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

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SC Court of Appeals

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 3)

James D. Nance
Nance, McCants & Massey
P.O. Box 2881
218 Newberry Street
Aiken, SC 29801
(803) 649-6200
jimnance@nancefirm.com

Andrew F. Lindemann
Davidson & Lindemann, P.A.
P.O. Box 8568
1611 Devonshire Drive
Columbia, SC 29202
(803) 806-8222
alindemann@dml-law.com

Attorneys for Respondent

J. Stephen Welch
McGowan, Hood & Felder, LLC
1501 N. Fant Street
Anderson, SC 29621
(864) 225-6228
(864) 225-7928 (fax)
swelch@mcgowanhood.com

Jordan C. Calloway
McGowan, Hood & Felder, LLC
1539 Health Care Drive
Rock Hill, SC 29732
(803) 327-7800
(803) 328-5656 (fax)
jcalloway@mcgowanhood.com

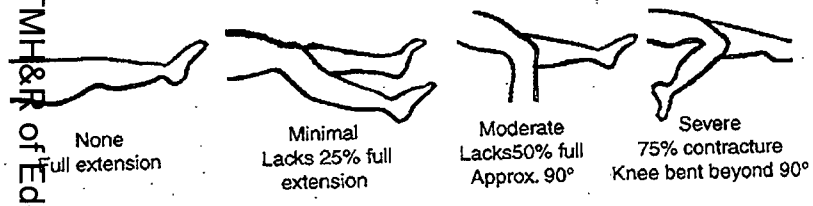
Attorneys for Appellant

CONTRACTURE ASSESSMENT

FACILITY	DATE	3-06			
		L R	L R	L R	L R

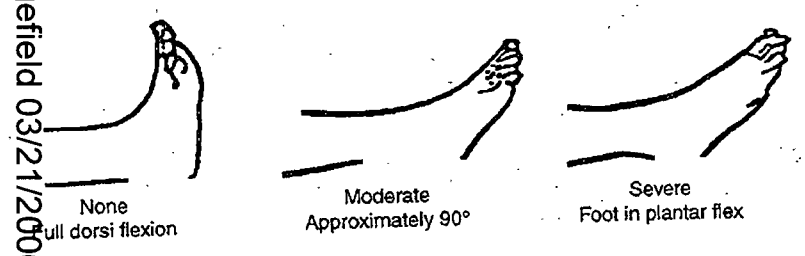
HIP FLEXION

None: Full extension
Minimal: 75% full extension
Moderate: 50% full extension
Severe: 25% full extension



KNEE FLEXION

None: Full extension
Minimal: Lacks 25% full extension
Moderate: Lacks 50% full Approximately 90°
Severe: 75% contracture Knee bent beyond 90°



ANKLE DORSI-PLANTAR FLEXION

None: Full dorsi flexion
Moderate: Approximately 90°
Severe: Foot in plantar flex

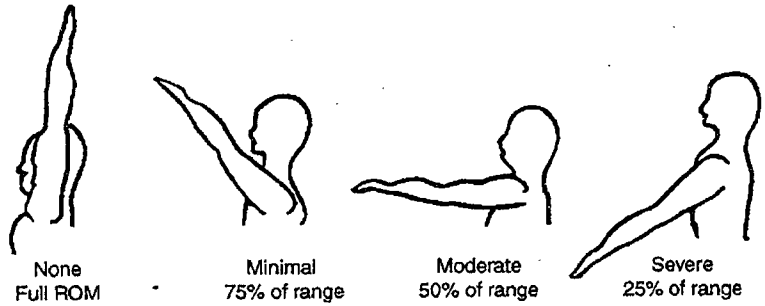
SIGNATURES W

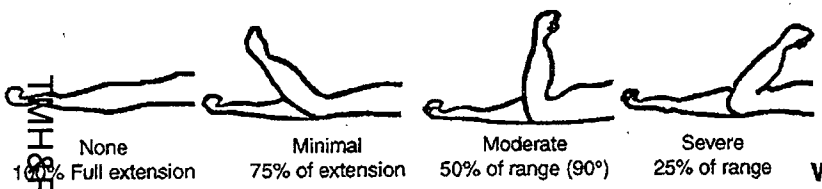
COMMENTS:

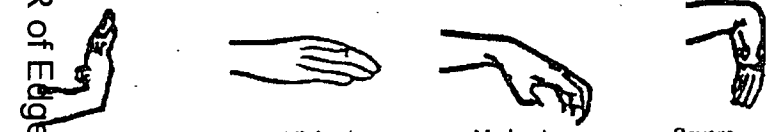
PLAN OF CARE:

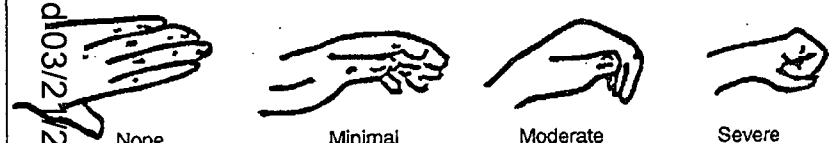
RESIDENT	ROOM #	MR#	THERAPIST

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0136









	DATE	3-06						
	L	R	L	R	L	R	L	R
SHOULDER FLEXION								
None: Full ROM								
Minimal: 75% of range								
Moderate: 50% of range								
Severe: 25% of range								
ELBOW FLEXION								
None: 100% full extension								
Minimal: 75% of extension								
Moderate: 50% of range (90°)								
Severe: 25% of range								
WRIST FLEXION								
None: Full range								
Minimal: 75%								
Moderate: 50%								
Severe: 25%								
FINGERS								
None: Full extension								
Minimal: 75% of full extension								
Moderate: 50% of full extension								
Severe: Full finger flexion (contracture)								
SIGNATURES	W							

COMMENTS:

PLAN OF CARE:

PATIENT	ROOM #	MR#	THERAPIST

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0137

INITIAL NURSING ASSESSMENT

SPECIAL INSTRUCTIONS	SENSORY REVIEW	NURSING INTERVENTION / INITIAL CARE PLAN
HEARING (c.1) Assess with hearing aide if used routinely PE1.1.4 Date Completed: 03/21/06 Initials: [illegible]	**HEARING ACUITY** YES / NO Hears adequately: YES ☒ NO ☐ Minimal difficulty: ☒ ☐ Special situation only: ☐ ☒ Highly impaired: ☐ ☒ Hearing aide used? ☐ ☒	1. Hearing aide marked Yes ☐ No ☐ N/A 2. Needs communication board Yes ☐ No ☐ N/A 3. Location of batteries and type: N/A 4. Additional assessment recommended Yes ☐ No ☒ 5. Special instructions for communication: N/A 6. Presence of ear wax Yes ☐ No ☐ unable to examine 7. If wax present is amount excessive? Yes ☐ No ☐ 8. Treatment obtained for excessive wax Yes ☐ No ☐
VISION (d.1) Assess with glasses and adequate light present PE1.1.4 Date Completed: 03/21/06 Initials: [illegible]	**VISUAL ACUITY** YES / NO Adequately: YES ☑ NO ☐ Impaired: ☐ ☑ Moderately Impaired: ☐ ☑ Severly impaired: ☐ ☑ **APPLIANCES USED** YES / NO Glasses: ☐ ☑ Reading: ☐ ☑ YES / NO Contacts: ☐ ☑ Artificial Eye: ☐ ☑	1. Eye glasses marked Yes ☐ No ☐ N/A 2. Vision exam recommended Yes ☐ No ☑ 3. Resident preferred use of glasses Yes ☐ No ☑ 4. Special instructions: Res. stated "maybe I ought to wear glasses but I don't"
COMMUNICATION (c.3, 5) Interview resident in a quiet calm environment PE1.1.3 Date Completed: 03/21/06 Initials: [illegible]	**COMMUNICATION SKILLS** Predominant language: English ☑ Other ☐ Methods of communication: YES / NO Writing: YES ☑ NO ☑ (error) Speech: ☑ ☐ Sign: ☐ ☑ Braille: ☐ ☑ Sounds: ☐ ☑ Gestures: ☐ ☑ Resident is able to make self understood? ☑ ☐ Resident is able to express needs? ☑ ☐	1. Interpretor provided if necessary Yes ☐ No ☐ N/A 2. Braille support provided Yes ☐ No ☐ N/A 3. Best method of communication 4. Staff has been educated on appropriate communication needs Yes ☐ No ☐ N/A

RESIDENT'S NAME	PHYSICIAN	
Peterson, William	NR&LM	
MEDICAL RECORD #	TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0138	
1050	P 214	W

SPECIAL INSTRUCTIONS	SENSORY REVIEW	NURSING INTERVENTION / INITIAL CARE PLAN
COGNITIVE PATTERNS (b. 3) PE1.1.4 Date Completed: 03/21/06 Initials:	**LEVEL OF CONSCIOUSNESS ORIENTATION** Person ☑ Place ☐ Time ☐ Alert ☑ Confused ☑ Comatose ☐ Lethargic ☐	1. Appropriate call light system and teaching Yes ☑ No ☐ 2. Needed orientation and training provided to Resident and/or Responsible Party Yes ☑ No ☐ 3. Describe orientation/memory status and nursing interventions requested

COGNITIVE PERFORMANCE SCALE

Step 1: Determine Impairment Count by assigning 1 point to each when applicable.

Step 2: Determine Severe Impairment Count by assigning 1 point to each when applicable.

Step 3: Run totals on scale.

Date Completed: 3/21/06 Initials:

Cognitive Performance Scale – (Check all that apply)

B4 – Cognitive Skill for Daily Decision-Making – *Made decisions regarding tasks of daily life.*

		Ans.	*I.C.	**S.I.C.
0	Independent – decisions consistent/reasonable	☐	■	■
1	Modified Independence – some difficulty in new situations only	☐	☐	
2	Moderately Impaired – decisions poor; cues/supervision required	☑	☑	☐
3	Severely Impaired – never/rarely made decisions	☐	■	■

C4 – Making Self Understood– *Expressing information content — however able.*

0	Understood	☐	■	■
1	Usually Understood – difficulty finding words or finishing thoughts	☑	☑	
2	Sometimes Understood – Ability is limited to making concrete requests	☐	☐	☐
3	Rarely/Never understood	☐	☐	☐

B2a – Short-Term Memory – *Recall of what was learned or known*

	Short-term memory OK – seem/appears to recall after 5 minutes	☐	■
	Short-term memory problem – unable to recall after 5 minutes	☑	☑
	Total	3	0

Cognitive Performance Interpretation

Start Here: ⟶

Match — left to right

B1 = Comatose	B4 Answer	*Impairment Count *Total [3]	** Severe Impairment Count *Total [ ]	Totally Dependent Eating (G1h)		CPS	Nursing Intervention / Initial Care Plan
NO	1 0 - 2	0			→ 1	No. Cog. Impairment	Intro to Act. & Environ.
		1			→ 2	Very Mild Cog. Imp.	Candidate for Self-Meds
		2 or 3	0		→ 3	Mild Cog. Impairment	Mod. Smoking Privilege
			1		→ 4	Moderately Cog. Imp.	Mod. Act.
			2		→ 5	Mod. Severe Cog. Imp.	Provide Supervision
	3			NO	→ 6	Sever Cog. Impairment	Potential Smoke Risk
				YES	→ 7	Very Severe Cog. Imp.	Potential 1:1 Act. Safety Risk
YES					→		
		*Total cannot exceed 3	*Total cannot exceed 2				

RESIDENT'S NAME: Peterson, William MEDICAL RECORD #: 1935

SPECIAL INSTRUCTIONS	SENSORY REVIEW	NURSING INTERVENTION / INITIAL CARE PLAN
MOOD AND BEHAVIOR PATTERNS (e.1,4) Indicate patterns regardless of assumed cause. Indicate behavior during initial interview Date Completed: nke 3/21/06 Initials: nke	**MOOD AND BEHAVIOR** Withdrawn ☐ Tearful ☐ Apathetic ☐ Anxious ☑ Angry ☐ Sad ☐ Happy ☐ Wandered ☐ Verbally abusive ☐ Physically abusive ☐ Disruptive to care ☐ **MEDICATION THERAPY** Anti-psychotic ☐ Anti-anxiety ☐ Anti-depressant ☐ Hypnotic ☐ **SLEEP PATTERN HISTORY** Sleeps all night ☑ Naps during day ☑ Awakens frequently during night ☐ Stays up late (after 9 pm) ☐	1. Psych screen recommended Yes ☐ No ☑ 2. Currently using medication to treat Yes ☐ No ☑ 3. Currently involved in therapy for behavior or mood issues Yes ☐ No ☑ 4. Diagnosis to support medication _____ _____ _____ 5. Referral to Social Services Director Yes ☐ No ☑ Why _____ _____ _____ 6. Monitor for side effects: Movement Yes ☐ No ☐ Non-Movement Yes ☐ No ☐ 7. Referral to Activity Director Yes ☑ No ☐ 8. Family/Significant Other/ Responsible Party involved in assessment Yes ☐ No ☑ 9. Behavior monitoring sheet implemented Yes ☐ No ☐
PSYCHOSOCIAL WELL-BEING (F.2) Date Completed: 3/21/06 Initials: nke	**WELL BEING** Family involvement: Yes ☐ No ☑ Significant other involved Yes ☐ No ☑	

SPECIAL INSTRUCTIONS	SYSTEM REVIEW	NURSING INTERVENTION / INITIAL CARE PLAN
VITAL STATISTICS PE1.1.6 Date Completed: 03/21/06 Initials: nke	**VITAL SIGNS** Temperature: 99° Route: Oral ☒ Axillary ☐ Rectal ☐ Ear ☐ Pulse: 63 Location: Apical ☐ Radial ☒ Other ☐ Respirations 22	

RESIDENT'S NAME: Peterson, William

SPECIAL INSTRUCTIONS	SYSTEM REVIEW	NURSING INTERVENTION / INITIAL CARE PLAN
VITAL STATISTICS PE1.1.6 Date Completed: 03/21/06 Initials: mlc	**VITAL SIGNS (Cont.)** Lung sounds clear Right Left Wheezing ☐ ☐ Wet ☐ ☐ Muffled ☐ ☐ Oxygen Usage: Yes ☐ No ☑ Route: Nasal cannula ☐ Trach ☐ Mask ☐ Blood Pressure 131/76 Position: Lying ☑ Standing ☐ Sitting ☐ Orthostatic Blood Pressure Lying/Sitting ____/____ Sitting/Standing ____/____ Weight 164 lbs. (diff) Weight loss in last 30 days? Yes ☐ No ☐ Reported normal body Weight 164 lbs. Height ____ in. Abdomen/GI: Soft ☑ Nondistended ☑ Tender ☐ Firm ☐ Distended ☐ Bowel sounds asculated: Yes ☑ No ☐ Handedness Left ☐ Right ☑ Both ☐	**Suggested Vital Sign Routine:** 1. Every shift and PRN for first 72 hours. 2. If stable after 72 hours, per facility policy and procedures. **Suggested Vital Sign Interventions:** 1. If elevated temperature, MD notified and treatment instituted? N/A Yes ☐ No ☐ 2. Oxygen order of ____ amount ____ frequency ____ route 3. Is oxygen humidified? Yes ☐ No ☐ 4. Weight protocol implemented if weight loss is occurring Yes ☐ No ☐ 5. Call light, personal supplies, fluids, etc., placed appropriately Yes ☐ No ☐
ELIMINATION STATUS (H) Usual pattern before admittance to Nursing Home or Hospital. May require interview with caregiver, responsible party, etc. PE1.1.4 Date Completed: 03/21/06 Initials: mlc	**CONTINENCE** **BLADDER INCONTINENCE:** 4/c Continent ☐ Usually continent ☐ Occasionally continent ☑ Frequently incontinent ☐ Incontinent ☐ **BOWEL INCONTINENCE:** Continent ☑ Usually continent ☐ Occasionally continent ☐ Frequently incontinent ☐ Incontinent ☐ **APPLIANCES USED:** **BLADDER:** External catheter ☐ Indwelling catheter ☑ Size 16 Balloon 5 Intermittent Catheter Yes ☐ No ☐ If yes, order ____	1. If resident incontinent, referral to Bowel and Bladder Program? Yes ☑ No ☐ 2. Use of pads or briefs Yes ☐ No ☑ 3. Assistive devices needed: Type ____ Urinal ☐ Bedpan ☑ Bedside Commode ☐ 4. Any recent changes in status of incontinence? Yes ☑ No ☐ (Referral to B&B program) 5. Diagnosis for catheter use ____ 6. Digital check? Yes ☐ No ☑ If yes, results of check ____ 7. Further evaluation of incontinence needed? Yes ☑ No ☐ 8. Placed on Intake and Output for monitoring? Yes ☐ No ☑ 9. Timed toileting? Yes ☐ No ☑ 10. List any other aids used in elimination, ie., dietary supplement, exercise, etc. ____

RESIDENT'S NAME Peterson, William

MEDICAL RECORD # 1050

SPECIAL INSTRUCTIONS	SYSTEM REVIEW	NURSING INTERVENTION / INITIAL CARE PLAN
ELIMINATION STATUS (H) Usual pattern before admittance to Nursing Home or Hospital PE1.1.4 Date Completed: 03/21/06 Initials: nlh	**CONTINENCE (Cont.)** Ostomy Type N/A **BOWEL:** Ostomy Type N/A **BOWEL HABITS** Date of last BM Unknown USUAL ROUTINE: Time of Day God Frequency _____ Laxative use? Yes ☐ No ☐ Type _____ Freq. _____	
PHYSICAL FUNCTION AND STRUCTURAL PROBLEMS (G) Interview Resident or caregiver for information. Observe Resident's abilities. PE1.1.4 Date Completed: 03/21/06 Initials: nlh	**MOBILITY** **MODE OF LOCOMOTION:** Independent Ambulation Assisted Ambulation One ☐ Two ☑ Independent Bed Mobility Assisted Bed Mobility One ☑ Two ☐ ASSISTED DEVICES: Wheelchair ☑ Cane ☐ Geri-Chair ☐ Crutches ☐ Quad Cane ☐ Walker ☐ Brace/Splint ☐ Trapeze ☐ **MUSCULOSKELETAL** **UPPER EXTREMITIES:** Hand Grips Equal ☑ Unequal ☐ Limited Range Specify _____ Contracture or paralysis Specify Unable to Move legs Tremors ☐ Amputation ☐	1. Referral to Therapy for Screen or Evaluation? PT Yes ☑ No ☐ OT Yes ☑ No ☐ If no referral, why? 2. Referral to Restorative Nursing Program for Range of Motion? 3. Why does this resident require assist of 1 or 2 to transfer? post Surgical Surgery 4. What can the resident do to assist with transfer. (Be specific.)

SPECIAL INSTRUCTIONS	SYSTEM REVIEW	NURSING INTERVENTION / INITIAL CARE PLAN

PHYSICAL FUNCTION AND STRUCTURAL PROBLEMS
(G) Interview Resident or caregiver for information. Observe Resident's abilities.

PE1.1.6

Date Completed: 3/21/06
Initials: MLe

MUSCULOSKELETAL (Cont.)

~~LOWER~~ EXTREMITIES:
Limited Range
Specify post cervical surgery

Contracture or paralysis
Specify N/A unable to move leg

Amputation
Specify N/A

ORAL DYSFUNCTION SCORE: _____
No Dysfunction: 5 — Mild Disfunction: 6-10
Moderate Disfunction: 11-15 — Severe Dysfunction: 16-20

NO DYSFUNCTION – Maintain correct resident routine
Daily oral care by: Self ☐ Staff ☑

MILD DYSFUNCTION – Daily oral care by: Self ☐ Staff ☐

MODERATE DYSFUNCTION – Daily oral care by: Self ☐ Staff ☑
Consider nutrition texture changes ☐
Use soft brush or toothettes ☑
Use mouthwash ☑

SEVERE DYSFUNCTION – Daily oral care by: Self ☐ Staff ☐
Contact DDS for intervention ☐
Consider nutrition texture changes ☐
If pain present, treat ☐
Use soft brush or toothettes ☐
Use mouthwash ☐

ADL
(G) Interview Resident or spokesperson for Resident to obtain history and preferences

Date Completed: 03/21/06
Initials: MLe

PERSONAL HYGIENE

HAIR CARE:
Condition of hair (Describe)
Very short

Frequency prefers to have hair washed? NO
Requires assistance? Yes ☑ No ☐
Makeup preferences (Describe)

NAIL CARE:
Condition of fingernails (Describe)
long & dirty

Nail care preference?
Short ☐ Long ☑
Polished if applicable? Yes ☐ No ☑

ORAL CARE:
Natural Teeth ☐
Broken or missing teeth ☑
Upper ☑ Lower ☑ Partial ☐
Preferred use of dentures:
At all times ☐ When OOB only ☐
Meals only ☐ Never ☑
Product used NO dentures

Last dental visit unknown

Category	Rating	1	2	3	4
Lips	1 2 3 4	Smooth, pink moist, and intact	Slightly wrinkled and dry; one or more isolated reddened areas	Dry and somewhat swollen; may have one or two isolated blisters; inflammatory line of demarcation	Very dry and edematous; entire lip inflamed; generalized blisters or ulceration
Gingiva and Oral Mucosa	1 2 3 4	Smooth, pink moist, and intact	Pale and slightly dry; one or two isolated lesions, blisters or reddened areas	Dry and somewhat swollen; generalized redness; more than two isolated lesions, blisters, or reddened areas	Very dry and edematous; entire mucosa very red and inflamed; multiple confluent ulcers
Tongue	1 2 3 4	Smooth, pink moist, and intact	Slightly dry; one or two isolated reddened areas; papillae prominent particularly at base	Dry and somewhat swollen; generalized redness but tip and papillae are redder; one or two isolated lesions or blisters	Very dry and edematous; thick and engorged; entire tongue very inflamed; tip very red and demarcated with coating; multiple blisters or ulcers
Teeth	1 2 3 4	Clean; no debris N/A	Minimal debris; mostly between teeth	Moderate debris clinging to 1/2 of visible enamel	Teeth covered with debris
Saliva	1 2 3 4	Thin, watery, plentiful	Increase in amount	Saliva scanty and may be somewhat thicker than normal	Saliva thick and ropy, viscid or mucid

RESIDENT'S NAME: Peterson, William — MEDICAL RECORD: 1050

SPECIAL INSTRUCTIONS	SYSTEM REVIEW	NURSING INTERVENTION / INITIAL CARE PLAN

ADL
(G) Interview Resident or spokesperson for Resident to obtain history and preferences

Date Completed: 03/21/06
Initials: Linda

PERSONAL HYGIENE (Cont.)

BATHING:
Bathing preference: Shower ☑ Tub bath ☐
Usual bath time: AM ☑ PM ☐
Independent? Yes ☐ No ☑
Requires assistance? Yes ☑ No ☐

SHAVING:
Facial hair present? Yes ☑ No ☐
Shaving preference: Shave Daily ☐ Shave PRN ☑
Moustache Yes ☑ No ☐
Beard Yes ☐ No ☑
Other _____

1. Beauty Shop routine explained? Yes ☐ No ☑
2. Beauty Shop notified if necessary Yes ☐ No ☑
3. Dentures marked? Yes ☐ No ☑
4. Dental referral recommended? Yes ☐ No ☑
5. Clothing marked and added to personal inventory list? Yes ☐ No ☐
6. Laundry by: Facility ☑ Family ☐
7. Electric Razor marked? Yes ☐ No ☑
8. Any clothing needs referred to Social Services? Yes ☐ No ☑
9. Showers or baths scheduled? Yes ☐ No ☐

SKIN CONDITION
(M 1.2.4.5.6)

SKIN CONDITION

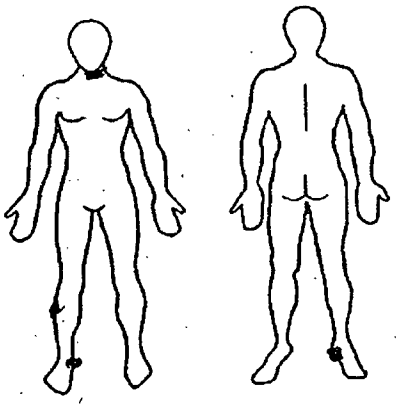
Warm Yes ☑ No ☐
Dry Yes ☑ No ☐
Color (Describe) _____
Turgor Good ☑ Poor ☐
Edema Yes ☐ No ☑
Pitting Yes ☐ No ☑
Describe _____

SKIN INTEGRITY BREAKS:
Pressure Areas? Yes ☑ No ☐
Location R heel Stage ____
Location _____ Stage ____
Location _____ Stage ____
Location _____ Stage ____

Stasis Ulcers? Yes ☐ No ☐
Location _____ Size ____
Location _____ Size ____
Location _____ Size ____
Location _____ Size ____

OTHER SKIN CONDITIONS:
Abrasion ☐ Bruise ☐
Burn ☐ Rash ☐
Skin Tears
Description incision / drsg.
~~Description~~ collar
~~Description~~ neck

1. Pressure reduction device needed? heel pads
   Yes ☐ No ☐
   Bed Yes ☐ No ☐
   Chair Yes ☐ No ☐



2. Turning and repositioning program? Yes ☑ No ☐
3. Treatment order obtained if needed? _____
4. Wound care protocol implemented? Yes ☑ No ☐
5. Referral to Registered Dietician? Yes ☑ No ☐
6. Referral to Podiatrist? Yes ☐ No ☐
7. Referral for pain management? Yes ☐ No ☐
8. Usual method of relieving pain _____

PE1.1.6

Date Completed: 03/21/06
Initials: Linda

SPECIAL INSTRUCTIONS	SYSTEM REVIEW	NURSING INTERVENTION / INITIAL CARE PLAN
SKIN CONDITION (M1.2.4.5.6) Date Completed: 03/21/06 Initials: mh	**SKIN CONDITION (Cont.)** TED HOSE **FEET:** Bunion Yes ☐ No ☐ Corns or Calluses Yes ☐ No ☐ Toe Nails: Clean ☐ Clipped ☐ Thick ☐ Fungus ☐	
PAIN Date Completed: 03/21/06 Initials: mh	**PAIN** Resident complains of pain? Some Yes ☑ No ☐ Pain location: _____ _____ _____	1. Non-pharmacological interventions are in place Yes ☑ No ☐ Positioning ☑ Support affected painful area ☑ Hot/Cold applications ☐ Medications ☐ Relaxation ☐ Other ☐ Describe: _____ _____ 2. Pharmacological interventions are in place and on-going assessment? Yes ☐ No ☐ Medication: _____ _____
NUTRITIONAL AND ORAL STATUS (K1.5) PE1.1.4 Date Completed: 03/21/06 Initials: mh	**NUTRITIONAL AND ORAL STATUS** Post cervical spine surgery Swallowing Difficulties? Yes ☐ No ☑ Chewing difficulties? Yes ☐ No ☑ Diet Reg. Pureed Texture: Regular ☑ Mechanical ☐ Soft ☐ Puree ☑ Intake: PO ☑ NG ☐ GT ☐ TPN ☐ Eating Skills: Independent Yes ☑ No ☐ Assist Yes ☑ No ☐ Total Assist Yes ☐ No ☐ Adaptive Equipment? Yes ☐ No ☐ Describe _____ _____ Nutritional Supplement? Yes ☐ No ☑ Type _____ _____	1. Referral to Speech Therapy for evaluation? Yes ☐ No ☑ 2. Referral to Registered Dietician for evaluation? Yes ☐ No ☑ 3. Referral to Occupational Therapist for evaluation? Yes ☐ No ☑ 4. Referral to Restorative Feeding Program? Yes ☐ No ☑ 5. Resident should be placed on Intake and Output? Yes ☐ No ☑ 6. If fluid restriction, how much allowed each shift? 7 - 3 _____ 3 - 11 _____ 11 - 7 _____ 7. Enteral Directions: _____ _____ _____

RESIDENT'S NAME: Peterson, William

MEDICAL RECORD #

SPECIAL INSTRUCTIONS	SYSTEM REVIEW	NURSING INTERVENTION / INITIAL CARE PLAN
SPECIAL TREATMENTS AND PROCEDURES (P1) PE1.1.1 Date Completed: 03/21/06 Initials: mk	**SPECIAL TREATMENTS** YES / NO Chemotherapy ☐ ☑ Dialysis ☐ ☐ IV Medication ☐ ☑ Intake and Output ☐ ☐ Ostomy Care ☐ ☑ Oxygen Therapy ☐ ☑ Radiation Therapy ☐ ☑ Suctioning ☐ ☑ Tracheostomy Care ☐ ☑ Ventilator or Respirator ☐ ☑ TB Testing ☐ ☐ When: 03/17/06 Influenza Vaccination ☐ ☐ When: _____ Pneumonia Vaccination ☐ ☐ When: _____	1. Appropriate Diet for Dialysis? Yes ☐ No ☐ 2. If Oxygen used, Tank ☐ Concentrator ☐ 3. Suction machine set up? Yes ☐ No ☐ 4. Referral to Respiratory Therapy? Yes ☐ No ☐ 5. TB testing set up? Yes ☐ No ☐ 6. Influenza Vaccination consent received? Yes ☐ No ☐ 7. Pneumonia Vaccine consent received? Yes ☐ No ☐
MEDICATIONS (O) Diuretics, Cardiac Meds, Oral Hypoglycemics, Insulin, Seizure Meds, Antibiotics, Review medications as ordered PE1.1.1 Date Completed: 03/21/06 Initials: mk	**MEDICATIONS** Allergies: Meds NKA Food NKA Other _____	1. Resident receiving hypertensive Medications? Yes ☑ No ☐ Blood Pressure monitoring? Yes ☐ No ☐ 2. Resident receiving cardiac Medications? Yes ☐ No ☑ Pulse monitoring? Yes ☐ No ☐ 3. Resident is Diabetic? Yes ☐ No ☑ Chem BGs monitored? Yes ☐ No ☐ 4. Resident has seizure disorder? Yes ☐ No ☑ Seizure monitoring Implemented? Yes ☐ No ☐ 5. Resident receiving Antibiotic therapy? Yes ☐ No ☑ Temperature monitored during treatment? Yes ☐ No ☐ 6. Appropriate Labs ordered? Yes ☐ No ☐

ASSESSMENT COMPLETED BY:

Print Name Margaret Capell, RN

Signature Margaret Capell, RN

Title ADON Date 03/21/06

RESIDENT'S NAME Peterson, William

MEDICAL RECORD 1050

Resident Risk Assessment Profile

*If you trigger any of the (*) areas, you must care plan for high risk.

Assessment Question			Answer	Nutrition	Dehydration	Elopement	Fall	Skin	Contracture	Poly Pharm	Impaction	Restraint	Entrapment	Pain
Age	> 80	4	4	4	4		4		4	4	4			
	65-79	3												
	50-64	2												
Mental Status	B6 Deterioration of cognitive status	2	2				2	2	2	2				
	Disoriented to Person	2												
	Disoriented to Place	2	2	2	2	2	2				2	2		
	Disoriented to Time	2	2	2	2	2	2				2	2		
	Confused or Sedated	3	3	3	3	3	3		3		3	3		
	Delusional	2												
Behaviors	Exit Seeking	2												
	***Hx of Elopement**	2												
	Verbalizations of wanting to go home	1												
	***Hx of Falls in last month**	5												
	Hx of more than one fall in last 6 months	3												
	Prefers to sit on floor	1												
	Resists Care	1												
	Strikes out	1												
	***P4c Daily trunk restraint**	3												
Communication	Wears glasses	1												
	Poor / blind eyesight without glasses	2	2	2	2		2						2	
	Aphasic	2												
	Speech slurred	1												
	Different language other than English	1												
	HOH either ear	1	1	1	1		1							
ROM	***Upper Limited**	2												
	Upper Immobile	2												
	***Lower Limited**	2	2				2		2		2	2	2	
	Lower Immobile	2												
	Poor Balance while sitting	2	2	2	2		2		2		2	2	2	
	Poor Balance while standing	2	2				2		2		2	2	2	
Mobility	Amputation	2												
	Cane	2												
	Prothesis	2												
	Wheelchair	2	2				2		2		2	2		
	Walker	2												
	Ataxia or shuffles feet	2												
	***G1aA Bed mobility self performance**	2,3,4	4				4	4	4			4		
	G1bA Transfer self performance	2,3,4	4				4	4	4			4		
	***G6a Bed fast**	1												
Bowel & Bladder	H1b Bladder Incontinence	2,3,4	2				2	2			2		2	
	Incontinent of bowel	3												
	***Hx of impaction**	2												
Eating & Drinking	Texture of diet altered	2	2	2	2						2			
	Calories of diet altered	2												
	Eats <75% or refuses to eat	2	2	2	2						2			
	***Unintended weight loss**	3												
	Tube feeding	3												
	Dx of dehydration	2												

TN RRA 4E 03/21/2006

*If you trigger any of the (*) areas, you must care plan for high risk.

Assessment Question			Answer	Nutrition	Dehydration	Elopement	Fall	Skin	Contracture	Poly Pharm	Impaction	Restraint	Entrapment	Pain
Eating & Drinking (Cont.)	(error) Dx of malnutrition / anemia	2	2	2	2		2			2	2			
	(error) Limits self on food choices	1	1	1	1						1			
	Limits self on drink choices	1	1											
	Poor dentition/missing teeth/dentures	2	2	2	2									
	(error) K2a or K2b BMI under 23	1	1											
	Weight < 100 lbs.	2												
	Weight > 300 lbs.	1												
Skin Condition	Areas red or mottled or edematous	2	2	2	2			2						
	*M4e Skin desensitized to pain	1	1	1	1			1						
	*M2a Pressure ulcer present	1	1	1	1			1						
	*M3 Hx of resolved pressure ulcer	1												
Medication Usage	*Uses more than 8 meds	1												
	Diuretic	2												
	Analgesics	1												
	Antihypertensive	2	2		2		2			2	2	2	2	
	Sedatives	2												
	Antipsychotics	2												
	Antidepressants	2												
	Hypnotic	2												
	Antianxiety	2												
Diseases	Dementia / delirium	3	3	3	3		3		3	3	3	3	3	
	BP / cardiac / pulmonary	2	2	2	2		2		2	2	2			
	Mental illness	3												
	I1a Diabetes	3												
	*I1j Peripheral vascular disease	1												
	Post hospitalization	1	1	1	1	1	1		1	1	1	1	1	
	J4c Hip fx last 180 days	5												
	Osteoarthritis / Arthritis	1												
	J5c Endstage disease or malignancy	1												
	J2a Pain Frequency	0,1,2	2	2	2	2	2		2	2	2	2	2	
	J2b Pain Intensity	1,2,3	1	1	1	1	1		1	1	1	1	1	
Movement Scale – 0 (no movement) to 4 (severe movement)														
Facial and Oral	Facial Expression	0-4												
	Lips and Periorbital	0-4												
	Jaw	0-4												
	Tongue	0-4												
Extremity	Upper Torso	0-4												
	Lower Torso	0-4	4				4		4	4		4	4	
Global	Incapacitation	0-4												
	Total AIM Score →													
Totals	Add column													
	Divide by possible			51	47	23	64	15	42	33	46	47	41	21
Risk Levels	High > 68%													
	Moderate 34% to 67%													
	Low < 33%													

Completed by: Margaret Capell, RN Date: 03/21/06

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ABNORMAL INVOLUNTARY MOVEMENT SCALE

INSTRUCTIONS: Complete examination before making rating. Have resident sit in a chair without arms and ask them to let their arms dangle. Ask resident to stand up and walk.

CODE: 0 = NONE 1 = MINIMAL 3 = MODERATE 4 = SEVERE

Facial and Oral Movements	**Muscles of Facial Expression** – forehead, eyebrow, periorbital areas, smile, frown
	Lips and Perioral Area – puckering, chewing, pouting, smacking
	Jaw – biting, clenching, internal movements, opening
	Tongue – only increase in movement ability
Extremity Movements	**Upper Torso (arms, wrists, hands, neck, shoulders)** – purposeless movements not regular tremors
	Lower Torso (hips, legs, knees, ankles, toes) – knee lateral, foot tapping/inversion/aversion, pelvic gyrations
Incapacitation	**Resident awareness of abnormal movements** 0 = no awareness 1 = aware no distress 2 = aware mild distress 3 = aware moderate distress 4 = aware severe distress

***Place score on previous page.**

Pain Risk Scale	Frequency	Intensity
No pain	0	0
Pain less than daily, if mild	1	2
Pain less than daily, if moderate	1	3
Pain less than daily, if excruciating	1	4
Pain daily, if mild	2	3
Pain daily, if moderate	2	4
Pain daily, if excruciating	2	5

Pressure Ulcer RAP Item

Any of the items listed below that are checked on your Resident Risk Assessment Profile indicate either an existing pressure ulcer or risk for pressure ulcer. Care plan for treatment/prevention.

MDS ITEM	DESCRIPTION
M2a	Pressure Ulcer present
I1j	Peripheral Vascular Disease
M3	History of resolved pressure ulcer
M4e	Skin desensitized to pain
G1aA	Bed Mobility
G6a	Bedfast
P4c	Daily trunk restraint

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Numeric Identifier (7-30-6586

MINIMUM DATA SET (MDS) - VERSION 2.0

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

REENTRY TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME*	WILLIAM PETERSON a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)	
2.	GENDER*	1. Male 2. Female	1
3.	BIRTHDATE*	[redacted] Month Day Year	
4.	RACE/ ETHNICITY*	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin	3
5.	SOCIAL SECURITY* AND MEDICARE NUMBERS* [C in 1st box if non med. no.]	a. Social Security Number [redacted] b. Medicare number (or comparable railroad insurance number) [redacted]	
6.	FACILITY PROVIDER NO.*	a. State No. 0 5 9 1 N H b. Federal No. 4 2 5 2 9 3	
7.	MEDICAID NO. ["+" if pending, "N" if not a Medicaid recipient]*		
8.	REASONS FOR ASSESSMENT	[Note - Other codes do not apply to this form] a. Primary reason for assessment 9. Reentry	09

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

4a.	DATE OF REENTRY	Date of reentry 0 3 - 2 1 - 2 0 0 6 Month Day Year	
4b.	ADMITTED FROM (AT REENTRY)	1. Private home/apt. with no home health services 2. Private home/apt. with home health services 3. Board and care/assisted living/group home 4. Nursing home 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Other	5
6.	MEDICAL RECORD NO.	1 0 5 0	

9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form

I certify that accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature and Title	Sections	Date
a. Kathleen Dykes LPN ASA		3/22/06
b.		
c.		

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Resident WILLIA PETERSON Numeric Identifier 7-30-6586

SECTION W. SUPPLEMENTAL MDS ITEMS

1.	National Provider ID	Enter for all assessments and tracking forms, if available. ☐☐☐☐☐☐☐☐☐☐	
If the ARD of this assessment or the discharge date of this discharge tracking form is between July 1 and September 30, skip to W3.			
2.	Influenza Vaccine	a. Did the resident receive the influenza vaccine in this facility for this year's influenza season (October 1 through March 31)? 0. No (If No, go to item W2b) 1. Yes (If Yes, go to item W3) b. If influenza vaccine not received, state reason: 1. Not in facility during this year's flu season 2. Received outside of this facility 3. Not eligible 4. Offered and declined 5. Not offered 6. Inability to obtain vaccine	
3.	Pneumo-coccal Vaccine	a. Is the resident's PPV status up to date? 0. No (If No, go to item W3b) 1. Yes (If Yes, skip item W3b) b. If PPV not received, state reason: 1. Not eligible 2. Offered and declined 3. Not offered	

Generic Identifier 2 0-6586

MINIMUM DATA SET (MDS) - VERSION 2.0
FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BASIC ASSESSMENT TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME*	WILLIAM PETERSON a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2.	GENDER*	1. Male 2. Female — 1
3.	BIRTHDATE*	[redacted] Month Day Year
4.	RACE/* ETHNICITY	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin — 3
5.	SOCIAL SECURITY AND MEDICARE NUMBERS*	a. Social Security Number [redacted] b. Medicare number (or comparable railroad insurance number) [redacted]
6.	FACILITY PROVIDER NO.*	a. State No. 0 5 9 1 N H b. Federal No. 4 2 5 2 9 3
7.	MEDICAID NO. ["+" *if pending, "N" if not a Medicaid recipient*]*	
8.	REASONS FOR ASSESSMENT	(Note - Other codes do not apply to this form) a. Primary reason for assessment — 00 01. Admission assessment (required by day 14) 02. Annual assessment 03. Significant change in status assessment 04. Significant correction of prior full assessment 05. Quarterly review assessment 10. Significant correction of prior quarterly assessment 00. *NONE OF ABOVE* *b. Codes for assessments required for Medicare PPS or the State* — 5 *1. Medicare 5 day assessment* *2. Medicare 30 day assessment* *3. Medicare 60 day assessment* *4. Medicare 90 day assessment* *5. Medicare readmission/return assessment* *6. Other state required assessment* *7. Medicare 14 day assessment* *8. Other Medicare required assessment*

9.	Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form	
	I certify that accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.	
	Signature and Title	Sections / Date
a.	Kathleen Dykes MARSH HUMOPOIES	3/27/06
b.	Mattie Gordon Dom IC	3/27/06
c.	Sharon Nicholson SS	8+9 3/27/06
d.	Leonie Dunston WCN	3/27/06
e.		
f.		
g.		
h.		
i.		
j.		
k.		
l.		

GENERAL INSTRUCTIONS

Complete this information for submission with all full and quarterly assessments (Admission, Annual, Significant Change, State or Medicare required assessments, or Quarterly Reviews, etc.)

* = Key items for computerized resident tracking

Resident WILLIA PETERSON ( ) heric Identifier 2 ( )-6586

MINIMUM DATA SET (MDS) - VERSION 2.0

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

FULL ASSESSMENT FORM

(Status in last 7 days, unless other time frame indicated)

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1.	RESIDENT NAME	WILLIAM PETERSON a.(First) b.(Middle Initial) c.(Last) d.(Jr/Sr)	
2.	ROOM NUMBER	P 2 1 4 D	
3.	ASSESSMENT REFERENCE DATE	a. *Last day of MDS observation period* 0 3 - 2 5 - 2 0 0 6 Month Day Year b. Original (0) or corrected copy of form (enter number of correction)	0
4a.	DATE OF REENTRY	Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days) 0 3 - 2 1 - 2 0 0 6 Month Day Year	
5.	MARITAL STATUS	1. Never married 3. Widowed 5. Divorced 2. Married 4. Separated	3
6.	MEDICAL RECORD NO.	1 0 5 0	
7.	CURRENT PAYMENT SOURCES FOR N. H. STAY	*(Billing Office to indicate; check all that apply in last 30 days)* a. Medicaid per diem [a.] b. Medicare per diem [b. ✓] c. Medicare ancillary part A [c.] d. Medicare ancillary part B [d.] e. CHAMPUS per diem [e.] f. VA per diem [f.] g. Self or family pays for full per diem [g.] h. Medicaid resident liability or Medicare co-payment [h.] i. Private insurance per diem (including co-payment) [i.] j. Other per diem [j.]	
8.	REASONS FOR ASSESSMENT *[Note - If this is a discharge or reentry assessment, only a limited subset of MDS items need be completed]*	a. Primary reason for assessment 01. Admission assessment (required by day 14) 02. Annual assessment 03. Significant change in status assessment 04. Significant correction of prior full assessment 05. Quarterly review assessment 06. Discharged - return not anticipated 07. Discharged - return anticipated 08. Discharged prior to completing initial assessment 09. Reentry 10. Significant correction of prior quarterly assessment 00. *NONE OF ABOVE* b. ***Codes for assessments required for Medicare PPS or the State*** *1. Medicare 5 day assessment* *2. Medicare 30 day assessment* *3. Medicare 60 day assessment* *4. Medicare 90 day assessment* *5. Medicare readmission/return assessment* *6. Other state required assessment* *7. Medicare 14 day assessment* *8. Other Medicare required assessment*	00 5
9.	RESPONSIBILITY/ LEGAL GUARDIAN	*(Check all that apply)* a. Legal guardian [a.] b. Other legal oversight [b.] c. Durable power of attorney/health care [c.] d. Durable power of attorney/financial [d.] e. Family member responsible [e. ✓] f. Patient responsible for self [f.] g. *NONE OF ABOVE* [g.]	
10.	ADVANCED DIRECTIVES	*(For those items with supporting documentation in the medical record, check all that apply)* a. Living will [a.] b. Do not resuscitate [b. ✓] c. Do not hospitalize [c.] d. Organ donation [d.] e. Autopsy request [e.] f. Feeding restrictions [f. ✓] g. Medication restrictions [g.] h. Other treatment restrictions [h. ✓] i. *NONE OF ABOVE* [i.]	

SECTION B. COGNITIVE PATTERNS

1.	COMATOSE	*(Persistent vegetative state/no discernible consciousness)* 0. No 1. Yes (If yes, skip to Section G)	0
2.	MEMORY	*(Recall of what was learned or known)* a. Short-term memory OK-seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem b. Long-term memory OK-seems/appears to recall long past 0. Memory OK 1. Memory problem	1 1
3.	MEMORY/ RECALL ABILITY	*(Check all that resident was normally able to recall during last 7 days)* a. Current season [a.] b. Location of own room [b.] c. Staff names/faces [c.] d. That he/she is in a nursing home [d. ✓] e. *NONE OF ABOVE* are recalled [e.]	
4.	COGNITIVE SKILLS FOR DAILY DECISION-MAKING	*(Made decisions regarding tasks of daily life)* 0. *INDEPENDENT*-decisions consistent/reasonable 1. *MODIFIED INDEPENDENCE*-some difficulty in new situations only 2. *MODERATELY IMPAIRED*-decisions poor; cues/supervision required 3. *SEVERELY IMPAIRED* - never/rarely made decisions	2
5.	INDICATORS OF DELIRIUM - PERIODIC DISORDERED THINKING/ AWARENESS	*(Code for behavior in the last 7 days.) [Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time].* 0. Behavior not present 1. Behavior present, not of recent onset 2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening) a. EASILY DISTRACTED-(e.g., difficulty paying attention; gets sidetracked) b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS-(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day) c. EPISODES OF DISORGANIZED SPEECH-(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought) d. PERIODS OF RESTLESSNESS-(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out) e. PERIODS OF LETHARGY-(e.g., sluggishness; staring into space, difficult to arouse; little body movement) f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY-(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)	0 0 0 0 1
6.	CHANGE IN COGNITIVE STATUS	Resident's cognitive status, skills, or abilities have changed as compared to status of **90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	0

SECTION C. COMMUNICATION/HEARING PATTERNS

1.	HEARING	*(With hearing appliance, if used)* 0. *HEARS ADEQUATELY*-normal talk, TV, phone 1. *MINIMAL DIFFICULTY* when not in quiet setting 2. *HEARS IN SPECIAL SITUATIONS ONLY*-speaker has to adjust tonal quality and speak distinctly 3. *HIGHLY IMPAIRED*/absence of useful hearing	2
2.	COMMUNICATION DEVICES/ TECHNIQUES	*(Check all that apply during last 7 days)* a. Hearing aid, present and used [a.] b. Hearing aid, present and not used regularly [b.] c. Other receptive comm. techniques used (e.g., lip reading) [c.] d. *NONE OF ABOVE* [d. ✓]	
3.	MODES OF EXPRESSION	*(Check all used by resident to make needs known)* a. Speech [a. ✓] b. Writing messages to express or clarify needs [b.] c. American sign language or Braille [c.] d. Signs/gestures/sounds [d. ✓] e. Communication board [e.] f. Other [f.] g. *NONE OF ABOVE* [g.]	
4.	MAKING SELF UNDERSTOOD	*(Expressing information content - however able)* 0. *UNDERSTOOD* 1. *USUALLY UNDERSTOOD*-difficulty finding words or finishing thoughts 2. *SOMETIMES UNDERSTOOD*-ability is limited to making concrete requests 3. *RARELY/NEVER UNDERSTOOD*	1
5.	SPEECH CLARITY	*(Code for speech in the last 7 days)* 0. *CLEAR SPEECH* - distinct, intelligible words 1. *UNCLEAR SPEECH* - slurred, mumbled words 2. *NO SPEECH* - absence of spoken words	0
6.	ABILITY TO UNDERSTAND OTHERS	*(Understanding verbal information content-however able)* 0. *UNDERSTANDS* 1. *USUALLY UNDERSTANDS*-may miss some part/intent of message 2. *SOMETIMES UNDERSTANDS*-responds adequately to simple, direct communication 3. *RARELY/NEVER UNDERSTANDS*	2
7.	CHANGE IN COMMUNICATION/ HEARING	Resident's ability to express, understand, or hear information has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	0

IMH&R of Edgefield 03/21/2006 05/25/2006 0153

Resident WILLI/ PETERSON ( ) eric Identifier 30-6586

SECTION D. VISION PATTERNS

1.	VISION	*(Ability to see in adequate light and with glasses if used)* 0. *ADEQUATE* - sees fine detail, including regular print in newspapers/books 1. *IMPAIRED* - sees large print, but not regular print in newspapers/books 2. *MODERATELY IMPAIRED* - limited vision; not able to see newspaper headlines, but can identify objects 3. *HIGHLY IMPAIRED* - object identification in question, but eyes appear to follow objects 4. *SEVERELY IMPAIRED* - no vision or sees only light, colors, or shapes; eyes do not appear to follow objects	0
2.	VISUAL LIMITATIONS/ DIFFICULTIES	a. Side vision problems - decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self) b. Experiences any of following: sees halos or rings around lights; sees flashes of light; sees "curtains" over eyes c. *NONE OF ABOVE*	a. b. c. ✓
3.	VISUAL APPLIANCES	Glasses; contact lenses; magnifying glass 0. No 1. Yes	0

SECTION E. MOOD AND BEHAVIOR PATTERNS

1.	INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	***(Code for indicators observed in last 30 days, irrespective of the assumed cause)*** 0. Indicator not exhibited in last 30 days 1. Indicator of this type exhibited up to five days a week 2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)	
		VERBAL EXPRESSIONS OF DISTRESS	
		a. Resident made negative statements-e.g. *"Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die"*	0
		b. Repetitive questions-e.g., *"Where do I go; What do I do?"*	0
		c. Repetitive verbalizations-e.g.,calling out for help, *("God help me")*	0
		d. Persistent anger with self or others-e.g.,easily annoyed, anger at placement in nursing home; anger at care received	0
		e. Self deprecation-e.g., *"I am nothing; I am of no use to anyone"*	0
		f. Expressions of what appear to be unrealistic fears-e.g.,fear of being abandoned, left alone, being with others	0
		g. Recurrent statements that something terrible is about to happen-e.g., believes he or she is about to die, have a heart attack	0
		h. Repetitive health complaints-e.g.,persistently seeks medical attention, obsessive concern with body functions	0
		i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/ reassurance regarding schedules, meals, laundry, clothing, relationship issues	0
		SLEEP-CYCLE ISSUES	
		j. Unpleasant mood in morning	0
		k. Insomnia/change in usual sleep pattern	0
		SAD, APATHETIC, ANXIOUS APPEARANCE	
		l. Sad, pained, worried facial expressions-e.g., furrowed brows	0
		m. Crying, tearfulness	0
		n. Repetitive physical movements-e.g., pacing, hand wringing, restlessness, fidgeting, picking	0
		LOSS OF INTEREST	
		o. Withdrawal from activities of interest - e.g., no interest in long standing activities or being with family/friends	0
		p. Reduced social interaction	0
2.	MOOD PERSISTENCE	One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days 0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered	0
3.	CHANGE IN MOOD	Resident's mood status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	0
4.	BEHAVIORAL SYMPTOMS	(A) *Behavioral symptom frequency in last 7 days* 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred 1 to 3 days in last 7 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily (B) *Behavioral symptom alterability in last 7 days* 0. Behavior not present OR behavior was easily altered 1. Behavior was not easily altered	

	(A)	(B)
a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)	0	0
b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)	0	0
c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)	0	0
d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/ feces, hoarding, rummaged through others' rooms/ belongings)	0	0
e. RESISTS CARE (resisted taking medications/injections, ADL assistance, or eating)	0	0

5.	CHANGE IN BEHAVIORAL SYMPTOMS	Resident's behavior status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	0

SECTION F. PSYCHOSOCIAL WELL-BEING

1.	SENSE OF INITIATIVE/ INVOLVEMENT	a. At ease interacting with others	a. ✓
		b. At ease doing planned or structured activities	b.
		c. At ease doing self-initiated activities	c.
		d. Establishes own goals	d.
		e. Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services)	e.
		f. Accepts invitations into most group activities	f.
		g. *NONE OF ABOVE*	g.
2.	UNSETTLED RELATIONSHIPS	a. Covert/open conflict with or repeated criticism of staff	a.
		b. Unhappy with roommate	b.
		c. Unhappy with residents other than roommate	c.
		d. Openly expresses conflict/anger with family/friends	d.
		e. Absence of personal contact with family/friends	e.
		f. Recent loss of close family member/friend	f.
		g. Does not adjust easily to change in routines	g. ✓
		h. *NONE OF ABOVE*	h.
3.	PAST ROLES	a. Strong identification with past roles and life status	a.
		b. Expresses sadness/anger/empty feeling over lost roles/status	b.
		c. Resident perceives that daily routine (customary routine, activities) is very different from prior pattern in the community	c.
		d. *NONE OF ABOVE*	d. ✓

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. (A) ADL SELF-PERFORMANCE-***(Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days - Not including setup)***
0. *INDEPENDENT* - No help or oversight - OR - Help/oversight provided only 1 or 2 times during last 7 days
1. *SUPERVISION* - Oversight, encouragement or cueing provided 3 or more times during last 7 days - OR - Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
2. *LIMITED ASSISTANCE* - Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times - OR - More help provided only 1 or 2 times during last 7 days
3. *EXTENSIVE ASSISTANCE* - While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
--Weight bearing support
--Full staff performance during part (but not all) of last 7 days
4. *TOTAL DEPENDENCE* - Full staff performance of activity during entire 7 days
8. *ACTIVITY DID NOT OCCUR* during entire 7 days

(B) ADL SUPPORT PROVIDED - ***(Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification)***
0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist
8. ADL activity itself did not occur during entire 7 days

			(A) SELF-PERF	(B) SUPPORT
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed	3	2
b.	TRANSFER	How resident moves between surfaces - to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)	4	3
c.	WALK IN ROOM	How resident walks between locations in his/her room	8	8
d.	WALK IN CORRIDOR	How resident walks in corridor on unit	8	8
e.	LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	4	2
f.	LOCOMOTION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair	8	
g.	DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis	3	
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g.,tube feeding, total parenteral nutrition)	3	
i.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal): transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes	3	
j.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)	3	

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2.	BATHING	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) *Code for most dependent in self-performance and support.* (A) BATHING SELF-PERFORMANCE codes appear below: 0. Independent - No help provided; 1. Supervision - Oversight help only; 2. Physical help limited to transfer only; 3. Physical help in part of bathing activity; 4. Total dependence; 8. Activity itself did not occur during entire 7 days. *(Bathing support codes are as defined in Item 1,code B above)*	(A) 3 (B) 2
3.	TEST FOR BALANCE (see training manual)	*(Code for ability during test in the last 7 days)* 0. Maintained position as required in test; 1. Unsteady, but able to rebalance self without physical support; 2. Partial physical support during test; or stands (sits) but does not follow directions for test; 3. Not able to attempt test without physical help	
		a. Balance while standing	3
		b. Balance while sitting - position, trunk control	3
4.	FUNCTIONAL LIMITATION IN RANGE OF MOTION (see training manual)	*(Code for limitations during last 7 days that interfered with daily functions or placed resident at risk of injury)* (A) *RANGE OF MOTION*: 0. No limitation; 1. Limitation on one side; 2. Limitation on both sides. (B) *VOLUNTARY MOVEMENT*: 0. No loss; 1. Partial loss; 2. Full loss	(A) (B)
		a. Neck	2 0
		b. Arm - including shoulder or elbow	2 1
		c. Hand - including wrist or fingers	0 0
		d. Leg - including hip or knee	2 2
		e. Foot - including ankle or toes	2 2
		f. Other limitation or loss	0 0
5.	MODES OF LOCOMOTION	*(Check all that apply during last 7 days)* a. Cane/walker/crutch; b. Wheeled self; c. Other person wheeled ✓; d. Wheelchair primary mode of locomotion; e. *NONE OF ABOVE*	
6.	MODES OF TRANSFER	*(Check all that apply during last 7 days)* a. Bedfast all or most of time ✓; b. Bed rails used for bed mobility or transfer ✓; c. Lifted manually; d. Lifted mechanically; e. Transfer aid (e.g., slide board, trapeze, cane, walker, brace); f. *NONE OF ABOVE*	
7.	TASK SEGMENTATION	Some or all of ADL activities were broken into subtasks during last 7 days so that resident could perform them. 0. No 1. Yes	0
8.	ADL FUNCTIONAL REHABILITATION POTENTIAL	a. Resident believes he/she is capable of increased independence in at least some ADLs; b. Direct care staff believe resident is capable of increased independence in at least some ADLs; c. Resident able to perform tasks/activity but is very slow; d. Difference in ADL Self-Performance or ADL Support, comparing mornings to evenings; e. *NONE OF ABOVE* ✓	
9.	CHANGE IN ADL FUNCTION	Resident's ADL self-performance status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	0

SECTION H. CONTINENCE IN LAST 14 DAYS

1.	CONTINENCE SELF-CONTROL CATEGORIES *(Code for resident's PERFORMANCE OVER ALL SHIFTS)* 0. *CONTINENT* - Complete control *(includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool)*; 1. *USUALLY CONTINENT* - BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly; 2. *OCCASIONALLY INCONTINENT* - BLADDER, 2 or more times a week but not daily; BOWEL, once a week; 3. *FREQUENTLY INCONTINENT* - BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week; 4. *INCONTINENT* - Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time	
a.	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed	4
b.	BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed	0
2.	BOWEL ELIMINATION PATTERN	a. Bowel elimination pattern regular - at least one movement every three days ✓; b. Constipation; c. Diarrhea; d. Fecal impaction; e. None of the above	c. d.

3.	APPLIANCES AND PROGRAMS	a. Any scheduled toileting plan ✓; b. Bladder retraining program; c. External (condom) catheter; d. Indwelling catheter ✓; e. Intermittent catheter; f. Did not use toilet room/commode/urinal ✓; g. Pads/briefs used ✓; h. Enemas/irrigation; i. Ostomy present; j. *NONE OF ABOVE*	
4.	CHANGE IN URINARY CONTINENCE	Resident's urinary continence has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	0

SECTION I. DISEASE DIAGNOSES

Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses)

1. DISEASES *(If none apply, CHECK the NONE OF ABOVE box)*

ENDOCRINE/METABOLIC/NUTRITIONAL
- a. Diabetes mellitus
- b. Hyperthyroidism
- c. Hypothyroidism

HEART/CIRCULATION
- d. Arteriosclerotic heart disease (ASHD)
- e. Cardiac dysrhythmias
- f. Congestive heart failure
- g. Deep vein thrombosis
- h. Hypertension ✓
- i. Hypotension
- j. Peripheral vascular disease
- k. Other cardiovascular disease

MUSCULOSKELETAL
- l. Arthritis
- m Hip fracture
- n. Missing limb (e.g., amputation)
- o. Osteoporosis
- p. Pathological bone fracture

NEUROLOGICAL
- q. Alzheimer's disease
- r. Aphasia
- s. Cerebral palsy
- t. Cerebrovascular accident (stroke)
- u. Dementia other than Alzheimer's disease ✓
- v. Hemiplegia/Hemiparesis
- w. Multiple sclerosis
- x. Paraplegia
- y. Parkinson's disease
- z. Quadriplegia
- aa. Seizure disorder
- bb. Transient ischemic attack (TIA)
- cc. Traumatic brain injury

PSYCHIATRIC/MOOD
- dd. Anxiety disorder
- ee. Depression
- ff Manic depression (bipolar disease)
- gg Schizophrenia

PULMONARY
- hh Asthma
- ii. Emphysema/COPD

SENSORY
- jj. Cataracts
- kk. Diabetic retinopathy
- ll. Glaucoma
- mm Macular degeneration

OTHER
- nn. Allergies
- oo. Anemia
- pp. Cancer
- qq. Renal failure
- rr. *NONE OF ABOVE*

2. INFECTIONS *(If none apply, CHECK the NONE OF ABOVE box)*
- a. Antibiotic resistant infection (e.g., Methicillin resistant staph)
- b. Clostridium difficile (c.diff.)
- c. Conjunctivitis
- d. HIV infection
- e. Pneumonia
- f. Respiratory infection
- g. Septicemia
- h. Sexually transmitted diseases
- i. Tuberculosis
- j. Urinary tract infection in last 30 days
- k. Viral hepatitis
- l. Wound infection
- m NONE OF ABOVE ✓

3. OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9 CODES

a.	Cervical Spinal Stenosis	723.0
b.	Aftcre Surg Nerv Sys Nec	V58.7
c.	Bph Nos W/O Urinary Obst	600.9
d.	Cyst Of Kidney, Acquired	593.2
e.	Lack Of Coordination	781.3

SECTION J. HEALTH CONDITIONS

1. PROBLEM CONDITIONS *(Check all problems present in last 7 days unless other time frame is indicated)*

INDICATORS OF FLUID STATUS
- a. Weight gain or loss of 3 or more pounds within a 7 day period
- b. Inability to lie flat due to shortness of breath
- c. Dehydrated; output exceeds input
- d. Insufficient fluid; did NOT consume all/almost all liquids provided during last 3 days

OTHER
- e. Delusions
- f. Dizziness/Vertigo
- g. Edema
- h. Fever
- i. Hallucinations
- j. Internal bleeding
- k. Recurrent lung aspirations in last 90 days
- l. Shortness of breath
- m. Syncope (fainting)
- n. Unsteady gait
- o. Vomiting
- p. *NONE OF ABOVE*

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2. PAIN SYMPTOMS *(Code the highest level of pain present in the last 7 days)*
- a. FREQUENCY with which resident complains or shows evidence of pain: 0. No pain *(skip to J4)* | 1. Pain less than daily | 2. Pain daily — [0]
- b. INTENSITY of pain: 1. Mild pain | 2. Moderate pain | 3. Times when pain is horrible or excruciating

3. PAIN SITE *(If pain present, check all sites that apply in last 7 days)*

a. Back pain	e.	f. Incisional pain	
b. Bone pain	b.	g. Joint pain (other than hip)	g.
c. Chest pain while doing usual activities	c.	h. Soft tissue pain (e.g., lesion, muscle)	h.
d. Headache	d.	i. Stomach pain	i.
e. Hip pain	e.	j. Other	j.

4. ACCIDENTS *(Check all that apply)*

a. Fell in past 30 days	a.	c. Hip fracture in last 180 days	c.
b. Fell in past 31-180 days	b. ✓	d. Other fracture in last 180 days	d.
		e. NONE OF ABOVE	e.

5. STABILITY OF CONDITIONS
- a. Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable - (fluctuating, precarious, or deteriorating) — a. ✓
- b. Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem — b. ✓
- c. End-stage disease, 6 or fewer months to live — c.
- d. NONE OF ABOVE — d.

SECTION K. ORAL/NUTRITIONAL STATUS

1. ORAL PROBLEMS
- a. Chewing problem — a. ✓
- b. Swallowing problem — b.
- c. Mouth pain — c.
- d. NONE OF ABOVE — d.

2. HEIGHT AND WEIGHT *Record (a) height in inches and (b) weight in pounds. Base weight on most recent measure in last 30 days; measure weight consistently in accord with standard facility practice - e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes*
- a. HT (in.) 70
- b. WT (lb.) 164

3. WEIGHT CHANGE
- a. Weight loss - 5% or more in last 30 days; or 10% or more in last 180 days (0. No | 1. Yes) — 0
- b. Weight gain - 5% or more in last 30 days; or 10% or more in last 180 days (0. No | 1. Yes) — 0

4. NUTRITIONAL PROBLEMS

a. Complains about the taste of many foods	a.	c. Leaves 25% or more of food uneaten at most meals	c.
b. Regular or repetitive complaints of hunger	b.	d. NONE OF ABOVE	d. ✓

5. NUTRITIONAL APPROACHES *(Check all that apply in last 7 days)*

a. Parenteral/IV	a. ✓	f. Dietary supplement between meals	f.
b. Feeding tube	b.	g. Plate guard, stabilized built-up utensil, etc.	g.
c. Mechanically altered diet	c. ✓	h. On a planned weight change program	h.
d. Syringe (oral feeding)	d.	i. NONE OF ABOVE	i.
e. Therapeutic diet	e.		

6. PARENTERAL OR ENTERAL INTAKE *(Skip to Section L if neither 6a nor 6b is checked)*
- a. Code the proportion of total calories the resident received through parenteral or tube feedings in the last 7 days (0. None | 1. 1% to 25% | 2. 26% to 50% | 3. 51% to 75% | 4. 76% to 100%) — 0
- b. Code the average fluid intake per day by IV or tube in last 7 days (0. None | 1. 1 to 500 cc/day | 2. 501 to 1000 cc/day | 3. 1001 to 1500 cc/day | 4. 1501 to 2000 cc/day | 5. 2001 or more cc/day) — 2

SECTION L. ORAL/DENTAL STATUS

1. ORAL STATUS AND DISEASE PREVENTION
- a. Debris (soft, easily movable substances) present in mouth prior to going to bed at night — a.
- b. Has dentures or removable bridge — b.
- c. Some/all natural teeth lost - does not have or does not use dentures (or partial plates) — c. ✓
- d. Broken, loose, or carious teeth — d.
- e. Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes — e.
- f. Daily cleaning of teeth/dentures provided or supervised by resident or staff — f.
- g. NONE OF ABOVE — g.

SECTION M. SKIN CONDITION

1. ULCERS (Due to any cause) *(Record the number of ulcers at each ulcer stage - regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during last 7 days. Code 9 = 9 or more.) (Requires full body exam.)* — Number at Stage
- a. Stage 1. A persistent area of skin redness (without a bre- in the skin) that does not disappear when press is relieved.
- b. Stage 2. A partial thickness loss of skin layers that prese clinically as an abrasion, blister, or shallow crat
- c. Stage 3. A full thickness of skin is lost, exposing the sub taneous tissues - presents as a deep crater wit without undermining adjacent tissue.
- d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

2. TYPE OF ULCER *(For each type of ulcer, code for the highest stage in the las 7 days using scale in item M1 - i.e., 0=none; stages 1,2,3,4)*
- a. Pressure ulcer - any lesion caused by pressure resulting in damage of underlying tissue
- b. Stasis ulcer - open lesion caused by poor circulation in the lower extremities

3. HISTORY OF RESOLVED ULCERS Resident had an ulcer that was resolved or cured in LAST 90 DAYS (0. No | 1. Yes)

4. OTHER SKIN PROBLEMS OR LESIONS PRESENT *(Check all that apply during last 7 days)*
- a. Abrasions, bruises — a. ✓
- b. Burns (second or third degree) — b.
- c. Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions) — c.
- d. Rashes - e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster — d.
- e. Skin desensitized to pain or pressure — e. ✓
- f. Skin tears or cuts (other than surgery) — f.
- g. Surgical wounds — g. ✓
- h. NONE OF ABOVE — h.

5. SKIN TREATMENTS *(Check all that apply during last 7 days)*
- a. Pressure relieving device(s) for chair — a.
- b. Pressure relieving device(s) for bed — b. ✓
- c. Turning/repositioning program — c. ✓
- d. Nutrition or hydration intervention to manage skin problems — d. ✓
- e. Ulcer care — e. ✓
- f. Surgical wound care — f. ✓
- g. Application of dressings (with or without topical medications) other than to feet — g. ✓
- h. Application of ointments/medications (other than to feet) — h.
- i. Other preventative or protective skin care (other than to feet) — i. ✓
- j. NONE OF ABOVE — j.

6. FOOT PROBLEMS AND CARE *(Check all that apply during last 7 days)*
- a. Resident has one or more foot problems - e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems — a. ✓
- b. Infection of the foot - e.g., cellulitis, purulent drainage — b.
- c. Open lesions on the foot — c.
- d. Nails/calluses trimmed during last 90 days — d. ✓
- e. Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) — e.
- f. Application of dressings (with or without topical medications) — f.
- g. NONE OF ABOVE — g.

SECTION N. ACTIVITY PURSUIT PATTERNS

1. TIME AWAKE *(Check appropriate time periods over last 7 days)* Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:

a. Morning	a. ✓	c. Evening	c. ✓
b. Afternoon	b. ✓	d. NONE OF ABOVE	d.

(If resident is comatose, skip to Section O)

2. AVERAGE TIME INVOLVED IN ACTIVITIES *(When awake and not receiving treatments or ADL care)* (0. Most-more than 2/3 of time | 1. Some-from 1/3 to 2/3 of time | 2. Little-less than 1/3 of time | 3. None) — 1

3. PREFERRED ACTIVITY SETTINGS *(Check all settings in which activities are preferred)*

a. Own room	a. ✓	d. Outside facility	d.
b. Day/activity room	b.	e. NONE OF ABOVE	e.
c. Inside NH/off unit	c.		

4. GENERAL ACTIVITY PREFERENCES (adapted to resident's current abilities) *(Check all PREFERENCES whether or not activity is currently available to resident)*

a. Cards/other games	a.	g. Trips/shopping	g.
b. Crafts/arts	b.	h. Walking/wheeling outdoors	h.
c. Exercise/sports	c.	i. Watching TV	i.
d. Music	d.	j. Gardening or plants	j.
e. Reading/writing	e.	k. Talking or conversing	k.
f. Spiritual/religious activities	f.	l. Helping others	l.
		m. NONE OF ABOVE	m.

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5.	PREFERS CHANGE IN DAILY ROUTINE	Code for resident preferences in daily routines 0. No change 1. Slight change 2. Major change	
		a. Type of activities in which resident is currently involved	0
		b. Extent of resident involvement in activities	0

SECTION O. MEDICATIONS

1.	NUMBER OF MEDICATIONS	(Record the number of different medications used in the last 7 days; enter "0" if none used)	13
2.	NEW MEDICATIONS	(Resident currently receiving medications that were initiated during the last 90 days) 0. No 1. Yes	1
3.	INJECTIONS	(Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used)	2
4.	DAYS RECEIVED THE FOLLOWING MEDICATION	(Record the number of DAYS during last 7 days; enter "0" if not used. Note - enter "1" for long-acting meds used less than weekly) a. Antipsychotic 0 b. Antianxiety 0 c. Antidepressant 0 d. Hypnotic e. Diuretic	0 0

SECTION P. SPECIAL TREATMENTS AND PROCEDURES

1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS

a. SPECIAL CARE - Check treatments or programs received during the last 14 days

TREATMENTS		PROGRAMS	
a. Chemotherapy	a.	l. Ventilator or respirator	l.
b. Dialysis	b.	m. Alcohol/drug treatment program	m.
c. IV medication	c. ✓	n. Alzheimer's/dementia special care unit	n.
d. Intake/output	d. ✓	o. Hospice care	o.
e. Monitoring acute medical condition	e. ✓	p. Pediatric unit	p.
f. Ostomy care	f.	q. Respite care	q.
g. Oxygen therapy	g.	r. Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs)	r.
h. Radiation	h.	s. NONE OF ABOVE	s.
i. Suctioning	i.		
j. Tracheostomy care	j.		
k. Transfusions	k.		

b. THERAPIES - Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the last 7 calendar days (Enter 0 if none or less than 15 min. daily)

[Note - count only post admission therapies]

	(A) DAYS	(B) MIN
(A) = # of days administered for 15 minutes or more (B) = total # of minutes provided in last 7 days		
a. Speech-language pathology and audiology services	0	0000
b. Occupational therapy	1	0045
c. Physical therapy	1	0030
d. Respiratory therapy	0	0000
e. Psychological therapy (by any licensed mental health professional)	0	0000

2. INTERVENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS

(Check all interventions or strategies used in last 7 days - no matter where received)

a. Special behavior symptom evaluation program	a.
b. Evaluation by a licensed mental health specialist in last 90 days	b.
c. Group therapy	c.
d. Resident-specific deliberate changes in the environment to address mood/behavior patterns - e.g., providing bureau in which to rummage	d.
e. Reorientation - e.g., cueing	e. ✓
f. NONE OF ABOVE	f.

3. NURSING REHABILITATION/ RESTORATIVE CARE

Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was provided to the resident for more than or equal to 15 minutes per day in the last 7 days (Enter 0 if none or less than 15 min. daily.)

a. Range of motion (passive)	0	f. Walking	0
b. Range of motion (active)	0	g. Dressing or grooming	0
c. Splint or brace assistance	0	h. Eating or swallowing	0
TRAINING AND SKILL PRACTICE IN:		i. Amputation/prosthesis care	0
d. Bed mobility	0	j. Communication	0
e. Transfer	0	k. Other	0

4.	DEVICES AND RESTRAINTS	(Use the following codes for last 7 days.) 0. Not used 1. Used less than daily 2. Used daily	
		Bed rails	2
		a. - Full bed rails on all open sides of bed	0
		b. - Other types of side rails used (e.g., half rail, one side)	0
		c. Trunk restraint	0
		d. Limb restraint	0
		e. Chair prevents rising	01
5.	HOSPITAL STAY(S)	Record number of times resident was admitted to hospital with an overnight stay in last 90 days (or since last assessment if less than 90 days). (Enter 0 if no hospital admissions)	01
6.	EMERGENCY ROOM (ER) VISIT(S)	Record number of times resident visited ER without an overnight stay in last 90 days (or since last assessment if less than 90 days). (Enter 0 if no ER visits)	01
7.	PHYSICIAN VISITS	In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? (Enter 0 if none)	03
8.	PHYSICIAN ORDERS	In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? Do not include order renewals without change. (Enter 0 if none)	1
9.	ABNORMAL LAB VALUES	Has the resident had any abnormal lab values during the last 90 days (or since admission)? 0. No 1. Yes	

SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

1.	DISCHARGE POTENTIAL	a. Resident expresses/indicates preference to return to the community 0. No 1. Yes	0
		b. Resident has a support person who is positive towards discharge 0. No 1. Yes	0
		c. Stay projected to be of a short duration - discharge projected within 90 days (do not include expected discharge due to death) 0. No 2. Within 31-90 days 1. Within 30 days 3. Discharge status uncertain	3
2.	OVERALL CHANGE IN CARE NEEDS	Resident's overall self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved-receives fewer supports, needs less restrictive level of care 2. Deteriorated-receives more support	2

SECTION R. ASSESSMENT INFORMATION

1.	PARTICIPATION IN ASSESSMENT	a. Resident:	0. No	1. Yes	1
		b. Family:	0. No	1. Yes 2. No family	1
		c. Significant other:	0. No	1. Yes 2. None	0

2. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:

a. Signature of RN Assessment Coordinator (sign on above line)

b. Date RN Assessment Coordinator signed as complete 0 3 (Month) - 2 7 (Day) - 2 0 0 6 (Year)

Resident WILLI PETERSON Numeric Identifier -30-6586

SECTION T. THERAPY SUPPLEMENT FOR MEDICARE PPS

			DAYS (A)	MIN (B)
1.	SPECIAL TREATMENTS AND PROCEDURES	a. RECREATION THERAPY -*Enter number of days and total minutes of recreation therapy administered (for at least 15 minutes a day) in the last 7 days (Enter 0 if none)* (A) = # of days administered for 15 minutes or more (B) = total # of minutes provided in last 7 days		
		Skip unless this is a Medicare 5 day or Medicare readmission/return assessment. b. ORDERED THERAPIES - *Has physician ordered any of following therapies to begin in FIRST 14 days of stay - physical therapy, occupational therapy, or speech pathology service?* 0. No 1. Yes		1
		If not ordered, skip to item 2 c. Through day 15, provide an estimate of the number of days when at least 1 therapy service can be expected to have been delivered.		08
		d. Through day 15, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered?		0650
2.	WALKING WHEN MOST SELF SUFFICIENT	***Complete item 2 if ADL self-performance score for TRANSFER (G.1.b.A) is 0, 1, 2, or 3 AND at least one of the following are present:*** Resident received physical therapy involving gait training (P.1.b.c.) Physical therapy was ordered for the resident involving gait training (T.1.b) Resident received nursing rehabilitation for walking (P.3.f.) Physical therapy involving walking has been discontinued within the past 180 days ***Skip to item 3 if resident did not walk in last 7 days*** ***(FOR FOLLOWING FIVE ITEMS, BASE CODING ON THE EPISODE WHEN THE RESIDENT WALKED THE FARTHEST WITHOUT SITTING DOWN. INCLUDE WALKING DURING REHABILITATION SESSIONS.)***		
		a. Furthest distance walked without sitting down during this episode. 0. 150+ feet 1. 51-149 feet 2. 26-50 feet 3. 10-25 feet 4. Less than 10 feet		
		b. Time walked without sitting down during this episode. 0. 1-2 minutes 1. 3-4 minutes 2. 5-10 minutes 3. 11-15 minutes 4. 16-30 minutes 5. 31+ minutes		
		c. Self-Performance in walking during this episode. 0. *INDEPENDENT* - No help or oversight 1. *SUPERVISION* - Oversight, encouragement or cueing provided 2. *LIMITED ASSISTANCE* - Resident highly involved in walking; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3. *EXTENSIVE ASSISTANCE* - Resident received weight bearing assistance while walking		
		d. Walking support provided associated with this episode (code regardless of resident's self-performance classification). 0. No setup or physical help from staff 1. Setup help only 2. One person physical assist 3. Two+ persons physical assist		
		e. Parallel bars used by resident in association with this episode. 0. No 1. Yes		
3.	CASE MIX GROUP	Medicare RMX09 State RMX09		

Resident WILLI PETERSON Numeric Identifier 7-30-6586 -680-

SECTION W. SUPPLEMENTAL MDS ITEMS

1.	National Provider ID	Enter for all assessments and tracking forms, if available.	
If the ARD of this assessment or the discharge date of this discharge tracking form is between July 1 and September 30, skip to W3.			0
2.	Influenza Vaccine	a. Did the resident receive the influenza vaccine in this facility for this year's influenza season (October 1 through March 31)? 0. No (If No, go to item W2b) 1. Yes (If Yes, go to item W3) b. If influenza vaccine not received, state reason: 1. Not in facility during this year's flu season 2. Received outside of this facility 3. Not eligible 4. Offered and declined 5. Not offered 6. Inability to obtain vaccine	2 1
3.	Pneumo-coccal Vaccine	a. Is the resident's PPV status up to date? 0. No (If No, go to item W3b) 1. Yes (If Yes, skip item W3b) b. If PPV not received, state reason: 1. Not eligible 2. Offered and declined 3. Not offered	

neric Identifier 2)-6586

MINIMUM DATA SET (MDS) - VERSION 2.0
FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BASIC ASSESSMENT TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME*	WILLIAM PETERSON a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)	
2.	GENDER*	1. Male 2. Female	1
3.	BIRTHDATE*	[redacted] Month Day Year	
4.	RACE/ ETHNICITY*	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin	3
5.	SOCIAL SECURITY AND MEDICARE NUMBERS*	a. [redacted] Number b. Medicare number (or comparable railroad insurance number) [redacted]	
6.	FACILITY PROVIDER NO.*	a. State No. 0 5 9 1 N H b. Federal No. 4 2 5 2 9 3	
7.	MEDICAID NO. ["+" If pending, "N" If not a Medicaid recipient]*		
8.	REASONS FOR ASSESS-MENT	[Note - Other codes do not apply to this form] a. Primary reason for assessment 01. Admission assessment (required by day 14) 02. Annual assessment 03. Significant change in status assessment 04. Significant correction of prior full assessment 05. Quarterly review assessment 10. Significant correction of prior quarterly assessment 00. *NONE OF ABOVE*	00
		b. Codes for assessments required for Medicare PPS or the State 1. *Medicare 5 day assessment* 2. *Medicare 30 day assessment* 3. *Medicare 60 day assessment* 4. *Medicare 90 day assessment* 5. *Medicare readmission/return assessment* 6. *Other state required assessment* 7. *Medicare 14 day assessment* 8. *Other Medicare required assessment*	7

9.	Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form	
	I certify that accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.	
	Signature and Title	Sections / Date
a.	Kathleen Dyches LAAABCOGHUCMOPQEW	4/3/06
b.	Mattie Gordon DonK	4/3/06
c.	Leonica Denston WC N	4/3/06
d.	Sharon Nicholson RN E&D	4/3/06
e.		
f.		
g.		
h.		
i.		
j.		
k.		
l.		

