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S.C. SUPREME COURT

Progress Notes

Signed Mar 23, 2026

Progress Notes by Kayleigh Noelle Kemmy, ACNP at 3/23/2026 10:47 AM

Attestation signed by William E Spears IV, MD at 3/23/2026 4:05 PM (Updated)

HPI
Duane Evans is a 71 y/o M with PMH HTN, tobacco use admitted on 2/3 with acute onset of L hemiparesis, HTN, found to have a R thalamic ICH with intraventricular extension and hydrocephalus, ultimately requiring EVD placement. Course c/b respiratory failure requiring intubation, encephalopathy, pneumonia.

Exam: Eyes open to simulation, attends intermittently when called, follows occasionally midline commands, attempts to nod/shake head in response but not always appropriately. No BTT. Pupils equal,+ cough. RUE localizes antigravity, LUE extends. RLE triple flexes, LLE prominent TF with stimulus induced movement.

A/P:

Neuro:
#R thalamic ICH: ICH score 1, volume 18cc. Etiology is chronic HTN
#Hydrocephalus: EVD placed 2/3, s/p IT tPA on 2/4, 2/5. EVD removed 2/22. Repeat CT 3/9 to evaluate ventricle size showed expected evolution.

Cardiovascular: Keep MAP > 65. TTE with normal EF, LVH
#HTN: Target SBP < 180. Continue amlodipine 10mg, Coreg 6.125mg BID, losartan 50mg

Respiratory:
#Intubated due to persistent encephalopathy, and respiratory failure on 2/6: Continue pressure support trials. Barrier to extubation is primarily mental status. See GOC.

Renal: Cr stable, avoid nephrotoxic meds
#Urinary retention: Continue intermittent catheterization, continue flomax

GI:
#Dysphagia: Continue TFs via DHT. Bowel regimen

ID:
#PNA: Completed course of CTX for H. Flu PNA (2/7-2/13)
#UTI: Urine growing Enterobacter, continue cefepime, 5d course (3/21-3/25)

Endo: A1c 6, TSH 0.8. Glucose checks, SS

Heme: Lovenox, SCDs

Tubes/lines/drains: PIV, NGT, ETT
Ppx: Lovenox
Skin: 2 documented wounds
GOC: Partial code. I expect long term L sided motor deficits and significant debility. Remains incapacitated. Patient's wife Elizabeth is legal decision maker. Further decisions regarding next steps in care are on hold with ongoing court proceedings.

William Spears, MD
Neurointensivist
Prisma Health Neurology

Split/shared services include pre- and post-visit activities, face-to-face time with the patient, and other coordination of care. I evaluated the patient with Kemmy, Kayleigh Noelle, ACNP on 3/23/2026. I personally spent 38 minutes providing critical care for this patient. I have reviewed and verified this documentation and it accurately reflects our care.
Critical care time was exclusive of separately billable procedures and teaching time. Critical care was necessary to treat or prevent imminent or life-threatening clinical/neurological deterioration due to ICH, encephalopathy, and acute respiratory failure requiring mechanical ventilation.

Cerebrovascular and Stroke Center

Neurocritical Care Progress Note

Date/Time: 03/23/26 - 10:49 AM
Admitted: 2/3/2026
Admitting MD: William Eugene Spears IV, MD

Duane Alan Evans is a 71 y.o. male with HTN, former smoker who presented to GMH on 2/3/2026 for acute left sided weakness with dysarthria. HPI per patient's wife report, chart review, and stroke team report. Patient lives at

home with his wife. Per her report he was in his normal states of health until about 10-10:30 when she left home. When she returned to the home at around 12pm she found him down in the kitchen. EMS was called. Initial evaluation per EMS noted to have left sided weakness and dysarthria on exam. Patient was noted to have SBP >180 mmhg with EMS.

On arrival to ED, Stroke team evaluated the patient, SBP >200 mmhg, Initial NIHSS 14. CTH revealing for R BG ICH with IVH. Patient was started on cardene for BP management, HTS for cerebral edema initiated. NCC was contacted for Admission.

