THE STATE OF SOUTH CAROLINA
In the Court of Appeals

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SC Court of Appeals

APPEAL FROM EDGEFIELD COUNTY
Court of Common Pleas

Doyet A. Early, III, Circuit Court Judge

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

Cecelia Jackson, PR of the
Estate of William Peterson ..... Appellant

v.

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

RECORD ON APPEAL (VOLUME 2)

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page 32 of the Trinity second admission.

THE COURT: What page?

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

THE COURT: Or you can look at that right here. Can you see it from there?

BY MR. WELCH:

Q. Doctor, in your deposition we went through a series of these physicians' orders that you told me in the deposition the nurse would fax over something, you would okay, send it back, then the nurse would write the order, like for Smoak and, I think, Smith, and then you'd come in and sign it or they'd bring it over and you'd sign it; correct?

A. That's correct.

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

A. I didn't examine Mr. Peterson.

Q. You never saw him, did you?

A. No, I didn't.

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

A. Which one?

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

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

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

A. Based upon the above order, yes.

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

A. They both debride, yes.

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

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

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

A. Okay.

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

A. I did sign this order.

Q. This patient was under your care; right?

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

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

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

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

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

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

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

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

THE COURT: Well, you're not.

BY MR. WELCH:

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

A. I'm sorry. Repeat that.
Q. You didn't know that day you signed this order that they ran out of one of those agents and had to switch it to another, did you?
A. At the time I didn't, no.
Q. So the information you had that day or the information that you gave me was that the Aczone was a stronger debriding agent.
A. It's my understanding that they're both debriding agents and Aczone is a different formulation from the Panafil and may be stronger. Yes, I did say that.
Q. This patient is in your care. When you found out he needed a stronger debriding agent, did you go over to check on that?
A. I was not called by physical therapy, I was not called by the nursing staff regarding the wound or a change in the wound, so there's nothing in particular that alerted me that that needed to be done. This order was written by the physical therapist who is a trained professional who knows his wounds and he knows his treatments.
Q. So you didn't go over to check on this man at all, did you?
A. Not without an alert from the nursing staff

that he needed to be seen.

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

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

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

A. I do.

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

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

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

A. It does.

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

THE COURT: Which exhibit?

MR. WELCH: Exhibit 9, Judge.

THE COURT: Sir?

MR. WELCH: Exhibit 9.

BY MR. WELCH:

Q. Would you say those are your initials?

A. They are.

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

A. Because it was on my desk.

Q. That means you received it?

A. That means I received it.

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

A. Yes.

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

A. It was.

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

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

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

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

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

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

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

A. You didn't ask me.

Q. I asked you about the --

THE COURT: Ma'am.

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

BY MR. WELCH:

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

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

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

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

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

A. But I wasn't told that.

Q. No, you told me.

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

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

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

I have her deposition right here.

MR. WELCH: You got the original, Judge?

THE COURT: Yes, sir.

BY MR. WELCH:

Q. Ma'am, if you will --

MR. WELCH: Will you hand her the deposition?

THE WITNESS: Thank you.

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

BY MR. WELCH:

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

A. I do.

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

A. Yes, sir.

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

A. Yes.

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

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

Q. And then I asked you which one is being

referred to on 5/2. Your answer, please?
A. Since the right heel had healed, I assume it was the left hip, and that was after the review of the records noting he had a hip wound. At the time of this, I was not aware he had a hip wound.
Q. Well, you read the deposition to me, ma'am. You told me you assumed it was the left hip wound. Did I read it correct?
A. That's correct, after my review of the records.
Q. And you also told me the second one, Aczone, was a more powerful agent?
A. I did.
Q. Now you've got that information, you've got the MRSA culture, and you think your normal course was to talk to another doctor, but you don't have a recollection?
A. I know what my normal course of action would be. To ignore a lab report is not a normal course of action for me.
Q. Ma'am, you agree this lab shouldn't be ignored, should it?
A. It was not ignored by me.
Q. Then it shouldn't be ignored by any doctor, should it, who sees it?
A. Anybody who sees it.

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

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

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

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

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

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

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

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

MR. WELCH: No further questions.

THE COURT: Redirect, if any.

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

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

THE JURY: Yes, keep going.

THE COURT: Next witness please.

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

THE COURT: Next witness.

You need a break?

THE JURY: I would like a break.

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

Don't discuss the case, don't deliberate. Anything for the record before we break?

MR. WELCH: Nothing from the plaintiff, Judge.

MR. PARKINSON: No, sir.

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

(Short break.)

THE COURT: Ready to proceed?

MR. WELCH: Yes, Judge.

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

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

THE CLERK: Raise your right hand, please.

STUART EADS,

being first duly sworn, testified as follows:

THE WITNESS: I do.

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

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

DIRECT EXAMINATION

BY MR. PARKINSON:

Q. Are you a medical doctor?

A. Yes.

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

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

A. Yes, I was.

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

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

Q. What kind of physician are you?
A. I'm an internal medicine physician.
Q. Okay. Where do you practice? What is your practice setting?
A. I work in an office in an area just outside of Charleston, a private practice office with three other physicians in the office.
Q. Okay. And how old are you?
A. Forty-seven.
Q. And where did you go to college and medical school?
A. I went to both at the University of Virginia.
Q. And after that, did you go on for additional medical training?
A. Yes. I did a residency in internal medicine at the Medical University of South Carolina in Charleston. Subsequent to that I spent a year there as chief medical resident and then entered private practice.
Q. Have you been living and practicing medicine in Charleston ever since you finished your training?
A. I have; since 1997.
Q. And, Doctor, are you board certified in any medical specialty?
A. Yes. I'm board certified in internal medicine.

Q. And do you have any additional training or experience beyond basic internal medicine?
A. No further specific training, no.
Q. In the course of your practice -- do you have an office practice of internal medicine?
A. That is correct.
Q. Doctor, have you ever been involved in providing medical care and treatment to nursing home patients?
A. Yes, I have.
Q. Please tell the jury about that.
A. For many years, I think it's reflected on my CV which I don't have in front of me right now, I believe five or six years I was a medical director at a nursing home in the Charleston area.
Q. And in the course of your practice, your office practice of internal medicine, do you follow the patients who are in the nursing home?
A. Yes. I continue to follow patients who may be my patients in the nursing home. I don't visit the nursing home at this stage in my career, but there may be patients who still come to the office for visits. I also still attend, work in the hospital seeing patients, and it's not uncommon for me to see patients in the hospital who have come from a

nursing home.

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

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

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

A. It was over 70.

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

A. Yes, I have.

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

A. Yes.

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

A. Yes, I have.

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

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

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

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

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

A. Yes, I do.

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

MR. WELCH: No objection, Judge.

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

BY MR. PARKINSON:

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

A. Yes, I did.

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

A. Not that I recall.

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

A. I don't believe so.

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

A. Yes, I was.

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

A. I did.

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

A. I did.

Q. And the records from Hospice?

A. Yes, I did.

Q. And the Edgefield Medical Clinic?

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

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

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

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

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

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

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

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

A. Absolutely.

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

A. I did.

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

A. Yes, I did.

Q. The deposition of Dr. Leaphart?

A. Yes, I did.
Q. The deposition of Dr. Nicholson?
A. I did.
Q. The deposition of Dr. Rainsford?
A. Yes, I did.
Q. Deposition of Dr. Gordineer?
A. I did.
Q. Did you review the deposition of various family members?
A. Yes, I did.
Q. Okay. Did you review the deposition of Dr. Levine or the Plaintiff's expert witness from New York?
A. Yes, I did review that deposition.
Q. Was your own deposition taken --
A. It was.
Q. -- during the course of this litigation by Mr. Welch?
A. It was.
Q. And did you review the depositions of various personnel from Trinity Nursing Home, such as nurses, physical therapists, et cetera?
A. That's my recollection.
Q. Okay. And having reviewed both the medical records and all of the depositions, is it still your

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

A. Absolutely.

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

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

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

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

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

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

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

dementia.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Four places that I recall from the record.

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

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

Q. Okay. But is it not infrequent?

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

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

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

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

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

A. I do have an opinion.

Q. What is that opinion?

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

Q. Yes, please.

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

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

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

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

A. No. There's no indication at all in the medical record before May 14th at the very earliest, certainly nothing before May 14th that suggested there was any impending, immediate problem. Certainly, as I described, his prognosis was extraordinarily poor in general, but there was certainly nothing before May 14th-15th that would indicate there was any developing sepsis, to answer your specific question.

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

A. Yes, I did see that.

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

A. I do. I believe reasonable, appropriate care was provided, specifically in the sense that it's documented in the record that the staff recognized the need to turn the patient every two hours. The physical therapists who were certified to provide local wound care did that. The debriding agents were used as was discussed a short time ago. Really, there's not much you can do for a pressure ulcer, as I alluded to previously, other than take pressure off and clean the wound and hope it heals.

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

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

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

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

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

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

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

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

A. He would have to, yes.

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

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

Q. And had dementia?

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

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

A. Absolutely.

Q. Tell us why.

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

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

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

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

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

Q. And that was within the standard of care?

A. Yes, it was.

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

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

Q. Yes, sir.

A. Well, in reviewing these specific records --

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

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

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

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

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

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

A. Absolutely. I rely on it daily.

Q. Do those people actually know more about wound care than you do as an internal medical physician?
A. In terms of the minute-to-minute, day-to-day care of a wound, we may have medical degrees, but that doesn't necessarily make us the ultimate experts in things like debridement of a wound or speech therapy or physical therapy. You know, we may ask those people to perform those jobs for us and provide their expertise. That doesn't mean we're the ultimate experts in those fields. And so we rely very heavily on those healthcare providers, as you described, and the information they provide us and the care they provide, yes.
Q. We'd sent you the records that Dr. Nicholson ordered a culture of the left hip wound on May 7th. Did you see that?
A. Yes, I did.
Q. And did you also see in the records and understand from the testimony -- were you in the courtroom when Dr. Massey testified?
A. I was.
Q. Did you listen to that testimony?
A. I did.
Q. And I believe there was testimony about the results of that culture coming back to the doctors'

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

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

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

A. Yes, I did see that.
Q. And she ordered Levaquin, an antibiotic, in connection with that?
A. Yes.
Q. In this case, the physician who ordered the lab culture was Dr. Nicholson -- the ordering physician was Dr. Nicholson.
A. You mean on the -- what we know to be the hip wound culture?
Q. Yes.
A. Yes.
Q. And there's been some testimony that when Dr. Massey saw that on her desk on May 9th or 10th, that she initially, you know, passed it on to Dr. Nicholson --

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

THE COURT: Overruled.

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

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

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

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

A. No.

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

A. Absolutely. I do it every day.

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

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

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

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

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

A. No, they did not.

Q. And did they remain stable?

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

Q. Were they in a relatively normal range?

A. They were as I recall.

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

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

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

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

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

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

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

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

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

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

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

Q. Did she meet the standard of care?

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

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

A. Absolutely not.

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

THE COURT: Mr. Nance.

CROSS-EXAMINATION

BY MR. NANCE:

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

A. I think that's a fair characterization, yes.
Q. Thank you.
MR. WELCH: Thank you, Judge.
THE COURT: All right. Go ahead.

CROSS-EXAMINATION

BY MR. WELCH:
Q. Do you have the deposition there?
A. I have my deposition, yes.
Q. Doctor, you say that diagnosing the infection by what the nurses see, by what the physical therapist sees; is that what you said?
A. I don't quite understand your characterization.
Q. This is the answer you gave Mr. Parkinson about failure to diagnose this infection, that you would have to go by what the nurses see and physical therapist sees because they're your eyes and ears.
A. I didn't say you have to, I said you can.
Q. That's my point. Isn't it important for a doctor at some point in time to examine a wound?
A. It depends on the clinical circumstances and how comfortable you are with the staff that you work with. It sounds to me like the Edgefield Clinic was very well-acquainted with and had a good relationship with and, more importantly, had trust and faith in the clinical abilities of the staff at

Trinity Mission.

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

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

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

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

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

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

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

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

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

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

A. I think so, yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

BY MR. WELCH:

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

A. Yes --

Q. That was their choice; right?
A. Those are initialed. And you have to take them out of the context I just elaborated on.
Q. I'm not asking what the doctors were ordered. But that was their desire; correct? Doctor, you agree that you looked at the records of Aiken Hospital; correct?
A. I did.
Q. And you agree that when he got to the Aiken Hospital, he got some wound debridement, he got some treatment there, got some antibiotics, he got better, and before he went to Augusta, he was actually talking to the doctors in complete sentences?
A. I don't recall the record specifically, but if it's in there, I won't dispute it.
Q. And so he got well enough going to the hospital to now have conversations with the doctors and know his family?
A. If that's in the record, I don't dispute that.
Q. But it's your opinion that God's will should have been done, and he passed the 15th or 16th?
A. I think my opinion is bore out by the fact that in spite of all the measures that are undertaken, not many months later he was in Hospice care.

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

A. That's correct.

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

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

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

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

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

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

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

A. If that's what the record reflects.

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

A. I have.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Nobody can predict the future no matter what.

THE COURT: All right. Redirect, if any?

REDIRECT EXAMINATION

BY MR. PARKINSON:

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

A. That's correct.

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

A. That's correct.

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

placed?

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

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

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

BY MR. PARKINSON:

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

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

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

A. That's correct.

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

A. That's correct.

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

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

Q. Is that what you meant by changing the rules?
A. It is.
THE COURT: You may step down.
MR. WELCH: Judge, based on that, I should be able --
THE COURT: Step down. I feed everybody out of the same spoon.
All right, it's 1:00. I'll see everybody back at 2:30. Don't discuss the case, don't deliberate, and we'll see you back at 2:30.
(The jury exits the courtroom at 1:00 PM.)
THE COURT: Is there anything for the record before we break for lunch?
MR. WELCH: Nothing from the plaintiff, Judge.
MR. PARKINSON: Your Honor, we'd ask that Dr. Eads be excused since his testimony is concluded. I just don't want to send him on his way without the Court knowing that.
THE COURT: Any objection?
MR. WELCH: No, sir, Judge.
MR. PARKINSON: Thank you, Your Honor.
THE COURT: We'll stand at ease until 2:30.
(A luncheon recess transpired.)
THE COURT: Anything for the record before we start back?

MR. WELCH: Nothing from the plaintiff, Judge.

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

THE COURT: Mr. Nance?

MR. NANCE: I'm ready.

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

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

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

THE CLERK: Raise your right hand.

ELEANOR LEAPHART

being first duly sworn, testified as follows:

THE WITNESS: I do.

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

THE WITNESS: Eleanor Reese Leaphart, L-E-A-P-H-A-R-T.

DIRECT EXAMINATION

BY MR. NANCE:

Q. How are you doing today?

A. Okay.

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

A. Yes, sir.

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

A. I live in Gilbert, South Carolina.

Q. And where are you originally from?

A. Here, Edgefield.

Q. Did you grow up here?

A. Yes. I went to high school here.

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

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

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

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

Q. Here where?

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

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

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

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

Q. What does he do?

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

Q. Where are you now employed?

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

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

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

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

A. Approximately 2003 to 2010.

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

A. Yes, I did.

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

A. Yes, I did.

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

A. I believe it was March 30th.

Q. 2006?
A. I'm so sorry. 2006, yes.
Q. What about the last one?
A. I know it was in April of 2006. I'm sorry. I don't have the exact date.
Q. Let me ask you this -- I'm not going to go through all of your orders. I think we've seen enough of them so far. But did you have any contact, obtain any information about, or from anyone, pertaining to Mr. Peterson during May of 2006?
A. No, I did not.
Q. Did you ever know during May of 2006 about this culture coming back with a MRSA colonization on it?
A. No, I did not.
Q. Did anyone from the nursing home call you or contact you and tell you about this MRSA situation?
A. No.
Q. Were you ever requested to come over there and look at it during May of 2006?
A. No.
Q. How do you treat -- what do you do in regards to a MRSA colonization that someone such as Mr. Peterson had?
A. I think the answer to that is you -- you're not

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

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

A. Yes.

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

A. No.

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

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

THE COURT: Hold on a second.

Everybody okay on the jury?

BY MR. NANCE:

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

A. Yes.

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

A. No.

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

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

THE COURT: Certainly.

CROSS-EXAMINATION

BY MR. WELCH:

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

A. Yes, I do.

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

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

A. Yes.

Q. Problems with nutrition?

A. Yes.

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

A. Yes.

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

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

A. Yes. That's my handwriting.

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

A. I did.

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

A. Yes.

Q. Did you see the patient?

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

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

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

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

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

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

Q. Page 36 at the bottom.

A. Okay.

Q. You got it.

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

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

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

Q. And you went through this history and physical.

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

A. It does.

Q. And you signed off on that?

A. I did, for Dr. Anderson.

Q. Read that, please.

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

Q. Is that actually your handwriting?

A. That is not my handwriting.

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

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

Q. But you signed for his physician?

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

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

A. Yes.

Q. And did you examine him that day?

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

Dr. Anderson and I agreed with the order.

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

A. 90?

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

It says physical therapy date of treatment. Do you see that?

A. Yes, sir.

Q. Do you see that bottom row there, the testimony as to the days debridement were done on these wounds?

A. Yes.

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

A. I see that, yes.

Q. And some of these orders were signed on April 20th?

A. Yes.

Q. But did you look at the wound?

A. No, not on April 20th. But I do want to say, again, the physical therapist was caring for this wound and we know that our staff at Trinity Nursing Home is very good and we respect what the physical therapist tells us about these wounds and advises us, because, again, they're there every day, the physical therapist, the wound care nurse, the

nursing staff.

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

A. Yes.

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

A. Yes, it does.

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

A. On that day, yes, I did.

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

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

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

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

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

A. Yes.

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

on the 15th?
A. Yes, I did.
Q. And to you, that's proper care?
A. I know it was proper care because we did everything we could to prevent that from occurring.
Q. Did you give him any antibiotics?
A. I didn't think they were indicated at that time.
MR. WELCH: I don't have any further questions.
MR. PARKINSON: No questions, Judge.
MR. NANCE: Nothing further, Your Honor.
THE COURT: You may step down.
Call your next witness.
MR. NANCE: We call Dr. George Rainsford.

GEORGE RAINSFORD

being first duly sworn, testified as follows:
THE WITNESS: I do.
THE CLERK: Have a seat, state your full name, and spell your last, please.
THE WITNESS: George Rainsford, R-A-I-N-S-F-O-R-D.

DIRECT EXAMINATION

BY MR. NANCE:
Q. So far you're doing pretty good. I was worried about you. Be sure to speak up, use that

microphone.
A. Yes, sir.
Q. Dr. Rainsford, where do you reside?
A. 709 Buncombe Street, Edgefield.
Q. And where do you work?
A. The Edgefield Medical Clinic, PA, Edgefield.
Q. What type of business entity is Edgefield Medical Clinic, PA?
A. A professional association.
Q. In 2006 was it a professional association?
A. That's correct.
Q. And were you a stockholder?
A. That's correct.
Q. Are you still a stockholder?
A. Yes, sir.
Q. At that time was Dr. Nicholson a stockholder?
A. He was. Well, there was a buyout. I'm not sure in 2006. He may not have been at that time. He probably was still in 2006.
Q. As far as you know?
A. As far as I know.
Q. What about Dr. Leaphart?
A. She was.
Q. And Dr. Massey?
A. She was.

Q. And all of y'all were both stockholders and employees of Edgefield Medical Clinic, PA?
A. That's correct.
Q. Now tell the jury something about yourself. Where did you go to high school?
A. Strom Thurmond High School, finished in 1969.
Q. Are you originally from Edgefield?
A. Grew up in Edgefield.
Q. And after high school, give us a brief outline of your education, training, and experience.
A. In 1969 I went to USC in Columbia and I was there until 1972; I did not graduate. I went to MUSC 1972 through 1976, and then to MUSC family medicine training program from 1976 to 1979. And in 1979 I came back to Edgefield and been here ever since.
Q. Okay. When you came back here, who did you practice with?
A. Dr. Wiley Turner and Dr. B.E. Nicholson.
Q. Have you reviewed records pertaining to Mr. William Peterson that were generated in 2006?
A. Yes, sir, I have.
Q. Before that did you know Mr. Peterson?
A. I did.
Q. Had he ever been a patient of yours?

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

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

A. Yes, sir.

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

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

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

A. I did issue an order.

Q. And what was that for?

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

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

A. That's correct.

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

A. That's correct.

Q. And he had a cervical fusion?
A. That's correct. And a catheter placed because of a nonfunctioning bladder.
Q. And subsequently he came back to Trinity Mission?
A. That's correct.
Q. And on the 21st of March of 2006, he was readmitted?
A. That's correct.
Q. The first time he was at Trinity Mission, was there a do-not-resuscitate directive in place?
A. Yes, sir.
Q. When he came back on March the 21st, was it reinstated?
A. It was reinstated.
Q. Same as before?
A. Same as before.
Q. Did you see Mr. Peterson on May the 15th, 2006?
A. I did not.
Q. Did you see Mr. Peterson or have any at all during his stay at Trinity Mission between March the 21st and May the 15th, 2006?
A. I saw him on three occasions.
Q. Did you see him as a patient?
A. Not as a patient to examine.

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

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

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

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

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

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

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

A. No, sir.
Q. Were you contacted by a nurse at Trinity Mission requesting that you -- or give you some information pertaining to Mr. Peterson on May the 15th, 2006?
A. Yes, sir, through my nurse initially.
Q. And what was the request?
A. The initial request was for Ativan and --
Q. What's Ativan?
A. Ativan is a drug for anxiety, very similar to Valium.
Q. What was your response?
A. My response was I would not issue that order, but that I would come see and evaluate him.
Q. Why wouldn't you issue it?
A. Well, not knowing his condition and if he -- it sounded like he was worsening. At some point in that conversation somewhere, I was aware that he was on oxygen. It wouldn't be proper to give him a sedating drug without evaluating him that may make his condition worse, and I needed an evaluation to see exactly what his condition was.
Q. And I think you were contacted again by someone from Trinity Mission regarding Mr. Peterson?
A. Right. That would be Pam Dunn. And the

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

Q. And what did you say?

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

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

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

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

A. They have the right to do that.

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

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

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

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

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

A. That's the family's choice.

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

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

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

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

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

A. That's correct.

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

A. No, sir.

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

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

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

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

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

A. No, sir.

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

A. No, sir.

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

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

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

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

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

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

A. Between 4:00 and 5:00, I believe, was the first beginnings of calls, around about then.
Q. Was it for that particular purpose?
A. It was for the purpose of Ativan.
Q. Okay. Well, as far as somebody indicating that there may be a change in situation significant enough that maybe the MRSA should be examined and reacted to at that time, did you ever receive a call in that regard?
A. No, sir. It was about the Ativan. And then the change in condition that I -- my strong advice was to let me come and see him.
Q. Okay. And did you attempt to go see him?
A. I was getting ready to walk out the door when the last call occurred, and my strong advice was to let me come and see him. And I felt I could offer something to the family about the pathways. And he was in very bad condition and --
Q. Was treatment of the MRSA found in Mr. Peterson's left hip wound necessary or required before the May 15th, 2014 [sic]?
A. No, sir.
Q. Okay. Did you -- having reviewed the records and so forth, have you reached any conclusion s as to whether or not other personnel may have had

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

A. Would you repeat that?

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

A. Yes, sir.

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

CROSS-EXAMINATION

BY MR. WELCH:

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

A. 69?

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

A. All right. 69.

Q. It's the nurses notes.

A. Yes, sir.

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

A. Yes, sir.

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

Is that the call you're referring to?

A. I assume so. Yes, sir.

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

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

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

A. Somewhere in there, yes, sir.

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

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

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

doesn't know what's going on, does he?
A. I wasn't there to examine him, but that would be what the note would say.
Q. And she's trying to get the man some medication to help him, isn't she? She's trying to get the man some medication to ease his anxiety?
A. That's correct.
Q. Because he's going through this sepsis change; correct?
A. That's what the note would appear to have meant, yes, sir.
Q. Thank you, sir.
THE COURT: All right. That's all you have?
MR. WELCH: No, I got some more questions.
THE COURT: Oh, I thought you said thank you.
BY MR. WELCH:
Q. In fact, sir, when we talked previously about what happened in this case, at deposition you told me --
MR. WELCH: Judge, I think you got his deposition up there, Judge. Your Honor, you have his deposition up there?
THE COURT: Maybe I do. Hold on.
BY MR. WELCH:
Q. Sir, if you could turn to page 79 in that

deposition, please.

A. Yes, sir.

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

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

THE COURT: You can ask him the question.

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

BY MR. WELCH:

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

A. This is on page 79?

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

A. What line?

Q. I'm talking about line 21.

A. That would be correct.

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

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

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

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

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

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

A. No, sir.

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

A. If it were sepsis.

Q. Which it turned out to be?

A. Right.

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

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

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

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

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

Q. Did you look at the chart?

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

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

A. Yes, sir.

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

A. I believe he did.

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

A. That would be one of the choices.

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

A. I didn't have discussion with the family.
Q. In fact, Doctor, if you would look at page 69 and 70 -- let's start on 69. That record, the bottom, it's the 5/15, 2:45 entry. Do you see that entry, Doctor?
A. Is there a line?
Q. Yes. It's 5/15, 2:45. There's several lines. I want to make sure you've got the right location.
A. I'm on page 69.
Q. 69 at the bottom, 5/15 on the left, 2:45 PM.
MR. PARKINSON: He's looking at the deposition.
BY MR. WELCH:
Q. I'm sorry. It's the exhibit over to your left.
Doctor, you heard the nurse testify she wrote down verbatim what your nurse told her. And she wrote, put it in quotes: Dr. Rainsford did not advise family to send resident to hospital. Instead told family if it was their desire, the family could take him to the hospital.
MR. NANCE: May I approach the bench, please?
THE COURT: Come on.
(Sidebar conference).
BY MR. WELCH:
Q. Doctor, that language that's in quotes, that's what she said your nurse said; correct?

A. That's what she wrote.
Q. And, Doctor, I want you to go over to page 34 of that same record.
THE COURT: 34?
MR. WELCH: Yes, sir.
BY MR. WELCH:
Q. If you look at that top physician's order, it's dated 5/15/2006, says: Transported to Aiken Hospital emergency room via EMS per insistence of family against medical advice.
Do you see that?
A. I do.
Q. Whose signature is that signed on the next day, the 16th?
A. It's mine.
Q. And, Doctor, you didn't ask anybody to change that note before you signed it, did you?
A. No, sir. I don't remember asking anybody to change it.
Q. And you never told anybody they took it down incorrectly, did you?
A. No, sir.
Q. Now, Doctor, you agree with me that this is the shape the man was in on the 15th?
A. I didn't see him on the 15th.

Q. Well, this is a picture taken -- it says 5/16 at -- the next day at Aiken. And he was in substantially the same condition late in the afternoon on the 15th, wasn't he, Doctor?
A. I can't answer that. I didn't see him on the 15th.
Q. Doctor, do you believe it changed to a much worse condition in 12 to 16 hours?
A. Mr. Welch, decubitus can change very quickly into sepsis, so I can't answer that because I didn't see him.
Q. Doctor, you've seen everything from the record in Aiken where when they got him there from the hospital, when the family asked you to come over, that he had sepsis in the bloodstream, he had sepsis in the decubiti -- he had MRSA in his decubiti, he had MRSA infection in the kidneys, he had all of that in the nursing home, didn't he?
A. I can't answer that.
Q. So you don't have an opinion as to whether or not that, more probable than not, it was taking place in the nursing home?
A. I think he was changing and systemic infection was a likely cause for that change, yes. It was occurring at that time.

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

A. I think he received good medical care.

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

MR. PARKINSON: No questions, Your Honor.

MR. NANCE: No questions, Your Honor.

THE COURT: Doctor, you may step down.

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

THE CLERK: Raise your right hand, please.

OSCAR LOVELACE, JR.

being first duly sworn, testified as follows:

THE WITNESS: I do.

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

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

DIRECT EXAMINATION

BY MR. NANCE:

Q. How are you doing today?

A. I'm doing well.

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

A. I live in Chapin, South Carolina.

Q. And where do you work?
A. Prosperity, South Carolina.
Q. And what do you do?
A. I'm a family doctor.
Q. Are you originally from South Carolina?
A. I am.
Q. Where?
A. Columbia, South Carolina.
Q. Would you give the jury a brief outline of your education, experience and training, beginning in college, including dates of graduation through today, please.
A. Clemson University, Medical University of South Carolina, University of Virginia, Medical University of South Carolina, back to Prosperity.
Q. Give me the years of graduation.
A. Sorry. Finished high school in '77; went to Clemson, finished in '81; MUSC in '85; went to University of Virginia, finished my residency in family medicine in 1988; and then after being in Prosperity for a while, went back to Medical University to train to do operative obstetrics.
Q. Are you board certified?
A. I am.
Q. In what area?

A. Family medicine.

Q. What is family medicine?

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

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

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

Q. Have you been the medical director at any?

A. At two of those four.

Q. Which ones do you go to now?

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

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

A. Twenty-five years.

Q. Are you a member of any professional associations?

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

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

A. Yes, sir.

Q. How?

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

Q. And whose term is that?

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

Q. But it's the academy itself?

A. Yes, sir.

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

MR. WELCH: No objection.

BY MR. NANCE:

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

A. Exhaustively.

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

A. I have.

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

A. I have.

Q. Medical records of Trinity Mission Nursing Home

beginning in March and ending in May of 2006?

A. I have.

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

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

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

A. I have.

Q. Select Specialty?

A. I have.

Q. Hospice Care?

A. Yes.

Q. Edgefield Medical Clinic?

A. I have.

Q. Edgefield Hospital?

A. I have.

Q. Have you reviewed depositions in this matter?

A. I have.

Q. Those of all of the physicians involved?

A. I have.

Q. Personnel of Trinity Mission?

A. Yes.

Q. The family members of Mr. Peterson?

A. Yes.

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

A. I have.

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

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

Q. What about Dr. Massey?

A. Same.

Q. What about Dr. Nicholson?

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

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

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

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

at a later time?

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

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

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

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

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

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

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

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

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

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

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

In this case it proved to be the organism that

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

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

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

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

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

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

A. Yes.

Q. Did that meet the standard of care?

A. Yes.

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

A. Yes.

Q. Did that meet the standard of care?

A. Yes.

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

A. Yes.

Q. Did that meet the standard of care?

A. Yes.

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

A. Yes.

Q. Did that meet the standard of care?
A. Yes.
Q. Did you find Mr. Peterson used a urinary catheter?
A. That was required because his bladder was incontinent, and being constantly wet would increase his risk for skin ulcers.
Q. Does that meet the standard of care?
A. Yes.
Q. Did you find that Mr. Peterson was incontinent of both bowel and bladder?
A. Also a result of his spinal stenosis.
Q. Did you find that Mr. Peterson was provided with a wedge to aid him in keeping off bony prominences?
A. Yes. But it's notable that when they were able to get his right heel ulcer healed -- he had a pressure ulcer on his heel -- he developed one on the left hip. So you can't -- you can't suspend someone in midair.
Q. Did that meet the standard of care?
A. Yes.
Q. Did you find that a wound care nurse or physical therapist performed wound care which would include cleaning, bandaging, medicating, and

debriding?
A. Yes.
Q. Did that meet the standard of care?
A. Yes.
Q. In the state of South Carolina, are physical therapists allowed by law to do debridement, including debridement with a sharp object?
A. They are. And in this case, in the deposition by Mr. Melton, the physical therapist, he specifically states he went to continuing education courses on it as well.
Q. Do you have an opinion within a reasonable degree of medical certainty as to whether or not any of the medical expenses incurred on behalf of Mr. Peterson after May 15, 2006 referred to inactions, actions, or breaches of the standard of care of any of the physicians involved in this matter?
A. I don't believe there was any way that, if the family had chosen aggressive care, which they did, those expenses could have been averted because of his steady decline because of all of his multiple medical problems.
MR. NANCE: Thank you, Dr. Lovelace. Answer any questions Mr. Welch may have.

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

(Short break.)

CROSS-EXAMINATION

BY MR. WELCH:

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

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

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

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

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

A. Yes.
Q. And do you believe that it was in the same condition when he came in on the 15th late?
A. I doubt it looked very different. It could have changed over that time.
Q. And you've also said previously that there was really no clinically significant change in this man during the two weeks he was at Aiken; is that correct?
A. You need to tell me what two weeks you're referring to.
Q. The two weeks he was at Aiken from May 15th when he came in until the May the 30th when he went to Augusta.
A. That there was no significant change in his condition?
Q. Yes, sir.
A. What I'm saying is that he was on a steady downhill course. He continued to have recurring infections, pseudomonas, a variety of difficult-to-treat infections until it was decided he should get palliative care and was placed on Hospice care and died two days later.
Q. You're aware that while he was at Aiken during that two weeks that he actually improved to the

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

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

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

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

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

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

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

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

A. I just said I remember the interchange.

Q. But did you make the statement?

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

Q. Page 38 in your deposition, Doctor.

A. Okay.

THE COURT: What's the line?

MR. WELCH: Line 9.

BY MR. WELCH:

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

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

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

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

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

A. I think I've clarified my statement.

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

A. I have.

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

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

THE COURT: Sir, answer the question.

BY MR. WELCH:

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

A. I have testified, not in court.

Q. In South Carolina?

A. That's correct.

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

MR. PARKINSON: No questions, Your Honor.

MR. NANCE: None, Your Honor.

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

MR. NANCE: Yes, sir.

THE COURT: Next witness.

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

THE COURT: Anything in reply, Mr. Welch?

MR. WELCH: No, sir, Judge.

THE COURT: Thank you.

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

I know one person's got a medical -- who is that? Is 9:30 an imposition?

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

THE JURY: (Nods heads.)

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

THE JURY: In Beech Island at 10:30.

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

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

Have a pleasant evening. Everybody else remain seated.

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

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

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

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

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

(Juror No. 22 excused.)

MR. WELCH: Judge, can we approach?

THE COURT: Sure.

(Sidebar conference.)

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

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

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

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

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

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

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

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

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

MR. PARKINSON: Thank you.

Your Honor, at this time I would re-move the

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

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

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

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

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

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

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

MR. PARKINSON: Your Honor --

THE COURT: I respectfully deny your motion.

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

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

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

THE COURT: You're protected.

Mr. Nance, I assume yours is likewise. Anything else you want to add?

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

a matter of fact.

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

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

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

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

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

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

THE COURT: So there's just one defendant?

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

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

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

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

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

had an opportunity to, he didn't.

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

THE COURT: Anything else, Mr. Nance?

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

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

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

THE COURT: All right. Anything else?

MR. WELCH: That's all, Judge.

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

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

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

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

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

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

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

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

THE COURT: Cross-examination of who?

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

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

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

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

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

Anything else?

MR. WELCH: Nothing else, Judge.

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

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

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

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

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

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

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

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

probably caused to suffer.

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

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

So what else do you want, Mr. Welch?

MR. WELCH: Nothing for the plaintiff, Judge.

THE COURT: Mr. Parkinson?

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

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

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

yours has the hindsight type charge in there as well?

THE COURT: No.

MR. PARKINSON: Not to be judged in hindsight?

THE COURT: No.

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

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

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

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

THE COURT: I'll charge that.

Anything else y'all want?

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

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

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

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

defendant as to what is best for the patient.

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

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

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

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

What else, Mr. Nance?

MR. NANCE: Number 5.

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

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

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

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

MR. NANCE: That's good.

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

we use in these cases.

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

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

THE COURT: Okay.

MR. PARKINSON: Okay.

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

MR. PARKINSON: I guess I hadn't thought about it the way the Court is suggesting. I didn't know if we would have one that says we find for the plaintiff X-dollars against Massey or, you know, pick one or all of the defendants, or we find for the defendants -- I guess I need to think about that a little bit more because the damages are nonseverable damages.

THE COURT: They are. What's your suggestion as to what --

MR. WELCH: Judge --

THE COURT: I mean, they could find Dr. Massey

and not against the other two; they could find against Dr. Leaphart and the other two; they could find against all three, they could find for all three. I mean, there's all kinds of combinations.

MR. WELCH: That verdict form allows them to check which one or it basically depends on who they check or find for all the defendants against the plaintiff, or they go ahead and go to the next page where they do economic and it makes it clear, and there's also potentially a special verdict form in the back that they do the percentages.

THE COURT: All right, gentlemen, y'all think about it this evening and let's be here at 9:00 in the morning or maybe quarter of 9:00.

MR. WELCH: Quarter of.

THE COURT: Anything else before we break?

MR. WELCH: That's it from the plaintiff.

MR. PARKINSON: Nothing further.

THE COURT: Let me see y'all back in chambers.

(Court in recess for the evening.)

THE COURT: After everybody was gone yesterday, we had a chitchat in chambers. And, first of all, I'm going to elevate Juror No. 46, that's James Foley, to the jury. He was Alternate No. 1.

Secondly, we talked about the verdict form.

And when we left yesterday, I think everybody was pretty much in agreement with the form that Mr. Welch had given to us that simply said we find for the plaintiffs against the following defendants, and it lists each defendant separately -- Massey, Rainsford, Leaphart -- and the medical center, or we find for the defendants against the plaintiff.

But then the second page, I don't think we all looked at the second page because it had the breakdown between economic and noneconomic damages. And I stand by my ruling; there will be no economic damages, it will just be a matter of the verdict. So we need to probably revise page 2, depending on my ruling. Okay?

MR. WELCH: Yes, sir.

THE COURT: So when we finish this little exercise on the pain and suffering, if y'all will get with Cassie.

All right. I am going to stand by my ruling on the pain and suffering. After further reflection I feel like that I am correct in that matter. Mr. Welch, and I know at 1:00 this morning, and I read it about 5:30 or 6:00 this morning, submitted a memo outlining a lot of your argument from yesterday, so I want you to please make that a part

of the record so you'll be protected on that angle of it. I think that will protect you for the record. If you need to add anything in addition to what've you've outlined in the memo, I thought your memo was very thorough.

MR. WELCH: No, sir. I'll pass this up to the clerk and make it part of the record.

THE COURT: But this is -- I've been doing this a long time; other than Mr. Nance, probably longer than anybody in the courtroom. But this is not a typical run-of-the-mill medical malpractice case, and it's an interesting case. We have a man who's obviously very elderly, he as an unfortunate event at home, and because he lives alone, unfortunately he was not found for a number of days -- I think the testimony revealed three days -- he had a do-not-resuscitate order both times he was in the nursing home and, quite honestly, from the testimony, he was on death's doorstep to the point that when the family got there on the 15th, I think one of the ladies said he was leaving or passing or getting ready to die. I mean, he was in bad shape and he was in bad shape throughout his tenure at the nursing home. He experienced paralysis, a lot of unconsciousness. And then the cause of action is a

survival action and alleging that the doctors failed to diagnose not the bedsore particularly itself, but the -- where the bedsore had increased to the stage that it had MRSA. And I'm just of the opinion that the record is void of any evidence dealing with the failing to diagnose the MRSA and any associated pain and suffering with that alleged failure to diagnose. I mean, he was paralyzed and he had the bedsore anyway. There's no criticism of getting the bedsore or the treatment of the bedsore, but they're having to debride it and do all that. Notwithstanding whether he got the MRSA or not, they were doing that before the MRSA showed up. So, I mean, all that, if there were pain and suffering -- I don't think there was any evidence that showed it was proximately caused by the failure to diagnose and treat.

Really, as I said a number of times, was that Dr. Levine, who testified about the standard of care and the deviation in his opinion in this case, and then Mr. Welch very -- as he had to do at the top, proximate cause, and my notes were just as bold as they could be; if he had been treat ed, the outcome would have been that he would not have incurred the additional expenses. So the additional expenses is what -- in my opinion, what's shown proven to the

jury or presented to the jury as the proximate cause of the failure to diagnose. Therefore, those are the reasons for my ruling. I stand by my ruling. I understand everybody's position and I think everybody is protected. I've allowed Mr. Welch to present the memo.

Do you need to put anything else on the record?

MR. WELCH: No, sir, Judge. If I could have one minute to discuss, since you're going to stand by your ruling, Judge, something with both counsel?

THE COURT: Absolutely.

So other than getting the verdict form modified, I don't think we have anything else to do.

MR. WELCH: If I can have one minute, Judge.

THE COURT: Absolutely. Absolutely.

(Brief pause in the proceedings.)

MR. NANCE: Your Honor, you might recall that yesterday I moved to dismiss Dr. Leaphart and Dr. Rainsford individually.

THE COURT: You did. We discussed that in chambers last night and we were going to revisit that this morning. That slipped my mind.

MR. WELCH: Here's what I've offered them, considering your ruling. The practice only has $200,000 in coverage. Considering the ruling, the

medical bills are less than 200,000, so I've offered to release the physicians, go in against the practice, with the understanding put on the record, which will be the law, that they are not going to assert a defense later of releasing the agent is releasing the principal in this case.

THE COURT: Well, I don't know that you have to release them. What if I granted Mr. Nance's motion? I don't know if he could raise that then if you got a verdict against the practice.

MR. WELCH: Judge, that does not permit me to argue anything in my opinion, if you do that, about anything they did.

THE COURT: Well, no, but they're members of the practice.

MR. WELCH: I understand that. But...

THE COURT: I'll be quiet, let you all discuss it.

MR. WELCH: They're willing to do that. I just want to put that on the record. That way, the doctors are no longer at risk.

THE COURT: So it will be just against the PA?

MR. WELCH: Yes.

MR. NANCE: Well, I've got to talk to some people about that.

THE COURT: Well, you made the motion. Want to withdraw it?

MR. NANCE: I made the motion in regards to Leaphart and Rainsford, who are my clients, that they be dismissed; they never treated this man --

THE COURT: You also made the motion about them being members of the PA and all of --

MR. NANCE: That's the basis of it, why they can't -- they're not partners, so they're not liable for each other's actions vicariously. They would be if they were partners. They're just employees and shareholders of the PA. The PA is the principal and the doctors are the employees, agents.

THE COURT: My ruling on that is going to be that I'm going to leave everybody in unless y'all decide something different. So I'll let you have a minute.

MR. PARKINSON: Your Honor, I think what -- Dr. Massey is not on the -- is insured by a different carrier. And for that reason, if the PA -- I'm willing to do this on behalf of Dr. Massey, what Mr. Welch is suggesting. But it's not my monetary skin in the game for my carrier, it's the carrier that relates to --

THE COURT: Gentlemen, I'm going to leave it

just like it is unless y'all decide something different. We're going to stand at ease until 9:30.

(Short break.)

THE COURT: Please be seated. We have an agreement as to -- go ahead.

MR. WELCH: Judge, we're going to stipulate as follows: Based on Court's ruling, the plaintiff is releasing the three named individual doctors as defendants with the understanding that the practice will not assert the defense of release of agent as release of principal in this case.

Plaintiff also agrees that if any verdict is in excess of the 2006 practice policy limits, which our understanding --

THE COURT: 2000 --

MR. WELCH: '6 policy limits --

THE COURT: The year 2006; right?

MR. WELCH: Yes. Which our understanding is, is the $200,000 JUA coverage, no PCF coverage, limits to $200,000 per occurrence individual, 600,000 per occurrence, Plaintiff will not seek collection above the policy limits.

THE COURT: Is that correct, Mr. Parkinson?

MR. PARKINSON: That's correct, Your Honor. And I just want to say on the record that the

dismissal of Dr. Massey needs to be with prejudice, still with that understanding so that the -- there's not going to be any kind of appeal that involves Dr. Massey; she's done.

MR. WELCH: Judge, if -- statute of limitations has run once these parties are dismissed. There's practically no way to bring them back. So...

THE COURT: But it would be with prejudice?

MR. WELCH: Yes, sir.

THE COURT: Mr. Nance?

MR. NANCE: Same on behalf of Drs. Leaphart and Rainsford.

THE COURT: Both of those are dismissed with prejudice. Verdict form will be: We find for the Plaintiff; blacked out is actual damage against the defendant --

MR. WELCH: Edgefield Family Practice --

THE COURT: -- we find for the Defendant?

MR. WELCH: Yes, sir.

THE COURT: Make that change, please, ma'am.

(Brief pause in the proceedings.)

THE COURT: All right. How do y'all want me to inform the jury about how to posture the case?

MR. WELCH: Judge, the plaintiff's preference would be just that you inform the jury that the

defendant that the jury will be considering would be only the practice.

THE COURT: I'll just tell them that in light of some developments yesterday, that the posture of the case now is as follows. Fair enough?

MR. WELCH: Very good.

THE COURT: So we'll have that new verdict form in just a little bit.

MR. PARKINSON: I guess I will vacate my spot at this table or do you want me to sit here?

THE COURT: I know where I would be, on my way home. You're welcome to stay with us.

MR. PARKINSON: I think I'll stay and see how it goes.

(The jury enters the courtroom at 9:44 AM.)

THE COURT: Mr. Foley, raise your hand, please. Mr. Foley, I'm going to elevate you to the regular jury panel from an alternate status. So if you would just come down and please have a seat here. We had one juror who had a longstanding doctor's appointment this morning, so he had to be excused. That's why we have alternates.

