

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

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APPEAL FROM EDGEFIELD COUNTY
Court of Common Pleas

SC Court of Appeals

Doyet A. Early, III, Circuit Court Judge

Appellate Case No. 2014-001031
Case No. 2009-CP-19-0276

Cecelia Jackson, PR of the
Estate of William Peterson

Appellant

v.

Edgefield Medical Clinic or
Edgefield Medical Clinic, P.A.,

Respondent.

RECORD ON APPEAL (VOLUME 2)

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1 page 32 of the Trinity second admission.

2 THE COURT: What page?

3 MR. WELCH: It's Exhibit 3, page 32.

4 THE COURT: Or you can look at that right here.

5 Can you see it from there?

6

7 BY MR. WELCH:

8 Q. Doctor, in your deposition we went through a
9 series of these physicians' orders that you told me
10 in the deposition the nurse would fax over

11 something, you would okay, send it back, then the
12 nurse would write the order, like for Smoak and, I
13 think, Smith, and then you'd come in and sign it or
14 they'd bring it over and you'd sign it; correct?

15 A. That's correct.

16 Q. And how many times did you actually physically
17 examine Mr. Peterson while he was in the nursing
18 home?

19 A. I didn't examine Mr. Peterson.

20 Q. You never saw him, did you?

21 A. No, I didn't.

22 Q. Okay. Now, on this one that we've got here
23 that's on page 32, the one you went over, read it
24 again for me, please.

25 A. Which one?

1 Q. The middle one, the one you were asked about by
2 your attorney.

3 A. Change Panafil to Aczone for better wound care
4 for physical therapy.

5 Q. And you told me at the deposition that you
6 thought that since the heel wound was getting
7 better, this probably applied to the left hip wound;
8 is that right?

9 A. Based upon the above order, yes.

10 Q. Okay. So on this date, 5/2, you also told me
11 in the deposition that one of the first medications
12 debrides; correct?

13 A. They both debride, yes.

14 Q. But you told me the second one, the Aczone, is
15 actually a stronger medication.

16 A. To my understanding they're both debriding.
17 Aczone may use a different formulation and it may be
18 stronger. Yes.

19 Q. You told me in your deposition it was stronger.

20 A. Okay.

21 Q. So you got information now that that patient is
22 under your care because you signed this order,
23 didn't you?

24 A. I did sign this order.

25 Q. This patient was under your care; right?

1 A. He was under the care of our practice and
2 myself, yes.

3 Q. And, in fact, when you signed this, you had
4 information that the physical therapist actually
5 needed a stronger debridement agent, didn't you?

6 A. Actually, as it turns out, the nursing home no
7 longer had the Panafil and had to change it to the
8 Aczone because of availability.

9 Q. Ma'am, you're the one in the deposition that
10 told me --

11 THE COURT: Mr. Welch, we don't have the
12 deposition. Now, if you're going to impeach her on
13 the deposition, show her what she said, line and
14 page.

15 MR. WELCH: She's already admitted it, Judge.
16 She said she did write the order.

17 THE COURT: Mr. Welch, play by the rules,
18 please.

19 MR. WELCH: I thought I was, Judge, because
20 she's already said what she said and what you said.

21 THE COURT: Well, you're not.

22 BY MR. WELCH:

23 Q. Ma'am, you had that information on that day,
24 you didn't know that day they ran out of one or the
25 other, did you?

1 A. I'm sorry. Repeat that.

2 Q. You didn't know that day you signed this order
3 that they ran out of one of those agents and had to
4 switch it to another, did you?

5 A. At the time I didn't, no.

6 Q. So the information you had that day or the
7 information that you gave me was that the Aczone was
8 a stronger debriding agent.

9 A. It's my understanding that they're both
10 debriding agents and Aczone is a different
11 formulation from the Panafil and may be stronger.
12 Yes, I did say that.

13 Q. This patient is in your care. When you found
14 out he needed a stronger debriding agent, did you go
15 over to check on that?

16 A. I was not called by physical therapy, I was not
17 called by the nursing staff regarding the wound or a
18 change in the wound, so there's nothing in
19 particular that alerted me that that needed to be
20 done. This order was written by the physical
21 therapist who is a trained professional who knows
22 his wounds and he knows his treatments.

23 Q. So you didn't go over to check on this man at
24 all, did you?

25 A. Not without an alert from the nursing staff

1 that he needed to be seen.

2 Q. So basically your testimony is, unless a nurse
3 or physical therapist tells you this person needs to
4 see a doctor, you're not going to go over there;
5 correct?

6 A. We're alerted to problems by the staff who see
7 and take care of them every day. Unfortunately we
8 don't work 24/7 in the nursing home and we're not
9 there to see them. And we depend on them to alert
10 us to issues that may come up regarding patients,
11 and we're happy to see them when we're notified that
12 we need to.

13 Q. Ma'am, let's go to page 81, the lab report. Do
14 you have that?

15 A. I do.

16 Q. And that's the one that was in the record there
17 at Trinity Mission. And if you look at the top, who
18 does it say it was sent to the attention of?

19 A. It was sent to the attention of me. But I'm
20 not the physician who ordered the lab.

21 Q. I understand. But it says: Attention,
22 Dr. Massey?

23 A. It does.

24 Q. And then we go to page 6 of the Edgefield
25 record.

1 THE COURT: Which exhibit?

2 MR. WELCH: Exhibit 9, Judge.

3 THE COURT: Sir?

4 MR. WELCH: Exhibit 9.

5 BY MR. WELCH:

6 Q. Would you say those are your initials?

7 A. They are.

8 Q. And why is it you'd initial a lab report,
9 Doctor?

10 A. Because it was on my desk.

11 Q. That means you received it?

12 A. That means I received it.

13 Q. In fact, it's required by a physician that gets
14 a lab report to show that they received it, isn't
15 it?

16 A. Yes.

17 Q. In fact, Doctor, whatever day you got that lab
18 report, it was before the 15th of May, wasn't it?

19 A. It was.

20 Q. In fact, several days before the 15th.

21 A. I can't be certain of the date.

22 Q. Well, you were certain with your attorney about
23 the date. Now, ma'am, when it comes down to this
24 patient, you say you did what with it, the lab
25 report?

1 A. As per my usual practice, I would have found
2 out more about the lab report 'since it's not
3 something I ordered and I would have passed it along
4 to the ordering physician, assuming that the
5 ordering physician would have had more information
6 about why it was ordered.

7 Q. You've got information now on the patient that
8 you've been signing orders on, that you had the lab
9 report sent to you on, and do you have a specific
10 recollection that you walked over with this to a
11 physician and said, hey, this is a MRSA wound, it's
12 cultured, and I wanted to make sure you see it? Are
13 you telling me you specifically remember doing that?

14 A. As a specific recollection, no. But as part of
15 my usual practice and my usual routine, that would
16 be something I would have done, yes.

17 Q. And you didn't tell me you did that in
18 deposition when I took your deposition, did you?

19 A. You didn't ask me.

20 Q. I asked you about the --

21 THE COURT: Ma'am.

22 Sir, use the deposition properly, which is, if
23 you think she said something differently, go to the
24 line and the page and ask her about it.

25 BY MR. WELCH:

1 Q. Ma'am, you've got the information now about
2 this infection and you basically didn't go see the
3 patient then or make sure another doctor saw the
4 patient, did you?

5 A. I don't think you can say that correctly, sir.

6 Q. Okay. Let me ask you this question: You were
7 told that -- what you said was a stronger
8 debridement agent was needed on the left hip ulcer.
9 Now you find out a few days later --

10 A. I didn't say I was told that a stronger
11 debriding agent needed to be done.

12 Q. A stronger debriding agent -- you told me the
13 Aczone was a stronger agent.

14 A. But I wasn't told that.

15 Q. No, you told me.

16 THE COURT: Sir, if she told you that, show us
17 what she told you.

18 MR. WELCH: But she's already admitted she did,
19 Judge.

20 THE COURT: If you're going to use the
21 deposition, do it right, which is to cite the line
22 and page. You know how to do that. You've been
23 doing it a long time.

24 I have her deposition right here.

25 MR. WELCH: You got the original, Judge?

1 THE COURT: Yes, sir.

2 BY MR. WELCH:

3 Q. Ma'am, if you will --

4 MR. WELCH: Will you hand her the deposition?

5 THE WITNESS: Thank you.

6 THE COURT: He's going to refer you to a line
7 and a page. Please turn to it when he does.

8 BY MR. WELCH:

9 Q. Go to page 46 of your deposition, ma'am --
10 actually, page 45. Do you have that page?

11 A. I do.

12 Q. And look at line 20. When asked about the note
13 that we're going over here --

14 A. Yes, sir.

15 Q. And I said that would be a course of physical
16 therapy. And what's your answer?

17 A. Yes.

18 Q. And that would be that person's recommendation
19 now, one of those substances changed what to what?
20 Read your answer, please.

21 A. Panafil is a debriding agent. It breaks down
22 proteins and breaks down dead cells in order to keep
23 the wound clean for healing. Aczone is the same,
24 but a bit more powerful.

25 Q. And then I asked you which one is being

1 referred to on 5/2. Your answer, please?

2 A. Since the right heel had healed, I assume it
3 was the left hip, and that was after the review of
4 the records noting he had a hip wound. At the time
5 of this, I was not aware he had a hip wound.

6 Q. Well, you read the deposition to me, ma'am.
7 You told me you assumed it was the left hip wound.
8 Did I read it correct?

9 A. That's correct, after my review of the records.

10 Q. And you also told me the second one, Aczone,
11 was a more powerful agent?

12 A. I did.

13 Q. Now you've got that information, you've got the
14 MRSA culture, and you think your normal course was
15 to talk to another doctor, but you don't have a
16 recollection?

17 A. I know what my normal course of action would
18 be. To ignore a lab report is not a normal course
19 of action for me.

20 Q. Ma'am, you agree this lab shouldn't be ignored,
21 should it?

22 A. It was not ignored by me.

23 Q. Then it shouldn't be ignored by any doctor,
24 should it, who sees it?

25 A. Anybody who sees it.

1 Q. So whichever doctor, according to you at that
2 time was treating him, should have acted on this
3 lab?

4 A. Let me attest to this lab. To begin with, as
5 per the procedure of the nurses and physical
6 therapists, this actually represents a surface wound
7 culture. This does not indicate systemic infection
8 at all. It would indicate, at best, a colonization
9 of an infection without other signs and symptoms.
10 So it's something that could have been attended to
11 certainly by the change in the treatment that day,
12 but not something I would have ignored.

13 Q. Do you know what the wound looked like on the
14 day you got the lab?

15 A. I do not. I was not aware that he had a left
16 hip wound on the day that I got the lab.

17 Q. Do you know of -- what any physician -- did you
18 talk to any physician that went over to look at the
19 wound the day you got that lab report?

20 A. I don't see anything in the chart that they had
21 actually seen the patient. The conversations that
22 they may have had, I'm not aware of.

23 Q. So when it comes down to it, you really don't
24 know what happened after the lab because you were
25 going to pass it on?

1 A. I passed it on to the partners that I trust,
2 yes.

3 MR. WELCH: No further questions.

4 THE COURT: Redirect, if any.

5 MS. MASSEY: I don't have any questions.

6 THE COURT: Everybody okay? It's 11:30. Keep
7 going?

8 THE JURY: Yes, keep going.

9 THE COURT: Next witness please.

10 MR. PARKINSON: The next witness is going to be
11 our expert.

12 THE COURT: Next witness.

13 You need a break?

14 THE JURY: I would like a break.

15 THE COURT: All right. We're going to take a
16 break for the Georgia Bulldog.

17 Don't discuss the case, don't deliberate.

18 Anything for the record before we break?

19 MR. WELCH: Nothing from the plaintiff, Judge.

20 MR. PARKINSON: No, sir.

21 THE COURT: All right. Stand at ease for a few
22 minutes.

23 (Short break.)

24 THE COURT: Ready to proceed?

25 MR. WELCH: Yes, Judge.

1 THE COURT: Bring the jury in, please. You may
2 call your next witness.

3 MS. MASSEY: Thank you, Your Honor. We call
4 Dr. Stuart Eads.

5 THE CLERK: Raise your right hand, please.

6 STUART EADS,
7 being first duly sworn, testified as follows:

8 THE WITNESS: I do.

9 THE CLERK: Have a seat, state your full name
10 and spell your last name, please.

11 THE WITNESS: Robert Stuart Eads -- E-A-D-S --
12 Jr.

13 DIRECT EXAMINATION

14 BY MR. PARKINSON:

15 Q. Are you a medical doctor?

16 A. Yes.

17 Q. Okay. I'm going to give you a little more
18 space.

19 Dr. Eads, before we go any further, just so the
20 jury knows, were you asked to appear as an expert on
21 behalf of Dr. Massey in this case?

22 A. Yes, I was.

23 Q. Okay. Dr. Eads, where do you live?

24 A. I live in Mount Pleasant, South Carolina, which
25 is just outside of Charleston.

1 Q. What kind of physician are you?

2 A. I'm an internal medicine physician.

3 Q. Okay. Where do you practice? What is your
4 practice setting?

5 A. I work in an office in an area just outside of
6 Charleston, a private practice office with three
7 other physicians in the office.

8 Q. Okay. And how old are you?

9 A. Forty-seven.

10 Q. And where did you go to college and medical
11 school?

12 A. I went to both at the University of Virginia.

13 Q. And after that, did you go on for additional
14 medical training?

15 A. Yes. I did a residency in internal medicine at
16 the Medical University of South Carolina in
17 Charleston. Subsequent to that I spent a year there
18 as chief medical resident and then entered private
19 practice.

20 Q. Have you been living and practicing medicine in
21 Charleston ever since you finished your training?

22 A. I have; since 1997.

23 Q. And, Doctor, are you board certified in any
24 medical specialty?

25 A. Yes. I'm board certified in internal medicine.

1 Q. And do you have any additional training or
2 experience beyond basic internal medicine?

3 A. No further specific training, no.

4 Q. In the course of your practice -- do you have
5 an office practice of internal medicine?

6 A. That is correct.

7 Q. Doctor, have you ever been involved in
8 providing medical care and treatment to nursing home
9 patients?

10 A. Yes, I have.

11 Q. Please tell the jury about that.

12 A. For many years, I think it's reflected on my CV
13 which I don't have in front of me right now, I
14 believe five or six years I was a medical director
15 at a nursing home in the Charleston area.

16 Q. And in the course of your practice, your office
17 practice of internal medicine, do you follow the
18 patients who are in the nursing home?

19 A. Yes. I continue to follow patients who may be
20 my patients in the nursing home. I don't visit the
21 nursing home at this stage in my career, but there
22 may be patients who still come to the office for
23 visits. I also still attend, work in the hospital
24 seeing patients, and it's not uncommon for me to see
25 patients in the hospital who have come from a

1 nursing home.

2 Q. And you said you didn't have a copy of your CV
3 or resumé in front of you. I've got it here. Tell
4 the jury, if that reminds you, of the years that you
5 were acting as a medical director of a nursing home.

6 A. Yes. From 1998 to 2003 I was medical director
7 of -- at the time it was called Driftwood Nursing
8 Home in Charleston.

9 Q. How many patients or patient beds did that
10 facility have?

11 A. It was over 70.

12 Q. Okay. And both in your career as that medical
13 director and in your practice outside of being the
14 medical director, have you had occasion to treat
15 patients that for one reason or another had a
16 pressure ulcer?

17 A. Yes, I have.

18 Q. And are you familiar with the standard of care
19 for physicians following patients in a nursing home
20 who have a pressure ulcer?

21 A. Yes.

22 Q. Have you reviewed the medical records of
23 Mr. Peterson while he was a patient at Trinity
24 Nursing Home?

25 A. Yes, I have.

1 Q. Based on what you reviewed in those records, do
2 you believe that you are aware of and familiar with
3 the standard of care that would be required of the
4 Edgefield Clinic, of Dr. Massey in particular, and
5 any one of the physicians providing care to
6 Mr. Peterson?

7 A. Yes, I believe I'm familiar with that.

8 Q. Okay. And in reviewing the records of
9 Mr. Peterson at Trinity Nursing Home and seeing what
10 his condition appeared to be while he was a patient
11 there, have you had, yourself, patients like
12 Mr. Peterson?

13 A. Yes, I have. I would say often, if not
14 frequently.

15 Q. Okay. And do you believe that you're familiar,
16 based on your knowledge, training and experience, to
17 express medical opinions about the type of medical
18 conditions Mr. Peterson had and the treatment he
19 received?

20 A. Yes, I do.

21 MR. PARKINSON: Your Honor, we could go
22 further, but at this time I'll tender Dr. Eads as an
23 expert in the field of internal medicine and
24 particularly the care of elderly nursing home
25 patients such as Mr. Peterson in this case.

1 MR. WELCH: No objection, Judge.

2 THE COURT: He'll be qualified in that area,
3 ladies and gentlemen.

4 BY MR. PARKINSON:

5 Q. Now, Dr. Eads, at my office's request, did you
6 agree to review certain documents in this case?

7 A. Yes, I did.

8 Q. Did you know me before my office contacted you?

9 A. Not that I recall.

10 Q. Ever reviewed a case for me or at my law firm?

11 A. I don't believe so.

12 Q. And in doing so, were you provided with the
13 records of both admissions to Trinity Nursing
14 Center?

15 A. Yes, I was.

16 Q. And did you also review records from Aiken
17 Regional Medical Center?

18 A. I did.

19 Q. Did you review records from the Select
20 Specialty Hospital in Augusta?

21 A. I did.

22 Q. And the records from Hospice?

23 A. Yes, I did.

24 Q. And the Edgefield Medical Clinic?

25 A. To the best of my recollection, yes, I did.

1 Q. And did you also review certain depositions in
2 the case?

3 A. I did review a number of depositions, yes,
4 that's correct.

5 Q. Before reviewing the depositions did you -- and
6 when you just had the medical records, did you come
7 to some opinions about the case to a reasonable
8 degree of medical certainty?

9 A. I did because I believe I had the medical
10 records before I had the depositions, as I recall.

11 Q. All right. And do you have an opinion to a
12 reasonable degree of medical certainty as to whether
13 Dr. Tami Massey met the standard of care required of
14 her in the care and treatment of William Peterson?

15 A. Yes, I do have an opinion with respect to that.

16 Q. And is -- in your opinion, did Dr. Massey meet
17 the standard of care?

18 A. Absolutely.

19 Q. Okay. Now, before we go into that in detail, I
20 want the jury to know what else you reviewed. You
21 did review depositions as well?

22 A. I did.

23 Q. Did you review the deposition of Dr. Massey?

24 A. Yes, I did.

25 Q. The deposition of Dr. Leaphart?

1 A. Yes, I did.

2 Q. The deposition of Dr. Nicholson?

3 A. I did.

4 Q. The deposition of Dr. Rainsford?

5 A. Yes, I did.

6 Q. Deposition of Dr. Gordineer?

7 A. I did.

8 Q. Did you review the deposition of various family
9 members?

10 A. Yes, I did.

11 Q. Okay. Did you review the deposition of
12 Dr. Levine or the Plaintiff's expert witness from
13 New York?

14 A. Yes, I did review that deposition.

15 Q. Was your own deposition taken --

16 A. It was.

17 Q. -- during the course of this litigation by
18 Mr. Welch?

19 A. It was.

20 Q. And did you review the depositions of various
21 personnel from Trinity Nursing Home, such as nurses,
22 physical therapists, et cetera?

23 A. That's my recollection.

24 Q. Okay. And having reviewed both the medical
25 records and all of the depositions, is it still your

1 opinion that Dr. Massey complied with and met the
2 standard of care?

3 A. Absolutely.

4 Q. Tell the jury an overview of what
5 Mr. Peterson's medical condition was from the time
6 he came in -- and I think we're really just focusing
7 on the second admission from March 22nd to May
8 15th -- what the course was and what the trajectory
9 of his medical course was there.

10 A. Sure. From the time he came in initially, it
11 was clear that he was -- I'll start with this: That
12 he was extraordinarily, severely debilitated,
13 particularly from the standpoint of his cognitive or
14 thinking function, to the point that the staff of
15 the facility administered a number of times what's
16 called a mini mental status exam.

17 And what that test is, is a test that allows us
18 to determine the level of somebody's cognitive
19 function, not how smart or intelligent they are, but
20 whether or not their brain has been damaged,
21 particularly by dementia. Most commonly, although
22 not always, that would be Alzheimer's disease.

23 It was apparent when he came in that he was
24 suffering from a severe degree of cognitive
25 disfunction or dementia. His scores on the mini

1 mental status exams range from zero to nine, and
2 anything less than 10 -- the test goes up to a score
3 of 30. And anything less than 10 is equated with
4 very severe, what I would term in my expert opinion,
5 endstage or terminal dementia.

6 So with that as a backdrop, he came in for the
7 first admission after having been in the hospital
8 with acute kidney failure, and that was treated. He
9 was admitted to the nursing facility at Trinity
10 Mission, stayed there for a short period of time
11 before developing an occurrent kidney failure and
12 high potassium levels, was transferred back out to
13 the hospital once that was recognized. And while in
14 the hospital, once again it was recognized that in
15 addition to the acute problems that had been
16 recognized at the nursing home, that he was also
17 suffering from paralysis of the legs that they
18 determined was the result of the pinching of the
19 spinal cord in the cervical region.

20 Subsequently in between the two Trinity Mission
21 Hospital stays, they elected to perform a
22 decompressive surgical procedure on the neck, which
23 I would say is a very, very aggressive procedure of
24 somebody of his age -- I believe at the time he was
25 83 -- and his cognitive malfunction or advanced

1 dementia.

2 In any case, subsequent to that he was
3 transferred back to the nursing home for further
4 rehab. Rehabilitation proved to be fruitless in his
5 case. Regardless of any interventions that were
6 undertaken, there was simply no way that -- and it
7 became apparent after he arrived that there was no
8 way he was going to recover any significant function
9 to his legs. The surgery had not proven successful
10 in fixing the problem with the paralysis of the
11 legs. That, combined with his poor mini mental
12 status exam and severe dementia, meant that his
13 longevity, his lifespan, was going to be very short,
14 you know, measured in terms of months in all
15 likelihood, no matter what interventions were or
16 weren't undertaken by anybody.

17 You know, when I talk to my patients in the
18 office, I equate a mini mental status score of less
19 than 10, with dementia that's that advanced, with a
20 terminal cancer. Dementia is not a cancer, I'm not
21 saying that; what I am saying is that once your
22 brain function is damaged to the point that you
23 can't score over a 10 -- and in fact in one case
24 Mr. Peterson scored a zero on the mini mental status
25 test -- that it's akin to having a metastatic cancer

1 in the sense that your body can't recover and even,
2 unlike cancer, there's no treatment for dementia.

3 Q. Let me pause for a minute and show you
4 something that's in the record. Exhibit 3, page 10,
5 is this what you're referring to as the mini mental
6 state exam?

7 A. That appears to be one of the tests that I
8 reviewed, yes.

9 Q. And I'll go to the last page where it's scored.
10 The total score is 9. And what does the scale say
11 if you score 15 and below?

12 A. On that paper it says absolute dementia. And I
13 would concur with that.

14 Q. Okay. And that was done by -- on March the
15 21st?

16 A. That's what it seems to reflect, yes.

17 Q. Okay. Now, go on with your explanation of his
18 course.

19 A. Well, I suppose I was just making a point that
20 once somebody has reached that state of ability, not
21 only the advanced endstage dementia, but couple that
22 with the fact that he was paralyzed, at least from
23 the waist down, it seems for the record he was able
24 to move his arms and hands to some degree, but it's
25 inevitable that once any of us are unfortunately

1 debilitated to that degree, there's no chance of
2 recovery, and eventually we're going to succumb to
3 something. Inevitably we're going to get sores.
4 And my experience and in my expert opinion is that
5 even with the best intervention, people will develop
6 bedsores once they are as debilitated as
7 Mr. Peterson was. Infections are going to happen,
8 particularly pneumonias and bladder infections,
9 especially in people like Mr. Peterson who had a
10 catheter in his penis to let urine drain out of the
11 bladder.

12 So inevitably, in this circumstance, we're all
13 going to succumb to some medical complication sooner
14 rather than later. And the family made the very
15 appropriate decision, in my opinion; same thing I
16 would have done if it was my mother or father or
17 grandparent, whoever it may be, to say that we
18 aren't going to institute any resuscitative measures
19 in the event that he were to pass away. And, in
20 addition, they decided they were not to going to
21 place any feeding tubes, either through the nose or
22 a more permanent type feeding tube through the
23 abdominal wall in the stomach, and I think those
24 were all very appropriate interventions which were
25 supported by the family and the physicians.

1 Q. And we've talked about this and you made a
2 mention of that, the do-not-resuscitate order,
3 that's page 7, and the page 6, no nasal gastric
4 tubes or gastric tubes, those are the feeding tubes
5 that you were talking about?

6 A. That's what I'm referring to. And I think it's
7 important to point out that I saw, I think, on that
8 page, it was present with each admission, not just
9 the second admission, but also the first admission
10 as well, as well as documented at least twice in the
11 physician orders that I recall.

12 Q. Okay. So there's three or four different
13 places where the do-not-resuscitate note to decision
14 is documented?

15 A. Four places that I recall from the record.

16 Q. All right. Now, Doctor, does the fact that a
17 patient -- is it relatively common for nursing home
18 patients to have a DNR, do-not-resuscitate order, on
19 their chart?

20 A. I don't know that I've counted it and can say
21 it in terms of common or uncommon because each case
22 is unique.

23 Q. Okay. But is it not infrequent?

24 A. It's not infrequent because just by definition,
25 in a nursing home there tend to be people who are

1 older, those of us who are older and more
2 debilitated, so it's not uncommon at all.

3 Q. Okay. Doctor, does do not resuscitate and do
4 not tube-feed, does that mean the same thing as do
5 not treat?

6 A. They don't mean the same thing. But, again, as
7 I alluded to a moment ago, every case has to be
8 taken on its individual merits. And facts is a
9 better term. And so it's true that you might say do
10 not resuscitate does not mean do not treat, but
11 that's a vast oversimplification. You have to take
12 each person as they are and make decisions on
13 whether or not you're going to treat them based on
14 what you think you can accomplish in helping them or
15 whether or not you think in the long run or even the
16 short run, if somebody's lifespan is very limited,
17 if you think you're going to do them more harm than
18 good by -- or perhaps just not do them any good by
19 rendering certain treatments.

20 Q. Based on your review of the records, do you
21 have an opinion as to whether reasonable and
22 appropriate treatment and care was provided to
23 Mr. Peterson at the nursing home?

24 A. I do have an opinion.

25 Q. What is that opinion?

1 A. I believe that reasonable and appropriate care
2 was given to him the entire time he was there. And
3 I believe that -- would you like me to elaborate
4 specifically?

5 Q. Yes, please.

6 A. Certainly both admissions, reasonable and good
7 care was provided to him. I will speak specifically
8 to the date that's been bandied about in some of the
9 discussion here today, that being May 15th,
10 approximately, of 2006, when the patient was sent to
11 the hospital. And my impression from the medical
12 record and even before I reviewed the depositions
13 was that the physicians felt -- and Dr. Rainsford;
14 in particular, I mention his name only because I
15 believe he was the physician with whom the nursing
16 home was in contact on the 15th. I believe that
17 their plan was that the patient, as I've described
18 previously, that their plan for this man who they
19 determined was severely demented, paralyzed and
20 suffering from, basically, a number of irreversible
21 and untreatable problems, that the best course was
22 to not resuscitate him, to not provide aggressive
23 measures like feeding tubes, and to basically -- and
24 it's difficult to say, but basically let nature take
25 its course and let God's will be done. And that's

1 not to minimize it in any way, either Mr. Peterson
2 or his life, obviously.

3 But at some point, all of us and many of my
4 patients reach that point and difficult decisions
5 have to be made like that. And I think that that
6 was the plan that had been conveyed to the
7 physicians. It was my impression from reading the
8 medical record, and I believe that was the plan that
9 they were attempting to adhere to on the 15th.

10 Q. And, Doctor, did -- in looking through the
11 patient's records, medical records, did you see any
12 indication of this patient developing sepsis at any
13 time before the May 14th-15th timeframe?

14 A. No. There's no indication at all in the
15 medical record before May 14th at the very earliest,
16 certainly nothing before May 14th that suggested
17 there was any impending, immediate problem.

18 Certainly, as I described, his prognosis was
19 extraordinarily poor in general, but there was
20 certainly nothing before May 14th-15th that would
21 indicate there was any developing sepsis, to answer
22 your specific question.

23 Q. And you saw in the records that he did have a
24 pressure ulcer on his left hip area?

25 A. Yes, I did see that.

1 Q. And based on what you reviewed and based on
2 your knowledge, training, and experience, do you
3 have an opinion as to whether reasonable and
4 appropriate care was provided for that hip wound?

5 A. I do. I believe reasonable, appropriate care
6 was provided, specifically in the sense that it's
7 documented in the record that the staff recognized
8 the need to turn the patient every two hours. The
9 physical therapists who were certified to provide
10 local wound care did that. The debriding agents
11 were used as was discussed a short time ago.

12 Really, there's not much you can do for a pressure
13 ulcer, as I alluded to previously, other than take
14 pressure off and clean the wound and hope it heals.

15 Unfortunately, when you have somebody as
16 debilitated as Mr. Peterson was, the chances that
17 that wound are going to heal are really nil.
18 Particularly -- and it's important to remember this,
19 I think: Particularly since the family decided they
20 didn't want any feeding tubes placed, meaning the
21 patient was not eating well, you're limited to what
22 you can do in terms of nutritional support by what
23 you can give the patient by mouth, which isn't much.

24 Now, I'm not going to criticize that decision.
25 In fact, I'm very supportive of that decision to not

1 place a feeding tube, because I don't think that in
2 the long run, or in this case the short run, it
3 would make any meaningful difference in his
4 lifespan, and certainly not quality of life.

5 Q. And tell us how nutritional decline has an
6 impact on a patient like this in treatment and
7 course of a pressure ulcer.

8 A. Well, a wound can't heal without nutrition.
9 Just like anything you're trying to build, you have
10 to have the building blocks to construct something.
11 And your body's building blocks -- if you've got a
12 cut or any kind of injury, your body's building
13 blocks are the proteins and sugars and other
14 nutrients and vitamins that we take in. So if you
15 have a sore, for the reasons we discussed previously
16 which were inevitable in this case, and you were not
17 able to get in the building blocks to heal that
18 sore, the sore is going to persist, it will not get
19 better.

20 Q. And was Mr. Peterson incontinent of bowel and
21 bladder?

22 A. That's my recollection, that he had a Foley
23 catheter and he was not able to control his bowels.

24 Q. And wear a brief or a diaper because of that?

25 A. He would have to, yes.

1 Q. Okay. And he was basically immobile in bed;
2 correct?

3 A. He was immobile in bed, that's correct.

4 Q. And had dementia?

5 A. Advanced dementia, as what I would describe
6 again as endstage dementia.

7 Q. Are all of those factors that would impact the
8 progress of his pressure ulcer and the progress of
9 his health in general?

10 A. Absolutely.

11 Q. Tell us why.

12 A. Well, it was simply -- without getting too
13 technical, there's simply no way that he was -- he
14 was never going to walk again. The sore was not
15 going to heal on its own, certainly without any sort
16 of nutritional supplementation. And I believe in
17 the long run it proved out it wasn't going to heal
18 on its own even with the nutritional supplementation
19 because I believe other procedures were elected to
20 be undertaken.

21 But, again, there was simply no way he was
22 going to recover in the long run and have any
23 meaningful quality of life given the state he was in
24 at Trinity Mission.

25 Q. Now, Doctor, we've heard some mention made of

1 the use of telephone orders going back and forth
2 between the nursing staff and the doctors at the
3 clinic, either by direct phone calls or by faxing of
4 orders to be seen by the doctors. Do you have an
5 opinion about whether that -- in this case with
6 Mr. Peterson, that that was a reasonable method of
7 providing care to the patient that was within the
8 standard of care?

9 A. Yes, I believe it was. That's what I did in my
10 office with my patients and I still do it with the
11 hospital or residential facilities or wherever my
12 patients may be.

13 Q. And that was within the standard of care?

14 A. Yes, it was.

15 Q. Now, Dr. Levine, the Plaintiff's expert, when
16 he was here yesterday, spoke about his opinions as
17 it relates to diagnosis and treatment of an
18 infection. And, Doctor, do you have -- and he was
19 critical of those actions by the doctors. Do you
20 have opinions on the subject of diagnosis and
21 treatment of the infection in this case?

22 A. Are you speaking specifically about the
23 question of infection in the hip wound?

24 Q. Yes, sir.

25 A. Well, in reviewing these specific records --

1 and again. I'm going to speak specifically about
2 this case, not in general. And every case has to be
3 taken based on its facts. An infection is best
4 diagnosed, especially in this circumstance, by what
5 you see, what the nurses see, what the staff sees,
6 and whether or not they believe there could be an
7 infection present. This question of a culture and
8 whether or not a culture should or should not be
9 treated in this case is a very difficult one to
10 answer because we all have bacteria. If we just
11 swab the skin of everyone in this room and sent it
12 down to the lab, everybody would grow out some
13 bacteria. Some of us would probably even grow out
14 MRSA because it's very common. There's nothing
15 magical about MRSA. All MRSA is is a staphylococcus
16 bacteria which is incredibly common on our skin.
17 The MR in that staphylococcus aureus just stands for
18 methicillin resistant, just means that it's
19 basically the same staph that's everywhere, it's
20 just the one that's resistant to penicillin
21 antibiotics.

22 So with that said, that MRSA organism and staph
23 in general is very common in hospitals and nursing
24 homes and, as I said, some of us here probably have
25 it on our skin. That doesn't mean we're infected.

1 You have to look at a site and a spot to determine
2 whether it's infected or not. So, in other words,
3 if you take somebody like Mr. Peterson in a nursing
4 home who's got a sore and you swab the sore, the
5 ulcer, I would be quite surprised if it didn't grow
6 something out, because he's incontinent of his
7 bowels. So sometimes you're going to get bacteria
8 that are on the skin or maybe some bacteria in or
9 near a wound and you're going to have staph, so it's
10 not unexpected that there's going to be growth in a
11 culture that's sent out to a lab. And it doesn't
12 necessarily mean that there's an infection present.

13 Q. Now, Doctor, you mentioned looking at it.
14 We've heard reference to the term medical staff -- I
15 mean, nursing staff, physical therapists being the
16 eyes and ears of the doctor in the facility. Do you
17 agree with that title and that assignment of
18 responsibility?

19 A. I think that's a fair way to put it, yes.

20 Q. And as the doctor in your office, does -- is it
21 reasonable and appropriate to rely on trained
22 physical therapists trained in wound care and wound
23 care nurses to be evaluating those wounds and
24 reporting to the doctor?

25 A. Absolutely. I rely on it daily.

1 Q. Do those people actually know more about wound
2 care than you do as an internal medical physician?

3 A. In terms of the minute-to-minute, day-to-day
4 care of a wound, we may have medical degrees, but
5 that doesn't necessarily make us the ultimate
6 experts in things like debridement of a wound or
7 speech therapy or physical therapy. You know, we
8 may ask those people to perform those jobs for us
9 and provide their expertise. That doesn't mean
10 we're the ultimate experts in those fields. And so
11 we rely very heavily on those healthcare providers,
12 as you described, and the information they provide
13 us and the care they provide, yes.

14 Q. We'd sent you the records that Dr. Nicholson
15 ordered a culture of the left hip wound on May 7th.
16 Did you see that?

17 A. Yes, I did.

18 Q. And did you also see in the records and
19 understand from the testimony -- were you in the
20 courtroom when Dr. Massey testified?

21 A. I was.

22 Q. Did you listen to that testimony?

23 A. I did.

24 Q. And I believe there was testimony about the
25 results of that culture coming back to the doctors'

1 office around the 9th or 10th of May after being
2 ordered on May the 2nd. Did you see, from May the
3 2nd or May the 9th and 10th up to the 15th of May,
4 any indication that the nursing home personnel
5 reported any changes or decline in the wound to the
6 doctors?

7 A. I didn't see any indication of that, nor did I
8 see any indication in the medical record that there
9 was a change in the wound, deterioration with
10 respect to the wound. I certainly didn't see any
11 indication that Dr. Massey was given any keys or
12 what you might call sort of a cue to act any
13 differently than she did. She acted appropriately
14 and in keeping with the medical standard of care, to
15 use a medical term. But she acted appropriately
16 with the information she had at her disposal. None
17 of us can act any way except as we can with the
18 information we have. We don't have a crystal ball
19 or a way to know magically what's going on
20 somewhere. So we have to use information that's
21 provided.

22 Q. Did you see in the record that from earlier in
23 the patient's stay at Trinity, around March 30th or
24 so, that Dr. Massey had ordered some lab studies and
25 they had been resulted and sent back to her?

1 A. Yes, I did see that.

2 Q. And she ordered Levaquin, an antibiotic, in
3 connection with that?

4 A. Yes.

5 Q. In this case, the physician who ordered the lab
6 culture was Dr. Nicholson -- the ordering physician
7 was Dr. Nicholson.

8 A. You mean on the -- what we know to be the hip
9 wound culture?

10 Q. Yes.

11 A. Yes.

12 Q. And there's been some testimony that when
13 Dr. Massey saw that on her desk on May 9th or 10th,
14 that she initially, you know, passed it on to
15 Dr. Nicholson --

16 MR. WELCH: Your Honor, I object. She didn't
17 testify she passed it on to Dr. Nicholson. She said
18 she didn't know who she passed it on to.

19 THE COURT: Overruled.

20 BY MR. PARKINSON:

21 Q. Dr. Massey, having found the lab result on her
22 desk on May 9th or 10th, initialed it, but passed it
23 along to another physician in her practice who had
24 ordered the culture. Is that reasonable and
25 appropriate in the standard of care?

1 A. It is. And, honestly, I'd say I do that every
2 day. Virtually every day something that maybe
3 belongs -- in terms of who needs to act on it, one
4 of my partners, I mean, it ends up on a pile on my
5 desk, a stack of results, or now that we're on
6 electronic medical records, it comes up on the
7 screen.

8 But I agree with the way she put it. It's just
9 my standard practice, my customary practice in that
10 case is to go down the hall and say, here, this came
11 in on your patient. So, yes, it's perfectly
12 appropriate.

13 Q. And in your opinion, did the fact that
14 Dr. Massey may have seen that lab report on May 9th
15 or 10th require a call to action on her part other
16 than passing it to the ordering physician?

17 A. No.

18 Q. And was that within the standard of care to
19 pass it along to the ordering physician?

20 A. Absolutely. I do it every day.

21 Q. Now, tell the jury and explain this in a little
22 bit more detail, if appropriate, why you say based
23 on your review that the patient did not develop any
24 signs or symptoms of sepsis until right in the last
25 18 hours or so before he was sent to the hospital.

1 A. Well, the patient's -- the things we look
2 for -- sepsis means not just that you have an
3 infection somewhere, but that it's entered the body
4 and got into the bloodstream. And things that we
5 commonly see with sepsis are high temperature, low
6 blood pressure. Those are the two primary things.
7 And neither of those were present leading up to the
8 day that Mr. Peterson went to the hospital.
9 Temperature was normal until 18 hours or so before,
10 at best, blood pressure was normal. And so there
11 was no -- again, to get back to what I said earlier,
12 there was no sign or signal or symptom, not only
13 that the doctors didn't know about, but nothing in
14 the medical record that the nurses should have acted
15 on any differently.

16 Q. If someone is developing a systemic bacteremia
17 or sepsis, what do you expect -- what is the typical
18 change in vital signs as far as heart rate, blood
19 pressure, respirations is concerned?

20 A. Well, usually the heart rate -- speaking
21 specifically about vital signs, usually the heart
22 rate will go up, respiratory rate will go up or
23 you'll breathe faster, blood pressure will
24 frequently drop, and temperature can go up or down,
25 either one.

1 Q. Okay. And did any of those things happen in a
2 pattern to suggest sepsis before the last 18 to 24
3 hours he was in the nursing home?

4 A. No, they did not.

5 Q. And did they remain stable?

6 A. They did, until that last 24 hours or so.

7 Q. Were they in a relatively normal range?

8 A. They were as I recall.

9 Q. Okay. Now Dr. Levine, the Plaintiff's expert,
10 talked about four different ways that he thought
11 there was a violation of the standard of care. Two
12 of them related to the diagnosing and treating the
13 infection. One of them also was in not transferring
14 the patient to the hospital.

15 Do you have an opinion about whether the
16 standard of care required Dr. Massey to take action
17 to transfer this man to the hospital?

18 A. There's no way -- even if one were to argue
19 that it were indicated, which I think could be
20 debated as well, based on the total clinical
21 picture, there's no way that Dr. Massey could have
22 been involved because she was completely not
23 involved in that decision-making process, had no
24 knowledge of it, was not notified of it, was not any
25 part of it. And that's not to say she should have

1 been. It looks like appropriate calls were made,
2 appropriate contact was made, and none of those
3 required Dr. Massey to perform.

4 Q. The last thing that I wanted to ask you about
5 that was mentioned by Dr. Levine was in not
6 examining the patient when he was getting worse. Do
7 you have an opinion to a reasonable degree of
8 medical certainty regarding Dr. Massey and whether
9 she met the standard of care regarding examination
10 of the patient?

11 A. She absolutely did meet the standard of care
12 because there's no way you can act on something you
13 don't know about.

14 Q. Did you see anything in the record that the
15 nurse or any -- or depositions either -- that anyone
16 in the nursing home ever attempted to reach
17 Dr. Massey to request that she come to the nursing
18 home regarding the hip wound?

19 A. No, I saw nothing to that effect. I would
20 describe all of Dr. Massey's interaction with the
21 nursing home in terms of Mr. Peterson as incidental.
22 The one instance in which it was not incidental was
23 pertaining to a urinary infection that the patient
24 had. And she acted appropriately, ordered all the
25 appropriate tests, ordered the appropriate MRI to

1 treat the urinary infection. And that problem,
2 based on the record clinically, vital signs, et
3 cetera, all other contact was incidental, didn't
4 warrant any, quote, call to action or anything of
5 that nature.

6 Q. So, Doctor, in your opinion, did Dr. Tami
7 Massey comply with the standard of care required of
8 a physician in her position and situation as it
9 relates to a patient like Mr. Peterson?

10 A. She absolutely did. I would not have acted any
11 differently than she did.

12 Q. Did she meet the standard of care?

13 A. She did meet the standard of care in this case.

14 Q. Did anything that Dr. Massey did or did not do
15 contribute to any adverse outcome of this patient?

16 A. Absolutely not.

17 MR. PARKINSON: That's all the questions I
18 have.

19 THE COURT: Mr. Nance.

20 CROSS-EXAMINATION

21 BY MR. NANCE:

22 Q. One thing. I thought I heard you say if a
23 doctor didn't know about a particular situation they
24 could not violate the standard of care. Is that
25 correct?

1 A. I think that's a fair characterization, yes.

2 Q. Thank you.

3 MR. WELCH: Thank you, Judge.

4 THE COURT: All right. Go ahead.

5 CROSS-EXAMINATION

6 BY MR. WELCH:

7 Q. Do you have the deposition there?

8 A. I have my deposition, yes.

9 Q. Doctor, you say that diagnosing the infection
10 by what the nurses see, by what the physical
11 therapist sees; is that what you said?

12 A. I don't quite understand your characterization.

13 Q. This is the answer you gave Mr. Parkinson about
14 failure to diagnose this infection, that you would
15 have to go by what the nurses see and physical
16 therapist sees because they're your eyes and ears.

17 A. I didn't say you have to, I said you can.

18 Q. That's my point. Isn't it important for a
19 doctor at some point in time to examine a wound?

20 A. It depends on the clinical circumstances and
21 how comfortable you are with the staff that you work
22 with. It sounds to me like the Edgefield Clinic was
23 very well-acquainted with and had a good
24 relationship with and, more importantly, had trust
25 and faith in the clinical abilities of the staff at

1 Trinity Mission.

2 Q. So you don't have a problem in this case that
3 none of the doctors saw the wound at all?

4 A. I didn't see a specific point in time that I
5 felt that wound evaluation was indicated by the
6 physician.

7 Q. Okay. If Dr. Massey had chosen to -- and I
8 understand your opinion. But if Dr. Massey had
9 chosen to -- on the day that she got the lab report,
10 to go over and examine that wound, she could have
11 done that, couldn't she?

12 A. I'm not sure she could have because I'm not
13 sure, based on her testimony, unless you can show me
14 otherwise, that she knew even at that time that the
15 culture came from a wound or where it came from.

16 Q. Well, Doctor, you agree that she testified --
17 you were here for her testimony -- that the patients
18 in the nursing home, all the doctors in the
19 practice, could see him; correct?

20 A. I believe in the general sense they have
21 privileges there so they can see patients in the
22 nursing home.

23 Q. But you didn't hear the testimony that all the
24 doctors -- that these patients didn't have just one
25 doctor in the practice; that all the doctors saw all

1 the patients, depending upon their day or their call
2 week? You heard that from her testimony. Weren't
3 you here for that?

4 A. They could see them if they felt there was a
5 reason to. Yes.

6 Q. And if she felt there was a reason to though,
7 she could go see that patient, look at the chart and
8 examine the wound, couldn't she?

9 A. I think so, yes.

10 Q. Now, Doctor, you told the jury here that
11 sometimes you need to let God's will be done.

12 A. That's what I said, that's correct.

13 Q. And I believe you've also said that if the
14 patient had not been taken out -- not today, but in
15 your deposition, if the patient had not been taken
16 out, he probably would have died within a day or
17 two?

18 A. I believe that to be the case, yes.

19 Q. And you -- so is it your opinion that the
20 reasonable thing here would have been to let him
21 stay in the nursing home and let God's will be done
22 at that time?

23 A. It's much more complicated than you're trying
24 to make it sound. What we have here is the context
25 in which the patient's family say they didn't want

1 Mr. Peterson resuscitated but they did not want
2 feeding tubes placed, and his nutritional state was
3 such that there was no way he was going to get
4 better from bed sore, sepsis, or anything, unless he
5 got some sort of feeding tube or more nutrition. So
6 given that context, and as I said, the family had
7 signed off twice in the nursing home that they
8 didn't want any of that support provided; given that
9 context, there was no benefit at all to Mr. Peterson
10 in taking him out of the hospital.

11 Now, if you take him out of the hospital and
12 you change all the rules, which seems to be what
13 happened, then all bets are off. Not all bets are
14 off, he's still not going to live very long as is
15 proven out here, but given the rules that were in
16 place from the family for the physicians on May
17 15th, there's nothing different that they should
18 have done.

19 Q. Well, the rules in place on May 15th said the
20 family wanted him to have antibiotics. You're aware
21 of that?

22 A. Again, you're oversimplifying it. I wouldn't
23 give somebody antibiotics if I didn't feel that
24 giving them antibiotics for a week was going to make
25 a difference. And giving Mr. Peterson antibiotics

1 and not nutritional support made zero difference in
2 his outcome; he still would have died within days.

3 Q. My question is, you're aware of the fact that
4 the DNR said that they did want their father to have
5 antibiotics; you're aware of that?

6 A. Again, you're oversimplifying what you're
7 saying, because that doesn't mean that as a doctor,
8 we're obligated to say, well, this person is about
9 to die from a stroke, but they have a urinary
10 infection, so we're going to give them antibiotics.
11 We would not do that. We would not give antibiotics
12 to a patient if we don't think the antibiotics are
13 going to make a difference, if there are other
14 things we can do, whether it's because there's just
15 no medical means to do it or because there's no
16 other limitations that are imposed on us.

17 THE COURT: Rephrase the question, re-ask the
18 question.

19 BY MR. WELCH:

20 Q. Doctor, my question is simply: On the DNR that
21 was signed both times -- simple question -- the
22 family clearly checked the blank that says I do want
23 the patient to receive IV fluids. And they said, I
24 do want to receive IV antibiotics.

25 A. Yes --

1 Q. That was their choice; right?

2 A. Those are initialed. And you have to take them
3 out of the context I just elaborated on.

4 Q. I'm not asking what the doctors were ordered.
5 But that was their desire; correct? Doctor, you
6 agree that you looked at the records of Aiken
7 Hospital; correct?

8 A. I did.

9 Q. And you agree that when he got to the Aiken
10 Hospital, he got some wound debridement, he got some
11 treatment there, got some antibiotics, he got
12 better, and before he went to Augusta, he was
13 actually talking to the doctors in complete
14 sentences?

15 A. I don't recall the record specifically, but if
16 it's in there, I won't dispute it.

17 Q. And so he got well enough going to the hospital
18 to now have conversations with the doctors and know
19 his family?

20 A. If that's in the record, I don't dispute that.

21 Q. But it's your opinion that God's will should
22 have been done, and he passed the 15th or 16th?

23 A. I think my opinion is bore out by the fact that
24 in spite of all the measures that are undertaken,
25 not many months later he was in Hospice care.

1 Q. And, Doctor, you said he was never going to
2 walk again, had some dementia. You agree that was
3 the condition he was in?

4 A. That's correct.

5 Q. And you said he had no meaningful quality of
6 life?

7 A. I don't think I said he had no meaningful
8 quality of life. I think I said that -- or I'll say
9 now, that the chances for a -- the limited amount of
10 time he had left to live, regardless of
11 interventions which were undertaken which is
12 measured, even with the most aggressive
13 interventions in terms of months, that quality of
14 life would be very limited.

15 Q. Well, I took the notes down when you said
16 meaningful quality of life. Whose decision is the
17 quality of life? Who makes that decision about what
18 our quality of life is? Is that your decision as
19 the doctor?

20 A. Part of it. I wouldn't say it's my decision,
21 but certainly it's my role based on experience and
22 what I've seen with different diseases and prognoses
23 and outcomes and degree of recuperative potential
24 that I give patients and their families,
25 particularly their families in this case, advice.

1 Q. Well, Doctor, on the 15th when they took him
2 over to Aiken, page 31 of Exhibit 5 says that the
3 decubiti, necrotic with gangrenous changes as well
4 as puerile material. That's infection, isn't it?

5 A. Not necessarily. It's possible that there's
6 infection there, but there could be gangrene without
7 infection. Gangrene is not necessarily infection.

8 Q. And you agree that on the 15th when they got
9 him there, he had sepsis with MRSA, urinary tract
10 infection with MRSA, sacral cubital ulcers infected,
11 right kidney complex cyst assumed infected. That
12 was the condition he was in when he got into the
13 hospital on the 15th; correct?

14 A. If that's what the record reflects.

15 Q. That's what the record reflects. And on the
16 day they got him to the hospital, this is his hip
17 wound. And you've seen this picture before, haven't
18 you?

19 A. I have.

20 Q. So you would agree with me this is the
21 condition he was in when he left the nursing home;
22 correct?

23 A. In all likelihood, but there's no way to tell
24 how long it appeared that way.

25 Q. So it's possible, in your opinion, that from

1 3:00 or 4:00 when they left the nursing home until
2 they took the picture on the 16th, that it could
3 have gotten a lot worse?

4 A. No. My opinion is that in the 24 or so hours
5 before he was transferred out it could have gotten a
6 lot worse.

7 Q. So, Doctor, your opinion is nobody did anything
8 wrong here, God's will be done, leave him there, he
9 doesn't have a good quality of life, don't give him
10 any antibiotics like they did at Aiken and don't get
11 the family three more months with him; is that
12 right?

13 A. No. You're mischaracterizing what I said.
14 What I said was that the rules that were given to
15 the doctors at the nursing home limited their
16 ability to resuscitate. And more importantly, given
17 the instructions preventing them from providing
18 any -- not preventing them from providing, but
19 stating that they -- the family did not want any
20 supplementing feeding. You're mischaracterizing
21 what I said in the sense that I'm not saying that
22 the doctors should have said let God's will be done.
23 My interpretation is that based on the instructions
24 given to the doctors by the family, that there were
25 no other options for him. In other words, if you're

1 going to move him to another facility and change the
2 rules as I said, and say let's put in a feeding
3 tube, then it's a different game, the rules are
4 different.

5 But in the context under which the doctors at
6 the nursing home were operating, my impression was
7 that the instructions that had been given by the
8 family were that if he became severely ill, that
9 God's will should be done. So that's a better
10 characterization of what I'm saying than how you put
11 it.

12 Q. Doctor, you -- at Aiken when he was talking to
13 the doctors, making complete sense, talking to his
14 family, being with them, he didn't have a feeding
15 tube, did he?

16 A. I don't recall specifically, but he may not
17 have.

18 Q. No, he didn't. He didn't have a feeding tube
19 until the third week of June over at Select
20 Hospital. In fact, they got to see their dad and
21 talk to him for a few more months, didn't they?

22 A. Yes. And that also included the feeding tube.

23 I'll also point out that you're using the
24 benefit of hindsight to make that statement to me,
25 which we don't have as physicians. We have to act

1 in the moment. We don't have the benefit
2 of hindsight. At the time, on May 15th, nobody
3 could predict the future. Now, if you want to say
4 we should be able to predict the future, that's
5 going to make it really hard for me and all of the
6 doctors to practice medicine.

7 Q. Doctor, it's kind of hard to predict the future
8 if you've never seen the wound, isn't it?

9 A. Well, I don't think you can predict the future
10 whether you have or haven't seen the wound. That
11 doesn't make any sense.

12 Q. Well, if you've never seen the wound, you don't
13 know anything about it, do you? You can't predict
14 the future if you've never seen it, can you, Doctor?

15 A. Nobody can predict the future no matter what.

16 THE COURT: All right. Redirect, if any?

17 REDIRECT EXAMINATION

18 BY MR. PARKINSON:

19 Q. Dr. Eads, medical science exists so that life
20 can be extended?

21 A. That's correct.

22 Q. And certain interventions were done at Aiken
23 that did extend his living days; is that correct?

24 A. That's correct.

25 Q. While he was there, did he have a gastric tube

1 placed?

2 MR. WELCH: I object, Your Honor. At Aiken?

3 MR. PARKINSON: I'm asking the question and
4 you're objecting before he answers. I just asked
5 whether he had a feeding tube.

6 THE WITNESS: I don't recall right now exactly
7 where the feeding tube was. I defer to the record
8 for that. And I'm happy to defer to the record.

9 BY MR. PARKINSON:

10 Q. He had a feeding tube and he had IV
11 antibiotics. And they actually opened a hole in his
12 abdomen and put a tube into his stomach to provide
13 liquid nutrition to him, didn't they?

14 A. That's what a feeding tube is. Yes.

15 Q. And he had a colonoscopy done while he was
16 there; correct?

17 A. That's correct.

18 Q. And bronchoscopy done where they put a big old
19 tube into his trachea and into his lungs; correct?

20 A. That's correct.

21 Q. And he had a number of other interventions done
22 that were not in play while he was at the Trinity
23 Nursing Home; correct?

24 A. That was correct. I was quite surprised that
25 they were that aggressive.

1 Q. Is that what you meant by changing the rules?

2 A. It is.

3 THE COURT: You may step down.

4 MR. WELCH: Judge, based on that, I should be
5 able --

6 THE COURT: Step down. I feed everybody out of
7 the same spoon.

8 All right, it's 1:00. I'll see everybody back
9 at 2:30. Don't discuss the case, don't deliberate,
10 and we'll see you back at 2:30.

11 (The jury exits the courtroom at 1:00 PM.)

12 THE COURT: Is there anything for the record
13 before we break for lunch?

14 MR. WELCH: Nothing from the plaintiff, Judge.

15 MR. PARKINSON: Your Honor, we'd ask that
16 Dr. Eads be excused since his testimony is
17 concluded. I just don't want to send him on his way
18 without the Court knowing that.

19 THE COURT: Any objection?

20 MR. WELCH: No, sir, Judge.

21 MR. PARKINSON: Thank you, Your Honor.

22 THE COURT: We'll stand at ease until 2:30.

23 (A luncheon recess transpired.)

24 THE COURT: Anything for the record before we
25 start back?

1 MR. WELCH: Nothing from the plaintiff, Judge.

2 MR. PARKINSON: I'm not going to have more
3 witnesses. I'll say on the record that I've
4 completed my case. But I'm done with my witnesses,
5 just so you know.

6 THE COURT: Mr. Nance?

7 MR. NANCE: I'm ready.

8 (The jury enters the courtroom at 2:45 PM.)

9 THE COURT: Mr. Nance, you may call your first
10 witness.

11 MR. NANCE: We'd call Dr. Eleanor Leaphart.

12 THE CLERK: Raise your right hand.

13 ELEANOR LEAPHART

14 being first duly sworn, testified as follows:

15 THE WITNESS: I do.

16 THE CLERK: Have a seat, state your full name
17 and spell your last name, please.

18 THE WITNESS: Eleanor Reese Leaphart,

19 L-E-A-P-H-A-R-T.

20 DIRECT EXAMINATION

21 BY MR. NANCE:

22 Q. How are you doing today?

23 A. Okay.

24 Q. Good. I can hear you back here, that's what I
25 want to be sure about.

1 A. Yes, sir.

2 Q. Tell the jury something about yourself. Where
3 do you live?

4 A. I live in Gilbert, South Carolina.

5 Q. And where are you originally from?

6 A. Here, Edgefield.

7 Q. Did you grow up here?

8 A. Yes. I went to high school here.

9 Q. All right. That's the next thing. Tell them
10 what your education, experience, and training is,
11 beginning high school through today.

12 A. I graduated here in '92 from Strom Thurmond
13 High School. I then went to College of Charleston,
14 and that was '92 to '96. And then I went to medical
15 school at MUSC in Charleston, which was '96 to 2000.
16 And then I did my residency in Greenwood, so that
17 was three years, 2003.

18 Q. When you finished your residency, where did you
19 go?

20 A. When I finished my residency, I came here.

21 Q. Here where?

22 A. I'm sorry. The Edgefield Medical Clinic.

23 Q. Are you still employed at the Edgefield Medical
24 Clinic?

25 A. No, sir. Approximately four years ago, my

1 husband got a job in another part of the state and
2 we decided to go with him, my family.

