MEDICAL CHRONOLOGY

Overview and Usage Guides:

Brief Summary/Flow of Events:
In the beginning of the chronology, a Brief Summary/Flow of Events outlining significant medical events is provided which gives general picture of the focus points in the case.

Patient History:
Details related to the patient's past history (medical, surgical, social and family history) present in the medical records.

Detailed Medical Chronology:
Information captured "as it is" in the medical records without alteration of the meaning. Type of information captured (all details/zoom-out model and relevant details/zoom-in model) is per the demands of the case elaborated under 'Specific Instructions'

Reviewer's Comments:
Comments on contradictory information and misinterpretations in the medical record, illegible handwritten notes, missing records, clarifications needed etc. are given in bold italics and red font color and will appear as **** Reviewer's Comment.*** *Definitions of medical terminology are available as pop-up balloon text over blue font color and appear as* definition. *In situ commentary is also displayed in blue font color and is further bolded appearing as* **Reviewer inline commentary.**

Illegible Dates: *Illegible and missing dates are presented as "00/00/0000"(mm/dd/yyyy format)*

Illegible Notes: *Illegible handwritten notes are left as a blank space "_____" with a note as "Illegible Notes" in the heading of the particular consultation/report.*

Specific Instructions:

Prior records:
The prior records are reviewed and the skin condition alone was included if there are any predisposing factors for pressure ulcer.
09/22/2014-10/17/2014:
During this time period the records are summarized in detail to show co-morbid conditions, pressure ulcer prevention protocol followed, daily shift/skin assessments, pressure ulcer evaluation and its management. The details pertinent to other medical conditions are included in brief.
10/17/2014-04/02/2015:
During this time period the records are summarized in detail to show the treatment and progress of the pressure ulcer, including detailed physician progress notes and wound assessments with treatment. The details pertinent to other medical conditions are included in brief. The rehab records are included in brief to show the continued complications and suffering. Only the records which contain the wound details are elaborated; other hospitalization and rehab records are not included in the chronology.

If the name or signature of the provider is not decipherable, an image is captured and included in place or the provider's name in the chronology.

For ease of reference the treatment records are presented in snapshot.

Brief Summary/Flow of Events

09/22/2014-10/08/2014
Hospitalization for Acute Respiratory Distress Syndrome (ARDS)
09/22/2014: Presented with symptoms of sepsis – Intubated – Skin intact and warm – Started on Levaquin and Cefepime
09/23/2014: Braden scale 14/23 – Bilateral heels dry and scaly – Mepilex border ordered
09/26/2014: Sacral **stage I** pressure ulcer – Bariatric bed ordered – Mepilex dressing ordered
09/27/2014: Braden scale 11/23
09/28/2014: Dressing removed – Skin noted to be boggy, dark purple with broken fluid filled blisters – Area cleansed and large Mepilex applied
10/01/2014: Sacral ulcer **stage III** – Broken blister with serous drainage Mepilex border applied
10/02/2014: Mepilex replaced
From 10/03/2014 to 10/08/2014 wound details are not available for review.
10/08/2014: Discharged to rehab

* * * * * * * * * * * * * * * * * * *

10/08/2014-10/17/2014
Rehabilitation stay status post respiratory failure
10/08/2014: 10 x 8 cm sacral ulcer
10/15/2014: 8.3 x 13.4 x 3.9 cm – Foul purulent with odor – Ordered **Dakin's** wet to dry dressing twice daily
10/8/2014-10/17/2014: On wound care as ordered
10/17/2014: Planned to send to Statewide for surgical debridement of **sacrococcygeal** decubitus

* * * * * * * * * * * * * * * * * * *

10/17/2014-10/24/2014
Hospitalization for sacral wound
10/17/2014: Placed on Zosyn –**Stage IV** 21 x 15 x 6 cm – **Plavix** stopped
10/20/2014: 21 x 15 x 9 cm sacral ulcer
10/21/2014: Underwent debridement of sacral decubitus ulcer – **Wound vac** placed
10/24/2014: 9.5 x 13 x 6.6 cm sacral decubitus ulcer – Discharged to rehab

* * * * * * * * * * * * * * * * * * *

10/24/2014-10/29/2014
Rehabilitation stay for wound management
On wound vac – Transferred to Statewide for bleeding from wound vac

* * * * * * * * * * * * * * * * * * *

10/29/2014-11/26/2014
Hospitalization for bleeding from wound vac
Wound was managed as ordered – Hemoglobin and hematocrit were corrected – **Nicotine** patch discontinued – Plastic Surgery consulted – Planned for wound closure after 6 weeks as of 11/20/2014 visit – Discharged on home health care

* * * * * * * * * * * * * * * * * * *

12/06/2014: Wound culture with **MRSA**
01/08/2014: Plastic Surgery office visit – Scheduled OR debridement on 01/16/2015

* * * * * * * * * * * * * * * * * * * *

01/15/2015-02/19/2015
Hospitalization for wound closure
01/16/2015: Underwent sacral soft tissue biopsy for culture – Culture with no growth – Placed on **KinAir bed**
01/23/2015: Underwent bilateral **fasciocutaneous flaps** for closure of sacral ulcer
01/23/2015-02/19/2015: On antibiotics – Wound **dehisced inferiorly** which was packed – Discharged home

* * * * * * * * * * * * * * * * * * * *

02/20/2015-02/27/2015
Hospitalization for wound care – Wound culture with **E. coli**– Placed on antibiotics

* * * * * * * * * * * * * * * * * * * *

03/06/2015-04/02/2015
Hospitalization for depression, suicidal ideation and wound management
On wound care per order - **Wound VAC** discontinued
Discharged to Very Skilled Nursing Facility

* * * * * * * * * * * * * * * * * * * *

Patient History

Past Medical History: Coronary artery disease, chronic obstructive pulmonary disease (COPD), hypertension, diabetes mellitus (Type II), chronic back pain, neuropathy, obesity, allergic rhinitis.

Surgical History: Cardiac catheterization, back operations, multiple fractures left ankle and leg requiring plating.

Family History: Mother had cancer (possibly pancreatic). Two sisters died of lung cancer. Father is diabetic with heart disease.

Social History: Smokes half a pack day as of 08/02/2014. No drugs or alcohol abuse.

Allergy: No known drug allergies.

Detailed Chronology

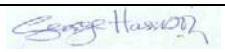
DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
06/23/2012 - 08/03/2014	*Multiple Providers*	**Multiple hospitalizations for abdominal pain and chest pain, office visits for labs and radiographs:** **06/23/2012-06/28/2012:** Hospitalization for perforated appendix. Presented with abdominal pain. Secondary diagnoses include bipolar disorder, depression and other psychiatric issues. *(Ref 4292)* **08/02/2014-08/03/2014:** Hospitalization for atypical chest pain, possibly pleuritic, community acquired pneumonia, chronic obstructive pulmonary disease exacerbation, chronic pain. ***(Ref 4103-4104)*** ****Reviewer's comment: These records reviewed and the skin remained intact without any lesions except for tattoos.***	4100-4426
		Statewide Regional Medical Center	
09/22/2014	David Crosby, M.D.	**Admission for cough, shortness of breath:** She states she had been doing well up until this last week where she has been constantly coughing. She has had productive sputum. Her breathing has been getting steadily worse to the point where most recently she has not been able to use her Continuous Positive Airway Pressure (CPAP) secondary to the cough. She has been kept up all night. She has also noted some belly pain in the middle of her belly, in the epigastrium. She has also noted chills and sweats. She states she has had diarrhea constantly for the last 3 months and has seen her primary for this and a colonoscopy is set up in October. Her shortness of breath is severe in intensity. The patient was seen in Emergency Room (ER) for shortness of breath and initially was minimally responsive. She was placed on Biphasic Positive Airway Pressure (BiPAP) and is now more able to contribute to history, as above. She is referred for admission with chest X-ray consistent with pneumonia by Dr. Martin Short. **Review of systems:** The patient has had chills and sweats, but no noted fevers. Her appetite has been poor. She only eats once a day, she states. She has had some sternal chest pains over the last couple days, but thinks it might be related to the cough. She has had severe cough and shortness of breath. She has had some epigastric and periumbilical abdominal pain. Stable diarrhea. No dysuria, but she notes, "my nuts hurt when I cough". Chronic back pain. Borderline diabetic. **Physical examination:** **Vital signs:** Temperature 101.6, BP 198/86, HR 97, RR 24, O2 saturation 78%. Weight 154.2 kg. **Respiratory:** Decreased breath sounds throughout with prolonged expiratory phase, diffuse expiratory wheezes, bibasilar rales, scattered rhonchi. **Abdomen:** Soft, moderate **periumbilical** pain, but no rebound or guarding, no bruit. Bowel sounds are hypoactive but present. **Extremities:** Warm and dry, 1+ bilateral lower extremity pitting edema. **Skin:** No suspicious rash, palpable nodule or induration. Numerous tattoos.	3332-3335

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Assessment and plan: **A 53-year-oldwhite male:** 1. Probable bacterial healthcare-associated pneumonia, **procalcitonin** pending. 2. Severe sepsis. 3. Metabolic encephalopathy, improving with bi-level positive airway pressure and fluid resuscitation. 4. Probable diabetes, unknown control, **A1C** pending. 5. Hypertension. 6. Bipolar disorder with anxiety. 7. Leukocytosis. 8. Chronic pain syndrome. 9. Abdominal pain. 10. **Lactic acidosis** secondary to acute illness. 11. Known coronary artery disease. 12. Obesity. 13. Probable chronic obstructive pulmonary disease. No pulmonary function testing available in the computer. 14. Chronic diastolic congestive heart failure with most recent echocardiogram on August 4, 2014, showing an Ejection Fraction (EF) of 50% to 55% and a normal Right Ventricular Systolic Pressure (RVSP). No significant valvular abnormalities. 15. Acute respiratory failure. **Plan:** The patient's breathing remains tenuous and she may need intubation. She remains in critical condition. We will treat her as a healthcare-associated bacterial pneumonia given her recent hospitalization here 6 weeks ago. She will be placed on Levaquin and Cefepime, as there has been some influenza in the area. We will also add a rapid influenza swab, sputum culture, blood culture, Legionella. With her abdominal pains, I suspect that this may be related to her cough; however, her lactate is fairly elevated, and we will obtain a CT scan renal stone protocol. Okay Oxycodone orally for pain relief. We will monitor accu-checks and with her probable diabetes, check a Thyroid Stimulating Hormone (TSH) and A1C. Use nicotine patch for withdrawal and provide smoking cessation education. We will use Lovenox and sequential compression devices for deep venous thrombosis prophylaxis. As the patient normally uses continuous positive airway pressure at home, we will continue noninvasive ventilator support, but here bi-level positive airway pressure. Check a **procalcitonin** tonight and in the morning and monitor serial lactates with her sepsis. We will aggressively fluid resuscitate. **Addendum:** The patient's procalcitonin has now returned back and is less than 0.05. Her influenza swab has also returned negative. Her lactic acid is improving, down to 2.5, possible viral pneumonia. For now, we will continue her current antibiotics and we will consult Pulmonology in the morning. She continues to have the severe cough and codeine cough syrup is being added as well.	
09/22/2014	Beth W. Davis, R.N.	**Positioning assessment:**	3476

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Date **Time** **Observation** **09/22/2014** 2235 hrs Independent	
09/22/2014		**Labs:** **High:** Lactate (2.5-4.7), White Blood Cells (WBC) (17.6), Red Blood Cells (RBC) (4.47), Hemoglobin (13.9), Hematocrit (40.9)	3349, 3353
09/23/2014	Angela Kennedy, M.D.	**Consultation for severe acute respiratory distress syndrome and likely healthcare-associated pneumonia:** *History reviewed.* **Physical examination:** **Vital signs:** Temperature 100.6, heart rate 74-129, BP 93-154/48-87. Ins and outs: 449 in, 1290 out. **Neurologic:** Intubated and sedated. Currently on Propofol at 45 mcg per hour and Fentanyl at 50 mcg per hour. The patient still opens her eyes to voice and becomes extremely tachypneic. No focal deficits appreciated. **Respiratory:** Coarse breath sounds bilaterally. **Plan:** **Neurologic:** The patient is quite agitated at times. We will attempt to keep her comfortable while on the ventilator. Have recommended as needed Versed usage between when agitated with Propofol. Additionally, we will increase analgesia to 100 mcg per hour. **Cardiovascular:** Currently, no acute issues. Appears to be well-resuscitated, her lactate has cleared and she has good urine output. Echocardiogram performed today showed good cardiac function with an ejection fraction of 50% to 55%. We will continue to monitor, likely hold blood pressure medications as long as she is on Propofol, secondary to hypotensive effects of Propofol. **Pulmonary:** Likely healthcare-associated pneumonia. She does have an elevated white blood cell count on admission as well as a cough with productive sputum. Given her recent hospitalization, agree with covering for healthcare-associated pneumonia. She is currently on Levaquin and Cefepime. I have obtained a sputum culture, and we will send this to microbiology. We can taper antibiotics appropriately when this returns. Additionally, the patient meets criteria for acute respiratory distress syndrome. She has bilateral infiltrates as well as a **P/F ratio** of less than 200. We will proceed with ventilator management based on **ARDSNet** recommendations with low tidal volumes (6 to 8 ml/kg) and high positive end-expiratory pressure (**PEEP**) as needed. She is currently on a tidal volume of 500 and a positive end-expiratory pressure of 8. We could increase her tidal volume to even 600 based on her ideal body weight, but her pCO2 is trending down currently. Additionally, her positive end-expiratory pressure is currently at 8 and her pO2 appears much improved on her most recent gas. We will continue to titrate ventilator settings based on arterial blood gases. Chronic obstructive pulmonary disease. Agree with steroids given her recent hospitalization with Prednisone. Unsure if she was taking Prednisone recently or if she tapered off of this fairly quickly in August. **Gastrointestinal**, we will continue nasogastric tube to low continuous wall suction, currently secondary to a distended stomach seen on post-intubation	3336-3338

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		chest X-ray and recent use of bi-level positive airway pressure. Suspect that she had some gastric distention from bi-level positive airway pressure. If minimal output is obtained overnight, we will consider starting tube feeds on 09/24/2014. **Fluids, electrolytes, nutrition.** Currently on maintenance intravenous fluids. As mentioned above, feel that she is well resuscitated, given the fact that her lactate has cleared and her urine output has been good. I suspect that her lactic acidosis was secondary to sepsis. Currently, her electrolytes are within normal limits. We will continue to monitor. As mentioned above, we will consider starting tube feeds tomorrow. We will consult nutrition for goal tube feeds, given the caloric input she is receiving from the Propofol. **Genitourinary:** No acute issues. We will continue to monitor. Continue Foley for strict ins and outs. **Hematologic and Oncologic:** **Leukocytosis**, likely secondary to underlying infection with healthcare-associated pneumonia. We will continue to tend this; however, I suspect that she may have continued leukocytosis secondary to steroid use. **Infectious Disease.** Likely healthcare-associated pneumonia, as mentioned above. We will follow up cultures and taper antibiotics as needed. Agree with broad spectrum coverage with Levaquin and Cefepime. **Endocrine:** History of diabetes and steroid usage. We will check finger-stick blood sugars every 6 hours and use moderate sliding scale Insulin to correct. Prophylaxis: Gastrointestinal is Pepcid, deep venous thrombosis is Lovenox.	
09/23/2014	Daniel J. Glover, M.D.	**Hospitalist progress note:** **Vital signs:** Temperature max 100.6. BP 93/68, pulse 90, RR 22, O2 saturation 95%. Sedated. Expiratory wheezing bilaterally. Some erythema on the right lower extremity – indurations on the heels bilaterally. Patient with acute respiratory failure requiring intubation on Tuesday morning 09/23/2014 after failing BiPAP trial with high respiratory rates with associated cough. Chest X-ray of 09/23/2014 demonstrates diffuse **bilateral infiltrates.** Consult wound care.	3442-3446
09/23/2014	 **?Lisa A. Bragg, R.N.?**	**Wound care treatment plan:** ***(Illegible notes)*** Wound location/type: Bilateral dry, cracked heels. Apply _____***(?Sween 24?)***. Cover with Mepilex border. Change dressing Tuesday and Friday and as needed for excess soiling. Recommend sof-care heel lift boots from storeroom.	3449
09/23/2014	Katy W. Bray, R.N. Katy W. Bray, R.N. Lisa A. Bragg, R.N.	**Nursing daily assessment:** **@ 0730 hrs:** Braden scale for risk: 14/23. **Skin:** Dry, warm, intact. **Skin color:** Race appropriate. **Turgor:** Elastic. No lesions noted. **@ 0730 hrs, 1000 hrs:** Fall precautions. Pressure prevention measures. Head of Bed elevated. **@ 1432 hrs:** Wound care #1: **Location:** Bilateral heels. **Type of wound:** Other. Dry, scaly skin.	3484, 3494, 3485, 3488, 3503

<table>
<tr><th>DATE</th><th>PROVIDER</th><th>OCCURRENCE/TREATMENT</th><th>PDF REF</th></tr>
<tr><td></td><td></td><td>Periwound skin: Dry, scaly skin throughout heels.
Treatment: Topical Sween 24. Cover with Mepilex border heel dressing. Treatment plan initiated. Recommend sof-care heel boots.</td><td></td></tr>
<tr><td>09/23/2014</td><td></td><td>Positioning assessment:

<table>
<tr><th>Date</th><th>Time (Documented)</th><th>Observation</th><th>Pdf Ref</th></tr>
<tr><td>09/23/2014</td><td>0030 hrs</td><td>Independent</td><td>3478</td></tr>
<tr><td></td><td>0200 hrs</td><td>Independent</td><td>3479</td></tr>
<tr><td></td><td>0218 hrs</td><td>Independent</td><td>3480</td></tr>
<tr><td></td><td>1000 hrs</td><td>Turned/positioned for comfort</td><td>3494</td></tr>
<tr><td></td><td>1200 hrs</td><td>Turned/positioned for comfort</td><td>3497</td></tr>
<tr><td></td><td>1400 hrs</td><td>Turned/positioned for comfort</td><td>3500</td></tr>
<tr><td></td><td>1545 hrs</td><td>Turned/positioned for comfort</td><td>3504</td></tr>
<tr><td></td><td>1800 hrs</td><td>Turned/positioned for comfort</td><td>3506</td></tr>
<tr><td></td><td>1930 hrs</td><td>Turned/positioned for comfort</td><td>3508</td></tr>
<tr><td>3.75 hrs</td><td>2315 hrs</td><td>Turned/positioned for comfort</td><td>3517
D W Davis</td></tr>
</table></td><td>3478-3517</td></tr>
<tr><td>09/23/2014</td><td></td><td>Labs:
High: Cortisol PM (20.7)
Low: Total protein (5.6), Albumin (2.9), Lactate (1)</td><td>3347-3348, 3355</td></tr>
<tr><td>09/24/2014</td><td> 
?Angela Kennedy, M.D.?</td><td>Critical care progress note:
No overnight events. Sedated and calm on Propofol/Fentanyl.

Vital signs: Temperature 100.3, Pulse 66-94, BP 104-138/50-65.
Improved breath sounds with decreased rhonchi.

Continue Fentanyl, Propofol, as needed Versed for sedation/analgesia. Titrate to SAS 4. Well resuscitated. Keep on dry side secondary to ARDS. HCAP and ARDS. Continue Levaquin and Cefepime. Follow-up cultures. WBC improved. Continue vent. Start TFs at trickle via Nasogastric Tube (NGT). Lactate within normal limits. Leukocytosis improving. On Gastrointestinal (GI) and Deep Vein Thrombosis (DVT) prophylaxis.</td><td>3389</td></tr>
<tr><td>09/24/2014</td><td>Katy W. Bray, R.N.

Nancy E. Holmes, R.N.</td><td>Daily nursing assessment:
@ 0700 hrs: Braden score: 13/23.
Skin: Dry, warm and intact.
Skin color: Race appropriate.
Turgor: Elastic.

@ 1955 hrs: Braden score: 12/23.
Skin: Dry, warm and intact.
Skin color: Race appropriate.
Turgor: Elastic.</td><td>3526, 3550</td></tr>
<tr><td>09/24/2014</td><td></td><td>Positioning assessment:

<table>
<tr><th>Date</th><th>Time (Documented)</th><th>Observation</th><th>Pdf Ref</th></tr>
<tr><td>09/24/2014</td><td>0700 hrs</td><td>Turned/positioned for</td><td>3526</td></tr>
</table></td><td>3526-3557</td></tr>
</table>

<table>
<tr><th>DATE</th><th>PROVIDER</th><th>OCCURRENCE/TREATMENT</th><th>PDF REF</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td></td><td>(0849)</td><td>comfort</td><td>C L Bray</td></tr>
<tr><td></td><td>0900 hrs (1226)</td><td>Turned/positioned for comfort</td><td>3533 C L Bray</td></tr>
<tr><td></td><td>1000 hrs (1228)</td><td>Turned/positioned for comfort</td><td>3537 C L Bray</td></tr>
<tr><td></td><td>1200 hrs (1234)</td><td>Turned/positioned for comfort</td><td>3540 C L Bray</td></tr>
<tr><td></td><td>1400 hrs (1523)</td><td>Turned/positioned for comfort</td><td>3543 C L Bray</td></tr>
<tr><td></td><td>1600 hrs (1837)</td><td>Turned/positioned for comfort</td><td>3546 C L Bray</td></tr>
<tr><td></td><td>1800 hrs (1842)</td><td>Turned/positioned for comfort</td><td>3548 C L Bray</td></tr>
<tr><td></td><td>2200 hrs (2237)</td><td>Turned/positioned for comfort</td><td>3557 N E Holmes</td></tr>
</table>
</td><td></td></tr>
<tr><td>09/24/2014</td><td></td><td>Labs:
High: CRP (270), WBC (12.4), Cortisol AM (21)
Low: Total protein (8.3), Albumin (3), Lactate (1), RBC (3.71), Hemoglobin (11.4), Hematocrit (34.3)</td><td>3347-3348, 3352, 3354</td></tr>
<tr><td>09/25/2014</td><td>Nancy E. Holmes, R.N.</td><td>Daily nursing assessment:
@ 1935 hrs: Braden score: 10/23.
Skin: Dry, warm and intact.
Skin color: Race appropriate.
Turgor: Elastic.</td><td>3589</td></tr>
<tr><td>09/25/2014</td><td></td><td>Positioning assessment:
<table>
<tr><th>Date</th><th>Time (Documented)</th><th>Observation</th><th>Pdf Ref</th></tr>
<tr><td>09/25/2014</td><td>0210 hrs (0244)</td><td>Turned/positioned for comfort</td><td>3562 N E Holmes</td></tr>
<tr><td>>4 hrs since last</td><td>0700 hrs (1440)</td><td>Turned/positioned for comfort</td><td>3571 J L Scott</td></tr>
<tr><td>12 hrs since last</td><td>1900 hrs (1920)</td><td>Turned/positioned for comfort</td><td>3588 J L Scott</td></tr>
<tr><td></td><td>2100 hrs (2104)</td><td>Turned/positioned for comfort</td><td>3596 N E Holmes</td></tr>
<tr><td></td><td>2300 hrs (2320)</td><td>Turned/positioned for comfort</td><td>3599 A S Davis, CN</td></tr>
</table>
</td><td>3562-3599

Note gaps in notation of positioning for comfort. This is outside the standard of care for nursing.</td></tr>
<tr><td>09/25/2014</td><td></td><td>Labs:
High: CRP (214.3), WBC (16.9)
Low: Albumin (3.1), RBC (3.68), Hemoglobin (11.4), Hematocrit (33.5)</td><td>3346-3347, 3352</td></tr>
<tr><td>09/26/2014</td><td>?Daniel J. Glover, M.D.?</td><td>@ 0730 hrs: Physician order:
Order Bariatric bed with turning capabilities.</td><td>3099</td></tr>
<tr><td>09/26/2014</td><td>Nancy E. Holmes, R.N.</td><td>Daily nursing assessment:
@ 0200 hrs: Mepilex sacral dressing placed on coccyx area that is reddened.</td><td>3603, 3610-3611, 3617,</td></tr>
</table>

<table>
<tr><th>DATE</th><th>PROVIDER</th><th>OCCURRENCE/TREATMENT</th><th>PDF REF</th></tr>
<tr><td></td><td></td><td>Right hip stage I pressure ulcer. Stage I pressure ulcers to coccyx AND right hip described.

