Medical Chronology/Summary

Confidential and privileged information

Usage guideline/Instructions

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

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

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

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

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

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

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

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

General Instructions:

- *The medical summary focuses on nursing home admission of **XXXX** post stroke on 12/22/YYYY, followed by development of pressure ulcer and its management in detail. All details including pressure ulcer prevention measures, development of pressure ulcer, wound assessments, wound care, complications including sepsis and management were included*
- *Wound care related details are summarized in detail to the show the progress of the patient.*
- *Rest of inpatient progress are presented cumulatively in a brief manner*

Flow of Events

Coney Island Hospital

12/22/YYYY: *Patient had left side facial drop and left sided weakness – transported by EMS to Coney Island Hospital – assessed with cerebral infarction – neuro suggested patient as not a candidate for IV TPA due to abnormal non-contrast head CT scan – transported to Lutheran ER for further treatment*

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NYU Langone Health System

12/22/YYYY-12/30/YYYY*: Patient presented with extremity weakness – TPA bolus was given after discussion with MD Selas – admitted to stroke unit – CT angio of head and neck showed evolving right MCA territory stroke without evidence of hemorrhagic transformation -neurology consulted on 12/23/YYYY – symptoms thought to be secondary to ischemic stroke – treated with Aspirin, Plavix and Statin therapy – transferred on 12/30/YYYY to home health services for long-term cardiac monitoring to look for paroxysmal atrial fibrillation*

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MJHC

12/30/YYYY-02/13/YYYY*: Transferred to home health care – Plan: Skilled nursing 1 x day x 7 - pressure ulcer stage I to sacrum area 5.3 x 5 cm noted on 12/31/YYYY, care givers instructed on skin care, repositioning, incontinence management, moisture barrier application and state understanding – under physical/occupational therapy and skilled nursing care – noted to have right upper buttock unstageable pressure ulcer, right lower buttock unstageable pressure ulcer and left buttock stage 2 pressure ulcer on 01/19/YYYY – treated with Bacitracin and Zinc, Santyl, Medi-honey Alginate - Patient required a higher level of care – patient was receiving 7 x 24 pressure ulcer wound from Village Care – wound deteriorated – patient was transferred to Coney Island Hospital for extensive surgical debridement*

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Coney Island Hospital

02/13/YYYY-02/24/YYYY: *Admitted for surgical wound debridement – underwent excision of necrotic tissue of sacral area on 02/21/YYYY – placed on Vancomycin, Zosyn – advised to consider MRI to rule out osteomyelitis – discharged on 02/24/YYYY to Menorah Center for Rehab and Nursing Care for further care*

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Menorah Center for Rehab and Nursing Care

02/24/YYYY-04/17/YYYY: *Admitted for further management – on 02/27/YYYY patient noted to have right outer buttock stage 3 pressure ulcer, right heel deep tissue injury, left heel unstageable pressure ulcer – on 02/28/YYYY, patient was transferred to Coney Island Hospital on 04/17/YYYY for treatment of infected buttock pressure ulcer and to rule out osteomyelitis*

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Coney Island Hospital

04/17/YYYY-05/01/YYYY: *Admitted for evaluation of worsening sacral decubiti with purulent discharge despite completion of 10-days of Vancomycin and Zosyn - MRI of lumbar spine showed possibility of osteomyelitis - Infection treated with IV Vancomycin and Zosyn and transitioned to oral Bactrim and Levofloxacin – advised to continue antibiotics until 05/15/YYYY – received referral for gastrointestinal clinic and Hem/Onc for evaluation of anemia – discharged on 05/01/YYYY to Menorah Rehab*

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Menorah Center for Rehabilitation and Nursing Care

05/01/YYYY-07/10/YYYY: *Patient was admitted on 05/01/YYYY for completing oral antibiotics, wound care and rehab – completed oral Bactrim and Levaquin – pressure ulcer*

extended left buttock was treated with Collagenase and Vac with improvement – transferred to Coney Island Hospital on 07/10/YYYY for left heel unstageable pressure ulcer debridement

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Coney Island Hospital

07/10/YYYY-07/20/YYYY: *Admitted on 07/01/YYYY for pressure ulcer debridement – underwent debridement up to the bone of heel decubitus as well as bone biopsy and debridement of the superficial bone on the left heel on 07/12/YYYY – underwent sacral ulcer debridement on 07/19/YYYY – discharged on 07/20/YYYY to skilled nursing home for further care*

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Menorah Center for Rehab

07/20/YYYY-09/04/YYYY: *Patient was admitted for wound care management – had regular wound assessments – treated with multiple antibiotics – developed altered mental status and hypotension on 09/04/YYYY – transferred to Coney Island Hospital for further management*

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Coney Island Hospital

09/04/YYYY-09/15/YYYY: *Presented to ER with hypotension – assessed with sepsis secondary to pressure ulcers and urinary tract infection – started on empiric Vancomycin and Zosyn IV – developed septic shock – on 09/15/YYYY, patient went into cardiac arrest – resuscitation failed and patient pronounced dead at 0930 hrs*

Patient History

Past Medical History: Diabetic mellitus type II; hypertension; hyperlipidemia

Surgical History: No pertinent past surgical history

Family History: No pertinent family history

Social History: Never smoker; none alcohol use

Allergy: No known allergies

Detailed Summary

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
12/22/YYYY	Hospital/Provider Name	**Emergency medical service report:** **Call information:** Call received: 1934 Dispatched: 1935 En route: 1935 On scene: 1942 Patient contact: 1944 Left scene: 2002 At destination: 2007 In service: 2050 **Disposition/location details**:	2366-2371

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Disposition: Treated/transferred care Unit #: 43V3 - 43V Tour 3: 1500-2300, Ambulance-Land trip type Run type to scene: Emergency (Immediate) Incident location: 2911 W 36 ST ##4M - Brooklyn, NY (Kings County) Incident type: Residence (Home) Receiving facility: 42-Coney Island (Hospital)-2601 Ocean Parkway, Brooklyn, NY 11235 **Chief complaint**: Stroke. **Vitals:** 1945: BP 170/104. Pulse 96 bpm. RR 16. Spo2 100%. Blood sugar 258. 1958: BP 162/96. Pulse 90 bpm. RR 16. Spo2 100%. **Provider impression:** CVA (Cerebrovascular Accident)/Stroke **Narrative:** 76 year-old-female found in care of BLS (Basic Life Support) on their stair chair in building hall way. Patient had left side facial droop and left sided weakness. Patient spoke Russian, BLS crew member was translating and stated patient had slurred speech as well. Patient stated she had no complaints and wanted to stay home, but daughter in law noticed the physical changes and immediately called 911 fearful of patient having a stroke. Patient negative shortness of breath, chest pain, nausea/vomiting, positive PEARL, lungs sounds C+E bilateral. The patient was administered on high concentrated O2 via NRB (Non-Rebreather Face Mask) 15-litre per minute, no prior cerebrovascular accident history, history of diabetes, hypertension. BP 170/104, HR 96 strong regular, RR 16 unlabored, Spo2 100% on High concentrated O2, no other findings or complaints, assisted 43D3 in rapid transport to 42, closest stroke center, with note given.	
12/22/YYYY	Hospital/Provider Name	**Triage report:** **Date/time:** 12/22/YYYY at 2013 hrs. **Chief complaint:** Left-sided weakness. **Vitals:** BP 152/78, PR 96 bpm, RR 20, Spo2 94%, temp 98.7 (37.1). **ESI level:** 2. **Triage to:** Red Zone. **Narrative:** Report given to RN Moon and MD Norman. **Comment:** She presented to ER as notification call by emergency medical services with new onset of left side weakness, started approximately 2-3 hours (At 1930 hrs). Patient denies any falls, injuries. Patient remains alert, oriented x 3. Denies chest pain, shortness of breath. CT scan done. Placed on cm. Rhythm is sinus and regular. Being evaluated by Dr. Norman. Awaiting for further	1627-1633

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		disposition. **Nursing notes:** **@2040 hrs:** Initiated evaluate neurologic observation left side weakness noted. See neurologic observation sheet, blood sugar level 208 *(Hee Suk Moon, RN)*	
12/22/YYYY	Hospital/Provider Name	**ER visit:** **Time seen:** @ 2015 hrs **Chief complaint**: New left sided weakness. **History of present illness:** 76 year-old-woman BIB (Brought In By) EMS and family for evaluation of new onset left sided weakness since approximately 1930 hrs. Patient had been sitting with family watching TV when family noted her slumped over and not moving left side. On EMS arrival to residence. Patient noted with left facial droop and entire left sided weakness. No mental status change. No recent injuries. **Physical examination:** Extremities: Non-pitting edema, symmetrical distal pulses. Skin: Dry Pressure ulcer questionable: No **Primary diagnosis:** Other cerebral infarction **Addendum report on 12/22/YYYY at 2044**: Patient has returned from head CT scan, prelim head CT scan positive possible hypodensity to right basal ganglia unknown age as per radiologist, full report to follow, neurology service at bedside at this time. **Findings:** Patient re-examined positive persistent facial droop however more movement to left upper extremity at this time. **Disposition:** Transferred to another hospital **Transfer to:** Lutheran Hospital. **Reason:** Interventional neurology. **Condition:** Stable. **Addendum report on 12/23/YYYY @ 0933:** Possible acute right MCA infarct; not a candidate for IV TPA (Tissue Plasminogen Activator) due to stroke seen on noncontrast head CT scan; patient was transferred to NYU Lutheran Medical center-Dr. A. Tewari for emergent endovascular clot retrieval treatment.	1622-1626
12/22/YYYY	Hospital/Provider Name	**@2051 hrs: Neurology consultation report:**	1634-1636

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Reason for request: New onset left sided weakness since 1930 **Present history:** Patient presents to the ER with facial droop and left sided weakness. Per family at the bedside, patient was in her usual state of health, they were visiting her in her home at which time she started drooling and having left sided facial weakness at approximately 1930. The family states her symptoms progressed to left sided weakness and EMS was called at that time. Noncontrast Head CT read by Dr. Inna Nutenson: Hypoattenuation involving right anterior lentiform nucleus as well as the anterior limb of the right internal capsule and right subinsular white matter. Smaller areas of hypoattenuation left anterior lentiform nucleus and left subinsular white matter. Evaluation of hemorrhage is limited due to patient's motion. Focal calcification and hyperdensity w/in the right middle cerebral artery at the middle cerebral artery cistern. This patient is not a candidate for IV TPA due to the above abnormal findings on CT suggestive of early right MCA infarction. **Physical examination:** Neuro: Left arm weakness (3-4/5 strength). 5/5 Strength right upper extremity, bilateral lower extremities. Babinski downward bi1ateral. **Radiology:** CT of the head report reviewed. **Assessment:** Possible acute Right MCA infarct Known history of HTN, DM, Obesity **Plan:** 1. Patient is not a candidate for IV TPA due to abnormal non-contrast head CT scan 2. Patient is to be transferred STAT to NYU/Lutheran Medical Center Dr. Tewari neuro interventional radiology for endovascular clot retrieval therapy. Case discussed with neurology attending on-call.	
12/22/YYYY	Hospital/Provider Name	**CT of the head without contrast:** **Clinical history:** New onset left-sided weakness since 1930 hrs. **Impression:** Examination is degraded due to motion. 1. Hypoattenuation involving the right anterior lentiform nucleus as well as the anterior limb of the right internal capsule and right subinsular white matter, age indeterminate. Smaller areas of hypoattenuation left anterior lentiform nucleus and left subinsular white matter, age indeterminate. 2. Evaluation of hemorrhage is limited due to patient's motion.	1653-1654

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		3. Focal calcification and hyperdensity within the right middle cerebral artery at the middle cerebral artery cistern. Findings were discussed with Dr. Norman on 12/22/YYYY at 2036 with read back confirmation.	
12/22/YYYY	Hospital/Provider Name	**EKG:** **Result:** Sinus rhythm with 1st degree AV block, left anterior fascicular block, possible lateral infarct, age undetermined, abnormal EKG.	2363
12/22/YYYY	Hospital/Provider Name	**Inter hospital transfer report:** *(Illegible notes)* **From:** Coney Island. **To:** Lutheran ER. **Diagnosis:** Dr. Behan-ER attending. Acute left cerebrovascular accident. **Past medical history:** Hypertension, diabetes mellitus. **Physical findings and treatment:** Left-sided weakness.	677
12/22/YYYY	Hospital/Provider Name	**Emergency medical service report:** **Call details:** Received: 2139 Dispatch: 2139 En route: 2140 At scene: 2203 At patient: 2205 Transport: 2219 At destination: 2228 In service: 2257 **Response info**: Medical/trauma: Emergency 1 Call type: ALS (Advanced Life Support) Response priority: Stat Call taken by: Hospital Location type: Health care facility Location: Coney island hospital, 2601, Ocean Parkway KWY, ER, Brooklyn, Kings, NY 11235 **Disposition:** Outcome: Treated, transported Destination reason: Managed care Transport priority: Stat Patient transport: Semi-fowlers position Destination: Lutheran medical center, 150, 55th street, ER, Brooklyn, Kings, NY	683-686

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		11220 **Chief complaint**: General illness-weakness (Primary) **Vitals:** @ 2206: BP 124/58. Pulse 92 bpm. RR 20. Spo2 96% @ 2219: BP 120/60. Pulse 90 bpm. RR 20. Spo2 96% **Impression:** Primary impression: Stroke/CVA (Cardiovascular Accident)-other **Narrative:** UAF 78 year old female asleep on hospital bed in ER on 6-litre per minute of O2 with bilateral 20g IV access sites on A/C's. Patient is being transported from Coney Hospital to NYU Lutheran for acute cerebrovascular accident. The patient presented with acute left sided weakness since 1930. Patient is alert oriented x 4 with patent airway, equal and bilateral chest rise with clear lumbar spine bilateral, strong regular radial pulses with pink warm and dry skin condition. Vitals were obtained and found to be within acceptable limits. Patient was transferred NTO crews stretcher and secured with straps x 5 on semi-fowlers position. The patient was transport onto crews O2 at 6-litre per minute via nasal cannula, patient was placed on cardiac monitor for observation during transport. No significant changes in condition during transport to Lutheran NYU where patient was transport onto hospital bed and left in care of ER staff.	
12/22/YYYY	Hospital/Provider Name	**ER visit:** **Time seen:** @ 2351 **Chief complaint:** Patient presents with: Extremity weakness **History:** **History of present illness comments**: She presented with history of diabetes mellitus, hypertension on Plavix for unknown reasons presenting with facial droop and left sided weakness. The patient was talking to her son when suddenly at 1930 was noted to have left facial droop. EMS called and patient brought to CIH. Patient transferred to LMC for Neuro IR evaluation. No previous history of similar symptom. No recent head trauma or bleeding. No seizure activity. The patient is a 76 year-old-female presenting with strokes. The history is provided by the patient and a relative. The history is limited by a language barrier. A language interpreter was used. **Stroke:** Presenting symptoms: Focal sensory loss and weakness. No headaches. Pre-hospital notification for suspected stroke questionable: Pre-hospital	22-25

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		notification was received. Location: Left upper extremity, left lower extremity and left facial Severity: Mild Last known well (specify date and time): 12/22/YYYY at 1930 Onset quality: Sudden Duration: 4 hours Progression: Unchanged Similar to previous episodes: No previous episodes similar to stroke no chest pain, no trouble swallowing, no dizziness, no facial pain, no fall, no fever, no hearing loss, no bladder incontinence, no nausea, no neck pain, no seizures, no vertigo and no vomiting. **Vitals:** BP 124/58. HR 81 bpm. RR 16. Spo2 92%. Pain not recorded **Review of systems:** Neurological: Positive for facial asymmetry and weakness. **Physical examination:** Constitutional: Morbidly obese female, with eyes closed but answering questions appropriately. Eyes: Positive right gaze deviation Musculoskeletal: 3/5 left upper extremity 3/5 left lower extremity 5/5 right upper extremity/right lower extremity. Positive drift to left upper extremity/left lower extremity. Neurological: Patient with eyes closed and right gaze preference, does not respond to threat to left eye. Patient opens eyes slightly when stimulated but otherwise alert. Skin: Skin is warm and dry. **Assessment/plan**: Patient with history of diabetes mellitus, hypertension presented with sudden onset left facial droop and left weakness, on exam patient without noticeable facial droop but does have gaze preference, inattention to left side, left upper extremity/left lower extremity weakness. Stroke code activated, stroke team at bedside. The current pain management plan is: Patient denies pain at this time. **12/23/YYYY:** **@ 1214:** As per stroke team patient will be admitted to stroke unit, receive TPA. Patient and family understand diagnosis. **@ 1215:** The care of this patient has transferred to stroke service. Current disposition: Admitted inpatient. At this time, the care of this patient was transferred to the Stroke neurology service. The reason for admission or placement in observation is CVA. Patient condition is guarded.	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Pertinent results: CT head negative for bleed. Significant ER interventions: TPA, stroke consult. Pending studies: All bloodwork. Please follow-up on: All bloodwork. Isolation/precaution status: None. Does this patient have sepsis questionable: No	
12/22/YYYY	Hospital/Provider Name	**Stroke service initial consultation notes:** **Chief complaint**: Right MCA (Middle Cerebral Artery) stroke **History of present illness:** Patient with a history of hypertension, hyperlipidemia, type II diabetic mellitus, mostly chair and bedbound secondary to severe arthritis of bilateral knees, on dual antiplatelet for unknown reason BIBEMS (Brought in By Emergency Medical Services) as a transfer from CIH hospital for possible Neuro-intervention for RMCA syndrome. Patient was last seen in her USOH 1930 when her son noticed acute onset of drooping from left side of face and falling to left side. Patient was initially taken to CIH where a CT was obtained with findings of possible changes in right MCA territory and no TPA was given. Upon arrival stroke code was activated and patient was escorted to CT suite. Family denies history of cerebrovascular accident, seizures or infection. **Total NIH stroke scale:** 13. **Physical examination:** **Skin:** Normal temperature, no evident rash or skin breakdown. **Neurological:** Cranial nerves: Cranial nerve III, IV, VI: Forced right gaze. Cranial nerve VII: Nasolabial flattening of left side. **Motor:** **Upper extremity strength:** Left upper extremity spastic with fluctuations in ability to lift antigravity. Seems to be blood pressure depended. Right upper extremity normal. **Lower extremity strength:** Left lower extremity able to be maintained against gravity with mild drift. **Sensation:** Sensory neglect on right side. **Reflexes:** 2+ in the bilateral upper and lower extremities. **Plantar response:** Positive Babinski on left side. Coordination: Abnormal finger to nose Gait/station: Deferred	28-32

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Radiology: CT of head, CTA of neck, head, EKG and chest X-ray done, report reviewed. **Assessment:** The patient presented with stroke risk factors of DM II (Diabetes Mellitus type II), HTN (Hypertension) and HLD (Hyperlipidemia) now presenting symptoms consistent with right MCA (Middle Cerebral Artery) syndrome likely secondary to embolus. CT with findings of right MCA stroke and CTA findings of distal right MCA segmental stenosis. NIHSS 12. Given that patient was within TPA window, consent was obtain explaining the risk and benefits including but not limited improvement of stroke symptoms and prevention of worsening of symptoms and adversely the risk of hemorrhage including but not limited to intracranial hemorrhage and death. I reviewed the list of contraindications to TPA with family as well. TPA bolus was given ater discussion with MD Selas at 2331 and infusion started at 2336. Neurological exam significant for right gaze, left hemiparesis with left VF deficit and hemisensory inattention. Neurological exam is perfusion dependent. Notified by RN that systolic BP 130s with worsening neurological exam. NS 500ml bolos given with improvement in BP. **Plan:** Admit to stroke unit Continue post-TPA neuro checks as per protocol Repeat head CT at 2300 hrs Close monitoring and frequent neuro checks for signs of neurologic deterioration STAT head CT for any neurologic change Maintain normoglycemia, normothermia, and normovolemia BP goal: 140-180 Secure MRI brain Holter, Echo Stroke labs Monitor fever curve and leukocytosis, obtain UA and chest X-ray No anti-platelet or anti-coagulation Please perform dysphagia screen before giving anything by mouth Physical therapy evaluation Discussed case with Dr Selas and MD Farkas.	
12/22/YYYY	Hospital/Provider Name	**CT of the head without contrast:** **Clinical history:** Cerebrovascular accident. **Findings:** Brain: There are focal hypodensities involving the right frontoparietal lobes including the subinsular contacts as well as the basal ganglia, suggestive of early right MCA territory infarct. **Impression:** 1. Head CT with contrast: Evolving right MCA territory stroke, without evidence of hemorrhagic transformation	330-331

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		2. CT angiogram head: Focal short segment stenosis involving the distal right M1 segment for a length of approximately 4 mm. Poor visualization of the superior branch of the right middle cerebral artery. 3. CT angiogram neck: Mild to moderate right proximal ICA stenosis secondary to underlying atherosclerotic disease, not significant by Nascet criteria. These findings were discussed with stroke PA Kaslyn by Dr. Rehmani at the time of examination on 12/23/YYYY at 2345 with read back verification.	
12/22/YYYY	Hospital/Provider Name	**CT angio of the head & neck with/without contrast:** **Clinical history:** CVA **Findings:** CTA head: Mild to moderate atherosclerotic disease at the bilateral carotid siphons. CTA neck: The origins of the great vessels of the neck from the aortic arch appear unremarkable. Moderate atherosclerotic disease at the bilateral carotid bulbs and proximal ICA (Internal Carotid Artery). There is approximately 57% stenosis at the right proximal ICA and minimal left proximal ICA stenosis as per NASCET criteria. **Impression:** 1. Head CT with contrast: Evolving right MCA territory stroke, without evidence of hemorrhagic transformation 2. CT angiogram head: Focal short segment stenosis involving the distal right M1 segment for a length of approximately 4 mm. Poor visualization of the superior branch of the right middle cerebral artery. 3. CT angiogram neck: Mild to moderate right proximal ICA stenosis secondary to underlying atherosclerotic disease, not significant by NASCET criteria. These findings were discussed with stroke PA Kaslyn by Dr. Rehmani at the time of examination on 12/23/YYYY at 2345 with read back verification.	329
12/22/YYYY	Hospital/Provider Name	**EKG:** **Report:** Sinus rhythm with 1st degree A-V block, cannot rule out anterior infarct, age undetermined, abnormal EKG.	399-400
12/23/YYYY	Hospital/Provider Name	**Nursing notes:** **@ 0114:** Assumed care of patient at 0114. Status post TPA. Patient is alert placed on cardiac monitor. Post-TPA protocol followed family at bedside plan of care explained to son. Verbalized understanding. Will continue to monitor patient closely.	25-26

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		@ 0256: BP 120/84 stroke Pa notified. Ns 500 ml given as ordered. Will continue to monitor patient. **@ 0445**: Patient transferred to unit accompanied by nurse and placed on cardiac monitor. **@ 0500:** Patient transferred to assigned room with portable monitor, accompanied by nurse and son. No complaints of an incident occurred. Report endorsed to primary nurse.	
12/23/YYYY	Hospital/Provider Name	**Neurology consultation report:** **Chief complaint:** Left sided weakness. **History of present illness:** Briefly, the patient with HTN, HLD, DM, transferred from CIH to NYU with right MCA stroke for possible mechanical thrombectomy. Last known well time around 1930 on 12/22/YYYY after son found that she slumped to left side and left facial droop. Brought to CIH where IV TPA was initially not given due to possible changes on HCT. She was transferred to NYU Lutheran for evaluation of mechanical thrombectomy. Upon arrival to NYU Lutheran, NIHSS was 13. NCHCT showed signs of early ischemic changes but no hemorrhage. She was given IV TPA at 2331. She was not a candidate for mechanical thrombectomy since CTA showed right M1 steno-occlusive disease but no LVO. Her exam is perfusion dependent with worsening exam at SBP 130's. Her exam worsened around 0500 with left sided hemiparesis, repeat head CT done this morning showed evolving right MCA territory infarcts. CTA showed persistent right M1 stenosis without occlusion and perhaps slightly improved flow through M2 branches. I personally reviewed the patient's chart to obtain additional information. **Social history**: Reports that she has never smoked. She does not have any smokeless tobacco history on file. **Physical examination:** Skin: Normal temperature, no evident rash or skin breakdown Neurologic: There is a right gaze preference but she is able to bring gaze to midline. There is a left field cut. There is a left facial droop. Left arm strength fluctuates between 1-3. Left leg strength from 2-3. Sensation to light touch and temperature is decreased on the left. She appears to be neglecting her arm. **Radiology**: Brain CT and CTA head/neck was done. Reports are reviewed. **Echocardiogram:** TTE EF 65%, LA diameter 4.3 cm, no RWMA or valvular abnormalities	32-41

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		EKG: Sinus rhythm with 1st degree AV block, LAFB (Left Anterior Fascicular Block) **Chest X-ray:** No infiltrate **Assessment:** Patient with HTN, HLD, DM on home regimen of dual antiplatelet therapy who presents with right MCA stroke. Etiology is probably athero thromboembolism from intracranial atherosclerosis (Calcification at distal M1 where the steno-occlusive disease is), although cannot rule out other causes such as cardio embolism at this point. **Plan:** **Neuro:** Ischemic Infarct-Initial NIHSS 13. Close monitoring and frequent neuro checks for signs of neurologic deterioration: worsening motor exam despite stable vessel imaging, could be due to evolution of stroke STAT head CT for any neurologic change Maintain systolic BP 140-180 mmHg Perform finger sticks every 6 hours, cover with insulin sliding scale Continue IV fluids Maintain normoglycemia, normothermia, and normovolemia Hold all antiplatelet/anticoagulants for 24 hours Check head CT 24 hours after TPA administered, if no bleed resume dual antiplatelet therapy/pharmacologic DVT prophylaxis. Increase Aspirin to 325 mg from 81 mg Start Crestor 40 mg for LDL < 70 Check transthoracic echocardiogram without bubble Bed rest for 24 hours, head of bed flat. Tomorrow, slowly liberate head of bed over hours until she is sitting up, monitor for fluctuating exam **Cardiovascular:** Hypertension, questionable CHF (Congestive Heart Failure) Continuous cardiac monitoring for arrhythmias Blood pressure and anti-platelet/anti-coagulation plan as above Follow-up cardiac echo Check Holter **Pulmonary:** NAD (No Acute Disease) No clinical evidence of pneumonia Stable on room air **Infectious disease:** Leukocytosis Currently no clinical evidence of infection Monitor white count and fever curve **Heme:** No acute disease. Monitor Hgb/HCT after IV TPA **FEN/GI:** Dysphagia	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Check formal speech evaluation Bowel regimen **Prophylaxis:** Continue sequential compressive devices No pharmacologic DVT prophylaxis given TPA within 24 hours **Disposition:** Patient discharge planning was discussed during interdisciplinary rounds **Attestation signed by Ting Zhou, M.D on 12/23/YYYY at 2154**: I saw and evaluated the patient. I discussed the case with the NP and agree with the NP's findings and plan as documented in the NP's note.	
12/23/YYYY	Hospital/Provider Name	**Admission history and physical examination report:** **Chief complaint:** Facial droop and slumped to left side **History of present illness:** Patient with past medical history of DM, HTN, HLD, CHF questionable. Was brought into the ER after her son noticed she was slumped to her left side and had a left facial droop at the time of onset, around 1930 pm suddenly with no shaking and was transferred from CIH to LMC for possible Neuro IR intervention. Her BP on admission was 124/58. He states at baseline she talks and is oriented, but does not walk due to arthritis. She reportedly did not have recent head trauma or bleeding, or similar episodes or CVA's in the past. She is on Aspirin and Plavix for unknown reasons. She was within 4 hours and was given TPA. Her BP was slightly elevated at 160's during infusion, was given a dose of Labetalol with fluctuating symptoms based on BP. **Diet:** Nil per oral **Physical examination:** **Neuro:** Mild left facial droop Motor: Right upper extremity 5/5, left upper extremity 3/5 right lower extremity 4/5 left lower extremity 3/5 Reflexes: +2 throughout, toes are upgoing on left **Diagnosis:** CVA (cerebral vascular accident) **Imaging:** CT of head, CTA head/neck and x-ray chest reports reviewed. **Impression:** Patient was brought into the ER after her son noticed she was slumped to her left side and had a left facial droop at the time of onset, around 1930 suddenly with no shaking and was transferred from CIH to LMC for possible Neuro IR intervention. Her BP on admission was 124/58. She was within 4 hours and was given TPA. Her BP was slightly elevated at 160's during infusion, was given a	51-61

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		dose of Labetalol with fluctuating symptoms based on BP. Labs significant for, CT shows focal hypodensities in right MCA (Mid-cerebral Artery), CTA shows short segment of distal right M1 and mild to mod atherosclerosis in bilateral proximal ICA's (Intracranial Artery), 57% stenosis of prox right ICA. MRI pending will admit to stroke unit for further workup. **Plan:** **Right MCA syndrome status post TPA:** CT shows focal hypodensities in right MCA CTA shows short segment of distal right M1 and mild to mod atherosclerosis in bilateral proximal ICA's Status post TPA, follow-up repeat CT in 24hrs Follow-up MRI If clinically worsens, IR will consider angio but not a candidate at this time with low NIHSS Hold Aspirin/Plavix/Heparin subcutaneous for 24-hrs Continue Statin Physical therapy/Occupational therapy/Speech therapy **Hypertension:** Permissive hypertension Hold home meds **Congestive heart failure questionable:** On Spironolactone, Carvedilol at home Will hold for now **Diabetes mellitus:** On Metformin, will hold Regular insulin sliding scale Follow-up A1C Discussed with stroke team. **Neuro endovascular fellow addendum:** This patient was seen and discussed with the stroke PA on service and discussed with the stroke attending on service, Dr. Zhou. The patient with multiple ischemic stroke risk factors detailed above who presented with right M1 cerebral artery occlusion and an elevated NIHSS of 12 within the window for thrombolytic therapy with IV TPA. She was appropriately bolused and infused for her weight and presentation. She was there after immediately taken to the neuro endovascular angio suite for emergent mechanical thrombectomy of the above mentioned right M1 occlusion.	
12/23/YYYY	Hospital/Provider Name	**Speech therapy notes:** Unable to evaluate due to medical status.	64

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Consult received. Chart reviewed. History taken. SLP attempted Clinical dysphagia evaluation, however upon room entry and discussion with MD Grayson, patient unable to evaluate 2 head of bed precautions. SLP to follow-up to assess swallow safety/function pending scheduling.	
12/23/YYYY	Hospital/Provider Name	**Physical therapy notes:** Unable to evaluate due to medical status. Patient's chart reviewed. Patient received t-PA early this am and therefore not appropriate for physical therapy evaluation at this time. Will follow-up when medically cleared to be seen by physical therapy.	64
12/23/YYYY	Hospital/Provider Name	**Occupational therapy notes:** Unable to evaluate due to medical status. Occupational therapy consult received. Chart reviewed. As per Dr. Grayson, patient unavailable for evaluation at this time 2° head of bed precautions. Initial occupational therapy evaluation to follow when appropriate.	65
12/23/YYYY	Hospital/Provider Name	**Echocardiogram:** **Indication**: CVA **Conclusion:** Technically difficult study. LV ejection fraction is normal. LVEF 65% The right ventricle is normal in size. The right ventricle has normal wall motion. There is mild aortic valve thickening. There is no aortic stenosis. There is mild mitral annular calcification. There is no mitral stenosis. There is no pericardial effusion.	304-306
12/23/YYYY	Hospital/Provider Name	**CT angio brain with contrast:** **Indication:** CVA or TIA **Impression:** Atherosclerotic changes of the vasculature. Interval recanalization of the proximal superior M2 segment of the right middle cerebral artery. Asymmetric decreased contrast opacification and irregular narrowing of the rest of the M2, M3 segments of the right middle cerebral arteries may be related to decrease vascular flow secondary to acute infarct seen on previous CT head, although vasospasm cannot be excluded. Further evaluation with conventional cerebral angiogram maybe of help, if clinically indicated. The findings were discussed with stroke PA Alexander on 12/23/YYYY at 1220. Official read back policy was followed.	326
12/23/YYYY	Hospital/Provider Name	**CT of head without contrast:** **Indication:** CVA or TIA **Impression:** Slight atrophy. Interval increase and evolution of acute right MCA	327

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		infarct, which now involves right temporal lobe, right insular cortex, right basal ganglia, right caudate nucleus and causes mass effect upon right lateral ventricle. Chronic right superior cerebellar infarct. Mild patchy low-attenuation areas noted within periventricular and subcortical white matter may represent sequela of chronic small vessel ischemic disease, although the findings are nonspecific. Atherosclerotic changes of intracranial vascular. Thrombus/embolus versus right middle cerebral artery mid M1 segment. Further evaluation with MRI of the brain maybe of help if clinically indicated.	
12/23/YYYY	Hospital/Provider Name	**X-ray of chest:** **Clinical indication**: 1.stroke code **Findings:** Osseous structures: Multilevel degenerative spondylosis of the thoracic spine. **Impression:** No active pulmonary disease. Bibasilar atelectasis.	328
12/23/YYYY	Hospital/Provider Name	**@ 0051 hrs: EKG:** **Result:** Accelerated junctional rhythm with premature ventricular complexes or fusion complexes, left anterior fascicular block, cannot rule out anterior infarct, age undetermined, abnormal EKG.	689-691
12/23/YYYY	Hospital/Provider Name	**@ 1445 EKG:** **Result:** Sinus rhythm with 1st degree A-V block with premature supraventricular complexes left anterior fascicular block, abnormal EKG.	399
12/23/YYYY	Hospital/Provider Name	**Holter monitor report:** **Indications**: CVA **Comments:** Patient was in sinus rhythm with a heart rate of 82-123 bpm. Rare multifocal VE (Ventricular Ectopy) singles and 2 couplets were recorded. Rare SVE (Supraventricular Ectopy) singles and one pair were noted. No diary submitted.	692-700
12/24/YYYY	Hospital/Provider Name	**Nutrition initial assessment note:** She was admitted with right MCA syndrome status post TPA 12/22, hypertension, questionable congestive heart failure, uncontrolled diabetes mellitus with hyperglycemia, leukocytosis. Noted patient failed, 12/24 SLP evaluation-per NP, the patient is status post nasogastric tube placement today 12/24, to start enteral feedings. **Current diet order:** Nil per oral. Met with patient at bedside, who is lethargic. Patient is status post insertion of nasogastric tube today, and per NP to start enteral feeding. Recommend when EN feasible to initiate Diabetisource AC at 30 ml/hr, advance rate as tolerated to	42-46

