THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM THE FULL COMMISSION OF THE SOUTH CAROLINA WORKERS' COMPENSTION COMMISSION

WCC FILE NO.: 1206355
Appellate Tracking No.: 2013-002666

FRANCES BARON, EMPLOYEE, APPELLANT

V.

SANCTUARY HOSPICE EMPLOYER,

AND

GUARANTEE INSURANCE COMPANY C/O PATRIOT NATIONAL INSURANCE GROUP, CARRIER, RESPONDENTS.

RECORD ON APPEAL
VOLUME 2

William G. Jenkins, Jr.
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P.O. Box 12519
Columbia, South Carolina, 29211-2519

15:18:46 COASTAL CAROLINA MED CNTR REGISTRATION
1000 MEDICAL CENTER DR HARDEEVILLE SC 29927 RECORD-F01

PATIENT NO: [redacted]
NS/ROOM/BED:
ADMIT DT/TIME: 6/21/12 13:30 M/R NO: [redacted]
CLINICS: WC
RESISTANT ORG:

IENT NAME: BARON, FRANCES
NG ADDR: [redacted]
TY/STATE: [redacted]
HYSICAL ADR:
CITY/STATE:
OCCUPATION: RN
POB: XX
DOB: [redacted]
AGE: 70 Y RACE: WHI
SEX: F REF PHY: 1202-COTTER, JASON WIL PHN: 843 705-8888
PCP PHY: -
ETHNICITY: NON FLAG:

BY: AUTO
TITLE:
SOCIAL SECURITY: [redacted]
PHONE: [redacted]
NPP: 2.0 DATE: 12/08/03
PHONE: ( )
LANGUAGE: EN FC: 05
ADMT PHYS: 1202- COTTER, JASON WIL HSV: 60
ADMT PHYS PHONE: (843) 705-8888 RLG: PAR:
ATTEND PHYS: 1202- COTTER, JASON WIL MS: M
SMK: N
PHN: VAL: PT: 2
FATHER'S DOB: MOTHER'S DOB:

MER CONTACT: BARON, EDWARD
ADDRESS: [redacted]
CITY/STATE: [redacted]
EAREST RELT: BARON, EDWARD
ADDRESS: [redacted]
CITY/STATE: [redacted]

REL: SPOUSE
PHONE: [redacted]
REL: SPOUSE
PHONE: [redacted]
RESEARCH ID:

GUARANTOR: BARON, FRANCES A
ADDRESS 1: [redacted]
ADDRESS 2:
CTY/STE/ZIP: [redacted]
AYOR NAME 1: NATIONWIDE MUTUAL IN
PLAN NAME: AUTO INSURANCE/600
C/O NAME:
ADDRESS: 1 NATIONWIDE PLAZA
E/CNTRY: COLUMBUS OH 43215
ILLING NAME:
INSURED: BARON, FRANCES
EMPLOYER: SANCTUARY HOSPICE
ADDRESS: 10911 N JACOB SMART BLVD
CITY/STATE: RIDGELAND
AYOR NAME 2: MEDICARE/618
PLAN NAME: MEDICARE/618
LL C/O NAME:
ILL ADDRESS: P O BOX 1602
Y/STE/CNTRY: OMAHA NE 68101
ILLING NAME:
INSURED: BARON, FRANCES
EMPLOYER: SANCTUARY HOSPICE
ADDRESS: 10911 N JACOB SMART BLVD
CITY/STATE: RIDGELAND

REL: SELF
PHONE: ( ) [redacted]
SOCIAL SECURITY: [redacted]
9842 OCC:RN AF: USA
INS. PLAN ID: Q9701 SRV/TYPE: ALLOP
IPA:
AUTH #:
CERT-SSN-HIC-ID#: [redacted]
BILL PHONE: ( ) 000-0000
GP #: NONE
SEX/REL: F SELF
MSP: Y TRACKING#:
EMP PHONE: (843) 645-6540
ESC: 1
INS. PLAN ID: [redacted]

AUTH #:
CERT-SSN-HIC-ID#: [redacted]
BILL PHONE: (866) 580-5981
GP #: NONE
SEX/REL: F SELF
TRACKING#:
EMP PHONE: (843) 645-6450
ESC: 1

SPAN CODE:
ROM/TO DATE:
ONDITION CD
10
CONDITION CD
PRIOR VISIT: 6/14/12
PRIOR HOSPITAL:
OCCURRENCE CD/DATE
01 5/21/12
OCCURRENCE CD/DATE

HIEF COMPLAINT DESCRIPTION:
WOUND CARE
MENTS:
CHIEF COMPLAINT CODE:

PRINTED BY: TARABLOOM
DATE: 08/17/2012

Visit Report for 6/21/2012

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

Arrival Information Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 6/21/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Visit Information

Arrival Condition:	Stable
Ambulatory Status:	Ambulatory
Accompanied By:	spouse
Reason for today's visit:	MD visit
Patient Identification Verified:	Yes
Secondary Verification Process Completed:	Yes
Patient is in Isolation Precaution?	No
Is patient oriented to person, place, and time?	Yes

History Since Last Visit

Added or deleted any medications:	No
Any new allergies or adverse reactions:	No
Added any significant procedures or medical diagnosis:	No
Experienced change in activities of daily living that may affect risk of falls:	No
Experienced any changes in pain level or management:	No
Signs or symptoms of abuse/neglect since last visit?	No

Entered By: Cole, Lori on 06/21/2012 3:20:11 PM

Signature(s): **Date(s):**

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

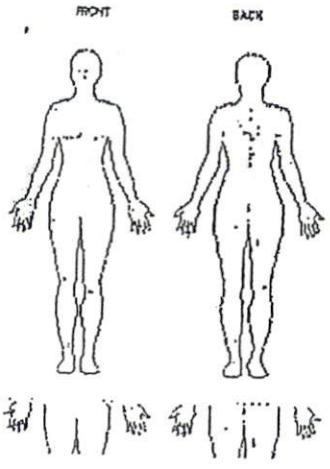
Pain Assessment Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 6/21/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Location of Pain

[redacted]



Severity and Temporal Description of Pain

Patient Has Pain?	Yes
Duration of the Pain.	
Constant / Intermittent?	Intermittent
Rate the pain.	
Current Pain Level:	2
Worst Pain Level:	4
Least Pain Level:	2
Tolerable Pain Level:	4

Character of Pain

Describe the Pain: Aching, Tender

Pain Management and Medication

Current Pain Management:

Medication:	Yes	Is the Current Pain Management Adequate:	Adequate
Rest:	Yes		
Activity:	Yes		

Entered By: Cole, Lori on 06/21/2012 3:20:35 PM

Signature(s): Date(s):

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

Lower Extremity Assessment Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 6/21/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Edema Assessment

	Left:	Right:
Edema:		
Compression Device In Use:		Yes
Device Used Correctly:		Yes
Compression Device Used:		Yes
		Tubigrip or Tubifast

Foot

Point of Measurement: cm	From:	cm	cm

Vascular Assessment

	Left:	Right:
Pulses:		
Popliteal:		
Extremity colors, hair growth, and conditions:		
Extremity Color:		Red
Erythema:		Yes

Entered By: Cole, Lori on 06/21/2012 3:20:46 PM

Signature(s): **Date(s):**

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

Adherence to Plan of Care Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 6/21/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Adherence to Plan of Care Items

Wound Visits:	Yes	Limb Elevation:	Yes
Dressing Changes:	Yes		

Notes

Entered By: Cole, Lori on 06/21/2012 3:22:48 PM

Signature(s):

Date(s):

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

Patient/Caregiver Education Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 6/21/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Patient/Caregiver Education Items

Teaching Provided To: Patient

Dressing:	Yes
Methods:	Explain/Verbal
Responses:	Reinforcements needed

Entered By: Cole, Lori on 06/21/2012 3:25:48 PM

Signature(s):

Date(s):



COASTAL CAROLINA
HOSPITAL

Hilton Head Regional Healthcare

Visit Discharge Information Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 6/21/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Visit Discharge Information Items

Discharge Condition:	Stable
Ambulatory Status:	Wheelchair
Discharge Destination:	Home
Transportation:	Private Auto
Accompanied By:	spouse
Schedule Follow-up Appointment:	Yes
Medication Reconciliation completed and provided to Patient/Care Provider:	No
Clinical Summary of Care Provided:	No

Facility Notification

Facility Type:	Home Health Services
Orders Sent:	Yes

Entered By: Cole, Lori on 06/21/2012 3:29:09 PM

Signature(s): **Date(s):**

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

Wound Assessment Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 6/21/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Wound Status

Wound Number:	1	Wound Status:	Resolved
Wound Location:	Right, Proximal, Anterior Lower Leg		
Wound Type:	Trauma		
Date Acquired:	5/21/2012		

Photos

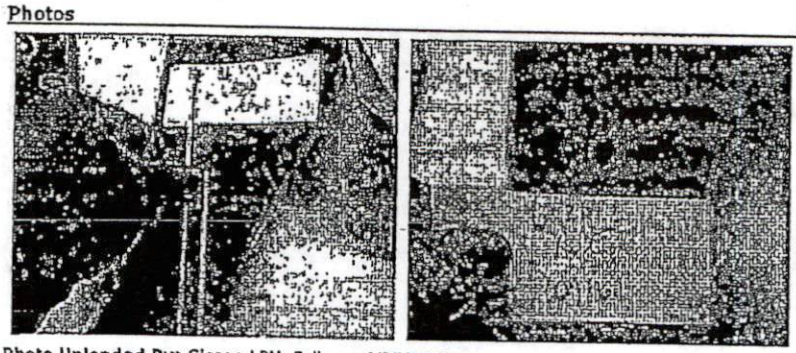


Photo Uploaded By: Sisson LPN, Sally on 6/25/2012

Wound Measurements

Hypergranulated: No

Wound Description

			Exposed Structure
Epithelialization:	Percentage 76-100%	Tendon Exposed:	No
		Muscle Exposed:	No
		Joint Exposed:	No
		Bone Exposed:	No

Peripheral Skin Appearance

	Texture		Color
Normal For Patient:	Yes	Normal For Patient:	Yes
	Moisture		Temperature
Normal For Patient:	Yes	Temperature:	Warm
			S/S of Infection
		S/S Present:	No
			Local Pulse
		Local Pulse:	Normal

Entered By: Cole, Lori on 06/21/2012 2:39:48 PM

Signature(s):

Date(s):

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

Wound Assessment Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 6/21/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Wound Status

Wound Number:	3
Wound Location:	Distal, Anterior Lower Leg
Wound Type:	Trauma
Wound Status:	Not Healed

Wound Measurements

Length: (cm)	0.8
Width: (cm)	0.8
Depth: (cm)	1
Hypergranulated:	No
Area: (sq cm) based on L*W	0.64
Volume: (cm^3) based on Area*D	0.64
Tunneling:	Yes
Position (o'clock):	12
Maximum Distance: (cm)	5.5
Undermining:	No
Sinus Tract:	No

Wound Description

Thickness:	Full Thickness
Exudate Amount:	Large
Exudate Type:	Sero-sanguineous
Odor:	None
Pain:	3
Wound Margin:	Flat and Intact

Exposed Structure

Tendon Exposed:	No
Muscle Exposed:	No
Joint Exposed:	No
Bone Exposed:	No

Percentage

Peripheral Skin Appearance

Texture

Normal For Patient:	No
Edema:	Yes
Induration:	Yes

Moisture

Normal For Patient:	Yes

Color

Normal For Patient:	Yes

Temperature

Temperature:	Warm

S/S of Infection

S/S Present:	Yes

Confirmation Description & Treatment Plan: Signs & Symptoms Present, Systemic Antibiotics Prescribed

Local Pulse

Local Pulse:	Normal

Treatment Notes

Wound #3 (Distal, Anterior Lower Leg)

Wound Treatment Note

- Pt ID by name and photo, correct site ID.
- Assessed patient's pain status and effectiveness of pain management plan
- Removed old dressing, taking care to avoid trauma to the wound bed
- Cleansed wound and periwound with non-cytotoxic agent using Wound cleanser (1)
- Obtained wound photo
- Applied primary wound dressing using Iodoform (1)

- Applied Secondary Wound Dressing using Gauze (1), Kerlix (1)
- Dressing secured dressing in place using Netting (1)
- Applied Compression device using Tubigrip (1)

Entered By: Cole, Lori on 06/21/2012 2:40:24 PM

Signature(s):

Date(s):

Treatment Notes Summary

Wound #3 (Distal, Anterior Lower Leg)

Wound Treatment Note

- Pt ID by name and photo, correct site ID.
- Assessed patient's pain status and effectiveness of pain management plan
- Removed old dressing, taking care to avoid trauma to.the wound bed
- Cleansed wound and periwound with non-cytotoxic agent using Wound cleanser (1)
- Obtained wound photo
- Applied primary wound dressing using Iodoform (1)
- Applied Secondary Wound Dressing using Gauze (1), Kerlix (1)
- Dressing secured dressing in place using Netting (1)
- Applied Compression device using Tubigrip (1)

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

Physician Orders Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 6/21/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Verbal / Phone Orders: No

Follow-Up Appointments

- **Return Appointment in 1 wee k.**

Anesthetic

- **Topical Xylocaine to wo und bed prior to debridement.** - 4%

Wound Cleansing & Dressings

- **Pack wound** - 1/4 inch Iodoform BID to distal wound

Compression /Edema Control/ Off-Loading

- **Elevate leg(s) above the level of the heart when sitting.**
- **Avoid prolonged standing in one place.**
- **Single Layer Compression Wrap** - tubigrip

Dietary

- **Increased protein**
- **Supplement with multi-vitamin**

Ancillary Services

- **Home Health Services** - SN for wound care daily x 1 week, pack distal wound to tunnel at 12 and undermining 1-11

Notes

Electronic Signature(s)

Signed By:	Date:
Cotter, Jason	06/25/2012 8:23:50 AM
Cotter, Jason	06/25/2012 8:23:57 AM

Entered By: Cotter, Jason on 06/21/2012 4:38:52 PM

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

Progress Note Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 6/21/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Subjective

Allergies
mango

70 year old female who was in a car accident suffering a left lower leg fracture and right lower leg wounds. Her right lower leg x-rays were negative. She has been using Santyl on her proximal wound, and packing her distal wound with iodoform twice daily. There have been no improving or worsening factors. Her risk factors for wound healing include diabetes and venous hypertension. She has had nausea, but denies vomiting, fever, or chills. She has been receiving wound care for 3 weeks. Her pain is much better this week. She had a negative venous ultrasound and her WBC was normal.

Objective

Integumentary (Hair, Skin)
Wound #1, located on the Right,Proximal,Anterior Lower Leg has resolved with 76-100% epithelialization.

Wound #3 presents as a Full Thickness Trauma located on the Distal,Anterior Lower Leg and measures 0.8cm length x 0.8cm width x 1cm depth; 0.64cm^2 area and 0.64cm^3 volume, calculated based on L*W and Area*D, respectively. There is no sinus tract or undermining noted, however, there is tunneling at 12:00 with a maximum distance of 5.5cm. There is a large amount of sero-sanguineous drainage noted which has no odor. The wound pain is a level 3. Systemic antibiotics prescribed - refer to new medications prescribed. The wound margin is flat and intact.

Assessment

Diagnoses
250.00: Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled
891.0: Open wound knee, leg, ankle (not thigh)- w/o complication
459.33: Chronic venous hypertension with ulcer and inflammation
729.92: Nontraumatic hematoma of soft tissue

Procedures

Plan

Follow-Up Appointments:
Return Appointment in 1 week.
Anesthetic:
Topical Xylocaine to wound bed prior to debridement. - 4%

Wound Cleansing & Dressings:
Pack wound - 1/4 inch iodoform BID to distal wound
Compression/Edema Control/ Off-Loading:
Elevate leg(s) above the level of the heart when sitting.
Avoid prolonged standing in one place.
Single Layer Compression Wrap - tubigrip
Dietary:
Increased protein
Supplement with multi-vitamin
Ancillary Services ordered were:
Home Health Services - SN for wound care daily x 1 week, pack distal wound to tunnel at 12 and undermining 1-11

Follow-Up Appointments:
A follow-up appointment should be scheduled.

Continue her Bactrim. Continue packing wound. Return for follow up in one week. No further tests since her symptoms have improved.