Jeanie D. Scott, R.N.
@ 0800 hrs: Braden scale: 12/23.
Skin: Dry, warm.
Skin color: Race appropriate.
Turgor: Elastic.

Jeanie D. Scott, R.N.
@ 1000 hrs: Moved to bariatric bed.

Jeanie D. Scott, R.N.
@ 1100 hrs: Rotational bed.

Lori Robinson, R. N.
@ 1930 hrs: Braden scale 15/23. Sacral dressing dry and intact. Braden Scale assessment indicates this intubated and sedated patient’s nutritional intake is adequate and friction and shear are no apparent problem. This is inconsistent with Braden Scale instructions.</td><td>3619, 3630, 3634</td></tr>
<tr><td>09/26/2014

09/26/2014</td><td></td><td>Positioning assessment:

<table>
<tr><th>Date</th><th>Time (Documented)</th><th>Observation</th><th>Pdf Ref</th></tr>
<tr><td>09/26/2014</td><td>0100 hrs (0122)</td><td>Turned/positioned for comfort</td><td>3602 N E Holmes</td></tr>
<tr><td></td><td>0300 hrs (0328)</td><td>Turned/positioned for comfort</td><td>3604 A S Davis</td></tr>
<tr><td></td><td>0410 hrs (0635)</td><td>Turned/positioned for comfort</td><td>3605 N E Holmes</td></tr>
<tr><td></td><td>0500 hrs (0541)</td><td>Turned/positioned for comfort</td><td>3609 A S Davis</td></tr>
<tr><td></td><td>0617 hrs (0617)</td><td>Turned/positioned for comfort</td><td>3609 C R Rivers</td></tr>
<tr><td>>5 hrs since last</td><td>1200 hrs (1633)</td><td>Rotational bed</td><td>3620 J L Scott</td></tr>
<tr><td></td><td>1300 hrs (1659)</td><td>Rotational bed</td><td>3622 J L Scott</td></tr>
<tr><td></td><td>1400 hrs (1700)</td><td>Rotational bed</td><td>3623 J L Scott</td></tr>
<tr><td></td><td>1450 hrs (1703)</td><td>Rotational bed</td><td>3624 J L Scott</td></tr>
<tr><td></td><td>1600 hrs (1706)</td><td>Rotational bed</td><td>3625 J L Scott</td></tr>
<tr><td></td><td>1700 hrs (1756)</td><td>Rotational bed</td><td>3628 J L Scott</td></tr>
<tr><td></td><td>1757 hrs (1757)</td><td>Rotational bed - Independent</td><td>3628 J L Scott</td></tr>
<tr><td></td><td>1900 hrs (1918)</td><td>Turned/positioned for comfort</td><td>3629 A S Davis</td></tr>
<tr><td></td><td>1930 hrs (2052)</td><td>Turned/positioned for comfort</td><td>3630 L Robinson</td></tr>
</table>
</td><td>3602-3639</td></tr>
</table>

<table>
<tr><th>DATE</th><th>PROVIDER</th><th>OCCURRENCE/TREATMENT</th><th>PDF REF</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>2000 hrs (2206)</td><td>Turned/positioned for comfort</td><td>3636 L Robinson</td></tr>
<tr><td>2100 hrs (2105)</td><td>Turned/positioned for comfort</td><td>3637 A S Davis</td></tr>
<tr><td>2211 hrs (2211)</td><td>Turned/positioned for comfort</td><td>3639 L Robinson</td></tr>
<tr><td>2300 hrs (2306)</td><td>Turned/positioned for comfort</td><td>3639 A S Davis</td></tr>
</table>
</td><td></td></tr>
<tr><td>09/26/2014</td><td></td><td>Labs:
High: CRP (87.6)
Low: Total protein (6.1), Albumin (2.9), RBC (3.69), Hemoglobin (11.3), Hematocrit (33.6)</td><td>3346-3347, 3352</td></tr>
<tr><td>09/27/2014</td><td>Debra L. Franks, R.N.

Debra L. Franks, R.N.

Debra L. Franks, R.N.
Rebekah C. Nashten, R.N.

Rebekah C. Nashten, R.N.</td><td>Daily nursing assessment:
@ 0748 hrs: Bari-Maxx II air bed turning patient every 15 minutes. Braden scale 13/23. Skin dry, warm and intact. Mepilex dressing to sacral area clean, dry, and intact.

@ 1418 hrs: Bariatric bed continues to turn patient from left to right to back every 15 minutes.

@ 1615 hrs: Skin moist/diaphoretic.

@ 1940 hrs: Sacral wound. Braden scale 11/23. Skin dry, warm, reddened and ecchymosis. NOT DOCUMENTED UNTIL 09/29/2015 @ 0152

@ 2200 hrs: Bari-Maxx II air bed turning patient every 15 minutes.</td><td>3653, 3655, 3667, 3669, 3676-3677</td></tr>
<tr><td>09/27/2014</td><td></td><td>Positioning assessment:
<table>
<tr><th>Date</th><th>Time (Documented)</th><th>Observation</th><th>Pdf Ref</th></tr>
<tr><td>09/27/2014</td><td>0031 hrs (0031)</td><td>Turned/positioned for comfort</td><td>3641 L Robinson</td></tr>
<tr><td></td><td>0100 hrs (0118)</td><td>Turned/positioned for comfort</td><td>3643 A S Davis</td></tr>
<tr><td></td><td>0201 hrs (0201)</td><td>Turned/positioned for comfort</td><td>3644 L Robinson</td></tr>
<tr><td></td><td>0300 hrs (0321)</td><td>Turned/positioned for comfort</td><td>3646 A S Davis</td></tr>
<tr><td></td><td>0406 hrs (0406)</td><td>Turned/positioned for comfort</td><td>3648 L Robinson</td></tr>
<tr><td></td><td>0500 hrs (0502)</td><td>Turned/positioned for comfort</td><td>3651 A S Davis</td></tr>
<tr><td></td><td>0558 hrs (0558)</td><td>Turned/positioned for comfort</td><td>3652 L Robinson</td></tr>
<tr><td></td><td>0748 hrs (0748)</td><td>Turned/positioned for comfort</td><td>3652 D L Franks</td></tr>
<tr><td></td><td>1016 hrs</td><td>Turned/positioned for</td><td>3661</td></tr>
</table>
</td><td>3641-3681</td></tr>
</table>

<table>
<tr><th>DATE</th><th>PROVIDER</th><th>OCCURRENCE/TREATMENT</th><th>PDF REF</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>2.5 hrs</td><td>(1017)</td><td>comfort</td><td>J D Stiles</td></tr>
<tr><td>4 minutes after last</td><td>1020 hrs (1028)</td><td>Turned/positioned for comfort</td><td>3661 D L Franks</td></tr>
<tr><td></td><td>1200 hrs (1426)</td><td>Turned/positioned for comfort</td><td>3664 D L Franks</td></tr>
<tr><td></td><td>1418 hrs (1418)</td><td>Turned/positioned for comfort</td><td>3667 D L Franks</td></tr>
<tr><td></td><td>1615 hrs (1814)</td><td>Turned/positioned for comfort</td><td>3669 D L Franks</td></tr>
<tr><td></td><td>1818 hrs (1818)</td><td>Turned/positioned for comfort</td><td>3672 D L Franks</td></tr>
<tr><td></td><td>2200 hrs (2218)</td><td>Turned/positioned for comfort</td><td>3681 R C Nashten</td></tr>
</table>
</td><td></td></tr>
<tr><td>09/27/2014</td><td></td><td>Labs:
Low: Total protein (5.1), Albumin (2.4), RBC (3.65), Hemoglobin (11.1), Hematocrit (33)</td><td>3345, 3352</td></tr>
<tr><td>09/28/2014</td><td>Debra L. Franks, R.N.

Debra L. Franks, R.N.

Debra L. Franks, R.N.

Ibid.

Debra L. Franks, R.N.
Rebekah C. Nashten, R.N.</td><td>Daily nursing assessment:
@ 0719 hrs: Bari-Maxx II air bed rotating patient in bed every 16 minutes from left to back to right and so forth. Braden scale 12/23. Skin intact and moist.
Sacral area covered with Mepilex.

@ 0820 hrs: Automatic turn stopped on bed and patient turned by nursing onto left side.
Sacral stage II pressure ulcer: Dressing removed and skin is noted to be boggy, dark purple with broken fluid filled blisters. Area cleansed with saline and large Mepilex applied to cover area.

@ 0940 hrs: Patient turned to right side.

@ 1206 hrs: Patient turned well over onto left side off of sacral area. Arms elevated on pillows.

@ 1449 hrs: Patient turned on right side.

@ 2004 hrs: Repositioned on right side. Braden scale 11/23. Skin dry, warm, reddened and ecchymosis. Dressing to pressure ulcer is clean, dry and intact.
Documented @ 0141</td><td>3693-3694, 3696, 3701-3702, 3707, 3709, 3717, 3720</td></tr>
<tr><td>09/28/2014</td><td></td><td>Positioning assessment:
<table>
<tr><th>Date</th><th>Time (Documented)</th><th>Observation</th><th>Pdf Ref</th></tr>
<tr><td>09/28/2014</td><td>0219 hrs (0802)</td><td>Turned/positioned for comfort</td><td>3687 R C Nashten</td></tr>
<tr><td></td><td>0440 hrs (0800)</td><td>Turned/positioned for comfort</td><td>3690 R C Nashten</td></tr>
<tr><td></td><td>0600 hrs (0757)</td><td>Turned/positioned for comfort</td><td>3692 R C Nashten</td></tr>
</table>
</td><td>3687-3717</td></tr>
</table>

<table>
<tr><th>DATE</th><th>PROVIDER</th><th>OCCURRENCE/TREATMENT</th><th>PDF REF</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td></td><td>0719 hrs (0719)</td><td>Turned/positioned for comfort</td><td>3693 D L Franks</td></tr>
<tr><td></td><td>0820 hrs (0854)</td><td>Turned/positioned for comfort – Left side</td><td>3701 D L Franks</td></tr>
<tr><td>5 minutes after last</td><td>0825 hrs (0834)</td><td>Turned/positioned for comfort</td><td>3701 J D Stiles</td></tr>
<tr><td></td><td>0940 hrs (0940)</td><td>Turned/positioned for comfort - Right side</td><td>3702 D L Franks</td></tr>
<tr><td>>2.25 hrs</td><td>1206 hrs (1206)</td><td>Turned/positioned for comfort – Left side</td><td>3707 D L Franks</td></tr>
<tr><td>>2.5 hrs</td><td>1449 hrs (1450)</td><td>Turned/positioned for comfort – Right side</td><td>3709 D L Franks</td></tr>
<tr><td>11 minutes after last</td><td>1500 hrs (1617)</td><td>Turned/positioned for comfort</td><td>3710 J D Stiles</td></tr>
<tr><td></td><td>1755 hrs (1756)</td><td>Turned/positioned for comfort - Back</td><td>3713 D L Franks</td></tr>
<tr><td></td><td>2004 hrs (0141)</td><td>Turned/positioned for comfort – Right side</td><td>3717 R C Nashten</td></tr>
</table>
</td><td></td></tr>
<tr><td>09/28/2014</td><td></td><td>Labs:
Low: Total protein (5.9), Albumin (2.7), RBC (3.7), Hemoglobin (11.5), Hematocrit (33.3)</td><td>3345, 3352</td></tr>
<tr><td>09/29/2014</td><td>Multiple Providers</td><td>Daily nursing assessment:
@ 0015 hrs: Turned on left side.

@ 0630 hrs: Turned to right side.

@ 0745 hrs: Braden scale 14/23. Braden assessment by C L Bray, R.N. shows scoring of 4 defined as: No impairment: Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort. (Ref 3735) Neurological assessment note shows patient with Glasgow Coma Score of 5, and sedated; opens eyes, does not follow commands. (Ref 3736)

@ 1931 hrs: Braden scale 10/23. Skin dry, warm, reddened and ecchymosis. Mepilex dressing in place.

@ 2220 hrs: Mepilex dressing clean, dry and intact. Turned to left side.</td><td>3727, 3733, 3735, 3754, 3757, 3761</td></tr>
<tr><td>09/29/2014</td><td></td><td>Positioning assessment:
<table>
<tr><th>Date</th><th>Time (Documented)</th><th>Observation</th><th>Pdf Ref</th></tr>
<tr><td>09/29/2014</td><td>0015 hrs</td><td>Turned/positioned for comfort</td><td>3727</td></tr>
<tr><td></td><td>0225 hrs</td><td>Turned/positioned for comfort</td><td>3728</td></tr>
<tr><td>>4 hrs</td><td>0630 hrs</td><td>Turned/positioned for comfort</td><td>3733 R C Nashten</td></tr>
</table>
</td><td>3727-3761</td></tr>
</table>

<table>
<tr><th>DATE</th><th>PROVIDER</th><th>OCCURRENCE/TREATMENT</th><th>PDF REF</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td></td><td>0745 hrs</td><td>Turned/positioned for comfort</td><td>3735</td></tr>
<tr><td></td><td>0957 hrs</td><td>Turned/positioned for comfort</td><td>3741
J D Stiles</td></tr>
<tr><td>3 minutes after last</td><td>1000 hrs</td><td>Turned/positioned for comfort</td><td>3742
C L Bray</td></tr>
<tr><td></td><td>1200 hrs</td><td>Turned/positioned for comfort</td><td>3745</td></tr>
<tr><td></td><td>1400 hrs</td><td>Turned/positioned for comfort</td><td>3747</td></tr>
<tr><td></td><td>1500 hrs</td><td>Turned/positioned for comfort</td><td>3749</td></tr>
<tr><td></td><td>1600 hrs</td><td>Turned/positioned for comfort</td><td>3750</td></tr>
<tr><td></td><td>1800 hrs</td><td>Turned/positioned for comfort</td><td>3752</td></tr>
<tr><td></td><td>2015 hrs</td><td>Turned/positioned for comfort</td><td>3759</td></tr>
<tr><td></td><td>2220 hrs</td><td>Turned/positioned for comfort</td><td>3761</td></tr>
</table>
</td><td></td></tr>
<tr><td>09/29/2014</td><td></td><td>Labs:
High: Glucose (111), WBC (11)
Low: Total protein (6), Albumin (2.9), RBC (3.97), Hemoglobin (11.7), Hematocrit (35.9)</td><td>3345, 3352</td></tr>
<tr><td>09/30/2014</td><td>Multiple Providers</td><td>Daily nursing assessment:
@ 0148 hrs: Turned on back.

@ 0405 hrs: Turned right side.

@ 0600 hrs: Turned on back.

@ 0730 hrs: Braden scale 14/23. Skin warm and diaphoretic.

@ 2049 hrs: Braden scale 14/23. Skin dry and warm. Mepilex in place.</td><td>3768, 3770, 3773-3774, 3795-3797</td></tr>
<tr><td>09/30/2014</td><td></td><td>Positioning assessment:
<table>
<tr><th>Date</th><th>Time (Documented)</th><th>Observation</th><th>Pdf Ref</th></tr>
<tr><td>09/30/2014</td><td>0148 hrs</td><td>Turned/positioned for comfort</td><td>3768</td></tr>
<tr><td></td><td>0405 hrs</td><td>Turned/positioned for comfort</td><td>3770</td></tr>
<tr><td></td><td>0600 hrs</td><td>Turned/positioned for comfort</td><td>3773</td></tr>
<tr><td></td><td>0730 hrs</td><td>Turned/positioned for comfort</td><td>3774</td></tr>
<tr><td></td><td>0900 hrs</td><td>Turned/positioned for comfort</td><td>3781</td></tr>
</table>
</td><td>3768-3800</td></tr>
</table>

<table>
<tr><th>DATE</th><th>PROVIDER</th><th>OCCURRENCE/TREATMENT</th><th>PDF REF</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td></td><td>1000 hrs</td><td>Turned/positioned for comfort</td><td>3782</td></tr>
<tr><td></td><td>1200 hrs</td><td>Turned/positioned for comfort</td><td>3784</td></tr>
<tr><td></td><td>1400 hrs</td><td>Turned/positioned for comfort</td><td>3787</td></tr>
<tr><td></td><td>1800 hrs</td><td>Turned/positioned for comfort</td><td>3792</td></tr>
<tr><td>>5.5 hrs</td><td>2338 hrs</td><td>Turned/positioned for comfort</td><td>3800
D W Davis</td></tr>
</table>
</td><td></td></tr>
<tr><td>09/30/2014</td><td></td><td>Labs:
Low: Albumin (2.8), RBC (4.05), Hemoglobin (12.4), Hematocrit (36.6)</td><td>3344, 3351</td></tr>
<tr><td>10/01/2014</td><td>Multiple Providers</td><td>Daily nursing assessment:
@ 0700 hrs: Braden scale 11/23. Skin warm and diaphoretic. Pressure ulcer stage III, right hip and sacral.

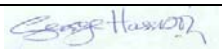
@ 0900 hrs: Dressing change on coccyx. Has purple areas with large broken blisters, draining serous fluid, Mepilex border sacrum applied.

@ 1940 hrs: Braden scale 13/23. Skin warm and moist. Dressing to coccyx in place.

@ 2230 hrs: Complaining of buttocks and sacral pain, repositioned in bed, Fentanyl given as ordered.

@ 2358 hrs: Refused to be turned at this time.</td><td>3810, 3813, 3818, 3828, 3830-3832</td></tr>
<tr><td>10/01/2014

10/01/2014</td><td></td><td>Positioning assessment:
<table>
<tr><th>Date</th><th>Time (Documented)</th><th>Observation</th><th>Pdf Ref</th></tr>
<tr><td>10/01/2014</td><td>0030 hrs (0129)</td><td>Turned/positioned for comfort</td><td>3802
D W Davis</td></tr>
<tr><td></td><td>0239 hrs (0239)</td><td>Turned/positioned for comfort</td><td>3804
D W Davis</td></tr>
<tr><td></td><td>0408 hrs (0408)</td><td>Turned/positioned for comfort</td><td>3806
D W Davis</td></tr>
<tr><td></td><td>0800 hrs</td><td>Independent</td><td>3817</td></tr>
<tr><td></td><td>0900 hrs</td><td>Independent</td><td>3818</td></tr>
<tr><td></td><td>1000 hrs</td><td>Independent</td><td>3819</td></tr>
<tr><td></td><td>1500 hrs</td><td>Independent</td><td>3824</td></tr>
<tr><td></td><td>1600 hrs</td><td>Independent</td><td>3824</td></tr>
<tr><td></td><td>1700 hrs</td><td>Independent</td><td>3826</td></tr>
<tr><td></td><td>1800 hrs</td><td>Independent</td><td>3826</td></tr>
<tr><td></td><td>1940 hrs</td><td>Turned/positioned for comfort</td><td>3827</td></tr>
<tr><td></td><td>2358 hrs</td><td>Refused to be turned</td><td>3832</td></tr>
</table>
</td><td>3802-3832</td></tr>
</table>

<table>
<tr><th>DATE</th><th>PROVIDER</th><th>OCCURRENCE/TREATMENT</th><th>PDF REF</th></tr>
<tr><td>10/01/2014</td><td></td><td>Labs:
High: Glucose (107), WBC (11.4)
Low: Albumin (2.7), RBC (4.13), Hemoglobin (12.5), Hematocrit (37.2)</td><td>3344, 3351</td></tr>
<tr><td>10/02/2014</td><td>  </td><td>@ 0835 hrs: Physician order:
Full liquid diet advance to diabetic as tolerated. Up to chair as tolerated with PT.</td><td>3055</td></tr>
<tr><td>10/02/2014</td><td>Katy W. Bray, R.N.

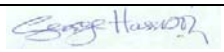
Nancy E. Holmes, R.N.

Nancy E. Holmes, R.N.</td><td>Daily nursing assessment:
@ 0710 hrs: Braden scale 12/23. Skin warm and diaphoretic.

@ 2002 hrs: Braden scale 13/23. Skin dry and warm. Sacral stage II pressure ulcer.