GENERAL INSTRUCTIONS

Complete this information for submission with all full and quarterly assessments (Admission, Annual, Significant Change, State or Medicare required assessments, or Quarterly Reviews, etc.)

Resident WILLI PETERSON ( ) eric Identifier 2 ( )-6586

MINIMUM DATA SET (MDS) - VERSION 2.0

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

FULL ASSESSMENT FORM

(Status in last 7 days, unless other time frame indicated)

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1.	RESIDENT NAME	WILLIAM PETERSON a.(First) b.(Middle Initial) c.(Last) d.(Jr/Sr)	
2.	ROOM NUMBER	P 2 1 4 D	
3.	ASSESSMENT REFERENCE DATE	a. *Last day of MDS observation period* 0 4 (Month) - 0 3 (Day) - 2 0 0 6 (Year) b. Original (0) or corrected copy of form (enter number of correction)	0
4a.	DATE OF REENTRY	Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days) Month - Day - Year	
5.	MARITAL STATUS	1. Never married 3. Widowed 5. Divorced 2. Married 4. Separated	3
6.	MEDICAL RECORD NO.	1 0 5 0	
7.	CURRENT PAYMENT SOURCES FOR N. H. STAY	*(Billing Office to indicate; check all that apply in last 30 days)* a. Medicaid per diem [a.] f. VA per diem b. Medicare per diem [b. ✓] g. Self or family pays for full per diem c. Medicare ancillary part A [c.] h. Medicaid resident liability or Medicare co-payment d. Medicare ancillary part B [d.] i. Private insurance per diem (including co-payment) e. CHAMPUS per diem [e.] j. Other per diem	f. g. h. i. j.
8.	REASONS FOR ASSESSMENT *[Note - If this is a discharge or reentry assessment, only a limited subset of MDS items need be completed]*	a. Primary reason for assessment 01. Admission assessment (required by day 14) 02. Annual assessment 03. Significant change in status assessment 04. Significant correction of prior full assessment 05. Quarterly review assessment 06. Discharged - return not anticipated 07. Discharged - return anticipated 08. Discharged prior to completing initial assessment 09. Reentry 10. Significant correction of prior quarterly assessment 00. *NONE OF ABOVE* b. *Codes for assessments required for Medicare PPS or the State* 1. *Medicare 5 day assessment* 2. *Medicare 30 day assessment* 3. *Medicare 60 day assessment* 4. *Medicare 90 day assessment* 5. *Medicare readmission/return assessment* 6. *Other state required assessment* 7. *Medicare 14 day assessment* 8. *Other Medicare required assessment*	00 7
9.	RESPONSIBILITY/ LEGAL GUARDIAN	*(Check all that apply)* a. Legal guardian [a.] d. Durable power of attorney/financial [d.] b. Other legal oversight [b.] e. Family member responsible [e. ✓] c. Durable power of attorney/health care [c.] f. Patient responsible for self [f.] g. *NONE OF ABOVE* [g.]	d. e. ✓ f. g.
10.	ADVANCED DIRECTIVES	*(For those items with supporting documentation in the medical record, check all that apply)* a. Living will [a.] f. Feeding restrictions [f. ✓] b. Do not resuscitate [b. ✓] g. Medication restrictions [g.] c. Do not hospitalize [c.] h. Other treatment restrictions [h. ✓] d. Organ donation [d.] i. *NONE OF ABOVE* [i.] e. Autopsy request [e.]	f. ✓ g. h. ✓ i.

SECTION B. COGNITIVE PATTERNS

1.	COMATOSE	*(Persistent vegetative state/no discernible consciousness)* 0. No 1. Yes (If yes, skip to Section G)	0
2.	MEMORY	*(Recall of what was learned or known)* a. Short-term memory OK-seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem b. Long-term memory OK-seems/appears to recall long past 0. Memory OK 1. Memory problem	1
3.	MEMORY/ RECALL ABILITY	*(Check all that resident was normally able to recall during last 7 days)* a. Current season [a.] d. That he/she is in a nursing home [d. ✓] b. Location of own room [b.] e. *NONE OF ABOVE* are recalled [e.] c. Staff names/faces [c. ✓]	d. ✓ e.
4.	COGNITIVE SKILLS FOR DAILY DECISION-MAKING	*(Made decisions regarding tasks of daily life)* 0. *INDEPENDENT*-decisions consistent/reasonable 1. *MODIFIED INDEPENDENCE*-some difficulty in new situations only 2. *MODERATELY IMPAIRED*-decisions poor; cues/supervision required 3. *SEVERELY IMPAIRED* - never/rarely made decisions	2
5.	INDICATORS OF DELIRIUM - PERIODIC DISORDERED THINKING/ AWARENESS	*(Code for behavior in the last 7 days.) [Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time].* 0. Behavior not present 1. Behavior present, not of recent onset 2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening) a. EASILY DISTRACTED-(e.g., difficulty paying attention; gets sidetracked) b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS-(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day) c. EPISODES OF DISORGANIZED SPEECH-(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought) d. PERIODS OF RESTLESSNESS-(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out) e. PERIODS OF LETHARGY-(e.g., sluggishness; staring into space, difficult to arouse; little body movement) f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY-(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)	0 0 1 0 0 1
6.	CHANGE IN COGNITIVE STATUS	Resident's cognitive status, skills, or abilities have changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	0

SECTION C. COMMUNICATION/HEARING PATTERNS

1.	HEARING	*(With hearing appliance, if used)* 0. *HEARS ADEQUATELY*-normal talk, TV, phone 1. *MINIMAL DIFFICULTY* when not in quiet setting 2. *HEARS IN SPECIAL SITUATIONS ONLY*-speaker has to adjust tonal quality and speak distinctly 3. *HIGHLY IMPAIRED*/absence of useful hearing	2
2.	COMMUNICATION DEVICES/ TECHNIQUES	*(Check all that apply during last 7 days)* a. Hearing aid, present and used b. Hearing aid, present and not used regularly c. Other receptive comm. techniques used (e.g., lip reading) d. *NONE OF ABOVE*	a. b. c. d. ✓
3.	MODES OF EXPRESSION	*(Check all used by resident to make needs known)* a. Speech [a. ✓] d. Signs/gestures/sounds [d. ✓] b. Writing messages to express or clarify needs [b.] e. Communication board [e.] c. American sign language or Braille [c.] f. Other [f.] g. *NONE OF ABOVE* [g.]	d. ✓ e. f. g.
4.	MAKING SELF UNDERSTOOD	*(Expressing information content - however able)* 0. *UNDERSTOOD* 1. *USUALLY UNDERSTOOD*-difficulty finding words or finishing thoughts 2. *SOMETIMES UNDERSTOOD*-ability is limited to making concrete requests 3. *RARELY/NEVER UNDERSTOOD*	1
5.	SPEECH CLARITY	*(Code for speech in the last 7 days)* 0. *CLEAR SPEECH* - distinct, intelligible words 1. *UNCLEAR SPEECH* - slurred, mumbled words 2. *NO SPEECH* - absence of spoken words	0
6.	ABILITY TO UNDERSTAND OTHERS	*(Understanding verbal information content-however able)* 0. *UNDERSTANDS* 1. *USUALLY UNDERSTANDS*-may miss some part/intent of message 2. *SOMETIMES UNDERSTANDS*-responds adequately to simple, direct communication 3. *RARELY/NEVER UNDERSTANDS*	2
7.	CHANGE IN COMMUNICATION/ HEARING	Resident's ability to express, understand, or hear information has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	0

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SECTION D. VISION PATTERNS

1.	VISION	*(Ability to see in adequate light and with glasses if used)* 0. *ADEQUATE* - sees fine detail, including regular print in newspapers/books 1. *IMPAIRED* - sees large print, but not regular print in newspapers/books 2. *MODERATELY IMPAIRED* - limited vision; not able to see newspaper headlines, but can identify objects 3. *HIGHLY IMPAIRED* - object identification in question, but eyes appear to follow objects 4. *SEVERELY IMPAIRED* - no vision or sees only light, colors, or shapes; eyes do not appear to follow objects	0
2.	VISUAL LIMITATIONS/ DIFFICULTIES	a. Side vision problems - decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self) b. Experiences any of following: sees halos or rings around lights; sees flashes of light; sees "curtains" over eyes c. *NONE OF ABOVE*	a. b. c. ✓
3.	VISUAL APPLIANCES	Glasses; contact lenses; magnifying glass 0. No 1. Yes	0

SECTION E. MOOD AND BEHAVIOR PATTERNS

1.	INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	*(Code for indicators observed in last 30 days, irrespective of the assumed cause)* 0. Indicator not exhibited in last 30 days 1. Indicator of this type exhibited up to five days a week 2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)	

VERBAL EXPRESSIONS OF DISTRESS

a. Resident made negative statements-e.g. *"Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die"* — 0

b. Repetitive questions-e.g., *"Where do I go; What do I do?"* — 0

c. Repetitive verbalizations-e.g., calling out for help, *("God help me")* — 0

d. Persistent anger with self or others-e.g., easily annoyed, anger at placement in nursing home; anger at care received — 0

e. Self deprecation-e.g., *"I am nothing; I am of no use to anyone"* — 0

f. Expressions of what appear to be unrealistic fears-e.g., fear of being abandoned, left alone, being with others — 0

g. Recurrent statements that something terrible is about to happen-e.g., believes he or she is about to die, have a heart attack — 0

h. Repetitive health complaints-e.g., persistently seeks medical attention, obsessive concern with body functions — 0

i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues — 0

SLEEP-CYCLE ISSUES

j. Unpleasant mood in morning — 0

k. Insomnia/change in usual sleep pattern — 0

SAD, APATHETIC, ANXIOUS APPEARANCE

l. Sad, pained, worried facial expressions-e.g., furrowed brows — 0

m. Crying, tearfulness — 0

n. Repetitive physical movements-e.g., pacing, hand wringing, restlessness, fidgeting, picking — 0

LOSS OF INTEREST

o. Withdrawal from activities of interest - e.g., no interest in long standing activities or being with family/friends — 0

p. Reduced social interaction — 0

2.	MOOD PERSISTENCE	One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days 0. No mood Indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered	0
3.	CHANGE IN MOOD	Resident's mood status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	0
4.	BEHAVIORAL SYMPTOMS	(A) *Behavioral symptom frequency in last 7 days* 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred 1 to 3 days in last 7 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily (B) *Behavioral symptom alterability in last 7 days* 0. Behavior not present OR behavior was easily altered 1. Behavior was not easily altered	

	(A)	(B)
a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)	0	0
b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)	0	0
c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)	0	0
d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self abusive acts, sexual behavior or disrobing in public, smearing/throwing food, feces, hoarding, rummaged through others' belongings)	0	0
e. RESISTS CARE (resisted taking medications/injections, ADL assistance, or eating)	0	0

5.	CHANGE IN BEHAVIORAL SYMPTOMS	Resident's behavior status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	0

SECTION F. PSYCHOSOCIAL WELL-BEING

1.	SENSE OF INITIATIVE/ INVOLVEMENT	a. At ease interacting with others b. At ease doing planned or structured activities c. At ease doing self-initiated activities d. Establishes own goals e. Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services) f. Accepts invitations into most group activities g. *NONE OF ABOVE*	a. ✓ b. c. d. e. f. g.
2.	UNSETTLED RELATIONSHIPS	a. Covert/open conflict with or repeated criticism of staff b. Unhappy with roommate c. Unhappy with residents other than roommate d. Openly expresses conflict/anger with family/friends e. Absence of personal contact with family/friends f. Recent loss of close family member/friend g. Does not adjust easily to change in routines h. *NONE OF ABOVE*	a. b. c. d. e. f. g. ✓ h.
3.	PAST ROLES	a. Strong identification with past roles and life status b. Expresses sadness/anger/empty feeling over lost roles/status c. Resident perceives that daily routine (customary routine, activities) is very different from prior pattern in the community d. *NONE OF ABOVE*	a. b. c. d. ✓

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. (A) ADL SELF-PERFORMANCE-*(Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days - Not including setup)*
0. *INDEPENDENT* - No help or oversight - OR - Help/oversight provided only 1 or 2 times during last 7 days
1. *SUPERVISION* - Oversight, encouragement or cueing provided 3 or more times during last 7 days - OR - Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
2. *LIMITED ASSISTANCE* - Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times - OR - More help provided only 1 or 2 times during last 7 days
3. *EXTENSIVE ASSISTANCE* - While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
--Weight bearing support
--Full staff performance during part (but not all) of last 7 days
4. *TOTAL DEPENDENCE* - Full staff performance of activity during entire 7 days
8. *ACTIVITY DID NOT OCCUR* during entire 7 days

(B) ADL SUPPORT PROVIDED - *(Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification)*
0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist
8. ADL activity itself did not occur during entire 7 days

			(A) SELF-PERF	(B) SUPPORT
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed	3	2
b.	TRANSFER	How resident moves between surfaces - to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)	4	3
c.	WALK IN ROOM	How resident walks between locations in his/her room	8	8
d.	WALK IN CORRIDOR	How resident walks in corridor on unit	8	8
e.	LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	4	2
f.	LOCOMOTION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair	8	8
g.	DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis	3	2
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)	3	2
i.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal): transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes	3	2
j.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands, and perineal hygiene (EXCLUDE baths and showers)	3	

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2. BATHING — How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) *Code for most dependent in self-performance and support.*

(A) BATHING SELF-PERFORMANCE codes appear below — (A) 3 (B) 2

0. Independent - No help provided
1. Supervision - Oversight help only
2. Physical help limited to transfer only
3. Physical help in part of bathing activity
4. Total dependence
8. Activity itself did not occur during entire 7 days

(Bathing support codes are as defined in Item 1,code B above)

3. TEST FOR BALANCE (see training manual) — *(Code for ability during test in the last 7 days)*

0. Maintained position as required in test
1. Unsteady, but able to rebalance self without physical support
2. Partial physical support during test; or stands (sits) but does not follow directions for test
3. Not able to attempt test without physical help

a. Balance while standing	3
b. Balance while sitting - position, trunk control	3

4. FUNCTIONAL LIMITATION IN RANGE OF MOTION (see training manual) — *(Code for limitations during last 7 days that interfered with daily functions or placed resident at risk of injury)*

(A) *RANGE OF MOTION*: 0. No limitation; 1. Limitation on one side; 2. Limitation on both sides
(B) *VOLUNTARY MOVEMENT*: 0. No loss; 1. Partial loss; 2. Full loss

	(A)	(B)
a. Neck	2	0
b. Arm - Including shoulder or elbow	2	1
c. Hand - Including wrist or fingers	0	0
d. Leg - Including hip or knee	2	2
e. Foot - Including ankle or toes	2	2
f. Other limitation or loss	0	0

5. MODES OF LOCOMOTION — *(Check all that apply during last 7 days)*

a. Cane/walker/crutch [a.] — d. Wheelchair primary mode of locomotion [d. ✓]
b. Wheeled self [b.] — e. *NONE OF ABOVE* [e.]
c. Other person wheeled [c. ✓]

6. MODES OF TRANSFER — *(Check all that apply during last 7 days)*

a. Bedfast all or most of time [a.] — d. Lifted mechanically [d. ✓]
b. Bed rails used for bed mobility or transfer [b. ✓] — e. Transfer aid (e.g., slide board, trapeze, cane, walker, brace) [e.]
c. Lifted manually [c.] — f. *NONE OF ABOVE* [f.]

7. TASK SEGMENTATION — Some or all of ADL activities were broken into subtasks during last 7 days so that resident could perform them
0. No 1. Yes — 0

8. ADL FUNCTIONAL REHABILITATION POTENTIAL

a. Resident believes he/she is capable of increased independence in at least some ADLs	a.
b. Direct care staff believe resident is capable of increased independence in at least some ADLs	b.
c. Resident able to perform tasks/activity but is very slow	c.
d. Difference in ADL Self-Performance or ADL Support, comparing mornings to evenings	d.
e. *NONE OF ABOVE*	e. ✓

9. CHANGE IN ADL FUNCTION — Resident's ADL self-performance status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days)
0. No change 1. Improved 2. Deteriorated — 0

3. APPLIANCES AND PROGRAMS

a. Any scheduled toileting plan	a. ✓	f. Did not use toilet room/commode/urinal	f. ✓
b. Bladder retraining program	b.	g. Pads/briefs used	g. ✓
c. External (condom) catheter	c.	h. Enemas/irrigation	h.
d. Indwelling catheter	d. ✓	i. Ostomy present	i.
e. Intermittent catheter	e.	j. *NONE OF ABOVE*	j.

4. CHANGE IN URINARY CONTINENCE — Resident's urinary continence has changed as compared to status of 90 days ago (or since last assessment if less than 90 days)
0. No change 1. Improved 2. Deteriorated — 0

SECTION I. DISEASE DIAGNOSES

Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses)

1. DISEASES — *If none apply, CHECK the NONE OF ABOVE box)*

ENDOCRINE/METABOLIC/NUTRITIONAL
a. Diabetes mellitus [a.]
b. Hyperthyroidism [b.]
c. Hypothyroidism [c.]
HEART/CIRCULATION
d. Arteriosclerotic heart disease (ASHD) [d.]
e. Cardiac dysrhythmias [e.]
f. Congestive heart failure [f.]
g. Deep vein thrombosis [g.]
h. Hypertension [h. ✓]
i. Hypotension [i.]
j. Peripheral vascular disease [j.]
k. Other cardiovascular disease [k.]
MUSCULOSKELETAL
l. Arthritis [l.]
m Hip fracture [m.]
n. Missing limb (e.g., amputation) [n.]
o. Osteoporosis [o.]
p. Pathological bone fracture [p.]
NEUROLOGICAL
q. Alzheimer's disease [q.]
r. Aphasia [r.]
s. Cerebral palsy [s.]
t. Cerebrovascular accident (stroke) [t.]
u. Dementia other than Alzheimer's disease [u. ✓]
v. Hemiplegia/Hemiparesis [v.]
w. Multiple sclerosis [w.]
x. Paraplegia [x.]
y. Parkinson's disease [y.]
z. Quadriplegia [z.]
aa. Seizure disorder [aa.]
bb. Transient ischemic attack (TIA) [bb.]
cc. Traumatic brain injury [cc.]
PSYCHIATRIC/MOOD
dd. Anxiety disorder [dd.]
ee. Depression [ee.]
ff Manic depression (bipolar disease) [ff.]
gg Schizophrenia [gg.]
PULMONARY
hh Asthma [hh.]
ii. Emphysema/COPD [ii.]
SENSORY
jj. Cataracts [jj.]
kk. Diabetic retinopathy [kk.]
ll. Glaucoma [ll.]
mm Macular degeneration [mm.]
OTHER
nn. Allergies [nn.]
oo. Anemia [oo.]
pp. Cancer [pp.]
qq. Renal failure [qq. ✓]
rr. *NONE OF ABOVE* [rr.]

2. INFECTIONS — *(If none apply, CHECK the NONE OF ABOVE box)*

a. Antibiotic resistant infection (e.g., Methicillin resistant staph) [a.]
b. Clostridium difficile (c.diff.) [b.]
c. Conjunctivitis [c.]
d. HIV infection [d.]
e. Pneumonia [e.]
f. Respiratory infection [f. ✓]
g. Septicemia [g.]
h. Sexually transmitted diseases [h.]
i. Tuberculosis [i.]
j. Urinary tract infection in last 30 days [j.]
k. Viral hepatitis [k.]
l. Wound infection [l.]
m. NONE OF ABOVE [m.]

3. OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9 CODES

a.	Cervical Spinal Stenosis	723.0
b.	Aftcre Surg Nerv Sys Nec	V58.72
c.	Resp System Disease Nec	519.8
d.		
e.		

SECTION H. CONTINENCE IN LAST 14 DAYS

1. CONTINENCE SELF-CONTROL CATEGORIES *(Code for resident's PERFORMANCE OVER ALL SHIFTS)*

0. *CONTINENT* - Complete control *(includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool)*
1. *USUALLY CONTINENT* - BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly
2. *OCCASIONALLY INCONTINENT* - BLADDER, 2 or more times a week but not daily; BOWEL, once a week
3. *FREQUENTLY INCONTINENT* - BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week
4. *INCONTINENT* - Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time

a.	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed	4
b.	BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed	0
2.	BOWEL ELIMINATION PATTERN	a. Bowel elimination pattern regular - at least one movement every three days [a. ✓]	c.
		b. Constipation [b.]	e.
		c. Diarrhea [c.]	
		e. *NONE OF ABOVE* [e.]	

SECTION J. HEALTH CONDITIONS

1. PROBLEM CONDITIONS — *(Check all problems present in last 7 days unless other time frame is indicated)*

INDICATORS OF FLUID STATUS
a. Weight gain or loss of 3 or more pounds within a 7 day period [a.]
b. Inability to lie flat due to shortness of breath [b.]
c. Dehydrated; output exceeds input [c.]
d. Insufficient fluid; did not consume all/almost all liquids provided during last 3 days [d.]
OTHER
e. Delirium [e.]
f. Dizziness/Vertigo [f.]
g. Edema [g. ✓]
h. Fever [h.]
i. Hallucinations [i.]
j. Internal bleeding [j.]
k. Recurrent lung aspirations in last 90 days [k.]
l. Shortness of breath [l.]
m. Syncope (fainting) [m.]
n. Unsteady gait [n.]
o. Vomiting [o.]
p. *NONE OF ABOVE* [p.]

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2. PAIN SYMPTOMS — *(Code the highest level of pain present in the last 7 days)*
- a. FREQUENCY with which resident complains or shows evidence of pain: 0. No pain *(skip to J4)* / 1. Pain less than daily / 2. Pain daily — [0]
- b. INTENSITY of pain: 1. Mild pain / 2. Moderate pain / 3. Times when pain is horrible or excruciating

3. PAIN SITE — *(If pain present, check all sites that apply in last 7 days)*

a. Back pain	a.	f. Incisional pain	f.
b. Bone pain	b.	g. Joint pain (other than hip)	g.
c. Chest pain while doing usual activities	c.	h. Soft tissue pain (e.g., lesion, muscle)	h.
d. Headache	d.	i. Stomach pain	i.
e. Hip pain	e.	j. Other	j.

4. ACCIDENTS — *(Check all that apply)*

a. Fell in past 30 days	a.	c. Hip fracture in last 180 days	c.
b. Fell in past 31-180 days	b. ✓	d. Other fracture in last 180 days	d.
		e. *NONE OF ABOVE*	e.

5. STABILITY OF CONDITIONS
- a. Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable - (fluctuating, precarious, or deteriorating) — a. ✓
- b. Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem — b. ✓
- c. End-stage disease, 6 or fewer months to live — c.
- d. *NONE OF ABOVE* — d.

SECTION K. ORAL/NUTRITIONAL STATUS

1. ORAL PROBLEMS
- a. Chewing problem — a. ✓
- b. Swallowing problem — b. ✓
- c. Mouth pain — c.
- d. *NONE OF ABOVE* — d.

2. HEIGHT AND WEIGHT — *Record (a) height in inches and (b) weight in pounds. Base weight on most recent measure in last 30 days; measure weight consistently in accord with standard facility practice - e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes*
a. HT (in.) [7 0] b. WT (lb.) [1 6 2]

3. WEIGHT CHANGE
- a. Weight loss - 5% or more in last 30 days; or 10% or more in last 180 days (0. No / 1. Yes) — 1
- b. Weight gain - 5% or more in last 30 days; or 10% or more in last 180 days (0. No / 1. Yes) — 0

4. NUTRITIONAL PROBLEMS

a. Complains about the taste of many foods	a.	c. Leaves 25% or more of food uneaten at most meals	c. ✓
b. Regular or repetitive complaints of hunger	b.	d. *NONE OF ABOVE*	d.

5. NUTRITIONAL APPROACHES — *(Check all that apply in last 7 days)*

a. Parenteral/IV	a.	f. Dietary supplement between meals	f. ✓
b. Feeding tube	b.	g. Plate guard, stabilized built-up utensil, etc.	g.
c. Mechanically altered diet	c. ✓	h. On a planned weight change program	h. ✓
d. Syringe (oral feeding)	d.	i. *NONE OF ABOVE*	i.
e. Therapeutic diet	e.		

6. PARENTERAL OR ENTERAL INTAKE — *(Skip to Section L if neither 5a nor 5b is checked)*
- a. Code the proportion of total calories the resident received through parenteral or tube feedings in the last 7 days: 0. None / 1. 1% to 25% / 2. 26% to 50% / 3. 51% to 75% / 4. 76% to 100%
- b. Code the average fluid intake per day by IV or tube in last 7 days: 0. None / 1. 1 to 500 cc/day / 2. 501 to 1000 cc/day / 3. 1001 to 1500 cc/day / 4. 1501 to 2000 cc/day / 5. 2001 or more cc/day

SECTION L. ORAL/DENTAL STATUS

1. ORAL STATUS AND DISEASE PREVENTION
- a. Debris (soft, easily movable substances) present in mouth prior to going to bed at night — a.
- b. Has dentures or removable bridge — b.
- c. Some/all natural teeth lost - does not have or does not use dentures (or partial plates) — c. ✓
- d. Broken, loose, or carious teeth — d.
- e. Inflamed gums (gingiva): swollen or bleeding gums; oral abscesses; ulcers or rashes — e.
- f. Daily cleaning of teeth/dentures or daily mouth care by resident or staff — f. ✓
- g. *NONE OF ABOVE* — g.

SECTION M. SKIN CONDITION

1. ULCERS (Due to any cause) — *(Record the number of ulcers at each ulcer stage - regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during last 7 days. Code 9 = 9 or more.) [Requires full body exam.]* — Number at Stage
- a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. — 0
- b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater. — 2
- c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue. — 0
- d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone. — 1

2. TYPE OF ULCER — *(For each type of ulcer, code for the highest stage in the last 7 days using scale in item M1 - i.e., 0=none; stages 1,2,3,4)*
- a. Pressure ulcer - any lesion caused by pressure resulting in damage of underlying tissue — 4
- b. Stasis ulcer - open lesion caused by poor circulation in the lower extremities — 0

3. HISTORY OF RESOLVED ULCERS — Resident had an ulcer that was resolved or cured in LAST 90 DAYS (0. No / 1. Yes) — 0

4. OTHER SKIN PROBLEMS OR LESIONS PRESENT — *(Check all that apply during last 7 days)*
- a. Abrasions, bruises — a. ✓
- b. Burns (second or third degree) — b.
- c. Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions) — c.
- d. Rashes - e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster — d.
- e. Skin desensitized to pain or pressure — e. ✓
- f. Skin tears or cuts (other than surgery) — f.
- g. Surgical wounds — g. ✓
- h. *NONE OF ABOVE* — h.

5. SKIN TREATMENTS — *(Check all that apply during last 7 days)*
- a. Pressure relieving device(s) for chair — a.
- b. Pressure relieving device(s) for bed — b. ✓
- c. Turning/repositioning program — c. ✓
- d. Nutrition or hydration intervention to manage skin problems — d. ✓
- e. Ulcer care — e. ✓
- f. Surgical wound care — f. ✓
- g. Application of dressings (with or without topical medications) other than to feet — g. ✓
- h. Application of ointments/medications (other than to feet) — h. ✓
- i. Other preventative or protective skin care (other than to feet) — i. ✓
- j. *NONE OF ABOVE* — j.

6. FOOT PROBLEMS AND CARE — *(Check all that apply during last 7 days)*
- a. Resident has one or more foot problems - e.g., corns, calluses, bunions, hammer toes, overlapping toes, pain, structural problems — a. ✓
- b. Infection of the foot - e.g., cellulitis, purulent drainage — b.
- c. Open lesions on the foot — c.
- d. Nails/calluses trimmed during last 90 days — d. ✓
- e. Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) — e.
- f. Application of dressings (with or without topical medications) — f.
- g. *NONE OF ABOVE* — g.

SECTION N. ACTIVITY PURSUIT PATTERNS

1. TIME AWAKE — *(Check appropriate time periods over last 7 days)*
Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:

a. Morning	a. ✓	c. Evening	c. ✓
b. Afternoon	b. ✓	d. *NONE OF ABOVE*	d.

(If resident is comatose, skip to Section O)

2. AVERAGE TIME INVOLVED IN ACTIVITIES — (When awake and not receiving treatments or ADL care)
0. Most-more than 2/3 of time / 1. Some-from 1/3 to 2/3 of time / 2. Little-less than 1/3 of time / 3. None — 1

3. PREFERRED ACTIVITY SETTINGS — *(Check all settings in which activities are preferred)*

a. Own room	a. ✓	d. Outside facility	d.
b. Day/activity room	b.	e. *NONE OF ABOVE*	e.
c. Inside NH/off unit	c.		

4. GENERAL ACTIVITY PREFERENCES (adapted to resident's activities) — *(Check all PREFERENCES whether or not activity is currently available to resident)*

a. Cards/other games	a.	g. Trips/shopping	g.
b. Crafts/arts	b.	h. Walking/wheeling outdoors	h.
c. Exercise/sports	c.	i. Watching TV	i. ✓
d. Music	d.	j. Gardening or plants	j.
e. Reading/writing	e.	k. Talking or conversing	k. ✓
f. Spiritual/religious activities	f.	l. Helping others	l.
		m. *NONE OF ABOVE*	m.

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5.	PREFERS CHANGE IN DAILY ROUTINE	*Code for resident preferences in daily routines* 0. No change 1. Slight change 2. Major change	
		a. Type of activities in which resident is currently involved	0
		b. Extent of resident involvement in activities	0

SECTION O. MEDICATIONS

1.	NUMBER OF MEDICATIONS	*(Record the number of different medications used in the last 7 days; enter "0" if none used)*	08
2.	NEW MEDICATIONS	*(Resident currently receiving medications that were initiated during the last 90 days)* 0. No 1. Yes	1
3.	INJECTIONS	*(Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used)*	1
4.	DAYS RECEIVED THE FOLLOWING MEDICATION	*(Record the number of DAYS during last 7 days; enter "0" if not used. Note - enter "1" for long-acting meds used less than weekly)*	
		a. Antipsychotic 0	d. Hypnotic 0
		b. Antianxiety 0	e. Diuretic 0
		c. Antidepressant 0	

SECTION P. SPECIAL TREATMENTS AND PROCEDURES

1.	SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS	a. SPECIAL CARE - *Check treatments or programs received during the last 14 days*	
		TREATMENTS	
		a. Chemotherapy — a.	l. Ventilator or respirator — l.
		b. Dialysis — b.	PROGRAMS
		c. IV medication — c.	m. Alcohol/drug treatment program — m.
		d. Intake/output — d. ✓	n. Alzheimer's/dementia special care unit — n.
		e. Monitoring acute medical condition — e. ✓	o. Hospice care — o.
		f. Ostomy care — f.	p. Pediatric unit — p.
		g. Oxygen therapy — g.	q. Respite care — q.
		h. Radiation — h.	r. Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs) — r.
		i. Suctioning — i.	s. *NONE OF ABOVE* — s.
		j. Tracheostomy care — j.	
		k. Transfusions — k.	

b. THERAPIES - *Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the last 7 calendar days (Enter 0 if none or less than 15 min. daily)*

[Note - count only post admission therapies]

(A) = # of days administered for 15 minutes or more
(B) = total # of minutes provided in last 7 days

	DAYS (A)	MIN (B)
a. Speech-language pathology and audiology services	1	0045
b. Occupational therapy	3	0180
c. Physical therapy	5	0150
d. Respiratory therapy	0	0000
e. Psychological therapy (by any licensed mental health professional)	0	0000

2.	INTERVENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS	(Check all interventions or strategies used in last 7 days - no matter where received)	
		a. Special behavior symptom evaluation program	a.
		b. Evaluation by a licensed mental health specialist in last 90 days	b.
		c. Group therapy	c.
		d. Resident-specific deliberate changes in the environment to address mood/behavior patterns - e.g., providing bureau in which to rummage	d.
		e. Reorientation - e.g., cueing	e. ✓
		f. *NONE OF ABOVE*	f.

3.	NURSING REHABILITATION/ RESTORATIVE CARE	*Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was provided to the resident for more than or equal to 15 minutes per day in the last 7 days* *(Enter 0 if none or less than 15 min. daily.)*	
		a. Range of motion (passive) 0	f. Walking 0
		b. Range of motion (active) 0	g. Dressing or grooming 0
		c. Splint or brace assistance 0	h. Eating or swallowing 0
		TRAINING AND SKILL PRACTICE IN:	i. Amputation/prosthesis care 0
		d. Bed mobility 0	j. Communication 0
		e. Transfer 0	k. Other 0

4.	DEVICES AND RESTRAINTS	*(Use the following codes for last 7 days.)* 0. Not used 1. Used less than daily 2. Used daily	
		Bed rails	
		a. – Full bed rails on all open sides of bed	2
		b. – Other types of side rails used (e.g., half rail, one side)	0
		c. Trunk restraint	0
		d. Limb restraint	0
		e. Chair prevents rising	0
5.	HOSPITAL STAY(S)	Record number of times resident was admitted to hospital with an overnight stay in last 90 days (or since last assessment if less than 90 days). *(Enter 0 if no hospital admissions)*	00
6.	EMERGENCY ROOM (ER) VISIT(S)	Record number of times resident visited ER without an overnight stay in last 90 days (or since last assessment if less than 90 days). *(Enter 0 if no ER visits)*	00
7.	PHYSICIAN VISITS	In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? *(Enter 0 if none)*	01
8.	PHYSICIAN ORDERS	In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? *Do not include order renewals without change. (Enter 0 if none)*	08
9.	ABNORMAL LAB VALUES	Has the resident had any abnormal lab values during the last 90 days (or since admission)? 0. No 1. Yes	1

SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

1.	DISCHARGE POTENTIAL	a. Resident expresses/indicates preference to return to the community 0. No 1. Yes	0
		b. Resident has a support person who is positive towards discharge 0. No 1. Yes	0
		c. Stay projected to be of a short duration - discharge projected within 90 days (do not include expected discharge due to death) 0. No 1. Within 30 days 2. Within 31-90 days 3. Discharge status uncertain	3
2.	OVERALL CHANGE IN CARE NEEDS	Resident's overall self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved-receives fewer supports, needs less restrictive level of care 2. Deteriorated-receives more support	0

SECTION R. ASSESSMENT INFORMATION

1.	PARTICIPATION IN ASSESSMENT	a. Resident: 0. No 1. Yes	1
		b. Family: 0. No 1. Yes 2. No family	1
		c. Significant other: 0. No 1. Yes 2. None	0

2. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:

a. Signature of RN Assessment Coordinator (sign on above line)

b. Date RN Assessment Coordinator signed as complete 0 4 (Month) - 0 3 (Day) - 2 0 0 6 (Year)

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SECTION T. THERAPY SUPPLEMENT FOR MEDICARE PPS

1. SPECIAL TREATMENTS AND PROCEDURES

a. **RECREATION THERAPY** - *Enter number of days and total minutes of recreation therapy administered (for at least 15 minutes a day) in the last 7 days (Enter 0 if none)*

	DAYS (A)	MIN (B)
(A) = # of days administered for 15 minutes or more		
(B) = total # of minutes provided in last 7 days		

Skip unless this is a Medicare 5 day or Medicare readmission/return assessment.

b. **ORDERED THERAPIES** - *Has physician ordered any of following therapies to begin in FIRST 14 days of stay - physical therapy, occupational therapy, or speech pathology service?*

0. No 1. Yes

If not ordered, skip to item 2

c. Through day 15, provide an estimate of the number of days when at least 1 therapy service can be expected to have been delivered.

d. Through day 15, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered?

2. WALKING WHEN MOST SELF SUFFICIENT

Complete item 2 if ADL self-performance score for TRANSFER (G.1.b.A) is 0, 1, 2, or 3 AND at least one of the following are present:

Resident received physical therapy involving gait training (P.1.b.c.)

Physical therapy was ordered for the resident involving gait training (T.1.b)

Resident received nursing rehabilitation for walking (P.3.f.)

Physical therapy involving walking has been discontinued within the past 180 days

Skip to item 3 if resident did not walk in last 7 days

(FOR FOLLOWING FIVE ITEMS, BASE CODING ON THE EPISODE WHEN THE RESIDENT WALKED THE FARTHEST WITHOUT SITTING DOWN. INCLUDE WALKING DURING REHABILITATION SESSIONS.)

a. **Furthest distance walked** without sitting down during this episode.

0. 150+ feet
1. 51-149 feet
2. 26-50 feet
3. 10-25 feet
4. Less than 10 feet

b. **Time walked** without sitting down during this episode.

0. 1-2 minutes
1. 3-4 minutes
2. 5-10 minutes
3. 11-15 minutes
4. 16-30 minutes
5. 31+ minutes

c. **Self-Performance** in walking during this episode.

0. *INDEPENDENT* - No help or oversight
1. *SUPERVISION* - Oversight, encouragement or cueing provided
2. *LIMITED ASSISTANCE* - Resident highly involved in walking; received physical help in guided maneuvering of limbs or other nonweight bearing assistance
3. *EXTENSIVE ASSISTANCE* - Resident received weight bearing assistance while walking

d. **Walking support provided** associated with this episode (code regardless of resident's self-performance classification).

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist

e. **Parallel bars** used by resident in association with this episode.

0. No 1. Yes

3. CASE MIX GROUP

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SECTION W. SUPPLEMENTAL MDS ITEMS

1.	National Provider ID	Enter for all assessments and tracking forms, if available.	
If the ARD of this assessment or the discharge date of this discharge tracking form is between July 1 and September 30, skip to W3.			
2.	Influenza Vaccine	a. Did the resident receive the influenza vaccine in this facility for this year's influenza season (October 1 through March 31)? 0. No (If No, go to item W2b) 1. Yes (If Yes, go to item W3)	0
		b. If influenza vaccine not received, state reason: 1. Not in facility during this year's flu season 2. Received outside of this facility 3. Not eligible 4. Offered and declined 5. Not offered 6. Inability to obtain vaccine	2
3.	Pneumo-coccal Vaccine	a. Is the resident's PPV status up to date? 0. No (If No, go to item W3b) 1. Yes (If Yes, skip item W3b)	1
		b. If PPV not received, state reason: 1. Not eligible 2. Offered and declined 3. Not offered	

Care Plan

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Name: PETERSON, WILLIAM *No:* 1050 *Location:* P 214 D *Weight:* 162 *Height:* 70 *Sex:*

Date Admitted: 03/21/2006 *Date of Birth:* [redacted] *Physician:* MASSEY, TAMI *Phone:* (803) 637-3146

ADVANCE DIRECTIVES: DNR MEDICAL ALERT: NO NG OR G TUBES

Problem/Need	*Goal & Target Date*	*Approaches*	*Role(s)*	*Time Code*	*Comments*
Related Dx: 519.8 Resp System Disease Nec					
Problem Onset: 12/30/1899					
POTENTIAL FOR ACTIVITY INTOLERANCE R/T HTN AND URI RES IS DNR CP 4/5/06	RES WILL HAVE NORMAL ACTIVITY LEVEL WITH NO SOB AND CHEST PAIN 7/01/06 5/12/06 resolved	* MONITOR RES FOR SIGNS OF ACTIVITY INTOLERANCE- SOB, FATIGUE, CYANOSIS, CHEST PAIN, CHANGES IN PULSES AND B/P, SWEATING, PALLOR	N		4/4 clear DNR ⊘tubes
		* MONITOR VITAL SIGNS Q SHIFT AND NOTIFY MD OF ANY CHANGES	N		4/14 CBC, BMP 4/1 5/12 O2@2LNC 2° apnea pt
		* ENC RES TO REST BETWEEN ACTIVITIES	AST		Clean filter QWOC
		* GRADUAL TOLERANCE WITH PERFORMANCE OF ACTIVITIES	AST		Humid. Q3days + PRN
		* HONOR CODE STATUS	AST		monthly
		* BMP/CBC NEXT WEEK	PH		
		* 3/17 TRANSPORT TO ECH ER FOR EVAL	NNA		5/15 Send to ARMC ER 2° apnea via EMS
		* ADMIT TO ARMC			
		* PNEUMONIA VAC 2/23/6 @ARMC	N		
		* FLU VAC 2/27/06 @ARMC	N		
		* 3/30 UA/CXR/BLOOD CULTURES	PH		
		* 3/30 LEVAQUIN 500MG DAILY X 7	PH		
		* 3/30 FAX CREAT RESULT MOST RECENT	PH		
		* 3/30 DECREAE LEVAQUIN TO 250MG PO Q HS X 6 MORE DOSES	PH		
		* 3/21 RE-ADMIT	PH		
		* VS & I&O QS	NNA		
		* NORVASC 5MG DAILY	N		
		* ATENOLOL 12.5MG BID	N		
		VS I+O QS			

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Name: PETERSON, WILLIAM *No:* 1050 *Location:* P 214 D *Weight:* 162 *Height:* 70 *Sex:*

Problem/Need	*Goal & Target Date*	*Approaches*	*Role(s)*	*Time Code*	*Comments*
...elated Dx: 530.81 Esophageal Reflux		*Nursing Dx:* Nutrition, altered: Less than body requir			
Problem Onset: 02/27/2006					
NOTED FOR WEIGHT LOSS 18LB SINCE 3/1/06... REC MECHANICALLY ALTERED DIET...LEAVES 25% OR MORE OF MEALS. NEEDS TO BE FED TO ENSURE INTAKE DESIRES NO NG/G-TUBE CP 4/5/06 High risk for aspiration c Chewing + swallow prob	* WILL NOT EXPERIENCE GI DISTRESS TNRD 7/01/06 * RES WILL NOT EXPERIENCE FURTHER WEIGHT LOSS TNRD 7/01/06 * No episodes of aspiration pneumonia CXR clear	* 3/29 INCREASE NOVASOURCE/RESOURCE 2.0 TO 180CC PO QID	N&D		4/11/06 Reviewed + Revised MD orders
		* 3/29 PROSTAT 101-30CC IN 4 OZ JUICE TID X 2 MOS	N&D		4/1 D/C ST - Res pt safe compensatory strategies, NSG to monitor weight d/s, *MS diet
		* 3/29 SLP TO SCREEN FOR DYSPHAGIA	PH		
		* 3/31 ST RECOMMEND TO CONTINUE MS DIET. ST REC TO INCREASE PO INTAKE AND TX FOR SAFE SWALLOWING OF MS. PT/STAFF TRAINING–10 VISITS X 1 MONTH → Ed back to Puree'd	ST	4h 8	
		~~* ZANTAC 150MG Q HS~~	~~N~~		
		~~* 3/3 PROSTAT 101 GIVE 30CC PO IN 4 OZ JUICE BID(LOW PRE-ALBUMIN)~~	~~N&D~~		4/14 Periactin PO TID
		~~* 3/3 BOOST SUPPLEMENT 1 CAN TID AFTER MEALS~~	~~N&D~~		
		~~* 3/21 DC BOOST AND ZANTAC~~	~~PH~~		
		* 3/21 SILVERVITE DAILY X 2 MOS—DC MAY 21	N&D		
		* 3/21 PROTONIX 40MG DAILY	N		
		~~* 3/21 NOVOSOURCE 120CC QID BETWEEN MEALS~~	~~N&D~~		
		* Determine food preferences	N&D		
		* Ask family/significant others about resident's food preferences	N&D		
		* Prompt resident to eat at least one bite of each food served at meal	N&D		
		* Offer bedtime snack	N&D		
		* Weigh resident every WEEK	NNA		
		* Refer to dietitian for evaluation and recommendations	D		
		* Engage resident in conversation during meal to entice eating as part	NNA		
		Puree diet Magic cup L-S			

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Name: PETERSON, WILLIAM *No:* 1050 *Location:* P 214 D *Weight:* 162 *Height:* 70 *Sex:*

Problem/Need	*Goal & Target Date*	*Approaches*	*Role(s)*	*Time Code*	*Comments*
		of socialization			
		* SET UP TRAY AND ENC RES TO EAT Feed Pt at meals	NNA		
		* SIT RES AT THE TABLE WITH OTHER RES	N&T		
		* MONITOR THE AMT OF MEAL ACCEPTED Q SHIFT	NSA		
		* OFFER SUBSTITUTES AS NEEDED	D		
		* Monitor for S/S of aspiration pneumonia	ALL		
Related Dx: 728.87 Muscle Weakness-General		*Nursing Dx:* Injury, risk for			
Problem Onset: 02/27/2006					
REQUIRES ASSIST TO TRANSFER, AMBULATORY DX CERVICAL SPINAL STENOSIS WITH S/P SPINAL EFFUSION CP 4/5/06	* RES WILL INCREASE STRENGTH AND ENDURANCE AEB PARTICIPATION WITH PT TNRD 7/01/06 * Receive no injury due to falling by: 7/01/06	* PT 3-5 X WEEKLY FOR THER-EX/ACT; ~~GAIT/TRANSFER TRAINING AND NEUROMUSCULAR RE-ED~~	PT		4/11 C Spine Xray V.O. Dr Santiago 4/25 D/C OT
		* TRANSFER OOB TO GCR AS TOL	PT		
		* HALF SIDE RAILS UP X2 TO ASSIST WITH TURNING AND TRANSFERS	NSA		
		* FALL ASSESSMENT ON ADMISSION AND QUARTERLY	N		
		* PROVIDE FOR SAFE CLUTTER FREE ENVIRONMENT	AST		
		* ENSURE FOOT WEAR WORN IS SLIP RESISTANT	NSA		
		* STAFF TO BE AWARE OF RISK FOR FALLS	AST		
		* MONITOR RES TO ENSURE ASSISTANCE WITH AMBULATION	AST		
		* MONITOR SITTING BALANCE AND POSITIONING WHEN UP IN W/C	N		
		* ENC RES TO ATTEND WELLNESS ACTIVITIES	AST		

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Name: PETERSON, WILLIAM *No:* 1050 *Location:* P 214 D *Weight:* 162 *Height:* 70 *Sex:*

Problem/Need	*Goal & Target Date*	*Approaches*	*Role(s)*	*Time Code*	*Comments*
Related Dx: 290.0 Senile Dementia Uncomp		*Nursing Dx:* Social isolation			
Problem Onset: 02/27/2006					
NEED FOR ACTIVITIES TO PROMOTE SOCIALATION/INTERACTI N WITH OTHERS CP 4/5/06	* ACTIVITIES STAFF TO VISIT 1:1 DAILY TNRD 7/01/06 * RES WILL ATTEND1-2 GROUP ACTIVITES A WEEK THRU NEXT REVIEW DATE 7/01/06	* INFORM RES OF SCHEDULED ACTIVITIES * ENCOURAGE RES TO ATTEND AND PARTICIPATE IN SCHEDULED ACTIVITIES * PRAISE RES FOR COOPERATION AND PARTICIPATION * ASSIST RES TO AND FROM ACTIVITIES * DETERMINE INTERESTS AND SCHEDULE ACTIVITY WHEN APPICABLE * 1 : 1 VISITS FROM STAFF AND FAMILY DAILY	A AST AST N&A A T&A		
Related Dx: 600.90 Bph Nos W/O Urinary Obst		*Nursing Dx:* Infection, risk for			
Problem Onset: 03/27/2006					
POTENTIAL FOR UTI DX BPH AND INCREASED PSA=PROSTATE OBSTRUCTION NEUROPATHIC BLADDER-REQUIRES CATHETER #16F/10CC S/P RENAL FAILURE CP 4/5/06	* WILL MAINTAIN PATENT FOLEY CATHETER 7/01/06 * Show no sign of urinary tract infection by: 7/01/06	* FLOMAX 0.4MG Q HS * 3/22 NEEDS F/U APPT WITH DR ANDERSON IN 1 MONTH * FOLEY CARE QS—#16F 10CC—CHANGE Q6-8 WEEKS * ASSIST TO BATHROOM Q TWO HOURS AND PRN * ENC RES TO VOICE NEEDS WITH CUEING * CALL LIGHT WITHIN REACH AND ANSWER ASAP * INCONT CARE AFTER INCONT EPISODES	PH N TR NNA NNA NNA A		4/14 UA + cult 4/19 ∆ foley 4/26 and Q 4wks Enc Pofluids

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Name: PETERSON, WILLIAM *No:* 1050 *Location:* P 214 D *Weight:* 162 *Height:* 70 *Sex:*

Problem/Need	*Goal & Target Date*	*Approaches*	*Role(s)*	*Time Code*	*Comments*
		* I & O Q SHIFT	NSA		
		* MONITOR FOR S/S OF UTI-CHANGES IN LOC, FEVER, PAINFUL URINATION, CHANGES IN COLOR, ODOR AND CONSISTENCY	N		
		* LABS AS ORDERED-MONITOR-NOTIFY MD OF RESULTS	N		
		* MONITOR B & B CONTROL	N		
		* OFFER FLUIDS BETWEEN MEALS TID	NNA		
Related Dx: 780.79 Malaise And Fatigue Nec					
roblem Onset: 02/27/2006					
REQUIRES ASSIST WITH BED MOBILITY, DRESSING, EATING, TOILET USE, PERSONAL HYGIENE, AND BATHING CP 4/5/06 Contractures	* RES WILL INCERASE STRENGTH AND ENDURANCE AEB PARTICIPATION WITH OT TNRD 7/01/06 4/25/06 * RES WILL INCREASE IN THEIR PERFORMANCE WITH ALD'S AEB REQUIRING LESS ASSIST BY STAFF BY NEXT REVIEW DATE 7/01/06 * RES WILL BE NEAT CLEAN AND ODOR FREE BY NEXT REVIEW DATE 7/01/06	* 3/2 OT 3-5X WEEKLY FOR ADL'S, THER-EX/ACT AND CAREGIVER ED	OT	4/25 D/C OT	
		* 3/23 PT 3-5X WEEKLY FOR ROM, STRETCHING LE, TEHR-EX/ACT, WC PROPULSION/MGMT	PT	5/3/06 Pt to use anti-cont wedge to LE when be	
		* 3/23 OT 3-5X WEEKLY FOR ADL'S, THER-EX/ACT AND CAREGIVER RE-ED	OT	5/1/06 D/C Collars	
		* 3/28 ASPEN COLLAR TO BE WORN FOR MOBILIZATION WHEN OOB IN CHAIR, AMBULATING AND REHAB SESSIONS	NNA		
		* ONE PERSON TO ASSIST RES WITH GROOMING, BATHING, PERSONAL HYGIENE, BED MOBILITY AND TOILETING NEEDS	NNA		
		* SET UP SUPPLIES FOR BATHING, DRESING, AND	NNA		

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Name: PETERSON, WILLIAM *No:* 1050 *Location:* P 214 D *Weight:* 162 *Height:* 70 *Sex:*

Problem/Need	*Goal & Target Date*	*Approaches*	*Role(s)*	*Time Code*	*Comments*
		GROOMING AND ENC RES TO PARTICIPATE/ IF UNABLE STAFF TO COMPLETE			
		* SET UP TRAY AND ENC RES TO FEED SELF	NNA		
		* NAIL CARE DAILY AND PRN	NNA		
		* ORAL CARE DAILY AND CHECK ORAL CAVITY FOR INFLAMMATION, BLEEDING OR BLISTERS	NNA		
		* DENTAL CONSULT PRN	N		
		* HALF SIDE RAILS UP X 2 TO ASSIST WITH TURNING AND REPOSITIONING	NNA		
		* ENC AND PRAISE RES FOR SELF-PERFORMANCE	AST		
		* ENSURE RES IS UP AND DRESSED IN STREET CLOTHERS DAILY	NNA		
		* PT/OT AS ORDERED-FOLLOW RECOMMENDATIONS AS INDICATED	NNA		
		* ASSIST WITH LOCOMOTION TO AND FROM ACTIVITIES	AST		
		* ASSIST WITH TRANSFERS AND AMBULATION	NNA		

Related Dx: 389.9 Hearing Loss Nos *Nursing Dx:* Sensory/perceptual alterations

Problem Onset: 02/27/2006

IMPAIRED COMMUNICATION R/T HEARING LOSS SLOW TO RESPOND CP 4/5/06	* RES WILL RESPOND APPROPRIATELY TO SIMPLE DIRECT COMMUNICATION TNRD 7/01/06 * RES WILL VOICE SOME OF THEIR NEEDS WITH CUEING FROM STAFF DAILY THUR NEXT REVIEW	* Ask resident questions that require one- or two-word answers * Touch resident before beginning to speak to resident * Face resident when speaking to resident * Remove as much background noise	AST AST AST AST	

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Name: PETERSON, WILLIAM *No:* 1050 *Location:* P 214 D *Weight:* 162 *Height:* 70 *Sex:*

Problem/Need	*Goal & Target Date*	*Approaches*	*Role(s)*	*Time Code*	*Comments*
	DATE 7/01/06	as possible when speaking with resident			
		* Use short, direct phrases when talking with resident	AST		
		* ADJUST TONE WHEN SPEAKING TO RES	AST		
		* MONITOR FACIAL EXPRESSION FOR UNDERSTANDING OF SPEAKER'S INTENT	AST		
		* PROVIDE RES WITH VERBAL CUES AS NEEDED TO ENHANCE RESPONSE	AST		
		* APPROACH IN A WARM FRIENDLY MANNER	AST		
		* PRAISE APPROPRIATE RESPONSES	AST		
		* ANTICIPATE RES NEEDS AND PROMPT RES TO VERIFY	AST		
Related Dx: 290.0 Senile Dementia Uncomp		*Nursing Dx:* Memory, impaired			
Problem Onset: 02/27/2006					
COGNITIVE OSS-IMPAIRED THOUGHT PROCESS R/T DEMENTIA...CONFUSED TO TIME, DATE AND PLACE MINI-MENTAL SCORE 9 CP 4/5/06	* RES WILL MAINTAIN CURRENT COGNITIVE STATUS AEB ANSWERING TO THEIR NAME AND RECOGNIZING FAMILY MEMEBERS WHEN THEY VISIT THRU NEXT REVIEW DATE 7/01/06 * RES WILL BE ABLE TO VOICE THEIR NEEDS APPROPRIATELY THRY NEXT REVIEW DATE 7/01/06	* Provide 24-hour reality orientation	AST		4/14 √ mini mental
		* Ensure that resident has access to clock or watch at all times	AST		
		* Place calendar where resident has access to it	A		
		* Observe for changes in cognitive status	N		
		* Provide consistent caregiver	NNA		
		* Ensure that staff wear name tags at all times when caring for resident	AST		
		* Ensure that staff introduce themselves to resident at initiation of each interaction with resident	AST		
		* Give one instruction at a time to resident	AST		

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Name: PETERSON, WILLIAM *No:* 1050 *Location:* P 214 D *Weight:* 162 *Height:* 70 *Sex:*

Problem/Need	*Goal & Target Date*	*Approaches*	*Role(s)*	*Time Code*	*Comments*
		* Give resident two choices when presenting decisions	AST		
		* Praise resident for each decision made	AST		
		* DO NOT RUSH RESIDENT-ALLOW TIME TO GATHER THOUGHTS	AST		
		* INTERACT WITH RES DURING CARE-INFORM RES OF EACH ACTIVITY BEFORE ATTEMPTING TO COMPLETE	AST		
		* ENSURE DIGNITY AT ALL TIMES	AST		
		* NOTIFY MD AND FAMILY OF CHANGES IN COGNITIVE STATUS	N		
		* CALL RESIDENT BY NAME-MR PETERSON	AST		
Related Dx: V58.72 Aftcre Surg Nerv Sys Nec		*Nursing Dx:* Skin integrity, risk for impaired			
Problem Onset: 03/21/2006					
Potential for skin breakdown related to immobility DMITTED WITH HEALED ABRASION TO SHIN(SCABBED) READMITTED WITH STAGE 4 TO RIGHT HEEL, AREAS TO PENIS, AND SURGICAL INCISION 3/23 RIGHT HEEL -7X2CM-BLACK ESCHAR	* ~~STAGE 4 TO HEEL WILL DECREASE IN SIZE BY 4/23/06~~ resolved 5/2/06 * SURGICAL INCISION WILL HEAL WITHOUT EVIDENCE OF INFECTION BY 4/23/06 4/19/06 Areas to penis will resolve by 5/1/06	* ~~3/2 CLEAN R LOWER LEG RE-OPENED ABRASION W/WOUND CLEANER-APPLY BACITRACIN AND BA DAILY~~ * ~~3/6 HEEL BOOTIES WHILE IN BED~~ * 3/22 ALTERNATING PRESSUE MATTRESS * ~~3/22 DC HEEL PADS~~ * 3/22 VASOLINE TO PENIS BID * ~~3/22 CLEAN NECK INCISION SITE WITH WOUND CLEANER-APPLY DRY DRESSING DAILY~~ * ENSURE BED LINENS ARE CLEAN, DRY AND WRINKLE FREE	TR NNA TR TR TR TR A	4/19 10 DC'd per Penis BLS until resolved DC'd 4/19 to neck Incis 4/20 Δ Neosporin to penis QS 4/20 PT to do wound care Sx. Qhup - clean c wx, Apply panafil oint + Cover c optifoam Nsg to do St/Sx 5/2 Δ panafil to accuzyme per PT protocol Cust Qhup	

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Name: PETERSON, WILLIAM *No:* 1050 *Location:* P 214 D *Weight:* 162 *Height:* 70 *Sex:*

Problem/Need	*Goal & Target Date*	*Approaches*	*Role(s)*	*Time Code*	*Comments*
		* ASSIST TO TURN AND REPOSITION Q 2 HR	A		5/12 clarification - alt pressure functioning + inflation
		* INCONT CARE Q 2 HR WHEN INDICATED	A		
		* HALF SIDE RAILS UP X 2 AS ENABLER	NNA		
		* BODY AUDIT DAILY	TR		
		* SKIN ASSESSMENT QUARTERLY	N		
		* ENC RES TO EAT MEALS TO ENSURE ADEQUATE NUTRITION AND HYDRATION	NNA		
		~~Wash~~ Wash clean & wet, apply bacitracin + Optifoam daily			
Related Dx: 723.0 Cervical Spinal Stenosis					
Problem Onset: 12/30/1899					
OTENTIAL FOR UNRELIEVED PAIN AND DISCOMFORT...RECENT CERVICAL STENOSIS SURGERY...WEARING CERVICAL COLLAR	* RES WILL NOT HAVE UNCONTROLLED PAIN TNRD 7/01/06	* MONITOR FOR SIGNS OF PAIN ASK RES TO DESCRIBE PAIN IN A SCALE OF 0-10- MONITOR FOR GUARDING, FACIAL EXPRESSIONS, HOLDING AFFECTED AREA	N		
	* RES WILL NOT REQUIRE PAIN MEDICATION TNRD 7/01/06	* ASSESS PAIN FOR INTENSITY AND CHARACTER-ONSET-LOCATION-DISCRIPTION-INTENSITY (0-10)-AGGRAVATING AND RELIEVING FACTORS- EFFECT-	N		
CP 4/5/06		* MEDICATE FOR PAIN AS ORDERED- ASSESS FOR RELIEF OF PAIN AND NOTIFY MD IF NOT EFFECTIVE	N		
		* TEACH RES NON-PHARMACOLOGICAL INTERVENTIONS TO RELIEVE PAIN-POSITIONING -SUPPORT AFFECTED PAINFUL AREA-HOT/COLD APPLICAION,	N		

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Name: PETERSON, WILLIAM *No:* 1050 *Location:* P 214 D *Weight:* 162 *Height:* 70 *Sex:* M

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Problem/Need	*Goal & Target Date*	*Approaches*	*Role(s)*	*Time Code*	*Comments*
		RELAXATION, MASSAGE			
		* FILL OUT PAIN ASSESSMENT SHEET AFTER EACH PRN PAIN MED.	N		
		* PAIN ASSESSMENT SHEET ON ADMISSION AND QUARTERLY	N		
		* 3/22 CALL DR SANTIAGO(NEUROSURGEON) FOR F/U AND ORDERS ON CERVICAL COLLAR(LENGTH TO WEAR)	N		
		* 3/24 ~~SOFT COLLAR PRN FOR COMFORT X 6 WEEKS~~(DC MAY 2)	PH		
		* 3/24 F/U APPT DR SANTIAGO 5/1/06 @1045AM	PH		
		* 3/24 ~~XRAY C-SPINE AP/LAT W/FLEXION AND EXTENTION BRING COPIES TO F/U APPT~~	PH		

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ESIDENT REQUIRES MEDICAL SUPERVISION PROVIDED BY NURSING HOME
LACEMENT. NO DISCHARGE IS INDICATED AT THIS TIME.

		Signature:	*Date:*
A	Activities		
D	Dietary	Mattie Gordon, RN	4-5-06
M	Family		
MDS	MDS NURSE	Kathleen Deyches	4-5-06
SS	Social Service	Sharon Nicholson, SS	4/5/06
T&A	THERAPY & ACTIVITIES	Leona Bernstine	4/5/06
		Jay Logan RN	4/5/06

Name: PETERSON, WILLIAM *No:* 1050 *Location:* P 214 D *Weight:* 162 *Height:* 70 *Sex:* M

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Problem/Need	*Goal & Target Date*	*Approaches*	*Role(s)*	*Time Code*	*Comments*

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Numeric Identifier 247[illegible]0-6586 -700-

MINIMUM DATA SET (MDS) - VERSION 2.0
FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BASIC ASSESSMENT TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME*	WILLIAM PETERSON a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2.	GENDER*	1. Male 2. Female — 1
3.	BIRTHDATE*	[redacted] Month Day Year
4.	RACE/* ETHNICITY	1. American Indian/Alaskan Native 4. Hispanic 2. Asian/Pacific Islander 5. White, not of Hispanic origin 3. Black, not of Hispanic origin — 3
5.	SOCIAL SECURITY AND MEDICARE NUMBERS*	a. Social Security Number [redacted] b. Medicare number (or comparable railroad insurance number) [redacted]
6.	FACILITY PROVIDER NO.*	a. State No. 0 5 9 1 N H b. Federal No. 4 2 5 2 9 3
7.	MEDICAID NO. ["+" *If pending, "N" if not a Medicaid recipient*]*	
8.	REASONS FOR ASSESS-MENT	[Note - Other codes do not apply to this form] a. Primary reason for assessment — 00 01. Admission assessment (required by day 14) 02. Annual assessment 03. Significant change in status assessment 04. Significant correction of prior full assessment 05. Quarterly review assessment 10. Significant correction of prior quarterly assessment 00. *NONE OF ABOVE* *b. Codes for assessments required for Medicare PPS or the State* — 2 *1. Medicare 5 day assessment* *2. Medicare 30 day assessment* *3. Medicare 60 day assessment* *4. Medicare 90 day assessment* *5. Medicare readmission/return assessment* *6. Other state required assessment* *7. Medicare 14 day assessment* *8. Other Medicare required assessment*

9.	Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form		
	I certify that accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.		
	Signature and Title	Sections	Date
a.	Kathleen Dycles LPN AABCDEGHIJMNOPQCW		4/18/06
b.	Sharon Nicholson RN	E&J	4/18/06
c.	Mattie Boyd RN K		4/18/06
d.	Leonora Dunston LVN N		4/18/06
e.			
f.			
g.			
h.			
i.			
j.			
k.			
l.			

GENERAL INSTRUCTIONS

Complete this information for submission with all full and quarterly assessments (Admission, Annual, Significant Change, State or Medicare required assessments, or Quarterly Reviews, etc.)

Resident WILLIA[illegible] PETERSON ( ) Numeric Identifier 247 [illegible]-6586

MINIMUM DATA SET (MDS) - VERSION 2.0

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

FULL ASSESSMENT FORM

(Status in last 7 days, unless other time frame indicated)

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1. RESIDENT NAME — WILLIAM PETERSON
a.(First) b.(Middle Initial) c.(Last) d.(Jr/Sr)

2. ROOM NUMBER — P 2 1 4 D

3. ASSESSMENT REFERENCE DATE
a. *Last day of MDS observation period* — 0 4 - 1 8 - 2 0 0 6 (Month - Day - Year)
b. Original (0) or corrected copy of form (enter number of correction) — 0

4a. DATE OF REENTRY
Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days)
Month - Day - Year

5. MARITAL STATUS — 3
1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced

6. MEDICAL RECORD NO. — 1 0 5 0

7. CURRENT PAYMENT SOURCES FOR N. H. STAY
(Billing Office to indicate; check all that apply in last 30 days)

a. Medicaid per diem	a.	f. VA per diem	f.
b. Medicare per diem	b. ✓	g. Self or family pays for full per diem	g.
c. Medicare ancillary part A	c.	h. Medicaid resident liability or Medicare co-payment	h.
d. Medicare ancillary part B	d.	i. Private insurance per diem (including co-payment)	i.
e. CHAMPUS per diem	e.	j. Other per diem	j.

8. REASONS FOR ASSESSMENT — 00
[Note - If this is a discharge or reentry assessment, only a limited subset of MDS items need be completed]
a. Primary reason for assessment
01. Admission assessment (required by day 14)
02. Annual assessment
03. Significant change in status assessment
04. Significant correction of prior full assessment
05. Quarterly review assessment
06. Discharged - return not anticipated
07. Discharged - return anticipated
08. Discharged prior to completing initial assessment
09. Reentry
10. Significant correction of prior quarterly assessment
00. *NONE OF ABOVE*

b. *Codes for assessments required for Medicare PPS or the State* — 2
1. *Medicare 5 day assessment*
2. *Medicare 30 day assessment*
3. *Medicare 60 day assessment*
4. *Medicare 90 day assessment*
5. *Medicare readmission/return assessment*
6. *Other state required assessment*
7. *Medicare 14 day assessment*
8. *Other Medicare required assessment*

9. RESPONSIBILITY/ LEGAL GUARDIAN
(Check all that apply)

a. Legal guardian	e.	d. Durable power of attorney/financial	d.
b. Other legal oversight	b.	e. Family member responsible	e. ✓
c. Durable power of attorney/health care	c.	f. Patient responsible for self	f.
		g. *NONE OF ABOVE*	g.

10. ADVANCED DIRECTIVES
(For those items with supporting documentation in the medical record, check all that apply)

a. Living will	a.	f. Feeding restrictions	f. ✓
b. Do not resuscitate	b. ✓	g. Medication restrictions	g.
c. Do not hospitalize	c.	h. Other treatment restrictions	h. ✓
d. Organ donation	d.	i. *NONE OF ABOVE*	i.
e. Autopsy request	e.		

SECTION B. COGNITIVE PATTERNS

1. COMATOSE — 0
(Persistent vegetative state/no discernible consciousness)
0. No 1. Yes (If yes, skip to Section G)

2. MEMORY
(Recall of what was learned or known)
a. Short-term memory OK-seems/appears to recall after 5 minutes — 1
0. Memory OK 1. Memory problem
b. Long-term memory OK-seems/appears to recall long past — 1
0. Memory OK 1. Memory problem

3. MEMORY/ RECALL ABILITY
(Check all that resident was normally able to recall during last 7 days)

a. Current season	a.	d. That he/she is in a nursing home	d. ✓
b. Location of own room	b.	e. *NONE OF ABOVE* are recalled	e.
c. Staff names/faces	c. ✓		

4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING — 2
(Made decisions regarding tasks of daily life)
0. *INDEPENDENT*-decisions consistent/reasonable
1. *MODIFIED INDEPENDENCE*-some difficulty in new situations only
2. *MODERATELY IMPAIRED*-decisions poor; cues/supervision required
3. *SEVERELY IMPAIRED* - never/rarely made decisions

5. INDICATORS OF DELIRIUM - PERIODIC DISORDERED THINKING/ AWARENESS
(Code for behavior in the last 7 days.) [Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time].
0. Behavior not present
1. Behavior present, not of recent onset
2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)

a. EASILY DISTRACTED-(e.g., difficulty paying attention; gets sidetracked)	0
b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS-(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)	0
c. EPISODES OF DISORGANIZED SPEECH-(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)	1
d. PERIODS OF RESTLESSNESS-(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)	0
e. PERIODS OF LETHARGY-(e.g., sluggishness; staring into space, difficult to arouse; little body movement)	0
f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY-(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)	1

6. CHANGE IN COGNITIVE STATUS — 0
Resident's cognitive status, skills, or abilities have changed as compared to status of 90 days ago (or since last assessment if less than 90 days)
0. No change 1. Improved 2. Deteriorated

SECTION C. COMMUNICATION/HEARING PATTERNS

1. HEARING — 2
(With hearing appliance, if used)
0. *HEARS ADEQUATELY*-normal talk, TV, phone
1. *MINIMAL DIFFICULTY* when not in quiet setting
2. *HEARS IN SPECIAL SITUATIONS ONLY*-speaker has to adjust tonal quality and speak distinctly
3. *HIGHLY IMPAIRED*/absence of useful hearing

2. COMMUNICATION DEVICES/ TECHNIQUES
(Check all that apply during last 7 days)

a. Hearing aid, present and used	a.
b. Hearing aid, present and not used regularly	b.
c. Other receptive comm. techniques used (e.g., lip reading)	c.
d. *NONE OF ABOVE*	d. ✓

3. MODES OF EXPRESSION
(Check all used by resident to make needs known)

a. Speech	a. ✓	d. Signs/gestures/sounds	d. ✓
b. Writing messages to express or clarify needs	b.	e. Communication board	e.
c. American sign language or Braille	c.	f. Other	f.
		g. *NONE OF ABOVE*	g.

4. MAKING SELF UNDERSTOOD — 1
(Expressing information content - however able)
0. *UNDERSTOOD*
1. *USUALLY UNDERSTOOD*-difficulty finding words or finishing thoughts
2. *SOMETIMES UNDERSTOOD*-ability is limited to making concrete requests
3. *RARELY/NEVER UNDERSTOOD*

5. SPEECH CLARITY — 0
(Code for speech in the last 7 days)
0. *CLEAR SPEECH* - distinct, intelligible words
1. *UNCLEAR SPEECH* - slurred, mumbled words
2. *NO SPEECH* - absence of spoken words

6. ABILITY TO UNDERSTAND OTHERS — 2
(Understanding verbal information content-however able)
0. *UNDERSTANDS*
1. *USUALLY UNDERSTANDS*-may miss some part/intent of message
2. *SOMETIMES UNDERSTANDS*-responds adequately to simple, direct communication
3. *RARELY/NEVER UNDERSTANDS*

7. CHANGE IN COMMUNICATION/HEARING — 0
Resident's ability to express, understand, or hear information has changed as compared to status of 90 days ago (or since last assessment if less than 90 days)
0. No change 1. Improved 2. Deteriorated

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SECTION D. VISION PATTERNS

1.	VISION	*(Ability to see in adequate light and with glasses if used)* 0. *ADEQUATE* - sees fine detail, including regular print in newspapers/books 1. *IMPAIRED* - sees large print, but not regular print in newspapers/books 2. *MODERATELY IMPAIRED* - limited vision; not able to see newspaper headlines, but can identify objects 3. *HIGHLY IMPAIRED* - object identification in question, but eyes appear to follow objects 4. *SEVERELY IMPAIRED* - no vision or sees only light, colors, or shapes; eyes do not appear to follow objects	0
2.	VISUAL LIMITATIONS/ DIFFICULTIES	a. Side vision problems - decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self) b. Experiences any of following: sees halos or rings around lights; sees flashes of light; sees "curtains" over eyes c. *NONE OF ABOVE*	a. b. c. ✓
3.	VISUAL APPLIANCES	Glasses; contact lenses; magnifying glass 0. No 1. Yes	0

SECTION E. MOOD AND BEHAVIOR PATTERNS

1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD

(Code for indicators observed in last 30 days, irrespective of the assumed cause)
0. Indicator not exhibited in last 30 days
1. Indicator of this type exhibited up to five days a week
2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)

VERBAL EXPRESSIONS OF DISTRESS
- a. Resident made negative statements-e.g. *"Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die"* — 0
- b. Repetitive questions-e.g., *"Where do I go; What do I do?"* — 0
- c. Repetitive verbalizations-e.g., calling out for help, *("God help me")* — 0
- d. Persistent anger with self or others-e.g., easily annoyed, anger at placement in nursing home; anger at care received — 0
- e. Self deprecation-e.g., *"I am nothing; I am of no use to anyone"* — 0
- f. Expressions of what appear to be unrealistic fears-e.g., fear of being abandoned, left alone, being with others — 0
- g. Recurrent statements that something terrible is about to happen-e.g., believes he or she is about to die, have a heart attack — 0
- h. Repetitive health complaints-e.g., persistently seeks medical attention, obsessive concern with body functions — 0
- i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/ reassurance regarding schedules, meals, laundry, clothing, relationship issues — 0

SLEEP-CYCLE ISSUES
- j. Unpleasant mood in morning — 0
- k. Insomnia/change in usual sleep pattern — 0

SAD, APATHETIC, ANXIOUS APPEARANCE
- l. Sad, pained, worried facial expressions-e.g., furrowed brows — 0
- m. Crying, tearfulness — 0
- n. Repetitive physical movements-e.g., pacing, hand wringing, restlessness, fidgeting, picking — 0

LOSS OF INTEREST
- o. Withdrawal from activities of interest - e.g., no interest in long standing activities or being with family/friends — 0
- p. Reduced social interaction — 0

2. MOOD PERSISTENCE

One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days
0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered — 0

3. CHANGE IN MOOD

Resident's mood status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days)
0. No change 1. Improved 2. Deteriorated — 0

4. BEHAVIORAL SYMPTOMS

(A) *Behavioral symptom frequency in last 7 days*
0. Behavior not exhibited in last 7 days
1. Behavior of this type occurred 1 to 3 days in last 7 days
2. Behavior of this type occurred 4 to 6 days, but less than daily
3. Behavior of this type occurred daily

(B) *Behavioral symptom alterability in last 7 days*
0. Behavior not present OR behavior was easily altered
1. Behavior was not easily altered

	(A)	(B)
a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)	0	0
b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)	0	0
c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)	0	0
d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/ feces, hoarding, rummaged through others' belongings)	0	0
e. RESISTS CARE (resisted taking medications/injections, ADL assistance, or eating)	0	0

5. CHANGE IN BEHAVIORAL SYMPTOMS

Resident's behavior status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days)
0. No change 1. Improved 2. Deteriorated — 0

SECTION F. PSYCHOSOCIAL WELL-BEING

1.	SENSE OF INITIATIVE/ INVOLVEMENT	a. At ease interacting with others	a. ✓
		b. At ease doing planned or structured activities	b.
		c. At ease doing self-initiated activities	c.
		d. Establishes own goals	d.
		e. Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services)	e.
		f. Accepts invitations into most group activities	f.
		g. *NONE OF ABOVE*	g.
2.	UNSETTLED RELATIONSHIPS	a. Covert/open conflict with or repeated criticism of staff	a.
		b. Unhappy with roommate	b.
		c. Unhappy with residents other than roommate	c.
		d. Openly expresses conflict/anger with family/friends	d.
		e. Absence of personal contact with family/friends	e.
		f. Recent loss of close family member/friend	f.
		g. Does not adjust easily to change in routines	g. ✓
		h. *NONE OF ABOVE*	h.
3.	PAST ROLES	a. Strong identification with past roles and life status	a.
		b. Expresses sadness/anger/empty feeling over lost roles/status	b.
		c. Resident perceives that daily routine (customary routine, activities) is very different from prior pattern in the community	c.
		d. *NONE OF ABOVE*	d. ✓

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. (A) ADL SELF-PERFORMANCE- *(Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days - Not including setup)*
0. *INDEPENDENT* - No help or oversight - OR - Help/oversight provided only 1 or 2 times during last 7 days
1. *SUPERVISION* - Oversight, encouragement or cueing provided 3 or more times during last 7 days - OR - Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
2. *LIMITED ASSISTANCE* - Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times - OR - More help provided only 1 or 2 times during last 7 days
3. *EXTENSIVE ASSISTANCE* - While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
--Weight bearing support
--Full staff performance during part (but not all) of last 7 days
4. *TOTAL DEPENDENCE* - Full staff performance of activity during entire 7 days
8. *ACTIVITY DID NOT OCCUR* during entire 7 days

(B) ADL SUPPORT PROVIDED - *(Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification)*
0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist
8. ADL activity itself did not occur during entire 7 days

			(A) SELF-PERF	(B) SUPPORT
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed	3	2
b.	TRANSFER	How resident moves between surfaces - to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)	4	3
c.	WALK IN ROOM	How resident walks between locations in his/her room	8	8
d.	WALK IN CORRIDOR	How resident walks in corridor on unit	8	8
e.	LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	4	2
f.	LOCOMOTION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair	8	8
g.	DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis	4	2
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)	4	2
i.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal): transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes	4	2
j.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)	4	2

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2.	BATHING	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) *Code for most dependent in self-performance and support.* (A) BATHING SELF-PERFORMANCE codes appear below: 0. Independent - No help provided; 1. Supervision - Oversight help only; 2. Physical help limited to transfer only; 3. Physical help in part of bathing activity; 4. Total dependence; 8. Activity itself did not occur during entire 7 days. *(Bathing support codes are as defined in Item 1,code B above)*	(A) 4 (B) 2
3.	TEST FOR BALANCE (see training manual)	*(Code for ability during test in the last 7 days)* 0. Maintained position as required in test; 1. Unsteady, but able to rebalance self without physical support; 2. Partial physical support during test; or stands (sits) but does not follow directions for test; 3. Not able to attempt test without physical help	
		a. Balance while standing	3
		b. Balance while sitting - position, trunk control	3
4.	FUNCTIONAL LIMITATION IN RANGE OF MOTION (see training manual)	*(Code for limitations during last 7 days that interfered with daily functions or placed resident at risk of injury)* (A) *RANGE OF MOTION*: 0. No limitation; 1. Limitation on one side; 2. Limitation on both sides. (B) *VOLUNTARY MOVEMENT*: 0. No loss; 1. Partial loss; 2. Full loss	(A) (B)
		a. Neck	2 0
		b. Arm - Including shoulder or elbow	2 1
		c. Hand - Including wrist or fingers	0 0
		d. Leg - Including hip or knee	2 2
		e. Foot - Including ankle or toes	2 2
		f. Other limitation or loss	0 0
5.	MODES OF LOCOMOTION	*(Check all that apply during last 7 days)* a. Cane/walker/crutch [a.]; b. Wheeled self [b.]; c. Other person wheeled [c. ✓]; d. Wheelchair primary mode of locomotion [d.]; e. *NONE OF ABOVE* [e.]	
6.	MODES OF TRANSFER	*(Check all that apply during last 7 days)* a. Bedfast all or most of time [a. ✓]; b. Bed rails used for bed mobility or transfer [b. ✓]; c. Lifted manually [c.]; d. Lifted mechanically [d. ✓]; e. Transfer aid (e.g., slide board, trapeze, cane, walker, brace) [e.]; f. *NONE OF ABOVE* [f.]	
7.	TASK SEGMENTATION	Some or all of ADL activities were broken into subtasks during last 7 days so that resident could perform them. 0. No 1. Yes	0
8.	ADL FUNCTIONAL REHABILITATION POTENTIAL	a. Resident believes he/she is capable of increased independence in at least some ADLs [a.]; b. Direct care staff believe resident is capable of increased independence in at least some ADLs [b.]; c. Resident able to perform tasks/activity but is very slow [c.]; d. Difference in ADL Self-Performance or ADL Support, comparing mornings to evenings [d.]; e. *NONE OF ABOVE* [e. ✓]	
9.	CHANGE IN ADL FUNCTION	Resident's ADL self-performance status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days). 0. No change 1. Improved 2. Deteriorated	0

SECTION H. CONTINENCE IN LAST 14 DAYS

1.	CONTINENCE SELF-CONTROL CATEGORIES *(Code for resident's PERFORMANCE OVER ALL SHIFTS)* 0. *CONTINENT* - Complete control *[includes use of indwelling urinary catheter or ostomy device that does not leek urine or stool]*; 1. *USUALLY CONTINENT* - BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly; 2. *OCCASIONALLY INCONTINENT* - BLADDER, 2 or more times a week but not daily; BOWEL, once a week; 3. *FREQUENTLY INCONTINENT* - BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week; 4. *INCONTINENT* - Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time	
a.	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed	4
b.	BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed	0
2.	BOWEL ELIMINATION PATTERN	a. Bowel elimination pattern regular - at least one movement every three days [a. ✓]; b. Constipation [b.]; c. Diarrhea [c.]; d. Fecal impaction [d.]; e. *NONE OF ABOVE* [e.]	