3 Q. What does he do?

4 A. He's the head football coach at Swansea High
5 School.

6 Q. Where are you now employed?

7 A. Batesburg. Lexington Medical Center,
8 Batesburg-Leesville.

9 Q. And is that a part of the Lexington Hospital
10 system?

11 A. Yes, sir. I practice family practice, but it's
12 part of the Lexington Hospital system.

13 Q. During what period of time were you employed at
14 the Edgefield Medical Clinic?

15 A. Approximately 2003 to 2010.

16 Q. During that period of time, did you, so to
17 speak, come in contact with, issue orders with,
18 receive orders from, or have some conversation about
19 Mr. William Peterson?

20 A. Yes, I did.

21 Q. And did you issue some orders, sign some orders
22 pertaining to him?

23 A. Yes, I did.

24 Q. Do you know when the first one was dated?

25 A. I believe it was March 30th.

1 Q. 2006?

2 A. I'm so sorry. 2006, yes.

3 Q. What about the last one?

4 A. I know it was in April of 2006. I'm sorry. I
5 don't have the exact date.

6 Q. Let me ask you this -- I'm not going to go
7 through all of your orders. I think we've seen
8 enough of them so far. But did you have any
9 contact, obtain any information about, or from
10 anyone, pertaining to Mr. Peterson during May of
11 2006?

12 A. No, I did not.

13 Q. Did you ever know during May of 2006 about this
14 culture coming back with a MRSA colonization on it?

15 A. No, I did not.

16 Q. Did anyone from the nursing home call you or
17 contact you and tell you about this MRSA situation?

18 A. No.

19 Q. Were you ever requested to come over there and
20 look at it during May of 2006?

21 A. No.

22 Q. How do you treat -- what do you do in regards
23 to a MRSA colonization that someone such as
24 Mr. Peterson had?

25 A. I think the answer to that is you -- you're not

1 going to treat the -- these are dirty wounds.
2 They're in the nursing home, these are going to be
3 dirty wounds, meaning they have bacteria. And the
4 point is, until that becomes systemic, until that
5 person shows you that they're becoming sick by way
6 of a lower blood pressure, low temperature or
7 hypothermia, or an elevated temperature, you're not
8 automatically going to put this person on -- or
9 you're not going to automatically treat this culture
10 until you have evidence of a systemic infection.

11 Q. Have you looked at the records pertaining to
12 Mr. Peterson and the last few days he was at Trinity
13 Mission?

14 A. Yes.

15 Q. Between, well, May the 2nd and May the 14th of
16 2006, was there ever any indication that the MRSA
17 may be becoming systemic?

18 A. No.

19 Q. Was the MRSA, in fact, treatable before May
20 15th, 2006, based upon the clinical --

21 A. Based upon what I've seen, there was no
22 indication for treating this infection, this
23 culture. He was being treated. He was having
24 physical therapy address his wounds so he was --
25 there was treatment.

1 THE COURT: Hold on a second.

2 Everybody okay on the jury?

3 BY MR. NANCE:

4 Q. Was the treatment by the personnel at Edgefield
5 Medical Clinic as it pertains to the MRSA
6 colonization bacteria properly within the standard
7 of care?

8 A. Yes.

9 Q. Could anything else have been done for
10 Mr. Peterson that would have improved his overall
11 health situation while he was at Trinity Mission?

12 A. No.

13 MR. NANCE: Thank you. That's all of the
14 questions I have. Answer any questions Mr. Welch
15 may have.

16 MR. WELCH: Thank you, Judge. If I could have
17 just one second.

18 THE COURT: Certainly.

19 CROSS-EXAMINATION

20 BY MR. WELCH:

21 Q. Doctor, would you agree with me that
22 Mr. Peterson was in the nursing home because he
23 needed skilled nursing care?

24 A. Yes, I do.

25 Q. In fact, you agree to take on patients in a

1 nursing home and many of those patients do have
2 needs like mental issues; correct?

3 A. Yes.

4 Q. Problems with nutrition?

5 A. Yes.

6 Q. Kind of things that he had, you know that when
7 you agree to become their doctor, don't you?

8 A. Yes.

9 Q. In fact, with Mr. Peterson, we're going to go
10 to page 30 of the record, Exhibit 3, page 30.

11 Now, if we look at this page 30, this is the
12 order that I think you signed off on on 4/20, it's
13 the middle one.

14 A. Yes. That's my handwriting.

15 Q. And it says: Discontinue order for Neosporin
16 BID Q shift. And you signed off on that one;
17 correct?

18 A. I did.

19 Q. And that was April the 20th; right?

20 A. Yes.

21 Q. Did you see the patient?

22 A. No, not to change Neosporin to be given, change
23 from twice a day to three times a day. No.

24 Q. And if we look at page 36 of that same record,
25 which would be the history and physical that you had

1 been asked about earlier, that's dated April 14th,
2 2006. And, Doctor, when you went through this
3 history and physical that we have here -- I can get
4 you a copy.

5 A. I think I can see it, sir. I can see it now
6 that it's bigger. I couldn't see it before.

7 Q. When you did this history and physical, I think
8 it's on the -- it's dated, it says, the 17th, AM,
9 and then it says 4/14 below that. Do you know why
10 the two dates?

11 A. Okay. I see the 4/14. I'm so sorry. Can you
12 tell me where the 4/17 is? I just can't -- I'm sure
13 it has a date. I would dictate it and then
14 Ms. Webby [phonetic] would type it for us. That may
15 be the difference. Is there a page number?

16 Q. Page 36 at the bottom.

17 A. Okay.

18 Q. You got it.

19 A. Again, this says 4/14 and then it says 4/17 at
20 the top. I'm going to assume that would be when she
21 took my dictation off of the Dictaphone. That's --

22 Q. Okay. But here in mid-April, you were his
23 physician?

24 A. I did -- I went to evaluate him, yes.

25 Q. And you went through this history and physical.

1 And then if we go to page 30, that same record --
2 excuse me, I'm sorry. Yes, page 30. If we look at
3 that top block on page 30, it also has your name in
4 that top block there, doesn't it?

5 A. It does.

6 Q. And you signed off on that?

7 A. I did, for Dr. Anderson.

8 Q. Read that, please.

9 A. Change Foley on 4/20/06. Then Q 4 weeks.
10 Neosporin to penis sore BID until resolved.

11 Q. Is that actually your handwriting?

12 A. That is not my handwriting.

13 Q. And is that one of the ones that was called in
14 by somebody else?

15 A. Again, this was per Dr. Anderson the urologist,
16 yes. And then I signed for Dr. Anderson because
17 he's the urologist who gave that order. But he does
18 not come to Edgefield.

19 Q. But you signed for his physician?

20 A. I signed for Dr. Anderson, yes; for this order
21 for this patient, yes.

22 Q. But you signed as Dr. Peterson's physician?

23 A. Yes.

24 Q. And did you examine him that day?

25 A. 4/19, no, I did not. Again, this was per

1 Dr. Anderson and I agreed with the order.

2 Q. If you look at page 90 in that book.

3 A. 90?

4 Q. Yes, ma'am, nine, zero.

5 It says physical therapy date of treatment. Do

6 you see that?

7 A. Yes, sir.

8 Q. Do you see that bottom row there, the testimony

9 as to the days debridement were done on these

10 wounds?

11 A. Yes.

12 Q. And you'll see on the 20th, they're debriding

13 his wounds.

14 A. I see that, yes.

15 Q. And some of these orders were signed on April

16 20th?

17 A. Yes.

18 Q. But did you look at the wound?

19 A. No, not on April 20th. But I do want to say,

20 again, the physical therapist was caring for this

21 wound and we know that our staff at Trinity Nursing

22 Home is very good and we respect what the physical

23 therapist tells us about these wounds and advises

24 us, because, again, they're there every day, the

25 physical therapist, the wound care nurse, the

1 nursing staff.

2 Q. Let's go to page 34. And the middle one there?

3 A. Yes.

4 Q. That's dated 5/23. But it says: Discontinued
5 physical therapy effective 5/15. Is that correct?

6 A. Yes, it does.

7 Q. And you signed off on that as Mr. Peterson's
8 physician, didn't you?

9 A. On that day, yes, I did.

10 Q. But during this time that you were his
11 physician, you never checked the wound?

12 A. Again, I relied on the staff who was following
13 these wounds, the wound care nurse, the physical
14 therapist. And, yes, I do respect what they have to
15 say and take into consideration what they have to
16 say. And I did look at the patient on 4/14 and
17 evaluated him then.

18 Q. But you didn't look at his wounds, did you?

19 A. It's not -- I did not put that in my dictation.

20 Q. And, ma'am, are you -- do you -- is it your
21 opinion that the nurses and the physical therapists
22 were not negligent at all in this case? Do you
23 approve of how they treated Mr. Peterson?

24 A. Yes.

25 Q. Did you see the pictures of what he looked like

1 on the 15th?

2 A. Yes, I did.

3 Q. And to you, that's proper care?

4 A. I know it was proper care because we did
5 everything we could to prevent that from occurring.

6 Q. Did you give him any antibiotics?

7 A. I didn't think they were indicated at that
8 time.

9 MR. WELCH: I don't have any further questions.

10 MR. PARKINSON: No questions, Judge.

11 MR. NANCE: Nothing further, Your Honor.

12 THE COURT: You may step down.

13 Call your next witness.

14 MR. NANCE: We call Dr. George Rainsford.

15 GEORGE RAINSFORD

16 being first duly sworn, testified as follows:

17 THE WITNESS: I do.

18 THE CLERK: Have a seat, state your full name,
19 and spell your last, please.

20 THE WITNESS: George Rainsford,

21 R-A-I-N-S-F-O-R-D.

22 DIRECT EXAMINATION

23 BY MR. NANCE:

24 Q. So far you're doing pretty good. I was worried
25 about you. Be sure to speak up, use that

1 microphone.

2 A. Yes, sir.

3 Q. Dr. Rainsford, where do you reside?

4 A. 709 Buncombe Street, Edgefield.

5 Q. And where do you work?

6 A. The Edgefield Medical Clinic, PA, Edgefield.

7 Q. What type of business entity is Edgefield
8 Medical Clinic, PA?

9 A. A professional association.

10 Q. In 2006 was it a professional association?

11 A. That's correct.

12 Q. And were you a stockholder?

13 A. That's correct.

14 Q. Are you still a stockholder?

15 A. Yes, sir.

16 Q. At that time was Dr. Nicholson a stockholder?

17 A. He was. Well, there was a buyout. I'm not
18 sure in 2006. He may not have been at that time.
19 He probably was still in 2006.

20 Q. As far as you know?

21 A. As far as I know.

22 Q. What about Dr. Leaphart?

23 A. She was.

24 Q. And Dr. Massey?

25 A. She was.

1 Q. And all of y'all were both stockholders and
2 employees of Edgefield Medical Clinic, PA?

3 A. That's correct.

4 Q. Now tell the jury something about yourself.
5 Where did you go to high school?

6 A. Strom Thurmond High School, finished in 1969.

7 Q. Are you originally from Edgefield?

8 A. Grew up in Edgefield.

9 Q. And after high school, give us a brief outline
10 of your education, training, and experience.

11 A. In 1969 I went to USC in Columbia and I was
12 there until 1972; I did not graduate. I went to
13 MUSC 1972 through 1976, and then to MUSC family
14 medicine training program from 1976 to 1979. And in
15 1979 I came back to Edgefield and been here ever
16 since.

17 Q. Okay. When you came back here, who did you
18 practice with?

19 A. Dr. Wiley Turner and Dr. B.E. Nicholson.

20 Q. Have you reviewed records pertaining to
21 Mr. William Peterson that were generated in 2006?

22 A. Yes, sir, I have.

23 Q. Before that did you know Mr. Peterson?

24 A. I did.

25 Q. Had he ever been a patient of yours?

1 A. He was a patient of the Edgefield Medical
2 Clinic from about 1978 through 2002.

3 Q. Okay. Are you aware that he was a patient at
4 the Trinity Mission Nursing Home during March,
5 April, and May of 2006?

6 A. Yes, sir.

7 Q. And during that period of time, did you ever
8 see him as a patient?

9 A. To examine, no; I did see him.

10 Q. Did you ever issue an order pertaining to him?

11 A. I did issue an order.

12 Q. And what was that for?

13 A. That was on, I believe, March the 7th. I
14 received a call on an extremely abnormal lab report
15 which involved dangerously high potassium that was
16 nearly incompatible with life and very high BUN,
17 which is a measure of kidney function. And I called
18 the nurse and had him transferred to the Edgefield
19 County emergency room for immediate treatment.

20 Q. And did he subsequently go to Aiken Regional
21 Medical Center?

22 A. That's correct.

23 Q. And during that stay at Aiken Regional Medical
24 Center, I guess his kidney problems were stabilized?

25 A. That's correct.

1 Q. And he had a cervical fusion?

2 A. That's correct. And a catheter placed because
3 of a nonfunctioning bladder.

4 Q. And subsequently he came back to Trinity
5 Mission?

6 A. That's correct.

7 Q. And on the 21st of March of 2006, he was
8 readmitted?

9 A. That's correct.

10 Q. The first time he was at Trinity Mission, was
11 there a do-not-resuscitate directive in place?

12 A. Yes, sir.

13 Q. When he came back on March the 21st, was it
14 reinstated?

15 A. It was reinstated.

16 Q. Same as before?

17 A. Same as before.

18 Q. Did you see Mr. Peterson on May the 15th, 2006?

19 A. I did not.

20 Q. Did you see Mr. Peterson or have any at all
21 during his stay at Trinity Mission between March the
22 21st and May the 15th, 2006?

23 A. I saw him on three occasions.

24 Q. Did you see him as a patient?

25 A. Not as a patient to examine.

1 Q. Did you issue any orders or perform any
2 treatment pertaining to him during that period of
3 time?

4 A. There was a clarification order involving a
5 pressure mattress that I signed that was sent. I
6 did not see him at that time.

7 Q. Okay. Well, what were the occasions you saw
8 him during that period of time?

9 A. When I go to the Trinity Nursing Home, I see a
10 number of patients that I'm asked to see. But I
11 generally will see one, two, three patients that I
12 may see in the hall, in a bed, and I may sit, talk
13 to them. I don't consider that an official visit
14 although I am seeing them. And I saw him once in
15 the bed, once in the wheelchair, and once when his
16 decubitus pressure sore was being treated by a
17 physical therapist.

18 Q. And in your observation of that, was it being
19 treated properly?

20 A. Yes, sir. It was properly draped, he had
21 gloves, he appeared to be doing an excellent job,
22 and that would be John Melton.

23 Q. Were you contacted by any member of
24 Mr. Peterson's family on May 15th, 2006, you
25 personally?

1 A. No, sir.

2 Q. Were you contacted by a nurse at Trinity
3 Mission requesting that you -- or give you some
4 information pertaining to Mr. Peterson on May the
5 15th, 2006?

6 A. Yes, sir, through my nurse initially.

7 Q. And what was the request?

8 A. The initial request was for Ativan and --

9 Q. What's Ativan?

10 A. Ativan is a drug for anxiety, very similar to
11 Valium.

12 Q. What was your response?

13 A. My response was I would not issue that order,
14 but that I would come see and evaluate him.

15 Q. Why wouldn't you issue it?

16 A. Well, not knowing his condition and if he -- it
17 sounded like he was worsening. At some point in
18 that conversation somewhere, I was aware that he was
19 on oxygen. It wouldn't be proper to give him a
20 sedating drug without evaluating him that may make
21 his condition worse, and I needed an evaluation to
22 see exactly what his condition was.

23 Q. And I think you were contacted again by someone
24 from Trinity Mission regarding Mr. Peterson?

25 A. Right. That would be Pam Dunn. And the

1 initial conversation started with my nurse who was
2 Donna Boatwright [phonetic]. And during that
3 conversation, the -- it was passed to me that the
4 family wanted to rescind his DNR and call 911. At
5 that point I took the telephone and talked directly
6 to the nurse.

7 Q. And what did you say?

8 A. I said the family had every right to do that.

9 Q. Okay. But you never had the opportunity to see
10 him that day?

11 A. No, sir. When the family rescinded the DNR and
12 requested to call 911, I think they had made a
13 decision.

14 Q. Like you say, they have the right to do that?

15 A. They have the right to do that.

16 Q. Okay. Now, having examined, read and reviewed
17 all of the records during that time period, have you
18 had an opportunity to go to Trinity Mission and
19 examine Mr. Peterson, had the family members
20 indicated they wanted to revoke the DNR directive?
21 What would you have done?

22 A. He was clearly changing and changing very
23 quickly based on the review of the records. And
24 there would have been two pathways, I think, from my
25 advice: One pathway would be in which you proceed

1 with comfort care and pain control and remain there,
2 would be one option.

3 A second option would be to pursue more
4 aggressive care, which would require moving,
5 hospitalization, and the things that are attendant
6 with that, IVs, antibiotics. Sepsis would be a
7 likely condition to cause the change.

8 Q. Whose choice would that be to make, comfort
9 care versus aggressive care?

10 A. That's the family's choice.

11 Q. Had they told you they wanted aggressive care,
12 what would have occurred then?

13 A. One of two things: Either transport by
14 ambulance to the emergency room or, perhaps, more
15 practically, call the doctor who admitted him before
16 and go for a direct admission.

17 Q. But either way, he was about to leave Trinity
18 Mission?

19 A. That's correct, if that was their choice.

20 Q. And that's the choice they made and that's what
21 they got that day?

22 A. That's correct.

23 Q. It wouldn't be any different than what you
24 would have done had they made the choice with you?

25 A. No, sir.

1 Q. What's the difference between what you describe
2 as comfort care and aggressive care?

3 A. Well, comfort care still involves treating the
4 patient, but the goal of comfort care is geared
5 towards pain relief and treating the anxiety,
6 treating the conditions, making the patient more
7 comfortable versus trying to increase length of life
8 necessarily or do procedures that might have a
9 possibility of extending life.

10 Q. Between May the 2nd of 2006 and May the 15th,
11 2006, when you were called, your office was
12 contacted, you had a conversation about Mr. Peterson
13 that day. Were you ever aware of this culture
14 result which indicated there was a MRSA colonization
15 on Mr. Peterson?

16 A. Between May the 2nd and -- no, sir.

17 Q. Did you ever receive a copy of the MRSA report
18 during that time?

19 A. No, sir.

20 Q. Did you have anything to do with a decision to
21 treat or not treat this MRSA situation during that
22 period of time?

23 A. No, sir.

24 Q. What's the proper way or method of treating or
25 reacting to a positive MRSA culture?

1 A. If it's a colonizing culture, a nose culture --
2 and MRSA lives in many of us, nose, throat, armpits,
3 groin. We are -- medicine has not found a good way
4 to eradicate that. Many different treatments have
5 been tried, it's still not clear how we can
6 eradicate that. So the most common treatment is
7 universal precautions to protect from spread; that
8 is, gloves and particularly handwashing.

9 Invasive or systemic MRSA will require
10 antibiotics. The most common one would be
11 vancomycin. That -- an invasive MRSA or systemic
12 MRSA has an explosive onset with frequently a change
13 in heart rate, blood pressure; temperature up, down,
14 sweats, chills, a very toxic appearance, and it
15 occurs very quickly.

16 Q. Having reviewed the records now and getting
17 other information, I guess, maybe, in your opinion,
18 did this MRSA ever become clinically significant to
19 require treatment?

20 A. It would appear he was changing on the 15th or
21 between the 14th and 15th, or in that period of
22 time, it appears he was changing.

23 Q. Were you ever contacted by anyone from Trinity
24 Mission telling you that they were beginning to see
25 changes and maybe you needed to look at him too?

1 A. Between 4:00 and 5:00, I believe, was the first
2 beginnings of calls, around about then.

3 Q. Was it for that particular purpose?

4 A. It was for the purpose of Ativan.

5 Q. Okay. Well, as far as somebody indicating that
6 there may be a change in situation significant
7 enough that maybe the MRSA should be examined and
8 reacted to at that time, did you ever receive a call
9 in that regard?

10 A. No, sir. It was about the Ativan. And then
11 the change in condition that I -- my strong advice
12 was to let me come and see him.

13 Q. Okay. And did you attempt to go see him?

14 A. I was getting ready to walk out the door when
15 the last call occurred, and my strong advice was to
16 let me come and see him. And I felt I could offer
17 something to the family about the pathways. And he
18 was in very bad condition and --

19 Q. Was treatment of the MRSA found in
20 Mr. Peterson's left hip wound necessary or required
21 before the May 15th, 2014 [sic]?

22 A. No, sir.

23 Q. Okay. Did you -- having reviewed the records
24 and so forth, have you reached any conclusions as
25 to whether or not other personnel may have had

1 something to do with this MRSA situation that
2 Edgefield Medical Clinic may have exceeded the
3 standard of care?

4 A. Would you repeat that?

5 Q. Did the doctors working with you meet or exceed
6 the standard of care in their care of Mr. Peterson
7 in regard to the MRSA?

8 A. Yes, sir.

9 MR. NANCE: Thank you, sir. That's all I have.
10 Answer any questions Mr. Welch may have.

11 CROSS-EXAMINATION

12 BY MR. WELCH:

13 Q. Dr. Rainsford, you say you received a call
14 about the Ativan on the 15th. And I just want to
15 make sure -- and, in fact, let's go to exhibit --
16 you received a call on the 15th. I want to make
17 sure I'm on the right page with you. If you look at
18 page 69 there on Exhibit 3 you're reading from --

19 A. 69?

20 Q. Yes, sir, the bottom of the page.

21 A. All right. 69.

22 Q. It's the nurses notes.

23 A. Yes, sir.

24 Q. You see that? And you see the one that says
25 1:45 PM, 5/15/06?

1 A. Yes, sir.

2 Q. Says: Resident anxious, restless, continuously
3 shuffling and moving, moans when touched, eyes open,
4 no blinking noted. Called Dr. Rainsford's office,
5 spoke to Nurse Donna, requesting meds to manage
6 anxiety. Awaiting return call.

7 Is that the call you're referring to?

8 A. I assume so. Yes, sir.

9 Q. And, Doctor, if we look a few days over, he's
10 taking his medication by mouth with applesauce and
11 things of that nature. But now, I think you said,
12 your opinion now -- let me make sure I'm clear on
13 what I heard -- some changes are taking place and
14 maybe sepsis from the 14th to the 15th?

15 A. I can't pin down the exact time, but he
16 appeared to be changing.

17 Q. But that was your testimony, correct, that
18 14th-15th thing?

19 A. Somewhere in there, yes, sir.

20 Q. And, Doctor, sepsis is setting in, which is
21 that infection, that MRSA and the other pathogen
22 possibly getting into the bloodstream. It's going
23 to affect his brain, isn't it?

24 A. Yes, sir, that's one of the signs of sepsis.

25 Q. In fact, this point to where he's anxious, he

1 doesn't know what's going on, does he?

2 A. I wasn't there to examine him, but that would
3 be what the note would say.

4 Q. And she's trying to get the man some medication
5 to help him, isn't she? She's trying to get the man
6 some medication to ease his anxiety?

7 A. That's correct.

8 Q. Because he's going through this sepsis change;
9 correct?

10 A. That's what the note would appear to have
11 meant, yes, sir.

12 Q. Thank you, sir.

13 THE COURT: All right. That's all you have?

14 MR. WELCH: No, I got some more questions.

15 THE COURT: Oh, I thought you said thank you.

16 BY MR. WELCH:

17 Q. In fact, sir, when we talked previously about
18 what happened in this case, at deposition you told
19 me --

20 MR. WELCH: Judge, I think you got his
21 deposition up there, Judge. Your Honor, you have
22 his deposition up there?

23 THE COURT: Maybe I do. Hold on.

24 BY MR. WELCH:

25 Q. Sir, if you could turn to page 79 in that

1 deposition, please.

2 A. Yes, sir.

3 Q. Sir, you told me that on that 15th, starting at
4 line 21 --

5 MR. PARKINSON: Your Honor, I object to him (
6 reading from the deposition if he's not going to
7 just ask him questions. I mean --

8 THE COURT: You can ask him the question.

9 MR. WELCH: As a party, also as a party, I'll
10 ask him that way.

11 BY MR. WELCH:

12 Q. Sir, did you tell me that day that you wanted
13 to go over, be able to get his chart, literally
14 examine him, and then give the family some advice?

15 A. This is on page 79?

16 Q. Yes, sir. Do you remember saying that that
17 day?

18 A. What line?

19 Q. I'm talking about line 21.

20 A. That would be correct.

21 Q. Yes, sir. So you're telling us now today that
22 you didn't have enough information, you needed to go
23 examine him, you didn't know what you could tell the
24 family, you didn't know much about him, did you?

25 A. No, sir. I knew he was changing, he was not

1 doing well, he was on oxygen. I did have
2 information about him, enough to know there was a
3 change taking place, that I would have preferred --
4 the preferred method for me would be to go examine
5 him and confirm the changes and to help make
6 decisions.

7 Q. Before this day you never examined him, had
8 you?

9 A. I saw him on three occasions. I did not
10 examine him.

11 Q. Right. In fact, you didn't go to the nursing
12 home at all that day?

13 A. No, sir.

14 Q. And you also have said that he only had an hour
15 or maybe a day or two to live?

16 A. If it were sepsis.

17 Q. Which it turned out to be?

18 A. Right.

19 Q. But on March the 7th, you testified today that
20 you saw the lab number, he was ill, and you took him
21 to the hospital, you got him some treatment and he
22 came back.

23 A. That was an emergency. That would have been
24 inappropriate to go and examine him. That was so
25 life-threatening, there was not time to call family.

1 My preferred method would be to examine him and then
2 make a decision. That would have been
3 inappropriate. The appropriate treatment was so
4 severe was to move him immediately.

5 Q. But he'd also just come into the facility just
6 a few days before and you knew he had kidney issues,
7 didn't you, on March 7th?

8 A. On March the 7th, the first I knew of him was
9 when I was handed that lab report.

10 Q. Did you look at the chart?

11 A. I did not. I looked at the lab report.

12 Q. And you knew from that lab report it was
13 serious?

14 A. Yes, sir.

15 Q. But he got treated, came back and talked with
16 his family and everything after March 7th, didn't
17 he?

18 A. I believe he did.

19 Q. Dr. Rainsford, you've also expressed opinion
20 that this type situation, palliative care would have
21 been an option because he's not going to get any
22 better?

23 A. That would be one of the choices.

24 Q. But the family was never able to discuss with
25 anybody that choice, did they?

1 A. I didn't have discussion with the family.

2 Q. In fact, Doctor, if you would look at page 69
3 and 70 -- let's start on 69. That record, the
4 bottom, it's the 5/15, 2:45 entry. Do you see that
5 entry, Doctor?

6 A. Is there a line?

7 Q. Yes. It's 5/15, 2:45. There's several lines.
8 I want to make sure you've got the right location.

9 A. I'm on page 69.

10 Q. 69 at the bottom, 5/15 on the left, 2:45 PM.

11 MR. PARKINSON: He's looking at the deposition.

12 BY MR. WELCH:

13 Q. I'm sorry. It's the exhibit over to your left.

14 Doctor, you heard the nurse testify she wrote
15 down verbatim what your nurse told her. And she
16 wrote, put it in quotes: Dr. Rainsford did not
17 advise family to send resident to hospital. Instead
18 told family if it was their desire, the family could
19 take him to the hospital.

20 MR. NANCE: May I approach the bench, please?

21 THE COURT: Come on.

22 (Sidebar conference).

23 BY MR. WELCH:

24 Q. Doctor, that language that's in quotes, that's
25 what she said your nurse said; correct?

1 A. That's what she wrote.

2 Q. And, Doctor, I want you to go over to page 34
3 of that same record.

4 THE COURT: 34?

5 MR. WELCH: Yes, sir.

6 BY MR. WELCH:

7 Q. If you look at that top physician's order, it's
8 dated 5/15/2006, says: Transported to Aiken
9 Hospital emergency room via EMS per insistence of
10 family against medical advice.

11 Do you see that?

12 A. I do.

13 Q. Whose signature is that signed on the next day,
14 the 16th?

15 A. It's mine.

16 Q. And, Doctor, you didn't ask anybody to change
17 that note before you signed it, did you?

18 A. No, sir. I don't remember asking anybody to
19 change it.

20 Q. And you never told anybody they took it down
21 incorrectly, did you?

22 A. No, sir.

23 Q. Now, Doctor, you agree with me that this is the
24 shape the man was in on the 15th?

25 A. I didn't see him on the 15th.

1 Q. Well, this is a picture taken -- it says 5/16
2 at -- the next day at Aiken. And he was in
3 substantially the same condition late in the
4 afternoon on the 15th, wasn't he, Doctor?

5 A. I can't answer that. I didn't see him on the
6 15th.

7 Q. Doctor, do you believe it changed to a much
8 worse condition in 12 to 16 hours?

9 A. Mr. Welch, decubitus can change very quickly
10 into sepsis, so I can't answer that because I didn't
11 see him.

12 Q. Doctor, you've seen everything from the record
13 in Aiken where when they got him there from the
14 hospital, when the family asked you to come over,
15 that he had sepsis in the bloodstream, he had sepsis
16 in the decubiti -- he had MRSA in his decubiti, he
17 had MRSA infection in the kidneys, he had all of
18 that in the nursing home, didn't he?

19 A. I can't answer that.

20 Q. So you don't have an opinion as to whether or
21 not that, more probable than not, it was taking
22 place in the nursing home?

23 A. I think he was changing and systemic infection
24 was a likely cause for that change, yes. It was
25 occurring at that time.

1 Q. It's your testimony today, Doctor, that it's
2 acceptable medical care to allow a man to get to
3 this condition?

4 A. I think he received good medical care.

5 MR. WELCH: I don't have any further questions,
6 Doctor.

7 MR. PARKINSON: No questions, Your Honor.

8 MR. NANCE: No questions, Your Honor.

9 THE COURT: Doctor, you may step down.

10 MR. NANCE: At this time we call Dr. Lovelace.

11 THE CLERK: Raise your right hand, please.

12 OSCAR LOVELACE, JR.

13 being first duly sworn, testified as follows:

14 THE WITNESS: I do.

15 THE CLERK: Have a seat. State your full name
16 and spell your last name, please.

17 THE WITNESS: Oscar Fred Lovelace, Jr.,
18 L-O-V-E-L-A-C-E.

19 DIRECT EXAMINATION

20 BY MR. NANCE:

21 Q. How are you doing today?

22 A. I'm doing well.

23 Q. Dr. Lovelace, tell the jury something about
24 yourself. Where do you live?

25 A. I live in Chapin, South Carolina.

1 Q. And where do you work?

2 A. Prosperity, South Carolina.

3 Q. And what do you do?

4 A. I'm a family doctor.

5 Q. Are you originally from South Carolina?

6 A. I am.

7 Q. Where?

8 A. Columbia, South Carolina.

9 Q. Would you give the jury a brief outline of your
10 education, experience and training, beginning in
11 college, including dates of graduation through
12 today, please.

13 A. Clemson University, Medical University of South
14 Carolina, University of Virginia, Medical University
15 of South Carolina, back to Prosperity.

16 Q. Give me the years of graduation.

17 A. Sorry. Finished high school in '77; went to
18 Clemson, finished in '81; MUSC in '85; went to
19 University of Virginia, finished my residency in
20 family medicine in 1988; and then after being in
21 Prosperity for a while, went back to Medical
22 University to train to do operative obstetrics.

23 Q. Are you board certified?

24 A. I am.

25 Q. In what area?

1 A. Family medicine.

2 Q. What is family medicine?

3 A. I think it's servant medicine. My chairman at
4 UVA taught me that well. The word family is derived
5 from the Latin word familia, so I tell the students
6 when I talk to them that it's doing what's needed in
7 your community.

8 Q. And in your capacity and in your practice, do
9 you have any affiliation with any nursing homes?

10 A. I currently practice in three. I used to
11 practice in four.

12 Q. Have you been the medical director at any?

13 A. At two of those four.

14 Q. Which ones do you go to now?

15 A. White Oak Manor in Newberry, J.F. Hawkins in
16 Newberry, and Springfield Place in Newberry.

17 Q. How long have you been affiliated with nursing
18 homes in some manner?

19 A. Twenty-five years.

20 Q. Are you a member of any professional
21 associations?

22 A. The American Medical Association, the South
23 Carolina Academy of Family Physicians.

24 Q. And have you ever been honored by either of
25 them in some manner?

1 A. Yes, sir.

2 Q. How?

3 A. In 2012, I was South Carolina's Family
4 Physician of the Year.

5 Q. And whose term is that?

6 A. The South Carolina Academy. I've never been
7 part of that process.

8 Q. But it's the academy itself?

9 A. Yes, sir.

10 MR. NANCE: Your Honor, at this time we would
11 tender Dr. Lovelace as an expert in the area of
12 family medicine and nursing home care.

13 MR. WELCH: No objection.

14 BY MR. NANCE:

15 Q. Have you reviewed medical records in regards to
16 this matter?

17 A. Exhaustively.

18 Q. Have you reviewed medical records of Trinity
19 Mission beginning in February and ending in March of
20 2006?

21 A. I have.

22 Q. What about medical records of the Aiken
23 Regional Medical Center in March of 2006?

24 A. I have.

25 Q. Medical records of Trinity Mission Nursing Home

1 beginning in March and ending in May of 2006?

2 A. I have.

3 Q. What about medical records of the Aiken
4 Regional Medical Center in May and June of 2006?

5 A. All the way until he was discharged to Select
6 Hospital.

7 Q. What about medical records of Medical College
8 of Georgia?

9 A. I have.

10 Q. Select Specialty?

11 A. I have.

12 Q. Hospice Care?

13 A. Yes.

14 Q. Edgefield Medical Clinic?

15 A. I have.

16 Q. Edgefield Hospital?

17 A. I have.

18 Q. Have you reviewed depositions in this matter?

19 A. I have.

20 Q. Those of all of the physicians involved?

21 A. I have.

22 Q. Personnel of Trinity Mission?

23 A. Yes.

24 Q. The family members of Mr. Peterson?

25 A. Yes.

1 Q. Having done that, have you reached any opinions
2 in regards to this matter?

3 A. I have.

4 Q. Do you have an opinion within a reasonable
5 degree of medical certainty as to whether or not
6 Drs. Rainsford and Leaphart and the Edgefield
7 Medical Clinic met or exceeded the standard of care
8 in their treatment of Mr. Peterson?

9 A. I believe they met or exceeded the standard of
10 care of the medical treatment of Mr. Peterson.

11 Q. What about Dr. Massey?

12 A. Same.

13 Q. What about Dr. Nicholson?

14 A. I also believe that Dr. Nicholson did, although
15 he's passed on.

16 Q. In review of the records, did you reach an
17 opinion as to whether or not there was good and
18 adequate communication between the nursing home
19 staff and the physicians?

20 A. I feel it was the usual type of communication.
21 I take care of hundreds of patients in the nursing
22 home, and it was pretty standard practice the way it
23 was done.

24 Q. In your affiliation with the nursing homes, do
25 staff members actually write orders for you to sign

1 at a later time?

2 A. Nursing home, because it's called a nursing
3 home, has nurses and therapists that are there 24/7
4 and they write orders. It's not uncommon when I go
5 in to see two or three patients, as Dr. Rainsford
6 talked about; I may sign 100 orders when I'm there
7 about this person using Woolite to wash their
8 clothes or giving Tylenol. It's -- the trouble with
9 nursing home care, honestly, is we have to sign for
10 absolutely anything to be done.

11 Even, as Dr. Leaphart was saying, changing the
12 application of Neosporin ointment, an
13 over-the-counter medicine from twice a day to three
14 times a day. If I had a patient call me from home
15 and ask me is that okay to do, I'd say you can use
16 your judgment on that. But in a nursing home, a
17 doctor has to sign that order.

18 Q. I see. Do you agree with the statement that
19 the nurses are the eyes and ears of the physicians?

20 A. Definitely. I encounter that a lot in
21 practicing obstetrics.

22 Q. Do you have an opinion based upon your review
23 of the documents as to whether or not Mr. Peterson's
24 health deteriorated while he was at Trinity Mission?

25 A. There's no question about that. His cervical

1 spinal stenosis that was unfortunately unable to be
2 remedied by surgery was causing his neurogenic
3 bladder, all his kidney problems, and his gradual
4 decline despite all the aggressive things that
5 happened.

6 Q. Do you have an opinion as to whether or not
7 this decline in health was caused or contributed to
8 by a lack of attention or neglect on the part of the
9 physicians treating him?

10 A. I don't think there was any neglect there. I
11 know the jury may not understand how often a nursing
12 home calls a physician's office for advice and we're
13 constantly having to filter those calls and faxes as
14 to which ones are significant and require our
15 presence or require our immediate action.

16 Q. Did you reach a conclusion or form an opinion
17 as to whether or not the MRSA colonization
18 Mr. Peterson developed was caused by improper care
19 or inattention or neglect by these physicians?

20 A. I'm aware that we've been talking about MRSA
21 colonization. But this wound also had Aerococcus
22 circellus [phonetic] in it. It wasn't just
23 colonized with MRSA. I think that there's a fright
24 factor that goes along with MRSA.

25 In this case it proved to be the organism that

1 caused Mr. Peterson to get very sick. He had a
2 blood culture at Aiken Hospital. But I just want to
3 point out that these bacteria were present on the
4 surface of the wound. And it's not uncommon for us
5 to get a urine culture back in a nursing home
6 patient that has more than one organism, and we
7 don't consider that to be an active infection in the
8 urine or anywhere else, unless there's symptoms of
9 illness like fever, low blood pressure, or signs of
10 sepsis. And we don't treat a urine culture that
11 comes back with two organisms until you get another
12 sample. Maybe it's a dirty catheter.

13 Q. Have you reached a conclusion as to whether or
14 not the physicians properly addressed the treatment
15 of the MRSA wound colonization?

16 A. Yes, because it would appear to me, looking at
17 the record, that that actually was an order written
18 by the physical therapist who was in charge of wound
19 management. But just the fact that it was colonized
20 or there was bacteria present does not indicate a
21 need for treatment. It might help guide treatment
22 in the event of a change in his clinical status, but
23 not antibiotics at that time.

24 And let me just say further, the reason that we
25 don't do that is because we don't want to give a

1 patient antibiotics for colonization and then have
2 them get ill and the antibiotics don't work because
3 the bug is now resistant to that antibiotic.

4 Q. In review of the records between March 21st,
5 2006 and May 15th, 2006, did you find Mr. Peterson
6 was provided with a pressure-relief mattress?

7 A. Yes.

8 Q. Did that meet the standard of care?

9 A. Yes.

10 Q. Did you find that a dietician saw Mr. Peterson
11 so he could be provided adequate supplements and for
12 a complete nutritional evaluation?

13 A. Yes.

14 Q. Did that meet the standard of care?

15 A. Yes.

16 Q. And finally, did you find that a speech
17 therapist saw Mr. Peterson in an effort to improve
18 his swallowing?

19 A. Yes.

20 Q. Did that meet the standard of care?

21 A. Yes.

22 Q. Did you find that an occupational physical
23 therapist saw Mr. Peterson in an effort to improve
24 his mobility?

25 A. Yes.

1 Q. Did that meet the standard of care?

2 A. Yes.

3 Q. Did you find Mr. Peterson used a urinary
4 catheter?

5 A. That was required because his bladder was
6 incontinent, and being constantly wet would increase
7 his risk for skin ulcers.

8 Q. Does that meet the standard of care?

9 A. Yes.

10 Q. Did you find that Mr. Peterson was incontinent
11 of both bowel and bladder?

12 A. Also a result of his spinal stenosis.

13 Q. Did you find that Mr. Peterson was provided
14 with a wedge to aid him in keeping off bony
15 prominences?

16 A. Yes. But it's notable that when they were able
17 to get his right heel ulcer healed -- he had a
18 pressure ulcer on his heel -- he developed one on
19 the left hip. So you can't -- you can't suspend
20 someone in midair.

21 Q. Did that meet the standard of care?

22 A. Yes.

23 Q. Did you find that a wound care nurse or
24 physical therapist performed wound care which would
25 include cleaning, bandaging, medicating, and

1 debriding?

2 A. Yes.

3 Q. Did that meet the standard of care?

4 A. Yes.

5 Q. In the state of South Carolina, are physical
6 therapists allowed by law to do debridement,
7 including debridement with a sharp object?

8 A. They are. And in this case, in the deposition
9 by Mr. Melton, the physical therapist, he
10 specifically states he went to continuing education
11 courses on it as well.

12 Q. Do you have an opinion within a reasonable
13 degree of medical certainty as to whether or not any
14 of the medical expenses incurred on behalf of
15 Mr. Peterson after May 15, 2006 referred to
16 inactions, actions, or breaches of the standard of
17 care of any of the physicians involved in this
18 matter?

19 A. I don't believe there was any way that, if the
20 family had chosen aggressive care, which they did,
21 those expenses could have been averted because of
22 his steady decline because of all of his multiple
23 medical problems.

24 MR. NANCE: Thank you, Dr. Lovelace. Answer
25 any questions Mr. Welch may have.

1 THE COURT: Hang on one second. I got one
2 juror that needs to go to the restroom.

3 (Short break.)

4 CROSS-EXAMINATION

5 BY MR. WELCH:

6 Q. Dr. Lovelace, you've looked at all of the
7 records. Do you agree with the findings at the
8 Aiken Medical Center that upon arrival this
9 gentleman had sepsis due to MRSA and a urinary tract
10 infection from MRSA and a kidney infection?

11 A. On arrival, that diagnosis had not been made
12 until the blood cultures turned positive. And the
13 sepsis was secondary to MRSA. So on arrival, the
14 emergency room doctor had to try to make sense of
15 the presentation on his own initially without some
16 benefit of those lab results.

17 Q. Let me rephrase that. From the lab results
18 that were taken upon arrival, do you agree that the
19 medical record shows diagnosis of MRSA in the wound,
20 sepsis with MRSA, and urinary tract infection with
21 MRSA?

22 A. During his subsequent hospitalization, that's
23 correct.

24 Q. And you saw the picture of the decubiti on the
25 hip that was taken on the 16th?

1 A. Yes.

2 Q. And do you believe that it was in the same
3 condition when he came in on the 15th late?

4 A. I doubt it looked very different. It could
5 have changed over that time.

6 Q. And you've also said previously that there was
7 really no clinically significant change in this man
8 during the two weeks he was at Aiken; is that
9 correct?

10 A. You need to tell me what two weeks you're
11 referring to.

12 Q. The two weeks he was at Aiken from May 15th
13 when he came in until the May the 30th when he went
14 to Augusta.

15 A. That there was no significant change in his
16 condition?

17 Q. Yes, sir.

18 A. What I'm saying is that he was on a steady
19 downhill course. He continued to have recurring
20 infections, pseudomonas, a variety of
21 difficult-to-treat infections until it was decided
22 he should get palliative care and was placed on
23 Hospice care and died two days later.

24 Q. You're aware that while he was at Aiken during
25 that two weeks that he actually improved to the

1 point where he was talking to the physicians and
2 answering their questions verbally?

3 A. Again, what I'm saying is that his overall
4 course, there may have been some small improvements,
5 but it was overall a steady downhill course. An
6 example of that is the fact that he had a feeding
7 tube placed, and despite being artificially fed, his
8 prealbumin, which is a measure of protein, didn't
9 improve significantly.

10 Q. Here's my question, Doctor: From when he got
11 to the emergency room and he was totally out of it
12 and the family thought he was dying, to improve over
13 two weeks to where you can have a conversation with
14 him and eat food and answer doctors' questions,
15 that's an improvement, isn't it?

16 A. I agree with you. The point that I'm making is
17 that he was on a steady downhill course because of a
18 very unfortunate situation which was his spinal
19 stenosis. And, unfortunately, when the neurosurgeon
20 saw him on May the 10th, he said there was no need
21 to see him back again, he should go back to the
22 nursing home. And that May the 10th was five days
23 before he was transferred out of the facility. So
24 the surgeon who saw him and operated on his neck
25 said he didn't show any sign of improvement with

1 that aggressive surgery and it was best just to get
2 him nursing home care.

3 Q. Now, Doctor, you've told me previously in your
4 deposition that the physician should review or look
5 at the wound to make -- to agree clinically that the
6 treatment's necessary. That's a statement you made,
7 isn't it?

8 A. I remember that interchange and I think that --

9 Q. Answer the question. Did you make that
10 statement? Did you agree with that statement in the
11 deposition?

12 A. I just said I remember the interchange.

13 Q. But did you make the statement?

14 A. I mean, I could look at it. I don't doubt
15 the -- that it's true.

16 Q. Page 38 in your deposition, Doctor.

17 A. Okay.

18 THE COURT: What's the line?

19 MR. WELCH: Line 9.

20 BY MR. WELCH:

21 Q. So my question is, should the physician review
22 or look at the wound to make -- to agree clinically
23 that debridement's necessary?

24 A. Thank you for letting me look at this because I
25 said: I think that's good, yes, that a physician

1 would review the wound care and see the patient
2 regarding that.

3 And further I clarified that in this
4 environment, what happens is there's a protocol for
5 wound management in a nursing facility, and if the
6 physician is called and said I need your assistance
7 in managing this wound, he'll be called to look at
8 this wound.

9 Q. Well, Doctor, if you look at the next line,
10 when I say: When you say by good, that would be
11 reasonable practice? Your answer is: That would be
12 reasonable practice.

13 A. I think I've clarified my statement.

14 Q. And, Doctor, you've reviewed over 100
15 medical-legal cases, haven't you, for breach of
16 standard of care testimony?

17 A. I have.

18 Q. And out of over 100, you've never testified
19 against a doctor in South Carolina, have you, in
20 deposition or court, have you?

21 A. Mr. Welch, as you know, we review records when
22 we're sent them by attorneys. I don't know how to
23 list myself in a service so the --

24 THE COURT: Sir, answer the question.

25 BY MR. WELCH:

1 Q. Answer my question. Out of over 100, you've
2 never testified at court or in deposition against a
3 doctor, have you?

4 A. I have testified, not in court.

5 Q. In South Carolina?

6 A. That's correct.

7 MR. WELCH: I don't have any further questions.

8 MR. PARKINSON: No questions, Your Honor.

9 MR. NANCE: None, Your Honor.

10 THE COURT: You may step down. May he be
11 excused from the subpoena?

12 MR. NANCE: Yes, sir.

13 THE COURT: Next witness.

14 MR. NANCE: That concludes the defense of these
15 doctors, Your Honor.

16 THE COURT: Anything in reply, Mr. Welch?

17 MR. WELCH: No, sir, Judge.

18 THE COURT: Thank you.

19 Mr. Foreman, ladies and gentlemen of the jury,
20 it is 4:00. I've got about an hour, 45 minutes to
21 an hour to spend with these lawyers. It'll be 5:00
22 by the time everybody goes to the restroom and
23 stretches their legs. The testimony is all in. I'd
24 like to spend this next hour with them and then
25 start back in the morning. Is 9:30 an imposition?

1 I know one person's got a medical -- who is that?

2 Is 9:30 an imposition?

3 Here's what will happen in the morning: Once
4 we get here and started in the morning, the lawyers
5 will present their final arguments. And once that's
6 done, then I'll charge you on the law, instruct you
7 on the law, and you'll receive the case to start
8 deliberating. I suspect 9:30 to 10:30, 11:00 to
9 11:15-ish, and then we'll order lunch in so you
10 don't have to go out for lunch so you can deliberate
11 right through lunch. Is that a game plan?
12 Everybody okay with that?

13 THE JURY: (Nods heads.)

14 THE COURT: What time is your doctor's
15 appointment?

16 THE JURY: In Beech Island at 10:30.

17 THE COURT: Go back to the jury room, sit tight
18 one second, I'll deal with that situation and talk
19 about that.

20 Don't deliberate, don't discuss the case with
21 anyone. You want some biscuits in the morning or
22 are you tired of them? What you want for breakfast
23 in the morning? Fruit is good. Peaches?

24 Have a pleasant evening. Everybody else remain
25 seated.

1 (The jury exits the courtroom at 4:02 PM.)

2 THE COURT: Madam Court Reporter, when we
3 selected the jury on Monday, Steve D. Carpenter,
4 Juror No. 22, informed me of this situation this
5 Thursday and he assured me he would not miss that
6 medical appointment, so I'm going to relieve him
7 from his duties as a juror.

8 I appreciate your services. You're welcome to
9 stay with us if you'd like to change your
10 appointment or --

11 JUROR NO. 22: This is my last opportunity.
12 I've been on medical leave since December 23rd. I
13 have to go.

14 THE COURT: We appreciate your service. And
15 leave your badge with the ladies. They'll send you
16 a check. Thank you.

17 (Juror No. 22 excused.)

18 MR. WELCH: Judge, can we approach?

19 THE COURT: Sure.

20 (Sidebar conference.)

21 THE COURT: Any motions at the conclusion of
22 all of this?

23 MR. WELCH: Judge, I would ask that you
24 reconsider -- I would ask the evening to possibly do
25 some briefing and reconsider the issue of the pain

1 and suffering. This was a man that was
2 communicating with family and staff, eating ice
3 cream, showing signs of no acute distress. Their
4 failure to properly diagnose and treat with
5 appropriate antibiotics, he basically -- you heard
6 the testimony of the effect of the sepsis, of the
7 first time he had a need for anxiety medication,
8 moving his arms and legs, moaning to the touch, had
9 the problems brought on by sepsis. The daughters
10 say when they got there he was grimacing, bug-eyed,
11 dry mouth. Testimony from even Dr. Rainsford, which
12 was really unsolicited today, that the sepsis was
13 taken place at that time which is from the bacteria
14 that he cultured out from MRSA that was not treated.
15 That was the testimony.

16 I could go on, Judge, in terms of they started
17 giving him oxygen there at the facility the day
18 before. There was testimony that it causes
19 confusion. All of those are things, especially to a
20 man with Alzheimer's sometimes have a harder time
21 putting that all together. The treatment at Aiken,
22 the testimony that the sepsis that was instituted by
23 the MRSA infection required the treatments at Aiken
24 Select Specialty Hospital which included skin
25 grafts. That's in the record. You saw the state of

1 the decubiti, the debridement of the decubiti
2 because of the stage they got to, all of those do
3 involve, Judge, what the jury should be able to
4 consider as pain and suffering. And again, the
5 testimony this afternoon was unsolicited that that
6 sepsis was taking place the 14th and the 15th. And
7 we've got the calls for the Ativan and the moaning
8 to the touch and all that. And I'd ask for at least
9 tonight that we submit a small brief by the morning.

10 THE COURT: I don't want you to have to write a
11 brief tonight. We've been taking testimony
12 throughout the day, we've looked at a number of
13 cases dealing with pain and suffering, and I'll
14 revisit that in the morning and we'll discuss that
15 in chambers before we leave tonight.

16 MR. WELCH: Very good. Thank you, Judge.
17 Nothing else.

18 MR. PARKINSON: Your Honor, as it relates to
19 that matter about the pain and suffering, do you
20 want me to speak to that now?

21 THE COURT: No. We'll talk about it informally
22 in chambers and you can reply to it on the record in
23 the morning.

24 MR. PARKINSON: Thank you.
25 Your Honor, at this time I would re-move the

1 motion I made for a directed verdict on behalf of
2 Dr. Massey at the end of Plaintiff's case for
3 essentially the same reasonings; that Dr. Massey --
4 there's been no testimony that -- from the
5 plaintiff's expert that specifically identifies
6 Dr. Massey as an individual who, on a particular
7 date and time and occasion, departed from the
8 standard of care. And again, I'll remind the Court
9 that Dr. Levine had not read the deposition of
10 Dr. Massey nor did Dr. Levine have the benefit of
11 hearing courtroom testimony from Dr. Massey and he
12 did not identify anything with any specificity that
13 had anything to do with Dr. Massey that did directly
14 cause or contribute to an adverse outcome. So I'd
15 re-move my motion for directed verdict on that
16 basis.

17 MR. WELCH: Judge, I'm not going to repeat.
18 You've already took notes as to what the doctor
19 testified to. But bottom line too, in the testimony
20 there's evidence and testimony from Dr. Massey that
21 she was aware of the MRSA and the other bacteria
22 that cultured out, that she did receive the report,
23 it was directed to her; her choice at that time was
24 to pass it on to another physician. She can't name
25 the physician, she can't name the conversation. She

1 said it's her usual practice, but she can't say with
2 any specificity that she did.

3 The testimony from all the doctors is that all
4 the patients at that facility are the patients of
5 all the doctors of the practice, that that's how
6 they practice, and when it's your week on or your
7 day on, it's your obligation to see the patient.
8 She testified she did not examine the patient even
9 though she wrote an order for that patient to have a
10 stronger debridement agent used. She testified that
11 she knew at the time that they were going from one
12 debridement agent to a strong debridement agent on
13 that very wound, but she chose not to examine the
14 patient, Judge. And I think there is more than a
15 scintilla of evidence that should be allowed to go
16 to the jury.

17 THE COURT: I'm going to stand by my ruling.
18 Even though it's not the strongest testimony I've
19 ever heard, it's not sharp, and not the weight, but
20 the existence of the testimony. But once again, as
21 I said at the conclusion of the plaintiff's case,
22 Levine from Manhattan talked about the deviation
23 from the standard of care.

24 First of all, he testified about what the
25 standard should be. And then he said if the patient...

1 starts declining, then you have to have a
2 face-to-face, eye-to-eye examination. A deviation
3 is the failure to diagnose the infection, the
4 failure to transfer, and then apply it to all three
5 defendants. No transfer, no treatment. So I think
6 that's enough to get him over the hump.

7 MR. PARKINSON: Your Honor --

8 THE COURT: I respectfully deny your motion.

9 MR. PARKINSON: And, Your Honor, I know the
10 Court has already expressed a desire to discuss the
11 pain and suffering issue tomorrow and not tonight,
12 but to the extent that I might forget tomorrow, I
13 want to -- I know the Court has already ruled on
14 that.

15 THE COURT: I've ruled, but I said I was going
16 to revisit it. I don't think there's a question
17 that was --

18 MR. PARKINSON: To the extent that I need to
19 renew the motion for directed verdict as to pain and
20 suffering, I just wanted to say that on the record
21 at this time.

22 THE COURT: You're protected.

23 Mr. Nance, I assume yours is likewise.

24 Anything else you want to add?

25 MR. NANCE: Yes, sir. I have a bit to add, as

1 a matter of fact.

2 As we know, Edgefield Medical Clinic is a PA,
3 not a partnership. It's a PA. And unlike a
4 partnership, by law, the shareholders and employees
5 are not responsible for each other's actions. Now,
6 partners are responsible for partners' actions.
7 Principals are responsible for agents' actions.
8 These people, all four of them, unbeknownst to
9 Dr. Levine, it's his opinion that they were
10 partners. They're just employees, they're
11 shareholders, and are not responsible for other
12 people's actions.

13 Now, the practice is, mind you, but not the
14 individual doctors, by law. And Dr. Levine could
15 not say which doctor did what. I asked him, I
16 wanted to know who was doing what, and he couldn't
17 say, he didn't say, he just says everybody. As a
18 matter of law, everybody can't be. You've got to
19 know something about what's going on, and the only
20 evidence in this case is that Dr. Leaphart and
21 Dr. Rainsford knew nothing about the MRSA culture or
22 the finding of it or anything else. It was ordered
23 by Dr. Nicholson, who is no longer in the case. It
24 was faxed to Dr. Massey and, rightfully so,
25 Dr. Massey passed it on to the person who was

1 treating the patient. Of course the expert says so
2 many things should have been done, this, that, and
3 the other, we've heard testimony of that, but it's
4 just a fact. As a matter of law, Leaphart and
5 Rainsford, they can't be responsible for something
6 they did not know and they're not responsible for
7 other actions of other employees or shareholders.
8 It's just different from a partnership.

9 THE COURT: So you want me to release Rainsford
10 and Leaphart and the PA?

11 MR. NANCE: I think the PA stays in, frankly.
12 Whoever is doing this is working for the PA, an
13 employee of the PA. Leaphart and Rainsford
14 individually, it's just as a matter of law, should
15 get out.

16 MR. PARKINSON: And, Your Honor, to the extent
17 Mr. Welch is going to argue about that, I'd add that
18 ground to my motion as well.

19 THE COURT: So there's just one defendant?

20 MR. PARKINSON: One defendant, the PA. But I
21 don't think the individual doctors -- there's
22 nothing that's pointed them out individually by
23 Dr. Levine.

24 MR. WELCH: I'm not going to address Dr. Massey
25 again. The Court's ruled on that. In terms of the

1 PA, Dr. Levine's opinion had nothing to do with
2 being a partnership. It had to do with taking
3 medical responsibility for patients. The testimony
4 from everybody in this case is the patients in the
5 nursing home are the patients of each of the doctors
6 at the practice. When you take on the
7 responsibility to see a patient, you take on the
8 responsibility to read the chart, to know something
9 about that patient, to check on that patient, to
10 have information to make informed decisions. Each
11 of these doctors has testified that they have
12 written orders on a wound that none of them saw.
13 They had an obligation to see it. Those orders were
14 written both before the 15th and Dr. Leaphart's on
15 the discharge was after that 15th.

16 The bottom line is, the testimony of Dr. Levine
17 was based on the responsibility taken on as a
18 physician, not upon the partnership. So to say I
19 knew nothing about it is a circular argument.
20 That's because you didn't look, that's because you
21 didn't examine, that's because you didn't ask.

22 Dr. Rainsford testified that he came by and saw
23 a physical therapist that was debriding the wound,
24 but he didn't -- he wasn't seeing the patient. He
25 didn't glove up, he didn't examine the wound. He

1 had an opportunity to, he didn't.

2 Dr. Leaphart testified that she wrote a few
3 orders that had to do with the wound and then the
4 debridement started on the 21st when she was writing
5 the order there on the 21st, but she didn't do
6 anything to see what the wound was really like. So
7 the testimony is about their obligation when they
8 take on the care of the physician, not about the
9 partnership. And there's adequate testimony from
10 the record as to what each of them did. What they
11 actually did was nothing.

12 THE COURT: Anything else, Mr. Nance?

13 MR. NANCE: No, sir. I've already said,
14 regardless of what he said, they didn't see him. If
15 they had seen him, that'd be another thing.

16 THE COURT: Well, they should have, is the
17 question.

18 MR. NANCE: They weren't scheduled to see him.
19 I mean, that's the way the practice went. I mean,
20 you just don't walk over there by osmosis and walk
21 around and see everybody -- and nobody even knew he
22 had any problem until -- or even suspected it until
23 the 2nd of May. And Dr. Rainsford never saw him
24 during this second period. And Dr. Leaphart never
25 saw him in May.

