:** MD admit SNF Follow-up: Type 2 diabetes mellitus Follow-up: Anemia Follow-up: Cellulitis of lower limb Follow-up: Sepsis Seen and examined following BMC hospitalization 01/29/YYYY for septic arthritis and N. Meningitidis bacteremia. He was intubated and, in the ICU,	3123-3125

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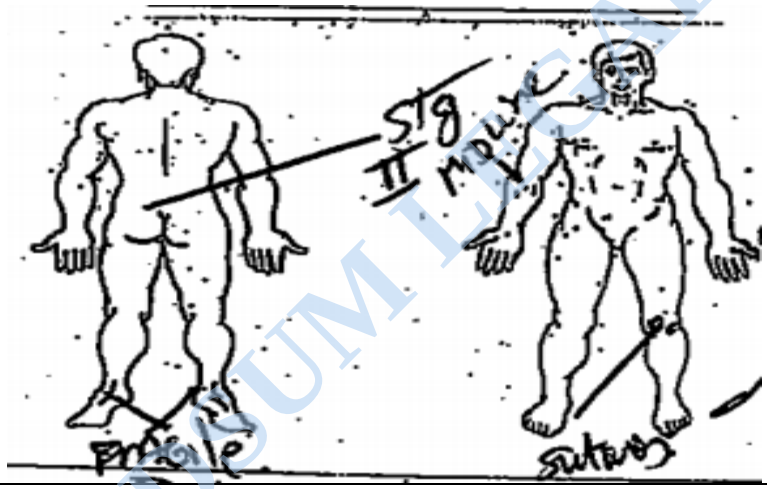
		initially for sepsis. **Physical examination:** Constitutional: Gait not observed. Psychiatric: Trouble driving. ENMT: Partial lower plate. Musculoskeletal: Strength and tone: Abnormal and hypotonicity. Tenderness; sutures over surgical sties on left and right knees and right wrist. Neurologic: Not observed. Back: Appearance: Kyphosis. Status post both cervical and lumbar spine surgery. **Assessment/plan:** Afebrile and fairly stable, labs pending, and new labs ordered Sepsis-Finish IV antibiotics on 02/13/YYYY. ID follow-up at BMC. Sepsis, unspecified organism Cellulitis of lower limb: ID and Ortho follow-up at BMC. Cellulitis of unspecified part of limb Type 2diabetes mellitus-Hemoglobin A1c was.6.4% on admission to BMC. j Type 2 diabetes mellitus with diabetic polyneuropathy Anemia-CBC and anemia panel if still anemic Anemia, unspecified **Patient goals:** Discharge following treatment of Neisseria sepsis and joint infections. **Discussion notes:** Mass PAT utilized.	
02/11/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* 11-7: Patient is alert and verbally responsive. No complains of pain or discomfort. Has a midline present in the right arm. Slept throughout the night.	3144
02/11/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* 1535hrs: Labs reported to NP Dan Buzzard, D.O. Labs CBC for Wednesday requisition made out and order carry on.	3144
02/11/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* 3 p.m.-11 p.m.: Alert and verbally responsive. No signs/symptoms of pain or discomfort. FS 154. Continue Ceftriaxone for cellulitis. IV site patent.	3144

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
02/11/YYYY	Hospital/ Provider Name	**Orders:** *(Illegible notes)* CBC, CMP and CRP May resume _	3097
02/12/YYYY	Hospital/ Provider Name	**NP visit:** Has been on IV antibiotics or sepsis with severe lower extremity cellulitis Tx for hyponatremia, AKI, meningitidis septic arthritis, hyperglycemia, dysphagia, at risk for aspiration and will continue present aspiration precautions, continues to be weak, albumin very low and will obtain dietary consult, albumin may also be related to body edema, and this will be repeated Had mental status changes, unclear etiology Will obtain admit labs **Review of systems:** Musculoskeletal: Stiffness, muscle aches, arthralgias/joint pain, and back pain Additional reports: Feels weak, no new pain, has generalized chronic aches and pains **Physical examination:** Psychiatric: Hesitant speech Lungs: Decreased breath sounds. Musculoskeletal: Limited range of motion He is in PICC line intact, right upper extremity splint, per NSG has multiple open areas on back side. Appears to be shivering, co-operative, pleasant 2/4 bilateral pedal edema, DJD changes of all joints **Assessment/plan:** 1. Cellulitis of lower limb-IV antibiotics, monitor temp and WBC, follow-up wound consult as needed Cellulitis of unspecified part of limb 2. Sepsis-IV antibiotics completing, monitor temp and WBC Sepsis, unspecified organism 3. Dysphagia-Status post consult as needed Dysphagia, unspecified 4. Chronic pain syndrome-Continue present analgesics Chronic pain syndrome	3117-3119
02/12/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* 1535hrs: Resident is alert, responsive, deep tissue injury, _, present on admission, new order for air mattress and wound care consult placed. Resident agrees with plan. Change nurse aware.	3144
02/12/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)*	3144

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		7-3 shift: Patient continues on IV Ceftriaxone. No adverse reactions noted. Last dose 02/13/YYYY. Patient has new order to increase Dilantin to 200mg twice daily and two check Dilantin levels.	
02/12/YYYY	Hospital/ Provider Name	**2200hrs: Nursing notes:** *(Illegible notes)* Resident is alert, awake, oriented x 3, course on IV antibiotics for arthritis and pain managed with effects. Midline patents and flew well. Dressing intact. Both heels skin intact. Deep tissue injury present. Appetite is fair. Continue to monitor.	3145
02/12/YYYY	Hospital/ Provider Name	**Orders:** *(Illegible notes)* 1233hrs: Place air mattress, set to pressure reduction, low air loss setting, check for placement and function evening shift. Obtain wound care consult and treatment with Dr. Falls, M.D. on _ wound care specialist. Telephone order Dr. _ /Buzzard, NP	3093
02/12/YYYY	Hospital/ Provider Name	**Orders:** *(Illegible notes)* CBC on Monday, increase Dilantin 200mg twice daily, Dilantin level in 1-week.	3093
02/13/YYYY	Hospital/ Provider Name	**NP visit:** Complicated medical issues New labs reviewed, platelets >600, unclear why, was not a problem in hospital and no past medical history of this will repeat Has midline for IV antibiotics Was in hospital for sepsis with severe lower extremity cellulitis, this is resolving Treatment for hyponatremia, AKI, meningitidis septic arthritis, hyperglycemia, dysphagia, Had mental status changes, unclear etiology, today he is clearer less vomiting **Review of systems:** Musculoskeletal: Stiffness, muscle aches, arthralgias/joint pain, and back pain. Additionally, reports less nausea. **Physical examination:** Psychiatric: Hesitant speech. Lungs: Decreased breath sounds Musculoskeletal: Limited range of motion Has bilateral upper extremity edema. Right upper extremity splint. Per NSG has multiple open areas on back side. Co-operative, pleasant 2/4 bilateral pedal edema, DJD changes of all joints. **Assessment/plan:** Bacterial arthritis-Has been on IV antibiotics, follow-up Rheum consult as needed Arthritis due to other bacteria, unspecified joint	3111-3113

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Sepsis-IV antibiotics completing, monitor temp and WBC Sepsis, unspecified organism Seizure, continue present seizure meds Unspecified convulsions	
02/13/YYYY	Hospital/ Provider Name	**Weekly skin evaluation report:** *(Illegible notes)* Bruise: No Rash: No Skin tear: No Blanchable: No Non-blanchable: Buttocks Open area: Buttocks 	3067
02/13/YYYY	Hospital/ Provider Name	**Orders:** *(Illegible notes)* 5 p.m., To R. B. Carolyn Dollan, NP. Please wash buttocks area with Darkin's solutions, park with wet gauge 4 x 4 with Darkin, then cover with border gauge twice daily	3092
02/13/YYYY	Hospital/ Provider Name	**Orders:** *(Illegible notes)* Add uric acid level and CBC every Monday.	3093
02/14/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* 11-7: Resident is alert and verbally responsive. Complains of pain, as needed Oxycodone given with effect. Has a midline present in the right arm. Had a quite night.	3145
02/14/YYYY	Hospital/ Provider Name	**NP visit:** **History of present illness:** Complicated medical case, platelets > 600, x 2 unclear why, will obtain weekly CBC and consider hematology consult after discharge.	3114-3116

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Has just completed IV antibiotics. See by wound doctor for coccyx stage III wound and was debrided, will monitor for infection, WBC is ok. Earlier this month was in hospital for sepsis with severe i.e., cellulitis, this is resolving, treatment for hyponatremia, acute kidney injury, meningitidis septic arthritis, hyperglycemia, dysphagia. Had mental status change, unclear etiology, today he is more clear **Review of systems:** Musculoskeletal: Stiffness, muscle aches, arthralgias/joint pain and back pain. **Physical examination:** Lungs: Decreased breath sounds. Musculoskeletal: Limited range of motion. Stage III coccyx ulcer. Right upper extremity splint 2/4 bilateral pedal edema, degenerative joint disease changes of all joints. **Assessment:** Hypoalbuminemia-Protein supplements ordered, dietary consult	
02/14/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* 2100hrs: Resident is alert, awake, oriented x 3. Status post IV antibiotics for sepsis, continue on pain management with effects. FBS 143. Right hand. Left foot edema. Elevated it. Appetite is good. No aspiration noted. Continue to monitor. NP saw patient. Weekly CBC, Vitamin C, _ liquid Protein order noted.	3145
02/14/YYYY	Hospital/ Provider Name	**Orders:** *(Illegible notes* 11-7: 24-hours order checked.	3092
02/15/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* 11-7: Alert, verbally responsive, denied pain/discomfort, status post IV antibiotics therapy for sepsis, left lower extremity weight bearing as tolerated, left knee surgical incision, no signs of infection, 6 a.m. FS 101, left foot edema, elevated. Right arm edema, pillow put under right arm, call bell in reach, continue to monitor.	3145-3146
02/15/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* Left knee: No signs/symptoms of infections.	3137
02/16/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* 3-11 p.m.: Patient is alert & oriented x 3. Denis pain/discomfort. Status post IV antibiotics. Right midline with dressing. Clean/dry/intact and flushed. Right arms, _ with edema. Tolerated meal and meds with no complaints. Safety maintained.	3149

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
02/17/YYYY	Hospital/ Provider Name	**Orders:** *(Illegible notes)* CBC weekly-Begin next Wednesday, Prosource 30cc per oral daily, Zinc 220 per oral daily, Vitamin C 500mg daily	3092
02/17/YYYY	Hospital/ Provider Name	**Orders:** *(Illegible notes)* Speech therapy: Evaluation and treatment. Skilled speech therapy x 5 days per week for 4 weeks in _. Evaluation swallow function. Treatment of swallowing dysfunction/oral function feeding. Physical therapy: Evaluation and treatment. Skilled physical therapy x 5 days per week with 1 weeks in _. Exercises, therapeutic activity, neuromuscular re-education, gait training, manual therapy	3098
02/18/YYYY	Hospital/ Provider Name	**MD visit:** **Encounter/reason:** MD visit Follow-up: Cellulitis of lower limb Follow-up: Disorder of lumbar disc Follow-up: Sepsis Follow-up: Bacterial arthritis **History of present illness:** This is an SNF visit with Mr. Hicks, who is seen for anemia, type 2 diabetes, cellulitis of his lower extremities and sepsis. **Physical examination:** He is alert, cooperative, oriented x 3 and pleasant. He is clearly doing much better and is fully cooperating with his treatment. He is stable. On most recent laboratories his platelet count is stilt elevated at 663,000, white count 8,100, hematocrit 29.7%. On chemistries his albumin is 2.1 so he has severe hypoalbuminemia. His GFR is 85. His last hemoglobin A1c on 02/11/YYYY was 6.8. His MCV was as high as 102.3. **Assessment/plan:** I am going to make certain we have an anemia panel. For diabetes, his hemoglobin A1c is fine. Laboratories will be done on 02/20/YYYY. Sepsis-Finish IV antibiotics on 02/13/YYYY. ID follow-up at BMC. His thrombocytosis is probably part of his sepsis. Sepsis, unspecified organism Bacterial arthritis: Arthritis due to other bacteria, unspecified joint Cellulitis of lower limb-ID and Ortho follow-up at BMC. His cellulitis is resolving. Cellulitis of unspecified part of limb	3120-3122

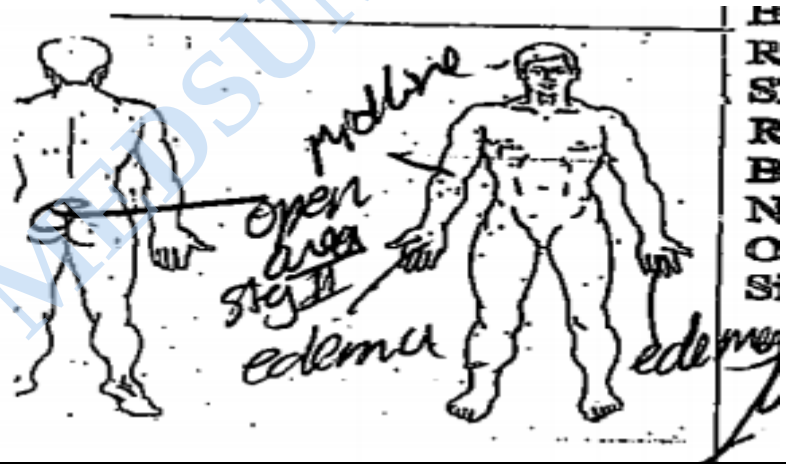
DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Disorder of lumbar disc Unspecified thoracic, thoracolumbar and lumbosacral Intervertebral disc disorder He is receiving very nice care here. We will have to discuss what the goals of care are.	
02/18/YYYY	Hospital/ Provider Name	**Labs:** **Phenytoin:** 2.9 *(Low)*	3172
02/18/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* 3-11 p.m.: Upon resumption of care. Patient is alert and responsive. Complains of pain, 9/10 and spasms at 1700 hrs. Patient received 5mg Oxycodone per oral and 5mg Flexeril with results. Patient Dilantin levels critically low < 2.5. Repeat levels drawn awaiting results. Midline patent and intact. Air mattress on. Patient repositioned frequently. Call bell and personal belongings with reach. Will continue to monitor.	3149
02/18/YYYY	Hospital/ Provider Name	**Orders:** *(Illegible notes)* Ordered labs (CMP, pre-albumin, ferritin, iron, iron binding, iron saturation, folate, B12 and TSH)	3092
02/18/YYYY	Hospital/ Provider Name	**MD visit:** SNF _ Vero Health & Rehab Parkway. Follow-up: Cellulitis of lower limb Follow-up: Disorder of lumbar disc Follow-up: Sepsis Follow-up: Bacterial arthritis This is an SNF visit with Mr. Hicks, who is seen today for sepsis for which he is continuing on IV antibiotics, bacterial arthritis, cellulitis of his lower limbs and type II diabetes mellitus. He continues to do well and appears to be quite comfortably. **Physical examination:** He is clearly doing much better and is fully cooperating with his treatment. Musculoskeletal examination reveals a trace of pre-tibial edema; otherwise his knee joints and the lower extremities are healing nicely. He is stable. On most recent laboratories his platelet count is still elevated at 663000, white count 8100, hematocrit 29.7%. On chemistries his albumin is 2.1. So, he has severe hypoalbuminemia. His GFR is 85. His last hemoglobin A1C on 02/11/YYYY was 6.8. His MCV was as high as 102.3. **Assessment/plan:**	3102-3104

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		I am going to make certain we have an anemia panel. For diabetes, his A1c is fine. Laboratories will be done on 02/20/YYYY. Sepsis: Sepsis, unspecified organism His thrombocytosis is probably part of his sepsis. We will continue his antibiotic therapy. Bacterial arthritis: Arthritis due to other bacteria, unspecified joint We will continue his antibiotic therapy Cellulitis of lower limb: Cellulitis of unspecified part of limb ID and Ortho follow-up at BMC. We will continue his antibiotic therapy, Disorder of lumbar disc: Unspecified thoracic, thoracolumbar and lumbosacral intervertebral disc disorder Rehab and adequate analgesia Type 2 diabetes mellitus Type 2 diabetes mellitus with diabetic polyneuropathy Hemoglobin A1c was 6.4% on admission to BMC. We will be monitoring his finger sticks and his hemoglobin A1c. **Patient goals:** Heal wounds and improve deconditioned status. j **Discussion notes:** He is receiving very nice care here. We will have to discuss what the ii goals of care are. Mass PAT utilized.	
02/19/YYYY	Hospital/ Provider Name	**Dietary/nutrition note:** **Assessment type:** Initial **Pertinent diagnosis:** Sepsis **Pertinent past medical history:** Hyperlipidemia, arthritis, seizures, dysphagia, cellulitis, diabetes mellitus type II, spinal stenosis, heart disease, hypertension Ht 5'10", Wt 246.6 lbs, BMI 35.4 **Significant loss or gain in 30 or 180 days:** Unknown **Diet and texture:** NAS, CCD, puree textures and thin liquids **Supplements and/or fortified foods:** N/A	3138-3139

