THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

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SC Court of Appeals

Appeal from Charleston County
Court of Common Pleas

Bentley D. Price, Circuit Court Judge

Appellate Case No. 2020-001643
Circuit Court Case No. 2016-CP-10-05379

The Estate of Delila Parrott,

Respondent

v.

Sandpiper Independent and Assisted Living-Delaware, LLC,

Appellant.

RECORD ON APPEAL
VOLUME 4

REEVES AND LYLE, LLC
Paul L. Reeves (SC Bar No. 4674)
Todd R. Lyle (SC Bar No. 102308)
John G. Boswell (SC Bar No. 778)
P.O. Box 11126
Columbia, South Carolina 29211
(803) 920-0001
Attorneys for Respondent

CLEMENT RIVERS, LLP
Stephen L. Brown (SC Bar No. 66468)
D. Jay Davis, Jr. (SC Bar No. 12084)
Russell G. Hines (SC Bar No. 72100)
Matthew O. Riddle (SC Bar No. 76650)
25 Calhoun Street, Suite 400 (29401)
P.O. Box 993
Charleston, South Carolina 29402
(843) 720-5488
Attorneys for Appellant

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STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON	)	IN THE COURT OF COMMON PLEAS FOR THE NINTH JUDICIAL CIRCUIT CA#: 2016-CP-10-5379
THE ESTATE OF DELILA PARROTT, Plaintiff, vs SANPIPER INDEPENDENT AND ASSISTED LIVING-DELAWARE, LLC Defendant.	)	PLAINTIFF'S PRE-TRIAL BRIEF

I. A concise, non-argumentative statement of the facts of the case.

This case arises from the damages Delila Parrott, an 80-year-old resident of Sandpiper Senior Living Center, suffered after falling and breaking her hip and being on the floor of her apartment from Tuesday evening to Friday evening with no one from Sandpiper rescuing her.

Ms. Parrott and her daughter, Joan Acosta, began to look for a suitable senior residence for Ms. Parrott in early 2013. Ms. Parrott and Acosta met with Corrine Carrington, the Director of Sandpiper's senior living facility prior to making the decision to lease a residence at Sandpiper. One of the facts that led Parrott and Acosta to choose Sandpiper was Sandpiper's representations that it had a policy (hereinafter referred to as the "Policy") of visually accounting for each of the residents daily. Based on the existence of the Policy and other factors, Ms. Parrott executed a lease with Sandpiper on April 26, 2013 and moved into Sandpiper's senior complex (an assisted living place and a nursing home are located on the same property). The executed lease did not reference the Policy that was presented to Ms. Parrott by Carrington.

The lease contained an arbitration clause denying Ms. Parrott any redress outside of arbitration. After the pleadings were filed, the parties agreed to waive the arbitration requirement and allow this Court to hear the matter non-jury.

Ms. Parrott suffered mild paranoia prior to moving onto Sandpiper's complex. While she enjoyed her privacy, she functioned well and was independent in carrying out activities usually associated with someone her age, such as managing her financial affairs, managing a small stock account, paying bills, socializing, using a computer, watching her favorite television shows, and going away from the property to shop and visit with friends and family. She was in excellent physical health, which allowed her to quickly recover from the physical injuries of her fall.

While Ms. Parrott lived alone at Sandpiper, she became friends with Lila Waters (and others) who also resided at Sandpiper. Ms. Parrott and Ms. Waters interacted often and would socialize and have meals together.

Ms. Parrott changed the locks to her residence on March 4, 2014. Shortly after the lock was replaced, Ms. Parrott gave a copy of the residence key to Carrington. Carrington notified other staff about the key and told staff where to locate the key, as it was kept with the other residents' master keys. Ms. Parrott's residence was less than a minute from the office where staff and a copy of her residence key were located.

On Tuesday June 3, 2014, Ms. Parrott fell in her apartment. She was trying to manipulate a curtain while standing on a chair. The fall caused her to fracture her hip and rendered her immobile and in pain.

Sandpiper admits to knowing that Ms. Parrott was missing and unaccounted for on Wednesday. Staff, per the Policy, telephoned Ms. Parrott's residence but could not get Ms.

Parrott to answer the telephone. Staff then visited Ms. Parrott's apartment and could not get her to the door. Staff tried to enter Ms. Parrott's residence; however, staff brought the wrong key and therefore could not open the lock. Staff then returned to the office and, rather than returning with the correct key, took no further action to account for Ms. Parrott.

Lila Waters reported to staff on Thursday that Ms. Parrott was missing. She also reported to staff that Ms. Parrott was missing on Friday. Sandpiper will offer testimony that Ms. Parrott was seen and checked off by staff on Thursday but Sandpiper has been unable to produce records that would substantiate that Ms. Parrott was seen on Thursday.

Ms. Parrott was found on the evening of Friday, June 6 at 8 p.m. by Lila Waters. There is a controversy about whether staff was also involved in rescuing Ms. Parrott. Ms. Parrott was covered in feces, dried urine, had decubitus ulcers on her thigh and buttock and was in pain. She was taken by EMS to Roper Hospital, where she was admitted for a treatment of the hip fracture, decubitus ulcers, dehydration, and infection.

After the fall and lying on the floor for three days, Ms. Parrott recovered fully from the hip fracture and other physical injuries associated with the fall but never returned to independent living. She spent time in a rehabilitation hospital. She was then moved to an assisted living complex. She was hospitalized in October 2014. She then was moved to a nursing home and finally entered hospice in January of 2015. She died on February 9, 2015.

Ms. Parrott's estate brought this action for conscious pain and suffering and wrongful death.

II. An objective statement of the issues in controversy.

1. Whether the Policy of visually confirming the wellbeing of each resident daily existed at the time Ms. Parrott entered Sandpiper?

2. Whether the Policy provided instructions as to how staff was to respond to a missing resident?

3. Whether the Policy created a duty for Sandpiper to confirm the wellbeing of its residents daily?

4. Whether Sandpiper followed the steps of its Policy relevant to its treatment of Ms. Parrott?

5. Whether Ms. Parrott was on the floor, immobile and unattended from June 3, 2014 to June 6, 2014 or for a shorter period of time?[1]

6. Whether Ms. Parrott suffered conscious pain and suffering from the long lie, from June 3, 2014 until she was rescued on June 6, 2014?

7. Whether Ms. Parrott suffered conscious pain and suffering from the point of her rescue from the long lie until February 9, 2015?

8. Whether the long lie, as opposed to the actual broken hip, caused, aggravated, and/or contributed to her death on February 9, 2015?

9. Whether Ms. Parrott is entitled to actual damages for her conscious pain and suffering for the harm caused by Sandpiper?

10. Whether Ms. Parrott is entitled to actual damages for the harm caused by Sandpiper in causing, aggravating, and/or contributing to her death under her wrongful death cause of action?

11. Whether Ms. Parrot is entitled to punitive damages for Sandpiper's failure to follow the Policy thereby causing harm to Ms. Parrott?

12. Whether Sandpiper took any remedial measures after its failure follow its own Policy, such as additional training, adverse employment actions, revisions to the Policy, additional checks etc., and if not, are punitive damages even more appropriate?

13. Whether Ms. Parrott is entitled to damages and attorney's fees under the South Carolina Unfair Trade Practices Act?

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[1] The event of an elderly person lying on the floor with the inability to get up for any time over one hour is referred to as a long lie.

14. Did Sandpiper intentionally destroy the critical records for the week of June 2, 2014?

15. Should the Court infer that the critical records Sandpiper either lost or destroyed for the week of June 2, 2014, would have refuted Sandpiper's contention that its staff saw Ms. Parrott on Thursday June 5, 2014?

III. The law applicable to the cause of action and the defense.

To prove a cause of action for negligence, a plaintiff must show: (1) the defendant owes a duty of care to the plaintiff; (2) the defendant breached that duty by a negligent act or omission; (3) the defendant's breach was the actual and proximate cause of the plaintiff's injury; and (4) the plaintiff suffered an injury or damages. *Madison ex rel. Bryant v. Babcock Ctr., Inc.*, 371 S.C. 123, 135, 638 S.E.2d 650, 656 (2006); *Roddey v. Wal-Mart Stores E., LP*, 784 S.E.2d 670, 675 (S.C. 2016).

Duty and Breach (Issues 1-4 above)

A legal duty of care owed by the defendant to the plaintiff must exist to maintain an action for negligence. *Bishop v. South Carolina Dep't of Mental Health,* 331 S.C. 79, 502 S.E.2d 78 (1998). Duty is generally defined as "the obligation to conform to a particular standard of conduct toward another." *Shipes v. Piggly Wiggly St. Andrews, Inc.*, 269 S.C. 479, 483, 238 S.E.2d 167, 168 (1977).

In determining the standard of care, the court may look to the *common law*, statutes, administrative regulations, industry standards, *or a defendant's own policies and guidelines. Id.* at 140, 638 S.E.2d at 659 (Emphasis Added). Additionally, an affirmative legal duty to act may be created "by statute, *contract, relationship*, status, property interest, *or some other special circumstance*." *Carson v. Adgar*, 326 S.C. 212, 486 S.E.2d 3 (1997); *Wyatt v. Fowler*, 326 S.C.

97, 484 S.E.2d 590 (1997); *Hubbard v. Taylor*, 529 S.E.2d 549, 552 (S.C. App. 2000) (Emphasis Added).

While the common law ordinarily imposes no duty on a person to act, once an act is undertaken, the actor assumes the duty to use due care. *Miller v. City of Camden*, 329 S.C. 310, 314, 494 S.E.2d 813, 815 (1997). The Restatement (Second) of Torts recognizes this concept in § 314 and § 323. Under § 314, there is no duty to act to provide aid or protection to another, even if the individual realizes or should realize that action on his part is necessary to protect the other party. *Cf. Rogers v. South Carolina Dep't of Parole & Community Corrections*, 320 S.C. 253, 255, 464 S.E.2d 330, 332 (1995). However, there is a duty to exercise reasonable care to another when one "undertakes, *gratuitously or for consideration*, to render services to another." *Restatement (Second) of Torts* § 323 (1965) (Emphasis Added). In this situation, the individual should realize that action is "necessary for the protection of the other's person or things." *Id.*

Next, the Restatement (Second) of Torts recognizes that a breach occurs when an individual, who undertook to render service, fails "to exercise reasonable care to perform his undertaking, if his failure to exercise such care increases the risk of such harm, or the harm is suffered because of the other's reliance upon the undertaking." *Id.*

In South Carolina, the courts have recognized the use of Defendant's internal policies to determine duty and the failure to follow those policies to determine breach. In *Peterson v. Nat'l R.R. Passenger Corp.*, the court stated that "evidence of a company's deviation from its own internal policies is relevant to show the company deviated from the standard of care and is properly admitted to show the element of breach," 365 S.C. 391, 397, 618 S.E.2d 903, 906 (2005). Furthermore, in *Caldwell v. K–Mart Corp.*, the court held that K-Mart's loss prevention manual

was relevant because "internal policies or self-imposed rules are often admissible as relevant on the issue of failure to exercise due care." 306 S.C. 27, 31, 410 S.E.2d 21, 24 (Ct.App.1991).

In this case, Sandpiper takes the position that the Policy did not exist, and if it did exist, Sandpiper was unaware of its existence. However, Carrington, Sandpiper's manager in charge of the senior living complex, and all of Sandpiper's staff testified that the Policy as set forth herein did exist. Even Sandpiper's expert witness called to testify about the responsibilities Sandpiper had toward Ms. Parrott testified, although reluctantly, that the procedure outlined above constituted a Policy and that Sandpiper should have followed it in a reasonable manner.

Carrington and staff testified that the Policy was in writing and housed in Carrington's office at Sandpiper. The Policy required that staff "check off" each resident who had been seen by making a mark by the resident's name on a written document designed for that purpose. Sandpiper has taken the position, when these documents were requested in discovery, that the documents for the entire relevant time period are now missing, destroyed, or lost. Sandpiper, despite the testimony from staff and their expert, still denies the policy existed, and if it did exist, it was only a "courtesy."

In chronological order, Sandpiper denied the existence of any policy and procedure in its Answers to Plaintiff's complaints. Sandpiper denied the existence of any policy and procedure in their responses to interrogatories. Sandpiper did not produce any documents relevant to the Policy, other than one page which reflected how the current Policy is recorded. In response to Plaintiff's request for admissions, Sandpiper simultaneously and artfully both denied and admitted that the policy existed. Sandpiper's 30(b)(6) designee denied the existence of the policy, then admitted that Carrington had the authority to offer and maintain the Policy. The designee also testified that such a Policy was used as a marketing tool. After being pressed in the 30(b)(6) deposition recently

completed, Sandpiper admitted that its staff used the Policy but then denied knowing that the policy was in place.

Proximate Cause/Foreseeability (Issue 8 above)

"For an act to be a proximate cause of an injury, the injury must be a foreseeable consequence of the act." *Wallace v. Owens–Illinois, Inc.*, 300 S.C. 518, 389 S.E.2d 155 (Ct.App.1989). "The test of foreseeability is whether some injury to another is the natural and probable consequence of the complained of act." *Id.*

"The defendant's negligence does not have to be the sole proximate cause of the plaintiff's injury; instead, the plaintiff must prove the defendant's negligence was at least one of the proximate causes of the injury." *Hughes v. Children's Clinic, P.A.*, 269 S.C. 389, 398, 237 S.E.2d 753, 757 (1977). "The question of proximate cause ordinarily is one of fact for the jury, and it may be resolved either by direct or circumstantial evidence." *Childers v. Gas Lines, Inc.*, 248 S.C. 316, 325, 149 S.E.2d 761, 765 (1966). See also *McNair v. Rainsford*, 330 S.C. 332, 349, 499 S.E.2d 488, 497 (Ct.App.1998).

Damages (Issues 5-7, 9-12 above)

A plaintiff is "entitled to recover all damages proximately resulting from the negligent acts of the defendant, including the aggravation of his [or her] pre-existing condition." *Watson v. Wilkinson Trucking Co.*, 136 S.E.2d 286, 291 (S.C. 1964) (quoting 15 *Am.Jur., Damages, Sections 80 and 81*). In determining the amount of damages a plaintiff can recover, a "jury could properly consider ... his [or her] loss of earning power, pain and suffering, and medical expenses, including any future damages resulting from permanent injuries." *Id.* at 291. However, "these cannot be determined with certainty, and the monetary value to be placed upon them." *Id.*

"The defendant takes the plaintiff as he [or she] is found and the plaintiff is entitled to recover damages resulting from the aggravation of a pre-existing condition." *Id.* "As a general rule, liability for the consequences of one's tortious act is not lessened by reason of the fact that the injuries were aggravated by the plaintiff's unhealthy conditions due to his own bad habits." *22 Am.Jur.2d Damages § 282* (1988); *Raino v. Goodyear Tire and Rubber Co.*, 422 S.E.2d 98, 100 (S.C. 1992).

In a survival action, "actual damages . . . are awarded for the benefit of the decedent's estate." *Scott v. Porter*, 340 S.C. 158, 530 S.E.2d 389 (Ct.App.2000). These damages "include those for medical, surgical, and hospital bills, conscious pain, suffering, and mental distress of the deceased." *Id.*

"In a wrongful death case, the issue of damages is not directed toward the value of the human life that was lost, but rather the damages sustained by the beneficiaries as a result of the death." *Zorn v. Crawford*, 252 S.C. 127, 165 S.E.2d 640 (1969); *Self v. Goodrich*, 300 S.C. 349, 387 S.E.2d 713 (Ct.App.1989). Damages recoverable in a wrongful death action include: (1) pecuniary loss; (2) mental shock and suffering; (3) wounded feelings; (4) grief and sorrow; (5) loss of companionship; and (6) deprivation of the use and comfort of the intestate's society, including the loss of his experience, knowledge, and judgment in managing the affairs of himself and of his beneficiaries." *Smith v. Wells*, 258 S.C. 316, 188 S.E.2d 470 (1972); *Scott*, supra. *Welch v. Epstein*, 536 S.E.2d 408, 421 (S.C. App. 2000).

In South Carolina, "punitive damages are allowed in the interest of society in the nature of punishment and as a warning and example to deter the wrongdoer and others from committing like offenses in the future." *Laird v. Nationwide Ins. Co.*, 243 S.C. 388, 396, 134 S.E.2d 206, 210 (1964). Moreover, they serve "as a vindication of private rights when it is proved that such have

been wantonly, willfully or maliciously violated." *Harris v. Burnside*, 261 S.C. 190, 196, 199 S.E.2d 65, 68 (1973). Lastly, punitive damages may be awarded only upon a finding of actual damages." *Carroway v. Johnson*, 245 S.C. 200, 139 S.E.2d 908 (1965).

In *Gamble v. Stevenson*, the South Carolina Supreme Court has developed an eight factor post-verdict review that trial courts are required to conduct to determine if a punitive damages award comports with due process, S.E.2d 350, 354 (S.C. 1991). The *Gamble* factors are: (1) defendant's degree of culpability; (2) duration of the conduct; (3) defendant's awareness or concealment; (4) the existence of similar past conduct; (5) likelihood the award will deter the defendant or others from like conduct; (6) whether the award is reasonably related to the harm likely to result from such conduct; (7) defendant's ability to pay; and finally, (8) as noted in *Haslip*, "other factors" deemed appropriate. Id. at 354. Under *Gamble*, the trial court is not required to make findings of fact for each factor to uphold a punitive damage award. *McGee v. Bruce Hosp. Sys.*, 321 S.C. 340, 468 S.E.2d 633 (1996); see also *Welch v. Epstein*, 536 S.E.2d 408, 422 (S.C. App. 2000).

The amount of damages, actual, or punitive remains largely within the discretion of the jury, as reviewed by the trial judge. See *Fennell v. Littlejohn*, 240 S.C. 189, 125 S.E.2d 408 (1962). We adhere to the precedent that this Court's review is limited. The rationale for vesting discretion in the trial court was aptly expressed in *Lucht v. Youngblood*, 266 S.C. 127, 138, 221 S.E.2d 854, 860 (1976) (stating that after a trial judge heard all of the testimony and the evidence and was more familiar than the appellate court with the evidentiary atmosphere at trial, he said "we think, a better informed view than we have; this is particularly true when the elements of damage are intangibles and the appraisal depends somewhat on an observation of the [witnesses] and evaluation of their testimony." *Gamble* at 355, 112).

IV. South Carolina Unfair Trade Practices Act (Issue 13 above)

"SCUTPA prohibits "[u]nfair methods of competition and unfair or deceptive acts or practices in the conduct of any trade or commerce." *S.C. Code Ann.* § 39–5–20(a). To state a SCUTPA claim, the plaintiff must allege "(1) that the defendant engaged in an unlawful trade practice, (2) that the plaintiff suffered actual, ascertainable damages as a result of the defendant's use of the unlawful trade practice, and (3) that the unlawful trade practice engaged in by the defendant had an adverse impact on the public interest." *Havird Oil Co. v. Marathon Oil Co.*, 149 F.3d 283, 291 (4th Cir. 1998). *Big Red Box, LLC v. Square, Inc.*, CV 3:18-758-SAL-SVH, 2020 WL 465928, at 14 (D.S.C. Jan. 22, 2020).

"Under South Carolina law, unfair or deceptive acts have an adverse impact upon the [public] if those acts have the potential for repetition." *Bessinger v. Food Lion, Inc.*, 305 F.Supp.2d 574, 581 (D.S.C. 2003). Potential for repetition can be demonstrated by either "showing the same kind of actions occurred in the past, thus making it likely they will continue to occur absent deterrence" or "showing the company's procedures created a potential for repetition of the unfair and deceptive acts." *Singleton v. Stokes Motors, Inc.*, 595 S.E.2d 461, 466 (S.C. 2004).

"[T]he plaintiff in a SCUTPA action is required only to allege and prove those facts sufficient to demonstrate potential for repetition; at that point, [the] plaintiff has proven an adverse effect on the public interest sufficient to recover under the SCUTPA." *Liberty Mut. Ins. Co. v. Emp. Res. Mgmt., Inc.*, 176 F.Supp.2d 510, 516 (D.S.C. 2001). "However, conduct that affects only the parties to the transaction and not the public interest provides no basis for a SCUTPA claim." *Bessinger*, 305 F.Supp.2d at 581. *Big Red Box, LLC* at *15 (D.S.C. Jan. 22, 2020).

The holding in *Taylor v. Medenica* 324 S.C. 200, 479 S.E.2d 35 (1996) is illustrative of the broad application of the SCUTPA to businesses:

> "The UTPA declares unlawful "[a]ny unfair methods of competition and unfair or deceptive acts or practices within the conduct of any trade or commerce." S.C.Code Ann. § 39–5–20(a). "Trade and commerce" are defined as the "sale or distribution of any services." S.C. Code Ann. § 39–5–10(b)." The provision of any service constitutes commerce within the meaning of the UTPA. The statute does not exclude professional services from its definition. Accordingly, even if medical laboratory services are considered professional services, they still constitute a trade within the meaning of the UTPA." *Id.* 217, 44.

The case of *Wright v. PRG Real Estate Management Inc.* 775 S.E.2d 399 (S.C. App. 2015), rev'd, 826 S.E.2d 285 (S.C. 2019)[2] holding that the SCUTPA is not applicable to a landlord is distinguishable. The Court of Appeals held:

> Wright argues Wellspring's property manager made deceptive statements to her when she filled out her rental application. Specifically, she contends the manager told her Wellspring was a "safe and secure place" and that courtesy officers patrolled the premises. The circuit court found Wright failed to prove these statements constituted unfair or deceptive acts. We agree. The *generalized statements* that the apartments are safe and secure and are patrolled by courtesy officers—on the facts of this case—simply cannot be unfair or deceptive acts under subsection 39–5–20(a). See *Johnson v. Collins Entm't Co.*, 349 S.C. 613, 636, 564 S.E.2d 653, 665 (2002) ("An act is 'unfair' when it is offensive to public policy or when it is immoral, unethical, or oppressive; a practice is 'deceptive' when it has a tendency to deceive." (citation omitted)); *deBondt v. Carlton Motorcars, Inc.*, 342 S.C. 254, 269, 536 S.E.2d 399, 407 (Ct.App.2000) (stating "[a]n unfair trade practice has been defined as a practice which is offensive to public policy or which is immoral, unethical, or oppressive" and "[a] deceptive practice is one which has a tendency to deceive"). We affirm the award of summary judgment.

Wright at 399, 406–407.

V. Spoliation of Evidence (Issue 14-15 above)

[2] The Supreme Court reversed the Court of Appeals decision on the single issue that the Court of Appeals erred failing to apply Section 323 of the *Restatement of Torts* 2d.

The Supreme Court of South Carolina upheld a jury charge in *Kershaw County Board of Education v. U.S. Gypsum Co.* that "when evidence is lost or destroyed by a party an inference may be drawn by the jury that the evidence which was lost or destroyed by that party would have been adverse to that party." *Pringle v. SLR, Inc. of Summerton,* 675 S.E.2d 783, 787 (S.C. App. 2009). "As an initial matter, however, the party seeking the inference "must be prepared to make a showing that the document or evidence might reasonably have supported whatever presumption is being requested of the fact finder." *Id.*, quoting Kevin Eberle, *Spoliation in South Carolina*, 19-SEP S.C. Law., Sept. 2007, 26, 32.

VI. A listing of exhibits, indicating those to which there is disagreement and a listing of witnesses who may be called and, if available, their address and phone number.

Records to be admitted:

1. Lease	
2. Sandpiper's Records pre fall	(produced in discovery)
3. Sandpiper's Record regarding the fall	(produced in discovery)
4. Photographs of Plaintiff	(produced in discovery)
5. Plaintiffs financial records	(produced in discovery)
6. Plaintiffs records of daily activities	(produced in discovery)
7. Medical records Roper Hospital June 2014 admission	(produced in discovery)
8. Medical Bills	(produced in discovery)
9. Medical records Sandpiper Rehab	(produced in discovery)
10. Medical records Roper October 2014 admission	(produced in discovery)
11. Medical records assisted living	(produced in discovery)
12. Medical records nursing home	(produced in discovery)
13. Medical records hospice	(produced in discovery)
14. Richard Mills, M.D. (treating physician)	(produced in discovery)
15. Death Certificate	(produced in discovery)

Witnesses:

1. Joan Acosta	(Plaintiff's Personal Representative)
2. Corrine Carrington	(Former Director of Sandpiper)
3. Beth Auld	(current employee of Sandpiper)
4. Rebecca Munoz	(current employee of Sandpiper)
5. Sandpiper's 30(b)(6) designee	(current employee of Sandpiper)
6. Richard Mills, M.D.	(Plaintiff's expert, treating physician)

7. Lila Waters (video for use at trial)
8. Larry Bergmann, Ph.D., LPC (Plaintiff's expert) (video for use at trial)
9. Sally Damm, NHA (Plaintiff's Expert)
10. Potential Deposition excerpts that may be presented during Plaintiff's case in chief:
    1. Brian J. Lancenese, MBA, NHA (Defendant's expert)
    2. Beth Auld (Defendant's staff)
    3. Rebecca Munoz (Defendant's staff)
    4. Sandpiper's 30(b)(6) designee
    5. Scott Davis, M.D. (Defendant's expert)
    6. Jeffery Wagner, Ph.D. (Defendant's expert)

VII. Any unusual problems relating to evidence to be introduced, such as "Business Records as Evidence Act," hearsay, use of depositions, etc.

1. The Plaintiff and Defendant agreed to compromise on the issue of mandatory arbitration. The parties agreed that rather than litigate the issue of arbitration, the parties would agree to this matter being heard by a Circuit Court Judge non-jury. The decision of the Circuit Court would be binding, with the right for either party to appeal the judgement to the appellate courts of this state.

2. Sandpiper's spoliation of critical records regarding the wellbeing of Ms. Parrott would support the application of the negative inference law to Sandpiper's position that Ms. Parrott was seen on June 5, 2014.

3. Plaintiff may use certain depositions and discovery responses from Defendant in her case in chief.

4. Plaintiff plans to call four witnesses that work for or are identified with Defendant Sandpiper. Plaintiff seeks to use leading questions as allowed by SCRE 611.

5. Plaintiff and Defendant have agreed to waive any objections regarding the authentication of any medical records that have been exchanged in discovery.

6. If this Court considers awarding punitive damages, Plaintiff has requested Defendant produce financial information to show the net worth of Sandpiper. An agreement has been reached that Defendant will provide the net worth for Sandpiper upon commencement of the trial.

7. There may be issues with hearsay under SCRE 802, 803, 804, and 805.

VIII. Any unusual question or matter which should be brought to the attention of the court.

None anticipated.

IX. A statement that settlement negotiations were attempted before the date of the pre-trial hearing and the status of settlement negotiations.

Settlement negotiations were attempted but were unsuccessful.

Respectfully Submitted:

REEVES & LYLE, LLC

s/Paul L. Reeves
Paul L. Reeves (SC Bar #4671)
John G. Boswell (SC Bar #778)
PO Box 11126
Columbia, South Carolina 29211
Office: 803-929-0001
Facsimile: 803-929-0927
paul@reevesandlyle.com
john.boswell.us@gmail.com
Attorneys for Plaintiff

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STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	NINTH JUDICIAL CIRCUIT
COUNTY OF CHARLESTON	)	CASE NO. 2016-CP-10-5379
THE ESTATE OF DELILA PARROTT,	)	
	)	**DEFENDANT'S POST-TRIAL/JUDGMENT**
Plaintiff,	)	**MOTION FOR RELIEF PURSUANT TO**
	)	**RULES 52 AND/OR 59, SCRCP, AND/OR,**
vs.	)	**TO THE EXTENT APPLICABLE,**
	)	**RULES 41 AND/OR 50, SCRCP**
SANDPIPER INDEPENDENT AND	)	
ASSISTED LIVING-DELAWARE, LLC,	)	***Hearing Requested***
	)	
Defendant.	)	
	)	

TO: THE HONORABLE BENTLEY D. PRICE, Presiding Circuit Judge, and PAUL L. REEVES, ESQUIRE, TODD R. LYLE, ESQUIRE, and JOHN G. BOSWELL, ESQUIRE, Attorneys for Plaintiff

NOW COMES Defendant, Sandpiper Independent and Assisted Living-Delaware, LLC, by and through its undersigned counsel, pursuant to Rules 52 and/or 59, SCRCP, and/or, to the extent applicable, Rules 41 and 50, SCRCP, within ten days after receiving written notice of entry of the order (the "Subject Order") and corresponding judgment (the "Judgment") disposing of this case,[1] and, on the following grounds, hereby moves this Honorable Court (1) to amend its findings, and/or make additional findings, and amend the Subject Order, and in turn the Judgment, to favor Defendant;[2] (2) to reconsider and/or otherwise alter and/or amend the Subject Order, and in turn

[1] The Subject Order refers to the order setting forth the Court's findings of fact and conclusions of law. The Judgment refers to the corresponding $1,000,000.00 judgment in favor of Plaintiff, The Estate of Delila Parrott ("Plaintiff") ("Ms. Parrott" refers to the decedent herself). Both the Subject Order and the Judgment were filed on October 16, 2020. Defendant received written notice of their entry that same day, via the E-Filing System.

[2] *See* Rule 52(b) ("Upon motion of a party made not later than 10 days after receipt of written notice of entry of judgment the court may amend its findings or make additional findings and may amend the judgment accordingly, and the motion may be made with a timely motion for a new trial."); Rule 59(b) ("In non-jury actions the motion [for a new trial] shall be made not later than 10 days after the receipt of written notice of the entry of judgment or of the filing of an order disposing of the action, if no judgment has been entered."); Rule 59(e) ("A motion to alter or amend the judgment shall be served not later than 10 days after receipt of written notice of the

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the Judgment, to favor Defendant; or, alternatively, (3) to grant Defendant a new trial or, as a lesser alternative, to open the record, take additional testimony and/or receive additional evidence, amend its findings of fact and conclusions of law or make new findings and conclusions, and enter a new order directing judgment in favor of Defendants or, as a lesser alternative, to grant Defendants a new trial nisi remittitur[3]:

1. **Most respectfully, Defendant asks the Court to (re)consider and expressly rule on each and every distinct issue/argument Defendant raised at trial, each of which is hereby repeated, reasserted, and incorporated herein by reference, to include especially, but without limitation: (a) Defendant's motion for involuntary dismissal/judgment as a matter of law, both solely as to Plaintiff's wrongful death claim and as to the entirety of Plaintiff's case, which motion Defendant hereby renews; (b) Defendant's defense based on the terms of Ms. Parrott's lease; (c) Defendant's comparative negligence defense, both as a means of reducing the amount of Plaintiff's recovery against Defendant and as a means of barring Plaintiff from any recovery against Defendant at all; and (d) Defendant's arguments on all evidentiary issues on which the Court ruled against Defendant.**

"[I]t is proper to view a Rule 59(e) motion not only as a vehicle to request the trial court 'alter or amend the judgment,' but also as a vehicle to seek 'reconsideration' of issues and arguments." *Elam v. S.C. Dep't of Transp.*, 361 S.C. 9, 21, 602 S.E.2d 772, 778 (2004). "[O]ur rules contemplate two basic situations in which a party should consider filing a Rule 59(e) motion. A party *may* wish to file such a motion when she believes the court has misunderstood, failed to fully consider, or perhaps failed to rule on an argument or issue, and the party wishes for the court

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entry of the order."); *see also* Rule 41(b) (regarding a motion by the defendant for a dismissal, operating as an adjudication on the merits, on the ground that, under the facts and the law, the plaintiff has shown no right to relief); Rule 50(a), (b), and (e) (regarding motions during trial for a directed verdict and, thereafter, for JNOV, i.e., motions for judgment as a matter of law).

[3] *See* Rule 59(a) ("A new trial may be granted to all or any of the parties and on all or part of the issues . . . in an action tried without a jury, for any of the reasons for which rehearings have heretofore been granted in the courts of the State. On a motion for a new trial in an action tried without a jury, the court may open the judgment if one has been entered, take additional testimony, amend findings of fact and conclusions of law or make new findings and conclusions, and direct the entry of a new judgment.").

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to reconsider or rule on it. A party *must* file such a motion when an issue or argument has been raised, but not ruled on, in order to preserve it for appellate review." *Id.* at 24, 602 S.E.2d at 780 (emphasis in original). Most respectfully, Defendant asks the Court to (re)consider and expressly rule on each and every distinct issue/argument Defendant raised at trial, each of which is hereby repeated, reasserted, and incorporated herein by reference, to include especially, but without limitation: (a) Defendant's motion for involuntary dismissal/judgment as a matter of law, both solely as to Plaintiff's wrongful death claim and as to the entirety of Plaintiff's case, which motion Defendant hereby renews; (b) Defendant's defense based on the terms of Ms. Parrott's lease; (c) Defendant's comparative negligence defense, both as a means of reducing the amount of Plaintiff's recovery against Defendant and as a means of barring Plaintiff from any recovery against Defendant at all; and (d) Defendant's arguments on all evidentiary issues on which the Court ruled against Defendant.

2. In numerous respects, the Court's findings of fact and conclusions of law are materially incomplete, unsupported by the evidentiary record, and/or erroneous as a matter of law.[4]

(a) The Court erred in finding that the so-called "wellness" check policy created a legal duty of care owed by Defendant to Ms. Parrott.

(i) The Court erred in failing to recognize that the legal relationship between Defendant and Ms. Parrott was simply that of landlord and tenant and governed by the SCRLTA and the terms of Ms. Parrott's lease.

"[V]erdicts may not be permitted to rest upon surmise, conjecture, or speculation." *The Huffines Co., LLC v. Lockhart*, 365 S.C. 178, 188, 617 S.E.2d 125, 130 (Ct. App. 2005). The undisputed evidence shows that Sandpiper Village is not an assisted-living facility, a long-term-

[4] To be clear, the points raised herein (under No. 2) are subject to and without waiving or otherwise taking anything away from the all-encompassing scope of the above request (in No. 1).

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care facility, or any other type of regulated entity (collectively, an "Assisted-Living Facility"), but rather that it is an *independent*-living community, where Ms. Parrott lived *independently* in her own private apartment pursuant to a written lease with Defendant. The legal relationship between Defendant and Ms. Parrott was simply that of landlord and tenant, and it was governed by the South Carolina Residential Landlord and Tenant Act, S.C. Code Ann. § 27-40-10 to -940 (the "SCRLTA"), and the terms of Ms. Parrott's lease.

(ii) The daily check service Defendant provided as a courtesy to residents is still a *courtesy* service notwithstanding Defendant's internal policy to provide the service.

Neither the SCRLTA nor the lease conferred on Ms. Parrott any right to, or imposed on Defendant any responsibility to perform, a daily check. Plaintiff's theory of liability against Defendant (negligence[5]), which the Subject Order relies on, is entirely—and erroneously—based on the daily check system somehow giving rise to a legal duty of care owed by Defendant to Ms. Parrott, even in the absence of any claim (or evidence to support such a claim) of a violation by Defendant of the SCRLTA or the terms of Ms. Parrott's lease.

A person signing a contract, such as Ms. Parrott when she signed her lease, is "presumed to have read, understood, and assented to [the contract's] terms." *Gibson v. Epting*, 426 S.C. 346, 352, 827 S.E.2d 178, 181 (Ct. App. 2019). The undisputed evidence is that Ms. Parrott wanted, and contracted with Defendant for, *independent* living. The lease terms make plain and clear all parties' understanding and agreement that Sandpiper Village is *not* an Assisted-Living Facility and that Defendant only offered an enumerated list of specified services, which included social

[5] Negligence is Plaintiff's only cause of action against Defendant. As the Subject Order notes, Plaintiff had asserted a cause of against Defendant for violation of the South Carolina Unfair Trade Practices Act but dropped it at trial. (Subject Order p. 1 n.11; *see also id.* at p. 10 (setting forth the elements of a negligence cause of action—and only a negligence cause of action—at the outset of the Court's "Conclusions of Law").)

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opportunities, dining services, housekeeping and laundry service, and other such conveniences to its residents. Because she, like most residents of Sandpiper Village, was choosing to live independently at an advanced age (she was 79 when signed her lease), Ms. Parrott expressly agreed in the lease to assume the risk of, and be responsible for, her day-to-day life decisions—such as her unfortunate decision to place herself, alone and without her emergency call button, in the particularly precarious position she was in (*standing* on a *rocking* chair hanging curtains) when she fell. In fact, the lease expressly provided that Ms. Parrott assumed all risk and waived all liability associated with her "*freedom to make personal health and non-health related decisions, the freedom to travel, to come and go as you please, [and] the decisions that effect and control your day-to-day activities.*" Erroneously, the Subject Order does not acknowledge, much less analyze, the lease and its effect on Plaintiff's claims, which effect, Defendant maintains, is indeed to wholly undermine those claims.

The Subject Order erroneously uses the mere existence of Defendant's internal policy of conducting daily checks as a courtesy to residents to transmute what was in fact a *courtesy* service—which Defendant had no obligation to provide or continue to provide and about which Ms. Parrott had no legal right to complain should Defendant not provide it or continue to provide it—into a legal duty of care, even though Defendant's supposed assumption of such a duty is not only unsupported by any consideration but also is in direct contravention of the terms of the parties' contract (i.e., the lease), which terms Ms. Parrott is presumed to have read, understood, and assented to.

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(iii) The Court erred in finding that the daily check system was a "wellness" check, i.e., that the purpose of the check was to protect Ms. Parrott from the kind of harm Plaintiff complains about in this case, or that Defendant assumed any such duty, and indeed, Plaintiff did not in any way dispute the testimony of Defendant's duly qualified expert about the relevant industry standard.

The Court's characterization of the daily check systems as a "wellness" check, or of Defendant as having assumed any duty to protect Ms. Parrott from the kind of harm Plaintiff complaints about in this case, is not supported by the evidence. *Huffines*, 365 S.C. at 188, 617 S.E.2d at 130 ("[V]erdicts may not be permitted to rest upon surmise, conjecture, or speculation."). Rather, Defendant's duly qualified expert Brian Lancenese testified that the industry standard for responding to falls ~~was~~ is the panic button or emergency call button system and that a daily check system ~~was~~ is not used in the industry to respond to falls or otherwise check on the well-being of residents, explaining that, as the undisputed facts of this case well illustrate, a daily check system allows for a person to lay on the floor for some 24 hours after a fall. And Plaintiff did nothing to undermine Defendant's expert's testimony in this regard.

(iv) The Subject Order conflates the threshold question of the existence of a legal duty of care with the question of whether such a duty (once found to exist) was or was not breached, viewing the very existence of the so-called "wellness" check policy as establishing the existence of a duty of care on the part of Defendant.[6]

As recognized in the Subject Order, the elements of a negligence cause of action are, of course, (1) duty, (2) breach, (3) causation, and (4) damages. (Subject Order p. 10.) The Subject

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[6] (*Compare* Subject Order p. 11 ("Here, the preponderance of the evidence presented in this case is more than sufficient to convince me and support my conclusion that that Defendant Sandpiper *had a policy* of providing daily wellness checks and that *this policy created a duty* to follow the protocol established in its own policy.") (emphasis added) *with id.* ("In determining the *standard of care*, the court may look to the common law, statutes, administrative regulations, industry standards, or a defendant's own *policies* and guidelines.") (emphasis added).)

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Order, however, fails to recognize that the question of whether a legal duty of care exists is a *separate* question from the questions of what standard of care is required to meet the duty and whether the applicable standard was met.

The first element of a negligence claim (duty) asks *the fundamental* question: Does a legal duty of care exist? If the answer is no, everything else is, of course, moot. It is only if the answer is yes that the second element (breach) even need be considered.

The breach element encompasses two questions: (a) Given that the first element of the claim (the existence of a legal duty of care owed by the defendant to the plaintiff) is met, what standard of conduct must the defendant meet to satisfy the duty of care owed? In other words, what is the *standard of care*? And (b) did the defendant meet the standard of care?

As the Subject Order recognizes, "an affirmative legal duty to act may be created 'by statute, contract, relationship, status, property interest, or some other special circumstance.'" (Subject Order p. 11 (citing *Carson v. Adgar*, 326 S.C. 212, 217, 486 S.E.2d 3, 5 (1997)). Notice, however, that the defendant's internal policies/procedures are not referenced here as a means for creating a duty to act. While it is true, as the Subject Order states, that in determining *the standard of care*, a court may look to the defendant's own *policies*,[7] this, however, does not mean that a court can look to the defendant's policies to answer the *threshold* question of *whether a legal duty of care exists* in the first place.

