THE STATE OF SOUTH CAROLINA
In the Court of Appeals

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SC Court of Appeals

APPEAL FROM EDGEFIELD COUNTY
Court of Common Pleas

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 4)

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Attorneys for Appellant

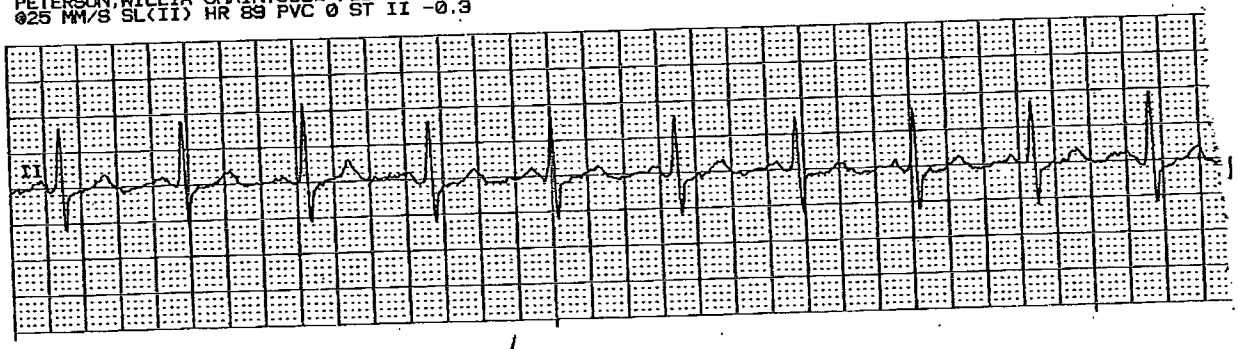
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REMARKS:

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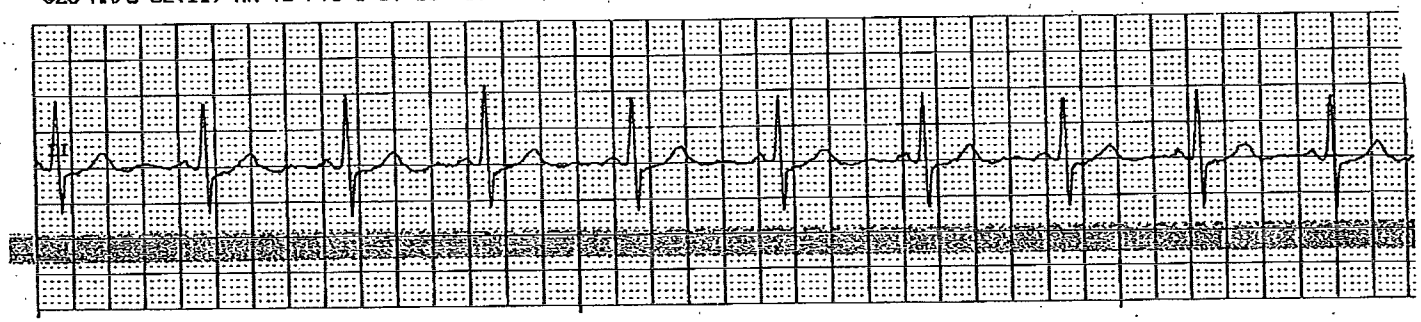
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DOB: [redacted] 85 SX: M IMD
MRN: 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

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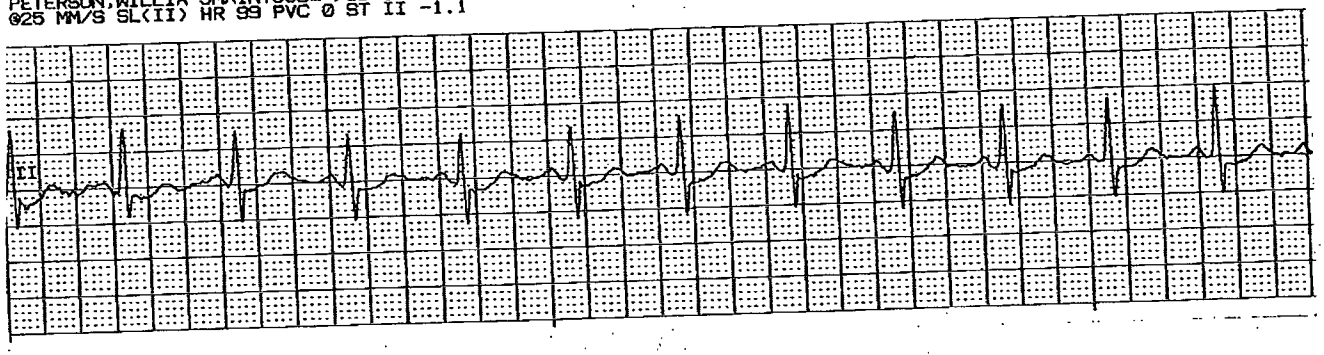
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TIME: 1500 RATE: 89 INTERPRETATION: SR

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@25 MM/S SL(II) HR 76 PVC 0 ST II -0.8



DATE: PR: .16 QRS: .08 TREATED:
TIME: 1900 RATE: 76 INTERPRETATION: SR

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL SAVED 28-MAY-2006 23:11:02
@25 MM/S SL(II) HR 99 PVC 0 ST II -1.1



DATE: PR: .16 QRS: .08 TREATED:
TIME: 2300 RATE: 100 INTERPRETATION: SR

HRR-0226-NS

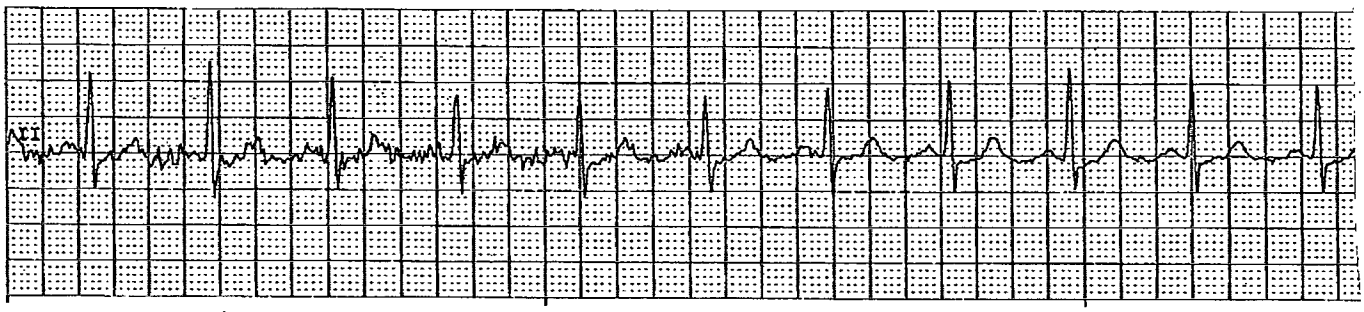
RHYTHM STRIP CHART FORM

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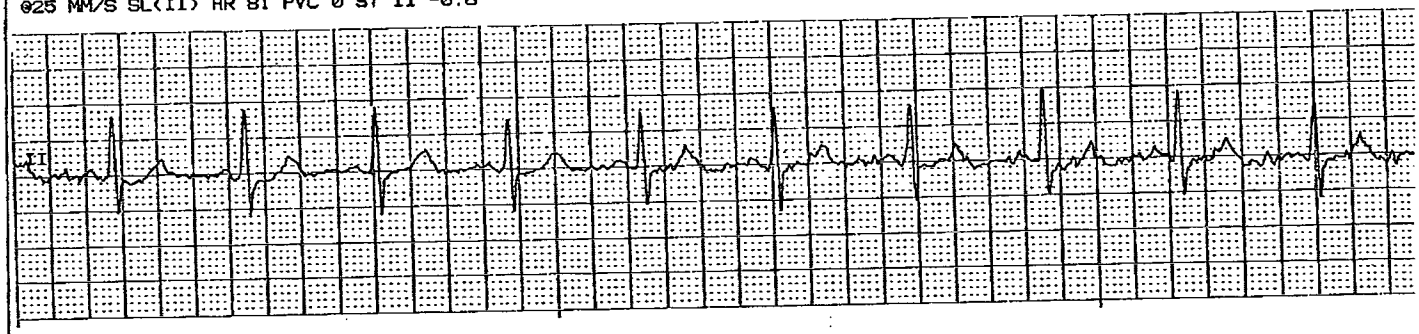
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DOB: [redacted] 85 SX: M IMD
[illegible] 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

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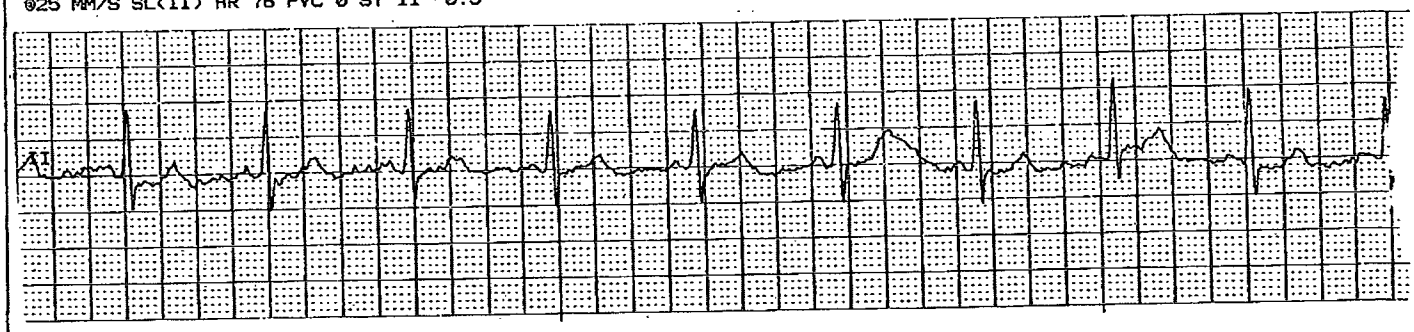
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TIME: [illegible] RATE: 87 INTERPRETATION: SR

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@25 MM/S SL(II) HR 81 PVC 0 ST II -0.6



DATE: [illegible] PR: .14 QRS: .06 TREATED: [illegible]
TIME: [illegible] RATE: 81 INTERPRETATION: SR

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL 28-MAY-2006 11:06:51
@25 MM/S SL(II) HR 76 PVC 0 ST II -0.5



DATE: [illegible] PR: .14 QRS: .06 TREATED: [illegible]
TIME: [illegible] RATE: 76 INTERPRETATION: SR

HRR-0226-NS

RHYTHM STRIP CHART FORM

-989-

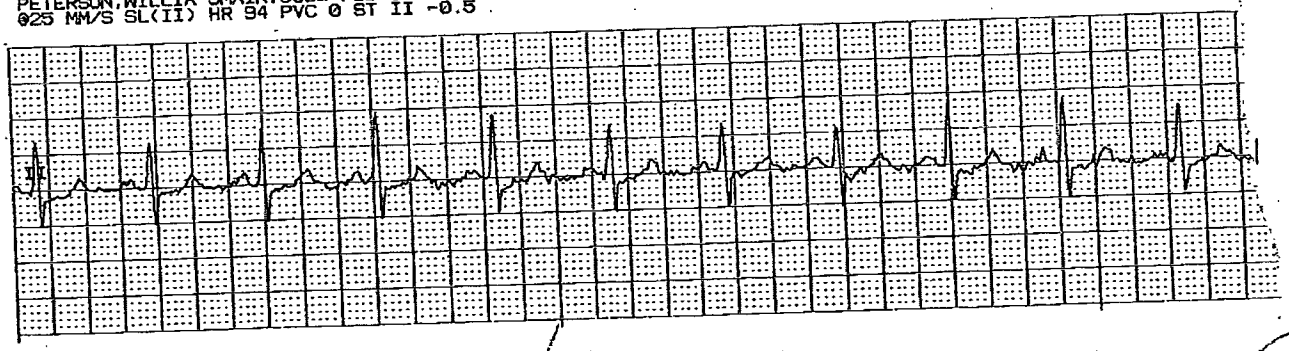
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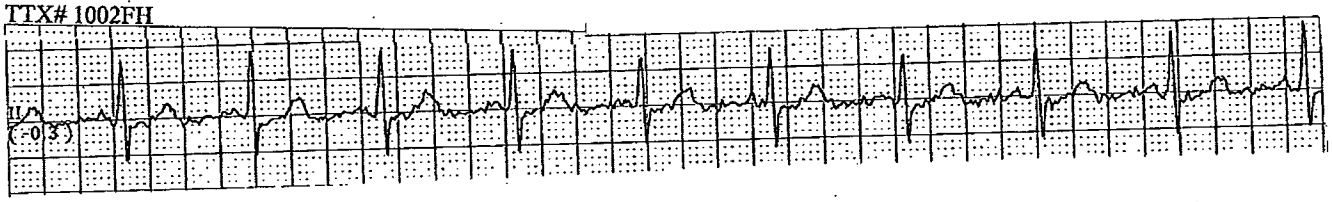
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DOB: [redacted] 85 SX: M IMD
MRN: 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

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@25 MM/S SL(II) HR 94 PVC 0 ST II -0.5



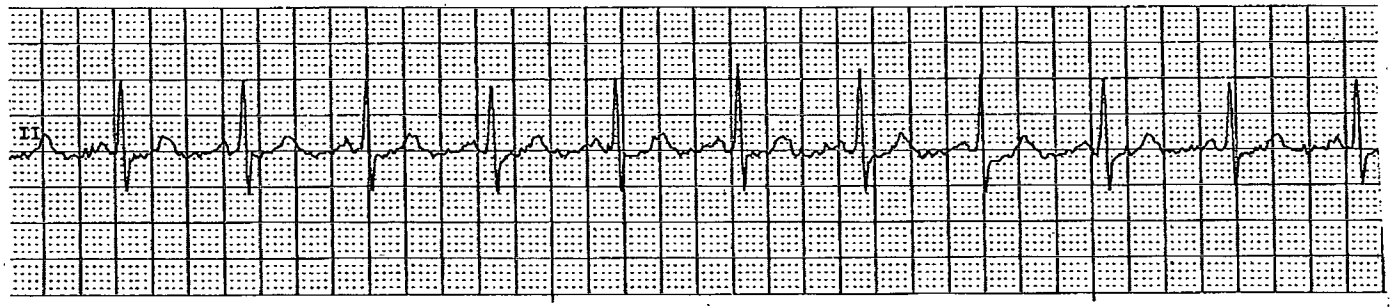
DATE: 5/27 PR: 0.12 QRS: 0.08 TREATED:
TIME: 1600 RATE: 94 INTERPRETATION: SR KCl

PETERSON,WILLIA 102829710 5/27/2006 7:29:11 PM
HR 79 PVC 0 ST II -0.3 mm
TTX# 1002FH



DATE: PR: 120 QRS: 104 TREATED:
TIME: RATE: 79 INTERPRETATION: SR TW

PETERSON,WILLIA 5MAIN!503* PID:102829710 TTX#1002FH MANUAL 27-MAY-2006 23:30:20
@25 MM/S SL(II) HR 87 PVC 0 ST II -0.8



DATE: PR: 120 QRS: 104 TREATED:
TIME: RATE: 87 INTERPRETATION: SR TW

HRR-0226-NS

RHYTHM STRIP CHART FORM

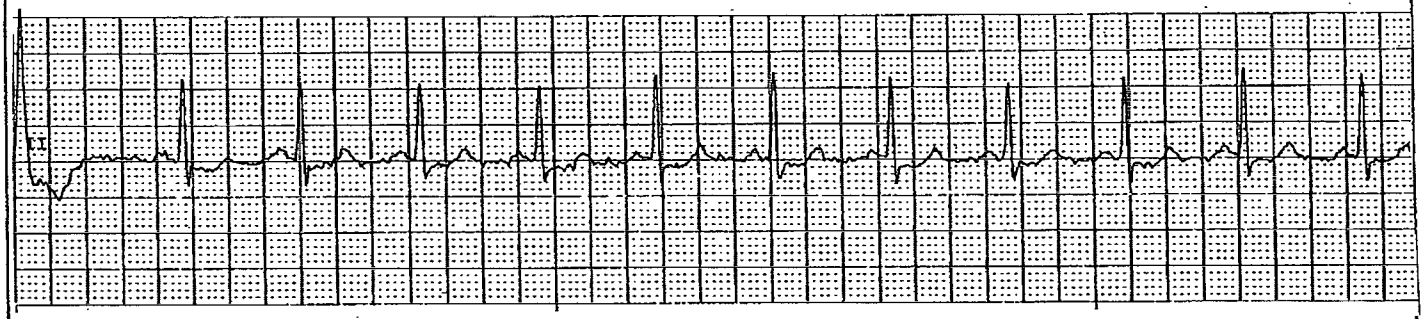
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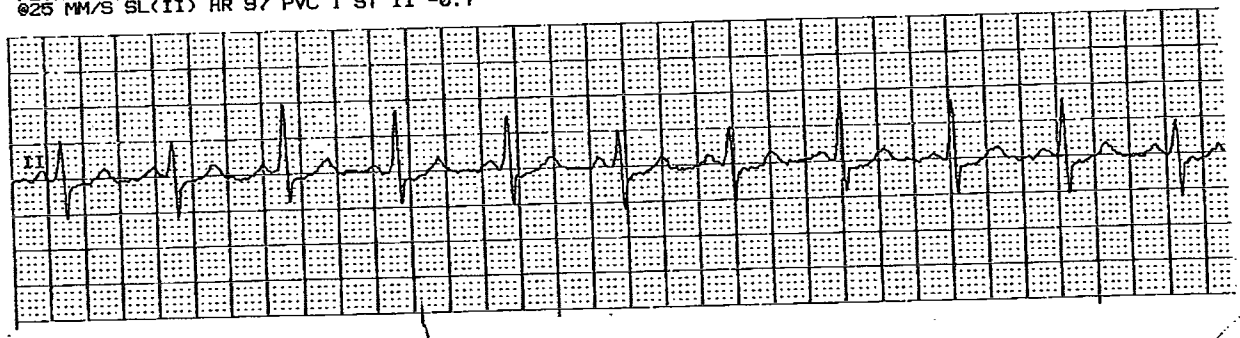
PETERSON SR, WILLIAM SR
DOB: [redacted] 85 SX: M IMD
MRN: 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

PETERSON,WILLIA 5MAIN!503* PID:102829710 TTX#1002FH MANUAL 27-MAY-2006 02:54:34
@25 MM/S SL(II) HR 87 PVC 3 ST II -0.9



DATE: _____ PR: 12 QRS: .08 TREATED: EC
TIME: _____ RATE: 87 INTERPRETATION: SVT, PVC

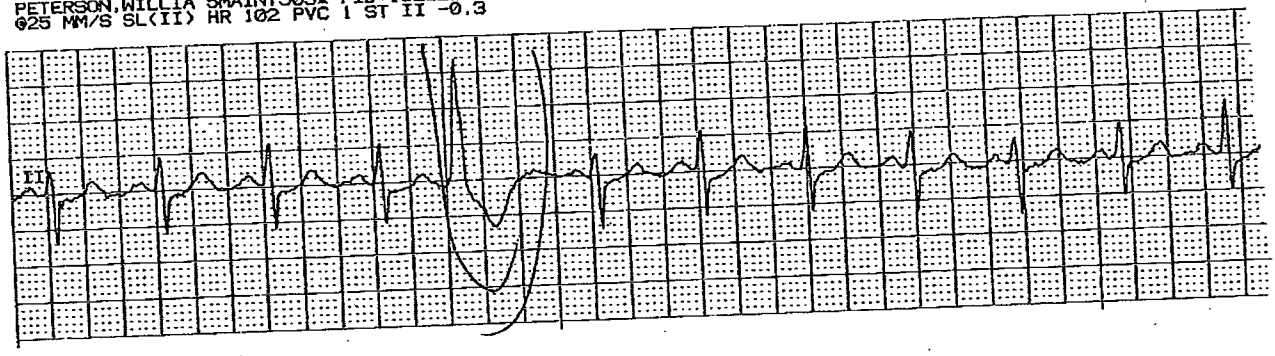
PETERSON,WILLIA 5MAIN!503* PID:102829710 TTX#1002FH MANUAL 27-MAY-2006 08:54:06
@25 MM/S SL(II) HR 97 PVC 1 ST II -0.7



DATE: 5/27 PR: 0.12 QRS: 0.08 TREATED: _____
TIME: 0709 RATE: 97 INTERPRETATION: SR

KE

PETERSON,WILLIA 5MAIN!503* PID:102829710 TTX#1002FH MANUAL SAVED 27-MAY-2006 10:54:18
@25 MM/S SL(II) HR 102 PVC 1 ST II -0.3



DATE: 5/27 PR: 0.14 QRS: 0.08 TREATED: _____
TIME: 1100 RATE: 102 INTERPRETATION: ST & PVC

KE

HRR-0226-NS

RHYTHM STRIP CHART FORM

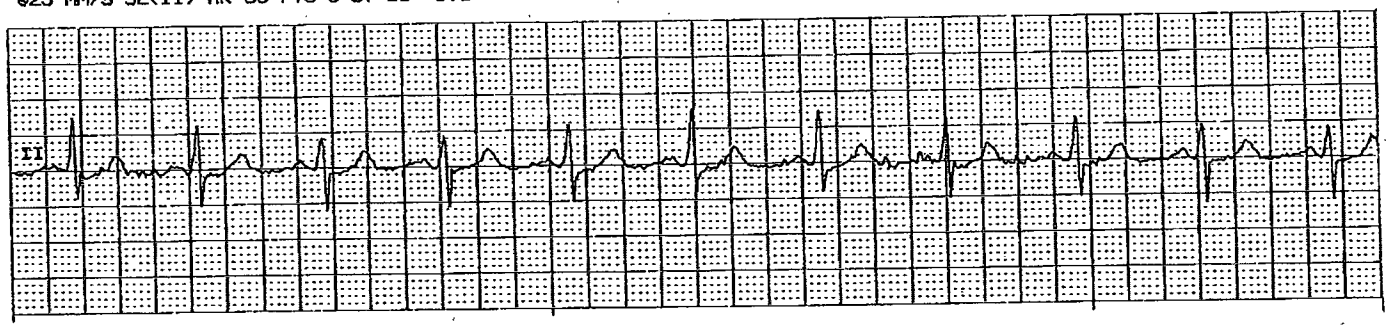
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REMARKS:

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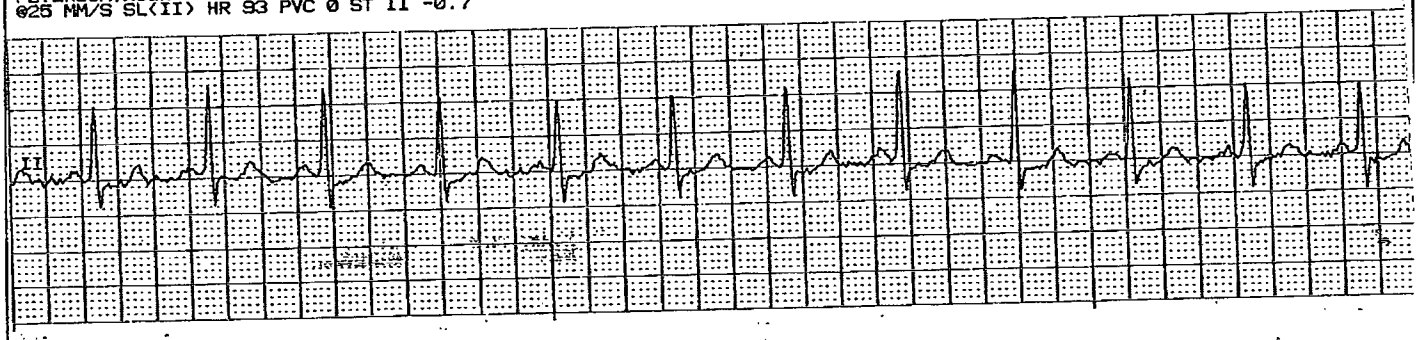
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MRN: 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

PETERSON,WILLIA 5MAIN!503* PID:102829710 TTX#1002FH MANUAL SAVED 26-MAY-2006 15:00:35
@25 MM/S SL(II) HR 85 PVC 0 ST II -0.3



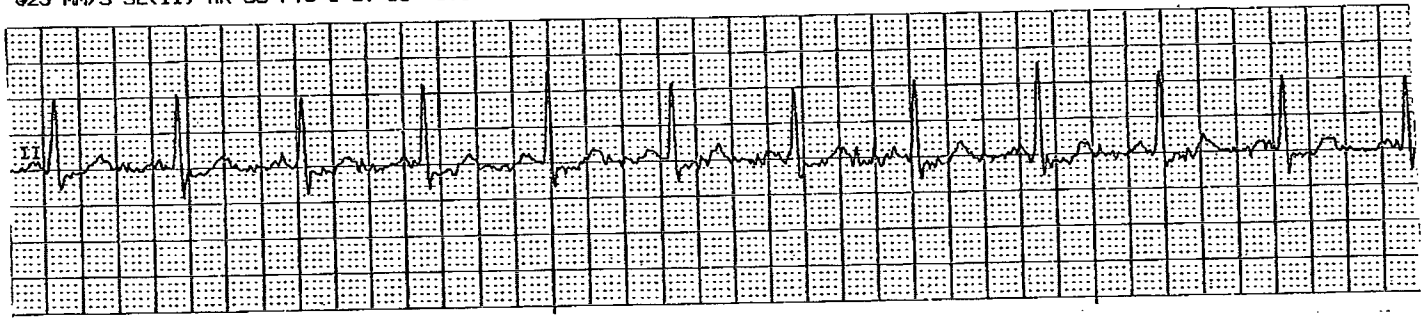
DATE: 5-26-06 PR: .14 QRS: .08 TREATED:
TIME: 1500 RATE: 85 INTERPRETATION: SR TAW

PETERSON,WILLIA 5MAIN!503* PID:102829710 TTX#1002FH MANUAL 26-MAY-2006 19:04:32
@25 MM/S SL(II) HR 93 PVC 0 ST II -0.7



DATE: PR: .12 QRS: .06 TREATED: EC
TIME: RATE: 93 INTERPRETATION: SR

PETERSON,WILLIA 5MAIN!503* PID:102829710 TTX#1002FH MANUAL 26-MAY-2006 22:58:30
@25 MM/S SL(II) HR 88 PVC 0 ST II -0.5



DATE: PR: .12 QRS: .06 TREATED: EC
TIME: RATE: 88 INTERPRETATION: SR

HRR-0226-NS

RHYTHM STRIP CHART FORM

-992-

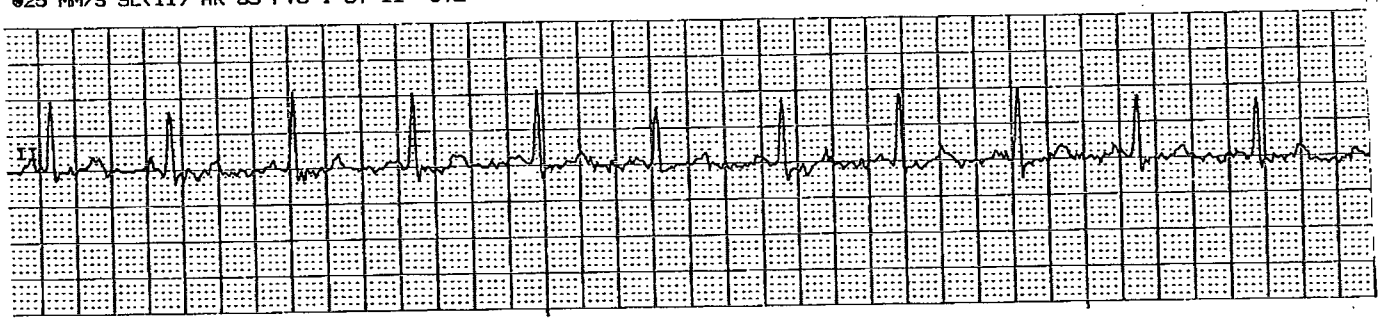
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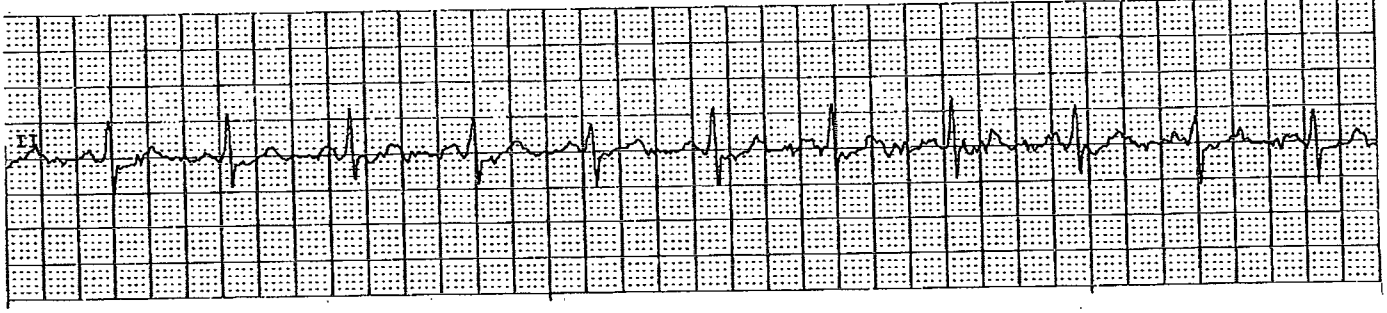
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DOB: [redacted] 85 SX: M IMD
MRN: 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

PETERSON,WILLIA 5MAIN:503* PID:102829710 TTX#1002FH MANUAL SAVED 26-MAY-2006 03:07:41
@25 MM/S SL(II) HR 89 PVC 1 ST II -0.2



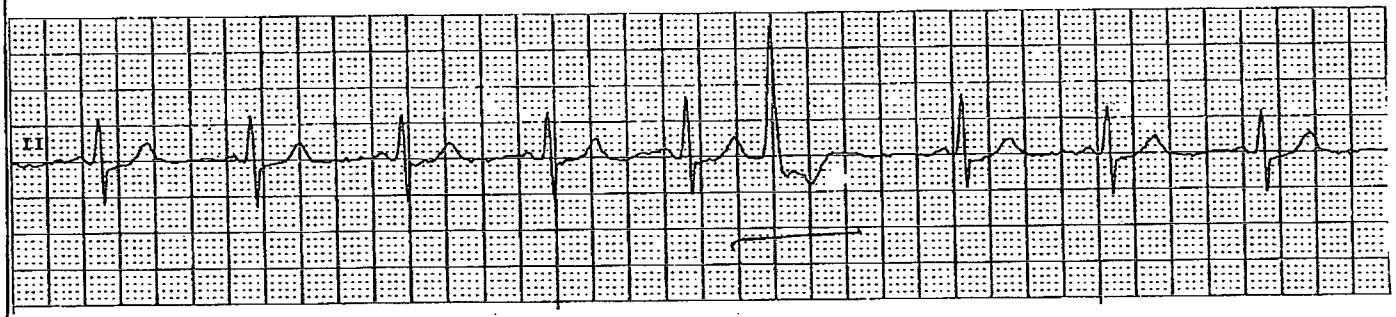
DATE: 52606 PR: .12 QRS: .04 TREATED:
TIME: 3AM RATE: 89 INTERPRETATION: SR

PETERSON,WILLIA 5MAIN:503* PID:102829710 TTX#1002FH MANUAL SAVED 26-MAY-2006 07:00:28
@25 MM/S SL(II) HR 89 PVC 0 ST II -0.7



DATE: 5-26-06 PR: .16 QRS: .08 TREATED:
TIME: 0700 RATE: 89 INTERPRETATION: SR TAW

PETERSON,WILLIA 5MAIN:503* PID:102829710 TTX#1002FH MANUAL SAVED 26-MAY-2006 11:00:31
@25 MM/S SL(II) HR 74 PVC 1 ST II -0.7



DATE: 5-26-06 PR: .12 QRS: .08 TREATED:
TIME: 1100 RATE: 74 INTERPRETATION: SR ± PVC TAW

HRR-0226-NS

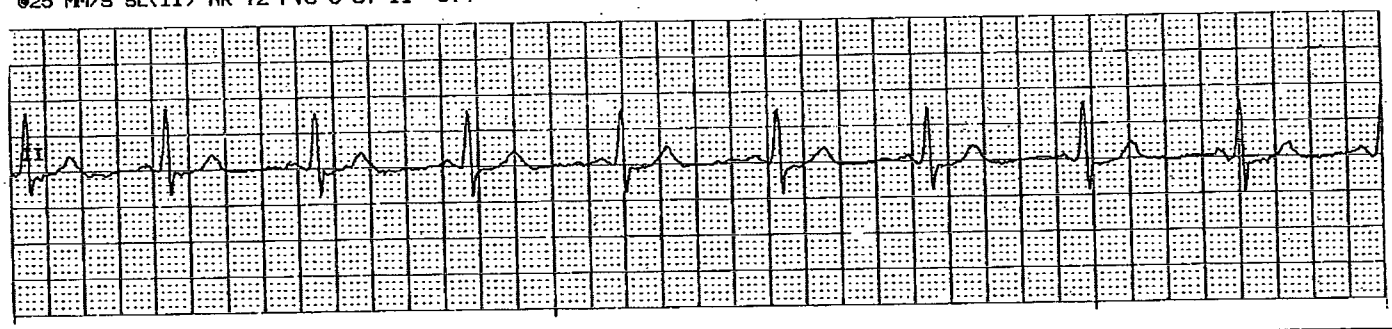
RHYTHM STRIP CHART FORM

REMARKS:

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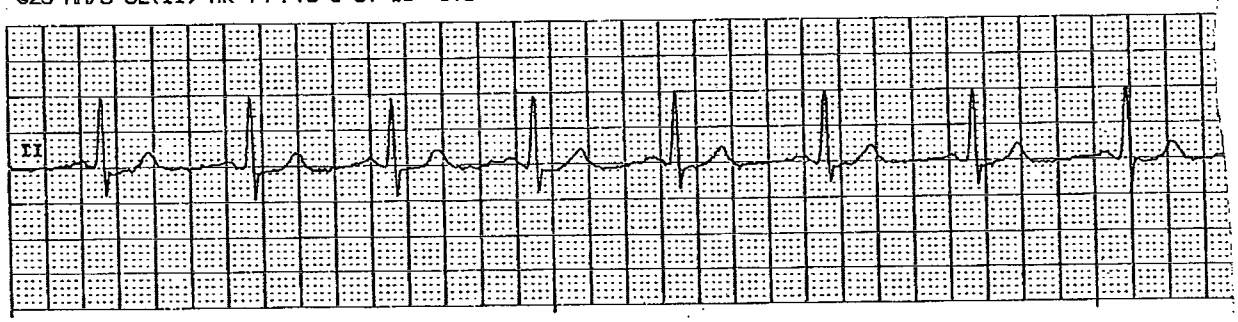
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PETERSON SR, WILLIAM SR
DOB: [redacted] 85 SX: M IMD
MRN:
ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

PETERSON,WILLIA 5MAIN!503* PID:102829710 TTX#1002FH MANUAL 25-MAY-2006 15:06:34
@25 MM/S SL(II) HR 72 PVC 0 ST II -0.4



DATE: 5-25-06 PR: .14 QRS: .10 TREATED: TAW
TIME: 1500 RATE: 72 INTERPRETATION: SR

PETERSON,WILLIA 5MAIN!503* PID:102829710 TTX#1002FH MANUAL SAVED 25-MAY-2006 19:00:25
@25 MM/S SL(II) HR 74 PVC 0 ST II -0.6



DATE: 5-25-06 PR: .16 QRS: .016 TREATED:
TIME: 7P RATE: 74 INTERPRETATION: SR

PETERSON,WILLIA 5MAIN!503* PID:102829710 TTX#1002FH MANUAL SAVED 25-MAY-2006 22:55:51
@25 MM/S SL(II) HR 87 PVC 2 ST II -0.8



DATE: 5-25-06 PR: .16 QRS: .04 TREATED:
TIME: 11P RATE: 87 INTERPRETATION: SR c PVC

HRR-0226-NS

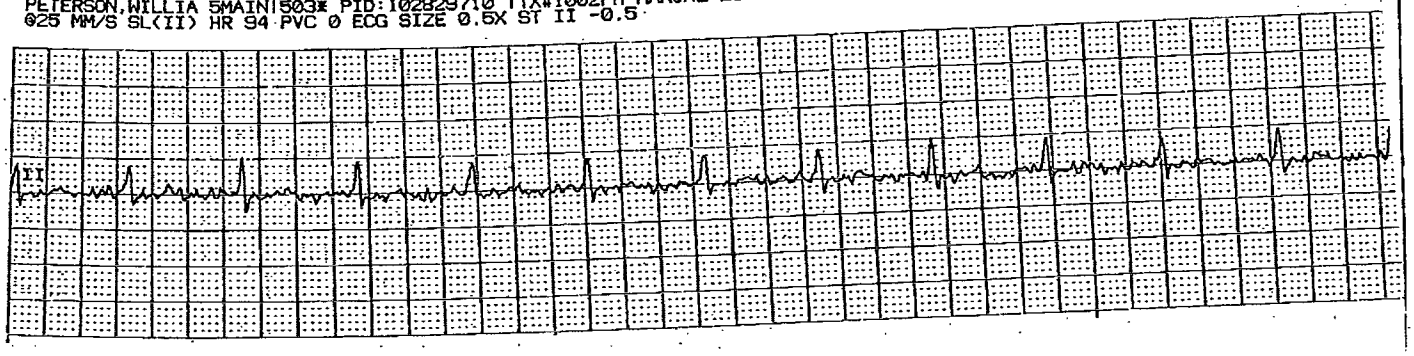
RHYTHM STRIP CHART FORM

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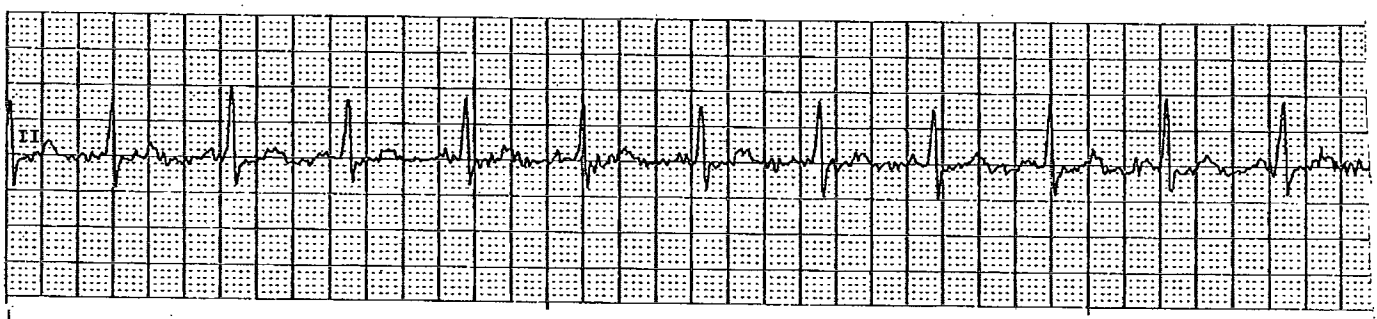
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PETERSON SR, WILLIAM SR
DOB: [redacted] 85 SX: M IMD
MRN: 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL 25-MAY-2006 04:09:33
@25 MM/S SL(II) HR 94 PVC 0 ECG SIZE 0.5X ST II -0.5



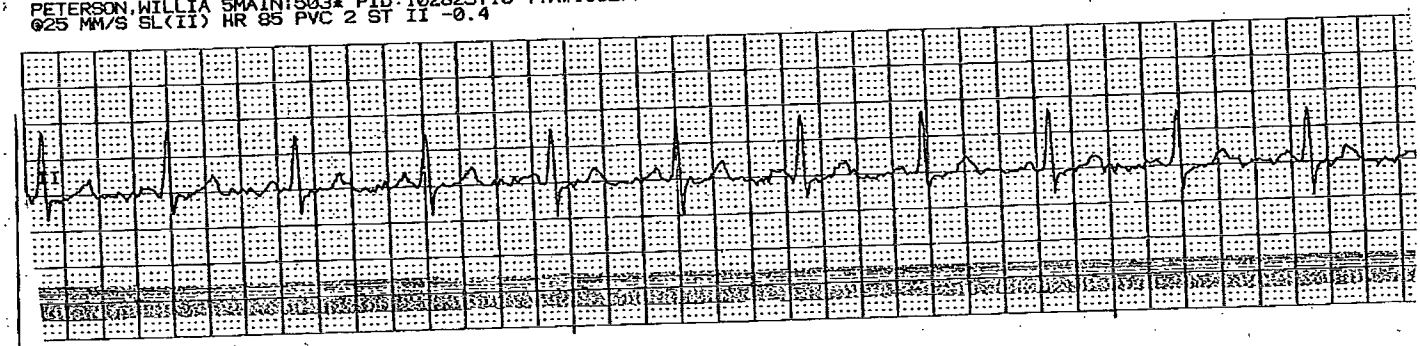
DATE: 52506 PR: 112 QRS: 106 TREATED:
TIME: 1304 RATE: 94 INTERPRETATION: SR

PETERSON,WILLIA *CHNGE BATTERY* 5MAIN|503* PID:102829710 TTX#1002FH MANUAL 25-MAY-2006 07:26:27 CHNGE BATTERY
@25 MM/S SL(II) HR 92 PVC 0 ST II -0.1



DATE: PR: 114 QRS: 106 TREATED: GC
TIME: RATE: 94 INTERPRETATION: SR

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL 25-MAY-2006 11:33:37
@25 MM/S SL(II) HR 85 PVC 2 ST II -0.4



DATE: PR: 116 QRS: 108 TREATED: GW
TIME: RATE: 98 INTERPRETATION: SR

HRR-0228-NS

RHYTHM STRIP CHART FORM

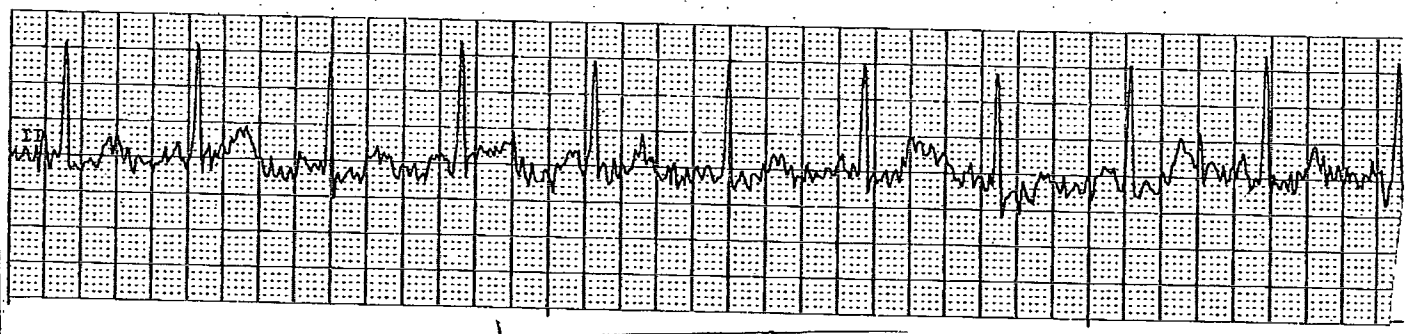
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PETERSON SR, WILLIAM SR
DOB: [redacted] 85 SX: M IMD
MRN: 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL SAVED 24-MAY-2006 14:36:08
@25 MM/S HR 81 PVC 0 ECG SIZE 2X ST V1 0.4



DATE: _____ PR: .12 QRS: .08 TREATED: SB

TIME: _____ RATE: 80 INTERPRETATION: SB

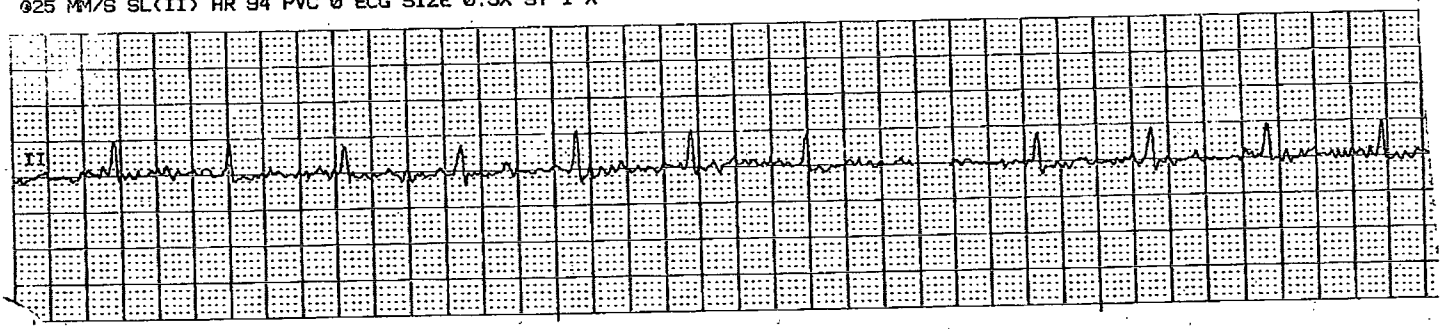
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@25 MM/S HR 91 PVC 0 ECG SIZE 2X ST II -0.7



DATE: 52406 PR: .16 QRS: .08 TREATED: _____

TIME: 7p RATE: 91 INTERPRETATION: SR

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL SAVED 24-MAY-2006 23:22:08
@25 MM/S SL(II) HR 94 PVC 0 ECG SIZE 0.5X ST I X



DATE: 52406 PR: .16 QRS: .08 TREATED: _____

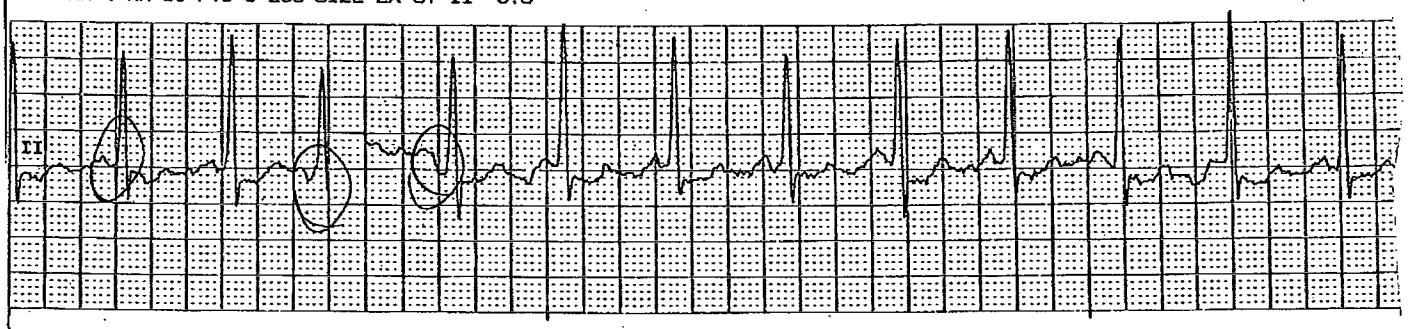
TIME: 11p RATE: 94 INTERPRETATION: SR

REMARKS:

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PETERSON SR, WILLIAM SR
DOB: [redacted] 85 SX: M IMD
MRN: 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL SAVED 24-MAY-2006 02:59:07
@25 MM/S HR 95 PVC 0 ECG SIZE 2X ST II -0.9



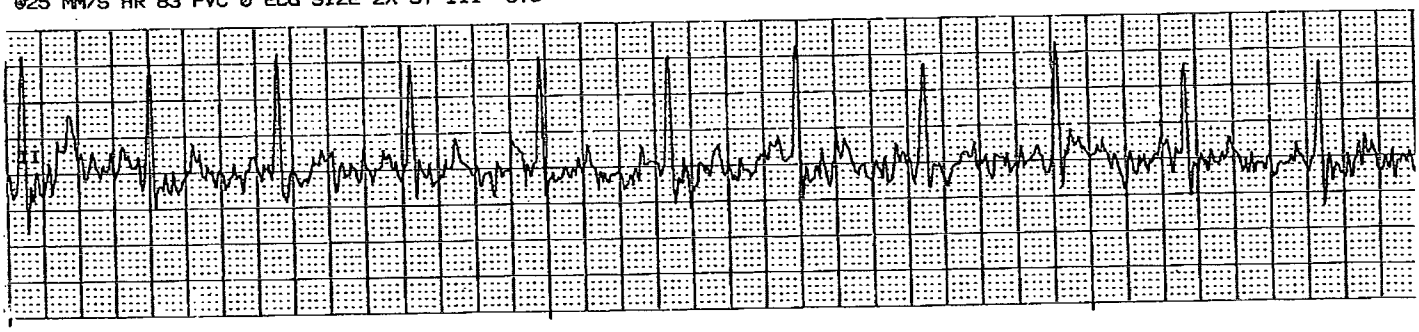
DATE: _____ PR: _____ QRS: .08 TREATED: EC
TIME: _____ RATE: 95 INTERPRETATION: WAP

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL 24-MAY-2006 06:55:25
@25 MM/S HR 83 PVC 0 ECG SIZE 2X ST II -0.7



DATE: _____ PR: _____ QRS: .08 TREATED: BB
TIME: _____ RATE: 83 INTERPRETATION: WAP

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL 24-MAY-2006 11:05:07
@25 MM/S HR 83 PVC 0 ECG SIZE 2X ST III -0.5



DATE: _____ PR: .16 QRS: .08 TREATED: BB
TIME: _____ RATE: 83 INTERPRETATION: BBB

HRR-0228-NS

RHYTHM STRIP CHART FORM

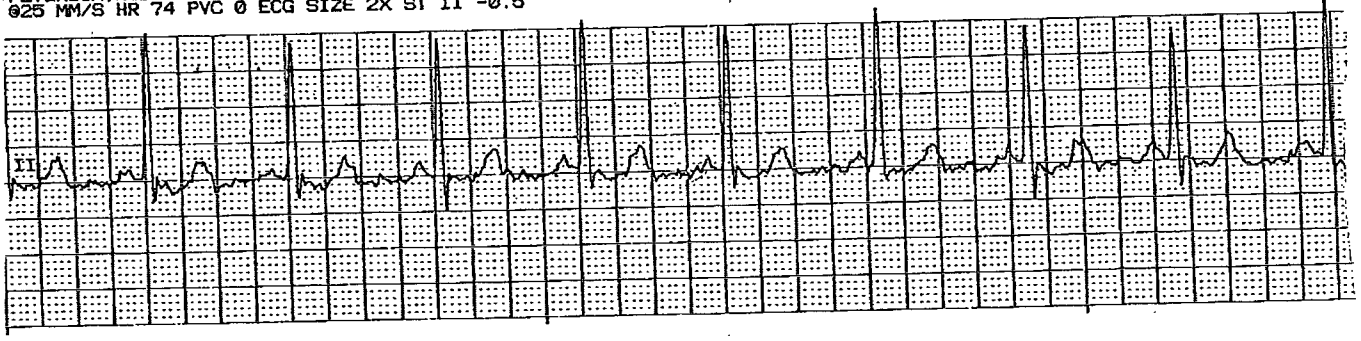
REMARKS:

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1v2829710

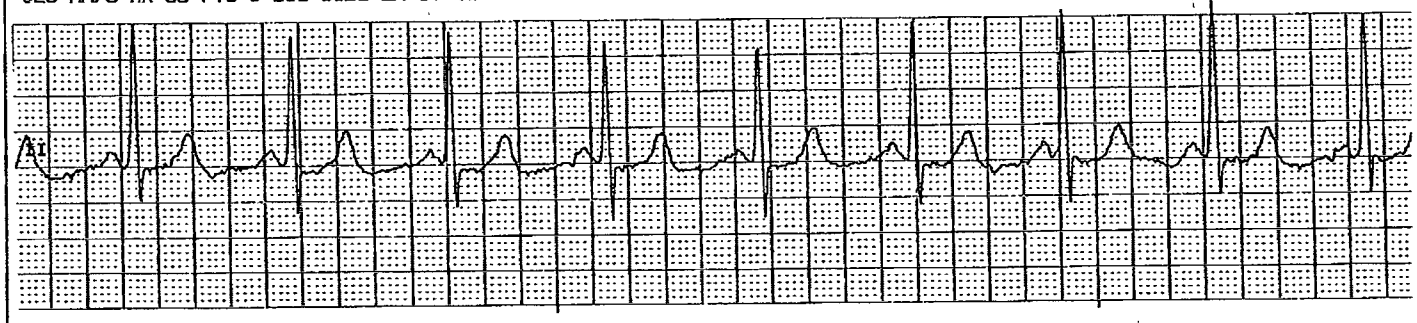
PETERSON SR, WILLIAM SR
DOB: [redacted] 85 SX: M IMD
MRN: 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL 23-MAY-2006 14:47:53
@25 MM/S HR 74 PVC 0 ECG SIZE 2X ST II -0.5



DATE: _____ PR: .12 QRS: .06 TREATED: NC
TIME: _____ RATE: 72 INTERPRETATION: SR

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL 23-MAY-2006 18:46:52
@25 MM/S HR 69 PVC 0 ECG SIZE 2X ST II -0.5



DATE: _____ PR: .14 QRS: .08 TREATED: EC
TIME: _____ RATE: 69 INTERPRETATION: SR

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL 23-MAY-2006 23:20:36
@25 MM/S HR 77 PVC 0 ECG SIZE 2X ST V1 0.8



DATE: _____ PR: .14 QRS: .08 TREATED: EC
TIME: _____ RATE: 77 INTERPRETATION: SR

HRR-0226-NS

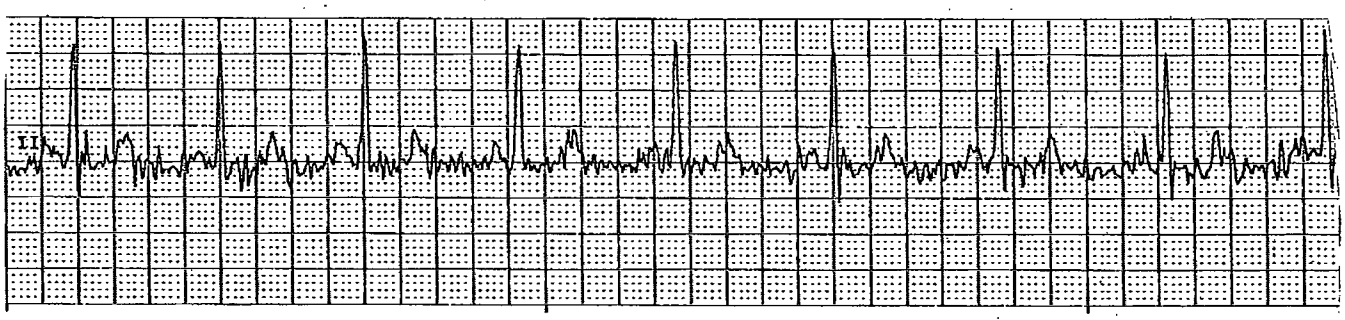
RHYTHM STRIP CHART FORM

REMARKS:

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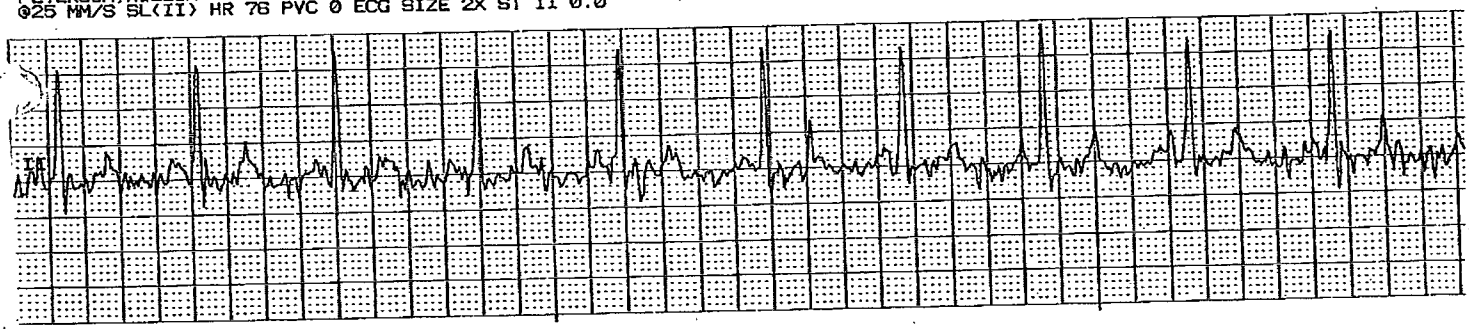
102829710
PETERSON SR, WILLIAM SR
DOB: [redacted] 85 SX: M IMD
MRN: 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

PETERSON,WILLIA 5MAIN!503* PID:102829710 TTX#1002FH MANUAL SAVED 23-MAY-2006 03:01:01
@25 MM/S SL(II) HR 69 PVC 1 ECG SIZE 2X ST II -0.5



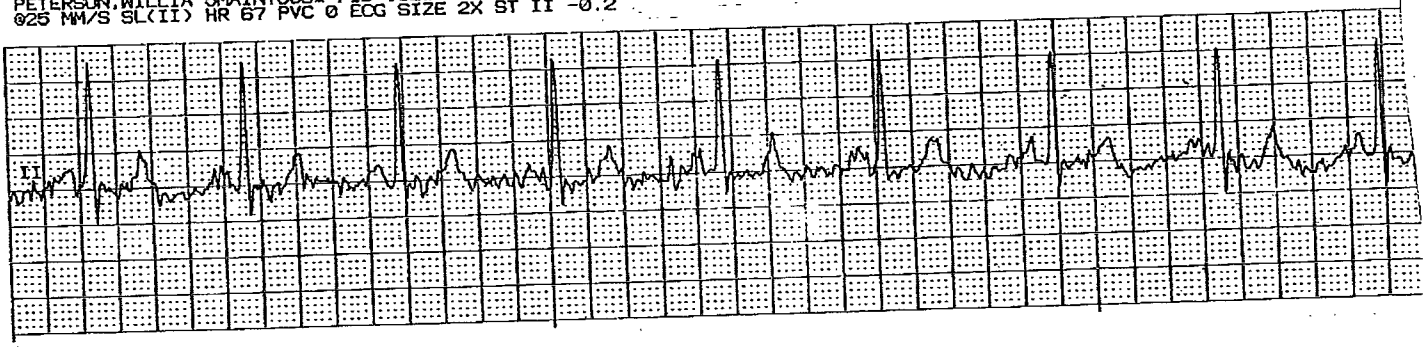
DATE: DSW PR: .18 QRS: .08 TREATED:
TIME: RATE: 68 INTERPRETATION: SR BSW

PETERSON,WILLIA 5MAIN!503* PID:102829710 TTX#1002FH MANUAL 23-MAY-2006 07:14:17
@25 MM/S SL(II) HR 76 PVC 0 ECG SIZE 2X ST II 0.0



DATE: PR: .16 QRS: .08 TREATED: YC
TIME: RATE: 72 INTERPRETATION: SR

PETERSON,WILLIA 5MAIN!503* PID:102829710 TTX#1002FH MANUAL SAVED 23-MAY-2006 10:55:45
@25 MM/S SL(II) HR 67 PVC 0 ECG SIZE 2X ST II -0.2



DATE: PR: .16 QRS: .06 TREATED: YC
TIME: RATE: 65 INTERPRETATION: SR

HRR-0228-NS

RHYTHM STRIP CHART FORM

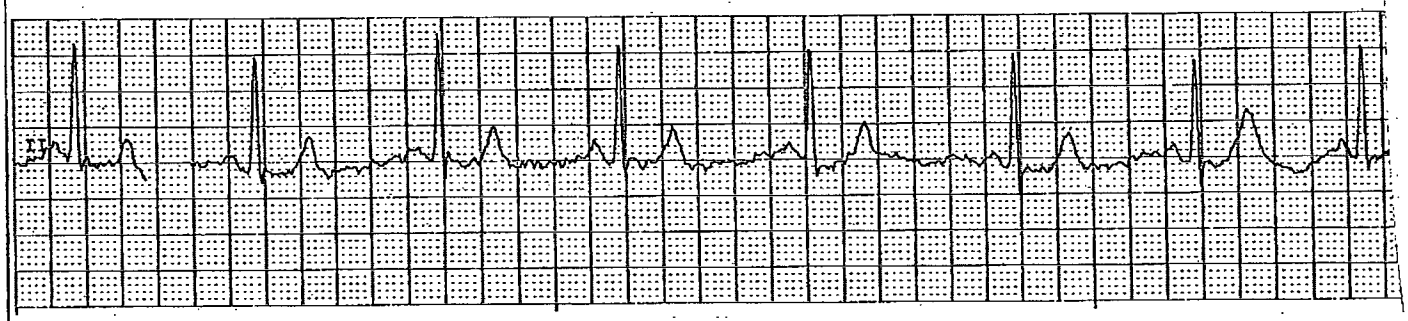
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REMARKS:

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102829710
PETERSON SR, WILLIAM SR
DOB: [redacted] 85 SX: M IMD
MRN: 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

PETERSON,WILLIA *CHNGE BATTERY* 5MAIN!503* PID:102829710 TTX#1002FH MANUAL 22-MAY-2006 15:01:48 CHNGE BATTERY
@25 MM/S V FAIL HR 59 PVC 0 ECG SIZE 2X ST II -0.4



DATE: _____ PR: .16 QRS: .06 TREATED: _____
TIME: _____ RATE: 59 INTERPRETATION: NL TW

PETERSON,WILLIA 5MAIN!503* PID:102829710 TTX#1002FH MANUAL SAVED 22-MAY-2006 19:01:41
@25 MM/S SL(II) HR 68 PVC 0 ECG SIZE 2X ST II 0.0



DATE: _____ PR: .16 QRS: .08 TREATED: _____
TIME: 1900 RATE: 72 INTERPRETATION: SR BT W

PETERSON,WILLIA 5MAIN!503* PID:102829710 TTX#1002FH MANUAL SAVED 22-MAY-2006 23:30:32
@25 MM/S SL(II) HR 69 PVC 0 ECG SIZE 2X ST II -0.6



DATE: _____ PR: .16 QRS: .09 TREATED: _____
TIME: 2300 RATE: 72 INTERPRETATION: SR 1900 W

HRR-0228-NS

RHYTHM STRIP CHART FORM

REMARKS:

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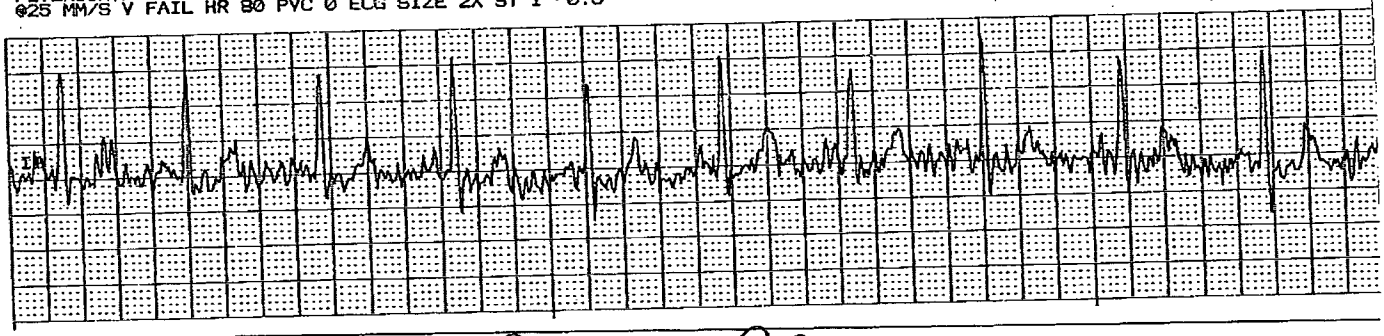
PETERSON SR, WILLIAM SR
DOB: [redacted] 85 SX: M IMD
MRN: 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL SAVED 22-MAY-2006 04:07:39
@25 MM/S HR X PVC 0 ECG SIZE 2X ST I -0.3



DATE: _____ PR: .16 QRS: .08 TREATED: _____
TIME: 5:20 RATE: 68 INTERPRETATION: SL

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL SAVED 22-MAY-2006 07:05:45
@25 MM/S V FAIL HR 80 PVC 0 ECG SIZE 2X ST I -0.5



DATE: _____ PR: .16 QRS: .08 TREATED: EC
TIME: _____ RATE: 80 INTERPRETATION: SH

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL 22-MAY-2006 10:56:02
@25 MM/S V FAIL HR 83 PVC 0 ECG SIZE 2X ST II -0.4



DATE: _____ PR: .12 QRS: .06 TREATED: EC
TIME: _____ RATE: 83 INTERPRETATION: SH

RRR-0228-NS

RHYTHM STRIP CHART FORM

-1001-

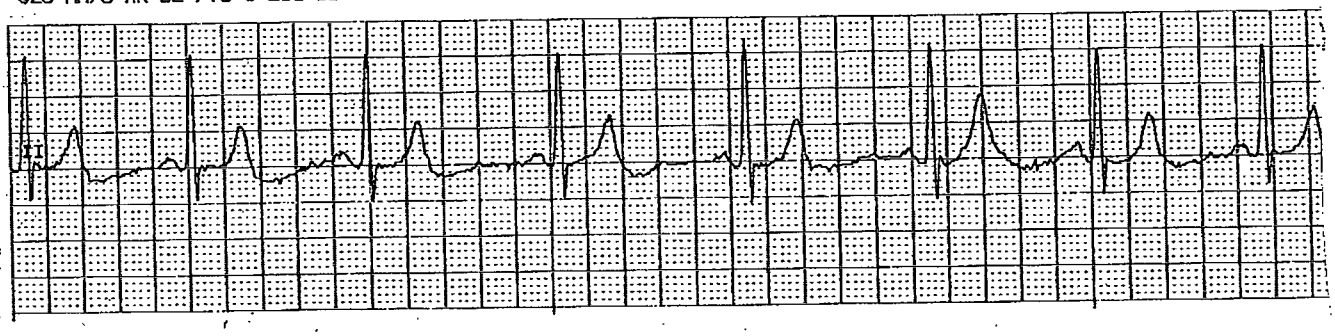
REMARKS:

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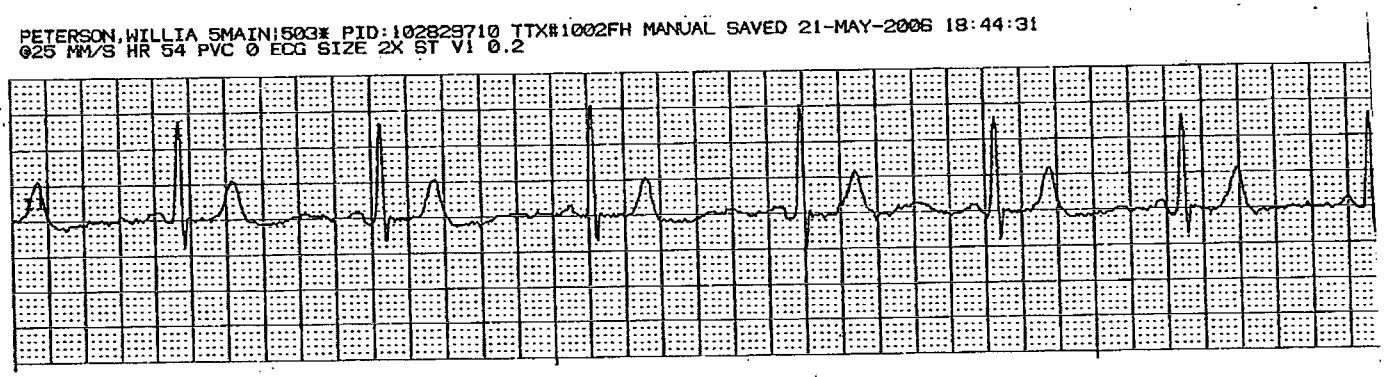
PETERSON SR, WILLIAM SR
DOB: [redacted] 85 SX: M IMD
MRN: 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL 21-MAY-2006 14:50:14
@25 MM/S HR 62 PVC 0 ECG SIZE 2X ST V1 0.3



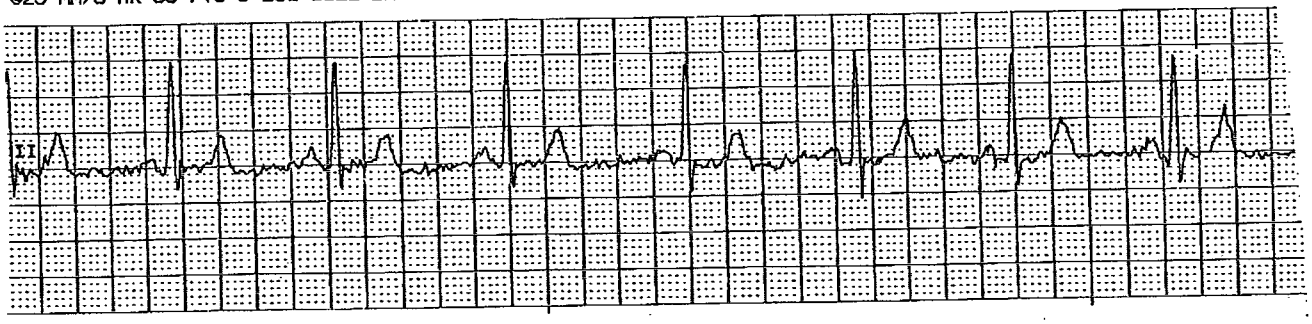
DATE: _____ PR: 120 QRS: .08 TREATED: NR NC
TIME: _____ RATE: 60 INTERPRETATION: SA

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL SAVED 21-MAY-2006 18:44:31
@25 MM/S HR 54 PVC 0 ECG SIZE 2X ST V1 0.2



DATE: _____ PR: .16 QRS: .08 TREATED: _____
TIME: 1900 RATE: 54 INTERPRETATION: SBA

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL SAVED 21-MAY-2006 23:04:05
@25 MM/S HR 65 PVC 0 ECG SIZE 2X ST I -0.4



DATE: 2320 PR: .16 QRS: .08 TREATED: _____
TIME: 2320 RATE: 108 INTERPRETATION: SR

HRR-022E-NS

RHYTHM STRIP CHART FORM

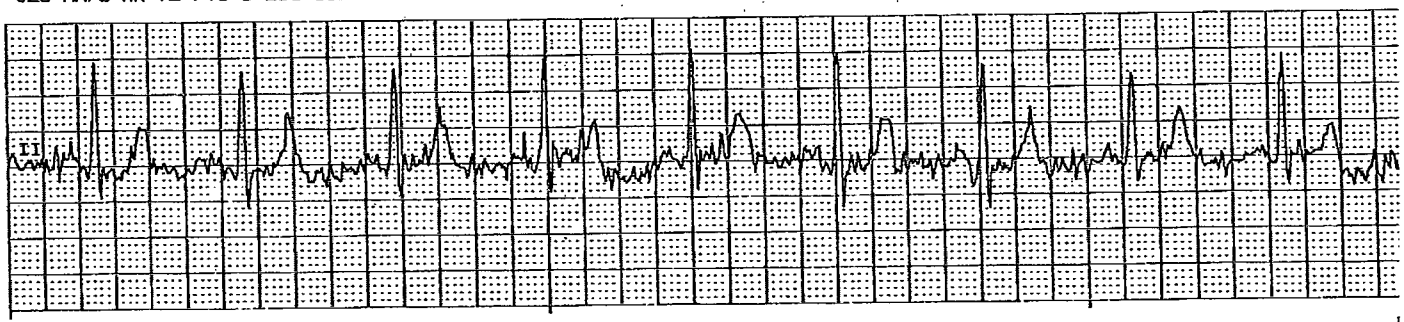
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REMARKS:

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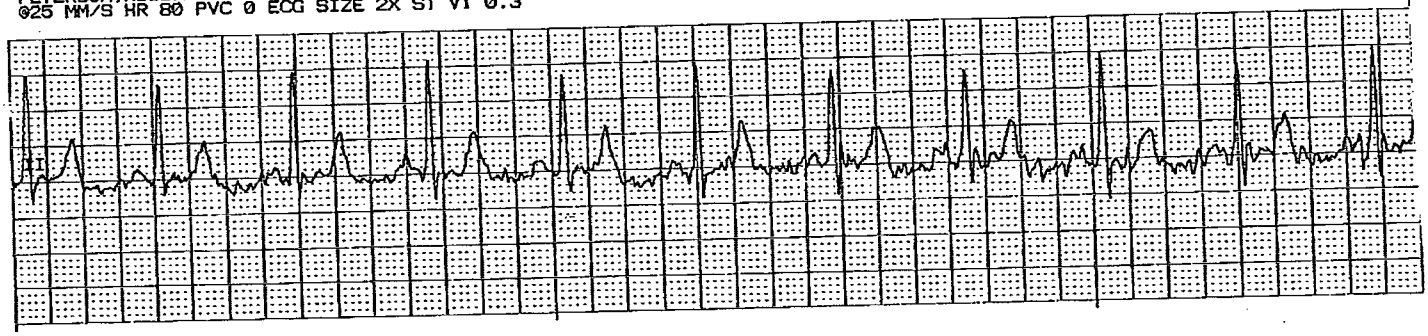
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PETERSON SR, WILLIAM SR
DOB: [redacted] 85 SX: M IMD
MRN: 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

PETERSON,WILLIA 5MAIN|503¤ PID:102829710 TTX#1002FH MANUAL SAVED 21-MAY-2006 03:21:50
@25 MM/S HR 72 PVC 0 ECG SIZE 2X ST II 0.5



DATE: PR: .18 QRS: .09 TREATED:
TIME: 0300 RATE: 75 INTERPRETATION: SR

PETERSON,WILLIA 5MAIN|503¤ PID:102829710 TTX#1002FH MANUAL 21-MAY-2006 06:50:14
@25 MM/S HR 80 PVC 0 ECG SIZE 2X ST V1 0.3



DATE: PR: .16 QRS: .08 TREATED: NC
TIME: RATE: 80 INTERPRETATION: SR

PETERSON,WILLIA 5MAIN|503¤ PID:102829710 TTX#1002FH MANUAL 21-MAY-2006 11:02:20
@25 MM/S HR 79 PVC 0 ECG SIZE 2X ST I 0.5



DATE: PR: .16 QRS: .08 TREATED: NC
TIME: RATE: 79 INTERPRETATION: SR, PVC

1RR-0226-NS

RHYTHM STRIP CHART FORM

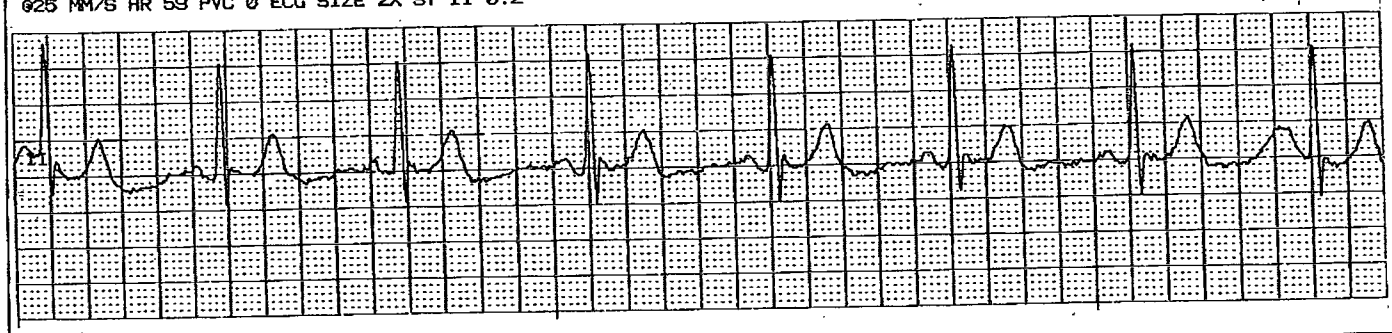
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REMARKS:

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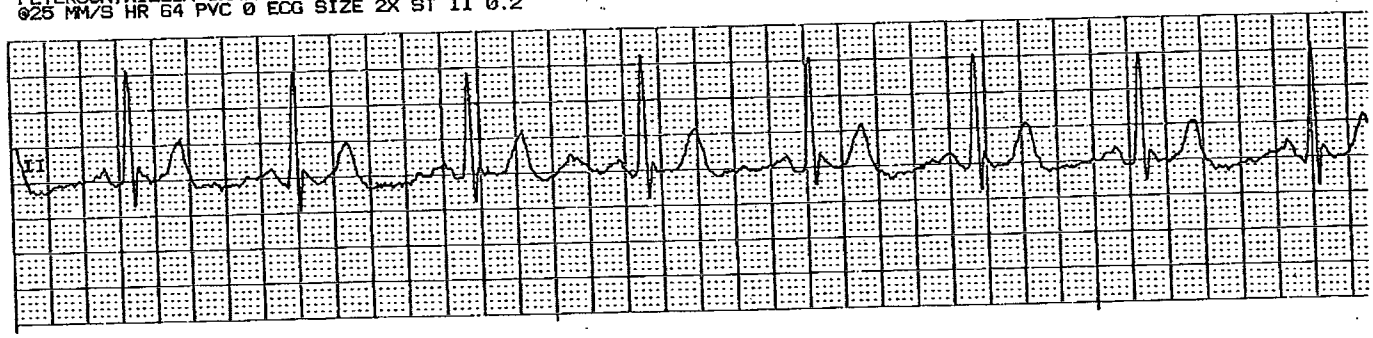
102829710
PETERSON SR, WILLIAM SR
DOB: [redacted] 85 SX: M IMD
MRN: 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL SAVED 19-MAY-2006 15:00:33
@25 MM/S HR 59 PVC 0 ECG SIZE 2X ST II 0.2



DATE: 5-19-06 PR: .16 QRS: .08 TREATED:
TIME: 1500 RATE: 60 INTERPRETATION: SR

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL SAVED 19-MAY-2006 18:49:15
@25 MM/S HR 64 PVC 0 ECG SIZE 2X ST II 0.2



DATE: PR: .18 QRS: .08 TREATED:
TIME: 1900 RATE: 65 INTERPRETATION: SR

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL SAVED 19-MAY-2006 23:30:46
@25 MM/S HR 63 PVC 0 ECG SIZE 2X ST I -0.2



DATE: PR: .16 QRS: .08 TREATED:
TIME: 2300 RATE: 62 INTERPRETATION: SR

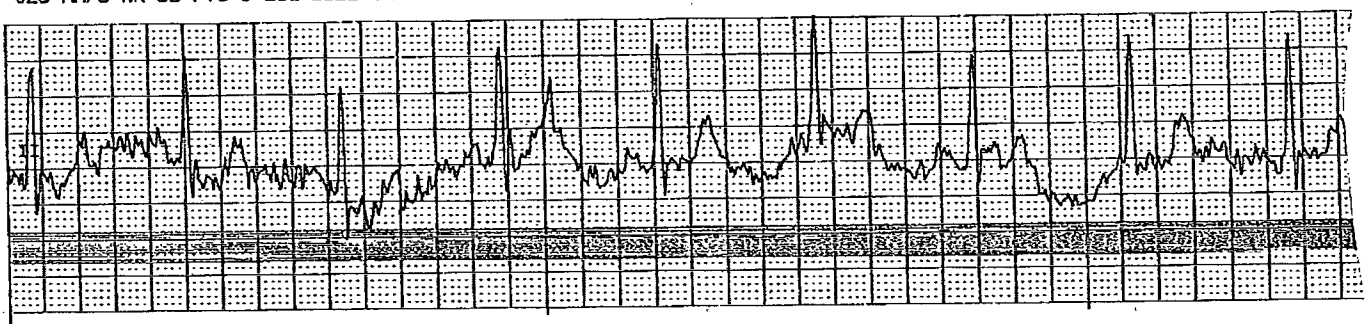
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REMARKS:

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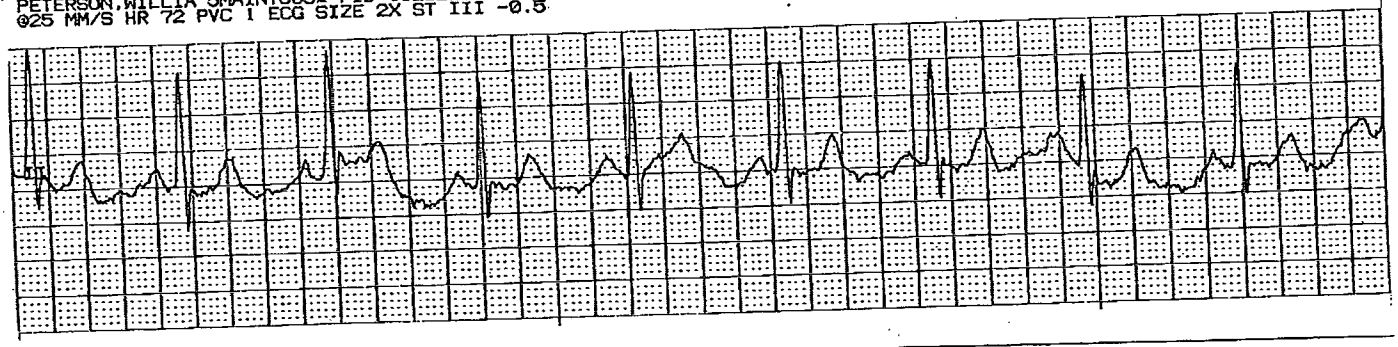
102829710
PETERSON SR, WILLIAM SR
DOB: [redacted] 85 SX: M IMD
MRN: 26523 ADM/REC DT: 05/15
AIKEN REGIONAL MEDICAL CENTER

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL 19-MAY-2006 04:00:42
@25 MM/S HR 68 PVC 0 ECG SIZE 2X ST I -0.5



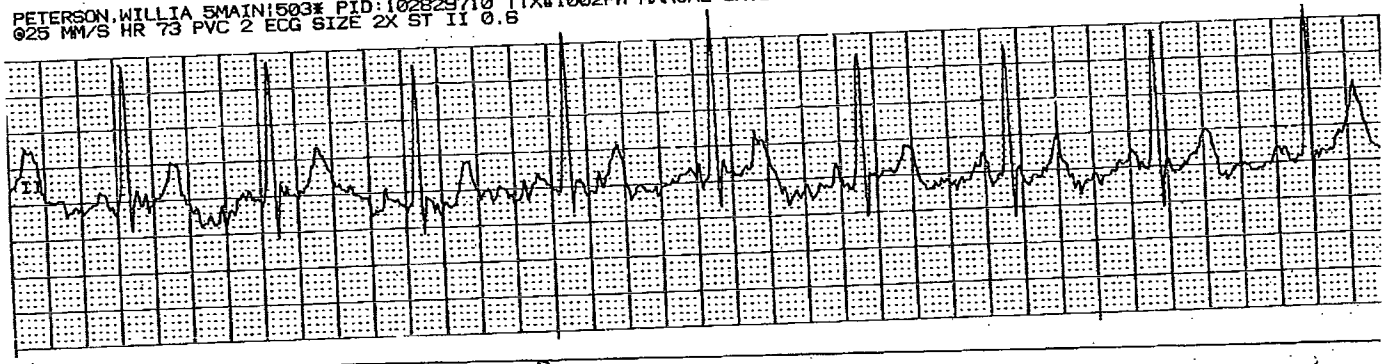
DATE: _____ PR: .14 QRS: .100 TREATED: _____
TIME: _____ RATE: 68 INTERPRETATION: SR TW

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL 19-MAY-2006 07:14:04
@25 MM/S HR 72 PVC 1 ECG SIZE 2X ST III -0.5



DATE: 5-19-06 PR: .16 QRS: .08 TREATED: _____
TIME: 0700 RATE: 72 INTERPRETATION: SR TAW

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL SAVED 19-MAY-2006 11:00:30
@25 MM/S HR 73 PVC 2 ECG SIZE 2X ST II 0.6



DATE: 5-19-06 PR: .16 QRS: .08 TREATED: _____
TIME: 1100 RATE: 73 INTERPRETATION: SR TAW

4RR-0226-NS

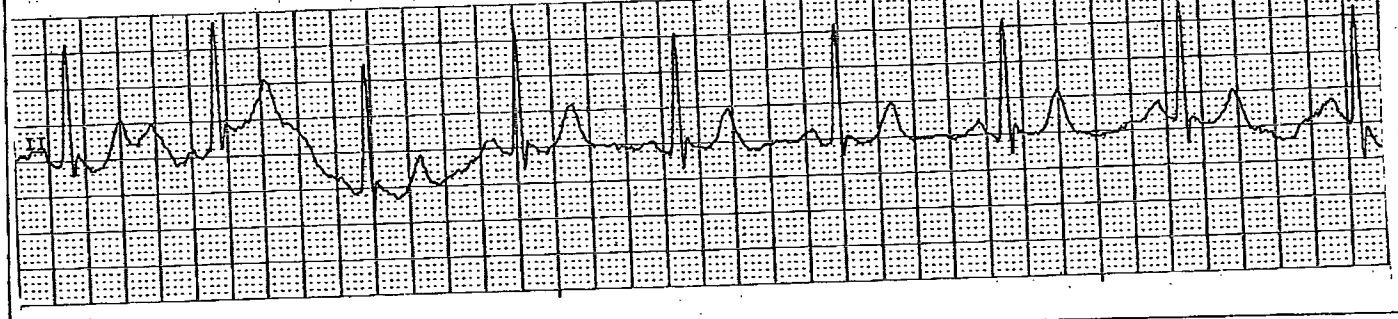
RHYTHM STRIP CHART FORM

REMARKS:

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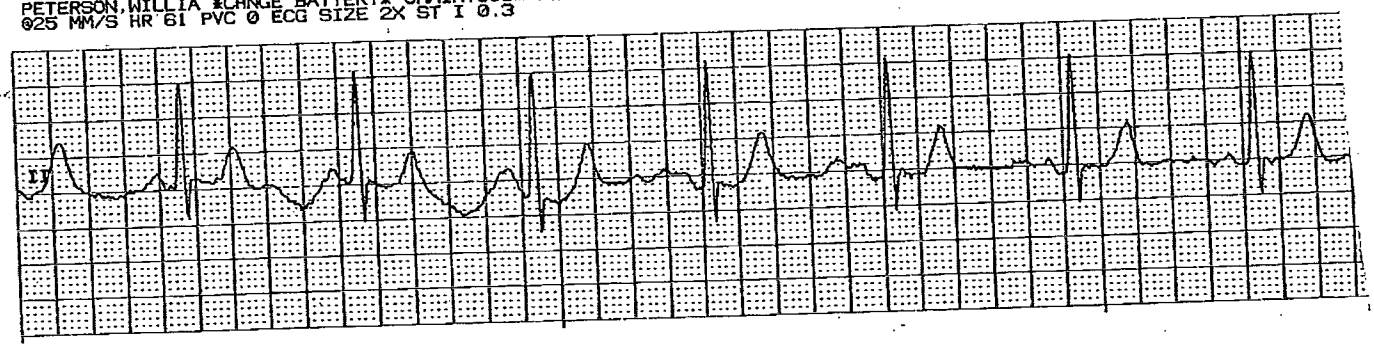
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PETERSON SR, WILLIAM SR
DOB: [redacted] 85 SX: M IMD
MRN: 26525 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

PETERSON,WILLIA 5MAIN!503* PID:102829710 TTX#1002FH MANUAL SAVED 18-MAY-2006 15:00:22
@25 MM/S HR 69 PVC 0 ECG SIZE 2X ST II 0.1



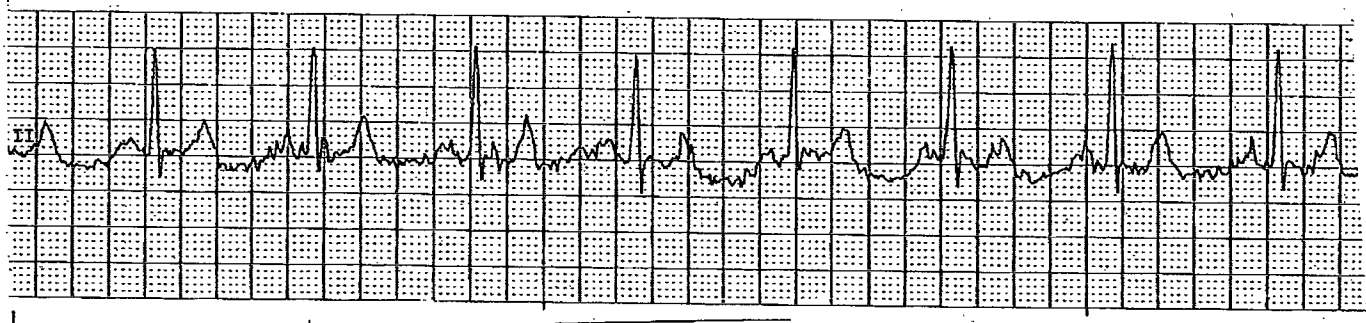
DATE: 5-18-06 PR: .20 QRS: .08 TREATED: TAW
TIME: 1500 RATE: 69 INTERPRETATION: SR

PETERSON,WILLIA *CHNGE BATTERY* 5MAIN!503* PID:102829710 TTX#1002FH MANUAL 18-MAY-2006 18:56:45 CHNGE BATTERY
@25 MM/S HR 61 PVC 0 ECG SIZE 2X ST I 0.3



DATE: PR: .20 QRS: .08 TREATED: TW
TIME: RATE: 61 INTERPRETATION: SR

PETERSON,WILLIA 5MAIN!503* PID:102829710 TTX#1002FH MANUAL 18-MAY-2006 23:52:35
@25 MM/S HR 68 PVC 0 ECG SIZE 2X ST I 0.3



DATE: PR: .19 QRS: .09 TREATED: TW
TIME: RATE: 68 INTERPRETATION: SR

HRR-0226-NS

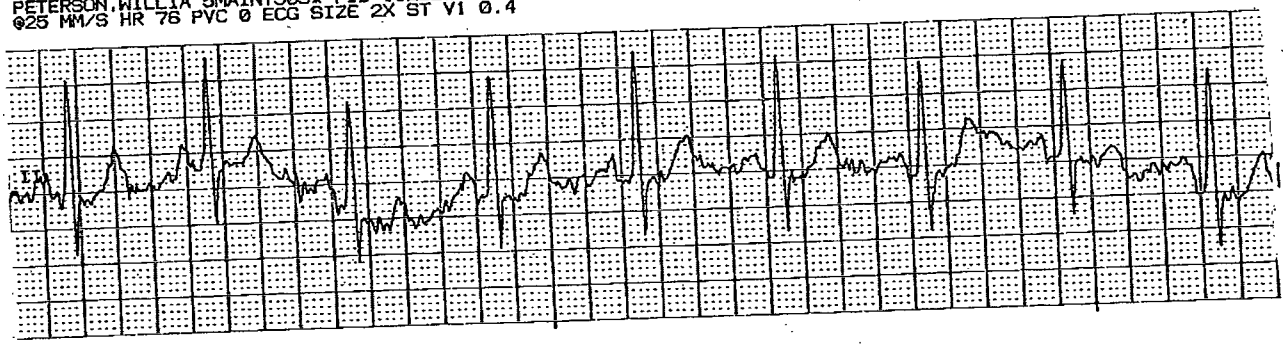
RHYTHM STRIP CHART FORM

REMARKS:

IMPRINT AREA

102829710
PETERSON SR, WILLIAM SR
DOB: [redacted] 85 SX: M IMD
MRN: 26523 ADM/REG DT:05/15/
AIKEN REGIONAL MEDICAL CENTER

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL 18-MAY-2006 03:12:16
@25 MM/S HR 76 PVC 0 ECG SIZE 2X ST V1 0.4



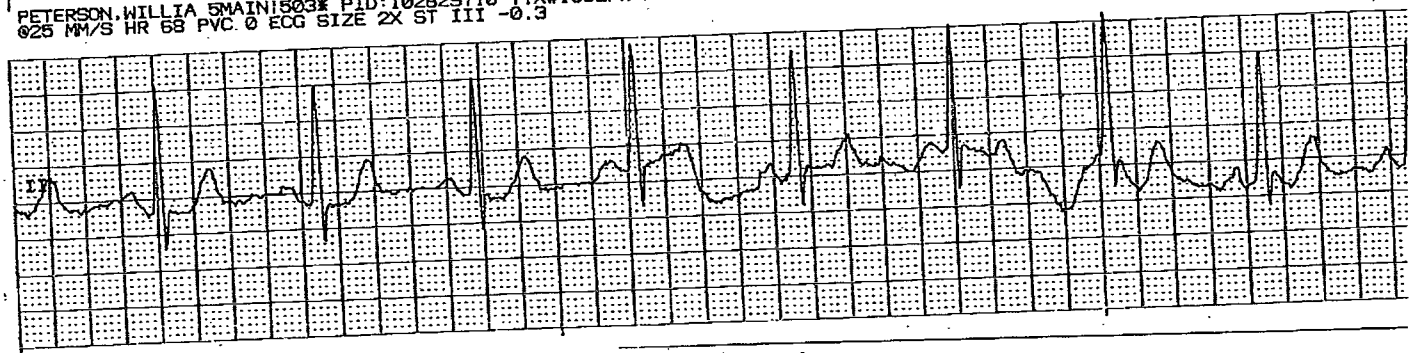
DATE: _____ PR: .14 QRS: .08 TREATED: EC
TIME: _____ RATE: 76 INTERPRETATION: SR

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL 18-MAY-2006 06:54:17
@25 MM/S HR 77 PVC 0 ECG SIZE 2X ST II -0.8



DATE: _____ PR: .18 QRS: .08 TREATED: EC
TIME: _____ RATE: 80 INTERPRETATION: SR

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL 18-MAY-2006 10:53:30
@25 MM/S HR 68 PVC 0 ECG SIZE 2X ST III -0.3