Electronic Signature(s)

Signed By:	Date:
Cotter, Jason	06/25/2012 8:23:50 AM
Cotter, Jason	06/25/2012 8:23:57 AM

Entered By: Cotter, Jason on 06/21/2012 4:40:44 PM

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

Clinic Level Of Care Assessment Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 6/21/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Clinic Level Of Care Assessment Items

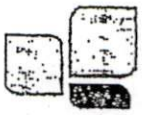
	Quantity	Score
Admission / AMA		
☐ Hospital Admission (Inpatient Observation)		0
☐ AMA or LWBS		0
Interventions		
☐ Specimen Collection # of		0
☐ Hematoccult / Glucostix		0
☐ Glucose Scan / Urine Dipstick		0
☑ Elastic Wrap	1	10
☐ Compression Therapy Single Extremities		0
☐ Compression Therapy Multiple Extremities		0
Assisting / Monitoring		
☐ Ankle, Brachial Index		0
☐ Doppler		0
☐ Monitoring - Extensive		0
☐ Nursing Assessment - Initial		0
☑ Nursing Assessment - Subsequent Partial	1	10
Wound Care		
☐ Simple Suture Removal		0
☐ Complex Suture Removal		0
☑ Wound Assessment	1	10
☐ Wound Measurement		0
☑ Wound Measurement - Extensive	1	10
☐ Wound Cleansing - Simple		0
☑ Wound Cleansing - Complex	1	15
☑ Photography	1	10
☐ Extremity		0

☐	Tissue Expander Injection (Episodes of:)		0
☐	Dressing - Simple		0
☐	Dressing - Moderate		0
☐	Dressing - Moderately Complex		0
☐	Dressing - Complex		0
☑	Dressing - Extensive	1	30
☐	Dressing - Extensive Complex (VAC)		0
Special Needs			
☐	Special Teaching Needs		0
☐	Special Emotional Needs		0
☐	Special Service Needs (Each needs episod e of:)		0
☐	Coordination of Care		0
☐	Combative Patient		0
Medications			
☐	Medications - PO Suppository Topical		0
☐	IV Preexisting		0
Education Discharge (Instructions)			
☑	Discharge Instructions	1	5
☐	Discharge Instructions		0
☐	Extensive Education / Counseling		0

Is this the patient's first visit: No **Total Score:** 100 **Level Of Care:** New / Est Patient Level 4 - Moderate to High

Entered By: Cole, Lori on 06/21/2012 3:30:12 PM

Signature(s): **Date(s):**



COASTAL CAROLINA
HOSPITAL

Hilton Head Regional Healthcare

SuperBill Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 6/21/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

ICD9 Coding

Code	Description
250.00	Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled
891.0	Open wound knee, leg, ankle (not thigh)- w/o complication
459.33	Chronic venous hypertension with ulcer and inflammation
729.92	Nontraumatic hematoma of soft tissue

Facility Procedures

CPT4 Code	Description	Modifier	Quantity
760171	99214 Est. Patient Level 4 - Moderate to High		1

Physician Procedures

CPT4 Code	Description	Modifier	Quantity
99214	Est. Patient Level 4 - Moderate to High		1

Electronic Signature(s)

Signed By:	Date:
Cotter, Jason	06/25/2012 8:23:50 AM
Cotter, Jason	06/25/2012 8:23:57 AM

Entered By: Cotter, Jason on 06/21/2012 4:37:35 PM

PATIENT NO: [redacted] ADMIT DT/TIME: 6/28/12 13:30 M/R NO: [redacted]
NS/ROOM/BED: CLINICS: WC RESISTANT ORG:

BY: AUTO
TITLE:

PATIENT NAME: BARON, FRANCES
ING ADDR: [redacted] SOCIAL SECURITY: [redacted]
TY/STATE: [redacted] PHONE: [redacted]
PHYSICAL ADR: NPP: 2.0 DATE: 12/08/03
CITY/STATE: PHONE: ( )
OCCUPATION: RN LANGUAGE: EN FC: 05
POB: XX ADMT PHYS: 1202- COTTER, JASON WIL HSV: 60
DOB: [redacted] ADMT PHYS PHONE: (843) 705-8888 RLG: PAR:
AGE: [redacted] Y RACE: [redacted] ATTEND PHYS: 1202- COTTER, JASON WIL MS: M
SEX: F REF PHY: 1202-COTTER, JASON WIL PHN: 843 705-8888 SMK: N
PCP PHY: - PHN: VAL: PT: 2
ETHNICITY: NON FLAG: FATHER'S DOB: MOTHER'S DOB:

EMER CONTACT: BARON, EDWARD REL: SPOUSE
ADDRESS: [redacted] PHONE: [redacted]
CITY/STATE: [redacted]
NEAREST RELT: BARON, EDWARD REL: SPOUSE
ADDRESS: [redacted] PHONE: [redacted]
CITY/STATE: [redacted] RESEARCH ID:

GUARANTOR: BARON, FRANCES A REL: SELF
ADDRESS 1: [redacted] PHONE: [redacted]
ADDRESS 2: SOCIAL SECURITY: [redacted]
CTY/STE/ZIP: [redacted] 9842 OCC:RN AF: USA
PAYOR NAME 1: NATIONWIDE MUTUAL IN INS. PLAN ID: Q9701 SRV/TYPE: ALLOP
PLAN NAME: AUTO INSURANCE/600 IPA:
C/O NAME: AUTH #:
ADDRESS: 1 NATIONWIDE PLAZA CERT-SSN-HIC-ID#: [redacted]
CY E/CNTRY: COLUMBUS OH 43215 BILL PHONE: ( ) 000-0000
BILLING NAME: GP #: NONE
INSURED: BARON, FRANCES SEX/REL: F SELF
EMPLOYER: SANCTUARY HOSPICE MSP: Y TRACKING#:
ADDRESS: 10911 N JACOB SMART BLVD EMP PHONE: (843) 645-6540
CITY/STATE: RIDGELAND ESC: 1
PAYOR NAME 2: MEDICARE/618 INS. PLAN ID: [redacted]
PLAN NAME: MEDICARE/618
LL C/O NAME: AUTH #:
BILL ADDRESS: P O BOX 1602 CERT-SSN-HIC-ID#: [redacted]
Y/STE/CNTRY: OMAHA NE 68101 BILL PHONE: (866) 580-5981
BILLING NAME: GP #: NONE
INSURED: BARON, FRANCES SEX/REL: F SELF
EMPLOYER: SANCTUARY HOSPICE TRACKING#:
ADDRESS: 10911 N JACOB SMART BLVD EMP PHONE: (843) 645-6450
CITY/STATE: RIDGELAND ESC: 1

SPAN CODE: PRIOR VISIT: 6/21/12
FROM/TO DATE: PRIOR HOSPITAL:

CONDITION CD	CONDITION CD	OCCURRENCE CD/DATE	OCCURRENCE CD/DATE
10		01 5/21/12	

CHIEF COMPLAINT DESCRIPTION: CHIEF COMPLAINT CODE:
WOUND CARE
COMMENTS:

PRINTED BY: TARABLOOM
DATE: 08/17/2012

Visit Report for 6/28/2012

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

Arrival Information Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 6/28/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Visit Information

Arrival Condition:	Stable
Ambulatory Status:	Wheelchair
Accompanied By:	spouse
Reason for today's visit:	MD visit
Patient Identification Verified:	Yes
Secondary Verification Process Completed:	Yes
Patient is in Isolation Precaution?	No
Is patient oriented to person, place, and time?	Yes

History Since Last Visit

Added or deleted any medications:	No
Any new allergies or adverse reactions:	No
Added any significant procedures or medical diagnosis:	No
Experienced change in activities of daily living that may affect risk of falls:	No
Experienced any changes in pain level or management:	No
Signs or symptoms of abuse/neglect since last visit?	No

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	06/29/2012 12:07:28 PM
Cole, Lori RN	06/29/2012 12:08:03 PM

Entered By: Cole, Lori on 06/29/2012 10:32:47 AM

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

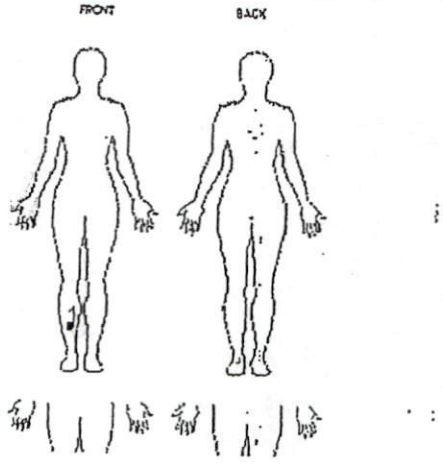
Pain Assessment Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 6/28/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Location of Pain

[redacted]



Severity and Temporal Description of Pain

Patient Has Pain?	Yes
Duration of the Pain.	
Constant / Intermittent?	Intermittent
Rate the pain.	
Current Pain Level:	2
Worst Pain Level:	5
Least Pain Level:	2
Tolerable Pain Level:	2

Character of Pain

Describe the Pain: Tender

Pain Management and Medication

Current Pain Management:

Medication:	Yes	Is the Current Pain Management Adequate:	Adequate
Rest:	Yes		
Activity:	Yes		

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	06/29/2012 12:07:28 PM
Cole, Lori RN	06/29/2012 12:08:03 PM

Entered By: Cole, Lori on 06/29/2012 10:36:40 AM

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

Lower Extremity Assessment Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 6/28/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Edema Assessment

	Left:	Right:
Edema:		Yes
Compression Device In Use:		Yes
Device Used Correctly:		Yes
Compression Device Used:		Tubigrip or Tubifast

Foot

Point of Measurement: cm	From:	cm	cm

Vascular Assessment

	Left:	Right:
Pulses:		
Popliteal:		
Extremity colors, hair growth, and conditions:		
Extremity Color:		Red
Erythema:		Yes

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	06/29/2012 12:07:28 PM
Cole, Lori RN	06/29/2012 12:08:03 PM

Entered By: Cole, Lori on 06/29/2012 10:36:54 AM



COASTAL CAROLINA
HOSPITAL

Hilton Head Regional HealthCare

Adherence to Plan of Care Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 6/28/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Adherence to Plan of Care Items

Wound Visits:	Yes		
Dressing Changes:	Yes	Limb Elevation:	Yes

Notes

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	06/29/2012 12:07:28 PM
Cole, Lori RN	06/29/2012 12:08:03 PM

Entered By: Cole, Lori on 06/29/2012 10:37:09 AM

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

Patient/Caregiver Education Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 6/28/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Patient/Caregiver Education Items

Teaching Provided To: Patient

Dressing:	
Methods:	Yes
Responses:	Explain/Verbal
	State content correctly
Negative Pressure Therapy:	
Methods:	Yes
Responses:	Explain/Verbal
	Reinforcements needed

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	06/29/2012 12:07:28 PM
Cole, Lori RN	06/29/2012 12:08:03 PM

Entered By: Cole, Lori on 06/29/2012 10:38:09 AM

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

Visit Discharge Information Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 6/28/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Visit Discharge Information Items

Discharge Condition:	Stable
Ambulatory Status:	Wheelchair
Discharge Destination:	Home
Transportation:	Private
Accompanied By:	Auto
Schedule Follow-up Appointment:	spouse
Medication Reconciliation completed and provided to Patient/Care Provider:	Yes
Clinical Summary of Care Provided:	No
	No

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	06/29/2012 12:07:28 PM
Cole, Lori RN	06/29/2012 12:08:03 PM

Entered By: Cole, Lori on 06/29/2012 10:39:52 AM

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

Wound Assessment Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 6/28/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Wound Status

Wound Number:	3		
Wound Location:	Distal, Anterior Lower Leg	Wound Status:	Not Healed
Wound Type:	Trauma		

Photos

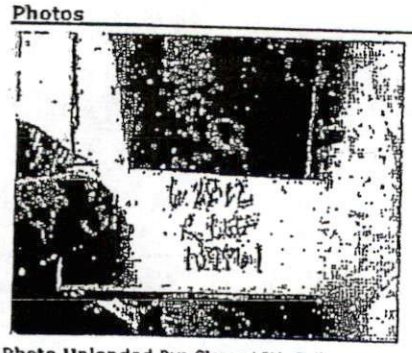


Photo Uploaded By: Sisson LPN, Sally on 6/29/2012

Wound Measurements

Length: (cm)	0.8	Tunneling:	Yes
Width: (cm)	0.8	Position (o'clock):	12
Depth: (cm)	1	Maximum Distance: (cm)	6.5
Hypergranulated:	No		
Area: (sq cm) based on L*W	0.64	Undermining:	No
Volume: (cm³) based on Area*D	0.64	Sinus Tract:	No

Wound Description

Thickness:	Full Thickness		
Exudate Amount:	Large	Exposed Structure	
Exudate Type:	Sero-sanguineous	Tendon Exposed:	No
Odor:	None	Muscle Exposed:	No
Pain:	3	Joint Exposed:	No
Wound Margin:	Flat and Intact	Bone Exposed:	No

Percentage

Peripheral Skin Appearance

	Texture		Color
Normal For Patient:	No	Normal For Patient:	Yes
Edema:	Yes		

Temperature

Induration:	Yes	Temperature:	Warm
Moisture		**S/S of Infection**	
Normal For Patient:	Yes	S/S Present:	Yes
		Confirmation Description & Treatment Plan: Signs & Symptoms Present, Systemic Antibiotics Prescribed	
		Local Pulse	
		Local Pulse:	Normal

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	06/29/2012 12:07:28 PM
Cole, Lori RN	06/29/2012 12:08:03 PM

Entered By: Cole, Lori on 06/28/2012 2:48:14 PM

Treatment Notes Summary

Wound #3 (Distal, Anterior Lower Leg)

Wound Treatment Note

- Pt ID by name and photo, correct site ID.
- Assessed patient's pain status and effectiveness of pain management plan
- Removed old dressing, taking care to avoid trauma to the wound bed
- Cleansed wound and periwound with non-cytotoxic agent using Wound cleanser (1)
- Obtained wound photo
- Applied primary wound dressing using Iodoform (1)
- Applied Secondary Wound Dressing using Gauze (1), Kerlix (1)
- Dressing secured dressing in place using Netting (1)
- Applied Compression device using Tubigrip (1)

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

Physician Orders Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]
Verbal / Phone Orders: No

Date: 6/28/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Follow-Up Appointments

- Return Appointment in 1 week.

Anesthetic

- Topical Xylocaine to wound bed prior to debridement. - 4%

Wound Cleansing & Dressings

- Pack wound - 1/4 inch Iodoform BID to distal wound
- Wound VAC, arrange to start

Compression /Edema Control/ Off-Loading

- Elevate leg(s) above the level of the heart when sitting.
- Avoid prolonged standing in one place.
- Single Layer Compression Wrap - tubigrip

Dietary

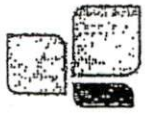
- Increased protein
- Supplement with multi-vitamin

Notes

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	06/29/2012 12:07:28 PM
Cole, Lori RN	06/29/2012 12:08:03 PM
Cotter, Jason	07/02/2012 8:49:40 AM

Entered By: Cole, Lori on 06/29/2012 10:45:14 AM



COASTAL CAROLINA
HOSPITAL

Hilton Head Regional Healthcare

Progress Note Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]
Date: 6/28/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Subjective

Allergies
mango

70 year old female who was in a car accident suffering a left lower leg fracture and right lower leg wounds. Her right lower leg x-rays were negative. She has been packing her distal wound with iodoform twice daily. There have been no improving or worsening factors. Her risk factors for wound healing include diabetes and venous hypertension. She has had nausea, but denies vomiting, fever, or chills. She has been receiving wound care for 4 weeks. She had a negative venous ultrasound and her WBC was normal.

Objective

Integumentary (Hair, Skin)
Wound #3 presents as a Full Thickness Trauma located on the Distal,Anterior Lower Leg and measures 0.8cm length x 0.8cm width x 1cm depth; 0.64cm^2 area and 0.64cm^3 volume, calculated based on L*W and Area*D, respectively. There is no sinus tract or undermining noted, however, there is tunneling at 12:00 with a maximum distance of 6.5cm. There is a large amount of sero-sanguineous drainage noted which has no odor. The wound pain is a level 3. Systemic antibiotics prescribed - refer to new medications prescribed. The wound margin is flat and intact.

Assessment

Diagnoses
250.00: Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled
891.0: Open wound knee, leg, ankle (not thigh)- w/o complication
459.33: Chronic venous hypertension with ulcer and inflammation
729.92: Nontraumatic hematoma of soft tissue

Procedures

Plan

Follow-Up Appointments:
Return Appointment in 1 week.
Anesthetic:
Topical Xylocaine to wound bed prior to debridement. - 4%
Wound Cleansing & Dressings:
Pack wound - 1/4 inch iodoform BID to distal wound
Wound VAC, arrange to start

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

Clinic Level Of Care Assessment Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 6/28/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Clinic Level Of Care Assessment Items

	Quantity	Score
Admission / AMA		
☐ Hospital Admission (Inpatient Observation)		0
☐ AMA or LWBS		0
Interventions		
☐ Specimen Collection # of		0
☐ Hematoccult / Glucostix		0
☐ Glucose Scan / Urine Dipstick		0
☐ Elastic Wrap		0
☐ Compression Therapy Single Extremities		0
☐ Compression Therapy Multiple Extremities		0
Assisting / Monitoring		
☐ Ankle, Brachial Index		0
☐ Doppler		0
☐ Monitoring - Extensive		0
☐ Nursing Assessment - Initial		0
☑ Nursing Assessment - Subsequent Partial	1	10
Wound Care		
☐ Simple Suture Removal		0
☐ Complex Suture Removal		0
☑ Wound Assessment	1	10
☑ Wound Measurement	1	5
☐ Wound Measurement - Extensive		0
☑ Wound Cleansing - Simple	1	10
☐ Wound Cleansing - Complex		0
☑ Photography	1	10
☐ Extremity		0

☐ Tissue Expander Injection (Episodes of:)		0
☐ Dressing - Simple		0
☐ Dressing - Moderate		0
☐ Dressing - Moderately Complex		0
☐ Dressing - Complex		0
☑ Dressing - Extensive		0
☐ Dressing - Extensive Complex (VAC)	1	30
Special Needs		0
☐ Special Teaching Needs		
☐ Special Emotional Needs		0
☐ Special Service Needs (Each needs episod e of:)		0
☐ Coordination of Care		0
☐ Combative Patient		0
Medications		0
☑ Medications - PO Suppository Topical		
☐ IV Preexisting	1	5
Education Discharge (Instructions)		0
☑ Discharge Instructions		
☐ Discharge Instructions	1	5
☐ Extensive Education / Counseling		0
		0

Is this the patient's first visit: No **Total Score:** 85 **Level Of Care:** New / Est Patient Level 3 - Moderate

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	06/29/2012 12:07:28 PM
Cole, Lori RN	06/29/2012 12:08:03 PM

Entered By: Cole, Lori on 06/29/2012 10:30:57 AM

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

SuperBill Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 6/28/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

ICD9 Coding

Code	Description
250.00	Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled
891.0	Open wound knee, leg, ankle (not thigh)- w/o complication
459.33	Chronic venous hypertension with ulcer and inflammation
729.92	Nontraumatic hematoma of soft tissue

Facility Procedures

CPT4 Code	Description	Modifier	Quantity
760170	99213 Est. Patient Level 3 - Moderate		1

Physician Procedures

CPT4 Code	Description	Modifier	Quantity
99213	Est. Patient Level 3 - Moderate		1

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	06/29/2012 12:07:28 PM
Cole, Lori RN	06/29/2012 12:08:03 PM
Cotter, Jason	07/02/2012 8:49:40 AM
Sisson LPN, Sally	07/02/2012 9:14:05 AM
Sisson LPN, Sally	07/02/2012 9:14:23 AM

Entered By: Sisson LPN, Sally on 06/29/2012 9:38:12 AM

11:26:31 COASTAL CAROLINA MED CNTR REGISTRATION
1000 MEDICAL CENTER DR HARDEEVILLE SC 29927 RECORD-F01

PATIENT NO: [redacted]
NS/ROOM/BED:
ADMIT DT/TIME: 7/02/12 10:00 M/R NO: [redacted]
CLINICS: WC
RESISTANT ORG:

ENT NAME: BARON, FRANCES
ING ADDR: [redacted]
TY/STATE: [redacted]
PHYSICAL ADR:
CITY/STATE:
OCCUPATION: RN
POB: XX
DOB: [redacted]
AGE: [redacted] Y RACE: [redacted]
SEX: F REF PHY: 1202-COTTER, JASON WIL
PCP PHY: -
ETHNICTY: NON FLAG:

BY: AUTO
TITLE:
SOCIAL SECURITY: [redacted]
PHONE: [redacted]
NPP: 2.0 DATE: 12/08/03
PHONE: ( )
LANGUAGE: EN FC: 05
ADMT PHYS: 1202- COTTER, JASON WIL HSV: 60
ADMT PHYS PHONE: (843) 705-8888 RLG: PAR:
ATTEND PHYS: 1202- COTTER, JASON WIL MS: M
PHN: 843 705-8888 SMK: N
PHN: VAL: PT: 2
FATHER'S DOB: MOTHER'S DOB:

EMER CONTACT: BARON, EDWARD
ADDRESS: [redacted]
CITY/STATE: [redacted]
NEAREST RELT: BARON, EDWARD
ADDRESS: [redacted]
CITY/STATE: [redacted]

REL: SPOUSE
PHONE: [redacted]
REL: SPOUSE
PHONE: [redacted]
RESEARCH ID:

GUARANTOR: BARON, FRANCES A
ADDRESS 1: [redacted]
ADDRESS 2:
CTY/STE/ZIP: [redacted]
PAYOR NAME 1: NATIONWIDE MUTUAL INS
PLAN NAME: AUTO INSURANCE/600
C/O NAME:
ADDRESS: 1 NATIONWIDE PLAZA
Y, E/CNTRY: COLUMBUS OH 43215
BILLING NAME:
INSURED: BARON, FRANCES
EMPLOYER: SANCTUARY HOSPICE
ADDRESS: 10911 N JACOB SMART BLVD
CITY/STATE: RIDGELAND
AYOR NAME 2: MEDICARE/618
PLAN NAME: MEDICARE/618
LL C/O NAME:
ILL ADDRESS: P O BOX 1602
Y/STE/CNTRY: OMAHA NE 68101
ILLING NAME:
INSURED: BARON, FRANCES
EMPLOYER: SANCTUARY HOSPICE
ADDRESS: 10911 N JACOB SMART BLVD
CITY/STATE: RIDGELAND

REL: SELF
PHONE: [redacted]
SOCIAL SECURITY: [redacted]
9842 OCC:RN AF: USA
INS. PLAN ID: Q9701 SRV/TYPE: ALLOP
IPA:
AUTH #:
CERT-SSN-HIC-ID#: [redacted]
BILL PHONE: ( ) 000-0000
GP #: NONE
SEX/REL: F SELF
MSP: Y TRACKING#:
EMP PHONE: (843) 645-6540
ESC: 1
INS. PLAN ID: [redacted]

AUTH #:
CERT-SSN-HIC-ID#: [redacted]
BILL PHONE: (866) 580-5981
GP #: NONE
SEX/REL: F SELF
TRACKING#:
EMP PHONE: (843) 645-6450
ESC: 1

SPAN CODE:
ROM/TO DATE:
ONDITION CD
10
CONDITION CD
PRIOR VISIT: 6/28/12
PRIOR HOSPITAL:
OCCURRENCE CD/DATE
01 5/21/12
OCCURRENCE CD/DATE

IIEF COMPLAINT DESCRIPTION:
WOUND CARE
CHIEF COMPLAINT CODE:
MENTS:

PRINTED BY: TARABLOOM
DATE: 08/17/2012

Visit Report for 7/2/2012

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

Arrival Information Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 7/2/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Visit Information

Arrival Condition:	Stable
Ambulatory Status:	Wheelchair
Accompanied By:	husband
Reason for today's visit:	wc
Patient Identification Verified:	Yes
Secondary Verification Process Completed:	Yes
Patient is in Isolation Precaution?	No
Is patient oriented to person, place, and time?	Yes

History Since Last Visit

Added or deleted any medications:	No
Any new allergies or adverse reactions:	No
Added any significant procedures or medical diagnosis:	No
Experienced change in activities of daily living that may affect risk of falls:	No
Experienced any changes in pain level or management:	Yes
Signs or symptoms of abuse/neglect since last visit?	No

Electronic Signature(s)

Signed By:
Cole, Lori RN

Date:
07/06/2012 10:06:35 AM

Entered By: Sisson LPN, Sally on 07/02/2012 11:19:49 AM

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

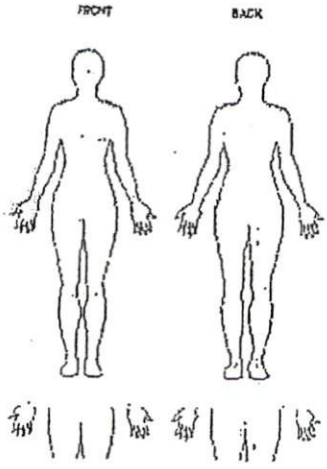
Pain Assessment Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 7/2/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Location of Pain

[redacted]



Severity and Temporal Description of Pain

Patient Has Pain?	Yes
Duration of the Pain.	
Constant / Intermittent?	Intermittent
Rate the pain.	
Current Pain Level:	3
Worst Pain Level:	8
Least Pain Level:	0
Tolerable Pain Level:	3

Character of Pain

Describe the Pain: Easy to Pinpoint, Exhausting, Tender

Pain Management and Medication

Current Pain Management:

Medication:	Yes	Is the Current Pain Management Adequate:	Adequate
Rest:	Yes		

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	07/06/2012 10:06:35 AM

Entered By: Sisson LPN, Sally on 07/02/2012 11:20:52 AM

COASTAL CAROLINA HOSPITAL

Hunter Hearl Personal Healthcare

Lower Extremity Assessment Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 7/2/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Edema Assessment

	Left:	Right:
Edema:		Yes
Compression Device In Use:		Yes
Device Used Correctly:		Yes
Compression Device Used:		Tubigrip or Tubifast

Foot

Point of Measurement: cm	From:	cm	cm

Vascular Assessment

	Left:	Right:
Pulses:		
Popliteal:		
Extremity colors, hair growth, and conditions:		
Extremity Color:		Red
Erythema:		Yes

Electronic Signature(s)

Signed By: Cole, Lori RN
Date: 07/06/2012 10:06:35 AM

Entered By: Sisson LPN, Sally on 07/02/2012 11:21:03 AM

COASTAL CAROLINA HOSPITAL

[illegible] Regional Healthcare

Adherence to Plan of Care Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 7/2/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Adherence to Plan of Care Items

Wound Visits:	Yes	Limb Elevation:	Yes
Dressing Changes:	Yes		

Notes

Electronic Signature(s)

Signed_By:
Cole, Lori RN

Date:
07/06/2012 10:06:35 AM

Entered By: Sisson LPN, Sally on 07/02/2012 11:21:38 AM

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

Plan of Care Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 7/2/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Fall Prevention - High Risk

Inform patient and family of high risk of falling and discuss prevention strategies.
Provide call bell or other means of summoning help and educate patient in use.
Keep bed/chair in low position with wheels locked.
Keep personal possessions within easy reach of patient.
Advise patient to rise slowly from setting or lying position.
Use assistive devices in good operation condition as needed to enhance mobility.
Modify environment to reduce fall risk hazards.
Avoid leaving patient in room alone.

Nutritional

increase protein intake
multivitamin daily
vitamin C daily
increase fluid intake
handout on nutritional guidelines for patients with wounds

Patient/Wound Assessment

Review history of present illness, patient, family and social history, and review of systems.
Record current medications and treatments.
Determine presence of food, drug, or other allergies.
Focused physical exam on admission and every visit
Complete nutritional assessment on admission. Repeat every 4 weeks if initial assessment puts patient at risk or patient has pressure ulcer
Complete Braden Skin Assessment on admission and every visit if patient is not mobile or if patient has marked change in condition that can impact skin integrity.
Complete Fall Risk Assessment on admission. Repeat whenever changes in mobility occur or whenever a new offloading device is used for patients with leg/foot ulcers.
Complete Pain Assessment every visit. Refer non-wound-related pain management to PCP.
Assess wound pain every visit, before and after procedures and after pain relief interventions.
Complete Educational Assessment and determine preferred method of learning on admission.
X-ray Stage III-IV wounds or Wagner Grade 3 or > wounds, and full thickness wounds with exposed structure.
Culture base of wound following debridement if there are S&S of infection
Measure wound(s) every visit and record
Wound photo on admission, every 4 weeks during treatment, and prn
Assign Wound Type, i.e., cause for non-healing of chronic wound or "how acquired" for acute wounds.

Electronic Signature(s)

Signed By: Cole, Lori RN
Date: 07/06/2012 10:06:35 AM

Entered By: Sisson LPN, Sally on 07/02/2012 11:24:19 AM

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

Patient/Caregiver Education Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 7/2/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Patient/Caregiver Education Items

Teaching Provided To: Patient/ husband

Dressing:	
Methods:	Yes
Responses:	E/V
	State content correctly
Fall Risks:	
Methods:	Yes
Responses:	E/V
	State content correctly
Medication:	
Methods:	Yes
Responses:	E/V
	State content correctly
Pain Management:	
Methods:	Yes
Responses:	E/V
	State content correctly
Negative Pressure Therapy:	
Methods:	Yes
Responses:	E/V
	State content correctly

Electronic Signature(s)

Signed By: Cole, Lori RN

Date: 07/06/2012 10:06:35 AM

Entered By: Sisson LPN, Sally on 07/02/2012 11:22:17 AM

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

Visit Discharge Information Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 7/2/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Visit Discharge Information Items

Discharge Condition:	Stable
Ambulatory Status:	Wheelchair
Discharge Destination:	Home
Transportation:	Private Auto
Accompanied By:	husband
Schedule Follow-up Appointment:	Yes
Medication Reconciliation completed and provided to Patient/Care Provider:	No
Clinical Summary of Care Provided:	No

Electronic Signature(s)

Signed By:
Cole, Lori RN

Date:
07/06/2012 10:06:35 AM

Entered By: Sisson LPN, Sally on 07/02/2012 11:22:48 AM

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

Wound Assessment Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: 1[redacted]

Date: 7/2/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Wound Status

Wound Number:	3	Wound Status:	Not Healed
Wound Location:	Distal, Anterior Lower Leg		
Wound Type:	Trauma		
Date Acquired:	5/28/2012		

Photos

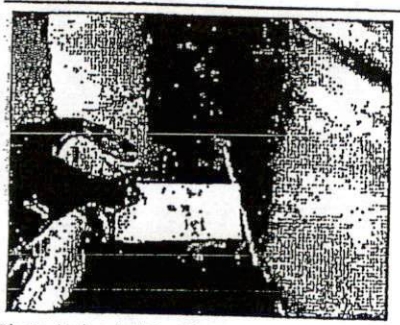


Photo Uploaded By: Sisson LPN, Sally on 7/3/2012

Wound Measurements

Length: (cm)	0.8	Tunneling:	Yes
Width: (cm)	0.8	Position (o'clock):	12
Depth: (cm)	1	Maximum Distance: (cm)	7.2
Hypergranulated:	No		
Area: (sq cm) based on L*W	0.64		
Volume: (cm³) based on Area*D	0.64		

Wound Description

Thickness:	Full Thickness	**Exposed Structure**	
Exudate Amount:	Large	Tendon Exposed:	No
Exudate Type:	Sero-sanguineous	Muscle Exposed:	No
Odor:	None	Joint Exposed:	No
Pain:	3	Bone Exposed:	No
Wound Margin:	Flat and Intact		

Percentage

Peripheral Skin Appearance

Texture		Color	
Normal For Patient:	No	Normal For Patient:	Yes

Edema: Yes

Induration: Yes

Moisture

Normal For Patient: Yes

Temperature

Temperature: Warm

S/S of Infection

S/S Present: Yes

Confirmation Description & Treatment Plan: Signs & Symptoms Present, Systemic Antibiotics Prescribed

Local Pulse

Local Pulse: Normal

Assessment Notes

Increased pain/ tenderness

Treatment Notes

Wound #3 (Distal, Anterior Lower Leg)

Wound Treatment Note

- Pt ID by name and photo, correct site ID.
- Assessed patient's pain status and effectiveness of pain management plan
- Removed old dressing, taking care to avoid trauma to the wound bed
- Cleansed wound and periwound with non-cytotoxic agent using Wound cleanser (1)
- Obtained wound photo
- Applied topical anesthetic for procedural pain control per physician order using Lidocaine 4% Topical (1)
- Applied Negative Pressure Therapy Dressing using Black foam (1)
- Dressing secured dressing in place using Netting (1)

Electronic Signature(s)

Signed By:
Cole, Lori RN

Date:
07/06/2012 10:06:35 AM

Entered By: Sisson LPN, Sally on 07/02/2012 10:38:08 AM

Treatment Notes Summary

Wound #3 (Distal, Anterior Lower Leg)

Wound Treatment Note

- Pt ID by name and photo, correct site ID.
- Assessed patient's pain status and effectiveness of pain management plan
- Removed old dressing, taking care to avoid trauma to the wound bed
- Cleansed wound and periwound with non-cytotoxic agent using Wound cleanser (1)
- Obtained wound photo
- Applied topical anesthetic for procedural pain control per physician order using Lidocaine 4% Topical (1)
- Applied Negative Pressure Therapy Dressing using Black foam (1)
- Dressing secured dressing in place using Netting (1)

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

Negative Pressure Wound Therapy Application (NPWT) Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 7/2/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

NPWT Application Performed for:	Wound #3 Distal, Anterior Lower Leg
Performed By:	Cole, Lori, RN
Type:	VAC Freedom System
Coverage Size (sq cm):	0.64
Pressure Type:	Constant
Pressure Setting:	125 mmHG
Drain Type:	Other
Sponge Type:	Black
Sponge Size:	Small
Date Initiated:	7/2/2012

Electronic Signature(s)

Signed By: Cole, Lori RN

Date: 07/06/2012 10:06:35 AM

Entered By: Sisson LPN, Sally on 07/02/2012 11:19:25 AM

COASTAL CAROLINA HOSPITAL

[illegible] Hand Regional Healthcare

Physician Orders Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 7/2/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Verbal / Phone Orders: No

Follow-Up Appointments
- Return Appointment in 1 week.

Anesthetic
- Topical Xylocaine to wound bed prior to debridement. - 4%

Wound Cleansing & Dressings
- Wound VAC, arrange to start

Compression /Edema Control/ Off-Loading
- Elevate leg(s) above the level of the heart when sitting.
- Avoid prolonged standing in one place.
- Single Layer Compression Wrap - tubigrip

Dietary
- Increased protein
- Supplement with multi-vitamin

Notes

Electronic Signature(s)

Signed By:
Cotter, Jason

Date:
07/12/2012 3:07:56 PM

Entered By: Cotter, Jason on 07/02/2012 1:41:11 PM

COASTAL CAROLINA HOSPITAL

Part of Hilton Head Regional Healthcare

Progress Note Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 7/2/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Subjective

Allergies
mango

70 year old female who was in a car accident suffering a left lower leg fracture and right lower leg wounds. Her right lower leg x-rays were negative. She has been packing her distal wound with iodoform twice daily. There have been no improving or worsening factors. Her risk factors for wound healing include diabetes and venous hypertension. She denies nausea, vomiting, fever, or chills. She has been receiving wound care for 5 weeks. She had a negative venous ultra sound and her WBC was normal. She states that she is still having pain in the region of her trauma.

Objective

Integumentary (Hair, Skin)
Wound #3 presents as a Full Thickness Trauma located on the Distal,Anterior Lower Leg and measures 0.8cm length x 0.8cm width x 1cm depth; 0.64cm^2 area and 0.64cm^3 volume, calculated based on L*W and Area*D, respectively. There is tunneling at 12:00 with a maximum distance of 7.2cm. There is a large amount of sero-sanguineous drainage noted which has no odor. The wound pain is a level 3. Systemic antibiotics prescribed - refer to new medications prescribed. The wound margin is flat and intact.

Assessment

Diagnoses
250.00: Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled
891.0: Open wound knee, leg, ankle (not thigh)- w/o complication
459.33: Chronic venous hypertension with ulcer and inflammation
729.92: Nontraumatic hematoma of soft tissue

Procedures

Plan

Follow-Up Appointments:
Return Appointment in 1 week.
Anesthetic:
Topical Xylocaine to wound bed prior to debridement. - 4%
Wound Cleansing & Dressings:
Wound VAC, arrange to start
Compression/Edema Control/ Off-Loading:

Elevate leg(s) above the level of the heart when sitting.
Avoid prolonged standing in one place.
Single Layer Compression Wrap - tubigrip
Dietary:
Increased protein
Supplement with multi-vitamin

Follow-Up Appointments:
A follow-up appointment should be scheduled.

We will begin wound VAC today. She has a trip planned pending her wound healing. She may benefit from an MRI if her wound is not making appropriate progress when she returns. Although she has minimal drainage, consider repeat WBC if continued slow healing.

Electronic Signature(s)

Signed By:
Cotter, Jason

Date:
07/12/2012 3:07:56 PM

Entered By: Sisson LPN, Sally on 07/02/2012 4:01:35 PM

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

SuperBill Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 7/2/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

ICD9 Coding

Code	Description
250.00	Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled
891.0	Open wound knee, leg, ankle (not thigh)- w/o complication
459.33	Chronic venous hypertension with ulcer and inflammation
729.92	Nontraumatic hematoma of soft tissue

Facility Procedures

CPT4_Code	Description	Modifier	Quantity
760766	97605 Negative pressure wound tx, 50 sq cm or less		1

Physician Procedures

CPT4_Code	Description	Modifier	Quantity
99213	Est. Patient Level 3 - Moderate		1

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	07/06/2012 10:06:35 AM
Cotter, Jason	07/12/2012 3:07:56 PM

Entered By: Sisson LPN, Sally on 07/02/2012 4:00:17 PM

PATIENT NO: [redacted] ADMIT DT/TIME: 7/05/12 13:30 M/R NO: [redacted]
NS/ROOM/BED: CLINICS: WC RESISTANT ORG:
BY: AUTO
TITLE:
ENT NAME: BARON, FRANCES
NG ADDR: [redacted] SOCIAL SECURITY: [redacted]
CITY/STATE: [redacted] PHONE: [redacted]
HYSICAL ADR: NPP: 2.0 DATE: 12/08/03
CITY/STATE: PHONE: ( )
OCCUPATION: RN LANGUAGE: EN FC: 05
POB: XX ADMT PHYS: 1202- COTTER, JASON WIL HSV: 60
DOB: [redacted] ADMT PHYS PHONE: (843) 705-8888 RLG: PAR:
AGE: [redacted] Y RACE: [redacted] ATTEND PHYS: 1202- COTTER, JASON WIL MS: M
SEX: F REF PHY: 1202-COTTER, JASON WIL PHN: 843 705-8888 SMK: N
PCP PHY: - PHN: VAL: PT: 2
ETHNICTY: NON FLAG: FATHER'S DOB: MOTHER'S DOB:

MER CONTACT: BARON,EDWARD REL: SPOUSE
ADDRESS: [redacted] PHONE: [redacted]
CITY/STATE: [redacted]
EAREST RELT: BARON,EDWARD REL: SPOUSE
ADDRESS: [redacted] PHONE: [redacted]
CITY/STATE: [redacted] RESEARCH ID:

GUARANTOR: BARON, FRANCES A REL: SELF
ADDRESS 1: [redacted] PHONE: [redacted]
ADDRESS 2: SOCIAL SECURITY: [redacted]
CTY/STE/ZIP: [redacted] 9842 OCC:RN AF: USA
AYOR NAME 1: NATIONWIDE MUTUAL IN INS. PLAN ID: Q9701 SRV/TYPE: ALLOP
PLAN NAME: AUTO INSURANCE/600 IPA:
C/O NAME: AUTH #:
ADDRESS: 1 NATIONWIDE PLAZA CERT-SSN-HIC-ID#: [redacted]
Y/ E/CNTRY: COLUMBUS OH 43215 BILL PHONE: ( ) 000-0000
ILLING NAME: GP #: NONE
INSURED: BARON, FRANCES SEX/REL: F SELF
EMPLOYER: SANCTUARY HOSPICE MSP: Y TRACKING#:
ADDRESS: 10911 N JACOB SMART BLVD EMP PHONE: (843) 645-6540
CITY/STATE: RIDGELAND ESC: 1
AYOR NAME 2: MEDICARE/618 INS. PLAN ID: [redacted]
PLAN NAME: MEDICARE/618
LL C/O NAME: AUTH #:
ILL ADDRESS: P O BOX 1602 CERT-SSN-HIC-ID#: [redacted]
Y/STE/CNTRY: OMAHA NE 68101 BILL PHONE: (866) 580-5981
ILLING NAME: GP #: NONE
INSURED: BARON, FRANCES SEX/REL: F SELF
EMPLOYER: SANCTUARY HOSPICE TRACKING#:
ADDRESS: 10911 N JACOB SMART BLVD EMP PHONE: (843) 645-6450
CITY/STATE: RIDGELAND ESC: 1