Again, the undisputed evidence shows that Sandpiper Village is not an Assisted-Living Facility, but rather it is an *independent*-living community, where Ms. Parrott lived *independently* in her own private apartment pursuant to a written lease with Defendant. Indeed, Ms. Parrott's lease expressly states what services Defendant will be provide, and the so-called "wellness" check

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[7] (Subject Order p. 11.)

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is not among them. Moreover, the lease includes express provisions limiting Defendant's liability and making clear Ms. Parrott's assumption of risk associated with her decision to live independently.

There is no statute, contract, relationship, status, property interest, or other special circumstance that gives rise to the existence of a legal duty of care owed by Defendant to Ms. Parrott, and where the Subject Order finds the creation of a legal duty based, in whole or in part, on a supposed special relationship between Defendant and Ms. Parrott[8] it is erroneous.

Again, the undisputed evidence is that the terms of Ms. Parrott's lease with Defendant conferred upon her no right to have Defendant check-in on her and imposed no duty upon Defendant to do so. Citing *Miller v. City of Camden*, 329 S.C. 310, 314, 494 S.E.2d 813, 815 (1997), the Court correctly recognizes that "the common law ordinarily imposes no duty on a person to act;" however, the Court erroneously relies on the exception to this rule that provides, "once an act is undertaken, the actor assumes the duty to use due care,"[9] without explaining what "act" Defendant is supposed to have undertaken so as to assume a duty of care to Ms. Parrott—and indeed the record here discloses no act (or acts) capable of properly supporting the Court's invocation of the aforementioned exception.

In addressing the rule that "the common law ordinarily imposes no duty on a person to act," in *Degenhart v. Knights of Columbus*, 309 S.C. 114, 116, 420 S.E.2d 495, 496 (1992), our Supreme Court explained, "a person usually incurs no liability when he fails to take steps to protect others *from harm not created by his own wrongful conduct.*" (emphasis added). The theory of

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[8] (*See* Subject Order p. 11 ("Both the existence of the policy and *the special relationship between Sandpiper and the resident, Ms. Parrott*, created a duty owed by Sandpiper to follow its own policy.") (emphasis added).)

[9] (*See* Subject Order p. 11.)

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Plaintiff's case is not in fact that Defendant "created" any harm "by [its] own conduct." Rather, it is that, after Ms. Parrott created harm to herself by her own conduct, i.e., after Ms. Parrott, through no fault of Defendant's whatsoever, had willfully placed herself, alone and without access to any means of communicating with the outside world (to include, most notably, without her emergency call button), in the undeniably awkward and dangerous position from which she fell (*standing* on a *rocking* chair), Defendant did not discover her soon enough.

By its very nature, Plaintiff's theory concedes that Defendant had nothing at all to do with, and cannot be blamed for, Ms. Parrott falling and hurting herself, or Ms. Parrott not being able to use her emergency call button, or even Ms. Parrott's pain and suffering (including any future consequences thereof) for approximately the first *24 hours* after the fall. In other words, her theory concedes that Defendant did not in fact cause Ms. Parrott to suffer a "long lie." As the evidence shows, and as expressly stated in Plaintiff's pre-trial brief, "The event of an elderly person lying on the floor with the inability to get up for *any time over one hour* is referred to as a long lie." (Pl.'s Pre-Trial Brief p. 4 n.1 (emphasis added).) Plaintiff's theory of the case necessarily concedes that it was not until Ms. Parrott had already suffered a "long lie" *plus approximately 23 hours* that Plaintiff even attempts to point any finger of blame at Defendant. And even then, the most that Plaintiff can say is not that Defendant "created" any harm to Ms. Parrott but that, had Defendant done something it was indeed under no legal obligation to do, i.e., the so-called "wellness" check, the harm Ms. Parrott created for herself would have been discovered "sooner," i.e., after "only" about 24 hours.

The idea underlying the rule that a voluntarily actor must act with due care is that the voluntarily actor must not make things worse than they would have been *had the voluntary actor not acted at all*. *See* 57A Am. Jur. 2d *Negligence* § 104 ("One who undertakes to act, even though

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gratuitously, is required to act carefully and with the exercise of due care and will be liable for injuries proximately caused by the failure to use such care. Thus, once a person steps into the role of caregiver, *such that others are discouraged or precluded from filling that rule*, that person has a duty to act reasonably in fulfilling the adopted role.") (emphasis added). There is no evidence that Defendant's so-called "wellness" check policy discouraged or precluded anyone from providing aid to Ms. Parrott or otherwise increased the risk of harm to Ms. Parrott.

Though there is some evidence that Ms. Parrott found the check-in policy appealing in deciding to live at Sandpiper Village, there is not enough evidence to support a reasonable, non-speculative[10] inference that this had any particular causal relationship to the incident at issue here. There is no evidence that Ms. Parrott would not have chosen to live at Sandpiper Village in the absence of the so-called "wellness" check policy. As stated in Plaintiff's pre-trial brief, "*One of* the facts that led Parrott and Acosta to choose Sandpiper was Sandpiper's representations that it had a policy . . . of visually accounting for each of the residents daily." (Pl.'s Pre-Trial Brief p. 1 (emphasis added).) There is no evidence of any other living arrangements that Ms. Parrott considered or of whether any of them offered a daily check-in. There is no evidence that anyone else was discouraged or otherwise precluded or hindered from protecting Ms. Parrott or coming to Ms. Parrott's aid because of the so-called "wellness" check policy. Moreover, Ms. Parrott could not possibly be found to have reasonably relied on the existence of a check-in policy that Defendant was under no obligation to provide to her, and this is all the more so given express terms of her lease, which, again, she is presumed to have read, understood, and assented to. *See Gibson*, 426 S.C. at 352, 827 S.E.2d at 181 (A person signing a contract is "presumed to have read, understood,

[10] *Huffines*, 365 S.C. at 88, 617 S.E.2d at 130 ("[V]erdicts may not be permitted to rest upon surmise, conjecture, or speculation.").

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and assented to its terms."). Indeed, the lease itself expressly states, "Once signed by all Parties, this Agreement becomes an enforceable contract. Therefore, if anything in this Agreement is confusing or different from what has been previously explained, you are encouraged to ask for a written explanation and to seek legal counsel before signing." And, to be clear, there is no claim here that the terms of Ms. Parrott's lease were unconscionable or otherwise unenforceable—nor, again, is there is any claim that Defendant actually breached any term of the lease or obligation imposed by the SCRLTA.

Most respectfully, the Court erred in finding that the so-called "wellness" check policy created a legal duty. Defendant was indeed under no duty to do it in the first place. The Court erred in finding that the daily courtesy check system was a "wellness" check for the purpose of protecting Ms. Parrott from the kind of harm Plaintiff complains about in this case, or that Defendant assumed any such duty. There is simply no evidence reasonably supporting such a finding. Likewise, the Court's use of the mere existence of the so-called "wellness" check policy to support the existence of legal duty of care is erroneous.

(b) The Court fails to recognize that Defendant did not cause the "long lie," and its damages awards (for both survival and wrongful death) are wholly undue and speculative or, alternatively, excessive.

"Negligence is not actionable unless it is a proximate cause of the injuries, and it may be deemed a proximate cause only when without such negligence the injury would not have occurred or could have been avoided." *Hughes v. Children's Clinic, P. A.*, 269 S.C. 389, 398, 237 S.E.2d 753, 757 (1977). "When one relies solely upon the opinion of medical experts to establish a causal connection between the alleged negligence and the injury, *the experts must, with reasonable certainty, state that in their professional opinion, the injuries complained of most probably resulted from the defendant's negligence*." *Ellis v. Oliver*, 323 S.C. 121, 125, 473 S.E.2d 793, 795

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(1996) (emphasis added); *see also id.* (When expert testimony is the only evidence of proximate cause relied upon, the testimony "must provide a significant causal link between the alleged negligence and the plaintiff's injuries, rather than a tenuous and hypothetical connection.").

Not only does Plaintiff concede that Defendant is not responsible for the fall itself, but because Plaintiff's theory rests solely on Defendant's alleged breach of a duty to conduct the so-called daily "wellness" check, Plaintiff also concedes that Defendant is not responsible for approximately the first 24 hours after the fall and any consequential damages arising out of the fall and the first approximately 24 hours thereafter. Accordingly, the only damages/injuries recoverable under Plaintiff's theory are those that can be proved (beyond speculation[11]) to have been suffered by Ms. Parrott, not because of the fall and the state she was in for the first approximately 24 hours thereafter, but because of what she went through from (approximately) hour 25 until she was found.

The Subject Order does not recognize the undeniable fact that Plaintiff's theory of the case necessarily concedes that it was not until Ms. Parrott had already suffered a "long lie" *plus approximately 23 hours* that Plaintiff even attempts to point any finger of blame at Defendant. And even then, the most that Plaintiff can say is not that Defendant "created" any harm to Ms. Parrott, but rather that, had Defendant done something it was indeed under no legal obligation to do, i.e., the so-called "wellness" check, the harm Ms. Parrott created for herself would have been discovered "sooner," i.e., after "only" about 24 hours. The Subject Order never explains or otherwise accounts for how the damages awarded were determined in a reasonable, non-speculative way that accounts for the fact that Defendant's alleged role in the harm Ms. Parrott suffered does not, even under Plaintiff's theory, begin until Ms. Parrott had suffered a comminuted

[11] *See Huffines*, 365 S.C. at 188, 617 S.E.2d at 130.

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hip fracture that left her on the floor of her apartment unable to move for at least approximately 24 hours. By failing to account for the foregoing, the Court's damages awards (for both survival and wrongful death) are wholly undue and speculative or, alternatively, excessive. This is especially so given the Court's view that, "[t]o the extent that Ms. Parrott had some degree of pre-existing mental health conditions, it was certainly foreseeable that those pre-existing conditions would be exacerbated by the pain and agony of from that long lie." (Subject Order p. 13.) While Defendant denies that there is sufficient evidence to support this assertion insofar as foreseeability is concerned, the potential for Ms. Parrott's pre-existing mental health conditions to be exacerbated by the long lie makes it all the more important for any proper award of damages against Defendants to be free of speculation, so that any such award is only for damages that would not have occurred not simply in the absence of the long lie but solely because of hour 25 of the long lie to the end—as, without question, all injuries/damages from the fall itself and the first 24 hours thereafter and all attendant future consequences therefrom, to include any/all ways in which all of the foregoing were exacerbated by Ms. Parrott's pre-existing mental health conditions, are not Defendant's fault and Defendant cannot be held liable therefor.

(c) There is no evidence to support the Court's ruling in Plaintiff's favor on wrongful death.

With respect to wrongful death in particular, Plaintiff's theory requires her to prove (by presenting medical expert testimony from which a reasonable, non-speculative conclusion can be reached, *see Hughes*, 269 S.C. at 398, 237 S.E.2d at 757; *Ellis*, 323 S.C. at 125, 473 S.E.2d at 795) that her death was most probably caused not just by "delay" in discovering her, but specifically by the delay from "hour 25" on. In other words, her experts needed to testify that, to a reasonable degree of medical certainty, had she only been lying there for approximately 24 hours after the fall, she most probably would have lived.

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Plaintiff's experts' testimony falls short of the "most probable"/reasonable degree of medical certainty standard that is required to substantiate a non-speculative causal relationship between the alleged negligence and Ms. Parrott's death. They could not quantify the significance of the length of Ms. Parrott's "long lie" and admitted they could not say at what point the hours (i.e. 9, 24, or 36) would have (supposedly) caused her death 8 months later.

Dr. Bergmann's testimony was presented via *de benne esse* deposition. In that deposition, he confirmed that, as to Ms. Parrott's death, the substance of the opinion he was expressing at trial was the same as he had expressed in his earlier discovery deposition, which was: "[Q]: Do you intend to provide the opinion at trial that [Ms. Parrott's] decline and demise would not have occurred but for some alleged delay in finding her? [A]: *I don't think there's anybody that can say that.*" (Bergman Trial Dep. p. 40:6–41:21 (emphasis added).) And Dr. Mills, too, failed to offer sufficient testimony to substantiate a claim for wrongful death.

At most, Plaintiff and Plaintiff's experts are arguing for some sort of ersatz form of recovery on the basis of loss of chance, which is a doctrine which our state has expressly rejected. *See Jones v. Owings*, 318 S.C. 72, 456 S.E.2d 371 (1995).

(d) Defendant was prejudiced by the Court's improper admission of evidence regarding Ms. Parrott's phone records.

The Court wrongfully admitted Ms. Parrott's phone records without necessary testimony as to what the records contained and wrongfully allowed a summary of the records prepared by Plaintiff's lawyers.

(e) The Court improperly speculated about the meaning of Ms. Parrott's phone records.

The Court used the absence of phone activity by Ms. Parrott between June 3–6, 2014, to support its conclusion that the fall happened on June 3rd and its rejection of Defendant's evidence

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that Ms. Parrott had been checked on June 5th. The Court never explains how the absence of Ms. Parrott's phone activity on the three days in question is different from her phone activity on other days.

(f) The Court's improper finding regarding Ms. Parrott's BUN levels.

Without supporting medical evidence, the Court also wrongfully found that the BUN levels found in Ms. Parrott rise and fall at the same rate.

(g) The Court's failure to address, much less rule in Defendant's favor on, comparative negligence.

The undisputed evidence is that Ms. Parrott *stood* on a *rocking* chair, while failing to wear her emergency/panic button and, for that matter, failing to take advantage of maintenance services set out in her lease. There is no reasonable view of the evidence under which Ms. Parrott is not guilty of comparative negligence. Defendant duly raised and supported a comparative defense and is entitled to a finding in its favor on the same. Indeed, because the only reasonable view of the evidence is that Ms. Parrott's comparative negligence exceeds 50%, Plaintiff should be barred from recovery, but at a minimum, Defendant is entitled to a reduction of any damages to which Plaintiff may be entitled based on Ms. Parrott's comparative fault.

(h) The Court never accounts for Defendant's rights under the lease.

As explained elsewhere, and without question, Ms. Parrott assumed all risk of living independently and waived of liability in lease. Defendant did not assume the duty to "make daily well checks" in the lease. There is a difference between the daily check and the "duty" to confirm well-being on a daily basis. The duty to protect Ms. Parrot's "wellbeing" is simply not in the lease; nor was there any consideration to support such a duty. Also, violation of a policy alone not enough so support a negligence finding, and a policy to see a resident daily does not equal a duty to conduct a "wellbeing check."

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(i) The Court relied on patently unreliable testimony from Lila Waters.

The Court relied on Ms. Watters's testimony despite its own finding, in the Subject Order, that she was confused. Ms. Watters's testimony was inconsistent and suffered from her own confusion and is not capable of supporting reasonable, non-speculative inferences on which to support a ruling in favor of Plaintiff.

(j) The Court was inconsistent and unduly selective in choosing to accept only the testimony from Joan Acosta that was helpful to Plaintiff's case.

On the one hand, the Court believed Ms. Acosta as to the so-called "wellness" check policy being in place; however, on the other hand, the Court simply disregarded her investigation findings and testimony that Ms. Parrott was checked off on June 5th; confirming the two occasions that Beth Auld saw Ms. Parrott on June 5th; and that Ms. Waters never came to her on June 5th or 6th asking for help and must have had her days confused.

(k) There is no evidence to support the Court's ruling that "[t]o the extent that Ms. Parrott had some degree of pre-existing mental health conditions, it was certainly foreseeable that those pre-existing conditions would be exacerbated by the pain and agony of from that long lie."

There is no evidence on which to base a reasonable, non-speculative conclusion to this effect.

(l) The Court confused and/or conflated/commingled and/or misapplied the relevant legal standards governing claims for survival and wrongful death.

Survival and wrongful death and separate claims with their own particular legal standards and under which particular damages are/are not recoverable. The Subject Order confuses and/or conflates/commingles and/or misapplies the relevant legal standards governing claims for survival and wrongful death.

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WHEREFORE, for the foregoing reasons (and, for that matter, for all of the reasons previously advanced to the Court in support of Defendant's position, whether in written or oral form, all of which Defendant now ask the Court to (re)consider and expressly rule on), Defendant asks the Court (1) to amend its findings, and/or make additional findings, and amend the Subject Order, and in turn the Judgment, to favor Defendant; (2) to reconsider and/or otherwise alter and/or amend the Subject Order, and in turn the Judgment, to favor Defendant; or, alternatively, (3) to grant Defendant a new trial or, as a lesser alternative, to open the record, take additional testimony and/or receive additional evidence, amend its findings of fact and conclusions of law or make new findings and conclusions, and enter a new order directing judgment in favor of Defendants or, as a lesser alternative, to grant Defendants a new trial nisi remittitur

PLEASE NOTE: Defendant reserves all rights to provide further support for this motion via such briefing, argument (to include oral argument), and/or additional submissions as the Court may permit or require.

Respectfully submitted,
YOUNG CLEMENT RIVERS, LLP

By: s/ D. Jay Davis, Jr.

D. Jay Davis, Jr.
Matthew O. Riddle
P.O. Box 993
Charleston, SC 29402
(843) 720-5406
jdavis@ycrlaw.com
mriddle@ycrlaw.com
Attorneys for Defendant

Charleston, South Carolina

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SPECIAL ARTICLE

PERSONS FOUND IN THEIR HOMES HELPLESS OR DEAD

R. JAN GURLEY, M.D., NANCY LUM, M.S., MERLE SANDE, M.D., BERNARD LO, M.D., AND MITCHELL H. KATZ, M.D.

Abstract *Background.* Health care providers and providers of emergency services are sometimes called to help with people who are found alone in their homes either helpless or dead. It is not known who is at risk for being found helpless or dead, what the mortality rates are among those found alive, or how frequently this situation occurs.

Methods. We conducted a population-based study of patients who were found in their homes either helpless or dead. Over 12 weeks, paramedics employed by the city of San Francisco identified 387 such events involving 367 persons. We obtained information on these patients from the emergency-medical-services department or the hospitals to which they were taken and determined their outcomes.

Results. The median age of the persons found helpless or dead was 73 years; 51 percent were women. The frequency of such incidents increased sharply with age, from a rate of 3 per 1000 per year among those 60 to 64 years of age to 27 per 1000 per year among those 85 years of age or older. The highest rate was among men 85 years and older who were living alone (123 per 1000 per year). In 23 percent of the cases, the person was found dead; an additional 5 percent died in the hospital. Thus, total mortality was 28 percent. Of the patients found alive, 62 percent were admitted to the hospital. The average hospital stay was eight days, and 52 percent of those admitted required intensive care. Of the survivors, 62 percent were unable to return to living independently. The total mortality was 67 percent for patients who were estimated to have been helpless for more than 72 hours, as compared with 12 percent for those who had been helpless for less than 1 hour.

Conclusions. For elderly people who live alone, becoming incapacitated and unable to get help is a common event, which usually marks the end of their ability to live independently. (N Engl J Med 1996;334:1710-6.)

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HEALTH care providers and emergency-medical-services personnel are sometimes called on to assist when elderly people are found in their homes in need of emergency attention and unable to summon help. In a typical case, a neighbor notices an elderly person's absence or the fact that mail has piled up and calls emergency services. The precipitating incident can be a fall, a stroke, failure to thrive, or some other event. The clinical course for persons found alive but incapacitated can be complicated by factors related to the duration of time since the person became helpless, such as severe dehydration or decubitus ulcers.[1] The prognosis for such elderly patients is thought to be poor. Because of the variety of possible causes of these events, some health care providers refer to patients found in these circumstances as "found down," with the amount of time that the patient is helpless referred to as "down time." In this article, we refer to such patients as found helpless or dead, and we refer to the down time as the time spent incapacitated.

It is unknown who is at risk for being found helpless or dead in the home, how often such events occur, and what the mortality rate is among patients found alive but helpless. We undertook a prospective, population-based study of this phenomenon in San Francisco. Our goals were to determine how often elderly people are found helpless or dead in their homes and to assess the demographic characteristics of such patients and the outcomes of those found alive but incapacitated.

From the Robert Wood Johnson Clinical Scholars Program, University of California, San Francisco (R.J.G., B.L.); the Department of Public Health, City and County of San Francisco (R.J.G., M.H.K.); the Joint Medical School Program, University of California, San Francisco and Berkeley (N.L.); and the Department of Medicine, San Francisco General Hospital, San Francisco (M.S.). Address reprint requests to Dr. Gurley at the Department of Public Health, AIDS Office, Suite 500, 25 Van Ness Ave., San Francisco, CA 94102.

Supported in part by a grant from the Walter and Evelyn Haas, Jr., Foundation. Dr. Gurley is a Robert Wood Johnson Clinical Scholar.

METHODS

During a 12-week period, from March through May 1993, paramedics employed by the city of San Francisco responded to 88 percent of all calls for emergency medical assistance (10,402 total calls). Persons encountered by paramedics in responding to these calls were included in this study if they lived alone and had been reported missing or were found helpless or dead in their homes. There were no other criteria for inclusion based on age, residence, or presentation. The case definition was designed to exclude people who were found helpless or dead outside their homes, who did not live alone, or whose illness did not warrant involvement of the emergency medical system. Persons who did not live alone were excluded under the assumption that those living with them would be able to provide them with assistance. Persons found dead were not excluded from our study if the other case criteria were met. Paramedics estimated the length of time the patient had been incapacitated, choosing from several categories ranging from less than 1 hour to more than 72 hours.

Data were abstracted from the records of the emergency medical system and from the hospital charts of patients transported to 13 hospitals. Information on medications taken by the patients before the emergency call was also obtained from the records of the emergency medical system and the hospitals. We also obtained diagnostic and procedural codes (from the *International Classification of Diseases, 9th revision* [ICD-9][2]) from hospital records. Death certificates were obtained for all persons who were found dead, and demographic information was recorded from these certificates, from hospital records, or from the paramedics' records (in descending order of priority).

Data on persons found dead were excluded from the analyses of outcomes and costs of care. Rates of incidence were calculated with the use of 1990 U.S. Census data for the population of San Francisco, both overall and according to age, race, and sex. The annual number of cases was determined, assuming a constant rate over time. Proportions were compared with two-tailed chi-square analyses. Rates were compared with an indirect method of standardization based on the 95 percent confidence intervals for Poisson distributions. An average community income was assigned to each patient on the basis of housing-tract data from the 1990 Census.

The outcomes we studied included survival, duration of hospitalization, and return to independent living. Patients who were evaluated by

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Table 1. Characteristics of Persons Found Helpless or Dead in Their Homes.

Characteristic	Found Alive (N = 297)	Found Dead (N = 90)
Race or ethnic group — no. (%)		
Non-Hispanic white	191 (64)	54 (60)
Black	38 (13)	19 (21)
Asian	27 (9)	9 (10)
Unknown	26 (9)	0
Hispanic	13 (4)	7 (8)
Other	1 (<1)	1 (1)
Native American	1 (<1)	0
Age — yr		
Median	75	65
Range	26–101	25–93
Female sex — no. (%)	170 (57)	29 (32)
Median community income — $	31,966	30,247
Estimated time spent incapacitated — no. (%)		
<1 hr	92 (31)	8 (9)
1 to <3 hr	47 (16)	5 (6)
3 to <6 hr	25 (8)	6 (7)
6 to <12 hr	22 (7)	15 (17)
12 to <24 hr	33 (11)	11 (12)
24 to <48 hr	14 (5)	6 (7)
48 to 72 hr	12 (4)	5 (6)
>72 hr	13 (4)	26 (29)
Unknown	39 (13)	8 (9)
Median time spent incapacitated — hr	2	18
Insurance — no. (%)		
Private	152 (51)	
Medicaid	72 (24)	
Medicare only	36 (12)	
None	11 (4)	
Unknown	26 (9)	
Reason for incapacitation — no. (%)		
Inability to get up or weakness	88 (30)	
Fall	67 (23)	
Shortness of breath or chest pain	21 (7)	
Altered mental status	18 (6)	
Found unresponsive	16 (5)	
Cerebrovascular accident	13 (4)	
Miscellaneous*	74 (25)	

*Includes overdose, suicide or attempted suicide, seizures, no identified problem, syncope, severe pain, diabetes with hypoglycemia, and previous assault. Each category included eight or fewer patients.

paramedics but not transported to a hospital or who were seen in emergency departments and discharged were assumed to have survived and continued living independently. Patients who were discharged to a nursing home, a family member's home, a rehabilitation facility, a board-and-care facility, or a skilled-nursing facility were considered discharged to "other care." Information on who contacted the paramedics was obtained from the records of the emergency medical system or the hospitals. In cases in which no family member was mentioned, the contact person was categorized as "not family." All patients 65 years of age or older were assumed to be covered by Medicare. Patients covered by both Medicare and private supplemental insurance were classified as having private insurance. We estimated costs by calculating 70 percent of 1993 charges for evaluation and transport by paramedics, number of days in the hospital, and number of days in the intensive care unit.

Results

Characteristics of the Patients

During a 12-week period, paramedics were called on to assist 367 persons found incapacitated or dead in their homes; these people accounted for 387 episodes of being found helpless or dead and 3.7 percent of all calls to the emergency-medical-services department (Table 1 and Fig. 1). The median age of the women (78 years) was significantly higher than that of the men (65 years). Women made up only 27 percent of the patients under 65, but 63 percent of those 65 years of age or older. A typical patient was an 82-year-old white woman who was found by a neighbor during a routine check. She was lying on the floor, soiled by dirt, feces, and urine, and had garbled speech. She was estimated to have been incapacitated for more than 72 hours. She was admitted with decubitus ulcers and dehydration. After 21 days, she was discharged to a skilled-nursing facility.

Clinical Presentation

The people found helpless had a variety of precipitating problems (Table 2). The most frequently cited precipitating causes of incapacitation among those who survived were weakness or inability to get up and falls. There was some variation according to age; weakness or inability to get up was the most frequent cause of incapacitation among patients 65 and older (n = 72). For example, one 78-year-old woman was found on her bed by the paramedics after a neighbor called for help. She stated that she had been unable to get up for two days. She denied falling. She appeared dehydrated, and her lips had cracked and bled. She spent nine days in the intensive care unit and was then discharged to a skilled-nursing facility.

There were no patients under 65 who had multiple falls or who fell and became lodged in place. Overdose (n = 7) and suicide attempts (n = 5) occurred only in the cases of patients less than 65 years of age. Contributing factors included gastrointestinal symptoms (n = 31; mean age, 62 years) and alcohol or drug use (n = 32; mean age, 51 years). Twenty patients (16 percent of those under 65; mean age, 43 years) were identified as having the acquired immunodeficiency syndrome (AIDS) as a contributing condition.

Ratings on the Glasgow coma scale were available for 295 of the 297 patients found alive (99 percent). For-

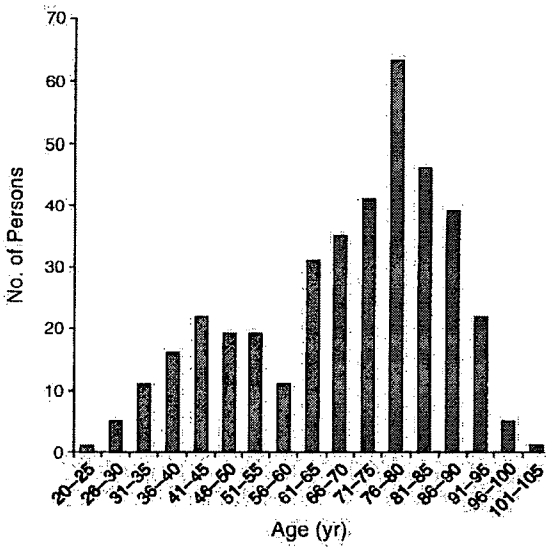


Figure 1. Distribution of Persons Found Helpless or Dead in Their Homes, According to Age.

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Table 2. Examples of Patients' Clinical Presentations and Chief Causes of Immobilization.*

Inability to get up or weakness

General weakness and confusion for 2 to 3 days; found on well-being check; questionable food and liquid intake for 2 days.

Patient could not get up from toilet, moved to the ground, and became wedged between toilet and bathtub for 9½ hours.

Person found dead

Family unable to contact patient for 24 hours; patient found extremely cold in heaps of garbage and feces at home.

Patient not seen in 10 days; found decomposed in bathroom by apartment manager. Blood covering bed with trail to bathroom where patient was lying.

Patient not seen for 3 to 4 days; younger brother found patient prone on floor by bed with questionable coffee-ground emesis, diarrhea, or blood.

Falls

Caretaker found patient supine on floor, complaining of occipital pain; left shoulder abrasion from fall.

Recurrent falls for 24 hours; fire department there earlier today; evidence of diarrhea in clothing, bedroom, bathroom.

Patient with a dislocated left hip causing fall; dislocation several times per year.

Shortness of breath or chest pain

Extreme respiratory distress; white frothy sputum from mouth; complaining of severe shortness of breath, nausea, and vomiting; extremely drowsy, unresponsive to verbal stimulation.

Altered mental status

Patient found on bedroom floor by manager; speech incomprehensible.

Home nurse found patient shivering and defecating while standing, possibly over- or undermedicated.

Psychiatric history; patient has been noncompliant with medications; sequestered in apartment; increased depression for 1 month after losing job; last seen by family several days ago; found supine.

Patient found sitting on floor, conscious, but no verbal response, not following simple commands, incontinent of urine, poor skin turgor.

Person found unresponsive

Patient with end-stage acquired immunodeficiency syndrome found unconscious in bed, incontinent of urine and feces.

Patient unconscious, unresponsive, clothes soaked in urine, supine on floor, dinner untouched on table.

Patient emaciated, dehydrated, found unconscious on toilet for unknown duration; ecchymoses on buttocks.

Cerebrovascular accident

Patient found by friend on living-room floor with right-sided weakness and aphasia.

Patient found supine on floor, nonverbal, left side flaccid; San Francisco Fire Department came to check smoke alarm (teakettle boiled dry).

Overdose

Patient found unconscious, unresponsive, dragged to cold shower before arrival of paramedics; found sitting on stairs, agitated; took heroin, codeine, alcohol.

Suicide attempt

Patient lacerated wrists and ankles; found unconscious in bathtub by friend.

Seizures

Two seizures this p.m., patient postictal, oriented to self only.

No identified problem

Patient with tender hips, ecchymoses on hands; pale, cool, dehydrated; found on floor.

Syncope

Patient found prone on floor with respiratory distress following syncope, scheduled for pacemaker tomorrow.

Severe pain

Patient unable to urinate or defecate for 5 days; burning pain in lower abdomen for 1 week.

Diabetic patient with hypoglycemia

Friend heard patient fall out of bed; patient with insulin-dependent diabetes mellitus, unable to speak but became alert and oriented after the administration of dextrose solution.

Previous assault

Assault yesterday; patient had facial trauma with massive bleeding, eyes open to voice.

*These examples have been condensed from the paramedics' records. The categories appear in descending order of frequency.

ty-four patients (15 percent) had moderately to severely depressed scores (1 through 16). Fifty-four patients (18 percent) had scores of 17 through 19, with 74 percent of this group exhibiting "confused verbal response." The remaining 197 patients (67 percent) had a normal score (20).

In the 387 cases in which persons were found incapacitated or dead in their homes, paramedics found 90 persons (23 percent) dead (Fig. 2). Patients who were found dead were significantly more likely than the patients found alive to be male (68 percent vs. 43 percent, $P<0.01$), younger (median age, 65 vs. 75 years; $P<0.01$), and black (21 percent vs. 13 percent, $P=0.08$). Before being found incapacitated, the patients were taking an average of 3 medications (range, 0 to 17); 21 percent (median age, 70 years) were taking sedative–hypnotic agents.

Insurance and Income

Information on insurance coverage was available for 91 percent of the patients found alive. Those under 65 were most commonly covered by Medicaid, which was the sole form of insurance for 27 percent, whereas persons 65 and older most commonly had private insurance (70 percent). Medicare was the sole form of insurance for only 16 percent of those 65 and older.

Community income varied according to race; the vast majority of whites lived in middle-to-high-income communities, the majority of blacks lived in low-income communities, and the majority of Asians lived in either the very-lowest-income or middle-income communities.

Who Called the Paramedics?

Only 11 percent ($n=42$) of the patients were found by family members. The most common category of contact person was "other" ($n=76$), which included visiting nurses, caretakers, housekeepers, and home health aides. In one typical case, a 95-year-old white man was found by his caretaker wedged between the toilet and the bathtub. The patient said that he had sat on the toilet at noon the day before and was unable to get up. He tried to move to the floor but mistakenly lowered himself between the toilet and the bathtub. He refused transportation to the hospital. The remaining categories of persons who contacted the emergency medical services were friends ($n=41$), neighbors ($n=36$), landlords ($n=3$), and unidentified persons ($n=169$).

Calls made to the paramedics by friends resulted in shorter lengths of time spent helpless than any other category (median, 4.5 hours), except for patients who were eventually able to call for help themselves (median, 2 hours). Calls by family members (9 hours), neighbors (9 hours), landlords (more than 72 hours), and

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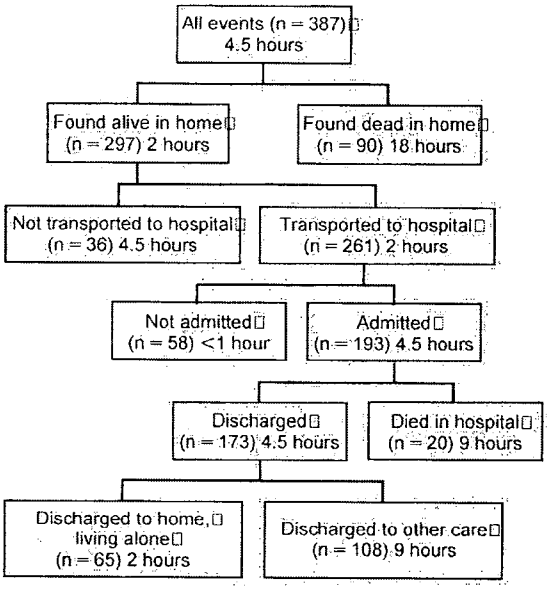


Figure 2. Outcomes of Persons Found Helpless or Dead in Their Homes.

For each group of patients, the median time spent incapacitated, as estimated by the paramedics, is indicated. Data on admission and hospital outcomes are shown for only 251 of the 261 persons transported to the hospital, since the records of 10 persons could not be found.

others (18 hours) were associated with much longer estimated times spent incapacitated.

Frequency of Incidents

The age-specific frequency of incidents of persons being found incapacitated or dead in the city of San Francisco reached a peak of 27 per 1000 persons per year among those 85 years of age or older (Fig. 3). Overall, the rates for men and women were similar. However, among blacks, the rate for men 85 and older was more than twice that for women (36 per 1000 vs. 16 per 1000, $P<0.05$). The rates among non-Hispanic whites and blacks were generally about twice those among Asians and Hispanics. The rates varied according to the average annual income in the community, with the highest rates (27 per 1000) among patients living in communities with incomes between $30,000 and $40,000.

We recalculated the frequency of incidents with the number of persons living alone as the denominator. The annual rate per 1000 persons living alone was 14.0. The annual rates for men and women living alone were 14.3 per 1000 and 13.6 per 1000, respectively. Annual rates were 10.1 per 1000 for Hispanics, 10.6 per 1000 for Asians, 11.6 per 1000 for non-Hispanic whites, and 22.3 per 1000 for blacks.

The annual rates among people 65 or older who lived alone were 31.6 per 1000 overall, 42.2 per 1000 for men, and 27.6 per 1000 for women. Rates continued to rise with age, even when adjusted for the number of people living alone (Fig. 4). The peak rate — among persons 85 years of age or older who were living alone — was 123 per 1000 for men and 59 per 1000 for women (P not significant).

Outcomes

Duration of Hospital Stay, Survival, and Return to Independent Living

In the 297 episodes in which patients were found alive, 261 patients (88 percent) were transported to the hospital (Fig. 2). When patients were not taken to the hospital, the most frequent reason was the patient's refusal (n=29). Seventy-four percent of the 261 patients transported to a hospital (n=193) were admitted. Those who were admitted were older than those not admitted (median age, 77 years vs. 67 years; $P<0.01$) and significantly more likely to be women (64 percent, $P<0.05$).

ICD-9 disease and procedure codes were available for 82 percent of the patients transported to a hospital and 97 percent of those admitted (Table 3). Patients frequently had altered mental status (39 percent of all transported patients); central nervous system imaging was performed in 69 patients. Many patients (25 percent) had acute injuries; 36 had fractures. Alcohol or drug abuse was diagnosed in 38 patients, sepsis or hypotension in 20, decubitus ulcers in 10, and aspiration pneumonia in 10. Dehydration occurred in 42 patients.

For patients admitted to hospitals, the average duration of stay was eight days. Intensive care was required for 52 percent (n=100), with an average stay in the intensive care unit of seven days. In-hospital mortality was 10 percent overall and 16 percent among those requiring intensive care.

Among those who survived until discharge, 62 percent did not return to independent living. Patients discharged to supportive care were significantly older (me-

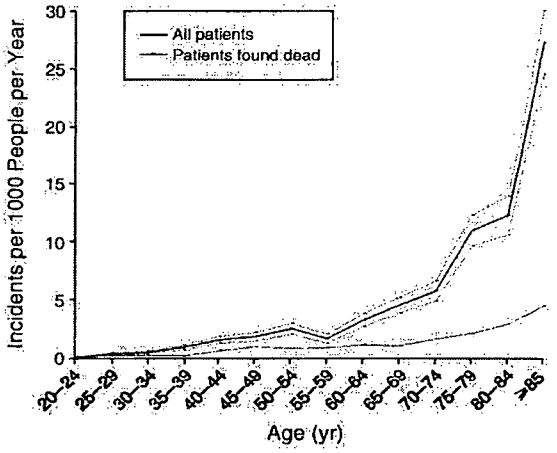


Figure 3. Frequency of Incidents According to Age.

This graph shows the rate at which persons were found helpless or dead in their homes (per 1000 population per year) according to age. The rate for those found dead is also shown. The dotted lines show the 95 percent confidence intervals for all patients.

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dian age, 79 years; $P<0.01$), were more likely to be female (64 percent, $P=0.07$), and were commonly discharged to institutions (77 percent to nursing homes or skilled-nursing or rehabilitation facilities, with only 4 percent discharged to live with family or friends). Of those who were hospitalized, two thirds either died or did not return to independent living.

Estimated Time Spent Incapacitated in Relation to Outcome

Longer times spent helpless, as estimated by the paramedics, were associated with the person's being found dead or being transported to the hospital, being admitted, and being discharged to other care rather than to independent living ($P<0.05$ for all these comparisons). Male sex was significantly associated with estimated times of more than 12 hours spent helpless ($P<0.05$), but age, race or ethnic group, and insurance status were not significantly associated with the length of time spent incapacitated.

The number of deaths, both in the home and in the hospital, varied according to the estimated time since the person had become incapacitated. Of the people for whom this time was estimated to be less than one hour, 10 percent were found dead and 2 percent died in the hospital, for a total mortality rate of 12 percent. Of this group, 11 percent were black, 58 percent were women, and the median age was 75 years. Of those estimated to have been immobilized for more than 72 hours, 62 percent were found dead and 5 percent died in the hospital, for a total mortality rate of 67 percent. Of this group, 28 percent were black, 36 percent were women, and the median age was 64 years.

Costs

The estimated average cost of care for each patient was $9,985.

Discussion

The number of people 85 years of age or older in the United States is expected to increase from 3.1 million in 1990 to 17.7 million by 2050.[3] Longer life spans, declining birth rates, the expanding role of women in the work force, and the breakdown of the extended family have all been cited as reasons for the increasing number of elderly people at risk for institutionalization.[4-7] Yet elderly people clearly prefer independent living to institutionalization.[8,9]

Elderly people who live alone may fear being unable to obtain help if they are injured or ill. For many families, the specter of such an event can dominate decisions about living arrangements. This fear has generated an industry marketing automatic alarm-and-notification systems. Health care professionals who counsel those who are concerned about being incapacitated or those who have survived such an event have little or no information on which to base recommendations.

Our results indicate that it is common for elderly people living alone to be found helpless or dead in their homes. Among men who were 85 or older and lived alone, there were an estimated 123 such incidents per 1000 persons per year in San Francisco in 1993. For comparison, the incidence of myocardial infarction among people 65 years of age or older is estimated to be between 1.7 per 1000 and 4.4 per 1000 persons per year,[10] and the incidence of hip fracture among 85-year-old white women is estimated to be 35 per 1000 per year.[11]

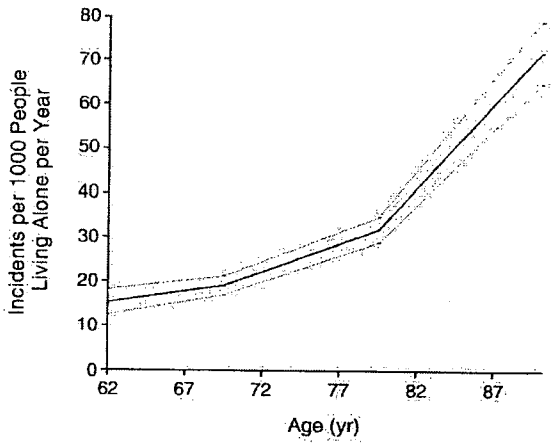


Figure 4. Frequency of Incidents among Elderly People Living Alone.