DATE: _____ PR: .20 QRS: .08 TREATED: EC
TIME: _____ RATE: 90 INTERPRETATION: SR

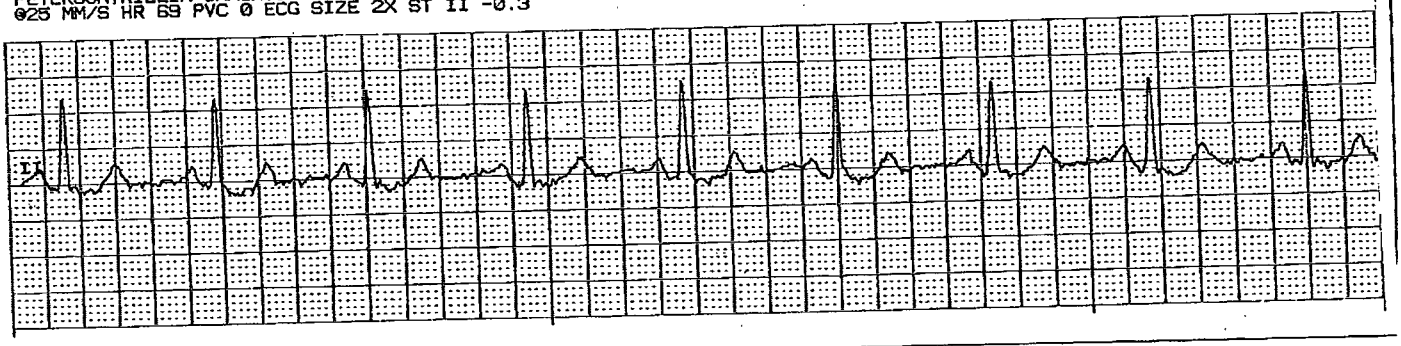
1007-

REMARKS:

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102829710
PETERSON SR, WILLIAM SR
DOB: [redacted] 85 SX: M IMD
MRN: [redacted] ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL 17-MAY-2006 15:08:42
@25 MM/S HR 69 PVC 0 ECG SIZE 2X ST II -0.3



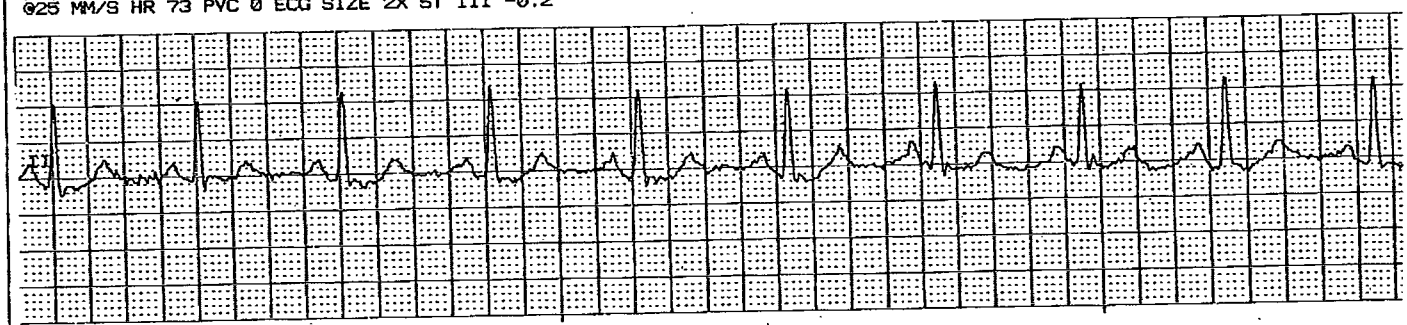
DATE: 5-17-06 PR: .16 QRS: .08 TREATED: TAW
TIME: 1500 RATE: 69 INTERPRETATION: SR

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL 17-MAY-2006 18:57:53
@25 MM/S HR 81 PVC 0 ECG SIZE 2X ST V1 0.4



DATE: _____ PR: .18 QRS: .08 TREATED: EC
TIME: _____ RATE: 81 INTERPRETATION: SR

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL 17-MAY-2006 23:10:19
@25 MM/S HR 73 PVC 0 ECG SIZE 2X ST III -0.2



DATE: _____ PR: .18 QRS: .08 TREATED: EC
TIME: _____ RATE: 73 INTERPRETATION: SR

HRR-0226-NS

RHYTHM STRIP CHART FORM

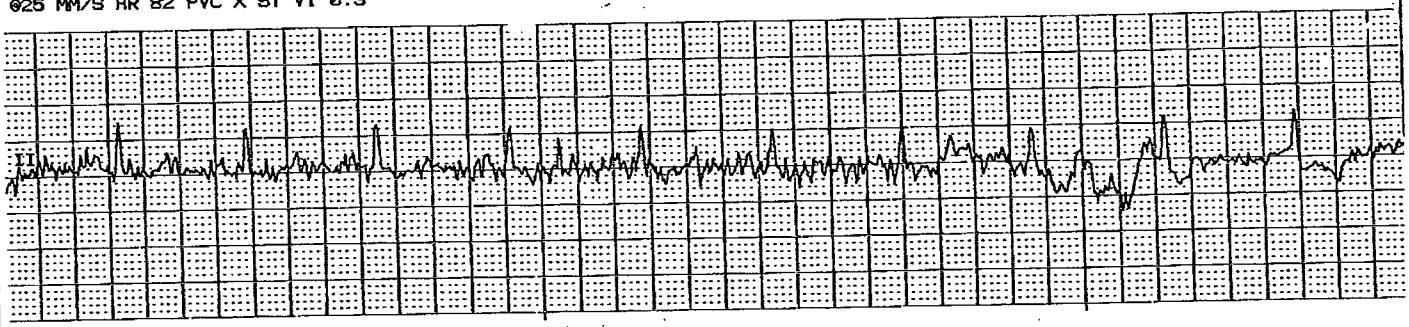
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REMARKS:

IMPRINT AREA

102829710
PETERSON SR, WILLIAM SR
DOB: [redacted]85 SX: M IMD
MRN: 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

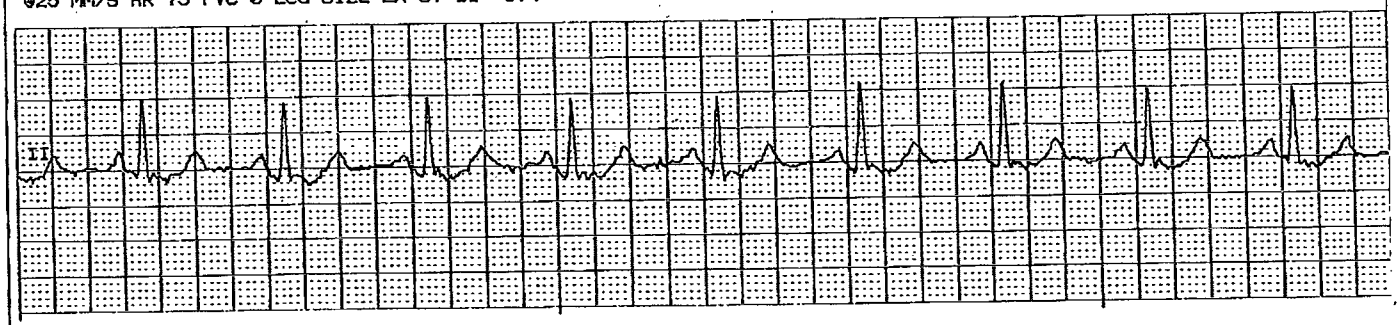
PETERSON 5MAIN!503* PID:999999999 TTX#1002FH MANUAL SAVED 17-MAY-2006 02:59:34
@25 MM/S HR 82 PVC X ST VI 0.3



DATE: _____ PR: _____ QRS: _____ TREATED: _____

TIME: _____ RATE: _____ INTERPRETATION: _____

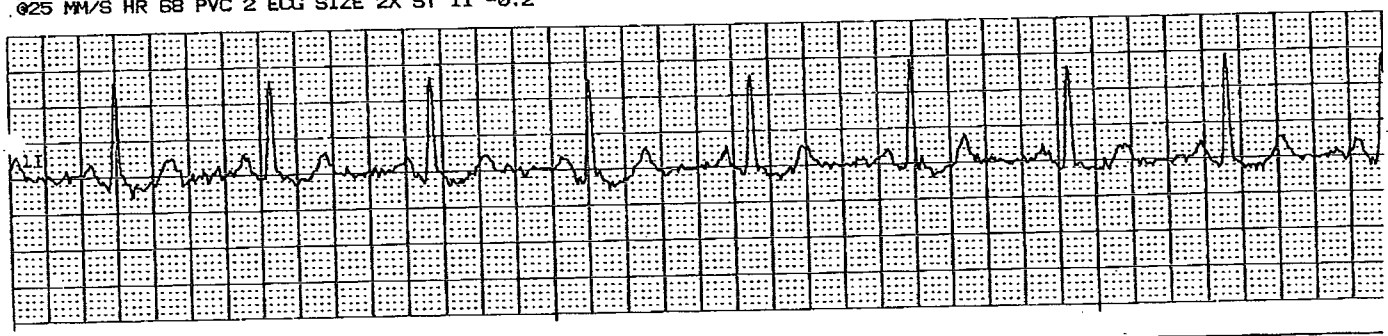
PETERSON 5MAIN!503* PID:999999999 TTX#1002FH MANUAL SAVED 17-MAY-2006 07:00:31
@25 MM/S HR 75 PVC 0 ECG SIZE 2X ST II -0.4



DATE: 5-17-06 PR: .18 QRS: .08 TREATED: _____ THW

TIME: 0700 RATE: 75 INTERPRETATION: SR

PETERSON 5MAIN!503* PID:999999999 TTX#1002FH MANUAL 17-MAY-2006 11:56:06
@25 MM/S HR 68 PVC 2 ECG SIZE 2X ST II -0.2



DATE: 5-17-06 PR: .16 QRS: .08 TREATED: _____ THW

TIME: 1150 RATE: 68 INTERPRETATION: SR

HRR-0226-NS

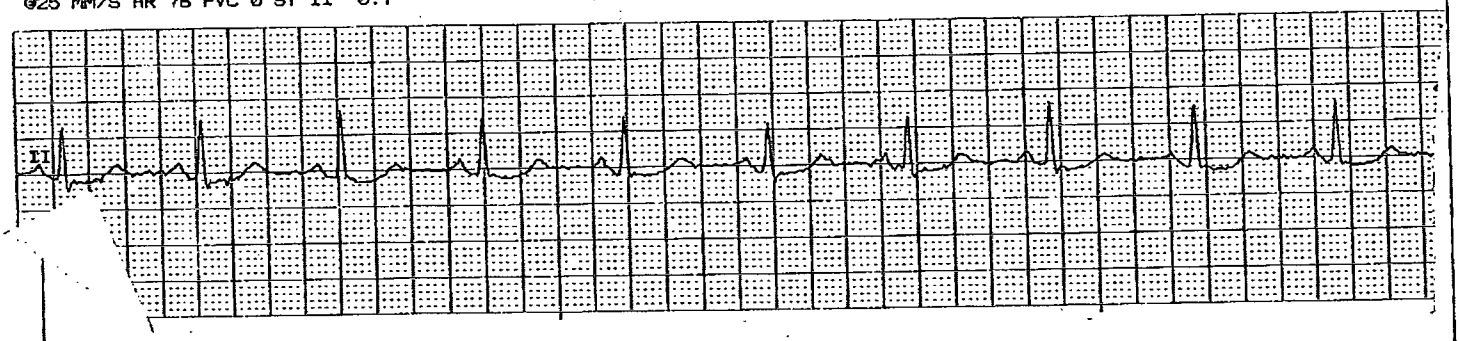
RHYTHM STRIP CHART FORM

REMARKS:

IMPRINT

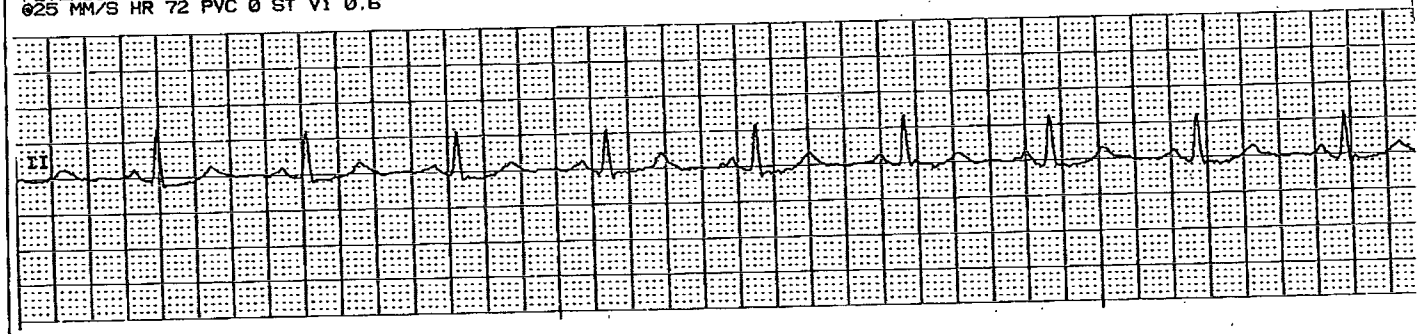
102829710
PETERSON SR, WILLIAM SR
DOB: [redacted] 85 SX: M IMD
MRN: 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

PETERSON 5MAIN!503* PID:999999999 TTX#1002FH MANUAL SAVED 16-MAY-2006 14:50:15
@25 MM/S HR 76 PVC 0 ST II -0.7



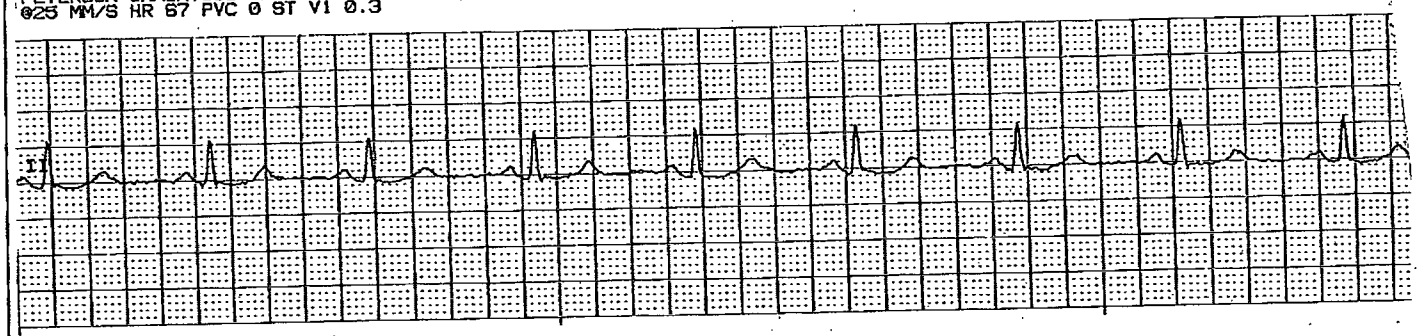
DATE: _____ PR: .16 QRS: .06 TREATED: NC
TIME: _____ RATE: 75 INTERPRETATION: SR

PETERSON 5MAIN!503* PID:999999999 TTX#1002FH MANUAL 16-MAY-2006 19:00:52
@25 MM/S HR 72 PVC 0 ST V1 0.6



DATE: _____ PR: .14 QRS: .06 TREATED: EC
TIME: _____ RATE: 72 INTERPRETATION: SR

PETERSON 5MAIN!503* PID:999999999 TTX#1002FH MANUAL SAVED 16-MAY-2006 22:52:25
@25 MM/S HR 67 PVC 0 ST V1 0.3



DATE: _____ PR: .14 QRS: .06 TREATED: EC
TIME: _____ RATE: 67 INTERPRETATION: SR

HRR-0228-NS

RHYTHM STRIP CHART FORM

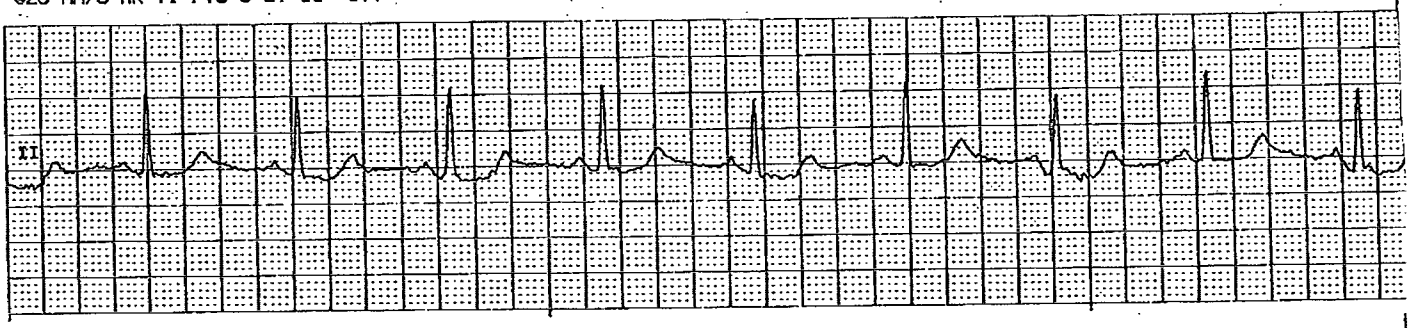
-1010-

REMARKS:

IMPRINT AREA

102829710
PETERSON SR, WILLIAM SR
DOB: [redacted] 85 SX: M IMD
MRN: 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

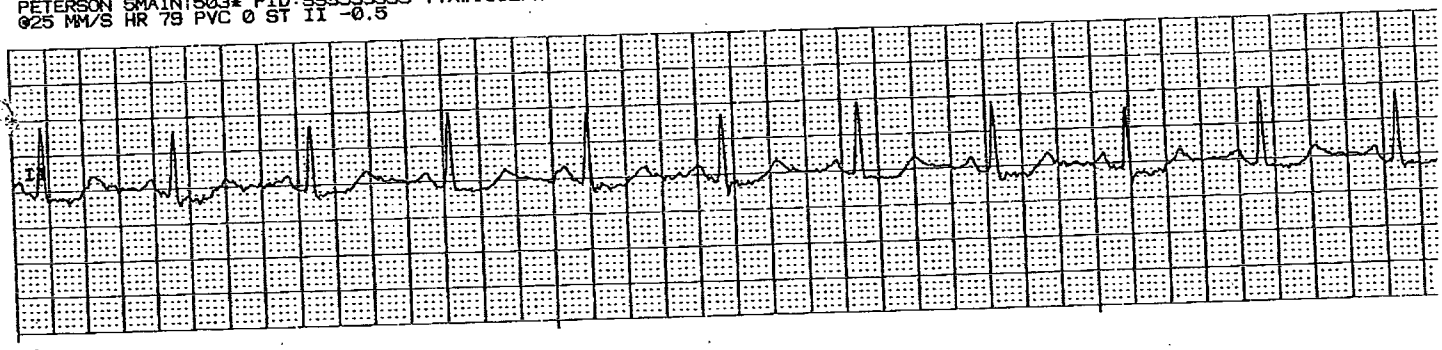
PETERSON *CHNGE BATTERY* 5MAIN!503* PID:999999999 TTX#1002FH MANUAL SAVED 16-MAY-2006 02:56:25 CHNGE BATTERY
@25 MM/S HR 71 PVC 0 ST II -0.7



Initial Strip

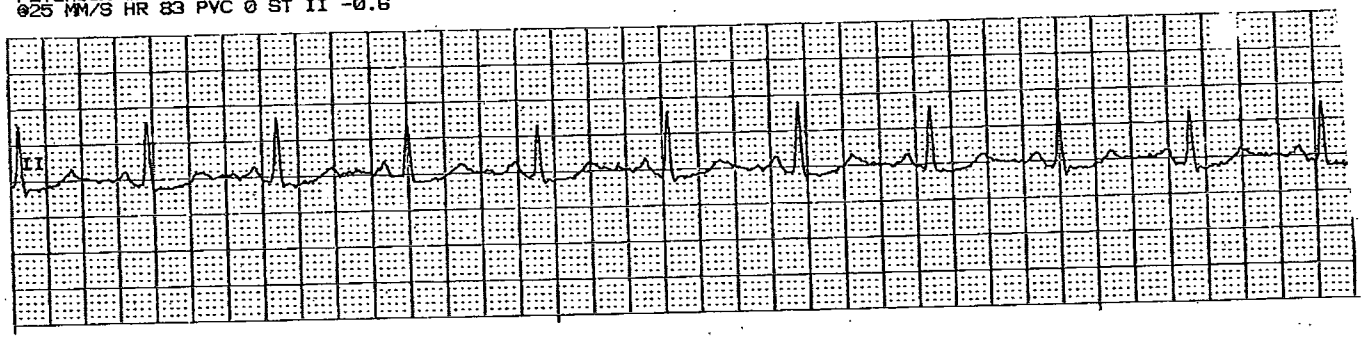
DATE: _____ PR: .14 QRS: .06 TREATED: EC
TIME: _____ RATE: 71 INTERPRETATION: SR

PETERSON 5MAIN!503* PID:999999999 TTX#1002FH MANUAL 16-MAY-2006 06:58:44
@25 MM/S HR 79 PVC 0 ST II -0.5



DATE: _____ PR: .14 QRS: .06 TREATED: NC
TIME: _____ RATE: 79 INTERPRETATION: SR

PETERSON 5MAIN!503* PID:999999999 TTX#1002FH MANUAL 16-MAY-2006 11:07:38
@25 MM/S HR 83 PVC 0 ST II -0.6



DATE: _____ PR: .16 QRS: .06 TREATED: NC
TIME: _____ RATE: 84 INTERPRETATION: SR

IRR-0226-NS

RHYTHM STRIP CHART FORM

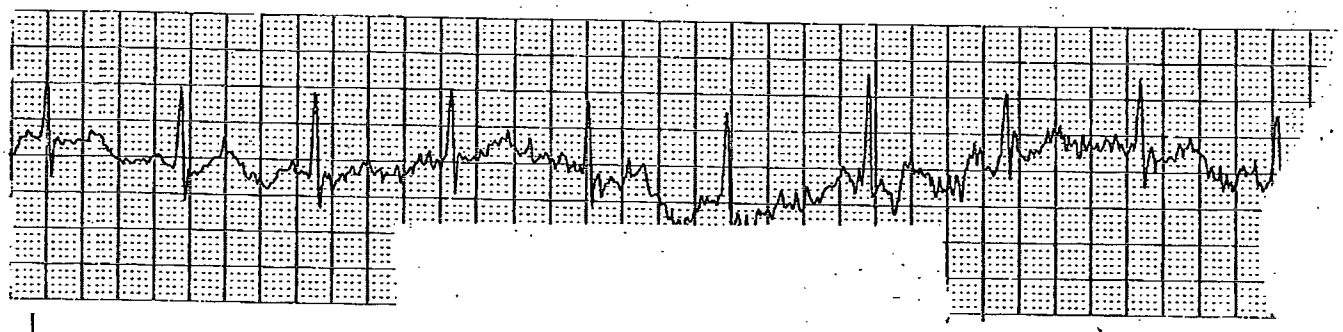
-1011-

REMARKS:

IMPRINT AREA

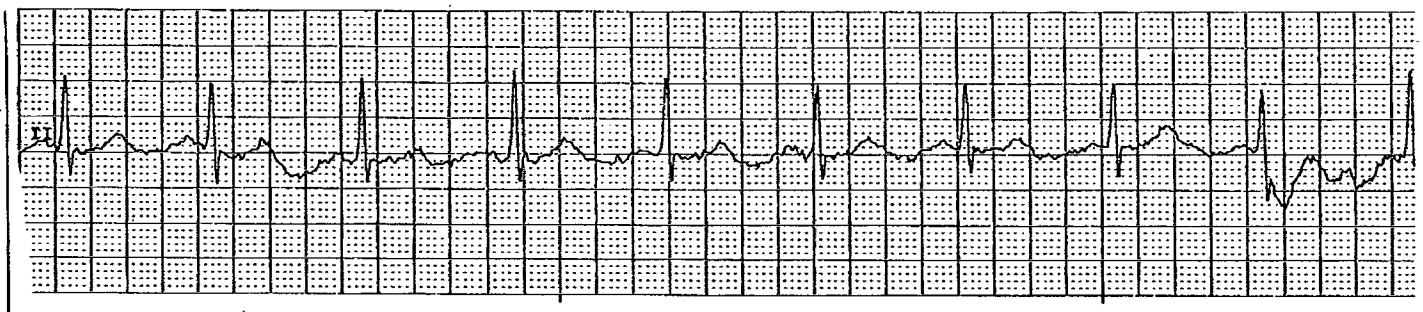
102829710
PETERSON SR, WILLIAM SR
DOB: [redacted] 85 SX: M IMD
MRN: 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

,WILLIA *ARTIFACT* 5MAIN!503* PID:102829710 TTX#1002FH MANUAL 01-JUN-2006 04:55:53
SL(II) HR 79 ARTIFACT PVC 0 ST II -0.7



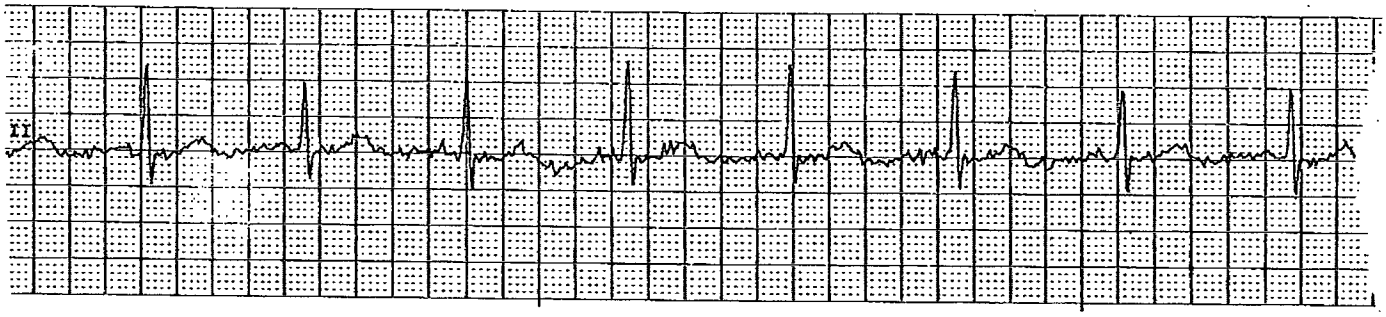
DATE: _____ PR: .16 QRS: .08 TREATED: _____
TIME: _____ RATE: 79 INTERPRETATION: SR TW

PETERSON,WILLIA 5MAIN!503* PID:102829710 TTX#1002FH MANUAL 01-JUN-2006 07:25:41
@25 MM/S SL(II) HR 72 PVC 0 ST II -0.2



DATE: _____ PR: .16 QRS: .06 TREATED: _____
TIME: _____ RATE: 72 INTERPRETATION: SR

PETERSON,WILLIA 5MAIN!503* PID:102829710 TTX#1002FH MANUAL 01-JUN-2006 11:11:03
@25 MM/S SL(II) HR 66 PVC 0 ST II 0.0



DATE: _____ PR: .16 QRS: .06 TREATED: _____
TIME: _____ RATE: 66 INTERPRETATION: SR

TRR-0226-NS

RHYTHM STRIP CHART FORM

AIKEN REGIONAL MEDICAL CENTER
CARDIOPULMONARY
AIKEN, S.C. 29801

Date 5/15/2006

Med Rec No:	26523		Account #:
Name:	PETERSON, WILLIAM	Age:	Physician: JACKSON
Room:	EMR	Sex: M	DOB:

	Results		Reference Range	Critical Range
pH	7.335 ↓		7.350 - 7.450	7.200 - 7.600
PCO2	39.2	mmHg	35.0 - 45.0	20.0 - 60.0
PO2	112.4 ↑	mmHg	75.0 - 100.0	49.0 - 511.0
BE	-5.0	mmol/L	-	-
HCO3-	20.4	mmol/L	-	10.0 - 60.0
O2Sat	97.9	%	-	-
AaDO2		mmHg	-	-
a/A Gradient			-	-
tHb	12.4	g/dL	12.0 - 18.0	7.0 - 22.0
O2Hb	97.2 ↑	%	94.0 - 97.0	-
COHb	0.3 ↓	%	0.5 - 1.5	-
MetHb	1.1	%	0.0 - 1.5	-
O2ct	17.1	ml/dl	15.0 - 23.0	-
Na+	148.6 ↑	mmol/L	135.0 - 148.0	120.0 - 160.0
K+	4.03	mmol/L	3.50 - 5.30	2.8 - 6.0
Ca++	1.19	mmol/L	1.13 - 1.32	0.2 - 5.0
Cl-	110 ↑	mmol/L	98 - 106	-
Glucose	96 ↑	mmol/L	67 - 93	50.0 - 500.0
Lactate	1.58	mg/dL	0.50 - 2.00	0.5 - 8.0
Hct	36 ↓	%	37 - 50	27.0 - 50.0

Analyzer:	865-09713		**Conditions**		
Draw Date/Time:	5/15/2006	16:50	Mode:	NRB	Flow: 15.00
Analyze Date/Time:	05/15/06	16:54	RR:		FIO2 100.0
Sample Type:	Arterial		Tidal Vol:		
Sample Site:	RRX1		CPAP/PEEP:		
Pat Temp:			PS:		
Tech ID:	M YATES RRT		Time Reported: 1715		
Allens Test:	YES		**Comments:**	REPORTED TO DR JACKSON @ 1715	
Reported To:	JACKSON		**Beyond Reference Range: ↑↓ Critical Range: ↑↑ ↓↓**		

Summary of All Tests

Date	Time	pH	PCO2	PO2	BEvt	HCO3a	O2Sat	tHb	O2Hb	COHb	MetHb	A-aDO2	Na+	K+	Ca++	Cl-	Gluc	Lact	Hct
	FiO2	Flow	Mode	RR	Vt	PEEP/CPAP	PS	PIP	Comments										
5/15/06	16:54	7.335 ↓	39.2	112.4 ↑	-5.0	20.4	97.9	12.4	97.2 ↑	0.3 ↓	1.1		148.6 ↑	4.03	1.19	110 ↑	96 ↑	1.58	36 ↓
	100.00	15.00	NRB						REPORTED TO DR JACKSON @ 1715										
3/7/06	22:29	7.415	24.3 ↓	132.2 ↑	-7.4	15.2	98.7	14.0	97.4 ↑	0.7	0.8		138.2	7.75 ↑	1.06 ↓	100			41
	28.00	2.00							RBX1WOD TO DR DIBONA @2240										

Signature: M Yates RRT

AIKEN REGIONAL MEDICAL CENTERS
ECHOCARDIOGRAM/DOPPLER REPORT

Patient: PETERSON, SR., WILLIAM Race/Sex/Age: M85 Room#: 503 Date 5/16/2006
Order Physician: GORDON Primary Physician Read Physician: CUNDEY
EKG #: 67243 MR# 26523 Sonographer: KJ Tape # 21-06

Left Ventricle	Normal		Abnormal
Diastolic Dimension	39 mm(37-56)		
End Systolic Dimension	30 mm (20-38)		
Septal Thickness	12 mm(7-11)		
Posterior Wall Thickness	12 mm (7-11)		
Estimated LV Ejection Fractio	55-60 % (55+)		
Abnormal Wall Motion	Yes		No
Paradoxical Septal Motion	Yes		No
Hypertrophy	Yes		No

Aortic Valve	Normal		Dilated
Root	34 mm (20-37)		
Cusp Excursion	mm (15-26)		
Gradient	mmHg		
	Normal		Abnormal
	Thickened		Calcified
	MAC		Mass
	Prosthetic Valve		
LVOT Diameter	2 cm		

Doppler	**V1**		**V2**
Peak Velocity	cm/sec		cm/sec
Mean Velocity	cm/sec		cm/sec
V Integral	cm/sec		cm/sec
Valve Area	cm2 (3-4)		

Aortic Insufficiency	Yes	X	No
	Trace		Moderate
	Mild		Severe
Pressure Half Time	msec		Vmax
Aortic Arch	Normal		Dilated
	Not Visualized		

Mitral Valve	Normal		Abnormal
E wave	cm/sec		
A wave	cm/sec		
Thickened	Prolapse		SAM
Calcified Ring	Mass		Prosthetic
MAC	Flail Leaflet		
T	m/s		
Valve Area	cm2(4-6)		
Mitral Regurgitation	Yes		No

Trace Mild Moder Severe

Left Atrium	X Normal		Abnormal
28 mm(19-40)	Mass		
Right Atrium	Normal		Abnormal
	Mass		
IVC collapses	Yes		No
Right Ventricle	Normal		Abnormal
	mm (7-26)		
	Wall Thickness (6)		
	Mass		

Tricuspid Valve	Normal		Abnormal
Thickened	Mass		Prolapse
Tricuspid Regurgit	X Yes		No
	Trace		Mild
	Moderate	X	Severe
	3.39 m/s		
Estimated RVSP	56 mmHg (<35)		

Pulmonic Valve	Normal		Abnormal
A Wave	Present		Absent
	Not Visualized		

Doppler			
Acceleration Time			M/s
Velocity		59	cm/s

Pulmonic Insuffic	Yes		No
	Trace		Mild
	Moderate		Severe

Pericardium	Normal		Abnormal
	Thickened		

Pericardial Effusion	Posterior		Anterior
	Trace		Mild
	Moderate		Severe

Patient presenting with sepsis.
Left ventricular end diastolic and end systolic dimensions were normal. Septum and posterior wall thickness were increased. Ejection fraction was normal. Echo was suboptimal. There was no obvious valvular abnormality. There was some sclerosis of the aortic valve. SUMMARY: Echo demonstrating normal ejection fraction, concentric hypertrophy of the left ventricle.

DWC/lw
DICTATED: 05/17/06
TRANSCRIBED: 05/18/06

DAVID W. CUNDEY, M. D.

CHARTED

26523

05/16/2006 05.47.54 AM PETERSON, WILLIAM
85 years Male Black

67243

AIKEN REGIONAL MEDICAL CENTER
Dept: 2
Room: 503
Oper: AH

-1014-

Rate	81
PR	156
QRSD	95
QT	379
QTc	440

. Normal sinus rhythm, rate 81
. Nonspecific Anterolateral T abnormalities

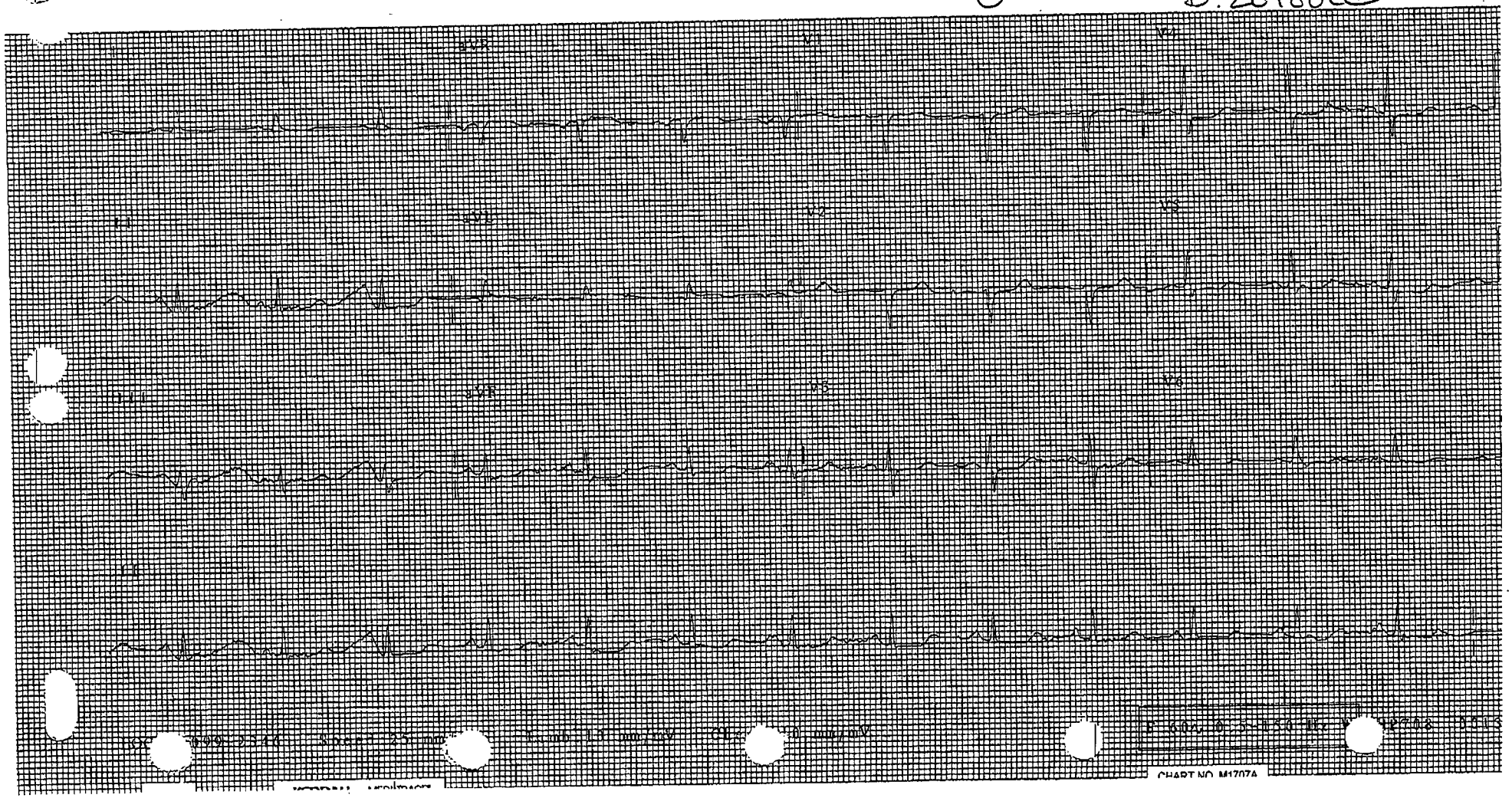
--AXIS--

P	76
QRS	17
T	64

Requested by:
BOKKISAM

- BORDERLINE ECG -

PRELIMINARY-MD MUST REVIEW
D. Zotovic



PETERSON, ~~WILLIAM~~ WILLIAM C
ID: 26523

05/15/2006 16:52:08

503

85 YEARS
MALE BLACK
Loc: 2,14
Dr: JACKSON
Tech: MTY

503 @ 26ATVC

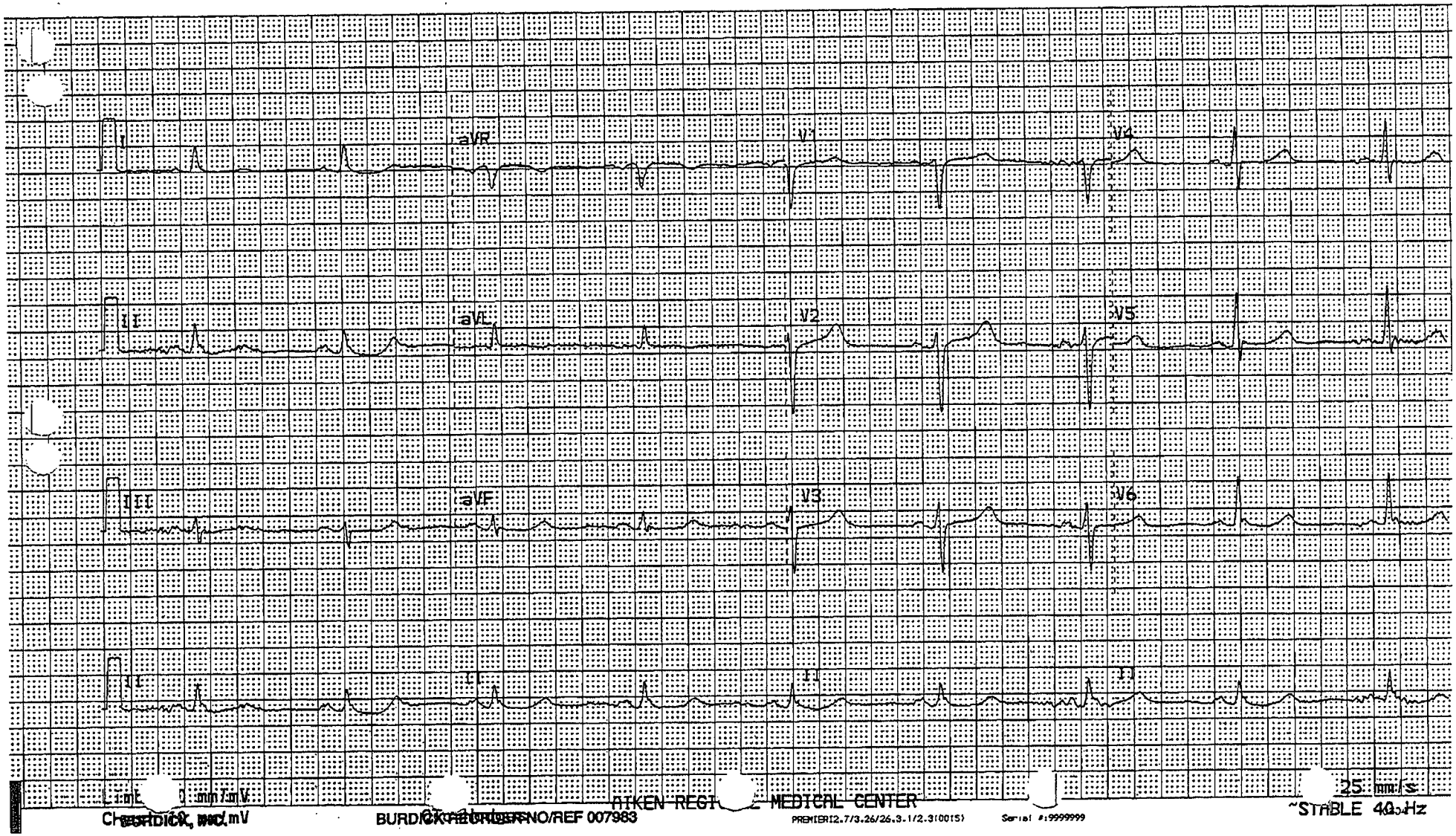
Vent. Rate:	53 bpm
RR Interval:	1123 ms
PR Interval:	170 ms
QRS Duration:	102 ms
QT Interval:	506 ms
QTc Interval:	494 ms
QT Dispersion:	22 ms
P-R-T AXIS:	60° 23° 70°

SINUS ~~BRADYCARDIA~~
PROLONGED QT INTERVAL
~~Low maximum QRS spatial~~ velocity
Broad QRS in (V1 or V2) and (V5 or V6)
INCOMPLETE LEFT BUNDLE BRANCH BLOCK

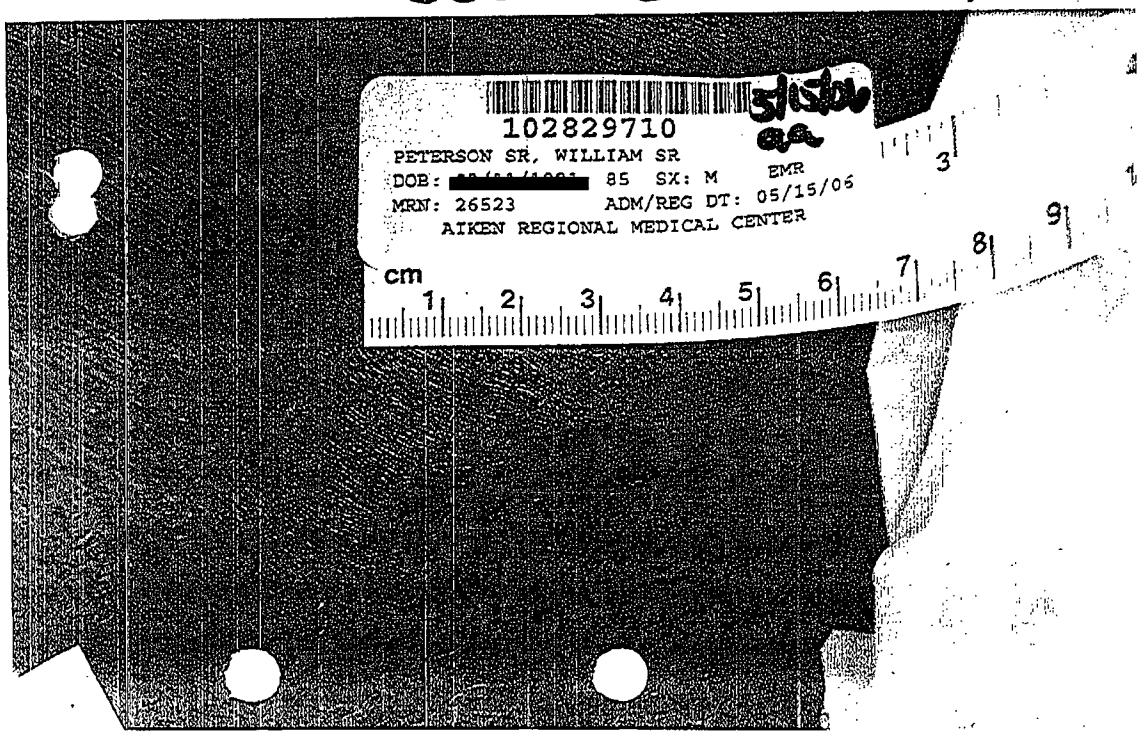
Summary: ABNORMAL ECG

* Unconfirmed Analysis *

-1015-



Low Back 5/15/06 aa



oa 5/15/06 L Hip

Wound Healing Institute of Carolina at Aiken Regional
www.aikenregional.com

WoundExpert

Aiken Regional Medical Center

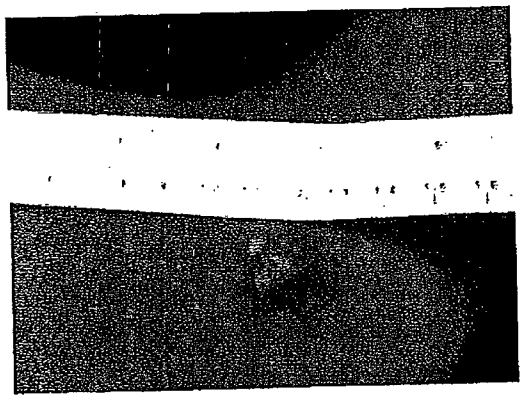
Wound Assessment Details

Identification Information

Peterson, William
Patient Number: 26523
Date of Birth: [redacted]
Wound Number: 5
Location: Ankle (), Left, , Lateral, .
Type of Wound: Pressure Ulcer
Wound Acquired:

Wound Status: Not Healed
Clinician: Mark Melton
Attending Physician:
Assessment Date: 5/31/2006
Treatment Duration: minutes
In-patient Visit: Yes

Wound Measurements



[Click to Enlarge]

Length (mm): 10
Width (mm): 7
Depth (mm):
Hypergranulated: No
Area (mm^2): 54.976
Volume (mm^3):

Tunneling: N/A
Tunneling Position (o'clock):
Maximum Distance (mm):
Undermining: N/A
Starting Position (o'clock):
Ending Position (o'clock):
Maximum Distance (mm):
Sinus Tract: N/A
Sinus Tract Position (o'clock):
Maximum Distance (mm):

Wound Details

Wound Progess:	Initial Exam
Stage:	N/A
Exudate Amount:	N/A
Exudate Type:	N/A
s/s of Infection:	N/A
Pulse:	N/A
Odor:	N/A
Pain:	N/A
Wound Margin:	Flat and Intact

Debridement:	N/A
Pain Control:	N/A
Level (per physician):	N/A

Tissue Debrided (per physician)

Necrotic:	Bone:	Cartilage:
Fibrous:	Muscle:	Fat:
Callous/Skin:	Eschar:	Clots:
Tendon:	Exudates:	Other:

Instrument:	N/A
Bleeding:	N/A
Hemostasis Achieved:	N/A
Procedural Pain:	N/A
Post Procedural Pain:	N/A
Paring:	N/A
Vacuum Assisted Closure (VAC) applied:	No
VAC type:	N/A

VAC pressure type:	N/A
VAC pressure setting:	N/A
VAC drain type:	N/A
VAC sponge size:	N/A
Date VAC initiated:	
Daily hours of therapy:	
Days on VAC:	
Dressing change:	
Reset clock to 0 hours:	
Date VAC discontinued:	

Peripheral Skin Appearance

Cellulitis	N/A
Edema	N/A
Induration	N/A
Rubor	N/A
Temperature:	N/A

Texture

Callus	N/A
Dry/Scaly	N/A
Friable	N/A
Maceration	N/A
Moist	N/A
Rash	N/A
Shiny	N/A
Colors Present:	N/A

Wound Base

Wound Base Descriptions

Slough	N/A
Eschar:	N/A
Granulation:	N/A
Color:	Pink
Epithelialization:	N/A

Exposed Structure

Exposed Tendon	N/A
Exposed Ligament	N/A
Exposed Muscle	N/A
Exposed Joint	N/A
Exposed Bone	N/A

Assessment Notes
This wound was just a dark spot last week but is now open. Wound care order written and dressed. He remainson first step overlay. We will follow while inpatient.

Protocol Information

William Peterson **Patient #:26523**
Wound #: 6 **Ankle (), Left, , Lateral,** **5/31/2006**

Electronically Signed by:
Mark Melton at 5/31/2006 11:50:00 AM

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Wound Healing Institute of Carolina at Aiken Regional
www.aikenregional.com

WoundExpert
Wound Assessment Details

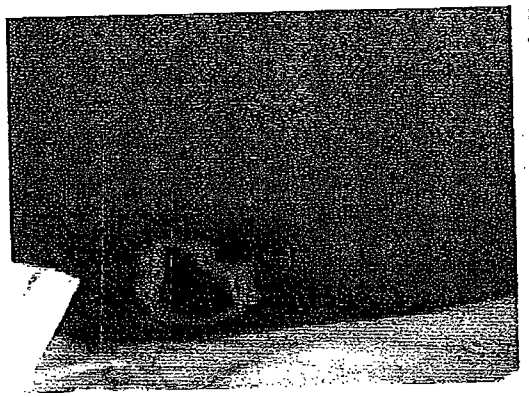
Aiken Regional Medical Center

Identification Information

Peterson, William
Patient Number: 26523
Date of Birth: [redacted]
Wound Number: 4
Location: Back (lower), , , ,
Type of Wound: Pressure Ulcer
Wound Acquired:

Wound Status: Not Healed
Clinician: Mark Melton
Attending Physician:
Assessment Date: 5/31/2006
Treatment Duration: minutes
In-patient Visit: Yes

Wound Measurements



[Click to Enlarge]

Length (mm): 30
Width (mm): 30
Depth (mm):
Hypergranulated: No
Area (mm^2): 706.838
Volume (mm^3):

Tunneling: N/A
Tunneling Position (o'clock):
Maximum Distance (mm):
Undermining: N/A
Starting Position (o'clock):
Ending Position (o'clock):
Maximum Distance (mm):
Sinus Tract: N/A
Sinus Tract Position (o'clock):
Maximum Distance (mm):

Wound Details

Wound Progess: Deteriorating
Stage: Necrotic Tissue (unstageable)
Exudate Amount: N/A
Exudate Type: N/A
s/s of Infection: N/A
Pulse: N/A
Odor: N/A
Pain: N/A
Wound Margin: Flat and Intact

Debridement: N/A
Pain Control: N/A
Level (per physician): N/A
Tissue Debrided (per physician)

Necrotic:	Bone:	Cartilage:
Fibrous:	Muscle:	Fat:
Callous/Skin:	Eschar:	Clots:
Tendon:	Exudates:	Other:

Instrument: N/A
Bleeding: N/A
Hemostasis Achieved: N/A
Procedural Pain: N/A
Post Procedural Pain: N/A
Paring: N/A
Vacuum Assisted Closure (VAC) applied: No
VAC type: N/A

VAC pressure type:	N/A
VAC pressure setting:	N/A
VAC drain type:	N/A
VAC sponge size:	N/A
Date VAC initiated:	
Daily hours of therapy:	
Days on VAC:	
Dressing change:	
Reset clock to 0 hours:	
Date VAC discontinued:	

Peripheral Skin Appearance

Cellulitis	N/A
Edema	N/A
Induration	N/A
Rubor	N/A
Temperature:	N/A

Texture	
Callus	N/A
Dry/Scaly	N/A
Friable	N/A
Maceration	N/A
Moist	N/A
Rash	N/A
Shiny	N/A
Colors Present:	N/A

Wound Base

Wound Base Descriptions	
Slough	N/A
Eschar:	76-100%
Granulation:	N/A
Color:	
Epithelialization:	N/A

Exposed Structure	
Exposed Tendon	N/A
Exposed Ligament	N/A
Exposed Muscle	N/A
Exposed Joint	N/A
Exposed Bone	N/A

Assessment Notes

This wound has gone from 25x5to10mm to this area of eschar. It has been evolving for the duration of his stay. Dr Hagan called reguarding possible debridement. He remains on the first step and is turned by staff. Wound dressed and orders written. He may be discharged later this week. We will follow while inpatient.

Protocol Information

William Peterson **Patient #:26523**
Wound #: 4 **Back (lower), , , ,** **5/31/2006**

Electronically Signed by:
Mark Melton at 5/31/2006 11:50:00 AM

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WoundExpert
Wound Assessment Details

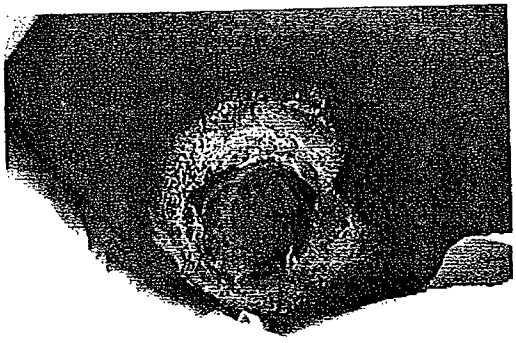
Aiken Regional Medical Center

Identification Information

Peterson, William
Patient Number: 26523
Date of Birth: [redacted]
Wound Number: 3
Location: Hip (), Left, , , ,
Type of Wound: Pressure Ulcer
Wound Acquired:

Wound Status: Not Healed
Clinician: Mark Melton
Attending Physician:
Assessment Date: 5/31/2006
Treatment Duration: 60 minutes
In-patient Visit:

Wound Measurements



[Click to Enlarge]

Length (mm):	65
Width (mm):	45
Depth (mm):	18
Hypergranulated:	No
Area (mm^2):	2297.222
Volume (mm^3):	41349.994

Tunneling: N/A
Tunneling Position (o'clock):
Maximum Distance (mm):
Undermining: N/A
Starting Position (o'clock):
Ending Position (o'clock):
Maximum Distance (mm):
Sinus Tract: N/A
Sinus Tract Position (o'clock):
Maximum Distance (mm):

Wound Details

Wound Progess:	No Change
Stage:	N/A
Exudate Amount:	Small
Exudate Type:	Sanguineous
s/s of Infection:	N/A
Pulse:	N/A
Odor:	N/A
Pain:	N/A
Wound Margin:	Flat and Intact

Debridement:	N/A
Pain Control:	N/A
Level (per physician):	N/A

Tissue Debrided (per physician)

Necrotic:	Bone:	Cartilage:
Fibrous:	Muscle:	Fat:
Callous/Skin:	Eschar:	Clots:
Tendon:	Exudates:	Other:

Instrument:	N/A
Bleeding:	N/A
Hemostasis Achieved:	N/A
Procedural Pain:	N/A
Post Procedural Pain:	N/A
Paring:	N/A
Vacuum Assisted Closure (VAC) applied:	No
VAC type:	N/A

VAC pressure type:	N/A
VAC pressure setting:	N/A
VAC drain type:	N/A
VAC sponge size:	N/A
Date VAC initiated:	
Daily hours of therapy:	
Days on VAC:	
Dressing change:	
Reset clock to 0 hours:	
Date VAC discontinued:	

Peripheral Skin Appearance

Cellulitis	N/A
Edema	N/A
Induration	N/A
Rubor	N/A
Temperature:	N/A

Texture	
Callus	N/A
Dry/Scaly	N/A
Friable	N/A
Maceration	N/A
Moist	N/A
Rash	N/A
Shiny	N/A
Colors Present:	N/A

Wound Base

Wound Base Descriptions	
Slough	1-25%
Eschar:	N/A
Granulation:	N/A
Color:	Pink
Epithelialization:	N/A

Exposed Structure	
Exposed Tendon	N/A
Exposed Ligament	N/A
Exposed Muscle	N/A
Exposed Joint	N/A
Exposed Bone	N/A

Assessment Notes
Follow up eval done. This wound is unchanged in texture from last visit except for possibly less slough in the base. The rest of the base is pink. Dressing changed. Orders rewritten for all 3 wounds today. He remains on the overlay.

Protocol Information

William Peterson **Patient #:26523**
Wound #: 3 **Hip (), Left, , ,** **5/31/2006**

Electronically Signed by:
Mark Melton at 5/31/2006 11:50:00 AM

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WoundExpert
Wound Assessment Details

Aiken Regional Medical Center

Identification Information

Peterson, William
Patient Number: 26523
Date of Birth: [redacted]
Wound Number: 3
Location: Hip (), Left, , , ,
Type of Wound: Pressure Ulcer
Wound Acquired:

Wound Status: Not Healed
Clinician: Mark Melton
Attending Physician:
Assessment Date: 5/23/2006
Treatment Duration: 30 minutes
In-patient Visit: Yes

Wound Measurements

No Photo

Length (mm):	60
Width (mm):	45
Depth (mm):	20
Hypergranulated:	No
Area (mm^2):	2120.513
Volume (mm^3):	42410.25

Tunneling: N/A
Tunneling Position (o'clock):
Maximum Distance (mm):
Undermining: N/A
Starting Position (o'clock):
Ending Position (o'clock):
Maximum Distance (mm):
Sinus Tract: N/A
Sinus Tract Position (o'clock):
Maximum Distance (mm):

Wound Details

Wound Progess:	Initial Exam
Stage:	Stage 4
Exudate Amount:	Moderate
Exudate Type:	Fresh blood
s/s of Infection:	
Pulse:	N/A
Odor:	None
Pain:	N/A
Wound Margin:	Flat and Intact

Debridement: N/A
Pain Control: N/A
Level (per physician): N/A
Tissue Debrided (per physician)

Necrotic:	Bone:	Cartilage:
Fibrous:	Muscle:	Fat:
Callous/Skin:	Eschar:	Clots:
Tendon:	Exudates:	Other:

Instrument: N/A
Bleeding: N/A
Hemostasis Achieved: N/A
Procedural Pain: N/A
Post Procedural Pain: N/A
Paring: N/A
Vacuum Assisted Closure (VAC) applied:
VAC type: N/A
VAC pressure type: N/A
VAC pressure setting: N/A
VAC drain type: N/A

VAC sponge size:	N/A
Date VAC initiated:	
Daily hours of therapy:	
Days on VAC:	
Dressing change:	
Reset clock to 0 hours:	
Date VAC discontinued:	

Peripheral Skin Appearance

		Texture	
Cellulitis	N/A	Callus	N/A
Edema	N/A	Dry/Scaly	N/A
Induration	N/A	Friable	N/A
Rubor	N/A	Maceration	N/A
Temperature:	N/A	Moist	N/A
		Rash	N/A
		Shiny	N/A
		Colors Present:	N/A

Wound Base

Wound Base Descriptions		Exposed Structure	
Slough	26-50%	Exposed Tendon	N/A
Eschar:	N/A	Exposed Ligament	N/A
Granulation:	N/A	Exposed Muscle	N/A
Color:		Exposed Joint	N/A
Epithelialization:	N/A	Exposed Bone	N/A

Assessment Notes
This wound has been debrided sinse last assessment by Dr Hagan. It is cleaner with less slough and more regular in shape. It has a beefy red base and bloody drainage. Discharge plans are for him to go to select tomorrow. He remains on the first step overlay.

Protocol Information

NSD

William Peterson
Wound #: 3
Hip (), Left, , ,
Patient #:26523
5/23/2006

Electronically Signed by:
Mark Melton at 5/23/2006 4:40:00 PM

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WoundExpert
Wound Assessment Details

Aiken Regional Medical Center

Identification Information

Peterson, William
Patient Number: 26523
Date of Birth: [redacted]
Wound Number: 4
Location: Back (lower), , , ,
Type of Wound: Pressure Ulcer
Wound Acquired:

Wound Status: Not Healed
Clinician: Mark Melton
Attending Physician:
Assessment Date: 5/23/2006
Treatment Duration: 30 minutes
In-patient Visit: Yes

Wound Measurements

No Photo

Length (mm): 25
Width (mm): 5
Depth (mm):
Hypergranulated: No
Area (mm^2): 98.172
Volume (mm^3):

Tunneling: N/A
Tunneling Position (o'clock):
Maximum Distance (mm):
Undermining: N/A
Starting Position (o'clock):
Ending Position (o'clock):
Maximum Distance (mm):
Sinus Tract: N/A
Sinus Tract Position (o'clock):
Maximum Distance (mm):

Wound Details

Wound Progess: No Change
Stage: N/A
Exudate Amount: N/A
Exudate Type: N/A
s/s of Infection: N/A
Pulse: N/A
Odor: N/A
Pain: N/A
Wound Margin: Flat and Intact

Debridement: N/A
Pain Control: N/A
Level (per physician): N/A
Tissue Debrided (per physician)

Necrotic:	Bone:	Cartilage:
Fibrous:	Muscle:	Fat:
Callous/Skin:	Eschar:	Clots:
Tendon:	Exudates:	Other:

Instrument: N/A
Bleeding: N/A
Hemostasis Achieved: N/A
Procedural Pain: N/A
Post Procedural Pain: N/A
Paring: N/A
Vacuum Assisted Closure (VAC) applied:
VAC type: N/A
VAC pressure type: N/A
VAC pressure setting: N/A
VAC drain type: N/A

VAC sponge size:	N/A
Date VAC initiated:	
Daily hours of therapy:	
Days on VAC:	
Dressing change:	
Reset clock to 0 hours:	
Date VAC discontinued:	

Peripheral Skin Appearance

Cellulitis	N/A
Edema	N/A
Induration	N/A
Rubor	N/A
Temperature:	N/A

Texture	
Callus	N/A
Dry/Scaly	N/A
Friable	N/A
Maceration	N/A
Moist	N/A
Rash	N/A
Shiny	N/A
Colors Present:	N/A

Wound Base

Wound Base Descriptions	
Slough	N/A
Eschar:	N/A
Granulation:	N/A
Color:	Pink
Epithelialization:	N/A

Exposed Structure	
Exposed Tendon	N/A
Exposed Ligament	N/A
Exposed Muscle	N/A
Exposed Joint	N/A
Exposed Bone	N/A

Assessment Notes
This area remains unchanged in size. He remains on the first step overlay. Wound is covered with calazime as ordered. He is turned to side. Nurse Page RN is aware of findings.

Protocol Information

William Peterson
Wound #: 4
Back (lower), , , ,
Patient #:26523
5/23/2006

Electronically Signed by:
Mark Melton at 5/23/2006 4:40:00 PM

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Aiken Regional Medical Centers

Individual Patient Note
and
Any/All Addenda

Admission Date: 5/15/06
Med. record No.: 026523
Visit No.: 102829710
Attending Phys.: Bokkisam, Chakravarthy 045591, MD

Patient: William Sr Peterson
D.O.B. [redacted] Age: 85
Gender: Male
Location: 5M
Room/Bed: 503 / A

***DTY** Note, performed 5/22/06 at 14:13, entered 5/22/06 at 14:27 by Patricia Skolnik,RD:*

Nutrition f/u: Pt on TF's of 1/2 strength Impact 1.5 now @ 60ml/hr, pushes BID of one scoop Promod and one package Arginade in 120ml H2O. This is now providing 1200 kcal, 79g pro, 1802ml free H2O/d.
RN stated low residuals, but pt has had multiple loose stools over the past few days.
Labs 5/21: Na 146 (h), CO2 21 (l), Cl 121 (h), BUN 30 (h), Creat 1.5 (h), Ca 7.5 (l).
Chem-8 blood glucose levels 266, 184 (h).
Pt s/p debridement of L hip wound of necrotic SQ and muscle.
PLAN: Will change Promod in pushes to Glutasolve to aid /c gut absorption of TF's, will keep TF's @ half-strength for now. THis is inadequate to meet kcal needs, but it is imperitive to insure TF's are being absorbed before goal rate and strength is attempted. Will write verbal order, will f/u @ high nutr risk.

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Aiken Regional Medical Centers

Individual Patient Note
and
Any/All Addenda

Admission Date: 5/15/06
Med. record No.: 026523
Visit No.: 102829710
Attending Phys.: Bokkisam, Chakravarthy 045591, MD

Patient: William Sr Peterson
D.O.B.: [redacted] Age: 85
Gender: Male
Location: 5M
Room/Bed: 503 / A

IPOC Note, performed 5/20/06 at 14:07, entered 5/20/06 at 14:08 by Patricia Morell, RD:

clarified TF orders and nutritional pushes with pt's nurse Shannon. Diet office to deliver formual of 1/2 str Impact 1.5 to begin @ 20 ml/hr and incr by 10 ml/hr q 10 hrs till at goal rate of 60 ml/hr. On Mon will evaluate to incr to full str.

Addended 5/20/06 14:10 by Patricia Morell, RD:

Arginade and promod pushes being given.

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Aiken Regional Medical Centers

Individual Patient Note
and
Any/All Addenda

Admission Date: 5/15/06
Med. record No.: 026523
Visit No.: 102829710
Attending Phys.: Bokkisam, Chakravarthy 045591, MD

Patient: William Sr Peterson
D.O.B.: [redacted] Age: 85
Gender: Male
Location: 5M
Room/Bed: 503 / A

DTY Note, performed 5/19/06 at 16:05, entered 5/19/06 at 16:14 by Patricia Skolnik,RD:

Nutrition f/u: Pt s/p PEG today, MD ordered TF's to re-start in am per previous recommendations.
Noted per RN progress notes that TF's were started last pm per NG @ 20ml/hr, and residuals @ 2200 were ~100ml, and TF's were held.
IVF of D5 1/2 NS @ 100ml/hr = 2400ml fld, 408 kcal/d from dextrose.
Verbally reviewed TF orders /c RN for clarification, who showed understanding. Instructed RN that TF bag that is currently hanging (and not running) is from last night, and should be discarded in the am before TF's start again. Also requested RN write push orders on MAR for clarity in report from shift to shift.
TF order: 1/2 strength Impact 1.5 @ 20ml/hr to adv by 10ml q10 hrs as tolerated to goal of 60ml/hr; pushes of one package Arginade one scoop Promod in 120ml H2O BID. Once TF's are established, will change to full strength at goal of 55ml/hr.
PLAN: Will f/u @ high nutritional risk for tolerance to TF's.

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Aiken Regional Medical Centers

Individual Patient Note
and
Any/All Addenda

Admission Date: 5/15/06
Med. record No.: 026523
Visit No.: 102829710
Attending Phys.: Bokkisam, Chakravarthy 045591, MD

Patient: William Sr Peterson
D.O.B.: [redacted] Age: 85
Gender: Male
Location: 5M
Room/Bed: 503 / A

DTY Note, performed 5/19/06 at 16:05, entered 5/19/06 at 16:14 by Patricia Skolnik,RD:

Nutrition f/u: Pt s/p PEG today, MD ordered TF's to re-start in am per previous recommendations.
Noted per RN progress notes that TF's were started last pm per NG @ 20ml/hr, and residuals @ 2200 were ~100ml, and TF's were held.
IVF of D5 1/2 NS @ 100ml/hr = 2400ml ftd, 408 kcal/d from dextrose.
Verbally reviewed TF orders /c RN for clarification, who showed understanding. Instructed RN that TF bag that is currently hanging (and not running) is from last night, and should be discarded in the am before TF's start again. Also requested RN write push orders on MAR for clarity in report from shift to shift.
TF order: 1/2 strength Impact 1.5 @ 20ml/hr to adv by 10ml q10 hrs as tolerated to goal of 60ml/hr; pushes of one package Arginade one scoop Promod in 120ml H2O BID. Once TF's are established, will change to full strength at goal of 55ml/hr.
PLAN: Will f/u @ high nutritional risk for tolerance to TF's.

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WoundExpert
Wound Assessment Details

503

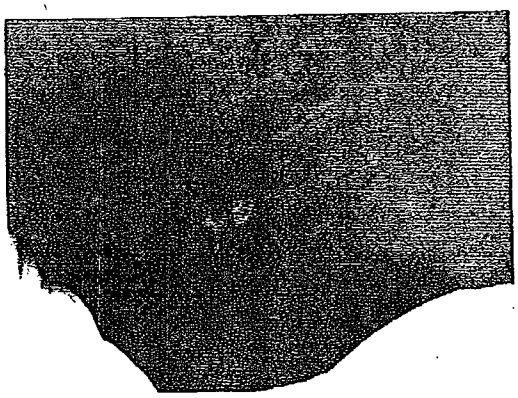
Aiken Regional Medical Center

Identification Information

Peterson, William
Patient Number: 26523
Date of Birth: [redacted]
Wound Number: 4
Location: Back (lower), , , , ,
Type of Wound: Pressure Ulcer
Wound Acquired:

Wound Status: Not Healed
Clinician: Mark Melton
Attending Physician:
Assessment Date: 5/16/2006
Treatment Duration: minutes
In-patient Visit: Yes

Wound Measurements



[Click to Enlarge]

Length (mm): 25
Width (mm): 5
Depth (mm): 1
Hypergranulated: No
Area (mm^2): 98.172
Volume (mm^3): 98.172

Tunneling: N/A
Tunneling Position (o'clock):
Maximum Distance (mm):
Undermining: N/A
Starting Position (o'clock):
Ending Position (o'clock):
Maximum Distance (mm):
Sinus Tract: N/A
Sinus Tract Position (o'clock):
Maximum Distance (mm):

Wound Details

Wound Progess:	Initial Exam
Stage:	N/A
Exudate Amount:	N/A
Exudate Type:	N/A
s/s of Infection:	N/A
Pulse:	N/A
Odor:	N/A
Pain:	N/A
Wound Margin:	Flat and Intact

Debridement:	N/A
Pain Control:	N/A
Level (per physician):	N/A

Tissue Debrided (per physician)

Necrotic:	Bone:	Cartilage:
Fibrous:	Muscle:	Fat:
Callous/Skin:	Eschar:	Clots:
Tendon:	Exudates:	Other:

Instrument:	N/A
Bleeding:	N/A
Hemostasis Achieved:	N/A
Procedural Pain:	N/A
Post Procedural Pain:	N/A
Paring:	N/A
Vacuum Assisted Closure (VAC) applied:	No
VAC type:	N/A

VAC pressure type:	N/A
VAC pressure setting:	N/A
VAC drain type:	N/A
VAC sponge size:	N/A
Date VAC initiated:	
Daily hours of therapy:	
Days on VAC:	
Dressing change:	
Reset clock to 0 hours:	
Date VAC discontinued:	

Peripheral Skin Appearance

		Texture	
Cellulitis	N/A	Callus	N/A
Edema	N/A	Dry/Scaly	N/A
Induration	N/A	Friable	N/A
Rubor	N/A	Maceration	N/A
Temperature:	N/A	Moist	N/A
		Rash	N/A
		Shiny	N/A
		Colors Present:	N/A

Wound Base

Wound Base Descriptions		Exposed Structure	
Slough	N/A	Exposed Tendon	N/A
Eschar:	N/A	Exposed Ligament	N/A
Granulation:	N/A	Exposed Muscle	N/A
Color:	Pink	Exposed Joint	N/A
Epithelialization:	N/A	Exposed Bone	N/A

Assessment Notes
This patient has a small superficial wound o his sacral/ lower back area. Calazime applied and calazime applied to buttocks. First step overlay ordered to offload this tissue area. We will continue to follow.

Protocol Information

William Peterson **Patient #:26523**
Wound #: 4 **Back (lower), , , ,** **5/16/2006**

Electronically Signed by:
Mark Melton at 5/16/2006 12:19:00 PM

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WoundExpert
Wound Assessment Details

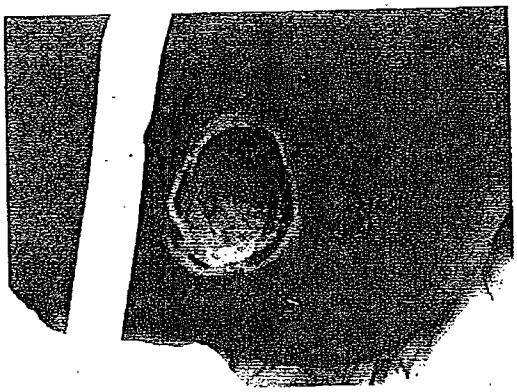
Aiken Regional Medical Center

Identification Information

Peterson, William
Patient Number: 26523
Date of Birth: [redacted]
Wound Number: 3
Location: Hip (), Left, , , ,
Type of Wound: Pressure Ulcer
Wound Acquired:

Wound Status: Not Healed
Clinician: Mark Melton
Attending Physician:
Assessment Date: 5/16/2006
Treatment Duration: 45 minutes
In-patient Visit: Yes

Wound Measurements



[Click to Enlarge]

Length (mm):	60
Width (mm):	50
Depth (mm):	10
Hypergranulated:	No
Area (mm^2):	2356.125
Volume (mm^3):	23561.25

Tunneling: N/A
Tunneling Position (o'clock):
Maximum Distance (mm):
Undermining: N/A
Starting Position (o'clock):
Ending Position (o'clock):
Maximum Distance (mm):
Sinus Tract: N/A
Sinus Tract Position (o'clock):
Maximum Distance (mm):

Wound Details

Wound Progess:	Initial Exam
Stage:	Stage 4
Exudate Amount:	Moderate
Exudate Type:	Purulent
s/s of Infection:	
Pulse:	N/A
Odor:	Strong
Pain:	N/A
Wound Margin:	Flat and Intact

Debridement:	N/A
Pain Control:	N/A
Level (per physician):	N/A

Tissue Debrided (per physician)

Necrotic:	Bone:	Cartilage:
Fibrous:	Muscle:	Fat:
Callous/Skin:	Eschar:	Clots:
Tendon:	Exudates:	Other:

Instrument:	N/A
Bleeding:	N/A
Hemostasis Achieved:	N/A
Procedural Pain:	N/A
Post Procedural Pain:	N/A
Paring:	N/A
Vacuum Assisted Closure (VAC) applied:	No
VAC type:	N/A

VAC pressure type:	N/A
VAC pressure setting:	N/A
VAC drain type:	N/A
VAC sponge size:	N/A
Date VAC initiated:	
Daily hours of therapy:	
Days on VAC:	
Dressing change:	
Reset clock to 0 hours:	
Date VAC discontinued:	

Peripheral Skin Appearance

Cellulitis	N/A
Edema	N/A
Induration	N/A
Rubor	N/A
Temperature:	N/A

Texture

Callus	N/A
Dry/Scaly	N/A
Friable	N/A
Maceration	N/A
Moist	N/A
Rash	N/A
Shiny	N/A
Colors Present:	N/A

Wound Base

Wound Base Descriptions

Slough	76-100%
Eschar:	N/A
Granulation:	N/A
Color:	
Epithelialization:	N/A

Exposed Structure

Exposed Tendon	N/A
Exposed Ligament	N/A
Exposed Muscle	N/A
Exposed Joint	N/A
Exposed Bone	N/A

Assessment Notes

Patient was admitted with this wound. It was documented in the nurses notes and a photo is on the chart. This gentleman is unresponsive to verbal stimuli and did not respond when dressings applied. His feet are dry but intact. He has a small open area to his sacrum. see next wound assessment. This wound is open and has a bad odor. Apply hydrogel dressing to wound base, cover with 4x4 and secure with medpore tape. Calazime is also applied directly around the wound edges. some red areas noted there. Orders written to change daily. First step overlay also ordered. We will continue to follow.

Protocol Information

William Peterson
Wound #: 3

Hip (), Left, , ,

Patient #:26523
5/16/2006

Electronically Signed by:
Mark Melton at 5/16/2006 12:19:00 PM

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Aiken Regional Medical Centers

Admission Date: 5/15/06
Med. record No.: 026523
Visit No.: 102829710
Attending Phys.: Bokkisam, Chakravarthy 045591, MD

Individual Patient Note
and
Any/All Addenda

Patient: William Sr Peterson
D.O.B.: [redacted], *Age:* 85
Gender: Male
Location: 5M
Room/Bed: 503 / A

DTY Note, performed 5/26/06 at 16:22, entered 5/26/06 at 16:28 by Patricia Skolnik,RD:

Nutrition f/u: TF's remain, they were changed to Fibersource HN @ 60ml/hr /c 25ml/hr H2O flushes, pushes BID of one package glutasolve, one package Arginade in 120ml H2O. This now provides 1978 kcal, 115g pro, 1887ml free H2O to meet all needs /x fld needs.

Pt tolerating well, had a BM today that RN described as soft but not diarrhea.

Pt s/p bronch. Pt /c GNR, which has held up d/c.

Labs 5/25: Na 149 (h), K 2.8 (l),CL 120 (h), BUN 46 (h), Ca 7.0 (l).

Noted fld boluses of 240ml x3, to provide 720ml free H2O.

Wound care eval noted pt's wound is more regularly shaped, cleaner /c a beefy red color.

PLAN: Verbal order written to increase H2O flushes to 35ml/hr to provide 2127ml free H2O/d to better meet pt's needs. Will con't to monitor @ high nutritional risk.

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Individual Patient Note
and
Any/All Addenda

Admission Date: 5/15/06
Med. record No.: 026523
Visit No.: 102829710
Attending Phys.: Bokkisam, Chakravarthy 045591, MD

Patient: William Sr Peterson
D.O.B.: [redacted], Age: 85
Gender: Male
Location: 5M
Room/Bed: 503 / A

DTY Note, performed 5/24/06 at 11:49, entered 5/24/06 at 11:55 by Patricia Skolnik,RD:

Nutrition f/u: Pt remains on TF if 1/2 strength Impact 1.5 @ 60ml/hr, and pushes BID of one pkg Arginade and one pkg Glutasolve in 120ml H2O. This provides 1330 kcal, 99g pro, 2121ml free H2O/d.

Pt continues to have very loose watery stool per RN. RN also stated pt is to transfer to NH today. Transfer orders written in chart.

Spoke /c MD yesterday regarding TF's, explained this RD's logic behind current formula, /c plans to change to full strength or change formula if pt does not tolerate. MD indicated understand.

Upon transfer, MD ordered pt to have full strength Fibersource HN @ 60 ml/hr /c pushes BID as ordered. This will provide 1978 kcal, 115g pro, 2007 ml free H2O/d to meet needs.

PLAN: Will not change formula as pt is to d/c today. Will f/u if pt remains in hospital.

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Aiken Regional Medical Centers

Individual Patient Note
and
Any/All Addenda

Admission Date: 5/15/06
Med. record No.: 026523
Visit No.: 102829710
Attending Phys.: Bokkisam, Chakravarthy 045591, MD

Patient: William Sr Peterson
D.O.B.: [redacted] Age: 85
Gender: Male
Location: 5M
Room/Bed: 503 / A

IPOC Note, performed 5/18/06 at 15:28, entered 5/18/06 at 15:41 by Patricia Skolnik,RD:

nutrition f/u: c/s received for TF recommendations. NG is to be placed, and possibly a PEG if family decides.
Labs 5/18: Na 148 (h), CL 123 (h), CO2 19 (l), BUN 36 (h), K 3.0 (l), Creat 1.9 (h), Ca 7.7 (l).
Wound care eval noted, pt has a pressure ulcer on lower back, and a stage 4 pressure ulcer on his L hip. Feeding tube and debridement to be done per family's wishes.
TF goal of Impact 1.5 @ 50ml/hr, with pushes BID of one package Arginade and one scoop Promod in 120ml H2O. This will provide 1920 kcal, 119g pro/d to meet needs. H2O flushes to be determined depending on IVF's at the time goal is met.
TF orders written for pushes as above, and TF's of continuous feed @ half-strength Impact 1.5 goal of 60ml/hr. TF's to start @ 20ml/hr, and adv by 10ml q 10hrs as tolerated. Slow adv of TF vital to ensure pt tolerates nutrition and volume. Once this is established, TF's will be changed to full-strength for maximum nutrition.
PLAN: Will f/u for tolerance of TF's and make changes as seen fit.

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Aiken Regional Medical Centers

Nutritional Assessment

Patient: Peterson, William Sr
D.O.B.: [redacted] Age: 85
Gender: Male
Location: 5M
Room/Bed: 503/A

Admission Date: 5/15/06
Med. record No.: 026523
Visit No.: 102829710
Attending Phys.: Bokkisam, Chakravarthy 045591, MD

Scheduled: 5/17/06 17:02
Performed: 5/17/06 17:03
User: Patricia Skolnik,RD
Status: Finished

Subjective & Nutr Support Assessment

Patient is unable to eat. Patient is not receiving nutritional support. Patient presently has difficulty swallowing. Patient requires feeding assistance. Home diet consists of unknown diet, but supplement of Novasource Renal 180ml QID. Patient/family comments: pt too lethargic to speak to, unable to feed d/t aspiration precautions.

Objective Assessment

Diagnosis: urosepsis, AMS, hypothermia, mild HTN. Medical history includes bedosres, ARF, hyperkalemia, BPH, rhabdomyolysis, HTN, anterior cervical fusion. Diet order: NPO. Pertinent Drug-Nutrient interactions include: protonix, zosyn, vancomycin, flagyl. Additional nutritional concern comments: Referral received d/t "very poor" nutrition on the admission assessment braden score. IVF of D5 1/4 NS @ 200ml/hr = 4800ml fld, 816 kcal/d from dextrose. Pt was supposed to have debridement, but pt declared comfort measures including no surgical interventions. RN stated that BP ws getting a little better, and UOP a bit better. Pt on aspiration precautions. Wound care eval not on chart yet. Lab Results: BUN 41 Creatinine 2.4 Other pertinent lab results: Na 150 (h), Cl 123 (h), CO2 21 (l), Ca 7.6 (l). Admission weight: 179 lb 16 oz (81 kg 646.6 gm). Ht is 5 Ft 11 in (1 Meter 80.3 cm). IBW: 172 lb. IBW: 104%.

Nutrition Goals/Orders

Nutritional needs estimated at 1825-1977 calories a day, 97-121 grams of protein, 2430 ml of fluid. Nutritional risk assessed as high d/t diet status. Nutrition Therapy Goals as follows: Promote wound healing: est pro needs @ 1.2-1.5g/kg ABW to promote wound healing by now. Maintain normal fluid status: est fld needs @ 30ml/kg ABW to maint hydration by now. Weight maintenance: est energy needs @ BEE (1521) x1.2-1.3 IF d/t stress of dx and wound healing by now. Strategies for achieving goals: maintain current therapy, and monitor lab work. Other strategy described as Will monitor pt's status and make suggestions as seen appropriate.

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Aiken Regional Medical Centers

Visit Record

Admission Date: 5/15/06
Med. record No.: 026523
Visit No.: 102829710
Attending Phys.: Bokkisam, Chakravarthy 045591, MD

Patient: Peterson, William Sr
D.O.B.: [redacted] Age: 85
Gender: Male
Location: DIS
Room/Bed:

Entered by:	Scheduled:	Performed:	Effective:	Status:

Charted Activities

Quick Triage

Paige Donahue RN 5/15/06 16:44 5/15/06 16:44 5/15/06 16:48 **Finished**

Quick Triage Info

Patient triaged as URGENT. PRIMARY COMPLAINT: pt arrived from tm health/ rehab of edgefield w ams. pt responds to painful stimuli. Patient's level of pain is 0 (no pain). Patient arrived via stretcher accompanied by relative. EMS treatment prior to arrival. Temperature 91.2 F (32.89 C) rectally. Pulse 46 bpm. Resp rate 22. O2 SAT 100%. BP 119/ 86 mmHg.. There is no evidence of abuse and/or neglect. After triage patient went to ED room 14.

Allergy History

No known allergies.

Home Meds

See attached medication list.

ER Discharge Assessment

Amanda Abbot RN 5/15/06 16:44 5/16/06 02:09 5/16/06 02:11 **Finished**

ER Discharge

ER Discharge Date/Time: 05/16/2006 02:10. Patient discharged to monitored room # 503. Patient discharged via stretcher, accompanied by staff. Patient condition is stable. Room checked. No personal belongings found.

Pain

Patient's level of pain is 0 (no pain). Faces pain scale used to assess patient's pain level. Use of pain scale was explained to patient and/or family.

Admission Assessment

Rachel Harris Jones,LPN 5/15/06 23:58 5/16/06 02:30 5/16/06 05:53 **Finished**

Current Illness

Diagnosis: urosepsis, ams, hypothermia. History of present illness: uti,arf,neurogenic bladder,. Unable to obtain whether patient would object to a blood transfusion if needed. Additional comments: previous anesthesia according to history..

Past Medical/Surgical History

Patient's past medical history includes HTN. Other past medical history also includes arf, cervical spine stenosis, cervical dis degen, arf, hyperpotassium, rhabdolyolysis, protein-cal mulnut, retention of urine, hematuria, uti, neurogenic bladder, paraplegia, pros hypertrophy w/obstruction, anenia chr illness nec, htn, ant cervical fusion nec, iv disc excision, fusion/refusion 2-3 vert, insert interbody fus dev, insert recombinant bone. Past relevant surgeries: cervical spinal fusion w cc.

GU History

Hx of prostate problems includes pros hypertr w/ obstruction. GU Hx includes Renal Failure, and UTI. Patient wears protective undergarments.

Psych-Social History

Patient tobacco usage is unknown. Unable to obtain if patient was threatened or physically hurt in last12 months. There is no evidence of abuse and/or neglect.

Nutrition History

Nutrition history assessed and the following concerns were identified Nutritional concerns: Additional nutritional concern comments: pt appears unable to swallow at present.

Vaccine Information

Patient does not know if He/She has received the pneumonia vaccine. Patient has not received the Hepatitis B vaccine. Comments: unable to obtain.

Diabetes

Patient does not have diabetes.

Entered by: Scheduled: Performed: Effective: Status:

Admission Assessment (cont'd)

Arrival Data
Patient arrived via stretcher admitted from ED. Arrived onto unit: 05/16/2006 02:30. Emergency contact is Mary peterson ; can be reached at 8036494858. Relation to patient: daugh. Secondary emergency contact is Raymond Peterson ; can be reached at803 6444 8084. Relation to patient: son. Unable to orient patient to hospital enviroment ID bracelet on. Allergy bracelet not applicable.

Belongings Inventory
No belongings at time of admission.

Assistive Devices Inventory
Assistive devices not in use at time of admission.

Advance Directive
Patient has a dnr on the chart.

Braden Risk
Sensory Perception: Completely Limited; Moisture: Occasionally Moist; Activity: Bedfast; Mobility: Completely Immobile; Nutrition: Very Poor; Friction/Shearing: Problem; Braden Risk Score =8.

Fall Risk Assessment
Fall Risk Score= 50. No history of falling this admission or having fallen within the last3 months. There is a secondary diagnosis noted which could increase the risk of a fall. Ambulatory aid: None or on bed rest or uses wheel chair or needs Nurse. IV /Heparin Lock present. Gait/Transferring: Normal or on bed rest or immobile. Mental status: Forgets limitations. Patient is taking 3 or less medications from the following list: Anesthesia within past 48 hours, Anticoagulants, Antidepressants, Benzodiazepines, Laxative/diuretics, Opioids (narcotics), Sedatives/hypnotics, Vasodilators. High Risk Fall Prevention Interventions were implemented, based on a score of greater than50 obtained using the Fall Assessment and Intervention policy.

Pain Initial
Patient's level of pain is 0 (no pain). Numerical pain scale used to assess patient's pain level. Unable to explain use of pain scale to patient and/or family because pt non responsive.

Home Medication
Additional comments regarding patient's home medications see list on chart.

Learning Needs
Unable to assess patient at this time. Comments: pt nonresponsive

Anticipated Discharge Plan
Patient lives in Extended Care Facility. Anticipated discharge to an Extended Care Facility.

Education Needs
Unable to assess patient's preferred learning method. Reason: pt nonresponsive. Unable to assess if patient is ready or motivated to learn. Unable to assess if there are factors that will affect the patient's ability to learn. Plan of Care initiated: urosepsis, hypothermia, non responsive,

Spiritual Assessment
Not known if patient has religious or spiritual concerns. Not known if patient has a religious or spiritual preference.

HEENT
Unable to assess patient at this time. Comments: pt non responsive

NeuroMusculoSkeletal
Unable to assess patient at this time. Comments: pt non responsive. knees appear contracted and no movement of any extremities seen during admission

Orthopaedic Assessment
Orthopaedic assessment is not indicated for this patient at this time.

Cardiovascular
Patient is on a cardiac monitor. Rhythm regular. Lead II. Heart rate 72 bpm. Interpretations as follows: Normal Sinus Rhythm. +4 pitting edema of bilateral feet.

Respiratory
O2 SAT 99 %. Patient on Oxygen at 15 liters per minute FIO2 is 100% via nrb mask. Rhonchi auscultated in All lobes.

Gastrointestinal
Patient is experiencing incontinence. Patient on NPO diet.

Genitourinary
Voiding patterns include: indwelling cath. Patient wears protective undergarments.

Entered by: | Scheduled: | Performed: | Effective: | Status:

Admission Assessment (cont'd)

Integumentary

Skin integrity: bruise, denuded, and scar(s). Additional Integumentary related comments: lt lateral decub drsg c/d/i. see picture on chart. lower back decub. see picture on chart. dry blisters on feet and feet are scaley. open blister inner lt ankle non draining. healed scabbed sore outter rt foot..

IV Information

IV in Right Hand. Gauge: 20. Site is patent. Inserted 051606.

Functional Assessment

Transport Method: bed. Patient unable to stand. Required level of assistance with ADLs as follows: current level of activity bedrest , requires total assistance with hygiene, requires total assistance with toileting, requires total assistance with dressing, unable to ambulate , requires total assistance with eating

Equipment

No Equipment being used at this time.

Restraints

Patient is not in restraints.

Psych/Knowledge

Unable to assess patient at this time. Comments: pt non responsive

Resp Education Assessment

Ashley Hamilton, RRT 5/16/06 04:10 5/16/06 04:10 5/16/06 06:37 **Finished**

Respiratory Education Assessment

Learning needs: none. Content taught: nebulizer instruct. Information taught to patient. Knowledgeable about health problem: No. Learning barriers: cognitive. Description of barrier(s): pt not responsive. Unable to assess readiness/motivation to learn Teaching format(s) include one on one. Response to teaching: seemed disinterested. Patient tobacco usage is unknown.

Resp O2 Rounds

Ashley Hamilton, RRT 5/16/06 04:10 5/16/06 04:10 5/16/06 06:37 **Finished**

Respiratory O2 Rounds

Patient currently on O2 at 15 liters per minute FIO2 is 100% via nrb mask. Level of consciousness is unresponsive. Heart rate 74 bpm. O2 SAT 100%.

Resp Therapy Care Activity

Ashley Hamilton, RRT 5/16/06 04:10 5/16/06 04:10 5/16/06 06:39 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: decreased in All lobes. fine crackles auscultated in LUL, and RML. Heart rate 74 bpm. O2 SAT 100%. Breath sounds and vitals after treatment were noted to be: decreased in All lobes. fine crackles auscultated in LUL, and RML. Heart rate 73 bpm. O2 SAT 91%. Patient currently on O2 at 15 liters per minute FIO2 is 100% via nrb mask. Patient's level of pain is 0 (no pain).

Respiratory Assessment

Ashley Hamilton, RRT 5/16/06 04:10 5/16/06 04:10 5/16/06 06:42 **Finished**

Vitals and General Info

Heart rate 74 bpm. O2 SAT 100%. Patient on continuous O2 at 15 L per min. Current diagnosis is ams, hupothermia, copd. Current therapy: duonebs q4h. Pulmonary hx includes: COPD/Asthma. Level of consciousness is unresponsive.

Respiratory

Patient on Oxygen at 15 liters per minute FIO2 is 100% via nrb mask. Breath sounds: decreased in All lobes. fine crackles auscultated in LUL, and RML. Patient's level of pain is 0 (no pain).

Med Surg Shift Assessment

Diana Undertilo,RN 5/16/06 08:00 5/16/06 08:00 5/16/06 20:18 **Finished**

NeuroMusculoSkeletal

Level of consciousness is lethargic. Weakness/Abnormal movements described as: bed ridden; unresponsive.

Cardiovascular

Patient is on a cardiac monitor. Heart rate 89 bpm. Interpretations as follows: Normal Sinus Rhythm.

Respiratory

via venti mask

Entered by: Scheduled: Performed: Effective: Status:

Med Surg Shift Assessment (cont'd)

GI/GU
WNL as evidence by: Abdomen soft, non-tender, bowel sounds active. Continent, voids without difficulty or pain Urine color within individual normal limits

Integumentary
Skin integrity: abrasion, bruise, denuded, and scar(s). Integrity described as: shear abrasion to sacral area. There is no evidence of abuse and/or neglect. Pressure sore on L hip was present on admission. Additional Integumentary related comments: pressure sore to L hip, wound care in to see pt; changed dressing; sacral area has"shear" abrasion; cream being placed for this area.

IV Information
IV in Right Forearm. Gauge: 20. Site is patent. Inserted 5/16/06. Additional IV related comments: IVF infusing; NS.

Pain
Patient's level of pain is 0 (no pain). FLACC pain scale used to assess patient's pain level. Use of pain scale was explained to patient and/or family. Comments: Explained to family that if pt becomes aggitated or fidgeting, will give pain med; pt resting without diff today.

Restraint Reassessment
Patient is not in restraints.

Fall Risk Assessment
Fall Risk Score= 50. No history of falling this admission or having fallen within the last3 months. There is a secondary diagnosis noted which could increase the risk of a fall Ambulatory aid: None or on bed rest or uses wheel chair or needs Nurse. IV /Heparin Lock present. Gait/Transferring: Normal or on bed rest or immobile. Mental status: Forgets limitations. Patient is taking 3 or less medications from the following list: Anesthesia within past 48 hours, Anticoagulants, Antidepressants, Benzodiazepines, Laxative/diuretics, Opioids (narcotics), Sedatives/hypnotics, Vasodilators. Standard (low risk) Fall Prevention Interventions were implemented, based on a score of25 - 50 obtained using the Fall Assessment and Intervention policy. Additional Fall Risk related comments: Pt lethargic/unresponsive except to stimuli .