3.	APPLIANCES AND PROGRAMS	a. Any scheduled toileting plan [a. ✓]; b. Bladder retraining program [b.]; c. External (condom) catheter [c.]; d. Indwelling catheter [d. ✓]; e. Intermittent catheter [e.]; f. Does not use toilet room/commode/urinal [f. ✓]; g. Pads/briefs used [g. ✓]; h. Enemas/irrigation [h.]; i. Ostomy present [i.]; j. *NONE OF ABOVE* [j.]	
4.	CHANGE IN URINARY CONTINENCE	Resident's urinary continence has changed as compared to status of 90 days ago (or since last assessment if less than 90 days). 0. No change 1. Improved 2. Deteriorated	0

SECTION I. DISEASE DIAGNOSES

Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses)

1.	DISEASES	*If none apply, CHECK the NONE OF ABOVE box)*	
		ENDOCRINE/METABOLIC/NUTRITIONAL	
		a. Diabetes mellitus [a.]	
		b. Hyperthyroidism [b.]	
		c. Hypothyroidism [c.]	
		HEART/CIRCULATION	
		d. Arteriosclerotic heart disease (ASHD) [d.]	
		e. Cardiac dysrhythmias [e.]	
		f. Congestive heart failure [f.]	
		g. Deep vein thrombosis [g.]	
		h. Hypertension [h. ✓]	
		i. Hypotension [i.]	
		j. Peripheral vascular disease [j.]	
		k. Other cardiovascular disease [k.]	
		MUSCULOSKELETAL	
		l. Arthritis [l.]	
		m Hip fracture [m.]	
		n. Missing limb (e.g., amputation) [n.]	
		o. Osteoporosis [o.]	
		p. Pathological bone fracture [p.]	
		NEUROLOGICAL	
		q. Alzheimer's disease [q.]	
		r. Aphasia [r.]	
		s. Cerebral palsy [s.]	
		t. Cerebrovascular accident (stroke) [t.]	
		u. Dementia other than Alzheimer's disease [u. ✓]	
		v. Hemiplegia/Hemiparesis [v.]	
		w. Multiple sclerosis [w.]	
		x. Paraplegia [x.]	
		y. Parkinson's disease [y.]	
		z. Quadriplegia [z.]	
		aa. Seizure disorder [aa.]	
		bb. Transient ischemic attack (TIA) [bb.]	
		cc. Traumatic brain injury [cc.]	
		PSYCHIATRIC/MOOD	
		dd. Anxiety disorder [dd.]	
		ee. Depression [ee.]	
		ff Manic depression (bipolar disease) [ff.]	
		gg Schizophrenia [gg.]	
		PULMONARY	
		hh Asthma [hh.]	
		ii. Emphysema/COPD [ii.]	
		SENSORY	
		jj. Cataracts [jj.]	
		kk. Diabetic retinopathy [kk.]	
		ll. Glaucoma [ll.]	
		mm Macular degeneration [mm]	
		OTHER	
		nn. Allergies [nn]	
		oo. Anemia [oo.]	
		pp. Cancer [pp.]	
		qq. Renal failure [qq. ✓]	
		rr. *NONE OF ABOVE* [rr.]	
2.	INFECTIONS	*(If none apply, CHECK the NONE OF ABOVE box)* a. Antibiotic resistant infection (e.g., Methicillin resistant staph) [a.]; b. Clostridium difficile (c.diff.) [b.]; c. Conjunctivitis [c.]; d. HIV infection [d.]; e. Pneumonia [e.]; f. Respiratory infection [f. ✓]; g. Septicemia [g.]; h. Sexually transmitted diseases [h]; i. Tuberculosis [i.]; j. Urinary tract infection in last 30 days [j. ✓]; k. Viral hepatitis [k.]; l. Wound infection [l.]; m NONE OF ABOVE [m.]	
3.	OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9 CODES	a. Cervical Spinal Stenosis	723.0
		b. Aftcre Surg Nerv Sys Nec	V58.72
		c. Muscle Weakness-General	728.87
		d. Dysphagia	787.2
		e. Lack Of Coordination	781.3

SECTION J. HEALTH CONDITIONS

1.	PROBLEM CONDITIONS	*(Check all problems present in last 7 days unless other time frame is indicated)*	
		INDICATORS OF FLUID STATUS	
		a. Weight gain or loss of 3 or more pounds within a 7 day period [a.]	
		b. Inability to lie flat due to shortness of breath [b.]	
		c. Dehydrated; output exceeds input [c.]	
		d. Insufficient fluid; did NOT consume all/almost all liquids provided during last 3 days [d.]	
		OTHER	
		e. Delusions [e.]	
		f. Dizziness/Vertigo [f.]	
		g. Edema [g. ✓]	
		h. Fever [h.]	
		i. Hallucinations [i.]	
		j. Internal bleeding [j.]	
		k. Recurrent lung aspirations in last 90 days [k.]	
		l. Shortness of breath [l.]	
		m. Syncope (fainting) [m.]	
		n. Unsteady gait [n.]	
		o. Vomiting [o.]	
		p. *NONE OF ABOVE* [p.]	

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2.	PAIN SYMPTOMS	*(Code the highest level of pain present in the last 7 days)* a. FREQUENCY with which resident complains or shows evidence of pain 0. No pain *(skip to J4)* 1. Pain less than daily 2. Pain daily b. INTENSITY of pain 1. Mild pain 2. Moderate pain 3. Times when pain is horrible or excruciating	a: 0 b:
3.	PAIN SITE	*(If pain present, check all sites that apply in last 7 days)* a. Back pain b. Bone pain c. Chest pain while doing usual activities d. Headache e. Hip pain f. Incisional pain g. Joint pain (other than hip) h. Soft tissue pain (e.g., lesion, muscle) i. Stomach pain j. Other	a: b: c: d: e: f: g: h: i: j:
4.	ACCIDENTS	*(Check all that apply)* a. Fell in past 30 days b. Fell in past 31-180 days c. Hip fracture in last 180 days d. Other fracture in last 180 days e. *NONE OF ABOVE*	a: b: ✓ c: d: e:
5.	STABILITY OF CONDITIONS	a. Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable - (fluctuating, precarious, or deteriorating) b. Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem c. End-stage disease, 6 or fewer months to live d. *NONE OF ABOVE*	a: ✓ b: ✓ c: d:

SECTION K. ORAL/NUTRITIONAL STATUS

1.	ORAL PROBLEMS	a. Chewing problem b. Swallowing problem c. Mouth pain d. *NONE OF ABOVE*	a: ✓ b: c: d:
2.	HEIGHT AND WEIGHT	*Record (a) height in inches and (b) weight in pounds. Base weight on most recent measure in last 30 days; measure weight consistently in accord with standard facility practice - e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes* a. HT (in.) 70 b. WT (lb.) 152	
3.	WEIGHT CHANGE	a. Weight loss - 5% or more in last 30 days; or 10% or more in last 180 days 0. No 1. Yes b. Weight gain - 5% or more in last 30 days; or 10% or more in last 180 days 0. No 1. Yes	1 0
4.	NUTRITIONAL PROBLEMS	a. Complains about the taste of many foods b. Regular or repetitive complaints of hunger c. Leaves 25% or more of food uneaten at most meals d. *NONE OF ABOVE*	c: ✓ d:
5.	NUTRITIONAL APPROACHES	*(Check all that apply in last 7 days)* a. Parenteral/IV b. Feeding tube c. Mechanically altered diet d. Syringe (oral feeding) e. Therapeutic diet f. Dietary supplement between meals g. Plate guard, stabilized built-up utensil, etc. h. On a planned weight change program i. *NONE OF ABOVE*	a: b: c: ✓ d: e: f: ✓ g: h: ✓ i:
6.	PARENTERAL OR ENTERAL INTAKE	*(Skip to Section L if neither 6a nor 6b is checked)* a. Code the proportion of total calories the resident received through parenteral or tube feedings in the last 7 days 0. None 3. 51% to 75% 1. 1% to 25% 4. 76% to 100% 2. 26% to 50% b. Code the average fluid intake per day by IV or tube in last 7 days 0. None 3. 1001 to 1500 cc/day 1. 1 to 500 cc/day 4. 1501 to 2000 cc/day 2. 501 to 1000 cc/day 5. 2001 or more cc/day	

SECTION L. ORAL/DENTAL STATUS

1.	ORAL STATUS AND DISEASE PREVENTION	a. Debris (soft, easily movable substances) present in mouth prior to going to bed at night b. Has dentures or removable bridge c. Some/all natural teeth lost - does not have or does not use dentures (or partial plates) d. Broken, loose, or carious teeth e. Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes f. Daily cleaning of teeth/dentures or daily mouth care - by resident or staff g. *NONE OF ABOVE*	a: b: c: ✓ d: e: f: ✓ g:

SECTION M. SKIN CONDITION

1.	ULCERS (Due to any cause)	*(Record the number of ulcers at each ulcer stage - regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during last 7 days. Code 9 = 9 or more.) (Requires full body exam.)* a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater. c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue. d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	Number at Stage a: 0 b: 1 c: 0 d: 1
2.	TYPE OF ULCER	*(For each type of ulcer, code for the highest stage in the last 7 days using scale in item M1 - i.e., 0=none; stages 1,2,3,4)* a. Pressure ulcer - any lesion caused by pressure resulting in damage of underlying tissue b. Stasis ulcer - open lesion caused by poor circulation in the lower extremities	a: 4 b: 0
3.	HISTORY OF RESOLVED ULCERS	Resident had an ulcer that was resolved or cured in LAST 90 DAYS 0. No 1. Yes	0
4.	OTHER SKIN PROBLEMS OR LESIONS PRESENT	*(Check all that apply during last 7 days)* a. Abrasions, bruises b. Burns (second or third degree) c. Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions) d. Rashes - e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster e. Skin desensitized to pain or pressure f. Skin tears or cuts (other than surgery) g. Surgical wounds h. *NONE OF ABOVE*	a: ✓ b: c: d: e: ✓ f: g: ✓ h:
5.	SKIN TREATMENTS	*(Check all that apply during last 7 days)* a. Pressure relieving device(s) for chair b. Pressure relieving device(s) for bed c. Turning/repositioning program d. Nutrition or hydration intervention to manage skin problems e. Ulcer care f. Surgical wound care g. Application of dressings (with or without topical medications) other than to feet h. Application of ointments/medications (other than to feet) i. Other preventative or protective skin care (other than to feet) j. *NONE OF ABOVE*	a: b: ✓ c: ✓ d: ✓ e: ✓ f: ✓ g: ✓ h: ✓ i: ✓ j:
6.	FOOT PROBLEMS AND CARE	*(Check all that apply during last 7 days)* a. Resident has one or more foot problems - e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems b. Infection of the foot - e.g., cellulitis, purulent drainage c. Open lesions on the foot d. Nails/calluses trimmed during last 90 days e. Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) f. Application of dressings (with or without topical medications) g. *NONE OF ABOVE*	a: ✓ b: c: d: ✓ e: f: g:

SECTION N. ACTIVITY PURSUIT PATTERNS

1.	TIME AWAKE	*(Check appropriate time periods over last 7 days)* Resident awake all or most of time (i.e..naps no more than one hour per time period) in the: a. Morning b. Afternoon c. Evening d. *NONE OF ABOVE*	a: ✓ b: ✓ c: ✓ d:
		(If resident is comatose, skip to Section O)	
2.	AVERAGE TIME INVOLVED IN ACTIVITIES	(When awake and not receiving treatments or ADL care) 0. Most-more than 2/3 of time 2. Little-less than 1/3 of time 1. Some-from 1/3 to 2/3 of time 3. None	1
3.	PREFERRED ACTIVITY SETTINGS	*(Check all settings in which activities are preferred)* a. Own room b. Day/activity room c. Inside NH/off unit d. Outside facility e. *NONE OF ABOVE*	a: ✓ b: c: d: e:
4.	GENERAL ACTIVITY PREFERENCES (adapted to resident's current abilities)	*(Check all PREFERENCES whether or not activity is currently available to resident)* a. Cards/other games b. Crafts/arts c. Exercise/sports d. Music e. Reading/writing f. Spiritual/religious activities g. Trips/shopping h. Walking/wheeling outdoors i. Watching TV j. Gardening or plants k. Talking or conversing l. Being with others m. *NONE OF ABOVE*	a: b: c: d: e: f: g: h: i: ✓ j: k: ✓ l: m:

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Resident WILLI/ PETERSON ( ) meric Identifier 24)-6586

5.	PREFERS CHANGE IN DAILY ROUTINE	*Code for resident preferences in daily routines* 0. No change 1. Slight change 2. Major change	
		a. Type of activities in which resident is currently involved	0
		b. Extent of resident involvement in activities	0

SECTION O. MEDICATIONS

1.	NUMBER OF MEDICATIONS	*(Record the number of different medications used in the last 7 days; enter "0" if none used)*	10
2.	NEW MEDICATIONS	*(Resident currently receiving medications that were initiated during the last 90 days)* 0. No 1. Yes	1
3.	INJECTIONS	*(Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used)*	0
4.	DAYS RECEIVED THE FOLLOWING MEDICATION	*(Record the number of DAYS during last 7 days; enter "0" if not used. Note - enter "1" for long-acting meds used less than weekly)*	
		a. Antipsychotic: 0	
		b. Antianxiety: 0	
		c. Antidepressant: 0	
		d. Hypnotic	0
		e. Diuretic	0

SECTION P. SPECIAL TREATMENTS AND PROCEDURES

1.	SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS	a. SPECIAL CARE - *Check treatments or programs received during the last 14 days*	
		TREATMENTS	
		a. Chemotherapy	a.
		b. Dialysis	b.
		c. IV medication	c.
		d. Intake/output	d. ✓
		e. Monitoring acute medical condition	e. ✓
		f. Ostomy care	f.
		g. Oxygen therapy	g.
		h. Radiation	h.
		i. Suctioning	i.
		j. Tracheostomy care	j.
		k. Transfusions	k.
		l. Ventilator or respirator	l.
		PROGRAMS	
		m. Alcohol/drug treatment program	m.
		n. Alzheimer's/dementia special care unit	n.
		o. Hospice care	o.
		p. Pediatric unit	p.
		q. Respite care	q.
		r. Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs)	r.
		s. *NONE OF ABOVE*	s.

b. THERAPIES - *Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the last 7 calendar days (Enter 0 if none or less than 15 min. daily)*

[Note - count only post admission therapies]

	DAYS (A)	MIN (B)
(A) = # of days administered for 15 minutes or more		
(B) = total # of minutes provided in last 7 days		
a. Speech-language pathology and audiology services	0	0000
b. Occupational therapy	4	0180
c. Physical therapy	5	0150
d. Respiratory therapy	0	0000
e. Psychological therapy (by any licensed mental health professional)	0	0000

2.	INTERVENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS	(Check all interventions or strategies used in last 7 days - no matter where received)	
		a. Special behavior symptom evaluation program	a.
		b. Evaluation by a licensed mental health specialist in last 90 days	b.
		c. Group therapy	c.
		d. Resident-specific deliberate changes in the environment to address mood/behavior patterns - e.g., providing bureau in which to rummage	d.
		e. Reorientation - e.g., cueing	e. ✓
		f. *NONE OF ABOVE*	f.

3.	NURSING REHABILITATION/ RESTORATIVE CARE	*Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was provided to the resident for more than or equal to 15 minutes per day in the last 7 days (Enter 0 if none or less than 15 min. daily.)*	
		a. Range of motion (passive)	0
		b. Range of motion (active)	0
		c. Splint or brace assistance	0
		TRAINING AND SKILL PRACTICE IN:	
		d. Bed mobility	0
		e. Transfer	0
		f. Walking	0
		g. Dressing or grooming	0
		h. Eating or swallowing	0
		i. Amputation/prosthesis care	0
		j. Communication	0
		k. Other	0

4.	DEVICES AND RESTRAINTS	*(Use the following codes for last 7 days.)* 0. Not used 1. Used less than daily 2. Used daily	
		Bed rails	
		a. - Full bed rails on all open sides of bed	2
		b. - Other types of side rails used (e.g., half rail, one side)	0
		c. Trunk restraint	0
		d. Limb restraint	0
		e. Chair prevents rising	1
5.	HOSPITAL STAY(S)	Record number of times resident was admitted to hospital with an overnight stay in last 90 days (or since last assessment if less than 90 days). *(Enter 0 if no hospital admissions)*	00
6.	EMERGENCY ROOM (ER) VISIT(S)	Record number of times resident visited ER without an overnight stay in last 90 days (or since last assessment if less than 90 days). *(Enter 0 if no ER visits)*	00
7.	PHYSICIAN VISITS	In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? *(Enter 0 if none)*	02
8.	PHYSICIAN ORDERS	In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? *Do not include order renewals without change. (Enter 0 if none)*	03
9.	ABNORMAL LAB VALUES	Has the resident had any abnormal lab values during the last 90 days (or since admission)? 0. No 1. Yes	1

SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

1.	DISCHARGE POTENTIAL	a. Resident expresses/indicates preference to return to the community 0. No 1. Yes	0
		b. Resident has a support person who is positive towards discharge 0. No 1. Yes	0
		c. Stay projected to be of a short duration - discharge projected within 90 days (do not include expected discharge due to death) 0. No 1. Within 30 days 2. Within 31-90 days 3. Discharge status uncertain	3
2.	OVERALL CHANGE IN CARE NEEDS	Resident's overall self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved-receives fewer supports, needs less restrictive level of care 2. Deteriorated-receives more support	0

SECTION R. ASSESSMENT INFORMATION

1.	PARTICIPATION IN ASSESSMENT	a. Resident:	0. No	1. Yes		1
		b. Family:	0. No	1. Yes	2. No family	1
		c. Significant other:	0. No	1. Yes	2. None	0

2. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:

a. Signature of RN Assessment Coordinator (sign on above line)

b. Date RN Assessment Coordinator signed as complete: 04 (Month) - 18 (Day) - 2006 (Year)

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Resident WILLI/ PETERSON (_____ Numeric Identifier _ (-30-6586

SECTION T. THERAPY SUPPLEMENT FOR MEDICARE PPS

1.	SPECIAL TREATMENTS AND PROCEDURES	a. **RECREATION THERAPY** -*Enter number of days and total minutes of recreation therapy administered (for at least 15 minutes a day) in the last 7 days (Enter 0 if none)*	DAYS (A)	MIN (B)
		(A) = # of days administered for 15 minutes or more		
		(B) = total # of minutes provided in last 7 days		
		Skip unless this is a Medicare 5 day or Medicare readmission/return assessment.		
		b. **ORDERED THERAPIES** - *Has physician ordered any of following therapies to begin in FIRST 14 days of stay - physical therapy, occupational therapy, or speech pathology service?* 0. No 1. Yes		
		If not ordered, skip to item 2		
		c. Through day 15, provide an estimate of the number of days when at least 1 therapy service can be expected to have been delivered.		
		d. Through day 15, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered?		
2.	WALKING WHEN MOST SELF SUFFICIENT	***Complete item 2 if ADL self-performance score for TRANSFER (G.1.b.A) is 0, 1, 2, or 3 AND at least one of the following are present:*** Resident received physical therapy involving gait training (P.1.b.c.) Physical therapy was ordered for the resident involving gait training (T.1.b) Resident received nursing rehabilitation for walking (P.3.f.) Physical therapy involving walking has been discontinued within the past 180 days		
		Skip to item 3 if resident did not walk in last 7 days		
		(FOR FOLLOWING FIVE ITEMS, BASE CODING ON THE EPISODE WHEN THE RESIDENT WALKED THE FARTHEST WITHOUT SITTING DOWN. INCLUDE WALKING DURING REHABILITATION SESSIONS.)		
		a. Furthest distance walked without sitting down during this episode. 0. 150+ feet 1. 51-149 feet 2. 26-50 feet 3. 10-25 feet 4. Less than 10 feet		
		b. Time walked without sitting down during this episode. 0. 1-2 minutes 1. 3-4 minutes 2. 5-10 minutes 3. 11-15 minutes 4. 16-30 minutes 5. 31+ minutes		
		c. Self-Performance in walking during this episode. 0. *INDEPENDENT* - No help or oversight 1. *SUPERVISION* - Oversight, encouragement or cueing provided 2. *LIMITED ASSISTANCE* - Resident highly involved in walking; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3. *EXTENSIVE ASSISTANCE* - Resident received weight bearing assistance while walking		
		d. Walking support provided associated with this episode (code regardless of resident's self-performance classification). 0. No setup or physical help from staff 1. Setup help only 2. One person physical assist 3. Two+ persons physical assist		
		e. Parallel bars used by resident in association with this episode. 0. No 1. Yes		
3.	CASE MIX GROUP	Medicare RHC09 State RHC09		

SECTION W. SUPPLEMENTAL MDS ITEMS

1.	National Provider ID	Enter for all assessments and tracking forms, if available. ☐☐☐☐☐☐☐☐☐☐	
If the ARD of this assessment or the discharge date of this discharge tracking form is between July 1 and September 30, skip to W3.			
2.	Influenza Vaccine	a. Did the resident receive the influenza vaccine in this facility for this year's influenza season (October 1 through March 31)? 0. No (If No, go to item W2b) 1. Yes (If Yes, go to item W3)	0
		b. If influenza vaccine not received, state reason: 1. Not in facility during this year's flu season 2. Received outside of this facility 3. Not eligible 4. Offered and declined 5. Not offered 6. Inability to obtain vaccine	2
3.	Pneumo-coccal Vaccine	a. Is the resident's PPV status up to date? 0. No (If No, go to item W3b) 1. Yes (If Yes, skip item W3b)	1
		b. If PPV not received, state reason: 1. Not eligible 2. Offered and declined 3. Not offered	

MINIMUM DATA SET (MDS) - *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

DISCHARGE TRACKING FORM [do not use for temporary visits home]

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME*	WILLIAM PETERSON a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2.	GENDER*	1. Male 2. Female → 1
3.	BIRTHDATE*	03 - 11 - 1922 Month Day Year
4.	RACE/ ETHNICITY*	1. American Indian/Alaskan Native 4. Hispanic 2. Asian/Pacific Islander 5. White, not of Hispanic origin 3. Black, not of Hispanic origin → 3
5.	SOCIAL SECURITY* AND MEDICARE NUMBERS* [C in 1st box if non med. no.]	a. Social Security Number [redacted] b. Medicare number (or comparable railroad insurance number) [redacted]
6.	FACILITY PROVIDER NO.*	a. State No. 0591NH b. Federal No. 425293
7.	MEDICAID NO. *("+" if pending, "N" if not a Medicaid recipient)**	
8.	REASONS FOR ASSESS-MENT	(Note - Other codes do not apply to this form) a. Primary reason for assessment 06. Discharged - return not anticipated 07. Discharged - return anticipated 08. Discharged prior to completing initial assessment → 07

9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form

I certify that accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with all Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that patients receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature and Title	Sections	Date
a. Kathleen Dyches & AAMR		5/15/06
b.		
c.		

SECTION AB DEMOGRAPHIC INFORMATION

[Complete only for stays less than 14 days] (AA8a=8)

1.	DATE OF ENTRY	*Date the stay began. Note - Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date* Month - Day - Year
2.	ADMITTED FROM (AT ENTRY)	1. Private home/apt. with no home health services 2. Private home/apt. with home health services 3. Board and care/assisted living/group home 4. Nursing home 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Other

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

6.	MEDICAL RECORD NO.	1050

SECTION R. ASSESSMENT/DISCHARGE INFORMATION

3.	DISCHARGE STATUS	a. *Code for resident disposition upon discharge* → 5 1. Private home/apartment with no home health services 2. Private home/apartment with home health services 3. Board and care/assisted living 4. Another nursing facility 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Deceased 9. Other b. *Optional State Code* → 0
4.	DISCHARGE DATE	*Date of death or discharge* 05 - 15 - 2006 Month Day Year

* = Key items for computerized resident tracking

[ ] = When box blank, must enter number or letter [a.] = When letter in box, check if condition applies

Resident WILLIAM PETERSON Numeric Identifier 7-30-6586 -709-

SECTION W. SUPPLEMENTAL MDS ITEMS

1.	National Provider ID	Enter for all assessments and tracking forms, if available.	
If the ARD of this assessment or the discharge date of this discharge tracking form is between July 1 and September 30, skip to W3.			
2.	Influenza Vaccine	a. Did the resident receive the influenza vaccine in this facility for this year's influenza season (October 1 through March 31)? 0. No (If No, go to item W2b) 1. Yes (If Yes, go to item W3)	0
		b. If influenza vaccine not received, state reason: 1. Not in facility during this year's flu season 2. Received outside of this facility 3. Not eligible 4. Offered and declined 5. Not offered 6. Inability to obtain vaccine	2
3.	Pneumococcal Vaccine	a. Is the resident's PPV status up to date? 0. No (If No, go to item W3b) 1. Yes (If Yes, skip item W3b)	1
		b. If PPV not received, state reason: 1. Not eligible 2. Offered and declined 3. Not offered	

NUTRITIONAL RISK ASSESSMENT

Name William Peterson Adm date 2-24-06 Rm P240 Assess type 5 day

DOB [redacted] Age 84 Sex: (M) F Advance directive Elect DNR Physician VRDL

Diagnosis Cervical spinal stenosis, Aortic surg, New Syncope, Rhabdomyolysis, Muscle Weakness-Gen., Malaise and Fatigue, Senile Dementia Uncomp, BPH, Nos w/o Urinary Obs, Cyst of Kidney, Esophageal Reflux, Hearing Loss, Poor Balance, Gradual, HTN, IBS

Ht (in.) 70 Wt (lb) 165 Wt (kg) 75 Usual body wt range 148-181 BMI 24

BEE 1418 Activity factor 1.2 Injury factor 1.2 Total cal 2293 (+250 for 2043-2350) Total protein >120 g (1.6 g/kg)

Total fluids 2350 cc (30 cc/kg) Fluid restriction —

Diet order Pureed Food allergies/sensitivities —

Supplement/snack Novosource 2.0 120ml qid Cultural/religious preferences —

Risk Factor	No/Low Risk (0 Pts.)	Moderate Risk (1 pts.)	High Risk (3 pts.)	MDS Ref.	Pts.	Comments
Weight status; loss or gain	BMI 19-27 No weight change	<9% wt. change in 30 days; <7.5% within 90 days; or <10% within 6 months	BMI <19 or > 27 ≥5% wt. change in 30 days; ≥7.5% in 90 days; or ≥10% within 6 months	J, K, E	0	
Oral/nutrition intake; food	Intake meets 76-100% of estimated needs	Intake meets 26-75% or estimated needs	Intake meets ≤25% of estimated needs	AC, J, K	1	Intake 48%
Oral/nutrition intake; fluids	Consumes 1,500-2,000 cc/day	Consumes 1,000-1,499 cc/day	Consumes <1,000 cc/day	AC, J, K	3	Fluids 670-1300ccs
Medications; nutrition-related	0-1 drugs/day	2-4 drugs/day	5 or more drugs/day	O	1	Norvasc, Atenolol
Relevant conditions and diagnoses	HTN, DM, heart disease, or other controlled disease/ conditions	Anemia, infection, CVA (recent), fracture, UTI, alcohol abuse, drug abuse, COPD, edema, surgery (recent), osteoporosis, hx of GI bleed, food intolerances and allergies, poor circulation, constipation, diarrhea, GERD, anorexia, Parkinson's	Cancer (advanced), septicemia, liver failure, dialysis, ESRD, Alzheimer's, dementia, depression, dehydration, dysphagia, radiation/chemo, active GI bleed, chronic nausea, vomiting, ostomy, gastrectomy, fecal impaction, uncontrolled diseases or conditions	E, H, I, J, M, P	3	Cyst of kidney, Esophageal Reflux, Cervical Spinal Stenos, Lack of Coordination, Hearing Loss,
Physical and mental functioning	Ambulatory, alert, able to feed self, no chewing or swallowing problems	Out of bed w/assistance, motor agitation (tremors, wandering), limited feeding assistance, supervision while eating, chewing or swallowing problems, teeth in poor repair, ill-fitting dentures or refusal to wear dentures, edentulous, taste and sensory changes, unable to communicate needs	Bedridden, inactive, total dependence, extensive or total assistance or dependence while eating, aspirates, tube feeding, TPN, mouth pain	A, B, E, G, L, P	1	
Lab values	Albumin and other nutrition-related lab values WNL	Albumin 3.0-3.4 g/dL., 1-2 other nutrition-related labs abnormal	Albumin less than 3.0 g/dL., 3-5 other nutrition-related labs abnormal	P	1	3/12/06 K+4.1, TP 5.1/2, Bun 18, creat 1. 3/14/06 PT: P5.3 alb. 1.8 3/14-06
Skin conditions	Skin intact	Stage I/II pressure ulcers or skin tears not healing, hx of pressure ulcers, stasis ulcer, fecal incontinence	Stage III/IV pressure ulcers or multiple impaired areas	M	3	Neck collar heel pads, waffle bed, Rt heel stage II

Overall Risk Category: 0-2 points: NO/LOW RISK 3-7 points: MODERATE RISK ≥8 points: HIGH RISK

Total Points: 13 Overal Risk Category: HR

Signature: Mattie Gordon, Dtn Date: 3-27-06

3/27/06 Note this date, MA Walters MS RD LD

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NUTRITION PROGRESS REPORT

CURRENT WEIGHT:			
% GAIN			
% LOSS			
CURRENT DIET			
TUBE FEEDING			
SELF HELP DEVICE			
SUPPLEMENT:			
TYPE			
FREQUENCY			
% ACCEPTED			
FOOD ACCEPTANCE %:			
% BREAKFAST			
% LUNCH			
% DINNER			
SKIN CONDITION:			
FLUID OUNCES:			
BOWEL HABITS:			
NORMAL			
CONSTIPATION			
DIARRHEA, CHRONIC			
LAB DATA:			
HGB			
HCT			
BUN			
K+			
ALBUMIN			
FBS			
TOTAL PRO			
OTHER			
MEDICATION: CHANGES SINCE LAST REVIEW			
CHANGES / RECOMMENDATIONS SINCE LAST SUMMARY:			
DATE:			
SIGNATURE:			

RESIDENT	ROOM #

VDI-600B

DIETARY PROGRESS NOTES

DATE	Progress Notations, Other Recommendations, Signature & Title
3/21/06	MNT / Readm.
	Resident to be readmitted today from the hospital. He has been in the hosp. since 3/7 for ARF ↑K. Prev. in hosp 3/06 c ARF ↑K. During this prev. adm at this NH he was on a Mech Soft c Boost Supplements b/w meals.
	Hx of HTN, Spinal Stenosis,
	Hosp Labs by 3/18 showed resolved ARF + pt s/p back surgery.
	Recommend on readm:
	① Mech Soft Diet
	② 120 ml 2 cal MedPass (Novosource 2.0) 4x day b/w meals.
	③ MVI c Mineral x 2 months - Silvervite
	Adm Nutrition Assessment to follow.
	MG Walters MMSc RD LD
3/27/06	See 5 day assessment. Mattie Dodson
3/27/06	MNT / Readm
	Ht-70" Wt-165# IBW-166 ± 17# Currently 99% IBW
	In hosp 3/06 + 3/06 for ARF c ↑K+, resolved during hospitalization.
	Also 3/06 hosp. - had cervical radical diskectomy C5-6-7 = no improvement in sensation/movement w/ spastic paresis / Es + weakness UEs.
	Is able to feed himself but it is slow - staff assisting pt.
	Diet - Pureed → poor intake
	Supp - 120 ml Novosource 2.0 4x day → ≥75% intake
	Press. Ulcer - (R) heel IV
	Hosp. 3/19 — 138 / 110 / 21 / 100 — PO4-2.3↓ — H/H-10.3↓/31.1%
	4.3 / 26 / 1.3↑ — alb-1.8↓
	Changed to Pureed diet at hosp 2° to chewing/swallowing prob - post op cervical diskectomy.
	Wt↓ 15# from 1st adm 3/22/06 - ↓15#/↓8.3% w/c + month
	Needs 1 cal + pro intake but intake is poor except for his PO. Supp. intake. Nursing trying different foods / favorite foods to entice resident to eat — Continued —

Pt. Name Peterson, Wm Pt. Number

DIETARY PROGRESS NOTES

DATE	Progress Notations, Other Recommendations, Signature & Title
3/27/06	MNT - continued - Needs ↑ supplement, would benefit from Vit/Mini, may need to see Screen by SLP. Recommend: ① Pureed diet as ordered ② Magic Cup 4oz c L+S/meal (600cal/18gm pro) X 1 month ③ ↑ 2.0 cal Novosource to 180ml 4X day (1440cal/60gm) ④ MVI w/min/d. ⑤ ~~Rx~~ 30ml Prostat 101 in Jce or NOVOsource 2.0 3X day (303 cal/45gm pro) X 2 months ⑥ Weekly wts. ⑦ SLP screen for appropriate diet consistency — D Walkers MMScRDLD
3/31/06	Diet changed to Mech Soft by Speech Therapist. Will continue to monitor. — Mattie Anderson
4/4/06	Res 14 day PPS wt 162.2 lbs. Intake 25% c fluids at 580 - 1200 cc's. Res receive Magic Cup c lunch & Supper X/mo. Will continue to monitor. — Mattie Anderson
4/5/06	MNT/ F/U MD ordered DNR - no G or NG tube Ht - 70" Wt - 3/28 - 162# IBW 166 ± 19# Currently 98% IBW Wt p Week - ↓ 3#, ↓ 18# (↓ 10%) p month (from prev. admit) Diet - Pureed Supp - 30ml Prostat 101 tid (3/29 - 5/29) (303cal/45gm pro) — Intake 15-100% - 180ml Novosource 2.0 po 4X day b/w meals (1440 cal/60gm pro) Resident was Sed to Mech Soft diet by SLP but po intake has been very poor c this diet + some good pocketing noted. Nursing Sed pt back to Pureed diet this date + RE ate 25% of lunch today. On MVI c Min. No recent labs No Noted skin breakdown Like Magic Cups → 300cal/8gm pro. Requires Pureed diet for adequate po intake. Recommend: ① Pureed diet c Magic Cup TID c L+S X 2 months ② Continue other supp as ordered. — D Walkers MMScRDLD

Pt. Name Wm Peterson Pt. Number 1050

DIETARY PROGRESS NOTES

DATE	Progress Notations, Other Recommendations, Signature & Title
4/11/06	MNT Staff records poor food intake along c good po fluid intake. He is apparently constipated at this time. Nursing to f/u with for constipation. Magic Cup started c 2 meals qd and he continues on a Pureed Diet. + 2 cal Med Ass Supp b/w meals Wt since 3/21/06 readm - 156 - 165#, ↓9# (↓5%), is now 94% IBW. Noted directive for No NG tube or G tube for nourishment. Staff will continue to work c resident to ↑ cal + pro / food intake. Continue to monitor. — MWalters MHSc RDLD
4/27/06	Due to Resident's wt loss, Super Shake will be offered c lunch and supper to help enhance intakes. He will accept food at this time, he says that he has enough. Will continue to monitor. — Mattie Davidson

Pt. Name Wm Peterson Pt. Number 1050

VDI-605 (REV. 3/96)

DIETARY PROGRESS NOTES

DATE	Progress Notations, Other Recommendations, Signature & Title

Pt. Name _____ Pt. Number _____

VDI-605 (REV. 3/96)

ACTIVITY ASSESSMENT

Date of Initial Visit 3/22/06
Length of Initial Visit 15 min.

Check = Yes 0 = No N = Not Applicable

ADMISSION DATA

Marital Status W Anniversary Date ____
Photo Release ✓ Media Release ✓

COGNITION

___ Comatose
✓ Alert with confusion
___ Short Term Memory - Appears to recall after 5 minutes
___ Long Term Memory - Appears to recall long past

COGNITIVE RECALL

✓ Own Name ___ Date ___ Location of Room
___ Season ___ Place of Residence ___ Staff Names/Faces

COGNITIVE DECISION SKILLS

___ 0. Independent - Decisions consistent/reasonable
___ 1. Modified Independent - Some difficulty in new situations
✓ 2. Moderately Impaired - Decisions poor, supervision required
___ 3. Severely Impaired - Never/rarely makes decisions

COMMUNICATION PATTERNS/PHYSICAL STATUSE (Describe)

✓ Hearing adequate
✓ Speech adequate, clear
✓ Makes Self Understood usually
✓ Understands Others usually
✓ Vision adequate
✓ Mobility/Locomotion Wheelchair
✓ Other Physical Limitations unable to move legs

PHYSICIAN'S ACTIVITY ORDERS (Transcribe)

✓ Level of Participation approved
✓ L.O.A. not to exceed mcad regs
___ Alcohol
___ Food Allergies

COGNITIVE THERAPEUTIC SESSIONS

___ RO ✓ Sensory Simulation
___ Remotivation ___ Validation
___ Advanced RO/Current Events ___ Resocialization

RESIDENT AWAKE PERIODS (Describe)

___ Morning will establish
___ Afternoon
___ Evening

AVAILABLE ACTIVITY TIME (Describe)

___ More than 2/3 ✓ 1/3 - 2/3 ___ Less than 1/3 ___ None

INTEREST LIST (Describe)

___ Resident Council
___ Arts/Crafts (Type)
___ Cooking/Baking
___ Movies (Type)
___ Exercise (Type)
___ Social Hour/Parties
___ Cards (Type)
___ Gardening (Type)
___ Intellectual (Type)
___ Pet Visits
___ Reading (Type)
___ Current Events
✓ Trips/Shopping
___ Spiritual Religious Act
___ Fine Arts (Type)
___ Games (Type)
___ Walking Wheeling Outdoors
___ Watching TV (Type)
___ Writing
___ Music (Type)
___ Past Hobbies/Skills
___ Past Affiliations
___ Other

PREFERRED LEVEL OF PARTICIPATION IN ACTIVITIES

___ Active ___ Passive ✓ 1 : 1
___ Independent ___ Small Groups ___ Large Groups

Resident: Peterson, William
Number: 1050 Admission Date: 3/21/06
Room: P214 Bed: W
Attending Physician: NRGLM
Physician Phone: 637-3146

Jennifer Lanham, aa
Signature, Title

3/22/06
Date

VS-111 (Rev. 03/04) / VN-199

PATIENT ACTIVITIES PROGRESS NOTES

Name Peterson, William Room P214-W Physician NRGLM

DATE	
3/25/06 INIT 5D	Mr. Peterson is an 84 year old BM who was admitted to the facility from the Aiken Regional Hospital. He is a widower and has nine children. He enjoys taking trips and riding in his car. Mr. Peterson spends a majority of his time in bed. Act/Wellness staff will visit with him 1:1. — Jennifer Lanham, ac
4/3/06 14 DAY	Mr. Peterson is alert. Act/Wellness staff continues to visit with him 1:1. He spends most of his time in bed but will sit up in a chair at times. He likes to stay in his room. — Jennifer Lanham, ac
4/18/06 30 DAY	Mr. Peterson is alert. He continues to choose to be in his room and is mainly in the bed. Act/Wellness staff continues to visit 1:1 for socialization. — Jennifer Lanham, ac

MAR

-718-

Resident Name Peterson, William Room 214B Mo./Yr. March 2006 Physician _____

TMH4

	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Atenolol 12.5mg PO BID	8A																					X										
	[redacted]																				X											
	[redacted]																															
Protonix 40mg q day	[redacted]																					X										
Norvasc 5mg PO q day	8A																					X										
Silvervite PO q day X 2 mths.	8A																					X										
Nonsource/Resource 2.0 120cc. PO qid between meals.	9A																				X	X										
	1P																				X	X										
	[redacted]																				X											
	[redacted]																				X											
2nd step PPD due 4/2/06																																
	7-3																															
	Site																															
	Result																															

TMH R of Edgefield 03/21/2006 - 05/25/2006 0197

Date	Hour	Medication & Dosage	Route	Reason	Initials	Results or Response	Hour	Initials

Initials		Nurse's Signature	Initials		Nurse's Signature	Initials		Nurse's Signature
1			5			9		
2			6			10		
3			7			11		
4			8			12		

A. Initial or chart symbol in appropriate box when medication is given or refused.
B. If reason for mediation not given is required, document reason in Nurses Notes.
C. Chart PRN medications below.

D. Symbols: X Patient out of facility *R Refused medications
*M Out of medication *S Patient overly sedated
C Patient out of facility with medications
*W Withheld *U Unresponsive
* Require Nurses Notes

Injection Site Code	1. Buttock (Gluteus) Left	3. Arm (Deltoid) Left	5. Thigh (Quadriceps) Left	7. ILIAC Crest Left	9. Other (Specify)
	2. Buttock (Gluteus) Right	4. Arm (Deltoid) Right	6. Thigh (Quadriceps) Right	8. ILIAC Crest Right	

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0198

MAR

Resident Name Peterson, William Room P240 Mo./Yr. March 2006 Physician _____

TMH&R

-720-

↑ Novasource/Resource 2
180 cc po q id

Prostat 101
30cc po TID c 4oz
juice ~~Nonenee~~
x 2 mths

Actos 30mg po
Q am

Lantus 10units
q HS

Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
8 AM																														
9A																														
1P																														
9																														
8 AM																														
8pm																														

TMH&R of Edgefield 03/2006 0799

Date	Hour	Medication & Dosage	Route	Reason	Initials	Results or Response	Hour	Initials

Initials		Nurse's Signature	Initials		Nurse's Signature	Initials		Nurse's Signature
1			5			9		
2			6			10		
3			7			11		
4			8			12		

A. Initial or chart symbol in appropriate box when medication is given or refused.
B. If reason for mediation not given is required, document reason in Nurses Notes.
C. Chart PRN medications below.

D. Symbols:
X Patient out of facility
*R Refused medications
*M Out of medication
*S Patient overly sedated
C Patient out of facility with medications
*W Withheld
*U Unresponsive
* Require Nurses Notes

Injection Site Code	1. Buttock (Gluteus) Left	3. Arm (Deltoid) Left	5. Thigh (Quadriceps) Left	7. ILIAC Crest Left	9. Other (Specify)
	2. Buttock (Gluteus) Right	4. Arm (Deltoid) Right	6. Thigh (Quadriceps) Right	8. ILIAC Crest Right	

GP-235 (Rev. 5/04)

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0200

Antibiotic's

-722- Resident Name Peterson, William Room 214P Mo./Yr. March 06 Physician Massey

TMH4

Levaquin 500mg
(1) po q day x 7 days

8p

3/30/06

↓ Levaquin to
250 mg
1 po qhs x 6 days

Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
8p																														
8pm																														

MAR PRN

Resident Name Peterson, William Room 214W Mo./Yr. March 2006 Physician

TMH

-723-

Tylenol 650 mg po q4° PRN Temp/pain	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	°																							PO			PO					

Date	Hour	Medication & Dosage	Route	Reason	Initials	Results or Response	Hour	Initials
3/23	8AM	Tylenol 650mg	po	T 100.6	DD	T ↓ 98.1	9A	DD
3/26	12AM	Tylenol 650 mg	po	T 101.6	PO	Temp ↓ 99.	1:40A	PO
3/30	1130A	Tylenol 650mg	po	T 100.8	DD	T 100.2	1Pm	DD
3/30/06	8pm	Tylenol 650mg	po	T. 101.2	pmd	Temp ↓ 100.4	930pm	pmd
3/31/06	4AM	Tylenol 325mg x2	PO	~~temp~~ ↑	DB	temp ↓	6AM	DB

Initials		Nurse's Signature	Initials		Nurse's Signature	Initials		Nurse's Signature
1			5			9		
2			6			10		
3			7			11		
4			8			12		

A. Initial or chart symbol in appropriate box when medication is given or refused.
B. If reason for mediation not given is required, document reason in Nurses Notes.
C. Chart PRN medications below.

D. Symbols:
X Patient out of facility
*M Out of medication
C Patient out of facility with medications
*W Withheld
*R Refused medications
*S Patient overly sedated
*U Unresponsive
* Require Nurses Notes

Injection Site Code	1. Buttock (Gluteus) Left	3. Arm (Deltoid) Left	5. Thigh (Quadriceps) Left	7. ILIAC Crest Left	9. Other (Specify)
	2. Buttock (Gluteus) Right	4. Arm (Deltoid) Right	6. Thigh (Quadriceps) Right	8. ILIAC Crest Right	

GP-235 (Rev. 5/04)

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0203

LAB TO DO

-725-

Resident Name Peterson, William Room 314P Mo./Yr. March 06 Physician Massey

TMH+D

TMH&R of Edgefield 03/21/2006 05/24/2006 00204

Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
UA																															
3-11																															
Chest X ray																															
3-11																															
Blood Cx																															
11-7																															

Date	Hour	Medication & Dosage	Route	Reason	Initials	Results or Response	Hour	Initials

Initials		Nurse's Signature	Initials		Nurse's Signature	Initials		Nurse's Signature
1			5			9		
2			6			10		
3			7			11		
4			8			12		

A. Initial or chart symbol in appropriate box when medication is given or refused.
B. If reason for mediation not given is required, document reason in Nurses Notes.
C. Chart PRN medications below.

D. Symbols:
X Patient out of facility
*R Refused medications
*M Out of medication
*S Patient overly sedated
C Patient out of facility with medications
*W Withheld
*U Unresponsive
* Require Nurses Notes

Injection Site Code
1. Buttock (Gluteus) Left
2. Buttock (Gluteus) Right
3. Arm (Deltoid) Left
4. Arm (Deltoid) Right
5. Thigh (Quadriceps) Left
6. Thigh (Quadriceps) Right
7. ILIAC Crest Left
8. ILIAC Crest Right
9. Other (Specify)

GP-235 (Rev. 5/04)

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0205

Tx.

-727-

Resident Name Peterson, William Room 214W Mo./Yr. March 2006 Physician NEGLM

TMH+R

	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Foleycare q shift 16FR ~~BCC~~ Bard	7-3																					X										
	3-11																				→											
	11-7																					X										
Change foley every 6-8 WKS.	7-3																															
Heel pads on while in bed.	11-7																															
	7-3																															
	3-11																				X											
TED Hose on during day off 7pm	~~D/C~~																					~~X~~										
	7-3																															
	3-11																				X											
Alternating Pressure mattress																																
	~~D/C~~																															
Clean Neck w/ Biosite Wound Cleanser Foamy Apply ~~Dry Dsg~~ daily	7-3																															

TMH&R of Edgefield 03/21/2006 - 05/20/2006

Date	Hour	Medication & Dosage	Route	Reason	Initials	Results or Response	Hour	Initials

Initials		Nurse's Signature	Initials		Nurse's Signature	Initials		Nurse's Signature
1			5			9		
2			6			10		
3			7			11		
4			8			12		

A. Initial or chart symbol in appropriate box when medication is given or refused.
B. If reason for mediation not given is required, document reason in Nurses Notes.
C. Chart PRN medications below.

D. Symbols:
X Patient out of facility
*R Refused medications
*M Out of medication
*S Patient overly sedated
C Patient out of facility with medications
*W Withheld
*U Unresponsive
* Require Nurses Notes

Injection Site Code	1. Buttock (Gluteus) Left	3. Arm (Deltoid) Left	5. Thigh (Quadriceps) Left	7. ILIAC Crest Left	9. Other (Specify)
	2. Buttock (Gluteus) Right	4. Arm (Deltoid) Right	6. Thigh (Quadriceps) Right	8. ILIAC Crest Right	

GP-235 (Rev. 5/04)

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0207

Tx.

Resident Name Peterson, William Room 214 Wm Mr. March 06 Physician NRbhm

TMH+R

-729-

Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
7-3																															
3-11																															
PRN																															

Date	Hour	Medication & Dosage	Route	Reason	Initials	Results or Response	Hour	Initials

Initials		Nurse's Signature	Initials		Nurse's Signature	Initials		Nurse's Signature
1			5			9		
2			6			10		
3			7			11		
4			8			12		

A. Initial or chart symbol in appropriate box when medication is given or refused.
B. If reason for mediation not given is required, document reason in Nurses Notes.
C. Chart PRN medications below.

D. Symbols:
X Patient out of facility
*R Refused medications
*M Out of medication
*S Patient overly sedated
C Patient out of facility with medications
*W Withheld
*U Unresponsive
* Require Nurses Notes

Injection Site Code	1. Buttock (Gluteus) Left	3. Arm (Deltoid) Left	5. Thigh (Quadriceps) Left	7. ILIAC Crest Left	9. Other (Specify)	GP-235 (Rev. 5/04)
	2. Buttock (Gluteus) Right	4. Arm (Deltoid) Right	6. Thigh (Quadriceps) Right	8. ILIAC Crest Right		

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0209

INTAKE AND OUTPUT RECORD

Date	SHIFT	ORAL	OTHER	TOTAL	VOIDED	CATHETER	OTHER	TOTAL
3/21/06	7-3			Admitted				
	3-11	360		360		450		450
	11-7	120		120		400		400
				480				850
3/22/06	7-3	580		580		500		500
	3-11	540		540		350		350
	11-7	100		100		300		300
				1220				1150
3/23/06	7-3	780		780		600		600
	3-11	420		420		400		400
	11-7	100		100		300		300
				1300				1300
3/24/06	7-3	800		800		500		500
	3-11	400		400		350		350
	11-7	100		100		300		300
				1300				1150
3/25/06	7-3	360		360		250		250
	3-11	320		320		300		300
	11-7	100		100		200		200
				780				750
3/26/06	7-3	240		240		250		250
	3-11	300		300		250		250
	11-7	120		120		100		100
				660				600
3/27/06	7-3	330		330		400		400
	3-11	180		180		200		200
	11-7	100		100		100		100
				610				700

NAME-LAST	FIRST	MIDDLE	ROOM NO.	ATTENDING PHYSICIAN	HOSP. NO.
Peterson,	William		214W	NRGLM	1050

TMH&R-2001

INTAKE AND OUTPUT RECORD

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0210

INTAKE AND OUTPUT RECORD

Date	SHIFT	ORAL	OTHER	TOTAL	VOIDED	CATHETER	OTHER	TOTAL
3/28/06	7-3	1,100		1,100		400		400
	3-11	540		540		350		350
	11-7	120		120		250		250
				1760				1000
3/29/06	7-3	1,050		1,050		350		350
	3-11	300		300		200		200
	11-7	120		120		600		600
				2530				1150
3/30/06	7-3	890		890		300		300
	3-11	420		420		100		100
	11-7	120		120		~~400~~		400
				1430		400		800
3/31/06	7-3	1,000		1,000		450		450
	3-11	~~300~~		300		200		200
	11-7	120		120		350		350
				1420				1000
4/1/06	7-3	240		240		250		250
	3-11	320		320		200		200
	11-7	100		100		300		300
				1160				750
4/2/06	7-3	1000		1000		400		400
	3-11	320		320		250		250
	11-7	100		100		250		250
				1420				900
4/3/06	7-3	800		800		450		450
	3-11	240		240		200		200
	11-7	100		100		300		300
				1140				950

NAME-LAST	FIRST	MIDDLE	ROOM NO.	ATTENDING PHYSICIAN	HOSP. NO.
Peterson,	William		214W	NRGim	1050

TMH&R-901

TAKE AND PUT REC

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0211

INTAKE AND OUTPUT RECORD

Date	SHIFT	ORAL	OTHER	TOTAL	VOIDED	CATHETER	OTHER	TOTAL
4/4/06	7-3	800		800		350		350
	3-11	270		270		300		300
	11-7	120		120		250		250
				1190				900
4/5/06	7-3	950		950		500		500
	3-11	440		440		350		350
	11-7	120		120		200		200
				1510				1050
4/6/06	7-3	900		900		500		500
	3-11	320		320		300		300
	11-7	120		120		200		200
				1340				1000
4/7/06	7-3	1200		1200		600		600
	3-11	300		300		450		450
	11-7	100		100		300		380
				1600				1350
4/8/06	7-3	600		600		300		300
	3-11	420		420		400		400
	11-7	120		120		900		900
				1140				900
4/9/06	7-3	360		360		200		200
	3-11	300		300		350		356
	11-7	100		100		300		300
				1060				850
4/10/06	7-3	900		900		600		600
	3-11	300		300		400		400
	11-7	100		100		300		300
				1300				1300

NAME - LAST	FIRST	MIDDLE	ROOM NO.	ATTENDING PHYSICIAN	HOSP. NO.
Peterson	William		2140	WRHM	1050

INTAKE AND OUTPUT RECORD

Date	SHIFT	ORAL	OTHER	TOTAL	VOIDED	CATHETER	OTHER	TOTAL
4/11/06	7-3	980		980		400	Ly BM	400
	3-11	320		320		200		200
	11-7	100		100		200		200
				1400				800
4/12/06	7-3	1500		1500		800		800
	3-11	600		600		500		500
	11-7	100		100		100		100
				2200				1400
4/13/06	7-3	1500		1500		825		825
	3-11	400		400		300		300
	11-7	100		100		150		150
				2000				1275
4/14/06	7-3	1380		1380		800		800
	3-11	600		600		500		500
	11-7	100		100		400		400
				2080				1700
4/15/06	7-3	420		420		800		800
	3-11	300		300		350		350
	11-7	120		120		400		400
				440				1650
4/16/06	7-3	720		720		300		300
	3-11	320		320		400		400
	11-7	120		120		250		250
				1160				950
4/17/06	7-3	300		300		300		300
	3-11	240		240		250		250
	11-7	100		100		200		200
				700				750

NAME-LAST	FIRST	MIDDLE	ROOM NO.	ATTENDING PHYSICIAN	HOSP. NO.
Peterson	William		2140	N. Rahim	1050

TMH-R-

INTAKE AND OUTPUT RECORD

4/18/06

Date	SHIFT	ORAL	OTHER	TOTAL	VOIDED	CATHETER	OTHER	TOTAL
	7-3	1,200		1,200	X	650	BM	650
	3-11	180		180		75		75
	11-7	100		100		200		200
				1480				925
4/19/06								
	7-3	1,150		1,150		600		600
	3-11	540		540		75		75
	11-7	100		100		~~X~~ 100		100
				1790				775
4/20/06								
	7-3	980		980		1200		1200
	3-11	180		180		200		200
	11-7	100		100		250		250
				1260				1650
4/21/06								
	7-3	1,100		1,100		900		900
	3-11	200		200		450		450
	11-7	100		100		200		900
				1400				1850
4/22/06								
	7-3	520		520		300		300
	3-11	200		200		200		200
	11-7	100		100		200		200
				820				700
4/23/06								
	7-3	180		180		200		200
	3-11	60		60		150		150
	11-7	60		60		200		200
				200				550
4/24/06								
	7-3	570		570		400		400
	3-11	360		360		200		200
	11-7	100		100		200		200
				1030				800

NAME-LAST	FIRST	MIDDLE	ROOM NO.	ATTENDING PHYSICIAN	HOSP. NO.
Peterson,	William		2140	WRQuin	1050

TMH&R-2001

INTAKE AND OUTPUT RECORD

INTAKE AND OUTPUT RECORD

4/25/06

Date	SHIFT	ORAL	OTHER	TOTAL	VOIDED	CATHETER	OTHER	TOTAL
	7-3	800		800		400		400
	3-11	540		540		300		300
	11-7	120		120		200		200
				1460				900

4/26/06

Date								
	7-3	780		780		500		500
	3-11	480		480		350		350
	11-7	120		120		150		150
				1380				1000

4/27/06

Date								
	7-3	480		480		250		250
	3-11	360		360		50		50
	11-7	100		100		100		100
				940				400

4/28/06

Date								
	7-3	800		800		400		400
	3-11	220		220		100		100
	11-7	100		100		100		100
				1120				600

4/29/06

Date								
	7-3	520		520		250		250
	3-11	300		300		200		200
	11-7	100		100		200		200
				920				650

4/30/06

Date								
	7-3	320		320		300		300
	3-11	100		100		250		250
	11-7	100		100		100		100
				520				650

5/1/06

Date								
	7-3	600		600		400		400
	3-11	360		360		350		350
	11-7	120		120		100		100
				1080				850

NAME-LAST	FIRST	MIDDLE	ROOM NO.	ATTENDING PHYSICIAN	HOSP. NO.
Peterson,	William		2140	[illegible]	1050

T[illegible]H+R- [illegible]

TMOR of Edgefield 05/24/2006 - 05/25/2006 - 0210

TAKE AND PUT RECO

INTAKE AND OUTPUT RECORD

Date	SHIFT	ORAL	OTHER	TOTAL	VOIDED	CATHETER	OTHER	TOTAL
5/2/06	7-3	900		900		400		400
	3-11	540		540		250		250
	11-7	120		120		300		300
				1560				960
5/3/06	7-3	800		800		500		500
	3-11	360		360		250		250
	11-7	100		100		200		200
				1260				950
5/4/06	7-3	750		750		250		250
	3-11	540		540		300		300
	11-7	100		100		200		200
				1390				750
5/5/06	7-3	675		675		400		400
	3-11	300		300		250		250
	11-7	100		100		200		200
				1075				850
5/6/06	7-3	850		850		300		300
	3-11	120		120		200		200
	11-7	60		60		200		200
				1040				700
5/7/06	7-3	720		720	500	200		500
	3-11	100		100		250		250
	11-7	60		60		100		100
				480				550
5/8/06	7-3	520		520		400		400
	3-11	160		160		200	X 4 loose	200
	11-7	60		60		250	X 2 loose	250
				740				950

NAME-LAST	FIRST	MIDDLE	ROOM NO.	ATTENDING PHYSICIAN	HOSP. NO.
Peterson	William		2140	NRGhm	1050

TMH&R-2001

INTAKE AND OUTPUT RECORD

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0216

INTAKE AND OUTPUT RECORD

5-9-06

Date	SHIFT	ORAL	OTHER	TOTAL	VOIDED	CATHETER	OTHER	TOTAL
	7-3	420		420		300		300
	3-11	180		180		250		250
	11-7	60		60		200		200
				660				750

5-10-06

Date	SHIFT	ORAL	OTHER	TOTAL	VOIDED	CATHETER	OTHER	TOTAL
	7-3	500		500		300		300
	3-11	360		360		300		300
	11-7	60		60		250		250
				920				850

5-11-06

Date	SHIFT	ORAL	OTHER	TOTAL	VOIDED	CATHETER	OTHER	TOTAL
	7-3	120		120		300		300
	3-11	480		480		450		480.
	11-7	100		100		200		200
				700				950

5-12-06

Date	SHIFT	ORAL	OTHER	TOTAL	VOIDED	CATHETER	OTHER	TOTAL
	7-3	240		240		200		200
	3-11	360		360		300		300
	11-7	720		120		150		150
				720				650

5-13-06

Date	SHIFT	ORAL	OTHER	TOTAL	VOIDED	CATHETER	OTHER	TOTAL
	7-3	200		200		250		250
	3-11	100		100		200		200
	11-7	100		100		200		200
				400				650

5-14-06

Date	SHIFT	ORAL	OTHER	TOTAL	VOIDED	CATHETER	OTHER	TOTAL
	7-3	Ø		Ø		150		150
	3-11	Ø		Ø		100		100
	11-7	Ø		Ø		50		50
				Ø				300

5-15-06

Date	SHIFT	ORAL	OTHER	TOTAL	VOIDED	CATHETER	OTHER	TOTAL
	7-3	Ø		Ø		120		120
	3-11	Hosp		Hosp		Hosp		Hosp
	11-7	Hosp				Hosp		

NAME-LAST	FIRST	MIDDLE	ROOM NO.	ATTENDING PHYSICIAN	HOSP. NO.
Peterson	William		214D	NRGUM	1050

TMH&R-

TAKE AND PUT RECO

CL6200b

T M Health & Rehab of Edgefield LP
For the month of: March 2006

ADL

RECORD NURSES NOTES ON BACK

Description	Time Codes	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Diet: Record amount % consumed: Fluids in cc's ( )Regular ( )1800 ADA ( )Mech Soft ( )Pureed ( )Liquid ( )LCS ( )LCS w/diet fruits ( )Low fat ( )Low residue ( )Thickened liquids ( )Pudding ( )Nectar ( )Honey Reg Pureed.	BKFST																						20	30	40	D	D	120	80	30	20
	SB/SUP																														
	FLUIDS																						120	120	90	30	0	0	240	30	180
	REPMT																														
	AM-SNK																														
	LUNCH																						80	30	40	0	0	20	80	20	0
	FLUIDS																						120	120	180	30	0	90	30	120	0
	REPMT																														
	PM-SNK																														
	SB/SUP																														
	SUPPR																						30	10	40	10	10	230	30	120	0
	SB/SUP																														
	REPMT																														
	FLUIDS																						30	30	120	180	30	90	120	0	0
	HS SNK																														
	REPMT																														
Record meals as percentage = 25%, 50%, 75%, 100%, or as R = Refused																															

Signature	Init.	Signature	Init.	Signature	Init.	Signature	Init.
Linnard Jackson	TJ	Darlene Walker	dlw	Catina Campbell	CC	Tina Jones	TJ
Jacquanta Moore	JM					Bill K Mims	BM

Dx:

Allergies:

Physician:
Phys. Ph:
Alt. Phys:
Alt. Phys. Ph:
Ht:
Wt:
M/R No.:

Resident Name	Res No.	Unit Room Bed	D.O.B.	Sex	Admit Date
Peterson, William	1050	P214W	[redacted]	M	03-21-06

Page: 1

TM H&R of Edgefield 08/21/2006 08:25:28

CL6200b

TM Health & Rehab of Edgefield LP
For the month of: March 2006

ADL

RECORD NURSES NOTES ON BACK

Description	Time Codes	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Bath ( ) Bed ( )Shower ( )Sponge ( )Tub ( )W-pool ( )I ( )A ( )TH	7-3																						SP D	SP D	SP C	SP	SP O	SP D	SP D	SP D	SP D	
	3-11																															
	11-7																									SP						
F. Nail Care ( )I ( )A ( )TH																																
T. . . il Care ( )I ( )A ( )TH																																
Shave/Trim ( )I ( )A ( )TH																																
Shampoo ( )I ( )A ( )TH																																

Signature	Init.	Signature	Init.	Signature	Init.	Signature	Init.

Dx:

A. . . ies:

Physician: Alt. Phys: Ht: Wt:

Phys. Ph: Alt. Phys. Ph: M/R No.:

Resident Name	Res No.	Unit Room Bed	D.O.B.	Sex	Admit Date
Peterson, William	1050	P214W	[redacted]	M	03-21-06

Page: 2

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0219

CL6200b

T M Health & Rehab of Edgefield LP
For the month of: Mar 1 2006

ADL

RECORD NURSES NOTES ON BACK

Description	Time Codes	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Beauty Shop																																
C Care ( )Toothless ( )Dentures ( )Upper ( )Lower ( )Teeth ( )I ( )A ( )TH	7-3																						✓	✓	✓	✓	✓	✓	✓	✓	✓	
	3-11																						✓	✓	✓	✓	✓	✓	✓	✓		
	11-7																															
Locomotion & Transfer ( )Walker ( )Amb ( )Cane ( )PWB ( )SR ( )Bedfast ( )Chair ( )W/C ( )I ( )A ( )TH	7-3																						✓	✓	✓	✓	✓	✓	✓	✓	✓	
	3-11																						✓	✓	✓	✓	✓	✓	✓	✓		
	11-7																															
S Precautions ( )S/R ( )Lap Buddy ( )Cushion Belt ( )Geri Chr ( )Wand Guards ( )Padded S/R ( )PVC Beds *Chk Q30MINS *Release Q2HRS	7-3																															
	3-11																															
	11-7																															
BM ( )Cont ( )Incont ( )BR ( )BSC ( )BP ( )Lg ( )Med ( )Sm ( )None	7-3																					0	0	0	0	0	0	0	0	0		
	3-11																					0	0	0	0	0	0	0	0	0		
	11-7																					0	0	0	0	0	0	0	0	0		

Signature	Init.	Signature	Init.	Signature	Init.	Signature	Init.

Dx:

Allergies:

Physician:
Phys. Ph:
Alt. Phys:
Alt. Phys. Ph:
Ht:
Wt:
M/R No.:

Resident Name	Res No.	Unit Room Bed	D.O.B.	Sex	Admit Date
Peterson, William	1050	P214W	[redacted]	M	03-21-06

Page: 3

FMH&R of Edgefield LP 03/21/2006 - 05/25/2006 - 0220

CL6200b

TM Health & Rehab of Edgefield LP
For the month of: March 2006

ADL

RECORD NURSES NOTES ON BACK

Description	Time Codes	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Urine ( )Cont ( )Incont ( )Cath ( )Urinal	7-3																															
	.																															
	.																															
	.																															
	3-11																															
	.																															
	.																															
	.																															
	11-7																															
	.																															
	.																															
	.																															
Restorative ( )NA ( )ROM A P ( )AE ( )URE ( )LRE ( )LLE ( )Splints ( )Bed Mobility ( )Transfer ( )Walking ( )Dressing/ Grooming ( )Eating/ swallowing ( )Communication ( )Prosth	7-3																															
	3-11																															
	11-7																															
Maintenance ( )NA ( )ROM A P ( )AE ( )URE ( )LRE ( )LLE ( )Splints ( )Bed Mobility ( )Transfer ( )Walking ( )Dressing/ Grooming ( )Eating/ swallowing ( )Commun ( )Prosth	7-3																															
	3-11																															
	11-7																															

Signature	Init.	Signature	Init.	Signature	Init.	Signature	Init.

Dx:

Allergies:

Physician:
Phys. Ph:
Alt. Phys:
Alt. Phys. Ph:
Ht:
Wt:
M/R No.:

Resident Name	Res No.	Unit Room Bed	D.O.B.	Sex	Admit Date
Peterson William	1050	P 214W	[redacted]	M	03-21-06

Page: 4

MH R&R of Edgefield 03/21/2006 03/21/2006

CL6200b

T M Health & Rehab of Edgefield, LP

For the month of: March 2006

ADL

RECORD NURSES NOTES ON BACK

Description	Time Codes	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Skin Care *TURN AND REPOSITION Q2HRS ( )Maxiflo ( )Maxiflo ( )Eggcrate	7-3																															
	3-11																															
	11-7																															
Splint _____ *Check circulatory status prior to and after removing	7-3																															
	3-11																															
	11-7																															
Sleep patterns	GOOD																															
	RSTLSS																															
	WKFUL																															
	NAPS																															
FALL PRECAUTION	7-3																															
	3-11																															
	11-7																															
I LS	7-3																															
	3-11																															
	11-7																															

TMH&R Edgefield 03/21/2006 - 05/25/2006 - 0222

Signature	Init.	Signature	Init.	Signature	Init.	Signature	Init.

Dx:

Allergies:

Physician:

Alt. Phys:

Phys. Ph:

Alt. Phys. Ph:

Ht: Wt:

M/R No.:

Resident Name	Res No.	Unit Room Bed	D.O.B.	Sex	Admit Date
Peterson, William	1050	P 214 W	[redacted]	M	03-21-06

Page: 5

Antibiotic's

-744-

Resident Name Peterson, William Room 214D Mo./Yr. April 2006 Physician NRGL M.

TMH+R

Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
8PM	PO	PO	PO	PO	PO	✓																									
	2	2	2	2	2																										
	3	3	3	3	3																										

Levaquin 250mg PO qhs X6Days

TMH&R of Edgefield 03/21/2006 05/25/2006 - 0223

Date	Hour	Medication & Dosage	Route	Reason	Initials	Results or Response	Hour	Initials

Initials		Nurse's Signature	Initials		Nurse's Signature	Initials		Nurse's Signature
1			5			9		
2			6			10		
3			7			11		
4			8			12		

A. Initial or chart symbol in appropriate box when medication is given or refused.
B. If reason for mediation not given is required, document reason in Nurses Notes.
C. Chart PRN medications below.

D. Symbols:
X Patient out of facility
*R Refused medications
*M Out of medication
*S Patient overly sedated
C Patient out of facility with medications
*W Withheld
*U Unresponsive
* Require Nurses Notes

Injection Site Code	1. Buttock (Gluteus) Left	3. Arm (Deltoid) Left	5. Thigh (Quadriceps) Left	7. ILIAC Crest Left	9. Other (Specify)
	2. Buttock (Gluteus) Right	4. Arm (Deltoid) Right	6. Thigh (Quadriceps) Right	8. ILIAC Crest Right	

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0224

MAR

-746-

Resident Name William Peterson Room 214D Mo./Yr. April 2006 Physician NKG-LM

TMH4

Silvervite 1 po
1 day x 2 months
DIC p May 21st

Prostat 101 .30cc po
in 4oz of juice
tid x2 months

Periactin 4mg po
TID

Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
8AM																															
9A																															
1p																															
6p																															
7A														X																	
11A														X																	
7p														X																	

TMH&R of Edmonton 8/7/2006 - 05/25/2006 P225

Date	Hour	Medication & Dosage	Route	Reason	Initials	Results or Response	Hour	Initials

Initials		Nurse's Signature	Initials		Nurse's Signature	Initials		Nurse's Signature
1			5			9		
2			6			10		
3			7			11		
4			8			12		

A. Initial or chart symbol in appropriate box when medication is given or refused.
B. If reason for mediation not given is required, document reason in Nurses Notes.
C. Chart PRN medications below.

D. Symbols:
X Patient out of facility
*R Refused medications
*M Out of medication
*S Patient overly sedated
C Patient out of facility with medications
*W Withheld
*U Unresponsive
* Require Nurses Notes

Injection Site Code	1. Buttock (Gluteus) Left	3. Arm (Deltoid) Left	5. Thigh (Quadriceps) Left	7. ILIAC Crest Left	9. Other (Specify)
	2. Buttock (Gluteus) Right	4. Arm (Deltoid) Right	6. Thigh (Quadriceps) Right	8. ILIAC Crest Right	

GP-235 (Rev. 5/04)

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0226

CL6200b

T M Health & Rehab of Edgefield LP
For the month of: April 2006

Medication

RECORD NURSES NOTES ON BACK

Description	Time Codes	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
A[illegible]OLOL 12.5MG PO BID 4[illegible] Hypertension Nos	8AM																															
	8PM																															
PROTONIX 40MG PO Q DAY 530.81 Esophageal Reflux	~~8AM~~ [redacted]																															
NORVASC 5MG PO DAILY 401.9 Hypertension Nos	8AM																															
SILVERVITE 1 PO Q DAY X 2 MONTHS D/C AFTER MAY 21ST	8AM		D/C'd		ERROR																											
N[illegible] ASOURCE/ RESOURCE 2.0 ~~120cc~~ QID B[illegible] EEN MEALS 180cc	~~8AM~~ 9A																															
	~~12N~~ 1P																															
	~~4PM~~ 6P																															
	~~8PM~~ 9P																															
VITAL SIGNS Q SHIFT FYI	7-3																															
	~~3-11~~ [redacted]																															
	~~11-7~~ [redacted]																															
2N[illegible] STEP PPD DUE APRIL 2ND	7-3																															
WEEKLY B/P	7-3	*	*	*	92	*	*	*	*	*	110	*	*	*	*	*	*	121	*	*	*	*	*	*	116	*	*	*	*	*	*	*
		*	*	*	62	*	*	*	*	*	68	*	*	*	*	*	*	63	*	*	*	*	*	*	74	*	*	*	*	*	*	*

Signature	Init.	Signature	Init.	Signature	Init.	Signature	Init.

MEDICAL ALERT		
NO NG OR G TUBES		
Dx: 723.0 Cervical Spinal Stenosis	728.87 Muscle Weakness-General	600.90 Bph Nos W/O Urinary Obst
V58.72 Aftcre Surg Nerv Sys Nec	780.79 Malaise And Fatigue Nec	593.2 Cyst Of Kidney, Acquired
728.88 Rhabdomyolysis	290.0 Senile Dementia Uncomp	530.81 Esophageal Reflux

Allergies: NKA

Physician: MASSEY, TAMI — *Alt. Phys:* Morgan, Walter — *Ht:* 70 — *Wt:* 162.00
Phys. Ph: (803) 637-3146 — *Alt. Phys. Ph:* (803) 275-4653 — *M/R No.:* 1050

Resident Name	*Res No.*	*Unit Room Bed*	*D.O.B.*	*Sex*	*Admit Date*	*Page:*
PETERSON, WILLIAM	1050	P 214 D	[redacted]	M	3/21/2006	1

-749-

Date	Hour	Medication & Dosage	Route	Reason	Initials	Results or Response	Hour	Initials
4-23-06	8am	refused all 8am po meds, states "I don't need any medicine this morning."						CW
4-23-06	9am	Refused resource 2.0 180cc & prostat 101 30cc						CW
4-23	8PM	Refused meds & Resource.				P. Overton RN		

TMH&R of Eggefield 03/21/2006 - 05/25/2006 - 0228

Initials		Nurse's Signature	Initials		Nurse's Signature	Initials		Nurse's Signature
1			5			9		
2			6			10		
3			7			11		
4			8			12		

A. Initial or chart symbol in appropriate box when medication is given or refused.
B. If reason for mediation not given is required, document reason in Nurses Notes.
C. Chart PRN medications below.

D. Symbols: X Patient out of facility; *R Refused medications; *M Out of medication; *S Patient overly sedated; C Patient out of facility with medications; *W Withheld; *U Unresponsive; * Require Nurses Notes

Injection Site Code

1. Buttock (Gluteus) Left
2. Buttock (Gluteus) Right
3. Arm (Deltoid) Left
4. Arm (Deltoid) Right
5. Thigh (Quadriceps) Left
6. Thigh (Quadriceps) Right
7. ILIAC Crest Left
8. ILIAC Crest Right
9. Other (Specify)

GP-235 (Rev. 5/04)

CL6200b

T M Health & Rehab of Edgefield LP
For the month of: *April 2006*

PRN

RECORD NURSES NOTES ON BACK

Description	*Time Codes*	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
EDED																																
MYLANTA/MAALOX 15-30CC BY MOUTH AS NEEDED Q2HRS FOR INDIGESTION OR NAUSEA X48HRS.	PRN																															
	PRN																															
	PRN																															
	PRN																															
ACETAMINOPHEN 5 GR'TAB 2 TABS BY MOUTH AS NEEDED Q4HRS FOR PAIN OR FEVER X48HRS	PRN																															
	PRN																															
	PRN																															
	PRN																															
MILK OF MAGNESIA 30CC BY MOUTH AS NEEDED DAILY X48HRS. DX CONSTIPATION	PRN																															
	PRN																															
	PRN																															
	PRN																															
K ECTATE 30CC BY MOUTH AS NEEDED EVERY 2HRS UNTIL DIARRHEA SUBSIDES X48HRS	PRN																															
	PRN																															
	PRN																															
	PRN																															

Signature	*Init.*	*Signature*	*Init.*	*Signature*	*Init.*	*Signature*	*Init.*

MEDICAL ALERT			
NO NG OR G TUBES			
Dx:	723.0 Cervical Spinal Stenosis	728.87 Muscle Weakness-General	600.90 Bph Nos W/O Urinary Obst
	V58.72 Aftcre Surg Nerv Sys Nec	780.79 Malaise And Fatigue Nec	593.2 Cyst Of Kidney, Acquired
	728.88 Rhabdomyolysis	290.0 Senile Dementia Uncomp	530.81 Esophageal Reflux

Allergies: NKA

Physician: MASSEY, TAMI
Phys. Ph: (803) 637-3146
Alt. Phys: Morgan, Walter
Alt. Phys. Ph: (803) 275-4653
Ht: 70 *Wt:* 162.00
M/R No.: 1050

Resident Name	*Res No.*	*Unit Room Bed*	*D.O.B.*	*Sex*	*Admit Date*
PETERSON, WILLIAM	1050	P 214 D	[redacted]	M	3/21/2006

Page: 1

TMH&R of Edgefield 03/21/2006 - 05/25/2006 0025

Date	Hour	Medication & Dosage	Route	Reason	Initials	Results or Response	Hour	Initials

Initials		Nurse's Signature	Initials		Nurse's Signature	Initials		Nurse's Signature
1			5			9		
2			6			10		
3			7			11		
4			8			12		

A. Initial or chart symbol in appropriate box when medication is given or refused.
B. If reason for mediation not given is required, document reason in Nurses Notes.
C. Chart PRN medications below.

D. Symbols:
X Patient out of facility
*R Refused medications
*M Out of medication
*S Patient overly sedated
C Patient out of facility with medications
*W Withheld
*U Unresponsive
* Require Nurses Notes

Injection Site Code	1. Buttock (Gluteus) Left	3. Arm (Deltoid) Left	5. Thigh (Quadriceps) Left	7. ILIAC Crest Left	9. Other (Specify)
	2. Buttock (Gluteus) Right	4. Arm (Deltoid) Right	6. Thigh (Quadriceps) Right	8. ILIAC Crest Right	

GP-235 (Rev. 5/04)

TMH&R of Edgefield 03/21/2006 05/25/2006 0230

LAB TO DO

-752-

Resident Name Peterson, Williams Room 214D Mo./Yr. April 2006 Physician LNRGM

TMH+R

CBC + BMP
4-18-06
also UA & Culture

Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
																		B													

Date	Hour	Medication & Dosage	Route	Reason	Initials	Results or Response	Hour	Initials

Initials		Nurse's Signature	Initials		Nurse's Signature	Initials		Nurse's Signature
1			5			9		
2			6			10		
3			7			11		
4			8			12		

A. Initial or chart symbol in appropriate box when medication is given or refused.
B. If reason for mediation not given is required, document reason in Nurses Notes.
C. Chart PRN medications below.