@ 2205 hrs: Patient has large area on her coccyx are that has broken skin and is purple in color. Mepilex replaced.</td><td>3835-3836, 3851-3852, 3854, 3857</td></tr>
<tr><td>10/02/2014</td><td></td><td>Positioning assessment:

<table>
<tr><th>Date</th><th>Time (Documented)</th><th>Observation</th><th>Pdf Ref</th></tr>
<tr><td>10/02/2014</td><td>0230 hrs (0230)</td><td>Turned/positioned for comfort</td><td>3833 D W Davis</td></tr>
<tr><td></td><td>0415 hrs (0607)</td><td>Turned/positioned for comfort</td><td>3834 D W Davis</td></tr>
<tr><td></td><td>0710 hrs</td><td>Independent</td><td>3835</td></tr>
<tr><td></td><td>0800 hrs</td><td>Independent</td><td>3840</td></tr>
<tr><td></td><td>0900 hrs</td><td>Independent</td><td>3841</td></tr>
<tr><td></td><td>1000 hrs</td><td>Independent</td><td>3842</td></tr>
<tr><td></td><td>1120 hrs</td><td>Independent</td><td>3843</td></tr>
<tr><td></td><td>1200 hrs</td><td>Independent</td><td>3844</td></tr>
<tr><td></td><td>1300 hrs</td><td>Independent</td><td>3845</td></tr>
<tr><td></td><td>1400 hrs</td><td>Independent</td><td>3846</td></tr>
<tr><td></td><td>1500 hrs</td><td>Independent</td><td>3847</td></tr>
<tr><td></td><td>1600 hrs</td><td>Independent</td><td>3848</td></tr>
<tr><td></td><td>1700 hrs</td><td>Independent</td><td>3849</td></tr>
<tr><td></td><td>1800 hrs</td><td>Independent</td><td>3849</td></tr>
<tr><td></td><td>1900 hrs</td><td>Turned/positioned for comfort</td><td>3851</td></tr>
<tr><td></td><td>2002 hrs</td><td>Independent</td><td>3851</td></tr>
<tr><td></td><td>2100 hrs</td><td>Turned/positioned for comfort</td><td>3856</td></tr>
<tr><td></td><td>2205 hrs</td><td>Independent</td><td>3856</td></tr>
<tr><td></td><td>2300 hrs</td><td>Turned/positioned for comfort</td><td>3857</td></tr>
</table></td><td>3833-3857</td></tr>
<tr><td>10/02/2014</td><td></td><td>Labs:
High: Glucose (127), WBC (18)</td><td>3344, 3351</td></tr>
<tr><td>10/03/2014</td><td></td><td>Positioning assessment:
<table>
<tr><th>Date</th><th>Time</th><th>Observation</th><th>Pdf Ref</th></tr>
<tr><td>10/03/2014</td><td>0015 hrs</td><td>Independent</td><td>3858</td></tr>
</table></td><td>3858</td></tr>
</table>

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Reviewer's comment: The daily nursing notes from 10/03/2014 0015 hrs to the discharge dated 10/08/2014 are not available for review to know the repositioning, Braden score and the skin assessments done during the time period.	
		Reviewer's comment: All the physician progress notes are reviewed and there are no significant details related to the pressure ulcer, therefore not detailed chronology. Wound assessment records are not available for review.	
10/03/2014		**Labs:** **High:** (Glucose (140), WBC (17.8) **Low:** Albumin (3.3)	3343, 3350
10/04/2014		**Labs:** **High:** Glucose (116), WBC (17.3)	3343, 3350
10/05/2014		**Labs:** **High:** Glucose (119), WBC (16.4) **Low:** Albumin (3.3) **Urinalysis:** Urine protein (75), Urine ketones (5), Urine urobilinogen (4), Urine bilirubin (1), Urine blood (250), Urine WBC (6-10), Urine RBC (25-50), Urine bacteria (Trace), Urine mucus (Slight), Squamous epithelial (2-5)	3343, 3350, 3362
10/06/2014	Barry White, M.D.	**Hospitalist progress note:** Discharge summary done today. She will need to go to rehabilitation from here. Seeing as how she is walking a little bit she is not quite ready for discharge home but it is certain that she will not need even a 30 days of rehabilitation. She has been encouraged to get up move around without help with healing from her ulcer or from keeping pressure off of it.	3396-3398
10/06/2014	 **?Lisa A. Bragg, RN?**	**@ 1211 hrs: Wound care treatment plan:** **Wound location/Type:** Bilateral **ischium**/Deep tissue injury. **Cleanse with:** Normal saline. **Apply barrier up to edge of wound:** Skin Prep. **Cover wound with:** Two Mepilex border sacrum. **Change dressing:** Every Monday and as needed excess soiling. **Additional instructions:** Offloading at all times, chair cushion given.	5815
10/06/2014		**Long term care services review:** **Admission date:** 09/22/2014. **Current level of care:** Hospital. **Recommended level of care:** SNF. **Discharge plan:** Skilled Nursing Facility (SNF). Semi ambulatory with assistance. Bilateral ischial deep tissue injury. Dressing with Mepilex. Diabetic diet. On CPAP. PT 2 times daily for 5-7 days a week.	5813-5814
10/06/2014	Barry White, M.D.	**Discharge summary:** **Discharge diagnoses:** Health care associated pneumonia with severe sepsis. Acute on chronic respiratory failure with ARDS had home oxygen recently. Volume overload. Hypokalemia. Hyperglycemia with A1C 5.5. Bipolar disorder.	5649-5653

<table>
<tr><th>DATE</th><th>PROVIDER</th><th>OCCURRENCE/TREATMENT</th><th>PDF REF</th></tr>
<tr><td></td><td></td><td>Coronary artery disease.
Chronic Obstructive Pulmonary Disease (COPD).
Obstructive sleep apnea on CPAP.

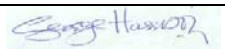
Patient admitted through the Emergency Room on 09/22 with possible viral pneumonia versus ARDS, et cetera. She failed BiPAP therapy, was intubated. It was felt that this was at possibly help care associated pneumonia and very broad-spectrum antibiotics initiated. Her sputum culture grew out light growth normal flora. She did have severe sepsis and systemic inflammatory response with the pneumonia. She received significant fluids which caused overload which is now improving with diuresis. She is restarted on her home diuretics at discharge. Patient was monitored with serial pro-Calcitonin is in with a brick came undetectable; her IV antibiotics were stopped and placed on Bactrim. She will received a couple doses of Bactrim which is stopped as she had had adequate therapy with the new recommendations to use short course therapy for pneumonia. Just really stable for discharge to rehabilitation having completed antibiotics.

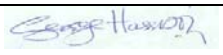
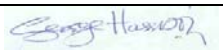
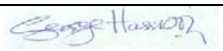
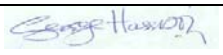
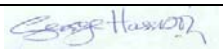
Patient with prolonged ventilation but has been able to be extubated several days ago. After extubation she has done well and is down to 4 L nasal cannula. She does wear CPAP at night which will need to continue.

Patient has developed a sacral decubitus ulcer after being on the ventilator. Wound care is consulted for that and will need to have continued therapy as an outpatient.

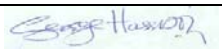
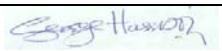
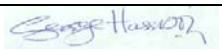
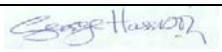
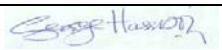
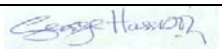
Discharge diet: Regular.
Discharge activity: As tolerated.

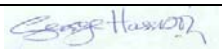
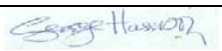
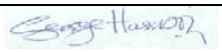
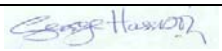
Follow-up: Dr. Ward after rehabilitation. Facility provider within 2 weeks. Wound care consult for sacral decubitus ulcer.</td><td></td></tr>
<tr><td>10/06/2014</td><td></td><td>Labs:
High: WBC (12.5)
Low: Albumin (3.2)</td><td>3343, 3349</td></tr>
<tr><td>09/23/2014
-
10/06/2014</td><td></td><td>Vital signs:
<table>
<tr><th>Date</th><th>BP</th><th>Pulse</th><th>Temp</th><th>RR</th><th>O2 Sat</th></tr>
<tr><td>09/23/2014</td><td>93/66</td><td>90</td><td>100.6</td><td>22</td><td>96</td></tr>
<tr><td>09/24/2014</td><td>107/57</td><td>60</td><td>98.2</td><td>32</td><td>96</td></tr>
<tr><td>09/25/2014</td><td>119/64</td><td>57</td><td>99</td><td>32</td><td>96</td></tr>
<tr><td>09/26/2014</td><td>109/80</td><td>55</td><td>98.1</td><td>4</td><td>90</td></tr>
<tr><td>09/27/2014</td><td>111/42</td><td>67</td><td>99.8</td><td>22</td><td>90</td></tr>
<tr><td>09/28/2014</td><td>121/58</td><td>73</td><td>99.8</td><td>21</td><td>91</td></tr>
<tr><td>09/29/2014</td><td>145/89</td><td>65</td><td>99.5</td><td>24</td><td>96</td></tr>
<tr><td>10/01/2014</td><td>110/58</td><td>97</td><td>98.8</td><td>24</td><td>100</td></tr>
<tr><td>10/02/2014</td><td>138/83</td><td>102</td><td>99.8</td><td>18</td><td>97</td></tr>
<tr><td>10/03/2014</td><td>152/91</td><td>77</td><td>98.1</td><td>25</td><td>96</td></tr>
<tr><td>10/04/2014</td><td>131/72</td><td>72</td><td>98.4</td><td>27</td><td>95</td></tr>
<tr><td>10/05/2014</td><td>121/74</td><td>59</td><td>98.1</td><td>18</td><td>95</td></tr>
</table></td><td>3396-3446
09/26/2014</td></tr>
</table>

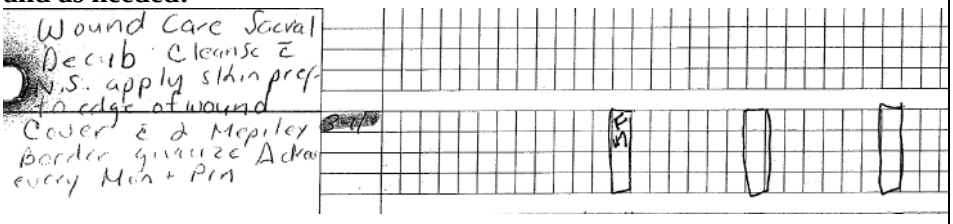
DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		10/06/2014 136/77 56 97.8 18 93 ***Reviewer's comment: Respiratory rate of four breaths per minute recorded 09/26/2014. Patient intubated and on ventilator support. This is likely errant charting though many EMR systems require either correction of such a deviation from expected findings or explanatory note detailing interventions undertaken.***	
10/07/2014	David Crosby, M.D.	**Hospitalist progress note:** No new complaints. Still some dysuria. Eating better. Motivated to get stronger. **Vital signs:** Temperature max 98.4, BP 123/80, Pulse 68, Temperature 98.4, RR 18, O2 saturations 93% on 3L Nasal Cannula (NC). Antibiotics now completed. Continue supplemental O2. Hyperglycemia stress induced with A1C 5.5. Continue CPAP every night. Potassium replaced. Decub ulceration discussed with wound care. Related to her recent near death critical illness. MRSA in sputum. Now off antibiotics. Unclear if colonization, or related to recent pneumonia. No further fevers. Breathing well. Discussed with discharge planner. Probable discharge to Care Partners or Brian Center 10/08/2014.	3393-3395
10/07/2014		**Positioning assessment:** **@ 0610 hrs:** Positioning independent. **@ 0719 hrs:** Positioning independent. Pressure ulcer. **@ 0727 hrs:** Turned and positioned for comfort. **@ 0900 hrs:** Turned and positioned for comfort. **@ 1100 hrs:** Turned and positioned for comfort. **@ 1142 hrs:** Positioning independent.	5820, 5822
10/07/2014		**Labs:** **High:** WBC (12.5). **Low:** Albumin (3.4)	3343, 3349
10/08/2014		**Wound care treatment plan:** **Wound location/Type:** Bilateral ischemia/Pressure ulcer **DTI** healing. Discontinue previous wound care treatment plan. Cleanse with normal saline. Apply barrier up to edge of wound Skin Prep. Lightly fill wound with wound dress. Cover wound with border foam dressing (currently has Mepilex border secure) Offloading at all times.	3447
10/08/2014		**Labs:** **High:** WBC (11.5). **Low:** Albumin (3.4)	3343, 3349
09/22/2014 - 10/08/2014		**Other hospitalization records:** Labs, physician progress notes, medication administration records, physician orders, consent and authorizations, ER record, radiology reports, nursing assessment, EKG ***Reviewer's comment: These records reviewed and the significant details related to the pressure ulcer are included in the chronology above from these records, therefore these records are not detailed here.***	3475-4066, 4069-4099, 3026-3170, 3173-3318, 5816-5822
		Brian Center Health & Rehabilitation/Waynesville	

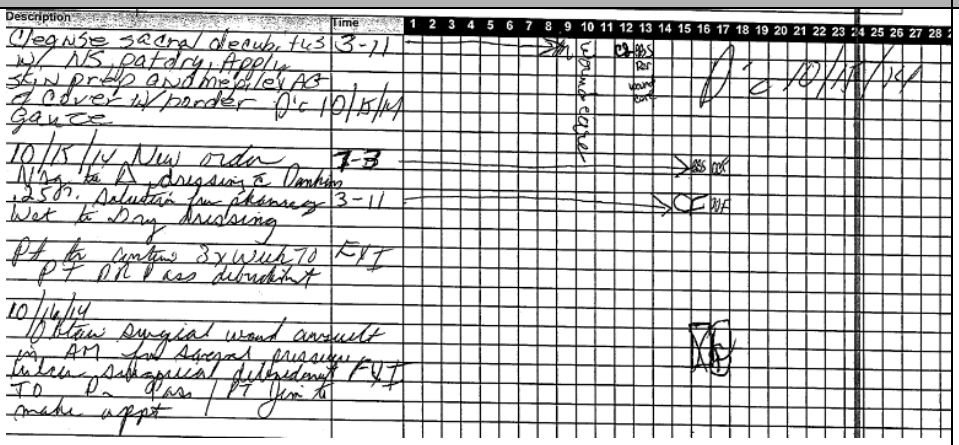
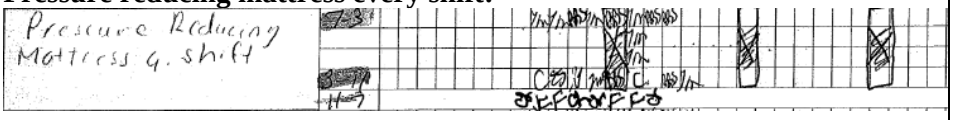
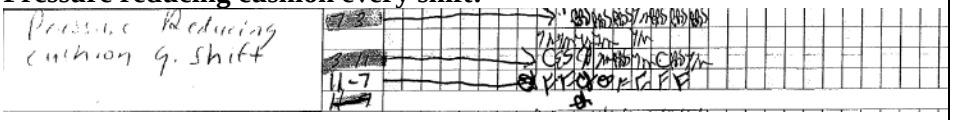
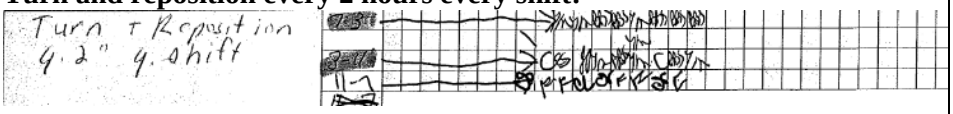
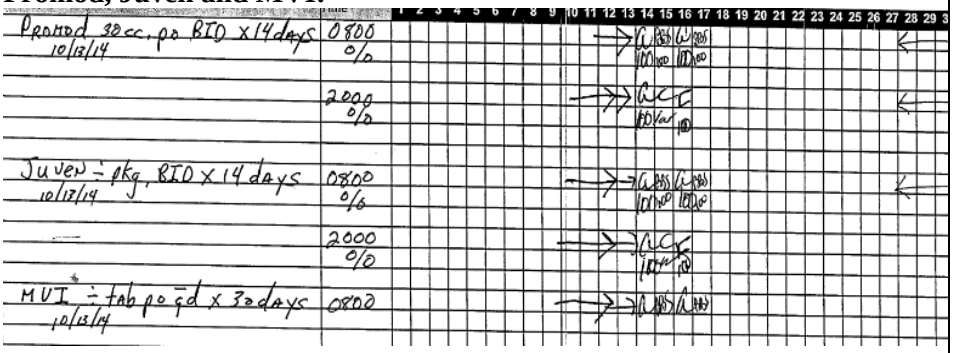
DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
10/08/2014		**Nursing admission intake form:** **Vital signs:** Temperature 98.4, Pulse 80, RR 18, BP 114/74, Weight 357.28. Bed rest. Weak balance. ADL with limited assistance for transfers, extensive assistance for locomotion and bathing. Independent for bed mobility and eating. Resident arrived on SouthWing at 1500 hrs via ambulance with 2 EMTs. She is alert and oriented. She complains of left hip discomfort. Her vital signs were stable. She expressed help desires from PT to walk again. She is pleasant and cooperative.	5732-5735
10/08/2014		**Plan of care – Wound:** Skin potential for skin break down. Pressure ulcer hips. **Interventions initiated:** Provide wound care/preventive skin care per order. Observe wound healing. Skin checks weekly per facility protocol, document findings. Notify MD of changes in wound, or emerging wounds.	5731
10/08/2014		**Head to toe skin assessment:** **Skin intact:** No, buttocks 10 x 8 cm, surrounding area red. **Bruises:** Yes. Arms from injections. **Previously identified area:** No. Preventive measures in place: Yes.	5795
10/08/2014	*Provider not available – Notes unsigned*	**Wound assessment:** **Site/location:** Sacral both buttock cheeks. **Wound #: 1.** **Stage:** Unstageable. **Size in cm:** 10 x 8 cm. **Depth:** <0.5 cm. **Undermining:** Undermining. **Exudate type:** None. **Exudate amount:** None. **Wound bed:** Red, yellow and black. **Surrounding skin color:** Bright red. **Surrounding skin:** Peripheral tissue edema. **Pain related to wound:** Yes Cleanse sacral decubitus with normal saline, pat dry. Apply skin prep to edges, cover with Mepilex Ag and border gauze and CDD every Monday and as needed. (Reddened area 12 x 12 cm surrounding WB)	5796
10/08/2014		**Evaluation for bowel and bladder training:** **Present bladder status:** No incontinence. **Present bowel status:** No incontinence.	5797
10/08/2014		**Daily nursing assessment:** Balance and gait unsteady. Urine dark yellow. Decubitus ulcer on buttocks.	5760
10/08/2014		**Nurse notes:** **@ 2230 hrs:** Admit note: Resident arrived approximately at 1330 hrs via ambulance and 2 attendants and gurney. Resident continent of bowel and bladder, voided 500 cc dark yellow urine this shift. Appetite fair. Moderate assistance with Activities of Daily Living (ADLs). Resident easily agitated.	5761

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Complaining of severe pain. Pain medications given x 2 this shift with only small results. Resident easily agitated, now cooled to calm resident and 1:1. Skin check to wait till morning till resident pain and resident less tired and agitated, resident medications arrived and resident took night medications and Bipap on. Resting at this time.	
10/09/2014	Michael Pass, M.D.	**Rehabilitation admission status post sepsis:** *History reviewed.* **Review of systems:** Positive for the patient having some back discomfort but it is more related to the sacral decubitus that developed in the hospital while she was on the ventilator. This is being evaluated by physical therapy and wound care. The patient was concerned that she was not signed up for the right therapy. Her main reason for being here was to get physical therapy to get her strength back in her legs and get back on her feet so she can take care of himself and get home. She has no other concerns. She is somewhat agitated at the time of my arrival because everything was not being done exactly the way she wanted and she misunderstood some communications from the administration. Nurses knew of no other specific problems except they were concerned that her mania from bipolar may be getting out of control with the amount of agitation they were witnessing. **Physical examination:** The physical exam shows a blood pressure of 114/74, temperature 98.4 orally. Pulse of 80 and regular, respirations 18 and unlabored and weight 357 pounds. Her oxygen saturation was 94% on 4 liters per nasal cannula. **In general**, she is a well-developed, obese, very large. I think 6 feet 7 inches white male, in no acute distress, but somewhat agitated but calm fairly quickly once she was able to vent some of her frustrations and get some degree of reassurance. **HEENT** exam showed no evidence of trauma. Mucous membranes are moist. Neck is negative for adenopathy and Jugular Venous Distention (JVD). **Chest** is clear to percussion. Auscultation reveals diminished breath sounds diffusely. Some rhonchi. No rales, wheezes, or rubs. **Heart** has regular rate and rhythm without significant murmur. **Abdomen** is obese but benign. No real tenderness. No masses or organomegaly. Bowel sounds are within normal limits. **Extremities** show no significant clubbing, cyanosis, or edema. She has just had her sacral wound redressed and was not examined specifically by myself. **Assessment and plan:** Healthcare associated pneumonia and sepsis, acute on chronic respiratory failure and ARDS, complicating her COPD and obstructive sleep apnea, now extubated and on CPAP with naps and bedtime 4 liters of oxygen per nasal cannula. Is pretty adequate while she is off of CPAP. Bipolar disorder, may not be adequately controlled. We will have to watch and see how her agitation and manic tendency is controlled from here on and decide about further medications and intervention. Coronary disease, asymptomatic. Diabetes, will be followed closely. Obesity, certainly would help all of her problems if she had significant weight loss but she reports she not had much hunger at this time and may be losing	5676-5677

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		some weight just since hospitalization. Sacral decubitus. We will have wound care help take care of this and she knows to move frequently to keep the pressure off of that area while here. Chronic back pain and chronic narcotics, we will have adequate pain control for the back and the sacrum wound. The patient will work with therapy to try and regain strength and better ambulation. We did clarify some of-her medications that were being given to her at Practice Center but had been discontinued somewhere along the line through hospitalization including Trileptal, which she had been on for sometime, Trazodone 300 mg every night and Neurontin 600 mg three times daily instead of 100 mg every night, that she came to the facility on. We will watch closely with these medications to make sure there is not excessive sedation that might have caused pneumonia to start with. The patient will be rechecked at least within a month, sooner if things are not improving well.	
10/09/2014		**Nurse notes:** Resident well this shift. No acute distress noted. Temperature 98.2, pulse 78, RR 20, BP 120/74, O2 94%.	5761
10/09/2014		**Nurse notes:** **Time arrived:** 1500 hrs. **Complaints:** Hip and back pain from prior surgery. **Notes:** Resident is alert and oriented and cooperative. Her vital signs are stable. She has a wound to her buttocks to be referred to wound care. She expressed the desire to walk again although she complains of leg weakness	5762
10/10/2014		**Daily nursing assessment:** Alert and anxious. Balance and gait unsteady. Temperature 98.8, Pulse 82, RR 20, BP 120/72. Bed mobility with extensive assist. Transfer with extensive assist. Decubitus buttock wound VAC. ***Reviewer's comment: The placement of wound VAC is not found in the record prior to 10/21/2014.*** Wound care and management.	5759
10/10/2014		**Nurse notes:** Temperature 98, pulse 80, RR 22, BP 118/60, O2 saturation 95%. Resident weaning CPAP. Tolerating well. No acute distress noted. Call light within reach.	5761
10/11/2014		**Daily nursing assessment:** Often incontinence. Urine yellow. Temperature 99.2, pulse 74, RR 18, BP 115/60. SpO2 96%. Bed mobility and transfers with extensive assistance. Decubitus ulcer buttocks. Wound care and management.	5758
10/11/2014		**Nurse notes:** Remains on antibiotics without problems. Temperature 99.2.	5761
10/12/2014		**Daily nursing assessment:** Vital signs: Temperature 98.2, pulse 74, RR 18, BP 115/60. SpO2 96%. Other assessment remains unchanged from previous day.	5756
10/12/2014		**Daily nursing assessment:** Temperature 99.8, pulse 84, RR 18, BP 130/65. O2 sat 92%. Other assessment	5757

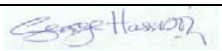
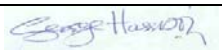
DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		remains unchanged from previous day.	
10/13/2014		**Initial nutritional assessment:** **Diet order:** **RCS**. **Physical condition:** Height 81 inches, weight 357.3 lbs, Body Mass Index (BMI) 38. States 70# loss while hospitalized. **Skin condition:** Pressure ulcer. Admitted with wound from hospital. Dentition complete. Comprehension alert and verbal. Activity wheel chair. Feeding independent. **Nutrient needs:** Estimate needs >3000 calorie. Estimate intake calorie >2100. Estimate protein needs >110, estimated protein intake >100 gram. Estimated fluid needs >2500. Admitted for rehab, has wound on buttock; states wound came from "being in a coma at the hospital and I did not get turned". Discussed importance of protein intake; requested liquid diet related to complaining of gastric pain, agreeable to protein supplements. States she lost nearly 75 # at hospital and would like to maintain the loss. Agreed to add protein and supplements for wound healing. Will consume diet as ordered focusing on protein for healing. Monitor weights per protocol, monitor for lab results. ***Reviewer's comment: The patient is elsewhere reported as approximately 72" in height (6 ft) this notation appears to be erroneous.***	5793-5794
10/14/2014		**Daily nursing assessment:** Temperature 97.6, pulse 95, RR 20, BP 98/45. Decubitus buttocks. O2 saturations 93%. I and E program in place and wound care in place.	5753
10/14/2014		**Nursing weekly summary:** Bowel and bladder continent. Alert and wanders. Understands information conveyed without difficulty. Skin turgor poor. Preventive skin care, pressure relieving or reduction mattress. Pressure relieving/reduction chair pad. Eating habits usually good. Vision adequate. Hearing adequate. Ambulation with assistance. Bed to chair. Transfers assist of 2. Resident continues to turn and position self routinely.	5754-5755
10/08/2014 - 10/15/2014		**Assessment:** **10/08/2014: Pain evaluation:** On pain management. Pain is constant. Hard to sleep at night. Limited activities due to pain. **Location of pain:** Bone, bilateral buttock. **Potential underlying cause:** Ulcer/wound. Neuropathy. Mental illness. **Braden scale:** 10/08/2014: Braden scale: 17 (Mild risk) 10/15/2014: Braden scale: 17 (Mild risk)	5715-5719