Education
Diana Undertilo,RN 5/16/06 08:00 5/16/06 08:00 5/16/06 20:20 **Finished**

Education Assessment
Learning needs: meds; wound care. Content taught: meds; wound care. Learning barriers: cognitive. Plan of care has been reviewed/revised. Plan of care initiated: wound care.

Braden Risk Assessment
Diana Undertilo,RN 5/16/06 08:00 5/16/06 08:00 5/16/06 20:22 **Finished**

Braden Risk
Sensory Perception: Slightly Limited; Moisture: Rarely Moist; Activity: Bedfast; Mobility: Very Limited; Nutrition: Inadequate; Friction/Shearing: Problem; Braden Risk Score =13.

Resp Therapy Care Activity
Ernie Bargeron,RRT 5/16/06 08:05 5/16/06 08:05 5/16/06 09:52 **Finished**

Treatment
Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: decreased in All lobes. Heart rate 84 bpm. RR 10. Breath sounds and vitals after treatment were noted to be: decreased in All lobes. Heart rate 86 bpm. RR 12. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity
Buffy Russ, RRT 5/16/06 19:00 5/16/06 21:30 5/17/06 02:19 **Finished**

Treatment
Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Breath sounds and vitals before treatment were noted to be: decreased in All lobes. rhonchi auscultated in All lobes. Patient's level of pain is 0 (no pain).

Med Surg Shift Assessment
Renee Ensley,LPN 5/16/06 20:00 5/16/06 20:42 5/16/06 20:50 **Finished**

NeuroMusculoSkeletal
Weakness/Abnormal movements described as: generlized weakness.

Entered by: Scheduled: Performed: Effective: Status:

Med Surg Shift Assessment (cont'd)

Cardiovascular
Patient is on a cardiac monitor. Heart rate 68 bpm. Interpretations as follows: Normal Sinus Rhythm.

Respiratory
Patient on Oxygen at 5 liters per minute via veni mask O2 SAT 94 % on O2.

GI/GU
WNL as evidence by: Abdomen soft, non-tender, bowel sounds active. Continent, voids without difficulty or pain
Urine color within individual normal limits.

Integumentary
Skin integrity: abrasion, denuded, and scar(s). Integrity described as: abrasion to the sacral area. There is no evidence of abuse and/or neglect. Pressure sore on left hip was present on admission.

IV Information
IV in Right Forearm. Gauge: 20. Site is patent. Inserted 5/16/06.

Pain
Patient's level of pain is 0 (no pain). FLACC pain scale used to assess patient's pain level. Unable to explain use of pain scale to patient and/or family because pt is noresponsive..

Restraint Reassessment
Patient is not in restraints.

Fall Risk Assessment
Fall Risk Score= 45. No history of falling this admission or having fallen within the last3 months. No secondary diagnosis noted to increase the risk of a fall. Ambulatory aid: None or on bed rest or uses wheel chair or needs Nurse. IV /Heparin Lock present. Gait/Transferring: Weak. Mental status: Forgets limitations. Patient is taking 3 or less medications from the following list: Anesthesia within past 48 hours, Anticoagulants, Antidepressants, Benzodiazepines, Laxative/diuretics, Opioids (narcotics), Sedatives/hypnotics, Vasodilators. High Risk Fall Prevention Interventions were implemented, based on a score of greater than50 obtained using the Fall Assessment and Intervention policy.

Education

Renee Ensley,LPN 5/16/06 20:00 5/16/06 20:50 5/16/06 20:50 **Finished**

Education Assessment
Learning barriers: cognitive. No learning needs identified at this time Plan of care has been reviewed/revised.

Resp Therapy Care Activity

Buffy Russ, RRT 5/17/06 00:20 5/17/06 00:20 5/17/06 02:22 **Finished**

Treatment
Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Breath sounds and vitals before treatment were noted to be: decreased in All lobes. rhonchi auscultated in All lobes. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Buffy Russ, RRT 5/17/06 04:00 5/17/06 04:00 5/17/06 05:05 **Finished**

Treatment
Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Breath sounds and vitals before treatment were noted to be: rhonchi auscultated in All lobes. Patient's level of pain is 0 (no pain).

Resp O2 Rounds

Rebecca Hake Flickinger, CRTT 5/17/06 07:10 5/17/06 07:10 5/17/06 09:25 **Finished**

Respiratory O2 Rounds
Patient currently on O2 at FIO2 is 100% via non rebreather mask. Level of consciousness is asleep. Heart rate 76 bpm. O2 SAT 99%.

Resp Therapy Care Activity

Rebecca Hake Flickinger, CRTT 5/17/06 08:00 5/17/06 07:10 5/17/06 09:27 **Finished**

Entered by: | Scheduled: | Performed: | Effective: | Status:

Resp Therapy Care Activity (cont'd)

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: H-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: rhonchi auscultated in LUL, and RUL. Heart rate 76 bpm. RR 12. O2 SAT 99%. Breath sounds and vitals after treatment were noted to be: Heart rate 74 bpm. RR 14. Patient currently on O2 at FIO2 is 100% via non rebreather mask. Patient's level of pain is 0 (no pain).

Braden Risk Assessment

Stephanie K. Bell, ATC SN 5/17/06 08:00 5/17/06 08:00 5/17/06 12:40 **Finished**

Braden Risk

Sensory Perception: Slightly Limited; Moisture: Occasionally Moist; Activity: Bedfast; Mobility: Very Limited; Nutrition: Very Poor; Friction/Shearing: Problem; Braden Risk Score = 11.

Med Surg Shift Assessment

Stephanie K. Bell, ATC SN 5/17/06 08:00 5/17/06 08:30 5/17/06 12:43 **Finished**

NeuroMusculoSkeletal

Level of consciousness is unresponsive. Weakness/Abnormal movements described as: Bedbound, weak but resists manipulation and movement for bathing and blood pressure check Patient's behavior/mood is sleeping. Affect is flat.

Cardiovascular

Edema: +3 pitting edema feet bilateral +1 pitting edema lower legs bilateral. Patient is on a cardiac monitor. Heart rate 76 bpm. Interpretations as follows: Normal Sinus Rhythm. Additional Cardiovascular related comments: Telemetry.

Respiratory

via Nonrebreathe mask O2 SAT 100 % on O2. Rhonchi auscultated in all lobes.

GI/GU

Hypoactive bowel sounds. Patient is experiencing incontinence. Patient has indwell catheter in place. Patient wears protective undergarments.

Integumentary

Skin temp is: cool. Skin Moisture is: dry/scaly. Skin integrity: denuded, scar(s), and skin tear. Integrity described as: small lesions on legs and buttocks. There is no evidence of abuse and/or neglect. Ulcer on L Hip was present on admission. Size: Length - 5 cm. Width - 5 cm. Depth - 3 cm. Stage 3. Color yellow. Foul odor. Periwound skin is eschared. Pressure sore on sacrum was present on admission. Size: Length - 2 cm. Width - 4 cm. Depth - 0 cm. Stage 2. Color pink/red.

IV Information

IV in Right Forearm. Gauge: 20. Site is patent. Inserted 5/15/06. Additional IV related comments: changed to D5/0.2NS.

Pain

Patient's level of pain is 0 (no pain). Faces pain scale used to assess patient's pain level. Unable to explain use of pain scale to patient and/or family because pt unresponsive. family not responsive.. Comments: Pt opens eyes and resists movement with groans, but unable to communicate verbally.

Restraint Reassessment

Patient is not in restraints.

Fall Risk Assessment

Fall Risk Score= 50. No history of falling this admission or having fallen within the last3 months. There is a secondary diagnosis noted which could increase the risk of a fall. Ambulatory aid: None or on bed rest or uses wheel chair or needs Nurse. IV /Heparin Lock present. Gait/Transferring: Normal or on bed rest or immobile. Mental status: Forgets limitations. Patient is taking 3 or less medications from the following list: Anesthesia within past 48 hours, Anticoagulants, Antidepressants, Benzodiazepines, Laxative/diuretics, Opioids (narcotics), Sedatives/hypnotics, Vasodilators. Standard (low risk) Fall Prevention Interventions were implemented, based on a score of25 - 50 obtained using the Fall Assessment and Intervention policy. Additional Fall Risk related comments: Pt has very limited mobility and is bedfast. .

Resp Therapy Care Activity

Rebecca Hake Flickinger, CRTT 5/17/06 12:00 5/17/06 12:10 5/17/06 13:22 **Finished**

Entered by: Scheduled: Performed: Effective: Status:

Resp Therapy Care Activity (cont'd)

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: decreased in All lobes. rhonchi auscultated in LUL, and RUL. Heart rate 72 bpm. RR 14. O2 SAT 100%. Breath sounds and vitals after treatment were noted to be: Heart rate 74 bpm. RR 14. Patient currently on O2 at FIO2 is 100% via non rebreather mask. Patient's level of pain is 0 (no pain). Additional Treatment related comments: patient placed on 50% venti mask.

Resp Therapy Care Activity

Rebecca Hake Flickinger, CRTT — 5/17/06 16:00 — 5/17/06 15:40 — 5/17/06 16:25 — **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: decreased in LLL, and RLL. Heart rate 96 bpm. RR 14. O2 SAT 99%. Breath sounds and vitals after treatment were noted to be: Heart rate 97 bpm. RR 14. Patient currently on O2 at FIO2 is 50% via venti mask. Patient's level of pain is 0 (no pain). Additional Treatment related comments: decreased to40% venti maskspo2 97%.

Nutritional Assessment

Patricia Skolnik,RD — 5/17/06 17:02 — 5/17/06 17:03 — 5/17/06 17:10 — **Finished**

Subjective & Nutr Support Assessment

Patient is unable to eat. Patient is not receiving nutritional support. Patient presently has difficulty swallowing. Patient requires feeding assistance. Home diet consists of unknown diet, but supplement of Novasource Renal180ml QID. Patient/family comments: pt too lethargic to speak to, unable to feed d/t aspiration precautions.

Objective Assessment

Diagnosis: urosepsis, AMS, hypothermia, mild HTN. Medical history includes bedosres, ARF, hyperkalemia, BPH, rhabdomyolysis, HTN, anterior cervical fusion. Diet order: NPO. Pertinent Drug-Nutrient interactions include: protonix, zosyn, vancomycin, flagyl. Additional nutritional concern comments: Referral received d/t "very poor" nutrition on the admission assessment braden score. IVF of D5 1/4 NS @ 200ml/hr = 4800ml fld, 816 kcal/d from dextrose. Pt was supposed to have debridement, but pt declared comfort measures including no surgical interventions. RN stated that BP ws getting a little better, and UOP a bit better. Pt on aspiration precautions. Wound care eval not on chart yet. Lab Results: BUN 41 Creatinine 2.4 Other pertinent lab results: Na 150 (h), Cl 123 (h), CO2 21 (l), Ca 7.6 (l). Admission weight: 179 lb 16 oz (81 kg 646.6 gm). Ht is 5 Ft 11 in (1 Meter 80.3 cm). IBW: 172 lb. IBW: 104%.

Nutrition Goals/Orders

Nutritional needs estimated at 1825-1977 calories a day, 97-121 grams of protein, 2430 ml of fluid. Nutritional risk assessed as high d/t diet status. Nutrition Therapy Goals as follows: Promote wound healing: est pro needs @ 1.2-1.5g/kg ABW to promote wound healing by now. Maintain normal fluid status: est fld needs @ 30ml/kg ABW to maint hydration by now. Weight maintenance: est energy needs @ BEE (1521) x1.2-1.3 IF d/t stress of dx and wound healing by now. Strategies for achieving goals: maintain current therapy, and monitor lab work. Other strategy described as: Will monitor pt's status and make suggestions as seen appropriate.

Med Surg Shift Assessment

Renee Ensley,LPN — 5/17/06 20:00 — 5/17/06 21:39 — 5/17/06 21:54 — **Finished**

NeuroMusculoSkeletal

Weakness/Abnormal movements described as: generlized weakness.

Cardiovascular

Patient is on a cardiac monitor. Heart rate 95 bpm. Interpretations as follows: Normal Sinus Rhythm.

Respiratory

WNL as evidenced by Respirations even and unlabored. Breath sounds clear bilaterally.

GI/GU

Patient has indwell catheter in place.

Integumentary

Skin integrity: abrasion, denuded, and scar(s). Integrity described as: abrasion on butocks. There is no evidence of abuse and/or neglect. Pressure sore on left hip was present on admission.

IV Information

IV in Right Forearm. Gauge: 20. Site is patent. Inserted 5/16/06.

Entered by: | Scheduled: | Performed: | Effective: | Status:

Med Surg Shift Assessment (cont'd)

Pain

Patient's level of pain is 0 (no pain). Numerical pain scale used to assess patient's pain level. Use of pain scale was explained to patient and/or family.

Restraint Reassessment

Patient is not in restraints.

Fall Risk Assessment

Fall Risk Score= 45. No history of falling this admission or having fallen within the last3 months. No secondary diagnosis noted to increase the risk of a fall. Ambulatory aid: None or on bed rest or uses wheel chair or needs Nurse. IV /Heparin Lock present. Gait/Transferring: Weak. Mental status: Forgets limitations. Patient is taking 3 or less medications from the following list Anesthesia within past 48 hours, Anticoagulants, Antidepressants, Benzodiazepines, Laxative/diuretics, Opioids (narcotics), Sedatives/hypnotics, Vasodilators. High Risk Fall Prevention Interventions were implemented, based on a score of greater than 50 obtained using the Fall Assessment and Intervention policy.

Education

Renee Ensley,LPN 5/17/06 20:00 5/17/06 21:53 5/17/06 21:54 **Finished**

Education Assessment

Learning barriers: cognitive. No learning needs identified at this time Plan of care has been reviewed/revised.

Resp Therapy Care Activity

Robert Guggenheim, CRT 5/17/06 20:00 5/17/06 20:04 5/18/06 00:28 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. Adverse reactions: none. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: rhonchi auscultated in All lobes. Heart rate 80 bpm. O2 SAT 93%. Level of consciousness is alert. Breath sounds and vitals after treatment were noted to be: Heart rate 85 bpm. Patient noted to have strong cough effort. Non-productive cough. Patient currently on O2 at FIO2 is 40% via venti mask. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Robert Guggenheim, CRT 5/18/06 00:00 5/17/06 23:54 5/18/06 00:39 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. Adverse reactions: none. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: rhonchi auscultated in All lobes. Heart rate 81 bpm. O2 SAT 97%. Level of consciousness is alert. Breath sounds and vitals after treatment were noted to be: Heart rate 85 bpm. Patient noted to have strong cough effort. Non-productive cough. Patient currently on O2 at FIO2 is 40% via venti mask. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Robert Guggenheim, CRT 5/18/06 04:00 5/18/06 03:54 5/18/06 04:43 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. Adverse reactions: none. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: rhonchi auscultated in All lobes. Heart rate 88 bpm. O2 SAT 93%. Level of consciousness is alert. Breath sounds and vitals after treatment were noted to be: Heart rate 94 bpm. Patient currently on O2 at FIO2 is 40% via venti mask. Patient's level of pain is 0 (no pain).

Resp O2 Rounds

Anna Sheets,RRT 5/18/06 07:40 5/18/06 07:40 5/18/06 15:10 **Finished**

Respiratory O2 Rounds

Patient currently on O2 at 8 liters per minute FIO2 is 40% via venti mask. Level of consciousness is confused. Heart rate 77 bpm. O2 SAT 91%.

Resp Therapy Care Activity

Anna Sheets,RRT 5/18/06 08:00 5/18/06 07:40 5/18/06 15:12 **Finished**

Entered by: Scheduled: Performed: Effective: Status:

Resp Therapy Care Activity (cont'd)

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: decreased rhonchi, and improved aeration. Breath sounds and vitals before treatment were noted to be: decreased in All lobes. rhonchi auscultated in All lobes. Heart rate 77 bpm. RR 24. O2 SAT 91%. Level of consciousness is lethargic. Breath sounds and vitals after treatment were noted to be: decreased in All lobes. Heart rate 76 bpm. RR 24. O2 SAT 97%. Suctioned cough. Sputum color: tan. Copious amounts of sputum. Sputum consistency thick. Nasotracheal suctioning performed. Patient's level of pain is 0 (no pain).

Braden Risk Assessment

Teresa Meador, RN 5/18/06 08:00 5/18/06 08:00 5/18/06 21:03 **Finished**

Braden Risk

Sensory Perception: Very Limited; Moisture: Occasionally Moist; Activity: Bedfast; Mobility: Very Limited; Nutrition: Very Poor; Friction/Shearing: Problem; Braden Risk Score =10.

Education

Teresa Meador, RN 5/18/06 08:00 5/18/06 08:00 5/18/06 21:04 **Finished**

Education Assessment

Learning needs: treatment. Content taught: care as rendered. Information taught to patient. Knowledgeable about health problem: No. Learning barriers: cognitive. Description of barrier(s): unresponsive excepts for occasionalmoans. Follow up actions: continue to tell care as rendered. Unable to assess readiness/motivation to learn Response to teaching: monitor. Plan of care has been reviewed/revised.

Med Surg Shift Assessment

Teresa Meador, RN 5/18/06 08:00 5/18/06 08:00 5/18/06 21:13 **Finished**

NeuroMusculoSkeletal

E4 - Eyes open spontaneously. V2 - Patient making incomprehensible sounds. M4 - Patient withdraws. GCS: 10. Level of consciousness is confused. Weakness/Abnormal movements described as: rt sided weakness. Speech is aphasic.

Cardiovascular

Edema: +2 pitting edema feet. Patient is on a cardiac monitor. Heart rate 68 bpm. Interpretations as follows: Normal Sinus Rhythm.

Respiratory

via venti mask O2 SAT 96 % on O2. Breath sounds decreased in all lobes. Ineffective cough. yellow Moderate amounts of sputum. Sputum consistency thick. Nasotracheal suctioning performed. Additional Respiratory related comments: rales.

GI/GU

Patient has indwell catheter in place. Urine is cloudy. Urine color is milky.

Integumentary

denuded, and scar(s) There is no evidence of abuse and/or neglect. Pressure sore on lt hip was present on admission. Size: Stage 3. Color yellow. Slight exudate. Purulent drainage. No odor. Periwound skin is erythematic. Pressure sore on sacrum was present on admission. Size: Stage 1. Color pink/red. No odor. Additional Integumentary related comments: 1st stepoverlay on bed.

IV Information

IV in Right Forearm. Gauge: 20. Site is patent. Inserted 5/15/06. Additional IV related comments: d5 1/4nsinfusing at 200cc/h.

Pain

Patient's level of pain is 0 (no pain). Faces pain scale used to assess patient's pain level. Unable to explain use of pain scale to patient and/or family because pt unresponsive.

Restraint Reassessment

Patient is not in restraints.

Entered by: Scheduled: Performed: Effective: Status:

Med Surg Shift Assessment (cont'd)

Fall Risk Assessment

Fall Risk Score= 50. No history of falling this admission or having fallen within the last3 months. There is a secondary diagnosis noted which could increase the risk of a fall Ambulatory aid: None or on bed rest or uses wheel chair or needs Nurse. IV /Heparin Lock present. Gait/Transferring: Normal or on bed rest or immobile. Mental status: Forgets limitations. Patient is taking 3 or less medications from the following list Anesthesia within past 48 hours, Anticoagulants, Antidepressants, Benzodiazepines, Laxative/diuretics, Opioids (narcotics), Sedatives/hypnotics, Vasodilators. Standard (low risk) Fall Prevention Interventions were implemented, based on a score of25 - 50 obtained using the Fall Assessment and Intervention policy.

Resp Therapy Care Activity

Anna Sheets,RRT 5/18/06 12:00 5/18/06 12:00 5/18/06 15:14 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well Response to treatment: decreased rhonchi, and improved aeration Breath sounds and vitals before treatment were noted to be decreased in All lobes. rhonchi auscultated in RLL, and RML. Heart rate 74 bpm. RR 24. O2 SAT 93%. Level of consciousness is lethargic. Breath sounds and vitals after treatment were noted to be decreased in All lobes. Heart rate 73 bpm. RR 20. O2 SAT 97%. Patient noted to have weak cough effort Non-productive cough. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Anna Sheets,RRT 5/18/06 16:00 5/18/06 16:00 5/18/06 16:49 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well Response to treatment: decreased rhonchi, and improved aeration Breath sounds and vitals before treatment were noted to be decreased in All lobes. rhonchi auscultated in All lobes. Heart rate 71 bpm. RR 20. O2 SAT 94%. Level of consciousness is confused Breath sounds and vitals after treatment were noted to be decreased in All lobes. rhonchi auscultated in LLL, and RLL. Heart rate 65 bpm. RR 20. O2 SAT 96%. Suctioned cough. Sputum color: white. Moderate amounts of sputum. Sputum consistency thick. Oropharyngeal suctioning performed Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Ashley Hamilton, RRT 5/18/06 20:00 5/18/06 20:10 5/18/06 21:10 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: H-fowlers. No adverse reactions noted, treatment tolerated well Response to treatment: no change. Breath sounds and vitals before treatment were noted to be decreased in LLL, and RLL. expiratory wheezes auscultated in LUL. Heart rate 67 bpm. O2 SAT 99%. Breath sounds and vitals after treatment were noted to be decreased in LLL, and RLL. expiratory wheezes auscultated in LUL, and RUL Heart rate 69 bpm. O2 SAT 100%. Patient currently on O2 at 15 liters per minute FIO2 is 40% via venti mask. Patient's level of pain is 0 (no pain).

Med Surg Shift Assessment

Renee Ensley,LPN 5/18/06 20:00 5/18/06 22:53 5/18/06 23:44 **Finished**

NeuroMusculoSkeletal

Weakness/Abnormal movements described as generlized weakness..

Cardiovascular

Patient is on a cardiac monitor. Heart rate 68 bpm. Interpretations as follows: Atrial Fibrillation.

Respiratory

WNL as evidenced by Respirations even and unlabored Breath sounds clear bilaterally.

GI/GU

Patient has indwell catheter in place.

Integumentary

denuded, and scar(s) There is no evidence of abuse and/or neglect. Pressure sore on left hip was present on admission.

IV Information

IV in Right Forearm. Gauge: 20. Site is patent. Inserted 5/15/06.

Pain

Patient's level of pain is 0 (no pain). Numerical pain scale used to assess patient's pain level Use of pain scale was explained to patient and/or family.

Entered by: | Scheduled: | Performed: | Effective: | Status:

Med Surg Shift Assessment (cont'd)

Restraint Reassessment

Patient is not in restraints.

Fall Risk Assessment

Fall Risk Score= 45. No history of falling this admission or having fallen within the last3 months. No secondary diagnosis noted to increase the risk of a fall. Ambulatory aid: None or on bed rest or uses wheel chair or needs Nurse. IV /Heparin Lock present. Gait/Transferring: Weak. Mental status: Forgets limitations. Patient is taking 3 or less medications from the following list Anesthesia within past 48 hours, Anticoagulants, Antidepressants, Benzodiazepines, Laxative/diuretics, Opioids (narcotics), Sedatives/hypnotics, Vasodilators. High Risk Fall Prevention Interventions were implemented, based on a score of greater than50 obtained using the Fall Assessment and Intervention policy.

Education

Renee Ensley,LPN 5/18/06 20:00 5/18/06 23:44 5/18/06 23:45 **Finished**

Education Assessment

Learning barriers: cognitive. No learning needs identified at this time Plan of care has been reviewed/revised.

Resp Therapy Care Activity

Ashley Hamilton, RRT 5/19/06 00:00 5/19/06 00:10 5/19/06 00:42 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: H-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be decreased in All lobes. expiratory wheezes auscultated in LUL, and RUL. Heart rate 62 bpm. O2 SAT 97%. Breath sounds and vitals after treatment were noted to be: decreased in LLL, and RLL. expiratory wheezes auscultated in LUL, and RUL. Heart rate 68 bpm. O2 SAT 99%. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Ashley Hamilton, RRT 5/19/06 04:00 5/19/06 04:10 5/19/06 06:28 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: H-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be decreased in LLL, and RLL. clear in All lobes. Heart rate 60 bpm. O2 SAT 98%. Breath sounds and vitals after treatment were noted to be decreased in LLL, and RLL. clear in All lobes. Heart rate 65 bpm. O2 SAT 100%. Patient noted to have weak cough effort. Non-productive cough. Sputum color: white. Moderate amounts of sputum. Nasopharyngeal, Oral, and Oropharyngeal suctioning performed Patient currently on O2 at 15 liters per minute FIO2 is 40% via venti mask. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Monica Robbins,RRT 5/19/06 08:00 5/19/06 08:25 5/19/06 10:35 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be rhonchi auscultated in All lobes. Heart rate 71 bpm. RR 16. O2 SAT 96%. Breath sounds and vitals after treatment were noted to be: Heart rate 74 bpm. RR 16. O2 SAT 95%. Patient's level of pain is 0 (no pain).

Resp O2 Rounds

Monica Robbins,RRT 5/19/06 08:00 5/19/06 08:00 5/19/06 10:40 **Finished**

Respiratory O2 Rounds

Patient currently on O2 at 8 liters per minute FIO2 is 40% via venturi mask mask. O2 SAT 96%.

Med Surg Shift Assessment

Lavern Jackson,LPN 5/19/06 08:00 5/19/06 08:00 5/19/06 13:02 **Finished**

NeuroMusculoSkeletal

E1 - Eyes do not open. V1 - Patient does not respond verbally. M2 - Patient demonstrates extension. GCS: 4. Level of consciousness is unresponsive. Weakness/Abnormal movements described as: Pt is unresponsive. has gerneralized weakness..

Cardiovascular

Patient is on a cardiac monitor. Heart rate 73 bpm. Interpretations as follows: Normal Sinus Rhythm.

Entered by: | Scheduled: | Performed: | Effective: | Status:

Med Surg Shift Assessment (cont'd)

Respiratory
Additional Respiratory related comments: has 02/ venti mask..

GI/GU
Feeding tube type: Nasal Gastric Tube. Feeding tube is patent. Tube placement verified. Additional GI/GU related comments: NG tube intact. No feeding infusing at this time..

Integumentary
denuded, and scar(s) There is no evidence of abuse and/or neglect. Pressure sore on Buttocks was present on admission.

IV Information
IV in Right Hand. Gauge: 20. Heplock in place . Site is patent. Inserted 05/15/06.

Pain
Patient's level of pain is 0 (no pain). Numerical pain scale used to assess patient's pain level. Use of pain scale was— explained to patient and/or family.

Restraint Reassessment
Patient is not in restraints.

Fall Risk Assessment
Fall Risk Score= 35. No history of falling this admission or having fallen within the last3 months. No secondary diagnosis noted to increase the risk of a fall. Ambulatory aid: None or on bed rest or uses wheel chair or needs Nurse. IV /Heparin Lock present. Gait/Transferring: Normal or on bed rest or immobile. Mental status: Forgets limitations. Patient is taking 3 or less medications from the following list: Anesthesia within past 48 hours, Anticoagulants, Antidepressants, Benzodiazepines, Laxative/diuretics, Opioids (narcotics), Sedatives/hypnotics, Vasodilators. Standard (low risk) Fall Prevention Interventions were implemented, based on a score of25 - 50 obtained using the Fall Assessment and Intervention policy.

Education
Lavern Jackson,LPN 5/19/06 08:00 5/19/06 08:00 5/19/06 13:20 **Finished**

Education Assessment
Learning barriers: cognitive. No learning needs identified at this time Plan of care has been reviewed/revised. Plan of care initiated: Neurological assessment..

Braden Risk Assessment
Lavern Jackson,LPN 5/19/06 08:00 5/19/06 08:00 5/19/06 13:21 **Finished**

Braden Risk
Sensory Perception: Completely Limited; Moisture: Occasionally Moist; Activity: Bedfast; Mobility: Completely Immobile; Nutrition: Very Poor; Friction/Shearing: Problem; Braden Risk Score =8.

Resp Therapy Care Activity
Monica Robbins,RRT 5/19/06 16:00 5/19/06 16:50 5/19/06 18:20 **Finished**

Treatment
Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: rhonchi auscultated in All lobes. Heart rate 71 bpm. RR 16. O2 SAT 96%. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity
James Martin,RRT 5/19/06 20:00 5/19/06 19:30 5/19/06 21:06 **Finished**

Treatment
Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Breath sounds and vitals before treatment were noted to be: decreased in LLL, and RLL anteriorly. Heart rate 72 bpm. O2 SAT 91%. Breath sounds and vitals after treatment were noted to be: decreased in LLL, and RLL anteriorly. Heart rate 74 bpm. Non-productive cough. Patient's level of pain is 0 (no pain). Additional Treatment related comments: pt. on room air. replaced 40% venti mask.

Med Surg Shift Assessment
Katica Foreman RN 5/19/06 20:00 5/19/06 21:00 5/20/06 00:06 **Finished**

NeuroMusculoSkeletal
Weakness/Abnormal movements described as: generalized.

Entered by: Scheduled: Performed: Effective: Status:

Med Surg Shift Assessment (cont'd)

Cardiovascular
Patient is on a cardiac monitor. Heart rate 67 bpm. Interpretations as follows: Normal Sinus Rhythm.

Respiratory
via venti mask O2 SAT 95 % on O2.

GI/GU
Feeding tube type: PEG Tube. Feeding tube is patent. Tube placement verified. Patient has indwell catheter in place.

Integumentary
WNL as evidenced by: Skin integrity intact. Tissues show no evidence of redness, inflammation, rashes, ulcerations or wounds. No surgical tubes/drains. denuded, and scar(s) There is no evidence of abuse and/or neglect.

IV Information
IV in Right Hand. Gauge: 20. Site is patent. Inserted 5/17/06.

Pain
Patient's level of pain is 0 (no pain). Numerical pain scale used to assess patient's pain level. Use of pain scale was explained to patient and/or family.

Restraint Reassessment
Patient is not in restraints.

Fall Risk Assessment
Fall Risk Score= 50. No history of falling this admission or having fallen within the last3 months. There is a secondary diagnosis noted which could increase the risk of a fall. Ambulatory aid: None or on bed rest or uses wheel chair or needs Nurse. IV /Heparin Lock present. Gait/Transferring: Normal or on bed rest or immobile. Mental status: Forgets limitations. Patient is taking 3 or less medications from the following list: Anesthesia within past 48 hours, Anticoagulants, Antidepressants, Benzodiazepines, Laxative/diuretics, Opioids (narcotics), Sedatives/hypnotics, Vasodilators. Standard (low risk) Fall Prevention Interventions were implemented, based on a score of25 - 50 obtained using the Fall Assessment and Intervention policy.

Education

Katica Foreman RN 5/19/06 20:00 5/19/06 21:00 5/20/06 00:07 **Finished**

Education Assessment
Learning barriers: cognitive. No learning needs identified at this time. Plan of care has been reviewed/revised.

Resp Therapy Care Activity

James Martin,RRT 5/20/06 00:00 5/19/06 23:15 5/19/06 23:21 **Finished**

Treatment
Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Breath sounds and vitals before treatment were noted to be: decreased in LLL, and RLL anteriorly. Heart rate 74 bpm. Breath sounds and vitals after treatment were noted to be: decreased in LLL, and RLL anteriorly. Heart rate 78 bpm. Non-productive cough. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

James Martin,RRT 5/20/06 04:00 5/20/06 03:00 5/20/06 03:06 **Finished**

Treatment
Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: decreased in LLL, and RLL anteriorly. Heart rate 78 bpm. Breath sounds and vitals after treatment were noted to be: decreased in LLL, and RLL anteriorly. Heart rate 80 bpm. Suctioned cough. Sputum color: tan. Small amounts of sputum. Sputum consistency: thin. Oropharyngeal suctioning performed. Patient currently on O2 at 8 liters per minute FIO2 is 40% via vewnti mask. Patient's level of pain is 0 (no pain).

Resp O2 Rounds

James Manahan, RRT 5/20/06 07:45 5/20/06 07:45 5/20/06 09:26 **Finished**

Respiratory O2 Rounds
Patient currently on O2 at 8 liters per minute FIO2 is 40% via venti mask. Level of consciousness is lethargic. O2 SAT 99%. Comments: decreased o2 to 35%.

Braden Risk Assessment

Shannon Schander,RN 5/20/06 08:00 5/20/06 08:00 5/20/06 08:26 **Finished**

Entered by: | Scheduled: | Performed: | Effective: | Status:

Braden Risk Assessment (cont'd)

Braden Risk

Sensory Perception: Slightly Limited; Moisture: Occasionally Moist; Activity: Bedfast; Mobility: Very Limited; Nutrition: Inadequate; Friction/Shearing: Problem; Braden Risk Score =12.

Education

Shannon Schander,RN 5/20/06 08:00 5/20/06 08:00 5/20/06 08:26 **Finished**

Education Assessment

Learning barriers: cognitive. No learning needs identified at this time Plan of care has been reviewed/revised.

Med Surg Shift Assessment

Shannon Schander,RN 5/20/06 08:00 5/20/06 08:00 5/20/06 08:32 **Finished**

NeuroMusculoSkeletal

E4 - Eyes open spontaneously. V1 - Patient does not respond verbally. M5 - Patient localizes. GCS: 10. Weakness/Abnormal movements described as: Weakness noted.

Cardiovascular

Edema: +1 edema Hands +2 pitting edema Legs and feet. Patient is on a cardiac monitor. Heart rate 68 bpm.

Respiratory

via Venti mask Breath sounds decreased in all lobes. Fine crackles auscultated in all lobes.

GI/GU

Patient has indwell catheter in place.

Integumentary

Skin integrity: denuded, other, and scar(s). Integrity described as: Dry skin noted. Multiple areas on legs with abrasions.. There is no evidence of abuse and/or neglect.

IV Information

IV in Right Forearm. Gauge: 20. Site is patent. Inserted 05/17/06.

Pain

Patient's level of pain is 0 (no pain). FLACC pain scale used to assess patient's pain level. Unable to explain use of pain scale to patient and/or family because Pt unable to understand.

Restraint Reassessment

Patient is not in restraints.

Fall Risk Assessment

Fall Risk Score= 50. No history of falling this admission or having fallen within the last3 months. There is a secondary diagnosis noted which could increase the risk of a fall. Ambulatory aid: None or on bed rest or uses wheel chair or needs Nurse. IV /Heparin Lock present. Gait/Transferring: Normal or on bed rest or immobile. Mental status: Forgets limitations. Patient is taking 3 or less medications from the following list: Anesthesia within past 48 hours, Anticoagulants, Antidepressants, Benzodiazepines, Laxative/diuretics, Opioids (narcotics), Sedatives/hypnotics, Vasodilators. High Risk Fall Prevention Interventions were implemented, based on a score of greater than50 obtained using the Fall Assessment and Intervention policy.

Resp Therapy Care Activity

James Manahan, RRT 5/20/06 08:00 5/20/06 07:45 5/20/06 09:28 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: rhonchi auscultated in all lobes. Heart rate 75 bpm. RR 18. O2 SAT 99%. Level of consciousness is lethargic. Breath sounds and vitals after treatment were noted to be: rhonchi auscultated in all lobes. Heart rate 82 bpm. RR 18. O2 SAT 99%. Level of consciousness is lethargic. Patient noted to have weak cough effort. Non-productive cough. Patient currently on O2 at 8 liters per minute FIO2 is 40% via venti mask. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

James Manahan, RRT 5/20/06 12:00 5/20/06 12:15 5/20/06 13:12 **Finished**

Entered by: Scheduled: Performed: Effective: Status:

Resp Therapy Care Activity (cont'd)

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: rhonchi auscultated in all lobes. Heart rate 90 bpm. RR 18. O2 SAT 94%. Level of consciousness is confused. Breath sounds and vitals after treatment were noted to be: rhonchi auscultated in all lobes. Heart rate 89 bpm. RR 19. O2 SAT 95%. Level of consciousness is confused. Patient noted to have weak cough effort. Non-productive cough. Patient currently on O2 at 8 liters per minute FIO2 is 35% via venti mask. Unable to assess if patient is in pain. Reason: pt confused.

Resp Therapy Care Activity

James Manahan, RRT 5/20/06 16:00 5/20/06 16:20 5/20/06 16:50 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: rhonchi auscultated in all lobes. Heart rate 77 bpm. RR 17. O2 SAT 94%. Level of consciousness is confused. Breath sounds and vitals after treatment were noted to be: rhonchi auscultated in all lobes. Heart rate 76 bpm. RR 17. O2 SAT 96%. Level of consciousness is confused. Additional comments: no cough. Patient currently on O2 at 8 liters per minute FIO2 is 35% via venti mask. Unable to assess if patient is in pain. Reason: pt sedated.

Resp Therapy Care Activity

Sharon Wilson, CRT 5/20/06 20:00 5/20/06 19:20 5/20/06 19:39 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: improved aeration. Breath sounds and vitals before treatment were noted to be: fine crackles auscultated in all lobes. Heart rate 70 bpm. O2 SAT 35%. Suctioned cough. Sputum color: white. Copious amounts of sputum. Sputum consistency thick. Nasotracheal suctioning performed. Patient currently on O2 at 8 liters per minute FIO2 is 35% via venti mask. Patient's level of pain is 0 (no pain). Additional Treatment related comments: decreased to 31% fio2.

Education

Jim Mingus,RN 5/20/06 20:00 5/20/06 20:00 5/20/06 20:47 **Finished**

Education Assessment

Learning barriers: cognitive. No learning needs identified at this time. Plan of care has been reviewed/revised.

Med Surg Shift Assessment

Jim Mingus,RN 5/20/06 20:00 5/20/06 20:00 5/20/06 20:53 **Finished**

NeuroMusculoSkeletal

WNL as evidenced by: Alert and oriented to person, place and time. Moves all extremities.

Cardiovascular

WNL as evidenced by: Pulses regular and palpable. No peripheral edema. Skin warm, dry to touch, color within individual normal limits.

Respiratory

WNL as evidenced by Respirations even and unlabored. Breath sounds clear bilaterally.

GI/GU

WNL as evidence by: Abdomen soft, non-tender, bowel sounds active. Continent, voids without difficulty or pain. Urine color within individual normal limits.

Integumentary

WNL as evidenced by: Skin integrity intact. Tissues show no evidence of redness, inflammation, rashes, ulcerations or wounds. No surgical tubes/drains. denuded, and scar(s) There is no evidence of abuse and/or neglect.

IV Information

IV in Left Hand. Site is patent. Inserted 051906.

Pain

Patient's level of pain is 0 (no pain). Numerical pain scale used to assess patient's pain level. Use of pain scale was explained to patient and/or family.

Restraint Reassessment

Patient is not in restraints.

Entered by: Scheduled: Performed: Effective: Status:

Med Surg Shift Assessment (cont'd)

Fall Risk Assessment

Fall Risk Score= 20. No history of falling this admission or having fallen within the last3 months. No secondary diagnosis noted to increase the risk of a fall. Ambulatory aid: None or on bed rest or uses wheel chair or needs Nurse. IV /Heparin Lock present. Gait/Transferring: Normal or on bed rest or immobile. Mental status: Oriented to own ability. Patient is taking 3 or less medications from the following list: Anesthesia within past 48 hours, Anticoagulants, Antidepressants, Benzodiazepines, Laxative/diuretics, Opioids (narcotics), Sedatives/hypnotics, Vasodilators. Basic nursing care interventions were implemented based on a score of0-24 obtained using the Fall Assessment and Intervention policy,

Resp Therapy Care Activity

Sharon Wilson, CRT 5/21/06 00:00 5/21/06 00:00 5/21/06 04:14 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: improved aeration. Breath sounds and vitals before treatment were noted to be: rhonchi auscultated in LUL, and RUL. Heart rate 76 bpm. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Sharon Wilson, CRT 5/21/06 04:00 5/21/06 04:00 5/21/06 04:15 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: improved aeration. Breath sounds and vitals before treatment were noted to be: rhonchi auscultated in LUL, and RUL. Heart rate 77 bpm. Suctioned cough. Moderate amounts of sputum. Sputum consistency thick. Oropharyngeal suctioning performed. Patient's level of pain is 0 (no pain).

Braden Risk Assessment

Shannon Schander,RN 5/21/06 08:00 5/21/06 08:10 5/21/06 08:11 **Finished**

Braden Risk

Sensory Perception: Slightly Limited; Moisture: Occasionally Moist; Activity: Bedfast; Mobility: Very Limited; Nutrition: Inadequate; Friction/Shearing: Problem; Braden Risk Score =12.

Education

Shannon Schander,RN 5/21/06 08:00 5/21/06 08:10 5/21/06 08:11 **Finished**

Education Assessment

Learning barriers: cognitive. No learning needs identified at this time Plan of care has been reviewed/revised.

Med Surg Shift Assessment

Shannon Schander,RN 5/21/06 08:00 5/21/06 08:10 5/21/06 08:38 **Finished**

NeuroMusculoSkeletal

E4 - Eyes open spontaneously. V1 - Patient does not respond verbally. M5 - Patient localizes. GCS: 10. Weakness/Abnormal movements described as: Weakness noted..

Cardiovascular

Edema: +2 pitting edema bilat legs and feet +1 edema Hands bilat. Patient is on a cardiac monitor. Heart rate 80 bpm.

Respiratory

O2 SAT 97 % on O2. Rhonchi auscultated in all lobes. Expiratory wheezes auscultated in RLL, RML, and RUL.

GI/GU

Feeding tube type: PEG Tube. Feeding tube residual is greater than 100ml. Feeding tube is patent. Method of feeding administration is via continuous drip. Formula type: see below. Rate per hour: 30 ml. Tube placement verified. Patient has indwell catheter in place. Additional GI/GU related comments: 1/2 strength Impact 1.5 @ 30 ml/hr. Will increase by 10ml every 10 hours as tolerated for goal rate of 60/hr..

Integumentary

Skin integrity: denuded, other, and scar(s). Integrity described as: Legs with multiple scabbed and old scared areas noted. Dressing to left buttock intact. 1st layer of skin breakdown noted to buttocks. Skin dry.. There is no evidence of abuse and/or neglect.

IV Information

IV in Right Forearm. Gauge: 20. Heplock in place . Site is patent. Inserted 05/17/06.

Entered by: Scheduled: Performed: Effective: Status:

Med Surg Shift Assessment (cont'd)

Pain

Patient's level of pain is 0 (no pain). FLACC pain scale used to assess patient's pain level. Unable to explain use of pain scale to patient and/or family because Pt with AMS. No family at bed side..

Restraint Reassessment

Patient is not in restraints.

Fall Risk Assessment

Fall Risk Score= 70. No history of falling this admission or having fallen within the last3 months. There is a secondary diagnosis noted which could increase the risk of a fall. Ambulatory aid: None or on bed rest or uses wheel chair or needs Nurse. IV /Heparin Lock present. Gait/Transferring: Impaired. Mental status: Forgets limitations. Patient is taking 3 or less medications from the following list: Anesthesia within past 48 hours, Anticoagulants, Antidepressants, Benzodiazepines, Laxative/diuretics, Opioids (narcotics), Sedatives/hypnotics, Vasodilators. High Risk Fall Prevention Interventions were implemented, based on a score of greater than 50 obtained using the Fall Assessment and Intervention policy.

Resp Therapy Care Activity

Ernie Bargeron,RRT 5/21/06 08:00 5/21/06 07:45 5/21/06 09:14 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: rhonchi auscultated in all lobes. Heart rate 76 bpm. RR 22. O2 SAT 96%. Breath sounds and vitals after treatment were noted to be: rhonchi auscultated in all lobes. Heart rate 80 bpm. RR 18. O2 SAT 100%. Patient currently on O2 at FIO2 is 31% via venturi mask. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Ernie Bargeron,RRT 5/21/06 12:00 5/21/06 12:20 5/21/06 12:55 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: decreased in all lobes. Heart rate 84 bpm. RR 18. Breath sounds and vitals after treatment were noted to be: decreased in all lobes. Heart rate 86 bpm. RR 20. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Scott Snavely, RRT 5/21/06 20:00 5/21/06 19:40 5/21/06 20:15 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: decreased in all lobes. rhonchi auscultated in LUL, and RUL. Heart rate 66 bpm. Breath sounds and vitals after treatment were noted to be: decreased in all lobes. rhonchi auscultated in LUL, and RUL. Heart rate 63 bpm. Patient noted to have weak cough effort. Non-productive cough. Patient's level of pain is 0 (no pain).

Education

Marlene Accardi LPN 5/21/06 20:00 5/21/06 20:00 5/22/06 00:55 **Finished**

Education Assessment

Learning needs: call system. Information taught to patient. Learning barriers: cognitive. Description of barrier(s): pt is nonverbal. Follow up actions: frequent checks. Teaching format(s) include: demo, and one on one. Response to teaching: needs reinforcement. Plan of care has been reviewed/revised.

Med Surg Shift Assessment

Marlene Accardi LPN 5/21/06 20:00 5/21/06 20:00 5/22/06 01:09 **Finished**

NeuroMusculoSkeletal

E4 - Eyes open spontaneously. V1 - Patient does not respond verbally. M5 - Patient localizes. GCS: 10. Weakness/Abnormal movements described as: generalized weakness.

Cardiovascular

Edema: +2 edema bilateral feet/ankles +1 edema bilateral hands. Patient is on a cardiac monitor. Heart rate 74 bpm.

Respiratory

via 31% venti mask O2 SAT 97 % on O2. Rhonchi auscultated in all lobes. Expiratory wheezes auscultated in RLL, RML, and RUL.

Entered by: Scheduled: Performed: Effective: Status:

Med Surg Shift Assessment (cont'd)

GI/GU

Last BM date: 05/21/2006. Patient is experiencing diarrhea. Feeding tube type: PEG Tube. Feeding tube residual is greater than 100ml. Method of feeding administration is via continuous drip Formula type: 1/2 St. Impact. Rate per hour: 40 ml. Tubing changed on 05/21/2006. Patient has indwell catheter in place. Patient wears protective undergarments. Additional GI/GU related comments: foley cath draining dark yellow urine to bedside

Integumentary

Skin integrity: denuded, other, and scar(s). Integrity described as: multiple scabbed over skin tears on legs, decub on L buttocks. There is no evidence of abuse and/or neglect. Additional Integumentary related comments: dsg. to buttocks is cdi.

IV Information

IV in Right Forearm. Gauge: 20. Site is patent. Inserted 5/17/06. Additional IV related comments: IVFs infusing as ordered.

Pain

Patient's level of pain is 0 (no pain). FLACC pain scale used to assess patient's pain level. Unable to explain use of pain scale to patient and/or family because pt is nonverbal.

Restraint Reassessment

Patient is not in restraints.

Fall Risk Assessment

Fall Risk Score= 70. No history of falling this admission or having fallen within the last3 months. There is a secondary diagnosis noted which could increase the risk of a fall. Ambulatory aid: None or on bed rest or uses wheel chair or needs Nurse. IV /Heparin Lock present. Gait/Transferring: Impaired. Mental status: Forgets limitations. Patient is taking 3 or less medications from the following list: Anesthesia within past 48 hours, Anticoagulants, Antidepressants, Benzodiazepines, Laxative/diuretics, Opioids (narcotics), Sedatives/hypnotics, Vasodilators. High Risk Fall Prevention Interventions were implemented, based on a score of greater than 50 obtained using the Fall Assessment and Intervention policy.

Resp Therapy Care Activity

Scott Snavely, RRT 5/22/06 00:00 5/21/06 23:49 5/21/06 23:51 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: expiratory wheezes auscultated in all lobes. Heart rate 74 bpm. Breath sounds and vitals after treatment were noted to be: expiratory wheezes auscultated in all lobes. Heart rate 73 bpm. Non-productive cough. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Scott Snavely, RRT 5/22/06 04:00 5/22/06 04:00 5/22/06 04:09 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: decreased in all lobes. rhonchi auscultated in LUL, and RUL. Heart rate 79 bpm. Breath sounds and vitals after treatment were noted to be: decreased in all lobes. rhonchi auscultated in LUL, and RUL. Heart rate 76 bpm. Patient noted to have weak cough effort. Non-productive cough. Patient's level of pain is 0 (no pain).

Med Surg Shift Assessment

Diana Undertilo,RN 5/22/06 08:00 5/22/06 08:10 5/22/06 09:31 **Finished**

NeuroMusculoSkeletal

Weakness/Abnormal movements described as: pt lethargic; overlay mattress on bed; turn

Cardiovascular

Patient is on a cardiac monitor. Heart rate 78 bpm. Interpretations as follows: Normal Sinus Rhythm.

Respiratory

Patient on Oxygen at 31% liters per minute via 31% venti mask O2 SAT 98 % on O2. Rhonchi auscultated in all lobes. Additional Respiratory related comments: Resp therapist in room; stated may try pt on NC.

GI/GU

Patient has indwell catheter in place. Patient wears protective undergarments. Additional GI/GU related comments: urine dark yellow to lt orange with sediment noted

Entered by: | Scheduled: | Performed: | Effective: | Status:

Med Surg Shift Assessment (cont'd)

Integumentary

Skin integrity: denuded, other, and scar(s). Integrity described as: small area to sacral area just a little red; overlay mattress on bed. There is no evidence of abuse and/or neglect. abd Drain/tube type: peg tube. Pressure sore on L hip was present on admission. Additional Integumentary related comments: turned of TF at 09:00 to check residual; TF infusing at 50cc/hr.

IV Information

IV in Right Forearm. Gauge: 20. Site is patent. Inserted 5/17/06. Additional IV related comments: New IV HL has been attempted many times without success; will inform MD

Pain

Patient's level of pain is 0 (no pain). FLACC pain scale used to assess patient's pain level. Use of pain scale was explained to patient and/or family. Comments: Pt does not moan/sound or appear to be in any distress.

Restraint Reassessment

Patient is not in restraints.

Fall Risk Assessment

Fall Risk Score=70. No history of falling this admission or having fallen within the last3 months. There is a secondary diagnosis noted which could increase the risk of a fall. Ambulatory aid: None or on bed rest or uses wheel chair or needs Nurse. IV /Heparin Lock present. Gait/Transferring: Impaired. Mental status: Forgets limitations. Patient is taking 3 or less medications from the following list: Anesthesia within past 48 hours, Anticoagulants, Antidepressants, Benzodiazepines, Laxative/diuretics, Opioids (narcotics), Sedatives/hypnotics, Vasodilators. High Risk Fall Prevention Interventions were implemented, based on a score of greater than50 obtained using the Fall Assessment and Intervention policy. Additional Fall Risk related comments: Pt lethargic for most part does open eyes .

Education

Diana Undertilo,RN 5/22/06 08:00 5/22/06 08:00 5/22/06 17:26 **Finished**

Education Assessment

Learning needs: meds; activity. Learning barriers: cognitive. Plan of care has been reviewed/revised. Plan of care initiated: cognitive.

Braden Risk Assessment

Diana Undertilo,RN 5/22/06 08:00 5/22/06 08:00 5/22/06 17:31 **Finished**

Braden Risk

Sensory Perception: No Impairment; Moisture: Rarely Moist; Activity: Bedfast; Mobility: Very Limited; Nutrition: Inadequate; Friction/Shearing: Problem; Braden Risk Score =14.

Resp Therapy Care Activity

Monica Robbins,RRT 5/22/06 08:00 5/22/06 08:50 5/22/06 18:57 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be rhonchi auscultated in all lobes. Heart rate 68 bpm. RR 16. O2 SAT 96%. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Monica Robbins,RRT 5/22/06 12:00 5/22/06 12:10 5/22/06 18:56 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be rhonchi auscultated in all lobes. Heart rate 68 bpm. RR 16. O2 SAT 96%. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Monica Robbins,RRT 5/22/06 16:00 5/22/06 16:15 5/22/06 18:55 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be rhonchi auscultated in all lobes. Heart rate 62 bpm. RR 20. O2 SAT 97%. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Teresa Sharkey, RRT 5/22/06 20:00 5/22/06 20:35 5/22/06 22:38 **Finished**

Entered by: Scheduled: Performed: Effective: Status:

Resp Therapy Care Activity (cont'd)

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: rhonchi auscultated in LUL, and RUL anteriorly. Heart rate 68 bpm. Breath sounds and vitals after treatment were noted to be: rhonchi auscultated in LUL, and RUL anteriorly. Heart rate 68 bpm. Additional comments: no cough. Patient's level of pain is 0 (no pain).

Education

Phyllis Cockrell,LPN 5/22/06 20:00 5/22/06 20:00 5/23/06 01:15 **Finished**

Education Assessment

Learning barriers: cognitive. No learning needs identified at this time Plan of care has been reviewed/revised.

Resp Therapy Care Activity

Teresa Sharkey, RRT 5/23/06 00:00 5/22/06 23:50 5/23/06 00:29 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: improved aeration. Breath sounds and vitals before treatment were noted to be: rhonchi auscultated in LUL, and RUL anteriorly. Heart rate 70 bpm. Breath sounds and vitals after treatment were noted to be: rhonchi auscultated in LUL, and RUL anteriorly. Heart rate 70 bpm. Patient noted to have weak cough effort. Non-productive cough. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Ashley Hamilton, RRT 5/23/06 04:00 5/23/06 03:40 5/23/06 04:31 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: H-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: decreased in LLL, and RLL. rhonchi auscultated in LLL, and RML. Heart rate 73 bpm. Breath sounds and vitals after treatment were noted to be: decreased in LLL, and RLL. rhonchi auscultated in LLL, and RML. Heart rate 76 bpm. Patient's level of pain is 0 (no pain).

Braden Risk Assessment

Tracy Page,RN 5/23/06 08:00 5/23/06 08:00 5/23/06 09:37 **Finished**

Braden Risk

Sensory Perception: Completely Limited; Moisture: Occasionally Moist; Activity: Bedfast; Mobility: Very Limited; Nutrition: Inadequate; Friction/Shearing: Potential Problem; Braden Risk Score =11.

Education

Tracy Page,RN 5/23/06 08:00 5/23/06 08:00 5/23/06 09:38 **Finished**

Education Assessment

Learning needs: activity. Content taught: turn q2hours. Information taught to patient. Learning barriers: cognitive. Description of barrier(s): pt unresponsive at this time. Follow up actions: turn pt with pillow support. Unable to assess readiness/motivation to learn. Teaching format(s) include one on one. Plan of care has been reviewed/revised.

Med Surg Shift Assessment

Tracy Page,RN 5/23/06 08:00 5/23/06 08:00 5/23/06 09:48 **Finished**

NeuroMusculoSkeletal

E3 - Eyes open to sound. V1 - Patient does not respond verbally. M1 - Patient demonstrates no motor response. GCS: 5. Level of consciousness is lethargic. Weakness/Abnormal movements described as: pt weak arems and legs.

Cardiovascular

Edema: +2 edema bilat arms +2 edema bilat thighs and knees +3 edema bilat feet. Patient is on a cardiac monitor. Interpretations as follows: Normal Sinus Rhythm.

Respiratory

Rhonchi auscultated in all lobes.

GI/GU

Last BM date: 05/22/2006. Hyperactive bowel sounds. Feeding tube type: PEG Tube. Feeding tube is patent. Method of feeding administration is via continuous drip. Formula type: impact. Rate per hour: 60 ml. Tube placement verified. Additional GI/GU related comments: tube feeding on hold due to renal us to be done.

Entered by: Scheduled: Performed: Effective: Status:

Med Surg Shift Assessment (cont'd)

Integumentary
Skin integrity: denuded, other, and scar(s). Integrity described as: wound to left hip and coccyx. There is no evidence of abuse and/or neglect. Pressure sore on left hip was present on admission. Pressure sore on coccyx was present on admission.

IV Information
IV in Right Hand. Gauge: 20. Site is patent. Inserted 051706.

Pain
Patient's level of pain is 0 (no pain). Faces pain scale used to assess patient's pain level. Unable to explain use of pain scale to patient and/or family because pt nonverbal and family not present

Restraint Reassessment
Patient is not in restraints.

Fall Risk Assessment
Fall Risk Score= 35. No history of falling this admission or having fallen within the last3 months. There is a secondary diagnosis noted which could increase the risk of a fall. Ambulatory aid: None or on bed rest or uses wheel chair or needs Nurse. IV /Heparin Lock present. Gait/Transferring: Normal or on bed rest or immobile. Mental status: Oriented to own ability. Patient is taking 3 or less medications from the following list: Anesthesia within past 48 hours, Anticoagulants, Antidepressants, Benzodiazepines, Laxative/diuretics, Opioids (narcotics), Sedatives/hypnotics, Vasodilators. Standard (low risk) Fall Prevention Interventions were implemented, based on a score of25 - 50 obtained using the Fall Assessment and Intervention policy.

Resp Therapy Care Activity
Jason Webb, CRT 5/23/06 08:00 5/23/06 08:35 5/23/06 09:59 **Finished**

Treatment
Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: L-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: rhonchi auscultated in all lobes. Heart rate 70 bpm. RR 16. O2 SAT 97%. Level of consciousness is alert. Breath sounds and vitals after treatment were noted to be: rhonchi auscultated in all lobes. Heart rate 75 bpm. RR 16. O2 SAT 99%. Level of consciousness is alert. Patient's level of pain is 0 (no pain).

Resp O2 Rounds
Jason Webb, CRT 5/23/06 08:00 5/23/06 08:35 5/23/06 10:00 **Finished**

Respiratory O2 Rounds
Patient currently on O2 at 4 liters per minute FIO2 is 28% via venti mask. Level of consciousness is alert. Heart rate 70 bpm. O2 SAT 97%.

Resp Therapy Care Activity
Jason Webb, CRT 5/23/06 12:00 5/23/06 12:35 5/23/06 13:05 **Finished**

Treatment
Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: rhonchi auscultated in all lobes. Heart rate 75 bpm. RR 20. O2 SAT 98%. Level of consciousness is alert. Breath sounds and vitals after treatment were noted to be: rhonchi auscultated in all lobes. Heart rate 80 bpm. RR 16. O2 SAT 97%. Patient's level of pain is 0 (no pain).

Nursing Intervention Checklist
Tracy Page,RN 5/23/06 15:00 5/23/06 15:00 5/23/06 18:10 **Finished**

Safety
Precautions in place for patient's safety include: Bed in low position, Direct Observation, Head of bed up, and Instructed to call for assistance. Side rails up x2.

Hygiene
The following hygiene care was provided to patient: bed bath, indwelling catheter care, linen changed, oral care, and pericare.

Activity
Patient is on bedrest. Patient is not able to reposition self. Requires positional support. Unable to ambulate.

Miscellaneous Care
Dressing/Wound checked q2h. IV Site Checked: Yes. Automatic feeding tube in use.

Resp Therapy Care Activity

Entered by:	Scheduled:	Performed:	Effective:	Status:

Resp Therapy Care Activity (cont'd)

Jason Webb, CRT — 5/23/06 16:00 — 5/23/06 16:05 — 5/23/06 16:29 — Finished

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: L-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: rhonchi auscultated in all lobes. Heart rate 72 bpm. RR 16. O2 SAT 97%. Breath sounds and vitals after treatment were noted to be: rhonchi auscultated in all lobes. Heart rate 75 bpm. RR 16. O2 SAT 98%. Unable to assess if patient is in pain. Reason: pt dosent respond to commands.

Education

Jenny Stearns, RN — 5/23/06 20:00 — 5/23/06 20:00 — 5/23/06 20:56 — Finished

Education Assessment

Learning barriers: cognitive. No learning needs identified at this time Plan of care has been reviewed/revised.

Med Surg Shift Assessment

Jenny Stearns, RN — 5/23/06 20:00 — 5/23/06 20:00 — 5/23/06 21:08 — Finished

NeuroMusculoSkeletal

Level of consciousness is lethargic. Weakness/Abnormal movements described as: generalized. Speech is garbled. HOH bilaterally.

Cardiovascular

Edema: +2 edema generalized. Patient is on a cardiac monitor. Heart rate 84 bpm. Interpretations as follows: Normal Sinus Rhythm.

Respiratory

Patient on Oxygen at 8 liters per minute via venti mask Rhonchi auscultated in all lobes

GI/GU

Last BM date: 05/23/2006. Hypoactive bowel sounds. Feeding tube type: PEG Tube. Feeding tube is patent. Method of feeding administration is via continuous drip. Formula type: Fibersource. Rate per hour: 60 ml. Flush amount 25 ml. Flush frequency every 1 hr(s). Tube placement verified. Patient has indwell catheter in place.

Integumentary

Skin integrity: denuded, other, and scar(s). Integrity described as: dressing to right debrided hip and sacral wound; clean, dry, and intact;. There is no evidence of abuse and/or neglect.

IV Information

IV in Right Wrist. Gauge: 20. Site is patent. Inserted 5/17/2006.

Pain

Patient's level of pain is 0 (no pain). Numerical pain scale used to assess patient's pain level. Use of pain scale was explained to patient and/or family.

Restraint Reassessment

Patient is not in restraints.

Fall Risk Assessment

Fall Risk Score= 50. No history of falling this admission or having fallen within the last3 months. There is a secondary diagnosis noted which could increase the risk of a fall. Ambulatory aid: None or on bed rest or uses wheel chair or needs Nurse. IV /Heparin Lock present. Gait/Transferring: Normal or on bed rest or immobile. Mental status: Forgets limitations. Patient is taking 3 or less medications from the following list: Anesthesia within past 48 hours, Anticoagulants, Antidepressants, Benzodiazepines, Laxative/diuretics, Opioids (narcotics), Sedatives/hypnotics, Vasodilators. High Risk Fall Prevention Interventions were implemented, based on a score of greater than50 obtained using the Fall Assessment and Intervention policy.

Resp Therapy Care Activity

Scott Snavely, RRT — 5/23/06 20:00 — 5/23/06 20:20 — 5/23/06 22:59 — Finished

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: rhonchi auscultated in all lobes. Heart rate 78 bpm. Breath sounds and vitals after treatment were noted to be: rhonchi auscultated in all lobes. Heart rate 78 bpm. Patient noted to have weak cough effort. Non-productive cough. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Scott Snavely, RRT — 5/24/06 00:00 — 5/24/06 00:00 — 5/24/06 02:32 — Finished

Entered by: Scheduled: Performed: Effective: Status:

Resp Therapy Care Activity (cont'd)

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: decreased in all lobes. Heart rate 79 bpm. Breath sounds and vitals after treatment were noted to be: decreased in all lobes. Heart rate 78 bpm. Patient noted to have weak cough effort. Non-productive cough. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Scott Snavely, RRT 5/24/06 04:00 5/24/06 04:00 5/24/06 05:18 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: decreased rhonchi, decreased work of breath, and improved aeration. Breath sounds and vitals before treatment were noted to be: decreased in all lobes. rhonchi auscultated in all lobes. Heart rate 78 bpm. Breath sounds and vitals after treatment were noted to be: decreased in all lobes. expiratory wheezes auscultated in LUL, and RUL. Heart rate 79 bpm. Patient noted to have weak cough effort. Suctioned cough. Sputum color: tan. Copious amounts of sputum. Sputum consistency thick. Nasotracheal suctioning performed. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Jason Webb, CRT 5/24/06 08:00 5/24/06 08:15 5/24/06 09:57 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: L-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: rhonchi auscultated in all lobes. Heart rate 82 bpm. RR 20. O2 SAT 98%. Level of consciousness is alert. Breath sounds and vitals after treatment were noted to be: rhonchi auscultated in all lobes. Heart rate 84 bpm. RR 20. O2 SAT 92%. Level of consciousness is alert. Patient's level of pain is 0 (no pain).

Resp O2 Rounds

Jason Webb, CRT 5/24/06 08:00 5/24/06 08:15 5/24/06 10:03 **Finished**

Respiratory O2 Rounds

Patient currently on O2 at 4 liters per minute FIO2 is 28% via venti mask. Level of consciousness is alert. Heart rate 82 bpm. O2 SAT 98%.

Braden Risk Assessment

Sherry Christensen,RN 5/24/06 08:00 5/24/06 07:25 5/24/06 14:29 **Finished**

Braden Risk

Sensory Perception: Slightly Limited; Moisture: Moist; Activity: Bedfast; Mobility: Completely Immobile; Nutrition: Adequate; Friction/Shearing: Problem; Braden Risk Score =11.

Education

Sherry Christensen,RN 5/24/06 08:00 5/24/06 07:40 5/24/06 14:34 **Finished**

Education Assessment

Learning needs: use of call light, pt unable to push button by himself. Content taught: use of call light, pt made aware that nurse and nursing tech will be checking on him frequently. Information taught to patient. Knowledgeable about health problem: Yes. Learning barriers: cognitive. Description of barrier(s): AMS of admit ds.. Follow up actions: reinforce teaching.. Readiness/motivation to learn: uninterested. Teaching format(s) include one on one. Response to teaching: needs reinforcement, and seemed disinterested. Plan of care has been reviewed/revised. Plan of care initiated: urosepsis.

Med Surg Shift Assessment

Sherry Christensen,RN 5/24/06 08:00 5/24/06 07:40 5/24/06 15:13 **Finished**

NeuroMusculoSkeletal

Weakness/Abnormal movements described as: bedrest only..

Cardiovascular

Patient is on a cardiac monitor. Interpretations as follows: Normal Sinus Rhythm.

Respiratory

Rhonchi auscultated in all lobes.

GI/GU

Patient has indwell catheter in place.

Entered by: Scheduled: Performed: Effective: Status:

Med Surg Shift Assessment (cont'd)

Integumentary

Skin integrity: denuded, other, and scar(s). Integrity described as: right hip decube.. There is no evidence of abuse and/or neglect.

IV Information

IV in Right Wrist. Gauge: 20. Site is patent. Inserted 5/17/2006.

Pain

Patient's level of pain is 0 (no pain). Faces pain scale used to assess patient's pain level. Use of pain scale was explained to patient and/or family.

Restraint Reassessment

Patient is not in restraints.

Fall Risk Assessment

Fall Risk Score= 35. No history of falling this admission or having fallen within the last3 months. There is a secondary diagnosis noted which could increase the risk of a fall Ambulatory aid: None or on bed rest or uses wheel chair or needs Nurse. IV /Heparin Lock present. Gait/Transferring: Normal or on bed rest or immobile. Mental status: Oriented to own ability. Patient is taking 3 or less medications from the following list: Anesthesia within past 48 hours, Anticoagulants, Antidepressants, Benzodiazepines, Laxative/diuretics, Opioids (narcotics), Sedatives/hypnotics, Vasodilators. Standard (low risk) Fall Prevention Interventions were implemented, based on a score of25 - 50 obtained using the Fall Assessment and Intervention policy.

Resp Therapy Care Activity

Jason Webb, CRT 5/24/06 12:00 5/24/06 12:20 5/24/06 12:44 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: L-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: decreased in all lobes. Heart rate 82 bpm. RR 20. O2 SAT 98%. Level of consciousness is alert. Breath sounds and vitals after treatment were noted to be: decreased in all lobes. Heart rate 84 bpm. RR 20. O2 SAT 100%. Level of consciousness is alert. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Jason Webb, CRT 5/24/06 16:00 5/24/06 16:10 5/24/06 17:14 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: L-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: rhonchi auscultated in all lobes. Heart rate 85 bpm. RR 20. O2 SAT 97%. Level of consciousness is alert. Sputum color: yellow. Moderate amounts of sputum. Sputum consistency thick. Nasotracheal suctioning performed. Unable to assess if patient is in pain. Reason: pt does not respond to questions.

Resp Therapy Care Activity

Ashley Hamilton, RRT 5/24/06 20:00 5/24/06 19:40 5/24/06 20:36 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: decreased in LLL, and RLL. rhonchi auscultated in LLL. Heart rate 94 bpm. O2 SAT 98%. Breath sounds and vitals after treatment were noted to be: decreased in LLL, and RLL. rhonchi auscultated in LLL. Heart rate 90 bpm. O2 SAT 99%. Patient currently on O2 at 8 liters per minute FIO2 is 28% via venti mask. Patient's level of pain is 0 (no pain).

Education

Jenny Stearns, RN 5/24/06 20:00 5/24/06 20:00 5/24/06 22:19 **Finished**

Education Assessment

Learning barriers: cognitive. No learning needs identified at this time Plan of care has been reviewed/revised.

Med Surg Shift Assessment

Jenny Stearns, RN 5/24/06 20:00 5/24/06 20:00 5/24/06 22:27 **Finished**

NeuroMusculoSkeletal

E3 - Eyes open to sound. V2 - Patient making incomprehensible sounds. M4 - Patient withdraws. GCS: 9. Level of consciousness is confused. Weakness/Abnormal movements described as: generalized. Speech is garbled.

Entered by: Scheduled: Performed: Effective: Status:

Med Surg Shift Assessment (cont'd)

Cardiovascular
Edema: +2 edema upper extremities +2 edema lower extremities. Patient is on a cardiac monitor. Heart rate 85 bpm. Interpretations as follows: Normal Sinus Rhythm

Respiratory
Patient on Oxygen at 8 liters per minute via venti mask Rhonchi auscultated in all lobes

GI/GU
Last BM date: 05/24/2006. Hypoactive bowel sounds. Abdomen tender. Patient has indwell catheter in place. Additional GI/GU related comments: patient has PEG tube with Impact 1.5 1/2 strength infusing at 60 ml/hr.

Integumentary
Skin integrity: denuded, other, and scar(s). Integrity described as: pt has breakdown to sacral area; breakdown to left hip, wet to dry dressing clean, dry, and intact. There is no evidence of abuse and/or neglect.

IV Information
IV in Right Wrist. Site is patent. Inserted 5/17/2006.

Pain
Patient's level of pain is 0 (no pain). Numerical pain scale used to assess patient's pain level. Use of pain scale was explained to patient and/or family.

Restraint Reassessment
Patient is not in restraints.

Fall Risk Assessment
Fall Risk Score= 70. No history of falling this admission or having fallen within the last3 months. There is a secondary diagnosis noted which could increase the risk of a fall Ambulatory aid: None or on bed rest or uses wheel chair or needs Nurse. IV /Heparin Lock present. Gait/Transferring: Impaired. Mental status: Forgets limitations. Patient is taking 3 or less medications from the following list Anesthesia within past48 hours, Anticoagulants, Antidepressants, Benzodiazepines, Laxative/diuretics, Opioids (narcotics), Sedatives/hypnotics, Vasodilators. High Risk Fall Prevention Interventions were implemented, based on a score of greater than50 obtained using the Fall Assessment and Intervention policy.

Resp Therapy Care Activity
Ashley Hamilton, RRT 5/25/06 00:00 5/24/06 23:40 5/25/06 00:12 **Finished**

Treatment
Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be decreased in LLL, and RLL. rhonchi auscultated in LLL. Heart rate 88 bpm. O2 SAT 97%. Breath sounds and vitals after treatment were noted to be decreased in LLL, and RLL. rhonchi auscultated in LLL. Heart rate 91 bpm. O2 SAT 97%. Patient currently on O2 at 8 liters per minute FIO2 is 28% via venti mask. Patient's level of pain is 0 (no pain).

Nursing Intervention Checklist
Jenny Stearns, RN 5/25/06 03:00 5/25/06 03:00 5/25/06 06:53 **Finished**

Safety
Precautions in place for patient's safety include: Bed in low position, Call light within reach, and Instructed to call for assistance. Side rails up x2.

Hygiene
The following hygiene care was provided to patient bed bath, indwelling catheter care, linen changed, and pericare.

Activity
Patient is on bedrest. Patient is not able to reposition self. Turn interval: q 2 hrs. Requires positional support. Unable to ambulate.

Miscellaneous Care
Dressing/Wound checked yes. IV Site Checked: Yes. Automatic feeding tube in use. Patency checked. Tubing flushed q2hr.

Resp Therapy Care Activity
Ashley Hamilton, RRT 5/25/06 04:00 5/25/06 04:00 5/25/06 05:45 **Finished**

Entered by: Scheduled: Performed: Effective: Status:

Resp Therapy Care Activity (cont'd)

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: decreased in LLL, and RLL. rhonchi auscultated in LLL. Heart rate 85 bpm. O2 SAT 93%. Breath sounds and vitals after treatment were noted to be: decreased in LLL, and RLL. rhonchi auscultated in LLL. Heart rate 86 bpm. O2 SAT 98%. Patient currently on O2 at 8 liters per minute FIO2 is 28% via venti mask. Patient's level of pain is 0 (no pain).

Med Surg Shift Assessment

Rachel A Perez,LPN 5/25/06 08:00 5/25/06 08:00 5/25/06 08:11 **Finished**

NeuroMusculoSkeletal

Weakness/Abnormal movements described as: cv.

Cardiovascular

WNL as evidenced by: Pulses regular and palpable. No peripheral edema. Skin warm, dry to touch, color within individual normal limits.

Respiratory

Additional Respiratory related comments: 02 IN PLACE SEE RESP T NOTES. BILATERAL CRACKLES IN LOWER BASES.

GI/GU

Additional GI/GU related comments: FOLEY TO BSD WITHDARK YELLOW URINE.

Integumentary

Skin integrity: denuded, other, and scar(s). Integrity described as: DECUBB LT HIP.SACRAL. There is no evidence of abuse and/or neglect.

IV Information

IV in Right Wrist. Site is patent. Inserted 5/17/2006.

Pain

Patient's level of pain is 0 (no pain). Faces pain scale used to assess patient's pain level. Unable to explain use of pain scale to patient and/or family because COGNITIVE.

Restraint Reassessment

Patient is not in restraints.

Fall Risk Assessment

Fall Risk Score= 50. No history of falling this admission or having fallen within the last3 months. No secondary diagnosis noted to increase the risk of a fall. Ambulatory aid: Crutches, cane, walker. IV /Heparin Lock present. Gait/Transferring: Normal or on bed rest or immobile. Mental status: Forgets limitations. Patient is taking 3 or less medications from the following list: Anesthesia within past 48 hours, Anticoagulants, Antidepressants, Benzodiazepines, Laxative/diuretics, Opioids (narcotics), Sedatives/hypnotics, Vasodilators. Standard (low risk) Fall Prevention Interventions were implemented, based on a score of25 - 50 obtained using the Fall Assessment and Intervention policy.

Resp Therapy Care Activity

Rebecca Hake Flickinger, CRTT 5/25/06 08:00 5/25/06 08:10 5/25/06 09:26 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: H-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: decreased rhonchi, and decreased work of breath. Breath sounds and vitals before treatment were noted to be: rhonchi auscultated in LUL, and RUL. Heart rate 87 bpm. RR 16. O2 SAT 98%. Breath sounds and vitals after treatment were noted to be: Heart rate 89 bpm. RR 16. Patient noted to have strong cough effort. Suctioned cough. Sputum color: yellow. Moderate amounts of sputum. Sputum consistency thick. Additional comments: cough stimulated when sxn'd orally. Patient currently on O2 at FIO2 is 28% via venti mask. Patient's level of pain is 0 (no pain).

Resp O2 Rounds

Rebecca Hake Flickinger, CRTT 5/25/06 08:10 5/25/06 08:10 5/25/06 09:23 **Finished**

Respiratory O2 Rounds

Patient currently on O2 at FIO2 is 28% via venti mask. Level of consciousness is lethargic. Heart rate 87 bpm. O2 SAT 98%.

Entered by:	Scheduled:	Performed:	Effective:	Status:

Resp Therapy Care Activity
Rebecca Hake Flickinger, CRTT — 5/25/06 12:00 — 5/25/06 11:30 — 5/25/06 11:52 — Finished

Treatment
Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: H-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: decreased rhonchi. Breath sounds and vitals before treatment were noted to be: rhonchi auscultated in LUL, and RUL. Heart rate 96 bpm. RR 14. O2 SAT 96%. Breath sounds and vitals after treatment were noted to be: Heart rate 97 bpm. RR 14. Patient noted to have strong cough effort. Suctioned cough. Sputum color: yellow. Moderate amounts of sputum. Sputum consistency thick. Additional comments: oral suctioned. Patient currently on O2 at FIO2 is 28% via venti mask. Patient's level of pain is 0 (no pain).

Respiratory Misc Activity
Ernie Bargeron,RRT — 5/25/06 13:15 — 5/25/06 13:15 — 5/25/06 15:08 — Finished

Miscellaneous
Bronchoscopy Assist date: 05/25/2006. Time started: 13:15. Time finished: 13:25. Duration of Bronchoscopy Assist: 10 minutes. Procedure performed at bedside. Bronchoscopic Approach: Nasal. Specimens obtained: bronchial biopsy. Specimens sent to lab for: AFB, C&S, Cytology, and Fungus. No adverse reactions noted, treatment tolerated well. Patient's level of pain is 0 (no pain).

Respiratory Misc Activity
Ernie Bargeron,RRT — 5/25/06 13:15 — 5/25/06 13:15 — 5/25/06 15:10 — Finished

Miscellaneous
Bronchoscopy Assist date: 05/25/2006. Time started: 13:15. Time finished: 13:25. Duration of Bronchoscopy Assist: 10 minutes. Procedure performed at bedside. Bronchoscopic Approach: Nasal. Specimens obtained: bronchial biopsy. Specimens sent to lab for: AFB, C&S, Cytology, and Fungus. No adverse reactions noted, treatment tolerated well. Additional Bronchoscopy Assist related comments: time procedure called prior to bronchoscopy. Patient's level of pain is 0 (no pain)

Nursing Intervention Checklist
Cathy Riley RN — 5/25/06 15:00 — 5/25/06 16:00 — 5/25/06 16:04 — Finished

Safety
Precautions in place for patient's safety include: Call light within reach, and Instructed to call for assistance

Hygiene
The following hygiene care was provided to patient: bed bath.

Activity
Turn interval: 2.

Miscellaneous Care
No miscellaneous care activity at this time.

Resp Therapy Care Activity
Rebecca Hake Flickinger, CRTT — 5/25/06 16:00 — 5/25/06 16:20 — 5/25/06 17:11 — Finished

Treatment
Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: decreased rhonchi. Breath sounds and vitals before treatment were noted to be: decreased in all lobes. rhonchi auscultated in LUL, and RUL. Heart rate 96 bpm. RR 16. O2 SAT 98%. Breath sounds and vitals after treatment were noted to be: Heart rate 97 bpm. RR 14. Patient noted to have weak cough effort. Suctioned cough. Sputum color: yellow. Small amounts of sputum. Sputum consistency thick. Patient currently on O2 at FIO2 is 28% via venti mask. Patient's level of pain is 0 (no pain).

Education
Rhonda Platt,RN — 5/25/06 20:00 — 5/25/06 21:00 — 5/26/06 00:23 — Finished

Education Assessment
Learning needs: act.. Content taught: turn q 2 hours. Information taught to patient. Knowledgeable about health problem: No. Learning barriers: cognitive. Description of barrier(s): Pt. unresponsive. Follow up actions: Discuss needs with family. Teaching format(s) include one on one. Response to teaching: asked questions, needs reinforcement, and verbalized understanding of content. Plan of care has been reviewed/revised. Plan of care initiated: impaired tissue integrity.

Entered by:	Scheduled:	Performed:	Effective:	Status:

Med Surg Shift Assessment

Rhonda Platt,RN 5/25/06 20:00 5/25/06 21:00 5/26/06 00:31 **Finished**

NeuroMusculoSkeletal

Weakness/Abnormal movements described as: bedridden. Patient's behavior/mood is sleeping..

Cardiovascular

Edema: +2 edema gen. body edema. Patient is on a cardiac monitor. Heart rate 83 bpm. Interpretations as follows: Normal Sinus Rhythm.

Respiratory

via venti mask O2 SAT 95 % on O2. Breath sounds decreased in LLL, and RLL. Fine crackles auscultated in LLL, RLL, and RML. Rhonchi auscultated in all lobes.

GI/GU

Last BM date: 05/25/2006. Patient has indwell catheter in place.

Integumentary

Skin integrity: denuded, other, and scar(s). Integrity described as: Pt. has skin tear to rt hip. red and cracked area to saccrum.. There is no evidence of abuse and/or neglect. Wound on left hip was present on admission Color green.

IV Information

IV in Right Wrist. Inserted 5/17/2006.

Pain

Patient's level of pain is 0 (no pain). Numerical pain scale used to assess patient's pain level. Use of pain scale was explained to patient and/or family.

Restraint Reassessment

Patient is not in restraints.

Fall Risk Assessment

Fall Risk Score= 70. No history of falling this admission or having fallen within the last3 months. There is a secondary diagnosis noted which could increase the risk of a fall. Ambulatory aid: None or on bed rest or uses wheel chair or needs Nurse. IV /Heparin Lock present. Gait/Transferring: Impaired. Mental status: Forgets limitations. Patient is taking 3 or less medications from the following list Anesthesia within past 48 hours, Anticoagulants, Antidepressants, Benzodiazepines, Laxative/diuretics, Opioids (narcotics), Sedatives/hypnotics, Vasodilators. High Risk Fall Prevention Interventions were implemented, based on a score of greater than50 obtained using the Fall Assessment and Intervention policy.

Resp Therapy Care Activity

Teresa Sharkey, RRT 5/25/06 20:00 5/25/06 21:10 5/26/06 02:12 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: rhonchi auscultated in LUL, and RUL anteriorly. Heart rate 80 bpm. Breath sounds and vitals after treatment were noted to be: rhonchi auscultated in LUL, and RUL anteriorly. Heart rate 80 bpm. Additional comments: no cough. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Teresa Sharkey, RRT 5/26/06 00:00 5/26/06 00:40 5/26/06 02:14 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: improved aeration. Breath sounds and vitals before treatment were noted to be: rhonchi auscultated in LUL, and RUL anteriorly. Heart rate 82 bpm. Breath sounds and vitals after treatment were noted to be: rhonchi auscultated in LUL, and RUL anteriorly. Heart rate 79 bpm. Additional comments: no cough. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Teresa Sharkey, RRT 5/26/06 04:00 5/26/06 04:25 5/26/06 05:48 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: improved aeration. Breath sounds and vitals before treatment were noted to be: rhonchi auscultated in LUL, and RUL anteriorly and laterally. Heart rate 89 bpm. Level of consciousness is alert. Patient noted to have weak cough effort. Suctioned cough. Sputum color: yellow. Moderate amounts of sputum. Sputum consistency thick. Nasotracheal suctioning performed. Patient's level of pain is 0 (no pain).

Entered by:	Scheduled:	Performed:	Effective:	Status:

Braden Risk Assessment

April Harrell,RN 5/26/06 08:00 5/26/06 08:00 5/26/06 09:26 **Finished**

Braden Risk

Sensory Perception: Very Limited; Moisture: Occasionally Moist; Activity: Bedfast; Mobility: Very Limited; Nutrition: Adequate; Friction/Shearing: No Problem; Braden Risk Score =14.

Education

April Harrell,RN 5/26/06 08:00 5/26/06 08:00 5/26/06 09:27 **Finished**

Education Assessment

Learning barriers: cognitive. Description of barrier(s): Pt does not speak. No learning needs identified at this time Plan of care has not been reviewed/revised.

Med Surg Shift Assessment

April Harrell,RN 5/26/06 08:00 5/26/06 08:00 5/26/06 09:39 **Finished**

NeuroMusculoSkeletal

Level of consciousness is confused. Weakness/Abnormal movements described as: does not move spontanously. Additional Neuro related comments: non verbal.

Cardiovascular

Additional Cardiovascular related comments: regular rate and rhythm.

Respiratory

Additional Respiratory related comments: diminshed breath sounds..

GI/GU

Feeding tube type: PEG Tube. Feeding tube is patent. Method of feeding administration is via continuous drip Formula type: fibersource. Rate per hour: 60 ml. Tube placement verified. Patient has indwell catheter in place.

Integumentary

Skin integrity: denuded, other, and scar(s). Integrity described as: left hip decubitus dressing changed wet to dry.. There is no evidence of abuse and/or neglect. Additional Integumentary related comments on air overlay matress. turn Q 2.

IV Information

IV in Right Wrist. Site is patent. Inserted 5/26/06.

Pain

Patient's level of pain is 0 (no pain). Faces pain scale used to assess patient's pain level. Use of pain scale was explained to patient and/or family.

Restraint Reassessment

Patient is not in restraints.

Fall Risk Assessment

Fall Risk Score= 55. No history of falling this admission or having fallen within the last3 months. There is a secondary diagnosis noted which could increase the risk of a fall Ambulatory aid: None or on bed rest or uses wheel chair or needs Nurse. IV /Heparin Lock present. Gait/Transferring: Impaired. Mental status: Oriented to own ability. Patient is taking 3 or less medications from the following list: Anesthesia within past 48 hours, Anticoagulants, Antidepressants, Benzodiazepines, Laxative/diuretics, Opioids (narcotics), Sedatives/hypnotics, Vasodilators. High Risk Fall Prevention Interventions were implemented, based on a score of greater than50 obtained using the Fall Assessment and Intervention policy. Additional Fall Risk related comments: Pt is high risk for fall, checks made every30 minutes fall band on welllighted room floor free of clutter bedfast .

Resp Therapy Care Activity

Michael Yates, RRT 5/26/06 08:00 5/26/06 08:05 5/26/06 17:44 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with3mg Albuterol). Treatment given via A-mask. Patient position: L-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: rhonchi auscultated in all lobes. Heart rate 91 bpm. RR 15. O2 SAT 98%. Level of consciousness is unresponsive. Breath sounds and vitals after treatment were noted to be: rhonchi auscultated in all lobes. Additional comments: no cough effort. Patient currently on O2 at 6 liters per minute FIO2 is 28% via venti mask. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Michael Yates, RRT 5/26/06 12:00 5/26/06 12:00 5/26/06 17:45 **Finished**

Entered by:	Scheduled:	Performed:	Effective:	Status:

Resp Therapy Care Activity (cont'd)

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: rhonchi auscultated in all lobes. Heart rate 91 bpm. RR 15. O2 SAT 98%. Level of consciousness is unresponsive. Breath sounds and vitals after treatment were noted to be: rhonchi auscultated in all lobes. Additional comments: no cough effort. Patient currently on O2 at 6 liters per minute FIO2 is 28% via venti mask. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Michael Yates, RRT 5/26/06 16:00 5/26/06 16:00 5/26/06 17:47 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: rhonchi auscultated in all lobes. Heart rate 91 bpm. RR 15. O2 SAT 98%. Level of consciousness is unresponsive. Breath sounds and vitals after treatment were noted to be: rhonchi auscultated in all lobes. Additional comments: no cough effort. Patient currently on O2 at 6 liters per minute FIO2 is 28% via venti mask. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Robert Guggenheim, CRT 5/26/06 20:00 5/26/06 19:32 5/26/06 22:00 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. Adverse reactions: none. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: rhonchi auscultated in all lobes. Heart rate 91 bpm. Level of consciousness is alert. Breath sounds and vitals after treatment were noted to be: Heart rate 95 bpm. Patient noted to have strong cough effort. Non-productive cough. Patient currently on O2 at FIO2 is 28% via venti mask. Patient's level of pain is 0 (no pain).

Education

Rhonda Platt,RN 5/26/06 20:00 5/26/06 21:00 5/27/06 02:11 **Finished**

Education Assessment

Learning needs: act. Content taught: turn q 2 hours. Information taught to patient. Learning barriers: cognitive. Description of barrier(s): Pt. not very responsive. Follow up actions: Will turn pt. q 2 hours and any needs assist.. Teaching format(s) include one on one. Plan of care has been reviewed/revised. Plan of care initiated: impaired tissue integrity.

Med Surg Shift Assessment

Rhonda Platt,RN 5/26/06 20:00 5/26/06 20:00 5/27/06 02:20 **Finished**

NeuroMusculoSkeletal

Weakness/Abnormal movements described as: bedridden.

Cardiovascular

Patient is on a cardiac monitor. Heart rate 95 bpm. Interpretations as follows: Normal Sinus Rhythm.

Respiratory

via 28liter mask O2 SAT 94 % on O2. Breath sounds decreased in LLL, and RLL. Rhonchi auscultated in all lobes. yellow Copious amounts of sputum. Sputum consistency thick. Nasotracheal suctioning performed.

GI/GU

Last BM date: 05/26/2006. Patient is experiencing diarrhea. Feeding tube type: PEG Tube. Method of feeding administration is via continuous drip. Formula type: Fibersource. Total amount to be infused: 60 ml. Flush amount 35 ml. Flush frequency every 1 hr(s). Tubing changed on 05/26/2006. Patient has indwell catheter in place.

Integumentary

Skin integrity: denuded, other, and scar(s). Integrity described as: Wound to left hip has green area. Cleaned with NS and Applied hydrogel. Applied cream to buttocks.. There is no evidence of abuse and/or neglect. Wound on left hip was present on admission. ; also green.

IV Information

IV in Right Wrist. Inserted 5/26/06.

Pain

Patient's level of pain is 0 (no pain). Faces pain scale used to assess patient's pain level. Use of pain scale was explained to patient and/or family.

Entered by: Scheduled: Performed: Effective: Status:

Med Surg Shift Assessment (cont'd)

Restraint Reassessment

Patient is not in restraints.

Fall Risk Assessment

Fall Risk Score= 60. No history of falling this admission or having fallen within the last3 months. There is a secondary diagnosis noted which could increase the risk of a fall Ambulatory aid: None or on bed rest or uses wheel chair or needs Nurse. IV /Heparin Lock present. Gait/Transferring: Weak. Mental status: Forgets limitations. Patient is taking 3 or less medications from the following list Anesthesia within past 48 hours, Anticoagulants, Antidepressants, Benzodiazepines, Laxative/diuretics, Opioids (narcotics), Sedatives/hypnotics, Vasodilators. High Risk Fall Prevention Interventions were implemented, based on a score of greater than50 obtained using the Fall Assessment and Intervention policy.

Resp Therapy Care Activity

Robert Guggenheim, CRT 5/27/06 00:00 5/27/06 00:10 5/27/06 04:39 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. Adverse reactions: none. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: rhonchi auscultated in all lobes. Heart rate 89 bpm. O2 SAT 95%. Level of consciousness is alert. Breath sounds and vitals after treatment were noted to be: Heart rate 90 bpm. Patient noted to have strong cough effort. Non-productive cough. Patient currently on O2 at FIO2 is 28% via venti mask. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Robert Guggenheim, CRT 5/27/06 04:00 5/27/06 04:15 5/27/06 04:40 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. Adverse reactions: none. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: rhonchi auscultated in all lobes. Heart rate 91 bpm. O2 SAT 97%. Level of consciousness is alert. Breath sounds and vitals after treatment were noted to be: Heart rate 90 bpm. Patient noted to have strong cough effort. Non-productive cough. Patient currently on O2 at FIO2 is 28% via venti mask. Patient's level of pain is 0 (no pain).

Braden Risk Assessment

Sherry Christensen,RN 5/27/06 08:00 5/27/06 08:00 5/27/06 08:52 **Finished**

Braden Risk

Sensory Perception: Very Limited; Moisture: Occasionally Moist; Activity: Bedfast; Mobility: Very Limited; Nutrition: Adequate; Friction/Shearing: Problem; Braden Risk Score =12.

Education

Sherry Christensen,RN 5/27/06 08:00 5/27/06 08:00 5/27/06 08:54 **Finished**

Education Assessment

Learning needs: Call button use. Learning barriers: cognitive, and physical. Unable to assess readiness/motivation to learn Plan of care has been reviewed/revised.

Med Surg Shift Assessment

Sherry Christensen,RN 5/27/06 08:00 5/27/06 08:00 5/27/06 09:08 **Finished**

NeuroMusculoSkeletal

Level of consciousness is lethargic. Weakness/Abnormal movements described as: Pt. bedfast.

Cardiovascular

Edema: Trace edema Hands +1 edema Feet. Patient is on a cardiac monitor. Heart rate 97 bpm. Interpretations as follows: Normal Sinus Rhythm.

Respiratory

via venti mask O2 SAT 95 % on O2. Rhonchi auscultated in all lobes. Additional Respiratory related comments: Pt. is NT Suctioned by Respiratory Therapy.

GI/GU

Last BM date: 05/26/2006. Patient has indwell catheter in place.

Integumentary

Patient's skin is dusky. Skin integrity: denuded, other, and scar(s). Integrity described as: L hip, sacral area. There is no evidence of abuse and/or neglect. Pressure sore on L hip was present on admission. Pressure sore on sacral area was present on admission.

Entered by: Scheduled: Performed: Effective: Status:

Med Surg Shift Assessment (cont'd)

IV Information

IV in Right Wrist. Site is patent. Inserted 5/26/06.

Pain

Patient's level of pain is 0 (no pain). Faces pain scale used to assess patient's pain level. Unable to explain use of pain scale to patient and/or family because Cognitively deficient

Restraint Reassessment

Patient is not in restraints.

Fall Risk Assessment

Fall Risk Score= 95. No history of falling this admission or having fallen within the last3 months. There is a secondary diagnosis noted which could increase the risk of a fall Ambulatory aid: None or on bed rest or uses wheel chair or needs Nurse. IV /Heparin Lock present. Gait/Transferring: Impaired. Mental status: Forgets limitations. Patient is taking 4 or more medications from the following list Anesthesia within past 48 hours, Anticoagulants, Antidepressants; Benzodiazepines, Laxative/diuretics, Opioids (narcotics), Sedatives/hypnotics, Vasodilators. High Risk Fall Prevention Interventions were implemented, based on a score of greater than50 obtained using the Fall Assessment and Intervention policy.

Resp Therapy Care Activity

Anna Sheets,RRT 5/27/06 08:00 5/27/06 08:20 5/27/06 10:35 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: decreased rhonchi, and improved aeration. Breath sounds and vitals before treatment were noted to be: decreased in all lobes. rhonchi auscultated in LLL, RLL, and RML. Heart rate 96 bpm. RR 24. O2 SAT 92%. Level of consciousness is confused. Breath sounds and vitals after treatment were noted to be: decreased in all lobes. rhonchi auscultated in LLL, and RLL. Heart rate 96 bpm. RR 24. O2 SAT 98%. Additional comments: no cough. Patient's level of pain is 0 (no pain).

Resp O2 Rounds

Anna Sheets,RRT 5/27/06 08:20 5/27/06 08:20 5/27/06 10:30 **Finished**

Respiratory O2 Rounds

Patient currently on O2 at 4 liters per minute FIO2 is 28% via venti mask. Level of consciousness is confused. Heart rate 96 bpm. O2 SAT 92%.

Resp Therapy Care Activity

Anna Sheets,RRT 5/27/06 12:00 5/27/06 11:30 5/27/06 17:36 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: decreased rhonchi, and improved aeration. Breath sounds and vitals before treatment were noted to be: decreased in all lobes. rhonchi auscultated in all lobes. Heart rate 103 bpm. RR 20. O2 SAT 93%. Level of consciousness is unresponsive. Breath sounds and vitals after treatment were noted to be: decreased in all lobes. rhonchi auscultated in LLL, and RLL. Heart rate 102 bpm. RR 20. O2 SAT 96%. Patient noted to have weak cough effort Non-productive cough. Unable to assess if patient is in pain. Reason: pt unresponsive.