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		reach goal of 60 ml per hour (x 24 hrs to provide patient with 1728 kcal, 86.4 gm protein and 1181 ml tree H2O) to meet 100% daily estimated needs. Per RN, no GI distress noted at this time. Patient is lethargic and non-verbal-Unable to assess patient's weight history. Skin intact per RN, skin flow sheet, pain assessment reviewed. **Plan of care/recommendations:** Recommend to initiate Diabetisource AC at 30 ml/hour, advance rate as tolerated to reach goal of 60 ml/hr x 24 hours Maintain all aspiration precautions Additional free water flushes if needed, suggest 150 ml every 6 hours daily Goal-Optimize nutritional status, tolerate tube feed well, preserve lean body mass, patient-centered care Monitor nutrition-related labs, body weight, input/output, overall nutrition and hydration status	
12/24/YYYY	Hospital/Provider Name	**Speech therapy initial evaluation report:** **Pain assessment**: No pain. **Oxygen therapy:** Spo2 95%; O2 device nasal cannula 2 litre/minute **Functional level prior:** Communication: Understands/Communicates without difficulty Swallowing: Swallows foods and liquids without difficultly **Cognitive:** Level of consciousness: Lethargic Arousal level: Arouses to repeated stimulation **Clinical impression:** **SLP diagnosis:** Dysphagia. **Prognosis:** Fair. **Functional level at time of evaluation:** Impaired. **Rehab potential:** Fair, will monitor progress closely. **Therapy frequency:** 3-5 times/week **Predicted duration of therapy intervention:** Ongoing until discharge **Functional level current:** **Communication:** Difficulty speaking (not related to language barrier); Difficulty understanding (not related to language barrier) **Swallowing:** Difficulty swallowing liquids; difficulty swallowing foods **Subjective:**	77-82

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		Patient seen bedside for a clinical dysphagia evaluation. Patient received asleep, however arousable to max noxious stimuli. Patient's son present in the room for evaluation to provide Live Russian interpretation along with Pacific Line interpreters. **Objective:** Respiratory status: Impaired Current diet: Nil per oral with alt means of nutrition/hydration as appropriate Oral care administered as per clinical practice guidelines. **Oral peripheral examination:** Lips: Structure: Left sided asymmetry Strength: Decreased Function: Decreased range of motion **Assessment:** Patient seen bedside for a clinical dysphagia evaluation. Patient is Alert & Oriented x 2 (person and place) and follows 1-step commands. Patient received asleep, however arousable to max noxious stimuli. Patient noted with a hoarse vocal quality at baseline and left-sided facial asymmetry. Patient without complaint of pain. Aggressive oral care provided prior to oral trials of: Ice chips (x 3), thin liquids (x 2), nectar-thick liquids (x 2), and puree (x 3). Patient fed via cup and teaspoon delivery by SLP 2 upper extremity weakness. Patient presents with clinical evidence of an oropharyngeal dysphagia characterized by decreased orientation/reception to teaspoon, which improved given max multimodal cues. Patient with decreased AP transport and increased OTT across textures. Pat6ient with a suspected delay in pharyngeal swallow trigger and diminished hyolaryngeal elevation/excursion upon palpation across textures. Overt clinical signs/symptoms of penetration/aspiration included: Wet/gurgle vocal quality across all trials (ice chips, thin, nectar, and puree), throat clear with ice chips (x 2), thin (x 1), and puree (x 1), and an increase in work of breathing as evidenced by clavicular breathing across all trials. Patient also noted with increased lethargy and fatigue as assessment progressed. Given overt clinical signs/symptoms of penetration/aspiration, and increased lethargy, pt deemed at high aspiration risk for all oral intake at this time. SLP to continue to follow-up to monitor candidacy for oral intake pending scheduling. **Recommendations:** Diet consistency: Nil per oral with alt means of nutrition/hydration as appropriate Swallow guidelines: Non-oral feeder, aspiration precautions, head of bed 30 degrees, implement Oral care before/after all meals and frequent oral suctioning. **Plan of care:** Patient would benefit from skilled speech therapy services to improve: Swallow safety/function	

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		Next treatment session: Follow-up bedside, speech, language, and cognitive linguistic evaluation, monitor candidacy for oral intake and dysphagia treatment Consult with: Neurology, nutrition and pulmonology Treatment frequency: 3-5 times a week for 30 minute sessions **Patient/family education and home exercise program:** Aspiration precautions Oral care Role of speech-language pathologist Dietary modification Safe swallowing guidelines **Discharge plan:** Post inpatient hospitalization, in consultation with the physician, patient/family, interdisciplinary team, and case manager and pending insurance approval, the patient would benefit from: TBD pending further assessment and discussion with interdisciplinary team.	
12/24/YYYY	Hospital/Provider Name	**Physical therapy notes:** Other (see comments); patient/family decline, not feeling well Orders received, charts reviewed I attempted to see patient. Patient was very lethargic and unable to participate with physical therapy. Patient's family at bed side. Patient taught ankle pumps and was encouraged to do them. Physical therapy will follow patient tomorrow.	83
12/24/YYYY	Hospital/Provider Name	**Occupational therapy initial evaluation:** **Subjective:** "Son states he would like his mom to be home again" **Objective:** Patient encountered supine in bed: With: Home exercise program lock and SCDs bilateral length of time off: 30 minutes for evaluation. **Observation:** Posture: Laterally flexed to right side Skin: Positive Heparin lock Edema: None as per clinical observation **Vision screening**: Impaired for fixation, visual field and pursuits 2° cognition **Cognitive/perceptual skills:** Deficits noted in: Attention Memory Safety awareness Praxis Spatial relations	83-91

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		Organization Sequencing Unilateral body neglect Perseveration Kinesthesia Proprioception Right/left discrimination Initiation Termination Problem solving Topographical orientation **Endurance:** Poor: Symptoms may be present at rest; if any physical activity is undertaken, distress is increased. Standing tolerance less than one minute **Range of motion:** AROM (Active Range of Motion): Right upper extremity: Within functional limits grossly throughout Left upper extremity: Unable to formerly evaluate 2 left side weakness; patient unable to raise arm PROM (Passive Range of Motion): Right upper extremity: Within functional limits grossly throughout Left upper extremity: Within functional limits grossly throughout **Strength:** Right upper extremity: 4/5 grossly throughout Left upper extremity: 3+/5 hand, unable to formerly evaluate all other joints 2 left side weakness; patient unable to raise arm **Hand function:** Right hand: Grasp 4/5; range of motion within functional limits grossly throughout. Left hand: Grasp 3+/5; coordination/opposition: Unable to formerly evaluate all other joints 2 left side weakness; patient unable to raise arm; range of motion within functional limits grossly throughout. **Assessment:** Patient is admitted to NYU Lutheran status post cerebrovascular accident. Patient presents with decreased strength, balance, endurance, coordination, active range of motion, cognition, perception, and safety, self-care tasks, which impacts independence in all areas of activity of daily livings, functional transfers, and functional mobility. Patient will benefit from occupational therapy skilled services to address above impairments and increase safety and independence throughout. **Plan:**	

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		Patient will benefit from skilled occupational therapy including: Activity of daily living retraining Caregiver training Cognitive retraining Community reintegration Durable medical equipment assessment and provision Fine motor/gross motor activities Functional task training Mental training Neuromuscular education Patient and family education Repetitive task training Strength training Therapeutic activities **Treatment frequency:** 5 days/week x 30 minutes. **Discharge recommendation**: Post-inpatient hospitalization, in consultation with the physician, patient/family and case manager and pending insurance approval, the patient would benefit from: TBD pending further assessment.	
12/24/YYYY	Hospital/Provider Name	**Procedure report:** She underwent nasogastric tube placement for dysphagia.	93-94
12/24/YYYY	Hospital/Provider Name	**@ 1410 X-ray of chest:** **Clinical indication**: To confirm NGT (Nasogastric Tube) placement. **Findings/impression:** Interval placement of enteric tube which courses along the mediastinum below the from outside field of view. No evidence of consolidation, pleural effusion or pneumothorax. Atelectatic streaking in the left lower lung. Cardiac silhouette is normal in size.	323-324
12/24/YYYY	Hospital/Provider Name	**@ 1726 hrs: X-ray of chest:** **Clinical indication**: To confirm NGT (Nasogastric Tube) placement **Findings/impression**: Enteric tube extends into the abdomen, with tip projecting in the right upper quadrant. The lung apices are cut off the film limiting the study. Linear densities right lung base likely represent areas of linear atelectasis. No definite focal airspace consolidation or gross effusion. Cardiomediastinal silhouette is enlarged, although likely stable in size given differences in technique.	323
12/24/YYYY	Hospital/Provider Name	**CT of the head without contrast:** **History:** Follow-up cerebrovascular accident. **Impression:**	325

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		Evolving acute right middle cerebral artery territory infarct without evidence for new infarct or hemorrhagic conversion.	
12/25/YYYY	Hospital/Provider Name	**Endocrinology consultation report:** **Reason for consultation:** Hyperglycemia The patient is admitted for cerebrovascular accident. Patient has diabetes mellitus diagnosed in 1986. At home she was taking 70 units of Lantus daily, Metformin and Glimepiride. Currently patient is on continuous NGT feeding at 50 ml/hr and getting NovoLog coverage alone. Fasting sugar are all below 200. **Physical examination:** Left hemiparesis **Impressions and recommendations:** Initial diagnosis: Diabetes-2, uncontrolled Therapeutic interventions: Add Lantus 15 units every night. Continue correction with NovoLog. D5 IV if tube feeding is interrupted.	46-51
12/25/YYYY	Hospital/Provider Name	**Physical therapy notes:** Patient unavailable for evaluation Consult received. Chart reviewed. As per discussed with RN Arfa patient out of the room for a follow-up MRI. On hold for physical therapy secondary to above reason. Will follow-up for full evaluation	107
12/25/YYYY	Hospital/Provider Name	**MRI of the brain without contrast:** **Clinical indication**: CVA. Present with left-sided weakness and left facial droop. Follow-up examination. **Findings:** There is a confluent area of reduced diffusion involving the right striatum (caudate and lentiform nuclei), right insula, and right temporal lobe, with additional scattered punctate foci involving the cortex and subcortical white matter of the right frontal and parietal lobes. There is mild cerebral swelling with mild effacement of regional sulci, and mass effect by swollen striatum over the right lateral ventricular frontal horn. There are patchy areas of susceptibility within the right caudate head and lentiform nucleus, consistent with blood products. There are confluent periventricular and numerous scattered white matter 2/FLAIR hyperintensities, likely a result of chronic microvascular ischemic disease. There is mild paranasal sinus disease predominately in the left ethmoid air cells. The mastoids are largely clear.	324-325

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		Impression: Acute infarcts involving the right MCA territory. Blood products in the right caudate head and right putamen suggest hemorrhagic conversion.	
12/26/YYYY	Hospital/Provider Name	**Physical therapy initial evaluation:** **Precautions:** Falls/safety Aspiration/dysphagia Left arm precaution **Subjective:** The patient agreeable to physical therapy interventions; complains of dry mouth requested water. The patient is nil per oral. **Objective**: With: Foley catheter, Heparin lock, nasal cannula 2-litre/min, NGT (Nasogastric Tube)/Dobbhoff and SCDs (Sequential Compression Devices) bilateral length of time off: 30 minutes **Observation:** Posture: Kyphotic Skin: Areas seen intact Edema: Left hand and forearm, swelling noted **Endurance:** Poor: Comfortable at rest, light non-resistive activity of brief duration causes fatigue, palpitation, dyspnea or pain. Standing tolerance 1-3 minutes **Strength:** Upper extremity: Right upper extremity grossly 3/5; left upper extremity: 0/5 Lower extremity: Right lower extremity grossly 3/5 ; left hip flexion 3-/5; left hip IR/ER 2/5 **Functional independence measure (FIM):** Bed mobility: Total assistance (Patient can perform less than 25% of the task or requires more than one person to assist). Comment: The patient required maximum assist x 2 for lifting and lower of bilateral lower extremity and trunk from supine to sit at edge of bed and back. Transfers: Unable to perform at this time secondary to safety Ambulation: Patient has been wheelchair dependent for 12 years. Gait assessment: Unable to assess **Assessment:** patient is presenting with left sided weakness secondary to right inferior cerebellar infarct. Patient is total A in bed mobility and cannot sit independently at edge of bed, slumps to left side. Patient is able to voluntarily IR/ER left hip and flex left knee while in supine position, but cannot voluntarily move left upper extremities. Patient will benefit from physical therapy interventions to address above mentioned impairments and improve QOL (Quality of Life). Prior to admission the patient was wheelchair bound and did	131-138

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		not ambulate. Will not qualify for Subacute rehab secondary to no restorative goal. **Plan:** **The patient could benefit from skilled physical therapy including:** Bed mobility training, transfer training, Home Exercise Program (HEP), patient and family education. **Treatment frequency:** 5 days/week x 30 minutes **Discharge recommendation:** In consultation with the physician, patient/family and case manager and pending insurance approval, the patient would benefit from: Other: SNF Vs home with 24 x 7 HHA (Home Health Assist) and home physical therapy.	
12/26/YYYY	Hospital/Provider Name	**@ 1312 hrs: X-ray of chest:** **Clinical indication**: Shortness of breath. **Findings/impression:** The patient is rotated to the right. Enteric tube is again seen extending below the diaphragm outside the field-of-view. The cardiac silhouette is suboptimally evaluated on this examination. Degenerative changes of the thoracic spine are again seen. There is right small pleural effusion. Stable basilar atelectasis. No evidence of large consolidation or pneumothorax.	321
12/26/YYYY	Hospital/Provider Name	**@ 0515 hrs: X-ray of chest:** **Clinical indication**: Fever. **Findings/impression:** Orogastric tube below the diaphragm. Limited examination by portable technique and patient rotation. Mild bibasilar atelectasis/vascular congestion. No pleural effusion or pneumothorax. Cardiomediastinal silhouette is suboptimally evaluated on this examination. Degenerative changes of the spine.	321-322
12/26/YYYY	Hospital/Provider Name	**X-ray of abdomen:** **History:** Fever. **Findings**: An Orogastric tube is seen at the left upper abdomen. The colon is redundant. Gas and stool is seen throughout the colon. Possible fibroid uterus. Degenerative changes of the spine. **Impression:** Limited examination. Recommend abdominal series or CT if there is concern for abdominal pathology.	322
12/23/YYYY-12/26/YYYY	Hospital/Provider Name	**Culture report:** **12/23/YYYY: Urine culture:** Bacteria negative	339, 356, 366-367

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		12/24/YYYY: Blood culture: No growth **12/26/YYYY: Urine culture:** Bacteria positive. Greater than 100,000 CFU/ml Escherichia coli.	
12/27/YYYY	Hospital/Provider Name	**X-ray of chest:** **Clinical indication:** 1. Confirm NG tube placement **Findings/impression:** The enteric catheter course into the left upper abdomen, the tip is not imaged. Cardiomediastinal silhouette and hilar contours are within normal limits. There is no overt pulmonary edema. Minimal bibasilar atelectasis noted. No pneumothorax or discernible pleural effusion.	320
12/26/YYYY-12/27/YYYY	Hospital/Provider Name	**Interim physical therapy summary:** **Therapies given:** Bed mobility training; transfer training, Home Exercise Program (HEP), patient and family education, therapeutic exercise, therapeutic activities *She received physical therapy on following dates: 12/26/YYYY; 12/27/YYYY.* ***No of completed visits**: 2*	131-138, 187-190
12/24/YYYY-12/28/YYYY	Hospital/Provider Name	**Interim occupational therapy summary:** **Therapies given:** Care giver training, cognitive retraining, mental training, neuromuscular education, patient and family education, task training, strength training, therapeutic activities, activity of daily living training, functional task training *She received occupational therapy on following dates: 12/24/YYYY; 12/25/YYYY; 12/26/YYYY; 12/28/YYYY.* ***No of completed visits**: 4.*	83-93, 108-111, 149-155, 179-180, 223-228
12/29/YYYY	Hospital/Provider Name	**X-ray of swallow study:** **Clinical indication**: Rule out aspiration **Findings**: Study performed using liquid barium, thick barium, semisolid and solid food. **Impression and recommendations**: Please refer to speech pathology report.	319-320
12/24/YYYY-12/29/YYYY	Hospital/Provider Name	**Interim speech therapy summary:** **Therapies given:** Speech, language, cognitive linguistic, oral care, safe swallowing guidelines, patient and family education *She received speech therapy on following dates: 12/24/YYYY; 12/26/YYYY; 12/27/YYYY; 12/28/YYYY; 12/29/YYYY.*	77-82, 152-156, 175-187, 218-223, 247-252

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		No of completed visits: *5.*	
12/30/YYYY	Hospital/Provider Name	**Endocrinology progress notes:** **Chief complaint:** Follow glycemic control. **Subjective:** No hypoglycemic events overnight. Patient is on diabetic diet, minimal per oral intake however. Planned for discharge this afternoon. **Vitals:** BP 155/58. **Physical examination:** Skin: Normal turgor, no rash. Eyes: Right gaze preference. Neuro: Left-sided hemiparesis. **Impression and recommendations:** Diabetes mellitus type II, uncontrolled. Can discharge home on home dose Lantus 17 units, Metformin 1000mg twice daily. **Attestation:** Diabetes mellitus type II controlled. Continue same therapy. The patient may be discharge home on Lantus 15 units daily, Prandin 1mg thrice daily, Metformin 500mg twice daily.	284-287
12/22/YYYY-12/30/YYYY	Hospital/Provider Name	***Hospitalization related records:*** *Progress notes, nursing notes, orders, flow sheets, assessment, labs* *Ref: 61-63, 65-77, 82-83, 94-108, 111-131, 138-149, 156-175, 187, 190-218, 228-247, 253-283, 9-10, 287-303, 21-22*	
12/30/YYYY	Hospital/Provider Name	**Neurology stroke discharge narrative:** **Date of admission:** 12/22/YYYY. **Indication for admission:** Ischemic stroke. **Admission condition:** Poor. **Date of discharge:** 12/30/YYYY. **Discharged condition:** Fair. **Disposition:** Home with services: MJHS Occupational therapy/physical therapy. **Principal problems:** Cerebral vascular accident.	10-20

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		Active problem: Cerebral vascular accident. Hyperglycemia. **History of present illness/hospital course:** This is a 76 year-old-obese female, right handed with a past medical history of hypertension, hyperlipidemia, diabetes mellitus, presented with left-sided hemi-paresis was transferred from Coney Island Hospital for right MCA syndrome. NIHSS 13, status post IV TPA at Lutheran, and was not a candidate for mechanical thrombectomy since CTA showed right M1 steno occlusive disease, 57% stenosis of proximal right ICA (Intracranial Artery). She presented with a with a past medical history significant for hypertension, hyperlipidemia and diabetes mellitus type II who was transferred from Coney Island Hospital admitted to the neurology service at NYU Lutheran Medical Center on 12/22/YYYY with Ischemic Stroke Patient was last seen normal at 7:30 am on 12/22/YYYY. Upon arrival to the emergency department, exam was notable for left arm weakness, left leg weakness and left facial droop. NIHSS was 13. A head CT was obtained and revealed evolving right MCA territory, CTA showed right M1 steno occlusive disease, 57% stenosis of proximal right ICA. TPA was given. Initial management of the patient included given ischemic stroke/TIA-Post-TPA: maintaining SBP <180/105, maintaining bleeding precautions, holding all anticoagulants and antiplatelets for 24 hours after TPA administration and obtaining 24-hour post-TPA head imaging, insulin sliding scale to maintain normoglycemia, administration of IV fluids, maintenance of normothermia and normovolemia, administration of Aspirin and administration of statin therapy. **Further work up revealed:** *Stroke labs: A1c 8.0, TC/LDL/HDL 170/109/39.* *CT angio head/neck with and without IV contrast & CT of head without contrast results reviewed.* *MRI of brain without IV contrast dated 12/25/YYYY reviewed.* *Swallow study dated 12/29/YYYY reviewed.* *X-ray of abdomen dated 12/26/YYYY reviewed.* The patient's symptoms were thought to be secondary to an ischemic stroke. The etiology of the ischemic stroke was thought to be large vessel disease with 57% stenosis of the right carotid. Management of an ischemic stroke risk was with Aspirin, Plavix, and Statin therapy with Lipitor 80 mg and aggressive blood pressure control with a goal	

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		SBP < 140/90. Further workup includes: Long-term cardiac monitoring to look for paroxysmal atrial fibrillation. Other medical issues addressed during this hospitalization included the following: Urinary tract infection: The patient was found to have a positive UA and urine culture showing a positive E. Coli urinary tract infection. It was treated with Unasyn 1.5g. The patient was evaluated by physical therapy and is recommended for home physical therapy/occupational therapy. The patient has reached maximal benefit from this hospitalization and is being discharged to Home with services: MJHS PT (Physical Therapy)/OT (Occupational Therapy). The patient was noted to have the following risk factors and during the admission was given the following counseling: **Hypertension**: The patient should continue all antihypertensives as instructed and was counseled to work with their primary care physician in order to achieve a goal blood pressure under 140/90. **Hyperlipidemia**: The patient was started on statin therapy with a goal LDL < 70. The patient was counseled on the importance of medication compliance, regular visits with their primary care physician and lifestyle modifications such as weight loss and regular exercise in reaching their goal LDL. **Diabetes**: The patient was found to have a hemoglobin A1c of 8. The patient was counseled to work with their primary care physician in order to better manage their glucose and lower their hemoglobin A1c to a goal < 7.0. The patient was counseled about the importance of lifestyle factors in stroke prevention including refraining from tobacco use, diet (Mediterranean diet) that emphasizes vegetables, fruits, and whole grains and includes low-fat dairy products, poultry, fish, legumes, olive oil, and nuts while limiting intake of sweets and red meats, moderate- to vigorous-intensity aerobic physical exercise lasting at least 40 minutes 3-4 times per week, adequate glucose control with goal, medication compliance, and consistent outpatient follow-up for monitoring of blood pressure, glucose levels and lipids with a goal blood pressure under 140/90, hemoglobin A1c < 7 0 and goal LDL under 70. We also discussed the importance of adequate hydration and making sure to drink eight eight-ounce glasses of water daily. We discussed general symptoms that should prompt immediate presentation to the emergency department for evaluation of acute stroke including: sudden onset of focal weakness, numbness difficulty with speech production or comprehension, slurred speech, visual changes, gait imbalance, and/or sudden/ severe headache.	

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		Physical examination: **General:** Diaphoretic. **Lungs:** Mild wheezing noted on right. **GU:** Foley catheter in place with clear, yellow urine. **Extremities:** Edema in left hand. **Skin:** Bruising in left upper extremity, texture, turgor normal. Skin abrasion in right upper scapula. **Neurological examination:** Mental status: State: Positive anosognosia. Language: Speech is mildly dysarthric. **Cranial nerves:** CN I: Deferred CN II: Visual fields intact to confrontation, pupils are equal, round and reactive to light and accommodation: Left pupil 2mm; Right pupil 2mm CN III, IV, VI: Normal, extraocular muscles are intact, right gaze preference, doesn't cross midline, left gaze neglect, no ptosis is present, palpebral fissures are symmetric and no nystagmus is present. CN V: Deferred CN VII: Left nasolabial fold. CN VIII: Deferred. CN IX, X: Normal, palate rises symmetrically, and uvula is midline CN XI: Deferred CN XII: Deferred **Motor:** Upper extremity strength: Full 4/5 right, left 0/10 Lower extremity strength: Full 2/5 bilaterally **Reflexes:** **Upper extremities:** Biceps (C5/6): Right 2+/4 and Left 1+/4 Triceps (C7/8): Right 2+/4 and Left 1+/4 Brachioradialis: Right 2+/4 and Left 1+/4 **Lower extremities:** Patellar (L3/4): Right 2+/4 and Left1+/4 Achilles (S1/2): Right 2+/4 and Left1+/4 Left lower extremity triple flexion **The patient was discharged on:**	

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		Start taking these meds: Albuterol 90mcg/at inhaler inhale 2-puffs every 4 hours as needed for shortness of breath, Cipro 250mg every 12 hours x 3 days, Ticagrelor 60mg two times daily x 30 days **Continue taking these meds:** ASA 81mg chewable, Coreg 25mg, Isordil 30mg, Insulin Glargine 100/ml soln injection, Amitiza 24mcg, Glucophage 1000mg, Omeprazole 40mg, Aldactone 25mg. **Stop taking these meds:** Plavix 75mg.	
12/30/YYYY	Hospital/Provider Name	**Skilled nursing home initial visit:** **Assessment type:** HCP, patient not seen. **Medical history:** Asthma, cerebrovascular accident, type II diabetes mellitus, hyperlipidemia, hypertension. **Description of clinical illness:** She was admitted to NYU Lutheran status post cerebrovascular accident presenting with left sided weakness secondary to right inferior cerebellar infarct. The patient presents with decreased strength, balance, endurance, coordination, AROM, cognition, AROM, cognition, perception and safety, self-care tasks, which impacts independence in all areas of ADLs, functional transfers, and functional mobility. Patient is now medically cleared for discharge and will be discharged home with homecare services. MD is requesting RN to conduct a comprehensive clinical assessment of all home care needs, provide medication teaching, disease process management, home safety and to reinforce adherence to medication/dietary regimen and to evaluate for physical therapy services. **Physician ordered plan of care:** The patient's condition has been discussed and there is agreement as to the plan of care between the home health agency staff and the physician. Enter Physician's name and phone: Tiwari, Ambooj. Hospitalist, name of physician who will supervise the patient's home health services in the community: Tiwari, Ambooj. **Skilled nursing:** Skilled assessment/observation, visit frequency: 1-2/week x 6-weeks. Assess cardio-pulmonary status including assessing/monitoring weight status as applicable, assess/monitor/mitigate pain, assess safety/functional status/implement fall prevention interventions, instruct medications, precautions and adverse effects, instruct diabetes care including, but not limited to diabetes foot care, including the monitoring for the presence of skin lesions on the lower extremities and patient/care giver education on proper foot care, instruct on diabetes management, blood glucose monitoring, signs and symptoms of hypo/hyperglycemia, interventions to prevent pressure ulcers. **Meds:** CHN to verify meds in home against the patient's discharge med summary list and reconcile with PMD (Primary Medical Doctor).	703
12/31/YYYY	Hospital/Provider Name	**Home health certification and plan of care:**	704-706

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Other pertinent diagnosis: Other sequelae of cerebral infarction Muscle weakness (Generalized) Dysphagia following cerebral infarction Urinary tract infection, site not specified **Durable medical equipment and supplies:** Wheelchair, hospital bed, commode, incontinence supplies, glucometer, lancets, strips. **Nutrition:** Pureed, nectar thick liquids, diabetic diet portion. **Functional limitations:** Bowel/bladder (Incontinence), endurance. **Activities permitted:** Up as tolerated. **Safety measures:** 24-hour supervision, avoid respiratory irritations, avoid constricting clothing, change position slowly, functional **Prognosis:** Fair. **Orders for discipline and treatments:** SN 12/31/YYYY 1 x day x 7 days At the conclusion of services, a discharge summary will be available upon request Assess pain level every visit using appropriate standardized scale Perform falls/risk assessment and provide patient/PCG with related teaching materials Instruct patient/PCG in medical appointment follow through, reportable signs/symptoms to call MD/911 Instruct patient/PCG in proscribed diet Pureed, nectar thick liquids, diabetic diet portion controlled, low fat/low cholesterol, 2gm Na, no fluid restrictions. Assess vital signs: BP, Temp, Pulse, RR Assess temp and inform M.D. of Temp greater than 101 Assess BP and Inform M.D. of BP greater than or equal to 150/90 Assess BP and inform M.D. of BP less than 90/60 Assess pulse and inform M.D. of pulse greater than 100 bpm Assess pulse and inform M.D. of pulse less than 50 bpm Assess Respirations find inform M.D. of respirations greater than less than 12: more than 24 resp/min **Diagnoses:** Diabetes mellitus Hypertension Debility Asthma Hyperlipidemia Long-term use of current oral hypoglycemic drugs Long-term current use of insulin	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Wound care orders: Sacrum pressure ulcer-Keep the site dry and clean, apply moisture barrier twice daily and as needed, reposition patient every 2 hours and as needed. **Physical therapy:** 1-2 times per week for 6-weeks. Physical therapist to perform evaluation visit. Instruct patient/care giver in therapeutic exercise, home exercise program and home safety/fall prevention Assess/instruct patient/care giver in activities of daily living **Occupational therapy:** 1-2 times per week for 6-weeks. Occupational therapist to perform evaluation visit Instruct patient/care giver in therapeutic exercise, home exercise program and home safety/fall prevention Assess/instruct patient/care giver in activities of daily living	
12/31/YYYY	Hospital/Provider Name	**Skilled nursing routine visit:** **Functional status:** **Activities of daily living/Instrumental activities of daily living:** Totally dependent - Bathing-Sponge Totally dependent - Bathing tub/shower Totally dependent - Grooming Totally dependent - Toileting Totally dependent - Dressing Totally dependent - Ambulating Totally dependent - Transfers Totally dependent - Bed mobility Totally dependent - Eating Totally dependent - Food preparation Needs assist - Use of telephone **Braden scale:** 11 (High risk). **Skin:** Skin integrity: Non-surgical wound Skin character: Normal See incision/wound assessment. Indicate the number of incision/wound sites: 1. Skin color and warmth-extremities: Upper, lower-No abnormalities noted. **Skin/wound education:** Instructed on: Pressure relief measures, wound disease process, standard precautions, friction/shear relief measures, incontinence management, and nutrition to foster wound healing. **Physical/skin/incision/wound:** Site location: Specify location: Site #1-Sacrum pressure ulcer Type: Pressure ulcer	723-731

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Pressure ulcer stage: Stage 1 Healing: Other: N/A Wound measurement: Length in centimeters: 5.7, width in centimeters: 5 Incision/wound tissue observed: Epithelial Surrounding tissue: Erythema Wound margins: Tunneling absent Drain site and type: None Drainage: None Dressing changed this visit: No	
12/31/YYYY	Hospital/Provider Name	**Skilled nursing plan of care:** **Primary reason and goal for home care:** Diabetes mellitus, cerebrovascular accident. **Other pertinent diagnoses for home care:** Hypertension, hyperlipidemia, debility. **Level of risk for re-hospitalization:** Moderate. **Knowledge deficits:** Patient/care giver require teaching on the disease process, prescribed medications, daily insulin administration, all aspect of diabetes mellitus management, skin care, PU prevention, pain management, prescribed diet restrictions, aspiration precautions, fall/safety precautions, emergencies reportable to PMD/911 services, follow-up appointments compliance. Medications regimen reviewed with the patient/care giver (Indications, frequency, significant side effects); verbalizes understanding; further teaching required. Detailed list of medications provided; patient's daughter pre-pours medications for the patient weekly. Patient's daughter requires teaching on Insulin administration. Patient's previously independent, but not able to perform injection due to left-sided weakness. Today PCG (daughter) observes insulin administration procedure today; instructed in the technic, clean technic, sharps disposal, sites rotation; further teaching required. **Functional deficits**: Patient's previously transferable to wheelchair and commode; with left-sided weakness after the recent cerebrovascular accident and bed-bound at this time; requires total care. Patient has PCW services 24/7 from Guild-Net for assistance with all her needs. Daughter Bella visits daily. **Discharge plan**: Patient's to be discharged to family/PMD/Long-term program after the CHHA episode. **MD contact**: M.D. Tiwari contacted (paged) for plan of care, meds verification; not available due to holidays; will follow-up. **Parameters verified with MD:** BP: More than 150/90; less than 90/50 Pulse: More than 100 bpm; less than 50 bpm	718

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Temp: 100.4. RR: Less than 12; more than 24 resp/min Blood glucose (when appropriate): More than 250 mg/dl; less than 70 mg/dl **Wound status/measurements and wound care ordered:** Patient's noted with pressure ulcer stage I to sacrum area 5.3 x 5cm; CGs instructed on skin care, repositioning, incontinence management, and moisture barrier application; state understanding. **Disciplines needed/reason and frequency:** Skilled nursing 1 x day x 7. Will follow-up for physical therapy and occupational therapy evaluation with M.D. after the holidays.	
12/31/YYYY	Hospital/Provider Name	**Nurse notes:** Returned call from Dr. Tiwari; physical therapy, occupational therapy evaluation approved and assigned accordingly.	718
12/31/YYYY	Hospital/Provider Name	**Order:** **Care team:** Home care planner: Catherine Bell Case manager: Irina Gornak Admission RN: Ioulia Cheiko **Medical diagnosis:** Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side Other sequelae of cerebral infarction Muscle weakness (Generalized) **Safety:** 24-hour supervision, avoid respiratory irritations, avoid constricting clothing, change position slowly, Functional placement of furniture, transfer and ambulation with assistive device, standard precautions, Anti-coagulant precautions, person assist for transfer, remove outdated medications, side rails up at all times, use nightlights. **Diet:** Pureed, nectar thick liquids, diabetic diet portion controlled, low fat/low cholesterol, 2gm Na, no fluid restrictions. **DME (Durable Medical Equipment)/supplies:** Wheelchair, hospital bed, commode, incontinence supplies, glucometer, lancets, strips **Functional limits:** Bowel/bladder (incontinence), endurance, Other: General weakness, risk for fall, left-sided weakness **Activities permitted:** Up as tolerated, transfer bed/chair, exercises prescribed **Mental status:** Oriented.	702

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Prognosis: Fair.	
01/01/YYYY	Hospital/Provider Name	**Skilled nursing routine visit:** **Physical/clinical monitoring:** Lower extremity edema: Mid-calf, ankle, instep. Abdomen: Active bowel sounds all 4 quadrants, regular bowel pattern, normal stool, abdomen not distended. GU: Voiding method: Incontinent-Total Voiding pattern: Normal **Nutrition:** Nutritional assessment: Good appetite Hydration: Good Meal Pattern: 3 meals/day Knowledge/compliance with prescribed diet: Requires more instruction **Physical/skin/evaluation:** Incision/wound assessment. Indicate the number of incision/wound sites: #1. Skin color and warmth-extremities: Upper, lower-No abnormalities noted. Skin assessment: Skin/wound education. Instructed on: Pressure relief measures, standard precautions, friction/shear relief measures, incontinence management Instructions: Patient, primary care giver, other-Verbal instruction given to Patient, primary care giver, other-Needs reinforcement **Wound:** Site location: Specify location: site #1-Sacrum pressure ulcer Type: Pressure ulcer Pressure ulcer stage: Stage 1 Healing: Not healing Wound measurement: Measure weekly Incision/wound tissue observed: Beefy red Surrounding tissue: Erythema Wound margins: Tunneling absent, undermining absent Drain site and type: None Drainage: None Dressing changed this visit: No	732-735
01/01/YYYY	Hospital/Provider Name	**Skilled nursing notes:** CHN continue to teach PCG how to use blood sugar glucometer and insulin administration. CHN instructed PCG on proper handwashing technique and aseptic technique. PCG still needs a lot of teaching will follow up on next visit.	717

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		PCG is very anxious, afraid that doesn't do good job needs an additional teaching until she will comfortable.	
01/02/YYYY	Hospital/Provider Name	**Skilled nursing routine visit:** **Assessment:** **Lower extremity edema:** Mid-calf, ankle and instep. **Abdomen:** Active bowel sounds all 4 quadrants, regular bowel pattern, normal stool, abdomen not distended. **Nutrition:** Nutritional assessment: Good appetite Hydration: Good Meal pattern: 3 meals/day Knowledge/compliance with prescribed diet: Requires more instruction **Skin:** Incision/wound assessment. Indicate the number of incision/wound sites: 1. Skin/wound education. **GU:** Voiding method: Incontinent: Total Voiding pattern: Normal **Wound:** Site location: Specify location: Site #1-Sacrum pressure ulcer Type: Pressure ulcer Pressure ulcer stage: Stage 1 Healing: Not-healing Wound measurement: Measure weekly Incision/wound tissue observed: Beefy red Surrounding tissue: Erythema Wound margins: Tunneling absent, Undermining absent Drain site and type: None Drainage: None Dressing changed this visit: No	736-739
01/02/YYYY	Hospital/Provider Name	**Skilled nursing notes:** CHN continue to teach and reinforce PCG on use blood sugar glucometer and insulin administration. CHN reinstructed PCG on proper handwashing technique, aseptic technique and sharps disposal. PCG still needs some teaching and re-enforcement. CHN will follow next visit.	717
01/03/YYYY	Hospital/Provider Name	**Skilled nursing routine visit:** **Assessment:** **Lower extremity edema:** Mid-calf, ankle and instep. **Abdomen:** Soft, non-tender.	740-743