SPAN CODE: PRIOR VISIT: 7/02/12
ROM/TO DATE: PRIOR HOSPITAL:
ONDITION CD CONDITION CD OCCURRENCE CD/DATE OCCURRENCE CD/DATE
10 01 5/21/12

HIEF COMPLAINT DESCRIPTION: CHIEF COMPLAINT CODE:
WOUND CARE
~~MMENTS: NURSE VISIT~~

PRINTED BY: TARABLOOM
DATE: 08/17/2012

Visit Report for 7/5/2012

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

Arrival Information Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 7/5/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Visit Information

Arrival Condition:	Stable
Ambulatory Status:	Wheelchair
Accompanied By:	spouse
Reason for today's visit:	MD visit
Patient Identification Verified:	Yes
Secondary Verification Process Completed:	Yes
Patient is in Isolation Precaution?	No
Is patient oriented to person, place, and time?	Yes

History Since Last Visit

Added or deleted any medications:	No
Any new allergies or adverse reactions:	No
Added any significant procedures or medical diagnosis:	No
Experienced change in activities of daily living that may affect risk of falls:	No
Experienced any changes in pain level or management:	No
Signs or symptoms of abuse/neglect since last visit?	No

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	07/12/2012 9:18:32 AM
Cole, Lori RN	07/12/2012 9:19:03 AM

Entered By: Cole, Lori on 07/05/2012 2:43:27 PM

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

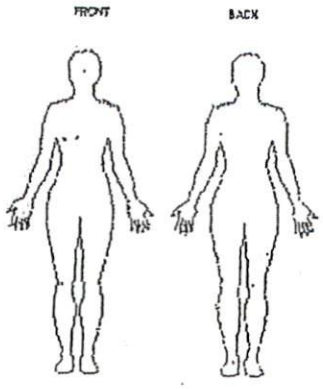
Pain Assessment Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 7/5/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Location of Pain

Site Locations



Severity and Temporal Description of Pain

Patient Has Pain?	Yes
Duration of the Pain.	
Constant / Intermittent?	Intermittent
Rate the pain.	
Current Pain Level:	1
Worst Pain Level:	3
Least Pain Level:	0
Tolerable Pain Level:	3

Character of Pain

Describe the Pain: Tender

Pain Management and Medication

Current Pain Management:

Medication:	Yes	Is the Current Pain Management Adequate:	Adequate
Rest:	Yes		
Activity:	Yes		

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	07/12/2012 9:18:32 AM
Cole, Lori RN	07/12/2012 9:19:03 AM

Entered By: Cole, Lori on 07/05/2012 2:44:29 PM

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

Lower Extremity Assessment Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 7/5/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Edema Assessment

	Left:	Right:
Edema:		Yes
Compression Device In Use:		No

Foot

Point of Measurement: cm	From:	cm	cm

Vascular Assessment

	Left:	Right:
Pulses:		
Popliteal:		
Extremity colors, hair growth, and conditions:		
Extremity Color:		Red
Erythema:		Yes

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	07/12/2012 9:18:32 AM
Cole, Lori RN	07/12/2012 9:19:03 AM

Entered By: Cole, Lori on 07/05/2012 2:44:42 PM

COASTAL CAROLINA
HOSPITAL

Hilton Head Regional Healthcare

Adherence to Plan of Care Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 7/5/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Adherence to Plan of Care Items

Wound Visits:	Yes	Limb Elevation:	Yes
Dressing Changes:	Yes		

Notes

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	07/12/2012 9:18:32 AM
Cole, Lori RN	07/12/2012 9:19:03 AM

Entered By: Cole, Lori on 07/05/2012 3:06:06 PM

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

Patient/Caregiver Education Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 7/5/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Patient/Caregiver Education Items

Teaching Provided To: Patient

Negative Pressure Therapy:	Yes
Methods:	Explain/Verbal
Responses:	State content correctly

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	07/12/2012 9:18:32 AM
Cole, Lori RN	07/12/2012 9:19:03 AM

Entered By: Cole, Lori on 07/05/2012 4:34:53 PM

COASTAL CAROLINA
HOSPITAL

[illegible] Regional Healthcare

Visit Discharge Information Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 7/5/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

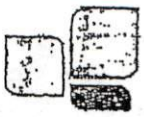
Visit Discharge Information Items

Discharge Condition:	Stable
Ambulatory Status:	Wheelchair
Discharge Destination:	Home
Transportation:	Private Auto
Accompanied By:	spouse
Schedule Follow-up Appointment:	Yes
Medication Reconciliation completed and provided to Patient/Care Provider:	No
Clinical Summary of Care Provided:	No

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	07/12/2012 9:18:32 AM
Cole, Lori RN	07/12/2012 9:19:03 AM

Entered By: Cole, Lori on 07/05/2012 4:35:12 PM



COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

Wound Assessment Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 7/5/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Wound Status

Wound Number:	3	Wound Status:	Not Healed
Wound Location:	Distal, Anterior Lower Leg		
Wound Type:	Trauma		
Date Acquired:	5/28/2012		

Wound Measurements

Length: (cm)	0.5	Tunneling:	Yes
Width: (cm)	0.5	Position (o'clock):	12
Depth: (cm)	0.5	Maximum Distance: (cm)	0.8
Hypergranulated:	No		
Area: (sq cm) based on L*W	0.25	Undermining:	No
Volume: (cm^3) based on Area*D	0.125	Sinus Tract:	No

Wound Description

Thickness:	Full Thickness	**Exposed Structure**	
Exudate Amount:	None	Tendon Exposed:	No
Exudate Type:	Sero-sanguineous	Muscle Exposed:	No
Odor:	None	Joint Exposed:	No
Pain:	3	Bone Exposed:	No
Wound Margin:	Flat and Intact		

Percentage

Peripheral Skin Appearance

Texture		**Color**	
Normal For Patient:	No	Normal For Patient:	Yes
Edema:	No	**Temperature**	
Induration:	No	Temperature:	Warm
Moisture		**S/S of Infection**	
Normal For Patient:	Yes	S/S Present:	No
		Local Pulse	
		Local Pulse:	Normal

Treatment Notes

Wound #3 (Distal, Anterior Lower Leg)

Wound Treatment Note

- Pt ID by name and photo, correct site ID.
- Assessed patient's pain status and effectiveness of pain management plan
- Removed old dressing, taking care to avoid trauma to the wound bed
- Cleansed wound and periwound with non-cytotoxic agent using Wound cleanser (1)
- Applied Negative Pressure Therapy Dressing using Black foam (1)
- Applied black foam sponge dressing, opsite, therapy at 125 mmHg continuous. using Black foam (1)
- Dressing secured dressing in place using Netting (1)

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	07/12/2012 9:18:32 AM
Cole, Lori RN	07/12/2012 9:19:03 AM

Entered By: Cole, Lori on 07/05/2012 2:19:00 PM

Treatment Notes Summary

Wound #3 (Distal, Anterior Lower Leg)

Wound Treatment Note

- Pt ID by name and photo, correct site ID.
- Assessed patient's pain status and effectiveness of pain management plan
- Removed old dressing, taking care to avoid trauma to the wound bed
- Cleansed wound and periwound with non-cytotoxic agent using Wound cleanser (1)
- Applied Negative Pressure Therapy Dressing using Black foam (1)
- Applied black foam sponge dressing, opsite, therapy at 125 mmHg continuous. using Black foam (1)
- Dressing secured dressing in place using Netting (1)

COASTAL CAROLINA HOSPITAL

Tenet Healthcare

Negative Pressure Wound Therapy Maintenance (NPWT) Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 7/5/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

NPWT Maintenance Performed for:	Wound #3 Distal, Anterior Lower Leg
Performed By:	Cole, Lori, RN
Type:	VAC Freedom System
Coverage Size (sq cm):	0.25
Pressure Type:	Constant
Pressure Setting:	125 mmHG
Drain Type:	Other
Sponge Type:	Black
Sponge Size:	Small
Date Initiated:	7/2/2012
Dressing Change:	Yes
Canister Changed:	No
Days On NPWT:	4

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	07/12/2012 9:18:32 AM
Cole, Lori RN	07/12/2012 9:19:03 AM

Entered By: Cole, Lori on 07/05/2012 2:19:42 PM

COASTAL CAROLINA
HOSPITAL

Hilton Head Regional Healthcare

Problem List Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 7/5/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Active Problems

Problem	Active Date
OPEN WOUND OF THE LEG	7/5/2012

Entered By: Sisson LPN, Sally on 07/06/2012 9:25:11 AM

Signature(s): **Date(s):**

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

SuperBill Details

Patient Name:	Baron, Frances	**Date:**	7/5/2012
Patient Number:	[redacted]	**RN/LPN:**	Cole, Lori
Patient Date of Birth:	[redacted]	**Physician / Extender:**	Cotter, Jason

ICD9 Coding

Code	Description
250.00	Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled
891.0	Open wound knee, leg, ankle (not thigh)- w/o complication
459.33	Chronic venous hypertension with ulcer and inflammation
729.92	Nontraumatic hematoma of soft tissue

Facility Procedures

CPT4 Code	Description	Modifier	Quantity
760766	97605 Negative pressure wound tx, 50 sq cm or less		1

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	07/12/2012 9:18:32 AM
Cole, Lori RN	07/12/2012 9:19:03 AM

Entered By: Sisson LPN, Sally on 07/06/2012 9:23:28 AM

7/09/12 COASTAL CAROLINA MED CNTR REGISTRATION
1:39:29 1000 MEDICAL CENTER DR HARDEEVILLE SC 29927 RECORD-F01

PATIENT NO: [redacted] ADMIT DT/TIME: 7/09/12 13:30 M/R NO: [redacted]
NS/ROOM/BED: CLINICS: WC RESISTANT ORG:
BY: AUTO
ENT NAME: BARON, FRANCES TITLE:
NG ADDR: [redacted] SOCIAL SECURITY: [redacted]
C. Y/STATE: [redacted] PHONE: ([redacted]) [redacted]
HYSICAL ADR: NPP: 2.0 DATE: 12/08/03
CITY/STATE: PHONE: ( )
OCCUPATION: RN LANGUAGE: EN FC: 05
POB: XX ADMT PHYS: 1202- COTTER, JASON WIL HSV: 60
DOB: [redacted] ADMT PHYS PHONE: (843) 705-8888 RLG: PAR:
AGE: [redacted] Y RACE: [redacted] ATTEND PHYS: 1202- COTTER, JASON WIL MS: M
SEX: F REF PHY: 1202-COTTER, JASON WIL PHN: 843 705-8888 SMK: N
PCP PHY: - PHN: VAL: PT: 2
ETHNICITY: NON FLAG: FATHER'S DOB: MOTHER'S DOB:

MER CONTACT: BARON,EDWARD REL: SPOUSE
ADDRESS: [redacted] PHONE: ([redacted]) [redacted]
CITY/STATE: [redacted]
EAREST RELT: BARON,EDWARD REL: SPOUSE
ADDRESS: [redacted] PHONE: ([redacted]) [redacted]
CITY/STATE: [redacted] RESEARCH ID:

GUARANTOR: BARON, FRANCES A REL: SELF
ADDRESS 1: [redacted] PHONE: ([redacted]) [redacted]
ADDRESS 2: SOCIAL SECURITY: 189322746
CTY/STE/ZIP: [redacted] OCC:RN AF: USA
AYOR NAME 1: NATIONWIDE MUTUAL INS INS. PLAN ID: Q9701 SRV/TYPE: ALLOP
PLAN NAME: AUTO INSURANCE/600 IPA:
C/O NAME: AUTH #:
ADDRESS: 1 NATIONWIDE PLAZA CERT-SSN-HIC-ID#: [redacted]
Y/ E/CNTRY: COLUMBUS OH 43215 BILL PHONE: ( ) 000-0000
ILLING NAME: GP #: NONE
INSURED: BARON, FRANCES SEX/REL: F SELF
EMPLOYER: SANCTUARY HOSPICE MSP: N TRACKING#:
ADDRESS: 10911 N JACOB SMART BLVD EMP PHONE: (843) 645-6540
CITY/STATE: RIDGELAND ESC: 1
AYOR NAME 2: MEDICARE/618 INS. PLAN ID: [redacted]
PLAN NAME: MEDICARE/618
LL C/O NAME: AUTH #:
ILL ADDRESS: P O BOX 1602 CERT-SSN-HIC-ID#: [redacted]
Y/STE/CNTRY: OMAHA NE 68101 BILL PHONE: (866) 580-5981
ILLING NAME: GP #: NONE
INSURED: BARON, FRANCES SEX/REL: F SELF
EMPLOYER: SANCTUARY HOSPICE TRACKING#:
ADDRESS: 10911 N JACOB SMART BLVD EMP PHONE: (843) 645-6450
CITY/STATE: RIDGELAND ESC: 1

SPAN CODE: PRIOR VISIT: 7/05/12
ROM/TO DATE: PRIOR HOSPITAL:
ONDITION CD CONDITION CD OCCURRENCE CD/DATE OCCURRENCE CD/DATE
10
11 7/09/12

HIEF COMPLAINT DESCRIPTION: CHIEF COMPLAINT CODE:
WOUND CARE
ENTS:

PRINTED BY: TARABLOOM
DATE: 08/17/2012

Visit Report for 7/9/2012

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

Arrival Information Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 7/9/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Visit Information

Arrival Condition:	Stable
Ambulatory Status:	Wheelchair
Accompanied By:	spouse
Reason for today's visit:	MD visit
Patient Identification Verified:	Yes
Secondary Verification Process Completed:	Yes
Patient is in Isolation Precaution?	No
Is patient oriented to person, place, and time?	Yes

History Since Last Visit

Added or deleted any medications:	No
Any new allergies or adverse reactions:	No
Added any significant procedures or medical diagnosis:	No
Experienced change in activities of daily living that may affect risk of falls:	No
Experienced any changes in pain level or management:	No
Signs or symptoms of abuse/neglect since last visit?	No

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	07/12/2012 9:18:32 AM
Cole, Lori RN	07/12/2012 9:19:03 AM

Entered By: Cole, Lori on 07/09/2012 3:53:48 PM

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

Pain Assessment Details

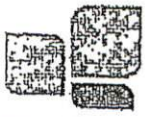
Patient Name:	Baron, Frances	**Date:**	7/9/2012
Patient Number:	[redacted]	**RN/LPN:**	Cole, Lori
Patient Date of Birth:	[redacted]	**Physician / Extender:**	Cotter, Jason

Patient has no pain management issues.

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	07/12/2012 9:18:32 AM
Cole, Lori RN	07/12/2012 9:19:03 AM

Entered By: Cole, Lori on 07/09/2012 3:54:05 PM



COASTAL CAROLINA
HOSPITAL

Hilton Head Regional Healthcare

Lower Extremity Assessment Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 7/9/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Edema Assessment

	Left:	Right:
Edema:		
Compression Device In Use:		Yes No

Foot

Point of Measurement: cm	From:	cm	cm

Vascular Assessment

	Left:	Right:
Pulses:		
Popliteal:		
Extremity colors, hair growth, and conditions:		
Extremity Color:		Red
Erythema:		Yes

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	07/12/2012 9:18:32 AM
Cole, Lori RN	07/12/2012 9:19:03 AM

Entered By: Cole, Lori on 07/09/2012 3:54:22 PM

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

Adherence to Plan of Care Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 7/9/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Adherence to Plan of Care Items

Wound Visits:	Yes	Limb Elevation:	Yes
Dressing Changes:	Yes		

Notes

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	07/12/2012 9:18:32 AM
Cole, Lori RN	07/12/2012 9:19:03 AM

Entered By: Cole, Lori on 07/09/2012 3:55:15 PM

COASTAL CAROLINA HOSPITAL

Hilton Head Regional HealthCare

Patient/Caregiver Education Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 7/9/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Patient/Caregiver Education Items

Teaching Provided To: Patient

Dressing:	Yes
Methods:	Explain/Verbal
Responses:	State content correctly

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	07/12/2012 9:18:32 AM
Cole, Lori RN	07/12/2012 9:19:03 AM

Entered By: Cole, Lori on 07/09/2012 3:56:13 PM

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

Visit Discharge Information Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 7/9/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Visit Discharge Information Items

Discharge Condition:	Stable
Ambulatory Status:	Wheelchair
Discharge Destination:	Home
Transportation:	Private Auto
Accompanied By:	alone
Schedule Follow-up Appointment:	Yes
Medication Reconciliation completed and provided to Patient/Care Provider:	No
Clinical Summary of Care Provided:	No

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	07/12/2012 9:18:32 AM
Cole, Lori RN	07/12/2012 9:19:03 AM

Entered By: Cole, Lori on 07/09/2012 3:57:02 PM

COASTAL CAROLINA HOSPITAL

Sisson Head Regional Healthcare

Wound Assessment Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 7/9/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Wound Status

Wound Number:	3	Wound Status:	Not Healed
Wound Location:	Distal, Anterior Lower Leg		
Wound Type:	Trauma		
Date Acquired:	5/28/2012		

Photos

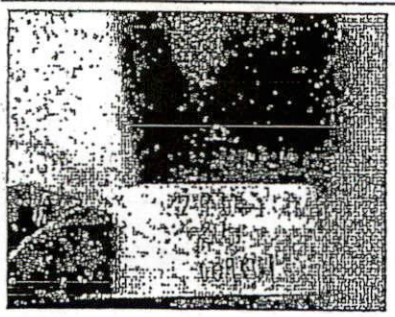


Photo Uploaded By: Sisson LPN, Sally on 7/11/2012

Wound Measurements

Length: (cm)	0.5	Tunneling:	Yes
Width: (cm)	0.5	Position (o'clock):	12
Depth: (cm)	0.5	Maximum Distance: (cm)	0.8
Hypergranulated:	No		
Area: (sq cm) based on L*W	0.25	Undermining:	No
Volume: (cm^3) based on Area*D	0.125	Sinus Tract:	No

Wound Description

Thickness:	Full Thickness	Exposed Structure	
Exudate Amount:	None	Tendon Exposed:	No
Exudate Type:	Sero-sanguineous	Muscle Exposed:	No
Odor:	None	Joint Exposed:	No
Pain:	3	Bone Exposed:	No
Wound Margin:	Flat and Intact		