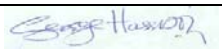
DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Fall risk assessment: 10/08/2014: 7 10/15/2014: 11 **10/15/2014:** Weight: 359.2 lbs.	
10/15/2014		**Wound assessment:** ***(Illegible notes)*** **Location:** Buttock. Necrotic open area. **Stage:** Unstageable. **Size in cms:** 8.3 x 13.4 cm. **Depth:** 3.9 cm. **Undermining:** Undermining. **Exudate type:** Foul purulent. Odor present. **Exudate amount:** Moderate. **Wound bed:** Red, yellow and black. **Surrounding skin color:** Bright red. **Surrounding skin:** Induration. **Pain related to wound:** Yes. Wound care consult in morning and twice daily Dakin's wet to dry dressing. Patient _____ debridement treatment 3x/week _____. **Speciality interventions:** Air mattress bed. Positioning devices pillows.	5765
10/16/2014		**Daily nursing assessment:** Temperature 98.2, pulse 78, RR 78, BP 132/70. Balance and gait unsteady. Weakness. Bed mobility with extensive assistance and 2 person assist. Transfer with extensive assistance and 2 person assist. Feeding ability independent. Decubitus coccyx/buttocks. Wound care and management. Turn and position program in place; wound care in place.	5752
10/17/2014		**Nurse notes:** Order received from Dr. Pass to send to Statewide Regional Hospital to be seen for surgical debridement of sacrococcygeal decubitus that recently reopened and presents with necrotic tissue and depth. EMS transport contacted and report called to ER.	5761
10/08/2014 - 10/17/2014		**Treatment flow sheet:** **Wound care sacral decub cleanse with normal saline. Apply skin prep to edge of wound. Cover with 2 Mepilex border gauze change every Monday and as needed:** 	5775, 5777, 5764

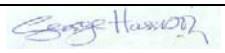
DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		 **Pressure reducing mattress every shift:**  **Pressure reducing cushion every shift:**  **Turn and reposition every 2 hours every shift:**  **Promod, Juven and MVI:**  ***Reviewer's comment: For ease of reference the snap shot for the protein supplementation and treatment records is provided abovey.***	
10/17/2014	Briggs Healthcare	**Transfer report:** **Reason for transfer:** Newly opened sacral/coccygeal decubitus with necrotic tissue.	5636
		Statewide Regional Medical Center	
10/17/2014	Ben Jackson, M.D.	**ER visit for pressure ulcer:** Pressure ulcer much worse. This started yesterday. She had sacral decub that	2715-2720

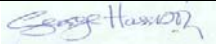
DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		worsened when recently on vent for pneumonia and respiratory failure. Has been at the Brian Center but it has worsened, opened and now has foul odor, and is still present and worsening. It was gradual in onset. No loss of appetite, weight loss, headache, visual disturbance or muscle aches. Denies sleep problem. No decreased urine output. **Similar symptoms previously:** Milder. **Review of systems:** She has had nausea. She has had vomiting (yesterday episode resolved). **Physical examination:** **Vital signs:** BP 112/51, HR 88, RR 18, O2 saturation 81% on room air. Weight 147.4 kg. Temperature 98.1. Pain level 10/10. BMI 36.6. Respiratory: Mild rales present bilaterally. **Back:** Probable grade 4 foul smelling ulcer with damage down to muscle. Located on sacral area. **General orders:** Wound culture. Complete Blood Count (CBC) with differentials. Comprehensive Metabolic Panel (CMP) stat. Lactate. Blood culture. Urinalysis. **Progress and procedures:** **Disposition:** Admitted. **Clinical impression:** Sacral decubitus – severe.	
10/17/2014	Daniel J. Glover, M.D.	**Admission for draining sacral wound:** *History reviewed.* She was later extubated, but she states she developed a wound after being in bed for that period of time. She states that it was addressed while she was at Statewide Medical Center and in the Brian Center as well; however, it worsened and it worsened to the point where it was foul smelling at the Brian center. Because of the worsening smell and because the wound itself had progressed she was sent back to the Emergency Room here at Statewide Hospital, where it was evaluated and it was felt that it needed surgical debridement intervention. The patient states that the wound was draining. She states that she had some pain from the wound, but she has pain also because of, for the most part, deconditioning. She states that she has not walked. She has only stood with assistance. **Review of systems:** **Constitutional:** The patient states that she had a temperature up to 101.1 at the Brian Center. She has also admitted to constant sweating. The patient received a pneumonia and influenza shot prior to being discharged recently from Statewide Hospital following her previous Intensive Care Unit (ICU) stay. **ENMT:** She admits to cotton dry, cotton type mouth. **Neck:** Pain along with her other symptoms. **Pulmonary:** Dyspnea this morning upon awakening this morning. **Cardiovascular:** No reported chest pain in the central part of her chest, but	2722-2725

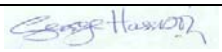
DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		she does admit to rib pain on the left and she cannot lie on her left. She states that it hurts on the left. **Gastrointestinal:** Nausea and vomiting this morning. **Genitourinary:** Some dysuria, which she feels is from having the catheter in long-term earlier doing her ICU stay. She admits to having improved, clear urine, but now it is dark. **Musculoskeletal:** The patient admits to left-sided rib pain, for which it hurts for her to lie on her left side. She states she has been unable to walk for 3 weeks now. **Neurological:** She is weak in her legs. **Psychiatric:** Bipolar disorder with, she states, a lot episodes and recurrences of anxiety. **Endocrine:** Diabetes mellitus type 2. **Skin:** No rash or skin condition such as psoriasis. **Physical examination:** **Vital signs:** Temperature is 98.1, heart rate is 90, respirations are 18, blood pressure is 112/50. O2 saturation is 96% on room air. **Constitutional:** The patient is in no acute distress. She is uncomfortable from many of her body aches from cramping and weak muscles. She is alert and oriented to person, place and time and situation. **Gastrointestinal:** Positive bowel sounds, soft, mild diffuse tenderness. Bowel sounds are present. No organomegaly. **Psychiatric:** The patient admits to anxiety, but she is cooperative, she is calm and she is appropriate. **Assessment and plan:** Acute cellulitis with sacral decubitus. We will place the patient on Zosyn. Diabetes mellitus type 2. We will check a hemoglobin A1C. We will place the patient on sliding scale regimen. Hyperlipidemia. We will continue the patient's statin. Hypertension. We will continue the patient's antihypertensive medicines. Bipolar disorder. We will continue the patient's mood medicines. Coronary artery disease. We will continue Plavix and Lisinopril. It does not look like the patient has a beta blocker, likely due to underlying lung disease. Peripheral neuropathy. We will continue Neurontin. Insomnia. We will continue melatonin. **CODE STATUS:** The patient's code status is FULL CODE.	
10/17/2014	Statewide Regional Medical Center	**Admission assessment:** **@ 1519 hrs:** Temperature 98.4, Pulse 86, RR 18, BP 95/53. Weight 146.90 kg. **@ 1544 hrs:** SpO2 92%. *(Ref 2780)* **@ 1641 hrs:** Left buttock acute pain. 10/10. *(Ref 2775)* **Braden scale:** 13/23. *(Ref 2775-2776)* Requires assistance with positioning. *(Ref 2779)*	2768-2780
10/17/2014	Lisa Bragg, R.N.	**Wound assessment:** **Location of wound:** Bilateral **ischium**. **Type of wound:** Pressure ulcer. **Wound size in cm:** 21 x 15 x 6 cm.	2781

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Undermining: From 3 to 6 o clock measuring 3.5. **Odor:** Foul. **Staging:** Stage IV. **Drainage:** Large, other. (Grey, malodorous) **Wound appearance pre-debridement:** (Surgical consult recommended for large amount of grey slough throughout depth of wound and distal aspect). **Periwound skin:** Intact. **Treatment:** Cleanse with normal saline, antiseptic other Anasept. Fill with Maxorb ES Ag. Cover with Alleyn sacrum with two Mepilex border 6 x 6. **Debridement:** Non selective. **Other interventions:** Nurse, Sally, informed this nurse that Dr. Tucci is currently in surgery and will be seeing this patient after said surgery.	
10/17/2014		**Wound care treatment plan:** **Wound location/type:** Bilateral ischium stage IV pressure ulcer. Cleanse with normal saline and Anasept wound cleanser. Lightly fill wound with Aquacel Ag. Cover wound with Mepilex border 6 x 6 (3). Change dressing daily. **Additional instructions:** Recommend surgical debridement and wound VAC placement. Recommend silver wound VAC granufoam.	2767
10/17/2014		**Daily nursing assessment:** **@ 1700 hrs:** Transferred to bariatric air flo bed. **@ 1854 hrs:** Pain 3/10 left buttock. **@ 2000 hrs:** Braden scale: 18/23. **@ 2054 hrs:** Pain 10/10, left buttock. **@ 2100 hrs:** Positioning independent. **@ 2154 hrs:** Pain reassessment 5/10, left buttock.	2781, 2783-2784, 2786-2787
10/17/2014		**Labs:** **High:** C Reactive Protein **(**CRP) (196.1), WBC (13.3) **Low:** Total protein (5.9), Albumin (2.8), Prealbumin (10.1), RBC (4.27), hemoglobin (12.9), Hematocrit (37.6)	2728, 2730
10/18/2014		**@ 1320 hrs: Surgery progress note:** Met with patient regarding decubitus and she clearly needs debridement. On Plavix, however, and will prefer to wait a few days before surgery. Will discontinue Plavix.	2741
10/18/2014	Daniel J. Glover, M.D.	**Hospitalist progress note:** Patient with draining sacral stage 4 decubitus. Tolerating diet. **Vital signs:** Temperature max 98.6. BP 102/55, Pulse 92, Temperature 98.6, RR 18. O2 saturation 96%. **Abdomen:** Mild right sided abdominal tenderness to palpation. **Extremities:** Trace edema bilaterally in the lower extremities. **Skin:** Stage 4 sacral decubitus with treatment application over the wound. **Assessment and plan:** Acute stage 4 sacral decubitus. General Surgery consulted for debridement and management. Wound care team consulted and also involved. On IV Zosyn until debridement with antibiotic day #2 on Saturday 10/18/2014.	2763-2766

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Recent prolonged hospital stay last month with acute severe sepsis, severe ARDS, acute healthcare acquired pneumonia. Leukocytosis. Severe protein calorie malnutrition with prealbumin of 10.1. On Lovenox 40 mg subcutaneous daily for DVT prophylaxis.	
10/18/2014		**Daily nursing assessment:** **@ 0100 hrs:** Positioning independent. Pain score 10/10, left buttock. **@ 0200 hrs, 0240 hrs:** Pain reassessment: 6/10, left buttock. **@ 0300 hrs:** Positioning independent. **@ 0340 hrs:** Pain assessment: 4/10, left buttock. **@ 0745 hrs:** Positioning independent. Pain 10/10, left buttock. Braden scale 19/23. Decubitus sacral ulcer, dressing with some noted drainage, surgery consult ordered. Heels dry, scaly. **@ 0845 hrs, 0925 hrs:** Pain 7/10, left buttock. **@ 1142 hrs:** Pain 10/10, left buttock. **@ 1226 hrs:** Dressing change performed. **@ 1323 hrs:** Pain 10/10 left buttock. **@ 1421 hrs:** Pain 4/10, left buttock. **@ 1758 hrs:** Pain 10/10, left buttock. **@ 1825 hrs:** Pain 7/10, Left buttock. **@ 2000 hrs:** Braden scale: 18/23.	2788-2791, 2795, 2802-2804
10/18/2014		**Labs:** **High:** WBC (15) **Low:** Total protein (5.8), Albumin (2.6), RBC (4.07), Hemoglobin (11.9), Hematocrit (36.9)	2728, 2730
10/19/2014		**@ 0850 hrs: Surgery progress note:** Patient aware of delay reason. Will attempt debridement Tuesday.	2741
10/19/2014	Daniel J. Glover, M.D.	**Hospitalist progress note:** Foul smelling draining sacral decubitus. Abdominal pain. Tolerating diet. **Vital signs:** Temperature max 98.6, BP 105/55, Pulse 88, Temperature 98.4, RR 16, O2 saturation 93%. **Physical examination:** Patient is worried about her sacral decubitus. Abdominal mild diffuse tenderness. Stage 4 sacral decubitus with treatment application over the wound. **Assessment and plan:** Dr. Tucci General Surgery to debride soon after patient has been off Plavix for several days. Plavix stopped by Dr. Tucci on Saturday. Wound care team consulted and also involved. On IV Zosyn until debridement with antibiotic day #3 on Sunday. On nicotine patch. Tobacco cessation recommended. Persistently elevated LFTs. On Pepcid 20 mg orally twice daily.	2759-2762
10/19/2014		**Daily nursing assessment:** **@ 0915 hrs:** Positioning independent. Pain 10/10, left buttock. Braden scale 21/23. Dressing to sacrum, buttock intact with noted drainage. Appetite good. **@ 1020 hrs:** Pain 6/10, left buttock. **@ 1315 hrs:** Pain 10/10, left buttock. **@ 1409 hrs:** Dressing change performed as ordered. Drainage with foul odor.	2808-2809, 2811, 2813, 2815-2818, 2820-2821

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Pain 6/10, left buttock. **@ 1620 hrs:** Pain 10/10, left buttock. **@ 1720 hrs, 1728 hrs:** Pain 9/10, left buttock. **@ 1830 hrs:** Pain 6/10, left buttock. **@ 1905 hrs:** Positioning independent. **@ 2000 hrs:** Braden scale 20/23. **@ 2118 hrs:** Positioning independent. **@ 2332 hrs:** Positioning independent.	
10/19/2014		**Labs:** **High:** WBC (12.7) **Low:** Total protein (5.8), Albumin (2.6), RBC (3.93), Hemoglobin (11.6), Hematocrit (35) **Wound culture:** **Collected date:** 10/17/2014. **Source:** Buttocks. **Direct exam:** White blood cells seen on smear. Moderate amount of gram negative rods seen on smear. Light amount of gram positive cocci seen on smear. Acceptable specimen, culture results to follow. **Culture exam:** Heavy growth Escherichia coli. **Susceptibility:** Sensitive to Amikacin, Cefepime, Cefotaxime, Ceftazidime, Cefuroxime, Gentamicin, Imipenem, Tobramycin. Resistant to Ampicillin/Sulbactam, Cefazolin, Ciprofloxacin, Levofloxacin, Piperacillin, Piperacillin/Tazobactam, Tetracycline, Ticarcillin/K Clavulanate, Amoxicillin, Ampicillin.	2727, 2729, 2731-2732
10/20/2014		**@ 1220 hrs: PICC double lumen insertion procedure report:** **Indication for line:** Inadequate peripheral access. **Type of line:** PICC double lumen. **Site of insertion:** Right central placement. Basilic. **Catheter size:** 5 Fr. **Catheter length:** 55 cm, not trimmed. **Secure at cm:** 50 cm. **Notes:** Statseal powder to insertion site. **Complications:** No complications.	2739-2740
10/20/2014	Daniel J. Glover, M.D.	**Hospitalist progress note:** Draining sacral decubitus. Abdominal pain. Tolerating diet. **Vital signs:** Temperature 98.8, BP 112/57, Pulse 68, Temperature 98.6, RR 16, O2 saturation 96%. Mild upper abdominal discomfort to palpation predominantly in the muscle tissue. Bowel sound present. Trace edema bilaterally in the lower extremities. Stage 4 sacral decubitus with treatment application over the wound. Day #4 antibiotics. Decrease Lasix to 20 mg orally daily. Hold for systolic BP less than 130 mmHg. Decrease Lisinopril 10 mg orally daily. Hold for systolic BP less than 120 mmHg.	2755-2758
10/20/2014	Lisa Bragg, R.N.	**Wound assessment:** **Location of wound:** Bilateral ischium. **Type of wound:** Pressure ulcer.	2824

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Wound size in cms: 21 x 15 x 9. **Odor:** Foul. **Staging:** Stage IV. **Drainage:** Large. Grey, tan, malodorous. Dr. Tucci to see patient. Not able to go to surgery for debridement until lab values stabilize – has been on Plavix. **Periwound skin:** **Macerated**, **erythemic**, **denuded**. **Treatment:** Cleanse with normal saline, antiseptic – Anasept. Periwound with skin prep, fill with Aquacel Ag, cover with Mepilex sacrum and two Mepilex borders 6 x 6. **Treatment plan:** Continue treatment plan. **Other interventions:** Dressing change. Mepilex border 6 x 6 placed on both hips prophylactic ally. Patient repositions frequently to keep pressure off her sacrum and ischemia.	
10/20/2014		**Daily nursing assessment:** **@ 0127 hrs:** Positioning independent. **@ 0304 hrs:** Positioning independent. **@ 0506 hrs:** Positioning independent. **@ 0722 hrs:** Turned and positioned for comfort. **@ 0900 hrs:** Positioning independent. **@ 1100 hrs:** Positioning independent. **@ 1300 hrs:** Turned and positioned for comfort. **@ 1506 hrs:** Referral made to care partner rehab. Patient for debridement and wound VAC application 10/21/2014 (had to be held as patient had been on Plavix). **@ 1700 hrs:** Turned and positioned for comfort. **@ 1930 hrs:** Positioning independent. Patient on bariatric bed. Turns self side to side. Has trapeze. Pain 9/10, left buttock. Braden scale 18/23. Dressing changed, removed soiled packing and cleaned with normal saline and repacked with Aquacel Ag and recovered with Mepilex border 6x 6. Area is bilateral ischium. **@ 2125 hrs:** Pain 9/10, left buttock. **@ 2225 hrs:** Pain 9/10, left buttock. Positioning independent. Braden scale 18/23. **@ 2253 hrs:** Pain 10/10, left buttock. **@ 2342 hrs:** Positioning independent. Pain 8/10. Braden scale 18/23.	2821-2823, 2826-2830, 2832, 2834-2838
10/20/2014		**Labs:** **Low:** Total protein (5.8), Albumin (2.6), RBC (3.98), Hemoglobin (11.9), Hematocrit (35.3)	2727, 2729
10/21/2014	Daniel J. Glover, M.D.	**Hospitalist progress note:** Debridement today. Abdominal pain. Tolerating diet. **Vital signs:** Temperature max 98.3, BP 124/73, Pulse 77, Temperature 98.1, RR 18, O2 saturation 92%. Generalized abdominal tenderness likely from this past month's Lovenox injections. Stage 4 sacral decubitus with treatment application over the wound. Decreased the doses of both Lasix and Lisinopril.	2751-2754
10/21/2014		**Anesthesia record:** **Diagnosis:** Buttock lesion.	2987

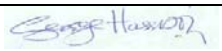
DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Procedure: I &D exploration right buttock lesion.	
10/21/2014		**Operative note:** **Pre and post operative diagnosis:** Decubitus ulcer. **Procedure:** Buttocks I & D/Exploration. **Drains:** Unknown. **Case notes:** Decubitus ulcer I & D. ***Reviewer's comment: The operative report is dated as 10/23/2014 (Ref 2989) and is summarized below with same date.***	2988
10/21/2014		**Daily nursing assessment:** **@ 0200 hrs:** Positioning independent. Braden scale 18/23. **@ 0305 hrs:** Dressing changed. Pain 9/10, left buttock. Bleed through old dressing. Noted 2 blood clots in old dressing. Cleansed with saline and packed with Aquacel Ag. Applied Mepilex with borders 6/6 x3. Patient given Ativan 1 mg with a sip of water for dressing change. **@ 0405 hrs:** Positioning independent. Pain 8/10, left buttock. Braden scale 18/23. **@ 0600 hrs:** Positioning independent. Pain 8/10, left buttock. Braden scale 17/23. **@ 0700 hrs:** Pain 10/10, left buttock. **@ 0719 hrs:** Positioning independent. **@ 0847 hrs:** Braden scale 16/23. **@ 0936 hrs:** Positioning independent. **@ 1415 hrs:** Pain 8/10, left buttock. **@ 1517 hrs:** Turned and positioned for comfort. **@ 1611 hrs:** Turned and positioned for comfort. Pain 4/10, left buttock. **@ 1700 hrs:** Turned and positioned for comfort. **@ 1825 hrs:** Pain 8/10, left buttock. **@ 1949 hrs:** Wound VAC in place to 125 mmHg suction. Dressing intact. Positioning independent. Pain 10/10, left buttock. Braden scale 18/23. **@ 2049 hrs:** Pain 9/10, left buttock. **@ 2132 hrs:** Turned and positioned for comfort. Pain 10/10, left buttock. Braden scale 17/23. **@ 2230 hrs:** Pain 9/10, left buttock. @ 2334 hrs: Positioning independent. Pain 10/10 left buttock. Braden scale 17/23.	2840-2843, 2845, 2847-2848, 2853-2858, 2862-2867
10/21/2014		**Labs:** **Low:** Total protein (6.1), Albumin (2.8), RBC (4.08), hemoglobin (12.4), hematocrit (36.1)	2727, 2729
10/22/2014	Daniel J. Glover, M.D.	**Hospitalist progress note:** Draining sacral decubitus status post debridement by Dr. Tucci on yesterday. Vital signs: Temperature max 98.9, BP 117/60, Pulse 72, Temperature 98.3, RR 18, O2 saturation 94%. Anxious concerning her sacral wound. Wound VAC is present. Dr. Tucci recommended continuing antibiotic therapy.	2746-2750
10/22/2014	Lisa Bragg, R.N.	**Wound assessment:** **Location of wound:** Bilateral ischium. **Type of wound:** Surgical wound. **Wound size in cms:** 13 x 10 x 6.	2886-2887

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Undermining: From 0930 to 0400 o'clock measures 7.5 cm. **Drainage:** Large, serosanguineous. **Wound appearance:** 95% pale pink, 5% slough. Wound appearance post debridement 100% pale pink. Periwound skin erythemic and denuded. **Treatment:** Cleanse with normal saline and Anasept. Periwound with skin prep and Marathon. Fill with white foam. Cover with silver granulofoam. Secure with KCl drape. Debridement non selective. Wound VAC therapy ongoing set at 125 mmHg continuous.	
10/22/2014		**Daily nursing assessment:** **@ 0034 hrs:** Pain 9/10, left buttock. **@ 0248 hrs:** Pain 9/10, left buttock. Positioning independent. Braden scale 17/23. **@ 0333 hrs:** Pain 9/10, left buttock. **@ 0430 hrs:** Positioning independent. Pain 8/10 left buttock. Braden scale 17/23. **@ 0539 hrs:** Pain 9/10, left buttock. **@ 0623 hrs:** Positioning independent. Pain 8/10, left buttock. Braden scale 17/23. **@ 0729 hrs:** Positioning independent. **@ 0743 hrs:** Pain 10/10, left buttock. Braden scale 21/23. Wound VAC to sacral wound. **@ 0842 hrs:** Pain 7/10, left buttock. **@ 0907 hrs:** Positioning independent. **@ 1048 hrs:** Pain 9/10, left buttock. **@ 1052 hrs:** Weight 1445.9 kgs. **@ 1126 hrs:** Positioning independent. **@ 1139 hrs:** 10/10, left buttock pain. **@ 1226 hrs:** 7/10, left buttock pain. **@ 1319 hrs:** Wound care nurses in with patient to perform wound VAC dressing change. Patient pre-medicated with Morphine IV as ordered. **@ 1357 hrs:** Positioning independent. **@ 1500 hrs:** Positioning independent. **@ 1547 hrs:** Pain 9/10, left buttock. **@ 1648 hrs:** Pain 9/10, left buttock. **@ 1700 hrs:** Positioning independent. **@ 1753 hrs:** Pain 7/10, left buttock. **@ 1920 hrs:** Positioning independent. Patient has a bariatric bed with a trapeze and turns well and often. Pain 7/10, left buttock. Braden scale 18/23. **@ 2059 hrs:** Pain 9/10, left buttock. **@ 2120 hrs:** Pain 7/10, left buttock. Positioning independent. **@ 2300 hrs:** Positioning independent.	2868-2870, 2872-2875, 2877-2878, 2882-2886, 2888-2892, 2896-2897
10/22/2014		**Labs:** **Low:** Total protein (5.6), Albumin (2.6), RBC (3.58), Hemoglobin (10.8), Hematocrit (31.6)	2726, 2729
10/23/2014	Robin Benz, M.D.	**Hospitalist progress note:** Patient notes that she has pain in the wound region. Vital signs: Temperature max 97.8, BP 102/50, Pulse 65, Temperature 97.8,	2742-2745