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Nutrition: Nutritional assessment: Good appetite Hydration: Poor. Meal pattern: Small frequent meals. Knowledge/compliance with prescribed diet: States compliance with prescribed diet, requires more instruction **Skin:** Incision/wound assessment. Indicate the number of incision/wound sites: 1. Skin/wound education. **GU:** Voiding method: Incontinent: Functional Voiding pattern: Normal **Functional status:** **Activities of daily living/instrumental activities of daily living:** Totally dependent - Bathing-Sponge, Totally dependent - Bathing Tub/shower, Totally dependent - Grooming, Totally dependent - Toileting, Totally dependent - Dressing, Totally dependent - Ambulating, Totally dependent - Transfers, Totally dependent - Bed mobility, Totally dependent - Eating, Totally dependent - Food preparation, Needs assist - Use of telephone Instructed on: Home safety modifications/precautions, use/care of assistive devices, transfer techniques Instructions: Patient, primary care giver, other-Verbal instruction given to **Wound:** Site location: Specify location: Site #1-Sacrum pressure ulcer Type: Pressure ulcer Pressure ulcer stage: Stage 1 Healing: Not-healing Wound measurement: Measure weekly Incision/wound tissue observed: Beefy red Surrounding tissue: Erythema Wound margins: Tunneling absent, Undermining absent Drain site and type: None Drainage: None Dressing changed this visit: No	
01/04/YYYY	Hospital/Provider Name	**Skilled nursing routine visit:** **Assessment:**	744-747

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Lower extremity edema: Knee, mid-calf, ankle and instep. **Abdomen:** Distended. **Nutrition:** Nutritional assessment: Good appetite Hydration: Good. Meal pattern: Small frequent meals. Knowledge/compliance with prescribed diet: Requires more instruction **Skin:** Incision/wound assessment. Indicate the number of incision/wound sites: 1. Skin/wound education. Instructed on: Pressure relief measures, Standard precautions, Friction/Shear relief measures, signs & symptoms of infection. Instructions: Patient, primary care giver, other-verbal instruction given to **GU:** Voiding method: Incontinent: Functional bowel/bladder **Wound:** Site location: Specify location: Site #1-Sacrum pressure ulcer Type: Pressure ulcer Pressure ulcer stage: Stage 1 Healing: N/A Wound measurement: Measure weekly, length in cm-10, width in cm-15, depth in cm-Not available. Incision/wound tissue observed: Beefy red Surrounding tissue: Erythema Wound margins: Tunneling absent, undermining absent Drain site and type: None Drainage: None Dressing changed this visit: No	
01/04/YYYY	Hospital/Provider Name	**Nurse notes:** SN visit performed for clinical assessment and teaching, patient alert not at any acute distress, pressure ulcer on sacral area assess, no skin breakdown noted at this time, M.D. Sosonkin update on patient clinical status, as per M.D. Patient will be seen on 01/05/YYYY and MD will update COC on further POC for PU treatment. COC contacted patient daughter over the phone, verbal instruction provided/reviewed over the phone on proper insulin administration, PEG daughter voiced fully understanding with teaching provided. PCG unable to present during the COC visit time. Patient vitals within normal limit. Signs/symptoms of hypo/hyperglycemia reviewed with PCW, importance to adhere Pureed, nectar thick liquids, Diabetic diet portion controlled, low fat/low cholesterol, 2gm Na. No fluid restrictions diet reinforced. I Gornak COC.	717
01/04/YYYY	Hospital/Provider Name	**Physical therapy note:**	717

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		The patient seen for physical therapy initial evaluation to continue for improved muscle strength, transfers, wheelchair mobilization, bed mobility, balance, activities of daily living, Dr. Tiwari aware and agreed. Patient given home exercise program handout. Continue with plan to achieve rehab goals. E-mail to Glenda Tavano and Ioulia Cheiko regarding physical therapy plan of care.	
01/05/YYYY	Hospital/Provider Name	**Skilled nursing routine visit:** **General:** **Homebound status:** Unable to ambulate, unsteady gait/balance, requires assist of 1-2 people, confined to wheelchair **Assessment:** **Lower extremity edema:** Mid-thigh, knee, mid-calf, ankle and instep. **Abdomen:** Distended. **Nutrition:** Nutritional assessment: Good appetite Hydration: Good. Meal pattern: Small frequent meals. Knowledge/compliance with prescribed diet: States compliance with prescribed diet. **Skin:** Character: Normal. Incision/wound assessment. Indicate the number of incision/wound sites: 1. Skin/wound education. Instructed on: Pressure relief measures, Standard precautions, Friction/Shear relief measures, signs & symptoms of infection. Instructions: Patient, primary care giver, other-verbal instruction given to **GU:** Voiding method: Incontinent: Functional Voiding pattern: Normal Frequent infectious: Currently being treated **Wound:** Site location: Specify location: Site #1-Sacrum pressure ulcer Type: Pressure ulcer Pressure ulcer stage: Stage 1 Healing: Not healing Wound measurement: Measure weekly. Incision/wound tissue observed: Beefy red Surrounding tissue: Erythema Wound margins: Tunneling absent Drain site and type: None Drainage: None Dressing changed this visit: No	748-751

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
01/06/YYYY	Hospital/Provider Name	**Skilled nursing routine visit:** **Home bound reasons:** Unable to ambulate, requires assist of 1-2 people **Assessment:** **Lower extremity edema:** Mid-thigh, knee, mid-calf, ankle and instep. **GI:** Abdomen, soft, non-tender. **Nutrition:** Appetite: Poor. Hydration: Good. Meals patterns: 3 meals per day. **Skin:** Skin integrity: Non-surgical wound Skin character: Normal See incision/wound assessment. Indicate the number of incision/wound sites: 1. Instructed on: Pressure relief measures, wound disease process, standard precautions, friction/Shear relief measures, incontinence management, signs & symptoms of infection. Instructions: Patient, primary care giver, Other-Verbal instruction given to **Genitourinary:** Voiding method: Incontinent: Functional Voiding pattern: Normal **Wound:** Site location: Specify location: Site #1-Sacrum pressure ulcer Type: Pressure ulcer Pressure ulcer stage: Stage #1 Healing: N/A Wound measurement: Measure weekly. Incision/wound tissue observed: Beefy red Surrounding tissue: Erythema Wound margins: Tunneling absent, undermining absent Drain site and type: None Drainage: None Dressing changed this visit: Yes, per orders, see care plan	752-755
01/06/YYYY	Hospital/Provider Name	**Skilled nursing notes:** SN visit made for clinical, assessment and evaluation. Patient was seen and evaluated by PMD Sosonkin on 01/05/YYYY, changes in meds regimen updated in meds profile as Rx, V/F and changes in plan of care/wound care conformed with M.D. and updated in Care plan Charting, supplemental order created. Patient is in agreement with new care plan COC, will follow-up with patient accordingly. Vitals monitored recorded, wound on sacrum area reassess, no major changes noted, PCW instructed on importance to change patient position every 2 hours,	717

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		keep skin clean and dry as possible, verbalized understanding with teaching provided. I Gornak COC.	
01/06/YYYY	Hospital/Provider Name	**Occupational therapy note:** The patient was seen for an initial occupational therapy evaluation and treatment on 01-06-2017. Patient will benefit from further skilled occupational therapy services to achieve maximal functional ADL's goals at home. Discharge planning initiated.	716
01/09/YYYY	Hospital/Provider Name	**Skilled nursing routine visit:** **Homebound reasons:** Unable to ambulate, requires assist of 1-2 people, bedbound **Assessment:** **Lower extremity edema:** Sacrum, mid-thigh, knee, mid-calf, ankle and instep. **GI:** Abdomen, soft, non-tender. **Genitourinary:** Voiding method: Incontinent: Functional Voiding pattern: Normal **Nutrition:** Appetite: Good. Hydration: Good. Meals patterns: 3 meals per day. **Wound:** Site location: Specify location: Site #1-Sacrum pressure ulcer Type: Pressure ulcer Pressure ulcer stage: Stage #1 Healing: Not healing Wound measurement: Measure weekly. Incision/wound tissue observed: Beefy red Surrounding tissue: Intact Wound margins: Tunneling absent, undermining absent Drain site and type: None Drainage: None Dressing changed this visit: Yes, per orders, see care plan	756-759
01/11/YYYY	Hospital/Provider Name	**Skilled nursing routine visit:** **Homebound reasons:** Unable to ambulate. **Assessment:** **Lower extremity edema:** Mid-thigh, knee, mid-calf, ankle and instep. **GI:** Abdomen soft, non-tender.	760-763

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Genitourinary: Voiding method: Incontinent: Functional Voiding pattern: Normal **Nutrition:** Appetite: Good. Hydration: Good. Meals patterns: Small frequent meals. **Wound:** Site location: Specify location: Site #1-Sacrum pressure ulcer Type: Pressure ulcer Pressure ulcer stage: Stage #2 Healing: Not healing Wound measurement: Measure weekly, length in cm-10, width in cm-15 Incision/wound tissue observed: Pink, Beefy red Surrounding tissue: Erythema Wound margins: Tunneling absent, undermining absent Drain site and type: None Drainage: Serosanguineous Drainage amount: Moderate Dressing changed this visit: Yes, per orders, see care plan	
01/11/YYYY	Hospital/Provider Name	**Nursing notes:** SN visit performed for clinical assessment, teaching and wound care. PCG (Primary Care Giver) patient's daughter present during the visit time. PCG demonstrated proper insulin administrations, standard precautions, aware on signs/symptoms reportable to M.D. PCG administer insulin for patient at evening time, after work hours. PCG visit patient on daily basis. Wound on sacral area assess, no changes noted, M.D. aware. PCW instructed on importance to change patient position every 2-hour, incontinent care/management teaching provided. I Gornak COC.	716
01/13/YYYY	Hospital/Provider Name	**Skilled nursing routine visit:** **Homebound status:** Unable to ambulate, unsteady gait/balance, requires assist of 1-2 people. **Assessment:** **Neurological:** Mental status: Alert, forgetful. **Lower extremity edema:** Knee, mid-calf, ankle and instep. **GI:** Abdomen soft, non-tender. **Genitourinary:** Voiding method: Incontinent: Functional Voiding pattern: Normal	764-767

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Nutrition: Appetite: Good. Hydration: Good. Meals patterns: 3 meals per day. **Wound:** Site location: Specify location: Site #1-Sacrum pressure ulcer Type: Pressure ulcer Pressure ulcer stage: Stage #2 Healing: Not healing Wound measurement: Measure weekly, length in cm-10, width in cm-15 Incision/wound tissue observed: Pink Surrounding tissue: Erythema Wound margins: Tunneling absent, undermining absent Drain site and type: None Drainage: Serous Drainage amount: Moderate Dressing changed this visit: Yes, per orders, see care plan	
01/15/YYYY	Hospital/Provider Name	**Skilled nursing routine visit:** **Homebound status:** Unable to ambulate. **Assessment:** **Neurological:** Mental status: Alert, confused-intermittently. **Lower extremity edema:** Mid-thigh, knee, mid-calf, ankle and instep. **Nutrition:** Appetite: Good. Hydration: Good. Meals patterns: 3 meals per day. **GI:** Abdomen soft, non-tender. **Genitourinary:** Voiding method: Incontinent: Functional Voiding pattern: Normal **Wound:** Site location: Specify location: Site #1-Sacrum pressure ulcer Type: Pressure ulcer Pressure ulcer stage: Unstageable Healing: Not healing Wound measurement: Not measured Incision/wound tissue observed: Slough-100% Surrounding tissue: Erythema	768-771

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Wound margins: Not evaluated Drain site and type: None Drainage: Serosanguineous Drainage amount: Large Dressing changed this visit: Yes, per orders, see care plan	
01/15/YYYY	Hospital/Provider Name	**Nursing notes:** Patient seen for clinical assessment and wound care. Sacral area deep tissue injury vs pressure ulcer, deteriorating. TCT M.D. Sosonkin notified about changes. At present time, patient developed 3 pressure ulcers. Right buttock upper side unstageable pressure ulcer with 100% slough, right buttock lower side unstageable pressure ulcer with 100% slough and left buttock/sacral area stage 3 pressure ulcer. Join visit scheduled with PMD on 01/20/17. COC to follow-up with PMD for further instructions.	716
01/17/YYYY	Hospital/Provider Name	**Skilled nursing routine visit:** **Homebound status:** Unable to ambulate, requires assist of 1-2 people **Assessment:** **Neurological:** Mental status: Alert, forgetful **Nutrition:** Appetite: Good. Hydration: Good. Meals patterns: 3 meals per day. **GI:** Abdomen soft, non-tender. **Genitourinary:** Voiding method: Incontinent: Functional Voiding pattern: Normal **Skin:** Character: Normal. Instructed on: Wound care as per orders, pressure relief measures, wound disease process, standard precautions, friction/shear relief measures, incontinence management, nutrition to foster wound healing, signs & symptoms of infection. **Wound:** Site location: Specify location: Site #1-Sacrum pressure ulcer Type: Pressure ulcer Pressure ulcer stage: Stage II Healing: Not healing Wound measurement: Measure weekly Incision/wound tissue observed: Pink Surrounding tissue: Erythema Wound margins: Tunneling absent, undermining absent	772-774

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Drain site and type: None Drainage: Serosanguineous Drainage amount: Moderate Dressing changed this visit: Yes, per orders, see care plan Comments: Patient tolerated wound care well	
01/19/YYYY	Hospital/Provider Name	**Skilled nursing routine visit:** **Homebound status:** Unable to ambulate **Assessment:** **Neurological:** Mental status: Alert, confused-intermittently. **Lower extremity edema:** Mid-thigh, knee, mid-calf, ankle, instep **Nutrition:** Appetite: Good. Hydration: Good. Meals patterns: 3 meals per day. **GI:** Abdomen soft, non-tender. **Genitourinary:** Voiding method: Incontinent: Functional Voiding pattern: Normal **Skin:** **Character:** Normal. **Instructed on:** Wound care as per orders, dressing change (Type, frequency, procedure), pressure relief measures, wound disease process, incontinence management, signs & symptoms of infection. **Wound:** **#1. Right buttock upper wound:** Site location: Specify location: #1 right buttock upper wound Type: Pressure ulcer Pressure ulcer stage: Unstageable Healing: Not healing Wound measurement: Length in centimeters 7.0, width in centimeters 8.0, depth in centimeters: 0.5 Incision/wound tissue observed: slough %: 100% Surrounding tissue: Erythema Wound margins: Tunneling absent, undermining absent Drain site and type: None Drainage: Serosanguineous Drainage amount: Moderate Dressing changed this visit: Yes, per orders, see care plan	775-778

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		#2. Right buttock lower wound: Site location: Specify location: #2 Right buttock lower wound Type: Pressure ulcer Pressure ulcer stage: Unstageable Healing: Not healing Wound measurement: Length in centimeters: 10.0, width in centimeters: 5.5. Incision/wound tissue observed: Slough 100%. Surrounding tissue: Erythema Wound margins: Tunneling absent, undermining absent Drain site and type: None Drainage: Serosanguineous Drainage amount: Moderate Dressing changed this visit: Yes, per orders, see Care Plan **#3. Left buttock wound:** Site location: Specify location: #3 left buttock Type: Pressure ulcer Pressure ulcer stage: Stage 3 Healing: Not healing Wound measurement: Length in centimeters: 10.5, Width in centimeters: 11.0 Incision/wound tissue observed: Beefy red, Slough 15% Surrounding tissue: Erythema Wound margins: Tunneling absent, undermining absent Drain site and type: None Drainage: Serosanguineous Drainage amount: Moderate Dressing changed this visit: Yes, per orders, see care plan	
01/19/YYYY	Hospital/Provider Name	**Orders:** *(Irina Gornak, RN)* Skilled nursing 1 x day x 40 days Skilled nursing wound care orders Right buttock upper wound pressure ulcer-Cleanse with NSS, pat dry, apply Bacitracin to peri-wound and Santyl to wound bed cover with 4 x 4 and DSD secure with tape daily performed by RN. SN wound care orders: Right buttock lower wound pressure ulcer-cleanse with NSS, pat dry, apply Bacitracin to peri-wound and Santyl to wound bed cover with 4 x 4 and DSD secure with tape daily performed by RN. SN wound care orders: Left buttock pressure ulcer-cleanse with NSS, pat dry apply Medi-honey Alginate to wound bed, Bacitracin with Zinc to peri-wound, cover with 4 x 4 and DSD, secure with tape daily performed by RN. *(Irina Gornak, RN)*	708
01/20/YYYY	Hospital/Provider Name	**Skilled nursing routine visit:** **Homebound status:** Unable to ambulate	779-782

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Assessment: **Neurological:** Mental status: Alert, confused-intermittently. **Lower extremity edema:** Mid-thigh, knee, mid-calf, ankle, instep **Nutrition:** Appetite: Good. Hydration: Good. Meals patterns: Small frequent meals. Knowledge/compliance with prescribed diet: States compliance with prescribed diet **GI:** Abdomen soft, non-tender. **Genitourinary:** Voiding method: Incontinent: Functional Voiding pattern: Normal **Skin:** Character: Normal. Incision/wound assessment. Indicate the number of incision/wound sites: 3. **Instructed on:** Dressing change (type, frequency, procedure), drain site care (empty, cleansing), pressure relief measures, wound disease process, standard precautions, friction/shear relief measures, nutrition to foster wound healing, signs & symptoms of infection **Wound:** **#1. Right buttock upper wound:** Site location: Specify location: #1 right buttock upper wound Type: Pressure ulcer Pressure ulcer stage: Unstageable Healing: Not healing Wound measurement: Measure weekly Incision/wound tissue observed: Slough: 100% Surrounding tissue: Intact Wound margins: Tunneling absent Drain site and type: None Drainage: Serosanguineous Drainage amount: Moderate Dressing changed this visit: Yes, per orders, see care plan **#2. Right buttock lower wound:** Site location: Specify location: #2 Right buttock lower wound Type: Pressure ulcer Pressure ulcer stage: Unstageable	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Healing: Not healing Wound measurement: Measure weekly Incision/wound tissue observed: Slough 100%. Surrounding tissue: Intact Wound margins: Tunneling absent Drain site and type: None Drainage: Serosanguineous Drainage amount: Moderate Dressing changed this visit: Yes, per orders, see Care Plan **#3. Left buttock wound:** Site location: Specify location: #3 left buttock Type: Pressure ulcer Pressure ulcer stage: Stage 3 Healing: Not healing Wound measurement: Measure weekly Incision/wound tissue observed: Beefy red, Slough 15% Surrounding tissue: Erythema Wound margins: Tunneling absent Drain site and type: None Drainage: Serosanguineous Drainage amount: Moderate Dressing changed this visit: Yes, per orders, see care plan	
01/20/YYYY	Hospital/Provider Name	**Skilled nursing notes:** Join visit performed with PMD Sosonkin, wound assess and measure as per MHJS policy, new treatment plan initiated as ordered by M.D. see updated care plan, V/F changed for daily x 40 days. Wound care supply order placed with Medline. New prescription for air mattress faxed to Village care, PCW instructed on importance to change patient position every hour. Patient with diagnosis of cerebrovascular accident, obesity, keep skin clean and dry, incontinence management teaching provided.	716
01/20/YYYY	Hospital/Provider Name	**Physical therapy note:** Clinical update: Continue with therapeutic exercises, bed mobility, and home exercise program. Patient progressing as per plan of care. Continue with plan to achieve rehab goals. Discharge planning: 2-3 weeks.	716
01/21/YYYY	Hospital/Provider Name	**Skilled nursing routine visit:** **Homebound status:** Unable to ambulate, requires assist of 1-2 people, bedbound **Assessment:** **Neurological:** Mental status: Alert, confused-intermittently, forgetful. **Lower extremity edema:** Sacrum, mid-thigh, knee, mid-calf, ankle, instep	783-786

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Nutrition: Appetite: Good. Hydration: Good. Meals patterns: 3 meals per day. Knowledge/compliance with prescribed diet: Not evaluated **GI:** Abdomen soft, non-tender. **Genitourinary:** Voiding method: Incontinent: Total Voiding pattern: Normal **Skin:** Character: Normal. Incision/wound assessment. Indicate the number of incision/wound sites: 3. **Wound:** **#1. Right buttock upper wound:** Site location: Specify location: #1 right buttock upper wound Type: Pressure ulcer Pressure ulcer stage: Unstageable Healing: Not healing Wound measurement: Measure weekly Incision/wound tissue observed: Slough: 100% Surrounding tissue: Erythema Wound margins: Tunneling absent, undermining absent Drain site and type: None Drainage: Serosanguineous Drainage amount: Moderate Dressing changed this visit: Yes, per orders, see care plan Comments: Patient tolerated wound care well **#2. Right buttock lower wound:** Site location: Specify location: #2 Right buttock lower wound Type: Pressure ulcer Pressure ulcer stage: Unstageable Healing: Not healing Wound measurement: Measure weekly Incision/wound tissue observed: Slough 100%. Surrounding tissue: Erythema Wound margins: Tunneling absent, undermining absent Drain site and type: None Drainage: Serosanguineous Drainage amount: Moderate Dressing changed this visit: Yes, per orders, see care plan Comments: Patient tolerated wound care well	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		#3. Left buttock wound: Site location: Specify location: #3 left buttock Type: Pressure ulcer Pressure ulcer stage: Stage 3 Healing: Not healing Wound measurement: Measure weekly Incision/wound tissue observed: Eschar 100% Surrounding tissue: Erythema Wound margins: Tunneling absent, undermining absent Drain site and type: None Drainage: Serosanguineous Drainage amount: Moderate Dressing changed this visit: Yes, per orders, see care plan Comments: Patient tolerated wound care well	
01/22/YYYY	Hospital/Provider Name	**Skilled nursing routine visit:** **Homebound status:** Unable to ambulate, requires assist of 1-2 people, requires assistive devices **Assessment:** **Neurological:** Mental status: Alert, confused-intermittently, forgetful. **Lower extremity edema:** Sacrum, mid-thigh, knee, mid-calf, ankle, instep **Nutrition:** Appetite: Good. Hydration: Good. Meals patterns: 3 meals per day. Knowledge/compliance with prescribed diet: Not evaluated **GI:** Abdomen-Nausea. **Genitourinary:** Voiding method: Incontinent: Total Voiding pattern: Normal **Skin:** Character: Normal. Incision/wound assessment. Indicate the number of incision/wound sites: 3. **Wound:** **#1. Right buttock upper wound:** Site location: Specify location: #1 right buttock upper wound Type: Pressure ulcer Pressure ulcer stage: Unstageable Healing: Not healing Wound measurement: Measure weekly	787-790

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Incision/wound tissue observed: Slough: 100% Surrounding tissue: Erythema Wound margins: Tunneling absent, undermining absent Drain site and type: None Drainage: Serosanguineous Drainage amount: Moderate Dressing changed this visit: Yes, per orders, see care plan Comments: Patient tolerated wound care well **#2. Right buttock lower wound:** Site location: Specify location: #2 Right buttock lower wound Type: Pressure ulcer Pressure ulcer stage: Unstageable Healing: Not healing Wound measurement: Measure weekly Incision/wound tissue observed: Slough 100%. Surrounding tissue: Erythema Wound margins: Tunneling absent, undermining absent Drain site and type: None Drainage: Serosanguineous Drainage amount: Moderate Dressing changed this visit: Yes, per orders, see care plan Comments: Patient tolerated wound care well **#3. Left buttock wound:** Site location: Specify location: #3 left buttock Type: Pressure ulcer Pressure ulcer stage: Stage 3 Healing: Not healing Wound measurement: Measure weekly Incision/wound tissue observed: Eschar 100% Surrounding tissue: Erythema Wound margins: Tunneling absent, undermining absent Drain site and type: None Drainage: Serosanguineous Drainage amount: Moderate Dressing changed this visit: Yes, per orders, see care plan Comments: Patient tolerated wound care well	
01/23/YYYY	Hospital/Provider Name	**Skilled nursing routine visit:** **Homebound status:** Bedbound **Assessment:** **Neurological:** Mental status: Alert, confused-intermittently, forgetful. **Lower extremity edema:** Mid-thigh, knee, mid-calf, ankle, instep	791-794

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Nutrition: Appetite: Good. Hydration: Good. Meals patterns: 3 meals per day. **GI:** Abdomen-Soft, non-tender, active bowel sounds all 4 quadrants, regular bowel pattern, normal stool, not distended abdomen **Genitourinary:** Voiding method: Incontinent: Total Voiding pattern: Normal **Skin:** Character: Normal. Incision/wound assessment. Indicate the number of incision/wound sites: 3. **Wound:** **#1. Right buttock upper wound:** Site location: Specify location: #1 right buttock upper wound Type: Pressure ulcer Pressure ulcer stage: Unstageable Healing: Not healing Wound measurement: Measure weekly Incision/wound tissue observed: Slough: 100% Surrounding tissue: Erythema Wound margins: Tunneling absent Drain site and type: None Drainage: Serosanguineous Drainage amount: Moderate Dressing changed this visit: Yes, per orders, see care plan **#2. Right buttock lower wound:** Site location: Specify location: #2 Right buttock lower wound Type: Pressure ulcer Pressure ulcer stage: Unstageable Healing: Not healing Wound measurement: Measure weekly Incision/wound tissue observed: Slough 100%. Surrounding tissue: Erythema Wound margins: Tunneling absent Drain site and type: None Drainage: None Dressing changed this visit: Yes, per orders, see care plan **#3. Left buttock wound:** Site location: Specify location: #3 left buttock Type: Pressure ulcer Pressure ulcer stage: Stage 3	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Healing: Not healing Wound measurement: Measure weekly Incision/wound tissue observed: Pink, slough 15% Surrounding tissue: Erythema Wound margins: Tunneling absent Drain site and type: None Drainage: Serosanguineous Drainage amount: Moderate Dressing changed this visit: Yes, per orders, see care plan	
01/24/YYYY	Hospital/Provider Name	**Skilled nursing routine visit:** **Homebound status:** Unable to ambulate, bedbound **Assessment:** **Neurological:** Mental status: Alert, confused-intermittently, **Lower extremity edema:** Mid-thigh, knee, mid-calf, ankle, instep **Nutrition:** Appetite: Good. Hydration: Good. Meals patterns: 3 meals per day. **GI:** Abdomen-Soft, non-tender, active bowel sounds all 4 quadrants, regular bowel pattern, normal stool, not distended abdomen **Genitourinary:** Voiding method: Incontinent: Total Voiding pattern: Normal **Skin:** Character: Normal. Incision/wound assessment. Indicate the number of incision/wound sites: 3. **Wound:** **#1. Right buttock upper wound:** Site location: Specify location: #1 right buttock upper wound Type: Pressure ulcer Pressure ulcer stage: Unstageable Healing: Not healing Wound measurement: Measure weekly Incision/wound tissue observed: Slough: 100% Surrounding tissue: Erythema Wound margins: Tunneling absent, undermining absent Drain site and type: None Drainage: Serosanguineous Drainage amount: Moderate	795-797

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Dressing changed this visit: Yes, per orders, see care plan **#2. Right buttock lower wound:** Site location: Specify location: #2 Right buttock lower wound Type: Pressure ulcer Pressure ulcer stage: Unstageable Healing: Not healing Wound measurement: Measure weekly Incision/wound tissue observed: Slough 100%. Surrounding tissue: Erythema Wound margins: Tunneling absent, undermining absent Drain site and type: None Drainage: Serosanguinous Drainage amount: Moderate Dressing changed this visit: Yes, per orders, see care plan **#3. Left buttock wound:** Site location: Specify location: #3 left buttock Type: Pressure ulcer Pressure ulcer stage: Stage 3 Healing: Not healing Wound measurement: Measure weekly Incision/wound tissue observed: Eschar 100% Surrounding tissue: Erythema Wound margins: Tunneling absent, undermining absent Drain site and type: None Drainage: Serosanguineous Drainage amount: Moderate Dressing changed this visit: Yes, per orders, see care plan	
01/06/YYYY-01/24/YYYY	Hospital/Provider Name	**Orders:** *(Irina Gornak, RN)* 01/06/YYYY-Skilled Nurse wound care orders. 01/09/YYYY-Skilled Nurse every 2 days x 14 days 01/24/YYYY-Skilled Nurse every 2-3 x week x 2-weeks #1 sacrum area-cleanse with normal saline, pat dry, apply Silicone dressing every other day for 2-weeks than re-evaluate. **Meds:** Nexium 40mg DR, ended on 01-06-2017. Brilinta 60mg twice daily ended on 01-06-2017 Plavix 75mg daily	707
01/25/YYYY	Hospital/Provider Name	**Skilled nursing routine visit:** **Homebound status:** Bedbound **Assessment:** **Neurological:**	798-800

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Mental status: Alert, confused-intermittently, **Lower extremity edema:** Mid-thigh, knee, mid-calf, ankle, instep **Nutrition:** Appetite: Good. Hydration: Good. Meals patterns: 3 meals per day. **GI:** Abdomen-Soft, non-tender **Genitourinary:** Voiding method: Incontinent: Total Voiding pattern: Normal **Skin:** Character: Normal. Incision/wound assessment. Indicate the number of incision/wound sites: 3. **Wound:** **#1. Right buttock upper wound:** Site location: Specify location: #1 right buttock upper wound Type: Pressure ulcer Pressure ulcer stage: Unstageable Healing: Not healing Wound measurement: Measure weekly, length 6cm, width 7cm Incision/wound tissue observed: Slough: 100% Surrounding tissue: Erythema Wound margins: Tunneling absent, undermining absent Drain site and type: None Drainage: Serosanguineous Drainage amount: Moderate Dressing changed this visit: Yes, per orders, see care plan **#2. Right buttock lower wound:** Site location: Specify location: #2 Right buttock lower wound Type: Pressure ulcer Pressure ulcer stage: Unstageable Healing: Not healing Wound measurement: Measure weekly, length 10cm, depth 0.1cm Incision/wound tissue observed: Slough 100%. Surrounding tissue: Erythema Wound margins: Tunneling absent, undermining absent Drain site and type: None Drainage: Serosanguinous Drainage amount: Moderate Dressing changed this visit: Yes, per orders, see care plan	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		#3. Left buttock wound: Site location: Specify location: #3 left buttock Type: Pressure ulcer Pressure ulcer stage: Stage 3 Healing: Not healing Wound measurement: Measure weekly, length 10cm, width 10cm Incision/wound tissue observed: Eschar 100% Surrounding tissue: Erythema Wound margins: Tunneling absent, undermining absent Drain site and type: None Drainage: Serosanguineous Drainage amount: Moderate Dressing changed this visit: Yes, per orders, see care plan	
01/26/YYYY	Hospital/Provider Name	**Skilled nursing routine visit:** **Homebound status:** Bedbound **Assessment:** **Neurological:** Mental status: Alert **Lower extremity edema:** Mid-thigh, knee, mid-calf, ankle, instep **Nutrition:** Appetite: Good. Hydration: Good. Meals patterns: 3 meals per day. **GI:** Abdomen-Soft, non-tender **Genitourinary:** Voiding method: Incontinent: Total Voiding pattern: Normal **Skin:** Character: Normal. Incision/wound assessment. Indicate the number of incision/wound sites: 3. **Wound:** **#1. Right buttock upper wound:** Site location: Specify location: #1 right buttock upper wound Type: Pressure ulcer Pressure ulcer stage: Unstageable Healing: Not healing Wound measurement: Measure weekly Incision/wound tissue observed: Slough: 100% Surrounding tissue: Erythema Wound margins: Tunneling absent, undermining absent	801-803

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Drain site and type: None Drainage: Serosanguineous Drainage amount: Moderate Dressing changed this visit: Yes, per orders **#2. Right buttock lower wound:** Site location: Specify location: #2 Right buttock lower wound Type: Pressure ulcer Pressure ulcer stage: Unstageable Healing: Not healing Wound measurement: Measure weekly Incision/wound tissue observed: Slough 100%. Surrounding tissue: Erythema Wound margins: Tunneling absent, undermining absent Drain site and type: None Drainage: Serosanguinous Drainage amount: Moderate Dressing changed this visit: Yes, per orders, see care plan **#3. Left buttock wound:** Site location: Specify location: #3 left buttock Type: Pressure ulcer Pressure ulcer stage: Stage 3 Healing: Not healing Wound measurement: Measure weekly, length 10cm, width 10cm Incision/wound tissue observed: Eschar 100% Surrounding tissue: Erythema Wound margins: Tunneling absent, undermining absent Drain site and type: None Drainage: Serosanguineous Drainage amount: Moderate Dressing changed this visit: Yes, per orders, see care plan	
01/27/YYYY	Hospital/Provider Name	**Skilled nursing routine visit:** **Homebound status:** Requires assist of 1-2 people, requires assistive devices **Assessment:** **Neurological:** Mental status: Alert, forgetful **Lower extremity edema:** No edema noted **Nutrition:** Appetite: Good. Hydration: Good. Meals patterns: 3 meals per day. Knowledge/compliance with prescribed diet: States compliance with prescribed diet.	804-806

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		GI: Abdomen-Soft, non-tender, active bowel sounds all 4 quadrants, regular bowel pattern, normal stool **Genitourinary:** Voiding method: Incontinent: Total Voiding pattern: Normal **Skin:** Character: Normal. Incision/wound assessment. Indicate the number of incision/wound sites: 3. **Wound:** **#1. Right buttock upper wound:** Site location: Specify location: #1 right buttock upper wound Type: Pressure ulcer Pressure ulcer stage: Unstageable Healing: Not healing Wound measurement: Measure weekly Incision/wound tissue observed: Slough: 100% Surrounding tissue: Erythema Wound margins: Tunneling absent, undermining absent Drain site and type: None Drainage: Serosanguineous Drainage amount: Moderate Dressing changed this visit: Yes, per orders, see care plan Comments: Patient tolerated well wound care. **#2. Right buttock lower wound:** Site location: Specify location: #2 Right buttock lower wound Type: Pressure ulcer Pressure ulcer stage: Unstageable Healing: Not healing Wound measurement: Measure weekly Incision/wound tissue observed: Eschar100%. Surrounding tissue: Erythema Wound margins: Tunneling absent, undermining absent Drain site and type: None Drainage: Serosanguinous Drainage amount: Moderate Dressing changed this visit: Yes, per orders, see care plan **#3. Left buttock wound:** Site location: Specify location: #3 left buttock Type: Pressure ulcer Pressure ulcer stage: Stage 3 Healing: Not healing Wound measurement: Measure weekly	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Incision/wound tissue observed: Eschar 15% Surrounding tissue: Erythema Wound margins: Tunneling absent, undermining absent Drain site and type: None Drainage: Serosanguineous Drainage amount: Moderate Dressing changed this visit: Yes, per orders, see care plan	
01/28/YYYY	Hospital/Provider Name	**Skilled nursing routine visit:** **Homebound status:** Requires assist of 1-2 people, bedbound, compromised mental status **Assessment:** **Neurological:** Mental status: Alert, confused-intermittently, forgetful **Lower extremity edema:** Knee, mid-calf, ankle, instep. **Nutrition:** Appetite: Good. Hydration: Good. Meals patterns: 3 meals per day. Knowledge/compliance with prescribed diet: States compliance with prescribed diet. **GI:** Regular bowel pattern **Genitourinary:** Voiding method: Incontinent: Functional Voiding pattern: Normal **Skin:** Character: Normal. Incision/wound assessment. Indicate the number of incision/wound sites: 3. **Wound:** **#1. Right buttock upper wound:** Site location: Specify location: #1 right buttock upper wound Type: Pressure ulcer Pressure ulcer stage: Unstageable Healing: Not healing Wound measurement: Measure weekly Incision/wound tissue observed: Slough: 100% Surrounding tissue: Intact Wound margins: Tunneling absent Drain site and type: None Drainage: Serosanguineous Drainage amount: Moderate	807-810