Resp Therapy Care Activity

Anna Sheets,RRT 5/27/06 16:00 5/27/06 16:30 5/27/06 17:38 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: decreased rhonchi, and improved aeration. Breath sounds and vitals before treatment were noted to be: decreased in all lobes. Heart rate 92 bpm. RR 24. O2 SAT 91%. Level of consciousness is lethargic. Breath sounds and vitals after treatment were noted to be: decreased in all lobes. rhonchi auscultated in LLL, and RLL. Heart rate 98 bpm. RR 24. O2 SAT 98%. Patient noted to have weak cough effort. Non-productive cough. Unable to assess if patient is in pain. Reason: pt unresponsive.

Education

Rhonda Platt,RN 5/27/06 20:00 5/27/06 20:00 5/27/06 21:30 **Finished**

Entered by: Scheduled: Performed: Effective: Status:

Education (cont'd)

Education Assessment

Learning needs: act.. Content taught: turn q 2 hours. Information taught to patient. Knowledgeable about health problem: No. Learning barriers: cognitive, and physical. Description of barrier(s): Pt. not responsive and is bed ridden. Follow up actions: Turn q 2 and provide all needs. Plan of care has been reviewed/revised. Plan of care initiated: impaired tissue integrity.

Med Surg Shift Assessment

Rhonda Platt,RN 5/27/06 20:00 5/27/06 20:00 5/27/06 21:37 **Finished**

NeuroMusculoSkeletal

Weakness/Abnormal movements described as: bed ridden.

Cardiovascular

Patient is on a cardiac monitor. Heart rate 86 bpm. Interpretations as follows: Normal Sinus Rhythm.

Respiratory

via venti mask O2 SAT 95 % on O2. Breath sounds decreased in LLL, and RLL. Rhonchi auscultated in all lobes.

GI/GU

Patient has indwell catheter in place.

Integumentary

Skin integrity: denuded, other, and scar(s). Integrity described as: skin tears to saccral area and to scrotum and foreskin of penis.. There is no evidence of abuse and/or neglect. Wound on left hip was present on admission.

IV Information

IV in Right Wrist. Inserted 5/26/06.

Pain

Patient's level of pain is 0 (no pain). Faces pain scale used to assess patient's pain level. Unable to explain use of pain scale to patient and/or family because pt. unresponsive.

Restraint Reassessment

Patient is not in restraints.

Fall Risk Assessment

Fall Risk Score= 70. No history of falling this admission or having fallen within the last3 months. There is a secondary diagnosis noted which could increase the risk of a fall. Ambulatory aid: None or on bed rest or uses wheel chair or needs Nurse. IV /Heparin Lock present. Gait/Transferring: Impaired. Mental status: Forgets limitations. Patient is taking 3 or less medications from the following list: Anesthesia within past 48 hours, Anticoagulants, Antidepressants, Benzodiazepines, Laxative/diuretics, Opioids (narcotics), Sedatives/hypnotics, Vasodilators. High Risk Fall Prevention Interventions were implemented, based on a score of greater than50 obtained using the Fall Assessment and Intervention policy.

Resp Therapy Care Activity

Robert Guggenheim, CRT 5/27/06 20:00 5/27/06 20:39 5/28/06 00:49 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. Adverse reactions: none. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: rhonchi auscultated in all lobes. Heart rate 78 bpm. O2 SAT 98%. Level of consciousness is alert. Breath sounds and vitals after treatment were noted to be: Heart rate 85 bpm. Patient noted to have strong cough effort. Non-productive cough. Patient currently on O2 at FIO2 is 28% via venti mask. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Robert Guggenheim, CRT 5/28/06 00:00 5/27/06 23:45 5/28/06 00:50 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. Adverse reactions: none. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: rhonchi auscultated in all lobes. Heart rate 85 bpm. Level of consciousness is alert. Breath sounds and vitals after treatment were noted to be: Heart rate 88 bpm. Patient noted to have strong cough effort. Non-productive cough. Patient currently on O2 at FIO2 is 28% via venti mask. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Robert Guggenheim, CRT 5/28/06 04:00 5/28/06 03:52 5/28/06 05:03 **Finished**

Entered by: Scheduled: Performed: Effective: Status:

Resp Therapy Care Activity (cont'd)

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. Adverse reactions: none. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: rhonchi auscultated in all lobes. Heart rate 81 bpm. O2 SAT 95%. Level of consciousness is alert. Breath sounds and vitals after treatment were noted to be: Heart rate 80 bpm. Patient currently on O2 at FIO2 is 28% via venti mask. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Rebecca Hake Flickinger, CRTT 5/28/06 08:00 5/28/06 08:10 5/28/06 10:03 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: decreased in all lobes. Heart rate 80 bpm. RR 14. O2 SAT 95%. Breath sounds and vitals after treatment were noted to be: Heart rate 84 bpm. RR 14. Patient currently on O2 at FIO2 is 28% via venti mask. Patient's level of pain is 0 (no pain).

Braden Risk Assessment

Laura Murphy,LPN 5/28/06 08:00 5/28/06 08:00 5/28/06 13:28 **Finished**

Braden Risk

Sensory Perception: Very Limited; Moisture: Rarely Moist; Activity: Bedfast; Mobility: Completely Immobile; Nutrition: Adequate; Friction/Shearing: Problem; Braden Risk Score =12.

Education

Laura Murphy,LPN 5/28/06 08:00 5/28/06 08:00 5/28/06 13:38 **Finished**

Education Assessment

Learning needs: unable to teach,. Content taught: no family available. Learning barriers: cognitive, and physical. Description of barrier(s): confused,generalized weakness. Follow up actions: will check on pt frequently. Plan of care has been reviewed/revised.

Med Surg Shift Assessment

Laura Murphy,LPN 5/28/06 08:00 5/28/06 09:00 5/28/06 13:49 **Finished**

NeuroMusculoSkeletal

E4 - Eyes open spontaneously. V1 - Patient does not respond verbally. M1 - Patient demonstrates no motor response. GCS: 6. Weakness/Abnormal movements described as: generalized weakness.

Cardiovascular

Edema: pitting edema arms/hands +2 pitting edema feet.

Respiratory

via venti mask Ineffective cough Oral suctioning performed.

GI/GU

Last BM date: 05/28/2006. Patient has indwell catheter in place.

Integumentary

Skin integrity: denuded, other, and scar(s). Integrity described as: buttocks with sm reddened areas noted,calazime lotion applied. There is no evidence of abuse and/or neglect.

IV Information

IV in Right Wrist. Site is patent. Inserted 5/26/06.

Pain

Patient's level of pain is 0 (no pain). Faces pain scale used to assess patient's pain level. Unable to explain use of pain scale to patient and/or family because nonverbal. Comments: will check on pt frequently..

Restraint Reassessment

Patient is not in restraints.

Entered by: Scheduled: Performed: Effective: Status:

Med Surg Shift Assessment (cont'd)

Fall Risk Assessment

Fall Risk Score= 70. Patient has fallen since admission or within the last3 months. No secondary diagnosis noted to increase the risk of a fall. Ambulatory aid: None or on bed rest or uses wheel chair or needs Nurse. IV /Heparin Lock present. Gait/Transferring: Normal or on bed rest or immobile. Mental status: Oriented to own ability. Patient is taking 4 or more medications from the following list: Anesthesia within past 48 hours, Anticoagulants, Antidepressants, Benzodiazepines, Laxative/diuretics, Opioids (narcotics), Sedatives/hypnotics, Vasodilators. High Risk Fall Prevention Interventions were implemented, based on a score of greater than50 obtained using the Fall Assessment and Intervention policy.

Resp O2 Rounds

Rebecca Hake Flickinger, CRTT 5/28/06 08:10 5/28/06 08:10 5/28/06 10:01 **Finished**

Respiratory O2 Rounds

Patient currently on O2 at FIO2 is 28% via venti mask. Level of consciousness is asleep. Heart rate 80 bpm. O2 SAT 95%.

Resp Therapy Care Activity

Rebecca Hake Flickinger, CRTT 5/28/06 12:00 5/28/06 12:00 5/28/06 13:00 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: decreased in LLL, and RLL. Heart rate 85 bpm. RR 14. O2 SAT 96%. Breath sounds and vitals after treatment were noted to be: Heart rate 86 bpm. RR 14. Patient currently on O2 at FIO2 is 28% via venti mask. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Rebecca Hake Flickinger, CRTT 5/28/06 16:00 5/28/06 15:10 5/28/06 16:07 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: decreased in all lobes. Heart rate 89 bpm. RR 14. O2 SAT 95%. Breath sounds and vitals after treatment were noted to be: Heart rate 91 bpm. RR 14. Patient noted to have strong cough effort. Non-productive cough. Additional comments: loose cough. Patient currently on O2 at FIO2 is 28% via venti mask. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Ashley Hamilton, RRT 5/28/06 20:00 5/28/06 20:05 5/28/06 21:09 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: decreased in LLL, and RLL. clear in all lobes. Heart rate 85 bpm. O2 SAT 95%. Breath sounds and vitals after treatment were noted to be: decreased in LLL, and RLL. clear in all lobes. Heart rate 82 bpm. O2 SAT 99%. Patient currently on O2 at 8 liters per minute FIO2 is 28% via venti mask. Patient's level of pain is 0 (no pain).

Education

Stephanie Butterfield,RN 5/28/06 20:00 5/28/06 20:00 5/28/06 23:53 **Finished**

Education Assessment

Learning needs: meds, orientation. Learning barriers: cognitive, and physical. Plan of care has been reviewed/revised.

Med Surg Shift Assessment

Stephanie Butterfield,RN 5/28/06 20:00 5/28/06 20:00 5/28/06 23:55 **Unfinished**

NeuroMusculoSkeletal

Weakness/Abnormal movements described as: pt is a total asst.

Cardiovascular

Patient is on a cardiac monitor. Interpretations as follows: Normal Sinus Rhythm.

Med Surg Shift Assessment

Stephanie Butterfield,RN 5/28/06 20:00 5/28/06 20:00 5/29/06 00:23 **Finished**

Entered by: Scheduled: Performed: Effective: Status:

Med Surg Shift Assessment (cont'd)

NeuroMusculoSkeletal
Weakness/Abnormal movements described as: pt is a total asst.

Cardiovascular
Patient is on a cardiac monitor. Interpretations as follows: Normal Sinus Rhythm

Respiratory
via venti mask O2 SAT 96 % on O2. Breath sounds decreased in all lobes.

GI/GU
Last BM date: 05/28/2006.

Integumentary
Skin integrity: denuded, other, and scar(s). Integrity described as: pt has dsg intact on lft hip, pt has a ulcer to sacral area w/ eschar tissue, pt has an old ulcer to rt hip. There is no evidence of abuse and/or neglect.

IV Information
IV in Right Forearm. Gauge: 20. Site is patent. Inserted 5/26/06.

Pain
Patient's level of pain is 0 (no pain). Numerical pain scale used to assess patient's pain level. Unable to explain use of pain scale to patient and/or family because pr unable to communicate, pt resting comfortably.

Restraint Reassessment
Patient is not in restraints.

Fall Risk Assessment
Fall Risk Score= 20. No history of falling this admission or having fallen within the last3 months. No secondary diagnosis noted to increase the risk of a fall. Ambulatory aid: None or on bed rest or uses wheel chair or needs Nurse. IV /Heparin Lock present. Gait/Transferring: Normal or on bed rest or immobile. Mental status: Oriented to own ability. Patient is taking 3 or less medications from the following list: Anesthesia within past 48 hours, Anticoagulants, Antidepressants, Benzodiazepines, Laxative/diuretics, Opioids (narcotics), Sedatives/hypnotics, Vasodilators. Basic nursing care interventions were implemented based on a score of0-24 obtained using the Fall Assessment and Intervention policy,

Resp Therapy Care Activity

Ashley Hamilton, RRT 5/29/06 00:00 5/28/06 23:50 5/29/06 00:55 **Finished**

Treatment
Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: decreased in LLL, and RLL. rhonchi auscultated in LLL, and RLL. Heart rate 81 bpm. O2 SAT 96%. Breath sounds and vitals after treatment were noted to be: decreased in LLL, and RLL. rhonchi auscultated in LLL, and RLL. Heart rate 83 bpm. O2 SAT 99%. Patient noted to have weak cough effort. Non-productive cough. congested cough. Patient currently on O2 at 8 liters per minute FIO2 is 28% via venti mask. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Ashley Hamilton, RRT 5/29/06 04:00 5/29/06 03:40 5/29/06 04:14 **Finished**

Treatment
Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals after treatment were noted to be: decreased in LLL, and RLL. rhonchi auscultated in LLL, and RLL. clear in all lobes. Heart rate 78 bpm. O2 SAT 96%. Patient currently on O2 at 8 liters per minute FIO2 is 28% via venti mask. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Ernie Bargeron,RRT 5/29/06 08:00 5/29/06 08:10 5/29/06 09:41 **Finished**

Treatment
Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with3mg Albuterol). Treatment given via A-mask. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: Heart rate 78 bpm. RR 20. O2 SAT 98%. Breath sounds and vitals after treatment were noted to be: Heart rate 82 bpm. RR 18. O2 SAT 100%. Patient currently on O2 at FIO2 is 28% via venturi mask. Patient's level of pain is 0 (no pain). Additional Treatment related comments: bbs coarse.

Braden Risk Assessment

Jane Wilson,RN 5/29/06 08:00 5/29/06 09:46 5/29/06 09:47 **Finished**

Entered by: Scheduled: Performed: Effective: Status:

Braden Risk Assessment (cont'd)

Braden Risk

Sensory Perception: Very Limited; Moisture: Rarely Moist; Activity: Bedfast; Mobility: Very Limited; Nutrition: Inadequate; Friction/Shearing: Problem; Braden Risk Score =12.

Education

Jane Wilson,RN 5/29/06 08:00 5/29/06 09:48 5/29/06 09:51 **Finished**

Education Assessment

Learning needs: meds, feeding, activity, d/c planing. Content taught: continue care. Information taught to patient. Learning barriers: cognitive, and physical. Description of barrier(s): pt confused and pt has to be turned. Follow up actions: reorient often and reposition. Readiness/motivation to learn: asking questions. Teaching format(s) include one on one. Response to teaching: asked questions, needs reinforcement, and verbalized understanding of content Plan of care has not been reviewed/revised. Plan of care initiated: Urosepsis; AMS; Hypothermia.

Med Surg Shift Assessment

Jane Wilson,RN 5/29/06 08:00 5/29/06 09:51 5/29/06 10:00 **Finished**

NeuroMusculoSkeletal

E4 - Eyes open spontaneously. V4 - Patient is confused. M5 - Patient localizes. GCS: 13. Weakness/Abnormal movements described as: bilateral weakness.

Cardiovascular

Patient is on a cardiac monitor. Heart rate 67 bpm. Interpretations as follows: Normal Sinus Rhythm.

Respiratory

via 28% mask O2 SAT 99 % on O2.

GI/GU

Patient has indwell catheter in place. Additional GI/GU related comments: cloudy yellow urine noted with segments

Integumentary

Skin integrity: denuded, other, and scar(s). Integrity described as: DSG to left hip. DSG to dry and intact with no drainage nor bleeding noted. There is no evidence of abuse and/or neglect.

IV Information

IV in Right Forearm. Gauge: 20. Site is patent. Inserted 5/26/06.

Pain

Patient's level of pain is 0 (no pain). Faces pain scale used to assess patient's pain level. Use of pain scale was explained to patient and/or family. Comments: Pt verablized that he understands. Pt denies pain.

Restraint Reassessment

Patient is not in restraints.

Fall Risk Assessment

Fall Risk Score= 35. No history of falling this admission or having fallen within the last3 months. No secondary diagnosis noted to increase the risk of a fall. Ambulatory aid: None or on bed rest or uses wheel chair or needs Nurse. No IV/Heparin Lock present. Gait/Transferring: Impaired. Mental status: Forgets limitations. Patient is taking 3 or less medications from the following list Anesthesia within past 48 hours, Anticoagulants, Antidepressants, Benzodiazepines, Laxative/diuretics, Opioids (narcotics), Sedatives/hypnotics, Vasodilators. Standard (low risk) Fall Prevention Interventions were implemented, based on a score of25 - 50 obtained using the Fall Assessment and Intervention policy.

Resp Therapy Care Activity

Ernie Bargeron,RRT 5/29/06 12:00 5/29/06 12:10 5/29/06 14:15 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: Heart rate 84 bpm. RR 18. Breath sounds and vitals after treatment were noted to be: Heart rate 88 bpm. RR 20. Patient's level of pain is 0 (no pain). Additional Treatment related comments: bbs coarse.

Resp Therapy Care Activity

Ernie Bargeron,RRT 5/29/06 16:00 5/29/06 16:05 5/29/06 16:57 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: Heart rate 92 bpm. RR 18. Breath sounds and vitals after treatment were noted to be: Heart rate 88 bpm. RR 22. Patient's level of pain is 0 (no pain). Additional Treatment related comments: bbs coarse.

Entered by:	Scheduled:	Performed:	Effective:	Status:

Education

Jenny Stearns, RN 5/29/06 20:00 5/29/06 20:00 5/29/06 22:47 **Finished**

Education Assessment

Learning barriers: cognitive, and physical. No learning needs identified at this time Plan of care has been reviewed/revised.

Med Surg Shift Assessment

Jenny Stearns, RN 5/29/06 20:00 5/29/06 20:00 5/29/06 22:58 **Finished**

NeuroMusculoSkeletal

Level of consciousness is confused. Weakness/Abnormal movements described as: generalized.

Cardiovascular

Edema: +2 edema upper extremities +2 edema lower extremities. Patient is on a cardiac monitor. Heart rate 66 bpm. Interpretations as follows: Normal Sinus Rhythm.

Respiratory

Patient on Oxygen at 2 liters per minute via nasal cannula O2 SAT 98 % on O2. Rhonchi auscultated in all lobes.

GI/GU

Patient has indwell catheter in place.

Integumentary

Skin integrity: denuded, other, and scar(s). Integrity described as: wound to left buttocks, wet to dry dressing in place clean, dry, and intact; wound to buttocks and legs open to air; no drainage noted and no S&S of infection noted There is no evidence of abuse and/or neglect.

IV Information

IV in Right Forearm. Gauge: 20. Site is patent. Inserted 5/26/06.

Pain

Patient's level of pain is 0 (no pain). Numerical pain scale used to assess patient's pain level. Use of pain scale was explained to patient and/or family.

Restraint Reassessment

Patient is not in restraints.

Fall Risk Assessment

Fall Risk Score= 70. No history of falling this admission or having fallen within the last3 months. There is a secondary diagnosis noted which could increase the risk of a fall. Ambulatory aid: None or on bed rest or uses wheel chair or needs Nurse. IV /Heparin Lock present. Gait/Transferring: Impaired. Mental status: Forgets limitations. Patient is taking 3 or less medications from the following list: Anesthesia within past 48 hours, Anticoagulants, Antidepressants, Benzodiazepines, Laxative/diuretics, Opioids (narcotics), Sedatives/hypnotics, Vasodilators. High Risk Fall Prevention Interventions were implemented, based on a score of greater than50 obtained using the Fall Assessment and Intervention policy.

Resp Therapy Care Activity

Ashley Hamilton, RRT 5/29/06 20:00 5/29/06 19:55 5/29/06 23:19 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: improved aeration. Breath sounds and vitals before treatment were noted to be: decreased in LLL, and RLL. expiratory wheezes auscultated in LUL, RML, and RUL. Heart rate 71 bpm. O2 SAT 99%. Breath sounds and vitals after treatment were noted to be: decreased in LLL, and RLL. expiratory wheezes auscultated in LUL, and RUL. Heart rate 68 bpm. O2 SAT 100%. Patient currently on O2 at 2 liters per minute FIO2 is 28% via nasal cannula. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Ashley Hamilton, RRT 5/30/06 00:00 5/30/06 00:00 5/30/06 00:16 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: decreased wheezing, and improved aeration. Breath sounds and vitals before treatment were noted to be: decreased in LLL, and RLL. expiratory wheezes auscultated in LUL, and RUL. Heart rate 66 bpm. O2 SAT 98%. Breath sounds and vitals after treatment were noted to be: decreased in LLL, and RLL. expiratory wheezes auscultated in LUL, and RUL. Heart rate 72 bpm. O2 SAT 100%. Patient currently on O2 at 2 liters per minute FIO2 is 28% via nasal cannula. Patient's level of pain is 0 (no pain).

Entered by:	Scheduled:	Performed:	Effective:	Status:

Resp Therapy Care Activity

Ashley Hamilton, RRT — 5/30/06 04:00 — 5/30/06 04:10 — 5/30/06 04:44 — **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: improved aeration. Breath sounds and vitals before treatment were noted to be: decreased in LLL, and RLL, expiratory wheezes auscultated in LUL, and RUL. Heart rate 69 bpm. O2 SAT 96%. Breath sounds and vitals after treatment were noted to be: decreased in LLL, and RLL, expiratory wheezes auscultated in LUL, and RUL. Heart rate 72 bpm. O2 SAT 100%. Patient currently on O2 at 2 liters per minute FIO2 is 28% via nasal cannula. Patient's level of pain is 0 (no pain).

Braden Risk Assessment

Sherry Christensen,RN — 5/30/06 08:00 — 5/30/06 08:20 — 5/30/06 08:30 — **Finished**

Braden Risk

Sensory Perception: Very Limited; Moisture: Occasionally Moist; Activity: Bedfast; Mobility: Very Limited; Nutrition: Adequate; Friction/Shearing: Problem; Braden Risk Score =12.

Education

Sherry Christensen,RN — 5/30/06 08:00 — 5/30/06 08:20 — 5/30/06 08:35 — **Finished**

Education Assessment

Learning needs: Call button operation. Information taught to patient. Learning barriers: cognitive, and physical. Unable to assess readiness/motivation to learn. Teaching format(s) include one on one. Plan of care has been reviewed/revised.

Med Surg Shift Assessment

Sherry Christensen,RN — 5/30/06 08:00 — 5/30/06 08:20 — 5/30/06 08:46 — **Finished**

NeuroMusculoSkeletal

Weakness/Abnormal movements described as: Pt. turned q2 hrs.. Speech is garbled.

Cardiovascular

Patient is on a cardiac monitor. Heart rate 74 bpm. Interpretations as follows: Normal Sinus Rhythm.

Respiratory

Patient on Oxygen at 2 liters per minute via nasal cannula

GI/GU

Additional GI/GU related comments: Pt. having loose, dark stools..

Integumentary

Skin integrity: denuded, other, and scar(s). Integrity described as: L Hip ulcer, sacral area breakdown. There is no evidence of abuse and/or neglect.

IV Information

IV in Right Forearm. Site is patent. Inserted 5/26/06.

Pain

Patient's level of pain is 0 (no pain). Faces pain scale used to assess patient's pain level. Use of pain scale was explained to patient and/or family.

Restraint Reassessment

Patient is not in restraints.

Fall Risk Assessment

Fall Risk Score= 95. No history of falling this admission or having fallen within the last3 months. There is a secondary diagnosis noted which could increase the risk of a fall. Ambulatory aid: None or on bed rest or uses wheel chair or needs Nurse. IV /Heparin Lock present. Gait/Transferring: Impaired. Mental status: Forgets limitations. Patient is taking 4 or more medications from the following list: Anesthesia within past 48 hours, Anticoagulants, Antidepressants, Benzodiazepines, Laxative/diuretics, Opioids (narcotics), Sedatives/hypnotics, Vasodilators. High Risk Fall Prevention Interventions were implemented, based on a score of greater than50 obtained using the Fall Assessment and Intervention policy.

Resp Therapy Care Activity

Rebecca Hake Flickinger, CRTT — 5/30/06 08:00 — 5/30/06 08:10 — 5/30/06 09:51 — **Finished**

Entered by: Scheduled: Performed: Effective: Status:

Resp Therapy Care Activity (cont'd)

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: H-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: decreased in all lobes. Heart rate 73 bpm. RR 14. O2 SAT 97%. Breath sounds and vitals after treatment were noted to be: Heart rate 74 bpm. RR 14. Patient noted to have strong cough effort. Non-productive cough. Patient currently on O2 at 2 liters per minute FIO2 is 28% via nasal cannula. Patient's level of pain is 0 (no pain).

Resp O2 Rounds

Rebecca Hake Flickinger, CRTT 5/30/06 08:10 5/30/06 08:10 5/30/06 09:47 **Finished**

Respiratory O2 Rounds

Patient currently on O2 at 2 liters per minute FIO2 is 28% via nasal cannula. Level of consciousness is alert. Heart rate 78 bpm. O2 SAT 97%.

Resp Therapy Care Activity

Rebecca Hake Flickinger, CRTT 5/30/06 12:00 5/30/06 11:30 5/30/06 12:08 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: decreased in all lobes. Heart rate 87 bpm. RR 14. O2 SAT 94%. Breath sounds and vitals after treatment were noted to be: Heart rate 89 bpm. RR 14. Patient currently on O2 at 2 liters per minute FIO2 is 28% via nasal cannula. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Rebecca Hake Flickinger, CRTT 5/30/06 16:00 5/30/06 15:30 5/30/06 15:45 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: H-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: decreased in all lobes. Heart rate 69 bpm. RR 14. O2 SAT 96%. Breath sounds and vitals after treatment were noted to be: Heart rate 71 bpm. RR 14. Patient currently on O2 at 2 liters per minute FIO2 is 28% via nasal cannula. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Scott Snavely, RRT 5/30/06 20:00 5/30/06 20:05 5/30/06 21:43 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: decreased in all lobes. expiratory wheezes auscultated in all lobes. Heart rate 60 bpm. Breath sounds and vitals after treatment were noted to be: decreased in all lobes. expiratory wheezes auscultated in all lobes. Heart rate 60 bpm. Patient noted to have weak cough effort. Non-productive cough. Patient's level of pain is 0 (no pain).

Education

Jenny Stearns, RN 5/30/06 20:00 5/30/06 20:00 5/30/06 22:36 **Finished**

Education Assessment

Learning barriers: cognitive, and physical. No learning needs identified at this time. Plan of care has been reviewed/revised.

Med Surg Shift Assessment

Jenny Stearns, RN 5/30/06 20:00 5/30/06 20:00 5/30/06 22:43 **Finished**

NeuroMusculoSkeletal

Level of consciousness is lethargic. Weakness/Abnormal movements described as: generalized. Speech is slurred. HOH bilaterally.

Cardiovascular

Edema: +2 edema upper extremities +2 edema lower extremities. Patient is on a cardiac monitor. Heart rate 62 bpm. Interpretations as follows: Normal Sinus Rhythm.

Entered by: Scheduled: Performed: Effective: Status:

Med Surg Shift Assessment (cont'd)

Respiratory

Patient on Oxygen at 2 liters per minute via nasal cannula Rhonchi auscultated in all lobes

GI/GU

Last BM date: 05/30/2006. Feeding tube type: PEG Tube. Feeding tube is patent. Method of feeding administration is via continuous drip. Formula type: Fibersource. Rate per hour: 60 ml. Flush amount 40 ml. Flush frequency every 1 hr(s). Tube placement verified.

Integumentary

Skin integrity: denuded, other, and scar(s). Integrity described as: generalized dryness; wounds to legs bilaterally; wound to left hip, wet to dry dressing in place; wound to sacral area, dressing clean, dry, and intact. There is no evidence of abuse and/or neglect.

IV Information

IV in Right Forearm. Site is patent. Inserted 5/26/06.

Pain

Patient's level of pain is 0 (no pain). Faces pain scale used to assess patient's pain level. Use of pain scale was explained to patient and/or family.

Restraint Reassessment

Patient is not in restraints.

Fall Risk Assessment

Fall Risk Score= 70. No history of falling this admission or having fallen within the last3 months. There is a secondary diagnosis noted which could increase the risk of a fall. Ambulatory aid: None or on bed rest or uses wheel chair or needs Nurse. IV /Heparin Lock present. Gait/Transferring: Impaired. Mental status: Forgets limitations. Patient is taking 3 or less medications from the following list: Anesthesia within past 48 hours, Anticoagulants, Antidepressants, Benzodiazepines, Laxative/diuretics, Opioids (narcotics), Sedatives/hypnotics, Vasodilators. High Risk Fall Prevention Interventions were implemented, based on a score of greater than50 obtained using the Fall Assessment and Intervention policy.

Resp Therapy Care Activity

Scott Snavely, RRT 5/31/06 00:00 5/31/06 00:10 5/31/06 01:48 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: decreased in all lobes. expiratory wheezes auscultated in all lobes. Heart rate 65 bpm. Breath sounds and vitals after treatment were noted to be: decreased in all lobes. expiratory wheezes auscultated in all lobes. Heart rate 104 bpm. Patient noted to have weak cough effort. Non-productive cough. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Scott Snavely, RRT 5/31/06 04:00 5/31/06 03:40 5/31/06 04:22 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: decreased in all lobes. expiratory wheezes auscultated in all lobes. Heart rate 66 bpm. Breath sounds and vitals after treatment were noted to be: decreased in all lobes. expiratory wheezes auscultated in all lobes. Heart rate 65 bpm. Patient noted to have weak cough effort. Non-productive cough. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Jason Webb, CRT 5/31/06 08:00 5/31/06 08:15 5/31/06 12:29 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: decreased in all lobes. Heart rate 64 bpm. RR 20. O2 SAT 98%. Level of consciousness is alert. Patient's level of pain is 0 (no pain).

Braden Risk Assessment

Sherry Christensen,RN 5/31/06 08:00 5/31/06 07:30 5/31/06 16:12 **Finished**

Entered by: | Scheduled: | Performed: | Effective: | Status:

Braden Risk Assessment (cont'd)

Braden Risk

Sensory Perception: Very Limited; Moisture: Moist; Activity: Bedfast; Mobility: Very Limited; Nutrition: Inadequate; Friction/Shearing: Problem; Braden Risk Score =10.

Education

Sherry Christensen,RN 5/31/06 08:00 5/31/06 07:30 5/31/06 16:33 **Finished**

Education Assessment

Learning needs: use of call light, will check on pt frequently.. Content taught: use of call light, will check on pt frequently.. Information taught to patient. Knowledgeable about health problem: No. Learning barriers: cognitive, and physical. Description of barrier(s): sepsis. Follow up actions: reinforce teaching, pt has been able to talk to nurses, but unable to move,or feed himself.. Readiness/motivation to learn: uninterested. Teaching format(s) include one on one. Response to teaching: needs reinforcement. Plan of care has been reviewed/revised. Plan of care initiated: urosepsis.

Med Surg Shift Assessment

Sherry Christensen,RN 5/31/06 08:00 5/31/06 07:30 5/31/06 16:39 **Finished**

NeuroMusculoSkeletal

Weakness/Abnormal movements described as: generalized..

Cardiovascular

Patient is on a cardiac monitor. Interpretations as follows: Normal Sinus Rhythm.

Respiratory

Expiratory wheezes auscultated in LLL, and RLL

GI/GU

Last BM date: 05/31/2006. Patient is experiencing diarrhea. Patient has indwell catheter in place.

Integumentary

Skin integrity: denuded, other, and scar(s). Integrity described as: peg tube, right hip breakdown. wound care is seeing pt.. There is no evidence of abuse and/or neglect.

IV Information

IV in Right Forearm. Gauge: 20. Site is patent. Inserted 5/26/06.

Pain

Patient's level of pain is 0 (no pain). Numerical pain scale used to assess patient's pain level. Use of pain scale was explained to patient and/or family.

Restraint Reassessment

Patient is not in restraints.

Fall Risk Assessment

Fall Risk Score= 70. No history of falling this admission or having fallen within the last3 months. There is a secondary diagnosis noted which could increase the risk of a fall. Ambulatory aid: None or on bed rest or uses wheel chair or needs Nurse. IV /Heparin Lock present. Gait/Transferring: Impaired. Mental status: Forgets limitations. Patient is taking 3 or less medications from the following list: Anesthesia within past 48 hours, Anticoagulants, Antidepressants, Benzodiazepines, Laxative/diuretics, Opioids (narcotics), Sedatives/hypnotics, Vasodilators. High Risk Fall Prevention Interventions were implemented, based on a score of greater than 50 obtained using the Fall Assessment and Intervention policy.

Med Surg Shift Assessment

Sherry Christensen,RN 5/31/06 08:00 5/31/06 07:30 5/31/06 16:49 **Finished**

NeuroMusculoSkeletal

Weakness/Abnormal movements described as: generalized..

Cardiovascular

Patient is on a cardiac monitor. Interpretations as follows: Normal Sinus Rhythm.

Respiratory

Expiratory wheezes auscultated in LLL, and RLL

GI/GU

Last BM date: 05/31/2006. Patient is experiencing diarrhea. Patient has indwell catheter in place.

Integumentary

Skin integrity: denuded, other, and scar(s). Integrity described as: peg tube, right hip breakdown. wound care is seeing pt.. There is no evidence of abuse and/or neglect.

IV Information

IV in Right Forearm. Gauge: 20. Site is patent. Inserted 5/26/06.

Entered by: Scheduled: Performed: Effective: Status:

Med Surg Shift Assessment (cont'd)

Pain

Patient's level of pain is 0 (no pain). Numerical pain scale used to assess patient's pain level. Use of pain scale was explained to patient and/or family.

Restraint Reassessment

Patient is not in restraints.

Fall Risk Assessment

Fall Risk Score= 70. No history of falling this admission or having fallen within the last3 months. There is a secondary diagnosis noted which could increase the risk of a fall. Ambulatory aid: None or on bed rest or uses wheel chair or needs Nurse. IV /Heparin Lock present. Gait/Transferring: Impaired. Mental status: Forgets limitations. Patient is taking 3 or less medications from the following list: Anesthesia within past 48 hours, Anticoagulants, Antidepressants, Benzodiazepines, Laxative/diuretics, Opioids (narcotics), Sedatives/hypnotics, Vasodilators. High Risk Fall Prevention Interventions were implemented, based on a score of greater than 50 obtained using the Fall Assessment and Intervention policy.

Resp Therapy Care Activity

Jason Webb, CRT 5/31/06 12:00 5/31/06 12:20 5/31/06 15:11 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: decreased in all lobes. Heart rate 72 bpm. O2 SAT 99%. Level of consciousness is alert. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Ashley Hamilton, RRT 5/31/06 20:00 5/31/06 19:40 5/31/06 23:16 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: decreased in LLL, and RLL. clear in all lobes. Heart rate 56 bpm. O2 SAT 98%. Breath sounds and vitals after treatment were noted to be: decreased in LLL, and RLL. clear in all lobes. Heart rate 61 bpm. O2 SAT 100%. Patient currently on O2 at 2 liters per minute FIO2 is 28% via nasal cannula. Patient's level of pain is 0 (no pain).

Education

Jenny Stearns, RN 5/31/06 20:00 5/31/06 20:00 6/1/06 01:01 **Finished**

Education Assessment

Learning barriers: cognitive, and physical. No learning needs identified at this time. Plan of care has been reviewed/revised.

Med Surg Shift Assessment

Jenny Stearns, RN 5/31/06 20:00 5/31/06 20:00 6/1/06 01:23 **Finished**

NeuroMusculoSkeletal

Level of consciousness is confused. Weakness/Abnormal movements described as: generalized. Speech is slurred. HOH bilaterally. Patient's behavior/mood is confused. Affect is flat.

Cardiovascular

Patient is on a cardiac monitor. Heart rate 53 bpm. Interpretations as follows: Bradycardia, and Normal Sinus Rhythm.

Respiratory

Patient on Oxygen at 2 liters per minute via nasal cannula O2 SAT 96 % on O2.

GI/GU

Feeding tube type: PEG Tube. Feeding tube is patent. Method of feeding administration is via continuous drip. Formula type: Fibersource. Rate per hour: 60 ml. Flush amount 40 ml. Flush frequency every 1 hr(s). Tube placement verified. Patient has indwell catheter in place.

Integumentary

Skin integrity: denuded, other, and scar(s). Integrity described as: wound to left hip; wet to dry dressing in place and is clean, dry, and intact. wound to sacral area;dressing clean, dry, and intact. Skin breakdown to bilateral legs. There is no evidence of abuse and/or neglect.

IV Information

IV in Right Forearm. Gauge: 20. Site is patent. Inserted 5/26/06.

Entered by: | Scheduled: | Performed: | Effective: | Status:

Med Surg Shift Assessment (cont'd)

Pain

Patient's level of pain is 0 (no pain). Numerical pain scale used to assess patient's pain level. Use of pain scale was explained to patient and/or family.

Restraint Reassessment

Patient is not in restraints.

Fall Risk Assessment

Fall Risk Score= 70. No history of falling this admission or having fallen within the last3 months. There is a secondary diagnosis noted which could increase the risk of a fall. Ambulatory aid: None or on bed rest or uses wheel chair or needs Nurse. IV /Heparin Lock present. Gait/Transferring: Impaired. Mental status: Forgets limitations. Patient is taking 3 or less medications from the following list: Anesthesia within past 48 hours, Anticoagulants, Antidepressants, Benzodiazepines, Laxative/diuretics, Opioids (narcotics), Sedatives/hypnotics, Vasodilators. High Risk Fall Prevention Interventions were implemented, based on a score of greater than 50 obtained using the Fall Assessment and Intervention policy.

Resp Therapy Care Activity

Ashley Hamilton, RRT 6/1/06 00:00 6/1/06 00:00 6/1/06 00:34 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: decreased in LLL, and RLL. clear in all lobes. Heart rate 53 bpm. O2 SAT 97%. Breath sounds and vitals after treatment were noted to be: decreased in LLL, and RLL. clear in all lobes. Heart rate 59 bpm. O2 SAT 100%. Patient currently on O2 at 2 liters per minute FIO2 is 28% via nasal cannula. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Ashley Hamilton, RRT 6/1/06 04:00 6/1/06 03:40 6/1/06 05:43 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: no change. Breath sounds and vitals before treatment were noted to be: decreased in LLL, and RLL. clear in all lobes. Heart rate 62 bpm. O2 SAT 98%. Breath sounds and vitals after treatment were noted to be: decreased in LLL, and RLL. clear in all lobes. Heart rate 55 bpm. O2 SAT 100%. Patient currently on O2 at 2 liters per minute FIO2 is 28% via nasal cannula. Patient's level of pain is 0 (no pain).

Resp Therapy Care Activity

Anna Sheets,RRT 6/1/06 08:00 6/1/06 08:10 6/1/06 17:32 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: improved aeration. Breath sounds and vitals before treatment were noted to be: decreased in all lobes. Heart rate 75 bpm. RR 20. O2 SAT 98%. Level of consciousness is confused. Breath sounds and vitals after treatment were noted to be: decreased in all lobes. Heart rate 77 bpm. RR 20. O2 SAT 99%. Patient noted to have weak cough effort. Non-productive cough. Patient's level of pain is 0 (no pain).

Resp O2 Rounds

Anna Sheets,RRT 6/1/06 08:10 6/1/06 08:10 6/1/06 17:30 **Finished**

Respiratory O2 Rounds

Patient currently on O2 at 2 liters per minute FIO2 is 28% via nasal cannula. Level of consciousness is confused. Heart rate 75 bpm. O2 SAT 98%.

Resp Therapy Care Activity

Anna Sheets,RRT 6/1/06 12:00 6/1/06 11:45 6/1/06 17:33 **Finished**

Treatment

Treatment type: HHN/SVN. Medications/dosages used: Duoneb (0.5mg Atrovent with 3mg Albuterol). Treatment given via A-mask. Patient position: S-fowlers. No adverse reactions noted, treatment tolerated well. Response to treatment: improved aeration. Breath sounds and vitals before treatment were noted to be: decreased in all lobes. Heart rate 73 bpm. RR 20. O2 SAT 99%. Level of consciousness is confused. Breath sounds and vitals after treatment were noted to be: decreased in all lobes. Heart rate 68 bpm. RR 20. O2 SAT 99%. Additional comments: no cough. Patient's level of pain is 0 (no pain).

Entered by: Performed: Effective: Status:

Patient Notes & Addenda

NUR Note
Rachel Harris Jones,LPN 5/16/06 07:15 5/16/06 07:16
assessment unchanged from admission reposn approx q 2 hrs. hob elevated to comfort. foul smell at lt hip decub. uneventful shift.

IPOC Note
Jennifer Halupa,SocialWork,QOM 5/16/06 13:38 5/16/06 13:38
Please see social work note. Jennifer Halupa LMSW

IPOC Note
Jennifer Halupa,SocialWork,QOM 5/16/06 13:40 5/16/06 13:40
Please see social work notes. Jennifer Halupa LMSW

IPOC Note
Diana Undertilo,RN 5/16/06 20:22 5/16/06 20:29
Pt has been seen by Dr. Dibona and Dr. Gordon. Pt has IVF infusing at 200cc/hr then increased to 300cc/hr. IVPB hung. Pt transferred to stretcher for transport down for abd series, etc. Pt returned and IVF restarted. Vanc hung. Vanc peak orderd. WC in to see pt and did wound care changes. Pressure sore to L hip and skin shear to sacral area. Overlay mattress placed to bed. Family at bedside.

NUR Note
Renee Ensley,LPN 5/16/06 23:56 5/17/06 00:00
pt lying in bed with no movement of pain or discomfort pt family at bedside. pt o2 94% on veni mask. 2200 Dr Gordon called to let him know of Vanco peak(18.3) Dr Gordon said give 1g Vancomyacin. pt is noresponsive when name is called pt responds when body parts is moved. pt will be monitored during the night

NUR Note
Renee Ensley,LPN 5/17/06 06:26 5/17/06 06:29
Pt checked on duirng the night q2h with no change in status pt opened his eyes for a monment pt was turned and dbrevement tray in room at bedside. pt instructed to call for assistance call light wihtin reach

IPOC Note
Rebecca Hake Flickinger, CRTT 5/17/06 09:28 5/17/06 09:28
spo2 on 100% non rebreather 99% no sob faint rhonchi heard in apices no cough when asked

NUR Note
Stephanie K. Bell, ATC SN 5/17/06 10:49 5/17/06 10:51
Bed bath. Changed linens. Changed dressing to L Hip. Wet to Dry, cover with 4x4 and Medipore tape. Calazime applied to Stage 2 sore on sacrum.

IPOC Note
Mary Lockwood,RN 5/17/06 14:51 5/17/06 14:55
1400 wife here;social service talked to wife about dnr and dni; chest is clear; urine is550 cc of yellowish colored urine;turned and positioned; ventimask-100 % ventimask ; b/p 119/ 46 t 96.7 p 87 r 16; ky jelly to lips and nose; iv-1000 cc d5.2 ns at 200 cc /hour now-site is clear and not swollen

IPOC Note
Rebecca Hake Flickinger, CRTT 5/17/06 16:25 5/17/06 16:26
spo2 on 50% venti mask 99% decreased to 40% venti maskspo2 97%

IPOC Note
Helena Jackson,RN 5/17/06 18:07 5/17/06 18:18
1800 turned and positioned; respirations are easy on 50 % ventimask; has small amout of mucus in throat; maintained npo; patient only opens eyes and moves head;iv d5/.2 ns at 200 cc/hour-site is clear and not swollen

Entered by:	Performed:	Effective:	Status:

NUR Note
Renee Ensley,LPN 5/17/06 21:54 5/17/06 21:57
pt lying in bed with no signs of pain or distress pt not able to speak pt will open eyes with moving of extremities will continue to monitor. call light within reach.

NUR Note
Renee Ensley,LPN 5/18/06 06:28 5/18/06 06:31
Pt was cheecked on during the night q2h and turned. pt dressing to the left hip was changed 0615 DR Bokkisam was called to let him know of Potassiam of3.0 orders were given. Give KCL 60meq IV x1. Call light wihtin reach.

NUR Note
Teresa Meador, RN 5/18/06 08:00 5/18/06 20:55
am assessment completed-assisted resp therapy w/nt suctioning-pt has no gag reflex.mod amt thick yellow secretions obtained.remains npoand dnr

NUR Note
Teresa Meador, RN 5/18/06 12:30 5/18/06 20:57
placed on contact isolation for mrsa inblood and urine-family in roomand explained procedures for maintaining isolation

NUR Note
Teresa Meador, RN 5/18/06 13:00 5/18/06 20:57
spoke w/pts dtr mary-states family wants peg tube for feeding-will notify md

IPOC Note
Patricia Skolnik,RD 5/18/06 15:28 5/18/06 15:41
nutrition f/u: c/s received for TF recommendations. NG is to be placed, and possibly a PEG if family decides.
Labs 5/18: Na 148 (h), CL 123 (h), CO2 19 (l), BUN 36 (h), K 3.0 (l), Creat 1.9 (h), Ca 7.7 (l).
Wound care eval noted, pt has a pressure ulcer on lower back, and a stage4 pressure ulcer on his L hip. Feeding tube and debridement to be done per family's wishes
TF goal of Impact 1.5 @ 50ml/hr, with pushes BID of one package Arginade and one scoop Promod in120ml H2O. This will provide 1920 kcal, 119g pro/d to meet needs. H2O flushes to be determined depending on IVF's at the time goal is met.
TF orders written for pushes as above, and TF's of continuous feed @ halfstrength Impact 1.5 goal of 60ml/hr. TF's to start @ 20ml/hr, and adv by 10ml q 10hrs as tolerated. Slow adv of TF vital to ensure pt tolerates nutrition and volume. Once this is established, TF's will be changed to full-strength for maximum nutrition
PLAN: Will f/u for tolerance of TF's and make changes as seen fit

IPOC Note
Patricia Skolnik,RD 5/18/06 15:42 5/18/06 15:42
TF's to start via NGT, possible PEG. ORders written. Please see nutrition note for further detail.

NUR Note
Teresa Meador, RN 5/18/06 17:00 5/18/06 21:01
#18 salem sump inserted rt nare-placement checked x3 and correct;golden stomach contents aspirated;started impact 1.5half strength at 20ml/hr via pump.drsg changedoen to lt hip area;noted much necrotic tissueno odor;small amt yellow drainage.calazime to sacral area.nt suction for mod amt thick yellow secretionsnote that tube feeding is colored w/green food coloring for identification

NUR Note
Teresa Meador, RN 5/18/06 18:00 5/18/06 21:02
tolerating tube feeding w/o any s/sxof increasing sob

NUR Note
Renee Ensley,LPN 5/18/06 20:00 5/19/06 00:27
pt lying in bed turned to the door. pt on tube feeding at 20cc. 2200 pt's residual was checked 100cc returned from tube. tube feeding stopped. will recheck in one hour. pt turned on back. call light within reach will continue to monitor.

NUR Note
Renee Ensley,LPN 5/19/06 07:32 5/19/06 07:34
pt checked on during the night q2h. Dr Gordon was informed of pt IV fluids at 200cc/h Dr Gordon said to drop fluids to 50cc. call light within reach.

Entered by:	Performed:	Effective:	Status:

NUR Note
Lavern Jackson,LPN 5/19/06 08:00 5/19/06 13:25
Resting quietly in bed. Pt has eyes open,yet,unresponsive.Pt repositioned. Unable to obtain oral,axillary or rectal temp. Skin feels normal. No distress noted.

NUR Note
Lavern Jackson,LPN 5/19/06 10:30 5/19/06 14:18
To OR for Peg tube placement. Daughter in to sign consent.

DTY Note
Patricia Skolnik,RD 5/19/06 16:05 5/19/06 16:14
Nutrition f/u: Pt s/p PEG today, MD ordered TF's to re-start in am per previous recommendations.
Noted per RN progress notes that TF's were started last pm per NG @ 20ml/hr, and residuals @ 2200 were ~100ml, and TF's were held.
IVF of D5 1/2 NS @ 100ml/hr = 2400ml fld, 408 kcal/d from dextrose.
Verbally reviewed TF orders /c RN for clarification, who showed understanding. Instructed RN that TF bag that is currently hanging (and not running) is from last night, and should be discarded in the am before TF's start again. Also requested RN write push orders on MAR for clarity in report from shift to shift.
TF order: 1/2 strength Impact 1.5 @ 20ml/hr to adv by 10ml q10 hrs as tolerated to goal of 60ml/hr; pushes of one package Arginade one scoop Promod in 120ml H2O BID. Once TF's are established, will change to full strength at goal of 55ml/hr.
PLAN: Will f/u @ high nutritional risk for tolerance to TF's.

IPOC Note
Patricia Skolnik,RD 5/19/06 16:15 5/19/06 16:15
PEG placed today, TF's to start tomorrow in am. Clarified order /cRN. Please see DTY notes for details.

NUR Note
Katica Foreman RN 5/19/06 21:00 5/20/06 00:09
Pt. resting in bed; opens eyes to verbal stimulation; IV infusing without difficulty; peg site healing with no s/sx of infection; bed low and locked; call light in reach; will cont to monitor.

IPOC Note
Katica Foreman RN 5/20/06 00:10 5/20/06 00:10
TF's to start tomorrow

NUR Note
Shannon Schander,RN 5/20/06 08:00 5/20/06 08:39
Pt resting in bed without distress noted. Pt sleepy. Nonverbal. Lungs with rales bilat and decreased breath sounds. 02@35% venti mask. Air mattress intact. Turn Q2 hours. F/C to bedsdie drainage with dark yellow urine noted. Binder noted to abd, over peg tube placement. Nursing assesment complete. Will cont. to monitor.

NUR Note
Shannon Schander,RN 5/20/06 11:00 5/20/06 13:44
Pt resting in bed without distress noted. No change in status. Turn Q2 hours. Will cont. to monitor.

IPOC Note
Patricia Morell, RD 5/20/06 14:07 5/20/06 14:08
clarified TF orders and nutritional pushes with pt's nurse Shannon. Diet office to deliver formual of 1/2 str Impact 1.5 to begin @ 20 ml/hr and incr by 10 ml/hr q 10 hrs till at goal rate of 60 ml/hr. On Mon will evaluate to incr to full str.
Addended 5/20/06 at 14:10 by Patricia Morell, RD:
Arginade and promod pushes being given

NUR Note
Shannon Schander,RN 5/20/06 15:30 5/20/06 15:54
1/2 strength Impact 1.5 @ 20ml/hr. Tube feeding to be advanced by 10ml/hr as tolerated to a goal of 60 ml/hr. Will cont. to monitor.

NUR Note
Shannon Schander,RN 5/20/06 18:15 5/20/06 18:19
Pt resting in bed without distress noted. Tube feeding infusing without distress noted. IV site remains without redness and swelling noted. Family remains at bedside. No change is status. Report to be given to next shift.

Entered by: | Performed: | Effective: | Status:

NUR Note
Shannon Schander,RN 5/21/06 08:25 5/21/06 08:42
Pt resting in bed without distress noted. Lungs with rhonchi and exp wheezing noted 02@ 31% venti mask. See nursing assessment for skin assessment Turn every 2 hours. Air mattress intact. IV site without redness or swelling. Tube feeding infusing without problems. Pt nonverbal. nursing assessment complete. Will cont. to monitor.

NUR Note
Shannon Schander,RN 5/21/06 11:00 5/21/06 11:38
Pt turned every 2 hours. Pt with large amount of loose brown stool X2. Tube feeding @ 30ml/hr infusing without problems. Family at bedside. No change in status. Will cont. to monitor.

NUR Note
Shannon Schander,RN 5/21/06 13:00 5/21/06 16:39
Tube feeding rate increased to 30 ml/hr. Will increase rate to 40 ml/hr in 10hrs if pt tolerates.

NUR Note
Shannon Schander,RN 5/21/06 15:00 5/21/06 16:38
Pt resting in bed without distress noted. No change in status. Tube feeding infusing without problems. IV site remains without redness or swelling. Will cont. to monitor.

NUR Note
Shannon Schander,RN 5/21/06 18:30 5/21/06 18:54
Pt resting in bed without distress noted. Dressing to left buttocks changed after Dr. Hagan debrided wound. Pt with large amounts of brown loose stool X3 today. No change in status. tube feeding infusing without problems. IV site remains without redness or swelling. No change in status. Report to be given to M Accardi LPN.

NUR Note
Marlene Accardi LPN 5/21/06 20:00 5/22/06 01:11
pm assessment complete. pt resting in bed w/o signs of distress. tube feeding at 40cc/hr, IVFs infusing as ordered. pt repositioned. bed is low and locked. will continue to monitor. vss.

NUR Note
Marlene Accardi LPN 5/21/06 23:30 5/22/06 01:12
pt had large, loose, brown stool. given bed bath w/ linens changed. feeding increased to 50cc/hr as ordered. repositioned. no distress noted.

IPOC Note
Marlene Accardi LPN 5/22/06 00:54 5/22/06 00:54
tube feeding currently at 50cc/hr, pt experiencing large, loose stools x4 since tube feeding started.

NUR Note
Marlene Accardi LPN 5/22/06 07:32 5/22/06 07:33
pt had another large, loose, brown stool. cleaned, repositioned, dressing on L buttocks changed. tube feeding infusing as ordered. IVFs infusing as ordered. no distress noted. report given to oncoming nurse.

IPOC Note
Diana Undertilo,RN 5/22/06 09:20 5/22/06 09:20
Resp therapist may change venti mask to NC to see how pt tolerates r/t 98% on 31% venti mask

IPOC Note
Diana Undertilo,RN 5/22/06 09:21 5/22/06 09:21
ronchi noted upon auscultation

IPOC Note
Diana Undertilo,RN 5/22/06 09:31 5/22/06 09:33
Turned off TF to check residuals. TF was infusing at 50cc/hr. IVF infusing at 60cc/hr. Pt has abd binder covering peg tube. IV HL outdated; multiple attempts; will inform MD. Pt has 31% venti mask applied; resp therapist in room stated sats 98% and will attempt to try NC. Rhonci noted.

IPOC Note
Diana Undertilo,RN 5/22/06 13:24 5/22/06 13:27
Called the kitchen this am for arginade and promode for push into tube but was not delivered so when dietary Patricia Skolnik arrived, I informed her and she went to pick it up for me Will push now. IVPB x 2 hung.

Entered by: | Performed: | Effective: | Status:

DTY Note
Patricia Skolnik,RD 5/22/06 14:13 5/22/06 14:27
Nutrition f/u: Pt on TF's of 1/2 strength Impact 1.5 now @ 60ml/hr, pushes BID of one scoop Promod and one package Arginade in 120ml H2O. This is now providing 1200 kcal, 79g pro, 1802ml free H2O/d.
RN stated low residuals, but pt has had multiple loose stools over the past few days
Labs 5/21: Na 146 (h), CO2 21 (l), Cl 121 (h), BUN 30 (h), Creat 1.5 (h), Ca 7.5 (l).
Chem-8 blood glucose levels 266, 184 (h).
Pt s/p debridement of L hip wound of necrotic SQ and muscle
PLAN: Will change Promod in pushes to Glutasolve to aid /c gut absorption of TF's, will keep TF's @ half-strength for now. THis is inadequate to meet kcal needs, but it is imperitive to insure TF's are being absorbed before goal rate and strength is attempted. Will write verbal order, will f/u @ high nutr risk.

IPOC Note
Patricia Skolnik,RD 5/22/06 14:29 5/22/06 14:29
TF's of Impact 1.5 half strength @ 60ml/hr, pushes BID of one scoop Promod, one pkg Arginade in 120ml H2O. Will change Promod to Glutasolve to aid /c diarrhea and gut absorption. Please see DTY notes for further detail

IPOC Note
Diana Undertilo,RN 5/22/06 17:41 5/22/06 17:43
New bag of TF hung. IVPB's hung per orders. I&O charted.

IPOC Note
Monica Robbins,RRT 5/22/06 18:58 5/22/06 18:58
28% venturi mask

IPOC Note
Diana Undertilo,RN 5/22/06 19:51 5/22/06 19:52
TF hung; med IVP given. IVPB hung.

IPOC Note
Tracy Page,RN 5/23/06 09:45 5/23/06 18:12
pt in the bed with eyes closed, pt does open his eyes with loud verbal stimulation however, immediately closes eyes and keeps them closed. assessment was completed, pt cleaned of incont stool, drsgs intact to hip. pt given pillow support, feet elevated. nad noted, otherwise. will monitor.

IPOC Note
Tracy Page,RN 5/23/06 12:00 5/23/06 18:15
pt cleaned of incont stool, drsg intact. pt repositioned. will monitor.

NUR Note
Jenny Stearns, RN 5/23/06 19:30 5/23/06 22:52
Patient found in bed with eyes closed; pt opens eyes to loud stimuli and responds with garbled responses when asked questions; VSS; call bell within reach; bed low and locked; will continue to monitor

DTY Note
Patricia Skolnik,RD 5/24/06 11:49 5/24/06 11:55
Nutrition f/u: Pt remains on TF if 1/2 strength Impact 1.5 @ 60ml/hr, and pushes BID of one pkg Arginade and one pkg Glutasolve in 120ml H2O. This provides 1330 kcal, 99g pro, 2121ml free H2O/d.
Pt continues to have very loose watery stool per RN. RN also stated pt is to transfer to NH today. Transfer orders written in chart.
Spoke /c MD yesterday regarding TF's, explained this RD's logic behind current formula,/c plans to change to full strength or change formula if pt does not tolerate. MD indicated understand.
Upon transfer, MD ordered pt to have full strength Fibersource HN @ 60 ml/hr /c pushes BID as ordered. This will provide 1978 kcal, 115g pro, 2007 ml free H2O/d to meet needs.
PLAN: Will not change formula as pt is to d/c today. Will f/u if pt remains in hospital.

IPOC Note
Patricia Skolnik,RD 5/24/06 11:56 5/24/06 11:56
Pt to d/c today

Entered by: | Performed: | Effective: | Status:

NUR Note
Jenny Stearns, RN 5/24/06 19:30 5/24/06 22:30
Patient found in bed with eyes closed; pt opens eyes to loud stimuli and responds with unrecognizable words; VSS; call bell within reach; bed low and locked; will continue to monitor

NUR Note
Jenny Stearns, RN 5/25/06 06:55 5/25/06 06:56
Patient checked; VSS; call bell within reach; bed low and locked; report given to next shift

NUR Note
Rachel A Perez,LPN 5/25/06 08:02 5/25/06 08:05
pt resting in bed, responds to tactile/verbal stimuli. 02 full mask inplace, lung fields congested,hob up, peg tf infusing via pump as per orders. foley to bsd with dark yellow urine in drain bag iv site intact/patent. siderails up x3 call bell in reach.contact isolation maintained. will continue to monitor.

IPOC Note
Rebecca Hake Flickinger, CRTT 5/25/06 09:27 5/25/06 09:27
spo2 on 27% venti mask 98% no sob noted strong cough stimulated with oral suction moderate amount thick yellow sputum

NUR Note
Rachel A Perez,LPN 5/25/06 11:36 5/25/06 11:40
pt sounds wet in upper chest. dr suhrer aware. see chart

NUR Note
Rachel A Perez,LPN 5/25/06 14:22 5/25/06 14:25
dr sanito did broch approx 40cc of dark secretions suctioned see note. pt tolerated well, didnot require sedation . pt resting in bed post procedure no distress. 02 sats 96%. will continue to monitor. ss aware pt will not go to select today. discharge canceled.

IPOC Note
Cathy Riley RN 5/25/06 16:04 5/25/06 16:04
no change in assessment, resting in bed with eyes closed

IPOC Note
Rhonda Platt,RN 5/25/06 21:00 5/26/06 00:38
Pt. is lying in bed with eyes closed. He does open eyes to verbal stimuli and attempts to respond, but I cannot understand. Pt. had green BM. Cleaned pt. and turned to left side. Wound care given. See note. O2 sat 95 on venti mask. Will cont. to monitor. Call bell in reach. Bed low and locked.

IPOC Note
Rhonda Platt,RN 5/26/06 00:36 5/26/06 00:36
Changed dressing to left hip. Cleaned with NS. Applied hydrogel gauze and covered. Site had greenish areas inside.

IPOC Note
Rhonda Platt,RN 5/26/06 06:38 5/26/06 06:42
Pt. is lying in bed with eyes closed. He rested well and had an uneventful night resp did NT suction him this am as he had alot of secretions. Turned pt. through the night. Pt. had small brown BM this am. Cleaned pt. and turned pt. to rt. side. VSS. Will cont. to monitor. Call bell in reach. Bed low and locked.

DTY Note
Patricia Skolnik,RD 5/26/06 16:22 5/26/06 16:28
Nutrition f/u: TF's remain, they were changed to Fibersource HN @60ml/hr /c 25ml/hr H2O flushes, pushes BID of one package glutasolve, one package Arginade in 120ml H2O. This now provides 1978 kcal, 115g pro, 1887ml free H2O to meet all needs /x fld needs.
Pt tolerating well, had a BM today that RN described as soft but not diarrhea
Pt s/p bronch. Pt /c GNR, which has held up d/c.
Labs 5/25: Na 149 (h), K 2.8 (l),CL 120 (h), BUN 46 (h), Ca 7.0 (l).
Noted fld boluses of 240ml x3, to provide 720ml free H2O.
Wound care eval noted pt's wound is more regularly shaped, cleaner/c a beefy red color.
PLAN: Verbal order written to increase H2O flushes to 35ml/hr to provide 2127ml free H2O/d to better meet pt's needs.
Will con't to monitor @ high nutritional risk

Entered by:	Performed:	Effective:	Status:

IPOC Note
Patricia Skolnik,RD 5/26/06 16:29 5/26/06 16:29
TF's of Fibersource HN @ 60ml/hr /c pushes BID of arginade and glutasolve in 120ml H2O.

IPOC Note
Rhonda Platt,RN 5/26/06 20:00 5/27/06 02:24
Pt. is lying in bed with eyes open. Audible secretions heard. Resp. NT suctioned large amounts of yellow phlem Pt. tolerated well. Pt. had loose dark brown BM. Cleaned pt. and turned to left side. 0 residual in peg. Gave meds as ordered. Will cont. to monitor. Call bell in reach. Bed low and locked.

IPOC Note
Rhonda Platt,RN 5/27/06 05:30 5/27/06 06:27
Pt. had another BM. Cleaned and turned pt. to right side. Applied baza to bottom. He was turned through the night He had more audible secretions. Resp. NT suctioned and he sounds much better. Sats 95 on venti mask. Will cont. to monitor. Call bell in reach. Bed low and locked.

IPOC Note
Sherry Christensen,RN 5/27/06 09:26 5/27/06 09:27
Pt. lying in bed, eyes open. No symptoms of discomfort at this time.BDR

IPOC Note
Sherry Christensen,RN 5/27/06 16:00 5/27/06 16:02
Reference pt. Arginade, Dietary only had one pack, given to ptBDR

IPOC Note
Sherry Christensen,RN 5/27/06 16:08 5/27/06 16:10
Pt. had dark, liquid BM. Cleaned. BDR

IPOC Note
Rhonda Platt,RN 5/27/06 20:00 5/27/06 21:45
Pt. is lying in bed with eyes closed. No distress noted. VSS. Turned pt. to left side. and repositioned. 0 residual from peg. Tube feeds at 60 cc hour. Will cont. to monitor. Call bell in reach. Bed low and locked.

IPOC Note
Rebecca Hake Flickinger, CRTT 5/28/06 10:04 5/28/06 10:04
spo2 on 28% venti mask 95% no sob decreased breath sounds no rhonchi at this time

IPOC Note
Laura Murphy,LPN 5/28/06 13:52 5/28/06 13:52
left hip dsg dry and intact,calazime lotipn applied to buttocks and perineal area

IPOC Note
Laura Murphy,LPN 5/28/06 13:53 5/28/06 13:53
CONT.ON TF

NUR Note
Laura Murphy,LPN 5/28/06 13:53 5/28/06 13:53
Incontinent of lg amt dark greenish stool

IPOC Note
Tena Priester,LPN 5/28/06 19:11 5/28/06 19:11
drsing to left hip changed as ordered. with no drainage noted but slimy green tissue noted

IPOC Note
Stephanie Butterfield,RN 5/28/06 22:00 5/29/06 00:26
pt resting, vitals stable, pt repositioned in bed, incontentinent care given, pt had med loose stool, sr on tele, pt has general swelling, no distress noted, sats 94%, on mask, will monitor pt

IPOC Note
Jane Wilson,RN 5/29/06 10:00 5/29/06 10:02
Pt in bed. Pt speaks very little when spoken to. Pt on 28% venti-mask his sat is 99%. DSG to hip is dry and intact with no drainage nor bleeding noted. call light within reach and will continue to monitor,

Entered by:	Performed:	Effective:	Status:
IPOC Note			
Jane Wilson,RN	5/29/06 14:09	5/29/06 14:12	

1100 reposition patient. Pt voices no complaints. will continue to monitior.
1330 reposition pt. will continue to monitor. Flushes PEG with 120cc per md orders. PEG feeding going with no problem call light within reach and will continue to monitor

NUR Note			
Jenny Stearns, RN	5/29/06 19:30	5/29/06 23:00	

Patient found resting in bed; voicing no complaints and in no apparent distress; VSS; O2 @2L via nc; call bell within reach; bed low and locked; will continue to monitor.

NUR Note			
Jenny Stearns, RN	5/29/06 20:45	5/30/06 02:40	

First Unit of PRBC's started

NUR Note			
Jenny Stearns, RN	5/29/06 23:30	5/30/06 02:41	

First unit of PRBC's infused; patient tolerated well and no evidence of reaction shown

NUR Note			
Jenny Stearns, RN	5/30/06 01:30	5/30/06 07:10	

Second unit of PRBC's started.

NUR Note			
Jenny Stearns, RN	5/30/06 04:30	5/30/06 07:12	

Second unit of PRBC's infused. Patient tolerated well; no evidence of reaction; will continue to monitor.

IPOC Note			
Sherry Christensen,RN	5/30/06 08:46	5/30/06 08:47	

Pt. sleeping comfortably in bed. More lucid this assessment. No s/s of pain. BDR

IPOC Note			
Rebecca Hake Flickinger, CRTT	5/30/06 09:54	5/30/06 09:54	

spo2 on 2lpm 97% no sob decreased

NUR Note			
Jenny Stearns, RN	5/30/06 19:30	5/30/06 22:52	

Patient found resting in bed; voicing no complaints and in no apparent distress; VSS; call bell within reach; bed low and locked; will continue to monitor.

NUR Note			
Jenny Stearns, RN	5/31/06 06:45	5/31/06 07:19	

Patient's blood sugar checked and was 56; pt has no signs and symptoms of hypoglycemia, 1/2 amp of D50 pushed; patient tolerated well; will continue to monitor.

NUR Note			
Jenny Stearns, RN	5/31/06 07:15	5/31/06 07:20	

Patient's blood sugar rechecked and was 102; will continue to monitor.

NUR Note			
Jenny Stearns, RN	5/31/06 07:24	5/31/06 07:25	

Patient found resting in bed; voicing no complaints and in no apparent distress; VSS; no change in status from beginning of shift; call bell within reach; bed low and locked; will continue to monitor

IPOC Note			
Sherry Christensen,RN	5/31/06 07:30	5/31/06 16:40	

pt alert to nurse in room, no c/o voiced. TF on hold for EGD and Colonoscopy this p.m.

IPOC Note			
Sherry Christensen,RN	5/31/06 16:40	5/31/06 16:41	

See consent for info on phone consent for EGD and Colonoscopy this pm

Entered by: | Performed: | Effective: | Status:

IPOC Note

Patricia Morell, RD 5/31/06 18:10 5/31/06 18:10

late entry for 5/30. Arginaid not available tod, should be in on Thrus. Spoke with pt's nurse, Bob regarding this. To cont to give Glutamine pushes in 120 ml water b.i.b. TF regime without Arginaid will still provide pt with 1908 cal and 106 gm pro, meeting his estimated needs. This is from Fibersource HN @ 60 ml/hr with 35 ml/hr flushes. labs, low: H/H 9.4/28.5. Hi: Na 149, Cl 114, glu 142, bun 43-incr. Cr wnl. Given 2 u pRBC. O2 @ 2Lpm. There are now 3 wounds, Lt hip pres ulcer, ankle wound has opened up, and lowere back pres ulcer. Pt ordered CL and Golytely down fdg tube today to prepare for c-scope tomorrow. stooling will f/u for results of colonoscopy.

IPOC Note

Patricia Morell, RD 5/31/06 18:11 5/31/06 18:11

Just back from c-scope and being cleaned when attempted to see. Scope showed diverticula which are being bx. C-scope done 2° to 3 heme in stool and anemia. TF not yet resumed. Stooling.

NUR Note

Jenny Stearns, RN 5/31/06 19:30 6/1/06 01:24

Patient found resting in bed; voicing no complaints and in no apparent distress; VSS; call bell withinreach; bed low and locked; will continue to monitor.

Plan of Care

Entered	User Name	Permission Action	Details
5/16/06 06:43	*Ashley Hamilton, RRT (hamila)*	Add/Edit Plan of Care	Added Care Plan Medical Diagnosis: Hypoxemia. Low Priority. EO: Improvement in Oxygen saturation, Target Date: 05/18/2006 Indicator: Oxygenation Status.
5/16/06 06:43	*Ashley Hamilton, RRT (hamila)*	Add/Edit Plan of Care	Added Care Plan Need: bronchodilation. Low Priority. Goal: Improves and maintains breath sounds and respiratory pattern within patients normal parameters. Target Date: 05/18/2006 Indicator: Breath sounds consistant with patient's baseline. Indicator: No adventitious breath sounds..
5/16/06 09:53	*Ernie Bargeron,RRT (bargee)*	Evaluate Goal	Reviewed Goal Goal on bronchodilation care plan. Goal: Improves and maintains breath sounds and respiratory pattern within patients normal parameters. Progress: updated to Unchanged. Status: Not Met. Target Date: 05/18/2006 (no change).
5/16/06 09:53	*Ernie Bargeron,RRT (bargee)*	Evaluate Plan of Care	Reviewed Care Plan for bronchodilation. Priority: LOW, Status: ACT.
5/16/06 13:38	*Jennifer Halupa,SocialWork,QOM (halupj)*	Add/Edit Plan of Care	Added Care Plan Need: Discharge Plan. High Priority. Goal: Patients discharge needs addressed, Target Date: Unspecified. Indicator: Discuss and review discharge plan with patient
5/16/06 13:38	*Jennifer Halupa,SocialWork,QOM (halupj)*	Evaluate Plan of Care	Reviewed Care Plan for Discharge Plan. Priority: HIGH. Status: ACT.
5/16/06 13:40	*Jennifer Halupa,SocialWork,QOM (halupj)*	Evaluate Plan of Care	Reviewed Care Plan for Discharge Plan. Priority: HIGH. Status: ACT.
5/17/06 09:28	*Rebecca Hake Flickinger, CRTT (flickr)*	Evaluate Plan of Care	Reviewed Care Plan for bronchodilation. Priority: LOW. Status: ACT.
5/17/06 17:11	*Patricia Skolnik,RD (skolnp)*	Add/Edit Plan of Care	Added Care Plan Problem: Nutritional deficit. High Priority. Goal: Patient will tolerate diet advancement, Target Date: Unspecified.
5/18/06 15:15	*Anna Sheets,RRT (sheeta)*	Evaluate Indicator	Reviewed indicator on care plan for bronchodilation, Goal: Improves and maintains breath sounds and respiratory pattern within patients normal parameters. Indicator: No adventitious breath sounds.. Evaluation: rhonchi Relevant data: decreased in All lobes, rhonchi auscultated in RLL, and RML, 5/18/2006 12:00 decreased in All lobes. 5/18/2006 12:00 decreased in All lobes. rhonchi auscultated in All lobes. 5/18/2006 07:40

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Entered	User Name	Permission Action	Details
5/18/06 15:15	*Anna Sheets,RRT (sheeta)*	Evaluate Plan of Care	Reviewed Care Plan for bronchodilation. Priority: Changed from 'LOW' to 'MOD'. Status: ACT.
5/18/06 15:15	*Anna Sheets,RRT (sheeta)*	Evaluate Indicator	Reviewed indicator on care plan for bronchodilation, Goal: Improves and maintains breath sounds and respiratory pattern within patients normal parameters. Indicator: Breath sounds consistant with patient's baseline. Evaluation: decreased. Relevant data: decreased in All lobes. rhonchi auscultated in RLL, and RML. 5/18/2006 12:00 decreased in All lobes. 5/18/2006 12:00 decreased in All lobes. rhonchi auscultated in All lobes. 5/18/2006 07:40
5/18/06 15:15	*Anna Sheets,RRT (sheeta)*	Evaluate Goal	Reviewed Goal Goal on bronchodilation care plan. Goal: Improves and maintains breath sounds and respiratory pattern within patients normal parameters. Progress: changed from Unchanged to Declining. Status: Not Met. Target Date: 05/18/2006 (no change).
5/18/06 15:16	*Anna Sheets,RRT (sheeta)*	Evaluate Goal	Reviewed Goal Expected Outcome on Hypoxemia care plan. Expected Outcome: Improvement in Oxygen saturation. Progress: updated to Unchanged. Status: Not Met. Target Date: 05/18/2006 (no change).
5/18/06 15:16	*Anna Sheets,RRT (sheeta)*	Evaluate Indicator	Reviewed indicator on care plan for Hypoxemia, Expected Outcome: Improvement in Oxygen saturation Indicator: Oxygenation Status. Evaluation: 88% room air 91% venti-50%. Relevant data: 100% 5/16/2006 04:10 99 % 5/16/2006 02:30 100% 5/15/2006 16:44
5/18/06 15:16	*Anna Sheets,RRT (sheeta)*	Evaluate Plan of Care	Reviewed Care Plan for Hypoxemia. Priority: Changed from 'LOW' to 'MOD'. Status: ACT.
5/18/06 15:42	*Patricia Skolnik,RD (skolnp)*	Add/Edit Goal	Added Goal to Nutritional deficit with Target Date: Not Specified.
5/18/06 15:42	*Patricia Skolnik,RD (skolnp)*	Evaluate Plan of Care	Reviewed Care Plan for Nutritional deficit. Priority: HIGH. Status: ACT.
5/19/06 16:15	*Patricia Skolnik,RD (skolnp)*	Evaluate Goal	Reviewed Goal Goal on Nutritional deficit care plan. Goal: Patient will tolerate tube feedings. Progress: updated to Unchanged. Status: Not Met. Target Date: n/a.
5/19/06 16:15	*Patricia Skolnik,RD (skolnp)*	Evaluate Plan of Care	Reviewed Care Plan for Nutritional deficit. Priority: HIGH. Status: ACT.

Entered	User Name	Permission Action	Details
5/20/06 00:10	*Katica Foreman RN (foreka)*	Evaluate Goal	Reviewed Goal Goal on Nutritional deficit care plan. Goal: Patient will tolerate diet advancement. Progress: updated to Unchanged. Status: Not Met. Target Date: n/a.
5/20/06 00:10	*Katica Foreman RN (foreka)*	Evaluate Plan of Care	Reviewed Care Plan for Nutritional deficit. Priority: HIGH. Status: ACT.
5/20/06 00:10	*Katica Foreman RN (foreka)*	Evaluate Goal	Reviewed Goal Goal on Nutritional deficit care plan. Goal: Patient will tolerate tube feedings. Progress: Unchanged (no change). Status: Not Met. Target Date: n/a.
5/20/06 09:24	*James Manahan, RRT (manahj)*	Evaluate Indicator	Reviewed indicator on care plan for bronchodilation. Goal: Improves and maintains breath sounds and respiratory pattern within patients normal parameters. Indicator: No adventitious breath sounds. Evaluation: bbs-rhonchi. Relevant data: Breath sounds decreased in all lobes. Fine crackles auscultated in all lobes. 5/20/2006 08:00 decreased in LLL, and RLL anteriorly. 5/20/2006 03:00 decreased in LLL, and RLL anteriorly. 5/19/2006 23:15
5/20/06 09:24	*James Manahan, RRT (manahj)*	Evaluate Plan of Care	Reviewed Care Plan for bronchodilation. Priority: MOD. Status: ACT.
5/20/06 09:24	*James Manahan, RRT (manahj)*	Evaluate Goal	Reviewed Goal Goal on bronchodilation care plan. Goal: Improves and maintains breath sounds and respiratory pattern within patients normal parameters. Progress: changed from Declining to Unchanged. Status: Not Met. Target Date: 05/18/2006 (no change).
5/20/06 09:25	*James Manahan, RRT (manahj)*	Evaluate Plan of Care	Reviewed Care Plan for Hypoxemia. Priority: MOD. Status: ACT.
5/20/06 09:25	*James Manahan, RRT (manahj)*	Evaluate Goal	Reviewed Goal Expected Outcome on Hypoxemia care plan. Expected Outcome: Improvement in Oxygen saturation. Progress: Unchanged (no change). Status: Not Met. Target Date: 05/18/2006 (no change).
5/20/06 09:25	*James Manahan, RRT (manahj)*	Evaluate Indicator	Reviewed indicator on care plan for Hypoxemia, Expected Outcome: Improvement in Oxygen saturation Indicator: Oxygenation Status. Evaluation: sats 99% 40%. Relevant data: 100% 5/16/2006 04:10 99 % 5/16/2006 02:30 100% 5/15/2006 16:44
5/20/06 20:53	*Jim Mingus,RN (minguj)*	Evaluate Plan of Care	Reviewed Care Plan for Discharge Plan. Priority: HIGH. Status: ACT.

Entered	User Name	Permission Action	Details
5/20/06 20:53	*Jim Mingus,RN (minguj)*	Evaluate Goal	Reviewed Goal Goal on Discharge Plan care plan. Goal: Patients discharge needs addressed. Progress: updated to Unchanged. Status: Not Met. Target Date: n/a.
5/21/06 09:15	*Ernie Bargeron,RRT (bargee)*	Evaluate Plan of Care	Reviewed Care Plan for bronchodilation. Priority: MOD. Status: ACT.
5/21/06 09:15	*Ernie Bargeron,RRT (bargee)*	Evaluate Goal	Reviewed Goal Goal on bronchodilation care plan. Goal: Improves and maintains breath sounds and respiratory pattern within patients normal parameters. Progress: Unchanged (no change). Status: Not Met. Target Date: 05/18/2006 (no change).
5/21/06 09:15	*Ernie Bargeron,RRT (bargee)*	Evaluate Goal	Reviewed Goal Expected Outcome on Hypoxemia care plan. Expected Outcome: Improvement in Oxygen saturation. Progress: Unchanged (no change). Status: Not Met. Target Date: 05/18/2006 (no change).
5/21/06 09:15	*Ernie Bargeron,RRT (bargee)*	Evaluate Plan of Care	Reviewed Care Plan for Hypoxemia. Priority: MOD. Status: ACT.
5/21/06 11:48	*Shannon Schander,RN (schans)*	Add/Edit Plan of Care	Added Care Plan Nursing Diagnosis: Care for the patient with skin breakdown. High Priority. EO: Nursing staff promptly recognizes, assesses, and intervenes to prevent skin breakdown., Target Date: Unspecified. Indicator: Wound care per wound care nurse,.
5/22/06 00:52	*Marlene Accardi LPN (accarm)*	Evaluate Goal	Reviewed Goal Goal on Discharge Plan care plan. Goal: Patients discharge needs addressed. Progress: Unchanged (no change). Status: Not Met. Target Date: n/a.
5/22/06 00:52	*Marlene Accardi LPN (accarm)*	Evaluate Plan of Care	Reviewed Care Plan for Discharge Plan. Priority: HIGH. Status: ACT.
5/22/06 00:54	*Marlene Accardi LPN (accarm)*	Evaluate Plan of Care	Reviewed Care Plan for Nutritional deficit. Priority: HIGH. Status: ACT.
5/22/06 09:20	*Diana Undertilo,RN (underd)*	Evaluate Indicator	Reviewed indicator on care plan for Hypoxemia, Expected Outcome: Improvement in Oxygen saturation. Indicator: Oxygenation Status. Evaluation: 96-98%; resp therapist checked. Relevant data: 100% 5/16/2006 04:10 99 % 5/16/2006 02:30 100% 5/15/2006 16:44
5/22/06 09:20	*Diana Undertilo,RN (underd)*	Evaluate Plan of Care	Reviewed Care Plan for Hypoxemia. Priority: MOD. Status: ACT.
5/22/06 09:20	*Diana Undertilo,RN (underd)*	Evaluate Goal	Reviewed Goal Expected Outcome on Hypoxemia care plan. Expected Outcome: Improvement in Oxygen saturation. Progress: changed from Unchanged to Improving. Status: Not Met. Target Date: 05/18/2006 (no change).

Entered	User Name	Permission Action	Details
5/22/06 09:21	*Diana Undertilo,RN (underd)*	Evaluate Indicator	Reviewed indicator on care plan for bronchodilation, Goal: Improves and maintains breath sounds and respiratory pattern within patients normal parameters. Indicator: No adventitious breath sounds.. Evaluation: ronchi. Relevant data: decreased in all lobes. rhonchi auscultated in LUL, and RUL. 5/22/2006 04:00 Rhonchi auscultated in all lobes. Expiratory wheezes auscultated in RLL, RML, and RUL. 5/21/2006 20:00 expiratory wheezes auscultated in all lobes. 5/21/2006 23:49
5/22/06 09:21	*Diana Undertilo,RN (underd)*	Evaluate Plan of Care	Reviewed Care Plan for bronchodilation. Priority: MOD. Status: ACT.
5/22/06 09:21	*Diana Undertilo,RN (underd)*	Evaluate Goal	Reviewed Goal Goal on bronchodilation care plan. Goal: Improves and maintains breath sounds and respiratory pattern within patients normal parameters. Progress: Unchanged (no change). Status: Not Met. Target Date: 05/18/2006 (no change).
5/22/06 14:29	*Patricia Skolnik,RD (skolnp)*	Evaluate Goal	Reviewed Goal Goal on Nutritional deficit care plan. Goal: Patient will tolerate tube feedings. Progress: Unchanged (no change). Status: Not Met. Target Date: n/a.
5/22/06 14:29	*Patricia Skolnik,RD (skolnp)*	Evaluate Plan of Care	Reviewed Care Plan for Nutritional deficit. Priority: HIGH. Status: ACT.
5/22/06 18:58	*Monica Robbins,RRT (robbim)*	Evaluate Plan of Care	Reviewed Care Plan for Hypoxemia. Priority: MOD. Status: ACT.
5/22/06 18:58	*Monica Robbins,RRT (robbim)*	Evaluate Goal	Reviewed Goal Expected Outcome on Hypoxemia care plan. Expected Outcome: Improvement in Oxygen saturation Progress: Improving (no change). Status: Not Met. Target Date: 05/18/2006 (no change).
5/23/06 09:48	*Tracy Page,RN (pagetr)*	Evaluate Indicator	Reviewed indicator on care plan for Care for the patient with skin breakdown., Expected Outcome: Nursing staff promptly recognizes, assesses, and intervenes to prevent skin breakdown. Indicator: Wound care per wound care nurse.. Evaluation: yes.
5/23/06 09:48	*Tracy Page,RN (pagetr)*	Evaluate Indicator	Reviewed indicator on care plan for Care for the patient with skin breakdown, Expected Outcome: Nursing staff promptly recognizes, assesses, and intervenes to prevent skin breakdown. Indicator: Wound care per wound care nurse.. Evaluation: yes.

Entered	User Name	Permission Action	Details
5/23/06 09:49	*Tracy Page,RN (pagetr)*	Evaluate Indicator	Reviewed indicator on care plan for Care for the patient with skin breakdown., Expected Outcome: Nursing staff promptly recognizes, assesses, and intervenes to prevent skin breakdown., Indicator: Wound care per wound care nurse., Evaluation: yes.
5/23/06 09:49	*Tracy Page,RN (pagetr)*	Evaluate Plan of Care	Reviewed Care Plan for Care for the patient with skin breakdown. Priority: HIGH. Status: ACT.
5/23/06 09:49	*Tracy Page,RN (pagetr)*	Evaluate Goal	Reviewed Goal Expected Outcome on Care for the patient with skin breakdown care plan. Expected Outcome: Nursing staff promptly recognizes, assesses, and intervenes to prevent skin breakdown., Progress: updated to Unchanged. Status: Not Met. Target Date: n/a.
5/23/06 09:49	*Tracy Page,RN (pagetr)*	Evaluate Goal	Reviewed Goal Goal on Nutritional deficit care plan. Goal: Patient will tolerate diet advancement. Progress: changed from Unchanged to Declining. Status: Not Met. Target Date: n/a.
5/23/06 09:49	*Tracy Page,RN (pagetr)*	Evaluate Goal	Reviewed Goal Goal on Nutritional deficit care plan. Goal: Patient will tolerate tube feedings. Progress: changed from Unchanged to Improving. Status: Not Met. Target Date: n/a.
5/23/06 09:49	*Tracy Page,RN (pagetr)*	Evaluate Plan of Care	Reviewed Care Plan for Nutritional deficit. Priority: HIGH. Status: ACT.
5/23/06 09:51	*Tracy Page,RN (pagetr)*	Evaluate Goal	Reviewed Goal Goal on Discharge Plan care plan. Goal: Patients discharge needs addressed. Progress: changed from Unchanged to Improving. Status: Not Met. Target Date: n/a.
5/23/06 09:51	*Tracy Page,RN (pagetr)*	Evaluate Indicator	Reviewed indicator on care plan for Discharge Plan, Goal: Patients discharge needs addressed. Indicator: Discuss and review discharge plan with patient Evaluation: no family in the room.
5/23/06 09:51	*Tracy Page,RN (pagetr)*	Evaluate Plan of Care	Reviewed Care Plan for Discharge Plan. Priority: HIGH. Status: ACT.
5/23/06 09:52	*Tracy Page,RN (pagetr)*	Evaluate Goal	Reviewed Goal Goal on bronchodilation care plan. Goal: Improves and maintains breath sounds and respiratory pattern within patients normal parameters. Progress: changed from Unchanged to Declining. Status: Not Met. Target Date: 05/18/2006 (no change).
5/23/06 09:52	*Tracy Page,RN (pagetr)*	Evaluate Plan of Care	Reviewed Care Plan for bronchodilation. Priority: MOD. Status: ACT.

Entered	User Name	Permission Action	Details
5/23/06 09:53	*Tracy Page,RN (pagetr)*	Evaluate Indicator	Reviewed indicator on care plan for Hypoxemia, Expected Outcome Improvement in Oxygen saturation Indicator: Oxygenation Status Evaluation: 97. Relevant data: 100% 5/16/2006 04:10 99 % 5/16/2006 02:30 100% 5/15/2006 16:44
5/23/06 09:53	*Tracy Page,RN (pagetr)*	Evaluate Goal	Reviewed Goal Expected Outcome on Hypoxemia care plan. Expected Outcome: Improvement in Oxygen saturation. Progress: changed from Improving to Unchanged. Status: Not Met. Target Date: 05/18/2006 (no change).
5/23/06 09:53	*Tracy Page,RN (pagetr)*	Evaluate Plan of Care	Reviewed Care Plan for Hypoxemia Priority: MOD. Status: ACT.
5/23/06 09:56	*Jason Webb, CRT (webbja)*	Evaluate Goal	Reviewed Goal Goal on bronchodilation care plan. Goal: Improves and maintains breath sounds and respiratory pattern within patients normal parameters. Progress: changed from Declining to Unchanged. Status: Not Met. Target Date: 05/18/2006 (no change).
5/23/06 09:56	*Jason Webb, CRT (webbja)*	Evaluate Plan of Care	Reviewed Care Plan for bronchodilation. Priority: MOD. Status: ACT.
5/23/06 09:57	*Jason Webb, CRT (webbja)*	Evaluate Plan of Care	Reviewed Care Plan for Hypoxemia. Priority: MOD. Status: ACT.
5/23/06 09:57	*Jason Webb, CRT (webbja)*	Evaluate Goal	Reviewed Goal Expected Outcome on Hypoxemia care plan. Expected Outcome: Improvement in Oxygen saturation Progress: Unchanged (no change). Status: Not Met. Target Date: 05/18/2006 (no change).
5/24/06 09:54	*Jason Webb, CRT (webbja)*	Evaluate Goal	Reviewed Goal Goal on bronchodilation care plan. Goal: Improves and maintains breath sounds and respiratory pattern within patients normal parameters. Progress: Unchanged (no change). Status: Not Met. Target Date: 05/18/2006 (no change).
5/24/06 09:54	*Jason Webb, CRT (webbja)*	Evaluate Plan of Care	Reviewed Care Plan for bronchodilation. Priority: MOD. Status: ACT.
5/24/06 09:54	*Jason Webb, CRT (webbja)*	Evaluate Goal	Reviewed Goal Expected Outcome on Hypoxemia care plan. Expected Outcome: Improvement in Oxygen saturation. Progress: Unchanged (no change). Status: Not Met. Target Date: 05/18/2006 (no change).
5/24/06 09:54	*Jason Webb, CRT (webbja)*	Evaluate Plan of Care	Reviewed Care Plan for Hypoxemia Priority: MOD. Status: ACT.
5/24/06 11:56	*Patricia Skolnik,RD (skolnp)*	Evaluate Plan of Care	Reviewed Care Plan for Nutritional deficit. Priority: HIGH. Status: ACT.

Entered	User Name	Permission Action	Details
5/24/06 22:27	*Jenny Stearns, RN (steaje)*	Evaluate Goal	Reviewed Goal Expected Outcome on Care for the patient with skin breakdown care plan. Expected Outcome: Nursing staff promptly recognizes, assesses, and intervenes to prevent skin breakdown. Progress: Unchanged (no change). Status: Not Met. Target Date: n/a.
5/24/06 22:27	*Jenny Stearns, RN (steaje)*	Evaluate Plan of Care	Reviewed Care Plan for Care for the patient with skin breakdown. Priority: HIGH. Status: ACT.
5/24/06 22:27	*Jenny Stearns, RN (steaje)*	Evaluate Goal	Reviewed Goal Goal on Discharge Plan care plan. Goal: Patients discharge needs addressed. Progress: Improving (no change). Status: Not Met. Target Date: n/a.
5/24/06 22:27	*Jenny Stearns, RN (steaje)*	Evaluate Plan of Care	Reviewed Care Plan for Discharge Plan. Priority: HIGH. Status: ACT.
5/25/06 01:40	*Jenny Stearns, RN (steaje)*	Evaluate Plan of Care	Reviewed Care Plan for Care for the patient with skin breakdown. Priority: HIGH. Status: ACT.
5/25/06 01:40	*Jenny Stearns, RN (steaje)*	Evaluate Goal	Reviewed Goal Expected Outcome on Care for the patient with skin breakdown care plan. Expected Outcome: Nursing staff promptly recognizes, assesses, and intervenes to prevent skin breakdown. Progress: Unchanged (no change). Status: Not Met. Target Date: n/a.
5/25/06 01:40	*Jenny Stearns, RN (steaje)*	Evaluate Plan of Care	Reviewed Care Plan for Nutritional deficit. Priority: HIGH. Status: ACT.
5/25/06 01:40	*Jenny Stearns, RN (steaje)*	Evaluate Goal	Reviewed Goal Goal on Nutritional deficit care plan. Goal: Patient will tolerate tube feedings. Progress: Improving (no change). Status: Not Met. Target Date: n/a.
5/25/06 01:40	*Jenny Stearns, RN (steaje)*	Evaluate Goal	Reviewed Goal Goal on Nutritional deficit care plan. Goal: Patient will tolerate diet advancement. Progress: Declining (no change). Status: Not Met. Target Date: n/a.
5/25/06 01:40	*Jenny Stearns, RN (steaje)*	Evaluate Plan of Care	Reviewed Care Plan for Discharge Plan. Priority: HIGH. Status: ACT.
5/25/06 01:40	*Jenny Stearns, RN (steaje)*	Evaluate Goal	Reviewed Goal Goal on Discharge Plan care plan. Goal: Patients discharge needs addressed. Progress: Improving (no change). Status: Not Met. Target Date: n/a.
5/25/06 01:41	*Jenny Stearns, RN (steaje)*	Evaluate Plan of Care	Reviewed Care Plan for bronchodilation. Priority: MOD. Status: ACT.
5/25/06 01:41	*Jenny Stearns, RN (steaje)*	Evaluate Goal	Reviewed Goal Goal on bronchodilation care plan. Goal: Improves and maintains breath sounds and respiratory pattern within patients normal parameters. Progress: Unchanged (no change). Status: Not Met. Target Date: 05/18/2006 (no change).

Entered	User Name	Permission Action	Details
5/25/06 01:41	*Jenny Stearns, RN (steaje)*	Evaluate Goal	Reviewed Goal Expected Outcome on Hypoxemia care plan. Expected Outcome: Improvement in Oxygen saturation. Progress: Unchanged (no change). Status: Not Met. Target Date: 05/18/2006 (no change).
5/25/06 01:41	*Jenny Stearns, RN (steaje)*	Evaluate Plan of Care	Reviewed Care Plan for Hypoxemia Priority: MOD. Status: ACT.
5/25/06 09:27	*Rebecca Hake Flickinger, CRTT (flickr)*	Evaluate Plan of Care	Reviewed Care Plan for bronchodilation. Priority: MOD. Status: ACT.
5/26/06 00:36	*Rhonda Platt,RN (plattr)*	Evaluate Plan of Care	Reviewed Care Plan for Care for the patient with skin breakdown. Priority: HIGH. Status: ACT.
5/26/06 00:36	*Rhonda Platt,RN (plattr)*	Evaluate Goal	Reviewed Goal Expected Outcome on Care for the patient with skin breakdown. care plan. Expected Outcome: Nursing staff promptly recognizes, assesses, and intervenes to prevent skin breakdown.. Progress: Unchanged (no change). Status: Not Met. Target Date: n/a.
5/26/06 00:39	*Rhonda Platt,RN (plattr)*	Evaluate Plan of Care	Reviewed Care Plan for Hypoxemia Priority: MOD. Status: ACT.
5/26/06 00:39	*Rhonda Platt,RN (plattr)*	Evaluate Goal	Reviewed Goal Expected Outcome on Hypoxemia care plan. Expected Outcome: Improvement in Oxygen saturation. Progress: Unchanged (no change). Status: Not Met. Target Date: 05/18/2006 (no change).
5/26/06 00:39	*Rhonda Platt,RN (plattr)*	Evaluate Indicator	Reviewed indicator on care plan for Hypoxemia, Expected Outcome: Improvement in Oxygen saturation Indicator: Oxygenation Status. Evaluation: 95 on 28% venti mask. Relevant data: 100% 5/16/2006 04:10 99 % 5/16/2006 02:30 100% 5/15/2006 16:44
5/26/06 16:29	*Patricia Skolnik,RD (skolnp)*	Evaluate Goal	Reviewed Goal Goal on Nutritional deficit care plan. Goal: Patient will tolerate tube feedings. Progress: Improving (no change). Status: Not Met. Target Date: n/a.
5/26/06 16:29	*Patricia Skolnik,RD (skolnp)*	Evaluate Plan of Care	Reviewed Care Plan for Nutritional deficit. Priority: HIGH. Status: ACT.
5/26/06 17:49	*Michael Yates, RRT (yatesm)*	Evaluate Plan of Care	Reviewed Care Plan for bronchodilation. Priority: MOD. Status: ACT.
5/26/06 17:49	*Michael Yates, RRT (yatesm)*	Evaluate Goal	Reviewed Goal Goal on bronchodilation care plan. Goal: Improves and maintains breath sounds and respiratory pattern within patients normal parameters. Progress: changed from Unchanged to Declining. Status: Not Met. Target Date: changed from 05/18/2006 to 05/28/2006.