Mr. Foreman, ladies and gentlemen, we're now at the stage of the trial where what is left is the final arguments by the lawyers. Once they have

completed their final arguments, then I will instruct you or charge you on the law, and then you'll be in position to start your deliberations.

As a result -- after y'all left yesterday, as a result of some posttrial meetings and discussions, the status of the case is as follows: Remaining in the case, obviously, is the plaintiff, Ms. Jackson as the personal representative of the late Mr. Peterson, and the only defendant remaining is the Edgefield Medical Clinic, PA. The individual doctors are no longer parties, their practice is now the sole defendant. So that's the status of the case after several things posturing yesterday. And if the lawyers want to explain that to you, they can.

Please bear in mind that you've heard all the evidence from which you'll make your decision. The final arguments are not evidence in the case. Obviously both of these lawyers, Mr. Nance and Mr. Welch, represent their respective clients and they'll be arguing the evidence in the light most favorable to their clients, but that simply is argument.

You've heard the evidence from which you'll make your decision. I ask that you pay close

attention. I suspect you'll be receiving the case not too far from now. You've been great, paid great attention, so I ask that you do that for a few more hours this morning and then you'll be in a position to deliberate.

Any objections to those remarks?

MR. WELCH: No, sir, Judge.

MR. NANCE: No, sir.

THE COURT: All right. Then you may move forward.

Mr. Welch, before you start, let me see you and Mr. Nance just a second.

(Sidebar conference.)

MR. WELCH: Ladies and gentlemen, my job is almost over. My job is to bring to you the evidence in the case. I told you at the beginning some things that I will follow up on, then your job starts. Because once the Judge is finished, I'm finished, and the defense is finished. Then it's up to you.

Now, one thing you need to understand as we start this process is this: That a corporation, Edgefield Medical Clinic, PA, acts through its individual employees. So what you have is a situation where the employees' and the clinic's

action become the actions of the corporation. So you're still going to look at the activities of the employees, but the only verdict will be against the corporation, not against the individual doctors.

So as you listen to the discussions that I'm going to give you now, when you go back in the jury room you're going to have a verdict form that's going to have just the Edgefield Medical Clinic, PA, and then you're going to say, well, they were talking about the doctors. The reason is, is that the actions of the doctors are the actions of the corporation. So if you analyze what was done here as a breach of the standard of care and you find those breaches caused the damage or proximately caused the damage, then you're finding against the corporation. But again, the verdict itself would be against the corporation, not against the individual doctors.

Let me tell you why that's important what we're looking at. When you get back into that jury room, you're going to have three tasks, three main jobs to start with. The first one is to identify the important issue or question the Judge gives you to answer. I'll come back to that.

The second one is to discuss your points and to

listen to the others. This is a discussion that takes place in the jury room. And it's private and confidential. But you have an obligation to look at the evidence. And a group as large as 12 people, the chances are you're not going to agree at first, but you have an obligation, you took an oath before this Court, that you would do three basic things.

The first one is you would put aside any personal prejudices you have, any personal feelings you have. Some of you even said in the voir dire part that you maybe knew one of the individual defendants. You agreed to put all that aside and not let any of that make a difference. The other thing you agreed to do is to look at the evidence, to actually listen to the evidence. Based upon that, you agreed that you would faithfully and truly and honestly find a verdict in this case based upon the facts no matter how you felt personally. So when you get back there, you want to discuss your points and listen to the others.

The third thing that's one of your tasks as a juror is to make sure that nobody brings into that jury room anything that's not in evidence in this courtroom; anything you've heard, somebody's opinion, somebody that's got a relative that had

something similar happen, here's what happened, that's got no place in the discussion back there. And you have the right as a juror, if someone insists on violating the law the Judge is going to give you and considering information that's not in evidence, you have the right to ask the foreperson to ask the Judge to address that. And you've got a right on that jury to tell the person, we are not to listen to that. So when you take that oath as a juror, it's not just for you just to follow the law, but to make sure that other people follow the law as well.

I told you in opening there are two rules we have to look at. The first one is, if you agree to be the treating doctor of the nursing home patient, you must have reasonable face-to-face contact with that patient to make medical decisions in the patient's best interest. Now, you've heard testimony that under certain rules and regulations that there was an obligation on the physician to do an initial visit within 24 to 48 hours, then every 30 days, then after that every 60 days. But you also heard testimony from not just Dr. Levine that testified, but from the other doctors, that that's not just the maximum or a minimum, that means that

under those regs, you have to do that, but if the patient needs consideration or care or treatment or review in a medical situation other than that, you have an obligation to go face to face and see the patient, make an examination. You heard the phrase that the nurses and the physical therapists are the eyes and the ears of the doctor. We don't dispute that. But they're not the brain of the doctor, they're not the decision-making portion; that's up to the physician, and the physician can only do that after a proper examination.

Number two, if you do not properly examine the patient on a reasonable basis, the doctor is responsible for problems from treatable conditions that develop. And that's a simple premise. You have an obligation to go examine. If you don't make the personal examination and gather enough information to properly treat the patient and that patient suffers a condition that is preventable because of your inaction, you're responsible.

Now, there's four elements of the case. The Judge is going to give you the law on this and you can follow along what the Judge says. And anything that I saw that may be different on this, obviously the law the Judge give s you is what it is. But

there's four things the plaintiff has got to prove. The first one is the standard of care. That means what should the physician have done or refrained from doing. The second one is that there was a breach of that standard of care. What that means is, is that now that we've told you or the physicians have told you what should have been done or not done, then actually the physicians either didn't do it or did it when they weren't supposed to, that's the breach of the standard of are. The third one is what's called proximate cause, and it's one of those almost archaic legal terms. What does it mean? Why does somebody use the word proximate anymore in 2014? It's a term that basically means -- and the Judge will give you the specific language on it -- but not just that there was a breach, but that breach actually had a logical conclusion following to cause those damages. You can see that connection, that it was foreseeable in a way. The last one is damages. There has to be damages resulting from that breach. I'm going to come back to each of those individually, but those are the four things in sequence that you have to consider. Number one, did the plaintiff show the standard of care; number two, did they show that

that was broken or breached; number three, was that action what caused the damages; and number four, what are the damages.

Now, I will tell you that the law does not allow you to give a verdict based on sympathy or prejudice or emotion or public opinion; none of that has any place in the courtroom. I assure you that Ms. Jackson, on behalf of her father's estate, doesn't want any sympathy from you, doesn't want any verdict but the truth. She doesn't want any passion or opinion either way. She wants you to basically simply look at the truth and do what the law requires you to do under the circumstances.

Now, the burden the plaintiff has is called the preponderance of the evidence. In other words, another one of those legal terms and issues that we don't use in everyday life. All that really means, and the law discusses it as, it means the greater weight of the evidence. It is the evidence which as a whole shows that the fact sought to be proved is more likely true than not. More likely, 51 percent; moving the ball from the 50-yard line to the 51-yard line. That's the burden. This is not a criminal case. This is not something where we have to show you the standard of care, the breach or the breaking

of that standard of care, the proximate cause or the cause issue, and damages by a -- beyond a reasonable doubt. That's a criminal case. That's not a civil case. The civil burden is much lower. It is 51 percent, it's moving that ball one yard past the 50-yard line.

You see the scales of justice? Everybody's seen those, she's blindfolded. But that scale, that 51 percent means for the plaintiff to carry the burden of proof, that scale's got to tip ever so slightly toward the plaintiff. Not tip down, just tip every so slightly.

Now what is negligence? The best thing I can tell you is, is when you think of the word negligence, think of the word reasonable. And I want to give you an example. I don't know how many of you are NASCAR fans. My mother, quite frankly, is a NASCAR fan and her favorite driver is Dale Earnhardt, Jr., and I understand he drives Chevrolets. Now, I can tell you that Dale can be at the track in Charlotte practicing and decide to go home, and get on that four-lane outside the track in Charlotte and go up toward I-85. And there's three lights before you get to I-85 from that track. And Dale may put his cell phone on that seat beside him,

and I'm assuming he's driving a Chevrolet home. And as he heads through the first light, it's green, and the cell phone rings. And he looks down to see if it's his new girlfriend. And while he's looking at that cell phone and goes to pick it up, the light changes to red and he goes through the red light. Now, that inattention, that failure to act reasonably, is negligence; doesn't mean that Dale Earnhardt is a bad driver or a bad person, doesn't mean any of that. And the same principle applies in a case like this. If you're negligent and not acting reasonably, that's not an indication you're a bad person, that doesn't mean you acted intentionally, that's not what negligence is. If someone back there starts saying, well, it wasn't done intentionally, that's not the standard, that's not what negligence is. It means the physicians simply did not act reasonably.

This is what's called a survivor action. And what that means is -- and there's a statute, that's what's up here. And it says that Mr. Peterson, when he was alive, suffered certain damages. And because he passed away doesn't mean that he lost the right or his estate lost the right to recover those damages. So the award that you're going to make in

this case is actually to the estate of Mr. Peterson for those medical bills and things that he incurred. And the testimony was from Dr. Levine for those things that were made necessary because of the fact that the negligence occurred.

Now, what does this case boil down to? Who saw Mr. Peterson and examined him after April 14th, 2006? Dr. Massey didn't, Dr. Rainsford didn't, Dr. Leaphart didn't. From April the 14th to May the 15th, not one of these doctors physically examined him. I'm going to go through some more specifics with you in a minute, but even though you can see in the chart, you're going to have in evidence that Dr. Leaphart was writing orders that changes one of the debriding agents to another debriding agent; that the doctor was actually looking, at a time, writing other orders in the chart, signing off on them; that one of the physical therapists or the nurse would write and recommend and say, okay, that's fine, write off on it. At the time that debridement was actually starting on that wound on April the 21st, you see in the record and heard in evidence that that wound went from -- there's a four-stage classification. Number one just being red skin, number four being a penetration of the

skin down through the layers. That's what you see at the very end. By April 21st in there, that had gone to a stage three, and by May it was a stage four. At that point in the process, no physician is looking at this wound or examining this wound.

Now, what are you going to base your decision on? One of the things you've got in this case is what's referred to in the law as expert testimony. And, quite frankly, all that means is to be an expert you have to have knowledge that's not in our everyday common knowledge base. You have to have special knowledge that may assist the jury. In medical cases, it's physician's testimony as to what the standard of care is.

Now, you're going to be faced with a decision, because you have a physician, Dr. Levine, and they make a big deal out of the fact that he's from Manhattan. Dr. Levine is a board certified internal medicine doctor, geriatric physician, that publishes, that researches, that sees patients, and he came down here to give you his honest testimony about the treatment of this patient. Where he's from should have nothing to do with it. The fact that he's not from South Carolina should play absolutely no role in your determination of his

testimony. Now, if you disagree with his testimony, let it be for some specific reason you find, not because of where he's from. But what you'll find from his testimony is, is that you should face the patient, physically see the patient. When you take on the obligation to be the physician, you take on the obligation to have knowledge of your patient, and that the clinical evidence in the medical record showed this patient, the wound developing, going downhill. Keep in mind the plaintiff is not saying that that wound was preventable; that's not what the plaintiff is saying, that's not what Dr. Levine said. But knowing patients like Mr. Peterson have these wounds, when you see it start getting worse and worse, you have to go see the patient. And when you culture out something like this MRSA, you have to treat it immediately. If you don't, you're going to get the results you had in this case.

When you look at the qualifications of the experts, that's one of the first things you look at: Do they teach? Do they publish? Do they actually develop information in this area? Do they train other physicians? Their credibility. Do you feel like they were being open and honest with you, with all of us in everything they said? The reasons for

their opinion. What are the reasons the expert had to view the case the way they did? And quite frankly, I'm going to tell you that one of the best examples is Dr. Lovelace, Dr. 100-case Lovelace. Everyone, never testified for a plaintiff in South Carolina, always testified for the doctor.

Number four, the facts that they assume to be true. And for instance, you heard Dr. Eads say something like, well, he didn't get any better at Aiken which shows they did everything okay at the nursing home. Well, he did get better at Aiken. So Dr. Eads says, well, that's because they put a feeding tube in. No, they didn't put a feeding tube in at Aiken. So really the facts underlying his opinion, and I'll come to the other part of his opinion in a minute, but you got to question those type things when somebody comes before you and says, here's the facts I base it on, and that doesn't turn out to match the record.

Dr. Eads, his defense is let God's plan be done, no quality of life. That's not Dr. Eads' decision to make; that's Mr. Peterson's and the family. The doctor doesn't have the right to say, in my opinion, this man had no quality of life. You heard the testimony that he got better at Aiken,

that he was talking to the doctors at Aiken in complete sentences. You heard the testimony that the family was able to see and go visit him and that he knew them and he talked with them in Aiken and in Augusta. And, yes, he was 84 and, yes, he did have health issues. But every day of life is precious. And to let this infection get so rampant it's in the bloodstream and then say the best thing to do is let him go because he got that sick because you did not follow the standard of care and give him the medicine is a circular argument. And, quite frankly, I find it a little offensive when you say, God's will be done. Sometimes God's will is that you give medicine to this patient.

Dr. Lovelace, I'm going to say it again, this is kind of what he does, he looks at records, I've got your back, I'll cover it. Dr. Massey, Dr. Leaphart, and Dr. Rainsford, I'm going to tell you that they all have something to gain from their testimony, and that is their self-protection. That's human nature. We all are at risk and we testify in our self-interest. That's human nature.

But you have to look at the testimony. What does it show? How does it differ? I'm going to tell you that -- and I'm going to show you at the

very end. But when we come down to Dr. Rainsford's, the medical record says Dr. Rainsford -- the nurse told that Dr. Rainsford said I'm not coming over there, they shouldn't take him out, it's against medical advice. Dr. Rainsford said, that's not what I said; I wanted to come examine him, maybe give him some better advice once I examined him. But what he told you on the stand is he didn't have enough information about that patient to make the decision, and he said that he told you in deposition that he wanted to go over, look at the patient, get more information. That should have been sooner, not the day that the man literally is going to die.

You heard Dr. Eads and Dr. Rainsford say that if the family had not gone through whoever the nurse or person was that said you can't leave, got him on the gurney, got him out, he would have died, because his body was full of the MRSA infection. It got in his bloodstream.

Dr. Leaphart wrote the discharge order at the end, examined him on the 14th, wrote one of the other orders changing out medications at the same time they're doing debridements. Look at the record. If you want to know what happened in this case, forget the testimony, look at the record,

compare the two. And when you compare the two, the record was made at the time, it's required by law to be made. It's the best memory anybody has of what happened was the day it happened. And you heard Dr. Rainsford tell you that he came in and he signed that order that said the patient was discharged against medical advice. He didn't tell anybody they wrote it down wrong, he didn't tell anybody that's not what he said, he didn't tell anybody to change it. He signed it, which by law means that's what I'm saying, that's what I mean.

The damages. Damages is about harms and losses. I want to point out something to you. Number one, compensation is the amount that equals the harms and losses caused by the negligence. Compensate means to balance the scales. That's what the word compensate literally means. Let's put it back where it was. A verdict for the plaintiff is an award of damages, but not in the sense that award means gift. It's not a gift. It simply means I've incurred a loss because of this behavior and it's only fair that you get me back where I was, you bring me back level, the balancing. No place for sympathy or pity, just what the law sets out. Balance it, bring it back so the estate doesn't have

the loss that it currently has because of the negligence.

Do not listen to the defense smokescreens in this case, because that's what they are. I'm going to get you to look over here, if you concentrate over here, it's not the real issue. But if you concentrate over here enough, you get in the jury room and buy into it, then it will cloud the issue enough to where you go, I can't decide.

Here's the smokescreens. Number one, Mr. Peterson's condition. He was old, he was paralyzed from the waist down, he had some dementia, he had some issues, some kidney function issues. His condition, they knew every single portion of that when they agreed to treat him. They agreed to treat him in that condition. They knew those conditions. That's not the issue. The issue is how do you treat a patient like that? What do you do to help prolong life?

Number two, the harm came from the failure to examine and give timely antibiotics. That's the issue, not the fact that the man had a hip injury or had a sacral wound on the hip, the decubiti, the pressure ulcer, we'll call it. The fact that it formed is not the issue. If you get back there and

somebody says, well, the testimony was you can't keep it from forming so you can't blame the doctors, we're not blaming the doctors for that. A patient like Mr. Peterson does have some of those things forming. The issue is, did you diagnose the severity of it timely and did you give the medication that was called for.

Number four, the doctors had a duty to know about the patient. That's an issue. If they tell you that the doctors couldn't go see the patient because the physical therapist and the nurses didn't tell them to, that's the rabbit hole. That's what they want you to chase over to and go in the back and say, you know what, the doctors and the nurses never really said anything about how bad it was. Well, yes, they did. They told them it changed stages from 1 to 2 to 3 to 4. They asked for stronger medications to debride it. They put in the chart they were debriding it. All of those things were there. But to know, you have to go look at the chart and see the patient. Eyes and ears, but the doctor's the brain. I've talked to you about that before. They can't tell you that they depend totally on what they're told. They have an obligation to have the information on that patient

to be able to make a decision at the critical time. It's too late on the 15th, when this man is what's called septic, when the sepsis, the infection has gotten in his bloodstream. It's too late. You need to know what's going on with that patient when you get that MRSA culture back. If it was the 7th, the 8th, the 9th, or the 10th, you can't say, as Dr. Massey did, I saw it, I initialed it, I think it was probably the 10th because I was off on the 9th, I did what I normally do, I gave it to whichever physician was in charge. The testimony has been very clear from the beginning, all these physicians see all the patients, and when you get that MRSA culture back and initial off, you can't just take it and give it to somebody you don't remember who. You have an obligation to follow through, knowing that this gentleman's cultured out two different pathogens, one that, seriously in the bloodstream, causes death.

Now proximate cause, I told we'd come back to that. Something that produces a natural chain of events which in the end brings about the injury. It is the direct cause of the injury. Now that sounds kind of circular. What it means again is, is that this is something that actually causes the natural

course of events or natural chain of events of the injury. In this case, it's very clear that it's the chain of events that took place of the developing illness in Mr. Peterson, the infection that's starting to set in, the notice of the infection to the doctors, and then the failure to do anything about that until it was just rampant, until it was too late, until it had gone past the wound into the bloodstream. The proximate cause, that's a natural chain. Proximate cause may not be the only cause. There may be more than one proximate cause. The defendant's act can be the proximate cause to decedent's injury if it was at least one of the direct concurring causes of the injury.

And in this case, to find against the corporation, Edgefield Medical Clinic, PA, you don't have to find that all of the doctors were negligent, you only have to find that one of the doctors was negligent and that negligence caused the injury. So when you get back there and somebody says, well, I think maybe Dr. A was negligent and I can see that that failure to do so-and-so caused the injury, somebody else says, well, that's not enough, you got to find them all, no, you don't. The law is that since each of these is the agent of the corporation,

if you find that there was one of these three doctors negligent and that negligence caused the injury, then your verdict should be against Edgefield Medical Clinic, PA, for the amount that you find is fair and reasonable.

Again, I've told you to follow the law. Don't bring things that are not into evidence. If you have firm feelings about a point, make sure you argue it, make sure it's to the more-likely-than-not standard. Don't hold the plaintiff to anything other than the 51 percent.

What are the medical bills? What are we asking? Here's what it comes down to: You heard the testimony, Trinity Nursing Home, 64 days costs $35,720. That comes to $558 per day. Now, Ms. Jackson told you on the stand that the estate says if everything had gone like it was supposed to, if he got the antibiotic he was supposed to in the nursing home in a timely fashion there earlier in May and it didn't get so out of hand it got in his bloodstream, then we'd still be having the nursing home and be paying that. So we don't want the jury to pay us for something we were going to pay anyway. So that $558 per day is taken out of the two medical bills that you're going to have that they're asking

for recovery on.

The first one is Aiken Regional Medical Center, the May 15th to the May 31st stay. That's where they took him to the emergency room, that's where the doctors treated him immediately there and identified what's wrong, that's where they gave him the IV antibiotics in the intensive care unit because at that point in time it was so serious and they kept him there for two weeks. If you look at that total bill, it's $57,220, that comes to $3,576 per day. If you deduct out the 558 that they would pay if he's still in the nursing home, that comes to $3,018 per day, for a total of $48,288. So they're not asking for the 57,000, they're asking for $48,298. That deducts out what the nursing home care would have been if everything had gone okay.

The other thing they're asking for is Select Specialty Hospital of Augusta. That's where he was in June and July, SSH, Select Specialty Hospital of Augusta. That's where he was transferred to, that's a facility that's there for long-term care. If you look at that bill, it was $146,911. That's $2,028 per day. Again you deduct out what the nursing home cost, that's $1,850, for the 61 days he was there, total is $112,850. They're not asking for the

entirety, just what it would cost over and above the nursing home.

There was $383 that the doctors billed him while he was in the nursing home that the estate is saying you didn't do the job, and so we're entitled to get the $383 back. There's the 48,288 at Aiken Regional. And again, that's already deducted out the nursing home charges. There was a 112,850, again, Select Specialty Hospital, nursing home taken out; the total is $161,500. That's what the estate is asking from you, from the corporation, that you put them back even, that you say, your negligence caused this extended care over and above what was needed to correct the situation. So now we want you to bring the estate back in balance, that's all.

Your Honor, at this time I reserve the last ten minutes.

THE COURT: I'm sorry. Do what?

MR. NANCE: Five; count them, five board certified physicians from South Carolina took that stand under oath and told you that the treatment in this case was correct and it was appropriates. And for you to find for the plaintiff in this case, you've got to determine that every one of them, all five of them, got up there under oath and lied to

you --

MR. WELCH: Your Honor, I object. They can find it's a difference, but to say they lied is not the law.

THE COURT: Ladies and gentlemen, y'all determine the credibility or the believability of the witnesses, it's your decision to decide what the true testimony is.

MR. NANCE: Let's talk about them for just a second. The first one is Dr. Rainsford. Dr. Rainsford is a lifelong resident of Edgefield. He grew up here, went to high school here, he went off, got his education, came back, and since 1977 he's dedicated his life to taking care of the people in Edgefield County and anybody else who happens to seek his medical care.

Dr. Leaphart, she's a lifelong resident, until recently, of Edgefield County. She was born here, grew up here, went to high school here, went off, got an education, came back and practiced here for some period of time. I think I told you before, she's in Leesville, but in any event, she's still dedicated her life to taking care of sick people, people who need her help.

Dr. Massey is not from here but she went to

nursing school, became a nurse, an RN, and later went to medical school and came here and has been here for some period of time taking care of these people.

Dr. Eads -- Dr. Eads, graduate of the University of Virginia, undergraduate, medical school, did his residency in internal medicine in Charleston and now practices there, taking care of people, worked in nursing homes, been a medical director, and Dr. Lovelace, who they categorize is the Dr. 100-Cases. I call him Mr. Family Doctor of the Year for 2012 in the state of South Carolina.

Now, every one of those people got up and told you that the care that was done in this particular case was appropriate. The Plaintiff does not contend, it's my understanding, that the treatment of this pressure sore was improper. They don't contend that it was avoidable, and they agree that what was done by all of these doctors was appropriate. But what they do talk about is they say, well, nobody examined him from April 14th until Mr. Peterson was taken to the Aiken Regional Medical Center on May the 15th. But what they don't tell you is what they would have done different. What if they had examined him? Did they tell you or give

you anything they would have done different? Did they give you any reason that the treatment they were given was not appropriate and proper? No. What they say, and this is what the facts show, that on May the 5th of 2000 -- May the 2nd of 2006, Dr. Nicholson, who, by the way, is not a part of this case and never was, while you've been hearing, ordered a culture. It came back, the evidence has shown, I think on the 7th it was faxed over to the nursing home and it was faxed to the practice on a day when Dr. Massey was not there. She got it the next day and then she would have sent it on to Dr. Nicholson because he was the one who ordered it. And every one of these five doctors told you that although it showed there was a MRSA colonization, that it was superficial, it was on the skin, it was not within the system, it was not treatable at that time. And every one of them told you that you've got to wait, to watch it, and when you get an increase or decrease in temperature and a decrease in blood pressure, that's when you begin to look at it, and that didn't occur until late on the 14th. But it wasn't reported to anybody and nothing occurred until the 15th when Dr. Rainsford was called and he was going over to take a look at this

gentleman, Mr. Peterson.

Mr. Peterson had a do-not-resuscitate directive which could be withdrawn. Fine. He was going to look at it, to talk to the family, and they'd make a decision as to what to do; not him, they would. But they had already chosen to renounce the DNR. Fine. And they had chosen that they wanted him to begin to get aggressive care, which he got after he got to the Aiken Regional Medical Center. That's fine. And Dr. Rainsford told you that, looking in the records, and knowing they renounced the DNR, do-not-resuscitate directive, that certainly what happened would have been fine with him, family's decision. So they got just what they wanted. They got just what he would have done had he been there and given an opportunity to examine him. There are no damages. Why is it this practice should be liable for the expenses they incurred after that when they got exactly what they wanted and they got exactly what Dr. Rainsford would have done under the circumstances had he been allowed? Just doesn't make good sense, does it? Just doesn't make good sense.

You know, I just don't have a lot to say about this case. It's really a pretty simple thing, and

I've gone through it. We're accused of throwing smokescreens and this, that, and the other, but it's just a fact. Mr. Peterson was not in good shape. He had endstage dementia. He had two mini mental tests. The first one was done in March and you can look in the records when you get them. They'll be in the records you'll get to look at. And I think he scored a 9 and the other one was done in April and he scored 2. And you heard anything under 10 is very, very poor. He was paralyzed, he had renal failure, his skin was failing, he was developing these ulcers, his appetite was very poor. He was incontinent to bowel and bladder. It's a tough situation. But, you know, the fact of the matter is, and although his death is not an issue in this case, it's just about these medical bills, that's all it's really about, trying to get them some money, the fact of the matter is, is that death is an absolute constant. The rate of death everywhere is 100 percent. It's going to happen to everybody at some point in time. It's unfortunate, but that's the way it is. Mr. Peterson was nearing the end of his life, no doubt. He died, I think, on August the 3rd, 2006 when he was in the Hospice care and, you know, it's really unfortunate. But these doctors

did not do anything for which they should be liable. And you've heard that now this case is just against the medical practice, and it is, but that's the type of a corporation.

The corporations act through their employees, their agents, and every one of these doctors is the agent of that corporation. And if you find for the plaintiff and not for the defendants, you'll be saying, pointing the finger, some of them, I don't know who, but some doctor in that practice, Dr. Massey, Dr. Leaphart, or Dr. Rainsford, wasn't being a good doctor.

Ladies and gentlemen, you've been here several days. I'd like to thank you for your attention. I've watched all of you. I know -- I hope this has been an educational experience for you. Not everybody gets the opportunity to sit on a jury, and I know sometimes it's an inconvenience to some people, but it's a very important duty. And it's very important to the plaintiff and I guarantee you it's very important to Dr. Rainsford, Massey and Leaphart, very important. And all that they ask is that once you get all of the evidence and go back into the jury room and deliberate, that you assign credibility to the witnesses, weight to the

evidence, listen to his Honor as he tells you what the law is that should apply, apply it, and bring back a true and just verdict. Thank you very much.

MR. WELCH: I get to talk to you again, and I can tell you what the plaintiff wanted was antibiotics. What they wanted.

The DNR, ladies and gentlemen, that you're going to have in evidence, when you look at the page, middle of the page, page 4, it says: We do want Daddy to have IV fluids, want him to have IV antibiotics. So the DNR has really nothing to do with what's going on in this case. It's another smokescreen. What the DNR says, if you read it, and you heard the testimony, if he has a heart attack, if he's dying from something like that, don't use the paddles. But it doesn't say, you know what, if he gets a real bad infection, don't give him antibiotics, let him die. That's not what it says. That's not what the family wanted.

And Mr. Nance made a statement that is something that you do need to consider. It says that if you go back there and come back with a verdict against the corporation, that you're saying a doctor did something wrong, you are, because they did. And sometimes that's uncomfortable. But you

took an oath that you would do something uncomfortable if you had to, to follow the law. You took an oath that said that if you look at the facts and you find that this infection was identified and he said that we didn't tell you what we would have done differently. Yes, we did. Dr. Levine, in fact, fairly clearly early on in his testimony told you that the obligation of the physician, number one, is to be over there looking, examine the patient; but number two, when you go culture that wound, and they can talk all they want about, we got MRSA on our skin, that type of thing, they cultured that wound for a purpose. They wanted to know what bacteria, and they got the result and it went to Dr. Massey, that's her initials and, in fact, it was over at the nursing home even before it got to Dr. Massey. Got to the nursing home on the 7th in the chart. If you look at the chart, you'd see it right there, and you'd see the two pathogens or bacteria, or the MRSA and this one, and you'd know that, you know what, MRSA is a bad thing, MRSA is a bad bug, and as the doctor said, you start the antibiotics immediately. Because you see, ladies and gentlemen, the goal here is to treat it before it gets in the bloodstream, that's the real issue

here. And Dr. Levine said more probable than not, if antibiotics had been started when that came back like they should have been, this gentleman would not have gotten septic, wouldn't have gotten in the bloodstream, wouldn't have gotten in his urinary tract. It would have started deproducing in the wound like it did at Aiken when they started the antibiotics on the 15th.

What's your responsibility? He also told you that you're telling the doctors they're bad people doing a bad thing. You're not. You're telling the doctors, in fact, including Dr. Nicholson, he was an agent and employee of the corporation, you're telling whichever doctor you find negligent, one or more, that you know something, at that point in time, you didn't pay attention for a period of time and you should have, doesn't make you a bad person any more than it makes Dale Earnhardt a bad driver because he wasn't paying attention looking at a phone. You can call it human nature, you can say well, everybody does it. You know what, that doesn't matter. If you're supposed to be paying attention as a physician and you're not, reasonable physicians don't do that. And for that short period of time, you were negligent, and there's

responsibilities for it.

Jury service is a public trust. You, ladies and gentlemen, are Edgefield County right now. It's a public trust. You're doing this under oath. You agreed to do it. You've agreed to follow the law. And in doing so, you agree that if it's a little uncomfortable for you to do it, you'll do it anyway. You agreed that if you are on the street or scared somebody's going to say which doctor or why, Judge is going to tell you, you don't have to talk to anybody. But you do have to follow the law and render a true and just verdict. And when you do that, you don't owe an explanation to anybody. Don't allow two standards.

There should not be one standard for physicians and hospitals and doctors and medical clinics where you say, well, you know what, they help people, they do good things, everybody makes a mistake. That's not the law. I don't care how good you are. If you're not paying attention at a critical time and somebody gets hurt, there's responsibilities. If you run a medical red light, you can't say, well, a lot of people have done it or I didn't mean to. There's no excuse. It happens. And when it happens, there's accountability. The patient is

entitled to just as much respect, just as much consideration as the physicians are.

What kind of medicine? That's going to be up to you, because your decision basically says, you know what, as individuals and as a group, we're willing, if the facts show it, to do what may be kind of a hard thing for us, and we don't have to explain it to anybody because that's the law.

Now, you took an oath, you promised to abide by the preponderance of the evidence, you promised to say, you know what, Plaintiff, I'm not going to make you do any more than go to the 51-yard line on each of your things you have to do, each of the items the Judge gives you that Plaintiff's required to do; I'm not going to make you score a touchdown, just to the 51, just move it. And we've done that.

You wanted to be presented the facts, you've got the facts. You took an oath to do the truth of justice. Mr. Peterson has carried his burden. And I want to show you when you get back there, ladies and gentlemen, then I'm done, you're going to have the record. This is Exhibit 3, this is page 69, this is what the nurse read to you, what she charted for you, that she called -- first of all, she called earlier herself because Mr. Peterson was anxious, he

was moaning when touched. She wanted some Ativan, something to calm him down. Nurse said Dr. Rainsford said no. Then she called back because the family wanted to move him. And she wrote this in quotes: Dr. Rainsford did not advise family to send resident to hospital. Instead told family it was their desire, family could take him to the hospital. She charted that. And when Dr. Rainsford came over the next day or whenever he came over to look, all he had to do is look at that and say, that's not what I said. The nurse's notes are things that doctors are supposed to read.

She also said that the resident's DNR status -- in other words, he's got a directive, but it doesn't apply here because what he needs is antibiotics. This man is sick and dying because the infection got out of hand, that you didn't give him antibiotics for when you got the lab results saying he had a bad infection. Explain conversation to family members, Patricia and Mary Peterson, regarding call to Dr. Rainsford. All family members, possibly 15, all insisted that they take him. They told them it was against medical advice.

A little bit later in the day, she read this to you, she charted this: Resident transported via EMS

to Aiken. Hospital transportation to -- transportation to hospital not recommend by Dr. Rainsford, transported per family against medical advice. Dr. Rainsford said don't take him. Dr. Rainsford came in here now and he said, I'm coming over there to examine him. The family said, nobody told us that day, he didn't go there that day, he told us he didn't go that day.

How do we know how bad it got? You're going to have the medical record from Aiken, and in the first 20 pages you're going to have what they found, which was that MRSA bacteria in his bloodstream. That's why it's too late. It's also in his urinary tract, which is your bladder, the part to your body where you urinate, that type thing, MRSA. The wound was infected. They suspected it was in his kidneys. And it could have been prevented by antibiotics earlier, IV antibiotics, that were clearly allowed in the rules of the DNR. It didn't have to be like that. It didn't have to be.

This case comes down to periods of time when you look to say, hey, what should we do in this circumstance? What would a reasonable physician do? And I assert to you, a reasonable physician would follow up on what clearly is a building decubiti and

an infection. Why did they order the wound cultured? Because it was showing signs of infection. What's the infection? I don't know, let's see. Well, what is the bacteria? And it comes back and says, you know what, this is MRSA. And that's a serious thing. You can't just initial it and say I think I did what I normally would have done which is take it to whatever doctor is treating him. You're all treating him. That's what you all said under oath in this courtroom. And when you've got this kind of bad bug and you've got a gentleman that's weak to begin with -- and you know the antibiotics today, all you've got to do is look at the gentleman. That's what this case boils down to, ladies and gentlemen.

And all they're asking is that that amount of money they had to spend, as -- as the doctors have said, this man would have been dead the next day, by the next day, if they hadn't taken him to the hospital. And what they're saying is, we simply want you to give us back the money we had to spend to keep Daddy alive for a few more months to be with us. That's all we're asking. And if they had given the antibiotics, we wouldn't have to spend that. But we did, that's what it took. And once you

subtract the nursing home fees out, $161,500.

I'm going to sit down because my job is totally done. The job is now yours. And I simply ask -- I'm going to say for the last time because it's important, being on a jury is not an easy job in a case like this, especially. But you took an oath to say, you know what, I know it's not easy, but I'm going to follow the oath and follow the law. When you get back there and deliberate and look at the facts and you find that, you know what, more probable than not, 51 percent, if they simply had given him the antibiotics like they were supposed to when they found out it was MRSA, he wouldn't have been that sick on the 15th, they would have taken him somewhere, and the estate is entitled to those medical bills back. Thank you.

THE COURT: Mr. Foreman, ladies and gentlemen of the jury, my instructions are 15 minutes maybe. Y'all are okay? You want a quick bathroom break or move along?

Mr. Foreman and ladies and gentlemen, let me remind you that obviously during the trial of the case, as I explained to you when we started, that you and I have two distinct responsibilities during a trial. My responsibility is to rule on the

admissibility of the evidence. My responsibility is to instruct and charge you and tell you what the law is in these types of cases. Obviously your responsibility as the judges of the facts is the most important responsibility in the trial, the most responsible job, you've got a big job to place. So if at any time during the trial of this case you've looked up here and I've been frowning or smiling or raising my eyebrow, doing anything that makes you think I've got an opinion about the facts, please disregard that. The law does not allow me to have any opinion whatsoever about the facts. My job is to tell you what the law is and to rule on the admissibility. So please don't let anything I've done influence you or make you think I have some opinion about the facts. That's solely your job; you're the finders of the facts in the case.

Now, as I said when we started, this is a civil case. And in a civil case the burden of proof is on the plaintiff, and the plaintiff has to prove his or her case by the preponderance or greater weight of the evidence. And it's simply evidence which, as a whole, shows that the facts sought to be proved is more likely true than not true. As some of the lawyers have argued and I explained to you when this

started, the parties come in on equal footing. For the plaintiff to prevail, they have to prove the elements of their cause of action by the preponderance or the greater weight of the evidence. They have to tip the scales ever so slightly. If they're able to do that, they've met their burden of proof. However, at the close of the case, if all the evidence remains the same or it tips in favor of the defendant, then they have failed to meet their burden of proof. So the burden of proof is on the plaintiff to prove the case by the preponderance or greater weight of the evidence.

Now, in doing that, obviously -- and you make that decision as to whether or not the plaintiff has met their burden of proof. In deciding that, obviously your main job is to determine the credibility of the witnesses who have testified in the case. Credibility simply means believability. It becomes your duty as jurors to evaluate the evidence and determine which evidence convinces you of its truth. In determining the believability or the credibility of the witnesses who have testified in the case, you have the right to believe one witness over several, several over one. You can disbelieve everything a witness says, you can

believe everything a witness says. You can believe a little bit of it and disregard the rest. You can believe a lot of it and disregard the rest. So you have the right to determine the believability or the credibility of the witnesses who have testified in the case.

I told you when we started you need to use your ordinary common sense in dealing with people. You deal with husbands, wives, children, employees, employers, family, friends. You know how to Judge the believability or the credibility of the witnesses who have testified in this case. You have the right to consider whether a witness has an interest in the result of a trial, whether the witness is prejudiced for either the plaintiff or the defendant, and the opportunity for the witnesses to have seen the matters and things about which the witnesses may testify and even the way the witness acts on the witness stand.

This case now is a case against Edgefield Medical Clinic, PA. A PA is a legal entity similar to a corporation. In our courts no distinction is made between corporations and individuals. A PA is a person in the eyes of a law, a professional association that's entitled to the same fair and

impartial consideration and justice by the same legal standards as an individual would be.

Now there's one other proposition of law that's sort of general to all cases we try in the civil arena, as well as the criminal arena, and that is a rule dealing with expert witnesses. During the trial of this case I qualified a number of witnesses to -- I qualified them as an expert in the field of medicine. Normally our rules of evidence do not permit a witness to testify about opinions or conclusions. There's an exception to this rule which we call the expert witness rule. A witness who by education and experience has become an expert in some art, science, or profession such as medicine may give an opinion as to the subject the witness claims to be an expert in and may also give the reasons for that opinion. You should consider any expert opinion given by a witness like any other evidence; give it the weight, if any, you think it deserves. If you decide that an expert witness' opinion is not based on sufficient education and experience or if you decide the reasons given in support of the opinion are not sound or that the opinion is outweighed by other evidence, you can disregard the testimony entirely. An expert

witness' testimony should be given no greater weight than that of any other witness simply because he's an expert. And our rules say that you do not have to accept an expert's opinion even though it is uncontradicted. So that's the rule dealing with expert witnesses.

Now, Mr. Foreman, ladies and gentlemen, that's sort of the general propositions of law that are charged around the state on all civil cases. Let's turn to the case at hand. And as I told you when we were striking the jury about our civil side of the law, we have a -- just a host of all types of civil cases. This case happens to be what we call a medical negligence or medical malpractice case. It's one of the many types of civil cases we have. So let's talk about medical malpractice.

In this case, the plaintiff claims that the defendant PA, or professional association, committed medical malpractice, which is a form of carelessness or negligence. In order to prevail in a medical malpractice action, the plaintiff must prove by the preponderance or the greater weight of the evidence basically four things: They must first prove what the standard of care is. Secondly, when they prove what that standard is, they must prove in this case

that that defendant breached the standard of care; in other words, the care fell below the standard. That's the breach and that that falling below that standard of care, that breach is the proximate cause of the damages. Four things: What the standard is, that they fell below the standard, by falling below the standard they caused injury which was proximately caused by the breach. Okay?

Now, let's talk about these one at a time. Plaintiff must prove by the preponderance of the greater weight of the evidence what the standard of care the defendant owed to the plaintiff in treating the plaintiff or, in this case, action of the survival action because the person being treated died and his estate, through their representative, is bringing the action. So when I say Plaintiff, I'm meaning the PR. But the care would be to the personal representatives of the estate in this case, of Mr. Peterson.

Now, Plaintiff has to prove to you what the standard of care is by the preponderance of the evidence. When a doctor treats a patient, the law does not require perfection; the law does require that the doctor use that degree of knowledge, care, and skill ordinarily used by doctors in good

standing in the doctor's field of medicine under the same or similar circumstances and that the doctor followed generally accepted practices and procedures in the profession. In other words, the doctor has to -- the standard of care is what an ordinary doctor in similar circumstances would do under the same or similar circumstances. That's what the standard of care is. They have to prove that there's been a breach in the standard of care. The plaintiff must prove by the preponderance or the greater weight of the evidence that the defendant, the doctors, negligently departed or fell below the standard of care in treating, in this case, Mr. Peterson. And negligence, our courts have defined, is the failure to do what an ordinary careful doctor in the doctor's field of medicine would have done under the same or similar circumstances or the doing of something that an ordinarily careful doctor would not have done under the same or similar circumstances.

I charge you that a doctor is not an insurer of a cure or even a positive result, therefore, the mere fact that a treatment does not benefit the patient or that it even harms the patient does not in and of itself mean that the defendant doctor was

negligent. A bad result, injury or death or failure to cure is not by itself enough to show that the defendant doctor was negligent. The plaintiff has to show that the doctor did not do what an ordinarily careful doctor would have done under the like or similar circumstances or did something that he should not have done under the same or similar circumstances.

Also, a doctor's mistake or error in making a decision alone does not constitute negligence; however, if the doctor fails to gather information reasonably available, which a reasonable doctor would have gathered before making a decision, the doctor fails to comply with the recognized standard of care which would be exercised by a similar doctor under similar circumstances.

The difficulties and uncertainties in the practice of medicine and the unpredictable variations in the response of treatment are such that no doctor can guarantee results. Where there is more than one recognized diagnosis or treatment, no one of them is used exclusively or uniformly by all doctors in good standing. It's not malpractice for a doctor making the decision to choose one of the approved methods, even when that choice later

turns out to be the wrong selection. Qualified doctors and experts may differ as to what constitutes the best course of treatment, and these differences do not amount to malpractice. If doctors in good standing disagree on a medical authority or are divided with regard to a specific course of treatment or care, the doctor's bound only to exercise his or her best judgment in determining which course on the whole is best for the patient. Just because another doctor might have used a different course of treatment does not mean the defendant committed malpractice. However, if a doctor does not have the requisite degree of learning or skill required or if the doctor does not use the care required, it is no defense in the charge of malpractice that the doctor did the best he could.

In considering whether the doctor made a reasonable decision, you must consider the decision in relation to the facts as they existed at the time and not in light of what hindsight may reveal. So that's the law dealing with the breach or falling below the standard.

The third thing that Plaintiff must prove by the preponderance or greater weight of the evidence

is what we call proximate cause. Plaintiff must prove that the defendant's breach of the standard of care proximately caused the plaintiff's damages. Legally, proximate cause is something that produces a natural chain of events which in the end brings about the injury. It's the direct cause of the injury. To prove that the defendant's malpractice proximately caused the plaintiff's injury, the plaintiff must first prove, by a preponderance or greater weight of the evidence, causation and fact. This is proven by showing that the injuries from the damages would not have occurred but for the defendant's negligence.

Plaintiff also must prove legal cause. Legal cause is proven by showing that the injury was foreseeable. This means that the injury occurred as a natural and probable consequence of the defendant's negligence. Plaintiff must prove that some injury or damage from the defendant's negligence was foreseeable, but does not have to prove that the particular damage that occurred was foreseeable. Proximate cause does not mean the only cause. There may be more than one proximate cause, but Defendant's act can be a proximate cause of the plaintiff's damages if it was at least one of the

direct causes of the injuries.

In this action, there's been allegations that there was a failure to diagnose and treat. Plaintiff must prove beyond the preponderance or greater weight of the evidence that the defendant's negligent failure to discover and treat the condition of which the plaintiff suffered most probably caused the damages in this case. The plaintiff is not required to prove conclusively that the patient would have suffered these injuries; however, a mistaken diagnosis by itself would not support a verdict for the plaintiff.

I further charge you that a patient who is treated by a doctor is entitled to a careful evaluation. The evaluation should be made with the diligence and methods and diagnoses that are usually approved and practiced by doctors of ordinary judgment and skill acting under the same or similar circumstances. So that is what the plaintiff must prove by the preponderance or greater weight of the evidence.

Ladies and gentlemen of the jury, Mr. Foreman, if you find that the plaintiff has proven by a greater weight, preponderance of the evidence, the standard of care, that the doctors have deviated or

fell below that standard, and if you find that the injuries or the medical bills in this case claimed by the plaintiff were proximately caused by that breach, then you must consider to award the damages. In this case, we're talking about actual damages. That's the type of damages we're talking about. So if you find those three things, the standard, the deviation, the probable cause, the next step is to decide -- if the plaintiff is entitled to the verdict, then you decide how much money the defendant should be required to pay. And obviously under our form of justice, we don't do an eye for an eye or a tooth for a tooth. We have a much more civil way to handle that through monetary compensation of damages. That's the way our system has been.