2/3 EVD placed.
2/4, 2/5 IT tPA administered per NSGY.
2/5 CTH shows improvement in IVH
2/6 Patient intubated for airway protection 2/2 decreased mentation. Repeat CTH remained stable.
2/9 - 2/13 EVD wean
2/13 EVD clamped per NSGY
2/14 Patient's mentation worse, drain re-opened at 10 cmH20. rCTH pending. Ongoing GOC discussions with family at bedside.
2/16 Following discussion with Palliative Care, decision made to pursue palliative extubation/comfort care measures on Wednesday 2/18
2/18: Sharing hope involvement as of 2/17. Initial plans for compassionate extubation and potential transition to DCD pending time course after extubation this morning. However, family disagreements have stalled current plan of transition of care. Medical management and supportive care continues for the time being. No acute clinical changes over the last 24h.
2/19: Neurologically unchanged
2/22: Persistent rhythmic left lower extremity movement noted today, plan for LTM EEG. EVD removed per neurosurgery. CT head completed evolution of ICH, no worsening hydrocephalus.
2/23: LTM without seizures. Amantadine restarted. Neurologically without change from day prior. Anti-HTN regimen escalated to meet SBP less than 160 goal. He continues to fail PSV trials.
2/27: GOC decisions pending today's legal trial. Tolerating intermittent PST.
3/2: No change in exam. Remains encephalopathic and hemiplegic on the left.

No acute changes as of 3/23/2026. Continues on PSV. Continue abx for UTI. Following commands and nodding appropriately this morning on exam when asked questions.

Neuro

Acute Right BG Intracranial Hemorrhage
Intraventricular Hemorrhage
Etiology: Hypertensive

See above for admission and imaging details
- Vitals signs hourly
- NIHSS Q4 hours
- HOB >30 degrees to reduce ICP
- Treat BP with ordered medications to maintain: SBP less than 160 with Cardene gtt/labetalol/ hydralazine PRN
- Seizure/fall precautions
- 2/14 rCTH stable, decreased hematoma
- 2/22 CT head completed prior to EVD removal - stable
- 3/9/26 CT head reviewed evolution of the right thalamic hematoma and mild dilation of the ventricles - Exam consistent, no need for further imaging at this time

Concern for Hypoactive Delirium
- Discontinue amantadine
- Melatonin PRN nightly

Left Lower Extremity Movements
- Left foot rhythmic movements
- LTM without seizures x 24h monitoring. Discontinued 2/23

MSK

Left Hemiparesis
Left Neglect
Generalized Weakness
- Nursing to help perform ROM if patient unable to be mobilized.
    - Unchanged

CV

Essential HTN
Patient with history of HTN - previously was on Valsartan but stopped taking due to "side effects." Hypertensive emergency noted on arrival to GMH
- Treat BP with ordered medications to maintain: SBP <160, MAP >65; Cardene, Labetalol, Hydralazine PRN
- Maintain Stroke SBP goals
- Monitor on telemetry
- ECHO with EF 55-65% and LVH; also notes left atrial mass vs artifact; per previous documentation: communicated with Cardiology to review, again favors artifact but recommends outpatient cardiology referral per Dr. Dassanayake
- Continue on telemetry
- Continue Amlodipine 10mg daily
- Continue Losartan 50mg nightly
- Continue Coreg 6.25mg BID

Hyperlipidemia

- LDL on admission 155; initially on Lipitor 80mg daily
- Stopped Lipitor per family request due to previously reported side effects

Respiratory

Intubated for Airway Protection
Acute Hypoxic Respiratory Failure

- 2/6 Intubated due to inability to arouse, snoring respirations and increased oxygen requirements
- ABG PRN
- Chest X-Ray PRN
- Chest percussion, encourage turn/cough/deep breath, incentive spirometry and OOB when able/as indicated
- Tolerating PSV well

Ventilator Information

Flowsheet Row	Most Recent Value
Ventilation Day(s)	44 at 03/22/2026 1159
Vent Mode	Pressure Support at 03/23/2026 0859
Set Frequency	15 at 03/23/2026 0250
Vt (Set, mL)	500 mL at 03/23/2026 0250
Pressure Support	8 cm H20 at 03/23/2026 0859
FiO2%	40 % at 03/23/2026 0859
Vt Insp (mL)	329.8 mL at 03/23/2026 0859

Renal

Acute Urinary Retention, resolved

- Patient voiding spontaneously
- Continue straight cath as needed
- Continue Flomax 0.4mg daily
- Monitor I/O.