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Adaptive devices: N/A **Eating ability:** Assistance needed **Food allergies/intolerances:** NKFA/NKFI **Swallowing issues:** No, tolerates current diet textures/consistencies **Enteral or parenteral:** N/A **Skin:** Coccyx stage III pressure injury, left hip stage I pressure injury, right knee scab, left knee with sutures, right heel purple, left heel blister/bruise, right arm site **Edema:** Bilateral lower extremity edema **Dentition:** Broken teeth, partial upper dentures **Labs:** (2/13): Na 136 (Within Normal Limit), K 4 (Within Normal Limit), BUN 10 (Within Normal Limit), Cr 1 (Within Normal Limit), Glucose 111(Within Normal Limit), Ca 8.1 (Corrected Ca 9.62), Alb 2.1(Low), CRP 169.7 (High), (2/18): Uric acid 5.6 (Within Normal Limit), Hgb 9.1(Low) , HCT 29.5 (Low). **Meds:** Lantus, Bowel regimen as needed, Tylenol, ASA, Vit D3, Neurontin, Keppra, Metformin, Dilantin, Pravastatin, Ceftriaxone **Average intakes:** Less than 50% per resident **Estimated needs:** Based on weight of 186 lbs/85kg (adjusted birth weight) Calories kcal: 2550-2975 kcals (30-35 cal/kg) Protein gm: 130 grams (1.5g/kg) Fluid: 2550mls (30ml/kg) **Narrative assessment:** Resident is a 74 year-old-male admitted with septic left knee arthritis. He also had an AKI (Acute Kidney Injury), severe hypovolemia, hyperglycemia, and noted dysphagia PTA (Prior To Arrival). He was on tube feeds, weaned back to per orals during hospital admission. Joe is having difficulty with/dislikes the puree textures, reported that he vomits after eating. He is mostly tolerating mashed potato. He is working with SLP and tried scrambled eggs with SLP today. Joe likes pudding, oatmeal, pancakes, sausage, chicken noodle soup, baked potato. He usually eats a light breakfast. Joe was receptive to Glucerna shakes (Vanilla or Strawberry) thrice daily due to poor intake and increased needs for wound healing. Also recommend the addition of an MVI and Vit C/Zn pending wound healing. **Nutrition diagnosis:** Increased nutrient (Kcal-Protein) needs related to wound healing as evidenced by pressure ulcers documented on coccyx and left hip.	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Inadequate oral intake related to lack of appetite and vomiting as evidenced by resident report of primarily tolerating mashed potatoes, eating less than 50% of meals.	
02/20/YYYY	Hospital/ Provider Name	**Hospital follow-up visit:** He presented with back pain, displacement of lumbar discs and disc degeneration, cervical spondylitis, rotator cuff injury, hypertension, epilepsy, diabetes mellitus type II. Here for hospital discharge appointment, admitted 01/29-02/06/YYYY for septic arthritis secondary to N. Meningitidis. Sent from Vero rehab today for discharge appointment. The patient reports he is improving while in rehab. Continues to have pain in back, hip, knee. He was not given his pm oxycodone prior to clinic appointment today because of time constraints. Is uncomfortable in clinic today, increased pain. Reviewed vitals in clinic today, med records from Vero rehab, and blood sugars results trend from Vero rehab. **Outstanding at discharge:** Sacral decubitus ulcer: Offload affected area, encourage ambulation, optimize nutrition Wound care and wound dressing as needed **Review of systems:** Constitutional: Positive for fatigue. Musculoskeletal: Positive for arthralgias, back pain, joint swelling and myalgias. Neurological: Positive for weakness. **Physical examination:** **Constitutional:** Laying in stretcher, strapped in. Appears in pain. Musculoskeletal: Left knee: He exhibits decreased range of motion and swelling. Tenderness found. Right heel ulcer with eschar. No active drainage/bleeding. Left hip dressing clean/dry/intact. Left knee with sutures in place. Limited range of motion from pain. Joint swelling present. No warmth, no erythema. **Assessment/plan:** Benign essential hypertension Type II diabetes mellitus without complications Acute kidney injury	2615-2648

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Septic arthritis N. Meningitidis. Knee and wrist. S/p Ortho I & D. S/p Ceftriaxone 2g every l2 hours (02/01-02/06) and 2g every 24 hours (02/07-02/13) Continues with joint pains and decreased mobility. Currently in rehab. No signs of active infection on history or exam. Current assessment & plan: Rehab per Vero Follow-up in ID clinic today Follow-up Ortho clinic 03/11/YYYY	
02/20/YYYY	Hospital/ Provider Name	**Infectious disease note:** He is for hospital follow-up. He presents today for hospital follow up after having been seen for Neisseria Meningitidis septic arthritis of the right wrist, and question of disseminated Neisseria after being found down at home. He was treated with a 2-weeks course of Ceftriaxone. Dose was 2g every 12 hours for the first week, and then went to 2g every 24 hours for the second week. He completed this course on 02/13/YYYY. He had a midline in place for this treatment, it remains in place today. Has had improving mobility in right wrist. Still quite weak and stiff in other joints, including left knee. No fevers or chills. He has follow-up coming up with orthopedics. Of note, during hospitalization he was additionally noted to have CPPD crystals in his joints when aspirated. **Review of systems:** Musculoskeletal: Positive for gait problem and joint swelling. Neurological: Positive for weakness. **Physical examination:** Musculoskeletal: Right wrist: He exhibits swelling and effusion. He exhibits normal range of motion and no crepitus. Left knee: He exhibits swelling and effusion. Tenderness found. Preserved passive range of motion in right wrist. Left knee with exquisite tenderness to palpation. Left middle finger PIP with redness. Sutures overlying left knee. **Assessment/plan:** Septic arthritis: N. Meningitidis. Knee and wrist. Status post Ortho I & D. Status post Ceftriaxone 2g every 12 hours (02/01-02/06) and 2g every 24 hours (02/07-02/13). Continues with joint pains and decreased mobility. Currently in rehab. No	2649-2670

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		signs of active infection on history or exam. Completed course for N. Meningitidis, no need for further antibiotic therapy. No need to return to infectious disease clinic. Continue to follow up with orthopedics and primary doctors to work on continued pain and decreased mobility. **Attending attestation note:** Unusual case of patient with septic arthritis due to N meningitides and pseudogout right wrist and left knee. Now status post 2-weeks of IV Ceftriaxone. Midline removed in clinic today No additional antibiotics for ID workup at this time Patient to continue follow-up with Ortho Rest as noted in fellow's note. >50% of this 40 min visit was spent in review of records, discussion with house staff, patient and family members if present.	
02/20/YYYY	Hospital/ Provider Name	**Weekly skin evaluation report:** *(Illegible notes)* Bruise: No Rash: No Blanch able: No Non-blanchable: Buttocks Open area: Buttocks  	3067
02/20/YYYY	Hospital/ Provider Name	**Orders:** *(Illegible notes)* To Dr. Rohren/_ RN. Apply Prevalon heel boots to both feet, while on bed of shift.	3096
02/21/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* **11-7:** Patient is alert and verbally responsive. Pain well managed during this night with scheduled Oxycodone every 4hours. Slept throughout the night.	3149
02/21/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)*	3149

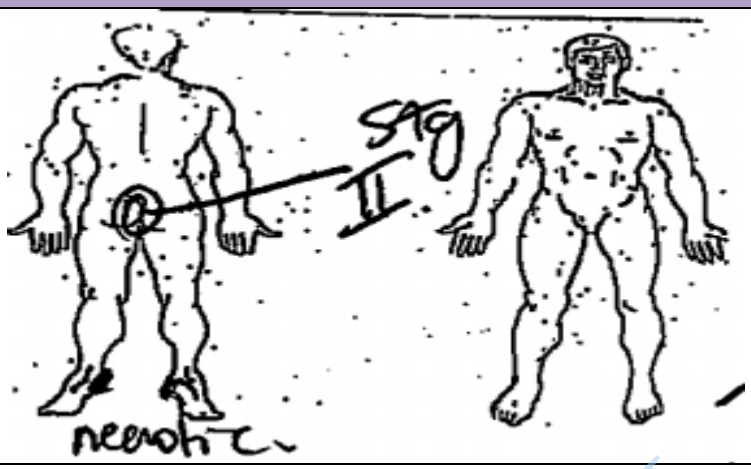
DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Resident is alert and oriented. Status post sepsis/left lower extremity cellulitis. BP 122/70, PR 88, RR 19, Temp 97.5, Spo2 96% on room air.	
02/21/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* Buttocks/coccyx area wound base post-surgical procedure, with yellow drainage tissue and surrounded by granulating tissue.	3137
02/22/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* Buttocks/coccyx area stage II, slough on wound base with no change, no odor, no drainage. Bilateral heel necrotic tissue skin prep as ordered. Patient denied change of dressing, stated he "had" it done today, during 3-11 shift	3137
02/07/YYYY-02/22/YYYY	Hospital/ Provider Name	***Interim occupational therapy summary:*** ***Therapies given:*** *Therapeutic exercise* *Neuromuscular re-education* *Occupational therapy evaluation-Moderate complexity* *Therapeutic activities* *Self-care training* ***He received occupational therapy sessions on the following dates:*** *02/07/YYYY, 02/08/YYYY, 02/11/YYYY, 02/12/YYYY, 02/13/YYYY, 02/14/YYYY, 02/15/YYYY, 02/18/YYYY, 02/19/YYYY, 02/20/YYYY, 02/21/YYYY, 02/22/YYYY* ***Condition of patient as on 02/22/YYYY:*** *Patient observed to have compression sleeve on right hand when therapist arrived. Patient reported tolerating glove for 4-5 hours on this date. Swelling noted to be decreased upon doffing. FM manipulation completed while squeezing green Theraputty with right hand to Increase strength during ADLs. Patient without complains of pain. Patient tolerated sitting at EOB throughout therapy session while maintaining upright posture with supervision. Upper body bathing completed of washing face using left upper extremity with SBA. Patient completed upper body dressing of donning Johnny with contact guard assist-minimal assist.* ****Reviewer's comment:*** *Interim visits have been presented cumulatively to avoid repetition and for ease of reference.*	3160, 3154-3159
02/07/YYYY-02/22/YYYY	Hospital/ Provider Name	**Interim speech therapy summary:** **Therapies given:** Treatment of swallowing dysfunction and/or oral function for feeding Evaluate swallowing function (bedside) **He received speech therapy sessions on the following dates:** *02/07/YYYY, 02/08/YYYY, 02/11/YYYY, 02/12/YYYY, 02/13/YYYY, 02/14/YYYY, 02/15/YYYY, 02/18/YYYY, 02/19/YYYY, 02/20/YYYY, 02/21/YYYY, 02/22/YYYY*	3168-3169, 3165-3167

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Condition of patient as on 02/22/YYYY: Trial of mechanical soft solids consisted for fish, mashed potatoes and spinach. Patient tolerated single small bites at a slow pace. Patient has dentures in place which niece brought in yesterday. Mastication was slow and prolonged yet complete oral clearance. Max cues to facilitate head turn and tuck. Patient consumed 80% of meal without signs/symptoms of aspiration. ***Reviewer's comment:** Interim visits have been presented cumulatively to avoid repetition and for ease of reference.*	
02/23/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* Buttocks/coccyx wound dressing changed, skin prep applied. Tissue yellow, no drainage, no odor noted.	3137
02/07/YYYY-02/23/YYYY	Hospital/ Provider Name	**Interim physical therapy summary:** **Therapies given:** Therapeutic exercise Neuromuscular re-education Gait training Manual therapy Physical therapy evaluation-Moderate complexity Therapeutic activities **He received physical therapy sessions on the following dates:** *02/07/YYYY, 02/08/YYYY, 02/11/YYYY, 02/12/YYYY, 02/13/YYYY, 02/14/YYYY, 02/15/YYYY, 02/18/YYYY, 02/19/YYYY, 02/20/YYYY, 02/21/YYYY, 02/22/YYYY, 02/23/YYYY* **Condition of patient as on 02/23/YYYY:** Patient sleep all afternoon. He is best treated/seen in the morning. This has been conveyed to dept. ***Reviewer's comment:** Interim visits have been presented cumulatively to avoid repetition and for ease of reference.*	3151-3153, 3174-3176
02/24/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* 11-7: Patient is alert and verbally responsive. Continues on scheduled Oxycodone as ordered with good effect. Slept throughout the night. Lungs clear. Positive bowel sounds, skin dry, requires assist of 2 with ADLs and transfers. Appetite poor, consumed on average of 20% dinner, nutrition supplement encourage and tolerated. Continue on scheduled Oxycodone for pain management. Dressing change to buttock per M.D. order. Large amount of serosanguinous, 90% slough, Prevalon boots applied to bilateral foot, fluids is encouraged with meals and will continue to monitor.	3150
02/24/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* 2200hrs: Alert, able to make the needs known. Coccyx, buttock open area with yellowish slough, no active drainage, dressing changed this evening. Continue pain management with effect.	3150
02/25/YYYY	Hospital/	**MD visit:**	3108-3110

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
	Provider Name	Follow-up: Hypoalbuminemia Follow-up: Anemia Follow-up: Chronic pain syndrome Follow-up: Pressure ulcer of lower back This is an SNF visit with Mr. Hicks, who is seen today for rather severe pressure ulcers of the lower back and beginning developing pressure ulcers of his heels. He is also having even worse pain especially in the decubitus of his lower back. He has hypoalbuminemia and anemia. His last laboratory work on 02/18/YYYY revealed his uric acid to be 5.6. His Phenytoin level is still low at less than 2.5. His white blood cell count was 11,400 up a bit from previous. Hgb and HCT 9.1 and 29.5%, MCV 101.7. Platelets had dropped from 663,000 to 452,000. His overall condition unfortunately looks worse. He has been having the Wound Care consultants here see him and they have been doing a fine job debriding and observing his wounds but unfortunately his pain has gotten much worse and he is asking to be hospitalized. **Physical examination:** On examination this morning, he is lying flat complaining bitterly of pain in his lower back. Abdomen is soft and non-tender with normoactive bowel sounds and no palpable masses. On musculoskeletal examination, his legs look good with no edema and skin is being nicely moisturized. His heels reveal breakdown and his lower back has quite a significant deep decubitus and he is in pain. **Assessment/plan:** This man clearly needs aggressive wound care and if it can't be delivered at BMC will refer to our Wound Care Clinic in Needham which offers a multi-modality approach. In the meantime, his pain regimen has been increased considerably. Pressure ulcer of lower back: Pressure ulcer of unspecified part of back, unspecified stage He is asking to go back to Boston Medical Center. We will see if we can get a Wound Care Clinic appointment so far as the pressure ulcers of his lower back and heels. If we cannot either today or tomorrow l am going to have to send him to be looked at by a wound surgeon at the emergency department at Boston Medical Center. He simply is insisting if we cannot get him this appointment. Chronic pain syndrome: In the meantime, I am going to bump his Oxycodone-IR up to 10mg per oral every 4 hours for pain. I am going to start him on Fentanyl patch 12.5mcg, changed every 72 hours for pain. Ultimately, we may be able to reduce his Oxycodone and increase his Fentanyl. He is certainly not opioid nave.	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Hypoalbuminemia: Dietary supplementation. Other disorders of plasma-protein metabolism, not elsewhere classified Anemia-CBC and anemia panel if still anemic. I am going to get CBC, CMP, Magnesium and pre-albumin on 02/27/YYYY if he does not get admitted and his Phenytoin is going to up to 200mg per oral thrice daily. We will check a level in 10-days or so. I will order it depending on if and when he returns back to the facility. **Patient goals:** Improve pain and decubiti care. Wound care clinic care. **Discussion notes:** His prognosis overall is quite guarded. Mass PAT utilized.	
02/25/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* 11-7: Patient is alert and verbally responsive. Remains on the scheduled Oxycodone as ordered with good effort. Slept throughout the night.	3150
02/25/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* 3-11 p.m.: Patient is alert and verbally responsive. Coccyx wound cleaned and re-dressed. Foul odor noted with drainage, wet to dry dressing applied. Patient complains of pain 10/10. Patient has appointment with wound care at 1300 hrs. patient is medicated with Oxycodone. Fentanyl Patch 12mcg, unable to given because it was not brought from pharmacy. Fentanyl 125mcg discontinued. Safety maintained, will continue to monitor.	3150
02/25/YYYY	Hospital/ Provider Name	**Orders:** *(Illegible notes)* To N.P Anne Carr/Ruth Rene, RN. Discontinue Fentanyl 12.5mcg Add Fentanyl 12mcg every 72 hours Noted Ruth Rene.	3095
02/25/YYYY	Hospital/ Provider Name	**Orders:** *(Illegible notes)* Wound clinic appt at BMC today or tomorrow. If not available, please find to BMC ER for surgical evaluation of wounds. Increase Oxycodone IR to 10mg every 4 hours for pain Fentanyl patch 12.5mcg every 72 hours for pain Ordered labs Increase Phenytoin due to 200mg per too thrice daily as needed.	3096
02/26/YYYY	Hospital/ Provider Name	**Nursing notes:** **Diagnosis:** Sepsis, unspecified organism Other hyperlipidemia	3139

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Arthritis due to other bacteria, right wrist Other seizures Dysphagia, oral phase Cellulitis of unspecified part of limb Type 2 diabetes mellitus with other skin ulcer Muscle weakness (generalized) Spinal stenosis, cervical region Type 2 diabetes mellitus without complications Atherosclerotic heart disease of native coronary artery without angina pectoris, Essential (primary) hypertension Resident alert and oriented. Continues on opioid therapy for pain management. Discussed with Dr. Rohrer. MD plans for wound clinic visit on Thursday at 1 p.m. Dr. Fills, MD to evaluate wound and treat tomorrow, resident aware of plan of care. New order for Oxycodone parameters posted. Charge nurse aware.	
02/26/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* 1930hrs: Upon resumption of care. Patient is alert and responsive. Denies any respiratory distress or discomfort. Coccyx wound dressing with four odor and serosanguinous drainage, small amounts. Wound care Dr. to see patient tomorrow (02/27/YYYY). Wound care appt 02/28/YYYY at 1300 hrs. Fentanyl 12mcg patch applied topical to left upper shoulder. Continues on scheduled 10mg Oxycodone with positive effects. No signs/symptoms of glycemic reactions noted.	3146, 3150
02/26/YYYY	Hospital/ Provider Name	**Orders:** *(Illegible notes)* Hold Oxycodone for lethargy.	3094
02/27/YYYY	Hospital/ Provider Name	**Weekly skin evaluation report:** *(Illegible notes)* Bruise: No Rash: No Skin tear: No Blanch able: No Non-blanchable: Buttocks and heels Open area: Buttocks	3067

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
			
02/27/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* Resident is alert, verbally responsive, continue on pain management. Labs reported to NP _, continue on protein source daily. Wound doctor to see him today. Coccyx _ not improvement. Appt scheduled tomorrow. Safety precautions maintained.	3146
02/27/YYYY	Hospital/ Provider Name	**Orders:** *(Illegible notes)* Duragesic patch 12mcg every 72 hours.	3094
02/28/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* Patient is alert and verbally responsive. Pain well managed with scheduled Oxycodone 10mg. Slept throughout the night.	3146
02/28/YYYY	Hospital/ Provider Name	**Nursing notes:** *(Illegible notes)* Resident left at 1245hrs to second re-schedule appt with wound doctor at twice daily, Needham returned at 1430 hrs. Resident didn't make it to appt. On time NP Dan Buzzard gave order to send him to BID Needham ER to evaluation condition of wound and abnormal labs values, questionable infection on the wound, questionable intravenous protein require all unavailable to take him over BID (Beth Israel Deaconess) Needham. MC call called again to him over appropriate hospital.	3146
02/28/YYYY	Hospital/ Provider Name	**NP visit:** SNF _ Vero Health & Rehab Parkway. To go out to wound clinic appointment today, at present ambulance is two hours late and not sure she can go, albumin is extremely low at 1.9 and this is delaying wound healing, has been on per oral protein supplements May need IV/TPN protein WBC 19 and then decreased to 9.3 Will repeat tomorrow Status post new IV antibiotics Has been seen by wound MD here, will monitor to send him to the hospital	3105-3107