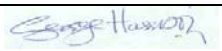
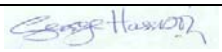
DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		RR 20, O2 saturation 98%. **Assessment and plan:** Sacral decubitus – debrided by Dr. Tucci on 10/21/2014, wound care team involved – case management working on placement. The patient continues to be on Zosyn we will discuss with Dr. Tucci.	
10/23/2014	Statewide Regional Medical Center Eric Tucci, M.D.	**Wound debridement operative report:** **Pre and postoperative diagnosis:** Sacral decubitus ulcer. **Indication:** The patient is a 53-year-old gentleman who has returned to the hospital with a worsening sacral decubitus ulcer. The exact cause is unclear, but apparently several weeks or a month earlier, she had had a severe pneumonia requiring prolonged ventilator support, possibly developing it at that time only to have it worsen once she had gone to rehabilitation or a nursing home. **Findings at surgery:** A very large, deep, widespread sacral decubitus ulcer, one of the worst that I have ever seen. **Description of procedure:** After receiving her informed consent, she was brought to the Operating Room, placed under satisfactory general anesthetic then rolled into the prone jackknife position. She was already on therapeutic antibiotics. The area of external skin breakdown measured about 10 to 12 cm in diameter and was irregular and just to the left of center, but as I debrided deeply through the necrotic fat as well as even muscle it tunneled out in all directions for a good 4 to 6 inches. After debriding, several bleeding points were found requiring suture ligature but most were controlled with pressure and cautery. Once I had debrided a good 90% or so of the necrotic material, we then placed a silver sponge wound VAC into the cavity. The wound VAC was then assembled and put to suction. She tolerated this well with perhaps only 100 ml or so of blood loss and went back to recovery in good condition. **Reviewer's comment: The sacral debridement was carried out on 10/21/2014, but in the medical records it was documented as 10/23/2014. We have the brief operative note, the anesthesia record, and procedure flow sheets dated 10/21/2014.*	2989-2990
10/23/2014		**Assessment:** Braden scale: 19. Wound VAC to lower left buttocks. Only skin deformity noted	5712-5714
10/23/2014		**Daily nursing assessment:** **@ 0002 hrs:** Positioning independent. **@ 0006 hrs:** Pain 9/10, left buttock. **@ 0109 hrs:** Pain 8/10, left buttock. **@ 0156 hrs:** Pain 9/10, left buttock. **@ 0209 hrs:** Positioning independent. **@ 0215 hrs:** Pain 8/10, left buttock. **@ 0302 hrs:** Positioning independent. **@ 0402 hrs:** Positioning independent. **@ 0603 hrs:** Positioning independent. Pain 10/10, left buttock.	2897-2904, 2910-2913, 2915-2917, 2921-2922

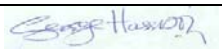
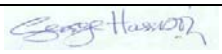
DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		@ 0620 hrs: Pain 9/10, left buttock. **@ 0700 hrs:** Positioning independent. **@ 0813 hrs:** Pain 9/10, left buttock. **@ 0830 hrs:** Turned and positioned for comfort. Braden scale 18/23. Wound VAC in place functioning appropriately. **@ 0900 hrs:** Positioning independent. **@ 0912 hrs:** Pain 7/10, left buttock. **@ 1051 hrs:** Turned and positioned for comfort. Pain 9/10, left buttock. **@ 1100 hrs:** Positioning independent. **@ 1122 hrs:** Pain 6/10, left buttock. **@ 1220 hrs:** Turned and positioned for comfort. **@ 1315 hrs:** Positioning independent. Turned and positioned for comfort. **@ 1438 hrs:** Pain 9/10, left buttock. **@ 1510 hrs:** Out of bed in chair. Turned and positioned for comfort. **@ 1536 hrs:** Pain 5/10, left buttock. **@ 1702 hrs:** Positioning independent. **@ 1839 hrs:** Turned and positioned for comfort. Pain 8/10, left buttock. **@ 1912 hrs:** Positioning independent. Braden scale 17/23. Patient is quite down concerning her SNF placement, as her first choice will not take her with her wound VAC. The only place that has accepted her is the Brian Center which she is adamant that she does not want to go back there. **@ 2001 hrs:** Positioning independent. **@ 2100 hrs:** Positioning independent. **@ 2202 hrs:** Positioning independent. **@ 2245 hrs:** Pain 9/10, left buttock. **@ 2300 hrs:** Positioning independent.	
10/23/2014		**Labs:** **Low:** Total protein (5.7), Albumin (2.7), RBC (3.56), hemoglobin (10.5), Hematocrit (31.2)	2726, 2729
10/24/2014	Jill Young, R.N.	**Wound assessment:** **Location of wound:** Bilateral ischium. **Type of wound:** Surgical wound. **Wound in size:** 9.5 x 13 x 6.6 cm. **Undermining:** 2-4 o'clock at 7 cm and 10-11 5 cm. **Drainage:** Large. Serosanguineous. **Wound appearance:** 100% slough. Pre debridement; post debridement 25% pale pink and 75% slough. **Periwound skin:** Erythemic, denuded. **Treatment:** Cleanse with normal saline, antiseptic and periwound with skin prep. Applied Aquacel Ag to outer areas of wound. Fill with white foam. Cover with black granufoam. Secure with drape. Debridement non selective. **Wound VAC therapy:** Ongoing set 125 mmHg continuous. Patient was medicated for pain prior to dressing change.	2935
10/24/2014		**Daily nursing assessment:** **@ 0020 hrs:** Pain 9/10, left buttock. **@ 0040 hrs:** Pain 0/10, left buttock. **@ 0100 hrs:** Positioning independent. **@ 0204 hrs:** Positioning independent.	2923-2927, 2931-2938

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		@ 0300 hrs: Positioning independent. **@ 0352 hrs:** Positioning independent. Pain 8/10, left buttock. **@ 0500 hrs:** Positioning independent. **@ 0615 hrs:** Positioning independent. **@ 0700 hrs:** Positioning independent. **@ 0759 hrs:** Positioning independent. Pain 9/10, left buttock. Braden scale 20/23. **@ 0853 hrs**: Pain 7/10, left buttock. **@ 0900 hrs:** Turned and positioned for comfort. **@ 1043 hrs:** Patient expressed desire to go to Mountain Trace instead of Brian Center. Called Mountain Trace, no medicare beds available at facility. Patient instructed she could be transferred to Mountain Trace from Brian Center when a bed became available if she desired. **@ 1055 hrs:** Pain 10/10, left buttock. **@ 1100 hrs:** Positioning independent. **@ 1211 hrs, 1230 hrs:** Pain 8/10, left buttock. **@ 1317 hrs:** Turned and positioned for comfort. **@ 1500 hrs:** Turned and positioned for comfort.	
10/24/2014		**Labs:** **Low:** Albumin (2.9), Total protein (5.9), RBC (3.56), Hemoglobin (10.7), Hematocrit (31.3)	2726, 2729
10/24/2014	Robin Benz, M.D.	**Discharge summary:** **Final diagnoses:** Sacral decubitus with wound infection. **Hospital course:** The patient was admitted. She was seen by the general surgery team management. Due to being on Plavix, they wanted to hold off on doing surgery and was not begun until October 23, 2014. The patient was placed on IV Zosyn. Wound care team was involved. Again, the patient had a sacral decubitus. Operative procedure done on October 23, 2014, noting that there was some tunneling and it was debrided. For additional discussion of the surgical debridement/wide debridement, please see the operative report from October 23, 2014. The patient was subsequently felt to be stabilized and we have arranged for her to go back to the Brian Center for treatment of her continued treatment of her wound. Antibiotics have been discontinued. ***Reviewer's comment: The wound debridement was done on 10/21/2014, but it was given as 10/23/2014.***	2599-2600
		Brian Center Health & Rehabilitation/Waynesville	
10/24/2014 - 10/29/2014	*Multiple Providers*	**Rehabilitation stay for wound care:** **10/24/2014:** Braden scale 19. *(Ref 5711)* Vital signs: Temperature 98.7, Pulse 76, RR 18, BP 118/91. *(Ref 5746)* Wound plan of care: Skin: Actual surgical site, pressure ulcer – history of ulcers. **Interventions:** Provide wound care/preventive skin care per order. Observe wound healing. Skin checks weekly per facility protocol, document findings. Notify MD of changes in wound, or emerging wounds. Turn and reposition frequently to decrease pressure.	5711, 5746, 5729, 5744, 5743, 5742, 5748, 5635, 5771

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Encourage participation in daily care needs as able. *(Ref 5729)* **10/25/2014:** Wound vac to coccyx. Temperature 98.6, Pulse 80, RR 22, BP 130/74. *(Ref 5744)* **10/26/2014:** Temperature 98.6, Pulse 78, RR 20, BP 116/66. Wound vac to coccyx. *(Ref 5743)* **10/27/2014:** Temperature 98, Pulse 84, RR 20, BP 104/56, SpO2 96%. Wound vac to coccyx. *(Ref 5748)* **10/28/2014:** Temperature 97.4, Pulse 75, RR 18, BP 135/74. Wound vac to coccyx. *(Ref 5742)* **10/29/2014:** Tramic copious blood coming around wound VAC. *(Ref 5635)* **Treatment sheets:** **10/25/2014-10/29/2014:** *(Ref 5771)* Pressure reducing mattress every shift while in bed. Pressure relieving cushion when out of bed in wheel chair every shift. Turn and reposition every 2 hours every shift. Head to toe skin assessment every Wednesday 3-11 shift.	
10/29/2014		**Discharge summary:** Large amount bright blood, tramic, blood coming around wound vac to left buttock. Discharged to Medwest Statewide.	5634
		Statewide Regional Medical Center	
10/29/2014 - 10/30/2014	Marvin Williams, M.D.	**ER visit fro hemorrhage from wound:** Complaints of hemorrhage from wound. This started just prior to arrival. Patient had recent debridement of sacral decubitus. She ha s a wound vac in place. Patient reports that she had a bowel movement tonight and trained, and had sudden onset of copious bleeding from wound, and is still present. At its maximum, severity described as moderate. When seen in the ED, severity described as moderate. Modifying factors. Not worsened by anything. Not relieved by anything. **Physical examination:** **Rectal:** Large amount of blood present. Bleeding appears controlled with clamping of wound VAC at this time. Weight 120.2 kgs. **Progress and procedures:** **Course of care:** Discussed patient with surgeon, Dr. Tucci and hospitalist. Patient hemoglobin is decreased about 2 grams since 09/22/2014. Patient is on Plavix. Decision is made to admit for monitoring of hemoglobin/hematocrit. **Disposition:** Admitted to the medical/surgical unit. A medical screening exam was performed. The patient should continue through the ED for further evaluation. **Clinical impression:** Post operative wound hemorrhage.	2369-2376

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		10/29/2014: Labs: *(Ref 2388, 2394)* **High:** WBC (15.8) **Low:** Total protein (6), Albumin (3), RBC (3.79), Hemoglobin (11.3), Hematocrit (33.1)	
10/30/2014	Robert Planck, M.D.	**Admission for wound bleeding:** Massive gross prevalent bleeding from her wound VAC and sacral decubitus ulcer. Bleeding was bright red and also cherry-colored. *History reviewed.* She returns tonight with report of "massive bleeding" from her wound VAC and sacral decubitus ulcer. Reportedly, the wound VAC had to be cut off and dis-applied and, after the wound VAC was stopped, the bleeding was subsequently significantly decreased. The area of the sacral decubitus ulcer is still quite moist and bloody, but I do not see any obvious active bleeding. Her hemoglobin has dropped from 13.9 to 11.3. Will go ahead and admit for further observation, and will request surgical consultation in the morning obviously, her Plavix and Aspirin will be on hold for the moment given her active bleeding. Will continue to monitor closely and if her hemoglobin drops anywhere below 10 or 9.0, could consider a blood transfusion to optimize oxygen delivery given her history of coronary artery disease. Will continue to monitor. Wound care consultation will be requested. **Admitting diagnoses:** Active bleeding from sacral decubitus ulcer. Active bleeding from wound VAC and sacral decubitus ulcer. Sacral decubitus ulcer pain. Sacral decubitus ulcer, status post wound VAC. wound VAC stopped given active bleeding. Coronary artery disease with a history of coronary artery stenting. obviously, Aspirin and Plavix will have to be on hold for the moment given her active bleed. **Physical examination:** **Vital signs:** Blood pressure is 150/59. Heart rate is 94, respirations 18, temperature is 98.5, oxygen saturation is 96%. **Skin:** There is evidence of a large sacral decubitus ulcer which looks moist and bloody all around both with bright red blood and also cherry-colored blood. I do not see any obvious active bleeding at the moment. I do not see any pus or significant purulent secretions. **Assessment and plan:** The patient is a 53-year-old male who comes to the Emergency Department referred from skilled nursing facility due to what was described as "a massive amount" of active bright red blood bleeding from her wound VAC and sacral decubitus ulcer that reportedly started a few hours ago. Wound VAC was turned off and the patient was sent to the Emergency Department for further evaluation. Her hemoglobin at the present time is 11.3. Actually, her post-discharge hemoglobin from October 24, 2014, was only 10.7, so no significant blood drop so far; will continue serial hemoglobins overnight. Given her active	2378-2382

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		bleeding, ER physician called surgery on call, Dr. Tucci, who is the surgeon who performed the original debridement and so Dr. Tucci will consult with the patient in the morning will request wound care consultation as well. Obviously, wound VAC will be on hold as well as her blood thinners, including Aspirin and Plavix. Will continue to monitor. Of Note, per Dr. Tucci's operative report from 7 days ago, it noted after debriding, the patient actually had several acute bleeding points that on occasion required ligature suture, but mostly were controlled with pressure and cautery. Will continue to monitor closely and if re-bleeding starts again, could consider calling Dr. Tucci emergently for evaluation. Obviously, for the moment her Plavix and Aspirin will be on hold. She takes those chronically given her history of coronary artery disease, myocardial infarction and coronary artery stenting. Will place on sequential compression devices for deep venous thrombosis prophylaxis. Will request wound care consultation. She is currently afebrile.	
10/30/2014		**PICC placement note:** Indication: Inadequate peripheral access and GI bleed. Type of line: PICC double lumen. Site of insertion: Right central placement. Brachial. 5Fr catheter size, 50 cm length, secured at 46 cm.	2402-2403
10/30/2014	Robin Benz, M.D.	**Hospitalist progress note:** Temperature max 98.3, BP 100/52, Pulse 85, Temperature 98, RR 18, O2 saturation 5%. 8 x 6 x 6 cm stage IV sacral decubitus now without active bleeding. **Assessment and plan:** Bleeding from wound VAC pump sacral decubitus. She returned this evening with large amount of bleeding. Hemoglobin dropped from 13.9 to 11.3. Plavix and Aspirin were held.	2496-2498
10/30/2014		**Labs:** **Low:** Hemoglobin (10.5-10.6), Hematocrit (31.4-32.1)	2393-2394
10/31/2014		**Surgery progress note:** Concerns of bleeding this morning and decreased hemoglobin. Wound checked with wound care, some clots, no active fresh bleeding. Somewhat cleaner. Continue same.	2403
10/31/2014	Robin Benz, M.D.	**Hospitalist progress note:** Patient noted to be still miserable, she started having more brisk bleeding from her wound. **Vital signs:** Temperature max 98.2, BP 107/55, Pulse 66, Temperature 98, RR 18, O2 saturation 95%. Wound VAC was restarted yesterday. This morning she began developing more brisk bleeding. Her hemoglobin dropped a half a point from previous check less than 2 hours previous. Surgery is aware and will come to see the patient shortly we will go ahead and transfuse the patient. We are stopping the wound VAC. Severity is severe. Without hospitalization the patient might bleed to death.	2492-2495, 2491

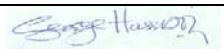
DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
10/31/2014	Lisa A. Bragg, R.N.	**Wound care treatment plan:** *(Illegible notes)* **Wound location/Type:** Bilateral ischial surgical wound. Discontinue previous wound care treatment plan – Used wound VAC. Cleanse with normal saline. Apply barrier up to edge of wound: Mepitel (can be _____ unless soiled). Lightly fill wound with saline soaked Kerlix. Cover wound with ABD x3. Secure dressing with Tegaderm. Change dressing daily and as needed dressing saturated. Additional instructions: Sween 24 to bilateral heels and all dry skin areas daily.	2501
10/31/2014		**Labs:** **Low:** Hemoglobin (7.8-9.7), Hematocrit (22.1-27.7), RBC (3.14)	2393
11/01/2014		**Surgery progress note:** *(Illegible notes)* Complaining of ___ pain. No drainage. H/H pending. Status post 2 units transfusion.	2403
11/01/2014	Daniel J. Glover, M.D.	**Hospitalist progress note:** Bleeding sacral decubitus wound. Temperature max 98.9, BP 118/68, Pulse 65, Temperature 98, RR 17, O2 saturation 98%. Abdomen mild diffuse tenderness. Skin with rash and cellulitis. Transfused 3 units PRBCs on Friday morning 10/31/2014. Wound VAC stopped. Plan to discuss this case with Dr. Tucci General Surgery on Monday 11/03/2014.	2487-2490
11/01/2014		**Labs:** **Low:** RBC (3.68), Hemoglobin (10.9), Hematocrit (31.9)	2393
11/02/2014	Daniel J. Glover, M.D.	**Hospitalist progress note:** Abdominal pain and tolerating diet. Temperature max 98.7, BP 101/51, Pulse 68, RR 17, O2 saturation 92%. Anxious about her stage 4 sacral decubitus wound. Very mild abdominal tenderness diffusely. Plan to discuss with Dr. Almina General Surgery (covering for Dr. Tucci) today 11/02/2014. Checking H/H every 6 hours. Keeping 4 units of PRBC on hold.	2483-2486
11/02/2014		**@ 1900 hrs: Surgery progress note:** Brisk bleeding from wound bed this morning. Hemoglobin 12.5. Dressing changed. Clot intact without no visible vessel bleeding. Cleaned and cauterized with silver nitrate. No current bleeding noted. Repacked and told patient to be flat on back for 1 hour.	2401
11/02/2014		**Labs:** **Low:** Hemoglobin (8.1-10.9), Hematocrit (23.5-28.6)	2392-2393
11/03/2014	Daniel J. Glover, M.D.	**Hospitalist progress note:** Tolerating diet. Vital signs: Temperature max 98.2, BP 126/58, Pulse 88, Temperature 97.8, RR 16, O2 saturation 98%. Stage 4 sacral decubitus examined today 11/03/2014 measuring 9 cm by 7 cm by 5cm with clot and no bleeding and good granulation tissue. **Assessment and plan:** I discussed this case with Dr. Tucci General Surgery	2479-2482

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		on today 11/03/2014. Patient will need intervention from Plastic Surgery.	
11/03/2014		**Labs:** **Low:** Hemoglobin (9.3-9.8), Hematocrit (28-28.5)	2392
11/04/2014	Daniel J. Glover, M.D.	**Hospitalist progress note:** Tolerating diet. Vital signs: Temperature max 98, BP 95/48, Pulse 75, Temperature 97.7, RR 16, O2 saturation 98%. Large stage 4 sacral decubitus wound on the buttock with wound VAC. Wound VAC back in place again after the bleeding has stopped. I spoke with Dr. Simms at Sleepy Hollow Medical Center in Winston Salem, NC. She believes that the patient will be a candidate in the next 3 to 6 weeks but not today. Patient needs to be evaluated and treated for any MRSA infection. I will call other North Carolina tertiary centers with Plastic Surgeons. I plan to discuss this situation with Dr. Tucci. Discontinued tobacco patch on 11/04/2014. Patient will need to be off any nicotine for any plastic surgery flap procedure.	2475-2478
11/04/2014		**Labs:** **Low:** Hemoglobin (9.2-9.5), Hematocrit (27.6-29.4)	2392
11/05/2014	Daniel J. Glover, M.D.	**@ 1400 hrs: Hospitalist progress note:** Patient has a complex stage 4 extensive deep stage 4 sacral decubitus. She will need a short term rehabilitation stay of less than a month with a wound care nurse or team where her wound can be treated. She will need an appointment with a specialized Plastic Surgeon who can perform a complex bilateral flap procedure.	2400
11/05/2014	Daniel J. Glover, M.D.	**Hospitalist progress note:** Patient with large stage 4 sacral decubitus wound. Patient complains of consistent burning pain from the sacral decubitus. Abdominal pain and tolerating diet. **Vital signs:** Temperature max 98.3, BP 112/57, Pulse 65, Temperature 97.7, RR 16, O2 saturation 98%. Anemia resolved.	2470-2474
11/05/2014		**Labs:** **Low:** Total protein (5.6), Albumin (2.9), Hemoglobin (9.3-10.1), Hematocrit (28.7-30.4), RBC (3.23)	2387, 2390-2391
11/06/2014	Daniel J. Glover, M.D.	**Hospitalist progress note:** Abdominal pain and tolerating diet. **Vital signs:** Temperature max 97.7, BP 106/54, Pulse 68, Temperature 97.6, RR 16, O2 saturation 95%.	2466-2469
11/06/2014		**Labs:** **Low:** Total protein (5.9), Albumin (3), Hemoglobin (9.4-9.8), Hematocrit (27.9-29.6), RBC (3.39)	2387, 2390
11/07/2014	Daniel J. Glover, M.D.	**Hospitalist progress note:** Patient had some foul smell to her sacral decubitus. Abdominal pain and tolerating diet.	2461-2465