Entered	User Name	Permission Action	Details
5/26/06 17:50	*Michael Yates, RRT (yatesm)*	Evaluate Goal	Reviewed Goal Expected Outcome on Hypoxemia care plan. Expected Outcome: Improvement in Oxygen saturation. Progress: changed from Unchanged to Improving. Status: Not Met. Target Date: changed from 05/18/2006 to 05/28/2006.
5/26/06 17:50	*Michael Yates, RRT (yatesm)*	Evaluate Plan of Care	Reviewed Care Plan for Hypoxemia Priority: Changed from 'MOD' to 'LOW'. Status: ACT.
5/27/06 10:35	*Anna Sheets,RRT (sheeta)*	Evaluate Indicator	Reviewed indicator on care plan for bronchodilation, Goal: Improves and maintains breath sounds and respiratory pattern within patients normal parameters. Indicator: No adventitious breath sounds. Evaluation: rhonchi. Relevant data: decreased in all lobes. rhonchi auscultated in LLL, and RLL. 5/27/2006 08:20 decreased in all lobes. rhonchi auscultated in LLL, RLL, and RML. 5/27/2006 08:20 Rhonchi auscultated in all lobes. 5/27/2006 08:00
5/27/06 10:35	*Anna Sheets,RRT (sheeta)*	Evaluate Indicator	Reviewed indicator on care plan for bronchodilation, Goal: Improves and maintains breath sounds and respiratory pattern within patients normal parameters. Indicator: Breath sounds consistant with patient's baseline. Evaluation: decreased. Relevant data: decreased in all lobes. rhonchi auscultated in LLL, and RLL. 5/27/2006 08:20 decreased in all lobes. rhonchi auscultated in LLL, RLL, and RML. 5/27/2006 08:20 Rhonchi auscultated in all lobes. 5/27/2006 08:00
5/27/06 10:35	*Anna Sheets,RRT (sheeta)*	Evaluate Goal	Reviewed Goal Goal on bronchodilation care plan. Goal: Improves and maintains breath sounds and respiratory pattern within patients normal parameters. Progress: changed from Declining to Unchanged. Status: Not Met. Target Date: 05/28/2006 (no change).
5/27/06 10:35	*Anna Sheets,RRT (sheeta)*	Evaluate Plan of Care	Reviewed Care Plan for bronchodilation. Priority: MOD. Status: ACT.
5/27/06 10:36	*Anna Sheets,RRT (sheeta)*	Evaluate Plan of Care	Reviewed Care Plan for Hypoxemia. Priority: LOW. Status: ACT.
5/27/06 10:36	*Anna Sheets,RRT (sheeta)*	Evaluate Indicator	Reviewed indicator on care plan for Hypoxemia, Expected Outcome: Improvement in Oxygen saturation Indicator: Oxygenation Status. Evaluation: 92% 28% venti. Relevant data: 100% 5/16/2006 04:10 99 % 5/16/2006 02:30 100% 5/15/2006 16:44

Entered	User Name	Permission Action	Details
5/27/06 10:36	*Anna Sheets,RRT (sheeta)*	Evaluate Goal	Reviewed Goal Expected Outcome on Hypoxemia care plan. Expected Outcome: Improvement in Oxygen saturation. Progress: Improving (no change). Status: Not Met. Target Date: 05/28/2006 (no change).
5/28/06 10:04	*Rebecca Hake Flickinger, CRTT (flickr)*	Evaluate Plan of Care	Reviewed Care Plan for bronchodilation. Priority: MOD. Status: ACT.
5/28/06 13:52	*Laura Murphy,LPN (murphl)*	Evaluate Indicator	Reviewed indicator on care plan for Care for the patient with skin breakdown., Expected Outcome: Nursing staff promptly recognizes, assesses, and intervenes to prevent skin breakdown.. Indicator: Wound care per wound care nurse.. Evaluation: being seen by WCN.
5/28/06 13:52	*Laura Murphy,LPN (murphl)*	Evaluate Plan of Care	Reviewed Care Plan for Care for the patient with skin breakdown. Priority: HIGH. Status: ACT.
5/28/06 13:52	*Laura Murphy,LPN (murphl)*	Evaluate Goal	Reviewed Goal Expected Outcome on Care for the patient with skin breakdown. care plan. Expected Outcome: Nursing staff promptly recognizes, assesses, and intervenes to prevent skin breakdown.. Progress: Unchanged (no change). Status: Not Met. Target Date: n/a.
5/28/06 13:53	*Laura Murphy,LPN (murphl)*	Evaluate Goal	Reviewed Goal Goal on Nutritional deficit care plan. Goal: Patient will tolerate diet advancement. Progress: changed from Declining to Improving Status: Not Met. Target Date: n/a.
5/28/06 13:53	*Laura Murphy,LPN (murphl)*	Evaluate Goal	Reviewed Goal Goal on Nutritional deficit care plan. Goal: Patient will tolerate tube feedings. Progress: Improving (no change). Status: Not Met. Target Date: n/a.
5/28/06 13:53	*Laura Murphy,LPN (murphl)*	Evaluate Plan of Care	Reviewed Care Plan for Nutritional deficit. Priority: HIGH. Status: ACT.
5/28/06 19:11	*Tena Priester,LPN (priest)*	Evaluate Plan of Care	Reviewed Care Plan for Care for the patient with skin breakdown.. Priority: HIGH. Status: ACT.
5/29/06 09:41	*Ernie Bargeron,RRT (bargee)*	Evaluate Plan of Care	Reviewed Care Plan for bronchodilation. Priority: MOD. Status: ACT.
5/29/06 09:41	*Ernie Bargeron,RRT (bargee)*	Evaluate Goal	Reviewed Goal Goal on bronchodilation care plan. Goal: Improves and maintains breath sounds and respiratory pattern within patients normal parameters. Progress: Unchanged (no change). Status: Not Met. Target Date: 05/28/2006 (no change).
5/29/06 09:42	*Ernie Bargeron,RRT (bargee)*	Evaluate Goal	Reviewed Goal Expected Outcome on Hypoxemia care plan. Expected Outcome: Improvement in Oxygen saturation Progress: Improving (no change). Status: Not Met. Target Date: 05/28/2006 (no change).

Entered	User Name	Permission Action	Details
5/29/06 09:42	*Ernie Bargeron,RRT (bargee)*	Evaluate Plan of Care	Reviewed Care Plan for Hypoxemia. Priority: LOW. Status: ACT.
5/29/06 10:45	*Jane Wilson,RN (wilsoj)*	Evaluate Goal	Reviewed Goal Goal on Discharge Plan care plan. Goal: Patients discharge needs addressed. Progress: changed from Improving to Unchanged. Status: Not Met. Target Date: updated to 05/30/2006.
5/29/06 10:45	*Jane Wilson,RN (wilsoj)*	Evaluate Plan of Care	Reviewed Care Plan for Discharge Plan. Priority: HIGH. Status: ACT.
5/29/06 10:46	*Jane Wilson,RN (wilsoj)*	Evaluate Goal	Reviewed Goal Goal on Nutritional deficit care plan. Goal: Patient will tolerate tube feedings. Progress: Improving (no change). Status: Not Met. Target Date: updated to 05/30/2006.
5/29/06 10:46	*Jane Wilson,RN (wilsoj)*	Evaluate Goal	Reviewed Goal Goal on Nutritional deficit care plan. Goal: Patient will tolerate diet advancement. Progress: changed from Improving to Unchanged. Status: Not Met. Target Date: updated to 05/30/2006.
5/29/06 10:46	*Jane Wilson,RN (wilsoj)*	Evaluate Plan of Care	Reviewed Care Plan for Nutritional deficit. Priority: HIGH. Status: ACT.
5/29/06 10:46	*Jane Wilson,RN (wilsoj)*	Evaluate Goal	Reviewed Goal Expected Outcome on Care for the patient with skin breakdown care plan. Expected Outcome: Nursing staff promptly recognizes, assesses, and intervenes to prevent skin breakdown. Progress: changed from Unchanged to Improving. Status: Not Met. Target Date: updated to 05/30/2006.
5/29/06 10:46	*Jane Wilson,RN (wilsoj)*	Evaluate Plan of Care	Reviewed Care Plan for Care for the patient with skin breakdown. Priority: HIGH. Status: ACT.
5/30/06 09:54	*Rebecca Hake Flickinger, CRTT (flickr)*	Evaluate Plan of Care	Reviewed Care Plan for bronchodilation. Priority: MOD. Status: ACT.
5/30/06 22:50	*Jenny Stearns, RN (steaje)*	Evaluate Goal	Reviewed Goal Expected Outcome on Care for the patient with skin breakdown care plan. Expected Outcome: Nursing staff promptly recognizes, assesses, and intervenes to prevent skin breakdown. Progress: Improving (no change). Status: Not Met. Target Date: 05/30/2006 (no change).
5/30/06 22:50	*Jenny Stearns, RN (steaje)*	Evaluate Plan of Care	Reviewed Care Plan for Care for the patient with skin breakdown. Priority: HIGH. Status: ACT.
5/30/06 22:50	*Jenny Stearns, RN (steaje)*	Evaluate Goal	Reviewed Goal Goal on Nutritional deficit care plan. Goal: Patient will tolerate tube feedings. Progress: changed from Improving to Unchanged Status: Not Met. Target Date: 05/30/2006 (no change).

Entered	User Name	Permission Action	Details
5/30/06 22:50	*Jenny Stearns, RN (steaje)*	Evaluate Goal	Reviewed Goal Goal on Nutritional deficit care plan. Goal: Patient will tolerate diet advancement. Progress: Unchanged (no change). Status: Not Met. Target Date: 05/30/2006 (no change).
5/30/06 22:50	*Jenny Stearns, RN (steaje)*	Evaluate Plan of Care	Reviewed Care Plan for Nutritional deficit. Priority: HIGH. Status: ACT.
5/30/06 22:51	*Jenny Stearns, RN (steaje)*	Evaluate Plan of Care	Reviewed Care Plan for Discharge Plan. Priority: HIGH. Status: ACT.
5/30/06 22:51	*Jenny Stearns, RN (steaje)*	Evaluate Goal	Reviewed Goal Goal on Discharge Plan care plan. Goal: Patients discharge needs addressed. Progress: Unchanged (no change). Status: Not Met. Target Date: 05/30/2006 (no change).
5/30/06 22:51	*Jenny Stearns, RN (steaje)*	Evaluate Plan of Care	Reviewed Care Plan for Hypoxemia. Priority: LOW. Status: ACT.
5/30/06 22:51	*Jenny Stearns, RN (steaje)*	Evaluate Goal	Reviewed Goal Expected Outcome on Hypoxemia care plan. Expected Outcome: Improvement in Oxygen saturation Progress: Improving (no change). Status: Not Met. Target Date: 05/28/2006 (no change).
5/31/06 12:30	*Jason Webb, CRT (webbja)*	Evaluate Plan of Care	Reviewed Care Plan for Hypoxemia. Priority: LOW. Status: ACT.
5/31/06 12:30	*Jason Webb, CRT (webbja)*	Evaluate Goal	Reviewed Goal Expected Outcome on Hypoxemia care plan. Expected Outcome: Improvement in Oxygen saturation Progress: Improving (no change). Status: Not Met. Target Date: 05/28/2006 (no change).
5/31/06 12:30	*Jason Webb, CRT (webbja)*	Evaluate Goal	Reviewed Goal Goal on bronchodilation care plan. Goal: Improves and maintains breath sounds and respiratory pattern within patients normal parameters. Progress: Unchanged (no change). Status: Not Met. Target Date: 05/28/2006 (no change).
5/31/06 12:30	*Jason Webb, CRT (webbja)*	Evaluate Plan of Care	Reviewed Care Plan for bronchodilation. Priority: MOD. Status: ACT.
5/31/06 18:10	*Patricia Morell, RD (morelp)*	Evaluate Goal	Reviewed Goal Goal on Nutritional deficit care plan. Goal: Patient will tolerate diet advancement. Progress: Unchanged (no change). Status: Not Met. Target Date: 05/30/2006 (no change).
5/31/06 18:10	*Patricia Morell, RD (morelp)*	Evaluate Goal	Reviewed Goal Goal on Nutritional deficit care plan. Goal: Patient will tolerate tube feedings. Progress: Unchanged (no change). Status: Not Met. Target Date: 05/30/2006 (no change).
5/31/06 18:10	*Patricia Morell, RD (morelp)*	Evaluate Plan of Care	Reviewed Care Plan for Nutritional deficit. Priority: HIGH. Status: ACT.

Entered	User Name	Permission Action	Details
5/31/06 18:11	*Patricia Morell, RD (morelp)*	Evaluate Goal	Reviewed Goal Goal on Nutritional deficit care plan. Goal: Patient will tolerate diet advancement. Progress: Unchanged (no change). Status: Not Met. Target Date: 05/30/2006 (no change).
5/31/06 18:11	*Patricia Morell, RD (morelp)*	Evaluate Goal	Reviewed Goal Goal on Nutritional deficit care plan. Goal: Patient will tolerate tube feedings. Progress: Unchanged (no change). Status: Not Met. Target Date: 05/30/2006 (no change).
5/31/06 18:11	*Patricia Morell, RD (morelp)*	Evaluate Plan of Care	Reviewed Care Plan for Nutritional deficit. Priority: HIGH. Status: ACT.

AIKEN REGIONAL MEDICAL CENTERS

302 University Parkway • Aiken, South Carolina 29802

Plan of Care:_____ RN Signature:_____

Circle all that apply:
Activity: BR Turn q2 BSC BRP MAE
OOB Chair Ambulates Assist Tests Procedures
ROM: Active Passive Bath: Tub Shower Bed
Oral Care Skin Care Heel/Elbow protectors
Assist Total Care Independent Heels elevated
Isolation:_____
Pain Management:
Location:_____ Med Time:_____
Pain Scale Score before_____ after_____
Location:_____ Med Time:_____
Pain Scale Score before_____ after_____
Location:_____ Med Time:_____
Pain Scale Score before_____ after_____
Location:_____ Med Time:_____
Pain Scale Score before_____ after_____

Patient at risk for impaired skin integrity?
Score:_____ ( ) Yes ( ) No

BRADEN ASSESSMENT SCALE

Sensory perception
(1) Completely limited (2) Very limited
(3) Slightly limited (4) No limitation
Moisture (1) Constantly moist (2) Moist
(3) Occasionally moist (4) Rarely moist
Activity (1) Bedfast (2) Chairfast
(3) Walks Occasionally (4) Walks frequenty
Mobility (1) Completely immobile (2) Very limited
(3) Slightly limited (4) No limitation
Nutrition (1) Very poor (2) Probably inadequate
(3) Adequate (4) Excellent
Friction or Sheer (1) Problem
(2) Potential problem (3) No Problem
Patient at risk for skin breakdown/pressure ulcer?
Score:_____ ( ) Yes ( ) No
Skin precautions implemented? ( ) Yes ( ) No

**Consult ET nurse for score of 14 or below, trauma, or existing skin breakdown.
Specialty bed? ( ) Yes ( ) No

IV start date/time:_____
Size/Type:_____ # attempts:_____
Site check WNL: ( )8a ( )10a ( )12a
( )2p ( )4p ( )6p ( )8p ( )10p ( )12p
( )2a ( )4a ( )6a
Diet:_____
B'fast:_____% Lunch_____%Dinner_____%
Tube Feeding:_____
Rate:_____
Additives:_____
Safety: bed low position bed locked
call bell in reach crib code alert
Fall Risk Assessment for change of treat plan, transfer, change of condition recent fall?
( ) Yes ( ) No

Wandering behavior ( ) *Yes ( ) No
*Describe:_____

If yes, implement wandering precautions

EACH ENTRY REQUIRES DATE, TIME, SIGNATURE AND TITLE

DATE/TIME	VARIANCE NOTES
5/29/06 0600	pt resting, vitals stable, pt has been bathed, no change in status, dsg D completed to hip will monitor pt — SBrannon

Shift	Signatures
7-3	
3-7	
7-11	
11-7	SBrannon
7-3	
3-7	

ADDRESSOGRAPH

102829710
PETERSON SR [redacted]LIAM SR
DOB: [redacted]85 SX: M IMD
MRN: 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

MEDICAL-SURGICAL VARIANCE NOTES

**EXPLA. . VARIANCE ON PROGRESS NOT

Date:

Day/Time assessed: 12 hour/8 hour	Eve./Time assessed: 12 hour/8 hour	Night/Time assessed: 12 hour/8 hour

NEUROLOGICAL WNL
LOC: Disoriented Forgetful Confused Mental Retardation Listless Lethargic Unresponsive
Pupils: Unequal Dilated: Right Left Constricted: Right Left Nonreactive: Right Left Both Gait: Weak Unsteady Falls

HEENT WNL
Eyes: Jaundice Redness Discharge Right Left Both
Ears: Redness Discharge Pain Lesion Right Left Both
Nose: Deviation Discharge Obstruction Lesion Right Left Both
Throat: Pain Redness Drainage
Head: Lesion Shunt Headache Fontanelle: Full Sunken
Other:

CARDIOVASCULAR WNL
Rhythm: Irregular Murmur Gallop Rub Monitor Telemetry
Pulse: Weak Thready JVD distention Edema
Nails: Cyanosis Pallor Cap refill > 3 sec's Pulse Ox
Mucuous Membranes: Dry Cracked
Other:

RESPIRATORY WNL
Effort: Labored Tachypnea Dyspnea Accessory Muscle Use
Sounds: Rales Rhonchi Wheezing Stridor Right Left
Depth: Diminished Retractions
Cough: Productive Harsh Continuous
Oxygen: Nasal Mask Tent Liters/%:_____TCDB q2
Suction Aerosol/Nebulizer CPT Incentive Spirometry Specimen
Other:

GASTROINTESTINAL WNL
Bowel sounds: Absent Sluggish Hyperactive
Appetite: Absent Diminished N/V
Stool: Diarrhea Constipation
NG tube/Suction Feeding tube

GENITOURINARY WNL
Voiding: Incontinent Dysuria Polyuria Catheter Itching
Urine: Dark Cloudy Clots Specimen: _____Color:_____
Vaginal/Urethral: Odor Redness Itching Drainage: Min Mod Max
Other:

MUSCULOSKELETAL WNL
Grips: Unequal R>L L>R Weak: Right Left Both
Pain Weak Flaccid Numb Tingling
Location:

Traction Type:
Leg Elevation: ( ) Right ( ) Left
Other:

INTEGUMENT WNL
Skin: Redness Burn Lesion Rash Bruises Jandice Mottled Pallor
Turgor: Fair Poor
Wound: Healing Open Drainage Odor Staples Sutures Tubes
Site:
Other:

EMOTIONAL/PSYCHOSOCIAL WNL
Emotional: Crying Depressed Anxiety Panic Irritable Lonely
Family: Not involved Not Present
Other:

PATIENT EDUCATION
Education: Pre-op Post-op Safety Diet NPO Diabetes Treatment Tests Activity
Signature:

NEUROLOGICAL WNL
LOC: Disoriented Forgetful Confused Mental Retardation Listless Lethargic Unresponsive
Pupils: Unequal Dilated: Right Left Constricted: Right Left Nonreactive: Right Left Both Gait: Weak Unsteady Falls

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Other:

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Other:

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Education: Pre-op Post-op Safety Diet NPO Diabetes Treatment Tests Activity
Signature:

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Turgor: Fair Poor
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Site:
Other:

EMOTIONAL/PSYCHOSOCIAL WNL
Emotional: Crying Depressed Anxiety Panic Irritable Lonely
Family: Not involved Not Present
Other:

PATIENT EDUCATION
Education: Pre-op Post-op Safety Diet NPO Diabetes Treatment Tests Activity
Signature:

Medical - Surgical Variance Form

ADDRESSOGRAPH

Aiken Regional Medical Centers

Admission Assessment

Admission Date: 5/15/06
Med. record No.: 026523
Visit No.: 102829710
Attending Phys.: Bokkisam, Chakravarthy 045591, MD

Patient: Peterson, William Sr
D.O.B.: [redacted] Age: 85
Gender: Male
Location: 5M
Room/Bed: 503/A

Scheduled: 5/15/06 23:58
Performed: 5/16/06 02:30

User: Rachel Harris Jones,LPN
Status: Finished
Cosigned By: Jim Mingus,RN

Current Illness

Diagnosis: urosepsis, ams, hypothermia. History of present illness: uti,arf,neurogenic bladder,. Unable to obtain whether patient would object to a blood transfusion if needed. Additional comments: previous anesthesia according to history..

Past Medical/Surgical History

Patient's past medical history includes HTN. Other past medical history also includes arf, cervical spine stenosis, cervical dis degen, arf, hyperpotassium, rhabdolyolysis, protein-cal mulnut, retention of urine, hematuria, uti, neurogenic bladder, paraplegia, pros hypertrophy w/obstruction, anenia chr illness nec, htn, ant cervical fusion nec, iv disc excision, fusion/refusion 2-3 vert, insert interbody fus dev, insert recombinant bone.. Past relevant surgeries: cervical spinal fusion w cc.

GU History

Hx of prostate problems includes pros hypertr w/ obstruction. GU Hx includes Renal Failure, and UTI. Patient wears protective undergarments.

Psych-Social History

Patient tobacco usage is unknown. Unable to obtain if patient was threatened or physically hurt in last 12 months. There is no evidence of abuse and/or neglect.

Nutrition History

Nutrition history assessed and the following concerns were identified. Nutritional concerns: Additional nutritional concern comments: pt appears unable to swallow at present.

Vaccine Information

Patient does not know if He/She has received the pneumonia vaccine. Patient has not received the Hepatitis B vaccine. Comments: unable to obtain.

Diabetes

Patient does not have diabetes.

Vitals on Admission

Patient's estimated height is . Patient's estimated weight is 180 lb 0 oz (81 kg 646.6 gm). Temperature 99.5 F (37.5 C). pulse 68 bpm. RR 32. BP 67/ 35 mmHg.

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Arrival Data
Patient arrived via stretcher admitted from ED. Arrived onto unit: 05/16/2006 02:30. Emergency contact is Mary peterson ; can be reached at 8036494858. Relation to patient: daugh. Secondary emergency contact is Raymond Peterson ; can be reached at803 6444 8084. Relation to patient: son. Unable to orient patient to hospital enviroment. ID bracelet on. Allergy bracelet not applicable.

Belongings Inventory
No belongings at time of admission.

Assistive Devices Inventory
Assistive devices not in use at time of admission.

Advance Directive
Patient has a dnr on the chart.

Braden Risk
Sensory Perception: Completely Limited; Moisture: Occasionally Moist; Activity: Bedfast; Mobility: Completely Immobile; Nutrition: Very Poor; Friction/Shearing: Problem; Braden Risk Score =8.

Fall Risk Assessment
Fall Risk Score= 50. No history of falling this admission or having fallen within the last 3 months. There is a secondary diagnosis noted which could increase the risk of a fall. Ambulatory aid: None or on bed rest or uses wheel chair or needs Nurse. IV /Heparin Lock present. Gait/Transferring: Normal or on bed rest or immobile. Mental status: Forgets limitations. Patient is taking 3 or less medications from the following list: Anesthesia within past 48 hours, Anticoagulants, Antidepressants, Benzodiazepines, Laxative/diuretics, Opioids (narcotics), Sedatives/hypnotics, Vasodilators. High Risk Fall Prevention Interventions were implemented, based on a score of greater than 50 obtained using the Fall Assessment and Intervention policy.

Pain Initial
Patient's level of pain is 0 (no pain). Numerical pain scale used to assess patient's pain level. Unable to explain use of pain scale to patient and/or family because pt non responsive.

Home Medication
Additional comments regarding patient's home medications: see list on chart.

Learning Needs
Unable to assess patient at this time. Comments: pt nonresponsive

Anticipated Discharge Plan
Patient lives in Extended Care Facility. Anticipated discharge to an Extended Care Facility.

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Education Needs
Unable to assess patient's preferred learning method. Reason: pt nonresponsive. Unable to assess if patient is ready or motivated to learn. Unable to assess if there are factors that will affect the patient's ability to learn. Plan of Care initiated: urosepsis, hypothermia, non responsive,.

Spiritual Assessment
Not known if patient has religious or spiritual concerns. Not known if patient has a religious or spiritual preference.

HEENT
Unable to assess patient at this time. Comments: pt non responsive

NeuroMusculoSkeletal
Unable to assess patient at this time. Comments: pt non responsive. knees appear contracted and no movement of any extremities seen during admission

Orthopaedic Assessment
Orthopaedic assessment is not indicated for this patient at this time.

Cardiovascular
Patient is on a cardiac monitor. Rhythm regular. Lead II. Heart rate 72 bpm. Interpretations as follows: Normal Sinus Rhythm. +4 pitting edema of bilateral feet.

Respiratory
O2 SAT 99 %. Patient on Oxygen at 15 liters per minute FIO2 is 100% via nrb mask. Rhonchi auscultated in All lobes.

Gastrointestinal
Patient is experiencing incontinence. Patient on NPO diet.

Genitourinary
Voiding patterns include: indwelling cath. Patient wears protective undergarments.

Integumentary
Skin integrity: bruise, denuded, and scar(s). Additional Integumentary related comments: lt lateral decub drsg c/d/i. see picture on chart. lower back decub. see picture on chart. dry blisters on feet and feet are scaley. open blister inner lt ankle non draining. healed scabbed sore outter rt foot..

IV Information
IV in Right Hand. Gauge: 20. Site is patent. Inserted 051606.

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Cosigned By: Jim Mingus

Functional Assessment

Transport Method: bed. Patient unable to stand. Required level of assistance with ADLs as follows: current level of activity bedrest , requires total assistance with hygiene, requires total assistance with toileting, requires total assistance with dressing, unable to ambulate , requires total assistance with eating.

Equipment

No Equipment being used at this time.

Restraints

Patient is not in restraints.

Psych/Knowledge

Unable to assess patient at this time. Comments: pt non responsive

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Cosigned By: Jim Mingus, M

Consults & Notices Needed

Referrals and Notices

Dietician Referral
Nutrition: Very Poor;

ET RN Referral
Braden Risk Score =8.

Occupational Therapy Referral
requires total assistance with toileting,
, requires total assistance with eating
+4 pitting edema of bilateral feet.

Physical Therapy Referral
unable to ambulate

Social Services Referral
Anticipated discharge to an Extended Care Facility.
Patient lives in Extended Care Facility.

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Cosigned By: Jim Mingus,

Belongings Inventory

No belongings at time of admission.

Home Medication

Additional comments regarding patient's home medications: see list on chart.

Money in Patient's Possession on Arrival

If money was in patient's possession upon arrival, the nurse admitting the patient and a witness must sign below confirming the amount documented in the Valuables Inventory Section above. (Leave blank if no money in patient's possession on arrival.)

Admitting Nurse	Date & Time	Employee Witness	Date & Time

Liability Waiver for Personal Belongings/Medications

The hospital will not be responsible for valuables that are not considered necessary for the patients activities of daily living such as credit cards, jewelry, and cash that are not checked in with Security.

Printed name	Relationship to patient
Signature	Date & Time

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503 Peterson, Willi[illegible] n Regional Medical Centers -1115-

Interdisciplinary Patient Care Conference Record

Date: May 16, 2006

Disciplines Represented at Conference

- ☑ Nursing
- ☐ Respiratory Therapy
- ☐ Nutrition
- ☐ Other _____
- ☑ Social Work
- ☑ Wound Care
- ☐ Physical Therapy
- ☑ Case Management
- ☑ Diabetes
- ☑ Chaplain

Disciplines Currently Involved/Current Plan

Discipline	*Current Plan* Dx Hypothermia unresponsive
Nursing DNR/DNI	99° 75/41 Comfort measures
Social Work	Extended Dsg Home
Respiratory Therapy	O2 therapy
Wound Care	Decub (L) hip & coccyx
Diabetes	
Nutrition	
Physical Therapy	
Chaplain	will visit

New Consults/Follow-Up to Patient's Care

Discipline	*Plan*
Social Work	
Respiratory Therapy	
Wound Care	
Diabetes	
Nutrition	
Physical Therapy	
Chaplain	

Anticipated Discharge Location:

☐ Home by self ☐ Home with family ☐ Home with home health

☐ Rehab placement ☐ Nursing home placement ☐ Assisted Living Placement

☒ Other: Hospice

PLAN OF CARE: (List)

Signature: Mary E Brandel RN

-1116-

AIKEN REGIONAL MEDICAL CENTERS

302 University Parkway
Aiken, South Carolina 29802

INSTRUCTIONS FOR COMPLETING FORM: Use the appropriate code letter in the legend to complete each column. Use more than one letter in each column when applicable.

I. LEARNING STYLE ASSESSMENT
(Method best suited to facilitate learning)
R = Reading a handout
L = Listening to lecture, speaker, video
P = Practicing an activity

II. FACTORS AFFECTING LEARNING
N = None
F = Fatigue
P = Pain
C = Communication, ie., cognitive disorder; language barrier
D = Physical, psychomotor disability
L = Lack of motivation
R = Refuse education

III. TEACHING FORMAT USED
A = Audiovisual
D = Demonstration
I = Individual instruction
G = Group class
H = Handout, pamphlet, booklet
R = Return demonstration

IV. WHO WAS TAUGHT
P = Patient
S = Significant other
F = Family

V. OUTCOME
D = Demonstrates understanding
CR = Continue reinforcement
V = Verbalizes understanding

TEACHING THEME	DATE & TIME	DISCIPLINE / INITIALS	CONTENT	I. Learning Style Assessment	II. Factors Affecting Learning	III. Teaching Format Used	IV. Who Was Taught	V. Outcome
DIAGNOSIS RELATED EDUCATION	5/26/06 1515	Radiology [illegible]	Pre procedure teaching Re: Risks | complications	L	N	I	F	V
IV / MEDICATION TEACHING		Radiology	Conscious sedation meds, adverse, monitors		NA			
DRUG / FOOD INTERACTIONS								
PAIN MANAGEMENT	5/26/06 1515	Radiology [illegible]	Pain scale - Numeric Wong faces chart	L	N	I	F	V
NUTRITION / DIET								
REHABILITATION TECHNIQUES								
DISCHARGE PLANNING Social Svc. (see progress notes)	5/26/06	Radiology [illegible]	Post procedure activity level, reasons to return	L	N	I	F	V
MEDICAL EQUIPMENT	5/26/06	Radiology [illegible]	Monitor equipment alarms	L	N	I	F	V
COMMUNITY RESOURCES								
CARDIO PULMONARY	5/26/06	Radiology [illegible]	O2 as needed | Sat readings	L	N	I	F	V

Signature / Title	Initials	Signature / Title	Initials	Signature / Title	Initials
Dr. J. M. Hunt, [illegible]	[illegible]				

Addressograph
102829710
PETERSON SR, WILLIAM SR
[redacted] 85 SX: M IMD
MRN: 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

601.46 (REV. 9/99) **PATIENT / FAMILY EDUCATION RECORD** 10-1921

PLAN OF CARE – CARDIOPULMONARY INVASIVE PROCEDURES

-1117-

NURSING DIAGNOSIS	PLAN	IMPLEMENTATION	EVALUATION
Anxiety regarding impending diagnostic procedure and possible findings of disease processes **EXPECTED OUTCOMES** **The patient will express feelings of increased understanding and lessened anxiety prior to beginning of procedure.**	1. Explain to patient who you are and your role 2. Assess level of anxiety and possible causes. 3. Assess patient's level of understanding of procedure and potential for learning. 4. Explain each step you will be taking (in terms understandable to the patient) during the preparatory phase. 5. Answer questions related to Nursing, equipment, personnel, and environment. 6. Give simple concise directions when sedated. 7. Direct questions related to medical care to MD.	5/25/06 GK	GE
NURSING DIAGNOSIS	**PLAN**	**IMPLEMENTATION**	**EVALUATION**
Alterations in comfort related to pain or discomfort. **EXPECTED OUTCOMES** **Optimal comfort while in the Endoscopy Lab.**	1. Maintain privacy 2. Encourage patient to verbalize pain or discomfort. 3. Provide blankets, pillows as needed. 4. Notify MD of alteration or unrelated pain.	5/25/06 GK	GE
NURSING DIAGNOSIS	**PLAN**	**IMPLEMENTATION**	**EVALUATION**
Prevention for infection related to invasive procedures and cross-contamination **EXPECTED OUTCOMES** **No controllable post-procedure infection exists.**	1. Maintain proper technique for intravenous needle insertion. 2. Practice Universal Precautions. 3. Practice Aseptic Technique.	5/25/06 GK	GE

102829710
PETERSON SR, WILLIAM SR
DOB: [redacted] 85 SX: M IMD
MRN: 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

NURSING DIAGNOSIS	PLAN	IMPLEMENTATION	EVALUATION
Potential for physical injury related to inability to protect self. **EXPECTED OUTCOME** **No injury occurs**	1. Stabalize stretcher and keep siderails in up position. 2. Document patient's status according to procedural sedation policy. 3. Check lab if ordered; notify MD of abnormals. 4. Handle and document specimens according to procedure. 5. Ascertain electrical safety of equipment. 6. Have resuscitative equipment and emergency cart available. 7. Release patients to responsible driver. 9. Observe for signs/symptoms of abuse and report any noted.	DK 5/25/06 inpt. Rm 503	DK
NURSING DIAGNOSIS	**PLAN**	**IMPLEMENTATION**	**EVALUATION**
Health maintenance; alteration due to disease process **EXPECTED OUTCOMES** **Patient will leave hospital with knowledge of his diagnosis, guidelines for treatment, and follow-up care.**	1. Give written instructions to out-patients. 2. Provide patient teaching based on assessment of prior knowledge, cultural health beliefs, and tolerance for medical information. Supplement with appropriate literature. 3. Include family/significant others. 4. Refer medical questions to MD.	DK 5/25/06	DK

5/25/06 M. Kaufmann RN

102829710
[redacted]SON SR, WILLIAM SR
[redacted] 85 SX: M IMD
ADM/REG DT: 05/15/06
MRN: 26523
AIKEN REGIONAL MEDICAL CENTER

-1119-

NURSING DIAGNOSIS	PLAN	IMPLEMENTATION	EVALUATION
Potential for physical injury related to inability to protect self. **EXPECTED OUTCOME** No injury occurs	1. Stabalize stretcher and keep siderails in up position. 2. Document patient's status according to procedural sedation policy. 3. Check lab if ordered; notify MD of abnormals. 4. Handle and document specimens according to procedure. 5. Ascertain electrical safety of equipment. 6. Have resuscitative equipment and emergency cart available. 7. Observe abdomen for swelling and tenderness, heed patient complaints, note bleeding, report to physician. 8. Release patients to responsible driver. 9. Observe for signs/symptoms of abuse and report any noted.	5/19/06 OC	5/19/06 OC

NURSING DIAGNOSIS	PLAN	IMPLEMENTATION	EVALUATION
Prevention for infection related to invasive procedures and cross-contamination **EXPECTED OUTCOMES** **No controllable post-procedure infection exists.**	1. Maintain proper technique for intravenous needle insertion. 2. Practice Universal Precautions. 3. Practice Aseptic Technique. 4. Follow proper cleaning and disinfection techniques of scopes.	5/19/06 OC	5/19/06

NURSING DIAGNOSIS	PLAN	IMPLEMENTATION	EVALUATION
Health maintenance; alteration due to disease process **EXPECTED OUTCOMES** **Patient will leave hospital with knowledge of his diagnosis, guidelines for treatment, and follow-up care.**	1. Give written instructions to out-patients. 2. Provide patient teaching based on assessment of prior knowledge, cultural health beliefs, and tolerance for medical information. Supplement with appropriate literature. 3. Include family/significant others. 4. Refer medical questions to MD.	5/19/06	5/19/06

102829710
PETERSON SR, WILLIAM SR
DOB [redacted] 85 SX: M IMD
MRN: 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

PLAN OF CARE – ENDOSCOPY LAB PATIENT

NURSING DIAGNOSIS	PLAN	IMPLEMENTATION	EVALUATION
Anxiety regarding impending diagnostic procedure and possible findings of disease processes **EXPECTED OUTCOMES** **The patient will express feelings of increased understanding and lessened anxiety prior to beginning of procedure.**	1. Explain to patient who you are and your role 2. Assess level of anxiety and possible causes. 3. Assess patient's level of understanding of procedure and potential for learning. 4. Explain each step you will be taking (in terms understandable to the patient) during the preparatory phase. 5. Answer questions related to Nursing, equipment, personnel, and environment. 6. Give simple concise directions when sedated. 7. Direct questions related to medical care to MD.	5/19/06 DE	5/19/06 DE
NURSING DIAGNOSIS	**PLAN**	**IMPLEMENTATION**	**EVALUATION**
Nourishment, Alteration due to disease process **EXPECTED OUTCOMES** **Patient will receive adequate nutrition**	1. Assess patient for need for dietary consult. 2. Provide specific patient teaching for meeting dietary needs.	5/19/06 DE	5/19/06 DE
NURSING DIAGNOSIS	**PLAN**	**IMPLEMENTATION**	**EVALUATION**
Alterations in comfort related to pain or discomfort. **EXPECTED OUTCOMES** **Optimal comfort while in the Endoscopy Lab.**	1. Maintain privacy 2. Encourage patient to verbalize pain or discomfort. 3. Provide blankets, pillows as needed. 4. Notify MD of alteration or unrelated pain.	5/19/06 DE	5/19/06 DE

-1121-

PLAN OF CARE – ENDOSCOPY LAB PATIENT 5/31/06

NURSING DIAGNOSIS	PLAN	IMPLEMENTATION	EVALUATION
Anxiety regarding impending diagnostic procedure and possible findings of disease processes **EXPECTED OUTCOMES** **The patient will express feelings of increased understanding and lessened anxiety prior to beginning of procedure.**	1. Explain to patient who you are and your role 2. Assess level of anxiety and possible causes. 3. Assess patient's level of understanding of procedure and potential for learning. 4. Explain each step you will be taking (in terms understandable to the patient) during the preparatory phase. 5. Answer questions related to Nursing, equipment, personnel, and environment. 6. Give simple concise directions when sedated. 7. Direct questions related to medical care to MD.		

NURSING DIAGNOSIS	PLAN	IMPLEMENTATION	EVALUATION
Nourishment, Alteration due to disease process **EXPECTED OUTCOMES** **Patient will receive adequate nutrition**	1. Assess patient for need for dietary consult. 2. Provide specific patient teaching for meeting dietary needs.		

NURSING DIAGNOSIS	PLAN	IMPLEMENTATION	EVALUATION
Alterations in comfort related to pain or discomfort. **EXPECTED OUTCOMES** **Optimal comfort while in the Endoscopy Lab.**	1. Maintain privacy 2. Encourage patient to verbalize pain or discomfort. 3. Provide blankets, pillows as needed. 4. Notify MD of alteration or unrelated pain.		



102829710
PETERSON SR, WILLIAM SR
DOB: [redacted] 85 SX: M IMD
MRN: 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

NURSING DIAGNOSIS	PLAN	IMPLEMENTATION	EVALUATION
Potential for physical injury related to inability to protect self. **EXPECTED OUTCOME** No injury occurs	1. Stabalize stretcher and keep siderails in up position. 2. Document patient's status according to procedural sedation policy. 3. Check lab if ordered; notify MD of abnormals. 4. Handle and document specimens according to procedure. 5. Ascertain electrical safety of equipment. 6. Have resuscitative equipment and emergency cart available. 7. Observe abdomen for swelling and tenderness, heed patient complaints, note bleeding, report to physician. 8. Release patients to responsible driver. 9. Observe for signs/symptoms of abuse and report any noted.		

NURSING DIAGNOSIS	PLAN	IMPLEMENTATION	EVALUATION
Prevention for infection related to invasive procedures and cross-contamination **EXPECTED OUTCOMES** **No controllable post-procedure infection exists.**	1. Maintain proper technique for intravenous needle insertion. 2. Practice Universal Precautions. 3. Practice Aseptic Technique. 4. Follow proper cleaning and disinfection techniques of scopes.		

NURSING DIAGNOSIS	PLAN	IMPLEMENTATION	EVALUATION
Health maintenance; alteration due to disease process **EXPECTED OUTCOMES** **Patient will leave hospital with knowledge of his diagnosis, guidelines for treatment, and follow-up care.**	1. ~~Give written instructions to out-patients.~~ 2. Provide patient teaching based on assessment of prior knowledge, cultural health beliefs, and tolerance for medical information. Supplement with appropriate literature. 3. Include family/significant others. 4. Refer medical questions to MD.		

AIKEN REGIONAL MEDICAL CENTER

SITE CODES
① ABDOMEN
② RIGHT UPPER OUTER QUADRANT BUTTOCK
③ LEFT UPPER OUTER QUADRANT BUTTOCK
④ RIGHT UPPER ARM
⑥ LEFT UPPER ARM
⑤ RIGHT ANTERIOR THIGH
⑦ LEFT ANTERIOR THIGH

MEDICATION ADMINISTRATION RECORD

PATIENT NAME	BED NO.	AGE	WEIGHT	BSA m²	ADM. DATE	DOSE PERIOD
PETERSON, WILLIAM SR	0503 A		81.648 kg	2.030 M2	05/15/2006	06/01/06-06/01/06

MEDICAL RECORD NO.	ACCOUNT NO.	PHYSICIAN	DIAGNOSIS
26523	102829710	BOKKISAM, CHAKRAVARTHY	UROSEPSIS, AMS, HYPOTHERMIA

ALLERGIES: NKA

MEDICATION ADMINISTRATION TIMES

ORDER CHECK NURSE	00:00-06:59 TIME	SITE	INITIAL	07:00-14:59 TIME	SITE	INITIAL	15:00-23:59 TIME	SITE	INITIAL
JS									

ACETAMINOPHEN — START DT: 05/16/06 00:01
TYLENOL (EQV) — STOP DT:
EVERY 4 HOURS AS NEEDED — BY MOUTH
Dose: 650 MG = 2 TAB — Dose: 650 MG = 2 TAB

TEMP) 101.5
DO NOT GIVE MORE THAN 4 GRAMS PER DAY ACETAMINOPHEN

ORDER CHECK NURSE	00:00-06:59 TIME	SITE	INITIAL	07:00-14:59 TIME	SITE	INITIAL	15:00-23:59 TIME	SITE	INITIAL
JS							1500		

CS DEXTROSE 5%-WATER — 1000 ML
SIG:FREQUENCY: 24 — INTRAVENOUS

START DT:05/28/06 15:00
RATE:30 ML/HR — TOTAL VOLUME:1000

ORDER CHECK NURSE	00:00-06:59 TIME	SITE	INITIAL	07:00-14:59 TIME	SITE	INITIAL	15:00-23:59 TIME	SITE	INITIAL
JS				1000	CD				

SODIUM CHLORIDE 0.9% — 250 ML
VANCOMYCIN — 1 GM = 1 VIAL
SIG:FREQUENCY: 24 — INTRAVENOUS

START DT:05/31/06 10:00 — INFUSE OVER:1HRS
RATE:250 ML/HR — TOTAL VOLUME:250
INFUSE OVER AT LEAST 1 HR — INFUSE OVER AT LEAST 1 HR

ORDER CHECK NURSE	00:00-06:59 TIME	SITE	INITIAL	07:00-14:59 TIME	SITE	INITIAL	15:00-23:59 TIME	SITE	INITIAL
JS									

DEXTROSE 5% — 100 ML
CEFTAZIDIME — 1 GM = 1 VIAL
SIG:AS DIRECTED — INTRAVENOUS

START DT:05/27/06 13:00 — INFUSE OVER:1HRS
RATE:100 ML/HR — TOTAL VOLUME:100
GIVE Q 8H FOR NEXT TEMP) 100.5 — GIVE Q 8H FOR NEXT TEMP) 100.5
CALL RX WHEN NEEDED — CALL RX WHEN NEEDED
ALL MINI BAGS IN D5W — ALL MINI BAGS IN D5W

ORDER CHECK NURSE	00:00-06:59 TIME	SITE	INITIAL	07:00-14:59 TIME	SITE	INITIAL	15:00-23:59 TIME	SITE	INITIAL
JS	0200	JS		1000	CD		1800		
	0000	JS		1400	CD		2200		

Tap water Flush 120mL q4°

DATE & TIME	OMISSIONS RESPONSE TO MEDS ADVERSE EFFECTS ETC.	ORDER DATE	NON-RECURRING MEDICATION	DATE	TIME GIVEN	INITIA

24-HR. VALIDATION CHECK NURSE: J. Stanworth

PATIENT NAME	BED NO.

J. Stanworth (JS) CD

10-26956 (5/04)
740.14

AIKEN REGIONAL MEDICAL CENTER

SITE CODES
① ABDOMEN
② RIGHT UPPER OUTER QUADRANT BUTTOCK
③ LEFT UPPER OUTER QUADRANT BUTTOCK
④ RIGHT UPPER ARM
⑤ LEFT UPPER ARM
⑥ RIGHT ANTERIOR THIGH
⑦ LEFT ANTERIOR THIGH

MEDICATION ADMINISTRATION RECORD

PATIENT NAME	BED NO.	AGE	WEIGHT	BSA m²	ADM. DATE	DOSE PERIOD
PETERSON, WILLIAM SR	0503 A		81.648 kg	2.030 M2	05/15/2006	06/01/06-06/01/06

MEDICAL RECORD NO.	ACCOUNT NO.	PHYSICIAN	DIAGNOSIS
26523	102829710	BOKKISAM, CHAKRAVARTHY	UROSEPSIS, AMS, HYPOTHERMIA

ALLERGIES: NKA

ORDER	ORDER CHECK NURSE	MEDICATION ADMINISTRATION TIMES 00:00-06:59 TIME / SITE / INITIAL	07:00-14:59 TIME / SITE / INITIAL	15:00-23:59 TIME / SITE / INITIAL
ALBUT/IPRATROPIUM2.5-0.5MG/3ML DUONEB 2.5-0.5MG/3ML EVERY 4 HOURS-SCHEDULED Dose: 3 ML = 3 ML START DT: 05/16/06 10:00 STOP DT: INHALATION Dose: 3 ML = 3 ML GIVE PER RESPIRATORY PROTOCOL	JS	0200 ET 0600 RT	1000 RT 1400 RT	1800 2200
FAMOTIDINE PEPCID (EQV) 2 TIMES A DAY Dose: 20 MG = 1 TAB START DT: 05/24/06 10:00 STOP DT: BY MOUTH Dose: 20 MG = 1 TAB	JS		1000 CP	2200
PREDNISONE PREDNISONE DAILY Dose: 10 MG = 1 TAB START DT: 05/27/06 10:00 STOP DT: BY MOUTH Dose: 10 MG = 1 TAB	JS		1000 CP	
INSULIN R HUMAN (PER DOSE) NOVOLIN R (PER DOSE) EVERY SIX HOURS 151 TO 200 2 UNIT 201 TO 250 4 UNIT 251 TO 300 6 UNIT NOTIFY DR IF >301 SUBCUTANEOUS *HIGH ALERT MED- DOUBLE CHECK DRUG & DOSE* START DT: 05/28/06 12:00 STOP DT: SUBCUTANEOUS	JS	0600 149 JS 2400 146 JS	1200 4 units CP	1800
Wd. care to ② hip + buttocks + R. heel	JS			
Arginaid 1pk + Glutasolve 1pk in 120mL H_2O BID	JS			

DATE & TIME	OMISSIONS RESPONSE TO MEDS ADVERSE EFFECTS ETC.	ORDER DATE	NON-RECURRING MEDICATION	DATE	TIME GIVEN	INITIA

24-HR. VALIDATION CHECK NURSE: J Stanford

PATIENT NAME	BED NO.			
PETERSON, WILLIAM SR	0503 A	J Stanford (JS)	( )	( )

10-26956 (5/04)

740.14

Aiken Regional Medical Centers

302 University Parkway • Aiken, South Carolina 29801

Date: 5.25.06 Time: 2100

Patient in pain? ☐ Yes ☒ No Pain Scale used? ☒ numerical ☐ faces ☐ cognitively impaired

Pain Score: 1 2 3 4 5 6 7 8 9 10 Location of pain: _____

Pain Interventions: ☐ heat ☐ cold ☐ position ☐ diversion ☐ analgesic ☐ narcotic Other _____

Was the intervention effective? ☐ yes ☐ no* Date: _____ Time: _____

Signature: _____ *See Nurse's note

Date: 5/26/06 Time: 0800

Patient in pain? ☐ Yes ☒ No Pain Scale used? ☐ numerical ☒ faces ☐ cognitively impaired

Pain Score: 1 2 3 4 5 6 7 8 9 10 Location of pain: 0

Pain Interventions: ☐ heat ☐ cold ☐ position ☐ diversion ☐ analgesic ☐ narcotic Other _____

Was the intervention effective? ☐ yes ☐ no* Date: _____ Time: _____

Signature: _____ *See Nurse's note

Date: 5/26/06 Time: 2100

Patient in pain? ☐ Yes ☒ No Pain Scale used? ☐ numerical ☐ faces ☐ cognitively impaired

Pain Score: 1 2 3 4 5 6 7 8 9 10 Location of pain: _____

Pain Interventions: ☐ heat ☐ cold ☐ position ☐ diversion ☐ analgesic ☐ narcotic Other _____

Was the intervention effective? ☐ yes ☐ no* Date: _____ Time: _____

Signature: _____ *See Nurse's note

Date: 5-27-06 Time: 0800

Patient in pain? ☐ Yes ☒ No Pain Scale used? ☐ numerical ☐ faces ☐ cognitively impaired

Pain Score: 1 2 3 4 5 6 7 8 9 10 Location of pain: _____

Pain Interventions: ☐ heat ☐ cold ☐ position ☐ diversion ☐ analgesic ☐ narcotic Other _____

Was the intervention effective? ☐ yes ☐ no* Date: _____ Time: _____

Signature: _____ *See Nurse's note

PAIN EVALUATION FLOWSHEET

PATIENT LABEL

102829710

PETERSON SR, WILLIAM SR

DOB: [redacted] 85 SX: M IMD

MRN: 26523 ADM/REG DT: 05/15/06

AIKEN REGIONAL MEDICAL CENTER

Date: 5/27/06 Time: 2100

ent in pain? ☐ Yes ☑ No Pain Scale used? ☐ numerical ☑ faces ☐ cognitively impaired

Pain Score: 1 2 3 4 5 6 7 8 9 10 Location of pain: _____

Pain Interventions: ☐ heat ☐ cold ☐ position ☐ diversion ☐ analgesic ☐ narcotic Other _____

Was the intervention effective? ☐ yes ☐ no* Date: _____ Time: _____

Signature: _____ *See Nurse's note

Date: 5-29-06 Time: 2100

Patient in pain? ☐ Yes ☒ No Pain Scale used? ☐ numerical ☒ faces ☐ cognitively impaired

Pain Score: 1 2 3 4 5 6 7 8 9 10 Location of pain: _____

Pain Interventions: ☐ heat ☐ cold ☐ position ☐ diversion ☐ analgesic ☐ narcotic Other _____

Was the intervention effective? ☐ yes ☐ no* Date: _____ Time: _____

Signature: _____ *See Nurse's note

Date: 5-30-06 Time: 0815

Patient in pain? ☐ Yes ☑ No Pain Scale used? ☐ numerical ☑ faces ☐ cognitively impaired

Pain Score: 1 2 3 4 5 6 7 8 9 10 Location of pain: _____

Pain Interventions: ☐ heat ☐ cold ☐ position ☐ diversion ☐ analgesic ☐ narcotic Other _____

Was the intervention effective? ☐ yes ☐ no* Date: _____ Time: _____

Signature: _____ *See Nurse's note

Date: _____ Time: _____

Patient in pain? ☐ Yes ☐ No Pain Scale used? ☐ numerical ☐ faces ☐ cognitively impaired

Pain Score: 1 2 3 4 5 6 7 8 9 10 Location of pain: _____

Pain Interventions: ☐ heat ☐ cold ☐ position ☐ diversion ☐ analgesic ☐ narcotic Other _____

Was the intervention effective? ☐ yes ☐ no* Date: _____ Time: _____

Signature: _____ *See Nurse's note

Date: _____ Time: _____

Patient in pain? ☐ Yes ☐ No Pain Scale used? ☐ numerical ☐ faces ☐ cognitively impaired

Pain Score: 1 2 3 4 5 6 7 8 9 10 Location of pain: _____

Pain Interventions: ☐ heat ☐ cold ☐ position ☐ diversion ☐ analgesic ☐ narcotic Other _____

Was the intervention effective? ☐ yes ☐ no* Date: _____ Time: _____

Signature: _____ *See Nurse's note

AIKEN REGIONAL MEDICAL CENTER

MEDICATION ADMINISTRATION RECORD

SITE CODES
① ABDOMEN
② RIGHT UPPER OUTER QUADRANT BUTTOCK
③ LEFT UPPER OUTER QUADRANT BUTTOCK
④ RIGHT UPPER ARM
⑤ LEFT UPPER ARM
⑥ RIGHT ANTERIOR THIGH
⑦ LEFT ANTERIOR THIGH

PATIENT NAME	BED NO.	AGE	WEIGHT	BSA m²	ADM. DATE	DOSE PERIOD
PETERSON, WILLIAM SR	0503 A		81.648 kg	2.030 M2	05/15/2006	05/31/06-05/31/06

MEDICAL RECORD NO.	ACCOUNT NO.	PHYSICIAN	DIAGNOSIS
26523	102829710	BOKKISAM, CHAKRAVARTHY	UROSEPSIS, AMS, HYPOTHERMIA

ALLERGIES: NKA

	ORDER CHECK NURSE	00:00-06:59 TIME	SITE	INITIAL	07:00-14:59 TIME	SITE	INITIAL	15:00-23:59 TIME	SITE	INITIAL
ALBUT/IPRATROPIUM2.5-0.5MG/3ML START DT: 05/16/06 10:00 DUONEB 2.5-0.5MG/3ML STOP DT:<~~EVERY 4 HOURS SCHEDULED~~ ~~INHALATION~~ Dose: 3 ML = 3 ML Dose: 3 ML = 3 ML	JS	0600		RT	1000		RT	1800		RT
		0000		RT	1400		RT	2200		RT
GIVE PER RESPIRATORY PROTOCOL										
FAMOTIDINE START DT: 05/24/06 10:00 PEPCID (FQV) STOP DT: 2 TIMES A DAY BY MOUTH Dose: 20 MG = 1 TAB Dose: 20 MG = 1 TAB	JS				1000			2200		JS
PREDNISONE START DT: 05/27/06 10:00 PREDNISONE STOP DT: DAILY BY MOUTH Dose: 10 MG = 1 TAB Dose: 10 MG = 1 TAB	JS				1000					
INSULIN R HUMAN (PER DOSE) START DT: 05/28/06 12:00 NOVOLIN R (PER DOSE) STOP DT: EVERY SIX HOURS SUBCUTANEOUS 151 TO 200 2 UNIT 201 TO 250 4 UNIT 251 TO 300 6 UNIT NOTIFY DR IF >301 SUBCUTANEOUS *HIGH ALERT MED- DOUBLE CHECK DRUG & DOSE*	JS	0600	5	6 JS	1200			1800		
		2400	JS	102				BS=78		
Wd care to ① hip + Buttocks	JS							2100		JS
Arginaid 1pk + Glutasolve 1pk in 120mL H_2O BID	JS				1000			2200		JS

DATE & TIME	OMISSIONS RESPONSE TO MEDS ADVERSE EFFECTS ETC.	ORDER DATE	NON-RECURRING MEDICATION	DATE	TIME GIVEN	INITIA
9/30/06 1200	Pt. in ENDO. SG					

24-HR. VALIDATION CHECK NURSE: J Stanman RN

PATIENT NAME	BED NO.
PETERSON, WILLIAM SR	0503 A

J Stanman (RN) _____ ( ) _____ ( )
_____ (RT) _____ ( ) _____ ( )

10-26956 (5/04)

740.14

AIKEN REGIONAL MEDICAL CENTER

SITE CODES
① ABDOMEN
② RIGHT UPPER OUTER QUADRANT BUTTOCK
③ LEFT UPPER OUTER QUADRANT BUTTOCK
④ RIGHT UPPER ARM
⑤ LEFT UPPER ARM
⑥ RIGHT ANTERIOR THIGH
⑦ LEFT ANTERIOR THIGH

MEDICATION ADMINISTRATION RECORD

PATIENT NAME	BED NO.	AGE	WEIGHT	BSA m²	ADM. DATE	DOSE PERIOD
PETERSON, WILLIAM SR	0503 A		81.648 kg	2.030 M2	05/15/2006	05/31/06-05/31/06

MEDICAL RECORD NO.	ACCOUNT NO.	PHYSICIAN	DIAGNOSIS
26523	103029710	BOKKISAM, CHAKRAVARTHY	UROSEPSIS, AMS, HYPOTHERMIA

ALLERGIES: NKA

MEDICATION ADMINISTRATION TIMES

ORDER CHECK NURSE	00:00-06:59 TIME	SITE	INITIAL	07:00-14:59 TIME	SITE	INITIAL	15:00-23:59 TIME	SITE	INITIAL
JS									
JS							1500 1800		JS
JS									
JS	0200		JS	1000			1800		JS
	0600		JS	1400			2200		JS
JS							1800		JS

ACETAMINOPHEN — START DT: 05/16/06 08:01
TYLENOL (PRN) — STOP DT:
EVERY 4 HOURS AS NEEDED — BY MOUTH
Dose: 650 MG = 2 TAB — Dose: 650 MG = 2 TAB

TEMP) 101.5
DO NOT GIVE MORE THAN 4 GRAMS PER DAY ACETAMINOPHEN

D5 DEXTROSE 5%-WATER — 1000 ML
SIG:FREQUENCY: 24 — INTRAVENOUS

START DT:05/28/06 15:00
RATE:30 ML/HR — TOTAL VOLUME:1000

DEXTROSE 5% — 100 ML
CEFTAZIDIME — 1 GM = 1 VIAL
SIG:AS DIRECTED — INTRAVENOUS

START DT:05/27/06 13:00 — INFUSE OVER:1HRS
RATE:100 ML/HR — TOTAL VOLUME:100
GIVE Q 8H FOR NEXT TEMP) 100.5 — GIVE Q 8H FOR NEXT TEMP) 100.5
CALL RX WHEN NEEDED — CALL RX WHEN NEEDED
ALL MINI BAGS IN D5W — ALL MINI BAGS IN D5W

Tap water flush 120mL @4°

Fibersource HN @60 @40mL/hr Flush

DATE & TIME	OMISSIONS RESPONSE TO MEDS ADVERSE EFFECTS ETC.	ORDER DATE	NON-RECURRING MEDICATION	DATE	TIME GIVEN	INIT
5/31/06@1000	NPO for EGD/colonoscopy. SE					

24-HR. VALIDATION CHECK NURSE:

PATIENT NAME	BED NO.			
		(B)	( )	( )
		(B)	( )	( )

10-26956 (5/04)
740.14

Aiken Regional Medical Center
302 University Aiken, South Carolina 29802

DIAGNOSIS: _____
ALLERGIES: _____
NOTES: _____
_____

DATE:

DRUG NAME, STRENGTH, DOSAGE FORM DOSE RATE ROUTE SCHEDULE	START TIME DATE	START TIME DATE	TIME PERIOD TO	TIME PERIOD TO	TIME PERIOD TO
RX: Vancomycin 1gm IV q24h					0000 JS
NURSE:					
RX:					
NURSE:					
RX:					
NURSE:					
RX:					
NURSE:					
RX:					
NURSE:					
RX:					
NURSE:					
RX:					
NURSE:					
RX:					
NURSE:					
RX:					
NURSE:					
RX:					
NURSE:					

INITIALS	SIGNATURE/TITLE	INITIALS	SIGNATURE/TITLE		

NOTES: _____
_____
_____
_____
_____

Peterson, William, Sr.

MEDICATION ADMINISTRATION RECORD

PAGE ____ OF ____ PAGES

503
ROOM _____ NAME _____ PAT. NO. _____ AGE _____ SEX _____ PHYSICIAN'S NAME _____

601-39 (5/04) WHITE – ORIGINAL COPY CANARY – PHARMACY BILLING 10-1934

AIKEN REGIONAL MEDICAL CENTER

SITE CODES
① ABDOMEN
③ RIGHT UPPER OUTER QUADRANT BUTTOCK
④ LEFT UPPER OUTER QUADRANT BUTTOCK
⑤ RIGHT UPPER ARM
⑥ LEFT UPPER ARM
⑥ RIGHT ANTERIOR THIGH
⑦ LEFT ANTERIOR T

MEDICATION ADMINISTRATION RECORD

PATIENT NAME	BED NO.	AGE	WEIGHT	BSA m²	ADM. DATE	DOSE PERIOD
PETERSON, WILLIAM SR	0503 A		81.648 kg	2.038 M2	05/15/2006	05/30/06-05/30/06

MEDICAL RECORD NO.	ACCOUNT NO.	PHYSICIAN	DIAGNOSIS
26523	102829710	SOKKISAM, CHAKRAVARTHY	UROSEPSIS, AMS, HYPOTHERMIA

ALLERGIES: NKA

ORDER	ORDER CHECK NURSE	00:00-06:59 TIME	SITE	INITIAL	07:00-14:59 TIME	SITE	INITIAL	15:00-23:59 TIME	SITE	INITIAL
ALBUT/IPRATROP (UN) 2.5-0.5MG/3ML. START DT: 05/16/06 10:00 DUONEB 2.5-0.5MG/3ML STOP DT: EVERY 4 HOURS-SCHEDULED INHALATION Dose: 3 ML = 3 ML Dose: 3 ML = 3 ML	JS	0400		BS RT	1000	RT		1600	RT	RT
GIVE PER RESPIRATORY PROTOCOL										
FAMOTIDINE START DT: 05/24/06 10:00 PEPCID (FOR) STOP DT: 2 TIMES A DAY BY MOUTH Dose: 20 MG = 1 TAB Dose: 20 MG = 1 TAB	JS				1000	B		2000		JS
PREDNISONE START DT: 05/27/06 10:00 PREDNISONE STOP DT: DAILY BY MOUTH Dose: 10 MG = 1 TAB Dose: 10 MG = 1 TAB	JS				1000	B				
INSULIN R HUMAN (PER DOSE) START DT: 05/28/06 12:00 NOVOLIN R (PER DOSE) STOP DT: EVERY SIX HOURS SUBCUTANEOUS 151 TO 200 2 UNIT 201 TO 250 4 UNIT 251 TO 300 6 UNIT NOTIFY DR IF >301	JS	0600 2400	41 90	JS JS	1200 BS 144	B	BS 180	1800		B
SUBCUTANEOUS *HIGH ALERT MED- DOUBLE CHECK DRUG & DOSE*	JS	900		JS						
wound care left hip & buttocks	JS									
Arginaid 1pk + GlutaSolve 1pk in 120mL H_2O BID	JS				1000	B		2200		J

DATE & TIME	OMISSIONS RESPONSE TO MEDS ADVERSE EFFECTS ETC.	ORDER DATE	NON-RECURRING MEDICATION	DATE	TIME GIVEN	INITI

24-HR. VALIDATION CHECK NURSE: JS JS JS ( ) ( ) ( )

PATIENT NAME	BED NO.
PETERSON, WILLIAM SR	0503 A

10-26956 (5/04)

740.14

AIKEN REGIONAL MEDICAL CENTER

MEDICATION ADMINISTRATION RECORD

SITE CODES
① ABDOMEN
② RIGHT UPPER OUTER QUADRANT BUTTOCK
③ LEFT UPPER OUTER QUADRANT BUTTOCK
④ RIGHT UPPER ARM
⑤ LEFT UPPER ARM
⑥ RIGHT ANTERIOR THIGH
⑦ LEFT ANTERIOR THIGH

PATIENT NAME	BED NO.	AGE	WEIGHT	BSA m²	ADM. DATE	DOSE PERIOD
PETERSON, WILLIAM SR	0503 A		81.648 kg	2.030 M2	05/15/2006	05/30/06-05/30/06

MEDICAL RECORD NO.	ACCOUNT NO.	PHYSICIAN	DIAGNOSIS
26523	102829710	BOKKISAM, CHAKRAVARTHY	UROSEPSIS, AMS, HYPOTHERMIA

ALLERGIES: NKA

MEDICATION ADMINISTRATION TIMES

ORDER / CHECK NURSE	00:00-06:59 TIME	SITE	INITIAL	07:00-14:59 TIME	SITE	INITIAL	15:00-23:59 TIME	SITE	INITIAL
ACETAMINOPHEN (TYLENOL) (EQV) EVERY 4 HOURS AS NEEDED Dose: 650 MG = 2 TAB START DT: 05/16/06 09:01 STOP DT: BY MOUTH Dose: 650 MG = 2 TAB TEMP) 101.5 DO NOT GIVE MORE THAN 4 GRAMS PER DAY ACETAMINOPHEN	JS								
D5 DEXTROSE 5%-WATER 1000 ML SIG:FREQUENCY: 24 INTRAVENOUS START DT:05/28/06 15:00 RATE:30 ML/HR TOTAL VOLUME:1000	JS	0445	JS				1500		
DEXTROSE 5% 100 ML CEFTAZIDIME 1 GM = 1 VIAL SIG:AS DIRECTED INTRAVENOUS START DT:05/27/06 13:00 INFUSE OVER:1HRS RATE:100 ML/HR TOTAL VOLUME:100 GIVE Q 8H FOR NEXT TEMP) 100.5 GIVE Q 8H FOR NEXT TEMP) 100.5 CONT. RX WHEN NEEDED CONT. RX WHEN NEEDED ALL MINI BAGS IN D5W ALL MINI BAGS IN D5W	JS								
Tap Water Flush 120mL Q4°	JS	0200 0600	JS JS	1000 1400			1800 2200		
Fibersource HN@60 @ 40mL/hr Flush	JS								

DATE & TIME	OMISSIONS RESPONSE TO MEDS ADVERSE EFFECTS ETC.	ORDER DATE	NON-RECURRING MEDICATION	DATE	TIME GIVEN	INIT

24-HR. VALIDATION CHECK NURSE: JS JS JS

PATIENT NAME	BED NO.
Peterson	503

10-26956 (5/04)

740.14

AIKEN REGIONAL MEDICAL CENTER

MEDICATION ADMINISTRATION RECORD

SITE CODES
① ABDOMEN
② RIGHT UPPER OUTER QUADRANT BUTTOCK
③ LEFT UPPER OUTER QUADRANT BUTTOCK
④ RIGHT UPPER ARM
⑤ LEFT UPPER ARM
⑥ RIGHT ANTERIOR THIGH
⑦ LEFT ANTERIOR THIGH

PATIENT NAME	BED NO.	AGE	WEIGHT	BSA m²	ADM. DATE	DOSE PERIOD
PETERSON, WILLIAM SR	0503 A		81.648 kg	2.030 M²	05/15/2005	05/29/06-05/29/06

MEDICAL RECORD NO.	ACCOUNT NO.	PHYSICIAN	DIAGNOSIS
26523	102829710	BOKKISAM, CHAKRAVARTHY	UROSEPSIS, AMS, HYPOTHERMIA

ALLERGIES: NKA

ORDER / CHECK NURSE	MEDICATION ADMINISTRATION TIMES 00:00-06:59 (TIME / SITE / INITIAL)	07:00-14:59 (TIME / SITE / INITIAL)	15:00-23:59 (TIME / SITE / INITIAL)

ALBUT/IPRATROP(UNS)2.5-0.5MG/3ML START DT: 05/16/06 10:00
DUONEB 2.5-0.5MG/3ML STOP DT:
EVERY 4 HOURS-SCHEDULED INHALATION
Dose: 3 ML = 3 ML Dose: 3 ML = 3 ML — JS

0800 RT | 1400 RT | 1800 RT
0800 RT | 1400 RT | 2000 RT

GIVE PER RESPIRATORY PROTOCOL

FAMOTIDINE START DT: 05/24/06 10:00
PEPCID (EDV) STOP DT:
2 TIMES A DAY BY MOUTH
Dose: 20 MG = 1 TAB Dose: 20 MG = 1 TAB — JS

1000 SW | 2200 JS

PREDNISONE START DT: 05/27/06 10:00
PREDNISONE STOP DT:
DAILY BY MOUTH
Dose: 10 MG = 1 TAB Dose: 10 MG = 1 TAB — JS

1000 SW

INSULIN R HUMAN (PER DOSE) START DT: 05/28/06 12:00
NOVOLIN R (PER DOSE) STOP DT:
EVERY SIX HOURS SUBCUTANEOUS

0600 196 SP | 1200 190 SW 2 units | 1800 192 SW 2 units
2400 104 SP

151 TO 200 2 UNIT
201 TO 250 4 UNIT
251 TO 300 6 UNIT
NOTIFY DR IF >300 — JS
SUBCUTANEOUS
HIGH ALERT MED- DOUBLE CHECK DRUG & DOSE

Wound care lft hip — JS — 0600 SP | 1800 SW

Arginade 1pk + Glutamine 1pk in 120ml H20 Bid — JS — 1000 SW | 2000 JS

DATE & TIME	OMISSIONS RESPONSE TO MEDS ADVERSE EFFECTS ETC.	ORDER DATE	NON-RECURRING MEDICATION	DATE	TIME GIVEN	INIT
5/29/06	Hold Vancomycin					
	Vanco levels q 12°		When Vanco levels			
	< 20 give Vanco.		1gm IV. SW 05/29/06			

24-HR. VALIDATION CHECK NURSE: JS (Stanworth) SW (Wilson) ( ) ( ) ( )

PATIENT NAME	BED NO.
PETERSON, WILLIAM SR	0503 A

10-26956 (5/04)
740.14

AIKEN REGIONAL MEDICAL CENTER

MEDICATION ADMINISTRATION RECORD

SITE CODES
① ABDOMEN
② RIGHT UPPER OUTER QUADRANT BUTTOCK
③ LEFT UPPER OUTER QUADRANT BUTTOCK
④ RIGHT UPPER ARM
⑤ LEFT UPPER ARM
⑥ RIGHT ANTERIOR THIGH
⑦ LEFT ANTERIOR THIGH

PATIENT NAME	BED NO.	AGE	WEIGHT	BSA m²	ADM. DATE	DOSE PERIOD
PETERSON, WILLIAM SR	0503 A		81.648 kg	2.030 M2	05/15/2006	05/29/06-05/29/06

MEDICAL RECORD NO.	ACCOUNT NO.	PHYSICIAN	DIAGNOSIS
26523	102829710	SIKKISAM, CHAKRAVARTHY	UROSEPSIS,AWS,HYPOTHERMIA

ALLERGIES: NKA

MEDICATION ADMINISTRATION TIMES

ORDER / CHECK NURSE	00:00-06:59 TIME	SITE	INITIAL	07:00-14:59 TIME	SITE	INITIAL	15:00-23:59 TIME	SITE	INITIAL
ACETAMINOPHEN (TYLENOL (FGV) EVERY 4 HOURS AS NEEDED Dose: 650 MG = 2 TAB START DT: 05/16/06 09:01 STOP DT: BY MOUTH Dose: 650 MG = 2 TAB TEMP) 101.5 DO NOT GIVE MORE THAN 4 GRAMS PER DAY ACETAMINOPHEN	JS								
CS DEXTROSE 5%-WATER SIG:FREQUENCY: 24 1000 ML INTRAVENOUS START DT:05/28/06 15:00 RATE:30 ML/HR TOTAL VOLUME:1000	JS			1230		[illegible]	1500		
DEXTROSE 5% CEFTAZIDIME SIG:AS DIRECTED 100 ML 1 GM = 1 VIAL INTRAVENOUS START DT:05/27/06 13:00 INFUSE OVER:1HRS RATE:100 ML/HR TOTAL VOLUME:100 GIVE Q 8H FOR NEXT TEMP)100.5 CALL RX WHEN NEEDED ALL MINI BAGS IN D5W	JS								
Fibersource HN @60 ~~75~~ 40ml/hr flush Tap H2O 120ml q4h	JS								
	0200	[illegible]		1600	[illegible]		1800	[illegible]	
	0600	[illegible]		1900	[illegible]		2200	JS	
PPD read							2000	[illegible]	

DATE & TIME	OMISSIONS RESPONSE TO MEDS ADVERSE EFFECTS ETC.	ORDER DATE	NON-RECURRING MEDICATION	DATE	TIME GIVEN	INIT

24-HR. VALIDATION CHECK NURSE: [signature] (JS) [signature] (RN) _____ ( ) _____ ( ) _____ ( )

PATIENT NAME	BED NO.

10-26956 (5/04)

740.14

AIKEN REGIONAL MEDICAL CENTER

MEDICATION ADMINISTRATION RECORD

SITE CODES
① ABDOMEN
② RIGHT UPPER OUTER QUADRANT BUTTOCK
③ LEFT UPPER OUTER QUADRANT BUTTOCK
④ RIGHT UPPER ARM
⑤ LEFT UPPER ARM
⑥ RIGHT ANTERIOR THIGH
⑦ LEFT ANTERIOR THIGH

PATIENT NAME	BED NO.	AGE	WEIGHT	BSA m²	ADM. DATE	DOSE PERIOD
PETERSON, WILLIAM SR	0503 A		81.648 kg	2.030 M2	05/15/2006	05/28/06-05/28/06

MEDICAL RECORD NO.	ACCOUNT NO.	PHYSICIAN	DIAGNOSIS
26523	103829710	BOKKISAM, CHAKRAVARTHY	UROSEPSIS, AMS, HYPOTHERMIA

ALLERGIES: NKA

ORDER	ORDER CHECK NURSE	00:00-06:59 TIME	SITE	INITIAL	07:00-14:59 TIME	SITE	INITIAL	15:00-23:59 TIME	SITE	INITIA
ALBUT/IPRATROPIUM 2.5-0.5MG/3ML DUONEB 2.5-0.5MG/3ML EVERY 4 HOURS SCHEDULED Dose: 3 ML = 3 ML	START DT: 05/16/06 10:00 STOP DT: INHALATION Dose: 3 ML = 3 ML	0200	RT		1000	RT		1800	RT	
		0600	RT		1400	RT		2200	SB	
GIVE PER RESPIRATORY PROTOCOL										
SODIUM CL 0.9% BACTERIOSTATIC SODIUM CL 0.9% BACTERIOSTATIC EVERY EIGHT HOURS Dose: 2 ML	START DT: 05/23/06 14:00 STOP DT: INTRAVENOUS Dose: 2 ML	0600	KB		1400			2200	KB	
FLUSH PERIPHERAL INTERMITTENT IV DEVICE										
FAMOTIDINE PEPCID (EQV) 2 TIMES A DAY Dose: 20 MG = 1 TAB	START DT: 05/24/06 10:00 STOP DT: BY MOUTH Dose: 20 MG = 1 TAB				1000		AM	2200		SA
PREDNISONE PREDNISONE DAILY Dose: 10 MG = 1 TAB	START DT: 05/27/06 10:00 STOP DT: BY MOUTH Dose: 10 MG = 1 TAB				1000		AM			
FUROSEMIDE FUROSEMIDE DAILY Dose: 20 MG = 1 TAB **USE CAUTION** LOOK ALIKE OR SOUND ALIKE DRUG	START DT: 05/27/06 12:41 STOP DT: PEG TUBE Dose: 20 MG = 1 TAB				1000		AM			
Wound care to left hip + Sacral area		0600	KB					1800	KB	
ARginade (pack) + Glutasolve 1 pack in 120 ml H2O BID					1000		AM	2200		

DATE & TIME	OMISSIONS RESPONSE TO MEDS ADVERSE EFFECTS ETC.	ORDER DATE	NON-RECURRING MEDICATION	DATE	TIME GIVEN	INITI

24-HR. VALIDATION CHECK NURSE: Matthew (S) Humphreys (AM) Thomas (S)

PATIENT NAME	BED NO.
PETERSON, WILLIAM SR	0503 A

10-26956 (5/04)
740.14

AIKEN REGIONAL MEDICAL CENTER

MEDICATION ADMINISTRATION RECORD

SITE CODES
① ABDOMEN
② RIGHT UPPER OUTER QUADRANT BUTTOCK
③ LEFT UPPER OUTER QUADRANT BUTTOCK
④ RIGHT UPPER ARM
⑤ LEFT UPPER ARM
⑥ RIGHT ANTERIOR THIGH
⑦ LEFT ANTERIOR THIGH

PATIENT NAME	BED NO.	AGE	WEIGHT	BSA m²	ADM. DATE	DOSE PERIOD
PETERSON, WILLIAM SR	0503 A		81.640 kg	2.030 M2	05/15/2006	05/28/06-05/28/06

MEDICAL RECORD NO.	ACCOUNT NO.	PHYSICIAN	DIAGNOSIS
26523	102829710	BOKKISAM, CHAKRAVARTHY	UROSEPSIS,ANS,HYPOTHERMIA

ALLERGIES: NKA

MEDICATION ADMINISTRATION TIMES

ORDER / CHECK NURSE	00:00-06:59 TIME	SITE	INITIAL	07:00-14:59 TIME	SITE	INITIAL	15:00-23:59 TIME	SITE	INITIA
POTASSIUM CL 20MEQ/15ML ORAL POTASSIUM CHLORIDE 10% ORAL DAILY Dose: 20 MEQ = 15 ML START DT: 05/27/06 12:41 STOP DT: PRN THIS Dose: 20 MEQ = 15 ML				1000		AM			
ACETAMINOPHEN TYLENOL (EQV) EVERY 4 HOURS AS NEEDED Dose: 650 MG = 2 TAB START DT: 05/16/06 08:01 STOP DT: BY MOUTH Dose: 650 MG = 2 TAB TEMP>101.5 DO NOT GIVE MORE THAN 4 GRAMS PER DAY ACETAMINOPHEN									
DEXTROSE 5% VANCOMYCIN SIG:FREQUENCY: 24 250 ML 1.5 GM = 1.5 VIAL INTRAVENOUS START DT:05/28/06 11:00 INFUSE OVER:1HRS RATE:250 ML/HR TOTAL VOLUME:250 INFUSE OVER AT LEAST 1 HOUR ALL MINI BAGS IN D5W INFUSE OVER AT LEAST 1 HOUR ALL MINI BAGS IN D5W				1100		AM			
DEXTROSE 5% CEFTAZIDIME SIG:AS DIRECTED 100 ML 1 GM = 1 VIAL INTRAVENOUS START DT:05/27/06 13:00 INFUSE OVER:1HRS RATE:100 ML/HR TOTAL VOLUME:100 GIVE Q 8H FOR NEXT TEMP>100.5 CALL RX WHEN NEEDED ALL MINI BAGS IN D5W GIVE Q 8H FOR NEXT TEMP>100.5 CALL RX WHEN NEEDED ALL MINI BAGS IN D5W				1000		AM			

Fibersource HN @ 60 cc/hr Flush H2O

DATE & TIME	OMISSIONS RESPONSE TO MEDS ADVERSE EFFECTS ETC.	ORDER DATE	NON-RECURRING MEDICATION	DATE	TIME GIVEN	INITI
	Vanco level in AM 5/29/06					

24-HR. VALIDATION CHECK NURSE: Matthew

PATIENT NAME	BED NO.

Matthew ( ) Murphy ( ) ( )

10-26356 (5/04)

740.14

Aiken Regional Medical Center
302 University Aiken, South Carolina 29802

DIAGNOSIS: _____
ALLERGIES: _____
NOTES: _____
_____

DATE:

DRUG NAME, STRENGTH, DOSAGE FORM / DOSE RATE ROUTE SCHEDULE	START TIME / DATE	START TIME / DATE	TIME PERIOD TO	TIME PERIOD TO	TIME PERIOD TO
RX: SSRI					(2400) 1005B
NURSE: 150-200=2units 201-250=4units					
RX: 251-300=6units					
NURSE: 301+ call md					
RX: Tap H20 120cc q4o					2200 5B
NURSE:					
RX: accu q60					
NURSE:					
RX: D5W @ 30ml/hr					2200 5B
NURSE:					
RX:					
NURSE:					
RX:					
NURSE:					
RX:					
NURSE:					
RX:					
NURSE:					
RX:					
NURSE:					
RX:					
NURSE:					

INITIALS	SIGNATURE/TITLE	INITIALS	SIGNATURE/TITLE		

NOTES: _____
_____
_____
_____
_____

MEDICATION ADMINISTRATION RECORD

PAGE _____ OF _____ PAGES

102829710
PETERSON SR, WILLIAM SR
DOB: [redacted] 85 SX: M IMD
MRN: 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

ROOM _____ NAME _____ PAT. NO. _____ AGE _____ SEX _____ PHYSICIAN'S NAME _____

601 39 (5/04) WHITE – ORIGINAL COPY CANARY – PHARMACY BILLING 10-1934

AIKEN REGIONAL MEDICAL CENTER

MEDICATION ADMINISTRATION RECORD

SITE CODES
① ABDOMEN
② RIGHT UPPER OUTER QUADRANT BUTTOCK
③ LEFT UPPER OUTER QUADRANT BUTTOCK
④ RIGHT UPPER ARM
⑤ LEFT UPPER ARM
⑥ RIGHT ANTERIOR THIGH
⑦ LEFT ANTERIOR THIGH

PATIENT NAME	BED NO.	AGE	WEIGHT	BSA m²	ADM. DATE	DOSE PERIOD
PETERSON, WILLIAM SR	6503 A	03/11/1921	81.648 kg	2.030 M2	05/15/2006	05/27/06-05/27/06

MEDICAL RECORD NO.	ACCOUNT NO.	PHYSICIAN	DIAGNOSIS
26523	102029710	BOKKISAM, CHAKRAVARTHY	UROSEPSIS,AMS,HYPOTHERMIA

ALLERGIES: NKA

	ORDER CHECK NURSE	00:00-06:59 TIME	SITE	INITIAL	07:00-14:59 TIME	SITE	INITIAL	15:00-23:59 TIME	SITE	INITIA
ACETAMINOPHEN TYLENOL (EQV) ~~EVERY 4 HOURS AS NEEDED~~ Dose: 650 MG = 2 TAB		START DT: 05/15/06 08:01 STOP DT: ~~BY MOUTH~~ Dose: 650 MG = 2 TAB								
TEMP)101.5 DO NOT GIVE MORE THAN 4 GRAMS PER DAY ACETAMINOPHEN	✓									
SODIUM CHLORIDE 0.9% VANCOMYCIN SIG:FREQUENCY: 24	✓	250 ML 1.5 GM = 1.5 VIAL INTRAVENOUS			1100		G			
START DT:05/21/06 11:00 RATE:175 ML/HR INFUSE OVER AT LEAST 1.5 HOURS		INFUSE OVER:1.50HRS TOTAL VOLUME:250 INFUSE OVER AT LEAST 1.5 HOURS								
SODIUM CHLORIDE 0.9% CEFTAZIDIME SIG:AS DIRECTED	✓	100 ML 1 G INTRAVENOUS								
START DT:05/26/06 09:16 RATE:100 ML/HR GIVE Q8H FOR NEX TEMP >100.5 CALL RX WHEN NEEDED		INFUSE OVER:1HRS TOTAL VOLUME:100 GIVE Q8H FOR NEX TEMP >100.5 CALL RX WHEN NEEDED								
Fipersource HN @60 cc/hr E 35cc H2O Flush/hour	✓							1500		G
1 pack Arginade/1 pack Glutasolve in 120 ml of H2O BID	✓				1000		G	2000		G

DATE & TIME	OMISSIONS RESPONSE TO MEDS ADVERSE EFFECTS ETC.	ORDER DATE	NON-RECURRING MEDICATION	DATE	TIME GIVEN	INITI

24-HR. VALIDATION CHECK NURSE: Blatt RN

PATIENT NAME	BED NO.