1 THE COURT: All right. Anything else?

2 MR. WELCH: That's all, Judge.

3 MR. NANCE: Yeah, as a matter of fact.

4 THE COURT: I'm going to take that under
5 advisement.

6 MR. NANCE: The testimony was, by
7 Dr. Rainsford, that had he had the opportunity to
8 see Mr. Peterson on the 15th, and based upon the
9 records and change in circumstances and had the
10 family removed the DNR directive, that Mr. Peterson
11 would have had to go somewhere else to get
12 antibiotics and that they desired, so they're just
13 getting what they wanted. Wouldn't have been any
14 different than what he would have done had he been
15 there, but he wasn't able to do that. And for that
16 reason, these charges are not appropriate to be
17 charged to a jury to even consider the charges be
18 made against them. They were incurred because the
19 family wanted it, they would have been incurred
20 regardless had Dr. Rainsford been allowed to see him
21 and the DNR been directed and rescinded.

22 THE COURT: Well, that's your side of the
23 story. Dr. Levine said had it been treated or
24 diagnosed, if he had been treated, he would not have
25 needed advanced care. If he had been treated, my

1 note says he would not have needed transfer to Aiken
2 or the advanced care.

3 MR. WELCH: That was the testimony of the
4 doctor, yes.

5 THE COURT: He says right then, if he'd been
6 treated earlier, if the sepsis had allegedly been
7 caught earlier, the transfer would not have been
8 necessary and would not have incurred the additional
9 expenses, so that's a jury question.

10 MR. NANCE: I'd like to point out one other
11 thing, Your Honor. I spent a lot of time going
12 through these records and pulling out everything
13 that said he was not -- Mr. Peterson was not in
14 pain. It's replete with entries by nurses of no
15 pain. And that was going to be my cross-examination
16 this morning. And I didn't need it, so I'm just
17 saying --

18 THE COURT: Cross-examination of who?

19 MR. NANCE: Whoever was getting ready to
20 testify. It's in the records.

21 THE COURT: If I allow it in you can still
22 argue it until 5:00 tomorrow afternoon. I'm going
23 to talk to y'all about that in chambers.

24 MR. PARKINSON: I know you're going to talk
25 about that in chambers, but since that came up with

1 Mr. Nance, I was just going to point out that my
2 case is closed, my expert witness has gone home. I
3 could have addressed those things about pain and
4 suffering and I elected not to based on the Court's
5 previous ruling. So I'm prejudiced now if that
6 changes because I elected not to present evidence
7 about it.

8 THE COURT: I understand. I've been down there
9 for 30 years.

10 Anything else?

11 MR. WELCH: Nothing else, Judge.

12 THE COURT: All right. Jury charges, here they
13 are: Duties of the Judge and jury, preponderance of
14 the evidence, credibility of witnesses, expert
15 testimony.

16 MR. WELCH: Judge, I gave you mine previously.

17 THE COURT: I know. I'm telling you what I'm
18 going to charge. It's the same thing y'all always
19 give me. Those are the general charges.

20 Standard medical malpractice charge. And in
21 order to prove medical malpractice or medical
22 negligence, there are four elements: You have to
23 establish the duty, establish the standard of care,
24 establish deviation from the standard of care, you
25 have to establish injuries and injuries or damages

1 were proximal cause by the deviation from the
2 standard of care. Standard of care is that degree
3 of knowledge, care, and skill ordinarily possessed
4 by the doctors skilled in medicine under the same or
5 similar circumstances, and that the doctor followed
6 generally accepted practices and procedures in the
7 profession.

8 Breach of the standard: That the doctors
9 negligently departed from the standard of care of
10 treating the patient. Negligence: Failure to do
11 what an ordinarily careful doctor skilled in
12 medicine would have done under the same or similar
13 circumstances or not doing something that an
14 ordinary doctor would have done. Would cure that
15 doctor's mistake or error and make the decision
16 alone does not constitute negligence. It's the same
17 charge y'all have heard a thousand times.

18 Proximate cause: Going to prove that the
19 defendant's negligence proximately caused the
20 plaintiff's damage. Proximate cause is something
21 that produced a chain of events, et cetera.

22 The charge on failure to diagnose and treat:
23 The plaintiff must prove that the defendants'
24 negligent failure to discover and treat the disease
25 or condition in which the plaintiff suffered or was

1 probably caused to suffer.

2 Pain and suffering or expenses, how it's ruled.

3 So that's basically what I charge. And if I
4 charge actual damages, it will be reasonable and
5 necessary medical expenses. I will charge that. If
6 I charge pain and suffering, it will be the regular
7 pain and suffering charge.

8 So what else do you want, Mr. Welch?

9 MR. WELCH: Nothing for the plaintiff, Judge.

10 THE COURT: Mr. Parkinson?

11 MR. PARKINSON: The only thing I will say is
12 that to the extent that my submitted proposed
13 charges had standard charges regarding damages
14 related to pain and suffering and similar type
15 damages, I would not be suggesting to the Court that
16 I thought that was appropriate. That just came out
17 in my standard charges.

18 THE COURT: I understand. And when we get to
19 damages, what we know right now is that reasonable
20 and necessary medical expenses caused by the
21 deviation from the standard of care, and then if I
22 charge pain and suffering, that will be the only
23 other element of probable cause.

24 MR. PARKINSON: And you're correct; I think
25 we've all heard the standard a number of times. But

1 yours has the hindsight type charge in there as
2 well?

3 THE COURT: No.

4 MR. PARKINSON: Not to be judged in hindsight?

5 THE COURT: No.

6 MR. PARKINSON: I actually think Mr. Welch has
7 one on that. It might be easier to find since he
8 has the table of contents.

9 MR. NANCE: I request the Charge No. 1.

10 THE COURT: Mr. Welch, what do you say to that?

11 MR. WELCH: I don't have an objection to that.

12 THE COURT: I'll charge that.

13 Anything else y'all want?

14 MR. NANCE: I request number 2, that experts
15 can disagree and just because they do doesn't mean
16 that one or the other is a breach of the standard of
17 care.

18 THE COURT: Mr. Welch, what do you say to that
19 one?

20 MR. WELCH: I'm looking at the charge.

21 THE COURT: It says the mere fact that the
22 plaintiff's expert may use a different approach is
23 not considered a deviation from the recognized
24 standard of medical care, nor is the standard
25 violated by an expert that disagrees with the

1 defendant as to what is best for the patient.

2 MR. WELCH: Judge, I would have an objection to
3 that charge for this reason: For instance, surgery,
4 take out a gallbladder, even if you do it with a
5 laparoscope, there's three different approaches.
6 One of those approaches has actually been shown to
7 give a lot better result to the patient, but it's a
8 littler and most doctors won't do it. But either
9 one of those three approaches, if you use them and
10 there's another risk or consequence that's not a
11 breach in the standard of care. That's not the case
12 here.

13 This case is about treating or not treating the
14 infection. And those aren't necessarily different
15 approaches, it's not a different methodology. It's
16 totally different in terms of whether you treat a
17 disease or don't treat the disease. They basically
18 say we saw nothing to treat. Our physician says,
19 yes, it should have been treated. So I don't think
20 it's just a difference in methodology like it is a
21 surgical procedure. If that were the case, then
22 every single med mal case, you would say that
23 there's really no malpractice because we use
24 different approaches. It's one of those circular
25 arguments again.

1 If you're talking about a different recognized
2 methodology on something and there's two or three
3 ways to do it taught in medical school, that's one
4 thing. But to say I'm not going to treat, I don't
5 see anything to treat, and the other one says
6 clinically it should have been treated, then those
7 disputes are the ones that rise and that literally
8 becomes a mere difference, a different approach,
9 then there's really no such thing as malpractice. I
10 don't think it's necessary here.

11 THE COURT: All right. I will not charge that.
12 I will rely on my regular standard charge.

13 What else, Mr. Nance?

14 MR. NANCE: Number 5.

15 THE COURT: I think the rest of them are pretty
16 much in my regular charge.

17 MR. NANCE: They may be. Number 5, number 6.

18 THE COURT: Here's what I charge, sort of all
19 of that put together, it says: The difficulties and
20 uncertainties in the practice of medicine and the
21 unpredictable variations in the response to
22 treatment are such that no doctor can guarantee
23 results. Where there's more than one recognized
24 diagnosis or treatment, if one of them is used
25 exclusively and uniformly by all doctors in good

1 standing, it's not negligence for a doctor to make a
2 decision to use one of the approved methods, even
3 when the choice later turns out to be a wrong
4 selection. Qualified doctors and experts may differ
5 as to what constitutes the best course of treatment,
6 and these differences do not amount to malpractice
7 if doctors in good standing disagree on what medical
8 authorities regard as the specific course of
9 treatment or care, then the doctors are bound only
10 to exercise his or her best judgment in determining
11 which course on the whole is the best for the
12 patient. Just because another doctor may have used
13 a different course of treatment does not make the
14 defendant negligent; however, if the doctor does not
15 have the degree of learning or skill required or if
16 the doctor does not use the care required, it's no
17 fence to a charge of negligence that the doctor did
18 the best that he could. In considering whether the
19 defendant made a reasonable decision you must
20 consider the decision in relation to the facts as
21 they existed at the time, not in the light of
22 hindsight.

23 MR. NANCE: That's good.

24 THE COURT: And that's coming straight out of
25 our charges that Court Administration suggests that

1 we use in these cases.

2 Anything else? Verdict form. If I keep
3 everybody in, we have to have one for Dr. Massey,
4 one for Dr. Leaphart, one for Dr. Rainsford, one for
5 the PA, and one for the practice? We find for the
6 Plaintiff against Dr. Massey, we find for
7 Dr. Massey?

8 MR. PARKINSON: On separate pieces of paper for
9 each defendant?

10 THE COURT: Okay.

11 MR. PARKINSON: Okay.

12 THE COURT: Then you get to the problem of
13 damages. I guess they could be joint and several.

14 MR. PARKINSON: I guess I hadn't thought about
15 it the way the Court is suggesting. I didn't know
16 if we would have one that says we find for the
17 plaintiff X-dollars against Massey or, you know,
18 pick one or all of the defendants, or we find for
19 the defendants -- I guess I need to think about that
20 a little bit more because the damages are
21 nonseverable damages.

22 THE COURT: They are. What's your suggestion
23 as to what --

24 MR. WELCH: Judge --

25 THE COURT: I mean, they could find Dr. Massey

1 and not against the other two; they could find
2 against Dr. Leaphart and the other two; they could
3 find against all three, they could find for all
4 three. I mean, there's all kinds of combinations.

5 MR. WELCH: That verdict form allows them to
6 check which one or it basically depends on who they
7 check or find for all the defendants against the
8 plaintiff, or they go ahead and go to the next page
9 where they do economic and it makes it clear, and
10 there's also potentially a special verdict form in
11 the back that they do the percentages.

12 THE COURT: All right, gentlemen, y'all think
13 about it this evening and let's be here at 9:00 in
14 the morning or maybe quarter of 9:00.

15 MR. WELCH: Quarter of.

16 THE COURT: Anything else before we break?

17 MR. WELCH: That's it from the plaintiff.

18 MR. PARKINSON: Nothing further.

19 THE COURT: Let me see y'all back in chambers.

20 (Court in recess for the evening.)

21 THE COURT: After everybody was gone yesterday,
22 we had a chitchat in chambers. And, first of all,
23 I'm going to elevate Juror No. 46, that's James
24 Foley, to the jury. He was Alternate No. 1.

25 Secondly, we talked about the verdict form.

1 And when we left yesterday, I think everybody was
2 pretty much in agreement with the form that
3 Mr. Welch had given to us that simply said we find
4 for the plaintiffs against the following defendants,
5 and it lists each defendant separately -- Massey,
6 Rainsford, Leaphart -- and the medical center, or we
7 find for the defendants against the plaintiff.

8 But then the second page, I don't think we all
9 looked at the second page because it had the
10 breakdown between economic and noneconomic damages.
11 And I stand by my ruling; there will be no economic
12 damages, it will just be a matter of the verdict.
13 So we need to probably revise page 2, depending on
14 my ruling. Okay?

15 MR. WELCH: Yes, sir.

16 THE COURT: So when we finish this little
17 exercise on the pain and suffering, if y'all will
18 get with Cassie.

19 All right. I am going to stand by my ruling on
20 the pain and suffering. After further reflection I
21 feel like that I am correct in that matter.
22 Mr. Welch, and I know at 1:00 this morning, and I
23 read it about 5:30 or 6:00 this morning, submitted a
24 memo outlining a lot of your argument from
25 yesterday, so I want you to please make that a part

1 of the record so you'll be protected on that angle
2 of it. I think that will protect you for the
3 record. If you need to add anything in addition to
4 what've you've outlined in the memo, I thought your
5 memo was very thorough.

6 MR. WELCH: No, sir. I'll pass this up to the
7 clerk and make it part of the record.

8 THE COURT: But this is -- I've been doing this
9 a long time; other than Mr. Nance, probably longer
10 than anybody in the courtroom. But this is not a
11 typical run-of-the-mill medical malpractice case,
12 and it's an interesting case. We have a man who's
13 obviously very elderly, he as an unfortunate event
14 at home, and because he lives alone, unfortunately
15 he was not found for a number of days -- I think the
16 testimony revealed three days -- he had a
17 do-not-resuscitate order both times he was in the
18 nursing home and, quite honestly, from the
19 testimony, he was on death's doorstep to the point
20 that when the family got there on the 15th, I think
21 one of the ladies said he was leaving or passing or
22 getting ready to die. I mean, he was in bad shape
23 and he was in bad shape throughout his tenure at the
24 nursing home. He experienced paralysis, a lot of
25 unconsciousness. And then the cause of action is a

1 survival action and alleging that the doctors failed
2 to diagnose not the bed sore particularly itself, but
3 the -- where the bed sore had increased to the stage
4 that it had MRSA. And I'm just of the opinion that
5 the record is void of any evidence dealing with the
6 failing to diagnose the MRSA and any associated pain
7 and suffering with that alleged failure to diagnose.
8 I mean, he was paralyzed and he had the bed sore
9 anyway. There's no criticism of getting the bed sore
10 or the treatment of the bed sore, but they're having
11 to debride it and do all that. Notwithstanding
12 whether he got the MRSA or not, they were doing that
13 before the MRSA showed up. So, I mean, all that, if
14 there were pain and suffering -- I don't think there
15 was any evidence that showed it was proximately
16 caused by the failure to diagnose and treat.

17 Really, as I said a number of times, was that
18 Dr. Levine, who testified about the standard of care
19 and the deviation in his opinion in this case, and
20 then Mr. Welch very -- as he had to do at the top,
21 proximate cause, and my notes were just as bold as
22 they could be; if he had been treated, the outcome
23 would have been that he would not have incurred the
24 additional expenses. So the additional expenses is
25 what -- in my opinion, what's shown proven to the

1 jury or presented to the jury as the proximate cause
2 of the failure to diagnose. Therefore, those are
3 the reasons for my ruling. I stand by my ruling. I
4 understand everybody's position and I think
5 everybody is protected. I've allowed Mr. Welch to
6 present the memo.

7 Do you need to put anything else on the record?

8 MR. WELCH: No, sir, Judge. If I could have
9 one minute to discuss, since you're going to stand
10 by your ruling, Judge, something with both counsel?

11 THE COURT: Absolutely.

12 So other than getting the verdict form
13 modified, I don't think we have anything else to do.

14 MR. WELCH: If I can have one minute, Judge.

15 THE COURT: Absolutely. Absolutely.

16 (Brief pause in the proceedings.)

17 MR. NANCE: Your Honor, you might recall that
18 yesterday I moved to dismiss Dr. Leaphart and
19 Dr. Rainsford individually.

20 THE COURT: You did. We discussed that in
21 chambers last night and we were going to revisit
22 that this morning. That slipped my mind.

23 MR. WELCH: Here's what I've offered them,
24 considering your ruling. The practice only has
25 \$200,000 in coverage. Considering the ruling, the

1 medical bills are less than 200,000, so I've offered
2 to release the physicians, go in against the
3 practice, with the understanding put on the record,
4 which will be the law, that they are not going to
5 assert a defense later of releasing the agent is
6 releasing the principal in this case.

7 THE COURT: Well, I don't know that you have to
8 release them. What if I granted Mr. Nance's motion?
9 I don't know if he could raise that then if you got
10 a verdict against the practice.

11 MR. WELCH: Judge, that does not permit me to
12 argue anything in my opinion, if you do that, about
13 anything they did.

14 THE COURT: Well, no, but they're members of
15 the practice.

16 MR. WELCH: I understand that. But...

17 THE COURT: I'll be quiet, let you all discuss
18 it.

19 MR. WELCH: They're willing to do that. I just
20 want to put that on the record. That way, the
21 doctors are no longer at risk.

22 THE COURT: So it will be just against the PA?

23 MR. WELCH: Yes.

24 MR. NANCE: Well, I've got to talk to some
25 people about that.

1 THE COURT: Well, you made the motion. Want to
2 withdraw it?

3 MR. NANCE: I made the motion in regards to
4 Leaphart and Rainsford, who are my clients, that
5 they be dismissed; they never treated this man --

6 THE COURT: You also made the motion about them
7 being members of the PA and all of --

8 MR. NANCE: That's the basis of it, why they
9 can't -- they're not partners, so they're not liable
10 for each other's actions vicariously. They would be
11 if they were partners. They're just employees and
12 shareholders of the PA. The PA is the principal and
13 the doctors are the employees, agents.

14 THE COURT: My ruling on that is going to be
15 that I'm going to leave everybody in unless y'all
16 decide something different. So I'll let you have a
17 minute.

18 MR. PARKINSON: Your Honor, I think what --
19 Dr. Massey is not on the -- is insured by a
20 different carrier. And for that reason, if the
21 PA -- I'm willing to do this on behalf of
22 Dr. Massey, what Mr. Welch is suggesting. But it's
23 not my monetary skin in the game for my carrier,
24 it's the carrier that relates to --

25 THE COURT: Gentlemen, I'm going to leave it

1 just like it is unless y'all decide something
2 different. We're going to stand at ease until 9:30.

3 (Short break.)

4 THE COURT: Please be seated. We have an
5 agreement as to -- go ahead.

6 MR. WELCH: Judge, we're going to stipulate as
7 follows: Based on Court's ruling, the plaintiff is
8 releasing the three named individual doctors as
9 defendants with the understanding that the practice
10 will not assert the defense of release of agent as
11 release of principal in this case.

12 Plaintiff also agrees that if any verdict is in
13 excess of the 2006 practice policy limits, which our
14 understanding --

15 THE COURT: 2000 --

16 MR. WELCH: '6 policy limits --

17 THE COURT: The year 2006; right?

18 MR. WELCH: Yes. Which our understanding is,
19 is the \$200,000 JUA coverage, no PCF coverage,
20 limits to \$200,000 per occurrence individual,
21 600,000 per occurrence, Plaintiff will not seek
22 collection above the policy limits.

23 THE COURT: Is that correct, Mr. Parkinson?

24 MR. PARKINSON: That's correct, Your Honor.

25 And I just want to say on the record that the

1 dismissal of Dr. Massey needs to be with prejudice,
2 still with that understanding so that the -- there's
3 not going to be any kind of appeal that involves
4 Dr. Massey; she's done.

5 MR. WELCH: Judge, if -- statute of limitations
6 has run once these parties are dismissed. There's
7 practically no way to bring them back. So...

8 THE COURT: But it would be with prejudice?

9 MR. WELCH: Yes, sir.

10 THE COURT: Mr. Nance?

11 MR. NANCE: Same on behalf of Drs. Leaphart and
12 Rainsford.

13 THE COURT: Both of those are dismissed with
14 prejudice. Verdict form will be: We find for the
15 Plaintiff; blacked out is actual damage against the
16 defendant --

17 MR. WELCH: Edgefield Family Practice --

18 THE COURT: -- we find for the Defendant?

19 MR. WELCH: Yes, sir.

20 THE COURT: Make that change, please, ma'am.

21 (Brief pause in the proceedings.)

22 THE COURT: All right. How do y'all want me to
23 inform the jury about how to posture the case?

24 MR. WELCH: Judge, the plaintiff's preference
25 would be just that you inform the jury that the

1 defendant that the jury will be considering would be
2 only the practice.

3 THE COURT: I'll just tell them that in light
4 of some developments yesterday, that the posture of
5 the case now is as follows. Fair enough?

6 MR. WELCH: Very good.

7 THE COURT: So we'll have that new verdict form
8 in just a little bit.

9 MR. PARKINSON: I guess I will vacate my spot
10 at this table or do you want me to sit here?

11 THE COURT: I know where I would be, on my way
12 home. You're welcome to stay with us.

13 MR. PARKINSON: I think I'll stay and see how
14 it goes.

15 (The jury enters the courtroom at 9:44 AM.)

16 THE COURT: Mr. Foley, raise your hand, please.
17 Mr. Foley, I'm going to elevate you to the regular
18 jury panel from an alternate status. So if you
19 would just come down and please have a seat here.
20 We had one juror who had a longstanding doctor's
21 appointment this morning, so he had to be excused.
22 That's why we have alternates.

23 Mr. Foreman, ladies and gentlemen, we're now at
24 the stage of the trial where what is left is the
25 final arguments by the lawyers. Once they have

1 completed their final arguments, then I will
2 instruct you or charge you on the law, and then
3 you'll be in position to start your deliberations.

4 As a result -- after y'all left yesterday, as a
5 result of some posttrial meetings and discussions,
6 the status of the case is as follows: Remaining in
7 the case, obviously, is the plaintiff, Ms. Jackson
8 as the personal representative of the late
9 Mr. Peterson, and the only defendant remaining is
10 the Edgefield Medical Clinic, PA. The individual
11 doctors are no longer parties, their practice is now
12 the sole defendant. So that's the status of the
13 case after several things posturing yesterday. And
14 if the lawyers want to explain that to you, they
15 can.

16 Please bear in mind that you've heard all the
17 evidence from which you'll make your decision. The
18 final arguments are not evidence in the case.
19 Obviously both of these lawyers, Mr. Nance and
20 Mr. Welch, represent their respective clients and
21 they'll be arguing the evidence in the light most
22 favorable to their clients, but that simply is
23 argument.

24 You've heard the evidence from which you'll
25 make your decision. I ask that you pay close

1 attention. I suspect you'll be receiving the case
2 not too far from now. You've been great, paid great
3 attention, so I ask that you do that for a few more
4 hours this morning and then you'll be in a position
5 to deliberate.

6 Any objections to those remarks?

7 MR. WELCH: No, sir, Judge.

8 MR. NANCE: No, sir.

9 THE COURT: All right. Then you may move
10 forward.

11 Mr. Welch, before you start, let me see you and
12 Mr. Nance just a second.

13 (Sidebar conference.)

14 MR. WELCH: Ladies and gentlemen, my job is
15 almost over. My job is to bring to you the evidence
16 in the case. I told you at the beginning some
17 things that I will follow up on, then your job
18 starts. Because once the Judge is finished, I'm
19 finished, and the defense is finished. Then it's up
20 to you.

21 Now, one thing you need to understand as we
22 start this process is this: That a corporation,
23 Edgefield Medical Clinic, PA, acts through its
24 individual employees. So what you have is a
25 situation where the employees' and the clinic's

1 action become the actions of the corporation. So
2 you're still going to look at the activities of the
3 employees, but the only verdict will be against the
4 corporation, not against the individual doctors.

5 So as you listen to the discussions that I'm
6 going to give you now, when you go back in the jury
7 room you're going to have a verdict form that's
8 going to have just the Edgefield Medical Clinic, PA,
9 and then you're going to say, well, they were
10 talking about the doctors. The reason is, is that
11 the actions of the doctors are the actions of the
12 corporation. So if you analyze what was done here
13 as a breach of the standard of care and you find
14 those breaches caused the damage or proximately
15 caused the damage, then you're finding against the
16 corporation. But again, the verdict itself would be
17 against the corporation, not against the individual
18 doctors.

19 Let me tell you why that's important what we're
20 looking at. When you get back into that jury room,
21 you're going to have three tasks, three main jobs to
22 start with. The first one is to identify the
23 important issue or question the Judge gives you to
24 answer. I'll come back to that.

25 The second one is to discuss your points and to

1 listen to the others. This is a discussion that
2 takes place in the jury room. And it's private and
3 confidential. But you have an obligation to look at
4 the evidence. And a group as large as 12 people,
5 the chances are you're not going to agree at first,
6 but you have an obligation, you took an oath before
7 this Court, that you would do three basic things.

8 The first one is you would put aside any
9 personal prejudices you have, any personal feelings
10 you have. Some of you even said in the voir dire
11 part that you maybe knew one of the individual
12 defendants. You agreed to put all that aside and
13 not let any of that make a difference. The other
14 thing you agreed to do is to look at the evidence,
15 to actually listen to the evidence. Based upon
16 that, you agreed that you would faithfully and truly
17 and honestly find a verdict in this case based upon
18 the facts no matter how you felt personally. So
19 when you get back there, you want to discuss your
20 points and listen to the others.

21 The third thing that's one of your tasks as a
22 juror is to make sure that nobody brings into that
23 jury room anything that's not in evidence in this
24 courtroom; anything you've heard, somebody's
25 opinion, somebody that's got a relative that had

1 something similar happen, here's what happened,
2 that's got no place in the discussion back there.
3 And you have the right as a juror, if someone
4 insists on violating the law the Judge is going to
5 give you and considering information that's not in
6 evidence, you have the right to ask the foreperson
7 to ask the Judge to address that. And you've got a
8 right on that jury to tell the person, we are not to
9 listen to that. So when you take that oath as a
10 juror, it's not just for you just to follow the law,
11 but to make sure that other people follow the law as
12 well.

13 I told you in opening there are two rules we
14 have to look at. The first one is, if you agree to
15 be the treating doctor of the nursing home patient,
16 you must have reasonable face-to-face contact with
17 that patient to make medical decisions in the
18 patient's best interest. Now, you've heard
19 testimony that under certain rules and regulations
20 that there was an obligation on the physician to do
21 an initial visit within 24 to 48 hours, then every
22 30 days, then after that every 60 days. But you
23 also heard testimony from not just Dr. Levine that
24 testified, but from the other doctors, that that's
25 not just the maximum or a minimum, that means that

1 under those regs, you have to do that, but if the
2 patient needs consideration or care or treatment or
3 review in a medical situation other than that, you
4 have an obligation to go face to face and see the
5 patient, make an examination. You heard the phrase
6 that the nurses and the physical therapists are the
7 eyes and the ears of the doctor. We don't dispute
8 that. But they're not the brain of the doctor,
9 they're not the decision-making portion; that's up
10 to the physician, and the physician can only do that
11 after a proper examination.

12 Number two, if you do not properly examine the
13 patient on a reasonable basis, the doctor is
14 responsible for problems from treatable conditions
15 that develop. And that's a simple premise. You
16 have an obligation to go examine. If you don't make
17 the personal examination and gather enough
18 information to properly treat the patient and that
19 patient suffers a condition that is preventable
20 because of your inaction, you're responsible.

21 Now, there's four elements of the case. The
22 Judge is going to give you the law on this and you
23 can follow along what the Judge says. And anything
24 that I saw that may be different on this, obviously
25 the law the Judge give s you is what it is. But

1 there's four things the plaintiff has got to prove.
2 The first one is the standard of care. That means
3 what should the physician have done or refrained
4 from doing. The second one is that there was a
5 breach of that standard of care. What that means
6 is, is that now that we've told you or the
7 physicians have told you what should have been done
8 or not done, then actually the physicians either
9 didn't do it or did it when they weren't supposed
10 to, that's the breach of the standard of care. The
11 third one is what's called proximate cause, and it's
12 one of those almost archaic legal terms. What does
13 it mean? Why does somebody use the word proximate
14 anymore in 2014? It's a term that basically
15 means -- and the Judge will give you the specific
16 language on it -- but not just that there was a
17 breach, but that breach actually had a logical
18 conclusion following to cause those damages. You
19 can see that connection, that it was foreseeable in
20 a way. The last one is damages. There has to be
21 damages resulting from that breach. I'm going to
22 come back to each of those individually, but those
23 are the four things in sequence that you have to
24 consider. Number one, did the plaintiff show the
25 standard of care; number two, did they show that

1 that was broken or breached; number three, was that
2 action what caused the damages; and number four,
3 what are the damages.

4 Now, I will tell you that the law does not
5 allow you to give a verdict based on sympathy or
6 prejudice or emotion or public opinion; none of that
7 has any place in the courtroom. I assure you that
8 Ms. Jackson, on behalf of her father's estate,
9 doesn't want any sympathy from you, doesn't want any
10 verdict but the truth. She doesn't want any passion
11 or opinion either way. She wants you to basically
12 simply look at the truth and do what the law
13 requires you to do under the circumstances.

14 Now, the burden the plaintiff has is called the
15 preponderance of the evidence. In other words,
16 another one of those legal terms and issues that we
17 don't use in everyday life. All that really means,
18 and the law discusses it as, it means the greater
19 weight of the evidence. It is the evidence which as
20 a whole shows that the fact sought to be proved is
21 more likely true than not. More likely, 51 percent;
22 moving the ball from the 50-yard line to the 51-yard
23 line. That's the burden. This is not a criminal
24 case. This is not something where we have to show
25 you the standard of care, the breach or the breaking

1 of that standard of care, the proximate cause or the
2 cause issue, and damages by a -- beyond a reasonable
3 doubt. That's a criminal case. That's not a civil
4 case. The civil burden is much lower. It is 51
5 percent, it's moving that ball one yard past the
6 50-yard line.

7 You see the scales of justice? Everybody's
8 seen those, she's blindfolded. But that scale, that
9 51 percent means for the plaintiff to carry the
10 burden of proof, that scale's got to tip ever so
11 slightly toward the plaintiff. Not tip down, just
12 tip every so slightly.

13 Now what is negligence? The best thing I can
14 tell you is, is when you think of the word
15 negligence, think of the word reasonable. And I
16 want to give you an example. I don't know how many
17 of you are NASCAR fans. My mother, quite frankly,
18 is a NASCAR fan and her favorite driver is Dale
19 Earnhardt, Jr., and I understand he drives
20 Chevrolets. Now, I can tell you that Dale can be at
21 the track in Charlotte practicing and decide to go
22 home, and get on that four-lane outside the track in
23 Charlotte and go up toward I-85. And there's three
24 lights before you get to I-85 from that track. And
25 Dale may put his cell phone on that seat beside him,

1. and I'm assuming he's driving a Chevrolet home. And
2. as he heads through the first light, it's green, and
3. the cell phone rings. And he looks down to see if
4. it's his new girlfriend. And while he's looking at
5. that cell phone and goes to pick it up, the light
6. changes to red and he goes through the red light.
7. Now, that inattention, that failure to act
8. reasonably, is negligence; doesn't mean that Dale
9. Earnhardt is a bad driver or a bad person, doesn't
10. mean any of that. And the same principle applies in
11. a case like this. If you're negligent and not
12. acting reasonably, that's not an indication you're a
13. bad person, that doesn't mean you acted
14. intentionally, that's not what negligence is. If
15. someone back there starts saying, well, it wasn't
16. done intentionally, that's not the standard, that's
17. not what negligence is. It means the physicians
18. simply did not act reasonably.

19. This is what's called a survivor action. And
20. what that means is -- and there's a statute, that's
21. what's up here. And it says that Mr. Peterson, when
22. he was alive, suffered certain damages. And because
23. he passed away doesn't mean that he lost the right
24. or his estate lost the right to recover those
25. damages. So the award that you're going to make in

1 this case is actually to the estate of Mr. Peterson
2 for those medical bills and things that he incurred.
3 And the testimony was from Dr. Levine for those
4 things that were made necessary because of the fact
5 that the negligence occurred.

6 Now, what does this case boil down to? Who saw
7 Mr. Peterson and examined him after April 14th,
8 2006? Dr. Massey didn't, Dr. Rainsford didn't,
9 Dr. Leaphart didn't. From April the 14th to May the
10 15th, not one of these doctors physically examined
11 him. I'm going to go through some more specifics
12 with you in a minute, but even though you can see in
13 the chart, you're going to have in evidence that
14 Dr. Leaphart was writing orders that changes one of
15 the debriding agents to another debriding agent;
16 that the doctor was actually looking, at a time,
17 writing other orders in the chart, signing off on
18 them; that one of the physical therapists or the
19 nurse would write and recommend and say, okay,
20 that's fine, write off on it. At the time that
21 debridement was actually starting on that wound on
22 April the 21st, you see in the record and heard in
23 evidence that that wound went from -- there's a
24 four-stage classification. Number one just being
25 red skin, number four being a penetration of the

1 skin down through the layers. That's what you see
2 at the very end. By April 21st in there, that had
3 gone to a stage three, and by May it was a stage
4 four. At that point in the process, no physician is
5 looking at this wound or examining this wound.

6 Now, what are you going to base your decision
7 on? One of the things you've got in this case is
8 what's referred to in the law as expert testimony.
9 And, quite frankly, all that means is to be an
10 expert you have to have knowledge that's not in our
11 everyday common knowledge base. You have to have
12 special knowledge that may assist the jury. In
13 medical cases, it's physician's testimony as to what
14 the standard of care is.

15 Now, you're going to be faced with a decision,
16 because you have a physician, Dr. Levine, and they
17 make a big deal out of the fact that he's from
18 Manhattan. Dr. Levine is a board certified internal
19 medicine doctor, geriatric physician, that
20 publishes, that researches, that sees patients, and
21 he came down here to give you his honest testimony
22 about the treatment of this patient. Where he's
23 from should have nothing to do with it. The fact
24 that he's not from South Carolina should play
25 absolutely no role in your determination of his

1 testimony. Now, if you disagree with his testimony,
2 let it be for some specific reason you find, not
3 because of where he's from. But what you'll find
4 from his testimony is, is that you should face the
5 patient, physically see the patient. When you take
6 on the obligation to be the physician, you take on
7 the obligation to have knowledge of your patient,
8 and that the clinical evidence in the medical record
9 showed this patient, the wound developing, going
10 downhill. Keep in mind the plaintiff is not saying
11 that that wound was preventable; that's not what the
12 plaintiff is saying, that's not what Dr. Levine
13 said. But knowing patients like Mr. Peterson have
14 these wounds, when you see it start getting worse
15 and worse, you have to go see the patient. And when
16 you culture out something like this MRSA, you have
17 to treat it immediately. If you don't, you're going
18 to get the results you had in this case.

19 When you look at the qualifications of the
20 experts, that's one of the first things you look at:
21 Do they teach? Do they publish? Do they actually
22 develop information in this area? Do they train
23 other physicians? Their credibility. Do you feel
24 like they were being open and honest with you, with
25 all of us in everything they said? The reasons for

1 their opinion. What are the reasons the expert had
2 to view the case the way they did? And quite
3 frankly, I'm going to tell you that one of the best
4 examples is Dr. Lovelace, Dr. 100-case Lovelace.
5 Everyone, never testified for a plaintiff in South
6 Carolina, always testified for the doctor.

7 Number four, the facts that they assume to be
8 true. And for instance, you heard Dr. Eads say
9 something like, well, he didn't get any better at
10 Aiken which shows they did everything okay at the
11 nursing home. Well, he did get better at Aiken. So
12 Dr. Eads says, well, that's because they put a
13 feeding tube in. No, they didn't put a feeding tube
14 in at Aiken. So really the facts underlying his
15 opinion, and I'll come to the other part of his
16 opinion in a minute, but you got to question those
17 type things when somebody comes before you and says,
18 here's the facts I base it on, and that doesn't turn
19 out to match the record.

20 Dr. Eads, his defense is let God's plan be
21 done, no quality of life. That's not Dr. Eads'
22 decision to make; that's Mr. Peterson's and the
23 family. The doctor doesn't have the right to say,
24 in my opinion, this man had no quality of life. You
25 heard the testimony that he got better at Aiken,

1 that he was talking to the doctors at Aiken in
2 complete sentences. You heard the testimony that
3 the family was able to see and go visit him and that
4 he knew them and he talked with them in Aiken and in
5 Augusta. And, yes, he was 84 and, yes, he did have
6 health issues. But every day of life is precious.
7 And to let this infection get so rampant it's in the
8 bloodstream and then say the best thing to do is let
9 him go because he got that sick because you did not
10 follow the standard of care and give him the
11 medicine is a circular argument. And, quite
12 frankly, I find it a little offensive when you say,
13 God's will be done. Sometimes God's will is that
14 you give medicine to this patient.

15 Dr. Lovelace, I'm going to say it again, this
16 is kind of what he does, he looks at records, I've
17 got your back, I'll cover it. Dr. Massey,
18 Dr. Leaphart, and Dr. Rainsford, I'm going to tell
19 you that they all have something to gain from their
20 testimony, and that is their self-protection.
21 That's human nature. We all are at risk and we
22 testify in our self-interest. That's human nature.

23 But you have to look at the testimony. What
24 does it show? How does it differ? I'm going to
25 tell you that -- and I'm going to show you at the

1 very end. But when we come down to Dr. Rainsford's,
2 the medical record says Dr. Rainsford -- the nurse
3 told that Dr. Rainsford said I'm not coming over
4 there, they shouldn't take him out, it's against
5 medical advice. Dr. Rainsford said, that's not what
6 I said; I wanted to come examine him, maybe give him
7 some better advice once I examined him. But what he
8 told you on the stand is he didn't have enough
9 information about that patient to make the decision,
10 and he said that he told you in deposition that he
11 wanted to go over, look at the patient, get more
12 information. That should have been sooner, not the
13 day that the man literally is going to die.

14 You heard Dr. Eads and Dr. Rainsford say that
15 if the family had not gone through whoever the nurse
16 or person was that said you can't leave, got him on
17 the gurney, got him out, he would have died, because
18 his body was full of the MRSA infection. It got in
19 his bloodstream.

20 Dr. Leaphart wrote the discharge order at the
21 end, examined him on the 14th, wrote one of the
22 other orders changing out medications at the same
23 time they're doing debridements. Look at the
24 record. If you want to know what happened in this
25 case, forget the testimony, look at the record,

1 compare the two. And when you compare the two, the
2 record was made at the time, it's required by law to
3 be made. It's the best memory anybody has of what
4 happened was the day it happened. And you heard
5 Dr. Rainsford tell you that he came in and he signed
6 that order that said the patient was discharged
7 against medical advice. He didn't tell anybody they
8 wrote it down wrong, he didn't tell anybody that's
9 not what he said, he didn't tell anybody to change
10 it. He signed it, which by law means that's what
11 I'm saying, that's what I mean.

12 The damages. Damages is about harms and
13 losses. I want to point out something to you.
14 Number one, compensation is the amount that equals
15 the harms and losses caused by the negligence.
16 Compensate means to balance the scales. That's what
17 the word compensate literally means. Let's put it
18 back where it was. A verdict for the plaintiff is
19 an award of damages, but not in the sense that award
20 means gift. It's not a gift. It simply means I've
21 incurred a loss because of this behavior and it's
22 only fair that you get me back where I was, you
23 bring me back level, the balancing. No place for
24 sympathy or pity, just what the law sets out.
25 Balance it, bring it back so the estate doesn't have

1 the loss that it currently has because of the
2 negligence.

3 Do not listen to the defense smokescreens in
4 this case, because that's what they are. I'm going
5 to get you to look over here, if you concentrate
6 over here, it's not the real issue. But if you
7 concentrate over here enough, you get in the jury
8 room and buy into it, then it will cloud the issue
9 enough to where you go, I can't decide.

10 Here's the smokescreens. Number one,
11 Mr. Peterson's condition. He was old, he was
12 paralyzed from the waist down, he had some dementia,
13 he had some issues, some kidney function issues.
14 His condition, they knew every single portion of
15 that when they agreed to treat him. They agreed to
16 treat him in that condition. They knew those
17 conditions. That's not the issue. The issue is how
18 do you treat a patient like that? What do you do to
19 help prolong life?

20 Number two, the harm came from the failure to
21 examine and give timely antibiotics. That's the
22 issue, not the fact that the man had a hip injury or
23 had a sacral wound on the hip, the decubiti, the
24 pressure ulcer, we'll call it. The fact that it
25 formed is not the issue. If you get back there and

1 somebody says, well, the testimony was you can't
2 keep it from forming so you can't blame the doctors,
3 we're not blaming the doctors for that. A patient
4 like Mr. Peterson does have some of those things
5 forming. The issue is, did you diagnose the
6 severity of it timely and did you give the
7 medication that was called for.

8 Number four, the doctors had a duty to know
9 about the patient. That's an issue. If they tell
10 you that the doctors couldn't go see the patient
11 because the physical therapist and the nurses didn't
12 tell them to, that's the rabbit hole. That's what
13 they want you to chase over to and go in the back.
14 and say, you know what, the doctors and the nurses
15 never really said anything about how bad it was.
16 Well, yes, they did. They told them it changed
17 stages from 1 to 2 to 3 to 4. They asked for
18 stronger medications to debride it. They put in the
19 chart they were debriding it. All of those things
20 were there. But to know, you have to go look at the
21 chart and see the patient. Eyes and ears, but the
22 doctor's the brain. I've talked to you about that
23 before. They can't tell you that they depend
24 totally on what they're told. They have an
25 obligation to have the information on that patient.

1 to be able to make a decision at the critical time.
2 It's too late on the 15th, when this man is what's
3 called septic, when the sepsis, the infection has
4 gotten in his bloodstream. It's too late. You need
5 to know what's going on with that patient when you
6 get that MRSA culture back. If it was the 7th, the
7 8th, the 9th, or the 10th, you can't say, as
8 Dr. Massey did, I saw it, I initialed it, I think it
9 was probably the 10th because I was off on the 9th,
10 I did what I normally do, I gave it to whichever
11 physician was in charge. The testimony has been
12 very clear from the beginning, all these physicians
13 see all the patients, and when you get that MRSA
14 culture back and initial off, you can't just take it
15 and give it to somebody you don't remember who. You
16 have an obligation to follow through, knowing that
17 this gentleman's cultured out two different
18 pathogens, one that, seriously in the bloodstream,
19 causes death.

20 Now proximate cause, I told we'd come back to
21 that. Something that produces a natural chain of
22 events which in the end brings about the injury. It
23 is the direct cause of the injury. Now that sounds
24 kind of circular. What it means again is, is that
25 this is something that actually causes the natural

1 course of events or natural chain of events of the
2 injury. In this case, it's very clear that it's the
3 chain of events that took place of the developing
4 illness in Mr. Peterson, the infection that's
5 starting to set in, the notice of the infection to
6 the doctors, and then the failure to do anything
7 about that until it was just rampant, until it was
8 too late, until it had gone past the wound into the
9 bloodstream. The proximate cause, that's a natural
10 chain. Proximate cause may not be the only cause.
11 There may be more than one proximate cause. The
12 defendant's act can be the proximate cause to
13 decedent's injury if it was at least one of the
14 direct concurring causes of the injury.

15 And in this case, to find against the
16 corporation, Edgefield Medical Clinic, PA, you don't
17 have to find that all of the doctors were negligent,
18 you only have to find that one of the doctors was
19 negligent and that negligence caused the injury. So
20 when you get back there and somebody says, well, I
21 think maybe Dr. A was negligent and I can see that
22 that failure to do so-and-so caused the injury,
23 somebody else says, well, that's not enough, you got
24 to find them all, no, you don't. The law is that
25 since each of these is the agent of the corporation,

1 if you find that there was one of these three
2 doctors negligent and that negligence caused the
3 injury, then your verdict should be against
4 Edgefield Medical Clinic, PA, for the amount that
5 you find is fair and reasonable.

6 Again, I've told you to follow the law. Don't
7 bring things that are not into evidence. If you
8 have firm feelings about a point, make sure you
9 argue it, make sure it's to the more-likely-than-not
10 standard. Don't hold the plaintiff to anything
11 other than the 51 percent.

12 What are the medical bills? What are we
13 asking? Here's what it comes down to: You heard
14 the testimony, Trinity Nursing Home, 64 days costs
15 \$35,720. That comes to \$558 per day. Now,
16 Ms. Jackson told you on the stand that the estate
17 says if everything had gone like it was supposed to,
18 if he got the antibiotic he was supposed to in the
19 nursing home in a timely fashion there earlier in
20 May and it didn't get so out of hand it got in his
21 bloodstream, then we'd still be having the nursing
22 home and be paying that. So we don't want the jury
23 to pay us for something we were going to pay anyway.
24 So that \$558 per day is taken out of the two medical
25 bills that you're going to have that they're asking

1 for recovery on.

2 The first one is Aiken Regional Medical Center,
3 the May 15th to the May 31st stay. That's where
4 they took him to the emergency room, that's where
5 the doctors treated him immediately there and
6 identified what's wrong, that's where they gave him
7 the IV antibiotics in the intensive care unit
8 because at that point in time it was so serious and
9 they kept him there for two weeks. If you look at
10 that total bill, it's \$57,220, that comes to \$3,576
11 per day. If you deduct out the 558 that they would
12 pay if he's still in the nursing home, that comes to
13 \$3,018 per day, for a total of \$48,288. So they're
14 not asking for the 57,000, they're asking for
15 \$48,298. That deducts out what the nursing home
16 care would have been if everything had gone okay.

17 The other thing they're asking for is Select
18 Specialty Hospital of Augusta. That's where he was
19 in June and July, SSH, Select Specialty Hospital of
20 Augusta. That's where he was transferred to, that's
21 a facility that's there for long-term care. If you
22 look at that bill, it was \$146,911. That's \$2,028
23 per day. Again you deduct out what the nursing home
24 cost, that's \$1,850, for the 61 days he was there,
25 total is \$112,850. They're not asking for the

1 entirety, just what it would cost over and above the
2 nursing home.

3 There was \$383 that the doctors billed him
4 while he was in the nursing home that the estate is
5 saying you didn't do the job, and so we're entitled
6 to get the \$383 back. There's the 48,288 at Aiken
7 Regional. And again, that's already deducted out
8 the nursing home charges. There was a 112,850,
9 again, Select Specialty Hospital, nursing home taken
10 out; the total is \$161,500. That's what the estate
11 is asking from you, from the corporation, that you
12 put them back even, that you say, your negligence
13 caused this extended care over and above what was
14 needed to correct the situation. So now we want you
15 to bring the estate back in balance, that's all.

16 Your Honor, at this time I reserve the last ten
17 minutes.

18 THE COURT: I'm sorry. Do what?

19 MR. NANCE: Five; count them, five board
20 certified physicians from South Carolina took that
21 stand under oath and told you that the treatment in
22 this case was correct and it was appropriate. And
23 for you to find for the plaintiff in this case,
24 you've got to determine that every one of them, all
25 five of them, got up there under oath and lied to

1 you --

2 MR. WELCH: Your Honor, I object. They can
3 find it's a difference, but to say they lied is not
4 the law.

5 THE COURT: Ladies and gentlemen, y'all
6 determine the credibility or the believability of
7 the witnesses, it's your decision to decide what the
8 true testimony is.

9 MR. NANCE: Let's talk about them for just a
10 second. The first one is Dr. Rainsford.
11 Dr. Rainsford is a lifelong resident of Edgefield.
12 He grew up here, went to high school here, he went
13 off, got his education, came back, and since 1977
14 he's dedicated his life to taking care of the people
15 in Edgefield County and anybody else who happens to
16 seek his medical care.

17 Dr. Leaphart, she's a lifelong resident, until
18 recently, of Edgefield County. She was born here,
19 grew up here, went to high school here, went off,
20 got an education, came back and practiced here for
21 some period of time. I think I told you before,
22 she's in Leesville, but in any event, she's still
23 dedicated her life to taking care of sick people,
24 people who need her help.

25 Dr. Massey is not from here but she went to

1 nursing school, became a nurse, an RN, and later
2 went to medical school and came here and has been
3 here for some period of time taking care of these
4 people.

5 Dr. Eads -- Dr. Eads, graduate of the
6 University of Virginia, undergraduate, medical
7 school, did his residency in internal medicine in
8 Charleston and now practices there, taking care of
9 people, worked in nursing homes, been a medical
10 director, and Dr. Lovelace, who they categorize is
11 the Dr. 100-Cases. I call him Mr. Family Doctor of
12 the Year for 2012 in the state of South Carolina.

13 Now, every one of those people got up and told
14 you that the care that was done in this particular
15 case was appropriate. The Plaintiff does not
16 contend, it's my understanding, that the treatment
17 of this pressure sore was improper. They don't
18 contend that it was avoidable, and they agree that
19 what was done by all of these doctors was
20 appropriate. But what they do talk about is they
21 say, well, nobody examined him from April 14th until
22 Mr. Peterson was taken to the Aiken Regional Medical
23 Center on May the 15th. But what they don't tell
24 you is what they would have done different. What if
25 they had examined him? Did they tell you or give

1 you anything they would have done different? Did
2 they give you any reason that the treatment they
3 were given was not appropriate and proper? No.
4 What they say, and this is what the facts show, that
5 on May the 5th of 2000 -- May the 2nd of 2006,
6 Dr. Nicholson, who, by the way, is not a part of
7 this case and never was, while you've been hearing,
8 ordered a culture. It came back, the evidence has
9 shown, I think on the 7th it was faxed over to the
10 nursing home and it was faxed to the practice on a
11 day when Dr. Massey was not there. She got it the
12 next day and then she would have sent it on to
13 Dr. Nicholson because he was the one who ordered it.
14 And every one of these five doctors told you that
15 although it showed there was a MRSA colonization,
16 that it was superficial, it was on the skin, it was
17 not within the system, it was not treatable at that
18 time. And every one of them told you that you've
19 got to wait, to watch it, and when you get an
20 increase or decrease in temperature and a decrease
21 in blood pressure, that's when you begin to look at
22 it, and that didn't occur until late on the 14th.
23 But it wasn't reported to anybody and nothing
24 occurred until the 15th when Dr. Rainsford was
25 called and he was going over to take a look at this

1 gentleman, Mr. Peterson.

2 Mr. Peterson had a do-not-resuscitate directive
3 which could be withdrawn. Fine. He was going to
4 look at it, to talk to the family, and they'd make a
5 decision as to what to do; not him, they would. But
6 they had already chosen to renounce the DNR. Fine.
7 And they had chosen that they wanted him to begin to
8 get aggressive care, which he got after he got to
9 the Aiken Regional Medical Center. That's fine.
10 And Dr. Rainsford told you that, looking in the
11 records, and knowing they renounced the DNR,
12 do-not-resuscitate directive, that certainly what
13 happened would have been fine with him, family's
14 decision. So they got just what they wanted. They
15 got just what he would have done had he been there
16 and given an opportunity to examine him. There are
17 no damages. Why is it this practice should be
18 liable for the expenses they incurred after that
19 when they got exactly what they wanted and they got
20 exactly what Dr. Rainsford would have done under the
21 circumstances had he been allowed? Just doesn't
22 make good sense, does it? Just doesn't make good
23 sense.

24 You know, I just don't have a lot to say about
25 this case. It's really a pretty simple thing, and

1 I've gone through it. We're accused of throwing
2 smokescreens and this, that, and the other, but it's
3 just a fact. Mr. Peterson was not in good shape.
4 He had endstage dementia. He had two mini mental
5 tests. The first one was done in March and you can
6 look in the records when you get them. They'll be
7 in the records you'll get to look at. And I think
8 he scored a 9 and the other one was done in April
9 and he scored 2. And you heard anything under 10 is
10 very, very poor. He was paralyzed, he had renal
11 failure, his skin was failing, he was developing
12 these ulcers, his appetite was very poor. He was
13 incontinent to bowel and bladder. It's a tough
14 situation. But, you know, the fact of the matter
15 is, and although his death is not an issue in this
16 case, it's just about these medical bills, that's
17 all it's really about, trying to get them some
18 money, the fact of the matter is, is that death is
19 an absolute constant. The rate of death everywhere
20 is 100 percent. It's going to happen to everybody
21 at some point in time. It's unfortunate, but that's
22 the way it is. Mr. Peterson was nearing the end of
23 his life, no doubt. He died, I think, on August the
24 3rd, 2006 when he was in the Hospice care and, you
25 know, it's really unfortunate. But these doctors

1 did not do anything for which they should be liable.
2 And you've heard that now this case is just against
3 the medical practice, and it is, but that's the type
4 of a corporation.

5 The corporations act through their employees,
6 their agents, and every one of these doctors is the
7 agent of that corporation. And if you find for the
8 plaintiff and not for the defendants, you'll be
9 saying, pointing the finger, some of them, I don't
10 know who, but some doctor in that practice,
11 Dr. Massey, Dr. Leaphart, or Dr. Rainsford, wasn't
12 being a good doctor.

13 Ladies and gentlemen, you've been here several
14 days. I'd like to thank you for your attention.
15 I've watched all of you. I know -- I hope this has
16 been an educational experience for you. Not
17 everybody gets the opportunity to sit on a jury, and
18 I know sometimes it's an inconvenience to some
19 people, but it's a very important duty. And it's
20 very important to the plaintiff and I guarantee you
21 it's very important to Dr. Rainsford, Massey and
22 Leaphart, very important. And all that they ask is
23 that once you get all of the evidence and go back
24 into the jury room and deliberate, that you assign
25 credibility to the witnesses, weight to the

1 evidence, listen to his Honor as he tells you what
2 the law is that should apply, apply it, and bring
3 back a true and just verdict. Thank you very much.

4 MR. WELCH: I get to talk to you again, and I
5 can tell you what the plaintiff wanted was
6 antibiotics. What they wanted.

7 The DNR, ladies and gentlemen, that you're
8 going to have in evidence, when you look at the
9 page, middle of the page, page 4, it says: We do
10 want Daddy to have IV fluids, want him to have IV
11 antibiotics. So the DNR has really nothing to do
12 with what's going on in this case. It's another
13 smokescreen. What the DNR says, if you read it, and
14 you heard the testimony, if he has a heart attack,
15 if he's dying from something like that, don't use
16 the paddles. But it doesn't say, you know what, if
17 he gets a real bad infection, don't give him
18 antibiotics, let him die. That's not what it says.
19 That's not what the family wanted.

20 And Mr. Nance made a statement that is
21 something that you do need to consider. It says
22 that if you go back there and come back with a
23 verdict against the corporation, that you're saying
24 a doctor did something wrong, you are, because they
25 did. And sometimes that's uncomfortable. But you

1 took an oath that you would do something
2 uncomfortable if you had to, to follow the law. You
3 took an oath that said that if you look at the facts
4 and you find that this infection was identified and
5 he said that we didn't tell you what we would have
6 done differently. Yes, we did. Dr. Levine, in
7 fact, fairly clearly early on in his testimony told
8 you that the obligation of the physician, number
9 one, is to be over there looking, examine the
10 patient; but number two, when you go culture that
11 wound, and they can talk all they want about, we got
12 MRSA on our skin, that type of thing, they cultured
13 that wound for a purpose. They wanted to know what
14 bacteria, and they got the result and it went to
15 Dr. Massey, that's her initials and, in fact, it was
16 over at the nursing home even before it got to
17 Dr. Massey. Got to the nursing home on the 7th in
18 the chart. If you look at the chart, you'd see it
19 right there, and you'd see the two pathogens or
20 bacteria, or the MRSA and this one, and you'd know
21 that, you know what, MRSA is a bad thing, MRSA is a
22 bad bug, and as the doctor said, you start the
23 antibiotics immediately. Because you see, ladies
24 and gentlemen, the goal here is to treat it before
25 it gets in the bloodstream, that's the real issue

1 here. And Dr. Levine said more probable than not,
2 if antibiotics had been started when that came back
3 like they should have been, this gentleman would not
4 have gotten septic, wouldn't have gotten in the
5 bloodstream, wouldn't have gotten in his urinary
6 tract. It would have started deproducing in the
7 wound like it did at Aiken when they started the
8 antibiotics on the 15th.

9 What's your responsibility? He also told you
10 that you're telling the doctors they're bad people
11 doing a bad thing. You're not. You're telling the
12 doctors, in fact, including Dr. Nicholson, he was an
13 agent and employee of the corporation, you're
14 telling whichever doctor you find negligent, one or
15 more, that you know something, at that point in
16 time, you didn't pay attention for a period of time
17 and you should have, doesn't make you a bad person
18 any more than it makes Dale Earnhardt a bad driver
19 because he wasn't paying attention looking at a
20 phone. You can call it human nature, you can say
21 well, everybody does it. You know what, that
22 doesn't matter. If you're supposed to be paying
23 attention as a physician and you're not, reasonable
24 physicians don't do that. And for that short period
25 of time, you were negligent, and there's

1 responsibilities for it.

2 Jury service is a public trust. You, ladies
3 and gentlemen, are Edgefield County right now. It's
4 a public trust. You're doing this under oath. You
5 agreed to do it. You've agreed to follow the law.
6 And in doing so, you agree that if it's a little
7 uncomfortable for you to do it, you'll do it anyway.
8 You agreed that if you are on the street or scared
9 somebody's going to say which doctor or why, Judge
10 is going to tell you, you don't have to talk to
11 anybody. But you do have to follow the law and
12 render a true and just verdict. And when you do
13 that, you don't owe an explanation to anybody.
14 Don't allow two standards.

15 There should not be one standard for physicians
16 and hospitals and doctors and medical clinics where
17 you say, well, you know what, they help people, they
18 do good things, everybody makes a mistake. That's
19 not the law. I don't care how good you are. If
20 you're not paying attention at a critical time and
21 somebody gets hurt, there's responsibilities. If
22 you run a medical red light, you can't say, well, a
23 lot of people have done it or I didn't mean to.
24 There's no excuse. It happens. And when it
25 happens, there's accountability. The patient is

1 entitled to just as much respect, just as much
2 consideration as the physicians are.

3 What kind of medicine? That's going to be up
4 to you, because your decision basically says, you
5 know what, as individuals and as a group, we're
6 willing, if the facts show it, to do what may be
7 kind of a hard thing for us, and we don't have to
8 explain it to anybody because that's the law.

9 Now, you took an oath, you promised to abide by
10 the preponderance of the evidence, you promised to
11 say, you know what, Plaintiff, I'm not going to make
12 you do any more than go to the 51-yard line on each
13 of your things you have to do, each of the items the
14 Judge gives you that Plaintiff's required to do; I'm
15 not going to make you score a touchdown, just to the
16 51, just move it. And we've done that.