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Dressing changed this visit: Yes, per orders, see care plan **#2. Right buttock lower wound:** Site location: Specify location: #2 Right buttock lower wound Type: Pressure ulcer Pressure ulcer stage: Unstageable Healing: Not healing Wound measurement: Measure weekly Incision/wound tissue observed: Slough 100%. Surrounding tissue: Intact Wound margins: Tunneling absent Drain site and type: None Drainage: Serosanguinous Drainage amount: Moderate Dressing changed this visit: Yes, per orders, see care plan **#3. Left buttock wound:** Site location: Specify location: #3 left buttock Type: Pressure ulcer Pressure ulcer stage: Stage 3 Healing: Not healing Wound measurement: Measure weekly Incision/wound tissue observed: Eschar 100% Surrounding tissue: Intact Wound margins: Tunneling absent Drain site and type: None Drainage: Serosanguineous Drainage amount: Moderate Dressing changed this visit: Yes, per orders, see care plan	
01/29/YYYY	Hospital/Provider Name	**Skilled nursing routine visit:** **Homebound status:** Requires assist of 1-2 people, bedbound, compromised mental status **Assessment:** **Neurological:** Mental status: Alert, co-operative, forgetful **Lower extremity edema:** Mid-calf, ankle, instep. **Nutrition:** Appetite: Good. Hydration: Good. Meals patterns: 3 meals per day. Knowledge/compliance with prescribed diet: States compliance with prescribed diet. **GI:** Abdomen soft, non-tender	811-814

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Genitourinary: Voiding method: Incontinent: Functional Voiding pattern: Normal **Skin:** Character: Normal. Incision/wound assessment. Indicate the number of incision/wound sites: 3. **Wound:** **#1. Right buttock upper wound:** Site location: Specify location: #1 right buttock upper wound Type: Pressure ulcer Pressure ulcer stage: Unstageable Healing: Not healing Wound measurement: Measure weekly Incision/wound tissue observed: Slough: 100% Surrounding tissue: Intact Wound margins: Tunneling absent Drain site and type: None Drainage: Serosanguineous Drainage amount: Moderate Dressing changed this visit: Yes, per orders, see care plan **#2. Right buttock lower wound:** Site location: Specify location: #2 Right buttock lower wound Type: Pressure ulcer Pressure ulcer stage: Unstageable Healing: Not healing Wound measurement: Measure weekly Incision/wound tissue observed: Slough 100%. Surrounding tissue: Intact Wound margins: Tunneling absent Drain site and type: None Drainage: Serosanguinous Drainage amount: Moderate Dressing changed this visit: Yes, per orders, see care plan **#3. Left buttock wound:** Site location: Specify location: #3 left buttock Type: Pressure ulcer Pressure ulcer stage: Stage 3 Healing: Not healing Wound measurement: Measure weekly Incision/wound tissue observed: Eschar 100% Surrounding tissue: Intact Wound margins: Tunneling absent Drain site and type: None	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Drainage: Serosanguineous Drainage amount: Moderate Dressing changed this visit: Yes, per orders, see care plan	
01/30/YYYY	Hospital/Provider Name	**Skilled nursing routine visit:** **Homebound status:** Unable to ambulate, requires assist of 1-2 people, bedbound **Assessment:** **Neurological:** Mental status: Alert, forgetful **Lower extremity edema:** Mid-thigh, knee, mid-calf, ankle, instep. **Nutrition:** Appetite: Good. Hydration: Good. Meals patterns: 3 meals per day. Knowledge/compliance with prescribed diet: States compliance with prescribed diet. **GI:** Abdomen soft, non-tender **Genitourinary:** Voiding method: Incontinent: Functional Voiding pattern: Normal **Skin:** Character: Normal. Incision/wound assessment. Indicate the number of incision/wound sites: 3. Instructed on: Pressure relief measures, wound disease process, friction/shear relief measures, incontinence management, nutrition to foster wound healing, signs & symptoms of infection. **Wound:** **#1. Right buttock upper wound:** Site location: Specify location: #1 right buttock upper wound Type: Pressure ulcer Pressure ulcer stage: Unstageable Healing: Not healing Wound measurement: Measure weekly Incision/wound tissue observed: Slough: 100% Surrounding tissue: Intact Wound margins: Tunneling absent Drain site and type: None Drainage: Serosanguineous Drainage amount: Moderate Dressing changed this visit: Yes, per orders, see care plan	815-818

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		#2. Right buttock lower wound: Site location: Specify location: #2 Right buttock lower wound Type: Pressure ulcer Pressure ulcer stage: Unstageable Healing: Not healing Wound measurement: Measure weekly Incision/wound tissue observed: Slough 100%. Surrounding tissue: Intact Wound margins: Tunneling absent Drain site and type: None Drainage: Serosanguinous Drainage amount: Moderate Dressing changed this visit: Yes, per orders, see care plan **#3. Left buttock wound:** Site location: Specify location: #3 left buttock Type: Pressure ulcer Pressure ulcer stage: Stage 3 Healing: Not healing Wound measurement: Measure weekly Incision/wound tissue observed: Eschar 100% Surrounding tissue: Intact Wound margins: Tunneling absent Drain site and type: None Drainage: Serosanguineous Drainage amount: Moderate Dressing changed this visit: Yes, per orders, see care plan	
01/30/YYYY	Hospital/Provider Name	**Skilled nursing note:** Patient seen by RN for wound care, alert not at any acute distress, wound care performed as per MD order. Patient tolerated procedure well. Authorization for air mattress pending from MLTC program. Case conference with Case manager from MLTC program, update on patient clinical and wound status. Family members' patient daughter and son refused any changes in PCW hours. PCW instructed in importance to change patient position every 2 hours and keep patient clean and dry, Incontinence management instructions provided in details. Blood glucose monitoring done on daily basis and log by family. Within normal limit. COC to follow-up with patient daily as scheduled. Wound pictures emailed to WOCN for recommendations. I Gornak COC.	715
01/04/YYYY-01/30/YYYY	Hospital/Provider Name	**Interim physical therapy summary:** ***Treatments performed:*** *Active exercises, balance/co-ordination and education* *She received physical therapy sessions on the following dates: 01/04/YYYY, 01/06/YYYY, 01/09/YYYY, 01/13/YYYY, 01/18/YYYY, 01/20/YYYY, 01/25/YYYY, 01/27/YYYY, 01/30/YYYY*	855-883
01/06/YYYY-01/30/YYYY	Hospital/Provider Name	**Occupational therapy summary:** ***Treatments performed:*** *Therapeutic activities/exercises, activities of daily*	884-908

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		living/instrumental activities of daily living training, functional training *She received occupational therapy sessions on the following dates: 01/06/YYYY, 01/10/YYYY, 01/13/YYYY, 01/17/YYYY, 01/20/YYYY, 01/23/YYYY, 01/25/YYYY, 01/30/YYYY*	
01/31/YYYY	Hospital/Provider Name	**Skilled nursing routine visit:** **Homebound status:** Unable to ambulate. **Assessment:** **Neurological:** Mental status: Alert, forgetful **Lower extremity edema:** No edema noted. **Nutrition:** Appetite: Good. Hydration: Good. Meals patterns: 3 meals per day. Knowledge/compliance with prescribed diet: States compliance with prescribed diet. **GI:** Abdomen soft, non-tender **Genitourinary:** Voiding method: Incontinent: Functional Voiding pattern: Normal **Skin:** Character: Normal. Incision/wound assessment. Indicate the number of incision/wound sites: 3. Instructed on: Wound care as per orders, dressings change (type, frequency, procedure), pressure relief measures, and wound disease process, standard precautions, incontinence management, signs & symptoms of infection. **Wound:** **#1. Right buttock upper wound:** Site location: Specify location: #1 right buttock upper wound Type: Pressure ulcer Pressure ulcer stage: Unstageable Healing: Not healing Wound measurement: Measure weekly Incision/wound tissue observed: Slough: 100% Surrounding tissue: Intact Wound margins: Tunneling absent Drain site and type: None Drainage: Serosanguineous Drainage amount: Moderate	819-822

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Dressing changed this visit: Yes, per orders, see care plan **#2. Right buttock lower wound:** Site location: Specify location: #2 Right buttock lower wound Type: Pressure ulcer Pressure ulcer stage: Unstageable Healing: Not healing Wound measurement: Measure weekly Incision/wound tissue observed: Slough 100%. Surrounding tissue: Intact Wound margins: Tunneling absent Drain site and type: None Drainage: Serosanguinous Drainage amount: Moderate Dressing changed this visit: Yes, per orders, see care plan **#3. Left buttock wound:** Site location: Specify location: #3 left buttock Type: Pressure ulcer Pressure ulcer stage: Stage 3 Healing: Not healing Wound measurement: Measure weekly Incision/wound tissue observed: Eschar 100% Surrounding tissue: Intact Wound margins: Tunneling absent Drain site and type: None Drainage: Serosanguineous Drainage amount: Moderate Dressing changed this visit: Yes, per orders, see care plan	
02/01/YYYY	Hospital/Provider Name	**Orders:** *(Irina Gornak, RN)* 02/01/YYYY: Wound care orders: Left buttock-Cleanse with NSS, pat dry, apply Santyl to wound bed and Bacitracin with Zinc to peri-wound cover with 4 x 4, Abd pad secure with Tegaderm daily, performed by RN.	709
02/03/YYYY	Hospital/Provider Name	**Nurse notes:** Patient seen for clinical assessment and wound care. Alert not at any acute distress, wound care performed as per M.D. order, patient tolerated procedure well. Foley catheter inserted under sterile tech as per M.D. request. Yellow clear color urine output noted in the bag. PCW instructed on proper foley catheter care. Verbalized understanding with teaching provided. I Gornak COC.	715
02/03/YYYY	Hospital/Provider Name	**Orders:** *(Irina Gornak, RN)* Catheter care every visit, 16-fr, balloon size 10cc SN to change catheter as needed x 2 for complications. SN to insert/apply catheter (type) monthly, as needed. Frequency of catheterization-every month or as needed.	709

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Goals/expected outcomes: Patient/PCG will demonstrate independence in catheter management: 4-weeks.	
02/04/YYYY	Hospital/Provider Name	**Skilled nursing notes:** Primary care giver reports episode of vomiting this morning; spoke to PMD (Primary Medical Doctor) Sosonkin. Patient's meds adjusted as following Protonix 40mg daily in the morning; Famotidine 20mg daily at bedtime; Reglan as needed. PCG (Daughter) will pick up newly prescribed Reglan from pharmacy today; patient has Protonix and Famotidine at home and will start taking them as prescribed today. Spoke to PMD regarding protein supplement (Pro-stat or Juven). PMD is in agreement; states patient's kidneys function permits for the patient to administer protein supplements for faster wounds healing; daughter made aware to obtain Pro-stat for the patient and is in agreement.	715
02/06/YYYY	Hospital/Provider Name	**Skilled nursing notes:** Join visit performed with WOCN for recommendations on proper wound care. Patient's left side paralyzed cerebrovascular accident, morbidly obese under high risk to developed new pressure ulcer, has PCW services for 7 days x 24 hour. On each visit RN instructed PCW on importance to change position every 1-2 hour, keep patient clean and dry. During join visit #2 new pressure ulcers noted on patient's right hip stage 1 and right upper back deep tissue injury. All wounds assess and measure as per MJHS protocol. New recommendation provided by WOCN discuss with PMD Sosonkin. New wound care plan initiated as discussed with PMD. Patient tolerated procedure well. Delivery on new Air matrass alternative pressure scheduled on 02/07/17 as per PCG. Safety and foley catheter care teaching provided, PCW verbalized understanding with instruction provided. COC will follow up with patient as scheduled. I Gornak COC.	715
02/06/YYYY	Hospital/Provider Name	**Orders:** 02/06/YYYY: Wound care orders: #1 Sacrum area-Cleanse with 1/2 Dakin's solution, apply Bacitracin with Zinc to peri-wound, Santyl to wound bed cover moist with NSS 4 x 4, ABD pad and Tegaderm daily performed by RN. Right upper back-Cleanse with NSS, pat dry, apply skin prep and Bacitracin to peri-wound, Medihoney alginate to wound bed cover with Opti-foam Border 4 x 4 bi-weekly or as needed, performed by RN. Right hip-Cleanse with NSS, pat dry, apply skin prep to peri wound and A & D to wound, cover with Opti-foam border 4 x 4 bi-weekly or as needed performed by RN. Right buttock-Cleanse with 1/2 Dakin's solution, apply Bacitracin with Zinc to peri-wound, Santyl to wound bed cover moist with NSS 4 x 4, ABD pad and Tegaderm daily performed by RN. Left buttock cleanse with 1/2 Dakin's solution, NSS, apply Santyl to wound bed	710

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		and Bacitracin with Zinc and skin prep to peri-wound, cover with 4x4 moisten with NSS, ABD pads and Tegaderm daily performed by RN.	
02/08/YYYY	Hospital/Provider Name	**Skilled nursing notes:** SN visit performed for clinical assessment and wound care, patient noted today more lethargic and sleepy, vitals and blood sugar within normal limit. Wound care performed as ordered, patient tolerated procedure well. TCT to M.D. Sosonkin to obtain on patient clinical status, as per M.D. Blood test and X-ray will be ordered to be performed in pt home. M.D. also requested if patient condition will get worse activate 911. TCT to PCG patient daughter Bella, instructed on same. As per daughter she will visit patient today at 6p.m. and will inform nurse on patient status. COC to follow-up with patient as scheduled. I Gornak. COC.	714
02/08/YYYY	Hospital/Provider Name	**Occupational therapy discharge summary:** **Discharge date:** 02/08/YYYY. **Initial visit:** 01/06/YYYY. **Discipline:** Occupational therapy. **Treatment rendered:** Therapeutic exercise, ADL training, transfer training, safety/falls prevention/energy conservation training, home exercise program. **Progress made:** Patient presents with improvement in functional mobility and ADL care. **Summary of patient's discharge status:** Range of motion: Within functional limits: Bilateral upper extremities, bed mobility: Minimal/moderate. Transfers: Dependent. Activities of daily living: Maximal/dependent. Home exercise program: Supervision. Adjustment: Support of family. Continuing symptom management: Continue with home exercise program. Follow-up with primary M.D. TCT Dr. Tiwari to inform of discharge TCT R.N. Gornak informed of discharge TCT PT, Zeltser to inform of discharge TCT rehab supervisor physical therapy Tavano informed of discharge.	714
02/09/YYYY	Hospital/Provider Name	**Skilled nursing note:** SN visit performed for wound care and clinical assessment/teaching. Patient is more awake and alert today, denies any complains of this time, wound care performed as ordered, patient tolerated procedure well. Blood test and X-ray results pending. Proper patient care to prevent new pressure developed, instructions reviewed, importance to change patient position every 1-2 hours reinforced. I Gornak COC.	714

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
02/09/YYYY	Hospital/Provider Name	**Skilled nursing note:** SN visit performed for wound care, patient awake alert, vitals and blood glucose level within normal limit. Wounds care performed as per M.D. order, patient tolerated procedure well. New pressure ulcer/deep tissue injury noted on bilateral heels with no skin breakdown measure as per MJHS protocol, TCT to M.D. Sosonkin to obtain on patient status and further recommendation. Voice mail left with call back #. COC to follow-up with patient accordingly. I Gornak COC.	714
02/10/YYYY	Hospital/Provider Name	**Physical therapy discharge summary:** **Discharge date:** 02/10/YYYY **Initial visit:** 01/04/YYYY **Discipline:** Physical therapy **Treatment rendered:** Therapeutic exercise, bed mob, transfers, and balance training, home exercise program. **Progress made:** Patient progressed with bed mob and improved sitting balance. **Summary of patient's discharge status:** ROM: Right upper extremity/lower extremity within functional limits, left upper extremity/lower extremity spastic. Manual muscle test: Right upper extremity/lower extremity 3+/5 Left upper extremity/lower extremity 1/5 Bed mobility: Minimal assist with rolling right/left; moderate assist with supination to sit. Transfers: N/A. Patient bedbound. Ambulation: N/A. Patient bedbound. Stairs: N/A. Home exercise program: Care giver. Adjustment: Support of family and assistive device Continuing symptom management: Continue with home exercise program. TCT Dr. Tiwari to inform of discharge. TCT (E-mail) Ioulia Cheiko, RN informed of discharge. TCP (E-mail) Rehab supervisor Glenda Tavano informed of discharge.	713
02/10/YYYY	Hospital/Provider Name	**Orders:** Left heel pressure ulcer-Cleanse with NSS, pat dry apply 4 x 4 moist with Iodine, cover with ABD pad bi-weekly, performed by RN.	710

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Right heel-Cleanse with NSS, pat dry apply 4 x 4 moist with Iodine , cover with ABD pad bi-weekly, performed by RN *(Irina Gornak, RN)*	
02/13/YYYY	Hospital/Provider Name	**Skilled nursing note:** SN visit performed for clinical assessment and wound care. Wound care performed as ordered, as per decision between primary medical doctor/family. Patient will be transfer to CIH hospital for wounds debridement. I Gornak COC.	713
02/13/YYYY	Hospital/Provider Name	**Skilled nursing note:** As per patient daughter Bella, patient admitted to CIH on 7E room 16. Team K3 notified. I Gornak COC.	713
02/13/YYYY	Hospital/Provider Name	**Skilled nursing note:** PAD: Patient requires a higher level of care. Patient is bedbound, paralyzed on the left side from a cerebrovascular accident, morbidly obese, currently has seven pressure ulcers, development of new pressure ulcers and deterioration of the existing pressure ulcers noted during this episode of care. Patient is receiving 7 x 24 PCW from Village Care. Case was discussed with Village Care co-ordinator, split shift was offered, and family refused split shift as they do not want to lose the existing PCW. Family not very involved in care, depend a lot on the PCW, not able to participate in the wound care. Patient required two-person assist for most in-bed activities due to obesity and paralysis. Would benefit from LTRH placement. The patient is on the way to CIH (Per family's choice) due to wound deterioration and requiring extensive surgical debridement.	713
02/13/YYYY	Hospital/Provider Name	**Triage report:** **Date/time:** 02/13/YYYY @ 1357 hrs. **ESI level:** 3. **Traige to:** Blue zone. **Chief complaint:** As per EMS, referred by visiting RN for sacral ulcer, also complains of abdominal pain. **Pain level:** Yes. **Narrative note:** Report given to Dr. Kucherina and RN Brown.	1665
02/13/YYYY	Hospital/Provider Name	**ER attending note:** **Diagnoses:** Pressure ulcer of unspecified site, unspecified stage **Admit to:** Medicine. **Receiving provider/physician:** Dmitriy Khazron, M.D. **Condition:** Guarded.	1662

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Estimated length of stay: This patient requires inpatient admission and I anticipate that medical treatment will require at least 2 midnights length of stay with appropriate discharge planning. **Lab/rad review:** Yes, I have reviewed all the laboratory and radiology results on this patient.	
02/13/YYYY	Hospital/Provider Name	**ER attending history and physical examination report:** **Chief complaint:** Infected pressure ulcer. **Vitals:** BP 123/53, PR 96 bpm, RR 20, GCS 15. **Pain level:** Location: Back. Started: 2-days ago. Duration: 2-days duration. Aggravating factors: At rest. Pain level: 6-7/10, moderate pain. **History of preset illness:** She presented with past medical history of cerebrovascular accident, left hemiparesis, coronary artery disease, hypertension sent to ER by visiting nurse secondary to infected sacral decubitus ulcer. **Past medical history:** Diabetes mellitus, hypertension. **Physical examination:** General: Appears chronically ill in mild discomfort, obese, alert. Neuro: Left hemiparesis. Skin: Sacral pressure ulcer stage IV. Pressure ulcer: Yes. **Deep vein thrombosis pre-existing condition:** Obesity. **Assessment:** She presented with infected pressure ulcer. **Plan:** Labs. Blood/urine culture. Antibiotics.	1663-1665
02/13/YYYY	Hospital/Provider Name	**ER disposition:** **Disposition:** 02/13/YYYY. **Diagnosis:** Pressure ulcer of unspecified site, unspecified stage. **Admit to:** Medicine. **Estimated length of stay:** This patient requires inpatient admission and I	1795

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		anticipate that medical treatment will require at least 2-midnights length of stay with appropriate all the laboratory and radiology results on this patient.	
02/13/YYYY	Hospital/Provider Name	**History and physical examination report:** **Chief complaint:** Infected sacral decubiti. **History of present illness:** She presented with past medical history of cerebrovascular accident with left sided hemiparesis, hypertension, diabetes mellitus, HFPEF that presents for worsening sacral decubitus ulcers and superimposed infection. The patient lives at home with 24/7 HHA (Home Health Assist), visiting nurse has been monitoring DU but reports it is getting worse and requires hospitalization. Patient denies any fevers or chills. Denies any significant back pain. Reports she has a good appetite, is having good bowel movements. **Hospitalization:** Recently seen for cerebrovascular accident and transferred to Lutheran for clot retrieval. **Social history:** Bed bound, lives at home with 24/7 skilled nursing. **Physical examination:** General: Alert, awake, oriented x 3. Somewhat lethargic, son says this is the baseline. Abdomen: Obese. Back: Stage IV sacral decubiti with foul smelling discharge. GU: Foley in place. Neuro: Left arm 0/5 power, left leg 2/5 power. Labs reviewed. Radiology reviewed. EKG pending. **Assessment:** Sacral decubiti ulcer Urinary tract infection Hypertension History of cerebrovascular accident Hyperlipidemia **Plan:** Admit to medicine Surgery evaluation for debridement Vanco, Zosyn for gram positive, gram negative, anaerobic, pseudomonas coverage	1711-1715

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Follow-up blood cultures and de-escalate Follow-up Vanco through after 4th dose Palliative evaluation Follow-up urine culture ID consult as needed Tylenol as needed for Plan of care FS, LISS Restart other home meds **Deep vein thrombosis prophylaxis:** Heparin subcutaneous. **Pressure ulcer:** The patient has pressure ulcer on admission. Refer to the initial interdisciplinary. **Assessment:** Skin integrity section. **Admitting diagnosis:** Infected decubiti. **Current active problems:** Infected decubiti. **Priority:** A high priority acute. **DVT risk level:** High risk score 3-4 **Suggested prophylactic regiments:** Heparin (5000 units every 8 hours & 2 hours pre-op) or SCD with TED stockings or SCD (Sequential Compression Device) without TED stockings or LMWH (Low-Molecular Weight Heparin). Remember to place orders for suggested prophylactic regimens. **Plan:** Moderate to high risk (>3): Lovenox 40mg subcutaneous daily; if renal failure: Heparin 5000 units every 8 hours	
02/13/YYYY	Hospital/Provider Name	**History and physical examination report:** **History of present illness:** She presented with history of cerebrovascular accident with residing left side hemiparesis, hypertension, bedbound referred to ER by visiting nurse for likely infected sacral decubitus ulcer. As per family members, patient has an ulcer with pus discharge and foul smell. Deny fevers, chills. **Physical examination:** Extremities: Stage 3 decubitus bilateral lower extremity, dressing in place. Back/spine: Stage 4 decubitus. Clean dressing in place. Neuro: Alert, awake, oriented x 3, left hemiparesis. **Admission diagnosis:** Infected decubiti.	1716-1718

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Current problem: Infected decubiti. **Priority:** A (High priority-acute). **Plan: She presented with sacral decubitus.** **Infected sacral decubitus/urinary tract infection:** Follow-up urine culture. Continue with Zosyn 3g IV and Vancomycin 1g IV Follow-up Vanco trough NS 75 ml per hour Follow-up general surgery for debridement and biopsy Follow-up ESR/CRP Consider MRI to rule out osteomyelitis depending on surgery plan Follow-up ID **History of cerebrovascular accident/hypertension/coronary artery disease/ hyperlipidemia/diabetes mellitus type II:** Continue with ASA 81mg, Plavix 75mg Continue Imdur, Coreg, Lipitor as per home prescription Continue Lantus 25 units at night, Humalog sliding sale Blood sugar monitor, morning, night and afternoon **DVT prophylaxis:** Heparin 5000 units thrice daily **All treated diagnosis:** Pressure ulcer of unspecified site, unspecified stage. Essential primary hypertension. **Level of service/evaluation & management:** Initial hospital care/day 70 mins.	
02/13/YYYY	Hospital/Provider Name	**X-ray of chest:** **Clinical history:** Chest pain. **Impression:** No gross radiographic evidence of active pulmonary disease on this portable chest.	2291
02/15/YYYY	Hospital/Provider Name	**Infectious disease initial consultation report:** **Reason for request:** She presented with past medical history of cerebrovascular accident, left sided hemiparesis, hypertension, diabetes mellitus, admitted for sacral decubitus ulcers. She is receiving Vanco and Zosyn, blood culture showed no growth in 24 hrs, WBCs is trending down, please evaluate. **Pertinent/presenting history:** She presented with past medical history of diabetes mellitus, hypertension, cerebrovascular accident with left sided hemiparesis and stage-4 sacral decubitus ulcer, admitted on 02/13/YYYY from home for worsening sacral ulcer discharge, she had no fever. After admission, she was found to have leukocytosis, but remained afebrile. Also found to have an abnormal UA with polymicrobial culture. She has been on Vanco and Zosyn, her	1782-1784

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		WBC is improving and she underwent bedside debridement by surgery. **Physical examination:** General: Obese. Back/spine: Stage IV sacral ulcer with necrotic margin, wound packing in place. **Impression:** 1. Infected sacral decubitus ulcer status post debridement 2. Abnormal UA, may have urinary tract infection, symptom assessment was not possible in this patient. **Suggestions:** 1. Continue Vanco and Zosyn to complete 7-10 days of therapy from time of admission. Please follow Vanco trough level and renal function. 2. Surgery follow-up to determine need for additional debridement before pt is discharged. 3. If patient must have foley in place, please replace prior to discharge (If it was not already done during this admission) **Recommendations:** AA. **All treated diagnosis:** Pressure ulcer of unspecified site, unspecified stage urinary tract infection, site not specified **Follow-up:** As needed.	
02/16/YYYY	Hospital/Provider Name	**Inpatient surgery consult follow-up note:** **Subjective:** The patient presented for follow-up status post sacral decubitus ulcer debridement. **Assessment:** Morbidly obese. Back with left sided decubitus ulcer stage 3, partial eschar noted, drainage from the soft tissue are noted, right side with small skin ulcer unstageable covered by eschar. Labs reviewed, no leukocytosis, poor glucose control with glucose in 300s. **Plan:** She presented with sacral decubitus ulcers. The patient requires serial debridements. Consent is obtained in the chart. Will debride in morning.	1785-1786
02/17/YYYY	Hospital/Provi	**General surgery follow-up note:**	1787-

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
	der Name	**Subjective:** The patient seen and examined at bedside. No acute events overnight. **Objective:** Sacrum: Approximately 6 x 7cm decubitus ulcer, unstageable, foul smelling, no purulence. Reviewed labs: WBC 12.1. **Assessment/plan:** She presented with multiple co-morbidities plan for OR sacral decubitus ulcer debridement. Please obtain medical clearance for procedure. Please have active T+S on Sunday 02/19/YYYY Please keep patient nil per oral after midnight On 02/19/YYYY. Management as per primary team.	1788
02/20/YYYY	Hospital/Provider Name	**IP surgery consult follow-up note:** **Objective:** Sacrum: Approximately 6 x 7cm decubitus ulcer, unstageable, foul smelling, no purulence. Reviewed labs: WBC 15.6. **Assessment/plan:** She presented with multiple co-morbidities plan for OR sacral decubitus ulcer debridement. Please obtain medical clearance for procedure. Please have active T+S on Sunday 02/19/YYYY Please keep patient nil per oral after midnight On 02/19/YYYY. Management as per primary team	1789-1790
02/21/YYYY	Hospital/Provider Name	**Operative report:** **Pre/post-operative diagnosis:** Stage IV sacral decubitus with a lot of necrotic tissue. **Operation:** Excision of the necrotic tissue of the sacral area. **Post-operative condition:** Stable. **Description of findings:** Large stage IV sacral decubitus and two small sacral decubitus. **Indications:** She was admitted with signs and symptoms of sepsis and part of the work up sacral area was evaluated. It was draining purulent discharge but no obvious abscess collection. The patient was preop. The risks and benefits of the procedure were explained to the patient in her native language. She clearly	2158-2160

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		understood and accepted. **Procedure:** The patient was brought to the operating room, placed on the operating room table right upside position lateral. The skin was prepped and draped in the usual sterile fashion. 1% lidocaine with Epinephrine was used to infiltrate the skin and subcutaneous tissue around sacral area. Sharply using #10-blade; all necrotic tissues were removed. The necrotic fat tissue which was also sharply removed. No signs of any bleeding identified. This debridement was continued until we reached muscle layer. The muscle layer was also necrotic. After removal of necrotic tissue, some signs of bleeding were identified. Laterally, to left side, there were some granulation tissues superiorly and medially to right side. Hemostasis was achieved in the wound. The wound was irrigated. Size of the large sacral decubitus is 13 x 10 on the skin level but deeper tissues 18 x 15 cm area of involved necrotic tissues. Another two areas of the skin with necrotic skin was excised. One area close to right buttock 4 x 3 cm, another one 2 x 1 cm. All skin was irrigated and hemostasis obtained. Collagen was applied and wound was packed and dressing was applied. The patient tolerated the procedure well. She was taken to the postanesthesia care unit in stable condition. **Disposition:** The patient left the OR in stable condition.	
02/22/YYYY	Hospital/Provider Name	**Wound assessment:** **Date of onset:** 02/13/YYYY **Location:** Left upper buttock. **Site status:** Status post sharp debridement. **Acquisition:** Community. **Primary etiology:** Pressure. **Site details:** Left upper buttock/sacrum. **Area, length, width, depth:** 90.67 cm2, 10.50cm, 11.00cm, 4.50 cm **Push score:** 13.00. **Tissue type:** Granulation tissue. **Wound edge description:** Flat/intact. **Classification:** Stage IV pressure injury. **Drainage odor, amount:** No light. **Drainage consistency:** Thick.	4371

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Wound bed description: Red 40%, black 0%, yellow 30%, pink 0%, other 30% **Peri-wound status:** Other, dermal erosion. **Wound protocol:** Negative pressure therapy dressing application 02/22/YYYY at per MD order and surgery recommendation.	
02/22/YYYY	Hospital/Provider Name	**General surgery progress notes:** The patient seen and examined at bedside. No acute events. Wound Vac placed by wound care team. **Objective:** Gluteal: Wound vac in place. **Assessment/plan:** She is now status post sacral decubitus ulcer debridement status post wound Vac placement. No acute surgical intervention. Recommend wound care to change vac in 72 hours. Will continue to follow patient.	1791-1792
02/23/YYYY	Hospital/Provider Name	**General surgery follow up note:** **Subjective:** Patient seen and examined at bedside. No acute events. Wound vac function properly with no leakage. Approximately 50cc in container. **Objective:** Gluteal: Wound vac in place. **Assessment/plan:** Status post sacral decubitus ulcer debridement, status post wound vac placement No acute surgical intervention Recommend wound care to change vac every 72 hours Will continue to follow patient.	1793-1794
02/24/YYYY	Hospital/Provider Name	**Wound care addendum:** Spoke with case manager Marina regarding patient and type of foam to be recommended for wound VAC in nursing home. Recommending continuation of Silver/Gray Foam.	1801
02/13/YYYY-02/24/YYYY	Hospital/Provider Name	**Cumulative inpatient progress notes:** *CBC significant for WBC 15.4 mildly trending down, Hgb/HCT 9.7/29.8, PLT 508 (Trending down), consider her had hemoconcentration on admission. CMP*	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		significant for Na 134, Cl 94, Glu 234, Alb 2.8, and Mg 0.8 replaced, TSH 2.36, CRP 116, and ESR 18. On Vanco and Zosyn. Surgery consulted for possible debridement ordered. Continue Vanco/Zosyn. She was currently managed with decubitus ulcers status post I & D, urinary tract infection on antibiotics. Urine tract infection-Positive Leukocytes, negative nitrites, 50-100 WBC, many bacterial and negative culture. Advised to consider MRI to rule out osteomyelitis depending on surgery. *Ref: 1719-1781, 4376-4378, 1809-1835, 4367-4370, 2024-2055* ***Reviewer's comment:** The discharge summary is detailed enough; hence the interim progress notes are not elaborated.*	
02/24/YYYY	Hospital/Provider Name	**Discharge summary:** **Interventions:** Comfort/pain Mobility Nutrition Skin integrity **Discharge note:** The patient was admitted from home for infected sacral decubiti ulcer. Patient was treated and was seen by the wound care specialist. Safety measures were provided. Patient conditions stable was cleared by MD for discharge to a nursing home for continuity of care. First time placement, the patient was placed in Menorah Nursing Home. SW has made arrangements for transportation. **Comment:** Wound vac will be removed as per MD/Patient's nurse called the wound care specialist who will be removing the Vac prior to patient leaving the hospital.	2022-2023
02/24/YYYY	Hospital/Provider Name	**Discharge summary:** **Date of admission:** 02/13/YYYY. **Functional status:** Modified dependence in activities of daily living (Patient needs supervision and set up) **All diagnoses this visit:** Pressure ulcer of unspecified site, unspecified stage. Chronic ulcer of sacral regions. **Reason for admission:** Infected sacral decubiti. **Aspirin on discharge:** Yes. **Hospital course:** She presented with past medical history of cerebrovascular accident with left sided hemiparesis, hypertension, diabetes mellitus, HFPEF, bedridden that presented for worsening sacral decubitus ulcers and superimposed infection. The patient lives at home with 24/7 home health assist, visiting nurse	1796-1799