Blatt RN (8) _____ ( ) _____ (
_____ (8) _____ ( ) _____ (

10-26956 (5/04)
740.14

AIKEN REGIONAL MEDICAL CENTER

MEDICATION ADMINISTRATION RECORD

SITE CODES
① ABDOMEN
② RIGHT UPPER OUTER QUADRANT BUTTOCK
③ LEFT UPPER OUTER QUADRANT BUTTOCK
④ RIGHT UPPER ARM
⑤ LEFT UPPER ARM
⑥ RIGHT ANTERIOR THIGH
⑦ LEFT ANTERIOR THIGH

PATIENT NAME	BED NO.	AGE	WEIGHT	BSA m²	ADM. DATE	DOSE PERIOD
PETERSON, WILLIAM SR	0503 A		81.648 kg	2.030 M2	05/15/2006	05/27/06-05/27/06

MEDICAL RECORD NO.	ACCOUNT NO.	PHYSICIAN	DIAGNOSIS
26523	102829710	DOKKISAM, CHAKRAVARTHY	UROSEPSIS, AMS, HYPOTHERMIA

ALLERGIES: NKA

	ORDER CHECK NURSE	00:00-06:59 TIME	SITE	INITIAL	07:00-14:59 TIME	SITE	INITIAL	15:00-23:59 TIME	SITE	INITIAL
ALBUT/IPRATROPIUM2.5-0.5MG/3ML DUONEB 2.5-0.5MG/3ML ~~EVERY 4 HOURS-SCHEDULED~~ Dose: 3 ML = 3 ML START DT: 05/16/06 10:00 STOP DT: ~~INHALATION~~ Dose: 3 ML = 3 ML		0200	RT		1000	RT		1800	RT	
		~~0600~~	~~RT~~		1400	RT		~~2200~~	~~RT~~	
GIVE PER RESPIRATORY PROTOCOL										
SODIUM CL 0.9% BACTERIOSTATIC SODIUM CL 0.9% BACTERIOSTATIC EVERY EIGHT HOURS Dose: 2 ML START DT: 05/23/06 14:00 STOP DT: INTRAVENOUS Dose: 2 ML		0600		lb	1400		B	2200		lb
FLUSH PERIPHERAL INTERMITTENT IV DEVICE	✓									
FAMOTIDINE PEPCID (ELV) 2 TIMES A DAY Dose: 20 MG = 1 TAB START DT: 05/24/06 10:00 STOP DT: BY MOUTH Dose: 20 MG = 1 TAB	✓				1000		B	2200		lb
PREDNISONE PREDNISONE DAILY Dose: 10 MG = 1 TAB START DT: 05/27/06 10:00 STOP DT: BY MOUTH Dose: 10 MG = 1 TAB	✓				1000		B			
POTASSIUM CL 20MEQ/15ML ORAL POTASSIUM CHLORIDE 10% ORAL Dose: 40 MEQ = 30 ML START DT: 05/26/06 24:00 STOP DT: 05/26/06 24:00 BY MOUTH Dose: 40 MEQ = 30 ML	NO DOSES SCHEDULED									
AT MIDNIGHT										
Wound care to left hip + sacral area BID (See Kardex)					Clarify if this was 1 x order on 2					
					1000		B	2200		lb

DATE & TIME	OMISSIONS RESPONSE TO MEDS ADVERSE EFFECTS ETC.	ORDER DATE	NON-RECURRING MEDICATION	DATE	TIME GIVEN	INITI

24-HR. VALIDATION CHECK NURSE: Matt Rn

PATIENT NAME	BED NO.
PETERSON, WILLIAM SR	0503 A

Matt RN ( ) ( ) ( )

10-26956 (5/04)

740.14

Aiken Regional Medical Center
302 University Aiken, South Carolina 29802

DIAGNOSIS: _____
ALLERGIES: NKA
NOTES: _____

DATE:

DRUG NAME, STRENGTH, DOSAGE FORM / DOSE, RATE, ROUTE, SCHEDULE	START TIME / DATE	START TIME / DATE	TIME PERIOD / TO	TIME PERIOD / TO	TIME PERIOD / TO
RX: Lasix 20mg via PEG now	5-27-06			1140 B	
NURSE:					
RX: Lasix 20mg via PEG qAM	5-28-06				
NURSE:					
RX: KCl 20meq via PEG now	5-27-06			1500 B	
NURSE:					
RX: KCl 20meq via PEG qAM	5-28-06				
NURSE:					
RX:					
NURSE:					
RX:					
NURSE:					
RX:					
NURSE:					
RX:					
NURSE:					
RX:					
NURSE:					
RX:					
NURSE:					
RX:					
NURSE:					
RX:					
NURSE:					

INITIALS	SIGNATURE/TITLE	INITIALS	SIGNATURE/TITLE		
b	[signature]				

NOTES: _____

102829710
PETERSON SR, WILLIAM SR
DOB: [redacted] 85 SX: M IMD
MRN: 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

MEDICATION ADMINISTRATION RECORD PAGE ____ OF ____ PAGES

503 Peterson, William
ROOM NAME PAT. NO. AGE SEX PHYSICIAN'S NAME

601.39 (5/04) WHITE – ORIGINAL COPY CANARY – PHARMACY BILLING 10-1934

AIKEN REGIONAL MEDICAL CENTER

MEDICATION ADMINISTRATION RECORD

SITE CODES
① ABDOMEN
② RIGHT UPPER OUTER QUADRANT BUTTOCK
③ LEFT UPPER OUTER QUADRANT BUTTOCK
④ RIGHT UPPER ARM
⑤ LEFT UPPER ARM
⑥ RIGHT ANTERIOR THIGH
⑦ LEFT ANTERIOR THIGH

PATIENT NAME	BED NO.	AGE	WEIGHT	BSA m²	ADM. DATE	DOSE PERIOD
PETERSON, WILLIAM SR	0503 A	03/11/1921	81.648 kg	2.030 M2	05/15/2006	05/26/06-05/26/06

MEDICAL RECORD NO.	ACCOUNT NO.	PHYSICIAN	DIAGNOSIS
26523	102029710	OKKISAM, CHAKRAVARTHY	UROSEPSIS, AMS, HYPOTHERMIA

ALLERGIES: NKA

	ORDER CHECK NURSE	00:00-06:59 TIME	SITE	INITIAL	07:00-14:59 TIME	SITE	INITIAL	15:00-23:59 TIME	SITE	INITIAL
ALBUT/IPRATROPIUM2.5-0.5MG/3ML. START DT: 05/15/06 10:00 DUONEB 2.5-0.5MG/3ML STOP DT: ~~EVERY 4 HOURS SCHEDULED~~ INHALATION Dose: 3 ML = 3 ML Dose: 3 ML = 3 ML	✓	0200		KT	1000		KT	1800		KT
		0600		KT	1400		KT	2200		KT
GIVE PER RESPIRATORY PROTOCOL										
SODIUM CL 0.9% BACTERIOSTATIC START DT: 05/23/06 14:00 SODIUM CL 0.9% BACTERIOSTATIC STOP DT: EVERY EIGHT HOURS INTRAVENOUS Dose: 2 ML Dose: 2 ML	✓	0500		VP	1400			2200		VP
FLUSH PERIPHERAL INTERMITTENT IV DEVICE										
FAMOTIDINE START DT: 05/24/06 10:00 PEPCID (EQV) STOP DT: 2 TIMES A DAY BY MOUTH Dose: 20 MG = 1 TAB Dose: 20 MG = 1 TAB	✓				1000			2200		
PREDNISONE START DT: 05/26/06 10:00 PREDNISONE STOP DT: 05/26/06 10:00 DAILY BY MOUTH Dose: 20 MG = 2 TAB Dose: 20 MG = 2 TAB	✓				LAST DOSE					
PREDNISONE START DT: 05/27/06 10:00 PREDNISONE STOP DT: DAILY BY MOUTH Dose: 10 MG = 1 TAB Dose: 10 MG = 1 TAB	✓	NO DOSES SCHEDULED								
Fibersource HN @ 60/hr ~~@ 25cc~~ H2O flush 35cc/hr	✓							2100		
1 packet Arginade / 1 packet Glutasolve in 120ml H2O BID	✓				1000			2000		

DATE & TIME	OMISSIONS RESPONSE TO MEDS ADVERSE EFFECTS ETC.	ORDER DATE	NON-RECURRING MEDICATION	DATE	TIME GIVEN	INITIAL

24-HR. VALIDATION CHECK NURSE:

PATIENT NAME	BED NO.
PETERSON, WILLIAM SR	0503 A

10-26956 (5/04)
740.14

AIKEN REGIONAL MEDICAL CENTER

SITE CODES
① ABDOMEN
② RIGHT UPPER OUTER QUADRANT BUTTOCK
③ LEFT UPPER OUTER QUADRANT BUTTOCK
④ RIGHT UPPER ARM
⑤ LEFT UPPER ARM
⑥ RIGHT ANTERIOR THIGH
⑦ LEFT ANTERIOR THIGH

MEDICATION ADMINISTRATION RECORD

PATIENT NAME	BED NO.	AGE	WEIGHT	BSA m²	ADM. DATE	DOSE PERIOD
PETERSON, WILLIAM SR	0503 A		81.648 kg	2.030 M2	05/15/2006	05/26/06-05/26/06

MEDICAL RECORD NO.	ACCOUNT NO.	PHYSICIAN	DIAGNOSIS
26523	102829710	BOKKISAM, CHAKRAVARTHY	UROSEPSIS, AMS, HYPOTHERMIA

ALLERGIES: NKA

	ORDER CHECK NURSE	00:00-05:59 TIME	SITE	INITIAL	07:00-14:59 TIME	SITE	INITIAL	15:00-23:59 TIME	SITE	INITIAL
POTASSIUM CL 20MEQ/15ML ORAL POTASSIUM CHLORIDE 10% ORAL START DT: 05/26/06 24:00 STOP DT: 05/26/06 24:00 ~~BY MOUTH~~		2400		LF						
Dose: 40 MEQ = 30 ML Dose: 40 MEQ = 30 ML AT MIDNIGHT	✓									
ACETAMINOPHEN TYLENOL (EQV) EVERY 4 HOURS AS NEEDED Dose: 650 MG = 2 TAB START DT: 05/16/06 08:01 STOP DT: BY MOUTH Dose: 650 MG = 2 TAB TEMP) 101.5 DO NOT GIVE MORE THAN 4 GRAMS PER DAY ACETAMINOPHEN	✓									
SODIUM CHLORIDE 0.9% VANCOMYCIN SIG:FREQUENCY: 24 250 ML 1.5 GM = 1.5 VIAL INTRAVENOUS START DT:05/21/06 11:00 INFUSE OVER:1.50HRS RATE:175 ML/HR TOTAL VOLUME:250 INFUSE OVER AT LEAST 1.5 HOURS INFUSE OVER AT LEAST 1.5 HOURS	✓				1100	AH				
For next temp ≥ 100.5 - Blood Cx x2 & start Ceftazidine 1gm IVPB Q8° Wound Care to left hip & sacral area BID	✓				1000	AH		2200		LF

DATE & TIME	OMISSIONS RESPONSE TO MEDS ADVERSE EFFECTS ETC.	ORDER DATE	NON-RECURRING MEDICATION	DATE	TIME GIVEN	INITIA

24-HR. VALIDATION CHECK NURSE: Matthew

PATIENT NAME	BED NO.
PETERSON, WILLIAM SR	0503 A

Matthew (LF) ( ) ( )
( ) Deborah (AH) ( )

10-26956 (5/04)
740.14

AIKEN REGIONAL MEDICAL CENTER

SITE CODES
① ABDOMEN
② RIGHT UPPER OUTER QUADRANT BUTTOCK
③ LEFT UPPER OUTER QUADRANT BUTTOCK
④ RIGHT UPPER ARM
⑤ LEFT UPPER ARM
⑥ RIGHT ANTERIOR THIGH
⑦ LEFT ANTERIOR THIGH

MEDICATION ADMINISTRATION RECORD

PATIENT NAME	BED NO.	AGE	WEIGHT	BSA m²	ADM. DATE	DOSE PERIOD
PETERSON, WILLIAM SR	0503 A		81.648 kg	2.030 M2	05/15/2006	05/25/06-05/25/06

MEDICAL RECORD NO.	ACCOUNT NO.	PHYSICIAN	DIAGNOSIS
26523	102829710	BOKKISAM, CHAKRAVARTHY	UROSEPSIS, ANS, HYPOTHERMIA

ALLERGIES: NKA

ORDER / CHECK NURSE	00:00-06:59 TIME	SITE	INITIAL	07:00-14:59 TIME	SITE	INITIAL	15:00-23:59 TIME	SITE	INITIAL
ALBUT/IPRATROPIUM2.5-0.5MG/3ML. START DT: 05/16/06 10:00 DUONEB 2.5-0.5MG/3ML STOP DT: EVERY 4 HOURS-SCHEDULED INHALATION Dose: 3 ML = 3 ML Dose: 3 ML = 3 ML	0200		RT	1000		RT	1800		RT
	0600		RT	1400		RT	2200		RT
GIVE PER RESPIRATORY PROTOCOL									
SODIUM CL 0.9% BACTERIOSTATIC START DT: 05/23/06 14:00 SODIUM CL 0.9% BACTERIOSTATIC STOP DT: EVERY EIGHT HOURS INTRAVENOUS Dose: 2 ML Dose: 2 ML JS	0600		JS	1400		JS	2200		JS
FLUSH PERIPHERAL INTERMITTENT IV DEVICE									
FAMOTIDINE START DT: 05/24/06 10:00 PEPCID (EQV) STOP DT: 2 TIMES A DAY ~~BY MOUTH~~ ↓PEG Dose: 20 MG = 1 TAB Dose: 20 MG = 1 TAB JS				1000		JS	2200		JS
PREDNISONE START DT: 05/25/06 10:00 PREDNISONE STOP DT: 05/25/06 10:00 DAILY BY MOUTH Dose: 30 MG = 3 TAB Dose: 30 MG = 3 TAB				LAST DOSE		wrong order			
PREDNISONE START DT: 05/26/06 10:00 PREDNISONE STOP DT: 05/26/06 10:00 DAILY BY MOUTH Dose: 20 MG = 2 TAB Dose: 20 MG = 2 TAB			NO DOSES SCHEDULED			wrong order			
PREDNISONE START DT: 05/27/06 10:00 PREDNISONE STOP DT: DAILY ~~BY MOUTH~~ ↓NGT ↓PEG JS Dose: 10 MG = 1 TAB Dose: 10 MG = 1 TAB			NO DOSES SCHEDULED	0900		JS			
Drug KCl now tinted Red & pkg				1140		JS	1540		JS

DATE & TIME	OMISSIONS RESPONSE TO MEDS ADVERSE EFFECTS ETC.	ORDER DATE	NON-RECURRING MEDICATION	DATE	TIME GIVEN	INITI

24-HR. VALIDATION CHECK NURSE: Shawnee Johnson JS Matthew

PATIENT NAME	BED NO.
PETERSON, WILLIAM SR	0503 A

10-26956 (5/04)

740.14

AIKEN REGIONAL MEDICAL CENTER

MEDICATION ADMINISTRATION RECORD

SITE CODES
① ABDOMEN
② RIGHT UPPER OUTER QUADRANT BUTTOCK
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④ RIGHT UPPER ARM
⑤ LEFT UPPER ARM
⑥ RIGHT ANTERIOR THIGH
⑦ LEFT ANTERIOR THIGH

PATIENT NAME	BED NO.	AGE	WEIGHT	BSA m²	ADM. DATE	DOSE PERIOD
PETERSON, WILLIAM SR	0503 A		81.648 kg	2.030 M2	05/15/2006	05/25/06-05/25/06

MEDICAL RECORD NO.	ACCOUNT NO.	PHYSICIAN	DIAGNOSIS
26523	102829710	SOKKISAM, CHAKRAVARTHY	UROSEPSIS, AMS, HYPOTHERMIA

ALLERGIES: NKA

ORDER / CHECK NURSE	MEDICATION ADMINISTRATION TIMES 00:00-06:59 (TIME / SITE / INITIAL)	07:00-14:59 (TIME / SITE / INITIAL)	15:00-23:59 (TIME / SITE / INITIAL)
ACETAMINOPHEN TYLENOL (EQV) ~~EVERY 4 HOURS AS NEEDED~~ Dose: 650 MG = 2 TAB START DT: 05/16/06 08:01 STOP DT: ~~BY MOUTH~~ Dose: 650 MG = 2 TAB TEMP) 101.5 DO NOT GIVE MORE THAN 4 GRAMS PER DAY ACETAMINOPHEN	JS		
SODIUM CHLORIDE 0.9% VANCOMYCIN SIG:FREQUENCY: 24 250 ML 1.5 GM = 1.5 VIAL INTRAVENOUS START DT:05/21/06 11:00 INFUSE OVER:1.50HRS RATE:175 ML/HR TOTAL VOLUME:250 INFUSE OVER AT LEAST 1.5 HOURS INFUSE OVER AT LEAST 1.5 HOURS	JS	1100 ① 2300 JS	
1 pkt Arginaate + 1 pkt Glutasolve in 120mL H_2O ↓PEG BID	JS	0900 JS	2100 hf
wound care to hip & bottom			2200 hf
Vent ——— for Bronch 240 cc tap H_2O down PEG	✓		2200 hf
ICU 40 mEq @ 12 MN			

DATE & TIME	OMISSIONS RESPONSE TO MEDS ADVERSE EFFECTS ETC.	ORDER DATE	NON-RECURRING MEDICATION	DATE	TIME GIVEN	INITIA

24-HR. VALIDATION CHECK NURSE Jennifer Stegall RN JS Matthew Blatt RN

PATIENT NAME	BED NO.
PETERSON, WILLIAM SR	0503 A

10-26955 (5/04)
740.14

AIKEN REGIONAL MEDICAL CENTER

MEDICATION ADMINISTRATION RECORD

SITE CODES
① ABDOMEN
② RIGHT UPPER OUTER QUADRANT BUTTOCK
③ LEFT UPPER OUTER QUADRANT BUTTOCK
④ RIGHT UPPER ARM
⑤ LEFT UPPER ARM
⑥ RIGHT ANTERIOR THIGH
⑦ LEFT ANTERIOR THIGH

PATIENT NAME	BED NO.	AGE	WEIGHT	BSA m²	ADM. DATE	DOSE PERIOD
PETERSON, WILLIAM SR	0503 A		81.648 kg	2.030 M2	05/15/2006	05/24/06-05/24/06

MEDICAL RECORD NO.	ACCOUNT NO.	PHYSICIAN	DIAGNOSIS
26523	102829710	BOKKISAM, CHAKRAVARTHY	UROSEPSIS,ANS,HYPOTHERMIA

ALLERGIES
NKA

ORDER	ORDER CHECK NURSE	00:00-06:59 TIME	SITE	INITIAL	07:00-14:59 TIME	SITE	INITIAL	15:00-23:59 TIME	SITE	INITIAL
ALBUT/IPRATROPIUM2.5-0.5MG/3ML DUONEB 2.5-0.5MG/3ML ~~EVERY 4 HOURS SCHEDULED~~ Dose: 3 ML = 3 ML	JS	0200 0600		RT RT	1000 1400		RT RT	1800 2200		RT RT
GIVE PER RESPIRATORY PROTOCOL										
HYDROCORTISONE SOD SUCCINATE SOLU-CORTEF EVERY EIGHT HOURS Dose: 100 MG = 2 ML	JS	0400		JS	1200		JS	2000		JS
PANTOPRAZOLE SODIUM PROTONIX IV 40 MG EVERY 24 HOURS Dose: 40 MG = 10 ML	JS							1900 2000		JS
RECONSTITUTE WITH 10ML OF NS GIVE IVP OVER A MINIMUM 2MIN										
SODIUM CL 0.9% BACTERIOSTATIC SODIUM CL 0.9% BACTERIOSTATIC EVERY EIGHT HOURS Dose: 2 ML	JS	0600		JS	1400		JS	2200		JS
FLUSH PERIPHERAL INTERMITTENT IV DEVICE										

DATE & TIME	OMISSIONS RESPONSE TO MEDS ADVERSE EFFECTS ETC.	ORDER DATE	NON-RECURRING MEDICATION	DATE	TIME GIVEN	INITIA

24-HR. VALIDATION CHECK NURSE: JS Schuster RN(S) _____ ( ) _____ ( ) _____ (

PATIENT NAME	BED NO.
PETERSON, WILLIAM SR	0503 A

10-26956 (5/04)
740.14

AIKEN REGIONAL MEDICAL CENTER

MEDICATION ADMINISTRATION RECORD

SITE CODES
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⑤ LEFT UPPER ARM
⑥ RIGHT ANTERIOR THIGH
⑦ LEFT ANTERIOR THIGH

PATIENT NAME	BED NO.	AGE	WEIGHT	BSA m²	ADM. DATE	DOSE PERIOD
PETERSON, WILLIAM SR	0503 A		81.648 kg	2.030 M2	05/15/2006	05/24/06-05/24/06

MEDICAL RECORD NO.	ACCOUNT NO.	PHYSICIAN	DIAGNOSIS
26523	102829710	BOKKISAM, CHAKRAVARTHY	UROSEPSIS, AMS, HYPOTHERMIA

ALLERGIES: NKA

MEDICATION ADMINISTRATION TIMES

ORDER / CHECK NURSE	00:00-06:59 TIME	SITE	INITIAL	07:00-14:59 TIME	SITE	INITIAL	15:00-23:59 TIME	SITE	INITIAL
ACETAMINOPHEN START DT: 05/15/06 08:01 TYLENOL (EQV) STOP DT: ~~EVERY 4 HOURS AS NEEDED~~ ~~BY MOUTH~~ Dose: 650 MG = 2 TAB Dose: 650 MG = 2 TAB JS TEMP) 101.5 DO NOT GIVE MORE THAN 4 GRAMS PER DAY ACETAMINOPHEN									
SODIUM CHLORIDE 0.9% 100 ML ZOSYN 3.375 GRAM SIG:FREQUENCY: 6 INTRAVENOUS JS START DT:05/16/06 03:30 INFUSE OVER:1HRS RATE:100 ML/HR TOTAL VOLUME:100	0330	JS		0930			1530 2130		
SODIUM CHLORIDE 0.9% 250 ML VANCOMYCIN 1.5 GM = 1.5 VIAL SIG:FREQUENCY: 24 INTRAVENOUS JS START DT:05/21/06 11:00 INFUSE OVER:1.50HRS RATE:175 ML/HR TOTAL VOLUME:250 INFUSE OVER AT LEAST 1.5 HOURS INFUSE OVER AT LEAST 1.5 HOURS				1100 1400					
Prednisone 40mg ↓PEG this AM + 40mg ↓PEG q day until off JS				1000					
1 pkt Arginaide + 1 pkt Glutasolve in 120 mL H2O ↓PEG BID JS				1000			2200		

DATE & TIME	OMISSIONS RESPONSE TO MEDS ADVERSE EFFECTS ETC.	ORDER DATE	NON-RECURRING MEDICATION	DATE	TIME GIVEN	INITIA

24-HR. VALIDATION CHECK NURSE: J. Stanford J. Stanford (JS) S. Quiste RN (SE)

PATIENT NAME	BED NO.
PETERSON, WILLIAM SR	0503 A

10-20956 (5/04)
740.14

AIKEN REGIONAL MEDICAL CENTER

SITE CODES
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MEDICATION ADMINISTRATION RECORD

PATIENT NAME	BED NO.	AGE	WEIGHT	BSA m²	ADM. DATE	DOSE PERIOD
PETERSON, WILLIAM SR	0503 A		81.648 kg	2.030 M2	05/15/2006	05/23/06-05/23/06

MEDICAL RECORD NO.	ACCOUNT NO.	PHYSICIAN	DIAGNOSIS
26523	102829710	BOKKISAM, CHAKRAVARTHY	UROSEPSIS,AMS,HYPOTHERMIA

ALLERGIES: NKA

ORDER	ORDER CHECK NURSE	00:00-06:59 TIME	SITE	INITIAL	07:00-14:59 TIME	SITE	INITIAL	15:00-23:59 TIME	SITE	INITIAL
ALBUT/IPRATROPIUM2.5-0.5MG/3ML DUONEB 2.5-0.5MG/3ML EVERY 4 HOURS SCHEDULED Dose: 3 ML = 3 ML START DT: 05/16/06 10:00 STOP DT: INHALATION Dose: 3 ML = 3 ML	JS	0200	RT		1000	RT		1800	RT	
		0600	RT		1400	RT		2200	RT	
GIVE PER RESPIRATORY PROTOCOL										
HYDROCORTISONE SOD SUCCINATE SOLU-CORTEF EVERY EIGHT HOURS Dose: 100 MG = 2 ML START DT: 05/16/06 12:00 STOP DT: INTRAVENOUS Dose: 100 MG = 2 ML	JS	0400	W		1200 1300 1400	W W		2000 2100 1400	W	
PANTOPRAZOLE SODIUM PROTONIX IV 40 MG EVERY 24 HOURS Dose: 40 MG = 10 ML START DT: 05/18/06 19:00 STOP DT: INTRAVENOUS Dose: 40 MG = 10 ML	JS							1900	W	
RECONSTITUTE WITH 10ML OF NS GIVE IVP OVER A MINIMUM 2MIN										
ACETAMINOPHEN TYLENOL (EQV) EVERY 4 HOURS AS NEEDED Dose: 650 MG = 2 TAB START DT: 05/16/06 08:01 STOP DT: BY MOUTH Dose: 650 MG = 2 TAB	JS									
TEMP)101.5 DO NOT GIVE MORE THAN 4 GRAMS PER DAY ACETAMINOPHEN										

DATE & TIME	OMISSIONS RESPONSE TO MEDS ADVERSE EFFECTS ETC.	ORDER DATE	NON-RECURRING MEDICATION	DATE	TIME GIVEN	INITI

24-HR. VALIDATION CHECK NURSE: JS

PATIENT NAME	BED NO.
PETERSON, WILLIAM SR	0503 A

10-26956 (5/04)
740.14

AIKEN REGIONAL MEDICAL CENTER

MEDICATION ADMINISTRATION RECORD

SITE CODES
① ABDOMEN
② RIGHT UPPER OUTER QUADRANT BUTTOCK
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④ RIGHT UPPER ARM
⑤ LEFT UPPER ARM
⑥ RIGHT ANTERIOR THIGH
⑦ LEFT ANTERIOR THIGH

PATIENT NAME	BED NO.	AGE	WEIGHT	BSA m²	ADM. DATE	DOSE PERIOD
PETERSON, WILLIAM SR	0503 A		81.648 kg	2.030 M2	05/15/2006	05/23/06-05/23/06

MEDICAL RECORD NO.	ACCOUNT NO.	PHYSICIAN	DIAGNOSIS
26523	102829710	BOKKISAM, CHAKRAVARTHY	UROSEPSIS, AMS, HYPOTHERMIA

ALLERGIES: NKA

ORDER - CHECK NURSE	00:00-06:59 TIME	SITE	INITIAL	07:00-14:59 TIME	SITE	INITIAL	15:00-23:59 TIME	SITE	INITIAL
SODIUM CHLORIDE 0.9% 100 ML ZOSYN 3.375 GRAM ~~SIG:FREQUENCY: 6 INTRAVENOUS~~ START DT:05/16/06 03:30 INFUSE OVER:1HRS RATE:100 ML/HR TOTAL VOLUME:100	0330		DL	0930		KP	1530 2130		KP JS
METRONIDAZOLE 500MG/NS 100ML 100 ML SIG:FREQUENCY: 8 INTRAVENOUS START DT:05/16/06 14:00 INFUSE OVER:1HRS RATE:100 ML/HR TOTAL VOLUME:100 DC'd	0600		DL	1400			2200		
D5W/0.45% SODIUM CHLORIDE 1000 ML POTASSIUM CHLORIDE 40 MEQ = 20 ML SIG:FREQUENCY: 17 INTRAVENOUS START DT:05/19/06 15:30 RATE:60 ML/HR TOTAL VOLUME:1020 *HIGH ALERT MED- DOUBLE CHECK DRUG & DOSE* DC'd	0430		DL	1000		KP	2130		
SODIUM CHLORIDE 0.9% 250 ML VANCOMYCIN 1.5 GM = 1.5 VIAL SIG:FREQUENCY: 24 INTRAVENOUS START DT:05/21/06 11:00 INFUSE OVER:1.5HRS RATE:175 ML/HR TOTAL VOLUME:250 INFUSE OVER AT LEAST 1.5 HOURS Peak ③ Trough This PSE Peak Draws (unable to draw) For 5/24/06 Vanc Peak w/ next dose				1100		KP			
Prednisone 10mg ↓ PEG @ 9pm tonight x 4							2100		JS

DATE & TIME	OMISSIONS RESPONSE TO MEDS ADVERSE EFFECTS ETC.	ORDER DATE	NON-RECURRING MEDICATION	DATE	TIME GIVEN	INITIA

24-HR. VALIDATION CHECK NURSE: (JS) (KP) ( ) ( )

PATIENT NAME	BED NO.
Peterson, William SR	503

10-26956 (5/04)

740.14

AIKEN REGIONAL MEDICAL CENTER

MEDICATION ADMINISTRATION RECORD

SITE CODES
① ABDOMEN
② RIGHT UPPER OUTER QUADRANT BUTTOCK
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④ RIGHT UPPER ARM
⑤ LEFT UPPER ARM
⑥ RIGHT ANTERIOR THIGH
⑦ LEFT ANTERIOR THIGH

PATIENT NAME	BED NO.	AGE	WEIGHT	BSA m²	ADM. DATE	DOSE PERIOD
PETERSON, WILLIAM SR	0503 A		81.648 kg	2.030 M2	05/15/2006	05/22/06-05/22/06

MEDICAL RECORD NO.	ACCOUNT NO.	PHYSICIAN	DIAGNOSIS
26523	102829710	BOKKISAM, CHAKRAVARTHY	UROSEPSIS, AMS, HYPOTHERMIA

ALLERGIES: NKA

	ORDER CHECK NURSE	00:00-06:59 TIME	SITE	INITIAL	07:00-14:59 TIME	SITE	INITIAL	15:00-23:59 TIME	SITE	INITIAL
ALBUT/IPRATROPIUM2.5-0.5MG/3ML START DT: 05/16/06 10:00 DUONEB 2.5-0.5MG/3ML STOP DT: ~~EVERY 4 HOURS-SCHEDULED~~ INHALATION Dose: 3 ML = 3 ML Dose: 3 ML = 3 ML	✓	0200 0600			1000 1400	RT RT		1800 2200	①	
GIVE PER RESPIRATORY PROTOCOL										
HYDROCORTISONE SOD SUCCINATE START DT: 05/16/06 12:00 SOLU-CORTEF STOP DT: EVERY EIGHT HOURS INTRAVENOUS Dose: 100 MG = 2 ML Dose: 100 MG = 2 ML	✓	0400	MC		1200	MM		2000	①	
PANTOPRAZOLE SODIUM START DT: 05/18/06 19:00 PROTONIX IV 40 MG STOP DT: EVERY 24 HOURS INTRAVENOUS Dose: 40 MG = 10 ML Dose: 40 MG = 10 ML	✓							1900		
RECONSTITUTE WITH 10ML OF NS GIVE IVP OVER A MINIMUM 2MIN										
ACETAMINOPHEN START DT: 05/16/06 08:01 TYLENOL (EQV) STOP DT: EVERY 4 HOURS AS NEEDED BY MOUTH Dose: 650 MG = 2 TAB Dose: 650 MG = 2 TAB	✓									
TEMP) 101.5 DO NOT GIVE MORE THAN 4 GRAMS PER DAY ACETAMINOPHEN										
Arginade + one scoop Promod in 4 oz. H2O + push in peg tube BID					1000 called Katelyn for 1330		MM	2200		

DATE & TIME	OMISSIONS RESPONSE TO MEDS ADVERSE EFFECTS ETC.	ORDER DATE	NON-RECURRING MEDICATION	DATE	TIME GIVEN	INITIA

24-HR. VALIDATION CHECK NURSE MA

PATIENT NAME	BED NO.
PETERSON, WILLIAM SR	0503 A

10-26956 (5/04)

740.14

AIKEN REGIONAL MEDICAL CENTER

SITE CODES
① ABDOMEN
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MEDICATION ADMINISTRATION RECORD

PATIENT NAME	BED NO.	AGE	WEIGHT	BSA m²	ADM. DATE	DOSE PERIOD
PETERSON, WILLIAM SR	0503 A		81.648 kg	2.030 M2	05/15/2006	05/22/06-05/22/06

MEDICAL RECORD NO.	ACCOUNT NO.	PHYSICIAN	DIAGNOSIS
26523	102829710	BOKKISAM, CHAKRAVARTHY	UROSEPSIS, AMS, HYPOTHERMIA

ALLERGIES: NKA

MEDICATION ADMINISTRATION TIMES

	ORDER CHECK NURSE	00:00-06:59 TIME	SITE	INITIAL	07:00-14:59 TIME	SITE	INITIAL	15:00-23:59 TIME	SITE	INITIAL
SODIUM CHLORIDE 0.9% 100 ML ZOSYN 3.375 GRAM SIG:FREQUENCY: 6 INTRAVENOUS START DT:05/16/06 03:30 INFUSE OVER:1HRS RATE:100 ML/HR TOTAL VOLUME:100	✓	0330		NA	0930		MG	1530		MG
								2130		RC
METRONIDAZOLE 500MG/NS 100ML 100 ML SIG:FREQUENCY: 8 INTRAVENOUS START DT:05/16/06 14:00 INFUSE OVER:1HRS RATE:100 ML/HR TOTAL VOLUME:100	✓	0600		NA	1400		MG	2200		RC
D5W/0.45% SODIUM CHLORIDE 1000 ML POTASSIUM CHLORIDE 40 MEQ = 20 ML SIG:FREQUENCY: 17 INTRAVENOUS START DT:05/19/06 15:30 RATE:60 ML/HR TOTAL VOLUME:1020 *HIGH ALERT MED- DOUBLE CHECK DRUG & DOSE*	✓				1130					
SODIUM CHLORIDE 0.9% 250 ML VANCOMYCIN 1.5 GM = 1.5 VIAL SIG:FREQUENCY: 24 INTRAVENOUS START DT:05/21/06 11:00 INFUSE OVER:1.5HRS RATE:175 ML/HR TOTAL VOLUME:250 INFUSE OVER AT LEAST 1.5 HOURS INFUSE OVER AT LEAST 1.5 HOURS	✓				1100		MG			
½ Strength Impact Advance by 10 mL q10° as tolerated to goal of 60 mL/hr.					0900 held @ 0700 to transfer 1150 MG ↑60 c/o					

DATE & TIME	OMISSIONS RESPONSE TO MEDS ADVERSE EFFECTS ETC.	ORDER DATE	NON-RECURRING MEDICATION	DATE	TIME GIVEN	INITIA

24-HR. VALIDATION CHECK NURSE: NA

PATIENT NAME	BED NO.

( ) ( )

10-26956 (5/04)

740.14

AIKEN REGIONAL MEDICAL CENTER

MEDICATION ADMINISTRATION RECORD

SITE CODES
① ABDOMEN
② RIGHT UPPER OUTER QUADRANT BUTTOCK
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⑥ RIGHT ANTERIOR THIGH
⑦ LEFT ANTERIOR THIGH

PATIENT NAME	BED NO.	AGE	WEIGHT	BSA m²	ADM. DATE	DOSE PERIOD
PETERSON, WILLIAM SR	0503 A		81.648 kg	2.030 M²	05/15/2006	05/21/06-05/21/06

MEDICAL RECORD NO.	ACCOUNT NO.	PHYSICIAN	DIAGNOSIS
26523	102829710	BOKKISAM, CHAKRAVARTHY	UROSEPSIS, AMS, HYPOTHERMIA

ALLERGIES: NKA

	ORDER CHECK NURSE	00:00-06:59 TIME	SITE	INITIAL	07:00-14:59 TIME	SITE	INITIAL	15:00-23:59 TIME	SITE	INITIAL
ALBUT/IPRATROPIUM2.5-0.5MG/3ML DUONEB 2.5-0.5MG/3ML EVERY 4 HOURS-SCHEDULED Dose: 3 ML = 3 ML START DT: 05/16/06 10:00 STOP DT: INHALATION Dose: 3 ML = 3 ML		0200 0600	⑤ ⑤	[illegible] [illegible]	1000 1400	⑤ ⑤	RT RT	1800 2200	⑤	RT
GIVE PER RESPIRATORY PROTOCOL										
HYDROCORTISONE SOD SUCCINATE SOLU-CORTEF EVERY EIGHT HOURS Dose: 100 MG = 2 ML START DT: 05/16/06 12:00 STOP DT: INTRAVENOUS Dose: 100 MG = 2 ML		0400		[illegible]	1200		SS	2000		SS
PANTOPRAZOLE SODIUM PROTONIX IV 40 MG EVERY 24 HOURS Dose: 40 MG = 10 ML START DT: 05/18/06 19:00 STOP DT: INTRAVENOUS Dose: 40 MG = 10 ML								1900		SB
RECONSTITUTE WITH 10ML OF NS GIVE IVP OVER A MINIMUM 2MIN										
ACETAMINOPHEN TYLENOL (EQV) EVERY 4 HOURS AS NEEDED Dose: 650 MG = 2 TAB START DT: 05/16/06 08:01 STOP DT: BY MOUTH Dose: 650 MG = 2 TAB										
TEMP) 101.5 DO NOT GIVE MORE THAN 4 GRAMS PER DAY ACETAMINOPHEN										
Ambien; one scoop Promod in 1N 4 oz H2O + push BID					0900		SS	2100		SS

DATE & TIME	OMISSIONS RESPONSE TO MEDS ADVERSE EFFECTS ETC.	ORDER DATE	NON-RECURRING MEDICATION	DATE	TIME GIVEN	INITIA

24-HR. VALIDATION CHECK NURSE [signature] [signature] (RT) S Schrader RN (SS) ( ) ( ) (

PATIENT NAME	BED NO.
PETERSON, WILLIAM SR	0503 A

10-26856 (5/04)
740.14

AIKEN REGIONAL MEDICAL CENTER

SITE CODES
① ABDOMEN
② RIGHT UPPER OUTER QUADRANT BUTTOCK
③ LEFT UPPER OUTER QUADRANT BUTTOCK
④ RIGHT UPPER ARM
⑤ LEFT UPPER ARM
⑥ RIGHT ANTERIOR THIGH
⑦ LEFT ANTERIOR THIGH

MEDICATION ADMINISTRATION RECORD

PATIENT NAME	BED NO.	AGE	WEIGHT	BSA m²	ADM. DATE	DOSE PERIOD
PETERSON, WILLIAM SR	0503 A	[redacted]	81.648 kg	2.030 M2	05/15/2006	05/21/06-05/21/06

MEDICAL RECORD NO.	ACCOUNT NO.	PHYSICIAN	DIAGNOSIS
26523	102829710	BOKKISAM, CHAKRAVARTHY	UROSEPSIS, ANS, HYPOTHERMIA

ALLERGIES: NKA

ORDER	ORDER CHECK NURSE	00:00-06:59 TIME	SITE	INITIAL	07:00-14:59 TIME	SITE	INITIAL	15:00-23:59 TIME	SITE	INITIAL
MORPHINE SULFATE MORPHINE SULFATE EVERY 8 HOURS AS NEEDED Dose: 1 MG = 0.1 ML										
START DT: 05/16/06 11:48 STOP DT: 05/21/06 11:48 INTRAVENOUS Dose: 1 MG = 0.1 ML										
FOR PAIN ***USE CAUTION** LOOK ALIKE OR SOUND ALIKE DRUG										
SODIUM CHLORIDE 0.9% ZOSYN SIG:FREQUENCY: 6		0330		[signature]	0930		SS	1530 2130		SS NA
100 ML 3.375 GRAM INTRAVENOUS										
START DT:05/16/06 03:30 RATE:100 ML/HR										
INFUSE OVER:1HRS TOTAL VOLUME:100										
METRONIDAZOLE 500MG/NS 100ML SIG:FREQUENCY: 8		0500		[signature]	1400		SS	2200		NA
100 ML INTRAVENOUS										
START DT:05/16/06 14:00 RATE:100 ML/HR										
INFUSE OVER:1HRS TOTAL VOLUME:100										
D5W/0.45% SODIUM CHLORIDE POTASSIUM CHLORIDE SIG:FREQUENCY: 17		0130		[signature]				1830 2330		NA
1000 ML 40 MEQ = 20 ML INTRAVENOUS										
START DT:05/19/06 15:30 RATE:60 ML/HR TOTAL VOLUME:1020 *HIGH ALERT MED- DOUBLE CHECK DRUG & DOSE*										
1/2 STRENGTH IMPACT 1.5 @ 20ml/Hr ADVANCE BY 10 ml q 10 Hrs until goal of 60ml/Hr								2200		NA

DATE & TIME	OMISSIONS RESPONSE TO MEDS ADVERSE EFFECTS ETC.	ORDER DATE	NON-RECURRING MEDICATION	DATE	TIME GIVEN	INITIA

24-HR. VALIDATION CHECK NURSE: [signature] (JC) _____ ( ) SSchroder RN SS

PATIENT NAME	BED NO.
PETERSON, WILLIAM SR	0503 A

_____ ( ) _____ ( ) _____ (

10-26956 (5/04)

740.14

AIKEN REGIONAL MEDICAL CENTER

MEDICATION ADMINISTRATION RECORD

SITE CODES
① ABDOMEN
② RIGHT UPPER OUTER QUADRANT BUTTOCK
③ LEFT UPPER OUTER QUADRANT BUTTOCK
④ RIGHT UPPER ARM
⑤ LEFT UPPER ARM
⑥ RIGHT ANTERIOR THIGH
⑦ LEFT ANTERIOR THIGH

PATIENT NAME	BED NO.	AGE	WEIGHT	BSA m²	ADM. DATE	DOSE PERIOD
PETERSON, WILLIAM SR	0503 A		81.648 kg	2.030 M2	05/15/2006	05/21/06-05/21/06

MEDICAL RECORD NO.	ACCOUNT NO.	PHYSICIAN	DIAGNOSIS
26523	102829710	BOKKISAM, CHAKRAVARTHY	UROSEPSIS, AMS, HYPOTHERMIA

ALLERGIES: NKA

ORDER	ORDER CHECK NURSE	MEDICATION ADMINISTRATION TIMES 00:00-06:59 TIME / SITE / INITIAL	07:00-14:59 TIME / SITE / INITIAL	15:00-23:59 TIME / SITE / INITIAL
SODIUM CHLORIDE 0.9% 250 ML VANCOMYCIN ~~1.25 GRAM~~ ~~SIG:FREQUENCY:24 INTRAVENOUS~~ *↑Dose to 1.5gm Q24hrs* START DT:05/21/06 09:00 INFUSE OVER:1.50HRS RATE:175 ML/HR TOTAL VOLUME:250 INFUSE OVER AT LEAST 1.5 HOURS		~~0300~~	1200 SS	

INFUSE OVER AT LEAST 1.5 HOURS

DATE & TIME	OMISSIONS RESPONSE TO MEDS ADVERSE EFFECTS ETC.	ORDER DATE	NON-RECURRING MEDICATION	DATE	TIME GIVEN	INITIA

24-HR. VALIDATION CHECK NURSE: ( ) ( ) SS

PATIENT NAME	BED NO.
PETERSON, WILLIAM SR	0503 A

( ) ( ) ( ) ( )

10-26956 (5/04)

740.14

AIKEN REGIONAL MEDICAL CENTER

SITE CODES
① ABDOMEN
② RIGHT UPPER OUTER QUADRANT BUTTOCK
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⑦ LEFT ANTERIOR THIGH

MEDICATION ADMINISTRATION RECORD

PATIENT NAME	BED NO.	AGE	WEIGHT	BSA m²	ADM. DATE	DOSE PERIOD
PETERSON, WILLIAM SR	0503 A	[redacted]	81.648 kg	2.030 M2	05/15/2006	05/20/06-05/20/06

MEDICAL RECORD NO.	ACCOUNT NO.	PHYSICIAN	DIAGNOSIS
26523	102829710	BOKKISAM, CHAKRAVARTHY	UROSEPSIS, AMS, HYPOTHERMIA

ALLERGIES: NKA

ORDER	ORDER CHECK NURSE	00:00-06:59 TIME	SITE	INITIAL	07:00-14:59 TIME	SITE	INITIAL	15:00-23:59 TIME	SITE	INITIAL
ALBUT/IPRATROPIUM2.5-0.5MG/3ML DUONEB 2.5-0.5MG/3ML EVERY 4 HOURS-SCHEDULED Dose: 3 ML = 3 ML START DT: 05/16/06 10:00 STOP DT: INHALATION Dose: 3 ML = 3 ML GIVE PER RESPIRATORY PROTOCOL	RT	0200 0600	① ①	VK VK	1000 1400	RT RT		1800 2200	RT RT	
HYDROCORTISONE SOD SUCCINATE SOLU-CORTEF EVERY EIGHT HOURS Dose: 100 MG = 2 ML START DT: 05/16/06 12:00 STOP DT: INTRAVENOUS Dose: 100 MG = 2 ML	KF	0400		KF	1200		SS	2000		
PANTOPRAZOLE SODIUM PROTONIX IV 40 MG EVERY 24 HOURS Dose: 40 MG = 10 ML START DT: 05/18/06 19:00 STOP DT: INTRAVENOUS Dose: 40 MG = 10 ML RECONSTITUTE WITH 10ML OF NS GIVE IVP OVER A MINIMUM 2MIN	KF							1900		
ACETAMINOPHEN TYLENOL (EQV) EVERY 4 HOURS AS NEEDED Dose: 650 MG = 2 TAB START DT: 05/16/06 08:01 STOP DT: BY MOUTH Dose: 650 MG = 2 TAB TEMP) 101.5 DO NOT GIVE MORE THAN 4 GRAMS PER DAY ACETAMINOPHEN	KF							1200		SS
Arginade: One Scoop Promodium in 4oz H2O & Push BID	KF									

DATE & TIME	OMISSIONS RESPONSE TO MEDS ADVERSE EFFECTS ETC.	ORDER DATE	NON-RECURRING MEDICATION	DATE	TIME GIVEN	INITIAL

24-HR. VALIDATION CHECK NURSE: K. Inemaupu

PATIENT NAME	BED NO.
PETERSON, WILLIAM SR	0503 A

K. Inemaupu (KF) _____ ( ) SSchandera (SS)
_____ ( ) _____ ( ) _____ (

10-26956 (5/04)
740.14

AIKEN REGIONAL MEDICAL CENTER

MEDICATION ADMINISTRATION RECORD

SITE CODES
① ABDOMEN
② RIGHT UPPER OUTER QUADRANT BUTTOCK
③ LEFT UPPER OUTER QUADRANT BUTTOCK
④ RIGHT UPPER ARM
⑤ LEFT UPPER ARM
⑥ RIGHT ANTERIOR THIGH
⑦ LEFT ANTERIOR THIGH

PATIENT NAME	BED NO.	AGE	WEIGHT	BSA m²	ADM. DATE	DOSE PERIOD
PETERSON, WILLIAM SR	0503 A		81.648 kg	2.030 M2	05/15/2006	05/20/06-05/20/06

MEDICAL RECORD NO.	ACCOUNT NO.	PHYSICIAN	DIAGNOSIS
26523	102829710	BOKKISAM, CHAKRAVARTHY	UROSEPSIS, AMS, HYPOTHERMIA

ALLERGIES: NKA

ORDER	ORDER CHECK NURSE	00:00-06:59 TIME	SITE	INITIAL	07:00-14:59 TIME	SITE	INITIAL	15:00-23:59 TIME	SITE	INITIAL
MORPHINE SULFATE MORPHINE SULFATE EVERY 8 HOURS AS NEEDED Dose: 1 MG = 0.1 ML FOR PAIN ***USE CAUTION** LOOK ALIKE OR SOUND ALIKE DRUG	START DT: 05/16/06 11:48 STOP DT: 05/21/06 11:48 INTRAVENOUS Dose: 1 MG = 0.1 ML	KF								
SODIUM CHLORIDE 0.9% ZOSYN SIG:FREQUENCY: 6 START DT:05/16/06 03:30 RATE:100 ML/HR	100 ML 3.375 GRAM INTRAVENOUS INFUSE OVER:1HRS TOTAL VOLUME:100	KF	0330		KF	0930		SS	1530 2130		SS
METRONIDAZOLE 500MG/NS 100ML SIG:FREQUENCY: 8 START DT:05/16/06 14:00 RATE:100 ML/HR	100 ML INTRAVENOUS INFUSE OVER:1HRS TOTAL VOLUME:100	KF	0600		SS	1400		SS	2200		
D5W/0.45% SODIUM CHLORIDE POTASSIUM CHLORIDE SIG:FREQUENCY: 17 START DT:05/19/06 15:30 ~~RATE:60 ML/HR~~ 100 ml/hr *HIGH ALERT MED- DOUBLE CHECK DRUG & DOSE* When TF's Started ↓ to 60 mL/Hr 1/2 Strength Impact 1.5 @ 20ml/hr. advance by 10ml every 10hrs as tolerated to goal of 60ml/hr.	1000 ML 40 MEQ = 20 ML INTRAVENOUS TOTAL VOLUME:1020	KF				0830		SS			
									1530		SS

DATE & TIME	OMISSIONS RESPONSE TO MEDS ADVERSE EFFECTS ETC.	ORDER DATE	NON-RECURRING MEDICATION	DATE	TIME GIVEN	INITIAL

24-HR. VALIDATION CHECK NURSE: K. Fremaux RN

K. Fremaux (KF) ( ) SSchanderRN (SS
( ) ( ) (

PATIENT NAME	BED NO.
PETERSON, WILLIAM SR	0503 A

10-26956 (5/04)
740.14

AIKEN REGIONAL MEDICAL CENTER

SITE CODES
① ABDOMEN
② RIGHT UPPER OUTER QUADRANT BUTTOCK
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④ RIGHT UPPER ARM
⑤ LEFT UPPER ARM
⑥ RIGHT ANTERIOR THIGH
⑦ LEFT ANTERIOR THIGH

MEDICATION ADMINISTRATION RECORD

PATIENT NAME	BED NO.	AGE	WEIGHT	BSA m²	ADM. DATE	DOSE PERIOD
PETERSON, WILLIAM SR	0503 A		81.648 kg	2.030 M2	05/15/2006	05/20/06-05/20/06

MEDICAL RECORD NO.	ACCOUNT NO.	PHYSICIAN	DIAGNOSIS
26523	102829710	BOKKISAM, CHAKRAVARTHY	UROSEPSIS, AMS, HYPOTHERMIA

ALLERGIES: NKA

ORDER	ORDER CHECK NURSE	00:00-06:59 TIME	SITE	INITIAL	07:00-14:59 TIME	SITE	INITIAL	15:00-23:59 TIME	SITE	INITIAL
SODIUM CHLORIDE 0.9% 250 ML VANCOMYCIN 1 GM = 1 VIAL SIG:AS-NEEDED INTRAVENOUS START DT:05/16/06 13:55 INFUSE OVER:1HRS RATE:250 ML/HR TOTAL VOLUME:250 GIVE IF LEVEL <20 GIVE IF LEVEL <20 Vanc. Level Q 12° if <20 Give Vanc. Vancomycin 1.5gm IV Then Vancomycin 1.25 gm Q24hrs. Get Vancomycin peak p 2nd dose. Notify MD p 2nd dose	KF				0800 Level 24.2 1200 SS			2000		

DATE & TIME	OMISSIONS RESPONSE TO MEDS ADVERSE EFFECTS ETC.	ORDER DATE	NON-RECURRING MEDICATION	DATE	TIME GIVEN	INITIA

24-HR. VALIDATION CHECK NURSE: K. Tremain RN

PATIENT NAME	BED NO.			
PETERSON, WILLIAM SR	0503 A	K. Tremain (KT)	( )	S Schanden RN (SS)
		( )	( )	( )

10-26956 (5/04)
740.14

AIKEN REGIONAL MEDICAL CENTER

MEDICATION ADMINISTRATION RECORD

SITE CODES
① ABDOMEN
② RIGHT UPPER OUTER QUADRANT BUTTOCK
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⑤ LEFT UPPER ARM
⑥ RIGHT ANTERIOR THIGH
⑦ LEFT ANTERIOR THIGH

PATIENT NAME	BED NO.	AGE	WEIGHT	BSA m²	ADM. DATE	DOSE PERIOD
PETERSON, WILLIAM SR	0503 A	9	81.648 kg	2.030 M2	05/15/2006	05/19/06-05/19/06

MEDICAL RECORD NO.	ACCOUNT NO.	PHYSICIAN	DIAGNOSIS
26523	102829710	BOKKISAM, CHAKRAVARTHY	UROSEPSIS, AMS, HYPOTHERMIA

ALLERGIES: NKA

ORDER	ORDER CHECK NURSE	00:00-06:59 TIME	SITE	INITIAL	07:00-14:59 TIME	SITE	INITIAL	15:00-23:59 TIME	SITE	INITIAL
ALBUT/IPRATROPIUM2.5-0.5MG/3ML DUONEB 2.5-0.5MG/3ML EVERY 4 HOURS SCHEDULED Dose: 3 ML = 3 ML START DT: 05/16/06 10:00 STOP DT: INHALATION Dose: 3 ML = 3 ML GIVE PER RESPIRATORY PROTOCOL	✓	0200	RX		1000	RX		1800	RX	
		0600	RX		1400	RX		2200	RX	
HYDROCORTISONE SOD SUCCINATE SOLU-CORTEF EVERY EIGHT HOURS Dose: 100 MG = 2 ML START DT: 05/16/06 12:00 STOP DT: INTRAVENOUS Dose: 100 MG = 2 ML	✓	0400	M		1200	[illegible]		2000	KG	
PANTOPRAZOLE SODIUM PROTONIX IV 40 MG EVERY 24 HOURS Dose: 40 MG = 10 ML START DT: 05/10/06 19:00 STOP DT: INTRAVENOUS Dose: 40 MG = 10 ML RECONSTITUTE WITH 10ML OF NS GIVE IVP OVER A MINIMUM 2MIN	✓							1600	[illegible]	
ACETAMINOPHEN TYLENOL (EQV) EVERY 4 HOURS AS NEEDED Dose: 650 MG = 2 TAB START DT: 05/16/06 08:01 STOP DT: BY MOUTH Dose: 650 MG = 2 TAB TEMP) 101.5 DO NOT GIVE MORE THAN 4 GRAMS PER DAY ACETAMINOPHEN	✓									

DATE & TIME	OMISSIONS RESPONSE TO MEDS ADVERSE EFFECTS ETC.	ORDER DATE	NON-RECURRING MEDICATION	DATE	TIME GIVEN	INITIA

24-HR. VALIDATION CHECK NURSE: Renee Ensley LPN

PATIENT NAME	BED NO.
PETERSON, WILLIAM SR	0503 A

Renee Ensley LPN (RE) [illegible] (KG) [illegible]
[illegible] (M) [illegible]

10-26956 (5/04)
740.14

AIKEN REGIONAL MEDICAL CENTER

MEDICATION ADMINISTRATION RECORD

SITE CODES
① ABDOMEN
② RIGHT UPPER OUTER QUADRANT BUTTOCK
③ LEFT UPPER OUTER QUADRANT BUTTOCK
④ RIGHT UPPER ARM
⑤ LEFT UPPER ARM
⑥ RIGHT ANTERIOR THIGH
⑦ LEFT ANTERIOR THIGH

PATIENT NAME	BED NO.	AGE	WEIGHT	BSA m²	ADM. DATE	DOSE PERIOD
PETERSON, WILLIAM SR	0503 A		81.648 kg	2.030 M2	05/15/2006	05/19/06-05/19/06

MEDICAL RECORD NO.	ACCOUNT NO.	PHYSICIAN	DIAGNOSIS
26523	102829710	BOKKISAM, CHAKRAVARTHY	UROSEPSIS,AMS,HYPOTHERMIA

ALLERGIES: NKA

	ORDER CHECK NURSE	MEDICATION ADMINISTRATION TIMES 00:00-06:59 TIME	SITE	INITIAL	07:00-14:59 TIME	SITE	INITIAL	15:00-23:59 TIME	SITE	INITIAL
MORPHINE SULFATE MORPHINE SULFATE ~~EVERY 6 HOURS AS NEEDED~~ INTRAVENOUS Dose: 1 MG = 0.1 ML Dose: 1 MG = 0.1 ML FOR PAIN ***USE CAUTION** LOOK ALIKE OR SOUND ALIKE DRUG	✓									
START DT: 05/16/06 11:48 STOP DT: 05/21/06 11:48										
SODIUM CHLORIDE 0.9% 100 ML ZOSYN 3.375 GRAM SIG:FREQUENCY: 6 INTRAVENOUS START DT:05/16/06 03:30 INFUSE OVER:1HRS RATE:100 ML/HR TOTAL VOLUME:100	✓	0330		KE	0930			1530 2130		KE
METRONIDAZOLE 500MG/NS 100ML 100 ML SIG:FREQUENCY: 8 INTRAVENOUS START DT:05/16/06 14:00 INFUSE OVER:1HRS RATE:100 ML/HR TOTAL VOLUME:100	✓	0600		KE	1400			2200		KE
CS DEXTROSE 5%/0.25%NS 1000ML 1000 ML SIG:FREQUENCY: 5 INTRAVENOUS START DT:05/17/06 10:00 RATE:200 ML/HR TOTAL VOLUME:1000	✓	0200		KE	0700 1200			1700 2200		
Arginade: one scoop pomd in 4oz H2O & push b.i.d (start 1pm)										

DATE & TIME	OMISSIONS RESPONSE TO MEDS ADVERSE EFFECTS ETC.	ORDER DATE	NON-RECURRING MEDICATION	DATE	TIME GIVEN	INITIA

24-HR. VALIDATION CHECK NURSE: Renee Easley (RE)

PATIENT NAME	BED NO.
PETERSON, WILLIAM SR	0503 A

Renee Easley (RE) ( ) R. Frenchm (RF) ( )

10-26956 (5/04)

740.14

AIKEN REGIONAL MEDICAL CENTER

SITE CODES
① ABDOMEN
② RIGHT UPPER OUTER QUADRANT BUTTOCK
③ LEFT UPPER OUTER QUADRANT BUTTOCK
④ RIGHT UPPER ARM
⑤ LEFT UPPER ARM
⑥ RIGHT ANTERIOR THIGH
⑦ LEFT ANTERIOR THIGH

MEDICATION ADMINISTRATION RECORD

PATIENT NAME	BED NO.	AGE	WEIGHT	BSA m²	ADM. DATE	DOSE PERIOD
PETERSON, WILLIAM SR	0503 A		81.648 kg	2.030 M2	05/15/2006	05/19/06-05/19/06

MEDICAL RECORD NO.	ACCOUNT NO.	PHYSICIAN	DIAGNOSIS
26523	102829710	BOKKISAM, CHAKRAVARTHY	UROSEPSIS, AWS, HYPOTHERMIA

ALLERGIES: NKA

MEDICATION ADMINISTRATION TIMES

ORDER CHECK NURSE	00:00-06:59 TIME	SITE	INITIAL	07:00-14:59 TIME	SITE	INITIAL	15:00-23:59 TIME	SITE	INITIAL
√									

- SODIUM CHLORIDE 0.9% 250 ML
  VANCOMYCIN 1 GM = 1 VIAL
  SIG:AS NEEDED INTRAVENOUS

  START DT:05/16/06 13:55 INFUSE OVER:1HRS
  RATE:250 ML/HR TOTAL VOLUME:250
  GIVE IF LEVEL (20 GIVE IF LEVEL (20

Vancomycin level Q12° if level < 20 give Vancomycin 1gm IV

1730 2000 Vanco level 18.5

DS1/2NS + 40meq KCl @150

(when TFs started in AM + 1566cc/hr)

DATE & TIME	OMISSIONS RESPONSE TO MEDS ADVERSE EFFECTS ETC.	ORDER DATE	NON-RECURRING MEDICATION	DATE	TIME GIVEN	INITI

24-HR. VALIDATION CHECK NURSE: Renee Early RN

PATIENT NAME	BED NO.
PETERSON, WILLIAM SR	0503 A

Renee Early (RN) ( ) K. Freeman (RN) ( )

10-26356 (5/04)
740.14

AIKEN REGIONAL MEDICAL CENTER

SITE CODES
① ABDOMEN
② RIGHT UPPER OUTER QUADRANT BUTTOCK
③ LEFT UPPER OUTER QUADRANT BUTTOCK
④ RIGHT UPPER ARM
⑤ LEFT UPPER ARM
⑥ RIGHT ANTERIOR THIGH
⑦ LEFT ANTERIOR THIGH

MEDICATION ADMINISTRATION RECORD

PATIENT NAME	BED NO.	AGE	WEIGHT	BSA m²	ADM. DATE	DOSE PERIOD
PETERSON, WILLIAM SR	0503 A		81.648 kg	2.030 M2	05/15/2006	05/18/06-05/18/06

MEDICAL RECORD NO.	ACCOUNT NO.	PHYSICIAN	DIAGNOSIS
26523	102829710	BOKKISAM, CHAKRAVARTHY	UROSEPSIS, AMS, HYPOTHERMIA

ALLERGIES: NKA

	ORDER CHECK NURSE	MEDICATION ADMINISTRATION TIMES 00:00-06:59 TIME / SITE / INITIAL	07:00-14:59 TIME / SITE / INITIAL	15:00-23:59 TIME / SITE / INITIAL
PANTOPRAZOLE SODIUM PROTONIX DAILY Dose: 40 MG = 1 TAB	START DT: 05/16/06 07:57 STOP DT: BY MOUTH Dose: 40 MG = 1 TAB	✓	1000 NPO Route Ald	
CYPROHEPTADINE HCL PERIACTIN (EQV) BEFORE MEALS Dose: 4 MG = 1 TAB	START DT: 05/16/06 08:01 STOP DT: BY MOUTH Dose: 4 MG = 1 TAB	✓	0730 NPO 1130 NPO Mord	1630
ALBUT/IPRATROPIUM2.5-0.5MG/3ML DUONEB 2.5-0.5MG/3ML EVERY 4 HOURS-SCHEDULED Dose: 3 ML = 3 ML GIVE PER RESPIRATORY PROTOCOL	START DT: 05/16/06 10:00 STOP DT: INHALATION Dose: 3 ML = 3 ML	✓	0200 RX 0600 RX	1000 RX 1400 RX 1800 RX 2200 RX
HYDROCORTISONE SOD SUCCINATE SOLU-CORTEF EVERY EIGHT HOURS Dose: 100 MG = 2 ML	START DT: 05/16/06 12:00 STOP DT: INTRAVENOUS Dose: 100 MG = 2 ML	✓	0400 JD	1200 IV 2an 2000 IV
ACETAMINOPHEN TYLENOL (EQV) EVERY 4 HOURS AS NEEDED Dose: 650 MG = 2 TAB TEMP) 101.5 DO NOT GIVE MORE THAN 4 GRAMS PER DAY ACETAMINOPHEN	START DT: 05/16/06 08:01 STOP DT: BY MOUTH Dose: 650 MG = 2 TAB	✓		
Rec 60 mcg IV x 1 now (Mixed in 100ml D5 1/4NS) to infuse @ 170 ml/hr			0945 IV 2an	

DATE & TIME	OMISSIONS RESPONSE TO MEDS ADVERSE EFFECTS ETC.	ORDER DATE	NON-RECURRING MEDICATION	DATE	TIME GIVEN	INITIAL

24-HR. VALIDATION CHECK NURSE: Renee Ealy LPN

PATIENT NAME	BED NO.			
TERSON, WILLIAM SR	0503 A	Renee Ealy LPN (RE)	( )	( )
		Waldyo RN (W)	( )	( )

AIKEN REGIONAL MEDICAL CENTER

SITE CODES
① ABDOMEN
② RIGHT UPPER OUTER QUADRANT BUTTOCK
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⑤ LEFT UPPER ARM
⑥ RIGHT ANTERIOR THIGH
⑦ LEFT ANTERIOR THIGH

MEDICATION ADMINISTRATION RECORD

PATIENT NAME	BED NO.	AGE	WEIGHT	BSA m²	ADM. DATE	DOSE PERIOD
PETERSON, WILLIAM SR	0503 A		81.648 kg	2.030 M2	05/15/2006	05/18/06-05/18/06

MEDICAL RECORD NO.	ACCOUNT NO.	PHYSICIAN	DIAGNOSIS
26523	102829710	BOKKISAM, CHAKRAVARTHY	UROSEPSIS, ANS, HYPOTHERMIA

ALLERGIES: NKA

	ORDER CHECK NURSE	00:00-05:59 TIME	SITE	INITIAL	07:00-14:59 TIME	SITE	INITIAL	15:00-23:59 TIME	SITE	INITIAL
MORPHINE SULFATE START DT: 05/16/06 11:48 MORPHINE SULFATE STOP DT: 05/21/06 11:48 EVERY 8 HOURS AS NEEDED INTRAVENOUS Dose: 1 MG = 0.1 ML Dose: 1 MG = 0.1 ML FOR PAIN ***USE CAUTION** LOOK ALIKE OR SOUND ALIKE DRUG	✓									
SODIUM CHLORIDE 0.9% 100 ML ZOSYN 3.375 GRAM SIG:FREQUENCY: 6 INTRAVENOUS START DT:05/16/06 03:30 INFUSE OVER:1HRS RATE:100 ML/HR TOTAL VOLUME:100	✓	0330		RE	0930		JW 2a	1530 2130		JW 2a RE
METRONIDAZOLE 500MG/NS 100ML 100 ML SIG:FREQUENCY: 8 INTRAVENOUS START DT:05/16/06 14:00 INFUSE OVER:1HRS RATE:100 ML/HR TOTAL VOLUME:100	✓	0600		RE	1400		JW 2a	2200		RE
CS DEXTROSE 5%/0.25%NS 1000ML 1000 ML SIG:FREQUENCY: 5 INTRAVENOUS START DT:05/17/06 10:00 RATE:200 ML/HR TOTAL VOLUME:1000	✓	0100 0600		RE V	1100			1600 1700		1630 IW 2a
Protonix 40mg IV daily					1400			1800 2200		IW

DATE & TIME	OMISSIONS RESPONSE TO MEDS ADVERSE EFFECTS ETC.	ORDER DATE	NON-RECURRING MEDICATION	DATE	TIME GIVEN	INITIAL
5/18/06 1600	NOT available from Rx					
5/18/06 1800	NOT available from Rx					

2HR. VALIDATION CHECK NURSE: Renee Eslyn (RE) Attendant (AA) Heather (H)

PATIENT NAME	BED NO.
...SON, WILLIAM SR	0503 A

AIKEN REGIONAL MEDICAL CENTER

SITE CODES
① ABDOMEN
③ RIGHT UPPER OUTER QUADRANT BUTTOCK
⑤ LEFT UPPER OUTER QUADRANT BUTTOCK
④ RIGHT UPPER ARM
⑥ LEFT UPPER ARM
⑧ RIGHT ANTERIOR THIGH
⑦ LEFT ANTERIOR THIGH

MEDICATION ADMINISTRATION RECORD

PATIENT NAME	BED NO.	AGE	WEIGHT	BSA m²	ADM. DATE	DOSE PERIOD
PETERSON, WILLIAM SR	0503 A		81.648 kg	2.030 M2	05/15/2006	05/18/06-05/18/06

MEDICAL RECORD NO.	ACCOUNT NO.	PHYSICIAN	DIAGNOSIS
26523	102829710	BOKKISAM, CHAKRAVARTHY	UROSEPSIS, AMS, HYPOTHERMIA

ALLERGIES: NKA

	ORDER CHECK NURSE	00:00-06:59 TIME	SITE	INITIAL	07:00-14:59 TIME	SITE	INITIAL	15:00-23:59 TIME	SITE	INITIAL
SODIUM CHLORIDE 0.9% 250 ML VANCOMYCIN 1 GM = 1 VIAL SIG:AS NEEDED INTRAVENOUS START DT:05/16/06 13:55 INFUSE OVER:1HRS RATE:250 ML/HR TOTAL VOLUME:250 GIVE IF LEVEL <20 GIVE IF LEVEL <20					0500	25.4		1700	15.0	
					ΦVancomycin 2gm IV			2000		CS
Vancomycin level @12° if level < 20 give vancomycin 1gm IV										

DATE & TIME	OMISSIONS RESPONSE TO MEDS ADVERSE EFFECTS ETC.	ORDER DATE	NON-RECURRING MEDICATION	DATE	TIME GIVEN	INITIA

24-HR. VALIDATION CHECK NURSE: Renee Ensley RN

PATIENT NAME	BED NO.
PETERSON, WILLIAM SR	0503 A

Renee Ensley RN (RE) Mcleland (2S)

740.14 10-268956 (5/04)

AIKEN REGIONAL MEDICAL CENTER

MEDICATION ADMINISTRATION RECORD

SITE CODES
① ABDOMEN
② RIGHT UPPER OUTER QUADRANT BUTTOCK
③ LEFT UPPER OUTER QUADRANT BUTTOCK
④ RIGHT UPPER ARM
⑤ LEFT UPPER ARM
⑥ RIGHT ANTERIOR THIGH
⑦ LEFT ANTERIOR THIGH

PATIENT NAME	BED NO.	AGE	WEIGHT	BSA m²	ADM. DATE	DOSE PERIOD
PETERSON, WILLIAM SR	0502 A		81.648 kg	2.030 M2	05/15/2006	05/17/06-05/17/06

MEDICAL RECORD NO.	ACCOUNT NO.	PHYSICIAN	DIAGNOSIS
25523	10202971Q	RAKRISHNAN, CHOKKALINGAM	HYPERGLYCEMIA, DMII, HYPOTHERMIA

ALLERGIES
NKA

MEDICATION ADMINISTRATION TIMES

ORDER CHECK NURSE	00:00-06:59 TIME	SITE	INITIAL	07:00-14:59 TIME	SITE	INITIAL	15:00-23:59 TIME	SITE	INITIAL
✓				0800		NR MAR			
				0730		NR MAR	1530		NR MAR
✓				1134		NR MAR			
✓				1930	LT		1800	LT	
				1400	LT				
	0400			1200A			1700		
	0100			0900		NR MAR	1700		NR MAR
				1015		NR MAR			

PANTOPRAZOLE SODIUM — START DT: 05/16/06 07:57
PROTONIX — STOP DT:
DAILY — BY MOUTH
Dose: 40 MG = 1 TAB — Dose: 40 MG = 1 TAB

CYPROHEPTADINE HCL — START DT: 05/16/06 09:01
PERIACTIN (EDV) — STOP DT:
BEFORE MEALS — BY MOUTH
Dose: 4 MG = 1 TAB — Dose: 4 MG = 1 TAB

ALBUTEROL/IPRATROPIUM 2.5-0.5MG/3ML — START DT: 05/16/06 10:00
DUONEB 2.5-0.5MG/3ML — STOP DT:
EVERY 4 HOURS-SCHEDULED — INHALATION
Dose: 3 ML = 3 ML — Dose: 3 ML = 3 ML

GIVE PER RESPIRATORY PROTOCOL

HYDROCORTISONE SOD SUCCINATE — START DT: 05/16/06 12:00
SOLU-CORTEF — STOP DT:
EVERY EIGHT HOURS — INTRAVENOUS
Dose: 100 MG = 2 ML — Dose: 100 MG = 2 ML

ACETAMINOPHEN — START DT: 05/16/06 08:01
TYLENOL (EDV) — STOP DT:
EVERY 4 HOURS AS NEEDED — BY MOUTH
Dose: 650 MG = 2 TAB — Dose: 650 MG = 2 TAB

TEMP) 101.5
DO NOT GIVE MORE THAN 4 GRAMS PER DAY ACETAMINOPHEN

D5 1/2 at 200cc/hr,

DATE & TIME	OMISSIONS RESPONSE TO MEDS ADVERSE EFFECTS ETC.	ORDER DATE	NON-RECURRING MEDICATION	DATE	TIME GIVEN	INITIA
5/17 0832	unable to swallow MBR					

24-HR. VALIDATION CHECK NURSE: RRDunn RN (RRD) Bonnie Endsley RN (BE) ( ) Lockwood RN (MB) ( )

PATIENT NAME	BED NO.
PETERSON, WILLIAM SR	0502 A

(5/04)

AIKEN REGIONAL MEDICAL CENTER

SITE CODES
① ABDOMEN
② RIGHT UPPER OUTER QUADRANT BUTTOCK
③ LEFT UPPER OUTER QUADRANT BUTTOCK
④ RIGHT UPPER ARM
⑤ LEFT UPPER ARM
⑥ RIGHT ANTERIOR THIGH
⑦ LEFT ANTERIOR THIGH

MEDICATION ADMINISTRATION RECORD

PATIENT NAME	BED NO.	AGE	WEIGHT	BSA m²	ADM. DATE	DOSE PERIOD
PETERSON, WILLIAM SR	0503 A		81.640 kg	2.030 M2	05/15/2006	05/17/06-05/17/06

MEDICAL RECORD NO.	ACCOUNT NO.	PHYSICIAN	DIAGNOSIS
26523	102829710	BOKKISAM, CHAKRAVARTHY	UROSEPSIS, AMS, HYPOTHERMIA

ALLERGIES: NKA

MEDICATION ADMINISTRATION TIMES

ORDER / MEDICATION	ORDER CHECK NURSE	00:00-06:59 TIME	SITE	INITIAL	07:00-14:59 TIME	SITE	INITIAL	15:00-23:59 TIME	SITE	INITIAL
MORPHINE SULFATE MORPHINE SULFATE ~~EVERY 4 HOURS AS NEEDED~~ Dose: 1 MG = 0.1 ML START DT: 05/16/06 11:48 STOP DT: 05/21/06 11:48 ~~INTRAVENOUS~~ Dose: 1 MG = 0.1 ML	✓									
FOR PAIN ***USE CAUTION*** LOOK ALIKE OR SOUND ALIKE DRUG										
SODIUM CHLORIDE 0.9% ZOSYN SIG:FREQUENCY: 6 100 ML 3.375 GRAM INTRAVENOUS START DT:05/16/06 03:00 RATE:100 ML/HR INFUSE OVER:1HRS TOTAL VOLUME:100		0300	RE		0930	IV MBZ	a	1530 2136	IV MBZ RE	a
NS 0.9% SODIUM CHLORIDE SIG:FREQUENCY: 3 1000 ML INTRAVENOUS START DT:05/16/06 12:15 RATE:300 ML/HR TOTAL VOLUME:1000		0915 (315)	RE		0915 (1315)	IV MBZ	a	(1515) (1915)	DC	
METRONIDAZOLE 500MG/NS 100ML SIG:FREQUENCY: 8 100 ML INTRAVENOUS START DT:05/16/06 14:00 RATE:100 ML/HR INFUSE OVER:1HRS TOTAL VOLUME:100		0515 0540	RE		1400	IV MBZ		(2115) 2200	RE	
Vancomycin level 9:20 if vanc level 7.2 20 gms Vancomycin 1gm	LIK	0559	21.8 MBZ					1800 2 18.6	IV MBZ	

DATE & TIME	OMISSIONS RESPONSE TO MEDS ADVERSE EFFECTS ETC.	ORDER DATE	NON-RECURRING MEDICATION	DATE	TIME GIVEN	INITI

24-HR. VALIDATION CHECK NURSE: Renee Endy RN

PATIENT NAME	BED NO.
PETERSON, WILLIAM SR	0503 A

Renee Endy RN (RE) Schwarz RN (MBZ) _____ ( )
_____ ( ) _____ ( ) _____ ( )

10-26956 (5/04)
740.14

AIKEN REGIONAL MEDICAL CENTER

MEDICATION ADMINISTRATION RECORD

SITE CODES
① ABDOMEN
② RIGHT UPPER OUTER QUADRANT BUTTOCK
③ LEFT UPPER OUTER QUADRANT BUTTOCK
④ RIGHT UPPER ARM
⑤ LEFT UPPER ARM
⑥ RIGHT ANTERIOR THIGH
⑦ LEFT ANTERIOR THIGH

PATIENT NAME	BED NO.	AGE	WEIGHT	BSA m²	ADM. DATE	DOSE PERIOD
PETERSON, WILLIAM SR	0503 A		81.648 kg	2.030 M²	05/15/2006	05/17/06-05/17/06

MEDICAL RECORD NO.	ACCOUNT NO.	PHYSICIAN	DIAGNOSIS
26523	102829710	BOKHTSOM, CHAKRAVARTHY	UNSPECIFIED, OMS: HYPOTHERMIA

ALLERGIES: NKA

ORDER	ORDER CHECK NURSE	MEDICATION ADMINISTRATION TIMES 03:00-06:59 TIME / SITE / INITIAL	07:00-14:59 TIME / SITE / INITIAL	15:00-22:59 TIME / SITE / INITIAL
SODIUM CHLORIDE 0.9% 250 ML VANCOMYCIN 1 GM = 1 VIAL SIGIAS NEEDED INTRAVENOUS START 01:05/16/06 13:55 INFUSE OVER:1HRS RATE:250 ML/HR TOTAL VOLUME:250 GIVE IF LEVEL <20 GIVE IF LEVEL >20				pivalterlance

DATE & TIME	OMISSIONS RESPONSE TO MEDS ADVERSE EFFECTS ETC.	ORDER DATE	NON-RECURRING MEDICATION	DATE	TIME GIVEN	INITIA

24-HR. VALIDATION CHECK NURSE: Renee Exley (RE)

PATIENT NAME	BED NO.
PETERSON, WILLIAM SR	0503 A

Renee Exley (RE) (MB)

10-26956 (5/04)
740.14

Aiken Regional Medical Center
302 University Aiken, South Carolina 29802

DIAGNOSIS: ↓thermia, A in Mental Status, Urosepsis
ALLERGIES: NKDA
NOTES:

DATE: 5/16/06

DRUG NAME, STRENGTH, DOSAGE FORM / DOSE, RATE, ROUTE, SCHEDULE	START TIME / DATE	START TIME / DATE	TIME PERIOD TO	TIME PERIOD TO	TIME PERIOD TO
RX: Protonix 40mg po q day				1000	
NURSE:					
RX: Periactin 4mg PO q8°			0600 RMH	1400	2200
NURSE:					
RX: Zosyn 3.325gm IV q6°			0600 RMH	1200 MH	1800 2000 RE
NURSE:					
RX: NS @ 200/hr IV				1140 MH	
NURSE: 30					
RX: Vancomycin 1gm IVPB				1700 MH	2300 RE
NURSE:					
RX: Hydrocortisone 100mg IV q8°				1700 MH	~~2100~~ 0100
NURSE:					
RX: Morphine 1mg IV q8° if needed for pain					
NURSE:					
RX: Flagyl 500mg IV q8°					2200 RE
NURSE:					
RX:					
NURSE:					
RX:					
NURSE:					
RX: Tylenol 650mg po q4° prn ↑ temp >101.5					
NURSE:					

INITIALS	SIGNATURE/TITLE	INITIALS	SIGNATURE/TITLE		
RMH	RM Harris LPN	MH	M Hunsucker RN		
RE	Renee Eudy LPN				

NOTES:
0600 - Med unavailable @ this time.
Pt is NPO

MEDICATION ADMINISTRATION RECORD

PAGE ____ OF ____ PAGES

102829710
PETERSON SR, WILLIAM SR
DOB: [redacted] 85 SX: M IMD
MRN: 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

ROOM | NAME | PAT. NO. | AGE | SEX | PHYSICIAN'S NAME

601.20 (5/04) WHITE – ORIGINAL COPY CANARY – PHARMACY BILLING 10-1934

Select Specialty Hospital

Peterson, William SH# 10873
DOB: 03/11/21 AGE:85 SEX:M
MR# 001395729 (LTAC)
MCGHI ACCT#002478334-9743
Physician: Dr. Dabney-Smith

DISCLOSURE AND CONSENT MEDICAL AND SURGICAL PROCEDURES

TO THE PATIENT: *You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risk and the hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.*

I voluntarily request Dr. Mullins, as my physician, and such associates, technical assistants and other health care providers as they may deem necessary, to treat my condition, which has been explained to me as: Cut away dead tissue.

I understand that the following surgical, medical and/or diagnostic procedures are planned for me and I voluntarily consent and authorize these procedures: Sharp debridement.

I understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I authorize my physician, and such associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgement.

I ☒ do consent to the use of blood and blood products as deemed necessary. ☐ do not

I understand that no warranty or guarantee has been made to me as to result or cure.

Just as there may be risk and hazards in continuing my present condition without treatment, there are also risks and hazards related to performance of the surgical, medical, and/or diagnostic procedure planned for me. I realize that common to surgical, medical, and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. My physician has discussed with me the other risks involved and I agree to assume them

I understand that anesthesia involves additional risks and hazards, but I request the use of anesthetics for the relief and protection from pain during the planned and additional procedures. I realize the anesthesia may have to be changed possibly without explanation to me.

I understand that certain complications may result from the use of any anesthetic including respiratory problems, drug reaction, paralysis, brain damage or even death. Other risks and hazards which may result from the use of a general anesthetic range from minor discomfort to injury to the vocal cords, teeth or eyes.

I have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risk of nontreatment, the procedure to be used, and the risks and hazards involved, and I believe that I have sufficient information to give this informed consent.

I certify this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in, and that I understand its contents.

(CROSS OUT AND INITIAL ANY PARAGRAPH ABOVE WHICH DOES NOT APPLY OR WHERE CONSENT IS WITHHELD)

William Peterson	6/19/06	H Haggerty RNMCC	6/19/06
PRINT PATIENT NAME	DATE / TIME	WITNESS' NAME	DATE / TIME
Melinda Butler-telephone.		Tammy Major	
SIGNATURE OF PATIENT / OTHER LEGALLY RESPONSIBLE PERSON		ADDRESS	
daughter		Select, Aug. Ga - MCG	
IF OTHER THAN PATIENT, STATE RELATIONSHIP		CITY, STATE, ZIP CODE	

I have explained the matters indicated above related to the operation and/or procedure and the risks, consequences and alternative. The patient and/or the legally responsible person indicated appeared to understand and consented to the procedures described above.

PHYSICIAN — DATE

SELECT SPECIALTY HOSPITAL - MCG

DISCHARGE SUMMARY

PATIENT NAME: PETERSON, William
MR#: 001395729
ROOM#:
ADMISSION DATE: 06/01/2006
DISCHARGE DATE: 08/01/2006

ADMISSION DIAGNOSES: Decubitus ulcers, acute renal failure, and hypertension.

DISCHARGE DIAGNOSES: Decubitus ulcers, C. difficile colitis, urinary tract infection, anemia, and PEG tube feeding.

HISTORY OF PRESENT ILLNESS: This is an 85-year-old male who was admitted to Select Care Hospital with a large left sacral decubitus ulcers and bacteremia secondary to MRSA and enterococcus. A 2 months before being admitted to Select Hospital, he had a cervical spinal fusion done along with the lumbar spinal cord decompression. This was done at Aiken Regional Medical Center.

PAST MEDICAL HISTORY: His past medical history includes benign prostatic hypertrophy, rhabdomyolysis, cervical spinal stenosis, hypertension, and anemia.

MEDICATION: At that time was vancomycin 1.5 g q.24 h., albuterol and Atrovent nebulizer treatment, and Zantac 150 mg b.i.d.

HOSPITAL COURSE: The patient was then admitted to Select Care Hospital. He was initially continued on intravenous vancomycin for his MRSA bacteremia. He was then treated for bacteremia and after the cultures came negative, antibiotics was then stopped. For his sacral decubitus ulcers, plastic surgery was consulted and he underwent debridement for his ulcer. Once the wound started getting better, he also had a skin flap placed by Plastic Surgery. Since then the wound has been healing well. He had 2 episodes of urinary tract infection for which he was treated with antibiotics. While being treated with antibiotics, he has developed diarrhea that came positive for C. difficile colitis. He was then treated orally through his PEG tube with vancomycin orally along with metronidazole. Vancomycin was then stopped after a few days and was continued on metronidazole. His urine again got infected with protease, which was sensitive to Augmentin and was started on Augmentin again. He has been continued on his PEG tube feedings at the rate of 85 mL/hour, which was then decreased to 60 mL, which seems to be helping with his diarrhea. While being in the hospital, he was anemic and had transfused 2 units of packed RBCs. For the last few days, he has been getting intravenous fluid for his elevated BUN and tachycardia that seems to be getting better. BUN has come down to 79 and his tachycardia has resolved. The patient will be discharged to the hospital under the care of the medical director of the hospice.

DISCHARGE SUMMARY

PATIENT NAME: PETERSON, William
MR#: 001395729
PAGE 2

DISCHARGE MEDICATIONS: His medication would include Flagyl 500 mg b.i.d. for 7 more days, Augmentin 875 mg per PEG tubes twice a day for 7 days, and he would be continued on this PEG tube feedings at 60 mL/hour, and rest of the medication would be started by the medical director of the hospice management.

Kashif Naseem, MD

Dictated by:
KN/MM48
DD: 08/01/2006 12:05:00
DT: 08/02/2006 08:49:11
JOB#: 519425

cc:

DOCTORS HOSPITAL
HEALTH INFORMATION MANAGEMENT

OPERATIVE/PROCEDURE REPORT

PATIENT'S NAME: PETERSON,WILLIAM
UNIT NUMBER: G000573451
DICTATING DR. Mullins,MD Robert F

PATIENT'S NAME: PETERSON , WILLIAM
UNIT NUMBER: G000573451
DICTATING DR.: Robert F Mullins, MD

DATE OF OPERATION: 06/29/2006

PREOPERATIVE DIAGNOSIS:
Stage IV left ischial ulcer.

POSTOPERATIVE DIAGNOSIS:
Stage IV left ischial ulcer.

PROCEDURE PERFORMED:
1. Excision of left ischial ulcer in preparation for flap.
2. Debridement of _____, partial thickness skin, with application of cadaver skin to the right buttock 6 x 4 cm, left buttock 2 x 2 cm.

SURGEON:
Robert F. Mullins, MD.

ASSISTANT:
Jan Samples, PA-C, and Beretta Craft-Coffman, PA-C.

ANESTHESIA:
IV sedation.

ESTIMATED BLOOD LOSS:
100 mL.

IV FLUIDS:
Crystalloid 250 mL.

PROCEDURE IN DETAIL:
The patient was taken to the operating suite and placed in the supine position. After adequate IV sedation, he was placed in the prone position. His left ischium as well as buttocks, sacrum were prepped with Betasept and draped in a sterile fashion. Using Metzenbaum scissors and Maxtin pickups, debridement was carried out over areas on the right buttock and left buttock, followed by application of 1:1 meshed cadaver skin held in place with surgical steel staples. Excision was then carried out using a #15 blade as well as Bovie electrocautery to the left ischial region, excising down to healthy viable tissue, removing nonviable skin and subcutaneous tissue. After adequate excision of this area and hemostasis, it was covered with antibiotic-soaked gauze. The cadaver skin was covered with bridal veil followed by sterile dressing.

DOCTORS HOSPITAL
HEALTH INFORMATION MANAGEMENT

OPERATIVE/PROCEDURE REPORT

PATIENT'S NAME: PETERSON,WILLIAM
UNIT NUMBER: G000573451
DICTATING DR. Mullins,MD Robert F

Robert F Mullins, MD

RFM:Spher:s22924
D: 07/16/06 16:34 T: 07/16/06 15:12 DOCUMENT: 200607151330162900

RX0R02 — SSH-A ...TA MCG — Page: 1 of 5
Rx Location: Pharmacy — MEDICATION ADMINISTRATION RECORD — Date: 7/31/2006
User : AUU0GB — 08/01/2006 07:30:00 through 08/02/2006 07:29:00 — Time: 16:06:19

Patient : PETERSON WILLIAM 0010873 Sex : M Admit Date: 6/01/06 Location: NUR1 655-A
Physician: DABBENEY SMITH KILA 00500 Height: 6 ft 01 in Weight : 172 lb 0 oz

No:	Medication	Start/Stop	Adm			
	Scheduled Orders					
0059293	ACIDOPHILUS/CITRUS PECTIN 1 TABLETS PO TWICE DAILY ONE DOSE = 1 TABLETS (*Lactobacillus Tab**) * = LACTOBACILLUS *	06/21/2006 AT 2100 09/28/2006 AT 0900		0900	2100	
0061209	AUGMENTIN 875 MILLIGRAM PEG TWICE DAILY ONE DOSE = 875 MILLIGRAM = 1 TABLETS (Amoxicillin & K Clavulanate Tab 875-125 MG)	07/31/2006 AT 0900 08/09/2006 AT 2100		0900	2100	
0059777	DAKINS (FULL STRENGTH) 0.5 % 1 APPL TOPICAL ONCE DAILY ONE DOSE = 1 APPL DAKIN'S FULL STRENGTH 480ML (Dakin's Solution 0.5%) * TO L. ISCHIUM * ****FLOOR STOCK****	06/30/2006 AT 0900 10/06/2006 AT 0900		0900		
0058364	FLOMAX 0.4 MILLIGRAM PO ONCE DAILY ONE DOSE = 0.4 MILLIGRAM = 1 CAPSULE TAMSULOSIN 0.4MG CAPSULE (Tamsulosin HCl Cap SR 24HR 0.4 MG)	06/09/2006 AT 0900 09/15/2006 AT 0900		0900		
0058445	HYDROPHOR 1 APPL TOPICAL USE AS DIRECTED ONE DOSE = 1 APPL (*Emollient - Ointment**) ****FLOOR STOCK****	06/10/2006 AT 0859 09/16/2006 AT 0859				
0059674	LOVENOX 40 MILLIGRAM SQ ONCE DAILY ONE DOSE = 40 MILLIGRAM = 0.4 MILLILITER ENOXAPARIN 40MG (Enoxaparin Sodium Inj 10 MG/0.1ML (100 MG/ML))	07/01/2006 AT 0900 10/07/2006 AT 0900		0900		
0061154	METRONIDAZOLE 500 MILLIGRAM PEG EVERY 8 HOURS ONE DOSE = 500 MILLIGRAM = 2 TABLETS GENERIC FOR FLAGYL (Metronidazole Tab 250 MG)	07/21/2006 AT 2200 08/10/2006 AT 1400		1400	2200 0600	
0058973	PROTONIX 40 MILLIGRAM NG ONCE DAILY ONE DOSE = 40 MILLIGRAM (Pantoprazole Sodium EC Tab 40 MG (Base Equiv)) * 40 MG = 10 ML * * SHAKE WELL & REFRIGERATE *	06/17/2006 AT 0900 09/23/2006 AT 0900		0900		
0060823	RISPERDAL 0.5 MILLIGRAM PO AT BEDTIME ONE DOSE = 0.5 MILLIGRAM = 0.5 TABLETS RISPERADONE (Risperidone Tab 1 MG)	07/21/2006 AT 2100 10/27/2006 AT 2100			2100	
0059292	THERA MULTIVITAMIN 1 TABLETS PO ONCE DAILY ONE DOSE = 1 TABLETS THERAPEUTIC MULTIVITAMIN (*Multiple Vitamin Tab**)	06/21/2006 AT 0900 09/27/2006 AT 0900		0900		
0058084	VITAMIN C 500 MILLIGRAM PO TWICE DAILY ONE DOSE = 500 MILLIGRAM ASCORBIC ACID 500 MG (Ascorbic Acid Tab 500 MG)	06/03/2006 AT 0900 09/09/2006 AT 2100		0900	2100	

Signatures	Init	Shift	Signatures	Init	Shift
			Wanda Clark LPN	WC	7A

Patient : PETERSON WILLIAM 0010873
Admitted : 6/01/06 15:53
Admit Physician: DABBENEY SMITH KILA
Age : 84 Y Date of Birth: [redacted]
Sex : Male Hist.#: 4940771

Admit Diag: DECUBITUS ULCER,LOW 707.03
Discharge: 0/00/00 00:00
Note :
Location : NUR1 655-A

Allergies: No Known Drug Allergy
Patient: 0010873 PETERSON WILLIAM
Room/Bed: 655-A
Verified By:

RXOR02
Rx Location: Pharmacy
User : AUU0GB

SSH-A[illegible]TA MCG
MEDICATION ADMINISTRATION RECORD
08/01/2006 07:30:00 through 08/02/2006 07:29:00

Page: 2 of 5
Date: 7/31/2006
Time: 16:06:19

Patient : PETERSON WILLIAM 0010873 Sex : M Admit Date: 6/01/06 Location: NUR1 655-A
Physician: DABENEY SMITH KILA 00500 Height: 6 ft 01 in Weight : 172 lb 0 oz

No:	Medication	Start/Stop	Adm			
	Scheduled Orders					
0058083	ZINC SULFATE 220 MILLIGRAM PO ONCE DAILY ONE DOSE = 220 MILLIGRAM = 1 CAPSULE (Zinc Sulfate Cap 220 MG)	06/03/2006 AT 0900 09/09/2006 AT 0900		0900		

Signatures	Init	Shift	Signatures	Init	Shift
Wanda Clark LPN	WC	7A			

Patient : PETERSON WILLIAM 0010873
Admitted : 6/01/06 15:53
Admit Physician: DABENEY SMITH KILA
Age : 84 Y Date of Birth: [redacted]
Sex : Male Hist.#: 4940771

Admit Diag: DECUBITUS ULCER,LOW 707.03
Discharge: 0/00/00 00:00
Note :
Location : NUR1 655-A

Allergies: No Known Drug Allergy
Patient: 0010873 PETERSON WILLIAM

Room/Bed: 655-A

Verified By: V. Clark RN

RX0R02
Rx Location: Pharmacy
User : AUU0GB

SSH-AUGUSTA MCG
MEDICATION ADMINISTRATION RECORD
08/01/2006 07:30:00 through 08/02/2006 07:29:00

Date: 7/31/2006
Time: 16:06:19

Patient : PETERSON WILLIAM 0010873 Sex : M Admit Date: 6/01/06 Location: NUR1 655-A
Physician: DABBENEY SMITH KILA 00500 Height: 6 ft 01 in Weight : 172 lb 0 oz

No:	Medication	Start/Stop	Adm			
	PRN Orders					
0060907	ACETAMINOPHEN 650 MILLIGRAM PO EVERY 8 HOURS AS NEEDED ONE DOSE = 650 MILLIGRAM GENERIC FOR TYLENOL 160 MG/5 ML (Acetaminophen Soln 160 MG/5ML) * FOR PAIN/FEVER *	07/24/2006 AT 1400 10/31/2006 AT 1359				
0057949	HEP-LOCK FLUSH 100 UNITS IV AS NEEDED ONE DOSE = 100 UNITS = 1 UNITS HEPARIN 100U/ML INJ (Heparin Sodium (Porcine) Lock Flush Soln 100 Unit/ML) ****FLOOR STOCK****	06/02/2006 AT 0900 09/09/2006 AT 0859				

Signatures	Init	Shift	Signatures	Init	Shift

Patient : PETERSON WILLIAM 0010873
Admitted : 6/01/06 15:53
Admit Physician: DABBENEY SMITH KILA
Age : 84 Y Date of Birth: [redacted]
Sex : Male Hist.#: 4940771

Admit Diag: DECUBITUS ULCER,LOW 707.03
Discharge: 0/00/00 00:00
Note :
Location : NUR1 655-A

Allergies: No Known Drug Allergy
Patient: 0010873 PETERSON WILLIAM

Room/Bed: 655-A

Verified By:

RX0R02
Rx Location: Pharmacy
User : AUU0GB

SSH-A[illegible]TA MCG
MEDICATION ADMINISTRATION RECORD
08/01/2006 07:30:00 through 08/02/2006 07:29:00

Date: 7/31/2006
Time: 16:06:19

Patient : PETERSON WILLIAM 0010873 Sex : M Admit Date: 6/01/06 Location: NUR1 655-A
Physician: DABBENEY SMITH KILA 00500 Height: 6 ft 01 in Weight : 172 lb 0 oz

No:	Medication	Start/Stop	Adm			
		Scheduled Orders				
0061155	Bag# 11, 12 SODIUM CHLORIDE 0.45 % 1000 MILLILITER IV CONT ONE DOSE = 1000 MILLILITER (Sodium Chloride Inj 0.45%) RATE: 100 ML /HR ****FLOOR STOCK****	07/28/2006 AT 1326 11/04/2006 AT 1325		1726	0326	

Signatures	Init	Shift	Signatures	Init	Shift

Patient : PETERSON WILLIAM 0010873
Admitted : 6/01/06 15:53
Admit Physician: DABBENEY SMITH KILA
Age : 84 Y Date of Birth: [redacted]
Sex : Male Hist.#: 4940771

Admit Diag: DECUBITUS ULCER,LOW 707.03
Discharge: 0/00/00 00:00
Note :
Location : NUR1 655-A

Allergies: No Known Drug Allergy
Patient: 0010873 PETERSON WILLIAM
Room/Bed: 655-A
Verified By: V. [illegible]

RX0R02 SSH-A[illegible]STA MCG Page: 5 of 5
Rx Location: Pharmacy MEDICATION ADMINISTRATION RECORD Date: 7/31/2006
User : AUU0GB 08/01/2006 07:30:00 through 08/02/2006 07:29:00 Time: 16:06:19

Patient : PETERSON WILLIAM 0010873 Sex : M Admit Date: 6/01/06 Location: NUR1 655-A
Physician: DABENBY SMITH KILA 00500 Height: 6 ft 01 in Weight : 172 lb 0 oz

No:	Medication	Start/Stop	Adm			
	PRN Orders					
0060924 ✓	SODIUM CHLORIDE 0.9 % 250 MILLILITER IV AS NEEDED ONE DOSE = 250 MILLILITER (Sodium Chloride IV Soln 0.9%) * BOLUS FOR BP 90/50 OR LESS * RATE: 250 ML /HR ****FLOOR STOCK****	07/25/2006 AT 0900 11/01/2006 AT 0859				

Signatures	Init	Shift	Signatures	Init	Shift

Patient : PETERSON WILLIAM 0010873
Admitted : 6/01/06 15:53
Admit Physician: DABENBY SMITH KILA
Age : 84 Y Date of Birth: [redacted]
Sex : Male Hist.#: 4940771

Admit Diag: DECUBITUS ULCER,LOW 707.03
Discharge: 0/00/00 00:00
Note :
Location : NUR1 655-A

Allergies: No Known Drug Allergy
Patient: 0010873 PETERSON WILLIAM
Room/Bed: 655-A
Verified By:

RXOR02 — SSH-A PA MCG — Page: 1 of 5
Rx Location: Pharmacy — MEDICATION ADMINISTRATION RECORD — Date: 7/30/2006
User : AUGOGPS — 07/31/2006 07:30:00 through 08/01/2006 07:29:00 — Time: 11:54:32

Patient : PETERSON WILLIAM 0010873 Sex : M Admit Date: 6/01/06 Location: NURI 655-A
Physician: DABBNEY SMITH KILA 00500 Height: 6 ft 01 in Weight : 172 lb 0 oz

No:	Medication	Start/Stop	Adm			
		Scheduled Orders				
0059293	ACIDOPHILUS/CITRUS PECTIN 1 TABLETS PO TWICE DAILY ONE DOSE = 1 TABLETS (*Lactobacillus Tab**) * = LACTOBACILLUS *	06/21/2006 AT 2100 09/28/2006 AT 0900		0900 MD	2100 SMA	
0058112	ARANESP 40 MICROGRAM SQ EVERY MONDAY ONE DOSE = 40 MICROGRAM = 1 MICROGRAM ARANESP=DARBEPOETIN ALFA (Darbepoetin Alfa-Albumin (Human) Soln Inj 40 MCG/ML)	06/05/2006 AT 0900 09/11/2006 AT 0900		0900 MD		
0059777	DAKINS (FULL STRENGTH) 0.5 % 1 APPL TOPICAL ONCE DAILY ONE DOSE = 1 APPL DAKIN'S FULL STRENGTH 480ML (Dakin's Solution 0.5%) * TO L. ISCHIUM * ****FLOOR STOCK****	06/30/2006 AT 0900 10/06/2006 AT 0900		0900 MD		
0058364	FLOMAX 0.4 MILLIGRAM PO ONCE DAILY ONE DOSE = 0.4 MILLIGRAM = 1 CAPSULE TAMSULOSIN 0.4MG CAPSULE (Tamsulosin HCl Cap SR 24HR 0.4 MG)	06/09/2006 AT 0900 09/15/2006 AT 0900		0900 MD		
0058445	HYDROPHOR 1 APPL TOPICAL USE AS DIRECTED ONE DOSE = 1 APPL (*Emollient - Ointment**) ****FLOOR STOCK****	06/10/2006 AT 0859 09/16/2006 AT 0859				
0058974	IMDUR 30 MILLIGRAM NG ONCE DAILY ONE DOSE = 30 MILLIGRAM = 1 TABLETS ISOSORBIDE MONONITRATE (Isosorbide Mononitrate Tab SR 24HR 30 MG) * HOLD FOR SBP < 110 *	06/17/2006 AT 0900 09/23/2006 AT 0900		0900 DC'd	7/30/06	
0059674	LOVENOX 40 MILLIGRAM SQ ONCE DAILY ONE DOSE = 40 MILLIGRAM = 0.4 MILLILITER ENOXAPARIN 40MG (Enoxaparin Sodium Inj 10 MG/0.1ML (100 MG/ML))	07/01/2006 AT 0900 10/07/2006 AT 0900		0900 MD		
0061154	METRONIDAZOLE 500 MILLIGRAM PEG EVERY 8 HOURS ONE DOSE = 500 MILLIGRAM = 2 TABLETS GENERIC FOR FLAGYL (Metronidazole Tab 250 MG)	07/21/2006 AT 2200 08/10/2006 AT 1400		1400 MD	2200 SMA 0600	
0058973	PROTONIX 40 MILLIGRAM NG ONCE DAILY ONE DOSE = 40 MILLIGRAM (Pantoprazole Sodium EC Tab 40 MG (Base Equiv)) * 40 MG = 10 ML * * SHAKE WELL & REFRIGERATE *	06/17/2006 AT 0900 09/23/2006 AT 0900		0900 MD		
0060823	RISPERDAL 0.5 MILLIGRAM PO AT BEDTIME ONE DOSE = 0.5 MILLIGRAM = 0.5 TABLETS RISPERADONE (Risperidone Tab 1 MG)	07/21/2006 AT 2100 10/27/2006 AT 2100			2100 SMA	

Signatures	Init	Shift	Signatures	Init	Shift
Wanda Clark RN	WC	7A	S. Addison RN	SMA	7P
			V. Dolan RN	VD	11P

Patient : PETERSON WILLIAM 0010873
Admitted : 6/01/06 15:53
Admit Physician: DABBNEY SMITH KILA
Age : 84 Y Date of Birth: [redacted]
Sex : Male Hist.#: 4940771

Admit Diag: DECUBITUS ULCER,LOW 707.03
Discharge: 0/00/00 00:00
Note :
Location : NURI 655-A

Allergies: No Known Drug Allergy
Patient: 0010873 PETERSON WILLIAM
Room/Bed: 655-A
Verified By: SMA

RXOR02 SSH-A GA MCG Page: 2 of 5
Rx Location: Pharmacy MEDICATION ADMINISTRATION RECORD Date: 7/30/2006
User : AUGOGPS 07/31/2006 07:30:00 through 08/01/2006 07:29:00 Time: 11:54:32

Patient : PETERSON WILLIAM 0010873 Sex : M Admit Date: 6/01/06 Location: NUR1 655-A
Physician: DABBNEY SMITH KILA 00500 Height: 6 ft 01 in Weight : 172 lb 0 oz