17 You wanted to be presented the facts, you've
18 got the facts. You took an oath to do the truth of
19 justice. Mr. Peterson has carried his burden. And
20 I want to show you when you get back there, ladies
21 and gentlemen, then I'm done, you're going to have
22 the record. This is Exhibit 3, this is page 69,
23 this is what the nurse read to you, what she charted
24 for you, that she called -- first of all, she called
25 earlier herself because Mr. Peterson was anxious, he

1 was moaning when touched. She wanted some Ativan,
2 something to calm him down. Nurse said
3 Dr. Rainsford said no. Then she called back because
4 the family wanted to move him. And she wrote this
5 in quotes: Dr. Rainsford did not advise family to
6 send resident to hospital. Instead told family it
7 was their desire, family could take him to the
8 hospital. She charted that. And when Dr. Rainsford
9 came over the next day or whenever he came over to
10 look, all he had to do is look at that and say,
11 that's not what I said. The nurse's notes are
12 things that doctors are supposed to read.

13 She also said that the resident's DNR status --
14 in other words, he's got a directive, but it doesn't
15 apply here because what he needs is antibiotics.
16 This man is sick and dying because the infection got
17 out of hand, that you didn't give him antibiotics
18 for when you got the lab results saying he had a bad
19 infection. Explain conversation to family members,
20 Patricia and Mary Peterson, regarding call to
21 Dr. Rainsford. All family members, possibly 15, all
22 insisted that they take him. They told them it was
23 against medical advice.

24 A little bit later in the day, she read this to
25 you, she charted this: Resident transported via EMS

1 to Aiken. Hospital transportation to --
2 transportation to hospital not recommend by
3 Dr. Rainsford, transported per family against
4 medical advice. Dr. Rainsford said don't take him.
5 Dr. Rainsford came in here now and he said, I'm
6 coming over there to examine him. The family said,
7 nobody told us that day, he didn't go there that
8 day, he told us he didn't go that day.

9 How do we know how bad it got? You're going to
10 have the medical record from Aiken, and in the first
11 20 pages you're going to have what they found, which
12 was that MRSA bacteria in his bloodstream. That's
13 why it's too late. It's also in his urinary tract,
14 which is your bladder, the part to your body where
15 you urinate, that type thing, MRSA. The wound was
16 infected. They suspected it was in his kidneys.
17 And it could have been prevented by antibiotics
18 earlier, IV antibiotics, that were clearly allowed
19 in the rules of the DNR. It didn't have to be like
20 that. It didn't have to be.

21 This case comes down to periods of time when
22 you look to say, hey, what should we do in this
23 circumstance? What would a reasonable physician do?
24 And I assert to you, a reasonable physician would
25 follow up on what clearly is a building decubiti and

1 an infection. Why did they order the wound
2 cultured? Because it was showing signs of
3 infection. What's the infection? I don't know,
4 let's see. Well, what is the bacteria? And it
5 comes back and says, you know what, this is MRSA.
6 And that's a serious thing. You can't just initial
7 it and say I think I did what I normally would have
8 done which is take it to whatever doctor is treating
9 him. You're all treating him. That's what you all
10 said under oath in this courtroom. And when you've
11 got this kind of bad bug and you've got a gentleman
12 that's weak to begin with -- and you know the
13 antibiotics today, all you've got to do is look at
14 the gentleman. That's what this case boils down to,
15 ladies and gentlemen.

16 And all they're asking is that that amount of
17 money they had to spend, as -- as the doctors have
18 said, this man would have been dead the next day, by
19 the next day, if they hadn't taken him to the
20 hospital. And what they're saying is, we simply
21 want you to give us back the money we had to spend
22 to keep Daddy alive for a few more months to be with
23 us. That's all we're asking. And if they had given
24 the antibiotics, we wouldn't have to spend that.
25 But we did, that's what it took. And once you

1 subtract the nursing home fees out, \$161,500.

2 I'm going to sit down because my job is totally
3 done. The job is now yours. And I simply ask --
4 I'm going to say for the last time because it's
5 important, being on a jury is not an easy job in a
6 case like this, especially. But you took an oath to
7 say, you know what, I know it's not easy, but I'm
8 going to follow the oath and follow the law. When
9 you get back there and deliberate and look at the
10 facts and you find that, you know what, more
11 probable than not, 51 percent, if they simply had
12 given him the antibiotics like they were supposed to
13 when they found out it was MRSA, he wouldn't have
14 been that sick on the 15th, they would have taken
15 him somewhere, and the estate is entitled to those
16 medical bills back. Thank you.

17 THE COURT: Mr. Foreman, ladies and gentlemen
18 of the jury, my instructions are 15 minutes maybe.
19 Y'all are okay? You want a quick bathroom break or
20 move along?

21 Mr. Foreman and ladies and gentlemen, let me
22 remind you that obviously during the trial of the
23 case, as I explained to you when we started, that
24 you and I have two distinct responsibilities during
25 a trial. My responsibility is to rule on the

1 admissibility of the evidence. My responsibility is
2 to instruct and charge you and tell you what the law
3 is in these types of cases. Obviously your
4 responsibility as the judges of the facts is the
5 most important responsibility in the trial, the most
6 responsible job, you've got a big job to place. So
7 if at any time during the trial of this case you've
8 looked up here and I've been frowning or smiling or
9 raising my eyebrow, doing anything that makes you
10 think I've got an opinion about the facts, please
11 disregard that. The law does not allow me to have
12 any opinion whatsoever about the facts. My job is
13 to tell you what the law is and to rule on the
14 admissibility. So please don't let anything I've
15 done influence you or make you think I have some
16 opinion about the facts. That's solely your job;
17 you're the finders of the facts in the case.

18 Now, as I said when we started, this is a civil
19 case. And in a civil case the burden of proof is on
20 the plaintiff, and the plaintiff has to prove his or
21 her case by the preponderance or greater weight of
22 the evidence. And it's simply evidence which, as a
23 whole, shows that the facts sought to be proved is
24 more likely true than not true. As some of the
25 lawyers have argued and I explained to you when this

1 started, the parties come in on equal footing. For
2 the plaintiff to prevail, they have to prove the
3 elements of their cause of action by the
4 preponderance or the greater weight of the evidence.
5 They have to tip the scales ever so slightly. If
6 they're able to do that, they've met their burden of
7 proof. However, at the close of the case, if all
8 the evidence remains the same or it tips in favor of
9 the defendant, then they have failed to meet their
10 burden of proof. So the burden of proof is on the
11 plaintiff to prove the case by the preponderance or
12 greater weight of the evidence.

13 Now, in doing that, obviously -- and you make
14 that decision as to whether or not the plaintiff has
15 met their burden of proof. In deciding that,
16 obviously your main job is to determine the
17 credibility of the witnesses who have testified in
18 the case. Credibility simply means believability.
19 It becomes your duty as jurors to evaluate the
20 evidence and determine which evidence convinces you
21 of its truth. In determining the believability or
22 the credibility of the witnesses who have testified
23 in the case, you have the right to believe one
24 witness over several, several over one. You can
25 disbelieve everything a witness says, you can

1 believe everything a witness says. You can believe
2 a little bit of it and disregard the rest. You can
3 believe a lot of it and disregard the rest. So you
4 have the right to determine the believability or the
5 credibility of the witnesses who have testified in
6 the case.

7 I told you when we started you need to use your
8 ordinary common sense in dealing with people. You
9 deal with husbands, wives, children, employees,
10 employers, family, friends. You know how to Judge
11 the believability or the credibility of the
12 witnesses who have testified in this case. You have
13 the right to consider whether a witness has an
14 interest in the result of a trial, whether the
15 witness is prejudiced for either the plaintiff or
16 the defendant, and the opportunity for the witnesses
17 to have seen the matters and things about which the
18 witnesses may testify and even the way the witness
19 acts on the witness stand.

20 This case now is a case against Edgefield
21 Medical Clinic, PA. A PA is a legal entity similar
22 to a corporation. In our courts no distinction is
23 made between corporations and individuals. A PA is
24 a person in the eyes of a law, a professional
25 association that's entitled to the same fair and

1 impartial consideration and justice by the same
2 legal standards as an individual would be.

3 Now there's one other proposition of law that's
4 sort of general to all cases we try in the civil
5 arena, as well as the criminal arena, and that is a
6 rule dealing with expert witnesses. During the
7 trial of this case I qualified a number of witnesses
8 to -- I qualified them as an expert in the field of
9 medicine. Normally our rules of evidence do not
10 permit a witness to testify about opinions or
11 conclusions. There's an exception to this rule
12 which we call the expert witness rule. A witness
13 who by education and experience has become an expert
14 in some art, science, or profession such as medicine
15 may give an opinion as to the subject the witness
16 claims to be an expert in and may also give the
17 reasons for that opinion. You should consider any
18 expert opinion given by a witness like any other
19 evidence; give it the weight, if any, you think it
20 deserves. If you decide that an expert witness'
21 opinion is not based on sufficient education and
22 experience or if you decide the reasons given in
23 support of the opinion are not sound or that the
24 opinion is outweighed by other evidence, you can
25 disregard the testimony entirely. An expert

1 witness' testimony should be given no greater weight
2 than that of any other witness simply because he's
3 an expert. And our rules say that you do not have
4 to accept an expert's opinion even though it is
5 uncontradicted. So that's the rule dealing with
6 expert witnesses.

7 Now, Mr. Foreman, ladies and gentlemen, that's
8 sort of the general propositions of law that are
9 charged around the state on all civil cases. Let's
10 turn to the case at hand. And as I told you when we
11 were striking the jury about our civil side of the
12 law, we have a -- just a host of all types of civil
13 cases. This case happens to be what we call a
14 medical negligence or medical malpractice case.
15 It's one of the many types of civil cases we have.
16 So let's talk about medical malpractice.

17 In this case, the plaintiff claims that the
18 defendant PA, or professional association, committed
19 medical malpractice, which is a form of carelessness
20 or negligence. In order to prevail in a medical
21 malpractice action, the plaintiff must prove by the
22 preponderance or the greater weight of the evidence
23 basically four things: They must first prove what
24 the standard of care is. Secondly, when they prove
25 what that standard is, they must prove in this case

1 that that defendant breached the standard of care;
2 in other words, the care fell below the standard.
3 That's the breach and that that falling below that
4 standard of care, that breach is the proximate cause
5 of the damages. Four things: What the standard is,
6 that they fell below the standard, by falling below
7 the standard they caused injury which was
8 proximately caused by the breach. Okay?

9 Now, let's talk about these one at a time.
10 Plaintiff must prove by the preponderance of the
11 greater weight of the evidence what the standard of
12 care the defendant owed to the plaintiff in treating
13 the plaintiff or, in this case, action of the
14 survival action because the person being treated
15 died and his estate, through their representative,
16 is bringing the action. So when I say Plaintiff,
17 I'm meaning the PR. But the care would be to the
18 personal representatives of the estate in this case,
19 of Mr. Peterson.

20 Now, Plaintiff has to prove to you what the
21 standard of care is by the preponderance of the
22 evidence. When a doctor treats a patient, the law
23 does not require perfection; the law does require
24 that the doctor use that degree of knowledge, care,
25 and skill ordinarily used by doctors in good

1 standing in the doctor's field of medicine under the
2 same or similar circumstances and that the doctor
3 followed generally accepted practices and procedures
4 in the profession. In other words, the doctor has
5 to -- the standard of care is what an ordinary
6 doctor in similar circumstances would do under the
7 same or similar circumstances. That's what the
8 standard of care is. They have to prove that
9 there's been a breach in the standard of care. The
10 plaintiff must prove by the preponderance or the
11 greater weight of the evidence that the defendant,
12 the doctors, negligently departed or fell below the
13 standard of care in treating, in this case,
14 Mr. Peterson. And negligence, our courts have
15 defined, is the failure to do what an ordinary
16 careful doctor in the doctor's field of medicine
17 would have done under the same or similar
18 circumstances or the doing of something that an
19 ordinarily careful doctor would not have done under
20 the same or similar circumstances.

21 I charge you that a doctor is not an insurer of
22 a cure or even a positive result, therefore, the
23 mere fact that a treatment does not benefit the
24 patient or that it even harms the patient does not
25 in and of itself mean that the defendant doctor was

1 negligent. A bad result, injury or death or failure
2 to cure is not by itself enough to show that the
3 defendant doctor was negligent. The plaintiff has
4 to show that the doctor did not do what an
5 ordinarily careful doctor would have done under the
6 like or similar circumstances or did something that
7 he should not have done under the same or similar
8 circumstances.

9 Also, a doctor's mistake or error in making a
10 decision alone does not constitute negligence;
11 however, if the doctor fails to gather information
12 reasonably available, which a reasonable doctor
13 would have gathered before making a decision, the
14 doctor fails to comply with the recognized standard
15 of care which would be exercised by a similar doctor
16 under similar circumstances.

17 The difficulties and uncertainties in the
18 practice of medicine and the unpredictable
19 variations in the response of treatment are such
20 that no doctor can guarantee results. Where there
21 is more than one recognized diagnosis or treatment,
22 no one of them is used exclusively or uniformly by
23 all doctors in good standing. It's not malpractice
24 for a doctor making the decision to choose one of
25 the approved methods, even when that choice later

1 turns out to be the wrong selection. Qualified
2 doctors and experts may differ as to what
3 constitutes the best course of treatment, and these
4 differences do not amount to malpractice. If
5 doctors in good standing disagree on a medical
6 authority or are divided with regard to a specific
7 course of treatment or care, the doctor's bound only
8 to exercise his or her best judgment in determining
9 which course on the whole is best for the patient.
10 Just because another doctor might have used a
11 different course of treatment does not mean the
12 defendant committed malpractice. However, if a
13 doctor does not have the requisite degree of
14 learning or skill required or if the doctor does not
15 use the care required, it is no defense in the
16 charge of malpractice that the doctor did the best
17 he could.

18 In considering whether the doctor made a
19 reasonable decision, you must consider the decision
20 in relation to the facts as they existed at the time
21 and not in light of what hindsight may reveal. So
22 that's the law dealing with the breach or falling
23 below the standard.

24 The third thing that Plaintiff must prove by
25 the preponderance or greater weight of the evidence

1 is what we call proximate cause. Plaintiff must
2 prove that the defendant's breach of the standard of
3 care proximately caused the plaintiff's damages.
4 Legally, proximate cause is something that produces
5 a natural chain of events which in the end brings
6 about the injury. It's the direct cause of the
7 injury. To prove that the defendant's malpractice
8 proximately caused the plaintiff's injury, the
9 plaintiff must first prove, by a preponderance or
10 greater weight of the evidence, causation and fact.
11 This is proven by showing that the injuries from the
12 damages would not have occurred but for the
13 defendant's negligence.

14 Plaintiff also must prove legal cause. Legal
15 cause is proven by showing that the injury was
16 foreseeable. This means that the injury occurred as
17 a natural and probable consequence of the
18 defendant's negligence. Plaintiff must prove that
19 some injury or damage from the defendant's
20 negligence was foreseeable, but does not have to
21 prove that the particular damage that occurred was
22 foreseeable. Proximate cause does not mean the only
23 cause. There may be more than one proximate cause,
24 but Defendant's act can be a proximate cause of the
25 plaintiff's damages if it was at least one of the

1 direct causes of the injuries.

2 In this action, there's been allegations that
3 there was a failure to diagnose and treat.
4 Plaintiff must prove beyond the preponderance or
5 greater weight of the evidence that the defendant's
6 negligent failure to discover and treat the
7 condition of which the plaintiff suffered most
8 probably caused the damages in this case. The
9 plaintiff is not required to prove conclusively that
10 the patient would have suffered these injuries;
11 however, a mistaken diagnosis by itself would not
12 support a verdict for the plaintiff.

13 I further charge you that a patient who is
14 treated by a doctor is entitled to a careful
15 evaluation. The evaluation should be made with the
16 diligence and methods and diagnoses that are usually
17 approved and practiced by doctors of ordinary
18 judgment and skill acting under the same or similar
19 circumstances. So that is what the plaintiff must
20 prove by the preponderance or greater weight of the
21 evidence.

22 Ladies and gentlemen of the jury, Mr. Foreman,
23 if you find that the plaintiff has proven by a
24 greater weight, preponderance of the evidence, the
25 standard of care, that the doctors have deviated or

1 fell below that standard, and if you find that the
2 injuries or the medical bills in this case claimed
3 by the plaintiff were proximately caused by that
4 breach, then you must consider to award the damages.
5 In this case, we're talking about actual damages.
6 That's the type of damages we're talking about. So
7 if you find those three things, the standard, the
8 deviation, the probable cause, the next step is to
9 decide -- if the plaintiff is entitled to the
10 verdict, then you decide how much money the
11 defendant should be required to pay. And obviously
12 under our form of justice, we don't do an eye for an
13 eye or a tooth for a tooth. We have a much more
14 civil way to handle that through monetary
15 compensation of damages. That's the way our system
16 has been.

17 So if you find that the plaintiff is entitled
18 to a verdict, then you look at actual damages. And
19 actual damages, under our law, are designed to
20 compensate the plaintiff for the plaintiff's losses.
21 You attempt to put the plaintiff as near as possible
22 in the same position that the plaintiff was in
23 before the incident occurred. In other words,
24 actual damages would be the actual expenses which
25 were proximately caused in this matter. In this

1 particular case, we're speaking solely of the
2 medical bills. So in an action such as this, a
3 survival action, the general rule is that the
4 plaintiff may recover for the necessary and
5 reasonable expenses caused by the alleged
6 malpractice, or if you find that the doctor has
7 deviated, caused by that deviation, proximately
8 caused. And these would be for such items that
9 would be necessarily incurred, such as medical
10 services, hospital expense, and care. A person who
11 suffers damage that was caused by the negligence of
12 a physician is entitled to recover the reasonable
13 value of medical care and expenses incurred for the
14 treatment of the condition that was incurred as a
15 result of the negligence.

16 Ladies and gentlemen, in your decision,
17 obviously, your verdict must be unanimous. All 12
18 of you must unanimously agree as to the verdict
19 either for the defendant or for the plaintiff. You
20 have taken an oath that you will decide this case
21 based solely on what was presented to you in the
22 courtroom. You obviously have no enemies to punish
23 or friends to reward. You're to make a careful
24 deliberation of the facts that have been presented
25 to you. You determine what the true facts are or

1 were, you take those facts and you apply it to the
2 law as I've given it to you, and then obviously
3 you'll be in a position to render a true and just
4 verdict. That's what verdict means in Latin, speak
5 the truth.

6 You'll have a verdict form in the jury room.
7 And basically, it's very -- simply, it names the
8 plaintiff, Ms. Jackson, as the PR of the estate of
9 Mr. William Peterson, versus the sole remaining
10 Defendant, Edgefield Medical Clinic, PA. And the
11 verdict form's -- you've got two choices: You
12 either find for the plaintiff, that means you found
13 that the plaintiff was proven by the preponderance
14 or the greater weight of the evidence, the
15 standard -- the deviation was proximately caused by
16 the defendant. If you find that that's been proven,
17 then you put the amount that you find they're
18 entitled to as actual damages, date it, and sign
19 your name as foreperson. On the other hand, if you
20 find that the plaintiff has failed to meet their
21 burden of proof, then your decision would be for the
22 defendant. There's a box there and you'd check for
23 that. So check one or the other, and then the
24 amount of damages. Okay? Very simple.

25 Oftentimes, Mr. Foreman, during deliberations

1 you may have a question. The protocol for that is
2 to write it out on a slip of paper and knock on the
3 door and give it to the bailiff, and they'll bring
4 it out to me. Sometimes I can answer it, sometimes
5 I can't, just depending on what the question is.
6 But I'll try to give an explanation one way or the
7 other. Your verdict must be unanimous.

8 It's 11:00. I don't know how long you'll be
9 deliberating. We can see if you're going to go for
10 a while and give you a menu and we can order some
11 lunch. You're in charge of that. Okay?

12 THE FOREMAN: Okay.

13 THE COURT: You're going to return to the jury
14 room. I'll ask you to please not start deliberating
15 quite yet. I have to ask the lawyers if I've left
16 anything out or if I need to add anything or take
17 anything out. When we do that, we'll gather up the
18 exhibits, they'll be brought back to the jury room,
19 along with the verdict form, and once you receive
20 the evidence and the exhibits and the verdict form,
21 you may start your deliberation. So I'm going to
22 ask you at this time to go back to your jury room.
23 Do not start deliberating until I send the verdict
24 form and the exhibits to you. Thank you.

25 (The jury retires to the jury room at

1 11:06 AM.)

2 THE COURT: Any objections, requested additions
3 or deletions from the plaintiff?

4 MR. WELCH: Nothing from the plaintiff.

5 THE COURT: Mr. Nance?

6 MR. NANCE: None from the defense.

7 THE COURT: I've revised the verdict form.

8 Please come look at it and give me your approval on
9 that. Also, we'll mark the exhibits and make sure
10 we've got everything that goes back.

11 (Brief pause in the proceedings.)

12 THE COURT: Let the record reflect the lawyers
13 have reviewed the verdict form and are in agreement
14 with it.

15 THE CLERK: This is it?

16 MR. WELCH: That's it.

17 THE COURT: Y'all have reviewed all of the
18 exhibits and everything is in order?

19 MR. WELCH: Yes, sir.

20 THE COURT: Mr. Nance?

21 MR. NANCE: Yes, sir.

22 THE COURT: And I've instructed the bailiff to
23 separate the alternate, Mr. Myers. That alternate
24 has been removed.

25 All right. If you'd take the verdict form and

1 exhibits back to the jury room and tell them they
2 may commence their deliberations. I'll stand at
3 ease. I'll be in my chambers if y'all need me.
4 Don't get too far, please. Thank you.

5 (The jury begins deliberations at 11:09 AM.)

6 (Court's Exhibit No. 7 marked for
7 identification.)

8 THE COURT: Is the plaintiff ready to receive
9 the verdict?

10 MR. WELCH: Yes, Judge.

11 THE COURT: Defendant?

12 MR. NANCE: Yes, Judge.

13 THE COURT: Bring the jury in, please.

14 (The jury enters the courtroom at 1:59 PM.)

15 THE COURT: Mr. Foreman, have you reached a
16 verdict?

17 THE FOREMAN: Yes, Your Honor, we have.

18 THE COURT: Pass it, please.

19 THE CLERK: Your Honor, this is Case

20 No. 2009-CP-190276, *Cecilia Jackson as PR of the*
21 *Estate of William Peterson vs. Edgefield Medical*
22 *Clinic, PA.* We the jury unanimously find for the
23 plaintiff against the defendant Edgefield Medical
24 Clinic, PA, in the amount of \$27,086, signed by John
25 Womack, March the 20th, '14.

1 Mr. Foreman, ladies and gentlemen of the jury,
2 if that is your verdict, please indicate, each of
3 you, by raising your right hand.

4 All hands are raised.

5 THE COURT: Anything for the jury before I
6 dismiss them?

7 MR. WELCH: Not for the jury, Judge.

8 MR. PARKINSON: No, sir.

9 THE COURT: Mr. Foreman, ladies and gentlemen
10 of the jury, I can't thank you enough. Y'all have
11 paid exceptional attention to this case over four
12 days. It's not the most pleasant experience in the
13 world to sit on a jury, but it's a very interesting
14 experience. And I think you'll agree with me that
15 when two sides can't agree, this is the best way in
16 the world to resolve a dispute. And I respect your
17 verdict and commend you. You've been wonderful.
18 I'm going to now excuse you. The clerk will be
19 sending a check out very shortly. I think it's \$20
20 a day. It's not that much, but it's better than
21 nothing. Anyone need a work excuse, just sit --
22 y'all have already taken care of that? That's been
23 done. I've enjoyed being here in Edgefield, always
24 a pleasure, this is an interesting place to hold
25 court. I've enjoyed your city. I spent some money

1 before I left, I just can't tell my wife.

2 Anyway, thank you. I've enjoyed it and y'all
3 are free to go. Thank you very much.

4 (Jury excused.)

5 THE COURT: All right. Any posttrial motions
6 by the plaintiff?

7 MR. WELCH: Judge, based on the verdict we'd
8 move for additur. And being for the plaintiff, we
9 feel that the amount of bills awarded based upon the
10 testimony should be in excess of the \$27,086.

11 That's all of the motion we have at this time.

12 THE COURT: Mr. Nance?

13 MR. NANCE: Your Honor, I feel --

14 THE COURT: Would y'all like to have ten days?

15 MR. WELCH: Yeah. I was going to ask for ten
16 days, Judge.

17 MR. NANCE: Ten days to file a motion? Sure.

18 THE COURT: Whatever suits you.

19 MR. WELCH: I'd like to have ten days.

20 MR. NANCE: It's his motion. I don't care. I
21 have a motion I need to make now.

22 It's my understanding, although I wasn't in the
23 case at that point in time, that Trinity Mission was
24 a named defendant and they settled for an amount, I
25 don't know what it was, but more than \$27,086. It's

1 my understanding it was about \$90,000. And we'd be
2 entitled to a setoff.

3 THE COURT: I don't think there's any question.

4 MR. WELCH: No question about that, Judge.

5 THE COURT: All right. That will be granted
6 contingent upon whatever I do with whatever
7 posttrial motions he makes. I'll give you ten days
8 to make them, and if you want to argue them, I'll be
9 in Aiken a bunch. You can come down to Aiken and
10 argue them or we can do it however you want to do
11 it.

12 MR. WELCH: Thank you, Judge.

13 THE COURT: Thank you very much. I've enjoyed
14 working with you.

15 -- END OF TRANSCRIPT OF RECORD --

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INTERDISCIPLINARY DISCHARGE SUMMARY

INSTRUCTIONS: Complete this form when a resident is discharged. All items must be addressed. Record additional comments/notes on the reverse.

RECAPITULATION OF RESIDENT'S STAY

Admission date 03/21/06 Discharge date 05/25/06
 Reason for admission: acute renal failure, hyperkalemia, prostatic obs., inability to walk
 Treatment provided: maintain highest level of functioning
 Progress (include any complications experienced): condition worsen
 Reason for discharge/discharge diagnosis(es): Transferred on the 15th Akin hosp. & discharged 5/25/06
SAA

FINAL SUMMARY OF THE RESIDENT'S STATUS

SOCIAL SERVICES

Sensory impairments unknown
 Mental and psychosocial status: Able to make needs known Unable to make needs known
 Attitude about discharge (describe) unknown
 Cognitive status unknown
 Discharge potential D/C to Akin hosp.
SOCIAL SERVICES DIRECTOR Sharon Nicholson, SS Date 5/26/06
Signature and title
 Additional Social Services notes on reverse.
 Personal Belongings sent: with resident with family Other _____

NURSING SERVICES

Vital signs at time of discharge: Temp. _____ Pulse _____ Resp. _____ BP 1
 Clinical lab values or diagnostic tests: _____
 Physical functioning status: Ambulatory Nonambulatory Needs assist with ADLs No ADL assist needed
 Assistive device(s) needed (specify) _____
 Other comments: _____
 Special treatments or procedures planned for discharge: None P.T. S.T. O.T. Ostomy G Tube
 NG Tube Other Res. Trans. to Armc 5/15/06 for eval. & adm. to Armc @ that time. Dischg. to Armc 5/25/06
 Dental condition: Own teeth Upper dentures Lower dentures Partial dentures No teeth or dentures
 Refuses to use dentures Teeth/mouth problems (specify) _____
 Drug therapy required _____
NURSE SIGNATURE Margaret Opell, RN Date 5/26/06
Signature and title
 Additional Nursing Service notes on reverse. Disposition of Meds: Meds. Ret. to Pharmacy

DIETARY SERVICES

Weight 147 Height 90 Weight trend Varied
 Chewing problems Swallowing problems Needs assist (specify) Fed only & set up
 Eating habits/preferences Prefer eating habits
 Diet order: Pureed Texture: Blended Allergies: NKA
DIETARY DIRECTOR Mattie Gordon, DM Date 5/26/06
Signature and title
 Additional Dietary Service notes on reverse.

NAME-Last <u>Peterson, William</u>	First <u>William</u>	Middle <u>NRGLM</u>	Attending Physician <u>NRGLM</u>	Record No. <u>1050</u>	Room/Bed <u>P214D</u>
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TRANSFER AND REFERRAL RECORD

NAME: Peterson William ROOM: 214D SEX: M AGE: _____ DATE: 5/15/06

RESPONSIBLE PARTY
 NAME: See attached
 ADDRESS: _____
 PHONE: Home: _____ Work: _____
 RELATION: _____

MARITAL STATUS: _____
RELIGION: _____
ALLERGIES: NKA

BIRTHDAY: _____
 SSN: _____
 Medicare: _____
 Medicaid: See attached
 VA: _____
INSURANCE NAME & NUMBER: _____

DIAGNOSIS

CODE: _____	LOC ICF
CODE: _____	
CODE: _____	
CODE: _____	
CODE: _____	
CODE: _____	
CODE: _____	

DOCTOR
 DOCTOR: _____
 PHONE: _____
 ALT. DR.: _____
 PHONE: _____

NOTIFY IN CASE OF EMERGENCY
 NAME: _____
 ADDRESS: _____
 PHONE: Home: _____ Work: _____

DIET ORDER

MEDICATIONS
 LAST ADMINISTERED: _____

PRN

TREATMENTS

CIRCLE IF PRESENT

INCONTINENT: Bowel
Bladder
 Saliva

DISABILITIES: Amputation
 Paralysis
Contracture
Decub. Ulcer

IMPAIRMENTS: Mental:
 Speech:
 Hearing: _____
 Vision: _____
 Sensation: _____

ADDITIONAL COMMENTS

Vital Signs: unable to obtain
 Temperature: _____
 Mobility: _____
 Functional CAP: _____
 Date of Last BM: _____
 PPD: _____
 Chest X Ray: _____
 Comments: AMA

SIGNATURE: [Signature] DATE: 5/15/06 TIME: 3:35p

ATTACH: RESIDENT FACE SHEET PHYSICIAN ORDERS
 BED HOLD POLICY MOST RECENT NURSES NOTES

BED HOLD POLICY

Facility Name: TMH&R of Edgefield

The Facility will hold the bed for residents who transfer to the hospital or go out on therapeutic leave according to the following policy:

MEDICAID – According to state regulations, Medicaid will pay a facility to hold the bed for 10 days for anyone transferred to a hospital. Days begin with the day of transfer and do not count the day of return to the facility. After 10 days, a resident will have to be discharged from the Facility. Should the resident wish to return to the facility at a later time and the resident meets the criteria of the facility, favorable consideration will be given to the resident to be re-admitted.

All overnight days must be documented as therapeutic leave days. Residents going out on overnight therapeutic leave are allowed by the State plan 18 overnight visits per year from July 1 of one year through June 30 of the following year. No more than 9 therapeutic days may be taken at one time. Should leave days exceed the amount allowed, the State will be contacted for the correct procedures for payment.

Should a **MEDICAID** resident who meets **MEDICARE** criteria have to be transferred to the hospital, Medicaid will pay to hold the bed 10 days and the policy will be the same as noted above.

PRIVATE PAY – The State plan does not limit the number of days a private paying resident may remain in the hospital or out on therapeutic days. It is the policy of the facility to hold the bed of private paying residents as long as the resident so desires and is willing to pay for the bed hold days. This request to hold the bed will have to be in writing. The facility does require 7 days written notice of release of the bed. The facility will fill the bed as soon as possible after notification.

Should a private pay resident who meets **MEDICARE** criteria have to be transferred to the hospital, the policy is the same as noted above.

This policy will be explained to the resident and responsible party upon admission and will be posted at each nurse's station so it can be reviewed by resident, family, or friends before transfer to the hospital or therapeutic leave.

Date policy became effective
Revised September 1, 1995

The above BED HOLD POLICY has been explained to me.

Patterson, William
Resident

Responsible Party

5-15-06
Date

Witness

DISCHARGE DATE: _____

OBRA - Patient Self Determination Checklist

William Peterson

A. Facility Policy

It is our policy that every resident will be resuscitated until a physician's DNR (Do Not Resuscitate) Order, signed and dated is in place. In the event the heart stops beating - CPR will not be instituted and/or in the event that respiration cease the patient will not be intubated or placed on a respirator if the Do Not Resuscitate order is signed.

B. DNR Policy

The physician will dictate the need for a "DNR" order for any patient. He or she must, along with the facility, provide informed consent and discuss in detail the meaning of a "DNR" with the resident surrogate (guardian, spouse, child or parent). The physician must write the order himself/herself, sign it, and date it: No telephone orders accepted. The physician must write a note in the progress notes that he/she has discussed this decision with the resident, surrogate and/or immediate family. The facility should document consent with written confirmation from the same. It is strongly encouraged that a family member countersign this note. The order must be reviewed and revised at least annually. The order must be kept on the resident's chart. The care plan must indicate there is such an order on the chart.

I/We *Mary Ruth Peterson*, certify that I/We have reviewed the attached materials and had the resident rights explained to me (or as responsible party the rights of the resident) and the facility's medical self determination policies. Please check appropriate boxes and complete.

Elect DNR. I hereby instruct my physician and the facility to place the DNR authorization/policy in my medical chart.

Reject DNR. I direct the facility to administer all available indicated medical care. In the event of cardiac or pulmonary arrest, CPR shall be initiated if available. The facility may defer CPR to an emergency agency and reserves the right to do so.

Living Will. I have/~~have not~~executed a living will or other advance directive. Attach executed copy.

Surrogate Decision Maker. I have appointed _____ as my medical surrogate to speak for me in the event of my incompetence.

Relation to resident _____ Form of appointment _____ . Attach copy

Power of Attorney - Health Care. I have executed a Power of Attorney naming _____ to act on my behalf in the event of my inability to direct my health care affairs.

Guardian. _____ has been appointed by the court as my guardian. Attach copy of court papers.

Informed Consent. I understand the facility's policies and attached documents which describe in general the state law on advanced directives and patient's rights. I have received the materials and they have been explained to me.

I understand if I have additional questions about documents I should contact an attorney. I understand that the forms provided are a convenience and not a condition of admission. I will not hold the facility responsible for the carrying out of advanced directives or its policies which may not be consistent with the directives.

The facility's DNR (Do Not Resuscitate) policy has been received and discussed. **TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 05**

William Peterson
Karen Wilson
Facility Representative

03 - 21 - 06
Date

Signature of Resident

Mary Ruth Peterson (daughter)
Responsible Party

C. Artificial forms of nutrition and hydration

Artificial forms of nutrition and hydration have been explained and discussed with me, to include nasogastric tubes, gastric tubes, and IV's.

In the event my physician has determined these are life sustaining measures, following are my wishes.

^{daughter}
Mary Ruth Peterson
Signature

03 - 21 - 06
Date

I DO want to receive nasogastric tubes.

I DO NOT want to receive nasogastric tubes.

I DO want to receive gastric tubes.

I DO NOT want to receive gastric tubes.

I DO want to receive IV fluids.

I DO NOT want to receive IV fluids.

I DO want to receive IV antibiotics.

I DO NOT want to receive IV antibiotics.

Emergency Medical Services
Do Not Resuscitate Order

SOUTH CAROLINA EMERGENCY MEDICAL SERVICES



DO NOT RESUSCITATE ORDER

NOTICE TO EMS PERSONNEL

This notice is to inform all emergency personnel who may be called to render assistance to William Peterson that he/she has a terminal condition which has been diagnosed by me and has specifically requested that no resuscitative efforts including artificial stimulation of the cardiopulmonary system by electrical, mechanical, or manual means be made in the event of cardio-pulmonary arrest.

REVOCATION PROCEDURE

THIS FORM MAY BE REVOKED BY AN ORAL STATEMENT BY THE PATIENT TO EMS PERSONNEL, OR BY MUTILATING, OBLITERATING, OR DESTROYING THE DOCUMENT IN ANY MANNER.

Date: 3/22/04
Patient's Signature (or Surrogate or Agent) (daughter) Mary Ruth Peterson

Physician's Signature [Signature] Physician's Address 200 Ridge Medical Plaza
Edgefield SC 29824

Physician's Telephone Number 803-637-3146

DO NOT REMOVE [Handwritten initials]

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

PASARR - Level I SCREENING FORM

Name: <u>William Peterson</u>	Date of admission: <u>3-21-06</u>
BSN: <u>[REDACTED]</u>	Location of admission: <u>Armc</u>
Medicaid: <u>Non-Medicaid</u> <input checked="" type="checkbox"/>	CLTCU: <u>[REDACTED]</u>
Date of birth: <u>[REDACTED]</u>	Referral source: <u>Armc</u>
All Diagnosis (If dementia diagnosed or suspected, complete and attach the Mini-Mental Form): <u>Acute renal failure, Hyperkalemia</u>	

I. SCREENING FOR MENTAL RETARDATION INDICATORS:

	YES	NO
1. Diagnosis of mental retardation or related disability made prior to age 21		<input checked="" type="checkbox"/>
2. IQ tested below 70?		<input checked="" type="checkbox"/>
3. Was ever of legal age prior to age 21		<input checked="" type="checkbox"/>
4. Does client have 3rd grade education? If not, state reason in Comments Section.	<input checked="" type="checkbox"/>	
5. Adaptive behavior: Could client ever perform self care activities?	<input checked="" type="checkbox"/>	
- Did he/she help care for spouse/parents/children?	<input checked="" type="checkbox"/>	
- Was client ever able to cook and perform household duties?	<input checked="" type="checkbox"/>	
- Was client ever fully employed? If not, explain in Comments Section.	<input checked="" type="checkbox"/>	
- Did client have driver's license?	<input checked="" type="checkbox"/>	
6. Cognitive Functioning:		
- Memory: Does client remember what he/she had for breakfast or lunch?		<input checked="" type="checkbox"/>
- Simple math: Can client add 12 + 6?		<input checked="" type="checkbox"/>
- Concept formation: Can client describe the difference between a fish and dog?		<input checked="" type="checkbox"/>

7. Comments: _____

II. SCREENING FOR MENTAL ILLNESS INDICATORS:

1. Diagnosis of mental illness: No Yes _____ Diagnosis: _____

2. History of psychiatric hospitalization within previous two years. (Give dates of treatment) If no hospitalization, indicate here: N/A
 _____ to _____ to _____ to _____

3. Current behavioral indicators:

Attempted suicide	<u>N/A</u>	Self-harm/abuse	<u>N/A</u>
Aggressive	<u>[REDACTED]</u>	Combative	<u>[REDACTED]</u>
Incessant loud talking	<u>[REDACTED]</u>	Social isolation	<u>[REDACTED]</u>
Uncooperative	<u>[REDACTED]</u>	Destruction of property	<u>[REDACTED]</u>
Hoarding	<u>[REDACTED]</u>	Unrealistic fear of strangers	<u>[REDACTED]</u>
		None of these indicators	<u>[REDACTED]</u>

4. Comments (Include explanation of major symptoms): _____
 TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 08

III. LIST ALL PSYCHOPHARMACOLOGICAL PROCEDURES INCLUDING DOSAGE AND FREQUENCY.

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____

IV. RECOMMENDATION OF REVIEWER

- Recommend further evaluation based on essential retardation indicators.
- Recommend further evaluation based on essential illness indicators.
- No further evaluation recommended.
- No further evaluation recommended, but indicators present. (State reasons below.)

Comments: (Give justification for above recommendations, if needed.)

V. PERTINENT INFORMATION

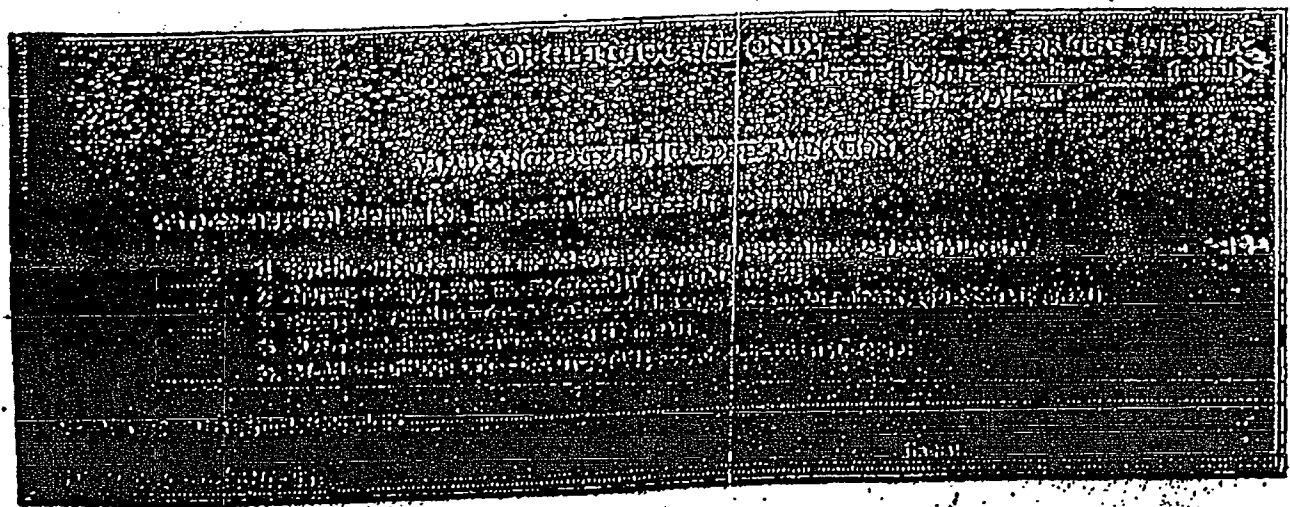
IMD admission requested; if so, indicate facility: _____
 Primary diagnosis of admission; must be confirmed by a Mini-Mental Form.

Referral source: Pt. - Medical Record CLTC/Amal

Signature and title of reviewer: V. Johnson, CM

Agency/Institution completing form: ARMC

Submitting Nursing Facility: Edgefield NH Date of Admission (if known) 3/21/06



SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

MINI-MENTAL STATE EXAM

Name: <i>William Peterson</i>		Date: <i>April 18, 2006</i>
TEST ITEMS	SCORE	INSTRUCTIONS
<p>Orientation</p> <p>1. What is the (year) (season) (date) (day)(month)?</p> <p>2. Where are we (state) (county) (town) (hospital) (floor)?</p>	<p>Max of 5</p> <p><i>0</i></p> <p><i>0</i></p>	<p>1. Ask for the date. Then ask specifically for any part omitted, e.g., "Can you also tell me what season it is?" One point for each correct answer.</p> <p>2. Ask in turn, "Can you tell me the name of this Hospital (town, county, etc.) One point for each correct answer.</p>
<p>Registration</p> <p>1. Name three objects and have patient repeat them. (0 to 3)</p> <p>2. Number of trials. (0 to 6)</p> <p>_____</p>	<p>Max of 3</p> <p><i>0</i></p>	<p>1. Ask the patient if you may test his memory. Then say the names of three unrelated objects, clearly and slowly, talking about one second for each. After you have said all three, ask the patient to repeat them. This first repetition determines the score.</p> <p>2. Keep saying the names of the items until the patient can repeat all three up to six trials. If the patient does not eventually learn all three, recall cannot be meaningfully tested.</p>
<p>Attention and Calculation</p> <p>1. Serial 7's: Counting backwards from 100 by 7.</p> <p>or</p> <p>2. Alternate Test: Spell "world" backwards.</p>	<p>Max of 5</p> <p><i>0</i></p> <p><i>1</i></p>	<p>1. Ask the patient to begin with 100 and count backwards by 7. Stop after 5 subtractions (93, 86, 79, 72, 65.) Score the total number of correct answers. If the patient cannot or will not perform this test, use the number 2.</p> <p>2. Ask the patient to spell "world" backwards. The score is the number of letters in correct order, e.g., "dlrow" = 5, "dlorw" = 2, etc.</p>
<p>RECALL</p> <p>1. Ask the patient to recall the three objects above. Score 0 to 3.</p>	<p>Max of 3</p> <p><i>0</i></p>	<p>1. Ask the patient if he can remember the three objects you previously named for him. (In the Registration Section of the test.) Score one point for each correct recall. Do not prompt.</p>

<p>LANGUAGE</p> <p>1. Name a pencil and a watch. (Max of 2 points)</p> <p>2. Repeat the sentence, "No ifs, ands, or buts." (Max of 1 point)</p> <p>3. Follow this three stage command, "Take a piece of paper, fold it in half, then hand it to me." (Max of 3 points)</p> <p>4. Please do the following: a. Close your eyes. (Max of 1 point) b. Write a sentence. (Max of 1 point) c. Draw intersecting pentagons. (Max of 1 point)</p>	<p>Max of 9</p> <p><u>0</u></p> <p><u>1</u></p> <p><u>0</u></p> <p><u>1</u></p> <p><u>0</u></p> <p><u>0</u></p>	<p>1. <u>Naming</u>: Show the patient a wristwatch and ask him to name what it is. Repeat this for a pencil. Score 0 to 2 points. Do not prompt.</p> <p>2. <u>Repetition</u>: Say to the patient, "Please repeat this sentence after me, 'No ifs, ands, or buts.'" Allow only one trial or attempt.</p> <p>3. <u>Three Stage Command</u>: Give the patient a piece of paper and state the full three part command. Score one point for each part correctly executed. Do not prompt or recite the three stages separately.</p> <p>4. <u>Reading, Writing, Copying</u>: a. Show the patient the statement, "Close your eyes." Ask him to read it and do what it says. b. Give the patient a blank piece of paper and ask him to write a sentence for you. Do not prompt or assist as spontaneity is important. It must contain a subject and a verb and be sensible. Correct grammar and punctuation are not necessary. c. Show the picture of the intersecting pentagons to the patient. Give him a blank piece of paper and ask him to draw it exactly as it is. All ten angles must be present and two must intersect to score one point.</p>
<p>TOTAL SCORE</p>	<p><u>2</u></p>	
<p>Level of Consciousness</p> <p>1. Assess the level of consciousness on the following continuum: <u>4</u> 3 2 1 Alert Drowsy Stupor Coma</p> <p>2. Assess the level of intelligence on the following continuum: 4 3 2 <u>1</u> Superior Above Average Below Average</p>	<p>1. Make a judgment about the patient's level of consciousness. <i>Res. is alert and oriented to his surroundings, able to communicate</i></p> <p>2. Make a judgment about the patient's level of intelligence. <i>Res. was hesitant to participate questionnaire</i></p>	
<p>Conclusion: The Mini-Mental State Exam is Based on an 8th Grade Education. 30 Points Total</p>		
<p>Normal - 26 & above Borderline - 21 to 25 Demented - 20 & below Absolute Dementia - 15 & below</p>		
<p>Reviewer's Signature: <i>Sharon Nicholas</i></p>	<p>Date: <i>April 18, 2006</i></p>	

**SOUTH CAROLINA STATE
HEALTH AND HUMAN SERVICES
FINANCE COMMISSION**

MINI-MENTAL STATE EXAM

NAME: <u>Peterson, William</u>	DATE: <u>3-21-06</u>
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TEST ITEMS	SCORE	INSTRUCTIONS
<p style="text-align: center;">ORIENTATION</p> <p>WHAT IS THE (YEAR) (SEASON) (DATE) (DAY) (MONTH)</p> <p>WHERE ARE WE: STATE, COUNTY, TOWN, HOSPITAL, FLOOR</p>	<p>MAX. OF 5</p> <p style="font-size: 1.5em;"><u>2</u></p> <p>MAX. OF 5</p> <p style="font-size: 1.5em;"><u>3</u></p>	<p style="text-align: center;">INSTRUCTIONS FOR ORIENTATION</p> <p>1. ASK FOR THE DATE, THEN ASK SPECIFICALLY FOR ANY PART OMITTED, E.G. "CAN YOU ALSO TELL ME WHAT SEASON IT IS." ONE POINT FOR EACH CORRECT ANSWER.</p> <p>2. ASK IN TURN, "CAN YOU TELL ME THE NAME OF THIS HOSPITAL (TOWN, COUNTY, ETC). ONE POINT FOR EACH CORRECT ANSWER.</p>
<p style="text-align: center;">REGISTRATION</p> <p>NAME THREE OBJECTS AND HAVE PATIENT REPEAT THEM. (0 TO 3)</p> <p>NUMBER OF TRIALS (0 TO 6)</p>	<p>MAX OF 3</p> <p style="font-size: 1.5em;"><u>0</u></p> <p style="font-size: 1.5em;"><u>6</u></p>	<p style="text-align: center;">INSTRUCTION FOR REGISTRATION</p> <p>1. ASK THE PATIENT IF YOU MAY TEST HIS MEMORY THEN SAY THE NAMES OF THREE UNRELATED OBJECTS, CLEARLY AND SLOWLY, TAKING ABOUT ONE SECOND FOR EACH, AFTER YOU HAVE SAID ALL THREE, ASK THE PATIENT TO REPEAT THEM. THIS FIRST REPETITION DETERMINES HIS SCORE.</p> <p>2. KEEP SAYING THE NAMES OF THE ITEMS UNTIL THE PATIENT CAN REPEAT ALL THREE UP TO SIX TRIALS. IF HE DOES NOT EVENTUALLY LEARN ALL THREE, RECALL CANNOT BE MEANINGFULLY TESTED.</p>
<p style="text-align: center;">ATTENTION AND CALCULATION</p> <p>SERIAL TO COUNTING BACKWARDS FROM 100 BY 7.</p> <p>OR</p> <p>ALTERNATE TEST: SPELL "WORLD" BACKWARDS</p>	<p>MAX. OF 5</p> <p style="font-size: 1.5em;"><u>0</u></p> <p style="font-size: 1.5em;"><u>0</u></p>	<p style="text-align: center;">INSTRUCTIONS OF ATTEN. AND CALC.</p> <p>1. ASK THE PATIENT TO BEGIN WITH 100 AND COUNT BACKWARDS BY 7. STOP AFTER 5 SUBTRACTIONS (93, 86, 79, 72, 65). SCORE THE TOTAL NUMBER OF CORRECT ANSWERS. IF THE PATIENT CANNOT OR WILL NOT PERFORM THIS TEST, USE THE NUMBER 2.</p> <p>2. ASK THE PATIENT TO SPELL WORLD BACKWARDS, THE SCORE IS THE NUMBER OF LETTERS IN CORRECT ORDER, E.G. DLROW - 5, or 2, ETC.</p>
<p style="text-align: center;">RECALL</p> <p>ASK THE PATIENT TO RECALL THE THREE OBJECTS ABOVE. SCORE 0 TO 3.</p>	<p>MAX. OF 3</p> <p style="font-size: 1.5em;"><u>0</u></p>	<p style="text-align: center;">INSTRUCTIONS FOR RECALL</p> <p>1. ASK THE PATIENT IF HE CAN REMEMBER THE THREE OBJECTS YOU PREVIOUSLY NAMED FOR HIM. (IN THE REGISTRATION SECTION OF THE TEST). SCORE ONE POINT FOR EACH CORRECT RECALL. DO NOT PROMPT.</p>
<p style="text-align: center;">LANGUAGE</p> <p>NAME A PENCIL AND A WATCH. (MAX. OF 2 POINTS)</p> <p>REPEAT THE STATEMENT, "NO IFS, ANDS OR BUTS." (MAX. OF 1 POINT)</p> <p>NOW THIS THREE STAGE COMMAND, "TAKE A PIECE OF PAPER, FOLD IT IN HALF, THEN HAND IT TO ME." MAX. 3 POINTS</p>	<p>MAX. OF 9</p> <p style="font-size: 1.5em;"><u>2</u></p> <p style="font-size: 1.5em;"><u>1</u></p> <p style="font-size: 1.5em;"><u>0</u></p>	<p style="text-align: center;">INSTRUCTIONS FOR LANGUAGE</p> <p>1. NAMING: SHOW THE PATIENT A WRISTWATCH AND ASK HIM TO NAME WHAT IT IS. REPEAT THIS FOR A PENCIL SCORE TO 0 TO 2 POINTS. DO NOT PROMPT.</p> <p>2. REPETITIONS: SAY TO THE PATIENT, "PLEASE REPEAT THIS SENTENCE AFTER ME, "NO IFS, ANDS OR BUTS." ALLOW ONLY ONE TRIAL OR ATTEMPT.</p> <p>3. THE THREE STAGE COMMAND; GIVE THE PATIENT A PIECE OF PAPER AND STATE THE FULL THREE PART COMMAND. SCORE ONE POINT FOR EACH PART CORRECTLY EXECUTED. DO NOT PROMPT OR RECITE THE THREE STAGES SEPARATELY.</p>

LANGUAGE CONTINUED:

4. PLEASE DO THE FOLLOWING:

A. CLOSE YOUR EYES.
MAX OF 1 POINT.

1

B. WRITE A SENTENCE.
MAX OF 1 POINT.

0

C. DRAW INTERSECTING PENTAGONS.
MAX OF 1 POINT

0

4. READING, WRITING, AND COPYING:

A. SHOW THE PATIENT THE STATEMENT, "CLOSE YOUR EYES. ASK HIM TO READ IT AND DO WHAT IT SAYS.

B. GIVE THE PATIENT A BLANK PIECE OF PAPER, AND ASK HIM TO WRITE A SENTENCE FOR YOU. DO NOT PROMPT OR ASSIST AS SPONTANEITY IS IMPORTANT. IT MUST CONTAIN A SUBJECT AND A VERB AND BE SENSIBLE. CORRECT GRAMMAR AND PUNCTUATION ARE NOT NECESSARY.

C. SHOW THE PICTURE OF THE INTERSECTING PENTAGRAMS TO THE PATIENT; GIVE HIM A BLANK PIECE OF PAPER AND ASK HIM TO DRAW IT EXACTLY AS IT IS. ALL TEN ANGLES MUST BE PRESENT AND TWO MUST INTERSECT TO SCORE ONE POINT.

TOTAL SCORE

9

LEVEL OF CONSCIOUSNESS

ASSESS THE LEVEL OF CONSCIOUSNESS ON THE FOLLOWING CONTINUUM:

4 3 2 1
ALERT DROWSY STUPOR COMA

ASSESS THE LEVEL OF INTELLIGENCE ON THE FOLLOWING CONTINUUM:

4 3 2 1
SUPERIOR ABOVE AVERAGE BELOW
AVERAGE AVERAGE

INSTRUCTIONS FOR LEVEL OF CONSCIOUSNESS

1. MAKE A JUDGMENT ABOUT THE PATIENT'S LEVEL OF CONSCIOUSNESS.

2. MADE A JUDGMENT ABOUT THE PATIENT'S LEVEL OF INTELLIGENCE.

CONCLUSION: THE MINI-MENTAL STATE EXAM IS BASED ON AN 8TH GRADE EDUCATION.

- 30 POINTS TOTAL
- 26 AND ABOVE - NORMAL
- 21 TO 25 - BORDERLINE
- 20 AND BELOW - DEMENTED
- 15 AND BELOW - ABSOLUTE DEMENTIA

REVIEWER'S SIGNATURE:

Wendy Johnson, RN

DATE:

3-21-06

MT

-535-

2148

CERTIFICATION AND RECERTIFICATION FOR MEDICARE SERVICES SKILLED NURSING FACILITY SERVICES

Peterson, William
(Resident Name)

03-21-06
(Admission Date)

247306586A
(Health Ins. Claim #)

CERTIFICATION

of patient admission.
Required at time of
Admission.

I certify that post-hospital nursing facility skilled services are required on an inpatient basis because of the above named patient's need for skilled care on a continued basis.

RUGs Level RMP

Diagnosis/Skilled Service S/p Surgery Cervical Stenosis muscle weakness
Dementia - DUBHECKS HTN - BPH BPH Card Rehab Services

J. Money
Physician Signature

3-21-6
Date

RECERTIFICATION

of continued skilled inpatient
care - on or before the 14th day.

Continued SNF inpatient care is necessary for the above patient.

RUGs Level RHC

Diagnosis/Skilled Service S/p Cervical Surgery - muscle weakness

Dementia - BPH - Rehab Services
J. Money
Physician Signature

4-3-6
Date

RECERTIFICATION

of continued skilled inpatient
care - on or before the 44th day.

Continued SNF inpatient care is necessary for the above patient for the following reasons:

RUGs Level RHC

Diagnosis/Skilled Service S/p Cervical Surgery - muscle weakness

Dementia - BPH - Card - Rehab Services
J. Money
Physician Signature

5-3-6
Date

RECERTIFICATION

of continued skilled inpatient
care - on or before the 74th day.