So if you find that the plaintiff is entitled to a verdict, then you look at actual damages. And actual damages, under our law, are designed to compensate the plaintiff for the plaintiff's losses. You attempt to put the plaintiff as near as possible in the same position that the plaintiff was in before the incident occurred. In other words, actual damages would be the actual expenses which were proximately caused in this matter. In this

particular case, we're speaking solely of the medical bills. So in an action such as this, a survival action, the general rule is that the plaintiff may recover for the necessary and reasonable expenses caused by the alleged malpractice, or if you find that the doctor has deviated, caused by that deviation, proximately caused. And these would be for such items that would be necessarily incurred, such as medical services, hospital expense, and care. A person who suffers damage that was caused by the negligence of a physician is entitled to recover the reasonable value of medical care and expenses incurred for the treatment of the condition that was incurred as a result of the negligence.

Ladies and gentlemen, in your decision, obviously, your verdict must be unanimous. All 12 of you must unanimously agree as to the verdict either for the defendant or for the plaintiff. You have taken an oath that you will decide this case based solely on what was presented to you in the courtroom. You obviously have no enemies to punish or friends to reward. You're to make a careful deliberation of the facts that have been presented to you. You determine what the true facts are or

were, you take those facts and you apply it to the law as I've given it to you, and then obviously you'll be in a position to render a true and just verdict. That's what verdict means in Latin, speak the truth.

You'll have a verdict form in the jury room. And basically, it's very -- simply, it names the plaintiff, Ms. Jackson, as the PR of the estate of Mr. William Peterson, versus the sole remaining Defendant, Edgefield Medical Clinic, PA. And the verdict form's -- you've got two choices: You either find for the plaintiff, that means you found that the plaintiff was proven by the preponderance or the greater weight of the evidence, the standard -- the deviation was proximately caused by the defendant. If you find that that's been proven, then you put the amount that you find they're entitled to as actual damages, date it, and sign your name as foreperson. On the other hand, if you find that the plaintiff has failed to meet their burden of proof, then your decision would be for the defendant. There's a box there and you'd check for that. So check one or the other, and then the amount of damages. Okay? Very simple.

Oftentimes, Mr. Foreman, during deliberations

you may have a question. The protocol for that is to write it out on a slip of paper and knock on the door and give it to the bailiff, and they'll bring it out to me. Sometimes I can answer it, sometimes I can't, just depending on what the question is. But I'll try to give an explanation one way or the other. Your verdict must be unanimous.

It's 11:00. I don't know how long you'll be deliberating. We can see if you're going to go for a while and give you a menu and we can order some lunch. You're in charge of that. Okay?

THE FOREMAN: Okay.

THE COURT: You're going to return to the jury room. I'll ask you to please not start deliberating quite yet. I have to ask the lawyers if I've left anything out or if I need to add anything or take anything out. When we do that, we'll gather up the exhibits, they'll be brought back to the jury room, along with the verdict form, and once you receive the evidence and the exhibits and the verdict form, you may start your deliberation. So I'm going to ask you at this time to go back to your jury room. Do not start deliberating until I send the verdict form and the exhibits to you. Thank you.

(The jury retires to the jury room at

11:06 AM.)

THE COURT: Any objections, requested additions or deletions from the plaintiff?

MR. WELCH: Nothing from the plaintiff.

THE COURT: Mr. Nance?

MR. NANCE: None from the defense.

THE COURT: I've revised the verdict form. Please come look at it and give me your approval on that. Also, we'll mark the exhibits and make sure we've got everything that goes back.

(Brief pause in the proceedings.)

THE COURT: Let the record reflect the lawyers have reviewed the verdict form and are in agreement with it.

THE CLERK: This is it?

MR. WELCH: That's it.

THE COURT: Y'all have reviewed all of the exhibits and everything is in order?

MR. WELCH: Yes, sir.

THE COURT: Mr. Nance?

MR. NANCE: Yes, sir.

THE COURT: And I've instructed the bailiff to separate the alternate, Mr. Myers. That alternate has been removed.

All right. If you'd take the verdict form and

exhibits back to the jury room and tell them they may commence their deliberations. I'll stand at ease. I'll be in my chambers if y'all need me. Don't get too far, please. Thank you.

(The jury begins deliberations at 11:09 AM.)

(Court's Exhibit No. 7 marked for identification.)

THE COURT: Is the plaintiff ready to receive the verdict?

MR. WELCH: Yes, Judge.

THE COURT: Defendant?

MR. NANCE: Yes, Judge.

THE COURT: Bring the jury in, please.

(The jury enters the courtroom at 1:59 PM.)

THE COURT: Mr. Foreman, have you reached a verdict?

THE FOREMAN: Yes, Your Honor, we have.

THE COURT: Pass it, please.

THE CLERK: Your Honor, this is Case No. 2009-CP-190276, *Cecilia Jackson as PR of the Estate of William Peterson vs. Edgefield Medical Clinic, PA*. We the jury unanimously find for the plaintiff against the defendant Edgefield Medical Clinic, PA, in the amount of $27,086, signed by John Womack, March the 20th, '14.

Mr. Foreman, ladies and gentlemen of the jury, if that is your verdict, please indicate, each of you, by raising your right hand.

All hands are raised.

THE COURT: Anything for the jury before I dismiss them?

MR. WELCH: Not for the jury, Judge.

MR. PARKINSON: No, sir.

THE COURT: Mr. Foreman, ladies and gentlemen of the jury, I can't thank you enough. Y'all have paid exceptional attention to this case over four days. It's not the most pleasant experience in the world to sit on a jury, but it's a very interesting experience. And I think you'll agree with me that when two sides can't agree, this is the best way in the world to resolve a dispute. And I respect your verdict and commend you. You've been wonderful. I'm going to now excuse you. The clerk will be sending a check out very shortly. I think it's $20 a day. It's not that much, but it's better than nothing. Anyone need a work excuse, just sit -- y'all have already taken care of that? That's been done. I've enjoyed being here in Edgefield, always a pleasure, this is an interesting place to hold court. I've enjoyed your city. I spent some money

before I left, I just can't tell my wife.

Anyway, thank you. I've enjoyed it and y'all are free to go. Thank you very much.

(Jury excused.)

THE COURT: All right. Any posttrial motions by the plaintiff?

MR. WELCH: Judge, based on the verdict we'd move for additur. And being for the plaintiff, we feel that the amount of bills awarded based upon the testimony should be in excess of the $27,086. That's all of the motion we have at this time.

THE COURT: Mr. Nance?

MR. NANCE: Your Honor, I feel --

THE COURT: Would y'all like to have ten days?

MR. WELCH: Yeah. I was going to ask for ten days, Judge.

MR. NANCE: Ten days to file a motion? Sure.

THE COURT: Whatever suits you.

MR. WELCH: I'd like to have ten days.

MR. NANCE: It's his motion. I don't care. I have a motion I need to make now.

It's my understanding, although I wasn't in the case at that point in time, that Trinity Mission was a named defendant and they settled for an amount, I don't know what it was, but more than $27,086. It's

my understanding it was about $90,000. And we'd be entitled to a setoff.

THE COURT: I don't think there's any question.

MR. WELCH: No question about that, Judge.

THE COURT: All right. That will be granted contingent upon whatever I do with whatever posttrial motions he makes. I'll give you ten days to make them, and if you want to argue them, I'll be in Aiken a bunch. You can come down to Aiken and argue them or we can do it however you want to do it.

MR. WELCH: Thank you, Judge.

THE COURT: Thank you very much. I've enjoyed working with you.

-- END OF TRANSCRIPT OF RECORD --

INTERDISCIPLINARY DISCHARGE SUMMARY

INSTRUCTIONS: Complete this form when a resident is discharged. All items must be addressed. Record additional comments/ notes on the reverse.

RECAPITULATION OF RESIDENT'S STAY

Admission date 03/21/06 Discharge date 05/25/06

Reason for admission: acute renal failure, hyperkalemia, prostatic obs., inability to void

Treatment provided: maintain highest level of functioning

Progress (include any complications experienced): condition worsen

Reason for discharge/discharge diagnosis(es): transferred on the 15th AKH hosp. & discharged 5/25 SAA

FINAL SUMMARY OF THE RESIDENT'S STATUS

SOCIAL SERVICES

Sensory impairments unknown

Mental and psychosocial status: ☐ Able to make needs known ☑ Unable to make needs known

Attitude about discharge (describe) unknown

Cognitive status unknown

Discharge potential D/C to Aiken hosp.

SOCIAL SERVICES DIRECTOR Sharon Nicholson, SS (Signature and title) Date 5/26/06

☐ Additional Social Services notes on reverse.

Personal Belongings sent: ☐ with resident ☐ with family ☐ Other

NURSING SERVICES

Vital signs at time of discharge: Temp. _____ Pulse _____ Resp. _____ BP _____/_____

Clinical lab values or diagnostic tests:

Physical functioning status: ☐ Ambulatory ☑ Nonambulatory ☑ Needs assist with ADLs ☐ No ADL assist needed

☐ Assistive device(s) needed (specify)

Other comments:

Special treatments or procedures planned for discharge: ☐ None ☐ P.T. ☐ S.T. ☐ O.T. ☐ Ostomy ☐ G Tube ☐ NG Tube ☐ Other Res. trans. to ARMC 5/15/06 for eval. & adm. to ARMC @ that time. Dischg. to ARMC 5/25/06

Dental condition: ☐ Own teeth ☐ Upper dentures ☐ Lower dentures ☐ Partial dentures ☑ No teeth or dentures

☐ Refuses to use dentures ☐ Teeth/mouth problems (specify)

Drug therapy required

NURSE SIGNATURE Margaret Bell, RN (Signature and title) Date 5/26/06

☐ Additional Nursing Service notes on reverse. Disposition of Meds Meds. Ret. to Pharmacy

DIETARY SERVICES

Weight 147 Height 70 Weight trend Varied

☐ Chewing problems ☐ Swallowing problems ☑ Needs assist (specify) Fed Sally & set up

Eating habits/preferences Poor eating habits

Diet order: Pureed Texture: Blended Allergies: NKA

DIETARY DIRECTOR Mattie Gadson, DM (Signature and title) Date 5/26/06

☐ Additional Dietary Service notes on reverse.

NAME-Last	First	Middle	Attending Physician	Record No.	Room/Bed
Peterson,	William		NRelm	1050	P214B

TRANSFER AND REFERRAL RECORD

NAME: Petterson William | ROOM: 214D | SEX: M | AGE: | DATE: 5/15/06

RESPONSIBLE PARTY
NAME: See attached.
ADDRESS:
PHONE: Home:
Work:
RELATION:

MARITAL STATUS:

BIRTHDAY:

RELIGION

ALLERGIES
NKA

SSN: [redacted]
Medicare:
Medicaid: See attached
VA:

INSURANCE NAME & NUMBER

DIAGNOSIS
CODE:
CODE:
CODE:
CODE:
CODE:
CODE:
CODE:
CODE:

LOC
ICF

DOCTOR
DOCTOR:
PHONE:
ALT. DR.:
PHONE:

NOTIFY IN CASE OF EMERGENCY
NAME:
ADDRESS:
PHONE: Home: Work:

DIET ORDER

MEDICATIONS
LAST ADMINISTERED

See attached

PRN

TREATMENTS

CIRCLE IF PRESENT

INCONTINENT: (Bowel) (Bladder) Saliva

DISABILITIES: Amputation, Paralysis, Contracture, (Decub. Ulcer)

IMPAIRMENTS: Mental: ✓, Speech: ✓, Hearing:, Vision:, Sensation:

ADDITIONAL COMMENTS

Vital Signs: unable to obtain
Temperature:
Mobility:
Functional CAP:
Date of Last BM:
PPD:
Chest X Ray:
Comments: AMA

SIGNATURE: M McCabe LPN DATE: 5/15/06 TIME: 3:35p.

ATTACH: RESIDENT FACE SHEET, BED HOLD POLICY, PHYSICIAN ORDERS, MOST RECENT NURSES NOTES

BED HOLD POLICY

Facility Name: TMH&R of Edgefield

The Facility will hold the bed for residents who transfer to the hospital or go out on therapeutic leave according to the following policy:

MEDICAID – According to state regulations, Medicaid will pay a facility to hold the bed for 10 days for anyone transferred to a hospital. Days begin with the day of transfer and do not count the day of return to the facility. After 10 days, a resident will have to be discharged from the Facility. Should the resident wish to return to the facility at a later time and the resident meets the criteria of the facility, favorable consideration will be given to the resident to be re-admitted.

All overnight days must be documented as therapeutic leave days. Residents going out on overnight therapeutic leave are allowed by the State plan 18 overnight visits per year from July 1 of one year through June 30 of the following year. No more than 9 therapeutic days may be taken at one time. Should leave days exceed the amount allowed, the State will be contacted for the correct procedures for payment.

Should a MEDICAID resident who meets MEDICARE criteria have to be transferred to the hospital, Medicaid will pay to hold the bed 10 days and the policy will be the same as noted above.

PRIVATE PAY – The State plan does not limit the number of days a private paying resident may remain in the hospital or out on therapeutic days. It is the policy of the facility to hold the bed of private paying residents as long as the resident so desires and is willing to pay for the bed hold days. This request to hold the bed will have to be in writing. The facility does require 7 days written notice of release of the bed. The facility will fill the bed as soon as possible after notification.

Should a private pay resident who meets MEDICARE criteria have to be transferred to the hospital, the policy is the same as noted above.

This policy will be explained to the resident and responsible party upon admission and will be posted at each nurse's station so it can be reviewed by resident, family, or friends before transfer to the hospital or therapeutic leave.

Date policy became effective
Revised September 1, 1995

The above BED HOLD POLICY has been explained to me.

Patterson, William
Resident

Responsible Party

5-15-06
Date

Witness

DISCHARGE DATE: _____

OBRA – Patient Self Determination Checklist

William Peterson

A. Facility Policy

It is our policy that every resident will be resuscitated until a physician's DNR (Do Not Resuscitate) Order, signed and dated is in place. In the event the heart stops beating – CPR will not be instituted and/or in the event that respiration cease the patient will not be intubated or placed on a respirator if the Do Not Resuscitate order is signed.

B. DNR Policy

The physician will dictate the need for a "DNR" order for any patient. He or she must, along with the facility, provide informed consent and discuss in detail the meaning of a "DNR" with the resident surrogate (guardian, spouse, child or parent). The physician must write the order himself/herself, sign it, and date it. No telephone orders accepted. The physician must write a note in the progress notes that he/she has discussed this decision with the resident, surrogate and/or immediate family. The facility should document consent with written confirmation from the same. It is strongly encouraged that a family member countersign this note. The order must be reviewed and revised at least annually. The order must be kept on the resident's chart. The care plan must indicate there is such an order on the chart.

I/We (daughter) Mary Ruth Peterson, certify that I/We have reviewed the attached materials and had the resident rights explained to me (or as responsible party the rights of the resident) and the facility's medical self determination policies. Please check appropriate boxes and complete.

[ ] **Elect DNR.** I hereby instruct my physician and the facility to place the DNR authorization/policy in my medical chart.

[ ] **Reject DNR.** I direct the facility to administer all available indicated medical care. In the event of cardiac or pulmonary arrest, CPR shall be initiated if available. The facility may defer CPR to an emergency agency and reserves the right to do so.

[ ] **Living Will.** I have/have not executed a living will or other advance directive. Attach executed copy.

[ ] **Surrogate Decision Maker.** I have appointed _____ as my medical surrogate to speak for me in the event of my incompetence.

Relation to resident _____ Form of appointment _____. Attach copy

[ ] **Power of Attorney – Health Care.** I have executed a Power of Attorney naming _____ to act on my behalf in the event of my inability to direct my health care affairs.

[ ] **Guardian.** _____ has been appointed by the court as my guardian. Attach copy of court papers.

[ ] **Informed Consent.** I understand the facility's policies and attached documents which describe in general the state law on advanced directives and patient's rights. I have received the materials and they have been explained to me.

[ ] I understand if I have additional questions about documents I should contact an attorney. I understand that the forms provided are a convenience and not a condition of admission. I will not hold the facility responsible for the carrying out of advanced directives or its policies which may not be consistent with the directives.

[ ] The facility's DNR (Do Not Resuscitate) policy has been received and discussed.

William Peterson
Karen Wilson
Facility Representative

03 - 21 - 06
Date

Signature of Resident

Mary Ruth Peterson (daughter)
ResponsibleParty

C. Artificial forms of nutrition and hydration

Artificial forms of nutrition and hydration have been explained and discussed with me, to include nasogastric tubes, gastric tubes, and IV's.

In the event my physician has determined these are life sustaining measures, following are my wishes.

(daughter) Mary Ruth Peterson
Signature

03 - 21 - 06
Date

____ I DO want to receive nasogastric tubes.

MRP I DO NOT want to receive nasogastric tubes.

____ I DO want to receive gastric tubes.

MRP I DO NOT want to receive gastric tubes.

MRP I DO want to receive IV fluids.

____ I DO NOT want to receive IV fluids.

MRP I DO want to receive IV antibiotics.

____ I DO NOT want to receive IV antibiotics.

Emergency Medical Services
Do Not Resuscitate Order

SOUTH CAROLINA EMERGENCY MEDICAL SERVICES

DO NOT RESUSCITATE ORDER

NOTICE TO EMS PERSONNEL

This notice is to inform all emergency personnel who may be called to render assistance to William Peterson (Name of Patient) that he/she has a terminal condition which has been diagnosed by me and has specifically requested that no resuscitative efforts including artificial stimulation of the cardiopulmonary system by electrical, mechanical, or manual means be made in the event of cardio-pulmonary arrest.

REVOCATION PROCEDURE

THIS FORM MAY BE REVOKED BY AN ORAL STATEMENT BY THE PATIENT TO EMS PERSONNEL, OR BY MUTILATING, OBLITERATING, OR DESTROYING THE DOCUMENT IN ANY MANNER.

3/22/04 (daughter) Mary Ruth Peterson
Date: Patient's Signature (or Surrogate or Agent)

200 Medical Plaza Edgefield SC 29824
Physician's Signature Physician's Address

803-637-3146
Physician's Telephone Number

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

DO NOT REMOVE CHART

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

PASARR - Level I SCREENING FORM

Name: William Peterson	Date of review: 3-21-06
SSN: [redacted]	Location of assessment: AEMC
Medicaid: Non-Medicaid: X	CLAC#:
Date of birth: [redacted]	Referral source: AEMC
All Diagnosis (If dementia diagnosed or suspected, complete and attach the Mini-Mental Form):	
Acute renal failure, Hyperkalemia	

I. SCREENING FOR MENTAL RETARDATION INDICATORS:

	YES	NO
1. Diagnosis of mental retardation or related disability made prior to age 22?		✓
2. IQ tested below 70?		✓
3. Was time of test prior to age 22?		✓
4. Does client have 3rd grade education? If not, state reason in Comments Section.	✓	
5. Adaptive behavior: Could client ever perform self care activities?	✓	
- Did he/she help care for spouse/parents/children?	✓	
- Was client ever able to cook and perform household duties?	✓	
- Was client gainfully employed? If not, explain in Comments Section.	✓	
- Did client have driver's license?	✓	
6. Cognitive Functioning:		
- Memory: Does client remember what he/she had for breakfast or lunch?		✓
- Simple math: Can client add 12 + 61		✓
- Concept formation: Can client describe the difference between a fish and dog?		✓

7. Comments: _____

II. SCREENING FOR MENTAL ILLNESS INDICATORS:

1. Diagnosis of mental illness: No ✓ Yes ___ Diagnosis: _____

2. History of psychiatric hospitalization within previous two years. (Give date of treatment) If no hospitalization, indicate here: N/A

___/___/___ to ___/___/___ ___/___/___ to ___/___/___ ___/___/___ to ___/___/___

3. Current behavioral indicators:

Attempted suicide	N/A	Self-mutilation	N/A
Assaultive		Combative	
Inappropriate loud talking		Social isolation	
Uncooperative		Destruction of property	
Hostile		Unrealistic fear of strangers	
		None of these indicators	

4. Comments: (Include explanation of major symptoms): _____

III. LIST ALL PSYCHOTROPIC MEDICATIONS PRESCRIBED INCLUDING DOSAGE AND FREQUENCY.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

IV. RECOMMENDATION OF REVIEWER

_____ Recommend further evaluation based on mental retardation indicators.
_____ Recommend further evaluation based on mental illness indicators.
X Mo further evaluation recommended.
_____ No further evaluation recommended, but indicators present. (State reasons below.)

Comments: (Give justification for above recommendations, if needed.)

V. PERTINENT INFORMATION

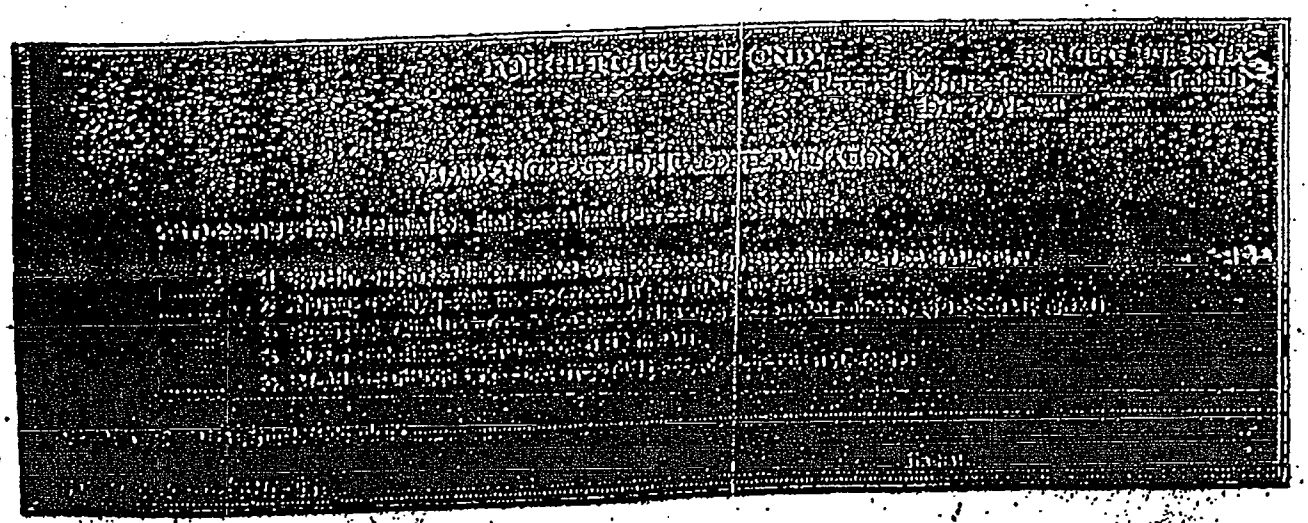
_____ DMD admission requested; if so, indicate facility: _____
_____ Primary diagnosis of dementia must be confirmed by a Mind-Mental Form.

Information obtained from: Pt. & Medical Record CLTC Area: _____

Signature and title of assessor: V. Johnson, CM

Agency/institution completing form: ARMC

Admitting Nursing Facility: Edgefield NH Date of Admission (if known) 3/21/06



SOUTH CAROLINA DEPARTMENT OF
HEALTH AND HUMAN SERVICES

MINI-MENTAL STATE EXAM

Name: William Peterson		Date: April 18, 2006
TEST ITEMS	**SCORE**	**INSTRUCTIONS**
Orientation 1. What is the (year) (season) (date) (day)(month)? 2. Where are we (state) (county) (town) (hospital) (floor)?	Max of 5 4 4	1. Ask for the date. Then ask specifically for any part omitted, e.g., "Can you also tell me what season it is?" One point for each correct answer. 2. Ask in turn, "Can you tell me the name of this Hospital (town, county, etc.) One point for each correct answer.
Registration 1. Name three objects and have patient repeat them. (0 to 3) 2. Number of trials. (0 to 6) _____	Max of 3 3	1. Ask the patient if you may test his memory. Then say the names of three unrelated objects, clearly and slowly, talking about one second for each. After you have said all three, ask the patient to repeat them. This first repetition determines the score. 2. Keep saying the names of the items until the patient can repeat all three up to six trials. If the patient does not eventually learn all three, recall cannot be meaningfully tested.
Attention and Calculation 1. Serial 7's: Counting backwards from 100 by 7. **or** 2. Alternate Test: Spell "world" backwards.	Max of 5 5 —	1. Ask the patient to begin with 100 and count backwards by 7. Stop after 5 subtractions (93, 86, 79, 72, 65.) Score the total number of correct answers. If the patient cannot or will not perform this test, use the number 2. 2. Ask the patient to spell "world" backwards. The score is the number of letters in correct order, e.g., "dlrow" = 5, "dlorw" = 2, etc.
RECALL 1. Ask the patient to recall the three objects above. Score 0 to 3.	Max of 3 0	1. Ask the patient if he can remember the three objects you previously named for him. (In the Registration Section of the test.) Score one point for each correct recall. Do not prompt.

LANGUAGE	Max of 9	
1. Name a pencil and a watch. (Max of 2 points)	0	1. Naming: Show the patient a wristwatch and ask him to name what it is. Repeat this for a pencil. Score 0 to 2 points. Do not prompt.
2. Repeat the sentence, "No ifs, ands, or buts." (Max of 1 point)	1	2. Repetition: Say to the patient, "Please repeat this sentence after me, 'No ifs, ands, or buts.'" Allow only one trial or attempt.
3. Follow this three stage command, "Take a piece of paper, fold it in half, then hand it to me." (Max of 3 points)	0	3. Three Stage Command: Give the patient a piece of paper and state the full three part command. Score one point for each part correctly executed. Do not prompt or recite the three stages separately.
4. Please do the following:		4. Reading, Writing, Copying:
a. Close your eyes. (Max of 1 point)	1	a. Show the patient the statement, "Close your eyes." Ask him to read it and do what it says.
b. Write a sentence. (Max of 1 point)	0	b. Give the patient a blank piece of paper and ask him to write a sentence for you. Do not prompt or assist as spontenaity is important. It must contain a subject and a verb and be sensible. Correct grammar and punctuation are not necessary.
c. Draw intersecting pentagons. (Max of 1 point)	0	c. Show the picture of the intersecting pentagons to the patient. Give him a blank piece of paper and ask him to draw it exactly as it is. All ten angles must be present and two must intersect to score one point.
TOTAL SCORE	2	

Level of Consciousness

1. Assess the level of consciousness on the following continuum:

   4 3 2 1

   Alert Drowsy Stupor Coma

1. Make a judgment about the patient's level of consciousness.

   Res. is alert and oriented to her surroundings, able to communicate

2. Assess the level of intelligence on the following continuum:

   4 3 2 1

   Superior Above Average Average Below Average

2. Make a judgment about the patient's level of intelligence.

   Res. was resistant to participate questionnaire.

Conclusion: The Mini-Mental State Exam is Based on an 8th Grade Education. 30 Points Total

Normal - 26 & above Borderline - 21 to 25 Demented - 20 & below Absolute Dementia - 15 & below

Reviewer's Signature: Sharon Nicholson Date: April 18, 2006

SOUTH CAROLINA STATE
HEALTH AND HUMAN SERVICES
FINANCE COMMISSION

MINI-MENTAL STATE EXAM

NAME: Peterson, William	DATE: 3-21-06

TEST ITEMS	SCORE	INSTRUCTIONS
ORIENTATION	MAX. OF 5	**INSTRUCTIONS FOR ORIENTATION**
WHAT IS THE (YEAR) (SEASON) (DATE) (DAY) (MONTH)	2	1. ASK FOR THE DATE, THEN ASK SPECIFICALLY FOR ANY PART OMITTED, E.G. "CAN YOU ALSO TELL ME WHAT SEASON IT IS." ONE POINT FOR EACH CORRECT ANSWER.
WHERE ARE WE: STATE, COUNTY, TOWN, HOSPITAL, FLOOR	MAX. OF 5 3	2. ASK IN TURN, "CAN YOU TELL ME THE NAME OF THIS HOSPITAL (TOWN, COUNTY, ETC). ONE POINT FOR EACH CORRECT ANSWER.
REGISTRATION	MAX OF 3	**INSTRUCTION FOR REGISTRATION**
NAME THREE OBJECTS AND HAVE PATIENT REPEAT THEM. (0 TO 3)	0	1. ASK THE PATIENT IF YOU MAY TEST HIS MEMORY THEN SAY THE NAMES OF THREE UNRELATED OBJECTS, CLEARLY AND SLOWLY, TAKING ABOUT ONE SECOND FOR EACH, AFTER YOU HAVE SAID ALL THREE, ASK THE PATIENT TO REPEAT THEM. THIS FIRST REPETITION DETERMINES HIS SCORE.
NUMBER OF TRIALS (0 TO 6)	6	2. KEEP SAYING THE NAMES OF THE ITEMS UNTIL THE PATIENT CAN REPEAT ALL THREE UP TO SIX TRIALS. IF HE DOES NOT EVENTUALLY LEARN ALL THREE, RECALL CANNOT BE MEANINGFULLY TESTED.
ATTENTION AND CALCULATION	MAX. OF 5	**INSTRUCTIONS OF ATTEN. AND CALC.**
SERIAL TO COUNTING BACKWARDS FROM 100 BY 7.	0	1. ASK THE PATIENT TO BEGIN WITH 100 AND COUNT BACKWARDS BY 7. STOP AFTER 5 SUBTRACTIONS (93, 86, 79, 72, 65). SCORE THE TOTAL NUMBER OF CORRECT ANSWERS. IF THE PATIENT CANNOT OR WILL NOT PERFORM THIS TEST, USE THE NUMBER 2.
OR		
ALTERNATE TEST: SPELL "WORLD" BACKWARDS	0	2. ASK THE PATIENT TO SPELL WORLD BACKWARDS, THE SCORE IS THE NUMBER OF LETTERS IN CORRECT ORDER, E.G. DLROW - 5, or 2, ETC.
RECALL	MAX. OF 3	**INSTRUCTIONS FOR RECALL**
ASK THE PATIENT TO RECALL THE THREE OBJECTS ABOVE. SCORE 0 TO 3.	0	1. ASK THE PATIENT IF HE CAN REMEMBER THE THREE OBJECTS YOU PREVIOUSLY NAMED FOR HIM. (IN THE REGISTRATION SECTION OF THE TEST). SCORE ONE POINT FOR EACH CORRECT RECALL. DO NOT PROMPT.
LANGUAGE	MAX. OF 9	**INSTRUCTIONS FOR LANGUAGE**
NAME A PENCIL AND A WATCH. (MAX. OF 2 POINTS)	2	1. NAMING: SHOW THE PATIENT A WRISTWATCH AND ASK HIM TO NAME WHAT IT IS. REPEAT THIS FOR A PENCIL SCORE TO 0 TO 2 POINTS. DO NOT PROMPT.
REPEAT THE STATEMENT, "NO IFS, ANDS OR BUTS." (MAX. OF 1 POINT)	1	2. REPETITIONS: SAY TO THE PATIENT, "PLEASE REPEAT THIS SENTENCE AFTER ME, "NO IFS, ANDS OR BUTS." ALLOW ONLY ONE TRIAL OR ATTEMPT.
NOW THIS THREE STAGE COMMAND, "TAKE A PIECE OF PAPER, FOLD IT IN HALF, THEN HAND IT TO ME." MAX. 3 POINTS	0	3. THE THREE STAGE COMMAND; GIVE THE PATIENT A PIECE OF PAPER AND STATE THE FULL THREE PART COMMAND. SCORE ONE POINT FOR EACH PART CORRECTLY EXECUTED. DO NOT PROMPT OR RECITE THE THREE STAGES SEPARATELY.

LANGUAGE CONTINUED:

4. PLEASE DO THE FOLLOWING:		**4. READING, WRITING, AND COPYING:**
A. CLOSE YOUR EYES. MAX OF 1 POINT.	1	A. SHOW THE PATIENT THE STATEMENT, "CLOSE YOUR EYES. ASK HIM TO READ IT AND DO WHAT IT SAYS.
B. WRITE A SENTENCE. MAX OF 1 POINT.	0	B. GIVE THE PATIENT A BLANK PIECE OF PAPER, AND ASK HIM TO WRITE A SENTENCE FOR YOU. DO NOT PROMPT OR ASSIST AS SPONTANEITY IS IMPORTANT. IT MUST CONTAIN A SUBJECT AND A VERB AND BE SENSIBLE. CORRECT GRAMMAR AND PUNCTUATION ARE NOT NECESSARY.
C. DRAW INTERSECTING PENTAGONS. MAX OF 1 POINT	0	C. SHOW THE PICTURE OF THE INTERSECTING PENTAGRAMS TO THE PATIENT; GIVE HIM A BLANK PIECE OF PAPER AND ASK HIM TO DRAW IT EXACTLY AS IT IS. ALL TEN ANGLES MUST BE PRESENT AND TWO MUST INTERSECT TO SCORE ONE POINT.
TOTAL SCORE	9	

LEVEL OF CONSCIOUSNESS

ASSESS THE LEVEL OF CONSCIOUSNESS ON THE FOLLOWING CONTINUUM:

4	3	2	1
ALERT	DROWSY	STUPOR	COMA

ASSESS THE LEVEL OF INTELLIGENCE ON THE FOLLOWING CONTINUUM:

4	3	2	1
SUPERIOR	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE

INSTRUCTIONS FOR LEVEL OF CONSCIOUSNESS

1. MAKE A JUDGMENT ABOUT THE PATIENT'S LEVEL OF CONSCIOUSNESS.

2. MADE A JUDGMENT ABOUT THE PATIENT'S LEVEL OF INTELLIGENCE.

CONCLUSION: THE MINI-MENTAL STATE EXAM IS BASED ON AN 8TH GRADE EDUCATION.

30 POINTS TOTAL
26 AND ABOVE - NORMAL
21 TO 25 - BORDERLINE
20 AND BELOW - DEMENTED
15 AND BELOW - ABSOLUTE DEMENTIA

REVIEWER'S SIGNATURE: Wenla Johnson, RN DATE: 3-21-06

mT

2140

-535-

CERTIFICATION AND RECERTIFICATION FOR MEDICARE SERVICES
SKILLED NURSING FACILITY SERVICES

Peterson, William (Resident Name) | 03-21-06 (Admission Date) | 247306586A (Health Ins. Claim #)

CERTIFICATION

of patient admission. Required at time of Admission.

RUGs Level RMX

I certify that post-hospital nursing facility skilled services are required on an inpatient basis because of the above named patient's need for skilled care on a continued basis.

Diagnosis/Skilled Service S/P Surgery Cervical Stenosis, muscle weakness Dementia ~~DU Buttocks HTN~~ BPH Oend RehaB Services

[signature] Physician Signature — 3-21-6 Date

RECERTIFICATION

of continued skilled inpatient care – on or before the 14th day.

RUGs Level RHC

Continued SNF inpatient care is necessary for the above patient.

Diagnosis/Skilled Service S/P Cervical Surgery - muscle weakness Dementia - BPH - RehaB Services

[signature] Physician Signature — 4-3-6 Date

RECERTIFICATION

of continued skilled inpatient care – on or before the 44th day.

RUGs Level RHC

Continued SNF inpatient care is necessary for the above patient for the following reasons:

Diagnosis/Skilled Service S/O Cervical Surgery - muscle weakness Dementia - BPH - Oend - RehaB Services

[signature] Physician Signature — 5-3-6 Date

RECERTIFICATION

of continued skilled inpatient care – on or before the 74th day.

RUGs Level ______

D/C'ed

Continued SNF inpatient care is necessary for the above patient for the following reasons:

Diagnosis/Skilled Service ____________

____

Physician Signature — Date

GP-AP/CR (Rev. 7/03)

Name Peterson, William Room No. P214W Date 03-21-03

Sex M Age 84 Hospital No. 1050 Dr. NRGLM

Allergies NKA

DIAGNOSIS

1. ARF 2° OBS
2. Hyperkalemia
3. s/p decompression from cervical spine stenosis
4. BPH
5. GERD
6. HTN

84 y o BM readmitted from Aiken Regional after ARF 2° BPH, Hyperkalemia + s/p urgent spinal effusion 2° cx stenosis & neurological Δ's. Pt's renal failure has returned to nl at time of d/c.

See Med list

VSS

Pt alert & pleasant, in s/p collar

HEENT - well healing incision, clean & dry (R) side of neck

CV RRR

Lungs clear

Abdomen benign

Neuro nonfocal

Rehab [illegible]

[signature] 3/22/06

(Signature) (Date)

RESIDENT IMMUNIZATION RECORD

RESIDENT NAME: Peterson, William CASE#: 1050

	DATE	REACTION	SITE
ADMISSION TB SCREENING			
#1	3/19/06	Ømm	Rt FA
#2	4-2-06	Ømm	Lt FA
ADMISSION CHEST X-RAY			
PNEUMONIA VACCINE	2/23/06		
TETANUS TOXOID			
FLU VACCINE	2/27/06		
#1			
#2			
#3			
#4			
#5			
ANNUAL TB SCREENING			
#1			
#2			
#3			
#4			
#5			
#6			

Physici's Orders

-538- CL6100a

For the month of: 2006

TM Health & Rehab of Eu[illegible]efield LP

Order Date	Order Type	Order No.	Time Code	Orders
3/21/06				GENERIC EQUIVALENTS MAY BE USED UNLESS OTHERWISE NOTED BY PHYSICIAN.
				ROUTINE VISITS BY M.D. NOT MEDICALLY NECESSARY FOR THIS RESIDENT BUT EVERY 30 DAYS.
	MD	5		CODE STATUS:
	MD	6		I HAVE INFORMED RESIDENT OR DESIGNATED DECISION MAKER OF DIAGNOSIS AND OVERALL HEALTH STATUS
	MD	7		DIET: Reg pureed.
	MD	8		REHAB POTENTIAL: fair
	MD	9		TREATMENT:
	MD	10		FLU VACCINE: ANNUALLY
	MD	11		RESIDENT MAY SEE DENTIST, PODIATRIST, OPTOMETRIST
	MD	12		RESIDENT ACTIVITY PLAN APPROVED AND IS NOT IN CONFLICT WITH THE OVERALL PLAN OF CARE
	MD	13		RESIDENT MAY HAVE PLANNED THERAPEUTIC LOA FROM FACILITY OVERNIGHT NOT TO EXCEED MEDICAID REGULATIONS
	MD	14		ALT PHYS & PHONE # Dr Morgan 803-275-4653
	MD	15		MEDICAID#
	MED	1		MYLANTA/MAALOX 15-30CC BY MOUTH AS NEEDED Q2HRS FOR INDIGESTION OR NAUSEA X48HRS.
	MED	2		ACETAMINOPHEN 5 GR TAB 2 TABS BY MOUTH AS NEEDED Q4HRS FOR PAIN OR FEVER X48HRS
	MED	3		MILK OF MAGNESIA 30CC BY MOUTH AS NEEDED DAILY X48HRS. DX CONSTIPATION
	MED	4		KAOPECTATE 30CC BY MOUTH AS NEEDED EVERY 2HRS UNTIL DIARRHEA SUBSIDES X48HRS
				I HAVE REVIEWED RESIDENT'S PLAN OF CARE.
				I AGREE RESIDENT MEETS CASE MIX CATEGORY [A] OR [B] OR [C] OR [D] CRITERIA.
				I CERTIFY THAT RESIDENT NEEDS CONTINUED CARE IN NURSING HOME ON A CONTROL BASIS. .
				Admit to Skilled Nursing
				SR's ↑ x 2 for enablers
				Flu & urology x 1 wks
				PT + OT to evaluate.
				May crush allowable meds.
				VS q shift
				I + O q shift.

Phys. Sig.	☒	Massey	Date: 3-28-6	Above Orders Noted by:	☒		Date:
Nurse Review	☒	P. Dennis	Date: 3/21/06	Pharmacy Review	☒		Date:

Rehabilitative Potential

☐ Yes ☑ No

Dx: Acute renal failure. S/P cervical diskectomy + fusion
Prostatic enlargement GERD
HTN

Allergies: NKA

Physician: Dr. Massey
Phys. Ph: 637-3146

Alt. Phys: Morgan, Hugh
Alt. Phys. Ph: 275-4653

Resident Name	Room No.	Bed	Admission Date	Sex	Birth Date
Peterson, William	1050	P	03-11-22	M	03-21-06

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 017

Physician's Orders

For the month of:

Order Date	Order Type	Order No.	Time Code	Orders
3/21/06				Atenolol 12.5mg BID for BP Protonix 40mg q day for GERD Norvasc 5mg daily for HTN Silvervite q day x 2 mths. Novasource / Resource 2.0 120cc qid between meals. Pressure mattress to bed. Foley Care q Shift May use leg bag when ambulating and use BSD at night Change foley every 6-8 weeks 2nd Step PPD x 2 wks due 4/2/06 Wkly BP Heel pads while in bed.

Phys. Sig.	☒	Massey 3-21-6	Date:	Above Orders Noted by:	☒		Date:
Nurse Review	☒	P. Dunlap	Date: 3/21/06	Pharmacy Review	☒		Date:

Rehabilitative Potential	Yes	No

Dx: Acute Renal failure — S/P Cervical diskectomy + fusion
Prostatic enlargement — GERD
HTN

Allergies: NKA

Physician: Massey
Phys. Ph: 637-3146

Alt. Phys: Morgan, Hugh
Alt. Phys. Ph: 275-4653

Ht: Wt:
M/R No.:

Resident Name	Res. No.	Unit Room Bed	D.O.B.	Sex	Admit Date	Page
Peterson, William	[illegible]	[illegible]	[redacted]	M	3/21/06	1 of 2

GP-139 (Rev. 10/03)

Physician's Orders

-540- CL6100a

For the month April 2006 TMH. h & Rehab of El. ield LP

Order Date	Order Type	Order No.	Interval Code	Time Code	Orders
					GENERIC EQUIVALENTS MAY BE USED UNLESS OTHERWISE NOTED BY PHYSICIAN. ROUTINE VISITS BY M.D. NOT MEDICALLY NECESSARY FOR THIS RESIDENT BUT EVERY 30 DAYS.
3/21/2006	MED	21		BID	401.9 Hypertension Nos ATENOLOL 12.5MG PO BID
3/21/2006	MED	22		QD	530.81 Esophageal Reflux PROTONIX 40MG PO Q DAY
3/21/2006	MED	23		QD	401.9 Hypertension Nos NORVASC 5MG PO DAILY
3/29/06	MED			TID	Prostat 101 - 30cc in 4oz juice tid x 2 months DIC P 5/29/06
3/21/2006	MED	24		QD	SILVERVITE 1 PO Q DAY X 2 MONTHS D/C AFTER MAY 21ST
3/29/06 3/21/2006	MED	26		QID	NORVASOURCE/ RESOURCE 2.0 ~~120~~ 180 CC QID BETWEEN MEALS
3/21/2006	MED	20		SHIFT	VITAL SIGNS Q SHIFT
3/21/2006	MED	18		SHIFT1	2ND STEP PPD DUE APRIL 2ND
3/21/2006	MED	31	QTUE	SHIFT1	WEEKLY B/P
3/21/2006	PRN	1		PRN	MYLANTA/MAALOX 15-30CC BY MOUTH AS NEEDED Q2HRS FOR INDIGESTION OR NAUSEA X48HRS.
3/21/2006	PRN	2		PRN	ACETAMINOPHEN 5 GR TAB 2 TABS BY MOUTH AS NEEDED Q4HRS FOR PAIN OR FEVER X48HRS
3/21/2006	PRN	3		PRN	MILK OF MAGNESIA 30CC BY MOUTH AS NEEDED DAILY X48HRS. DX CONSTIPATION
3/21/2006	PRN	4		PRN	KAOPECTATE 30CC BY MOUTH AS NEEDED EVERY 2HRS UNTIL DIARRHEA SUBSIDES X48HRS
3/21/2006	TX	29			MAY USE LEG BAG WHEN AMBULATING AND USE BSD AT NIGHT
3/22/2006	TX	25		BID	VASOLINE TO PENIS BID
3/24/2006	TX	34		PRN	SOFT COLLAR USED PRN FOR COMFORT X 6 WEEKS D/C AFTER MAY 2ND
3/21/2006	TX	27		SHIFT	ALTERNATING PRESSURE RELIEF MATTRESS TO BED
3/21/2006	TX	28		SHIFT	FOLEY CARE Q SHIFT
3/21/2006	TX	30		SHIFT1	CHANGE FOLEY EVERY 6-8 WEEKS
3/22/2006	TX	32		SHIFT1	CLEAN NECK INCISION SITE WITH WOUND CLEANSER APPLY DRY DRESSING DAILY
2/27/2006	MD	5			CODE STATUS:DNR NO NG OR G-TUBE

Phys. Sig.	☒	Massey	Date: 4-1-6	Above Orders Noted by:	☒		Date:
Nurse Review	☒	Sheila Whidbee	Date: 3/28/06	Pharmacy Review	☒		Date:

Rehabilitative Potential	
FAIR	☑ Yes ☐ No

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

Allergies: NKA

Physician: MASSEY, TAMI Alt. Phys: Morgan, Walter Ht: 70 Wt: 164.0
Phys. Ph: (803) 637-3146 Alt. Phys. Ph: (803) 275-4653 M/R No.: 1050

Resident Name	Bed No.	Unit, Room, Bed	DOB	Sex	Admit Date	Page:
PETERSON, WILLIAM	1050	P 214 D	[redacted]	M	3/21/2006	1 of 2

Physician's Orders

-541- CL6100a

For the month April 2006 — T M H: h & Rehab of E. ield LP

Order Date	Type	No.	Interval Code	Time Code	Orders
3/21/2006	MD	6			I HAVE INFORMED RESIDENT OR DESIGNATED DECISION MAKER OF DIAGNOSIS AND OVERALL HEALTH STATUS
3/21/2006	MD	8			REHAB POTENTIAL: FAIR
3/21/2006	MD	9			FLU VACCINE: ANNUALLY
3/21/2006	MD	10			RESIDENT MAY SEE DENTIST, PODIATRIST, OPTOMETRIST
3/21/2006	MD	11			RESIDENT ACTIVITY PLAN APPROVED AND IS NOT IN CONFLICT WITH THE OVERALL PLAN OF CARE
3/21/2006	MD	12			RESIDENT MAY HAVE PLANNED THERAPEUTIC LOA FROM FACILITY OVERNIGHT NOT TO EXCEED MEDICAID REGULATIONS
3/21/2006	MD	13			ALT PHY & PHONE # DR. MORGAN 803-275-4653
3/21/2006	MD	14			MAY CRUSH ALLOWABLE MEDICATIONS
3/21/2006	MD	16			ADMIT TO SKILLED CARE NURSING
3/21/2006	MD	17			F/U WITH UROLOGY IN 1 MONTH
3/24/2006	MD	35			FOLLOW UP APPOINTMENT WITH DR. SANTIAGO @ 10:45 AM X-RAY C-SPINE AP AND LAT WITH FLEXION AND EXTENSION BRING COPIES TO F/U APPOINT.
3/21/2006	CRB	7		MEALS	DIET:REGULAR ~~PUREED~~ 3/31 msdiet
3/21/2006	R	15			SIDERAILS UP X 2 AS ENABLERS
3/23/2006	TH	19			PT TO TX PT 3-5X/WK FOR ROM, STRENGTHENING BOTH LOWER EXT, THEREX, W/C PROPULSION/ MANAGEMENT PER POC
3/23/2006	TH	33			OT TO TX PT 3-5X/WK FOR 4 WEEKS FOR ADL'S, THERAP EXERCISES AND CAREGIVER ED
3/30/06	A1B				Levaquin ~~500mg~~ po 3 Day X7 Days
3/31/06	A1B				Levaquin 250mg x 6 more doses
3/29/06	TH				Speech to screen for dysphagia

Additional Diagnoses:

389.9 Hearing Loss Nos

781.3 Lack Of Coordination

401.9 Hypertension Nos

436 Cva

I HAVE REVIEWED RESIDENT'S PLAN OF CARE.
I AGREE RESIDENT MEETS CASE MIX CATEGORY [A] OR [B] OR [C] OR [D] CRITERIA.
I CERTIFY THAT RESIDENT NEEDS CONTINUED CARE IN NURSING HOME ON A CONTROL BASIS.