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		has been monitoring decubitus ulcer but reports, it is getting worse and requires hospitalization. Patient denies any fevers or chills. Denies any significant back pain. Reports she has a good appetite, is having good bowel movements. Currently being managed for sacral decubiti ulcers status post I & D, urinary tract infection on antibiotics. Day of discharge. No new events overnight. Vital signs are stable. The patient has received 10-days of Vancomycin and Zosyn. The patient is status post sacral ulcer debridement Wound vac **Hospital course:** **Sacral decubiti ulcer status post I & D:** Blood cultures negative ID recommendations appreciated Surgery consult appreciated Continue Vanco and Zosyn total 7-10 days from admissions for gram positive, gram negative, anaerobic, Pseudomonas coverage Multivitamins Follow-up Vanco trough after 4th dose. Change foley if not done so in this admission before discharge **Urinary tract infection:** UA-2+ leukocytes esterase, negative nitrates, 50-100 WBC, many bacteria, urine culture negative. **Hyponatremia:** Follow-up osmolality and lytes (resolved) **Constipation:** Colace, monitor bowel movements. **Hypertension:** Coreg, Imdur **Diabetes mellitus:** Continue with POC FS, LISS, insulin glargine **History of cerebrovascular accident:** ASA, Plavix, Statin **Hyperlipidemia** GOC-Palliative consult appreciated-Discharged to subacute, long term to home with HHA (Home Health Assist) Full code. Deep vein thrombosis prophylaxis- Heparin subcutaneous.	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		GI prophylaxis. Diet: Diabetes mellitus heart diet. Activity Discussed with attending. **Discharge plan:** Diet: Pure thick liquid diet Disposition: Nursing home Activity as tolerated Follow-up with PMD in 1-week Come to ER if condition gets worse **Discharge meds:** Clopidogrel 75 mg once daily Aspirin 81 mg once daily Coreg 25 mg twice daily Isosorbide mononitrate 120 mg once daily Lipitor 80 mg once daily Insulin glargine 30 units Tylenol 325mg every 6 hrs for pain as needed Metformin 1000 mg twice daily For wound vac maintenance-Apply grey foam to wound, set suction to 125mm of hg. Change dressing every 72 hours. **Consultations:** General Surg 02/15/17, Palliative Care 02/14/17, Rehabilitation 02/22/17, Infectious Disease 02/15/17,	
02/24/YYYY	Hospital/Provider Name	**Nursing notes:** A female resident born 07/22/1940 was admitted from Coney Island Hospital via stretcher at 5:39 p.m. transported by two EMTs. Resident is Russian speaking. Primary diagnosis, past medical history: HTN, acute systolic heart failure, Type 2 diabetes mellitus with other circulatory complications and gastro-esophageal reflux disease without esophagitis. Resident has no glasses present. Has no hearing impairment. Lung sounds are clear on auscultation. Breathing is regular, with symmetrical chest movements. Abdomen is soft, non-tender on palpation, and non-distended. Bowel sounds can be heard in all four quadrants. Resident is continent of bladder with Foley Cath and incontinent of bowel. Skin assessment completed with Pressure ulcer of sacral region, stage 4. Pressure ulcer of unspecified for both heel, unstageable. Pressure ulcer of unspecified buttock, stage 4. Pressure ulcer of right buttock, stage 3. Nataliya Gorelko, M.D. was called upon admission. Resident was instructed on the use of call bell. Verbalized and demonstrated understanding on the use of same. Bed placed in lowest	4679

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		position. All need items within reach of resident. Also, made aware to call for assistance when needed. All safety and fall precautions in place. Will continue to monitor. Vitals: BP 177/94, PR 88, Temp 98.6, Spo2 95%, RR 18.	
02/25/YYYY	Hospital/Provider Name	**Nursing notes:** Resident status post new admission day #1. Resident received in bed. Alert, responsive, Russian speaking. Need assistance in all activities of daily living. Transfer with mechanical lift with 2 assist. Foley catheter in place, patent, draining yellow color urine. Slept fairly well. No complains of pain or any discomfort. Emotional support provided, with good effect. Safety precautions maintained. Bed in lowest position, call bell within reach.	4679
02/26/YYYY	Hospital/Provider Name	**Nursing notes:** Resident alert and verbally responsive with periods of confusion status post day #2 admission. Resident in stable condition with no acute distress, adjusting well to the unit. Turn and positioned provided every 2 hours. Resident was noted with swelling to left arm. Resident with history of CVA and left hemiplegia, left arm keep elevated on extra pillow for promotion venous return. Safety and aspiration precaution maintained.	4680
02/27/YYYY	Hospital/Provider Name	**X-ray of chest:** **Clinical indication:** Cough. **Impression:** No acute cardiopulmonary disease.	4440
02/27/YYYY	Hospital/Provider Name	**Speech therapy initial note:** Swallow evaluation was completed during lunch meal today. Phone conversation held with res daughter who reports at home resident consumed a pureed diet & nectar thick liquids (Since her CVA in Dec). Daughter reports history of coughing with intake of solid food or thin liquid. For today's assessment SLP Spoon-fed trials. Resident presented with functional tolerance of pureed solids & nectar thick liquids. With thin liquid trials, a prompt swallow was suspected with slightly increased work of breathing & wet VQ noted, though no coughing or signs/symptoms distress. Resident refused trials of soft solids. At this time, given resident history of dysphagia & management with trials during today's assessment, continuation of current diet of pureed solids & nectar thick liquids judged appropriate. Staff should feed slowly, with general safe feeding guidelines maintained. No further speech therapy recommended at this time.	4682
02/27/YYYY	Hospital/Provider Name	**Nursing wound assessment:** **Pressure ulcer location:** Right buttock Stage: 3 Measurements: 3 x 8 x 1.3 Undermining/tunneling: No Status of surrounding skin: Dry Pressure ulcer tissue base is: 65% slough, 35% red a semi-circle shape ulcer Ulcer is: Shallow Drainage amount is: Minimum	4680-4682

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Drainage type is: Serosanguineous Is there odor: No Periwound is: Healthy Present treatment: Santyl **Pressure ulcer location:** Right outer buttock Stage: 3 Measurements: 1.5 x 2 x 0.2 Status of surrounding skin: Dry Pressure ulcer tissue base is: 100% superficial yellow tissue Ulcer is: Shallow Drainage amount is: Minimum Drainage type is: Serosanguineous Is there odor: No Periwound is: Healthy Present treatment: Santyl **Pressure ulcer location:** Left buttock Stage: 4 Measurements: 12 x 10 x 5 Undermining from: 9-1 o' clock measures 7cm Tunneling: No Status of surrounding skin: Dry Pressure ulcer Tissue base is 80% tan/yellow tissue necrosis, 20% red granulating tissue bone palpable Ulcer is: Deep Drainage amount is: Minimum Drainage type is: Serosanguineous Is there odor: No Periwound is: Healthy Present treatment: Santyl **Pressure ulcer location:** Right heel Stage: Deep tissue injury. Measurements: 4 x 5 x 0 Status of surrounding skin: Dry Pressure ulcer tissue base is: 100% maroon hemorrhagic blister reabsorbing Drainage amount is: None Odor: No Periwound is: Healthy Present treatment: Dry dressing. **Pressure ulcer location:** Left heel Stage: Unstageable Measurements: 3 x 3 x 0 Status of surrounding skin: Dry Pressure ulcer tissue base is:100% black eschar, dry Drainage amount is: None	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Odor: No. Peri-wound is: Healthy Present treatment: DD (Dry Dressing). **Preventative measures:** Turn and positioning every 2 hours Incontinent care Level 2 mattress Positioning wedge/pillows Wheelchair cushion Pillow under calves to offload heels Out of bed scheduled **Comments:** Resident was admitted with HTN, acute systolic heart failure, type 2 diabetes mellitus, and multiple pressure ulcers. Resident pressure injuries to buttocks are not appropriate for negative pressure secondary to the percentage of tissue necrosis, suggest to continue Santyl	
02/27/YYYY	Hospital/Provider Name	**Speech therapy note:** Swallow evaluation was completed during lunch meal today. Phone conversation held with resident daughter who reports at home resident consumed a pureed diet & nectar thick liquids (since her CVA in Dec). Daughter reports history of coughing with intake of solid food or thin liquid. For today's assessment SLP spoon-fed trials. Resident presented with functional tolerance of pureed solids & nectar thick liquids. With thin liquid trials, a prompt swallow was suspected with slightly increased work of breathing & wet VQ noted, though no coughing or signs/symptoms of distress. Resident refused trials of soft solids. At this time, given resident history of dysphagia & management with trials during today's assessment, continuation of current diet of pureed solids & nectar thick liquids judged appropriate. Staff should feed slowly, with general safe feeding guidelines maintained. No further speech therapy recommended at this time.	4682
02/28/YYYY	Hospital/Provider Name	**Agency discharge summary:** **Date of referral:** 12/30/YYYY. **Date of admission:** 12/31/YYYY. **Final date of service:** 02/28/YYYY. **Length of stay:** 60. **Discharge reason:** Discharge-Episode ended. **Services provided:** Skilled nurse community health nurse: 6. Skilled nursing COC: 32. Physical therapy-FFS: 12. Occupational therapy-COC: 11.	719-722, 823-854

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Clinical notes: **Occupational therapy discharge summary:** Initial visit: The patient presented with improvement in functional mobility and activities of daily living care. **Treatments rendered:** Therapeutic exercise, ADL training, transfer training, safety/falls prevention/energy conservation training, home exercise program. **Progress made:** Patient presents with improvement in functional mobility and ADL care. **Summary of patient's discharge status:** ROM: Within functional limits bilateral upper extremities. Bed mobility: Minimal/Moderate. Transfers: Dependent. ADLs: Maximal/Dependent. HEP: Supervision. Adjustment: Support of family. **Continuing symptom management:** Continue with home exercise program follow-up with primary M.D. TCT Dr. Tiwari to inform of discharge TCT RN Gornak informed of discharge TCT PT Zeltser to inform of discharge TCT Rehab Supervisor PT Tavano informed of discharge. **02/10/YYYY:** Discharge date: 02/10/YYYY Initial visit: 01/04/YYYY Discipline: Physical therapy Treatment rendered: Therapeutic exercise, bed mobility, transfers, balance training, HEP. Progress made: Patient progressed with bed mob and improved sitting balance. Summary of patient's discharge status: ROM: Right upper extremity/lower extremity within functional limits, left upper extremity/lower extremity spastic. Manual muscle test: Right upper extremity/lower extremity 3+/5 Left upper extremity/lower extremity 1/5 Bed mobility: Min assist with rolling right/left; moderate assist with sup to sit Transfers: N/A. Patient bedbound Ambulation: N/A, Patient bedbound Stairs: N/A. HEP: E.g. Adjustment: Support of family and assistive device. Continuing symptom management: Continue with home exercise program.	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		TCT Dr. Tiwari to inform of discharge TCT (E-mail) Ioulia Cheiko, RN informed of discharge. TCT (E-mail) rehab supervisor-Glenda Tavano informed of discharge. **02/13/YYYY:** As per patient daughter Bella, patient admitted to CIH on 7E room 16. Team K3 notified. I Gornak COC. **02/13/YYYY:** SN visit performed for clinical assessment and wound care Wound care performed as ordered as per decision between PMD/family; the patient will be transfer to CIH hospital for wounds debridement. I Gornak COC.	
03/01/YYYY	Hospital/Provider Name	**Social worker note:** **Admission note:** Resident is admitted from Coney Island Hospital for short term rehab. Resident has diagnosis of HTN, acute systolic heart failure, type 2 diabetes mellitus with other circulatory complications and gastro-esophageal reflux disease without esophagitis. Resident is alert and verbal. Social worker Galina provided Russian translation. Resident is alert, oriented x 2 person, place with confusion to time. Resident has periods of confusion and forgetfulness. Resident scored 8/15 on BIMs assessment. Residents left memory has some impairment. ST memory impaired. Resident is able to verbalize her needs. Resident is able to participate in basic decision making however she is unable to participate in complex decision making. Resident's mood is stable at this time. SW spoke with resident's daughter Diane via telephone to discuss resident's background. As per residents daughter, resident was living alone in elevator building. Resident has 24 x 7 HHA (Home Health Assist) via Village care max. Resident was utilizing w/c to assist with ambulation. Resident was partially dependent in ADLs such as dressing and bathing. Resident's medications were managed by family. As per daughter, resident had nurse who would come to the residents home to address wound care. Resident's daughter will follow-up with SW regarding skilled nursing agency information. Plan is for resident to return home with reinstated home care hours. Resident has two daughters a son and granddaughter who are actively involved in her care. Resident is widowed, her husband passed in 2014. Resident is Jewish, inactive. Resident enjoys watching TV. Resident is retired factory worker. SW reviewed advance directives with resident's daughter who declined to enact advance directives at this time. Residents daughter verbalized understanding that resident is full code at this time. SW informed resident's daughter of resident rights including advance directives, clothing needs, safekeeping of valuables, grievance/lost property complaints, financial aspects of short and long term placement, out of facility medical appointments, room change, therapeutic leave & bed-hold status.	4684
03/06/YYYY	Hospital/Provider Name	**Nursing wound assessment:** **Pressure ulcer location:** Right buttock Stage: 3 Measurements: 11 x 8 x 1.5 Undermining/tunneling: No Status of surrounding skin: Dry Pressure ulcer tissue base is: 75% slough, 25% red a semi-circle shape ulcer	4684-4686

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Ulcer is: Shallow Drainage amount is: Minimum Drainage type is: Serosanguineous Is there odor: No Periwound is: Healthy Present treatment: Santyl **Pressure ulcer location:** Right outer buttock Stage: 3 Measurements: 1.0 x 1.5 x 0.2 Status of surrounding skin: Dry Pressure ulcer tissue base is: 70% superficial yellow tissue, 30% red granulating tissue Ulcer is: Shallow Drainage amount is: Minimum Drainage type is: Serosanguineous Is there odor: No Periwound is: Healthy Present treatment: Santyl **Pressure ulcer location:** Left buttock Stage: 4 Measurements: 11 x 10 x 5 Undermining from: 9-1 o' clock measures 7cm Tunneling: No Status of surrounding skin: Dry Pressure ulcer tissue base is 90% tan/yellow tissue necrosis, 10% red granulating tissue bone palpable Ulcer is: Deep Drainage amount is: Minimum Drainage type is: Serosanguineous Is there odor: Yes Periwound is: Healthy Present treatment: Santyl **Pressure ulcer location:** Right heel Stage: Deep tissue injury. Measurements: 3.5 x 4 x 0 Status of surrounding skin: Dry Pressure ulcer tissue base is: 100% maroon hemorrhagic blister reabsorbing Drainage amount is: None Odor: No Periwound is: Healthy Present treatment: Dry dressing. **Pressure ulcer location:** Left heel Stage: Unstageable Measurements: 3.5 x 3 x 0	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Status of surrounding skin: Dry Pressure ulcer tissue base is:100% black eschar, dry Drainage amount is: None Odor: No. Peri-wound is: Healthy Present treatment: DD (Dry Dressing). **Preventative measures:** Turn and positioning every 2 hours Incontinent care Level 2 mattress Heel protectors Positioning wedge/pillows Wheelchair cushion Pillow under calves to offload heels Out of bed scheduled **Comments:** Continue plan of care.	
03/08/YYYY	Hospital/Provider Name	**Nursing notes:** Resident alert and verbally responsive with confusion all times. No nausea or vomiting was noted this tour. Turn and positioned provided every 2 hours. Extra fluids given and tolerated well. Safety precaution maintained.	4687
03/13/YYYY	Hospital/Provider Name	**Nursing notes:** Resident was seen at the bedside by Dr. Nahata (Vascular) for minor debridement of sacral ulcer. Resident noted with minor bleeding status post debridement, pressure applied by MD and wound packed as per treatment orders. Wound site rechecked 1-hour after debridement, bleeding had stopped. Following shift endorsed to monitor.	4687
03/21/YYYY	Hospital/Provider Name	**Nutrition notes:** Resident noted poor per oral intake, frequently consuming 25% of meals. Recommend to discontinue LC therapeutic restriction for diet liberalization and for greater per oral intake. Order Glucerna 1.2 8oz per oral daily to help meet nutritional requirements. Weekly weights are being monitored. Continue to monitor ongoing and follow-up as needed.	4689
03/24/YYYY	Hospital/Provider Name	**Interim speech therapy summary:** ***No of completed treatments:*** *8.* ***No of missed treatments:*** *0.* ***Ref:*** *4423-4425, 4431, 4687, 4688, 4433-4435, 4334-4336*	
03/27/YYYY	Hospital/Provider Name	**Interim occupational therapy summary:** ***Treatments given:*** *Therapeutic exercises, neuromuscular re-education, manual therapy, therapeutic activities, self-care training*	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		No of completed treatments: *13.* ***Missed treatments:*** *0.* *Ref: 4437-4438, 4459-4460, 4462-4464, 4427-4429, 4344-4347*	
03/27/YYYY	Hospital/Provider Name	**Nursing wound assessment:** **Pressure ulcer location:** Right buttock Stage: 3 Measurements: 11 x 10 x 1.0 Undermining/tunneling: No Status of surrounding skin: Dry Pressure ulcer tissue base is: 50% slough, 50% red a semi-circle shape ulcer a cluster of ulcers Ulcer is: Shallow Drainage amount is: Minimum Drainage type is: Serosanguineous Is there odor: No Periwound is: Healthy Present treatment: Santyl **Pressure ulcer location:** Right outer buttock Stage: 3 Measurements: 1.0 x 1.0 x 0.1 Status of surrounding skin: Dry Pressure ulcer tissue base is: 20% superficial yellow tissue, 80% red granulating tissue Ulcer is: Shallow Drainage amount is: Minimum Drainage type is: Serosanguineous Is there odor: No Periwound is: Healthy Present treatment: Santyl **Pressure ulcer location:** Left buttock Stage: 4 Measurements: 10 x 11 x 4 Undermining from: 10-3 o' clock measures 6cm Tunneling: No Status of surrounding skin: Dry Pressure ulcer tissue base is 60% tan/yellow tissue necrosis, 40% red granulating tissue bone palpable Ulcer is: Deep Drainage amount is: Minimum Drainage type is: Serosanguineous Is there odor: No Periwound is: Healthy	4690-4692

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Present treatment: Santyl **Pressure ulcer location:** Right heel Stage: Deep tissue injury. Measurements: 3 x 4 x 0 Status of surrounding skin: Dry Pressure ulcer tissue base is: 100% maroon hemorrhagic blister reabsorbing Drainage amount is: None Odor: No Periwound is: Healthy Present treatment: Dry dressing. **Pressure ulcer location:** Left heel Stage: Unstageable Measurements: 2 x 3 x 0 Status of surrounding skin: Dry Pressure ulcer tissue base is:100% black eschar, dry Drainage amount is: None Odor: No. Peri-wound is: Healthy Present treatment: DD (Dry Dressing). **Preventative measures:** Turn and positioning every 2 hours Incontinent care Level 2 mattress Heel protectors Positioning wedge/pillows Wheelchair cushion Pillow under calves to offload heels Out of bed scheduled **Comments:** Continue plan of care. **Pain:** Resident showed no signs and symptoms of pain during assessment.	
03/28/YYYY	Hospital/Provider Name	**Speech therapy note:** Late entry-Speech therapy discharged from 3/24. Resident has been followed by SLP for possible diet upgrade. At this time, it is rec to continue with a pureed diet & thin liquids. However, resident does display the ability to tolerate some very soft/moist solid items. Bread & egg salad cup will be added to dietary order. Resident should be positioned as upright as possible during per oral intake. Per documentation from staff, the plan is for resident to return home at this end of this week. SLP reviewed diet recommendations with res daughter & also reviewed a list of several soft solid items that res has been able to tolerate, which family intend to provide once she returns home. Discharge from speech therapy recommendations at this time.	4695
04/10/YYYY	Hospital/Provi	**Nursing wound assessment:**	4696-

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
	der Name	**Pressure ulcer location:** Right buttock inner (A cluster of 4) Stage: 3 Measurements: 10 x 11 x 1 Undermining/tunneling: No Status of surrounding skin: Dry Pressure ulcer tissue base is: 60% slough, 4% red granulating tissue a semi-circle shape ulcer a cluster of 4 ulcers Ulcer is: Shallow Drainage amount is: Minimum Drainage type is: Serosanguineous Is there odor: No Periwound is: Healthy Present treatment: Santyl **Pressure ulcer location:** Right outer buttock Stage: 3 Measurements: 0.5 x 1.0 x 0.1 Status of surrounding skin: Dry Pressure ulcer tissue base is: 100% red granulating tissue Ulcer is: Superficial Drainage amount is: Scant Drainage type is: Serosanguineous Is there odor: No Periwound is: Healthy Present treatment: Santyl **Pressure ulcer location:** Left buttock Stage: 4 Measurements: 10 x 11.4 x 4 Undermining from: 10-3 o' clock measures 6cm Tunneling: No Status of surrounding skin: Dry Pressure ulcer tissue base is 60% tan/yellow tissue necrosis, 40% red granulating tissue bone palpable Ulcer is: Deep Drainage amount is: Moderate Drainage type is: Serosanguineous Is there odor: Yes Periwound is: Healthy Present treatment: Santyl Recommended treatment change: Dakin's moist dressings. Comment: Pressure injury to left buttock connects with one of the right inner buttock ulcer at 3 o' clock **Pressure ulcer location:** Right heel Stage: Deep tissue injury, no unstageable Measurements: 3 x 4 x 0	4698

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Status of surrounding skin: Dry Pressure ulcer tissue base is: 100% black stable eschar Drainage amount is: None Odor: No Periwound is: Healthy Present treatment: Dry dressing. **Pressure ulcer location:** Left heel Stage: Unstageable Measurements: 3 x 3 x 0 Status of surrounding skin: Dry Pressure ulcer tissue base is:100% black eschar, dry Drainage amount is: None Odor: No. Peri-wound is: Healthy Present treatment: DD (Dry Dressing). **Preventative measures:** Turn and positioning every 2 hours Incontinent care Level 2 mattress Heel protectors Positioning wedge/pillows Wheelchair cushion Pillow under calves to offload heels Out of bed scheduled Other: Foley. **Comments:** Continue plan of care. **Pain:** Resident showed no signs and symptoms of pain during assessment.	
04/12/YYYY	Hospital/Provider Name	**Nutrition notes:** Recently triggered for weight loss. Resident noted poor per oral intake, frequently consuming 25% of meals. LC therapeutic restriction previous. Discontinued for diet liberalization and for greater per oral intake. Ordered Glucerna 1.2 8oz daily to help meet nutritional requirements. Weekly weights are being monitored. Episodes of vomiting undigested foods noted, as per NSG notes. Weight remains > IBW range 123-151lbs, BMI 39 (Obese). Continue to monitor ongoing and follow-up as needed.	4698
04/15/YYYY	Hospital/Provider Name	**Progress notes:** **Subjective:** Patient is seen for discoloration in the right upper thigh noted during care today. Patient has indwelling cath. **Objective:** Right thigh: Linear purplish red discoloration in the right upper thigh. **Assessment/plan:** Skin changes-Peri-guard and cover with combine.	4699

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
04/16/YYYY	Hospital/Provider Name	**Progress notes:** Resident observed with maroon color linear shape skin changes on anterior aspect of right upper thigh. **Assessment/plan:** Deep tissue injury from pressure by Foley catheter-Apply dry dressing daily.	4699
04/17/YYYY	Hospital/Provider Name	**Nursing wound assessment:** **Pressure ulcer location:** Right inner thigh secondary to medical device (Foley catheter) Stage: Deep tissue injury Measurements: 1 x 13 x 0 Undermining/tunneling: No Status of surrounding skin: Dry Pressure ulcer tissue base is: 100% maroon, dry, closed, linear Drainage amount is: None Is there odor: No Periwound is: Healthy Present treatment: Peri-guard with dry dressings. **Pressure ulcer location:** Right buttock inner (A cluster of 4) Stage: 3 Measurements: 10 x 10 x 2 Undermining/tunneling: No Status of surrounding skin: Dry Pressure ulcer tissue base is: 60% slough, 4% red granulating tissue a semi-circle shape under a cluster of 4 ulcers Ulcer is: Shallow Drainage amount is: Minimum Drainage type is: Serosanguineous Is there odor: No Periwound is: Healthy Present treatment: Peri-guard with dry dressings. **Pressure ulcer location:** Right outer buttock Stage: 3 Measurements: 0.5 x 1.0 x 0.1 Status of surrounding skin: Dry Pressure ulcer tissue base is: 100% red granulating tissue Ulcer is: Superficial Drainage amount is: Scant Drainage type is: Serosanguineous Is there odor: No Periwound is: Healthy Present treatment: Santyl **Pressure ulcer location:** Left buttock	4700-4702

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Stage: 4 Measurements: 10 x 10 x 4 Undermining from: 10-3 o' clock measures 6cm Tunneling: No Status of surrounding skin: Dry Pressure ulcer tissue base is 60% tan/yellow tissue necrosis, 40% red granulating tissue bone palpable Ulcer is: Deep Drainage amount is: Moderate Drainage type is: Purulent/thick/yellow Is there odor: Yes Periwound is: Healthy Present treatment: Dakin's moist dressings. Comment: Pressure injury to left buttock connects with one of the right inner buttock ulcer at 3 o' clock **Pressure ulcer location:** Right heel Stage: Unstageable Measurements: 2 x 2 x 0 Status of surrounding skin: Dry Pressure ulcer tissue base is: 100% black stable eschar Drainage amount is: None Odor: No Periwound is: Healthy Present treatment: Dry dressing. **Pressure ulcer location:** Left heel Stage: Unstageable Measurements: 3 x 3 x 0 Status of surrounding skin: Dry Pressure ulcer tissue base is:100% black eschar, dry Drainage amount is: None Odor: No. Peri-wound is: Healthy Present treatment: DD (Dry Dressing). **Preventative measures:** Turn and positioning every 2 hours Incontinent care Level 2 mattress Heel protectors Positioning wedge/pillows Wheelchair cushion Pillow under calves to offload heels Out of bed scheduled Other: Foley. **Comments:** Resident was seen today, resident noted with left buttock pressure	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		injury with thick yellow pus drainage, odor presently on Dakin's moist dressings, to decrease bio -burden and odor which was ineffective. Plan of care discussed with MD, to transfer to hospital for debridement and to rule out osteomyelitis to left buttocks at 4. **Pain:** Resident showed no signs and symptoms of pain during assessment.	
02/24/YYYY-04/17/YYYY	Hospital/Provider Name	**Nursing home related records:** *Certification, orders, assessment, flow sheets, labs, MDS sheets* *Ref: 4693, 4454, 4088-4330, 4662-4678, 4698-4699, 4653-4661, 4694-4695, 4684, 4689, 4465-4652*	
04/17/YYYY	Hospital/Provider Name	**Medical transfer summary:** **Reason for transfer:** Infected left buttock pressure ulcer stage IV, rule out osteomyelitis. **Advance directives:** Full code. **Clinical summary (including medical history, events leading up to transfer, any pertinent labs/data, etc.):** She presented with past medical history of cerebrovascular accident with left hemiparesis, hypertension, diabetes mellitus, bedridden admitted to the hospital with worsening pressure ulcers. Sacral decubiti ulcer status post debridement. Completed 10-days of IV antibiotics-Vanco and Zosyn. Currently she has multiple pressure ulcers. Left buttock pressure ulcer stage IV has purulent drainage with 60% tan yellow tissue, bone palpable. Transfer to rule out osteomyelitis, infected pressure ulcer. **Physical examination:** Abdomen: Soft, non-tender, bowel sounds present. Extremities: Trace edema bilateral legs. Neurological: Left side weakness Other: Skin-Nurse assessment pressure ulcer. **Assessment/plan:** Infected left buttock pressure ulcer, rule out osteomyelitis. **Destination (facility being transferred to):** CIH (Coney Island Hospital).	4703-4704
04/17/YYYY	Hospital/Provider Name	**ER nursing notes:** Patient alert and responsive to voice, brought in from nursing home for sacral wound decubiti with purulent drainage. Bilateral stage II heel decubiti. No acute distress noted. Awaiting to be seen	2391-2392
04/17/YYYY	Hospital/Provider Name	**ER visit for wound infection:** **Chief complaint:** Wound infection from Nursing Home. **History of present illness:** The patient is transferred from nursing home for	2390-2391

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		evaluation of worsening sacral decubiti with purulent drainage despite recent completion of 10-days of Vancomycin and Zosyn. **Physical examination:** Constitutional: Lying on stretcher. Appears chronically ill. GU: Foley catheter intact with amber urine in bag. Neurological: Responds to name. Does not follow directions. Skin: Decubiti to heels. Sacral decubiti extending to bone with yellowish discharge. **Assessment and plan:** Wound cultures. IV antibiotics. Admit.	
04/17/YYYY	Hospital/Provider Name	**History and physical examination report:** **Chief complaint:** Wound infection from nursing home. **History of present illness:** She presented with past medical history of cerebrovascular accident with residual left sided hemiparesis, HTN, DM, CHF, sacral decubitus ulcer Who was sent from menorah NH due to foul smelling discharge from sacral decubitus ulcer. She was discharged from CIH in February after sacral decubitus ulcer debridement and received Zosyn and Vanco for 10-days. As per the son by bedside, the doctor in NH sent her to ER due to smelly discharge from ulcer. Denies fever, chill, back pain, chest pain, abdominal pain, change in urination, change in bowel movement, bloody bowel movement, vomiting blood. Told by Nursing Home doctor that she has anemia. The patient doesn't walk at baseline. Wheelchair bound. **Vitals:** Temp 99.4. **Physical examination:** Skin: Sacral decubitus ulcer, right heel ulcer. Neurology: Alert, awake, oriented x 3; left sided arm muscle strength 0/5, lower extremity muscle strength -2/5. **Labs on 04/17:** WBC 14.0 *(High)*, RBC 2.45 *(Low)*, Hgb 6.7 *(Low)*, HCT 20.5 *(Low)*, MPV 6.7 *(Low)*, RDW 17.4 *(High)*, PLT 557 *(High)* **Assessment/plan:**	2394-2399

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Infected sacral decubitus ulcer Urinary tract infection Normocytic anemia CVA with residual left sided hemiparesis Hypertension Diabetes mellitus Congestive heart failure Gentle hydration Zosyn and Vancomycin Follow-up pan cultures Urine lytes Renal ultrasound Type and screen Repeat CBC Will give 1 unit of PRBC when blood is available Consent is in the chart Continue nursing home meds Hold metformin in v/o elevated lactate; hold ASA, Plavix in v/o anemia. Stool Guaiac Plan of care Sliding scale Doppler deep vein thrombosis study , if negative deep vein thrombosis prophylaxis with sequential compression device Anemia work up Surgery evaluation	
04/17/YYYY	Hospital/Provider Name	**X-ray of chest:** **Clinical history:** Rule out infiltrate. Osteoarthritis of thoracic spine. Cardiomegaly with congestive heart failure with bilateral pleural effusions. No obvious pulmonary infiltrate. Repeat exam is recommended. Limited rotated view. Cardiomegaly with congestive heart failure with bilateral pleural effusions. No obvious pulmonary infiltrate. Repeat exam is recommended.	2533-2534
04/17/YYYY	Hospital/Provider Name	**Labs:** Blood culture: No growth at 5-days. Urine culture: Culture grew 3 or more types of organisms which indicate collection contamination; consider re-collection only if clinically indicated	2527-2529
04/18/YYYY	Hospital/Provider Name	**General surgery consultation report:** She presented with past medical history of cerebrovascular accident with residual left sided hemiparesis, HTN, DM, CHF, sacral decubitus ulcer, who was sent to	2399

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		ER from nursing home due to foul smelling worsening sacral decubitus ulcer with purulent discharge. The patient last received debridement of sacral decubitus ulcer in 02/YYYY and received 10-days of Zosyn/Vancomycin. **Physical exam:** Back: Full-thickness skin loss extends into muscle, bone, joints, tendons, purulent drainage. **Labs:** WBC 15.3, BUN 24, Cr 1.36. **Radiology:** **Chest X-ray:** Cardiomegaly with congestive heart failure with bilateral pleural effusions. **Assessment:** She presented with infected stage IV sacral decubitus ulcer. **Plan:** 1. Surgical debridement of necrotic tissue performed at bedside by senior chief resident 2. Wound care 3. Wet-dry dressings 4. Antibiotics 5. Pressure off loading	
04/18/YYYY	Hospital/Provider Name	**General surgery follow-up note:** She presented presenting with sacral decubitus ulcer. Ulcer was debrided bedside in the afternoon, with necrotic tissue debrided with sharp instrumentation. Sacral ulcer still appears to have some fibrous tissue and edges have good granulation, pink and non-bloody. **Assessment/plan:** Continue wound care Apply collagenase over exposed sacral decubitus ulcer Wet to dry dressing Pressure dressing over wet to dry Antibiotics Pressure off loading Surgery to follow Continue management as per primary team	2400
04/18/YYYY	Hospital/Provider Name	**Initial nutrition assessment:** **Diagnosis:** Sacral decubitus ulcer, stage IV Wound infection Hypokalemia **Skin integrity:** Stage III pressure ulcers, unstageable pressure ulcers, deep tissue injury.	2426-2429

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Nutrition risk level: High (Changed to moderate). **Diet order/oral supplements:** Diet: Diabetic; mechanical soft; medium CCD (1800-2000 Kcal) Estimated nutritional requirements based on: IBW (Ideal Birth Weight) Calories: 1560 kcal/day based on 30 kcal/kg Protein: 62.4 gm/day based on 1.2 gm/kg. Fluid: 1300 ml/day based on 25 ml/kg. Current nutrition order meets estimated needs: Yes. **Recommendations:** Maintain current diet; add prot 1 pack twice daily.	
04/18/YYYY	Hospital/Provider Name	**Speech-language pathology dysphagia evaluation:** **Related medical diagnosis:** History of cerebrovascular accident. **Diagnostic impression:** The patient presented with mild pharyngeal phase dysphagia complicated by mildly disco-ordinated pharyngeal swallow with overt signs/symptoms of aspiration on thin liquids with sequential sips via straw. Functional swallow of thin liquids without overt s/s of aspiration with controlled sips via open cup. No overt signs/symptoms of aspiration on regular solids on all trials. Functional oral management of regular solids and thin liquids. Oral phase dysphagia ruled out. **Recommendations:** Risk for aspiration: Low (with use of safe swallow strategies) Risk for malnutrition: None Feeding: Continue oral feeding Diet solids: Regular Diet liquids: Thin Form of medications: Whole Compensatory swallowing strategies/instructions for feeding: Position patient as upright as possible for all oral intake, remain upright after oral intake for at least 30 minutes, utensils, modification to bolus size, eat/feed slowly, monitor for clinical signs/symptoms of aspiration, monitor for fatigue, nutritional intake and pulmonary status. Utensil: Spoon, cup, no straws Modification to bolus size: Small controlled sips **Plan for treatment:** **Dysphagia treatment:** No. **Reason for not providing treatment:** Functional swallowing skills with use of safe swallow strategies (small bolus size, pacing, thin liquids via tsp and cup, and no straws). Will follow-up x 1 to review safe swallow strategies. **Duration:** N/A.	2430-2433, 5071-5075