D. Symbols:
X Patient out of facility
*R Refused medications
*M Out of medication
*S Patient overly sedated
C Patient out of facility with medications
*W Withheld
*U Unresponsive
* Require Nurses Notes

Injection Site Code	1. Buttock (Gluteus) Left	3. Arm (Deltoid) Left	5. Thigh (Quadriceps) Left	7. ILIAC Crest Left	9. Other (Specify)
	2. Buttock (Gluteus) Right	4. Arm (Deltoid) Right	6. Thigh (Quadriceps) Right	8. ILIAC Crest Right	

GP-235 (Rev. 5/04)

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0232

CL6200b

T M Health & Rehab of Edgefield LP
For the month of: *April 2006*

Treatment

RECORD NURSES NOTES ON BACK

Description	*Time Codes*	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
~~N~~ ISE LEG BAG WHEN AMBULATING AND USE B~~.~~ T NIGHT																																
VASOLINE TO PENIS BID	~~BAM~~ 7-3																															
	~~BPM~~ 3-11	Po	Po	PRN	PRN	PRN			Po	Po	PRN	PRN	PRN			Po	03	PRN	PRN	PRN												
SOFT COLLAR USED PRN FOR COMFORT X 6 WEEKS D/C AFTER MAY 2ND	PRN																															
	PRN																															
	PRN																															
	PRN																															
ALTERNATING PRESSURE RELIEF MATTRESS TO BED	7-3																															
	~~3-11~~																															
	~~11-7~~																															
FOLEY CARE Q SHIFT	7-3																															
	[redacted]	Po	Po	PRN	PRN	PRN			Po	Po	PRN	PRN	PRN			Po	03	PRN	PRN	PRN		Po	Po	Po	PRN	PRN	PRN			Po	Po	
	[redacted]	03	Po	Po	03	03	03	03	Po	Po	Po	03	03	03	03	03	Po	03	03	03	03	Po	Po	Po	Po	03	03	03	03	03	Po	
CHANGE FOLEY EVERY 6-8 WEEKS Δ 4/1/06	7-3																															
CLEAN NECK INCISION SITE WITH WOUND CLEANSER APPLY DRY DRESSING DAILY	7-3																				D/C 4/19/06											

Signature	*Init.*	*Signature*	*Init.*	*Signature*	*Init.*	*Signature*	*Init.*

MEDICAL ALERT		
NO NG OR G TUBES		
Dx: 723.0 Cervical Spinal Stenosis	728.87 Muscle Weakness-General	600.90 Bph Nos W/O Urinary Obst
V58.72 Aftcre Surg Nerv Sys Nec	780.79 Malaise And Fatigue Nec	593.2 Cyst Of Kidney, Acquired
728.88 Rhabdomyolysis	290.0 Senile Dementia Uncomp	530.81 Esophageal Reflux

Allergies: NKA

Physician: MASSEY, TAMI
Phys. Ph: (803) 637-3146
Alt. Phys: Morgan, Walter
Alt. Phys. Ph: (803) 275-4653
Ht: 70 *Wt:* 162.00
M/R No.: 1050

Resident Name	*Res No.*	*Unit Room Bed*	*D.O.B.*	*Sex*	*Admit Date*
PETERSON, WILLIAM	1050	P 214 D	[redacted]	M	3/21/2006

Page: 1

TMH&R of Edgefield 03/21/2006 - 05/25/2006 0233

Date	Hour	Medication & Dosage	Route	Reason	Initials	Results or Response	Hour	Initials

Initials		Nurse's Signature	Initials		Nurse's Signature	Initials		Nurse's Signature
1			5			9		
2			6			10		
3			7			11		
4			8			12		

A. Initial or chart symbol in appropriate box when medication is given or refused.
B. If reason for mediation not given is required, document reason in Nurses Notes.
C. Chart PRN medications below.

D. Symbols:
X Patient out of facility
*M Out of medication
C Patient out of facility with medications
*W Withheld
*R Refused medications
*S Patient overly sedated
*U Unresponsive
* Require Nurses Notes

Injection Site Code	1. Buttock (Gluteus) Left	3. Arm (Deltoid) Left	5. Thigh (Quadriceps) Left	7. ILIAC Crest Left	9. Other (Specify)
	2. Buttock (Gluteus) Right	4. Arm (Deltoid) Right	6. Thigh (Quadriceps) Right	8. ILIAC Crest Right	

GP-235 (Rev. 5/04)

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0234

CL6200b

T M Health & Rehab of Edgefield LP
For the month of: *April 2006*

Treatment

RECORD NURSES NOTES ON BACK

Description	*Time Codes*	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Δ @ hip & wound Cleanser. apply Bacitracin & OptiFoam daily.	7-3	→	→	→	→	→	→	Q	Q	Q	Q	Q	Q	Q	Q	Q	Q	Q	Q	Q	Q	>	Δd 4/20/06									
Δ foley 16FR 10cc	7-3																			>	RA	<										
Δ foley q 4 wks	7-3																															
Neosporin to penis sore BID until resolved	7-3 ~~3-11~~																			>	>		d/c'ed.									
Neosporin to penis 7-Shift	7-3 3-11 11-7																			>	Q Po X	Q Po Po	Q Po Po	Q PRN Po	Q PRN Po	Q PRN Po	Q PRN Po	Q PRN Po	Q PRN Po	Q Po Po	Q Po Po	Q Po Po
NRSG to Δ L hip desg + wound care on ~~Sat + Sun~~ daily: wound cleanser - paraffin oint. - cover c optfoam	7-3																				X	Q	Q	X	X	X	X	X	Q	Q	X	

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0236

Signature	*Init.*	*Signature*	*Init.*	*Signature*	*Init.*	*Signature*	*Init.*

MEDICAL ALERT			
NO NG OR G TUBES			
Dx:	723.0 Cervical Spinal Stenosis	728.87 Muscle Weakness-General	600.90 Bph Nos W/O Urinary Obst
	V58.72 Aftcre Surg Nerv Sys Nec	780.79 Malaise And Fatigue Nec	593.2 Cyst Of Kidney, Acquired
	728.88 Rhabdomyolysis	290.0 Senile Dementia Uncomp	530.81 Esophageal Reflux

Allergies: NKA

Physician: MASSEY, TAMI
Phys. Ph: (803) 637-3146
Alt. Phys: Morgan, Walter
Alt. Phys. Ph: (803) 275-4653
Ht: 70 *Wt:* 162.00
M/R No.: 1050

Resident Name	*Res No.*	*Unit Room Bed*	*D.O.B.*	*Sex*	*Admit Date*
PETERSON, WILLIAM	1050	P 214 D	[redacted]	M	3/21/2006

Page: 2

Date	Hour	Medication & Dosage	Route	Reason	Initials	Results or Response	Hour	Initials

Initials		Nurse's Signature	Initials		Nurse's Signature	Initials		Nurse's Signature
1			5			9		
2			6			10		
3			7			11		
4			8			12		

A. Initial or chart symbol in appropriate box when medication is given or refused.
B. If reason for mediation not given is required, document reason in Nurses Notes.
C. Chart PRN medications below.

D. Symbols:
X Patient out of facility
*R Refused medications
*M Out of medication
*S Patient overly sedated
C Patient out of facility with medications
*W Withheld
*U Unresponsive
* Require Nurses Notes

Injection Site Code

1. Buttock (Gluteus) Left
2. Buttock (Gluteus) Right
3. Arm (Deltoid) Left
4. Arm (Deltoid) Right
5. Thigh (Quadriceps) Left
6. Thigh (Quadriceps) Right
7. ILIAC Crest Left
8. ILIAC Crest Right
9. Other (Specify)

GP-235 (Rev. 5/04)

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0236

Tx.

Resident Name Peterson, William Room 214D Mo./Yr. April 06 Physician Krohn

TMH+R

Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
17.3																														

Date	Hour	Medication & Dosage	Route	Reason	Initials	Results or Response	Hour	Initials

Initials		Nurse's Signature	Initials		Nurse's Signature	Initials		Nurse's Signature
1			5			9		
2			6			10		
3			7			11		
4			8			12		

A. Initial or chart symbol in appropriate box when medication is given or refused.
B. If reason for mediation not given is required, document reason in Nurses Notes.
C. Chart PRN medications below.

D. Symbols:
X Patient out of facility
*R Refused medications
*M Out of medication
*S Patient overly sedated
C Patient out of facility with medications
*W Withheld
*U Unresponsive
* Require Nurses Notes

Injection Site Code	1. Buttock (Gluteus) Left	3. Arm (Deltoid) Left	5. Thigh (Quadriceps) Left	7. ILIAC Crest Left	9. Other (Specify)	GP-235 (Rev. 5/04)
	2. Buttock (Gluteus) Right	4. Arm (Deltoid) Right	6. Thigh (Quadriceps) Right	8. ILIAC Crest Right		

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0238

CL6200b

T M Health & Rehab of Edgefield LP

For the month of: April 2006

ADL

RECORD NURSES NOTES ON BACK

Description	Time Codes	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Record amount % consumed. Fluids in cc's (X)Regular ( )1800 ADA (X)Mech Soft (X)Pureed ( )NAS ( )LCS ( )LCS w/diet fruits ( )Low fat ( )Low residue ( )Thickened liquids ( )Pudding ( )Nectar ( )Honey	BKFST	20	5	30	50	10	20	40	10	0	0	0	20	5	0	0	0	30	20	40	40	0	10	0	0	0	0	15	10	0	0	
	SB/SUP																															
	FLUIDS	240	240	240	240	240	240	240	0	360	180	240	240	240	360	360	180	240	240	240	240	0	240	240	240	240	180	180	240	120	240	
	REPMT																															
	AM-SNK																															
	LUNCH	20	20	20	0	80	60	10	60	0	5	10	0	10	20	10	20	10	30	0	0	5	30	0	10	0	0	5	0	0	0	
	FLUIDS	120	180	240	0	240	120	240	240	180	240	90	240	240	240	240	180	240	240	240	0	120	240	240	240	0	0	20	0	0	0	
	REPMT																															
	PM-SNK																															
	SB/SUP																															
	SUPPR	0	25	10	0	20	20	0	20	10	10	0	10	40	20	20	20	10	40	10	10	10	30	10	30	20	25	20	10	30	10	
	SB/SUP																															
	REPMT																															
	FLUIDS	120	180	180	240	240	240	240	180	240	240	240	240	240	240	180	180	240	240	180	180	180	180	180	180	180	180	180	180	240	240	
	HS SNK	0	0	0	0	0		0	0	0	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	REPMT																															
Record meals as percentage = 25%, 50%, 75%, 100%, or as R = Refused																																

3/31/06 Mech Soft Magic cup @ lunch supper X1 month 329-06 thru 4-29-06

Signature	Init.	Signature	Init.	Signature	Init.	Signature	Init.
Maple Jones						Jacquie Stevens	JS
				Tommie Jackson	TJ	Gina Jones	GJ
		Calisa Campbell	CC	Easter Brown		Rimanna McManus	KM

MEDICAL ALERT

NO NG OR G TUBES

Dx:			
	723.0 Cervical Spinal Stenosis	728.87 Muscle Weakness-General	600.90 Bph Nos W/O Urinary Obst
	V58.72 Aftcre Surg Nerv Sys Nec	780.79 Malaise And Fatigue Nec	593.2 Cyst Of Kidney, Acquired
	728.88 Rhabdomyolysis	290.0 Senile Dementia Uncomp	530.81 Esophageal Reflux

Allergies: NKA

Physician: MASSEY, TAMI
Phys. Ph: (803) 637-3146
Alt. Phys: Morgan, Walter
Alt. Phys. Ph: (803) 275-4653
Ht: 70 **Wt:** 162.00
M/R No.: 1050

Resident Name	Res No.	Unit Room Bed	D.O.B.	Sex	Admit Date
PETERSON, WILLIAM	1050	P 214 D	[redacted]	M	3/21/2006

Page: 1

TMH&R of Edgefield LP 03/21/2006 09:25:57 AM

CL6200b

T M Health & Rehab of Edgefield LP
For the month of: *April 2006*

ADL

RECORD NURSES NOTES ON BACK

Description	*Time Codes*	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
PARTIAL OR SPONGE BATH OPPOSITE SHOWER DAYS	7-3																															
	3-11																															
	11-7																															
Bath ( ) Bed (X)Shower ( )Sponge ( )Tub ( )W-pool ( )I ( )TH	7-3																															
F. Nail Care ( )I ( )A (X)TH	7-3																															
	3-11																															
	11-7																															
T. Nail Care ( )I ( )A (X)TH																																

Signature	*Init.*	*Signature*	*Init.*	*Signature*	*Init.*	*Signature*	*Init.*

MEDICAL ALERT		
NO NG OR G TUBES		
Dx: 723.0 Cervical Spinal Stenosis	728.87 Muscle Weakness-General	600.90 Bph Nos W/O Urinary Obst
V58.72 Aftcre Surg Nerv Sys Nec	780.79 Malaise And Fatigue Nec	593.2 Cyst Of Kidney, Acquired
728.88 Rhabdomyolysis	290.0 Senile Dementia Uncomp	530.81 Esophageal Reflux

Allergies: NKA

Physician: MASSEY, TAMI
Phys. Ph: (803) 637-3146
Alt. Phys: Morgan, Walter
Alt. Phys. Ph: (803) 275-4653
Ht: 70 *Wt:* 162.00
M/R No.: 1050

Resident Name	*Res No.*	*Unit Room Bed*	*D.O.B.*	*Sex*	*Admit Date*	*Page:*
PETERSON, WILLIAM	1050	P 214 D	[redacted]	M	3/21/2006	2

MH&R of Edgefield 03/21/2006 - 05/25/2006 - 0241

CL6200b

T M Health & Rehab of Edgefield LP
For the month of: *April 2006*

ADL

RECORD NURSES NOTES ON BACK

Description	*Time Codes*	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
S Trim ( )I ( )A (X)TH																																
Shampoo ( )I ( )A (X)TH																																
Beauty Shop/ BARBER SHOP	7-3																															
Oral Care ( )Toothless ( )Dentures ( )Upper ( )Lower ( )Teeth ( )I ( )A ( )TH	7-3																															
	3-11																															
	11-7																															
Locomotion & Transfer ( )Walker ( )Amb ( )Cane ( )PWB ( )SR ( )Bedfast ( )Chair ( )W/C ( )I ( )A ( )TH	7-3																															
	3-11																															
	11-7																															
Safety Precautions (X)S/R ( )Lap Buddy ( )Cushion Belt ( )Geri Chr ( )Wand Guards ( )Padded S/R ( )PVC Beds *Chk Q30MINS *Release Q2HRS	7-3																															
	3-11																															
	11-7																															
BM ( )Cont ( )Incont ( )BR ( )BSC ( )BP ( )Lg ( )Med ( )Sm ( )None	7-3																															
	3-11																															
	11-7																															

Signature	*Init.*	*Signature*	*Init.*	*Signature*	*Init.*	*Signature*	*Init.*

MEDICAL ALERT
NO NG OR G TUBES

Dx:	723.0 Cervical Spinal Stenosis	728.87 Muscle Weakness-General	600.90 Bph Nos W/O Urinary Obst
	V58.72 Aftcre Surg Nerv Sys Nec	780.79 Malaise And Fatigue Nec	593.2 Cyst Of Kidney, Acquired
	728.88 Rhabdomyolysis	290.0 Senile Dementia Uncomp	530.81 Esophageal Reflux

Allergies: NKA

Physician: MASSEY, TAMI
Phys. Ph: (803) 637-3146
Alt. Phys: Morgan, Walter
Alt. Phys. Ph: (803) 275-4653
Ht: 70 *Wt:* 162.00
M/R No.: 1050

Resident Name	*Res No.*	*Unit Room Bed*	*D.O.B.*	*Sex*	*Admit Date*	*Page:*
PETERSON, WILLIAM	1050	P 214 D	[redacted]	M	3/21/2006	3

7-76 1-2006 05-2006 06-2006 07-2006 08-2006 09-2006 10-2006 11-2006 12-2006 01-2007 02-2007 03-2007 04-2007 MH&R of Edgefield

Resident Refuses to eat or drink anymore. Got nurse Charlene W. to try Refuse for her and Refuse meds.
4-23-06

CL6200b

T M Health & Rehab of Edgefield LP

For the month of: *April 2006*

ADL

RECORD NURSES NOTES ON BACK

Description	*Time Codes*	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
( )Cont ( )Incont ( )Cath ( )Urinal	7-3																															
	.																															
	.																															
	.																															
	3-11																															
	.																															
	.																															
	.																															
	11-7																															
	.																															
	.																															
	.																															
Restorative ( )NA ( )ROM A P ( )AE ( )URE ( )LRE ( )LLE ( )Splints ( )Bed Mobility ( )Transfer ( )Walking ( )Dressing/ Grooming ( )Eating/ swallowing ( )Communication ( )Prosth	7-3																															
	3-11																															
	11-7																															
Maintenance ( )NA ( )ROM A P ( )AE ( )URE ( )LRE ( )LLE ( )Splints ( )Bed Mobility ( )Transfer ( )Walking ( )Dressing/ Grooming ( )Eating/ swallowing ( )Commun ( )Prosth	7-3																															
	3-11																															
	11-7																															

Signature	*Init.*	*Signature*	*Init.*	*Signature*	*Init.*	*Signature*	*Init.*

MEDICAL ALERT		
NO NG OR G TUBES		
Dx: 723.0 Cervical Spinal Stenosis	728.87 Muscle Weakness-General	600.90 Bph Nos W/O Urinary Obst
2 Aftcre Surg Nerv Sys Nec	780.79 Malaise And Fatigue Nec	593.2 Cyst Of Kidney, Acquired
728.88 Rhabdomyolysis	290.0 Senile Dementia Uncomp	530.81 Esophageal Reflux

Allergies: NKA

Physician: MASSEY, TAMI *Alt. Phys:* Morgan, Walter *Ht:* 70 *Wt:* 162.00

Phys. Ph: (803) 637-3146 *Alt. Phys. Ph:* (803) 275-4653 *M/R No.:* 1050

Resident Name	*Res No.*	*Unit Room Bed*	*D.O.B.*	*Sex*	*Admit Date*	*Page:*
PETERSON, WILLIAM	1050	P 214 D	[redacted]	M	3/21/2006	4

MH&R of Edgefield 03/21/2006 to 05/25/2006

CL6200b

T M Health & Rehab of Edgefield LP
For the month of: April 2006

ADL

RECORD NURSES NOTES ON BACK

Description	*Time Codes*	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
S /URN AND REPOSITION Q2HRS ( )Maxiflo ( ) iflo ( )Eggcrate	7-3																															
	3-11	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		
	11-7						✓	✓																								
ASPEN COLLAR TO BE WORN FOR MOBILIZATION WHEN OOB IN CHAIR AMB, AND REHAB SESSIONS.*Check circulatory status prior to and after removing	7-3																															
	3-11																															
	11-7																															
S patterns	GOOD	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	RSTLSS																															
	WKFUL																															
	NAPS																															
FALL PRECAUTION	7-3																															
	3-11																															
	11-7																															
INITIALS	7-3																															
	3-11																															
	11-7																															

Signature	*Init.*	*Signature*	*Init.*	*Signature*	*Init.*	*Signature*	*Init.*

MEDICAL ALERT		
NO NG OR G TUBES		
Dx: 723.0 Cervical Spinal Stenosis	728.87 Muscle Weakness-General	600.90 Bph Nos W/O Urinary Obst
Aftcre Surg Nerv Sys Nec	780.79 Malaise And Fatigue Nec	593.2 Cyst Of Kidney, Acquired
726.68 Rhabdomyolysis	290.0 Senile Dementia Uncomp	530.81 Esophageal Reflux

Allergies: NKA

Physician: MASSEY, TAMI — *Alt. Phys:* Morgan, Walter — *Ht:* 70 — *Wt:* 162.00
Phys. Ph: (803) 637-3146 — *Alt. Phys. Ph:* (803) 275-4653 — *M/R No.:* 1050

Resident Name	*Res No.*	*Unit Room Bed*	*D.O.B.*	*Sex*	*Admit Date*	*Page:*
PETERSON, WILLIAM	1050	P 214 D	[redacted]	M	3/21/2006	5

MH&R of Edgefield 03/21/2006 - 05/25/2006 * 0244

Resident

I ought him the
Shake and He Refuse it
but he did drink at 20%
Cwt Dina
4/27-06

CL6200b

T M Health & Rehab of Edgefield LP
For the month of: May 2006

Medication

RECORD NURSES NOTES ON BACK

Description	Time Codes	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
OLOL 12.5MG PO BID 401.9 Hypertension Nos	8AM																															
	8PM																															
PROTONIX 40MG PO Q DAY 530.81 Esophageal Reflux	~~8AM~~ [redacted]																															
NORVASC 5MG PO DAILY 401.9 Hypertension Nos	8AM																															
SILVERVITE 1 PO Q DAY X 2 MONTHS D/C AFTER MAY 21ST	8AM																															
[redacted]/RESOURCE 2.0 180CC QID BETWEEN MEALS	~~8AM~~ 9A																															
	~~12N~~ 1P																															
	~~4PM~~ [redacted]																															
	~~8PM~~ [redacted]																															
VITAL SIGNS Q SHIFT	7-3																															
	[redacted]																															
	[redacted]																															
WEEKLY B/P	7-3		97/60							110/72																						

Signature	Init.	Signature	Init.	Signature	Init.	Signature	Init.

MEDICAL ALERT

NO NG OR G TUBES

Dx:			
	519.8 Resp System Disease Nec	728.88 Rhabdomyolysis	290.0 Senile Dementia Uncomp
	723.0 Cervical Spinal Stenosis	728.87 Muscle Weakness-General	600.90 Bph Nos W/O Urinary Obst
	V58.72 Aftcre Surg Nerv Sys Nec	780.79 Malaise And Fatigue Nec	593.2 Cyst Of Kidney, Acquired

Allergies: NKA

Physician: MASSEY, TAMI
Phys. Ph: (803) 637-3146
Alt. Phys: Morgan, Walter
Alt. Phys. Ph: (803) 275-4653
Ht: 70 *Wt:* 150.00
M/R No.: 1050

Resident Name	Res No.	Unit Room Bed	D.O.B.	Sex	Admit Date	Page:
PETERSON, WILLIAM	1050	P 214 D	[redacted]	M	3/21/2006	1

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TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0248

Date	Hour	Medication & Dosage	Route	Reason	Initials	Results or Response	Hour	Initials
5/10	lep	RN Novasource —		accepted approx 60cc				
5/10	9p	accepted approx		120cc Novasource				
5/14	8Pm	Meds held DIT Vomiting, Unable to swallow.				P. Dvestion LPN		
5/15	8A	Meds held		Unable to swallow				pmd
5/15/06	1P	po Resource held		not able to swallow				pmd

Initials		Nurse's Signature	Initials		Nurse's Signature	Initials		Nurse's Signature
1			5			9		
2			6			10		
3			7			11		
4			8			12		

A. Initial or chart symbol in appropriate box when medication is given or refused.
B. If reason for mediation not given is required, document reason in Nurses Notes.
C. Chart PRN medications below.

D. Symbols:
X Patient out of facility
*R Refused medications
*M Out of medication
*S Patient overly sedated
C Patient out of facility with medications
*W Withheld
*U Unresponsive
* Require Nurses Notes

Injection Site Code	1. Buttock (Gluteus) Left	3. Arm (Deltoid) Left	5. Thigh (Quadriceps) Left	7. ILIAC Crest Left	9. Other (Specify)	GP-235 (Rev. 5/04)
	2. Buttock (Gluteus) Right	4. Arm (Deltoid) Right	6. Thigh (Quadriceps) Right	8. ILIAC Crest Right		

TMH&R of Edgefield 03/21/2006 - 05/25/2006 0247

CL6200b

T M Health & Rehab of Edgefield LP

For the month of: May 2006

Medication

RECORD NURSES NOTES ON BACK

Description	Time Codes	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
STAT 101 30CC IN 4OZ OF JUICE TID X 2 MONTHS D/C AFTER MAY 29TH	~~8AM~~ GA																															
	~~12N~~ IP																															
	~~4PM~~ GL																															
PERIACTIN 4MG PO TID	~~8AM~~ [redacted]																															
	~~12N~~ HA																															
	~~4PM~~ [redacted]																															

Signature	Init.	Signature	Init.	Signature	Init.	Signature	Init.

MEDICAL ALERT		
NO NG OR G TUBES		
Dx: 519.8 Resp System Disease Nec	728.88 Rhabdomyolysis	290.0 Senile Dementia Uncomp
723.0 Cervical Spinal Stenosis	728.87 Muscle Weakness-General	600.90 Bph Nos W/O Urinary Obst
V58.72 Aftcre Surg Nerv Sys Nec	780.79 Malaise And Fatigue Nec	593.2 Cyst Of Kidney, Acquired

Allergies: NKA

Physician: MASSEY, TAMI — *Alt. Phys:* Morgan, Walter — *Ht:* 70 — *Wt:* 150.00

Phys. Ph: (803) 637-3146 — *Alt. Phys. Ph:* (803) 275-4653 — *M/R No.:* 1050

Resident Name	Res No.	Unit Room Bed	D.O.B.	Sex	Admit Date	Page:
PETERSON, WILLIAM	1050	P 214 D	[redacted]	M	3/21/2006	2

J769

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 07/24/2006

-770-

Date	Hour	Medication & Dosage	Route	Reason	Initials	Results or Response	Hour	Initials
5/11/06	11A	Periactin sandwich		out of mouth + would not swallow				SA
5/15/06	8A	Meds held		unable to swallow				pm

Initials		Nurse's Signature	Initials		Nurse's Signature	Initials		Nurse's Signature
1			5			9		
2			6			10		
3			7			11		
4			8			12		

A. Initial or chart symbol in appropriate box when medication is given or refused.
B. If reason for mediation not given is required, document reason in Nurses Notes.
C. Chart PRN medications below.

D. Symbols:
X Patient out of facility
*M Out of medication
C Patient out of facility with medications
*W Withheld
*R Refused medications
*S Patient overly sedated
*U Unresponsive
* Require Nurses Notes

Injection Site Code	1. Buttock (Gluteus) Left	2. Buttock (Gluteus) Right	3. Arm (Deltoid) Left	4. Arm (Deltoid) Right	5. Thigh (Quadriceps) Left	6. Thigh (Quadriceps) Right	7. ILIAC Crest Left	8. ILIAC Crest Right	9. Other (Specify)

GP-235 (Rev. 5/04)

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0249

CL6200b

TMH Health & Rehab of Edgefield LP

For the month of: *May 2006*

PRN

RECORD NURSES NOTES ON BACK

Description	*Time Codes*	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
A EDED																																
MYLANTA/MAALOX 15-30CC BY MOUTH AS NEEDED Q2HRS FOR INDIGESTION OR NAUSEA X48HRS.	PRN																															
	PRN																															
	PRN																															
	PRN																															
ACETAMINOPHEN 5 GR TAB 2 TABS BY MOUTH AS N ED Q4HRS FOR PAIN OR FEVER X48HRS	PRN																															
	PRN																															
MILK OF MAGNESIA 30CC BY MOUTH AS NEEDED DAILY X48HRS. DX CONSTIPATION	PRN																															
	PRN																															
	PRN																															
KAOPECTATE 30CC BY MOUTH AS NEEDED EVERY 2HRS UNTIL DIARRHEA SUBSIDES X48HRS	PRN																															
	PRN																															
	PRN																															
	PRN																															

Signature	*Init.*	*Signature*	*Init.*	*Signature*	*Init.*	*Signature*	*Init.*

MEDICAL ALERT		
NO NG OR G TUBES		
Dx: 519.8 Resp System Disease Nec	728.88 Rhabdomyolysis	290.0 Senile Dementia Uncomp
723.0 Cervical Spinal Stenosis	728.87 Muscle Weakness-General	600.90 Bph Nos W/O Urinary Obst

Allergies: NKA

Physician: MASSEY, TAMI *Alt. Phys:* Morgan, Walter *Ht:* 70 *Wt:* 150.00

Phys. Ph: (803) 637-3146 *Alt. Phys. Ph:* (803) 275-4653 *M/R No.:* 1050

Resident Name	*Res No.*	*Unit Room Bed*	*D.O.B.*	*Sex*	*Admit Date*	*Page:*
PETERSON, WILLIAM	1050	P 214 D	[redacted]	M	3/21/2006	1

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0255

Date	Hour	Medication & Dosage	Route	Reason	Initials	Results or Response	Hour	Initials

Initials		Nurse's Signature	Initials		Nurse's Signature	Initials		Nurse's Signature
1			5			9		
2			6			10		
3			7			11		
4			8			12		

A. Initial or chart symbol in appropriate box when medication is given or refused.
B. If reason for mediation not given is required, document reason in Nurses Notes.
C. Chart PRN medications below.

D. Symbols:
X Patient out of facility
*R Refused medications
*M Out of medication
*S Patient overly sedated
C Patient out of facility with medications
*W Withheld
*U Unresponsive
* Require Nurses Notes

Injection Site Code	1. Buttock (Gluteus) Left	3. Arm (Deltoid) Left	5. Thigh (Quadriceps) Left	7. ILIAC Crest Left	9. Other (Specify)	GP-235 (Rev. 5/04)
	2. Buttock (Gluteus) Right	4. Arm (Deltoid) Right	6. Thigh (Quadriceps) Right	8. ILIAC Crest Right		

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0251

CL6200b

T M Health & Rehab of Edgefield LP

For the month of: May 2006

Treatment

RECORD NURSES NOTES ON BACK

Description	Time Codes	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
N JSE LEG BAG WHEN AMBULATING AND USE BSD AT NIGHT																																
SOFT COLLAR USED PRN FOR COMFORT X 6 WEEKS D/C AFTER MAY 2ND	PRN																															
	PRN																															
	PRN																															
	PRN																															
Neosporin to penis sore — 8 shift.	7-3																															
	3-11																															
	11-7																															
Alternating pressure relief Matress — to bed. Check 8 shift for proper inflation & function	7-3																															
	3-11																															
	11-7																															
FOLEY CARE 8 SHIFT	7-3																															
	3-11																															
	11-7																															
CHANGE FOLEY EVERY 4 WEEKS	7-3	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	→		L	—	—	—	—	—	—	—	—	—	—	—

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0252

MEDICAL ALERT

NO NG OR G TUBES

Allergies: NKA

Physician: MASSEY, TAMI
Phys. Ph: (803) 637-3146

Alt. Phys: Morgan, Walter
Alt. Phys. Ph: (803) 275-4653

Ht: 70 *Wt:* 150.00
MR No.: 1050

Resident Name	Res No.	Unit Room Bed	D.O.B.	Sex	Admit Date
PETERSON, WILLIAM	1050	P 214 D	[redacted]	M	3/21/2006

Page: 1

Date	Hour	Medication & Dosage	Route	Reason	Initials	Results or Response	Hour	Initials

Initials		Nurse's Signature	Initials		Nurse's Signature	Initials		Nurse's Signature
1			5			9		
2			6			10		
3			7			11		
4			8			12		

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B. If reason for mediation not given is required, document reason in Nurses Notes.
C. Chart PRN medications below.

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X Patient out of facility
*R Refused medications
*M Out of medication
*S Patient overly sedated
C Patient out of facility with medications
*W Withheld
*U Unresponsive
* Require Nurses Notes

Injection Site Code	1. Buttock (Gluteus) Left	3. Arm (Deltoid) Left	5. Thigh (Quadriceps) Left	7. ILIAC Crest Left	9. Other (Specify)
	2. Buttock (Gluteus) Right	4. Arm (Deltoid) Right	6. Thigh (Quadriceps) Right	8. ILIAC Crest Right	

GP-235 (Rev. 5/04)

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0253

O2 Respiratory

-775-

Resident Name Peterson William Room 3140 mo./yr. May 2006 Physician Rainsford

TMH&R

O_2 - 2 LPM via NC DIT periods of apnea.

5/14/06

Clean O_2 filter Nightly.

5/14/06

Change O_2 Humidifier q 3 days.

5/14/06

~~Changing~~ Error

Change O_2 tubing q month. Due 6/14/06.

Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
7-3																														
3-11														Po																
11-7														Po																
11-7														Po	X	X		X	X		X	X		X	X		X	X		X
11-7														Po																
11-7														Po																

Date	Hour	Medication & Dosage	Route	Reason	Initials	Results or Response	Hour	Initials

Initials		Nurse's Signature	Initials		Nurse's Signature	Initials		Nurse's Signature
1			5			9		
2			6			10		
3			7			11		
4			8			12		

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*R Refused medications
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*U Unresponsive
* Require Nurses Notes

Injection Site Code	1. Buttock (Gluteus) Left	3. Arm (Deltoid) Left	5. Thigh (Quadriceps) Left	7. ILIAC Crest Left	9. Other (Specify)	GP-235 (Rev. 5/04)
	2. Buttock (Gluteus) Right	4. Arm (Deltoid) Right	6. Thigh (Quadriceps) Right	8. ILIAC Crest Right		

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0255

CL6200b

T M Health & Rehab of Edgefield LP

For the month of: *May 2006*

Treatment

RECORD NURSES NOTES ON BACK

Description	*Time Codes*	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
~~N~~ LEFT HIP WITH WOUND CLEANSER. APPLY BACITRACIN AND ~~OPTIFOAM~~ DAILY	7-3																															
NURSING TO TX 1X A DAY ON SAT AND SUN CLEAN LEFT HIP WITH WOUND CLEANSER. APPLY ~~PANAFIL~~ OINTMENT AND COVER WITH OPTIFOAM Accuzyme	7-3	X	X	X	X	X	R	R	X	X	X	X	X	R	R	X																
Clean R hip wound with wound cleanser. Apply Bacitracin once daily	7-3	qd	D/C 5/2/06 qd																													

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0256

MEDICAL ALERT

NO NG OR G TUBES

Allergies: NKA

Physician: MASSEY, TAMI *Alt. Phys:* Morgan, Walter *Ht:* 70 *Wt:* 150.00

Phys. Ph: (803) 637-3146 *Alt. Phys. Ph:* (803) 275-4653 *MR No.:* 1050

Resident Name	*Res No.*	*Unit Room Bed*	*D.O.B.*	*Sex*	*Admit Date*	*Page:*
PETERSON, WILLIAM	1050	P 214 D	[redacted]	M	3/21/2006	2

Date	Hour	Medication & Dosage	Route	Reason	Initials	Results or Response	Hour	Initials

Initials		Nurse's Signature	Initials		Nurse's Signature	Initials		Nurse's Signature
1			5			9		
2			6			10		
3			7			11		
4			8			12		

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C. Chart PRN medications below.

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Injection Site Code	1. Buttock (Gluteus) Left	3. Arm (Deltoid) Left	5. Thigh (Quadriceps) Left	7. ILIAC Crest Left	9. Other (Specify)	GP-235 (Rev. 5/04)
	2. Buttock (Gluteus) Right	4. Arm (Deltoid) Right	6. Thigh (Quadriceps) Right	8. ILIAC Crest Right		

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0257

CL6200b

T M Health & Rehab of Edgefield LP
For the month of: ***May 2006***

ADL

RECORD NURSES NOTES ON BACK

Description	Time Codes	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
t ecord amount % consumed. Fluids in cc's ( )R. ular ()Mech Soft (X)Pureed ( )NAS ( )LCS ( )LCS w/diet fruits ( )Thickened liquids ( )Pudding ( )Nectar ( )HoneyMAGIC CUP WITH LUNCH AND SUPPER	BKFST																															
	SB/SUP																															
	FLUIDS																															
	REPMT																															
	AM-SNK																															
	LUNCH																															
	FLUIDS																															
	REPMT																															
	PM-SNK																															
	SB/SUP																															
	SUPPR																															
	SB/SUP																															
	REPMT																															
	FLUIDS																															
	HS SNK																															
	REPMT																															
Record meals as percentage = 25%, 50%, 75%, 100%, or as R = Refused																																

Signature	Init.	Signature	Init.	Signature	Init.	Signature	Init.
		Ruth McKinney	RM	Jeanette Talbert	JT	Jammie Jackson	JJ
				Alice Dobey		Dina Jones	DJ
						Rebecca Green	RG

MEDICAL ALERT			
NO NG OR G TUBES			
Dx:	519.8 Resp System Disease Nec	728.88 Rhabdomyolysis	290.0 Senile Dementia Uncomp
	723.0 Cervical Spinal Stenosis	728.87 Muscle Weakness-General	600.90 Bph Nos W/O Urinary Obst
	V58.72 Aftcre Surg Nerv Sys Nec	780.79 Malaise And Fatigue Nec	593.2 Cyst Of Kidney, Acquired

Allergies: NKA

Physician: MASSEY, TAMI
Phys. Ph: (803) 637-3146
Alt. Phys: Morgan, Walter
Alt. Phys. Ph: (803) 275-4653
Ht: 70 ***Wt:*** 150.00
M/R No.: 1050

Resident Name	*Res No.*	*Unit Room Bed*	*D.O.B.*	*Sex*	*Admit Date*
PETERSON, WILLIAM	1050	P 214 D	[redacted]	M	3/21/2006

Page: 1

MH&R of Edgefield 03/21/2006 - 05/25/2006 - 0258

CL6200b

T M Health & Rehab of Edgefield LP
For the month of: *May 2006*

ADL

RECORD NURSES NOTES ON BACK

Description	*Time Codes*	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
PARTIAL OR SPONGE BATH OPPOSITE SHOWER DAYS	7-3																															
	3-11																															
	11-7																															
Bath ( ) Bed (X)Shower ( )Sponge ( )Tub ( )W-pool ( )I ( )A ( )TH	7-3	*		*		*		*	*		*		*		*	*		*		*		*	*		*		*		*	*	*
		*		*		*		*	*		*		*		*	*		*		*		*	*		*		*		*	*	*
F. Nail Care ( )I ( )A (X)TH	7-3																															
	3-11	✓	✓	✓	✓		✓	✓	✓					✓	✓		✓															
	11-7																															
T. Nail Care ( )I ( )A (X)TH																																

Signature	*Init.*	*Signature*	*Init.*	*Signature*	*Init.*	*Signature*	*Init.*

MEDICAL ALERT			
NO NG OR G TUBES			
Dx:	519.8 Resp System Disease Nec	728.88 Rhabdomyolysis	290.0 Senile Dementia Uncomp
	723.0 Cervical Spinal Stenosis	728.87 Muscle Weakness-General	600.90 Bph Nos W/O Urinary Obst
	V58.72 Aftcre Surg Nerv Sys Nec	780.79 Malaise And Fatigue Nec	593.2 Cyst Of Kidney, Acquired

Allergies: NKA

Physician: MASSEY, TAMI
Phys. Ph: (803) 637-3146
Alt. Phys: Morgan, Walter
Alt. Phys. Ph: (803) 275-4653
Ht: 70 *Wt:* 150.00
M/R No.: 1050

Resident Name	*Res No.*	*Unit Room Bed*	*D.O.B.*	*Sex*	*Admit Date*
PETERSON, WILLIAM	1050	P 214 D	[redacted]	M	3/21/2006

Page: 2

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TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0259

CL6200b

T M Health & Rehab of Edgefield LP
For the month of: *May 2006*

ADL

RECORD NURSES NOTES ON BACK

Description	*Time Codes*	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
/Trim ( )I ( )A (X)TH																																
Shampoo ( )I ( )A (X)TH																																
Beauty Shop/ BARBER SHOP	7-3																															
Oral Care ( )Toothless ( )Dentures ( )Upper ( )Lower ( )Teeth ( )I ( )A ( )TH	7-3																															
	3-11																															
	11-7																															
Locomotion & Transfer ( )Walker ( )Amb ( )Cane ( )PWB ( )SR ( )Bedfast ( )Chair (X)W/C ( )I ( )A ( )TH	7-3																															
	3-11																															
	11-7																															
Safety Precautions (X)S/R ( )Lap Buddy ( )Cushion Belt ( )Geri Chr ( )Wand Guards ( )Padded S/R ( )PVC Beds *Chk Q30MINS *Release Q2HRS	7-3																															
	3-11																															
	11-7																															
BM ( )Cont (X)Incont ( )BR ( )BSC ( )BP ( )Lg ( )Med ( )Sm ( )None	7-3																															
	3-11																															
	11-7																															

Signature	*Init.*	*Signature*	*Init.*	*Signature*	*Init.*	*Signature*	*Init.*

MEDICAL ALERT

NO NG OR G TUBES

Dx:			
	519.8 Resp System Disease Nec	728.88 Rhabdomyolysis	290.0 Senile Dementia Uncomp
	723.0 Cervical Spinal Stenosis	728.87 Muscle Weakness-General	600.90 Bph Nos W/O Urinary Obst
	V58.72 Aftcre Surg Nerv Sys Nec	780.79 Malaise And Fatigue Nec	593.2 Cyst Of Kidney, Acquired

Allergies: NKA

Physician: MASSEY, TAMI
Phys. Ph: (803) 637-3146

Alt. Phys: Morgan, Walter
Alt. Phys. Ph: (803) 275-4653

Ht: 70 *Wt:* 150.00
M/R No.: 1050

Resident Name	*Res No.*	*Unit Room Bed*	*D.O.B.*	*Sex*	*Admit Date*
PETERSON, WILLIAM	1050	P 214 D	[redacted]	M	3/21/2006

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0266

CL6200b

T M Health & Rehab of Edgefield LP
For the month of: *May 2006*

ADL

RECORD NURSES NOTES ON BACK

Description	Time Codes	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
t ( )Cont ( )Incont (X)Cath ( )Urinal	7-3																															
	3-11																															
	11-7																															
Restorative ( )NA ( )ROM A P ( )AE ( )URE ( )LRE ( )LLE ( )Splints ( )Bed Mobility ( )Transfer ( )Walking ( )Dressing/ Grooming ( )Eating/ swallowing ( )Communication ( )Prosth	7-3																															
	3-11																															
	11-7																															
nance ( )NA ( )ROM A P ( )AE ( )URE ( )LRE ( )Splints ( )Bed Mobility ( )Transfer ( )Walking ( )Dressing/ Grooming ( )Eating/ swallowing ( )Commun ( )Prosth	7-3																															
	3-11																															
	11-7																															
Skin Care *TURN AND REPOSITION Q2HRS ( )Maxiflo ( )Flexiflo ( )Eggcrate	7-3																															
	3-11																															
	11-7																															
A N COLLAR TO BE WORN FOR MOBILIZATION W. OOB IN CHAIR AMB, AND REHAB SESSIONS.*Check circulatory status prior to and after removing	7-3																															
	3-11																															
	11-7																															

Signature	Init.	Signature	Init.	Signature	Init.	Signature	Init.

MEDICAL ALERT		
NO NG OR G TUBES		
Dx: 519.8 Resp System Disease Nec	728.88 Rhabdomyolysis	290.0 Senile Dementia Uncomp
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V58.72 Aftcre Surg Nerv Sys Nec	780.79 Malaise And Fatigue Nec	593.2 Cyst Of Kidney, Acquired

Allergies: NKA

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Phys. Ph: (803) 637-3146
Alt. Phys: Morgan, Walter
Alt. Phys. Ph: (803) 275-4653
Ht: 70 *Wt:* 150.00
M/R No.: 1050

Resident Name	*Res No.*	*Unit Room Bed*	*D.O.B.*	*Sex*	*Admit Date*
PETERSON, WILLIAM	1050	P 214 D	[redacted]	M	3/21/2006

Page: 4

MH&R of Edgefield 03/21/2006 - 05/25/2006 - 036

CL6200b

T M Health & Rehab of Edgefield LP

For the month of: *May 2006*

ADL

RECORD NURSES NOTES ON BACK

Description	*Time Codes*	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
patterns	GOOD	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓																	
	RSTLSS																															
	WKFUL																															
	NAPS																															
FALL PRECAUTION	7-3	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓		✓																
	3-11	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓																	
	11-7	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓																	
INITIALS	7-3	TS	TS	TS	TS	TS	TS	TS	TS	TS	TS	TS	TS	TS	TS	TS	TS	TS	TS	TS	TS	TS	TS	TS	TS	TS						
	3-11	TS	TS	TS	TS	TS		TS	TS	TS	TS	TS	TS	TS	TS					TS	TS	TS										
	11-7	MS	MS	MS	MS	MS	MS	MS	MS	MS	MS	MS	MS	MS	MS	MS	MS	MS	MS	MS	MS	MS	MS	MS	MS	MS						

Signature	*Init.*	*Signature*	*Init.*	*Signature*	*Init.*	*Signature*	*Init.*
						Valerie Hayes	A

MEDICAL ALERT		
NO NG OR G TUBES		
Dx: 519.8 Resp System Disease Nec	728.88 Rhabdomyolysis	290.0 Senile Dementia Uncomp
723.0 Cervical Spinal Stenosis	728.87 Muscle Weakness-General	600.90 Bph Nos W/O Urinary Obst
V58.72 Aftcre Surg Nerv Sys Nec	780.79 Malaise And Fatigue Nec	593.2 Cyst Of Kidney, Acquired

Allergies: NKA

Physician: MASSEY, TAMI
Phys. Ph: (803) 637-3146

Alt. Phys: Morgan, Walter
Alt. Phys. Ph: (803) 275-4653

Ht: 70 *Wt:* 150.00
M/R No.: 1050

Resident Name	*Res No.*	*Unit Room Bed*	*D.O.B.*	*Sex*	*Admit Date*	*Page:*
PETERSON, WILLIAM	1050	P 214 D	[redacted]	M	3/21/2006	5

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0262

782

RESIDENT'S RIGHTS

This is to assure that William Peterson
Name of Resident

a resident at Trinity Mission Health & Rehab of Edgefield
Name of Facility

1. Is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations, and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents;

2. Is fully informed, and is given a written statement prior to or at the time of admission and during stay, of services available in the facility, and of related charges including any charges for services not covered by sources of third-party payments or not covered by the facility's basic per diem rate;

3. Is assured of adequate and appropriate medical care, is fully informed, by a physician, of his medical condition unless medically contraindicated (as documented, by a physician, in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to refuse to participate in experimental research, and to refuse medication and treatment after being fully informed of and understanding the consequences of such actions;

4. Is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given reasonable advance notice of 30 days to ensure orderly transfer or discharge, and such actions are documented in his medical record;

5. Is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other said relief for deprivations or infringements of his rights to adequate and proper treatment and care established by any applicable statute, rule regulation, or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

6. May manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with state law;

7. Is free from mental, sexual and physical abuse, and free from chemical and physical restraints except those restraints authorized in writing by a physician for a specified and limited period of time or when necessary to protect the resident from injury to himself or to others, or as are necessitated by an emergency in which case the restraint may only be applied by a licensed nurse who shall set forth in writing the circumstances requiring the use of restraint and in the case of a chemical restraint a physician shall be consulted within 24 hours; physician orders required prior to admission;

8. Is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except in the case of his transfer to another health care institution, or as required by law or third-party payment contract;

9. Is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

10. Is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

11. May associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician in his medical record).

12. May meet with, and participate in activities of social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician in his medical record);

13. May retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by the attending physician in the medical record);

14. If married, is assured privacy for visits by his/her spouse; if both are residents in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician in the medical record);

15. Is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choices shall not be infringed and the facility shall encourage and assist in the fullest possible exercise of these rights.

16. Is assured of established daily visiting hours;

17. May have members of the clergy admitted at the request of the patient or person responsible at any time.

18. Shall be allowed relatives or persons responsible to visit critically ill patients at any time, unless medically contraindicated;

19. Is allowed privacy for visits with family, friends, clergy, social workers, or for professional business purposes;

20. Shall have reasonable access to telephone both to make and receive confidential calls.

All rights and responsibilities specified in (1) through (4) of the above as they pertain to a patient adjudicated incompetent in accordance with State law, or a patient who is found by his physician, to be medically incapable of understanding these rights, or a patient who exhibits a communication barrier, shall devolve to such patient's guardian, next of kin, sponsoring agency(ies) or representative payee (except when the facility itself is representative payee) selected pursuant to the Social Security Act.

Resident by his/her signature hereto acknowledges that he/she has been fully informed of his/her rights as a resident at TMH&R of Edgefield, and he/she received a copy outlining his/her Resident's Rights.

This form has been fully explained to me and I acknowledge that I understand its contents, and the physician and other personnel assigned, if any, are acceptable to me.

The undersigned agrees to comply with this Agreement, with the Schedule of Rates and Charges in its entirety hereto appended and with the terms and conditions stated herein.

COMMENTS _____

03 - 21 - 06
Date

Mary Ruth Peterson
Signature

Karen Wilkins
Witness

daughter
Relationship to Resident

A HORIZATIC IND RELEA

Initial Approval

Resident's Name: William Peterson

MRP **BEAUTICIAN SERVICES**

I hereby authorize this facility to allow the facility beautician to cut and generally work with the following individual's hair according to the indicated schedule. I release the facility from any liabilities for any or all services provided in the beauty/barber shop. Refer to Charge Description Listing.

[ ] Bill to Patient Trust Fund.

MRP **PHARMACY APPROVAL**

I hereby authorize Kindred or facility contractual service to provide medicines for said patient while at this facility The pharmacy will send their statement to the resident/ responsible party for any co-payment and noncovered medications. This is to be paid within 30 days of the statement date.

MRP **PODIATRIST/DENTAL/HEARING/EYE**

Upon Physician Orders, I hereby authorize will refer

for Podiatry treatment, will refer for Dental treatment,

will refer for Hearing services,

will refer for Eye care or facility contractual service to perform and administer such treatments and/or procedures as may be deemed necessary.

MRP **PHOTO RELEASE**

I give permission to be photographed for films, video tapes and audio recordings to be published and/or facility web page, broadcast in the facility and/or in the public media and/or publications issued by the facility and for medical purposes.

[ ] Medical Purposes Only.

MRP **OUTING RELEASE**

I hereby authorize this facility to transport to various recreational events outside the premises of the facility (with his or her permission) where the attending physician approves such activity for him/her and absolve the facility from responsibility or liability for any unforeseen events or accidents.

[ ] For Appointments Only.

MRP **ACKNOWLEDGMENT OF RECEIPT**

I acknowledge that I have received a copy, if applicable, of the State's Medical Assistance (Medicaid) Program and information regarding the Requirement for Medicare Admission to a Skilled Nursing Facility.

MRP **PHYSICIAN ASSIGNMENT**

I have chosen N K G L M as my attending physician.

MRP **FUNERAL HOME ARRANGEMENTS**

I understand that in the absence of a stated choice, the facility, by law must contact a funeral home to begin the necessary arrangements. I understand that all financial responsibilities are the expense of the family.

My choice for a funeral home is Davis Funeral Home in Johnston, SC.

TMH&R of Edgefield 03/21/2006 - 05/25/2006 ; 0265

A[illegible]HORIZATIC[illegible]ND RELEA[illegible]

Initial Approval

Resident's Name: William Peterson

MRP **LAUNDRY CARE**

[✓] Laundry services will be performed by the facility.

[ ] Laundry will be performed by the family and picked up on a weekly basis or as needed.

MRD **INSURANCE AND / OR HOSPICE**

I assign payment of medical benefits by my private insurance carrier _____ and / or Hospice carrier _____ to Trinity Missin Health Rehab of Edgefield.

I understand that there may be deductibles, co-insurance amounts, or non-covered charges that either my private insurance carrier or Hospice carrier may not pay for. I also understand that these deductibles, co-insurance amounts, or non-covered charges will be my financial obligation. I hereby authorize any holder of medical or other information about me to release such information to _____ related to an insurance and / or Hospice claim. The information authorized may include records which indicate the presence of a communicable disease(s).

MRD **LIFT POLICY**

It is the policy of this facility to have a lift free environment. Any resident that needs to be lifted and/or transferred MUST be lifted and/or transferred with the aid of the mechanical lifts provided.

Each employee is to be in-serviced upon hire and annually on the lift policy and should sign that they have read and understand the procedure that is provided.

Each employee is to adhere to this policy including the therapy department.

MRD **SMOKING POLICY**

The Facility is a NON-SMOKING Facility and has a designated smoking area outside for the residents.

MRD **WEB PAGE**

I authorize the Facility to maintain on its web page information regarding me. I further authorize the Facility to notify _____ of my password to view my information.

MRD **RESIDENT RIGHTS**

I hereby acknowledge I have been given copies of the Bill of Rights, Admission Information, and pertinent information pertaining to the List of Services for residents of this facility.

A HORIZATIOI ND RELEAS

Initial
Approval

Resident's Name: William Peterson

MRP **NOTIFICATION OF OTHERS**

I authorize the facility to notify the following individuals in the event of accident, injury, or adverse change in my condition and/or to discuss any medical information regarding my case, plans for discharge, plans for room change, or financial matters:

1. Mary Ruth Peterson 803-649-4858 Telephone # _____
2. Belinda Butler Telephone # 803-644-4300
3. Patricia Peterson 803-644-0369

MRP **MAIL**

I authorize the facility to handle my mail as follows:

[4 I hereby consent that facility staff and/or volunteers may OPEN my mail for me. Then keep for family to see

[4 I hereby consent that facility staff and/or volunteers may READ my mail to me.

MRP **MEDICARE ASSIGNMENT**

I certify that the following information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. (I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize each physician or organization to submit claim to Medicare for payment to be made.) All treatment must be ordered by my attending physician. This authorization shall apply to the period of time I am a resident of this facility.

In case of denial of payment by Medicare, I authorize the facility to represent me in an appeal process.

Date 03 - 21 - 06

Resident Name William Peterson

Resident Number 1050

Resident Signature _____

Responsible Party Mary Ruth Peterson

P.O.A. (if applicable) _____

Legal Guardian (if applicable) _____

Facility Representative Karen Wells

If applicable, reason resident unable to sign _____

MEDICAL RECORD RELEASE AUTHORIZATION

-789-

Name: William Peterson

Date of Birth: [redacted] Social Security Number: [redacted]

1. I authorize (Name of Facility) _____ to disclose my health information specific to the following dates or time period:

   from _____ to _____.

2. Individual or entity authorized to receive my health information:

   _____

   _____

3. Purpose for which disclosure is to be made: _____

4. Information to be disclosed: (check all that apply)

   ____ MD Orders
   ____ Medication records
   ____ Nursing Notes
   ____ Treatment Sheets
   ____ Nutritional Assessment
   ____ I & O Record
   ____ MDS
   ____ Other (list) _____
   ____ MD Progress Notes
   ____ Physical Therapy
   ____ Occupational Therapy
   ____ Speech Therapy
   ____ Lab & X-ray reports
   ____ Care Plan Documents
   ____ Billing Statements

5. Subject to the terms of this medical authorization and the Health Insurance Portability & Accountability Act (HIPAA), you are instructed to maintain the privacy of all of my medical records. This authorization allows only the individual listed above to receive my Medical Information. No other dissemination of my medical record is authorized.

6. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____
Signature of Resident

_____
Print Name of Resident

Mary Ruth Peterson
Signature of Resident's Legal Representative

Mary Ruth Peterson
Print Name of Legal representative

daughter
Legal Representative's Relationship to Resident

_____
Date

Karen Williams
Signature of Facility Privacy Officer & Date

Karen Williams
Signature of Witnes

Palmetto Ambulance Service
"Hands That Care"
1-800-648-4999

Preferred Provider Form

Patient's Name: William Peterson

The above stated patient requests Palmetto Ambulance Service as the preferred provider for transportation needs.

Patient Signature	**Date**
Mary Ruth Peterson **Guardian Signature** **(If patient unable to sign)**	03-21-06 **Date**
Karen Nelli Witness	03-21-06 Date

BED HOLD POLICY

Facility Name: Trinity Mission Health & Rehab of Edgefield

William Peterson

The Facility will hold the bed for residents who transfer to the hospital or go out on therapeutic leave according to the following policy:

MEDICAID – According to state regulations, Medicaid will pay a facility to hold the bed for 10 days for anyone transferred to a hospital. Days begin with the day of transfer and do not count the day of return to the facility. After 10 days, a resident will have to be discharged from the Facility. Should the resident wish to return to the facility at a later time and the resident meets the criteria of the facility, favorable consideration will be given to the resident to be re-admitted.

All overnight days must be documented as therapeutic leave days. Residents going out on overnight therapeutic leave are allowed by the State plan 18 overnight visits per year from July 1 of one year through June 30 of the following year. No more than 9 therapeutic days may be taken at one time. Should leave days exceed the amount allowed, the State will be contacted for the correct procedures for payment.

Should a MEDICAID resident who meets MEDICARE criteria have to be transferred to the hospital, Medicaid will pay to hold the bed 10 days and the policy will be the same as noted above.

PRIVATE PAY – The State plan does not limit the number of days a private paying resident may remain in the hospital or out on therapeutic days. It is the policy of the facility to hold the bed of private paying residents as long as the resident so desires and is willing to pay for the bed hold days. This request to hold the bed will have to be in writing. The facility does require 7 days written notice of release of the bed. The facility will fill the bed as soon as possible after notification.

Should a private pay resident who meets MEDICARE criteria have to be transferred to the hospital, the policy is the same as noted above.

This policy will be explained to the resident and responsible party upon admission and will be posted at each nurse's station so it can be reviewed by resident, family, or friends before transfer to the hospital or therapeutic leave.

Date policy became effective
Revised September 1, 1995

The above BED HOLD POLICY has been explained to me.

	mary Ruth Peterson
Resident	Responsible Party
03-21-06	Karen Williams
Date	Witness

DISCHARGE DATE: _____

IMMUNIZATION PROGRAM

I agree to participate in the Immunization Program, based on the recommendation of the Center for Disease Control, the Medical Director and Attending Physician.

✓ Agreed ____ Denied

IMMUNIZATION & VACCINATION HISTORY

____ Yes	✓ No	Pneumovax
____ Yes	✓ No	Tetanus
____ Yes	✓ No	Flu-vaccine

William Peterson
Resident Name

Mary Ruth Peterson
Resident/Responsible Party

Witness

03-21-06
Date

Trinity Mission H&R of Edgefield, LP
P.O. Box 8
Edgefield, SC 29824

INFLUENZA VACCINE INFORMED CONSENT FORM

THE FLU - Influenza (flu) is a respiratory infection caused by viruses. When people get the flu, they may have fever, chills, headaches, dry cough or muscle aches. Illness may last several days to a week or more and complete recovery is usual. However, complications may lead to pneumonia or death in some people.

It is not possible to estimate the risk of an individual getting the flu this year, but for the elderly and for people with diabetes or heart, lung or kidney diseases, flu may be especially serious. For health care workers, immunization may help prevent transmission to residents.

THE VACCINE - An injection of flu vaccine will not give you the flu because the vaccine is made from killed viruses. The vaccine is made from viruses selected by the Office of Biologics, Food and Drug Administration and the Public Health Services.

RISK AND POSSIBLE SIDE EFFECTS - Side effects of influenza vaccine are generally mild in adults and occur at low frequency. These reactions consist of tenderness at the injection site, fever, chills, headaches or muscular aches. These symptoms last up to forty-eight hours.

SPECIAL PRECAUTIONS - Children under three years of age and pregnant women should consult with their personal physicians before receiving this vaccine.

Persons who are allergic to eggs, chickens, chicken feathers or chicken dander should not receive this vaccine until they have consulted their personal physicians. Persons with fever should not receive this vaccine. Persons who have received another type of vaccine within the past fourteen days should see their personal physicians before receiving this vaccine.

If you have a reaction, see your personal physician immediately. If you have any questions, please ask.

CONSENT

I have read the above information and have had an opportunity to ask questions. I understand the benefits and risks of flu vaccinations as described. I request that the vaccine be given to me or to the person named below for whom I am authorized to sign.

INFORMATION CONCERNING PERSON TO RECEIVE INFLUENZA VACCINE

Name (Please Print)	Date of Birth	Age
William Peterson	03-11-22	84

Address	City	State	Zip
3021 Edgefield Hwy	Trenton	SC	29847

mary Ruth Peterson

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0272

Signature of person to receive vaccine (or Parent or Guardian)

PNEUMOCOCCAL PNEUMONIA IMMUNIZATION PROGRAM CONSENT FORM

The pneumococcal vaccination policy has been modified to implement the Immunization Practice Advisory Committee (ACIP) and the Centers for Disease Control and Prevention (CDC) recommendations.

Prior to or upon admission to this facility, a pneumococcal immunization history will be obtained. If his vaccine has not been given within the past six (6) years or if verification of last vaccination is not available, then the pneumococcal polysaccharide vaccine is recommended.

The Pneumococcal Polysaccharide Vaccine is effective against 23 pneumococcal types, which cause 90 percent of all pneumococcal pneumonia, and is effective for approximately six (6) years. Anyone 65 years of age or older or having chronic health problems is considered high risk for exposure to and complications from pneumococcal pneumonia.

With your consent and the Attending Physician's approval this vaccine will be provided.

Please discuss any concerns or questions, with your nurse or Attending Physician.

PLEASE COMPLETE THE FOLLOWING INFORMATION

PNEUMOCOCCAL POLYSACCHARIDE VACCINE

✓ Yes — I want to receive the pneumococcal vaccine
____ No — I do not want to receive the pneumococcal vaccine
Reason why: _____

William Peterson
Resident Name (Please Print)

_____ / _____
Resident's Signature/Date

Mary Ruth Peterson / 03-21-06
Guarantor's Signature/Date (As appropriate)

RECORD OF PNEUMOCOCCAL POLYSACCHARIDE VACCINE

DATE

RESIDENT TB TESTING POLICY

It is the policy of this facility that residents will be screened for TB upon admission and routinely according to state and federal requirements. This policy is designed to put in place measures which address prevention of infection common to nursing home residents (e.g., vaccination for influenza and pneumococcal pneumonia as appropriate and TB screening and testing).

Mary Ruth Reterman — 03-21-06

Resident and/or Responsible Party — Date

Karen Wilkins — 03-21-06

Facility Representative — Date

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0274

PATIENT NAME Peterson, William

ROOM NUMBER P214W | PATIENT NUMBER 1050

INVENTORY OF PERSONAL EFFECTS

DATE OF INVENTORY 03-21-06

QTY.	ARTICLES	✓
	BELTS – SUSPENDERS	
	BLOUSES	
	BRASSIERES	
	COATS	
	DRESSES	
	GLOVES	
	HANDKERCHIEFS	
1	HATS	
1	HOSE	
	HOUSECOATS – ROBES	
	HOUSE SLIPPERS	
	LUGGAGE	
	NIGHTGOWNS	
	PAJAMAS	
	PANTIES	
	POCKET BOOKS – WALLETS	
	SHAVING KIT	
1	SHOES	
	SKIRTS	
3	SLACKS	
	SLIPS	
3pr	SOCKS	
1	SPORT JACKETS	
	SUITS	
	SWEATERS	
	TIES	
3	UNDERSHIRTS	

ITEMS OF SPECIFIC VALUE - JEWELRY, T.V., EQUIP., RADIO, ETC. ✓

DATE	DESCRIPTION	VALUE

ACQUIRED AFTER ORIGINAL ENTRY ✓

DATE	ITEM	GIFT OR PURCHASED	VALUE

INDICATE ITEMS DAMAGED OR DESTROYED ✓

DATE		VALUE

REMARKS:

A

A

CERTIFICATION OF RECEIPT

ON ADMISSION

SIGNED _____ / ___ / ___
PATIENT OR RESPONSIBLE PARTY — DATE

SIGNED _____ / ___ / ___
TITLE — DATE

ON DISCHARGE

SIGNED _____ / ___ / ___
PATIENT OR RESPONSIBLE PARTY — DATE

SIGNED _____ / ___ / ___
TITLE — DATE

Facility Name: TMH&R of Edgefield

NOTICE OF PRIVACY PRACTICES

Effective Date: April 10, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the Privacy Office (Administrator) at the facility or the Corporate Compliance Officer at 901-937-7994, ext. 1209.

WHO WILL FOLLOW THIS NOTICE.

This notice describes the facility's practices and that of:

- The physician members of the facility's medical staff and credentialed, non-physician health care professionals who may provide care in the facility.
- Departments and units of the facility.
- Volunteers who perform volunteer work in the facility.
- Employees, staff, and other facility personnel.

OUR EMPLOYEE CODE OF CONDUCT:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the facility to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care generated by the facility, whether made by facility personnel or your personal doctor.

Confidentiality Policy: All employee of this facility have read and signed agreement to this confidentiality policy as a condition of employment.

This policy states that each employee understands and agrees that while employed they may have access to and knowledge of medical information that is strictly confidential in nature. This information may include, but is not limited to, patient medical information, operational information, and other information related to the Resident's stay and care. They further agree that during and subsequent to the term of employment, they will not disclose said information to any party other than other care givers, employees of the Company, the Resident, and as appropriate Resident's family, and government officials. They further state they will not disclose said information to any other third party or attorney without written authorization from the President of Operations for the Company.

(Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's own office or clinic.)

Mary Ruth Pete

03-21-06

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Keep private medical information that identifies you;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the Notice of Privacy Rights currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose medical information. For better understanding, we have provided some examples in each category. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

⇨ ***For Treatment:*** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, students in other health care fields, or other facility personnel who are involved in taking care of you in the facility. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietician if you have diabetes so that we can arrange for appropriate meals. Different departments of the facility also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work, and x-rays. We may disclose medical information about you to people outside the facility, such as family members assisting you or other health care providers, such as medical equipment providers, or hospitals. We also may use your medical information to contact you to check that you are progressing in your recovery.

⇨ ***For Payment:*** We may use and disclose medical information about you so that the treatment and services you receive at the facility may be billed to and payment may be collected form you, an insurance company, or a third party. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We may share your information with other health care providers who trea you during your stay in the facility, such as an ambulance service or a physician who serves as a consultant during your treatment.

⇨ ***For Health Care Operations:*** We may use and disclose medical information about you for facility operations. These uses and disclosures are necessary to run the facility and make sure that all of our residents receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many facility residents to decide what additional services the facility should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, students in other health care fields, and other facility personnel for review and learning purposes. We may also combine the medical information we have with medical information from other facilities to compare how we are doing and see where we can make improvements in the care and

services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific residents are.

⇨ ***Photographs:*** We may photograph residents for security and identification purposes. As well as use photographs for advertisement and family communications via www.----------

⇨ ***Resident Satisfaction Surveys:*** We may use a limited amount of information about you to conduct resident satisfaction surveys by telephone, written communications, and via use of www.----------

⇨ ***Family Satisfaction Surveys:*** We may use a limited amount of information about you to conduct family satisfaction surveys by telephone, written communications, and via www.----------

⇨ ***Health Awareness Materials:*** We may use your information to send general health information to your family to create awareness in the community of important health topics.

⇨ ***Health Fairs/Screenings:*** We may use your information to contact your family with the results of any screenings that are not available on the day of the health fair/screening. We may keep a copy of your screening to verify that you received screenings at a health fair.

⇨ ***Personal Representatives:*** If you or a court has authorized another individual to act on your behalf, we will share information regarding your treatment with your personal representative unless we believe that the sharing of information would jeopardize your health or safety.

⇨ ***Appointment Reminders:*** We may use and disclose medical information to contact your family or personal representative as a reminder that you have an appointment for treatment or medical care at your physician's office, the hospital, or Care Planning. This practice includes contact by telephone and/or written communication.

⇨ ***Health-Related Benefits and Services:*** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

⇨ ***Fund Raising Activities:*** We may use your information in a limited manner in an effort to raise money for the facility and its operations. We may disclose information to a foundation so that the foundation may contact you in raising money for the facility. We would only release contact information such as name, address, and phone number. If you do not want to be contacted by a foundation, you must notify your facility.

⇨ ***Facility Directory:*** We may include certain limited information about you in the facility directory while you are a resident at the facility so that your family and friends can visit you and generally know how you are doing. This information includes your name, location in the facility, and your general condition (e.g., good, satisfactory, critical, etc.). The directory information may be released to people who ask for you by name, unless you specifically request that we do not include you in the facility directory. Additionally, your religious affiliation, if you provide it on admission, may be given to a minister of your faith even if they do not ask for you by name. This allows you to receive visits from a clergy of your faith. If you do not provide us with your religious affiliation during admission, your name will not be given to any visiting clergy.

MRP

⇨ *Individuals Involved in Your Care or Payment for Your Care:* We may release medical information about you to a friend or family member who is involved with your medical care or payment for services, unless you inform us that you object to such disclosure. (However, you may not use such an objection to avoid payment for services by a responsible party.) We may use or disclose information about you to locate and notify your family, personal representative, or other person responsible for your care that you are in the hospital and your general condition. In the event of a disaster, we may disclose medical information about you to an entity assisting in a disaster relief effort (such as the Red Cross) so that your family can be notified about your condition, status and location.

⇨ *As Required By Law:* We will disclose medical information about you when required to do so by federal, state, or local law.

⇨ *To Avert a Serious Threat to Health or Safety:* We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to prevent the threat.

SPECIAL SITUATIONS

⇨ *Organ and tissue Donation:* If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

⇨ *Access by Parents:* Some state laws concerning minors permit or require disclosure of protected health information to parents, guardians, and persons acting in a similar status. We will act consistently with the law of the state where the treatment is provided and will make disclosures following such laws.

⇨ *Military and Veterans:* If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreigh military authority.

⇨ *Worker's Compensation:* We may release medical information about you for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

⇨ *Medical Surveillance of the Workplace:* If you are an employee who is being evaluated at the request of your employer for medical surveillance of the workplace or in relation to a work-related illness or injury, we may share information obtained from such evaluation with your employer.

⇨ *Public Health Risks:* We may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability
- To report births and deaths
- To report suspected child or adult abuse or neglect
- To report reactions to medications or problems with products

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 0279

MRP

- To notify people of recalls of products they may be using
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
- To notify the appropriate government authority if we believe a resident has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law

⇨ ***Health Oversight Activities:*** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care systems, government programs, and compliance with civil rights and other laws, regulations, and regulatory advice. We may also disclose medical information to lawyers or consultants who are providing services to the facility or related entity regarding a legal or regulatory matter.

⇨ ***Lawsuits and Disputes:*** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if we receive written assurances that the party seeking your medical information has made efforts to tell you about the request or to obtain an order protecting the information requested. We may use your medical information to defend a legal action against the facility or other related legal entity.

⇨ ***Law Enforcement:*** We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons, or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the facility; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

⇨ ***Coroners, Medical Examiners and Funeral Directors:*** We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about residents of the facility to funeral directors as necessary to carry out their duties.

⇨ ***National Security and Intelligence Activities:*** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

⇨ ***Protective Services for the President and Others:*** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state or conduct special investigations.

⇨ ***Inmates:*** If you are an inmate of a correctional institution or under the custody of a law

MRP.

enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

- ***Right to Inspect and Copy:*** You have the right to inspect and copy medical information used to make decisions about your care. Usually, this generally includes medical and billing records.

  To inspect and copy medical information used to make decisions about you, you must submit your request in writing to the facility's Medical Records Department or to the Business/Billing Office for billing records. If you request a copy of the information, you may charged a fee for the costs of copying, mailing, or other supplies associated with your request.

  We may deny your request to inspect and copy in certain, limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the facility will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- ***Right to Amend:*** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the facility.

  To request an amendment, your request must be made in writing and submitted to the facility's Medical records Department, Attention: Privacy Contact. In addition, you must provide a reason that supports your request.

  We may deny your request for amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the medical information kept by or for the facility;
  - Is not part pf the information which you would be permitted to inspect and copy; or
  - Is accurate and complete.

- ***Right to an Accounting of Disclosures:*** You have the right to request an "accounting of disclosures". This is a list of the disclosures we made of medical information about you for reasons other than treatment, payment or health care operations. For example, an accounting of disclosures would include disclosures that we are required by law to make, such as reporting communicable diseases to the county health department.

  To request this accounting of disclosures, you must submit your request in writing to the facility's

Medical Records Department, Attention: Privacy Contact. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, you may be charged for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- ***Right to Request Restrictions:*** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations.

  We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or if disclosure is required by law.

  To request restrictions, you must make your request in writing to the facility. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

- ***Right to Request Confidential Communications:*** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location/ for example, you can ask that we only contact you at work. However, you must provide us with an address to which we can send all written correspondence, including your bill.

  At the time of admission to the facility, you may request a change to your confidential communications address and phone number by submitting a written request to the Medical records Department, Attention: Privacy Contact. We will not ask you the reason for your request. We will accommodate reasonable requests. Your request must specify how or where you wish to be contacted.

- ***Right to a Paper Copy of This Notice:*** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Paper copies are available in each facility's admission area.

CHANGES TO THIS NOTICE

- ***We reserve the right to change this notice.*** We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the curren't notice in the facility. The notice will contain on the first page, in the top right-hand corner, the effective date.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the facility. Services. To file a privacy complaint with the facility, contact the Privacy Officer (Administrator) at your facility, or submit in writing to the Corporate Compliance Officer, Attention Privacy Officer, 475 Jack Kramer Drive, Memphis, Tennessee, 38117 or e-mail to lw@ourmemphisconnection.com

You will not be penalized for filing a complaint.

M.R.P

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provided to you.

03-21-06

Mary Ruth Peterson

NURSING FACILITIES
PRIVACY ACT STATEMENT – HEALTH CARE RECORDS 8/9/2000

THIS FORM PROVIDES YOU THE ADVICE REQUIRED BY THE PRIVACY ACT OF 1974. THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.

1. AUTHORITY FOR COLLECTION OF INFORMATION, INCLUDING SOCIAL SECURITY NUMBER AND WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY.

Sections 1819(f), 1919(f), 1819(b)(3)(A), 1919(b)(3)(A), and 1864 of the Social Security Act.

Medicare and Medicaid participating long-term care facilities are required to conduct comprehensive, accurate, standardized and reproducible assessments of each resident's functional capacity and health status. To implement this requirement, the facility must obtain information from every resident. This information also is used by the Federal Centers for Medicare and Medicaid Services (CMS) to ensure that the facility meets quality standards and provides appropriate care to all residents. For this purpose, as of June 22, 1998, all such facilities are required to establish a database of resident assessment information, and to electronically transmit this information to the HCFA contractor in the State government, which in turn transmits the information to HCFA.

Because the law requires disclosure of this information to Federal and State sources as discussed above, a resident does not have the right to refuse consent to these disclosures.

These data are protected under the requirements of the Federal Privacy Act of 1974 and the MDS Long-Term Care System of Records.

2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED

The information will be used to track changes in health and functional status over time for purposes of evaluating and improving the quality of care provided by nursing facilities that participate in Medicare or Medicaid. Submission of MDS information may also be necessary for the nursing facilities to receive reimbursement for Medicare services.

3. ROUTINE USES

The primary use of this information is to aid in the administration of the survey and certification of Medicare/Medicaid long-term care facilities and to improve the effectiveness and quality of care given in those facilities. This system will also support regulatory, reimbursement, policy, and research functions. This system will collect the minimum amount of personal data needed to accomplish its Stated purpose.

The information collected will be entered into the Long-Term Care Minimum Data Set (LTC MDS) system of records, system No. 09-07-1517. Information from this system may be disclosed, under specific circumstances (routine uses), which include: (1) a congressional office from the record of an individual in response to an inquiry from the congressional made at the request of that individual; (2) the Federal Bureau of Census; (3) the Federal Department of Justice; (4) an individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease of disability, or the restoration of health; (5) contractors working for HCFA to carry out Medicare/Medicaid functions, collating or analyzing data, or to detect fraud or abuse; (6) an agency of a state government for purposes of determining, evaluating and/or assessing overall or aggregate cost, effectiveness, and/or quality of health care services provided in the State; (7) another Federal agency to fulfill a requirement of a Federal statute that implements a health benefits program funded in whole or in part with Federal funds or to detect fraud or abuse; (8) Quality Improvement Organizations to perform Title XI or title XVIII functions; (9) another entity that makes payment for or oversees administration of health care services for preventing fraud or abuse under specific conditions.

4. EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION

The information contained in the Long-Term Care Minimum Data Set is generally necessary for the facility to provide appropriate and effective care to each resident. If a resident fails to provide such information, for example on medical history, inappropriate and potentially harmful care may result. Moreover, payment for such services by third parties, including Medicare and Medicaid, may not be available unless the facility has sufficient information to identify the individual and support a claim for payment.

03 – 21 – 06
Date

William Peterson
Resident Name

[redacted]
Social Security #

Resident Signature

Mary Ruth Peterson
Responsible Party

P.O.A.

Legal Guardian

Karen Nelson
Facility Representative

If applicable, reason resident unable to sign:

RELEASE FOR ELECTRONIC TRANSMISSION OF MINIMUM DATA SET (MDS)

POLICY: NOTIFICATION OF RESIDENTS

It is necessary for providers of Medicare/Medicaid to inform residents about the automation and electronic transmission of the Minimum Data Set (MDS). The data will be part of the Long Term Care Minimum Data Set (LTC MDS) system of records, System No. 009-70-1516, and therefore are ultimately subject to the Privacy Act of 1974. To properly inform the individual of their rights under the Privacy Act, the below Release has been given. Residents or their representative do not need to sign this form, they must, however, be given a copy of this notice. For residents currently residing in the facility, providers should review the information in the notice and then provide the resident with a copy. For residents who have legal representatives, providers can provide a copy of the notice in person or by mail. For new admissions, a copy of the Privacy Act Notification should be as part of the admission packet that is given to the resident or representative at the time of admission.

RELEASE:

The Health Care Financing Administration (HCFA) is authorized to collect Long Term Care Minimum Data Set (LTC MDS) system of records per Sections 1819(f), 1919(f), 1819 (b)(3)(A), and 1864 of the Social Security Act. The purpose of this data collection is to aid in the administration of the survey and certification of Medicare/Medicaid long term care facilities and to study the effectiveness and quality of care given in those facilities. This system will also support regulatory, reimbursement, policy, and research functions. This system will collect the minimum amount of personal data needed to accomplish its stated purpose.

The information collected will be entered into the Long Term Care Minimum Data Set (LTC MDS) system of records, System No. 009-70-1516. Information from this system may be disclosed, under specific circumstances, to: (1) a congressional office from the record of an individual in response to an inquiry from the congressional made at the request of that individual; (2) the Bureau of Census; (3) the Department of Justice; (4) an individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease of disability, or the restoration of health; (5) contractors working for HCFA to carry out Medicare/Medicaid functions, collating analyzing data, or to detect fraud or abuse; (6) an agency of a State government for purposes of determining, evaluating and/or assessing overall or aggregate costs, effectiveness, and/or quality of health care services provided in the State; (7) another Federal agency to fulfill a requirement of a Federal statute that implements a health benefits program funded in whole or in part with Federal funds or to detect fraud or abuse; (8) Peer Review Organizations to perform Title XI or Titles XVIII functions; (9) another entity that makes payment for or oversees administration of health care services for preventing fraud or abuse under specific conditions.

The Computer Matching and Privacy Protection Act of 1988, permits the government to verify information by way of computer matches.

Collection of the Social Security Number is voluntary; however, failure to provide this information may result in the loss of Medicare benefits provided by the nursing home. The Social Security Number will be used to verify the association of information to the appropriate individual.

03 – 21 – 06
Date

William Peterson
Resident Name

[redacted]
Social Security Number

Resident Signature

Mary Ruth Peterson
Responsible Party

P.O.A.