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Earlier this month was in hospital for sepsis with severe le cellulitis, this is resolving Treatment for hyponatremia, acute kidney injury, meningitidis septic arthritis, hyperglycemia, dysphagia Had mental status changes, unclear etiology **Review of systems:** Musculoskeletal: Stiffness, muscle aches Arthralgias/joint pain, and back pain. Additionally, reports no new falls, no dizziness, per oral intake is only fair. **Physical examination:** **Psychiatric:** Anxious. Hesitant speech. **Lung:** Decreased breath sounds. **Musculoskeletal:** Limited range of motion. See HPI, stage III coccyx ulcer, no new focal findings, mildly labored breathing pattern. **Assessment/plan:** Hypoalbuminemia-Protein supplements ordered, dietary consult, may need TPN Other disorders of plasma-protein metabolism, not elsewhere classified Type II diabetes mellitus: Diabetic assessment will be done. Will monitor for diabetic complications. Plan will be to monitor A1C, FSBS as needed, adjust diabetic agents as needed, dietary consult Seizure: Continue present seizure meds Unspecified convulsions.	
02/28/YYYY	Hospital/ Provider Name	**Transfer form:** *(Illegible notes)* This notice is to inform you that Vero Pharmacy (Nursing Facility) seeks to transfer you to BID Needham on 02/28/YYYY. Transfer is necessary for the resident's welfare and the resident's needs cannot by met by the facility. Long-term care Ombudsman program: ETHOS Boston LTC, Ombudsman Program.	3130-3132
02/28/YYYY	Hospital/ Provider Name	**Transfer form:** *(Illegible notes)* **Diet:** Needs assistance with feeding: Yes Trouble swallowing: Yes Special consistence (thickened liquids, crush meds, etc.): NAS CCO, Puree texture	3147

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Physical rehabilitation therapy: Physical therapy Occupational therapy Speech therapy **Skin/wound care:** Stage IV with 6 cm depth. **Activities of daily living:** Bathing: Dependent Dressing: Dependent Transfers: Dependent Toileting: Dependent Eating: Dependent **Impairments-musculoskeletal:** Contraction. **Continence:** Date of last bowel movement 02/2x/YYYY. **Additional relevant information:** Resident has critical labs, stage IV coccyx, seen by wound doctor in house with no improvement. Questionable sepsis. Pain 10/10 with no relief.	
02/28/YYYY	Hospital/ Provider Name	**Transfer form:** *(Illegible notes)* **Admitted date:** 02/06/YYYY. **Transfer date:** 02/28/YYYY. **Sent from:** Vero Parkway Galway. **Primary diagnosis for admission:** Type II diabetes mellitus, hypertension, spinal stenosis cervical region **Mode of transfer:** Yes **Course of clinical situation:** Yes **Code status:** Full code **Reason for transfer:** Stage IV with 6m depth, questionable septic, labs abnormal **Relevant diagnosis:** Diabetes mellitus. Other: Hypertension, seizures, herniated lumbar disc **Vitals:** BP 128/70, HR 99 bpm, RR 20, Temp 98.6, Spo2 98%. **Pain level:** 10/10 **Pain location:** Wound/back.	3148

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Most recent pain med: Oxy 10mg. **Risk alerts:** Pressure ulcers, seizures, swallowing precautions, left limited non-weight bearing, swallowing precautions	
02/28/YYYY	Hospital/ Provider Name	**Nurse triage/initial assessment:** **Vitals:** Temp 98.7F (37.1C), PR 96, RR 17, BP 120/59, Spo2 96%. The patient complains of wound/laceration. The patient is here with worsening sacral wound. Status post fall a month ago at home where he was lying for a day and a half. Was taken to Boston Medical Center and admitted for a few days. Sent to skilled nursing facility where he has been for the past month. Facility sent him in for a low albumin level and wound assessment. Patient denies any fevers or chills. **Physical examination:** Unstageable sacral wound with significant foul odor and purulent drainage. No surrounding cellulitis appreciated. Skin: No rash, no petechiae, warm and dry. **Medical decision making:** He presented here with worsening sacral wound since a fall 1-month ago. Staff at skilled nursing facility concerned that patient's albumin was too low and sent him here for that. On arrival patient with unstageable very foul-smelling sacral wound with purulent drainage. No surrounding cellulitis appreciated. Patient denies fevers or chills. Also denies vomiting or diarrhea. Patient is hemodynamically stable. Evaluated by surgery and agree admission for likely debridement, IV antibiotics. Direct patient care supervision and electronic documentation review by Chris Cary, M.D. on 03/01/YYYY at 0003.	47-49
02/28/YYYY	Hospital/ Provider Name	**ER physician addendum:** He complains of wound/laceration. This patient was seen primarily by the NP under my supervision. The patient presenting from rehab for a wound evaluation and concern for sepsis. Paperwork sent with patient reports “critical labs” however, review of labs drawn yesterday shows no acute lab abnormalities, but multiple chronic ones. Recent severe leukocytosis from 6 days ago, now resolved. Exam notable for a severe, malodorous, very large stage 4 sacral decubitus ulcer. Calling rehab facility to obtain additional information. **Re-evaluation:** Rehab reportedly concerned with patient’s low albumin levels. These are likely secondary to poor nutritional intake. Surgery has seen patient after being consulted for likely surgical debridement of wound and will be admitting the patient to their service for operative management. **Clinical impression:** 1. Purulent sacral decubitus ulcer.	50-51

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		2. Malnutrition. 3. Wound infection. **Disposition:** Admitted. **Condition:** Stable.	
02/28/YYYY	Hospital/ Provider Name	**General surgery initial consultation report:** **Reason for consult:** Sacral decubitus. **Requesting physician:** Chris Cary. **Chief complaint:** Gluteal pain at site of decubitus ulcer. **History of present illness:** A 74 year-old-male presented with diabetes mellitus type II, hypertension, and epilepsy who reportedly was down on his living room floor under unclear circumstances for 36-48 hours duration approximately 30 days ago. He reportedly spent 4-days at BMC and was then discharged to a rehab facility. Per rehab notes, he was transferred to their facility with a stage IV sacral decub ulcer. Their notes state the wound has worsened and his pain has increased to 10/10. It is quite foul smelling. His WBC 5-days ago was 18K but yesterday was reportedly within a normal range at his rehab facility. He has terrible nutrition labs (Albumin 1.8 -2, prealbumin 3). HCT recently 24. Currently complains of pain at his bottom but denies fever or chills. No shortness of breath or chest pain. **Vitals:** Temp 98.7, PR 96, RR 17, BP 120/59, Spo2 96%. **Physical examination:** Sacrum: Decubitus ulcer with necrotic tissue to the left of gluteal cleft, 10cm x 10 cm, foul smelling, sensate and tender. **Assessment/plan:** He presented with epilepsy, diabetes mellitus, hypertension and a recent fall with prolonged stay down on a hard floor in supine position that led to sacral decubitus ulcer, presenting with poor nutrition and poor healing of the decubitus ulcer. Admit to Surgery under Dr. Qureshi. Regular diabetic diet, nil per oral and MN in case of OR tomorrow. IVF IV Clindamycin Sliding scale insulin Pain control Follow-up ER labs Nutrition consult Will plan for bedside debridement tomorrow, if fails to tolerate will consider operating room for debridement Discussed with Dr. Qureshi who agrees with plan.	40-44

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
02/28/YYYY	Hospital/ Provider Name	**MRI of pelvis without contrast:** **Indication:** Very large sacral decub evaluation for osteo. **Impression:** Limited exam. 1. Large, deep left sacral decubitus ulcer closely abutting the left sacroiliac joint, without convincing findings of septic arthritis or osteomyelitis. 2. Signal abnormalities about the SI joints, may relate to sacroiliitis, rather than degenerative changes. 3. Extensive asymmetric muscular edema may partially be reactive or relate to infectious/inflammatory myositis. There are foci of gas with architectural distortion within the right gluteus muscle, may relate to recent trauma or site of intramuscular injection, rather than infection from a gas-forming organism, for clinical correlation. **Wet read:** The patient was unable to complete the examination. No postcontrast imaging was performed. Lumbar spine fusion hardware results in susceptibility artifact which degrades the diagnostic quality of the imaging. Large left sacral decubitus ulcer is noted (series 4, image 18). Small effusion in the posterior aspect of the left SI joint just anterior to the ulcer (series 4, image 13). No definite abnormal bone marrow signal to suggest underlying osteomyelitis. Myositis with abscess formation in the right gluteal muscles measuring approximately an 85 x 25 mm in axial diameter (series 4, image 28). Edematous changes also noted in the left gluteus muscles, obturator muscles as well as proximal left quadriceps and hamstring muscles suggesting myositis, in the differential diagnosis consider denervation. Marked presacral edema. Extensive subcutaneous edema. Marrow edema noted in relation to the SI joints bilateral, left more than right (series 4, image 17) which is most likely degenerative/reactive in nature. Degenerative changes noted in the L5-S1 endplates. Full read to follow in the morning.	62-64
03/01/YYYY	Hospital/ Provider Name	**History and physical examination report:** **Reason for consult:** Sacral decub.	37-39

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Chief complaint: Gluteal pain at site of decubitus ulcer. **History of present illness:** He presented with DM type 2, HTN, and epilepsy who reportedly was down on his living room floor under unclear circumstances for 36-48 hours duration approximately 30-days ago. He reportedly spent 4-days at BMC and was then discharged to a rehab facility. Per rehab notes, he was transferred to their facility with a stage IV sacral decub ulcer. Their notes state the wound has worsened and his pain has increased to 10/10. It is quite foul smelling. His WBC 5-days ago was 18K but yesterday was reportedly within a normal range at his rehab facility. He has terrible nutrition labs (Albumin 1.8-2, prealbumin 3). HCT recently 24. Currently complains of pain at his bottom but denies fever or chills. No shortness of breath or chest pain. **Vitals:** Temp 98.7, PR 96, RR 17, BP 120/59, Spo2 96%. **Physical examination:** No acute distress, appears uncomfortable. Alert, awake, oriented x 3. Sacrum: Decubitus ulcer with necrotic tissue to the left of gluteal cleft, 10cm x 10 cm, foul smelling, sensate and tender. **Results** Labs: Labs pending, recent labs from his rehab facility showed a normal WBC but a WBC of 18K 2/21, HCT 24, poor nutrition labs, and good kidney function **Assessment and plan:** A 74 year-old-male with epilepsy, diabetes mellitus 2, HTN, and a recent fall with prolonged stay down on a hard floor in supine position that led to sacral decubitus ulcer, presenting with poor nutrition and poor healing of the decubitus ulcer. Admit to surgery under Dr. Qureshi Regular diabetic diet, nil per oral and MN in case of OR tomorrow IVF IV Clindamycin Sliding scale insulin Pain control Follow-up ER labs Nutrition consult Will plan for debridement tomorrow, and will do operating room for debridement	
03/01/YYYY	Hospital/ Provider Name	**Operative report:** **Pre/post-operative diagnosis:** Grade 4 sacral wound. **Procedure:** Intraoperative debridement of sacral wound.	45-46

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Indication: This is a 74-year-old gentleman who presented to the emergency department yesterday with signs and symptoms concerning for a foul-smelling deep grade 4 sacral wound, and evidence of copious necrotic tissues and material surrounding, with possible infection and osteomyelitis down to the bone. Imaging was arranged. We did discuss with the patient, based on his presentation, is that he would benefit from operative debridement. The risks of the procedure were discussed with him, including bleeding, infection, recurrence, scar and pain. He consented fully. **Description of procedure:** After consent was obtained, the patient was brought to the operating room, placed in the prone position. MAC anesthesia was induced, and he was prepped and draped in the usual sterile fashion. A time-out was conducted. Pre-operatively, he was on clindamycin 600 mg IV. We then proceeded, after a time-out was complete, to identify copious amounts of white scaling necrotic material that was adhered to his sacral wound, which was approximately 15cm x 10cm and approximately 5 cm deep, right down to the sacrum. There were obvious areas of necrotic muscle, as well as the entire defect demonstrated infection and necrosis. We proceeded to excise all obvious sloughed material. Where we could see muscle, we did resect down to healthy tissue as best as we could. We then irrigated and proceeded to pack with Betadine soaked Kerlix. The patient tolerated the procedure well. **Total fluids in:** 400cc of Ringers Lactate. **Estimated blood loss**: Less than 5cc. He was taken to recovery in stable condition.	
03/01/YYYY	Hospital/ Provider Name	**Progress notes:** Admitted to floor, made nil per oral at midnight. Gentle IVF, receiving IV antibiotics. Has IV antibiotics. Has continued 9/10 pain at ulcer site. Has received multiple doses of IV pain medications. **Physical examination**: Left gluteal ulcer in 10 cm x 10 cm and measured at 7 cm deep, + exquisitely tender to palpation, smells foul **Assessment/Plan:** Patient with epilepsy, DM 2, hypertension, and a recent fall with prolonged stay down on a hard floor in supine position that led to sacral decubitus ulcer, presenting with poor nutrition and poor healing of the decubitus ulcer • NPO for OR 03/01 for debridement under MAC • IV Clindamycin • Sliding scale Insulin • Pain control • Nutrition consult	58-61

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		• IV forms of seizure prophylaxis Discussed with and rounded on by Dr. Qureshi who agrees with plan.	
03/01/YYYY	Hospital/ Provider Name	**Pathology report:** **Final diagnosis** Sacral decubitus ulcer; debridement: Fragments of necrotic fibro adipose tissue with acute inflammation. Note: Gram-positive organisms and gram-negative rods are seen on tissue Gram stain. No fungal organisms seen on GMS stain. See concurrent microbiology report.	75
03/01/YYYY	Hospital/ Provider Name	**Nutrition evaluation report:** He was admitted for stage 4 sacral decubitus ulcer. Per ER MD note patient presented to ER with worsening sacral wound; s/p fall a month ago at home where he was lying for a day and a half; patient was taken to BMC and admitted for a few days and sent to skilled nursing facility where he has been for the past month; facility sent him in for a low albumin level and wound assessment; patient is hemodynamically stable; evaluated by surgery and agree admission for likely debridement, IV ABX. Per MD note 2/28 plan for beside debridement 3/1 and if patient fails to tolerate will consider operating room for debridement; made NPO. Patient receiving IVF LR at 75 ml/hr. Per I & Os patient Na 135 L. Per RN note 3/1 plan to hold Lantus for poor nutritional status. Per patient binder in rounding room patient followed pureed, thin liquids diet at rehab facility. Nutrition met with patient for MD consult for poor oral intake at rehab facility and poor wound healing. Upon entering room patient laying down in bed. Pt reports no appetite since yesterday. Reports that he came from rehab facility and was on a pureed diet however unsure if he was on thickened liquids (Patient binder documentation from rehab records patient was on thin liquids). Pt reports that he dislikes the pureed diet and would "throw up anything pureed," except the mashed potatoes stating that for breakfast lunch and dinner would mainly have mashed potatoes with gravy, cranberry juice, coffee and ensure and occasionally eggs and yogurt. Denies any difficulty chewing/swallowing however, reports that at one point did have trouble swallowing, Nutrition asked patient if food was getting stuck in throat and patient pointed to throat and said "no, I just had trouble swallowing;" and patient was unable to elaborate further on swallowing difficulties. Patient reports 20# weight loss due to "not eating anything," in unknown time frame; reports UBW of 247#; patient current weight documented as 233#- 18% weight loss in unknown time frame. Nutrition was unable to perform NFPE as patient was scheduled for debridement of wound; will conduct NFPE upon follow-up. Nutrition spoke with SLP-If patient continues with poor per oral intake on pureed diet recommend SLP consult.	250-257

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Nutrition educated patient on importance of adequate protein and caloric intake in setting of wound. Nutrition offered nutritional supplements of ensure and Juven to promote wound healing upon diet advancement, patient receptive. Nutrition WCTM diet advancement, need for SLP consult, and supplement tolerance/acceptance. **Nutrition diagnosis:** Inadequate energy intake. **Nutrition intervention:** Co-ordinate other care (Encouragement with meals upon diet advancement, weekly weights), feeding assistance, initial brief education (importance of adequate protein and caloric intake for wound healing), medical food supplement (Juven and ensure TID with meals upon diet advancement), Meals & Snacks (Nil per oral for procedure; recommend following rehab texture modifications of pureed and thin liquids upon diet advancement), Vitamin mineral supplement (Na low; monitor and replete as needed) **Nutrition monitoring/evaluation:** Diet advancement, monitor calorie intake, monitor labs, monitor at meal rounds, monitor protein intake, monitor skin integrity, monitor weight, supplement tolerated/acceptance, other (educational needs, monitor need for SLP consult)	
03/01/YYYY	Hospital/ Provider Name	**Initial note:** **Transfer urgency:** Routine. **Reason for transfer:** Surgical subspecialty services. **Brief clinical course:** A 74-year-old male with epilepsy, diabetes, hypertension, and a recent fall with prolonged stay down on a hard floor 4-5 days ago in supine position that is thought to have led to sacral decubitus ulcer, stage 4 presenting with poor nutrition and poor healing of the decubitus ulcer and concern for secondary infection. There is question of seizure precipitating him being on the floor. There is also concern for neglect at his rehab facility. He has eschar on the back of his heels. Surgery feels that he will need Podiatry and Plastic Surgery consult at BIDMC. Albumin is 1.8. Nutrition recommends pureed diet. WBC count is 11K. He received ceftriaxone at his rehab, started on clindamycin at Needham, then broadened to vancomycin, Zosyn and Fluconazole. MRI of pelvis showed extensive soft tissue defects but no osteomyelitis. Creatinine is 1.1. He is on low rate LR. Glucose has been well-controlled, hasn't been given home Lantus at Needham on sliding scale. **Code status:** Full code. **Consulting service required:** ACS, Podiatry, Plastics.	376-377
03/01/YYYY	Hospital/ Provider Name	**Discharge summary:** **Date of admission:** 02/28/YYYY.	30-36, 179-180

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Discharge date: 03/01/YYYY.

History of present illness: This gentleman is 74-year-old and presents with chief complaint of failure to thrive and sacral decubitus ulcer. His history includes a fall approximately 30 days ago that led to him being down for 36-48 hours, followed by 4-5 days at BMC where it was noted he had a sacral decubitus ulcer, and he was then discharged to a rehab facility in West Roxbury where he languished for approximately 30-days. He has a medical history of epilepsy, diabetes mellitus type 2, hypertension, and chronic back pain. He previously had a leukocytosis 7-days prior to presentation to the ER but it was most recently 8K at his rehab. He complains of 10/10 pain at the left superior aspect of gluteus. Foul smelling. Appears soupy and necrotic with gray, non-viable tissue. Also, he has bilateral heel eschar from not being turned at the rehab facility. Nutrition labs are quite terrible. He was admitted to the surgical service, IV antibiotics were administered, and it was planned that he would be debrided, but at time of admission it was unclear whether this would take place in the OR or at the bedside

Vitals:

	02/28 2152	**03/01 0808**	**03/01 1117**	**03/01 1257**	**03/01 1324**	**03/01 1500**
Temp	100.2	98.5	98.5	99.4	99.4	
PR	107	98	98	92	92	88
RR	18	18		16		24
BP	132/62	119/63	119/63	110/53	110/53	116/78
Spo2	96	91	91	95	95	99

	03/01 1503	**03/01 1515**	**03/01 1530**	**03/01 1545**	**03/01 1600**	**03/01 1615**
Temp	99.0					
PR	86	85	85	86	83	83
RR	20	18	15	16	21	17
BP	90/57	125/62	112/75	120/51	110/50	97/49
Spo2	100	100	100	100	100	100

Hospital course and plan:
He was admitted to the floor, given IV Clindamycin, made nil per oral at midnight, and given sliding scale insulin. His pain remained through multiple doses of intravenous pain medication. On 03/01, he was taken to the OR for debridement. Non-viable tissue was removed, and the wound was packed with a betadine soaked Kerlix gauze. Cultures were sent. His antibiotics were broadened to Vancomycin, Zosyn, and Fluconazole after the operating room. His home anti-epileptic prophylaxis was restarted. Home pain regimen was restarted. Due to the multiple medical needs as well as his need for podiatry for his bilateral heel eschar sites and potential for plastic surgery as well as further operative debridement, he was transferred to BIDMC Boston.