- ICU Electrolyte Replacement Protocol
- Q48hr BMP, Mg, phos, reviewed 3/23
- BUN and CR stable

GI

- Bowel Regimen: Colace/Senna
- Ok to hold guar gum if not having liquid stool
- Diet/Nutrition: Continue Osmolite 1.5 at 55ml/hr; FWF 50cc Q4H
- LBM: 3/22
- Zofran PRN for emesis
- Continue Pepcid 20mg daily while intubated

Transaminitis

- AST WNL

- ALT remains elevated
- Continue CMP Q48hrs

Overweight (not obese), if BMI is 25.0 to 29.9
Body mass index is 29.07 kg/m^2.
- Nutrition consult to assist with dietary recommendations
- Continue enteral feeds as tolerated
- Nursing to use Maxi-Slide or similar device to safely move patient

ID

H Flu PNA - Previously Treated
- A-Febrile
- Sputum culture with Hflu
    - s/p Rocephin x 7 days (EOT 2/14)
- CSF culture 2/17 with NGTD
- CSF culture 2/20/26 NGTD
- Continue Tylenol PRN
- Ibuprofen as needed for fevers
- q48h CBC, reviewed 3/22

E cloacae complex UTI
- UA with concerns of UTI. Urine noted to be malodorous and with particulate prompting UA
- Continue cefepime x 5 days

Endo

- Blood glucose goal 140-180
- Hgb A1C: 5.6
- TSH: 0.846

Heme

Normocytic, Normochromic Anemia
- No active signs of bleeding
- CBC q48h, reviewed 3/22
- DVT prophylaxis with SCDs and Lovenox

Lab Results

Component	Value	Date
HGB	10.7 (L)	03/23/2026
HCT	33.5 (L)	03/23/2026
PLT	287	03/23/2026

Integumentary

- Continue frequent skin assessments/repositioning per unit protocol

Cutaneous groin erythema, possible fungal infections, improving
- miconazole 2% powder with improvement erythema

PUD PPX: Pepcid
DVT Prophylaxis and/or antiplatelet therapy: SCDs and Lovenox

Subjective

Hospital Day: 48 days
Code Status: Partial Code

24-hour update:
Neurological exam improved this morning. Nods appropriately, follows commands consistently. Continue cefepime.

Objective

	Current	*Range (last 24 hours)*
Temperature:	**98.9 °F (37.2 °C)**	
Heart Rate:	83	[66-88]
Resp Rate:	**(!) 26**	[12-28]
Blood Pressure:	**114/69**	(102-153)/(65-86)
Oxygen Sats:	98 %	[94 %-100 %]

Patient was seen and examined by myself on 3/22/2026 Exam below reviewed and unchanged unless otherwise noted.

Physical Exam:
General appearance: No acute distress, intubated, laying in ICU bed.
HEENT: PERRL and sclera clear, anicteric
Lungs: intubated, equal chest rise, mild inline secretions
Heart: regular rate and rhythm, NSR on monitor
Abd: Soft, distended, Ventral hernia and umbilical hernia

Neurological:
GCS: E4 VT M6 = 10T
Mental Status: Patient is off sedation, will open eyes and stay alert during exam. Follows commands, nods yes/no appropriately.
Cranial Nerves: PERRL 3+, EOM intact. Left lower facial droop- previous, however ETT obstructs view.. Positive cough gag and corneal reflexes. +oculocephalics.
Strength/Sensation: RUE moves spontaneously and purposefully against gravity; LUE flaccid to noxious stimuli, no attempt to break gravity. LLE flaccid to noxious stimuli, no attempt to break gravity. RLE with some purposeful

movement, unable to break gravity. No tremors noted.

	NIH Stroke Scale- exam clouded by intubation	
Category		**Score**
1a.	Level of Consciousness	0 - Alert; keenly responsive
1b.	LOC Questions (Age & Month)	1 - Answers one question correctly
1c.	LOC Commands (Make fist & close eyes)	0 - Performs both tasks correctly
2.	Best Gaze	0 - Normal
3.	Visual	0 - No visual loss
4.	Facial palsy	0 - Normal symmetric movements
5a.	L Motor arm	4 - No movement
5b.	R Motor arm	0 - No drift
6a.	L Motor leg	4 - No movement
6b.	R Motor leg	2 - Some effort against gravity
7.	Limb ataxia	0 - Absent
8.	Sensory	2 - Severe-to-total sensory loss
9.	Best language	2 - Severe aphasia (UTA: ETT)
10.	Dysarthria	0 - Normal (UTA: ETT)
11.	Extinction and inattention (formerly neglect)	0 - No abnormality
	NIHHS Total:	**15**

Neurological Imaging

XR Chest 1 Vw
Result Date: 3/17/2026
EXAM: CHEST X-RAY SINGLE VIEW HISTORY: ;NGT placement verification; COMPARISON: 3/9/2026 TECHNIQUE: Frontal view FINDINGS: Lungs / Pleura: No focal consolidation. No effusion or pneumothorax. Heart / Mediastinum: The cardiac and mediastinal contours are stable. Bony thorax / Soft tissues: The bony thorax is stable. Lines / Support Apparatus: The endotracheal tube is positioned between the thoracic inlet and carina. Enteric tube reaches the stomach.