Phys. Sig.	☒	Massey	Date: 4-1-06	Above Orders Noted by:	☒		Date:
Nurse Review	☒	Sheila Whedbee RN	Date: 3/28/06	Pharmacy Review	☒		Date:

Rehabilitative Potential	
FAIR	☑ Yes ☐ No

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

Allergies: NKA

Physician: MASSEY, TAMI — *Alt. Phys:* Morgan, Walter — *Ht:* 70 *Wt:* 164.0
Phys. Ph: (803) 637-3146 — *Alt. Phys. Ph:* (803) 275-4653 — *M/R No.:* 1050

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

Physician's Orders

-542- CL6100a

For the month May 2006 — TMH. ...th & Rehab of E... ield LP

Order Date	Order Type	Order No.	Interval Code	Time Code	Orders
					GENERIC EQUIVALENTS MAY BE USED UNLESS OTHERWISE NOTED BY PHYSICIAN. ROUTINE VISITS BY M.D. NOT MEDICALLY NECESSARY FOR THIS RESIDENT BUT EVERY 30 DAYS.
3/21/2006	MED	21		BID	401.9 Hypertension Nos ATENOLOL 12.5MG PO BID
3/21/2006	MED	22		QD	530.81 Esophageal Reflux PROTONIX 40MG PO Q DAY
3/21/2006	MED	23		QD	401.9 Hypertension Nos NORVASC 5MG PO DAILY
3/21/2006	MED	24		QD	SILVERVITE 1 PO Q DAY X 2 MONTHS D/C AFTER MAY 21ST
3/29/2006	MED	26		QID	NORVASOURCE/ RESOURCE 2.0 180CC QID BETWEEN MEALS
3/21/2006	MED	20		SHIFT	VITAL SIGNS Q SHIFT
3/21/2006	MED	18		SHIFT1	~~2ND STEP PPD DUE APRIL 2ND.~~
3/21/2006	MED	31	QTUE	SHIFT1	WEEKLY B/P
3/29/2006	MED	37		TID	PROSTAT 101 30CC IN 4OZ OF JUICE TID X 2 MONTHS D/C AFTER MAY 29TH
4/14/2006	MED	42		TID	PERIACTIN 4MG PO TID
3/21/2006	PRN	1		PRN	MYLANTA/MAALOX 15-30CC BY MOUTH AS NEEDED Q2HRS FOR INDIGESTION OR NAUSEA X48HRS.
3/21/2006	PRN	2		PRN	ACETAMINOPHEN 5 GR TAB 2 TABS BY MOUTH AS NEEDED Q4HRS FOR PAIN OR FEVER X48HRS
3/21/2006	PRN	3		PRN	MILK OF MAGNESIA 30CC BY MOUTH AS NEEDED DAILY X48HRS. DX CONSTIPATION
3/21/2006	PRN	4		PRN	KAOPECTATE 30CC BY MOUTH AS NEEDED EVERY 2HRS UNTIL DIARRHEA SUBSIDES X48HRS
3/21/2006	TX	29			MAY USE LEG BAG WHEN AMBULATING AND USE BSD AT NIGHT
3/24/2006	TX	34		PRN	SOFT COLLAR USED PRN FOR COMFORT X 6 WEEKS D/C AFTER MAY 2ND
4/20/2006	TX	25		SHIFT	NEOSPORIN TO PENIS SORE Q SHIFT UNTIL RESOLVED
3/21/2006	TX	27		SHIFT	ALTERNATING PRESSURE RELIEF MATTRESS TO BED
3/21/2006	TX	28		SHIFT	FOLEY CARE Q SHIFT
4/19/2006	TX	30		SHIFT1	CHANGE FOLEY EVERY 4 WEEKS

Phys. Sig.	☒	Massey	Date: 5-1-6	Above Orders Noted by:	☒		Date:
Nurse Review	☒	Sheila Whitbeck RN	Date: 4/25/06	Pharmacy Review	☒		Date:

Rehabilitative Potential	
FAIR	☑ Yes ☐ No

Dx:
519.8 Resp System Disease Nec
723.0 Cervical Spinal Stenosis
V58.72 Aftcre Surg Nerv Sys Nec
728.88 Rhabdomyolysis
728.87 Muscle Weakness-General
780.79 Malaise And Fatigue Nec
290.0 Senile Dementia Uncomp
600.90 Bph Nos W/O Urinary Obst
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:** 150.0 **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 of 3

Physician's Orders

-543- CL6100a

For the month May 2006 — TMH & Rehab of Edgefield LP

Order Date	Type	No.	Interval Code	Time Code	Orders
4/6/2006	TX	41		SHIFT1	CLEAN LEFT HIP WITH WOUND CLEANSER. APPLY BACITRACIN AND OPTIFOAM DAILY
4/20/2006	TX	43		SHIFT1	NURSING TO TX 1X A DAY ON SAT AND SUN CLEAN LEFT HIP WITH WOUND CLEANSER. APPLY PANAFIL OINTMENT AND COVER WITH OPTIFOAM
4/4/2006	MD	5			CODE STATUS:DNR NO NG OR G-TUBE
3/21/2006	MD	6			I HAVE INFORMED RESIDENT OR DESIGNATED DECISION MAKER OF DIAGNOSIS AND OVERALL HEALTH STATUS
3/21/2006	MD	8			REHAB POTENTIAL: FAIR
3/21/2006	MD	9			FLU VACCINE: ANNUALLY
3/21/2006	MD	10			RESIDENT MAY SEE DENTIST, PODIATRIST, OPTOMETRIST
3/21/2006	MD	11			RESIDENT ACTIVITY PLAN APPROVED AND IS NOT IN CONFLICT WITH THE OVERALL PLAN OF CARE
3/21/2006	MD	12			RESIDENT MAY HAVE PLANNED THERAPEUTIC LOA FROM FACILITY OVERNIGHT NOT TO EXCEED MEDICAID REGULATIONS
3/21/2006	MD	13			ALT PHY & PHONE # DR. MORGAN 803-275-4653
3/21/2006	MD	14			MAY CRUSH ALLOWABLE MEDICATIONS
3/21/2006	MD	16			ADMIT TO SKILLED CARE NURSING
~~3/21/2006~~	~~MD~~	17			~~F/U WITH UROLOGY IN 1 MONTH~~
~~3/24/2006~~	~~MD~~	35			~~FOLLOW UP APPOINTMENT WITH DR. SANTIAGO @ 10:45 AM X-RAY C-SPINE AP AND LAT WITH FLEXION AND EXTENSION BRING COPIES TO F/U APPOINT~~.
3/28/2006	MD	36			~~ASPEN COLLAR TO BE WORN FOR MOBILIZATION WHEN OOB IN CHAIR, AMB, AND REHAB SESSIONS~~
4/6/2006	CRB	7		MEALS	DIET: PUREED MAGIC CUP WITH LUNCH AND SUPPER
3/21/2006	R	15			SIDERAILS UP X 2 AS ENABLERS
3/23/2006	TH	19			PT TO TX PT 3-5X/WK FOR ROM, STRENGTHENING BOTH LOWER EXT, THEREX, W/C PROPULSION/ MANAGEMENT PER POC
4/20/2006	TH	32			PT TO DO WOUND CARE 5X'S PER WEEK. NURSING TO CHANGE DRESSING SAT AND SUN 1X PER DAY. TREATMENT TO BE USED: LEFT HIP WOUND CLEANSER TO AREA APPLY PANAFIL OINTMENT AND COVER WITH OPTIFOAM
3/23/2006	TH	33			OT TO TX PT 3-5X/WK FOR 4 WEEKS FOR ADL'S, THERAP EXERCISES AND CAREGIVER ED
3/31/2006	TH	40			SPEECH FOR 10 VISITS TO INCREASE PO INTAKE AND TX FOR SAFE SWALLOWING OF MECH SOFT PT/STAFF TRAINING

Phys. Sig.	☒	Massey	*Date:* 5-1-6	*Above Orders Noted by:*	☒		*Date:*
Nurse Review	☒	Sheila Whidbee RN	*Date:* 4/25/06	*Pharmacy Review*	☒		*Date:*

Rehabilitative Potential

FAIR — ☑ *Yes* ☐ *No*

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

Allergies: NKA

Physician: MASSEY, TAMI — *Alt. Phys:* Morgan, Walter — *Ht:* 70 *Wt:* 150.0

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

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

TMH&R of Edgefield 03/21/2006 - 05/25/2006 022

Physician's Orders

For the month May 2006 — T M H... th & Rehab of E... ield LP

Order Date	Order Type	Order No.	Interval Code	Time Code	Orders
					Additional Diagnoses:
					530.81 Esophageal Reflux
					389.9 Hearing Loss Nos
					781.3 Lack Of Coordination
					401.9 Hypertension Nos
					436 Cva
					787.2 Dysphagia
					I HAVE REVIEWED RESIDENT'S PLAN OF CARE. I AGREE RESIDENT MEETS CASE MIX CATEGORY [A] OR [B] OR [C] OR [D] CRITERIA. I CERTIFY THAT RESIDENT NEEDS CONTINUED CARE IN NURSING HOME ON A CONTROL BASIS.

Phys. Sig.	☒	Massey	Date: 5-1-06	Above Orders Noted by:	☒		Date:
Nurse Review	☒	Sheila Whitbeck	Date: 4/25/06	Pharmacy Review	☒		Date:

Rehabilitative Potential	
FAIR	☑ Yes ☐ No

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

Allergies: NKA

Physician: MASSEY, TAMI **Alt. Phys:** Morgan, Walter **Ht:** 70 **Wt:** 150.0
Phys. Ph: (803) 637-3146 **Alt. Phys. Ph:** (803) 275-4653 **M/R No.:** 1050

Resident Name		Rm No.				Page:
PETERSON, WILLIAM	1050	P 214 D	[redacted]	M	3/21/2006	3 of 3

PHYSICIAN'S TELEPHONE ORDERS

PHYSICIAN'S TELEPHONE ORDERS

Form 989/4P © BRIGGS, Des Moines, IA 50306 (800) 247-2343

Facility Name			Address	
TMH+R			Edgefield	
Family Name	**First Name**	**Admission Number**	**Room Number**	**Attending Physician**
Peterson	William	1050	214W	B. Gardener

Date Ordered	Date Discontinued	ORDERS
3/22/06	①	Alternating Pressure Mattress to bed
		Clean Neck incision site c wound
		Cleanser. apply Dry Dsg daily.
	②	DC heel pads
	③	Vasoline to Penis BID

Signature of Nurse Receiving Order: [illegible] Time: 9A Signature of Physician: [signature] Date: 3/24/06

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PHYSICIAN'S TELEPHONE ORDERS

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Facility Name			Address	
TMH&R				
Family Name	**First Name**	**Admission Number**	**Room Number**	**Attending Physician**
Peterson	William	1050	214W	B Gordnier

Date Ordered	Date Discontinued	ORDERS
3/22/06		Move to Rm 214D

Signature of Nurse Receiving Order: D Smith LPN Time: Signature of Physician: [signature] Date: 3/24/06

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PHYSICIAN'S TELEPHONE ORDERS

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Facility Name			Address	
TMH+R			Edg	
Family Name	**First Name**	**Admission Number**	**Room Number**	**Attending Physician**
Peterson, William		1050	214W	B Gardner

Date Ordered	Date Discontinued	ORDERS
		Dr Santiago - Neurosurgeon
3/22/06		① call surgeon's office for orders on length
		of time to wear soft collar, & for return appt
		② Needs Urology F/U ō 1 month c
		Dr Anderson
		③ DNR, ∅ NG Tube, ∅ restrictive

Signature of Nurse Receiving Order: [illegible] RN Time: Signature of Physician: [signature] Date: 3/22/06

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PHYSICIAN'S TELEPHONE ORDERS

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Facility Name	TMH+R	Address	Edgefield
Family Name: Petersen	First Name: William	Admission Number: 1050	Room Number: 214-D / Attending Physician: B. Gardner

Date Ordered	Date Discontinued	ORDERS
3/23/06		Physical therapy clarification order: Physical therapy 3-5x/wk for ROM, stretch (B) LEs, ther ex, w/c propulsion/management per POC John [illegible] PT

Signature of Nurse Receiving Order: D Smith LPN | Time: | Signature of Physician: [signature] | Date: 3/24/06

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Facility Name	TMH+R	Address	Edgefield
Family Name: Peterson	First Name: William	Admission Number: 1050	Room Number: 214D / Attending Physician: B. Gardner

Date Ordered	Date Discontinued	ORDERS
3-23-06		OT clarification order to tx pt 3-5x's per wk for 4 wks for ADL's, therap exercises, + caregiver ed. V.V.O. [illegible] OTR/L

Signature of Nurse Receiving Order: D Smith LPN | Time: | Signature of Physician: [signature] | Date: 3/24/06

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Facility Name	TMH+R	Address	Edgefield
Family Name: Peterson	First Name: William	Admission Number: 1050	Room Number: 214 D / Attending Physician: Massey/Santiago

Date Ordered	Date Discontinued	ORDERS
3/24/06	①	Soft collar used PRN for comfort measures x 6 wks (DC May 2nd)
	②	f/u appt c̄ Dr. Santiago 5/1/06 @ 10:45 AM
	③	X-Ray C-spine AP + LAT c̄ flexion + extention - bring copies to f/u appt.

Signature of Nurse Receiving Order: [illegible] Coleman RN | Time: 2:08 | Signature of Physician: Massey | Date: 3-28-06

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PHYSICIAN'S TELEPHONE ORDERS

Facility Name	TMH+R	Address	Edgefield	
Family Name / First Name: Peterson, William	Admission Number: 1050	Room Number: 214 D	Attending Physician: Massey/Santiago	

Date Ordered	Date Discontinued	ORDERS
3/28/06		Aspen Collar to be worn for mobilization when OOB in chair, amb., + rehab sessions

Signature of Nurse Receiving Order: [illegible] | Time: [illegible] | Signature of Physician: Massey | Date: 3-31-6

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PHYSICIAN'S TELEPHONE ORDERS

Facility Name	TMH&R	Address		
Family Name / First Name: Peterson William	Admission Number: 1050	Room Number: 214D	Attending Physician: Massey	

Date Ordered	Date Discontinued	ORDERS
3/29/06		① ↑ Novasource/Resource 2.0 to 180cc po qid
		② Silvervite 1 po q AM Void/Repeat (Error DD)
		③ Prostat 101 - 30cc in 4oz juice/~~Novasource~~ TID X 2 mths (Error DS)
		④ SLP to screen for Dysphagia

Signature of Nurse Receiving Order: D Smith LPN | Time: | Signature of Physician: Massey | Date: 3-31-6

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PHYSICIAN'S TELEPHONE ORDERS

Facility Name	TMH+R	Address	Edgefield	
Family Name / First Name: Peterson, William	Admission Number: 105 D	Room Number: 214 D	Attending Physician: Massey	

Date Ordered	Date Discontinued	ORDERS
3/30/06		UA, CXR, Blood Cx
		Levaquin 500mg po q day x 7 days
		for creat. result most recent.

Signature of Nurse Receiving Order: P. Dunn[illegible] | Time: 3:30 pm | Signature of Physician: Massey | Date: 3-31-6

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PHYSICIAN'S TELEPHONE ORDERS

PHYSICIAN'S TELEPHONE ORDERS

Facility Name: TMH&R of Edgefield | Address:

Family Name	First Name	Admission Number	Room Number	Attending Physician
Peterson,	William	1050	214D	Massey

Date Ordered	Date Discontinued	ORDERS
3-31-06		decrease Levaquin to 250mg po q/hs X 6 more doses

Signature of Nurse Receiving Order: D Smith Lpn | Time: | Signature of Physician: [signature] | Date: 3/31/06

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PHYSICIAN'S TELEPHONE ORDERS

Facility Name: TMH&R | Address: Edgefield

Family Name	First Name	Admission Number	Room Number	Attending Physician
Peterson	William	1050	214D	Massey

Date Ordered	Date Discontinued	ORDERS
3/31/06		Speech Clarifications Steval - on this date Rec. to continue MS diet. ST rec. to ↑ PO intake & tx. for safe swallowing of MS. Pt. / staff training. ST for 10 visits for one month. Martha J. Walley, MA CCC-SLP

Signature of Nurse Receiving Order: D Smith Lpn | Time: | Signature of Physician: [signature] | Date: 3/31/06

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PHYSICIAN'S TELEPHONE ORDERS

Facility Name: TMH&R | Address:

Family Name	First Name	Admission Number	Room Number	Attending Physician
Peterson	William	1050	214D	Massey

Date Ordered	Date Discontinued	ORDERS
3/31/06		Clarification! Speech Therapy to eval for dysphagia

Signature of Nurse Receiving Order: D Smith Lpn | Time: | Signature of Physician: [signature] | Date: 3/31/06

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PHYSICIAN'S TELEPHONE ORDERS

PHYSICIAN'S TELEPHONE ORDERS

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Facility Name: TMH&R | Address:

Family Name	First Name	Admission Number	Room Number	Attending Physician
Peterson	William	1050	214D	Nicholson

Date Ordered	Date Discontinued	ORDERS
4/4		D/C NG & G Tube

Signature of Nurse Receiving Order: D Smith LPN | Time: | Signature of Physician: [signature] | Date: 4/4

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PHYSICIAN'S TELEPHONE ORDERS

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Facility Name: TMH&R | Address: Edgefield

Family Name	First Name	Admission Number	Room Number	Attending Physician
Peterson	William	1050	214D	Nicholson

Date Ordered	Date Discontinued	ORDERS
4/6/06		Clean (w) hip & Wound Cleanser. Apply Bacitracin & Optiforms daily

Signature of Nurse Receiving Order: [signature] | Time: 8:10A | Signature of Physician: [signature] | Date: 4/6

noted

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PHYSICIAN'S TELEPHONE ORDERS

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Facility Name: TMH&R | Address:

Family Name	First Name	Admission Number	Room Number	Attending Physician
Peterson	William	1050	214D	Leaphart

Date Ordered	Date Discontinued	ORDERS
4/14/06		CBC, BMP 4-18-06 UA and culture Temp to 101 √ Mini mental status

Signature of Nurse Receiving Order: D Smith LPN | Time: | Signature of Physician: [signature] | Date: 4-14-06

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PHYSICIAN'S TELEPHONE ORDERS

PHYSICIAN'S TELEPHONE ORDERS

Facility Name: TMHR | Address: Edgefield

Family Name	First Name	Admission Number	Room Number	Attending Physician
Peterson	William	1050	214D	Leaphart

Date Ordered	Date Discontinued	ORDERS
4/18/06		Clarification effective 4/5/06 Puree diet Magic cup @ lunch & supper

Signature of Nurse Receiving Order: Dykes | Time | Signature of Physician: [signature] | Date: 4/19/06

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PHYSICIAN'S TELEPHONE ORDERS

Facility Name: TMHaRD | Address: Edgefield

Family Name	First Name	Admission Number	Room Number	Attending Physician
Peterson	William	1050	214D	Leaphart

Date Ordered	Date Discontinued	ORDERS
4/19/06		D/C Dry Dsg to Neck incision site

Signature of Nurse Receiving Order: [signature] | Time: 8:35A | Signature of Physician: [signature] | Date: 4/20/06

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PHYSICIAN'S TELEPHONE ORDERS

Facility Name: TMHR | Address:

Family Name	First Name	Admission Number	Room Number	Attending Physician
Peterson	William	1050	214D	Leaphart

Date Ordered	Date Discontinued	ORDERS
4-19-06		Clarification order for 4-5-06 \ diet to Puree

Signature of Nurse Receiving Order: DSmith LPN | Time | Signature of Physician: [signature] | Date: 4/20/06

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PHYSICIAN'S TELEPHONE ORDERS

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Facility Name	TMH+R		Address	Edgefield
Family Name / First Name	Peterson, Williams	Admission Number:	Room Number: 214D	Attending Physician: Leaphart

Date Ordered	Date Discontinued	ORDERS
4/19/06		Δ Foley on 4/20/06 then q 4 wks.
		Neosporin to penis sore BID until
		resolved.
		Enc po flds.
		VO Dr Anderson

Signature of Nurse Receiving Order: P. Dunn | Time: 3p | Signature of Physician: [signature] | Date: 4/20/06

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Facility Name	TMH&R		Address	Edgefield
Family Name / First Name	Peterson William	Admission Number: 1050	Room Number: 214D	Attending Physician: Leaphart

Date Ordered	Date Discontinued	ORDERS
4/20/06		Δ order for Neosporin BID to
		q shift.
		[signature]

Signature of Nurse Receiving Order: [signature] | Time: 8:45A | Signature of Physician: [signature] | Date: 4/21/06

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Facility Name	TMH&R		Address	Edgefield
Family Name / First Name	Peterson William	Admission Number: 1050	Room Number: 214D	Attending Physician: Leaphart

Date Ordered	Date Discontinued	ORDERS
4-20-06		PT reclarification order to add wound care
		5x's per wk - nsg. to change dsg Sat-Sun
		1x per day. Treatment to be used: (L) hip
		wound cleanser to area, apply panafil ointment to
		cover c Opti foam. V.Vaz at TROL VO per B Swiger RPT

Signature of Nurse Receiving Order: [signature] | Time: 1:45P | Signature of Physician: [signature] | Date: 4/21/06

ORIGINAL COPY - Physician Please Sign and Return

PHYSICIAN'S TELEPHONE ORDERS

PHYSICIAN'S TELEPHONE ORDERS

Facility Name: TMH&R | Address:

Family Name: Peterson | First Name: William | Admission Number: 1050 | Room Number: P214D | Attending Physician: B. Gardner

Date Ordered	Date Discontinued	ORDERS
4-24-06		C spine X-ray VO Dr. Santiago

Signature of Nurse Receiving Order: D Smith Lpn | Time: | Signature of Physician: [signature] | Date: 4/24/06

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PHYSICIAN'S TELEPHONE ORDERS

Facility Name: TMH&R | Address: B. Gardner Edgefield

Family Name: Peterson | First Name: William | Admission Number: 1050 | Room Number: 214D | Attending Physician: B. Gardner

Date Ordered	Date Discontinued	ORDERS
4-25-06		Dc OT services. V.O. Dr. Santiago

Signature of Nurse Receiving Order: D Smith Lpn | Time: | Signature of Physician: [signature] | Date: 4/26/06

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PHYSICIAN'S TELEPHONE ORDERS

Facility Name: TMH&R of Edgefield | Address:

Family Name: Peterson | First Name: William | Admission Number: 1050 | Room Number: 214D | Attending Physician: J. Massey

Date Ordered	Date Discontinued	ORDERS
5/1/06		DC collars VO Dr. Santiago

Signature of Nurse Receiving Order: D Smith Lpn | Time: | Signature of Physician: Massey | Date: 5-2-06

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PHYSICIAN'S TELEPHONE ORDERS

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Facility Name	Address
TMH&R	Edgefield

Family Name	First Name	Admission Number	Room Number	Attending Physician
Peterson	William	1050	214W	Massey

Date Ordered	Date Discontinued	ORDERS
5/2/06		D/C Tx to (R) heel.

noted
[illegible]

Signature of Nurse Receiving Order	Time	Signature of Physician	Date
[illegible signature]	8 20/A	Massey	5-3-06

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Facility Name	Address
TM H+R	Edgefield

Family Name	First Name	Admission Number	Room Number	Attending Physician
Petersen,	William	1050	214-D	Massey

Date Ordered	Date Discontinued	ORDERS
5-2-06		A [illegible] to [illegible] [illegible] wound care per Physical therapy [illegible signature]

Signature of Nurse Receiving Order	Time	Signature of Physician	Date
D Smith LPN		Massey	5-3-06

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Facility Name	Address
TM H+ R	Edgefield

Family Name	First Name	Admission Number	Room Number	Attending Physician
Peterson,	William	1050	214D	Nicholas.

Date Ordered	Date Discontinued	ORDERS
5/2/06		Culture Lt hip wound.

Signature of Nurse Receiving Order	Time	Signature of Physician	Date
	5 pm	[illegible signature]	5/4

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PHYSICIAN'S TELEPHONE ORDERS

PHYSICIAN'S TELEPHONE ORDERS
Form 989/4P © BRIGGS, Des Moines, IA 50306 (800) 247-2343

Facility Name: TMH&R
Address: Edgefield

Family Name	First Name	Admission Number	Room Number	Attending Physician
Peterson	William	1050	214D	Massey

Date Ordered	Date Discontinued	ORDERS
5-3-06		Pt. to use anti-contracture wedge to LE's while in bed. V.Vo/[illegible] TRL

Signature of Nurse Receiving Order: D Smith LPN
Time:
Signature of Physician: Massey
Date: 5-10-06

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PHYSICIAN'S TELEPHONE ORDERS
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Facility Name: TMH & Rehab
Address: Edgefield

Family Name	First Name	Admission Number	Room Number	Attending Physician
Peterson	William	1050	214D	Rainsford

Date Ordered	Date Discontinued	ORDERS
5/12/06		Clarification: alternating pressure relief mattress to bed to be check q shift for proper inflation & functioning

Signature of Nurse Receiving Order: Sheila Wheelbuck
Time: 1215
Signature of Physician: [illegible]
Date: 5/12/06

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Facility Name: TMH&R
Address: Edgefield

Family Name	First Name	Admission Number	Room Number	Attending Physician
Peterson	William	1050	214D	Massey

Date Ordered	Date Discontinued	ORDERS
5/14/06		(1) O_2-2LPM via N/C D/T periods of apnea. (2) Clean O_2 filter q Night. (3) Change O_2 Humidifier q 3 days. (4) Change O_2 tubing q month.

Signature of Nurse Receiving Order: P. Overton LPN
Time: 11PM
Signature of Physician: Massey
Date: 5-20-06

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PHYSICIAN'S TELEPHONE ORDERS

PHYSICIAN'S TELEPHONE ORDERS

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Facility Name: TMH+R | Address: Edgefield

Family Name	First Name	Admission Number	Room Number	Attending Physician
Peterson,	William	1050	214D	Ransford

Date Ordered	Date Discontinued	ORDERS
5/15/06		Transported to Aiken Hosp ER via EMS per insistance of family against medical advice

Signature of Nurse Receiving Order: P. Dunn | Time: 3:45pm | Signature of Physician: [signature] | Date: 5/16/06

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PHYSICIAN'S TELEPHONE ORDERS

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Facility Name: TMH&R | Address: Edgefield

Family Name	First Name	Admission Number	Room Number	Attending Physician
Peterson,	William	1050	214-D	Lesphard

Date Ordered	Date Discontinued	ORDERS
5/23/06		DIC Physical therapy effective 5/25/06 John Lesphard PA

Signature of Nurse Receiving Order: D Smith lpn | Time | Signature of Physician: [signature] | Date: 5/24/06

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PHYSICIAN'S TELEPHONE ORDERS

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Facility Name: TMH&R of Edgefield | Address:

Family Name	First Name	Admission Number	Room Number	Attending Physician
Peterson	William	1050	214D	Nicholson

Date Ordered	Date Discontinued	ORDERS
5/25/06		Discharge to ARMC

Signature of Nurse Receiving Order: D Smith lpn | Time | Signature of Physician: [signature] | Date: 5/26

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DOCTOR'S PROGRESS NOTES

DATE	HOUR	
3/22/06		See Dr. B

PETERSON, WILLIAM (1050) *Room: P 214 D* *Medical Record no: 1050*

4/4/2006 3:31 PM *Role:* Physician *Category:* Progress Notes

04-04-06 WILLIAM PETERSON
THIS MAN HAS RECENTLY HAD CERVICAL SURGERY BECAUSE OF CERVICAL STENOSIS. HE IS REALLY IN BAD SHAPE. HE HAS HAD SOME RESPIRATORY INFECTION RECENTLY. CHEST X-RAY NORMAL. HE IS ON LEVAQUIN AND WILL COMPLETE IN A COUPLE OF DAYS AND THEN WE CAN REEVALUATE THEN . HE SEEMS TO BE STABLE. HIS INTAKE IS POOR AND SPEECH HAS BEEN ORDERED TO SEE IF THAT CAN HELP HIS SWALLOWING.

SIGN B.E. NICHOLSON
Prepared by: Sheila Whedbee *Co-signed by:*

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed
Peterson,	William		NRGH	1050	P 214 W

DOCTOR'S PP RESS NOTES
Continued on Reverse

DOCTOR'S PROGRESS NOTE

NAME–Last First Middle	Attending Physician	Record No.	Room/Bed
Peterson, William	NRGCM	1050	P214W

DATE HOUR

PETERSON, WILLIAM (1050) *Room: P 214 D* *Medical Record no: 1050*

4/17/2006 11:14 AM *Role:* **Physician** *Category:* **Progress Notes**

04-14-06 WILLIAM PETERSON
THIS IS A 94 YEAR OLD AFRICIAN AMERICAN MALE WITH PAST MEDICAL HISTORY OF RECENT ACUTE RENAL FAILURE SECONDARY TO NEUROGENIC BLADDER, SPINAL STENOSIS S/P ANTERIOR CERVICAL DISKECTOMY AND FUSION, HTN. ON EXAM PATIENT DENIES COMPLAINT OF SOB, CHEST PAIN OR ABDOMINAL PAIN. PATIENT DOES NOT APPEAR TO REALIZE THAT HE IS NOT ABLE TO MOVE HIS LOWER EXTREMETIES. NURSE'S ARE CONCERN WITH RESIDENT POOR PO INTAKE. PATIENT DRINKS LARGE AMOUNT OF BOOST AND WILL EAT ICE CREAM WITH NO PROBLEMS BUT REFUSES OTHER MEALS. VITAL SIGNS ARE STABLE. PATIENT HAS LOST APPROXIMATELY 10 LBS. SINCE ADMISSION. GOING FROM 164 TO 152.
GENERAL: NO ACUTE DISTRESS. VERY PLEASANT AFRICIAN AMERICAN MALE.
HEENT: NORMAL ACEPHALIC ATRAUMATIC, EXTRAOCULAR MUSCLES INTACT, PUPILS EQUAL AND REACTIVE TO LIGHT, OP IS CLEAR, MUCOUS MEMBRAINES ARE PINK AND MOIST
NECK: SUPPLE
CARDIOVASCULAR: REGULAR RATE AND RHYTHM WITHOUT MURMUR, LUNGS ARE CLEAR AUSCULTATION BILATERALLY
ABDOMEN: SOFT AND NONTENDER, ACTIVE BOWEL SOUNDS PRESENT IN ALL FOUR QUADRANTS.
EXTREMETIES: FLACCID BILATERAL LOWER EXTREMETIES, BILATERAL MILD PEDAL EDEMA.
ASSESSMENT AND PLAN:
1. NEUROGENIC BLADDER. PATIENT HAS FOLEY CATHETER IN PLACE. THIS WILL NOT BE REMOVED AND HE IS BEING FOLLOWED BY A UROLOGIST IN AIKEN. URINE APPEAR DARK IN COLOR. PATIENT RECENTLY HAD URINALYSIS CHECKED ON 3/30 AND WAS NEGATIVE. I WILL RECHECK THIS URINE DUE TO APPEARANCE.
2. CERVICAL STENOSIS S/P DISKECTOMY. PATIENT APPEARS TO HAVE REGAIN MOST OF HIS STRENGTH IN HIS UPPER EXTREMETIES BUT PARALYSIS IN LOWER EXTREMETIES. I AM GOING TO REINTERATE PHYSICAL THERAPY.
3. HYPERTENSION. STABLE AT THIS TIME. PATIENT IS CURRENTLY RECEIVING ATENTOLOL 12.5MG PO BID. WE WILL CHECK A BMP.
4. GERD. PATIENT IS ON PROTONIX 40MG PO QDAY
5. WEIGHT LOSS. PATIENT HAS VERY POOR APPITITE. HE IS ONLY TAKING BOOST OR ENSURE. I AM GOING TO CHECK A URINE, BMP AND CBC, PRE-ALBUMIN AND PLACING PATIENT ON PERIACTIN FOR APPITITE STIMULATION.

SIGN DR. LEAPHART
Prepared by: Sheila Whedbee *Co-signed by:* plr

Weight Change Notification

Nutritional at risk resident

In accordance with State and Federal regulations governing Long-Term Care facilities effective July 1, 1999. I realize that William Peterson is presently experiencing a change in weight loss.

Risk Level Low Moderate (High)

Current Diet order: Puree

Current Supplements: magic cup lunch + supper; Novosource 180cc QID; Silvervite QD; Prostat 1oz TID in juice

Current Intake record indicates average percent is <25% Breakfast, <25% Lunch, <25% Dinner, ______ Snack.

Weight record:
Current weight *See
3-month-old weight attached
6-month-old weight Sheet

3/1/06 180Lbs Hospitalized
3/21/06 164 lb
4/3/06 162 lbs
4/10/06 152
4/18/06 150 lbs
4/24/06 147 lbs
5/1/06 152

Pharmaceutical interventions used Periactin 4mg TID

Lab results on H & H and Albumin 11.6/35.8 Alb?

This is considered a Quality indicator which requires a review by the facility physician.
As the physician, I have reviewed the weight loss regimen in detail. My response is as follow:

- ☐ This is an unavoidable weight loss due to ______
- ☐ Continue as above
- ☐ I will try to affect this by doing the following: ______

Pysician's Signature ______ Date ______

Leave on Chart

Note: This report includes only the selection criteria listed below.
Resident Name *TERSON, WILLIAM (*

Weight Change History

T M Health & Rehab of Edgefield LP (EH)

Sort Order: Resident name

Resident	*Location*	*Date*	*Weight*
PETERSON, WILLIAM (1050)	P 214 D	2/27/2006	180.00
	hospitalized for surgery	3/1/2006	180.00
		~~3/21/2006~~	~~180.00~~
		3/21/2006	164.00
		3/27/2006	162.00
		~~4/3/2006~~	~~162.00~~
		4/3/2006	156.00
		4/13/2006	152.00
		4/18/2006	150.00
		4/24/2006	147.00

INSTRUCTIONS:
Form completed by pharmacist during DRR.
See pharmacist reviews and reports for details.

Do Not Thin From Chart!

KPS Kindred Pharmacy Services

DRUG REGIMEN REVIEW PHARMACIST SIGNATURE LOG

Comments	Notes
☑ No recommendations ☐ See Report – reported to: ☐ Nursing ☐ Physician/Prescriber ☐ Other	Pha - New admit R - φ M - follow BP 4
Signature [signature]	Date 3/30/06
☐ No recommendations ☑ See Report – reported to: ☐ Nursing ☑ Physician/Prescriber ☐ Other	Pha - 4/18 CBC, BMP R - Inappropriate tx per note M - follow BP 5
Signature [signature]	Date 4/26/06
☐ No recommendations ☐ See Report – reported to: ☐ Nursing ☐ Physician/Prescriber ☐ Other	
Signature	Date
☐ No recommendations ☐ See Report – reported to: ☐ Nursing ☐ Physician/Prescriber ☐ Other	
Signature	Date
☐ No recommendations ☐ See Report – reported to: ☐ Nursing ☐ Physician/Prescriber ☐ Other	
Signature	Date
☐ No recommendations ☐ See Report – reported to: ☐ Nursing ☐ Physician/Prescriber ☐ Other	
Signature	Date
☐ No recommendations ☐ See Report – reported to: ☐ Nursing ☐ Physician/Prescriber ☐ Other	
Signature	Date

Resident's Name William

Reorder From: MED-PASS 800-438-8884 Form # KPS007 (Rev. 1/05)

XFM 04169R

SIDE ONE

NURSES NOTES

DATE	TIME	
3/21/06	445pm	An 84 yr old BM admitted from Aiken Regional Hosp for skilled nursing care. Arrived via EMS. Placed in room 214W. A+O
BP 131/76		to self, confused to time, place + event. Verbally responds
P 63		to simple direct questions, follows directions c difficulty
R 23		long/short term memory impaired, impaired decision
T 99°		skills. Speech, hearing & vision adequate. No glasses or
		hearing aides present. No dentures or teeth c no noted oral
		problems. Foley intact + patent to BSD c straw colored urine.
		TED hose c heel pads intact to (B) feet/leg. No edema noted
		skin wld, no open areas. Area noted to Rt heel ≈ 4 cm in
		size, outer edges dk black c soft centers, no open areas noted.
		Scab noted to Rt ↓ leg. Dsg dry + intact to neck c cervical
		collar intact. Pressure relieving mattress to bed. No move-
		ment noted to LE c limited extention, c/o discomfort to
		knees upon extention. Grip strong to Rt hand c weak
		grip to Rt hand, no movement limitation to UE. Denies
		any swallowing problems. IV nurse to perform Foley audits
		and begin TV's as required per MD orders. Family notified
		of admission, left message to contact facility. Dr Massey
		notified of admission, will have Dr Massey evaluate
		surgery site and order required Tx. Meds faxed to pharmacy
		Orders at time of adm include: Diet: Reg Pureed, dietary
		notified. Meds on adm: Atenolol 12.5mg BID, Norvasc 5mg qd
		Protonix 40mg qd, Silvervite po qday, Novosource/Resource
		2.0 120cc qid between meals. Other orders include: Wkly BP
		I+O q shift VS q shift, PT & OT to eval + Tx. Foley cath care
		SP's ↑ x 2 for enablers, Hx c urology x 1 mth. 2nd step PPD
		due 4/2/06. orders noted. Wt = 164 lbs. No acute distress noted
		Voiced no c/o. Will monitor. Required staff (A) c ADL's, bowel
		incont, adult briefs, repositioning while in bed. Will —
		monitor condition. P Dunlap
3/21/06	930pm	Resting quietly, voiced no c/o. Vitals wnl. No acute distress
		noted. Will cont to monitor P Dunlap

Pt. Name Peterson, William Pt. Number 1050

Physician NRC-LM Month March

Room Number P 214W Year 2006

NURSES NOTES

DATE	TIME	
3/22/06	1³⁰p	V/S: 95/72 - 60 - 18 - 99%. Cervical neck brace in place. Heel pad in place. Foley intact, draining sl. dark yellow urine. No c/o pain or discomfort cervical. Fluids offered, taken slowly c encouragement. No acute distress noted. [illegible]
3/22/06	9Am	Resident moved to Rm 214D. ——— D Smith LPN
3/22/06	1²⁰/p	97⁹ 64 16 118/70. Resident placed on alternating pressure relief mattress. Foley @ BSD c dark, yellow urine noted. Take po meds whole s any problems noted. Drinking fluids good. Cervical neck brace in place. No c/o pain or discomfort. No acute distress. D Smith LPN
3/22/06	7pm	VS 98⁶ (3) 22 130/60 Resident in bed resting quietly c eyes open. Ø distress noted. Foley catheter intact & draining well @ bedside. MD (Barn Gordman) in to see resident. Ø drainage noted @ incision site. New orders noted, to call surgeon's office for orders on length of time to wear soft collar neck brace. Resident has a DNR order & need urology follow up appointment c D. Anderson. ——— W. [illegible], LPN
3/23/06	1⁰⁰/A	V/S: 103/65 - 60 - 18 - 96%. Foley intact, draining sl. amber colored urine. Collar brace in place. No drainage noted from neck incision. Voiced no c/o pain or discomfort. Resp unlabored. [illegible] LPN
3/23/06	9³⁰A	24° chart check done new orders noted & processed as follows; called Dr Santiago's office & left message for Deidre to call back [illegible]

Pt. Name Peterson, Wm. Pt. Number 1050

Physician NRGLM Month March

Room Number P 214W Year 2006

GP-136T (Rev. 1) VN-177

NURSES NOTES

DATE	TIME	
3/23/06	930A	cont (pt) re: how long to wear soft neck collar
98' 62	16 118/60	& for f/u apt — also called Dr Anderson spoke
		c ~~Mari~~ Marilyn made urology apt for 4/19
		wed @ 2pm; called & notified Ruth Peterson;
		made p/u apt by Palmetto Amb 4/19 wed @ 1pm
		B Robinson, RN
3/23/06	4p	Dr Santiago's office still has not called back re: f/u
		apt or neck collar B Robinson RN
3/23/06	5p	Lying on R side in bed collar in place
		Denies discomfort. Talkative c writer
		Foley to BSD c clear yellow urine draining.
		Fed meals by staff. TR via staff. Dsg
		intact. On alt. pressure mattress
		Stage 4 to R heel. Seen by PT/OT as outlined
		in their notes. Nonamb. Moves LE
		small amt on demand. SR x2 as
		enabler. Will monitor V/S 97.9-122/62 67 20 [illegible]
3/24/06	2am	Collar brace to neck in place.
		Foley intact, draining yellow colored
		urine. Resting quietly, O pre-
		sent c no sign of acute dis-
		tress. V/S: 100/60 - 68-18-99.3.
		N. Bagnell [illegible]
3/24/06	6am	Foley remains intact, but draining
		amber colored urine @ this time.
		N. Bagnell [illegible]
3/24/06	950A	Resident resting quietly in bed c cervical
		collar intact. Feeds himself p set up.
		Takes meds whole s any swallowing problems
		noted. Foley @ BSD c dark, yellow urine noted.
		No c/o pain or discomfort. Therapy is working
		c resident, PT and OT c slow progress. D Hutchinson