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Pelvic MRI showed although it remains diagnostic, the study is limited due to susceptibility artifact from partially visualized lumbar spinal fusion hardware as well as the patient was unable to complete the examination prior to contrast administration. Large, deep left sacral decubitus ulcer closely abutting the left sacroiliac joint where there is a possible small effusion but no definite marrow signal abnormality to suggest underlying osteomyelitis. Edema about the bilateral sacroiliac joints, left greater right, is most likely degenerative or reactive in etiology. Scattered foci of air and discrete STIR signal abnormality within the right gluteus maximus muscle which measures up to 8.5 cm is in keeping with muscular edema which could be infectious or secondary to intramuscular injection. No definite abscess formation, although the study was terminated prior to contrast administration. Extensive muscular edema throughout the bilateral gluteal and proximal left thigh muscles is nonspecific but worrisome for myositis. Marked presacral edema is nonspecific, possibly reactive. **Physical examination:** No acute distress but appears uncomfortable Backside: 10 x 10 x 7cm stage IV sacral decubitus ulcer status post debridement and packing Lower extremity: 1+ edema bilaterally, heel eschar present bilaterally. **Discharge meds list:** Cholecalciferol (vitamin D3) 02/28/19 Gabapentin 02/28/19 Tramadol 02/28/19 Levetiracetam (Keppra) 500mg twice daily 03/01/19 Phenytoin sodium extended [Dilantin Extended] 100mg thrice daily 03/01/19 Vancomycin Zosyn Fluconazole Tylenol Dilaudid Flexeril Gabapentin ***Related records:** Nurses notes.*	
03/02/YYYY	Hospital/ Provider Name	**Hospital admission note:** **Chief complaint:** Decubitus ulcer **History of present illness:** He presented with epilepsy, DM, HTN, and a recent fall with prolonged stay down on a hard floor 4-5 days ago in supine position that is thought to have led to sacral decubitus ulcer, stage 4. Until early February patient reports living independently at home. Regarding initial fall: Had an episode in early Feb in which he slid off couch onto floor and was down x48 hours with complicated BMC admission, though	378-382

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		details unclear. Regarding coccygeal ulcer: Up until above admission was ambulatory with a rolling walker living at home with some support from other family members who checked in. Over past month, at rehab facility where ulcer developed, prompting return transfer to Needham. Regarding seizure disorder: On Keppra/Dilantin. Denies seizure activity over the past 7 years, including during initial event **At Needham, records reviewed as follows:** Last vitals: 99.0, 84, 110/54, 16, 100% on 2 liter (Not on O2 as of arrival to BIDMC) On 02/28 sent to Needham. He received ceftriaxone at his rehab, started on clindamycin at Needham, then broadened to Vancomycin, Zosyn and Fluconazole. MRI of pelvis showed extensive soft tissue defects but no osteomyelitis. Creatinine is 1.1. On exam ulcer found to be foul-smelling, presenting with poor nutrition and poor healing of the decubitus ulcer and concern for secondary infection. Was taken for extensive debridement 3/1. There is also concern for neglect at his rehab facility. He has eschar on the back of his heels. Surgery feeling that patient will need Podiatry and Plastic Surgery consult at BIDMC. Prior labs from NH are included notable for albumin 1.8, Ca 7.5, prealbumin <3, Hgb 7.3. Albumin is 1.8. Nutrition recommends pureed diet. WBC count is 11K. Glucose has been well-controlled, hasn't been given home Lantus at Needham on sliding scale. On my encounter, feeling well except for some pain on buttocks at site of debridement. Denies fever, chills, confusion. **Social history:** Per patient was prior to the past month's admission to BMC living independently at apartment near Blue Hill Ave ambulating with walker with a cousin who helped him as a caretaker; now no ambulation for 1 month; denies tobacco, illicit. Has several supportive family members. **Physical examination:** Vitals: Afebrile and vital signs significant for normotensive, stable O2 on RA; some wasting of upper extremity musculature noted General: Alert and in no apparent distress; mentating appropriately and giving history GI: Abdomen soft, non-distended, non-tender to palpation. Bowel sounds present. GU: No suprapubic fullness or tenderness to palpation Skin: No rashes noted. Eschars on bilateral heels without drainage, erythema; large coccygeal ulcer s/p debridement, now about 8 x 13cm probing down to 5cm at deepest point. Stage 4. Mild surround erythema without cellulitis appearance; no draining collections noted. **Summary/assessment:**	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Acute/active problems: Sacral decubitus ulcer, stage IV: Difficult to assess the nature of infection on my exam given the extensive debridement. Notably the OSH documents muscular edema c/f myositis. Unclear why on Fluconazole per the notes except to say that this was started based on surgeon's evaluation in operating room, and whether there was some intraoperative detail that raised this concern; will continue this coverage but will need documentation/pathology from Needham in the coming days Wound nurse Vanc/Zosyn; will continue Fluc initially though needs some further information in the morning Pain: Per oral Dilaudid initially; will titrate up if needed and will give IV prior to procedures Surgical consult in morning-Likely plastics will need to be involved but question whether ACS may need to evaluate for further debridement first Will need to follow-up with Needham to see if micro pending from intra-op specimen Leukocytosis: Likely I/S/O the above wound. No other signs/symptoms infection, antibiotics per above FTT: Malnutrition: Alb and Prealbumin both severely reduced. Poor care reported in his rehab where he has been the past month Nutrition Social work as below Macrocytic anemia: Hgb 7.3 at outside lab with MCV 102 Will check Folate/B12 Social: C/F neglect at NH given decub and being found down Social work consult Will discuss with family DM: Hold home Metformin Home Lantus is 15unitts but per sign out has only been on HISS at Needham with good control; will continue HISS only CV: On Aspirin for prevention (Denies any history of heart attacks, stents); will hold post-op; restart as indicated Heel eschar: No signs/symptoms infection; monitor; boots in place **Chronic/stable problems:** Hypertension: Not on meds Seizure disorder: Continue Keppra, Dilantin Lumbar stenosis: Gabapentin for neuropathic pain	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		General/supportive care: Nutrition/Hydration: Ok for diabetic/cardiac diet; received puree at outside facility, may reassess as appropriate Functional status: prior to past month of hospitalization/rehab was ambulatory with rolling walker but now has been immobilized since Bowel function: Bowel regular, added given his pain needs lines/tubes/drains: PIV Precautions: none VTE prophylaxis: DVT Consulting services: Wound; will need plastics consult in am PCP: Needs to be clarified; patient states his care historically at BMC Contacts/HCP/surrogate and communication: Cousin Frankie Brown Code status/advance care planning: Full, patient clarifies at bedside) **Disposition:** Inpatient status Anticipate discharge to: SNF (on bed hold at rehab, though may not be appropriate to return) Anticipated discharge date: Pending. **Addendum:** The patient was evaluated, and I agree with the findings, assessment and plan in Dr Caldwell's 03/02/YYYY note. Will add that patient complains of 3-8 pain, worse with dressing change. Is upset about care at Vero (poor RN, PT coverage, food not palatable). He does not want surgery for his wound, stating it should "heal on its own." No BM in several days, does not want pureed diet On exam, he is well appearing, very pleasant, grimacing with wound change. He has diffuse mild edema, clear lungs, obese and soft abdomen. Wound is 9 cm height, 10 cm wide, and 3 cm deep with bone clearly visible. No foul smell or pus. Alb: 2.0 **Assessment/plan:** 1. Large sacral wound, bone visible. Will consult ID given osteomyelitis, follow-up Needham cultures; was transferred for plastics evaluation but per plastics, ACS "must manage wound" before they will see the patient, patient must be nutritionally optimized. Discussed with patient that he should meet with surgical staff before deciding against surgery. 2. Pain control: Oxycodone 5mg per oral twice daily before dressing change, and every 6 hours as needed. 3. Malnutrition: Nutrition consult 4. Constipation: Bowel regimen increased. In regard to antibiotics, awaiting deep tissue culture from Needham, discussed with AST, will continue Ceftriaxone and Flagyl for now, wound appears	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		clean.	
03/02/YYYY	Hospital/ Provider Name	**Acute care surgery consult/history and physical examination report:** **Chief complaint:** Sacral decubitus ulcer. **HPI:** The patient presented with history of seizure disorder, DM, HTN, chronic back pain, and left foot drop iso spinal surgery many years ago, who reportedly fell 30 days ago was on the floor for 36-48 hours was brought to the BMC where it was reportedly noted that he has a sacral decubitus ulcer, was at the BMC for a few days and then went to a rehab at West Roxbury, where he spent a month before reportedly falling down again and brought in to the BID-N where he was started on antibiotics and the wound was debrided on 03/01/19 (Dr Qureshi). The patient was then transferred to BIDMC because he also had bilateral heel eschars that needed podiatry as well as PRS consult. PRS was consulted earlier per the hospitalist report and requested ACS involvement for further debridement before a flap could be considered. An MRI of the pelvis at Needham did not show evidence of osteomyelitis. He also reports a left knee effusion/infection that was drained earlier, however, no report of that was found in the records from the OSH available to us. He is currently in no acute distress, afebrile, non-septic appearing, breathing on RA, and lying in the bed. complains of pain on the site of the decubitus ulcer. From a functional standpoint, he reportedly lived alone until a month ago when he fell, and the above sequence of events transpired. **Physical examination:** Back: A large sacral decubitus ulcer with clean edges noted 15 x 12cm in size approximately, area is sensitive, there is an area of deep tunneling with fibrin tissue on the floor on the 3 O' clock position. The anus is far away from the decubitus ulcer with no clear involvement. **Assessment/plan:** He presented with diabetes, hypertension, seizure, spinal stenosis, fall 1 month ago and sacral decub s/p debridement on 03/01/19 at BID-N, here for PRS evaluation, who recommended more debridement, currently afebrile and not septic, no sign of active infection on exam at this time, the wound would benefit from some additional debridement and it would be done in the OR given his level of sensitivity. We will add him on for OR on our next available time and notify the primary team of the timing. Discussed with Dr. Douglas who helped formulate and agrees with this plan. **Addendum:** Patient was seen and examined, agree with above. Large stage IV sacral decubitus ulcer s/p debridement at OSH but will need additional debridement to clean tissue. Plastics following for possibility of flap	386-388

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		closure when appropriate. Afebrile, non-toxic. Will arrange OR for debridement, likely early next week.	
03/03/YYYY	Hospital/ Provider Name	**Nutrition initial note:** The patient reports good appetite but decreased per oral at rehab as he did not like pureed foods offered. Is unsure of why he was ordered for a pureed diet, denies history of swallowing problems. Reports eating majority of breakfast this AM. UBW approx 245lbs, several months ago. **Physical examination:** Skin: Stage 4 pressure injury to coccyx (8 x 13cm probing down to 5cm at deepest point) **Assessment:** At risk for malnutrition. **Nutrition problem:** Increased nutrient needs (specify) related to increased demand for the nutrient as evidenced by stage 4 pressure injury **Interventions/recommendations:** Continue with diet as ordered, encourage POs as tolerated Sugar free carnation instant breakfast with 3 packets of Beneprotein TID (Each = 265kcal, 31g protein) Add 500 mg Vitamin C twice daily and 220mg Zinc Sulfate x 14-days. Check Zinc, Copper, and CRP after repletion Add multivitamin with minerals daily Monitor sodium/hydration status Monitor skin integrity Obtain zeroed bed scale weight, trend 3x/week Following	396-397
03/04/YYYY	Hospital/ Provider Name	**Physical therapy contact note:** Rehabilitation services-Inpatient physical therapy Consult received and appreciated. Chart reviewed and case discussed with team in patient progression rounds. Put admitted from rehab with large coccyx ulcer, plan for debridement in OR today. Acute physical therapy will follow up to perform initial evaluation when medically ready. Please page on call physical therapy with questions or concerns.	405
03/04/YYYY	Hospital/ Provider Name	**Wound consultation report:** He presented with epilepsy, diabetes mellitus, HTN, and a recent fall with prolonged stay down on a hard floor 4-5 days ago in supine position that is thought to have led to sacral pressure injury, stage 4.	406-408

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Until early February patient reports living independently at home. **Regarding initial fall:** Had an episode in early Feb in which he slid off couch onto floor and was down x48 hours with complicated BMC admission, though details unclear. **Reason for consult:** Bilateral heel pressure injuries & stage 4. Sacral coccygeal pressure injury -> all present on admission. Today I will only evaluate, bilateral heel pressure injuries patient is going to or with ACS for surgical sharp debridement. **Assessment:** The patient evaluated on 12 Reisman along with his Nurse, Molly. Patient is receptive to my visit. Will only evaluated bilateral heels this am as plan is for patient to got to OR for surgical sharp debridement of known stage 4 pressure injury sacral-coccygeal area. **Wound assessment:** **Location: Right heel** Type/etiology/stage: Unstageable pressure injury Size: 4 x 4cm, no depth Wound bed: 100% attached black stable eschar Wound edges: Attached Exudate: None Odor: None Peri-wound tissue: Intact Wound pain: Denies No signs/symptoms of infection **Location: Left lateral heel** Type/etiology/stage: Unstageable pressure injury Size: 6cm (Length) x 4 cm (Width), no depth Wound bed: 100% black stable eschar Wound edges: Attached Exudate: None Odor: None Peri-wound tissue: Intact Wound pain: Denies No signs/symptoms of infection **Left lateral malleolus:** Dry crusted scab approx. 0.5 cm (L) x 1 cm (W), no depth. No signs and symptoms of infection. Peri wound skin dry & intact. No drainage or odor noted. **Topical therapy/recommendations:** 1. Commercial wound cleanser or normal saline to cleanse wounds. Pat the tissue dry with dry gauze 2. Bilateral heels:	

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		Apply Soothe and code Moisture Barrier to intact skin only on bilateral left lower extremity & feet Apply Betadine to black stable dry eschar. Cover with Gauze, then wrap with Kerlix. Change daily. Aggressive offloading of heels at all times Consider Podiatry Consult for bilat heels, May be done as outpatient as long as wounds are not infected. 3. ROHO cushion -> obtain by PT Limit sitting time to 1 hour 4. Stage 4 sacral coccygeal pressure injury, Per ACS -> to go for surgical sharp debridement today. Is patient in agreement with the wound care plan-Yes Support nutrition and hydration. Notify M.D. or wound care nurse if wound or skin deteriorates. Wound care will follow Wound care will not follow. Contact ACS for sacral coccygeal pressure injury	
03/04/YYYY	Hospital/ Provider Name	**Plastic and reconstructive surgery consultation report:** **Chief complaint:** Sacral wound. **History of present illness:** He presented with PMH of seizure disorder (last seizure 7 years ago), DM, HTN, chronic back pain, and left foot drop iso spinal surgery many years ago, who presents to BIDMC with reportedly large sacral wound. He states the wound started when he fell 30 days ago was on the floor for 36-48 hours as he was not able to get up and get to a phone. He was brought to the BMC where it was reportedly noted that he has a sacral decubitus ulcer. He was treated with side to side positioning and offloading. He was at the BMC for a few days and then went to a rehab at West Roxbury where he worked with physical therapy a few times but did not get back to his normal ambulation status of ambulating with a walker. He fell again at rehab and was brought into the BID-N where his sacral wound was discovered, and he was started on antibiotics and the wound was debrided on 03/01/YYYY (Dr. Qureshi). The patient was then transferred to BIDMC for further care. The patient states that he was previously ambulatory with a walker prior to the fall at the end of January. He was extremely active, walking around town, going to the local Dunkin Donuts. **Physical examination:** Resp: Breathing comfortably on room air. No wheezing. Ext: Warm, well, perfused. Left knee incisions healing appropriately. Wound: Large 15 x 12 sacral wound extending down to sacrum. **Assessment/plan:** He presented with PMH of seizure disorder (last seizure 7 years ago), DM, HTN, chronic back pain, and left foot drop iso spinal surgery	409-411

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		many years ago, who presents to BIDMC with large stage IV sacral wound after being found down for 48-hours after a fall 1-month ago. He was previously ambulatory with a walker but has not ambulated since his fall, recently his nutrition has been lacking, but is slowly improving. He is currently on an air overlay bed and being positioned side to side. His wound is being cared for by the ACS team with vac therapy and serial debridement (Last one today 03/04/YYYY). Agree with air overlay or clinitron bed. Agree with every 2 side to side positioning. Agree with nutrition consult; would recommend checking HbA1c and nutrition labs (Pre-albumin, albumin, etc.)	
03/04/YYYY	Hospital/ Provider Name	**Nursing notes:** **Chief concerns:** OR debridement. **Assessment:** Denies pain upon initial assessment. Requesting as needed per oral Oxycodone 2.5mg prior to OR debridement, as patient will be under conscious sedation; given to patient just prior to transport. Denies shortness of breath. Maintained on aspiration precautions. Endorsing 7/10 pain to sacrum status post debridement. Nil per oral for debridement. Resume diet status post debridement. FSBG within normal limit. Lift out of bed. Patient is on air mattress. **Plan:** Monitor/Manage comfort, VS IV antibiotics Wound care twice daily Fall precautions, lift out of bed, turn and reposition every 2 hours Aspiration precautions, FSBG ACHS Work towards discharge	415
03/04/YYYY	Hospital/ Provider Name	**Operative report:** **Pre/post-operative diagnosis:** Sacral pressure ulcer. **Name of operation:** Debridement of sacral pressure ulcer. **Indications:** This man has had a pressure ulcer that we measured today at 14.5 x 9 cm. It was thought that he needed to have some debridement. **Procedure in detail:** He was taken to the operating room and placed in a supine position and given a general anesthetic. He was carefully transferred to the operating table and we noted that his both arms were rather stiff, and we therefore placed him by his side and placed the arm boards down and not taking the chance to put them up near his head. At this point, we prepped and draped using Betadine and after appropriate timeout, we initiated excision of some necrotic material that we could see mostly in the right side of the patient's wound and somewhat inferiorly and altogether some 25cm2 were debrided of some necrotic subcutaneous tissue and skin. This was excisionally and sharply down. The hemostasis was achieved with electrocautery. We did	561-563