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Vital signs: Temperature max 97.9, BP 102/50, Pulse 60, RR 17, saturation 95%. Foul smell to sacral wound. Requested that Dr. Tucci and the wound care nurse reevaluate the wound. Today called East Carolina University Medical/Vidant Medical Center for transfer but it was not felt to be an appropriate inpatient transfer. I discuss this situation with Dr. Tucci. Case management is now helping with other options for treatment of patient's large decubitus.	
11/07/2014		**Labs:** **Low:** Total protein (5.5), Albumin (2.8), RBC (3.27), Hemoglobin (9.6), Hematocrit (28.3)	2386, 2390
11/08/2014	Pincus Samuel, M.D.	**Hospitalist progress note:** Patient admits to increased anxiety and wants to know if she can be put back on her home medications Xanax. **Vital signs:** Temperature max 98.7, BP 112/72, Pulse 68, Temperature 98.3, RR 17, O2 saturation 97%. Vacuum noted on the sacral wound. Wound vacuum is noted with extensive amount of odor. We will continue current treatment. I am going to speak to the surgeon on Monday so that we can decide what will be the long term plan. At this time we do not have a place for transfer. Anemia stable at this time. Start her back on Xanax for general anxiety.	2458-2460
11/08/2014		**Labs:** **Low:** Total protein (5.6), Albumin (2.8), RBC (3.39), Hemoglobin (9.8), Hematocrit (29.6)	2386, 2389
11/09/2014	Pincus Samuel, M.D.	**Hospitalist progress note:** Patient admitted to mild pain in the sacral region this morning. **Vital signs:** Temperature max 98.3, BP 116/65, Pulse 61, Temperature 97.2, RR 16, O2 saturation 99%. Wound vacuum is noted with extensive amount of odor. Plan is to discharge her to another Nursing Facility. I am going to speak to case management in the morning to see if patient is scheduled to follow-up with Wake Plastic Surgeon in 3 weeks. Continue to follow hemoglobin and hematocrit.	2455-2457
11/09/2014		**Labs:** **Low:** Total protein (5.3), Albumin (2.6), RBC (3.31), Hemoglobin (9.7), Hematocrit (28.8)	2386, 2389
11/10/2014	Pincus Samuel, M.D.	**Hospitalist progress note:** She is complaining of a right sided chest pain. **Vital signs:** Temperature max 98.4, BP 105/83, Pulse 75, Temperature 97.8, RR 18, O2 saturation 96%. Ulceration noted in the sacrum area that still size of the boxing glove and can see the sacrum.	2452-2454

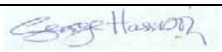
DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Give Toradol times one. Wound vacuum changed today. Anemia stable.	
11/10/2014		**Labs:** **Low:** Total protein (5.7), Albumin (2.9), RBC (3.42), Hemoglobin (9.9), Hematocrit (29.8)	2385, 2389
11/11/2014	Pincus Samuel, M.D.	**Hospitalist progress note:** She is complaining of sacral pain this morning. **Vital signs:** Temperature max 100.4, BP 119/65, Pulse 67, RR 16, saturation 93%. Vac on the sacral wound. Fever. Get procalcitonin level and follow temperature. Adjust pain medications. We have still waiting on discharge planning and disposition of her outpatient care.	2449-2451
11/11/2014		**Labs:** **Low:** Total protein (5.6), Albumin (2.8), RBC (3.46), Hemoglobin (10.1), Hematocrit (30.2)	2385, 2388
11/12/2014	Pincus Samuel, M.D.	**Hospitalist progress note:** Patient is complaining about sacrum pain this morning. She denies any shortness of breath, fever, or chills. **Vital signs:** Temperature max 98, BP 117/71, Pulse 73, Temperature 97.5, RR 18, O2 saturation 99%. Ulceration of the sacrum area with vac present. No fever in the last 24 hours. I am going to change her to oral medication for transition to outpatient setting. Patient was able to get an appointment Wake Forest Plastic Surgeon on 11/20/2014. Case manager to stay working on a long term facility for her that is close Wake Forest.	2446-2448
11/13/2014	Pincus Samuel, M.D.	**Hospitalist progress note:** Patient admitted that she did not sleep last night do to the pain with in her sacrum. She denies any fever or chills. **Vital signs:** Temperature max 98.6, BP 128/68, Pulse 76, Temperature 97.9, RR 18, O2 saturation 99%. Vac present on sacrum wound. Insomnia as needed medication for sleeping. Continue wound care and continue pain controlled. No new recommendation for today. We are stay waiting on placement.	2443-2445
11/14/2014	Pincus Samuel, M.D.	**Hospitalist progress note:** Patient admitted to trouble sleeping last night due to the pain in the sacrum area. **Vital signs:** Temperature max 98.4, BP 128/67, Pulse 68, Temperature 97.5, RR 20, O2 saturation 92%. Vac in sacrum region. Insomnia. As needed medication for sleeping and pain control. Continue	2440-2442

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		wound care and continue pain controlled. Get CMP and CBC. No new recommendation for today. We are stay waiting on placement.	
11/15/2014	Kristen Crosby, M.D.	**Hospitalist progress note:** Doing well overall but pain poorly controlled currently. **Vital signs:** Temperature max 98, BP 118/77, Pulse 65, RR 15, saturation 95%. Glucose have been good. Will discontinue Insulin sliding scale and glucometer. Continue with wound care, wound vac. Appointment at Wake Forest 11/20/2014. Pain is not controlled by oral Dilaudid; will add back IV Dilaudid as needed breakthrough pain. Patient states she has been on Norco 10/325 x 20 years for back pain so she has a high tolerance for narcotics. As needed Melatonin. Await appointment on Thursday, SNF placement sooner if able.	2437-2439
11/15/2014		**Labs:** **Low:** Total protein (6.1), Albumin (3.1), RBC (3.79), Hemoglobin (10.9), Hematocrit (32.8)	2385, 2388
11/16/2014	Kristen Crosby, M.D.	**Hospitalist progress note:** Reports pain is still severe and Dilaudid helps but pain still significant. Feels anxious about transfer on Thursday. **Vital signs:** Temperature max 98.3, BP 119/61, Pulse 76, Temperature 97.7, RR 20, O2 saturation 92%. Plan at this time is for patient stay here until she can be transferred to Wake Forest for surgical intervention, chronic narcotic use so tolerates high doses of narcotics without sedation or other side effects.	2434-2436
11/17/2014	Barry White, M.D.	**Hospitalist progress note:** Having sacral pain at times. Mild nausea. No new complaints. **Vital signs:** Temperature max 98.3, BP 142/79, Pulse 66, Temperature 97.5, RR 20, O2 saturation 97%. Plan is to go to Wake Forest Thursday; will contact provider before transfer/visit. Pain control. Sugars well controlled so stopped checks. Stable mood.	2431-2433
11/18/2014	Barry White, M.D.	**Hospitalist progress note:** Some sacral pain and getting IV narcotics a lot. Minimal nausea. Some feeling that she is hoarse. No shortness of breath. **Vital signs:** Temperature max 97.6, BP 112/58, Pulse 91, RR 18, saturation 97%. Plan is to go to Wake in 2 days; long talk 11/18/2014 about her pain and need to move to oral medications. She as titrated himself down from long acting medications for back pain in past. I told her my concern about tolerance balanced with pain control. Discussed with pharmacy and 12 mg Dilaudid is equigesic to Oxycontin 80 twice daily. Will use half of that but she will be on	2427-2430

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		narcotics for some time with wound. Stable mood.	
11/19/2014	Barry White, M.D.	**Hospitalist progress note:** Pain not that bad. Nausea improved. No shortness of breath. No cough. Able to ambulate a bit. **Vital signs:** Temperature max 98.5, BP 116/68, Pulse 63, Temperature 98.5, RR 16, O2 saturation 94%. Now on oral pain medications that she is doing okay with. Setting up for transport to Wake Forest. I called the office and her first OR date is 12/05/2014. Having to use IV medications as needed enroute.	2423-2426
11/20/2014	Sleepy Hollow Medical Center Anthony Simms, M.D.	**Plastic Surgery office visit for sacral stage 4 ulcer:** Large sacral pressure sore grade 4 sacral with 10 x 10 cm opening and 10 cm of undermining to right; 5 cm deep. Stopped nicotine patches 2 weeks ago. VAC in place; wound has been debrided well. **Plan:** Continue wound management with VAC and wound care debridement as currently being done. Vac may close wound to a smaller size to make flap easier. Must be off nicotine for 8 weeks to be a good flap candidate. This flap is already compromised by undermining. Discontinuation of nicotine is very important in this case for maximum flap survival.	4437-4462
11/21/2014	 Case Manager Signature image	**Multidisciplinary care conference note:** Patient evaluated by Plastic/Reconstructive Surgeon at Sleepy Hollow Hospital yesterday and will need 4-6 more weeks before re-evaluation. Patient wants to go home at this time. Rehab reevaluated patient today and she is walking 150 feet independently with and without walker and recommends patient to have homecare but safe to go home. Will need hospital bed with air mattress and evaluation for other equipment. Also cushion for seating. Care coordination will begin referrals for DME. Lisa Bragg will begin process and prior approval for Medicaid for wound VAC. Home care will be able to provide HH Nurse, physical therapist, aide and social work. Plan is to have a therapy in home daily if possible. Goal is to have patient home prior to thanksgiving if possible.	2398
11/21/2014	Barry White, M.D.	**Hospitalist progress note:** She is still having pain. She says she can walk. Intermittent nausea. No shortness of breath. **Vital signs:** Temperature max 99.1, BP 127/74, Pulse 71, Temperature 97.8, RR 17, O2 saturation 95%. Seen at Wake Forest 11/20/2014 and Plastic Surgeon recommended wound vac and follow-up in 6 weeks. Work on getting her home or to rehab. Stable.	2420-2422
11/22/2014	Samuel Pincus, M.D.	**Hospitalist progress note:** Patient admitted that her pain is not controlled. **Vital signs:** Temperature max 98.1, BP 110/77, Pulse 68, Temperature 97.9, RR 17, O2 saturation 95%. Adjust her pain medications. Stop IV Ativan. Increased duration of Xanax. Continue other treatment.	2416-2419

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
11/23/2014	Samuel Pincus, M.D.	**Hospitalist progress note:** She admitted having trouble sleeping at night. She denies any other acute medical symptom at this time. **Vital signs:** Temperature max 98.9, BP 109/56, Pulse 60, temperature 97.6, RR 16, O2 saturation 95%. Wound vac located on sacral area. Add Benadryl for insomnia. Continue current treatment. Waiting for placement at this time.	2413-2415
11/24/2014	Samuel Pincus, M.D.	**Hospitalist progress note:** Patient states a mild pain in the sacrum area. She denies any fevers or chills. **Vital signs:** Temperature max 99.1, BP 109/54, Pulse 73, Temperature 98.5, RR 18, O2 saturation 95%. Wound vac present in this sacrum area. No new recommendations today. We are still waiting for placement and wait home healthcare.	2410-2412
11/25/2014	Samuel Pincus, M.D.	**Hospitalist progress note:** She still complains about pain in the sacrum area. **Vital signs:** Temperature max 98.1, BP 113/66, Pulse 65, RR 18, saturation 95%. Get CBC and consider putting her back on Plavix.	2407-2409
11/25/2014		**Labs:** **High:** WBC (10.9) **Low:** RBC (4.14), Hemoglobin (11.6), Hematocrit (35)	2388
11/26/2014	Samuel Pincus, M.D.	**Hospitalist progress note:** Denies any acute problems at this time. **Vital signs:** Temperature max 98, BP 120/62, Pulse 62, Temperature 97.4, RR 18, O2 saturation 95%. Still waiting on placement.	2404-2406
11/26/2014	Samuel Pincus, M.D.	**Discharge summary:** **Discharge diagnoses:** Acute decubitus sacral ulcer bleed. Coronary artery disease, status post stent. Anxiety disorder. Acute blood loss secondary to sacrum wound bleeding. **Brief hospital course:** The patient was admitted. She was taken for surgical intervention by Dr. Mina, who was able to control the extensive nature of the bleeding. The patient did receive some blood transfusion while she was in the hospital. Within 7 to 8 days of admission her symptoms were relatively controlled. Due to the extensive degree of wound to the sacrum area, vacuum therapy was restarted.	2019-2020

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Surgery believed that the patient may need plastic. She was referred to a Wake Forest plastic surgeon on November 20, 2014, and felt that the patient needed to be off nicotine for at least 6 months before they could do any intervention. The patient was brought back and has been in the hospital simply due to logistics reason. She has been relatively stable. Pain is relatively now controlled with pain medication. Had anxiety, which was treated with Xanax. **Discharge instructions:** The patient will be discharged home with home health care. She will be discharged with physical therapy, occupation therapy, social worker, nursing and aides. The patient will see Wake Forest plastic surgeon as required. The patient is advised the importance of not using any nicotine based product due to the fact that she has to undergo plastic surgery after being free of nicotine. ***Reviewer's comment: The nursing daily assessment flow sheets are not available for this hospitalization to assess the Braden scale, positioning assessment and wound assessment.***	
		Multiple ER visits for abdominal pain, decubitus ulcer and Plastic Surgery office visit	
12/05/2014	Statewide Regional Medical Center Marvin Williams, M.D.	**ER visit for abdominal pain:** Patient infiltrates have improved, but not resolved completely. Discussed patient with hospitalist, and patient does not meet any criteria for inpatient admission. Will check influenza swab, but patient will likely be discharged to home. She states that she has not been on outpatient antibiotics since previous discharge. Will restart antibiotics. **Disposition:** Discharged home in stable condition. A medical screening exam was performed: the patient should continue through the ED for further evaluation. **Clinical impression:** Abdominal pain of unknown cause. Bacterial pneumonia. Vital signs recorded and reviewed, empiric antibiotics (Levaquin 500 mg every 24 hours for 10 days) given. Sacral decubitus.	1980-1993
12/06/2014	Statewide Regional Medical Center	**Wound culture:** **Site:** Buttock wound. **Collected date:** 12/04/2014. **Direct exam:** White blood cells seen in smear. Light amount of gram positive cocci seen on smear. Acceptable specimen, culture results to follow. **Culture exam:** Moderate growth MRSA. **Susceptibility:** Resistant to Ciprofloxacin, Clindamycin, Erythromycin, Levofloxacin, Oxacillin, Penicillin. Sensitive to Daptomycin, Linezolid, Rifampin, Tetracycline, Trimethoprim/Sulfamethoxazole and Vancomycin.	2010
12/18/2014	Statewide Regional Medical Center Marvin Williams, M.D.	**ER visit for decubitus ulcer:** This started weeks; patient states that her home health nurse was there today, and reported that her sacral decubitus appeared to be getting infected. Patient states that she has been taking antibiotics, but she does not know name of antibiotic she has been taking. She states that her local MD was called, and stated to send patient to ER. She states that her O2 level has been going up and	1956-1966

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		down. She is prescribed home O2, but reports that she has been out of this for a couple of days, and that it has not yet been reviewed and is still present. At its maximum, severity described as moderate. When seen in the ED, severity described as moderate. Patient has sacral decubitus. Currently dressing and wound vac are in place. Patient with low O2 saturation on room air. She uses home O2, and saturation is normal on O2. She has been out of her O2 for 2-3 days. Will try to contact O2 supply company and arrange for patient to continue O2 at home. Patient has been taking Bactrim for sacral decubitus. Will change patient to Doxycycline pending culture result. Patient WBC is normal, and patient is afebrile. Will discharge to home and patient to continue wound care with home health. **Impression:** Single pressure ulcer: Sacrum right buttock. Stage 4.	
01/02/2015	Statewide Regional Medical Center	**ER visit for depression:** **Impression:** Depression and suicidal ideation. Course improved in ED. Transferred to Psychiatric facility.	1914-1934
01/02/2015		**Wound assessment:** Removed wound vac dressing and cleaned wound bed with Anasept wound cleanser. Wound bed is pink and moist, granulation tissue present throughout wound bed. Wound measurement are 5.3 x 6 x 1.5 cm. undermining present at 9 o'clock to 3 o'clock with deepest measurement 3.5 at 9 o'clock. Placed black granufoam with Mepitel into site and covered with KCI drape. Resumed negative pressure at 125 mmHg continuous suction. Leak verified.	1947
01/08/2015	Baptist Medical Center Anthony Simms, M.D.	**Plastic Surgery office visit:** 6 x 6 cm sacral stage 4 ulcer. Odor with vac. Discontinue vac, Dakin's three times daily, scheduled for OR debridement.	4463-4486
		Sleepy Hollow Medical Center	
01/15/2015	Peter Tork, M.D.	**Admission for incision and debridement of wound:** Presents for surgery tomorrow. She will be admitted as inpatient for IV Ancef due to concern of osteomyelitis. *History reviewed.* **Physical examination:** Vital signs: Temperature 97.4, BP 114/58, Pulse 58, RR 20, SpO2 91%, Weight 136.079 kg. **Skin:** A stage 4 on sacral area, measuring about 5 x 5 x 5 cm. with Dakin dressing. **Assessment:** Presents for I & D tomorrow with Dr. Simms. **Plan:** Morphine orally and Dilaudid IV for pain management. HS diet and mIVF. Follow-up CMP, CBC and PT/PTT. Ancef IV. Nil per oral after midnight for surgery. Admit to the floor, Dr. Simms attending.	4492-4496
01/16/2015	Anthony Simms, M.D.	**Excision of sacral ulcer and biopsy operative report:** **Pre and postoperative diagnosis:** Sacral ulcer, stage IV.	4498-4499

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
	Michael Nesmith, M.D.	**Procedures:** Excision of sacral pressure ulcer dimensions 7 x 6.5 x 4 cm with 4 cm of undermining from 9 o'clock to 12 o'clock in preparation for flap closure Intraoperative soft tissue biopsy for culture, Gram stain, and sensitivity of sacrum. **Specimens:** Sacral soft tissue biopsy for culture **Indications for procedure:** Patient is a 53-year-old male with a sacral ulcer. She is brought to the Operating Room today for surgical excision and in preparation for flap closure. **Operative findings:** No exposed bone but the wound extended into muscle. **Description of procedure:** The patient was identified and brought to operating room two by Anesthesia Service, laid prone on the operating table after placing under general tracheal anesthetic. She was then prepped and draped in sterile fashion. Time out was performed for patient safety, appropriate antibiotics were given. A #10 blade was used to sharply incise the skin around the ulcer and dissection was carried down to subcutaneous tissue with Bovie Electrocautery. The complete contents of the ulcer cavity were excised with Bovie electrocautery. Care was taken to ensure hemostasis as bleeding vessels were encountered. Following excision of the cavity the soft tissue of the sacrum was debrided with rongeur and then a specimen was taken and sent for culture, Gram stain and sensitivities. Following complete excision, the wound was thoroughly irrigated Bacitracin containing saline and the wound was made hemostatic with electrocautery and the wound was excised down to bleeding healthy tissue in all directions. The wound was then thoroughly packed after ensuring hemostasis. The wound was packed with epinephrine saline gauze and this concluded the procedure. The patient tolerated the procedure very well with no immediate complications. **Disposition:** The patient was extubated and taken to the PACU in stable condition. She will be admitted for inpatient care including wound care and awaiting cultures while we anticipate coverage of the ulcer. She will be on positive pressure reduction at all times.	
01/16/2015	Graham Nash, R.D.	**Nutrition assessment:** **Assessment:** Status post I & D for stage IV sacral ulcer. Endorses significant weight loss during prior hospital stay. It just advanced, patient yet to eat. Reports normally good appetite. Endorses some nausea and diarrhea, now resolved. Denies difficulty chewing/swallowing. **Recommendations:** Added high protein Ice Cream twice daily and Ensure muscle health once daily. RD discussed protein food sources and encouraged good protein intake with all meals/snacks. Suggest daily MVI for wound healing.	4510-4512

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Nutritional diagnosis: Increased protein need related to healing, as evidenced by stage IV sacral pressure ulcer 7 x 6.5 x 4 cm with undermining. The status of this diagnosis is new.	
01/17/2015	Peter Tork, M.D.	**Surgery progress note:** Pain well controlled. On Cefazolin. **Vital signs:** Temperature 96.4-98.8; Pulse 51-162, RR 11-23, BP 109-160/54-89, SpO2 96%. Pain score 8. Wound: On sacral area is clean, dry and intact. Packed with Dakin dressing. **Assessment and plan:** She is recovering well on the floor and getting ready to get her flap closure in few days. Continue current pain medications. Dilaudid 1 mg IV every 6 hours and MSIR 30 mg orally every 4 hours as needed. Hemodynamically stable. Continue routine VS. Encourage deep breathing, ambulation and the use of IS. On house select diet. Phenergan and Zofran as needed for nausea. On Cefazolin. Afebrile with no current infectious concerns. NS at 50 ml/hour. Well hydrated. Monitor BS. Adequate UOP. Dakin's dressing changed three times daily. Stable on the floor. Planned for a flap covering of the ulcer in few days.	4640-4642
01/18/2015	Peter Tork, M.D.	**Surgery progress note:** Patient complaining of pain at the surgery site today. Her pain is increased with movement. **Physical examination:** Temperature 96.8-98.5; Pulse 52-54; RR 15-20; BP 98-109/54-56; SpO2 94-97%. Sacral area dry, clean and intact, packed with Dakin dressing. **Assessment and plan:** Remains unchanged from previous day progress note. Kin Air bed requested for the room. Will need SNF placement in a facility with a KinAir bed.	4637-4640
01/19/2015	Stephen Stills, R.D.	**Nutrition notes:** Patient reports that her appetite is good. Encouraged good oral intake of meals and supplements. **Recommendations:** Encouraged good oral intake of protein rich foods and supplements. Consider supplementing with Vitamin C and inc sulfate. **Nutrition risk:** High.	4508-4510
01/19/2015	Peter Tork, M.D.	**Surgery progress note:** She states she feels more comfortable in the KinAir bed. **Vital signs:** Temperature 96-98; Pulse 53-68; RR 14-18; BP 100-134/59-64; SpO2 94-98%. On Dakin's three times daily. Will need SNF placement in a facility with a KinAir bed.	4634-4637
01/20/2015	Peter Tork, M.D.	**Surgery progress note:** Temperature 96.9-97.6; Pulse 51-59; RR 17-18; BP 114-129/56-63; SpO2 94-98%. Surgery scheduled on 01/23/2014. On Cefazolin. On **Dakins** three times	4631-4634

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		daily. Per dietary recommendations started Zinc and Vitamin C today.	
01/21/2015	Joni Mitchell, M.D.	**Surgery progress note:** Patient reports improved pain control with change in pain medications. Temperature 96.5-97.5; Pulse 51-61; RR 16-20; SpO2 96-98%. Home **MSIR** with oral Oxy and IV Dilaudid for breakthrough pain. On Cefazolin. **Dakins** dressing three times daily.	4627-4629
01/22/2015	Allison Krauss, M.D.	**Surgery progress notes:** States ready for surgery tomorrow. Temperature 96-98.7; Pulse 54-62; RR 16-20; BP 98-103/51-57; SpO2 94-95%. Sacral wound packed with moistened gauze. Continue pain medications. Restart psych medications. On Cefazolin. **Dakin's** dressing three times daily.	4620-4623
01/23/2015	Anthony Simms, M.D.	**Flap for closure of sacral ulcer operative report:** **Pre and post operative diagnosis:** Sacral ulcer. **Procedure:** Bilateral **fasciocutaneous flaps** for closure of sacral ulcer, **Description of procedure:** The patient was brought in the room, anesthesia was induced. The patient was then placed in a prone position. The skin edge was excised with a scalpel as well as some of the remaining scar tissue. The flaps were designed by extending incision and at the midline of her back as a rotation flaps. The incision was brought down with dissection with cautery down to the fascial layer. At that point, the flaps were raised laterally. The lateral aspect of the pressure ulcer was also elevated including fascia and a back cut was made at the superior aspect of the incisions on each side to rotate the two flaps down, Also, it was extended at the midline and raised for rotation of the inferior skin. At that point, once it was adequately raised released, and hemostasis was achieved and was irrigated with copious amount of antibiotic solution. At that point, the flap was inset with 0 PDS, tacking it together as well as into the deep soft tissue to keep it down in place and eliminate dead space as well as tension. A deep layer of 0 PDS was used sewing the flaps together down to the deep tissue of the midline along the entire length. At that point, deep 0 PDS was placed in the Scarpa's layer. At that point, once the deep layers were closed including the back, 2-0 nylon vertical mattress sutures were placed in the entirety of the skin. Dermabond was then placed over the entirety of the wound. The patient tolerated the procedure well without apparent complications. Blood loss 100 ml. Two drains were placed coming out laterally on each side. The patient tolerated the procedure well without apparent complications,	4497
01/24/2015	Adam Mucci, M.D.	**Surgery progress note:** Doing well. Temperature 96.9-98.7; Pulse 58-89; RR 15-18; BP 100-126/53-81; SpO2 93-100%. Drains with serosanguineous drainage. Continue Cefazolin, dry dressing as needed. Stable on the floor. Working on placement after surgery.	4613-4616
01/25/2015	Adam Mucci, M.D.	**Surgery progress note:** Doing well. Temperature 96.9-98.9; Pulse 59-75; RR 16-20; BP 113-118/53-	4610-4613