Pt. Name Peterson, William Pt. Number 1050

Physician NRGLM Month March

Room Number P214W Year 2006

NURSES NOTES

DATE	TIME	
4-5-06	12AM	Resident unable to eat Mech Soft diet,
96.2	100/61	holds food in his mouth, will Δ diet back
61	16	to Pureed. Up in gerichair per staff.
		Foley @ bsd c̄ dark urine noted. D Smith LPN
4-5-06	12:30 p	Resident ate 80% of Pureed lunch. Drank
		300cc of fluids. D Smith LPN
4-5-06	9:30 pm	BP 135/77 P 68 R 20 T 96.9. ABT completed c̄ no S/E noted.
		Conts productive cough. Foley to BSD c̄ dk tea colored urine.
		Fld intake good, nutritional intake poor, ate 20%. Dsg
		dry + intact to neck. Fed per staff. ADL'S + incont care
		for bowels per staff. Voiced no c/o. No acute distress
		noted. Will cont to monitor. P Murray
4/6/06	1:00 A	V/S: 114/68 - 74 - 20 - 97.4. Foley intact,
		draining dark yellow colored urine.
		Resident has collar brace on @ this
		time for support per resident. No
		acute distress noted. D. Barnette
4/6/06	8:10 A	Ⓛ hip blister open. Skin Red. See Tx
		orders. Notified daughter of New
		orders. MD faxed. J Smoak LPN
4/6/06	11:00 a	See Tx sheet + Body audit sheet for
B/P -	129/81	Skin condition - Has Foley Cath c̄ BSD
T -	98.2	patency well - dark amber urine noted.
P -	70	Flds enc. Res OOB to recliner w/c per
R -	20	staff - Has pressure relief mattress on
		bed. TOP Q 2 hrs in bed. SRA x2 as
		enabler. Inc of bowels - Inc care prov.
		Q shift prn. Res seen by ST, PT + OT
		Dept - See notes. Has pressure relief mat-
		tress on bed. Aspen collar worn when
		OOB in chair etc - + soft collar used prn.
		Fed by staff meals - Appetite 20% - Consuming
		fluids well. K Williams

Pt. Name Peterson, William
Pt. Number 1050
Physician NRGLM
Month April
Room Number 214W
Year 2006

NURSES NOTES

DATE	TIME	
3/24/06	2:00P	Deidre called from Dr. Santiago's office c̄ orders for soft collar use, f/u appt. 5/1/06 @ 10:45 am + Xrays C-spine prior to f/u in order to bring copies — orders for aspen collar rec'd however res does not have an aspen collar - res was not admitted here c̄ aspen collar - only a soft collar; notified Dr. Santiago's office + was inst'd to call Midland's @ 641-6007 to request another aspen collar; spoke c̄ Mary Peterson + she stated not having the collar but remembered res having 2 collars @ ARMC; spoke c̄ Patrick (Palmetto EMS service) who states res was rec'd from ARMC c̄ only soft collar + wearing hospital gown - staff @ ARMC stated res family obtained all personal belongings - phoned Mary Peterson again to f/u on above statement + she denies being c̄ res + states ø other family c̄ res to get belongings + that res had nothing to bring here anyway; Midlands notified to remake aspen collar + fwd to our facility — [illegible]
3/24/06	6:40p	VS. 99 143/59, 62, 18. Resident lying in bed. Resp. even/unlabored. ø c/o pain. Confusion evident. Feeds self per set up. Foley to BSD intact & patent. Urine is dark yellow c̄ ø sediment. Skin intact to Ⓡ heel. Dark - black in color. Takes meds whole c̄ ø swallowing difficulty. — [illegible]
3/25/06	2Am	B/P 122/52 T 98.8 P 70 R 20. Resident presently asleep in bed. Collar brace intact. Respirations even & unlabored. Skin warm & dry to touch. Foley catheter patent and intact to BSD c̄ dark yellow urine. Incontinent of bowel. No S/S of distress noted. Will continue to monitor. — P. Overton [illegible]

Pt. Name: Peterson, William
Pt. Number: 1050
Physician: NRGLM
Month: March
Room Number: P 214 W
Year: 2006

NURSES NOTES

DATE	TIME	
3-25-06	1020 am	Resident is sitting up in bed, resp. even & unlabored. Foley catheter patent and intact. & dark yellow urine noted. Skin warm & dry to touch. Communicates needs to staff. Feed self & trays set up. NO S/S of acute distress noted. Will monitor. — C. Watkins, RN
3-25-06	1648	VS T 99.5 - P 68 - R 20 - BP 108/60. Resident is up in bed, resp. even & unlabored. Foley catheter is intact & patent to BSD & dark yellow urine noted. Skin warm & dry to touch. Will continue to monitor. — C. Watkins, RN
3/26/06	12 AM	Temp 101.4. Resident medicated & ii Tylenol 325 mg tabs p.o. Will re-check temperature. — P. Overton LPN
3/26/06	1:45 AM	B/P 114/80 T 99 P 74 R 20. Resident resting quietly in bed. Alert and responsive when awake. Neck collar in place. Respirations even & unlabored. Dressing intact to neck. Foley catheter patent and intact to BSD & dark colored urine. Has voiced no c/o pain or discomfort. Will continue to monitor. — P. Overton LPN
3-26-06 T 96.0 R 18	1025 am P 83 BP 136/70	Resident is lying in bed & eyes opened. Resp. even & unlabored, neck collar in place. Foley catheter patent and intact. No c/o pain or discomfort at this time. Will continue to monitor. — C. Watkins, RN
3/26/06	9 PM	B/P 95/47 T 98.2 P 70 R 20. Resident resting in bed. HOB ↑. Neck collar in place. Some edema noted to front of neck. Resident takes meds well & sips of juice PO ↑ some throat irritation. Foley catheter patent and intact to BSD & dark colored urine. Requires extensive assistance & ADLs. — P. Overton LPN
3/27/06	1 AM	B/P 114/68 T 99.4 P 68 R 20. Resident presently asleep in bed. HOB ↑. Respirations even & unlabored. Neck collar in place. Foley catheter patent and intact to BSD & dark colored urine. NO S/S of distress. Will continue to monitor. — P. Overton LPN

Pt. Name Peterson, William Pt. Number 1050

Physician NBGLM Month

Room Number 214W Year 2006

NURSES NOTES

DATE	TIME	
3/27/06	2³⁰/p	98⁹ 104/54 55 18. Residents appetite is very poor, Staff attempted to feed only ate 20% of lunch. Drinks Resource good. Foley @ BSD c̄ dark urine noted. No c/o voiced. PT/OT conts. [illegible]
3/27/06	8³⁰ pm	BP 132/74 P63 R22 T97⁶. Alert c̄ confusion. Fed per staff — tolerated 20%, drank Resource s̄ difficulty. Foley to BSD c̄ dk straw colored urine. Dsg to surgical wound dry + intact to Rt neck region. Requires total Ⓐ c̄ turning/repositioning. — Incont of bowels c̄ staff Ⓐ for care. Bathing, dressing + grooming per staff. Will hold cup in Ⓛ hand + bring to mouth to drink s̄ spillage. Takes small drinks, holds in mouth for few seconds then swallows s̄ difficulty. All needs met and anticipated by staff. Lays in semi-fetal position on back + while on side. does not extend legs keeps bent at knees. No noted Δ's in condition. Will con't to monitor. —— P Dunlp
3/28/06	1⁰⁰/p	V/S: 126/60 - 74 - 18 - 98³. Foley intact, draining sl. amber colored urine. Resting quietly c̄ present c̄ no s/s of acute distress. D. B[illegible]
3/28/06	9¹⁰/Am	Resident conts to lay on Lt side mostly.
133/78	82 18 97²	Ate 30% of bfast c̄ staff assist. Drinks fluids good. No c/o pain or discomfort. Dry dsg intact. Aspen collar received today. Therapy will be working c̄ resident. Foley @ bsd c̄ dark urine noted. —— DSmith lpn
3/28/06	9⁰⁰ pm	BP 108/57 P72 R20 T97⁸. Fed by staff ate 30%. Tolerated po flds well, no noted swallowing problems. Repositioned by staff. Dsg intact to surgical site clean + dry. No c/o pain or discomfort. Foley to BSD c̄ dk straw colored urine. No noted distress. All needs anticipated + met by staff. No noted cognitive or functional Δ's. —— P Dunlpn —
3/29/06	1³⁰/p	V/S: 112/71 - 81 - 20 - 97⁸. Foley intact, draining amber color urine. No collar on

Pt. Name Peterson, William
Pt. Number 1050
Physician NRGLM
Month MARCH
Room Number 214W
Year 2006

NURSES NOTES

DATE	TIME	
3/29/06	1:30p	@ this time. Voiced no complaints
	cont.	No acute distress noted. N. Bozeller
3/29/06	3:30/pm	Collar replaced @ resident's request.
		States he likes the support it gives.
		N. Bozeller
3/29/06	10:20/A	110/80 78 18 98.8, Resident ate 80% of b'fast,
		fed per staff. Drinking fluids good. Foley
		@ BSD c dark urine noted, soft collar washed,
		using it PRN. No c/o pain or discomfort.
		Therapy is working c resident. D Smith LPN
3/29/06	10pm	BP 101/58 P 71 R18 T 98.4. Fed by staff ate 20%. Drank
		liquids well through straw. Foley to BSD c dk straw colored
		urine, incont of BM care per staff. Repositioned q 2 hrs per
		staff. Dsg dry/intact to neck. No c/o pain or discomfort
		Will cont to monitor. P Dunn
3/30/06	2:00/p	V/S: 108/52 - 58 - 18 - 99.3. Collar brace
		in place (soft) per resident's req-
		uest to leave on. Fluids & food
		taken well. Foley intact draining
		of amber colored urine. Dsg
		to incision dry & intact. No acute
		distress noted. N. Bozeller
3/30/06	4:00/p	Soft collar brace removed @ resident's
		request. N. Bozeller
3/30/06	10:55/A	Resident conts to work c therapy. Fed
		per staff c appetite increasing. Dry dsg
		intact to neck. T&R per staff. Foley @
		BSD c dark yellow urine noted. No c/o pain
		or discomfort. D Smith LPN
3/30/06	11:30/A	Temp 100.8 - Tylenol 650mg po given. 90 18 122/71. D Smith LPN
3/30/06	1p	Temp 100.2. MD notified. D Smith LPN
3/30/06	3:30 pm	Dr Mussey ordered Levaquin 500mg q d x 7 days, UA, CXR +
		Blood Cx. orders noted + fax'd to pharmacy P Dunn

Pt. Name Peterson, William   Pt. Number 1050

Physician NRGLM   Month March

Room Number 214W   Year 2006

GP-136T (Rev. 1

NURSES NOTES

DATE	TIME	
3/30/06	4^00 pm	Transported via Staff Ⓐ to ECH for chest x ray. UA collected via foley and sent to ECH lab per MD orders — P Dunlap
3/30/06	4^15 pm	UA results rec'd. Returned from ECH via stretcher c̄ Staff Ⓐ. Dr Massey in facility informed of return + UA results. — P Dunlap
3/30/06	5^30 pm	Seen per Dr Massey no new orders — P Dunlap
3/30/06	6^30 pm	Refused to eat supper. tolerated flds well. Non productive cough c̄ wheezing noted. Will cont to monitor — P Dunlap
3/30/06	8pm	T. 101.2 Tylenol 650mg po given. Weakness noted. Cough continues. Tolerating po flds well. No wheezing noted at present time. Will monitor. — P Dunlap
3/30/06	9^30 pm	T 100.4. Conts to drink po flds well. No SOB noted, coughing. Alert c̄ weakness. Will cont to monitor. — P Dunlap
3/30/06	10pm	Started on Levaquin 500mg per MD orders, rec'd from pharmacy. Resident requested H2O, given tolerated well. No distress noted at present time. — P Dunlap
3/31/06	10/A	V/S: 112/66 - 74 - 97.4 - 20. No side effects noted from antibiotic therapy. Coughing @ intervals. Fluids offered taken well. No SOB noted. [illegible]
3/31/06	10:00A	Attempted X2 for bld ex draw - bil AC c̄ ø success - [illegible]
3/31/06	10^15/A	97.2 84/42 74 20. Resident up per therapy to geri chair. No c/o voiced. ABT started last p.m. No temp this AM. Foley @ BSD c̄ dark urine noted. Ate only 20%
3/31/06	10^25/A	Blood drawn & sent to Edgefield Hosp. Lab. — [illegible] Morrison
3/31/06	5:30p	Lab Report faxed back to TMHR from Dr. Massey. ø orders noted. Resident up in bed. Foley to BSD c̄ dark urine noted. Takes meds whole c̄ ø problems. ø c/o pain. Family @ BSD. Temp 100 oral. 149/77, 82, 18. [illegible]

Pt. Name Peterson, William Pt. Number 1050

Physician NRB-LM Month March

Room Number 214W Year 2006

NURSES NOTES

DATE	TIME	
4/1/06	1:30p	V/S: 102/68 - 72-18-97.4. No side effects noted from antibiotic therapy. Soft collar brace to neck in place @ resident's request. No acute distress noted. Foley intact draining sl. amber urine. D. Bozell LPN
4/1/06	10:00 Am	VS - 98.2 . 64 . 16 / 124/62. Resident in bed @ 30°. Dsg intact to cervical site. Foley catheter intact & draining amber colored urine @ bedside. Respirations even & unlabored. Accepted po meds s̄ difficulty. Continues on ABT therapy. Ø adverse reactions noted. — U. Cheatham LPN
4/1/06	9pm	B/p 132/70 T97.3 P76 R18. Resident resting quietly in bed. Alert c̄ responsive. Soft collar brace in place to neck. Accepts meds well. ABT continues, No adverse reaction Noted. Foley catheter patent & intact to BSD c̄ amber colored Urine. Denies pain or discomfort. — P. Overton LPN
4/2/06	1Am	B/p 118/58 T97.9 P74 R20. Resident asleep in bed. HOB ↑. Respirations even & unlabored. ABT continues No adverse reaction noted. Foley catheter patent & intact to BSD. Requires extensive assistance c̄ ADL'S. Denies pain or discomfort. Will continue to monitor. — P. Overton LPN
4/2/06	10Am	VS - 96.9. 78. 18. 122/63. Resident in bed @ 45°. Resting quietly Ø acute distress noted. Respirations even & unlabored. Accepted po meds s̄ difficulty. Foley catheter intact & draining @ bedside. Continues on ABT. Ø adverse reactions noted. — Mary Cheatham, LPN
4/2/06	6:15pm	VS - 97.9. 61. 18. 92/59. Resident in bed @ 45°. Denies discomfort @ this time. Assistance provided c̄ meals. Foley Catheter intact & draining @ bedside. — Mary Cheatham, LPN
4/3/06	2Am	B/p 112/52 T96.4 P68 R18. Resident resting quietly in bed. Respirations even & unlabored. Dressing clean & intact to Neck incision site. ABT continues. F/c patent & intact to BSD. No distress Noted. — P. Overton LPN

Pt. Name: Peterson, William | Pt. Number: 1050
Physician: NRG-LM | Month: March
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NURSES NOTES

DATE	TIME	
4-3-06	10AM	Resident ate 30% of bfast, drank fluids
98 101/62	73	good. Foley @ BSD c dark urine noted.
	16	ABT conts, Ø reactions noted. Therapy
		is working c resident c slow progress. [illegible]
4/3/06	9:00pm	BP 123/74 P90 R20 T97. Alert c confusion. Follows simple
		directions p verbal cueing s difficulty. Fed per staff.
		ate 30%. Foley intact to BSD c dk tea colored urine.
		Conts on ABT c no adverse reactions noted. No resp
		distress noted, no noted SOB. Non productive cough.
		Tolerating po fl[ui]ds well. Turned + repositioned by
		staff. Dsg dry + intact to surgical site. No noted Δ's
		in cognitive / functional status. Will con't to monitor.
		P. Dun[illegible]
4/4/06	2:00p	V/S: 103/65 - 68 - 20 - 98.2. Foley intact,
		draining sl. dark yellow urine.
		No side effects noted from anti-
		biotic therapy. W. B[illegible]
4-4-06	10AM	Resident fed per staff, appetite fair to
		poor. No c/o voiced. Drinks fluids good.
		Urine still dark, foley @ BSD. Therapy
		conts to work c resident. [illegible]
4/4/06	6:30pm	BP 124/67 P57 R22 T98.6. Family attempted to feed,
		ate only 3-4 bites of food. Drinking flds well. Foley
		to BSD c dk tea colored urine. No SOB noted. Dsg dry
		+ intact to neck. Alert + responding appropriately
		to direct questions. Conts on ABT c no noted reactions.
		Will con't to monitor. P. Dun[illegible]
4/5/06	2:00p	V/S: 156/76 - 58 - 18 - 96.6. Foley intact
		draining dark yellow urine. Fluids
		offered taken well. No use of neck
		pillow. W. B[illegible]

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Pt. Number: 1050
Physician: NRbim
Month: April
Room Number: 214W
Year: 2006

NURSES NOTES

DATE	TIME	
4/6/06	6pm	97.4 - 115/63-61-20 - [illegible] SRT x 2 - alert - fed per staff - Foley patent & draining to BSB - dsg dry & intact to neck & [illegible] — [illegible]
4/7/06	3:30p	V/S: 118/74 - 68 - 18 - 97 2/10. No [illegible] at this time per resident's choice. Fluids offered, taken slowly but well. Foley intact, draining amber colored urine. Voiced no complaints. No acute distress noted. D. [illegible]
4-7-06	10:10 AM	97.7 116/65 66 18. Foley @ BSD c dark urine noted. Ate 40% of bfast, fed per staff. ABT conts, Ø reactions noted. No c/o pain or discomfort. Therapy conts to work c resident c slow progress. — D Smith LPN
4-7-06	1:20/p	B/P 126/70 T96.6 P72 R20. Resident awake & alert in bed. HOB↑. Fed per staff in room. Accepts meds well. Requires extensive assistance c ADL'S. No voiced c/o pain or discomfort. — P. Overton LPN
4/8/06	1Am	B/P 130/70 T97 P68 R20. Resident presently asleep in bed. HOB↑. Respirations even & unlabored. Foley catheter patent & intact to BSD c dark, amber colored urine. Denies pain or discomfort. — P. Overton LPN
4-8-06 T96.7 R18	10:15 am P80 B/P 122/63	Resident is awake in bed, resp even & unlabored. Accepts meds well. Foley catheter patent & intact to BSD. Dressing dry & intact to neck. No c/o pain or discomfort at this time will monitor. — [illegible] Watkins, RN
4-8-06	9Pm	B/P 102/56 T96.8 P68 R19. Resident resting in bed. Alert and responsive. Accepted meds well. Foley catheter patent and intact to BSD c dark amber urine. No c/o pain. — P. Overton LPN
4/9/06	2AM	B/P 116/70 T98 P96 R20. Resident asleep in bed. HOB↑. No c/o pain or discomfort. — P. Overton LPN

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Physician [illegible]   Month April

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NURSES NOTES

DATE	TIME	
4-9-06	1050 am	VS T 98.4 - P 64 - R 20 - BP 110/60. Resident is awake in bed, resp. even & unlabored. Skin warm & dry to touch. Foley cath patent & intact to BSD & dark amber colored urine noted. Will monitor. ——— C. Watkins, RN
4-9-06	4p	VS T 96.7 - P 63 - R 20 - BP 117/73. Resident is resting quietly in bed, resp. even & unlabored. HOB ↑, Clean & dry dressing to neck incision. Will monitor. ——— C. Watkins, RN
4/10/06	2AM	B/P 122/80 T 99 P 71 & R 20. Resident asleep in bed. HOB ↑. Respirations even & unlabored. Foley catheter remains patent and intact to BSD & dark colored urine. NO S/S of distress noted. Will continue to monitor. ——— T. Overstreet
4-10-06	1030/A	97.4 68 20 122/60. Resident in bed this AM fed per staff ate 40% of brkst, drank 360cc of fluids. Foley @ BSD & dark urine noted. Turned & repos. per staff. Therapy cont. DA with tp
4/10/06	900 pm	BP 111/66 P 60 R 22 T 98.2. Fed per staff poor intake 20% tolerated po flds well. NO SOB noted HOB ↑. Foley intact to BSD & dk amber urine. Turned & repositioned per staff. Dsg dry & intact to neck. Voiced no C/O. No S/S of URI. All needs met & anticipated per staff. No distress noted. Will cont to monitor ——— P Overstreet
4/11/06	130/A	V/S: 122/78 - 78 - 18 - 96.2. Foley intact, draining amber colored urine. Also to front of neck, dry & intact. No collar being used @ this time. No acute distress noted. ——— W. Burnett, Jr
4-11-06	11A	110/68 59 17 98. Resident cont. to have a poor appetite, drinks fluids good. No C/O voiced. Foley @ BSD & dark urine. Therapy Cont. to work & resident. Turned & repos. per staff. Will monitor. ——— D Smith, LPN

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NURSES NOTES

DATE	TIME	
4/11/06	9³⁰pm	BP 102/60 P64 R16 T97⁶. No noted functional or cognitive Δ's. Foley cont's to BSD c̄ dk amber urine. Appetite - poor, po fld intake good. Alert c̄ confusion. All needs met and anticipated per staff. Will con't to monitor - PDunn LPN
4/12/06	1³⁰A	V/S: 112/64 - 76 - 18 - 98⁸. Fluids offered, only a few sips taken before becoming choke. Foley intact, draining amber colored urine. Dsg to front of neck dry & intact. No SOB noted. D. Bonell
4-12-06	10A	Resident is refusing to eat, drinks fluids
97 61	18 108/65	good. Foley @ BSD c̄ dark urine noted. Therapy
		in to work c̄ resident. No C/O voiced. DSmith LPN
4/12/06	8³⁰pm	BP 143/85 P64 R18 T96.8. Cont's to have poor nutritional intake, staff attempts to feed, resident refuses. Turned + repositioned by staff. Foley to BSD c̄ dk amber urine. Dsg intact to neck incision site. No SOB noted HOB↑. No noted Δ's in condition. ——— PDunn LPN
4/13/06	2¹⁰A	V/S: 124/73 - 73 - 18 - 95⁴Ax. Foley intact draining dark yellow urine. Dsg to front of neck dry & intact. Fluids offered, taken slowly, but well. No acute distress noted. D. Bonell
4-13-06	9⁴⁰A	97 125/69 72 18. Resident up in geri chair per staff c̄ hoyer lift. Appetite conts to ↓ but drinks fluids good. Dry dsg to surgical area. Foley @ BSD c̄ dark urine noted. No S/S of pain or discomfort. Will monitor ——— DSmith LPN
4/13/06	6¹⁵pm	96⁵. 108. 20. 113/70. Resident in bed @ 45° eating supper. Fed per staff. Foley catheter draining @ bedside. Dsg to cervical site intact. Denies discomfort @ this time. ——— Mary Cheatham LPN

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NURSES NOTES

DATE	TIME	
4/14/06	130/A	Foley intact draining dark yellow urine. Drsg to front of neck dry & intact. Fluids offered, encouragement needed to consume. No acute distress noted. V/S: 130/76-68-18-96.8. — D. Byrd LPN
4-14-06	10 30/A	97' 60 24 92/58. Resident resting quietly in bed this AM. Foley @ BSD c̄ dark urine noted. No C/o voiced. Therapy Conts. Food intake poor, drinks fluids very good. DSmith LPN
4-14-06	6 15/p	96.9 127/80 76 22. Resident resting in bed @ this time. Staff assisted c̄ eating supper. Drinks fluids good. New orders processed from MD this pm. Foley @ BSD c̄ dark urine noted. — DSmith LPN
4/15/06	130/A	V/S: 103/67-60-20-97.6. Foley intact draining dark yellow urine. Drsg to front of neck dry & intact. Fluids offered, taken c̄ encouragement to consume. No acute distress noted. — D. Byrd LPN
4/15/06	825 Am	VS-98.88.18.132/68. Resident in bed @ 45°. Assistance provided c̄ feeding. Fluids encouraged. Foley catheter intact / patent and draining @ bedside. Aspen collar intact. Dry dsg to cervical site intact + clean. Kept clean & dry per staff. — U. Cheatham LPN
4/15/06	6pm	VS-96.5.58.20.111/64. Resident fed per staff. Ø acute distress noted. Respirations even + unlabored. Foley Catheter draining @ bedside. — U. Cheatham LPN
4/16/06	2Am	B/P 128/72 T97 P64 R18. Resident presently asleep in bed HOBT. Respirations even & unlabored. Foley catheter remains patent & intact c̄ dark amber urine. No distress noted. — P. Dyer LPN

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NURSES NOTES

DATE	TIME	
4-16-06	10Am	97⁹- 118/63 -56-18 Res alert c confusion
		Patent foley c dark amber urine
		draining Denies discomforts. Dsg
		intact to neck incision Soft collar
		on @ present. Seen by PT/OT/ST as
		outlined appetite poor. Will Monitor Dykes
4/17/06	130p	V/S: 100/68-58-18-97.8. Foley intact,
		draining amber colored urine.
		Fluids offered, but encourage-
		ment needed to consume, but
		consumes a cup full. No acute
		distress needed. N. Bazellon
4-17-06	10¹⁰/A	Resident fed per staff, ate 30% of bfast.
		Foley @ BSD c dark urine noted. Therapy
		conts to work c Resident. Drink fluids
		good. Soft collar intact. No c/o voiced. DAnitslpn
4/17/06	9⁴⁵pm	BP 98/70 P62 R20 T 98². Alert c confusion responding
		appropriately to direct questions. Poor nutritional intake
		Foley to BSD c dk amber urine, sediment noted. NO
		SOB noted HOB ↑. Tolerates flds fair. Surgical site
		to neck c dry dsg intact. No acute distress noted. —
		Voiced no c/o. Will cont to monitor. P Dunly
4/18/06	5⁰⁰/p	V/S: 135/75 - 83 - 20 - 98⁷/₀. Bld drawn
		for CBC, BMP. ~~Urine~~ [illegible] x2 tries
		by this nurse. Urine obtained
		for U/A c C+S. N. Bazellon
4-18-06	10 Am	Resident conts to have poor food intake, he
121/63	17 67	drinks fluids good. Foley @ BSD c dark
	977	urine noted. Therapy conts c poor pro-
		gress. No dsg to surgery site, no open or
		drainage noted. HOB ↑. Turned + repositioned
		per staff, Resident turns back himself
		Will continue to monitor. DAnitslpn

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VN-177

NURSES NOTES

DATE	TIME	
4-18-06	12N	Lab faxed to MD. —— D Smith lpn
4/18/06	10pm	BP 120/65 P68 R20 T96'. Alert c confusion. Conts to require total staff (A) c ADL'S. Turned + repositioned while in bed per staff. Food intake poor, fld intake fair. Foley to BSD c dk amber urine present. No noted Δ's in condition —— P Dunn lpn
4/19/06	100/a	V/S: 110/68 - 62 - 18 - 96%. Resting quietly @ present c no signs of acute distress. Foley intact, draining amber colored urine. Dsg to front of neck dry & intact. —— N. Bozelleson
4/19/06	830/a	D/c Dsg to Neck incision site. Area intake Clean & Dry. —— [illegible]
4-19-06	1050/A	118/68 74 18 97⁸. Resident fed per staff this AM, ate eggs. Conts to drink fluids good. Foley @ BSD c dark urine noted. Going to Urologist today for f/u appt. Lab faxed to MD this AM. D Smith lpn
4-19-06	1250/p	LOA via Palmetto Amb. to MD appt. D Smith lpn
4/19/06	300pm	Returned from MD appt new order: Δ foley on 4/20/06 then q 4wks, Neosporin to penis sore BID, Enc po flds - orders noted. —— P Dunn lpn
4/19/06	900pm	BP 125/69 P69 R20 T96³. No SOB noted, HOB ↑. Foley at BSD c 75cc dk amber urine. Tolerated po flds well. Conts to have poor nutritional intake. Surgical site to neck clean + dry. Conts to require hands on (A) for bathing, dressing, grooming, oral care. Turned + repositioned per staff. No noted changes in condition —— P Dunn lpn
4/20/06	200/a	Foley intact, draining amber colored urine. Incision to front of neck dry & intact. V/S: 98/60 - 60 - 18 - 96.7. —— N. Bozelleson

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NURSES NOTES

DATE	TIME	
4-20-06	12[40]p	Foley D/C per Tx Nurse this AM, 1000 cc urine returned. No C/o pain or discomfort.
96[9] 20	56 90/60	Fed per staff, ate his eggs for b'last, drinks fluids good. Will monitor. D Smith LPN
4-20-06	1:45P	Order Rec'd from PT for Chip wand care - Medicare
4/20/06	3[30]p	T96[3], P60, R30, BP128/66, Neck dsg clean intact called as ordered. Proatat as ordered. Foley patent. ADL's per staff. Eats poorly drinks well. Denise
4/21/06	1Am	BP132/60 T98 P68 R20. Resident asleep in bed. HOB T. Respirations even & unlabored. Skin warm & dry to touch. Foley catheter patent and intact to BSD & clear urine. SR's Tx 2, call light in reach. No S/S of distress. P. Overton LPN
4-21-06	10[45]/A	Resident refused b'last & fluids this AM.
116/76 74	18 98[4]	Did drink 150 cc of juice & meds this AM. Foley @ BSD & clear urine noted. Therapy to do wound care now. Will monitor. D Smith
4-21-06	6[15]/p	96.3 94/60 53 17. Resident up in bed per staff for supper. No C/o pain or discomfort. Foley @ BSD & yellow urine noted. D Smith LPN
4/22/06	12pm	BP105/80 T96 P62 R18. Resident presently asleep in bed. HOB T. Alert & responsive when awake. Respirations even and unlabored. Foley catheter patent and intact to BSD & clear yellow urine. No S/S of Distress Noted. P. Overton LPN
4-22-06	10[30]m	Resident is awake in bed, resps even
T96.[0] R	P 62	unlabored. Foley catheter patent &
R 16	BP 121/61	intact to BSD & clear urine noted.
		accepts fluids well. Will monitor. C. Watkins
4/22/06	9Pm	Resident lying in bed & both eyes closed. HOB T. Alert & confusion. Accepts meds & difficulty & only small sips of juice. Requires extensive assistance & ADL's. Foley catheter patent and intact to BSD & clear yellow urine. No S/S of distress Noted. P. Overton LPN

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NURSES NOTES

DATE	TIME	
4/23/06	12Am	Resident resting quietly in bed. HOB↑. Respirations even and unlabored. Skin warm ē dry to touch. Foley catheter remains patent ē intact to BSD ē clear yellow urine. SR's Up x2. Will continue to monitor. ——— P. Overton LPN
4-23-06 T96.2 R 16	9 30 am P 64 BP 110/60	Resident is resting quietly in bed, resp. even & unlabored. Refused breakfast ē meds this morning. Foley catheter patent ē intact to BSD ē clear urine noted. Will continue to monitor. ——— C. Watkins, R
4/23/06	9Pm	B/P 102/80 T98 P62 R20. Resident lying quietly in bed. HOB↑. Respirations even ē unlabored. Refused 8Pm meds, states "I don't need it". Foley catheter patent and intact to BSD ē clear yellow urine. No S/S of distress noted. — P. Overton LPN
4/24/06	2Am	B/P 98/62 T99 P62 R20. Resident presently asleep in bed. HOB↑. Respirations even ē unlabored. Foley catheter patent and intact to BSD ē clear yellow urine. No S/S of acute distress noted. Will continue to monitor. ——— P. Overton LPN
4-24-06 121/63	9 20/A T 96.3 88	Resident refused bfast this AM, took po meds & drank juice. Foley @ BSD ē yellow urine noted. Wound care per therapy. Will continue to monitor. — D Smith LPN
4-24-06	12 20/p	Xray faxed to MD. ——— D Smith LPN
4/24/06	8 30 pm	BP 91/65 P59 R18 T98.3. Alert ē confusion, responded appropriately to direct question. Poor nutritional intake, po fld intake fair. Foley conts to BSD ē dk amber urine present. Turned + repositioned by staff. No resp distress noted HOB↑. Voiced no c/o pain or discomfort. No noted functional or cognitive Δ's. Will cont to monitor. ——— P. Auerly
4/25/06	1 30/p	V/S: 106/18-72-18-96.6. Foley intact, draining amber colored urine! Resting quietly @ present ē no signs of acute distress. W. Barlow

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NURSES NOTES

DATE	TIME	
4-25-06	9^40/A	Resident conts to refuse to eat, drinks good. Foley @ BSD c̄ yellow urine noted. Resident receives therapy for wound care. No C/O pain or discomfort. Will monitor. D Smith lpn
4-25-06	8^45 pm	BP 133/78 P 80 R 20 T 97.4. Foley conts to BSD c̄ dk amber urine. No SOB noted HOB ↑. Turned & repositioned by staff. All needs met & anticipated by staff. Refusing to eat. — Tolerates po flds good. Surgical site to neck healing well, no problems noted. Voiced no c/o pain/discomfort. Will cont to monitor. — P Dunn lpn
4/26/06	1^30/p	V/S: 90/73 - 60 - 18 - 95 ax. Foley intact draining sl. dark yellow urine. Resting quietly @ present c̄ no signs of acute distress. N. Bagwell
4-26-06	10^45/A	Resident's appetite conts to be poor for food
100/66 70	18	intake, drinks fluids good. Lower extr cont
	97^8	to be swollen. Foley @ BSD dark yellow urine noted. Therapy conts to do wound care. No C/o pain or discomfort. — D Smith lpn
4-26-06	8^30 pm	BP 116/80 P 71 R 20 T 97.2. Alert c̄ confusion. Conts c̄ poor intake of food, tolerates po flds well. Foley to BSD c̄ dk amber colored urine. Incont of bowels c̄ staff (A) for care. Turned & repositioned per staff. Heel boots intact to (B) feet. Alternating pressure relief mattress to bed. Wound care conts per therapy. No SOB noted HOB ↑. Denies any pain or discomfort. Will cont to monitor — P Dunn lpn
4/27/06	1^30/pm	V/S: 112/60 - 74 - 18 - ~~98~~ 98.5. Foley intact draining dark yellow urine. Fluids offered/taken slowly but well. Voiced no complaints. No acute distress noted. N. Bagwell
4/27/06	9^30 Am	Fed per staff, refuses to eat. Conts to drink flds well. Foley intact
BP 118/68	P 70 R 20	+ patent. No noted functional Δ's. No distress noted. — P Dunn lpn

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NURSES NOTES

DATE	TIME	
4/28/06 98/78 - 64 -	6p 20 - 97.2	In bed SR↑x2. Alert - incont of bowel - Foley patent & draining. Needs suff. Appetite remains poor. Po fluids encouraged - Turned & repositioned @ [illegible] [illegible] distress — D. McCobb
4/28/06	1:30p	V/S: 97/63 - 76 - 16 - 97.2 o. Foley intact, draining amber colored urine. Resting quietly @ present c no signs of acute distress. W. Bosket
4-28-06 118/68 68	9:10/A 18 98.4	Resident conts to have poor food intake, does drink fluids good. Foley intact & patent c yellow urine noted. Fed per staff, will not feed himself. Therapy conts c wound care. Turned & repos. per staff. — D. Austin LPN
4/29/06	1:00p	V/S: 106/60 - 78 - 18 - 98.5. Foley intact ~~c [illegible]~~ draining amber colored urine. Fluids offered taken well c encouragement to finish whole cup. No acute distress noted. — W. Bosket
4/29/06	12:35pm	VS-96.5, 78, 17, 120/63. Res c/o discomfort. Tylenol ii 325mg given, kept clean per staff. Foley Catheter intact & draining @ bedside. Fed meals per staff. All needs anticipated/met per staff. — Mary Cheatham, LPN
4/29/06	9Pm	B/p 134/70 T97.4 P74 R18. Resident awake in bed. Alert c confusion noted. Accepted meds. Appetite and fluid intake remain poor. Requires extensive assistance c ADL's. Will continue to monitor. — P. Overton LPN
4/30/06	2Am	B/p 112/64 T96 P68 R18. Resident presently asleep in bed. HOB↑. Respirations even & unlabored. Turned & positioned per staff. Foley catheter patent & intact to BSD. — P. Overton LPN

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NURSES NOTES

DATE	TIME	
4/30/06	1pm	VS-96° 77. 18. 124/69. Resident in bed @ 30°. Assistance provided c meals. Poor intake noted. Fluids encouraged & acute distress noted. Respirations even & unlabored. Kept clean per staff. Foley Catheter intact & draining @ bedside. Open collar (in place). Repositioned for comfort. Call light within reach. SR ↑ x3. —— Mary Cheatham, LPN
4/30/06	6pm	VS- 96°. 79. 16. 140/89. Resident in bed @ 30°. Poor intake noted. Assistance per staff provided c meals. Kept clean per staff. Foley Catheter intact & draining @ bedside. SR ↑ x3 for safety. —— Mary Cheatham LPN
5/1/06	4Am	B/P 142/90 T 97.2 P 78 R 20. Resident presently asleep in bed. HOB ↑. Respirations even & unlabored. Foley catheter patent & intact to BSD c dark amber urine. NO S/S of distress noted. —— P. Overton LPN
5/1/06	9:30/A	96.8 140/78 96 20. Residents intake is very poor. Perjactin not eff. Ø ↑ in appetite noted. LDA to MD office via Pal. Ambulance Assist
5/1/06	12:30/p	Returned from MD office. New orders received to DC collars - No further follow up needed. Foley @ BSD c yellow urine noted. No C/O pain or discomfort. —— D Austin LPN
5/1/06	8:30 pm	BP 118/77 P 82 R 20 T 97.7. Resting quietly in bed noted no C/O. Foley intact to BSD c dk straw colored urine noted. Cont to tolerate po fds well. Fed per staff ate 20%. Total staff (A) for ADL's. non participation in self care. NO SOB noted. HOB ↑. NO noted functional & cognitive ΔS's. Will cont to monitor. —— P Overton
5/2/06	1pm	V/S: 110/84 - 69 - 18 - 97.1. Foley draining sl. dark yellow urine. Resting quietly & present c no signs & acute distress —— K. Bagwell

Pt. Name Peterson, William Pt. Number 1050

Physician NRGLM Month May/April

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NURSES NOTES

DATE	TIME	
5/2/06	8 00 A	Dr. TV to (R) heel area per — gsmarr
5/2/06	10 25 A	Resident ate 40% of bfast, fed per staff c̄
97/60 57	18	much encouragement needed. Therapy conts
	98 2	to do wound care. Foley @ BSD c̄ dark
		yellow urine noted. No c/o pain or discomfort. [illegible]
5/2/06	2:15P	Cut + trimmed finger + toe nails, will cont to
		monitor ——— [illegible]
5/2/06	5 00 pm	Rec'd order per Dr Nicholson: PT to culture wound
		to (L) hip. Order noted ——— P Dunnlap
5/2/06	8 45 pm	BP 108/76 P68 R18 T97 4. Alert c̄ confusion. Foley
		intact to BSD c̄ dk. amber colored urine. Continues
		to tolerate po flds well. Turned + repositioned by staff.
		2+ edema noted to (B) feet, unable to ↑ feet due to
		contractures at knees. No cognitive Δ's noted, does
		respond appropriately to direct question, does follow
		simple directions c̄ verbal cueing. Voiced no c/o pain
		or discomfort. No acute distress noted. Will cont to
		monitor. ——— P Dunnlap
5/03/06	12 45 A	Resting quietly, eyes closed. FC patent
		and intact c̄ amber urine to BSD. No
		c/o's voiced. No noted distress. Call light
		within reach. V.S. 95.0-57-18 103/57
		[illegible]
5/3/06	10Am	Resident up in bed c̄ positioner in place.
96.3 78/53	52	Tx done per therapy. Wound will be cultured
	18	in AM. Edema contd to ↓ exts. Alert c̄ confusion
		noted. No c/o pain or discomfort. Has foley
		@ BSD c̄ dark urine noted. ——— D Smith [illegible]
5/3/06		BP 98/60 P50 R17 T97 2, Alert resting in bed quietly
		Staff (A) c̄ turning / repositioning. Remains off (L)
		side, repositioned on (Rt) side or back. Foley to BSD c̄
		yellow colored urine. Tolerating po flds s̄ difficulty.
		No noted functional / cognitive Δs ——— P Dunnlap

Pt. Name Peterson William Pt. Number 1050
Physician NR [illegible] Month April - May
Room Number 2140 Year 2006

GP-136T (Rev. 1(

NURSES NOTES

DATE	TIME	
5/4/06	1Am	B/P 120/66 T97 P60 R18. Resident presently asleep in bed.
		HOB↑. Respirations even & unlabored. Skin warm and
		dry to touch. Turned & positioned from back to Rt. side
		Only. Foley catheter patent and intact to BSD c̄ clear
		yellow urine. No S/S of acute distress noted. — P. Overton LPN
5/4/06	8^10 A	(R) heel blanching cont to monitor daily - J[illegible]
5/4/06	10^45 am	res T & P q 2 hrs in bed (Bk to Rt side) & Re uses wedg
B/P	110/66	to LE to help prev contractures in bed.
P-	64	Res seen by PT Dept - See notes.
R-	18	Inc of Bowels - incont care prov. daily.
T-	97.4	Has foley cath to BSD intact c̄ yellow
		urine noted. Ø S&S of UTI problems
		or noted. See Tx book & Body audit
		Sheet for skin condition. SR ↑ x 2 as
		enablers. HOB ↑. Ø c/o pain/disc noted
		@ present — [illegible] Wilkinson
5/4/06	5^30 pm	BP 101/54 P51 R18 T 97.6. Foley cont. to BSD c̄ dk straw
		colored urine. Fed per staff appetite fair. Drinks
		liquids through straw s̄ difficulty. Turned + repositioned
		by staff, remains off (Lt) side. No acute distress noted.
		No noted functional or cognitive Δ's. Will cont to monitor
		— P. Overton LPN
5/5/06	2^15 AM	In bed Resting peacefully. HOB↑
		Resp even / unlabored. Turn & reposition
		per staff. Foley cath intact to BSD c̄
		yellow urine noted - VS 96-51-18-99/51 - [illegible]
5/5/06	10^25 A	97 60 20 122/70. Resident in bed c̄ positioner
		in place. Foley @ BSD c̄ dark urine noted. Remains
		off Lt side. Appetite conts to be poor, periactin
		has been ordered. Will monitor. D Smith LPN
5/5/06	6pm	Resident in bed this pm, took po meds s̄
B/P 114/70	P 68	any problems. Foley @ BSD c̄ dark urine noted.
T 98	R 20	No S/S of pain noted. Appetite poor. D Smith LPN

Pt. Name Peterson William　　Pt. Number 1050

Physician NRGCM　　Month April - May

Room Number 2140　　Year 2006

NURSES NOTES

DATE	TIME	
5/6/06	1Am	B/P 98/46 T 96.8 P 68 R 18. Resident resting quietly in bed. HOB ↑. Respirations even & unlabored. Skin warm & dry to touch. Turned & repositioned from back to Rt. side only per staff. Foley catheter patent and intact to BSD & dark amber urine. No S/S of acute distress. — P. Overton LPN
5-6-06 T 96.0 R 17	10:40 am P 78 BP 122/63	Resident is awake in bed, resp. even & unlabored. Foley catheter patent & intact to BSD & amber urine noted. Skin warm & dry to touch. All needs met per staff. Call light in reach. — C. Watkins RN
5/6/06	9pm	B/P 136/62 T 97.4 P 64 R 18. Resident lying in bed awake & much confusion. "I Need some gas for my truck to go to work". Accepted meds well. Will continue to monitor. — P. Overton LPN
5/7/06	2Am	B/P 138/70 T 97.1 P 68 R 20. Resident presently asleep in bed. HOB ↑. Respirations even & unlabored. Turned & repositioned by staff. Foley catheter remains patent and intact to BSD & dark amber urine. No S/S of acute distress Noted. — P. Overton LPN
5/7/06	9:30 Am	VS - 96.3. 78. 17. 132/64. Resident in bed @ 30°. Kept clean & dry per staff. Incontinent of BM's. Foley Catheter (intact + draining @ bedside). Respirations even & unlabored. Skin w/o to touch. — M. Cheatham LPN
5/7/06	5pm	VS - 96.8. 80. 18. 105/62. Resident in bed. Repositioned for comfort. Kept clean & dry per staff. No acute distress noted. Respirations even & unlabored. Denies discomfort @ this time. Foley Catheter in place & draining @ bedside). — Mary Cheatham LPN
5/8/06	1Am	B/P 110/70 T 97.1 P 64 R 20. Resident is very confused tonight very restless. This writer stayed & resident for a while to help him settle down. Foley catheter patent and intact to BSD & dark amber urine & thick sediment. Will continue to monitor. — P. Overton LPN