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		send some for microbiology and the wound was dressed in moist Kerlix. The patient tolerated the procedure well. Estimated blood loss was 30ml. Dry dressing was placed on top and the procedure was terminated.	
03/05/YYYY	Hospital/ Provider Name	**Infectious disease initial consultation report:** **Reason for consult:** History of seizure disorder, admitted with deep sacral/coccygeal ulcer to BI-N, had a debridement there last week, and transferred here, and had a repeat debridement by ACS on 03/04/YYYY; intraoperative cultures obtained, remains on Ceftriaxone/Flagyl, please guide on antibiotic management. **History of present illness:** He presented with epilepsy, diabetes mellitus type 2, and lumbar stenosis who was living independently at home until early last month. Fell off his couch, was down 48 hours, had complicated hospitalization @ BMC (details unclear). Discharged to rehab facility, subsequently developed decubitus ulcer over the course of the next month when staff members of the rehab became sick and he was unable to perform physical therapy, transferred to BID-Needham for wound evaluation on 2/28. Upon admission received clindamycin IV, then went to the OR on 3/l for debridement (Intra-op cultures sent). Post-op started on Vancomycin, Zosyn, and Fluconazole. Transferred to BIDMC given c/f ongoing debridement needs and potential plastic surgery. Has been receiving Ceftriaxone & Metronidazole here. Went to OR with ACS yesterday 3/4, preliminary tissue cultures since returned with polymicrobial gram-stain. On interview today, patient confirms the above history. Able to clarify that part of his hospitalization at BMC included what sounds like arthroscopic procedure of the left knee for “infection that started from dragging my knee on the carpet when I fell and then spreading to the rest of my body.” Primary symptom right now is mild sacral soreness, but this is not severe. Bilateral heels, which also have pressure wounds to them, not currently painful. Appetite good. Denies fevers or chills. **Physical examination:** General: Obese elderly black male in no acute distress, seated in chair. Pulmonary: Bibasilar crackles, Abd: Non-distended, normoactive bowel sounds, soft, non-tender to palpation MSK: No gross deformities, unable to visualize feet under waffle boots and Kerlix Skin: Hypopigmentation to bilateral hand knuckles Neuro: Gait not-assessed, sensation grossly intact. **Assessment/plan:** He presented with epilepsy, DM type 2, and lumbar stenosis	418-422

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		who recently suffered a fall resulting in hospitalization @ BMC and subsequent rehab stay complicated by development of stage 4 sacral ulcer clinically consistent with osteo given clear bone visualized on admission (as well as bilateral heel pressure injuries). Clinically he has undergone debridement of the sacral wound (unfortunately not visualized as patient was about to work with PT upon my exam) and doesn't appear to have any evidence of systemic infection. Now have some preliminary culture data to guide therapy (Enterococcus and PSA). Without knowing the full details of his recent hospital course, parts of story are concerning, particular such rapid development of pressure wounds. OP note comments on bilateral upper extremity rigidity, so we are curious whether some neurologic/neuromuscular/cognitive process may have contributed to patient's immobility at the rehab facility. Degree of anemia also surprising for simple anemia of chronic disease/inflammation that may be present from osteo. **Recommendations:** Obtain OSH records from BMC admission (Discharge summary, culture results, operative note for any ortho procedures) Follow-up cultures from BIDMC and BID-Needham Check CRP and ESR to establish baseline to trend post-op Stop Ceftriaxone IV and Metronidazole IV Start Piperacillin/Tazobactam (Zosyn) 4.5g IV every 8 hours for coverage of E. Faecalis, PSA, and anaerobes Anticipate prolonged antibiotics (at least 6 weeks), but finals agents and duration TBD based on micro data and clinical course Agree with Nutrition consult to aid in wound healing Recommend neurology consult for consideration of neurologic/degenerative processes that may have pre-disposed to such immobility at rehab. **Addendum:** I have seen and examined the patient on, and I have reviewed the note of Dr. Kopelman dated 03/05/19. I have nothing to add or modify on the report of the history as noted, or the examination as recorded in the note above with the exception of any modification or additions as noted below. We have discussed both the history and the examination and the plan for further workup and care and I agree with all points of care for this patient with the exception of any modification or additions as noted below.	
03/05/YYYY	Hospital/ Provider Name	**Physical therapy initial evaluation report:** **Clinical impression/prognosis:** He presents to BIDMC with large stage IV sacral wound after being found down for 48 hours after a fall 1-month ago now status post sacral ulcer debridement presents to physical therapy evaluation functioning well below baseline limited by impairments in body structure and function including strength, endurance, balance, and ROM. The patient's basic mobility short form AM-PAC T-scale score less than 42.9 at the first visit is consistent with a requirement of rehabilitation at discharge. Patient will most benefit from discharge to inpatient rehabilitation to maximize functional potential. Patient has good potential for eventual return to	426-431

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		home/return to baseline level of mobility given: High level of function at baseline Good social supports Expected improvement in activity tolerance with medical Management of wound care Patient motivation **Treatment plan:** Progress functional mobility including bed mobility, transfers, gait and stairs as tolerated. Balance training Patient/caregiver education regarding fall risk **Frequency/duration:** 2-3x/week for 2-weeks **Recommendations for nursing:** Patient is at high risk for deconditioning please encourage frequent mobility and maximize independence in ADLs. Lift for all mobility including transfers to chair 3x/day. Limit sitting time to one hour on air cushion given patient's inability to effectively reposition in chair. Please use chair alarm when out of bed. Normalize sleep-wake cycle to decrease risk of delirium.	
03/05/YYYY	Hospital/ Provider Name	**ACS brief follow up/sign off:** **Summary:** A 74 year-old-male history of diabetes mellitus, hypertension, seizure, spinal stenosis, fall 1 month ago and sacral decub s/p debridement (BS and Qureshi at Needham, 03/01), here for PRS flap with status post debridement. **Interval change:** Patient seen and evaluated today with dressing taken down. No further debridement needed. **Recommendations:** No further indication for ACS involvement and debridement at this time. Would defer further wound care to plastics. Also recommend local wound care and agree with every 2 hours bed changes ACS will sign off at this time. Please call with further questions or concerns.	435
03/05/YYYY	Hospital/ Provider Name	**Telephone conversation:** Spoke with Dr. Prakash-Hospitalist at BIDMC. 4-days in BIDMC End of Jan fell at home, down on ground Left knee infection Small decub over coccyx Discontinue to Vero Rehab Not moved for a month Decub expanded Needham for debridement	2688-2705

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		BIDMC-Will need 2 more debridement Albumin low (2), macrocytic, Hgb 7, B12 normal Gave her information from previous to being found down and information from that admission.	
03/06/YYYY	Hospital/ Provider Name	**Wound care communication:** Sacral stage 4 Pressure injury serial debridement's completed by ACS team, they have signed off to Plastic surgery for flap closure. Wound care will defer to Plastics for topical therapy till OR. Wound care will continue to follow patient for bilateral heels pressure injuries. Patient will be-reevaluated next week for her heels.	436
03/06/YYYY	Hospital/ Provider Name	**Occupational therapy initial evaluation report:** **Clinical impression/prognosis:** He presenting to occupational therapy evaluation during hospitalization for stage IV decubitus sacral ulcer. Patient presents below functional baselines demonstrating impairments as detailed above. During today's evaluation patient requires assist with all ADLs and functional mobility grossly limited by weakness, activity tolerance, functional balance, and impaired strength in lower extremity. Patient's activity limitations in functional mobility and self-care contribute to difficulty participating in meaningful occupations and fulfilling societal roles of independent self and community dwelling individual. Patient AM-PAC T-scale score of <39.4 for daily activity supports recommendation for discharge to rehab following acute hospital stay. Therefore, once medically stable, recommend patient d/c to interdisciplinary rehab to maximize functional cognitive gains and optimize safety. Anticipate patient will tolerate and benefit from >/= 3 hours of therapy each day. Positive prognostic factors include patient's PLOF, good social support, and patient motivation. Acute occupational therapy will continue to follow while in house to progress goals as outlined below. **Treatment plan:** ADL training functional mobility training balance training **Frequency/duration:** 1-2 x/week for 1-week.	437-442
03/06/YYYY	Hospital/ Provider Name	**Podiatric surgery consultation report:** **Chief complaint:** Bilateral heel ulcers. **History of present illness:** He presented with epilepsy, DM, HTN, and a recent fall with prolonged stay down on a hard floor 4-5 days ago in supine position that is thought to have led to sacral decubitus ulcer, stage 4. Until early February patient reports living independently at home. Regarding initial	445-447

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		fall, had an episode in early Feb in which he slid off couch onto floor and was down x48 hours with complicated BMC admission, though details unclear. Podiatric Surgery was consulted for bilateral heel wounds that have been present since last month when he was supine for an extended period of time. Patient denies much pain to bilateral heel wounds. Denies any other pedal complaints. **Physical examination:** Lower extremity exam: DP/PT pulses non-palpable secondary to edema. CFT <3 secondary to digits bilateral. Gross sensation is diminished. Bilateral heels with stable eschar and hemorrhagic bullae formation present with no deep probing, no drainage, no surrounding erythema, no proximal streaking, no malodor present. Minimally tenderness to palpation surrounding the heel wounds. Drop foot noted to the left foot. Strength +5/5 to all muscle groups crossing the ankle joint on right lower extremity. **Assessment/plan:** He presented with diabetes mellitus, hypertension and epilepsy with recent fall here with severe coccygeal decubitus wound and bilateral heel wounds. Wounds to bilateral heels are stable at this time with dry eschar and hemorrhagic bullae formation. Patient would benefit from adequate offloading to bilateral heels in the form of waffle boots. There are no local signs of infection and thus, no surgical intervention is indicated at this time. For further analysis, bilateral foot X-rays will be beneficial to determine if there are any deeper bony changes, although this would be unlikely at this point. Bilateral heel wounds were dressed with ABD pads, Kerlix and Ace wraps. Dry dressing to bilateral heel Waffle boots bilateral Follow-up bilateral foot X-rays No surgical intervention indicated Patient was discussed with on-call attending, Dr. Dinh, who is in agreement with the treatment plan.	
03/07/YYYY	Hospital/ Provider Name	**Occupational therapy progress notes:** **Assessment:** During today's session continues to present below baseline for all ADLs. Patient requires assist with LB ADLs grossly limited by weakness and fatigue. Patient also requires assist with fine motor tasks in the setting of impaired strength and ROM in bilateral wrist and digits. Patient educated on ROM exercises for bilateral wrist and digits and demonstrates good understanding. Continue to recommend rehab to maximize functional independence. Continue plan of care.	452-454
03/07/YYYY	Hospital/ Provider Name	**Podiatric surgery final/sign off note:** **Assessment/plan:** He presented with diabetes, hypertension, and epilepsy with recent fall here with severe coccygeal decubitus wound and bilateral heel wounds. Wounds to bilateral heels are stable at this time with dry eschar and hemorrhagic bullae formation. Patient would benefit from adequate offloading	457

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		to bilateral heels in the form of waffle boots. There are no local signs of infection and thus, no surgical intervention is indicated at this time. Bilateral heel wounds were dressed with ABD pads, Kerlix and Ace wraps. Podiatric Surgery will sign off at this time as there is no indication for surgical intervention. Dry dressing to bilateral heel Waffle boots bilateral Follow-up bilateral foot X-rays No surgical intervention indicated Podiatric surgery to sign off	
03/08/YYYY	Hospital/ Provider Name	**Labs:** **Collected date:** 03/02/YYYY. **Wound:** **Gram stain:** Many Polyps Rare squamous epithelial cells Few red blood cells Many mixed bacterial flora **Culture:** **Organism 1:** Enterococcus Faecalis Rare growth **Organism 2:** Pseudomonas Aeruginosa Rare growth	68-72
03/08/YYYY	Hospital/ Provider Name	**Physical therapy progress notes:** **Assessment/clinical impression:** He presents to BIDMC with large stage IV sacral wound after being found down for 48 hours after a fall 1 month ago now s/p sacral ulcer debridement. Patient is motivated for therapy, remains limited by severe deconditioning and pain from sacral wound. Patient will benefit from discharge to STR when medically stable, acute physical therapy to continue to follow. Patient is at high risk for deconditioning please encourage frequent mobility and maximize independence in ADLs. Lift for all mobility including transfers to chair 3 x/day. Limit sitting time to one hour on air cushion given patient's inability to effectively reposition in chair. Normalize sleep-wake cycle to decrease risk of delirium.	472-474
03/09/YYYY	Hospital/ Provider Name	**X-ray of chest:** **Indication:** Chest port. Line placement. **Findings:** Distal tip of the right PICC line overlies the distal SVC. Anterior cervical spine fusion plate and screws overlies the lower cervical spine.	583

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		Costophrenic angles are sharp. The lungs are clear. No pneumothorax. The heart is mildly enlarged. **Impression:** Distal tip of right PICC line overlies the distal SVC.	
03/10/YYYY	Hospital/ Provider Name	**Sacral tissue culture:** **Collected date:** 03/04/YYYY. **Gram stain:** 1+ Polymorphonuclear Leukocytes 3+ Gram positive cocci in pairs and singly. 3+ Gram positive rods 1+ Gram negative rods **Organisms:** Pseudomonas Aeruginosa Citrobacter Freundii Complex Enterococcus Species. Mixed bacterial flora: Due to mixed bacterial types 0=33 an abbreviated workup is performed; all organisms will be identified and reported but only select isolates will have sensitivities performed. Pseudomonas Aeruginosa: Moderate growth. Citrobacter Freundii complex: Sparse growth. Cefepime Minimal Inhibitory Concentration: <=2.0mcg/l. Cefepime test result performed by Micro scan. Corynebacterium Species (Diphtheroids): Moderate growth Enterococcus Species: Sparse Growth.	365-366
03/02/YYYY-03/12/YYYY	Hospital/ Provider Name	***Cumulative progress notes:*** *The patient was admitted on 03/02/YYYY with management of stage IV sacral wound and bilateral heel eschars. Plastic reconstructive surgery and wound care consulted on 03/04/YYYY. He was given overlay bed. Sacral wound was 15 x 12 cm extending down to sacrum. He underwent debridement of sacral pressure ulcer. On 03/05/YYYY, Infectious disease consulted for antibiotic management. Ceftriaxone was stopped and placed on Metronidazole IV, Zosyn IV for coverage of E. Faecalis, PSA and anaerobes. Physical therapy evaluated him on 03/05/YYYY and recommended therapeutic treatment for 2-3 times a week for 2 weeks. Occupational therapy evaluated on 03/06/YYYY who recommended therapy 1-2 times for a week. Podiatric surgery consulted for bilateral heel ulcers. Dry dressing applied to bilateral heel; he was placed on Waffle boot. Surgical intervention was not indicated. Plastic surgery placed wound vac on 03/08 and replaced prior to discharge, he will need an appointment set up to see plastics in clinic in 1-2 weeks, at which point further debridement or reconstruction will be considered. Oxycodone 2.5mg as needed given for breakthrough pain or prior to wound care. Advised to continue antibiotics for 6-weeks for deep tissue/bone infection in back.*	

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03/12/YYYY	Hospital/ Provider Name	**Discharge summary:** **Admission date:** 03/02/YYYY. **Discharge date:** 03/12/YYYY. **Chief complaint:** Expedited workup of sacral ulcer Major surgical or invasive procedure: Debridement Wound vac placement **History of present illness:** He presented epilepsy, diabetes mellitus, hypertension, and a recent fall with prolonged stay down on a hard floor 4-5 days ago in supine position that is thought to have led to sacral decubitus ulcer, stage 4. Until early February patient reports living independently at home. **Regarding initial fall:** Had an episode in early Feb in which he slid off couch onto floor and was down x 48 hours with complicated BMC admission, though details unclear. **Regarding coccygeal ulcer:** Up until above admission was ambulatory with a rolling walker living at home with some support from other family members who checked in. Over past month, at rehab facility where ulcer developed, prompting return transfer to Needham. **Regarding seizure disorder:** On Keppra/Dilantin. Denies seizure activity over the past 7 years, including during initial event **At Needham, records reviewed as follows:** **Last vitals:** Temp 99.0, PR 84, BP 110/54, RR 16, Spo2 100% on 2 liter (not on O2 as of arrival to BIDMC). On 2/28 sent to Needham. He received ceftriaxone at his rehab, started on Clindamycin at Needham, then broadened to Vancomycin, Zosyn and Fluconazole. MRI of pelvis showed extensive soft tissue defects but no osteomyelitis. Creatinine is 1.1. On exam ulcer found to be foul-smelling, presenting with poor nutrition and poor healing of the decubitus ulcer and concern for secondary infection. Was taken for extensive debridement 03/01. There is also concern for neglect at his rehab facility. He has eschar on the back of his heels. Surgery feeling that patient will need Podiatry and Plastic Surgery consult at BIDMC. Prior labs from NH are included notable for albumin 1.8, Ca 7.5, prealbumin <3, Hgb 7.3. Albumin is 1.8. Nutrition recommends pureed diet. WBC count is 11K. Glucose has been well-	564-574

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		controlled, hasn't been given home Lantus at Needham on sliding scale. **Social history:** Per patient was prior to the past month's admission to BMC living independently at apartment near Blue Hill Ave ambulating with walker with a cousin who helped him as a caretaker; now no ambulation for 1 month; denies tobacco, illicit. Has several supportive family members. **Physical examination:** Vitals: Afebrile and vital signs significant for normotensive, stable O2 on room air; some wasting of upper extremity musculature noted. General: Alert and in no apparent distress; mentating appropriately and giving history. Abdomen: Soft, non-distended, non-tender to palpation. Bowel sounds present. GU: No suprapubic fullness or tenderness to palpation. MSK: Neck supple, moves all extremities, strength grossly full and symmetric bilaterally in all limbs. Skin: Eschars on bilateral heels without drainage, erythema; large coccygeal ulcer status post debridement, now about 8 x 13cm probing down to 5cm at deepest point. Stage 4. Mild surround erythema without cellulitis appearance; no drainage collections noted. Neuro: Alert, oriented, face symmetric, gaze conjugate with EOMI, speech fluent, moves all limbs, sensation to light touch grossly intact throughout. **Discharge physical exam:** GI: Abdomen soft, non-distended, non-tender to palpation. GU: No suprapubic tenderness Skin: Did not take down bilateral LE dressings today; wound vac from sacral wound intact and draining pinkish colored material Extremities: WWP mild bilateral lower extremity edema, mild right upper extremity edema (improving), bilateral lower extremity wounds Neuro: Alert, conversing appropriately, face symmetric, gaze conjugate with EOMI, speech fluent; bilateral lower extremity strength improving, grossly symmetric, right lower extremity strength improving but still slightly less than left lower extremity. **Psych:** Pleasant, appropriate affect; expresses gratitude for care. **Brief hospital course:** He presented with epilepsy, DM, HTN, chronic left foot drop, transferred from Needham after debridement of large	