Continued SNF inpatient care is necessary for the above patient for the following reasons:

RUGs Level _____

Diagnosis/Skilled Service _____

D/C'ed

Physician Signature

Date

Name Peterson, William

Room No. P214W Date 03-21-03

Sex M Age 84

Hospital No. 1050

Dr. NRGLM

Allergies NKA

DIAGNOSIS

- ① AKE 2° CBS
- ② Hyperkalemia
- ③ Sp decompression from cervical spine stenosis
- DBP 10
- ⑤ G BND
- 6 HTR

84yo BM readmitted from Arden
 Regional after AKE 2° BPH,
 Hyperkalemia + sp urgent spinal
 effusion 2° ex stenosis & neurogenic B's
 HTN renal failure has returned to
 nl at 2 mg qd/c

See Med list

VS
 Pt alert & pleasant in Sp hall
 HEENT - well healed throat, clear

② side of neck


Common

Large clear

Shin very

Nervous normal

Relief from

 3/23/06

RESIDENT IMMUNIZATION RECORD

RESIDENT NAME: Peterson, William

CASE#: 1050

	DATE	REACTION	SITE
ADMISSION TB SCREENING			
#1	3/19/04	Ømm	RT FA
#2	4-2-06	Ømm	LT FA
ADMISSION CHEST X-RAY			
PNEUMONIA VACCINE	2/23/06		
TETANUS TOXOID			
FLU VACCINE	2/27/06		
#1			
#2			
#3			
#4			
#5			
ANNUAL TB SCREENING			
#1			
#2			
#3			
#4			
#5			
#6			

Physicians Orders

-538- CL6100a

For the month of: 2006

T M Health & Rehab of Edgelyfield LP

Order			Time Code	Orders	
Date	Type	No.			
3/21/06				<p>GENERIC EQUIVALENTS MAY BE USED UNLESS OTHERWISE NOTED BY PHYSICIAN.</p> <p>ROUTINE VISITS BY M.D. NOT MEDICALLY NECESSARY FOR THIS RESIDENT BUT EVERY <u>30</u> DAYS.</p> <p>CODE STATUS: I HAVE INFORMED RESIDENT OR DESIGNATED DECISION MAKER OF DIAGNOSIS AND OVERALL HEALTH STATUS</p> <p>DIET: <i>Reg pureed.</i> REHAB POTENTIAL: <i>fair</i></p> <p>TREATMENT: FLU VACCINE: ANNUALLY</p> <p>RESIDENT MAY SEE DENTIST, PODIATRIST, OPTOMETRIST</p> <p>RESIDENT ACTIVITY PLAN APPROVED AND IS NOT IN CONFLICT WITH THE OVERALL PLAN OF CARE</p> <p>RESIDENT MAY HAVE PLANNED THERAPEUTIC LOA FROM FACILITY. OVERNIGHT NOT TO EXCEED MEDICAID REGULATIONS</p> <p>ALT PHYS & PHONE # <i>Dr Morgan 803-275-4653</i></p> <p>MEDICAID#</p> <p>MYLANTA/MAALOX 15-30CC BY MOUTH AS NEEDED Q2HRS FOR INDIGESTION OR NAUSEA X48HRS.</p> <p>ACETAMINOPHEN 5 GR TAB 2 TABS BY MOUTH AS NEEDED Q4HRS FOR PAIN OR FEVER X48HRS</p> <p>MILK OF MAGNESIA 30CC BY MOUTH AS NEEDED DAILY X48HRS. DX CONSTIPATION</p> <p>KAOPECTATE 30CC BY MOUTH AS NEEDED EVERY 2HRS UNTIL DIARRHEA SUBSIDES X48HRS</p> <p>I HAVE REVIEWED RESIDENT'S PLAN OF CARE.</p> <p>I AGREE RESIDENT MEETS CASE MIX CATEGORY [A] OR [B] OR [C] OR [D] CRITERIA.</p> <p>I CERTIFY THAT RESIDENT NEEDS CONTINUED CARE IN NURSING HOME ON A CONTROL BASIS.</p> <p><i>Admit to skilled nursing</i> <i>SR'S ↑ x 2 for enablers</i> <i>Flu & urology x 1 mth</i> <i>PT + OT to evaluate.</i> <i>may crush allowable meds.</i> <i>VS q shift</i> <i>I + O q shift.</i></p>	
	MD	5			
	MD	6			
	MD	7			
	MD	8			
	MD	9			
	MD	10			
	MD	11			
	MD	12			
	MD	13			
	MD	14			
	MD	15			
	MED	1			
	MED	2			
	MED	3			
	MED	4			
Phys. Sig.	<input checked="" type="checkbox"/>	<i>Morgan</i>	Date: <i>3/21/06</i>	Above Orders Noted by: <input checked="" type="checkbox"/>	Date:
Nurse Review	<input checked="" type="checkbox"/>	<i>P. Dennis</i>	Date: <i>3/21/06</i>	Pharmacy Review: <input checked="" type="checkbox"/>	Date:
Rehabilitative Potential					
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Dx: <i>Acute renal failure</i> <i>S/P cervical discectomy + fusion</i> <i>prostate enlargement</i> <i>GERD</i> <i>Allergies: NKA</i> <i>HTN</i>					
Physician: <i>Dr. Massey</i>			Alt. Phys: <i>Morgan, Hugh</i>		
Phys. Plt: <i>637-3146</i>			Alt. Phys. Ph: <i>275-4653</i>		
Resident Name		TMH&R of Edgelyfield		03/21/2006 - 05/25/2006 - 017	
<i>Peterson, William</i>		<i>1050 P 214W</i>		<i>03-11-22 m 03-21-06</i>	
Page: 1 of 2					

Physician's Orders

-539-

For the month of:

Order			Time Code	Orders
Date	Type	No.		
3/21/06				<p>Atenolol 12.5mg BID for BP Protonix 40mg qday for GERD Norvasc 5mg daily for HTN Silverite q day x 2 mths. Novosource / Resource 2.0 120cc qid between meals.</p> <p>Pressure mattress to bed. Foley Care q shift May use leg bag when ambulating and use BSD at night Change foley every 6-8 weeks 2nd step PPD x 2 wks due 4/2/06 Wkly BP heel pads while in bed.</p>

Phys. Sig.	<input checked="" type="checkbox"/>	M. Massey	3	Date: 3/21/06	Above Orders Noted by:	<input checked="" type="checkbox"/>	Date:
Nurse Review	<input checked="" type="checkbox"/>	P. Dunlap		Date: 3/21/06	Pharmacy Review	<input checked="" type="checkbox"/>	Date:

Rehabilitative Potential		Yes	No
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Dx: Acute Renal failure Prostatic enlargement	S/P Cervical discectomy + fusion GERD HTN
Allergies: NKA	
Physician: Massey Phys. Ph: 637-3146	Alt. Phys: Morgan, Hugh Alt. Phys. Ph: 275-4653
	Ht: Wt: M/R No.:

Resident Name	Res. No.	Unit Room Bed	D.O.B.	Sex	Admit Date	Page
Petersen, William	TMH 082	of Fogelfield 0		m	3/25/2006 - 018	1 of 2

Physician's Orders

-540- CL6100a

For the month April 2006

T M H. H & Rehab of El. field LP

Order			Interval	Time	Orders
Date	Type	No.	Code	Code	
GENERIC EQUIVALENTS MAY BE USED UNLESS OTHERWISE NOTED BY PHYSICIAN.					
ROUTINE VISITS BY M.D. NOT MEDICALLY NECESSARY FOR THIS RESIDENT BUT EVERY <u>30</u> DAYS.					
3/21/2006	MED	21		BID	401.9 Hypertension Nos ⊖ ATENOLOL 12.5MG PO BID
3/21/2006	MED	22		QD	530.81 Esophageal Reflux ⊖ PROTONIX 40MG PO Q DAY
3/21/2006	MED	23		QD	401.9 Hypertension Nos ⊖ NORVASC 5MG PO DAILY
<u>3/29/06</u>	<u>MED</u>			<u>TID</u>	<u>Prostat 101 - 30cc in 4oz juice tid x 2 months</u> <u>dic p 5/29/06</u>
3/21/2006	MED	24		QD	⊖ SILVERVITE 1. PO Q DAY X 2 MONTHS D/C AFTER MAY 21ST
<u>3/29/06</u>	<u>MED</u>	<u>26</u>		<u>QID</u>	⊖ NORVASOURCE/ RESOURCE 2.0 <u>120</u> CC QID BETWEEN MEALS <u>180</u>
3/21/2006	MED	20		SHIFT	⊖ VITAL SIGNS Q SHIFT
3/21/2006	MED	18		SHIFT1	⊖ 2ND STEP PPD DUE APRIL 2ND
3/21/2006	MED	31	QTUE	SHIFT1	⊖ WEEKLY B/P
3/21/2006	PRN	1		PRN	⊖ MYLANTA/MAALOX 15-30CC BY MOUTH AS NEEDED Q2HRS FOR INDIGESTION OR NAUSEA X48HRS.
3/21/2006	PRN	2		PRN	⊖ ACETAMINOPHEN 5 GR TAB 2 TABS BY MOUTH AS NEEDED Q4HRS FOR PAIN OR FEVER X48HRS
3/21/2006	PRN	3		PRN	⊖ MILK OF MAGNESIA 30CC BY MOUTH AS NEEDED DAILY X48HRS. DX CONSTIPATION
3/21/2006	PRN	4		PRN	⊖ KAOPECTATE 30CC BY MOUTH AS NEEDED EVERY 2HRS UNTIL DIARRHEA SUBSIDES X48HRS
3/21/2006	TX	29			⊖ MAY USE LEG BAG WHEN AMBULATING AND USE BSD AT NIGHT
3/22/2006	TX	25		BID	⊖ VASOLINE TO PENIS BID
3/24/2006	TX	34		PRN	⊖ SOFT COLLAR USED PRN FOR COMFORT X 6 WEEKS D/C AFTER MAY 2ND
3/21/2006	TX	27		SHIFT	⊖ ALTERNATING PRESSURE RELIEF MATTRESS TO BED
3/21/2006	TX	28		SHIFT	⊖ FOLEY CARE Q SHIFT
3/21/2006	TX	30		SHIFT1	⊖ CHANGE FOLEY EVERY 6-8 WEEKS
3/22/2006	TX	32		SHIFT1	⊖ CLEAN NECK INCISION SITE WITH WOUND CLEANSER APPLY DRY DRESSING DAILY
2/27/2006	MD	5			⊖ CODE STATUS:DNR NO NG OR G-TUBE

Phys. Sig.	<input checked="" type="checkbox"/>	<u>Massey</u>	Date:	<u>4-1-06</u>	Above Orders Noted by:	<input checked="" type="checkbox"/>	Date:
Nurse Review	<input checked="" type="checkbox"/>	<u>Sheila Whedburn</u>	Date:	<u>3/28/06</u>	Pharmacy Review	<input checked="" type="checkbox"/>	Date:

Rehabilitative Potential

FAIR

Yes No

Dx: 723.0 Cervical Spinal Stenosis 728.87 Muscle Weakness-General 600.90 Bph Nos W/O Urinary Obst
 V58.72 Aftcre Surg Nerv Sys Nec 780.79 Malaise And Fatigue Nec 593.2 Cyst Of Kidney, Acquired
 728.88 Rhabdomyolysis 290.0 Senile Dementia Uncomp 530.81 Esophageal Reflux

Allergies: NKA

Physician: MASSEY, TAMI
 Phys. Ph: (803) 637-3146

Alt. Phys: Morgan, Walter
 Alt. Phys. Ph: (803) 275-4653

Ht: 70 Wt: 164.0
 M/R No.: 1050

Resident Name	TMH & R of El. field LP			Date	<u>03/21/2006</u>	Date	<u>05/25/2006</u>	Page:
PETERSON, WILLIAM	1050	P 214 D		M	3/21/2006			1 of 2

Physician's Orders

541- CL6100a

For the month April 2006

TMH & Rehab of Edgefield LP

Order			Interval	Time	Orders
Date	Type	No.	Code	Code	
3/21/2006	MD	6			I HAVE INFORMED RESIDENT OR DESIGNATED DECISION MAKER OF DIAGNOSIS AND OVERALL HEALTH STATUS REHAB POTENTIAL: FAIR FLU VACCINE: ANNUALLY RESIDENT MAY SEE DENTIST, PODIATRIST, OPTOMETRIST RESIDENT ACTIVITY PLAN APPROVED AND IS NOT IN CONFLICT WITH THE OVERALL PLAN OF CARE RESIDENT MAY HAVE PLANNED THERAPEUTIC LOA FROM FACILITY OVERNIGHT NOT TO EXCEED MEDICAID REGULATIONS ALT PHY & PHONE # DR. MORGAN 803-275-4653 MAY CRUSH ALLOWABLE MEDICATIONS ADMIT TO SKILLED CARE NURSING F/U WITH UROLOGY IN 1 MONTH FOLLOW UP APPOINTMENT WITH DR. SANTIAGO @ 10:45 AM X-RAY C-SPINE AP AND LAT WITH FLEXION AND EXTENSION BRING COPIES TO F/U APPOINT. DIET: REGULAR PUREED <i>3/21 ms diet</i> SIDERAILS UP X 2 AS ENABLERS PT TO TX PT 3-5XWK FOR ROM, STRENGTHENING BOTH LOWER EXT, THEREX, W/C PROPULSION/ MANAGEMENT PER POC OT TO TX PT 3-5XWK FOR 4 WEEKS FOR ADL'S, THERAP EXERCISES AND CAREGIVER ED <i>Levamisole 500mg po 3 day x 7 day</i> <i>Levamisole 250mg x 6 more doses</i> <i>Speech to screen for dysphagia</i>
3/21/2006	MD	8			
3/21/2006	MD	9			
3/21/2006	MD	10			
3/21/2006	MD	11			
3/21/2006	MD	12			
3/21/2006	MD	13			
3/21/2006	MD	14			
3/21/2006	MD	16			
3/21/2006	MD	17			
3/24/2006	MD	35			
3/21/2006	CRB	7		MEALS	
3/21/2006	R	15			
3/23/2006	TH	19			
3/23/2006	TH	33			
3/30/06	A-B				
3/31/06	A-B				
3/29/06	TH				

Additional Diagnoses:

- 389.9 Hearing Loss Nos
- 781.3 Lack Of Coordination
- 401.9 Hypertension Nos
- 436 Cva

I HAVE REVIEWED RESIDENT'S PLAN OF CARE. I AGREE RESIDENT MEETS CASE MIX CATEGORY [A] OR [B] OR [C] OR [D] CRITERIA.

I CERTIFY THAT RESIDENT NEEDS CONTINUED CARE IN NURSING HOME ON A CONTROL BASIS.

Phys. Sig.	<input checked="" type="checkbox"/>	<i>Massey</i>	Date:	<i>4-1-06</i>	Above Orders Noted by:	<input checked="" type="checkbox"/>	Date:	
Nurse Review	<input checked="" type="checkbox"/>	<i>Shirley Whedbeek</i>	Date:	<i>3/28/06</i>	Pharmacy Review	<input checked="" type="checkbox"/>	Date:	

Rehabilitative Potential

FAIR

Yes No

Dx: 723.0 Cervical Spinal Stenosis	728.87 Muscle Weakness-General	600.90 Bph Nos W/O Urinary Obst
V58.72 Aftcre Surg Nerv Sys Nec	780.79 Malaise And Fatigue Nec	593.2 Cyst Of Kidney, Acquired
728.88 Rhabdomvolysis	290.0 Senile Dementia Uncomp	530.81 Esophageal Reflux

Allergies: NKA

Physician: MASSEY, TAMI
Phys. Ph: (803) 637-3146

Alt. Phys: Morgan, Walter
Alt. Phys. Ph: (803) 275-4653

Ht: 70 Wt: 164.0
M/R No.: 1050

Resident Name	TMH & R of Edgefield LP	03/21/2006 - 05/24/2006	020	Page:
PETERSON, WILLIAM	1050 P 214 D	M	3/21/2006	2 of 2

Physician's Orders

For the month **May 2006**

T M H. th & Rehab of E. field LP

-542- CL6100a

Order			Interval	Time	Orders
Date	Type	No.	Code	Code	
3/21/2006	MED	21		BID	GENERIC EQUIVALENTS MAY BE USED UNLESS OTHERWISE NOTED BY PHYSICIAN. ROUTINE VISITS BY M.D. NOT MEDICALLY NECESSARY FOR THIS RESIDENT BUT EVERY <u>30</u> DAYS. 401.9 Hypertension Nos Ⓛ ATENOLOL 12.5MG PO BID
3/21/2006	MED	22		QD	530.81 Esophageal Reflux Ⓛ PROTONIX 40MG PO Q DAY
3/21/2006	MED	23		QD	401.9 Hypertension Nos Ⓛ NORVASC 5MG PO DAILY
3/21/2006	MED	24		QD	Ⓛ SILVERVITE 1 PO Q DAY X 2 MONTHS D/C AFTER MAY 21ST
3/29/2006	MED	26		QID	Ⓛ NORVASOURCE/ RESOURCE 2.0 180CC QID BETWEEN MEALS
3/21/2006	MED	20		SHIFT	Ⓛ VITAL SIGNS Q SHIFT
3/21/2006	MED	18		SHIFT1	Ⓛ 2ND STEP PPD DUE APRIL 2ND
3/21/2006	MED	31	QTUE	SHIFT1	Ⓛ WEEKLY B/P
3/29/2006	MED	37		TID	Ⓛ PROSTAT 101 30CC IN 4OZ OF JUICE TID X 2 MONTHS D/C AFTER MAY 29TH
4/14/2006	MED	42		TID	Ⓛ PERIACTIN 4MG PO TID
3/21/2006	PRN	1		PRN	Ⓛ MYLANTA/MAALOX 15-30CC BY MOUTH AS NEEDED Q2HRS FOR INDIGESTION OR NAUSEA X48HRS.
3/21/2006	PRN	2		PRN	Ⓛ ACETAMINOPHEN 5 GR TAB 2 TABS BY MOUTH AS NEEDED Q4HRS FOR PAIN OR FEVER X48HRS
3/21/2006	PRN	3		PRN	Ⓛ MILK OF MAGNESIA 30CC BY MOUTH AS NEEDED DAILY X48HRS. DX CONSTIPATION
3/21/2006	PRN	4		PRN	Ⓛ KAOPECTATE 30CC BY MOUTH AS NEEDED EVERY 2HRS UNTIL DIARRHEA SUBSIDES X48HRS
3/21/2006	TX	29			Ⓛ MAY USE LEG BAG WHEN AMBULATING AND USE BSD AT NIGHT
3/24/2006	TX	34		PRN	Ⓛ SOFT COLLAR USED PRN FOR COMFORT X 6 WEEKS D/C AFTER MAY 2ND
4/20/2006	TX	25		SHIFT	Ⓛ NEOSPORIN TO PENIS SORE Q SHIFT UNTIL RESOLVED
3/21/2006	TX	27		SHIFT	Ⓛ ALTERNATING PRESSURE RELIEF MATTRESS TO BED
3/21/2006	TX	28		SHIFT	Ⓛ FOLEY CARE Q SHIFT
4/19/2006	TX	30		SHIFT1	Ⓛ CHANGE FOLEY EVERY 4 WEEKS

Phys. Sig.	<input checked="" type="checkbox"/>	<i>Massey</i>	Date:	<i>5-1-6</i>	Above Orders Noted by:	<input checked="" type="checkbox"/>	Date:
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Nurse Review	<input checked="" type="checkbox"/>	<i>Shirley Whitehead</i>	Date:	<i>4/25/06</i>	Pharmacy Review	<input checked="" type="checkbox"/>	Date:
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Rehabilitative Potential	
FAIR	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Dx: 519.8 Resp System Disease Nec	728.88 Rhabdomyolysis	290.0 Senile Dementia Uncomp
723.0 Cervical Spinal Stenosis	728.87 Muscle Weakness-General	600.90 Bph Nos W/O Urinary Obst
V58.72 Aftcre Surg Nerv Svs Nec	780.79 Malaise And Fatigue Nec	593.2 Cyst Of Kidney, Acquired

Allergies: NKA

Physician: MASSEY, TAMI Alt. Phys: Morgan, Walter Ht: 70 Wt: 150.0
 Phys. Ph: (803) 637-3146 Alt. Phys. Ph: (803) 275-4653 M/R No.: 1050

Resident Name	Res No	Unit Room Bed	D.O.B	Sex	Admit Date	Page:
PETERSON, WILLIAM	1050	F 214 D	03/21/2006	M	3/21/2006	021 1 of 3

Physician's Orders

-543- CL6100a

For the month **May 2006**

TMH & Rehab of Elderly LP

Order			Interval	Time	Orders
Date	Type	No.	Code	Code	
4/6/2006	TX	41		SHIFT1	<ul style="list-style-type: none"> Ⓐ CLEAN LEFT HIP WITH WOUND CLEANSER. APPLY BACITRACIN AND OPTIFOAM DAILY Ⓐ NURSING TO TX 1X A DAY ON SAT AND SUN CLEAN LEFT HIP WITH WOUND CLEANSER. APPLY PANAFIL OINTMENT AND COVER WITH OPTIFOAM Ⓐ CODE STATUS:DNR NO NG OR G-TUBE Ⓐ I HAVE INFORMED RESIDENT OR DESIGNATED DECISION MAKER OF DIAGNOSIS AND OVERALL HEALTH STATUS Ⓐ REHAB POTENTIAL: FAIR Ⓐ FLU VACCINE: ANNUALLY Ⓐ RESIDENT MAY SEE DENTIST, PODIATRIST, OPTOMETRIST Ⓐ RESIDENT ACTIVITY PLAN APPROVED AND IS NOT IN CONFLICT WITH THE OVERALL PLAN OF CARE Ⓐ RESIDENT MAY HAVE PLANNED THERAPEUTIC LOA FROM FACILITY OVERNIGHT NOT TO EXCEED MEDICAID REGULATIONS Ⓐ ALT PHY & PHONE # DR. MORGAN 803-275-4653 Ⓐ MAY CRUSH ALLOWABLE MEDICATIONS Ⓐ ADMIT TO SKILLED CARE NURSING Ⓐ F/U WITH UROLOGY IN 1 MONTH Ⓐ FOLLOW UP APPOINTMENT WITH DR. SANTIAGO @ 10:45 AM X-RAY C-SPINE AP AND LAT WITH FLEXION AND EXTENSION BRING COPIES TO F/U APPOINT. Ⓐ ASPEN COLLAR TO BE WORN FOR MOBILIZATION WHEN SOB IN CHAIR, AMB, AND REHAB SESSIONS Ⓐ DIET: PUREED MAGIC CUP WITH LUNCH AND SUPPER Ⓐ SIDERAILS UP X 2 AS ENABLERS Ⓐ PT TO TX PT 3-5X/WK FOR ROM, STRENGTHENING BOTH LOWER EXT, THEREX, W/C PROPULSION/ MANAGEMENT PER POC Ⓐ PT TO DO WOUND CARE 5X'S PER WEEK. NURSING TO CHANGE DRESSING SAT AND SUN 1X PER DAY. TREATMENT TO BE USED: LEFT HIP WOUND CLEANSER TO AREA APPLY PANAFIL OINTMENT AND COVER WITH OPTIFOAM Ⓐ OT TO TX PT 3-5X/WK FOR 4 WEEKS FOR ADL'S, THERAPY EXERCISES AND CAREGIVER ED Ⓐ SPEECH FOR 10 VISITS TO INCREASE PO INTAKE AND TX FOR SAFE SWALLOWING OF MECH SOFT PT/STAFF TRAINING
4/20/2006	TX	43		SHIFT1	
4/4/2006	MD	5			
3/21/2006	MD	6			
3/21/2006	MD	8			
3/21/2006	MD	9			
3/21/2006	MD	10			
3/21/2006	MD	11			
3/21/2006	MD	12			
3/21/2006	MD	13			
3/21/2006	MD	14			
3/21/2006	MD	16			
3/21/2006	MD	17			
3/24/2006	MD	35			
3/28/2006	MD	36			
4/6/2006	CRB	7		MEALS	
3/21/2006	R	15			
3/23/2006	TH	19			
4/20/2006	TH	32			
3/23/2006	TH	33			
3/31/2006	TH	40			

Phys. Sig.	<input checked="" type="checkbox"/>	Massey	Date:	5-1-06	Above Orders Noted by:	<input checked="" type="checkbox"/>	Date:	
Nurse Review	<input checked="" type="checkbox"/>	Shirley Whitebull	Date:	4/25/06	Pharmacy Review	<input checked="" type="checkbox"/>	Date:	

Rehabilitative Potential	
FAIR	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Dx: 519.8 Resp System Disease Nec 728.88 Rhabdomyolysis 290.0 Senile Dementia Uncomp
 723.0 Cervical Spinal Stenosis 728.87 Muscle Weakness-General 600.90 Bph Nos W/O Urinary Obst
 V58.72 Aftcre Surg Nerv Sys Nec 780.79 Malaise And Fatigue Nec 593.2 Cyst Of Kidney, Acquired

Allergies: NKA

Physician: MASSEY, TAMI **Alt. Phys:** Morgan, Walter **Ht:** 70 **Wt:** 150.0
Phys. Ph: (803) 637-3146 **Alt. Phys. Ph:** (803) 275-4653 **M/R No.:** 1050

Resident Name	TMH & R of Elderly	Unit Room	03/21/2006	Sex	M	Admit Date	05/25/2006	022	Page:	2 of 3
PETERSON, WILLIAM	1050	P 214 D				3/21/2006				

Physician's Orders

-544- CL6100a

For the month **May 2006**

T.M.H. & Rehab of Edgfield LP

Order			Interval	Time	Orders
Date	Type	No.	Code	Code	
					<p>Additional Diagnoses:</p> <p>530.81 Esophageal Reflux 389.9 Hearing Loss Nos 781.3 Lack Of Coordination 401.9 Hypertension Nos 436 Cva 787.2 Dysphagia</p> <p>I HAVE REVIEWED RESIDENT'S PLAN OF CARE. I AGREE RESIDENT MEETS CASE MIX CATEGORY [A] OR [B] OR [C] OR [D] CRITERIA.</p> <p>I CERTIFY THAT RESIDENT NEEDS CONTINUED CARE IN NURSING HOME ON A CONTROL BASIS.</p>

Phys. Sig.	<input checked="" type="checkbox"/>	Massey	Date: 5-1-06	Above Orders Noted by:	<input checked="" type="checkbox"/>	Date:
Nurse Review	<input checked="" type="checkbox"/>	Shirley Wildbalk	Date: 4/25/06	Pharmacy Review	<input checked="" type="checkbox"/>	Date:

Rehabilitative Potential	
FAIR	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Dx: 519.8 Resp System Disease Nec 728.88 Rhabdomyolysis 290.0 Senile Dementia Uncomp
 723.0 Cervical Spinal Stenosis 728.87 Muscle Weakness-General 600.90 Bph Nos W/O Urinary Obst
 V58.72 Aftcre Surg Nerv Sys Nec 780.79 Malaise And Fatigue Nec 593.2 Cyst Of Kidney, Acquired

Allergies: NKA

Physician: MASSEY, TAMI **Alt. Phys:** Morgan, Walter **Ht:** 70 **Wt:** 150.0
Phys. Ph: (803) 637-3146 **Alt. Phys. Ph:** (803) 275-4653 **M/R No.:** 1050

Resident Name	TMH & R of Edgfield LP	08/21/2006	05/25/2006	023	Page:
PETERSON, WILLIAM	1050 P 214 D		M 3/21/2006		3 of 3

PHYSICIAN'S TELEPHONE ORDERS

Form 989/AP © BRIGGS, Des Moines, IA 50306 (800) 247-2943

Facility Name TMH&R		Address Edgefield			
Family Name Peterson	First Name William	Admission Number 1050	Room Number 214W	Attending Physician B. Gardiner	
Date Ordered 3/22/06	Date Discontinued	ORDERS			
① Alternating Pressure Mattress to bed Clean Neck incision site & wound cleanser. Apply Dry Dsg daily.					
② DC heel pads					
③ Vaseline to Penis BID					
Signature of Nurse Receiving Order [Signature]	Time 1A	Signature of Physician [Signature]		Date 3/22/06	

ORIGINAL COPY - Physician Please Sign and Return

Form 989/AP © BRIGGS, Des Moines, IA 50306 (800) 247-2943

Facility Name TMH&R		Address			
Family Name Peterson	First Name William	Admission Number 1050	Room Number 214W	Attending Physician B. Gardiner	
Date Ordered 3/22/06	Date Discontinued	ORDERS			
Move to Rm 214D					
Signature of Nurse Receiving Order [Signature]	Time	Signature of Physician [Signature]		Date 3/22/06	

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Form 989/AP © BRIGGS, Des Moines, IA 50306 (800) 247-2943

Facility Name TMH&R		Address Edge			
Family Name Peterson	First Name William	Admission Number 1050	Room Number 214W	Attending Physician B. Gardiner	
Date Ordered 3/22/06	Date Discontinued	ORDERS			
Dr. Santiago - Neurosurgeon ① call surgeon's office for orders on length of + me to wear soft collar, + for return appt					
② Needs daily P/u + monitor Dr. Anderson					
Dr. No-Tal - orthopedic					
Signature of Nurse Receiving Order [Signature]	Time	Signature of Physician [Signature]		Date 3/22/06	

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PHYSICIAN'S TELEPHONE ORDERS

-546-

Form 989/4P © BRIGGS, Des Moines, IA 50306 (800) 247-2343

Facility Name <u>TMH+R</u>			Address <u>Edgefield</u>		
Family Name <u>Peterson</u>		First Name <u>William</u>	Admission Number <u>1050</u>	Room Number <u>214-D</u>	Attending Physician <u>B. Gordiner</u>
Date Ordered	Date Discontinued	ORDERS			
<u>3/27/06</u>		Physical Therapy Administration order: Physical Therapy 3-5x/week in ROM, stretch @ US, then, w/c propulsion / movement per POC <i>John Latta PT</i>			
Signature of Nurse Receiving Order <u>D. Donnell LPN</u>		Time	Signature of Physician <u>[Signature]</u>		Date <u>3/27/06</u>

ORIGINAL COPY - Physician Please Sign and Return

Form 989/4P © BRIGGS, Des Moines, IA 50306 (800) 247-2343

Facility Name <u>TMH+R</u>			Address <u>Edgefield</u>		
Family Name <u>Peterson</u>		First Name <u>William</u>	Admission Number <u>1050</u>	Room Number <u>214-D</u>	Attending Physician <u>B. Gordiner</u>
Date Ordered	Date Discontinued	ORDERS			
<u>3-23-06</u>		OT clarification ordered by pt 3-5's per wk for 4 wks for ADL's, therap exercises & caregiver ed. V. V. [Signature]			
Signature of Nurse Receiving Order <u>D. Donnell LPN</u>		Time	Signature of Physician <u>[Signature]</u>		Date <u>3/24/06</u>

ORIGINAL COPY - Physician Please Sign and Return

Form 989/4P © BRIGGS, Des Moines, IA 50306 (800) 247-2343

Facility Name <u>TMH+R</u>			Address <u>Edgefield</u>		
Family Name <u>Peterson</u>		First Name <u>William</u>	Admission Number <u>1050</u>	Room Number <u>214-D</u>	Attending Physician <u>Mossley/Santiago</u>
Date Ordered	Date Discontinued	ORDERS			
<u>3/24/06</u>		<ol style="list-style-type: none"> ① soft collar used per for comfort measures x 6 wks (DC may 2nd) ② flu appt c/ Dr. Santiago 5/1/06 @ 10⁴⁵am ③ X-ray c-spine AP + LAT c/ flexion + extension - bring copies to flu appt; 			
Signature of Nurse Receiving Order <u>J. Coleman RN</u>		Time <u>2:08</u>	Signature of Physician <u>Mossley</u>		Date <u>3-28-06</u>

ORIGINAL COPY - Physician Please Sign and Return

Form 989/4P © BRIGGS, Des Moines, IA 50308 (800) 247-2343

Facility Name		TMH+R		Address		Edgefield	
Family Name		Peterson, William		Admission Number		1050	
Room Number		2140		Attending Physician			
Mabey/Santiago		ORDERS					
Date Ordered	Date Discontinued	Aspen collar to be worn for mobilization when COB in chair, amb., & rehab sessions					
3/28/06							
Signature of Nurse Receiving Order		J. Domales		Time		1:15	
Signature of Physician		Massey		Date		3-29-06	

ORIGINAL COPY - Physician Please Sign and Return

Form 989/4P © BRIGGS, Des Moines, IA 50308 (800) 247-2343

Facility Name		TMH+R		Address		Edgefield	
Family Name		Peterson William		Admission Number		1050	
Room Number		2140		Attending Physician			
Massey		ORDERS					
Date Ordered	Date Discontinued	① ↑ Norassure/Resource 2.0 to 180cc po qid					
3/29/06		② Silverite 1 po q AM Void/Repeat ^{ERROR DS}					
		③ Protocol 101 - 30cc in for juice/ Norassure ^{ERROR DS} TID X 2 mths					
		④ SLP to screen for Dysphagia					
Signature of Nurse Receiving Order		D. Smith LPN		Time		3-31-06	
Signature of Physician		Massey		Date		3-31-06	

ORIGINAL COPY - Physician Please Sign and Return

Form 989/4P © BRIGGS, Des Moines, IA 50308 (800) 247-2343

Facility Name		TMH+R		Address		Edgefield	
Family Name		Peterson, William		Admission Number		1050	
Room Number		2140		Attending Physician			
Massey		ORDERS					
Date Ordered	Date Discontinued	UA, CRP, Blood Cx					
3/30/06		Levayquin 500mg po q day x 7 days					
		fast creat. result most recent					
Signature of Nurse Receiving Order		P. Dumlup		Time		3:30 pm	
Signature of Physician		Massey		Date		3-29-06	

ORIGINAL COPY - Physician Please Sign and Return

PHYSICIAN'S TELEPHONE ORDERS

-548-

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PHYSICIAN'S TELEPHONE ORDERS

Facility Name TMH&R of Edgefield		Address			
Family Name Peterson	First Name William	Admission Number 1050	Room Number 214D	Attending Physician Massey	
Date Ordered 3/31/06	Date Discontinued	ORDERS			
decrease Levaguin to 250mg po qhs X 6 more doses					
Signature of Nurse Receiving Order D Smith Lpn		Time	Signature of Physician <i>[Signature]</i>		Date 3/31/06

ORIGINAL COPY - Physician Please Sign and Return

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PHYSICIAN'S TELEPHONE ORDERS

Facility Name TMH&R		Address Edgefield			
Family Name Peterson	First Name William	Admission Number 1050	Room Number 214D	Attending Physician Massey	
Date Ordered 3/31/06	Date Discontinued	ORDERS			
Speech Clarifications Stewal. on this date Rec. to continue MS diet. ST rec. to ↑ PO intake + tr. for safe swallowing of MS. Pt. / staff training. ST for 10 visits for one month. <i>Martha J. Wilby, M.D. LCC-SP</i>					
Signature of Nurse Receiving Order D Smith Lpn		Time	Signature of Physician <i>[Signature]</i>		Date 3/31/06

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PHYSICIAN'S TELEPHONE ORDERS

Facility Name TMH&R		Address			
Family Name Peterson	First Name William	Admission Number 1050	Room Number 214D	Attending Physician Massey	
Date Ordered 3/31/06	Date Discontinued	ORDERS			
Clarification! Speech therapy to eval for dysphagia					
Signature of Nurse Receiving Order D Smith Lpn		Time	Signature of Physician <i>[Signature]</i>		Date 3/31/06

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PHYSICIAN'S TELEPHONE ORDERS

-549-

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PHYSICIAN'S TELEPHONE ORDERS

Facility Name TMH&R		Address			
Family Name Peterson	First Name William	Admission Number 1050	Room Number 214D	Attending Physician Nicholson	
Date Ordered 4/4	Date Discontinued	ORDERS :			
DNR - No NG or G Tube					
Signature of Nurse Receiving Order <i>D Smith Lpn</i>		Time	Signature of Physician <i>RJR</i>		Date 4/4

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PHYSICIAN'S TELEPHONE ORDERS

Facility Name TMH&R		Address Edgefield			
Family Name Peterson	First Name William	Admission Number 1050	Room Number 214D	Attending Physician Nicholson	
Date Ordered 4/6/06	Date Discontinued	ORDERS			
Clean @ Hip & Wound Cleanser. Apply Bacitracin & Optiforums daily					
Signature of Nurse Receiving Order <i>D Smith Lpn</i>		Time 8:10 A	Signature of Physician <i>RJR</i>		Date 4/6

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noted finish

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PHYSICIAN'S TELEPHONE ORDERS

Facility Name TMH&R		Address			
Family Name Peterson	First Name William	Admission Number 1050	Room Number 214D	Attending Physician Leaphart	
Date Ordered 4/14/06	Date Discontinued	ORDERS			
CBC, BMP 4-18-06 UA and culture Periaortic flow w/ TIP ✓ Mini mental status					
Signature of Nurse Receiving Order <i>D Smith Lpn</i>		Time	Signature of Physician <i>Leaphart</i>		Date 4-14-06

ORIGINAL COPY - Physician Please Sign and Return

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 028

PHYSICIAN'S TELEPHONE ORDERS

-550-

Form 989/4P © BRIGGS, Des Moines, IA 50306 (800) 247-2943

Facility Name TMHR		Address Edgefield			
Family Name Peterson	First Name William	Admission Number 1050	Room Number 214D	Attending Physician Leaphart	
Date Ordered	Date Discontinued	ORDERS			
4/18/06		clarification effective 4/5/06 pure diet magic cup @ lunch & supper			
Signature of Nurse Receiving Order Dykes		Time	Signature of Physician [Signature]		Date 4/19/06

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Form 989/4P © BRIGGS, Des Moines, IA 50306 (800) 247-2943

Facility Name TMHR		Address Edgefield			
Family Name Peterson	First Name William	Admission Number 1050	Room Number 214D	Attending Physician Leaphart	
Date Ordered	Date Discontinued	ORDERS			
4/19/06		D/c Dry Dsg to Neck incision Site			
Signature of Nurse Receiving Order [Signature]		Time 8:30 A	Signature of Physician [Signature]		Date 4/20/06

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Form 989/4P © BRIGGS, Des Moines, IA 50306 (800) 247-2943

Facility Name TMHR		Address			
Family Name Peterson	First Name William	Admission Number 1050	Room Number 214D	Attending Physician Leaphart	
Date Ordered	Date Discontinued	ORDERS			
4-19-06		Clarification order for 4-5-06 A diet to Pureed			
Signature of Nurse Receiving Order [Signature]		Time	Signature of Physician [Signature]		Date 4/20/06

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PHYSICIAN'S TELEPHONE ORDERS

-551-

Form 989/4P © BRIGGS, Des Moines, IA 50306 (800) 247-2943

Facility Name TMH&R		Address Edgfield		
Family Name Peterson	First Name Williams	Admission Number 1	Room Number 2140	Attending Physician Leaphart
Date Ordered 4/19/06	Date Discontinued	ORDERS		
Δ Foley on 4/20/06 then q 4wks. Neosporin to penis sore BID until resolved. Enc. po ydls.				
Signature of Nurse Receiving Order P. Dunne		Time 3:30	Signature of Physician VO Dr Anderson	Date 4/20/06

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Form 989/4P © BRIGGS, Des Moines, IA 50306 (800) 247-2943

Facility Name TMH&R		Address Edgfield		
Family Name Peterson	First Name William	Admission Number 1050	Room Number 2140	Attending Physician Leaphart
Date Ordered 4/20/06	Date Discontinued	ORDERS		
Δ order for Neosporin BID to q shifts.				
Signature of Nurse Receiving Order gsmorck		Time 8:45	Signature of Physician Leaphart	Date 4/21/06

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Form 989/4P © BRIGGS, Des Moines, IA 50306 (800) 247-2943

Facility Name TMH&R		Address Edgfield		
Family Name Peterson	First Name William	Admission Number 1050	Room Number 2140	Attending Physician Leaphart
Date Ordered 4-20-06	Date Discontinued	ORDERS		
PT reclassification order to add wound care 5x per wk - nsg. to change ds g Sato Sun 1x per day. Treatment to be used: (D)hip Wound cleanser to area, apply panafil ointment Cover Optifoam, V.Vaz ointment to per SW, g RPT				
Signature of Nurse Receiving Order J. Bloman		Time 11:45	Signature of Physician Leaphart	Date 4/21/06

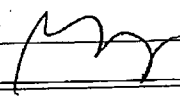
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PHYSICIAN'S TELEPHONE ORDERS

-552-

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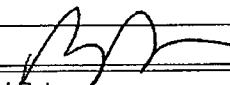
PHYSICIAN'S TELEPHONE ORDERS

Facility Name TMH&R		Address			
Family Name Peterson	First Name William	Admission Number 1050	Room Number P214D	Attending Physician B. Gardner	
Date Ordered 4-24-06	Date Discontinued	ORDERS			
		C spine Xray			
		VO Dr. Santiago			
Signature of Nurse Receiving Order D Smith lpn		Time	Signature of Physician 		Date 4/26/06

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PHYSICIAN'S TELEPHONE ORDERS

Facility Name TMH&R		Address B Gardner Edgefield			
Family Name Peterson	First Name William	Admission Number 1050	Room Number 214D	Attending Physician B. Gardner	
Date Ordered 4-25-06	Date Discontinued	ORDERS			
		Dr. OT services. V. Vaz			
		at OTAK			
Signature of Nurse Receiving Order D Smith lpn		Time	Signature of Physician 		Date 4/26/06

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PHYSICIAN'S TELEPHONE ORDERS

Facility Name TMH&R of Edgefield		Address			
Family Name Peterson	First Name William	Admission Number 1050	Room Number 214D	Attending Physician J. Massey	
Date Ordered 5/1/06	Date Discontinued	ORDERS			
		DC collars			
		VO Dr. Santiago			
Signature of Nurse Receiving Order D Smith lpn		Time	Signature of Physician Massey		Date 5-26

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TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 031

PHYSICIAN'S TELEPHONE ORDERS

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Facility Name TMH&R		Address Edgefield			
Family Name Peterson		First Name William	Admission Number 1050	Room Number 214W	Attending Physician Massey
Date Ordered	Date Discontinued	ORDERS			
5/2/06		DK Tx to Wheel.			
Signature of Nurse Receiving Order [Signature]		Time 8:20 A	Signature of Physician Massey		Date 5-3-06

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noted as needed

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Facility Name TMH&R		Address Edgefield			
Family Name Peterson		First Name William	Admission Number 1050	Room Number 214W	Attending Physician Massey
Date Ordered	Date Discontinued	ORDERS			
5-2-06		A consult to recognize the wound care per physical therapy for heel.			
Signature of Nurse Receiving Order D. Smith Lpn		Time	Signature of Physician Massey		Date 5-3-06

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Form 989/4P © BRIGGS, Des Moines, IA 50306 (800) 247-2343

Facility Name TMH&R		Address Edgefield			
Family Name Peterson		First Name William	Admission Number 1050	Room Number 214W	Attending Physician Nicholas
Date Ordered	Date Discontinued	ORDERS			
5/2/06		Culture of hip wound.			
Signature of Nurse Receiving Order [Signature]		Time 5:00 P	Signature of Physician [Signature]		Date 5/4

ORIGINAL COPY - Physician Please Sign and Return

PHYSICIAN'S TELEPHONE ORDERS

-554-

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Facility Name TMH&R		Address Edgefield		
Family Name Peterson	First Name William	Admission Number 1050	Room Number 214D	Attending Physician Massey
Date Ordered 5-3-06	Date Discontinued	ORDERS		
Pt. to use anti-contraction wedge to LE's while in bed. V. Van at CTM				
Signature of Nurse Receiving Order D. Smith IPN		Time	Signature of Physician Massey	Date 5-10-06

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Facility Name TMH & Rehab		Address Edgefield		
Family Name Peterson	First Name William	Admission Number 1050	Room Number 214D	Attending Physician Rausford
Date Ordered 5/12/06	Date Discontinued	ORDERS		
Classification: Alternating pressure relief mattress to be checked & shifted for proper inflation & functioning				
Signature of Nurse Receiving Order Shirley Wheeler		Time 12:15	Signature of Physician [Signature]	Date 5/12/06

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Form 989/4P © BRIGGS, Des Moines, IA 50306 (800) 247-2343

Facility Name TMH&R		Address Edgefield		
Family Name Peterson	First Name William	Admission Number 1050	Room Number 214D	Attending Physician Massey
Date Ordered 5/14/06	Date Discontinued	ORDERS		
① O ₂ - 2LPM via N/C D/T periods of apnea. ② Clean O ₂ filter & Night. ③ Change O ₂ humidifier & 3 days. ④ Change O ₂ tubing & month.				
Signature of Nurse Receiving Order P. Overton IPN		Time 11PM	Signature of Physician Massey	Date 5-20-06

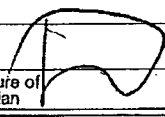
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PHYSICIAN'S TELEPHONE ORDERS

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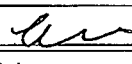
PHYSICIAN'S TELEPHONE ORDERS

Facility Name <u>TMH+R</u>			Address <u>Edgefield</u>		
Family Name <u>Peterson, William</u>		Admission Number <u>1050</u>	Room Number <u>2140</u>	Attending Physician <u>Rainford</u>	
Date Ordered	Date Discontinued	ORDERS			
<u>5/15/06</u>		<u>Transported to Aiken Hosp ER via EMS per insistence of family against medical advice</u>			
Signature of Nurse Receiving Order <u>P. Dunny</u>		Time <u>3:15</u>	Signature of Physician 		Date <u>5/16/06</u>

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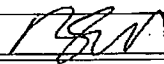
PHYSICIAN'S TELEPHONE ORDERS

Facility Name <u>TMH+R</u>			Address <u>Edgefield</u>		
Family Name <u>Peterson, William</u>		Admission Number <u>1050</u>	Room Number <u>214-D</u>	Attending Physician <u>Rainford</u>	
Date Ordered	Date Discontinued	ORDERS			
<u>5/23/06</u>		<u>D/C Physical therapy effective 5/23/06 for health P</u>			
Signature of Nurse Receiving Order <u>D Anitka LPN</u>		Time	Signature of Physician 		Date <u>5/24/06</u>

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PHYSICIAN'S TELEPHONE ORDERS

Facility Name <u>TMH+R of Edgefield</u>			Address		
Family Name <u>Peterson William</u>		Admission Number <u>1050</u>	Room Number <u>2140</u>	Attending Physician <u>Nicholson</u>	
Date Ordered	Date Discontinued	ORDERS			
<u>5/25/06</u>		<u>Discharge to ARMC</u>			
Signature of Nurse Receiving Order <u>D Anitka LPN</u>		Time	Signature of Physician 		Date <u>5/26</u>

ORIGINAL COPY - Physician Please Sign and Return
 TMH+R of Edgefield 03/21/2006 - 05/25/2006 - 034

DOCTOR'S PROGRESS NOTES

DATE	HOUR	
3/22/06		See below B

PETERSON, WILLIAM (1050)

Room: P 214 D

Medical Record no: 1050

4/4/2006 3:31 PM

Role: Physician

Category: Progress Notes

04-04-06 WILLIAM PETERSON
 THIS MAN HAS RECENTLY HAD CERVICAL SURGERY BECAUSE OF CERVICAL STENOSIS. HE IS REALLY IN BAD SHAPE. HE HAS HAD SOME RESPIRATORY INFECTION RECENTLY. CHEST X-RAY NORMAL. HE IS ON LEVAQUIN AND WILL COMPLETE IN A COUPLE OF DAYS AND THEN WE CAN REEVALUATE THEN. HE SEEMS TO BE STABLE. HIS INTAKE IS POOR AND SPEECH HAS BEEN ORDERED TO SEE IF THAT CAN HELP HIS SWALLOWING.



SIGN B.E. NICHOLSON

Prepared by: Sheila Whedbee

Co-signed by:

NAME-Last	First	Middle	Attending Physician	Record No.	Room/Bed
Peterson	William		Nicholson	1050	P 214 W

Weight Change Notification

Nutritional at risk resident

In accordance with State and Federal regulations governing Long-Term Care facilities effective July 1, 1999, I realize that William Peterson is presently experiencing a change in weight loss.

Risk Level Low Moderate High

Current Diet order: Puree

Current Supplements: magic cup lunch + supper Prostat 10z fruit juice
Novosource 180cc QID
Silverite QD

Current Intake record indicates average percent is 25% Breakfast,
25% Lunch, 25% Dinner, _____ Snack.

Weight record: Current weight *see 3/1/06 180lb ~ hospitalized
3-month-old weight attached 3/21/06 164 lb
6-month-old weight sheet 4/3/06 162 lb 4/18/06 150 lb
4/18/06 152 4/24/06 147 lb
5/1/06 152

Pharmaceutical interventions used Periactin 4mg TID

Lab results on H & H and Albumin 11.6/35.8 Alb?

This is considered a Quality Indicator which requires review by the facility/physician. As the physician, I have reviewed the weight loss regimen in detail. My response is as follows:

This is an unavoidable weight loss due to _____

Continue as above.

I will try to affect this by doing the following: _____

Physician's Signature _____ Date _____

Leave on Chart

Note: This report includes only the selection criteria listed below.

Resident Name PETERSON, WILLIAM (

-559-

Weight Change History
T M Health & Rehab of Edgefield LP (EH)

Page 1 of 1
5/1/2006 11:04AM
QA6200a

Sort Order: Resident name

Resident	Location	Date	Weight
PETERSON, WILLIAM (1050)	P 214 D	2/27/2006	180.00
		3/1/2006	180.00
	hospitalized for surgery	3/21/2006	180.00
		3/21/2006	164.00
		3/27/2006	162.00
		4/3/2006	162.00
		4/3/2006	156.00
		4/13/2006	152.00
		4/18/2006	150.00
		4/24/2006	147.00

INSTRUCTIONS:
Form completed by pharmacist during DRR.
See pharmacist reviews, and reports for details.

Do Not Thin From Chart!



Kindred Pharmacy Services

DRUG REGIMEN REVIEW PHARMACIST SIGNATURE LOG



Comments	Notes
<input checked="" type="checkbox"/> No recommendations <input type="checkbox"/> See Report - reported to: <input type="checkbox"/> Nursing <input type="checkbox"/> Physician/Prescriber <input type="checkbox"/> Other	pha - new admit R - P m. follow up
Signature: <i>[Signature]</i> Date: 3/30/06	
<input type="checkbox"/> No recommendations <input checked="" type="checkbox"/> See Report - reported to: <input type="checkbox"/> Nursing <input checked="" type="checkbox"/> Physician/Prescriber <input type="checkbox"/> Other	pha - 4/18 call BWP R - suggest to peracta m. follow up
Signature: <i>[Signature]</i> Date: 4/26/06	
<input type="checkbox"/> No recommendations <input type="checkbox"/> See Report - reported to: <input type="checkbox"/> Nursing <input type="checkbox"/> Physician/Prescriber <input type="checkbox"/> Other	
Signature: _____ Date: _____	
<input type="checkbox"/> No recommendations <input type="checkbox"/> See Report - reported to: <input type="checkbox"/> Nursing <input type="checkbox"/> Physician/Prescriber <input type="checkbox"/> Other	
Signature: _____ Date: _____	
<input type="checkbox"/> No recommendations <input type="checkbox"/> See Report - reported to: <input type="checkbox"/> Nursing <input type="checkbox"/> Physician/Prescriber <input type="checkbox"/> Other	
Signature: _____ Date: _____	
<input type="checkbox"/> No recommendations <input type="checkbox"/> See Report - reported to: <input type="checkbox"/> Nursing <input type="checkbox"/> Physician/Prescriber <input type="checkbox"/> Other	
Signature: _____ Date: _____	

Form # KPS007 (Rev. 1/05)

Reorder From: MED-PASS 800-438-8884

XPM 04-688R

Resident's Name William T. H. Edgefield 03/21/2006 - 05/25/2006 - 039

NURSES NOTES

DATE	TIME	
3/21/06	4:45 pm	An 84 yr old BM admitted from (Colum) Regional Hosp for skilled nursing care. Arrived via EMS. Placed in room 214W. A+O to self, confused to time, place + event. Verbally responds to simple direct questions, follows directions ³ difficulty. Long/short term memory impaired, impaired decision skills. Speech, hearing + vision adequate. No glasses or hearing aides present. No dentures or teeth or noted oral problems. Foley intact + patent to BSD + straw colored urine. TED hose + heel pads intact to B feet/leg. No edema noted skin w/d, no open areas. Area noted to Rt heel ≈ 4 cm in size outer edges dk black + sept center, no open areas noted. Scab noted to Rt + leg. Dog dry + intact to neck + cervical collar intact. Pressure relieving mattress to bed. No movement noted to LE + limited extension, no discomfort to knees upon extension. Grip strong to Rt hand + weak grip to Lt hand, no movement limitation to UE. Denied any swallowing problems. In nurse to perform body audits and begin TX's as required per MD orders. Family notified of admission, left message to contact facility. Dr Massey notified of admission, will have Dr Massey evaluate surgery site and order required TX. Meds. fwd to pharmacy Order at time of adm include: Diet: Reg Pureed; dietary notified. Meds on adm: Atonolol 12.5mg BID, Norvasc 5mg qd. Profonix 40mg qd, S/Werivite po q day, Novosource/Resource 2.0 120cc qid between meals. Other orders include: Wkly BP I + o/g shift VS q shift, PT + OT to eval + TX. Foley cath care SP'S ↑ x 2 for enablers, J/U + urology x 1 mths. 2nd stop PPD due 4/2/06. orders noted. Wt - 164 lbs. No acute distress noted. Voiced no Co. W/ct monitor. Required shift @ + ADL'S, bowel incont, adult briefs, repositioning while in bed. W/ct monitor condition. P Dec 21/06
3/21/06	9:30 pm	Resting quietly, voiced no Co. ⁴ 100% ^{100%} No acute distress noted. W/ct cont to monitor. P Dec 21/06

Pt. Name Peterson, William Pt. Number 1052
 Physician N.R.G.L.M Month March
 Room Number P 214W Year 2006

NURSES NOTES

DATE	TIME	
3/22/06	1:30/p	V/S: 95/72-60-18-99%. Cervical neck brace in place. Heel pad in place. Foley intact, draining st. dark yellow urine. No c/o pain or discomfort. Fluids offered, taken slowly & encouragement. No acute distress noted. <i>W. Barrett RN</i>
3/22/06	9am	Resident moved to Rm 214D. <i>Donith JRN</i>
3/22/06	1:20/p	979 64 16 118/70. Resident placed on alternating pressure relief mattress. Foley @ BSOc dash, yellow urine. Noted. Take po meds whole & any problems noted. Drinking fluids good. Cervical neck brace in place. No c/o pain or discomfort. No acute distress. <i>Donith JRN</i>
3/22/06	Topm	V/S 96 63 22 135/low. Resident in bed resting quietly & eyes open. No distress noted. Foley catheter intact & draining well @ bedside mn (Beth Gardner) in to see resident. No drainage noted @ insertion site. New orders noted, to call surgeon's office for orders on length of time to wear soft collar neck brace. Resident has a DNR order & need knowledge follow up regarding <i>C. D. Anderson</i> <i>Whinn JRN</i>
3/23/06	1:00/p	V/S: 103/65-60-18-96%. Foley intact, draining st. amber colored urine. Collar brace in place. No drainage noted for neck incision. Urine no c/o pain or discomfort. Resp unlabored. <i>W. Barrett RN</i>
3/23/06	9:30A	24' chart check down new orders noted & assessed as follows; called Dr Sarbiago's office & left message for bedside to call back <i>W. Barrett RN</i>

Pt. Name Peterson, Wm. Pt. Number 1050
 Physician NRC LM Month March
 Room Number P 214W Year 2006

NURSES NOTES

DATE	TIME	NOTES
3/23/06	9:30 A	cont (PT) re. how long to wear soft neck collar
3/23/06	16:18/10	4 pt for PT - also called Dr Anderson spoke to Marly Marly made vlog on apt for Hol 19 Wed, @ 2pm; called & notified Ruth Peterson; made ptw apt by Permetto Amb 4/4 Wed @ 1pm
3/23/06	4p	Dr. Santiago's Arthur still has not called back re: 4/4 apt of neck collar B Robinson RN
3/23/06	5p	lying on D side in bed collar in place Denies discomfort. Talkative with Joley to BSD clear yellow urine draining. Fed meals by staff. IV via staff. Dsg intact on apt. pressure mattress. Stay 4 to wheel seen by PT/OT as outlined in their notes. Non amb. Moves LE small amt on demand SR x 2 as enabler will monitor vs 97-12702 6720 Dept
3/24/06	2:00p	Collar brace to neck in place. Rtly intact, draining yellow colored urine. Resting quietly. A pre- sent a mild sort of acute dis- tress. V/S: 180/100 - 08-98-99 Dr. Borell
3/24/06	6:00p	Joley remains intact, but draining amber colored urine. Dr. Borell
3/24/06	9:50 A	Resident resting quietly in bed cervical collar intact. Feeds himself & set up. Takes meds while is any swallow wix problems noted. Joley @ BSD c dark yellow urine noted. No pain or discomfort. Therapy is working c resident, PT and OT c slow progress. Dr. Borell

Pt. Name Peterson, William Pt. Number 1050
 Physician NRGLM Month March
 Room Number P214W Year 2006

NURSES NOTES

DATE	TIME	
4-5-06	12 AM	Resident unable to eat. Neck soft dietz
9/6/2	100/61	holds food in his mouth, will A diet back
	61 16	to Pursed, up in geri chair per staff.
		Foley @ BSD & dark urine noted. D Smith
4-5-06	12:30/p	Resident ate 80% of Purred lunch. Drank
		300 cc. of fluids. D Smith
4-5-06	9:30 pm	BP 135/77 Pab R 20 T 96.9. ABT completed. E no S/E noted.
		Conts productive cough. Foley to BSD & dk tea colored urine
		Old intake good, nutritional intake poor, ate 20%. Dsg
		dry & intact to neck. Fed per staff, ADL's + incontinent care
		for bowels per staff. Voided no % no acute distress
		noted. Will cont to monitor. P Dundy
4/6/06	100/A	V/S: 114/74-20-97%. Foley intact,
		draining dark yellow colored urine.
		Resident has collar brace on @ this
		time for support per resident. No
		acute distress noted. N. Bonilla
4/6/06	8:10/A	Chip Dister open. Skin Red. See Tx
		orders. Notified Daughter of New
		Orleans. MD FAXED. J. Smalley
4/6/06	11:00	See Tx sheet + Body audit sheet for
B/p -	129/81	Skin condition - Has Foley Cath & BSD
T -	98.2	patency well - dark amber urine noted.
P -	70	Holds ene., Res obs to recliner w/c per
R -	20	staff - has pressure relief mattress on
		bed TOP @ this in bed, SRA x 2 as
		enabler. Inc of bowels - Inc care prov.
		@ shift pm. Res seen by ST, PT or OT
		Dept - See notes. Has pressure relief mat-
		tress on bed. Aspen collar worn when
		obs in chair etc - & soft collar used prev.
		Fed by staff meals - Appetite 20% - Consuming
		fluids well. N. Bonilla

Pt. Name Peterson, William Pt. Number 1050
 Physician NRW-LM Month April
 Room Number 214W Year 2006

NURSES NOTES

DATE	TIME	
3/24/06	2:00P	Deidero called from Dr. Santiago's office & orders for soft collar use, #u apt. 5/1/06 @ 10:45am + X rays C-spine prior to flu in order to bring copies - orders for aspen collar need however res does not have an aspen collar - res was not admitted here & aspen collar - only a soft collar; notified Dr. Santiago's office + was inst'd to call midland's @ 641-6007 to request another aspen collar; spoke to Mary Peterson + she stated not having the collar but remembered res having 2 collars @ AEMC; spoke to Patricia (Palnetto EMS service) who states res was rec'd from AEMC & only soft collar + wearing hospital gown - staff @ AEMC stated res family obtained all personal belongings - phoned Mary Peterson again to file on above statement + she states being w/res + states if other family & res to get belongings + that res had nothing to bring home anyway; midlands notified to remake aspen collar + pd to be to our facility - (admitted)
3/24/06	6:40P	VS. 99 143/59, 62, 18. Resident lying in Bed. Resp. Even/unlabored. C/O pain. Confusion evident. Feeds self per set up. Foley to BSD intact & patent. Urine is dark yellow & sediment. Skin intact to heel. Dark-black in color. Takes meals whole & swallowing difficulty. - Dinner
3/25/06	2AM	B/P 122/52 T 98.8 P 12 R 20. Resident presently asleep in bed. Collar brace intact. Respirations even & unlabored. Skin warm & dry to touch. Foley catheter patent and intact to BSD & dark yellow urine. Incontinent of bowel. NO S/S of distress noted. Will continue to monitor. - P. Dventura