Enteric tube reaches the level of the stomach. Signed by: 3/17/2026 12:21 AM: Mahatma MD, Sanjay

CT Head wo Contrast
Result Date: 3/10/2026

EXAM: CT HEAD WO CONTRAST INDICATION: Stroke, follow up. COMPARISON: CT head without contrast 2/22/2026 TECHNIQUE: Standard noncontrast brain CT. FINDINGS: Brain Parenchyma: -Approximate 7 mm leftward midline shift. -Evolving hemorrhage and edema in the right thalamus. -No intracranial hemorrhage. -Moderate chronic microvascular ischemic changes. Ventricles: Slightly increased caliber of the lateral ventricles, measuring 5 cm transverse. Interval removal of left frontal ventriculostomy catheter. Small volume hemorrhage layering in the lateral ventricles. Extra-Axial Spaces: No extra-axial fluid collection. Basal Cisterns: Normal. Paranasal Sinuses: Moderate mucosal thickening in the ethmoid air cells and sphenoid sinuses Mastoid air cells: Large volume mastoid fluid with fluid also noted in the middle ear spaces. Orbits: Bilateral cataract surgeries. Cranium and Bones: Left frontal burr hole. Soft Tissues: Partially visualized nasoenteric tube.

1. Continued evolution of right thalamic hematoma with no new areas of hemorrhage. 2. Slightly increased dilatation of the lateral ventricles following removal of ventriculostomy catheter. Signed by: 3/10/2026 8:56 AM: Heider MD, Robert

XR Chest 1 Vw
Result Date: 3/9/2026
EXAM: XR CHEST 1 VW, 3/9/2026 10:05 AM INDICATION: ;Ett placement; Comparison: 2/26/2026 FINDINGS: AP portable view chest shows small bore enteric tube tip to be below the level of the film but at least to the level of the upper abdomen. Endotracheal tube overlies mid thoracic trachea with its tip approximately 40 mm above the expected location of the carina. Remote right-sided rib fractures are noted. The right lung is otherwise clear. Blunting of the left costophrenic angle suggestive of small left-sided pleural effusion. CONCLUSION: 1. Endotracheal tube tip overlies mid thoracic trachea-see above. 2. Probable small left pleural effusion. 3. Remote right-sided rib fractures. Signed by: 3/9/2026 11:48 AM: Saunders MD, H. Stuart

XR Chest 1 Vw
Result Date: 2/26/2026
CHEST AP INDICATION: ;NG tube placement confirmation; ;NG tube placement confirmation; COMPARISON: 2/23/2026 TECHNIQUE: Single AP view FINDINGS: The imaging was reportedly the best obtainable. Lines/Tubes: There is an endotracheal tube with the tip projecting 7.8 cm above the level of the carina. There is an enteric tube with tip projecting over the left upper quadrant of the abdomen within the expected location of the stomach. Heart/mediastinum: The cardiomediastinal silhouette is within normal limits for size. There are vascular calcifications of the aorta. Lungs/pleura: No pneumothorax is seen. There is no evidence of focal consolidation or pleural effusion. Bony thorax / Soft tissues: The osseous structures are not well evaluated. There are chronic appearing right posterior

and lateral thoracic rib deformities.

1. There is an enteric tube with tip projecting over the left upper quadrant of the abdomen within the expected location of the stomach. 2. Please see other potentially clinically significant findings and details as described above. Signed by: 2/26/2026 9:48 PM: Epling MD, James

XR Chest 1 Vw
Result Date: 2/23/2026
EXAM: XR CHEST 1 VW COMPARISON: Chest radiograph 2/20/2026. INDICATION: ;ETT confirmation; Findings: Endotracheal tube tip overlies mid thoracic trachea. Weighted enteric tube tip overlies the stomach. ECG leads. Unchanged cardiomediastinal contours. Increased left basilar opacity. No pneumothorax or pleural effusion. Healed right rib fractures.

Endotracheal tube tip overlies mid thoracic trachea. Signed by: 2/23/2026 10:34 PM: Heider MD, Robert