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Frequency: N/A. **Prognosis:** Good. Functional swallow of the least restrictive per oral diet consistency with use of safe swallow strategies.	
04/19/YYYY	Hospital/Provider Name	**General surgery follow-up note:** She presented for status post sacral wound debridement. Patient seen and examined in the morning. No active issues overnight. Wound underwent extra debridement yesterday. **Objective:** General: No acute distress, lying comfortably in bed Sacrum: 4cm x 5cm stage IV ulcer with granulation tissue on edge, 2cm x 3cm left buttocks granulation tissue **Assessment/plan:** She is now status post sacral wound debridement Collagenase/ chemical debridement by wound care Wet to dry packing change daily Pressure dressing Optimize nutrition Continue care as per primary team Continue care with wound care Surgery signing off, re-consult as needed	2400-2401
04/19/YYYY	Hospital/Provider Name	**Dysphagia treatment note:** **Subjective:** The patient was seen for dysphagia f/u to reassess swallowing function with consistencies recommended (regular solids and thin liquids) and to review safe swallow strategies. The patient alert, oriented x 2, followed directions and expressed wants/needs in her primary language. **Assessment/functional status:** Functional oral management of regular solids and thin liquids. Functional pharyngeal phase of swallow without overt signs/symptoms of aspiration with use of safe swallow strategies (I.e., Small bolus size, pacing, liquids via cup, no straws). **Recommendations:** Risk for aspiration: Low (with use of safe swallow strategies) Risk for malnutrition: None Feeding: Continue oral feeding Diet solids: Regular Diet liquids: Thin Form of medications: Whole Compensatory swallowing strategies/instructions for feeding: Position patient as upright as possible for all oral intake, remain upright after oral intake for at least 30 minutes, utensils, modification to bolus size, eat/feed slowly, monitor for clinical signs/symptoms of aspiration, monitor for fatigue, nutritional intake and pulmonary status.	2433-2435, 5076

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Utensil: Spoon, cup, no straws Modification to bolus size: Small controlled sips **Reason for not providing treatment:** Functional swallowing skills with use of safe swallow strategies (small bolus size, pacing, thin liquids via tsp and cup, and no straws). Will discontinue dysphagia follow-up.	
04/19/YYYY	Hospital/Provider Name	**Ultrasound of lower extremity venous Doppler:** **Clinical history:** Rule out deep vein thrombosis, lower extremity swelling. **Impression:** No evidence of deep venous thrombosis in the visualized veins of the right and left lower extremity. Lower extremity venous system was obtained supplemented with color and spectral Doppler images.	2564
04/20/YYYY	Hospital/Provider Name	**Infectious disease consultation report:** **History of present illness:** She presented with past medical history of CVA with residual left sided hemiparesis, HTN, DM, and CHF, sacral decubitus ulcer, sent from NH for infected sacral decubitus ulcer. **Review of systems:** Complains of pain at sacral ulcer. **Physical examination:** Abdomen: Obese. Extremities: Right heel stage III ulcer. Skin: No rash. Sacral area stage 4 decubitus ulcer 5 x 5cm with necrotic base and purulent discharge. **Assessment/plan:** She presented with sacral decubitus ulcer, stage 4, status post debridement on 04/18, Patient is on Vancomycin and Zosyn IV, leukocytosis improving. Sacral bone MRI to rule out osteomyelitis. ESR/CRP. Continue current antibiotics. Will determine antibiotic therapy duration after MRI results are unknown.	2406-2409
04/23/YYYY	Hospital/Provider Name	**Infectious disease follow-up note:** **Review of systems:** Complains of pain at sacral ulcer. **Objective:** Skin: Sacral area stage 4 decubitus ulcer 5 x 5cm. **Radiology:** MRI of sacrum pending. **Assessment/plan:** She presented with sacral decubitus ulcer stage IV, status post debridement on 04/18. Patient is on Vancomycin and Zosyn IV, leukocytosis	2409-2411

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		improving. Sacral bone MRI to rule out osteomyelitis. ESR/CRP. Continue current antibiotics. ID will follow.	
04/25/YYYY	Hospital/Provider Name	**X-ray of sacrum and coccyx:** **Clinical history:** Sacral ulcer to rule out osteomyelitis. Examination of the sacrum in AP and lateral views reveals study is very limited. Degenerative disease of the lumbar spine. Artifact versus a low-attenuation of the left side of the sacrum is noted and for further evaluation CT of the sacrum is recommended. The lucency with air collections in the posterior soft tissues of the sacrum may represent ulcer. Large calcified leiomyoma of the uterus and leiomyoma measures about 8.82 cm x 1.46 cm in diameter of the leiomyoma is noted. Vascular calcifications. Study is very limited for evaluation of the sacrum to rule out osteomyelitis. Left side of the sacrum is poorly evaluated in this study and further evaluation CT of the sacrum is recommended. Ulcer in the posterior soft tissues of the sacrum is noted. Large calcified leiomyoma of the uterus.	2625
04/26/YYYY	Hospital/Provider Name	**Infectious disease follow-up note:** **Review of systems:** Complains of pain at sacral ulcer. **Objective:** Skin: Sacral stage IV ulcer. **Assessment/plan:** She presented with sacral decubitus ulcer, stage IV, status post debridement on 04/18, and large leiomyoma of the uterus. Patient is on Vancomycin and Zosyn IV. As per ID recommendations on 04/23. Sacral bone MRI to rule out osteomyelitis. ESR/CRP. Continue current antibiotics. ID will follow.	2411-2413
04/26/YYYY	Hospital/Provider Name	**MRI of lumbar spine without contrast:** **Clinical history:** Low back pain, prior surgery, sacral ulcer; rule out osteomyelitis. **Findings:**	2633-2634

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Evaluation is markedly limited on this study particularly without intravenous contrast. The lumbar spine demonstrates a mild levoscoliosis. The vertebral body heights are maintained. There is abnormal T1 hypointense signal involving the subcutaneous tissues and skin overlying the coccyx on the left likely the site of stated ulcer. There is abnormal T1 hypointense signal involving the left coccyx and left sacroiliac joint as well as apparent involvement of the medial left ilium and lateral sacrum on the left. There is T2 hyperintense signal in the pre-coccygeal area which may represent edema. Further evaluation with bone scan as well as MRI of the pelvis with contrast is recommended. There is disc desiccation and loss of intervertebral disc space height throughout the lumbar spine. The conus medullaris ends at approximately the T12/L1 level. At the L1/L2 level: There is a diffuse disc bulge without significant canal stenosis or neural foraminal narrowing. At the L2/L3 level: There is a diffuse disc bulge and superimposed central disc protrusion that in combination with bilateral facet degenerative changes/ ligamentum flavum infolding results in mild canal stenosis. There is mild bilateral neural foraminal narrowing. At the L3/L4 level: There is a diffuse disc bulge and right foraminal that in combination with bilateral facet degenerative changes/ligamentum flavum infolding results in mild to moderate canal stenosis. There is moderate left and moderate to severe right-sided neural foraminal narrowing. At the L4/L5 level: There is a diffuse disc bulge that in combination with bilateral facet degenerative changes/ligamentum flavum infolding results in moderate canal stenosis. There is severe left and moderate right-sided neural foraminal narrowing. At the L5/S1 level: There is a diffuse disc bulge that in combination with bilateral facet degenerative changes/ligamentum flavum infolding results in mild canal stenosis. There is mild to moderate bilateral neural foraminal narrowing. **Impression:** Markedly limited evaluation particularly without intravenous contrast. Abnormal signal involving the subcutaneous tissues and skin overlying the coccyx on the left likely the site of stated ulcer. Abnormal signal involving the left coccyx and left sacroiliac joint as well as apparent involvement of the medial aspect of the left ilium as well as lateral sacrum on the left. Abnormal signal in the pre-coccygeal area which may represent edema. Further evaluation with bone scan as well as MRI of the pelvis with contrast is recommended. Moderate canal stenosis at L4/L5. Neural foraminal narrowing as detailed above.	
04/27/YYYY	Hospital/Provi	**Nutrition re-assessment:**	2456-

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
	der Name	**Recommendations:** Maintain current diet, change suppl to DB oral 1can thrice daily. Continue Prot and Arg and glutin	2460
04/29/YYYY	Hospital/Provider Name	**Infectious disease follow-up note:** She is sent from nursing home for infected sacral decubitus ulcer. **Objective:** **Skin:** Sacral area stage IV decubitus ulcer 5 x 5 cm **Assessment/plan:** She presented with sacral decubitus ulcer stage IV, status post debridement on 04/18, patient is on Vancomycin and Zosyn IV, leukocytosis improved. High EST/CRP. Complete 2-weeks of IV Vancomycin and Zosyn (Last dose 04/30) From 05/01, start Bactrim DS and Levofloxacin 500mg x 2 more weeks. Daily wound care.	2413-2416
05/01/YYYY	Hospital/Provider Name	**Physical therapy inpatient evaluation report:** **Assessment:** **Activity tolerance:** Patient limited by fatigue. **Physical therapy impairments:** **Body function/ body structure control:** Coordination **Functional limitations:** Strength, gait, flexibility, attention, awareness, speech. **Activity limitations:** Locomotion. **Treatment/interventions:** Activities of daily living retraining, functional transfer training, bed mobility, gait training. **Recommendations:** Bedside physical therapy.	2469-2473
04/17/YYYY-05/01/YYYY	Hospital/Provider Name	**Hospitalization related records:** *Peri-op records, nursing notes, progress notes, case management note, transfusion record, social work note, plan of care, patient instruction, orders, MAR, patient education, discharge instruction, medication sheet, labs.* *Ref: 2519-2522, 2416, 2416, 2416-2417, 2417-2426, 2435-2437, 2516-2518, 2783, 4705, 2437-2439, 2402-2405, 2440-2442, 2443-2445, 2442-2443, 2445-2446, 2446-2454, 2454-2456, 5077-5084, 2463-2465, 2824-2828, 2460-2461, 2461-2463, 2482-2486, 2489-2515, 2465-2468, 2473-2482, 2482, 2482, 2486-2488, 2488, 2516, 2523-2669, 2670-2723, 2723-2769, 2772-2775, 5085-5097, 5098-5138, 5152, 2468-2469*	
05/01/YYYY	Hospital/Provider Name	**Discharge summary:** **Admit date**: 04/17/YYYY. **Discharge date:** 05/01/YYYY.	2392-2394, 2515-2516

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Admitting physician: Pavel Shulman, M.D. **Discharge physician**: Michael Hohyun Mun, D.O. **Admission diagnoses**: Hypokalemia Wound infection Sacral decubitus ulcer, stage IV History of cerebrovascular accident with left hemiparesis Hypertension Congestive heart failure, unknown systolic Vs diastolic Diabetes mellitus **Discharge diagnoses**: **Active problems:** Sacral decubitus ulcer sacral decubitus ulcer stage 4 History of cerebrovascular accident with left hemiparesis Hypertension Chronic congestive heart failure, unknown systolic Vs diastolic Diabetes mellitus Bilateral heel ulcer, unstageable **Hospital course**: Patient presented with foul smelling discharge from decubitus ulcer. Patient admitted for infected sacral ulcer and UTI (Urinary Tract Infection). MRI of lumbar spine shows possibility of osteomyelitis. Infection treated with IV Vancomycin and Zosyn and transitioned to oral Bactrim and Levofloxacin. Patient will continue treatment of oral antibiotics until 05/15/YYYY. Patient received referral for gastrointestinal clinic and Hem Onc clinic for evaluation of anemia. **Referrals on discharge**: Gastrointestinal and hematology/oncology **Discharged condition:** Stable **Discharge examination**: Abdomen: Positive bile sounds, round non-distended/non-tender Extremities: Positive edema/no cyanosis. **Discharge plan**: Continue oral Bactrim and Levofloxacin for 2 weeks (05/15/YYYY). Referral for gastrointestinal and Hem Onc Clinics. Follow-up Dr. Shulman in 2 weeks. **Discharge meds:** Atorvastatin 80mg, nightly Carvedilol 25mg, two times with meals Collagenase topical daily Heparin 5,000 units subcutaneous every 12 hours	

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		Insulin glargine 30units subcutaneous nightly Insulin Lispro 1-20 units subcutaneous meals & at bedtime Isosorbide Mononitrate 120mg daily Levofloxacin 500mg daily Pantoprazole 20mg every morning Sulfamethoxazole-Trimethoprim every 12 hours **Disposition**: Subacute rehab **Diet**: Diabetic, mechanical soft	
05/01/YYYY	Hospital/Provider Name	**Re-admission medical assessment:** **Reason for transfer to hospital:** Patient with past medical history of CVA with left hemiparesis, HTN, DM, bedridden admitted to the hospital with worsening pressure ulcers. Sacral decubiti ulcer status post debridement. Completed 10 days of IV antibiotics-Vancomycin and Zosyn. Left buttock Pu stage IV had purulent drainage, bone palpable. Transferred to CIH to rule out osteomyelitis. **Summary of hospitalization:** MRI done, showed osteomyelitis, treated with Vancomycin and Zosyn IV, then switched to oral antibiotics, transferred back here to completed oral antibiotics, wound care and rehab. **Physical examination:** Skin: Right buttock stage 3, left buttock stage 4, undermining and tunneling, right inner thigh DTI (Deep Tissue Injury) **Assessment & plan:** 1. Debility-physical therapy, occupational therapy 2. Right buttock stage 3, left buttock stage 4-Santyl 3. Osteomyelitis sacrum-treat with 2 weeks course of per oral Levaquin and Bactrim 4. HTN, CAD-Coreg, Imdur, Plavix not listed on discharge 5. DM-Lantus, Humalog 6. GERD-Pantoprazole 7. HLD-Lipitor The above orders were reconciled with the information that was received/available at the time of readmission as well as with the orders that were active prior to transfer to the hospital.	5507
05/01/YYYY	Hospital/Provider Name	**Re-admission note:** She was admitted from Coney Island Hospital via stretcher by ambulance, accompanied by 2 EMTs. She was transferred from Menorah on Hospitalized on 04/17/YYYY due to rule out osteomyelitis of sacrum. **Admission diagnosis:** Hypokalemia, wound infection, Sacral decubitus ulcer stage 4, history of CVA with left side hemiparesis, HTN, CHF.	5506

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Resident is alert and oriented x 2 (disoriented in time). No signs of any acute distress during admission. Resident has left side hemiparesis, unable to lift hand or leg. Resident has impaired vision, uses glasses for reading, glasses not present. Oral mucosa is moist and pink, broken teeth, uses partial dentures, not present during admission. Hearing is intact to both ears, no hearing aids. Breathing sounds vesicular in both lungs. Heart tones are regular. Abdomen is soft and painless to palpation, non-distended, last bowel movement during admission. Resident is incontinent of bowels, Foley catheter present during admission 16-Fr 30 ml balloon, 300 ml of clean yellow urine present during admission in drainage bag. Skin assessment revealed: stage 4 pressure ulcer to left buttock 10 x10 cm 3cm deep with undermining up to 3 cm and tunneling to sacral area with opening 2 x 4 cm at sacrum, 50% of wound is yellow slough, 50% red tissue, stage 3 PU to right buttock 4x3cm covered with yellow slough, Unstageable PU to left heel 4 x 3 cm black eschar, and right heel 3 x 3 cm black eschar, linear deep tissue injury to proximal right inner thigh (probably related to Foley catheter 1x8 purple color). Resident evaluated by Dr. Feldman. It was demonstrated and explained to resident how to use call bell to call for assistance with ADLs and she was able to return demonstration.	
05/02/YYYY	Hospital/Provider Name	**Nursing notes:** Resident alert and verbally responsive with periods of confusion status post readmission day #1. Resident continues antibiotic therapy with Bactrim for osteomyelitis sacral decubitus ulcer stage 4 with no signs/symptoms of adverse reaction. No nausea/vomiting or loose bowel movements was noted this tour Turn and positioned provided every 2 hours. Foley catheter intact and patent. Drainage yellow color amber urine. Extra fluids given and tolerated well. Safety precaution maintained.	5509
05/03/YYYY	Hospital/Provider Name	**Nursing notes:** Status post re-admission day #2. Resident continues antibiotic therapy with Bactrim for osteomyelitis sacral decubitus ulcer stage 4 with no signs/symptoms of adverse reaction. Resident alert and verbally responsive with periods of confusion. Resident consumed 50% of dinner, extra fluids given and tolerated well. Turn and positioned provided every 2 hours. Foley catheter intact and patent. Drainage yellow color amber.	5509
05/11/YYYY	Hospital/Provider Name	**Nursing notes:** Resident continues on antibiotic Bactrim, for acute hematogenous osteomyelitis and Levaquin for stage-4 pressure ulcer to sacral. No apparent adverse reaction to the ABT noted. Fluids provided and encouraged, well tolerated. Complains of pain at beginning of tour; pain meds provided with positive result at this time. All due care anticipated and met. General condition stable. Plan of care in progress.	5515
05/12/YYYY	Hospital/Provider Name	**Nursing notes:** Alert and verbally responsive, patient continues on Bactrim antibiotics for osteomyelitis and Levaquin antibiotic for pressure ulcer to sacrum. No adverse reactions noted. Daughter visiting at bedside this shift. As needed Tylenol administered with good results. No acute distress noted.	5515

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
05/15/YYYY	Hospital/Provider Name	**Progress notes:** Resident recently had debridement of pressure ulcer on sacrum with 40% of yellow slough tissue and large amount of serous drainage. Not improving with local chemical debridement. She most likely will take advantages from negative pressure treatment of this pressure ulcer. Spoke with family and explained changing in management resident pressure ulcer stage IV in sacrum. Agreed.	5520
05/15/YYYY	Hospital/Provider Name	**Wound assessment:** **Pressure ulcer location:** Right inner thigh Stage: Deep tissue injury Measurements: 0.3 x 10 x 0 Undermining/tunneling: No Status of surrounding skin: Dry Pressure ulcer tissue base is: 100% fading maroon, dry, closed linear Drainage amount is: None Is there odor: No Periwound is: Healthy **Pressure ulcer location:** Right buttock Stage: 3 Measurements: 3 x 2 x 0.1 Undermining/tunneling: No Status of surrounding skin: Dry Pressure ulcer tissue base is: 100% red dermal tissue Ulcer is: Superficial Drainage amount is: Scant Drainage type is: Serosanguineous Is there odor: No Periwound is: Healthy Present treatment: Santyl **Pressure ulcer location:** Left buttock extending to sacral Stage: 4 Measurements: 10 x 13 x 5 Undermining from: 12-2 o' clock measures 7cm Tunneling: No Status of surrounding skin: Dry Pressure ulcer tissue base is 40% tan/yellow tissue necrosis, 60% red granulating tissue, bone palpable Ulcer is: Deep Drainage amount is: Moderate Drainage type is: Serosanguineous Is there odor: Yes Periwound is: Healthy Present treatment: Santyl and moist dressings **Pressure ulcer location:** Right heel	5518-5520

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Stage: Unstageable Measurements: 2 x 2 x 0 Status of surrounding skin: Dry Pressure ulcer tissue base is: 100% black stable eschar Drainage amount is: None Odor: No Periwound is: Healthy Present treatment: Dry dressing. **Pressure ulcer location:** Left heel Stage: Unstageable Measurements: 3 x 3 x 0 Status of surrounding skin: Dry Pressure ulcer tissue base is:100% yellow/tan eschar, detaching from peri-wound Drainage amount is: None Odor: No. Peri-wound is: Healthy Present treatment: DD (Dry Dressing). **Preventative measures:** Turn and positioning every 2 hours Incontinent care Level 2 mattress Heel protectors Positioning wedge/pillows Wheelchair cushion Pillow under calves to offload heels Out of bed scheduled Other: Foley. **Comments:** Resident was readmitted 05/01/YYYY post-hospitalization for osteomyelitis to left buttock -sacral ST 4. **Pain:** Resident showed no signs and symptoms of pain during assessment.	
05/21/YYYY	Hospital/Provider Name	**Progress notes:** Resident observed with liner red line 5cm x 1cm to posterior aspect of left lower extremity leg, no pain to touch, no itching, skin looked dry. **Assessment/plan:** Dry skin, scratch mark-apply Lac-Hydrin ointment daily.	5524
06/01/YYYY	Hospital/Provider Name	**Wound assessment:** **Pressure ulcer location:** Right buttock Stage: 3 Measurements: 2 x 2 x 0.1 Undermining/tunneling: No Status of surrounding skin: Dry Pressure ulcer tissue base is: 100% red dermal tissue	5527-5528

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Ulcer is: Superficial Drainage amount is: Scant Drainage type is: Serosanguineous Is there odor: No Periwound is: Healthy Present treatment: Santyl **Pressure ulcer location:** Left buttock extending to sacral Stage: 4 Measurements: 8.5 x 12.6 x 4.8 Undermining from: 10-3 o' clock measures 10cm Tunneling: No Status of surrounding skin: Dry Pressure ulcer tissue base is 40% tan/yellow tissue necrosis, 60% red granulating tissue, bone palpable Ulcer is: Deep Drainage amount is: Moderate Drainage type is: Serosanguineous Is there odor: No Periwound is: Healthy Present treatment: Negative pressure **Pressure ulcer location:** Right heel Stage: Unstageable Measurements: 2 x 2 x 0 Status of surrounding skin: Dry Pressure ulcer tissue base is: 100% black stable eschar Drainage amount is: None Odor: No Periwound is: Healthy Present treatment: Dry dressing. **Pressure ulcer location:** Left heel Stage: Unstageable Measurements: 3 x 3 x 0 Status of surrounding skin: Dry Pressure ulcer tissue base is:100% yellow/tan eschar, detaching from peri-wound Drainage amount is: None Odor: No. Peri-wound is: Healthy Present treatment: Santyl. **Preventative measures:** Turn and positioning every 2 hours Incontinent care Level 2 mattress Heel protectors Positioning wedge/pillows	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Wheelchair cushion Pillow under calves to offload heels Out of bed scheduled Other: Foley. **Comments:** Resident was seen today, treatment done to sacral pressure ulcer with black foam, VAC continues at 125 mm of hg at continuous pressure. Resident tolerated treatment change well no complaints of pain or discomfort. **Pain:** Resident showed no signs and symptoms of pain during assessment.	
06/06/YYYY	Hospital/Provider Name	**Progress notes:** Resident was seen today for pressure ulcer right buttock and sacrum. There is less slough tissue now about 35% and 65 % red granulating tissue, but smell malodourous. We will hold vac treatment until Thursday and apply soaked with Dakin's solution dressing daily.	5529
06/09/YYYY	Hospital/Provider Name	**Wound assessment:** **Pressure ulcer location:** Left buttock extending to sacral Stage: 4 Measurements: 8.0 x 10 x 4 Undermining from: 9-4 o' clock measures 8cm Tunneling: No Status of surrounding skin: Dry Pressure ulcer tissue base is 30% tan/yellow tissue necrosis, 70% red granulating tissue, bone palpable Ulcer is: Deep Drainage amount is: Moderate Drainage type is: Serosanguineous Is there odor: Yes Periwound is: Healthy Present treatment: Dakin's moist dressing Comment: Continue Dakin's to decrease odor and bio-burden and bacteria overload **Preventative measures:** Turn and positioning every 2 hours Incontinent care Level 2 mattress Heel protectors Positioning wedge/pillows Wheelchair cushion Pillow under calves to offload heels Out of bed scheduled Other: Foley. **Comments:** Resident was seen today by M.D., charge nurse, and undersign to assess the sacral pressure ulcer, will continue to hold vac until Monday.	5530-5531

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Pain: Resident showed no signs and symptoms of pain during assessment.	
06/12/YYYY	Hospital/Provider Name	**Wound care consultation:** *(Illegible notes)* **Reason for consultation:** Consult-vascular surgery, please evaluate resident unstageable, pressure ulcer on left heel for possible debridement. Healing will be compromised. Left heel decubitus, non-ambulatory. On exam, left heel 2" x 3" stage IV decubitus ulcer, positive cellulitis. **Follow-up:** No pedal pulse. Debrided wound with 11 size blade, Santyl, off load boots. If renal function ok, Bactrim DS twice daily x 2-weeks.	5158
06/12/YYYY	Hospital/Provider Name	**Progress notes:** She was admitted to the hospital with worsening pressure ulcers. Sacral decubiti ulcer status post debridement. Completed 10-days of IV antibiotics-Vanco and Zosyn. Left buttock pressure ulcer stage IV had purulent drainage, bone palpable. Transferred to CIH to rule out osteomyelitis. **Summary of hospitalization:** MRI done, showed osteomyelitis, treated with Vanco and Zosyn IV, then switched to po antibiotics, transferred back here to complete per oral antibiotics, wound care and rehab. Completed per oral Bactrim and Levaquin. Pressure ulcer extended left buttock was treated with Collagenase and Vac with improvement. Wound has some malodorous. Treated with Dakin's solution, now with Bactrim and Vac treatment. Abdomen: Soft, non-tender, bowel sounds. Skin: Right buttock: Pressure ulcer stage III healing, size 0.8 x 0.5 x 0.1, 100% red; pressure ulcer stage IV left buttock extended to sacrum with size 7.5 x 10 x 4, undermining 9-4 o' clock, measured 8 cm, 30% tan yellow, 70% red granulating tissue; right heel 2 x 2 x 0 unstageable 1005 black eschar; left heel unstageable pressure ulcer, size 4 x 3 x 0.4, 100% black eschar, detaching. **Assessment/plan:** Pressure ulcer stage IV left buttock extended to sacrum; Bactroban ointment with Vac treatment: Left heel unstageable status post debridement Collagenase ointment, SMA-8. If creatinine > 1.30, we will start Doxycycline, if NR-Start Bactrim DS. HTN: Controlled with Carvedilol. DM: Lantus, controlled CVA: Ecotrin, Lipitor CADL: Isosorbide, Ecotrin, Lipitor, controlled.	5533

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Labs: CBC, SMA-13. **Comments:** Called to daughter Diane and informed about resident medical condition and plan of management. Plan of care have been reviewed.	
06/12/YYYY	Hospital/Provider Name	**Wound assessment:** **Pressure ulcer location:** Right buttock Stage: 3 healing Measurements: 0.8 x 0.5 x 0.1 Undermining/tunneling: No Status of surrounding skin: Dry Pressure ulcer tissue base is: 100% red dermal tissue Ulcer is: Superficial Is there odor: No Present treatment: Vaseline gauze **Pressure ulcer location:** Left buttock extending to sacral Stage: 4 Measurements: 7.5 x 10 x 4 Undermining from: 9-4 o' clock measures 8cm Tunneling: No Status of surrounding skin: Dry Pressure ulcer tissue base is 30% tan/yellow tissue necrosis, 70% red granulating tissue, bone palpable Ulcer is: Deep Drainage amount is: Moderate Drainage type is: Serosanguineous Is there odor: Yes Periwound is: Healthy Present treatment: Dakin's moist dressings Recommended treatment change: Negative pressure Comment: Continue Dakin's to decrease odor and bio-burden and bacteria overload. **Pressure ulcer location:** Right heel Stage: Unstageable Measurements: 2 x 2 x 0 Status of surrounding skin: Dry Pressure ulcer tissue base is: 100% black stable eschar Drainage amount is: None Odor: No Periwound is: Healthy Present treatment: Dry dressing. **Pressure ulcer location:** Left heel	5531-5532

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Stage: Unstageable Measurements: 4 x 3 x 0.4 Status of surrounding skin: Erythema Pressure ulcer tissue base is:100% black eschar, detaching from peri-wound Drainage amount is: Minimum Odor: Yes Peri-wound is: Healthy Present treatment: Santyl. Comment: Resident to start antibiotic therapy for infected left heel ulcer. **Preventative measures:** Turn and positioning every 2 hours Incontinent care Level 2 mattress Heel protectors Positioning wedge/pillows Wheelchair cushion Pillow under calves to offload heels Out of bed scheduled Other: Foley. **Changes made in resident plan of care:** Heel lift. **Comments:** Resident was seen today by Dr. Nahata vascular surgeon for debridement of left heel unstable eschar. Resident left heel eschar was cross hatched with recommendations to continue Santyl. Resident tolerated procedure well, no complaints of pain or discomfort. Resident resumed negative pressure therapy at 125 mm of hg at continuous pressure to sacral pressure injury. Resident tolerated treatment change well no complaints of pain or discomfort **Pain:** Resident showed no signs and symptoms of pain during assessment	
06/13/YYYY	Hospital/Provider Name	**Progress notes:** Hgb 7.2, HCT 24, Platelets 777-Most likely iron deficient anemia. Stool for occult blood x 3, iron study. Start Ferrous sulfate 7.5 ml (330 mg) thrice daily. WBC: 14.7-Start Bactrim for cellulitis left heel.	5535
06/15/YYYY	Hospital/Provider Name	**Podiatric consultation report:** **Subjective**: The patient presents today for evaluation for painful thickened elongated nails x 10. Patient has bilateral heel ulcerations **Objective:** Onychomycosis 1-5 right and left subjugal debris dystrophic elongated. Ulcer to planter inferior right heel 2 x 2 cm and medial left heel 3 x 3 cm. Both unstageable ulcerations with no cellulitis or malodor or purulence Class findings: Thickening of nails Distal cooling of extremities: Mild	5537

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Assessment: Atherosclerosis Diabetes mellitus Onychomycosis Onychocryptosis **Treatment plan**: Aseptic debridement of nails x 10 Betadine to nail plate. Recommend bilateral foot x-rays. Recommend Santyl to both heels and elevation of feet. **Follow-up**: 1 week.	
06/19/YYYY	Hospital/Provider Name	**Nutrition note:** Progressive weight loss since admission noted. Diet treatment: NAS, NCS, Puree consistency diet (allow bread & egg salad cup). Resident with poor per oral intake. Observed at meal time with poor appetite. Resident stated she does not want any food and has no appetite. LC therapeutic restriction prev. discontinued for diet liberalization and for greater per oral intake. Glucerna 1.2 8oz per oral was previously. Increased to twice daily. Weekly weights are being monitored. Current weight > IBW range 123-151 lbs, BMI 34 (Obese). Weight loss beneficial; however, not at such rapid rate. Weight possibly also due to wound vac and loss of large amounts of serous fluids. Hgb 7.2, Hct 24 Platelets 777-most likely iron deficient anemia. Stool for occult blood x 3, iron study. Start Ferrous sulfate 7.5 ml (330 mg) per oral thrice daily. WBC 14.7-Start Bactrim for cellulitis left heel. Monitor ongoing and follow-up as needed.	5541
06/21/YYYY	Hospital/Provider Name	**Wound assessment:** **Pressure ulcer location:** Right buttock, stage III healed, 06/19/YYYY. **Pressure ulcer location:** Left buttock extending to sacral Stage: 4 Measurements: 6.5 x 10 x 4 Undermining from: 9-4 o' clock measures 8cm Tunneling: No Status of surrounding skin: Dry Pressure ulcer tissue base is 25% tan/yellow tissue necrosis, 75% red granulating tissue, bone palpable Ulcer is: Deep Drainage amount is: Moderate Drainage type is: Serosanguineous Is there odor: No Periwound is: Healthy Present treatment: Negative pressure therapy **Pressure ulcer location:** Right heel Stage: Unstageable Measurements: 2 x 2 x 0	5543-5544

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Status of surrounding skin: Dry Pressure ulcer tissue base is: 100% black stable eschar Drainage amount is: None Odor: No Periwound is: Healthy Present treatment: Dry dressing. **Pressure ulcer location:** Left heel Stage: Unstageable Measurements: 5 x 4 x 0.2 Status of surrounding skin: Erythema Pressure ulcer tissue base is:100% black eschar, detaching from peri-wound Drainage amount is: Minimum Odor: Yes Peri-wound is: Healthy Present treatment: Santyl. **Preventative measures:** Turn and positioning every 2 hours Incontinent care Level 2 mattress Heel protectors Positioning wedge/pillows Wheelchair cushion Pillow under calves to offload heels Out of bed scheduled Other: Foley. Heel lift. **Comments:** Resident resumed negative pressure therapy at 125 mm of hg at continuous pressure to sacral pressure injury. **Pain:** Resident showed no signs and symptoms of pain during assessment.	
06/23/YYYY	Hospital/Provider Name	**Progress notes:** Resident observed with redness to bilateral cheeks-Apply Zinc Oxide 20% ointment 2 times a day.	5546
07/03/YYYY	Hospital/Provider Name	**Progress notes:** Pressure ulcer unstageable right heel was debrided at bed side. Now size 3 x 3 x 0.3, 100% yellow necrotizing tissue with odor-We will change treatment to cleanse with Dakin's solution, apply Bactroban 2% ointment, cover with dry dressing daily.	5552
07/03/YYYY	Hospital/Provider Name	**Wound assessment:** **Pressure ulcer location:** Left buttock extending to sacral Stage: 4 Measurements: 7 x 10 x 3	5551-5552

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Undermining from: 9-4 o' clock measures 7cm Tunneling: No Status of surrounding skin: Dry Pressure ulcer tissue base is 20% tan/yellow tissue necrosis, 80% red granulating tissue, bone palpable Ulcer is: Deep Drainage amount is: Moderate Drainage type is: Serosanguineous Is there odor: No Periwound is: Healthy Present treatment: Negative pressure therapy **Pressure ulcer location:** Right heel Stage: Unstageable Measurements: 3 x 3 x 0.1 Status of surrounding skin: Erythema Pressure ulcer tissue base is: 100% tan/yellow tissue necrosis Drainage amount is: Minimum Drainage type is: Serosanguineous Odor: Yes Periwound is: Healthy Present treatment: No sting and dry dressing Recommended treatment change: Cleanse with Dakin's and apply Santyl **Pressure ulcer location:** Left heel Stage: Unstageable Measurements: 6 x 6 x 0.3 Status of surrounding skin: Erythema Pressure ulcer tissue base is:100% black eschar, detaching from peri-wound Drainage amount is: Minimum Drainage type: Serosanguineous Odor: Yes Peri-wound is: Healthy Present treatment: Santyl. **Preventative measures:** Turn and positioning every 2 hours Incontinent care Level 2 mattress Heel protectors Positioning wedge/pillows Wheelchair cushion Pillow under calves to offload heels Out of bed scheduled Other: Foley. Heel lift. **Comments:** Resident continues on negative pressure therapy at 125 mm of hg at continuous pressure to sacral pressure injury.	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Pain: Resident showed no signs and symptoms of pain during assessment	
07/10/YYYY	Hospital/Provider Name	**Medical transfer summary:** **Reason for transfer:** For left heel unstageable pressure ulcer debridement and rule out osteomyelitis. **Advance directives:** Full code. **Clinical summary (including medical history, events leading up to transfer, any pertinent labs/data, etc.):** She presented with past medical history of cerebrovascular accident with left hemiparesis, hypertension, diabetes mellitus, bedridden admitted to the hospital with worsening pressure ulcers. Sacral decubiti ulcer status post debridement. Completed 10-days of IV antibiotics-Vanco and Zosyn. Left buttock pressure ulcer stage IV had purulent drainage, bone palpable. Transferred to CIH to rule out osteomyelitis. **Summary of hospitalization:** MRI done, showed osteomyelitis, treated with Vanco and Zosyn IV, then switched to po antibiotics, transferred back here to complete per oral antibiotics, wound care and rehab. Completed per oral Bactrim and Levaquin. Pressure ulcer extended left buttock was treated with Collagenase and Vac with improvement. Resident has unstageable pressure ulcer both heels. Right heel has unstageable wound with 100% black necrotic tissue, odor. Resident also has increased WBC to 18.6. Resident will be transfer to CIH to debridement the wound by Dr. Nahata and rule out osteomyelitis. **Objective:** Neurological: Left hemiparesis, left arm contracted. Skin: Pressure ulcer stage IV sacrum, unstageable, pressure ulcer in right heel. **Destination (facility being transferred to):** CIH. **ER and/or hospital physician contacted:** Dr. Chicherniken, for debridement wound Dr. Nahata.	5552-5553, 3279-3280
07/10/YYYY	Hospital/Provider Name	**Resident transfer summary:** **Date of transfer:** 07/10/YYYY. **Facility name:** Transferred to CIH. **Events leading to transfer:** The patient has history of osteomyelitis, treated with Vanco and Zosyn IV, then switched to per oral antibiotics. Today during wound rounds. Pressure ulcer extended left buttock was treated with Collagenase and Vac with improvement. Resident has unstageable pressure ulcer both heels. Right heel has unstageable wound with 100% black necrotic tissue, odor. Resident also has increased WBC to 18.6. Resident will be transfer to CIH to debridement the wound by Dr. Nahata and rule out osteomyelitis.	5555-5556