Percentage

Peripheral Skin Appearance

	Texture		Color
Normal For Patient:	No	Normal For Patient:	Yes

Edema:	No		
Induration:	No	Temperature:	Warm
Moisture		**S/S of Infection**	
Normal For Patient:	Yes	S/S Present:	No
		Local Pulse	
		Local Pulse:	Normal

Treatment Notes

Wound #3 (Distal, Anterior Lower Leg)

Wound Treatment Note

- Pt ID by name and photo, correct site ID.
- Assessed patient's pain status and effectiveness of pain management plan
- Removed old dressing, taking care to avoid trauma to the wound bed
- Cleansed wound and periwound with non-cytotoxic agent using Wound cleanser (1)
- Obtained wound photo
- Applied primary wound dressing using Iodoform (1)
- Applied Secondary Wound Dressing using Gauze (1)
- Dressing secured dressing in place using Netting (1)

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	07/12/2012 9:18:32 AM
Cole, Lori RN	07/12/2012 9:19:03 AM

Entered By: Cole, Lori on 07/09/2012 3:53:27 PM

Treatment Notes Summary

Wound #3 (Distal, Anterior Lower Leg)

Wound Treatment Note

- Pt ID by name and photo, correct site ID.
- Assessed patient's pain status and effectiveness of pain management plan
- Removed old dressing, taking care to avoid trauma to the wound bed
- Cleansed wound and periwound with non-cytotoxic agent using Wound cleanser (1)
- Obtained wound photo
- Applied primary wound dressing using Iodoform (1)
- Applied Secondary Wound Dressing using Gauze (1)
- Dressing secured dressing in place using Netting (1)

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

Physician Orders Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]
Verbal / Phone Orders: No

Date: 7/9/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Follow-Up Appointments

- **Return Appointment in 2 weeks.**

Anesthetic

- **Topical Xylocaine to wound bed prior to debridement. - 4%**

Wound Cleansing & Dressings

- **May shower and /or cleanse wound with mild soap and water.**
- **Pack wound - 1/4 inch Iodoform BID**

Compression /Edema Control/ Off-Loading

- **Elevate leg(s) above the level of the heart when sitting.**
- **Avoid prolonged standing in one place.**
- **Single Layer Compression Wrap - tubigrip**

Dietary

- **Increased protein**
- **Supplement with multi-vitamin**

Notes

Electronic Signature(s)

Signed By: Cotter, Jason
Date: 07/12/2012 3:07:56 PM

Entered By: Cotter, Jason on 07/09/2012 1:55:48 PM

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

Progress Note Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 7/9/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Subjective

Allergies
mango

70 year old female who was in a car accident suffering a left lower leg fracture and right lower leg wounds. Her right lower leg x-rays were negative. She was using a wound VAC for the past week. There have been no improving or worsening factors. Her risk factors for wound healing include diabetes and venous hypertension. She denies nausea, vomiting, fever, or chills. She has been receiving wound care for 6 weeks. She had a negative venous ultrasound and her WBC was normal. Her wound seems to have decreased in size dramatically.

Objective

Integumentary (Hair, Skin)
Wound #3 presents as a Full Thickness Trauma located on the Distal,Anterior Lower Leg and measures 0.5cm length x 0.5cm width x 0.5cm depth; 0.25cm^2 area and 0.125cm^3 volume, calculated based on L*W and Area*D, respectively. There is no sinus tract or undermining noted, however, there is tunneling at 12:00 with a maximum distance of 0.8cm. There was no drainage noted. The wound pain is a level 3. The wound margin is flat and intact.

Assessment

Diagnoses
250.00: Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled
891.0: Open wound knee, leg, ankle (not thigh)- w/o complication
459.33: Chronic venous hypertension with ulcer and inflammation
729.92: Nontraumatic hematoma of soft tissue

Procedures

Plan

Follow-Up Appointments:
Return Appointment in 2 weeks.
Anesthetic:
Topical Xylocaine to wound bed prior to debridement. - 4%
Wound Cleansing & Dressings:
May shower and/or cleanse wound with mild soap and water.
Pack wound - 1/4 inch Iodoform BID

Compression/Edema Control/ Off-Loading:
Elevate leg(s) above the level of the heart when sitting.
Avoid prolonged standing in one place.
Single Layer Compression Wrap - tubigrip
Dietary:
Increased protein
Supplement with multi-vitamin

Follow-Up Appointments:
A follow-up appointment should be scheduled.

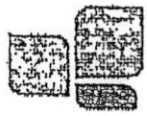
Wound is really too small for continuing her wound VAC. Will therefore resume packing her wound BID with Iodoform. She will be traveling for the next 2 weeks. She will return after her vacation.

Electronic Signature(s)

Signed By:
Cotter, Jason

Date:
07/12/2012 3:07:56 PM

Entered By: Sisson LPN, Sally on 07/10/2012 1:43:03 PM



COASTAL CAROLINA
HOSPITAL

Hilton Head Regional Healthcare

Clinic Level Of Care Assessment Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 7/9/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Clinic Level Of Care Assessment Items

	Quantity	Score
Admission / AMA		
☐ Hospital Admission (Inpatient Observation)		0
☐ AMA or LWBS		0
Interventions		
☐ Specimen Collection # of		0
☐ Hematoccult / Glucostix		0
☐ Glucose Scan / Urine Dipstick		0
☐ Elastic Wrap		0
☐ Compression Therapy Single Extremities		0
☐ Compression Therapy Multiple Extremities		0
Assisting / Monitoring		
☐ Ankle, Brachial Index		0
☐ Doppler		0
☐ Monitoring - Extensive		0
☐ Nursing Assessment - Initial		0
☑ Nursing Assessment - Subsequent Partial	1	10
Wound Care		
☐ Simple Suture Removal		0
☐ Complex Suture Removal		0
☑ Wound Assessment	1	10
☑ Wound Measurement	1	5
☐ Wound Measurement - Extensive		0
☑ Wound Cleansing - Simple	1	10
☐ Wound Cleansing - Complex		0
☑ Photography	1	10
☐ Extremity		0

☐ Tissue Expander Injection (Episodes of:)		0
☐ Dressing - Simple		0
☐ Dressing - Moderate		0
☐ Dressing - Moderately Complex		0
☑ Dressing - Complex	1	25
☐ Dressing - Extensive		0
☐ Dressing - Extensive Complex (VAC)		0
Special Needs		
☐ Special Teaching Needs		0
☐ Special Emotional Needs		0
☐ Special Service Needs (Each needs episod e of:)		0
☐ Coordination of Care		0
☐ Combative Patient		0
Medications		
☐ Medications - PO Suppository Topical		0
☐ IV Preexisting		0
Education Discharge (Instructions)		
☑ Discharge Instructions	1	5
☐ Discharge Instructions		0
☐ Extensive Education / Counseling		0

Is this the patient's first visit: No **Total Score:** 75 **Level Of Care:** New / Est Patient Level 3 - Moderate

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	07/12/2012 9:18:32 AM
Cole, Lori RN	07/12/2012 9:19:03 AM

Entered By: Cole, Lori on 07/09/2012 3:57:56 PM

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

SuperBill Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 7/9/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

ICD9 Coding

Code	Description
250.00	Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled
891.0	Open wound knee, leg, ankle (not thigh)- w/o complication
459.33	Chronic venous hypertension with ulcer and inflammation
729.92	Nontraumatic hematoma of soft tissue

Facility Procedures

CPT4 Code	Description	Modifier	Quantity
760170	99213 Est. Patient Level 3 - Moderate		1

Physician Procedures

CPT4 Code	Description	Modifier	Quantity
99213	Est. Patient Level 3 - Moderate		1

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	07/12/2012 9:18:32 AM
Cole, Lori RN	07/12/2012 9:19:03 AM
Cotter, Jason	07/12/2012 3:07:56 PM

Entered By: Sisson LPN, Sally on 07/10/2012 1:41:59 PM

PATIENT NO: [redacted] ADMIT DT/TIME: 8/02/12 11:30 M/R NO: [redacted]
NS/ROOM/BED: CLINICS: WC RESISTANT ORG:
BY: AUTO
ENT NAME: BARON, FRANCES TITLE:
NG ADDR: [redacted] SOCIAL SECURITY: [redacted]
ITY/STATE: [redacted] PHONE: [redacted]
HYSICAL ADR: NPP: 2.0 DATE: 12/08/03
CITY/STATE: PHONE: ( )
OCCUPATION: RN LANGUAGE: EN FC: 05
POB: XX ADMT PHYS: 1202- COTTER, JASON WIL HSV: 60
DOB: [redacted] ADMT PHYS PHONE: (843) 705-8888 RLG: PAR:
AGE: [redacted] Y RACE: [redacted] ATTEND PHYS: 1202- COTTER, JASON WIL MS: M
SEX: F REF PHY: 1202-COTTER, JASON WIL PHN: 843 705-8888 SMK: N
PCP PHY: - PHN: VAL: PT: 2
ETHNICITY: NON FLAG: FATHER'S DOB: MOTHER'S DOB:

MER CONTACT: EDWARD BARON REL: SPOUSE
ADDRESS: [redacted] PHONE: [redacted]
CITY/STATE: [redacted]
EAREST RELT: EDWARD BARON REL: SPOUSE
ADDRESS: [redacted] PHONE: [redacted]
CITY/STATE: [redacted] RESEARCH ID:

GUARANTOR: BARON, FRANCES A REL: SELF
ADDRESS 1: [redacted] PHONE: [redacted]
ADDRESS 2: SOCIAL SECURITY: [redacted]
CTY/STE/ZIP: [redacted] OCC:RN AF: USA
AYOR NAME 1: NATIONWIDE MUTUAL IN INS. PLAN ID: Q9701 SRV/TYPE: ALLOP
PLAN NAME: AUTO INSURANCE/600 IPA:
C/O NAME: AUTH #:
ADDRESS: 1 NATIONWIDE PLAZA CERT-SSN-HIC-ID#: [redacted]
Y/STE/CNTRY: COLUMBUS OH 43215 BILL PHONE: (866) 472-4043
ILLING NAME: GP #: ADJ TRUTTI WARD
INSURED: BARON, FRANCES SEX/REL: F SELF
EMPLOYER: SANCTUARY HOSPICE MSP: Y TRACKING#:
ADDRESS: 10911 N JACOB SMART BLVD EMP PHONE: (843) 645-6540
CITY/STATE: RIDGELAND ESC: 1
AYOR NAME 2: MEDICARE/618 INS. PLAN ID: [redacted]
PLAN NAME: MEDICARE/618
LL C/O NAME: AUTH #:
ILL ADDRESS: P O BOX 1602 CERT-SSN-HIC-ID#: [redacted]
Y/STE/CNTRY: OMAHA NE 68101 BILL PHONE: (866) 580-5981
ILLING NAME: GP #: NONE
INSURED: BARON, FRANCES SEX/REL: F SELF
EMPLOYER: SANCTUARY HOSPICE TRACKING#:
ADDRESS: 10911 N JACOB SMART BLVD EMP PHONE: (843) 645-6450
CITY/STATE: RIDGELAND ESC: 1

SPAN CODE: PRIOR VISIT: 7/09/12
ROM/TO DATE: PRIOR HOSPITAL:
ONDITION CD CONDITION CD OCCURRENCE CD/DATE OCCURRENCE CD/DATE
10 01 5/21/12

HIEF COMPLAINT DESCRIPTION: CHIEF COMPLAINT CODE:
WOUND CARE
MMENTS:

PRINTED BY: TARABLOOM
DATE: 08/17/2012

Visit Report for 8/2/2012

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

Arrival Information Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 8/2/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Visit Information

Arrival Condition:	Stable
Ambulatory Status:	Ambulatory
Accompanied By:	spouse
Reason for today's visit:	MD visit
Patient Identification Verified:	Yes
Secondary Verification Process Completed:	Yes
Patient is in Isolation Precaution?	No
Is patient oriented to person, place, and time?	Yes

History Since Last Visit

Added or deleted any medications:	No
Any new allergies or adverse reactions:	No
Added any significant procedures or medical diagnosis:	No
Experienced change in activities of daily living that may affect risk of falls:	No
Experienced any changes in pain level or management:	No
Signs or symptoms of abuse/neglect since last visit?	No

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	08/03/2012 12:13:13 PM
Cole, Lori RN	08/03/2012 12:13:38 PM

Entered By: Cole, Lori on 08/02/2012 12:14:19 PM

COASTAL CAROLINA
HOSPITAL

[illegible]

Pain Assessment Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 8/2/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Patient has no pain management issues.

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	08/03/2012 12:13:13 PM
Cole, Lori RN	08/03/2012 12:13:38 PM

Entered By: Cole, Lori on 08/02/2012 12:15:10 PM

COASTAL CAROLINA HOSPITAL

A Novant Health Regional Healthcare

Lower Extremity Assessment Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 8/2/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Edema Assessment

	Left:	Right:
Edema:	No	No
Compression Device In Use:	Yes	Yes
Device Used Correctly:	Yes	Yes
Compression Device Used:	Tubigrip or Tubifast	Tubigrip or Tubifast

Foot

Point of Measurement: cm	From:	cm	cm

Vascular Assessment

	Left:	Right:
Pulses:		
Popliteal:		
Extremity colors, hair growth, and conditions:		
Extremity Color:		WNL
Erythema:		No

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	08/03/2012 12:13:13 PM
Cole, Lori RN	08/03/2012 12:13:38 PM

Entered By: Cole, Lori on 08/02/2012 12:16:10 PM

COASTAL CAROLINA HOSPITAL

[illegible] Regional Healthcare

Adherence to Plan of Care Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 8/2/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Adherence to Plan of Care Items

Wound Visits:	Yes	Limb Elevation:	Yes
Dressing Changes:	Yes		

Notes

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	08/03/2012 12:13:13 PM
Cole, Lori RN	08/03/2012 12:13:38 PM

Entered By: Cole, Lori on 08/02/2012 12:18:07 PM

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

Patient/Caregiver Education Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 8/2/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Patient/Caregiver Education Items

Teaching Provided To: Patient

Skin Care:	Yes
Methods:	Explain/Verbal
Responses:	State content correctly

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	08/03/2012 12:13:13 PM
Cole, Lori RN	08/03/2012 12:13:38 PM

Entered By: Cole, Lori on 08/02/2012 4:48:10 PM

COASTAL CAROLINA HOSPITAL

Hilton Head Regional HealthCare

Visit Discharge Information Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 8/2/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Visit Discharge Information Items

Discharge Condition:	Stable
Ambulatory Status:	Ambulatory
Discharge Destination:	Home
Transportation:	Private Auto
Accompanied By:	spouse
Schedule Follow-up Appointment:	Yes
Medication Reconciliation completed and provided to Patient/Care Provider:	Yes
Clinical Summary of Care Provided:	Yes

Form	Type	Recipient
Paper	Patient	

Notes

discharge

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	08/03/2012 12:13:13 PM
Cole, Lori RN	08/03/2012 12:13:38 PM

Entered By: Cole, Lori on 08/02/2012 4:50:27 PM

COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

Wound Assessment Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 8/2/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Wound Status

Wound Number:	3	Wound Status:	Resolved
Wound Location:	Distal, Anterior Lower Leg		
Wound Type:	Trauma		
Date Acquired:	5/28/2012		

Photos

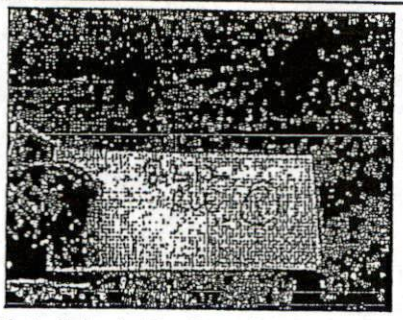


Photo Uploaded By: Sisson LPN, Sally on 8/3/2012

Wound Measurements

Hypergranulated:	No

Wound Description

Odor:	None	**Exposed Structure**	
		Tendon Exposed:	No
	Percentage	Muscle Exposed:	No
Epithelialization:	76-100%	Joint Exposed:	No
		Bone Exposed:	No

Peripheral Skin Appearance

Texture		**Color**	
Normal For Patient:	No	Normal For Patient:	Yes
Edema:	No	**Temperature**	
Induration:	No	Temperature:	Warm
Moisture		**S/S of Infection**	
Normal For Patient:	Yes	S/S Present:	No
		Local Pulse	
		Local Pulse:	Normal

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	08/03/2012 12:13:13 PM
Cole, Lori RN	08/03/2012 12:13:38 PM

Entered By: Cole, Lori on 08/02/2012 12:13:50 PM



COASTAL CAROLINA
HOSPITAL

Hilton Head Regional Healthcare

Physician Orders Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 8/2/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Verbal / Phone Orders: No

Follow-Up Appointments

- Discharge from Outpatient Services.

Wound Cleansing & Dressings

- May shower and/or cleanse wound with mild soap and water.
- Antibiotic/Antimicrobial Ointment/Cream - dermagran B

Compression/Edema Control/ Off-Loading

- Elevate leg(s) above the level of the heart when sitting.
- Avoid prolonged standing in one place.
- Single Layer Compression Wrap - tubigrip

Dietary

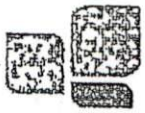
- Increased protein
- Supplement with multi-vitamin

Notes

Electronic Signature(s)

Signed By:	Date:
Cotter, Jason	08/02/2012 8:20:07 PM
Cotter, Jason	08/02/2012 8:20:10 PM

Entered By: Cotter, Jason on 08/02/2012 8:01:17 PM



COASTAL CAROLINA
HOSPITAL

[redacted]

Progress Note Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 8/2/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Subjective

Allergies
mango

70 year old female who was in a car accident suffering a left lower leg fracture and right lower leg wounds. Her right lower leg x-rays were negative. She was using a wound VAC for the past week. There have been no improving or worsening factors. Her risk factors for wound healing include diabetes and venous hypertension. She denies nausea, vomiting, fever, or chills. She has been receiving wound care for 8 weeks. She had a negative venous ultrasound and her WBC was normal. She recently has returned from traveling. Her wound is now healed.

Objective

Integumentary (Hair, Skin)
Wound #3, located on the Distal,Anterior Lower Leg has resolved with 76-100% epithelialization.

Assessment

Diagnoses
250.00: Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled
891.0: Open wound knee, leg, ankle (not thigh)- w/o complication
459.33: Chronic venous hypertension with ulcer and inflammation
729.92: Nontraumatic hematoma of soft tissue

Procedures

Plan

Follow-Up Appointments:
Discharge from Outpatient Services.
Wound Cleansing & Dressings:
May shower and/or cleanse wound with mild soap and water.
Antibiotic/Antimicrobial Ointment/Cream - dermagran 8
Compression/Edema Control/ Off-Loading:
Elevate leg(s) above the level of the heart when sitting.
Avoid prolonged standing in one place.
Single Layer Compression Wrap - tubigrip
Dietary:

Increased protein
Supplement with multi-vitamin

Follow-Up Appointments:
A follow-up appointment should be scheduled.
Medication Reconciliation completed and provided to Patient/Care Provider.