Pt. Name Peterson William Pt. Number 1050

Physician NRGlm Month May

Room Number 214D Year 2006

NURSES NOTES

DATE	TIME	
5/8/06	10¹⁰/A	Resident more alert, talkative but c̄ confusion
121/64	88 97⁶	Says "I'm going to Mims funeral Home" Foley
	18	@ BSD c̄ dark amber urine noted c̄ heavy
		sediment also. Fluids are being accepted
		fairly good by resident. MRSA noted in Lt
		hip wound. Culture results faxed to MD D Smith LPN
5/8/06	9³⁰pm	BP 103/62 P63 R18 T 97². Foley intact to BSD c̄ thick amber
		colored urine c̄ sediments noted. Turned + repositioned by
		staff, remains off (L) hip. Poor intake of food. 160cc po
		fluids. resident restless at present time attempting to turn
		in bed, pulling at brief. No acute distress noted, no SOB,
		HOB↑ Denies pain/discomfort. No noted cognitive or functional
		Δ's will cont to monitor. P Quill
5/9/06	1A	Resting quietly in bed. No c/o's voiced no
		noted distress 96-64-18 116/74. [illegible]
5/9/06	10Am	Up in bed per staff c̄ positioner intact
100/72	76 18	Foley @ BSD c̄ dark amber urine c̄ sediment
	97⁸	noted. Poor intake conts, accepts fluids OK.
		No c/o pain or discomfort. Therapy conts
		to do wound care to Lt hip. Will monitor.
		Does not feed self at this time. D Smith LPN
5/9/06	10²⁰pm	BP 103/59 P 55 R18 T 98³. No noted functional or cognitive
		Δ's. Foley conts at BSC c̄ dk amber urine c̄ sediments
		present. Turned + repositioned per staff, remains off
		(L) hip, denies any pain/discomfort this shift. Will
		cont to monitor P Quill LPN
5/10/06	2AM	Resident quietly in bed. Ø c/o voiced
		Ø distress noted. VS 97-60-15-124/76 [illegible]
5/10/06	10⁴⁵/A	Resident up in bed per staff this AM, conts
103/58	16 76	to have poor intake. Foley @ BSD c̄ amber
97⁸		urine + sediment noted. No c/o or s/s of pain D Smith LPN

Pt. Name Peterson William

Pt. Number 1056

Physician NRGLM

Month May

Room Number 214D

Year 2006

NURSES NOTES

DATE	TIME	
5/10/06	530pm	In bed, slow to respond, but verbal. Daughter visited earlier. Only accepted 60cc Novasource this afternoon. Poor P.O. intake Rec Periactin to enhance appetite. No noted effectiveness. Fed by staff. Staff anticipates + meets all needs. Has patent foley c̄ dark urine c̄ much sediment. Res states "I'm tired, ready to go home." Univ. Precaut maintained – MRSA to hip wound. Heel wound healed. On alt pres. mattress with anti-contracture wedge to LE – Both LE contracted severely. No c/o or gesture of pain/discomfort. I+O monitored. Will attempt to ↑ PO fluids/intake. MD + family aware of poor intake & wt loss. Is still seen by PT for wound care as outlined in their P/C. Nonambulatory. OOB to GCR as tolerated – bedfast @ this time. VS 94³ 97/60 76-17 Dykes
5/11/06	1Am	B/P 106/62 T97.¹ P68 R20. Resident presently asleep In bed. HOB↑. Respirations even & unlabored. Requires extensive assistance c̄ ADL's. Foley catheter patent and Intact to BSD c̄ dark urine c̄ thick sediment. Turned & positioned per staff. Will continue to monitor. P. Quenton LPN
5/11/06	9Am	Resident in bed this AM. Up in bed for bfast, very poor intake c̄ food & fluids. Foley @ BSD c̄ amber urine & sediment noted. Contracture wedge to ↓ exts. Feet are very edematous. No c/o or s/s of pain D Antt LPN
5/11/06	2p	V/S 12?/64-89-17-97.7 Poor intake. Speech visit ate applesauce. Dietary aware to send applesauce c̄ each meal — SWhedbee

Pt. Name Peterson, William Pt. Number 1056

Physician NRGLM Month

Room Number 24D Year

GP-136T (Rev. 1(

NURSES NOTES

DATE	TIME	
5-11-06	8p	98.6 - 114/64 - 56 - 21 - In bed SR↑ x 2 - alert c̄ confusion - foley patent draining dark urine to BSB - total assist c̄ ADL'S - po fluids encouraged - Ø c/o pain or SOB — D. McCall
5/12/06	10 1/2p	V/S: 187/83 - 60 - 18 - 97.7. Foley intact, draining dark colored urine (yellow). No acute distress noted c̄ this time. — D. Byrdsong
5/12/06		VS 97.9 80 20 138/80 Resident in bed resting quietly c̄ eyes open. HOB↑ Tolerated morning meds Ø any problems. Ø distress noted. Foley cath intact & draining well. Skin w/o. No complaints voiced. SR↑x2. Call light within reach — Wilson LPN
5/12/06	6pm	Resident in bed resting quietly. HOB ↑. Turn / reposition per staff. Foley intact and patent. Use 2° prostate enlargement. Ø c/o voiced. VS 96.9 - 19 - 55 155/80 — SQ
5/13/06	1 30/p	V/S: 137/65 - 67 - 18 - 97.3. Foley intact draining dark yellow urine. Resident cool to touch, but not calmy. No SOB, resp unlabored. Fluids offered taken well, but slowly. — D. Byrdsong
5/14/06	9 30 Am	VS - 97.80.20.128/82. Resident in bed @ 30°. Ø acute distress noted. Respirations even + unlabored. Alert c̄ confusion. Continues to spit out on floor. Repositioned to maintain skin integrity. Poor intake noted. Foley Catheter intact + draining @ bedside — Mary Cheatham, LPN

Pt. Name Peterson William
Pt. Number 1050
Physician NRGLM
Month May
Room Number 214D
Year 2006

NURSES NOTES

DATE	TIME	
5/13/06	5:25 pm	VS-96°. 71.17. 98/62. Resident in bed @ 45°. Fluids encouraged. Foley Catheter intact & draining @ bedside. Resting quietly. Eyes closed. Kept clean per staff. Ø c/o & s/s of discomfort noted. — Mary Cheatham LPN
5/14/06	2 AM	B/P 102/70 T97 P68 R30. Resident presently asleep in bed. HOBT. Respirations even & unlabored. Foley Catheter patent and intact to BSD & dark, thick, yellow Urine. Turned and positioned per staff. Takes fluids & much encouragement will continue to monitor. — Pam Overton LPN
5/14/06	10:25 Am	VS 64.14.168. Resident lying in bed resting quietly Ø acute distress accepted po meds in applesauce. Foley Catheter intact & draining @ bedside cloudy urine. Kept clean & dry per staff. — M. Cheatham LPN
5/14/06	4pm	VS- 91.8 (ax) 54. 12. 120/70. Resident very cool to touch. Ø pupillary response noted: Respirations slow & shallow. Alert & Confusion. Foley Catheter intact & draining cloudy urine. Repositioned for comfort. warmth applied to skin to promote circulation (blankets), Capillary refill extremely sluggish. Ø intake noted Ø meds accepted @ this time. — Mary Cheatham LPN
5/14/06	11Pm	Resident resting in bed & eyes slightly cracked, glazed and dilated. Upper and lower extremities are very cold to touch, blankets placed on resident to promote warmth and circulation Also having periods of apnea 2-3 seconds. O2-2LPM via NC to aid & respirations. Comfort measures provided. Will continue to monitor. — P. Overton LPN
5/15/06	1:30Am	B/P 93/70 T94 P60 R16. Resident lying in bed & eyes open, glazed & dilated. Resident found to be "reaching" in the air at one time. HOBT. O2-2LPM via NC continues to have periods of apnea 2-3 seconds. Foley Catheter patent and intact to BSD & thick dark cloudy urine. No intake, unable to accept p.o. meds or fluids. Upper & lower extremities remain cold. Comfort measures provided. Will continue to monitor. — P. Overton LPN

Pt. Name Peterson William Pt. Number 1050

Physician NRCLM Month May

Room Number 214D Year 2006

NURSES NOTES

DATE	TIME	
5/15/06	8 AM	lying in bed on back, slow to respond, non-verbal. Opens eyes and responding to physical stimuli. NO SOB noted — HOB ↑, O2 at 2L/m via NC intact. Foley to BSDC drk amber urine, 120cc present. Unable to drink, eat or swallows. will not open mouth. Skin cool to touch. No acute distress noted at this time. Will cont to monitor — P. Dunnlp
5/15/06	11:45 AM	Attempted to contact RP Mary Peterson no answer at phone # given. Also attempted to contact alternate family members listed Belinda Butler + Patricia Peterson c no answer. Will try at later time — P Dunnlp
5/15/06	12:20 pm	Rec'd call from Mary Peterson informed of resident's current condition. — P Dunnlp
5/15/06	1:45 pm	Resident awake/restless continuously shuffling & moving extremeties. Moans when touched, eyes opened & no distress noted. Called Dr Rainsfords Office spoke to nurse Donna. Requesting med to manage anxiety. Awaiting return call. Family present in room — P Dunnlp
5/15/06	2:45 pm	Family called Dr Rainsford and stated to this writer. "the doctor said for you to send daddy to the ER at Aiken Hospital, the Dr will call you." Did not rec call from Dr. Rainsford, called Dr Rainsford's office spoke c nurse Donna was informed by nurse Donna "Dr Rainsford did not advise family to send resident to hospital instead told family if it was their desire the family could take him to the hospital" Resident is DNR status. Explained conversation to family members's B. Butler Patricia Peterson and Mary P. Peterson. regarding call to Dr Rainsford's office. All family members present ≈ 15 all "insisted" that resident be transferred to Aiken ER. "Ms P. Peterson stated "you can call the ambulance or we will" Family again reminded transfer was AMA, cont'd to

Pt. Name Peterson William Pt. Number 1050

Physician NRDLM Month May

Room Number 214D Year 2006

NURSES NOTES

DATE	TIME	
5/15/06	2:45 pm	insist EMS be called. N. McCorkle lpn contacted 911 for transport to Aiken Hosp ER per insistence of family.
5/15/06	3:45 pm	Resident transported via EMS to Aiken Hosp. Transportation to Hosp was not recommended by Dr Rainsford. transported per family insistance against medical advise. — P Dunaly
5/15/06	9:00 pm	Called Aiken ER - Hosp to contact facility upon decision to admit or transfer back to facility — P Dunaly
5/25/06	2:00P	Res DC'd to ARMC, family aware & states they will pk up personal belongings, meds returned to RPS, all paperwork complete; — J Coleman RN

Pt. Name Peterson William
Pt. Number 1050
Physician NBGlm
Month May
Room Number 214D
Year 2006

NURSES NOTES

DATE	TIME	

Pt. Name Peterson William Pt. Number 1050

Physician NRGLM Month May

Room Number 214D Year 2006

ONTHLY NU SING REVIE

Month/Year	May 06		

001. Functional Communication

1 = Communicates without difficulty			
2 = Communicates, but requires extra time or assistance	✓		
3 = Communicates only basic needs			
4 = Communication is nonfunctional for expression of basic needs			
5 = Does not communicate			
6 = Cannot determine			

002. Vision

1 = Adequate in most situations	✓		
2 = Impaired -- supervision or assistance is not needed			
3 = Impaired -- supervision or assistance is required			
4 = Cannot determine			
5 = Wears glasses			

003. Hearing

1 = Hears speech at regular conversational levels	✓		
2 = Hears speech at regular conversational levels but may have difficulty hearing in noisy situations			
3 = Lip-reads or relies on other cues			
4 = Misses most conversation even when lip-reading or using other cues			
5 = Hearing cannot be used for communication			
6 = Wears hearing aide/aides			

004. Orientation / Memory

1 = Capable of functioning independently in his/her environment. Can be occasionally forgetful			
2 = Requires daily intervention from staff	✓		
3 = Complete disorientation or incoherence			
4 = Undetermined (Does not include recipients who speak another language or are non-verbal)			

005. Consciousness Level

1 = Conscious -- responsive, may be listless or lethargic, but is aware of surroundings	✓		
2 = Semi-conscious -- unaware of surroundings, but reacts to sensory stimuli			
3 = Comatose -- unresponsive to any stimuli			

006. Verbal Aggression

0 = Non reported or exhibited	✓		
1 = Requires immediate staff intervention one to four days per month, but not weekly			
2 = Requires immediate staff intervention one to six days per week			
3 = Requires staff intervention once a day or more			

007. Other disruptive acts (describe in Summary responses to #1, 2, or 3)

0 = Non reported or exhibited	✓		
1 = Requires immediate staff intervention one to four days per month, but not weekly			
2 = Requires immediate staff intervention one to six days per week			
3 = Requires staff intervention once a day or more			

Month/Year	May 06		

008. Elopement (Has wandered outside of facility this month)

0 = None reported of exhibited	✓		
1 = Requires immediate staff intervention one to four days per month			
2 = Requires staff intervention once a day or more, specify times ________			
3 = If resident has eloped this month, document in comment section			

009. Eating

1 = Independent (may require tray set-up)			
2 = Intermittent assistance; requires verbal or physical assistance less than 60% of the time			
3 = Requires assistance to spoon feed for 60% or more of the time	✓		
4 = Receives non-oral feeding for 60% or more of the recipient's nutrition (GT or NGT)			

010. Enteral Feeding (GT or NGT)

0 = Not receiving	✓		
1 = Less than once per week (bolus PRN)			
2 = One to six times per week (bolus PRN)			
3 = Once per day			
4 = Two times per day			
5 = Three to six times per day			
6 = Every two hours			
7 = Continuous via a pump			

011. Dressing / Grooming

1 = Dresses and grooms independently			
2 = Requires frequent, but not constant, one-to-one hands-on assistance			
3 = Requires continuous one-to-one assistance and supervision			
4 = The recipient does not participate in the dressing/grooming process	✓		

012. Transferring

1 = Independent, but recipient may use equipment			
2 = Recipient requires PRN assistance for transfers			
3 = One to transfer			
4 = Two to transfer (uses mechanical lift)	✓		
5 = Not transferred			

013. Turning / Positioning

0 = Not receiving (turns self independently)			
1 = Requires staff to turn and reposition	✓		
2 = Staff turns and reposition every 2 hours	✓		

RESIDENT	PHYSICIAN	ROOM NO.	MEDICAL RECORD NO.
Peterson, William	[illegible]	[illegible]	072

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 072

GP-MNR (Rev. 08/05)

014. Mobility: Ambulation/Wheelchair (Specify & circle type of mobility)

1 = Walks with no hands-on assistance. Recipient may require mechanical devices			
2 = Requires assistance for difficult parts of walking			
3 = Requires one-to-one assistance during the entire activity			
4 = Requires two-to-one assistance during the entire activity			
5 = Wheels self except for difficult maneuvers			
6 = Is wheeled, one-to-one assistance during the entire activity and maneuvers	✓		
7 = Is bedfast except for transfers to bath			

015. Contractures (Specify limbs)

0 = None			
1 = One extremity (limb) affected			
2 = Two extremities (limbs) affected	✓		
3 = Three extremities (limbs) affected			
4 = Four extremities (limbs) affected			

016. Toileting

1 = Independent, may require special equipment			
2 = Requires assistance but can be left alone for privacy			
3 = Requires physical or verbal assistance or supervision, excluding incontinent care, and cannot be left alone			
4 = Incontinent or has an indwelling catheter, specify which	✓		
5 = Documented toileting at least every 2 hrs. while awake			
6 = In and out catheterization by the staff two or more times each day			

017. Bladder Control

1 = Continent			
2 = Incontinent three times a day or less			
3 = Incontinent only at night			
4 = Incontinent four or more times in a 24-hour period includes external catheters, ostomies			
5 = Requires indwelling catheter or intermittent catheterization	✓		

018. Bowel Control

1 = Continent			
2 = Has an ostomy and is independent with its care			
3 = Incontinent one to three times per week			
4 = Incontinent four or more times per week	✓		
5 = Requires assistance with an ostomy, includes nursing care or teaching self-care			

019. Urinary Tract Infection within the last 30 days

0 = No	✓		
1 = If yes, what treatment was given?			

020. Intake and Output (State reason for I & O)

0 = Not receiving	✓		
1 = Recorded each shift			
2 = Record intake only each shift			
3 = Record output only each shift			

021. Restorative Nursing

0 = Not receiving	✓		
1 = Yes, careplanned as:			
1a = Bowel/Bladder retraining			
1b = Mobility/Ambulation			
1c = Eating/Dining			
1d = Other:			

022. Oral / Nasal Suctioning

0 = Not receiving	✓		
1 = Receiving every shift and prn			
2 = Other, state average times per day ________			

023. Tracheostomy Care

0 = Not receiving	✓		
1 = Receiving every shift and prn			
2 = Other, state average times per day ________			

024. Oxygen Administration

0 = Not receiving	✓		
1 = Receiving on a prn basis			
2 = Receiving nightly			
3 = Receiving continuously			
4 = Other, state average time used ________			

025. Renal Dialysis

0 = Not receiving	✓		
1 = Receiving ________ times per week			

026. Hemiplegia / Paraplegia / Quadriplegia (Specify)

0 = No	✓		
1 = Yes			

027. Recent Fracture (within last 3 mo.)

0 = No	✓		
1 = Yes			

028. Recent Amputation (within last 6 mo.)

0 = No	✓		
1 = Yes			

029. Therapy (PT, OT, ST)

0 = No			
1 = Yes, specify what therapy	✓		

030. Braces / Splints / Prostheses (Specify)

0 = Not receiving	✓		
1 = Worn daily	X		
2 = Worn two times per day			
3 = Worn each shift	X		
4 = Worn as ordered	X		

RESIDENT	PHYSICIAN	ROOM NO	MEDICAL RECORD NO.
Peterson, William TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 073			

031. Pressure Ulcer Staging (List number of each stage)

0 = None noted
1 = Stage I
2 = Stage II
3 = Stage III
4 = Stage IV

032. Pressure Ulcer / Stasis Ulcer Care

0 = No
1 = Yes, dressing orders as: _____

033. Internal Bleeding within the last 30 days

0 = No
1 = Yes, list signs and symptoms of internal bleeding

034. Seizures within the last 30 days

0 = No seizure disorder
1 = No seizure occurred
2 = If seizure disorder, on medication?
List medication:
3 = If on medication, lab work ordered?

035. Dyspnea

0 = None noted or reported
1 = Occurs with physical activity, such as walking or climbing stairs
2 = Occurs with physical activity, such as shaving, dressing or bathing
3 = Occurs at rest in any position

036. Edema

0 = None noted or reported
1 = Pedal and/or lower extremities edema, 1 to 2+
2 = Generalized edema of 3+ or greater
3 = Currently receiving a diuretic

037. Tremors

0 = None noted or only slight tremors
1 = Tremors interfere with functioning, intermittent supervision required
2 = Tremors interfere with functioning so that the recipient requires constant supervision

038. Terminal Illness

0 = No
1 = Yes
3 = Hospice program or facility terminal care (specify)

039. Pain Level within the last 30 days

1 = No pain
2 = Pain less than daily
3 = Pain daily
4 = If medicated and continues to rate high on the pain scale, complete a pain assessment

040. Use of siderails

0 = Not used
1 = Yes, specify why and how used:
*Document in Comments section

041. Physical or Chemical Restraint (Specify)

0 = Not used
1 = Yes, specify why and how used:
*Document in Comments section

042. Hospitalized within the last 30 days

0 = Not used
1 = Yes, specify reason for hospitalization:
*Document in Comments section

043. Did resident fall within the last 30 days

0 = Not used
1 = Yes, specify actions implemented in the care plan:
*Document in Comments section

044. Has there been a weight loss or gain > 5 lbs. this month?

0 = No
1 = Yes, specify actions implemented in the care plan:
*Document in Comments section

045. Abnormal Lab Values

0 = No
1 = Yes
*Document in Comments section

046. Medication changes

0 = No changes
1 = Yes
*Document in Comments section

First Monthly Summary Review:

Comments (address any new concerns or health problems, plan of action, and progress, new orders or medications, abnormal labs, PAR meeting outcomes and interventions):

PT does Stage IV wound Care, Culture grew MRSA
SR↑ X2 as Enablers
Edema to ↓ exts 2+ - Wt ↑ 5 pounds

Resp. Party Contacted: Mary Peterson
Nurse signature: Doshia Smith LPN
Date and Time: 5/10/06 2pm
Date: 5/10/06

Second Monthly Summary Review:

Comments (address any new concerns or health problems, plan of action, and progress, new orders or medications, abnormal labs, PAR meeting outcomes and interventions):

Resp. Party Contacted:
Nurse signature:
Date and Time:
Date:

Third Monthly Summary Review:

Comments (address any new concerns or health problems, plan of action, and progress, new orders or medications, abnormal labs, PAR meeting outcomes and interventions):

Resp. Party Contacted:
Nurse signature:
Date and Time:
Date:

RESIDENT	PHYSICIAN	ROOM NO.	MEDICAL RECORD NO.
W Peterson, William			

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 075

T.P.R. CHART

Ht 70"

DATE	T	P	R	B/P	WEIGHT	DATE	T	P	R	B/P	WEIGHT
3/21/06	99°	63	22	131/76	164						
3/23/06					165 mks						
3-28-06					162 cc						
4-3-06	98.1	70	20	118/68	156 lbs						
4-4-06					156 lbs						
4-13-06					152 lbs						
4-18-06					150 lbs						
4-25-06					147 cc						
5-1-06	98.2	60	16	98/60	152 cc						
5-4-06		Nemenji			149						
5-9-06					147						

RESIDENT	PHYSICIAN	ROOM NO.	ADMISSION NO.
Peterson, William	NP6Lm	P214W	1050

3 HORIZONTAL MOUNT

2 HORIZONTAL MOUNT

REMOVE TAPES

PLACE EDGE OF FORM AGAINST BROKEN LINE AND PRESS FIRMLY.

1 VERTICAL MOUNT

Faxed 3-31-06 DD

2 VERTICAL MOUNT

3 VERTICAL MOUNT

EDGEFIELD COUNTY HOSPITAL
300 RIDGE MEDICAL PLAZA
EDGEFIELD, SC 29824
(803) 637-3174

URINALYSIS

Peterson William
DOB 3/11/22
O/P Peach

REQUESTED BY: DATE: TIME:	ORDERING PHYSICIAN: Massey	
GLUCOSE (NEG): neg	MICROSCOPIC:	☐ RANDOM COLLECTION
BILIRUBIN (NEG): neg	WBC/HPF:	☐ MID-STREAM COLLECTION
KETONE (NEG): neg	RBC/HPF: 0-3	☑ CATH COLLECTION Foley
SP. GRAVITY (1.010-1.030): 1.020	CASTS/LPF: 0-3 RBC cast	
pH (5.0-7.0): 5.0	MUCOUS:	
PROTEIN (NEG): 2+	EPITHELIAL CELLS:	☐ REDUCING SUBSTANCE:
UROBILINOGEN (0.2-1.0): 1.0	BACTERIA many cocci	☐ ICLOTEST:
NITRATE (NEG): neg	CRYSTALS:	☐ ACETEST:
BLOOD (NEG): TR	OTHER:	☑ 3% SSA: 2+
LEUKOCYTES (NEG): neg		
COLOR/APPEARANCE: yellow hazy	☐ PREGNANCY	
DATE COLLECTED: TIME COLLECTED:	TECH / DATE TESTED	TIME TESTED / TECH mml

Viewed by & faxed to Dr Massey 3/30/06

'06 MAR 30 16:16

HUAIS 9

CHART COPY

LABORATORY

LABORATORY

AUGUSTA, GEORGIA 30909

( ) 722-1046

-599 MD

S.C. ...LINE, M.D.
...al Director

PATIENT INFORMATION

PATIENT ID: DP

PATIENT NAME: PETERSON, WILLIAM

AGE: 84 [redacted] M

LABORATORY NUMBER: 7117387

DATE DRAWN - TIME: 03/31/2006 11:34

DATE RECEIVED - TIME: 04/01/2006 11:00

DATE REPORTED: 04/07/2006 12:04

ACCOUNT INFORMATION

EDGEFIELD CO. HOSPITAL
P O BOX 590
EDGEFIELD, SC 29824

ATTN: DR. MASSEY
BT# 000 4 RT# 250

TMH&R / Dr. Massey

STATUS	FINAL	TEST	RESULT IN RANGE	RESULT OUT OF RANGE	REFERENCE RANGE	UNITS

AEROBIC/ANAEROBIC BLOOD CULTURE
REPORT STATUS: FINAL
SOURCE: BLOOD (NO SITE GIVEN)

NO AEROBIC OR ANAEROBIC GROWTH

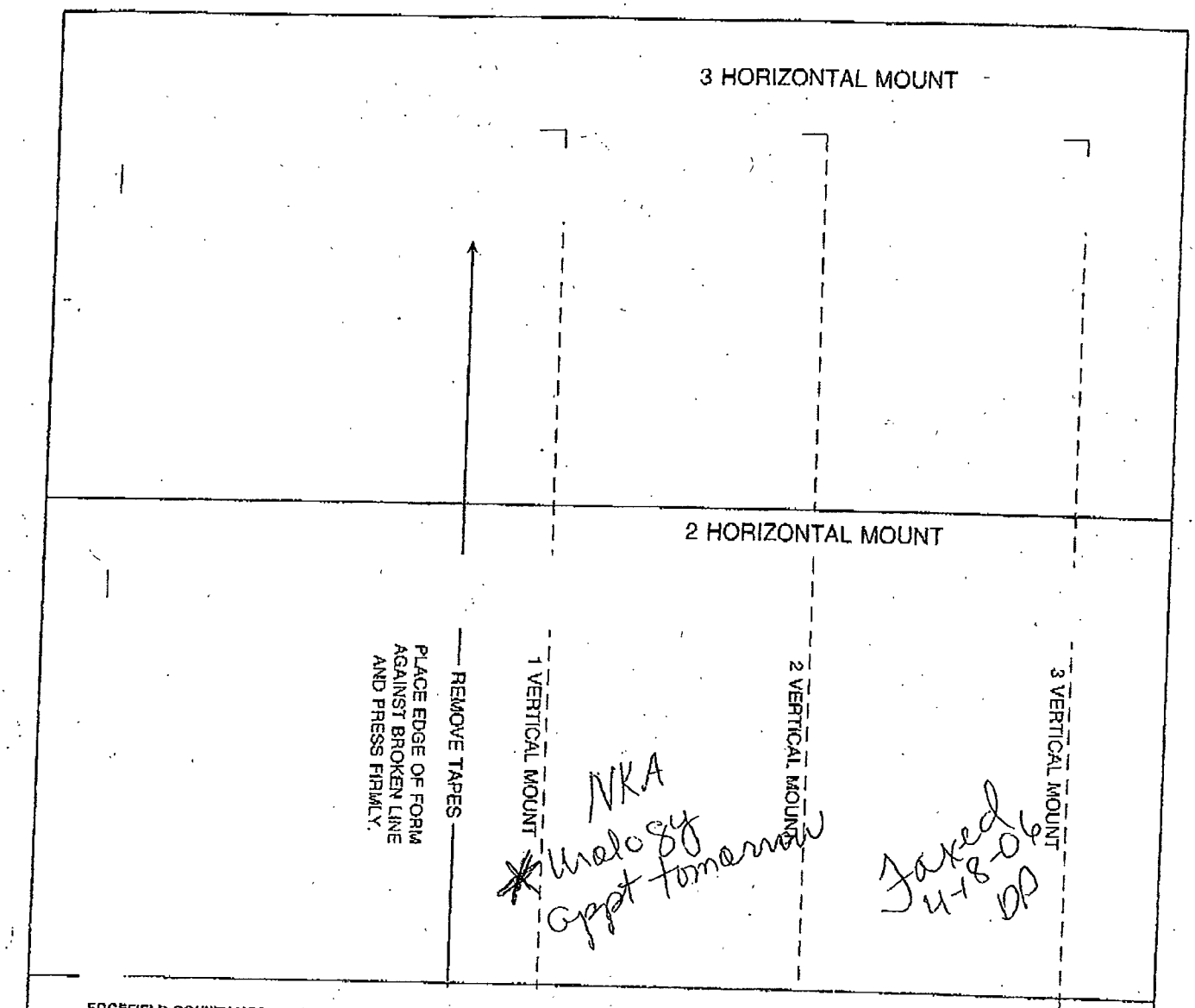
PLEASE NOTE: SPECIMEN QUANTITY APPEARS TO BE SUBOPTIMAL.
FOR ADULT BLOOD CULTURE ADD 5-10 ML OF BLOOD TO EACH AEROBIC
AND ANAEROBIC BOTTLES.

*** FINAL REPORT ***

Faxed 4-7-06 DD

Seen per MD

TMH&R of Edgefield 03/21/2006 - 05/25/2006 - 078



EDGEFIELD COUNTY HOSPITAL
300 RIDGE MEDICAL PLAZA
EDGEFIELD, SC 29824
(803) 637-3174

URINALYSIS

Peterson, William
DOB: 3-11-1922
MR # 32912
TMHR

REQUESTED BY: | DATE: | TIME: | ORDERING PHYSICIAN: Seaphast

GLUCOSE (NEG): Negative	MICROSCOPIC
BILIRUBIN (NEG): Negative	WBC/HPF: 2
KETONE (NEG): Negative	RBC/HPF: 3
SP. GRAVITY (1.010-1.030): ≥1.030	CASTS/LPF:
pH (5.0-7.0): 5.0	MUCOUS:
PROTEIN (NEG):	EPITHELIAL CELLS: 2
UROBILINOGEN (0.2-1.0): 0.2	BACTERIA: occ
NITRATE (NEG): Negative	CRYSTALS: Ca oxalate &
BLOOD (NEG): Negative	OTHER: many uric acid
LEUKOCYTES (NEG): Negative	
COLOR/APPEARANCE: yellow/cloudy	☐ PREGNANCY

☒ RANDOM COLLECTION
☐ MID-STREAM COLLECTION
☐ CATH COLLECTION

☐ REDUCING SUBSTANCE:
☐ ICLOTEST:
☐ ACETEST: APR 18 7:24
☐ 3% SSA:

DATE COLLECTED: | TIME COLLECTED: | TECH | DATE TESTED | TIME TESTED | TECH

CHART COPY

MULLINS PATHOLOGY and CYTOLOGY LABORATORY
1520 NORTH LEG ROAD
AUGUSTA, GEORGIA 30909

(706) 722-1846

S.C. MULLINS, M.D.
Laboratory Director

TRINITY MISSION HEATH & REH
226 W A REEL DR
EDGEFIELD, SC 29824

PATIENT NAME: PETERSON,WILLIAM
PATIENT SEX: MALE
PATIENT AGE: 84 [redacted]
PATIENT ID:
COLLECTED: 04/18/2006 3:15 AM EDT

REPORTED: 04/18/2006 4:00 PM
ACCESSION: A887775

RECEIVED: 04/18/2006 1:34 PM
REQST PHYS: LEAPHART

-- TEST --	-- RESULTS --		-- NORMALS --
COMPLETE BLOOD COUNT			
WBC	8.0		4.8-10.8 K/uL
RBC	4.07	(L)	4.7-6.1 MILL/uL
HGB	11.6	(L)	14.0-18.0 G/DL
HCT	35.8	(L)	42.0-52.0 %
MCV	87.9		80-100 FL
MCH	28.6		27-33 PG
MCHC	32.5		30-36 G/DL
PLATELET COUNT	431		150-450 K/uL
BASIC METABOLIC PANEL			
GLUCOSE	90		70-110 MG/DL
BUN	32	(H)	5-25 MG/DL
CREATININE	1.5		0-1.5 MG/DL
SODIUM	144		135-145 MEQ/L
POTASSIUM	4.7		3.5-5.5 MEQ/L
CHLORIDE	108		95-110 MEQ/L
CO2	24		22-33 MEQ/L
CALCIUM	8.7		8.5-10.5 MG/DL
BUN/CREATININE	21.3		
ANION GAP	16.7		
OSMOLALITY	304		

*** FINAL REPORT ***

Silvenite daily
Prostat 101 30cc TID.

Faxed
4-19-06
DA

Z119563 TRINITY MISSION HEATH & REH
226 W A REEL DR
PETERSON,WILLIAM 05/04/2006 14:00 EDGEFIELD, SC 29824

84 [redacted] M 05/05/2006 14:10

05/07/2006 16:00 ATTN: DR. MASSEY
BT# 000 1 RT# 250

ROUTINE (AEROBIC) WOUND CULTURE
REPORT STATUS: FINAL
SOURCE: LEFT HIP

HEAVY GROWTH OF METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS
HEAVY GROWTH OF ENTEROCOCCUS FAECALIS

	S.AUREUS		E. FAECALIS	
AMPICILLIN			2	S
AMP/SULBACTAM	<=4/2	R		
CEFAZOLIN	<=2	R		
CIPROFLOXACIN	>2	R		
CIPROFLOXACIN*			2	I
CLINDAMYCIN	>2	R		
ERYTHROMYCIN	>4	R	>4	R
GENTAMICIN	<=1	S		
METH / OXACILLIN	>2	R		
RIFAMPIN	<=1	S		
PENICILLIN G	>8	R	2	S
TETRACYCLINE	<=1	S		
TRIMETH SULFA	<=0.5/9.5	S		
VANCOMYCIN	<=2	S	<=2	S
GENT SYNERGY**			<=500	S
STREPTOMY SYN**			>1000	R

KEY:
S = SUSCEPTIBLE, I = INTERMEDIATE, R = RESISTANT

* SUSCEPTIBILITY RESULTS OF ANTIBIOTICS MARKED BY AN ASTERISK APPLY ONLY IF ORGANISM IS ISOLATED FROM THE URINARY TRACT.

** A SYNERGY RESULT OF S INDICATES THAT SYNERGISTIC SUSCEPTIBILITY WITH AMPICILLIN OR PENICILLIN IS LIKELY. A RESULT OF R INDICATES THAT SYNERGISTIC SUSCEPTIBILITY WITH THESE AGENTS IS NOT LIKELY.

Faxed to Emc 5/7/06 P. Overton LPN

*** FINAL REPORT ***

EDGEFIELD COUNTY HOSPITAL

RADIOLOGICAL CONSULTATION

Name Peterson, William Date 4/24/06
Address TMH&R Pvt. ☐ Staff ☐ Out Pt ☒
Race B Sex M Age 85 L.M.P. Room No.
Allergies Bun Creat.
CLINICAL DIAGNOSIS (Pertinent History) Cervical Spinal Stenosis
C-Spine
JD/SS AP/Lat Attending Physician Santiago/Dr. Beth Cardin
Findings:

CERVICAL SPINE TWO VIEWS 04-24-06

INDICATION: CERVICAL SPINAL STENOSIS.

TECHNIQUE: AP and lateral views without comparison.

FINDINGS: There is evidence of previous anterior spinal fusion at the C5-C7 levels with metallic plate bridging these levels anteriorly and attached to the contiguous vertebral bodies with threaded screws. No mal-alignment is detected. There is diffuse degenerative change with marginal osteophyte formation and posterior osteophytic ridging as well as loss of the C2-3, C3-4, and C4-5 levels. No vertebral collapse or destructive lesions are identified.

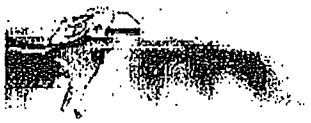
IMPRESSION: DIFFUSE HYPERTROPHIC DEGENERATIVE CHANGE AND MULTI-LEVEL DEGENERATIVE DISC DISEASE. STATUS POST ANTERIOR CERVICAL FUSION AT THE C5-C7 LEVELS WITH NO MAL-ALIGNMENT DETECTED.

Faxed 4-24-06 DS

X-ray No. 28564 Signed WJB

Date 04-24-06/gc William C Bruker Jr M.D.
Radiologist Edgefield County Hospital, Edgefield, S.C.
*Preliminary Report Until Signed

FORM # 31/4



EDGEFIELD COUNTY HOSPITAL

RADIOLOGICAL CONSULTATION

Date 3/30/06

Name Peterson, William Pvt. ( ) Staff ( ) Out Pt. ( )

Address TMH+R

Race B Sex M Age 85 L.M.P. _____ Room No. _____

Allergies _____ Bun _____ Creat. _____

CLINICAL DIAGNOSIS (Pertinent History) ↑ Temp Chest Xray

55 1V Attending Physician Massey, Tami

Findings:

faxed 3-31-06 DD

CHEST ONE VIEW 03-30-06

INDICATION: ELEVATED TEMPERATURE

TECHNIQUE: ERECT AP VIEW

COMPARISON: 04-23-05

FINDINGS: The heart is not enlarged and the pulmonary vasculature is unremarkable. The lungs are well aerated and no air space consolidation, mass, or pleural effusion is identified. There is mild accentuation of interstitial markings taken to represent chronic change and an element of pulmonary fibrosis. Thoracic spondylosis is noted and there is evidence of previous multi-level anterior cervical fusion and plating.

IMPRESSION: NO ACUTE CARDIOPULMONARY DISEASE.

X-ray No. 28564 Signed WB

Date 03-31-06/gc William C Bruker Jr M.D.
Radiologist Edgefield County Hospital, Edgefield, S. C.

FORM # 31/4

X-RAY REPORT

21,19

Physical Therapy Plan of Treatment

| Part A | Part B | Other |

ASSESSMENT/INITIAL PLAN OF TREATMENT

Patient's Last Name	First Name / M.I.	Provider No.	HICN
Petersen	William	425293	[redacted]
Provider Name	**Medical Record No. (Optional)**	**Onset Date**	**SOC Date**
Edgefield Health Care Center	1050	3-7-06	3/23/06

Type	Primary Diagnosis (Pertinent Medical Dx) & ICD-9	Treatment Diagnosis & ICD-9
PT	Acute Renal Failure 1230; Cervical Stenosis	Muscle weakness 728.87

Initial Assessment/Functional Goals

Age: 84 | Gender: M | Prior Hospitalization from 3-7-06 to 3-

Prior Medical History/Therapy: acute renal failure, spinal stenosis, rhabdomyolysis s/p ant discectomy & fusion 3/14/06

Prior Functional Level: [illegible] ADL's, [illegible], lived alone, [illegible]

Reason for Referral: weakness, risk of contractures

Tests Administered: X Balance (G3) X ROM (G4)
sitting: poor static dynamic [illegible]; standing: unable [illegible]

Rehab Potential: Fair to stated goals

B4 COGNITIVE SKILLS
- [ ] No Impairment
- [ ] Very Mild Imp.
- [ ] Mild Impairment
- [x] Moderately Impairment
- [ ] Moderately Severe Imp.
- [ ] Severe Impairment
- [ ] Very Severe Impairment

DEVICES & RESTRAINTS: bed rails

Precautions: fall risk, skin breakdown risk [illegible]

G	ADL FUNCTION	Current Performance	Current Support	STG 2 wks Performance	STG Support	LTG 4 wks Performance	LTG Support
G1a	Bed Mobility-turning	2.5	2	2.0	2	1	2
G1a	Bed Mobility-repositioning	4	2	3.5	2	3	2
G1b	Transfer-bed<->chair	4	2	3.5	2	3	2
G1b	Transfer-sit<->stand	8	8	4	2	3.5	2
G1e	Walk in Room	8	8	-	-	-	-
G1d	Walk in Corridor	8	8	-	-	-	-
G1e	Locomotion on Unit (mode) N/A	8	8	-	-	-	-
G1f	Locomotion off Unit (mode)			-	-	-	

Performance and Support Scale:
Performance: 0-Independent; 1-Supervision; 2-Limited Asst.(-); 2.5-Limited Asst.(+); 3-Extensive Asst.(-); 3.5-Extensive Asst.(+); 4-Total Dependence; 8-Did not occur/Not tested
Support: 0-No assistance; 1-Setup/Verbal cues; 2-One person assist; 3-Two(+) person assist; 8-Did not occur/Not tested

SKIN CONDITION (wounds, pain/edema, sensation): no open area. Yellow [illegible] [illegible] heel.

OTHER: pt cannot maintain fair sitting [illegible] max [illegible], cannot stand or transfer; transferred [illegible] max [illegible], need ROM, stretching to [illegible] LE & [illegible] and prevent contractures

Plan of Treatment
- [x] 97110 Therapeutic Exercises
- [ ] 97116 Gait Training
- [x] 97542 Wheelchair Mgmt/Propulsion
- [ ] 97032 E-stim
- [ ] 97112 Neuromuscular Re-education
- [x] 97530 Therapeutic Activities
- [ ] 97022 Whirlpool
- [ ] 97150 Group Therapy
- [x] ROM/stretch [illegible] LE's

Freq/Duration (e.g. 3/wk X4 wk): 3-5 x wk for 30 days

Signature/Date (professional establishing POC including prof. designation): John [illegible] PT 3/23/06

I CERTIFY THE NEED FOR THESE SERVICES FURNISHED UNDER THIS PLAN OF TREATMENT AND WHILE UNDER MY CARE

Certification from 3/23/06 to 4/22/06

Physician Signature [illegible] Date 4/1/06

Midlands
Prosthetics & Orthotics

William Peterson
Brian Collar

147 Pendleton Street • Aiken, SC 29801
(803) 641-6007 • fax (803) 641-6047

1018 Druid Park Avenue • Augusta, GA 30904
(706) 737-7371 • fax (706) 737-7372

240

-607-

Physical Therapy Updated Plan of Progress

Part A | Part B | Other

REASSESSMENT/UPDATED PLAN OF TREATMENT

Patient's Last Name	First Name	M.I.	Provider No.	HICN
Peterson	William		425293	[redacted]

Provider Name	Medical Record No. (Optional)	Onset Date	SOC Date
Edgefield Health Care Center	1050	3-7-06	3-23-06

Type	Primary Diagnosis (Pertinent Medical Dx) &ICD-9	Treatment Diagnosis &ICD-9
PT	acute renal failure 723.0 / cervical stenosis	muscle weakness 728.87 ✓

Performance and Support Scale:

Performance: 0-Independent; 1-Supervision; 2-Limited Asst.(-); 2.5-Limited Asst.(+); 3-Extensive Asst.(-); 3.5-Extensive Asst.(+); 4-Total Dependence; 8-Did not occur/Not tested

Support: 0-No assistance; 1-Setup/Verbal cues; 2-One person assist; 3-Two (+) person assist; 8-Did not occur/Not tested

G	ADL FUNCTION	Previous Performance	Previous Support	Current Performance	Current Support	STG 4 wks Performance	STG 4 wks Support	LTG 8 wks Performance	LTG 8 wks Support
G1a	Bed Mobility-turning	2.5	2	3.5	3.5	3	3	2.5	2.5
G1a	Bed Mobility-repositioning	4	2	3.5	3.5	3	3	2.5	2.5
G1b	Transfer-bed<->chair	4	2	3.5	3.5 EF	3	3	2.5	2.5
G1b	Transfer-sit<->stand	8	8	4	4	3.5	3.5	3	3
G1c	Walk in Room	8	8	8	8	8	8 EF	8	8
G1d	Walk in Corridor	8	8	8	8	8	8	8	8
G1e	Locomotion on Unit (mode)	8	8	8	8	8	8	8	8
G1f	Locomotion off Unit (mode)	8	8	8	8	8	8	8	8

P4 DEVICES & RESTRAINTS: gericlair rails ↑↑

Rehab Potential: poor to fair only.

REASONS FOR CONTINUING TREATMENT

Pt is positioned in gericlair during the day when OOB. He is followed for wound care (start by P.T 4/20/06) (L) hip c panafil for lysis of esclar & cover c optifoam dressing

wound measures 4cm x 4.3 cm & granulation & odor minimal drainage-clear unable to stage 2° to thick esclar

M SKIN CONDITION (wounds, pain/edema, sensation)

Plan of Treatment

- [X] 97110 Therapeutic Exercises
- [ ] 97116 Gait Training
- [X] 97542 Wheelchair Mgmt/Propulsion
- [ ] 97032 E-stim
- [ ] 97112 Neuromuscular Re-education
- [X] 97530 Therapeutic Activities
- [ ] 97022 Whirlpool
- [ ] 97150 Group Therapy
- [X] ROM stretch (B)KE's

Freq/Duration (e.g. 3wk X 4 wk): 3-5 x/wk x 30 days

Signature/Date (professional establishing POC including prof. designation): Elsie Faulkner PT 4/21/06

I CERTIFY THE NEED FOR THESE SERVICES FURNISHED UNDER THIS PLAN OF TREATMENT AND WHILE UNDER MY CARE

Recertification from 4/21/06 to 5/20/06

Physician Signature: B Gardineer Date: 4/21/06

214D

P.T. Therapy
Weekly Progress Notes

1. Patient Name: Peterson, William Physician: B Gardener MR# 1050

2. Patient Input/Communication: "doing pretty well today"

3. Patient Training/Education: 0

4. Progress to Goals:

Dx: ARF, spinal stenosis, rhabdomyolysis.

STG	Goal	current
Bed mobility-turn	2.0	2.5
Bed mobility-reposit	3.5	2.5
Transfer bed↔chair	3.5	4
Transfer sit↔stand	4	4
Gait	non amb	non amb.

Nursing service transfers pt via Hoyer. Unable to tolerate wgt on feet, inadequate strength in LE's. Recc high back W/C for trunk stability, attempt W/C mobility training to get him out of bed.