This graph shows the rate at which persons 62 years of age or older were found helpless or dead in their homes (per 1000 persons living alone per year) according to age. The dotted lines show the 95 percent confidence intervals.

The outcomes of such incidents are often poor. In 23 percent of the cases in which the paramedics were called on for aid, the patients were found dead, and an additional 5 percent died in the hospital, for a total mortality rate of 28 percent. Consideration also must be given to the suffering of those who are unable to get help for prolonged periods. Ten percent of the patients were estimated to have been unable to summon help for more than three days; 38 percent of them survived the experience. For those who survive, being found incapacitated and helpless usually leads to a loss of independence; the majority of those who are hospitalized do not return to independent living.

Although the incidence of such episodes is highest among very elderly men, members of all races and ethnic groups and all socioeconomic groups are susceptible to becoming incapacitated in their homes. The rate of such incidents increases dramatically with age. Most of the persons encountered by paramedics were elderly white women from fairly well-to-do communities, as indicated by a high community income and private health insurance coverage. Large differences among non-Hispanic whites, Asians, and Hispanics were eliminated when the rates were adjusted for the proportion of elderly people living alone. Elderly blacks, however, continued to have higher rates than the other racial and ethnic groups; black men were more likely than black women to be found helpless or dead by paramedics.

Our study identified a subgroup of patients found in-

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capacitated in their homes, who tended to be relatively young, male, poor, and black and who were frequently found dead. Drug overdoses, suicide, alcohol or drug abuse, and AIDS were contributing factors that predominantly affected people younger than 65.

In only a few cases was there any mention of family members in the records of the emergency medical system, a fact that suggests that patients found helpless or dead may be somewhat isolated socially. Neighbors and others were more likely to call the paramedics with requests for assistance than were friends and family.

Our study has several limitations. By design, we did not include patients who were found incapacitated or dead on the street or who lived with others. Our case definition was chosen to focus on people who were elderly and potentially isolated. Although the study was also designed to include all patients identified as meeting the inclusion criteria by paramedics employed by the city of San Francisco, the magnitude of the problem may have been underestimated because of patients who were seen by paramedics but not enrolled or who were transported to hospitals by private ambulances or by other means. Our assumptions about patients who were not admitted may have caused us to underestimate the mortality rate or the frequency of loss of independence associated with being found helpless in the home. We were unable to assess whether such incidents followed any seasonal pattern.

In this descriptive study, we assessed the magnitude of the phenomenon of patients being found helpless or dead in their homes, the demographic features of the patients found in this condition, and their outcomes. We did not attempt to determine relative risks or to generalize our results to groups other than those living in San Francisco. Therefore, some important questions that arise from our results cannot be reliably answered on the basis of our data. For example, we were unable to assess whether the patients who were found dead represented a distinctly different group from those found alive or, on the contrary, whether the two groups were similar but those found dead had been left a longer time without help. Our results indicate that the majority of persons who are not accounted for for more than three days are found dead. We were also unable to determine which deaths were preventable. Although some of the people in our study group may have died peacefully at home,

Table 3. Diagnoses of 261 Patients Transported to Hospitals, with Associated Procedures.*

Diagnosis	No. (%)†	Procedure	No.†
CNS events and alterations in consciousness	101 (39)	**CNS procedures**	107
Strokes, TIAs, syncope, seizures	71	CT or MRI	69
Paralysis, movement disorders, neuropathy	37	Lumbar puncture	13
Dementia, psychoses, delirium	22	EEG	9
CNS injuries, hemorrhage, infection	17		
Coma	5		
Cardiac disorders	96 (37)	**Cardiac procedures**	71
Dysrhythmias	42	Echocardiography	23
Heart failure	34	Cardiac catheterization	11
Acute MI and ischemic heart disease	26	PCWP monitoring	6
Infectious diseases	84 (32)		
Septicemia, shock	20		
HIV/AIDS	14		
Acute injury	64 (25)	**Orthopedic procedures**	65
Fractures	36	OR, femur or tibia–fibula	21
Wounds, abrasions, dislocations, sprains	30	Reduction of hip dislocation	4
		Fasciotomy	3
Electrolyte disorders	64 (25)		
Volume depletion	42		
Hypokalemia	21		
Acidosis	7		
Respiratory disorders	59 (23)	**Pulmonary procedures**	41
Pneumonia	25	Ventilation ≥96 hr	16
COPD	23	Ventilation <96 hr	9
Respiratory failure	13	Other oxygen supplementation	5
Urinary tract disorders	50 (19)	**Urinary procedures**	16
UTI	31	Renal dialysis	4
Renal failure	11	Renal ultrasonography	3
Joint, bone, and muscle disorders	47 (18)		
Arthritis, osteoporosis	35		
Hematologic disorders	43 (16)		
Alcohol or drug abuse	38 (15)		
Endocrine disorders	34 (13)		
Diabetes	25		
Gastrointestinal disorders	30 (11)	**Gastrointestinal procedures**	28
GI bleeding (not occult)	10	Abdominal ultrasonography	8
Psychiatric disorders	26 (10)		
Nonorganic psychoses	10		
Depressive disorders	7		
Skin disorders	25 (10)		
Cellulitis	14		
Decubitus ulcers	10		
Miscellaneous		**Radiographic procedures**	26
Cancer	18	CT of abdomen	8
Malnutrition	9	CT of area other than abdomen or thorax	5
Poisoning	8	Bone scanning	4
Gangrene	3	CT of thorax	3

*These data on diagnoses and procedures are based on the ICD-9 codes in the hospital records of 261 patients transported to the hospital after being found helpless in their homes. CNS denotes central nervous system, TIA transient ischemic attack, CT computed tomography, MRI magnetic resonance imaging, EEG electroencephalography, MI myocardial infarction, PCWP pulmonary-capillary wedge pressure, HIV human immunodeficiency virus, AIDS acquired immunodeficiency syndrome, OR open reduction, COPD chronic obstructive pulmonary disease, UTI urinary tract infection, and GI gastrointestinal.

†Major categories, in boldface type, include the numbers of patients and percentages. Selected subcategories are also shown, with the numbers of diagnoses.

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most cases seem to represent deaths or suffering that could have been prevented.

In this study, working with paramedics employed by the city of San Francisco, we examined a common set of circumstances that result in adverse outcomes. We were not able, however, to determine the independent influence of functional status, the length of time spent helpless, the extent of social support, diagnosis, demographic variables, or a number of other factors on the outcomes of persons found dead or helpless in their homes. We were also unable to determine the independent relative risk of being found incapacitated among people who live alone as compared with those who do not. For patients who survive prolonged periods of time spent helpless in their homes, our study suggests that tremendous suffering could be reduced by earlier intervention. The correlation between the estimated length of time since incapacitation and outcome implies that future studies should attempt to reduce mortality and suffering by devising ways for others to intervene earlier.

The results of this study also raise several important policy questions. Who can undertake the monitoring necessary to ensure the safety of relatively isolated, very elderly people living alone in the community? Many of the patients were already known to the health care system and were discovered by other health care professionals after prolonged periods spent helpless. Assisting such patients might require more frequent checks, perhaps every 12 to 24 hours. When is periodic monitoring cost effective or ethically justified? How can it be carried out in a way that is supportive of the individual person's wish for independence and not coercive or intrusive? An important first step would be to raise public awareness of the likelihood that elderly people may become helpless in their homes and to promote activism within a community. Checking on someone requires no specific training. Our finding that notification of the paramedics by patients' friends resulted in a significantly shorter time spent helpless than notification by others implies that the best preventive measure (as simple as it may sound) is the existence of active social relationships. Identifying, facilitating, and assisting in the maintenance of such friendships for relatively isolated elderly people may require creative social responses. Other possibilities for intervention include electronic telephone checks, calling circles among elderly people at risk, and the use of devices that are commercially available to summon help (only one patient in our study possessed such a device). How can limited resources be targeted to those at greatest risk? Our study indicates that very elderly men living alone, particularly black men, are especially in need of intervention.

This study may help health care providers to counsel patients at risk, but further research is needed to adequately address the fears of elderly people who live alone. Future studies should evaluate interventions to prevent elderly people from becoming helpless in their homes, lessen morbidity, and maintain independent living for patients who desire it.

We are indebted to the men and women of the San Francisco Department of Public Health Paramedic Division, who with diligence and compassion found and cared for each of the patients we studied; to Owen Linderholm, without whom the study could not have been conducted; to Charles Saunders and Tom Newman for their assistance; and to Ramona Doyle for her sharp eye and quick pen.

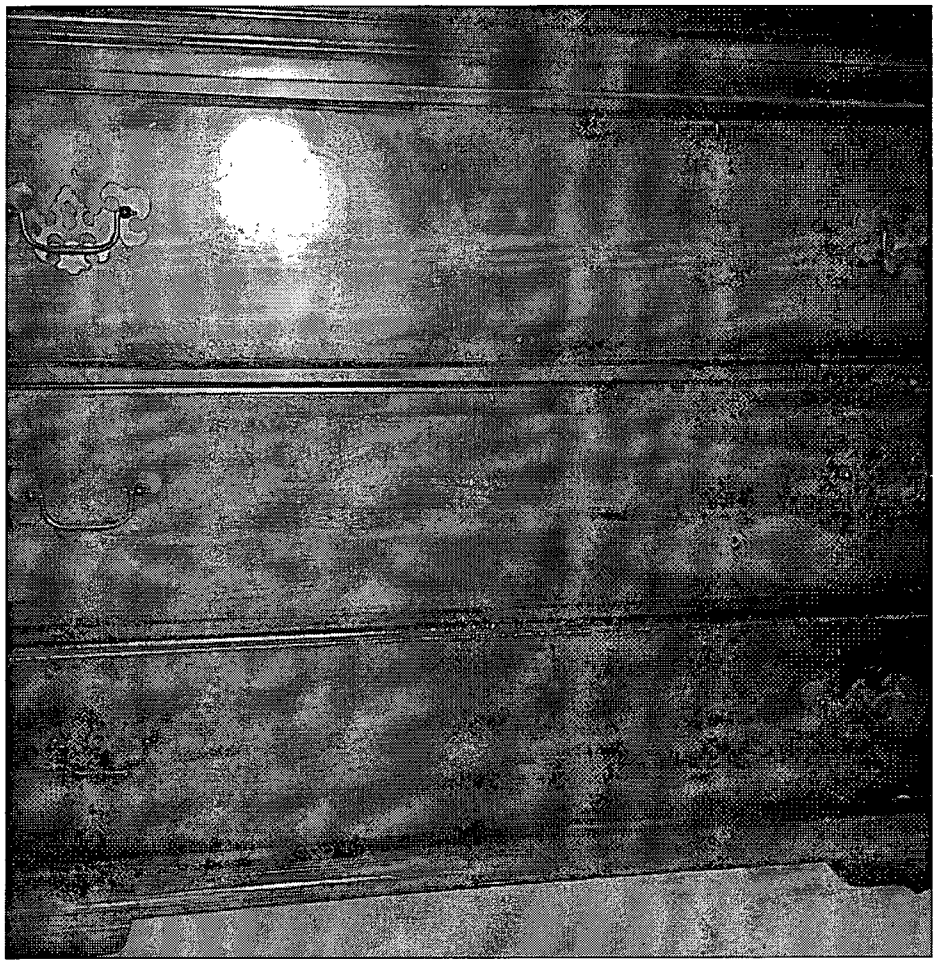
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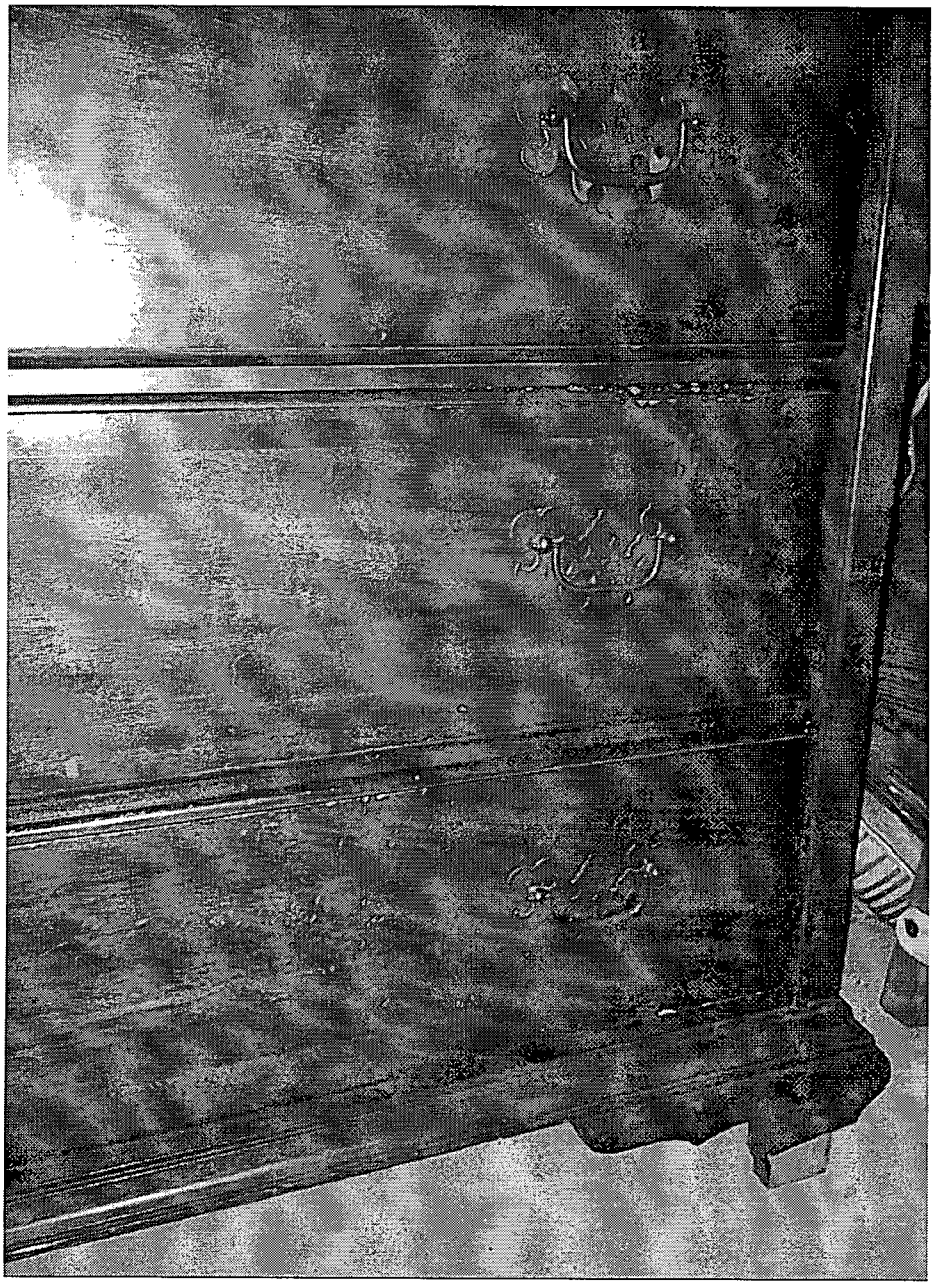
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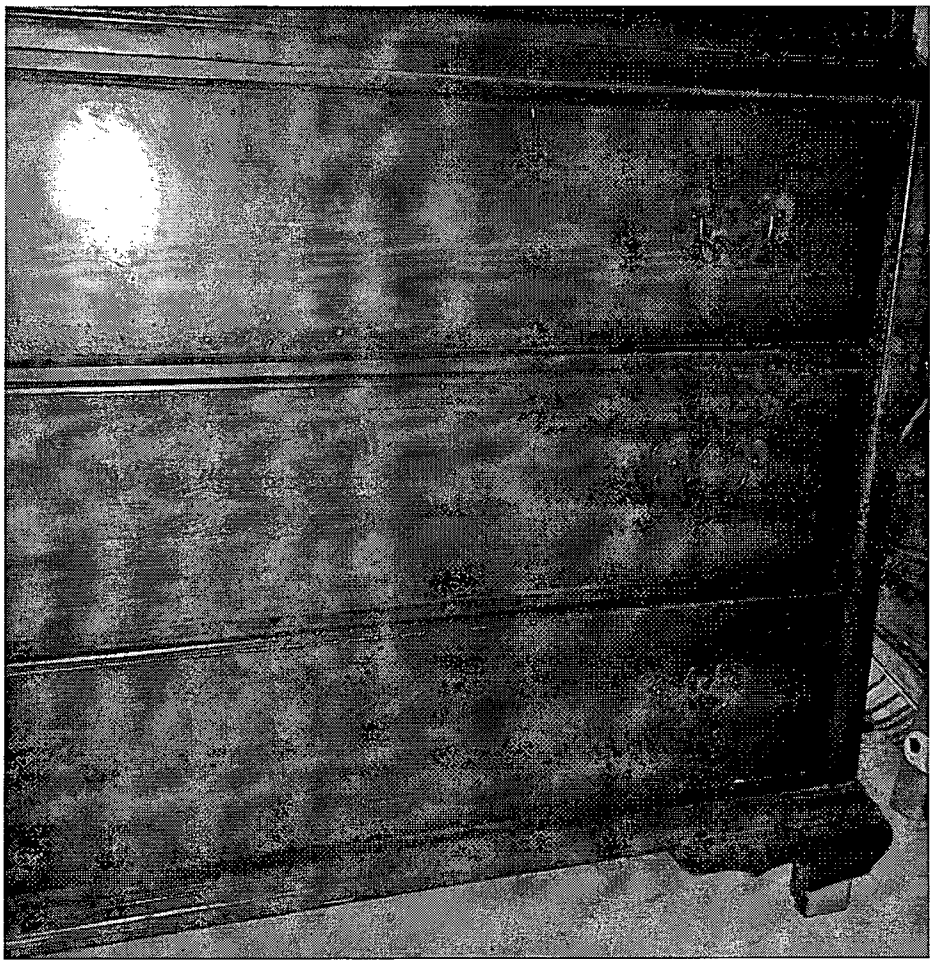
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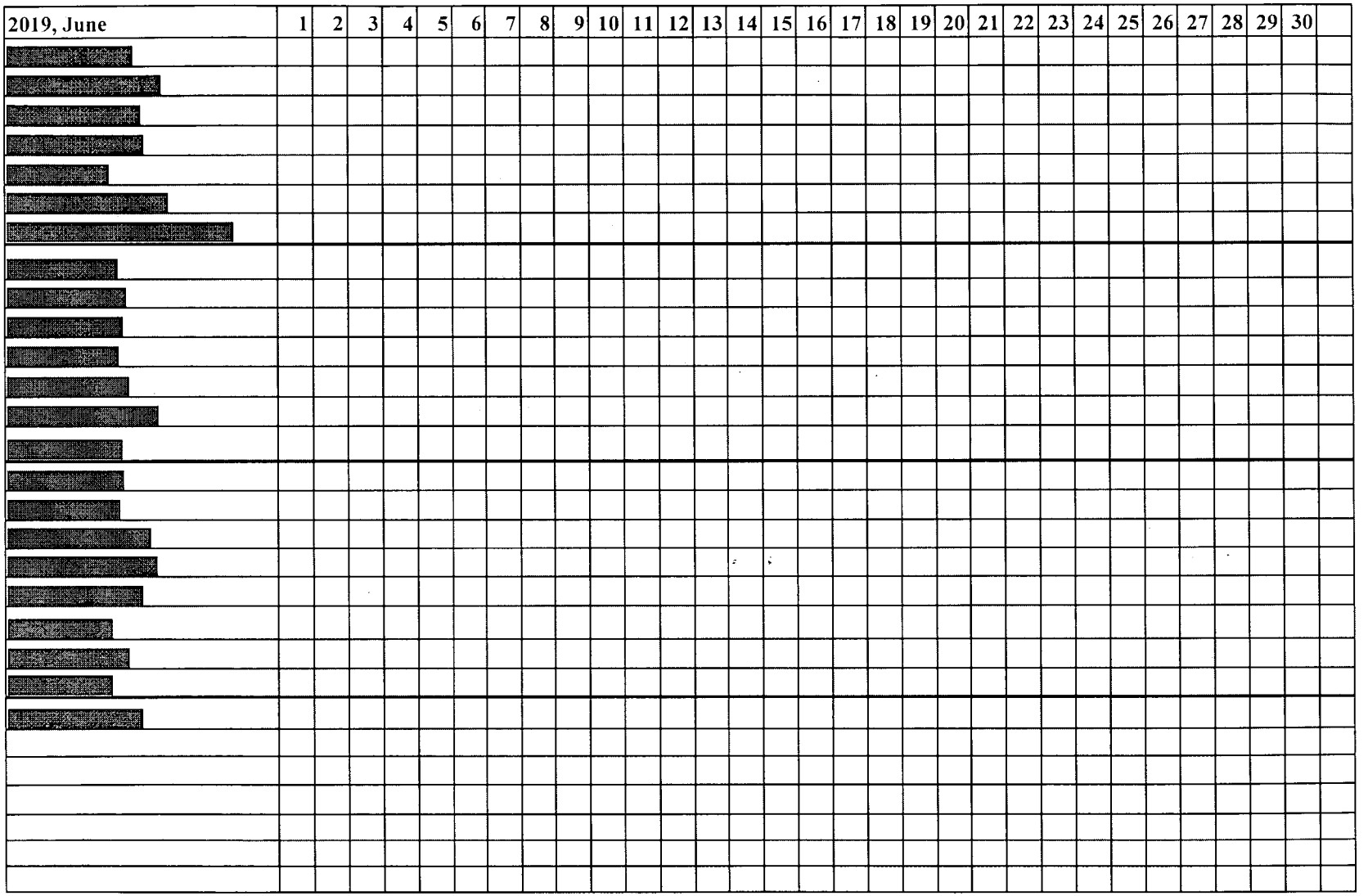
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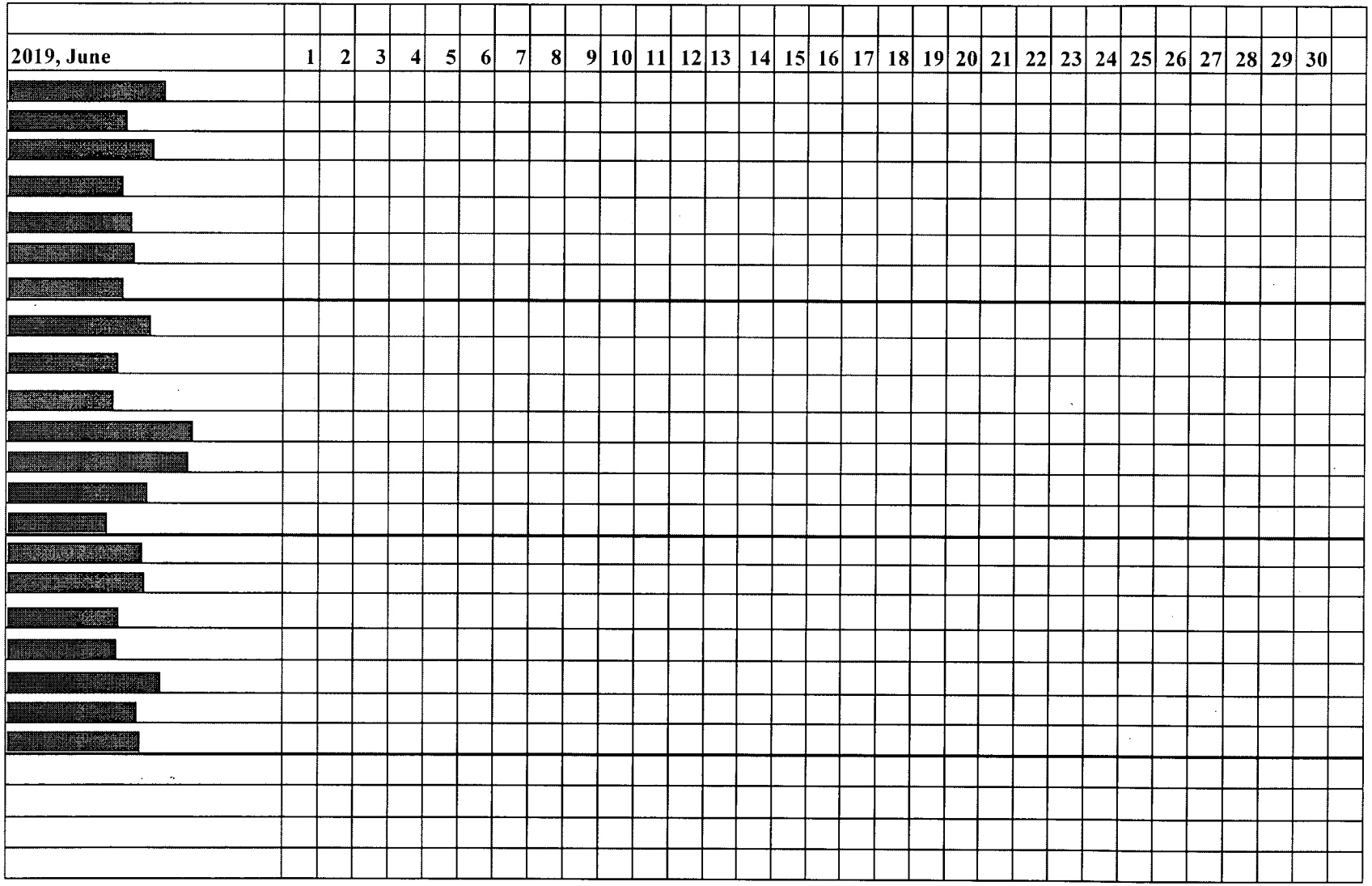






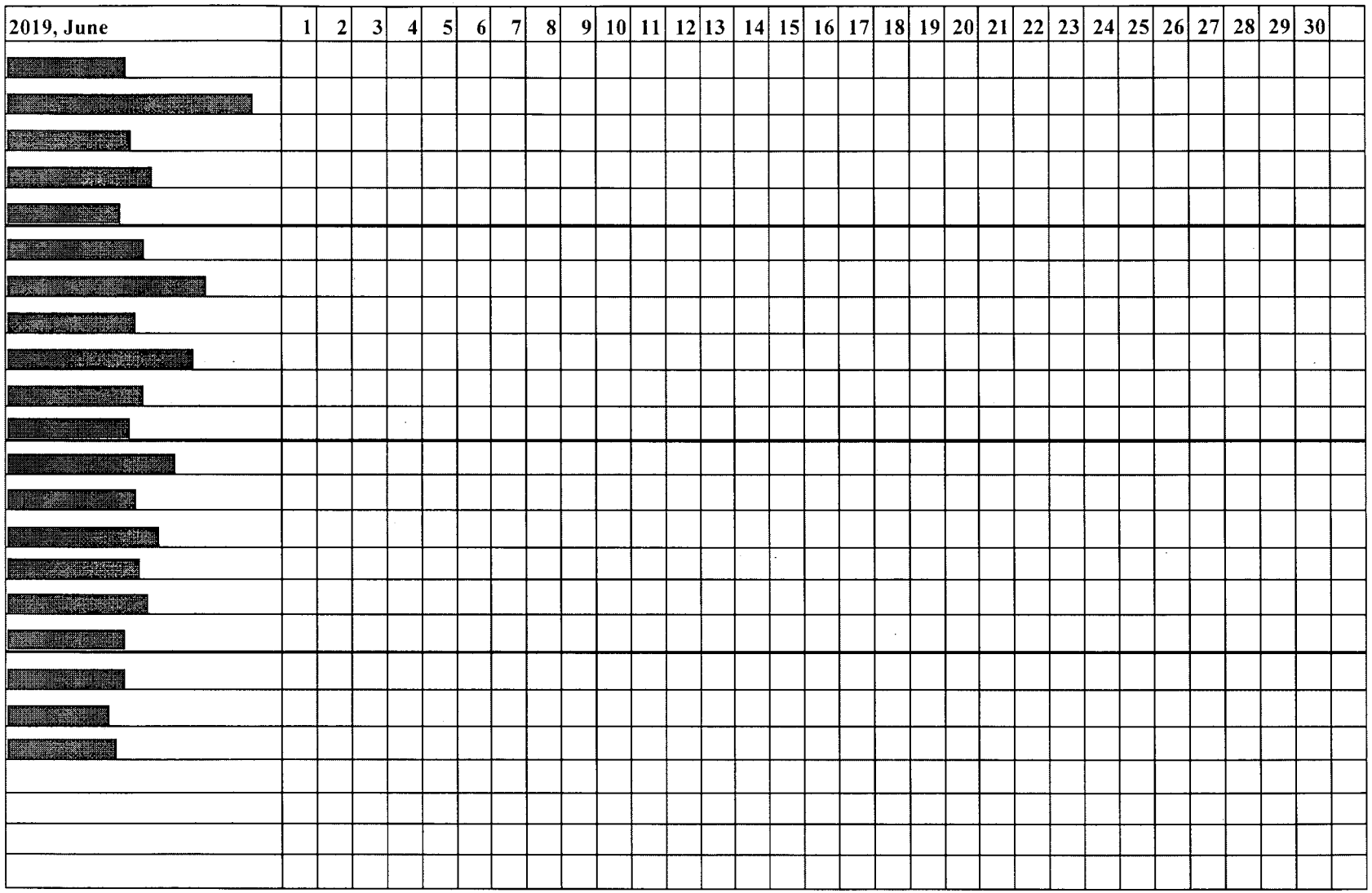
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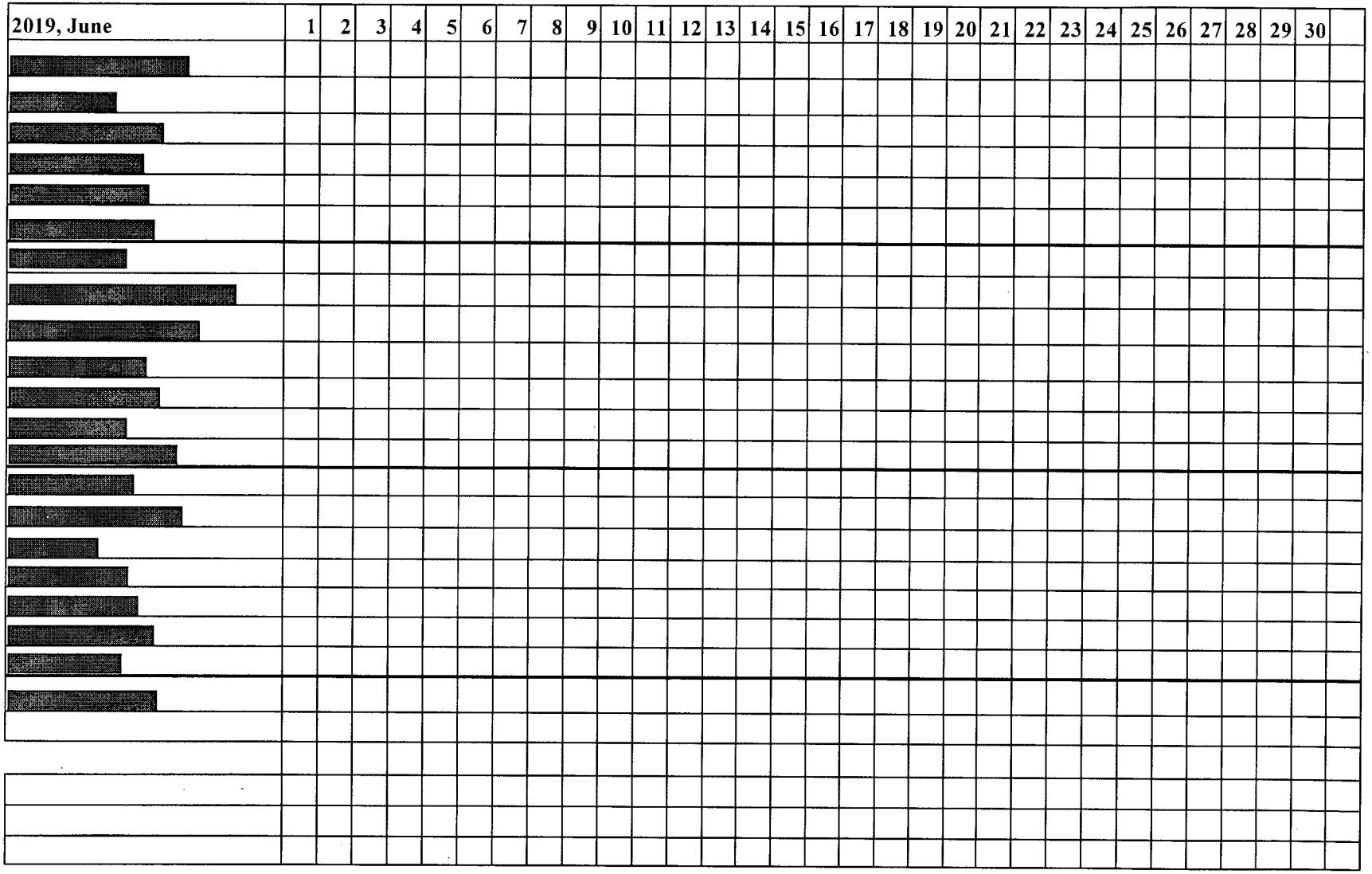
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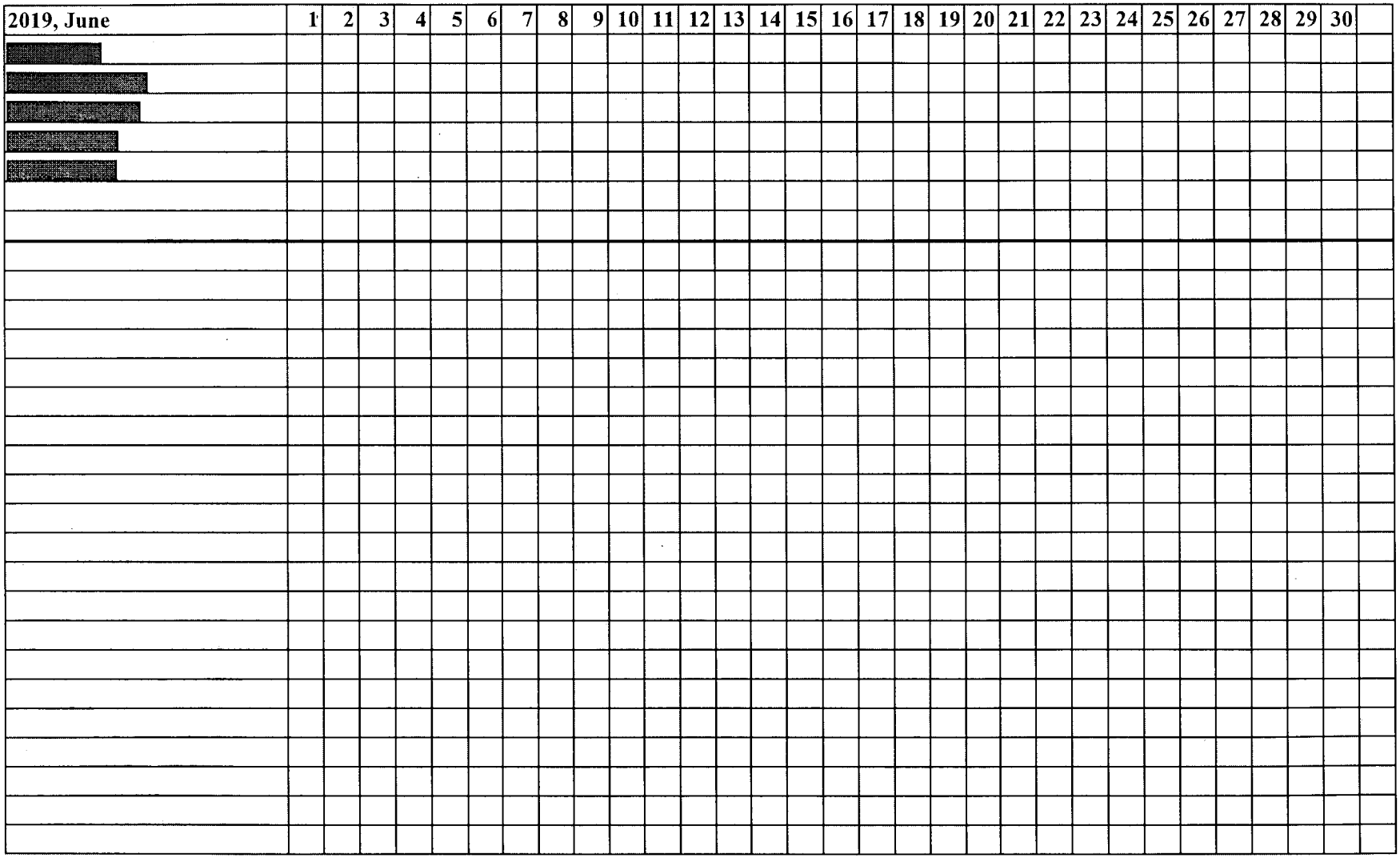
Sandpiper_Parrott 119

ROA 1417



ROA 1418

Sandpiper_Parrott 120



ROA 1419

Sandpiper_Parrott 121

On 6/7/14 received a call from Rebecca Whitfield stating the Mrs. Parrott fell at some point and she found her with what she thought was a broken him on Friday night around 7pm.

States she fell hanging curtains standing on a rocking chair. She was not wearing her panic alarm. Added that she told EMS she was down since Tuesday.

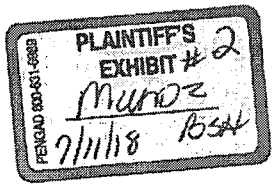
Came into work to investigate on 6/7/2014

Wednesday Mrs. Watters stated that she received a call from Mrs. Parrott to wish her a happy birthday. Was not signed off by Rebecca on Wednesday 6/4/ 2014 and she stated that she told her mother to make sure she saw her on Thursday. Beth Auld signed her as being seen on the 6/5/14. Called Beth and she was adamant that she would not sign anyone off unless she had seen them.

Mrs. Parrott did not show at Bingo on Friday 6/6/2014 as regular and so her friend Mrs. Watters came to Rebecca Mrs. Parrot's apartment without answer. While Rebecca called Mrs. Watters went to the unit and found her on the floor. 911 was called by Rebecca Whitfield.

Talked with daughter Joan Acosta and she also stated that her sister had called Mrs. Parrott without answer since Tuesday. The family never called here for us to check on her. Explained to the daughter that mother was very private and had personally told me on at least one occasion that she did not want anyone in her apartment.

Corrie Carrington
6/7/14



RECORD OF CONCERN

Date 2/28/14 TIME 12:30 ish NAME Linda Parrott

Undersigned walked thru courtyard of S building and Mrs. Parrott was having trouble getting into her unit. told her that I had my master keycard could help her. She the explained that she had her lock changed without our knowledge. I explained to her that we needed a key and she said no she did not want anyone.

Signature Connie Carrington

RECORD OF FOLLOW UP

Date/Time March 4th 11:30 - Came to undersigned to a key to her unit. But stated I was the only person to have access to it and the she does not want anyone in her apartment.

But the key in the key pad for her apartment to'd the front desk (Beth Reed) also told her to inform security guards

Signature Connie Carrington

DEFENDANT'S EXHIBIT #2
Carrington
7/11/18 BSN
PENGAD 800-631-6989

to have access to her apartment. Asked her what she/we are to do in an emergency and again she said no one is to go into her apartment -EVER! Asked her "What if there is a fire" she said "OH WELL". ~~Went on~~ went on to explain I must have a key ASAP. I also able to open the door with her key. Also explained to her that I would not encourage her to lock the storm door since that would also be an issue for us and she just shut the door.