Pt. Name Peterson, William Pt. Number 1050
 Physician NREG/lin Month March
 Room Number P 214W Year 2006

NURSES NOTES

DATE	TIME	
3-25-06	10:20 am	Resident is sitting up in bed, resp. even & unlabored. Foley catheter patent and intact. Dark yellow urine noted. Skin warm & dry to touch. Communicates needs to staff. Feel self p. tray setup NO S/S of acute distress noted. Will monitor. - P. Watkins RN
3-25-06	6:40 p	VST 99.5 - P68 - R20 - BP 108/60. Resident is up in bed, resp. even & unlabored. Foley catheter is intact & patent to BSD & dark yellow urine noted. Skin warm & dry to touch. Will continue to monitor. - P. Watkins RN
3/26/06	12 AM	Temp 101.4. Resident medicated w/ Tylenol 325mg tabs p.o. Will re-check temperature. - P. Querton RN
3/26/06	1:45 AM	B/P 114/80 T99 P74 R20. Resident resting quietly in bed. Alert and responsive when awake. Neck collar in place. Respirations even & unlabored. Dressing intact to neck. Foley catheter patent and intact to BSD & dark colored urine. Has voided no clots or discomfort. Will continue to monitor. - P. Querton RN
3-26-06	10:25 am	Resident is lying in bed & eyes open. Resp. even & unlabored; neck collar in place. Foley catheter patent and intact. No clots or discomfort at this time. Will continue to monitor. - P. Watkins RN
		96.0 P83 R18 BP136/70
3/26/06	9 pm	B/P 95/47 T98.2 P70 R20. Resident resting in bed. SOB ↑. Neck collar in place. Some edema noted to front of neck. Resident takes meds well & sips of juice P/T some throat irritation. Foley catheter patent and intact to BSD & dark colored urine. Requires assistance to ADLs. - P. Querton RN
3/27/06	1 AM	B/P 114/68 T99.4 P68 R20. Resident presently asleep in bed. SOB ↑. Respirations even & unlabored. Neck collar in place. Foley catheter patent and intact to BSD & dark colored urine. NO S/S of distress. Will continue to monitor. - P. Querton RN

Pt. Name Peterson, William

Pt. Number 1050

Physician NBGLM

Month

Room Number 214w

Year 2006

NURSES NOTES

DATE	TIME	
3/27/06	2:30/p	989 104/54 55/18. Resident's appetite is very poor. Staff attempted to feed only ate 20% of lunch. Drinks Resource good. Foley @ BSD & dark urine noted. No G/O voided. Pt/OT cont. Nite 6/7
3/27/06	8:30 pm	BP 132/74 PG 3 R 22 T 97°. Alert & confusion. Fed per staff - tolerated 20%, drink Resource 3 difficulty. Foley to BSD & dk straw colored urine. Dog to surgical wound dry & intact to Rt neck region. Requires total A & turning/repositioning. - descent of bowels & staff @ for care. Bathing, dressing & grooming per staff. Will hold cup in (R) hand + bring to mouth to drink & spillage. Takes small drinks, holds in mouth for few seconds then swallows 3 difficulty. All needs met and anticipated by staff. Lays in semi-fetal position on back, & while on side. does not extend legs - keeps bent at knees. No noted Δ's in condition. Will cont to monitor. — P Dunlop
3/28/06	1:00/p	V/S: 126/60 - 74 - 18 - 98°. Foley intact, draining, st. amber colored urine. Bristing quietly, present & gas. as is of acute distress. N. Bryant
3/28/06	9:10 Am	Resident conts to lay on R side mostly.
133/78	82/18 972	Ate 30% of breakfast & staff assist. Drinks fluids good. No G/O pain or discomfort. Dry dog intact. Aspen collar received today. Therapy will be working to resident. Foley @ BSD & dark urine noted. — D Smith pm
3/28/06	9:00 pm	BP 108/57 P 72 R 20 T 97°. Fed by staff ate 30%. Tolerated po feds well, no noted swallowing problems. Repositioned by staff. Dog intact to surgical site clean & dry. No G/O pain or discomfort. Foley to BSD & dk straw colored urine. No noted distress. All needs anticipated & met by staff. No noted Cognitive or Functional Δ's. — P Dunlop
3/29/06	3:30/p	V/S: 112/71 - 81 - 20 - 97°. Foley intact, draining amber color urine. No collar on

Pt. Name Peterson, William Pt. Number 1050
 Physician NBGGM Month MARCH
 Room Number 214W Year 2006

NURSES NOTES

DATE	TIME	NOTES
3/29/06	1:30 p	@ this time. Urine no complaints. No acute distress noted. W. Baylton
3/29/06	3:30 A	Collar replace @ resident's request. States he likes the support. if gives. W. Baylton
3/29/06	10:20 A	110/80 78 18 98%. Resident ate 80% of breakfast, fed per staff. Drinking fluids good. Foley @ BSD = dark urine noted, soft collar washed, using it per. No pain or discomfort. Therapy is working @ resident. D Smith per
3/29/06	10pm	BP 101/58 P 71 R 18 T 98.4. Fed by staff ate 20%. Drank liquids well through straw. Foley to BSD = dk straw colored urine, incant of BM care per staff. Repositioned @ 2 hrs per staff. Dry intact to neck. No pain or discomfort. Will cont to monitor. P Duncy
3/30/06	2:00 p	1/5: 108/52 - 58 - 18 - 99%. Collar brace in place (soft) per resident's request to leave on. Fluids & foley taken well. Foley intact @ dining st. amber colored urine. Wsg to incision dry & intact. No acute distress noted. W. Baylton
3/30/06	4:00 p	Soft collar brace removed @ resident's request. W. Baylton
3/30/06	10:55 A	Resident conts to work @ therapy. Fed per staff @ appetite increasing. Dry @ intact to neck. I&R per staff. Foley @ BSD = dark yellow urine noted. No pain or discomfort. D Smith per
3/30/06	11:30 A	Temp 100.8 - Tylenol 650mg po given. 98 18 12/17/06 P Duncy
3/30/06	1 p	Temp 100.2. MD notified. D Smith per
3/30/06	3:30 pm	Di Massey ordered: levofloxacin 500mg qd x 7 days, UA, CRP + Blood Cx. orders noted + fax'd to pharmacy. P Duncy

Pt. Name Peterson, William Pt. Number 1050
 Physician NEGLM Month March
 Room Number 214W Year 2006

NURSES NOTES

DATE	TIME	
3/30/06	4 ⁰⁰ pm	Transported via Staff (A) to ECH for chest x ray. UA collected via Foley and sent to ECH lab. per MD orders — P Dunlop
3/30/06	4 ¹⁵ pm	UA results rec'd. Returned from ECH via stretcher & Staff (A). Dr Massey in facility informed of return + UA results. — P Dunlop
3/30/06	5 ³⁰ pm	Seen per Dr Massey no new orders — P Dunlop
3/30/06	6 ³⁰ pm	Refused to eat supper. tolerated feds well. Non productive cough & wheezing noted. Will cont to monitor — P Dunlop
3/30/06	8 pm	T. 101.2 Tylenol 650mg po given. Weakness noted. Cough continues. Tolerating po feds well. No wheezing noted at present time. Will monitor. — P Dunlop
3/30/06	9 ³⁰ pm	T 100.4. Conts to drink, po feds well. No SOB noted, coughing. Out to weakness. Will cont to monitor. — P Dunlop
3/30/06	10 pm	Started on Bivoquin 500mg per MD orders, rec'd from pharmacy. Resident requested H ₂ O, given & tolerated well. No distress noted at present time. — P Dunlop
3/31/06	10/A	U/S: 112/40 - 74 - 97 ⁴ - 20. No side effects noted from antibiotic therapy. Coughing & wheezing. Fluids & feds taken well. No SOB noted. B. B. B. B.
3/31/06	10:00 A	Attempted x2 for bid ex draw - bil AC & success - P Dunlop
3/31/06	10 ¹⁵ /A	97 ² 84/42 74 20. Resident up per therapy to gen chair. No Gc voiced. ABT started last p.m. no temp this AM. Foley @ BSD & dark urine noted. Ate only 20%
3/31/06	10 ²⁵ /A	Blood drawn & sent to Edgefield Hosp Lab. — P Dunlop
3/31/06	5:30 p	Lab Report faxed back to TMH from Dr. Massey. S orders noted. Resident up in bed. Foley to BSD & dark urine noted. Takes meds w/out problems. S of pain. Family @ BSD. Temp 100 oral. 149/77, 82, 18. 2mm

Pt. Name Peterson, William Pt. Number 1050
 Physician NR6-LM Month March
 Room Number 2140 Year 2006

NURSES NOTES

DATE	TIME	
2/1/06	130h	V/S: 102/68-72-18-97. No side effects noted from antibiotic therapy. Soft collar brace to neck in place @ resident's request. No acute distress noted. Foley intact draining, amber urine. W. Beall
4/1/06	10 ⁰⁰ AM	V/S-98. 104. 10. 124/62. Resident in bed @ 30°. Disintact to cervical site. Foley catheter intact & draining amber colored urine @ bedside. Respirations even & unlabored. Accepted PO meds & difficulty, continues on ABT therapy. No adverse reactions noted. — U. Cheatham LP
4/1/06	9 PM	B/P 132/66 T 97.3 P 16 R 18. Resident resting quietly in bed. Alert & responsive. Soft collar brace in place to neck. Accepts meals well. ABT continues, NO adverse reaction noted. Foley catheter patent & intact to BSD & amber colored urine. Denies pain or discomfort. — P. Overton LP
4/2/06	1 AM	B/P 118/59 T 97.9 P 14 R 20. Resident asleep in bed. HOB ↑. Respirations even & unlabored. ABT continues No adverse reaction noted. Foley catheter patent & intact to BSD. Requires extensive assistance to ADL'S. Denies pain or discomfort. Will continue to monitor. — P. Overton LP
4/2/06	10 AM	V/S-96. 78. 18. 122/63. Resident in bed @ 45°. Resting quietly. No acute distress noted. Respirations even & unlabored. Accepted PO Meds & difficulty. Foley catheter intact & draining @ bedside. (continues) on ABT. No adverse reactions noted. — Mary Cheatham, LP
4/2/06	6 ¹⁵ PM	V/S-97. 101. 18. 92/59. Resident in bed @ 45°. Denies discomfort @ this time. Assistance provided to meals. Foley Catheter intact & draining @ bedside. — Mary Cheatham, LP
4/3/06	2 AM	B/P 112/52 T 96.9 P 16 R 18. Resident resting quietly in bed. Respirations even & unlabored. Dressing clean & intact to neck incision site. ABT continues. Flc patent & intact to BSD. No distress noted. — P. Overton LP

Pt. Name Peterson, William Pt. Number 1050
 Physician NRG-UM Month March
 Room Number 214W Year 2006

NURSES NOTES

DATE	TIME	
4-3-06	10AM	Resident ate 30% of blast, drank fluids good. Foley @ BSD & dark urine noted.
98 10/1/02	7:30	ABT cont'd, @ reactions noted. Therapy is working & resident is slow progress. <i>D. Duffley</i>
	16	
4/3/06	9:00 pm	BP 123/74 P 90 R 20 T 97. Alert & confusion. Follows simple directions p verbal cueing & difficulty. Fed per staff. ate 30%. Foley intact to BSD & dk tea colored urine. Conts on ABT & no adverse reactions noted. No resp distress noted, no noted SOB. Non productive cough. -> Saturating p/o feds well. Turned + repositioned by staff. Dsg dry + intact to surgical side. No noted A's in cognitive / functional status. Will cont to monitor. <i>P. Duffley</i>
4/4/06	2:00 pm	V/S: 103/65 - 68 - 20 - 98.5. Foley intact, draining sl. dark yellow urine. No side effects noted from anti-biotic therapy. <i>W. Byrrell</i>
4-4-06	10AM	Resident fed per staff, appetite fair to poor. Noct. voided. Drinks fluids good. Urine still dark, foley @ BSD. Therapy conts to work & resident. <i>D. Duffley</i>
4/4/06	6:30 pm	BP 124/67 P 57 R 22 T 98.6. Family attempted to feed, ate only 3-4 bites of food. Drinking feds well. Foley to BSD & dk tea colored urine. NO SOB noted. Dsg dry + intact to neck. Alert + responding appropriately to direct questions. Conts on ABT & no noted reactions. Will cont to monitor. <i>P. Duffley</i>
4/5/06	2:00 pm	V/S: 156/76 - 58 - 18 - 96.5. Foley intact draining dark yellow urine. Fluids offered taken well. No use of neck follow. <i>W. Byrrell</i>

Pt. Name Peterson, William Pt. Number 1050
 Physician NRBM Month April
 Room Number 214W Year 2006

NURSES NOTES

DATE	TIME	
4/6/06	6pm	974-11/63-61-20- in bed SRT-2- alert - food on table - Foley patent & dressing to BSB - drug tray intact, to neck of dex hose - Rom-Cable
4/7/06	3:30 p	V/S: 118/74 - 68-18 - 97%. No callus on @ this time re: resident's choice. Filtrials of fluid, taken slowly but well. Fully intact, draining amber colored urine. Voided no complaint. No acute distress noted. D. B. Patton
4-7-06	10am	97.7 116/65 66 18. Foley @ BSD & dark urine noted. Ate 40% of bfast, fed per staff. ABT conts, @ reactions noted. No c/o pain or discomfort. Therapy conts to work to resident & elbow progress. ——— D Smith RN
4-7-06	1:25 p	B/P 136/96 T 96.6 P 88 R 20. Resident awake & alert in bed. HOB T. Fed per staff in room. Accepts meds well. Requires extensive assistance to ADL'S. NO verbal c/o pain or discomfort. ——— P. Duenton RN
4/8/06	1AM	B/P 130/90 T 97 P 88 R 20. Resident presently asleep in bed. HOB T. Respirations even & unlabored. Foley catheter patent & intact to BSD & dark amber colored urine. Denies pain or discomfort. ——— P. Duenton RN
4-8-06	10:15 am	Resident is awake in bed, resp even & unlabored. Accepts meals well. Foley catheter patent & intact to BSD. Dressing dry & intact to neck. NO c/o pain or discomfort at this time will monitor. ——— J. Watkins RN
4-8-06	9PM	B/P 102/56 T 96.8 P 68 R 19. Resident resting in bed. Alert and responsive. Accepted meds well. Foley catheter patent and intact to BSD & dark amber urine. NO c/o pain. ——— P. Duenton RN
4/9/06	2AM	B/P 116/70 T 98 P 76 R 20. Resident asleep in bed. HOB T. No c/o pain or discomfort. ——— P. Duenton RN

Pt. Name Peterson, William Pt. Number 1050
 Physician NEWLM Month April
 Room Number 214W Year 2006

NURSES NOTES

DATE	TIME	
4-9-06	10 ⁵⁰ am	VS T 98.4 - P 64 - R 20 - BP 110/60. Resident is awake in bed, resp. even & unlabored. Skin warm & dry to touch. Foley cath patent & intact to BSD & dark amber colored urine noted. Will monitor. ——— / W. Wat. King, RN
4-9-06	4 p	VS T 96.7 - P 63 - R 20 - BP 117/73. Resident is resting quietly in bed, resp. even & unlabored. HOB ↑, Clean & dry dressing to neck incision. Will monitor. ——— / W. Wat. King, RN
4/10/06	2 AM	B/P 122/80 T 99 P 76 R 20. Resident asleep in bed. HOB ↑. Respirations even & unlabored. Foley catheter remains patent and intact to BSD & dark colored urine. No S/S of distress noted. Will continue to monitor. ——— P. Duvall, RN
4-10-06	10 ³⁰ A	97.4 68 20 122/60. Resident in bed this AM fed per staff ate 40% of breakfast, drank 3/4 Dec of fluids. Foley @ BSD & dark urine noted. Turned & reposed per staff. Therapy cont. ——— D. Smith, RN
4/10/06	9 ⁰⁰ pm	BP 111/66 P 66 R 22 T 98.2. Fed per staff poor intake 20% tolerated po flds well. No SOB noted HOB ↑. Foley intact to BSD & dk. amber urine. Turned + repositioned per staff. Dry dry + intact to neck. Voiced no CO. No S/S of URI. All needs met & anticipated per staff. No distress noted. Will cont to monitor ——— P. Duvall, RN
4/11/06	1:30 A	V/S: 122/78 - 78 - 18 - 96.2. Foley intact draining amber colored urine. Also to front of neck, dry & intact. No coll. or being used @ this time. No acute distress noted. ——— W. Buxell, RN
4-11-06	11A	110/68 59 17 98.1. Resident conts to have a poor appetite, drinks fluids good. No % voiced. Foley @ BSD & dark urine. Therapy conts to work & resident. Turned & reposed per staff. Will monitor. ——— D. Smith, RN

Pt. Name Peterson William Pt. Number 1050
 Physician NRGLM Month April
 Room Number 214W Year 2006

NURSES NOTES

DATE	TIME	
4/11/06	9:30 pm	BP 102/60 P64 R16 T97°. No noted functional or cognitive A's. Foley cants to BSD & dk amber urine. Appetite - poor, poor fluid intake noted. Alert & confusion. All needs met and anticipated per staff. Will cont to monitor - PDunlop
4/12/06	1:30 p	V/S: 112/64 - 76 - 18 - 98.8. Fluids refused, only a few sips taken before becoming choke. Foley intact, draining amber colored urine. Resp to front of neck dry & intact. NO SOB NO SOB noted. D. Banell
4-12-06	10A	Resident is refusing to eat, drinks fluids good. Foley @ BSD & dark urine noted. Therapy to work & resident, no C/O voiced. D. Banell
4/12/06	8:30 pm	BP 143/85 P64 R18 T96.8. Cants to have poor nutritional intake, staff attempts to feed, resident refuses. Turned & repositioned by staff. Foley to BSD & dk amber urine. Dry intact to neck insertion site. No SOB noted. NO SOB noted A's in condition. PDunlop
4/13/06	2:00 p	V/S: 124/73 - 73 - 18 - 95.8. Foley intact, draining dark yellow urine. Resp to front of neck dry & intact. Fluids refused, taken slowly, but well. No acute distress noted. D. Banell
4-13-06	9:40 A	97 125/69 72 18. Resident up in geri chair per staff & changes lift. Appetite cants to V but drinks fluids good. Dry dsq to surgical area. Foley @ BSD & dark urine noted. No S/S of pain or discomfort. Will monitor. PDunlop
4/13/06	6:15 pm	91.5, 108, 20, 113/70. Resident in bed @ 4:50 eatery supper. Fed per staff. Foley catheter draining @ bedside. Dsq to cervical site intact. Denies discomfort @ this time. Mary Cheatham

Pt. Name Peterson William Pt. Number 1050
 Physician NBC/LM Month April
 Room Number 214 W Year 2006

NURSES NOTES

DATE	TIME	
4/14/06	130/A	Foley intact, draining dark yellow urine. Dress to front of neck dry & intact. Fluids offered, encourage to consume. No acute distress noted. V/S: 130/76-68-18-96%. <u>D. Brunel</u>
4-14-06	10 ³⁰ /A	97 60 24 92/58. Resident resting quietly in bed this AM. Foley @ BSD & dark urine noted. No GV voiced. Therapy conts. Food intake poor, drinks fluids very good. <u>DA Smith</u>
4-14-06	6 ¹⁵ /P	96.9 127/80 76 22. Resident resting in bed @ this time. Staff assisted w/ eating supper. Drinks fluids good. New orders processed from MD this pm. Foley @ BSD & dark urine noted. <u>DA Smith</u>
4/15/06	130/A	V/S: 103/67-60-20-97%. Foley intact draining dark yellow urine. Dress to front of neck dry & intact. Fluids offered, taken & encourage to consume. No acute distress noted. <u>N. Brunel</u>
4/15/06	8 ²⁵ AM	Vs- 98. 88. 18. 139/68. Resident in bed @ 45°. Assistance provided w/ feeding. Fluids encouraged. Foley catheter intact/patent and draining @ bedside. Apical clear intact. Dry dress to conduit site intact & clean. Kept clear & dry for staff. <u>U. Cheatham</u>
4/15/06	10 PM	Vs- 96. 58. 20. 111/64. Resident fed per staff. No acute distress noted. Respirations even & unlabored. Foley catheter draining @ bedside. <u>U. Cheatham</u>
4/16/06	2 AM	B/P 128/72 T 97 P 64 R 18. Resident presently asleep in bed HOB T. Respirations even & unlabored. Foley catheter remains patent & intact & dark amber urine. No distress noted. <u>P. Dwyer</u>

Pt. Name Peterson, William Pt. Number 1050
 Physician NRG/UM Month April
 Room Number 214W Year 2006

NURSES NOTES

DATE	TIME	
4-16-06	10Am	979-118/63-56-18 Res alert & confusion patent Foley & dark amber urine draining. Denies discomforts. Drg intact to neck incision. Soft collar on @ present. Sels by PT/OT/ST as outlined. Appetite poor. Will Monitor Dphes
4/17/06	130/A	U/S: 100/108-58-18-979. Foley intact, draining on low flow (dark urine). Fluids offered, but encouragement needed to consume, but consumed a cup full. No acute distress needed. — N. Byrles
4-17-06	10 ¹⁰ /A	Resident fed per staff, ate 30% of plate. Foley @ BSD & dark urine noted. Therapy cont'd to work & resident. Drink fluids good. Soft collar intact. No wound. Dphes
4/17/06	9 ⁴⁵ pm	BP 98/70 P62 R20 T98°. Alert & confusion responding appropriately to direct questions. Poor nutritional intake. Foley to BSD & dk amber urine, sediment noted. NO SOB noted. HOB ↑. Sclerotic flds fair. Surgical site to neck & dry dsg intact. No acute distress noted. — P Dunsly
4/18/06	5 ⁰⁰ /A	U/S: 135/75-83-20-98°. Bld drawn for CBC, BMP. Urine sent to lab 1/2 times by this nurse. Urine obtained for U/A & C/S — N. Byrles
4-18-06	10Am	Resident conts to have poor food intake, he
12/1/63	17 67	drinks fluids good. Foley @ BSD & dark
	977	urine noted. Therapy conts & poor progress. No dsg to surgery site, NO open drainage noted. HOB ↑. Turned & repositioned per staff. Resident turns back himself. Will continue to monitor. DANIEL PR

Pt. Name Peterson, William Pt. Number 1050
 Physician NRGLM Month April
 Room Number 214W Year 2006

NURSES NOTES

DATE	TIME	
4/18-06	12N	Lab faxed to MD. ————— D Smith/pr
4/18/06	6 ⁰⁰ pm	BP 120/65 P 68 R 20 T 96°. Alert & confusion. Conts to require total staff (A) & ADL's. Turned + repositioned. While in bed per staff. Good intake, poor, fed intake per. Foley to BSD & dk amber urine present. No noted d's in condition. ————— P Dursley
4/19/06	100/A	V/S: 110/68 - 62 - 18 - 96%. Resting quietly @ present & no signs of acute distress. Foley intact, draining amber colored urine. Also to front of neck dry & intact. ————— W. Borrellson
4/19/06	830A	D/c Dsg to Neck incision site. Area intake clean & dry. ————— J Smorew
4-19-06	10 ⁵⁰ /A	118/68 74 18 97°. Resident fed per staff this AM, ate eggs. Conts to drink fluids good. Foley @ BSD & dark urine noted. Going to Urologist today for flu appt. Lab faxed to MD this AM. ————— D Smith/pr
4-19-06	12 ⁵⁰ /p	LOA via Palmetto Amb. to MD appt. D Smith/pr
4/19/06	300pm	Returned from MD appt new order: B. Foley on 4/20/06 then q 4 hrs, no pain to penis sore. B/P, Enc, po flds - orders noted. ————— P Dursley
4/19/06	9 ⁰⁰ pm	BP 125/69 P 69 R 20 T 96°. No SOB noted, HDB ↑. Foley at BSD & 75 cc dk amber urine. Solicated po flds well. Conts to have poor nutritional intake. Surgical site to neck clean & dry. Conts to require hands on (A) for bathing, dressing, grooming, oral care. Turned + repositioned per staff. No noted changes in condition. ————— P Dursley
4/20/06	200/A	Foley intact, draining amber colored urine. Incision to front of neck dry & intact. V/S: 98/60 - 60 - 98 - 96%. ————— W. Borrellson

Pt. Name Peterson William Pt. Number 1050
 Physician NRC/LM Month April
 Room Number 214.0 Year 2006

NURSES NOTES

DATE	TIME	NOTES
4-20-06	12:40 p	Foley Ad per Tx nurse this AM. 1000 cc
9/6/20	56	urine returned. No % pain or discomfort
	9/6/0	Fed per staff, ate his eggs for breakfast, drinks fluids good. Will monitor D.A. with Lpr
4-20-06	1:45 p	Order received from PT for Ohip wound care - Blomane
4/20/06	3:30 p	T96, P60, R30, BP 128/66, Neck dry clean intact callus as ordered. Pincet as ordered. Foley patient. ADL's per staff. Eats poorly drinks well. Miller
4/20/06	1 AM	Bp 110/60 T98 P68 R20. Resident asleep in bed. HOB T. Respirations even & unlabored. Skin warm & dry to touch. Foley catheter patent and intact to BSD & ^{clear} amber urine. SR's Tx 2 call light in reach. No S/S of distress. P. Oventon Lpr
4-21-06	10:45 A	Resident refused breakfast & fluids this AM. Did drink 150cc of juice & meds this AM. Foley @ BSD & clear urine noted. Therapy to do wound care now. Will monitor D.A. with Lpr
11/17/74	18/984	
4-21-06	6:15 p	T96.3 94/60 5.3 17. Resident up in bed per staff for supper. No % pain or discomfort. Foley @ BSD & yellow urine noted. D.A. with Lpr
4/21/06	12 AM	Bp 105/60 T96 P62 R18. Resident presently asleep in bed. HOB T. Alert & responsive when awake. Respirations even and unlabored. Foley catheter patent and intact to BSD & clear yellow urine. No S/S of distress noted. P. Oventon Lpr
4-22-06	10:30 am	Resident is awake in bed, resp even & unlabored. Foley catheter patent & intact to BSD & clear urine noted. Accepts fluids well. Will monitor % with Lpr
T96.8	P 62	
R 16	BP 121/61	
4/22/06	9 PM	Resident lying in bed & both eyes closed. HOB T. Alert & confusion. Accepts meds & difficulty & only small sips of juice. Requires extensive assistance to ADL's. Foley catheter patent and intact to BSD & clear yellow urine. No S/S of distress noted. P. Oventon Lpr

Pt. Name Peterson William Pt. Number 1050
 Physician NBGLM Month April
 Room Number 214W Year 2006

NURSES NOTES

DATE	TIME	
4/23/06	12AM	Resident resting quietly in bed. HOB ↑. Respirations even and unlabored. Skin warm & dry to touch. Foley catheter remains patent & intact to BSD & clear yellow urine. SR 5/25. Will continue to monitor. — P. Davenport LPN
4-23-06	9:30 am	Resident is resting quietly in bed, resp. even & unlabored. Refused breakfast & meds this morning. Foley catheter patent & intact to BSD. Clear urine noted. Will continue to monitor. — A. Watkins, R
T 96.2	P 64	
11/6	2P 110/60	
4/23/06	9pm	B/P 102/80 T 98.8 P 62 R 20. Resident lying quietly in bed. HOB ↑. Respirations even & unlabored. Refused 8pm meds, states "I don't need it". Foley catheter patent and intact to BSD & clear yellow urine. No S/S of distress noted. — P. Davenport LPN
4/24/06	2AM	B/P 98/62 T 99 P 62 R 20. Resident presently asleep in bed. HOB ↑. Respirations even & unlabored. Foley catheter patent and intact to BSD & clear yellow urine. No S/S of acute distress noted. Will continue to monitor. — P. Davenport LPN
4-24-06	9:30/A	Resident refused breakfast this AM, took po meds & drank juice. Foley @ BSD & yellow urine noted. Wound care per therapy. Will continue to monitor. — D. Smith LPN
12/163	88	
4-24-06	12:20/p	X-ray done for MD. — D. Smith LPN
4/24/06	8:30 pm	B/P 91/65 DP 59 R 18 T 98.3. Alert & confused, responded appropriately to direct questions. Poor nutritional intake, po & fluid intake fair. Foley conts to BSD & dk amber urine present. Turned & repositioned by staff. No resp distress noted HOB ↑. Denied no pain or discomfort. No noted functional or cognitive Δ's. Will cont to monitor. — P. Davenport LPN
4/25/06	1:30/p	1/15: 106/118-72-18-96.8. Foley intact, draining amber colored urine. Resting quietly @ present & no signs of acute distress. — P. Davenport LPN

Pt. Name Peterson William

Pt. Number 1050

Physician NRLM

Month April

Room Number 214W

Year 2006

NURSES NOTES

DATE	TIME	
4-25-06	9 ⁴⁰ /A	Resident conts to refuse to eat, drinks good. Foley @ BSD = yellow urine instead. Resident receives therapy for wound care. No C/O pain or discomfort. Will monitor. D Smith/pr
4-25-06	8 ⁴⁵ pm	BP 133/78 P 80 R 20 T 97°. Foley conts to BSD = dark amber urine. No SOB noted HOB ↑. Turned + repositioned by staff. All needs met + anticipated by staff. Refusing to eat. - Tolerates po flds good. Surgical site to neck. Healing well, no problems noted. Voided no C/O pain/discomfort. Will cont to monitor. P Duncn/pr
4/26/06	130p	V/S: 90/73 - 60 - 18 - 95 ⁴ /min. Foley intact draining sl. dark yellow urine. Resting quietly @ present = no signs of acute distress. N. Bezzell
4-26-06	10 ⁴⁵ /A	Resident's appetite conts to be poor for food intake, drinks fluids good. Lower Ext cont to be swollen. Foley @ BSD dark yellow urine noted. Therapy conts to do wound care. No C/O pain or discomfort. D Smith/pr
100/66 70 18 97°		
4-26-06	8 ³⁰ pm	BP 116/80 P 71 R 20 T 97°. Alert & conscious. Conts to poor intake of food, tolerates po flds well. Foley to BSD = dark amber colored urine. On cont of bowels @ staff @ for care. Turned + repositioned per staff. Heel boots intact to @ feet. Alternating pressure relief mattress to bed. Wound care conts per therapy. No SOB noted HOB ↑. Denies any pain or discomfort. Will cont to monitor - P Duncn/pr
4/27/06	130p	V/S: 112/60 - 74 - 18 - 98 ⁵ /min. Foley intact draining dark yellow urine. Fluids taken slowly, but well. Voided. No complaints. No acute distress noted. N. Bezzell
4/27/06	9 ³⁰ Am	Sed per staff, refuses to eat. Conts to drink flds well - Foley intact + patent. No noted functional AS. No distress noted. P Duncn/pr
BP 118/68 P 70 R 20		

Pt. Name Peterson William Pt. Number 1050
 Physician NRBlm Month April
 Room Number 214W Year 2006

NURSES NOTES

DATE	TIME	
4/27/06	6:00	In bed SR 7-12 - Alert - amount of 98/78 - 20 - loose - Foley patent & draining 64 - 97% feeds self - appetite remains poor - good fluids perched - feeding a crop of food per 1500 - 1600 - M.C. Cole
4/28/06	1:30 p	V/S: 97/63 - 76 - 16 - 97%. Foley int- act, draining amber colored urine. Resting quietly & present no signs of acute distress. N. Basler
4-28-06	9:10 A	Resident conts to have poor food intake, does 118/68 68 18 98% drink fluids good. Foley intact & patent & yellow urine noted. Fed per staff, will not feed himself. Therapy conts to wound care. Turned & reposed per staff. — D. Smith RN
4/29/06	1:00 p	V/S: 106/60 - 78 - 18 - 98%. Foley intact & draining amber colored urine. Fluids & feed taken well & encouragement to finish whole cup. No acute distress noted. N. Basler
4/29/06	12:30 pm	vs - 96/78 - 17 - 12/03. Res. No discomfort. Glycerol & 30% green, kept clear per staff. Foley Catheter intact & draining @ bedside. Fed meals per staff. All needs anticipated / met per staff. Mary P. Matham, RN
4/29/06	9pm	B/P 134/70 T 99.4 P 74 R 18. Resident awake in bed. Alert & confusion noted. Accepted meds. Appetite and fluid intake remain poor. Requires extensive assistance & ADL's. Will continue to monitor. — P. Overton RN
4/30/06	2AM	B/P 112/64 T 96 P 68 R 18. Resident presently asleep in bed. HOB 7. Respirations even & unlabored. Turned & reposed per staff. Foley catheter patent & intact to BSO. — P. Overton RN

Pt. Name Petersen, William Pt. Number 1050
 Physician NR & LM Month April / May
 Room Number 214W Year 2006

NURSES NOTES

DATE	TIME	
4/30/06	1pm	VS- 96° 77.18. 140/89. Resident in bed @ 30° (Assistance) provided c meals. Poor intake noted. Fluids encouraged & acute distress noted. Respirations even & unlabored. Kept clean per staff. Foley Catheter intact & draining @ bedside. Aggr collar in place. Repositioned for comfort. Call light within reach. SkT x3. — Mary Cheatham, LPN
4/30/06	6pm	VS- 96° 79.10. 140/89. Resident in bed @ 30°. Poor intake noted. Assistance per staff provided c meals. Kept clean per staff. Foley catheter intact & draining @ bedside. SkT x3 for safety. — Mary Cheatham LPN
5/1/06	4Am	B/P 142/90 T 97.2 P 78 R 20. Resident presently asleep in bed. HOB 9. Respirations even & unlabored. Foley catheter patent & intact to BSD & dark amber urine. NO S/B of distress noted. — P. Overton LPN
5/1/06	9:30/A	96° 140/78 96 20. Resident's intake is very poor. Peristalsis not eff. ↓ in appetite noted. LPA to MD on pt via Pal Ambulance. — D. A. Smith LPN
5/1/06	12:30/p	Returned from MD consult. New orders received for PC collars - No further follow up needed. Foley @ BSD & yellow urine noted. No % pain or discomfort. — D. A. Smith LPN
5/1/06	8:30 pm	B/P 118/77 P 82 R 20 T 97.9. Resting quietly in bed w/ call no %o. Foley intact to BSD & dk straw colored urine noted. Contin to tolerate po feds well. Fed per staff at 20%. Total staff @ for ADLs, non-participating in self care. No SOB noted HOB 9. No noted functional or cognitive A's Will cont to monitor. — P. Overton LPN
5/2/06	1:00/p	V/S: 110/84 - 69 - 97.5. Foley draining, sl. dark yellow urine. Resting quietly & present a no signs of acute distress. — K. B. Bell R

Pt. Name Peterson, William Pt. Number 1050
 Physician NRGLM Month May/april
 Room Number 2144 Year 2006

NURSES NOTES

DATE	TIME	NOTES
5/2/06	8 ⁴⁵ A	DR. TV to R heel. Area pink - ordered
5/2/06	10 ²⁵ A	Resident ate 40% of bfast, sed per staff c
5/2/06	57 18 98 ²	Much encouragement needed. Therapy conts to do wound care. Foley @ BSD & dark yellow urine noted. No lb pain or dis. comfort
5/2/06	2:15P	Cut + trimmed finger + toe nails, will cont to monitor <u>Edman R</u>
5/2/06	5 ⁰⁰ pm	Rec'd orders per Dr. Nicholson: PT to culture wound to (L) hip. Orders noted <u>P. Quinlan</u>
5/2/06	8 ⁴⁵ pm	BP 108/76 P 68 R 18 T 97 ⁴ . Alert & confusion. Foley intact to BSD & dk. amber colored urine. Continues to tolerate po flds well. Turned + repositioned by staff. 2 ⁺ edema noted to (B) feet, unable to ↑ feet due to contractures at knees. No cognitive Δ's noted, does respond appropriately to direct question, does follow simple directions & verbal cueing. Voiced no lb pain or discomfort. No acute distress noted. Will cont to monitor. <u>P. Quinlan</u>
5/03/06	12 ⁴⁵ A	A Resting quietly, occluded, FL intact and intact, amber urine to BSD. NO LOS VOICED. NO noted distress. Call light within reach. V.S. 95.0 - 57-18 10 ⁰⁰ AM <u>T. P. Walker</u>
5/3/06	10AM	Resident up in bed c positioned in place
5/3/06	78/53 52 18	Jx done per therapy. Wound will be cultured in AM. Edema conts to ↓ exts. Alert & confusion noted. No lb pain or dis. comfort. Has foley @ BSD & dark urine noted. <u>D. Smith</u>
5/3/06		BP 98/60 P 50 R 17 T 97 ² . Alert resting in bed quietly staff (A) & turnery/repositioning. Remains off (L) side, repositioned on (R) side or back. Foley to BSD & yellow colored urine. Tolerating po flds ↓ difficulty. No noted functional/cognitive Δ's <u>P. Quinlan</u>

Pt. Name Peterson William Pt. Number 1050
 Physician NR Blm Month April - May
 Room Number 2140 Year 2006

NURSES NOTES

DATE	TIME	
5/4/06	1Am	BP 120/60 T 97 P 60 R 18. Resident presently asleep in bed. HOB 4. Respirations even & unlabored. Skin warm and dry to touch. Turned & positional from back to Rt. side only. Foley catheter patent and intact to BSD & clear yellow urine. No S/S of acute distress noted. — P. Durne/PR
5/4/06	8:45A	Wheel Blanching cont to monitor daily (small res T+P @ 4 hrs in bed) (Bk to 8:15 Secs) He uses wedg
5/4/06	10:45	to LE to help prevent contractures in bed.
B/P	110/60	Res. seen by PT Dept — See notes.
P-	64	Inc of Bowels — ment care prov. daily.
R-	18	Has foley cath to BSD intact & yellow urine noted. @ S/S of UTI problems expected. See Tx book & body audit sheet for skin condition. SR 2 as enablers. NDB 2. @ C/O pain/disc noted @ present. — Will use
5/4/06	5:30 pm	BP 101/54 P 51 R 18 T 97. Foley coits to BSD & dk straw colored urine. Fed per staff appetite fair. Drinks liquids through straw w difficulty. Turned & repositioned by staff, remains off (L) side. No acute distress noted. No noted functional or cognitive D's Will cont to monitor — P. Durne/PR
5/5/06	2:15 PM	In bed Resting peacefully. HOB 4. Resp even / unlabored. Turn & reposition per staff. Foley cath intact to BSD & yellow urine noted. VS 96-51-18-99/51-20
5/5/06	10:25/4	97 60 20 122/70. Resident in bed & positioned in place. Foley @ BSD & dark urine noted, remains off Lt side. Appetite conts to be poor, periactin has been ordered. Will monitor. D Smith/PR
5/5/06	6pm	Resident in bed this pm, took po meds & any problems. Foley @ BSD & dark urine noted.
B/P 119/60	P 64	T 98 R 20
T 98	R 20	No S/S of pain noted. Appetite poor. D Smith/PR

Pt. Name Peterson William Pt. Number 1056
 Physician NRGM Month April - May
 Room Number 2140 Year 2006

NURSES NOTES

DATE	TIME	
5/6/06	1Am	Bp 98/46 T 90.8 P 68 R 18. Resident resting quietly in bed. HOB 7. Respirations even & unlabored. Skin warm & dry to touch. Turned & repositioned from back to rt. side only per staff. Foley catheter patent and intact to BSD & dark amber urine. No S/S of acute distress. — P. Oventon ^{LP}
5-606 T 96.0 R 17	10 ⁴⁰ am P 78 BP 122/76	Resident is awake in bed, resp. even & unlabored. Foley Catheter patent & intact to BSD & amber urine noted. Skin warm & dry to touch. All needs met per staff. Call light in reach. — W. Watkins ^{LP}
5/6/06	9pm	Bp 136/102 T 97.4 P 64 R 18. Resident lying in bed awake & much confusion. "I need some gas for my truck to go to work". Accepted meds well. Will continue to monitor. — P. Oventon ^{LP}
5/7/06	2Am	Bp 127/90 T 97.1 P 68 R 20. Resident presently asleep in bed. HOB 7. Respirations even & unlabored. Turned & repositioned by staff. Foley catheter remains patent and intact to BSD & dark amber urine. No S/S of acute distress noted. — P. Oventon ^{LP}
5/7/06	9 ³⁰ am	Vs - 96.3. 78. 17. 122/80 Resident in bed @ 3P. Kept clean & dry per staff. Incontinent & incontinent. Foley Catheter intact & draining @ bedside. Respirations even & unlabored. Skin w/d to touch. — M. Cheatham ^{LP}
5/7/06	5pm	Vs - 96.1. 76. 18. 105/62. Resident in bed. Repositioned for comfort. Kept clean & dry per staff. No acute distress noted. Respirations even & unlabored. Denies discomfort @ this time. Foley Catheter in place & draining @ bedside. — Mary Cheatham ^{LP}
5/8/06	1Am	Bp 110/70 T 97.1 P 64 R 20. Resident is very confused tonight very restless. This writer stayed @ resident for a while to help him settle down. Foley catheter patent and intact to BSD & dark amber urine & thick sediment. Will continue to monitor. — P. Oventon ^{LP}

Pt. Name Peterson William Pt. Number 1050
 Physician NRG/m Month May
 Room Number 214D Year 2006

NURSES NOTES

DATE	TIME	NOTES
5/8/06	10 ¹⁰ A	Resident more alert, talkative but c confusion
12/1/64	88 97 ¹⁸	Says "I'm going to Nims funeral Home." Foley @ BSD c dark amber urine noted c heavy sediment also. Fluids are being accepted fairly good by resident, MRSA noted in Lt hip wound. Culture results faxed to MRD Smith
5/8/06	9 ³⁰ pm	BP 103/62 P 63 R 18 T 97 ² . Foley intact to BSD c check amber color urine c sediments noted. Turned + repositioned by staff, remains off (L) hip. Poor intake of food. 160 cc po fluids - resident restless at present time attempting to turn in bed, pulling at brief. No acute distress noted, no SOB, - HOB + Dimes pain / discomfort. No noted cognitive or functional AS will cont to monitor.
5/9/06	1A	Resting quietly in bed. NO C/O'S VOICED ^{P. Quinn} noted distress. 96-04-18 11/6/74. T. Black
5/9/06	10 AM 100/72 76 18 97 ⁸	Up in bed per staff c positioned intact Foley @ BSD c dark amber urine c sediment noted. Poor intact conts, accepts fluids OK. No C/O pain or discomfort. Therapy conts to do wound care to Lt hip. Will monitor. Does not feed self at this time. D Smith pr
5/9/06	10 ²⁸ pm	BP 103/59 P 55 R 18 T 98 ³ . No noted functional or cognitive AS. Foley conts at BSD. c dk amber urine c sediments present. Turned + repositioned per staff, remains off (L) hip, denies any pain / discomfort this shift. Will cont to monitor ^{P. Quinn}
5/10/06	2 AM	Resident quietly in bed. C/O C/O VOICED ^{P. Quinn} distress noted. VS 97-60-15-124/76-80
5/10/06	10 ⁴⁵ A 103/58 16 76 97 ⁸	Resident up in bed per staff this AM, conts to have poor intake. Foley @ BSD c amber urine & sediment noted. NO C/O or S/S of pain ^{Smith pr}

Pt. Name Peterson William Pt. Number 1050
 Physician NRGLM Month May
 Room Number 214D Year 2006

NURSES NOTES

DATE	TIME	
5/10/06	5:30pm	<p>In bed, slow to respond, but verbal. Daughter visited earlier. Only accepted 60cc Norvasone this afternoon. Poor P.O. intake. Re Reiactin to enhance appetite. No noted effectiveness. Fed by staff. Staff anticipates + meets all needs. Has patent Foley + dark urine + much sediment. Res states "I'm tired, ready to go home." Univ. Precat maintained - MRSA to hip wound. Heel wound healed. On alt pres. mattress with anti-contraction wedge to LE - Both LE contracted severely. No ch or gesture of pain/discomfort. I+O monitored. Will attempt to ↑ PO fluids/intake. NP + family aware of poor intake + wt loss. Will be seen by PT for wound care as outlined in their PIC. Nonambulatory. SOB to gcr as tolerated - bedfast at this time. V# 943 9760 76-17 Dykes</p>
5/11/06	1Am	<p>B/P 106/62 T 99.1 P 16 R 20. Resident presently asleep in bed. Ho B ↑. Respirations even + unlabored. Requires ventilator assistance + ANLS. Foley catheter patent and intact to BSO + dark urine + thick sediment. Turned + positioned per staff. Will continue to monitor. P. Quintero LP</p>
5/11/06	9Am	<p>Resident in bed this AM. Up in bed for breakfast, very poor intake + food + fluids. Foley @ BSO + amber urine + sediment noted. Contraction wedge to R Lts. Feet are very edematous. No ch or S/S of pain. D with</p>
5/11/06	2p-	<p>V/S 121/64-89-17-97.7 Poor intake. Speech visit ate appearance. Dietary aware to send appearance + each meal. J Wheeler LP</p>

Pt. Name Peterson, William Pt. Number 1050
 Physician NRGLM Month _____
 Room Number 242 Year _____

NURSES NOTES

DATE	TIME	
5/11/06	5p	986-114 64-56-21. In bed SRT-V2 - alert & confusion - Foley patent draining dark urine to BSB - to bed about a ADL'S - go (ulcers) encouraged - clopains on SOB D. McCall
5/12/06	100%	V/S: 187/83 - 60 - 18 - 97%. Foley intact, draining dark colored urine (yellow). No acute distress noted @ this time. N. Baylton
5/12/06		V/S 91' 80 20 13/80 Resident in bed resting quietly & eyes open. HOB 1. J. Lander many med to any problems & distress noted. Foley cath intact & draining well. Skin W/O. No complaints noted. J. Lander
5/12/06	6pm	Resident in bed resting quietly. HOB R. Turn / reposition per staff. Foley intact and patent. Use 20 prostate enlargement. @ clo voiced VS 96 9 - 19 55 155/80 J. L.
5/13/06	130%	V/S: 137/65 - 67 - 18 - 97%. Foley intact, draining dark yellow urine. Resident cool to touch, but not clammy. No SOB, resp unlabored. Pupils (pupils taken) well, but slow. J. Baylton
5/14/06	939am	V/S - 97', 80, 20, 128/82. Resident in bed @ 30°. Acute distress noted. Respirations even & unlabored. Alert & confusion. Continues to spit out on floor. Repositioned to maintain skin integrity. Poor intake noted. Foley Catheter intact & draining @ bedside. Mary Cheatham, Lpn

Pt. Name Peterson William Pt. Number 1050
 Physician NBGLM Month May
 Room Number 2140 Year 2006

NURSES NOTES

DATE	TIME	
5/13/06	5:25 pm	vs-96 ³ . 71.17. 98/102. Resident in bed @ 45°. Fluids encouraged. Foley Catheter intact & draining @ bedside. Resting quietly. Eyes closed. Kept clean per staff. A/s. Discomfort noted. Mary Cheatham
5/14/06	2 AM	Bp 102/100 T 97 P 60 R 20. Resident presently asleep in bed. HOB ↑. Respirations even & unlabored. Foley Catheter patent and intact to BSD & dark, thick, yellow urine. Turned and positioned per staff. Takes fluids & much VNC. Will continue to monitor. Pam Dueston
5/14/06	10:25 Am	vs 104. 14. 108. Resident lying in bed resting quietly. Acute distress accepted p.o. meds in appearance. Foley Catheter intact & draining @ bedside cloudy urine. Kept clean & dry per staff. M. Cheatham
5/14/06	4 pm	vs- 91 ⁰ @ 54. 12. 120/70. Resident very cool to touch. Pupillary response noted: Respirations slow & shallow. Alert & confusion. Foley Catheter intact & draining cloudy urine. Repositioned for comfort. Warmth applied to skin to promote circulation (blankets). Capillary refill, extremities sluggish. No intake noted. P.o. meds accepted @ this time. Mary Cheatham
5/14/06	11 pm	Resident resting in bed & eyes slightly cracked, closed and dilated. Upper and lower extremities are very cold to touch. Blankets placed on resident to promote warmth and circulation. Also having periods of apnea 2-3 seconds. O ₂ -2LPM via N/C to aid respirations. Comfort measures provided. Will continue to monitor. P. Dueston
5/15/06	1:30 Am	Bp 92/70 T 94 P 60 R 16. Resident lying in bed & eyes open, fixed & dilated. Resident found to be "reaching" in the air at one time. HOB ↑. O ₂ -2LPM via N/C continues to have periods of apnea 2-3 seconds. Foley catheter patent and intact to BSD & thick dark cloudy urine. No intake, unable to accept p.o. meds or fluids. Upper & lower extremities remain cold. Comfort measures provided. Will continue to monitor. P. Dueston

Pt. Name Peterson William Pt. Number 1050
 Physician NRGL m Month May
 Room Number 214D Year 2006

NURSES NOTES

DATE	TIME	
5/15/06	8 ^{AM}	Lying in bed on back, slow to respond, non-verbal. Opens eyes and responding to physical stimuli. NO SOB noted - HRB ↑, O ₂ at 2l/m via NC intact. Foley to BSO & k&mb urine; 120cc present. Unable to drink, eat or swallow. Will not open mouth. Skin cool to touch. No acute distress noted at this time. Will cont to monitor P. Dunslop
5/15/06	11 ⁴⁵ AM	Attempted to contact R/P Mary Peterson no answer at phone # given. Also attempted to contact alternate family members listed Belinda Butler + Patricia Peterson no answers; Will try at later time P. Dunslop
5/15/06	12 ³⁰ PM	Rec'd call from Mary Peterson; informed of residents current condition. P. Dunslop
5/15/06	1 ⁴⁵ PM	Resident anxious/restless continuously shuffling & moving extremities. Moans when touched, eyes opened & no blinking noted. Called Dr Rainford's office; spoke to nurse Donna. Requesting med to manage anxiety. Awaiting return call. Family present in room P. Dunslop
5/15/06	2 ⁴⁵ PM	Family called Dr Rainford and stated to this writer. "If the doctor said for you to send daddy to the ER at Aiken Hospital, the Dr will call you." Did not rec call from Dr. Rainford, called Dr Rainford's office spoke to nurse Donna was informed by nurse Donna "Dr Rainford did not advise family to send resident to hospital instead told family if it was their desire the family could take him to the hospital" Resident is DNR status. Explained conversation to family members B. Butler Patricia Peterson and Mary P. Peterson. regarding call to Dr Rainford's office. All family members present ~ 15 all insisted that resident be transferred to Aiken ER. "Ms P. Peterson stated "you can call the ambulance or we will" Family again reminded transfer was AMA, cont'd to

Pt. Name Peterson William Pt. Number 1050
 Physician NRGLM Month May
 Room Number 214D Year 2006

NURSES NOTES

DATE	TIME	
5/15/06	2:45 pm	visit EMS he called. N. Mc Carble lpm contacted 911 for
		transport to Aiken Hosp ER per insistence of family.
5/15/06	3:45 pm	Resident transported via EMS to Aiken Hosp. Transportation
		to Hosp was not recommended by Dr Rainfordo transported
		per family insistence against medical advise. - P Dunslop
5/15/06	9:00 pm	called Aiken ER + Hosp to contact faculty upon decision
		to admit or transfer back to facility. - P Dunslop
5/15/06	2:00 P	Res DC'd to AFMC, family Aiken + states they will
		pk + personal belongings, meds returned to hosp,
		all paperwork complete; - J. Loman

Pt. Name Peterson William Pt. Number 1050
 Physician NP Calm Month May
 Room Number 214D Year 2006

MONTHLY NURSING REVIEW

Month/Year

May	06		
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Month/Year

Apr	06		
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001. Functional Communication

- 1 = Communicates without difficulty
- 2 = Communicates, but requires extra time or assistance
- 3 = Communicates only basic needs
- 4 = Communication is nonfunctional for expression of basic needs
- 5 = Does not communicate
- 6 = Cannot determine

1	2	3	4	5	6
✓					

002. Vision

- 1 = Adequate in most situations
- 2 = Impaired - supervision or assistance is not needed
- 3 = Impaired - supervision or assistance is required
- 4 = Cannot determine
- 5 = Wears glasses

1	2	3	4	5
✓				

003. Hearing

- 1 = Hears speech at regular conversational levels
- 2 = Hears speech at regular conversational levels but may have difficulty hearing in noisy situations
- 3 = Lip-reads or relies on other cues
- 4 = Misses most conversation even when lip-reading or using other cues
- 5 = Hearing cannot be used for communication
- 6 = Wears hearing aide/aides

1	2	3	4	5	6
✓					

004. Orientation / Memory

- 1 = Capable of functioning independently in his/her environment. Can be occasionally forgetful
- 2 = Requires daily intervention from staff
- 3 = Complete disorientation or incoherence
- 4 = Undetermined (Does not include recipients who speak another language or are non-verbal)

1	2	3	4
✓			

005. Consciousness Level

- 1 = Conscious - responsive, may be listless or lethargic, but is aware of surroundings
- 2 = Semi-conscious - unaware of surroundings, but reacts to sensory stimuli
- 3 = Comatose - unresponsive to any stimuli

1	2	3
✓		

006. Verbal Aggression

- 0 = Non reported or exhibited
- 1 = Requires immediate staff intervention one to four days per month, but not weekly
- 2 = Requires immediate staff intervention one to six days per week
- 3 = Requires staff intervention once a day or more

0	1	2	3
✓			

007. Other disruptive acts (describe in Summary responses to #1, 2, or 3)

- 0 = Non reported or exhibited
- 1 = Requires immediate staff intervention one to four days per month, but not weekly
- 2 = Requires immediate staff intervention one to six days per week
- 3 = Requires staff intervention once a day or more

0	1	2	3
✓			

008. Elopement (Has wandered outside of facility this month)

- 0 = None reported or exhibited
- 1 = Requires immediate staff intervention one to four days per month
- 2 = Requires staff intervention once a day or more, specify times _____
- 3 = If resident has eloped this month, document in comment section

0	1	2	3
✓			

009. Eating

- 1 = Independent (may require tray set-up)
- 2 = Intermittent assistance; requires verbal or physical assistance less than 60% of the time
- 3 = Requires assistance to spoon feed for 60% or more of the time
- 4 = Receives non-oral feeding for 60% or more of the recipient's nutrition (GT or NGT)

1	2	3	4
		✓	

010. Enteral Feeding (GT or NGT)

- 0 = Not receiving
- 1 = Less than once per week (bolus PRN)
- 2 = One to six times per week (bolus PRN)
- 3 = Once per day
- 4 = Two times per day
- 5 = Three to six times per day
- 6 = Every two hours
- 7 = Continuous via a pump

0	1	2	3	4	5	6	7
✓							

011. Dressing / Grooming

- 1 = Dresses and grooms independently
- 2 = Requires frequent, but not constant, one-to-one hands-on assistance
- 3 = Requires continuous one-to-one assistance and supervision
- 4 = The recipient does not participate in the dressing/grooming process

1	2	3	4
			✓

012. Transferring

- 1 = Independent, but recipient may use equipment
- 2 = Recipient requires PRN assistance for transfers
- 3 = One to transfer
- 4 = Two to transfer (uses mechanical lift)
- 5 = Not transferred

1	2	3	4	5
			✓	

013. Turning / Positioning

- 0 = Not receiving (turns self independently)
- 1 = Requires staff to turn and reposition
- 2 = Staff turns and reposition every 2 hours

0	1	2
✓		

RESIDENT <i>Peterson, William</i>	PHYSICIAN <i>TMH&R of Edgefield</i>	ROOM NO. <i>0221/2006</i>	MEDICAL RECORD NO. <i>05125/2006-002</i>
--------------------------------------	--	------------------------------	---

014. Mobility: Ambulation/Wheelchair (Specify & circle type of mobility)

- 1 = Walks with no hands-on assistance. Recipient may require mechanical devices
- 2 = Requires assistance for difficult parts of walking
- 3 = Requires one-to-one assistance during the entire activity
- 4 = Requires two-to-one assistance during the entire activity
- 5 = Wheels self except for difficult maneuvers
- 6 = Is wheeled, one-to-one assistance during the entire activity and maneuvers
- 7 = Is bedfast except for transfers to bath

015. Contractures (Specify limbs)

- 0 = None
- 1 = One extremity (limb) affected
- 2 = Two extremities (limbs) affected
- 3 = Three extremities (limbs) affected
- 4 = Four extremities (limbs) affected

016. Toileting

- 1 = Independent, may require special equipment
- 2 = Requires assistance but can be left alone for privacy
- 3 = Requires physical or verbal assistance or supervision, excluding incontinent care, and cannot be left alone
- 4 = Incontinent or has an indwelling catheter, specify which
- 5 = Documented toileting at least every 2 hrs. while awake
- 6 = In and out catheterization by the staff two or more times each day

017. Bladder Control

- 1 = Continent
- 2 = Incontinent three times a day or less
- 3 = Incontinent only at night
- 4 = Incontinent four or more times in a 24-hour period
Includes external catheters, ostomies
- 5 = Requires indwelling catheter or intermittent catheterization

018. Bowel Control

- 1 = Continent
- 2 = Has an ostomy and is independent with its care
- 3 = Incontinent one to three times per week
- 4 = Incontinent four or more times per week
- 5 = Requires assistance with an ostomy, includes nursing care or teaching self-care

019. Urinary Tract Infection within the last 30 days

- 0 = No
- 1 = If yes, what treatment was given?