No:	Medication	Start/Stop	Adm			
		Scheduled Orders				
0059292	THERA MULTIVITAMIN 1 TABLETS PO ONCE DAILY ONE DOSE = 1 TABLETS THERAPEUTIC MULTIVITAMIN (*Multiple Vitamin Tab**)	06/21/2006 AT 0900 09/27/2006 AT 0900		0900 WC		
0058084	VITAMIN C 500 MILLIGRAM PO TWICE DAILY ONE DOSE = 500 MILLIGRAM ASCORBIC ACID 500 MG (Ascorbic Acid Tab 500 MG)	06/03/2006 AT 0900 09/09/2006 AT 2100		0900 WC	2100	
0058082	ZINC SULFATE 220 MILLIGRAM PO ONCE DAILY ONE DOSE = 220 MILLIGRAM = 1 CAPSULE (Zinc Sulfate Cap 220 MG)	06/03/2006 AT 0900 09/09/2006 AT 0900		0900 WC		
	Augmentin 875mg BID through PEG tube	7/30/06		0900 WC	2100	

Signatures	Init	Shift	Signatures	Init	Shift
Wanda Clark LPN	WC	7A	S. Addison RN	SMA	7P
			V. Lashley RN	VL	11P

Patient : PETERSON WILLIAM 0010873
Admitted : 6/01/06 15:53
Admit Physician: DABBNEY SMITH KILA
Age : 84 Y Date of Birth: [redacted]
Sex : Male Hist.#: 4940771

Admit Diag: DECUBITUS ULCER,LOW 707.03
Discharge: 0/00/00 00:00
Note :
Location : NUR1 655-A

Allergies: No Known Drug Allergy
Patient: 0010873 PETERSON WILLIAM
Room/Bed: 655-A
Verified By:

RXOR02 SSH-A GA MCG Page: 3 of 5
Rx Location: Pharmacy MEDICATION ADMINISTRATION RECORD Date: 7/30/2006
User : AUGOGPS 07/31/2006 07:30:00 through 08/01/2006 07:29:00 Time: 11:54:32
Patient : PETERSON WILLIAM 0010873 Sex : M Admit Date: 6/01/06 Location: NUR1 655-A
Physician: DABENEY SMITH KILA 00500 Height: 6 ft 01 in Weight : 172 lb 0 oz

No:	Medication	Start/Stop	Adm			
	PRN Orders					
0060907	ACETAMINOPHEN 650 MILLIGRAM PO EVERY 8 HOURS AS NEEDED ONE DOSE = 650 MILLIGRAM GENERIC FOR TYLENOL 160 MG/5 ML (Acetaminophen Soln 160 MG/5ML) * FOR PAIN/FEVER *	07/24/2006 AT 1400 10/31/2006 AT 1359				
0057949	HEP-LOCK FLUSH 100 UNITS IV AS NEEDED ONE DOSE = 100 UNITS = 1 UNITS HEPARIN 100U/ML INJ (Heparin Sodium (Porcine) Lock Flush Soln 100 Unit/ML) ****FLOOR STOCK****	06/02/2006 AT 0900 09/09/2006 AT 0859				

Signatures	Init	Shift	Signatures	Init	Shift
Wanda Clark RN	WC	7A	V. Dabeney RN	VD	11P

Patient : PETERSON WILLIAM 0010873
Admitted : 6/01/06 15:53
Admit Physician: DABENEY SMITH KILA
Age : 84 Y Date of Birth: [redacted]
Sex : Male Hist.#: 4940771
Allergies: No Known Drug Allergy
Patient: 0010873 PETERSON WILLIAM

Admit Diag: DECUBITUS ULCER,LOW 707.03
Discharge: 0/00/00 00:00
Note :
Location : NUR1 655-A
Room/Bed: 655-A
Verified By:

RX0R02 SSH-A GA MCG Page: 4 of 5
Rx Location: Pharmacy MEDICATION ADMINISTRATION RECORD Date: 7/30/2006
User : AUG0GPS 07/31/2006 07:30:00 through 08/01/2006 07:29:00 Time: 11:54:32

Patient : PETERSON WILLIAM 0010873 Sex : M Admit Date: 6/01/06 Location: NUR1 655-A
Physician: DABBENEY SMITH KILA 00500 Height: 6 ft 01 in Weight : 172 lb 0 oz

No:	Medication	Start/Stop	Adm			
		Scheduled Orders				
0061155	Bag# 8, 9, 10 SODIUM CHLORIDE 0.45 % 1000 MILLILITER IV CONT ONE DOSE = 1000 MILLILITER (Sodium Chloride Inj 0.45%) RATE: 100 ML /HR ****FLOOR STOCK****	07/26/2006 AT 1326 11/04/2006 AT 1325		1126	2126 0726	

Signatures	Init	Shift	Signatures	Init	Shift
Wanda Clark CRT	WC	7A	V. Hodnett	VH	11P

Patient : PETERSON WILLIAM 0010873
Admitted : 6/01/06 15:53
Admit Physician: DABBENEY SMITH KILA
Age : 84 Y Date of Birth: [redacted]
Sex : Male Hist.#: 4940771

Admit Diag: DECUBITUS ULCER,LOW 707.03
Discharge: 0/00/00 00:00
Note :
Location : NUR1 655-A

Allergies: No Known Drug Allergy
Patient: 0010873 PETERSON WILLIAM Room/Bed: 655-A Verified By: SDH

RX0R02 SSH-A PA MCG Page: 5 of 5
Rx Location: Pharmacy MEDICATION ADMINISTRATION RECORD Date: 7/30/2006
User : AUGOOPS 07/31/2006 07:30:00 through 08/01/2006 07:29:00 Time: 11:54:32

Patient : PETERSON WILLIAM 0010873 Sex : M Admit Date: 6/01/06 Location: NUR1 655-A
Physician: DABBNEY SMITH KILA 00500 Height: 6 ft 01 in Weight : 172 lb 0 oz

No:	Medication	Start/Stop	Adm			
	PRN Orders					
0060924	SODIUM CHLORIDE 0.9 % 250 MILLILITER IV AS NEEDED ONE DOSE = 250 MILLILITER (Sodium Chloride IV Soln 0.9%) * BOLUS FOR BP 90/50 OR LESS * RATE: 250 ML /HR ****FLOOR STOCK****	07/25/2006 AT 0900 11/01/2006 AT 0859				

Signatures	Init	Shift	Signatures	Init	Shift
Wanda Clark RN	WC	7A	V. Hinderer RN	VH	11P

Patient : PETERSON WILLIAM 0010873
Admitted : 6/01/06 15:53
Admit Physician: DABBNEY SMITH KILA
Age : 84 Y Date of Birth: [redacted]
Sex : Male Hist.#: 4940771

Admit Diag: DECUBITUS ULCER,LOW 707.03
Discharge: 0/00/00 00:00
Note :
Location : NUR1 655-A

Allergies: No Known Drug Allergy
Patient: 0010873 PETERSON WILLIAM Room/Bed: 655-A Verified By: _____

RX0R02 SSH-AUGUSTA MCG Page: 1 of 5
Rx Location: Pharmacy MEDICATION ADMINISTRATION RECORD Date: 7/29/2006
User : AUGOLCT 07/30/2006 07:30:00 through 07/31/2006 07:29:00 Time: 11:55:24

Patient : PETERSON WILLIAM 0010873 Sex : M Admit Date: 6/01/06 Location: NUR1 655-A
Physician: DABBENEY SMITH KILA 00500 Height: 6 ft 01 in Weight : 172 lb 0 oz

No:	Medication	Start/Stop	Adm			
	Scheduled Orders					
0059293	ACIDOPHILUS/CITRUS PECTIN 1 TABLETS PO TWICE DAILY ONE DOSE = 1 TABLETS (*Lactobacillus Tab**) * = LACTOBACILLUS *	06/21/2006 AT 2100 09/28/2006 AT 0900		0900 TB	2100 SDA	
0059777	DAKINS (FULL STRENGTH) 0.5 % 1 APPL TOPICAL ONCE DAILY ONE DOSE = 1 APPL DAKIN'S FULL STRENGTH 480ML (Dakin's Solution 0.5%) * TO L. ISCHIUM * ****FLOOR STOCK****	06/30/2006 AT 0900 10/06/2006 AT 0900		0900 TB		
0058364	FLOMAX 0.4 MILLIGRAM PO ONCE DAILY ONE DOSE = 0.4 MILLIGRAM = 1 CAPSULE TAMSULOSIN 0.4MG CAPSULE (Tamsulosin HCl Cap SR 24HR 0.4 MG)	06/09/2006 AT 0900 09/15/2006 AT 0900		0900 TB		
0058445	HYDROPHOR 1 APPL TOPICAL USE AS DIRECTED ONE DOSE = 1 APPL (*Emollient - Ointment**) ****FLOOR STOCK****	06/10/2006 AT 0859 09/16/2006 AT 0859				
0058974	IMDUR 30 MILLIGRAM NG ONCE DAILY ONE DOSE = 30 MILLIGRAM = 1 TABLETS ISOSORBIDE MONONITRATE (Isosorbide Mononitrate Tab SR 24HR 30 MG) * HOLD FOR SBP < 110 *	06/17/2006 AT 0900 09/23/2006 AT 0900		0900 TB	D/C'd 7/30/06	
0059674	LOVENOX 40 MILLIGRAM SQ ONCE DAILY ONE DOSE = 40 MILLIGRAM = 0.4 MILLILITER ENOXAPARIN 40MG (Enoxaparin Sodium Inj 10 MG/0.1ML (100 MG/ML))	07/01/2006 AT 0900 10/07/2006 AT 0900		0900 TB		
0061154	METRONIDAZOLE 500 MILLIGRAM PEG EVERY 8 HOURS ONE DOSE = 500 MILLIGRAM = 2 TABLETS GENERIC FOR FLAGYL (Metronidazole Tab 250 MG)	07/21/2006 AT 2200 08/10/2006 AT 1400		1400 TB	2200 SDA 0600 SDA	
0061107	NORVASC 5 MILLIGRAM NG ONCE DAILY ONE DOSE = 5 MILLIGRAM = 1 TABLETS AMLODIPINE 5MG TAB (Amlodipine Besylate Tab 5 MG) * HOLD FOR SBP < 110 *	07/28/2006 AT 0900 11/03/2006 AT 0900		(0900)	D/C'd 7-29-06	
0058973	PROTONIX 40 MILLIGRAM NG ONCE DAILY ONE DOSE = 40 MILLIGRAM (Pantoprazole Sodium EC Tab 40 MG (Base Equiv)) * 40 MG = 10 ML * * SHAKE WELL & REFRIGERATE *	06/17/2006 AT 0900 09/23/2006 AT 0900		0900 TB		
0060823	RISPERDAL 0.5 MILLIGRAM PO AT BEDTIME ONE DOSE = 0.5 MILLIGRAM = 0.5 TABLETS RISPERADONE (Risperidone Tab 1 MG)	07/21/2006 AT 2100 10/27/2006 AT 2100			2100 SDA	

Signatures	Init	Shift	Signatures	Init	Shift
			TB LW	TB	7A
			S. Addison LN	SDA	7P

Patient : PETERSON WILLIAM 0010873
Admitted : 6/01/06 15:53
Admit Physician: DABBENEY SMITH KILA
Age : 84 Y Date of Birth: [redacted]
Sex : Male Hist.#: 4940771

Admit Diag: DECUBITUS ULCER,LOW 707.03
Discharge: 0/00/00 00:00
Note :
Location : NUR1 655-A

Allergies: No Known Drug Allergy
Patient: 0010873 PETERSON WILLIAM
Room/Bed: 655-A
Verified By: O Jgonzalez

RX0R02 — SSH-AUGUSTA MCG — Page: 2 of 5
Rx Location: Pharmacy — MEDICATION ADMINISTRATION RECORD — Date: 7/29/2006
User : AUGOLCT — 07/30/2006 07:30:00 through 07/31/2006 07:29:00 — Time: 11:55:24

Patient : PETERSON WILLIAM 0010873 Sex : M Admit Date: 6/01/06 Location: NUR1 655-A
Physician: DABENEY SMITH KILA 00500 Height: 6 ft 01 in Weight : 172 lb 0 oz

No:	Medication	Start/Stop	Adm	Scheduled Orders		
0059292	THERA MULTIVITAMIN 1 TABLETS PO ONCE DAILY ONE DOSE = 1 TABLETS THERAPEUTIC MULTIVITAMIN (*Multiple Vitamin Tab**)	06/21/2006 AT 0900 09/27/2006 AT 0900		0900 B		
0058084	VITAMIN C 500 MILLIGRAM PO TWICE DAILY ONE DOSE = 500 MILLIGRAM ASCORBIC ACID 500 MG (Ascorbic Acid Tab 500 MG)	06/03/2006 AT 0900 09/09/2006 AT 2100		0900 B	2100 SDA	
0058083	ZINC SULFATE 220 MILLIGRAM PO ONCE DAILY ONE DOSE = 220 MILLIGRAM = 1 CAPSULE (Zinc Sulfate Cap 220 MG)	06/03/2006 AT 0900 09/09/2006 AT 0900		0900 B		
	Augmentin 875mg BID through peg tube	7/31/06		(0900)	2100 SDA	

Signatures	Init	Shift	Signatures	Init	Shift
			[signature]	B	7A
			S. Addison RN	SDA	7P

Patient : PETERSON WILLIAM 0010873
Admitted : 6/01/06 15:53
Admit Physician: DABENEY SMITH KILA
Age : 84 Y Date of Birth: [redacted]
Sex : Male Hist.#: 4940771

Admit Diag: DECUBITUS ULCER,LOW 707.03
Discharge: 0/00/00 00:00
Note :
Location : NUR1 655-A

Allergies: No Known Drug Allergy
Patient: 0010873 PETERSON WILLIAM
Room/Bed: 655-A
Verified By: [signature]

RX0R02 SSH-AUGUSTA MCG Page: 3 of 5
Rx Location: Pharmacy MEDICATION ADMINISTRATION RECORD Date: 7/29/2006
User : AUGOLCT 07/30/2006 07:30:00 through 07/31/2006 07:29:00 Time: 11:55:24

Patient : PETERSON WILLIAM 0010873 Sex : M Admit Date: 6/01/06 Location: NUR1 655-A
Physician: DABENBY SMITH KILA 00500 Height: 6 ft 01 in Weight : 172 lb 0 oz

No:	Medication	Start/Stop	Adm			
	PRN Orders					
0060907	ACETAMINOPHEN 650 MILLIGRAM PO EVERY 8 HOURS AS NEEDED ONE DOSE = 650 MILLIGRAM GENERIC FOR TYLENOL 160 MG/5 ML (Acetaminophen Soln 160 MG/5ML) * FOR PAIN/FEVER *	07/24/2006 AT 1400 10/31/2006 AT 1359				
0057949	HEP-LOCK FLUSH 100 UNITS IV AS NEEDED ONE DOSE = 100 UNITS = 1 UNITS HEPARIN 100U/ML INJ (Heparin Sodium (Porcine) Lock Flush Soln 100 Unit/ML) ****FLOOR STOCK****	06/02/2006 AT 0900 09/09/2006 AT 0859				

Signatures	Init	Shift	Signatures	Init	Shift
			low	TB	7A

Patient : PETERSON WILLIAM 0010873
Admitted : 6/01/06 15:53
Admit Physician: DABENBY SMITH KILA
Age : 84 Y Date of Birth: [redacted]
Sex : Male Hist.#: 4940771

Admit Diag: DECUBITUS ULCER,LOW 707.03
Discharge: 0/00/00 00:00
Note :
Location : NUR1 655-A

Allergies: No Known Drug Allergy
Patient: 0010873 PETERSON WILLIAM Room/Bed: 655-A Verified By: [signature]

RX0R02
Rx Location: Pharmacy
User : AUGOLCT

SSH-AUGUSTA MCG
MEDICATION ADMINISTRATION RECORD
07/30/2006 07:30:00 through 07/31/2006 07:29:00

Page: 4 of 5
Date: 7/29/2006
Time: 11:55:24

Patient : PETERSON WILLIAM 0010873 Sex : M Admit Date: 6/01/06 Location: NUR1 655-A
Physician: DABENEY SMITH KILA 00500 Height: 6 ft 01 in Weight : 172 lb 0 oz

No:	Medication	Start/Stop	Adm			
		Scheduled Orders				
0061155	Bag# 6, 7 SODIUM CHLORIDE 0.45 % 1000 MILLILITER IV CONT ONE DOSE = 1000 MILLILITER (Sodium Chloride Inj 0.45%) RATE: 100 ML /HR ****FLOOR STOCK****	07/28/2006 AT 1326 11/04/2006 AT 1325		1526 No IV access	0126 No IV access	

Signatures	Init	Shift	Signatures	Init	Shift
				B.	A

Patient : PETERSON WILLIAM 0010873
Admitted : 6/01/06 15:53
Admit Physician: DABENEY SMITH KILA
Age : 84 Y Date of Birth: [redacted]
Sex : Male Hist.#: 4940771

Admit Diag: DECUBITUS ULCER,LOW 707.03
Discharge: 0/00/00 00:00
Note :
Location : NUR1 655-A

Allergies: No Known Drug Allergy
Patient: 0010873 PETERSON WILLIAM
Room/Bed: 655-A
Verified By:

RX0R02
Rx Location: Pharmacy
User : AUGOLCT

SSH-A AA MCG
MEDICATION ADMINISTRATION RECORD
07/30/2006 07:30:00 through 07/31/2006 07:29:00

Page: 5 of 5
Date: 7/29/2006
Time: 11:55:24

Patient : PETERSON WILLIAM 0010873 Sex : M Admit Date: 6/01/06 Location: NUR1 655-A
Physician: DABBENEY SMITH KILA 00500 Height: 6 ft 01 in Weight : 172 lb 0 oz

No:	Medication	Start/Stop	Adm			
	PRN Orders					
0060924	SODIUM CHLORIDE 0.9 % 250 MILLILITER IV AS NEEDED ONE DOSE = 250 MILLILITER (Sodium Chloride IV Soln 0.9%) * BOLUS FOR BP 90/50 OR LESS * RATE: 250 ML /HR ****FLOOR STOCK****	07/25/2006 AT 0900 11/01/2006 AT 0859				

Signatures	Init	Shift	Signatures	Init	Shift
				TB	7n

Patient : PETERSON WILLIAM 0010873
Admitted : 6/01/06 15:53
Admit Physician: DABBENEY SMITH KILA
Age : 84 Y Date of Birth: [redacted]
Sex : Male Hist.#: 4940771

Admit Diag: DECUBITUS ULCER,LOW 707.03
Discharge: 0/00/00 00:00
Note :

Location : NUR1 655-A

Allergies: No Known Drug Allergy
Patient: 0010873 PETERSON WILLIAM Room/Bed: 655-A Verified By:

RX0R02 — SSH- ATA MCG — Page: 1 of 5
Rx Location: Pharmacy — MEDICATION ADMINISTRATION RECORD — Date: 7/28/2006
User : AUU0GB — 07/29/2006 07:30:00 through 07/30/2006 07:29:00 — Time: 15:58:30

Patient : PETERSON WILLIAM — 0010873 Sex : M — Admit Date: 6/01/06 — Location: NUR1 655-A
Physician: DABBENEY SMITH KILA — 00500 Height: 6 ft 01 in Weight : 172 lb 0 oz

No:	Medication	Start/Stop	Adm			
	Scheduled Orders					
0059293	ACIDOPHILUS/CITRUS PECTIN 1 TABLETS PO TWICE DAILY ONE DOSE = 1 TABLETS (*Lactobacillus Tab**) * = LACTOBACILLUS *	06/21/2006 AT 2100 09/28/2006 AT 0900		0900 TB	2100	
0059777	DAKINS (FULL STRENGTH) 0.5 % 1 APPL TOPICAL ONCE DAILY ONE DOSE = 1 APPL DAKIN'S FULL STRENGTH 480ML (Dakin's Solution 0.5%) * TO L. ISCHIUM * ****FLOOR STOCK****	06/30/2006 AT 0900 10/06/2006 AT 0900		0900 TB		
0058364	FLOMAX 0.4 MILLIGRAM PO ONCE DAILY ONE DOSE = 0.4 MILLIGRAM = 1 CAPSULE TAMSULOSIN 0.4MG CAPSULE (Tamsulosin HCl Cap SR 24HR 0.4 MG)	06/09/2006 AT 0900 09/15/2006 AT 0900		0900 TB		
0058445	HYDROPHOR 1 APPL TOPICAL USE AS DIRECTED ONE DOSE = 1 APPL (*Emollient - Ointment**) ****FLOOR STOCK****	06/10/2006 AT 0859 09/16/2006 AT 0859				
0058974	IMDUR 30 MILLIGRAM NG ONCE DAILY ONE DOSE = 30 MILLIGRAM = 1 TABLETS ISOSORBIDE MONONITRATE (Isosorbide Mononitrate Tab SR 24HR 30. MG) * HOLD FOR SBP < 110 *	06/17/2006 AT 0900 09/23/2006 AT 0900		0900 TB		
0059674	LOVENOX 40 MILLIGRAM SQ ONCE DAILY ONE DOSE = 40 MILLIGRAM = 0.4 MILLILITER ENOXAPARIN 40MG (Enoxaparin Sodium Inj 10 MG/0.1ML (100 MG/ML))	07/01/2006 AT 0900 10/07/2006 AT 0900		0900 TB		
0061154	METRONIDAZOLE 500 MILLIGRAM PEG EVERY 8 HOURS ONE DOSE = 500 MILLIGRAM = 2 TABLETS GENERIC FOR FLAGYL (Metronidazole Tab 250 MG)	07/21/2006 AT 2200 08/10/2006 AT 1400		1400 TB	2200 0600	
0061107	NORVASC 5 MILLIGRAM NG ONCE DAILY ONE DOSE = 5 MILLIGRAM = 1 TABLETS AMLODIPINE 5MG TAB (Amlodipine Besylate Tab 5 MG) * HOLD FOR SBP < 110 *	07/28/2006 AT 0900 11/03/2006 AT 0900		0900 TB	DC'd 7/29/06	
0058973	PROTONIX 40 MILLIGRAM NG ONCE DAILY ONE DOSE = 40 MILLIGRAM (Pantoprazole Sodium EC Tab 40 MG (Base Equiv)) * 40 MG = 10 ML * * SHAKE WELL & REFRIGERATE *	06/17/2006 AT 0900 09/23/2006 AT 0900		0900 TB		
0060823	RISPERDAL 0.5 MILLIGRAM PO AT BEDTIME ONE DOSE = 0.5 MILLIGRAM = 0.5 TABLETS RISPERADONE (Risperidone Tab 1 MG)	07/21/2006 AT 2100 10/27/2006 AT 2100			2100	

Signatures	Init	Shift	Signatures	Init	Shift
				TB	7A

Patient : PETERSON WILLIAM 0010873
Admitted : 6/01/06 15:53
Admit Physician: DABBENEY SMITH KILA
Age : 84 Y Date of Birth: [redacted]
Sex : Male Hist.#: 4940771

Admit Diag: DECUBITUS ULCER,LOW 707.03
Discharge: 0/00/00 00:00
Note :
Location : NUR1 655-A

Allergies: No Known Drug Allergy
Patient: 0010873 PETERSON WILLIAM
Room/Bed: 655-A
Verified By:

RX0R02 SSH-AUGUSTA MCG Page: 2 of 5
Rx Location: Pharmacy MEDICATION ADMINISTRATION RECORD Date: 7/28/2006
User : AUU0GB 07/29/2006 07:30:00 through 07/30/2006 07:29:00 Time: 15:58:30

Patient : PETERSON WILLIAM 0010873 Sex : M Admit Date: 6/01/06 Location: NUR1 655-A
Physician: DABENEY SMITH KILA 00500 Height: 6 ft 01 in Weight : 172 lb 0 oz

No:	Medication	Start/Stop	Adm			
		Scheduled Orders				
0060173	SSD 1 % 1 APPL TOP ONCE DAILY ONE DOSE = 1 APPL (Silver Sulfadiazine Cream 1%) to sacrum	07/08/2006 AT 0900 08/06/2006 AT 0900		0900	D/C to calmoseptine	
0059292	THERA MULTIVITAMIN 1 TABLETS PO ONCE DAILY ONE DOSE = 1 TABLETS THERAPEUTIC MULTIVITAMIN (*Multiple Vitamin Tab**)	06/21/2006 AT 0900 09/27/2006 AT 0900		0900 CB		
0058084	VITAMIN C 500 MILLIGRAM PO TWICE DAILY ONE DOSE = 500 MILLIGRAM ASCORBIC ACID 500 MG (Ascorbic Acid Tab 500 MG)	06/03/2006 AT 0900 09/09/2006 AT 2100		0900 CB	2100	
0058083	ZINC SULFATE 220 MILLIGRAM PO ONCE DAILY ONE DOSE = 220 MILLIGRAM = 1 CAPSULE (Zinc Sulfate Cap 220 MG)	06/03/2006 AT 0900 09/09/2006 AT 0900		0900 CB		

Signatures	Init	Shift	Signatures	Init	Shift
			LPN	CB	7A

Patient : PETERSON WILLIAM 0010873
Admitted : 6/01/06 15:53
Admit Physician: DABENEY SMITH KILA
Age : 84 Y Date of Birth: [redacted]
Sex : Male Hist.#: 4940771

Admit Diag: DECUBITUS ULCER,LOW 707.03
Discharge: 0/00/00 00:00
Note :
Location : NUR1 655-A

Allergies: No Known Drug Allergy
Patient: 0010873 PETERSON WILLIAM
Room/Bed: 655-A
Verified By:

RX0R02
Rx Location: Pharmacy
User : AUU0GB

SSH-A STA MCG
MEDICATION ADMINISTRATION RECORD
07/29/2006 07:30:00 through 07/30/2006 07:29:00

Patient : PETERSON WILLIAM 0010873 Sex : M Admit Date: 6/01/06 Location: NUR1 655-A
Physician: DABBENEY SMITH KILA 00500 Height: 6 ft 01 in Weight : 172 lb 0 oz

No:	Medication	Start/Stop	Adm			
	PRN Orders					
0060907	ACETAMINOPHEN 650 MILLIGRAM PO EVERY 8 HOURS AS NEEDED ONE DOSE = 650 MILLIGRAM GENERIC FOR TYLENOL 160 MG/5 ML (Acetaminophen Soln 160 MG/5ML) * FOR PAIN/FEVER *	07/24/2006 AT 1400 10/31/2006 AT 1359			DOO	
0057949	HEP-LOCK FLUSH 100 UNITS IV AS NEEDED ONE DOSE = 100 UNITS = 1 UNITS HEPARIN 100U/ML INJ. (Heparin Sodium (Porcine) Lock Flush Soln 100 Unit/ML) ****FLOOR STOCK****	06/02/2006 AT 0900 09/09/2006 AT 0859				

Signatures	Init	Shift	Signatures	Init	Shift
				TB	7A

Patient : PETERSON WILLIAM 0010873
Admitted : 6/01/06 15:53
Admit Physician: DABBENEY SMITH KILA
Age : 84 Y Date of Birth: [redacted]
Sex : Male Hist.#: [redacted]

Admit Diag: DECUBITUS ULCER,LOW 707.03
Discharge: 0/00/00 00:00
Note :
Location : NUR1 655-A

Allergies: No Known Drug Allergy
Patient: 0010873 PETERSON WILLIAM
Room/Bed: 655-A
Verified By:

RX0R02
Rx Location: Pharmacy
User : AUU0GB

SSH-A STA MCG
MEDICATION ADMINISTRATION RECORD
07/29/2006 07:30:00 through 07/30/2006 07:29:00

Date: 7/28/2006
Time: 15:58:30

Patient : PETERSON WILLIAM 0010873 Sex : M Admit Date: 6/01/06 Location: NUR1 655-A
Physician: DABENEY SMITH KILA 00500 Height: 6 ft 01 in Weight : 172 lb 0 oz

No:	Medication	Start/Stop	Adm	Scheduled Orders		
0061155	Bag# 3, 4, 5 SODIUM CHLORIDE 0.45 % 1000 MILLILITER IV CONT ONE DOSE = 1000 MILLILITER (Sodium Chloride Inj 0.45%) RATE: 100 ML /HR ****FLOOR STOCK****	07/28/2006 AT 1326 11/04/2006 AT 1325		0926 1326	0526 2200	

Signatures	Init	Shift	Signatures	Init	Shift
				TB	N

Patient : PETERSON WILLIAM 0010873
Admitted : 6/01/06 15:53
Admit Physician: DABENEY SMITH KILA
Age : 84 Y Date of Birth: [redacted]
Sex : Male Hist.#: 4940771

Admit Diag: DECUBITUS ULCER,LOW 707.03
Discharge: 0/00/00 00:00
Note :
Location : NUR1 655-A

Allergies: No Known Drug Allergy
Patient: 0010873 PETERSON WILLIAM
Room/Bed: 655-A
Verified By:

RX0R02
Rx Location: Pharmacy
User : AUU0GB

SSH-AUGUSTA MCG
MEDICATION ADMINISTRATION RECORD
07/29/2006 07:30:00 through 07/30/2006 07:29:00

Date: 7/28/2006
Time: 15:58:30

Patient : PETERSON WILLIAM 0010873 Sex : M Admit Date: 6/01/06 Location: NUR1 655-A
Physician: DABENEY SMITH KILA 00500 Height: 6 ft 01 in Weight : 172 lb 0 oz

No:	Medication	Start/Stop	Adm			
	PRN Orders					
0060924	SODIUM CHLORIDE 0.9 % 250 MILLILITER IV AS NEEDED ONE DOSE = 250 MILLILITER (Sodium Chloride IV Soln 0.9%) * BOLUS FOR BP 90/50 OR LESS * RATE: 250 ML /HR ****FLOOR STOCK****	07/25/2006 AT 0900 11/01/2006 AT 0859				

Signatures	Init	Shift	Signatures	Init	Shift
			[signature]	[signature]	7P
			[signature]	TB	7A

Patient : PETERSON WILLIAM 0010873
Admitted : 6/01/06 15:53
Admit Physician: DABENEY SMITH KILA
Age : 84 Y Date of Birth: [redacted]
Sex : Male Hist.#: 4940771

Admit Diag: DECUBITUS ULCER,LOH 707.03
Discharge: 0/00/00 00:00
Note :
Location : NUR1 655-A

Allergies: No Known Drug Allergy
Patient: 0010873 PETERSON WILLIAM
Room/Bed: 655-A
Verified By: [signature]

RX0R02 SSH-A[redacted]STA MCG Page: 1 of 5
Rx Location: Pharmacy MEDICATION ADMINISTRATION RECORD Date: 7/27/2006
User : AUU0GB 07/28/2006 07:30:00 through 07/29/2006 07:29:00 Time: 16:05:04
Patient : PETERSON WILLIAM 0010873 Sex : M Admit Date: 6/01/06 Location: NUR1 655-A
Physician: DABENBY SMITH KILA 00500 Height: 6 ft 01 in Weight : 172 lb 0 oz

No:	Medication	Start/Stop	Adm	Scheduled Orders		
0059293	ACIDOPHILUS/CITRUS PECTIN 1 TABLETS PO TWICE DAILY ONE DOSE = 1 TABLETS (*Lactobacillus Tab**) * = LACTOBACILLUS *	06/21/2006 AT 2100 09/28/2006 AT 0900		0900 VB	2100	
0060892	BACTROBAN 2 % 1 APPL TOP ONCE DAILY ONE DOSE = 1 APPL MUPIROCIN OINT (Mupirocin Oint 2%)	07/24/2006 AT 0900 10/30/2006 AT 0900		0900	DC'd 7/28/06	
0059777	DAKINS (FULL STRENGTH) 0.5 % 1 APPL TOPICAL ONCE DAILY ONE DOSE = 1 APPL DAKIN'S FULL STRENGTH 480ML (Dakin's Solution 0.5%) * TO L. ISCHIUM * ****FLOOR STOCK****	06/30/2006 AT 0900 10/06/2006 AT 0900		0900 VB		
0058364	FLOMAX 0.4 MILLIGRAM PO ONCE DAILY ONE DOSE = 0.4 MILLIGRAM = 1 CAPSULE TAMSULOSIN 0.4MG CAPSULE (Tamsulosin HCl Cap SR 24HR 0.4 MG)	06/09/2006 AT 0900 09/15/2006 AT 0900		0900 VB		
0058445	HYDROPHOR 1 APPL TOPICAL USE AS DIRECTED ONE DOSE = 1 APPL (*Emollient - Ointment**) ****FLOOR STOCK****	06/10/2006 AT 0859 09/16/2006 AT 0859				
0058974	IMDUR 30 MILLIGRAM NG ONCE DAILY ONE DOSE = 30 MILLIGRAM = 1 TABLETS ISOSORBIDE MONONITRATE (Isosorbide Mononitrate Tab SR 24HR 30 MG) * HOLD FOR SBP < 110 *	06/17/2006 AT 0900 09/23/2006 AT 0900		0900 VB		
0059674	LOVENOX 40 MILLIGRAM SQ ONCE DAILY ONE DOSE = 40 MILLIGRAM = 0.4 MILLILITER ENOXAPARIN 40MG (Enoxaparin Sodium Inj 10 MG/0.1ML (100 MG/ML))	07/01/2006 AT 0900 10/07/2006 AT 0900		0900 VB		
0060822	METRONIDAZOLE 500 MILLIGRAM PEG EVERY 8 HOURS ONE DOSE = 500 MILLIGRAM = 2 TABLETS GENERIC FOR FLAGYL (Metronidazole Tab 250 MG)	07/21/2006 AT 2200 07/31/2006 AT 1400		1400 VB	2200 0600	
0061107	NORVASC 5 MILLIGRAM NG ONCE DAILY ONE DOSE = 5 MILLIGRAM = 1 TABLETS AMLODIPINE 5MG TAB (Amlodipine Besylate Tab 5 MG) * HOLD FOR SBP < 110 *	07/28/2006 AT 0900 11/03/2006 AT 0900		0900 VB		
0058973	PROTONIX 40 MILLIGRAM NG ONCE DAILY ONE DOSE = 40 MILLIGRAM (Pantoprazole Sodium EC Tab 40 MG (Base Equiv)) * 40 MG = 10 ML * * SHAKE WELL & REFRIGERATE *	06/17/2006 AT 0900 09/23/2006 AT 0900		0900 VB		

Signatures	Init	Shift	Signatures	Init	Shift
			[illegible] LW	VB	7A
			Ofloxacin	CA	7P

Patient : PETERSON WILLIAM 0010873
Admitted : 6/01/06 15:53
Admit Physician: DABENBY SMITH KILA
Age : 84 Y Date of Birth: [redacted]
Sex : Male Hist.#: 4940771

Admit Diag: DECUBITUS ULCER,LOW 707.03
Discharge: 0/00/00 00:00
Note :
Location : NUR1 655-A

Allergies: No Known Drug Allergy
Patient: 0010873 PETERSON WILLIAM
Room/Bed: 655-A
Verified By: R

RX0R02 SSH-AUGUSTA MCG Page: 2 of 5
Rx Location: Pharmacy MEDICATION ADMINISTRATION RECORD Date: 7/27/2006
User : AUU0GB 07/28/2006 07:30:00 through 07/29/2006 07:29:00 Time: 16:05:04

Patient : PETERSON WILLIAM 0010873 Sex : M Admit Date: 6/01/06 Location: NUR1 655-A
Physician: DABBENEY SMITH KILA 00500 Height: 6 ft 01 in Weight : 172 lb 0 oz

No:	Medication	Start/Stop	Adm			
		Scheduled Orders				
0060823	RISPERDAL 0.5 MILLIGRAM PO AT BEDTIME ONE DOSE = 0.5 MILLIGRAM = 0.5 TABLETS RISPERADONE (Risperidone Tab 1 MG)	07/21/2006 AT 2100 10/27/2006 AT 2100			2100	
0060173	SSD 1 % 1 APPL TOP ONCE DAILY ONE DOSE = 1 APPL (Silver Sulfadiazine Cream 1%) to sacrum	07/08/2006 AT 0900 08/06/2006 AT 0900		0900		
0059292	THERA MULTIVITAMIN 1 TABLETS PO ONCE DAILY ONE DOSE = 1 TABLETS THERAPEUTIC MULTIVITAMIN (*Multiple Vitamin Tab**)	06/21/2006 AT 0900 09/27/2006 AT 0900		0900		
0060903	VANCOMYCIN 250 MILLIGRAM PEG EVERY 6 HOURS ONE DOSE = 250 MILLIGRAM VANCOCIN (Vancomycin HCl For Inj 1000 MG) * 250 MG = 5 ML * * LOOK IN REFRIGERATOR * * MAY GIVE PO/PEG *	07/23/2006 AT 1800 08/02/2006 AT 1200		1200 1800	2400 0600	
0058084	VITAMIN C 500 MILLIGRAM PO TWICE DAILY ONE DOSE = 500 MILLIGRAM ASCORBIC ACID 500 MG (Ascorbic Acid Tab 500 MG)	06/03/2006 AT 0900 09/09/2006 AT 2100		0900	2100	
0058083	ZINC SULFATE 220 MILLIGRAM PO ONCE DAILY ONE DOSE = 220 MILLIGRAM = 1 CAPSULE (Zinc Sulfate Cap 220 MG)	06/03/2006 AT 0900 09/09/2006 AT 0900		0900		

DC'd 7/28/06

Signatures	Init	Shift	Signatures	Init	Shift

Patient : PETERSON WILLIAM 0010873
Admitted : 6/01/06 15:53
Admit Physician: DABBENEY SMITH KILA
Age : 84 Y Date of Birth: [redacted]
Sex : Male Hist.#: 4940771

Admit Diag: DECUBITUS ULCER,LOW 707.03
Discharge: 0/00/00 00:00
Note :
Location : NUR1 655-A

Allergies: No Known Drug Allergy
Patient: 0010873 PETERSON WILLIAM
Room/Bed: 655-A
Verified By:

RX0R02
Rx Location: Pharmacy
User : AUU0GB

SSH-[redacted]STA MCG
MEDICATION ADMINISTRATION RECORD
07/28/2006 07:30:00 through 07/29/2006 07:29:00

Page: 3 of 5
Date: 7/27/2006
Time: 16:05:04

Patient : PETERSON WILLIAM 0010873 Sex : M Admit Date: 6/01/06 Location: NUR1 655-A
Physician: DABENEY SMITH KILA 00500 Height: 6 ft 01 in Weight : 172 lb 0 oz

No:	Medication	Start/Stop	Adm			
	PRN Orders					
0060907	ACETAMINOPHEN 650 MILLIGRAM PO EVERY 8 HOURS AS NEEDED ONE DOSE = 650 MILLIGRAM GENERIC FOR TYLENOL 160 MG/5 ML (Acetaminophen Soln 160 MG/5ML) * FOR PAIN/FEVER *	07/24/2006 AT 1400 10/31/2006 AT 1359		0930	2030 0500	
0057949	HEP-LOCK FLUSH 100 UNITS IV AS NEEDED ONE DOSE = 100 UNITS = 1 UNITS HEPARIN 100U/ML INJ (Heparin Sodium (Porcine) Lock Flush Soln 100 Unit/ML) ****FLOOR STOCK****	06/02/2006 AT 0900 09/09/2006 AT 0859				

Signatures	Init	Shift	Signatures	Init	Shift
				TB	7A
					7P

Patient : PETERSON WILLIAM 0010873
Admitted : 6/01/06 15:53
Admit Physician: DABENEY SMITH KILA
Age : 84 Y Date of Birth: [redacted]
Sex : Male Hist.#: 4940771

Admit Diag: DECUBITUS ULCER,LOW 707.03
Discharge: 0/00/00 00:00
Note :
Location : NUR1 655-A

Allergies: No Known Drug Allergy
Patient: 0010873 PETERSON WILLIAM
Room/Bed: 655-A
Verified By: R

RX0R02 SSH-A STA MCG Page: 4 of 5
Rx Location: Pharmacy MEDICATION ADMINISTRATION RECORD Date: 7/27/2006
User : AUU0GB 07/28/2006 07:30:00 through 07/29/2006 07:29:00 Time: 16:05:04
Patient : PETERSON WILLIAM 0010873 Sex : M Admit Date: 6/01/06 Location: NUR1 655-A
Physician: DABBENEY SMITH KILA 00500 Height: 6 ft 01 in Weight : 172 lb 0 oz

No:	Medication	Start/Stop	Adm	Scheduled Orders		
0060923	Bag# 10, 11, 12 SODIUM CHLORIDE 0.9 % 1000 MILLILITER IV CONT ONE DOSE = 1000 MILLILITER (Sodium Chloride IV Soln 0.9%) RATE: 100 ML /HR ****FLOOR STOCK****	07/24/2006 AT 1603 10/31/2006 AT 1602		1003 TB Δ 1d 7/28/06	2003 0603	
	Δ I/V Fluids ½ NS at 100ml/hr	7/28/06		1604 TB	0300 CT	

Signatures	Init	Shift	Signatures	Init	Shift
			[signature]	TB	7A
			[signature]	CT	7P

Patient : PETERSON WILLIAN 0010873
Admitted : 6/01/06 15:53
Admit Physician: DABBENEY SMITH KILA
Age : 84 Y Date of Birth: [redacted]
Sex : Male Hist.#: 4940771

Admit Diag: DECUBITUS ULCER,LOW 707.03
Discharge: 0/00/00 00:00
Note :
Location : NUR1 655-A

Allergies: No Known Drug Allergy
Patient: 0010873 PETERSON WILLIAN Room/Bed: 655-A Verified By: R

RXOR02
Rx Location: Pharmacy
User : AUU0GB

SSH-[redacted]STA MCG
MEDICATION ADMINISTRATION RECORD
07/28/2006 07:30:00 through 07/29/2006 07:29:00

Page: 5 of 5
Date: 7/27/2006
Time: 16:05:04

Patient : PETERSON WILLIAM 0010873 Sex : M Admit Date: 6/01/06 Location: NUR1 655-A
Physician: DABENEY SMITH KILA 00500 Height: 6 ft 01 in Weight : 172 lb 0 oz

No:	Medication	Start/Stop	Adm			
	PRN Orders					
0060924	SODIUM CHLORIDE 0.9 % 250 MILLILITER IV AS NEEDED ONE DOSE = 250 MILLILITER (Sodium Chloride IV Soln 0.9%) * BOLUS FOR BP 90/60 OR LESS * RATE: 250 ML /HR ****FLOOR STOCK****	07/25/2006 AT 0900 11/01/2006 AT 0859				

Signatures	Init	Shift	Signatures	Init	Shift
				TB	7A
				CR	7P

Patient : PETERSON WILLIAM 0010873
Admitted : 6/01/06 15:53
Admit Physician: DABENEY SMITH KILA
Age : 84 Y Date of Birth: [redacted]
Sex : Male Hist.#: 4940771

Admit Diag: DECUBITUS ULCER,LOW 707.03
Discharge: 0/00/00 00:00
Note :
Location : NUR1 655-A

Allergies: No Known Drug Allergy
Patient: 0010873 PETERSON WILLIAM
Room/Bed: 655-A
Verified By: R

RX0R02
Rx Location: Pharmacy
User : AUU0GB

SSH-AUGUSTA MCG
MEDICATION ADMINISTRATION RECORD
07/27/2006 07:30:00 through 07/28/2006 07:29:00

Page: 1 of 5
Date: 7/26/2006
Time: 16:29:19

Patient : PETERSON WILLIAM 0010873 Sex : M Admit Date: 6/01/06 Location: NUR1 655-A
Physician: DABBENEY SMITH KILA 00500 Height: 6 ft 01 in Weight : 172 lb 0 oz

No:	Medication	Start/Stop	Adm			
	Scheduled Orders					
0059293	ACIDOPHILUS/CITRUS PECTIN 1 TABLETS PO TWICE DAILY ONE DOSE = 1 TABLETS (*Lactobacillus Tab**) * = LACTOBACILLUS *	06/21/2006 AT 2100 09/28/2006 AT 0900		0900 CK	~~2100 K~~	
0060892	BACTROBAN 2 % 1 APPL TOP ONCE DAILY ONE DOSE = 1 APPL MUPIROCIN OINT (Mupirocin Oint 2%)	07/24/2006 AT 0900 10/30/2006 AT 0900		0900 CR		
0059777	DAKINS (FULL STRENGTH) 0.5 % 1 APPL TOPICAL ONCE DAILY ONE DOSE = 1 APPL DAKIN'S FULL STRENGTH 480ML (Dakin's Solution 0.5%) * TO L. ISCHIUM * ****FLOOR STOCK****	06/30/2006 AT 0900 10/06/2006 AT 0900		0900 CR		
0058364	FLOMAX 0.4 MILLIGRAM PO ONCE DAILY ONE DOSE = 0.4 MILLIGRAM = 1 CAPSULE TAMSULOSIN 0.4MG CAPSULE (Tamsulosin HCl Cap SR 24HR 0.4 MG)	06/09/2006 AT 0900 09/15/2006 AT 0900		0900 CK		
0058445	HYDROPHOR 1 APPL TOPICAL USE AS DIRECTED ONE DOSE = 1 APPL (*Emollient - Ointment**) ****FLOOR STOCK****	06/10/2006 AT 0859 09/16/2006 AT 0859				
0058974	IMDUR 30 MILLIGRAM NG ONCE DAILY ONE DOSE = 30 MILLIGRAM = 1 TABLETS ISOSORBIDE MONONITRATE (Isosorbide Mononitrate Tab SR 24HR 30 MG) * HOLD FOR SBP < 110 *	06/17/2006 AT 0900 09/23/2006 AT 0900		0900 CR 93/42		
0059674	LOVENOX 40 MILLIGRAM SQ ONCE DAILY ONE DOSE = 40 MILLIGRAM = 0.4 MILLILITER ENOXAPARIN 40MG (Enoxaparin Sodium Inj 10 MG/0.1ML (100 MG/ML))	07/01/2006 AT 0900 10/07/2006 AT 0900		0900 CR		
0060822	METRONIDAZOLE 500 MILLIGRAM PEG EVERY 8 HOURS ONE DOSE = 500 MILLIGRAM = 2 TABLETS GENERIC FOR FLAGYL (Metronidazole Tab 250 MG)	07/21/2006 AT 2200 07/31/2006 AT 1400		1400 CA	~~2200 R~~ ~~0600 R~~	
0058975	NORVASC 10 MILLIGRAM NG ONCE DAILY ONE DOSE = 10 MILLIGRAM = 2 TABLETS AMLODIPINE 5MG TAB (Amlodipine Besylate Tab 5 MG) * HOLD FOR SBP < 110 *	06/16/2006 AT 0900 09/22/2006 AT 0900		****		
				* ON HOLD: 07/24/2006 1604 Thru 09/22/2006 0900 *		
0058973	PROTONIX 40 MILLIGRAM NG ONCE DAILY ONE DOSE = 40 MILLIGRAM (Pantoprazole Sodium EC Tab 40 MG (Base Equiv)) * 40 MG = 10 ML * * SHAKE WELL & REFRIGERATE *	06/17/2006 AT 0900 09/23/2006 AT 0900		0900 CR		

Signatures	Init	Shift	Signatures	Init	Shift
			[signature]	CR	7a-7p
			[signature]	R	7p-7a

Patient : PETERSON WILLIAM 0010873
Admitted : 6/01/06 15:53
Admit Physician: DABBENEY SMITH KILA
Age : 84 Y Date of Birth: [redacted]
Sex : Male Hist.#: 4940771

Admit Diag: DECUBITUS ULCER,LOW 707.03
Discharge: 0/00/00 00:00
Note :
Location : NUR1 655-A

Allergies: No Known Drug Allergy
Patient: 0010873 PETERSON WILLIAM
Room/Bed: 655-A
Verified By: [signature]

RX0R02 — SSH-AUGUSTA MCG — Page: 2 of 5
Rx Location: Pharmacy — MEDICATION ADMINISTRATION RECORD — Date: 7/26/2006
User : AUU0GB — 07/27/2006 07:30:00 through 07/28/2006 07:29:00 — Time: 16:29:19
Patient : PETERSON WILLIAM — 0010873 Sex : M — Admit Date: 6/01/06 — Location: NUR1 655-A
Physician: DABENEY SMITH KILA — 00500 Height: 6 ft 01 in Weight : 172 lb 0 oz

No:	Medication	Start/Stop	Adm			
		Scheduled Orders				
0060823	RISPERDAL 0.5 MILLIGRAM PO AT BEDTIME ONE DOSE = 0.5 MILLIGRAM = 0.5 TABLETS RISPERADONE (Risperidone Tab 1 MG)	07/21/2006 AT 2100 10/27/2006 AT 2100			~~2100~~ R	
0060173	SSD 1 % 1 APPL TOP ONCE DAILY ONE DOSE = 1 APPL (Silver Sulfadiazine Cream 1%) to sacrum	07/08/2006 AT 0900 08/06/2006 AT 0900		0900 CM		
0059292	THERA MULTIVITAMIN 1 TABLETS PO ONCE DAILY ONE DOSE = 1 TABLETS THERAPEUTIC MULTIVITAMIN (*Multiple Vitamin Tab**)	06/21/2006 AT 0900 09/27/2006 AT 0900		0900 CM		
0060903	VANCOMYCIN 250 MILLIGRAM PRG EVERY 6 HOURS ONE DOSE = 250 MILLIGRAM VANCOCIN (Vancomycin HCl For Inj 1000 MG) * 250 MG = 5 ML * * LOOK IN REFRIGERATOR * * MAY GIVE PO/PEG *	07/23/2006 AT 1800 08/02/2006 AT 1200		1200 CM 1800 CM	~~2400~~ R ~~0600~~ R	
0058084	VITAMIN C 500 MILLIGRAM PO TWICE DAILY ONE DOSE = 500 MILLIGRAM ASCORBIC ACID 500 MG (Ascorbic Acid Tab 500 MG)	06/03/2006 AT 0900 09/09/2006 AT 2100		0900 CM	~~2100~~ R	
0058083	ZINC SULFATE 220 MILLIGRAM PO ONCE DAILY ONE DOSE = 220 MILLIGRAM = 1 CAPSULE (Zinc Sulfate Cap 220 MG)	06/03/2006 AT 0900 09/09/2006 AT 0900		0900 CM		
7/27	Norvasc 5mg po Qday			7-28-06 ~~1300~~ CM	14/12	Relate 7-28-06 Lapyxie

Signatures	Init	Shift	Signatures	Init	Shift
				CM	7a-7p
					7p-7a

Patient : PETERSON WILLIAM 0010873
Admitted : 6/01/06 15:53
Admit Physician: DABENEY SMITH KILA
Age : 84 Y Date of Birth: [redacted]
Sex : Male Hist.#: 4940771

Admit Diag: DECUBITUS ULCER,LOW 707.03
Discharge: 0/00/00 00:00
Note :
Location : NUR1 655-A

Allergies: No Known Drug Allergy
Patient: 0010873 PETERSON WILLIAM
Room/Bed: 655-A
Verified By:

RX0R02
Rx Location: Pharmacy
User : AUU0GB

SSH-A[redacted]TA MCG
MEDICATION ADMINISTRATION RECORD
07/27/2006 07:30:00 through 07/28/2006 07:29:00

Page: 3 of 5
Date: 7/26/2006
Time: 16:29:19

Patient : PETERSON WILLIAM 0010873 Sex : M Admit Date: 6/01/06 Location: NUR1 655-A
Physician: DABBNEY SMITH KILA 00500 Height: 6 ft 01 in Weight : 172 lb 0 oz

No:	Medication	Start/Stop	Adm			
	PRN Orders					
0060907	ACETAMINOPHEN 650 MILLIGRAM PO EVERY 8 HOURS AS NEEDED ONE DOSE = 650 MILLIGRAM GENERIC FOR TYLENOL 160 MG/5 ML (Acetaminophen Soln 160 MG/5ML) * FOR PAIN/FEVER *	07/24/2006 AT 1400 10/31/2006 AT 1359			~~2206~~ R	
0057949	HEP-LOCK FLUSH 100 UNITS IV AS NEEDED ONE DOSE = 100 UNITS = 1 UNITS HEPARIN 100U/ML INJ (Heparin Sodium (Porcine) Lock Flush Soln 100 Unit/ML) ****FLOOR STOCK****	06/02/2006 AT 0900 09/09/2006 AT 0859				

Signatures	Init	Shift	Signatures	Init	Shift
			[signature]	R	7P-7A

Patient : PETERSON WILLIAM 0010873
Admitted : 6/01/06 15:53
Admit Physician: DABBNEY SMITH KILA
Age : 84 Y Date of Birth: [redacted]
Sex : Male Hist.#: 4940771

Admit Diag: DECUBITUS ULCER,LOW 707.03
Discharge: 0/00/00 00:00
Note :
Location : NUR1 655-A

Allergies: No Known Drug Allergy
Patient: 0010873 PETERSON WILLIAM
Room/Bed: 655-A
Verified By: [signature]

MAKE CHECKS PAYABLE TO BELOW

EDGEFIELD MEDICAL CLINIC PA
200 RIDGE MEDICAL PLAZA
EDGEFIELD SC 29824

RESPONSIBLE PARTY NAME

WILLIAM PETERSON
3021 EDGEFIELD HWY
C/O MARY R. PETERSON
TRENTON SC 29847

CHARGES OR PAYMENTS MADE AFTER CLOSING DATE WILL APPEAR ON YOUR NEXT STATEMENT

AMOUNT ENCLOSED

11/24/09

FOR QUESTIONS CONCERNING YOUR BILL, PLEASE TELEPHONE THE NUMBER BELOW:

803-649-4858

-1199-

CLOSING DATE
10/03/12

ACCOUNT NUMBER
99-46 99-46

TOTAL ACCOUNT BALANCE

TOTAL DUE FROM PATIENT

☐ FOR ADDRESS CORRECTION OR CREDIT CARD PAYMENT PLEASE COMPLETE REVERSE SIDE.

DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

WP WILLIAM PETERSON

1-B.E. NICHOLSON,M.D. 2-E.S. GORDINEER,M.D. 3-E.R. LEAPHART,M.D.

02/27/06		1 WP	EST PT DETAILED SKILLE	99.00
03/22/06		2 WP	INITIAL/NEW/OR EST.NUR	154.00
03/28/06	02/27/06	1 WP		
03/28/06	02/27/06	1 WP		
04/04/06		1 WP	F/U NURSING FACIL/EXP	77.00
04/12/06	03/22/06	2 WP		
04/12/06	03/22/06	2 WP		
04/15/06		3 WP	F/U NURSING FACILITY P	53.00
05/03/06	04/04/06	1 WP		
05/03/06	04/04/06	1 WP		
11/24/09		- WP		

CURRENT	OVER 30 DAYS	OVER 60 DAYS	OVER 90 DAYS	OVER 120 DAYS	TOTAL ACCOUNT BALANCE	INSURANCE PENDING	DUE FROM PATIENT

CLOSING DATE

ACCOUNT NUMBER

PRINTED IN U.S.A.

Edgefield.Clinic.Bill00001

HOLD

AIKEN REGIONAL MED CTRS
CO CARRIER 1117
AIKEN, SC
29802-1117
PHONE: (803)641-5650
FED ID #: 57-0291408

TYPE OF BILL	DATE OF BILL	DATE OF PREV. BILL
FINAL	06/05/06	
INP.		

PAGE NO. 1

M H	PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
	PETERSON ,WILLIAM SR	102829710	M	85	05/15/06	06/01/06	17

SECULAR PHY (803)649-4558

GUARANTOR NAME AND ADDRESS

WILLIAM SR PETERSON SR
3023 EDGEFIELD HWY
.
TRENTON SC 29847-0000

FIGHT

AMOUNT OF PAYMENT 0

DATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES
	SUMMARY OF CHARGES		
	R&C IP-IMC 17DAYS@ 908.00		15436.00
	PHARMACY		11363.00
	MED/SURG SUPPLY		2998.00
	LABORATORY		9872.00
	RADIOLOGY		986.00
	BLOOD		444.00
	IMAGING SVC		1573.00
	RESPIRATORY		4421.00
	EMERGENCY ROOM		867.00
	PULMONARY		35.00
	CARDIOLOGY		1145.00
	CT SCAN		1121.00
	OPER ROOM		1733.00
	EKG/ECG		344.00
	GASTRO SVCS		4300.00
	OTHER		8.00
	PHARM OTHER		574.00
	SUB-TOTAL OF CHARGES		57220.00
	AMOUNTS DUE HEREUNDER HAVE BEEN ASSIGNED TO UHS RECEIVABLES CORP. & US BANK, N.A. AS TRUSTEE		
	TOTAL		57220.00

PATIENT NUMBER 102829710

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS STATEMENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS BASED UNDER ESTIMATED INSURANCE COVERAGE.

AIKEN REGIONAL MED CTRS
AIKEN, SC

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07:10:46

SSH AUGUSTA MCG
1459 LANEY WALKER BLVD
AUGUSTA GA 30912
Phone#

DTLBIL2

PATIENT NAME	HOSP NBR	PATIENT NUMBER	CYCLE	ROOM/ BED	ADMISSION DATE	DISCHARGE DATE	PAGE
PETERSON WILLIAM	494	10873	1	655-A	06/01/06	08/01/06	1

GUARANTOR NAME / ADDRESS
PETERSON WILLIAM
EDGEFIELD NH
TRENTON SC 29847
1770

F/C 5 PAYORS 800 PLAN 500

BILLING DATE 8/12/06

BILL TYPE: 111 PATIENT AGE: 84 DR. NAME: DABENEY SMITH KILA

CHARGE DATE/CODE	REV	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
06/01/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
06/02/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
06/03/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
06/04/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
06/05/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
06/06/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
06/07/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
06/08/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
06/09/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
06/10/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
06/11/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
06/12/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
06/13/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
06/14/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
06/15/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
06/16/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
06/17/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
06/18/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
06/19/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
06/20/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
06/21/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
06/22/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
06/23/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
06/24/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
06/25/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
06/26/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
06/27/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
06/28/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
06/29/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
06/30/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
07/01/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
07/02/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
07/03/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
07/04/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
07/05/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
07/06/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
07/07/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
07/08/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
07/09/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
07/10/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
07/11/06 35100072	120	ROOM & BOARD	1	696.00	696.00	

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SSH AUGUSTA MCG
1459 LANEY WALKER BLVD
AUGUSTA GA 30912
Phone#

PATIENT NAME	HOSP NBR	PATIENT NUMBER	CYCLE	ROOM/ BED	ADMISSION DATE	DISCHARGE DATE	PAGE
PETERSON WILLIAM	494	10873	1	655-A	06/01/06	08/01/06	2

GUARANTOR NAME / ADDRESS
PETERSON WILLIAM
EDGEFIELD NH
TRENTON SC 29847
1770

F/C 5 PAYORS 800 PLAN 500

BILLING DATE 8/12/06

BILL TYPE: 111 PATIENT AGE: 84 DR. NAME: DABENEY SMITH KILA

CHARGE DATE/CODE	REV	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
07/12/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
07/13/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
07/14/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
07/15/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
07/16/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
07/17/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
07/18/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
07/19/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
07/20/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
07/21/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
07/22/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
07/23/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
07/24/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
07/25/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
07/26/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
07/27/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
07/28/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
07/29/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
07/30/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
07/31/06 35100072	120	ROOM & BOARD	1	696.00	696.00	
06/02/06 41200122	250	ACETAMINOPHEN 325MG	2	.50	1.00	
06/10/06 41200122	250	ACETAMINOPHEN 325MG	2	.50	1.00	
06/19/06 41200122	250	ACETAMINOPHEN 325MG	2	.50	1.00	
06/21/06 41200122	250	ACETAMINOPHEN 325MG	2	.50	1.00	
06/22/06 41200122	250	ACETAMINOPHEN 325MG	2	.50	1.00	
06/23/06 41200122	250	ACETAMINOPHEN 325MG	2	.50	1.00	
06/24/06 41200122	250	ACETAMINOPHEN 325MG	2	.50	1.00	
06/25/06 41200122	250	ACETAMINOPHEN 325MG	2	.50	1.00	
06/26/06 41200122	250	ACETAMINOPHEN 325MG	2	.50	1.00	
07/06/06 41200122	250	ACETAMINOPHEN 325MG	2	.50	1.00	
07/07/06 41200122	250	ACETAMINOPHEN 325MG	2	.50	1.00	
07/08/06 41200122	250	ACETAMINOPHEN 325MG	2	.50	1.00	
07/09/06 41200122	250	ACETAMINOPHEN 325MG	2	.50	1.00	
07/10/06 41200122	250	ACETAMINOPHEN 325MG	2	.50	1.00	
07/15/06 41200122	250	ACETAMINOPHEN 325MG	2	.50	1.00	
07/17/06 41200122	250	ACETAMINOPHEN 325MG	4	.50	2.00	
07/20/06 41200122	250	ACETAMINOPHEN 325MG	2	.50	1.00	
07/21/06 41200122	250	ACETAMINOPHEN 325MG	2	.50	1.00	
07/22/06 41200122	250	ACETAMINOPHEN 325MG	4	.50	2.00	
06/21/06 41200262	250	ACIDOPHIL/PECTIN TAB	1	3.00	3.00	

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SSH AUGUSTA MCG
1459 LANEY WALKER BLVD
AUGUSTA GA 30912
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PATIENT NAME	HOSP NBR	PATIENT NUMBER	CYCLE	ROOM/ BED	ADMISSION DATE	DISCHARGE DATE	PAGE
PETERSON WILLIAM	494	10873	1	655-A	06/01/06	08/01/06	3

GUARANTOR NAME / ADDRESS
PETERSON WILLIAM
EDGEFIELD NH
TRENTON SC 29847
1770

F/C 5
PAYORS 800
PLAN 500

BILLING DATE 8/12/06

BILL TYPE: 111 PATIENT AGE: 84 DR. NAME: DABENEY SMITH KILA

CHARGE DATE/CODE	REV	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
06/22/06 41200262	250	ACIDOPHIL/PECTIN TAB	2	3.00	6.00	
06/23/06 41200262	250	ACIDOPHIL/PECTIN TAB	2	3.00	6.00	
06/24/06 41200262	250	ACIDOPHIL/PECTIN TAB	2	3.00	6.00	
06/25/06 41200262	250	ACIDOPHIL/PECTIN TAB	2	3.00	6.00	
06/26/06 41200262	250	ACIDOPHIL/PECTIN TAB	2	3.00	6.00	
06/27/06 41200262	250	ACIDOPHIL/PECTIN TAB	2	3.00	6.00	
06/28/06 41200262	250	ACIDOPHIL/PECTIN TAB	2	3.00	6.00	
06/30/06 41200262	250	ACIDOPHIL/PECTIN TAB	2	3.00	6.00	
07/01/06 41200262	250	ACIDOPHIL/PECTIN TAB	1	3.00	3.00	
07/02/06 41200262	250	ACIDOPHIL/PECTIN TAB	2	3.00	6.00	
07/03/06 41200262	250	ACIDOPHIL/PECTIN TAB	2	3.00	6.00	
07/04/06 41200262	250	ACIDOPHIL/PECTIN TAB	2	3.00	6.00	
07/05/06 41200262	250	ACIDOPHIL/PECTIN TAB	2	3.00	6.00	
07/06/06 41200262	250	ACIDOPHIL/PECTIN TAB	2	3.00	6.00	
07/07/06 41200262	250	ACIDOPHIL/PECTIN TAB	2	3.00	6.00	
07/08/06 41200262	250	ACIDOPHIL/PECTIN TAB	2	3.00	6.00	
07/09/06 41200262	250	ACIDOPHIL/PECTIN TAB	1	3.00	3.00	
07/10/06 41200262	250	ACIDOPHIL/PECTIN TAB	2	3.00	6.00	
07/11/06 41200262	250	ACIDOPHIL/PECTIN TAB	2	3.00	6.00	
07/12/06 41200262	250	ACIDOPHIL/PECTIN TAB	2	3.00	6.00	
07/13/06 41200262	250	ACIDOPHIL/PECTIN TAB	2	3.00	6.00	
07/14/06 41200262	250	ACIDOPHIL/PECTIN TAB	2	3.00	6.00	
07/15/06 41200262	250	ACIDOPHIL/PECTIN TAB	2	3.00	6.00	
07/16/06 41200262	250	ACIDOPHIL/PECTIN TAB	2	3.00	6.00	
07/17/06 41200262	250	ACIDOPHIL/PECTIN TAB	2	3.00	6.00	
07/18/06 41200262	250	ACIDOPHIL/PECTIN TAB	2	3.00	6.00	
07/19/06 41200262	250	ACIDOPHIL/PECTIN TAB	2	3.00	6.00	
07/20/06 41200262	250	ACIDOPHIL/PECTIN TAB	2	3.00	6.00	
07/21/06 41200262	250	ACIDOPHIL/PECTIN TAB	2	3.00	6.00	
07/22/06 41200262	250	ACIDOPHIL/PECTIN TAB	2	3.00	6.00	
07/23/06 41200262	250	ACIDOPHIL/PECTIN TAB	3	3.00	9.00	
07/24/06 41200262	250	ACIDOPHIL/PECTIN TAB	3	3.00	9.00	
07/25/06 41200262	250	ACIDOPHIL/PECTIN TAB	2	3.00	6.00	
07/26/06 41200262	250	ACIDOPHIL/PECTIN TAB	2	3.00	6.00	
07/27/06 41200262	250	ACIDOPHIL/PECTIN TAB	2	3.00	6.00	
07/28/06 41200262	250	ACIDOPHIL/PECTIN TAB	2	3.00	6.00	
07/29/06 41200262	250	ACIDOPHIL/PECTIN TAB	2	3.00	6.00	
07/30/06 41200262	250	ACIDOPHIL/PECTIN TAB	2	3.00	6.00	
07/31/06 41200262	250	ACIDOPHIL/PECTIN TAB	2	3.00	6.00	
08/01/06 41200262	250	ACIDOPHIL/PECTIN TAB	1	3.00	3.00	
06/02/06 41201575	250	ASCORBIC ACID 500 MG	1	.50	.50	

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SSH AUGUSTA MCG
1459 LANEY WALKER BLVD
AUGUSTA GA 30912
Phone#

PATIENT NAME	HOSP NBR	PATIENT NUMBER	CYCLE	ROOM/ BED	ADMISSION DATE	DISCHARGE DATE	PAGE
PETERSON WILLIAM	494	10873	1	655-A	06/01/06	08/01/06	4

GUARANTOR NAME / ADDRESS
PETERSON WILLIAM
EDGEFIELD NH
TRENTON SC 29847
1770

F/C 5 PAYORS 800 PLAN 500

BILLING DATE 8/12/06

BILL TYPE: 111 PATIENT AGE: 84 DR. NAME: DABENEY SMITH KILA

CHARGE DATE/CODE	REV	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
06/03/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
06/04/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
06/05/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
06/06/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
06/07/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
06/08/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
06/09/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
06/10/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
06/11/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
06/16/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
06/17/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
06/18/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
06/19/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
06/20/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
06/21/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
06/22/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
06/23/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
06/24/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
06/25/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
06/26/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
06/27/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
06/28/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
06/30/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
07/01/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
07/02/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
07/03/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
07/04/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
07/05/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
07/06/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
07/07/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
07/08/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
07/09/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
07/10/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
07/11/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
07/12/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
07/13/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
07/14/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
07/15/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
07/16/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
07/17/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
07/18/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	

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SSH AUGUSTA MCG
1459 LANEY WALKER BLVD
AUGUSTA GA 30912
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PATIENT NAME	HOSP NBR	PATIENT NUMBER	CYCLE	ROOM/ BED	ADMISSION DATE	DISCHARGE DATE	PAGE
PETERSON WILLIAM	494	10873	1	655-A	06/01/06	08/01/06	5

GUARANTOR NAME / ADDRESS
PETERSON WILLIAM
EDGEFIELD NH
TRENTON SC 29847
1770

F/C 5 PAYORS 800 PLAN 500

BILLING DATE 8/12/06

BILL TYPE: 111 PATIENT AGE: 84 DR. NAME: DABENEY SMITH KILA

CHARGE DATE/CODE	REV	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
07/19/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
07/20/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
07/21/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
07/22/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
07/23/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
07/24/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
07/25/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
07/26/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
07/27/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
07/28/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
07/29/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
07/30/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
07/31/06 41201575	250	ASCORBIC ACID 500 MG	2	.50	1.00	
08/01/06 41201575	250	ASCORBIC ACID 500 MG	1	.50	.50	
06/01/06 41201815	250	AUGMENTIN 875 MG TAB	1	27.50	27.50	
06/02/06 41201815	250	AUGMENTIN 875 MG TAB	1	27.50	27.50	
06/03/06 41201815	250	AUGMENTIN 875 MG TAB	2	27.50	55.00	
06/04/06 41201815	250	AUGMENTIN 875 MG TAB	2	27.50	55.00	
06/05/06 41201815	250	AUGMENTIN 875 MG TAB	2	27.50	55.00	
06/06/06 41201815	250	AUGMENTIN 875 MG TAB	1	27.50	27.50	
07/30/06 41201815	250	AUGMENTIN 875 MG TAB	1	27.50	27.50	
07/31/06 41201815	250	AUGMENTIN 875 MG TAB	2	27.50	55.00	
08/01/06 41201815	250	AUGMENTIN 875 MG TAB	1	27.50	27.50	
06/06/06 41201856	250	AUGMENTIN 500MG TAB	1	20.50	20.50	
06/07/06 41201856	250	AUGMENTIN 500MG TAB	2	20.50	41.00	
06/08/06 41201856	250	AUGMENTIN 500MG TAB	1	20.50	20.50	
07/25/06 41202060	250	BACTROBAN 2% OINT 30	1	222.00	222.00	
06/02/06 41205253	250	DAKINS SOLN 480ML BR	1	25.00	25.00	
06/22/06 41205253	250	DAKINS SOLN 480ML BR	1	25.00	25.00	
07/09/06 41205253	250	DAKINS SOLN 480ML BR	1	25.00	25.00	
07/20/06 41205253	250	DAKINS SOLN 480ML BR	1	25.00	25.00	
07/24/06 41205253	250	DAKINS SOLN 480ML BR	1	25.00	25.00	
07/30/06 41205253	250	DAKINS SOLN 480ML BR	1	25.00	25.00	
07/31/06 41205253	250	DAKINS SOLN 480ML BR	1	25.00	25.00	
06/09/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
06/10/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
06/11/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
06/16/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
06/17/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
06/18/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
06/19/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	

6/06/2012
07:10:46

SSH AUGUSTA MCG
1459 LANEY WALKER BLVD
AUGUSTA GA 30912
Phone#

DTLBIL2

PATIENT NAME	HOSP NBR	PATIENT NUMBER	CYCLE	ROOM/ BED	ADMISSION DATE	DISCHARGE DATE	PAGE
PETERSON WILLIAM	494	10873	1	655-A	06/01/06	08/01/06	6

GUARANTOR NAME / ADDRESS
PETERSON WILLIAM
EDGEFIELD NH
TRENTON SC 29847
1770

F/C 5 PAYORS 800 PLAN 500

BILLING DATE 8/12/06

BILL TYPE: 111 PATIENT AGE: 84 DR. NAME: DABENEY SMITH KILA

CHARGE DATE/CODE	REV	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
06/20/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
06/21/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
06/22/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
06/23/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
06/24/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
06/25/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
06/26/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
06/27/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
06/30/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
07/01/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
07/02/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
07/03/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
07/04/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
07/05/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
07/06/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
07/07/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
07/08/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
07/09/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
07/10/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
07/11/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
07/12/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
07/13/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
07/14/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
07/15/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
07/16/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
07/17/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
07/18/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
07/19/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
07/20/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
07/21/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
07/22/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
07/23/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
07/24/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
07/25/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
07/26/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
07/27/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
07/28/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
07/29/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
07/30/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
07/31/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	
08/01/06 41207739	250	FLOMAX .4MG TAB	1	9.75	9.75	

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SSH AUGUSTA MCG
1459 LANEY WALKER BLVD
AUGUSTA GA 30912
Phone#

PATIENT NAME	HOSP NBR	PATIENT NUMBER	CYCLE	ROOM/ BED	ADMISSION DATE	DISCHARGE DATE	PAGE
PETERSON WILLIAM	494	10873	1	655-A	06/01/06	08/01/06	7

SSN: 247-30-6586

GUARANTOR NAME / ADDRESS
PETERSON WILLIAM
EDGEFIELD NH
TRENTON SC 29847
1770

F/C 5 PAYORS 800 PLAN 500

BILLING DATE 8/12/06

BILL TYPE: 111 PATIENT AGE: 84 DR. NAME: DABENEY SMITH KILA

CHARGE DATE/CODE	REV	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
06/06/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
06/07/06 41210196	250	IMDUR-ER 30MG TAB	2	9.00	18.00	
06/08/06 41210196	250	IMDUR-ER 30MG TAB	2	9.00	18.00	
06/09/06 41210196	250	IMDUR-ER 30MG TAB	2	9.00	18.00	
06/10/06 41210196	250	IMDUR-ER 30MG TAB	2	9.00	18.00	
06/11/06 41210196	250	IMDUR-ER 30MG TAB	2	9.00	18.00	
06/16/06 41210196	250	IMDUR-ER 30MG TAB	2	9.00	18.00	
06/17/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
06/18/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
06/19/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
06/20/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
06/21/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
06/22/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
06/23/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
06/24/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
06/25/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
06/26/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
06/27/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
06/28/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
06/29/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
06/30/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
07/01/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
07/02/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
07/03/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
07/04/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
07/05/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
07/06/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
07/07/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
07/08/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
07/09/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
07/10/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
07/11/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
07/12/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
07/13/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
07/14/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
07/15/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
07/16/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
07/17/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
07/18/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
07/19/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
07/20/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	

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SSH AUGUSTA MCG
1459 LANEY WALKER BLVD
AUGUSTA GA 30912
Phone#

PATIENT NAME	HOSP NBR	PATIENT NUMBER	CYCLE	ROOM/ BED	ADMISSION DATE	DISCHARGE DATE	PAGE
PETERSON WILLIAM	494	10873	1	655-A	06/01/06	08/01/06	8

GUARANTOR NAME / ADDRESS
PETERSON WILLIAM
EDGEFIELD NH
TRENTON SC 29847
1770

F/C 5 PAYORS 800 PLAN 500

BILLING DATE 8/12/06

BILL TYPE: 111 PATIENT AGE: 84 DR. NAME: DABENEY SMITH KILA

CHARGE DATE/CODE	REV	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
07/21/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
07/22/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
07/23/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
07/24/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
07/26/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
07/27/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
07/28/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
07/29/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
07/30/06 41210196	250	IMDUR-ER 30MG TAB	1	9.00	9.00	
06/22/06 41210824	250	K-DUR 20MEQ TAB	4	3.00	12.00	
07/08/06 41211491	250	LEVAQUIN 250MG TAB	2	43.25	86.50	
07/09/06 41211491	250	LEVAQUIN 250MG TAB	2	43.25	86.50	
07/10/06 41211491	250	LEVAQUIN 250MG TAB	2	43.25	86.50	
07/11/06 41211491	250	LEVAQUIN 250MG TAB	2	43.25	86.50	
07/12/06 41211491	250	LEVAQUIN 250MG TAB	2	43.25	86.50	
07/13/06 41211491	250	LEVAQUIN 250MG TAB	2	43.25	86.50	
07/14/06 41211491	250	LEVAQUIN 250MG TAB	2	43.25	86.50	
07/15/06 41211491	250	LEVAQUIN 250MG TAB	2	43.25	86.50	
07/16/06 41211491	250	LEVAQUIN 250MG TAB	2	43.25	86.50	
07/17/06 41211491	250	LEVAQUIN 250MG TAB	2	43.25	86.50	
07/18/06 41211491	250	LEVAQUIN 250MG TAB	2	43.25	86.50	
07/19/06 41211491	250	LEVAQUIN 250MG TAB	2	43.25	86.50	
06/12/06 41212242	250	LOVENOX 30MG/.3MLSYR	1	92.75	92.75	
06/13/06 41212242	250	LOVENOX 30MG/.3MLSYR	1	92.75	92.75	
06/16/06 41212242	250	LOVENOX 30MG/.3MLSYR	1	92.75	92.75	
06/17/06 41212242	250	LOVENOX 30MG/.3MLSYR	1	92.75	92.75	
06/18/06 41212242	250	LOVENOX 30MG/.3MLSYR	1	92.75	92.75	
06/19/06 41212242	250	LOVENOX 30MG/.3MLSYR	1	92.75	92.75	
06/02/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
06/20/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
06/21/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
06/22/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
06/23/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
06/24/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
06/25/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
06/26/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
06/27/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
06/28/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
07/01/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
07/02/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
07/03/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	

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SSH AUGUSTA MCG
1459 LANEY WALKER BLVD
AUGUSTA GA 30912
Phone#

PATIENT NAME	HOSP NBR	PATIENT NUMBER	CYCLE	ROOM/ BED	ADMISSION DATE	DISCHARGE DATE	PAGE
PETERSON WILLIAM	494	10873	1	655-A	06/01/06	08/01/06	9

GUARANTOR NAME / ADDRESS
PETERSON WILLIAM
EDGEFIELD NH
TRENTON SC 29847
1770

F/C 5 PAYORS 800 PLAN 500

BILLING DATE 8/12/06

BILL TYPE: 111 PATIENT AGE: 84 DR. NAME: DABENEY SMITH KILA

CHARGE DATE/CODE	REV	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
07/04/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
07/05/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
07/06/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
07/07/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
07/08/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
07/09/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
07/10/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
07/11/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
07/12/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
07/13/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
07/14/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
07/15/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
07/16/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
07/17/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
07/18/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
07/19/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
07/20/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
07/21/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
07/22/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
07/23/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
07/24/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
07/25/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
07/26/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
07/27/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
07/28/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
07/29/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
07/30/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
07/31/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
08/01/06 41212259	250	LOVENOX 40MG/.4MLSYR	1	123.75	123.75	
06/11/06 41213265	250	METOCLOP 10MG/2MLINJ	1	6.00	6.00	
06/14/06 41213265	250	METOCLOP 10MG/2MLINJ	2	6.00	12.00	
06/15/06 41213265	250	METOCLOP 10MG/2MLINJ	4	6.00	24.00	
06/16/06 41213265	250	METOCLOP 10MG/2MLINJ	2	6.00	12.00	
06/17/06 41213265	250	METOCLOP 10MG/2MLINJ	4	6.00	24.00	
06/18/06 41213265	250	METOCLOP 10MG/2MLINJ	3	6.00	18.00	
06/19/06 41213265	250	METOCLOP 10MG/2MLINJ	3	6.00	18.00	
06/20/06 41213265	250	METOCLOP 10MG/2MLINJ	4	6.00	24.00	
06/21/06 41213265	250	METOCLOP 10MG/2MLINJ	5	6.00	30.00	
06/22/06 41213265	250	METOCLOP 10MG/2MLINJ	1	6.00	6.00	
06/22/06 41213281	250	METOCLOP 5 MG TAB	1	3.00	3.00	
06/23/06 41213281	250	METOCLOP 5 MG TAB	2	3.00	6.00	

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07:10:46

SSH AUGUSTA MCG
1459 LANEY WALKER BLVD
AUGUSTA GA 30912
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DTLBIL2

PATIENT NAME	HOSP NBR	PATIENT NUMBER	CYCLE	ROOM/ BED	ADMISSION DATE	DISCHARGE DATE	PAGE
PETERSON WILLIAM	494	10873	1	655-A	06/01/06	08/01/06	10

GUARANTOR NAME / ADDRESS
PETERSON WILLIAM
EDGEFIELD NH
TRENTON SC 29847
1770

F/C 5 PAYORS 800 PLAN 500

BILLING DATE 8/12/06

BILL TYPE: 111 PATIENT AGE: 84 DR. NAME: DABENEY SMITH KILA

CHARGE DATE/CODE	REV	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
06/24/06 41213281	250	METOCLOP 5 MG TAB	1	3.00	3.00	
06/25/06 41213281	250	METOCLOP 5 MG TAB	2	3.00	6.00	
06/26/06 41213281	250	METOCLOP 5 MG TAB	2	3.00	6.00	
06/27/06 41213281	250	METOCLOP 5 MG TAB	1	3.00	3.00	
07/12/06 41213281	250	METOCLOP 5 MG TAB	1	3.00	3.00	
07/13/06 41213281	250	METOCLOP 5 MG TAB	1	3.00	3.00	
06/13/06 41213315	250	METOPRO TART 5M/5MIN	1	18.25	18.25	
06/14/06 41213315	250	METOPRO TART 5M/5MIN	3	18.25	54.75	
06/15/06 41213315	250	METOPRO TART 5M/5MIN	3	18.25	54.75	
06/16/06 41213315	250	METOPRO TART 5M/5MIN	1	18.25	18.25	
07/21/06 41213349	250	METRONIDAZOLE250MGTB	2	3.00	6.00	
07/22/06 41213349	250	METRONIDAZOLE250MGTB	6	3.00	18.00	
07/23/06 41213349	250	METRONIDAZOLE250MGTB	5	3.00	15.00	
07/24/06 41213349	250	METRONIDAZOLE250MGTB	8	3.00	24.00	
07/25/06 41213349	250	METRONIDAZOLE250MGTB	6	3.00	18.00	
07/26/06 41213349	250	METRONIDAZOLE250MGTB	7	3.00	21.00	
07/27/06 41213349	250	METRONIDAZOLE250MGTB	8	3.00	24.00	
07/28/06 41213349	250	METRONIDAZOLE250MGTB	4	3.00	12.00	
07/29/06 41213349	250	METRONIDAZOLE250MGTB	6	3.00	18.00	
07/30/06 41213349	250	METRONIDAZOLE250MGTB	8	3.00	24.00	
07/31/06 41213349	250	METRONIDAZOLE250MGTB	6	3.00	18.00	
08/01/06 41213349	250	METRONIDAZOLE250MGTB	2	3.00	6.00	
06/14/06 41216615	250	POTAS CHL 40MEQ/20ML	1	3.00	3.00	
06/02/06 41218108	250	RISPERDAL 1 MG TAB	1	16.75	16.75	
06/04/06 41218108	250	RISPERDAL 1 MG TAB	1	16.75	16.75	
06/16/06 41218108	250	RISPERDAL 1 MG TAB	1	16.75	16.75	
07/02/06 41218108	250	RISPERDAL 1 MG TAB	1	16.75	16.75	
07/09/06 41218108	250	RISPERDAL 1 MG TAB	1	16.75	16.75	
07/10/06 41218108	250	RISPERDAL 1 MG TAB	2	16.75	33.50	
07/11/06 41218108	250	RISPERDAL 1 MG TAB	2	16.75	33.50	
07/12/06 41218108	250	RISPERDAL 1 MG TAB	2	16.75	33.50	
07/13/06 41218108	250	RISPERDAL 1 MG TAB	2	16.75	33.50	
07/14/06 41218108	250	RISPERDAL 1 MG TAB	2	16.75	33.50	
07/15/06 41218108	250	RISPERDAL 1 MG TAB	2	16.75	33.50	
07/16/06 41218108	250	RISPERDAL 1 MG TAB	2	16.75	33.50	
07/17/06 41218108	250	RISPERDAL 1 MG TAB	2	16.75	33.50	
07/18/06 41218108	250	RISPERDAL 1 MG TAB	2	16.75	33.50	
07/19/06 41218108	250	RISPERDAL 1 MG TAB	2	16.75	33.50	
07/20/06 41218108	250	RISPERDAL 1 MG TAB	2	16.75	33.50	
07/21/06 41218108	250	RISPERDAL 1 MG TAB	2	16.75	33.50	
07/22/06 41218108	250	RISPERDAL 1 MG TAB	1	16.75	16.75	

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SSH AUGUSTA MCG
1459 LANEY WALKER BLVD
AUGUSTA GA 30912
Phone#

DTLBIL2

PATIENT NAME	HOSP NBR	PATIENT NUMBER	CYCLE	ROOM/ BED	ADMISSION DATE	DISCHARGE DATE	PAGE
PETERSON WILLIAM	494	10873	1	655-A	06/01/06	08/01/06	11

GUARANTOR NAME / ADDRESS
PETERSON WILLIAM
EDGEFIELD NH
TRENTON SC 29847
1770

F/C 5 PAYORS 800 PLAN 500

BILLING DATE 8/12/06

BILL TYPE: 111 PATIENT AGE: 84 DR. NAME: DABENEY SMITH KILA

CHARGE DATE/CODE	REV	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
07/23/06 41218108	250	RISPERDAL 1 MG TAB	1	16.75	16.75	
07/25/06 41218108	250	RISPERDAL 1 MG TAB	1	16.75	16.75	
07/26/06 41218108	250	RISPERDAL 1 MG TAB	1	16.75	16.75	
07/27/06 41218108	250	RISPERDAL 1 MG TAB	1	16.75	16.75	
07/28/06 41218108	250	RISPERDAL 1 MG TAB	1	16.75	16.75	
07/29/06 41218108	250	RISPERDAL 1 MG TAB	1	16.75	16.75	
07/30/06 41218108	250	RISPERDAL 1 MG TAB	1	16.75	16.75	
07/31/06 41218108	250	RISPERDAL 1 MG TAB	1	16.75	16.75	
06/07/06 41219221	250	SOD POLY SULF15GM/60	2	34.50	69.00	
06/03/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
06/04/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
06/05/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
06/06/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
06/07/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
06/08/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
06/09/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
06/10/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
06/11/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
06/16/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
06/17/06 41222910	250	ZINC SULF 220MG CAP	2	.50	1.00	
06/18/06 41222910	250	ZINC SULF 220MG CAP	2	.50	1.00	
06/19/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
06/20/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
06/21/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
06/22/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
06/23/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
06/24/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
06/25/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
06/26/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
06/27/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
06/28/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
06/30/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
07/01/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
07/02/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
07/03/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
07/04/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
07/05/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
07/06/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
07/07/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
07/08/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
07/10/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	

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SSH AUGUSTA MCG
1459 LANEY WALKER BLVD
AUGUSTA GA 30912
Phone#

DTLBIL2

PATIENT NAME	HOSP NBR	PATIENT NUMBER	CYCLE	ROOM/ BED	ADMISSION DATE	DISCHARGE DATE	PAGE
PETERSON WILLIAM	494	10873	1	655-A	06/01/06	08/01/06	12

GUARANTOR NAME / ADDRESS
PETERSON WILLIAM
EDGEFIELD NH
TRENTON SC 29847
1770

F/C 5 PAYORS 800 PLAN 500

BILLING DATE 8/12/06

BILL TYPE: 111 PATIENT AGE: 84 DR. NAME: DABENEY SMITH KILA

CHARGE DATE/CODE	REV	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
07/11/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
07/12/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
07/13/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
07/14/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
07/15/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
07/16/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
07/17/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
07/18/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
07/19/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
07/20/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
07/21/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
07/22/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
07/23/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
07/24/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
07/25/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
07/26/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
07/27/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
07/28/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
07/29/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
07/30/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
07/31/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
08/01/06 41222910	250	ZINC SULF 220MG CAP	1	.50	.50	
06/02/06 41224726	250	NORVASC 5MG TAB	1	7.00	7.00	
06/04/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
06/05/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
06/06/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
06/07/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
06/08/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
06/09/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
06/10/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
06/11/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
06/16/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
06/17/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
06/18/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
06/19/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
06/20/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
06/21/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
06/22/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
06/23/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
06/24/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
06/25/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	

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SSH AUGUSTA MCG
1459 LANEY WALKER BLVD
AUGUSTA GA 30912
Phone#

PATIENT NAME	HOSP NBR	PATIENT NUMBER	CYCLE	ROOM/ BED	ADMISSION DATE	DISCHARGE DATE	PAGE
PETERSON WILLIAM	494	10873	1	655-A	06/01/06	08/01/06	13

GUARANTOR NAME / ADDRESS
PETERSON WILLIAM
EDGEFIELD NH
TRENTON SC 29847
1770

F/C 5 PAYORS 800 PLAN 500

BILLING DATE 8/12/06

BILL TYPE: 111 PATIENT AGE: 84 DR. NAME: DABENEY SMITH KILA

CHARGE DATE/CODE	REV	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
06/26/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
06/27/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
06/28/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
06/29/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
06/30/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
07/01/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
07/02/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
07/03/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
07/04/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
07/05/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
07/06/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
07/07/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
07/08/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
07/09/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
07/10/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
07/11/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
07/12/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
07/13/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
07/14/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
07/15/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
07/16/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
07/17/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
07/18/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
07/19/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
07/20/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
07/21/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
07/22/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
07/23/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
07/24/06 41224726	250	NORVASC 5MG TAB	2	7.00	14.00	
07/28/06 41224726	250	NORVASC 5MG TAB	1	7.00	7.00	
07/29/06 41224726	250	NORVASC 5MG TAB	1	7.00	7.00	
07/23/06 41228339	250	ACETAMIN 160MG/5ML S	2	1.50	3.00	
07/24/06 41228339	250	ACETAMIN 160MG/5ML S	1	1.50	1.50	
07/25/06 41228339	250	ACETAMIN 160MG/5ML S	1	1.50	1.50	
07/26/06 41228339	250	ACETAMIN 160MG/5ML S	1	1.50	1.50	
07/27/06 41228339	250	ACETAMIN 160MG/5ML S	1	1.50	1.50	
07/28/06 41228339	250	ACETAMIN 160MG/5ML S	2	1.50	3.00	
07/29/06 41228339	250	ACETAMIN 160MG/5ML S	2	1.50	3.00	
07/30/06 41228339	250	ACETAMIN 160MG/5ML S	1	1.50	1.50	
08/01/06 41228339	250	ACETAMIN 160MG/5ML S	1	1.50	1.50	
07/18/06 41228578	250	GUIFENESIN 10ML LIQD	5	.50	2.50	

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1459 LANEY WALKER BLVD
AUGUSTA GA 30912
Phone#

DTLBIL2

PATIENT NAME	HOSP NBR	PATIENT NUMBER CYCLE	ROOM/ BED	ADMISSION DATE	DISCHARGE DATE	PAGE
PETERSON WILLIAM	494	10873 1	655-A	06/01/06	08/01/06	14

GUARANTOR NAME / ADDRESS
PETERSON WILLIAM
EDGEFIELD NH
TRENTON SC 29847
1770

F/C 5 PAYORS 800 PLAN 500

BILLING DATE 8/12/06

BILL TYPE: 111 PATIENT AGE: 84 DR. NAME: DABENEY SMITH KILA

CHARGE DATE/CODE	REV	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
07/03/06 41229139	250	TUBERCULIN PPD 5U	1	125.00	125.00	
06/09/06 41229337	250	AQUAPHOR OINT 14 OZ.	1	40.00	40.00	
07/31/06 41229337	250	AQUAPHOR OINT 14 OZ.	1	40.00	40.00	
06/02/06 41237819	250	PAPAIN-UREA OINT	1	178.00	178.00	
06/04/06 41237819	250	PAPAIN-UREA OINT	1	178.00	178.00	
06/09/06 41237819	250	PAPAIN-UREA OINT	1	178.00	178.00	
06/12/06 41237819	250	PAPAIN-UREA OINT	1	178.00	178.00	
06/15/06 41237819	250	PAPAIN-UREA OINT	1	178.00	178.00	
06/22/06 41237819	250	PAPAIN-UREA OINT	1	178.00	178.00	
06/25/06 41237819	250	PAPAIN-UREA OINT	1	178.00	178.00	
06/13/06 41238320	250	PEPCID IV	7	6.00	42.00	
06/03/06 41239609	250	RISPERDAL 0.5	18	15.75	283.50	
06/05/06 41239609	250	RISPERDAL 0.5	10	15.75	157.50	
06/27/06 41239609	250	RISPERDAL 0.5	14	15.75	220.50	
07/05/06 41239609	250	RISPERDAL 0.5	8	15.75	126.00	
07/14/06 41256975	250	PNEUMOCCAL VACCINE	1	133.00	133.00	
06/28/06 41257197	250	STERILE WATER 10ML V	1	6.00	6.00	
06/03/06 41257312	250	ARANESP 40 MCG/ML	1	889.25	889.25	
06/12/06 41257312	250	ARANESP 40 MCG/ML	1	889.25	889.25	
06/19/06 41257312	250	ARANESP 40 MCG/ML	1	889.25	889.25	
06/26/06 41257312	250	ARANESP 40 MCG/ML	1	889.25	889.25	
07/03/06 41257312	250	ARANESP 40 MCG/ML	1	889.25	889.25	
07/10/06 41257312	250	ARANESP 40 MCG/ML	1	889.25	889.25	
07/17/06 41257312	250	ARANESP 40 MCG/ML	1	889.25	889.25	
06/05/06 41285180	250	KCL INJ 20MEQ/10CC	2	6.00	12.00	
06/16/06 41285180	250	KCL INJ 20MEQ/10CC	2	6.00	12.00	
06/12/06 41287871	250	GASTROGRAFIN	1	258.00	258.00	
06/16/06 41290032	250	PROTONIX 40MG TABS	5	17.00	85.00	
06/17/06 41290032	250	PROTONIX 40MG TABS	1	17.00	17.00	
06/18/06 41290032	250	PROTONIX 40MG TABS	1	17.00	17.00	
06/24/06 41290032	250	PROTONIX 40MG TABS	1	17.00	17.00	
06/26/06 41290032	250	PROTONIX 40MG TABS	5	17.00	85.00	
06/28/06 41290032	250	PROTONIX 40MG TABS	1	17.00	17.00	
06/30/06 41290032	250	PROTONIX 40MG TABS	1	17.00	17.00	
07/01/06 41290032	250	PROTONIX 40MG TABS	1	17.00	17.00	
07/02/06 41290032	250	PROTONIX 40MG TABS	1	17.00	17.00	
07/03/06 41290032	250	PROTONIX 40MG TABS	5	17.00	85.00	
07/06/06 41290032	250	PROTONIX 40MG TABS	5	17.00	85.00	
07/09/06 41290032	250	PROTONIX 40MG TABS	1	17.00	17.00	
07/11/06 41290032	250	PROTONIX 40MG TABS	5	17.00	85.00	
07/12/06 41290032	250	PROTONIX 40MG TABS	1	17.00	17.00	

6/06/2012
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SSH AUGUSTA MCG
1459 LANEY WALKER BLVD
AUGUSTA GA 30912
Phone#

PATIENT NAME	HOSP NBR	PATIENT NUMBER	CYCLE	ROOM/ BED	ADMISSION DATE	DISCHARGE DATE	PAGE
PETERSON WILLIAM	494	10873	1	655-A	06/01/06	08/01/06	15