Wound is healed. Dermagran B to area. Return on an as needed basis.

Electronic Signature(s)

Signed By:	Date:
Cotter, Jason	08/02/2012 8:20:07 PM
Cotter, Jason	08/02/2012 8:20:10 PM

Entered By: Cotter, Jason on 08/02/2012 8:02:33 PM

COASTAL CAROLINA
HOSPITAL

Hilton Head Physician Practices

Clinic Level Of Care Assessment Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]

Date: 8/2/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

Clinic Level Of Care Assessment Items

		Quantity	Score
Admission / AMA			
☐	Hospital Admission (Inpatient Observation)		0
☐	AMA or LWBS		0
Interventions			
☐	Specimen Collection # of		0
☐	Hematoccult / Glucostix		0
☐	Glucose Scan / Urine Dipstick		0
☑	Elastic Wrap	1	10
☐	Compression Therapy Single Extremities		0
☐	Compression Therapy Multiple Extremities		0
Assisting / Monitoring			
☐	Ankle, Brachial Index		0
☐	Doppler		0
☐	Monitoring - Extensive		0
☐	Nursing Assessment - Initial		0
☑	Nursing Assessment - Subsequent Partial	1	10
Wound Care			
☐	Simple Suture Removal		0
☐	Complex Suture Removal		0
☑	Wound Assessment	1	10
☐	Wound Measurement		0
☐	Wound Measurement - Extensive		0
☐	Wound Cleansing - Simple		0
☐	Wound Cleansing - Complex		0
☑	Photography	1	10
☐	Extremity		0

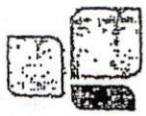
☐	Tissue Expander Injection (Episodes of:)		0
☐	Dressing - Simple		0
☐	Dressing - Moderate		0
☐	Dressing - Moderately Complex		0
☐	Dressing - Complex		0
☐	Dressing - Extensive		0
☐	Dressing - Extensive Complex (VAC)		0
Special Needs			
☐	Special Teaching Needs		0
☐	Special Emotional Needs		0
☐	Special Service Needs (Each needs episod e of:)		0
☐	Coordination of Care		0
☐	Combative Patient		0
Medications			
☐	Medications - PO Suppository Topical		0
☐	IV Preexisting		0
Education Discharge (Instructions)			
☑	Discharge Instructions	1	5
☐	Discharge Instructions		0
☐	Extensive Education / Counseling		0

Is this the patient's first visit: No **Total Score:** 45 **Level Of Care:** New / Est Patient Level 2 - Low to Moderate

Electronic Signature(s)

Signed By:	Date:
Cole, Lori RN	08/03/2012 12:13:13 PM
Cole, Lori RN	08/03/2012 12:13:38 PM

Entered By: Cole, Lori on 08/02/2012 4:50:47 PM



COASTAL CAROLINA
HOSPITAL

[illegible] Regional HealthCare

SuperBill Details

Patient Name: Baron, Frances
Patient Number: [redacted]
Patient Date of Birth: [redacted]
Date: 8/2/2012
RN/LPN: Cole, Lori
Physician / Extender: Cotter, Jason

ICD9 Coding

Code	Description
250.00	Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled
891.0	Open wound knee, leg, ankle (not thigh)- w/o complication
459.33	Chronic venous hypertension with ulcer and inflammation
729.92	Nontraumatic hematoma of soft tissue

Facility Procedures

CPT4 Code	Description	Modifier	Quantity
760169	99212 Est. Patient Level 2 - Low to Moderate		1

Physician Procedures

CPT4 Code	Description	Modifier	Quantity
99212	Est. Patient Level 2 - Low to Moderate		1

Electronic Signature(s)

Signed By:	Date:
Cotter, Jason	08/02/2012 8:20:07 PM
Cotter, Jason	08/02/2012 8:20:10 PM
Cole, Lori RN	08/03/2012 12:13:13 PM
Cole, Lori RN	08/03/2012 12:13:38 PM

Entered By: Cotter, Jason on 08/02/2012 8:00:18 PM

Randy K. Bottner, MD
Dale P. Daly, MD
Kenneth R. Hardigan, MD
William B. Hartley, MD

savannah cardiology

Jay M. Kalan, MD
Jonathan Macoobe, MD
Robert C. Rollinge, MD
J. Calvin Sharp, Jr., MD

In Savannah: 5301 Abercorn Street Savannah, GA 31405 (912) 303-8700 FAX (912) 354-5041
In South Carolina: Physicians Park Plaza & Hospital Center Blvd. Suite 130 Hilton Head Island, SC 29926 (843) 682-2740 FAX (843) 682-2876
8 Okatie Center Blvd. South, Suite 101 Okatie, SC 29909 (843) 705-8350 Fax (843) 707-0221

PATIENT JOURNAL LEDGER

DATE: 08/21/2012 ACCOUNT: [redacted]

PATIENT: Baron, Frances A
MRNO : [redacted]

SERVICE DATE	RDOC	SERVICE PERFORMED	CHARGE
09/15/09	.LE_KRH	EKG W/INTERPRETATION & REPORT	100.00
09/15/09	.LE_KRH	OFFICE CONSULTATION, LEVEL 4	341.00
09/15/09	.LE_KRH	NO RX GENERATED AT ENCOUNTER	.00
09/17/09	.LE_KRH	ECHOCARDIOGRAPHY STRESS WITH I	800.00
09/29/09	.LE_KRH	NO CHARGE	.00
11/06/09	.LE_KRH	ECHO TRANS 2D MMODE/DOPPLER	750.00
03/30/10	.LE_KRH	OFFICE ESTABLISHED PATIENT LEV	62.00
03/30/10	.LE_KRH	CCHIT CERTIFIED EHR	.00
03/30/10	.LE_KRH	TOBACCO USE ASSESSED	.00
03/30/10	.LE_KRH	CURRENT TOBACCO NON-USER	.00
05/23/12	.HH_JEM	ECHO TRANS 2D MMODE/DOPPLER	75.00
05/23/12	.HH_JEM	OFFICE ESTABLISHED PATIENT LEV	115.00
05/25/12	.LE_JEM	REGADENOSON 0.1MG	600.00
05/25/12	.LE_JEM	SPECT PERFUSION IMAGING MULTIPLE STUDIES	502.00
05/25/12	.LE_JEM	EXERCISE STRESS STUDY	98.00
05/25/12	.LE_JEM	MYOVIEW	300.00
05/25/12	.LE_JEM	THALLIUM	300.00

TOTAL CHARGES : 4043.00

SAVANNAH CARDIOLOGY MYOCARDIAL PERFUSION IMAGING

8 Okatie Center Blvd. South, Suite 101, Okatie, SC 29909/ 843-705-9350

atient ame:	BARON , FRANCES	Study Date:	25-May-2012
eight:65in	Weight:155lbs		BSA:1.78
tient ID:	[redacted]	Referring MD:	Tricia Etheridge, MD
OB:	[redacted]	Ordering MD:	Jonathan MacCabe, MD
ge/Sex:	[redacted]	Reporting MD:	Jonathan MacCabe, MD

revious Nuclear: N/A Previous Echo: 5-22-12 OUT

NDICATIONS: Syncope, Abnormal ECG, diabetes, HLP, HTN.

CONCLUSION

Scan significance was normal and indicates a low risk for hard cardiac events.

SUMMARY

Hypertensive blood pressure response to pharmacologic stress. Normal ST response. Chest pain was non-specific. LV myocardial perfusion was normal, consistent with 0 vessel disease. Global Stress LV function was normal. LV dilation was normal. RV perfusion was normal.

STRESS PROTOCOL: Regadenoson The patient was infused intravenously with Regadenoson at 0.08 mg/ml for a period of 10 seconds. A total Regadenoson dose of 0.4 mg was injected intravenously. The patient's heart rate increased from 81 bpm at rest to 138 at peak stress. The patient's blood pressure at rest was 140/80 mmHg and increased to 170/80 mmHg at peak stress. Blood pressure response was hypertensive. Chest pain symptoms non-specific. Other symptoms that occurred included dyspnea, headache.

STRESS TEST FINDINGS: Adequacy of Stress: adequate

	STRESS EKG DATA	REST EKG DATA
Test Status	abnormal	abnormal
Rhythm	sinus tachycardia	sinus rhythm
AV Block	none	none
IV Conduction	normal	normal
Arrhythmias	none	none
ST Response	Normal	
Repolarization		nonspecific ST-T changes

The patient was given 3.0mCi intravenous Thallium-201 upon resting. Myocardial perfusion imaging was performed 20 minutes post injection. The patient received 34.6mCi of intravenous Tc-99m Tetrofosmin following the intravenous injection of Regadenoson. Gated SPECT images were acquired 30-60 minutes post injection. Images were presented in SPECT, gated wall motion and planar formats. The patient received approximately 27.3mSv total body effective dose.

Overall Study Quality: excellent Extra Cardiac Activity: normal
LV Myocardial Perfusion Defects: Myocardial perfusion is normal
Scan Significance: normal and indicates a very low risk for hard cardiac events
RV Size: normal
Stress/Rest LV Volume Ratio: 1.00, normal Global Function: normal

SSS= 0	SRS= 0	SDS= 0
Ejection Fraction:	79%	

REPORTING

The study interpretation occurred on 2012-05-25 16:26:36.
s of the report is final. Reporting Physician: Jonathan MacCabe, MD

Randy K. Bottner, MD
Dale P. Daly, MD
Kenneth R. Hardigan, MD
William B. Hartley, MD

savannah cardiology

Jay M. Kalan, MD
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8 Okatie Center Blvd. South, Suite 101 Okatie, SC 29909 (843) 705-8350 Fax (843) 707-0221

PATIENT JOURNAL LEDGER

DATE: 08/21/2012 ACCOUNT: [redacted]

PATIENT: Baron, Frances A
MRNO : 126357

SERVICE DATE	RDOC	SERVICE PERFORMED	CHARGE
09/15/09	.LE_KRH	EKG W/INTERPRETATION & REPORT	100.00
09/15/09	.LE_KRH	OFFICE CONSULTATION, LEVEL 4	341.00
09/15/09	.LE_KRH	NO RX GENERATED AT ENCOUNTER	.00
09/17/09	.LE_KRH	ECHOCARDIOGRAPHY STRESS WITH I	800.00
09/29/09	.LE_KRH	NO CHARGE	.00
11/06/09	.LE_KRH	ECHO TRANS 2D MMODE/DOPPLER	750.00
03/30/10	.LE_KRH	OFFICE ESTABLISHED PATIENT LEV	62.00
03/30/10	.LE_KRH	CCHIT CERTIFIED EHR	.00
03/30/10	.LE_KRH	TOBACCO USE ASSESSED	.00
03/30/10	.LE_KRH	CURRENT TOBACCO NON-USER	.00
05/23/12	.HH_JEM	ECHO TRANS 2D MMODE/DOPPLER	75.00
05/23/12	.HH_JEM	OFFICE ESTABLISHED PATIENT LEV	115.00
05/25/12	.LE_JEM	REGADENOSON 0.1MG	600.00
05/25/12	.LE_JEM	SPECT PERFUSION IMAGING MULTIPLE STUDIES	502.00
05/25/12	.LE_JEM	EXERCISE STRESS STUDY	98.00
05/25/12	.LE_JEM	MYOVIEW	300.00
05/25/12	.LE_JEM	THALLIUM	300.00

TOTAL CHARGES : 4043.00

126357

COASTAL CAROLINA HOSPITAL

Coastal Carolina Hospital
1000 Medical Center Drive
Hardeeville, South Carolina 29927
(843) 784-8098

Report Status: Finalized

ICAEL

Transthoracic Echocardiography Report (TTE)

Demographics

Patient name	BARON, FRANCES	Age	[redacted]
Medical Record #	[redacted]	Gender	Female
Account Number		Height	[redacted] inches
Date of Birth	[redacted]	Weight	[redacted] pounds
Referring Physician	Condle Scott MD	BSA	1.8 m²
Sonographer	B. M.	BMI	28.1 kg/m²
Interpreting Physician	MacCabe Jonathan MD		

Type of Study:
TTE procedure

HR: 78 bpm BP: 140/74 mmHg Patient Status: Routine

Technical Quality: Adequate visualization.

Indications for Study: Syncope.

Measurement Summary

IVSd:	0.8 cm Normal Range (0.6-1.0)	Ao Root Diam:	3.1 cm Normal Range (2.0-3.8)
LVIDd:	4.7 cm Normal Range (3.9-5.9)	LVOT Diameter:	1.9 cm Normal Range (1.8-2.6)
LVIDs:	3 cm Normal Range (2.1-4.0)	RVDd:	2.7 cm Normal Range (2.7-3.3)
LVPWd:	0.9 cm Normal Range (0.6-1.0)	Est. RVSP:	13.91 mmHg Normal Range (18-30)
EF (Teicholz):	66%		

Conclusions

Summary

Normal left ventricular systolic function with a mild diastolic compliance impairment.
No hemodynamically significant valvular stenosis or regurgitation.

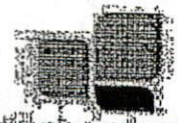
Signature

Electronically signed by MacCabe Jonathan MD(Interpreting physician) on 05/23/2012 04:11 PM.

Valves

Mitral Valve

Area (PHT):	2.78 cm²	E/A Ratio:	0.75
Peak E-Wave:	66 cm/s		
Peak A-Wave:	88 cm/s		
Peak Gradient:	1.74 mmHg		
P½t:	79 msec		



COASTAL CAROLINA HOSPITAL

Coastal Carolina Hospital
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Hardeeville, South Carolina 29927
(843) 784-8098

Report Status: Finalized

ICAEL

Mitral Valve Summary

The mitral valve leaflets appear normal; there is no evidence of stenosis, fluttering, or prolapse.
Trace mitral regurgitation is present.

Aortic Valve

Peak Velocity:	0 cm/s	Area (continuity):	3.1 cm²
Peak Gradient:	0 mmHg	Mean Gradient:	4.62 mmHg
PHT:	798 msec	AV VTI:	31.4 cm

Aortic Valve Summary

Structurally normal aortic valve with normal leaflet motion.
There appears to be trace aortic regurgitation.
The aortic root is normal in size.

Tricuspid Valve

TR Velocity:	149 cm/s	Estimated RAP:	5 mmHg
TR Gradient:	8.88 mmHg	Estimated RVSP:	13.91 mmHg

Tricuspid Valve Summary

The tricuspid valve leaflets are thin and pliable and motion is normal.
There is trace tricuspid regurgitation.
Normal pulmonary artery pressure.

Pulmonic Valve

Peak Velocity:	130 cm/s
Peak Gradient:	6.76 mmHg

Pulmonic Valve Summary

Grossly normal pulmonic valve structure and function.

LVOT

LVOT Diameter:	1.9 cm

Structures

Left Atrium

LA Dimension:	3.9 cm
LA/Aorta:	1.28

Left Atrium Summary

The left atrium is borderline dilated.

Left Ventricle

Diastolic Dimension:	4.7 cm	Systolic Dimension:	3 cm
Septum Diastolic:	0.8 cm	EF (Teicholz):	66%

COASTAL CAROLINA HOSPITAL
Coastal Carolina Hospital
1000 Medical Center Drive
Hardeeville, South Carolina 29927
(843) 784-8098
Report Status: Finalized

PW Diastolic:	0.9 cm	LV EDV/LV EDV Index:	104 ml/58 m²
FS:	36.17 %	LV ESV/LV ESV Index:	35 ml/19 m²

Left Ventricle Summary
The left ventricle is normal in size, wall thickness, contractility, and wall motion.
E-A reversal noted, suggestive of impaired relaxation pattern.

Right Atrium

Right Atrium Summary
The right atrium is normal in size.

Right Ventricle

Diastolic Dimension: 2.7 cm RV Systolic Pressure: 13.68 mmHg

Right Ventricle Summary
Normal right ventricle structure and function.

Additional Findings

Aorta

Aortic Root:	3.1 cm
Ascending Aorta:	3.3 cm

Miscellaneous Summary
IVC appears normal.
IVC collapses well with inspiration.

Pericardium

Pericardial effusion summary
No significant pericardial effusion is present.

Pleura

Pleural Effusion Summary
There is no pleural effusion present.

COASTAL CAROLINA MEDICAL CENTER
1000 Medical Center Drive
Hardeeville, SC 29927

Name: BARON, FRANCES
MRN: [redacted]
ACCT: [redacted]

Jonathan Maccabe, MD
ADM: 05/21/2012

Consultation

DATE OF SERVICE: 05/23/2012

REFERRING PHYSICIAN: Scott Condie, MD

REASON FOR REFERRAL: Syncope.

HISTORY: Ms. Baron is a 70-year-old nurse who presented to the Emergency Room after an automobile accident. She reports she was feeling well when she suddenly lost consciousness apparently ran off the road and drove into a tree. She woke with the airbag deployed. She has no recollection of running off the road. She reports no antecedent palpitations, chest pain, shortness of breath, dizziness or lightheadedness. She has a history of arrhythmias, diagnosed with PACs and PVCs in the past, but reports occasional "heart racing" which she can terminate with cough or Valsalva. These arrhythmias have never been documented by Holter monitoring over telemetry. She had a cardiac evaluation 3 years ago including a stress echocardiogram showing normal left ventricular systolic function and no evidence of ischemia. She has no history of recurrent syncope or near syncope in the past.

PAST MEDICAL HISTORY: Significant for a history of diabetes, hypertension, hypothyroidism and glaucoma.

HOME MEDICATIONS: Include lisinopril 5 mg daily, Glucophage 1000 mg twice daily, Xalatan eye drops daily, Synthroid 125 mcg daily, calcium and vitamin D daily, multivitamin daily and Motrin as needed for aches and pains.

ALLERGIES: She has no significant drug allergies.

SOCIAL HISTORY: She is a nonsmoker who very rarely drinks alcohol. She is married and currently works as a nurse in hospice. She lives in Ridgeland with her husband.

FAMILY HISTORY: There is a paternal history of cardiovascular disease. Her father died of myocardial infarction at age 74. Her mother had Parkinson disease before her death at age 78.

REVIEW OF SYSTEMS:
CONSTITUTIONAL: She reports no recent fever, chills or unexplained changes in weight.
CARDIAC: She denies chest pain or angina. She has a history of intermittent palpitations as described in the history of present illness. No history of previous syncope or near syncope prior to the current event.
RESPIRATORY: She denies shortness of breath, cough, wheezing, hemoptysis, orthopnea or PND. Remainder of 12-system review is unremarkable.