020. Intake and Output (State reason for I & O)

- 0 = Not receiving
- 1 = Recorded each shift
- 2 = Record intake only each shift
- 3 = Record output only each shift

021. Restorative Nursing

- 0 = Not receiving
- 1 = Yes, care planned as:
 - 1a = Bowel/Bladder retraining
 - 1b = Mobility/Ambulation
 - 1c = Eating/Dining
 - 1d = Other:

022. Oral / Nasal Suctioning

- 0 = Not receiving
- 1 = Receiving every shift and prn
- 2 = Other, state average times per day

023. Tracheostomy Care

- 0 = Not receiving
- 1 = Receiving every shift and prn
- 2 = Other, state average times per day

024. Oxygen Administration

- 0 = Not receiving
- 1 = Receiving on a prn basis
- 2 = Receiving nightly
- 3 = Receiving continuously
- 4 = Other, state average time used

025. Renal Dialysis

- 0 = Not receiving
- 1 = Receiving _____ times per week

026. Hemiplegia / Paraplegia / Quadriplegia (Specify)

- 0 = No
- 1 = Yes

027. Recent Fracture (within last 3 mo.)

- 0 = No
- 1 = Yes

028. Recent Amputation (within last 6 mo.)

- 0 = No
- 1 = Yes

029. Therapy (PT, OT, ST)

- 0 = No
- 1 = Yes, specify what therapy

030. Braces / Splints / Protheses (Specify)

- 0 = Not receiving
- 1 = Worn daily
- 2 = Worn two times per day
- 3 = Worn each shift
- 4 = Worn as ordered

Handwritten note: Check with [unclear]

RESIDENT Peterson, William	PHYSICIAN TMH&R of Ed	ROOM NO. 628512	MEDICAL RECORD NO. 25/20062 570
--------------------------------------	-------------------------------------	---------------------------	---

031. Pressure Ulcer Staging (List number of each stage)

- 0 = None noted
- 1 = Stage I
- 2 = Stage II
- 3 = Stage III
- 4 = Stage IV

✓		

032. Pressure Ulcer / Stasis Ulcer Care

- 0 = No
- 1 = Yes, dressing orders as: _____

✓		
---	--	--

033. Internal Bleeding within the last 30 days

- 0 = No
- 1 = Yes, list signs and symptoms of internal bleeding

✓		
---	--	--

034. Seizures within the last 30 days

- 0 = No seizure disorder
- 1 = No seizure occurred
- 2 = If seizure disorder, on medication?
List medication: _____
- 3 = If on medication, lab work ordered?

✓		

035. Dyspnea

- 0 = None noted or reported
- 1 = Occurs with physical activity, such as walking or climbing stairs
- 2 = Occurs with physical activity, such as shaving, dressing or bathing
- 3 = Occurs at rest in any position

✓		

036. Edema

- 0 = None noted or reported
- 1 = Pedal and/or lower extremities edema, 1 to 2+
- 2 = Generalized edema of 3+ or greater
- 3 = Currently receiving a diuretic

✓		

037. Tremors

- 0 = None noted or only slight tremors
- 1 = Tremors interfere with functioning, intermittent supervision required
- 2 = Tremors interfere with functioning so that the recipient requires constant supervision

✓		

038. Terminal Illness

- 0 = No
- 1 = Yes
- 3 = Hospice program or facility terminal care (specify)

✓		

039. Pain Level within the last 30 days

- 1 = No pain
- 2 = Pain less than daily
- 3 = Pain daily
- 4 = If medicated and continues to rate high on the pain scale, complete a pain assessment

✓		

040. Use of siderails

- 0 = Not used
- 1 = Yes, specify why and how used:
*Document in Comments section

✓		
---	--	--

041. Physical or Chemical Restraint (Specify)

- 0 = Not used
- 1 = Yes, specify why and how used:
*Document in Comments section

✓		
---	--	--

042. Hospitalized within the last 30 days

- 0 = Not used
- 1 = Yes, specify reason for hospitalization:
*Document in Comments section

✓		
---	--	--

043. Did resident fall within the last 30 days

- 0 = Not used
- 1 = Yes, specify actions implemented in the care plan:
*Document in Comments section

✓		
---	--	--

044. Has there been a weight loss or gain > 5 lbs. this month?

- 0 = No
- 1 = Yes, specify actions implemented in the care plan:
*Document in Comments section

✓		
---	--	--

045. Abnormal Lab Values

- 0 = No
- 1 = Yes
*Document in Comments section

✓		
---	--	--

046. Medication changes

- 0 = No changes
- 1 = Yes
*Document in Comments section

✓		
---	--	--

RESIDENT Peterson, William	PHYSICIAN TMH&R of Edgefield	ROOM NO. 2140	MEDICAL RECORD NO. 1050
03/21/2006 - 05/25/2006 - 074			

First Monthly Summary Review:

Comments (address any new concerns or health problems, plan of action, and progress, new orders or medications, abnormal labs, PAR meeting outcomes and interventions):

PT does Stage II wound Care, Culture grew MRSA
SRT X2 as Enablers
Edema to + extg 2+ - WT ↑ 5 pounds

Resp. Party Contacted: Mary Peterson

Nurse signature: Doshia Smith LPN

Date and Time: 5/10/06 2pm

Date: 5/10/06

Second Monthly Summary Review:

Comments (address any new concerns or health problems, plan of action, and progress, new orders or medications, abnormal labs, PAR meeting outcomes and interventions):

Resp. Party Contacted: _____

Nurse signature: _____

Date and Time: _____

Date: _____

Third Monthly Summary Review:

Comments (address any new concerns or health problems, plan of action, and progress, new orders or medications, abnormal labs, PAR meeting outcomes and interventions):

Resp. Party Contacted: _____

Nurse signature: _____

Date and Time: _____

Date: _____

RESIDENT <u>W Peterson, William</u>	PHYSICIAN <u>TIM H&R of Edgefield</u>	ROOM NO. <u>6321/2006205/25/2008</u>	MEDICAL RECORD NO. <u>575</u>
--	--	---	----------------------------------

3 HORIZONTAL MOUNT

2 HORIZONTAL MOUNT

REMOVE TAPES
PLACE EDGE OF FORM
AGAINST BROKEN LINE
AND PRESS FIRMLY.

1 VERTICAL MOUNT

2 VERTICAL MOUNT

3 VERTICAL MOUNT

*Faked
3-31-06
DD*

EDGEFIELD COUNTY HOSPITAL
300 RIDGE MEDICAL PLAZA
EDGEFIELD, SC 29824
(803) 637-3174

URINALYSIS

Peterson William
DOB 3/14/22

REQUESTED BY:	DATE: TIME:	ORDERING PHYSICIAN: <i>Massey</i>
GLUCOSE (NEG): <i>neg</i>	WBC/HPF:	MICROSCOPIC:
BILIRUBIN (NEG): <i>neg</i>	RBC/HPF: <i>0-3</i>	
KETONE (NEG): <i>neg</i>	CASTS/LPF: <i>0-3 RBC CAST</i>	
SP. GRAVITY (1.010-1.030): <i>1.020</i>	MUCOUS:	
pH (5.0-7.0): <i>5.0</i>	EPITHELIAL CELLS:	
PROTEIN (NEG): <i>2+</i>	BACTERIA: <i>many cocci</i>	
UROBILINOGEN (0.2-1.0): <i>1.0</i>	CRYSTALS:	
NITRATE (NEG): <i>neg</i>	OTHER:	
BLOOD (NEG): <i>TR</i>		
LEUKOCYTES (NEG): <i>neg</i>		

d/p Peach
 RANDOM COLLECTION
 MID-STREAM COLLECTION
 CATH COLLECTION *Potey*
 REDUCING SUBSTANCE:
 ICLOTTEST:
 ACETEST:
 3% SSA: *2+*

COLOR/APPEARANCE: <i>yellow haze</i>	PREGNANCY	TECH	DATE TESTED	TIME TESTED	TECH
DATE COLLECTED:	TIME COLLECTED:				<i>mml</i>

06 MAR 30 16:16

*reviewed by
I have
to RT Massey
3/30/06*

CHART COPY

TMH&R of Edgefield 03/01/06

LABORATORY

722-1846

599 MD

S.C. SALINE, M.D.
In. Ch Director

PATIENT ID	
OP	
PATIENT NAME	
PETERSON, WILLIAM	
AGE	SEX
84	M

LABORATORY NUMBER

7117387

DATE DRAWN - TIME

03/31/2006 11:34
DATE RECEIVED - TIME

04/01/2006 11:00
DATE REPORTED

04/07/2006 12:04

EDGEFIELD CO. HOSPITAL
P O BOX 590
EDGEFIELD, SC 29824

ATTN: DR. MASSEY

BT# 000 4 RT# 250

TMHr / Dr. Massey

STATUS	TEST	RESULT	REFERENCE RANGE	UNITS
FINAL				

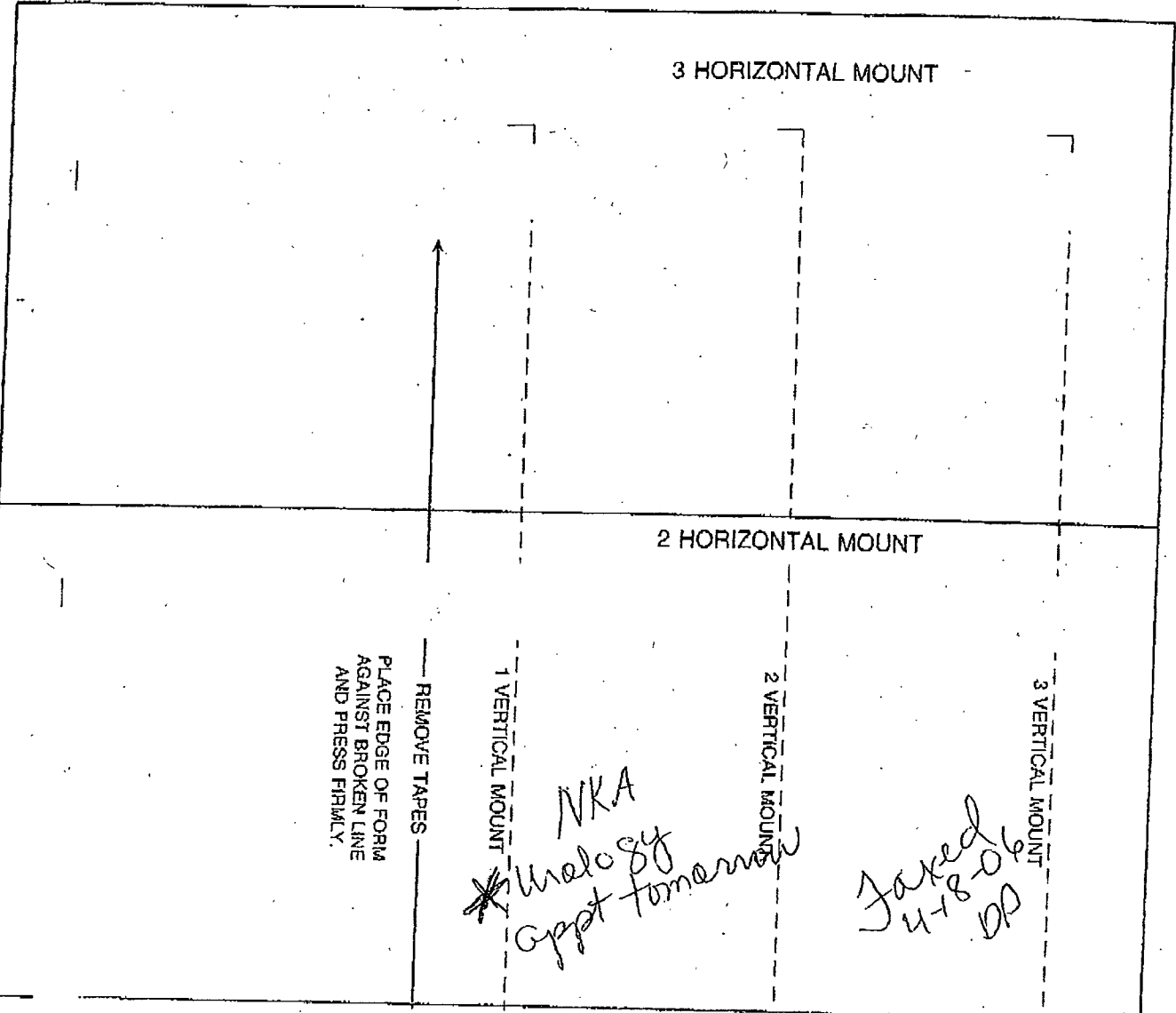
AEROBIC/ANAEROBIC BLOOD CULTURE
REPORT STATUS: FINAL
SOURCE: BLOOD (NO SITE GIVEN)

NO AEROBIC OR ANAEROBIC GROWTH

PLEASE NOTE: SPECIMEN QUANTITY APPEARS TO BE SUBOPTIMAL FOR ADULT BLOOD CULTURE ADD 5-10 ML OF BLOOD TO EACH AEROBIC AND ANAEROBIC BOTTLES.

*** FINAL REPORT ***

*Filed 4-7-06
DD
seen per MD*



EDGEFIELD COUNTY HOSPITAL
300 RIDGE MEDICAL PLAZA
EDGEFIELD, SC 29824
(803) 637-3179

URINALYSIS

Peterson, William

REQUESTED BY:	DATE/TIME:	ORDERING PHYSICIAN: <i>Geophant</i>	DOB: 3-11-1922
GLUCOSE (NEG): <i>Negative</i>	MICROSCOPIC:	WBC/HPF: <i>2</i>	MR # 32912
BILIRUBIN (NEG): <i>Negative</i>	RBC/HPF: <i>3</i>	CASTS/LPF:	<i>TMHR</i>
KETONE (NEG): <i>Negative</i>	MUCOUS:	EPITHELIAL CELLS: <i>2</i>	<input checked="" type="checkbox"/> RANDOM COLLECTION
SP. GRAVITY (1.010-1.030): <i>1.030</i>	BACTERIA: <i>OCC</i>	CRYSTALS: <i>Calcium oxalate & uric acid</i>	<input type="checkbox"/> MID-STREAM COLLECTION
pH (5.0-7.0): <i>5.0</i>	OTHER: <i>None</i>	OTHER: <i>None</i>	<input type="checkbox"/> CATH COLLECTION
PROTEIN (NEG): <i>1</i>	REDUCING SUBSTANCE:	ACETONE: <i>APR 18 7:24</i>	<input type="checkbox"/> REDUCING SUBSTANCE
UROBILINOGEN (0.2-1.0): <i>0.2</i>	ICLOTTEST:	3% SSA:	<input type="checkbox"/> ICLOTTEST
NITRATE (NEG): <i>Negative</i>	PREGNANCY:		<input type="checkbox"/> ACETONE
BLOOD (NEG): <i>Negative</i>			<input type="checkbox"/> 3% SSA
LEUKOCYTES (NEG): <i>Negative</i>			
COLOR/APPEARANCE: <i>Yellow/Cloudy</i>			

CHART COPY

OB

MULLINS PATHOLOGY and CYTOLOGY LABORATORY
1520 NORTH LEG ROAD
AUGUSTA, GEORGIA 30909

(706) 722-1846

S.C. MULLINS, M.D.
Laboratory Director

TRINITY MISSION HEATH & REH
226 W A REEL DR
EDGEFIELD, SC 29824

PATIENT NAME: PETERSON, WILLIAM
PATIENT SEX: MALE
PATIENT AGE: 84
PATIENT ID: [REDACTED]
COLLECTED: 04/18/2006 3:15 AM EDT

REPORTED: 04/18/2006 4:00 PM
ACCESSION: A887775

RECEIVED: 04/18/2006 1:34 PM
REQST PHYS: LEAPHART

TEST	RESULTS	NORMALS
COMPLETE BLOOD COUNT		
WBC	8.0	4.8-10.8 K/uL
RBC	4.07 (L)	4.7-6.1 MILL/uL
HGB	11.6 (L)	14.0-18.0 G/DL
HCT	35.8 (L)	42.0-52.0 %
MCV	87.9	80-100 FL
MCH	28.6	27-33 PG
MCHC	32.5	30-36 G/DL
PLATELET COUNT	431	150-450 K/uL
BASIC METABOLIC PANEL		
GLUCOSE	90	70-110 MG/DL
BUN	32 (H)	5-25 MG/DL
CREATININE	1.5	0-1.5 MG/DL
SODIUM	144	135-145 MEQ/L
POTASSIUM	4.7	3.5-5.5 MEQ/L
CHLORIDE	108	95-110 MEQ/L
CO2	24	22-33 MEQ/L
CALCIUM	8.7	8.5-10.5 MG/DL
BUN/CREATININE	21.3	
ANION GAP	16.7	
OSMOLALITY	304	

*** FINAL REPORT ***

Silverio baby

Prostat 101 30cc TID.

*Faxed
4-19-06
DS*

PETERSON, WILLIAM

Z119563
05/04/2006 14:00
05/05/2006 14:10
05/07/2006 16:00

TRINITY MISSION HEALTH & REH
226 W A REEL DR
EDGEFIELD, SC 29824
ATTN: DR. MASSEY
BT# 000 1 RT# 250

84 [REDACTED] M

ROUTINE (AEROBIC) WOUND CULTURE
REPORT STATUS: FINAL
SOURCE: LEFT HIP

HEAVY GROWTH OF METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS
HEAVY GROWTH OF ENTEROCOCCUS FAECALIS

	S. AUREUS		E. FAECALIS	
AMPICILLIN			2	S
AMP/SULBACTAM	<=4/2	R		
CEFAZOLIN	<=2	R		
CIPROFLOXACIN	>2	R		
CIPROFLOXACIN*			2	I
CLINDAMYCIN	>2	R		
ERYTHROMYCIN	>4	R	>4	R
GENTAMICIN	<=1	S		
METH / OXACILLIN	>2	R		
RIFAMPIN	<=1	S		
PENICILLIN G	>8	R	2	S
TETRACYCLINE	<=1	S		
TRIMETH SULFA	<=0.5/9.5	S		
VANCOMYCIN	<=2	S	<=2	S
GENT SYNERGY**			<=500	S
STREPTOMY SYN**			>1000	R

KEY:

S = SUSCEPTIBLE, I = INTERMEDIATE, R = RESISTANT

* SUSCEPTIBILITY RESULTS OF ANTIBIOTICS MARKED BY AN
ASTERISK APPLY ONLY IF ORGANISM IS ISOLATED FROM THE
URINARY TRACT.

** A SYNERGY RESULT OF S INDICATES THAT SYNERGISTIC
SUSCEPTIBILITY WITH AMPICILLIN OR PENICILLIN IS LIKELY.
A RESULT OF R INDICATES THAT SYNERGISTIC SUSCEPTIBILITY
WITH THESE AGENTS IS NOT LIKELY.

*70xrd to
Eme
5/11/06
P. WATSON JAY*

*** FINAL REPORT ***

EDGEFIELD COUNTY HOSPITAL

RADIOLOGICAL CONSULTATION

Name Peterson, William Date 4/24/06
Pvt. Staff Out Pt

Address TMH&R

Race B Sex M Age 85 L.M.P. _____ Room No. _____

Allergies _____ Bun _____ Creat. _____

CLINICAL DIAGNOSIS (Pertinent History) Cervical Spinal Stenosis

C spine

JD/SS
LS AP/Lat
Findings:

Attending Physician Santiago/ Dr. Beth Cardin

CERVICAL SPINE TWO VIEWS 04-24-06

INDICATION: CERVICAL SPINAL STENOSIS.

TECHNIQUE: AP and lateral views without comparison.

FINDINGS: There is evidence of previous anterior spinal fusion at the C5-C7 levels with metallic plate bridging these levels anteriorly and attached to the contiguous vertebral bodies with threaded screws. No mal-alignment is detected. There is diffuse degenerative change with marginal osteophyte formation and posterior osteophytic ridging as well as loss of the C2-3, C3-4, and C4-5 levels. No vertebral collapse or destructive lesions are identified.

IMPRESSION: DIFFUSE HYPERTROPHIC DEGENERATIVE CHANGE AND MULTI-LEVEL DEGENERATIVE DISC DISEASE. STATUS POST ANTERIOR CERVICAL FUSION AT THE C5-C7 LEVELS WITH NO MAL-ALIGNMENT DETECTED.

X-ray No. 28564 Signed WJ

Faxed
4-24-06
DS

Date 04-24-06/gc William C Bruker Jr M.D.

Radiologist Edgefield County Hospital, Edgefield, S.C.
*Preliminary Report Until Signed

EDGEFIELD COUNTY HOSPITAL

RADIOLOGICAL CONSULTATION

Name Peterson, William Date 3/30/06
 Pvt. () Staff () Out Pt. ()
 Address TMH&R
 Race B Sex m Age 85 L.M.P. _____ Room No. _____
 Allergies _____ Bun _____ Creat. _____
 CLINICAL DIAGNOSIS (Pertinent History) ↑ Temp Chest Xray

Findings: 35 IV Attending Physician Massey, Tami

CHEST ONE VIEW 03-30-06

*Janed
3-31-06
DD*

INDICATION: ELEVATED TEMPERATURE

TECHNIQUE: ERECT AP VIEW

COMPARISON: 04-23-05

FINDINGS: The heart is not enlarged and the pulmonary vasculature is unremarkable. The lungs are well aerated and no air space consolidation, mass, or pleural effusion is identified. There is mild accentuation of interstitial markings taken to represent chronic change and an element of pulmonary fibrosis. Thoracic spondylosis is noted and there is evidence of previous multi-level anterior cervical fusion and plating.

IMPRESSION: NO ACUTE CARDIOPULMONARY DISEASE.

X-ray No. 28564 Signed W3

Date 03-31-06/gc William C Bruker Jr M., D.
 Radiologist Edgefield County Hospital, Edgefield, S. C.

21.19

Physical Therapy Plan of Treatment

Part A | Part B | Other

ASSESSMENT/INITIAL PLAN OF TREATMENT

Patient's Last Name <i>Petersen</i>	First Name <i>WYATT</i>	M.I.	Provider No. 425293	HICN
Provider Name Edgefield Health Care Center	Medical Record No. (Optional) 1050	Onset Date 3-7-06	SOC Date 3/23/06	
Type PT	Primary Diagnosis (Pertinent Medical Dx & ICD-9) <i>acute neural Enflm, spinal stenosis, radiculopathy</i>	Treatment Diagnosis & ICD-9 <i>12310 MUSCLE WEAKNESS 728.87</i>		

Initial Assessment/Functional Goals			Prior Functional Level
Age 84	Gender M	Prior Hospitalization from 3-7-06 to 3-	<i>previously @ to all ADL's - in kitchen, lined alone, @ 4</i>
Prior Medical History/Therapy <i>acute neural Enflm, spinal stenosis, radiculopathy, slip mt discectomy & fusion 3/14/06</i>			

Reason for Referral <i>weakness, risk of contracture</i>	Tests Administered <i>sluggish, poor status agms, sluggish, unable</i>	<input checked="" type="checkbox"/> Balance (99)	<input checked="" type="checkbox"/> ROM (94)	Rehab Potential <i>Fair to good</i>
---	---	--	--	--

B4 COGNITIVE SKILLS	<input checked="" type="checkbox"/> Moderately Impairment	DEVICES & RESTRAINTS <i>bed rails</i>	Precautions <i>Fall risk, skin breakdown risk @ vt 70-4 min</i>
<input type="checkbox"/> No Impairment	<input type="checkbox"/> Moderately Severe Imp.		
<input type="checkbox"/> Very Mild Imp.	<input type="checkbox"/> Severe Impairment		
<input type="checkbox"/> Mild Impairment	<input type="checkbox"/> Very Severe Impairment		

ADL FUNCTION	Current		STG 2 wks		LTG 7 wks		Performance and Support Scale
	Performance	Support	Performance	Support	Performance	Support	
G1a Bed Mobility-turning	8.5	2	2.0	2	1	2	Performance: 0-Independent; 1-Supervision; 2-Limited Asst.(-); 2.5-Limited Asst.(+); 3-Extensive Asst.(-); 3.5-Extensive Asst.(+); 4-Total Dependence; 5-Did not occur/Not tested Support: 0-No assistance; 1-Setup/Verbal cues; 2-One person assist; 3-Two(+) person assist; 4-Did not occur/Not tested
G1a Bed Mobility-repositioning	9	2	3.5	2	3	2	
G1b Transfer-bed->chair	4	2	3.5	2	3	2	
G1b Transfer-sit->stand	8	8	4	2	3.5	2	
G1c Walk in Room	8	8	-	-	-	-	
G1d Walk in Corridor	8	8	-	-	-	-	
G1e Locomotion on Unit <i>(mode) w/c</i>	8	8	-	-	-	-	
G1f Locomotion off Unit <i>(mode)</i>			1				

OTHER
pt cannot maintain fair sitting & max DKL, must stand & transfer. transfer of & mr @ vt, need room, shakily to @ 2B to in and prevent contractions

SKIN CONDITION (wounds, pain/edema, sensation)
no open area. you receive sun @ heel.

Plan of Treatment	<input checked="" type="checkbox"/> 97110 Therapeutic Exercises	<input type="checkbox"/> 97032 E-stim	<input type="checkbox"/> 97022 Whirlpool
	<input type="checkbox"/> 97116 Gait Training	<input type="checkbox"/> 97112 Neuromuscular Re-education	<input type="checkbox"/> 97150 Group Therapy
	<input checked="" type="checkbox"/> 97542 Wheelchair Mgmt/Propulsion	<input checked="" type="checkbox"/> 97630 Therapeutic Activities	<input checked="" type="checkbox"/> ROM/stretches @ vt's

Freq/Duration (e.g. 3/wk X 4 wks) <i>3-5 x/wk for 30 day</i>	Signature/Date (professionals establishing POC including prof. designation) <i>John Miller PT 3/23/06</i>
---	--

I CERTIFY THE NEED FOR THESE SERVICES FURNISHED UNDER THIS PLAN OF TREATMENT AND WHILE UNDER MY CARE

Certification	Physician Signature <i>[Signature]</i>	Date <i>3/23/06</i>
---------------	---	------------------------

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 084
from 3/23/06 to 4/22/06

Midlands

Prosthetics & Orthotics

William Peterson
Aiken Editor

204D

607-

Physical Therapy Updated Plan of Progress

Part A | Part B | Other

REASSESSMENT/UPDATED PLAN OF TREATMENT

Patient's Last Name Peterson	First Name William	M.I. M.I.	Provider No. 425293	HICN [REDACTED]
Provider Name Edgefield Health Care Center	Medical Record No. (Optional) 1050	Onset Date 3-7-06	SOC Date 3-23-00	
Type PT	Primary Diagnosis (Pertinent Medical Dx) & ICD-9 acute renal failure 723.01	Treatment Diagnosis & ICD-9 muscle weakness 728.81		

Performance and Support Scale:
 Performance: 0-Independent; 1-Supervisor; 2-Limited Asst.(-); 2.5-Limited Asst.(+); 3-Extensive Asst.(-); 3.5-Extensive Asst.(+); 4-Total Dependence; 5-Did not occur/Not tested
 Support: 0-No assistance; 1-Setup/Verbal cues; 2-One person assist; 3-Two (+) person assist; 5-Did not occur/Not tested

G	ADL FUNCTION	Previous		Current		STG <u>4</u> wks		LTG <u>2</u> wks		F4 DEVICES & RESTRAINTS
		Performance	Support	Performance	Support	Performance	Support	Performance	Support	
G1a	Bed Mobility-turning	2.5	2	3.5	3.5	3	3	2.5	2.5	geri chair rails ↑ Rehab Potential poor to fair only
G1b	Bed Mobility-repositioning	4	2	3.5	3.5	3	3	2.5	2.5	
G1c	Transfer-bed->chair	4	2	3.5	3.5	3	3	2.5	2.5	
G1d	Transfer-sit->stand	8	8	4.8	8	3.5	3.5	3	3	
G1e	Walk in Room	8	8	8	8	8	8	8	8	
G1f	Walk in Corridor	8	8	8	8	8	8	8	8	
G1g	Locomotion on Unit (mode)	8	8	8	8	8	8	8	8	
G1h	Locomotion off Unit (mode)	8	8	8	8	8	8	8	8	

REASONS FOR CONTINUING TREATMENT

Pt is positioned in geri chair during the day when OOB. He is followed for wound care (start by P.T. 4/20/06). Dip c panafil for lysis of eschar & cover c optifoam dressing. wound measures 4cm x 4.3cm & granulation & odor minimal drainage-clear unable to stage 2° to thick eschar

SKIN CONDITION (wounds, pain/edema, sensation)

Plan of Treatment

- | | | |
|--|--|---|
| <input checked="" type="checkbox"/> 97110 Therapeutic Exercises | <input type="checkbox"/> 97032 E-stim | <input type="checkbox"/> 97022 Whirlpool |
| <input type="checkbox"/> 97116 Gait Training | <input type="checkbox"/> 97112 Neuromuscular Re-education | <input type="checkbox"/> 97150 Group Therapy |
| <input checked="" type="checkbox"/> 97542 Wheelchair Mgmt/Propulsion | <input checked="" type="checkbox"/> 97530 Therapeutic Activities | <input checked="" type="checkbox"/> ROM stretch (BLE's) |

qd/Duration (a.p. 2wks x 1 wk)
3-5 1/wk x 30 days

Signature/Date (professional establishing POC including prof. designation)
Elise Faulkner PT 4/21/06

I CERTIFY THE NEED FOR THESE SERVICES FURNISHED UNDER THIS PLAN OF TREATMENT AND WHILE UNDER MY CARE

Recertification: from **4/21/06** to **5/20/06**
 TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 086
 Physician Signature: **[Signature]** Date: **4/21/06**

P.T. Therapy
Weekly Progress Notes

1. Patient Name Peterson, William Physician B Gardner MR# 1050
2. Patient Input/Communication: "doing pretty well today"

3. Patient Training/Education: Ø

4. Progress to Goals:
Dx: ARE, spinal stenosis, rhabdomyelysis.

STG	Goal	Current
Bed mobility - turn	2.0	2.5
Bed mobility - reposit	3.5	2.5
Transfer bed to chair	3.5	4
Transfer sit to stand	4	4
Gait	non amb	non amb.

Nursing service transfers pt via Hoyer. Unable to tolerate wgt on feet, inadequate strength in LE's. Rec'd high back W/C for trunk stability, attempt W/C mobility training to get them out of bed.

5. Communication with other disciplines: _____

6. Family Communication: _____

7. Current Functional Status/Assessment: as above

8. Plan/Therapeutic Focus: continue rehab efforts

9. Referral to other disciplines: _____

10. Signature: Elvie Faulkner PT Date: 4/7/06

P.T. Therapy
Weekly Progress Notes

1. Patient Name Peterson, William Physician Massey MR# 1050

2. Patient Input/Communication: Ø

3. Patient Training/Education: Ø

4. Progress to Goals:

<u>ADL Function</u>	<u>Performance</u>	<u>Support</u>
	3.5	3.5
<u>Bed Mobility - turning</u>	3.5	3.5
<u>Bed Mobility - Repositioning</u>	3.5	3.5
<u>Transfer - Bed - chair</u>	4	4
<u>Transfer - Sit -> stand</u>	4	4
<u>Locomotion (Device)</u>		<u>Wheel - chair</u>

Pt has poor sitting balance, endurance is poor along w/ poor strength

5. Communication with other disciplines: Ø

6. Family Communication: Ø

7. Current Functional Status/Assessment: Being look at for wound care. Pt grimace during repositioning

8. Plan/Therapeutic Focus: Cont per POC

9. Referral to other disciplines: Ø

10. Signature: Connie Parker, PTA Date 04/20/06

PHYSICAL THERAPY DAILY RECORD OF TREATMENT

Name Peterson William	HIC# [REDACTED]	Onset Date of PT Tx. Diagnosis 3-7-06	Month: March 2006
Primary Diagnosis Incl. ICD-9 Code Acute renal failure	PT Treatment Diagnosis Incl. ICD-9 Code muscle weakness 728.87	Date of first PT Treatment 3-23-06	Payor Source (Medicare A, Private Pay, etc.) Med. A

Therapist Signature	Title	Therapist Signature	Title	Therapist Signature	Title	Therapist Signature	Title
<i>Connie Parker</i>	PTA						
<i>[Signature]</i>	PT						

HCPCS	Description	Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total	
97001	Physical Therapy Evaluation (untimed)	Units																																	1
		Min.																																	
97110	Therapeutic Exercise (15 minutes)	Units																																	
		Min.																																	
97112	Neuromuscular Reeducation (15 minutes)	Units																																	
		Min.																																	
97116	Gait Training (15 minutes)	Units																																	
		Min.																																	
97530	Therapeutic Activities (15 minutes)	Units																																	2
		Min.																																	30
	Wound Care, Selective Debridement (untimed)	Units																																	
		Min.																																	
		Units																																	
		Min.																																	
		Units																																	
		Min.																																	
		Units																																	
		Min.																																	
Initials of treating therapist																																			

If more than one therapist treats a patient in a given day, the treatment should be entered and initialed separately in one of the bottom sections of the grid. Part B treatment grids are to be reviewed by the DOT and turned in to the facility BOM weekly and at the end of the calendar month. Therapists should thoroughly review the Therapy Coding Manual for appropriate CPT and ICD-9 coding.

-610-

PH 87 of Edgefield 03/21/2006 - 05/25/2006 - 089

PHYSICAL THERAPY DAILY RECORD OF TREATMENT

-611-

Name Peterson, William	HIC# [REDACTED]	Onset Date of PT Tx, Diagnosis 3-7-06	Month: April 2006
Primary Diagnosis Incl. ICD-9 Code Acute renal failure 723.0	PT Treatment Diagnosis Incl. ICD-9 Code muscle weakness 728.87	Date of first PT Treatment 3-23-06	Payor Source (Medicare A, Private Pay, etc.) Med A

Therapist Signature	Title	Therapist Signature	Title	Therapist Signature	Title	Therapist Signature	Title
Connie Parker	PTA						
Eliou Foullon	PT						

HCPCS	Description	Date	Date																													Total			
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29		30	31	
97001	Physical Therapy Evaluation (untimed)	Units																																	
		Min																																	
97110	Therapeutic Exercise (15 minutes)	Units																																	
		Min																																	
97112	Neuromuscular Reeducation (15 minutes)	Units																																	
		Min																																	
97116	Gait Training (15 minutes)	Units																																	
		Min																																	
97530	Therapeutic Activities (15 minutes)	Units			2	2	2			11	2	2	2	2	2			2	2		2													23	
		Min			30	30	30			150	30	30	30	30	30			30	30		30													345	
97597	Wound Care, Selective Debridement (untimed)	Units																						1			1	1	1	1			6		
		Min																						30			30	30	30	30	30			180	
		Units																																	
		Min																																	
		Units																																	
		Min																																	
		Units																																	
		Min																																	
Initials of treating therapist					CP	CP	CP			E	CP	CP	CP	CP	CP			CP	CP	CP							CP	CP	CP	CP	CP				

TJH & R. Edgfield 03/27/2006 - 05/25/2006 - 090

If more than one therapist treats a patient in a given day, the treatment should be entered and initialed separately in one of the bottom sections of the grid. Part B treatment grids are to be reviewed by the DOT and turned in to the facility BOM weekly and at the end of the calendar month. Therapists should thoroughly review the Therapy Coding Manual for appropriate CPT and ICD-9 coding.

PHYSICAL THERAPY DAILY RECORD OF TREATMENT

-612-

<i>Name</i> Peterson William	<i>HIC #</i> [REDACTED]	<i>Order Date of PT Tx. Diagnosis</i> 3-7-06	<i>Month:</i> May 2006
<i>Primary Diagnosis Incl. ICD-9 Code</i> Acute renal failure	<i>PT Treatment Diagnosis Incl. ICD-9 Code</i> muscle weakness 728.87	<i>Date of first PT Treatment</i> 3-23-06	<i>Payor Source (Medicare A, Private Pay, etc.)</i> Med A

Therapist Signature	Title	Therapist Signature	Title	Therapist Signature	Title	Therapist Signature	Title
<i>John Nelson</i>	PT						
<i>Connie Parker</i>	PTA						

HCPCS	Description	Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total	
97001	Physical Therapy Evaluation (un timed)	Units																																	
		Min.																																	
97110	Therapeutic Exercise (15 minutes)	Units																																	
		Min.																																	
97112	Neuromuscular Reeducation (15 minutes)	Units																																	
		Min.																																	
97116	Gait Training (15 minutes)	Units																																	
		Min.																																	
97530	Therapeutic Activities (15 minutes)	Units																																	
		Min.																																	
	Wound Care, Selective Debridement (un timed)	Units	1	1	1	1	1				1	1	1	1				1																10	
		Min.	30	30	30	30	30				30	30	30	30				30																	300
		Units																																	
		Min.																																	
		Units																																	
		Min.																																	
<i>Initials of treating therapist</i>			CP	CP	CP	CP	CP				CP	CP	CP	CP				CP																	

JWH&P of Edgefield 03/21/2006 05/25/2006 - 091

If more than one therapist treats a patient in a given day, the treatment should be entered and initialed separately in one of the bottom sections of the grid. Part B treatment grids are to be reviewed by the DOT and turned in to the facility BOM weekly and at the end of the calendar month. Therapists should thoroughly review the Therapy Coding Manual for appropriate CPT and ICD-9 coding.

Physical Therapy Discharge Summary

4-1813-

Part A

Part B

Other

DISCHARGE SUMMARY

Patient's Last Name <i>Peterson</i>	First Name <i>W. TAM</i>	M.I.	HICN	SOC Date <i>3/23/06</i>
Type <i>PT</i>	Medical Record No. (Optional)	Onset Date <i>3/17/66</i>	Total Visits <i>34</i>	

ADL FUNCTION	At Evaluation		At Discharge	
	Performance	Support	Performance	Support
G1a Bed Mobility-turning	2.5	2	3.5	3
G1a Bed Mobility-repositioning	4	2	3.5	3
G1b Transfer-bed<->chair	4	2	3.5	3
G1b Transfer-sit<->stand	8	8	4	4
G1c Walk in Room	8	8	8	8
G1d Walk in Corridor	8	8	8	8
G1e Locomotion on Unit (mode) <i>u/c</i>	8	8	8	8
G1f Locomotion off Unit (mode)	8	8	8	8

Performance and Support Goals:
 Performance: 0-Independent; 1-Supervisory; 2-Limited Asst. (-);
 2.5-Limited Asst. (+); 3-Extensive Asst. (-); 3.5-Extensive Asst. (+);
 4-Total Dependence; 8-Did not occur/Not tested
 Support: 0-No assistance; 1-Setup/Verbal cues;
 2-One person assist; 2-Two (+) person assist;
 8-Did not occur/Not tested

1A SKIN CONDITION (wounds, pressure ulcers, sensation)

③ heel (4cm) wound
 ④ leg
 4/12/06

Reason for Referral
weakness, risk of contractures

Reason for Discharge/Summary of Progress

*pt. has regressed from ambulation
 progress is bed mobility/dressing/undressing
 pt remains dependent for hygiene/transf.*

Signature/Date
[Signature] 5/13/06

PLAN OF TREATMENT FOR OUTPATIENT REHABILITATION (COMPLETE FOR INITIAL CLAIMS ONLY)

614

Patient's Last Name: **Tolre** | First Name: **William** | M. | Provider No.: **425013** | HIGH [redacted]
 Provider Name: **TMH&R** | Medical Record No. (Optional): | Onset Date: **3/6/06** | SOC Date: **3/31/06**

Primary Diagnosis (Pertinent Medical Dx): **Muscle Weakness General** | Treatment Diagnosis: **Dysphagia**

Initial Assessment/Functional Goals: | Prior Functional Level: **Feeder**
ST

Age: **84** | Gender: **M** | Prior Hospitalization from: **3/6/06 to 3/31/06**
 Prior Medical History/Therapy: **Cervical spinal stenosis, Malaise & fatigue, Senile Dementia Uncomp.**

Reason for Referral: **was on pump, eval. for safety on MS** | Tests Administered: **Informal Assessment** | Rehab Potential: **Good**

B4 COGNITIVE SKILLS: No Impairment | Moderately Impairment, Moderately Severe Imp., Severe Impairment, Very Severe Impairment
 C2 COMMUNICATION DEVICES: **N/A** | Precautions: **aspiration & weight**

C4 MAKING SELF UNDERSTOOD: Understood | Usually Understood, Sometimes Understood, Rarely/Never Understood
 C5 SPEECH CLARITY: Clear Speech | Unclear Speech, No Speech
 C7 RECENT CHANGE: Improved | No Change, Deteriorated

C6 ADL FUNCTION: Current STG **4** wks, LTG **8** wks
 Eating: Performance **2**, Support **2** | Performance **1**, Support **1** | Performance **0**, Support **0**

K&L ORAL/NUTRITIONAL/DENTAL STATUS: **Pt. is edentulous, tolerated MS snack & S/S aspiration. OFN tasks yielded adequate for chewing/swallowing MS. Pt. was oriented to name, not location or date. Pt. was alert. Compensatory strategies used safe swallow function.**

OTHER: **Rec. diet to continue on MS. Rec. skilled ST services to ↑ safe swallow function on MS & to ↑ PO intake.**

Plan of Treatment: 92507 Speech/hearing therapy | 92526 Oral function therapy | G0198 Training for speech generating device | G0201 Modification/training for voice prosthetic device | Other

sig/Duration (e.g. 3wks x 4 wks): **10 visits x 4 wks.** | Signature/Date (professional establishing POC including prof. designation): **Matthew J. Wilson, MA, CCC-SLP**

I CERTIFY THE NEED FOR THESE SERVICES FURNISHED UNDER THIS PLAN OF TREATMENT AND WHILE UNDER MY CARE
 Certification: **TMH&R of Edgefield** | from: **3/31/06 to 4/30/06** | Date: **4-13-06**

Safe Swallow Precautions

Patient Name: William Peterson

PLEASE FOLLOW THE CIRCLED INSTRUCTIONS:

1. Seat patient upright.
2. Drape patient with extra towels.
3. Stand on the patient's weaker side (R/L) to feed him and turn his head toward the weaker side.
4. Give patient small bites (half a spoonful).
5. Allow extra time between bites (at least 10 seconds).
6. Alternate cold food (Italian Ice) between bites of other foods.
7. Encourage patient to take small bites.
8. Lower chin before swallow.
9. Dry swallow after each swallow to clear pooling.
10. Use _____ thick liquids only.
11. Give liquids by spoon/straw/cup only.
12. Encourage patient to cough if he chokes.
13. Discontinue feeding if patient continues to choke.
14. Leave patient upright 20-30 minutes after completion of meal.
15. Alternate solid/liquid presentation. (Give bite of food, then sip of liquid.)
16. Be sure the mouth is clear of food at completion of meal. Encourage the patient to swallow any pocketed food or remove it from mouth.

DATE PLAN OF PROGRAMS FOR OUTPATIENT REHABILITATION

Patient's Last Name Peterson	Name William	Provider No. 425293	HICN [REDACTED]
Provider Name TMH&R	Medical Record No. (Optional)	Onset Date 3/6/06	SOC Date 3/31/06

Type ST	Primary Diagnosis (Pertinent Medical Dx) Muscle Weakness General 708.87	Treatment Diagnosis Dysphagia. 187.2
B4 COGNITIVE SKILLS	<input type="checkbox"/> Moderately Impairment. <input type="checkbox"/> Moderately Severe Imp. <input checked="" type="checkbox"/> Very Mild Imp. <input type="checkbox"/> Mild Impairment	C5 SPEECH <input checked="" type="checkbox"/> Clear Speech CLARITY <input type="checkbox"/> Unclear Speech <input type="checkbox"/> No Speech C2 COMMUNICATION DEVICES N/A
C6 ABILITY TO UNDERSTAND OTHERS	<input type="checkbox"/> Understands <input checked="" type="checkbox"/> Usually Understands <input type="checkbox"/> Sometimes Understands <input type="checkbox"/> Rarely/Never Understands	K&L ORAL/NUTRITIONAL/DENTAL STATUS Feeder Pureed Ederulous
C4 MAKING SELF UNDERSTOOD	<input checked="" type="checkbox"/> Understood <input type="checkbox"/> Usually Understood <input type="checkbox"/> Sometimes Understood <input type="checkbox"/> Rarely/Never Understood	

Performance and Support Scales:
 Performance: 0-Independent; 1-Supervision; 2-Limited Assl.(-); 2.5-Limited Assl.(+); 3-Extensive Assl.(-); 3.5-Extensive Assl.(+); 4-Total Dependence; 8-Did not occur/Not tested
 Support: 0-No assistance; 1-Setup/Verbal cues; 2-One person assist; 3-Two(+) person assist; 8-Did not occur/Not tested

ADL FUNCTION	Previous	Current	STG <u>4</u> wks	LTG <u>8</u> wks	Rehab Potential
	Performance Support	Performance Support	Performance Support	Performance Support	
g Eating	<u>2</u> <u>2</u>	<u>2</u> <u>2</u>	<u>1</u> <u>1</u>	<u>0</u> <u>0</u>	food

REASONS FOR CONTINUING TREATMENT

Pt. exhibits ↓ d old skills but responds to tactile + verbal cuing. Pt. will also tolerate T'd po intake + encouragement + training + compensatory strategies.

Skilled ST + recommended + the following goals:

- 1) Pt. will consume pureed + T'd po intake by utilizing compensatory strategies (lingual sweep, alternate solids/liquids, double swallow).
- 2) Pt. will perform old ex. 10/10 to ↑ old strength + coordination for swallowing.
- 3) Staff training/instruction for safe swallowing techniques + compensatory strategies.

Plan of Treatment

<input type="checkbox"/> 92507 Speech/hearing therapy	<input type="checkbox"/> GO188 Training to speech generating device	<input type="checkbox"/> Other _____
<input checked="" type="checkbox"/> 92526 Oral function therapy	<input type="checkbox"/> GO201 Modification/training for voice prosthetic device	

Freq/Duration (e.g. 3wks X 4 wks) **5/1/06 ^{encl} 1WK1**

Signature/Date (professional establishing POC including prof. designation)
Maureen J. Wilton, MA, CM-RP 5/3/06

I CERTIFY THE NEED FOR THESE SERVICES FURNISHED UNDER THIS PLAN OF TREATMENT AND WHILE UNDER MY CARE

Recertification Physician Signature **Mason** Date _____

from **5/1/06** to **5/31/06** TMH&R of Edgfield 03/21/2006 - 05/25/2006 - 095

Rehabilitation Services Progress Report

Date	Disc.	Notes
3/31/06	ST	Pt. seen for bedside dysphagia evaluation on this date. Please see eval. report for further details. Martha J. Wilder, MA, LLC STP
4/3/06	ST	Pt. tolerated MS snack & SIS application. Compensatory strategies were established to ↑ pt intake & safe swallowing in function (lingual sweep, alternate solids & liquids). Ofln ex. to strengthen oral musculature yielded 80% acc. & verbal, tactile, and visual cues needed. Continue POC. Martha J. Wilder, MA, LLC STP
4/19/06	ST	Pt. is now on pureed diet & vid po intake. Pt. needed encouragement to eat 3oz of 4oz pureed snack. Pt. continues to be a feeder to ↑ po intake. VCs were needed to perform compensatory strategies (lingual sweep). Alternate, lig. & solids were provided. Pt. encouraged to request liquids during meals. Ofln ex. yielded 69% acc. Pt. produced a weak cough. Pt. needed tactile, verbal & visual cues for lingual excursions. Cont. POC. Martha J. Wilder, MA, LLC STP
4/26/06	ST	Pt. seen in p.m. at bedside for tx. & focus on dysphagia. Pt. tolerated pureed snack. Consumed 20% of solid & tolerated thin lig. & SIS application. Pt. needed 100% verbal & tactile cues for compensatory strategies (lingual sweep, double swallow). Pt. needed 100% tactile VCs for ofln ex. = lingual elevation, depression, retraction. Pt. produced 1K words & good contact. He averaged 3 seconds & falsetto ex. Pt. had a weak cough and a functional throat clearing. Pt. was oriented 2 of 5. Pt's po intake continues to be vid. He is receiving Magic Cues. It is rec. that skilled ST services continue to ↑ oral musculature to ↑ safe swallowing function & to ↑ po intake. Martha J. Wilder, MA, LLC STP
5/3/06	ST	Pt. seen in p.m. at bedside for tx. & focus on dysphagia. Pt. tolerated pureed snack of apple sauce, consuming 100% (4oz). No SIS application. ^{1st for comp. strategy} Ofln ex. yielded weak lingual elevation, back of tongue retracts. Pt. produced weak cough, good throat clearing. Tactile cues needed for lingual lateralization. Pt. was 2 sec. average for lingual protrusion. CNAs in-service in compensatory strategies. Pt. fatigued. Pt. was alert & some confusion. Cont. POC. Martha J. Wilder, MA, LLC STP

Resident Name William Peterson

Room # 214D

Physician Massey

Rehabilitation Services Progress Report

Date	Disc.	Notes
5-11-06	ST	Pt. seen @ bedside @ pm. Pt. Consumed 100% pureed snack (apple sauce - 4oz.) VLS needed for comp. strategies (lingual sweep, double swallow) Cons. c 100% re pt's apple sauce. An order for apple sauce to be provided at each meal was made. CNAs in-service to feed him desired snack & to give him time to eat. OLM ex. yielded 50% acc. for lingual protrusion, 70% acc. for lip purse/retraction, averaged 6 seconds for falsetto ex. Pt. yielded weak effort c grasping BOT ex. An appetite stimulant was tried, however, NG reports that this is not working. Cont. c above rec.
5-17-06	ST	ODF (Hospital) Martha J. Wilkins, MSW
5-22-06	ST	ODF (Hospital) Martha J. Wilkins, MSW
6-1-06	ST	ODF (Hospital) Martha J. Wilkins, MSW

Resident Name *Peterson, William*

Room # *214D*

Physician *Messing*

Speech Therapy/Dysphagia Therapy Daily Record of Treatment

-620-

Name <i>William Peterson</i>	HIC# <i>[Redacted]</i>	Date of ST Tr. Diagnosis <i>3-6-06</i>	Month: <i>March 2006</i>
Primary Diagnosis Incl. ICD-9 Code <i>Muscle weakness 728.57</i>	ST Treatment Diagnosis Incl. ICD-9 Code <i>Dysphagia 157.2</i>	Date of first ST Treatment <i>3-31-06</i>	Payor Source (Medicare "A", Private Pay, etc.) <i>MedA</i>

Therapist Signature <i>Michael J. Edgerfield</i>	Title <i>CCC-SLP</i>	Therapist Signature	Title	Therapist Signature	Title	Therapist Signature	Title
---	-------------------------	---------------------	-------	---------------------	-------	---------------------	-------

HCPCS	Description	Date	Days of Month																															Total			
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31				
92506	Evaluation of Speech Status (<i>15 minutes</i>)	Units																																			
		Mins																																			
92507	Treatment of Speech Function (<i>15 minutes</i>)	Units																																			
		Mins																																			
92508	Group Treatment, Speech only (<i>15 minutes</i>)	Units																																			
		Mins																																			
92610	Evaluation of Swallowing (<i>15 minutes</i>)	Units																																			
		Mins																																			1
92526	Treatment of Swallowing (<i>15 minutes</i>)	Units																																			
		Mins																																			15
97532	Cognitive Skills (<i>15 minutes</i>)	Units																																			
		Mins																																			3
97110	Therapeutic Exercise Speech only (<i>15 minutes</i>)	Units																																			
		Mins																																			45
		Units																																			
		Mins																																			
		Units																																			
		Mins																																			
Initials of treating therapist																																				<i>MJE</i>	

If more than one therapist treats a patient in a given day, the treatment should be entered and initialed separately in one of the bottom sections of the grid. Therapists should thoroughly review the Therapy Coding Manual for appropriate CPT and ICD-9 coding.

-05/25/2006 - 099
TMR of Edgerfield 03/21/2006

Speech Therapy/Dysphagia Therapy Daily Record of Treatment

-621-

Name <i>William Peterson</i>	HIC# [REDACTED]	Date of ST Tx. Diagnosis <i>3-6-06</i>	Month: <i>April 2006</i>
Primary Diagnosis Incl. ICD-9 Code <i>Muscle Weakness 728.57</i>	ST Treatment Diagnosis Incl. ICD-9 Code <i>Dysphagia 1870</i>	Date of first ST Treatment <i>3-31-06</i>	Payor Source (Medicare "A", Private Pay, etc.) <i>medA</i>

Therapist Signature	Title	Therapist Signature	Title	Therapist Signature	Title	Therapist Signature	Title
<i>Martha J. Wilder</i>	<i>MSL-Ed</i>						

HCPCS	Description	Date	Days of Month																												Total				
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28		29	30	31	
92506	Evaluation of Speech Status (untrained)	Units																																	
		Min																																	
92507	Treatment of Speech Function (untrained)	Units																																	
		Min																																	
92508	Group Treatment, Speech only (untrained)	Units																																	
		Min																																	
92610	Evaluation of Swallowing (untrained)	Units																																	
		Min																																	
92526	Treatment of Swallowing (untrained)	Units				1															1													3	
		Min				20															15													30	
97532	Cognitive Skills (15 minutes)	Units																																	
		Min																																	
97110	Therapeutic Exercise Speech only (15 minutes)	Units				1															1													5	
		Min				15															15														45
		Units																																	
		Min																																	
		Units																																	
		Min																																	
Initials of treating therapist																																			

If more than one therapist treats a patient in a given day, the treatment should be entered and initialed separately in one of the bottom sections of the grid. Therapists should thoroughly review the Therapy Coding Manual for appropriate CPT and ICD-9 coding.