P.O. BOX 15123
WILMINGTON, DE
19850-5123

[redacted]

Payment Due Date:	04/26/14
New Balance:	$188.03
Minimum Payment:	$25.00

Account number: [redacted]

$_____ Amount Enclosed

Make your check payable to: Chase Card Services

27924 BEX Z 09114 C
DELILA PARROTT
1224 VILLAGE CREEK LN
APT S6
MOUNT PLEASANT SC 29464-3162

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WILMINGTON DE 19886-5153

:5000160 28: [redacted]

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ACCOUNT SUMMARY

Account Number: [redacted]	
Previous Balance	$120.01
Payment, Credits	-$120.01
Purchases	+$188.03
Cash Advances	$0.00
Balance Transfers	$0.00
Fees Charged	$0.00
Interest Charged	$0.00
New Balance	$188.03
Opening/Closing Date	03/03/14 - 04/01/14
Credit Limit	$22,300
Available Credit	$22,111
Cash Access Line	$2,230
Available for Cash	$2,230
Past Due Amount	$0.00
Balance over the Credit Limit	$0.00

PAYMENT INFORMATION

New Balance	$188.03
Payment Due Date	04/26/14
Minimum Payment Due	$25.00

Late Payment Warning: If we do not receive your minimum payment by the date listed above, you may have to pay a late fee of up to $35.00 and your APR's will be subject to increase to a maximum Penalty APR of 29.99%.

Minimum Payment Warning: If you make only the minimum payment each period, you will pay more in interest and it will take you longer to pay off your balance. For example:

If you make no additional charges using this card and each month you pay...	You will pay off the balance shown on this statement in about...	And you will end up paying an estimated total of...
Only the minimum payment	8 months	$199

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Welcome to the all new BP Visa with Pump Rewards Program. Earn cents per gallon rebates on virtually all your purchases and choose from two ways to redeem: At the Pump: Redeem rebates for a one time fill of up to 20 gallons of fuel at participating BP stations. Statement Credit: Get a $15 statement credit for every $1.00 in cents per gallon rebates.

ACCOUNT ACTIVITY

Date of Transaction	Merchant Name or Transaction Description	$ Amount
PAYMENTS AND OTHER CREDITS		
03/13	Payment Thank You Specialist Assisted	-120.01
PURCHASES		
03/02	GOODWILL - MT. PLE MT. PLEASANT SC	27.68
03/10	FIRSTSTREET 800-958-6324 VA	9.95
03/10	CVS PHARMACY #4263 Q03 MT. PLEASANT SC	44.74
03/21	JACK FLASH MOUNT PLEASAN SC Can w cash	8.00
03/23	GOODWILL - MT. PLE MT. PLEASANT SC	12.46
03/22	DOLRTREE 363 00003632 MT PLEASANT SC	19.57
03/27	CVS PHARMACY #4263 Q03 MT. PLEASANT SC	12.14
03/27	DOLRTREE 363 00003632 MT PLEASANT SC	6.31
03/28	WAL-MART #0632 MOUNT PLEASAN SC	34.33
03/27	HESS 40383 MT PLEASANT SC	5.29
03/31	WAL-MART #0632 MOUNT PLEASAN SC	7.56

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City: _____

State: ___ Zip: _____ _____

*Home Phone: ____ _____ _____ *Work Phone: ____ _____ _____

E-mail Address: _____

*When you give us your mobile phone number, we have your permission to contact you at that number about all your Chase or J.P. Morgan accounts. Your consent allows us and companies working on our behalf to use text messaging, artificial or prerecorded voice messages and automatic dialing technology for informational and account service calls, but not for telemarketing or sales calls. Message and data rates may apply. You may contact us anytime to change these preferences.

To contact us regarding your account:

By Telephone:		Send Inquiries to:	Mail Payments to:	Visit Our Website:
In U.S.	1-800-BP VISA 1 (1-800-278-4721)	P.O. Box 15298 Wilmington, DE 19850-5298	P.O. Box 15153 Wilmington, DE 19886-5153	www.chase.com/bp
Español	1-888-446-3305			
TTY	1-800-955-6060			
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You may make payments by regular U.S. mail. Send your payment to the Payments address shown on this statement. Your payments by mail must comply with the instructions on this statement. Do not send cash. Write your Account number on your check or money order. Payments must be accompanied by the payment coupon in the envelope provided with our address visible through the envelope window; the envelope cannot contain more than one payment or coupon; and there can be no staples, paper clips, tape or correspondence included with your payment. If your payment is in accordance with our payment instructions and is made available to us on any day by 5:00 p.m. local time at our Payments address on this statement, we will credit the payment to your Account as of that day. If your payment is in accordance with our payment instructions, but is made available to us after 5:00 p.m. local time at the Payments address on this statement, we will credit it to your Account as of the next calendar day.

You may make payments electronically through our website shown on this statement. If we receive your completed request on our website by 8 p.m. Eastern Time, we will credit your payment as of that day. If we receive your request after 8 p.m. Eastern Time, we will credit your payment as of the next calendar day. If you specify a future date in your request we will credit your payment as of that day.

For all other payments or for any payment types above for which you do not follow our payment instructions, crediting of your payments may be delayed for up to 5 days.

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Notice About Electronic Check Conversion: When you pay by check, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day we receive your payment, and you will not receive your check back from your financial institution. Call the Customer Service number on this statement if you have questions about electronic check collection or do not want your payments collected electronically.

Conditional Payments: Any payment check or other form of payment that you send us for less than the full balance due that is marked "paid in full" or contains a similar notation, or that you otherwise tender in full satisfaction of a disputed amount, must be sent to Card Services, P.O. Box 15049, Wilmington, DE 19850-5049. We reserve all our rights regarding these payments (e.g., if it is determined there is no valid dispute or if any such check is received at any other address, we may accept the check and you will still owe any remaining balance). We may refuse to accept any such payment by returning it to you, not cashing it or destroying it. All other payments that you make should be sent to the regular Payment address shown on this statement.

Annual Renewal Notice: If your Account Agreement has an annual membership fee and/or similar charge for issuance or availability of your account, it will be billed each year or in monthly or quarterly installments. This fee and/or charge are owed whether or not you use your Account, and you agree to pay them when billed. The annual fee and charge are non-refundable unless you notify us that you wish to close your account within 30 days or one billing cycle (whichever is less) after we provide the statement on which the annual fee or charge is billed and at the same time, you pay your outstanding balance in full. If you do this, for a charge billed more often than annually such as a monthly service charge, you will not owe the last billed charge; however, prior billed charges are non-refundable and must be paid as part of paying your outstanding balance in full. Your payment of the annual fee or charge does not affect our rights to close your Account and to limit your right to make transactions on your Account. If your Account is closed by you or us, we will continue to impose the annual fee and/or charge until you pay your outstanding balance in full and terminate your Account relationship.

Calculation of Balance Subject to Interest Rate: To figure your periodic interest charges for each billing cycle when a daily periodic rate(s) applies, we use the daily balance method (including new transactions). To figure your periodic interest charges for each billing cycle when a monthly periodic rate(s) applies, we use the average daily balance method (including new transactions). For an explanation of either method, or questions about a particular interest charge calculation on your statement, please call us at the toll free customer service phone number listed above.

We calculate periodic interest charges separately for each feature (for example, purchases, balance transfers, cash advances or overdraft advances). These calculations may combine different categories with the same periodic rates. Variable rates will vary with the market based on the Prime Rate or such index described in your Account Agreement. There is a transaction fee for each balance transfer, cash advance, or check transaction in the amount stated in your Account Agreement. There is a foreign transaction fee of 3% of the U.S. dollar amount of any foreign transaction for some accounts. Please see your Account Agreement for information about these fees.

We add transactions and fees to your daily balance no earlier than:

1) the date of the transaction – for new purchases, balance transfers, overdraft advances or cash advances;

2) the date the payee deposits the check – for new cash advance checks or balance transfer checks;

3) the date of a related transaction, the date they are posted to your account, or the last day of the billing cycle, whichever we may choose – for fees

How to Avoid Paying Interest on Purchases: Your due date will be a minimum of 21 days after the close of each billing cycle. If you pay your account in full each billing period by the date and time due, no interest is charged on new purchases month to month. Also, we will not impose interest charges on any portion of a purchase balance you repay while that balance is subject to an interest-free period. Subject to any interest-free period for new purchases, we will begin charging interest from the date a transaction (including any balance transfer, cash advance or overdraft advance), fee or interest charge is added to your daily balance until your account is paid in full. Because we apply payments in excess of your minimum payment first to higher rate balances, you may not be able to avoid interest charges on new purchases if you have another balance at a higher interest rate unless you pay your balance in full each month.

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- Dollar amount: The dollar amount of the suspected error.
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You must contact us within 60 days after the error appeared on your statement.

You must notify us of any potential errors in writing or on the web at chase.com. You may call us, but if you do we are not required to investigate any potential errors and you may have to pay the amount in question.

While we investigate whether or not there has been an error, the following are true:

- We cannot try to collect the amount in question, or report you as delinquent on that amount.
- The charge in question may remain on your statement, and we may continue to charge you interest on that amount. But, if we determine that we made a mistake, you will not have to pay the amount in question or any interest or other fees related to that amount.
- While you do not have to pay the amount in question, you are responsible for the remainder of your balance.
- We can apply any unpaid amount against your credit limit.

Your Rights If You Are Dissatisfied With Your Credit Card Purchases

If you are dissatisfied with the goods or services that you have purchased with your credit card, and you have tried in good faith to correct the problem with the merchant, you may have the right not to pay the remaining amount due on the purchase.

To use this right, all of the following must be true:

1. The purchase must have been made in your home state or within 100 miles of your current mailing address, and the purchase price must have been more than $50. (Note: Neither of these are necessary if your purchase was based on an advertisement we mailed to you, or if we own the company that sold you the goods or services.)
2. You must have used your credit card for the purchase. Purchases made with cash advances from an ATM or with a check that accesses your credit card Account do not qualify.
3. You must not yet have fully paid for the purchase.

If all of the criteria above are met and you are still dissatisfied with the purchase, contact us in writing at Customer Service, P.O. Box 15299 Wilmington, DE 19850-5299 or on the web at chase.com.

While we investigate, the same rules apply to the disputed amount as discussed above. After we finish our investigation, we will tell you our decision. At that point, if we think you owe an amount and you do not pay we may report you as delinquent.

ROA 1423

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[redacted]0000250000004667000000004

P.O. BOX 15123
WILMINGTON, DE
19850-5123

Payment Due Date:	**05/26/14**
New Balance:	**$46.67**
Minimum Payment:	**$25.00**

Account number: [redacted]

$_____ Amount Enclosed
Make your check payable to: Chase Card Services

41562 BEX Z 12114 C
DELILA PARROTT
1224 VILLAGE CREEK LN
APT S6
MOUNT PLEASANT SC 29464-3162

CARDMEMBER SERVICE
PO BOX 15153
WILMINGTON DE 19886-5153

1:5000160281:[redacted]11*

bp

Manage your account online: www.chase.com/bp
Customer Service: 1-800-BP-VISA1
Mobile: Visit chase.com on your mobile browser

ACCOUNT SUMMARY

Account Number: [redacted]

Previous Balance	$188.03
Payment, Credits	-$201.01
Purchases	+$59.65
Cash Advances	$0.00
Balance Transfers	$0.00
Fees Charged	$0.00
Interest Charged	$0.00
New Balance	$46.67
Opening/Closing Date	04/02/14 - 05/01/14
Credit Limit	$22,300
Available Credit	$22,253
Cash Access Line	$2,230
Available for Cash	$2,230
Past Due Amount	$0.00
Balance over the Credit Limit	$0.00

PAYMENT INFORMATION

New Balance	$46.67
Payment Due Date	05/26/14
Minimum Payment Due	$25.00

Late Payment Warning: If we do not receive your minimum payment by the date listed above, you may have to pay a late fee of up to $35.00 and your APR's will be subject to increase to a maximum Penalty APR of 29.99%.

Minimum Payment Warning: If you make only the minimum payment each period, you will pay more in interest and it will take you longer to pay off your balance. For example:

If you make no additional charges using this card and each month you pay...	You will pay off the balance shown on this statement in about...	And you will end up paying an estimated total of...
Only the minimum payment	2 months	$49

If you would like information about credit counseling services, call 1-866-797-2885.

BP VISA WITH PUMP REWARDS SUMMARY

To view your current cents per gallon rebate balance, swipe your card at a participating BP station; log-in to www.chase.com/bp and click See Rewards® Detail and then Manage Rewards®; or call us at the number on the back of your card.

Welcome to the all new BP Visa with Pump Rewards Program. Earn cents per gallon rebates on virtually all your purchases and choose from two ways to redeem: At the Pump: Redeem rebates for a one time fill of up to 20 gallons of fuel at participating BP stations. Statement Credit: Get a $15 statement credit for every $1.00 in cents per gallon rebates.

ACCOUNT ACTIVITY

Date of Transaction	Merchant Name or Transaction Description	$ Amount
PAYMENTS AND OTHER CREDITS		
04/08	Payment Thank You Phone	-201.01
PURCHASES		
04/03	WAL-MART #0632 MOUNT PLEASAN SC	12.98
04/14	CVS PHARMACY #4263 Q03 MT. PLEASANT SC	17.00
04/16	PUBLIX #449 MT PLEASANT SC	16.89
04/27	PUBLIX #1055 MOUNT PLEASAN SC	7.41
04/27	GOODWILL - MT. PLE MT. PLEASANT SC	6.37

2014 Totals Year-to-Date	
Total fees charged in 2014	$0.00
Total interest charged in 2014	$30.48

Year-to-date totals do not reflect any fee or interest refunds you may have received.

INTEREST CHARGES

Your Annual Percentage Rate (APR) is the annual interest rate on your account.

Balance Type	Annual Percentage Rate (APR)	Balance Subject To Interest Rate	Interest Charges
PURCHASES			
Purchases	15.24% (v)	-0-	-0-
CASH ADVANCES			
Cash Advances	19.24% (v)	-0-	-0-
BALANCE TRANSFERS			
Balance Transfer	15.24% (v)	-0-	-0-

(v) = Variable Rate **30 Days in Billing Period**

Please see Information About Your Account section for the Calculation of Balance Subject to Interest Rate, Annual Renewal Notice, How to Avoid Interest on Purchases, and other important information, as applicable.

IMPORTANT NEWS

Great news..Double Up Days are better than ever! Now you can double your rewards every month in 2014. All year, on the 22nd of each month you will earn double rewards at the pump giving you more ways to save. The more rewards you earn the bigger your savings. Mark your calendar!

BP Gift Cards make the perfect Fathers Day or Graduation gift. Treat your Dad or Grad to quality fuel, food and more at BP! Purchase BP Gift Cards at your local BP Station or visit www.bpgiftcard.com.

5657

ROA 1424

ACCOUNT SUMMARY

Account Number: [redacted]

Previous Balance	$46.67
Payment, Credits	-$69.03
Purchases	+$431.20
Cash Advances	$0.00
Balance Transfers	$0.00
Fees Charged	$0.00
Interest Charged	$0.00
New Balance	$408.84
Opening/Closing Date	05/02/14 - 06/01/14
Credit Limit	$22,300
Available Credit	$21,891
Cash Access Line	$2,230
Available for Cash	$2,230
Past Due Amount	$0.00
Balance over the Credit Limit	$0.00

PAYMENT INFORMATION

New Balance	$408.84
Payment Due Date	06/26/14
Minimum Payment Due	$25.00

Late Payment Warning: If we do not receive your minimum payment by the date listed above, you may have to pay a late fee of up to $35.00 and your APR's will be subject to increase to a maximum Penalty APR of 29.99%.

Minimum Payment Warning: If you make only the minimum payment each period, you will pay more in interest and it will take you longer to pay off your balance. For example:

If you make no additional charges using this card and each month you pay...	You will pay off the balance shown on this statement in about...	And you will end up paying an estimated total of...
Only the minimum payment	19 months	$451

If you would like information about credit counseling services, call 1-866-797-2885.

BP VISA WITH PUMP REWARDS SUMMARY

To view your current cents per gallon rebate balance, swipe your card at a participating BP station; log-in to www.chase.com/bp and click See Rewards® Detail and then Manage Rewards®; or call us at the number on the back of your card.

Welcome to the all new BP Visa with Pump Rewards Program. Earn cents per gallon rebates on virtually all your purchases and choose from two ways to redeem: At the Pump: Redeem rebates for a one time fill of up to 20 gallons of fuel at participating BP stations. Statement Credit: Get a $15 statement credit for every $1.00 in cents per gallon rebates.

ACCOUNT ACTIVITY

Date of Transaction	Merchant Name or Transaction Description	$ Amount
PAYMENTS AND OTHER CREDITS		
05/12	Payment Thank You Phone	-69.03
PURCHASES		
05/04	WAL-MART #0632 MOUNT PLEASAN SC	22.36
05/16	GOODWILL - MT. PLE MT. PLEASANT SC	12.97
05/16	TRADER JOE'S #752 QPS MOUNT PLEASAN SC	4.81
05/15	CVS PHARMACY #4253 Q03 MT. PLEASANT SC	34.29
05/16	GOODWILL - NORTH C NORTH CHARLES SC	5.98
05/16	DOLRTREE 363 00003632 MT PLEASANT SC	10.51
05/18	OFFICE DEPOT #2002 MOUNT PLEASAN SC	303.79
05/18	DOLRTREE 363 00003632 MT PLEASANT SC	6.31
05/20	DOLLAR-GENERAL #3549 MOUNT PLEASAN SC	8.37
05/24	MCDONALD'S F5322 MT PLEASANT SC	7.27
05/25	PUBLIX #449 MT PLEASANT SC	7.27
05/29	MCDONALD'S F5322 MT PLEASANT SC	7.27

2014 Totals Year-to-Date	
Total fees charged in 2014	$0.00
Total interest charged in 2014	$30.48

Year-to-date totals do not reflect any fee or interest refunds you may have received.

INTEREST CHARGES

Your **Annual Percentage Rate (APR)** is the annual interest rate on your account.

Balance Type	Annual Percentage Rate (APR)	Balance Subject To Interest Rate	Interest Charges
PURCHASES			
Purchases	15.24% (v)	-0-	-0-
CASH ADVANCES			
Cash Advances	19.24% (v)	-0-	-0-
BALANCE TRANSFERS			
Balance Transfer	15.24% (v)	-0-	-0-

(v) = Variable Rate **31 Days in Billing Period**

Please see Information About Your Account section for the Calculation of Balance Subject to Interest Rate, Annual Renewal Notice, How to Avoid Interest on Purchases, and other important information, as applicable.

ROA 1425

ACCOUNT SUMMARY

Account Number: [redacted]

Previous Balance	$408.84
Payment, Credits	-$408.84
Purchases	+$153.70
Cash Advances	$0.00
Balance Transfers	$0.00
Fees Charged	$0.00
Interest Charged	$0.00
New Balance	$153.70
Opening/Closing Date	06/02/14 - 07/01/14
Credit Limit	$22,300
Available Credit	$22,146
Cash Access Line	$2,230
Available for Cash	$2,230
Past Due Amount	$0.00
Balance over the Credit Limit	$0.00

PAYMENT INFORMATION

New Balance	$153.70
Payment Due Date	07/25/14
Minimum Payment Due	$25.00

Late Payment Warning: If we do not receive your minimum payment by the date listed above, you may have to pay a late fee of up to $35.00 and your APR's will be subject to increase to a maximum Penalty APR of 29.99%.

Minimum Payment Warning: If you make only the minimum payment each period, you will pay more in interest and it will take you longer to pay off your balance. For example:

If you make no additional charges using this card and each month you pay...	You will pay off the balance shown on this statement in about...	And you will end up paying an estimated total of...
Only the minimum payment	7 months	$161

If you would like information about credit counseling services, call 1-866-797-2885.

BP VISA WITH PUMP REWARDS SUMMARY

To view your current cents per gallon rebate balance, swipe your card at a participating BP station; log-in to www.chase.com/bp and click See Rewards® Detail and then Manage Rewards®; or call us at the number on the back of your card.

Welcome to the all new BP Visa with Pump Rewards Program. Earn cents per gallon rebates on virtually all your purchases and choose from two ways to redeem: At the Pump: Redeem rebates for a one time fill of up to 20 gallons of fuel at participating BP stations. Statement Credit: Get a $15 statement credit for every $1.00 in cents per gallon rebates.

ACCOUNT ACTIVITY

Date of Transaction	Merchant Name or Transaction Description	$ Amount
PAYMENTS AND OTHER CREDITS		
06/11	OFFICE DEPOT #2002 MOUNT PLEASAN SC	-303.79
06/18	Payment Thank You Check	-105.05
PURCHASES		
06/01	WM SUPERCENTER #632 MOUNT PLEASAN SC	25.90
06/01	CVS PHARMACY #4263 Q03 MT. PLEASANT SC	85.30
06/02	CVS PHARMACY #4263 Q03 MT. PLEASANT SC	42.50

2014 Totals Year-to-Date	
Total fees charged in 2014	$0.00
Total interest charged in 2014	$30.48

Year-to-date totals do not reflect any fee or interest refunds you may have received.

INTEREST CHARGES

Your **Annual Percentage Rate (APR)** is the annual interest rate on your account.

Balance Type	Annual Percentage Rate (APR)	Balance Subject To Interest Rate	Interest Charges
PURCHASES			
Purchases	15.24% (v)	-0-	-0-
CASH ADVANCES			
Cash Advances	19.24% (v)	-0-	-0-
BALANCE TRANSFERS			
Balance Transfer	15.24% (v)	-0-	-0-

(v) = Variable Rate **30 Days in Billing Period**

Please see Information About Your Account section for the Calculation of Balance Subject to Interest Rate, Annual Renewal Notice, How to Avoid Interest on Purchases, and other Important Information, as applicable.

ROA 1426

ACCOUNT SUMMARY

Account Number: [redacted]

Previous Balance	$153.70
Payment, Credits	-$153.70
Purchases	$0.00
Cash Advances	$0.00
Balance Transfers	$0.00
Fees Charged	+$25.00
Interest Charged	+$1.94
New Balance	$26.94
Opening/Closing Date	07/02/14 - 08/01/14
Credit Limit	$22,300
Available Credit	$22,273
Cash Access Line	$2,230
Available for Cash	$2,230
Past Due Amount	$0.00
Balance over the Credit Limit	$0.00

PAYMENT INFORMATION

New Balance	$26.94
Payment Due Date	08/26/14
Minimum Payment Due	$26.94

Late Payment Warning: If we do not receive your minimum payment by the date listed above, you may have to pay a late fee of up to $35.00 and your APR's will be subject to increase to a maximum Penalty APR of 29.99%.

BP VISA WITH PUMP REWARDS SUMMARY

To view your current cents per gallon rebate balance, swipe your card at a participating BP station; log-in to www.chase.com/bp and click See Rewards® Detail and then Manage Rewards®; or call us at the number on the back of your card.

Welcome to the all new BP Visa with Pump Rewards Program. Earn cents per gallon rebates on virtually all your purchases and choose from two ways to redeem: At the Pump: Redeem rebates for a one time fill of up to 20 gallons of fuel at participating BP stations. Statement Credit: Get a $15 statement credit for every $1.00 in cents per gallon rebates.

ACCOUNT ACTIVITY

Date of Transaction	Merchant Name or Transaction Description	$ Amount
PAYMENTS AND OTHER CREDITS		
07/31	Payment Thank You Check	-153.70
FEES CHARGED		
07/27	LATE FEE	25.00
	TOTAL FEES FOR THIS PERIOD	$25.00
INTEREST CHARGED		
08/01	PURCHASE INTEREST CHARGE	1.94
	TOTAL INTEREST FOR THIS PERIOD	$1.94

2014 Totals Year-to-Date	
Total fees charged in 2014	$25.00
Total interest charged in 2014	$32.42

Year-to-date totals do not reflect any fee or interest refunds you may have received.

www.chase.com/bp 1-800-BP-VISA1 on your mobile browser

INTEREST CHARGES

Your **Annual Percentage Rate (APR)** is the annual interest rate on your account.

Balance Type	Annual Percentage Rate (APR)	Balance Subject To Interest Rate	Interest Charges
PURCHASES			
Purchases	15.24% (v)	$149.59	$1.94
CASH ADVANCES			
Cash Advances	19.24% (v)	-0-	-0-
BALANCE TRANSFERS			
Balance Transfer	15.24% (v)	-0-	-0-

(v) = Variable Rate **31 Days in Billing Period**

Please see Information About Your Account section for the Calculation of Balance Subject to Interest Rate, Annual Renewal Notice, How to Avoid Interest on Purchases, and other important information, as applicable.

ROA 1427

Day	Time	Orig #	2nd Orig #	Terminating #	Length
Sunday	8:06 AM	9102315453		Delilah Parrott	0:15
Sunday	8:12 AM	8433274773	Delilah Parrott Cell	Delilah Parrott	0:08
Sunday	12:40 PM	Delilah Parrott		Lila Watters	0:23
Sunday	3:17 PM	9102315453		Delilah Parrott	9:13
Sunday	3:28 PM	Delilah Parrott		8438848281	3:05
Sunday	3:46 PM	Delilah Parrott		8438848281	0:35
Sunday	3:49 PM	Delilah Parrott		8438848281	2:17
Sunday	7:56 PM	8436410002		Delilah Parrott	1:30
Monday	8:34 AM	8645997819		Delilah Parrott	0:36
monday	8:35 AM	711391	8645997819	Delilah Parrott	0:36
Monday	8:35 AM	8645997819		Delilah Parrott	0:36
Monday	1:23 PM	Lila Watters		Delilah Parrott	0:03
Monday	5:02 PM	Telemarketer		Delilah Parrott	0:11
Monday	5:02 PM	Telemarketer	Telemarketer	Delilah Parrott	0:05
Monday	6:56 PM	Telemarketer		Delilah Parrott	0:05
Monday	6:56 PM	Telemarketer	Telemarketer	Delilah Parrott	0:05

Monday	6:56 PM	Telemarketer		Delilah Parrott	0:05
Tuesday	11:27 AM	Amelda Johnson		Delilah Parrott	0:28
Tuesday	1:21 PM	8438810465		Delilah Parrott	0:32
Tuesday	4:43 PM	8434122730	8432701399	Delilah Parrott	0:42
Tuesday	7:13 PM	Telemarketer		Delilah Parrott	0:08
Tuesday	7:13 PM	Telemarketer	Telemarketer	Delilah Parrott	0:08
Tuesday	7:13 PM	Telemarketer		Delilah Parrott	0:08
Tuesday	7:40 PM	Amelda Johnson		Delilah Parrott	0:18
Wednesday	5:50 PM	Telemarketer		Delilah Parrott	0:06
Wednesday	5:50 PM	Telemarketer	Telemarketer	Delilah Parrott	0:06
Wednesday	5:50 PM	Telemarketer		Delilah Parrott	0:06
Wednesday	6:27 PM	8433750997		Delilah Parrott	0:07
Wednesday	7:03 PM	Telemarketer		Delilah Parrott	0:11
Wednesday	7:03 PM	Telemarketer	Telemarketer	Delilah Parrott	0:11
Wednesday	7:03 PM	Telemarketer		Delilah Parrott	0:11
Wednesday	7:45 PM	8433750997		Delilah Parrott	0:21
Wednesday	8:00 PM	Telemarketer		Delilah Parrott	0:05
Wednesday	8:00 PM	Telemarketer	Telemarketer	Delilah Parrott	0:05
Wednesday	8:00 PM	Telemarketer		Delilah Parrott	0:05

Thursday	6:56 PM	Lila Watters		Delilah Parrott	0:11
Thursday	7:54 PM	Amelda Johnson		Delilah Parrott	0:18
Thursday	8:45 PM	8433750997		Delilah Parrott	0:21
Friday	9:01 AM	663460	8647080202	Delilah Parrott Cell	0:07
Friday	9:27 AM	8433750997		Delilah Parrott	0:03
Friday	9:47 AM	8433750997		Delilah Parrott	0:13
Friday	11:06 AM			Delilah Parrott	0:01
Friday	11:06 AM	6820000000		Delilah Parrott	0:01
Friday	10:06 AM	627119		Delilah Parrott	0:01
Friday	2:45 PM	8017155504		Delilah Parrott	0:01
Friday	2:45 PM	1709428	8017155504	Delilah Parrott	0:01
Friday	6:38 PM	8433750997		Delilah Parrott	0:05
Friday	8:00 PM	Amelda Johnson		Delilah Parrott	0:17
Friday	8:09 PM	8433274773	Delilah Parrott Cell	Delilah Parrott	0:00
Friday	8:10 PM	8433274773	Delilah Parrott Cell	Delilah Parrott	0:00
Friday	8:12 PM	Delilah Parrott Cell		Joan Acosta	0:07
Friday	8:14 PM	8433274773	Delilah Parrott Cell	Charleston Dispatch	0:00
Friday	8:14 PM	Delilah Parrott Cell	911	Charleston Dispatch	0:00
Friday	8:14 PM	Chas Cty Sheriff		Delilah Parrott Cell	0:00

Friday	8:14 PM	Delilah Parrott Cell		Chas Cty Sheriff	0:13
Friday	8:17 PM	Delilah Parrott Cell		Joan Acosta	0:06
Friday	8:30 PM	Delilah Parrott Cell		Joan Acosta	2:00

WIRELINE

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:27:10
Voice Usage For: (843)276-1816

Item	ConnDateTime (UTC)	Originating Number	Sec. Orig.	Terminating Number	Dialed Number	Elapsed Time	CIC	Call Code	Orig. Acc.
1	04/04/14 17:29:33	709631	2676863985	8432761816		0:16	9020	827	848
2	04/04/14 17:30:17	709631	2676863985	8432761816		0:18	9020	827	848
3	04/04/14 17:30:30	432692	2676863985	8432761816		0:05	9020	827	785
4	04/04/14 17:30:56	709631	2676863985	8432761816		0:21	9020	827	848
5	04/04/14 17:31:53	709631	2676863985	8432761816		0:04	9020	827	848
6	04/13/14 00:37:25	8433274773	8432761816	8438811692		0:14	9	66	
7	04/14/14 14:46:34	8433274773	8432761816	8438811692		0:11	9	66	
8	04/14/14 23:24:51	629044	9108598285	8432761816		0:14	9020	827	884
9	04/14/14 23:25:51	515937	9108598285	8432761816		0:29	9020	827	884
10	04/15/14 22:54:55	9102315453		8432761816		0:03	288	119	
11	04/15/14 22:55:01	9102315453		8432761816		0:03	6963	60	43
12	05/12/14 14:05:35	8433274773	8432761816	8438811692		0:18	9	66	
13	05/12/14 14:45:56	8433274773	8432761816	8438811692		0:06	9	66	
14	05/13/14 00:01:42	8433274773	8432761816	8438811692		0:00	9	66	
15	05/13/14 00:04:04	8433274773	8432761816	8438811692		0:00	9	66	
16	05/13/14 00:06:23	8433274773	8432761816	8438811692		0:11	9	66	
17	05/13/14 00:11:07	8433274773	8432761816	8438811692		0:16	9	66	
18	05/13/14 00:11:57	8433274773	8432761816	8438811692		0:18	9	66	
19	05/13/14 00:16:29	8433274773	8432761816	8438811692		0:14	9	66	
20	05/13/14 00:35:45	8433274773	8432761816	8438811692		0:11	9	66	
21	05/13/14 18:28:30	1611515	8647080202	8432761816		0:07	9020	827	789
22	05/13/14 19:35:13	8433274773	8432761816	8438811692		0:00	9	66	
23	05/27/14 00:44:21	8433274773	8432761816	8438811692		0:14	9	66	
24	05/27/14 01:22:51	8433274773	8432761816	8438811692		1:56	9	66	
25	05/27/14 01:25:23	8433274773	8432761816	8438811692		0:09	9	66	
26	05/27/14 01:28:15	8433274773	8432761816	8438811692		0:30	9	66	
27	05/27/14 01:29:45	8433274773	8432761816	8438811692		0:40	9	66	
28	05/27/14 02:19:13	8433274773	8432761816	8438811692		0:24	9	66	
29	05/27/14 19:42:36	8433274773	8432761816	8438811692		0:07	9	66	
30	05/27/14 20:27:56	8433274773	8432761816	8438811692		0:07	9	66	
31	06/01/14 00:12:32	8433274773	8432761816	8438811692		0:08	9	66	
32	06/05/14 13:01:16	663460	8647080202	8432761816		0:07	9020	827	701
33	06/07/14 00:09:47	8433274773	8432761816	8438811692		0:00	9	66	
34	06/07/14 00:10:08	8433274773	8432761816	8438811692		0:00	9	66	
35	06/07/14 00:14:42	8433274773	8432761816	8437437200		0:00	9	66	
36	06/28/14 13:58:49	8433274773	8432761816	8435882831		0:00	9	66	
37	06/28/14 13:58:56	8432761816	18432761816	8435882831		0:00	9	119	
38	07/10/14 22:09:54	8433274773	8432761816	8436951688		0:09	9	66	

ROA 1432

AT&T Proprietary

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The information contained here is for use by authorized persons only and is not for general distribution.

WIRELINE

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:27:10
Voice Usage For: (843)276-1816

Item	ConnDateTime (UTC)	Originating Number	Sec. Orig.	Terminating Number	Dialed Number	Elapsed Time	CIC	Call Code	Orig. Acc.
39	07/10/14 22:10:00	8432761816	18432761816	8436951688		0:10	9	119	
40	07/10/14 22:18:53	8034141189	8432761816	8033316432		0:13	9	66	
41	07/13/14 22:28:02	8034141189	8432761816	8033316432		0:09	9	66	
42	07/24/14 20:04:49	8433274773	8432761816	8436971666		0:00	9	66	
43	07/31/14 00:14:10	1632926	7035367008	8432761816		0:36	913	827	859
44	07/31/14 00:37:41	3023002321		8432761816		0:49	5050	119	
45	07/31/14 23:03:11	8438846703		8432761816		0:27		1	
46	07/31/14 23:31:10	8438846703		8432761816		0:20		1	

ROA 1433

AT&T Proprietary

The information contained here is for use by authorized persons only and is not for general distribution.

WIRELINE

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:27:20
Voice Usage For: (843)881-1692

Item	ConnDateTime (UTC)	Originating Number	Sec. Orig.	Terminating Number	Dialed Number	Elapsed Time	CIC	Call Code	Orig. Acc.
1	04/01/14 13:47:42	8438811692		8436155030		0:28	377	110	
2	04/01/14 13:47:46	8438811692		8436155030		0:30	377	119	
3	04/01/14 13:47:54	8438811692		8436155030		0:30	377	60	
4	04/01/14 13:48:42	8436155030		8438811692		1:02	377	119	
5	04/01/14 13:48:54	8436155030		8438811692		1:03	314	60	
6	04/01/14 13:48:55	8436155030		8438811692		1:02	314	60	
7	04/01/14 13:51:44	8438811692		8436971688		1:03		1	
8	04/01/14 13:56:57	8438811692		8438497342		0:19		1	
9	04/01/14 14:11:01	8438497342		8438811692		24:05		1	
10	04/01/14 19:16:17			8438811692		0:02	288	119	
11	04/01/14 19:16:24	547103		8438811692		0:03	9020	827	701
12	04/02/14 01:09:13	9102315453		8438811692		0:16	555	119	
13	04/02/14 22:01:56	9102315453		8438811692		0:18	6963	119	
14	04/03/14 11:01:58	6179386170	8003471170	8438811692		0:07	9054	343	
15	04/03/14 12:01:52	8003471170		8438811692		0:07	288	119	
16	04/03/14 12:01:58	547442	8003471170	8438811692		0:07	9020	827	705
17	04/03/14 12:32:46	6179386170	8003471170	8438811692		0:07	9054	343	
18	04/03/14 13:32:40	8003471170		8438811692		0:07	288	119	
19	04/03/14 13:32:46	623134	8003471170	8438811692		0:07	9020	827	705
20	04/03/14 15:04:28	6179386170	8003471170	8438811692		0:07	9054	343	
21	04/03/14 16:04:22	8003471170		8438811692		0:07	288	119	
22	04/03/14 16:04:28	624013	8003471170	8438811692		0:08	9020	827	848
23	04/03/14 20:17:06	2126605351		8438811692		0:03	9054	343	
24	04/03/14 21:17:00	2126605351		8438811692		0:02	288	119	
25	04/03/14 21:17:07	547442	2126605351	8438811692		0:03	9020	827	705
26	04/03/14 21:30:20	6179386170	8003471170	8438811692		0:07	9054	343	
27	04/03/14 21:45:24	8439002485		8438811692		0:08	288	119	
28	04/03/14 21:45:31	1626178	8439002485	8438811692		0:08	9020	827	858
29	04/03/14 22:30:14	8003471170		8438811692		0:07	288	119	
30	04/03/14 22:30:21	624013	8003471170	8438811692		0:07	9020	827	848
31	04/03/14 23:29:03	9108598285		8438811692		17:19	9054	343	
32	04/04/14 00:28:57	9108598285		8438811692		17:18	288	119	
33	04/04/14 00:29:03	432692	9108598285	8438811692		17:19	9020	827	785
34	04/04/14 00:47:32	8438811692		8436971688		0:32		1	
35	04/04/14 14:24:03	8438811692		8886124444	8886124444	1:16	222	141	
36	04/05/14 16:17:12	8438846703		8438811692		0:24		1	
37	04/05/14 16:21:05	8438811692		8438846703		0:59		1	
38	04/05/14 16:22:54	8438811692		8438846703		0:26		1	

ROA 1434

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AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:27:20
Voice Usage For: (843)881-1692

Item	ConnDateTime (UTC)	Originating Number	Sec. Orig.	Terminating Number	Dialed Number	Elapsed Time	CIC	Call Code	Orig. Acc.
39	04/06/14 11:50:55	8438497342		8438811692		0:27		1	
40	04/06/14 12:11:50	8438811692		8438497342		2:21		1	
41	04/06/14 16:09:49	8438811692		8438846703		2:55		1	
42	04/06/14 17:02:37	8433750997		8438811692		0:34	9	66	
43	04/06/14 17:08:52	8438811692		8438566004		0:15		1	
44	04/07/14 12:56:05	8438566004		8438811692		0:26		1	
45	04/07/14 12:58:07	8438566004		8438811692		0:57		1	
46	04/07/14 13:03:34	8438811692		8438566004		0:15		1	
47	04/07/14 13:04:59	8438811692		8438846703		1:51		1	
48	04/07/14 16:33:40	8433750997		8438811692		0:21	9	66	
49	04/08/14 16:39:07	8438811692		8438846703		13:06		1	
50	04/08/14 16:53:11	8438811692		8884686502	8884686502	0:17	432	141	
51	04/08/14 16:54:04	8438811692		8004686502	8004686502	1:57	222	141	
52	04/08/14 16:57:22	8438811692		8004686502	8004686502	12:25	222	141	
53	04/08/14 17:13:48	8438811692		8438845735		0:29		1	
54	04/08/14 17:37:39	8438811692		8438846703		1:29		1	
55	04/08/14 17:40:15	8434789995	8435346289	8438811692		0:56	9	66	
56	04/08/14 17:45:33	8438811692		8435712810		1:55		1	
57	04/08/14 17:48:05	8438811692		8007770370	8007770370	15:55	222	141	
58	04/08/14 18:35:37	8438846703		8438811692		3:17		1	
59	04/08/14 18:45:21	8438811692		8438810348		0:56		1	
60	04/08/14 18:46:54	8438811692		8438846703		1:39		1	
61	04/08/14 18:51:23	8438846703		8438811692		6:40		1	
62	04/08/14 20:06:38	8438811692		8002784721	8002784721	4:18	222	141	
63	04/08/14 20:18:05	8438811692		8436155030		0:54	377	110	
64	04/08/14 20:18:09	8438811692		8436155030		0:56	377	119	
65	04/08/14 20:18:16	8438811692		8436155030		0:57	377	60	
66	04/08/14 20:22:03	6027535621		8438811692		0:07	288	119	
67	04/08/14 20:22:13	486392	6027535621	8438811692		0:07	9020	827	705
68	04/08/14 23:58:55	8434789995	8435346289	8438811692		0:43	9	66	
69	04/09/14 19:41:28	8436075293		8438811692		1:03	288	119	
70	04/09/14 19:41:38	8436075293		8438811692		1:03	314	306	202
71	04/09/14 20:21:23	8438846703		8438811692		3:09		1	
72	04/09/14 20:34:43	8438811692		8438816960		3:39		1	
73	04/09/14 23:23:32	8438811692		8438560361		2:12		1	
74	04/10/14 15:36:54	2027512455		8438811692		0:07	5158	119	
75	04/10/14 17:03:29	8433039426		8438811692		0:07	288	119	
76	04/10/14 17:03:36	711391	8433039426	8438811692		0:08	9020	827	823

WIRELINE

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:27:20
Voice Usage For: (843)881-1692