LTM EEG
EEG Report Department of Electro-Neuro Diagnostics Greenville Memorial Hospital -- Prisma Health-Upstate Patient Name: Duane Alan Evans
Date of Birth: 7/21/1954 MRN: 970077938 Date Performed: 2/22/2026
EEG Number: 26-0159 ACQ #: 15 Technologist Name: Lee Sealey
Requesting Physician: HIERHOLZER, SARAH HART Study Type: Hospital LTM EEG -- Day #1 Indication for EEG: Seizure TECHNICAL DESCRIPTION This video-EEG was performed utilizing 21 active electrodes placed according to the international 10-20 system. Eye-leads were included. A single channel EKG was included. The study was digitally recorded with a sampling rate of 200 Hz. Portions of the study were reviewed using bandpass filters of 1-70 Hz. Patient or observer recognized events were identified by a push button marker or notation by EEG technician. Activation procedures: Patient was not sleep deprived. Eye closure was not performed. Duane Alan Evans 71 y.o., male DOB: 7/21/1954 MRN: 970077938 Review start time: 12:52 on 2/22/2026 Review end time: 13:48 on 2/23/2026 Indication: 71 y.o. male with history of right thalamic hemorrhage and altered mental status. Current Facility-Administered Medications: · acetaminophen (CHILDREN'S TYLENOL) 325 mg/10.15 mL UD suspension 650 mg, 650 mg, Oral/Gastric Tube, Q6H PRN, Martin, Robert Seth, AGACNP, 650 mg at 02/19/26 2256 · albuterol 2.5 mg /3 mL (0.083 %) nebulizer solution 2.5 mg, 2.5 mg, Aerosol, Q6H PRN, Hayden, Emma Rose Boyer, PA · amLODIPine (NORVASC) tablet 10 mg, 10 mg, Oral/Gastric Tube, Daily, Martin, Robert Seth, AGACNP, 10 mg at 02/22/26 0902 · carvedilol (COREG) tablet 6.25 mg, 6.25 mg, Oral/Gastric Tube, BID, Antoshuk, Svetlana A, NP, 6.25 mg at 02/22/26 0903 · Oral Care for Mechanically Ventilated Patients, , , Until Discontinued **AND** cetylpyridinium 0.05% external solution 7 mL, 7 mL, Mouth/Throat, BID, 7 mL at 02/22/26 0903 **AND** cetylpyridinium 0.05% external solution

7 mL, 7 mL, Mouth/Throat, 4x Daily, Martin, Robert Seth, AGACNP, 7 mL at 02/22/26 1113 · [EXPIRED] Adult Hypoglycemic Standing Orders for Inpatient and Procedural Areas, , , Routine **AND** Glucose by Meter-POC, , , PRN **AND** dextrose (GLUTOSE) 40 % gel 37.5-75 g, 37.5-75 g, Oral, PRN **AND** dextrose (D50W) 50% injection 50 mL, 50 mL, Intravenous, PRN **AND** glucagon HCl injection 1 mg, 1 mg, Intramuscular, PRN, Hierholzer, Sarah Hart, NP · enoxaparin (LOVENOX) syringe 40 mg, 40 mg, Subcutaneous, Daily, Hierholzer, Sarah Hart, NP, 40 mg at 02/22/26 0903 · famotidine (PEPCID) tablet 20 mg, 20 mg, Oral/Gastric Tube, Daily, Ward, Ngan Kim, NP, 20 mg at 02/22/26 0903 · fentaNYL (SUBLIMAZE) injection 50 mcg, 50 mcg, Intravenous, Q1H PRN, Hayden, Emma Rose Boyer, PA, 50 mcg at 02/22/26 0844 · folic acid (FOLVITE) tablet 1 mg, 1 mg, Oral/Gastric Tube, Daily, Hierholzer, Sarah Hart, NP, 1 mg at 02/22/26 0903 · guar gum (NUTRISOURCE) packet 1 packet, 1 packet, Oral/Gastric Tube, BID, Hierholzer, Sarah Hart, NP, 1 packet at 02/22/26 0903 · hydrALAZINE (APRESOLINE) injection 10 mg, 10 mg, Intravenous, Q4H PRN, Hierholzer, Sarah Hart, NP, 10 mg at 02/22/26 0659 · hydrALAZINE (APRESOLINE) tablet 25 mg, 25 mg, Oral/Gastric Tube, Q8H, Hierholzer, Sarah Hart, NP, 25 mg at 02/22/26 0903 · ibuprofen (CHILDREN'S MOTRIN) 100 mg/5 mL suspension 600 mg, 600 mg, Oral/Gastric Tube, Q8H PRN, Martin, Robert Seth, AGACNP, 600 mg at 02/14/26 1031 · IVPB/Medication Flush 30 mL NS Flush, 30 mL, Intravenous, PRN **OR** IVPB/Medication Flush 30 mL D5W Flush, 30 mL, Intravenous, PRN, Lynch, Fredrick, MD · labetaloL (TRANDATE) injection 10 mg, 10 mg, Intravenous, Q4H PRN, Hierholzer, Sarah Hart, NP, 10 mg at 02/22/26 0243 · losartan (COZAAR) tablet 50 mg, 50 mg, Oral/Gastric Tube, Bedtime, Hierholzer, Sarah Hart, NP, 50 mg at 02/21/26 2040 · melatonin tablet 5 mg, 5 mg, Oral/Gastric Tube, Bedtime PRN, Ward, Ngan Kim, NP · ondansetron (ZOFRAN ODT) disintegrating tablet 4 mg, 4 mg, Oral/Gastric Tube, Q6H PRN, Hierholzer, Sarah Hart, NP · ondansetron (ZOFRAN) injection 4 mg, 4 mg, Intravenous, Q6H PRN, Hierholzer, Sarah Hart, NP · OSMOLITE 1.5 CAL 0.06 gram-1.5 kcal/mL enteral feeding, , Feeding Tube, Continuous, Martin, Robert Seth, AGACNP, Last Rate: 55 mL/hr at 02/22/26 1231, Rate Verify at 02/22/26 1231 · thiamine (VITAMIN B1) tablet 100 mg, 100 mg, Oral/Gastric Tube, Daily, Pasupuleti, Hemanth G, MD, 100 mg at 02/22/26 0904 EEG background description: There was no discernible Posterior Dominant Rhythm (PDR). The background was continuous, poorly organized and consisted of polymorphic theta > delta frequencies. This does appear to improve somewhat over the course of the study. Normal sleep architecture was not seen. State changes were not appreciated. Photic stimulation was not performed. Hyperventilation was not performed. Single Channel EKG when reliably obtained sinus rhythm. Interictal: None Ictal: None Clinical Events: None Impression: Generalized background slowing Clinical Interpretation: There have been no seizures or events to date. This EEG is suggestive of a non-specific, moderate-severe encephalopathy initially that does improve somewhat over the course of the recording. Thomas H. Gann, Jr. MD