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		sacral/coccygeal ulcer for surgical evaluation. Sacral decubitus ulcer, stage IV Suspected polymicrobial osteomyelitis (Pseudomonas, Citrobacter, Enterococcus) The patient presented with severe sacral ulcer, felt to be related to insufficient repositioning while at very rehab. He underwent debridement prior to transfer to Boston and a repeat debridement by surgery on 03/04. Due to presumed osteo and polymicrobial cultures he was started on Zosyn for osteomyelitis course per ID. Patient is to follow with OPAT after he leaves the hospital. Plastic surgery placed wound vac on 3/8 and replaced prior to discharge, he will need an appointment set up to see plastics in clinic in 1-2 weeks, at which point further debridement or reconstruction will be considered. Oxycodone 2.5mg as needed given for breakthrough pain or prior to wound care. **Plastic surgery recommendations:** Air overlay or clinitron bed. Every 2 side to side positioning. Continue wound vac Please call plastic surgery clinic for follow-up (see number below) **FTT:** **Malnutrition:** **Bilateral leg weakness:** Poor care reported in his rehab where he has been the past month with patient completely bedbound leading to resultant weakness. Given that he had decubitus ulcer and heel ulcers on presentation to BMC 1/28 admit, his decline is not entirely new; he has a caretaker (Frankie, also HCP) but declined having the team talk to her. Hospital team attempted to contact PCP and obtain additional records from BMC but without success. Pt tolerated regular diet, started on MVI, Zn, Vitamin C per nutrition. For weakness, will need outpatient neurology follow up if leg weakness does not improve with rehab (although at this time it appears to be improving). TSH borderline elevated, so would repeat in follow-up **Macrocytic anemia with widened RDW:** Now stable in low 7 range. Suspect anemia to be multifactorial, although labs not suggestive of B12 or significant reticulocytosis. Stable during admission **Diabetes mellitus:** Well controlled on sliding scale alone during admission. At discharge would hold off on Lantus, restart Metformin, and use sliding scale as needed for hyperglycemia to promote good wound healing. **CV:** On Aspirin for primary prevention (Denies any history heart attacks, stents); held initially and later restarted **Heel wounds with eschar:** No evidence of infection, seen by podiatry who	

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		recommended dry dressings waffle boots for offloading. **Chronic/stable problems:** Seizure disorder: Continued Keppra, Dilantin Lumbar stenosis: Continued Gabapentin for neuropathic pain OPAT antimicrobial regimen and projected duration: Agent & dose: Piperacillin/Tazobactam (Zosyn) 4.5g IV every 8 hours Start date: 03/04/YYYY (2nd and final debridement of word at the time of writing) Projected end date: 04/14/YYYY (tentative plan for 6 weeks) **Lab monitoring recommendations:** For lab work to be drawn after discharge, a specific standing order for outpatient lab work is required to be placed in the discharge worksheet. Zosyn: Weekly: CBC with differential, BUN, Cr, ESR, CRP. **Follow-up appointments:** The ID clinic will schedule follow-up and contact the patient or discharge facility. All questions regarding outpatient parenteral antibiotics after discharge should be directed to the Infectious Disease RNs or to the on-call ID fellow when the clinic is closed. **Discharge disposition:** Extended care. **Facility:** Wingate at Needham. **Discharge diagnosis:** Sacral decubitus ulcer Osteomyelitis Weakness Heel wound Anemia Diabetes **Discharge condition:** Mental status: Clear and coherent. Level of consciousness: Alert and interactive. Activity status: Out of bed with assistance to chair or wheelchair. **Discharge instructions:** You were admitted to the hospital because you developed a large pressure ulcer on your back from lying in bed. The surgical team debrided and cleaned the wound and plastic surgery placed a wound vacuum dressing to help with healing. They will likely need to perform additional debridement and ultimately hope to perform a reconstructive surgery. We also placed a PICC line and started you on Zosyn, an antibiotic you should take for 6-weeks for your deep tissue/bone infection in your back. **Follow-up instructions:**	

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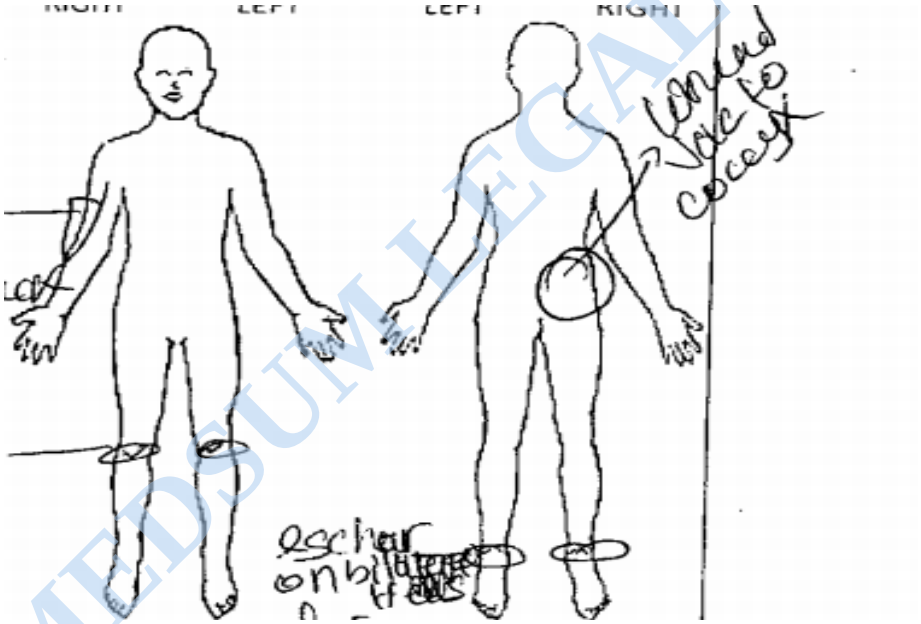
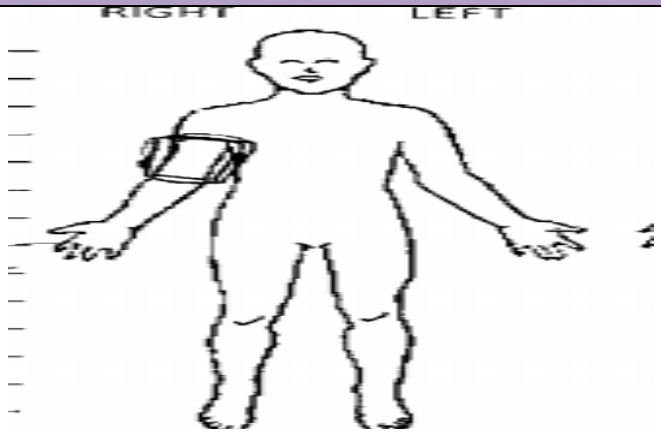
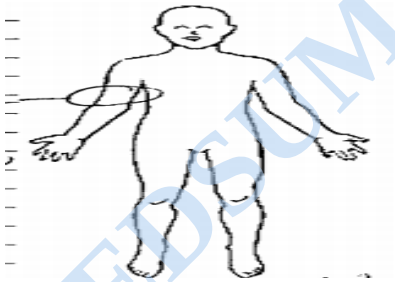
		Please call to set up an appointment with Dr. Johanna Riesel in plastic surgery clinic 1-2 weeks after discharge. You will also need follow-up scheduled with your primary care doctor, podiatry, and with the infectious disease outpatient antibiotic (OPAT) team. Michael Medow, M.D.-Primary care. Location: BMC primary care. Please discuss with the staff at the facility a follow-up appointment with your PCP when you are ready for discharge. We are working on a follow up appointment for your hospitalization in Plastic Surgery. The office will contact you at home with an appointment.	
03/13/YYYY	Hospital/ Provider Name	**Weekly skin evaluation report:** *(Illegible notes)*  Head: Negative. Chest: Negative. Arms: Picc line. Back: Wound vac on lower back. Legs: Old scabs.	3781

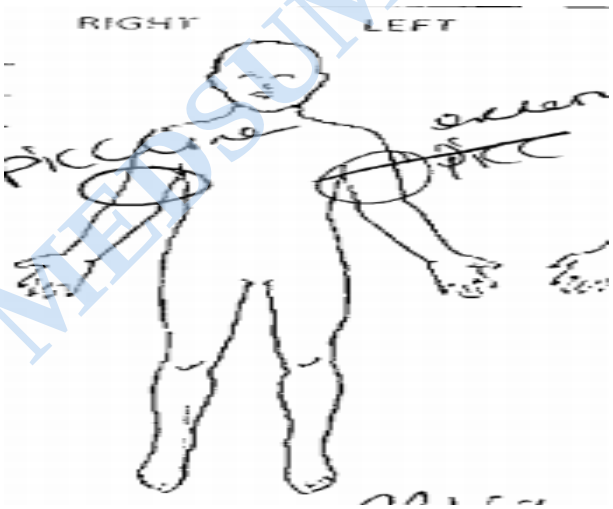
DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		 Head: Clean/dry/intact Chest: Clean/dry/intact Arms: PICC line Back: Clean/dry/intact Buttock/coccyx: Wound vac, stage IV Legs: Clean/dry/intact Feet: Clean/dry/intact	
03/18/YYYY	Hospital/ Provider Name	**Weekly skin evaluation report:** *(Illegible notes)*  Head: Clean/dry/intact Chest: Clean/dry/intact Arms: PICC right arm, simple lower Buttock/coccyx: Wound vac on coccyx Legs: Clean/dry/intact Feet: Clean/dry/intact	3782
03/19/YYYY	Hospital/ Provider Name	**X-ray of left knee:** **Results:** The knee joint is in alignment, but there is narrowing of the joint space due to modest degenerative changes. There is modest degenerative spurring involving tibial spine and femoral condyles. No fracture or dislocation is seen. No joint effusion is seen. There is osteopenia. **Conclusion:** Modest osteoarthritis of the left knee.	3719
03/25/YYYY	Hospital/ Provider Name	**Plastic surgery chief resident clinic note:** Mr. Hicks is a lovely 74-year-old male with PMH of seizure disorder (last	513-514

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		seizure 7 years ago), DM, HTN, chronic back pain, and L foot drop s/p spinal surgery many years ago, who was previously admitted to BIDMC for significant stage IV sacral wound after being found down for 48 hours after a fall approximately 1-1/2 months ago. He was previously ambulatory with a walker but has not ambulated since his fall. He was initially treated at BMC after his fall, but it was not until he was transferred to the BI that the sacral ulcer was debrided. As a result, he became extremely deconditioned during his initial hospitalization. However, after adequate debridement, a wound VAC was placed at the plastic and reconstructive surgery services suggestions, and the patient was sent to rehab. He presents today feeling quite well. He reports he is regaining significant strength and mobility in both his lower and upper extremities since being in rehab. He is participating in rehab twice a day. He is eating a healthy well-balanced diet, and he reports his blood sugars have been well controlled in the low 100s. At this point he is able to do limited walks with a walker and to start doing some of his own transfers from a chair. He reports that the wound VAC is being changed 3 times a week. He has no complaints. He denies fevers chills or feeling unwell. He has no modifying factors for the symptoms. **Physical examination:** Gait: Arrives in wheelchair. Extremities warm and well-perfused. Focused exam of the sacral area reveals a large stage IV sacral decubitus ulcer, approximately 10 x 7 cm in size and 5-6 cm in depth. It tunnels slightly under the right gluteal skin flaps. However, the wound base is covered with healthy pink granulation tissue. There are no signs of infection. There is no exposed bone. There is adequate scar free local gluteal tissue that could be used for advancement flaps. **Assessment and plan:** He presented with a history of type 2 diabetes, seizure disorder, hypertension, left foot drop in the setting of spinal surgery many years ago who developed a stage IV sacral pressure wound after a fall in which she could not get up for 48 hours. Patient is currently in rehab and regaining strength and doing extremely well. The sacral wound is contracted since the last time I saw him in the hospital however it is still quite large. I would like him to continue his work at rehab for regaining strength and balance as well as maintaining a carbohydrate consistent and well-balanced diet. Such sacral wounds can confer considerable protein losses. 1 would like him to continue wound VAC changes 3 times weekly in the hopes that that will help to shrink down the wound. Given that the wound is quite clean and is a large avenue for protein loss I would like to get this closed soon however I think it would be the better part of valor to allow it to contract even more while he continues to regain his strength and balance. After such a reconstructive surgery he would not be able to sit for approximately 6 weeks. He would still be able to lie flat and stand, so I want him to be quite comfortable with walking and transitions and transfers before we engage in this procedure. Patient expresses understanding and all of his questions were answered. Greater than 50% of this appointment were spent on counseling and education. We will plan to see Mr. Hicks back in 2 weeks for another wound	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		check and hopefully be able to book him for surgical closure shortly thereafter.	
03/27/YYYY	Hospital/ Provider Name	**Podiatry visit:** **Podiatric diagnosis:** Atherosclerosis of the extremities, onychomycosis Type II diabetes mellitus with peripheral circulation disorders **Treatment:** Anti-fungal treatment contra-indicated Reduced in length & thickness 2mm Method of reduction: Manual	3730
03/29/YYYY	Hospital/ Provider Name	**ID Follow-up for parenteral antimicrobial therapy:** **Chief complaint**: Sacral osteomyelitis status post debridement (polymicrobial) *History reviewed.* He underwent debridement of sacrum with ACS on 03/04. Cultures from both hospitals with polymicrobial growth (PSA, E. faecalis). Narrowed to Zosyn while awaiting planned flap procedure with Plastics (date TBD). Patient clinically doing well, no systemic symptoms/signs of infection. Since last seen by ID, patient was discharged 03/12 to Wingate at Needham on Zosyn IV. Since then, patient saw Plastics in clinic 03/25, sacral wound described as follows: "Large stage IV sacral decubitus ulcer, approximately 10 x 7 cm in size and 5-6 cm in depth. It tunnels slightly under the right gluteal skin flaps. However, the wound base is covered with healthy pink granulation tissue. There are no signs of infection. There is no exposed bone. There is adequate scar free local gluteal tissue that could be used for advancement flaps. Today, patient reports doing well at rehab. "Night and day - winter and summer" compared to prior experience at difference center. Working with PT, walking with walker multiple times daily. Upper extremity strength improving. Chronic foot drop persists but otherwise leg strength improving. Right heel still with pressure ulcer wound, non-draining/bleeding, mildly painful with ambulation. Bowel movements l-2x/day, loose, no associated nausea/vomiting, abdominal pain, or fever. No difficulties with right upper extremity PICC, receiving Zosyn IV 3x/day. Weight down from -248 to 227 lbs since arrival at rehab. Following up with Surgery in the coming weeks. Still with ultimate goal of returning home to his apartment where he lived independently prior to his fall. **Medications**: Zosyn 4.5 IV every 8 hours **Physical examination:** Vitals: BP 122/69, HR 90 bpm, O_2 saturation 100%, T 97.7 General: Seated in wheelchair with wound vac in lap Lungs: Slight inspiratory crackles at right base Musculoskeletal: 1+ right lower extremity peripheral edema, right heel with 2	515-520

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		cm circular eschar with surrounding flaking skin **Assessment/Plan:** Patient with epilepsy, DM2 and lumbar stenosis who recently suffered a fall resulting in hospitalization at BMC and subsequent rehab stay complicated by development of stage 4 sacral ulcer clinically c/w osteo given clear bone visualized on admission. Initially debrided @ BID-Needham on 03/01, subsequently transferred to BIDMC and underwent debridement of sacrum with ACS on 03/04. Cultures from OR at BID-Needham with E. Faecalis, PSA, and Bacteroides fragilis. Cultures from OR at BIDMC with Enterococcus Sp, PSA, Citrobacter Freundii, and Corynebacterium Sp. (Diphtheroids). Currently at rehab receiving Zosyn IV while awaiting definitive closure of large sacral wound with Plastics (date TBD). Appears to be doing quite well clinically. Low c/f worsening infection, though inflammatory markers remain elevated. Zosyn should be treating all organisms isolated in culture. Agree with Plastics that definitive closure would provide best long-term outcome. Prolonging antibiotics beyond typical 6-week course for osteomyelitis (which was mostly clinical diagnosis based on wound probing to bone, as opposed to pathologic given OR samples from BID-Needham) likely of limited benefit. • Continue Zosyn 4.5 g IV every 8 hours with tentative plans to complete 6-week course on 04/14/YYYY • Follow-up in 2 weeks prior to completion of therapy • Sacral wound care per Plastics • Follow-up with Plastics regarding OR for wound closure surgery Note: Should continue to explore potentially organic causes of weakness aside from old lumbar stenosis and deconditioning resulting in immobility at rehab. Patient's strength markedly improved (particularly BUE), though slightly unstable (Pataxic) on standing in clinic. Will consider formal evaluation by Neurology moving forward based on c/f degenerative neurologic condition, cerebellar lesion, paraneoplastic syndrome, etc.	
04/08/YYYY	Hospital/ Provider Name	**Plastic surgery progress notes:** **Diagnosis**: Sacral pressure wound Patient previously admitted to BIDMC for significant stage IV sacral wound after being found down for 48 hours after a fall approximately 2 months ago. He was initially treated at BMC after his fall, but it was not until he was transferred to the BI that the sacral ulcer was debrided. As a result, he became extremely deconditioned during his initial hospitalization and it was not until recently at rehab that was able to start walking again with a walker (baseline). The wound has been managed (after debridement with ACS) with 3 times weekly vac changes while at rehab. He presents today feeling quite well. He reports he is regaining significant strength and mobility in both his lower and upper extremities since being in rehab. He is participating in rehab twice a day. He is eating a healthy well-balanced diet, and he reports his blood sugars	523-524

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		have been well controlled in the low 80s-100s. He reports he is losing weight. He feels he may not need to be at rehab much longer. He has no complaints other than a stable right heel eschar that has not improved since his original fall 2 months ago. There is no drainage or erythema. He denies fevers chills or feeling unwell. He has no modifying factors for his symptoms. He is on Zosyn until April 14 per ID. **Physical examination**: Breathing comfortable on room air, speech is fluent. Gait: Arrives in wheelchair but is able to stand with support of exam table for exam. Extremities warm and well-perfused, with mild, symmetric edema. Focused exam of the sacral area reveals a large stage IV sacral decubitus ulcer, approximately 7x6 cm in size and 4-5 cm in depth. It is smaller than last time. It tunnels slightly under the right gluteal skin flap. However, the wound base is covered with healthy pink granulation tissue. There are no signs of infection. There is no exposed bone. There is adequate scar free local gluteal tissue that could be used for advancement flaps or a rotational flap. Of note, there are 3 parallel and vertical scars on the low central back just superior to the wound that are from a previous spinal surgery. The right heel has a 3x3 cm flat eschar on the posterior, non-weight bearing surface of the heel. there is no drainage, odor, or surrounding erythema. **Assessment/plan:** Patient with a history of type 2 diabetes, seizure disorder, hypertension, left foot drop in the setting of spinal surgery many years ago who developed a stage IV sacral pressure wound after a fall in which she could not get up for 48 hours. Patient is currently in rehab and regaining strength and doing extremely well. The sacral wound is contracted since the last time I saw him in the however it is still quite large and would benefit from debridement and closure. Given that the wound is quite clean and is a large avenue for protein loss I would like to get this closed in the near future. We could also address his right heel eschar at the same time with debridement and possible vac vs integra vs skin graft. After such a reconstructive surgery he would not be able to sit for approximately 6 weeks. He would still be able to lie flat and stand, so I want him to be quite comfortable with walking and transitions and transfers before we engage in this procedure. He seems to be at this point. Patient expresses understanding and all of his questions were answered. We will plan to see Mr. Hicks back in 2 weeks for another wound check and hopefully be able to book him for surgical closure shortly thereafter.	
04/12/YYYY	Hospital/ Provider Name	**OPAT follow-up for sacral osteomyelitis:** Last seen in clinic, patient continues to do well. Like he is continuing to get stronger, steadier on his feet. Denies fever/chills, abdominal pain, nausea, vomiting, and diarrhea. Seen in plastic surgery clinic recently, would feel to be progressing nicely. No concerns regarding the use of PICC for administration of antibiotics. **Physical examination:**	525-530