Item	ConnDateTime (UTC)	Originating Number	Sec. Orig.	Terminating Number	Dialed Number	Elapsed Time	CIC	Call Code	Orig. Acc.
77	04/11/14 00:08:44	8438811692		8436075293		0:50		1	
78	04/11/14 00:15:46	8438811692		8436971688		0:32		1	
79	04/11/14 13:08:12	6789991065		8438811692		0:31	9054	343	
80	04/11/14 14:08:05	6789991065		8438811692		0:30	288	119	
81	04/11/14 14:08:12	709631	6789991065	8438811692		0:31	9020	827	848
82	04/11/14 14:32:34	8438499044		8438811692		0:30		1	
83	04/11/14 19:10:21	8435017111		8438811692		0:18	9	66	
84	04/11/14 19:10:28	8435882831		8438811692		0:18	9	110	
85	04/11/14 21:21:29	8438811692		8436971688		0:36		1	
86	04/11/14 21:28:13	8438811692		8438195189		1:01		1	
87	04/11/14 21:47:45	9108598285		8438811692		0:20	9054	343	
88	04/11/14 22:47:39	9108598285		8438811692		0:20	288	119	
89	04/11/14 22:47:46	489796	9108598285	8438811692		0:20	9020	827	785
90	04/11/14 23:58:12	8438811692		8438848281		2:29		1	
91	04/12/14 14:07:42	8438811692		8438846703		6:35		1	
92	04/13/14 00:29:08	8438811692		8438195189		0:03		1	
93	04/13/14 00:30:07	8438811692		8438195189		0:37		1	
94	04/13/14 00:37:25	8433274773	8432761816	8438811692		0:14	9	66	
95	04/13/14 21:40:37	8438811692		8438848281		1:50		1	
96	04/13/14 23:45:59	8438811692		8438846703		37:26		1	
97	04/14/14 00:32:46	8438811692		8438846703		13:55		1	
98	04/14/14 12:11:32	7202391934	8438848281	8438811692		0:47	9054	343	
99	04/14/14 12:27:53	8438811692		8438499044		0:47		1	
100	04/14/14 12:38:32	8438811692		8009588324	8009588324	0:18	288	141	
101	04/14/14 12:38:40	8438811692		5110676510	8009588324	0:20	288	360	
102	04/14/14 13:05:28	8438811692		8009588324	8009588324	0:18	288	141	
103	04/14/14 13:05:36	8438811692		5110676510	8009588324	0:21	288	360	
104	04/14/14 13:11:26	8438848281		8438811692		0:47	288	119	
105	04/14/14 13:11:33	342378	8438848281	8438811692		0:47	9020	827	848
106	04/14/14 13:22:46	8438811692		8438846703		1:01		1	
107	04/14/14 14:18:01	8008882799		8438811692		0:28	6963	119	
108	04/14/14 14:21:27	8008882799		8438811692		0:34	6963	119	
109	04/14/14 14:46:34	8433274773	8432761816	8438811692		0:11	9	66	
110	04/14/14 22:23:28	9108598285		8438811692		0:00	9054	343	
111	04/14/14 23:20:32	8438811692		8436971688		4:42		1	
112	04/14/14 23:24:36	432692	9108598285	8438811692		0:00	9020	827	785
113	04/15/14 13:35:50	8438811692		8033316342		4:03	377	110	
114	04/15/14 13:35:55	8438811692		8033316342		4:05	377	119	

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ROA 1436

WIRELINE

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:27:20
Voice Usage For: (843)881-1692

Item	ConnDateTime (UTC)	Originating Number	Sec. Orig.	Terminating Number	Dialed Number	Elapsed Time	CIC	Call Code	Orig. Acc.
115	04/15/14 13:36:02	8438811692		8033316342		4:06	377	60	
116	04/15/14 13:52:30	8438811692		8436971688		0:57		1	
117	04/15/14 13:54:08	8438811692		8436155030		3:07	377	110	
118	04/15/14 13:54:12	8438811692		8436155030		3:07	377	119	
119	04/15/14 13:54:19	8438811692		8436155030		3:08	377	60	
120	04/15/14 15:27:51	8434122730	8439910304	8438811692		0:29	9	66	
121	04/15/14 19:14:04	8438845822		8438811692		0:32		1	
122	04/15/14 21:24:15	8433274773	8436971688	8438811692		0:34	9	66	
123	04/15/14 22:54:20	9102315453		8438811692		0:16	555	119	
124	04/16/14 00:00:34	8438811692		9102315453		5:49	377	110	
125	04/16/14 00:00:40	8438811692		9102315453		5:49	377	119	
126	04/16/14 00:00:46	8438811692		9102315453		5:49	377	60	
127	04/16/14 13:29:21	8438811692		8438845735		0:21		1	
128	04/16/14 13:34:33	8438811692		8438815154		0:10		1	
129	04/16/14 13:54:05	8438811692		8438815154		1:16		1	
130	04/16/14 14:02:24	8438811692		8438498604		1:20		1	
131	04/16/14 14:08:00	8438811692		8008882799	8008882799	0:20	222	141	
132	04/16/14 14:30:27	8438498604		8438811692		0:38	6233	119	
133	04/16/14 14:52:39	8438811692		8438846703		0:23		1	
134	04/16/14 19:39:14	8434122730	8033316342	8438811692		0:29	9	66	
135	04/17/14 12:58:34	8438491101		8438811692		1:34	6233	119	
136	04/17/14 13:03:17	8438811692		8438498004		0:03		1	
137	04/17/14 13:03:59	8438811692		8438498004		0:03		1	
138	04/17/14 13:06:52	8438811692		8438491101		0:52		1	
139	04/17/14 14:27:09	8438811692		8438846703		4:53		1	
140	04/17/14 14:57:11	8438811692		8033316342		0:44	377	110	
141	04/17/14 14:57:16	8438811692		8033316342		0:46	377	119	
142	04/17/14 14:57:23	8438811692		8033316342		0:46	377	60	
143	04/17/14 15:12:13	8438844116		8438811692		0:22		1	
144	04/17/14 15:46:04	8438491101		8438811692		0:46	6233	119	
145	04/17/14 16:28:37	5162281798		8438811692		0:46	288	119	
146	04/17/14 16:28:47	1608474	5162281798	8438811692		0:47	9020	827	789
147	04/17/14 17:00:35	8436075293		8438811692		1:06	288	119	
148	04/17/14 17:00:45	8436075293		8438811692		1:06	314	306	202
149	04/17/14 17:02:03	8436075293		8438811692		1:03	288	119	
150	04/17/14 17:02:13	8436075293		8438811692		1:03	314	306	202
151	04/18/14 13:45:12	8438811692		8436971688		0:37		1	
152	04/18/14 14:06:17	8438811692		8009588324	8009588324	2:25	288	141	

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ROA 1437

WIRELINE

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:27:20
Voice Usage For: (843)881-1692

Item	ConnDateTime (UTC)	Originating Number	Sec. Orig.	Terminating Number	Dialed Number	Elapsed Time	CIC	Call Code	Orig. Acc.
153	04/18/14 14:06:26	8438811692		5110676510	8009588324	2:27	288	360	
154	04/18/14 20:54:45	8435017111		8438811692		0:35	9	66	
155	04/18/14 20:54:52	8435882831		8438811692		0:35	9	110	
156	04/18/14 21:11:17	2537539030		8438811692		0:11	9053	343	
157	04/18/14 22:11:11	2537539030		8438811692		0:11	288	119	
158	04/18/14 22:11:18	1706945	2537539030	8438811692		0:11	9020	827	797
159	04/18/14 23:41:05	8438811692		8436971688		1:45		1	
160	04/19/14 14:27:25	8438811692		8436971688		0:56		1	
161	04/19/14 16:32:56	8438811692		8438846703		0:48		1	
162	04/19/14 21:22:54	8433750997		8438811692		0:07	9	66	
163	04/19/14 21:32:20	8438811692		8436971688		2:39		1	
164	04/19/14 21:51:38	8438811692		8436971688		0:18		1	
165	04/20/14 14:15:58	8433274773	8436155030	8438811692		3:22	9	66	
166	04/20/14 15:39:45	8438811692		8438846703		0:02		1	
167	04/20/14 18:04:39	8438811692		8438846703		0:04		1	
168	04/20/14 21:35:53	8434122730	8033316342	8438811692		0:21	9	66	
169	04/20/14 23:04:40	8438811692		8436971688		0:58		1	
170	04/20/14 23:13:29	8433274773	8436971688	8438811692		0:54	9	66	
171	04/21/14 00:20:02	7035367008		8438811692		1:02	6963	119	
172	04/21/14 13:01:24	8438811692		8438816960		0:33		1	
173	04/21/14 13:16:05	8438811692		8438845149		0:59		1	
174	04/21/14 13:46:13	8438811692		8438816960		0:14		1	
175	04/21/14 13:47:28	8438811692		8438846703		2:43		1	
176	04/21/14 15:00:36	5162283915		8438811692		0:46	288	119	
177	04/21/14 15:00:43	1620994	5162283915	8438811692		0:46	9020	827	789
178	04/21/14 21:29:37	8438811692		8438846703		8:42		1	
179	04/22/14 13:56:20	8438811692		8438491101		1:21		1	
180	04/22/14 15:01:59	8434122730	8033316342	8438811692		1:02	9	66	
181	04/22/14 17:31:50	8438491101		8438811692		0:53	6233	119	
182	04/22/14 17:50:56	8438811692		8438491101		7:35		1	
183	04/22/14 20:25:45	3053688265		8438811692		0:00	9054	343	
184	04/22/14 21:26:04	711391	3053688265	8438811692		0:00	9020	827	823
185	04/23/14 13:19:19	8438811692		8436155030		7:49	377	110	
186	04/23/14 13:19:24	8438811692		8436155030		7:49	377	119	
187	04/23/14 13:19:31	8438811692		8436155030		7:50	377	60	
188	04/23/14 14:37:58	8438514377		8438811692		2:20	377	119	
189	04/23/14 14:38:04	8438514377		8438811692		2:18	377	110	
190	04/23/14 14:38:10	8438514377		8438811692		2:20	377	60	

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ROA 1438

ATT Subpoena 007

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WIRELINE

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:27:20
Voice Usage For: (843)881-1692

Item	ConnDateTime (UTC)	Originating Number	Sec. Orig.	Terminating Number	Dialed Number	Elapsed Time	CIC	Call Code	Orig. Acc.
191	04/23/14 18:19:52			8438811692		0:02	555	119	
192	04/23/14 18:49:09	8434122730	8033316342	8438811692		0:17	9	66	
193	04/23/14 19:01:33	8434122730	8438478353	8438811692		1:00	9	66	
194	04/23/14 19:23:53			8438811692		0:07	555	119	
195	04/23/14 19:41:48	8438811692		8438845149		0:51		1	
196	04/23/14 23:14:45	2145964647		8438811692		0:33	6963	119	
197	04/24/14 00:23:14	8438811692		8432145964		0:21		1	
198	04/24/14 00:26:13	8438811692		2145984647		0:00	377	60	24
199	04/24/14 00:26:13	8438811692		2145984647		0:00	288	119	
200	04/24/14 00:26:18	8438811692		2145984647		0:00	377	110	
201	04/24/14 00:26:31	8438811692		2145984647		0:00	377	60	
202	04/24/14 00:26:57	8438811692		8432145984		0:24		1	
203	04/24/14 00:36:20	8438811692		8008882794	8008882794	0:00	432	141	
204	04/24/14 12:15:23	8438811692		8008882799	8008882799	2:14	222	141	
205	04/24/14 12:19:03	8438811692		8432145964		0:14		1	
206	04/24/14 12:19:45	8434122730	8432145964	8438811692		1:03	9	66	
207	04/24/14 13:07:32	8438811692		8008882795	8008882795	0:12	5102	141	
208	04/24/14 13:08:27	8438811692		8008882799	8008882799	0:43	222	141	
209	04/24/14 13:23:20	8438811692		8436971688		0:34		1	
210	04/24/14 13:35:07	8438811692		8009588324	8009588324	3:01	288	141	
211	04/24/14 13:35:16	8438811692		5110676510	8009588324	3:04	288	360	
212	04/24/14 14:20:44	8438811692		8008883799	8008883799	0:15	5102	141	
213	04/24/14 14:22:25	8438811692		8008882997	8008882997	0:00	222	141	
214	04/24/14 14:23:33	8438811692		8008882997	8008882997	0:00	222	141	
215	04/24/14 14:24:44	8438811692		8008882997	8008882997	0:00	222	141	
216	04/24/14 14:39:09	8438811692		8008887997	8008887997	0:10	5102	141	
217	04/24/14 14:39:58	8438811692		8008882799	8008882799	0:09	222	141	
218	04/24/14 14:43:35	8438811692		8008882799	8008882799	14:19	222	141	
219	04/24/14 17:21:55	8438811692		8438498604		2:46		1	
220	04/24/14 17:43:51			8438811692		0:00	555	119	
221	04/24/14 20:08:45	8438811692		7035367008		6:11	377	110	
222	04/24/14 20:08:53	8438811692		7035367008		6:13	377	60	24
223	04/24/14 20:08:57	8438811692		7035367008		6:13	377	60	
224	04/25/14 14:46:48	8438811692		8438846703		5:35		1	
225	04/25/14 14:52:46	8438811692		8438846703		1:14		1	
226	04/25/14 16:10:13	8438811692		8438846703		5:58		1	
227	04/25/14 16:24:21	8438811692		8437634466		3:43		1	
228	04/25/14 16:51:04			8438811692		0:26	555	119	

AT&T Proprietary

The information contained here is for use by authorized persons only and is not for general distribution.

ATT Subpoena 008

ROA 1439

WIRELINE

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:27:20
Voice Usage For: (843)881-1692

Item	ConnDateTime (UTC)	Originating Number	Sec. Orig.	Terminating Number	Dialed Number	Elapsed Time	CIC	Call Code	Orig. Acc.
229	04/25/14 16:54:02	8438811692		8438846703		9:38		1	
230	04/25/14 21:00:57	8438846703		8438811692		0:25		1	
231	04/26/14 13:47:15	8438811692		8438813210		1:01		1	
232	04/26/14 13:49:16	8438811692		8438845735		0:34		1	
233	04/27/14 21:28:28	8438811692		8438846703		0:29		1	
234	04/27/14 22:45:35	6177123508		8438811692		1:10	9053	343	
235	04/27/14 23:45:29	6177123508		8438811692		1:09	288	119	
236	04/27/14 23:45:36	1625027	6177123508	8438811692		1:10	9020	827	772
237	04/28/14 12:47:21	8438811692		8033316342		0:00	377	110	
238	04/28/14 12:47:28	8438811692		8033316342		0:01	377	119	
239	04/28/14 12:47:35	8438811692		8033316342		0:02	377	60	
240	04/28/14 13:08:19	8434122730	8033316342	8438811692		0:31	9	66	
241	04/28/14 13:33:20	8438811692		8438846703		3:13		1	
242	04/28/14 14:17:16	8438846703		8438811692		0:23		1	
243	04/28/14 14:22:23	8438811692		8438846703		0:29		1	
244	04/28/14 22:38:06	8438846703		8438811692		0:27		1	
245	04/28/14 23:09:03	8438811692		8438846703		0:17		1	
246	04/29/14 00:57:35	8438811692		8438846703		0:11		1	
247	04/29/14 12:24:59	8438846703		8438811692		1:46		1	
248	04/29/14 13:19:13	8438811692		8436971688		0:30		1	
249	04/29/14 13:26:00	8438811692		7035367889		0:00	377	60	24
250	04/29/14 13:26:05	8438811692		7035367889		0:00	377	110	
251	04/29/14 13:26:18	8438811692		7035367889		0:00	377	60	
252	04/29/14 13:27:04	8438811692		7035367889		0:00	377	60	24
253	04/29/14 13:27:12	8438811692		7035367889		0:00	377	110	
254	04/29/14 13:27:26	8438811692		7035367889		0:00	377	60	
255	04/29/14 13:32:14	8438811692		7035367008		0:43	377	110	
256	04/29/14 13:32:23	8438811692		7035367008		0:46	377	60	24
257	04/29/14 13:32:26	8438811692		7035367008		0:46	377	60	
258	04/29/14 14:08:19	7035367008		8438811692		5:07	6963	119	
259	04/29/14 14:35:23	8438811692		8888165214	8888165214	6:40	222	141	
260	04/29/14 14:46:52	8646421350		8438811692		0:19	288	119	
261	04/29/14 14:46:59	624013	8646421350	8438811692		0:19	9020	827	848
262	04/29/14 15:11:30	9108598285		8438811692		5:05	288	119	
263	04/29/14 15:11:37	489796	9108598285	8438811692		5:06	9020	827	785
264	04/29/14 16:38:18	8435017111		8438811692		0:16	9	66	
265	04/29/14 16:38:25	8435882831		8438811692		0:16	9	110	
266	04/29/14 20:08:12	8438811692		8009588324	8009588324	4:46	288	141	

ROA 1440

WIRELINE

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:27:20
Voice Usage For: (843)881-1692

Item	ConnDateTime (UTC)	Originating Number	Sec. Orig.	Terminating Number	Dialed Number	Elapsed Time	CIC	Call Code	Orig. Acc.
267	04/29/14 20:08:20	8438811692		5110676510	8009588324	4:47	288	360	
268	04/29/14 20:13:48	8438811692		8009588324	8009588324	21:55	288	141	
269	04/29/14 20:13:56	8438811692		5110676510	8009588324	21:57	288	360	
270	04/29/14 20:44:35	8438811692		7035367008		11:39	377	110	
271	04/29/14 20:44:43	8438811692		7035367008		11:41	377	60	24
272	04/29/14 20:44:47	8438811692		7035367008		11:41	377	60	
273	04/30/14 13:47:56	8433750997		8438811692		0:00	9	66	
274	04/30/14 13:56:58	8434122730	8033316342	8438811692		1:40	9	66	
275	04/30/14 14:00:36	8438811692		8009588324	8009588324	35:10	288	141	
276	04/30/14 14:00:45	8438811692		5110676510	8009588324	35:10	288	360	
277	04/30/14 15:37:04	5184171294		8438811692		0:43	288	119	
278	04/30/14 15:37:11	1243029	5184171294	8438811692		0:43	9020	827	772
279	04/30/14 15:37:11	5184171294		8438811692		0:43	9053	343	
280	04/30/14 17:51:34	8438491101		8438811692		1:27	6233	119	
281	04/30/14 18:00:40	8438811692		8438846703		0:12		1	
282	04/30/14 18:12:02	8438811692		8438846703		0:04		1	
283	04/30/14 18:13:38	8438811692		8438491601		0:33		1	
284	04/30/14 18:14:09	8438811692		-1		0:02		26	
285	04/30/14 18:14:23	8438811692		8438491101		1:17		1	
286	04/30/14 19:54:29	2722830000		8438811692		0:00	1	129	
287	04/30/14 23:53:47	2126601821		8438811692		0:00	9053	343	
288	04/30/14 23:54:07	1289729	2126601821	8438811692		0:00	9020	827	789
289	05/01/14 17:36:27	8434122730	8033316342	8438811692		0:36	9	66	
290	05/01/14 19:52:13	8438491101		8438811692		0:37	6233	119	
291	05/01/14 21:48:03	2722830000		8438811692		0:00	1	129	
292	05/02/14 14:46:51	8438811692		8438491101		1:56		1	
293	05/02/14 20:56:40	2741410000		8438811692		0:00	1	129	
294	05/03/14 14:23:19	8438811692		8438846703		0:26		1	
295	05/03/14 14:26:34	8438811692		8438816960		1:26		1	
296	05/03/14 14:30:01	8438811692		8438566004		0:30		1	
297	05/03/14 14:58:20	8438811692	18438811692	8435882831		0:00	9	119	
298	05/03/14 16:54:27	8433750997		8438811692		0:06	9	66	
299	05/03/14 22:36:46	8438846703		8438811692		0:51		1	
300	05/03/14 22:39:08	8438811692		8438846703		1:29		1	
301	05/04/14 17:29:51	8438811692		8438846703		0:04		1	
302	05/04/14 18:49:11	8438846703		8438811692		0:35		1	
303	05/04/14 19:20:02	8436487111		8438811692		0:29	9	66	
304	05/04/14 19:20:09	8438497350		8438811692		0:29	9	110	

ROA 1441

WIRELINE

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:27:21
Voice Usage For: (843)881-1692

Item	ConnDateTime (UTC)	Originating Number	Sec. Orig.	Terminating Number	Dialed Number	Elapsed Time	CIC	Call Code	Orig. Acc.
305	05/04/14 20:39:03	8438811692		8438846703		1:42		1	
306	05/04/14 20:47:39	8438811692		8433522165		0:36		1	
307	05/04/14 21:10:46	8438811692		8433522116		0:02		1	
308	05/04/14 21:15:22	8438811692		8433522165		0:42		1	
309	05/04/14 21:17:18	8438811692		8438497350		1:06		1	
310	05/04/14 21:17:27	8438811692	18438811692	8438497350		1:07	9	119	
311	05/04/14 23:51:49	8438846703		8438811692		4:42		1	
312	05/05/14 00:01:23	8438846703		8438811692		3:21		1	
313	05/05/14 13:01:59	8438811692		7035367008		3:48	377	110	
314	05/05/14 13:02:07	8438811692		7035367008		3:50	377	60	24
315	05/05/14 13:02:11	8438811692		7035367008		3:50	377	60	
316	05/05/14 13:42:17	8438811692		8438491101		1:02		1	
317	05/05/14 21:58:41	8036320918		8438811692		0:09	288	119	
318	05/05/14 21:58:47	1248919	8036320918	8438811692		0:10	9020	827	837
319	05/05/14 21:58:47	8036320918		8438811692		0:09	9053	343	
320	05/06/14 00:03:57	8036320918		8438811692		0:09	288	119	
321	05/06/14 00:04:03	1609271	8036320918	8438811692		0:10	9020	827	837
322	05/06/14 00:04:03	8036320918		8438811692		0:10	9053	343	
323	05/06/14 15:04:55	8668409226		8438811692		1:43	222	119	
324	05/06/14 22:44:05	8036320918		8438811692		0:01	288	119	
325	05/06/14 22:44:11	8036320918		8438811692		0:01	9053	343	
326	05/06/14 22:44:12	1706720	8036320918	8438811692		0:01	9020	827	837
327	05/06/14 23:58:33	8036320918		8438811692		0:09	288	119	
328	05/06/14 23:58:39	1609346	8036320918	8438811692		0:09	9020	827	837
329	05/06/14 23:58:39	8036320918		8438811692		0:09	9053	343	
330	05/07/14 13:20:26	8668409226		8438811692		0:21	222	119	
331	05/07/14 15:38:47	8438811692		8438845149		1:47		1	
332	05/07/14 15:43:41	8438844116		8438811692		0:37		1	
333	05/07/14 16:21:33	8438811692		8438846703		0:24		1	
334	05/07/14 16:28:34	8433750997		8438811692		0:47	9	66	
335	05/07/14 22:02:24	9102315453		8438811692		0:16	6963	119	
336	05/07/14 22:22:16	7035367008		8438811692		0:40	6963	119	
337	05/08/14 14:12:04	7035367008		8438811692		9:24	6963	119	
338	05/08/14 14:42:38	8438811692		8433436207		1:03		1	
339	05/08/14 15:44:43	8432249989	8433436207	8438811692		1:15	9	66	
340	05/08/14 18:23:41	8438811692		8433436207		10:54		1	
341	05/08/14 20:56:35	8554056313		8438811692		0:29	288	119	
342	05/08/14 20:56:41	8554056313		8438811692		0:29	9053	343	

ROA 1442

WIRELINE

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:27:21
Voice Usage For: (843)881-1692

Item	ConnDateTime (UTC)	Originating Number	Sec. Orig.	Terminating Number	Dialed Number	Elapsed Time	CIC	Call Code	Orig. Acc.
343	05/08/14 20:56:42	1542702	8554056313	8438811692		0:29	9020	827	772
344	05/09/14 12:00:58	8438811692		8554056313	8554056313	0:37	5102	141	
345	05/09/14 13:38:47	8554056313		8438811692		3:57	288	119	
346	05/09/14 13:38:53	8554056313		8438811692		3:58	9053	343	
347	05/09/14 13:38:54	1620994	8554056313	8438811692		3:58	9020	827	789
348	05/10/14 16:26:26	8033316342		8438811692		0:32	555	119	
349	05/10/14 17:40:51	8433274773	8436971688	8438811692		0:24	9	66	
350	05/10/14 17:44:18	8438811692		8436971688		1:55		1	
351	05/10/14 17:48:03	8438811692		8436155030		0:27	377	110	
352	05/10/14 17:48:07	8438811692		8436155030		0:30	377	119	
353	05/10/14 17:48:15	8438811692		8436155030		0:30	377	60	
354	05/10/14 17:52:42	8438811692		8438845735		0:36		1	
355	05/10/14 19:14:49	8433274773	8436155030	8438811692		0:02	9	66	
356	05/10/14 19:16:16	8438811692		8436155030		1:03	377	110	
357	05/10/14 19:16:20	8438811692		8436155030		1:02	377	119	
358	05/10/14 19:16:27	8438811692		8436155030		1:03	377	60	
359	05/10/14 20:56:02	8438846703		8438811692		0:34		1	
360	05/10/14 20:57:25	8438811692		8438846703		2:04		1	
361	05/11/14 10:36:14	8438811692		8002764721	8002764721	2:21	5102	141	
362	05/11/14 10:40:06	8438811692		8002764721	8002764721	2:20	5102	141	
363	05/11/14 12:17:14	8438811692		8002764721	8002764721	0:20	5102	141	
364	05/11/14 13:22:02	8434122730	8033315657	8438811692		1:35	9	66	
365	05/11/14 13:34:38	8434122730	8033316342	8438811692		5:45	9	66	
366	05/11/14 13:51:08	8438811692		8033316342		0:20	377	110	
367	05/11/14 13:51:13	8438811692		8033316342		0:20	377	119	
368	05/11/14 13:51:20	8438811692		8033316342		0:20	377	60	
369	05/11/14 13:52:10	8438811692		8033316342		0:52	377	110	
370	05/11/14 13:52:14	8438811692		8033316342		0:54	377	119	
371	05/11/14 13:52:21	8438811692		8033316342		0:55	377	60	
372	05/11/14 13:54:09	8438811692		8033315657		8:16	377	110	
373	05/11/14 13:54:14	8438811692		8033315657		8:16	377	119	
374	05/11/14 13:54:21	8438811692		8033315657		8:16	377	60	
375	05/11/14 14:40:31	8433274773	8436155030	8438811692		0:19	9	66	
376	05/11/14 15:24:54	8438811692		8436155030		0:10	377	110	
377	05/11/14 15:24:58	8438811692		8436155030		0:10	377	119	
378	05/11/14 15:25:05	8438811692		8436155030		0:11	377	60	
379	05/11/14 16:55:31	8438846703		8438811692		0:25		1	
380	05/11/14 17:09:43	8438811692		8436971688		0:09		1	

ROA 1443

WIRELINE

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:27:21
Voice Usage For: (843)881-1692

Item	ConnDateTime (UTC)	Originating Number	Sec. Orig.	Terminating Number	Dialed Number	Elapsed Time	CIC	Call Code	Orig. Acc.
381	05/11/14 23:41:04	8432155332		8438811692		1:29	807	119	
382	05/12/14 00:14:27	8434122730	8033315657	8438811692		0:00	9	66	
383	05/12/14 00:34:25	8438811692		9106497789		8:00	377	110	
384	05/12/14 00:34:32	8438811692		9106497789		8:02	377	119	
385	05/12/14 00:34:36	8438811692		9106497789		8:02	377	60	
386	05/12/14 10:37:46	8438811692		8002764721	8002764721	0:10	5102	141	
387	05/12/14 11:41:15	8438811692		8033316342		1:27	377	110	
388	05/12/14 11:41:20	8438811692		8033316342		1:29	377	119	
389	05/12/14 11:41:27	8438811692		8033316342		1:29	377	60	
390	05/12/14 12:44:23	8434122730	8439576094	8438811692		0:18	9	66	
391	05/12/14 13:08:53	8434122730	8439576094	8438811692		1:19	9	66	
392	05/12/14 13:30:06	8438811692		8439576094		0:08	377	110	
393	05/12/14 13:30:14	8438811692		8439576094		0:10	377	60	24
394	05/12/14 13:30:17	8438811692		8439576094		0:11	377	60	
395	05/12/14 13:32:27	8434122730	8439576094	8438811692		1:49	9	66	
396	05/12/14 14:05:35	8433274773	8432761816	8438811692		0:18	9	66	
397	05/12/14 14:08:17	8438811692		8438846703		1:05		1	
398	05/12/14 14:12:25	8438811692		8002784721	8002784721	5:11	222	141	
399	05/12/14 14:24:05	8438811692		8438566004		1:03		1	
400	05/12/14 14:45:56	8433274773	8432761816	8438811692		0:06	9	66	
401	05/12/14 15:02:58	8438846703		8438811692		3:22		1	
402	05/12/14 16:25:00	8438811692		8433522116		0:47		1	
403	05/12/14 19:15:37	8437634466		8438811692		0:45	288	119	
404	05/12/14 19:15:44	624013	8437634466	8438811692		0:46	9020	827	848
405	05/12/14 19:52:01	5162203819		8438811692		0:46	288	119	
406	05/12/14 19:52:08	342204	5162203819	8438811692		0:46	9020	827	841
407	05/12/14 19:52:08	5162203819		8438811692		0:46	9054	343	
408	05/13/14 00:01:42	8433274773	8432761816	8438811692		0:00	9	66	
409	05/13/14 00:04:04	8433274773	8432761816	8438811692		0:00	9	66	
410	05/13/14 00:06:23	8433274773	8432761816	8438811692		0:11	9	66	
411	05/13/14 00:11:07	8433274773	8432761816	8438811692		0:16	9	66	
412	05/13/14 00:11:57	8433274773	8432761816	8438811692		0:18	9	66	
413	05/13/14 00:16:29	8433274773	8432761816	8438811692		0:14	9	66	
414	05/13/14 00:35:45	8433274773	8432761816	8438811692		0:11	9	66	
415	05/13/14 13:03:35	8433750997		8438811692		0:00	9	66	
416	05/13/14 15:00:42	8434122730	8033316342	8438811692		0:00	9	66	
417	05/13/14 15:03:44	8434122730	8033316342	8438811692		1:26	9	66	
418	05/13/14 15:09:35	8438811692		8438846703		0:28		1	

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ROA 1444

ATT Subpoena 013

017

WIRELINE

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:27:21
Voice Usage For: (843)881-1692

Item	ConnDateTime (UTC)	Originating Number	Sec. Orig.	Terminating Number	Dialed Number	Elapsed Time	CIC	Call Code	Orig. Acc.
419	05/13/14 15:11:07	8438811692		8438846703		1:32		1	
420	05/13/14 15:15:47	8433750997		8438811692		0:14	9	66	
421	05/13/14 15:52:05	5408082361		8438811692		0:02	288	119	
422	05/13/14 15:52:15	1620994	5408082361	8438811692		0:02	9020	827	789
423	05/13/14 16:19:56	8037464250		8438811692		0:24	288	119	
424	05/13/14 16:20:02	8037464250		8438811692		0:25	9054	343	
425	05/13/14 16:20:03	711391	8037464250	8438811692		0:25	9020	827	823
426	05/13/14 19:35:13	8433274773	8432761816	8438811692		0:00	9	66	
427	05/14/14 00:01:35	7702174678		8438811692		0:47	288	119	
428	05/14/14 00:01:41	7702174678		8438811692		0:47	9054	343	
429	05/14/14 00:01:42	709631	7702174678	8438811692		0:47	9020	827	848
430	05/14/14 00:02:44	8433274773	7034007008	8438811692		14:36	9	66	
431	05/14/14 13:02:07	8438811692		8438845735		0:30		1	
432	05/14/14 13:03:47	8438811692		8438845735		0:46		1	
433	05/14/14 13:37:41	8433274773	7034007008	8438811692		0:15	9	66	
434	05/14/14 13:42:06	8438811692		9106497789		0:21	377	110	
435	05/14/14 13:42:13	8438811692		9106497789		0:23	377	119	
436	05/14/14 13:42:17	8438811692		9106497789		0:24	377	60	
437	05/14/14 14:39:04	8438811692		8433522165		0:09		1	
438	05/14/14 14:41:20	8438811692	18438811692	8435882831		0:00	9	119	
439	05/15/14 00:08:28	8438811692		8433522165		1:38		1	
440	05/15/14 00:11:27	8438811692	18438811692	8435882831		0:00	9	119	
441	05/15/14 00:20:02	8438811692		8438846703		22:18		1	
442	05/15/14 01:03:19	8438811692		8438848281		2:30		1	
443	05/15/14 12:23:47	8433274773	7034007008	8438811692		1:00	9	66	
444	05/15/14 12:37:15	8433274773	7034007008	8438811692		1:10	9	66	
445	05/15/14 12:46:31	8434122730	8033316342	8438811692		0:34	9	66	
446	05/15/14 12:53:01	8438811692		8033316342		4:27	377	110	
447	05/15/14 12:53:06	8438811692		8033316342		4:18	377	119	
448	05/15/14 12:53:13	8438811692		8033316342		4:19	377	60	
449	05/15/14 12:54:59	8434122730	8033316342	8438811692		0:00	9	66	
450	05/15/14 13:21:31	8434122730	8033316342	8438811692		3:33	9	66	
451	05/15/14 13:42:22	8438811692		8438846703		2:16		1	
452	05/15/14 13:50:33	8438811692		8438845735		0:25		1	
453	05/15/14 14:54:37	8433274773	7034007008	8438811692		1:03	9	66	
454	05/15/14 14:58:53	8433274773	7034007008	8438811692		11:17	9	66	
455	05/15/14 19:38:24	8665907026		8438811692		0:07	288	119	
456	05/15/14 19:38:30	1626176	8665907026	8438811692		0:07	9020	827	858

ROA 1445

WIRELINE

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:27:21
Voice Usage For: (843)881-1692

Item	ConnDateTime (UTC)	Originating Number	Sec. Orig.	Terminating Number	Dialed Number	Elapsed Time	CIC	Call Code	Orig. Acc.
457	05/15/14 19:38:30	8665907026		8438811692		0:07	9053	343	
458	05/16/14 20:39:28	8438811692		8438845735		0:52		1	
459	05/17/14 14:43:53	8433274773	7034007008	8438811692		0:24	9	66	
460	05/17/14 15:35:25	8433274773	7034007008	8438811692		0:06	9	66	
461	05/17/14 20:57:45	8438846703		8438811692		0:35		1	
462	05/18/14 13:17:44	8433274773	7034007008	8438811692		0:35	9	66	
463	05/18/14 13:23:18	8438811692		9106497789		2:09	377	110	
464	05/18/14 13:23:25	8438811692		9106497789		2:11	377	119	
465	05/18/14 13:23:30	8438811692		9106497789		2:12	377	60	
466	05/18/14 19:40:52	8438811692		8438566004		0:49		1	
467	05/18/14 19:44:32	8438811692		8438816960		2:03		1	
468	05/18/14 19:47:25	8438811692		8433522165		0:37		1	
469	05/18/14 21:20:25	8438811692		8433522165		0:45		1	
470	05/18/14 21:22:31	8438811692		8438846703		1:03		1	
471	05/19/14 23:16:28	9102315453		8438811692		14:33	6963	119	
472	05/20/14 00:52:08	8433274773	7034007008	8438811692		18:58	9	66	
473	05/20/14 14:28:49	8438846703		8438811692		1:52		1	
474	05/20/14 19:19:48	8438811692		8438846703		2:16		1	
475	05/21/14 15:10:58	8438811692		8438491101		0:37		1	
476	05/21/14 17:31:30	8436066199		8438811692		0:07	9	720	
477	05/22/14 14:20:19	8438811692		8438846703		7:18		1	
478	05/22/14 21:44:59	8438846703		8438811692		2:26		1	
479	05/22/14 22:57:18	8438811692		8433522165		0:45		1	
480	05/22/14 22:58:55	8438811692		8433522165		0:23		1	
481	05/23/14 14:30:05	8438811692		8438491101		6:28		1	
482	05/23/14 15:25:03	8438498604		8438811692		0:24	6233	119	
483	05/23/14 15:26:12	8438811692		8438498604		1:22		1	
484	05/23/14 16:44:53	8433274773	7034007008	8438811692		0:23	9	66	
485	05/23/14 19:00:33	4075191035		8438811692		0:09	288	119	
486	05/23/14 19:00:39	4075191035		8438811692		0:09	9054	343	
487	05/23/14 19:00:40	563523	4075191035	8438811692		0:09	9020	827	701
488	05/23/14 23:57:54	8433274773	7034007008	8438811692		18:32	9	66	
489	05/24/14 13:51:12	8438811692		8438846703		2:13		1	
490	05/24/14 14:18:26	8438811692		8433522165		0:36		1	
491	05/24/14 16:13:32	8438811692		8438846703		0:11		1	
492	05/24/14 16:22:02	9102315453		8438811692		9:44	6963	119	
493	05/25/14 16:33:15	8438811692		8438846703		0:15		1	
494	05/25/14 16:52:32	8438846703		8438811692		0:17		1	

ROA 1446

WIRELINE

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:27:21
Voice Usage For: (843)881-1692

Item	ConnDateTime (UTC)	Originating Number	Sec. Orig.	Terminating Number	Dialed Number	Elapsed Time	CIC	Call Code	Orig. Acc.
495	05/25/14 23:08:24	7035367008		8438811692		6:00	6963	119	
496	05/25/14 23:45:30	8438811692		8438499539		0:30		1	
497	05/26/14 14:32:07	8438811692		8436155030		0:33	377	110	
498	05/26/14 14:32:12	8438811692		8436155030		0:35	377	119	
499	05/26/14 14:32:19	8438811692		8436155030		0:35	377	60	
500	05/26/14 14:35:40	8438811692	18438811692	8435882831		0:00	9	119	
501	05/26/14 16:06:09	8433274773	8436155030	8438811692		0:02	9	66	
502	05/26/14 18:54:37	8433750997		8438811692		0:06	9	66	
503	05/26/14 18:56:06	8438811692		8438845735		0:39		1	
504	05/27/14 00:41:26	9102315453		8438811692		0:18	555	119	
505	05/27/14 00:44:21	8433274773	8432761816	8438811692		0:14	9	66	
506	05/27/14 01:22:51	8433274773	8432761816	8438811692		1:56	9	66	
507	05/27/14 01:25:23	8433274773	8432761816	8438811692		0:09	9	66	
508	05/27/14 01:28:15	8433274773	8432761816	8438811692		0:30	9	66	
509	05/27/14 01:29:45	8433274773	8432761816	8438811692		0:40	9	66	
510	05/27/14 02:19:13	8433274773	8432761816	8438811692		0:24	9	66	
511	05/27/14 19:42:36	8433274773	8432761816	8438811692		0:07	9	66	
512	05/27/14 20:27:56	8433274773	8432761816	8438811692		0:07	9	66	
513	05/27/14 23:43:52	8438811692		8438811755		0:44		1	
514	05/29/14 21:46:05	8438846703		8438811692		0:52		1	
515	05/29/14 22:55:18	7243001380		8438811692		0:05	288	119	
516	05/29/14 22:55:24	7243001380		8438811692		0:05	9053	343	
517	05/29/14 22:55:25	1242959	7243001380	8438811692		0:05	9020	827	789
518	05/29/14 23:40:59	8436197328		8438811692		0:35	288	119	
519	05/29/14 23:41:05	8436197328		8438811692		0:36	9053	343	
520	05/29/14 23:41:06	711391	8436197328	8438811692		0:36	9020	827	823
521	05/30/14 00:41:29	8438811692		8433522165		2:28		1	
522	05/30/14 00:46:19	8438811692		8438844435		1:30		1	
523	05/30/14 02:22:09	8436410002		8438811692		1:06	9	720	
524	05/30/14 13:02:55	8438811692		8438566004		0:35		1	
525	05/30/14 14:17:34	8438811692		8438846703		0:36		1	
526	05/31/14 16:47:09	8433750997		8438811692		0:19	9	66	
527	05/31/14 21:21:25	8438811692		8438848281		0:49		1	
528	05/31/14 21:24:11	8438811692		8438848281		5:37		1	
529	06/01/14 00:06:32	9102315453		8438811692		0:15	6963	119	
530	06/01/14 00:12:32	8433274773	8432761816	8438811692		0:08	9	66	
531	06/01/14 16:40:26	8438811692		8438846703		0:23		1	
532	06/01/14 19:17:55	9102315453		8438811692		9:13	6963	119	

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ROA 1447

ATT Subpoena 016

020

WIRELINE

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:27:21
Voice Usage For: (843)881-1692