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		58; SpO2 92-95%. Assessment and plan remains unchanged from previous day progress note.	
01/26/2015	Peter Tork, M.D.	**Surgery progress note:** Doing well. Temperature 96.8-98.5; Pulse 59-73; RR 14-20; BP 110-126/54-71; SpO2 92-96%. Drains with serosang drainage. Output 120 ml. on low residue diet. Dry dressing as needed. On Cefazolin.	4607-4610
01/27/2015	Peter Tork, M.D.	**Surgery progress note:** Doing well with better pain control. Temperature 96.9-97.8; Pulse 65-74; RR 16-19; BP 113-126/56-59; SpO2 94-97%. Drains with serosang drainage. Output 165 ml. on pain medications. On Cefazolin. Dry dressing as needed.	4603-4606
01/28/2015	Peter Tork, M.D.	**Surgery progress note:** Pain well controlled. Temperature 96.8-97; Pulse 67-68; RR 17-18; BP 105-127/54-60; SpO2 96-99%. Drains with serosang drainage. Output 90 ml. stable on floor. Patient now wanted to go home instead of SNF. Will set up to go home with a KinAir bed. On Cefazolin and dry dressing change as needed.	4600-4603
01/29/2015	Peter Tork, M.D.	**Surgery progress note:** Pain well controlled. Had some trouble having a BM and tried two different enemas then Sorbitol which then helped her to move her bowels. Temperature 97.2-99.7; Pulse 60-85; RR 16-20; BP 104-123/56-61; SpO2 94-97%. Drain output 200 ml. on Cefazolin, dry dressing as needed. Stable on floor. Will be discharged home next week on Friday if clinically stable.	4597-4599
01/30/2015	Joni Mitchell, M.D.	**Surgery progress note:** No complaints. Having bowel movements but reports some straining. Temperature 96.3-97.2; Pulse 67-74; RR 15-20; BP 110-130/59-69; SpO2 94-98%. Wound with small amount of fibrinous exudate, drains with serosang drainage. On Cefazolin, dry dressing as needed.	4594-4596
01/31/2015	Peter Tork, M.D.	**Surgery progress note:** Still feels constipated. Temperature 96.2-97.9; Pulse 61-71; RR 18-20; BP 119-125/57-77; SpO2 94-98%. Will try milk of molasses to help with having a bowel movement. On Cefazolin, dry dressing as needed. Dial soap 3-4 times daily on the wound.	4591-4593
02/01/2015	Adam Mucci, M.D.	**Surgery progress note:** Still feels constipated – some relief but does not feel completely empty. Temperature 96.2-97.2; Pulse 61-65; RR 18-20; BP 118-135/65-71; SpO2 96-98%. Small **dehiscence inferiorly** to the wound. Will try milk of molasses enema again to help with having a bowel movement. On Cefazolin. Skin wound with NS wet to moist started inferiorly. Dial soap 3-4 times daily on the wound.	4588-4590
02/02/2015	Peter Tork, M.D.	**Surgery progress note:** Still feels constipated but had 2 bowel movements yesterday. Temperature 97.1-97.9; Pulse 67-106; RR 19-22; BP 106-121/49-78; SpO2 95-97%. Small dehiscence inferiorly to wound. Assessment and plan remains unchanged from previous day progress note.	4585-4588
02/03/2015	Peter Tork, M.D.	**Surgery progress note:** No complaints this morning. Temperature 96.3-96.9; Pulse 68-71; RR 18; BP 118-128/59-84; SpO2 94-96%. Small dehiscence inferiorly to wound that is packed. Assessment and plan remains unchanged from previous day progress note.	4583-4585
02/04/2015	Peter Tork, M.D.	**Surgery progress note:**	4580-4582

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		No complaints. Temperature 96.5-97.1; Pulse 71-79; RR 16-17; BP 120-142/61-77; SpO2 94-99%. Small dehiscence inferiorly that is packed. On Cefazolin, started Cipro for UTI. NS wet to moist started inferiorly. Dial soap 3-4 times daily on the wound.	
02/05/2015	Peter Tork, M.D.	**Surgery progress note:** Patient is complaining of subjective fever and night sweats. Temperature 96.9-97.8; Pulse 72; RR 17-18; BP 110-118/55-67; SpO2 94-96%. Small dehiscence inferiorly that is packed. On Bactrim, afebrile. CBC and CMP ordered. NS wet to moist started inferiorly. Dial soap 3-4 times daily on the wound.	4577-4580
02/07/2015	Peter Tork, M.D.	**Surgery progress note:** Temperature 95.4-98.2; Pulse 69-72; RR 16-20; BP 93-126/66-73; SpO2 95-97%. Small dehiscence inferiorly that is packed. Home MSIR with oral Oxy for breakthrough pain. On **Cipro** and **Keflex**.Afebrile. NS wet to moist started inferiorly. Dial soap 3-4 times daily on the wound.	4573-4577
02/08/2015	Peter Tork, M.D.	**Surgery progress note:** Temperature 97.1-98.2; Pulse 66-78; RR 16-18; BP 110-116/68-72; SpO2 94-98%. Small dehiscence inferiorly that is packed. On probiotics. Other assessment and plan remains unchanged from previous day progress note.	4564-4567
02/09/2015	Peter Tork, M.D.	**Surgery progress note:** Temperature 96.7-98.1; Pulse 68-99; RR 16-18; BP 119-142/64-71; SpO2 95%. Small dehiscence inferiorly that is packed. Assessment and plan remains unchanged from previous day progress note.	4553-4556
02/10/2015	Jonathan Edwards, M.D.	**Surgery progress note:** Patient with complaints of uncontrolled pain this morning, afebrile. Temperature 96-98; Pulse 77-82; RR 16-18; BP 117-128/63-71; SpO2 90-96%. Last day of Cipro. On Keflex and probiotics. NS wet to moist started inferiorly. Dial soap 3-4 times daily on the wound.	4551-4553
02/11/2015	Jonathan Edwards, M.D.	**Surgery progress note:** Afebrile, hemodynamically stable. Good urine output. Temperature 96.9-98.2; Pulse 69-82; RR 16; BP 127-135/61-75; SpO2 95-97%. Assessment and plan remains unchanged from previous day progress note.	4548-4551
02/12/2015	Jonathan Edwards, M.D.	**Surgery progress note:** Patient complaining of sore throat. Temperature 97.1-97.8; Pulse 81-88; RR 16; BP 126-138/73-83; SpO2 93-94%. Assessment and plan remains unchanged from previous day progress note. Will need chloraseptic spray for sore throat.	4544-4546
02/13/2015	Jonathan Edwards, M.D.	**Surgery progress note:** Concerned for discharge problems. Temperature 97.2-98; Pulse 70-85; RR 16-17; BP 114-139/55-74; SpO2 94-97%. Previously started on Cipro for suspected UTI, however subsequent culture was negative, therefore no UTI diagnosed during this admission. On Keflex and probiotics. Aquacel Ag to open part of wound inferiorly. Dial sop 3-4 times daily on the wound.	4538-4540
02/14/2015	Adam Mucci, M.D.	**Surgery progress note:** Temperature 96.3-97.8; Pulse 72-80; RR 16; BP 98-134/53-75; SpO2 92-97%. Small dehiscence inferiorly that is packed with Aquacel Ag. Assessment and plan remains unchanged from previous day progress note.	4535-4537
02/15/2015	Adam Mucci, M.D.	**Surgery progress note:** Temperature 96.8-98.7; Pulse 77-91; RR 16-19; BP 119-145/62-75; SpO2 93-	4532-4535

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		97%. Assessment and plan remains unchanged from previous day progress note.	
02/16/2015	Jonathan Edwards, M.D.	**Surgery progress note:** Temperature 96.9-98.3; Pulse 74-84; RR 14-18; SpO2 91-98%. Assessment and plan remains unchanged from previous day progress note.	4530-4532
02/17/2015	Jonathan Edwards, M.D.	**Surgery progress note:** Sutures removed at bedside today, patient tolerated well. Temperature 96.8-97.3; Pulse 86-89; RR 17; BP 114-150/61-74; SpO2 93-94%. Assessment and plan remains unchanged from previous day progress note.	4527-4529
02/18/2015	Jonathan Edwards, M.D.	**Surgery progress note:** Discussed with patient possibility of home disposition and she was amenable. No other complaints. Temperature 97.2-97.6; Pulse 79-89; RR 16-18; BP 122-131/67-68; SpO2 93-95%. Assessment and plan remains unchanged from previous day progress note.	4524-4527
02/19/2015	Baptist Medical Center Jonathan Edwards, M.D.	**Discharge summary:** She was admitted to our service several days before debridement of sacral ulcer due to concern for infection surrounding the ulcer. During that time, she did well and had no problems or complications. On 01/16/2015, she underwent excision of her sacral pressure ulcer. She tolerated the procedure well with no complications. For a week following surgery, she underwent Dakin's dressing changes to the wound until 01/23/2015 when she underwent bilateral fasciocutaneous flaps for definitive closure of her sacral pressure ulcer. She tolerated this procedure well with no complications. Following this, she was admitted to our service for pressure offloading and wound monitoring. She was on a KinAir bed and did very well during this hospitalization. About a week following her fasciocutaneous closure, it was noted that a very small part of her sacral wound had reopened at the inferior aspect. This was begun on wet-to-dry dressings three times a day and was eventually transitioned to Aquacel AG one time a day. Over the course of this hospitalization, she did very well and had no significant complications. She did, however, have a prolonged hospital stay due to an inability to find her appropriate disposition, given her wound care needs. Eventually, her pain with dressing changes subsided, and she was able to teach himself how to perform her once a day dressing changes and was able to go home. On the date of discharge, she was afebrile, ambulating, taking solids and liquids p.o., voiding, and having bowel movements without difficulty. She was aware of all pressure offloading needs and did have a pressure offloading mattress at home. At that point, she was discharged to home without any further needs. She was discharged to home with by mouth pain medication and stool softener. She will follow up with our team in two weeks following discharge. **Wound:** Posterior sacral wound clean, dry, and intact. An approximately 1 inch long area of wound still open at the inferior aspect. Packed with Aquacel AG, clean, and dry with no evidence of tracking or undermining. No surrounding erythema, induration, or purulence from the wound.	4488-4491
		Statewide Regional Medical Center	
02/20/2015		**ER visit for tender area:**	1675-1678

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
	Rene Russo, M.D.	This started 6 months ago and is still present. It was gradual in onset and has been constant. It is described as painful. It has been located on the buttocks. Cause has been identified (pressure ulcer). (Patient had recent surgical debridement of wound, was sent home with home health to assist with wound care. Patient's wound care nurse today advised her to come to ER, with note from her stating that wound is too deep and complicated and too high risk for her to manage in home health setting, with no other caregiver for patient). **Skin:** Rash present on the trunk (superior gluteal cleft, deep full thickness wound with granulation tissue). The rash is erythematous. No warmth or swelling. There is tenderness. **Course of care:** Care transferred at shift change with labs pending and plan for surgical consultation. **Disposition:** Admitted to the Medical/Surgical unit. Condition stable. **Clinical impression:** Single pressure ulcer: Sacrum, stage unstageable.	
02/20/2015	Robert Planck, M.D.	**Admission for wound care:** Per outpatient wound care is postoperative wound drainage and possible wound infection. The patient states that she has had a malodorous yellow discharge from the wound since her discharge from Wake Forest the day before yesterday. She has also had some chills, although no specific report of fever. Her white count is elevated in the Emergency Department. **Admitting diagnoses:** 1. Possible sacral decubitus ulcer infection. 2. Sacral decubitus ulcer. 3. Leukocytosis. 4. Sacral decubitus ulcer pain 5. Coronary artery disease with a history of coronary artery stenting, on aspirin and Plavix. 6. History of plastic surgery intervention of the decubitus ulcer. Reportedly this occurred 1-1/2 weeks ago. The patient was discharged from Wake Forest just a couple of days ago. 7. Anxiety disorder. 8. Peripheral neuropathy. 9. Chronic low back pain, 10. Diabetes mellitus type 2, reportedly non-insulin dependent, 11. History of tobacco abuse. Reportedly, she quit smoking several months ago. 12. Obesity. 13. Bi-polar disorder. 14. Chronic obstructive pulmonary disease. 15. Appendectomy. 16. History of carpal tunnel release.	1686-1689

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		17. History of rotator cuff surgery. *History reviewed.* She was actually discharged from the hospital just the day before yesterday. She reports she has been having chills and she reports a malodorous yellow secretion discharge from the ulcer area. She was discharged with home health but after evaluation by the home health wound care nurse, thought the patient needed more assertive and complex interventions, so she was brought over to the Emergency Department for further evaluation. I have discussed the case with the case manager in the Emergency Department. The patient does meet inpatient criteria for the possibility of a sacral decubitus ulcer infection in the postop setting, so we will request a procalcitonin level and we will go ahead and request a wound culture and also blood cultures. Will cover with Unasyn IV for the moment and I will request a consultation with wound care service in the hospital and also a consultation with general surgery. Apparently, the patient does not meet criteria per insurance to go back to a skilled nursing facility, but she could perhaps qualify for assisted living, so the plan will be after discharge from the hospital will be to discharge her to assisted living where she will follow up with outpatient wound care. Will go ahead and admit at present time, given that the patient will be admitted as an inpatient. I anticipate a greater than 2-day hospital stay at least over the weekend and will go ahead and request consultation with general surgery and wound care. The risks of not hospitalizing this patient as an inpatient at present time, given that she really has no help at home, involve worsening of the wound and even development of sepsis from wound infection. Will request wound care and surgical consultations for further recommendations. **Assessment and plan:** The patient is a 53-year-old male with the above acute-on-chronic medical conditions who comes to the Emergency Department referred by home health nurse to the Emergency Department due to postoperative wound drainage and suspicion of wound infection in the setting after plastic surgery due to a sacral decubitus ulcer. Will continue workup in the Emergency Department. Will request a wound culture. Will request a wound care consultation and also a surgical consultation. Will admit as an inpatient for the moment. The plan, per discussion with the case manager, will be perhaps to discharge to an assisted living facility with outpatient wound care. Will continue to monitor closely.	
02/21/2015	Angela Kennedy, M.D.	**General Surgery progress note:** Admitted with possible decub wound infection. Temperature 97.8, Pulse 93, RR 16, BP 116/89. **Assessment and plan:** Patient with sacral decubitus status post flap rearrangement. Wound dressing with Aquacel, 4 x 4 s, Mepilex every day and as needed. Wound care culture and sensitivity. May benefit from wound vac at this point. Follow-up wound culture and taper antibiotics.	1695
02/21/2015	Daniel J. Glover, M.D.	**Hospitalist progress note:** Drainage from her wound. Patient requests IV narcotics. Patient with fatigue, ambulating, abdominal pain and tolerating diet.	1716-1719

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Vital signs: Temperature max 97.8, BP 82/50, Pulse 86, RR 16, Temperature 97.7. Patient has a small area of drainage. Area cultured. Continued antibiotics.	
02/22/2015	Daniel J. Glover, M.D.	**Hospitalist progress note:** Drainage from sacral wound. With fatigue, ambulating and tolerating diet. Vital signs: Temperature max 98.1, BP 91/50, Pulse 98, RR 16, O2 sat 92%. On IV Unasyn. Continue antibiotics and taper according to the wound culture growth.	1712-1715
02/23/2015	Angela Kennedy, M.D.	**General Surgery progress note:** OOB ambulating with PT earlier. Afebrile, pulse 74-91, BP 106-120/55-62. Sacrum incision healed except at midportion. **Micro: Wound NGTD**. Wound care to make recommendations. Follow-up cultures and taper accordingly. Follow-up at Wake outpatient.	1694
02/23/2015	Barry White, M.D.	**Hospitalist progress note:** She says her pain is inadequately controlled. She is able to ambulate. No new complaints. She desires to go home rather than rehabilitation. Temperature max 98, BP 107/59, Pulse 76, RR 16, Temperature 97.9, O2 saturation 98%. Dressed sacral wound. No erythema beyond edges. Discussed with wound care. Awaiting decision about if she needs a wound vac. She wants to go home with home health rather than to rehabilitation. Able to ambulate in the hall. Continue same therapy today. Increased pain medications a bit.	1708-1711
02/23/2015	Lisa Bragg, R.N.	**Wound assessment:** **Location of wound #1:** Coccyx. **Type of wound:** Surgical wound. **Wound size:** 2.3 x 1 x 2.7 cm. **Tunneling:** @ 1130 o'clock measures 3.4 cm. **Drainage:** Moderate. Serosanguineous. **Periwound skin:** Intact. **Treatment:** Cleanse with normal saline. Periwound with skin prep. Fill with Aquacel Ag, cover with Mepilex border 6x6. **Location of wound #2:** Left hip. **Type of wound:** Surgical wound. **Wound size:** 1 x 0.6 x 0.3 cm. **Drainage:** Scant, serous. **Periwound skin:** Intact. **Treatment:** Cleanse with normal saline. Periwound with skin prep. Fill with Aquacel Ag, cover with extra thin Duoderm. **Location of wound #3:** Right hip. **Type of wound:** Surgical wound. **Wound size:** 0.6 x 0.9 x 0.1 cm.	1789-1790

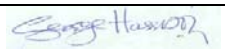
DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Drainage: Scant, serous. **Periwound skin:** Intact. **Treatment:** Cleanse with normal saline, periwound with skin prep. Fill with Aquacel AG, cover with extra thin Duoderm.	
02/24/2015	Barry White, M.D.	**Hospitalist progress note:** Ambulating, no fever. Temperature max 98.2, BP 98/53, Pulse 81, RR 20, O2 saturation 99%. Dressed sacral wound. Await wound cultures. Changed medications. Stopped SSI.	1704-1707
02/25/2015	Barry White, M.D.	**Hospitalist progress note:** Complaining of lot of pain. Next day she is getting some confusion confirm with nursing. She thinks she is holding her pain medications. She has had some nausea no emesis. She noted some drainage from her wound. Temperature max 98.8, BP 121/70, Pulse 83, RR 16, Temperature 97.9, O2 saturation 93%. Still waiting on her wound culture. Not comfortable sending her home without knowing that data as she make it worse. Confusion for medications. She does need continued pain control. She states it is not her pain medicines but her bipolar disorder. Am not excited about titrating up her pain medications with the confusion. Just try to use what she is getting. We will go with pain medicines she was receiving at outside hospital. Discussed with nursing. Stopped SSI. Good control at baseline.	1700-1703
02/26/2015	Barry White, M.D.	**Hospitalist progress note:** She still notes drainage. She states that she is no longer having thoughts of suicide. Apparently had told home health nursing or wound care that she was being suicidal. Notes it that was not serious and that she does not have those thoughts anymore. She is reluctant to go to an assisted living facility or nursing facility as she is afraid her check will be taken after some time and she cannot pay for her car, house, etc. Temperature max 97.9, BP 115/59, Pulse 87, RR 16, O2 saturation 93%. Dressing over sacral wound, no redness beyond the edges. Changed to **Cefuroxime**. She will be stable for discharge once we can ensure that she gets wound care. Confusion seems to resolve. We are giving her some medications. Not complaining of more back pain today. Diet controlled diabetes for now. Patient not safe for discharge as to have a disposition on her wound care. We will work that out tomorrow see how she does on oral therapy.	1696-1699
02/26/2015		**Wound culture:** **Source:** Coccyx. **Collected date:** 02/22/2015. **Final report:** E. coli. **Susceptibility:** Sensitive to Amikacin, Cefepime, Cefotaxime, Ceftazidime, Ceftriaxone, Cefuroxime, Gentamicin, Imipenem, Tobramycin. Resistant to Amoxicillin, Ampicillin, Ampicillin/Sulbactam, Cefazolin, Ciprofloxacin, Levofloxacin, Piperacillin, Piperacillin/Tazobactam, Tetracycline and Trimethoprim/Sulfamethoxazole.	1691-1692

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
02/27/2015	Barry White, M.D.	**Discharge summary:** **Discharge diagnoses:** Stage 4 sacral decubitus, Infected with E coli and Coag neg staph. Confusion; suspect from pain medications Patient had spent one month at Wake Forest for sacral decubitus ulcer therapy. Discharged 2 days prior to admission here. Home health nursing came out evaluated her weight at doctor was worse was sent to the ER. Wake Forrest would not take her back so it appears an inpatient. Here general surgery evaluated her and did not think she needed further debridement. Wound care is been following her. Placed on empiric antibiotics of with wound cultures pending. Consideration of a wound VAC done however decision made to avoid that for now as it looks that we will heal without it. She will complete oral antibiotics 7 days more.	1531-1534
		Statewide Regional Medical Center ***Hospitalization for small bowel obstruction***	
03/02/2015 - 03/06/2015	Statewide Regional Medical Center	**Hospitalization for small bowel obstruction versus ileus:** Admission date: 03/02/2015. Discharge date: 03/06/2015. **Discharge diagnoses:** Acute ileus versus partial small-bowel obstruction. These conditions have resolved. The patient is on a normal diet. Suicidal ideation with severe major depression. The patient is being admitted to the Behavioral Health Unit tonight. Bipolar depression. Anxiety disorder. Stage IV sacral decubitus, status post repair. The patient went to Sleepy Hollow Medical Center in Winston-Salem, North Carolina for repair and her decubitus has resolved. She has some surface wound drainage which had heavy growth of Escherichia coli but has been treated and she is undergoing basic wound care currently. **Procedures:** CT scan of the abdomen and pelvis without IV contrast on March 2, 2015, demonstrates bibasilar interstitial changes in the lower lung fields. There was surgical absence of the appendix. There were a few mildly dilated small bowel loops present in the left upper quadrant with otherwise normal bowel loops. This raised the possibility of earlier or partial small-bowel obstruction. There were 2 chronic adjacent supraumbilical fat areas containing midline ventral abdominal wall hernias measuring 5.2 cm and 2.2 cm. There is a decubitus ulcer with adjacent inflammatory changes seen posteriorly at the midline within the soft tissue superimposing at the level of the coccyx. No organizing fluid collections are seen. NG tube placement on admission. **Hospital course:** The patient was followed by surgery. It was thought that the NG tube had relieved any signs of any partial small-bowel obstruction and ileus. The patient still complained of abdominal pain, but improved. There was	1237-1239