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		General: Seated in wheelchair with wound vac on back of seat Musculoskeletal: 1+ right lower extremity peripheral edema Skin: Sacrum with wound vac in place, slightly smaller than it was previously, edges without erythema or tenderness to palpation **Assessment/Plan:** Appears to be doing quite well clinically. Low c/f worsening Infection, though inflammatory markers remain elevated. Zosyn should be treating all organisms isolated in culture. Agree with Plastics that definitive closure would provide best long-term outcome. Prolonging antibiotics beyond typical 6-week course for osteomyelitis (which was mostly clinical diagnosis based on wound probing to bone, as opposed to pathologic given OR samples from BID-Needham) likely of limited benefit. Would like to extend therapy with PO fluoroquinolone (good bone penetration) while awaiting definitive closure surgery. • OK to stop Zosyn 4.5 g IV every 8 hours on 04/14/YYYY to complete 6-week course • Start Ciprofloxacin 500 mg PO twice a day after stopping Zosyn IV (continue indefinitely until instructed otherwise by ID) • Follow-up with Plastics regarding OR for wound closure surgery • Follow-up in 1 month	
04/15/YYYY	Hospital/ Provider Name	**Weekly skin evaluation report:**  Head: Clean/dry/intact Chest: Clean/dry/intact Arms: Clean/dry/intact. PICC. Buttocks/coccyx: Wound vac stge IV ulcer. Legs: Clean/dry/intact Feet: Deep tissue injury with heels	3770
04/30/YYYY	Hospital/ Provider Name	**Operative report:** **Pre/post-operative diagnosis:** Stage IV sacral pressure ulcer and stage III	575-576

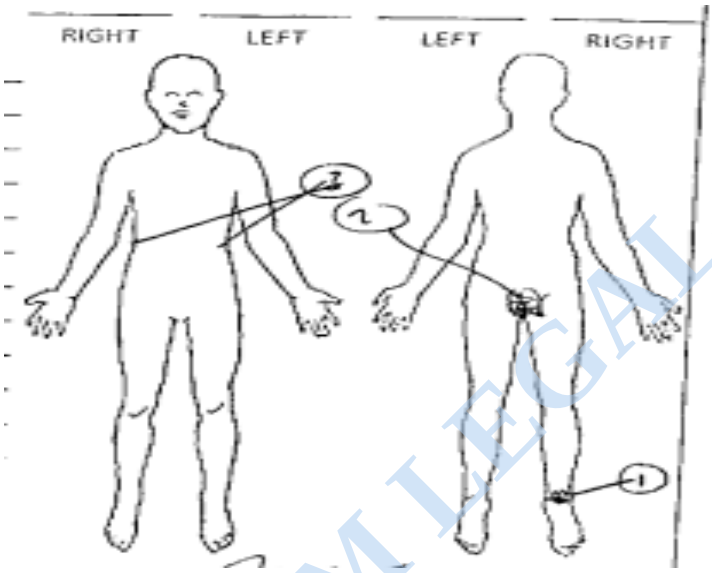
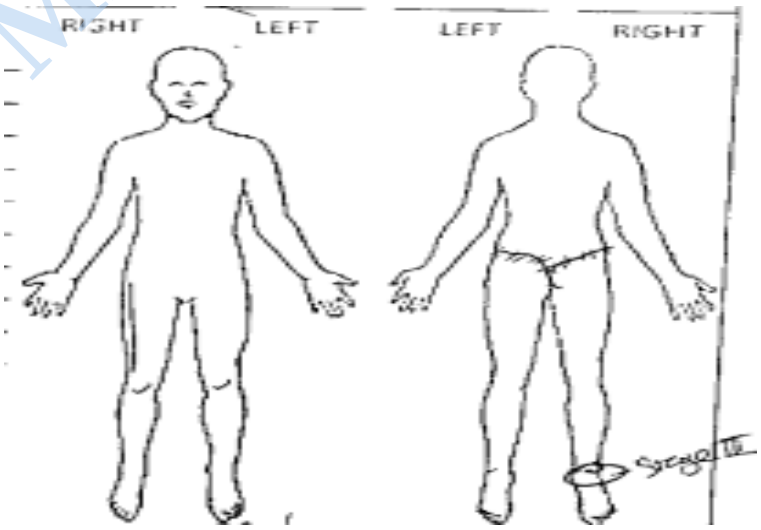
DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		right heel pressure ulcer. **Operation performed:** Excision of stage IV sacral pressure ulcer, closure of sacral defect with local fasciocutaneous flaps and debridement of right heel ulcer and placement of VAC. **Indications:** The patient is a 74-year-old gentleman who developed a left foot drop in the past and has suffered pressure ulcers as a result of falling and being down for a prolonged period of time. He has stage IV sacral pressure ulcer, which has been treated with wound care and VAC as well as a right heel eschar. He was brought to the operating room to address these problems. **Description of procedure:** The patient was brought to the operating room and general anesthesia was induced. He was then transferred to the prone position taking care to pad all pressure points. After induction of general anesthesia, the sites were prepped and draped in the usual sterile fashion. We began with the sacral wound. The ulcer was painted with methylene blue and the area was injected with 1% Lidocaine with Epinephrine. The entire ulcer was excised, making sure to remove all the areas painted with methylene blue. This was noted to go tracked all the way down to the sacrum. The excised ulcer was sent to Pathology. The wound was then copiously irrigated, and hemostasis was obtained. The defect measured 9cm x 17cm. We began by designing inferiorly based left gluteal rotation flap, which was a fasciocutaneous flap. The flap was elevated and undermined and transferred into the defect. We did use a Doppler to ensure that we are preserving a sufficient number of gluteal perforators. With the flap fully mobilized, a residual defect was still present on the right. Therefore, a superior based right gluteal rotation flap was designed, and this was raised on the fasciocutaneous plane and rotated into place. With the two flaps transferred, we were able to close the defect and obliterate the dead space. 19-French round Blake drains were placed and some Surgicel was placed over the sacrum. The flaps were then inset in layers with 2-0 PDS, 3-0 PDS and then 3-0 nylon sutures. The drains were sewn in place with 2-0 silk sutures. In the central portion of the wound, some additional Dermabond was applied. The total size of the left flap was a 28 x 15 cm including the defect and the size of the right flap was 30 x 15 cm. Attention was then turned to the right heel where there was a dry eschar that was present. The full-thickness of the eschar was excised until we visualized a healthy-appearing fat. This measured 4 x 3 cm. The VAC was then placed over the defect. The patient was then awoken from anesthesia and transferred to the post-anesthesia care unit in stable condition.	
04/30/YYYY	Hospital/ Provider Name	**Pathology report:** **Pathologic diagnosis:** 1. Sacral wound, excision: Skin and subcutaneous tissue with ulceration, acute and chronic inflammation, fibrosis, and granulation tissue formation. 2. Right heel ulcer, debridement: Gangrenous necrosis of skin and subcutaneous tissue.	581-582

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
05/01/YYYY	Hospital/ Provider Name	**Physical therapy initial evaluation report:** **Reason for referral**: Evaluation and treatment **Activity orders**: Ambulate • No sitting, no lying supine • Side to side positioning, standing or walking only • Do not raise HOB >30 • Right lower extremity partial weight bearing Patient with a history of diabetes, hypertension, chronic back pain, and left foot drop status post spinal surgery years ago who was previously admitted to BIDMC after being found down for prolonged period of time resulting in Stage IV sacral wound approximately 2 months ago. During that hospitalization patient underwent serial debridement of sacral wound and was discharged to rehab. Patient now returns for closure with Plastic Surgery and is POD #1 s/p excision of stage IV sacral pressure injury, closure of sacral defect with fasciocutaneous flaps, and debridement of right heel ulcer with VAC placement. Patient now presents for PT evaluation to assist with mobility recommendations and discharge planning. **Living environment:** Patient lives in multi-level home with elevator access, no steps to enter. Patient has lifeline like alert in home, cane, roller walker, rollator but breaks are not functioning. **Prior functional status/activity level:** At baseline patient ambulates with SC, has RW as needed. He had previously been a community ambulator, drives to Dunkin Donuts everyday then walks approximately 1 mile around a park. Prior to this admission patient was at a rehab facility and was ambulating short distances using RW. Patient reports this as the only fall. Independent for ADLs. Baseline mental status: Alert and oriented x 3 Pain: 5/10 at rest. 5/10 with activity. 5/10 at recovery. Location: Right heel Quality: Ache, discomfort Intervention: Elevation of right heel Limiting symptoms: Pain Posture: Within functional limits Range of motion: Appears grossly within functional limits bilateral upper/lower extremities noted with functional mobility Muscle performance: Bilateral upper/lower extremities grossly within functional limits noted with functional mobility and AROM with exception of left ankle; 0/5	539-543

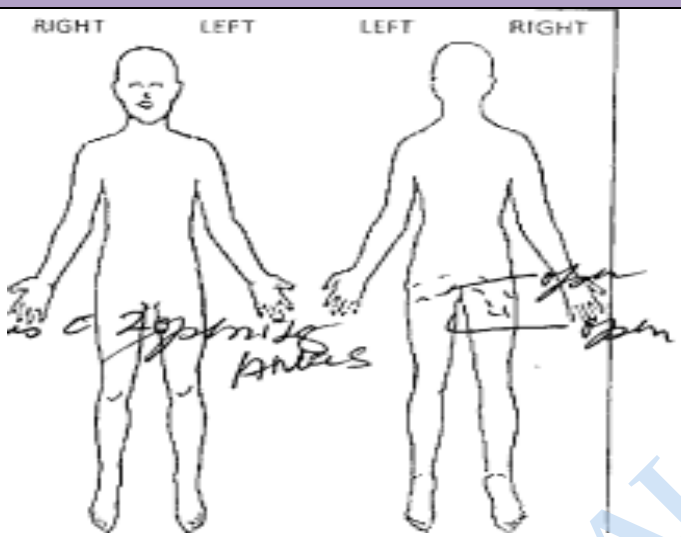
DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		dorsiflexion, 1/5 plantar flexion Motor function: Able to move all extremities in isolation **Functional status:** Rolling: Contact Guard Use of rail: Yes Supine/side-lying to sit > supine: CG Head of Bed Elevated: Yes Ambulation: Minimal assistance with RW **Mobility**: From 1/4 turn patient able to complete to full side-lying with CG and heavy reliance on bed railing; intention for side-lying > stand however patient required short seated rest break prior to stand; requires CG to complete stand and increased time to complete task. Moderate assistance to complete return to supine. Limited by HDR with systolic BP to 70; declines symptoms. RN and NP aware. **Gait**: Able to negotiate 3 steps laterally toward left with minimal assistance and heavy reliance on RW for bilateral upper extremities support and minimal VC for directional cueing. Maintains partial weight bearing right lower extremity. **Balance**: Requires CG for static standing with bilateral upper extremities support of RW; mina dynamic standing at this time **Diagnoses:** Impairments of body functions and structures, activity Limitations and participation restrictions • Knowledge deficit regarding: Rehab process, weight bearing status, activity restrictions • Impaired functional mobility • Impaired endurance • Impaired balance **Clinical impression/prognosis**: Patient with a history of stage IV sacral wound who presents to physical therapy during hospitalization for closure. Patient is functioning well below baseline limited by impairments in body structure and function including decreased functional strength, activity tolerance, and balance consistent with pain related to surgery as well as recently limited activity. Patient also presents with activity limitations in mobility and self-care contributing to difficulty in fulfilling societal role of independent adult. As consistent with patient's AM-PAC T-scale score <42.43, patient will benefit most from discharge to interdisciplinary rehabilitation to improve upon deficits and to maximize safety and functional mobility as able. Patient's preference is for discharge home however given current level of function and activity restrictions, recommending return to rehab upon discharge. Will continue to follow during acute stay.	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Recommended discharge: Rehab **Treatment plan:** Progress functional mobility as tolerated Therapeutic exercise program Endurance training Balance assessment / training Patient/Caregiver education **Frequency/duration**: 2-3x/week for 2 weeks **Recommendations for nursing:** Patient is at high risk for deconditioning please encourage frequent mobility and maximize independence in ADLs. Assist of 2 for out of bed using RW 3x/day. Use chair alarm when out of bed.	
04/30/YYYY-05/03/YYYY	Hospital/ Provider Name	***Cumulative inpatient progress notes:*** *The patient underwent sacral wound debridement with wound vac placement on 04/30/YYYY. Pain control was achieved with Dilaudid, Tylenol and Toradol. His condition improved; hospital course was uneventful. He was discharged on 05/03/YYYY after working with physical therapy.*	534-538, 544-552
05/03/YYYY	Hospital/ Provider Name	**Discharge summary:** **Admission date:** 04/30/YYYY. **Chief complaint:** He presented with past medical history of seizure disorder (Last seizure 7 years ago), diabetes mellitus, hypertension, chronic back pain, and left foot drop status post spinal surgery many years ago, who was previously admitted to BIDMC for significant stage IV sacral wound after being found down for 48-hours after a fall approximately 1-1/2 months ago, now status post sacral wound debridement and "ying-yang" flaps for closure as well as right heel debridement with VAC placement. **Major surgical or invasive procedure:** 04/30/YYYY-Flap closure of pressure wound **History of present illness:** He presented with past medical history of seizure disorder (Last seizure 7 years ago), diabetes mellitus, hypertension, chronic back pain, and left foot drop status post spinal surgery many years ago, who was previously admitted to BIDMC for significant stage IV sacral wound after being found down for 48-hours after a fall approximately 1-1/2 months ago, now status post sacral wound debridement and "ying-yang" flaps for closure as well as right heel debridement. **Social history:** Per patient was prior to the past month's admission to BMC living independently at apartment near Blue Hill Ave ambulating with walker with a cousin who helped him as a caretaker; now no ambulation for 1 month; denies tobacco, illicit. Has several supportive family members **Physical examination:**	577-579

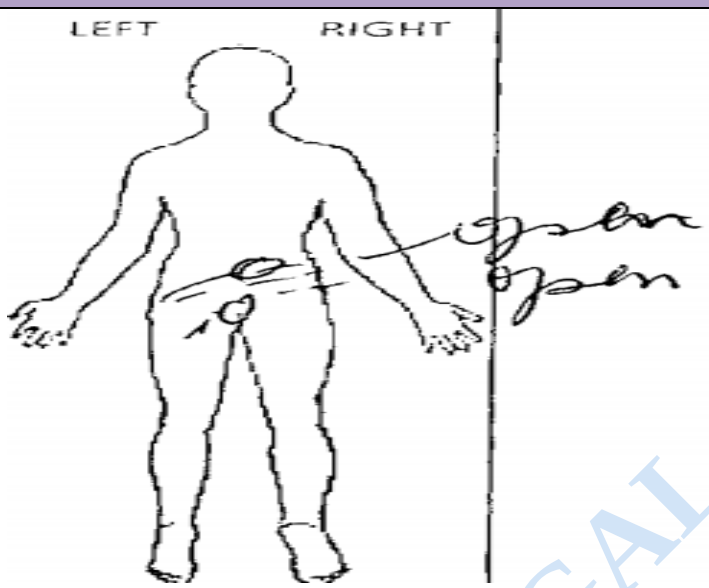
DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		General: Alert, oriented Back: “Ying-yang” flap closure. Bilateral suture lines have ischemia along the margin of the incision Right flap is soft, well-perfused Left flap mild congestion Right drain SS output approximately 200cc day of discharge Left drain SS output approximately 50cc day of discharge No dehiscence **Brief hospital course:** The patient was taken to the OR on 04/30 for the procedure listed above. He was admitted for pain control and incision monitoring. He was discharged on POD #3 after an uneventful hospital course after working with physical therapy. **Medications on admission:** 1. Acetaminophen 650mg thrice daily 2. Docusate Sodium 100 mg twice daily 3. Levetiracetam 500mg twice daily 4. Metformin XR (Glucophage XR) 500mg daily 5. Multivitamins 1 daily 6. Omeprazole 20mg daily 7. Phenytoin Sodium Extended 100mg twice daily **Discharge medications:** 1. Oxycodone (Immediate Release) 5mg every 4 hours as needed pain-moderate 2. Acetaminophen 650mg thrice daily 3. Docusate Sodium 100mg twice daily 4. Levetiracetam 500mg twice daily 5. Metformin XR (Glucophage XR) 500mg daily 6. Multivitamins 1 tab daily 7. Omeprazole 20mg daily 8. Phenytoin Sodium Extended 100mg twice daily **Discharge disposition:** Extended Care. **Facility:** Wingate at Needham. **Discharge diagnosis:** Sacral pressure wound. **Discharge condition:** Good. **Discharge instructions:** Please place dry dressings over incisions as needed for drainage Please pressure offload back (side to side positioning with frequent turning) Please strip and record drains daily Side to side positioning, standing and walking only No sitting	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		No HOB (Head of Bed) elevation >30 No supine positioning Pressure off-loading mattress **Follow-up instructions:** Dr. Eugene Fukudome in 2-weeks	
05/03/YYYY	Hospital/ Provider Name	**Weekly skin evaluation:** *(Illegible notes)*  Head: No Chest: 2 bilateral JP drain Arms: No Back: No Buttocks/coccyx: Flap reconstruction surgery with sutures Feet: Right heel ulcer	3628
05/06/YYYY	Hospital/ Provider Name	**Weekly skin evaluation:** *(Illegible notes)* 	3628