Item	ConnDateTime (UTC)	Originating Number	Sec. Orig.	Terminating Number	Dialed Number	Elapsed Time	CIC	Call Code	Orig. Acc.
533	06/01/14 19:28:53	8438811692		8438848281		3:05		1	
534	06/01/14 19:46:34	8438811692		8438848281		0:35		1	
535	06/01/14 19:49:17	8438811692		8438848281		2:17		1	
536	06/01/14 23:56:31	8436410002		8438811692		1:30	9	720	
537	06/02/14 12:34:58	8645997819		8438811692		0:36	288	119	
538	06/02/14 12:35:04	711391	8645997819	8438811692		0:36	9020	827	823
539	06/02/14 12:35:04	8645997819		8438811692		0:36	9054	343	
540	06/02/14 17:23:14	8436066199		8438811692		0:03	9	720	
541	06/02/14 21:02:29	7243001380		8438811692		0:11	288	119	
542	06/02/14 21:02:36	1686175	7243001380	8438811692		0:11	9020	827	775
543	06/02/14 22:56:25	7243001380		8438811692		0:05	288	119	
544	06/02/14 22:56:32	1242959	7243001380	8438811692		0:05	9020	827	789
545	06/02/14 22:56:32	7243001380		8438811692		0:05	9053	343	
546	06/03/14 15:27:26	7035367008		8438811692		0:28	6963	119	
547	06/03/14 17:21:36	8438810465		8438811692		0:32		1	
548	06/03/14 20:43:29	8434122730	8432701399	8438811692		0:42	9	66	
549	06/03/14 23:13:03	7243001380		8438811692		0:08	288	119	
550	06/03/14 23:13:10	1242959	7243001380	8438811692		0:08	9020	827	789
551	06/03/14 23:13:10	7243001380		8438811692		0:08	9053	343	
552	06/03/14 23:40:44	7035367008		8438811692		0:18	6963	119	
553	06/04/14 21:50:26	8036320918		8438811692		0:06	288	119	
554	06/04/14 21:50:32	342182	8036320918	8438811692		0:06	9020	827	844
555	06/04/14 21:50:32	8036320918		8438811692		0:06	9054	343	
556	06/04/14 22:27:56	8433750997		8438811692		0:07	9	66	
557	06/04/14 23:03:50	8036320918		8438811692		0:11	288	119	
558	06/04/14 23:03:56	1709428	8036320918	8438811692		0:11	9020	827	844
559	06/04/14 23:03:56	8036320918		8438811692		0:11	9053	343	
560	06/04/14 23:45:44	8433750997		8438811692		0:21	9	66	
561	06/05/14 00:00:14	8036320918		8438811692		0:05	288	119	
562	06/05/14 00:00:20	342182	8036320918	8438811692		0:05	9020	827	844
563	06/05/14 00:00:20	8036320918		8438811692		0:05	9054	343	
564	06/05/14 22:56:47	8436066199		8438811692		0:11	9	720	
565	06/05/14 23:54:23	7035367008		8438811692		0:18	6963	119	
566	06/06/14 13:27:40	8433750997		8438811692		0:03	9	66	
567	06/06/14 13:47:00	8433750997		8438811692		0:13	9	66	
568	06/06/14 15:06:48			8438811692		0:01	288	119	
569	06/06/14 15:06:54	6820000000		8438811692		0:01	9054	343	
570	06/06/14 15:06:55	627119		8438811692		0:01	913	827	859

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ROA 1448

WIRELINE

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:27:21
Voice Usage For: (843)881-1692

Item	ConnDateTime (UTC)	Originating Number	Sec. Orig.	Terminating Number	Dialed Number	Elapsed Time	CIC	Call Code	Orig. Acc.
571	06/06/14 18:45:48	8017155504		8438811692		0:01	288	119	
572	06/06/14 18:45:55	1709428	8017155504	8438811692		0:01	9020	827	844
573	06/06/14 22:38:26	8433750997		8438811692		0:05	9	66	
574	06/07/14 00:00:27	7035367008		8438811692		0:17	6963	119	
575	06/07/14 00:09:47	8433274773	8432761816	8438811692		0:00	9	66	
576	06/07/14 00:10:08	8433274773	8432761816	8438811692		0:00	9	66	
577	06/09/14 16:22:53	8034038407		8438811692		0:02	555	119	
578	06/09/14 18:32:22	8036320918		8438811692		1:00	288	119	
579	06/09/14 18:32:29	1289729	8036320918	8438811692		1:00	9020	827	789
580	06/10/14 18:20:03	5184179721		8438811692		0:43	288	119	
581	06/10/14 18:20:09	5184179721		8438811692		0:43	9054	343	
582	06/10/14 18:20:09	706342	5184179721	8438811692		0:43	9020	827	841
583	06/11/14 13:04:40	8438845140		8438811692		0:04		1	
584	06/11/14 15:03:09	8433750997		8438811692		0:36	9	66	
585	06/11/14 15:12:25	8433750997		8438811692		0:47	9	66	
586	06/12/14 21:42:35	8436066199		8438811692		1:34	9	720	
587	06/13/14 16:40:30	8433274773	8438178060	8438811692		0:00	9	66	
588	06/13/14 16:43:43	8433274773	8438178060	8438811692		0:29	9	66	
589	06/14/14 13:24:02	8433274773	8436155030	8438811692		0:00	9	66	
590	06/14/14 17:22:13	8436410002		8438811692		0:22	9	720	
591	06/17/14 12:31:48	8433274773	8436155030	8438811692		0:00	9	66	
592	06/17/14 14:15:32	8433274773	8436155030	8438811692		0:00	9	66	
593	06/20/14 15:43:10	8004180507		8438811692		0:03	288	119	
594	06/20/14 15:43:17	623134	8004180507	8438811692		0:04	9020	827	705
595	06/20/14 15:43:17	8004180507		8438811692		0:04	9054	343	
596	06/21/14 16:28:32	8438848281		8438811692		0:25	288	119	
597	06/21/14 16:28:41	8438848281		8438811692		0:25		129	
598	06/22/14 14:42:32	8438848281		8438811692		0:02	288	119	
599	06/22/14 14:42:41	8438848281		8438811692		0:03		129	
600	06/22/14 20:22:39	8438848281		8438811692		0:00		129	
601	06/23/14 00:18:21	8435017111		8438811692		0:00	9	66	
602	06/23/14 00:18:27	8432167189		8438811692		0:00	9	110	
603	06/23/14 13:21:17	8004180507		8438811692		0:04	288	119	
604	06/23/14 13:21:23	8004180507		8438811692		0:05	9053	343	
605	06/23/14 13:21:24	1432537	8004180507	8438811692		0:05	9020	827	797
606	06/23/14 15:15:28	8036320918		8438811692		1:02	288	119	
607	06/23/14 15:15:38	342204	8036320918	8438811692		1:03	9020	827	841
608	06/24/14 14:09:52	8434122730	7703557529	8438811692		0:44	9	66	

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ATT Subpoena 018

ROA 1449

WIRELINE

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:27:21
Voice Usage For: (843)881-1692

Item	ConnDateTime (UTC)	Originating Number	Sec. Orig.	Terminating Number	Dialed Number	Elapsed Time	CIC	Call Code	Orig. Acc.
609	06/24/14 14:11:34	8434122730	7703557529	8438811692		0:51	9	66	
610	06/24/14 19:52:20	1600468	8432071131	8438811692		0:00	9020	827	837
611	06/24/14 19:52:21	8432071131		8438811692		0:00	9053	343	
612	06/24/14 19:52:28	1621913	8432071131	8438811692		0:00	9020	827	779
613	06/25/14 13:11:21	8004180507		8438811692		0:03	288	119	
614	06/25/14 13:11:27	8004180507		8438811692		0:04	9053	343	
615	06/25/14 13:11:28	1706945	8004180507	8438811692		0:04	9020	827	797
616	06/25/14 23:01:53	8433274773	8438178060	8438811692		0:00	9	66	
617	06/25/14 23:02:39	8433274773	8438178060	8438811692		0:05	9	66	
618	06/27/14 13:32:10	8004180507		8438811692		0:02	288	119	
619	06/27/14 13:32:19	1706950	8004180507	8438811692		0:02	9020	827	797
620	06/28/14 16:34:24	2126621312		8438811692		0:00	9053	343	
621	06/28/14 16:34:44	1626176	2126621312	8438811692		0:00	9020	827	858
622	06/28/14 19:27:05	7862190825		8438811692		0:00	9054	343	
623	06/28/14 19:27:29	342204	7862190825	8438811692		0:00	9020	827	841
624	06/30/14 13:35:07	8433274773	8438178060	8438811692		0:09	9	66	
625	06/30/14 15:35:38	8438836183		8438811692		0:03	288	119	
626	06/30/14 15:35:45	625377	8438836183	8438811692		0:03	9020	827	705
627	06/30/14 15:35:45	8438836183		8438811692		0:03	9054	343	
628	06/30/14 17:40:29	8433274773	8438178060	8438811692		0:04	9	66	
629	06/30/14 17:48:27	8433274773	8438178060	8438811692		0:00	9	66	
630	06/30/14 20:31:38	8436066199		8438811692		1:37	9	720	
631	06/30/14 21:14:20	8004180507		8438811692		0:00	9053	343	
632	06/30/14 21:14:41	1706947	8004180507	8438811692		0:00	9020	827	797
633	07/01/14 15:16:45	1626178	5162203819	8438811692		0:00	9020	827	858
634	07/03/14 15:38:24	8433274773	8438178060	8438811692		0:00	9	66	
635	07/03/14 15:39:15	8433274773	8438178060	8438811692		0:00	9	66	
636	07/03/14 16:01:05	8433274773	8438178060	8438811692		0:07	9	66	
637	07/08/14 12:24:45	8433274773	8438178060	8438811692		0:13	9	66	
638	07/08/14 13:00:57	8433274773	8438178060	8438811692		0:00	9	66	
639	07/08/14 13:27:32	8433274773	8438178060	8438811692		0:00	9	66	
640	07/08/14 19:19:07	5184179721		8438811692		0:43	288	119	
641	07/08/14 19:19:13	5184179721		8438811692		0:43	9053	343	
642	07/08/14 19:19:14	1489796	5184179721	8438811692		0:43	9020	827	785
643	07/10/14 21:38:54	8436066199		8438811692		1:33	9	720	
644	07/15/14 18:17:15	8436067398		8438811692		0:22		1	
645	07/15/14 19:12:07	8436067641		8438811692		0:26		1	
646	07/16/14 14:18:08	1626176	2126625932	8438811692		0:00	9020	827	858

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ATT Subpoena 019

ROA 1450

WIRELINE

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:27:21
Voice Usage For: (843)881-1692

Item	ConnDateTime (UTC)	Originating Number	Sec. Orig.	Terminating Number	Dialed Number	Elapsed Time	CIC	Call Code	Orig. Acc.
647	07/18/14 15:30:52	1432537	4072785976	8438811692		0:00	9020	827	797
648	07/18/14 16:37:13	8436067642		8438811692		0:17		1	
649	07/18/14 18:52:38	7186224571		8438811692		0:12	288	119	
650	07/18/14 18:52:44	7186224571		8438811692		0:12	9054	343	
651	07/18/14 18:52:45	709631	7186224571	8438811692		0:12	9020	827	848
652	07/19/14 21:42:20	8438848281		8438811692		0:00		129	
653	07/21/14 13:55:57	8436066199		8438811692		0:30	9	720	
654	07/21/14 19:26:00	2126625375		8438811692		0:00	9053	343	
655	07/21/14 19:26:19	1620994	2126625375	8438811692		0:00	9020	827	789
656	07/21/14 19:35:25	3109334889		8438811692		0:11	288	119	
657	07/21/14 19:35:35	686175	3109334889	8438811692		0:11	9020	827	775
658	07/21/14 22:37:28	7702174678		8438811692		0:58	288	119	
659	07/21/14 22:37:34	7702174678		8438811692		0:58	9053	343	
660	07/21/14 22:37:35	1432537	7702174678	8438811692		0:58	9020	827	797
661	07/22/14 12:51:39	8433274773	8438178060	8438811692		0:02	9	66	
662	07/22/14 13:19:48	8433274773	8438178060	8438811692		0:00	9	66	
663	07/22/14 14:54:21	289858	4072785976	8438811692		0:00	9020	827	845
664	07/22/14 15:27:30	565805	5164351935	8438811692		0:00	9020	827	873
665	07/23/14 13:48:14	8438135571	8438178060	8438811692		0:13	9	66	
666	07/23/14 17:58:26	8433750997		8438811692		0:21	9	66	
667	07/24/14 13:11:53	8434122730	8033315657	8438811692		0:21	9	66	
668	07/25/14 20:06:48	8438836183		8438811692		0:04	288	119	
669	07/25/14 20:06:54	1486220	8438836183	8438811692		0:05	9020	827	772
670	07/25/14 20:06:54	8438836183		8438811692		0:05	9053	343	
671	07/28/14 15:00:32	1608474	8432071183	8438811692		0:00	9020	827	789
672	07/28/14 22:12:06	4804203576		8438811692		0:08	288	119	
673	07/28/14 22:12:12	4804203576		8438811692		0:09	9053	343	
674	07/28/14 22:12:13	1709428	4804203576	8438811692		0:09	9020	827	844
675	07/29/14 19:04:19	8436410002		8438811692		0:29	9	720	
676	07/30/14 16:50:10	4072785976		8438811692		0:00	9053	343	
677	07/30/14 16:50:34	1365150	4072785976	8438811692		0:00	9020	827	789
678	07/30/14 19:20:01	6067550236		8438811692		0:00	9054	343	
679	07/30/14 19:20:35	711391	6067550236	8438811692		0:00	9020	827	823
680	07/31/14 13:07:42	8882117690		8438811692		1:55	288	119	
681	07/31/14 13:07:50	5970460000	8882117690	8438811692		1:56		129	

ROA 1451

2460004
04/24/2018

MOBILITY

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:26:17
Voice Usage For: (843)276-1816

Item	Conn. Date	Conn. Time (UTC)	Seizure Time	ET	Originating Number	Terminating Number	IMEI	IMSI	CT	Feature
1	04/04/14	10:14:37	0:01	0:16	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
2	04/04/14	16:55:09	0:00	0:03	18432761816 17047789988(F)	17047789988		310410465449899	MO	[CFNR:VM]
3	04/04/14	16:55:09	0:01	0:03	18647080202 17047789988(F)	18432761816		310410465449899	MT	[CFNR:VM]
4	04/04/14	21:47:08	0:00	0:27	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
5	04/05/14	23:41:28	0:00	0:16	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
6	04/05/14	23:43:22	0:00	0:14	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
7	04/05/14	23:43:47	0:00	0:04	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
8	04/05/14	23:44:03	0:00	0:15	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
9	04/05/14	23:44:27	0:00	0:22	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
10	04/08/14	20:20:24	0:01	0:17	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
11	04/11/14	00:10:04	0:01	0:09	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
12	04/11/14	00:10:37	0:00	0:15	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
13	04/11/14	00:11:01	0:00	0:17	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
14	04/11/14	21:30:05	0:00	0:27	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
15	04/13/14	00:36:27	0:01	0:17	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]

ROA 1452

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MOBILITY

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:26:17
Voice Usage For: (843)276-1816

Item	Conn. Date	Conn. Time (UTC)	Seizure Time	ET	Originating Number	Terminating Number	IMEI	IMSI	CT	Feature
16	04/13/14	00:37:32	0:22	0:15	18432761816	18438811692	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
17	04/13/14	23:27:03	0:00	0:14	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
18	04/14/14	14:46:40	0:22	0:12	18432761816	18438811692	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
19	04/14/14	15:07:23	0:01	0:03	18432761816 17047789988(F)	17047789988		310410465449899	MO	[CFNR:VM]
20	04/14/14	15:07:23	0:01	0:03	18647080202 17047789988(F)	18432761816		310410465449899	MT	[CFNR:VM]
21	04/15/14	20:29:33	0:00	0:33	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
22	04/15/14	22:55:01	0:00	0:04	18432761816 17047789988(F)	17047789988		310410465449899	MO	[CFNR:VM]
23	04/15/14	22:55:01	0:01	0:04	19102315453 17047789988(F)	18432761816		310410465449899	MT	[CFNR:VM]
24	04/17/14	12:48:42	0:01	0:15	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
25	04/17/14	15:15:11	0:00	0:56	18432761816 17047789988(F)	17047789988		310410465449899	MO	[CFNR:VM]
26	04/17/14	15:15:11	0:01	0:56	18436971688 17047789988(F)	18432761816		310410465449899	MT	[CFNR:VM]
27	04/17/14	15:15:11	0:01	0:57	18436971688	18432761816			MO	[NIOR]
28	04/18/14	17:35:02	0:00	0:03	18432761816 17047789988(F)	17047789988		310410465449899	MO	[CFNR:VM]
29	04/18/14	17:35:02	0:01	0:03	18647080202 17047789988(F)	18432761816		310410465449899	MT	[CFNR:VM]
30	04/19/14	15:09:10	0:01	1:04	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
31	04/20/14	23:11:40	0:16	9:40	18432761816	18033316342	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
32	04/20/14	23:27:51	0:00	0:28	18432761816 17047789988(F)	17047789988		310410465449899	MO	[CFNR:VM]
33	04/20/14	23:27:51	0:01	0:28	18033311572 17047789988(F)	18432761816		310410465449899	MT	[CFNR:VM]

ROA 1453

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MOBILITY

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:26:17
Voice Usage For: (843)276-1816

Item	Conn. Date	Conn. Time (UTC)	Seizure Time	ET	Originating Number	Terminating Number	IMEI	IMSI	CT	Feature
34	04/23/14	14:24:37	0:01	0:34	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
35	04/23/14	18:48:37	0:00	0:08	18033316342 17047789988(F)	18432761816		310410465449899	MT	[CFNR:VM]
36	04/23/14	18:48:37	0:00	0:08	18432761816 17047789988(F)	17047789988		310410465449899	MO	[CFNR:VM]
37	04/30/14	00:11:46	0:01	0:19	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
38	05/01/14	13:54:24	0:00	0:03	18432761816 17047789988(F)	17047789988		310410465449899	MO	[CFNR:VM]
39	05/01/14	13:54:24	0:01	0:03	18647080202 17047789988(F)	18432761816		310410465449899	MT	[CFNR:VM]
40	05/02/14	16:19:42	0:01	0:44	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
41	05/02/14	16:21:02	0:07	0:00	18438811692	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP]
42	05/02/14	17:02:39	0:10	0:53	18438845101	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP]
43	05/02/14	17:16:20	0:07	1:06	18438841777	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP]
44	05/02/14	23:25:08	0:00	0:36	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
45	05/11/14	14:30:36	0:01	0:21	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
46	05/11/14	14:46:27	0:21	0:30	18432761816 19802539037(F)	18438195189			MT	[NIOP:CFNA:VM]
47	05/11/14	14:46:27	0:23	0:30	18432761816	18438195189	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
48	05/12/14	14:05:41	0:22	0:19	18432761816	18438811692	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
49	05/12/14	14:46:02	0:12	0:07	18432761816	18438811692	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]

ROA 1454

MOBILITY

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:26:17
Voice Usage For: (843)276-1816

Item	Conn. Date	Conn. Time (UTC)	Seizure Time	ET	Originating Number	Terminating Number	IMEI	IMSI	CT	Feature
50	05/13/14	00:01:38	0:11	0:00	18432761816	18438811692	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
51	05/13/14	00:03:52	0:19	0:00	18432761816	18438811692	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
52	05/13/14	00:06:30	0:11	0:13	18432761816	18438811692	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
53	05/13/14	00:11:14	0:11	0:17	18432761816	18438811692	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
54	05/13/14	00:12:04	0:11	0:20	18432761816	18438811692	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
55	05/13/14	00:16:36	0:23	0:16	18432761816	18438811692	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
56	05/13/14	00:35:52	0:23	0:12	18432761816	18438811692	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
57	05/13/14	15:01:04	0:01	0:04	18033316342 17047789988(F)	18432761816		310410465449899	MT	[CFNR:VM]
58	05/13/14	15:01:04	0:01	0:04	18432761816 17047789988(F)	17047789988		310410465449899	MO	[CFNR:VM]
59	05/13/14	19:33:40	0:00	0:22	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
60	05/13/14	19:35:10	0:10	0:00	18432761816	18438811692	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
61	05/13/14	19:35:49	0:00	0:31	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
62	05/13/14	20:14:42	0:00	0:14	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
63	05/22/14	13:24:57	0:31	0:36	18432761816	18033315657	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
64	05/22/14	22:33:06	0:01	0:17	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]

ROA 1455

MOBILITY

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:26:17
Voice Usage For: (843)276-1816

Item	Conn. Date	Conn. Time (UTC)	Seizure Time	ET	Originating Number	Terminating Number	IMEI	IMSI	CT	Feature
65	05/24/14	02:22:38	0:01	0:21	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
66	05/27/14	00:44:28	0:11	0:15	18432761816	18438811692	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
67	05/27/14	00:54:37	0:01	0:16	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
68	05/27/14	01:22:58	0:07	1:57	18432761816	18438811692	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
69	05/27/14	01:25:30	0:11	0:10	18432761816	18438811692	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
70	05/27/14	01:28:22	0:10	0:32	18432761816	18438811692	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
71	05/27/14	01:29:52	0:11	0:42	18432761816	18438811692	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
72	05/27/14	02:18:18	0:09	0:00	18432761816	18428811692	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
73	05/27/14	02:19:20	0:11	0:25	18432761816	18438811692	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
74	05/27/14	19:42:43	0:22	0:08	18432761816	18438811692	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
75	05/27/14	20:28:03	0:24	0:08	18432761816	18438811692	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
76	06/01/14	00:12:38	0:22	0:09	18432761816	18438811692	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
77	06/01/14	00:29:10	0:01	0:15	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
78	06/07/14	00:09:50	0:04	0:00	18432761816	18438811692	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]

ROA 1456

AT&T Proprietary

fm

The information contained here is for use by authorized persons only and is not for general distribution.

MOBILITY

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:26:17
Voice Usage For: (843)276-1816

Item	Conn. Date	Conn. Time (UTC)	Seizure Time	ET	Originating Number	Terminating Number	IMEI	IMSI	CT	Feature
79	06/07/14	00:10:11	0:04	0:00	18432761816	18438811692	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
80	06/07/14	00:12:46	0:31	0:07	18432761816	18033316342	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
81	06/07/14	00:14:07	0:00	0:00	18432761816 911(D)	18437437034	0126990072888004 PANTECH P2030	310410465449899	MO	[]
82	06/07/14	00:14:27	0:13	0:00	18437437200	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP]
83	06/07/14	00:14:45	0:04	0:00	18432761816	18437437200	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
84	06/07/14	00:17:13	0:25	0:06	18432761816	18033316342	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
85	06/07/14	00:30:51	0:07	2:00	18432761816	18033316342	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
86	06/07/14	03:52:07	0:21	0:19	18432761816 19802539037(F)	18436971688			MT	[NIOP:CFNA:VM]
87	06/07/14	03:52:07	0:23	0:19	18432761816	18436971688	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
88	06/08/14	14:38:03	0:20	0:00	17034007008 17047789988(F)	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP:CFNA:VM]
89	06/08/14	14:38:24	0:27	0:10	17034007008	18432761816			MO	[]
90	06/11/14	23:58:08	0:01	0:03	18432761816 17047789988(F)	17047789988		310410465449899	MO	[CFNA:VM]
91	06/11/14	23:58:08	0:21	0:03	18432761413 17047789988(F)	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[INIOR:CFNA:VM]
92	06/11/14	23:58:08	0:23	0:03	18432761413 A678432761816(D)	18432761816			MO	[NIOR]
93	06/15/14	14:15:31	0:03	0:04	17034007008	18432761816			MO	[]
94	06/21/14	15:23:55	0:01	0:22	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
95	06/23/14	12:48:06	0:21	0:55	18432761816 19802539037(F)	18436971688			MT	[NIOP:CFNA:VM]

ROA 1457

MOBILITY

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:26:17
Voice Usage For: (843)276-1816

Item	Conn. Date	Conn. Time (UTC)	Seizure Time	ET	Originating Number	Terminating Number	IMEI	IMSI	CT	Feature
96	06/23/14	12:48:06	0:23	0:55	18432761816	18436971688	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
97	06/23/14	12:51:37	0:11	0:23	18436971688	18432761816			MO	[NIOR]
98	06/23/14	12:51:37	0:08	0:23	18436971688	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP]
99	06/23/14	14:26:04	0:00	0:19	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
100	06/24/14	13:54:44	0:00	0:11	18432761816 17047789988(F)	17047789988		310410465449899	MO	[CFNA:VM]
101	06/24/14	13:54:44	0:20	0:11	18647080202 17047789988(F)	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP:CFNA:VM]
102	06/24/14	14:19:45	0:00	0:41	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
103	06/24/14	16:12:37	0:00	1:02	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
104	06/25/14	13:03:30	0:13	1:14	18432761816	18436971688			MT	[NIOP]
105	06/25/14	13:03:30	0:16	1:14	18432761816	18436971688	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
106	06/25/14	17:39:25	0:18	0:00	18432761816	3	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
107	06/25/14	18:41:08	0:22	0:39	18432761816 19802539037(F)	18436971688			MT	[NIOP:CFNA:CMW:VM]
108	06/25/14	18:41:08	0:22	0:39	18432761816	18436971688	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
109	06/25/14	18:51:46	0:10	0:12	18436971688	18432761816			MO	[NIOR]
110	06/25/14	18:51:46	0:07	0:12	18436971688	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP]
111	06/27/14	16:51:08	0:00	0:08	18432761816 17047789988(F)	17047789988		310410465449899	MO	[CFNR:VM]
112	06/27/14	16:51:08	0:00	0:08	18436971688	18432761816			MO	[NIOR]
113	06/27/14	16:51:08	0:01	0:08	18436971688 17047789988(F)	18432761816		310410465449899	MT	[CFNR:VM]

ROA 1458

MOBILITY

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:26:17
Voice Usage For: (843)276-1816

Item	Conn. Date	Conn. Time (UTC)	Seizure Time	ET	Originating Number	Terminating Number	IMEI	IMSI	CT	Feature
114	06/27/14	23:39:39	0:00	0:30	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
115	06/28/14	13:57:45	1:11	0:00	18432761816	18435882831	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
116	06/28/14	14:05:12	0:01	0:43	18432761816 19802539037(F)	18436971688			MT	[CFNR:VM]
117	06/28/14	14:05:12	0:01	0:43	18432761816	18436971688	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
118	06/28/14	14:48:30	0:36	0:00	18432761816 1843697(D)	18431843697	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
119	06/28/14	14:54:08	0:15	0:23	18432761816	18033316342	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
120	06/28/14	15:17:45	0:00	0:28	18432761816 19802539037(F)	18436971688			MT	[CFNR:VM]
121	06/28/14	15:17:45	0:01	0:28	18432761816	18436971688	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
122	06/28/14	15:21:51	0:08	3:16	18432761816	18033316342	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
123	06/30/14	11:49:10	0:17	0:00	18432761816	184369711699	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
124	06/30/14	11:49:57	0:12	0:00	18432761816 6971699(D)	18436971699	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
125	06/30/14	11:51:23	0:07	0:00	18432761816	84369746991	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
126	06/30/14	12:47:43	0:13	0:00	18432761816	18041111	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
127	06/30/14	12:49:51	0:20	0:46	18432761816 19802539037(F)	18436971688			MT	[NIOP:CFNA:VM]
128	06/30/14	12:49:51	0:24	0:46	18432761816	18436971688	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]

ROA 1459

MOBILITY

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:26:17
Voice Usage For: (843)276-1816

Item	Conn. Date	Conn. Time (UTC)	Seizure Time	ET	Originating Number	Terminating Number	IMEI	IMSI	CT	Feature
129	06/30/14	13:36:00	0:00	0:01	18432761816 17047789988(F)	17047789988		310410465449899	MO	[CFNA:VM]
130	06/30/14	13:36:00	0:21	0:01	18438178060 17047789988(F)	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP:CFNA:VM]
131	06/30/14	13:36:00	0:23	0:01	18438178060	18432761816			MO	[NIOR]
132	06/30/14	13:46:34	0:12	5:09	18432761816	18436971688	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
133	06/30/14	13:46:34	0:09	5:09	18432761816	18436971688			MT	[NIOP]
134	06/30/14	17:48:59	0:16	5:28	18438178060	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP]
135	06/30/14	17:48:59	0:19	5:28	18438178060	18432761816			MO	[NIOR]
136	07/02/14	16:40:12	0:01	0:38	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
137	07/03/14	16:18:13	0:01	0:02	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
138	07/03/14	17:14:48	0:12	0:35	18436971688	18432761816			MO	[NIOR]
139	07/03/14	17:14:48	0:09	0:35	18436971688	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP]
140	07/03/14	20:22:16	0:01	0:43	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
141	07/03/14	20:26:22	0:21	0:11	18432761816 19802539037(F)	18436971688			MT	[NIOP:CFNA:VM]
142	07/03/14	20:26:22	0:23	0:11	18432761816	18436971688	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
143	07/06/14	17:35:11	0:18	0:00	18432761816	4	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
144	07/07/14	00:33:46	0:19	0:00	18432761816	4	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
145	07/07/14	00:42:54	0:17	0:00	18432761816	4	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
146	07/07/14	01:10:25	0:21	2:27	18432761816 17047789988(F)	18033316343			MT	[NIOP:CFNA:VM]

ROA 1460

MOBILITY

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:26:17
Voice Usage For: (843)276-1816

Item	Conn. Date	Conn. Time (UTC)	Seizure Time	ET	Originating Number	Terminating Number	IMEI	IMSI	CT	Feature
147	07/07/14	01:10:25	0:24	2:27	18432761816	18033316343	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
148	07/07/14	01:13:42	0:18	1:12	18432761816	18033316342	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
149	07/07/14	01:25:16	0:18	0:00	18432761816	1803331632	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
150	07/07/14	12:49:30	0:00	0:00	18436971688	18432761816		310410465449899	MT	[]
151	07/07/14	12:49:30	0:01	0:00	18436971688	18432761816			MO	[NIOR]
152	07/07/14	15:59:54	0:16	0:04	18647080202	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP]
153	07/07/14	16:00:41	0:10	2:17	18436971688	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP]
154	07/07/14	16:00:41	0:13	2:16	18436971688	18432761816			MO	[NIOR]
155	07/08/14	00:14:32	0:14	21:45	18432761816	18033316342	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
156	07/08/14	12:59:58	0:00	0:05	18432761816 17047789988(F)	17047789988		310410465449899	MO	[CFNA:VM]
157	07/08/14	12:59:58	0:20	0:05	18438178060 17047789988(F)	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP:CFNA:VM]
158	07/08/14	12:59:58	0:23	0:05	18438178060	18432761816			MO	[NIOR]
159	07/08/14	13:00:08	0:08	0:00	18438178060	18432761816			MO	[NIOR]
160	07/08/14	13:00:11	0:05	0:00	18438178060	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP]
161	07/08/14	13:01:36	0:01	0:04	18432761816 17047789988(F)	17047789988		310410465449899	MO	[CFNA:VM]
162	07/08/14	13:01:36	0:21	0:04	18438178060 17047789988(F)	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP:CFNA:VM]
163	07/08/14	13:01:36	0:24	0:04	18438178060	18432761816			MO	[NIOR]
164	07/08/14	13:02:13	0:01	0:02	18432761816 17047789988(F)	17047789988		310410465449899	MO	[CFNA:VM]
165	07/08/14	13:02:13	0:21	0:02	18438178060 17047789988(F)	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP:CFNA:VM]

ROA 1461

MOBILITY

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:26:17
Voice Usage For: (843)276-1816

Item	Conn. Date	Conn. Time (UTC)	Seizure Time	ET	Originating Number	Terminating Number	IMEI	IMSI	CT	Feature
166	07/08/14	13:02:13	0:24	0:02	18438178060	18432761816			MO	[NIOR]
167	07/08/14	13:10:07	0:14	0:21	18432761816	18438178060			MT	[NIOP]
168	07/08/14	13:10:07	0:17	0:21	18432761816	18438178060	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
169	07/08/14	13:11:04	0:12	0:15	18438178060 17047789988(F)	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP:CFB:VM]
170	07/08/14	13:11:04	0:14	0:15	18438178060	18432761816			MO	[NIOR]
171	07/08/14	13:11:04	0:01	0:15	18432761816 17047789988(F)	17047789988		310410465449899	MO	[CFB:VM]
172	07/08/14	13:11:38	0:10	2:12	18438178060	18432761816			MO	[NIOR]
173	07/08/14	13:11:38	0:07	2:12	18438178060	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP]
174	07/08/14	13:13:59	0:00	0:00	18438178060	18432761816		310410465449899	MT	[]
175	07/08/14	13:13:59	0:00	0:00	18438178060	18432761816			MO	[NIOR]
176	07/08/14	13:26:52	0:00	0:24	18432761816 17047789988(F)	17047789988		310410465449899	MO	[CFNA:VM]
177	07/08/14	13:26:52	0:20	0:24	18438178060 17047789988(F)	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP:CFNA:VM]
178	07/08/14	13:26:52	0:23	0:24	18438178060	18432761816			MO	[NIOR]
179	07/08/14	13:28:17	0:00	0:39	18432761816 17047789988(F)	17047789988		310410465449899	MO	[CFNA:VM]
180	07/08/14	13:28:17	0:21	0:39	18438178060 17047789988(F)	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP:CFNA:VM]
181	07/08/14	13:28:17	0:23	0:39	18438178060	18432761816			MO	[NIOR]
182	07/08/14	13:29:27	0:01	0:03	18432761816 17047789988(F)	17047789988		310410465449899	MO	[CFB:VM]
183	07/08/14	13:29:27	0:04	0:03	18438178060 17047789988(F)	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP:CFB:VM]
184	07/08/14	13:29:27	0:06	0:04	18438178060	18432761816			MO	[NIOR]
185	07/08/14	14:57:20	0:01	0:31	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
186	07/08/14	15:02:42	0:06	10:06	18432761816	18436155030			MT	[NIOP]

ROA 1462

MOBILITY

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:26:17
Voice Usage For: (843)276-1816

Item	Conn. Date	Conn. Time (UTC)	Seizure Time	ET	Originating Number	Terminating Number	IMEI	IMSI	CT	Feature
187	07/08/14	15:02:42	0:09	10:06	18432761816	18436155030	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
188	07/08/14	22:31:40	0:01	0:07	18432761816 17047789988(F)	17047789988		310410465449899	MO	[CFNA:VM]
189	07/08/14	22:31:40	0:21	0:07	18438178060 17047789988(F)	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP:CFNA:VM]
190	07/08/14	22:31:40	0:23	0:07	18438178060	18432761816			MO	[NIOR]
191	07/09/14	16:12:05	0:00	0:48	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
192	07/09/14	17:14:15	0:17	0:53	18438195189	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP]
193	07/09/14	17:14:15	0:21	0:53	18438195189	18432761816			MO	[NIOR]
194	07/09/14	22:20:36	0:21	0:10	18432761816 19802548961(F)	18438178060			MT	[NIOP:CFNA:VM]
195	07/09/14	22:20:36	0:25	0:10	18432761816	18438178060	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
196	07/10/14	11:44:22	0:12	0:41	18438178060	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP]
197	07/10/14	11:44:23	0:15	0:41	18438178060	18432761816			MO	[NIOR]
198	07/10/14	11:54:01	0:12	1:36	18432761816	18436971688			MT	[NIOP]
199	07/10/14	11:54:01	0:15	1:36	18432761816	18436971688	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
200	07/10/14	22:10:01	0:13	0:11	18432761816	18436951688	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
201	07/10/14	22:12:39	0:12	2:47	18432761816	18436971688	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
202	07/10/14	22:12:39	0:09	2:47	18432761816	18436971688			MT	[NIOP]
203	07/10/14	22:18:58	0:36	0:14	18432761816	18033316432	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
204	07/10/14	22:19:34	0:10	0:13	18033316432	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP]

ROA 1463

MOBILITY

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:26:17
Voice Usage For: (843)276-1816

Item	Conn. Date	Conn. Time (UTC)	Seizure Time	ET	Originating Number	Terminating Number	IMEI	IMSI	CT	Feature
205	07/10/14	22:26:41	0:27	0:00	18432761816	18033313264	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
206	07/11/14	12:11:55	0:21	0:43	18432761816 19802539037(F)	18436971688			MT	[NIOP:CFNA:VM]
207	07/11/14	12:11:55	0:24	0:43	18432761816	18436971688	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
208	07/11/14	13:47:21	0:03	0:00	18436971688	18432761816			MO	[NIOR]
209	07/11/14	13:47:24	0:00	0:00	18436971688	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP]
210	07/11/14	13:48:00	0:12	0:17	18436971688	18432761816			MO	[NIOR]
211	07/11/14	13:48:00	0:08	0:17	18436971688	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP]
212	07/11/14	14:33:21	0:14	0:36	18432761816	18436971688			MT	[NIOP]
213	07/11/14	14:33:21	0:17	0:36	18432761816	18436971688	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
214	07/11/14	18:26:11	0:16	1:56	18436971688	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP]
215	07/11/14	18:26:11	0:18	1:56	18436971688	18432761816			MO	[NIOR]
216	07/11/14	18:29:57	0:10	0:09	18436971688	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP]
217	07/11/14	18:29:57	0:13	0:09	18436971688	18432761816			MO	[NIOR]
218	07/11/14	22:58:01	0:11	1:07	18436971688	18432761816			MO	[NIOR]
219	07/11/14	22:58:01	0:08	1:07	18436971688	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP]
220	07/12/14	12:24:19	0:21	0:54	18432761816 19802539037(F)	18436971688			MT	[NIOP:CFNA:VM]
221	07/12/14	12:24:19	0:24	0:54	18432761816	18436971688	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
222	07/12/14	12:41:29	0:10	0:46	18432761816	18436971688	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
223	07/12/14	12:41:30	0:08	0:46	18432761816	18436971688			MT	[NIOP]

ROA 1464

MOBILITY

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:26:17
Voice Usage For: (843)276-1816

Item	Conn. Date	Conn. Time (UTC)	Seizure Time	ET	Originating Number	Terminating Number	IMEI	IMSI	CT	Feature
224	07/12/14	12:43:23	0:00	0:11	18432761816 17047789988(F)	17047789988		310410465449899	MO	[CFB:VM]
225	07/12/14	12:43:23	0:06	0:11	18436971688 17047789988(F)	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP:CFB:VM]
226	07/12/14	12:43:23	0:09	0:11	18436971688	18432761816			MO	[NIOR]
227	07/12/14	12:45:02	0:06	1:06	18436971688	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP]
228	07/12/14	12:45:02	0:09	1:06	18436971688	18432761816			MO	[NIOR]
229	07/12/14	13:17:45	0:13	0:17	18438178060	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP]
230	07/12/14	13:17:45	0:16	0:17	18438178060	18432761816			MO	[NIOR]
231	07/12/14	13:18:26	0:12	1:50	18438178060	18432761816			MO	[NIOR]
232	07/12/14	13:18:26	0:09	1:50	18438178060	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP]
233	07/12/14	13:22:06	0:06	1:02	18432761816	18436971688			MT	[NIOP]
234	07/12/14	13:22:06	0:09	1:02	18432761816	18436971688	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
235	07/13/14	12:10:22	0:18	0:00	18432761816	1436971688	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
236	07/13/14	12:12:21	0:21	1:39	18432761816 19802539037(F)	18436971688			MT	[NIOP:CFNA:VM]
237	07/13/14	12:12:21	0:24	1:39	18432761816	18436971688	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
238	07/13/14	22:28:06	0:14	0:10	18432761816	18033316432	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
239	07/13/14	22:30:32	0:12	4:33	18432761816	18033316342	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
240	07/14/14	11:57:28	0:10	2:15	18033316342	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP]
241	07/14/14	18:15:01	0:13	2:39	18432761816	18436971688	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]

ROA 1465

MOBILITY

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:26:17
Voice Usage For: (843)276-1816