Legal Guardian

Karen Williams
Facility Representative

If applicable, reason resident is unable to sign: _____

Aiken Regional MEDICAL CENTERS
The Health Choice

202 University Parkway, Aiken, SC 29801

MED. REC. NO. 26523

PT NO 102829710	PATIENT NAME PETERSON SR, WILLIAM SR											PT STS: IC	
ADDRESS 3023 EDGEFIELD HWY												COUNTY 2	
CITY TRENTON			STATE SC	ZIP 29847-0000	PHONE 803-649-4858		EXT.	SOCIAL SECURITY NO [redacted]					
AGE 85	DOB [redacted]	SEX M	RACE 2	MS S	PREVIOUS NAME					RELIGION OTH	N/S 5M	RM/BED 503 A	
ADM DATE 05/15/06	TIME 23:57	SRC RA	PT TYPE H	PRI R	ACCIDENT INFO H	05/15/06 15:00		VOLUNTARY ADM		ORGAN DNR	ISOL	INFANT AGE	
PT EMPLOYER RET					TELEPHONE - -		EXT	OCCUPATION RET					
EMPLOYER ADDRESS													
CITY			STATE	ZIP						RETIREMENT DATE 01/01/1890			
NEAREST RELATIVE NAME PETERSON , RAYMOND SR													
RLTN C	ADDRESS 3025 EDGEFIELD HWY												
CITY TRENTON			STATE SC	ZIP 29847-0000	PHONE 803-644-8084		EXT						
EMERGENCY CONTACT NAME PETERSON , MARY RUTH SR													
RLTN C	ADDRESS 3021 EDGEFIELD HWY												
CITY TRENTON			STATE SC	ZIP 29847-0000	PHONE 803-649-4858		EXT						
GUARANTOR NAME PETERSON SR, WILLIAM SR									RLTN S	[redacted]			
ADDRESS 3023 EDGEFIELD HWY										PHONE 803-649-4858			
CITY TRENTON			STATE SC	ZIP 29847-0000	OCCUPATION RET					EXT			
GUARANTOR EMPLOYER RET					PHONE - -		EXT						
ADDRESS													
CITY			STATE	ZIP								FC M	
INSURANCE NAME 1 MEDICARE PART A 2006	CODE A06	POLICY # [redacted]		GROUP #			SUBSCRIBER PETERSON SR	REL S	AUTH #				
INSURANCE NAME 2 MEDICARE B PROFEE 06	CODE A16	POLICY # [redacted]		GROUP #			SUBSCRIBER PETERSON SR	REL S	AUTH #				
INSURANCE NAME 3	CODE	POLICY #		GROUP #			SUBSCRIBER	REL	AUTH #				
ATTENDING PHYSICIAN BOKKISAM CHAKRAVARTHY		ATTENDING # 045591	REF SRC	ADM BY ALLISL	PREV ADM DATE		PREVIOUS FACILITY				SURGERY DATE		
ADM DIAGNOSIS UROSEPSIS, AMS, HYPOTHERMIA		MED SVC IMD	CODE 038.11	ALLERGIES									
ADMITTING PHYSICIAN BOKKISAM CHAKRAVARTHY		ADMITTING # 045591	AUTHORIZED BY										
PROCEDURE		CLINICAL COMMENT					MODE OF ARRIVAL/ACCOMPANIED BY EMS EMERGENCY MEDICA						
REL OF INFO Y	ADV DIR	LIVING WILL	LOCATION OF WILL/DIRECTIVE		FAMILY DOCTOR BOKKISAM CHAKRAVARTHY 045591 Div:								

FINAL DIAGNOSES (FIRST DIAGNOSIS PRINCIPAL UNLESS NOTED)

CODE

See Dictation

PROCEDURES

COMPLETE

CONSULTING PHYSICIANS

DRG

LOS

TRANS TO:	ACUTE	SNF ☐	REHAB ☐	HOSPICE ☐	HOME HEALTH ☐	HOME IV ☐	AGAINST MED ADV ☐	HOME ☐	
DISCHARGE DATE	TIME	OTHER							
EXPIRED ☐	TIME	<48HRS ☐	>48HRS ☐	CORONER ☐	AUTOPSY	YES ☐	NO ☐		

5/17/06

ATTENDING PHYSICIAN SIGNATURE & DATE

Aiken Regional MEDICAL CENTERS
202 University Parkway, Aiken, SC 29801

PHYSICIAN ATTESTATION REPORT

PATIENT NAME: PETERSON ,WILLIAM SR
AGE: 85 **SEX:** M
ADMISSION DATE: 05/15/06
DISCHARGE DATE: 06/01/06
DISCHARGE STATUS: ATY TRANSFER TO LONG TERM CARE UPDATE BY: SIMSMI DATE: 06/03/06

MEDICAL RECORD NO.: 26523
ACCOUNT NUMBER: 102829710
PATIENT LOS: 17
FIN. CLASS: M MEDICARE

DRG ASSIGNMENT: 415 - O.R. PROCEDURE FOR INFECTIOUS **GMLOS:**

PRINCIPAL DIAGNOSIS:

CODE	DESCRIPTION
038.11	STAPH AUREUS SEPTICEMIA

SECONDARY DIAGNOSES:

CODE	DESCRIPTION
707.03	DECUBITUS ULCER-LOW BACK
785.4	GANGRENE
584.9	ACUTE RENAL FAILURE NOS
599.0	URINARY TRACT INF NOS
403.91	HTN KIDNEY DIS NOS W CKD
276.0	HYPEROSMOLALITY
511.9	PLEURAL EFFUSION NOS
995.92	SIRS D/T INF W ORG DYSF
753.10	CYSTIC KIDNEY DIS NOS
V09.0	PENICILLIN RESIST ORG
041.04	GROUP D STREP INFECTION
285.9	ANEMIA NOS
600.00	PROS HYPERTR W/O OBSTR
461.0	AC MAXILLARY SINUSITIS

PROCEDURES:

CODE	DESCRIPTION	DATE	PHYSICIAN #	PHYSICIAN NAME
83.45	MYECTOMY NEC	05/21/06	002253	HAGAN JAMES L
33.24	CLOSED BRONCHUS BIOPSY	05/25/06	004275	SANITO NICHOLAS J
43.11	PEG	05/19/06	002253	HAGAN JAMES L
45.25	CLOSED LG INTEST BIOPSY	05/31/06	002253	HAGAN JAMES L
34.91	THORACENTESIS	05/26/06	044347	ROBINSON RON
45.13	SM INTEST ENDOSCOPY NEC	06/01/06	002253	HAGAN JAMES L

I CERTIFY THAT THE NARRATIVE DESCRIPTIONS OF THE PRINCIPAL AND SECONDARY DIAGNOSES AND THE MAJOR PROCEDURES PERFORMED ARE ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

PHYSICIAN SIGNATURE: _____ (SIGNATURE) _____ (DATE)

ATTENDING PHYSICIAN: 045591 BOKKISAM CHAKRAVARTHY

RxLASER, INC. C2488-20008 (714)986-1559 (3/98)

Aiken Regional MEDICAL CENTERS
The Health Choice

202 University Parkway, Aiken, SC 29801

MED. REC. NO. 26523

PT NO 102829710	PATIENT NAME PETERSON SR, WILLIAM SR												PT STS: IC
ADDRESS 3023 EDGEFIELD HWY												COUNTY 2	
CITY TRENTON		STATE SC	ZIP 29847-0000	PHONE 803-649-4858	EXT.	[redacted]							
AGE 85	DOB [redacted]	SEX M	RACE 2	MS S	PREVIOUS NAME			BLDLESS:	RELIGION OTH	N/S 5M	NUMBED 503 A		
ADM DATE 05/15/06	TIME 23:57	SRC RA	PT TYPE H	PRI R	ACCIDENT INFO H	05/15/06 15:00		VOLUNTARY ADM	ORGAN DNR	ISOL	INFANT AGE		
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EMPLOYER ADDRESS													
CITY		STATE	ZIP					RETIREMENT DATE 01/01/1890					
NEAREST RELATIVE NAME PETERSON , RAYMOND SR													
RLTN C	ADDRESS 3025 EDGEFIELD HWY												
CITY TRENTON		STATE SC	ZIP 29847-0000	PHONE 803-644-8084	EXT								
EMERGENCY CONTACT NAME PETERSON , MARY RUTH SR													
RLTN C	ADDRESS 3021 EDGEFIELD HWY												
CITY TRENTON		STATE SC	ZIP 29847-0000	PHONE 803-649-4858	EXT								
GUARANTOR NAME PETERSON SR, WILLIAM SR								RLTN S	PHONE 803-649-4858	EXT			
ADDRESS 3023 EDGEFIELD HWY													
CITY TRENTON		STATE SC	ZIP 29847-0000	OCCUPATION RET				[redacted]					
GUARANTOR EMPLOYER RET				PHONE - -	EXT								
ADDRESS													
CITY		STATE	ZIP										FC: M
INSURANCE NAME 1 MEDICARE PART A 2006	PLAN A06	PHONE - -	POLICY # 247306586A				GROUP #				AUTH #		
MAILING ADDRESS P.O. BOX 1602				CITY OMAHA			STATE NE	ZIP 68101					
SUBSCRIBER NAME PETERSON SR, WILLIAM	MAIL TO NAME MEDICARE	INS SEX M	[redacted]	DOB 03/11/1921	GNM:								
INSURANCE NAME 2 MEDICARE B PROFEE 06	PLAN A16	PHONE - -	POLICY # [redacted]				GROUP #				AUTH #		
MAILING ADDRESS P.O. BOX 1602				CITY OMAHA			STATE NE	ZIP 68101					
SUBSCRIBER NAME PETERSON SR, WILLIAM	MAIL TO NAME MEDICARE	INS SEX M	[redacted]	DOB 03/11/1921	GNM:								
INSURANCE NAME 3	PLAN	PHONE - -	POLICY #				GROUP #				AUTH #		
MAILING ADDRESS				CITY			STATE	ZIP					
SUBSCRIBER NAME	MAIL TO NAME	INS SEX	SOCIAL SECURITY NUMBER	DOB	GNM:								
ATTENDING PHYSICIAN BOKKISAM CHAKRAVARTHY	ATTENDING # 045591	REF SRC	ADM BY ALLISI,	PREV ADM DATE	PREVIOUS FACILITY								
ADM DIAGNOSIS UROSEPSIS, AMS, HYPOTHERMIA	MED SVC IMD	CODE 038.11	ALLERGIES								SURGERY DATE		
ADMITTING PHYSICIAN BOKKISAM CHAKRAVARTHY	ADMITTING # 045591	AUTHORIZED BY											
PROCEDURE	CLINICAL COMMENT							MODE OF ARRIVAL/ACCOMPANIED BY EMS EMERGENCY MEDICA					
REL OF INFO Y	ADV DIR	LIVING WILL	LOCATION OF WILL/DIRECTIVE	FAMILY DOCTOR BOKKISAM CHAKRAVA 045591 DIV:									

VERIFIED BY: DATE:	VERIFIED BY: DATE:
NAME OF INS CO #1:	NAME OF INS CO #1:
GROUP-INDIVIDUAL	GROUP-INDIVIDUAL
TELEPHONE NO:	TELEPHONE NO:
NAME OF PERSON GIVING INFO:	NAME OF PERSON GIVING INFO:
PREAUTHORIZATION REQ? AUTHORIZATION #:	PREAUTHORIZATION REQ? AUTHORIZATION #:
EFF DATE OF INS POLICY: ELIGIBILITY:	EFF DATE OF INS POLICY: ELIGIBILITY:
WAITING PERIOD:	WAITING PERIOD:
PRE-EXIST: RN:	PRE-EXIST: RN:
BASIC BENEFITS:	BASIC BENEFITS:
SEMI @ _____ ANCILLARY @ _____	SEMI @ _____ ANCILLARY @ _____
MAJOR MEDICAL:	MAJOR MEDICAL:
DEDUCTIBLE: _____ BALANCE PAID @ _____	DEDUCTIBLE: _____ BALANCE PAID @ _____

INSURANCE COPY

Aiken Regional MEDICAL CENTERS
Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29802

PATIENT NAME: William Peterson DATE OF SERVICE/ADMISSION 05-15-06

CONSENT FOR TREATMENT, GUARANTY OF PAYMENT AGREEMENT, ASSIGNMENT OF INSURANCE BENEFITS, RELEASE OF MEDICAL INFORMATION AND ASSOCIATED NOTICES AND AUTHORIZATION.

NOTICE TO PATIENT AND ALL SIGNATORIES OF THIS DOCUMENT: By your signature below, each signatory of this document is agreeing to be jointly and severally bound by all of the terms and conditions hereinafter set forth unless otherwise noted. In consideration of the hospital care and treatment to be rendered to Patient by Hospital, the undersigned agree and consent to the following:

1. Consent and Conditions of Admission: The undersigned hereby agrees and gives consent to Hospital for the admission/treatment/testing of Patient. The undersigned hereby consents to any and all hospital care encompassing: X-Ray examination, laboratory procedures, diagnostic procedures, anesthesia and nursing or medical/surgical treatment which Patient's physician, his associates, partners or designees, may deem necessary or advisable under the general and special instructions of the same, during Patient's hospitalization.

2. Medical and Surgical Treatment: The undersigned agrees and understands that all physicians, dentists and or oral surgeons treating Patient are responsible and liable for their own acts or omissions and the Hospital is not responsible or liable for the acts omissions of the aforementioned. The undersigned is aware that the practice of medicine is not an exact science and further state that no guarantee has been made or can be made as to the results of the treatments or examinations in the Hospital.

The undersigned certifies that they have read all of this document, including the reverse side hereof, and that the undersigned is the Patient, or is duly authorized by the Patient or by law, to execute the above Agreement and understands its terms.

All Patients shall receive treatment or service within the hospital's capability and policies. Our hospital is committed to patient's impartial access to treatment or accommodations that are available or medically indicated regardless of race, creed, sex, national origin, or sources of payment for care.

3. Assignment of Insurance Benefits and Release of Medical Information: The undersigned hereby assign to Hospital, its successors and assigns, all benefits that may be payable to or on behalf of the Patient under any policy of insurance, (hospitalization, major medical, automobile, workmen's compensation, personal injury benefits available because of liability of a third party, or any other) and authorize Hospital to release specifically requested medical information related to Patient to include reference to conditions including psychological or psychiatric impairment, drug abuse and/or alcoholism, sexual assaults, tests for HIV, ARC and/or AIDS, or other infectious diseases necessary for settlement of benefit payment or money payable because of Patient's hospitalization, treatment or injury during this encounter. The undersigned further direct that the payer of any such payment make such payment directly to Hospital. In addition, the undersigned assign to Hospital, its successors and assigns, the proceeds of injury claim resulting from liability to Patient of a third party. Any payments to Hospital under authority of this Assignment shall not exceed the actual charges set forth in Hospital's billing statements issued in connection with Patient's account.

If Patient is eligible for Medicare, the undersigned requests Medicare services and benefits. The undersigned further agree that this Assignment will not be withdrawn or voided at any time until Patient's account is paid in full. The undersigned acknowledge that it is their responsibility to pay Hospital for any charges not covered by insurance. Further, undersigned agree and understand that if the Patient, or his duly authorized representative, requests a private room for the Patient the undersigned is responsible for the entire room difference.

The undersigned hereby authorize any agency or employee of the U.S., any State or Municipal Government to release to the Hospital, its employee, employees and/or its attorney, any and all information concerning governmental programs under which the above named Patient is or may be qualified to receive benefits due and further authorize payment of any and all such benefits direct to Hospital.

The insured whose signature appears in this item one (1), hereby represents to the Hospital that the following insurance policies are the only insurance policies offering coverage to the patient in this matter and hereby assigns to Hospital all benefits payable to or on behalf of Patient thereunder:

Written authorization for HMO/PPO plans: I understand that if my insurance carrier, HMO plan or PPO network requires preauthorization, the Hospital/Provider/Physician is unable to guarantee that my visit will be covered without a written authorization for the services rendered to me or my family members. If the Hospital/Provider/Physician is unable to obtain authorization for my visit, I will be responsible for any unpaid balance. I will be financially responsible for those charges that coincide with any service/procedures/day(s) not authorized by my insurance/managed care plan. I understand that the Hospital accepts no liability for failure to meet any pre/post certification procedures which may be required of me by my coverage carrier. I agree that any such procedures have been or will be properly executed by me.

Primary Insurance Co. _____

Patient Unable to Sign

Insured _____

Secondary Insurance Co. _____

Patient _____

Insured _____

Addressograph

102829710 503
PETERSON SR, WILLIAM SR
DOB [redacted] 85 SX: M EMR
MRN: 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

Form 902.02 (Rev 10/04) 10-1983

MEDICAL RECORDS

Aiken Regional Medical Centers

302 University Parkway • Aiken, SC 29801 • (803) 641-5000

Patient's Last Name	First Name	M.I.	Sex:	Date of Birth:
Date of ths Transfer:	Facility Name / Phone # Patient Transferring to:			

PATIENT EVALUATION (Inpatient Only)

Name of Physician at new facility:

Diagnosis at time of transfer:

Primary:

Secondary:

☑ See Discharge Summary

Physician Orders on Transfer:

Code Status:

Diet / Tube Feeds:

Activity:

Physical Therapy	☐ Yes	☐ No
Occupational Therapy	☐ Yes	☐ No
Speech Therapy	☐ Yes	☐ No

Labs:

Specialty Bed:

O_2:

Wound Care:

Meds:

Rehabilitation Potential: Fair

Level of Care: Skilled

Patient Informed of condition / diagnosis?

☑ Yes ☐ No If no, explain: Pt demented

Estimated medically necessary stay:

___ Days 4 Weeks ___ Months

Physician's Signature: [signature] Date Signed: 6/1/06

6/1/06

NURSING EVALUATION (Inpatient & Outpatient)

Transfer Nurse Checklist Complete #1 – 13
(ED Nurse – Complete #1 – 5)

☐ 1. Send copy of chart to include labs.

☐ 2. Prescriptions sent with patient (list here):

☐ 3. Report called to_____@_____am/pm

☐ 4. Current Vital Signs BP T P R

☐ 5. Complete this form. (White copy goes with patient)

☐ 6. Complete Consent for Release of Information form and place in patient's chart.

☐ 7. Ambulance called #_____

☐ 8. Return appointment made:
MD DATE TIME

☐ 9. Send copy of PPD

☐ 10. Send copy of current MAR.

☐ 11. Send MD Discharge Summary.

☐ 12. Family notified of transfer.

☐ 13. Other:

Impairments: ☐ Mental ☐ Speech ☐ Hearing ☐ Vision

Feeding: ☐ Tube Feeds ☐ Self ☐ Needs help ☐ Can't feed self

Appetite: ☐ N/A ☐ Good ☐ Fair ☐ Poor

Personal Care: ☐ Independent ☐ Needs help ☐ Unable to do

Incontinent: ☐ Bladder ☐ Bowel ☐ Last BM:

Mobility: ☐ Independent ☐ Walker/Assist ☐ W/C ☐ Bed bound

Level of Pain: ☐ None ☐ Mild ☐ Moderate ☐ Severe

Isolation: ☐ Yes ☐ No Specify:

Skin: ☐ Intact ☐ Drain ☐ IV Access ☐ Incision ☐ Tube ☐ Rash ☐ Broken Skin ☐ Bed Sore

Wound Care / Comments:

Allergies:

Valuables: ☐ Dentures ☐ Upper ☐ Lower ☐ Eye Glasses ☐ Hearing Aid ☐ Other:

Signature Date

Title / Unit

Addressograph:

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

PATIENT TRANSFER FORM
(Inter-Agency Referral)

Aiken Regional Medical Centers

302 University Parkway • Aiken, SC 29801 • (803) 641-5000

Patient's Last Name	First Name	M.I.	Sex:	Date of Birth:
Peterson, SR	Williams		M	[redacted]
Date of ths Transfer:	Facility Name / Phone # Patient Transferring to:			

PATIENT EVALUATION (Inpatient Only)

Name of Physician at new facility: _____

Diagnosis at time of transfer:

Primary: _____

Secondary: _____

☑ See Discharge Summary

Physician Orders on Transfer:

Code Status: _____

Diet / Tube Feeds: _____

Activity: _____

Physical Therapy	☐ Yes	☐ No
Occupational Therapy	☑ Yes	☐ No
Speech Therapy	☐ Yes	☐ No

Labs: _____

Specialty Bed: _____

O_2: _____

Wound Care: _____

Meds: See Orders

Rehabilitation Potential: Poor

Level of Care: Skilled

Patient Informed of condition / diagnosis?

☐ Yes ☑ No If no, explain: Dementia

Estimated medically necessary stay:

___ Days 6 to 12 Weeks ___ Months

Physician's Signature: [signature] Date Signed: 5/23/06

NURSING EVALUATION (Inpatient & Outpatient)

Transfer Nurse Checklist Complete #1 – 13
(ED Nurse – Complete #1 – 5)

☑ 1. Send copy of chart to include labs.

☑ 2. Prescriptions sent with patient (list here): N/A

☐ 3. Report called to Lo @ ___ am/pm

☐ 4. Current Vital Signs BP 140/ T 101 P 79 R 16

☑ 5. Complete this form. (White copy goes with patient)

☑ 6. Complete Consent for Release of Information form and place in patient's chart.

☐ 7. Ambulance called # _____

☐ 8. Return appointment made:

MD	DATE	TIME
N/A		

☑ 9. N/A Send copy of PPD

☐ 10. Send copy of current MAR.

☑ 11. Send MD Discharge Summary.

☑ 12. Family notified of transfer.

☐ 13. Other: _____

Impairments: ☑ Mental ☐ Speech ☐ Hearing ☐ Vision

Feeding: ☑ Tube Feeds ☐ Self ☐ Needs help ☐ Can't feed self

Appetite: ☐ N/A ☐ Good ☐ Fair ☐ Poor

Personal Care: ☐ Independent ☐ Needs help ☑ Unable to do

Incontinent: ☑ Bladder/Foley ☑ Bowel ☐ Last BM: _____

Mobility: ☐ Independent ☐ Walker/Assist ☐ W/C ☑ Bed bound

Level of Pain: ☑ None ☐ Mild ☐ Moderate ☐ Severe

Isolation: ☑ Yes ☐ No Specify: MRSA - urine

Skin: ☐ Intact ☐ Drain ☐ IV Access ☐ Incision ☐ Tube ☐ Rash ☐ Broken Skin ☑ Bed Sore

Wound Care / Comments: Decubitus ulcer care.

Allergies: _____

Valuables: ☐ Dentures ☐ Upper ☐ Lower ☐ Eye Glasses ☐ Hearing Aid ☑ Other: _____

Signature [signature] 6-1-06 Date

Title / Unit

Addressograph: Peterson, Wm

PA Aiken Regional Medical Centers cares about your health. Therefore, if you SMOKE we are advising this facility to encourage you to quit. For more information, call the SC Smoking Cessation Quitline @ 1-877-44U-QUIT.

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

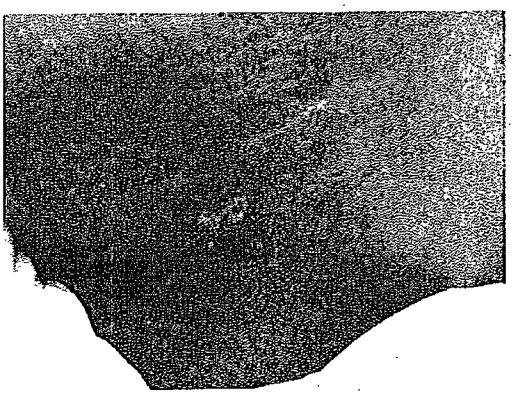
Wound Assessment

Identification Information

Peterson, William
Patient Number: 26523
Date of Birth: [redacted]
Wound Number: 4
Location: Back (lower), , , ,
Type of Wound: Pressure Ulcer
Date Wound Acquired:
Acquired At Facility: No

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	Tunneling:	N/A
Width (mm):	5	Undermining:	N/A
Depth (mm):	1	Sinus Tract:	N/A
Hypergranulated:	No		
Area (mm^2):	98.172		
Volume (mm^3):	98.172		

Wound Details

Wound Progess:	Initial Exam
Wound Margin:	Flat and Intact

Peripheral Skin Appearance

Texture

Wound Base

Wound Base Descriptions

Color: Pink

Exposed Structure

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

Submitted By: *mmelton at 5/16/2006 12:17:16 PM*

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

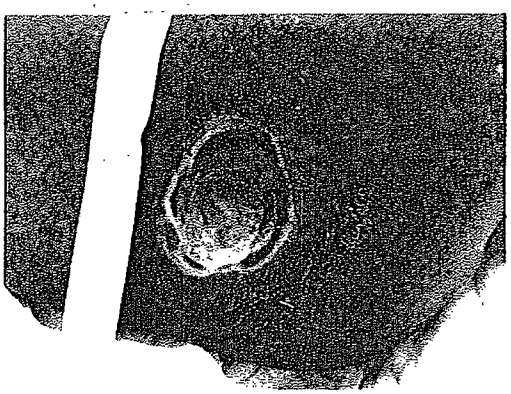
Wound Assessment

Identification Information

Peterson, William
Patient Number: 26523
Date of Birth: [redacted]
Wound Number: 3
Location: Hip (), Left, , , ,
Type of Wound: Pressure Ulcer
Date Wound Acquired:
Acquired At Facility: No

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	Tunneling:	N/A
Width (mm):	50	Undermining:	N/A
Depth (mm):	10	Sinus Tract:	N/A
Hypergranulated:	No		
Area (mm^2):	2356.125		
Volume (mm^3):	23561.25		

Wound Details

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

Peripheral Skin Appearance

Texture

Wound Base

Wound Base Descriptions

Slough 76-100%
Color:

Exposed Structure

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

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

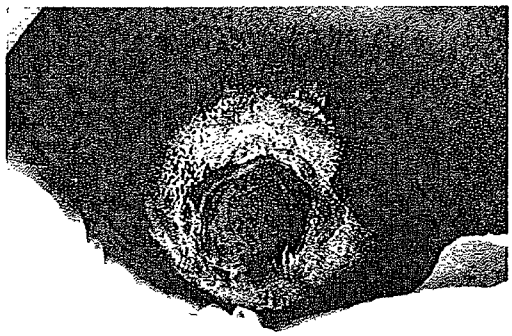
Wound Assessment

Identification Information

Peterson, William
Patient Number: 26523
Date of Birth: [redacted]
Wound Number: 3
Location: Hip (), Left, , , ,
Type of Wound: Pressure Ulcer
Date Wound Acquired:
Acquired At Facility: No

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	Tunneling:	N/A
Width (mm):	45	Undermining:	N/A
Depth (mm):	18	Sinus Tract:	N/A
Hypergranulated:	No		
Area (mm^2):	2297.222		
Volume (mm^3):	41349.994		

Wound Details

Wound Progess:	No Change
Exudate Amount:	Small
Exudate Type:	Sanguineous
Wound Margin:	Flat and Intact

Peripheral Skin Appearance

Texture

Wound Base

Wound Base Descriptions		Exposed Structure
Slough	1-25%	
Color:	Pink	

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

Submitted By: *mmelton at 5/31/2006 11:38:14 AM*

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

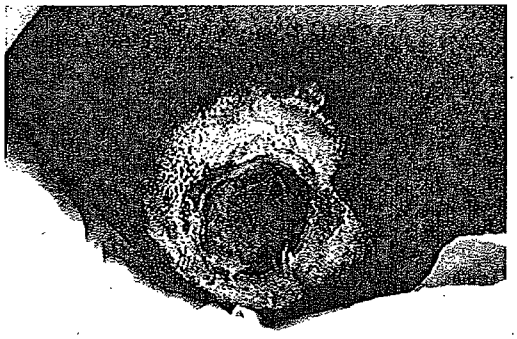
Wound Assessment

Identification Information

Peterson, William
Patient Number: 26523
Date of Birth: [redacted]
Wound Number: 3
Location: Hip (), Left, , , ,
Type of Wound: Pressure Ulcer
Date Wound Acquired:
Acquired At Facility: No

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	Tunneling:	N/A
Width (mm):	45	Undermining:	N/A
Depth (mm):	18	Sinus Tract:	N/A
Hypergranulated:	No		
Area (mm^2):	2297.222		
Volume (mm^3):	41349.994		

Wound Details

Wound Progess:	No Change
Exudate Amount:	Small
Exudate Type:	Sanguineous
Wound Margin:	Flat and Intact

Peripheral Skin Appearance

Texture

Wound Base

Wound Base Descriptions		Exposed Structure
Slough	1-25%	
Color:	Pink	

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

Submitted By: *mmelton at 5/31/2006 11:38:14 AM*

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

Wound Assessment

Identification Information

Peterson, William
Patient Number: 26523
Date of Birth: [redacted]
Wound Number: 4
Location: Back (lower), , , , ,
Type of Wound: Pressure Ulcer
Date Wound Acquired:
Acquired At Facility: No

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
Undermining: N/A
Sinus Tract: N/A

Wound Details

Wound Progess:	Deteriorating
Stage:	Necrotic Tissue (unstageable)
Wound Margin:	Flat and Intact

Peripheral Skin Appearance

Texture

Wound Base

Wound Base Descriptions

Eschar: 76-100%
Color:

Exposed Structure

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

Submitted By: *mmelton at 5/31/2006 11:41:53 AM*

AIKEN REGIONAL MEDICAL CENTER
302 UNIVERSITY PARKWAY
AIKEN, SOUTH CAROLINA 29802

PATIENT: PETERSON, WILLIAM SR **MR#:** 026523
ATTENDING: James H. Suhrer Jr., M.D. **ACCT#:** 102829710
ADMISSION DATE: 05/15/2006 **DISCHARGE DATE:** 06/01/2006
CC:

FINAL DIAGNOSES:
1. Sepsis with methicillin-resistant staphylococcus aureus.
2. Urinary tract infection with methicillin-resistant staphylococcus aureus and enterococcus.
3. Sacral decubitus ulcers, infected.
4. Right kidney complex cyst, assumed infected.
5. Acute renal failure--superimposed upon chronic renal failure.
6. Normocytic anemia.
7. Hypothermia--resolved.
8. History of high blood pressure.
9. Benign prostatic hypertrophy.
10. Cervical spinal stenosis, status post anterior diskectomy with fusion in March 2006.
11. Air-fluid levels in the maxillary and sphenoid sinuses, suggesting acute sinusitis.
12. Senile dementia.

PROCEDURES:
1. Esophagogastroduodenoscopy with a PEG placement 05/19/06.
2. Renal ultrasound 05/17/06 and one ordered for today.
3. CT of the brain without contrast 05/15/06.
4. Left hip films 05/16/06.
5. Acute abdominal series 05/16/06.
6. Portable chest x-ray 05/15/06.
7. Echocardiogram 05/16/06.

CONSULTING PHYSICIANS:
1. Dr. Gerald Gordon.
2. Dr. Jim Hagan
3. Dr. Frank Dibona

HISTORY OF PRESENT ILLNESS: This is an 85-year-old male who was admitted through the emergency department in consultation with emergency room physician and Dr. Bokkisam for evaluation and management of hypothermia, changes in mental status and mild hypertension.

The patient has been residing at TM Health and rehab of Edgefield, LP. He was on atenolol 12.5 mg p.o. q.12 h; Norvasc 5 mg p.o. q.24 h; Periactin 4 mg p.o. q.8 hours; Tylenol p.r.n. and Protonix 40 mg p.o. daily.

Please see admission history and physical for further details. Briefly, the patient's temperature was 91.2 rectally, pulse was 52, respiratory rate was 24 and BP was 119/86. His white count was 7.2 with a hemoglobin of 12.4 and platelet count 301,0000. Coags were essentially within normal limits. Sodium was 147, potassium 4.2, chloride 115, CO2 24, BUN 35 and creatinine 1.8. ABG revealed a pH of 7.34, pCO2 of 39, pO2 of 112.4 with a bicarb of 20 on 100% FIO2.

Please see hospital papers 98, again, please see admission history physical for further details.

AIKEN REGIONAL MEDICAL CENTER
302 UNIVERSITY PARKWAY
AIKEN, SOUTH CAROLINA 29802

PATIENT: PETERSON, WILLIAM SR
ATTENDING: James H. Suhrer Jr., M.D.
ADMISSION DATE: 05/15/2006
CC:

MR#: 026523
ACCT#: 102829710
DISCHARGE DATE: 06/01/2006

HOSPITAL COURSE: The patient was admitted to fifth floor telemetry and placed on Protonix, atenolol, Norvasc, Periactin and Tylenol. He is also started on vancomycin and Zosyn as well as DuoNeb aerosol treatments. Hydrocortisone 100 mg IV q.8 h was begun the next day.

PROBLEM LIST:
1. The patient's blood culture grew out MRSA and Dr. Gerald Gordon of infectious disease was consulted and his help in managing the patient has been greatly appreciated. The patient has been maintained on vancomycin and it is expected that he will need treatment for 6-12 weeks.
2. The patient has been again treated with vancomycin. He is also been on Zosyn. We are checking with Dr. Gordon to see how long he would like to continue the Zosyn. Please see #11.
3. The patients decubitus ulcers may be the source of the sepsis which then possibly cause the cyst to get infected, leading to the urinary tract infection, etc. Obviously the patient's decubitus ulcers will need to be followed. Here, Dr. Jim Hagan did debride the ulcers and wound care has been following.
4. Of note. This is the main reason for the long duration of the vancomycin treatment.
5. The patient's creatinine peaked at 2.4 during the hospital stay and is down to 1.4 now. Obviously this will need to be followed.
6. Of note.
7. Resolved.
8. Of note.
9. Of note, especially when the Foley eventually was discontinued.
10. Of note. This is the reason why the patient really cannot walk.
11. This might be a reason to continue the Zosyn for a total of 10 days or switch to Augmentin potentially for a total of 10 days from the 15th, which only be another couple days.
12. Per the records, the patient is demented. He did have a CT scan which revealed no evidence of strokes. He did have air-fluid levels seen in the maxillary and sphenoid sinuses suggestive of acute sinusitis.

DISPOSITION: The patient is felt safe for transfer to Select Specialty Hospital in Augusta via ambulance because of his bedridden status.

CONDITION: Fair.

MEDS:
1. Vancomycin 1.5 grams IV piggyback q.24 h for a total of 6-12 weeks starting 05/15/06.
2. DuoNeb aerosol treatments q.4 h p.r.n.
3. Prednisone 10 mg down PEG at 9:00 p.m. tonight x 1, then prednisone 40 mg down PEG q.a.m. starting 05/24/06 and decrease by 10 mg daily until off.
4. Zantac 150 mg down PEG b.i.d.
5. Zosyn 3.375 grams IV piggyback q.6 h.

DIET: Fiber source HN 60 cc per hour with 25 cc/hour tap water flushes. One pack arginine plus one pack glutasolve in 120 ml water down PEG b.i.d..
Note: The patient was on Impact 1.5 at half strength and was having some

AIKEN REGIONAL MEDICAL CENTER
302 UNIVERSITY PARKWAY
AIKEN, SOUTH CAROLINA 29802

PATIENT: PETERSON, WILLIAM SR
ATTENDING: James H. Suhrer Jr., M.D.
ADMISSION DATE: 05/15/2006
CC:

MR#: 026523
ACCT#: 102829710
DISCHARGE DATE: 06/01/2006

loose stools associated with that. The dietitian just recommended switching to the above.

Vital signs ~~awake~~ as per routine. Foley to bedside bag. Decubitus ulcer care (sacral). PT for range of motion, up in chair b.i.d.. The patient should return for fever, nausea, vomiting, shortness of breath or chest pain. Follow up with MDs at Select Care.

James H. Suhrer Jr., M.D.

615304/Medq
DD: 05/23/2006 10:57:45
DT: 05/23/2006 12:22:52

AIKEN REGIONAL MEDICAL CENTER
302 UNIVERSITY PARKWAY
AIKEN, SOUTH CAROLINA 29802

PATIENT: PETERSON, WILLIAM SR
ATTENDING: James H. Suhrer Jr., M.D.
ADMISSION DATE: 05/15/2006
CC: Select Specialty

MR#: 026523
ACCT#: 102829710
DISCHARGE DATE: 06/01/2006

ADDENDUM:

HOSPITAL COURSE: The patient was originally to be discharged on 05/23/2006, one week ago. At the time of discharge, the patient had gurgly respirations. Chest x-ray was potentially consistent with some pleural effusions. The patient underwent bronchoscopy where only thin secretions were seen. They did grow candida and a gram negative rod which our Infectious Disease Specialist felt was insignificant and not causing disease.

The patient was also discovered to be anemic down to a hemoglobin in the 7 range. He was given two units of packed RBC's which cleared his gurgly respirations. He also began to be a little bit more alert and actually at this time is responding to questions verbally which he was not throughout most of the hospital stay.

Because the stool he heme positive, I also had in this interval period of time, had the patient undergo upper and lower endoscopy by Dr. Jim Hagan. The patient was found to have a diverticular disease and benign polyp at 45 cm which was biopsied and photographed. Upper endoscopy revealed erosion at the G tube site with no active bleeding. The patient currently is stable. Yesterday, his white count was 6.0K with a hemoglobin of 11.2, and platelet count of 343K and electrolytes were within normal limits and his creatinine was 1.0.

The patient is felt to be stable for discharge to Select. He will be discharged to Select as follows:
The patient will be transferred to Select Specialty Hospital in Augusta via ambulance because of bedridden status.

MEDICATIONS:
1. Vancomycin one gram IV piggyback q. 24 h. with a CBC, chem 8, peak Vancomycin levels once or twice a week. He will finish out a six week course of Vancomycin which was started on 05/15/2006.
2. DuoNeb aerosols q.4h. p.r.n.
3. Prednisone 5 mg p.o. down tag daily times two.
4. Prilosec OTC down tag b.i.d.

DISCHARGE INSTRUCTIONS AND DIET: Fiber source HN 60 cc per hour with 25 cc per hour tap water flushes. One packet of Alginate plus one packet of Glucosyl in 120 ml H2O down PEG b.i.d. Vital signs and weight per routine. Follow bedside bag. Decubitus ulcer care. Physical therapy for range of motion and open care b.i.d. Return for fever, nausea, vomiting, shortness of breath or chest pain. O2 protocol. Regular insulin sliding scale, 151-200 two units, 201-250 four units, 251-300 six units, 301 plus call M.D.

James H. Suhrer Jr., M.D.

651016/MedQ
DD: 06/01/2006 11:41:19
DT: 06/01/2006 12:28:06

503K

AIKEN REGIONAL MEDICAL CENTER
302 UNIVERSITY PARKWAY
AIKEN, SOUTH CAROLINA 29802

PATIENT: PETERSON, WILLIAM SR
ATTENDING: James H. Suhrer Jr., M.D.
ADMISSION DATE: 05/15/2006
CC:

MR#: 026523
ACCT#: 102829710
DISCHARGE DATE: 05/23/2006

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2. Urinary tract infection with methicillin-resistant staphylococcus aureus and enterococcus.
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4. Right kidney complex cyst, assumed infected.
5. Acute renal failure--superimposed upon chronic renal failure.
6. Normocytic anemia.
7. Hypothermia--resolved.
8. History of high blood pressure.
9. Benign prostatic hypertrophy.
10. Cervical spinal stenosis, status post anterior diskectomy with fusion in March 2006.
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HISTORY OF PRESENT ILLNESS: This is an 85-year-old male who was admitted through the emergency department in consultation with emergency room physician and Dr. Bokkisam for evaluation and management of hypothermia, changes in mental status and mild hypertension.

The patient has been residing at TM Health and rehab of Edgefield, LP. He was on atenolol 12.5 mg p.o. q.12 h; Norvasc 5 mg p.o. q.24 h; Periactin 4 mg p.o. q.8 hours; Tylenol p.r.n. and Protonix 40 mg p.o. daily.

Please see admission history and physical for further details. Briefly, the patient's temperature was 91.2 rectally, pulse was 52, respiratory rate was 24 and BP was 119/86. His white count was 7.2 with a hemoglobin of 12.4 and platelet count 301,0000. Coags were essentially within normal limits. Sodium was 147, potassium 4.2, chloride 115, CO2 24, BUN 35 and creatinine 1.8. ABG revealed a pH of 7.34, pCO2 of 39, pO2 of 112.4 with a bicarb of 20 on 100% FIO2.

Please see hospital papers 98, again, please see admission history physical for further details.

AIKEN REGIONAL MEDICAL CENTER
302 UNIVERSITY PARKWAY
AIKEN, SOUTH CAROLINA 29802

PATIENT: PETERSON, WILLIAM SR
ATTENDING: James H. Suhrer Jr., M.D.
ADMISSION DATE: 05/15/2006
CC:

MR#: 026523
ACCT#: 102829710
DISCHARGE DATE: 05/23/2006

HOSPITAL COURSE: The patient was admitted to fifth floor telemetry and placed on Protonix, atenolol, Norvasc, Periactin and Tylenol. He is also started on vancomycin and Zosyn as well as DuoNeb aerosol treatments. Hydrocortisone 100 mg IV q.8 h was begun the next day.

PROBLEM LIST:
1. The patient's blood culture grew out MRSA and Dr. Gerald Gordon of infectious disease was consulted and his help in managing the patient has been greatly appreciated. The patient has been maintained on vancomycin and it is expected that he will need treatment for 6-12 weeks.
2. The patient has been again treated with vancomycin. He is also been on Zosyn. We are checking with Dr. Gordon to see how long he would like to continue the Zosyn. Please see #11. → No
3. The patients decubitus ulcers may be the source of the sepsis which then possibly cause the cyst to get infected, leading to the urinary tract infection, etc. Obviously the patient's decubitus ulcers will need to be followed. Here, Dr. Jim Hagan did debride the ulcers and wound care has been following.
4. Of note. This is the main reason for the long duration of the vancomycin treatment.
5. The patient's creatinine peaked at 2.4 during the hospital stay and is down to 1.4 now. Obviously this will need to be followed.
6. Of note.
7. Resolved.
8. Of note.
9. Of note, especially when the Foley eventually was discontinued.
10. Of note. This is the reason why the patient really cannot walk.
11. This might be a reason to continue the Zosyn for a total of 10 days or switch to Augmentin potentially for a total of 10 days from the 15th, which only be another couple days.
12. Per the records, the patient is demented. He did have a CT scan which revealed no evidence of strokes. He did have air-fluid levels seen in the maxillary and sphenoid sinuses suggestive of acute sinusitis.

DISPOSITION: The patient is felt safe for transfer to Select Specialty Hospital in Augusta via ambulance because of his bedridden status.

CONDITION: Fair.

MEDS:
1. Vancomycin 1.5 grams IV piggyback q.24 h for a total of 6-12 weeks starting 05/15/06.
2. DuoNeb aerosol treatments q.4 h p.r.n.
3. Prednisone 10 mg down PEG at 9:00 p.m. tonight x 1, then prednisone 40 mg down PEG q.a.m. starting 05/24/06 and decrease by 10 mg daily until off.
4. Zantac 150 mg down PEG b.i.d.
5. ~~Zosyn 3.375 grams IV piggyback q.6 h~~ (error)

DIET: Fiber source HN 60 cc per hour with 25 cc/hour tap water flushes. One pack arginine plus one pack glutasolve in 120 ml water down PEG b.i.d.. Note: The patient was on Impact 1.5 at half strength and was having some

AIKEN REGIONAL MEDICAL CENTER
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loose stools associated with that. The dietitian just recommended switching to the above.

Vital signs awake per routine. Foley to bedside bag. Decubitus ulcer care (sacral). PT for range of motion, up in chair b.i.d.. The patient should return for fever, nausea, vomiting, shortness of breath or chest pain. Follow up with MDs at Select Care.

James H. Suhrer Jr., M.D.

615304/MedQ
DD: 05/23/2006 10:57:45
DT: 05/23/2006 12:22:52

Aiken Regional ED ENCOUNTER Record

☐ Full Admission ☐ 23-B25 Observation

Chief Complaint: 84yo F c/o ?stroke, MVC, 3d ago, 3 AMS

HPI: Short history, dementia; normally talks (Per EMS, per family) family says pt seen at ARMC ED, BBI=90; feels different than usual per family

Current Meds: 0

☑ See ED nurses notes Alzheimer's, HTN, hx CVA, Dementia, PMD Mulley, Tammy

Past Medical History: ☐ HPI, Pmed Hx, Social Hx, Fam Hx, ☐ HTN ☐ IDDM ☐ NIDDM ☐ CAD ☐ Renal Disease ☐ Asthma ☐ COPD ☐ CHF
& ROS Unobtainable due to ☐ As Above ☐ Other: BPH, AFib, Ant ant. discectomy (7/14/06)

Past Surgical History: 2 ANS

Family History: ☐ HTN ☐ IDDM ☐ NIDDM ☐ CAD ☐ Asthma ☐ COPD ☐ CHF

Social History: Tobacco ☐ No ☐ Yes Amt ____ ETOH ☐ No ☐ Yes Amt ____ ☐ Other ____

Review Of Systems: (Other ROS Neg) (If not Checked then not applicable.)

	Check ☐ if normal	Check ○ if abnormal			
Eyes:	☐ Diplopia	☐ Blurred	☐ Vision chgs	GU:	☐ Dysuria ☐ Urgency ☐ Hematuria
ENT:	☐ Rhinitis	☐ Sore throat	☐ Nose bleeds	MS:	☐ Myalgia ☐ Back pain ☐ Neck pain
Card:	☐ CP	☐ Palpitation		Neuro:	☐ Seizures ☐ Dizziness ☐ Syncope
Respir:	☐ SOB	☐ Cough	☐ Hemoptysis		☐ Weakness ☐ Numbness
GI:	☐ Nausea	☐ Vomiting	☐ Diarrhea	Endo:	☐ Polyuria ☐ Hypoglyc ☐ Thyroid Dys
	☐ Abd pain	☐ Melena	☐ Hematochez	Hem/Lym:	☐ Anemia ☐ Bleeding

☐ For allergies see ED nurses notes

Other ROS ____

TETANUS STATUS:

ALLERGIES: NKDA

Physical Exam:

WEIGHT	TIME	PULSE	OX:	TEMP	P	R	BP
		100	91.2		22	19	156

☐ For vitals see ED nurses notes

Check ☐ if normal Check ○ if abnormal

						Abn Findings:
General:	○ Mental Status					Alert
Eyes:	○ Conjun NL	○ Lids	○ PERRL			
Head:	○ NL cephalic	○ Sinuses	○ Nose			
ENT:	○ Oropharynx	○ Right TM	○ Left TM			Not following commands
Neck:	○ Palpation	○ Thyroid	○ Trachea			
Chest:	○ Palpation	○ Excursion	○ Symmetry			eyes open, moving
Cardio:	○ Heart sounds	○ R & R				
Respir:	○ Respir effort	○ Lung sounds				weak cough reflex
Abdom:	○ Palpation	○ Bowel				normal BS
MS:	○ RUE	○ Sounds	○ Digits			
	○ LUE	○ RLE	○ Back			
	○ Pelvis	○ LLE				
Skin:	○ Temp	○ Galt	○ Color			
Neuro:	○ CNS	○ Appear	○ Sensation			
		Strength				

EKG – Dop HCG + Not

Med Decision Making: Cu=8.8

22.4 | 147 | 115 | 35 / 4.2 | 24 | 1.8 | 50

Trop 20.04 TS 20.9 S660 E34

S607 = 28 Ap 191 Amy = 86, Lip = 15

☐ Med records reviewed:
☐ Xrays reviewed by me:
☐ EKG reviewed by me:
☑ Labs reviewed by me:

CC TIME:

Diff Dx:

Consult/s:

NAME OF PHYSICIAN THAT ADMITTED PT:

NAME OF PHYSICIAN THAT PT IS ADMITTED TO: Bekkis, Sam

☑ Encounter only
☐ Dictated only
☐ Temp sheet only
☐ Dictated & Encounter
☐ Dictated & Temp sheet

DISCHARGE DIAGNOSIS: Acute Altered Level of Consciousness Delirium

CODES

☑ STABLE

☐ UNSTABLE SEE NOTE

Physician Signature: Walter Fullerton, M.D. Time MD IN: 1619

ED Encounter Record
630.70

TEST:	ORD	Initial	TIME INITIAL ✓TEST ORDERED:
CBC W DIFF:	✓		
CHEM 8:			
URINE PREG:			
CCUA:	✓		
CATH UA:			
URINE C&S:			
EKG:	✓		
OLD EKGS:			
TROPONIN:	✓		
PT/PTT:	✓		
FINGER ST GL:	✓		
BLOOD CULT X 2	✓		
TYPE & SCREEN:			
TYPE CROSS UNITS:			
LIVER PANEL:			
CMP:	✓		
AMYLASE:	✓		
LIPASE:	✓		
HEMOCULT:			
TYPE & RH:			
HCG QUANT:			
URINE DRUG S:			
ALCOHOL:			
ED ABG	✓		
PA/LAT CXR:			
PCXR:	✓		
C-SPINE:			
L-SPINE:			
ACUTE ABD:			
OLD RECORDS:			
OLD ED Record:	✓		

PHYSICIAN'S ORDERS:	TIME ORD:	TIME COMP Initials:
→ URINE PREG RESULTS:		
Rectal temp	1628 91.2	
Foley Flush Foley	1628 done	
NS TKO IV Bolus	1628 done	
Vdop	1628	
Rocephin	1628 now	
Unasyn 3g IV x1	1628	7dw 181C
Warming Blanket, 1L		done
CT Head	1825	
Foley to Bedside		
Keppra Vanc + Gm IV 1-Door	ord 2030	

Name: Peterson, William Race: W Sex: M Age: 85

Addressograph

102829710

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

10-24129

MEDICAL RECORDS

Aiken Regional Medical Centers

Quick Triage

Admission Date: 5/15/06
Med. record No.: 026523
Visit No.: 102829710
Attending Phys.: Scems D, MD

Patient: Peterson, William Sr
D.O.B.: [redacted] Age: 85
Gender: Male
Location: EMER
Room/Bed: EMER/14

Scheduled: 5/15/06 16:44 User: Paige Donahue RN
Performed: 5/15/06 16:44 Status: 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.

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DHEC PATIENT CARE FORM

Q.A. NO.

TRIP NO. 827

PATIENT IDENTIFICATION (Please Print)

LAST NAME (10–29): Peterson | FIRST NAME (30–45): William | MI (46): Sr

STREET (47–71): 3021 Edgefield Hwy | APT.#

CITY (72–87): Clinton | STATE (88–89): SC | ZIP CODE (90–94): 29325

(95–103):

SEX (104)

1 ☒ Male
2 ☐ Female
3 ☐ Undetermined

RACE (105)

1 ☒ White
2 ☐ Black
3 ☐ Am. Indian
4 ☐ Hispanic
5 ☐ Asian
6 ☐ Other

AGE (106–109)

081

CHECK ONE
1 ☒ YRS.
2 ☐ MOS.
3 ☐ DAYS

(110–111)

01 ☐ TREAT/NO TRANS.
02 ☐ DOA AT SCENE
03 ☒ HOSPITAL ER
04 ☐ HOSP. DIR. ADMIT.
06 ☐ PATIENT'S HOME
07 ☐ NURSING HOME
08 ☐ DR.'S OFFICE
09 ☐ OUTPATIENT
10 ☐ PT. REFUSED TREAT.
13 ☐ EMS TRANSFER

TYPE OF INCIDENT

TRAUMA (112)	MEDICAL (113)
1 ☒ MVA	1 ☒ ENVIRON
2 ☒ MC	2 ☒ BEHAV
3 ☒ BIKES	3 ☒ OB/GYN
4 ☒ PED	4 ☒ RESP
5 ☒ ASSAULT	5 ☒ CARDIAC
6 ☒ FALL	6 ☒ INTERFAC
7 ☒ FIRE	7 ☒ OTHER
8 ☒ INTERFAC	
9 ☒ OTHER	

CA

TO SCENE (114)
1 ☒ EMERGENT
2 ☐ NONEMERGENT
CODE 3

PATIENT STATUS

ON SCENE (115)
1 ☒ URGENT
2 ☐ NON URGENT
CODE

FROM SCENE (116)
1 ☒ URGENT
2 ☐ NON URGENT
CODE 3

INCIDENT LOCATION

ST. OR HWY. NAME OR NO.: Trinity Mission Bayshore
CITY: Edgefield

County (117–118): 19 | Zip Code (119–123): 29824

SAFETY EQP (124)

1 ☒ Seatbelts 4 ☒ Child Seat
2 ☒ Helmets 5 ☒ None
3 ☒ Airbags 6 ☒ Unkn.

SITE OF INCIDENT (125)

1 ☒ ROADWAY 4 ☒ RECREATIONAL
2 ☐ RESIDENCE 5 ☒ AGRICULTURAL
3 ☐ INDUSTRIAL 6 ☒ OTHER

PRELIMINARY IMPRESSIONS (MARK NO MORE THAN 4) (126–137)

003 ☒ Seizure
004 ☒ Diabetic
☐ Abrasion/Contusions
☐ Laceration
023 ☐ Fracture
024 ☒ Multitrauma/Shock
030 ☒ Head Injury
032 ☒ Spinal Injury
084 ☒ Stroke
051 ☒ G.I. Problems
074 ☒ Respiratory Distress
080 ☒ Coronary Problems
083 ☒ Cardiac Arrest
Other
Other

PRIMARY IMPRESSION (138–140)

046

TREATMENT PROCEDURES (141–174)

01 ☒ Dressing Applied
02 ☒ Limb Splinted
03 ☒ Spine Immobilized
04 ☒ Neck Immobilized
05 ☒ OB Assistance
06 ☒ Oral Airway Used
07 ☒ Oxygen Given
08 ☒ Suction Used
09 ☒ Antishock Trousers
10 ☒ Airway Maintained
11 ☒ Antishock Treatment
12 ☒ Artificial Resp.
13 ☒ Cardiac Massage
14 ☒ Bleeding Controlled
15 ☒ Cold Application
16 ☒ Patient Restrained
17 ☒ Other (Use Comments)
18 ☒ Ventilator

HCFA CODES (175–180)

SITE OF TRAUMA (181–189)

1 ☒ Head
2 ☒ Face
3 ☒ Neck
4 ☒ Chest
☐ Abdomen
☐ Pelvis
7 ☒ Upper Extr.
8 ☒ Lower Extr.
9 ☒ Back

ADVANCED PROCEDURES (190–223)

1 ☒ EKG Monitored — Rhythm: SR — Time:
2 ☐ First Defib Attempted — Wait Sec: 2 J — Time:
Post Defib — Rhythm:
3 ☐ Second Defib Attempted — Wait Sec: — Time:
Post Defib — Rhythm:
4 ☐ Third Defib Attempted — Wait Sec: — Time:
Post Defib — Rhythm:
INTUBATED 5 ☐ ET Size: — Total # Attempts: (224)
15 ☐ RSI 16 ☐ LMA 17 ☐ Cricho
6 ☐ EXTERNAL PACING
7 ☐ BLOOD DRAWN — DEXTROSE BGL: 91 mg/dl
8 ☐ IV STARTED/GAUGE — SOLUTION:
RATE: — IV TIME: — IV VOLUME:
9 ☐ IV STARTED/GAUGE — SOLUTION:
RATE: — IV TIME: — IV VOLUME:
14 ☒ IV ATTEMPTED Total #: 6 (229) — Time:
10 ☐ PLEURAL DECOMPRESSION
11 ☐ INTRAOSSEOUS INF.
12 ☐ AUTOMATIC DEFIB.
13 ☐ PATIENT ASSISTED MEDS: D50
Ordering Physician (Name) (Signature)

DRUGS USED (226–241)

DRUG	DOSE	TIME	DRUG	DOSE	TIME

REVISED TRAUMA SCORE

GCS: (242) EYES: — (243) VERBAL: — (244) MOTOR: — (245–246) GLASGOW:
(247–249) SBP: — (250–252) RR: — RTS (254–255):
(253) ANATOMICAL INJ. 1 ☒ YES 2 ☐ NO

VITAL SIGNS

BP	PULSE	RESPIRATIONS	PUPIL	LEVEL OF CONSC.	TIME
Rad	RATE ☒ REG. ☐ IRREG.	RATE ☐ REG. ☒ IRREG.	E U A V P U N C D	U	
104/54	81 ☐ REG. ☒ IRREG.	21 ☐ REG. ☒ IRREG.		U	
Rad	58 ☐ REG. ☒ IRREG.	21 ☐ REG. ☒ IRREG.		U	
104/54	81 ☐ REG. ☒ IRREG.	24 ☐ REG. ☒ IRREG.		U	
+	56 ☐ REG. ☒ IRREG.	24 ☐ REG. ☒ IRREG.		U	

EXPOSURE TO PT's BODY FLUIDS? (256) 1. ☒ YES 2. ☐ NO

1st Responder (257) 1. ☒ YES Name: 2. ☐ NO

COMMENTS (INCLUDE CHIEF COMPLAINTS, OBSERVATIONS AT SCENE, RESPONSE TO STIMULI)

Abs fall pt responsive to pain and movement. Per Fm pt has been this way x 3 days. Pt noted mall. CAO and talking. Pt non ambulatory. Fm wanted pt transp. to ARMC for evaluation. Ptc DNR, however fm rescinded the order. Pt on O2 NC at 2 lpm daily. Non Rebat 15 LPM placed on Pt. Unable to get O2 Sat d/t pt movement of hands and arms. IV attempted x6. Poor Access and Pt moving Arms. Pt moaned during transp, but only responsive as mentioned above. Pt placed on LP Showing SB-A-Fib, RA hx Acute Renal Failure, Cervical Spine Stenosis HTN Hyperkalemic. NDA MEDS zantac Flomax myrantin Maalox Tylenol Knopechate. D stick performed showing 91 mg/dl Difficulty obtaining Vital. Little to No Radial Pulses. Pt transp to ARMC c Report

Patient Care Form Left In (258): 1. ☒ ED 2. ☐ ICU 3. ☐ OTHER

See Page 2

TIME RECORD

RUN DATE (259–266): MONTH 08 DAY 13 YEAR 06

Call Received: (267–270)	
Dispatched: (271–274)	
Responded Base: (275–278)	
Arrive Scene: (279–282)	
Departed Scene: (283–286)	
Arrive Destination: (287–290)	

CAUSE OF DELAY:

DHEC PERMIT NO. (291–295)

02503

RECEIVING AGENCY (296–299)

4001

SENDING AGENCY (300–303)

PROVIDER TIME (OPTIONAL):

ATTENDANT'S SIGNATURE & CERTIFICATION NO.

Paul McAnew 8291 8

PRIMARY PATIENT ATTENDANT (304–308)

2ND ATTENDANT/DRIVER (309–313)

3RD ATTENDANT/DRIVER (314–318)

(RECEIVING NURSE OR PHYSICIAN)

DHEC 1050 REV. (01/2004) — RECEIVER'S COPY — REPORT NO. (1-9) 000187

AIKEN REGIONAL MEDICAL CENTERS

302 University Parkway • Aiken, South Carolina 29802

TREATMENT AREA Room # 14 Time 1644 Report to [illegible] VIA EMS

ED NURSING ASSESSMENT RECORD

NEUROMUSCULAR

☐ Normal Adult Pattern ☐ Normal Pediatric Pattern

MENTATION ☐ Disoriented ☐ Agitated ☐ Resp to verbal stim ☐ Combative ☐ Unresponsive ☒ Resp to painful stim

PUPILS ☐ Equal ☐ Unequal

Size R____mm L____mm

R ☐ Fixed ☐ Dilated ☐ Non-reactive ☐ Pinpoint ☐ Sluggish

L ☐ Fixed ☐ Dilated ☐ Non-reactive ☐ Pinpoint ☐ Sluggish

Visual Acuity R:_____ L:_____ Both:_____

SENSATIONS

		DECREASED	ABSENT
ARM	R		
ARM	L		
LEG	R		
LEG	L		

ROM

		DECREASED	ABSENT
ARM	R		
ARM	L		
LEG	R		
LEG	L		

CARDIOVASCULAR

☐ Normal Adult Pattern ☐ Normal Pediatric Pattern

HEART ☐ Chest pain Describe:_____

EXTREMITIES ☐ Edema ☐ Obvious deformity _____ Describe:_____

CAP REFILL ☐ < 2 Sec ☐ > 2 Sec

PULSES

		DECREASED	ABSENT
RADIAL	R		
RADIAL	L		
FEMORAL	R		
FEMORAL	L		
PEDAL	R		
PEDAL	L		

BP 46-60

RESPIRATORY

Review above information, assess patient, document changes.

☐ Normal Adult Pattern ☐ Normal Pediatric Pattern

☐ Dyspnea ☐ Stridor ☐ Retraction ☐ Nasal Flaring

COUGH ☐ Productive Describe:_____ ☐ Non-Productive

LUNG SOUNDS

	RIGHT	LEFT
Wheezes		
Rales		
Crackles/Course		
Diminished		

100% NRB

CHEST EXPANSION

SYMMETRICAL	
ASYMETRICAL	
TENDERNESS	

Describe:_____

GI / NUTRITIONAL STATUS ☐ N/A

☐ Normal Adult Pattern ☐ Normal Pediatric Pattern

ABDOMEN ☐ Firm ☐ Distended: ☐ Tenderness Describe:_____

APPETITE ☐ Fair ☐ Poor ☐ Special Diet at home:_____

STOOL ☐ Diarrhea ☒ Incontinence ☐ Incontinence ☐ Last BM:____ ☐ Nausea ☐ Vomiting

GU / REPRODUCTIVE ☐ N/A

☐ Normal Adult Pattern ☐ Normal Pediatric Pattern

FEMALE ☐ Vaginal Discharge Color:_____ ☐ Vaginal Bleeding Describe:_____ ☐ Breast Problem ☐ R ☐ L Describe:_____

MALE ☐ Prostate Problem Describe:_____ ☐ Genitalia tenderness / swelling / discharge Describe:_____

VOIDING ☐ Frequency ☐ Urgency ☐ Hematuria ☐ Incontinence ☐ Last Void: ☐ Catheter

INTEGUMENT

☐ Normal Adult Pattern ☐ Normal Pediatric ☐ Laceration ☐ Abrasion ☐ Amputation ☐ Avulsion ☐ Bruising ☐ Burn ☐ Bleeding ☐ Diaphoresis ☐ Abnormal Skin Color ☐ Lesions ☐ Rash

Describe: bed Sores buttocks, penis

EENT

Eyes: ☐ Contact Lenses ☐ Glasses ☐ Foreign Body ☐ Cataracts ☐ Mucous Membranes Moist/Dry ☐ Injury:_____

Ear/Nose/Throat/Mouth:_____

Visual Acuity: L_____ R_____

☐ Dentures ☐ Glasses ☐ Contacts ☐ Disposition_____

RN/LPN Signatures: [signature]

PAIN ASSESSMENT

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

ADDRESSOGRAPH

102829710

PETERSON SR, WILLIAM SR

DOB: [redacted] 85 SX: M EMR

MRN: 26523 ADM/REG DT: 05/15/06

AIKEN REGIONAL MEDICAL CENTER

ED NURSING ASSESSMENT RECORD

630.64 (Rev. 3/03) 10-20214

INFUSION DATA ** Hourly IV Site Checks Done (Initial) _____

Time	Infusion Site	Infiltration Scale	Solution (amount / type)	Rate	D/C'd-- Cath Intact	Cath Size/Type	# Attempts	Initials
2	RFA		SL			20		2

INTAKE AND OUTPUT

INTAKE	TOTAL	INITIALS	OUTPUT	OUTPUT CHARACTER	TOTAL	INITIALS
Blood Products			Foley/voided			
IVF's			NG/Emesis			
NG			Chest Tubes			
PO			Other			
Other						
Total Intake	cc		Total Output		cc	

Blood Drawn at _____ x _____ attempts _____ tubes to lab Lab notified to obtain at _____

To x-ray at _____ via _____ Returned at _____

TIME	PROCEDURE	COMMENTS	BY WHOM	RESULTS	INITIALS
	Ace wrap application			Pt. able to give return demonstration of reapplication and understanding of vascular checks	
	Arthrocentesis				
	Warming Measures	☐ Fluid ☐ Blanket			
	Cardiac Monitor			Rhythm	
	Cardioversion				
	Cast / Splint	Type: Supplies:		Cap refill post procedure: _____ sec Skin Color / Temp: _____ Splint Location: _____	
	Chest Tube Placement			Size: R L	
	Dressing applied	Type: Supplies:			
	Ear Irrigation				
	External Pacemaker				
	Eye Irrigation	☐ Morgan lenses Meds:		Eye(s): R L Both Fluid type: _____ Amount: _____ cc	
	Eye patch			Location: R L Instructed not to drive with eyepatch in place. Pt. verbalized understanding.	
1644	Foley Cath	☒ Regular ☐ I/O ☐ Temp Sensing ☐ Coude	PD	Color / amount: Order Size: 16Fr three way/latex 20	
	Gait training with crutches			Able to provide return demonstration for safe & proper use of crutches	
	Gastric Lavage	Fluid/Amount		Amount/Character:	
	Gastroccult/Hemoccult			☐ Positive ☐ Negative	
	Incision and Drainage				
	Intubation			Size: _____ Tube placement certified by ausculation ☐ = bilateral breath sound ☐ = absence of epigastric sounds	
	IV Central Line Placement				
	Knee Immobilizer	R L		Pt. able to give return demonstration of reapplication and understanding of vascular checks	
	Lumbar Puncture			Specimen tube x _____ to lab	

PROCEDURES / INTERVENTIONS

TIME	PROCEDURE	COMMENTS	BY WHOM	RESULTS	INITIALS
	☐ NG ☐ OG	Side/Location placement verified by auscultation		Amount	
1644	Pulse oximeter	NRB		O_2 Saturation 100%	RD
	Paracentesis/Thoracentesis			Character/Amount	
	PEG replacement			Size:	
	Pelvic Exam			Cultures obtained: ☐ Yes ☐ No	
	Ring Removal	Given to:		Skin color/temp. cap. refill ____ sec	
1644	Side rails up x 2 for patient safety & call bell given		RD	Verbalized understanding	RD
	Sling			Skin color/temp. cap. refill ____ sec	
	Suture placement	Supplies		Wound edges approximated	
	Tracheostomy/Cricothyrotomy				
2115	Other	Urine dipped, sent to lab - C&S.			
	Other				
	Wound Care			Verbalized understanding	

BELONGINGS CHECKLIST FOR ADMISSIONS OR TRANSFERS

Clothing: ☐ Shirt ☐ Sweater ☐ Coat ☐ Vest ☐ Pants ☐ Underwear ☐ Tie/Scarf ☐ Socks/Hose ☐ Hat/Cap ☐ Gloves ☐ Cutoff PTA/ETC (ED)

Accessories: ☐ Shoes ☐ Purse ☐ Wallet ☐ Keys ☐ Other _____

Jewelry: ☐ Yellow Metal (describe): _____ ☐ Yellow Metal (describe): _____

Miscellaneous: ☐ Home Meds ☐ W/Patient ☐ W/Family ☐ to Pharmacy
☐ Dentures ☐ Upper ☐ Lower ☐ Partial ☐ Glasses ☐ Contact Lenses R / L ☐ Hearing Aid R / L ☐ Walker/Cane

Valuables: ☐ W/Patient ☐ W/Family ☐ Security ☐ Other _____

ADMISSION INFORMATION

Admitting Physician _____

Room # _____ Time of Admission _____

VIA ☐ Nurse ☐ Escort ☐ Nsg. Agent

Report:
Time: _____
Called to: _____
Portable Monitor: ☐ Yes ☐ No Rhythm: _____
Portable Oxygen: ☐ Yes ☐ No _____ L/M Via _____
Transfer Restraints: ☐ Yes ☐ No

DISPOSITION

DISPOSITION	TYPE	INSTRUCTIONS
	☐ Morgue	☐ See Discharge Instruction Sheet
	☐ LWBS	☐ Verbal/Written Instruction Given To/By:
	☐ AMA	_____
VIA:	☐ Elopement	☐ Expresses Understanding
☐ Ambulatory	☐ Discharge	☐ Discharged by Physician
☐ Wheelchair	☐ Transfer - See Transfer Record	☐ Instructed not to drive
☐ Stretcher		
☐ Carried		

VS: BP _____ P _____ R _____ T _____ RTS _____ GCS _____

Signature: _____ Time _____

SIGNATURE / TITLE	INITIALS
P Stephens	PS
[illegible]	[illegible]

Medications/Procedure ordered by _____ M.D.

ASSESSMENTS

Review above information; assess patient; document changes.

☐ Unchanged From Initial Assessment _____ Time _____ Int.
☐ Unchanged From Initial Assessment _____ Time _____ Int.
☐ Unchanged From Initial Assessment _____ Time _____ Int.
Assessment changes (time & initials)

1644) Pt to room 14 via EMS. Pt unresponsive x painful stimuli. Pt cathed, changed very odorous / [illegible] and orange noted. dsg to (L) hip dated 5/15 Pt came to incont. diaper on — RD
1730) Pt N to RFA #20 by PB, RN Rectal temp received 91.9. Pt family @ BS NS (apnea) — PO
1830 98.9 100 86 BP (didn't read) Pt more awake, Pt responsive to Com Held. Pt more alert more awake Urine output to update DA. Pt wants to C/. ~~RD~~ PS 1855) Report to Amanda, RN — PO
1905 Report received Pt S S/S/ of immediate distress BP @ this time 116/80 Resp 28 HR 61

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

NURSING NOTES

Pt c eyes open Sats 98 % on NRB 2045 Pt to CT via Stretcher staff remained @ scanner to assist tech c transfering pt. @ 2100 Pt returned to room via stretcher. Pt still had Ø UOP in cath. cath position checked by deflating balloon + small amt UOP appeared in tube. 3cc cloudy urine collected @ 2115 urine dipped + sent to lab results to chart BP 107/70 HR 66 Resp 43 99% Temp 94.1 Warming measures Bair blanket still in place when checking rectal temp pt had liq brown stool sitting in rectum. Rn assisted pt c disimpaction of liq amount of soft brown stool c digital assistance @ 2230 Dr Bokka present for orders @ 2245 Supervison Notified of need for cath @ 0030 bone marrow aspiration IV initiated + NS @ 200 cc/hr IV site is patent + benign @ 0115 IVF infusing Pt BP 79/44 HR 79 Sats 99% on NRB. Dr Bokka paged for notification of TSH + CPK & response @

AIKEN REGIONAL MEDICAL CENTER
302 UNIVERSITY PARKWAY
AIKEN, SOUTH CAROLINA 29802

PATIENT: PETERSON, WILLIAM SR MR#: 026523
ATTENDING: Chakaravarthy Bokkisam, M.D. ACCT#: 102829710
ADMISSION DATE: 05/15/2006
CC:

CHIEF COMPLAINT:
1. Change in mental status for the past five days.
2. Hypothermia.
3. Mild hypertension.

HISTORY OF PRESENT ILLNESS: This is a very unfortunate 85-year-old black male who currently resides in some kind of nursing home rehab setting by name _____ Elton Rehab of Edgefield after he had anterior cervical fusion for cervical spinal stenosis and spinal cord compression by Dr. Santiago two months ago at Aiken Regional Hospital. The patient also was admitted to Dr. Dibona's service for acute renal failure and hyperkalemia and rhabdomyolysis. However, this admission he was brought down for a change in mental status for the past five to six days. In the ER the patient was found to have a rectal temperature of 91 and blood pressure was noted to be 119/86 and the urine was positive for leukocytes. The patient was given Unasyn 3 grams IV by the ER physician Dr. Jackson. Warm blankets were applied and he was given to in house medical service for further management and evaluation. The patient is currently lying in the bed on 100% nonrebreather mask. She only moves with painful stimuli. The patient is somewhat in the fetal position.

I was not able to obtain a history and there were no relatives at the bedside. I waited for at least 40 minutes to talk to them. However, finally I talked to the patient's daughter Mary Ruth Peterson with a phone number of 649-4859 and current information is that the patient has had a change in mental status for the past five days in the nursing home and they did not notify the family. However, today they sent the patient down to Aiken Regional.

PAST MEDICAL HISTORY:
1. The patient has a history of acute renal failure.
2. History of hyperkalemia.
3. History of rhabdomyolysis.
4. History of benign prostatic hypertrophy with a urinary obstruction problems.
5. Cervical spinal stenosis status post anterior discectomy with fusion in March 2006.
6. Hypertension.

PAST SURGICAL HISTORY: Cervical fusion for spinal stenosis with anterior discectomy with fusion by Dr. Santiago

ALLERGIES: No known drug allergies.

MEDICATIONS:
1. Atenolol 12.5 mg p.o. q.12 hours.
2. Norvasc 5 mg p.o. q.24 hours.
3. Periactin 4 mg p.o. q.8 hours.
4. Tylenol 650 mg p.o. q.4 hours as needed for a temperature more than 101.
5. _____, dose is unknown.

SOCIAL HISTORY: Not available.

503

AIKEN REGIONAL MEDICAL CENTER
302 UNIVERSITY PARKWAY
AIKEN, SOUTH CAROLINA 29802

PATIENT: PETERSON, WILLIAM SR MR#: 026523
ATTENDING: Chakaravarthy Bokkisam, M.D. ACCT#: 102829710
ADMISSION DATE: 05/15/2006
CC:

FAMILY HISTORY: Not available.

PHYSICAL EXAM ON PRESENTATION: VITAL SIGNS: Blood pressure is noted to be 119/86, respiratory rate 24, pulse of 52. Temperature rectal is 91.2, pulse ox is 100% on a nonrebreather.
HEENT: Head atraumatic. Eyes: Pupils are equal, round and reactive to light and conjunctival erythema was noted. I was not able to elicit extraocular movements because of the patient's lack of cooperativeness. No jaundice. Oral cavity: Currently on a 100% nonrebreather mask. Mucosa looks dry.
NECK: Supple. No JVD. No lymphadenopathy. No thyromegaly. However, the neck is emaciated and weak.
CARDIOVASCULAR: No murmur. Audible rhonchi were noted. S1, S2 heard, distant.
RESPIRATORY: Diffuse rhonchi and crackling was heard. I could not hear any wheezing.
ABDOMEN: Soft, nontender, nondistended. Bowel sounds are somewhat sluggish.
EXTREMITIES: He has a left hip and decubitus which is 3 cm in diameter with a white scab. It looks like a stage III in nature. No edema, no cyanosis and no clubbing.
NEUROLOGIC: The patient is currently lying in the fetal position and was responding to painful stimuli. Opens eyes and closes. However, the exam is very limited at this point.

LAB DATA ON PRESENTATION: Urine leukocytes large, nitrate positive. Blood is large in nature. Chest x-ray was under penetrated, however, there is a possible infiltrate seen in the left middle lobe and lower lobe. PTT is 55.8. CBC showed a WBC of 7.2. Hemoglobin is 12.4, hematocrit is 37. Platelets of 301. Segments are 90, lymphocytes 8, monocytes 2. Pro-time is 16.2, INR is 1.3. Chem 7: Sodium is 147, potassium 4.2, chloride 115, bicarb 24. BUN is 35, creatinine 1.8, blood glucose 90. Calcium is 8.8. Total bili is 0.9, SGOT is 34, amylase is 286, lipase 15. EKG showed a heart rate of 53 beats per minute with a prolonged Q-T interval. Some incomplete left bundle branch block was also noted. ABG showed a pH of 7.335, pCO2 of 39.2, pO2 of 112.4, bicarb 20. This was done on 100% FiO2. Chem 7: Sodium 147, potassium 4.2, chloride 115, bicarb 24, glucose 90, BUN 35, creatinine 1.8, calcium 8.8, total protein 6.5. albumin 2.1. Cardiac troponin 0.04.

IMPRESSION:
1. Change in mental status with hypothermia with positive urinalysis suggesting probably that the patient might have a urosepsis at this point, however, it needs to be ruled out other infections. That includes a wound on his left hip.
2. Acute renal failure, possibly secondary to sepsis or underlying prostatic problems.
3. Hypothermia with mild hypertension, possibly related to sepsis, however, he needs to be ruled out for hypothyroidism and also rhabdomyolysis.
4. History of hypertension, currently hypotensive.
5. History of cervical spinal stenosis with discectomy, currently stable, however, neuro exam was not elicitable.

AIKEN REGIONAL MEDICAL CENTER
302 UNIVERSITY PARKWAY
AIKEN, SOUTH CAROLINA 29802

PATIENT: PETERSON, WILLIAM SR MR#: 026523
ATTENDING: Chakaravarthy Bokkisam, M.D. ACCT#: 102829710
ADMISSION DATE: 05/15/2006
CC:

My plan is to admit this patient to telemetry and give him IV hydration of normal saline 200 cc an hour, cover with a broad spectrum antibiotics which includes Zosyn and also vancomycin to cover MRSA from wound infection and also urosepsis by Zosyn. Also, cover him with warm blankets to maintain his temperature and we will obtain stat TSH and CPK levels to rule out any rhabdomyolysis and also hypothyroidism or other causes for hypothermia. For acute renal failure, we will continue IV hydration to see his response with the fluid challenge. For his hypertension, we will do an IV hydration and try to raise his blood pressure. If he is not responsive, we will start dopamine and pressors. We will hold his atenolol and Norvasc and other medications at this point. We will repeat other labs in the morning.

I discussed with Mary Ruth Peterson, who is the daughter of the patient with the phone number 649-4859 and the code status was reinstated to DNR and DNI in case of cardiorespiratory arrest. However, she agreed with IV hydration and antibiotics at this point. No CPR, no ventilator, no electric shock in the event of cardiorespiratory arrest. I also spoke to the patient's granddaughter and grandson and explained the situation. I will closely follow up tonight with his blood pressure, sepsis and other medical problems.

Chakaravarthy Bokkisam, M.D.

585790/MedQ
DD: 05/15/2006 23:10:56
DT: 05/16/2006 01:29:30

AIKEN REGIONAL MEDICAL CENTER
302 UNIVERSITY PARKWAY
AIKEN, SOUTH CAROLINA 29802

PATIENT: PETERSON, WILLIAM SR
REFERRING: James H. Suhrer, M.D.
CONSULT DATE: 05/25/2006
CC:

MR#: 026523
ACCT#: 102829710

IMPRESSION: Retained secretions.

PATIENT PROFILE: I have been asked to consult on this 85-year-old black man who has been hospitalized since 05/15/2006. He is nearing discharge, but because of gurgling and retained secretions, I was asked to see him with consideration of bronchoscopy to clear out his airways and try to improve his respiratory status.

PAST MEDICAL HISTORY: Significant for being hospitalized for sacral decubiti associated with sepsis and hypothermia, rhabdomyolysis, hyperkalemia, and acute renal failure. He has a history of cervical spinal stenosis treated with anterior discectomy and fusion in March of this year. He has benign prostatic hyperplasia. Hypertension.

MEDICATION ALLERGIES: None.

SOCIAL HISTORY: Nonsmoker.

FAMILY HISTORY: Not known.

He had been living in a nursing home prior to this admission.

CURRENT MEDICATIONS: Listed as DuoNebs, supplemental oxygen, hydrocortisone, Protonix, vancomycin, and he had recently been on Zosyn as well.

He has a PEG tube and is receiving tube feedings for nutrition support.

PHYSICAL EXAMINATION: GENERAL: A bed-bound elderly man who was wearing a 35% oxygen Venturi mask. He was audibly gurgling. He was arousable but very slow to respond. When I explained that we were anticipating doing bronchoscopy, he seemed to understand.
HEENT: Arcus senilis. Oxygen mask in place. Dry mucous membranes.
NECK: Veins are flat.
HEART: Distant tones.
LUNGS: Coarse rhonchi in all fields.
ABDOMEN: Soft.

LABORATORY DATA: CBC shows a normocytic anemia.

PLAN: Proceed with bronchoscopy to clear out secretions and obtain a bronchoalveolar lavage specimen. The patient's daughter has given consent.

I appreciate the opportunity to see Mr. Peterson.

Nicholas J. Sanito, D.O.

626593/MedQ
DD: 05/25/2006 13:43:59
DT: 05/25/2006 17:24:42

Aiken Regional Medical Centers

302 University Parkway • Aiken, South Carolina 29801

CONSULTATION REQUEST

REQUEST DATE 5-16-06

TIME 1140 SW

TO: (CONSULT AND/OR SERVICE)
DR GORDON

- ☐ REQUEST CONSULTATION FOR PROCEDURE ONLY
- ☐ REQUEST OPINION ONLY REGARDING DIAGNOSIS AND TREATMENT
- ☐ REQUEST CONSULTATION AND JOINTLY MANAGE CARE WITH ATTENDTING PHYSICIAN
- ☐ REQUEST ASSUMPTION OF CARE

- ☐ STAT SPOKE TO VICKI
- ☐ TODAY
- ☐ ROUTINE

REASON FOR REQUEST _____

_____ M.D.

SIGNATURE OF ATTENDING PHYSICIAN

CONSULTATION REPORT CONSULTATION DATE _____

FINDINGS: (+) Blood ~~cast~~ Rash

DIAGNOSIS: See desk

RECOMMENDATIONS: _____

SIGNATURE OF CONSULTANT

DICTATED: YES ☐ NO ☐

CONSULTATION REQUEST

ADDRESSOGR

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

601.19 (Rev. 07/02) 10-2076

AIKEN REGIONAL MEDICAL CENTER
302 UNIVERSITY PARKWAY
AIKEN, SOUTH CAROLINA 29802

PATIENT: PETERSON, WILLIAM SR MR#: 026523
REFERRING: Chakaravarthy Bokkisam, M.D. ACCT#: 102829710
CONSULT DATE: 05/16/2006
CC:

The patient is an 85-year-old demented man who has bed sores on his buttocks. He is presenting here with hypothermia and sepsis. This is in the setting of antecedent hyperkalemia, rhabdomyolysis, acute renal failure, spinal stenosis with anterior diskectomy in March of 2006. He has had a history of hypertension. He has had surgical history of note for cervical fusion with anterior diskectomy about two months. He had urine which showed white cells and was given Unasyn for some reason in the emergency room. The patient has been on atenolol, Norvasc, Periactin and Tylenol.