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		no vomiting. She did not significantly complain of nausea. She more complained of the fact that she did not want to go home and she did not feel that she could live at home and live with himself with her current mood. The patient was gradually started on clear liquids and later advanced to solid foods. She had no nausea or vomiting. She still complained of abdominal pain, but that improved. The patient had had some chronic abdominal pain related to multiple subcutaneous Heparin injections, given the amount of time the patient has spent in the hospital. It is felt that her partial small-bowel obstruction had resolved. She was placed back on her home medications. The Behavioral Health Unit evaluated the patient and felt that she was a candidate for the Behavioral Health unit and the patient is being discharged there tonight with continued aggressive interventions for her significantly depressed mood. It is felt that the patient is a very good candidate for inpatient admission and the patient was agreeable to inpatient admission. **Discharge diet:** Regular diet. **Discharge activity:** As tolerated. **Discharge instructions:** The patient will transfer to the Behavioral Health unit tonight for the treatment of her mood as she requests.	
		Statewide Regional Medical Center ****Reviewer's comment: For this hospitalization only the significant records related to the wound assessment and patient's condition are elaborated. Other records have been reviewed and are not significant, therefore not included in chronology.***	
03/06/2015 - 03/09/2015	Statewide Regional Medical Center	**Hospitalization for depression:** Gabapentin decreased and Trileptal increased – On day of discharge continues to endorse suicidal ideation and states that if she went home she would commit suicide by overdose. Reports chronic pain issues even though she is being treated with pain medications. Transferred to the ICU.	1049-1054
03/09/2015	Jill Young, R.N.	**Wound assessment:** Location of wound #1: Sacral. Type of wound: Surgical wound. Wound size: 1.3 x 0.4 x 1.2 cm. Tunneling: 3 o'clock – 2.2, 6 o'clock 4 cm, 9 o'clock 3 cm. Drainage: Large, serosanguineous. Wound appearance: 100% red. Periwound skin: Intact. Treatment: Cleanse with antiseptic, periwound skin prep. Fill with Aquacel Ag, cover with Aquacel extra/secured with Duoderm extra thin, also placed abd pad in patient undergarment for added protection. Debridement non selective. With increased drainage over weekend.	1208-1209
03/13/2015	Lisa Bragg, R.N.	**Wound assessment:** Location of wound: Sacral. Type of wound: Surgical wound. Wound size: 1.1 x 0.9 x 2 cm. Tunneling: 12 o'clock measures 3.5 cm, at 11 o'clock measures 6.5 cm, and at	909-909

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		3 o'clock measures 3.5 cm. Drainage: Moderate, serous. Wound appearance: Pre debridement 50% pale pink, 50% slough; Post debridement 90% pale pink and 10% slough. Periwound skin: Intact. Treatment: Cleanse with antiseptic Anasept. Periwound with skin prep, Benzoin and extra thin Duoderm. Treatment: Topical Lidocaine 2% x1. Fill with white foam. Cover with black granufoam. Secure with KCl drape. Debridement nonselective. Mechanical debridement of nonviable non adherent yellow slough with wound cleansing. Wound vac therapy: At 125 mmHg continuous.	
03/16/2015	Lisa Bragg, R.N.	**Wound assessment:** Location of wound: Sacral. Type of wound: Surgical wound. Wound size: 1.5 x 1 x 2.1 cm. Tunneling: 12 o'clock measures 4.8 cm, t 6 o'clock measures 2.8 cm, at 9 o'clock measures 4.3 cm, and at 3 o'clock measures 3.1 cm. Drainage: Moderate, serous. Periwound skin: Intact. Treatment: Cleanse with antiseptic Anasept. Periwound with skin prep, Benzoin and extra thin Duoderm. Treatment: Topical Lidocaine 2% x1. Fill with white foam. Cover with black granufoam. Secure with KCl drape and Duoderm at 6 o'clock. Wound vac therapy: At 125 mmHg continuous. Discontinued Infovac and connected patient to freedom VAC.	971
03/09/2015 - 03/16/2015	Statewide Regional Medical Center	**ICU stay for wound drainage:** Patient transferred to a medical unit due to more drainage from her sacral wound then was able to be dealt with appropriately on the behavioral health unit: **Hospital course:** Decubitus ulcer of sacrum. The patient was treated by wound care. Wound VAC was placed. Once the wound VAC drainage was at an acceptable level. She was thought to be appropriate for return to the behavioral health unit. Diarrhea. Clostridium difficile testing was performed and was negative. The diarrhea resolved. Bipolar disorder. The patient was maintained on her usual medications as recommended by BHU. Chronic back pain. Pain management was somewhat of an issue. The patient did consistently rate her pain at 10/10 no matter the amount of pain medication that was being administered. We did try to decrease this to a level that would be manageable on the BHU prior to her transfer back up there. **Discharge disposition:** Behavioral health unit in stable condition.	620-621
03/23/2015	Lisa Bragg, R.N.	**Wound assessment:** **Location of wound#1:** Sacral. Type of wound: Surgical wound. Wound size: 1.2 x 1 x 2.9 cm. Difficult to fully visualize wound bed due to small opening.	450-451

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Tunneling: 12 o'clock measures 0.4 cm, at 6 o'clock measures 5.2 cm, at 9 o'clock measures 2.7 cm, and at 3 o'clock measures 3 cm, 11 o'clock measures 4 cm. Odor: Typical Vac odor. Drainage: Moderate, serous. Wound appearance: Pre debridement 100% pale pink. Periwound skin: Intact. Treatment: Cleanse with normal saline. Periwound with skin prep, Benzoin and extra thin Duoderm. Treatment: Topical Lidocaine 2% x1. Fill with white foam. Cover with black granufoam. Secure with KCI drape. Wound vac therapy: At 125 mmHg continuous. **Location of wound #2:** Right hip. Type of wound: Surgical wound. Wound size: 0.4 x 2 x 0.1 cm. Drainage: Minimal, serous. Wound appearance: Pre debridement 95% red and 5% slough. Post debridement 100% red. Periwound skin: Intact. Treatment: Cleanse with normal saline. Periwound skin prep. Fill with Aquacel Ag. Cover with extra thin Duoderm. Mechanical debridement of noninvasive tissue with wound cleansing.	
03/24/2015	Doris Smith, R.N.	**Nurse notes:** Called to social worker's office because patient's wound VAC was alarming. Patient states "I have a leak because I can feel it at the base of my spine. Site appeared sealed, but, I could not see between the gluteal fold. When patient went to her room she state "You don't have to call wound care because it sealed itself. Wound care was called to room again and there was a small area in the gluteal fold where the clear sheath had lifted. Duoderm placed in the gluteal fold to secure the air leak. Patient tolerated it well. Wound VAC setting was on 125 mmHg with a 6 intensity. Patient resting quietly in bed.	568
03/25/2015	Patricia Condon, R.N.	**Nurse notes:** Patient's wound VAC screen observed to be running properly at 125 mmHg continuous pressure.	568
04/02/2015	Lisa Bragg, R.N.	**Wound assessment:** Location of wound #1: Sacrum. Type of wound: Surgical wound. Wound size: 0.9 x 0.8 x 2 cm. Small wound opening difficult to place foam/alternate wound dressing today. Tunneling: At 9 o'clock measures 3 cm, at 3 o'clock measures 3.3 cm, at 12 o'clock measures 2.4 cm, at 11 o'clock measures 2.8 cm. Drainage: Large serous. Wound appearance: Pre debridement 100% pal pink. No debridement warranted today. Periwound skin: Intact. Treatment: Cleanse with normal saline, soap/cleanser, Seaclenz. Periwound with Benzoin. Fill with Aquacel Ag extra, cover with Aquacel Ag extra.	536

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Secure with Duoderm. Vac on hold. Patient may be transferring to a facility today. Treatment plan revised.	
04/02/2015	 Appears to be Lisa A. Bragg, R.N.	**Wound care treatment plan:** Discontinue previous wound care order. Cleanse with normal saline to irrigate wound and tunnels. Apply barrier up to edge of wound. Skin prep and Benzoin. Lightly fill with Aquacel Ag extra. Cover wound with Aquacel Ag extra. Secure dressing with Duoderm. Change dressing every other day and as needed excess soiling. Please send wound vac supplies with patient to facility. May need to have vac again in future.	372
04/02/2015	*Multiple Providers*	**Nurse notes:** Nursing Supervisor states wound care nurse will be in at 0800 hrs and she will leave note for her to see patient as soon as possible related to wound area leaking and foul smell. NS states have client stay in room and not to change dressing at this time because it will probably need to be cultured when wound nurse arrives. Wound VAC remains in place and on normal settings 125 mmHg. Patient came to Medical room door to ask for pain medications and stated, “my dressing is leaking. I can smell my wound and when I got up my bed was wet where it had leaked. Patient taken back to her room to observe her dressing. I could smell patient’s wound prior to reaching her doorway. I observed fresh serosanguinous drainage on her bed linens that had a foul odor. Patient’s wound VAC was still running at 125 continuous without alarming. Patient’s wound drape remains intact with scant drainage noted at superior aspect of perianal crack area. Patient has a towel in place to cover dressing for now. Patient states, “the wound care nurse is supposed to change the dressing this morning before I leave. I would rather just leave it alone until she comes to change it”. NS called for assistance.	568
03/10/2015 - 04/02/2015	Statewide Regional Medical Center	**Hospitalization for depression and suicidal ideation:** **Discharge diagnoses:** Bipolar disorder type II; Borderline personality disorder; Generalized anxiety disorder; stage IV sacral decubitus ulcer with some drainage (patient on a wound VAC, status post repair at Sleepy Hollow Hospital Center in Winston Salem, North Carolina), chronic low back pain, hypertension, diabetes mellitus Type 2, COPD, chronic respiratory failure, obstructive sleep apnea uses CPAP machine at home, previous tobacco use, Gastroesophageal Reflux Disease (GERD), morbid obesity, Coronary Artery Disease (CAD), ataxia, pernicious anemia, low High Density Lipoprotein (HDL) **Hospital course:** **Notes from treatment on medical unit:** 03/10/2015: Discussed medication options with patient. She's never been tried on Seroquel. Discontinue Geodon and begin Seroquel 100 mg every night and titrate up as tolerated. Hopefully she'll be able to tolerate at least 200-300 mg. This can increase efficacy of her antidepressant as well as work as a mood stabilizer. I will continue to round on the patient and work on her psychotropic medications while she is in ICU. Once she is medically stable then she can be	24-33

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		transferred to the BHU for further psychiatric treatment No other changes with her psychotropic medications at this time. 03/12/2015: The patient appears oversedated which could be from not sleeping last night or from pain medication. There is a big change from 03/11/2015 to 03/12/2015 and the only change I can see in medication besides what I've changed is the IV Morphine. I will continue to adjust her psychotropic medications to try and improve mood and decrease/resolve suicidal ideation. My impression of her mood is a 9 on scale of 1 to 10 with 1 being the best mood. She isn't harming himself in the hospital but continues to state she is suicidal with plan and intent should she be discharged. My impression of her response to medication and treatment for psychiatric illness at this time is also 9. Increase Seroquel, decrease and continue to taper Trileptal. Decrease Prozac as it's a once a day medication and the high dose of 80 mg could interfere with electrical activity of the heart and increase risk for serotonin syndrome. I will continue to round on this patient until she is either discharged or transferred to the BHU. 03/13/2015: The patient can speak more fluidly today now that her IV Morphine has been reduced. I educated the patient about being able to get up and walk around so that she can show us that she will be able to ambulate once she comes up to the behavioral health unit again. When the patient was in the ICU only receiving opiate pain medication by mouth her affect was much brighter and she was able to move around better. I will continue to taper Trileptal. Also the patient continues to have diarrhea and have noticed that she is on scheduled Colace and Simethicone 50 I will move those to when necessary. I met with a discharge team including Dr. White. The wound care nurse has ordered a portable wound VAC which the patient can wear under her close. The wound care nurse will come up as needed to care for it. Hopefully they will have this in sometime early next week. I will continue to round on this patient throughout the weekend and until she can be admitted to the behavioral health unit. She contracts for safety stating that she will not harm himself. She states that if she has any type of urges to do so that she will reach out for help. The patient has been able to keep himself safe in the hospital since she's been here. Dr. White is going to taper the IV Morphine. 03/14/2015: Patient continues to be severely depressed. She does not appear to be in any pain but continues to report pain. She is currently on oral pain medications. I reminded her that she cannot be on any IV, and she will need to wear is a portable wound VAC when she comes up to the unit. I have asked her to make sure that she is getting out of bed and walking as much as she can now because when she was on the behavioral health unit she complained of her legs being sore having to walk and be up so much. I reminded her that she is not going to be able to just stay in bed once she comes up toward unit. The patient states that she is looking forward to engaging in the groups. She'll have her last dose of Trileptal tonight. 03/15/2015: As stated above I have educated the patient concerning her inability to articulate her perception of pain. I am concerned that she is at this	

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		level of pain and has had 25 mg of Oxycodone since 5 AM this morning. About 5 AM she received her breakthrough pain medication of 5 mg of Oxycodone. Then at 9:39 AM she received another 5 mg, 10:43 AM she received 5 mg, and at 10:41 AM she received 10 mg of Oxycodone. I came to see her about 15-20 minutes after her last dose of pain medicine and she is still rating her pain to be at a "10." I taught her a visualization technique to help reduce her pain, and I have asked her to practice this and build upon it. I have educated her that we cannot handle someone on our psychiatric unit with severe pain issues that she would need to receive care on a medical/psychiatric unit, were that to be the case. The patient seems confident that she will do okay on the unit again however I have my reservations. The patient needs to be ambulating more during the day then she is right now. My impression of this patient is that no matter how much pain medicine she receives she will still report her pain to be a 10. While she was on the IV Morphine she could barely wake up and still reported her pain to be at 10. I believe that the patient is treating her emotional pain through the use of opiate pain medication. I have educated the patient concerning this but she has not developed any insight so far. With all of this said, it should be noted that if the patient continues to have to receive extra pain medicine by mouth she will not be an appropriate candidate for the behavioral health unit here. If that's the case then the utilization nurse needs to search for a medical psychiatric unit can handle that level of care. I will check the patient's MAR tomorrow morning to see if she has received any extra pain medication and make that decision then. We will have beds available tomorrow and I believe that they have received the portable wound VAC unit. I will get in touch with the hospitalist who is covering her now and also let them know my concerns. 03/17/2015: **Initial treatment plan with current BHU admission:** I reviewed the patient's labs. She will remain on Prozac 40 mg daily, Seroquel 300 mg by mouth each bedtime, and Lamictal 200 mg by mouth twice a day. We'll start to taper her off of Neurontin and we will reduced to 300 mg by mouth 3 times a day. Xanax will increase to 1 mg by mouth 3 times a day due to the patient's high level of agitation. I will continue with extended release OxyContin 30 mg by mouth twice a day. I will increase her Oxycodone IR to 20 mg every 6 hours when necessary for breakthrough pain. All of her other medications will remain the same. She believes that she might be getting constipated ***sialoadenectomy*** Colace 50 mg daily. When she was on the medical floor she was on Colace 100 mg twice a day with Simethicone scheduled 3 times a day and that's when she ended up with diarrhea. Once I stopped this the diarrhea resolved. I believe that this will be a balancing act do to all of the sedating medications that she is currently on which can cause constipation. The wound care nurse will come twice a week to attend to her wound VAC and to check the wound. If we need any help with medical management we will get the hospitalist's involved however right now I think I can manage. I will recheck her sodium level as well as hemoglobin in a day or 2. I've ordered a dietary consult as she was receiving some type of extra protein on the medical floor, for better wound healing. I have encouraged the patient to engage in the milieu and to attend groups. Currently she is using a wheelchair but once her strength	

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		regains we will encourage her to use a walker. Social worker will coordinate with outside agencies to try to place the patient in an assisted living home where she can be safe and continue to heal. 03/18/2015: I again educated the patient about her perception of pain. We also talked about ways that she can distract himself from her pain including visualization. No medication changes today. My impression of the patient's mood is 9, and my impression of her response to treatment and medication is also a 9. will increase Colace and add Miralax for constipation. Will continue to taper Neurontin. 03/19/2015: I reviewed the patient's labs. Hyponatremia has resolved. She has low B12 and appears to have pernicious anemia. Patient's HDL is very low. Even though the patient keeps stating that she will kill himself if she is discharged home she has kept himself safe here on our unit and on each medical unit that she has stayed on here in the hospital. She is trying to attend groups, but it's been difficult with her still being in a wheelchair. I will order physical therapy, evaluate her to try to help her slowly get out of the wheelchair and use walker. This will also help with wound healing. I have coordinated with the wound care nurse who continues to see her each day. She is going to try a new type of dressing and may remove the wound VAC even if this is for short time. The patient has had her dietary consult I believe that today is her last dose of Gabapentin SW to speak to Trish From ACS. I will order B12 1000 mcg IM daily x7 days then we'll go to once a week, also fish oil capsule 1 gm with each meal. I have asked the patient what we would see when she is safe to go to a nursing facility. She has said repeatedly that she needs to go to some type of nursing facility otherwise if she was discharged home she would kill himself. The patient does not answer my question and just says that we need to talk to "Trish." 03/20/2015: The patient reports that she would gladly go to a nursing home and she feels that she could keep himself safe and would not want to kill himself. She understands that she will not be able to keep her home or her vehicle. The patient continues to report her pain at a "10" however does not appear to be in severe pain. I'm sure she deals with some pain issues with the decubitus ulcer which has been healing however she actually reports more pain in her back from other issues when she tries to use the walker. Even when the patient was receiving IV Morphine and at that time was difficult to wake up she still reported her pain at a "10. In my impression of the patient's dangerousness is a 6 and my impression of her response to treatment and medication is a 7. 03/21/2015-03/22/2015: Patient was seen by the weekend provider on both Saturday and Sunday. No medication changes. 03/23/2015: The patient verbalizes that she can keep himself safe on our unit and she has kept himself safe the entire time that she's been in the hospital. She reports that she would be able to keep himself safe in a nursing home as well. Social work is currently working on placement. The patient was seen by the	

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		wound care nurse who recommends that the patient be up and walking with the walker for healing purposes. Also physical therapy has reported that the patient has no problems walking using a walker. I've explained to the patient again that she needs to be using the walker and not to wheelchair in order to help the healing process. I will go ahead and increase the frequency of her Oxycodone for breakthrough pain to every 4 hours as needed. I've explained to the patient that if she is over sedated or cannot walk well with the increase of frequency of the opiate pain medication then we will have to reduce it and she verbalizes understanding of this. She continues to be on extended release Morphine 30 mg twice a day schedule. No change in the patient's psychotropic medications as these medications here to be helping with her depression. My impression of the patient's mood is 4, and my impression of her response to treatment and medication is 5. Also there has been an overlay put on the patient's mattress in order to reduce pressure. Patient remains on a wound VAC. 03/24/2015: My impression of the patient's mood is a 7 and response 10 treatment and medications a 5. Have educated the patient as to why she should not be using the wheelchair and we need for her to walk using a walker. I've also educated her concerning her medications reminding her that there is medication for breakthrough pain that she needs to utilize. I've reminded her that the staff and myself included here to help her get better psychiatrically as well as physically and even though she may not agree with our recommendations she needs to follow those recommendations in order to get better. I'm sure that it is very frustrating going through what she has gone through and I have listened to her and allow her to attend her frustrations. I will schedule her Miralax' twice daily and add magnesium citrate as needed for constipation. I've educated her that it's a delicate balance between her stools becoming too soft increasing diarrhea which will put her at a higher risk of contaminating the wound site, and also keeping her out of constipation which is not good for her to strain either. Patient verbalizes understanding of this. 03/25/2015: Patient continues to complain and report mood and pain at a "10." She is unwilling to get out of bed for groups or to socialize but will get up for meals. She declines any suggestions of how to try and make improvements in her mood by engagement in our program in partnering with staff in a mutual relationship for recovery. Her expectation is that medication will fix her mood and her pain. She declines to take an active role in helping her wound to heal. SW has spoken to her peer support specialist at ACS and she reports that the patient is telling untruths about her providers and staff here on the unit. I encourage the patient and continue to educate her as to the steps she needs to take in order to become physically and mentally healthy again. I offered the patient to have her breakthrough pain medication early so she can go sit in group because she states she can't go to group because it "hurts too much to sit out there." I told her that the expectation is for her to get out of bed and go to the medication window to receive the early pain medication and then go to group even if for only 20 or 30 minutes. She states she is going to do that. 03/26/2015: Patient is not as irritable today and she has been out of her room. I think that her support system from Appalachian community services have been	

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		able to convince her to participate more. Social work is actively trying to seek out a nursing home. No changes in medications today. My impression of the patient's response to treatment and medications is 5. My impression that the patient's dangerousness and mood is 7. 03/27/2015-04/01/2015: During this time the patient's extended release Oxycodone was increased to 60 mg 3 times a day. Immediate release Oxycodone was decreased to 10 mg every 6 hours when necessary breakthrough pain. Doxepin was added at night for sleep last night however the patient states that it did not help and was discontinued. 04/02/2015: Day of discharge - Even though the patient's pain medicine has been significantly increased she continues to report her pain at a "10: The patient reports more draining from her decubitus ulcer however the wound care nurse did come up and redress as well as clean the wound. I pulled labs on the patient and there are no signs indicated that there is any infection. The patient's white blood cell count is within normal limits and procalcitonin is negative. The patient's vitamin B12 is now greater than 1000 so I will go ahead and discontinue the injections of 1000 mcg weekly. The patient's B12 level should be checked in another week or 2 and if it starts to decrease significantly then I would recommend starting vitamin B12 by mouth 500 mcg daily. The patient reports that she will be able to keep himself safe in a nursing home environment and has kept himself safe the entire time she has been here at the hospital. The patient has not engaged in any of the groups for the past several days and she should be encouraged moving forward to engage in any type of group activity that is allowed at the nursing home. **Recommendations:** It's recommended that the patient be treated at the Very Skilled Nursing home. It's recommended that she see someone for psychiatry at the nursing home as well as her medical care. The patient will continue to need attention for her decubitus ulcer with wound care. Appalachian community services have also continued to see this patient and I believe will continue to follow her at the nursing home. **Condition on discharge and prognosis:** Patient will be discharged in improved mood and condition to the nursing home. Patient's medications have been called to the pharmacy that the nursing home uses which is Stanley labs. A prescription of OxyContin was given to the patient to give to the nursing home as this prescription needs to be written out on a prescription pad. The patient will need close follow-up in the outpatient setting for her decubitus ulcer as well as her psychiatric care. She will be living in a nursing home environment in order to receive the care needed particularly for her psychiatric condition. The patient states that if she were to go home she would become suicidal again, but she states she can keep himself safe at a nursing home in a structured environment. **Disposition:** The Very Skilled nursing home will be coming to transport the patient.	

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
04/29/2015	Statewide Regional Medical Center Laboratory	**Labs:** **High:** Alkaline phosphatase (127), CRP (25.5), Erythrocyte Sedimentation Rate (ESR) (21) **Low:** Total protein (6), Albumin (3.3)	15
05/01/2015	Statewide Regional Medical Center Laboratory	**Labs:** **High:** CRP (20.2), Red Cell Distribution Width (RDW) (15.6), ESR (24) **Low:** Hemoglobin (13.2), Hematocrit (39.8), Mean Cell Hemoglobin (MCH) (27.3), % Lymphocytes (19.6)	10
05/06/2015	Statewide Regional Medical Center Laboratory	**Labs:** A1C (5.4)	5-6