Item	Conn. Date	Conn. Time (UTC)	Seizure Time	ET	Originating Number	Terminating Number	IMEI	IMSI	CT	Feature
242	07/14/14	18:15:01	0:09	2:39	18432761816	18436971688			MT	[NIOP]
243	07/16/14	01:21:17	0:01	0:04	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
244	07/18/14	14:34:33	0:01	0:03	18432761816 17047789988(F)	17047789988		310410465449899	MO	[CFNA:VM]
245	07/18/14	14:34:33	0:21	0:03	18436971688 17047789988(F)	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP:CFNA:VM]
246	07/18/14	14:34:33	0:24	0:03	18436971688	18432761816			MO	[NIOR]
247	07/19/14	00:01:00	0:01	0:20	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
248	07/19/14	12:44:22	0:13	0:33	18432761816	18436971688			MT	[NIOP]
249	07/19/14	12:44:23	0:17	0:33	18432761816	18436971688	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
250	07/19/14	13:38:29	0:12	0:58	18436971688	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP]
251	07/19/14	13:38:29	0:15	0:58	18436971688	18432761816			MO	[NIOR]
252	07/19/14	22:51:42	0:12	3:00	18432761816	18436971688	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
253	07/19/14	22:51:42	0:09	3:00	18432761816	18436971688			MT	[NIOP]
254	07/20/14	22:04:58	0:12	6:35	17034007008	18432761816			MO	[]
255	07/20/14	22:04:58	0:07	6:36	17034007008	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP]
256	07/22/14	12:52:09	0:00	0:02	18432761816 17047789988(F)	17047789988		310410465449899	MO	[CFNR:VM]
257	07/22/14	12:52:09	0:00	0:02	18438178060 17047789988(F)	18432761816		310410465449899	MT	[CFNR:VM]
258	07/22/14	12:52:09	0:01	0:02	18438178060	18432761816			MO	[NIOR]
259	07/22/14	12:52:19	0:01	0:29	18432761816 17047789988(F)	17047789988		310410465449899	MO	[CFNR:VM]
260	07/22/14	12:52:19	0:01	0:29	18438178060 17047789988(F)	18432761816		310410465449899	MT	[CFNR:VM]
261	07/22/14	12:52:19	0:01	0:29	18438178060	18432761816			MO	[NIOR]
262	07/22/14	13:00:50	0:01	0:05	18432761816 17047789988(F)	17047789988		310410465449899	MO	[CFNR:VM]

AT&T Proprietary

fm

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ATT Subpoena 035

ROA 1466

MOBILITY

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:26:17
Voice Usage For: (843)276-1816

Item	Conn. Date	Conn. Time (UTC)	Seizure Time	ET	Originating Number	Terminating Number	IMEI	IMSI	CT	Feature
263	07/22/14	13:00:50	0:01	0:05	18438178060 17047789988(F)	18432761816		310410465449899	MT	[CFNR:VM]
264	07/22/14	13:00:50	0:01	0:05	18438178060	18432761816			MO	[NIOR]
265	07/22/14	13:20:05	0:00	0:06	18432761816 17047789988(F)	17047789988		310410465449899	MO	[CFNR:VM]
266	07/22/14	13:20:05	0:01	0:06	18438178060 17047789988(F)	18432761816		310410465449899	MT	[CFNR:VM]
267	07/22/14	13:20:05	0:01	0:06	18438178060	18432761816			MO	[NIOR]
268	07/22/14	18:03:04	0:00	0:06	18432761816 17047789988(F)	17047789988		310410465449899	MO	[CFNR:VM]
269	07/22/14	18:03:04	0:01	0:06	18647080202 17047789988(F)	18432761816		310410465449899	MT	[CFNR:VM]
270	07/22/14	19:36:51	0:00	0:38	18432761816 17047789988(F)	17047789988		310410465449899	MO	[CFNR:VM]
271	07/22/14	19:36:51	0:00	0:38	18436971688 17047789988(F)	18432761816		310410465449899	MT	[CFNR:VM]
272	07/22/14	19:36:51	0:00	0:38	18436971688	18432761816			MO	[NIOR]
273	07/23/14	13:47:12	0:01	0:25	18432761816 17047789988(F)	17047789988		310410465449899	MO	[CFNR:VM]
274	07/23/14	13:47:12	0:01	0:25	18438178060 17047789988(F)	18432761816		310410465449899	MT	[CFNR:VM]
275	07/23/14	13:47:12	0:01	0:25	18438178060	18432761816			MO	[NIOR]
276	07/24/14	14:20:54	0:21	0:47	18432761816 19802539037(F)	18436971688			MT	[NIOP:CFNA:CMW:VM]
277	07/24/14	14:20:54	0:21	0:47	18432761816	18436971688	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
278	07/24/14	14:30:45	0:36	0:00	18432761816 6155030(D)	18436155030	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
279	07/24/14	14:33:18	0:10	1:33	18432761816	18436155030	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
280	07/24/14	14:33:18	0:07	1:33	18432761816	18436155030			MT	[NIOP]
281	07/24/14	14:57:31	0:01	0:38	18432761816 17047789988(F)	17047789988		310410465449899	MO	[CFNA:VM]
282	07/24/14	14:57:31	0:21	0:38	18436971688 17047789988(F)	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP:CFNA:VM]
283	07/24/14	14:57:31	0:24	0:38	18436971688	18432761816			MO	[NIOR]

ROA 1467

MOBILITY

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:26:17
Voice Usage For: (843)276-1816

Item	Conn. Date	Conn. Time (UTC)	Seizure Time	ET	Originating Number	Terminating Number	IMEI	IMSI	CT	Feature
284	07/24/14	15:59:02	0:01	0:17	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
285	07/24/14	16:00:58	0:12	0:37	18432761816	18436971688	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
286	07/24/14	16:00:58	0:09	0:37	18432761816	18436971688			MT	[NIOP]
287	07/24/14	16:18:44	0:10	1:28	18436971688	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP]
288	07/24/14	16:18:44	0:14	1:28	18436971688	18432761816			MO	[NIOR]
289	07/24/14	16:23:17	0:12	1:59	18436971688	18432761816			MO	[NIOR]
290	07/24/14	16:23:17	0:09	1:59	18436971688	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP]
291	07/24/14	20:04:37	0:19	0:00	18432761816	18436971666	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
292	07/24/14	20:10:25	0:20	0:32	18432761816 19802539037(F)	18436971688			MT	[NIOP:CFNA:VM]
293	07/24/14	20:10:25	0:23	0:32	18432761816	18436971688	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
294	07/24/14	20:34:04	0:13	4:18	18436971688	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP]
295	07/24/14	20:34:04	0:15	4:18	18436971688	18432761816			MO	[NIOR]
296	07/26/14	14:41:22	0:11	6:33	18432761816	18033316342	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
297	07/26/14	16:30:24	0:27	1:24	18432761816	18033316342	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
298	07/26/14	16:32:19	0:09	1:17	18033316342	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP]
299	07/27/14	16:32:10	0:00	0:04	18432761816 17047789988(F)	17047789988		310410465449899	MO	[CFNA:VM]
300	07/27/14	16:32:10	0:20	0:04	18436971688 17047789988(F)	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP:CFNA:VM]
301	07/27/14	16:32:10	0:24	0:04	18436971688	18432761816			MO	[NIOR]

ROA 1468

MOBILITY

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:26:17
Voice Usage For: (843)276-1816

Item	Conn. Date	Conn. Time (UTC)	Seizure Time	ET	Originating Number	Terminating Number	IMEI	IMSI	CT	Feature
302	07/28/14	00:05:56	0:09	0:00	18432761816	11843697161688	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
303	07/28/14	00:08:30	0:21	0:43	18432761816 19802539037(F)	18436971688			MT	[NIOP:CFNA:VM]
304	07/28/14	00:08:30	0:24	0:43	18432761816	18436971688	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
305	07/28/14	00:38:07	0:12	5:11	18436971688	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP]
306	07/28/14	00:38:07	0:15	5:11	18436971688	18432761816			MO	[NIOR]
307	07/28/14	23:51:36	0:21	0:34	18432761816 19802539037(F)	18436971688			MT	[NIOP:CFNA:VM]
308	07/28/14	23:51:36	0:24	0:34	18432761816	18436971688	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
309	07/28/14	23:59:47	0:04	1:57	18432761816	18436971688			MT	[NIOP]
310	07/28/14	23:59:47	0:07	1:57	18432761816	18436971688	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
311	07/29/14	13:00:42	0:20	0:37	18432761816 19802539037(F)	18436971688			MT	[NIOP:CFNA:VM]
312	07/29/14	13:00:42	0:23	0:38	18432761816	18436971688	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
313	07/29/14	13:05:50	0:12	0:00	18432761816	88744777	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
314	07/29/14	13:10:14	0:17	0:00	18432761816	7	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
315	07/29/14	13:16:26	0:09	4:16	18432761816	18033316342	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
316	07/29/14	13:23:23	0:16	2:45	18436971688	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP]
317	07/29/14	13:23:23	0:19	2:45	18436971688	18432761816			MO	[NIOR]
318	07/29/14	13:31:39	0:24	2:04	18432761816	18033316342	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]

ROA 1469

MOBILITY

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:26:17
Voice Usage For: (843)276-1816

Item	Conn. Date	Conn. Time (UTC)	Seizure Time	ET	Originating Number	Terminating Number	IMEI	IMSI	CT	Feature
319	07/29/14	14:14:16	0:10	0:10	18432761816	18033316342	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
320	07/29/14	14:15:12	0:12	0:05	18033316342 17047789988(F)	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP:CFB:VM]
321	07/29/14	14:15:12	0:01	0:05	18432761816 17047789988(F)	17047789988		310410465449899	MO	[CFB:VM]
322	07/29/14	15:02:56	0:05	0:00	18432761816	16971688	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
323	07/29/14	15:03:28	0:04	0:00	18432761816	16971688	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
324	07/29/14	15:04:16	0:21	0:27	18432761816 19802539037(F)	18436971688			MT	[NIOP:CFNA:VM]
325	07/29/14	15:04:16	0:25	0:27	18432761816	18436971688	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
326	07/29/14	16:20:08	0:12	6:52	18436971688	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP]
327	07/29/14	16:20:08	0:15	6:52	18436971688	18432761816			MO	[NIOR]
328	07/29/14	17:36:40	0:00	0:04	18432761816 17047789988(F)	17047789988		310410465449899	MO	[CFNA:VM]
329	07/29/14	17:36:40	0:21	0:04	18436971688 17047789988(F)	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP:CFNA:VM]
330	07/29/14	17:36:40	0:23	0:04	18436971688	18432761816			MO	[NIOR]
331	07/29/14	17:40:38	0:10	4:44	18432761816	18436971688	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
332	07/29/14	17:40:38	0:07	4:44	18432761816	18436971688			MT	[NIOP]
333	07/29/14	17:46:17	0:15	6:51	18436971688	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP:SUBCMH:CMH]
334	07/29/14	17:46:17	0:18	6:51	18436971688	18432761816			MO	[NIOR]
335	07/30/14	11:30:10	0:21	0:46	18432761816 19802539037(F)	18436971688			MT	[NIOP:CFNA:VM]
336	07/30/14	11:30:10	0:23	0:46	18432761816	18436971688	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]

ROA 1470

MOBILITY

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:26:17
Voice Usage For: (843)276-1816

Item	Conn. Date	Conn. Time (UTC)	Seizure Time	ET	Originating Number	Terminating Number	IMEI	IMSI	CT	Feature
337	07/30/14	11:38:11	0:14	0:00	18432761816	B225	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
338	07/30/14	11:42:44	0:11	1:29	18432761816	18033316342	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
339	07/30/14	14:28:50	0:00	0:04	18432761816 17047789988(F)	17047789988		310410465449899	MO	[CFB:VM]
340	07/30/14	14:28:50	0:06	0:04	18436971688 17047789988(F)	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP:CFB:VM]
341	07/30/14	14:28:50	0:08	0:04	18436971688	18432761816			MO	[NIOR]
342	07/30/14	14:31:54	0:12	0:28	18436971688	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP:SUBCMH:CMH]
343	07/30/14	14:31:54	0:15	0:28	18436971688	18432761816			MO	[NIOR]
344	07/30/14	14:33:23	0:11	0:14	18436971688	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP:SUBCMH]
345	07/30/14	14:33:23	0:14	0:14	18436971688	18432761816			MO	[NIOR]
346	07/30/14	14:33:54	0:01	0:07	18436971688	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP]
347	07/30/14	14:33:54	0:05	0:07	18436971688	18432761816			MO	[NIOR]
348	07/30/14	14:34:28	0:05	0:58	18436971688	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP]
349	07/30/14	14:34:28	0:09	0:58	18436971688	18432761816			MO	[NIOR]
350	07/30/14	19:21:09	0:12	1:02	18432761816	18436155030	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
351	07/30/14	19:21:09	0:08	1:02	18432761816	18436155030			MT	[NIOP]
352	07/31/14	00:13:48	0:21	0:00	17035367008 17047789988(F)	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP:CFNA:VM]
353	07/31/14	00:37:47	0:00	0:51	18432761816 17047789988(F)	17047789988		310410465449899	MO	[CFNA:VM]
354	07/31/14	00:37:47	0:20	0:51	13023002321 17047789988(F)	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP:CFNA:VM]

ROA 1471

MOBILITY

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:26:17
Voice Usage For: (843)276-1816

Item	Conn. Date	Conn. Time (UTC)	Seizure Time	ET	Originating Number	Terminating Number	IMEI	IMSI	CT	Feature
355	07/31/14	15:42:36	0:01	0:17	18432761816 01117047789989(D)	17047789989	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR:VM]
356	07/31/14	20:06:12	0:16	2:31	18432761816	18033316342	0126990072888004 PANTECH P2030	310410465449899	MO	[NIOR]
357	07/31/14	23:03:20	0:17	0:28	18438846703	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP:SUBCMH]
358	07/31/14	23:31:19	0:18	0:21	18438846703	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP:SUBCMH]
359	07/31/14	23:35:57	0:17	4:13	18436971688	18432761816	0126990072888004 PANTECH P2030	310410465449899	MT	[NIOP]
360	07/31/14	23:35:57	0:21	4:13	18436971688	18432761816			MO	[NIOR]

ROA 1472

MOBILITY

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:26:06
Voice Usage For: (843)881-1692

Item	Conn. Date	Conn. Time (UTC)	Seizure Time	ET	Originating Number	Terminating Number	IMEI	IMSI	CT	Feature
1	04/01/14	13:47:51	0:00	0:00	18438811692 16787619968(F)	18436155030			MT	[CFB:VM]
2	04/01/14	13:47:51	0:02	0:31	18438811692	18436155030			ST	[OOR]
3	04/01/14	13:48:53	0:06	1:03	18436155030	18438811692			MO	[NIOR]
4	04/01/14	13:51:53	0:08	1:04	18438811692	18436971688			MT	[NIOP]
5	04/04/14	00:47:41	0:20	0:35	18438811692 19802539037(F)	18436971688			MT	[NIOP:CFNA:VM]
6	04/08/14	20:18:14	0:07	0:57	18438811692	18436155030			MT	[NIOP]
7	04/09/14	19:41:38	0:12	1:04	18436075293	18438811692			MO	[NIOR]
8	04/11/14	00:08:32	0:21	0:00	18438811692 19802548961(F)	18436075293			MT	[NIOP:CFNA:VM]
9	04/11/14	00:08:53	0:25	0:53	18438811692	18436075293			ST	[OOR]
10	04/11/14	00:15:56	0:21	0:36	18438811692 19802539037(F)	18436971688			MT	[NIOP:CFNA:VM]
11	04/11/14	21:21:38	0:17	0:37	18438811692	18436971688			MT	[NIOP]
12	04/11/14	21:28:22	0:12	1:05	18438811692	18438195189			MT	[NIOP]
13	04/13/14	00:29:17	0:05	0:05	18438811692	18438195189			MT	[NIOP]
14	04/13/14	00:30:16	0:21	0:41	18438811692 19802539037(F)	18438195189			MT	[NIOP:CFNA:VM]
15	04/13/14	00:37:32	0:22	0:15	18432761816	18438811692			MO	[NIOR]
16	04/14/14	14:46:40	0:22	0:12	18432761816	18438811692			MO	[NIOR]
17	04/14/14	23:20:42	0:15	4:44	18438811692	18436971688			MT	[NIOP]
18	04/15/14	13:52:39	0:21	1:00	18438811692 19802539037(F)	18436971688			MT	[NIOP:CFNA:VM]
19	04/15/14	13:54:17	0:03	3:08	18438811692	18436155030			MT	[NIOP]
20	04/15/14	21:24:22	0:23	0:35	18436971688	18438811692			MO	[NIOR]
21	04/17/14	17:00:45	0:23	1:06	18436075293	18438811692			MO	[NIOR]
22	04/17/14	17:02:13	0:11	1:03	18436075293	18438811692			MO	[NIOR]
23	04/18/14	13:45:22	0:21	0:40	18438811692 19802539037(F)	18436971688			MT	[NIOP:CFNA:VM]
24	04/18/14	23:41:14	0:09	1:46	18438811692	18436971688			MT	[NIOP]
25	04/19/14	14:27:35	0:21	1:00	18438811692 19802539037(F)	18436971688			MT	[NIOP:CFNA:VM]
26	04/19/14	21:32:29	0:14	2:41	18438811692	18436971688			MT	[NIOP]
27	04/19/14	21:51:47	0:08	0:19	18438811692	18436971688			MT	[NIOP]
28	04/20/14	14:16:04	0:13	3:24	18436155030	18438811692			MO	[NIOR]
29	04/20/14	23:04:50	0:10	0:59	18438811692	18436971688			MT	[NIOP]
30	04/20/14	23:13:35	0:10	0:55	18436971688	18438811692			MO	[NIOR]

ROA 1473

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MOBILITY

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:26:06
Voice Usage For: (843)881-1692

Item	Conn. Date	Conn. Time (UTC)	Seizure Time	ET	Originating Number	Terminating Number	IMEI	IMSI	CT	Feature
31	04/23/14	13:19:28	0:00	7:51	18438811692	18436155030			MT	[NIOP:CMW]
32	04/24/14	13:23:29	0:20	0:38	18438811692 19802539037(F)	18436971688			MT	[NIOP:CFNA:VM]
33	04/29/14	13:19:22	0:20	0:33	18438811692 19802539037(F)	18436971688			MT	[NIOP:CFNA:VM]
34	05/02/14	16:21:02	0:07	0:00	18438811692	18432761816			MT	[NIOP]
35	05/10/14	17:40:58	0:22	0:25	18436971688	18438811692			MO	[NIOR]
36	05/10/14	17:44:27	0:07	1:57	18438811692	18436971688			MT	[NIOP]
37	05/10/14	17:48:12	0:21	0:31	18438811692 16787619968(F)	18436155030			MT	[NIOP:CFNA:VM]
38	05/10/14	19:14:56	0:10	0:04	18436155030	18438811692			MO	[NIOR]
39	05/10/14	19:16:25	0:07	1:04	18438811692	18436155030			MT	[NIOP]
40	05/11/14	14:40:38	0:13	0:20	18436155030	18438811692			MO	[NIOR]
41	05/11/14	15:25:03	0:07	0:11	18438811692	18436155030			MT	[NIOP]
42	05/11/14	17:09:53	0:11	0:11	18438811692	18436971688			MT	[NIOP]
43	05/12/14	14:05:41	0:22	0:19	18432761816	18438811692			MO	[NIOR]
44	05/12/14	14:46:02	0:12	0:07	18432761816	18438811692			MO	[NIOR]
45	05/13/14	00:01:38	0:11	0:00	18432761816	18438811692			MO	[NIOR]
46	05/13/14	00:03:52	0:19	0:00	18432761816	18438811692			MO	[NIOR]
47	05/13/14	00:06:30	0:11	0:13	18432761816	18438811692			MO	[NIOR]
48	05/13/14	00:11:14	0:11	0:17	18432761816	18438811692			MO	[NIOR]
49	05/13/14	00:12:04	0:11	0:20	18432761816	18438811692			MO	[NIOR]
50	05/13/14	00:16:36	0:23	0:16	18432761816	18438811692			MO	[NIOR]
51	05/13/14	00:35:52	0:23	0:12	18432761816	18438811692			MO	[NIOR]
52	05/13/14	19:35:10	0:10	0:00	18432761816	18438811692			MO	[NIOR]
53	05/14/14	00:02:51	0:10	14:37	17034007008	18438811692			MO	[NIOR]
54	05/14/14	13:37:48	0:13	0:16	17034007008	18438811692			MO	[NIOR]
55	05/15/14	12:23:54	0:05	1:02	17034007008	18438811692			MO	[NIOR]
56	05/15/14	12:37:22	0:09	1:12	17034007008	18438811692			MO	[NIOR]
57	05/15/14	14:54:44	0:10	1:05	17034007008	18438811692			MO	[NIOR]
58	05/15/14	14:59:00	0:05	11:18	17034007008	18438811692			MO	[NIOR]
59	05/17/14	14:44:00	0:23	0:25	17034007008	18438811692			MO	[NIOR]
60	05/17/14	15:35:32	0:10	0:07	17034007008	18438811692			MO	[NIOR]
61	05/18/14	13:17:51	0:23	0:36	17034007008	18438811692			MO	[NIOR]
62	05/20/14	00:52:14	0:18	18:59	17034007008	18438811692			MO	[NIOR]
63	05/23/14	16:45:00	0:12	0:25	17034007008	18438811692			MO	[NIOR]
64	05/23/14	23:58:01	0:20	18:33	17034007008	18438811692			MO	[NIOR]

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ATT Subpoena 043

MOBILITY

AT&T has queried for records from 04/01/2014 12:00:00am to 07/31/2014 11:59:59pm
AT&T has queried for records using Eastern Time Zone. AT&T's records are stored and provided in UTC.

Run Date: 04/24/2018
Run Time: 12:26:06
Voice Usage For: (843)881-1692

Item	Conn. Date	Conn. Time (UTC)	Seizure Time	ET	Originating Number	Terminating Number	IMEI	IMSI	CT	Feature
65	05/26/14	14:32:17	0:22	0:37	18438811692 16787619968(F)	18436155030			MT	[NIOP:CFNA:VM]
66	05/26/14	16:06:16	0:23	0:03	18436155030	18438811692			MO	[NIOR]
67	05/27/14	00:44:28	0:11	0:15	18432761816	18438811692			MO	[NIOR]
68	05/27/14	01:22:58	0:07	1:57	18432761816	18438811692			MO	[NIOR]
69	05/27/14	01:25:30	0:11	0:10	18432761816	18438811692			MO	[NIOR]
70	05/27/14	01:28:22	0:10	0:32	18432761816	18438811692			MO	[NIOR]
71	05/27/14	01:29:52	0:11	0:42	18432761816	18438811692			MO	[NIOR]
72	05/27/14	02:19:20	0:11	0:25	18432761816	18438811692			MO	[NIOR]
73	05/27/14	19:42:43	0:22	0:08	18432761816	18438811692			MO	[NIOR]
74	05/27/14	20:28:03	0:24	0:08	18432761816	18438811692			MO	[NIOR]
75	06/01/14	00:12:38	0:22	0:09	18432761816	18438811692			MO	[NIOR]
76	06/07/14	00:09:50	0:04	0:00	18432761816	18438811692			MO	[NIOR]
77	06/07/14	00:10:11	0:04	0:00	18432761816	18438811692			MO	[NIOR]
78	06/13/14	16:40:28	0:09	0:00	18438178060	18438811692			MO	[NIOR]
79	06/13/14	16:43:50	0:34	0:30	18438178060	18438811692			MO	[NIOR]
80	06/14/14	13:23:41	0:28	0:00	18436155030	18438811692			MO	[NIOR]
81	06/17/14	12:31:23	0:32	0:00	18436155030	18438811692			MO	[NIOR]
82	06/17/14	14:15:13	0:26	0:00	18436155030	18438811692			MO	[NIOR]
83	06/25/14	23:01:28	0:32	0:00	18438178060	18438811692			MO	[NIOR]
84	06/25/14	23:02:46	0:33	0:06	18438178060	18438811692			MO	[NIOR]
85	06/30/14	13:35:13	0:34	0:11	18438178060	18438811692			MO	[NIOR]
86	06/30/14	17:40:35	0:34	0:05	18438178060	18438811692			MO	[NIOR]
87	06/30/14	17:48:33	0:33	0:01	18438178060	18438811692			MO	[NIOR]
88	07/03/14	15:38:08	0:23	0:00	18438178060	18438811692			MO	[NIOR]
89	07/03/14	15:38:48	0:34	0:00	18438178060	18438811692			MO	[NIOR]
90	07/03/14	16:01:12	0:35	0:08	18438178060	18438811692			MO	[NIOR]
91	07/08/14	12:24:52	0:34	0:15	18438178060	18438811692			MO	[NIOR]
92	07/08/14	13:00:31	0:33	0:00	18438178060	18438811692			MO	[NIOR]
93	07/08/14	13:27:23	0:15	0:00	18438178060	18438811692			MO	[NIOR]
94	07/22/14	12:51:46	0:34	0:03	18438178060	18438811692			MO	[NIOR]
95	07/22/14	13:19:32	0:23	0:00	18438178060	18438811692			MO	[NIOR]
96	07/23/14	13:48:21	0:34	0:14	18438178060	18438811692			MO	[NIOR]

ROA 1475

AT&T Records key

AT&T searches all available databases to ensure all responsive records are provided. Multiple reports may be provided in response to your request.

Note: For each record described in this key, all times are stored and provided in UTC

AT&T Mobility Voice Descriptions

Column Name	Description
Item	Row Number
Conn.Date	Connection Date. The date of the call.
Conn.Time(UTC)	Connection Time. The time the call was connected. Time is in UTC. Times is expressed in military time as HH:MM:SS.
Conn Date Time	Connection date and time- Date and Time the call was connected. Displayed as one column on the Landline Call Detail Records.
SeizureTime	The time it takes to connect the call measured from the moment the caller presses "Send" to when the call is connected.
Originating Number	The phone number the call/text originated from. For data records, this does not necessarily mean the number originated the data transaction. The network constantly communicates with internet enabled devices and the data records do not indicate if a customer initiated a data transaction.
Terminating Number	The number the transaction terminated to.
DIALED (D)	The number that the originating party dialed. Appears in subsequent line of the same row in the Originating Number column. *(Note: only appears if the Terminating number differs from the Dialed number)* A = *, B = #
FORWARDED (F)	The number the terminated number forwarded the call to. Appears in subsequent line of the same row in the Originating Number column.
TRANSLATED (T)	Indicates if a number was translated to a different number. For example, if the number called is 911, then that gets translated to a ten digit number for routing to a 911 dispatch center. The (T) indicates the number the translation was from, not the number translated to.
ORIGINAL ORIGINATING (OO)	Denotes the number that originated the call before call forwarding was invoked. Appears in subsequent line of the same row in the Originating Number column.
ET (Elapsed Time)	Duration of the transaction. Duration is in MM:SS

ROA 1476

AT&T Proprietary
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IMEI International Mobile Equipment Identifier	A 15-digit number that uniquely identifies an individual wireless device Only the IMEI of the number requested is displayed.
IMSI International Mobile Subscriber Identity	The IMSI is a globally-unique code number that identifies a GSM subscriber to the network. The IMSI is linked to your account information with the carrier. The IMSI resides in the SIM card which can be moved from one GSM phone to another. Only the IMSI of the number requested in the legal demand is displayed.
CT (Call Type)	Denotes if the leg of a call is an originating leg or terminating leg. Mobile Originating (MO) Mobile Terminating (MT) Service Originating (SO) Service Terminating (ST) A leg of a call represents each time the call is processed through a network switch. Calls may go through several switches in AT&Ts network in order to reach the intended party. A service record is generated when the network generates a leg of a call to reach a service on the network. For example, a leg connecting to the voicemail platform denotes a service invoked on the network and may show up as a service record.
Feature	This column represents the type of call that occurred as recorded by our network and used for purposes of processing a call on AT&Ts network. These are not necessarily indicative of features on a customer's account or the types of services subscribed too.
Make	The Make of the handset used in the transaction.
Model	The Model of the handset used in the transaction.
Cell Location	**Identifiers:** 3G Network cell Site= LAC/CID 4G Network Cell Site= ECGI **Examples:** 3G Network Cell Site. [27077/11621:-80.05629:26.74779:350:90.0] **LAC/CID LONG:LAT Sector:Beamwidth**

ROA 1477

AT&T Proprietary
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	4G Network Cell Site {13315124:7520122: -96.912452:33.013937:358: 1.0 **ECGI:ENB-ID LONG:LAT Sector:Beamwidth** **Definitions:** LAC-Location Area Code. This number identifies the specific region a cell tower is located in. The number is used internally in AT&T and for network purposes. CID-Cell Identity. This number identifies the location of the tower within a specified region. The number is used internally in AT&T and for network purposes. ECGI-Enhanced cell global identity. A nine digit number that indicates the location of a cell tower when 4G technology is being used. The number is used internally in AT&T and for network purposes. ENB-ID- Evolved Node B (eNodeB) Hardware connected to the AT&T mobility network that communicates directly with a mobile device. This number is used internally to AT&T to identify a specific antenna on a tower when 4G technology is used. Longitude - A geographic coordinate that specifies an East-West Position of a point on the earth's surface. The Latitude represented is of the cell tower. Latitude - A geographic coordinate that specifies a North-South Position of a point on the earth's surface. The Longitude represented is of the cell tower. Sector-A number out of 360 degrees that indicates the side of the cell site antenna used in processing the call. Beamwidth-A number out of the 360 degrees that specifies the angle of coverage of the RF signal coming from a particular cell site sector.

ROA 1478

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Feature Definitions for Mobility Voice Report

Features represents the type of call that occurred as recorded by our network and used for purposes of processing a call on AT&Ts network. These are not necessarily indicative of features on a customer's account or the types of services subscribed to.

Feature Acronym	Feature Definition
'ADD'	Unstructured Supplementary Service Data
'CBI'	Barring of All Incoming Calls
'CBIOP'	Incoming Operator Determined Barring
'CBIP'	Barring of All Incoming Calls Roaming Outside Public Land Mobile Network
'CBIUK'	Barring of Incoming Calls
'CBO'	Barring of All Outgoing Calls
'CBOI'	Barring of All Outgoing Intl Calls
'CBOIP'	Barring of All Outgoing Intl Calls Except to Public Land Mobile Network
'CBOOP'	Outgoing Operator Determined Barring
'CBOUK'	Barring of Outgoing Calls
'CBUK'	All Barring
'CFB'	Call Forwarding Subscriber Busy
'CFC'	Call Forwarding All Conditional
'CFNA'	Call Forwarding No Reply
'CFNR'	Call Forwarding Not Reachable
'CFO'	Call Forwarding in Gateway (Unknown)
'CFU'	Call Forwarding Unconditional
'CFUK'	All Forwarding
'CGC'	Advice of Charge Charging
'CGI'	Advice of Charge Information
'CIAC'	Account Code Service
'CICUG'	Closed user Groups Service
'CIPCI'	Proprietary Customer Information
'CMH'	Call Hold

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ATT Subpoena 048

052

ROA 1479

'CMPRL'	Proprietary Release Link Trunk Service
'CMPVM'	Proprietary Voice Mail Call Dropback
'CMR'	Call Re-origination
'CMRC'	Call Re-Origination By Cause
'CMW'	Call Waiting
'ECT'	Explicit Call Transfer
'GREM'	Enhanced Multi
'INIOR'	Invoke Calling Number Identity Restriction
'MPS'	Multiparty Services
'NIND'	Proprietary Calling Name Delivery
'NIOP'	Calling Number Identity Presentation
'NIOR'	Calling Number Identity Restriction
'NITP'	Connected Line Identity Presentation
'NITR'	Connected Line Identity Restriction
'NSDA'	Directory Assistance Service Call
'OACR'	Anonymous Call Rejection
'OEXT'	Extension Service
'OMCT'	Malicious Call Trace
'OMSC'	MSC
'OOR'	Optimal Routing (of Late Call Forwarding)
'SUBCMH' Call hold	Call hold, Invoke, Invoked by Subscriber
V2G	Volte to 3G. It indicates the call was handed off from one Volte (a VOIP call) to the 3G network (circuit switched call)
VM	Voicemail involved in transaction
VCORR	4G Cell site was correlated with additional database
FCID	"Flexible Caller ID" This indicates a secondary device, such as a watch or tablet, originated the call. The number indicated as the Original Originating (OO) is the native number belonging to the secondary device that originated the call.

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Feature Definitions for Mobility Voice and Mobility SMS Report

Features represents the type of Call/SMS that occurred as recorded by our network and used for purposes of processing a Call/SMS on AT&Ts network. These are not necessarily indicative of features on a customer's account or the types of services subscribed to.

Feature Acronym	Feature Definition
'Wi-Fi'	This denotes when a Call/SMS was carried over Wi-Fi. No cell sites or any type of location information is available on these transactions because AT&T does not store this information.

AT&T Mobility SMS Descriptions

Column Name	Description
Originating Number	Number that originated the SMS
Terminating Number	Number that received the SMS
Description	If known, describes the direction of the SMS SMSO (SMS originating) SMST (SMS terminating)

AT&T Mobility SMS-Email Descriptions

Column Name	Description
Email	Email address associated
Email Status	SEND/RCVD
Description	MO (Mobile originating) MT (Mobile terminating) AO (Application originating) AT (Application terminating)

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ROA 1481

AT&T Mobility Data Descriptions

Column Name	Description
Bytes Up	The number of bytes sent from mobile station to the network.
Bytes Dn	The number of bytes from the network to the mobile station.
Originating Number	For data records, the Originating Number does not necessarily mean the number originated the data transaction. The network constantly communicates with internet enabled devices and the data records do not indicate if a customer initiated a data transaction.

AT&T Wi-Fi Data Descriptions

This report signifies data transactions where the customer is connected to Wi-Fi using AT&T VPN service.

Column Name	Description
Bytes Up	The number of bytes sent from mobile station to the network.
Bytes Dn	The number of bytes from the network to the mobile station.
Originating Number	For data records, the Originating Number does not necessarily mean the number originated the data transaction. The network constantly communicates with internet enabled devices and the data records do not indicate if a customer initiated a data transaction.

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ROA 1482

AT&T Wireline Descriptions

Column Name	Description
Sec. Orig	Secondary Originating Number. A secondary number associated with the call transaction. This number can either be a wireline or mobility number. As an example, if it is a non-mobility number, this could be a number that sits behind a customer's internal phone network such as a PBX. There are other numerous situations when secondary originating numbers are part of a call transaction.
CIC	Carrier Identification Code. The number in this column translates to identifying the interexchange carrier of the call. A public listing of CIC codes can be found at the following url: http://www.nanpa.com/reports/reports_cic.html
Call Code	Represents the type of call that was processed on the wireline network.
Orig. Acc.	Originating Access ID. When a call is received from another carrier and traverses AT&Ts VoIP network. This number translates to what carrier sent AT&T the call.

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ROA 1483

AT&T International Descriptions

Column Name	Description
Orig Country	The country the call originated from based on the NPA-NXX of the party that placed the call.
Dial Country	The country of the number dialed based on the NPA-NXX of the dialed number.
In Country	Inbound Country. The country AT&T terminated the call to. This does not necessarily mean the called party is in the listed country. This represents the country that AT&T directed the call to in order to properly route the call to its final destination. Other carriers may pick up the call after the call has left the AT&T network.
Out Country	Outbound Country. The country AT&T routed the call from. This does not necessarily mean the call originated from the listed country. This represents the country AT&Ts network was used in to properly route the call to its final destination.
Ans Ind	Indicates if the call was answered.
From CPN	From Calling Party Number. Indicates if the call originated from the Originating Number.

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ROA 1484

Physician Documentation

Roper Hospital Emergency Department

Name: Delila Parrott
Age: 80 years **Sex:** Female **DOB:** REDACTE
Arrival Date: 01/27/2015 **Time:** 14:48
Bed ER7
ED Physician Lewis, Daniel

MRN: 001787037
Account#: 1502701324
Private MD: Mills, Richard, E.

HPI: dle1

01/27 15:11 This 80 years old White Female presents to ED via EMS with complaints of **Shortness Of Breath**. dle1

15:11 The patient has shortness of breath at rest. Onset: The symptoms/episode began/occurred gradually. Timing is constant. Duration: The symptoms are continuous. The patient's shortness of breath has no apparent modifying factors. Associated signs and symptoms: Pertinent positives: non-productive cough, Pertinent negatives: fever, hemoptysis, loss of consciousness, nausea, vomiting. Severity of symptoms: At their worst the symptoms were mild in the emergency department the symptoms are unchanged. Unable to obtain HPI due to baseline dementia, pt had a 1 view cxr 2d ago which possibly revealed a RML infiltrate. It is unknown whether or not the patient has had similar symptoms in the past.

Historical:

- **Allergies:** NSAIDS; Chocolate; Aspirin; Toradol; ACE INHIBITORS; all nasal sprays; green vegetables;
- **Home Meds:**
  1. Nexium Oral 40 mg daily
  2. Celexa Oral 20 mg daily
  3. Diltiazem Oral 180 mg daily
  4. Risperdal Oral 0.25 every 12 hours
  5. Propranolol Oral 10 mg every 12 hours
  6. unknown
- **PMHx:** phobias; Schizophrenia; Urinary tract infectious disease
- **PSHx:** Breast biopsy; Fracture repair; ORIF 6/7/2014- lt hip
- **Social history::** Smoking Status: Patient/guardian denies using tobacco, never smoked,.
- **Advanced Directives::** Unable to obtain information,.

ROS:

15:12 Negative fever, chills, nausea, vomiting, diarrhea, vision changes, palpitations, weakness, syncope, weight loss, all other ROS negative. dle1

Exam: dle1

15:13

Head/Face: Normocephalic/atraumatic.
Eyes: Pupils equal, round and reactive to light. Conjunctiva and sclera are non-icteric and not injected.
ENT: Oropharynx with no redness, swelling, or masses. Mucous membranes moist.
Neck: Trachea midline. Non meningismus.
Cardiovascular: Regular rate and rhythm. No murmurs. No pulse deficits.
Abdomen/GI: soft, nt, nd, + bs, -r/g
Back: No spinal tenderness. No costovertebral tenderness. Full range of motion.
Skin: no rash or lesion, warm and dry
MS/ Extremity: Pulses equal, no cyanosis. Neurovascular intact.
Neuro: baseline ms, no focal neurologic deficits, sensation and motor equal and symmetric. CN 2-12 intact
Psych: Affect appropriate.
Constitutional: The patient appears awake, comfortable.
Cardiovascular: Rate: normal, Rhythm: regular.
Respiratory: The patient does not display signs of respiratory distress. Respirations: normal, Breath sounds: rales rhonchi.

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Height	Pain	Staff
14:54	136 / 60	67	18	98.0	100%	67.13 kg	5 ft. 5 in. (165 cm)	0/10	mr

Print Time: 1/26/2015 08:48:55 *** CHART COMPLETE *** Page 1 of 4

Physician Documentation Con't.

15:01	140 / 86 (auto/)								vgj
15:01		65 MON			98%				vgj
15:17	130 / 48 (auto/)								vgj
15:17		61 MON			97%				vgj
15:32	121 / 53 (auto/)								vgj
15:32		69 MON			96%				vgj
15:46	136 / 50 (auto/)								vgj
15:46		59 MON			97%				vgj
17:01	137 / 63 (auto/)	65	16		97%				vgj
17:29	137 / 63	66	18		97% on R/A				vgj
17:31	149 / 67 (auto/)	60	16		99%				vgj
17:47	145 / 62 (auto/)	57	16		99%				vgj
18:02	121 / 46 (auto/)	57	16		99%				vgj
18:19	118 / 47	65	18		96%				vgj
18:31	108 / 39 (auto/)	62	18		97%				vgj

15:46 Body Mass Index 24.7 (67.13 kg, 165 cm) vgj

MDM:

14:49 Medical screening evaluation initiated. sdl1

15:13 dle1

Antibiotic administration: The patient is discharged and will get outpatient antibiotics, Levaquin.
Data reviewed: Vital signs, nurses notes, old medical records ordered and reviewed.
Data interpreted: Cardiac Monitor: The patient is in normal sinus rhythm, no ectopy. Pulse oximetry: The pulse ox is greater than 96% on room air which is acceptable per my interpretation.

15:14 dle1

EKG: Normal rate, sinus rhythm. Normal QRS duration. Normal PR interval, no ST-segment elevation. Clinical impression: sinus rhythm without evidence of acute ischemia. Visualized and interpreted by me.

17:23 dle1

ED course: pt has a new decubitus ulcer on sacrum and failure to thrive per daughter, she is requesting a hospice consult and admit for further placment, mother has severe depression and otherwise is stable.