FAMILY HISTORY: Family history is not available.

REVIEW OF SYSTEMS: The review of systems is not possible.

SOCIAL HISTORY: He lives in the nursing home and has not a great deal of information associated with his transfer here.

PHYSICAL EXAMINATION: GENERAL: The physical examination shows a gentleman who has several decubiti, very large and necrotic and probably the source of sepsis.
HEAD, EYES, EARS, NOSE AND THROAT: Examination showed basically no significant findings.
VITAL SIGNS: The blood pressure is 75/41, pulse is 79 and temperature is 99.6.
NECK: The thyroid is okay. Carotids show no bruits.
LUNGS: Surprisingly clear to percussion and auscultation.
CARDIAC: Examination is quiet. There are no murmurs, rubs or gallops.
ABDOMINAL: Examination shows tenderness left abdomen. The remainder of the abdomen is benign. The liver and spleen are of normal size. There is guarding of the left abdomen, it is not clear of the tenderness. This gentleman has had an old stroke and is demented and presumably there is some spasm, it is not clear exactly what is going on there. In any case, his abdomen is not distended.
EXTREMITIES: Examination shows no clubbing or cyanosis. There is trace edema. Reflexes are absent. Toes are mid positional and the skin is slightly edematous.
NEUROLOGICAL: The patient has no reflexes.

The decubiti are necrotic with gangrenous changes as well as purulent material with _____.

IMPRESSION: Sepsis, probably related to his skin and the infected decubitus ulcerations. It is possible his urinary infection is part of this clostridium difficile enterocolitis. But in any case, we will proceed on with x-rays of his hip, do support him to the best way we can. He is DNR / DNI. Hopefully we can support him as is reasonable for his own situation. Antimicrobials have been altered. I have asked Dr. Hagan to see him and with the thought of possibly debriding the infected area of the hip. I will wait for cultures to return and hopefully we can adequately alter his antimicrobials which

AIKEN REGIONAL MEDICAL CENTER
302 UNIVERSITY PARKWAY
AIKEN, SOUTH CAROLINA 29802

PATIENT: PETERSON, WILLIAM SR MR#: 026523
REFERRING: Chakaravarthy Bokkisam, M.D. ACCT#: 102829710
CONSULT DATE: 05/16/2006
CC:

currently are vancomycin, Zosyn and I have actually added Flagyl at this point.

Gerald Gordon, M.D.

587805/MedQ
DD: 05/16/2006 12:58:40
DT: 05/16/2006 13:25:42

Aiken Regional Medical Centers

302 University Parkway • Aiken, South Carolina 29801

CONSULTATION REQUEST

REQUEST DATE 5-16-06

TIME 1145 SW

TO: (CONSULT AND/OR SERVICE)
DR DIBONA

- ☐ REQUEST CONSULTATION FOR PROCEDURE ONLY
- ☐ REQUEST OPINION ONLY REGARDING DIAGNOSIS AND TREATMENT
- ☐ REQUEST CONSULTATION AND JOINTLY MANAGE CARE WITH ATTENDTING PHYSICIAN
- ☐ REQUEST ASSUMPTION OF CARE

☐ STAT SPORIE E.
☐ TODAY PAT
☐ ROUTINE

REASON FOR REQUEST

M.D.

SIGNATURE OF ATTENDING PHYSICIAN

CONSULTATION REPORT

CONSULTATION DATE 5/17/06

#330047

FINDINGS:

DIAGNOSIS:

RECOMMENDATIONS:

SIGNATURE OF CONSULTANT

DICTATED: YES ☐ NO ☐

CONSULTATION REQUEST

601.19 (Rev. 07/02) 10-2076

ADDRESSOGRAPH

102829710
PETERSON SR, WILLIAM SR
DOB: [redacted] 85 SX: M IMD
MRN: 26523 ADM/REG DT: 05/15/0
AIKEN REGIONAL MEDICAL CENTER

AIKEN REGIONAL MEDICAL CENTER
302 UNIVERSITY PARKWAY
AIKEN, SOUTH CAROLINA 29802

PATIENT: PETERSON, WILLIAM SR MR#: 026523
REFERRING: Chakaravarthy Bokkisam, M.D. ACCT#: 102829710
CONSULT DATE: 05/17/2006
CC:

REASON FOR CONSULTATION: This consultation was requested by Dr. Bokkisam for evaluation of renal insufficiency.

HISTORY OF PRESENT ILLNESS: Mr. Peterson is an 84-year-old black gentleman who I know fairly well from his previous admission from 03/07/06 to 03/21/06. At that time, he had severe hyperkalemia, 10 on admission, and acute renal failure. This was finally found to be due to a cervical spine lesion with paralysis and neurogenic bladder. With IV fluids, drainage of the bladder, etc., his potassium problem and renal failure resolved completely. He underwent a spinal cord decompression in the neck but unfortunately did not seem to recover any significant neurologic function. He was sent to a nursing home after that. He has a DNR. He was sent here for hypothermia and sepsis. He also had a change in his mental status.

It is somewhat confusing as to his status. Family had said that they wanted comfort care but he is also been seen by infectious diseases, by surgery for debridement of wounds and is being aggressively treated for the infection. I was consulted because of a decreased renal function. The sodium was 147 but rose to 150. The BUN was 35 and has gone up to 41. The creatinine was 1.8 on admission and is now 2.4. He has a Foley catheter and he is receiving IV fluids.

No family is present at this time. He is semi conscious and does not respond. He does not appear to be in any distress but his respiratory effort is increased. His heart is regular without murmur. His lungs sound clear. Abdomen is scaphoid and no masses were present.

ASSESSMENT:
1. Status post acute renal failure secondary to a neurogenic bladder from a spinal cord lesion with return of almost normal renal function.
2. Hypernatremia.
3. Azotemia.

DISCUSSION: The hyponatremia and azotemia are probably secondary to prerenal causes, namely fluid deficit and infection. Given his profound dementia and paralysis, I do not feel we should be very aggressive in treating anything. This sounds like what the family wanted.

Francis Dibona, M.D.

330047/MedQ
DD: 05/17/2006 09:30:27
DT: 05/17/2006 10:33:06

Aiken Regional Medical Centers

302 University Parkway • Aiken, South Carolina 29801

CONSULTATION REQUEST

REQUEST DATE 5/18/06

TIME 1900 BK

TO: (CONSULT AND/OR SERVICE) Dr. Hagan

- ☐ REQUEST CONSULTATION FOR PROCEDURE ONLY
- ☐ REQUEST OPINION ONLY REGARDING DIAGNOSIS AND TREATMENT
- ☐ REQUEST CONSULTATION AND JOINTLY MANAGE CARE WITH ATTENDTING PHYSICIAN
- ☐ REQUEST ASSUMPTION OF CARE

- ☐ STAT
- ☐ TODAY Spoke to June
- ☒ ROUTINE

REASON FOR REQUEST peg tube placement

SIGNATURE OF ATTENDING PHYSICIAN _____ M.D.

CONSULTATION REPORT

CONSULTATION DATE 5/1

FINDINGS: PD, p CVA, poor nutrition decub ulcers

DIAGNOSIS: poor nutrition, decub. ulcers

RECOMMENDATIONS: will PEG if family agrees today

SIGNATURE OF CONSULTANT

DICTATED: YES ☐ NO ☐

CONSULTATION REQUEST

601.19 (Rev. 07/02) 10-2076

ADDRESSOGRAPH

102829710

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

Aiken Regional Medical Centers

302 University Parkway • Aiken, South Carolina 29801

CONSULTATION REQUEST

REQUEST DATE 5/30/06

TIME

TO: (CONSULT AND/OR SERVICE)
DR. Hagan

- ☐ REQUEST CONSULTATION FOR PROCEDURE ONLY
- ☐ REQUEST OPINION ONLY REGARDING DIAGNOSIS AND TREATMENT
- ☐ REQUEST CONSULTATION AND JOINTLY MANAGE CARE WITH ATTENDTING PHYSICIAN
- ☐ REQUEST ASSUMPTION OF CARE

☐ STAT
☐ TODAY
☐ ROUTINE Spoke Bridget

REASON FOR REQUEST Dr. Hall, PEG

M.D.

SIGNATURE OF ATTENDING PHYSICIAN

CONSULTATION REPORT

CONSULTATION DATE 5/30/06

FINDINGS: Pt who presents pcp, inadequate nutrition & PEG placed 6wks ago

DIAGNOSIS: weight loss, failure to thrive anemia

RECOMMENDATIONS: EGD & feed tube to eval for: Dr. Hall

DICTATED: YES ☐ NO ☐

SIGNATURE OF CONSULTANT

CONSULTATION REQUEST

ADDRESSOGRAPH

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

601.19 (Rev. 07/02) 10-2076

Aiken Regional Medical Centers

302 University Parkway • Aiken, South Carolina 29801

CONSULTATION REQUEST

TO: (CONSULT AND/OR SERVICE)
DR HIGGINS

REQUEST DATE 5-16-06

TIME 1365 SW

- ☐ REQUEST CONSULTATION FOR PROCEDURE ONLY
- ☐ REQUEST OPINION ONLY REGARDING DIAGNOSIS AND TREATMENT
- ☐ REQUEST CONSULTATION AND JOINTLY MANAGE CARE WITH ATTENDTING PHYSICIAN
- ☐ REQUEST ASSUMPTION OF CARE

☐ STAT SPOKE TO
☐ TODAY BRIDGETTE
☐ ROUTINE

REASON FOR REQUEST _____

_____ M.D.

SIGNATURE OF ATTENDING PHYSICIAN

CONSULTATION REPORT CONSULTATION DATE _____

FINDINGS: See 5/18 poor nutrition

DIAGNOSIS: CVA poor nutrition, decub ulcer

RECOMMENDATIONS: PEG if family agrees
decub decub

SIGNATURE OF CONSULTANT

DICTATED: YES ☐ NO ☐

ADDRESSOGR

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

CONSULTATION REQUEST

601.19 (Rev. 07/02) 10-2076

Home Medication List - Physician's Order Form

Height: feet inches

Weight: pounds actual stated estimated

Allergies: NKA

Nurse Signature Date/Time

ADMISSION

At time of entry, please check which medications should be continued and sign below to authenticate order

DISCHARGE

At time of discharge, check which medications should be continued and sign below to authenticate order.

Home Medications (Include Herbals/OTC/Vitamins) Do NOT administer herbals during hospitalization				Last dose taken ? = unknown	Give med during hospital	Do not give med	Continue at discharge	Do not give at discharge
Medication	Dose	Route	Frequency					
☐ No home medications								
☐ Unable to obtain list								
Mylanta/Maalox	15-30cc	PO	Q2hr PRN					
Tylenol	5Gm 2tab	PO	Q4hr PRN					
Mom	30cc	PO	PRN Q48°					
Kaopectate	30cc	PO	Q2° PRN x48°			✓		
Prostat 101 in 4oz juice	30cc	PO	TID					
Periactin	4mg	PO	TID		✓			
Atenolol	125	PO	BID			✓		
protonix	40mg	PO	daily		✓			
Norvasc	5mg	PO	daily			✓		
Silverite	1	PO	daily					
Norvasource Fiber 2.0	180cc	PO	QID Between meals					

Physician Signature (on admission): Date:

Physician Signature (on discharge): Date:

PHYSICIAN'S ORDER FORM

601.126 10-37036 (2/06)

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

ORDERS APPROACHING EXPIRATION REPORT

PER HOSPITAL POLICY THE FOLLOWING DRUG ORDERS NEED TO BE REVIEWED
PLEASE CHECK ( ) YOUR ACTION IN THE APPLICABLE BOX AND SIGN

IV TYPE	ORDER NO	IV DESCRIPTION	FREQUENCY / FLOW RATE	START DATE TIME	STOP DATE TIME	RENEW	DISCONTINUE
		INFUSE OVER AT LEAST 1.5 HOURS					
SCH	20	SODIUM CHLORIDE 0.9%	175 ML/HR	05/21 11:00	05/26 11:00		
		VANCOMYCIN 1.5 GM = 1.5 IV					

651016

Physician Signature_ Physician Signature_____ Date:_____
Return to Pharmacy for processing

Send a copy with physician signature to pharmacy for order processing.
Place original, which is part of the patient's permanent medical record, on the patient's chart.

Location: 5M
Room/Bed: 0503 A MRN#: 26523
ient ID:000102829710 PETERSON, WILLIAM SR
Physician: 045591 BOKKISAM, CHAKRAVARTHY

Admit Date:05/15/2006 DOB: [redacted] Age:85Y
Sex:M HT:5 F 11 IN WT:180 LB
Diagnosis:UROSEPSIS,AMS,HYPOTHERMIA
Allergies:

DATE/TIME	ANOTHER GENERIC BRAND OF DRUG IDENTICAL IN FORM AND CONTENT MAY BE DISPENSED UNLESS CHECKED	✔	NURSE'S SIGNATURE / DATE TIME
	☐ Observation admission (determine need for further treatment)		
	☐ Inpatient Admission		
6/1/06 11:55 AM	8) Decubitus Ulcer Care 9) PEG Care 10) PT for ROM/up in chair BID 11) FU for F/N/U/D/COB/CP (Return for) 12) FU MD @ Select. 13) O2 protocol 6/5/06 Addendum Pager 803 202-7425		

PROHIBITED ABBREVIATIONS | **QD** | **MgSO4**

MSO4, MS | **ug** | **1.0 mg** | **.5 mg** | **u**

ALLERGIES:

NAME

102829710

PETERSON SR, WILLIAM SR

DOB: [redacted] 85 SX: M IMD

MRN: 26523 ADM/REG DT: 05/15/06

AIKEN REGIONAL MEDICAL CENTER

AGE

PHYSICIAN'S ORDER FORM

601.40 10-2253

White: CHART COPY – Yellow: NURSING

DATE/TIME	ANOTHER GENERIC BRAND OF DRUG IDENTICAL IN FORM AND CONTENT MAY BE DISPENSED UNLESS CHECKED	✔	NURSE'S SIGNATURE /DATE /TIME
	☐ Observation admission (determine need for further treatment)		
	☐ Inpatient Admission		
6·1·06 — 0200 — 24° Chart ✓ —			C. Stuart
6/1/06 1145 AM	Transfer Orders 1) Transfer to Select Spec. Hosp in Augusta via amb (bedridden) 2) Dx: Sepsis (R) Kidney Cyst / Decubitus Ulcer 3) Condition: Fair to Good 4) ALLG 5) ~~Vancomycin~~ Meds: a) Vancomycin 1gm IVPB q 24h x 6 wks (started 5/15/06) b) Duoneb qid prn c) Prednisone 5mg + PEG q AM x 2 then D/C d) Protonix 20mg OTC ↑ PEG daily e) Insulin Reg SC: 151-200 2 units 201-250 4 " 251-300 6 " 301+ Call MD 6) Diet: Fibersource HN 60cc/h ē 25 cc/h tap water flushes + 1 pkt Arginade + 1 pkt Glutasolve in 120ml H2O ↑ PEG BID 7) VS/wt per routine		

PROHIBITED ABBREVIATIONS | QD | MgSO4

MSO4, MS | ug | 1.0 mg | .5 mg | u

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	☐ Observation admission (determine need for further treatment)		
	☐ Inpatient Admission		

5/31/06 Wound care orders

① Hip pack Curagel gauze to wound, cover with 4x4's and secure with Medipore tape. Change BID

Coccyx: Calamine around the wound, apply hydrogel to wound base, cover with 4x4, secure with Medipore tape. Change BID

① ankle - Hydrogel to wound base, cover with 4x4, secure with tape. Change BID

Mark Miller PW-WHNP 11/06 pp

5/31/06 Resume tube feeds + all pre procedure orders.

Defer diet night bid, #15 scalpels, 4x4's at bedside for sacral ulcer debridement

PROHIBITED ABBREVIATIONS	QD	MgSO4
MSO4, MS	ug	1.0 mg	.5 mg	u

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	☐ Observation admission (determine need for further treatment)		
	☐ Inpatient Admission		
5/30	① Ch dig diet #163		
	② Daily lytes + creatinine per 6 tube draw		
	4 hours begin 1 pm		
	③ dc permit ECG & telemetry #161 #163		
	do see why blood could be drawn		
	~~④ Heparin bolus x 1 then gtt~~		
5/30/06	12hr Chart V 1815		
5:31:06	0240 — 20 Crani		
	Neuro assessments		
	Vancomycin 1gm IV q 24hrs		
	peak & next dose		
	PROHIBITED ABBREVIATIONS QD MgSO4		
	MSO4, MS ug 1.0 mg .5 mg u		

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PETE[redacted] SR, WILLIAM SR IMD
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	☐ Observation admission (determine need for further treatment)		
	☐ Inpatient Admission		
5/29/06 1610 PM	1) T-TBWF (Tap Water Flushes) to 40cc/hr 2) T+C+Transfuse 2 units pRBC's #157 3) AM CBC c diff #151 4) Hemoccult next 3 stools		1645 PM
5/29/06 1700	Noted shaking, R		
5/29/06	12° chart ✓		
5/30/06	0210-24° Chart ✓		
5/30/06 1055 PM	1) Consult Dr. Hagan: ? Slope, anemia 2) AM CHEM-8 (158) 5/31 ~~HH~~ CBC (158) 3) Up in chair BID		

PROHIBITED ABBREVIATIONS

QD	MgSO4	MSO4, MS	ug	1.0 mg	.5 mg	u

ALLERGIES:

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	☐ Observation admission (determine need for further treatment)		
	☐ Inpatient Admission		
5/28/06 1250	1) Reg insulin SS: 151-200 2 units 201-250 4 " 251-300 6 " 301+ Call MD		FAXED 1453
5/24/06	24 hour 0230		
5/24	Hold Vancomycin #1 #1 Vancomycin Levels q 12 hrs when Vancomycin Level is <20 give Vancomycin		
5/29 1200			FAXED
5/29/06 1200	Gibson, R		
	PROHIBITED ABBREVIATIONS QD MgSO4		
	MSO4, MS ug 1.0 mg .5 mg u		

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	☐ Observation admission (determine need for further treatment)		
	☐ Inpatient Admission		
5/28/06	24° chart ✓ ——— 0300 ——— pt		
5/28/06	Hold Vancomycin IV Vanco level in AM #143 VOR Dr. Subra		1101 pp
5/28/06 1400	8 hr. chart imar ✓ ———		5/28/06 1400
5/28/06 1400	1) Tap water 120cc J NGT q4h, first dose now. 2) This ↑ is in addition to tap water flushes		
	3) AM CBC diff #143-144 CMP-8 #143-144		gave 240cc first dose.
	4) D/C Lasix / KCl		
	5) IVF: D5W @ 30cc/h		
	6) Glucometer q6h #145		
	PROHIBITED ABBREVIATIONS QD MgSO4		
	MSO4, MS ug 1.0 mg .5 mg u		1456 pp

ALLERGIES:

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	☐ Observation admission (determine need for further treatment)		
	☐ Inpatient Admission		
5/26/06 1720	Please T H2O flushes to 35 ml/hr. VOR Dr. Shriver/Patricia Skolnik, RN		
5/26/06 1700	START Portable CXR (133) post Thoracentesis VOR Dr. Robinson/L.V. McFadden Hunter, RN		
5/27/06 0000	— 24p chart —		1730
5/27	Unchanged Unchanged		0738
5/27/06 1120 AM	1) Maintain in D5W @ 125 2) Labet 20mg IVP now & q8h 3) KCl 20 Meq IVP now & q8h 4) AM CBC/BMP #138		
	PROHIBITED ABBREVIATIONS QD MgSO4		
	MSO4, MS ug 1.0 mg .5 mg u		

ALLERGIES:

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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

PHYSICIAN'S ORDER FORM

10-2253

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DATE/TIME	ANOTHER GENERIC BRAND OF DRUG IDENTICAL IN FORM AND CONTENT MAY BE DISPENSED UNLESS CHECKED	✔	NURSE'S SIGNATURE / DATE TIME
	☐ Observation admission (determine need for further treatment)		
	☐ Inpatient Admission		
5/26/2006 1511	1) STAT PT PTT for Heparin 98.5 (130) (189) PT 14.9 INR 1.2 PH = 33.3 Vol. Dr. Robison / L.J. McFadden-Hunter, M		SR 1530
	PROHIBITED ABBREVIATIONS QD MgSO4		
	MSO4, MS ug 1.0 mg .5 mg u		

ALLERGIES:

NAME

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PETERSON SR LLIAM SR
DOB: [redacted] 85 SX: M IMD
MRN: 26523 ADM/REG DT: 05/15/06
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DATE/TIME	ANOTHER GENERIC BRAND OF DRUG IDENTICAL IN FORM AND CONTENT MAY BE DISPENSED UNLESS CHECKED	✔	NURSE'S SIGNATURE / DATE TIME
	☐ Observation admission (determine need for further treatment)		
	☐ Inpatient Admission		
5/26/06 0000	(120) 24° chart — plat SR		
5/26/06 1:39pm	1) U/S (chart) pleural effusions (121) Thoracentesis, U/S guided please. 2) Send ~~Studies for~~ Fluid (pleural) for: (120) a) Glucose (121) b) Protein (122) c) LDH (123) d) Specific Gravity (124) e) Gm stain, C&S bact. (126) Cytology ~~sent slip~~		
	(125) 3) AM CBC with diff.		
	done		
5/26/06 2:20pm	REMOVE FROM DR SANTOS LIST		
	PROHIBITED ABBREVIATIONS QD MgSO4		
	MSO4, MS ug 1.0 mg 5 mg u		

ALLERGIES:

NAME

DATE

PHYS. 102829710
NERSON SR, WILLIAM SR

M.R. # 3: [redacted] 85 SX: M IMD
: 26523 ADM/REG DT: 05/15/06

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POST BRONCHOSCOPY ORDERS

DATE/TIME	ANOTHER GENERIC BRAND OF DRUG IDENTICAL IN FORM AND CONTENT MAY BE DISPENSED UNLESS CHECKED	✔	NURSE'S SIGNATURE / DATE TIME
5/25/06	(1) Vital signs and level of consciousness, Q 15 minutes until patient returns to pre-medication mental status and vitals are consistent with normal ranges for the patient. Then routine if stable.		
	(2) Resume diet when fully awake and alert.		
	~~3. Chloraseptic spray to bedside PRN sore throat.~~		
	~~4. Cepacol lozenges to bedside PRN sore throat.~~		
	(5) Pulse-ox in 2 hours, call if less than 90%. #117		
	(6) If on O2, titrate per Respiratory Department protocol. FAXED		
	(7) Convert IV fluids to heplock, flush Q shift.		SW 1425 5-25

Physician's Signature

ALLERGIES:

PHYSICIAN'S ORDER FORM

721.01 10-19062

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102829710
PETERSON SR, WILLIAM SR
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MRN: 26523 ADM/REG DT: 05/15/06
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DATE/TIME	ANOTHER GENERIC BRAND OF DRUG IDENTICAL IN FORM AND CONTENT MAY BE DISPENSED UNLESS CHECKED	✔	NURSE'S SIGNATURE / DATE TIME
	☐ Observation admission (determine need for further treatment)		
5/25/06 1135	☐ Inpatient Admission 40 meq KCl W peg - need 4 in 4 hrs per verbal repeat order Dr Seltzer / Rachel Kenyon 5/23/06 1135 5/25		
5/25/06 1845 PM	1) CBC c diff in AM 2) KCl 40 meq + PEG @ midnight 3) 240 cc tap water + PEG now, in 4h + in 10 hrs. 4) CMP-8 in AM #115-116 5) For next Temp ≥ 100.5: blood cult x2 sets + ~~UA~~ start Ceftazidine 1gm IVPB q8h		SW 1424 5-25-06

FAXED

PROHIBITED ABBREVIATIONS	QD	MgSO4
MSO4, MS	ug	1.0 mg	.5 mg	u

ALLERGIES:

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DATE
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ROC
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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

PHYSICIAN'S ORDER FORM

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	☐ Observation admission (determine need for further treatment)		
	☐ Inpatient Admission		
5-24-05	0145 — 24°Chart V		C. Stevens RN
5/24/05	7a-7p Chart		S. Christ RN
5/24/06 17:00	D/C Zosyn. VOR Dr. Suhrer		S. Christ RN 5/24/06 @ 1825
5-25-06	0100 — 24°Chart V #104		Faye RN
5/24/06 10:30 AM	Consult Dr. N. Sands (Branch - I spoke to him) CXR now - 4 secretions #105 CBC diff daily CHEM 7 & now #106-107		SW 1044 5-25
5/25/06 10:50 AM	Sputum for Bact C&S + gm stain (@ time of bronch)		
5/25/06 1050	Consent Bronch at 1 PM today - notify resp to have [illegible] per verbal order Dr. Sands RRT Rachel Keeler		

PROHIBITED ABBREVIATIONS: MSO4, MS — ug — 1.0 mg — .5 mg — u — QD — MgSO4

ALLERGIES:

102829710
PETERSON SR [illegible]LIAM SR
DOB: [redacted] 85 SX: M IMD
MRN: 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER
ROOM #
AGE

PHYSICIAN'S ORDER FORM

601.40 10-2253

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DATE/TIME	ANOTHER GENERIC BRAND OF DRUG IDENTICAL IN FORM AND CONTENT MAY BE DISPENSED UNLESS CHECKED	✔	NURSE'S SIGNATURE / DATE TIME

☐ Observation admission (determine need for further treatment)

☐ Inpatient Admission

615304

5/22/06 (D/C) 10) PT for ROM; up in chair BID
11) Return for Fever/N/V/SOB/DP
12) Flu: MDs ordered. Please √ = Dr Gordon as to how long to Rx = Zosyn; from Notes, Vanco for (6-12 hrs started: 5/15/06)
13) O2 Protocol - (Pharmacy on b/o mouth breathing.

803 202-3425 B/Pager

5/23/06 Vanc. Peak with next dose.
DC Vanc. Peak due @ 1345 today.
VOR Dr. Gordon/Pager EN

5/23/06 Na-Np chart check.

PROHIBITED ABBREVIATIONS

QD	MgSO4	MSO4, MS	ug	1.0 mg	.5 mg	u

ALLERGIES:

NAME

DATE

102829710

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

PHYSICIAN'S ORDER FORM

601.40 10-2

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DATE/TIME	ANOTHER GENERIC BRAND OF DRUG IDENTICAL IN FORM AND CONTENT MAY BE DISPENSED UNLESS CHECKED	✔	NURSE'S SIGNATURE / DATE TIME
	☐ Observation admission (determine need for further treatment)		
	☐ Inpatient Admission		
5/23/06 10Am	Transfer Orders 1) Transfer to Select Specialty Hosp in Augusta via ambulance (ambulance)		
	2) Dx: Sepsis; @ Kidney Complex Cyst.		
	3) Condition: Fair		
	4) ALL		
	5) Meds: Vancomycin 1.5gm IVPB q 24h Duonb aer q4h prn Prednisone 10mg PO @ 9AM tonight x1 Prednisone 40mg PO AM 5/24 ↓ by 10mg daily until off ~~Protonix (oral)~~ Zantac 150mg PO BID Zosyn 3.375gm IVPB q6h		
	6) Diet: Fibersource HN 60ml/hr x 10 hrs d/c tap water flushes 1 pkt Arginaid + 1 pkt Glutasolve in 120ml H2O PO BID		
	7) VS/Wt per routine		
	8) ~~Swan-Ganz q 4h (oral)~~ Foley to BSD		
	9) Preventive ulcer care.		
	PROHIBITED ABBREVIATIONS QD MgSO4		
	MSO4, MS ug 1.0 mg .5 mg u		

ALLERGIES:

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DATE

102829710

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

PHYSICIAN'S ORDER FORM

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	☐ Observation admission (determine need for further treatment)		
	☐ Inpatient Admission		
5/22/06	24° Chest J Albuterol Un 0340		
0622/06 1430	Please Δ Pramod to one package #45 Glutasolve. Mix 1 one package drainage in 120ml H2O BID as previously ordered. VOR Dr. Suliver / Patricia Skolnik, RD		1654 PP
5/22/06	CHEM-8 in AM #96 #97		
355PM	CBC with diff in AM		
	240 cc Tap water J FT now		
	Tap water 30 ml/h J FT please		
	Δ IV to NS Lock 1 RP Pushes		
	noted Rachelle 5/22/06 2000		1654 PP
5/23/06	24 hr chart / Rachelle #102		
623	Renal Ultrasound - mass ? clump		SW 0424 5-23
	Urinalysis peaks next dose		
	PROHIBITED ABBREVIATIONS QD MgSO4		
	MSO4, MS ug 1.0 mg .5 mg u		
	DIC Metronidazole		FAXED

ALLERGIES:

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	☐ Observation admission (determine need for further treatment)		
	☐ Inpatient Admission		
5/20/06	0330 — 24° Chart ✓ — K. Arenander D/C 5/24 Vancomycin Levels Vancomycin 1.5 gm IV Now Vancomycin 1.25 gms q 24 hrs Vancomycin Peak & Trough 89 Sphygmomanometer S Schander 5/20/06 @ 1030		
			0745
5/20	Debridement tray bedside, 2 #15 Scalpels S Schander 5/20/06 4 x 4s.		
5/20	TV Vancomycin to 1.5 gms IVPB q 24 hrs Vancomycin peaks and Lows S Schander 5/20/06 @ 1010		
	PROHIBITED ABBREVIATIONS QD MgSO4		
	MSO4, MS ug 1.0 mg .5 mg		FAXED
			0940

ALLERGIES:

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	☐ Observation admission (determine need for further treatment)		
	☐ Inpatient Admission		
5/19/06	24° Chart / —— 0130 —— R. Eadg RN		
5/19/06	12° Chart — Lauren Judd — 0845		
5/19	① May use PEG tube in AM — plz. let his medical doctor order feeding he/she desires in AM.		SW 1404 5-19
5/19/06 2PM	Start TF as per doctor recommend in AM (5/20) #85 IVF: D5 ½NS 40meq KCl @ 100 cc/h When TF's started in AM, d/c to 60 cc/h AM CMP & #83-84 ✓ CBC diff ✓ Noted Lauren Judd 5/19/06 2PM		SW 1500 5-19
	PROHIBITED ABBREVIATIONS QD MgSO4		
	MSO4, MS ug 1.0 mg .5 mg u		

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	☐ Observation admission (determine need for further treatment)		
	☐ Inpatient Admission.		
5/18/06 1525	Please start TF of ½ strength Impact 1.5 @ 20ml/° advance by 10ml q 10° as tolerated to goal of 60ml/°. Additionally: please mix 1 package Reginade in one scoop Promod in 4oz H2O and push BID. VOR Dr. Bokkisam / Patricia Skolnik, RD		
	5/19 FAXED 8/21/06 1600		
5/18/06 1900	Consult Dr. Nagar - Jejunostomy placement pho Dr. Wollen / Attended by Dr. Nagar - Done		SK 1905
	5/18/06 1900		
5/18/06 1900 5/19	Dr. Chart / Attended ✓ Blood cultures x 2 #79-80 ✓ Dr. Wollen to see pt.	FAXED	RST, SW RM21
	PROHIBITED ABBREVIATIONS QD MgSO4		
	MSO4, MS ug 1.0 mg .5 mg u		

ALLERGIES:

5/19/06 0845 5-19

NAME

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102829710

PETERSON SR, WILLIAM SR

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	☐ Observation admission (determine need for further treatment)		
	☐ Inpatient Admission		
5/18/06	Call family regarding feeding options. Is family agree for feeding. Call Dr. Hasan for Central line (TPN) or PEG placement for long term. Bokhari 5/18/06 1200		
5/18/06 1230	Dietary Consult for tube feeding recommendations Insert NG tube for tube feeding VO Dr. Bokhari MMeadors Repeated Verified MMeadors MMeadors 5/18/06 1235		

PROHIBITED ABBREVIATIONS — **QD** — **MgSO4**

MSO4, MS — **ug** — **1.0 mg** — **.5 mg** — **u**

ALLERGIES:

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	☐ Observation admission (determine need for further treatment)		
	☐ Inpatient Admission		
5/17	D/c Normal saline DS/0.2 @ 200 a/h. Chem 8 in am. #64	FAXED	SW- 0935 5-17
	5/17 Mailed at 1000 MB		
5/17/06	CBC & Diff.		
5/18/06	All charts ——— OBD ——— R Emley LPN		
5/18/06	KCl 60 meq IV x 1 NOW		
0615	T.O.R Dr Bokkisam/R. Emley LPN		
		FAXED	0700
5/18/06	(75) CBC in AM. (76) Chem 8 in AM Protonix 40mg IV q12hr Bolus Hold pending action.		
	PROHIBITED ABBREVIATIONS QD MgSO4		2000
	MSO4, MS ug 1.0 mg .5 mg u		

ALLERGIES:

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ROOM
AGE

PHYSICIAN'S ORDER FORM

601.40 10-2253

White: CHART COPY – Yellow: NURSING

DATE/TIME	ANOTHER GENERIC BRAND OF DRUG IDENTICAL IN FORM AND CONTENT MAY BE DISPENSED UNLESS CHECKED	✔	NURSE'S SIGNATURE / DATE TIME
	☐ Observation admission (determine need for further treatment)		
	☐ Inpatient Admission		
	[signature] [signature]		
5/16/6	Debridement tray, 4x4s, Betadine at bedside for use in AM + please make sure it is there -		
	[signature]		1814 PP
	Noted R Emily RN 5/16/06		
5/16/06	24° chart ✓ 0400 R. Emily RN		
5/17	✓ ESC SMO8 > 9 AM x 3 days		SW 0714 5-17
	#64-65		
	[signature]		
	PROHIBITED ABBREVIATIONS **QD** **MgSO4**		
	MSO4, MS **ug** **1.0 mg** **.5 mg** **u**		

ALLERGIES:

PHYSICIAN'S ORDER FORM

601.40 10-2253

NAME
DATE
PHYS.
M.R. # 102829710
ROOM PETERSON SR, WILLIAM SR
AGE DOB: [redacted] 85 SX: M IMD
MRN: 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

White: CHART COPY – Yellow: NURSING

DATE/TIME	ANOTHER GENERIC BRAND OR DRUG IDENTICAL IN FORM AND CONTENT MAY BE DISPENSED UNLESS CHECKED	✔	NURSE'S SIGNATURE / DATE TIME
	☐ Observation admission (determine need for further treatment)		
	☐ Inpatient Admission		
5/16/06	morphine 1mg IV Q 8hrs prn pain FAXED		SW 1147 5-16
5/16	Blood cultures x2 #50	#	53-54
	Phos 3mg IV 8h		
	Consult Dr Hayes SW		
	Labetalol drip per		
	Protocol (9.9)		#48
	Magnesium level now <2.0		
	give Mag per protocol		
	Magnesium level 5/17		#51-55
	Mag level <2.0 give Mag		
	Echocardiogram	#56	
	PROHIBITED ABBREVIATIONS QD MgSO4		SW
	MSO4, MS ug 1.0 mg .5 mg u		1355 5-16

ALLERGIES:

#57

NAME

DATE

PHYS.

M.R.# 102829710

ROOM PETERSON SR, WILLIAM SR

AGE DOB: [redacted] 85 SX: M IMD

MRN: 26523 ADM/REG DT: 05/15/06

AIKEN REGIONAL MEDICAL CENTER

PHYSICIAN'S ORDER FORM

601.40 10-2253

White: CHART COPY – Yellow: NURSING

CHART COPY

DATE/TIME	ANOTHER GENERIC BRAND OF DRUG IDENTICAL IN FORM AND CONTENT MAY BE DISPENSED UNLESS CHECKED	✔	NURSE'S SIGNATURE / DATE TIME

☐ Observation admission (determine need for further treatment)

☐ Inpatient Admission

5/16/06 9:45 Nausea/pain/wound care protocol

(L) Hip wound.

Clean & DS gauze

Use Coverlet gauze to (L) Hip wound. Base. Cover & 4x4 gauzes and secure & Hypafix Medipore tape.

Sacral wound.

Cover & Calazime

Calazime to buttocks BID and prn

1st Step every day to bed

Mark Mellstrom

SW 100 5:16

5/16/06

Consult Dr. DiBona. (Nephrology) SW

Consult ID Dr Gordon. SW today

CBC Diff admit #46-47

Chem 8 admit

NSS @ 300 ml/hr

Vancomycin 1 gram IV x1

Random Vanco levels #48 BokG

Hydrocortisone 100 mg IV Q 8 hrs.

Social service consult. #45 BokG

PROHIBITED ABBREVIATIONS

MSO4, MS	**ug**	**1.0 mg**	**.5 mg**	**u**
QD	**MgSO4**			

ALLERGIES:

PHYSICIAN'S ORDER FORM

NAME

D 102829710

P PETERSON SR, WILLIAM SR

DOB: [redacted] 85 SX: M IMD

V MRN: 26523 ADM/REG DT: 05/15/06

AIKEN REGIONAL MEDICAL CENTER

RO

AGE

601.40 10-2253

White: CHART COPY – Yellow: NURSING

DATE/TIME	ANOTHER GENERIC BRAND OF DRUG IDENTICAL IN FORM AND CONTENT MAY BE DISPENSED UNLESS CHECKED	✓	NURSE'S SIGNATURE / DATE TIME
	☐ Observation admission (determine need for further treatment)		
	☐ Inpatient Admission		
5/15/06	Pepcid 4mg PO Q8hrs		
	Tylenol 650mg PO Q4hrs as needed for temp >101°F.		
	Blood cultures x2 (23)(25) if not done in ER		
	Urine cultures (24) if not done in ER		
	Sputum cultures		
	Stool cultures.		
	Troponins q 8hrsx3 if not done in ER (21)		(38)(39)
	12 lead EKG on Am. #35		
	Vancomycin 1 gram IV x1 now then 1000 daily		
	Zosyn 3.375 gram IV Q6hrs.		
	IV Fluids NSS @ 200 ml/hr		0000
	Duonebs q 4hrs #36		
	Aspiration Precaution.		
	#3 Acute Abdominal Series		R/o (Perforation / Obstruction
	Continue on Warm blanket to maintain temp >98.5.		
5/16/06	2100 Chart Reviewed 0330		
	PROHIBITED ABBREVIATIONS QD MgSO4 MSO4, MS ug 1.0 mg .5 mg u		FAXED

ALLERGIES:

5/16/06 0240

PHYSICIAN'S ORDER FORM

601.40 10-2253

NAME
DATE
PHY
M.R.
ROC
AGE

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

White: CHART COPY – Yellow: NURSING

DATE/TIME	ANOTHER GENERIC BRAND OF DRUG IDENTICAL IN FORM AND CONTENT MAY BE DISPENSED UNLESS CHECKED	✔	NURSE'S SIGNATURE / DATE / TIME
	☐ Observation admission (determine need for further treatment)		
	☐ Inpatient Admission		
5/15/06	Admit to: ~~BSU~~. Telemetry ✓		
	Attending: Dr. Bokesjam		
	Diagnosis: Dimentia/Status / Hypothermia		
	Diet: NPO now #3 / Unspecified		
	Activity: Assisted.		
	#3 Oxygen: 2lit NC titrate to PO2 90%		
	Vitals & Nursing: As per Protocol		
	Allergies: NKDA		
	Consults: Cardiac Care #3 4		
	~~(2) ED~~		
	(3) Code status – DNR/DNI		DNR
	(20) TSH Stat } Comment results.		
	CPK (21) Stat } 222		
	#3 CBC & Diff AM 199		
	#3 Chem 7 AM		
	~~Levaquin 500mg IV Q24hrs~~		~~Hold~~
	~~Rocephin 1gram IV Q24hrs~~		~~Hold~~
	Protonix 40mg PO Q24hrs.		
	Hold → Atenolol 12.5mg PO Q12hrs		Hold
	Hold → Norvasc 5mg PO Q24hrs		~~Hold~~
	Silverite – ~~Hold~~		
	PROHIBITED ABBREVIATIONS QD MgSO4		FAXED
	MSO4, MS ug 1.0 mg .5 mg u		

ALLERGIES:

5/16/06

Bokesjam

NAME

DATE

PHYS.

M.R. #

ROOM

AGE

102829710

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

PHYSICIAN'S ORDER FORM

601.40 10-2253

White: CHART COPY – Yellow: NURSING

DATE	5/31/06	6/1			
HOSP. DAY/POST. OP					

HOUR	A.M.			P.M.			A.M.			P.M.			A.M.			P.M.			A.M.			P.M.			A.M.			P.M.		
	2 0200	6 0600	10 1000	2 1400	6 1800	10 2200	2 0200	6 0600	8 1000	1400	1800	10 2200	2 0200	6 0600	10 1000	2 1400	6 1800	10 2200	2 0200	6 0600	10 1000	2 1400	6 1800	10 2200	2 0200	6 0600	10 1000	2 1400	6 1800	10 2200

TEMPERATURE

C	F
40.6°	105°
40.0°	104°
39.5°	103°
38.9°	102°
38.4°	101°
37.8°	100°
37.2°	99°
36.7°	98°
36.1°	97°
35.6°	96°

PULSE	100	69	66			88	59	62		78	79	76																		
RESPIRATION	18	18	15			18	17	16		20	20	24																		
BLOOD PRESSURE	120	111	130			133	159	131		142	140	144																		
	68	86	78			75	78	68		82	76	78																		

WEIGHT																														
SHIFT	11p-7a	7a-3p	3p-11a	24 HR TOTAL	11p-7a	7a-3p	3p-11a	24 HR TOTAL	11p-7a	7a-3p	3p-11a	24 HR TOTAL	11p-7a	7a-3p	3p-11a	24 HR TOTAL	11p-7a	7a-3p	3p-11a	24 HR TOTAL	11p-7a	7a-3p	3p-11a	24 HR TOTAL						
INTAKE c.c. ORAL						140																								
INTRAVENOUS																														
BLOOD																														
SHIFT TOTAL																														
OUTPUT c.c. URINE																														
EMESIS																														
GASTRIC																														
STOOL	x3																													
Foley	750		150			100	1,225																							
SHIFT TOTAL																														

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

DATE	5/26						5/27						5/28						5/24						D5-30-06					
HOSP. DAY/POST. OP																														
HOUR	A.M.			P.M.			A.M.			P.M.			A.M.			P.M.			A.M.			P.M.			A.M.			P.M.		
	2 0200	6 0600	10 1000	2 1400	6 1800	10 2200	2 0200	6 0600	10 1000	2 1400	6 1800	10 2200	2 0200	6 0600	10 1000	2 1400	6 1800	10 2200	2 0200	6 0600	10 1000	2 1400	6 1800	10 2200	2 0200	6 0600	10 1000	2 1400	6 1800	10 2200
TEMPERATURE C																														
40.6°																														
40.0°																														
39.5°																														
38.9°																														
38.4°																														
37.8°																														
37.2°																														
36.7°																														
36.1°																														
35.6°																														
PULSE			87	84	98	85	84	93	99	97	91	87	92	84	84	76	84	90	88	86	90	88	80	71	73	67	74	70	68	77
RESPIRATION			20	16	24	20	20	20	28	24	24	18	18	18	28	24	16	20	20	20	16	17	18	16	16	20	17	16	17	18
BLOOD PRESSURE			142	135	145	131	168	147	148	146	148	132	137	125	132	138	141	144	141	115	133	128	130	124	141	109	150	128	130	135
			84	74	79	80	89	85	86	86	76	70	79	69	69	62	68	69	71	83	60	62	56	65	94	73	68	60	70	77
WEIGHT																														
SHIFT	11p-7a	7a-3p	3p-11a	24 HR TOTAL	11p-7a	7a-3p	3p-11a	24 HR TOTAL	11p-7a	7a-3p	3p-11a	24 HR TOTAL	11p-7a	7a-3p	3p-11a	24 HR TOTAL	11p-7a	7a-3p	3p-11a	24 HR TOTAL	11p-7a	7a-3p	3p-11a	24 HR TOTA
INTAKE C.C. ORAL		Ø				Ø			Ø	Ø	Ø				120		240							
INTRAVENOUS																								
BLOOD							500																	
Diet Food									320				480											
SHIFT TOTAL													140											
OUTPUT C.C. URINE																	1000	1000	1150					
EMESIS																								
GASTRIC																								
STOOL		Ø				Ø				X1					X1		1000							
Foley		500			800	1,050	540		500	700	(50)		450	800	1000				450					
[redacted]																								
SHIFT TOTAL																								

102829710

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

GRAPHIC/INTAKE/OUTPUT

DATE	5/21						5/22						05-23-06						5/24/06						5/25/06					
HOSP. DAY/POST. OP																														
HOUR	A.M.			P.M.			A.M.			P.M.			A.M.			P.M.			A.M.			P.M.			A.M.			P.M.		
	2 0200	6 0600	10 0800	12 1400	6 1800	10 2200	2 0200	6 0600	10 1000	2 1400	6 1800	10 2200	2 0200	6 0600	10 1000	2 1400	6 1800	10 2200	2 0200	6 0600	10 1000	2 1400	6 1800	10 2200	2 0200	6 0600	10 1000	12 1400	6 1800	10 2200
TEMPERATURE C / F																														
40.6° 105°																														
40.0° 104°																														
39.5° 103°																														
38.9° 102°																														
38.4° 101°				93.8 TEMP																										
37.8° 100°																														
37.2° 99°																														
36.7° 98°																														
36.1° 97°																												97.4	97.4	
35.6° 96°																														
PULSE	68	75		64	69	67	64	65	75	80	78	58	53	87	66	60		68	85	85	84	90	88	90	93	91	92	62	75	82
RESPIRATION	20	20		20	17	20	20	18	17	18	16	17	16	18	18	16		18	18	22	17	17	16	22	21	23	20	20	20	21
BLOOD PRESSURE	142	114		134	135	128	116	115	149	138	130	122	119	162	150	146		140	120	141	118	116	138	140	133	129	151	141	145	155
	76	98		80	71	68	74	88	90	88	78	61	58	89	80	78		72	85	81	80	74	76	87	71	82	85	75	70	88
WEIGHT			71			24 HR TOTAL			71			24 HR TOTAL					24 HR TOTAL						24 HR TOTAL						24 HR TOTA
SHIFT	11p-7a	7a-3p	3p-11a				11p-7a	7a-3p	3p-11a				11p-7a	7a-3p	3p-11a				11p-7a	7a-3p	3p-11a				11p-7a	7a-3p	3p-11a			
INTAKE C.C. ORAL		Ø	0				0	~~450~~						60												Ø				
INTRAVENOUS		1000	500				500	320																						
BLOOD																														
Tube Feed		380	320				400	370																						
SHIFT TOTAL								1100																						
OUTPUT C.C. URINE									550				450	600	400				450											
EMESIS																														
GASTRIC																														
STOOL		X3	X1				X2													650						Ø			
Foley	300	250	250				150		550												550				200	700	900			
SHIFT TOTAL																														

102829710
PETERSON SR, WILLIAM SR
DOB: [redacted] 65 SX: M IMD
MRN: 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

GRAPHIC/INTAKE/OUTPUT

DATE	5/16/04						5/17						5/18						5/19/06						5/20					
HOSP. DAY/POST. OP																														
HOUR	A.M.			P.M.			A.M.			P.M.			A.M.			P.M.			A.M.			P.M.			A.M.			P.M.		
	2 0200	6 0600	10 1000	2 1400	6 1800	10 2200	2 0200	6 0600	10 1000	2 1400	6 1800	10 2200	2 0200	6 0600	10 1000	2 1400	6 1800	10 2200	2 0200	6 0600	10 1000	12 1400	6 1800	10 2200	2 0200	6 0600	10 1000	2 1400	6 1800	10 2200
TEMPERATURE C / F																														
40.6° 105°																														
40.0° 104°																														
39.5° 103°																														
38.9° 102°																														
38.4° 101°																														
37.8° 100°																														
37.2° 99°																														
36.7° 98°																														
36.1° 97°																														
35.6° 96°																														
PULSE		77	79	75	77	78	71	77	75	87	81	83	83	86	81	73	64	84	68	75	71		67	69	78	72	88	78	80	65
RESPIRATION		20	22	16	24	20	20	20	16	16	16	20	23	20	20	20	20	24	20	22	20		16	11	12	10	18	18	16	18
BLOOD PRESSURE		64	75	78	64	78	80	96	90	119	96	112	94	111	98	112	118	104	111	115	113		114	117	128	115	130	138	142	110
		36	41	42	37	52	54	51	50	46	44	54	50	73	50	71	68	60	69	76	75		70	79	84	76	72	64	78	68
WEIGHT					24 HR TOTAL						24 HR TOTAL						24 HR TOTAL						24 HR TOTAL						24 HR TOTA
SHIFT	11p-7a	7a-3p	3p-11a				11p-7a	7a-3p	3p-11a				11p-7a	7a-3p	3p-11a				11p-7a	7a-3p	3p-11a				11p-7a	7a-3p	3p-11a			
INTAKE C.C. ORAL	0	NPO	NPO				NPO	NPO						NPO						Ø										
INTAKE C.C. INTRAVENOUS								2000						2200					1000							808				
INTAKE C.C. BLOOD														Ø																
INTAKE C.C.																														
INTAKE C.C. SHIFT TOTAL								2000																						
OUTPUT C.C. URINE																														
OUTPUT C.C. EMESIS																														
OUTPUT C.C. GASTRIC																														
OUTPUT C.C. STOOL								Y0												Ø										
OUTPUT C.C. Foley	0	50	250				150	450	300				175	400	600				1000	550	1200				175	250				
OUTPUT C.C.																														
OUTPUT C.C. SHIFT TOTAL								450																						

92-Axillary

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

GRAPHIC/INTAKE/OUTPUT

DATE	TIME	BLOOD SUGAR (finger stick)	TYPE INSULIN & AMOUNT	EDUCATION / SYMPTOMS / COMMENTS	SIGNATURE
5/29	0600	109			
5/29	0602	137			
05-30-06	0000	90			ASmith
05-30-06	0600	141			ASmith
5/30	1800	180			RS
5/31	0000	102			BBlocker
5/31	0630	506			BBlocker
5/31		78			RS
5/31	2100	118			MBell
6/1	0000	146			MBell
6/1	0600	199			MBell
6/1	10:00	196			Maria Pereira
6/1	14:00	202			Maria Pereira

AIKEN REGIONAL MEDICAL CENTERS

DIABETES FLOW SHEET

601.33

ADDRESSOGRAPH

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

10-2231

Aiken Regional Medical Centers

302 University Parkway • Aiken, South Carolina 29802

Date	NOTES
6/1/06 1139AM	IHMS Afebrile; (99²): 20; 78; 142/82 PE: He is able to respond verbally to simple questions. Cor a/l dd2 Lung-clear A Abd soft /nontender A/P Obs. Post Transfer See Addendum + D/C Sum

PROGRESS NOTES

ADDRESSOGRAPH

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

Aiken Regional Medical Centers

302 University Parkway • Aiken, South Carolina 29802

Date	NOTES
5/31/06 7:20pm	FHMC Colonoscopy Upper endo > as per prev. page. 140 | 108 | 259 < 1.0 3.7 | 28 | 84 Okay for Transfer to select if bed avail. WBC 6.0K Hgb 14.7 PLT 343K 67 y/o afebrile Patient Vapro Peak 354 to dosing frequency q24hrs until levels in therapeutic range Complete 6 more weeks w/ both CBC + CMP, peak/trough levels - 1-2x/week

PROGRESS NOTES

ADDRESSOGRAPH

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

FORM NO. 601.20 (REV. 3/06) 10-2081

Aiken Regional Medical Centers

302 University Parkway • Aiken, South Carolina 29802

Date	NOTES
5/30	Hct low ? GI bleed type & will judge upon & down per Dr Sullivan request Hgb q
5/31	10 Dilaudid 1mg q 2hrs prn pain Ativan - more alert - CXR ordered EGD / colonoscopy
5/31	Colonoscopy diverticula, small benign appearing polyp 45cm → 15x 4 pts EGD session d/t G-tube site, no bleeding Rec: ulcer prophylaxis, Heat diet

PROGRESS NOTES

ADDRESSOGRAPH

102829710

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

FORM NO. 601.20 (REV. 3/06)

10-2081

Aiken Regional Medical Centers

302 University Parkway • Aiken, South Carolina 29802

Date	NOTES
5/20	IP Vanc Cefepime 30 d days per Lovells will we have an idea as to treatment failure Gram more alert 01 148, 42 BP Urgency
5/20/06	ITMS
6:55 AM	Afebrile; 17; 94; 130/68 WBC 8.4K PE: More alert Hgb 9.4 Coarse PLT 282K Lungs - essentially Hemoccult ⊕ CTA
A/P	1) Resp - much better 2) CV - stable 3) FEN - recheck CMP & mg AM PPD ? 4) Anemia - ? Heme ⊕ stool from PPD ? - Scope ? - Quest Dr. Hagan.

PROGRESS NOTES

ADDRESSOGRAPH

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

Aiken Regional Medical Centers

302 University Parkway • Aiken, South Carolina 29802

Date	NOTES
5/29/06 12 PM	HMS Afebrile; 12; 88; 128/62 PE: Less groggy (except more) today Lungs - clear Labs: 149 / 114 / 42 / 12 Cr 1.3 3.7 / 30 / 42 WBC 9.3K 36 M Hgb 7.7 PLT 255K Random Vancos this AM 35 Glucometers d/c'ed. A/P 1) Anemia - hemoccult stools - type + transfuse 2 units pRBC 2) HS - agree on Cordarone hep. 3) dNa - better ↑ free water

PROGRESS NOTES

ADDRESSOGRAPH

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

FORM NO. 601.20 (REV. 3/06) 10-2081

Aiken Regional Medical Centers

302 University Parkway • Aiken, South Carolina 29802

Date	NOTES
5/28/06 2:45 AM	IHMC AVSS PE Lungs- c bsA (+ audible gurgling. O (no worse/no better) Labs: 151 | 120 | 41 <1.2 Ca 7.5 3.9 | 28 | 43 AP Agree c Dr. Gordon ↑ Free water, Will add more free water
5/29	10 Febrile more alert Coarse gr- sym abd soft Urine peak 55.7 10 hold more - adj as per GI

PROGRESS NOTES

ADDRESSOGRAPH

102829710
PETERSON GR [redacted] AM SR
DOB: [redacted] 35 SX: M IMD
MRN: 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

FORM NO. 601.20 (REV. 3/06) 10-2081

Aiken Regional Medical Centers

302 University Parkway • Aiken, South Carolina 29802

Date	NOTES
5/27/06 (cont)	AP will try Lasix daily + cl Tap water Fluoride slightly ⇒ However concerned about F Nat ⇒ Try Lasix alone 5 d Tap water Fluoride & see See order
5/28	D metabolic lytes exacerbated by diuresis Nacl supplement needed ↓ Urea so Lasix for water & replacement until we can get Urea up Stopped OR gtt cpt Rebuck continue D Urea

PROGRESS NOTES

ADDRESSOGRAPH

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

Aiken Regional Medical Centers

302 University Parkway • Aiken, South Carolina 29802

Date	NOTES
5/27	ID afebrile nl cBC BAL GUR ? signficance transudative effusion decubitus might benefit from fine adjustment diuresis IV meds creat 2.1.2
5/22/06 11:15 AM	THMC Afebrile: 28; 99; 148/86 PE: Eyes mitted Conj/Sclera Lungs - upper acrutes crackles again Calves Wide Hoist tte Bilateral Edema 2+ PVT 23SK

PROGRESS NOTES

ADDRESSOGRAPH

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

Aiken Regional Medical Centers

302 University Parkway
Aiken, SC 29802

Date	NOTES

POST OPERATIVE NOTE

DATE: TIME:

PROCEDURE PERFORMED US thoracentesis

SURGEON Robinson

ASSISTANTS

FINDINGS

(L) effusion

SPECIMENS REMOVED 350 cc yellow with clear

ESTIMATED BLOOD LOSS ℄

POST OP DIAGNOSIS path pending

SIGNATURE

PROGRESS NOTES

POST OPERATIVE NOTE

ADDRESSOGRAPH DATA

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

Aiken Regional Medical Centers

302 University Parkway • Aiken, South Carolina 29802

Date	NOTES
5/26/06 11AM	THMC T. 95.9 16 84 135/74 148/120/120< 1.2 PE: Lungs ↓ Bs bases 3.7/24/42 Starting to get gurgly again. Ca 1.2 WBC 8.4K Plts 61K Hgb 8.9 PLT 203K Cx H (P) AP U/S guided thoracentesis. Thoracic. Follow - otherwise, start [illegible]
5/26/06 2:12pM	PULM NO NEW ISSUES POST - BRONCH. GNR GROWING IN LARGE. COULD SIMPLY BE COLONIZER. WILL SIGN OFF.

PROGRESS NOTES

ADDRESSOGRAPH

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

FORM NO. 601.20 (REV. 3/06) 10-2081

Aiken Regional Medical Centers

302 University Parkway • Aiken, South Carolina 29802

Date	NOTES
5/25/06 1:30pm	PROCEDURE BRONCHOSCOPY W/BAL. REMOVAL OF RETAINED SECRETIONS — DARK ORANGE-TO-BROWNISH, NON-PURULENT. NORMAL ENDOBRONCHIAL ANATOMY. DICTATED. Thanks, JW 5/26 LD Afebrile GMCS U/O adequate & Cx sent — local can do when read Cont pen w/ allergies —NHS—?

PROGRESS NOTES

ADDRESSOGRAPH

PETERSON

102829710

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

Aiken Regional Medical Centers

302 University Parkway • Aiken, South Carolina 29802

Date	NOTES
6/25/06 1031 Am	I THMS A: Febrile; 22; 91; 129/82 PE: PE c purulent d/c from R ear. No acute distress Coarse BS b/l Lungs c to A Abd soft Labs: — A/P 1.) Respiratory - I tried to suction but nothing at back of throat. - I have asked Dr. Smith to see pt (bronch) - will send sputum for Bact GH + gm stain. - this may or may not delay transfer 2.) ID - Dr Gordon's note appreciated. - may need to add another antibiotic for ? infection ?... - √ CBC 3.) Na - √ CMP

PROGRESS NOTES

ADDRESSOGRAPH

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

Aiken Regional Medical Centers

302 University Parkway • Aiken, South Carolina 29802

Date	NOTES
5/24	ID Afebrile WBC Wound Clear CR 2D to be advised Cont I.V. Placement
5/24/06	Ith/ns AVSS Stable for Transfer MSCU Placement Note: U/S - no Δ in cyst ≥ no peripheral Stranding, overall benign appearance.
5/25	ID U/S renal repeat with Dr. Leschinsky drops Comp. Results - clear Consider Antibiotics

PROGRESS NOTES

Cor reg 2/0
Clear b/l
Abd soft
Bowel sounds x4
no

ADDRESSOGRAPH

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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

FORM NO. 601.20 (REV. 3/06) 10-2081

Aiken Regional Medical Centers

302 University Parkway • Aiken, South Carolina 29802

Date	NOTES
5/23/06 10:32 AM	FHMC Final Dx: 1) Sepsis MRSA 2) UTI " + Enterococcus 3) Sacral Decubitus Ulcers, infected 4) (A) Kidney complex cyst 5) ARF superimposed on CRF 6) Normocytic Anemia 7) Hypothermia - resolved 8) HTN HBP 9) BPH 10) Cervical Spinal Stenosis, S/P Anterior discectomy & fusion 3/2006 11) Air/fluid levels in Maxillary & ethmoid sinuses suggesting Acute Sinusitis 12) Senile Dementia. Afebrile VSS. (Renal U/S ordered for 6/1 can be done here or at select)

PROGRESS NOTES

ADDRESSOGRAPH

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

Aiken Regional Medical Centers

302 University Parkway • Aiken, South Carolina 29802

Date	NOTES
5/22	Admit Urine Resh 38.2 Creat 1.5 multiple ⊖ Blood cultures CXR neg Abd soft Rhonchi Sputum sent Detailed Hx per Dr Hogan
5/23/06 3:55 PM	THMS AVSS afeb, Cor/Lungs-nad Labs — ALP ↑, Free water ✓ labs in AM
5/23	VD Admit creat 1.4 CBC ok — probable contrast induced Kidney to see pt changes recommended in Hx and

PROGRESS NOTES

CXR neg
Abd soft
see orders

ADDRESSOGRAPH

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

Aiken Regional Medical Centers

302 University Parkway • Aiken, South Carolina 29802

Date	NOTES
5/21	TV meningioma (L) [illegible] 24hrs - [illegible]
5/21/06 11:25 AM	THMS Afebrile; VSS PE: Cor - RRR Lungs - clear Abd - soft Labs - AP NOD in place
5/22	proced: Debrided (L) temp wound of necrotic SQ and muscle.

PROGRESS NOTES

ADDRESSOGRAPH

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PETERSON SR, WILLIAM SR
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MRN: 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

Aiken Regional Medical Centers

302 University Parkway • Aiken, South Carolina 29802

Date	NOTES
5/20/06 4pm	IVMS Afebrile; 18; 28; 138/64 PE: Cor Lungs Abd Labs: Cr 1.6 WBC 6.4 NGMA 9.0 (mild) PLT 165 A/P 1) IVF – agree Dr. Gordon help. 2) TH – started thru AM 3) Mild NGMA – ? ARF (Cr better) – follow 4) Social – spoke c daughter
5/21	ID Temp defebrile WBC & plts ok urine cx ~25 (ok) Cor reg lungs clear abd soft Continue current Rx problem 1 longer term here

PROGRESS NOTES

ADDRESSOGRAPH

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

FORM NO. 601.20 (REV. 3/06) 10-2081

Aiken Regional Medical Centers

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Date	NOTES
5/19/06 2:40 PM	IHMS On service Afebrile, 20; 71; 113/75 PE: Eyes open Not responding Cor nl Lungs c Hall Abd – "thick" – no tenderness A/P Card c Current plan Will start TF in AM. Labs in AM
5/20	D Afebrile Dark dark level / BS Family advised ↑ all ✓ done yesterday Lungs & Blood Pressure Rx Home as Local wound Care

PROGRESS NOTES

ADDRESSOGRAPH

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AIKEN REGIONAL MEDICAL CENTER

Aiken Regional Medical Centers

302 University Parkway • Aiken, South Carolina 29802

Date	NOTES
5/19	ID Afebrile Complex renal lesion that could be reviewed Abscess - Rx Sq Flu Can be prolonged IV antibiotics & drainage But if this is a renal area Then not much to do - BP 97/ CBC with diff & BMP Cbcl & Lactate Echocardiogram - to repeat & Valvular dysfx Continue Vancomycin as ordered - 6-12 weeks tx Rx may be considered have serial renal US -
5/19	PCP & problems - may feed in AM -

PROGRESS NOTES

ADDRESSOGRAPH

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AIKEN REGIONAL MEDICAL CENTER

FORM NO. 601.20 (REV. 3/06) 10-2081

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Date	NOTES
	2 hrs S
	(1) · Unsteppers & Hypothermia.
	(4) MRSA urine
	on 2day + Vanco + metro/gent
	(2) Hypotension: on IV fluids
	(3) ARF. & ↑ Natremia: hydrony & IV fluids.
	(4) RS: oxygen/nipwell.
	(5) GI: awaiting swabs to decide on feeding.
	Code Status: DNR/DNI.
5/16	Whatever family wishes Re feeding tube & debridement — Body

PROGRESS NOTES

ADDRESSOGRAPH

Peterson, Wm.

102829710

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

Aiken Regional Medical Centers

302 University Parkway • Aiken, South Carolina 29802

Date	NOTES

Critical Test Result Notification

Patient Name: Peterson
Date: 5/15/06
Time Result Received: 0610
Test: K+
Result: 3.0
Test:
Result:
Test:
Result:
MD who was notified: Dr Bocklisch
Time of MD notification: 0615
☐ Result read back and verified
☐ Standing Orders in place
☑ Orders received
☐ No orders received
Comments:
Nurse's Signature: Connie Emlyn

5/16/06

PAMS

S: Pt awake, Open Eyes., Hypotensive

O: BP: 98/50, 80, 81

Cns: Sedated. RER

RS: Clear Bl

ABG: BSE

Ext: Generalized Paraplegia.

Cms: Pt not responsive to, Open Eyes

Labs: 148 | 23 | 36 (216
3.0 (19) | 1.9
11 anc - 25.7

8.3
6.6 / 190
25.1

Bobby

PROGRESS NOTES

ADDRESSOGRAPH

102829710
PETERSON SR, WILLIAM SR
DOB: [redacted] 85 SX: M IMD
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AIKEN REGIONAL MEDICAL CENTER

FORM NO. 601.20 (REV. 3/06) 10-2081

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Date	NOTES
5/12/06	Spoke to POA, daughter agree c/t Comfort measures / IVF/Abx/O2 ⊖ BV/CPR/ ∅ pressors/NO procedures. — No Surgical interventions. — Barb Sews
5/17/6	I gather from above note no deliriodenant but will check c Drs Bekkisam, Gordon Re this
5/18	ID Temp ↑ BP ↑ S. aureus in Blood (5/15) & Sputum S. aureus in culture Vancomycin levels 25.4 Creat 1.9 dosing Vancomycin per levels Rheumatology consult reasonable to obtain Procalcitonin level Dr's likely to suggest c current Rx

PROGRESS NOTES

1/1.9.0
replete
Sugars 216
CO2 19

ADDRESSOGRAPH

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PETERSON SR, WILLIAM SR
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MRN: 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

Aiken Regional Medical Centers

302 University Parkway • Aiken, South Carolina 29802

Date	NOTES
5/17/06	7 AM S!
	S: PC remain unresponsive.
	O: BP: 90/50, 16, 75 · 96.5
	PE: CVS: S1 S2 RRR.
	RS: clear b/l
	ABD: BS(+). [redacted]
	EXT: ↓ edema
	Back: ↓ ulcer. HP – ulcer ↓
	Labs: 9.16 / 220 / 150 / 123 / 41 / 166
	2 7.7 / 28.6 / 400 / 21 / 2.4.
	A/P ① Urosepsis? ↑ Hypothermia
	covered for CRT2/MRSA.
	On Zosyn + Vancof metro
	& Fenolds.
	VD-100,000 2nd blood Step
	Stop Purivs.
	② Hypotension: Continue IV fluids
	③ ARF + ↑ Natremia: on D5W
	④ RS: on Oxygen/ nebs.
	⑤ GI [redacted]
	PC Eve.

PROGRESS NOTES

ADDRESSOGRAPH

Cont feed once CATOVE

Bolus

102829710
PETERSON SR WILLIAM
DOB [redacted] 35 SX: M IMD
MRN: 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

Aiken Regional Medical Centers

302 University Parkway • Aiken, South Carolina 29802

Date	NOTES
5/16/06	Addendum: Spoke w/ family explained poss prognosis. pt family agree to DNR/DNI/Abx for now. ⊖ MV/CPR/Shock / ⊖ pressors. Comfort measures at this time.
5/17	BP 96/51 Temps ↓ Vent settings/abgs worsened somewhat recently Blood & urine cultures sent later today Soften for push w/ neosynephrine 30-40 peak start fluids

PROGRESS NOTES

ADDRESSOGRAPH

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

Aiken Regional Medical Centers

302 University Parkway • Aiken, South Carolina 29802

Date	NOTES
5/16/06	7 Hours:
	S: Pt still not responding. moves Extremities.
	O: Bp: 75/41, R-22, Sq.
	PE: CNS: Sedated
	RS: Ronchorous.
	ABD: BS(+). PEG(+)
	EXT: (RL) HP cond Sec cap cond(+).
	CNS: Pt opens & closes eyes.
	Labs: 10.6/260 150/118/35 (54)
	9.1/32.4 4.6/24/2.4
	Q-8.2
	PW pending <0.04.
	(2/p)
	A? Urosepsis c Hypothermia
	& MRSA. cont interior
	on Zosyn & Vancomy & Steroids
	IV fluids.
	Hypotension: Continue IV fluids may need pressors
	RS: on 100% oxygen. continue support
	Resp no: ORT/Neb Pneumonia 2° to Sepsis Bobby
	IV fluids
	Ord: Pt (+)
	CBT Abd/Pelvis
	Prophylaxis — ICD's. Bobby
	DVT Prophylaxis

PROGRESS NOTES

ADDRESSOGRAPH

102829710

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

FORM NO. 601.20 (REV. 3/06)

10-2981

(Mary RNIF Peterson. 649-4859.

Aiken Regional Medical Centers

302 University Parkway • Aiken, South Carolina 29802

Date	NOTES
	CC: ↓ MS / Hypothermic /
	DPDQ?
	Pmh: PSH Allergies Meds
	- ARF NKDA
	- ↑ Kalemia Cervical fusion
	Rhabdomyolysis for Spinal Stenosis
	- BPH
	- Cervical Spinal Stenosis
	S/P anterior Discectomy
	C fusion - 3/06.
	HTN.
CTOU Job# 5857990.	(P/P) (1) ↓ in mental status
	(2) Hypothermic
	(3) Hypotension.
	(4) ARF.
	Bob Glen

PROGRESS NOTES

ADDRESSOGRAPH

102829710
PETER [redacted] WILLIAM SR 85 SX: M EMR
DOB: 26525 ADM/REG DT: 05/15/06
MRN: AIKEN REGIONAL MEDICAL CENTER

FORM NO. 601.20 (REV. 3/06) 10-2081

For Facility: AIKEN REGIONAL MEDICAL CENTER

========== ENCOUNTER / UR DATA ==========

Acct No.: 102829710
Start Date: 5/15/2006
Location: 5 MAIN
Room: 503-A

Patient Name: PETERSON,WILLIAM SR
Adm Phys: BOKKISAM,CHAKRAVARTHY
Att Phys: BOKKISAM,CHAKRAVARTHY
Disch Date:
Enc Type: IP-TELE/STEP DOW(Inpatient)
ALOS:

Age: 85Y
MRN: 26523
Fac: AIKEN REGION
Current Stay: 15

DRG:
Admit Complaint: UROSEPSIS,AMS,HYPOTHERMIA
UR Diagnosis:

UR Procedure:

Dx Category:
Admit Review:

========== DISCHARGE PLANNING ==========

Case Worker: HALUPA,JENNIFER
Living Status: _____
Dependent Care: _____
Placement: _____

Discharge Phys: _____
Living Setting: _____
Dependent Care Hours: _____

Discharge Risk _____ _____

ADL Limits _____ _____

DME _____ _____

Patient Care _____ _____

Frequency _____ _____

UR Discharge Date: _____

Attribution Delay _____ _____

Discharge Screens _____ _____

Comments: 5/16/06 2:59pm Physician consulted for d/c planning. Pt is very ill at this time. Pt is from Edgefield nh. Social work contacted Corrine at Edgefield who is willing to take pt back when pt is medically stable. Jennifer Halupa LMSW

5/30/06 4:01pm CM spoke with Sara from Select and information was faxed for review. Pt. has been accepted but no bed available at this time. Sara will contact once bed is available for pt. Verita Johnson,CM

5/17/06 3:30pm Social work spoke with pt's daughter Ruth Peterson 649-4858. Ruth had questions regarding DNR and DNI. Social work educated pt's daughter. Ruth in agreement of keeping pt a DNR and DNI. Social work will continue to follow the pt. Jennifer Halupa LMSW

5/19/06 3:08pm Pt is having peg placed. Pt also will be on antibiotics for 6-8weeks. Physician in agreement of referral being made to SELECT. Social work contacted Sarah at Select and made the referral. Jennifer Halupa LMSW

5/22/06 2:00pm SELECT came and reviewed the chart. Select is willing to take the pt when bed is available. Jennifer Halupa LMSW

For Facility: AIKEN REGIONAL MEDICAL CENTER

Acct No.: 102829710 Patient Name: PETERSON,WILLIAM SR -- Age: 85Y
Facility: AIKEN REGIONAL MEDICAL CENTER

========== DISCHARGE PLANNING (continued) ==========

5/23/06 2:23PM Pt ready for d/c. Social work faxed d/c summary on pt. Select does not have a bed available at this time. Social work spoke with pt's daughter Ruth who is in agreement of pt going to Select when bed is available. Social work notified physician bed is not available at this time. Jennifer Halupa LMSW

5/24/06 5:03pm Select requested more information. Social work faxed the information on the pt. Social work gave physician the number to the admitting doctor at Select. Physician provided updated information to Select doctor. Pt should transfer tomorrow to SELECT. Chart already copied. Social work notified pt's daughter, Ruth pt will transfer tomorrow. Jennifer Halupa LMSW

5/25/06 1:40pm Pt. discharged to Select today. Kim Bryan, MSW

5/25/06 3:18pm Pt. became unstable and not able to go to Select. Kim Bryan ,MSW

503 Peterson, Willi[illegible]

Interdisciplinary Patient Care Conference Record

Date: May 23, 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*
Nursing	IV ABX x 6 weeks
Social Work	TD Select
Respiratory Therapy	
Wound Care	Following
Diabetes	
Nutrition	Tube feeding
Physical Therapy	
Chaplain	

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: _____

Signature: Mary E Grudier RN

Aiken Regional Medical Centers
302 University Parkway • Aiken, South Carolina 29802

I hereby give doctor: (Physician's Name): Dr. Hagan and/or such assistants as may be selected by him/her permission to perform: (Name of procedure(s): PEG tube placement.

_____ on (Myself or Name of Patient): _____

I consent to the administration of such anesthetics as may be considered necessary or advisable by the person responsible for such service.

I recognize that during the course of the operation, unforeseen conditions may necessitate additional or different procedures or services than those set forth above and I further authorize and request that the above-named physician or surgeon and/or his/her associates, partners, assistants or designees perform such procedures as are, in his/her professional judgement, necessary and desirable.

The: (1) diagnosis, (2) general nature of the contemplated procedure, (3) material risks involved in the procedure, (4) probability of success associated with the procedure, (5) prognosis if the procedure is not carried out, and (6) existence of any alternatives to the procedure have been fully explained to me by the physician performing the procedure. No guarantees or assurances have been made or given by anyone as to the results that may be obtained. I further acknowledge that all questions I have asked about the procedure have been answered in a satisfactory manner by my physician.

I understand I may be tested for any and all communicable diseases of any tissue or specimen which may be removed during the course of the operation.

I understand a pathologist will examine and/or dispose of any tissue or specimen which may be removed during the course of the operation.

My initials below indicate that I do or do not consent to the following:

____ **I do;** ____ **I do not;** consent to the presence of observers as authorized by the physician performing the procedure.

I, the undersigned, have read and understand the above information.

10:30
5/19/06

Witness Date/Time

X Mary Ruth Peterson Daughter
Signature of Patient

*Witness

X
Printed Name

**Two (2) witnesses are required if consent is via telephone or if patient cannot sign his/her name and only makes a mark.

Signature of Other Than Patient

I, the undersigned Physician, obtained informed consent.

Relationship to Patient Printed Name

PROCEED TO BACK FOR TIME OUT PROCEDURE

Signature of physician

Consent for Procedure/ Time Out Procedure

Patient Addressograph

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

Time Out Procedure

To be completed immediately before starting the procedure/surgery.

Initial appropriate box:

	YES	NO*	Not Applicable
Verify Patient ID	✓		
Verify H&P on chart	✓		
Verify Procedure	✓		
Verify informed consent signed by patient and physician	✓		
Verify correct side/site marked			✓
Verify correct position of patient			✓
Verify correct implants available			✓
Verify special equipment available			✓
Verify X-Ray images available, marked and displayed			✓

- All No's require clarification of discrepancy before procedure is started.

Date: 5/18/06 Time: _____

Associate Name: _____ Title: _____

Consent for Procedure/ Time Out Procedure

Patient Addressograph

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

Aiken Regional Medical Centers
302 University Parkway • Aiken, South Carolina 29802

I hereby give doctor: (Physician's Name): Hagan and/or such assistants as may be selected by him/her permission to perform: (Name of procedure(s): ESOPHAGOGASTRODUODENOSCOPY AND COLONOSCOPY

on (Myself or Name of Patient): WILLIAM PETERSON

I consent to the administration of such anesthetics as may be considered necessary or advisable by the person responsible for such service.

I recognize that during the course of the operation, unforeseen conditions may necessitate additional or different procedures or services than those set forth above and I further authorize and request that the above-named physician or surgeon and/or his/her associates, partners, assistants or designees perform such procedures as are, in his/her professional judgement necessary and desirable.

The: (1) diagnosis, (2) general nature of the contemplated procedure, (3) material risks involved in the procedure, (4) probability of success associated with the procedure, (5) prognosis if the procedure is not carried out, and (6) existence o any alternatives to the procedure have been fully explained to me by the physician performing the procedure. No guarantees or assurances have been made or given by anyone as to the results that may be obtained. I further acknowledge that al questions I have asked about the procedure have been answered in a satisfactory manner by my physician.

I understand I may be tested for any and all communicable diseases of any tissue or specimen which may be removed during the course of the operation.

I understand a pathologist will examine and/or dispose of any tissue or specimen which may be removed during the course of the operation.

My initials below indicate that I do or do not consent to the following:

____ **I do;** ____ **I do not;** consent to the presence of observers as authorized by the physician performing the procedure

I, the undersigned, have read and understand the above information.

RN 5-31-06/0830
Witness Date/Time

VO from Mary Ruth Peterson
Signature of Patient @ 649-4858

RN
*Witness

Mary Ruth Peterson
Printed Name

**Two (2) witnesses are required if consent is via telephone or if patient cannot sign his/her name and only makes a mark.

Signature of Other Than Patient

Daughter
Relationship to Patient Printed Nam

I, the undersigned Physician, obtained informed consent.

PROCEED TO BACK FOR TIME OUT PROCEDURE

Signature of physician

Consent for Procedure/ Time Out Procedure

Patient Addressograph

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

Time Out Procedure

To be completed immediately before starting the procedure/surgery.

Initial appropriate box:

	YES	NO*	Not Applicable
Verify Patient ID	✓		
Verify H&P on chart	✓		
Verify Procedure	✓		
Verify informed consent signed by patient and physician	✓		
Verify correct side/site marked			✓
Verify correct position of patient			✓
Verify correct implants available			✓
Verify special equipment available			✓
Verify X-Ray images available, marked and displayed			✓

- All No's require clarification of discrepancy before procedure is started.

Date: 5-31-16 Time: 1510

Associate Name: Teresa Cox Title: RN

Patient Addressograph

Consent for Procedure/ Time Out Procedure

Aiken Regional Medical Centers

302 University Parkway • Aiken, South Carolina 29802

Date 5-31-06 Time 1315 Physician Haigh
Admitting DX: IV Hct Anemic
ALLERGIES: NKDA

NPO Since: MN Colon Prep: Golytely
TEMP ____ ☐ Ear ☐ Oral ☐ PAIN SCORE 0
HR 70 ☐ Regular ☐ Irregular ☐ ____
RESP 20 ☐ Clear ☐ Diminished ☐ Crackles
☐ Wheeze ☐ Other ____
BP 140 / 70 Weight ____ Bowel Sounds ____
SaO2 97 % O2 ____ L/Min by ____
Psychosocial Status ☐ Alert ☐ Disoriented ☐ Other ____
Functional Status: Performs self care at home ☐ Yes ☒ No
Lives Alone ☐ Yes ☒ No Assisted By: ____
Cultural and Religious Beliefs Assessed ☒ G

☐ IP ☐ OP Contact / Phone ____
PROCEDURE EGD/colon

PRE SEDATION ASSESSMENT

☐ WNL ☐ HYPERTENSION ☐ STROKE
☐ HEART DISEASE ☐ DIALYSIS ☐ SEIZURES
☐ DIABETES ☐ CANCER ☐ GLAUCOMA
☐ HEPATITIS ☐ ASTHMA / EMPHYSEMA
☐ SURGERIES Sl Chart

Current Medications ____

Plan of Care/Education: ☒ Reviewed with patient and/or family ☐ Verbalizes understanding ☐ Return demo ☒ Reinforcement required
☒ Safety interventions - fall prevention interventions; procedure risks; post-procedure precautions
☐ Pain management - pain scale use to determine effectiveness of pain management; document interventions and patient response(s).
☐ Impaired respiratory function and/or - monitor status and utilize interventions for variances; document all variances and interventions.
☐ Education - equipment, discharge medications, follow-up care; document all instructions.