5. Communication with other disciplines: —

6. Family Communication: —

7. Current Functional Status/Assessment: as above

8. Plan/Therapeutic Focus: continue c̄ rehab efforts

9. Referral to other disciplines:

10. Signature: Eddie Faulkner PT Date 4/7/06

P.T. Therapy
Weekly Progress Notes

1: Patient Name Peterson, William Physician Massey MR# 1050

2. Patient Input/Communication: Ø

3. Patient Training/Education: Ø

4. Progress to Goals:

ADL Function	Performance	Support
	3.5	3.5
Bed Mobility - turning	3.5	3.5
Bed Mobility - Repositioning	3.5	3.5
Transfer: Bed - chair	4	4
Transfer: Sit → stand	4	4
Locomotion Device	Geri-chair	

Pt has poor sitting balance, endurance is poor along w/ poor strength

5. Communication with other disciplines: Ø

6. Family Communication: Ø

7. Current Functional Status/Assessment: Being work at for wound care. Pt grimace during repositioning

8. Plan/Therapeutic Focus: Cont per POC

9. Referral to other disciplines: Ø

10. Signature: Connie Parker, PTA Date 04/20/06

PHYSICAL THERAPY DAIL. RECORD OF TREATMENT

Name	HIC #	Onset Date of PT Tx. Diagnosis	Month:
Peterson, William	[redacted]	3-7-06	March 2006
Primary Diagnosis Incl. ICD-9 Code	**PT Treatment Diagnosis Incl. ICD-9 Code**	**Date of first PT Treatment**	**Payor Source (Medicare A, Private Pay, etc.)**
Acute Renal failure	Muscle Weakness 728.87	3-23-06	Med A

Therapist Signature	Title	Therapist Signature	Title	Therapist Signature	Title	Therapist Signature	Title
Connie Parker	PTA						
[signature]	PT						

HCPCS	Description	Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total
97001	Physical Therapy Evaluation (untimed)	Units																							1									1
		Min																							15									15
97110	Therapeutic Exercise *(15 minutes)*	Units																																
		Min																																
97112	Neuromuscular Reeducation *(15 minutes)*	Units																																
		Min																																
97116	Gait Training *(15 minutes)*	Units																																
		Min																																
97530	Therapeutic Activities *(15 minutes)*	Units																							2				2	2	2	2	2	12
		Min																							30				30	30	30	30	30	180
	Wound Care, Selective Debridement *(untimed)*	Units																																
		Min																																
		Units																																
		Min																																
		Units																																
		Min																																
		Units																																
		Min																																
	Initials of treating therapist																								[initials]				CP	CP	CP	CP	CP	

If more than one therapist treats a patient in a given day, the treatment should be entered and initialed separately in one of the bottom sections of the grid. Part B treatment grids are to be reviewed by the DOT and turned in to the facility BOM weekly and at the end of the calendar month. Therapists should thoroughly review the Therapy Coding Manual for appropriate CPT and ICD-9 coding.

Revised 11/03

PHYSICAL THERAPY DAILY RECORD OF TREATMENT

-611-

Name	HIC #	Onset Date of PT Tx. Diagnosis	Month:
Peterson, William	[redacted]	3-7-06	April 2006
Primary Diagnosis Ind. ICD-9 Code 723.0 Acute Renal Failure	**PT Treatment Diagnosis Ind. ICD-9 Code** muscle weakness 728.87	**Date of first PT Treatment** 3-23-06	**Payor Source (Medicare A, Private Pay, etc.)** Med A

Therapist Signature	Title	Therapist Signature	Title	Therapist Signature	Title	Therapist Signature	Title
Connie Parker	PTA						
Elsie Faulkner	PT						

HCPCS	Description	Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total
97001	Physical Therapy Evaluation (untimed)	Units																																
		Min.																																
97110	Therapeutic Exercise (15 minutes)	Units																																
		Min.																																
97112	Neuromuscular Reeducation (15 minutes)	Units																																
		Min.																																
97116	Gait Training (15 minutes)	Units																																
		Min.																																
97530	Therapeutic Activities (15 minutes)	Units				2	2	2		1		2	2		2	2	2			2	2		2											23
		Min.				30	30	30		15		30	30		30	30	30			30	30		30											345
97597	Wound Care, Selective Debridement (untimed)	Units																					1			1	1	1	1	1				6
		Min.																					30			30	30	30	30	30				180
		Units																																
		Min.																																
		Units																																
		Min.																																
		Units																																
		Min.																																
	Initials of treating therapist					CP	CP	CP		EE		CP	CP		CP	CP	CP			CP	CP		CP	EE			CP	CP	CP	CP	CP			

If more than one therapist treats a patient in a given day, the treatment should be entered and initialed separately in one of the bottom sections of the grid. Part B treatment grids are to be reviewed by the DOT and turned in to the facility BOM weekly and at the end of the calendar month. Therapists should thoroughly review the Therapy Coding Manual for appropriate CPT and ICD-9 coding.

Revised 11/03

IMR&R of Edgefield 03/24/2006 - 05/25/2006 - 090

PHYSICAL THERAPY DAILY RECORD OF TREATMENT

-612-

Name	HIC #	Onset Date of PT Tx. Diagnosis	Month:
Peterson, William	[redacted]	3-7-06	May 2006
Primary Diagnosis Ind. ICD-9 Code	**PT Treatment Diagnosis Ind. ICD-9 Code**	**Date of first PT Treatment**	**Payor Source (Medicare A, Private Pay, etc.)**
Acute Renal failure	Muscle Weakness 728.87	3-23-06	Med A

Therapist Signature	Title	Therapist Signature	Title	Therapist Signature	Title	Therapist Signature	Title
[signature]	PT						
Connie Parker	PTA						

HCPCS	Description	Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total
97001	Physical Therapy Evaluation (untimed)	Units																																
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97116	Gait Training *(15 minutes)*	Units																																
		Min																																
97530	Therapeutic Activities *(15 minutes)*	Units																																
		Min																																
	Wound Care, Selective Debridement *(untimed)*	Units	1	1	1	1	1			1	1	1	1				1																	10
		Min	30	30	30	30	30			30	30	30	30				30																	300
		Units																																
		Min																																
		Units																																
		Min																																
		Units																																
		Min																																
Initials of treating therapist			CP	CP	CP	CP	CP			CP	CP	CP	CP				CP																	

If more than one therapist treats a patient in a given day, the treatment should be entered and initialed separately in one of the bottom sections of the grid. Part B treatment grids are to be reviewed by the DOT and turned in to the facility BOM weekly and at the end of the calendar month. Therapists should thoroughly review the Therapy Coding Manual for appropriate CPT and ICD-9 coding.

Revised 11/03

Ph('cal Thera) Discharge (ummary 4-13-

| Part A | | Part B | | Other ____

DISCHARGE SUMMARY

Patient's Last Name	First Name M.I.	HICN	SOC Date
Petersen	William	[redacted]	3/23/06
Type PT	**Medical Record No.** *(Optional)*	**Onset Date** 3/7/06	**Total Visits** 34

Performance and Support Scale:

Performance: 0-Independent; 1-Supervision; 2-Limited Asst.(-); 2.5-Limited Asst.(+); 3-Extensive Asst.(-); 3.5-Extensive Asst.(+); 4-Total Dependence; 8-Did not occur/Not tested

Support: 0-No assistance; 1-Setup/Verbal cues; 2-One person assist; 3-Two(+) person assist; 8-Did not occur/Not tested

	ADL FUNCTION	At Evaluation Performance	At Evaluation Support	At Discharge Performance	At Discharge Support
G1a	Bed Mobility-turning	2.5	2	3.5	3
G1a	Bed Mobility-repositioning	4	2	3.5	3
G1b	Transfer-bed<->chair	4	2	3.5	3
G1b	Transfer-sit<->stand	8	8	4	4
G1c	Walk in Room	8	8	8	8
G1d	Walk in Corridor	8	8	8	8
G1e	Locomotion on Unit (mode) w/c	8	8	8	8
G1f	Locomotion off Unit (mode)	8	8	8	8

M SKIN CONDITION *(wounds, pain/edema, sensation)*

(R) heel (4cm) wound

(L) hip
4cm x 4.3cm

Reason for Referral

weakness, risk of contractures

Reason for Discharge/Summary of Progress

pt. has regressed due not in progress c̄ bed mobility/ transfers/ ambulation,
pt remains dependent for transfers/ amb.

Signature/Date [signature] 5/23/06

PLAN OF TREATMENT FOR OUTPATIENT REHABILITATION (COMPLETE FOR INITIAL CLAIMS ONLY) -614-

Patient's Last Name	First Name	M.I.	Provider No.	HICN
Tokre w	William		425073	[redacted]

Provider Name	Medical Record No. (Optional)	Onset Date	SOC Date
TMH&R		3/6/06	3/31/06

Type	Primary Diagnosis (Pertinent Medical Dx)	Treatment Diagnosis
ST	Muscle Weakness General 728.87	Dysphagia 787.2 ✓

Initial Assessment/Functional Goals

Age	Gender	Prior Hospitalization
64	M	from 3/6/06 to 3/31/06

Prior Functional Level: Feeder Pureed

Prior Medical History/Therapy: Cervical spinal stenos Malaise & fatigue Senile dementia Uncomp'

Reason for Referral: was on puree, eval. for safety on MS

Tests Administered: Informal Assessment

Rehab Potential: Good

Precautions: aspiration fd weight

B4 COGNITIVE SKILLS
- ✓ No Impairment
- Very Mild Imp.
- Mild Impairment
- Moderately Impairment
- Moderately Severe Imp.
- Severe Impairment
- Very Severe Impairment

C2 COMMUNICATION DEVICES: N/A

C4 MAKING SELF UNDERSTOOD
- ✓ Understood
- Usually Understood
- Sometimes Understood
- Rarely/Never Understood

C5 SPEECH CLARITY
- ✓ Clear Speech
- Unclear Speech
- No Speech

C7 RECENT CHANGE
- No Change
- ✓ Improved
- Deteriorated

C6 ABILITY TO UNDERSTAND OTHERS
- ✓ Understands
- Usually Understands
- Sometimes Understands
- Rarely/Never Understands

G ADL FUNCTION

	Current		STG 4 wks		LTG 8 wks	
	Performance	Support	Performance	Support	Performance	Support
G1h Eating	2	2	1	1	0	0

Performance and Support Scale:

Performance: 0-Independent; 1-Supervision; 2-Limited Asst.(-); 2.5-Limited Asst.(+); 3-Extensive Asst.(-); 3.5-Extensive Asst.(+); 4-Total Dependence; 8-Did not occur/Not tested

Support: 0-No assistance; 1-Setup/Verbal cues; 2-One person assist; 3-Two(+) person assist; 8-Did not occur/Not tested

I & L ORAL/NUTRITIONAL/DENTAL STATUS

Pt. is edentulous, tolerated MS snack c ϕ S/S aspiration. O/M tasks yielded adequate for chewing/swallowing MS. Pt. was oriented to name, not location or date. Pt. was alert. Compensatory strategies fcd safe swallow function.

OTHER

Rec. diet to continue at MS. Rec. skilled ST services to ↑ safe swallow function on MS & to ↑ PO intake.

Plan of Treatment
- ☐ 92507 Speech/hearing therapy
- ✓ 92526 Oral function therapy
- ☐ G0198 Training to speech generating device
- ☐ G0201 Modification/training for voice prosthetic device
- ☐ Other

Freq/Duration (e.g. 3wk X 4 wk): 10 visits x 4 wk.

Signature/Date (professional establishing POC including prof. designation): Martha J. Wilder, MA, CCC-SLP

I CERTIFY THE NEED FOR THESE SERVICES FURNISHED UNDER THIS PLAN OF TREATMENT AND WHILE UNDER MY CARE

Certification from 3/31/06 to 4/30/06

Physician Signature: Massey Date: 4-13-6

Safe Swallow Precautions

Patient Name: William Peterson
PLEASE FOLLOW THE CIRCLED INSTRUCTIONS:

(1) Seat patient upright.

2. Drape patient with extra towels.

3. Stand on the patient's weaker side (R/L) to feed him and turn his head toward the weaker side.

(4) Give patient small bites (half a spoonful).

(5) Allow extra time between bites (at least 10 seconds).

6. Alternate cold food (Italian Ice) between bites of other foods.

7. Encourage patient to take small bites.

8. Lower chin before swallow.

(9) Dry swallow after each swallow to clear pooling.

10. Use _____ thick liquids only.

11. Give liquids by spoon/straw/cup only.

(12) Encourage patient to cough if he chokes.

(13) Discontinue feeding if patient continues to choke.

(14) Leave patient upright 20-30 minutes after completion of meal.

(15) Alternate solid/liquid presentation. (Give bite of food, then sip of liquid.)

(16) Be sure the mouth is clear of food at completion of meal. Encourage the patient to swallow any pocketed food or remove it from mouth.

UPDATE PLAN OF PROGRESS FOR OUTPATIENT REHABILITATION

Patient's Last Name	First Name	Provider No.	HICN
Peterson	William	425293	[redacted]
Provider Name	**Medical Record No. (Optional)**	**Onset Date**	**SOC Date**
TMH&R		3/6/06	3/31/06

Type	Primary Diagnosis (Pertinent Medical Dx)	Treatment Diagnosis
ST	Muscle Weakness General 728.87	Dysphagia 787.2

B4 COGNITIVE SKILLS
- [ ] No Impairment
- [x] Very Mild Imp.
- [ ] Mild Impairment
- [ ] Moderately Impairment
- [ ] Moderately Severe Imp.
- [ ] Severe Impairment
- [ ] Very Severe Impairment

C5 SPEECH CLARITY
- [x] Clear Speech
- [ ] Unclear Speech
- [ ] No Speech

C2 COMMUNICATION DEVICES
N/A

C6 ABILITY TO UNDERSTAND OTHERS
- [ ] Understands
- [x] Usually Understands
- [ ] Sometimes Understands
- [ ] Rarely/Never Understands

K&L ORAL/NUTRITIONAL/DENTAL STATUS
Feeder
Pureed
Edentulous

C4 MAKING SELF UNDERSTOOD
- [x] Understood
- [ ] Usually Understood
- [ ] Sometimes Understood
- [ ] Rarely/Never Understood

Performance and Support Scale:
Performance: 0-Independent; 1-Supervision; 2-Limited Asst.(-); 2.5-Limited Asst.(+); 3-Extensive Asst.(-); 3.5-Extensive Asst.(+); 4-Total Dependence; 8-Did not occur/Not tested
Support: 0-No assistance; 1-Setup/Verbal cues; 2-One person assist; 3-Two(+) person asst; 8-Did not occur/Not tested

G ADL FUNCTION	Previous Performance	Previous Support	Current Performance	Current Support	STG 4 wks Performance	STG 4 wks Support	LTG 8 wks Performance	LTG 8 wks Support	Rehab Potential
G1h Eating	2	2	2	2	1	1	0	0	Good

REASONS FOR CONTINUING TREATMENT

Pt. exhibits ↓'d O/M skills but responds to tactile + verbal cuing. Pt. will also tolerate ↑'d po intake c̄ encouragement + training c̄ compensatory strategies.
Skilled ST tx. recommended c̄ the following goals:

1) Pt. will consume pureed c̄ ↑'d po intake by utilizing compensatory strategies (lingual sweep, alternate solids/liquids, double swallow).
2) Pt. will perform O/M ex. 10/10 to ↑ O/M strength + coordination for swallowing.
3) Staff training/instruction for safe swallowing techniques + compensatory strategies.

Plan of Treatment
- [ ] 92507 Speech/hearing therapy
- [x] 92526 Oral function therapy
- [ ] GO198 Training fo speech generating device
- [ ] GO201 Modification/training for voice prosthetic device
- [ ] Other

Freq/Duration (e.g. 3/wk X 4 wk)	Signature/Date (professional establishing POC including prof. designation)
~~5/1/06~~ error MW 1WK1	Matthew J. Wilder, MA, CCC-SLP 5/3/06

I CERTIFY THE NEED FOR THESE SERVICES FURNISHED UNDER THIS PLAN OF TREATMENT AND WHILE UNDER MY CARE

Recertification	Physician Signature	Date
from 5/1/06 to 5/31/06	Massey	05/17/06

Rehabilitation Services Progress Report

Date	Disc.	Notes
3/31/06	ST	Pt. seen for dysphagia Objective evaluation. Please see report for further details. Tx. rec. Martha A. Wilder, MA, CCC-SLP
4/1/06	ST	Pt. seen in p.m. tx while for MS snack. Pt. tolerated current diet c s/s aspiration, tolerated thin liq. c s/s aspiration. Staff report no difficulty c swallowing during meals. Compensatory strategies were performed c minimal cueing. Pt. has been consistent c PO intake, no. Safe Swallowing Guidelines have been provided. Rec. DC from Skilled ST. Nsg. to monitor wt loss & to consult c ST services for any ↓ in weight observed. Martha J. Wilder, MA, CCC-SLP

Resident Name Peterson, William

Room # 214D

Physician Massey

Rehabilitation Services Progress Report

Date	Disc.	Notes
3/31/06	ST	Pt. seen for bedside dysphagia evaluation on this date. Please see eval. report for further details. Martha J. Wilder, MA, CCC-SLP
4/3/06	ST	Pt. tolerated MS snack s̄ s/s aspiration. Compensatory strategies were established to ↑ PO intake & safe swallowing function (lingual sweep, alternate solids c̄ liquids). O/M ex. to strengthen oral musculature yielded 80% acc. c̄ verbal, tactile, and visual cues needed. Continue POC. Martha J. Wilder, MA, CCC-SLP
4/19/06	ST	Pt. is now on pureed diet c̄ ↓'d PO intake. Pt. needed encouragement to eat 3oz. of 4oz. pureed snack. Pt. continues to be a feeder to ↑ PO intake. VCs were needed to perform compensatory strategies (lingual sweep). Alternate liq. c̄ solids were provided, pt. encouraged to request liquids during meals. O/M ex. yielded 69% acc. Pt. produced a weak cough. Pt. needed tactile, verbal & visual cues for lingual exercises. Cont. POC. Martha J. Wilder, MA, CCC-SLP
4/26/06	ST	Pt. seen in p.m. at bedside for tx. c̄ focus on dysphagia. Pt. tolerated pureed snack. Consumed 2oz. of food & tolerated thin liq. c̄ ∅ s/s aspiration. Pt. needed 100% verbal & tactile cues for compensatory strategies (lingual sweep, double swallow). Pt. needed 100% tactile/VCs for O/M ex. - lingual elevation, depression, retraction. Pt. produced /k/ words c̄ good contact. He averaged 3 seconds c̄ falsetto ex. Pt. had a weak cough and a functional throat clearing. Pt. was oriented 2 of 5. Pt's PO intake continues to be ↓'d. He is receiving Magic Cups. It is rec. that skilled ST services continue to ↑ oral musculature to ↑ safe swallowing function & to ↑ PO intake. Martha J. Wilder, MA, CCC-SLP
5/3/06	ST	Pt. seen in p.m. at bedside for tx. c̄ focus on dysphagia. Pt. tolerated pureed snack of applesauce, consuming 100% (4oz). No s/s aspiration. VCs for comp. strategies. O/M ex. yielded weak lingual elevation, back-of-tongue, lateralization. Pt. produced weak cough, good throat clearing. Tactile cues needed for lingual lateralization. Pt. was 2 sec. average for lingual protrusion. CNAs in-serviced re compensatory strat. Pt. fatigued. Pt. was alert c̄ some confusion. Cont. POC. — Martha J. Wilder, MA, CCC-SLP

Resident Name William Peterson

Room # 214D

Physician Massey

Rehabilitation Services Progress Report

Date	Disc.	Notes
5-11-06	ST	Pt. seen @ bedside @ p.m. Pt. consumed 100% pureed snack (applesauce - 4oz.) VCs needed for comp. strategies (lingual sweep, double swallow) Cons. c RSG re pt's applesauce intake. An order for applesauce to be provided at each meal was made. CNAs in-serviced to feed him desired snack & to give him time to eat. OM ex. yielded 50% acc. for lingual protrusion, 70% acc. for lip purse/retraction, averaged 6 seconds for falsetto ex. Pt. yielded weak effort c gargling BOT ex. An appetite stimulant was tried, however, RSG reports that this is not working. Cont. c above rec. Martha J. Wilder MA CCC-SLP
5-17-06	ST	OOF (hospital) Martha J. Wilder MA CCC-SLP
5-22-06	ST	OOF (hospital) Martha J. Wilder MA CCC-SLP
6-1-06	ST	OOF (hospital) Martha J. Wilder MA CCC-SLP

Resident Name Peterson, William

Room # 214D

Physician Massey

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Speech Therapy/Dysphagia Therapy Daily Record of Treatment

Name	HIC#	Onset Date of ST Tx. Diagnosis	Month:
William Peterson	[redacted]	3-6-06	March 2006
Primary Diagnosis Ind. ICD-9 Code	**ST Treatment Diagnosis Ind. ICD-9 Code**	**Date of first ST Treatment**	**Payor Source (Medicare "A", Private Pay, etc.)**
Muscle Weakness 728.87	Dysphagia 787.2	3-31-06	medA

Therapist Signature	Title	Therapist Signature	Title	Therapist Signature	Title	Therapist Signature	Title
[illegible]	MA, CCC-SLP						

HCPCS	Description	Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total
92506	Evaluation of Speech Status *(untimed)*	Units																															1	1
		Min.																															15	15
92507	Treatment of Speech Function *(untimed)*	Units																																
		Min.																																
92508	Group Treatment, Speech only *(untimed)*	Units																																
		Min.																																
92610	Evaluation of Swallowing *(untimed)*	Units																															1	1
		Min.																															15	15
92526	Treatment of Swallowing *(untimed)*	Units																															3	3
		Min.																															45	45
97532	Cognitive Skills *(15 minutes)*	Units																																
		Min.																																
97110	Therapeutic Exercise Speech only *(15 minute)*	Units																																
		Min.																																
		Units																																
		Min.																																
		Units																																
		Min.																																
	Initials of treating therapist																															MJG	

If more than one therapist treats a patient in a given day, the treatment should be entered and initialed separately in one of the bottom sections of the grid.
Therapists should thoroughly review the Therapy Coding Manual for appropriate CPT and ICD-9 coding.

Revised 11/03

Speech Therapy/Dysphagia Therapy Daily Record of Treatment

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Name	HIC#	Onset Date of ST Tx. Diagnosis	Month:
William Peterson	[redacted]	3-6-06	April 2006
Primary Diagnosis Ind. ICD-9 Code: muscle weakness 728.87	ST Treatment Diagnosis Ind. ICD-9 Code: Dysphagia 787.20	Date of first ST Treatment: 3-31-06	Payor Source (Medicare "A", Private Pay, etc.): medA

Therapist Signature	Title	Therapist Signature	Title	Therapist Signature	Title	Therapist Signature	Title
Martha A. Wilder	MS, CCC-SLP						

HCPCS	Description	Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total
92506	Evaluation of Speech Status (initiated)	Units																																
		Min																																
92507	Treatment of Speech Function (initiated)	Units																																
		Min																																
92508	Group Treatment, Speech only (initiated)	Units																																
		Min																																
92610	Evaluation of Swallowing (initiated)	Units																																
		Min																																
92526	Treatment of Swallowing (initiated)	Units			1																1							1						2
		Min			20																15							15						35
97532	Cognitive Skills (15 minutes)	Units																																
		Min																																
97110	Therapeutic Exercise Speech only (15 minute)	Units			1																1							1						3
		Min			15																15							15						45
		Units																																
		Min																																
		Units																																
		Min																																
Initials of treating therapist					MDW																MDW							MDW						

If more than one therapist treats a patient in a given day, the treatment should be entered and initialed separately in one of the bottom sections of the grid.
Therapists should thoroughly review the Therapy Coding Manual for appropriate CPT and ICD-9 coding.

Revised 11-05

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Speech Therapy/Dysphagia Therapy Daily Record of Treatment

Name	HIC#	Onset Date of ST Tx. Diagnosis	Month
William Peterson	[redacted]	3-6-06	May 2006
Primary Diagnosis Ind. ICD-9 Code	**ST Treatment Diagnosis Ind. ICD-9 Code**	**Date of first ST Treatment**	**Payor Source (Medicare "A", Private Pay, etc.)**
Muscle weakness 728.87	Dysphagia 787.2	3-31-06	medA

Therapist Signature	Title	Therapist Signature	Title	Therapist Signature	Title	Therapist Signature	Title
Matthew J. Wilday	MA CCC SLP						

HCPCS	Description	Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total
92506	Evaluation of Speech Status *(untimed)*	Units																	H					H										
		Min																	O					O										
92507	Treatment of Speech Function *(untimed)*	Units																	S					P										
		Min																	P															
92508	Group Treatment, Speech only *(untimed)*	Units																																
		Min																																
92610	Evaluation of Swallowing *(untimed)*	Units																																
		Min																																
92526	Treatment of Swallowing *(untimed)*	Units			1								1																					
		Min			15								15																					
97532	Cognitive Skills *(15 minutes)*	Units																																
		Min																																
97110	Therapeutic Exercise Speech only *(15 minute)*	Units			1								1																					
		Min			15								15																					
		Units																																
		Min																																
		Units																																
		Min																																
Initials of treating therapist					MJW								MJW						MJW					MJW										

If more than one therapist treats a patient in a given day, the treatment should be entered and initialed separately in one of the bottom sections of the grid.
Therapists should thoroughly review the Therapy Coding Manual for appropriate CPT and ICD-9 coding.

Revised 11.05

Occupational Therapy Discharge Summary

Part A | Part B | Other

Patient's Last Name	First Name	M.I.	HICN	SOC Date
Petersen	William	C	[redacted]	3-23-06

Type	Medical Record No. (Optional)	Onset Date	Total Visits
OT	1050	3-7-06	

	ADL FUNCTION	At Evaluation Performance	At Evaluation Support	At Discharge Performance	At Discharge Support
G	ADL FUNCTION				
G1b	Bed Mobility-turning	4	2	3	2
G1a	Bed Mobility-repositioning	4	2	3	2
G1g	Dressing-upper body	4	2	3	2
G1g	Dressing-lower body	4	2	4	2
G1h	Eating	3	2	1	1
G1i	Toilet Use	8	8	4	2
G1i	Toilet Transfers	8	8	4	2
G1j	Personal Hygiene	8	8	4	2

Performance and Support Scale:

Performance: 0-Independent; 1-Supervision; 2-Limited Asst.(-); 2.5-Limited Asst.(+); 3-Extensive Asst.(-); 3.5-Extensive Asst.(+); 4-Total Dependence; 8-Did not occur/Not tested

Support: 0-No assistance; 1-Setup/Verbal cues; 2-One person assist; 3-Two(+) person asst; 8-Did not occur/Not tested

Performance: 0-Independent; 1-Supervision-oversight only; 2-Physical help limited to transfer; 3-Physical help in part of bathing activity; 4-Total dependence; 8-Did not occur/Not tested

Support: same as above

		Performance	Support	Performance	Support
G2	Bathing (not including back or hair)	4	2	4	2

B4 COGNITIVE SKILLS (compare evaluation results to discharge status)

Alert or oriented to self & situation.

M SKIN CONDITION (wounds, pain/edema, sensation, splints, etc.)

See NSG assessment

Reason for Referral

Ind ADLs, UB strength endurance.

Reason for Discharge/Summary of Progress

D/C OT services 2° pt. reaching max. potential.

Signature/Date: V. Van [illegible] OTR 4-24-06

O.T. Therapy
Weekly Progress Notes

1. Patient Name Peterson, William Physician NRGLM MR# 1050

2. Patient Input/Communication: —

3. Patient Training/Education: pt. instructed on ADL's, safety, UB strength & endurance.

4. Progress to Goals:
pt. provided c PROM & AROM exercises to both UE's.

ADL function -
Bed mobility - extensive (A)
Dsg UB extensive (A)
LB - (D)
Eating - supervision
Toileting - (D)
Bathing - (D)

5. Communication with other disciplines: pt. discussed in wkly rehab mtg, c nsg, & PT

6. Family Communication: —

7. Current Functional Status/Assessment: see above

8. Plan/Therapeutic Focus: plan for D/C

9. Referral to other disciplines: —

10. Signature: V. VanZant OTR/L Date: 4/14/06

O.T. Therapy
Weekly Progress Notes

1. Patient Name Peterson, William Physician NRGLM MR# [illegible]

2. Patient Input/Communication: ——

3. Patient Training/Education: pt. instructed on ADL's, safety, UB strength + endurance.

4. Progress to Goals:
pt. provided c PROM o AROM exercises to both UE's,
ADL function
Bed mobility - extensive (A)
Dsg UB (D)
LB (D)
Eating - limited (A)
Toileting (D)
Bathing (D)

5. Communication with other disciplines: pt. discussed in wkly rehab mtg, c nsg. + PT

6. Family Communication: ——

7. Current Functional Status/Assessment: see above

8. Plan/Therapeutic Focus: cont c POC

9. Referral to other disciplines: ——

10. Signature: [illegible] OTR Date [illegible]

Occupational Therapy Plan of Treatment

Part A ✓ | Part B | Other

PLAN OF TREATMENT FOR OUTPATIENT REHABILITATION *(COMPLETE FOR INITIAL CLAIMS ONLY)*

Patient's Last Name	First Name / M.I.	Provider No.	HICN
Peterson	William –	425293	[redacted]

Provider Name	Medical Record No. (Optional)	Onset Date	SOC Date
Edgefield Health Care Ct.	1050	3-7-06	3-23-06

Type	Primary Diagnosis (Pertinent Medical Dx) &ICD-9	Treatment Diagnosis &ICD-9
OT	cervical spinal stenosis 723.0	lack of coordination 781.3 ✓

Initial Assessment/Functional Goals

Age	Gender	Prior Hospitalization
84	M	from 3-7-06 to 3-21-06

Prior Functional Level: Prior to 1st hospitalization on 2-20-06 pt was living at home (I)ly

Prior Medical History/Therapy: Muscle weakness, malaise/fatigue, dementia, cyst of kidney, acute renal failure, cervical diskectomy fusion

Reason for Referral: ↓'ed ADLs, UB strength & endurance

Tests Administered: sitting-poor, standing-N/A

Balance (G3): see below

ROM (G4)

Rehab Potential: good for stated goals

B4 COGNITIVE SKILLS: Alert oriented to self & situation

P4 DEVICES & RESTRAINTS: geri-chair

Precautions: Risk for falls – precaution related to cervical fusion

G ADL FUNCTION	Current Performance	Current Support	STG 2 wks Performance	STG 2 wks Support	LTG 4 wks Performance	LTG 4 wks Support
G1a Bed Mobility-turning	4	2	3	2	2	2
G1a Bed Mobility-repositioning	4	2	3	2	2	2
G1g Dressing-upper body	4	2	3	2	2	2
G1g Dressing-lower body	4	2	3	2	2	2
G1h Eating	3	2	2	2	2	1
G1i Toilet Use	8	8	4	2	3	2
G1i Toilet Transfers	8	8	4	2	3	2
G1j Personal Hygiene	8	8	4	2	3	2
G2 Bathing (not including back or hair)	4	2	3	2	2	2

Performance and Support Scale:

Performance: 0-Independent; 1-Supervision; 2-Limited Asst.(-); 2.5-Limited Asst.(+); 3-Extensive Asst.(-); 3.5-Extensive Asst.(+); 4-Total Dependence; 8-Did not occur/Not tested

Support: 0-No assistance; 1-Setup/Verbal cues; 2-One person assist; 3-Two(+) person assist; 8-Did not occur/Not tested

Performance: 0-Independent; 1-Supervision-oversight only; 2-Physical help limited to transfer; 3-Physical help in part of bathing activity; 4-Total dependence; 8-Did not occur/Not tested

Support: same as above

D2 VISUAL LIMITATIONS: WFLs

OTHER: AROM both UE's WFLs, Muscle strength both UE's 3/5, Grip strength ↓'ed bilaterally

M SKIN CONDITION *(wounds, pain/edema, sensation, splints, etc.)*: see MDS assessment

Plan of Treatment

- [x] 97110 Therapeutic Exercises
- [ ] 97112 Neuromuscular Re-education
- [x] 97535 Self Care Management
- [ ] 97530 Therapeutic Activities
- [ ] 97504 Orthotics Training
- [ ] 97533 Sensory Integration
- [ ] 97532 Cognitive Skills Development
- [ ] 97150 Group Therapy
- [x] Caregiver ed.

Freq/Duration *(e.g. 3/wk X 4 wk)*: 3-5 x's per wk 4 wks

Signature/Date *(professional establishing POC including prof. designation)*: V. Vanzandt OTRL 3-23-06

I CERTIFY THE NEED FOR THESE SERVICES FURNISHED UNDER THIS PLAN OF TREATMENT AND WHILE UNDER MY CARE

Certification, from 3-23-06 to 4-22-06

Physician Signature: [signature] **Date:** 4/13/06

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Occupational Therapy Daily Record of Treatment

Nurse	HIC #	Onset Date of OT Tx. Diagnosis	Month:
Peterson, William	[redacted]	3-6-06	March 2006
Primary Diagnosis Ind. ICD-9 Code	**OT Treatment Diagnosis Ind. ICD-9 Code**	**Date of first OT Treatment**	**Payor Source (Medicare A, Private Pay, etc.)**
cervical spinal stenosis 723.0	lack of coordination 781.3	3-23-06	MedA

Therapist Signature	Title	Therapist Signature	Title	Therapist Signature	Title	Therapist Signature	Title
V. Vazeb	OTR/L						

HCPCS	Description	Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total
97003	Occupational Therapy Evaluation *(continued)*	Units																							1									1
		Min.																							15									15
97110	Therapeutic Exercise *(15 minutes)*	Units																							2				2	2	1			7
		Min.																							30				35	35	15			105
97112	Neuromuscular Reeducation *(15 minutes)*	Units																																
		Min.																																
97530	Therapeutic Activities *(15 minutes)*	Units																																
		Min.																																
97532	Cognitive Skills *(15 minutes)*	Units																																
		Min.																																
97535	Self-Care Training, ADLs *(15 minutes)*	Units																							1						1			2
		Min.																							15						20			35
		Units																																
		Min.																																
		Units																																
		Min.																																
		Units																																
		Min.																																
	Initials of treating therapist																								V				V	V	V			

If more than one therapist treats a patient in a given day, the treatment should be entered and initialed separately in one of the bottom sections of the grid.
Therapists should thoroughly review the Therapy Coding Manual for appropriate CPT and ICD-9 coding.

Revised 11/03

-628-

Occupational Therapy Daily Record of Treatment

Name	HIC #	Onset Date of OT Tx. Diagnosis	Month:
Peterson, William	[redacted]	3-7-06	April 2006
Primary Diagnosis Incl. ICD-9 Code	**OT Treatment Diagnosis Incl. ICD-9 Code**	**Date of first OT Treatment**	**Payor Source (Medicare A, Private Pay, etc.)**
Cervical Spinal stenosis 723.0	Lack of Coordination 781.3	3-23-06	medA

Therapist Signature	Title	Therapist Signature	Title	Therapist Signature	Title	Therapist Signature	Title
V. Vaz	OTR/L						

HCPCS	Description	Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total
97003	Occupational Therapy Evaluation *(untimed)*	Units																											1					1
		Min.																											60					60
97110	Therapeutic Exercise *(15 minutes)*	Units			2	2	2	1	1			2	2		2	2			2	2	2	2	1											14
		Min.			30	35	35	15	15			30	35		30	30			30	30	35	35	15											350
97112	Neuromuscular Reeducation *(15 minutes)*	Units																																
		Min.																																
97530	Therapeutic Activities *(15 minutes)*	Units																																
		Min.																																
97532	Cognitive Skills *(15 minutes)*	Units																																
		Min.																																
97535	Self-Care Training, ADLs *(15 minutes)*	Units			2			1	1						1	1			1	1			1											9
		Min.			30			20	20						15	15			15	15			20											135
		Units																																
		Min.																																
		Units																																
		Min.																																
		Units																																
		Min.																																
Initials of treating therapist					W	W	W	W	W			W	W		W	W			V	L	L	L	L										

If more than one therapist treats a patient in a given day, the treatment should be entered and initialed separately in one of the bottom sections of the grid.
Therapists should thoroughly review the Therapy Coding Manual for appropriate CPT and ICD-9 coding.

Revised 11/03

REPORT OF CONSULTATION

LAST NAME	FIRST NAME	MIDDLE NAME	ROOM NO.	PT. NO.
Peterson	William			

FROM: ATTENDING PHYSICIAN	TO: CONSULTING PHYSICAN	DATE
TMH & Rehab of Edgefield	Dr. Anderson	4-19-06

Findings: Do we change foley, if so how often? NO
Orders sent from Arctic c resident.
Had infection - received Levaquin x 7 days
See copy of Repeat UA attached.

Diagnosis: 85 y/o BM c obstructive uropathy managed
c foley catheterization. - some bacteria irritation 2° immobility
urine grossly concentrated.

Recommendations: Continue foley cath change - Δ q 4 weeks.
Encourage po fluids.
Polysporin (Neosporin) to penis bid x 10.

Date of Consultation 4/19/06 Physician _____
Signature of Consultant

REPORT OF CONSULTATION

LAST NAME	FIRST NAME	MIDDLE NAME	ROOM NO.	PT. NO.
Peterson	William			
FROM: ATTENDING PHYSICIAN	TO: CONSULTING PHYSICAN			DATE
TMH+R of Edgefield	Dr. Santiago			5-1-06

Findings: C spine - copy attached

Stable

No significant change (none was expected!, hopefully is not worse).

Doesn't need collars any longer

Diagnosis:

S/P ACDFP C5-6, C6-7

Stable

Recommendations: No further neurosurgery follow up needed.

Date of Consultation 5/1/06 Physician _____ Signature of Consultant

May 1, 2006

PETERSON, William (44098)

CLINIC NOTE

Mr. Peterson is an 84-year-old black male that I saw in the hospital at the request of Dr. Haas and Dr. DiBona. The patient had multiple medical problems. It was noted that he had severe weakness of the four extremities, worse in the right leg and also distally in the arms. The patient had severe spinal cord compression from spondylotic disease, primarily at C5/6 and C6/7. After undergoing medical management and cardiac clearance evaluation, Dr. Haas and Dr. DiBona felt that the patient's only chance to ever walk was to have surgery. After having a prolonged discussion with the patient and his family I took him to the operating room on 3/14/2006 and performed anterior cervical diskectomy, fusion and plating at C5/6 and C6/7. Post-operatively the patient had very minimal, if any, improvement and was eventually discharged to a nursing home on 3/21/2006, seven days after the surgery.

A couple of days after that we got a call from the Trinity Mission Health and Rehabilitation Hospital where he is at in Edgefield asking about length of soft cervical collar wearing and also about his post-surgical follow-up. I told them that the soft collar was to be worn primarily for comfort for 3-6 weeks as desired and that he needed to have the Aspen rehabilitation collar for about a month whenever being mobilized or trying to walk. I told them to schedule him for a follow-up in my office with cervical spine x-rays including flexion and extension to be done in five weeks.

Today the patient shows up at the wrong time, in the morning instead of the afternoon, but I was able to work him in. He brings x-ray reports, but not the films. The x-ray report is for an AP and lateral C-spine, not flex and extension. This states that everything is stable as expected. Clinically the patient has not shown any significant improvement. At this time this is pretty much what we expected. Therefore no further routine follow-up is necessary from a neurosurgical standpoint as no benefit from further surgery can be expected.

Jose A. Santiago, M.D.

JAS/sha

Cc: Melvyn Haas, M.D.
Francis DiBona, M.D.
Trinity Mission Health and Rehabilitation

SOCIAL HISTORY ASSESSMENT

Informant(s): Mary Ruth Peterson and Medical records
(include relationship) Daughter/RP

Name: William Peterson Birthdate: [redacted]
83 YRS
Place of Birth: McCormick County
Where Reared: "

Mother's Name: Josephine Talbert-Peterson Date of Death: __/__/__
Cause of Death: Natural cause
Employment: Homemaker/Farm

Father's Name: Harry "Cap" Peterson Date of Death: __/__/__
Cause of Death: Cancer
Employment: Farm

Sibling's Name(s)	Where Living (or) Death/Cause
Dora Simpkins	New York
Eddie Ruth Phillips	" "
Celia Graham	Washington, DC
Daisy Mae Peterson	New York

Other Comments Regarding Childhood:

Highest Level of Education: never attended College (specify):

Work History: Type	Where	When
Textile Mills	Graniteville, SC	

Other Comments Regarding Work:

Spouse's Name: Ellen Meadows-Peterson Wedding Date: __/__/__
Spouse's Occupation: Housewife Spouse's Date of Death: __/__/2003

Previous Marriages:

Other Comments Regarding Marriage:

RESIDENT	ROOM NO.	ADMISSION NO.
William Peterson	215 D	6501

Children's Name(s)	Where Living (or) Death Cause
Mary Ruth Peterson	Trenton, SC — Raymond Peterson - Trenton, SC
Patricia Peterson	Aiken, SC — Celia Jackson, Evans, GA.
William Peterson, Jr.	Aiken, SC — Robert L. Peterson - Ga.
Hattie Ashley	Greenwood, SC
Melinda Butler	Trenton SC
Mildred Peterson	New York

Pre-Admission Circumstances:
Family has requested long term stay - no expected discharge potential

Residence: _____ # of Floors: ____

How Long Lived in State: All his life # of Steps: ____

Current Interests:
Riding, sitting in his car

History of Major Operations/Medical Problems:
Dx. of dehydration, Acute Renal failure, Rhabdomyolysis, ↑ PSA, Hypothermia, Benign prostatic hypertrophy.

Family Involvement/Support:
Res. lived at home alone - Daughter, Mary Ruth Peterson who is this Res. responsible party; No Living Will or No POA present. Wife is deceased.

Family Interaction/Conflicts:
Res. requested to be a Do not Resuscitate - not wanting any tubing for feeding, wanting IV fluids and IV antibiotics.

Additional Information:
Res. have no hx. of mental illness, no hx. of alcoholic or tobacco use; Does not like to watch T.V. - goes to bed early about 6:00pm get up early about 5:30 am - 6:00 AM.

Additional Comments:
Res. was admitted to the Shady Grove of Greenwood - nursing home for rehab.; Res. loves to keep his beard and head shave - loves to drink milk and eat cookies.

Sharon Nicholson, LS
Signature, Title

Feb. 27, 2006
Date

RESIDENT	ROOM NO.	ADMISSION NO.
William Peterson	205/2	0412

The Red Sneet (Initial family contact post inquiry)

Inquiry for admitting whom William Peterson

Time and date of first contact 11:00 03-20-06

Person involved in interview Mary Ruth Peterson

Relationship to potential admit daughter

1. What is going on currently that leads you to seek nursing home placement?

Dad had surgery old age need you again

2. What services do you think will be needed?

all

3. What is important to you about a nursing home?

He was here. I want him back all good to him - here

4. Who all is involved in this decision and their relationship?

me & family

5. Who will be leading the charge to help us once they get to our facility?

me

6. Is there any information we can get to help you?

You give it to me

7. Whom would you like us to communicate with while you are making this decision?

me

9. Here is the list of key folks to contact us if an issue arise.

Mary Ruth Peterson - Belinda Butler Patricia Peterson

10. Here is the process that we know happens during the first week of the nursing home stay.
    a. Resident makes decision to come to the facility.
    b. Family is asked to do registration paperwork. Please remember that this is 3 hours of work.
    c. A copy of all the paperwork is taken home along with a resident/family information booklet.
    d. The resident and family are invited to a kickoff meeting to discuss life in a nursing facility, please bring questions.
    e. The resident and family discuss risk levels and approaches with the facility staff.
    f. The resident and family are invited to the first plan of care team with in the first 14 days of the stay.