Work Type: Consultation Work Type Code: CON
T001 Page: 1

COASTAL CAROLINA MEDICAL CENTER
1000 Medical Center Drive
Hardeeville, SC 29927

Name: BARON, FRANCES Jonathan MacCabe, MD
MRN: [redacted] ADM: 05/21/2012
ACCT: [redacted]

Consultation

PHYSICAL EXAMINATION:
GENERAL: She is a well-developed, well-nourished female in no acute distress.
HEENT: She has marked ecchymosis and swelling about the face. There is no scleral icterus or conjunctivitis. Extraocular movements are intact. Nares and oropharynx are unremarkable.
NECK: Supple. There is no cervical lymphadenopathy or thyromegaly.
LUNGS: Clear to auscultation bilaterally. There is no accessory muscle use or respiratory difficulty.
HEART: Regular in rate and rhythm with a normal S1 and S2. No murmurs, gallops or rubs are appreciated.
ABDOMEN: Flat, soft, nontender and nondistended with normoactive bowel sounds. No organomegaly.
EXTREMITIES: There is no clubbing, cyanosis or edema of the extremities.
NEUROLOGIC: She is alert and oriented x 3. There is no focal strength or sensory deficits.

Electrocardiogram shows a sinus rhythm without significant ST changes, her conduction intervals are normal. Chemistry and CBC are both unremarkable. Cardiac enzymes have been within normal limits.

ASSESSMENT:
1. Syncope.
2. Diabetes.

PLAN: Ms. Baron has a history of recent syncopal event concerning for cardiac dysrhythmia. She had a bedside echocardiogram performed in the hospital showing normal left ventricular systolic function without significant valvular stenosis or regurgitation. She has had no significant arrhythmias since her admission. There is no evidence of an acute ischemic event; however, given her history of diabetes, outpatient stress testing will be arranged to exclude any ischemia. I discussed her case with Dr. Mark Jenkins, electrophysiologist in Savannah who will see her in consultation as an outpatient. Medications will remain unchanged.

Jonathan MacCabe, MD

TR:JM/IN
DD:05/23/2012 17:37 EDT
DT:05/23/2012 23:52 EDT

Work Type: Consultation Work Type Code: CON
T001

COASTAL CAROLINA MEDICAL CENTER
1000 Medical Center Drive
Hardeeville, SC 29927

Name: BARON, FRANCES
MRN: [redacted]
ACCT: [redacted]

Jonathan MacCabe, MD
ADM: 05/21/2012

Consultation

Dictation ID: 6468549/Confirmation #: 2830764
R:

Work Type: Consultation
T001

Work Type Code: CON

SAVANNAH CARDIOLOGY MYOCARDIAL PERFUSION IMAGING

8 Okatie Center Blvd. South, Suite 101, Okatie, SC 29909/ 843-705-9350

Patient Name:	BARON , FRANCES	Study Date:	25-May-2012
Height:65in	Weight: [redacted]lbs		BSA:1.78
Patient ID:	[redacted]	Referring MD:	
DOB:	[redacted]	Ordering MD:	Tricia Etheridge, MD
Age/Sex:	[redacted]	Reporting MD:	Jonathan MacCabe, MD Jonathan MacCabe, MD

Previous Nuclear: N/A **Previous Echo: 5-22-12 OUT**

INDICATIONS: Syncope, Abnormal ECG, diabetes, HLP, HTN.

CONCLUSION

Scan significance was normal and indicates a low risk for hard cardiac events.

SUMMARY

Hypertensive blood pressure response to pharmacologic stress. Normal ST response. Chest pain was non-specific. LV myocardial perfusion was normal, consistent with 0 vessel disease. Global Stress LV function was normal. LV dilation was normal. RV perfusion was normal.

STRESS PROTOCOL: Regadenoson The patient was infused intravenously with Regadenoson at 0.08 mg/ml for a period of 10 seconds. A total Regadenoson dose of 0.4 mg was injected intravenously. The patient's heart rate increased from 81 bpm at rest to 138 at peak stress. The patient's blood pressure at rest was 140/80 mmHg and increased to 170/80 mmHg at peak stress. Blood pressure response was hypertensive. Chest pain symptoms non-specific. Other symptoms that occurred included dyspnea, headache.

STRESS TEST FINDINGS: Adequacy of Stress: adequate

	STRESS EKG DATA	REST EKG DATA
Test Status	abnormal	abnormal
Rhythm	sinus tachycardia	sinus rhythm
AV Block	none	none
IV Conduction	normal	normal
Arrhythmias	none	none
ST Response	Normal	
Repolarization		nonspecific ST-T changes

The patient was given 3.0mCi intravenous Thallium-201 upon resting. Myocardial perfusion imaging was performed 20 minutes post injection. The patient received 34.6mCi of intravenous Tc-99m Tetrofosmin following the intravenous injection of Regadenoson. Gated SPECT images were acquired 30-60 minutes post injection. Images were presented in SPECT, gated wall motion and planar formats. The patient received approximately 27.3mSv total body effective dose.

Overall Study Quality: excellent **Extra Cardiac Activity:** normal
LV Myocardial Perfusion Defects: Myocardial perfusion is normal
Scan Significance: normal and indicates a very low risk for hard cardiac events
RV Size: normal
Stress/Rest LV Volume Ratio: 1.00, normal **Global Function:** normal

SSS= 0	SRS= 0	SDS= 0
Ejection Fraction:	79%	

REPORTING

The study interpretation occurred on 2012-05-25 16:26:36.
Status of the report is **final.** Reporting Physician: Jonathan MacCabe, MD

SAVANNAH CARDIOLOGY MYOCARDIAL PERFUSION IMAGING

8 Okatie Center Blvd. South, Suite 101, Okatie, SC 29909/ 843-705-9350

Patient Name:	BARON , FRANCES	Study Date:	25-May-2012
Height:65in	Weight:[redacted]		BSA:1.78
Patient ID:	[redacted]	Referring MD:	Tricia Etheridge, MD
DOB:	[redacted]	Ordering MD:	Jonathan MacCabe, MD
Age/Sex:	[redacted]	Reporting MD:	Jonathan MacCabe, MD

Previous Nuclear: N/A Previous Echo: 5-22-12 OUT

INDICATIONS: Syncope, Abnormal ECG, diabetes, HLP, HTN.

CONCLUSION

Scan significance was normal and indicates a low risk for hard cardiac events.

SUMMARY

Hypertensive blood pressure response to pharmacologic stress. Normal ST response. Chest pain was non-specific. LV myocardial perfusion was normal, consistent with 0 vessel disease. Global Stress LV function was normal. LV dilation was normal. RV perfusion was normal.

STRESS PROTOCOL: Regadenoson The patient was infused intravenously with Regadenoson at 0.08 mg/ml for a period of 10 seconds. A total Regadenoson dose of 0.4 mg was injected intravenously. The patient's heart rate increased from 81 bpm at rest to 138 at peak stress. The patient's blood pressure at rest was 140/80 mmHg and increased to 170/80 mmHg at peak stress. Blood pressure response was hypertensive. Chest pain symptoms non-specific. Other symptoms that occurred included dyspnea, headache.

STRESS TEST FINDINGS: Adequacy of Stress: adequate

	STRESS EKG DATA	REST EKG DATA
Test Status	abnormal	abnormal
Rhythm	sinus tachycardia	sinus rhythm
AV Block	none	none
IV Conduction	normal	normal
Arrhythmias	none	none
ST Response	Normal	
Repolarization		nonspecific ST-T changes

The patient was given 3.0mCi intravenous Thallium-201 upon resting. Myocardial perfusion imaging was performed 20 minutes post injection. The patient received 34.6mCi of intravenous Tc-99m Tetrofosmin following the intravenous injection of Regadenoson. Gated SPECT images were acquired 30-60 minutes post injection. Images were presented in SPECT, gated wall motion and planar formats. The patient received approximately 27.3mSv total body effective dose.

Overall Study Quality: excellent **Extra Cardiac Activity:** normal
LV Myocardial Perfusion Defects: Myocardial perfusion is normal
Scan Significance: normal and indicates a very low risk for hard cardiac events
RV Size: normal
Stress/Rest LV Volume Ratio: 1.00, normal **Global Function:** normal

SSS= 0	SRS= 0	SDS= 0
Ejection Fraction:	79%	

REPORTING

The study interpretation occurred on 2012-05-25 16:26:36.
Status of the report is final. Reporting Physician: Jonathan MacCabe, MD

NAME: FRANCES DARON DATE OF ACCIDENT: 5-21-2012

HOME ADDRESS: [redacted] SOCIAL SECURITY NUMBER: [redacted]

HOME PHONE: [redacted] EMPLOYER: SANCUARY HOSPICE

DATE	List trip taken below such as: Home to (name) Hospital; Home to Dr. (Name) an return home; Office to Dr. (name) and return home, etc.	Round-trip Daily Mileage
5/24/12	HOME TO DR. SUTHERLAND, OKATIE SC	44 MILES
5/24/12	HOME TO DR. DIANA, RIDGELAND SC	2 MILES
5/25/12	HOME TO DR. MACCABE, OKATIE SC	44 MILES
5/29/12	HOME TO COASTAL CAROLINA HOSPITAL	30 MILES
	TOTAL MILEAGE	120 MILES
		$

I certify that the above information furnished by me is true and correct and, based on such information, I hereby claim pay for the mileage as indicated.

Frances A. Daron
Signature

6/1/12
Date

GA-009 (5/95)

NAME: FRANCES BARON DATE OF ACCIDENT: 5-21-12

HOME ADDRESS: [redacted] SOCIAL SECURITY NUMBER: [redacted]

HOME PHONE: [redacted] EMPLOYER: SANCUARY HOSPICE

DATE	List trip taken below such as: Home to (name) Hospital; Home to Dr. (Name) an return home; Office to Dr. (name) and return home, etc.	Round-trip Daily Mileage
6-5-12	HOME TO DR DIANA, RIDGELAND SC.	2 MILES
	NEW GLASSES TO REPL. BROKEN/LOST, IN ACCIDENT	$534.60
6-7-12	HOME TO COASTAL CAROLINA HOSPITAL	30 MILES
6-7-12	CAR RENTAL CHARGES	424.14
	COST ASSOCIATED WITH ACCIDENT	$958.74
	TOTAL MILEAGE	32
		$

I certify that the above information furnished by me is true and correct and, based on such information. I hereby claim pay for the mileage as indicated.

Frances A. Baron 6/8/12

Signature Date

GA-009 (5/95)

NAME: FRANCES ISARON DATE OF ACCIDENT: 3-21-12

HOME ADDRESS: [redacted] SOCIAL SECURITY NUMBER: [redacted]

HOME PHONE: [redacted] EMPLOYER: SANCUARY HOSPICE

DATE	List trip taken below such as: Home to (name) Hospital; Home to Dr. (Name) an return home; Office to Dr. (name) and return home, etc.	Round-trip Daily Mileage
6-11-12	HOME TO DR. SUTHERLAND, DKATIE SC (LEG INJURY) & RETURN	44
	APP. AT 10:30 AM.	
6-14-12	HOME TO DR DIANA EYES RIDGELAND & RETURN	2
	PM. 3:30	
6-14-12	HOME TO COASTAL CAROLINA HOSP & RETURN	30
	APP PM. 1:30	
	(DRESSED WOUND, BLOOD TEST &	
	NOTE: ADDITIONAL APP. WITH DR DIANA ON 6-19-12 if@ IMPROVEMENT WITH EYE BRow/forhead ON RIGHT SIDE of FACE, POSSIBLE SURGERY TO FOLLOW. PER DR. DIANNA. HEAD INJURY HAS TO BE TOTALLY free of ANY SWELLING TO DETERMINE NECESSARY MEDICAL NEEDS	
NUMEROUS	COSTS of MED'S CAN BE OBTAINED from RIDGELAND MAIN ST. PHARMACY for ALL PRESCRIPTIONS	
	TOTAL MILEAGE	76
		$

I certify that the above information furnished by me is true and correct and, based on such information, I hereby claim pay for the mileage as indicated.

Frances Baron
Signature

6/14/12
Date

GA-009 (5/95)

NAME: FRANCES A. BARON DATE OF ACCIDENT: 5-21-12

HOME ADDRESS: [redacted] SOCIAL SECURITY NUMBER: [redacted]

HOME PHONE: [redacted] EMPLOYER: SANCTUARY HOSPICE

DATE	List trip taken below such as: Home to (name) Hospital; Home to Dr. (Name) an return home; Office to Dr. (name) and return home, etc.	Round-trip Daily Mileage
5-21-12	Home To Coastal Carolina Hosp. & return	
	APP 1:30 P.M. WOUND CARE Right Leg	30
	RECEIVED A INVOICE DATED 6-1-12	
	from OKATIE SURGICAL PARTNERS	
	PO BOX 405820	
	ATLANTA GA. 30384-5820 for	
	The sum of $371.00 INVOICE	
	NOT PAID. COPY ATTACHED.	$371.00
	TOTAL MILEAGE	30
		$

I certify that the above information furnished by me is true and correct and, based on such information I hereby claim pay for the mileage as indicated.

Frances A Baron
Signature

6/22/12
Date

GA-009 (5/95)

NAME: FRANCES A. BARON DATE OF ACCIDENT: 5-21-12

HOME ADDRESS: [redacted] SOCIAL SECURITY NUMBER: [redacted]

HOME PHONE: [redacted] EMPLOYER: SAVANNAH HOSP. CE

DATE	List trip taken below such as; Home to (name) Hospital; Home to Dr. (Name) an return home; Office to Dr. (name) and return home, etc.	Round-trip Daily Mileage
5-21-12	HOME TO COASTAL HOSP & RETURN " WOUND CARE "	30
6-28-12	HOME TO COASTAL HOSP & RETURN " WOUND CARE "	30
7-2-12	HOME TO COASTAL HOSP & RETURN " WOUND CARE "	30
7-5-12	HOME TO COASTAL HOSP & RETURN " WOUND CARE "	30
7-9-12	HOME TO DR SUTHERLAND & KATIE LEG INJURY & RETURN	44
7-, 12	HOME TO COASTAL HOSP & RETURN " WOUND CARE "	30
	TOTAL MILEAGE	194
		$

I certify that the above information furnished by me is true and correct and, based on such information. I hereby claim pay for the mileage as indicated.

Frances A. Baron 7/9/12

Signature Date

GA-009 (5/95)

NAME: FRANCES A. BARON DATE OF ACCIDENT: 5-21-12

HOME ADDRESS: [redacted] SOCIAL SECURITY NUMBER: [redacted]

HOME PHONE: EMPLOYER:

DATE	List trip taken below such as: Home to (name) Hospital; Home to Dr. (Name) an return home; Office to Dr. (name) and return home, etc.	Round-trip Daily Mileage
7/22/12	To Charleston S.C. MUSC Dept of Neuro.	
	Per insurance carrier for Exam from	167.6
	PhD Mark T. Wagner on 8/23/12 at 8:30 AM.	
	& return To 363 Wiley ST.	
	Cost of Hotel Rm.	$185.00
	Cost of food	$50.00
9/4/12	Hilton Head Emergency Phys Inc.	531.00
9/10/12	Home To Dr Sutherland & return Leg Injury	44 miles
	Invoice - Optim Orthopedics	$117.28
	TOTAL MILEAGE	211.6
		$ [redacted]

I certify that the above information furnished by me is true and correct and, based on such information. I hereby claim pay for the mileage as indicated.

Frances A. Baron 9/10/12

Signature Date

GA-009 (5/95)

NAME: FRANCES A. BARON DATE OF ACCIDENT: 5-21-12

HOME ADDRESS: [redacted] SOCIAL SECURITY NUMBER [redacted]

HOME PHONE: [redacted] EMPLOYER: SANCTUARY HOSPICE

DATE	List trip taken below such as: Home to (name) Hospital; Home to Dr. (Name) an return home; Office to Dr. (name) and return home, etc.	Round-trip Daily Mileage
9-10-12	TO & RETURN DR SUTHERLAND FOR ANKLE	44 MILES
9-19-12	TO & RETURN PALMETTO EYE	2 MILES
	STATEMENT NEW FROM PALMETTO EYE DATED 9-21-2012	
	STATEMENT from OPTIM ORTHO. DATED 9/26/2012 ACT. # 736946	
	TOTAL MILEAGE	
		$

I certify that the above information furnished by me is true and correct and, based on such information. I hereby claim pay for the mileage as indicated.

Frances A. Baron 10/02/12

Signature Date

GA-009 (5/95)

NAME: FRANCES A. BARON DATE OF ACCIDENT: 5/21/12

HOME ADDRESS: [redacted] SOCIAL SECURITY NUMBER [redacted]

HOME PHONE: [redacted] EMPLOYER: Sanctuary Hospice

DATE	List trip taken below such as: Home to (name) Hospital; Home to Dr. (Name) an return home; Office to Dr. (name) and return home, etc.	Round-trip Daily Mileage
11/14/12	DR. DIANA JR. M.D.	2
11/20/12	Dr. DIANA JR M.D	2
	TOTAL MILEAGE	4.00
		$

I certify that the above information furnished by me is true and correct and, based on such information, I hereby claim pay for the mileage as indicated.

Frances A. Baron
Signature

12/01/12
Date

GA-009 (5/95)

outh Carolina Workers' Compensation Commission
33 Main Street, Suite 500
ost Office Box 1715
olumbia, South Carolina 29202-1715
03) 737-5739
ww.[illegible].sc.gov

PRE-HEARING BRIEF
WCC File No:1206355

rances Baron [redacted]
aimant's Name SSN

[redacted]
[redacted]
ldress City State Zip
[redacted]

ome Phone #

Work Phone #
Kathleen G. Lyall
Preparer's Name

Sanctuary Hospice
Employer's Name
10911B Jacob Smart Boulevard
Ridgeland, South Carolina 29936
Address City State Zip
Guarantee Insurance Company c/o Patriot National Insurance Group
Insurance Carrier
(864) 239-4016
Phone Number

claim for workers' compensation benefits is made based on the following grounds:.
Injury ☐ Illness ☐ Repetitive Trauma

. Comp. Rate: $725.47 2. AWW: $ 1,095.15 **Date of Injury** May 21, 2012

. Type of injury and body part(s): Claimant alleges injury to her right ankle, right foot, left leg, face, head and brain.

. Facts in controversy: Whether Claimant sustained a compensable injury; Whether Claimant was in the course and scope of employment at the time of injury; Whether the accident arose out of Claimant's employment; Whether Claimant is entitled to any compensation and/or medical benefits.

. Legal issues involved: 42-1-160; 42-1-120; 42-15-60; Other applicable regulations and laws.

. Unusual aspects: None known to Defendants.

. ..nesses (designate if expert)* Penny Abbott may testify on behalf of Defendants.

. Exhibits: Claimant's deposition transcript; Personnel file to include wage records.

. Medical evidence: (Indicate report pursuant to R.67-612; deposition or appearance)
Defendants submit report pursuant to Regulation 67-612.

0. Name, address, and specialty, if any, of the treating physician:

Mark T. Wagner, PhD, MUSC Department of Neurology 96 Jonathan Lucas Street Charleston South 29425

1. Impairment rating(s); body part(s); physician and date of opinion: None

2. I am amending my Form 50/51 in the following manner: N/A

erify the contents of this form are accurate and true to the best of my knowledge.