JMH & R of Edgewater 03/21/2006 - 05/25/2006 - 0100

Occupational Therapy Discharge Summary

Part A	Part B	Other																																																			
Patient's Last Name <i>Peterson</i>	First Name <i>William</i>	M.I. <i>C</i>	SOC Date <i>3-23-06</i>																																																		
Type <i>OT</i>	Medical Record No. (Optional) <i>1050</i>	Onset Date <i>3-7-06</i>	Total Visits																																																		
G ADL FUNCTION <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th colspan="2">At Evaluation</th> <th colspan="2">At Discharge</th> </tr> <tr> <th></th> <th>Performance</th> <th>Support</th> <th>Performance</th> <th>Support</th> </tr> </thead> <tbody> <tr> <td>G1a Bed Mobility-turning</td> <td>4</td> <td>2</td> <td>3</td> <td>2</td> </tr> <tr> <td>G1a Bed Mobility-repositioning</td> <td>4</td> <td>2</td> <td>3</td> <td>2</td> </tr> <tr> <td>G1g Dressing-upper body</td> <td>4</td> <td>2</td> <td>3</td> <td>2</td> </tr> <tr> <td>G1g Dressing-lower body</td> <td>4</td> <td>2</td> <td>3</td> <td>2</td> </tr> <tr> <td>G1h Eating</td> <td>3</td> <td>2</td> <td>1</td> <td>2</td> </tr> <tr> <td>G1i Toilet Use</td> <td>3</td> <td>2</td> <td>1</td> <td>2</td> </tr> <tr> <td>G1i Toilet Transfers</td> <td>3</td> <td>2</td> <td>1</td> <td>2</td> </tr> <tr> <td>G1j Personal Hygiene</td> <td>3</td> <td>2</td> <td>1</td> <td>2</td> </tr> </tbody> </table>			At Evaluation		At Discharge			Performance	Support	Performance	Support	G1a Bed Mobility-turning	4	2	3	2	G1a Bed Mobility-repositioning	4	2	3	2	G1g Dressing-upper body	4	2	3	2	G1g Dressing-lower body	4	2	3	2	G1h Eating	3	2	1	2	G1i Toilet Use	3	2	1	2	G1i Toilet Transfers	3	2	1	2	G1j Personal Hygiene	3	2	1	2	Performance and Support Scale: Performance: 0-Independent; 1-Supervision; 2-Limited Asst.(-); 2.5-Limited Asst(+); 3-Extensive Asst.(-); 3.5-Extensive Asst.(+); 4-Total Dependence; 5-Did not occur/Not tested Support: 0-No assistance; 1-Setup/Verbal cues; 2-One person assist; 3-Two(+) person assist; 5-Did not occur/Not tested	
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G2 Bathing (not including back or hair) <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Performance</th> <th>Support</th> </tr> </thead> <tbody> <tr> <td></td> <td>4</td> <td>2</td> </tr> </tbody> </table>			Performance	Support		4	2	M SKIN CONDITION (wounds, edema, sensation, splints, etc.) <i>see ASG assessment</i>																																													
	Performance	Support																																																			
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B4 COGNITIVE SKILLS <small>(compare evaluation results to discharge status)</small> <i>Alert-oriented to self/situation</i>																																																					
Reason for Referral <i>Red ADLs, w/ strength endurance</i>																																																					
Reason for Discharge/Summary of Progress <div style="text-align: center; padding: 20px;"> <p><i>D/c OT services 20 pt. reaching max. potential.</i></p> </div>																																																					
Signature/Date <i>V. Van Antwerp</i> 03/21/2006 - 05/25/2006 - 0102																																																					

O.T. Therapy Weekly Progress Notes

1. Patient Name Peterson, William Physician NAGLM MR# 1050

2. Patient Input/Communication: _____

3. Patient Training/Education pt. instructed on ADL's, safety,
LB strength & endurance.

4. Progress to Goals:
pt. provided PROM-AANOM
exercises to both L&R.

ADL - function -
Bed mobility - extensive (A)
Dsg LB - extensive (A)
LB - (D)
Eating - self-feeding
Toileting - (D)
Bathing - (D)

5. Communication with other disciplines: pt. discussed in wly
rehab mtg, & assg. & PT

6. Family Communication: _____

7. Current Functional Status/Assessment: see above

8. Plan/Therapeutic Focus plan for Dlc

9. Referral to other disciplines: _____

10. Signature: N. Van Zant TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0103

O.T. Therapy
Weekly Progress Notes

1. Patient Name Peterson, William Physician N.R. GLM MR# 1050

2. Patient Input/Communication: _____

3. Patient Training/Education: pt. instructed on ADL's, safety,
lb strength & endurance.

4. Progress to Goals: _____
pt. provided w/ PROM or AAROM
exercises to both UE's

- ADL function
- Bed mobility - extensive (A)
- Dsg LB (D)
- LB (D)
- Eating - limited (A)
- Toileting (D)
- Bathing (D)

5. Communication with other disciplines: pt. discussed in wkly
rehab mtg, ENSG, & PT

6. Family Communication: _____

7. Current Functional Status/Assessment: see above

8. Plan/Therapeutic Focus: cont POC

9. Referral to other disciplines: _____

10. Signature: V. Van Zant M&R of Edgefield 03/21/2006 - 05/25/2006 - 0104

Occupational Therapy Plan of Treatment

Part A
 Part B
 Other
PLAN OF TREATMENT FOR OUTPATIENT REHABILITATION (COMPLETE FOR INITIAL CLAIMS ONLY)

Patient's Last Name Peterson	First Name William	M.I. -	Provider No. 425293
Provider Name Edgefield Health Care Ct.	Medical Record No. (Optional) 1050	Onset Date 3-7-06	SOC Date 3-23-06

Type OT	Primary Diagnosis (Pertinent Medical Dx) & ICD-9 cervical spinal stenosis 730	Treatment Diagnosis & ICD-9 lack of coordination 781.3
-------------------	---	--

Initial Assessment/Functional Goals		Prior Functional Level
Age 84	Gender M	Prior Hospitalization from 3-7-06 to 3-21-06
Prior Medical History/Therapy Muscle weakness, malaise/fatigue, dementia, cyst of kidney, acute renal failure, cervical disc arthrosis, fusion		Prior Functional Level Prior to 1st hospitalization on 2-20-06 pt was living at home \oplus only

Reason for Referral Decl ADLs, w/o strength or endurance	Tests Administered Sitting - poor standing - N/A	Balance (G3) See below	ROM (G4) See below	Rehab Potential Good for stated goals
--	--	----------------------------------	------------------------------	---

B4 COGNITIVE SKILLS Alert oriented to self/situation	P4 DEVICES & RESTRAINTS geri-chair	Precautions Risk for falls - Precaution related to cervical fusion
--	--	--

	Current		STG 2 wks		LTG 4 wks		Performance and Support Scale: Performance: 0-Independent; 1-Supervision; 2-Limited Asslt (-); 2.5-Limited Asslt (+); 3-Extensive Asslt (-); 3.5-Extensive Asslt (+); 4-Total Dependence; 8-Did not occur/Not tested Support: 0-No assistance; 1-Setup/Verbal cues; 2-One person assist; 3-Two (+) person assist; 8-Did not occur/Not tested
	Performance	Support	Performance	Support	Performance	Support	
G ADL FUNCTION							
G1a Bed Mobility-turning	4	2	3	2	2	2	
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G1f Toilet Use	4	2	3	2	3	2	
G1g Toilet Transfers	4	2	3	2	3	2	
G1h Personal Hygiene	4	2	3	2	3	2	
G2 Bathing (not including back or hair)	4	2	3	2	2	2	8-Did not occur/Not tested Support: same as above

D2 VISUAL LIMITATIONS WFL	OTHER: Anom both UE's WFL Muscle strength both UE's 3/5 Grip strength weak bilaterally
M SKIN CONDITION (wounds, pain/edema, sensation, splints, etc.) See nsc assessed	

<input type="checkbox"/> 97110 Therapeutic Exercises <input type="checkbox"/> 97112 Neuromuscular Re-education <input type="checkbox"/> 97535 Self Care Management	<input type="checkbox"/> 97530 Therapeutic Activities <input type="checkbox"/> 97504 Orthotics Training <input type="checkbox"/> 97533 Sensory Integration	<input type="checkbox"/> 97632 Cognitive Skills Development <input type="checkbox"/> 97150 Group Therapy <input checked="" type="checkbox"/> Caregiver ed
--	--	---

Freq/Duration (e.g. 3hr X 4 wks) 3-5 x's per wk 4 wks	Signature/Date (professional establishing POC including prof. designation) V. Vazant OTR 3-23-06
---	--

I CERTIFY THE NEED FOR THESE SERVICES FURNISHED UNDER THIS PLAN OF TREATMENT AND WHILE UNDER MY CARE

Certification from 3-23-06 to 4-22-06	Physician Signature M. Mason	Date 4/13/06
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TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0105

REPORT OF CONSULTATION

LAST NAME <i>PETERSON</i>	FIRST NAME <i>William</i>	MIDDLE NAME	ROOM NO.	PT. NO.
FROM: ATTENDING PHYSICIAN <i>TMH& Rehab of Edgefield Dr. Anderson</i>			TO: CONSULTING PHYSICIAN	
FINDINGS:			DATE <i>4-19-06</i>	
<p><i>Do we change Foley, if so how often? NO</i> <i>Orders sent from AKMC - resident.</i> <i>Had infection - received Levagun x 7 days</i> <i>See copy of Repeat UA attached.</i></p>				
<p>Diagnosis: <i>85% BM - obstructive uropathy impacted managed</i> <i>- Foley catheterization - some bladder irritation - immobility</i> <i>urine grossly concentrated.</i></p>				
<p>Recommendations: <i>Continue Foley catheter - Δ 9 weeks.</i> <i>Encourage pt fluids.</i> <i>Foley spons (Neosporn) to pass for sure.</i></p>				
Date of Consultation <i>4/19/06</i>		Physician <i>[Signature]</i>		

TMH&R of Edgefield 03/21/2006 Signature of Consultant 05/25/2006 0108

REPORT OF CONSULTATION

LAST NAME <i>Peterson</i>	FIRST NAME <i>William</i>	MIDDLE NAME	ROOM NO.	PT. NO.
FROM: ATTENDING PHYSICIAN <i>TMH&R of Edgefield</i>		TO: CONSULTING PHYSICIAN <i>Dr. Santiago</i>		DATE <i>5-1-06</i>
Findings: <i>C spine - copy attached</i>				
<i>Stable</i>				
<i>No significant change (none was expected! , but he is not worse).</i>				
<i>Doesn't need collars any longer</i>				
Diagnosis:				
<i>S/P ACDFP C5-6, C6-7</i>				
<i>Stable</i>				
Recommendations:				
<i>No further necessary follow up needed.</i>				
Date of Consultation	<i>5/1/06</i>	Physician	<i>[Signature]</i>	

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0109

May 1, 2006

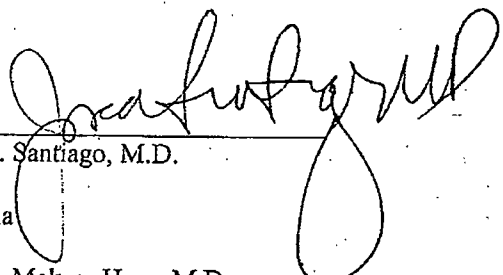
PETERSON, William (44098)

CLINIC NOTE

Mr. Peterson is an 84-year-old black male that I saw in the hospital at the request of Dr. Haas and Dr. DiBona. The patient had multiple medical problems. It was noted that he had severe weakness of the four extremities, worse in the right leg and also distally in the arms. The patient had severe spinal cord compression from spondylotic disease, primarily at C5/6 and C6/7. After undergoing medical management and cardiac clearance evaluation, Dr. Haas and Dr. DiBona felt that the patient's only chance to ever walk was to have surgery. After having a prolonged discussion with the patient and his family I took him to the operating room on 3/14/2006 and performed anterior cervical discectomy, fusion and plating at C5/6 and C6/7. Post-operatively the patient had very minimal, if any, improvement and was eventually discharged to a nursing home on 3/21/2006, seven days after the surgery.

A couple of days after that we got a call from the Trinity Mission Health and Rehabilitation Hospital where he is at in Edgefield asking about length of soft cervical collar wearing and also about his post-surgical follow-up. I told them that the soft collar was to be worn primarily for comfort for 3-6 weeks as desired and that he needed to have the Aspen rehabilitation collar for about a month whenever being mobilized or trying to walk. I told them to schedule him for a follow-up in my office with cervical spine x-rays including flexion and extension to be done in five weeks.

Today the patient shows up at the wrong time, in the morning instead of the afternoon, but I was able to work him in. He brings x-ray reports, but not the films. The x-ray report is for an AP and lateral C-spine, not flex and extension. This states that everything is stable as expected. Clinically the patient has not shown any significant improvement. At this time this is pretty much what we expected. Therefore no further routine follow-up is necessary from a neurosurgical standpoint as no benefit from further surgery can be expected.



Jose A. Santiago, M.D.

JAS/sha

Cc: Melvyn Haas, M.D.
Francis DiBona, M.D.
Trinity Mission Health and Rehabilitation

SOCIAL HISTORY ASSESSMENT

Informant(s): <u>Mary Ruth Peterson and Medical records</u>		
(include relationship) <u>Daughter/RP</u>		
Name: <u>William Peterson</u>	Birthdate: [REDACTED]	
Place of Birth: <u>McCormick County</u>	<u>83yrs</u>	
Where Reared: <u>"</u>		
Mother's Name: <u>Josephine Talbert - Peterson</u>	Date of Death: <u> / /</u>	
Cause of Death: <u>Natural cause</u>		
Employment: <u>Homemaker / Farm</u>		
Father's Name: <u>Harry "Cap" Peterson</u>	Date of Death: <u> / /</u>	
Cause of Death: <u>Cancer</u>		
Employment: <u>Farm</u>		
Sibling's Name(s)	Where Living (or) Death/Cause	
<u>Rosa Simpkins</u>	<u>New York</u>	
<u>Eddie Ruth Phillips</u>	<u>" "</u>	
<u>Celia Graham</u>	<u>Washington, DC</u>	
<u>Daisy Mae Peterson</u>	<u>New York</u>	
Other Comments Regarding Childhood:		
Highest Level of Education: <u>never attended</u> College (specify):		
Work History: Type	Where	When
<u>Textile Mills</u>	<u>Greenville, SC</u>	
Other Comments Regarding Work:		
Spouse's Name: <u>Ellen Mealine - Peterson</u>	Wedding Date: <u> / /</u>	
Spouse's Occupation: <u>Housewife</u>	Spouse's Date of Death: <u> / / 2003</u>	
Previous Marriages:		
Other Comments Regarding Marriage:		
RESIDENT <u>William Peterson</u>	ROOM NO. <u>6-1152B</u>	ADMISSION NO. <u>65011</u>

Children's Name(s)	Where Living (or) Death/Cause
Mary Ruth Peterson	Jackson, SC Raymond Peterson - Jackson, SC
Patricia Peterson	Aiken, SC Celia Jackson, Evans, GA
William Peterson, Jr.	Aiken, SC Robert L. Peterson - Fla.
Hattie Ashley	Greenwood, SC
Melinda Butler	Jackson, SC
Mildred Peterson	New York

Pre-Admission Circumstances:
 Family has requested long term stay - no expected discharge potential

Residence: _____ # of Floors: _____
 How Long Lived in State: All his life # of Steps: _____

Current Interests:
 Riding, sitting in his car

History of Major Operations/Medical Problems:
 Dx. of dehydration, Acute renal failure, Rhabdomyolysis, ↑ PSA, Hypo-thermia, Benign prostatic hypertrophy.

Family Involvement/Support:
 Res. lived at home alone - Daughter, Mary Ruth Peterson who is his Res. responsible party; No Giver/Will or No POA present. Wife is deceased.

Family Interaction/Conflicts:
 Res. requested to be a Do Not Resuscitate - not wanting any tubing for feeding, wanting TV fluids and IV antibiotics.

Additional Information:
 Res. have no Hx. of mental illness, no Hx. of alcoholic or tobacco use; Does not like to watch T.V. - goes to bed early about 6:00pm get up early about 5:30am - 6:00am.

Additional Comments:
 Res. was admitted to the Shady Grove of Greenwood - nursing home for rehab; Res. loves to keep his beard and head shave - loves to drink milk and eat cookies.

Sharon Nicholson, LS
 Signature, Title

Feb. 27, 2006
 Date

RESIDENT	Room No.	Admission No.
William Peterson	205/23/2006	50412

The Red Sneet (Initial family contact post inquiry)

Inquiry for admittng whom William Petersen
 Time and date of first contact 11:00 03-20-06
 Person involved in interview Mary Ruth Petersen
 Relationship to potential admit Sister

1. What is going on currently that leads you to seek nursing home placement?

Dad had surgery old age
need you again

2. What services do you think will be needed?

all

3. What is important to you about a nursing home?

He was here. I want him back
fall good to him - here

4. Who all is involved in this decision and their relationship?

me & family

5. Who will be leading the charge to help us once they get to our facility?

me

6. Is there any information we can get to help you?

you give it to me

7. Whom would you like us to communicate with while you are making this decision?

me

9. Here is the list of key folks to contact us if an issue arise.

Max Ruth Petersen - Belinda Butler Patricia Petersen

10. Here is the process that we know happens during the first week of the nursing home stay.

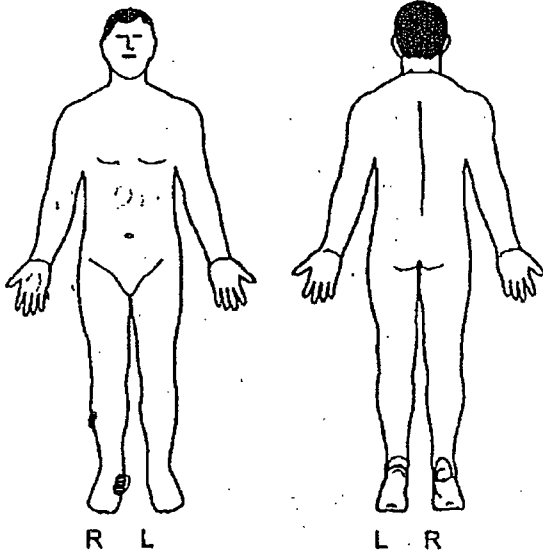
- a. Resident makes decision to come to the facility.
- b. Family is asked to do registration paperwork. Please remember that this is 3 hours of work.
- c. A copy of all the paperwork is taken home along with a resident/family information booklet.
- d. The resident and family are invited to a kickoff meeting to discuss life in a nursing facility, please bring questions.
- e. The resident and family discuss risk levels and approaches with the facility staff.
- f. The resident and family are invited to the first plan of care team with in the first 14 days of the stay.

11. Thank you for considering us and we hope you can become part of our team caring for you and yours.

Daily / Weekly / Monthly Body Audit and Hydration Report

Location: Peach Month of: March 2006

Resident's Name <u>Peterson, William</u>	Room Number <u>214W</u>	Physician <u>NRGM</u>	Initial Audit Date
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1	2	3	4	5	6		
7	8	9	10	11	12		
13	14	15	16	17	18		
19	20	21	22	23	24		
25	26	27	28	29	30		
31	Codes: NC = No Change NB = Note Below If any changes occur in Hydration, additional pressure sores occur, or possible bowel blockage, document in the Comment section below.						
← Indicate ALL pressure sores. Location and dates occurred.	Hydration (Circle one)	Poor	Fair	Good			
Skin Risk Factor (Circle one)	Low = Monthly	Moderate = Weekly	High = <u>Daily</u>	Impaction Potential (Circle one)	Low	Mod	High

Comment: 3/21/06

Area to Rt inner heel to dk black outer edges & soft center - no open area scab to Rt & leg. No edema, skin w/d.

Signature P. Dunlop

Date 03 21 / 06

3/22/06 (R) inner intact Back area 4cm x 2cm. Neck incision site clean & dry. Strips in place. (Ammon) on (D) & (R) side of tip of penis Red Raw. See tx orders.

Signature Ammon

Date 3 / 22 / 06

3/30/06 (L) hip Dark, area skin intact. Position off hip Ammon

Signature _____

Date / /

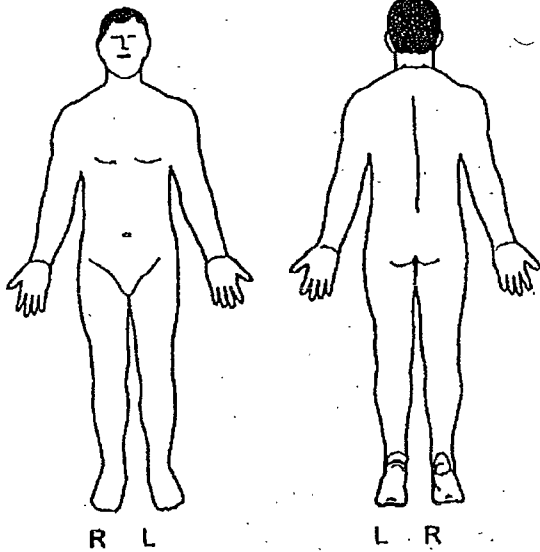
Comment: _____

Signature _____

Daily / Weekly / Monthly Body Audit and Hydration Report

Location: Peach Month of: April 2006

Resident's Name <u>Peterson, William</u>	Room Number <u>P 214W</u>	Physician <u>NRGLM</u>	Initial Audit Date
---	------------------------------	---------------------------	--------------------



1	2	3	4	5	6		
NB	nc	nc	nc	nc	NB		
7	8	9	10	11	12		
nc	nc	nc	nc	NB	nc		
13	14	15	16	17	18		
nc	nc	NB	nc	NB	nc		
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Skin Risk Factor (Circle one)	Low = Monthly	Moderate = Weekly	High = <u>Daily</u>	Impaction Potential (Circle one)	Low	Mod	High

Comment: Skin w/d tanger good abg to Penis neck clean
1 Steri strips intact. Vasalve cont. to Penis. 4/14/06
4/14/06 - (L) hip cont. Dantl to Blacl area. (S) marked
4/6/06 - (L) hip skin peeled. Area red. See TX order (S) m

Signature _____ Date 4/14/06

Comment: 4/18/06 Skin w/d tanger good Steri Strip to neck intact. Open area to penis + x cont. (L) hip area c. scar. (S) m
4/17/06 (R) heel peeled. Area pink cont to monitor (S) m
4/19/06 Neck incision site clean & dry. DIC neg. (S) m

Signature _____ Date 4/19/06

Comment: 4/21/06 PT Treating (L) hip mon-Fri (S) m
4/21/06 (R) heel Red open area. TC started. (S) m

Signature _____ Date 4/21/06

Comment: _____

Weekly Pressure Sore Progress Report

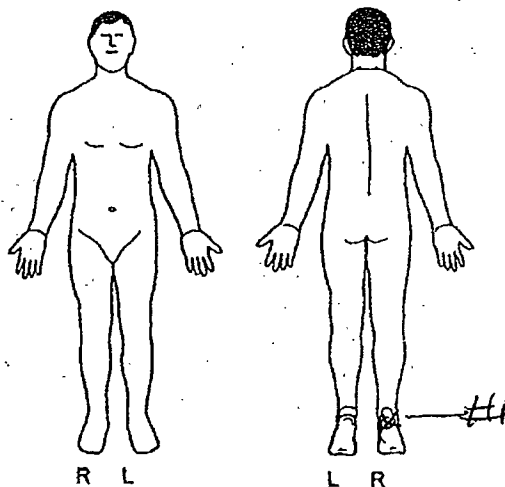
Location: Deacon Month of: March 06

Resident's Name <u>Peterson William</u>	Room Number <u>214W</u>	Physician <u>N. Robin</u>
	Initial Audit Date <u>3/22/06</u>	Risk Factor <u>High</u>

- Stage I: Inflammation or redness of the skin
- Stage II: Superficial skin break with redness of surrounding area
- Stage III: Skin break with deep tissue involvement
- Stage IV: Skin break with deep tissue involvement with necrotic tissue present

Show exact location of wounds. Use letters for each wound, if more than one is present.

NOTE: When MD or family is notified of any condition, document on back of this form under *Additional Comments*.



Date <u>3/22/06</u>	Date <u>3/29/06</u>	Date <u>4/0/06</u>
Location <u>##</u>	Location <u>##</u>	Location <u>##</u>
Size (cm or inch) <u>cm</u>	Size (cm or inch) <u>cm</u>	Size (cm or inch) <u>cm</u>
Length <u>M</u> Width <u>2</u> Depth <u>?</u>	Length <u>M</u> Width <u>2</u> Depth	Length <u>M</u> Width <u>2</u> Depth
Stage <u>IV</u>	Stage <u>IV</u>	Stage <u>IV</u>
Color <u>Black</u>	Color <u>Black</u>	Color <u>Black</u>
Odor <u>Ø</u>	Odor <u>Ø</u>	Odor <u>Ø</u>
Drainage (describe) <u>Ø</u>	Drainage (describe) <u>Ø</u>	Drainage (describe) <u>Ø</u>
Treatment <u>monitor</u>	Treatment <u>monitor</u>	Treatment <u>monitor</u>
Progress <u>new Admitted</u>	Progress <u>No Δ</u>	Progress <u>No Δ</u>
Special Device <u>Heel protectors</u>	Special Device <u>spurs / Alternating</u>	Special Device <u>Pressure Mattress</u>
Notified <input checked="" type="checkbox"/> MD <input checked="" type="checkbox"/> Family	Notified <input type="checkbox"/> MD <input type="checkbox"/> Family	Notified <input type="checkbox"/> MD <input type="checkbox"/> Family
Signature <u>[Signature]</u>	Signature <u>[Signature]</u>	Signature <u>[Signature]</u>
Date <u>4/12/06</u>	Date <u>4/17/06</u>	Date <u>4/26/06</u>
Location <u>##</u>	Location <u>##</u>	Location <u>##</u>
Size (cm or inch) <u>cm</u>	Size (cm or inch) <u>cm</u>	Size (cm or inch) <u>cm</u>
Length <u>M</u> Width <u>2</u> Depth	Length <u>M</u> Width <u>2</u> Depth	Length <u>.8</u> Width <u>.5</u> Depth <u>Ø</u>
Stage <u>IV</u>	Stage <u>I</u>	Stage <u>II</u>
Color <u>Black eschar</u>	Color <u>Pink</u>	Color <u>Red</u>
Odor <u>Ø</u>	Odor <u>Ø</u>	Odor <u>Ø</u>
Drainage (describe) <u>Ø</u>	Drainage (describe) <u>Ø</u>	Drainage (describe) <u>scant</u>
Treatment <u>monitor</u>	Treatment <u>monitor</u>	Treatment <u>Bacitracin & cover daily</u>
Progress <u>No Δ</u>	Progress <u>Eschar Pelled off</u>	Progress <u>↑ in Stage</u>
Special Device <u>Alternating</u>	Special Device <u>Pressure Mattress</u>	Special Device
Notified <input type="checkbox"/> MD <input type="checkbox"/> Family	Notified <input type="checkbox"/> MD <input type="checkbox"/> Family	Notified <input type="checkbox"/> MD <input type="checkbox"/> Family
Signature <u>[Signature]</u>	Signature <u>[Signature]</u>	Signature <u>[Signature]</u>

Date 5/2/06	Date 5/4/06	Date
Location #1	Location #1	Location
Size (cm or inch) 1cm	Size (cm or inch) 1cm	Size (cm or inch)
Length .5 Width .5 Depth 0	Length 0 Width Depth	Length Width Depth
Stage I	Stage 0	Stage
Color Pink	Color Normal Blanching	Color
Odor 0	Odor 0	Odor
Drainage (describe) 0	Drainage (describe) 0	Drainage (describe)
Treatment monitor	Treatment monitor	Treatment
Progress healing	Progress	Progress
Special Device Alternating Pressure Mattress	Special Device	Special Device
Notified <input type="checkbox"/> MD <input type="checkbox"/> Family	Notified <input type="checkbox"/> MD <input type="checkbox"/> Family	Notified <input type="checkbox"/> MD <input type="checkbox"/> Family
Signature [Signature]	Signature [Signature]	Signature
Date	Date	Date
Location	Location	Location
Size (cm or inch)	Size (cm or inch)	Size (cm or inch)
Length Width Depth	Length Width Depth	Length Width Depth
Stage	Stage	Stage
Color	Color	Color
Odor	Odor	Odor
Drainage (describe)	Drainage (describe)	Drainage (describe)
Treatment	Treatment	Treatment
Progress	Progress	Progress
Special Device	Special Device	Special Device
Notified <input type="checkbox"/> MD <input type="checkbox"/> Family	Notified <input type="checkbox"/> MD <input type="checkbox"/> Family	Notified <input type="checkbox"/> MD <input type="checkbox"/> Family
Signature	Signature	Signature

Additional Comments: _____

Weekly Non-Pressure Sore Progress Report

Location: Peach

Physician's Name: Peterson, William

Room Number: 214W

Date: 3/22/06

Type of Skin Problem: Neck incision site & Steri-Strips

Progress Notes: New - No Drainage

Treatment: Dry Dsg daily

Physician Notified? Yes No

Family Notified? Yes No

Signature: Amorican

Date: 3/29/06

Type of Skin Problem: Neck incision site & Steri-Strips

Progress Notes: No Drainage, No S/S of infection

Treatment: Dry Dsg daily

Physician Notified? Yes No

Family Notified? Yes No

Signature: Amorican

Date: 4/5/06

Type of Skin Problem: Neck incision site & Steri-Strips

Progress Notes: No S/S of infection

Treatment: Dry Dsg Daily

Physician Notified? Yes No

Family Notified? Yes No

Signature: Amorican

Date: 4/12/06

Type of Skin Problem: Neck incision site & Steri-Strips

Progress Notes: No S/S of infection

Treatment: Dry Dsg Daily

Physician Notified? Yes No

Family Notified? Yes No

Signature: Amorican

Weekly Non-Pressure Wound Progress Report

Location: Peacn

Resident's Name: Gilchrist Peterson, William Room Number: 214W

Date: 4/19/06

Type of Skin Problem: Steri-Strips to Neck

Progress Notes: D/C Dsg Steri-Strips off. Suture Site intact

Treatment: D/C Dsg

Physician Notified? Yes No

Family Notified? Yes No

Signature: [Signature]

Date: _____

Type of Skin Problem: _____

Progress Notes: _____

Treatment: _____

Physician Notified? Yes No

Family Notified? Yes No

Signature: _____

Date: _____

Type of Skin Problem: _____

Progress Notes: _____

Treatment: _____

Physician Notified? Yes No

Family Notified? Yes No

Signature: _____

Date: _____

Type of Skin Problem: _____

Progress Notes: _____

Treatment: _____

Physician Notified? Yes No

Family Notified? Yes No

Signature: _____

Weekly Pressure Sore Progress Report

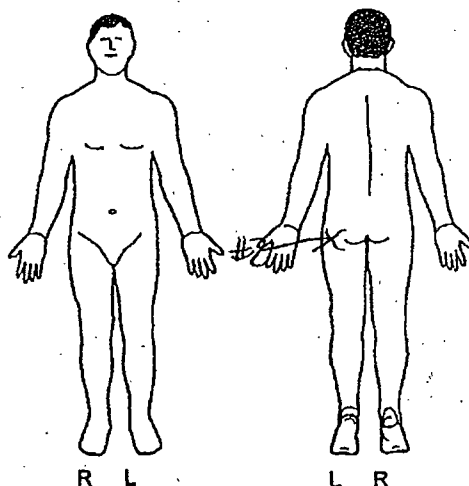
Location: Peach Month of: April 06

Resident's Name <u>Peterson, William</u>	Room Number <u>1050</u>	Physician <u>NRB/M</u>
	Initial Audit Date	Risk Factor

- Stage I: Inflammation or redness of the skin
- Stage II: Superficial skin break with redness of surrounding area
- Stage III: Skin break with deep tissue involvement
- Stage IV: Skin break with deep tissue involvement with necrotic tissue present

Show exact location of wounds. Use letters for each wound, if more than one is present.

NOTE: When MD or family is notified of any condition, document on back of this form under *Additional Comments*.



Date <u>4/16/06</u>	Date <u>4/12/06</u>	Date <u>4/19/06</u>
Location <u>#2</u>	Location <u>#2</u>	Location <u>#2</u>
Size (cm or inch) <u>cm</u>	Size (cm or inch) <u>cm</u>	Size (cm or inch) <u>cm</u>
Length <u>5</u> Width <u>4</u> Depth <u>∅</u>	Length <u>4 1/2</u> Width <u>3</u> Depth <u>∅</u>	Length <u>4 1/2</u> Width <u>3</u> Depth <u>∅</u>
Stage <u>II</u>	Stage <u>II</u>	Stage <u>IV</u>
Color <u>Red</u>	Color <u>Red</u>	Color <u>Red + Black</u>
Odor <u>∅</u>	Odor <u>∅</u>	Odor <u>∅</u>
Drainage (describe) <u>Small</u>	Drainage (describe) <u>Small</u>	Drainage (describe) <u>Small</u>
Treatment <u>Bacitracin & Opti Form daily</u>	Treatment <u>Bacitracin & Opti Form daily</u>	Treatment <u>Bacitracin & Opti Form daily</u>
Progress <u>New</u>	Progress <u>↓ in size</u>	Progress <u>↓ in color</u>
Special Device <u>Alternating Pressure Mattress</u>	Special Device <u>Pressure Mattress</u>	Special Device
Notified <input type="checkbox"/> MD <input checked="" type="checkbox"/> Family	Notified <input type="checkbox"/> MD <input type="checkbox"/> Family	Notified <input type="checkbox"/> MD <input type="checkbox"/> Family
Signature <u>[Signature]</u>	Signature <u>[Signature]</u>	Signature <u>[Signature]</u>
Date <u>4/26/06</u>	Date <u>5/3/06</u>	Date <u>5/10/06</u>
Location <u>#2</u>	Location	Location
Size (cm or inch)	Size (cm or inch)	Size (cm or inch)
Length Width Depth	Length Width Depth	Length Width Depth
Stage	Stage	Stage
Color	Color	Color
Odor	Odor	Odor
Drainage (describe)	Drainage (describe)	Drainage (describe)
Treatment	Treatment	Treatment
<u>PT dressing</u>	<u>PT dressing</u>	<u>PT dressing</u>
Progress	Progress	Progress
Special Device	Special Device	Special Device
Notified <input type="checkbox"/> MD <input type="checkbox"/> Family	Notified <input type="checkbox"/> MD <input type="checkbox"/> Family	Notified <input type="checkbox"/> MD <input type="checkbox"/> Family
Signature	Signature	Signature <u>[Signature]</u>

TMH&R of Edgefield 03/21/2006 - 05/25/2006 0421

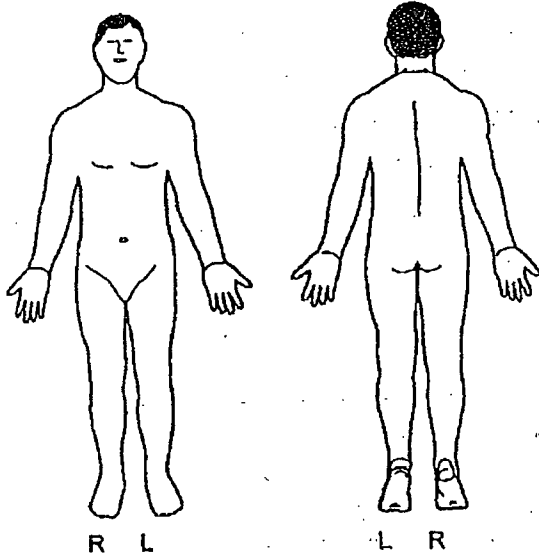
Date	5/17/06	Date		Date	
Location		Location		Location	
Size (cm or inch)		Size (cm or inch)		Size (cm or inch)	
Length	Width	Depth	Length	Width	Depth
Stage			Stage		
Color			Color		
Odor			Odor		
Drainage (describe)			Drainage (describe)		
Treatment			Treatment		
Resident in Hosp.					
Progress			Progress		
Special Device			Special Device		
Notified	<input type="checkbox"/> MD	<input type="checkbox"/> Family	Notified	<input type="checkbox"/> MD	<input type="checkbox"/> Family
Signature			Signature		
Date			Date		
Location			Location		
Size (cm or inch)			Size (cm or inch)		
Length	Width	Depth	Length	Width	Depth
Stage			Stage		
Color			Color		
Odor			Odor		
Drainage (describe)			Drainage (describe)		
Treatment			Treatment		
Progress			Progress		
Special Device			Special Device		
Notified	<input type="checkbox"/> MD	<input type="checkbox"/> Family	Notified	<input type="checkbox"/> MD	<input type="checkbox"/> Family
Signature			Signature		

Additional Comments:

Daily / Weekly / Monthly Body Audit and Hydration Report

Location: Peach Month of: May 06

Resident's Name	Room Number	Physician	Initial Audit Date
<u>Peterson, William</u>	<u>214W</u>	<u>NRBM</u>	



1	2	3	4	5	6
NB	NB	NB	NB	NC	NB
7	8	9	10	11	12
NC	NC	NC	NB	NC	NC
13	14	15	16	17	18
NC	NC	NC	HOSP	HOSP	HOSP
19	20	21	22	23	24
HOSP	Heal	Heal	HOSP	HOSP	HOSP
25	26	27	28	29	30
HOSP					
31	Codes: NC = No Change NB = Note Below If any changes occur in Hydration, additional pressure sores occur, or possible bowel blockage, document in the Comment section below.				
← Indicate ALL pressure sores. Location and dates occurred.				Hydration (Circle one)	Poor Fair Good
Skin Risk Factor (Circle one)		Low = Monthly Moderate = Weekly High = Daily		Impaction Potential (Circle one)	Low Mod High

Comment: Skin w/d & Turgor fair. No Edema. (L) hip open area conts. See Tyrodias. PT Mon-Fri (R) heel healing well. Neck incision site intact

Signature [Signature] Date 5/1/06

Comment: (R) heel closed area pink 5/2/06 [Signature]
(R) heel Normal Blanching. Edema to Both feet.
Small scab to Top (R) foot. [Signature] 5/4/06
5/6/06 - Heels intact, scab to (R) foot intact. (L) hip open dressing intact. Ecan loose & deep slough. [Signature]

Comment: 5/10/06 Scab to (R) leg & (R) knee. [Signature]

Signature _____ Date ____/____/____

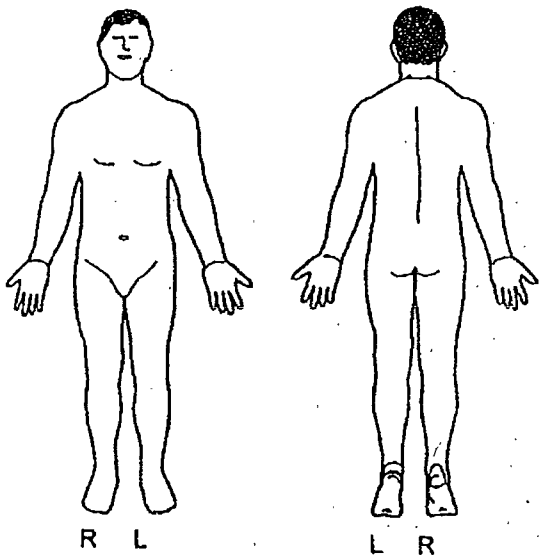
Comment: _____

Signature _____ Date ____/____/____

Daily / Weekly / Monthly Body Audit and Hydration Report

Location: Beach Month of: June 06

Resident's Name	Room Number	Physician	Initial Audit Date
<u>Peterson, William</u>	<u>214w</u>	<u>alblaw</u>	



1	2	3	4	5	6
7	8	9	10	11	12
13	14	15	16	17	18
19	20	21	22	23	24
25	26	27	28	29	30
31	Codes: NC = No Change NB = Note Below If any changes occur in Hydration, additional pressure sores occur, or possible bowel blockage, document in the Comment section below.				
← Indicate ALL pressure sores. Location and dates occurred.				Hydration (Circle one)	Poor Fair Good
Skin Risk Factor (Circle one)		Low = Monthly Moderate = Weekly High = Daily		Impaction Potential (Circle one)	Low Mod High

Comment: _____

Signature _____ Date ____/____/____

Comment: _____

Signature _____ Date ____/____/____

Comment: _____

Signature _____ Date ____/____/____

Comment: _____

SNAIL RAIL ASSESSMENT REVIEW

(This information is collected from the MDS and various assessment tools completed on residents)

Resident Name Peterson, William Last MDS Date _____

Height _____ Weight _____ Length of Bed _____

Fall Risk Assessment Score _____ B/P Sitting _____ B/P Standing _____

Medications with side effects of drowsiness _____

Cognitive Performance Scale Score:

- No Cognitive Impairment
- Very Mild Cognitive Impairment
- Mild Cognitive Impairment
- Moderately Cognitive Impairment
- Moderately Severe Cognitive Impairment
- Severe Cognitive Impairment
- Very Severe Cognitive Impairment

Ability to understand others (c.6.):

- Understands
- Usually Understands
- Sometimes Understands
- Rarely/Never Understands

Making self understood (c.4.):

- Understood
- Usually Understood
- Sometimes Understood
- Rarely/Never Understood

Bed Mobility (G.1.a.):

- Independent
- Supervision
- Limited Assistance
- Extensive Assistance
- Total Dependence
- Did not occur

- No assistance
- Set up help
- 1 person assistance
- 2+ person assistance

Transfers (G.1.g.):

- Independent
- Supervision
- Limited Assistance
- Extensive Assistance
- Total Dependence
- Did not occur

- No assistance
- Set up help
- 1 person assistance
- 2+ person assistance

Bowel Incontinence (H.1.a.):

-
-
-
-
-

- Continent
- Usually Continent
- Occasionally Incontinent
- Frequently Incontinent
- Incontinent

Bladder Incontinence (H.1.b.):

-
-
-
-
-

Joley

Standing Balance (G.3.a.):

- Maintained position as required in test
- Unsteady, but able to rebalance self without physical support
- Partial physical support during test
- Not able to attempt test without physical help

Sitting Balance (G.3.b.):

-
-
-
-

Resident Preference for side rail: _____

Family Preference for side rail: _____

Resident/Family have been educated on risks of side rail (strangling, suffocation, bodily injury or death when patients or part of their body are caught between rails or between bed rails and mattress; more serious injuries from falls when patient climbs over rails; skin bruising, cuts, and scrapes; inducing agitated behavior when bed rails are used as a restraint; preventing patients, who are able to get out of bed, from performing routine activities such as going to the bathroom or retrieving something from a closet.)

Recommendations:

- No Side Rails
- Side Rails with Pads
- Low Bed
- Other _____
- Bed Alarm
- Positioning Devices
- Mat Beside Bed
- Side Rails: Left J Right J
- Bolstered Mattress

- RAP Review Completed
- Side Rails have been Care Planned

Equipment Assessment:

- No gaps between bed surface and frame allowing for resident to get wedged in equipment.
- Side rails/equipment is appropriate for bed, attached correctly and in functioning condition.
- Bed and equipment are appropriate for resident's height and weight, ensuring reduction of potential injury.

Comments:

SR x 2 as enabled Dyh

Signature _____ Date _____

ASSESSMENT FOR BOWEL AND BLADDER RETRAINING ; -648-
INCONTINENCE / INVOLUNTARY MANAGEMENT

Complete if Incontinence RAP triggers

1. **Diagnosis:** Acute Renal Failure (Resolved) BPH Hypertension

2. **Medications:** a) Diuretics _____ b) Sedatives _____ c) Antidepressants _____
 d) Antipsychotic _____ e) Antiparkinsons _____ f) Antihistamines _____
 g) Antispasmodics _____ h) Phenothiazines _____ i) Other _____

3. **Vision:** adeq **Hearing:** slump

4. **Catheter: (H3d)** Yes No _____ **When?** 3/21/06, readmitted

5. **Urinary Incontinence: (H2b)**
 Length of incontinence _____ days _____ months _____ years
 Reason for incontinence BPH constipation

6. **Urinary Observations:**
 Voids often in small amounts _____ Fills bladder and voids large amount _____
 Dribbles: _____ constantly _____ after voiding _____ while coughing
 _____ lifting, etc. _____ unable to void
 Does resident appear uncomfortable: no
 Abdomen distended: Yes _____ No
 Does resident void upon:
 Arising: Yes _____ No _____ After meals: Yes _____ No _____
 After a nap: Yes _____ No _____ Constantly: Yes _____ No _____
 No apparent pattern: Yes _____ No
 Does resident appear to recognize the need to void: Yes _____ No
 Can resident communicate the need to void: Yes No _____
 How? _____ Commode _____ Bedside Commode _____
 Bedpan _____ Urinal _____ Assistance (pants, zipper, etc.) _____
 S & S of Urinary Infection Yes _____ No Treated Yes _____ No _____

7. **Bowel Incontinence: (H1a)**
 Length of incontinence _____ days 14 months _____ years
 Reason for incontinence none

Bowel Observation:
 Daily elimination: Yes _____ No
 Approximate time of daily elimination _____
 Other than daily elimination: (Explain) none

Is resident constipated? Yes _____ No
 Uses laxatives frequently? Yes _____ No How often? _____
 Type of laxative _____
 Enemas? Yes _____ No How often? _____
 Is stool soft: Yes No _____; Hard: Yes _____ No Liquid: Yes _____ No _____
 Is abdomen distended: Yes _____ No ; Hard: Yes _____ No
 Does the resident recognize the need to empty bowels: Yes _____ No

Nature of Bowel Pattern:
 Regular pattern _____ No apparent pattern
 Describe bowel pattern _____

RESIDENT <u>Peterson, William</u>	PHYSICIAN <u>NRB/LM</u>	ROOM NO. <u>P214W</u>	ADMISSION NO. <u>1050</u>
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PAIN ASSESSMENT

Resident Peterson, William

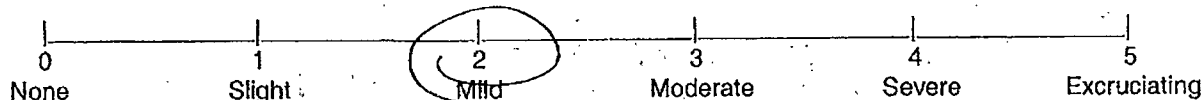
ID# 1050

Allergies NKA

Diagnosis _____

* IF RESIDENT UNABLE TO VERBALIZE or COGNITIVELY IMPAIRED, GO TO #2

1. Pain Intensity at Present: (Circle Score)

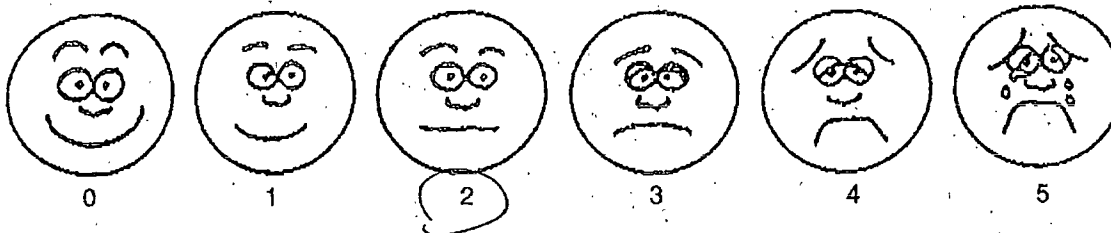


- A. How long have you had the pain? (Enter #) _____ days months _____ years
- B. What is the duration of pain? Brief _____ Intermittent Constant _____
- C. What best describes the type of pain?

Aching _____	Burning _____	Stabbing _____	Dull/Diffuse _____
Pulling _____	Cramping _____	Gnawing <input checked="" type="checkbox"/>	Pressing/Tight _____
Pricking _____	Throbbing _____	Shooting _____	Other _____
- D. What relieves the pain? meds
- E. What increases the pain? movement
- F. What is your current treatment? unk
- G. What response did you have to this treatment? unk

GO TO SECTION #2B

2. Cognitively Impaired Residents - Identify by listing behavior exhibited:



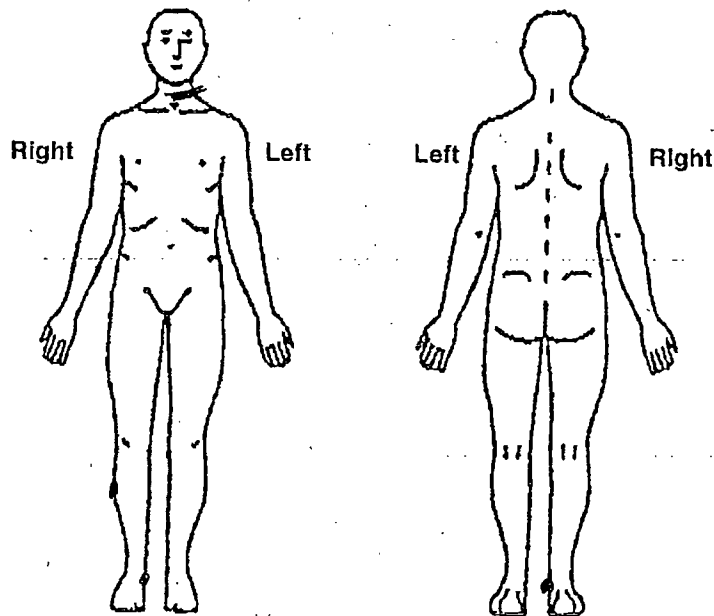
- A. Subjective Assessment:
 - 1. Facial Expressions: Flinching _____ Grimacing _____ Moaning/Crying out _____
Resident Physically Removing Caregivers Hand _____ Other _____
 - 2. Body Action guarded
 - 3. Behavior does not want to move or turn
 - 4. Other _____

B. History of pain and what relieves it: post cervical surgery

C. Physical Assessment by Nurse if any of the below observations are identified.
Physical Examination of painful areas: (Use illustration below)

Heat _____	Swelling/Inflammation _____	Tenderness _____	Redness Present _____
Aching _____	Burning _____	Stabbing _____	Dull/Diffuse _____
Pulling _____	Cramping _____	Gnawing _____	Pressing/Tight _____
Prickling _____	Throbbing <input checked="" type="checkbox"/>	Shooting _____	Other _____

Physical Assessment by Nurse: (identify area on illustration)



3. How Does The Pain Affect:

- a. Sleep? _____
- b. Appetite? poor
- c. Mobility? limited
- d. General Activity? 0
- e. Ability to Concentrate? confused
- f. Enjoyment of Life? _____

Notes: _____

Completed by: Margaret Capell, RN
Date: 03/21/06

Resident Peterson, William TMH&R of Edgefield # 1250 03/21/2006 - 05/25/2006 - 0130

Resident Name PETERSON, WILLIAM

Date: 3/22/06

Assessment Question		Answer	Nutrition	Dehydration	Elopement	Fall	Skin	Contracture	Poly Pharm	Impaction	Restraint	Entrapment	Pain
Age	> 80	4	4	4	4	4		4	4	4			
	65-79	3	0	0		0		0	0				
	50-64	2				0		0	0				
Mental Status	B6 Deterioration of cognitive status	2	2			2	2	2	2		0	0	
	Disoriented to person	2		0	0	0				0	0	2	
	Disoriented to place	2	2	2	2	2	2			2	2	2	
	Disoriented to time	2	2	2	2	2	2			2	2	2	
	Confused or sedated	3	3	3	3	3	3	3		3	3	3	
	Delusional	2		0	0	0	0		0		0	0	
Behaviors	Exit Seeking	2			0	0					0	0	
	*Hx of Elopement	2			0						0		
	Verbalizations of wanting to go home	1		0	0						5	5	
	*Hx of Falls In last month	5	5			5			5		3	3	
	Hx of more than 1 fall in last 6 months	3	3			3			3		0		
	Prefers to sit on floor	1				0					0		
	Resists Care	1		0	0	0		0	0		0		
	Strikes out	1				0					0		
	*P4c Daily trunk restraint	3				0					0		
	Wears Glasses	1		0	0	0						0	
Communication	Poor/blind eyesight without glasses	2		0	0	0				0			
	Aphasic	2		0	0	0							
	Speech slurred	1		0	0	0							
	Different language other than English	1		0	0	0							
	HOH either ear	1	1	1	1	1					2	2	2
	*Upper limited	2	2	2	2	2		2		0	0	0	
	Upper Immobile	2		0	0	0		0		2	2	2	
	*Lower Limited	2	2			2				0	0	0	
	Lower Immobile	2				0		0		2	2	2	
	Poor Bal. While sitting	2	2	2	2	2		2		2	2	2	
Mobility	Poor Bal while standing	2	2			2		2		2	2	2	
	Amputation	2				0		0			0		
	Cane	2				0		0					
	Prosthesis	2				0		0			0	0	
	Wheelchair	2				0	0	0					
	Walker	2				0		0			0		
	Ataxia or shuffles feet	2				0		0			0		
	*G1aA Bed mobility self performance	2,3,4	3			3	3	3			3		
	G1bA Transfer self performance	2,3,4	3			3	3	3			3		
	Bedfast most of time	1	1	1	1	1	1	1			1	1	1
Bowel and Bladder	H1b Bladder Incontinence	2,3,4				0	0			0		0	
	Incontinent of bowel	3				0				0	0	0	
	*Hx of impaction	2		0	0	0				0	0	0	
; & Drinking	Texture of diet altered	2	2	2	2					2			
	Calories of diet altered	2		0	0					0			
	Eat < 75% or refuses to eat	2		0	0					0			0
	*Unintended weight loss	3		0	0					0			
	Tube feeding	3		0	0					0			
	Dx of dehydration	2		0	0		0			0			

TJL 88 of Edgefield 03/21/2008 05/25/2016 0137

Resident Name **PETERSON, WILLIAM**

Date: **3/22/06**

Assessment Question		Answer	Nutrition	Dehydration	Elopement	Fall	Skin	Contracture	Poly Pharm	Impaction	Restraint	Entrapment	Pain
Eating & Drinking (Cont.)	Dx of malnutrition / anemia	2	0	0		0			0	0			
	Limits self on food choices	1	0	0						0			
	Limits self on drink choices	1	0	0						0			
	Poor dentition/missing teeth/dentures	2	2	2									
	K2a or K2b BMI under 23	1	0	0				0				0	
	Weight < 100 lbs.	2	0	0									
	Weight > 300 lbs.	1				0							
Skin Condition	Areas red or mottled or edematous	2	2	2			2						
	*M4e Skin desensitized to pain	1	0	0			0						
	*M2a Pressure ulcer present	1	1	1	1	1	1		1		1		
Medication Usage	*M3 Hx of resolved pressure ulcer	1	0	0	0	0	0		0	0	0	0	
	*Uses more than 8 medications	1	0	0	0	0			0	0	0	0	
	Diuretic	2	0	0	0	0			0	0	0	0	
	Analgesics	1	0			0		0	0	0	0	0	
	Antihypertensive	2	2	2		2			2	2	2	2	
	Sedatives	2	0			0		0	0	0	0	0	
	Antipsychotics	2	0			0		0	0	0	0	0	
	Antidepressants	2	0			0		0	0	0	0	0	
	Hypnotic	2				0		0	0	0	0	0	
	Anti-anxiety	2				0		0	0	0	0	0	
Diseases	Dementia / delirium	3	3	3	3	3		3	3	3	3	3	
	BP / cardiac / pulmonary	2	2	2	2	2		2	2	2			
	Mental illness	3	0	0	0	0		0	0		0	0	
	I1a Diabetes	3	0	0	0	0	0	0	0	0		0	
	*I1j Peripheral vascular disease	1	0	0	0	0	0	0	0	0		0	
	Post hospitalization	1	1	1	1	1		1	1	1	1	1	
	J4c Hip fx last 180 days	5	0	0	0	0	0	0	0	0	0	0	
	Osteoarthritis / arthritis	1	0	0	0	0	0	0	0	0	0	0	
	J5c Endstage disease or malignancy	1	0	0	0	0	0	0	0	0	0	0	
	J52a Pain Frequency	0,1,2	2	2	2	2	2		2	2	2	2	
J2b Pain Intensity	1,2,3	1	1	1	1	1		1	1	1	1		
AIMS	Facial and Oral	Facial expression	0-4	0	0	0				0			
		Lips and periorbital	0-4	0	0	0				0			
		Jaw	0-4	0	0	0				0			
	Extremity	Tongue	0-4	0	0	0				0			
		Upper torso	0-4	0	0	0		0		0		0	0
		Lower torso	0-4	0				0		0		0	0
	Global	Incapacitation	0-4	0				0		0		0	0

TMM & R of Equipment 03/21/2006 - 05/25/2006 - 0132

Resident Name PETERSON, WILLIAM

Date: 3/22/06

Assessment Question		Answer	Nutrition	Dehydration	Elopement	Fall	Skin	Contracture	Poly Pharm	Impaction	Restraint	Entrap ment	Pain
Totals	Total AIM Score	0											
	Add column		33	35	17	49	12	33	26	33	40	33	17
	Divide by possible		51	47	23	64	15	42	33	46	47	41	21
Risk Levels	High > 68%			74%	74%	77%	80%	79%	79%	72%	85%	80%	81%
	Moderate 34% to 67%		65%										
	Low < 33%												

Completed by: Kathleen Dwyer

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 013

THERAPY REFERRAL FORM

The following resident is being referred to the Therapy Department:

Resident Name: Peterson

Medical Record #: _____

Physician Name: _____

HICN #: _____

Diagnosis/Condition: _____

For the following reasons:

DOMAIN	YES	NO	N/A	Comments (optional)
Accidents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recent falls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recent fractures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cognitive Patterns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recent change in cognitive patterns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recent change in speech/language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Elimination/Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recent increase in incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nutrition/Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recent weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recent feeding tube	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recent dehydration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recent change in eating/swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Physical Functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recent change in ADLs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bed mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Transfers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recent change in ROM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Quality of Life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recent restraint or change in restraint	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recent change in skin condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

RECOMMENDATIONS	Comments (optional)
No skilled interventions <input type="checkbox"/>	_____
Restorative Nursing Program <input type="checkbox"/>	_____
Refer to routine nursing care <input type="checkbox"/>	_____
Other (specify) _____ <input type="checkbox"/>	_____
Formal Evaluation(s) Indicated	_____
PT <input type="checkbox"/>	_____
OT <input type="checkbox"/>	_____
ST <input type="checkbox"/>	_____

Resident Name _____

BALANCE WHILE STANDING

Obtain a watch with a second hand to time the test. Pick a time to test resident when he/she is at his/her best. Place a chair directly behind the resident in case he/she needs to sit down. Stand close to resident while testing balance in order to catch or balance him/her, if necessary. Obtain assistance from another staff member if needed to ensure resident safety. Test balance without assistive devices (but with prostheses, if used). For residents with walkers, make sure the walker is placed directly in front of the resident within easy reach in case it is needed for rebalancing. DO NOT attempt to test residents who cannot stand by themselves.

- SCORING: 0 Maintained position as required in test – Resident was able to maintain all 3 standing positions for 10 seconds without moving feet out of position.
- 1 Unsteady, but able to rebalance self without physical support – Resident was unable to maintain one or more standing positions for 10 seconds each without moving feet out of position. Resident was unsteady but was able to rebalance self without physical support from others or from an assistive device in at least the first position.
 - 2 Partial physical support during test, or stands but does not follow directions for test – While the resident performed part of the activity, resident was unable to maintain one or more standing positions without physical support from other(s) or from an assistive device. This category also includes residents who can stand but are unable or refuse to follow your directions to perform a test of balance.
 - 3 Not able to attempt test without physical help – Resident is not able to stand without physical help from another person or an assistive device.

TEST		
POSITION 1	Stand with feet together, side by side, firmly on floor. Maintain position for 10 seconds. If able,	SCORE 3
POSITION 2	Stand with one foot halfway in front of the other. Maintain position for 10 seconds. If able,	
POSITION 3	Stand with one heel in front of & touching the toes of other foot. Maintain position for 10 seconds.	

BALANCE WHILE SITTING

Obtain a watch with a second hand to time the test. Do not conduct sitting balance in wheelchair. Find a chair with a firm, solid seat to conduct the test. The height of the chair seat should be low enough to allow the bottom of the resident's feet to rest on the floor for support. It is safer to use a chair with arms in case the resident needs physical support during the test. Stand close to resident while testing balance in order to catch or balance him/her, if necessary. Obtain assistance from another staff member if needed to ensure resident safety.

- SCORING: 0 Maintained position as required in test – Resident was able to sit for 10 seconds without touching the back or sides of the chair for support.
- 1 Unsteady, but able to rebalance self without physical support – Resident was unable to maintain sitting balance for 10 seconds each without touching the back or sides of the chair for support. Resident was unsteady but was able to rebalance self.
 - 2 Partial physical support during test, or stands but does not follow directions for test – While the resident performed part of the activity, resident was unable to maintain sitting balance without physical support from other(s) or from touching the backs or sides of the chair for support.. This category also includes residents who can sit but are unable or refuse to follow your directions to perform a test of sitting balance.
 - 3 Not able to attempt test without physical help – Resident is not able to sit without physical help from another person or an assistive device or chair back/arm for support.

TEST		
POSITION 1	Sit in chair with feet on floor & arms folded across chest without using the back or arms for support. Maintain position for 10 seconds.	SCORE 0

ROM / VOLUNTARY MOVEMENT TEST FORM

LIMITATION IN RANGE OF MOTION

Perform each test on both sides of the resident's body. If the resident is unable to follow verbal directions demonstrate each movement. If resident is still unable to perform the activity, move the resident's joints through slow, active assistive range of motion to assess for limitations. STOP if the resident experiences pain.

- SCORING: 0 No limitation – Resident has full function range of motion on the right and left side.
- 1 Limitation on one side of the body (either right or left side).
 - 2 Limitation on both sides of the body.

LOSS OF VOLUNTARY MOVEMENT

For each body part, code the appropriate response for the resident's function during the past seven days. If the body part is missing, code "1", if missing bilaterally, code "2".

- SCORING: 0 No loss of voluntary movement – Resident moves body part to complete the required task. Movements are smooth and coordinated.
- 1 Partial loss of voluntary movement – Resident is able to initiate and complete the required task but movements are slow, spastic, uncoordinated, rigid, choreiform frozen, etc. on one or both sides.
 - 2 Full loss of voluntary movement – Resident is not able to initiate the required task. There is no voluntary movement on either side.

TEST		
Neck	With resident seated in a chair, ask him/her to turn the head slowly, looking side to side. Then ask the resident to return head to center and then try to reach the right ear towards the right shoulder, then left ear towards left shoulder.	SCORE 0
Arm	With resident seated in a chair, ask him/her to reach with both hands and touch palms to back of head. Then ask the resident to touch each shoulder with the opposite hand. Alternatively, observe the resident donning or removing a shirt over the head.	SCORE 2
Hand	For each hand, instruct the resident to make a fist, then open the hand.	SCORE 0
Leg	While resident is lying supine in a flat bed, instruct the resident to lift his/her leg (one at a time), bending it at the knee (90 degrees). Then ask the resident to slowly lower his/her leg, and extend it flat on the mattress.	SCORE 2
Foot	While supine in bed, instruct the resident to flex and extend each foot.	SCORE 2
Other	Decreased mobility in spine, jaw, or other joints that are not tested	SCORE 0

TEST		
		SCORE 0
		SCORE 1
		SCORE 0
		SCORE 0
		SCORE 2
		SCORE 2
		SCORE 0