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Transfer/discharge notice form sent with resident to hospital.	
07/10/YYYY	Hospital/Provider Name	**ER visit:** **Time seen:** @ 1718 hrs **Chief complaint**: Patient presents with sent from NH for wound debridement **History of present illness:** Delayed note: Patient bed bound with multiple co-morbidities sent from NH for debridement of left heel ulcer. Patient is demented. She is awake oriented x1 to self. Poor historian. As per NH papers patient completed a 10 day course of IV antibiotics with Vancomycin and Zosyn for a sacral decubiti ulcer. She was transferred to the ER to rule out osteomyelitis of left heel. **Physical examination:** Constitutional: Chronically ill Musculoskeletal: Right heel: Eschar noted. Left heel: Purulent discharge Patient is bed bound with left sided hemiparesis **Assessment and plan:** Patient bed bound sent from NH to rule out osteo of left heel ulcer. Spoke to private vascular surgery attending Dr. Nahata: Patient is to be admitted for debridement. Pending labs and x-ray.	2833-2835
07/10/YYYY	Hospital/Provider Name	**EKG:** **Result:** Sinus tachycardia 104 bpm, 1st degree AV block, low voltage and poor progression of the right wave.	2835-2836
07/10/YYYY	Hospital/Provider Name	**Nursing notes:** **@ 2104:** The patient remains in blue zone. Awaiting further dispo. No acute distress noted. Safety maintained. Provider at the bed side. IV antibiotics in progress, no infiltration noted. Will follow future orders. **@ 2325:** Blood transfusion in progress, started at 2130. Side effect of blood transfusion explained to patient, Verbalized understanding. Vitals obtained in the begging and after 15 min. No reaction noted at that time. Continue to monitor, Report given to the next shift.	2836
07/10/YYYY	Hospital/Provider Name	**History and physical examination report:** The patient presented to ER sent from NH for debridement of pressure ulcers on heels. As per note patient received Zosyn and Vancomycin in NH for 10 days. History obtained from EMR and NH documents as patient is confused and unable provide additional information. Patient complaints of pain in bilateral heels.	2840-2845

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Physical examination: Extremities: Foul smelling ulcers on bilateral heels, up to bone deep on left, subcutaneous tissues on right. Skin: Foul smelling ulcers on bilateral heels, up to bone deep on left, subcutaneous tissues on right. Subcutaneous tissue involvement in sacrum pressure ulcer. Peripheral vascular: Dorsal pedal pulses are 1/4 bilaterally. **Assessment:** Bilateral heels osteomyelitis 2/2 stage 4 pressure ulcers Sacrum stage 4 pressure ulcer Status post cerebrovascular accident with left sided hemiparesis DM type 2 CHF Elevated troponin, likely secondary to sepsis HTN Chronic constipation **Plans:** Telemetry monitoring Serial cardiac enzymes and EKG Cardiology consult Chest X-ray Wound care Follow-up vascular surgery consult - tentative schedule for bilateral heel surgery for 07/12/YYYY Start on Vancomycin 1250 mg daily IV and Merrem 500 mg every 8 hours IV Ascorbic acid Aspirin, Plavix Lipitor Carvedilol Levemir 16 units nightly ISS Senna 8.6mg Pain control with Tylenol as needed Infectious disease consult CBC, CMP, Coagulations, ESR, CRP, HgbA1C, UA Blood culture, Urine culture	
07/10/YYYY	Hospital/Provider Name	**Vascular consultation report:** Patient with bilateral decubitus heel sent from Menorah NH for debridement. Both heels decubitus left greater than right Left heel foul odor and cellulitis 2+ DP bilateral **Assessment/plan:** Suggest infectious disease consult	2845-2846

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		X-ray both heels Will debride this Wednesday once medically cleared Routine labs, chest x-ray, EKG Antibiotics	
07/10/YYYY	Hospital/Provider Name	**Cariology consultation report:** She presented with past medical history of coronary artery disease, IHD, hypertension, cerebrovascular accident, dementia, admitted for heel ulcer debridement, cardiology evaluation for optimization and pre-op eval prior to surgery. **Assessment:** 1. Coronary artery disease 2. IHD 3. Hypertension 4. History of cerebrovascular accident 5. Pre-op eval prior to heel debridement **Plan:** 1. No evidence of ACS or CHF 2. Mild elevated troponin non-specific , may be from CKD or from infection, obstructive CAD cannot be ruled out 3. Considering poor functional status cont conservative treatment 4. Cont current meds 5. Please get Echo 6. Patient is intermediate risk for low risk procedure for peri-procedural cardiac complications medically optimized from cardiac perspective no further cardiac work up indicated.	2846-2847
07/10/YYYY	Hospital/Provider Name	**Culture report**: **Blood culture:** No growth. **Urine culture:** Greater than 100,000 cfu/ml Proteus Mirabilis ESBL Greater than 100,000 cfu/ml Pseudomonas Aeruginosa	2990-2992, 3000-3001
07/10/YYYY	Hospital/Provider Name	**X-ray of bilateral foot:** **Clinical history**: Patient presents for evaluation of osteoarthritis. **Findings:** Right: Hallux valgus deformity is noted. Incidental vascular calcifications are present. Left: Hallux valgus deformity is noted. Inferior calcaneal heel spur is noted. The dental vascular calcifications are present.	2994-2995

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Impression: 1. Ulceration involving posterior right heel with suspicion for possible osteomyelitis involving the inferior calcaneus. 2. Ulceration involving the posterior left heel with bony destruction of the posterior calcaneus suggestive of osteomyelitis. 3. Please correlate with bone scan and/or MRI if clinically necessary in the proper clinical setting provided there is no contraindication.	
07/10/YYYY	Hospital/Provider Name	**EKG:** **Result:** Sinus tachycardia with 1st degree AV block, left axis deviation, possible inferior infarct , age undetermined, poor right wave progression, correlate clinically, abnormal EKG.	2995-2996
07/11/YYYY	Hospital/Provider Name	**X-ray of chest:** **Reason for exam:** Rule out infiltrates, rule out congestion **Findings**: There is mild ectasia of the aorta. **Impression:** COPD (Chronic Obstructive Pulmonary Disease) Cardiomegaly	1188
07/11/YYYY	Hospital/Provider Name	**Cardiology consultation report:** Patient past medical history of CAD, IHD, HTN, CVA, dementia, admitted for heel ulcer debridement, cardiology eval for optimization and pre-op eval prior to surgery. No chest pain or shortness of breath. Labs reviewed Radiology reviewed Cardiac work up EKG 07/10/YYYY: Sinus tachycardia 104 bpm, 1st degree AV block, LAD Q III, AVF **Assessment:** 1. CAD (Coronary Artery Disease) 2. IHD (Ischemic Heart Disease) 3. HTN 4. History of CVA 5. Pre-op evaluation prior to heel debridement **Plan:** 1. No evidence of ACS (Acute Coronary Syndrome) or CHF (Congestive Heart Failure) 2. Mild elevated troponin non-specific, may be from CKD (Chronic Kidney Disease) or from infection, obstructive CAD cannot be ruled out 3. Considering poor functional status cont conservative treatment	2846-2847

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		4. Continue current meds 5. Please get Echo 6. Patient is intermediate risk for low risk procedure for peri-procedural cardiac complications medically optimized from cardiac perspective no further cardiac work up indicated.	
07/11/YYYY	Hospital/Provider Name	**Infectious disease consultation report:** **History of present illness**: She presented to ER on 07/10/YYYY from NH for bilateral heel ulcer debridement. As per history & physical patient received Zosyn and Vancomycin in NH for 10 days. In the ER patient found to have positive urine analysis, leukocytosis of 18.1 with no left shift, Creatinine of 1.23 and Hb level of 7.0. **Review of systems:** Unable to obtain. Patient is non-verbal. **Physical examination:** Lungs: Bilateral air entry. Extremities: No edema, bilateral heel ulcer covered with eschar. Skin: No rash, stage sacral DU (Decubitus Ulcer). Neurology: Unable to obtain. **Radiology**: X-ray of bilateral foot and x-ray of chest reviewed. **Assessment/plan:** Patient with bilateral heel ulcers, x-ray finding suggestive OM, presented with anemia leukocytosis, AKI (Acute Kidney Injury) and UA (Urine Analysis). As per history &physiology patient was on Vancomycin and Zosyn at NH for 10 days prior to admission. Patient scheduled for debridement of heel ulcers On 07/12/YYYY. Follow-up with surgery Follow-up on blood and urine culture Send surgical wound culture Continue current antibiotics-check Vancomycin level before 3rd dose Monitor kidney function. Anemia work-up.	2851-2854
07/12/YYYY	Hospital/Provider Name	**Culture report:** **Culture (Other-osteomyelitis of the left foot):** Rare Morganella Morganii, rare coagulation negative staphylococcus (Pos). Organism: Mormor (Pos).	1191-1193
07/12/YYYY	Hospital/Provider Name	**Procedure report:** **Pre/post-op diagnosis:** Decubitus ulcer with gangrene of both heels as well as osteomyelitis of both calcaneum. **Operation:** Debridement up to the bone of heel decubitus as well as bone biopsy and debridement of the superficial bone on the left heel.	2949-2952

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Anesthesia: IV sedation and 1% Lidocaine. **Estimated blood loss**: 50ml. **Indications:** Patient is long standing nursing home patient who had right heel debridements in the past. Over the last few weeks, the left heel has gotten much worst with foul odor. Patient also known to have a large sacral decubitus. Patient admitted two days ago for debridement of both heels. All the risks, benefits, and alternatives were discussed with the patient's son and daughter. They understand and want to proceed with the debridement of the heels today. **Procedure:** Under IV sedation debridement up to the bone of both heel decubitus as well as bone biopsy and debridement of the superficial bone on the left heel was done. Patient was stable throughout the procedure. Plan is if she is stable, to bring her next week for the sacral decubitus debridement.	
07/12/YYYY	Hospital/Provider Name	**EKG:** **Result:** Sinus rhythm with 1st degree AV block, left axis deviation, poor R-wave progression, abnormal EKG.	3057-3058
07/13/YYYY	Hospital/Provider Name	**Echocardiogram:** **Narrative:** Left ventricular ejection fraction is 60%. Borderline concentric left ventricular hypertrophy (LVH). Left ventricular diastolic filling is consistent with elevated end diastolic pressure and elevated left atrial pressure. Increased left ventricular wall thickness. Mildly dilated left atrium. Moderate mitral annular calcification present. There is trans-valvular regurgitation present. Mild mitral regurgitation (MR). Aortic valve sclerosis without reduced excursion.	3031-3032
07/16/YYYY	Hospital/Provider Name	**Wound ostomy and continence progress notes:** **Diagnosis:** Sacral ulcer Sacral decubitus ulcer Osteomyelitis of left foot Osteomyelitis of right foot HTN (Hypertension) Sepsis Type 2 diabetes mellitus **Wound assessment:** 1. Location: Sacrum. Stage: IV. State of healing: Non-healing. Site assessment: Red slough.	1179-1184

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Peri-wound assessment: Hyperpigmented; maceration. Wound: Length 5, width 7, depth 1.5 Drainage amount: Moderate Odor: Absent Drainage description: Serosanguineous Treatment: Cleansed, Santyl, Off-loaded Tunneling: 0cm Undermining: 0cm Margins: Defined edges 2. Location: Right heel. Stage: Unstageable. State of healing: Eschar. Site assessment: Dry, eschar, slough Peri-wound assessment: Hyperpigmented; excoriated. Wound: Length 3, width 3, depth 0.2 Drainage amount: Small Odor: Absent Drainage description: Serosanguineous Treatment: Cleansed, Xeroform, off-loaded Tunneling: 0cm Undermining: 0cm Margins: Defined edges 3. Location: Left heel. Stage: Unstageable. State of healing: Eschar. Site assessment: Slough. Eschar. Peri-wound assessment: Excoriated. Wound: Length 7, width 5, depth 0.2 Drainage amount: Small Odor: Foul Drainage description: Serosanguineous Treatment: Cleansed, Xeroform Tunneling: 0cm Undermining: 0cm Margins: Defined edges **Site:** Sacrum stage IV-Suggest to apply Santyl with moist gauze, DSD, off load Right heel unstageable/eschar-suggest to apply Xeroform gauze, DPD Left heel unstageable/eschar-suggest to apply Xeroform gauze, DPD	
07/17/YYYY	Hospital/Provider Name	**Procedure report:** **Reason for exam**: Poor IV access **Procedure:** Placement of Peripherally inserted central venous catheter.	1187

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Indication: IV access for antibiotics. Total fluoroscopy time: 0.1 min. **Impression.** Successful placement of right arm PICC line	
07/19/YYYY	Hospital/Provider Name	**Procedure report:** **Pre/post-op diagnosis:** Sacral decubitus. **Operation:** Debridement, sacral decubitus. **Anesthesia**: Localized sedation. **Estimated blood loss**: 20 cc **Indications:** The patient is bedridden and has a large sacral decubitus about 5 x 4 inches in size and there are some necrotic areas in the depth of the decubitus. The plan is to debride the ulcer and after that offload this area by lying on the two sides rather than on the back. The patient also had debrided bilateral heel ulceration recently by myself as well **Operative findings:** The patient was identified in the holding area, brought to the operating room and the debridement was done on the bed itself. The patient was rotated on the lateral side and kept in position with pillows and tapes and some intravenous sedation was given by anesthesiologist Dr. Popuri and also used some 1% plain Lidocaine. The necrotic material on the corners and the depths of the wound was debrided with a No. 10 blade as well as curet and hemostasis was obtained with collating Bovie. Most of the sacral decubitus seems to be pink in color with some areas of necrosis in the corners. After the debridement was done and hemostasis was obtained, I left loose packing of Kling with saline and some 4 x 4 combines and paper tape on the skin. The plan is to continue with antibiotics and once the patient is stable, send to the nursing home on long-term antibiotics via PICC line.	2952-2953, 2915-2917
07/10/YYYY-07/20/YYYY	Hospital/Provider Name	**Hospitalization related records:** *Progress notes, case management note, nursing notes, anesthesia record, anesthesia record, respiratory therapy, plan of care, labs, MAR, patient education, medication sheet* *Ref: 2959-2973, 2847-2851, 2867-2871, 2871-2877, 2878-2880, 2956-2957, 2958, 2880, 2880-2883, 2911-2914, 2975-2976, 2976-2981, 3303-3308, 3309-3312, 3313-3316, 3317-3323, 3324-3329, 2855, 2883-2884, 2884-2886, 1185-1186, 2856, 2856-2858, 2901-2904, 2974, 2859, 2886-2887, 2887-2889, 1179-1184, 2859-2860, 2889-2890, 2890-2896, 5204-5209, 2860, 2860-2861, 2897, 2897-2899, 2899-2901, 3330-3334, 2861-2862, 2862-2864, 2904, 2904-2907, 2864-2865, 2907, 2907, 2907-2910, 3335-3339, 3339-3341, 1194-1197, 2865-2866, 2910-2911, 2918-2949, 2983-3115, 3116-3168, 3168-3178, 3217-3266, 5223-5229*	
07/20/YYYY	Hospital/Provider Name	**Discharge summary:**	2836-2840

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Admit date: 07/10/YYYY **Discharge date**: 07/20/YYYY **Discharge condition**: Stable. **Hospital course:** Patient with past medical history of CAD, HTN, stroke, presented from NH with bilateral heel ulcers. Bilateral heels osteomyelitis secondary to stage 4 pressure ulcers; urinary tract infection; stage IV sacral pressure ulcer. X-ray of bilateral feet-suspicious for osteomyelitis Status post debridement of ulcers on 07/12/YYYY. Wound cultures-rare Morganella Morganii, rare Coag Negative Staph and Mormor Blood culture: Negative to date Urine culture-100,000 colonies P. Mirabilis, P. Aeruginosa ESBL ID consult appreciated-recommended Meropenem for 4-6 weeks Continue wound care **Anemia of chronic disease:** Stable. **Diabetes mellitus type II:** Continue Levemir. **Hypertension:** Continue home meds. **Diet:** 2gm Na, mechanical soft. **Discharge medications**: Acetaminophen 325mg, 2 every 6 hours as needed Ascorbic acid 500mg, 1 daily Aspirin 81mg, 1 daily Atorvastatin 80mg, 1 daily night Carvedilol 12.5mg, 1 two times a day with meals Clopidogrel 75mg, 1 daily Collagenase ointment, apply 1 application topically daily for 10 days Famotidine 20mg, 1 daily Insulin detemir 100 unit/ml injection, inject 0.16ml (16 units), under the skin nightly Isosorbide mononitrate 120mg, 1 daily Sennosides 8.6mg, 1 daily night **Follow ups:** Follow-up with primary medical doctor in the NH in 1-2 days Monitor CBC, CMP, BG in the NH Continue daily wound care in the NH Sacrum stage 4-apply Santyl with moist gauze, DSD, off load Bilateral Heels-apply Santyl with moist gauze, DSD, off load	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Continue Merrem 500 mg every 8 hours via PICC line until 08/23 Follow-up with ID; Vascular as needed **Disposition:** Nursing home	
07/20/YYYY	Hospital/Provider Name	**Readmission medical assessment:** **Reason for transfer to hospital**: Left heel unstageable Pressure ulcer debridement and rule out osteomyelitis **Summary of hospitalization**: Patient with history of cerebrovascular accident with left hemiparesis, hypertension, and diabetes, bedridden admitted to the hospital with worsening pressure ulcers. Sacral decubiti ulcer status post debridement. Completed 10 days of IV antibiotics-Vanco and Zosyn. Left buttock pressure ulcer stage IV had purulent drainage, bone palpable. Transferred to CIH to rule out osteomyelitis, MRI done, showed osteomyelitis, treated with Vanco and Zosyn IV, then switched to per oral antibiotics, transferred back here to completed per oral antibiotics, wound care and rehab. Completed per oral Bactrim and Levaquin. Pressure ulcer extended left buttock was treated with Collagenase and Vac with improvement. Resident has unstageable pressure ulcer both heels. Patient transferred to CIH on 07/10/YYYY due to right heel has unstageable wound with 100% black necrotic tissue, odor. Resident also has increased WBC to 18.6. Patient transferred for right heel pressure ulcer debridement and rule out osteomyelitis. At CIH, patient found to have suspicious bilateral heels osteomyelitis secondary to infected bilateral heels unstageable pressure ulcer. Bilateral heels X-ray: Suspicious for osteomyelitis. Wound culture reported rare Morganella morganii, Rare Coag Stap negative, and Mormor Blood culture - no growth. Urine culture reported: 100 000 colonies P. mirabilis and P. aeruginosa ESBL (Extended Spectrum Beta Lactamase) ID recommended Meropenem for until 08/23/YYYY Patient has right arm PICC line. Patient readmitted today to MNH for rehab, patient alert awake verbally responsive. **Physical examination:** Neuro: Left hemiparesis, left arm contracted SKIN: Pressure ulcer stage IV sacrum, unstageable, pressure ulcer to right heel and left heel **Assessment/Plan:** 1.Debility post hospitalization – physical/occupational therapy evaluation 2.Pressure ulcer stage IV sacrum, unstageable, pressure ulcer to right heel and	1316-1317

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		left heel - local treatment with Santyl, pain management 3. Suspicious bilateral heels for osteomyelitis, Urinary tract infection P. mirabilis and P. aeruginosa ESBL = Meropenem 500 mg/50 ml in 0.9% Sodium chloride intravenous piggyback SIG: Give by intravenous route 500 mg IVPB every 8 hrs for 34 days. Contact precaution. Add acidophilus 4. Hypertension, coronary artery disease = Aspirin, Coreg, Imdur, Plavix 5. Diabetes - Lantus, Humalog coverage 6. Gastroesophageal reflux disease - Pantoprazole 7. Hyperlipidemia - Lipitor 8. Anemia – Fe2SO4 9. Constipation – Bisacodyl, Senna	
07/20/YYYY	Hospital/Provider Name	**Re-admission medical assessment:** Resident alert and verbally responsive with periods of confusion. She arrived to the unit at 4 p.m. via stretcher accompanied by 2 EMTs from CIH Resident was transfer to hospital 07/10/17 with diagnosis of left heel unstageable pressure ulcer debridement and rule out osteomyelitis MRI was done, showed osteomyelitis, treated with Vanco and Zosyn IV, then switched to per oral antibiotics. Slightly pedal edema and edema to left upper extremities persist. Last bowel movement today. Resident with foley catheter 16/30cc drainage yellow color amber, UA and Urine culture showed 100,000 colonies P. Mirabilis and P. Aeruginosa ESBL start contact precaution and IV antibiotics therapy with Meropenem PICC line intact to right arm 10cm one lumen Skin assessment showed general skin condition is fragile with pressure ulcer stage 4 to left buttock extending to sacral 13x8x3 cm Undermining from 9-4 o'clock - 8cm , right heel pressure ulcer unstageable 6 x 5cm , left Heel unstageable 12 x 10 x 1cm. Resident was evaluated by MD Yatcha ,new orders noted Resident requires Hoyer Lift for transfer and extensive assist of 2 for activities of daily living. No complains of pain or any discomfort at this time Was educated and demonstrated call bell system and safety precaution.	5558
07/20/YYYY	Hospital/Provider Name	**Nursing notes**: Skin assessment showed general skin condition is fragile with pressure ulcer stage 4 to left buttock extending to sacral 13 x 8 x 3 cm, undermining from 9-4 o'clock – 8 cm, right heel pressure ulcer unstageable 6 x 5 cm, left heel unstageable 12 x 10 x 1 cm. Resident was evaluated by Yatcha, M.D. New orders noted. Resident requires Hoyer Lift for transfer and extensive assist of 2 for activities of daily living.	1318
07/21/YYYY	Hospital/Provider Name	**Wound assessment:**	5558-5559

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Resident was seen this evening to assess pressure injuries. **Pressure ulcer location:** Sacral extending to buttock. Stage: 4 Measurements: 8 x 10 x 4 Undermining from: 10-3 o' clock measures 6cm Tunneling: No Status of surrounding skin: Dry Pressure ulcer tissue base is 25% yellow tissue slough, 75% red granulating tissue, bone palpable Ulcer is: Deep Drainage amount is: Moderate Drainage type is: Serosanguineous Is there odor: No Periwound is: Healthy Present treatment: Santyl **Pressure ulcer location:** Right heel Stage: Unstageable Measurements: 3.5 x 4 x 0.5 Status of surrounding skin: Erythema Pressure ulcer tissue base is: 100% tan/black tissue necrosis Drainage amount is: Minimum Drainage type: Serosanguineous Odor: No Periwound is: Healthy **Pressure ulcer location:** Left heel Stage: Unstageable, now stage 4 Measurements: 7 x 6 x 1 Status of surrounding skin: Dry Pressure ulcer tissue base is: 70% black eschar, 30% red granulating tissue, bone palpable Ulcer is: Deep Drainage amount is: Minimum Odor: No Peri-wound is: Healthy Present treatment: Santyl. Recommended treatment change: Santyl **Preventative measures:** Turn and positioning every 2 hours Incontinent care Level 2 mattress Heel protectors Positioning wedge/pillows Wheelchair cushion Pillow under calves to offload heels	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Out of bed scheduled Other: Foley catheter, heel lift **Comments:** Resident was readmitted 07/20/YYYY with diagnosis of left heel unstageable pressure injury debridement and osteomyelitis. Past medical history of cerebrovascular accident with left hemiparesis, HTN, DM and pressure injuries. **Pain:** Resident showed no signs and symptoms of pain during assessment.	
07/21/YYYY	Hospital/Provider Name	**MD follow-up progress notes:** She was admitted to the hospital with worsening pressure ulcers. Sacral decubiti ulcer status post debridement. Completed 10-days of IV antibiotics-Vanco and Zosyn. Left buttock pressure ulcer stage IV had purulent drainage, bone palpable. Transferred to CIH to rule out osteomyelitis, MRI done, showed osteomyelitis, treated with Vanco and Zosyn IV, and then switched to per oral antibiotics, transferred back here to complete per oral antibiotics, wound care and rehab. Completed per oral Bactrim and Levaquin. Pressure ulcer extended left buttock was treated with Collagenase and Vac with improvement. Resident has unstageable pressure ulcer both heels. At CIH, patient found to have suspicious bilateral heels osteomyelitis secondary to infected bilateral heels unstageable decubitus ulcer. Resident came to continue IV Meropenem. **Objective:** Skin: Pressure ulcer stage IV sacrum with size 8 x 10 x 4, undermining with size 8 x 10 x 4 with undermining 10-3 o' clock-6cm, base 255 yellow and 75 5 red; right heel unstageable pressure ulcer with size 3.5 x 4 x 0.5, 100% tab black tissue necrosis; left heel unstageable pressure ulcer, size 7 x 6 x 1cm, base 70% black, 30 % red. **Assessment/plan:** Osteomyelitis: IV Meropenem Pressure ulcer stage IV sacrum: From 7/24/17 start Vac therapy Pressure ulcer unstageable bilateral l heels: Santyl CVA with left hemiparesis: ASA, Plavix, Lipitor DM type II: Lantus, Humalog sliding scale, NCS diet HTN: Controlled with Carvedilol GERD: Controlled with Protonix Constipation: Laxatives Labs reviewed. **Comments:** Discussed with daughter regarding resident medical condition and plan of management. Patient will receive PROM B UE / B LE, 10 reps, BID. Goals: To	5560-5561

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		increase/maintain joint flexibility. (*Shaheen Quanungo, PT)*	
07/21/YYYY	Hospital/Provider Name	**Nursing wound assessment:** **Pressure ulcer 1:** Location: Sacral extending to buttock Stage: 4 Measurements: 8 x 10 x 4 Undermining from 10-3 O'clock measures 6 cm Tunneling: No Status of surrounding skin: Dry Pressure ulcer tissue base is 25% yellow slough 75% red granulating tissue bone palpable Ulcer is deep, moderate serosanguinous drainage, no odor. Periwound is healthy. Present treatment: Santyl **Pressure ulcer 2:** Location: Right heel Stage: Unstageable Measurements: 3.5 x 4 x 0.5 No undermining/tunneling Status of surrounding wound: Erythema Pressure ulcer tissue base is: 100% tan/black tissue necrosis Minimum serosanguinous drainage, no odor, periwound healthy Present treatment: Santyl **Pressure ulcer 3:** Location: Left heel Stage: Unstageable, now stage 4 Measurements: 7 x 6 x 1 No undermining/tunneling Status of surrounding wound: Dry Pressure ulcer tissue base is: 70% black eschar, 30% red granulating tissue bone palpable Ulcer is deep Minimum serosanguinous drainage, no odor, periwound healthy Present treatment: Santyl **Preventive measures:** Turn and positioning every 2 hours Incontinent care Level 1 Mattress Level 2 Mattress Heel Protectors Positioning wedge/pillows Wheelchair cushion Pillow under calves to offload heels Out of bed schedule: Yes Other: Foley catheter, heel lift	1318-1319

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Resident was readmitted 07/20/YYYY with left heel unstageable pressure injury debridement and osteomyelitis.	
08/07/YYYY	Hospital/Provider Name	**Pressure ulcer assessment:** **Pressure ulcer 1:** Location: Sacral extending to buttock Stage: 4 Measurements: 7 x 10 x 3 Undermining from 10-3 O'clock measures 6 cm Tunneling: No Status of surrounding skin: Dry Pressure ulcer tissue base is 20% yellow slough 80% red granulating tissue bone palpable Ulcer is deep, moderate serosanguinous drainage, no odor. Periwound is healthy. Present treatment: Negative therapy **Pressure ulcer 2:** Location: Right heel Stage: Unstageable Measurements: 2.8 x 3 x 0.4 No undermining/tunneling Status of surrounding wound: Erythema Pressure ulcer tissue base is: 100% tan/black tissue necrosis Scant serosanguinous drainage, no odor, periwound healthy Present treatment: Santyl and Bactroban **Pressure ulcer 3:** Location: Left heel Stage: Unstageable, now stage 4 Measurements: 7 x 6 x 1 No undermining/tunneling Status of surrounding wound: Dry Pressure ulcer tissue base is: 60% black eschar, 40% red granulating tissue bone palpable Ulcer is deep Minimum serosanguinous drainage, no odor, periwound healthy Present treatment: Santyl and Bactroban **Preventive measures:** Turn and positioning every 2 hours Incontinent care Level 1 Mattress Level 2 Mattress Heel Protectors Positioning wedge/pillows Wheelchair cushion Pillow under calves to offload heels	1335-1336

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Out of bed schedule: Yes Other: Foley catheter, heel lift **Comments**: Will continue plan of care.	
08/13/YYYY	Hospital/Provider Name	**Right upper extremity venous doppler:** **Diagnosis:** Generalized edema **Impression**: No evidence of deep venous thrombosis.	1212
08/17/YYYY	Hospital/Provider Name	**Speech therapy initial evaluation only:** **Medical Diagnosis:** Pressure ulcer of unspecified site, stage 4 **Treatment diagnosis:** Dysphagia, oropharyngeal phase **Reason for referral:** Patient was referred to therapy following requests from her family for a diet upgrade. Resident does have a history of dysphagia & is presently on a pureed diet with thin liquids. A swallow evaluation is recommended for determination of the current safest, least restrictive diet level. Without an evaluation resident is at risk of dysphagia related complications and/or compromised QOL (Quality Of Life). **Medical history related to diagnosis/condition:** Past medical history of CVA with left hemiparesis, HTN, DM, bedridden, multiple PU's (Pressure Ulcers). **Previous therapy:** Resident is known to this SLP from previous placement on program. She was followed by this SLP from 03/15/YYYY-03/24/YYYY for a diet upgrade. At start of care she was on a pureed diet with nectar thick liquids. By weeks end, her liquids were upgraded to thin liquid however, a full diet upgrade to solid food deemed unsafe due to sub-optimal position when in bed (res bedbound) & poor bolus formation. Therefore it was recommend continuing on a pureed diet however, bread & egg salad were added to menu for increased QOL as she was able to manage these very soft items. Discharge plans: To be determined **Initial assessment:** **Prior/current level of functioning:** Swallowing, swallow status: Minimal impairment (10-25% impairment; risk of trace aspiration, diet may need modified due to medical/ dental status) Swallowing, affected phase: Oral and pharyngeal Swallowing, intake method: Oral Swallowing, diet level: Pureed Swallowing, liquid level: Thin liquid Swallowing, posture: Adequate for oral intake	1208-1210

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Swallowing, dentition: Missing teeth Swallowing, respiratory coordination: Moderately impaired Swallowing, formation of bolus: Moderate impairment (50-75% impairment; combination of oral and non-oral nutrition; requires thickened liquids; difficulty masticating foods) Swallowing, swallow initiation: Within functional limits **Impairments:** Received consult to evaluate res for a diet upgrade, following request from family. Call placed to resident daughter Diane who reports family had brought in some soft fruit that resident was reportedly able to tolerate. Evaluation was conducted today, bedside. She has multiple PU's, she is obese & is bedbound. This does amount to a safety concern for the prospect of providing solid food, as res positioning in bed is sub-optimal despite re-positioning provided. With today's evaluation SLP fed trials however, res presented with a poor appetite & stated she was not hungry. Providing a plate of soft solid food did not result in improved acceptance from res. She accepted a few spoon-ful of pureed solids & several sips of thin liquid - demonstrating within functional limits management. She accepted 1 bite of chopped meat - demonstrating prolonged mastication for bolus formation with increased work of breathing noted throughout mastication. She requested a drink to help initiated AP transfer. She was able to clear the majority of the bolus with the liquid wash however; a brief episode of wheezing was observed post swallow. She refused additional trials of solids offered during today's assessment. At this time, in light of her presentation during today's evaluation coupled with the fact that she is bedbound & her positioning in bed is sub-optimal, a diet upgrade is judged inappropriate at this time. SLP discussed impressions with res daughter Diane, who voiced agreement. This service can reevaluate if/ when res overall condition improves & when she is able to consistently sit upright out of bed at meal time. No further speech therapy at this time. **Rehab potential:** Poor; due to: Evaluation only at this time **Requires skilled services to focus on**: Evaluate swallowing function (Bedside) **Frequency/duration:** 1 times a week for 1 week (Evaluation Only).	
08/21/YYYY	Hospital/Provider Name	**Pressure ulcer assessment:** **Pressure ulcer 1:** Location: Sacral extending to buttock Stage: 4 Measurements: 7 x 10 x 3 Undermining from 12-3 O'clock measures 6 cm Tunneling: No Status of surrounding skin: Dry Pressure ulcer tissue base is 30% yellow slough 70% red granulating tissue bone palpable Ulcer is deep, moderate serosanguinous drainage, no odor. Periwound is healthy.	1350-1352