CHECK LIST	Y	N	NA
CONSENT SIGNED	N		
RIDE ARRANGED			
GLASSES REMOVED			
DENTURES REMOVED			
SIDE RAILS UP	N		
VALUABLES SECURED	N		
H&P ON CHART	N		
ARM BRACELET IN PLACE	N		
SITE MARKED BY ( ) PT ( ) MD			
SITE =			

Pre Aldrete Score	
CIRC	2
O2 Sat	2
RESP	2
ACT	2
CONC	1
TOTAL	9
SEE BACK	
Time in Room:	1500
Time out Room	1610

IV	
LOCATION	Rd
JEL CO #	
FLUID	
HEPLOCK	
# OF ATTEMPTS	
BY	

CAUTERY	
G. PAD LOT #	EXP. DATE
G. PAD SITE	
G. PAD CONDITION	PRE
	POST
CUT	COAG

RISK ASSESSMENT
☐ CLASS I - Healthy - No Systemic Disease
☐ CLASS II - Mild to Mod. Systemic Disease
☐ CLASS III - Severe Systemic Disease
☐ CLASS IV - Incapacitating Life Threatening Systemic Dis.
☐ CLASS V - Cannot Survive 24 HRs. W/O Treatment
☐ See MD Orders
MD SIGNATURE: ____

SEDATION PLAN
☒ Moderate Sedation
☐ Local Anesthesia
☐ Other

1. Procedure EGD Start ~~1530~~ 1550 Stop 1600
2. Procedure Colonoscopy Start 1530 Stop 1600

PRE-ANESTHESIA ASSESSMENT

Alert MOEXT

Time	Drug, Dose, Route	Given By	Intra-Procedure Assessment
1535	versed 2.5	JG	AWAKE
1540	demerol 30	JG	ASLEEP

Time	Pre-Score
1515	9

Time	LOC*	BP	HR	RR	O2 SAT	O2 L/MIN	EKG Rhythm	Pain Score
1515	5	168/96	60	16	100	2L	SR	0/10
1530	5	132/68	56	16	100	2L	SR	0/10
1535	3	104/55	59	16	100	2L	SR	0/10
1540	3	122/68	58	16	100	2L	SR	0/10
1545	3	105/70	55	16	100	2L	SR	0/10
1550	3	120/81	61	16	99	2L	SR	0/10
1600		130/80	63	16	98		SR	

*LOC: 5=fully awake 4=arouses to verbal stimulus 3= Arouses with tactile stimulation 2=Responsive to painful stimuli 1=Unresponsive

Specimen: ☐ Biopsy ____ ☒ Polyp ____ ☐ Washing ____ ☒ Total Spec. # ____
Lab: ☐ Histology ____ ☐ Cytology ____ ☐ Microbiology ____

Notes
Hx T2DM, N

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

PROCEDURAL SEDATION

Post Procedure Monitoring

Time	BP	P	R	O2 Sat	O2 l/m	Pain Score	LOC	Observation	Initials
1605	106/60	59	18	100	R/A	0/10	3	RESP EVEN	
1620	89/51	54	16	94	R/A	0/10	3	RESP EVEN	DC
1630	89/51	57	16	98	RA	0	3		
1645	100/54	56	16	97	RA	0	4		

Patient Safety: ☒ Side rails up ☒ Stretcher wheels locked ☒ Stretcher low position

Abdominal Assessment (if applicable): ☒ Soft ☐ Distended

Notes: _____

Discharge Care:

IV discontinued: NO Site condition: _____ Total IV fluids: 400 Total PO fluids: 0

Returned to patient: ☒ Belongings ☐ Dentures ☐ Glasses ☐ Other _____

Discharge Aldrete Score

Circulation: 2 = BP within 20% of pre-op level 1 = BP within 50%-20% of pre-op level 0 = BP 50%, or less, of pre-op level	2
O2 saturation: 2 = SpO2 >92% on room air 1 = Needs O2 to maintain SpO2 >92% 0 = SpO2 <92% with O2	2
Respiration: 2 = Free deep breathing 1 = Dyspneic or limited breathing 0 = Apneic	2
Activity: 2 = Moves all extremities 1 = Moves two extremities 0 = No movement	1
Consciousness: 2 = Fully awake 1 = Responds to name 0 = No response	1
Total Discharge Score	8
Total Pre-Procedure Score	8

Discharge or transfer per physician and/or discharge criteria met

- ☒ Patient is awake and returns to pre-procedure assessment score
- ☒ Patient easily and consistently maintains patent airway
- ☒ O2 sat at pre-procedure baseline
- ☒ Patient able to move within pre-sedation abilities
- ☒ Minimal or absent nausea
- ☒ Minimal or absent bleeding
- ☒ Ability to retain oral fluid when appropriate
- ☒ Pain adequately controlled, Pain Score 0

Comments: _____

Discharge Instructions:

- ☐ Written and verbal post procedure & sedation discharge instruction given and/or family with stated understanding
- ☐ Additional Education Material given to patient:
  List: _____
- ☐ Discharge prescriptions given to patient
- ☐ Medication use explained to patient with stated understanding

Patient Discharged to: ☐ Home, in the care of responsible adult: _____

☒ Hospital Unit: 503 Report given to: _____

Mode: ☒ wheelchair ☐ stretcher ☐ bed ☐ ambulatory

Discharge Time: 1645 Nurse Signature: _____

ADDRESSOGRAPH

102829710

PETERSON SR WILLIAM SR

DOB: 03/11/1921 85 SX: M IMD

MRN: 26523 ADM/REG DT: 05/15/06

AIKEN REGIONAL MEDICAL CENTER

Aiken Regional Medical Centers

302 University Parkway • Aiken, South Carolina 29802

Date 5/19/06 Time 1120 Physician Hagan ☒IP ☐OP Contact / Phone 503

Admitting DX:

PROCEDURE ESD c PEG

ALLERGIES: NKA

PRE SEDATION ASSESSMENT

☐WNL ☒HYPERTENSION ☐STROKE

☐HEART DISEASE ☐DIALYSIS ☐SEIZURES

☐DIABETES ☐CANCER ☐GLAUCOMA

☐HEPATITIS ☐ASTHMA / EMPHYSEMA

☒SURGERIES Post Anterior discect & Fusion, C

NPO Since: MN Colon Prep: N/A

TEMP Unable to get ☐Ear ☐Oral ☒PAIN SCORE 0-2/10

HR 74 ☐Regular ☐Irregular ☐

RESP 22 ☐Clear ☐Diminished ☐Crackles ☐Wheeze ☐Other

BP 171, 122 Weight Bowel Sounds

SaO2 95 % O2 40 L/Min by mask

Psychosocial Status ☐Alert ☒Disoriented ☐Other

Functional Status: Performs **self care** at home ☐Yes ☒No

Lives Alone ☐Yes ☒No Assisted By:

Cultural and Religious Beliefs Assessed ☒

Current Medications See MAR Reviewed

Plan of Care/Education: ☐Reviewed with patient and/or family ☒Verbalizes understanding ☐Return demo ☐Reinforcement required

☒Safety interventions - fall prevention interventions; procedure risks; post-procedure precautions

☒Pain management - pain scale use to determine effectiveness of pain management; document interventions and patient response(s).

☒Impaired respiratory function and/or - monitor status and utilize interventions for variances; document all variances and interventions.

☒Education - equipment, discharge medications, follow-up care; document all instructions.

CHECK LIST	Y	N	NA
CONSENT SIGNED	☒		
RIDE ARRANGED			☒
GLASSES REMOVED			☒
DENTURES REMOVED			☒
SIDE RAILS UP	☒		
VALUABLES SECURED			☒
H&P ON CHART	☒		
ARM BRACELET IN PLACE	☒		
SITE MARKED BY ( ) PT ( ) MD			
SITE =			

Pre Aldrete Score: CIRC 2, O2 Sat 2, RESP 2, ACT 2, CONC 2, TOTAL 10, SEE BACK

Time in Room: 1140 Time out Room: 1305

IV	CAUTERY	
LOCATION	G. PAD LOT #	EXP DATE
JEL CO # exempt	G. PAD SITE	
FLUID	G. PAD CONDITION	PRE
HEPLOCK		POST
# OF ATTEMPTS	CUT	COAG
BY		

RISK ASSESSMENT
☐CLASS I - Healthy - No Systemic Disease
☐CLASS II - Mild to Mod. Systemic Disease
☐CLASS III - Severe Systemic Disease
☐CLASS IV - Incapacitating/Life Threatening Systemic Dis.
☐CLASS V - Cannot Survive 24 Hrs. W/O Treatment
☒See MD Orders

SEDATION PLAN
☒Moderate Sedation
☐Local Anesthesia
☐Other

MD SIGNATURE:

1. Procedure ESD c PEG Start 1150 Stop 1200
2. Procedure Start Stop

PRE-ANESTHESIA ASSESSMENT

obtunded

Time	Pre-Score	BP	H	R	O2 SAT	O2 L/MIN	EKG Rhythm	Pain Score
1150	5	95/53	68	16	98	2L	SR	8/10

Time	Drug, Dose, Route	Given By	Intra-Procedure Assessment
1140	Demerol 20mg	N	IV
1142	Versed 1.5mg	N	IV
			AWAKE ASLEEP

Time	LOC*	BP	HR	RR	O2 SAT	O2 L/MIN	EKG Rhythm	Pain Score
1150	5	109/59	72	16	100	2L	SR	0
1155	5	105/59	69	16	99	2L	SR	0
1200	5	100/50	72	16	96	2L	SR	0

*LOC: 5=fully awake 4=arouses to verbal stimulus 3= Arouses with tactile stimulation 2=Responsive to painful stimuli 1=Unresponsive

Specimen: ☐Biopsy ☐Polyp ☐Washing ☐Total Spec. # 0

Lab: ☐Histology ☐Cytology ☐Microbiology

Notes

No T Dayton

ADDRESSOGRAPH

102829710

PETERSON SR, WILLIAM SR

DOB: [redacted] 85 SX: M IMD

MRN: 26523 ADM/REG DT: 05/15/06

AIKEN REGIONAL MEDICAL CENTER

PROCEDURAL SEDATION

637.06 (1/06) 10-9400

Post Procedure Monitoring

Time	BP	P	R	O2 Sat	O2 l/m	Pain Score	LOC	Observation	Initials
1205	108/58	70	16	100	½	0	?	Aphasic	[illegible]
1220	110/63	67	14	100	40% venti mask	0	3		[illegible]
1235	138/80	62	16	100	40% venti	–	3		[illegible]
1255	129/72	66	16	100	40% venti	0	4		[illegible]

Patient Safety: ☒ Side rails up ☒ Stretcher wheels locked ☐ Stretcher low position

Abdominal Assessment (if applicable): ☒ Soft ☐ Distended

Notes: _____

Discharge Care:

IV discontinued: NO Site condition: WNL Total IV fluids: 400 Total PO fluids: 0

Returned to patient: ☒ Belongings ☐ Dentures ☐ Glasses ☐ Other _____

Discharge Aldrete Score

Circulation: 2 = BP within 20% of pre-op level 1 = BP within 50%-20% of pre-op level 0 = BP 50%, or less, of pre-op level	2
O2 saturation: 2 = SpO2 >92% on room air 1 = Needs O2 to maintain SpO2 >92% 0 = SpO2 <92% with O2	2
Respiration: 2 = Free deep breathing 1 = Dyspneic or limited breathing 0 = Apneic	2
Activity: 2 = Moves all extremities 1 = Moves two extremities 0 = No movement	2
Consciousness: 2 = Fully awake 1 = Responds to name 0 = No response	1
Total Discharge Score	9
Total Pre-Procedure Score	9

Discharge or transfer per physician and/or discharge criteria met

- ☒ Patient is awake and returns to pre-procedure assessment score
- ☒ Patient easily and consistently maintains patent airway
- ☒ O2 sat at pre-procedure baseline
- ☒ Patient able to move within pre-sedation abilities
- ☒ Minimal or absent nausea
- ☒ Minimal or absent bleeding
- ☒ Ability to retain oral fluid when appropriate
- ☒ Pain adequately controlled, Pain Score _____

Comments: _____

Discharge Instructions:

- ☒ Written and verbal post procedure & sedation discharge instruction given and/or family with stated understanding
- ☐ Additional Education Material given to patient:

List: _____

- ☐ Discharge prescriptions given to patient
- ☐ Medication use explained to patient with stated understanding

Patient Discharged to: ☐ Home, in the care of responsible adult: _____

☒ Hospital Unit: 503 Report given to: Vera, RN

Mode: ☐ wheelchair ☐ stretcher ☐ bed ☐ ambulatory

Discharge Time: 1300 Nurse Signature: [signature]

ADDRESSOGRAPH

102829710

PETERSON SR, WILLIAM SR

DOB: [redacted] 85 SX: M IMD

MRN: 26523 ADM/REG DT: 05/15/06

AIKEN REGIONAL MEDICAL CENTER

Aiken Regional Medical Centers

302 University Parkway • Aiken, South Carolina 29802

Date 5/25/06 Time _____ Physician Savitto ☒ IP ☐ OP Contact / Phone _____

Admitting DX: bed sores, dementia PROCEDURE Bronch

ALLERGIES: NKDA

NPO Since: MN Colon Prep: NA

TEMP NA ☐ Ear ☐ Oral ☐ PAIN SCORE 0

HR 103 ☒ Regular ☐ Irregular ☐ _____

RESP 31 ☐ Clear ☐ Diminished ☐ Crackles ☐ Wheeze ☐ Other _____

BP 168/83 Weight 180/65 Bowel Sounds NA

SaO2 95 % O2 4 L/Min by Venturi mask

Psychosocial Status ☐ Alert ☐ Disoriented ☐ Other _____

Functional Status: Performs **self care** at home ☐ Yes ☐ No

Lives Alone ☐ Yes ☒ No Assisted By: Nursing Home

Cultural and Religious Beliefs Assessed ☒

PRE SEDATION ASSESSMENT

☐ WNL ☒ HYPERTENSION ☐ STROKE

☐ HEART DISEASE ☐ DIALYSIS ☐ SEIZURES

☐ DIABETES ☐ CANCER ☐ GLAUCOMA

☐ HEPATITIS ☐ ASTHMA / EMPHYSEMA

☒ SURGERIES Diskectomy 2006, neurogenic bladder

Acute Renal Failure

Current Medications Ultram, Norvasc, Prinachin, Ultram

Plan of Care/Education: ☒ Reviewed with patient and/or family ☒ Verbalizes understanding ☐ Return demo ☐ Reinforcement required

☒ Safety interventions - fall prevention interventions; procedure risks; post-procedure precautions

☒ Pain management - pain scale use to determine effectiveness of pain management; document interventions and patient response(s).

☒ Impaired respiratory function and/or - monitor status and utilize interventions for variances; document all variances and interventions.

☒ Education - equipment, discharge medications, follow-up care; document all instructions.

CHECK LIST	Y	N	NA
CONSENT SIGNED	✓		
RIDE ARRANGED			✓
GLASSES REMOVED			✓
DENTURES REMOVED	✓		
SIDE RAILS UP	✓		
VALUABLES SECURED	✓		✓
H&P ON CHART	✓		
ARM BRACELET IN PLACE	✓		
SITE MARKED BY ( ) PT ( ) MD			✓
SITE =			

Pre Aldrete Score	
CIRC	2
O2 Sat	2
RESP	2
ACT	1
CONC	1
TOTAL	8
SEE BACK	
Time in Room:	1245
Time out Room:	1327

IV		CAUTERY	
LOCATION	R forearm	G. PAD LOT #	EXP. DATE
JEL CO #	20	G. PAD SITE	
FLUID	NS 500	G. PAD CONDITION	PRE
HEPLOCK	Yes flushed		POST
# OF ATTEMPTS	1	CUT	COAG
BY	RN Mann		

RISK ASSESSMENT
☐ CLASS I - Healthy - No Systemic Disease
☐ CLASS II - Mild to Mod. Systemic Disease
☒ CLASS III - Severe Systemic Disease
☐ CLASS IV - Incapacitating/Life Threatening Systemic Dis.
☐ CLASS V - Cannot Survive 24 HRs. W/O Treatment
☒ See MD Orders
MD SIGNATURE: [signature]

SEDATION PLAN
☒ Moderate Sedation
☐ Local Anesthesia
☐ Other: _____

1. Procedure Bronch Start 1247 Stop 1327

2. Procedure _____ Start _____ Stop _____

PRE-ANESTHESIA ASSESSMENT

Resp. Therapist: E. Barsamian RRT

Time	Drug, Dose, Route	Given By	Intra-Procedure Assessment
1326	Washing sample		

Time	Pre-Score	BP	H	R	O2 SAT	O2 L/MIN	EKG Rhythm	Pain Score

Time	LOC*	BP	HR	RR	O2 SAT	O2 L/MIN	EKG Rhythm	Pain Score
1320	4	151/74	102	20	99	4	Sinus	0
1325	4	190/91	111	20	96	4	Sinus Tach	0

*LOC: 5=fully awake 4=arouses to verbal stimulus 3= Arouses with tactile stimulation 2=Responsive to painful stimuli 1=Unresponsive

Specimen: ☐ Biopsy _____ ☐ Polyp _____ ☐ Washing ✓ ☐ Total Spec. # 1

Lab: ☐ Histology _____ ☐ Cytology ✓ ☐ Microbiology ✓

Notes

JK RS Kotowski RN

ADDRESSOGRAPH

102829710

PETERSON SR, WILLIAM SR

DOB: [redacted] 85 SX: M IMD

MRN: 26523 ADM/REG DT: 05/15/06

AIKEN REGIONAL MEDICAL CENTER

PROCEDURAL SEDATION

637.06 (1/06) 10-9400

Post Procedure Monitoring

Time	BP	P	R	O2 Sat	O2 l/m	Pain Score	LOC	Observation	Initials
1330	154/88	98	17	97	4	0	4	Venturi mask	HK
1335	134/78	90	17	96	4	0	4	Venturi mask	HK

Patient Safety: ☒ Side rails up ☒ Stretcher wheels locked ☐ Stretcher low position

Abdominal Assessment (if applicable): ☐ Soft ☐ Distended

Notes: _____

Discharge Care:

IV discontinued: NO Site condition: WNL Total IV fluids: 25 & NS Total PO fluids: none

Returned to patient: ☐ Belongings ☐ Dentures ☐ Glasses ☐ Other _____

Discharge Aldrete Score

Circulation: 2 = BP within 20% of pre-op level 1 = BP within 50%-20% of pre-op level 0 = BP 50%, or less, of pre-op level	2
O2 saturation: 2 = SpO2 >92% on room air 1 = Needs O2 to maintain SpO2 >92% 0 = SpO2 <92% with O2	2
Respiration: 2 = Free deep breathing 1 = Dyspneic or limited breathing 0 = Apneic	2
Activity: 2 = Moves all extremities 1 = Moves two extremities 0 = No movement	1
Consciousness: 2 = Fully awake 1 = Responds to name 0 = No response	1
Total Discharge Score	8
Total Pre-Procedure Score	

Discharge or transfer per physician and/or discharge criteria met

- ☒ Patient is awake and returns to pre-procedure assessment score
- ☒ Patient easily and consistently maintains patent airway
- ☒ O2 sat at pre-procedure baseline
- ☒ Patient able to move within pre-sedation abilities w/ sedation
- ☒ Minimal or absent nausea
- ☒ Minimal or absent bleeding
- ☐ Ability to retain oral fluid when appropriate
- ☒ Pain adequately controlled, Pain Score 0

Comments: _____

Discharge Instructions:

- ☐ Written and verbal post procedure & sedation discharge instruction given and/or family with stated understanding
- ☐ Additional Education Material given to patient:

List: _____

- ☐ Discharge prescriptions given to patient
- ☐ Medication use explained to patient with stated understanding

Patient Discharged to: ☐ Home, in the care of responsible adult: _____

☒ Hospital Unit: 5-Main Report given to: B Peterson

Mode: ☐ wheelchair ☐ stretcher ☐ bed ☐ ambulatory

Discharge Time: _____ Nurse Signature: H. Kotenkhi RN

ADDRESSOGRAPH

102829710

PETERSON SR, WILLIAM SR

DOB: [redacted] 85 SX: M IMD

MRN: 26523 ADM/REG DT: 05/15/06

AIKEN REGIONAL MEDICAL CENTER

Contact Isolation — H — DNR — H — MRSA -916- INR 1.2 PT 14.9 PTT 33.3

Aiken Regional Medical Centers

302 University Parkway • Aiken, South Carolina 29802

Date 5/16/06 Time 1600 Physician Robertson ☒ IP ☐ OP Contact / Phone

Admitting DX: Change in Mental Status, Hypothermia PROCEDURE Thoracentesis

ALLERGIES: NKA

PRE SEDATION ASSESSMENT

☐ WNL ☒ HYPERTENSION ☒ STROKE
☐ HEART DISEASE ☐ DIALYSIS ☐ SEIZURES
☐ DIABETES ☐ CANCER ☐ GLAUCOMA
☐ HEPATITIS ☐ ASTHMA / EMPHYSEMA
☐ SURGERIES Acute renal failure

NPO Since: 0.56 Feeding Colon Prep:

TEMP ☐ Ear ☒ Oral ☐ PAIN SCORE 0/10

HR 101 ☐ Regular ☐ Irregular ☐

RESP 22 ☐ Clear ☐ Diminished ☐ Crackles ☐ Wheeze ☐ Other

Refer to H&P

BP 146/76 Weight Bowel Sounds

SaO2 100 % O2 4 L/Min by 28/70 Venti MASK

Psychosocial Status ☐ Alert ☐ Disoriented ☐ Other Obtunded

Functional Status: Performs **self care** at home ☐ Yes ☒ No

Lives Alone ☐ Yes ☒ No Assisted By:

Cultural and Religious Beliefs Assessed ☒ Family

Current Medications Refer to MAR

Plan of Care/Education: ☒ Reviewed with patient and/or family ☒ Verbalizes understanding ☐ Return demo ☐ Reinforcement required

☒ Safety interventions - fall prevention interventions; procedure risks; post-procedure precautions

☐ Pain management - pain scale use to determine effectiveness of pain management; document interventions and patient response(s).

☒ Impaired respiratory function and/or - monitor status and utilize interventions for variances; document all variances and interventions.

☐ Education - equipment, discharge medications, follow-up care; document all instructions.

CHECK LIST	Y	N	NA
CONSENT SIGNED	✓		
RIDE ARRANGED			✓
GLASSES REMOVED			✓
DENTURES REMOVED			✓
SIDE RAILS UP	✓		
VALUABLES SECURED			✓
H&P ON CHART	✓		
ARM BRACELET IN PLACE			✓
SITE MARKED BY ( ) PT (X) MD			✓
SITE = (R) lower lung lobe			✓

Pre Aldrete Score	
CIRC	2
O2 Sat	2
RESP	2
ACT	2
CONC	2
TOTAL	10
SEE BACK	
Time in Room:	
Time out Room:	

IV	
LOCATION	R hand
JEL CO #	
FLUID	
HEPLOCK	in area
# OF ATTEMPTS	
BY	

CAUTERY	
G. PAD LOT #	EXP. DATE
G. PAD SITE	
G. PAD CONDITION	PRE
	POST
CUT	COAG

RISK ASSESSMENT
☐ CLASS I - Healthy - No Systemic Disease
☐ CLASS II - Mild To Mod. Systemic Disease
☐ CLASS III - Severe Systemic Disease
☐ CLASS IV - Incapacitating Life Threatening Systemic Dis
☐ CLASS V - Cannot Survive 24 HRS - W/O Treatment
☐ See MD Orders

MD SIGNATURE:

SEDATION PLAN
☒ Moderate Sedation
☐ Local Anesthesia
☐ Other:

1. Procedure Thoracentesis Start 1645 Stop 1655

2. Procedure Start Stop

PRE-ANESTHESIA ASSESSMENT

Time	Pre-Score	BP	HR	RR	O2 SAT	O2 L/MIN	EKG Rhythm	Pain Score
1615	Obtunded	153/82	100	19	96	4L Venti 28%	99	0/10

Time	Drug, Dose, Route	Given By	Intra-Procedure Assessment
1645	Xylocaine 1% - Buffered 5cc SQ Jai Dr. Robinson 5cc		Tolerating Procedure VSS
			Post I/S no SOB. VSS.

Time	LOC*	BP	HR	RR	O2 SAT	O2 L/MIN	EKG Rhythm	Pain Score
1645	Obtunded	165/81	97	22	98	4L Venti 30%	SR	0/10
1650	Obtunded	149/83	97	20	97	4L Venti 30%	SR	0/10
1655	Obtunded	139/61	93	16	95	4L Venti 30%	SR	0/10
1700	Obtunded	155/83	94	22	98	28%	SR	0/10
1710	Obtunded	158/79	100	20	98	28%	SR	0/10

*LOC: 5=fully awake 4=arouses to verbal stimulus 3= Arouses with tactile stimulation 2=Responsive to painful stimuli 1=Unresponsive

Specimen: ☐ Biopsy ☐ Polyp ☐ Washing ☐ Total Spec. # Glucose Protein LDH Sp. Gravity Gram Stain C/S

Lab: ☐ Histology ☐ Cytology ☐ Microbiology

Notes 1655 Thoracentesis Fluid = 350ml and sent for Analysis

Dr. J.M. Hunter, Jr.

ADDRESSOGRAPH

102829710

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

PROCEDURAL SEDATION

637.06 (1/06) 10-9400

NO Conscious Sedation

Post Procedure Monitoring

Time	BP	P	R	O2 Sat	O2 l/m	Pain Score	LOC	Observation	Initials

Patient Safety: ☒ Side rails up ☒ Stretcher wheels locked ☒ Stretcher low position

Abdominal Assessment (if applicable): ☐ Soft ☐ Distended NA

Notes: _____

Discharge Care:

IV discontinued: NA Site condition: No adverse reactions Total IV fluids: _____ Total PO fluids: _____

Returned to patient: ☐ Belongings ☐ Dentures ☐ Glasses ☐ Other NA

Discharge Aldrete Score

Circulation: 2 = BP within 20% of pre-op level 1 = BP within 50%-20% of pre-op level 0 = BP 50%, or less, of pre-op level	2
O2 saturation: 2 = SpO2 >92% on room air 1 = Needs O2 to maintain SpO2 >92% 0 = SpO2 <92% with O2	2
Respiration: 2 = Free deep breathing 1 = Dyspneic or limited breathing 0 = Apneic	2
Activity: 2 = Moves all extremities 1 = Moves two extremities 0 = No movement	2
Consciousness: 2 = Fully awake 1 = Responds to name 0 = No response	2
Total Discharge Score	10
Total Pre-Procedure Score	10

Discharge or transfer per physician and/or discharge criteria met

- ☒ Patient is awake and returns to pre-procedure assessment score
- ☒ Patient easily and consistently maintains patent airway
- ☒ O2 sat at pre-procedure baseline
- ☒ Patient able to move within pre-sedation abilities
- ☒ Minimal or absent nausea
- ☒ Minimal or absent bleeding
- ☒ Ability to retain oral fluid when appropriate
- ☒ Pain adequately controlled, Pain Score 0/10

Comments: _____

Discharge Instructions:

- ☐ Written and verbal post procedure & sedation discharge instruction given and/or family with stated understanding NA
- ☐ Additional Education Material given to patient:

List: _____

- ☐ Discharge prescriptions given to patient
- ☐ Medication use explained to patient with stated understanding

Patient Discharged to: ☐ Home, in the care of responsible adult: _____

☒ Hospital Unit: Done in for SOS Report given to: April Hassell, LVN

Mode: ☐ wheelchair ☐ stretcher ☐ bed ☐ ambulatory

Discharge Time: 1920 Nurse Signature: AHassell LVN 1720 5/26/06

ADDRESSOGRAPH

Aiken Regional Medical Centers

302 University Parkway • Aiken, South Carolina 29802

Date: 5/26/06 Time: 1520

My physician, Dr. Robinson, has explained to me that the administration of blood or blood components is recommended and/or advisable.

The major risks associated with this treatment are: 1) Fever, 2) Allergic reaction, 3) Transfusion reaction which may include kidney failure or anemia, 4) Heart failure, 5) Hepatitis, 6) AIDS (Acquired Immune Deficiency Syndrome), 7) Other infections.

My physician has fully explained to me: 1) The probability of success associated with the treatment, 2) prognosis if the treatment is not carried out, and 3) existence of any alternatives to the treatment.

No guarantees or assurances have been made or given by anyone as to the success or other results of the medical treatment. I further acknowledge that all questions I have asked about the treatment have been answered in a satisfactory manner by my physician.

I have read and understand all information written in this document. All blanks were filled in prior to my signing. This authorization and consent for the administration or refusal of blood and blood components is and shall remain valid until revoked by me in writing.

☑ I give consent for administration of blood and blood components.

☐ I refuse the administration of blood and blood components. This applies even if death is imminent without transfusion.

☐ I give consent for the transfusion of the following: ☐ Auto-transfusion (intra-operative or post-operative transfusion)

☐ Other: _____

Witness 5/26/06 — Signature of Patient / *PRINTED* Name

Witness #2* 5/26/06 1520 — Signature of Person Authorized to Consent / *PRINTED* Name

*Two (2) witnesses are required only if consent is via telephone, or if patient cannot sign his/her name and only makes a mark.

Relationship to Patient of Person Authorized to Consent

****

When ***refusing*** and signing for a ***minor*** child, please note:

If during the course of treatment, an emergency arises which allows no time for the medical team to report the matter to child welfare authorities, the team will do its best to honor your refusal and treat your child without blood. If, however, in such a situation the treating physicians deem blood is immediately necessary to save your child's life and/or is essential to the health of your child, to avoid permanent damage to his/her tissues, organs or body functions, the law permits the physician to administer blood to your child notwithstanding your refusal.

☐ I refuse the administration of blood and blood components to my minor child.

I, _____ (Name of Parent/Guardian) have read and understand the statement above. My signing of this statement should be construed only as an acknowledgement of my awareness of what the law may provide for in a true emergency. It should not be viewed in any way as authorization for a blood transfusion, nor as relinquishing any of my rights by law to decide and control what medical care should or should not be administered to my child.

Printed Name of the Minor Child — Signature of Parent or Legal Guardian / *PRINTED* Name

Signature of Witness / *PRINTED* Name

Consent/Refusal For Blood Products

Addressograph

102829710

PETERSON SR, WILLIAM SR

DOB: [redacted] 85 SX: M IMD

MRN: 26523 ADM/REG DT: 05/15/06

AIKEN REGIONAL MEDICAL CENTER

601.90A (3/04) 10-33016

503A

AIKEN REGIONAL MEDICAL CENTER
302 UNIVERSITY PARKWAY
AIKEN, SOUTH CAROLINA 29802

PATIENT: PETERSON, WILLIAM SR
MR#: 026523
SURGERY DATE: 05/31/2006
ACCT#: 102829710
CC:

SURGEON:
James Hagan, M.D.

ASSISTANT:

PROCEDURE PERFORMED: Colonoscopy.

PREPROCEDURE DIAGNOSIS: Anemia.

POSTPROCEDURE DIAGNOSIS:
1. A small benign appearing polyp at 45 cm.
2. Extensive diverticulosis of the sigmoid and descending colon.

DESCRIPTION OF PROCEDURE: The patient was placed in the left lateral decubitus position on the endoscopy table and following a normal rectal examination, the colonoscope was passed in the rectum without difficulty. Air was insufflated and the scope was advanced through the sigmoid and descending colon. There was noted to be extensive diverticulosis. The scope was then advanced without difficulty around the transverse and ascending portions of the colon and cecum. The cecum was normal in appearance. The scope was withdrawn gradually and a circumferential view of the colon was taken. Bowel prep was fairly good As the scope was withdrawn a small polyp (see photograph) was noted at 45 cm. It was benign in appearance. There was no evidence of bleeding. A biopsy was taken. Then, the scope was withdrawn the remainder of the way, the rest of the colon being visualized and no other abnormalities being noted. The procedure was terminated at this point, the patient having tolerated it well.

James Hagan, M.D.

649299/MedQ
DD: 05/31/2006 21:11:09
DT: 06/01/2006 10:27:42

AIKEN REGIONAL MEDICAL CENTER
302 UNIVERSITY PARKWAY
AIKEN, SOUTH CAROLINA 29802

PATIENT: PETERSON, WILLIAM SR MR#: 026523
SURGERY DATE: 05/19/2006 ACCT#: 102829710
CC:

SURGEON:
James Hagan, M.D.

ASSISTANT:

PROCEDURE PERFORMED: Esophagogastroduodenoscopy with insertion of percutaneous feeding tube.

PRE-PROCEDURE DIAGNOSIS: Post cerebrovascular accident (CVA) with poor nutrition, inability to swallow effectively.

POST-PROCEDURE DIAGNOSIS: Post CVA with poor nutrition, inability to swallow effectively.

PROCEDURE: The patient was placed in the supine position on the endoscopy table. Following administration of a small amount of intravenous sedation and topical anesthetization of the pharynx, the patient was turned into the left lateral decubitus position. Pediatric gastroscope was passed without difficulty into the esophagus and down into the stomach. Then area of the left upper quadrant was marked directly over the stomach with a skin marking pen and that area of the abdominal wall was prepped with Betadine and infiltrated with 1% Xylocaine local anesthetic. Then under direct vision with the gastroscope, the needle was passed into the anterior wall of the stomach. Guide wire passed through the needle was retrieved through the mouth with biopsy forceps. PEG feeding tube was secured to the guide wire and then pulled back through the esophagus and stomach out onto the skin. It was secured in place with a flange snugged against the skin. Gastroscope was passed, once again, and the stomach and the tube were found to be in good position with its buttress against the anterior gastric wall. The tube was secured to the skin with 2-0 Vicryl suture and an abdominal binder placed over the tube to further help prevent dislodgement. At this point, the patient had tolerated the procedure well and was returned to the observation area in stable condition.

James Hagan, M.D.

603815/MedQ
DD: 05/19/2006 14:45:35
DT: 05/20/2006 09:01:26

503A

AIKEN REGIONAL MEDICAL CENTER
302 UNIVERSITY PARKWAY
AIKEN, SOUTH CAROLINA 29802

PATIENT: PETERSON, WILLIAM SR
SURGERY DATE: 06/01/2006
CC:

MR#: 026523
ACCT#: 102829710

SURGEON:
James Hagan, M.D.

ASSISTANT:

PROCEDURE PERFORMED: Esophagogastroduodenoscopy.

PREPROCEDURE DIAGNOSIS: Anemia requiring transfusion.

POSTPROCEDURE DIAGNOSIS: Erosion in the area of the feeding tube.

DESCRIPTION OF PROCEDURE: The patient was placed in the supine position on the endoscopy table and then turned into the left lateral decubitus position. The throat was anesthetized using topical Xylocaine and pediatric gastroscope was passed without difficulty down the esophagus and into the stomach. The pylorus was visualized and felt to be normal in appearance. Scope was passed into the duodenum. A circumferential view was taken to the duodenal bulb and first portion of the duodenum. No abnormalities were noted. The scope was withdrawn into the stomach and retroflexed. No lesions of the proximal stomach were noted. There was noted to be an area of erosion adjacent to the feeding tube site. The feeding tube had been placed approximately one month prior to this procedure. Then, the scope was withdrawn through a normal-appearing esophagogastric junction of the esophagus. A circumferential view of the esophagus was taken as the scope was withdrawn to the mouth. No other abnormalities were noted at this point. The procedure terminated at this point, the patient having tolerated it well.

James Hagan, M.D.

649285/MedQ
DD: 06/31/2006 21:07:51
DT: 06/01/2006 10:20:51

PROCEDURE FINDINGS

DATE: 5/19/6

PROCEDURE: EGD/PEG

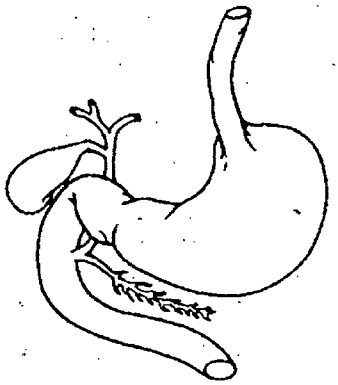
ESOPHAGUS: nl

STOMACH: nl

DUODENUM: non viz

SMALL INTESTINE: 0

POST-OP DIAGNOSIS: nl Stomach



RECOMMENDATIONS: May use peg in 4hrs.

ESTIMATED BLOOD LOSS

SPECIMEN

PHYSICIAN SIGNATURE

ADDRESSOGRAPH

Aiken Regional Medical Centers

302 University Parkway • Aiken, South Carolina 29802

HISTORY AND PHYSICAL

☐ H&P within 30 days - No Change ☐ H&P within 30 days - Changes in H&P noted below

Chief Complaint _____

Procedure / Indications _____

Pertinent Past Med HS/Surgeries _____

_____

Risk Assessment:
- ☐ Class I - Healthy - No systemic disease
- ☐ Class II - Mild to moderate systemic disease
- ☐ Class III - Severe systemic disease
- ☐ Class IV - Incapacitating/life threatening systemic disease
- ☐ Class V - Cannot survive 24 hrs w/o treatment

Cleared for Conscious Sedation ☐ Yes ☐ No

Anesthesia Plan: ☐ Conscious sedation ☐ Other _____

Conscious Sedation risks / options discussed with patient ☐ Yes

PROCEDURE ORDERS

DELIVER TO ENDOSCOPY FOR EGD c PEG insertion

1) Start IV with
   - ___ 1000 cc Normal Saline
   - ___ 1000 cc D5 W
   - ___ 1000 cc Lactated Ringers
2) Spray Throat with Cetacaine Topical Spray
3) Procedural Meds:
   - Versed 1.5 mgm IV
   - Demerol 20 mgm IV
   - Other _____
4) Observe patient for 15-40 minutes post-procedure
5) D/C IV:
6) NPO until numbness is gone
7) D/C Home when awake, alert, and stable
8) Follow up appointment on _____
9) Other _____

noted D.Ec 5+9 1pp

DATE 5/19/06 PHYSICIAN SIGNATURE _____

ADDRESSOGRAPH

ENDOSCOPY GASTRIC PROCEDURE NOTES

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

Aiken Regional Medical Centers
302 University Parkway • Aiken, South Carolina 29802

I hereby give doctor: (Physician's Name): Smith and/or such assistants as may be selected by him/her permission to perform: (Name of procedure(s): Bronchoscopy to remove secretions)

on (Myself or Name of Patient): Raymond Peterson

I consent to the administration of such anesthetics as may be considered necessary or advisable by the person responsible for such service.

I recognize that during the course of the operation, unforeseen conditions may necessitate additional or different procedures or services than those set forth above and I further authorize and request that the above-named physician or surgeon and/or his/her associates, partners, assistants or designees perform such procedures as are, in his/her professional judgement, necessary and desirable.

The: (1) diagnosis, (2) general nature of the contemplated procedure, (3) material risks involved in the procedure, (4) probability of success associated with the procedure, (5) prognosis if the procedure is not carried out, and (6) existence of any alternatives to the procedure have been fully explained to me by the physician performing the procedure. No guarantees or assurances have been made or given by anyone as to the results that may be obtained. I further acknowledge that all questions I have asked about the procedure have been answered in a satisfactory manner by my physician.

I understand I may be tested for any and all communicable diseases of any tissue or specimen which may be removed during the course of the operation.

I understand a pathologist will examine and/or dispose of any tissue or specimen which may be removed during the course of the operation.

My initials below indicate that I do or do not consent to the following:

____ **I do;** ____ **I do not;** consent to the presence of observers as authorized by the physician performing the procedure.

I, the undersigned, have read and understand the above information. Via Telephone

Rachel Rice RN 1105 5/25/06 — Witness / Date/Time

Per daughter Mary Ruth Peterson — Signature of Patient

S Schander RN 1105 5/25/06 — *Witness

Printed Name

**Two (2) witnesses are required if consent is via telephone or if patient cannot sign his/her name and only makes a mark.

Signature of Other Than Patient

Relationship to Patient — Printed Name

I, the undersigned Physician, obtained informed consent.

Signature of physician

PROCEED TO BACK FOR TIME OUT PROCEDURE

Consent for Procedure/ Time Out Procedure

Patient Addressograph

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

Time Out Procedure

To be completed immediately before starting the procedure/surgery.

Initial appropriate box:

	YES	NO*	Not Applicable
Verify Patient ID	✓ MC		
Verify H&P on chart	✓ MC		
Verify Procedure	✓ MC		
Verify informed consent signed by patient and physician	✓ MC		
Verify correct side/site marked			✓
Verify correct position of patient	✓ MC		
Verify correct implants available			✓
Verify special equipment available			✓
Verify X-Ray images available, marked and displayed			✓

- All No's require clarification of discrepancy before procedure is started.

Date: 5/25/06 Time: 1320

Associate Name: G. Kaczynski Title: RN

Consent for Procedure/ Time Out Procedure

Patient Addressograph

Aiken Regional Medical Centers
302 University Parkway • Aiken, South Carolina 29802

I hereby give doctor: (Physician's Name): Dr. Robinson and/or such assistants as may be selected by him/her permission to perform: (Name of procedure(s): Thora Centesis (removal of pleural fluid from thoracic (lung) possible complications bleeding and/or collapse lung.

on (Myself or Name of Patient): myself

I consent to the administration of such anesthetics as may be considered necessary or advisable by the person responsible for such service.

I recognize that during the course of the operation, unforeseen conditions may necessitate additional or different procedures or services than those set forth above and I further authorize and request that the above-named physician or surgeon and/or his/her associates, partners, assistants or designees perform such procedures as are, in his/her professional judgement, necessary and desirable.

The: (1) diagnosis, (2) general nature of the contemplated procedure, (3) material risks involved in the procedure, (4) probability of success associated with the procedure, (5) prognosis if the procedure is not carried out, and (6) existence of any alternatives to the procedure have been fully explained to me by the physician performing the procedure. No guarantees or assurances have been made or given by anyone as to the results that may be obtained. I further acknowledge that all questions I have asked about the procedure have been answered in a satisfactory manner by my physician.

I understand I may be tested for any and all communicable diseases of any tissue or specimen which may be removed during the course of the operation.

I understand a pathologist will examine and/or dispose of any tissue or specimen which may be removed during the course of the operation.

My initials below indicate that I do or do not consent to the following:

N/A **I do;** ____ **I do not;** consent to the presence of observers as authorized by the physician performing the procedure

I, the undersigned, have read and understand the above information.

Witness 5/26/06 Date/Time — Signature of Patient

*Witness Jessi J. M. Hunt, AR 5/26/06 1520 — Printed Name

Dtr Dru Wix daughter — Signature of Other Than Patient

**Two (2) witnesses are required if consent is via telephone or if patient cannot sign his/her name and only makes a mark.

Relationship to Patient — Printed Nam

I, the undersigned Physician, obtained informed consent.

PROCEED TO BACK FOR TIME OUT PROCEDURE

Signature of physician

Consent for Procedure/ Time Out Procedure

Patient Addressograph

102829710
PETERSON SR, WILLIAM SR
DOB: [redacted] 85 SX: M IMD
MRN: 26525 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

Time Out Procedure

To be completed immediately before starting the procedure/surgery.

Initial appropriate box:

	YES	NO*	Not Applicable
Verify Patient ID	✓		
Verify H&P on chart	✓		
Verify Procedure	✓		
Verify informed consent signed by patient and physician	✓		
Verify correct side/site marked	✓		
Verify correct position of patient	✓		
Verify correct implants available			✓
Verify special equipment available	✓		
Verify X-Ray images available, marked and displayed	✓		

- All No's require clarification of discrepancy before procedure is started.

Date: 5/26/06 Time: 1643

Associate Name: [signature] Title: RN

Patient Addressograph

Consent for Procedure/ Time Out Procedure

AIKEN REGIONAL MEDICAL CENTER
302 UNIVERSITY PARKWAY
AIKEN, SOUTH CAROLINA 29802

PATIENT: PETERSON, WILLIAM SR MR#: 026523
SURGERY DATE: 05/25/2006 ACCT#: 102829710
CC:

SURGEON:

ASSISTANT:

PROCEDURE PERFORMED: Bronchoscopy with bronchoalveolar lavage.

PREOPERATIVE DIAGNOSIS: Retained secretions.

POSTOPERATIVE DIAGNOSIS: Retained secretions.

SUMMARY OF PROCEDURE: Informed consent was obtained from the patient's daughter. The patient was monitored with EKG, pulse oximetry and blood pressure throughout the procedure. He was drowsy, and did not require any sedation.

The right naris was lubricated and anesthetized with lidocaine jelly. The pharynx was anesthetized with benzocaine spray. The Olympus video bronchoscope was lubricated and advanced via the right naris. The pharynx was unremarkable. The vocal cords demonstrated normal mobility on respiration. I did not see evidence of pooling of secretions in the hypopharynx. The bronchoscope was advanced translaryngeally. The trachea was unremarkable. The carina was sharp. There were a moderate amount of retained secretions in both the left and right lower lobes. The endobronchial anatomy was normal, showing no endobronchial lesions. Aggressive suctioning was carried out, with the intent of removing as much of the retained secretions as possible. A bronchoalveolar lavage specimen was obtained from the right and left lower lobes. The lavage specimen appears dark orange to brownish in color, but is nonpurulent. When all the secretions as possible could be cleared away, the procedure was terminated.

DISPOSITION: The patient tolerated the above well. No complications were encountered.

Nicholas J. Sanito, D.O.

374853/MedQ
DD: 05/25/2006 13:34:38
DT: 05/25/2006 14:38:19

AIKEN REGIONAL MEDICAL [illegible] RADIOLO[illegible] ONSULTATION -929-

PT NAME: PETERSON, WILLIAM S
ROOM #: 503-A
BILLING#:102829710
DOB: [redacted]
DATE DONE: 05/26/06
BOKKISAM
SSN: [redacted]
SEX: M
TEST REASON: pleu effusion

VT: IP SEQ: 00177
XRAY#: 1025803
MEDREC#: 26523
REF PHYS: JAMES SUHRER
PRI PHYS: CHAKRAVARTHY

COMMENTS:
ADMIT DIAG: UROSEPSIS,AMS,HYPOTHERMIA
PROCEDURE #1: US THORACENTESIS DX CPT#1: 32000
PROCEDURE #2: US GUIDANCE FOR BIOPSY CPT#2: 76942
PROCEDURE #3: CPT#3:
CONFIDENTIAL - IF NOT INTENDED FOR YOU, PLEASE CALL (803) 641-5060

Job Number:194836 Text Status:checked Text Body:

Job # 194836 MR# 26523 A0119191

Ultrasound Guided Thoracentesis

Indication: Urosepsis, bilateral pleural effusions, infection.

Procedure: Informed consent was obtained from the patients family. Under sterile conditions and using 1% Lidocaine over the left posterolateral chest wall, a Yeuh needle was ultrasound guided into the left pleural fluid collection. Permanent images were obtained. 350 cc of clear yellowish fluid were drained and sent for laboratory analysis. The patient tolerated the procedure well. There were no immediate complications.

Findings: Initial ultrasound demonstrates bilateral pleural effusions. Following thoracentesis no significant left-sided effusion is identified. There is no evidence of pneumothorax.

Impression:

Ultrasound guided thoracentesis on the left without difficulty or complication. Pathology is pending on fluid.

DATE DICTATED: 05/26/06

PT NAME: PETERSON, WILLIAM S
ROOM#: 503-A
DATE REQUESTED: 05/26/06 DATE SIGNED: 05-27-06
DATE TRANSCRIBED: 05/27/06 TIME SIGNED: 09:26
TRANSCRIBED BY: VINEK

READ BY: RONALD P ROBINSON, M.D.

ELECTRONICALLY SIGNED BY: RONALD P ROBINSON, M.D.

AIKEN REGIONAL MEDICAL(VI 3. RADIOLO(L ONSULTATION -930-

PT NAME: PETERSON, WILLIAM S
ROOM #: 503-A
BILLING#:102829710
DOB: [redacted]
DATE DONE: 05/26/06
BOKKISAM
SSN: [redacted]
SEX: M
TEST REASON: pleural eff

VT: IP SEQ: 00178
XRAY#: 1025803
MEDREC#: 26523
REF PHYS: JAMES SUHRER
PRI PHYS: CHAKRAVARTHY

COMMENTS:
ADMIT DIAG: UROSEPSIS,AMS,HYPOTHERMIA
PROCEDURE #1: US CHEST CPT#1: 76604
PROCEDURE #2: CPT#2:
PROCEDURE #3: CPT#3:

CONFIDENTIAL - IF NOT INTENDED FOR YOU, PLEASE CALL (803) 641-5060

Job Number:194795 Text Status:checked Text Body:

Job#194795 MR#26523 A0119192

Ultrasound Chest

Indication: Urosepsis, hypothermia.

Technique: Ultrasound of the chest was performed using a 4 MHz transducer.

Findings: There are bilateral pleural effusions at least moderate in size bilaterally. Fluid appears simple without echoes or septations.

Impression:

Moderate size simple appearing bilateral pleural effusions.

DATE DICTATED: 05/26/06

PT NAME: PETERSON, WILLIAM S
ROOM#: 503-A
DATE REQUESTED: 05/26/06 DATE SIGNED: 05-31-06
DATE TRANSCRIBED: 05/30/06 TIME SIGNED: 10:08
TRANSCRIBED BY: ECOOK

READ BY: RONALD P ROBINSON, M.D.

ELECTRONICALLY SIGNED BY: RONALD P ROBINSON, M.D.

AIKEN REGIONAL MEDICAL [illegible] RADIOLOG [illegible] AL CONSU

PT NAME: PETERSON, WILLIAM S
ROOM #: 503-A
BILLING#:102829710
DOB: [redacted]
DATE DONE: 05/26/06
SSN: [redacted]
SEX: M
TEST REASON: post thorocentesis
COMMENTS:

VT: IP SEQ: 00226
XRAY#: 1025803
MEDREC#: 26523
REF PHYS: RONALD ROBINSON
PRI PHYS: RONALD ROBINSON

ADMIT DIAG: UROSEPSIS,AMS,HYPOTHERMIA
PROCEDURE #1: CHEST 1V CPT#1: 71010
PROCEDURE #2: CPT#2:
PROCEDURE #3: CPT#3:

CONFIDENTIAL - IF NOT INTENDED FOR YOU, PLEASE CALL (803) 641-5060

Job Number:194874 Text Status:checked Text Body:

Job#194874 MedRec# 26523 A0119251

Chest

Indication: Urosepsis. Hypothermia. Status post thoracentesis.

Comparison: 5/25

Technique: Single view of the chest.

Findings: There is no evidence of pneumothorax. There are persistent bilateral pleural opacities, slightly improved on the left. The cardiomediastinal silhouette remains unchanged. There is the suggestion of pulmonary vascular congestion.

Impression:

1. Slightly improved pleural opacity, left. No pneumothorax identified.

2. Appearance suggestive of mild generalized pulmonary edema.

DATE DICTATED: 05/27/06

PT NAME: PETERSON, WILLIAM S
ROOM#: 503-A
DATE REQUESTED: 05/26/06 DATE SIGNED: 05-28-06
DATE TRANSCRIBED: 05/28/06 TIME SIGNED: 20:02
TRANSCRIBED BY: COOKSC

READ BY: RONALD P ROBINSON, M.D.

ELECTRONICALLY SIGNED BY: RONALD P ROBINSON, M.D.

PT NAME: PETERSON, WILLIAM S
ROOM #: 503-A
BILLING#:102829710
DOB: [redacted]
DATE DONE: 05/25/06
BOKKISAM
SSN: [redacted]
SEX: M
TEST REASON: increased secretions
COMMENTS:
ADMIT DIAG: UROSEPSIS,AMS,HYPOTHERMIA
PROCEDURE #1: CHEST 1V CPT#1: 71010
PROCEDURE #2: CPT#2:
PROCEDURE #3: CPT#3:

VT: IP SEQ: 00103
XRAY#: 1025803
MEDREC#: 26523
REF PHYS: JAMES SUHRER
PRI PHYS: CHAKRAVARTHY

CONFIDENTIAL - IF NOT INTENDED FOR YOU, PLEASE CALL (803) 641-5060

Job Number:194436 Text Status:checked Text Body:

Job # 194436 MR# 26523 A0118783

Chest, Single View

Indication: Urosepsis, altered mental status, increased secretions.

Technique: An AP portable chest is compared to the prior study of 15 May 2006.

Findings: There are cardiac monitor wires overlying the chest wall. Postoperative changes are seen in the base of the neck.

There is airspace opacity. There is distortion in the lung bases due to an apical lordotic projection. Small pleural effusions with basilar consolidation cannot be completely excluded. Clinical correlation and follow-up are recommended in this regard. The heart and mediastinum are stable in size and position.

Impression:

Airspace opacity with suggestion of pleural effusions and subsegmental atelectasis in the lung bases. Clinical correlation and continued follow-up are recommended in this regard.

DATE DICTATED: 05/25/06

PT NAME: PETERSON, WILLIAM S
ROOM#: 503-A
DATE REQUESTED: 05/25/06
DATE TRANSCRIBED: 05/25/06
TRANSCRIBED BY: VINEK

DATE SIGNED: 05-26-06
TIME SIGNED: 00:36

READ BY: ANTHONY L TOOMER, M.D.

ELECTRONICALLY SIGNED BY: ANTHONY L TOOMER, M.D.

AIKEN REGIONAL MEDICAL CENTERS

302 UNIVERSITY PARKWAY
AIKEN, SOUTH CAROLINA 29801
PATHOLOGISTS:
DENYSE N. PARNELL, M.D.
BONNIE S. SZYMIK, M.D.
JASON FANCEY, M.D.

Patient: PETERSON, WILLIAM SR
M.R.#: 026523
Financial #: 102829710
DOB: [redacted] *Age:* 85yr *Sex:* M
Location: 5M *Room/Bed:* 503 A
Admit Date: 05/15/06
Discharge Date:
Physician: BOKKISAM, CHAKRAVARTHY

CLINICAL LABORATORY REPORT

MICROBIOLOGY

Collected: 05/25/06 @ 13:30 *Received:* 05/25/06 @ 13:51 *Accn:* 37458 *Seq:* 7977

05/26/06	**Source**	Bronchial Washing
05/26/06	**Gram Stain**	
	Moderate WBC's Seen	
	Few Epithelial Cells	
	Many Budding Yeast	

Legend
High =H Low = L Critical =C

PT NAME: PETERSON, WILLIAM S
ROOM #: 503-A
BILLING#:102829710
DOB: [redacted]
DATE DONE: 05/23/06
BOKKISAM
SSN: [redacted]
SEX: M
TEST REASON: mass - ?change
COMMENTS:

VT: IP SEQ: 00032
XRAY#: 1025803
MEDREC#: 26523
REF PHYS: GERALD GORDON
PRI PHYS: CHAKRAVARTHY

ADMIT DIAG: UROSEPSIS,AMS,HYPOTHERMIA
PROCEDURE #1: US ABDOMEN RETROPERI COMP CPT#1: 76770
PROCEDURE #2: CPT#2:
PROCEDURE #3: CPT#3:

CONFIDENTIAL - IF NOT INTENDED FOR YOU, PLEASE CALL (803) 641-5060

Job Number:194087 Text Status:checked Text Body:

Job #194087 MR #26523 A0118067

Follow-up Renal Ultrasound

Indication: Mass right kidney.

Technique: A bedside renal ultrasound was performed. Comparison to prior renal study dated May 17, 2006.

Findings: The right kidney again shows an unchanged anechoic lobulated cystic structure in the interpolar region of the right kidney that has an apparent septation with some good through-transmission and possible some mural thickening. The overall appearance is unchanged in size and characteristics measuring 1.9 x 3.2 cm. No hydronephrosis. The cortical echotexture of the kidneys are stable and slightly isoechoic to the liver parenchyma.

Impression:

Stable anechoic/hypoechoic lesion right kidney measuring 3.2 x 1.9 cm with good through-transmission and apparent septation and macrolobulation. Overall appearance suggests a benign cyst, however, follow-up is indicated as cystic renal cell neoplasm cannot be completely excluded. No perinephric stranding or developing hydronephrosis.

DATE DICTATED: 05/23/06

PT NAME: PETERSON, WILLIAM S
ROOM#: 503-A
DATE REQUESTED: 05/23/06
DATE TRANSCRIBED: 05/24/06
TRANSCRIBED BY: PIERCS

DATE SIGNED: 05-24-06
TIME SIGNED: 21:58

READ BY: ROBERT F SEARLES, D.O.

ELECTRONICALLY SIGNED BY: ROBERT F SEARLES, D.O.

PT NAME: PETERSON, WILLIAM S
ROOM #: 503-A
BILLING#:102829710
DOB: [redacted]
DATE DONE: 05/17/06
BOKKISAM
SSN: [redacted]
SEX: M
TEST REASON: decrease urine output
COMMENTS:
ADMIT DIAG: UROSEPSIS,AMS,HYPOTHERMIA
PROCEDURE #1: US ABDOMEN RETROPERI COMP
PROCEDURE #2:
PROCEDURE #3:

VT: IP SEQ: 00013
XRAY#: 1025803
MEDREC#: 26523
REF PHYS: GERALD GORDON
PRI PHYS: CHAKRAVARTHY

CPT#1: 76770
CPT#2:
CPT#3:

CONFIDENTIAL - IF NOT INTENDED FOR YOU, PLEASE CALL (803) 641-5060

Job Number:192851 Text Status:checked Text Body:

Job # 192851 MR# 26523 A0116513

Renal Ultrasound

Indication: Elevated BUN and creatinine with a history of a complex cyst on the right kidney.

Technique: Transverse and longitudinal sonographic images were acquired through the kidneys. The study is compared to a renal ultrasound performed 22 February 2006.

Findings: The kidneys are normal in size and echotexture, measuring 10 x 4 x 5 cm on the right side and 10 x 6 x 4 cm on the left side. No hydronephrosis or nephrolithiasis is seen. There has been interval increase in size of the complex cystic lesion seen in the mid-pole region of the right kidney since the prior exam. The lesion measures 1.9 x 3 x 3 cm on today's exam compared to 1.4 x 1.2 cm on the prior study. This lesion was evaluated with CT. On CT this lesion has fluid attenuation. Clinical correlation and follow-up with a dedicated renal CT may be performed for better characterization, particularly given the interval increase in size since February 2006.

The bladder is decompressed under the effects of a Foley catheter.

Impression:

1. There has been interval increase in size of the complex cyst with septation in the mid pole region of the right kidney since the prior exam, for which clinical correlation and follow-up are recommended, as discussed in the above details.

DATE DICTATED: 05/17/06

PT NAME: PETERSON, WILLIAM S
ROOM#: 503-A
DATE REQUESTED: 05/17/06
DATE TRANSCRIBED: 05/17/06
TRANSCRIBED BY: VINEK

DATE SIGNED: 05-18-06
TIME SIGNED: 08:19

READ BY: ANTHONY L TOOMER, M.D.

ELECTRONICALLY SIGNED BY: ANTHONY L TOOMER, M.D.

PT NAME: PETERSON, WILLIAM S
ROOM #: 503-A
BILLING#:102829710
DOB: [redacted]
DATE DONE: 05/17/06
BOKKISAM
SSN: [redacted]
SEX: M
TEST REASON: decrease urine output
COMMENTS:
ADMIT DIAG: UROSEPSIS,AMS,HYPOTHERMIA
PROCEDURE #1: US ABDOMEN RETROPERI COMP
PROCEDURE #2:
PROCEDURE #3:

VT: IP SEQ: 00013
XRAY#: 1025803
MEDREC#: 26523
REF PHYS: GERALD GORDON
PRI PHYS: CHAKRAVARTHY

CPT#1: 76770
CPT#2:
CPT#3:

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2. The remainder of the exam is stable, as above.

DATE DICTATED: 05/17/06

PT NAME: PETERSON, WILLIAM S
ROOM#: 503-A
DATE REQUESTED: 05/17/06
DATE TRANSCRIBED: 05/17/06
TRANSCRIBED BY: VINEK

DATE SIGNED: 05-18-06
TIME SIGNED: 08:19

READ BY: ANTHONY L TOOMER, M.D.

ELECTRONICALLY SIGNED BY: ANTHONY L TOOMER, M.D.

PT NAME: PETERSON, WILLIAM S
ROOM #: 503-A
BILLING#: 102829710
DOB [redacted]
DATE DONE: 05/15/06
SSN: [redacted]
SEX: M
TEST REASON: chest pain
COMMENTS:
ADMIT DIAG: AMS
PROCEDURE #1: CHEST 1V
PROCEDURE #2:
PROCEDURE #3:

VT: IP SEQ: 00233
XRAY#: 1025803
MEDREC#: 26523
REF PHYS: WALTER JACKSON
PRI PHYS: WALTER JACKSON
CPT#1: 71010
CPT#2:
CPT#3:

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Job Number:192430 Text Status:checked Text Body:

Job #192430 MR #26523 A0116247

Single View Chest

Indication: Chest pain, altered mental status.

Technique: An AP portable chest is taken in the expiratory phase of respiration. The study is compared to March 7, 2006.

Findings: The heart and mediastinum are stable in size and position. No acute focal consolidation or pleural effusion is seen. The remainder of the chest is stable.

Impression:

Hypoventilatory changes in the chest. No acute focal process.

DATE DICTATED: 05/16/06

PT NAME: PETERSON, WILLIAM S
ROOM#: 503-A
DATE REQUESTED: 05/15/06
DATE TRANSCRIBED: 05/16/06
TRANSCRIBED BY: PIERCS

DATE SIGNED: 05-17-06
TIME SIGNED: 09:39

READ BY: ANTHONY L TOOMER, M.D.

ELECTRONICALLY SIGNED BY: ANTHONY L TOOMER, M.D.

PT NAME: PETERSON, WILLIAM S
ROOM #: 503-A
BILLING#:102829710
DOB: [redacted]
DATE DONE: 05/15/06
SSN: [redacted]
SEX: M
TEST REASON: alted mental state
COMMENTS:
ADMIT DIAG: AMS
PROCEDURE #1: CT BRAIN W/O CONTRAST
PROCEDURE #2:
PROCEDURE #3:

VT: IP SEQ: 00253
XRAY#: 1025803
MEDREC#: 26523
REF PHYS: WALTER JACKSON
PRI PHYS: WALTER JACKSON
CPT#1: 70450
CPT#2:
CPT#3:

CONFIDENTIAL - IF NOT INTENDED FOR YOU, PLEASE CALL (803) 641-5060

Job Number:192426 Text Status:checked Text Body:

Job #192426 MR #26523 A0116268

CT Brain without Contrast

Indication: Altered mental status.

Technique: Axial images are acquired through the brain without contrast. No prior films are available for direct comparison at the time of this dictation.

Findings: There is mild cortical atrophy with secondary increase in size of the CSF spaces. Hypoattenuation is seen in the white matter tracts suggesting small vessel ischemic demyelination. There are basal ganglia calcifications. No acute cortical infarction is appreciated in any major vascular territory. No intra or extra-axial mass, hemorrhage or midline shift is seen. The calvarium is intact. Air-fluid levels are seen in the left side of the sphenoid sinus and the bilateral maxillary sinuses. The findings suggest changes of sinusitis for which clinical correlation and follow-up is recommended.

Impression:

1. Air- fluid levels in the maxillary and sphenoid sinuses. Correlate clinically for changes of acute sinusitis.

2. Age-related changes in the brain, but no acute intracranial abnormality, as above.

DATE DICTATED: 05/16/06

PT NAME: PETERSON, WILLIAM S
ROOM#: 503-A
DATE REQUESTED: 05/15/06
DATE TRANSCRIBED: 05/16/06
TRANSCRIBED BY: PIERCS

DATE SIGNED: 05-17-06
TIME SIGNED: 09:39

READ BY: ANTHONY L TOOMER, M.D.

ELECTRONICALLY SIGNED BY: ANTHONY L TOOMER, M.D.

PT NAME: PETERSON, WILLIAM S
ROOM #: 503-A
BILLING#:102829710
DOB: [redacted]
BOKKISAM
DATE DONE: 05/16/06
BOKKISAM
SSN: [redacted]
SEX: M
TEST REASON: LT HIP WOUND
COMMENTS:
ADMIT DIAG:
PROCEDURE #1: HIP JOINT 2V LT
PROCEDURE #2:
PROCEDURE #3:

VT: IP SEQ: 00185
XRAY#: 1025803
MEDREC#: 26523
REF PHYS: CHAKRAVARTHY

PRI PHYS: CHAKRAVARTHY

CPT#1: 73510LT
CPT#2:
CPT#3:

CONFIDENTIAL - IF NOT INTENDED FOR YOU, PLEASE CALL (803) 641-5060

Job Number:192634 Text Status:checked Text Body:

Job#192634 MedRec# 26523 A0116505

Left Hip, 5/16/06

History: Hip wound.

Technique: Three views are obtained.

Findings: There is soft tissue defect inferolateral to the greater trochanter of the left hip. There is no underlying bony erosion. The hip is normally aligned. No fracture is identified. The joint space is preserved.

Conclusion:

No acute osseous abnormality of the left hip.

DATE DICTATED: 05/16/06

PT NAME: PETERSON, WILLIAM S
ROOM#: 503-A
DATE REQUESTED: 05/16/06
DATE TRANSCRIBED: 05/17/06
TRANSCRIBED BY: COOKSC

DATE SIGNED: 05-17-06
TIME SIGNED: 16:35

READ BY: ALFONSO GAY, M.D.

ELECTRONICALLY SIGNED BY: ALFONSO GAY, M.D.

AIKEN REGIONAL MEDICAL ([illegible] S RADIOLOG[illegible]L CONSULTATION -940-

PT NAME: PETERSON, WILLIAM S
ROOM #: 503-A
BILLING#:102829710
DOB: [redacted]
BOKKISAM
DATE DONE: 05/16/06
BOKKISAM
SSN: [redacted]
SEX: M
TEST REASON: r/o obstruction
COMMENTS:
ADMIT DIAG: UROSEPSIS,AMS,HYPOTHERMIA
PROCEDURE #1: ACUTE ABDOMEN W/PA CXR
PROCEDURE #2:
PROCEDURE #3:

VT: IP SEQ: 00039
XRAY#: 1025803
MEDREC#: 26523
REF PHYS: CHAKRAVARTHY

PRI PHYS: CHAKRAVARTHY

CPT#1: 74022
CPT#2:
CPT#3:

CONFIDENTIAL - IF NOT INTENDED FOR YOU, PLEASE CALL (803) 641-5060

Job Number:192636 Text Status:checked Text Body:

Job#192636 MedRec# 23523 A0116324

Acute Abdomen Series, 5/16/06

History: Urosepsis.

Technique: Three views are obtained.

Findings: The cardiac silhouette and pulmonary vasculature are within normal limits. Mild increased density is noted at the left lung base. I cannot exclude an infiltrate. Fusion hardware is noted in the cervical spine. No free air is seen beneath the hemidiaphragms.

The bowel gas pattern is unremarkable. Calcified phleboliths are noted in the pelvis.

Conclusion:

1. Questionable left lung base infiltrate.
2. No acute abdominal findings.

DATE DICTATED: 05/16/06

PT NAME: PETERSON, WILLIAM S
ROOM#: 503-A
DATE REQUESTED: 05/16/06
DATE TRANSCRIBED: 05/17/06
TRANSCRIBED BY: COOKSC

DATE SIGNED: 05-17-06
TIME SIGNED: 16:35

READ BY: ALFONSO GAY, M.D.

ELECTRONICALLY SIGNED BY: ALFONSO GAY, M.D.

AIKEN REGIONAL MEDICAL CENTERS

302 UNIVERSITY PARKWAY
AIKEN, SOUTH CAROLINA 29801
PATHOLOGISTS:
DENYSE N. PARNELL, M.D.
BONNIE S. SZYMIK, M.D.
JASON FANCEY, M.D.

CLINICAL LABORATORY REPORT

Patient: PETERSON, WILLIAM SR
M.R.#: 026523
Financial #: 102829710
DOB: [redacted] Age: 85yr *Sex:* M
Location: DIS *Room/Bed:*
Admit Date: 05/15/06
Discharge Date: 06/01/06
Physician: BOKKISAM, CHAKRAVARTHY

CHEMISTRY

Collection Date>	05/15/06 17:25	05/15/06 17:25	05/16/06 05:10	05/17/06 05:55	05/18/06 05:00	
Lab Accession #>	32150	32259	32413	32950	33578	
Ordering Dr. >	JACW	WEDD	BOKC	BOKC	GORG	
Test	Oldest				Most Recent	Reference Range
CHEM8						
CMP						
SODIUM	147 H		150 H	150 H	148 H	135 - 145 meq/l
POTASSIUM	4.2		4.6	4.0	3.0 C aa	3.5 - 5.5 meq/l
aa Called to and Read back by: RENE ENSLEY By:JCROW 05/18/2006 @ 06:01						
RECHECKED						
Chloride	115 H		118 H	123 H	123 H	99 - 111 meq/l
CO2	24		21 L	21 L	19 L	22 - 34 meq/l
GLUCOSE	90		54 L	166 H	216 H	70 - 120 mg/dl
BUN	35 H		35 H	41 H	36 H	7 - 22 mg/dl
CREATININE	1.8 H		2.4 H	2.4 H	1.9 H	0.5 - 1.2 mg/dl
CALCIUM	8.8		8.2 L	7.6 L	7.7 L	8.7 - 10.2 mg/d
CPK		222 H				38 - 173 U/L
BILI TOTAL	0.9					0.1 - 1.2 mg/dl
SGOT	34					0 - 45 U/L
SGPT	28					0 - 40 U/L
ALK PHOS	191 H					37 - 107 U/L
TOTAL PROTEIN	6.5					6.1 - 8.0 g/dl
ALBUMIN	2.1 L					3.5 - 4.8 g/dl
AMYLASE	286 H					34 - 122 U/L
LIPASE	15 L					22 - 51 U/L

Collection Date>	05/19/06 05:30	05/20/06 04:55	05/21/06 08:35	05/23/06 04:15	05/25/06 11:00	
Lab Accession #>	34193	34654	34998	35927	37368	
Ordering Dr. >	GORG	GORG	GORG	SUHJ	SUHJ	
Test	Oldest				Most Recent	Reference Range
CHEM8						
SODIUM	144	145	146 H	146 H	149 H	135 - 145 meq/l

Legend
High =H Low = L Critical =C

AIKEN REGIONAL MEDICAL CENTERS

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AIKEN, SOUTH CAROLINA 29801
PATHOLOGISTS:
DENYSE N. PARNELL, M.D.
BONNIE S. SZYMIK, M.D.
JASON FANCEY, M.D.

Patient: PETERSON, WILLIAM SR
M.R.#: 026523
Financial #: 102829710
DOB: [redacted] *Age:* 85yr *Sex:* M
Location: DIS *Room/Bed:*
Admit Date: 05/15/06
Discharge Date: 06/01/06
Physician: BOKKISAM, CHAKRAVARTHY

CLINICAL LABORATORY REPORT

CHEMISTRY

Collection Date>	05/19/06 05:30		05/20/06 04:55		05/21/06 08:35		05/23/06 04:15		05/25/06 11:00		
Lab Accession #>	34193		34654		34998		35927		37368		
Ordering Dr. >	GORG		GORG		GORG		SUHJ		SUHJ		
Test	Oldest								Most Recent		Reference Range
POTASSIUM	3.2	L	3.9	aa	4.3		3.8		2.8	C bb	3.5 - 5.5 meq/l
aa RECHECKED											
bb RECHECKED											
Called to and Read back by:											
C. SMITH											
By:SWELL 05/25/2006 @ 11:34											
Chloride	119	H	123	H	121	H	120	H	120	H	99 - 111 meq/l
CO2	19	L	19	L	21	L	22		24		22 - 34 meq/l
GLUCOSE	266	H	184	H	182	H	178	H	161	H	70 - 120 mg/dl
BUN	30	H	26	H	30	H	36	H	46	H	7 - 22 mg/dl
CREATININE	1.7	H	1.6	H	1.5	H	1.4	H	1.2		0.5 - 1.2 mg/dl
CALCIUM	7.6	L	7.7	L	7.5	L	7.2	L	7.0	L	8.7 - 10.2 mg/d

Collection Date>	05/26/06 05:45		05/28/06 04:05		05/29/06 07:12		05/31/06 05:00				
Lab Accession #>	37779		38694		39038		39848				
Ordering Dr. >	SUHJ		SUHJ		SUHJ		SUHJ				
Test	Oldest								Most Recent		Reference Range
CHEM8											
SODIUM	148	H	151	H	149	H	140				135 - 145 meq/l
POTASSIUM	3.7	aa	3.9		3.7		3.7				3.5 - 5.5 meq/l
aa POTASSIUM RECHECKED											
Chloride	120	H	120	H	114	H	108				99 - 111 meq/l
CO2	24		28		30		28				22 - 34 meq/l
GLUCOSE	126	H	141	H	142	H	59	L			70 - 120 mg/dl
BUN	42	H	43	H	43	H	34	H			7 - 22 mg/dl
CREATININE	1.2		1.2		1.2		1.0				0.5 - 1.2 mg/dl
CALCIUM	7.2	L	7.5	L	7.3	L	8.2	L			8.7 - 10.2 mg/d

Legend
High =H Low = L Critical =C

AIKEN REGIONAL MEDICAL CENTERS

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AIKEN, SOUTH CAROLINA 29801
PATHOLOGISTS:
DENYSE N. PARNELL, M.D.
BONNIE S. SZYMIK, M.D.
JASON FANCEY, M.D.

CLINICAL LABORATORY REPORT

Patient: PETERSON, WILLIAM SR
M.R.#: 026523
Financial #: 102829710
DOB: [redacted] Age: 85yr *Sex:* M
Location: DIS *Room/Bed:*
Admit Date: 05/15/06
Discharge Date: 06/01/06
Physician: BOKKISAM, CHAKRAVARTHY

SPECIAL CHEMISTRY

Collection Date>	05/15/06 17:25		05/15/06 17:25		05/16/06 01:50		05/16/06 09:00		05/16/06 19:00		
Lab Accession #>	32150		32259		32406		32417		32416		
Ordering Dr. ->	JACW		WEDD		BOKC		BOKC		BOKC		
Test	Oldest								Most Recent		Reference Range
TSH			1.99								0.50 - 5.40 uIU
Cardiac Troponin	0.04	aa			<0.04	aa	<0.04	aa	0.04	aa	0.00 - 0.04 ng/

aa INTERP FOR CARDIAC TROPONIN(cT-I)TESTING

0.00-0.04: No evidence of myocardial injury.(95% confidence interval for healthy adults).

Legend
High = H Low = L Critical = C

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JASON FANCEY, M.D.

CLINICAL LABORATORY REPORT

Patient: PETERSON, WILLIAM SR
M.R.#: 026523
Financial #: 102829710
DOB: [redacted] Age: 85yr *Sex:* M
Location: DIS *Room/Bed:*
Admit Date: 05/15/06
Discharge Date: 06/01/06
Physician: BOKKISAM, CHAKRAVARTHY

DRUG ANALYSIS / TOXICOLOGY

Collection Date>	05/16/06 12:20	05/16/06 19:40	05/17/06 05:55	05/17/06 16:42	05/18/06 05:00	
Lab Accession #>	32588	32776	32950	33300	33578	
Ordering Dr. >	BOKC	BOKC	BOKC	BOKC	GORG	
Test	Oldest				Most Recent	Reference Range
Vancomycin Rand	9.9		21.8	18.6	25.4	5.0 - 40.0 ug/m
Vanco Peak		18.1 L				30.0 - 40.0 ug/

Collection Date>	05/18/06 16:42	05/19/06 05:30	05/19/06 16:50	05/20/06 04:55	05/21/06 14:05	
Lab Accession #>	33577	34193	34190	34654	34997	
Ordering Dr. >	BOKC	GORG	BOKC	GORG	BOKC	
Test	Oldest				Most Recent	Reference Range
Vancomycin Rand	15.0	22.6	18.5	24.2		5.0 - 40.0 ug/m
Vanco Peak					38.2	30.0 - 40.0 ug/

Collection Date>	05/27/06 13:38	05/29/06 07:12	05/29/06 17:12	05/30/06 17:27	05/31/06 17:10	
Lab Accession #>	38483	39038	39153	39310	39847	
Ordering Dr. >	GORG	SUHJ	GORG	GORG	GORG	
Test	Oldest				Most Recent	Reference Range
Vancomycin Rand		34.8	30.1	20.4	15.6	5.0 - 40.0 ug/m
Vanco Peak	55.7 H aa					30.0 - 40.0 ug/

aa RESULT RECHECKED BY DILUTION.
Called to and Read back by:
MRS POWELL
By:RARTHU 05/27/2006 @ 14:45

Legend
High =H Low = L Critical =C

AIKEN REGIONAL MEDICAL CENTERS

302 UNIVERSITY PARKWAY
AIKEN, SOUTH CAROLINA 29801
PATHOLOGISTS:
DENYSE N. PARNELL, M.D.
BONNIE S. SZYMIK, M.D.
JASON FANCEY, M.D.

Patient: PETERSON, WILLIAM SR
M.R.#: 026523
Financial #: 102829710
DOB: [redacted] Age: 85yr *Sex:* M
Location: DIS *Room/Bed:*
Admit Date: 05/15/06
Discharge Date: 06/01/06
Physician: BOKKISAM, CHAKRAVARTHY

CLINICAL LABORATORY REPORT

BODY FLUID ANALYSIS

Collection Date>	05/26/06 17:30						
Lab Accession #>	38049						
Ordering Dr. >	SUHJ						
Test	Oldest					Most Recent	Reference Range
Body Fl Source	PLEURAL FLUID						
Body Fl Source	* In Process *						
BF SP Grav	1.014						
Body Fl GLU	156						mg/dl
Body Fl LDH	104						U/L
BdyFl PRO(mg/dl)	954.0	aa					mg/dl

aa - VERIFIED BY DILUTION

Legend
High =H Low = L Critical =C

AIKEN REGIONAL MEDICAL CENTERS

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AIKEN, SOUTH CAROLINA 29801
PATHOLOGISTS:
DENYSE N. PARNELL, M.D.
BONNIE S. SZYMIK, M.D.
JASON FANCEY, M.D.