IGNATURE Kat Lyall Email: katie.lyall@mgclaw.com

)ATE OF HEARING: September 6, 2012 Time needed for hearing: 60 minutes
)n behalf of ☐ Claimant ☒ Employer

ile this form and proof of service on the opposing party according to R.67-611 and R.67-212. Do not send medical reports.
Commissioners reserve the right to admit expert witnesses at hearings.

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 1206355

FRANCES BARON,

Employee,

Claimant,

vs.

SANCTUARY HOSPICE,

Employer,

AND

GUARANTEE INSURANCE COMPANY C/O PATRIOT NATIONAL INSURANCE GROUP,

Carrier,

Defendants.

NOTICE OF WITNESSES AND WRITTEN MEDICAL REPORTS TO BE INTRODUCED AS DIRECT EVIDENCE ON BEHALF OF DEFENDANT

TO: COMMISSIONER GENE MCCASKILL, SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION AND WILLIAM G. JENKINS, JR., ESQUIRE, ESQUIRE:

YOU ARE NOTIFIED that the Defendants, pursuant to the provisions of the South Carolina Workers' Compensation Act and Section 1-23-330 of the South Carolina Code of Laws (Cum. Supp. 1988) submit the following medical records and other documents as evidence:

APA#	DOCTOR	PRACTICE	DATES	PAGES
9.	Mark Wagner, PhD	MUSC Department of Neurology	08/23/2012	328-335
10.		Coastal Carolina Medical Center	09/10/2009	336

YOU ARE FURTHER NOTIFIED that you have the right to cross-examine or otherwise oppose this evidence and, should you desire to exercise this right, you are to promptly schedule

the deposition of any provider whose records are submitted, for the purposes of cross-examination, or otherwise promptly submit opposing medical records into evidence.

YOU ARE FURTHER NOTIFIED that these records, or photocopies of the same, will be provided to the South Carolina Workers' Compensation Commission for insertion in their file and for consideration as evidence on behalf of the Defendants.

YOU ARE FURTHER NOTIFIED that the following witnesses may be called on behalf of the Defendants: Penny Abbott and Will Abbott may testify on behalf of Defendants.

KATHLEEN G. LYALL
MCANGUS GOUDELOCK & COURIE, L.L.C.
Post Office Box 2980
Two Liberty Square, 75 Beattie Place, Suite 300
Greenville, South Carolina 29602
(864) 239-4000
Attorneys for the Employer/Carrier

Greenville, South Carolina
February 15, 2013

MUSC Department of Neurology
96 Jonathan Lucas Street, Suite 309
PO Box 25060
Charleston, SC 29425

RE: BARON, FRANCES
DOB: [redacted]
DOS: 08/23/2012
CONFIDENTIAL

IDENTIFYING INFORMATION: Frances Baron is a 70-year-old married Caucasian female who was seen in the Neurology Outpatient Clinic accompanied to the visit by her husband Edward Baron. Ms. Baron was referred for this evaluation by attorney, Kathleen Lyall. Her attorney is Mr. Jenkins. This referral was for a work-related accident. Records that were available for my review included premorbid records from Coastal Carolina Medical Center, Jasper County EMS report for the accident in question, more records from Coastal Carolina hospital for an acute admission, notes from Palmetto Eye Specialist, and within these records there were associated labs and other studies. Ms. Baron and her husband were interviewed. Ms. Baron was examined. Procedure 95958.

HISTORY: Ms. Baron and her husband were a delightful couple who were forthcoming and articulate with history. She described that she was involved in a motor vehicle accident on 05/21/12. She reported this accident occurred on a Monday in the mid afternoon when she was driving from Sanctuary Hospice, where she was providing patient care as a nurse, to her home base office to get equipment and medicines. She said that there was nothing unusual about the day and it was good weather. She reported that she was maybe 10 miles out of Beaufort, heading to her home office in Richland when she crashed her 2001 Cadillac into the woods. She suffered some injuries and was taken to Coastal Carolina where she was evaluated and admitted. Since this accident, she has been slowly recovering but has not returned to work.

Ms. Baron provided most of the information during the interview but her husband occasionally interjected. She stated that it was a normal work day. She had worked about two-thirds of her shift. She needed some supplies and medicines for patient care so she was heading back to her home office and planned to return to Sanctuary Hospice in Beaufort. She said that she was driving down Snake Road, which is a two-lane highway in a rural and wooded area. She remembered thinking about her patients and her

plans for the rest of the day. She said that she passed out. She was (and remains) amnestic for events leading up to the crash, but then had continuous memory after the impact. She could not remember having any symptoms that might have contributed to her passing out. She said that when she opened her eyes she was in the vehicle and saw smoke. She was a restrained driver and the airbag did deploy. She thought the car was on fire, but in actuality this may have been the mist from the airbag deployment. She was a little stunned, but realized the urgency of the situation and got out and walked away from the vehicle. She denied any lost of consciousness.

There was a good samaritan on the scene that came to Ms. Baron's assistance. She reported that she was totally amnestic for the accident and events immediately before the accident. She does not remember swerving off of the road or hitting the trees. Immediately after the accident she opened her eyes, she had continuous memory. There was no evidence of any anterograde memory loss (meaning after the accident that would be consistent with a head injury), but she did have significant retrograde memory loss associated with the reported syncopal event (suggesting she had experienced some sort of cardio- or neuro-event). She described that the good Samaritan had called 911. Ms. Baron had stated that at the scene she did not feel there was a need for an ambulance and did not report any pain or other significant symptoms at the scene. This was not the case because she had a laceration above her eye and it was ultimately discovered that she had a fractured ankle. She said, and her husband confirmed, that there were no skid marks on the highway. This would suggest that she was not aware of an eminent crash. This was a heavily wooded area and she may have hit a few pine trees before the car was ultimately stopped by a large tree that caused extensive damage to her vehicle.

At the scene, Ms. Baron was quite preoccupied with her medical records she was carrying from her place of work and was worried about HIPAA. She reported that the good Samaritan assured her that somebody from the office had been called and would take care of the records. The good Samaritan reportedly had also called the granddaughter; so multiple people were alerted as to this accident. Her husband came across the accident while he was en route to Coastal Carolina. He was allowed to enter the EMS vehicle and Ms. Baron reported that she was more concerned about her husband than herself. He followed the ambulance to the hospital.

EMS transported Ms. Baron from the scene of the accident to

Coastal Carolina. Bleeding above her eye was acutely addressed. She remembered much of the discussion at the scene of the accident, but reported that she felt a little foggy in the emergency room. She said that various x-rays were done and the wound(s) were treated. She remembered the emergency room doctor saying that she had "won an admission ticket to the hotel" meaning she was going to be admitted to the hospital.

In the emergency room Ms. Baron said she reported some head pain and was sore across her chest where she had impacted the seatbelt. She described that she had somewhat of a hypertensive crisis with systolic blood pressure greater than 200. This was far above her reportedly normal baseline. She remembered a discussion about taking her cervical collar off after there was a particular study that was to be completed. She was ultimately admitted to the hospital for further workup and observation. She was in Coastal Carolina until Wednesday evening when she was discharged. Apparently the focus of the workup was to determine the cause of her syncope, but she said the workup was negative for stroke, heart, and said that there was no EEG. She reported that there were no particular events that could conclusively be attributed to her syncopal event. She said that she had gotten a good night sleep and there were no particular stressors before this accident that might explain the syncopal event. Following the discharge, she had some ongoing cardiac workup including a stress test that was negative. She was, however, discovered to have an ankle fracture and this was treated on 02/29/12, with two pins in an ORIF orthopedic procedure. She also had a complication of a hematoma in her right calf that was treated in the wound clinic. She said that she was recently just discharged from that clinic. During the acute hospitalization she had a couple of PT sessions. Following discharge she had a couple of PT sessions and has continued to do her prescribed exercises.

In terms of current symptoms, Ms. Baron described that she still has some aches and pains, but is on the road to recovery. She reported some reduced range of motion and mild pain, right greater than left. She said the pain is not too bad and she will take a Motrin maybe twice a week for pain. She wears a compression stocking and occasionally uses ice. Her ambulation reportedly is somewhat reduced. She has some fatigue and her sleepiness has largely abated such that she no longer takes naps in the afternoon as she had done early in her recovery course. Her sleep schedule had been disturbed a little bit and her primary care physician gave her Restoril to help regulate the sleep. She uses Restoril infrequently nowadays. Her main

complaint is reduced endurance. She said that this would be a limiting factor preventing her from returning to work. Around the house, she does her normal chores, although, is slower and is limited by her endurance. She had been using a walker on occasion early on, but is now full weight bearing. She thinks she may need some eye surgery for some ptosis (drooping of the eyelid.) She has not been driving because of the ptosis and right leg pain.

Ms. Baron does admit to a cardiac history. She said that she has had an irregular heart rate for some time. Her irregular heart was extensively worked up about two or three years ago without any specific findings. She also had a pre-accident history of dizziness that sounded like benign positional vertigo. She said that some crystals were loose in her inner ear and this was successfully treated with Valium in her past. She denied any history of prior syncope (fainting). Psychologically, she feels that she has "lost my family" referring to her colleagues and friends in the workplace.

REVIEW OF MEDICAL RECORDS:
Review of Premorbid Medical Records: There were some premorbid medical records that came from Coastal Carolina Medical Center. There is a note from 2005 where Ms. Baron was worked up for some sort of diarrhea or flu. In 2008, she had a workup for lower extremity pain during ambulation with weak pulses in the lower extremities. Findings showed some plaque, but no significant stenosis or occlusion in the vascular of her legs by doppler. A couple of months later in 06/13/08, she was worked up for a low back pain and had a lumbar series that showed mild multilevel degenerative disc disease. In 2009, there was a workup for shortness of breath and exercise intolerance. Carotid Doppler showed some mild stenosis of the left carotid artery and moderate plaque without significant stenosis of the right carotid artery. She had an abnormal EKG that required a stress echocardiogram. This test was discontinued because of the hypertensive response but the study was otherwise largely unremarkable. She had an echocardiogram that showed mild aortic regurgitation. This series also included a CT of the brain with the indication of "syncope" performed on 09/10/09. The study showed mild cerebral atrophy only. It is curious that the indication was "syncope" as she denies (or forgot about) any prior history of syncope.

On 03/30/10, Ms. Baron had a cardiac follow-up to the 2009 visits. It was noted that her dyspnea (shortness of breath) and exercise intolerance were resolving over the evaluation

interval. She carried a diagnosis of dyspnea, abnormal EKG and aortic valve disorder around that time. Her workup was largely unremarkable and she continued to be followed for her mild regurgitation. Later in 2009, Ms. Baron had a workup for a nodule on her thyroid. Various studies were done including a biopsy that revealed no malignancy. Her thyroid was ultimately surgically resected.

Towards the end of 2009, Ms. Baron had another workup on 11/02/09, for shortness of breath and her studies were largely unremarkable. Finally there was a lumbar series for back pain that showed no change in the degenerative disc disease.

Review of Medical Records Post Accident: The notes from Jasper County EMS indicated a call that came in at 2:54 p.m. EMS arrived and was at the patient approximately 15 minutes after the call at 3:09 p.m. Her blood pressure was indeed high at 230/106. She was described as having a laceration above the right eye with bleeding that was controlled with dressing and pressure. There was abrasion and bruising noted at the lower medial leg and to the right lower arm. There were no neurological abnormalities. Her mental status per Glasgow Coma Scale was 15/15 and this remained unchanged. It was described that Ms. Baron was sitting on the side of the road and denied loss of consciousness. The report stated that she answered all questions appropriately. Blood pressure was noted to be abnormally high. She was transported to Coastal Carolina Hospital.

Ms. Baron was seen in the emergency room at Coastal Carolina hospital. She arrived by EMS at 4:05 p.m or 71 minutes after the initial call had been received. It was noted that this was a car vs. tree motor vehicle accident. She was described with an abrasion above the right eyebrow and hematoma. There is an abrasion to the right forearm and the right lower leg. The records stated that she did not remember what caused her to go off of the road. She had some head pain. Her mental status was described as alert, and oriented to person, place, and time. Her speech was normal. The records indicated that pertinent negatives were for confusion, numbness, weakness and loss of consciousness. This record indicated that she was driving and lost consciousness causing her to run off of the road and hit a tree. Her Glasgow Coma Score in the emergency room was 15/15. She was admitted to the hospital.

The admission H&P had a history that seemed to be in error with

a slightly different story than what Ms. Baron reported to me and what was recorded by EMS and her ER doctor. Her ultimate diagnosis was syncope with motor vehicle accident, with head trauma, concussion, and loss of consciousness less than 15 minutes. This doctor may have misinterpreted the situation thinking that she was unconscious after the accident rather than before the accident. There was a separate consultation note from Dr. McCabe that noted that she denied any antecedent palpations, chest pain, shortness of breath, dizziness, or lightheadedness. This doctor did note a history of arrhythmias with a diagnosis of PACs and PVCs in the past. It was reported that in she had a history her racing heart that she could terminate with a cough or a Valsalva maneuver. This consultation diagnostic formulation was syncope and diabetes. This doctor felt that the recent syncopal event was "concerning for cardiac dysrhythmia". Other studies included a CT of the brain that showed mild generalized atrophy with mild periventricular white matter disease. This generally ruled out a significant cerebrovascular event that would explain the syncope. Her cervical was unremarkable. A CT of the face showed right frontal scalp hematoma and laceration with no bone fracture. Her carotid study showed mild torturous carotid system, mild-to-moderate diffuse plaque involving the right carotid system with no significant stenosis and moderate plaque of the left carotid artery with no high-grade stenosis. An MRA of the brain showed significant regions of stenosis involving the origin of the right posterior cerebral artery in P1 segment of the left posterior cerebral artery. This did not explain the syncopal event, but does suggest a possible cerebrovascular etiology.

There was an ophthalmology note from 05/24/12. This note indicated new floaters from last year's exam.

On 05/29/12, Ms. Baron underwent ORIF of the left ankle. The surgery was uncomplicated. She got some subsequent physical therapy.

The rest of the records on Ms. Baron had to do with wound care and debridement of the lower extremity.

PAST MEDICAL HISTORY: Significant for hypercholesterolemia, diabetes, cardiac arrhythmias, she is status post T&A from her youth, appendectomy, cholecystectomy, ORIF of the left ankle, debridement of the right, she had an MRI of the brain that showed cerebral atrophy and mild periventricular white matter disease. Additionally, there is an MRA of the brain that shows

significant regions of stenosis in the right PCA and P1 segment of the left PCA.

MEDICATIONS: Glucophage, lisinopril, calcium, Synthroid, multivitamins, vitamin E, CoQ10 for irregular heart rate, fish oil, and rare Restoril. She on occasion uses Motrin for pain.

FAMILY HISTORY: The father died of MI at age 74. The mother died of Parkinson's disease at 78. There is a brother with right TKR and a sister in good health. Stroke and hypertension run in the extended family members.

SOCIAL HISTORY: Ms. Baron was born and raised in Pennsylvania. She graduated from high school and received a three-year diploma in nursing. She worked as a nurse her whole life. She has been married 50 years. The couple has two grown children. A son who is in the navy that works as an emergency room doctor and a daughter lives in Ridgeville. Ms. Baron and her husband live with the daughter in Ridgeville. She has continued to work into her retirement and has had great job satisfaction in hospice care. She suggested that she had been thinking about cutting down on her hours at work around the time of this accident. Her husband is mostly retired from construction. She said enjoys gardening and keeps up with her exercise program that was initiated by PT. She does not smoke and drinks socially on rare occasion.

EXAMINATION: Weight [redacted], height [redacted] feet [redacted] inches, blood pressure 157/51, pulse 83, temperature 98.0. Ms. Baron was ambulatory and spry. She was a little stiff after sitting for a while, but otherwise did not exhibit any significant overt pain behavior. She was exceptionally pleasant and cooperative. She was quite forthcoming with information. She was an excellent historian. Her mood and affect were appropriate. Her estimated level of intellectual function was probably average. She had no difficulty with concentration or recall. She did complain of some minor possible age-related forgetfulness. To the test effort, she completed the TOMM and word memory test scoring well within normal limits on both tests.

OPINION: For this evaluation I was asked to specifically opine about etiology. In response, seems very clear from the records, and Ms. Baron, that she experienced an episode of syncope that caused a motor vehicle accident. It seems quite clear that the syncopal event preceded the accident. Specifically, there was significant retrograde amnesia, but no anterograde amnesia. Clinically this demonstrates that there was unconsciousness

before, and not after the accident. This story has been very consistent throughout her medical records. It is the opinion of the cardiologist that the syncopal event was concerning for cardiac dysrhythmia. A premorbid history of dysrhythmia is clearly documented in the medical records, but a cardiogenic cause of syncope could not be proven. Additionally it was found that she has some possible cerebrovascular risks that could have caused syncope, but this also was never proven. She has no history of epilepsy and seizure as an explanation for syncope seems highly unlikely. There is nothing she particularly did or did not do to contribute to a syncopal event, such as medication usage or sleep deprivation. There were no particular stressors in the workplace and she was not distracted by a cell phone or text message. Ultimately, this is an unexplained syncopal event. It does not appear that the syncopal event was caused by any condition related to her employment, although, the event did occur during her employment when she was traveling from one location to another.

Mark Wagner, PhD
Clinical Neuropsychologist
Professor of Neurology

MW/am1621
dd: 08/23/2012
dt: 08/24/2012
JobID: 5797057

cc: Kathleen Lyall, McAngus Goudelock & Courie, LLC, Fairview Road, Ste 700, Charlotte, NC 28210-2267

THIS NOTE IS CONFIDENTIAL

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Name: BARON,FRANCES A
Attending Dr: Etheridge, Tricia
DOB: [redacted] Age: [redacted] Sex: F
Acct: [redacted] Loc: L.CT
Exam Date: 09/10/2009 Status: DEP CLI
Radiology No:
Unit No: [redacted]

Exams: 000080730 CT HEAD/BRAIN WO CONTRAST

CT SCAN OF THE BRAIN: 09/10/2009

HISTORY: A [redacted]-year-old female, syncope.

TECHNIQUE: This study was performed without IV contrast administration. 5 mm imaging was obtained through the posterior fossa and cerebral hemispheres.

FINDINGS: No subdural, epidural or acute intraparenchymal hemorrhage is noted. No subarachnoid hemorrhage is seen. Mild bilateral basal ganglia calcifications are noted. No mass effect, midline shift or acute cerebral edema is noted. No posterior fossa lesion is seen. The fourth ventricle is midline. The visualized paranasal sinuses are unremarkable.

IMPRESSION: Mild cerebral atrophy with no acute intracranial abnormality observed.

** Electronically Signed by MOESCH DEAN on 09/11/2009 at 0951 **
Reported and Signed by: MOESCH DEAN

CC: Tricia Etheridge

Dictated Date/Time: 09/10/2009 (1849)
Technologist: MCCANTS PATRICK
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Counsel for Appellant certifies that the Record on Appeal contains all material proposed to be included by any of the parties and not any other material.

April 4, 2014

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