11. Thank you for considering us and we hope you can become part of our team caring for you and yours.

PATIENT SOCIAL PROGRESS NOTES

NAME	SERVICE OR CB	ROOM #
William Peterson	NURSING	P

DATE	
3/21/06	Mr. Peterson is an 84 yr. elderly male ~~admitted~~ readmitted back to this facility from the Aiken Regional Hosp. of Aiken, SC for long term stay. He is alert and oriented to his surroundings able to communicate his simple needs - no behavior problems exhibited on admission. Res. was admitted to the hosp. on 3/7 and returned on 3/21; Dx. of acute renal failure - secondary to neurogenic bladder. Res. was posted admission to this facility 2/24. Daughter, Ruth Peterson is the responsible party. No restraints required. ——— Sharon Nicholson, SS
3/25/06	(5 Day) Res. spends his time in his bed - he remain alert and oriented to his surroundings. He receives therapy services — therapeutic activities and exercises, wheel chair management and range of motion. No behaviors exhibited at the present. He requires total care c ADLs. ——— Sharon Nicholson, SS
4/3/06	(14 Day) Res. is assisted up in the geri chair, continues to spend most of his time in bed. He remain alert, no behaviors exhibited — no complaints/concerns voiced. ——— Sharon Nicholson, SS
4/18/06	(30 Day) Res. stays in the bed most of the time - which he prefers - he makes his needs known. Very poor appetite, but drinks his liquids. No disruptive or inappropriate behaviors exhibited. Res. is assisted up in geri chair often. No restraints required at this time. ——— Sharon Nicholson, SS

Daily / Week(' Monthly Body Audit and H(ration Report

Location: Peach   Month of: March 2006

Resident's Name	Room Number	Physician	Initial Audit Date
Peterson, William	P 214W	NRGIM	

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

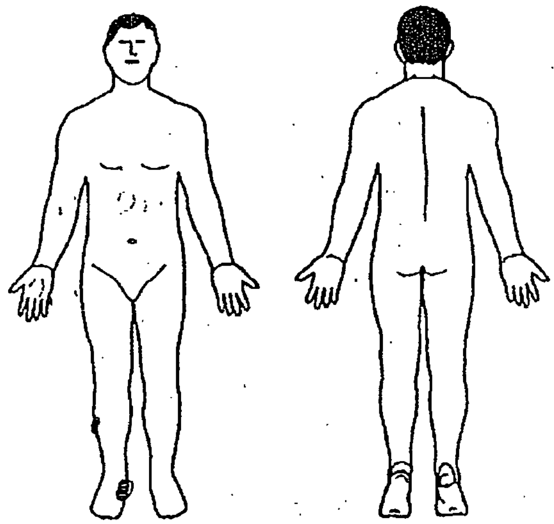
Codes: NC = No Change NB = Note Below
If any changes occur in Hydration, additional pressure sores occur, or possible bowel blockage, document in the Comment section below.

← Indicate ALL pressure sores. Location and dates occurred.

Hydration (Circle one): Poor / Fair / Good

Skin Risk Factor (Circle one): Low = Monthly / Moderate = Weekly / High = (Daily) [circled]

Impaction Potential (Circle one): Low / Mod / High



R L   L R

Comment: 3/21/06
↑ Area to Rt inner heal ē dk black outer edges ē soft center - no open area
scab to Rt ↓ leg. No edema, skin W/d.

Signature P. Dunlap   Date 03/21/06

Comment: 3/22/06 (R) inner intact Back area 7cm x 2cm. Neck incision
Site Clean & Dry. Steri-Strips in place. [signature]
On (L) & (R) side of tip of penis Red Raw. See Tx
orders.

Signature [signature]   Date 3/22/06

Comment: 3/30/06 (R) hip Dark area 3 in intake. Position off hip [signature]

Signature ______   Date __/__/__

Comment:

Signature

GP-115 (Rev. 10/03)

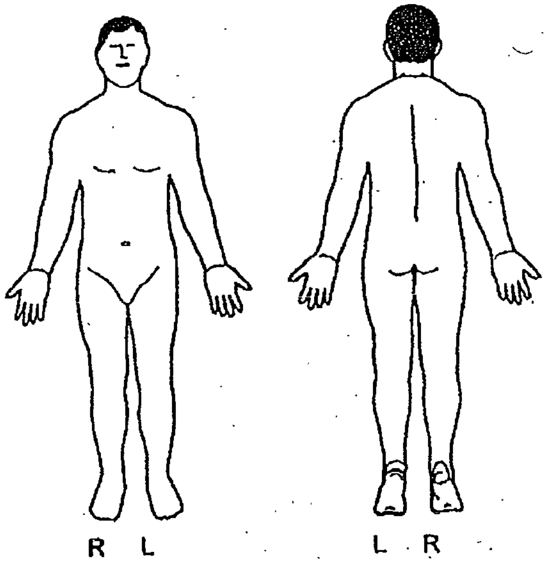
Daily / Weekly , Monthly Body Audit and Hydration Report

Location: Pearl   Month of: April 2006

Resident's Name	Room Number	Physician	Initial Audit Date
Peterson, William	P 214W	NRGLM	

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

Codes: NC = No Change NB = Note Below
If any changes occur in Hydration, additional pressure sores occur, or possible bowel blockage, document in the Comment section below.



← Indicate ALL pressure sores. Location and dates occurred.

Hydration (Circle one): Poor / Fair / Good

Skin Risk Factor (Circle one): Low = Monthly / Moderate = Weekly / High = **(Daily)**

Impaction Potential (Circle one): Low / Mod / High

Comment: Skin w/o turgor good dsg to (R) side neck clean
1 Steri strips intact. Vasoline cont. to Penis. [signature] 4-6-06
4/4/06 - (L) hip cont Dark to Black area [signature]
4/6/06 - (L) hip Skin peeled. area Red. See TX order [signature]

Signature ______ Date ___/___/___

4/18/ Comment: Skin w/o turgor good Steri Strips to neck intact. Open area to penis tx cont. (L) hip area c escar. [signature]
4/17/06 (R) heel peeled. area pink cont to monitor [signature]
4/19/06 Neck incision site clean & Dry. D/C Dsg. [signature]

Signature ______ Date ___/___/___

Comment: 4/21/06 PT Treating (L) hip Mon-Fri [signature]
4/26/06 (R) heel Red open area. TX Started. [signature]

Signature ______ Date ___/___/___

Comment:

Signature ______ Date

GP-115 (Rev. 10/03)

Weekly Pressure Sore Progress Report

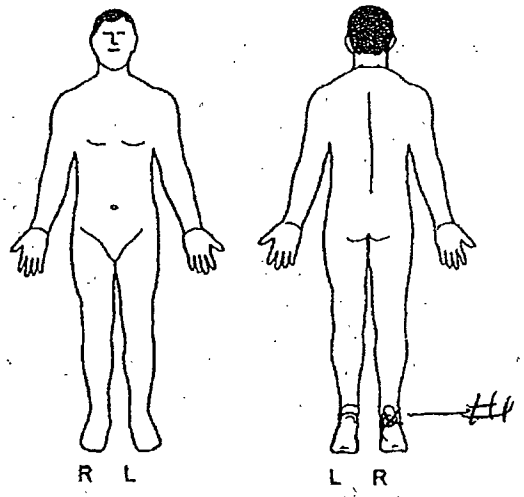
Location: Peach Month of: March 06

Resident's Name	Room Number	Physician
Peterson William	214W	NR Blue
	Initial Audit Date: 3/22/06	Risk Factor: High

Stage I: Inflammation or redness of the skin
Stage II: Superficial skin break with redness of surrounding area
Stage III: Skin break with deep tissue involvement
Stage IV: Skin break with deep tissue involvement with necrotic tissue present

Show exact location of wounds. Use letters for each wound, if more than one is present.

NOTE: When MD or family is notified of any condition, document on back of this form under *Additional Comments.*



Date	3/22/06	3/29/06	4/06/06
Location	#1	#1	#1
Size (cm or inch)	cm	CM	CM
Length	1	1	1
Width	2	2	2
Depth	?		
Stage	IV	IV	IV
Color	Black	Black	Black
Odor	Ø	Ø	Ø
Drainage (describe)	Ø	Ø	Ø
Treatment	Monitor	monitor	monitor
Progress	New Admit	No Δ	No Δ
Special Device	Heel ~~Protector~~ Boots	Boots / Alternating	Pressure Mattress
Notified	☑ MD ☑ Family	☐ MD ☐ Family	☐ MD ☐ Family
Signature	JSmoake	JSmoake	JSmoake

Date	4/12/06	4/17/06	4/26/06
Location	#1	#1	#1
Size (cm or inch)	cm	CM	CM
Length	1	1	,8
Width	2	2	,5
Depth			Ø
Stage	IV	I	II
Color	Black eschar	Pink	Red
Odor	Ø	Ø	Ø
Drainage (describe)	Ø	Ø	Scant
Treatment	Monitor	Monitor	Bacitracin & Covered dailey
Progress	No Δ	Scar Pelled off	↑ in stage
Special Device	Alternating	Pressure Mattress	
Notified	☐ MD ☐ Family	☐ MD ☐ Family	☐ MD ☐ Family
Signature	JSmoake	[illegible]	[illegible]

Date 5/2/06	Date 5/4/06	Date
Location #1	Location #1	Location
Size (cm or inch) cm	Size (cm or inch) cm	Size (cm or inch)
Length .3 Width .5 Depth Ø	Length Ø Width Depth	Length Width Depth
Stage I	Stage Ø	Stage
Color Pink	Color Normal Blanching	Color
Odor Ø	Odor Ø	Odor
Drainage (describe) Ø	Drainage (describe) Ø	Drainage (describe)
Treatment monitor	Treatment monitor	Treatment
Progress healing	Progress	Progress
Special Device Alternating	Special Device Pressure Mattress	Special Device
Notified ☐ MD ☐ Family	Notified ☐ MD ☐ Family	Notified ☐ MD ☐ Family
Signature GSmorrison	Signature GSmorrison	Signature
Date	Date	Date
Location	Location	Location
Size (cm or inch)	Size (cm or inch)	Size (cm or inch)
Length Width Depth	Length Width Depth	Length Width Depth
Stage	Stage	Stage
Color	Color	Color
Odor	Odor	Odor
Drainage (describe)	Drainage (describe)	Drainage (describe)
Treatment	Treatment	Treatment
Progress	Progress	Progress
Special Device	Special Device	Special Device
Notified ☐ MD ☐ Family	Notified ☐ MD ☐ Family	Notified ☐ MD ☐ Family
Signature	Signature	Signature

Additional Comments:

Weekly Non-Pressure Sore Progress Report

Location: Peach

Resident's Name: Peterson, William Room Number: 214W

Date: 3/22/06
Type of Skin Problem: Neck incision Site c Steri-Strips
Progress Notes: New - No Drainage
Treatment: Dry Dsg daily
Physician Notified? ☑ Yes ☐ No Family Notified? ☑ Yes ☐ No
Signature: JMonroe

Date: 3/29/06
Type of Skin Problem: Neck incision Site c Steri-Strips
Progress Notes: No Drainage No S/S of infection
Treatment: Dry Dsg daily
Physician Notified? ☐ Yes ☑ No Family Notified? ☐ Yes ☑ No
Signature: JMonroe

Date: 4/5/06
Type of Skin Problem: Neck incision Site c Steri-Strips
Progress Notes: No S/S of infection
Treatment: Dry Dsg Daily
Physician Notified? ☐ Yes ☑ No Family Notified? ☐ Yes ☑ No
Signature: JMonroe

Date: 4/12/06
Type of Skin Problem: Neck incision Site c Steri-Strips
Progress Notes: No S/S of infection
Treatment: Dry Dsg Daily
Physician Notified? ☐ Yes ☑ No Family Notified? ☐ Yes ☑ No
Signature: JMonroe

Weekly Non-Pressure Sore Progress Report

Location: Peach

Resident's Name: ~~Gilchrist~~ Peterson, William Room Number: 214W

Date: 4/19/06

Type of Skin Problem: Steri-Strips to Neck

Progress Notes: D/C Dsg Steri-Strips off. Suture site intact

Treatment: D/C Dsg

Physician Notified? ☐ Yes ☑ No Family Notified? ☐ Yes ☑ No

Signature: [signature]

Date:

Type of Skin Problem:

Progress Notes:

Treatment:

Physician Notified? ☐ Yes ☐ No Family Notified? ☐ Yes ☐ No

Signature:

Date:

Type of Skin Problem:

Progress Notes:

Treatment:

Physician Notified? ☐ Yes ☐ No Family Notified? ☐ Yes ☐ No

Signature:

Date:

Type of Skin Problem:

Progress Notes:

Treatment:

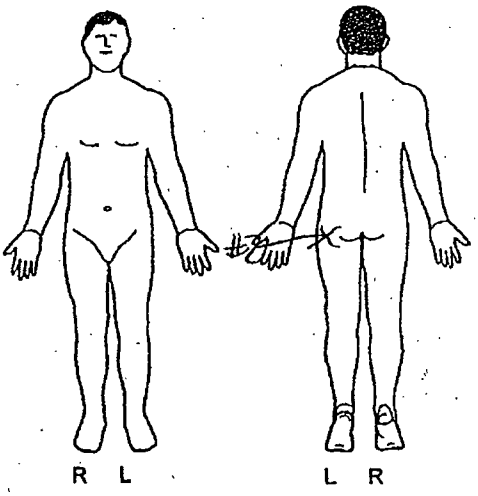
Physician Notified? ☐ Yes ☐ No Family Notified? ☐ Yes ☐ No

Signature:

Weekly Pressure Sore Progress Report

Location: Peach Month of: April 06

Resident's Name	Room Number	Physician
Peterson, William	1050	NRBMN
	Initial Audit Date	Risk Factor



Stage I: Inflammation or redness of the skin
Stage II: Superficial skin break with redness of surrounding area
Stage III: Skin break with deep tissue involvement
Stage IV: Skin break with deep tissue involvement with necrotic tissue present

Show exact location of wounds. Use letters for each wound, if more than one is present.

NOTE: When MD or family is notified of any condition, document on back of this form under *Additional Comments*.

Date 4/6/06	Date 4/12/06	Date 4/19/06
Location #2	Location #2	Location #2
Size (cm or inch) cm	Size (cm or inch) cm	Size (cm or inch) cm
Length 5 Width 4 Depth Ø	Length 4½ Width 3 Depth Ø	Length 4½ Width 3 Depth Ø
Stage II	Stage II	Stage IV
Color Red	Color Red	Color Red & Black
Odor Ø	Odor Ø	Odor Ø
Drainage (describe) Small	Drainage (describe) Small	Drainage (describe) Small
Treatment Bacitracin & Opti Form daily	Treatment Bacitracin & Opti Form daily	Treatment Bacitracin & Opti form daily
Progress New	Progress ↓ in size.	Progress Δ in color
Special Device Alternating Mattress	Special Device Alternating Mattress	Special Device
Notified ☐ MD ☑ Family	Notified ☐ MD ☐ Family	Notified ☐ MD ☐ Family
Signature [signature]	Signature [signature]	Signature [signature]
Date 4/26/06	Date 5/3/06	Date 5/10/06
Location #2	Location	Location
Size (cm or inch)	Size (cm or inch)	Size (cm or inch)
Length Width Depth	Length Width Depth	Length Width Depth
Stage	Stage	Stage
Color	Color	Color
Odor	Odor	Odor
Drainage (describe)	Drainage (describe)	Drainage (describe)
Treatment PT treating	Treatment PT treating	Treatment PT treating
Progress	Progress	Progress
Special Device	Special Device	Special Device
Notified ☐ MD ☐ Family	Notified ☐ MD ☐ Family	Notified ☐ MD ☐ Family
Signature	Signature	Signature [signature]

GP0007 (Rev. 7/02)

Date 5/17/06	Date	Date
Location	Location	Location
Size (cm or inch)	Size (cm or inch)	Size (cm or inch)
Length Width Depth	Length Width Depth	Length Width Depth
Stage	Stage	Stage
Color	Color	Color
Odor	Odor	Odor
Drainage (describe)	Drainage (describe)	Drainage (describe)
Treatment	Treatment	Treatment
Resident in Hosp.		
Progress	Progress	Progress
Special Device	Special Device	Special Device
Notified ☐ MD ☐ Family	Notified ☐ MD ☐ Family	Notified ☐ MD ☐ Family
Signature	Signature	Signature
Date	Date	Date
Location	Location	Location
Size (cm or inch)	Size (cm or inch)	Size (cm or inch)
Length Width Depth	Length Width Depth	Length Width Depth
Stage	Stage	Stage
Color	Color	Color
Odor	Odor	Odor
Drainage (describe)	Drainage (describe)	Drainage (describe)
Treatment	Treatment	Treatment
Progress	Progress	Progress
Special Device	Special Device	Special Device
Notified ☐ MD ☐ Family	Notified ☐ MD ☐ Family	Notified ☐ MD ☐ Family
Signature	Signature	Signature

Additional Comments:

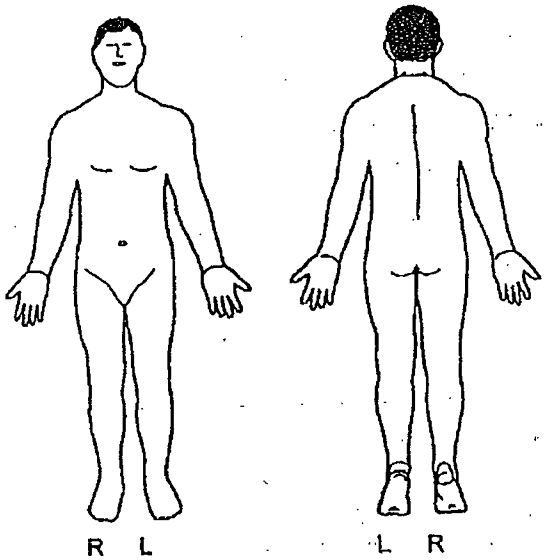
Daily / Weekl(Monthly Body Audit and Hy ation Report

Location: Pearn Month of: May 06

Resident's Name	Room Number	Physician	Initial Audit Date
Peterson, William	214W	[illegible]	

1	2	3	4	5	6
NB	NB	NC	NB	NC	NB
7	**8**	**9**	**10**	**11**	**12**
NC	NC	NC	NB	NC	NC
13	**14**	**15**	**16**	**17**	**18**
NC	NC	NC	HOSP	HOSP	HOSP
19	**20**	**21**	**22**	**23**	**24**
HOSP	Hosp.	Hosp.	HOSP	HOSP	HOSP
25	**26**	**27**	**28**	**29**	**30**
HOSP					
31					

Codes: NC = No Change NB = Note Below
If any changes occur in Hydration, additional pressure sores occur, or possible bowel blockage, document in the Comment section below.



⇐ Indicate ALL pressure sores. Location and dates occurred.

Hydration (Circle one)	Poor / Fair / Good
Skin Risk Factor (Circle one)	Low = Monthly / Moderate = Weekly / High = (Daily)
Impaction Potential (Circle one)	Low / Mod / High

Comment: Skin W/D & Turgor fair. No Edema. (L) hip Open area Cont's. See Tx orders. PT Mon-Fri (R) heel healing well. Neck incision site intact

Signature [signature] Date 5/1/06

Comment: (R) heel closed area pink 5/2/06 [signature]
(R) heel Normal Blanching. Edema to Both feet. Small scab to Top (R) foot. [signature] 5/4/06
5/6/06 - Heels intact, Scab to (R) foot intact. (L) hip open [illegible] Optifoam ordered. Eocan [illegible] & depth/slough [signature]

Signature Date ___/___/___

Comment: 5/10/06 Scab to (R) Lleg & (R) Knee. [signature]

Signature ____________ Date ___/___/___

Comment:

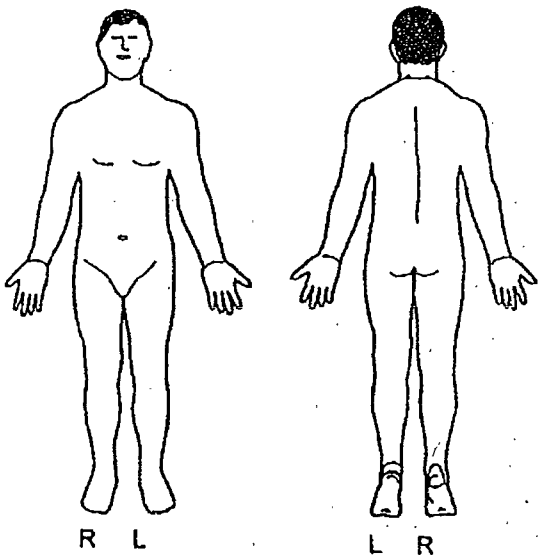
Signature ____________ Date ___/___/___

GP-115 (Rev. 10/03)

Daily / Weekly / Monthly Body Audit and Hydration Report

Location: Peach Month of: June 06

Resident's Name	Room Number	Physician	Initial Audit Date
Peterson, William	214W	[illegible]	



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

Codes: NC = No Change NB = Note Below
If any changes occur in Hydration, additional pressure sores occur, or possible bowel blockage, document in the Comment section below.

← Indicate ALL pressure sores, Location and dates occurred.

Hydration (Circle one): Poor Fair Good

Skin Risk Factor (Circle one): Low = Monthly Moderate = Weekly High = Daily

Impaction Potential (Circle one): Low Mod High

Comment: _____

Signature _____ Date ____/____/____

Comment: _____

Signature _____ Date ____/____/____

Comment: _____

Signature _____ Date ____/____/____

Comment: _____

Signature _____ Date ____/____/____

GP-115 (Rev. 10/03)

SI RAIL ASSESSMENT REVIE

(This information is collected from the MDS and various assessment tools completed on residents)

Resident Name Peterson, William Last MDS Date _____

Height _____ Weight _____ Length of Bed _____

Fall Risk Assessment Score _____ B/P Sitting _____ B/P Standing _____

Medications with side effects of drowsiness _____

Cognitive Performance Scale Score:

- ☐ No Cognitive Impairment
- ☐ Very Mild Cognitive Impairment
- ☒ Mild Cognitive Impairment
- ☐ Moderately Cognitive Impairment
- ☐ Moderately Severe Cognitive Impairment
- ☐ Severe Cognitive Impairment
- ☐ Very Severe Cognitive Impairment

Ability to understand others (c.6.):

- ☐ Understands
- ☒ Usually Understands
- ☐ Sometimes Understands
- ☐ Rarely/Never Understands

Making self understood (c.4.):

- ☐ Understood
- ☒ Usually Understood
- ☐ Sometimes Understood
- ☐ Rarely/Never Understood

Bed Mobility (G.1.a.):

- ☐ Independent
- ☐ Supervision
- ☒ Limited Assistance
- ☐ Extensive Assistance
- ☐ Total Dependence
- ☐ Did not occur

- ☐ No assistance
- ☐ Set up help
- ☒ 1 person assistance
- ☐ 2+ person assistance

Transfers (G.1.g.):

- ☐ Independent
- ☐ Supervision
- ☐ Limited Assistance
- ☒ Extensive Assistance
- ☐ Total Dependence
- ☒ Did not occur

- ☐ No assistance
- ☐ Set up help
- ☐ 1 person assistance
- ☐ 2+ person assistance

Bowel Incontinence (H.1.a.):

- ☐ Continent
- ☐ Usually Continent
- ☐ Occasionally Incontinent
- ☐ Frequently Incontinent
- ☒ Incontinent

Bladder Incontinence (H.1.b.):

- ☒ Foley
- ☐
- ☐
- ☐
- ☐

Standing Balanc (G.3.a.):		Sitting Bala J (G.3..b.):
☐	Maintained position as required in test	☐
☐	Unsteady, but able to rebalance self without physical support	☐
☐	Partial physical support during test	☐
☒	Not able to attempt test without physical help	☒

Resident Preference for side rail: _____

Family Preference for side rail: _____

☐ Resident/Family have been educated on risks of side rail (strangling, suffocation. bodily injury or death when patients or part of their body are caught between rails or between bed rails and mattress; more serious injuries from falls when patient climbs over rails; skin bruising, cuts, and scrapes; inducing agitated behavior when bed rails are used as a restraint; preventing patients, who are able to get out of bed, from performing routine activities such as going to the bathroom or retrieving something from a closet.)

Recommendations:

☐ No Side Rails
☐ Side Rails with Pads
☐ Low Bed
☐ Other _____
☐ Bed Alarm
☐ Positioning Devices
☐ Mat Beside Bed
☒ Side Rails: Left J Right J
☐ Bolstered Mattress

☐ RAP Review Completed

☐ Side Rails have been Care Planned

Equipment Assessment:

☐ No gaps between bed surface and frame allowing for resident to get wedged in equipment.
☐ Side rails/equipment is appropriate for bed, attached correctly and in functioning condition.
☐ Bed and equipment are appropriate for resident's height and weight, ensuring reduction of potential injury.

Comments:
3/22/06
SR x 2 as enabler Dyck

Signature _____ Date _____

ASSESSMENT FOR BOWEL AND BLADDER RETRAINING

INCONTINENCE / INVOLUNTARY MANAGEMENT

Complete if Incontinence RAP triggers

1. **Diagnosis:** Acute Renal Failure (Resolved) BPH Hyperlipidemia

2. **Medications:** a) Diuretics ____ b) Sedatives ____ c) Antidepressants ____
d) Antipsychotic ____ e) Antiparkinsons ____ f) Antihistamines ____
g) Antispasmodics ____ h) Phenothiazines ____ i) Other ____

3. **Vision:** adeq **Hearing:** Slump

4. **Catheter: (H3d)** Yes ✓ No ____ When? 3/21/06 admitted

5. **Urinary Incontinence: (H2b)**
Length of incontinence ____ days ____ months ____ years
Reason for incontinence BPH Constrict.

6. **Urinary Observations:**
Voids often in small amounts ____ Fills bladder and voids large amount ____
Dribbles: ____ constantly ____ after voiding ____ while coughing
____ lifting, etc. ____ unable to void
Does resident appear uncomfortable: no
Abdomen distended: Yes ____ No ✓
Does resident void upon:
Arising: Yes ____ No ____ After meals: Yes ____ No ____
After a nap: Yes ____ No ____ Constantly: Yes ____ No ____
No apparent pattern: Yes ____ No ✓
Does resident appear to recognize the need to void: Yes ____ No ✓
Can resident communicate the need to void: Yes ✓ No ____
How? ____ Commode ____ Bedside Commode ____
Bedpan ____ Urinal ____ Assistance (pants, zipper, etc.) ____
S & S of Urinary Infection Yes ____ No ✓ Treated Yes ____ No ____

7. **Bowel Incontinence: (H1a)**
Length of incontinence ____ days 14 months ____ years
Reason for incontinence ____
Unc.

Bowel Observation:
Daily elimination: Yes ____ No ✓
Approximate time of daily elimination ____
Other than daily elimination: (Explain) QOD

Is resident constipated? Yes ____ No ✓
Uses laxatives frequently? Yes ____ No ✓
Type of laxative ____ How often? ____
Enemas? Yes ____ No ✓ How often? ____
Is stool soft: Yes ✓ No ____; Hard: Yes ____ No ✓; Liquid: Yes ____ No ____
Is abdomen distended: Yes ____ No ✓; Hard: Yes ____ No ✓
Does the resident recognize the need to empty bowels: Yes ____ No ✓

Nature of Bowel Pattern:
Regular pattern ____ No apparent pattern ✓
Describe bowel pattern ____

RESIDENT	PHYSICIAN	ROOM NO.	ADMISSION NO.
Peterson, (Wilbeam)	NRBLM	P214W	1050

8. **Attitude / Communication:**
Cooperative ✓ Disoriented ____ Uncooperative ____ Alert ✓
Asphasic ____ Confused ✓ Other ____

9. **Mobility Status:**
Ambulatory ____ Semi-Ambulatory ____ Wheelchair ____ Bedfast ✓
Restrained? Yes ____ No ____ When ____ Type ____

10. **Fluid Intake:**
Drinks liquids in large amounts ____ Adequate amounts ✓ Small amounts ✓
Type of Liquid preferred: Water ____ Fruit Juice ____ Coffee ____ Tea ____
Milk ____ Type of juice preferred ____
Approximate intake in 24 hours: ____

11. **Conclusion:**
This resident is ____ is not ____ a candidate for bowel and bladder training.
Bowel: Yes ____ No ____ Bladder: Yes ____ No ____
Reason: Foley ordered per urologist until further notice.
Placed on bowel retraining to est pattern

Kathleen Dykes 3/22/06
Signature Date

12. **Reevaluations:**

Date/Time Signature/Date

RESIDENT	PHYSICIAN	ROOM NO.	ADMISSION NO.
Peterson, William	[illegible]	[illegible]	[illegible]

PAIN ASSESSMENT

Resident Peterson, William ID # 1050

Allergies NKA Diagnosis

** IF RESIDENT UNABLE TO VERBALIZE or COGNITIVELY IMPAIRED, GO TO #2*

1. Pain Intensity at Present: (Circle Score)

0	1	2	3	4	5
None	Slight	Mild	Moderate	Severe	Excruciating

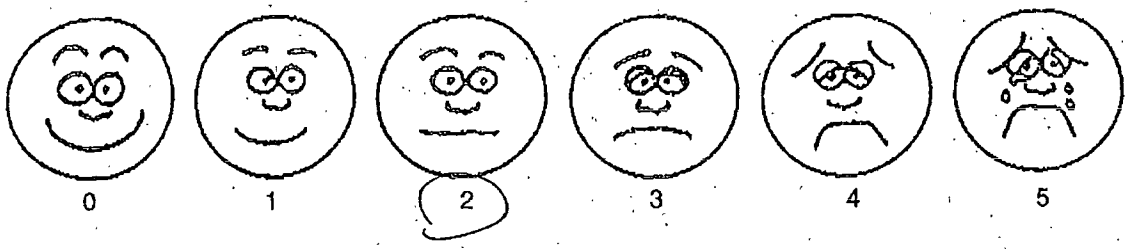
A. How long have you had the pain? (Enter #) ____ days ✓ months ____ years
B. What is the duration of pain? Brief ____ Intermittent ✓ Constant ____
C. What best describes the type of pain?

Aching ____	Burning ____	Stabbing ____	Dull/Diffuse ____
Pulling ____	Cramping ____	Gnawing ✓	Pressing/Tight ____
Pricking ____	Throbbing ____	Shooting ____	Other ____

D. What relieves the pain? meds.
E. What increases the pain? movement
F. What is your current treatment? unk
G. What response did you have to this treatment? unk

GO TO SECTION #2B

2. Cognitively Impaired Residents - Identify by listing behavior exhibited:



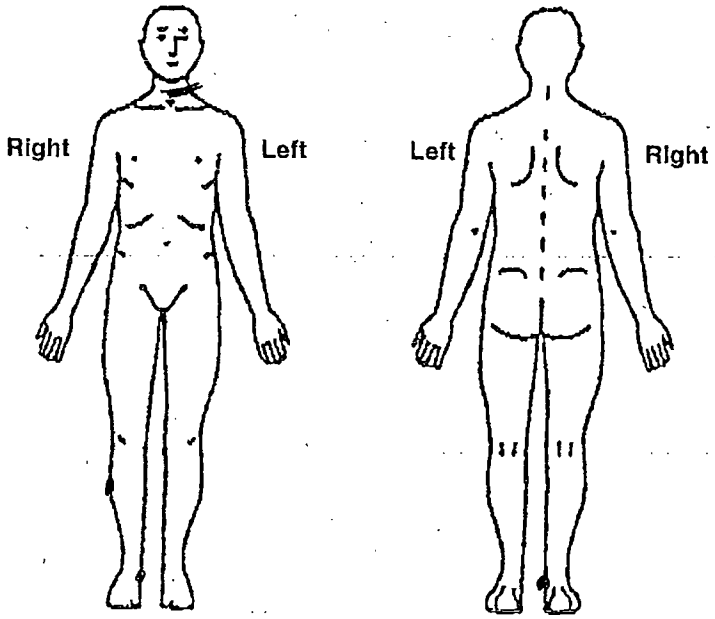
A. Subjective Assessment:
1. Facial Expressions: Flinching ____ Grimacing ____ Moaning/Crying out ____
Resident Physically Removing Caregivers Hand ____ Other ____
2. Body Action guarded
3. Behavior does not want to move or turn
4. Other

B. History of pain and what relieves it: post cervical surgery

C. Physical Assessment by Nurse if any of the below observations are identified.
Physical Examination of painful areas: (Use illustration below)

Heat _____	Swelling/Inflammation _____	Tenderness _____	Redness Present _____
Aching _____	Burning _____	Stabbing _____	Dull/Diffuse _____
Pulling _____	Cramping _____	Gnawing _____	Pressing/Tight _____
Prickling _____	Throbbing ✓	Shooting _____	Other _____

Physical Assessment by Nurse: (identify area on illustration)



3. How Does The Pain Affect:

a. Sleep? _____
b. Appetite? poor
c. Mobility? limited
d. General Activity? Ø
e. Ability to Concentrate? confused
f. Enjoyment of Life? _____

Notes: _____

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

Resident Peterson, W[illegible] TMH&R of Edgefield ID # 03/21/2006 - 05/25/2006 - 0130

-652-

Resident Name **PETERSON, WILLIAM**

Date: 3/22/06

Category	Assessment Question		Answer	Nutrition	Dehydration	Elopement	Fall	Skin	Contracture	Poly Pharm	Impaction	Restraint	Entrap ment	Pain
Age	> 80	4	4	4	4		4		4	4	4			
	65-79	3		0	0		0		0	0				
	50-64	2					0		0	0				
Mental Status	B6 Deterioration of cognitive status	2	2				2	2	2	2				
	Disoriented to person	2		0	0	0					0	0		
	Disoriented to place	2	2	2	2	2	2				2	2	2	
	Disoriented to time	2	2	2	2	2	2				2	2	2	
	Confused or sedated	3	3	3	3	3	3		3		3	3	3	
	Delsional	2		0	0	0	0			0		0	0	
Behaviors	Exit Seeking	2				0	0					0	0	
	***Hx of Elopement**	2				0						0		
	Verbalizations of wanting to go home	1		0		0						0		
	***Hx of Falls in last month**	5	5				5			5		5	5	
	Hx of more than 1 fall in last 6 months	3	3				3			3		3	3	
	Prefers to sit on floor	1					0					0		
	Resists Care	1		0	0		0		0	0		0		
	Strikes out	1					0					0		
	***P4c Daily trunk restraint**	3					0					0		
Communication	Wears Glasses	1		0	0		0							
	Poor/blind eysight without glasses	2		0	0		0						0	
	Aphasic	2		0	0		0				0			
	Speech slurred	1		0	0		0							
	Different language other than English	1		0	0		0							
	HOH either ear	1	1	1	1		1							
	***Upper limited**	2	2	2	2		2		2		2	2	2	
	Upper Immobile	2		0	0		0		0		0	0	0	
	***Lower Limited**	2	2				2		2		2	2	2	
	Lower Immobile	2					0		0		0	0	0	
	Poor Bal. While sitting	2	2	2	2		2		2		2	2	2	
	Poor Bal while standing	2	2				2		2		2	2	2	
Mobility	Amputation	2					0		0			0		
	Cane	2					0		0					
	Prosthesis	2					0		0					
	Wheelchair	2					0	0	0		0	0		
	Walker	2					0		0					
	Ataxia or shuffles feet	2					0		0			0		
	***G1aA Bed mobility self performance**	2,3,4	3				3	3	3			3		
	G1bA Transfer self performance	2,3,4	3				3	3	3			3		
	Bedfast most of time	1	1	1	1		1	1	1		1	1	1	
Bowel and Bladder	H1b Bladder Incontinence	2,3,4					0	0			0		0	
	Incontinent of bowel	3					0				0		0	
	***Hx of impaction**	2		0	0	0	0				0	0		0
; & Drinking	Texture of diet altered	2	2	2	2						2			
	Calories of diet altered	2		0	0						0			
	Eat < 75% or refuses to eat	2		0	0						0			
	***Unintended weight loss**	3		0	0						0			0
	Tube feeding	3		0	0						0			
	Dx of dehydration	2		0	0		0				0			

Resident Name PETERSON, WILLIAM

Date: 3/22/06

Assessment Question			Answer	Nutrition	Dohydration	Elopement	Fall	Skin	Contracture	Poly Pharm	Impaction	Restraint	Entrap ment	Pain
	Dx of malnutriton / anemia	2		0	0		0			0	0			
Eating & Drinking (Cont.)	Limits self on food choices	1		0	0						0			
	Limits self on drink choices	1		0	0						0			
	Poor dentition/missing teeth/dentures	2	2	2	2									
	K2a or K2b BMI under 23	1		0	0			0						
	Weight < 100 lbs.	2		0	0								0	
	Weight > 300 lbs.	1					0	0						
Skin Condition	Areas red or mottled or edematous	2	2	2	2			2						
	*M4e Skin desensitizaed to pain	1		0	0			0						
	*M2a Pressure ulcer present	1	1	1	1	1	1	1		1		1		
	*M3 Hx of resolved pressure ulcer	1		0	0	0	0	0		0		0		
Medication Usage	*Uses more than 8 medications	1		0	0	0	0			0	0	0	0	
	Diuretic	2		0	0	0	0			0	0	0	0	
	Analgesics	1		0			0		0	0	0	0	0	
	Antihypertensive	2	2		2		2			2	2	2	2	
	Sedatives	2		0			0		0	0	0	0	0	
	Antipsychotics	2		0			0		0	0	0	0	0	
	Antidepressants	2		0			0		0	0	0	0	0	
	Hypnotic	2					0		0	0	0	0	0	
	Antianxiety	2					0		0	0	0	0	0	
Diseases	Dementia / delirium	3	3	3	3	3	3		3	3	3	3	3	
	BP / cardiac / pulmonary	2	2	2	2	2	2		2	2	2			
	Mental illness	3		0	0	0	0		0	0		0	0	
	I1a Diabetes	3		0	0	0	0	0	0	0	0		0	
	*I1J Peripheral vascular disease	1		0	0	0	0	0	0	0	0		0	
	Post hospitalization	1	1	1	1	1	1		1	1	1	1	1	
	J4c Hip fx last 180 days	5		0	0	0	0	0	0	0	0	0	0	
	Osteoarthritis / arthritis	1		0	0	0	0	0	0	0	0	0	0	
	J5c Endstage disease or malignancy	1		0	0	0	0	0	0	0	0	0	0	
	J52a Pain Frequency	0,1,2	2	2	2	2	2		2	2	2	2	2	2
	J2b Pain Intensity	1,2,3	1	1	1	1	1		1	1	1	1	1	1
AIMS Facial and Oral	Facial expression	0-4	0	0	0					0				
	Lips and periorbital	0-4	0	0	0					0				
	Jaw	0-4	0	0	0					0				
	Tongue	0-4	0	0	0					0				
Extremity	Upper torso	0-4	0	0	0		0		0	0		0	0	
	Lower torso	0-4	0				0		0	0		0	0	
Global	Incapacitation	0-4	0				0		0	0	0	0	0	

Resident Name PETERSON, WILLIAM

Date: 3/22/06

Assessment Question		Answer	Nutrition	Dehydration	Elopement	Fall	Skin	Contracture	Poly Pharm	Impaction	Restraint	Entrap ment	Pain
Totals	Total AIM Score	0											
	Add column		33	35	17	49	12	33	26	33	40	33	17
	Divide by possible		51	47	23	64	15	42	33	46	47	41	21
Risk Levels	High > 68%			74%	74%	77%	80%	79%	79%	72%	85%	80%	81%
	Moderate 34% to 67%		65%										
	Low < 33%												

Completed by: Kathleen Dykes

THERAPY REFERRAL FORM

The following resident is being referred to the Therapy Department:

Resident Name: Peterson _____ Medical Record #: _____

Physician Name: _____ HICN #: _____

Diagnosis/Condition: _____

For the following reasons:

DOMAIN	YES	NO	N/A	Comments (optional)
Accidents				
Recent falls	☐	☐	☐	
Recent fractures	☐	☐	☐	
Cognitive Patterns				
Recent change in cognitive patterns	☐	☐	☐	
Recent change in speech/language	☐	☐	☐	
Elimination/Incontinence				
Recent increase in incontinence	☐	☐	☐	
Nutrition/Eating				
Recent weight loss	☐	☐	☐	
Recent feeding tube	☐	☐	☐	
Recent dehydration	☐	☐	☐	
Recent change in eating/swallowing	☐	☐	☐	
Physical Functioning				
Recent change in ADLs				
Bed mobility	☐	☐	☐	
Tolleting	☐	☐	☐	
Transfers	☐	☐	☐	
Eating	☐	☐	☐	
Other: _____	☐	☐	☐	
Recent change in ROM	☐	☐	☐	
Quality of Life				
Recent restraint or change in restraint	☐	☐	☐	
Skin Care				
Recent change in skin condition	☐	☐	☐	
Other				
_____	☐	☐	☐	

RECOMMENDATIONS		Comments (optional)
No skilled interventions	☐	
Restorative Nursing Program	☐	
Refer to routine nursing care	☐	
Other (specify) _____	☐	
Formal Evaluation(s) Indicated		
PT	☐	
OT	☐	
ST	☐	

V. Vanzetto OTR/L 3-06

Therapist's Signature Date

Resident Name _____ MDS Section G3

BALANCE WHILE STANDING

Obtain a watch with a second hand to time the test. Pick a time to test resident when he/she is at his/her best. Place a chair directly behind the resident in case he/she needs to sit down. Stand close to resident while testing balance in order to catch or balance him/her, if necessary. Obtain assistance from another staff member if needed to ensure resident safety. Test balance without assistive devices (but with prostheses, if used). For residents with walkers, make sure the walker is placed directly in front of the resident within easy reach in case it is needed for rebalancing. DO NOT attempt to test residents who cannot stand by themselves.

SCORING: 0 Maintained position as required in test – Resident was able to maintain all 3 standing positions for 10 seconds without moving feet out of position.

1 Unsteady, but able to rebalance self without physical support – Resident was unable to maintain one or more standing positions for 10 seconds each without moving feet out of position. Resident was unsteady but was able to rebalance self without physical support from others or from an assistive device in at least the first position.

2 Partial physical support during test, or stands but does not follow directions for test – While the resident performed part of the activity, resident was unable to maintain one or more standing positions without physical support from other(s) or from an assistive device. This category also includes residents who can stand but are unable or refuse to follow your directions to perform a test of balance.

3 Not able to attempt test without physical help – Resident is not able to stand without physical help from another person or an assistive device.

TEST		
POSITION 1	Stand with feet together, side by side, firmly on floor. Maintain position for 10 seconds. If able,	
POSITION 2	Stand with one foot halfway in front of the other. Maintain position for 10 seconds. If able,	
POSITION 3	Stand with one heel in front of & touching the toes of other foot. Maintain position for 10 seconds.	SCORE 3

BALANCE WHILE SITTING

Obtain a watch with a second hand to time the test. Do not conduct sitting balance in wheelchair. Find a chair with a firm, solid seat to conduct the test. The height of the chair seat should be low enough to allow the bottom of the resident's feet to rest on the floor for support. It is safer to use a chair with arms in case the resident needs physical support during the test. Stand close to resident while testing balance in order to catch or balance him/her, if necessary. Obtain assistance from another staff member if needed to ensure resident safety.

SCORING: 0 Maintained position as required in test – Resident was able to sit for 10 seconds without touching the back or sides of the chair for support.

1 Unsteady, but able to rebalance self without physical support – Resident was unable to maintain sitting balance for 10 seconds each without touching the back or sides of the chair for support. Resident was unsteady but was able to rebalance self.

2 Partial physical support during test, or stands but does not follow directions for test – While the resident performed part of the activity, resident was unable to maintain sitting balance without physical support from other(s) or from touching the backs or sides of the chair for support. This category also includes residents who can sit but are unable or refuse to follow your directions to perform a test of sitting balance.

3 Not able to attempt test without physical help – Resident is not able to sit without physical help from another person or an assistive device or chair back/arm for support.

TEST		
POSITION 1	Sit in chair with feet on floor & arms folded across chest without using the back or arms for support. Maintain position for 10 seconds.	SCORE 0

ROM / VOLUNTARY MOVEMENT TEST FORM

LIMITATION IN RANGE OF MOTION

Perform each test on both sides of the resident's body. If the resident is unable to follow verbal directions demonstrate each movement. If resident is still unable to perform the activity, move the resident's joints through slow, active assistive range of motion to assess for limitations. STOP if the resident experiences pain.

SCORING: 0 No limitation – Resident has full function range of motion on the right and left side.

1 Limitation on one side of the body (either right or left side).

2 Limitation on both sides of the body.

TEST		
Neck	With resident seated in a chair, ask him/her to turn the head slowly, looking side to side. Then ask the resident to return head to center and then try to reach the right ear towards the right shoulder, then left ear towards left shoulder.	SCORE 0
Arm	With resident seated in a chair, ask him/her to reach with both hands and touch palms to back of head. Then ask the resident to touch each shoulder with the opposite hand. Alternatively, observe the resident donning or removing a shirt over the head.	SCORE 0
Hand	For each hand, instruct the resident to make a fist, then open the hand.	SCORE 0
Leg	While resident is lying supine in a flat bed, instruct the resident to lift his/her leg (one at a time), bending it at the knee (90 degrees). Then ask the resident to slowly lower his/her leg, and extend it flat on the mattress.	SCORE 0
Foot	While supine in bed, instruct the resident to flex and extend each foot.	SCORE 0
Other	Decreased mobility in spine, jaw, or other joints that are not listed	SCORE 0

LOSS OF VOLUNTARY MOVEMENT

For each body part, code the appropriate response for the resident's function during the past seven days. If the body part is missing, code "1", if missing bilaterally, code "2".

SCORING: 0 No loss of voluntary movement – Resident moves body part to complete the required task. Movements are smooth and coordinated.

1 Partial loss of voluntary movement – Resident is able to initiate and complete the required task but movements are slow, spastic, uncoordinated, rigid, choreiform frozen, etc. on one or both sides.

2 Full loss of voluntary movement — Resident is not able to initiate the required task. There is no voluntary movement on either side.

TEST	
	SCORE 0
	SCORE 0
	SCORE 0
	SCORE 0
	SCORE 0
	SCORE 0