Epileptologist

LONG TERM MONITORING EEG
EEG Report Department of Electro-Neuro Diagnostics Greenville Memorial Hospital -- Prisma Health-Upstate Patient Name: Duane Alan Evans
Date of Birth: 7/21/1954 MRN: 970077938 Date Performed: 2/23/2026
EEG Number: 26-0159 ACQ #: NK 15 Technologist Name: Ja'Me Slaughter Requesting Physician: Study Type: Hospital LTM EEG -- Day #2
Indication for EEG: Seizure TECHNICAL DESCRIPTION This video-EEG was performed utilizing 21 active electrodes placed according to the international 10-20 system. Eye-leads were included. A single channel EKG was included. The study was digitally recorded with a sampling rate of 200 Hz. Portions of the study were reviewed using bandpass filters of 1-70 Hz. Patient or observer recognized events were identified by a push button marker or notation by EEG technician. Activation procedures: Patient was not sleep deprived. Eye closure was performed. Length of Study: LTM study (time to be added later)

CT Head wo Contrast
Result Date: 2/22/2026
EXAM: CT HEAD WO CONTRAST INDICATION: Packing upOther - See Order Comments;;Re-evaluate for hydrocephalus COMPARISON: CT head without contrast 2/14/2026. TECHNIQUE: Standard noncontrast brain CT. FINDINGS: -Left frontal approach ventriculostomy catheter in place, tip in the left lateral ventricle near the foramen of Monroe. -Unchanged caliber of the lateral ventricles measuring 4.8 cm transverse at the frontal horns (series 900, image 17). Similar mild dilatation of the temporal horns compared to 2/14/2026. -Slightly decreased effacement of third ventricle compared to prior study. -Approximate 5 mm leftward midline shift; similar to prior. -Continued evolution of right thalamic parenchymal hematoma with surrounding vasogenic edema. -No new areas of hemorrhage. -Persistent layering hemorrhage in the lateral ventricles, slightly decreased compared to prior. Extra-Axial Spaces: No extra-axial fluid collection. Paranasal Sinuses: Mild mucosal thickening in the left maxillary sinus. Small mucous retention cyst in the right maxillary sinus. Mild mucosal thickening in the ethmoid air cells. Moderate mucosal thickening in the inferior aspect of the left frontal sinus. Moderate mucosal in the sphenoid sinuses. Mastoid air cells: Moderate volume mastoid fluid bilaterally with fluid also noted in the middle ear spaces Orbits: Bilateral cataract surgeries. Cranium and Bones: Small left frontal burr hole. Soft Tissues: Partially visualized nasoenteric tube.