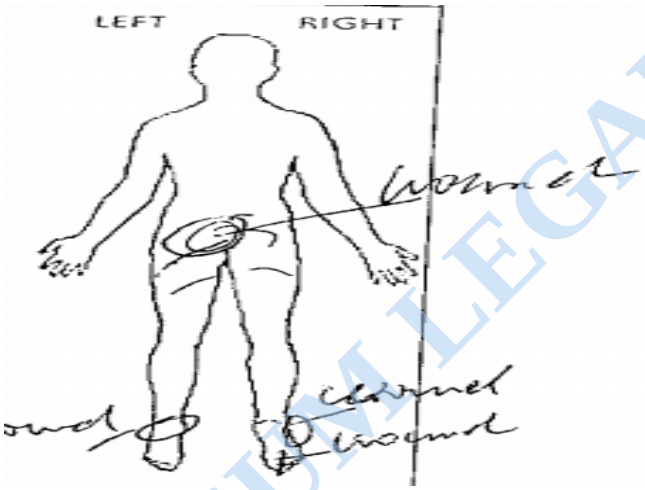
DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Head: Clean/dry/intact Chest: Clean/dry/intact Arms: Chest/dry/intact Back: Chest/dry/intact Buttocks/coccyx: Stitches to coccyx Legs: Clean/dry/intact Feet: Stage III ulcer (Deep Tissue Injury)	
05/09/YYYY	Hospital/ Provider Name	**Post-operative visit:** He presented with past medical history of seizure disorder (last seizure 7 years ago), DM, HTN, chronic back pain, and L foot drop s/p spinal surgery many years ago. He had fallen and was found down for 48 hours for which he endured a stage IV sacral wound. He is now s/p sacral wound debridement and ying-yang flaps for closure as well as right heel debridement with VAC placement. These procedures were done by Dr. Fukudome on 04/30/YYYY. Overall patient is doing generally well, he is now living at Wingate in Needham for rehab purposes but prior to surgery, he was living independently in an apartment. He states his sacral area is still very sore to touch. He has difficulty lying on his sides because of his drains but is trying to stay off his backside as much as possible. He states Wingate turns him frequently and empties his drains daily, although there is no record of his daily drain output in paperwork brought in today. Mr. Hicks says he has his normal appetite and has been trying to walk multiple times daily. On exam, patient seems to be in discomfort lying on the stretcher. Upon takedown of his dressings to his sacral area, the ying yang sutures are intact. Right flap is soft and well perfused with incision healing well. Left flap is soft and well perfused but suture line is slightly hyperemic with some dehiscence measuring 4-5 cm. No spreading erythema noted. Upon take down of the dressing of his right heel, there is some fibrinous exudate. Heel wound measuring roughly 3 x 3cm. No signs of infection present. Mr. Hicks will return to rehab today. I wrote instructions for the rehab which included, as much offloading of the left sacral/hip area as possible. Continue to change dressings on the sacral wound daily. Continue to monitor and record daily drain outputs. Regarding his right heal wound, start wet-to-dry dressings twice daily to right heal. Monitor per oral intake for adequate protein to optimize wound healing. Return to clinic in two weeks' time for possible drain removal and suture removal.	553
05/13/YYYY	Hospital/ Provider Name	**Weekly skin evaluation:** *(Illegible notes)*	3629

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		 Head: Intact Chest: Intact Arms: Intact Back: Intact Buttocks: Incision with stitches with _ right big toe discoloration Legs: Right foot 2nd toe _ area with brown drainage Feet: Right heel wound Left heel _ side wound	
05/13/YYYY	Hospital/ Provider Name	**Psychotherapy for medication management:** **Diagnosis:** Adjustment disorder with mixed disturbance of emotions and conduct Personal history of other specified conditions. **Comments:** Epilepsy, diabetes mellitus, neuropathy, status post fall, sacral decubitus ulcer status post debridement, malnutrition, anemia **Assessment:** Per nursing, patient has been irritable and agitated with staff. He is med compliant. **Target behaviors:** Anxiety/Apprehension, behavioral disturbances, changes in mood **Recommendations:** Recommended psychotherapy to help with adjustment. Continue to monitor mood and behavior and report mental. **Plan:** Status changes to provider. Instruct nursing staff to report worsening of symptoms or development of new symptoms. Continue to encourage participation in facility activities. **Care:** Discussed patient with nursing staff and unit manager. Reviewed	3740-3742

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		medical records including discharge summaries, physician and **Co-ordination:** Nursing progress notes, medications and labs. Details reflected in this note come from chart, nursing, and patient interview.	
05/20/YYYY	Hospital/ Provider Name	**Post-operative visit:** The patient returns for postoperative visit from rehab. Has had a previous sacral wound reconstruction on April 30, 2019 with Dr. Domi. Since his last visit he is doing much better. His last clinic visit he had significant amount of pain and discomfort. Today he is quite comfortable and very pleasant in the exam. On exam, he is well-appearing no acute distress. Thoughts are clear and coherent. He is not any pain. He has 2 remaining drains with yellowish output with sediment. He did not bring any recorded outputs, however stated that there is been more than 30cc from my either drain daily. The left rotational flap is healing quite well sutures remain intact. The right rotational flap has area of focal dehiscence superiorly as well as inferiorly. Remove the running nylon suture superiorly was not holding any tension anymore dehiscence. I infiltrated the area with 1% Lidocaine with Epinephrine and sterilized with alcohol wipes. I replaced the running nylons with 3-0 Prolene, series of interrupted and horizontal mattress sutures. The inferior portion of his flap also had some 1 cm dehiscence. I reinforced this area again with 3-0 Prolene, some interrupted as well as horizontal mattress sutures. There was some re-approximation of the wound edges at both the sites after suturing. I reinforced with the patient that he should not be laying on the left side. These areas of dehiscence appear to be somewhat related to pressure. He will return to rehab and follow-up in 2 weeks' time with drain outputs recorded as well as pressure offloading hope at that time I can remove some of his drains. And that his suture lines are not dehiscing anymore.	556
05/20/YYYY	Hospital/ Provider Name	**Weekly skin evaluation:** *(Illegible notes)*	3629

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		 Head: Intact Chest: Intact Arms: Intact Back: Intact, 2 JP drains Buttocks: Incision with sutures, _ Legs: Yellow IV stage with moderate _ Feet: Left heel wound Right heel wound Right foot 2nd toe, split area _ Right big toe discoloration	
05/20/YYYY	Hospital/ Provider Name	**Psychotherapy for medication management:** **Diagnosis:** Adjustment disorder with mixed disturbance of emotions and conduct Personal history of other specified conditions. **Comments:** Epilepsy, diabetes mellitus, neuropathy, status post fall, sacral decubitus ulcer status post debridement, malnutrition, anemia **Assessment:** Per nursing, patient has been irritable and agitated with staff. He is med compliant. **Target behaviors:** Anxiety/Apprehension, behavioral disturbances, changes in mood **Recommendations:** Continue Neurontin. Provided support to patient. Continue to monitor mood and behavior and report mental status. **Plan:** Changes to provider. Instruct nursing staff to report worsening of symptoms or development of new symptoms. Continue to encourage participation in facility activities.	3734-3736, 3737-3739

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
05/23/YYYY	Hospital/ Provider Name	**Telephone conversation:** Returned call to Rehab facility Stephanie Reported from nurse that patient had 3 seizures in one-week last seizure 5/14 Patient level done at first seizure and level less than 2.5-Per nurse no missed medications Patient's dose was increased from 100mg twice daily to 200 mg twice daily Level redrawn and 3.5. Patient dose was re-adjusted again on 5/20 to Dilantin 200 mg in am and 300 mg in evening. No new level drawn at this time. Per nurse patient's only possible trigger could be recent surgery on 5/3-Graft done for wound. Patient had had x 2. JP s for increased drainage of wound. Facility requesting sooner appt for patient for recommendations for treatment plan	2757-2758
05/29/YYYY	Hospital/ Provider Name	**Weekly skin evaluation:** *(Illegible notes)* Head: Intact. Chet: Intact. Arms: Intact. Back: Intact Buttocks/coccyx: Incision with sutures with open arms Legs: Yellow tissue, left heel wound-right heel lateral Feet: Side wound Right 2nd toe superficial open Right big toe dislocation	3630
05/30/YYYY	Hospital/ Provider Name	**Podiatry follow-up visit:** **Diagnosis:** Atherosclerosis of the extremities, onychomycosis, type II diabetes mellitus with peripheral circulatory disorders.	3725
06/03/YYYY	Hospital/ Provider Name	**Post-operative visit:** He returns for a post-operative visit from rehab. He had his previous sacral wound reconstruction on April 30, 2019. Since his last visit I had put in some Prolene sutures to try to reapproximate a superior and inferior area of dehiscence on the left flap. Unfortunately, this dehiscence has recurred, and the sutures are loose. In addition, his left JP drain had fallen out at rehab on Sunday. He has been otherwise well and is wanting to leave rehab to go back to his home in North and soon as possible. He has been in good spirits. He is by himself in the exam room today. He is doing quite well and appears in a good mood. The left-sided flap has superior dehiscence of approximately 4 cm x 2 cm x 3 cm deep. I probed this in the exam room and there is some serous fluid, likely remnant of the drain that was removed prematurely. I debrided some of this fibrinous material and packed this with a 4 x 4 gauze. The inferior portion did not appear to be progressing and I remove the prior 3-	559

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		0 Prolene sutures. The right-sided flap is healing very well. I removed all of his sutures today in the clinic. I instructed him that he will need to have twice daily packing to the left superior dehiscence. Whether this happens at rehab versus home is dependent on his ability to take care of himself as he does live alone. He should continue to pressure offload left-sided area to allow it to heal. I think that with good local wound care to the area of dehiscence that he should be able to heal this up without further intervention. I would like to see him back in 3 to 4 weeks to see how he is progressing.	
06/03/YYYY	Hospital/ Provider Name	**Weekly skin evaluation:**  Head: Intact Chest: Intact Arms: Intact Back: Intact Buttocks/coccyx: Surgical incision (wound) Legs: Intact Feet: Right big toe discoloration	3834
03/12/YYYY-06/07/YYYY	Hospital/ Provider Name	***Cumulative inpatient nursing progress notes:*** ***03/13:*** *He was admitted today around 6 p.m. from BID with a diagnostic of wound infection, sacral decubitus, weakness, diabetes. Abdomen-Soft, non-distended, bowel sounds present. On exam, ulcer found to be foul-smelling, he has eschar on bilateral heels without drainage, large coccygeal ulcer status post debridement stage 4 wound vac from sacral wound intact and draining pinkish colored. Patient has right site PICC line, no infection noted. He moves all extremities, no rashes noted.* *Vitals: BP 109/57, HR 99, Temp 97.3, RR 18, Spo2 99% on room air.* *He is out of bed for 1 hour for lunch. Complained of pain and headaches this afternoon, as needed oxy given with moderate relief. Wound vac changed again today, measurements were 8 x 12 x 5 cm, tunneling at 3 o' clock, 4cm*	3665-3694

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		deep. Wound bed is pink with slough covering. No odor noted. FSBS readings were 122/138, no insulin required. PICC site is GDI, no inflammation or signs/symptoms of infiltration noted, positive blood return. He continues on IV antibiotics, no fever or signs/symptoms of adverse reactions noted. No other changes noted. Vitals stable. BP 134/77, HR 90, Spo2 99%, RR 18 on RA and Temp 98.6. No other changes noted, will continue with plan of care. *On IV Zosyn 4.5mg in 100ml. Thrice daily infused over 60 minutes with no IV related issues, PICC line dressing changed according to policy flushed per house policy, BP 151/74, RR 18, PR 101 bpm, Temp 97.2, Spo2 97% on room air. Pleasant mood, sleeping in long naps, complains of pain from sacral wound treated with as needed meds effect.* ***06/07:** Alert/oriented x 3, ambulate with walker with steady gait, no signs/symptoms of hypo/hyperglycemia, patient denied pain/discomfort. Vitals: Temp 98.6, PR 89, RR 20, BP 124/70 sat 99 % room air, no shortness of breath/distress, no complaint voiced. Patient was discharged to home in stable condition, discharge teaching was done with positive feedback.* ***Short-term rehab related records:** Flow sheets, medication sheets, drain records, labs, referral reports, assessment, plan of care* ***Ref:** 3598-3600, 3601-3624, 3625-3627, 3642-3664, 3695-3711, 3724, 3726, 3728, 3729, 3731-3733, 3749-3757, 3758-3762, 3765-3769, 3772-3780, 3783-3789, 3790-3809, 3810-3811, 3812-3819, 3820-3832, 2979-2984, 2987-2998, 2985-2986, 3631-3641*	
06/10/YYYY	Hospital/ Provider Name	**Telephone conversation:** Patient called requesting call from MD regarding the surgery patient had. Patient would like to talk to the MD and patient experiencing pain. Patient experiencing 3 seizures two weeks ago, last Friday patient got discharge, now patient home alone. Returned call, had back surgery a month ago, went to rehab after surgery. Had a seizure 2 weeks ago while in rehab. Patient went home on 06/07/YYYY followed by PT and VNA. Patient was last seen 2018, scheduled to see Dr. Stefanidou 10/07/YYYY. Patient requests sooner appointment with Dr. Stefanidou I called the patient; I went over his medications. He is taking both Dilantin 200-300mg and Keppra 500mg twice daily as he is supposed to. He confirmed that he was getting the wrong dose of Dilantin when he had his seizure in May. He cannot come for labs until next month, but l will try to reach out to the facility as we had asked them to draw levels last week. I tried to add them on to today's labs, but they require different color tubes and the lab could not process the request. He has been seizure-free for many years on current AED regimen and I believe he should be adequately treated now that he has resulted the correct doses.	2740-2758

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
06/10/YYYY	Hospital/ Provider Name	**Follow-up visit:** Sacral decubitus. Now home from rehab stay at Wingate Needham in the last 3-months discharged home on 06/07/YYYY. Doing lots better Wound close to being healed and closed partners home care daily wound 844-744-4200-will have PT and HHA also at home. BIDMC orthotist Dr. Michaela Bonnar Boston BIDMC follows had 4 surgical debridements during stay Dr. Helene Almonor was MD following him while at rehab Needham Wingate Lives on own Family nearby 06/03/YYYY, Saw Dr. Fuillme plastic surgeon BIDMC on 07/01/YYYY next appt. Overall, now is doing well, no fevers. **Physical examination:** Healing decubitus at right lumbar/sacral region pink granulating tissue Wet/dry dressing changed in office Also, ulcer at left heel with granulating tissue and DSD dressing applied **Assessment/plan:** Decubitus ulcer: Dressing changed in office warm/dry, see VNA at home for ongoing assist with dressings. Also heel ulcer, DSD applied as patient brought extra dressing. Salonpas PTMD	2776-2871
06/11/YYYY	Hospital/ Provider Name	**Telephone conversation:** Called Wingate of Needham Requesting lab results for Dr. Stefanidou for patient upcoming appt 10/07/YYYY Facility aware requesting results letter sent and faxed. Awaiting results to be sent Attn Stefanidou.	2872-2888
06/13/YYYY	Hospital/ Provider Name	**Home health occupational therapy initial evaluation report:** **Assessment/summary:** He was admitted to home care status post rehab with sacral wound status post flap closure. Past medical history includes type II diabetes mellitus, spinal stenosis, septic arthritis. At baseline, patient was independent with all ADLs and minor IADLs. Patient presents to home care occupational therapy demonstrating decrease in safety with transfers to the shower. Patient was able to step in, however due to decreased balance, would benefit from seating system. Teaching/training focus: Adaptive equipment for showering.	3262-3269

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Assessments needed: Pain, medication, safety, vitals Education topics: Use of adaptive equipment, transfer technique Treatments/test: Tub transfer, discharge	
06/14/YYYY-06/18/YYYY	Hospital/ Provider Name	**Telephone conversation:** **06/14:** Durable medical equipment. Daisy is calling requesting prescription for medical equipment for patient. Transfer shower bench also wheelchair size 20inch, wide 16inch, deep together with letter for medical necessary and clinic note. Daisy is requesting a call back from the clinic today and stated she need this as soon as possible. TAT 72-hours was given. **06/17:** Daisy stated she would also like to request a Roho seat cushion to go along with the wheelchair, request per the physical therapist. Please contact Daisy, please fax the scripts and clinical notes. **06/18:** Return call to Daisy, CM at UHC. Left voice mail scripts, letter med nec, clinic notes printed and will be faxed after signed by PCP.	2889-2907
06/09/YYYY-06/25/YYYY	Hospital/ Provider Name	***Cumulative home health nurse visits:*** ***He received home health nurse visits on the following dates:*** *06/09/YYYY, 06/10/YYYY, 06/12/YYYY, 06/13/YYYY, 06/14/YYYY, 06/15/YYYY, 06/16/YYYY, 06/17/YYYY, 06/18/YYYY, 06/19/YYYY, 06/20/YYYY, 06/21/YYYY, 06/22/YYYY, 06/24/YYYY, 06/25/YYYY* ***Condition of patient as on 06/25/YYYY:*** *Wound care provided per care plan, copious amount of serous dressing, wound open at proximal end 3cm deep with yellow slough at base, remainder of wound is beefy red with yellow slough, surrounding area intact, no signs/symptoms of infection.* *Treatments/test: Wound care.* ***Ref:*** *3197-3228, 3243-3253, 3255-3261, 3271-3277, 3278-3281, 3282-3285, 3291-3294, 3300-3306, 3307-3312, 3313-3319, 3321-3328, 3334-3335, 3336-3342*	
06/10/YYYY-06/25/YYYY	Hospital/ Provider Name	***Cumulative home health physical therapy visits:*** ***Initial evaluation on 06/10/YYYY:*** *He was referred to PHH services status post admission to BIMC from rehab with flap closure of sacral wound JP drains. Patient is discharged on 06/03 to STR at Wingate Needham for continued care. He presented with impairments in lower extremity strength, dynamic balance, pressure ulcer risk, fall risk, decreased cardiovascular/muscular endurance and overall decrease in independent. Patient is to benefit from physical therapy services 1-2 x/week for approximately 6 weeks to address the above deficits. Interventions included lower extremity therapeutic exercises, dynamic balance training and gait training. Education topics included fall preventions, pressure ulcer preventions and home exercise program.*	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		He received home health physical therapy visits on the following dates:*06/10/YYYY, 06/17/YYYY, 06/19/YYYY, 06/24/YYYY, 06/25/YYYY* ***Condition of patient as on 06/25/YYYY:*** *Patient greeter physical therapy at door with use of rollator; no acute distress noted, Patient is to follow-up on requested DME with MD office on 06/26 per office request, patient reporting "I have been walking every day to help keep myself moving." Patient ambulation in uncontrolled environments.* ***Ref:*** *3229-3238, 3286-3290, 3296-3299, 3329-3333, 3343-3348*	

Other related records:

Plan of care, assessment, orders, telephone conversation, glucose monitoring strips, medication sheets, legal records, patient's information, blank pages, rhythm strip notes, anesthesia record, intra-op records, MAR, labs

PDF Ref: *1-2, 180-181, 181-246, 247-248, 249, 2546, 258-263, 264-363, 2671-2687, 2706-2722, 2723-2739, 2759-2775, 2944-2965, 3065, 3066, 3069-3072, 3075-3080, 3088-3091, 3073-3074, 3081-3087, 3100-3101, 3129, 3133, 3134-3136, 3164, 3173, 3180-3182, 3183-3186, 3191-3192, 3194-3196, 3594, 3597, 3595-3596, 364, 3-7, 3713-3718, 3720-3723, 3727, 3743-3748, 3763-3764, 3771, 3833, 3835-3880, 3881-3890, 511, 512, 521, 522, 531, 532, 533, 555, 557, 558, 560, 57, 580, 584, 585, 755-761, 761-769, 76-93, 94-97, 98-178, 367-375, 3349-3593, 2908-2925, 2926-2943, 2805, 554, 3239-3242, 3254, 3270, 3295, 3320, 8-29, 52-56, 65-67, 73-74, 3187-3190, 2968-2978*

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