GUARANTOR NAME / ADDRESS
PETERSON WILLIAM
EDGEFIELD NH
TRENTON SC 29847
1770

F/C 5 PAYORS 800 PLAN 500

BILLING DATE 8/12/06

BILL TYPE: 111 PATIENT AGE: 84 DR. NAME: DABENEY SMITH KILA

CHARGE DATE/CODE	REV	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
07/13/06 41290032	250	PROTONIX 40MG TABS	1	17.00	17.00	
07/15/06 41290032	250	PROTONIX 40MG TABS	1	17.00	17.00	
07/16/06 41290032	250	PROTONIX 40MG TABS	1	17.00	17.00	
07/18/06 41290032	250	PROTONIX 40MG TABS	1	17.00	17.00	
07/19/06 41290032	250	PROTONIX 40MG TABS	1	17.00	17.00	
07/20/06 41290032	250	PROTONIX 40MG TABS	1	17.00	17.00	
07/26/06 41290032	250	PROTONIX 40MG TABS	1	17.00	17.00	
06/22/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
06/23/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
06/24/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
06/25/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
06/26/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
06/27/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
06/28/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
06/30/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
07/01/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
07/02/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
07/03/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
07/04/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
07/05/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
07/06/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
07/07/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
07/08/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
07/09/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
07/10/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
07/11/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
07/12/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
07/13/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
07/14/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
07/15/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
07/16/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
07/17/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
07/18/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
07/19/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
07/20/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
07/21/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
07/22/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
07/23/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
07/24/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
07/25/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
07/26/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	

6/06/2012
07:10:46

SSH AUGUSTA MCG
1459 LANEY WALKER BLVD
AUGUSTA GA 30912
Phone#

DTLBIL2

PATIENT NAME	HOSP NBR	PATIENT NUMBER	CYCLE	ROOM/ BED	ADMISSION DATE	DISCHARGE DATE	PAGE
PETERSON WILLIAM	494	10873	1	655-A	06/01/06	08/01/06	16

GUARANTOR NAME / ADDRESS
PETERSON WILLIAM
EDGEFIELD NH
TRENTON SC 29847
1770

F/C 5 PAYORS 800 PLAN 500

BILLING DATE 8/12/06

BILL TYPE: 111 PATIENT AGE: 84 DR. NAME: DABENEY SMITH KILA

CHARGE DATE/CODE	REV	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
07/27/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
07/28/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
07/29/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
07/30/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
07/31/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
08/01/06 41295510	250	THERA VITAMIN TAB	1	.50	.50	
06/16/06 41311150	250	DEXTROSE 10% 1000 ML	1	36.75	36.75	
06/12/06 41311192	250	DEXT 5%/.45% 1000 ML	1	23.50	23.50	
06/13/06 41311192	250	DEXT 5%/.45% 1000 ML	1	23.50	23.50	
06/17/06 41311192	250	DEXT 5%/.45% 1000 ML	1	23.50	23.50	
06/18/06 41311192	250	DEXT 5%/.45% 1000 ML	1	23.50	23.50	
06/19/06 41311192	250	DEXT 5%/.45% 1000 ML	1	23.50	23.50	
06/16/06 41311341	250	ACETIC ACID IRR 1000 ML BOTTLE	1	83.00	83.00	
06/17/06 41311341	250	ACETIC ACID IRR 1000 ML BOTTLE	1	83.00	83.00	
06/02/06 41311473	250	HEP-LOCK 100 U/ML	2	6.00	12.00	
06/08/06 41311473	250	HEP-LOCK 100 U/ML	1	6.00	6.00	
06/15/06 41311473	250	HEP-LOCK 100 U/ML	1	6.00	6.00	
06/25/06 41311473	250	HEP-LOCK 100 U/ML	2	6.00	12.00	
06/28/06 41311473	250	HEP-LOCK 100 U/ML	2	6.00	12.00	
07/11/06 41311473	250	HEP-LOCK 100 U/ML	1	6.00	6.00	
06/07/06 41311481	250	SOD CHL BAC 30 ML VIL	1	6.00	6.00	
06/10/06 41311481	250	SOD CHL BAC 30 ML VIL	1	6.00	6.00	
06/19/06 41311481	250	SOD CHL BAC 30 ML VIL	3	6.00	18.00	
06/20/06 41311481	250	SOD CHL BAC 30 ML VIL	1	6.00	6.00	
06/21/06 41311481	250	SOD CHL BAC 30 ML VIL	4	6.00	24.00	
06/22/06 41311481	250	SOD CHL BAC 30 ML VIL	3	6.00	18.00	
06/23/06 41311481	250	SOD CHL BAC 30 ML VIL	4	6.00	24.00	
06/24/06 41311481	250	SOD CHL BAC 30 ML VIL	3	6.00	18.00	
06/25/06 41311481	250	SOD CHL BAC 30 ML VIL	4	6.00	24.00	
06/26/06 41311481	250	SOD CHL BAC 30 ML VIL	3	6.00	18.00	
06/27/06 41311481	250	SOD CHL BAC 30 ML VIL	3	6.00	18.00	
07/02/06 41311481	250	SOD CHL BAC 30 ML VIL	2	6.00	12.00	
07/05/06 41311481	250	SOD CHL BAC 30 ML VIL	1	6.00	6.00	
07/06/06 41311481	250	SOD CHL BAC 30 ML VIL	2	6.00	12.00	
07/07/06 41311481	250	SOD CHL BAC 30 ML VIL	2	6.00	12.00	
07/13/06 41311481	250	SOD CHL BAC 30 ML VIL	3	6.00	18.00	
07/18/06 41311481	250	SOD CHL BAC 30 ML VIL	1	6.00	6.00	
07/20/06 41311481	250	SOD CHL BAC 30 ML VIL	1	6.00	6.00	
06/01/06 41311507	250	ATROVENT 0.02% INH SL	3	7.00	21.00	
06/02/06 41311507	250	ATROVENT 0.02% INH SL	6	7.00	42.00	
06/03/06 41311507	250	ATROVENT 0.02% INH SL	6	7.00	42.00	

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SSH AUGUSTA MCG
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AUGUSTA GA 30912
Phone#

PATIENT NAME	HOSP NBR	PATIENT NUMBER	CYCLE	ROOM/ BED	ADMISSION DATE	DISCHARGE DATE	PAGE
PETERSON WILLIAM	494	10873	1	655-A	06/01/06	08/01/06	17

GUARANTOR NAME / ADDRESS
PETERSON WILLIAM
EDGEFIELD NH
TRENTON SC 29847
1770

F/C 5 PAYORS 800 PLAN 500

BILLING DATE 8/12/06

BILL TYPE: 111 PATIENT AGE: 84 DR. NAME: DABENEY SMITH KILA

CHARGE DATE/CODE	REV	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
06/04/06 41311507	250	ATROVENT 0.02% INH SL	6	7.00	42.00	
06/05/06 41311507	250	ATROVENT 0.02% INH SL	1	7.00	7.00	
06/06/06 41311507	250	ATROVENT 0.02% INH SL	2	7.00	14.00	
06/07/06 41311507	250	ATROVENT 0.02% INH SL	2	7.00	14.00	
06/08/06 41311507	250	ATROVENT 0.02% INH SL	2	7.00	14.00	
06/09/06 41311507	250	ATROVENT 0.02% INH SL	1	7.00	7.00	
06/10/06 41311507	250	ATROVENT 0.02% INH SL	4	7.00	28.00	
06/11/06 41311507	250	ATROVENT 0.02% INH SL	2	7.00	14.00	
06/12/06 41311507	250	ATROVENT 0.02% INH SL	2	7.00	14.00	
06/13/06 41311507	250	ATROVENT 0.02% INH SL	3	7.00	21.00	
06/14/06 41311507	250	ATROVENT 0.02% INH SL	2	7.00	14.00	
06/15/06 41311507	250	ATROVENT 0.02% INH SL	1	7.00	7.00	
06/01/06 41311614	250	ALBUTEROL 0.5% 20CC	3	3.00	9.00	
06/02/06 41311614	250	ALBUTEROL 0.5% 20CC	6	3.00	18.00	
06/03/06 41311614	250	ALBUTEROL 0.5% 20CC	6	3.00	18.00	
06/04/06 41311614	250	ALBUTEROL 0.5% 20CC	6	3.00	18.00	
06/05/06 41311614	250	ALBUTEROL 0.5% 20CC	1	3.00	3.00	
06/06/06 41311614	250	ALBUTEROL 0.5% 20CC	2	3.00	6.00	
06/07/06 41311614	250	ALBUTEROL 0.5% 20CC	2	3.00	6.00	
06/08/06 41311614	250	ALBUTEROL 0.5% 20CC	2	3.00	6.00	
06/09/06 41311614	250	ALBUTEROL 0.5% 20CC	1	3.00	3.00	
06/10/06 41311614	250	ALBUTEROL 0.5% 20CC	4	3.00	12.00	
06/11/06 41311614	250	ALBUTEROL 0.5% 20CC	2	3.00	6.00	
06/12/06 41311614	250	ALBUTEROL 0.5% 20CC	2	3.00	6.00	
06/13/06 41311614	250	ALBUTEROL 0.5% 20CC	3	3.00	9.00	
06/14/06 41311614	250	ALBUTEROL 0.5% 20CC	2	3.00	6.00	
06/15/06 41311614	250	ALBUTEROL 0.5% 20CC	1	3.00	3.00	
06/15/06 41311747	250	IPRATROPIUM 0.02% 2.5ML UD	1	5.25	5.25	
06/16/06 41311747	250	IPRATROPIUM 0.02% 2.5ML UD	2	5.25	10.50	
06/17/06 41311747	250	IPRATROPIUM 0.02% 2.5ML UD	3	5.25	15.75	
06/18/06 41311747	250	IPRATROPIUM 0.02% 2.5ML UD	2	5.25	10.50	
06/19/06 41311747	250	IPRATROPIUM 0.02% 2.5ML UD	1	5.25	5.25	
06/21/06 41311754	250	NACL 0.9% MINI BAG PLUS 100ML	13	58.00	754.00	
06/22/06 41311754	250	NACL 0.9% MINI BAG PLUS 100ML	4	58.00	232.00	
06/23/06 41311754	250	NACL 0.9% MINI BAG PLUS 100ML	4	58.00	232.00	
06/26/06 41311754	250	NACL 0.9% MINI BAG PLUS 100ML	3	58.00	174.00	
06/01/06 41312000	250	SODIUM CHLORIDE 0.9% 1000ML	1	29.00	29.00	
06/14/06 41312000	250	SODIUM CHLORIDE 0.9% 1000ML	1	29.00	29.00	
07/25/06 41312000	250	SODIUM CHLORIDE 0.9% 1000ML	2	29.00	58.00	
06/01/06 41312018	250	SODIUM CHLORIDE 0.9% 250 ML	1	36.50	36.50	
06/02/06 41312018	250	SODIUM CHLORIDE 0.9% 250 ML	3	36.50	109.50	

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PATIENT NAME	HOSP NBR	PATIENT NUMBER	CYCLE	ROOM/ BED	ADMISSION DATE	DISCHARGE DATE	PAGE
PETERSON WILLIAM	494	10873	1	655-A	06/01/06	08/01/06	18

GUARANTOR NAME / ADDRESS
PETERSON WILLIAM
EDGEFIELD NH
TRENTON SC 29847
1770

F/C 5 PAYORS 800 PLAN 500

BILLING DATE 8/12/06

BILL TYPE: 111 PATIENT AGE: 84 DR. NAME: DABENEY SMITH KILA

CHARGE DATE/CODE	REV	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
06/11/06 41312018	250	SODIUM CHLORIDE 0.9% 250 ML	2	36.50	73.00	
06/12/06 41312018	250	SODIUM CHLORIDE 0.9% 250 ML	1	36.50	36.50	
06/14/06 41312018	250	SODIUM CHLORIDE 0.9% 250 ML	4	36.50	146.00	
06/15/06 41312158	250	ALBUTEROL 0.5% 2.5MG/0.5ML	1	3.00	3.00	
06/16/06 41312158	250	ALBUTEROL 0.5% 2.5MG/0.5ML	2	3.00	6.00	
06/17/06 41312158	250	ALBUTEROL 0.5% 2.5MG/0.5ML	4	3.00	12.00	
06/18/06 41312158	250	ALBUTEROL 0.5% 2.5MG/0.5ML	2	3.00	6.00	
06/19/06 41312158	250	ALBUTEROL 0.5% 2.5MG/0.5ML	1	3.00	3.00	
07/03/06 49016363	250	SILVADENE 50 APP CREA	1	33.00	33.00	
07/09/06 49016363	250	SILVADENE 50 APP CREA	1	33.00	33.00	
06/21/06 41223157	258	ZOSYN 3.375 GM INJ	13	74.50	968.50	
06/22/06 41223157	258	ZOSYN 3.375 GM INJ	4	74.50	298.00	
06/23/06 41223157	258	ZOSYN 3.375 GM INJ	4	74.50	298.00	
06/26/06 41223157	258	ZOSYN 3.375 GM INJ	3	74.50	223.50	
06/01/06 41228628	258	VANCOMYCIN 1000MB SO	2	65.00	130.00	
06/02/06 41228628	258	VANCOMYCIN 1000MB SO	6	65.00	390.00	
06/11/06 41228628	258	VANCOMYCIN 1000MB SO	4	65.00	260.00	
06/14/06 41228628	258	VANCOMYCIN 1000MB SO	4	65.00	260.00	
06/15/06 41228628	258	VANCOMYCIN 1000MB SO	1	65.00	65.00	
06/16/06 41228628	258	VANCOMYCIN 1000MB SO	1	65.00	65.00	
06/19/06 41228628	258	VANCOMYCIN 1000MB SO	2	65.00	130.00	
06/20/06 41228628	258	VANCOMYCIN 1000MB SO	1	65.00	65.00	
06/24/06 41228628	258	VANCOMYCIN 1000MB SO	2	65.00	130.00	
06/26/06 41228628	258	VANCOMYCIN 1000MB SO	1	65.00	65.00	
07/24/06 41228628	258	VANCOMYCIN 1000MB SO	2	65.00	130.00	
07/25/06 41228628	258	VANCOMYCIN 1000MB SO	2	65.00	130.00	
07/27/06 41228628	258	VANCOMYCIN 1000MB SO	2	65.00	130.00	
06/15/06 41257189	258	10MEQ KCL BAG 100ML	2	58.50	117.00	
06/06/06 41311218	258	SOD CHLOR .45% INJ 1000 ML	1	6.00	6.00	
07/29/06 41311218	258	SOD CHLOR .45% INJ 1000 ML	2	6.00	12.00	
06/02/06 41311234	258	SOD CHLOR 0.9% INJ 250 ML	1	36.50	36.50	
06/08/06 41311234	258	SOD CHLOR 0.9% INJ 250 ML	1	36.50	36.50	
06/12/06 41311234	258	SOD CHLOR 0.9% INJ 250 ML	1-	36.50	36.50-	
06/15/06 41311234	258	SOD CHLOR 0.9% INJ 250 ML	1	36.50	36.50	
06/16/06 41311234	258	SOD CHLOR 0.9% INJ 250 ML	2	36.50	73.00	
06/19/06 41311234	258	SOD CHLOR 0.9% INJ 250 ML	2	36.50	73.00	
06/20/06 41311234	258	SOD CHLOR 0.9% INJ 250 ML	1	36.50	36.50	
06/24/06 41311234	258	SOD CHLOR 0.9% INJ 250 ML	2	36.50	73.00	
06/26/06 41311234	258	SOD CHLOR 0.9% INJ 250 ML	1	36.50	36.50	
06/05/06 41311358	258	D5 1000 ML INJ	2	33.00	66.00	

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PATIENT NAME	HOSP NBR	PATIENT NUMBER	CYCLE	ROOM/ BED	ADMISSION DATE	DISCHARGE DATE	PAGE
PETERSON WILLIAM	494	10873	1	655-A	06/01/06	08/01/06	19

GUARANTOR NAME / ADDRESS
PETERSON WILLIAM
EDGEFIELD NH
TRENTON SC 29847
1770

F/C 5 PAYORS 800 PLAN 500

BILLING DATE 8/12/06

BILL TYPE: 111 PATIENT AGE: 84 DR. NAME: DABENEY SMITH KILA

CHARGE DATE/CODE	REV	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
06/13/06 41311358	258	D5 1000 ML INJ	1	33.00	33.00	
06/13/06 41800343	270	BAG BARIUM ENEMA	1	5.18	5.18	
06/02/06 41800707	270	BOOT SPACE	2	73.00	146.00	
06/01/06 41800822	270	CANNULA LEVER LOCK	1	3.11	3.11	
06/02/06 41800822	270	CANNULA LEVER LOCK	1	3.11	3.11	
06/05/06 41800822	270	CANNULA LEVER LOCK	1	3.11	3.11	
06/08/06 41800822	270	CANNULA LEVER LOCK	1	3.11	3.11	
06/20/06 41800822	270	CANNULA LEVER LOCK	1	3.11	3.11	
06/21/06 41800822	270	CANNULA LEVER LOCK	1	3.11	3.11	
06/24/06 41800822	270	CANNULA LEVER LOCK	3	3.11	9.33	
06/27/06 41800822	270	CANNULA LEVER LOCK	1	3.11	3.11	
06/03/06 41800970	270	CATHETER IV PROTECTIVE	2	5.00	10.00	
07/29/06 41800970	270	CATHETER IV PROTECTIVE	3	5.00	15.00	
07/30/06 41800970	270	CATHETER IV PROTECTIVE	1	5.00	5.00	
07/10/06 41801333	270	CUFF BLD PRES DISP R	1	27.00	27.00	
07/12/06 41801333	270	CUFF BLD PRES DISP R	1	27.00	27.00	
06/01/06 41802133	270	ENT FEED PUMP	16	.33	5.28	
06/02/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
06/03/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
06/04/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
06/05/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
06/06/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
06/07/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
06/08/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
06/09/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
06/10/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
06/11/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
06/12/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
06/13/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
06/14/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
06/15/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
06/16/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
06/17/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
06/18/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
06/19/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
06/20/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
06/21/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
06/22/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
06/23/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
06/24/06 41802133	270	ENT FEED PUMP	24	.33	7.92	

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PATIENT NAME	HOSP NBR	PATIENT NUMBER	CYCLE	ROOM/ BED	ADMISSION DATE	DISCHARGE DATE	PAGE
PETERSON WILLIAM	494	10873	1	655-A	06/01/06	08/01/06	20

GUARANTOR NAME / ADDRESS
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TRENTON SC 29847
1770

F/C 5 PAYORS 800 PLAN 500

BILLING DATE 8/12/06

BILL TYPE: 111 PATIENT AGE: 84 DR. NAME: DABENEY SMITH KILA

CHARGE DATE/CODE	REV	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
06/25/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
06/26/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
06/27/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
06/28/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
06/29/06 41802133	270	ENT FEED PUMP	36	.33	11.88	
06/30/06 41802133	270	ENT FEED PUMP	21	.33	6.93	
07/03/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
07/04/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
07/05/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
07/06/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
07/07/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
07/08/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
07/09/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
07/10/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
07/11/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
07/12/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
07/13/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
07/14/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
07/15/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
07/16/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
07/17/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
07/18/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
07/19/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
07/20/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
07/21/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
07/22/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
07/23/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
07/24/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
07/25/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
07/26/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
07/27/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
07/28/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
07/29/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
07/30/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
07/31/06 41802133	270	ENT FEED PUMP	24	.33	7.92	
08/01/06 41802133	270	ENT FEED PUMP	7	.33	2.31	
06/02/06 41802141	270	ENT QUANT SET W/BAG	1	15.00	15.00	
06/05/06 41802141	270	ENT QUANT SET W/BAG	1	15.00	15.00	
06/07/06 41802141	270	ENT QUANT SET W/BAG	1	15.00	15.00	
06/10/06 41802141	270	ENT QUANT SET W/BAG	2	15.00	30.00	
06/20/06 41802141	270	ENT QUANT SET W/BAG	1	15.00	15.00	

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PETERSON WILLIAM	494	10873	1	655-A	06/01/06	08/01/06	21

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F/C 5 PAYORS 800 PLAN 500

BILLING DATE 8/12/06

BILL TYPE: 111 PATIENT AGE: 84 DR. NAME: DABENEY SMITH KILA

CHARGE DATE/CODE	REV	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
06/22/06 41802141	270	ENT QUANT SET W/BAG	1	15.00	15.00	
06/23/06 41802141	270	ENT QUANT SET W/BAG	1	15.00	15.00	
06/24/06 41802141	270	ENT QUANT SET W/BAG	1	15.00	15.00	
06/25/06 41802141	270	ENT QUANT SET W/BAG	1	15.00	15.00	
06/27/06 41802141	270	ENT QUANT SET W/BAG	1	15.00	15.00	
07/08/06 41802141	270	ENT QUANT SET W/BAG	1	15.00	15.00	
07/09/06 41802141	270	ENT QUANT SET W/BAG	1	15.00	15.00	
07/10/06 41802141	270	ENT QUANT SET W/BAG	1	15.00	15.00	
07/12/06 41802141	270	ENT QUANT SET W/BAG	1	15.00	15.00	
07/13/06 41802141	270	ENT QUANT SET W/BAG	1	15.00	15.00	
07/15/06 41802141	270	ENT QUANT SET W/BAG	1	15.00	15.00	
07/29/06 41802141	270	ENT QUANT SET W/BAG	2	15.00	30.00	
07/31/06 41802141	270	ENT QUANT SET W/BAG	1	15.00	15.00	
06/08/06 41802307	270	FILTER, BLOOD ADM	1	7.42	7.42	
06/21/06 41802612	270	IV INJECTION CAPS	1	5.00	5.00	
06/12/06 41802646	270	IV ST ADMN SECONDARY	1	5.18	5.18	
07/09/06 41802646	270	IV ST ADMN SECONDARY	1	5.18	5.18	
06/03/06 41802653	270	IV SET EXTENSION SET	1	13.00	13.00	
07/29/06 41802653	270	IV SET EXTENSION SET	1	13.00	13.00	
07/30/06 41802653	270	IV SET EXTENSION SET	1	13.00	13.00	
07/21/06 41802661	270	IV SET PRIMARY 2 PORT	1	12.00	12.00	
07/05/06 41802877	270	KIT STAPLE REMOVER	1	11.00	11.00	
06/06/06 41802885	270	KIT SUCT CATH W/GLOV	1	3.11	3.11	
06/01/06 41803248	270	NEBULIZER HANDHELD	1	3.00	3.00	
07/01/06 41803701	270	PILLOW ABDUCTION	1	73.00	73.00	
06/23/06 41803784	270	PROTECTOR HEEL/ELBOW	1	15.00	15.00	
07/21/06 41803784	270	PROTECTOR HEEL/ELBOW	1	15.00	15.00	
06/01/06 41804014	270	ISOLATION SUPPLIES	16	6.48	103.68	
06/02/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
06/03/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
06/04/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
06/05/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
06/06/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
06/07/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
06/08/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
06/09/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
06/10/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
06/11/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
06/12/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
06/13/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
06/14/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	

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SSH AUGUSTA MCG
1459 LANEY WALKER BLVD
AUGUSTA GA 30912
Phone#

PATIENT NAME	HOSP NBR	PATIENT NUMBER	CYCLE	ROOM/ BED	ADMISSION DATE	DISCHARGE DATE	PAGE
PETERSON WILLIAM	494	10873	1	655-A	06/01/06	08/01/06	22

GUARANTOR NAME / ADDRESS
PETERSON WILLIAM
EDGEFIELD NH
TRENTON SC 29847
1770

F/C 5 PAYORS 800 PLAN 500

BILLING DATE 8/12/06

BILL TYPE: 111 PATIENT AGE: 84 DR. NAME: DABENEY SMITH KILA

CHARGE DATE/CODE	REV	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
06/15/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
06/16/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
06/17/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
06/18/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
06/19/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
06/20/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
06/21/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
06/22/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
06/23/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
06/24/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
06/25/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
06/26/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
06/27/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
06/28/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
06/29/06 41804014	270	ISOLATION SUPPLIES	36	6.48	233.28	
06/30/06 41804014	270	ISOLATION SUPPLIES	21	6.48	136.08	
07/03/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
07/04/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
07/05/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
07/06/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
07/07/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
07/08/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
07/09/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
07/10/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
07/11/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
07/12/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
07/13/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
07/14/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
07/15/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
07/16/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
07/17/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
07/18/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
07/19/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
07/20/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
07/21/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
07/22/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
07/23/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
07/24/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
07/25/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
07/26/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
07/27/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	

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SSH AUGUSTA MCG
1459 LANEY WALKER BLVD
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PATIENT NAME	HOSP NBR	PATIENT NUMBER	CYCLE	ROOM/ BED	ADMISSION DATE	DISCHARGE DATE	PAGE
PETERSON WILLIAM	494	10873	1	655-A	06/01/06	08/01/06	23

GUARANTOR NAME / ADDRESS
PETERSON WILLIAM
EDGEFIELD NH
TRENTON SC 29847
1770

F/C 5 PAYORS 800 PLAN 500

BILLING DATE 8/12/06

BILL TYPE: 111 PATIENT AGE: 84 DR. NAME: DABENEY SMITH KILA

CHARGE DATE/CODE	REV	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
07/28/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
07/29/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
07/30/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
07/31/06 41804014	270	ISOLATION SUPPLIES	24	6.48	155.52	
08/01/06 41804014	270	ISOLATION SUPPLIES	7	6.48	45.36	
06/02/06 41804519	270	STOPCOCK	1	3.11	3.11	
06/16/06 41804519	270	STOPCOCK	1	3.11	3.11	
06/22/06 41804725	270	TAPE PAPER	1	3.11	3.11	
06/06/06 41804949	270	TRAY CATH FOLEY DISP	1	40.00	40.00	
06/07/06 41804949	270	TRAY CATH FOLEY DISP	1	40.00	40.00	
07/07/06 41804949	270	TRAY CATH FOLEY DISP	1	40.00	40.00	
08/01/06 41804949	270	TRAY CATH FOLEY DISP	1	40.00	40.00	
06/06/06 41804998	270	TRAY DRESSING MINOR DISP	1	20.00	20.00	
06/23/06 41804998	270	TRAY DRESSING MINOR DISP	1	20.00	20.00	
06/05/06 41805052	270	TRAY IRRIGATION DISP	1	5.00	5.00	
06/07/06 41805052	270	TRAY IRRIGATION DISP	1	5.00	5.00	
06/20/06 41805052	270	TRAY IRRIGATION DISP	1	5.00	5.00	
06/22/06 41805052	270	TRAY IRRIGATION DISP	1	5.00	5.00	
06/23/06 41805052	270	TRAY IRRIGATION DISP	1	5.00	5.00	
06/24/06 41805052	270	TRAY IRRIGATION DISP	1	5.00	5.00	
06/25/06 41805052	270	TRAY IRRIGATION DISP	1	5.00	5.00	
06/26/06 41805052	270	TRAY IRRIGATION DISP	1	5.00	5.00	
06/27/06 41805052	270	TRAY IRRIGATION DISP	1	5.00	5.00	
07/08/06 41805052	270	TRAY IRRIGATION DISP	1	5.00	5.00	
07/09/06 41805052	270	TRAY IRRIGATION DISP	1	5.00	5.00	
07/10/06 41805052	270	TRAY IRRIGATION DISP	1	5.00	5.00	
07/15/06 41805052	270	TRAY IRRIGATION DISP	1	5.00	5.00	
07/17/06 41805052	270	TRAY IRRIGATION DISP	1	5.00	5.00	
07/29/06 41805052	270	TRAY IRRIGATION DISP	2	5.00	10.00	
06/16/06 41805334	270	TUBE SALEM SUMP	3	8.00	24.00	
06/06/06 41805359	270	CATHETER YANKAUER	1	3.11	3.11	
06/16/06 41805532	270	VALVE ANTI-REFLUX	1	21.00	21.00	
06/01/06 41805722	270	IV SET PRIMARY 3 PORT	1	18.00	18.00	
06/02/06 41805722	270	IV SET PRIMARY 3 PORT	1	18.00	18.00	
06/05/06 41805722	270	IV SET PRIMARY 3 PORT	1	18.00	18.00	
06/12/06 41805722	270	IV SET PRIMARY 3 PORT	1	18.00	18.00	
06/20/06 41805722	270	IV SET PRIMARY 3 PORT	1	18.00	18.00	
06/21/06 41805722	270	IV SET PRIMARY 3 PORT	1	18.00	18.00	
06/24/06 41805722	270	IV SET PRIMARY 3 PORT	3	18.00	54.00	
06/27/06 41805722	270	IV SET PRIMARY 3 PORT	1	18.00	18.00	
06/22/06 41860370	270	HIBICLENS	1	13.00	13.00	

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SSH AUGUSTA MCG
1459 LANEY WALKER BLVD
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PATIENT NAME	HOSP NBR	PATIENT NUMBER CYCLE	ROOM/ BED	ADMISSION DATE	DISCHARGE DATE	PAGE
PETERSON WILLIAM	494	10873 1	655-A	06/01/06	08/01/06	24

GUARANTOR NAME / ADDRESS
PETERSON WILLIAM
EDGEFIELD NH
TRENTON SC 29847
1770

F/C 5 PAYORS 800 PLAN 500

BILLING DATE 8/12/06

BILL TYPE: 111 PATIENT AGE: 84 DR. NAME: DABENEY SMITH KILA

CHARGE DATE/CODE	REV	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
06/23/06 41860370	270	HIBICLENS	1	13.00	13.00	
07/31/06 41860487	270	BOWEL MGMT SYSTEM	1	850.00	850.00	
07/05/06 41860495	270	DRESSING,ANTIMICROBIAL 8X16	1	166.00	166.00	
06/23/06 41860800	270	DRESSING, ANTIMICROBIAL SM	1	21.00	21.00	
06/03/06 41860891	270	REAGENT STRIP	4	5.18	20.72	
06/04/06 41860891	270	REAGENT STRIP	4	5.18	20.72	
06/03/06 41802679	270	KIT IV START	1	3.11	3.11	A4222
07/29/06 41802679	270	KIT IV START	1	3.11	3.11	A4222
07/30/06 41802679	270	KIT IV START	1	3.11	3.11	A4222
06/23/06 41804709	270	TAPE HYPOALLERGENIC/OTHER	1	18.00	18.00	A4450
07/05/06 41804709	270	TAPE HYPOALLERGENIC/OTHER	1	18.00	18.00	A4450
07/09/06 41804709	270	TAPE HYPOALLERGENIC/OTHER	1	18.00	18.00	A4450
07/18/06 41804709	270	TAPE HYPOALLERGENIC/OTHER	1	18.00	18.00	A4450
07/19/06 41804709	270	TAPE HYPOALLERGENIC/OTHER	1	18.00	18.00	A4450
07/24/06 41804709	270	TAPE HYPOALLERGENIC/OTHER	1	18.00	18.00	A4450
06/01/06 41802000	270	ELECTRODES SET	2	8.00	16.00	A4556
06/01/06 41803073	270	MASK OXYGEN/AEROSOL	1	3.11	3.11	A4620
06/23/06 41805219	270	TRAY SUTURE REMOVAL DISP	1	7.00	7.00	A4649
06/23/06 41860602	270	DRESSING, FOAM MD	1	33.00	33.00	A6210
06/23/06 41860743	270	DRESSING, ABSORPTIVE COVER SM	1	3.11	3.11	A6216
06/26/06 41860743	270	DRESSING, ABSORPTIVE COVER SM	1	3.11	3.11	A6216
06/19/06 41860750	270	DRESSING, ABSORPTIVE COVER MD	1	4.00	4.00	A6217
06/22/06 41860750	270	DRESSING, ABSORPTIVE COVER MD	1	4.00	4.00	A6217
06/29/06 41860750	270	DRESSING, ABSORPTIVE COVER MD	1	4.00	4.00	A6217
07/11/06 41860750	270	DRESSING, ABSORPTIVE COVER MD	1	4.00	4.00	A6217
07/12/06 41860750	270	DRESSING, ABSORPTIVE COVER MD	1	4.00	4.00	A6217
07/18/06 41860750	270	DRESSING, ABSORPTIVE COVER MD	1	4.00	4.00	A6217
07/19/06 41860750	270	DRESSING, ABSORPTIVE COVER MD	1	4.00	4.00	A6217
08/01/06 41860750	270	DRESSING, ABSORPTIVE COVER MD	1	4.00	4.00	A6217
06/22/06 41860768	270	DRESSING, ABSORPTIVE LG	1	4.44	4.44	A6218
06/23/06 41860768	270	DRESSING, ABSORPTIVE LG	1	4.44	4.44	A6218
07/06/06 41860768	270	DRESSING, ABSORPTIVE LG	1	4.44	4.44	A6218
07/24/06 41860669	270	DRESSING, HYDROGELS LG	1	10.00	10.00	A6244
07/25/06 41860669	270	DRESSING, HYDROGELS LG	1	10.00	10.00	A6244
07/26/06 41860669	270	DRESSING, HYDROGELS LG	1	10.00	10.00	A6244
07/25/06 41801630	270	DRESSING,DRAIN	3	3.11	9.33	A6402
07/31/06 41801630	270	DRESSING,DRAIN	1	3.11	3.11	A6402
06/02/06 41860909	270	BANDAGE KERLIX	2	3.11	6.22	A6443
06/05/06 41860909	270	BANDAGE KERLIX	2	3.11	6.22	A6443
06/08/06 41860909	270	BANDAGE KERLIX	1	3.11	3.11	A6443
06/09/06 41860909	270	BANDAGE KERLIX	2	3.11	6.22	A6443

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1459 LANEY WALKER BLVD
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PATIENT NAME	HOSP NBR	PATIENT NUMBER	CYCLE	ROOM/ BED	ADMISSION DATE	DISCHARGE DATE	PAGE
PETERSON WILLIAM	494	10873	1	655-A	06/01/06	08/01/06	25

GUARANTOR NAME / ADDRESS
PETERSON WILLIAM
EDGEFIELD NH
TRENTON SC 29847
1770

F/C 5 PAYORS 800 PLAN 500

BILLING DATE 8/12/06

BILL TYPE: 111 PATIENT AGE: 84 DR. NAME: DABENEY SMITH KILA

CHARGE DATE/CODE	REV	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
06/10/06 41860909	270	BANDAGE KERLIX	3	3.11	9.33	A6443
06/13/06 41860909	270	BANDAGE KERLIX	3	3.11	9.33	A6443
06/14/06 41860909	270	BANDAGE KERLIX	2	3.11	6.22	A6443
06/15/06 41860909	270	BANDAGE KERLIX	1	3.11	3.11	A6443
06/16/06 41860909	270	BANDAGE KERLIX	2	3.11	6.22	A6443
06/19/06 41860909	270	BANDAGE KERLIX	1	3.11	3.11	A6443
06/22/06 41860909	270	BANDAGE KERLIX	4	3.11	12.44	A6443
06/23/06 41860909	270	BANDAGE KERLIX	3	3.11	9.33	A6443
06/24/06 41860909	270	BANDAGE KERLIX	2	3.11	6.22	A6443
06/25/06 41860909	270	BANDAGE KERLIX	2	3.11	6.22	A6443
06/26/06 41860909	270	BANDAGE KERLIX	1	3.11	3.11	A6443
06/29/06 41860909	270	BANDAGE KERLIX	2	3.11	6.22	A6443
07/05/06 41860909	270	BANDAGE KERLIX	5	3.11	15.55	A6443
07/06/06 41860909	270	BANDAGE KERLIX	1	3.11	3.11	A6443
07/07/06 41860909	270	BANDAGE KERLIX	2	3.11	6.22	A6443
07/08/06 41860909	270	BANDAGE KERLIX	2	3.11	6.22	A6443
07/09/06 41860909	270	BANDAGE KERLIX	3	3.11	9.33	A6443
07/11/06 41860909	270	BANDAGE KERLIX	2	3.11	6.22	A6443
07/12/06 41860909	270	BANDAGE KERLIX	1	3.11	3.11	A6443
07/13/06 41860909	270	BANDAGE KERLIX	1	3.11	3.11	A6443
07/15/06 41860909	270	BANDAGE KERLIX	2	3.11	6.22	A6443
07/18/06 41860909	270	BANDAGE KERLIX	1	3.11	3.11	A6443
07/19/06 41860909	270	BANDAGE KERLIX	1	3.11	3.11	A6443
07/21/06 41860909	270	BANDAGE KERLIX	1	3.11	3.11	A6443
07/24/06 41860909	270	BANDAGE KERLIX	2	3.11	6.22	A6443
07/25/06 41860909	270	BANDAGE KERLIX	1	3.11	3.11	A6443
07/26/06 41860909	270	BANDAGE KERLIX	1	3.11	3.11	A6443
07/28/06 41860909	270	BANDAGE KERLIX	1	3.11	3.11	A6443
08/01/06 41860909	270	BANDAGE KERLIX	1	3.11	3.11	A6443
06/06/06 41805276	270	GASTROSTOMY/JEJUNOSTOMY TUBE	2	4.00	8.00	B4087
06/01/06 41803891	270	BED OVERLAY	16	10.36	165.76	E0372
06/02/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
06/03/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
06/04/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
06/05/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
06/06/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
06/07/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
06/08/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
06/09/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
06/10/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
06/11/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372

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SSH AUGUSTA MCG
1459 LANEY WALKER BLVD
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PATIENT NAME	HOSP NBR	PATIENT NUMBER	CYCLE	ROOM/ BED	ADMISSION DATE	DISCHARGE DATE	PAGE
PETERSON WILLIAM	494	10873	1	655-A	06/01/06	08/01/06	26

GUARANTOR NAME / ADDRESS
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TRENTON SC 29847
1770

F/C 5 PAYORS 800 PLAN 500

BILLING DATE 8/12/06

BILL TYPE: 111 PATIENT AGE: 84 DR. NAME: DABENEY SMITH KILA

CHARGE DATE/CODE	REV	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
06/12/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
06/13/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
06/14/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
06/15/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
06/16/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
06/17/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
06/18/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
06/19/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
06/20/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
06/21/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
06/22/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
06/23/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
06/24/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
06/25/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
06/26/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
06/27/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
06/28/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
06/29/06 41803891	270	BED OVERLAY	36	10.36	372.96	E0372
06/30/06 41803891	270	BED OVERLAY	21	10.36	217.56	E0372
07/03/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
07/04/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
07/05/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
07/06/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
07/07/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
07/08/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
07/09/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
07/10/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
07/11/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
07/12/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
07/13/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
07/14/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
07/15/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
07/16/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
07/17/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
07/18/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
07/19/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
07/20/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
07/21/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
07/22/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
07/23/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
07/24/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372

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SSH AUGUSTA MCG
1459 LANEY WALKER BLVD
AUGUSTA GA 30912
Phone#

PATIENT NAME	HOSP NBR	PATIENT NUMBER	CYCLE	ROOM/ BED	ADMISSION DATE	DISCHARGE DATE	PAGE
PETERSON WILLIAM	494	10873	1	655-A	06/01/06	08/01/06	27

GUARANTOR NAME / ADDRESS
PETERSON WILLIAM
EDGEFIELD NH
TRENTON SC 29847
1770

F/C 5 PAYORS 800 PLAN 500

BILLING DATE 8/12/06

BILL TYPE: 111 PATIENT AGE: 84 DR. NAME: DABENEY SMITH KILA

CHARGE DATE/CODE	REV	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
07/25/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
07/26/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
07/27/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
07/28/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
07/29/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
07/30/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
07/31/06 41803891	270	BED OVERLAY	24	10.36	248.64	E0372
08/01/06 41803891	270	BED OVERLAY	7	10.36	72.52	E0372
06/02/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
06/03/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
06/04/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
06/05/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
06/06/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
06/07/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
06/08/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
06/09/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
06/10/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
06/11/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
06/12/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
06/13/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
06/14/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
06/15/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
06/16/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
06/17/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
06/18/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
06/19/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
06/20/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
06/21/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
06/22/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
06/23/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
06/24/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
06/25/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
06/26/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
06/27/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
06/28/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
06/29/06 41800145	270	COMPRES STOCK	36	1.00	36.00	E0652
06/30/06 41800145	270	COMPRES STOCK	21	1.00	21.00	E0652
07/03/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
07/04/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
07/05/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
07/06/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652

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SSH AUGUSTA MCG
1459 LANEY WALKER BLVD
AUGUSTA GA 30912
Phone#

PATIENT NAME	HOSP NBR	PATIENT NUMBER	CYCLE	ROOM/ BED	ADMISSION DATE	DISCHARGE DATE	PAGE
PETERSON WILLIAM	494	10873	1	655-A	06/01/06	08/01/06	28

GUARANTOR NAME / ADDRESS
PETERSON WILLIAM
EDGEFIELD NH
TRENTON SC 29847
1770

F/C 5 PAYORS 800 PLAN 500

BILLING DATE 8/12/06

BILL TYPE: 111 PATIENT AGE: 84 DR. NAME: DABENEY SMITH KILA

CHARGE DATE/CODE	REV	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
07/07/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
07/08/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
07/09/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
07/10/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
07/11/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
07/12/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
07/13/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
07/14/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
07/15/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
07/16/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
07/17/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
07/18/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
07/19/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
07/20/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
07/21/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
07/22/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
07/23/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
07/24/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
07/25/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
07/26/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
07/27/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
07/28/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
07/29/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
07/30/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
07/31/06 41800145	270	COMPRES STOCK	24	1.00	24.00	E0652
07/31/06 41805797	270	SLEEVE, SCD THIGH	1	211.00	211.00	E0673
06/01/06 43604248	300	VENIPUNCTURE	1	10.50	10.50	36415
06/02/06 43604248	300	VENIPUNCTURE	1	10.50	10.50	36415
06/03/06 43604248	300	VENIPUNCTURE	1	10.50	10.50	36415
06/04/06 43604248	300	VENIPUNCTURE	1	10.50	10.50	36415
06/05/06 43604248	300	VENIPUNCTURE	1	10.50	10.50	36415
06/06/06 43604248	300	VENIPUNCTURE	1	10.50	10.50	36415
06/07/06 43604248	300	VENIPUNCTURE	1	10.50	10.50	36415
06/10/06 43604248	300	VENIPUNCTURE	1	10.50	10.50	36415
06/11/06 43604248	300	VENIPUNCTURE	1	10.50	10.50	36415
06/12/06 43604248	300	VENIPUNCTURE	1	10.50	10.50	36415
06/13/06 43604248	300	VENIPUNCTURE	3	10.50	31.50	36415
06/15/06 43604248	300	VENIPUNCTURE	1	10.50	10.50	36415
06/21/06 43604248	300	VENIPUNCTURE	1	10.50	10.50	36415
06/23/06 43604248	300	VENIPUNCTURE	1	10.50	10.50	36415

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SSH AUGUSTA MCG
1459 LANEY WALKER BLVD
AUGUSTA GA 30912
Phone#

PATIENT NAME	HOSP NBR	PATIENT NUMBER	CYCLE	ROOM/ BED	ADMISSION DATE	DISCHARGE DATE	PAGE
PETERSON WILLIAM	494	10873	1	655-A	06/01/06	08/01/06	29

GUARANTOR NAME / ADDRESS
PETERSON WILLIAM
EDGEFIELD NH
TRENTON SC 29847
1770

F/C 5 PAYORS 800 PLAN 500

BILLING DATE 8/12/06

BILL TYPE: 111 PATIENT AGE: 84 DR. NAME: DABENEY SMITH KILA

CHARGE DATE/CODE	REV	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
06/25/06 43604248	300	VENIPUNCTURE	1	10.50	10.50	36415
06/27/06 43604248	300	VENIPUNCTURE	1	10.50	10.50	36415
07/06/06 43604248	300	VENIPUNCTURE	1	10.50	10.50	36415
07/07/06 43604248	300	VENIPUNCTURE	1	10.50	10.50	36415
07/08/06 43604248	300	VENIPUNCTURE	1	10.50	10.50	36415
07/16/06 43604248	300	VENIPUNCTURE	1	10.50	10.50	36415
07/19/06 43604248	300	VENIPUNCTURE	1	10.50	10.50	36415
07/23/06 43604248	300	VENIPUNCTURE	1	10.50	10.50	36415
07/24/06 43604248	300	VENIPUNCTURE	1	10.50	10.50	36415
07/25/06 43604248	300	VENIPUNCTURE	1	10.50	10.50	36415
07/27/06 43604248	300	VENIPUNCTURE	1	10.50	10.50	36415
07/28/06 43604248	300	VENIPUNCTURE	1	10.50	10.50	36415
07/29/06 43604248	300	VENIPUNCTURE	1	10.50	10.50	36415
07/31/06 43604248	300	VENIPUNCTURE	1	10.50	10.50	36415
06/03/06 43602754	300	BASIC METABOLIC PANEL	1	36.00	36.00	80048
06/06/06 43602754	300	BASIC METABOLIC PANEL	1	36.00	36.00	80048
06/07/06 43602754	300	BASIC METABOLIC PANEL	1	36.00	36.00	80048
06/08/06 43602754	300	BASIC METABOLIC PANEL	1	36.00	36.00	80048
06/09/06 43602754	300	BASIC METABOLIC PANEL	1	36.00	36.00	80048
06/13/06 43602754	300	BASIC METABOLIC PANEL	1	36.00	36.00	80048
06/16/06 43602754	300	BASIC METABOLIC PANEL	1	36.00	36.00	80048
06/17/06 43602754	300	BASIC METABOLIC PANEL	1	36.00	36.00	80048
06/22/06 43602754	300	BASIC METABOLIC PANEL	1	36.00	36.00	80048
06/23/06 43602754	300	BASIC METABOLIC PANEL	1	36.00	36.00	80048
06/26/06 43602754	300	BASIC METABOLIC PANEL	1	36.00	36.00	80048
06/28/06 43602754	300	BASIC METABOLIC PANEL	1	36.00	36.00	80048
07/01/06 43602754	300	BASIC METABOLIC PANEL	1	36.00	36.00	80048
07/08/06 43602754	300	BASIC METABOLIC PANEL	1	36.00	36.00	80048
07/09/06 43602754	300	BASIC METABOLIC PANEL	1	36.00	36.00	80048
07/10/06 43602754	300	BASIC METABOLIC PANEL	1	36.00	36.00	80048
07/20/06 43602754	300	BASIC METABOLIC PANEL	1	36.00	36.00	80048
07/21/06 43602754	300	BASIC METABOLIC PANEL	1	36.00	36.00	80048
07/23/06 43602754	300	BASIC METABOLIC PANEL	1	36.00	36.00	80048
07/24/06 43602754	300	BASIC METABOLIC PANEL	1	36.00	36.00	80048
07/25/06 43602754	300	BASIC METABOLIC PANEL	1	36.00	36.00	80048
07/26/06 43602754	300	BASIC METABOLIC PANEL	1	36.00	36.00	80048
07/28/06 43602754	300	BASIC METABOLIC PANEL	1	36.00	36.00	80048
07/30/06 43602754	300	BASIC METABOLIC PANEL	1	36.00	36.00	80048
08/01/06 43602754	300	BASIC METABOLIC PANEL	1	36.00	36.00	80048
06/02/06 43600824	300	COMP METABOLIC PANEL	1	42.95	42.95	80053
06/14/06 43600824	300	COMP METABOLIC PANEL	1	42.95	42.95	80053

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SSH AUGUSTA MCG
1459 LANEY WALKER BLVD
AUGUSTA GA 30912
Phone#

PATIENT NAME	HOSP NBR	PATIENT NUMBER	CYCLE	ROOM/ BED	ADMISSION DATE	DISCHARGE DATE	PAGE
PETERSON WILLIAM	494	10873	1	655-A	06/01/06	08/01/06	30

GUARANTOR NAME / ADDRESS
PETERSON WILLIAM
EDGEFIELD NH
TRENTON SC 29847
1770

F/C 5 PAYORS 800 PLAN 500

BILLING DATE 8/12/06

BILL TYPE: 111 PATIENT AGE: 84 DR. NAME: DABENEY SMITH KILA

CHARGE DATE/CODE	REV	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
06/28/06 43602705	300	HEPATIC FUNCTION PANEL	1	28.70	28.70	80076
06/05/06 43604214	300	VANCOMYCIN PEAK	1	91.95	91.95	80202
06/05/06 43604222	300	VANCOMYCIN TROUGH	1	91.95	91.95	80202
06/06/06 43604222	300	VANCOMYCIN TROUGH	1	91.95	91.95	80202
06/07/06 43604222	300	VANCOMYCIN TROUGH	1	91.95	91.95	80202
06/13/06 43604222	300	VANCOMYCIN TROUGH	1	91.95	91.95	80202
06/23/06 43604222	300	VANCOMYCIN TROUGH	1	91.95	91.95	80202
06/02/06 43604081	300	URINALYSIS AUTO W/MICRO	1	20.00	20.00	81001
06/26/06 43604081	300	URINALYSIS AUTO W/MICRO	1	20.00	20.00	81001
07/07/06 43604081	300	URINALYSIS AUTO W/MICRO	2	20.00	40.00	81001
07/22/06 43604081	300	URINALYSIS AUTO W/MICRO	1	20.00	20.00	81001
07/29/06 43604081	300	URINALYSIS AUTO W/MICRO	1	20.00	20.00	81001
06/02/06 43600857	300	CALCIUM IONIZED	1	134.65	134.65	82330
06/12/06 43601327	300	CREATININE SERUM	1	24.74	24.74	82565
06/03/06 43604255	300	VITAMIN B-12	1	3.00	3.00	82607
06/03/06 43601970	300	FERRITIN	1	49.84	49.84	82728
06/03/06 43602028	300	FOLATE SERUM	1	44.40	44.40	82746
06/03/06 43602531	300	IRON	1	21.00	21.00	83540
06/02/06 43602747	300	MAGNESIUM	1	39.00	39.00	83735
06/07/06 43602747	300	MAGNESIUM	1	39.00	39.00	83735
06/13/06 43602747	300	MAGNESIUM	1	39.00	39.00	83735
06/14/06 43602747	300	MAGNESIUM	1	39.00	39.00	83735
06/16/06 43602747	300	MAGNESIUM	1	39.00	39.00	83735
06/17/06 43602747	300	MAGNESIUM	1	39.00	39.00	83735
06/26/06 43602747	300	MAGNESIUM	1	39.00	39.00	83735
06/28/06 43602747	300	MAGNESIUM	1	39.00	39.00	83735
07/01/06 43602747	300	MAGNESIUM	1	39.00	39.00	83735
06/02/06 43603000	300	PHOSPHOROUS SERUM	1	33.76	33.76	84100
06/13/06 43603000	300	PHOSPHOROUS SERUM	1	33.76	33.76	84100
06/14/06 43603000	300	PHOSPHOROUS SERUM	1	33.76	33.76	84100
06/16/06 43603000	300	PHOSPHOROUS SERUM	1	33.76	33.76	84100
06/17/06 43603000	300	PHOSPHOROUS SERUM	1	33.76	33.76	84100
06/26/06 43603000	300	PHOSPHOROUS SERUM	1	33.76	33.76	84100
06/28/06 43603000	300	PHOSPHOROUS SERUM	1	33.76	33.76	84100
07/01/06 43603000	300	PHOSPHOROUS SERUM	1	33.76	33.76	84100
06/05/06 43603075	300	PRE-ALBUMIN	1	95.00	95.00	84134
06/12/06 43603075	300	PRE-ALBUMIN	1	95.00	95.00	84134
06/19/06 43603075	300	PRE-ALBUMIN	1	95.00	95.00	84134
06/26/06 43603075	300	PRE-ALBUMIN	1	95.00	95.00	84134
06/28/06 43603075	300	PRE-ALBUMIN	1	95.00	95.00	84134
07/03/06 43603075	300	PRE-ALBUMIN	1	95.00	95.00	84134

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SSH AUGUSTA MCG
1459 LANEY WALKER BLVD
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PATIENT NAME	HOSP NBR	PATIENT NUMBER	CYCLE	ROOM/ BED	ADMISSION DATE	DISCHARGE DATE	PAGE
PETERSON WILLIAM	494	10873	1	655-A	06/01/06	08/01/06	31

GUARANTOR NAME / ADDRESS
PETERSON WILLIAM
EDGEFIELD NH
TRENTON SC 29847
1770

F/C 5 PAYORS 800 PLAN 500

BILLING DATE 8/12/06

BILL TYPE: 111 PATIENT AGE: 84 DR. NAME: DABENEY SMITH KILA

CHARGE DATE/CODE	REV	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
07/10/06 43603075	300	PRE-ALBUMIN	1	95.00	95.00	84134
07/17/06 43603075	300	PRE-ALBUMIN	1	95.00	95.00	84134
07/24/06 43603075	300	PRE-ALBUMIN	1	95.00	95.00	84134
06/07/06 43603596	300	SODIUM URINE	1	38.13	38.13	84300
06/12/06 43654706	300	UREA URINE 24 HR	1	13.93	13.93	84540
06/07/06 43657196	300	BLOOD COUNT MAN DIFF WBC	1	16.66	16.66	85007
06/08/06 43657196	300	BLOOD COUNT MAN DIFF WBC	1	16.66	16.66	85007
07/23/06 43657196	300	BLOOD COUNT MAN DIFF WBC	1	16.66	16.66	85007
06/07/06 43660273	300	BLOOD SMEAR REVIEW	1	18.00	18.00	85008
06/22/06 43660307	300	BLOOD COUNT W/O MAN DIFF WBC	1	4.00	4.00	85008
06/06/06 43600949	300	CBC W/AUTO PLT W/AUTO DIFF	1	22.00	22.00	85025
06/13/06 43600949	300	CBC W/AUTO PLT W/AUTO DIFF	1	22.00	22.00	85025
06/14/06 43600949	300	CBC W/AUTO PLT W/AUTO DIFF	1	22.00	22.00	85025
06/17/06 43600949	300	CBC W/AUTO PLT W/AUTO DIFF	1	22.00	22.00	85025
06/22/06 43600949	300	CBC W/AUTO PLT W/AUTO DIFF	1	22.00	22.00	85025
06/26/06 43600949	300	CBC W/AUTO PLT W/AUTO DIFF	1	22.00	22.00	85025
06/28/06 43600949	300	CBC W/AUTO PLT W/AUTO DIFF	1	22.00	22.00	85025
07/01/06 43600949	300	CBC W/AUTO PLT W/AUTO DIFF	1	22.00	22.00	85025
07/07/06 43600949	300	CBC W/AUTO PLT W/AUTO DIFF	1	22.00	22.00	85025
06/02/06 43602267	300	CBC,AUTOMATED W/PLT (HEMOGRAM)	1	31.32	31.32	85027
06/03/06 43602267	300	CBC,AUTOMATED W/PLT (HEMOGRAM)	2	31.32	62.64	85027
06/07/06 43602267	300	CBC,AUTOMATED W/PLT (HEMOGRAM)	1	31.32	31.32	85027
06/08/06 43602267	300	CBC,AUTOMATED W/PLT (HEMOGRAM)	1	31.32	31.32	85027
06/09/06 43602267	300	CBC,AUTOMATED W/PLT (HEMOGRAM)	1	31.32	31.32	85027
06/12/06 43602267	300	CBC,AUTOMATED W/PLT (HEMOGRAM)	1	31.32	31.32	85027
06/16/06 43602267	300	CBC,AUTOMATED W/PLT (HEMOGRAM)	1	31.32	31.32	85027
06/23/06 43602267	300	CBC,AUTOMATED W/PLT (HEMOGRAM)	1	31.32	31.32	85027
07/08/06 43602267	300	CBC,AUTOMATED W/PLT (HEMOGRAM)	1	31.32	31.32	85027
07/23/06 43602267	300	CBC,AUTOMATED W/PLT (HEMOGRAM)	1	31.32	31.32	85027
07/24/06 43602267	300	CBC,AUTOMATED W/PLT (HEMOGRAM)	1	31.32	31.32	85027
07/25/06 43602267	300	CBC,AUTOMATED W/PLT (HEMOGRAM)	1	31.32	31.32	85027
07/26/06 43602267	300	CBC,AUTOMATED W/PLT (HEMOGRAM)	1	31.32	31.32	85027
07/28/06 43602267	300	CBC,AUTOMATED W/PLT (HEMOGRAM)	1	31.32	31.32	85027
07/29/06 43602267	300	CBC,AUTOMATED W/PLT (HEMOGRAM)	1	31.32	31.32	85027
08/01/06 43602267	300	CBC,AUTOMATED W/PLT (HEMOGRAM)	1	31.32	31.32	85027
06/03/06 43603364	300	RETICULOCYTE COUNT MANUAL	1	20.79	20.79	85044
06/28/06 43655117	300	ACTIVATED CLOTTING TIME	2	164.63	329.26	85347
06/16/06 43603216	300	PROTHROMBIN TIME	1	10.68	10.68	85610
06/19/06 43603216	300	PROTHROMBIN TIME	1	10.68	10.68	85610
06/28/06 43603216	300	PROTHROMBIN TIME	1	10.68	10.68	85610
06/16/06 43603232	300	PTT	1	28.00	28.00	85730

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PATIENT NAME	HOSP NBR	PATIENT NUMBER	CYCLE	ROOM/ BED	ADMISSION DATE	DISCHARGE DATE	PAGE
PETERSON WILLIAM	494	10873	1	655-A	06/01/06	08/01/06	32

GUARANTOR NAME / ADDRESS
PETERSON WILLIAM
EDGEFIELD NH
TRENTON SC 29847
1770

F/C 5 PAYORS 800 PLAN 500

BILLING DATE 8/12/06

BILL TYPE: 111 PATIENT AGE: 84 DR. NAME: DABENEY SMITH KILA

CHARGE DATE/CODE	REV	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
06/19/06 43603232	300	PTT	1	28.00	28.00	85730
06/28/06 43603232	300	PTT	1	28.00	28.00	85730
06/08/06 45800034	300	ANTIBODY SCREEN RBC EA	1	109.00	109.00	86850
06/08/06 45800232	300	BLOOD TYPING ABO	1	133.00	133.00	86900
06/08/06 45850252	300	BLOOD TYPING RH	1	74.50	74.50	86901
06/08/06 45800075	300	CROSSMATCH IMMED SPIN	2	176.00	352.00	86920
06/02/06 43601525	300	CULTURE BLOOD	2	24.90	49.80	87040
06/26/06 43601525	300	CULTURE BLOOD	2	24.90	49.80	87040
06/26/06 43654987	300	CULT, BACT AEROB ISOLATE	2	50.40	100.80	87077
07/07/06 43654987	300	CULT, BACT AEROB ISOLATE	1	50.40	50.40	87077
07/22/06 43654987	300	CULT, BACT AEROB ISOLATE	1	50.40	50.40	87077
06/02/06 43601657	300	CULTURE URINE	1	31.16	31.16	87086
06/26/06 43601657	300	CULTURE URINE	1	31.16	31.16	87086
07/07/06 43601657	300	CULTURE URINE	1	31.16	31.16	87086
07/22/06 43601657	300	CULTURE URINE	1	31.16	31.16	87086
07/29/06 43601657	300	CULTURE URINE	1	31.16	31.16	87086
07/29/06 43603497	300	SENSITIVITY (MIC)	1	41.79	41.79	87186
06/26/06 43603505	300	SENSITIVITY MICROTITER	2	41.79	83.58	87186
07/07/06 43603505	300	SENSITIVITY MICROTITER	1	41.79	41.79	87186
07/22/06 43603505	300	SENSITIVITY MICROTITER	1	41.79	41.79	87186
07/29/06 43603505	300	SENSITIVITY MICROTITER	1	41.79	41.79	87186
07/21/06 43600634	300	C DIFF A TOXIN SCRN	1	70.00	70.00	87324
06/20/06 42851295	320	RADIOLOGY MISC	1	1,638.87	1638.87	
06/05/06 42860296	320	PICC LINE INSRTN/NON-SSH PROC	1	1,295.00	1295.00	36569
06/20/06 42860296	320	PICC LINE INSRTN/NON-SSH PROC	1	1,295.00	1295.00	36569
06/30/06 42860296	320	PICC LINE INSRTN/NON-SSH PROC	1	1,295.00	1295.00	36569
06/05/06 42851287	320	CHEST 1 VIEW PORTABLE	1	187.35	187.35	71010
06/15/06 42851287	320	CHEST 1 VIEW PORTABLE	1	187.35	187.35	71010
06/20/06 42851287	320	CHEST 1 VIEW PORTABLE	1	187.35	187.35	71010
06/30/06 42851287	320	CHEST 1 VIEW PORTABLE	1	187.35	187.35	71010
07/24/06 42851287	320	CHEST 1 VIEW PORTABLE	1	187.35	187.35	71010
06/12/06 42800052	320	ABDOMEN 1 VIEW PORTABLE	2	90.00	180.00	74000
06/15/06 42800052	320	ABDOMEN 1 VIEW PORTABLE	1	90.00	90.00	74000
06/29/06 42200048	360	SURG MAJOR 1/2 HR	17	900.00	15300.00	
06/08/06 45850393	381	BLOOD, PACKED RED	2	146.67	293.34	P9021
06/08/06 45800174	391	PACKED CELL PROCESSI	2	175.00	350.00	
06/08/06 45800067	391	BLOOD ADMINISTRATION	2	175.00	350.00	36430

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GUARANTOR NAME / ADDRESS
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EDGEFIELD NH
TRENTON SC 29847
1770

F/C 5 PAYORS 800 PLAN 500

BILLING DATE 8/12/06

BILL TYPE: 111 PATIENT AGE: 84 DR. NAME: DABENEY SMITH KILA

CHARGE DATE/CODE	REV	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
06/07/06 42750273	402	US RETROPER COMPLETE	1	378.38	378.38	76770
06/11/06 45400033	410	AEROSOL PER HR	1	11.40	11.40	
06/14/06 45400033	410	AEROSOL PER HR	1	11.40	11.40	
06/02/06 45400314	410	MDI TREATMENT EACH	2	30.00	60.00	
06/18/06 45400470	410	PULSE OX HOURLY	1	5.18	5.18	
06/01/06 45400488	410	R.C. ASSESSMENT	1	70.00	70.00	
06/06/06 45450848	410	SUCTION 15 MIN BY RESP THERPST	1	47.00	47.00	
06/01/06 45400025	410	AEROSOL NEB TX EACH	1	47.00	47.00	94664
06/02/06 45400025	410	AEROSOL NEB TX EACH	4	47.00	188.00	94664
06/03/06 45400025	410	AEROSOL NEB TX EACH	6	47.00	282.00	94664
06/04/06 45400025	410	AEROSOL NEB TX EACH	3	47.00	141.00	94664
06/05/06 45400025	410	AEROSOL NEB TX EACH	4	47.00	188.00	94664
06/06/06 45400025	410	AEROSOL NEB TX EACH	2	47.00	94.00	94664
06/07/06 45400025	410	AEROSOL NEB TX EACH	2	47.00	94.00	94664
06/08/06 45400025	410	AEROSOL NEB TX EACH	2	47.00	94.00	94664
06/09/06 45400025	410	AEROSOL NEB TX EACH	2	47.00	94.00	94664
06/10/06 45400025	410	AEROSOL NEB TX EACH	2	47.00	94.00	94664
06/11/06 45400025	410	AEROSOL NEB TX EACH	1	47.00	47.00	94664
06/12/06 45400025	410	AEROSOL NEB TX EACH	2	47.00	94.00	94664
06/13/06 45400025	410	AEROSOL NEB TX EACH	2	47.00	94.00	94664
06/14/06 45400025	410	AEROSOL NEB TX EACH	1	47.00	47.00	94664
06/15/06 45400025	410	AEROSOL NEB TX EACH	2	47.00	94.00	94664
06/16/06 45400025	410	AEROSOL NEB TX EACH	2	47.00	94.00	94664
06/17/06 45400025	410	AEROSOL NEB TX EACH	2	47.00	94.00	94664
06/18/06 45400025	410	AEROSOL NEB TX EACH	2	47.00	94.00	94664
06/19/06 45400025	410	AEROSOL NEB TX EACH	1	47.00	47.00	94664
06/21/06 45400025	410	AEROSOL NEB TX EACH	3	47.00	141.00	94664
06/01/06 45400462	410	PULSE OX SPOT CHECK EACH	2	30.00	60.00	94760
06/02/06 45400462	410	PULSE OX SPOT CHECK EACH	2	30.00	60.00	94760
06/03/06 45400462	410	PULSE OX SPOT CHECK EACH	2	30.00	60.00	94760
06/04/06 45400462	410	PULSE OX SPOT CHECK EACH	2	30.00	60.00	94760
06/05/06 45400462	410	PULSE OX SPOT CHECK EACH	2	30.00	60.00	94760
06/06/06 45400462	410	PULSE OX SPOT CHECK EACH	2	30.00	60.00	94760
06/07/06 45400462	410	PULSE OX SPOT CHECK EACH	2	30.00	60.00	94760
06/08/06 45400462	410	PULSE OX SPOT CHECK EACH	2	30.00	60.00	94760
06/09/06 45400462	410	PULSE OX SPOT CHECK EACH	2	30.00	60.00	94760
06/10/06 45400462	410	PULSE OX SPOT CHECK EACH	2	30.00	60.00	94760
06/11/06 45400462	410	PULSE OX SPOT CHECK EACH	2	30.00	60.00	94760
06/12/06 45400462	410	PULSE OX SPOT CHECK EACH	2	30.00	60.00	94760
06/13/06 45400462	410	PULSE OX SPOT CHECK EACH	2	30.00	60.00	94760

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PATIENT NAME	HOSP NBR	PATIENT NUMBER	CYCLE	ROOM/ BED	ADMISSION DATE	DISCHARGE DATE	PAGE
PETERSON WILLIAM	494	10873	1	655-A	06/01/06	08/01/06	34

GUARANTOR NAME / ADDRESS
PETERSON WILLIAM
EDGEFIELD NH
TRENTON SC 29847
1770

F/C 5 PAYORS 800 PLAN 500

BILLING DATE 8/12/06

BILL TYPE: 111 PATIENT AGE: 84 DR. NAME: DABENEY SMITH KILA

CHARGE DATE/CODE	REV	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
06/14/06 45400462	410	PULSE OX SPOT CHECK EACH	2	30.00	60.00	94760
06/16/06 45400462	410	PULSE OX SPOT CHECK EACH	2	30.00	60.00	94760
06/17/06 45400462	410	PULSE OX SPOT CHECK EACH	2	30.00	60.00	94760
06/18/06 45400462	410	PULSE OX SPOT CHECK EACH	1	30.00	30.00	94760
06/19/06 45400462	410	PULSE OX SPOT CHECK EACH	2	30.00	60.00	94760
06/20/06 45400462	410	PULSE OX SPOT CHECK EACH	2	30.00	60.00	94760
06/21/06 45400462	410	PULSE OX SPOT CHECK EACH	3	30.00	90.00	94760
06/22/06 45400462	410	PULSE OX SPOT CHECK EACH	2	30.00	60.00	94760
06/23/06 45400462	410	PULSE OX SPOT CHECK EACH	2	30.00	60.00	94760
06/24/06 45400462	410	PULSE OX SPOT CHECK EACH	2	30.00	60.00	94760
06/25/06 45400462	410	PULSE OX SPOT CHECK EACH	2	30.00	60.00	94760
06/26/06 45400462	410	PULSE OX SPOT CHECK EACH	1	30.00	30.00	94760
06/05/06 46200051	420	PT - PHYSICAL THERAPY EVAL	1	141.00	141.00	97001 GP
06/06/06 46200093	420	PT-THERAPEUTIC EX/ROM 15 MIN	1	53.00	53.00	97110 GP
06/07/06 46200093	420	PT-THERAPEUTIC EX/ROM 15 MIN	1	53.00	53.00	97110 GP
06/08/06 46200093	420	PT-THERAPEUTIC EX/ROM 15 MIN	1	53.00	53.00	97110 GP
06/12/06 46200093	420	PT-THERAPEUTIC EX/ROM 15 MIN	1	53.00	53.00	97110 GP
06/12/06 46201117	420	PT-THERAPEUTIC ACTIVITY 15 MIN	1	70.00	70.00	97530 GP
06/02/06 45900057	430	OT - OCCUPATIONAL THERAPY EVAL	1	141.00	141.00	97003 GO
06/05/06 45900107	430	OT-THERAPEUTIC EXERCISE 15 MIN	1	53.00	53.00	97110 GO
06/07/06 45900107	430	OT-THERAPEUTIC EXERCISE 15 MIN	1	53.00	53.00	97110 GO
06/08/06 45900107	430	OT-THERAPEUTIC EXERCISE 15 MIN	1	53.00	53.00	97110 GO
06/09/06 45900107	430	OT-THERAPEUTIC EXERCISE 15 MIN	1	53.00	53.00	97110 GO
06/05/06 45960093	430	OT - ADLS 15 MIN	1	71.00	71.00	97535 GO
06/29/06 44460012	731	EKG 12 LEAD	1	134.82	134.82	93005
06/01/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
06/02/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
06/03/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
06/04/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
06/05/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
06/06/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
06/07/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
06/08/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
06/09/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
06/10/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
06/11/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
06/12/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
06/13/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225

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F/C 5 PAYORS 800 PLAN 500

BILLING DATE 8/12/06

BILL TYPE: 111 PATIENT AGE: 84 DR. NAME: DABENEY SMITH KILA

CHARGE DATE/CODE	REV	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
06/14/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
06/15/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
06/16/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
06/17/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
06/18/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
06/19/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
06/20/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
06/21/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
06/22/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
06/23/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
06/24/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
06/25/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
06/26/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
06/27/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
06/28/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
06/29/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
07/03/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
07/04/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
07/05/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
07/06/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
07/07/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
07/08/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
07/09/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
07/10/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
07/11/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
07/12/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
07/13/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
07/14/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
07/15/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
07/16/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
07/17/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
07/18/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
07/19/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
07/20/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
07/21/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
07/22/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
07/23/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
07/24/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
07/25/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
07/26/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
07/27/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225

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GUARANTOR NAME / ADDRESS
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TRENTON SC 29847
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F/C 5 PLAN 500
PAYORS 800
BILLING DATE 8/12/06

BILL TYPE: 111 PATIENT AGE: 84 DR. NAME: DABENEY SMITH KILA

CHARGE DATE/CODE	REV	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
07/28/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
07/29/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
07/30/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
07/31/06 44460038	731	TELEMETRY PER 24 HR	1	220.00	220.00	93225
06/15/06 47060017	942	NUTR RE-ASSESSMENT EA 15 MIN	1	15.00	15.00	97803
07/12/06 47060017	942	NUTR RE-ASSESSMENT EA 15 MIN	1	15.00	15.00	97803

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PATIENT NAME	HOSP NBR	PATIENT NUMBER	CYCLE	ROOM/ BED	ADMISSION DATE	DISCHARGE DATE	PAGE
PETERSON WILLIAM	494	10873	1	655-A	06/01/06	08/01/06	37

GUARANTOR NAME / ADDRESS	F/C	PAYORS	BILLING DATE
PETERSON WILLIAM	5	800	8/12/06
EDGEFIELD NH		PLAN 500	
TRENTON SC 29847			
1770			

BILL TYPE: 111 PATIENT AGE: 84 DR. NAME: DABENEY SMITH KILA

*** SUMMARY OF CHARGES ***

ROOM & BOARD	120	42,456.00	DAYS: 61
PHARMACY GENERAL	250	23,673.75	
PHARMACY IV SOLUTIONS	258	4,337.00	
MED/SUR SUPPLIES GENERAL	270	28,912.26	
LABORATORY GENERAL	300	6,521.82	
RADIOLOGY DIAGNOSTIC GENERAL	320	6,730.62	
OR SERVICES GENERAL	360	15,300.00	
BLOOD PACKED RED CELLS	381	293.34	
BLOOD ADMINISTRATION	391	700.00	
OTH IMAGING ULTRASOUND	402	378.38	
RESPIRATORY SERVICES GENERAL	410	3,836.98	
PHYSICAL THERAPY	420	423.00	
OCCUPATIONAL THERAPY GENERAL	430	424.00	
HOLTER MONITOR	731	12,894.82	
EDUCATION/TRAINING/DIETARY THRPY	942	30.00	

CYCLE 1 TOTAL CHARGES: 146,911.97




10 9 01



If we find in favor of the Plaintiff, may we deviate from the damages amount being sought?

yes
12:25 pm

We request a breakdown of the monetary damages, please. Cannot find in the notebooks provided.

Please refer to exhibits 10, 11, & 12.

1:20 pm

STATE OF SOUTH CAROLINA COUNTY OF EDGEFIELD	)	IN THE COURT OF COMON PLEAS ELEVENTH JUDICIAL CIRCUIT CIVIL ACTION NO. 2009-CP-19-0276
CECELIA JACKSON, PR of the Estate of WILLIAM PETERSON, Plaintiffs, v. TAMI MASSEY, M.D., GEORGE RAINSFORD, M.D., and ELEANOR LEAPHART, M.D., d/b/a EDGEFIELD MEDICAL CLINIC and/or EDGEFIELD MEDICAL CLINIC, P.A., Defendants.	)	PLAINTIFF'S MEMORANDUM IN SUPPORT OF SURVIVOR CLAIM PAIN AND SUFFERING AMAGES

Plaintiff Cecelia Jackson, PR of the Estate of William Peterson, through her attorneys, respectfully submits this supplemental authority on survival actions.

FACTS

William Peterson was a resident of Trinity Mission Health and Rehab ("Trinity") in Edgefield, South Carolina on two different occasions in 2006. During both stays at Trinity, Mr. Peterson was under the medical care and supervision of Defendant Edgefield Medical Clinic and its physicians Dr. Tami Massey, Dr. Eleanor Leaphart, and Dr. George Rainsford. Mr. Peterson was readmitted to Trinity on March 21, 2006, and his medical records indicate no skin breakdowns on his left hip. On March 30, 2006, Trinity medical records in evidence before the court indicate the discovery of a darkened area on Mr. Peterson's left hip. Documentary and testimonial evidence presented at trial showed how the skin breakdown on Mr. Peterson's left hip continued to worsen over the next six weeks. On April 6, 2006, a Stage II decubitus ulcer was noted and the wound had progressed to a Stage III ulcer by April 19, 2006, and a Stage IV ulcer by May 5, 2006. **EXHIBIT A**

While Physician's Telephone Orders are signed by all three physicians and noted in Mr. Peterson's chart both before and after May 15, 2006, there is no evidence that any of the defendants ever physically examined the wound, or even physically examined the patient after April 14, 2006. A culture of the wound was ordered on May 2, 2006 and the results reported back to the chart by May 7, 2006. The results indicated Mr. Peterson was suffering from MRSA. Mr. Peterson's condition declined sharply between May 10-15, 2006, as his infected hip wound went largely untreated by Defendants. As noted in the records and as recounted by witnesses at trial, Mr. Peterson began require supplemental oxygen, became anxious (the nurse called the doctors requesting Ativan for anxiety), and eventually the nurses contacted the family to come in and see their father as he was getting much worse.

Mr. Peterson's family testified that they saw their father grimacing, struggling for breath, bug-eyed and with a dry mouth looking dehydrated. They testified they got the nurse to call the doctor to have their father transferred to Aiken Regional Hospital immediately. The nurses notes in the medical record state that Dr. Rainsford did not think taking father out of nursing home was a good idea and to do so would be "Against Medical Advice." Dr. Rainsford also signed a Physician's Telephone Order stating the action was "AMA." The family called an ambulance and took their father to Aiken Regional.

At Aiken, the record shows Mr. Peterson was suffering from sepsis from MRSA (infection in the blood stream), MRSA infection of the urinary tract, infected decubitus ulcers of the hip and sacrum and other related injuries. All the injuries were documented by the Aiken Hospital emergency room upon admission. The evidence shows that with proper treatment (including IV antibiotics) Mr. Peterson regained consciousness, and by the second week, was talking in full sentences to his doctors. He lived until August 1, 2006.

ARGUMENT

Following Plaintiff's case-in-chief, the Court found as a matter of law that Plaintiff failed to present evidence supporting his survival action as to pain and suffering. Specifically, the Court concluded as a matter of law that Plaintiff presented no evidence that Mr. Peterson sustained conscious pain and suffering proximately caused by Defendants' alleged negligence in April-May of 2006. Plaintiff believes this ruling overlooks evidence Plaintiff presented in its case-and-chief and fails to acknowledge South Carolina law stating the standard a party must meet to present a jury question on the issue of conscious pain and suffering. Accordingly, Plaintiff respectfully requests that the Court reconsider its earlier ruling.

Legal claims regarding injuries sustained by a person before his death survive the person and may be pursued by the decedent's personal representative by way of a survival claim. S.C. Code Ann. § 15-5-90. Survival actions compensate the plaintiff for the decedent's "conscious pain and suffering." Stevens v. Allen, 342 S.C. 47, 52, 536 S.E.2d 663, 665 (2000) (citing Camp v. Petroleum Carrier Corp., 204 S.C. 133, 139, 28 S.E.2d 683, 685 (1944)). Conscious pain and suffering may be shown by direct evidence **or inferred through circumstantial evidence** (emphasis added). Vereen v. Liberty Life Ins. Co., 306 S.C. 423, 412 S.E.2d 425 (Ct. App. 1991). For example, in Smalls v. South Carolina Department of Education, 339 S.C. 208, 216, 528 S.E.2d 682, 686 (Ct. App. 2000), the court considered "the circumstances of the wreck" to be some evidence supporting conscious pain and suffering. Whether the decedent endured conscious pain and suffering is a jury issue so long as the plaintiff presents a scintilla of evidence that the decedent was conscious following the accident. See Croft v. Hall, 208 S.C. 187, 37 S.E.2d 537 (1946). The Croft court found that a survival claim presented a jury issue because, though the factual showing of conscious suffering following an accident was weak, "there was

more than a scintilla of evidence tending to prove the point." Id. at 193, 37 S.E.2d at 539. Summary judgment or a directed verdict on a survival claim is proper only in the rare instance where "a jury could not reasonably have concluded [Decedent] consciously experienced any pain or suffering prior to or after impact." Rutland v. S.C. Dep't of Transp., 400 S.C. 209, 215, 734 S.E.2d 142, 145 (2012).

In Smalls, an eight-year old girl was struck and killed by a truck as she crossed a street to board her school bus. 339 S.C. at 214, 528 S.E.2d at 685. The girl was discovered by her father who testified both that his daughter was "unconscious" and that she was "gasping for air and moaning somewhat." Id. at 216-17, 528 S.E.2d at 686. The Court acknowledged that the father's testimony was "somewhat contradictory" but refused to overturn a verdict on a survival claim. The father's contradictory testimony "was a question of fact properly left for the jury." Id. (citing Vereen, 306 S.C. at 432, 412 S.E.2d at 431 ("If there is **any evidence** from which a jury could reasonably conclude a decedent experienced conscious pain and suffering, the issue must be submitted to the jury") (emphasis added).

Finally, in Vereen, the Court of Appeals reversed a trial court's directed verdict finding no evidence of conscious pain and suffering even without testimony of a witness who observed the decedent in the moments before his death. 306 S.C. at 430-31, 412 S.E.2d at 431-32. Based on a trail of blood leading to the decedent's body and a postmortem photograph showing the position of the decedent's hands, the court concluded a jury could infer that the decedent survived a gunshot and crawled for a matter of seconds before dying. Id. The inference of a few seconds of post-injury survival from circumstantial evidence at a crime scene was enough to create a jury question on the conscious pain and suffering issue.

Plaintiff has made a much stronger showing of conscious pain and suffering than those considered sufficient in Smalls and Vereen. Plaintiff has presented medical records showing months of hospital treatment Mr. Peterson received following Defendants' negligent care in April-May 2006, including skin grafts. Plaintiff's expert testified that the May 15, 2006 Aiken Hospital admission and treatment and the Select Specialty Hospital admission and treatment would not have been necessary had these physicians not breached the standard of care. Nursing home and medical records show Mr. Peterson's gradual decline in consciousness during his physical decline May 7 through 15, 2006, including his loss "moaning when touched", need for supplemental oxygen (sepsis setting in), and anxiety (nurse calling Dr. Rainsford for Ativan). Mr. Richardson's distress secondary to sepsis was so apparent on May 15, 2006, that his family demanded the Edgefield Clinic doctors transfer Mr. Peterson to the hospital for proper treatment. Plaintiff also presented testimony of witnesses who observed Mr. Peterson's condition before, during, and after Defendant's improper treatment. These witnesses testified to Mr. Peterson's pain and discomfort. In sum, this evidence clearly demonstrated more than a "scintilla" of evidence that Mr. Peterson sustained conscious pain and suffering in April-July 2006. At the very least, Plaintiff's evidence has demonstrated circumstantial evidence from which a reasonable jury could conclude Mr. Peterson sustained conscious pain and suffering. Under the paltry standard stated in Smalls, Vereen, and other South Carolina cases, Plaintiff's conscious pain and suffering claim should be decided by a jury.

CONCLUSION

Based on the South Carolina law cited above and Plaintiff's evidence presented at trial, Plaintiff's survival claim presented a jury question on the issue of conscious pain and suffering.

Plaintiff respectfully requests the Court reconsider its earlier ruling and permit the jury to consider this claim.

Respectfully submitted,

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March 19, 2014
Anderson, SC

STATE OF SOUTH CAROLINA	)	**IN THE COURT OF COMON PLEAS**
	)	**ELEVENTH JUDICIAL CIRCUIT**
COUNTY OF EDGEFIELD	)	**CIVIL ACTION NO. 2009-CP-19-0276**
CECELIA JACKSON, PR of the Estate of WILLIAM PETERSON,	)	
Plaintiff,	)	**PLAINTIFF'S MOTION FOR NEW TRIAL *NISI* OR *ADDITUR*, NEW TRIAL UNDER THIRTEENTH JUROR DOCTRINE, OR NEW TRIAL UNDER SCRCP 59(a)**
v.	)	
EDGEFIELD MEDICAL CLINIC or EDGEFIELD MEDICAL CLINIC, PA	)	
Defendants.	)	

Plaintiff hereby moves this Court for the following relief:

(1) The Court grant Plaintiff a new trial *nisi additur* on economic damages alone as to the award for economic damages of $27,086.00 pursuant to S.C. Code Ann. § 15-33-125 (Cum. Supp. 2002) (a new trial may be granted to the plaintiff on the issue of damages only and not liability when the only reasonable inference to be drawn from all the evidence, viewed in the light most favorable to the defendant, is that the plaintiff is entitled to a verdict in his or her favor on the issue of liability as a matter of law). *See, e.g., O'Neal v. Bowles*, 314 S.C. 525, 431 S.E.2d 555 (1993) (where a verdict is merely inadequate, the trial judge has the power to grant a new trial *nisi additur*), *Graham v. Whitaker*, 282 S.C. 393, 321 S.E.2d 40 (1984) (trial court's additur of nearly seven (7) times award upheld on appeal where jury verdict was inadequate), *Waring v. Johnson*, 341 S.C. 248, 533 S.E.2d 906 (Ct. App. 2000)(trial judge's additur which nearly trebled actual award upheld on appeal);

(2) The Court grant a new trial in full or grant a new trial as to economic damages only under the "thirteenth juror" doctrine pursuant to *Folkens v. Hunt*, 300 S.C. 251, 387 S.E.2d 265 (1990)

(outlining the thirteenth juror doctrine as a vehicle by which the trial judge may grant a new trial when he or she is convinced that justice has not been served by the verdict).

(3) The Court grant a new trial pursuant to SCRCP 59 (a). The evidence in this case clearly shows that the award of damages was too low, against the weight of the evidence and unfair to the Plaintiff. Further, the Court's ruling to disallow any recovery for pain and suffering was not in compliance with the law concerning recovery of pain and suffering damages, and greatly prejudiced and was unfair to the Plaintiff. Under SCRCP 59(a), a new trial can be granted when the verdict is against the weight of the evidence, the damage award is too low, or the trial was for other reasons unfair to the moving party. *Norton v. Norfolk S. Ry. Co.*, 341 S.C. 165, 171, 533 S.E.2d 608, 612 (Ct. App. 2000). Plaintiff also incorporates by reference and adopts herein the brief filed with the Court during trial entitled "Plaintiff's Memorandum in Support of Survivor Claim for Pain and Suffering Damages," attached hereto as Exhibit "A."

ARGUMENT IN SUPPORT OF MOTION

When a jury verdict is inadequate, the trial judge has broad discretion in granting a new trial *nisi additur*. *Waring v. Johnson*, 533 S.E.2d 906 at 910 (S.C. App. 2000). A trial judge may grant a new trial *nisi additur* whenever he or she finds the amount of the verdict to be merely inadequate. *Patterson v. Reid,* 318 S.C. 183, 185, 456 S.E.2d 436, 438(Ct.App.1995). The consideration of a motion for a new trial *nisi additur* requires the trial judge to consider the adequacy of the verdict in light of the evidence presented. *Krepps v. Ausen*, 324 S.C. 597, 479 S.E.2d 290 (Ct. App. 1996). While the granting of such a motion rests within the sound discretion of the trial court, substantial deference must be afforded to the jury's determination of damages. *Evans v. Taylor Made Sandwich Co.*, 337 S.C. 95, 100, 522 S.E.2d 350, 352 (Ct.App.1999). To this end, a judge must

offer compelling reasons for invading the jury's province by granting a motion for *additur*. *Bailey v. Peacock*, 318 S.C. 13, 14, 455 S.E.2d 690, 691 (1995); *See Green vs. Fritz*, 356 S.C. 566, 590 S.E.2d 39 (Ct. App. 2003) and *O'Neal vs. Bowles*, 314 S.C. 525, 431 S.E.2d 555 (Sup. Ct. 1993).

Plaintiff moves for *nisi additur*, or in the alternative, for a new trial for the Estate of William Peterson for economic damages only. Plaintiff does not dispute any other finding of the jury in this case.

COMPELLING REASONS EXIST TO GRANT THIS MOTION

This case has several compelling reasons supporting the granting of the motion. At trial, the jury in this case found the Edgefield Medical Clinic PA (by and through its employed physicians Dr. Rainsford, Dr. Leaphart, Dr.Massey and Dr. Nicholson) liable for negligence in the care and treatment of a severe MRSA infection of William Peterson while a patient at the Trinity Mission Nursing Home. The jury also found that this negligence was the proximate cause of the injury to Mr. Peterson. The injuries included MRSA sepsis, a MRSA infection in a sacral decubiti, a MRSA infection in a large hip decubiti, and a MRSA urinary tract infection. These injuries required extensive treatment at Aiken Regional Medical center from May 15, 2006 to June 1, 2006, and treatment at Select Specialty Hospital from June 1, 2006 to July 31, 2006. The medical bills related to these hospitalizations totaled $204,131.97. However, plaintiff backed out the daily charge for the nursing home care from the bills ($558.00 per day), and requested only $161,521.00.

However, the jury awarded the Peterson Estate only $27,004.00 in economic damages. This is in spite of the evidence and testimony showing that the Aiken Regional Medical Center and the Select Specialty Hospital admission would not have been necessary if the doctors had paid

attention to the wound culture (showing MRSA) reported back to the nursing home on May 7, 2006.

The best the defense could do to refute this testimony was to say that if Dr. Rainsford had been allowed to come over on May 15, 2006 to examine Mr. Peterson (before the family called an ambulance to rescue their father), Dr. Rainsford would have ordered Mr. Peterson taken to the Aiken hospital and the treatment would have been the same, therefore no damages. This argument is not only a logical fallacy, it begs the true question.

The real question, answered by the jury, is why did the doctors not timely treat the obvious and dangerous MRSA infection in the hip, especially when it cultured out in the lab report on May 7, 2006, and thus prevent its spread to the sacral decubiti, the urinary tract and ultimately the entire blood stream. For Dr. Rainsford, or any of the named doctors for that matter, to wait until May 15, 2006 was the problem. By May 15, 2006 the MRSA had progressed to the lethal sepsis.

There is no doubt that Mr. Peterson suffered economic damages in the form of the substantial medical bills presented to the jury at Aiken Regional Medical Center and Select Specialty Hospital as a result of the rampant MRSA sepsis, decubiti and urinary tract infections. Timely treatment with IV antibiotics at the nursing home would have prevented the need to have intensive hospital treatment once sepsis set in. The total medical bills, less the cost of daily care at the Trinity Mission Nursing Home, came to $161,521.00. This includes skin grafts, required only because the hip and sacral decubiti were allowed to progress, and treatment for the sepsis (blood stream infection from the unchecked MRSA). There is no testimony to dispute this allegation.

The small amount of medical bills awarded is grossly inadequate in light of the evidence, and is an indication that the amount was a result of some type caprice, prejudice or partiality on the part of the jury.

Wherefore, Plaintiff moves for a new trial *nisi additur*, or a new trial on the issue of the Peterson Estate's economic damages only. Plaintiff moves this Court for a *nisi additur*, in a sum the Court determines is reasonable, or in the alternative a new trial on the issue of the Estate's economic damages.

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Anderson, South Carolina

March 27, 2014

72172

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM EDGEFIELD COUNTY
Court of Common Pleas

Doyet A. Early, Circuit Court Judge

Case No. 2009-CP-19-0276

Cecelia Jackson, Personal Representative of the Estate of William Peterson ..... Appellant

v.

Edgefield Medical Clinic, P.A., ... Respondent.

NOTICE OF APPEAL

Appellant Cecelia Jackson, Personal Representative of the Estate of William Peterson, appeals from a bench order of the Honorable Doyet A. Early on March 19, 2014, refusing to permit Appellant to seek damages for conscious pain and suffering. On March 27, 2014, Appellant filed a Motion for New Trial *Nisi* or *Additur*, New Trial under Thirteenth Juror Doctrine, or New Trial under SCRCP 59(a). Appellant's motion was denied in an order received on April 10, 2014.

Respectfully Submitted,

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MAY 13 2014
SC Court of Appeals

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Attorney for Edgefield Medical Clinic, P.A.

May 9, 2014
Rock Hill, SC

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM EDGEFIELD COUNTY
Court of Common Pleas

Doyet A. Early, Circuit Court Judge

Case No. 2009-CP-19-0276

Cecelia Jackson, Personal Representative of the Estate of William Peterson ..... Appellant

v.

Edgefield Medical Clinic, P.A. ..... Respondents.

PROOF OF SERVICE

The undersigned hereby certifies that on this 9th day of May, 2014, she served counsel for the Defendant with a copy of the Notice of Appeal along with Certificate of Counsel in this matter by mailing a copy of the same by United States Mail with first class postage prepaid to the following addresses:

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Susan Huntley Guard
Paralegal to Jordan Calloway

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MAY 13 2014
SC Court of Appeals

FORM 4

STATE OF SOUTH CAROLINA
COUNTY OF EDGEFIELD
IN THE COURT OF COMMON PLEAS

EDGEFIELD COUNTY
CLERK OF COURT
SHIRLEY F. NEWBY
2014 APR 14 AM 11:00

JUDGMENT IN A CIVIL CASE

CASE NO. 2009- CP-19-0276

Cecella Jackson, PR of the Estate of William Peterson — PLAINTIFF(S)

Edgefield Medical Clinic or Edgefield Medical Clinic, PA — DEFENDANT(S)

Submitted by:	Attorney for : ☐ Plaintiff ☐ Defendant or ☐ Self-Represented Litigant

DISPOSITION TYPE (CHECK ONE)

☐ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.

☐ **DECISION BY THE COURT.** This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered. ☐ See Page 2 for additional information.

☐ **ACTION DISMISSED** (*CHECK REASON*): ☐ Rule 12(b), SCRCP; ☐ Rule 41(a), SCRCP (Vol. Nonsuit); ☐ Rule 43(k), SCRCP (Settled); ☐ Other

☐ **ACTION STRICKEN** (*CHECK REASON*): ☐ Rule 40(j), SCRCP; ☐ Bankruptcy; ☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Other

☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT** (*CHECK APPLICABLE BOX*): ☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other

NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING LOWER COURT, TRIBUNAL, OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.

IT IS ORDERED AND ADJUDGED: ☐ See attached order (formal order to follow) ☒ Statement of Judgment by the Court: Plaintiff's Motion for New Trial Nisi or Additur, New Trial Under Thirteenth Juror Doctrine, or New Trial Under SCRCP 59(a) is DENIED.

ORDER INFORMATION

This order ☐ ends ☐ does not end the case.
Additional Information for the Clerk :

INFORMATION FOR THE JUDGMENT INDEX

Complete this section below when the judgment affects title to real or personal property or if any amount should be enrolled. If there is no judgment information, indicate "N/A" in one of the boxes below.

Judgment in Favor of (List name(s) below)	Judgment Against (List name(s) below)	Judgment Amount To be Enrolled (List amount(s) below)
		$
		$
		$

If applicable, describe the property, including tax map information and address, referenced in the order:

The judgment information above has been provided by the submitting party. Disputes concerning the amounts contained in this form may be addressed by way of motion pursuant to the SC Rules of Civil Procedure. Amounts to be computed such as interest or additional taxable costs not available at the time the form and final order are submitted to the judge may be provided to the clerk. **Note: Title abstractors and researchers should refer to the official court order for judgment details.**

Circuit Court Judge

0136
Judge Code

4/10/14
Date

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MAY 13 2014
SC Court of Appeals

For Clerk of Court Office Use Only

This judgment was entered on the day of , 20 and a copy mailed first class or placed in the appropriate attorney's box on this day of , 20 to attorneys of record or to parties (when appearing pro se) as follows:

ATTORNEY(S) FOR THE PLAINTIFF(S)

ATTORNEY(S) FOR THE DEFENDANT(S)

CLERK OF COURT

Court Reporter:

ADDITIONAL INFORMATION REGARDING DECISION BY THE COURT AS REFERENCED ON PAGE 1.

This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.

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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM EDGEFIELD COUNTY
Court of Common Pleas

Doyet A. Early, III, Circuit Court Judge

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., ... Respondents.

PROOF OF SERVICE

The undersigned hereby certifies that on this 25th day of February, 2015, she served counsel for the Defendants with a copy of the Record on Appeal and Certificate of Counsel in this matter by mailing a copy of the same by United States Mail with first class postage prepaid to the following addresses:

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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM EDGEFIELD COUNTY
Court of Common Pleas

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.

CERTIFICATE OF COUNSEL

Pursuant to Rule 210(g), SCACR, Appellant's counsel certifies that the Record on Appeal contains all material proposed to be included by any of the parties and not any other material.

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February 25, 2015
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