1. Continued evolution of right thalamic parenchymal hematoma. No new areas of hemorrhage. 2. Slightly decreased effacement of the third ventricle related to evolving thalamic hematoma, but lateral ventricles are similar in caliber compared to 2/14/2026. Signed by: 2/22/2026 4:46 AM: Heider MD, Robert

I&O:

Intake/Output Summary (Last 24 hours) at 3/23/2026 1049
Last data filed at 3/23/2026 1000

	Gross per 24 hour
Intake	1990.67 ml
Output	1200 ml
Net	**790.67 ml**

Net IO Since Admission: 17,921.71 mL [03/23/26 1049]

IV Infusions:
OSMOLITE 1.5 CAL, , Last Rate: 55 mL/hr at 03/23/26 1000

Diet:
NPO Diet NPO with Tube Feeding

Lines/Drains:
Active Lines

Peripheral Intravenous Line	Duration
Peripheral IV 02/23/26 Anterior;Right Forearm	28 days
Peripheral IV 02/23/26 Anterior;Right Upper Arm	28 days

Wound	Duration
PH Wound 02/24/26 Pressure Injury Sacral	27 days
PH Wound EVD site 02/28/26 Surgical Head	23 days
PH Wound 03/11/26 Pressure Injury Cheek Left Redness with delayed blanching; small area of nonblanchable redness	11 days
PH Wound 03/11/26 Pressure Injury Cheek Right Delayed blanching to cheek	11 days

Drain	Duration

NG/OG GI Tube 03/16/26 Right nostril	6 days
External Urinary Collection Device	<1 day

Airway	Duration
Hi-Lo Evac ETT 02/06/26 7.5	44 days

Active Tubes/Drains

Drain	Duration
NG/OG GI Tube 03/16/26 Right nostril	6 days
External Urinary Collection Device	<1 day

Lines, Drains, and Airways

Airway	Duration
Hi-Lo Evac ETT 02/06/26 7.5	44 days

Peripheral Intravenous Line	Duration
Peripheral IV 02/23/26 Anterior;Right Forearm	28 days
Peripheral IV 02/23/26 Anterior;Right Upper Arm	28 days

Wound	Duration

PH Wound 02/24/26 Pressure Injury Sacral	27 days
PH Wound EVD site 02/28/26 Surgical Head	23 days
PH Wound 03/11/26 Pressure Injury Cheek Left Redness with delayed blanching; small area of nonblanchable redness	11 days
PH Wound 03/11/26 Pressure Injury Cheek Right Delayed blanching to cheek	11 days

Drain	Duration
NG/OG GI Tube 03/16/26 Right nostril	6 days
External Urinary Collection Device	<1 day

Vent:
MODE: Pressure Support (03/23 0859)
Set Frequency: 15 (03/23 0250)
S VT: 500 mL (03/23 0250)
PR SUP: 8 cm H20 (03/23 0859)
MAP (cm H2O): 10.8 (03/23 0859)
Insp Time (sec): 0.9 sec (03/23 0250)
Vent / RT FiO2 (%): 40 % (03/23 0859)
VE exp: 10.76 L/min (03/23 0859)
PIP: 17.1 cm H2O (03/23 0859)
Vent Changes: Per Weaning Protocol (03/22 1514)

Meds:
Pain Meds:
Analgesics

acetaminophen (TYLENOL) suppository 650 mg	650 mg, Rectal, Every 4 hours PRN

ABx:
Antiinfectives

	Dose	Frequency	Start	End
ceFAZolin (ANCEF) injection 1 g (Completed)	1 g	Once	2/3/2026	2/3/2026

Admin Instructions: Obtain number of vials required to make the ordered dose. Reconstitute each vial with 2.5mL normal saline. Further dilute each vial with additional 5mL normal saline and draw into one syringe. Administer by slow IV push over 3-5 minutes.

Immediate use – BUD 4 hours.
Route: Intravenous

	Dose	Frequency	Start	End
cefepime (MAXIPIME) 2 g in sodium chloride (NS) 0.9 % 50 mL IVPB-MINI	2 g	Every 12 hours	3/21/2026	3/26/2026

Admin Instructions: Activate medication.
Route: Intravenous

	Dose	Frequency	Start	End
cefTRIAXone (ROCEPHIN) 2 g in sodium chloride (NS) 0.9 % 50 mL IVPB-MINI (Completed)	2 g	Every 24 hours	2/8/2026	2/14/2026

Admin Instructions: Activate medication.
Notes to Pharmacy: Mild-mod infection (UTI,SSTI,STI*): 1g IV q24h, consider 2g if >80kg
Severe infection (bacteremia, febrile neutropenia, endocarditis, pneumonia, sepsis): 2g IV q24h
CNS infection: 2g IV q12h
Entercoccal endocarditis (with ampicillin): 2g IV q12h
*Uncomplicated gonorrhea use IM
Route: Intravenous