Patient: PETERSON, WILLIAM SR
M.R.#: 026523
Financial #: 102829710
DOB: [redacted] Age: 85yr *Sex:* M
Location: DIS *Room/Bed:*
Admit Date: 05/15/06
Discharge Date: 06/01/06
Physician: BOKKISAM, CHAKRAVARTHY

CLINICAL LABORATORY REPORT

HEMATOLOGY

Collection Date>	05/15/06 17:25		05/16/06 05:10		05/17/06 05:55		05/18/06 05:00		05/19/06 05:30		
Lab Accession #>	32150		32413		32950		33578		34193		
Ordering Dr ->	JACW		BOKC		BOKC		GORG		GORG		
Test	Oldest								Most Recent		Reference Range
CBC/DIFF											
CBC											
WBC X 1000	7.2		9.1		7.7		6.6		5.3		3.4 - 10.0 /mm3
RBC X 1000000	4.28	L	3.75	L	3.35	L	2.90	L	3.05	L	4.31 - 5.83 /mm
HGB	12.4	L	10.6	L	9.6	L	8.3	L	8.7	L	13.6 - 17.3 g/d
HCT	37.0	L	32.4	L	28.8	L	25.1	L	26.1	L	39.7 - 50.4 %
MCV	86		86		86		86		86		80 - 98 fL
MCH	29		28		29		28		29		27 - 34 pg
MCHC	34		33		33		33		33		33 - 36 g/dL
RDW	19.1	H	19.5	H	19.4	H	19.4	H	19.5	H	10.9 - 14.6 %
PLT X 1000	301		260		220		190		170		140 - 360 /mm3
Automated DIFF											
%Segs	90	H									50 - 70 %
%Lymphs	8	L									20 - 40 %
%Monos	2										0 - 8 %
%Eos	0										0 - 2 %
%Basos	0										0 - 1 %
MANUAL DIFF											
Segs			71	H	78	H					50 - 70 %
Lymphs			9	L	5	L					20 - 40 %
Monos			1		2						0 - 8 %
Eos			0								0 - 2 %
Basos			0		1						0 - 1 %
Bands			19	H	14	H					0 - 5 %
NRBC					1						
Morphology1	Aniso 1+		Aniso 2+		Aniso 2+						
Morphology2			Elliptocyte 1+		Dohle Bod Pres						
			Target Cell 1+		Elliptocyte 1+						
			Acanthocyte 1+								
			Microcytes 1+								
			Poik 1+								

Legend
High =H Low = L Critical =C

AIKEN REGIONAL MEDICAL CENTERS

302 UNIVERSITY PARKWAY
AIKEN, SOUTH CAROLINA 29801
PATHOLOGISTS:
DENYSE N. PARNELL, M.D.
BONNIE S. SZYMIK, M.D.
JASON FANCEY, M.D.

Patient: PETERSON, WILLIAM SR
M.R.#: 026523
Financial #: 102829710
DOB: [redacted] Age: 85yr *Sex:* M
Location: DIS *Room/Bed:*
Admit Date: 05/15/06
Discharge Date: 06/01/06
Physician: BOKKISAM, CHAKRAVARTHY

CLINICAL LABORATORY REPORT

HEMATOLOGY

Test	Collection Date> 05/20/06 07:40 Lab Accession #> 34779 Ordering Dr > BOKC Oldest		05/23/06 04:15 35927 SUHJ		05/25/06 11:00 37368 SUHJ		05/26/06 05:45 37779 SUHJ		05/27/06 04:20 38353 SUHJ Most Recent		Reference Range
CBC/DIFF											
WBC X 1000	6.9		7.5		6.5		8.4		10.3	H	3.4 - 10.0 /mm3
RBC X 1000000	3.26	L	3.46	L	3.36	L	3.16	L	3.37	L	4.31 - 5.83 /mm
HGB	9.0	L	9.7	L	9.3	L	8.9	L	9.5	L	13.6 - 17.3 g/d
HCT	27.9	L	29.6	L	28.5	L	26.7	L	28.6	L	39.7 - 50.4 %
MCV	86		86		85		84		85		80 - 98 fL
MCH	28		28		28		28		28		27 - 34 pg
MCHC	32	L	33		32	L	33		33		33 - 36 g/dL
ROW	19.9	H	20.0	H	20.5	H	20.4	H	20.4	H	10.9 - 14.6 %
PLT X 1000	165		143		168		203		235		140 - 360 /mm3
MANUAL DIFF											
Segs	80	H	86	H	82	H	86	H	89	H	50 - 70 %
Lymphs	14	L	12	L	16	L	9	L	6	L	20 - 40 %
Monos	6		1		1		3		4		0 - 8 %
Eos					0		2		1		0 - 2 %
Basos					0						0 - 1 %
Bands			1		1						0 - 5 %
NRBC	4		5								
Morphology1			Hypochromia 2+		Acanthocyte 1+		Aniso 2+		Aniso 2+		
							Baso Stip Pres		Polychrom 1+		
							Target Cell 1+		Giant Plts Pre		
Morphology2	Aniso 2+		Aniso 2+				Giant Plts Pre				
	Poik 1+						Ovalocytes 1+				
	Microcytes 1+						Dohle Bod Pres				
Morphology3	Macrocytes 1+		Dohle Bod Pres								

Legend
High =H Low = L Critical =C

AIKEN REGIONAL MEDICAL CENTERS

302 UNIVERSITY PARKWAY
AIKEN, SOUTH CAROLINA 29801
PATHOLOGISTS:
DENYSE N. PARNELL, M.D.
BONNIE S. SZYMIK, M.D.
JASON FANCEY, M.D.

Patient: PETERSON, WILLIAM SR
M.R.#: 026523
Financial #: 102829710
DOB: [redacted] Age: 85yr *Sex:* M
Location: DIS *Room/Bed:*
Admit Date: 05/15/06
Discharge Date: 06/01/06
Physician: BOKKISAM, CHAKRAVARTHY

CLINICAL LABORATORY REPORT

HEMATOLOGY

Collection Date>	05/29/06 07:12		05/30/06 05:50		05/31/06 05:00				
Lab Accession #>	39038		39311		39848				
Ordering Dr. >	SUHJ		SUHJ		SUHJ				
Test	Oldest							Most Recent	Reference Range
CBC/DIFF									
CBC									
WBC X 1000	9.3		5.4		6.0				3.4 - 10.0 /mm3
RBC X 1000000	2.75	L	3.23	L	3.92	L			4.31 - 5.83 /mm
HGB	7.7	L	9.4	L	11.2	L			13.6 - 17.3 g/d
HCT	23.4	L	28.5	L	34.2	L			39.7 - 50.4 %
MCV	85		88		87				80 - 98 fL
MCH	28		29		29				27 - 34 pg
MCHC	33		33		33				33 - 36 g/dL
RDW	21.5	H	19.3	H	19.5	H			10.9 - 14.6 %
PLT x 1000	255	aa	282		343				140 - 360 /mm3
aa Results confirmed by smear review.									
MANUAL DIFF									
Segs	87	H	76	H					50 - 70 %
Lymphs	6	L	12	L					20 - 40 %
Monos	4		6						0 - 8 %
Eos			5	H					0 - 2 %
Bands	3		1						0 - 5 %
Morphology1	Dohle Bod Pres Giant Plts Pre Baso Stip Pres		Aniso 2+ Tox Vac Pres Baso Stip Pres						
Morphology2	Aniso 2+		Target Cell 1+ Hypochromia 1+						
Morphology3			Dohle Bod Pres Hyper-Seg pres						

Legend
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Patient: PETERSON, WILLIAM SR
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Financial #: 102829710
DOB: [redacted] Age: 85yr *Sex:* M
Location: DIS *Room/Bed:*
Admit Date: 05/15/06
Discharge Date: 06/01/06
Physician: BOKKISAM, CHAKRAVARTHY

CLINICAL LABORATORY REPORT

COAGULATION

Collection Date>	05/15/06 17:25		05/26/06 15:55					
Lab Accession #>	32150		38102					
Ordering Dr. >	JACW		ROBR					
Test	Oldest						Most Recent	Reference Range
PROTIME	16.2	H	14.9					11.6 - 15.2 sec
INR	1.3	H aa	1.2	aa				0.9 - 1.2
PTT	55.8	H	33.3					23.0 - 35.0 sec

aa THERAPEUTIC RANGE : 2.0-3.0
HIGH RISK THERAPEUTIC RANGE: 2.5-3.5
*** The INR result is recommended ***
*** specifically for patients ***
*** stabilized on long-term ***
*** anticoagulant therapy and it is ***
*** not intended for use on other ***
*** patients. ***

Legend
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CLINICAL LABORATORY REPORT

Patient: PETERSON, WILLIAM SR
M.R.#: 026523
Financial #: 102829710
DOB: [redacted] Age: 85yr *Sex:* M
Location: DIS *Room/Bed:*
Admit Date: 05/15/06
Discharge Date: 06/01/06
Physician: BOKKISAM, CHAKRAVARTHY

URINALYSIS

Test	Collection Date> 05/15/06 21:30 Lab Accession #> 32245 Ordering Dr > JACW	Oldest			Most Recent	Reference Range
UAMICRO						
U Color	Amber					
U Appear	Cloudy					
U Spec Gravity	1.024					1.000 - 1.025
PH	5.0					5.0 - 7.0
Protein	3+					Negative
Glucose URINE	Trace					Negative
Ketones	Trace					Negative
Blood	3+					Negative
Nitrite	Positive					Negative
Bilirubin	Negative					Negative
Urobilinogen	1.0					0.2 E.U/dL
Leukocyte Est	2+					Negative
U WBC	TNTC					0-5/HPF
U RBC	TNTC					0-3/HPF
Bacteria	3+					Negative
Epithelial Cells	5-10					0-5/HPF
Yeast	4+					Negative
Granular Casts	1-3					0/LPF

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Patient: PETERSON, WILLIAM SR
M.R.#: 026523
Financial #: 102829710
DOB: [redacted] Age: 85yr *Sex:* M
Location: DIS *Room/Bed:*
Admit Date: 05/15/06
Discharge Date: 06/01/06
Physician: BOKKISAM, CHAKRAVARTHY

CLINICAL LABORATORY REPORT

IMMUNOHEMATOLOGY

Test	Collection Date> 05/29/06 17:12 Lab Accession #> 39205 Ordering Dr. > SUHJ Oldest				Most Recent	Reference Range
Type Cross X 2						
ABO Type	O					
Rh Type	POS					
Antibody Screen	NEG					
Type Cross X 2	aa					
aa Products Available						

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CLINICAL LABORATORY REPORT

Patient: PETERSON, WILLIAM SR
M.R.#: 026523
Financial #: 102829710
DOB: [redacted] Age: 85yr *Sex:* M
Location: DIS *Room/Bed:*
Admit Date: 05/15/06
Discharge Date: 06/01/06
Physician: BOKKISAM, CHAKRAVARTHY

MICROBIOLOGY

Collected: 05/15/06 @ 17:25 *Received:* 05/15/06 @ 17:45 *Accn:* 32151 *Seq:* 7108

BLOOD CULTURE

05/16/06 **Source** Blood
05/16/06 **Gram Stain**
Gram Positive Cocci in Clusters
Gram Stain Results Phoned To: DR. GORDON
12:55 05/16/06 SP
READ BACK CONFIRMATION COMPLETED

05/17/06 **PRELIM REPORT 1:**
Possible Staph Aureus Isolated

05/18/06 **Organism 1 ID:** Staphylococcus aureus
Note: Methicillin/Oxacillin Resistant
Organism 1 ID:
Staph.aureus

Antibiotics	MIC	SYS UR	MIC	SYS UR	MIC	SYS UR	MIC	SYS UR
Amox/K Clav	<=4/2	R						
Ampicillin	>8	BL						
Cefazolin	<=2	R						
Chloramphenicol	<=8	S						
Ciprofloxacin	<=1	S						
Erythromycin	>4	R						
Gentamycin	<=1	S						
Imipenem	<=1	R						
Levofloxacin	<=2	S						
Linezolid	2	S						
Oxacillin	>2	R						
Penicillin	>8	BL						
Rifampin	<=1	S						
Tetracycline	<=4	S						
Trimeth/Sulfa	<=2/38	S						
Vancomycin	<=2	S						

MICROBIOLOGY LEGEND: S = Sensitive I = Intermediate R = Resisitant BL = Beta Lactamase
* Result interchangable with Cefotaxime
@ Pseudomonas, Enterobacter, Citrobacter, Serratia, Morganella, Providencia, or Aeromonas sp and may develop resistance during prolonged therapy with B-lactam agents (i.e. Penicillins, monitoring may be required.

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CLINICAL LABORATORY REPORT

Patient: PETERSON, WILLIAM SR
M.R.#: 026523
Financial #: 102829710
DOB: [redacted] *Age:* 85yr *Sex:* M
Location: DIS *Room/Bed:*
Admit Date: 05/15/06
Discharge Date: 06/01/06
Physician: BOKKISAM, CHAKRAVARTHY

MICROBIOLOGY

Collected: 05/15/06 @ 17:25 *Received:* 05/15/06 @ 17:45 *Accn:* 32151 *Seq:* 108

05/18/06 FINAL RESULTS
FINAL

MICROBIOLOGY LEGEND: S = Sensitive I = Intermediate R = Resisitant BL = Beta Lactamase IB = Inducible Beta Lactamse
* Result interchangable with Cefotaxime
@ Pseudomonas, Enterobacter, Citrobacter, Serratia, Morganella, Providencia, or Aeromonas species may induce beta-lactamases and may develop resistance during prolonged therapy with B-lactam agents (i.e. Penicillins, Cephalosporins). Additional monitoring may be required.

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CLINICAL LABORATORY REPORT

Patient: PETERSON, WILLIAM SR
M.R.#: 026523
Financial #: 102829710
DOB: [redacted] *Age:* 85yr *Sex:* M
Location: DIS *Room/Bed:*
Admit Date: 05/15/06
Discharge Date: 06/01/06
Physician: BOKKISAM, CHAKRAVARTHY

MICROBIOLOGY

Collected: 05/15/06 @ 17:35 *Received:* 05/15/06 @ 17:44 *Accn:* 32152 *Seq:* 7107

BLOOD CULTURE

05/17/06 **Source** Blood

05/17/06 **PRELIM REPORT 1:**
No Growth In 48 Hours

05/21/06 **FINAL RESULTS**
No Growth 5 Days

MICROBIOLOGY LEGEND: S = Sensitive I = Intermediate R = Resisitant BL = Beta Lactamase IB = Inducible Beta Lactamse
* Result interchangable with Cefotaxime
@ Pseudomonas, Enterobacter, Citrobacter, Serratia, Morganella, Providencia, or Aeromonas species may induce beta-lactamases and may develop resistance during prolonged therapy with B-lactam agents (i.e. Penicillins, Cephalosporins). Additional monitoring may be required.

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CLINICAL LABORATORY REPORT

Patient: PETERSON, WILLIAM SR
M.R.#: 026523
Financial #: 102829710
DOB: [redacted] *Age:* 85yr *Sex:* M
Location: DIS *Room/Bed:*
Admit Date: 05/15/06
Discharge Date: 06/01/06
Physician: BOKKISAM, CHAKRAVARTHY

MICROBIOLOGY

Collected: 05/15/06 @ 21:00 *Received:* 05/15/06 @ 21:45 *Accn:* 32149 *Seq:* 7140

URINE CULTURE

05/17/06 **Source** Urine

05/17/06 **Prelim Report 1**
Greater Than 100,000 COL/ML Alpha Hemolytic Strep
Possible Staph Aureus

05/18/06 **Organism 1 ID:** Enterococcus faecalis
05/18/06 **Organism 2 ID:** Staphylococcus aureus
Note: Methicillin/Oxacillin Resistant
Results Phoned To:dr.gordon;8:50;5/18-jk

Antibiotics	Organism 1 ID: Ent. faecalis MIC	SYS	UR	Organism 2 ID: Staph.aureus MIC	SYS	UR	MIC	SYS	UR	MIC	SYS	UR
Amox/K Clav				<=4/2	R	R						
Ampicillin	2	S	S	>8	BL	BL						
Cefazolin				4	R	R						
Ciprofloxacin	2	I	I	<=1	S	S						
Gentamycin				<=1	S	S						
Imipenem				<=1	R	R						
Levofloxacin	<=2	S	S	<=2	S	S						
Linezolid	2	S	S									
Nitrofurantoin	<=32		S	<=32		S						
Oxacillin				>2	R	R						
Penicillin	2	S	S	>8	BL	BL						
Rifampin	<=1	S	S	<=1	S	S						
Tetracycline	>8	R	R	<=4	S	S						
Trimeth/Sulfa				<=2/38	S	S						
Vancomycin	<=2	S	S	<=2	S	S						

05/18/06 **Final Report**
FINAL

MICROBIOLOGY LEGEND: S = Sensitive I = Intermediate R = Resisitant BL = Beta Lactamase IB = Inducible Beta Lactamse
* Result interchangable with Cefotaxime
@ Pseudomonas, Enterobacter, Citrobacter, Serratia, Morganella, Providencia, or Aeromonas species may induce beta-lactamases and may develop resistance during prolonged therapy with B-lactam agents (i.e. Penicillins, Cephalosporins). Additional monitoring may be required.

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CLINICAL LABORATORY REPORT

Patient: PETERSON, WILLIAM SR
M.R.#: 026523
Financial #: 102829710
DOB: [redacted] *Age:* 85yr *Sex:* M
Location: DIS *Room/Bed:*
Admit Date: 05/15/06
Discharge Date: 06/01/06
Physician: BOKKISAM, CHAKRAVARTHY

MICROBIOLOGY

Collected: 05/15/06 @ 23:40 *Received:* 05/15/06 @ 23:58 *Accn:* 32266 *Seq:* 7146

BLOOD CULTURE

05/18/06 **Source** Blood

05/18/06 **PRELIM REPORT 1:**
No Growth In 48 Hours

05/21/06 **FINAL RESULTS**
No Growth 5 Days

MICROBIOLOGY LEGEND: S = Sensitive I = Intermediate R - Resisitant BL = Beta Lactamase IB = Inducible Beta Lactamse
* Result interchangable with Cefotaxime
@ Pseudomonas, Enterobacter, Citrobacter, Serratia, Morganella, Providencia, or Aeromonas species may induce beta-lactamases and may develop resistance during prolonged therapy with B-lactam agents (i.e. Penicillins, Cephalosporins). Additional monitoring may be required.

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Patient: PETERSON, WILLIAM SR
M.R.#: 026523
Financial #: 102829710
DOB: [redacted] Age: 85yr *Sex:* M
Location: DIS *Room/Bed:*
Admit Date: 05/15/06
Discharge Date: 06/01/06
Physician: BOKKISAM, CHAKRAVARTHY

CLINICAL LABORATORY REPORT

MICROBIOLOGY

Collected: 05/15/06 @ 23:50 *Received:* 05/15/06 @ 23:57 *Accn:* 32268 *Seq:* 7145

BLOOD CULTURE

05/18/06 **Source** Blood

05/18/06 **PRELIM REPORT 1:**
No Growth In 48 Hours

05/21/06 **FINAL RESULTS**
No Growth 5 Days

MICROBIOLOGY LEGEND: S = Sensitive I = Intermediate R = Resisitant BL = Beta Lactamase IB = Inducible Beta Lactamse
* Result interchangable with Cefotaxime
@ Pseudomonas, Enterobacter, Citrobacter, Serratia, Morganella, Providencia, or Aeromonas species may induce beta-lactamases and may develop resistance during prolonged therapy with B-lactam agents (i.e. Penicillins, Cephalosporins). Additional monitoring may be required.

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CLINICAL LABORATORY REPORT

Patient: PETERSON, WILLIAM SR
M.R.#: 026523
Financial #: 102829710
DOB: [redacted] *Age:* 85yr *Sex:* M
Location: DIS *Room/Bed:*
Admit Date: 05/15/06
Discharge Date: 06/01/06
Physician: BOKKISAM, CHAKRAVARTHY

MICROBIOLOGY

Collected: 05/16/06 @ 16:07 *Received:* 05/16/06 @ 16:23 *Accn:* 32666 *Seq:* 7206

BLOOD CULTURE

05/18/06 **Source** Blood

05/18/06 **PRELIM REPORT 1:**
No Growth In 48 Hours
05/22/06 **FINAL RESULTS**
No Growth 5 Days

MICROBIOLOGY LEGEND: S = Sensitive I = Intermediate R - Resisitant BL = Beta Lactamase IB = Inducible Beta Lactamse
* Result interchangable with Cefotaxime
@ Pseudomonas, Enterobacter, Citrobacter, Serratia, Morganella, Providencia, or Aeromonas species may induce beta-lactamases and may develop resistance during prolonged therapy with B-lactam agents (i.e. Penicillins, Cephalosporins). Additional monitoring may be required.

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M.R.#: 026523
Financial #: 102829710
DOB: [redacted] *Age:* 85yr *Sex:* M
Location: DIS *Room/Bed:*
Admit Date: 05/15/06
Discharge Date: 06/01/06
Physician: BOKKISAM, CHAKRAVARTHY

CLINICAL LABORATORY REPORT

MICROBIOLOGY

Collected: 05/16/06 @ 16:15 *Received:* 05/16/06 @ 16:22 *Accn:* 32665 *Seq:* 7205

BLOOD CULTURE

05/18/06	Source	Blood
05/18/06	PRELIM REPORT 1:	
	No Growth In 48 Hours	
05/22/06	FINAL RESULTS	
	No Growth 5 Days	

MICROBIOLOGY LEGEND: S = Sensitive I = Intermediate R - Resisitant BL = Beta Lactamase IB = Inducible Beta Lactamse
* Result interchangable with Cefotaxime
@ Pseudomonas, Enterobacter, Citrobacter, Serratia, Morganella, Providencia, or Aeromonas species may induce beta-lactamases and may develop resistance during prolonged therapy with B-lactam agents (i.e. Penicillins, Cephalosporins). Additional monitoring may be required.

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CLINICAL LABORATORY REPORT

Patient: PETERSON, WILLIAM SR
M.R.#: 026523
Financial #: 102829710
DOB: [redacted] *Age:* 85yr *Sex:* M
Location: DIS *Room/Bed:*
Admit Date: 05/15/06
Discharge Date: 06/01/06
Physician: BOKKISAM, CHAKRAVARTHY

MICROBIOLOGY

Collected: 05/19/06 @ 07:40 *Received:* 05/19/06 @ 07:49 *Accn:* 34329 *Seq:* 7509

BLOOD CULTURE

05/22/06 **Source** Blood

05/21/06 **PRELIM REPORT 1:**
No Growth In 48 Hours

05/24/06 **FINAL RESULTS**
No Growth 5 Days

MICROBIOLOGY LEGEND: S = Sensitive I = Intermediate R - Resisitant BL = Beta Lactamase IB = Inducible Beta Lactamse
* Result interchangable with Cefotaxime
@ Pseudomonas, Enterobacter, Citrobacter, Serratia, Morganella, Providencia, or Aeromonas species may induce beta-lactamases and may develop resistance during prolonged therapy with B-lactam agents (i.e. Penicillins, Cephalosporins). Additional monitoring may be required.

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Patient: PETERSON, WILLIAM SR
M.R.#: 026523
Financial #: 102829710
DOB: [redacted] Age: 85yr Sex: M
Location: DIS Room/Bed:
Admit Date: 05/15/06
Discharge Date: 06/01/06
Physician: BOKKISAM, CHAKRAVARTHY

CLINICAL LABORATORY REPORT

MICROBIOLOGY

Collected: 05/19/06 @ 07:45 Received: 05/19/06 @ 07:49 Accn: 34328 Seq: 7510

BLOOD CULTURE

05/22/06 Source Blood

05/21/06 **PRELIM REPORT 1:**
No Growth In 48 Hours

05/24/06 **FINAL RESULTS**
No Growth 5 Days

MICROBIOLOGY LEGEND: S = Sensitive I = Intermediate R - Resisitant BL = Beta Lactamase IB = Inducible Beta Lactamse
* Result interchangable with Cefotaxime
@ Pseudomonas, Enterobacter, Citrobacter, Serratia, Morganella, Providencia, or Aeromonas species may induce beta-lactamases and may develop resistance during prolonged therapy with B-lactam agents (i.e. Penicillins, Cephalosporins). Additional monitoring may be required.

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CLINICAL LABORATORY REPORT

Patient: PETERSON, WILLIAM SR
M.R.#: 026523
Financial #: 102829710
DOB: [redacted] Age: 85yr *Sex:* M
Location: DIS *Room/Bed:*
Admit Date: 05/15/06
Discharge Date: 06/01/06
Physician: BOKKISAM, CHAKRAVARTHY

REFERENCE

Collected: 05/25/06 @ 13:30 Accn: 37459

Test	Result
Source	Bronchial Washing
AFB Culture	* In Process *

MICROBIOLOGY

05/25/06	Source	Bronchial Washing
05/27/06	AFB Stain	No Acid Fast Bacilli Seen On Direct Smear

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CLINICAL LABORATORY REPORT

Patient: PETERSON, WILLIAM SR
M.R.#: 026523
Financial #: 102829710
DOB: [redacted] Age: 85yr *Sex:* M
Location: DIS *Room/Bed:*
Admit Date: 05/15/06
Discharge Date: 06/01/06
Physician: BOKKISAM, CHAKRAVARTHY

REFERENCE

Collected: 05/25/06 @ 13:30 Accn: 37460

Test	Result
Source	Bronchial Washing
FUNGAL CULTURE	* In Process *

Legend
High =H Low = L Critical =C

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M.R.#: 026523
Financial #: 102829710
DOB: [redacted] *Age:* 85yr *Sex:* M
Location: DIS *Room/Bed:*
Admit Date: 05/15/06
Discharge Date: 06/01/06
Physician: BOKKISAM, CHAKRAVARTHY

MICROBIOLOGY

Collected: 05/25/06 @ 13:30 *Received:* 05/25/06 @ 13:51 *Accn:* 37458 *Seq:* 7977

05/26/06	Source	Bronchial Washing
05/26/06	Gram Stain	
	Moderate WBC's Seen	
	Few Epithelial Cells	
	Many Budding Yeast	

AIKEN REGIONAL MEDICAL CENTERS

302 UNIVERSITY PARKWAY
AIKEN, SOUTH CAROLINA 29801
PATHOLOGISTS:
DENYSE N. PARNELL, M.D.
BONNIE S. SZYMIK, M.D.
JASON FANCEY, M.D.

CLINICAL LABORATORY REPORT

Patient: PETERSON, WILLIAM SR
M.R.#: 026523
Financial #: 102829710
DOB: [redacted] Age: 85yr *Sex:* M
Location: DIS *Room/Bed:*
Admit Date: 05/15/06
Discharge Date: 06/01/06
Physician: BOKKISAM, CHAKRAVARTHY

MICROBIOLOGY

Collected: 05/25/06 @ 13:30 *Received:* 05/25/06 @ 13:51 *Accn:* 37453 *Seq:* 7981

BRONCH CULTURE

05/26/06 **Source** Bronchial Washing

05/28/06 **Prelim Report 1**
Moderate Growth Gram Negative Rod
Heavy Growth Budding Yeast
Normal Flora Absent

05/28/06 **Organism 1 ID:** Klebsiella pneumoniae
05/28/06 **Organism 2 ID:** Candida species, not albicans

Antibiotics	Organism 1 ID: Kleb.pneumo. MIC	SYS UR	Organism 2 ID: Candida not al MIC	SYS UR	MIC	SYS UR	MIC	SYS UR
Amikacin	<=2	S						
Amp/Sulbactam	<=8/4	S						
Ampicillin	>16	R						
Aztreonam	<=8	S						
Cefazolin	<=2	S						
Ceftazidime	<=8	S						
* Ceftriaxone	<=4	S						
Cefuroxime	16	I						
Ciprofloxacin	2	I						
Gentamycin	<=1	S						
Imipenem	<=4	S						
Levofloxacin	1	S						
Meropenem	<=1	S						
Piperacillin	16	S						
Tobramycin	<=1	S						
Trimeth/Sulfa	<=2/38	S						

05/28/06 **Final Report**
FINAL

MICROBIOLOGY LEGEND: S = Sensitive I = Intermediate R = Resisitant BL = Beta Lactamase IB = Inducible Beta Lactamse
* Result interchangable with Cefotaxime
@ Pseudomonas, Enterobacter, Citrobacter, Serratia, Morganella, Providencia, or Aeromonas species may induce beta-lactamases and may develop resistance during prolonged therapy with B-lactam agents (i.e. Penicillins, Cephalosporins). Additional monitoring may be required.

AIKEN REGIONAL MEDICAL CENTERS

302 UNIVERSITY PARKWAY
AIKEN, SOUTH CAROLINA 29801
PATHOLOGISTS:
DENYSE N. PARNELL, M.D.
BONNIE S. SZYMIK, M.D.
JASON FANCEY, M.D.

CLINICAL LABORATORY REPORT

Patient: PETERSON, WILLIAM SR
M.R.#: 026523
Financial #: 102829710
DOB: [redacted] *Age:* 85yr *Sex:* M
Location: DIS *Room/Bed:*
Admit Date: 05/15/06
Discharge Date: 06/01/06
Physician: BOKKISAM, CHAKRAVARTHY

MICROBIOLOGY

Collected: 05/26/06 @ 17:30 *Received:* 05/26/06 @ 17:38 *Accn:* 38050 *Seq:* 8095

BODY FLUID CULT

05/29/06 Source Pleural Fluid
05/29/06 Final Report
No Growth In 72 Hours

MICROBIOLOGY LEGEND: S = Sensitive I = Intermediate R - Resisitant BL = Beta Lactamase IB = Inducible Beta Lactamse
* Result interchangable with Cefotaxime
@ Pseudomonas, Enterobacter, Citrobacter, Serratia, Morganella, Providencia, or Aeromonas species may induce beta-lactamases and may develop resistance during prolonged therapy with B-lactam agents (i.e. Penicillins, Cephalosporins). Additional monitoring may be required.

AIKEN REGIONAL MEDICAL CENTERS

302 UNIVERSITY PARKWAY
AIKEN, SOUTH CAROLINA 29801
PATHOLOGISTS:
DENYSE N. PARNELL, M.D.
BONNIE S. SZYMIK, M.D.
JASON FANCEY, M.D.

Patient: PETERSON, WILLIAM SR
M.R.#: 026523
Financial #: 102829710
DOB: [redacted] Age: 85yr Sex: M
Location: DIS Room/Bed:
Admit Date: 05/15/06
Discharge Date: 06/01/06
Physician: BOKKISAM, CHAKRAVARTHY

CLINICAL LABORATORY REPORT

MICROBIOLOGY

Collected: 05/26/06 @ 17:30 Received: 05/26/06 @ 17:38 Accn: 38051 Seq: 8094

05/27/06	Source	Pleural Fluid
05/27/06	Gram Stain	
	Rare WBC Seen	
	No Bacteria Seen	

AIKEN REGIONAL MEDICAL CENTERS

302 UNIVERSITY PARKWAY
AIKEN, SOUTH CAROLINA 29801
PATHOLOGISTS:
DENYSE N. PARNELL, M.D.
BONNIE S. SZYMIK, M.D.
JASON FANCEY, M.D.

CLINICAL LABORATORY REPORT

Patient: PETERSON, WILLIAM SR
M.R.#: 026523
Financial #: 102829710
DOB: [redacted] *Age:* 85yr *Sex:* M
Location: DIS *Room/Bed:*
Admit Date: 05/15/06
Discharge Date: 06/01/06
Physician: BOKKISAM, CHAKRAVARTHY

MICROBIOLOGY

Collected: 05/30/06 @ 06:25 *Received:* 05/30/06 @ 07:26 *Accn:* 39405 *Seq:* 8243

05/30/06	Source	Stool
05/30/06	Occult Blood	Positive 1+

AIKEN REGIONAL MEDICAL CENTERS

302 UNIVERSITY PARKWAY
AIKEN, SOUTH CAROLINA 29801
PATHOLOGISTS:
DENYSE N. PARNELL, M.D.
BONNIE S. SZYMIK, M.D.
JASON FANCEY, M.D.

CLINICAL LABORATORY REPORT

Patient: PETERSON, WILLIAM SR
M.R.#: 026523
Financial #: 102829710
DOB: [redacted] Age: 85yr *Sex:* M
Location: DIS *Room/Bed:*
Admit Date: 05/15/06
Discharge Date: 06/01/06
Physician: BOKKISAM, CHAKRAVARTHY

MICROBIOLOGY

Collected: 05/30/06 @ 12:05 *Received:* 05/30/06 @ 14:13 *Accn:* 39573 *Seq:* 8265

05/30/06	Source	Stool
05/30/06	Occult Blood	Positive 3+

AIKEN REGIONAL MEDICAL CENTERS

302 UNIVERSITY PARKWAY
AIKEN, SOUTH CAROLINA 29801
PATHOLOGISTS:
DENYSE N. PARNELL, M.D.
BONNIE S. SZYMIK, M.D.
JASON FANCEY, M.D.

CLINICAL LABORATORY REPORT

Patient: PETERSON, WILLIAM SR
M.R.#: 026523
Financial #: 102829710
DOB: [redacted] *Age:* 85yr *Sex:* M
Location: DIS *Room/Bed:*
Admit Date: 05/15/06
Discharge Date: 06/01/06
Physician: BOKKISAM, CHAKRAVARTHY

MICROBIOLOGY

Collected: 05/31/06 @ 01:30 *Received:* 05/31/06 @ 01:31 *Accn:* 39951 *Seq:* 8303

05/31/06	Source	Stool
05/31/06	Occult Blood	Positive 3+

AIKEN REGIONAL MEDICAL CENTERS
302 UNIVERSITY PARKWAY
AIKEN, SC 29802
(803) 641-5170

SURGICAL PATHOLOGY REPORT

PATIENT: **WILLIAM PETERSON** FILE #: 26523
DOB: [redacted] (85) SEX: M RACE: B SSN: [redacted]
PHYSICIAN: JAMES HAGAN, M.D.

DEPT #: S06-2992
PERFORMED: 5/31/06
RECEIVED: 5/31/06
REPORTED: 6/01/06

CLINICAL DATA: EGD/COLON. ANEMIA. DECREASED HGB.
1. 45 CM.

GROSS DESCRIPTION:
The specimen is labeled "45 cm" and it consists of a 0.4 x 0.2 x 0.2 cm aggregate of two fragments of soft pink-tan tissue which are entirely submitted.
AD:bg

MICROSCOPIC DESCRIPTION:
Sections show two fragments of colonic mucosa, one of which contains glands with normal profiles lined by columnar cells with moderately enlarged hyperchromatic basally oriented oval nuclei. There is no evidence of malignancy.

DIAGNOSIS: **LARGE INTESTINE, 45 CM, ENDOSCOPIC BIOPSY:**
TUBULAR ADENOMA.

JTF/bg

ORIGINAL

DENYSE PARNELL, M.D. BONNIE SZYMIK, M.D. JASON FANCEY, M.D. CLAUDIA CROITORU, M.D.
PATHOLOGISTS

JASON FANCEY, M.D.

Aiken Regional
Medical Centers

PLACE TOP OF REPORT #3 HERE

HORIZONTAL

HISTOLOGY

Aiken Regional Medical Center
Aiken, South Carolina 29801

DATE OF SERVICE	PHYSICIAN
5-3-06	WAGAR
COLLECTED TIME	**TECH/NURSE**
1555 a.m. (p.m.)	HCR

PROCEDURE: EGD / colon

OPERATIVE DX: Anemia

BRIEF CLINICAL HISTORY: ↓HGB

SPECIMEN(S) SUBMITTED
1) 45 cm
2)
3)
4)

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

MAY 31 PM 5:50

1. ☒ Routine Gross And Microscopic.
2. ☐ Frozen Section **ROOM NUMBER:** _____
3. ☐ Take specimen immediately to Pathologist for examination - FRESH
4. ☐ Take specimen immediately to X-Ray and then immediately to Pathologist - FRESH
5. ☐ Bone Marrow Examination.
6. ☐ Other

LAB USE ONLY

SPECIMEN DESCRIPTION:

GROSS DX:

FS DX:

SPECIMEN NUMB

S06-2

10-1988

LABORATORY REPORTS

Aiken Regional Medical Centers
Blood Transfusion Record

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

☑ Blood consent signed ☑ Physician Order Verified

Date: 5.30.06

Monitoring Requirements	Time	Temp	Pulse	Resp	BP	S/S of Transfusion Reaction	Comments	Initials
Prior to transfusion	0130	97.4	83	16	137/66		2nd unit of PRBCs Started	JS
15 minutes	0145	97.3	74	18	126/65	☑ No ☐ Yes		JS
30 minutes	0215	97.3	76	16	112/62	☑ No ☐ Yes		JS
30 minutes	0245	97.5	74	16	116/69	☒ No ☐ Yes		JS
30 minutes	0315	97.5	69	16	111/66	☒ No ☐ Yes		JS
30 minutes	0345	97.4	74	18	121/71	☒ No ☐ Yes		JS
30 minutes	0415	97.4	67	20	109/71	☒ No ☐ Yes		JS
30 minutes						☐ No ☐ Yes		
30 minutes						☐ No ☐ Yes		
30 minutes						☐ No ☐ Yes		
1 hour post transfusion	0515	97.5	72	18	117/68	☒ No ☐ Yes		JS

Si Jennifer Stanwich RN

USE SEPARATE REQUEST FOR EACH UNIT OF BLOOD

PETERSON, WILLIAM SR
26523
O POS
1054684
O POS
ERA; 7796
247-30-6586

AIKEN REGIONAL MEDICAL CENTER
AIKEN, SOUTH CAROLINA 29801
NO. OF UNITS IN POOL

COMPONENT
PACKED RBC-ADSOL
UNIT EXPIRATION DATE/TIME06/28/06 23:59

TECH NO.
SW

CROSSMATCH
Patient Is Compatible With:

DATE/TIME 05/29/0618:02
CROSSMATCH EXPIRATION 06/01/06

ISSUED BY

RECEIVED BY JWS SW

DATE / TIME 5/30/06 0115

VISUAL INSPECTION INITIALS

I have checked the blood type and RH and all number on the transfusion record and blood container and also the patient's name and hospital number on both the transfusion record and the identification bracelet. I certify them to be identical and correct.

(1) NURSE # J. Stanwich
(2) AUTHORIZED PERSONNEL

CHART COPY

BLOOD CROSSMATCH

TRANSFUSION INFORMATION

DATE AND HOUR BEGUN	5.30.06 0130	AM / PM
DATE AND HOUR COMPLETE	5.30.06 0415	AM / PM
AMOUNT TRANSFUSED	All	
WAS THERE A TRANSFUSION REACTION?	☐ YES	☒ NO

10-37037 (2/06)

Aiken Regional Medical Centers
Blood Transfusion Record

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

☑ Blood consent signed ☑ Physician Order Verified

Date: 5.29.06

Monitoring Requirements	Time	Temp	Pulse	Resp	BP	S/S of Transfusion Reaction	Comments	Initials
Prior to transfusion	2045	97.6	71	16	124/65		1st unit of PRBCs started	JS
15 minutes	2100	97.5	72	16	115/63	☑ No ☐ Yes		JS
30 minutes	2130	97.4	76	16	123/68	☑ No ☐ Yes		JS
30 minutes	2200	97.3	73	16	128/66	☑ No ☐ Yes		JS
30 minutes	2230	97.3	75	16	142/72	☑ No ☐ Yes		JS
30 minutes	2300	97.3	74	16	138/70	☑ No ☐ Yes		JS
30 minutes	2330	97.3	78	16	141/74	☑ No ☐ Yes		JS
30 minutes						☐ No ☐ Yes		
30 minutes						☐ No ☐ Yes		
30 minutes						☐ No ☐ Yes		
1 hour post transfusion	0030	97.2	78	18	130/71	☑ No ☐ Yes		JS

Nursing Manual

USE SEPARATE REQUEST FOR EACH UNIT OF BLOOD

PETERSON, WILLIAM SR
26523
O POS
3027196
O POS
EBA 7796
247-30-6586

AIKEN REGIONAL MEDICAL CENTER
AIKEN, SOUTH CAROLINA 29801
NO. OF UNITS IN POOL

COMPONENT

PACKED RBC-ADSOL
UNIT EXPIRATION DATE/TIME06/28/06 23:59

TECH NO.
SW

CROSSMATCH
Patient Is Compatible With:

DATE/TIME 05/29/0618:02

CROSSMATCH EXPIRATION 06/01/06

ISSUED BY SW

RECEIVED BY JWS SM

DATE / TIME 5/29/06 20:30

VISUAL INSPECTION OK INITIALS SW

I have checked the blood type and RH and all number on the transfusion record and blood container and also the patient's name and hospital number on both the transfusion record and the identification bracelet. I certify them to be identical and correct.

(1) NURSE #1

(2) AUTHORIZED PERSONNEL J. Stevens RN

CHART COPY

BLOOD CROSSMATCH

TRANSFUSION INFORMATION

DATE AND HOUR BEGUN	5.29.06 2045 AM (PM)
DATE AND HOUR COMPLETE	2330 5.29.06 AM (PM)
AMOUNT TRANSFUSED	All
WAS THERE A TRANSFUSION REACTION?	☐ YES ☒ NO

10-37037 (2/06)

t Diagnostics Incorporated

Nichols Institute, Chantilly

SPECIMEN INFORMATION
SPECIMEN: 54585610
REQUISITION: 37460
LAB REF NO: 54585610

COLLECTED: 05/26/2006 04:03
RECEIVED: 503 00:00
REPORTED: 06/05/2006 16:17

PATIENT INFORMATION
PETERSON,WILLIAM SR

DOB: [redacted] Age: 85Y
GENDER: M
SS: 05/25/2006
ID: 026523
PHONE: [redacted]

Room/Loc: 5M

REPORT STATUS **Partial**

ORDERING PHYSICIAN
BOKKISAM, CHAKRAVARTHY 04

CLIENT INFORMATION
23393
AIKEN REGIONAL MEDICAL CENTER

302 UNIVERSITY PKWY
AIKEN, SC 29802-1117

Test Name	In Range	Out of Range	Reference Range	Lab
FUNGUS CULTURE AND SMEAR				AMD
FUNGUS CULTURE AND SMEAR	FUNGUS CULTURE AND SMEAR			
FUNGUS SMEAR				
SOURCE : BRONCHIAL WASHIN				
ORGANISM(S) ISOLATED				
1. Many Budding yeast				
FUNGUS CULTURE				
SOURCE : BRONCHIAL WASHIN				
ORGANISM(S) ISOLATED				
1. Heavy growth of Candida species				

PRELIMINARY REPORT

Performing Laboratory Information:

AMD QUEST DIAGNOSTICS INCORPORATED NICHOLS INSTITUTE 14225 NEWBROOK DR CHANTILLY VA 20151
Laboratory Director: NATHAN SHERMAN, MD

AIKEN REGIONAL MEDICAL CENTERS
302 UNIVERSITY PARKWAY
AIKEN, SC 29802
(803) 641-5170

503

CYTOPATHOLOGY REPORT

PATIENT: **WILLIAM PETERSON** FILE #: 26523
DOB: [redacted] (85) SEX: M RACE: SSN: [redacted]
PHYSICIAN: NICHOLAS J. SANITO, M.D.

DEPT #: C06-310
PERFORMED: 5/25/06
RECEIVED: 5/25/06
REPORTED: 5/26/06

CLINICAL DATA: BRONCH WASH, CYTOLOGY.

DIAGNOSIS: BRONCHIAL WASH, CYTOLOGY (THIN PREP, CELL BLOCK SPECIAL STAINS):
RARE SCATTERED UNREMARKABLE RESPIRATORY EPITHELIAL CELLS WITH SCATTERED BACKGROUND ACUTE INFLAMMATORY CELLS.
SCATTERED CLUSTERS OF SUPERFICIAL SQUAMOUS CELLS.
NUMEROUS YEAST FORMS AND HYPHAL ELEMENTS CONSISTENT WITH CANDIDA SPECIES.
NEGATIVE FOR OTHER SPECIFIC ORGANISMS (BROWN-HOPPS AND AFB).
NEGATIVE FOR MALIGNANCY.

JTF:slb

SPECIMEN: BRONCHIAL WASHING

ORIGINAL

DENYSE PARNELL, M.D. BONNIE SZYMIK, M.D. JASON FANCEY, M.D. CLAUDIA CROITURU, M.D.
PATHOLOGIST

JASON FANCEY, M.D.

PLACE TOP OF REPORT #3 HERE

HORIZONTAL

CYTOLOGY

Aiken Regional Medical Center
Aiken, South Carolina 29801

DATE OF SERVICE	PHYSICIAN
5/25/06	Smith
COLLECTED TIME	**TECH/NURSE**
1330 a.m. p.m.	BB

PROCEDURE: Bronch Wash

BRIEF CLINICAL HISTORY: RAC

SPECIMEN(S) SUBMITTED

	PAP		Urine
	Cervical		Peritoneal
	Vaginal		Esophagus
	Sputum		Breast
	Bronch. Brush.		CS F
✓	Bronch. Wash.		Other
	Pleural		

102829710 503
PETERSON SR, WILLIAM SR
DOB: [redacted] 85 SX: M IMD
MRN: 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

Lab Only:

Specimen Description: 10mls brown cloudy fluid in 30mls cyto

RCVD 25 PM 1:54

Number of slides received: 0

Number of sytospin slides made: 0

Number of thin prep slides made: 2

Number of cell blocks made: 1

Prep Tech: SM

Cell 5/25 1330
cytolyte added

SPECIMEN NUMBER: C06-310 SM

t Diagnostics Incorporated

REPORT STATUS **Partial**

ols Institute, Chantilly

PATIENT INFORMATION
PETERSON,WILLIAM SR

DOB: [redacted] Age: 85Y
GENDER: M
SS: 05/25/2006
ID: 026523
PHONE: [redacted]

ORDERING PHYSICIAN
BOKKISAM, CHAKRAVARTHY 04

503

CLIENT INFORMATION
23393
AIKEN REGIONAL MEDICAL CENTER

302 UNIVERSITY PKWY
AIKEN, SC 29802-1117

SPECIMEN INFORMATION
SPECIMEN: 54585610
REQUISITION: 37460
LAB REF NO: 54585610

COLLECTED: 05/26/2006 04:03
RECEIVED: 503 00:00
REPORTED: 05/27/2006 00:14

Room/Loc: 5M

Test Name	In Range	Out of Range	Reference Range	Lab
FUNGUS CULTURE AND SMEAR				AMD
FUNGUS CULTURE AND SMEAR		FUNGUS CULTURE AND SMEAR		
FUNGUS SMEAR				
SOURCE : BRONCHIAL WASHIN				
ORGANISM(S) ISOLATED				
1. Many Budding yeast				
FUNGUS CULTURE			PENDING	
RESULT/COMMENT:			PENDING	

Performing Laboratory Information:

AMD QUEST DIAGNOSTICS INCORPORATED NICHOLS INSTITUTE 14225 NEWBROOK DR CHANTILLY VA 20151
Laboratory Director: NATHAN SHERMAN, MD

st Diagnostics Incorporated

REPORT STATUS **Partial**

ols Institute, Chantilly

PATIENT INFORMATION
PETERSON,WILLIAM SR

DOB: [redacted] Age: 85Y
GENDER: M
SS: 05/25/2006
ID: 026523
PHONE: [redacted]

ORDERING PHYSICIAN
BOKKISAM, CHAKRAVARTHY 04

CLIENT INFORMATION 503
23393
AIKEN REGIONAL MEDICAL CENTER

302 UNIVERSITY PKWY
AIKEN, SC 29802-1117

SPECIMEN INFORMATION
SPECIMEN: 54585626
REQUISITION: 37459
LAB REF NO: 54585626

COLLECTED: 05/26/2006 04:04
RECEIVED: 503 00:00
REPORTED: 05/26/2006 16:43

Room/Loc: 5M

Test Name	In Range	Out of Range	Reference Range	Lab
ACID FAST CULTURE, PROGRESSIVE AND SMEAR (TB)				
ACID FAST CULTURE, PROGRESSIVE AND SMEAR (TB)				AMD
ACID FAST CULTURE, PROGRESSIVE AND SMEAR (TB)				
AFB SMEAR			PENDING	
SOURCE : Bronchial Washin			PENDING	
RESULT/COMMENT:			PENDING	
No acid-fast bacilli seen.				
ACID FAST CULTURE			PENDING	
RESULT/COMMENT:			PENDING	

Performing Laboratory Information:

AMD QUEST DIAGNOSTICS INCORPORATED NICHOLS INSTITUTE 14225 NEWBROOK DR CHANTILLY VA 20151
Laboratory Director: NATHAN SHERMAN, MD

AIKEN REGIONAL MEDICAL CENTER
EMERGENCY DEPARTMENT
URINE DIPSTICK & URINE PREGNANCY RESULTS

URINE DIPSTICK:

LEUKOCYTES _____

NITRITES _____

UROBILINOGEN _____

PROTEIN _____

PH _____

BLOOD _____

SPEC. GRAVITY _____

KETONES _____

BILIRUBIN _____

GLUCOSE _____

COLOR _____

CLARITY _____

URINE PREGNANCY:

NEGATIVE

POSITIVE

05-15-06

CLARITY: _____
COLOR: DK. YELLOW
GLU NEGATIVE
BIL* MODERATE
KET* TRACE
SG >=1.030
BLO* LARGE
pH 5.0
PRO* >=300 mg/dL
URO 1.0 E.U./dL
NIT* POSITIVE
LEU* LARGE

SPECIMEN SENT TO LAB **YES** **NO**

PLEASE NOTE: If any of the results in bold type have a value that is outside the normal value they MUST be sent to lab for confirmation and an order put in the system. Any urine pregnancy test with an indeterminate result MUST be reported to the physician.

ADDRESSOGRAPH

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

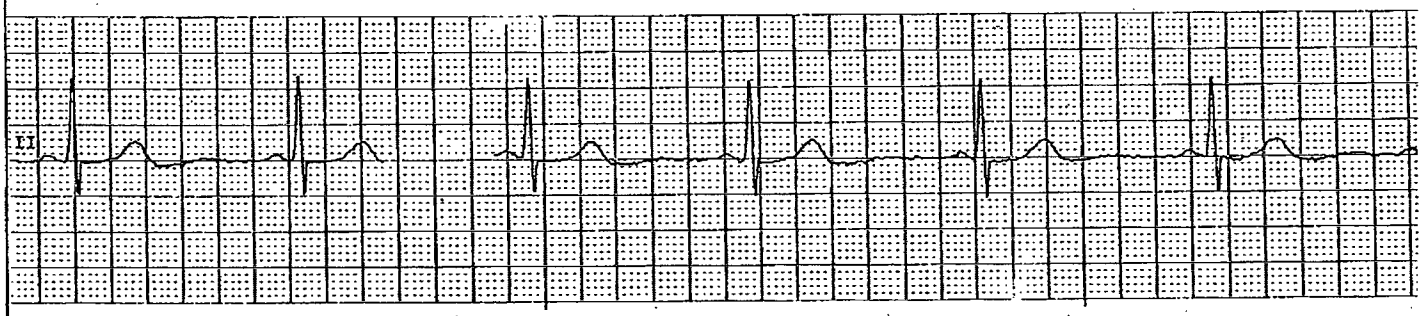
F G L F G L F -981-

REMARKS:

IMPRINT AREA

102829710
PETERSON SR [redacted] AM SR
DOB: [redacted] SX: M IMD
MRN: [redacted] DM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

PETERSON,WILLIA 5MAIN!503* PID:102829710 TTX#1002FH MANUAL 31-MAY-2006 15:00:16
@25 MM/S SL(II) HR 47 PVC 0 ST II -0.1

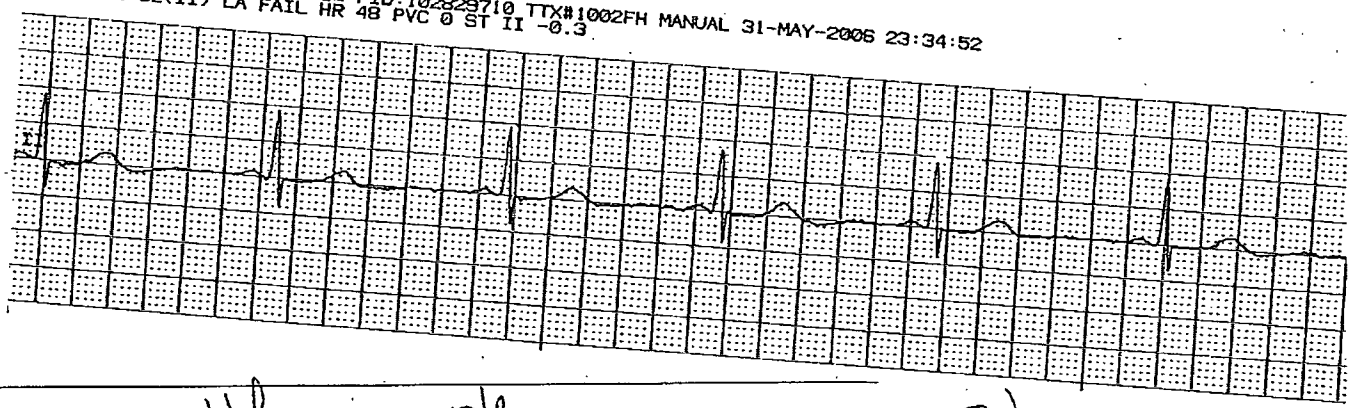


DATE: _____ PR: .12 QRS: .06 TREATED: _____
TIME: _____ RATE: 42 INTERPRETATION: SB

PETERSON,WILLIA 5MAIN!503* PID:102829710 TTX#1002FH MANUAL 31-MAY-2006 19:44:09
@25 MM/S SL(II) HR 56 PVC 0 ST II 0.0

DATE: _____ PR: 12 QRS: .08 TREATED: _____
TIME: _____ RATE: 56 INTERPRETATION: SB

PETERSON,WILLIA 5MAIN!503* PID:102829710 TTX#1002FH MANUAL 31-MAY-2006 23:34:52
@25 MM/S SL(II) LA FAIL HR 48 PVC 0 ST II -0.3



DATE: _____ PR: 14 QRS: .06 TREATED: _____
TIME: _____ RATE: 48 INTERPRETATION: SB

HRF-0226-NS

RHYTHM STRIP CHART FORM

REMARKS:

I M

102829710

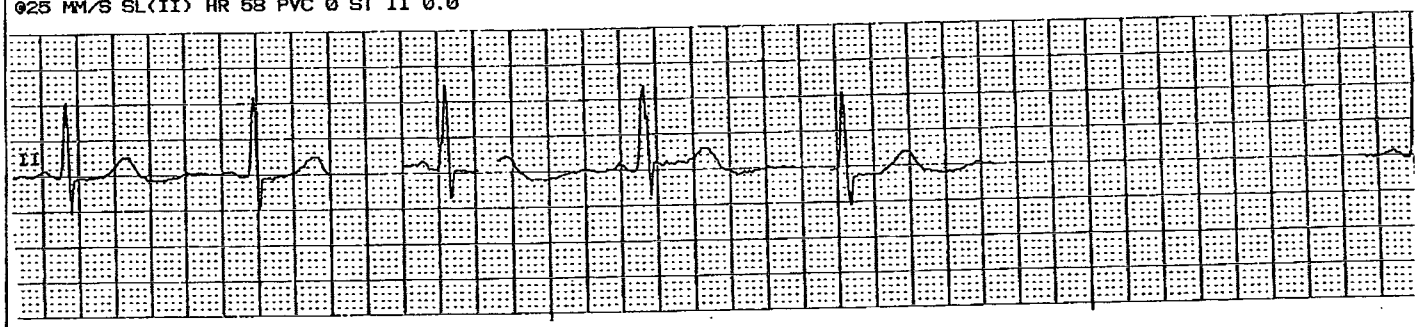
PETERSON, [redacted] IAM SR
DOB: [redacted] 35 SX: M IMD
MRN: 28523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

R E A

PETERSON,WILLIA 5MAIN!503* PID:102829710 TTX#1002FH MANUAL 31-MAY-2006 03:13:21
@25 MM/S SL(II) HR 65 PVC 0 ST II 0.1

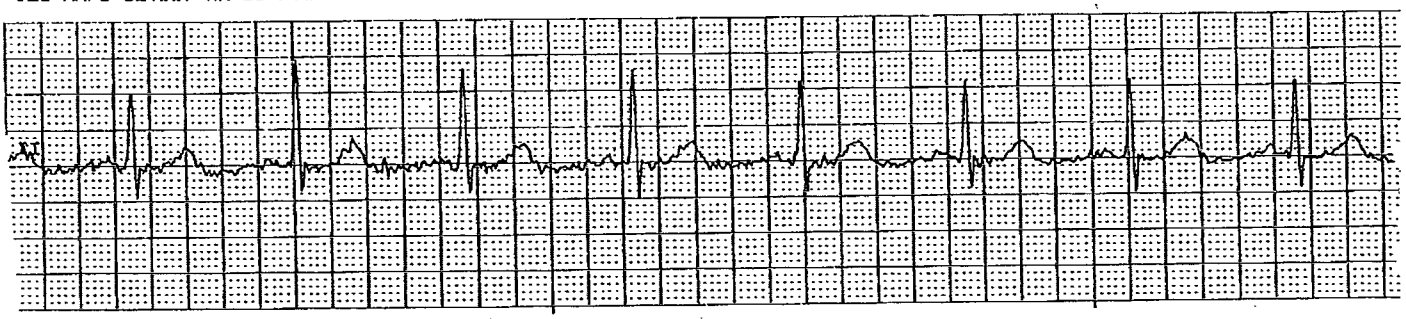
DATE: _____ PR: .14 QRS: .08
TIME: _____ RATE: 65 INTERPRETATION: SR TW

PETERSON,WILLIA 5MAIN!503* PID:102829710 TTX#1002FH MANUAL 31-MAY-2006 06:55:48
@25 MM/S SL(II) HR 58 PVC 0 ST II 0.0



DATE: _____ PR: .14 QRS: .06 TREATED: _____
TIME: _____ RATE: 58 INTERPRETATION: SB

PETERSON,WILLIA 5MAIN!503* PID:102829710 TTX#1002FH MANUAL 31-MAY-2006 10:56:02
@25 MM/S SL(II) HR 65 PVC 0 ST II -0.2



DATE: _____ PR: .14 QRS: .06 TREATED: _____
TIME: _____ RATE: 65 INTERPRETATION: SR

HRR-0228-NS

RHYTHM STRIP CHART FORM

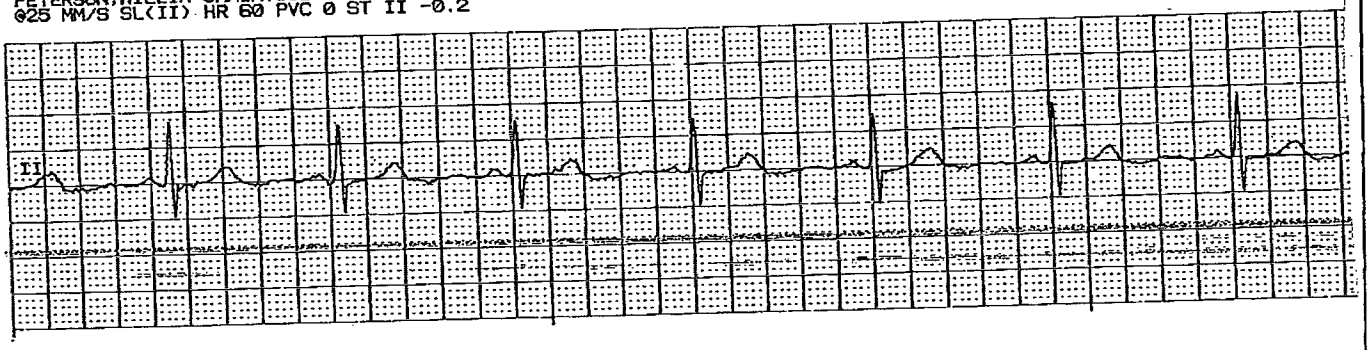
-983-

REMARKS:

IMPRINT AREA

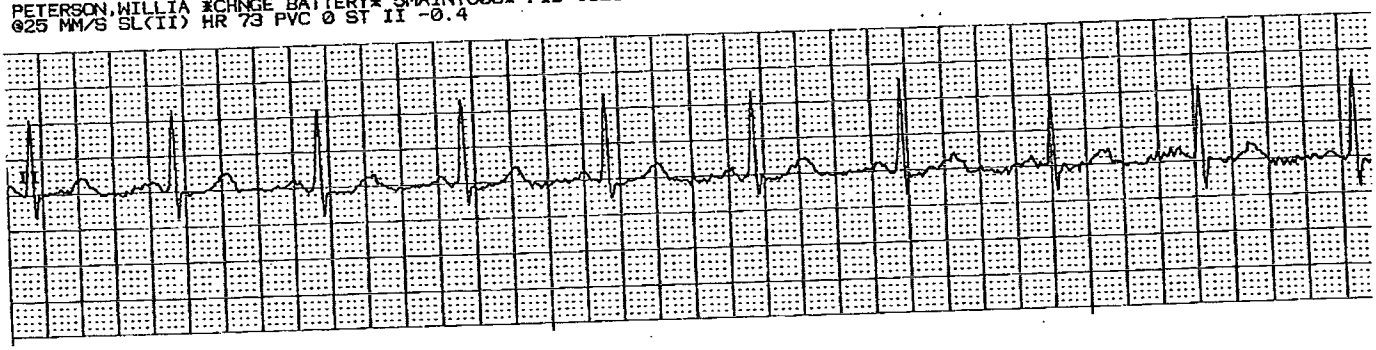
102829710
PETERSON SR, WILLIAM SR
DOB: [redacted] 85 SX: M IMD
MRN: 26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

PETERSON,WILLIA 5MAIN!503* PID:102829710 TTX#1002FH MANUAL SAVED 30-MAY-2006 15:06:43
@25 MM/S SL(II) HR 60 PVC 0 ST II -0.2



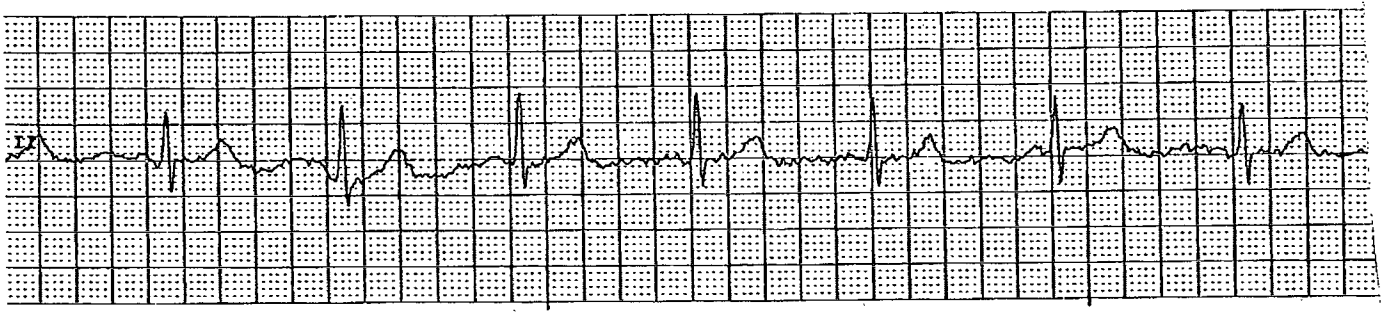
DATE: _____ PR: 16 QRS: .08 TREATED: GLC
TIME: _____ RATE: 60 INTERPRETATION: SR

PETERSON,WILLIA *CHNGE BATTERY* 5MAIN!503* PID:102829710 TTX#1002FH MANUAL SAVED 30-MAY-2006 20:28:22 CHNGE BATTE
@25 MM/S SL(II) HR 73 PVC 0 ST II -0.4



DATE: _____ PR: 14 QRS: 10 TREATED: TW
TIME: _____ RATE: 73 INTERPRETATION: SR

PETERSON,WILLIA 5MAIN!503* PID:102829710 TTX#1002FH MANUAL 30-MAY-2006 23:03:49
@25 MM/S SL(II) HR 59 PVC 0 ST II 0.0



DATE: _____ PR: 14 QRS: 10 TREATED: TW
TIME: _____ RATE: 60 INTERPRETATION: SR

HRR-0226-NS

RHYTHM STRIP CHART FORM

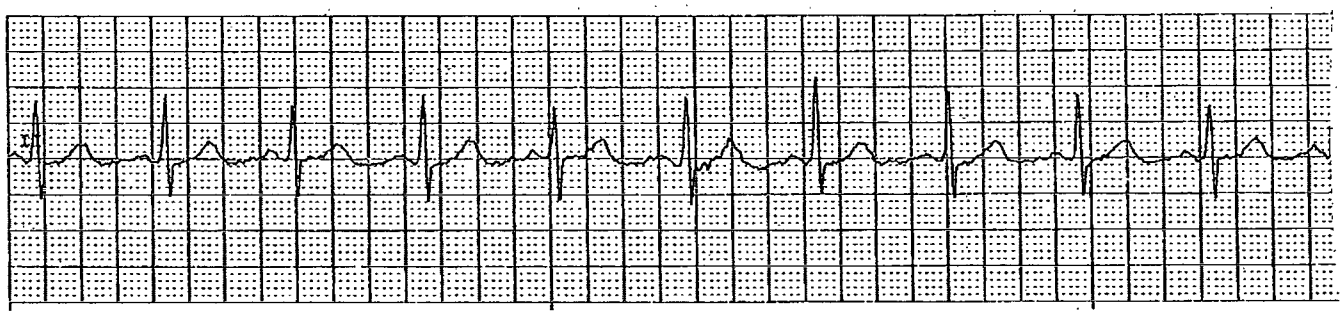
-984-

REMARKS:

IMPRINT AREA

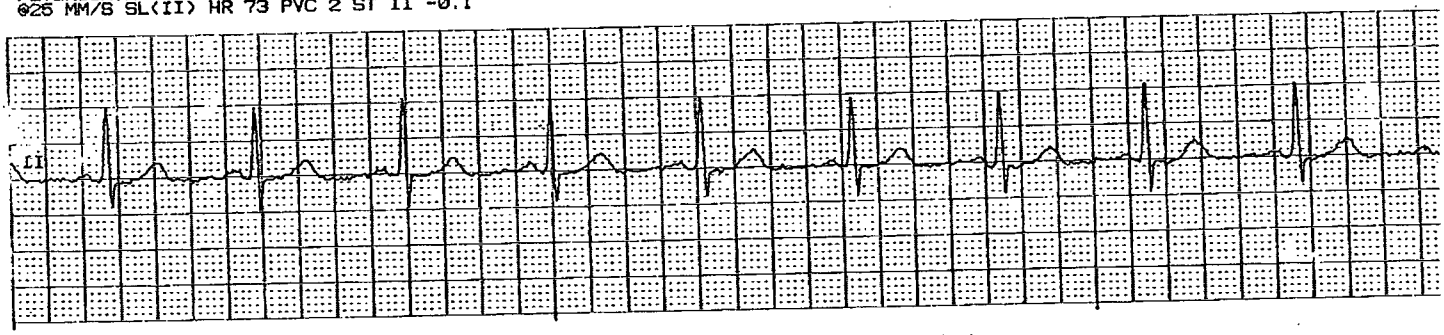
102829710
PETERSON SR, WILLIAM SR
DOB [redacted] 85 SX: M IMD
MRN: 26525 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL SAVED 30-MAY-2006 03:00:25
@25 MM/S SL(II) HR 82 PVC 0 ST II 0.0



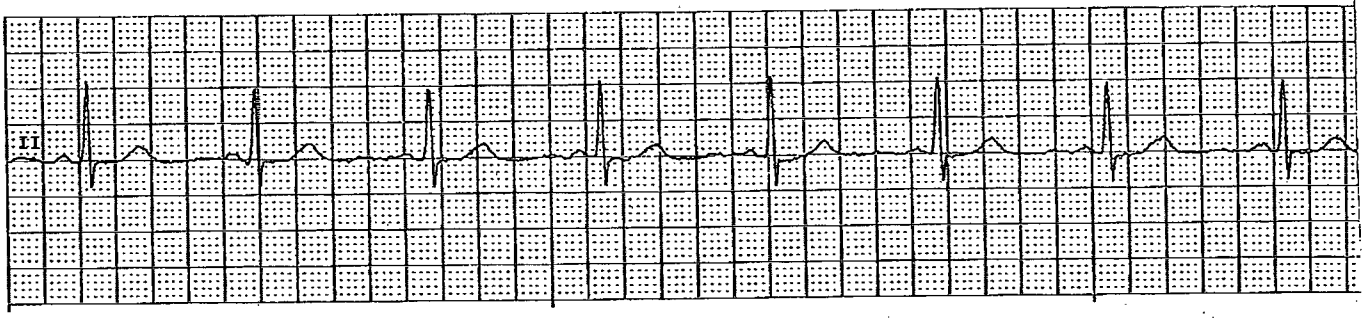
DATE: _____ PR: .14 QRS: .06 TREATED: TN
TIME: _____ RATE: 82 INTERPRETATION: SR

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL SAVED 30-MAY-2006 07:20:32
@25 MM/S SL(II) HR 73 PVC 2 ST II -0.1



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

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL 30-MAY-2006 11:12:57
@25 MM/S SL(II) HR 63 PVC 0 ST II -0.4



DATE: _____ PR: .14 QRS: .06 TREATED: TN
TIME: _____ RATE: 63 INTERPRETATION: SR

HRR-0226-NS

RHYTHM STRIP CHART FORM

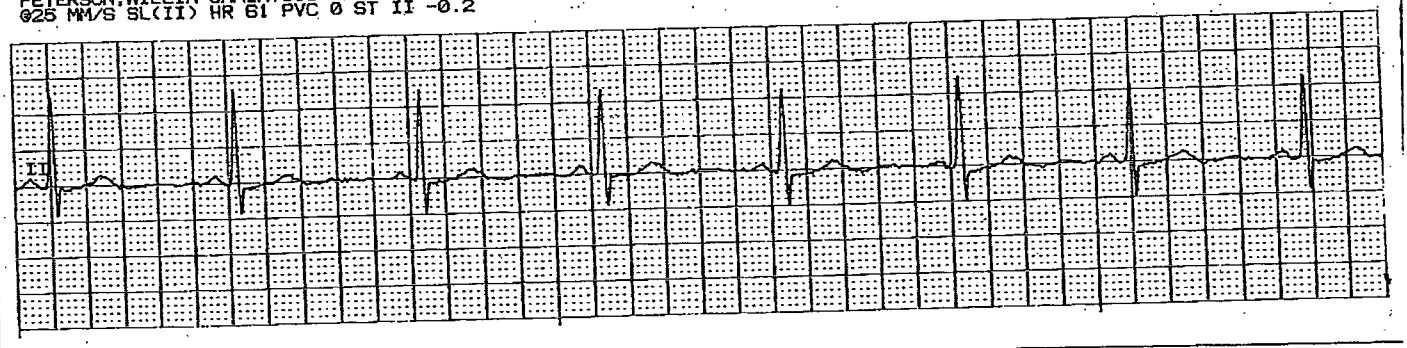
REMARKS:

IMPRINT AREA

102829710

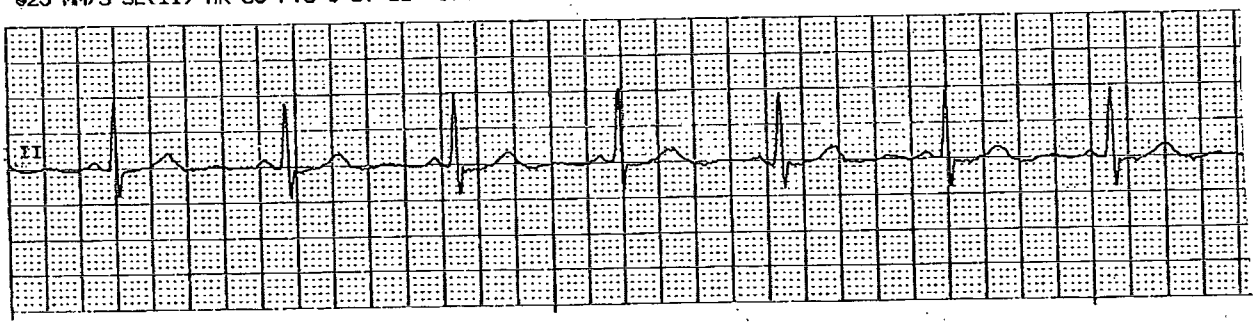
PETE[redacted]LLIAM SR
DOB: [redacted] 85 SX: M IMD
26523 ADM/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL SAVED 29-MAY-2006 15:00:18
@25 MM/S SL(II) HR 61 PVC 0 ST II -0.2



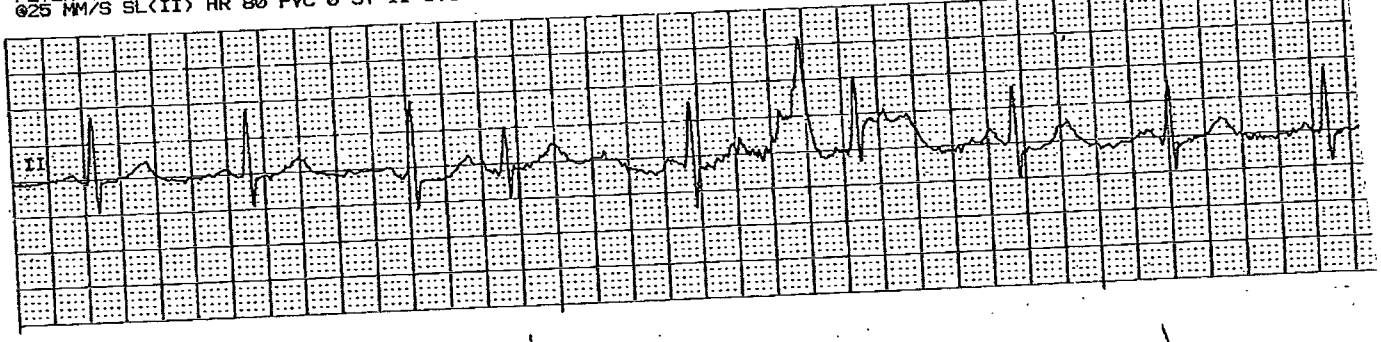
DATE: 5-29-06 PR: .14 QRS: .08 TREATED:
TIME: 1500 RATE: 61 INTERPRETATION: SR TAW

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL SAVED 29-MAY-2006 19:04:25
@25 MM/S SL(II) HR 65 PVC 0 ST II -0.4



DATE: PR: .12 QRS: .07 TREATED:
TIME: RATE: 48 INTERPRETATION: SR TW

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL 29-MAY-2006 23:19:24
@25 MM/S SL(II) HR 80 PVC 0 ST II 0.0



DATE: PR: .12 QRS: .04 TREATED: TW
TIME: RATE: 80 INTERPRETATION: SR

HRR-0226-NS

RHYTHM STRIP CHART FORM

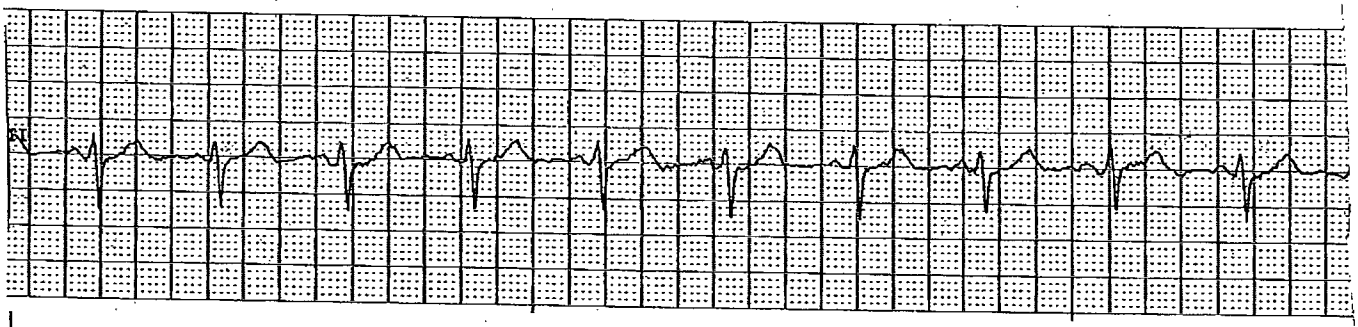
REMARKS:

IMPRINT AREA

102829710

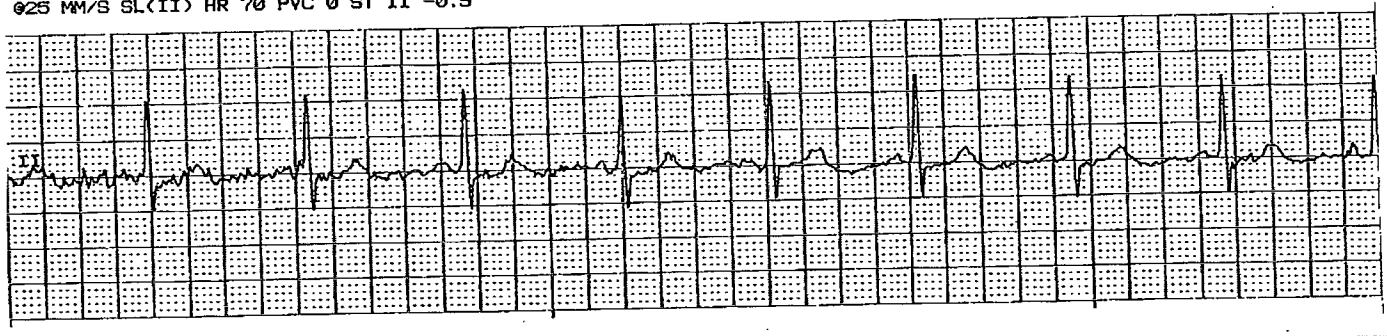
PETERSON SR, WILLIAM SR
DOB: [redacted] 85 SX: M IMD
MRN: 26523 ADN/REG DT: 05/15/06
AIKEN REGIONAL MEDICAL CENTER

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL SAVED 29-MAY-2006 02:56:00
@25 MM/S SL(II) HR 84 PVC 1 ST II 0.1



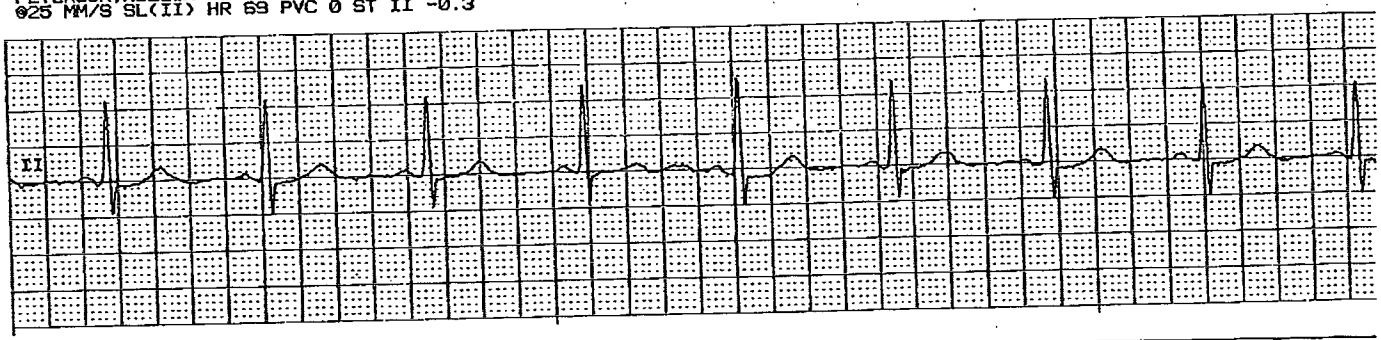
DATE: 0500 PR: .16 QRS: .08 TREATED: KF
TIME: RATE: 84 INTERPRETATION: SR

PETERSON,WILLIA 5MAIN|503* PID:102829710 TTX#1002FH MANUAL SAVED 29-MAY-2006 07:00:21
@25 MM/S SL(II) HR 70 PVC 0 ST II -0.9



DATE: 5-29-06 PR: .14 QRS: .08 TREATED: TAW
TIME: 0700 RATE: 70 INTERPRETATION: SR

PETERSON,WILLIA *CHNGE BATTERY* 5MAIN|503* PID:102829710 TTX#1002FH MANUAL SAVED 29-MAY-2006 11:00:20 CHNGE BATTE
@25 MM/S SL(II) HR 69 PVC 0 ST II -0.3



DATE: 5-29-06 PR: .16 QRS: .08 TREATED: TAW
TIME: 1100 RATE: 69 INTERPRETATION: SR

HRR-0226-NS

RHYTHM STRIP CHART FORM