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Present treatment: Negative pressure therapy **Pressure ulcer 2:** Location: Right heel Stage: Unstageable Measurements: 2.8 x 3 x 0.4 No undermining/tunneling Status of surrounding wound: Erythema Pressure ulcer tissue base is: 100% tan/black tissue necrosis Scant serosanguinous drainage, no odor, periwound healthy Present treatment: Santyl and Bactroban **Pressure ulcer 3:** Location: Left heel Stage: Unstageable, now stage 4 Measurements: 7 x 6 x 0.5 No undermining/tunneling Status of surrounding wound: Dry Pressure ulcer tissue base is: 50% black eschar, 50% red granulating tissue bone palpable Ulcer is deep Minimum serosanguinous drainage, no odor, periwound healthy Present treatment: Santyl and Bactroban **Preventive measures:** Turn and positioning every 2 hours Incontinent care Level 1 Mattress Level 2 Mattress Heel Protectors Positioning wedge/pillows Wheelchair cushion Pillow under calves to off-load heels Out of bed schedule: Yes Other: Foley catheter, heel lift **Comments**: Resident was seen today wound rounds to assess multiple ulcers. Vac dressing of one piece of black foam was applied to sacral pressure injury; continue negative pressure at 125 mmHg, continuous. Resident continues on IV antibiotics therapy of Meropenem for osteomyelitis. Will continue plan of care.	
07/20/YYYY-09/04/YYYY	Hospital/Provider Name	**Nursing home related records:** *Assessment, MAR, labs, orders, plan of care, medication sheet/orders, flow sheets* *Ref: 970-1039, 911-969, 1040-1078, 1079-1119, 1120-1136, 1294-1304, 1305-1315, 4015, 1213-1215, 1316-1365, 1205-1207, 4016, 4022-4025, 1216-1293, 3197-3203, 3283-3289, 5560, 5242-5459, 5565-5566, 4708-4795, 4796-4920, 4921-4984, 4985-5022, 5460-5473, 5474-5505, 5506-5569, 5508, 5524, 5525, 5525, 5023-5052*	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
09/04/YYYY	Hospital/Provider Name	**ER visit:** **Chief complaint:** Hypotension-BP 77/57. **Physical examination:** Skin: Skin is warm. **Assessment:** Sepsis **Plan:** Labs; chest X-ray; EKG; IV access; IV fluid; culture; antibiotics; admit **@ 1501:** Patient became hypotensive Admission held ICU consulted Dopamine started fluids going **@ 1955:** Patient with extensive colitis with hypotension, on pressure support. Follow-up MICU evaluation. **@ 2028:** Patients BP 98/56, HR 98, Dopamine was tapered and Levophed was started.	3359-3363
09/04/YYYY	Hospital/Provider Name	**Nursing notes:** **@ 1326:** Blood sample was obtained by MD Beacher and sent to lab, unable to get IV access. Patient came with PICC line in right cephalic area, line was accesses by MD Beacher and medications given via PICC line. **@ 1327:** Patient came with Foley catheter, urine sent to lab. **@ 1552:** Awake, skin warm and dry, breath easily, no complaints of pain noted, no distress noted. **@ 1855:** Awake, skin warm and dry, breath easily, no complaints of pain noted, no distress noted. **@ 1859:** Central line inserted to right femoral area by MD Beacher, line was sutured, steril dressing applied. **@ 1900:** Patient came back from CT, central line completely out. MD Beacher informed. **@ 2002:** Patient received in bed. Not in distress. Responsive to verbal and painful stimuli. Continuous on Dopamine drip via central line. Awaiting for further disposition. 09/05/YYYY @ 0621: Patient admitted to SICU from the ER, admitting diagnosis is Hypotension. Received patient from the ER with Levophed drip infusing at rate of 19 ml/hr. Patient came in from Menorah Nursing Home with	3361-3364

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		right brachial PICC and Foley catheter in place, draining cloudy amber color urine. Patient has multiple decubiti upon admission to the unit. Patient has right femoral CVP, dressing dry, and intact. IV fluid NS infusing at rate of 100 ml/hr as ordered. Patient made comfortable in bed with nursing care in progress. Patient Foley catheter is going to be changed being that she came to the hospital with the Foley catheter in place.	
09/04/YYYY	Hospital/Provider Name	**History and physical examination report:** **HPI:** The patient presented with a past medical history of hypertension, coronary artery disease, cerebrovascular accident with residual left sided weakness and bed bound, stage 4 sacral ulcer, bilateral stage 4 heel ulcers with osteomyelitis and urinary tract infection with long term Foley cath, presents from her rehab nursing home with worsening lethargy and poor oral intake for the past 3 days. Patient's family bedside reports that her mental status has declined, along with her eating, and she is no longer at her baseline. Patient is currently non-verbal or communicative. Of note, she was recently discharged from CIH with a PICC line receiving Merrem for 6-weeks for ESBL and P. Mirabilis urinary tract infection. Wound cultures at that time (07/12/YYYY) grew rare Morganella Morganii, rare Coag Negative Staph and Mormor. Patient's last surgical debridement was during that admission (07/12/YYYY). Patient's family states that she has not had a fever, chills, night sweats or any diarrhea in the last 3 days when they have visited her. Patient is currently hypotensive on Dopamine drip, afebrile, with a WBC of 71, UA (Urine Acetone) positive. **Objective:** Vitals: BP 82/59. Pulse 78 bpm. RR 18. Spo2 99%. **Physical examination:** Gastrointestinal: Tense, unable to assess tenderness given pts inability to verbalize pain, bowel sounds present, obese, no organomegaly appreciated given patients body habitus Neurology: Awake, alert, oriented x 0, left sided upper extremity contracted Skin: Pale, two deep large sacral ulcer with granulation tissue and pus **Assessment/plan:** Sepsis secondary to sacral ulcer, heel ulcers, urinary tract infection History of CVA with left sided weakness Acute kidney injury Diabetes mellitus type II Congestive heart failure Hypertension Follow-up MICU consult Follow-up surgery consult Follow-up CT abdomen/pelvis with oral contrast	3366-3372

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Start Vane per level and Merrem antibiotics given past admission for UTI (ESBL) and sacral ulcers and bilateral heel ulcers Continue Aspirin, Plavix, Lipitor, Ascorbic acid Due to patients hypotension home BP meds on hold (Coreg 12.5mg twice daily, Imdur 120mg every day), start when tolerated Sliding scale with plan of care Levemir 16 units every night Wound care consult Bowel regiment Infectious disease consult Follow-up blood culture and urine culture and wound culture Cardiac monitor IVF and Dopamine drip titrated keep MAP > 65, patient may require more pressors but will need ICU admission Nasal cannula keep 02 greater than 95% Elevate head greater than 45% Fall and aspiration precautions Nil per oral for now Deep vein thrombosis prophylaxis Heparin Discussed with attending	
09/04/YYYY	Hospital/Provider Name	**Medical intensive care consultation report:** Patient is unresponsive and history obtained from family GOC discussed - she is Full code MICU Consult for Hypotension and possible sepsis Patient with past medical history of nursing home resident, AOCD, CAD, HTN, stroke (with residual left side weakness and bed bound), recently managed in CIH For Stage IV sacral pressure ulcer, bilateral heel ulcers stage 4 complicated by bilateral heels osteomyelitis and UTI. She was discharged to NH on Merrem with a PICC line for 6 weeks to be completed 08/23/YYYY however line was left for access after completion of antibiotics. Per daughter patient stopped eating and experienced cognitive decline 1 day and she was given IVF but had no urine output. She was then brought to the ER. Family denies cough, shortness of breath, fever, nausea, vomiting, diarrhea, chest pain, however they admit that she has complained of abdominal pain for a few months. During my evaluation patient was unresponsive and family again states it is below baseline, patient abdomen was distended and urine sediment seen on Foley oath. She came in with a Foley oath. Last seen verbal and holding conversation 3 days ago by family, they state they don't know how she was when they were not there.	3372-3375

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Physical examination: BP 82/51 Extremities: Bilateral left extremities heel ulcers stage 4 clean dressed, left upper extremity PICC line Foley draining with sedimentation **Assessment:** AMS & failure to thrive Sepsis-leukocytosis, distended abdomen, urine sediment, hypotension and likely shock kidney with BUN/Cr much worse from discharge 2 months ago, UTI on UA Possible C. Diff with severe leukocytosis much worse than 2 months ago and hypotension Severe dehydration **Recommendation:** Would rule out abdomen abscess Vs obstruction with CT abdomen/pelvis with oral contrast Would start empiric antibiotic Vancomycin and Zosyn IV Would obtain stool for C. Diff and start oral Vancomycin for empiric coverage of severe C-DIFF STAT Sx consult to evaluated for obstruction Vs toxic megacolon (narrow window of opportunity for intervention if this is the case) Trend lactate, CBC, Procalcitonin, CRP IVF Obtain echo Control Glucose Consider removing PICC line for source of infection Change Foley Hold BP meds in view of hypotension HCT due to change in mental status Case discussed with attending	
09/04/YYYY	Hospital/Provider Name	**Medical intensive care consultation:** Patient seen and examined at bedside and chart reviewed; plan discussed with ICU team. I agree with the assessment and plan as documented by the medical house staff on the same date with the following modifications. Patient with past medical history HTN, CVA with left sided residual weakness since 12/YYYY making her bed-bound, CAD, recent debridement of sacral decubitus ulcer one month ago in CIH with current unstageable sacral ulcer, bilateral stage 4 heel ulcers with PICC line in place for management of OM with 6 weeks Meropenem and left in place subsequently for IV access, admitted with hypotension and poor oral intake. Patient was found to have distended and tender abdomen on exam, septic shock on pressors in ER, CT abdomen (noncontrast due to AKI) revealed pan-colitis. She also has UTI and a history of resistant organisms on prior urine cultures. Follows simple commands this evening but non-verbal.	3375-3377

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Physical examination: Skin: Good turgor, no rashes Abdomen: Soft, mild tenderness throughout, distended Extremities: Extremities with stage 4 heel ulcers, sacral unstageable ulcer Labs and radiology reviewed. **Assessment:** Septic shock AKI Encephalopathy Hypoxemia Diastolic heart failure Lactic acidosis Troponin elevation Pan-colitis, suspected C. Diff colitis CVA with left residual weakness Recent treatment for osteomyelitis In-dwelling PICC line CAD Decubiti, status post recent sacral debridement **Plan:** 1. Maintain MAP greater than 65 with NE; add vasopressin and stress steroids 2. Neuro checks every 1 hour 3. Maintain saturation greater than 95% with NC; low threshold for intubation 4. IVF hydration and trend renal function; target urine output greater than 0.5ml/kg/hr; NS 100ml/hr for now 5. Trend lactate level with IVF hydration 6. Electrolyte monitoring and correction 7. Hold all feeds 8. Trend serial CE's and EKG; cardiology consult 9. Follow results of pan-culture and start empiric antibiotic-Vancomycin/Meropenem; one dose Amikacin now; empiric C. Diff treatment started; send stool for testing; follow culture of urine 10. Echo pending 11. Wound care to heels and sacrum 12. DVT and gastrointestinal prophylaxis 13. Stat surgery consult 14. Infectious disease consult 15. Contact isolation 16. Aspirin continued; hold Plavix in case she is a surgery candidate 17. FS every 4 hours; RISS; target FS 140-180 Accepted to be under the care of MICU team.	
09/04/YYYY	Hospital/Provider Name	**Culture report:** **Blood culture:** Growth in aerobic bottles; coag negative staphylococcus	3559-3563

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Gram stain: Growth in aerobic bottle; gram positive cocci in clusters Growth in anaerobic bottle; gram positive cocci in clusters	
09/04/YYYY	Hospital/Provider Name	**@ 1347 X-ray of chest:** **Clinical history:** Patient with fever. **Impression:** Bibasilar atelectasis. Right PICC line catheter is in position.	3566-3567
09/04/YYYY	Hospital/Provider Name	**CT of the abdomen without contrast:** **Impression:** Diffuse pancolitis, worse distally. Dilated gallbladder with probable sludge. Correlate with gallbladder ultrasound. Pelvic fat containing hernia. Collapsed urinary bladder with a Foley catheter. Enlarged calcified myomatous uterus. Subcutaneous edema.	3570-3571
09/04/YYYY	Hospital/Provider Name	**@ 2257 X-ray of chest:** **History:** Fever **Impression:** Bilateral basilar atelectasis. Cannot rule out superimposed infiltrate. Right sided PICC line.	3582-3583
09/04/YYYY	Hospital/Provider Name	**Resident transfer summary:** **Date of transfer:** 09/04/YYYY. **Reason for transfer:** Altered mental status, not eating, not drinking, oliguria, hypotension. **Events leading to transfer**: Resident has stopped eating x 2 days, became hypotensive not drinking, Sodium Chloride 0.9 % intravenous solution. Give 40 ml/hour for 3 days started on 09/03/YYYY urinary output decreased. Has swelling right arm. Venous Doppler is negative for DVT. Patient with past history of cerebrovascular accident with left hemiparesis, hypertension, diabetes, bedridden, bilateral heels osteomyelitis, pressure ulcer stage IV sacrum and stage 4 to right and left heel. Vital signs: T 96.4 F, HR 98, BP 74/48 mmHg, RR 18, O2 saturation 94% on 2 liter O2 nasal cannula.	1364-1365
09/05/YYYY	Hospital/Provider Name	**General surgery consultation report:** **Subjective:** Patient was seen and examined at bedside by chief surgical resident Roudakova and surgical resident sacks. Patient with past medical history HTN, CVA with left sided residual weakness since 12/YYYY making her bedbound, CAD, recent debridement of sacral decubitus ulcer one month ago in CIH with current unstageable sacral ulcer, bilateral stage 4 heel ulcers with PICC line in place for management of OM with 6 weeks Meropenem and left in place subsequently for IV access, admitted with hypotension and poor oral intake and has UTI with long	3377-3382

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		term Foley cath, presents from her rehab NEI with worsening lethargy and poor oral intake x 1 day. Patient's family bedside reports that her mental status has declined, along with her eating, and she is no longer at her baseline, which is being able to recognize and respond to family. Patient is currently non-verbal or communicative. Patient's last surgical debridement was during that admission (07/12/YYYY). Patient was found to have distended and tender abdomen on exam, septic shock on pressors in ER, CT abdomen (noncontrast due to AKI) revealed pan-colitis Patient's family states that she has not had a fever, chills, night sweats or any diarrhea since yesterday when they have visited her. Patient is currently hypotensive on Dopamine drip, afebrile, with a WBC of 71, UA positive. **Physical examination:** BP 69/28 Gastrointestinal: Abdomen tender (patient making noise) and distended Extremities: Positive right upper extremities edema, bilateral heel ulcers left greater than right Neurology: Left sided upper extremity contracted Skin: Pale, two deep large sacral ulcers with granulation tissue. **Recent imaging results:** CT abdomen (noncontrast due to AKI) revealed pan-colitis **Assessment/plan**: Patient with sepsis, unstageable sacral ulcer, bilateral heel ulcers, UTI. Medically optimize Obtain studies for C. Diff Obtain stool studies including C. Diff Pre-empirical treatment for C. Diff with oral Vancomycin, IV Flagyl, Vanc Enema IVF Nil per oral Serial abdominal exams and surgery to follow-up Trend CBC UA and urine culture Deep vein thrombosis prophylaxis Improve fluid status Daily dressing changes for sacral and feel decubitus Recommend podiatry consult for heel ulcer dressings Wound care consult Admit to MICU team	
09/05/YYYY	Hospital/Provider Name	**Infectious disease consultation report:** **History of present illness**: Patient with a past medical history of HTN, CAD,	3382-3386

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		CVA with residual left sided weakness, stage 4 sacral ulcer, bilateral stage 4 heel ulcers with osteomyelitis, urinary tract infection, chronic indwelling Foley cath, presents from nursing home on 09/04/YYYY with lethargy, poor oral intake, WBC 71 with left shift, positive UA and stool positive for C. Diff. **Review of systems:** Unable to obtain. Patient is lethargic. **Physical examination:** BP 132/28 Lungs: Bilateral air entry decreased. Skin: No rash **Radiology:** Transthoracic Echocardiogram: Result date: 09/05/YYYY Mild concentric left ventricular hypertrophy (LVH). Mildly increased left ventricular wall thickness. Moderately dilated left atrium. No pericardial effusion Left ventricular ejection fraction is 55% using method of discs (modified Simpson's rule). CT abdomen/pelvis and X-ray chest report reviewed. **Assessment/plan:** Patient with history of sacral wound OM secondary to ESBL M. Morganii, status post debridement or: Admission In July and discharge to rehab center on IV Merrem. Patient presented to CIH in severe sepsis with septic shock, pancolitis Secondary to c. diff, possible UTI. Continue Vancomycin 500 mg oral and PR every 6 hours Continue Flagyl 500 mg IV every 8 hours Start Tygacil 100 mg x 1 dose IV, followed by 50 mg every 12 pending result urine culture Follow-up on blood and urine culture Pressure support. Discontinue Merrem.	
09/05/YYYY	Hospital/Provider Name	**Procedure report;** **Procedure**: Arterial line placement Ultrasound used to visualize the right radial and ulnar arteries. Right radial artery cannulated and catheter placed. Catheter secured with sutures and sterile dressing applied.	3411-3412
09/05/YYYY	Hospital/Provider Name	**Echocardiogram transthoracic:** **Narrative:** Mild concentric left ventricular hypertrophy (LVH). Mildly increased left ventricular wall thickness. Moderately dilated left atrium. No pericardial effusion	3579

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Left ventricular ejection fraction is 55% using method of discs (modified Simpson's rule).	
09/05/YYYY	Hospital/Provider Name	**@ 2030 X-ray of chest:** **History:** Intubated. **Findings:** There is an ET tube with tip 3 cm above the carina. NG tube extends below the diaphragm. There is a right-sided PICC line with tip superimposed over the junction of the SVC and right atrium. There is chronic interstitial lung changes **Impression:** ET tube, NG tube right subclavian line. Chronic interstitial lung changes.	3617-3618
09/06/YYYY	Hospital/Provider Name	**Podiatric consultation report:** **Subjective:** Patient ID: Patient was seen at bedside by podiatry in consultation for bilateral heel ulcerations. Patient is a nursing home resident who is non-verbal and intubated at this time. Her heel ulcerations were previously debrided by Dr. Nahata. She is comfortable in bed and is in no acute distress at this time. **Objective:** Vascular examination: Left dorsalis pedis: Absent/4 Right dorsalis pedis: Absent/4 Left posterior tibial: 1+/4 Right Posterior tibial: 1+/4 Capillary refill time: Intact x 10 toes Left signs of venous insufficiency absent Right signs of venous insufficiency absent Right signs of edema 2+ Left signs of edema 2+ TG warm to cool bilateral. Pedal hair growth absent Neurological exam: Patient does not withdraw her extremities to painful stimuli **Dermatological examination:** Left heel ulceration: Fibro granular base noted surrounded by a dry eschar. Area probes to bone but does not Undermine. Minimal peri-wound erythema with no proximal cellulitis. Mild malodor noted. Right heel ulceration: Dry eschar with fibro granular central area that probes to bone. Area does not undermine. Mild malodor. Minimal peri-wound erythema noted. **Assessment/plan:** Diagnosis: Patient with Bilateral heel ulcerations	3386-3390

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		1. Patient examined and evaluated 2. Aseptic sharp excisional debridement of non-viable tissue on bilateral heels was performed without incident. 3. Bilateral heels were dressed with Santyl collagenase, saline moistened gauze, gauze, and DSD. 4. Nursing please performs above dressing change daily. 5. Please offload bilateral heels with heel protector boots at all times. 6. Recommend bilateral foot radiographs 7. Podiatry will follow-up.	
09/06/YYYY	Hospital/Provider Name	**Culture report:** **Urine culture:** No growth **Blood culture**: No growth	3633-3634, 3645
09/07/YYYY	Hospital/Provider Name	**EKG:** **Result:** Accelerated junctional rhythm Vs sinus tachycardia 104 bpm, left axis deviation, low voltage QRS, inferior infarct, age undetermined, anterior infarct, abnormal EKG repeat EKG if clinically indicated.	3565-3566
09/07/YYYY	Hospital/Provider Name	**X-ray of bilateral foot:** **Findings:** There is prominent diffuse osteopenia that limits exam. Mild joint space narrowing noted. Prominent soft tissue edema noted. **Impression:** Degenerative changes. Cannot rule out osteo. Consider MRI correlation.	3642
09/07/YYYY	Hospital/Provider Name	**X-ray of chest:** **Findings:** New right basilar opacity suggesting atelectasis Vs air space disease. The lungs are hyperinflated. The heart is enlarged. **Impression:** Right basilar opacity as described.	3654
09/08/YYYY	Hospital/Provider Name	**X-ray of chest:** **Findings:** The heart is enlarged. The lungs are hyperinflated. **Impression:** No interval change.	3686-3687
09/09/YYYY	Hospital/Provider Name	**X-ray of chest:** **Clinical history:** Patient presents for follow-up: **Findings**: The lungs are expanded. Limited evaluation of cardiac silhouette and mediastinal structures are unchanged. Atherosclerotic tortuous aorta. Endotracheal tube appears to be in position about 3.5 cm above the carina. Nasogastric tube extends to the stomach. Right central line catheter tip remains in the SVC.	3712-3713

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Impression: Stable patchy bibasilar atelectasis. Support devices in place.	
09/10/YYYY	Hospital/Provider Name	**X-ray of chest:** **Clinical history**: She is for follow-up. **Findings**: The lungs are expanded. There is increasing patchy atelectasis at the lung bases versus infiltrate. Atherosclerotic tortuous aorta. **Impression:** Stable patchy bibasilar atelectasis versus infiltrate with small effusions not excluded. Support devices remain in place as described.	3724
09/11/YYYY	Hospital/Provider Name	**Hematology consultation report:** **Reason for consult**: Low platelets **History of present illness:** History obtained from chart review Patient with history of CVA with left residual weakness, bed bound, CAD, HTN, Stage 4 sacral ulcers, stage 4 heel ulcers with OM, status post debridement in July 2017 in CIH, discharged from CIH with PICC line for IV Merrem for 6 weeks for ESBL and P. Mirabilis UTI. She now presented from rehab NH with lethargy, poor PO intake. Patient admitted to SICU for AMS, septic shock, CT abdomen was positive for pan colitis, most likely due to C diff. Also has acalculous cholecystitis and is being evaluated for percutaneous cholecystotomy tube drainage by IR. Patient found to have 50% drop in platelets. Anemia status post 2 units PRBC. During my evaluation patient is intubated, off pressors. **Objective:** Patient is intubated, off pressors, obese Not responding to verbal commands Responds to touch Lower extremity edematous ++ Flexiseal and Foley cath **Assessment:** Patient with recent hospitalization in July for sacral and heel ulcers, OM, discontinue with IV antibiotics, presented from NH with AMS, septic shock, found to have pan colitis, acalculous cholecystitis, thrombocytopenia, coagulopathy. Thrombocytopenia-drop in platelet count from baseline, low clinical suspicion for HIT, thrombocytopenia possibly secondary to sepsis Rule out DIC	3401-3403

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Plan: Treat underlying condition Send Fibrinogen level B12 level Follow-up SRA If patient needs anticoagulation use IV argatroban (start at low dose 0.2mcg/kg/min with goal PTT 1.5 times baseline) or Arixtra reduced dose in view of renal failure Discussed with Dr. Shah Attending note I was present with the resident during the history and exam. I discussed the case with the resident and agree with the findings and plan as documented in the resident's note. See bottom of the attached note: As stated, I edited, supplemented and confirmed its entire content.	
09/11/YYYY	Hospital/Provider Name	**Wound ostomy and continence progress notes:** **Pertinent diagnosis:** Sepsis due to unspecified organism C. Difficile infection **Wound assessment:** 1. Location: Sacrum. Stage: IV. Pressure injury: Full thickness, full thickness loss and tissue loss. Wound bed: Red; yellow Length: 5cm, width 11cm Length: 55 cm, push sub score 10, exudate amount 2-moderate Tissue type: Granulation tissue Total push score: 14 Depth: 2cm Drainage description: Serosanguinous State of healing: Non-healing Wound margins/wound edges: Defined edges. Pressure injury treatment management: Enzymatic debriding agent; collagenase 2. Location: Right heel. Stage: Unstageable. Obscured full-thickness skin tissue loss. State of healing: Dressing removed. Wound bed assessment: Black; brown Length 3.5cm, width 3.5cm Length 12.25cm, push 9, exudate 1-minimal. Type of tissue: Necrotic tissue (Eschar) Total push score: 14 Depth: 0.2cm Drainage description: Black; brown State of healing: Non-healing Peri-wound: Intact; pink; red Pressure injury treatment management: Enzymatic debriding agent; collagenase.	3459-3466

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		3. Location: Left heel. Stage: IV. Pressure injury. Full thickness skin loss and tissue loss. State of healing: Dressing removed. Wound bed: Black; brown; red; tan; yellow. Wound: Length 8, width 5, depth 0.2 Length 40cm, push 10, educate 2-modrate Tissue type: 4-necrotic tissue (Eschar), total push score 16, depth 1cm Drainage description: Serous; yellow; tan; other drainage color. Pressure injury treatment management: Enzymatic debriding agent; collagenase. 4. Location: Left elbow. Cleanse with: Sterile normal saline. Collagenase. Packed with: Wet to dry dressing with normal saline. Cover with dry sterile dressing. Mepilex bordered.	
09/11/YYYY	Hospital/Provider Name	**X-ray of chest:** **Findings:** The heart is enlarged. The lungs are hyperinflated. Trace left effusion and mild congestion are stable. **Impression:** No interval change.	3736
09/11/YYYY	Hospital/Provider Name	**Bilateral lower extremity venous doppler ultra sound:** **Clinical history**: Rule out deep vein thrombosis. **Findings:** There is visualization of the right and left proximal greater saphenous, common femoral, superficial femoral, popliteal, and posterior tibial veins. The visualized veins are patent with normal color flow, phasicity and compressibility. Augmentation is seen in the popliteal vein. **Impression:** No evidence of deep venous thrombosis in the visualized veins of the right and left lower extremity. Extensive subcutaneous edema is noted bilaterally left greater than right, correlate with physical exam.	3747
09/11/YYYY	Hospital/Provider Name	**Ultra sound of right upper quadrant abdomen:** **Clinical history**: Rule out cholecystitis. **Impression:** The gallbladder is markedly an abnormally distended and contains sludge material. There is no definite evidence of acute cholecystitis. However clinically symptoms warrant, and nuclear medicine scan could be considered. The gallbladder demonstrates abnormal distention. There is trace fluid surrounding the gallbladder which is thought to be related to the adjacent mild ascites rather than inflammatory pericholecystic fluid however this could be colon. There is no gallbladder wall thickening. Patient did not complain of pain overlying the gallbladder.	3748-3749

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Hepatomegaly. The liver is echogenic and coarsened in echotexture, likely fatty infiltration or other diffuse hepatocellular disease. Correlate with liver function test or known history. Pancreas is obscured by bowel gas. Trace ascites. Trace right pleural effusion.	
09/11/YYYY	Hospital/Provider Name	**Procedure report:** **Indication:** Sepsis likely from cholecystitis. **Procedure:** Ultrasound-guided placement of percutaneous cholecystostomy. Accu Stick set was introduced into the gallbladder under direct ultrasound guidance via a transhepatic approach. Dark colored viscous bilious fluid was aspirated. Specimens were taken for cultures and Gram stain. **Impression:** Ultrasound-guided percutaneous cholecystostomy as described.	3753-3754
09/12/YYYY	Hospital/Provider Name	**X-ray of chest:** **Impression:** Stable mild infiltrates/edema and left pleural effusion.	3755-3756
09/13/YYYY	Hospital/Provider Name	**Inpatient nephrology consultation report:** The patient is seen and examined. She is a nursing home resident total care dependent. She presented with history of coronary artery disease, hypertension, sepsis, multiple decubitus ulcers. She is being managed in MICU for septic shock and multiple organ failure. Renal consultation for increased BUN/Cr and decreased urinary flow. **Objective:** Ill-looking woman who is intubated orally/mechanical ventilation. Extremity-Edema. **Assessment/plan:** Acute kidney injury Possible ATN (Acute Tubular Necrosis) due to sepsis Rule out obstructive uropathy **Recommendations:** Intake and output Bedside renal and bladder sonogram UA Urine lytes Follow BMP Serum Mg, P, PTH, uric acid	3403-3407

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		High AG acidosis: Etiology: Lactic acidosis, DKA and uremic acidosis **Recommendations:** Continue IV Na HCO3 Check Acetone and BHB Do not check serum lactate since it is going to high due to lactated Ringers infusion **Septic shock:** Follow culture results vasopressors Antibiotic coverage Wound care for decubiti	
09/13/YYYY	Hospital/Provider Name	**X-ray of chest:** **Impression:** Interval worsening infiltrates/edema and pleural effusions.	3772-3773
09/14/YYYY	Hospital/Provider Name	**Ultra sound of urinary bladder:** **Clinical history:** Worsening renal function. **Impression:** Non-diagnostic study. Unable to visualize urinary bladder as it was not distended.	3780
09/14/YYYY	Hospital/Provider Name	**Renal ultrasound:** **Clinical history:** Worsening renal function. There is poor visualization of bilateral kidneys. The right kidney measures 9.1 x 4.5 x 4.0 cm. The left kidney could not be seen due to the overlying bowel gas and patient s body habitus. **Impression:** Extremely technically limited study due to the presence of overlying bowel gas and patient's body habitus. No right hydronephrosis. Left kidney could not be evaluated.	3781
09/14/YYYY	Hospital/Provider Name	**X-ray of chest:** **Clinical statement:** Hypoxia intubated. **Impression:** Bilateral large pleural effusions left greater than right, slightly worse. Underlying lungs not well evaluated, atelectasis or infiltrate is not excluded.	3807
09/15/YYYY	Hospital/Provider Name	**X-ray of chest:** **Impression:** Bilateral pleural effusion and pulmonary edema/infiltrates with interval increase on the right side.	3809
09/15/YYYY	Hospital/Provider Name	**X-ray of chest:** Endotracheal tube, nasogastric tube and right central venous catheters in	3824

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		satisfactory position. Cardiomegaly with tortuous thoracic aorta. Pulmonary congestion/edema and bilateral pleural effusions are essentially unchanged since previous. **Impression:** Congestive changes/pulmonary edema and bilateral pleural effusions are essentially unchanged since previous.	
09/04/YYYY-09/15/YYYY	Hospital/Provider Name	***Hospitalization related records:** *Nursing notes, progress notes, nutrition notes, respiratory therapy, social work note, plan of care, labs, MAR, plan of care, patient education, assessment, transfusion record* *Ref: 3412-3435, 3609-3610, 3390-3395, 3438-3441, 3538-3539, 3397, 3432, 3434, 3435, 3435-3438, 3398-3401, 3441-3453, 3457-3459, 3453-3457, 3499, 3412, 3466-3474, 3536, 3754-3755, 4052-4059, 4071-4078, 3474, 3483-3486, 3474-3483, 3486-3488, 3541-3553, 3488-3537, 3553-3836, 3825-4000, 4032-4039, 3212-3213, 3214*	
09/15/YYYY	Hospital/Provider Name	**Discharge summary:** **Date of admission:** 09/04/YYYY. **Date of death:** 09/15/YYYY. **Assessment/plan:** She is a nursing home resident with past medical history of diabetes mellitus, coronary artery disease, hypertension, cerebrovascular accident 12/YYYY with right sided residual weakness, bed bound. Currently admitted and being managed with the unit of sepsis secondary to C. Diff colitis (CT showed pan colitis), PNA (Sputum + Pseudomonas). **Pulmonary:** Hypoxic respiratory failure; Intubated/ventilated/PRVC, off sedation, aspiration precautions; head of bed >30 degrees, freq suctioning, daily ABG, chest X-ray. Pneumonia; sputum culture on 09/07/YYYY positive for Pseudomonas Aeruginosa-Sensitive to Zosyn D3, dose adjusted for RF. **Infectious disease:** C. Diff colitis: No lose stool, afebrile, leukocytosis trending down (16-13). On contact isolation. Continue with IV Flagyl day 10/10-14, per oral Vancomycin discontinued today (Completed 10-days) Acalculous Cholecystitis: Status post per chole, follow-up body fluid cultures preliminary no growth. T. bilirubin stable (will continue to trend), Pig Tail flush-patent. PNA: As above Wound care with daily dressing changes for sacral decubitus ulcer by wound care/podiatry UA/Urine culture negative (Treated for positive culture on previous admission 07/17) **Endocrine:**	3364-3366

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		History of diabetes mellitus type II; POC at goal, on Levemir 16unit at night, sliding scale insulin (Monitor/24 hours and adjust as needed). Plan of care. Hypernatremia: Mild increase, continue with LR, free with diet **Cardiopulmonary:** I/O + 1 liter CAD/HTN history: LVEF 60%, mild congestion on chest X-ray, third spacing with extremity edema. Discontinue Lasix in light of worsening renal failure and hypernatremia, started diet, and mild hydration. Continue with Lipitor, Plavix, ASA Off beta blocker due to sepsis: Resolved, will consider restarting Strict input/output **Nephrology:** Acute renal failure: Pre-renal azotemia: Urea 32% (<35%) IV hydration, avoid nephrotoxic medications. Ultrasound renal reviewed; no hydronephrosis Nephrology evaluated **Neurology:** Intubated, off sedation, more awake today. **Hem/Onc:** Thrombocytopenia: Ruled out HIT (Heparin Induced Thrombocytopenia), unlikely to be DIC (Disseminated Intravascular Coagulation) considering high fibrinogen levels. Follow-up antibodies for HIT, (Serotonin release assay) Normocytic anemia: Hgb 8<8.9 Hgb/HCT, transfuse as needed, Goal 8 (Patient has been transfused on this admission) Follow-up B12/Folate levels Hematology evaluated **Skin:** Bilateral lower extremity edema, likely secondary to malnutrition, deep vein thrombosis ruled out. **GI:** Cholecystitis status post per chole. Nutrition: Diabetic diet via orogastric, gentle hydration with D5LR GI prophylaxis: Pepcid IVPB	
09/15/YYYY	Hospital/Provider Name	**Death note:** She was diagnosed septic shock. Patient with multiple codes. At 8:05 a.m., The patient went into cardiac arrest cardiac monitor scope displayed PEA (Pulseless Electrical Activity). M.D., at bedside and ACLS protocol initiated CPR (Cardiopulmonary Resuscitation) terminated at 8:12 a.m. with no pulses noted, pupils fixed and dilated. Subsequently family members signed DNR (Do-Not-	3540

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Resuscitate) and at 9:30 a.m. patient was pronounced dead. Patient was terminally extubated as per hospital protocol. Contacted Rabbi for the family who came and spoke with the family. Comfort measures provided for the family. Postmortem care done in preparation to send body to the morgue.	
09/15/YYYY	Hospital/Provider Name	**Death certificate:** **Name:** XXXX **Type of place:** Hospital inpatient **Borough:** Brooklyn **Date/time of death:** 09/15/YYYY at 0930 hrs **Name of physician:** Jude Poku, M.D. **Usual occupation:** Electrical engineer. **Name of hospital:** Coney Island Hospital. **Disposition:** Staten Island, New York. **Funeral establishment:** Lisovetsky Memorial Home, Inc	4085, 7, 1620, 4040
		***Related records:** *Assessment, orders, labs, patient education, flow sheets, social worker note, plan of care, MAR, medical bills, rhythm strip note, medication sheet, referral note, image note* *Ref: 1137-1139, 1146-1172, 1198-1204, 1-2, 1211, 1366-1619, 1621, 1637-1651, 1656-1660, 1666-1710, 1800-1808, 1836-2021, 2056-2149, 2152-2153, 2161, 2166-2290, 2253, 2292-2362, 2364, 2372-2389, 27-32, 2770-2771, 2776-2782, 2784-2786, 2792-2823, 2829-2832, 304-400, 3179-3192, 3195-3196, 3204-3211, 3215-3216, 3271-3278, 3281-3282, 3290-3302, 331-356, 3356-3358, 3-6, 382-396, 4001-4014, 400-404, 4017-4021, 4026-4031, 4041-4049, 404-422, 4050-4051, 4060-4064, 4079-4084, 4086-4087, 42, 422-472, 4331, 4332, 4333, 4337, 4343, 4348-4363, 4366, 4384-4422, 4426, 4430, 4432, 4439, 4441-4453, 4455-4458, 4461, 4706-4707, 473-499, 500-662, 5053-5055, 5061-5068, 5139-5151, 5153-5157, 5159-5164, 5171-5197, 5230-5241, 663-676, 678-682, 687-688, 701, 711-712, 8, 909-911* ***Reviewer's Comments:** All the significant details are included in the chronology. These records have been reviewed and do not contain any significant information. Hence not elaborated.*	