	Dose	Frequency	Start	End
miconazole 2 % powder (Completed)		2 times daily	3/11/2026	3/20/2026

Route: Topical

	Dose	Frequency	Start	End
cefTRIAXone (ROCEPHIN) 1 g in sodium chloride (NS) 0.9 % 50 mL IVPB-MINI (Discontinued)	1 g	Every 24 hours	3/20/2026	3/21/2026

Admin Instructions: Activate medication.
Notes to Pharmacy: Mild-mod infection (UTI,SSTI,STI*): 1g IV q24h, consider 2g if >80kg
Severe infection (bacteremia, febrile neutropenia, endocarditis, pneumonia, sepsis): 2g IV q24h
CNS infection: 2g IV q12h
Entercoccal endocarditis (with ampicillin): 2g IV q12h
*Uncomplicated gonorrhea use IM
Route: Intravenous

	Dose	Frequency	Start	End
cefTRIAXone (ROCEPHIN) 2 g in sodium chloride (NS) 0.9 % 50 mL IVPB-MINI (Discontinued)	2 g	Every 24 hours	2/8/2026	2/8/2026
Admin Instructions: Activate medication. Notes to Pharmacy: Mild-mod infection (UTI,SSTI,STI*): 1g IV q24h, consider 2g if >80kg Severe infection (bacteremia, febrile neutropenia, endocarditis, pneumonia, sepsis): 2g IV q24h CNS infection: 2g IV q12h Entercoccal endocarditis (with ampicillin): 2g IV q12h *Uncomplicated gonorrhea use IM Route: Intravenous				
piperacillin-tazobactam 4.5 g in sodium chloride (NS) 0.9 % 50 mL IVPB-MINI (Discontinued)	4.5 g	Every 6 hours	2/17/2026	2/20/2026
Admin Instructions: Activate medication. Route: Intravenous				

Ulcer PPx/Bowel Regimen:

Current GI Medications

ondansetron (ZOFRAN ODT) disintegrating tablet 4 mg	4 mg, Oral/Gastric Tube, Every 6 hours PRN
ondansetron (ZOFRAN) injection 4 mg	4 mg, Intravenous, Every 6 hours PRN
senna-docusate (PERICOLACE) 8.6-50 mg per tablet 2 tablet	2 tablets, Oral/Gastric Tube, Daily, Notify provider for loose stools

Labs:

Lab Results

Component	Value	Date
WBC	7.3	03/23/2026
HGB	10.7 (L)	03/23/2026
HCT	33.5 (L)	03/23/2026
PLT	287	03/23/2026
INR	1.2	02/21/2026
PTT	44 (H)	02/21/2026

Lab Results

Component	Value	Date
NA	139	03/23/2026
K	4.1	03/23/2026
CL	102	03/23/2026
CO2	25	03/23/2026
BUN	19	03/23/2026
CREATININE	0.68	03/23/2026
GLUCOSE	130 (H)	03/23/2026
CALCIUM	9.6	03/23/2026
MG	2.2	03/23/2026
PHOS	4.0	03/23/2026
BILITOT	0.3	03/23/2026
AST	46	03/23/2026
ALT	151 (H)	03/23/2026
ALKPHOS	102	03/23/2026
LIPASE	39	02/16/2026

Lab Results

Component	Value	Date/Time
PHBG	7.46 (H)	03/23/2026 0250
PCO2	41	03/23/2026 0250
PO2	132 (H)	03/23/2026 0250
HCO3	28.9 (H)	03/23/2026 0250
BASEDE	4.7	03/23/2026 0250

Lab Results

Component	Value	Date
LDLCALC	155 (H)	02/03/2026

Lab Results

Component	Value	Date
HGBA1C	6.0 (H)	02/17/2026

As part of split/shared services, I personally spent 16 minutes providing critical care for this patient. My provided care includes review of patients medical record (notes, recent lab work, imaging), examination of Duane Alan Evans , communication with patients nurse, and documentation in the medical record.

This patient is at high risk of imminent life threatening clinical deterioration and/or death due to respiratory failure requiring mechanical ventilation and ventilator management. The patient remains critically ill, requiring frequent reassessments, and decisions regarding complex medical care thereby

necessitating critical care to treat and prevent imminent or life-threatening deterioration in the patients condition. Time spent excludes procedure related time or time spent on the telephone.

Kayleigh Noelle Kemmy, ACNP
Neuro Critical Care
Prisma Health Neurology - Upstate
Neuroscience Intensive Care Unit
03/23/26 - 10:49 AM

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