Time	Order name	Complete Time	Staff
01/27 16:05	CBC (Complete Blood Count)	16:38	dle1
01/27 16:05	CMP	17:03	dle1
01/27 15:11	CXR PA/LAT Short of Breath	16:15	dle1
01/27 17:02	PO Trial	17:10	dle1

Dispensed Medications:

Time	Drug & Dose	Route	Rate	Duration	Site	Delivery	Staff
17:05	CANCELLED (Physician Discretion): K-Dur [20 mgEq] 20 mEq Oral once; []						vgj
17:14	Potassium Chloride Liquid [20 mEq/15 mL] 20 mEq	Oral					vgj
18:18	Follow up: Response: No adverse reaction						vgj
17:25	Tylenol Tablet 1000 mg	Oral					vgj

Name: Delila Parrott **MRN:** 001787037
Account#: 1502701324

Print Time: 1/28/2015 08:48:55 Page 2 of 4

OneContent: Generated By delela

Patient DOB: REDACT

HISTORY OF PRESENT ILLNESS: The patient is an 80-year-old who had been seen and treated and found to have a new opacification in the right mid lung field, findings of concern for developing pneumonia, has had progressive decline and inability to care for self. Has required considerably more assistance. Had initially been seen and evaluated in the office on 01/20/2015. Recently had weakness the left hand, complained of urinary tract infection, pain all over, especially in lower back. Caregiver and daughter described a tremendous decline in her function over the last few weeks and particularly on presentation to the Emergency Room today. She needs more help with her activities of daily living, has been afebrile, has had some left-sided weakness. Also, complained of green secretions as well as some dysuria. Was started on Levaquin at that time and also was felt to be depressed and was put on Celexa. Tried to get a urine specimen at that time, but could not. She is presented to the Emergency Room and found on reviewing her prior CT, no acute intracranial abnormality, moderate atrophy and bilateral small vessel hemispheric white matter disease. X-ray of the humerus on the 25th, no fractures were noted. The CT of the head was done on the 25th. There was some delay in starting the antibiotics initially as an outpatient because of the need for hard copy in the assisted living environment. The patient's p.p. intake has declined, inability to move. When I examine her on the floor after admission from the Emergency Room by covering physician, Dr. Livingston, she was unable to really converse. Dr. Livingston gave admission orders, then I examined the patient later on the floor that evening. Apparently in the Emergency Room, she complained of pain in the back.

CURRENT MEDICATIONS: Reviewing some of her recent records: Indoral-LA 60, Nexium 40, Colace 100, Ultram 50 q.6, Norco 1-2 q.4, Xanax 1 tablet t.i.d., Seroquel 50 at bedtime, risperidone 0.25 b.i.d., Celexa had been increased to 30 a day, Diltiazem 180 a day, Aricept 5 at bedtime.

PAST MEDICAL HISTORY: Includes: Macular degeneration, hypertension, gastroesophageal reflux disease, sleep apnea, osteoarthritis, had a colonoscopy done in August 2013 by Dr. Joyner, zoster vacc 2007, pneumonia vaccine 2004.

PAST SURGICAL HISTORY: Left breast biopsy, left wrist fracture, multiple eye surgeries both eyes, open reduction internal fixation left subtrochanteric femur by Dr. Murray 06/07/2014.

FAMILY HISTORY: Father died of a stroke. Spouse is deceased of an arrhythmia.

OneContent: Generated By delela

Says she was adopted at age 2 in the prior records, nonsmoker. No recent alcohol.

ALLERGIES NOTED: INCLUDE: NONSTEROIDALS, SULFA, ASPIRIN, ALTACE AND DIOVAN.

REVIEW OF SYSTEMS: Unable to obtain from the patient.

OTHER PAST HISTORY: Significant for: Diarrhea, recurrent urinary tract infections, supraventricular tachycardia, left-sided muscle weakness and bedsores.

LABORATORY DATA: Done on the 23rd of January includes a TSH of 3.54, BUN of 18, CO2 of 36, potassium 3.3, sodium 144, glucose 91. Liver tests were normal. LDL 132. Ferritin 199. Iron sat 14.7, iron 39, TIBC 266. Vitamin B12 497.

PHYSICAL EXAMINATION: GENERAL: Ill-appearing white female, unable to verbally respond when I saw her in the evening, pale diminished strength. VITAL SIGNS: Blood pressure report from the Emergency Room 135/60, pulse 67, respiratory rate 18. Had pale some bitemporal wasting. Sclerae nonicteric NECK: Trachea midline. No rigidity. CARDIOVASCULAR: Regular rate. ABDOMEN: Bowel sounds present. CHEST: Diminished breath sounds in the bases. ABDOMEN: Bowel sounds present, soft. Unable to really check neurologic function. Affect was flat. Apparently in the Emergency Room it had been appropriate, but I could not discuss with her.

ADMITTING DIAGNOSES:
1. Debility, failure to thrive. We will plan to admit, give gentle hydration. Consultation ordered by Dr. Livingston in coverage for palliative care, I believe that it is appropriate.
2. Right mid lung pneumonia, pleural effusion, partially treated as outpatient. We will continue treatment with IV.
3. Edema of the right arm. We will plan to obtain vascular studies.
4. Wound care. Consult wound team, early skin breakdown.
5. Probable dehydration. We will plan to give ProcalAmine. On recent labs elevated sodium.
6. Altered mental status. Plan to follow to the a.m.
7. Atrophy/dementia.
8. Dysphasia/dysarthria at present. We will follow overnight. Hold oral medications, reevaluate. Consult speech therapy in the morning.

OneContent: Generated By delela

9. Back pain. Could not express this to me. We will plan to follow in the a.m.

Update to the History and Physical if appropriate
[] I have reviewed the H&P and re-examined the patient and there are no changes to the physical examination and/or history of present illness.
[] I have reviewed the H&P and re-examined the patient and the following changes have occurred to the physical examination and /or history of present illness:

---

[x] Refer to the Admission Home Medication Orders (inpatient) or Outpatient/OBSERVATION Medication list (outpatient) for current medications.
Physician Signature: _____ Date: _____ Time:

Richard E Mills, MD
TR: dn DD: 01/27/2015 23:41 TD: 01/28/2015 00:38 Job#: 368043
DOC#: 471000

Authenticated by RICHARD E MILLS MD On 01/28/2015 03:56:16 PM

Physician Documentation Con't.

15:01	145 / 66 (auto/)								vgj
15:01		65 MON			98%				vgj
15:17	130 / 48 (auto/)								vgj
15:17		61 MON			97%				vgj
15:32	121 / 53 (auto/)								vgj
15:32		69 MON			96%				vgj
15:46	136 / 50 (auto/)								vgj
15:46		59 MON			97%				vgj
17:01	137 / 63 (auto/)	59	16		97%				vgj
17:29	137 / 63	66	18		97% on R/A				vgj
17:31	149 / 67 (auto/)	60	16		99%				vgj
17:47	135 / 62 (auto/)	57	16		99%				vgj
18:02	121 / 46 (auto/)	57	16		99%				vgj
18:19	118 / 47	65	18		96%				vgj
18:31	108 / 39 (auto/)	62	18		97%				vgj

15:46 Body Mass Index 24.7 (67.13 kg, 165 cm) vgj

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14:40 Medical screening evaluation initiated. dle1

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15:14
EKG: Normal rate, sinus rhythm. Normal QRS duration. Normal PR interval, no ST-segment elevation. Clinical impression: sinus rhythm without evidence of acute ischemia. Visualized and interpreted by me. dle1

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ED course: pt has a new decubitus ulcer on sacrum and failure to thrive per daughter, she is requesting a hospice consult and admit for further placment, mother has severe depression and otherwise is stable.

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01/27 17:02	PO Trial	17:10	dle1

Dispensed Medications:

Time	Drug & Dose	Route	Rate	Duration	Site	Delivery	Staff
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17:14	Potassium Chloride Liquid [20 mEq/15 mL] 20 mEq	Oral					vgj
18:18	Follow up: Response: No adverse reaction						vgj
17:25	Tylenol Tablet 1000 mg	Oral					vgj

Name: Delila Parrott **MRN:** 001787037
Account#: 1502701324
Page 2 of 4

Print Time: 1/28/2015 09:48:55

OneContent: Generated By delela

Patient DOB: REDACT

HISTORY OF PRESENT ILLNESS: The patient is an 80-year-old who had been seen and treated and found to have a new opacification in the right mid lung field, findings of concern for developing pneumonia, has had progressive decline and inability to care for self. Has required considerably more assistance. Had initially been seen and evaluated in the office on 01/20/2015. Recently had weakness the left hand, complained of urinary tract infection, pain all over, especially in lower back. Caregiver and daughter described a tremendous decline in her function over the last few weeks and particularly on presentation to the Emergency Room today. She needs more help with her activities of daily living, has been afebrile, has had some left-sided weakness. Also, complained of green secretions as well as some dysuria. Was started on Levaquin at that time and also was felt to be depressed and was put on Celexa. Tried to get a urine specimen at that time, but could not. She is presented to the Emergency Room and found on reviewing her prior CT, no acute intracranial abnormality, moderate atrophy and bilateral small vessel hemispheric white matter disease. X-ray of the humerus on the 25th, no fractures were noted. The CT of the head was done on the 25th. There was some delay in starting the antibiotics initially as an outpatient because of the need for hard copy in the assisted living environment. The patient's p.o. intake has declined, inability to move. When I examine her on the floor after admission from the Emergency Room by covering physician, Dr. Livingston, she was unable to really converse. Dr. Livingston gave admission orders, then I examined the patient later on the floor that evening. Apparently in the Emergency Room, she complained of pain in the back.

CURRENT MEDICATIONS: Reviewing some of her recent records: Inderal-LA 60, Nexium 40, Colace 100, Ultram 50 q.6, Norco 1-2 q.4, Xanax 1 tablet t.i.d., Seroquel 50 at bedtime, risperidone 0.25 b.i.d., Celexa had been increased to 30 a day, Diacer 180 a day, Aricept 5 at bedtime.

PAST MEDICAL HISTORY: Includes: Macular degeneration, hypertension, gastroesophageal reflux disease, sleep apnea, osteoarthritis, had a colonoscopy done in August 2013 by Dr. Joyner, zoster vacc 2007, pneumonia vaccine 2004.

PAST SURGICAL HISTORY: Left breast biopsy, left wrist fracture, multiple eye surgeries both eyes, open reduction internal fixation left suptrochanteric femur by Dr. Murray 06/07/2014.

FAMILY HISTORY: Father died of a stroke. Spouse is deceased of an arrhythmia.

OneContent: Generated By delela

CONSULTATION

MR#: 001787037 DOB: REDACT
PARROTT, DELILA W
Room IPA 0568-01
PHYS: LIVINGSTON-MD,R LE
ACCT#: 15027-01324 01/27/15

PATIENT LABEL

(Check one or more suitable blanks)
___ At convenience of consultant
___ Urgent, today if possible
___ Opinion & recommendation only
___ Write diagnostic orders & re-evaluate as indicated.
___ Evaluate & manage condition in your specialty.
___ Accept intransfer, if you will
___ Surgical procedure only.

Consulting Physician and/or Service Palliative Care 6066-7810

Reason for Request Goals

Date: 1/27/15 Requested by Dr. Livingston

Pt seen + examined
Met c pt + daughter/POA Joan.
Code status discussed- pt wishes DNR
Full note to be dictated
Pt interview to meet pt to
Columbia Hi Care. Florence NP
+/- hospice

Msg. Sent
0811
1-28-15

M.D.
Consultant

Date/Time ____/____

G08040 Rev. 02/10

G08040

MEDICAL RECORDS

Patient Identifier
MRN: 001787037 DOB: REDAC
PARROTT,DELILA W
Report
PHYS: MILLS-MD,RICHARD E
IPA 0558-01
ACCT#: 15027-01324 01/27/15

Occupational Therapy Evaluation
General

Script written within 30 days o

Date 1-29-15 Time In / Out 10:07-10:24

Admitting Diagnosis decubitus ulcer, UE swelling, SOB Treatment Diagnosis failure to thrive, pneumonia, uti

Treatment Requested consult Surgery & Date

Referring Physician Primary Physician

Mode of Transport Special Equipment

Previous Medical History schizophrenia, phobias, UTI, mac. degeneration, HTN, GERD, sleep apnea, OA

S: SUBJECTIVE "I'm too far gone," pt. said of need for OT. "That means stop," she said after hitting washcloth on towel held by OT.

O: OBJECTIVE Cognition

Orientation ☑ Self ☐ Place ☑ Time Level of Alertness ☐ Alert ☑ Semi-Alert ☐ Unarousable

Language ☑ verbal ☐ yes/no head movement ☐ dysarthric ☐ aphasia slow to respond, ↓ word retrieval.

Command Following: + = Intact - = impaired ☑ 1 step ☐ 2 step ☐ 3 step

Memory LTM ☐ intact ☑ impaired STM ☐ intact ☑ impaired Hand Dominance ☐ Right ☐ Left

Insight ☐ pt knows why hospitalized ☐ pt knows extent of injuries/ medical condition

☐ pt has realistic goals ☐ pt knows how condition affects abilities

Patient learns best through ☐ visual ☐ demonstration ☐ other

Sensation + = Intact - = impaired x = absent

☐ light touch ☐ pain ☐ temp ☐ stereognosis ☐ sharp/dull ☐ proprioception

Perception ☐ visual attention ☐ visual field ☐ right/left discrimination ☐ figure ground ☐ form constancy

☐ body scheme/ awareness ☐ depth perception ☑ praxis ☐ visual tracking ☐ other h/o macular degeneration,

Neglect ☐ Right ☐ Left

Coordination Fine Motor ☐ Intact ☑ Impaired: ☐ mild ☑ moderate ☐ severe

Gross Motor ☐ Intact ☑ Impaired: ☐ mild ☑ moderate ☐ severe

Skin Condition:

UE Range of Motion (A/PROM): ☐ WNL ☐ WFL Limitations ↓ B shoulder flex

Manual Muscle Testing	Right	Left
NT. Pt. required min A to raise RUE to face for washing. Did not move LUE to wash hands.		
Gross grasp tested.	3+/5	3+/5

Pain Location Level: 0 – 10 10=worse
shoulders, neck, R arm

Therapist Signature: Date: 1/29/15 Time: 10:34 am

Origin: 03/06
Revised: 09/09; 10/12; 04/13; 12/13

MRN: 001787037 DOB: REDA
PARROTT,DELILA W
Roper IPA 0558-01
PHYS: MILLS-MD,RICHARD E
ACCT#: 15027-01324 01/27/15

Palliative Medicine

☐ Initial Consult ☒ Follow up

Date: 1/30/15 Start Time: 2:30 Finish Time: 3:15 PCP: Mills

Referring MD: Livingston/Hodgson Reason for consult:

Current Code Status: DNR Living Will: ☐Y ☐N

Patient Capacity to make Healthcare Decisions today: ☐ INDependent ☐ Needs help ☐ Dependent

Surrogate/HCPOA: daughter Jean

Pt having generalized pain and more anxiety - Rad been evaluated + accepted to MT P IPU Hospice. Currently receiving morphine + Xanax + prn Norco. Pt daughter interested in moving to IPU. then to long-term care.

PE: Alert + oriented to self, person and situation 5 periods of delayed thought + speaking making of efforts to assess orientation to time.

Chest: Lungs CTAB

Heart: RRR

A/P: 1 Debility - PT/OT

2 Pneumonia/UTI - on antibiotics

3 Pain - nonspecific, difficult for pt to describe morphine, norco prn

4 Anxiety - xanax prn exacerbated by situation, and #5 and ? celexa

5 schizophrenia - meds per Dr Mills + Abcs

INTERDISCIPLINARY FAMILY MEETING
☐ Patient ☐ Family (list below) ☐ MD ☐ SW ☐ Chaplain ☐ RN ☐ CM ☐ NP
daughter Joan

☐ Assessed understanding of illness
☐ Info reviewed/questions answered
☐ Assessed desire for prognostic info
☐ Goals of treatment discussed
☐ Discussed broad care options
☐ Specified a plan of care
☐ Plan to meet again

Symptom	(0-3)	AB*
Pain		
Fatigue		
Nausea		
Depression		
Anxiety		
Drowsy		
Appetite		
Well-being		
SOB		
Symptom	**Yes/No**	**AB***
Secretions		
Constipation		
Delirium		

*Assessed By (AB): P=Patient – C=Clinician – F=Family

☐ AICD in place → ☐ deactivated ; PPS (Palliative Performance Scale): ECOG: Referral made to: ☐ SW ☐ Chaplain

Plan of care regarding patients condition and preferences was discussed with the interdisciplinary team members:
☒ Patient ☒ Family ☒ RN ☐ CM ☐ SW ☐ Chaplain ☐ NP ☐ Attending ☐ PCP ☐ Other:

☐ > 50% of visit time spent counseling/coordinating care; Total time: _____ ; Total Face-to-face time: _____ (:__) to __:__)

☐ Angie Baker, MD ☐ Scott Lake, MD ☒ Lisa Monroe, ANP Sign (date/time above): Lisa Monroe

☐ Tiffany Richter, DO ☐ Beth Wolf, MD ☐ Susan Yoose, FNP #843-606-7810

Original 1/10 Revised: 4/11, 8/11, 4/12, 7/12, 3/13, 9/13, 8/14

Roper St. Francis Healthcare
Department of Laboratory Medicine
Charleston, South Carolina 29401

PATIENT: PARROTT, DELILA WILSON
DOB: REDAC
PID: D0017870 37
ACCT # : D1415701389

LOCATION: D3D 3109-01
PHYSICIAN: MILLS-MD, RICHARD E
PRINTED: 06/11/14 06:53

ADMITTED: 06/06/14

DISCHARGED: 06/10/14

CHEMISTRY

Collected	06/10 05:30		06/09 05:40		06/08 05:45		06/07 05:40		06/06 22:35		Units	Reference
NA	145		146	H	146	H	147	H	147	H	mmol/L	135-145
K	3.9		3.4	L	4.2		4.0		3.8		mmol/L	3.5-5.1
CL	112	H	112	H	112	H	110	H	108	H	mmol/L	98-107
CO2	28		28		27		29		29		mmol/L	21-32
GLUCOSE	105	H	104	H	139	H	129	H	131	H	mg/dL	70-99
BUN	16		22		33	H	38	H	40	H	mg/dL	7-22
CREATININE	0.5	L	0.5	L	0.6		0.6		0.7		mg/dL	0.6-1.0
B/C RATIO CALC	36.0	H	44.0	H	55.0	H	63.3	H	57.1	H		6.0-17.0
ANION GAP CALC	5		8		7		8		10		mmol/L	2-17
OSMO CALC	291		294		300		303		304		mOsm/kg	285-309
CALCIUM	7.5	L	7.5	L	7.6	L	8.0	L	9.0		mg/dL	8.5-10.1
PROTEIN	4.1	L									g/dL	6.4-8.2
ALBUMIN	1.6	L									g/dL	3.4-5.0
GLOBULIN	2.5										g/dL	1.8-4.4
A/G RATIO CALC	0.64	L										1.00-2.20
BILI TOTAL	0.57										mg/dL	0.00-1.00
ALK PHOS	79›										U/L	45-117
SGOT	38	H									U/L	15-37
SGPT	39›										U/L	30-65
GLOM FILT RATE	126›		126›		102›		102›		88›			

›
ALKALINE PHOSPHATASE INTERPRETATION:

Effective 4/7/2014, revised Alkaline Phosphatase method.

Note revised adult reference range.

SGPT methodology change effective 2-4-2013.

Average GFR based on this patient's Age Group: 73 ml/min/1.73 sq.m.

LEGEND
L = LOW, H = HIGH, LC = LOW CRITICAL, HC = HIGH CRITICAL, <> = ABNORMAL, C = CRITICAL

Parrott, Delila (80987) *Room:* *Medical Record no: 80987*

WHERE SHE IS PROPELLED BY STAFF. RESIDENT REMAINS ACTIVE ON THERAPY CASELOAD. CURRENTLY SHE IS IN BED WITH EYES CLOSED AND IN NO ACUTE DISTRESS.
Signed by: Aziza Gary *Co-signed by:*

Addendum 7/7/2014 12:33 AM

THIS IS THE DAILY MEDICARE NOTE FOR 7/4/14.
Addendum signed by: Aziza Gary *Co-signed by:*

7/3/2014 5:23 PM *Role:* Social Service Assistant *Category:* SOCIAL SERVICES
Fourteen Day Assessment - Mrs. Parrot's BIMS' score did not show cognitive impairment. The Mood interview showed severe depression. Mrs. Parrott was tearful during the interview and stated, "I am not happy at all." She has thoughts that she would be better off dead. She feels that she will " not be able to be a full person again". She continues on Celexa and Valium PRN. SW requested psych eval after last assessment. An order for a psych consult was written on 6-26-2014. Mrs. Parrott told me that she is not thinking about returning to her condo at this time. Will continue to monitor her mood and behavior and to provide support if needed. Unit Manager was told of her negative thoughts.
Signed by: Carole Harvey *Co-signed by:*

7/2/2014 10:18 PM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE
RES IS ALERT AND ORIENTED X2 VERBALLY RESPONSIVE NO COMPLAINTS OF PAIN AT THIS TIME SCHEDULED NORCO GIVEN AS ORDERED FOR PAIN MAINTENANCE. NO RESIPRATORY DISTRESS NOTED NO SOB NO COUGH. NO CARDIAC ISSUES NOTED. NO N/V OR LOOSE STOOLS NOTED. ABD SOFT NONTENDER WITH POSITIVE BOWEL SOUNDS PRESENT ALL QUADS. INCONTINENT OF BOWEL AND BLADDER. SKIN DRY AND WARM DRESSINGS INTACT BOTH LOWER EXTREMITIES. TRANSFERS WITH ONE ASSIST USES W/C FOR TRANSPORT. CONTINUES PT/OT SERVICES ADLS WITH MODERATE ASSIST OF ONE. WEDGE PRESENT BETWEEN LOWER EXTRMITIES WHILE IN BED. PRESENTLY RESTING IN LONG INTERVALS NO DISTRESS CALL LIGHT AND FLUIDS IN REACH. VS 98.1 71 18 114/60 O2 95% ROOM AIR
Signed by: Michelle McCarley *Co-signed by:*

7/1/2014 5:56 PM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE
FAIR TO POOR APPETITE; ATE 25% OF BREAKFAST AND 40% OF LUNCH WITH SET UP HELP ONLY. RESIDENT C/O STOMACH PAIN WHILE EATING. APPOINTMENT SCHEDULED WITH DR. YANTIS WHO SUGGEST AN UPPER ENDOSCOPY; RESIDENT STATSE SHE WANTS THIS PROCEDURE: DAUGHTER AWARE AND AGREES. RESIDENT ALERT AND ORIENTED X 3. PLEASANT AND COOPERATIVE WITH CARES. CONTINENT OF BOWEL AND BLADDER. ABD SOFT WITH BS + X 4. CARDIOVASCULAR SYSTEM STABLE. SKIN IS WARM AND DRY; DRESSING TO RIGHT HIP. LEFT HIP AND LEFT UPPER CALF ARE CLEAN, DRY AND INTACT. 1+ EDEMA NOTED TO BILATEARL LOWER EXTREMITY; LEGS ELEVATED WHILE IN BED. RESPIRSTIONS EVEN AND UNLABORED; DENIES SOB. CONTINUES WITH THERAPY PER ORDER WITH GOOD PARTICPATION. VS: 104/59, 70, 18, 97.0 ORAL TEMP, 94% ON ROOM AIR.
Signed by: Cora Cunningham *Co-signed by:*

7/1/2014 2:46 AM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE
THIS IS THE DAILY MEDICARE NOTE FOR 6/30/14. VS: 149/73, 69, 97.5, 18, 96% ON RA. RESIDENT IS ALERT AND ORIENTED X3, ABLE TO VOICE WANTS AND NEEDS. PLEASANT AND COOPERATIVE WITH CARE. RESIDENT DENIES ANY BREAKTHROUGH PAIN NOTED. RESIDENT CONTINUES ON SCHEDULE NORCO WITH EFFECTIVE PAIN RELIEF NOTED. RESIDENT REQUIRES ASSIST X1 WITH ADL'S AND TRANSFERS. RESIDENT USES WHEELCHAIR FOR MOBILITY, ABLE TO PROPEL SELF. RESIDENT CONTINUES ON A NAS DIET, TOLERATING WELL. RESIDENT IS ABLE TO FEED SELF WITH SET UP, CONTINUES TO HAVE GOOD APPETITE.RESIDENT IS CONTINENT OF BOWEL AND BLADDER, WITH INCONTINENT EPISODES, KEPT CLEAN AND DRY BY STAFF. BOWEL SOUNDS PRESENT X4. ABDOMEN IS SOFT, NONTENDER, NONDISTENDED. NEUROLOGICAL AND GASTROINTESTINAL SYSTEM IN STABLE CONDITION. NO COMPLAINTS OF N/V NOTED. NO SIGNS OR SYMPTOMS OF ACUTE RESPIRATORY OR CARDIAC DISTRESS NOTED. RESPIRATIONS ARE EVEN AND UNLABORED. LUNG SOUNDS ARE CLEAR BILATERALLY. NO SOB NOTED. NO COMPLAINTS OF CHEST PAIN NOTED. SKIN IS WARM AND DRY. DRESSINGS IN PLACE TO BILATERAL LOWER EXTREMITIES. DRESSINGS ARE CLEAN, DRY AND INTACT. RESIDENT CONTINUES WITH THERAPY PER ORDER WITH GOOD PARTICIPATION. RESIDENT IS CURRENTLY RESTING IN BED. CALL LIGHT WITHIN REACH. NO SIGNS OR SYMPTOMS OF DISTRESS NOTED.
Signed by: Jenna Donovan *Co-signed by:*

6/30/2014 10:46 AM *Role:* LICENSED NURSE *Category:* NURSING NOTE
VOICE MAIL LEFT FOR DAUGHTER, JOAN, REQUESTING RETURN CALL R/T H.PYLORI TEST
Signed by: Cora Cunningham *Co-signed by:*

Parrott, Delila (80987) *Room:* *Medical Record no: 80987*

PAIN. CURRENTLY IN GYM WITH THERAPY. CONTINUES WITH THEARPY PER ORDERS WITH GOOD PARTICPATION. VS: 148/63, 64, 97.8 ORAL TMEP, 18, 96% ON ROOM AIR.
Signed by: Cora Cunningham *Co-signed by:*

Addendum 7/10/2014 1:47 PM

FROM 7/7/14: FEVER SORE TO LOWER LIP WELL HEALED. RESIDENT REQUEST TO D/C ABREVA CREAM. W. GREENE PA MADE AWARE WITH NEW ORDER TO D/C. ORDER IMPLAMENTED. RESIDENT AND FAMILY AWARE.
Addendum signed by: Cora Cunningham *Co-signed by:*

7/7/2014 3:26 AM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE

THIS IS THE DAILY MEDICARE NOTE FOR 7/6/14. VS: 139/60, 68, 98.4, 18, AND 96% ON ROOM AIR. SHE IS ALERT AND ORIENT X 2 WITH EPISODES OF CONFUSION/HALLUCINATIONS. SHE IS VERBAL AND ABLE TO MAKE MOST NEEDS KNOWN, NEEDS ARE ALSO ANTICIPATED AND MET BY STAFF. SHE IS PLEASANT AND COOPERATIVE WITH CARE, ALTHOUGH SHE OCCASIONALLY REFUSES ORDERED MEDS AND TX.SKIN IS WARM, DRY, AND INTACT WITH EXCEPTION OF DRESSINGS TO LEFT AND RIGHT THIGH, DRY DRESSINGS ARE INTACT AND DRY. NO CARDIAC, RESPIR., OR GU DISTRESS NOTED THIS SHIFT. RESIDENT C/O OF UPSET STOMACH THIS SHIFT AND ADMINISTRED PRN MAALOX WITH POSITIVE EFFECTIVENESS. RESIDENT RQST THIS NURSE CALL HER DAUGHTER VIA RES OWN CELL. RES STATED TO DAUGHTER THAT THIS WAS AN "EMERGENCY" AND THAT PEOPLE WERE COMING FROM THE WOODS AND LEAVING THINGS IN HER ROOM. ATTEMPTED TO REDIRECT RESIDENT-PARTIALLY SUCCESSFUL. DAUGHTER CALLED NURSE STATION AND RQST RESIDENT BE ADMINISTRED PRN VALIUM R/T ANXIETY. ADMINISTRED DOSE WITH POSITIVE EFFECTIVENESS. RESIDENT IS CONTINENT OF BOWEL AND BLADDER WITH OCCASIONAL ACCIDENTS. SHE ASSIST X 1 WITH ADLS AND TRANSFER AND IS ABLE TO FEED SELF WITH SET-UP ASSISTANCE FROM STAFF. CURRENTLY RESIDENT IS IN BED WITH EYES CLOSED AND IN NO ACUTE DISTRESS. SHE IS ACTIVE ON THERAPY CASELOAD.
Signed by: Aziza Gary *Co-signed by:*

7/5/2014 6:26 PM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE

RESIDENT ALERT AND ORIENTED X 3. NO COMPLAINST OF BREAKTHROUGH PAIN; RESIDENT IS ON SCHEDULED

NORCO. DRESSINGS CHANGED AND BACITRACIN APPLIED PER ORDER. LEGS ELEVATED TODAY WHILE IN BED.

ABLE TO VERBALIZE NEEDS. VERY NICE AND PLEASANT. COMPLIANT WITH CARE AND MEDICATIONS. NO S/S

OF RESPIRATORY DISTRESS; LUNG SOUNDS CLEAR AND PRESENT IN ALL LOBES. CONTINENT OF B AND B. RESIDENT REQUIRES SET UP FOR MEALS, AND ASSIST X 1 IN ADLS AND TRANSFERS. USES WHEELCHAIR FOR MOBILITY WITH ASSIST. SKIN WARM AND DRY. NO COMPLAINTS OF NAUSEA, VOMITING, OR DIAHRREA. RESIDENT HAS MODERATE APPETITE TODAY; ATE 40% OF BREAKFAST AND 50% OF LUNCH. NEUROLOGICAL SYSTEM IN STABLE CONDITION. CARDIAC STATUS IN STABLE CONDITION.

CONTINUES WITH PT/OT WITH GOOD RESPONSE. VS 108/56, 97.7, 60, 94%, 18.
Signed by: Dawn Thomas *Co-signed by:*

7/6/2014 1:16 PM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE

THIS IS A LATE ENTRY DAILY MEDICARE NOTE FOR 7/3/14. RESIDENT IS ALERT AND ORIENTED X3. NO COMPLAINTS OF BREAKTHROUGH PAIN AT TIME OF ASSESSMENT IN AFTERNOON. RESIDENT HAS FOAM WEDGE BETWEEN LEGS WHILE IN BED PER ORDERS. BACITRACIN AND DRESSING APPLIED PER ORDERS. RESIDENT REQUIRES SET UP FOR MEALS, ASSIST X1 FOR ADL'S AND TRANSFERS, AND USES WHEELCHAIR FOR MOBILITY. RESIDENT IS CONTINENT OF BOWEL AND INCONTINENT OF BLADDER X2; PERI CARE PROVIDED. BOWEL SOUNDS X 4 QUADRANTS. LUNG SOUNDS CLEAR AND PRESENT IN ALL LOBES. RESIDENT HAS NO COMPLAINTS OF SHORTNESS OF BREATH. S1 AND S2 AUSCULATED; NO SIGNS OF CARDIAC DISTRESS; NO COMPLAINTS OF CHEST PAIN. SKIN IS WARM AND DRY. POOR APPETITE TODAY, BUT COPIOUS FLUID CONSUMPTION, INCLUDING ENSURE PER ORDERS. RESIDENT IS ABLE TO MAKE NEEDS KNOWN. CONTINUES WITH THERAPY PER ORDERS WITH GOOD PARTICIPATION. VS 97.7, 18, 108/57, 67, 95%.
Signed by: Dawn Thomas *Co-signed by:*

7/5/2014 3:50 AM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE

VS: 128/67, 62, 97.7, 18, AND 97% ON ROOM AIR. RESIDENT IS ALERT AND ORIENT X 3 WITH WITH CONFUSION AT TIMES. SHE IS VERBAL AND ABLE TO MAKE NEEDS KNOWN. RESIDENT INCONT. OF BOWEL AND BLADDER WEARS ADULT BRIEFS AND IS KEPT CLEAN AND DRY BY STAFF. NO S/S OF CARDIAC, RESPIR., GI, AND GU DISTRESS AT THIS TIME. RESIDENT C/O PAIN ONCE THIS SHIFT, WAS IN TEARS, RES WAS ADMINISTERED SCHEDULED PAIN MED AND PRN VALIUM WITH POSITIVE EFFECTIVENESS. RESIDENT IS ASSIST X 1 WITH ADLS AND TRANSFERS TO W/C

MUSC Health

"CONSULT"

PHYSICIAN CONSULTATION REPORT

Page 1 of 2

Form Origination Date: 1/00
Version: 4 Version Date: 1/10

SP - Magnolia 125

Patient Name Parrott, Delila
MRN

PATIENT IDENTIFICATION LABEL

Physician / Service notified by: Date: 7-10-14
Requested by Attending Dr. Pager ID: Service being consulted: psych
CC / Reason for Request: flashbacks

HPI: 80 yo WLOF at SP since 6/10/14 following hosp. at MY. P Hosp. for LW, fx s/p ORIF, pt fell at Sandpiper Village & was discovered by a friend 2 days later. She was dehydrated & had some skin breakdown, also UTI. D/C'd home - CeDura 10 QD & Biz injections. Reports pt's Medicine Summary notes delirium & anxiety & problems. At SP pcp Valium started on 6/10/14. Pharmacy shows pt continued on 2/2 - stated people coming from woods & leaving glass - then from she received pcp Valium. She was fearful & expressed wishes she wanted the water off decol. She recalls the fall, her fear & hanging from wall for 2 days. Intrusive memories

Allergies: Aceclofenac, NSAIDs, ASA, nasal spray Medications: Lasix, Nexium, Colace, Ultega 1000, Diltiazem, Vit B12, M Mononitr, Norco PRN, Valium 2 daily PRN, Tramadol PRN, Indocin, Neuro. 7.5/325 BID

PMH: (D) Wrist fx s/p ORIF, chronic diarrhea/possible colitis, anemia of acute

SH: (P) CVA. (D) - psychiatric Disorder SH: widow (H) was pharmacist.

ROS: Constitutional PCP Dr. Wills in MT P.
Eyes
ENT
Cardio
Resp
GI chronic diarrhea — colonoscopy scheduled for July 8th
GU
☑ All others reviewed and negative ☐ UNABLE TO OBTAIN HISTORY DUE TO:

Integument
Musc / skeletal ↓ pain in wrist. Good PT effort.
Endo
Psych sleeps well, avg anxiety, WNL, cooperative
Neuro
Heme / Lymph anemia s/p 2 units RBC's.
Allerg / Immun

PHYSICAL EXAMINATION: T 97.8 °C P 104 RR 18 BP 146/63 O_2 Sat 96 %

Area	WNL	Area	WNL	Labs / Xrays
Genl appearance	☐ Meds (cont)	Heart	☐ At SP	Labs at P -
Skin	☐ —	GI / Abdomen	☐ H Pylori 1960 T	CXR - ↓ acute process
Head	☐	Genitourinary	☐ 1.16 - will	BNP C diff (-)
Eyes	☐	MS / Extremities	☐ Hx of.	Na 143, K 3.9, Cl 112,
ENT	☐	Neuro	☐ 10/12/14 -	CO2 28, BUN 18, cr 0.5
Neck	☐	Heme / Lymph	☐ 4.89/247	glc 105
Breasts	☐	Psych	☐ 10.5	LFT's WNL & SGOT 39
Lung / Chest	☐	Other	☐ 6/16 - wireworm (-).	EKG - SR PAC's.

Abnormal findings / Additional comments
Path (cont) - blood loss, HTN, Afib, chronic anemia, uterine colon s/p TX, Biz deficiency, macular degeneration, GERD, OSA

Lt - remote W/O smoking. (S) in Columbia. college edu. married twice, (H) also divorced from 1st (H). Nurse anesthetist. Caregiver for 2nd (H) also died from cancer at home in 2008. 1 son in Florence, (D) at folly beach, (D) in Columbia Nurse (RP). Pt adopted - mother died in childbirth. Adopted 1 her brother, 3 other sibs. ↓ childhood abuse or trauma.

Clinician Signature Pager ID Date of consult Time
all_all_consult_medconsult

Lived in Folly with 1 y ago — then SP Village. Quit driving a few months ago. ↓ etoh / Drugs / tobacco. (NC)

OTE 700321 Rev. 1/10

7/10/14

014

MUSC Health

"CONSULT"

PHYSICIAN CONSULTATION REPORT

Page 2 of 2

Form Origination Date: 1/00
Version: 3 Version Date: 2/08

SP - Moquova 125

Patient Name Parrott, Delila
MRN

PATIENT IDENTIFICATION LABEL

ASSESSMENT / PLAN:

4th - (pt + also (+) gang collateral). No formal 4th tx until 2003 when she was hosp. at baptist geri unit in Columbia for s/s of delirium of paranoia's. Briefly took seroquel but never compliant. Has taken celexa for years per PCP, + alc h/o + xanax prn for anxiety (hx of). Long h/o paranoia & delusions. For ex.) sees a van parked near house & thinks it is photographing her. No clear h/o AVH. Somatic delusions since last 4g's - 4levels washing, ? steroids can control her BP, for ex. Delusion of bug infestation more recent (since 2003 ? (+) drug). Has taped up her vagina/anus + keep bugs out & excessively used enemas & douches. ? insight into psychosis. ? formal suicide attempts.

(MSE) - pt in room c 5 yr-law visiting. Appropriately dressed & groomed. Gait & observed. ? tremor or abn. movements. Speech soft but slow normal. Mild word finding difficulty. Mood "I'm to stay upbeat & hopeful". Affect constricted, tearful. TC OS/PATHON (+) delirium of logic in woods by her room c mild, mostly grossly intact. TP - linear, coherent. A/C - mildly impaired SM/LTM - Blanked - A+O x 3. J/I - mild - mod impaired.

8 10/28

Clinician Signature _____ Pager ID _____ Date of consult _____ Time _____

ATTENDING PHYSICIAN COMMENTS:

I have reviewed the history, physical exam and plan of care and after my examination and interview of the patient, I agree with the findings. I have the following additional findings:

(A/P) - Delirium 2° opiates/dehydration/uti resolving
Depression NOS
Psychosis NOS (Delusional D/o v. MDD c psys) most likely

① Depression - worsened c acute trauma & health decline. + Celexa 20 mg QD. For acute anxiety use Xanax 0.25 Q8 prn. D/c Xanax.

② Psychosis - chronic, non-compliant c tx, refuses antipsychotic - likely delusional D/o.

③ Cognition - no h/o dementia or decline. ~~Deficits~~ Deficits on exam may be 2° depression/delirium, but needs to be tracked over time for improvement. may need AL level of care. ran flu in geriatric & clinic - 792-5567 x 2.

Attending Signature _____ Pager ID _____ Date of consult _____ Time _____

all_ell_consult_medconsult OTE 700321 Rev. 2/08

Plan also (D) WLD osteoporosis - Nurse/Celexa - Hx of MRSA - Hx of UTIs

Parrott, Delila (80987) *Room:* *Medical Record no: 80987*

SKIN IS WARM AND DRY. DRESSINGS IN PLACE TO BILATERAL LOWER EXTREMITIES. DRESSINGS ARE CLEAN, DRY AND INTACT. RESIDENT CONTINUES WITH THERAPY PER ORDER WITH GOOD PARTICIPATION. RESIDENT IS CURRENTLY RESTING IN BED, CALL LIGHT WITHIN REACH. NO SIGNS OR SYMPTOMS OF DISTRESS NOTED.
Signed by: Jenna Donovan *Co-signed by:*

7/10/2014 7:58 PM *Role:* LICENSED NURSE *Category:* NURSING NOTE
WEDGE D/C PER PT RECOMENDATION. NEW ORDER FOR L MULTIPODUS BOOT WHILE IN BED FOR POSITIONING WHILE IN BED. ORDER IMPLAMENTED. DAUGHTER, JOAN, MADE AWARE.
Signed by: Cora Cunningham *Co-signed by:*

7/10/2014 4:28 PM *Role:* Social Service Assistant *Category:* SOCIAL SERVICES
SS requested that MD evaluate Ms. Parrot's mental capacity.
Signed by: Carl Jo Merwin *Co-signed by:*

7/10/2014 3:59 PM *Role:* Social Service Assistant *Category:* SOCIAL SERVICES
30 Day Assessment
Ms. Parrott can be pleasant, has a very flat affect and it has been noted she can become tearful. She admits to depression, little pleasure in doing things, and little energy daily. When SS asked Ms. Parrott if she had any negative thoughts lately, she answered, "now that's a stupid question" and would not answer the question. SS asked her if she had any plan and she stated, "no." She also stated, "I don't have anything to be happy about." A psych consult was ordered on 6/26/14 and SS made DON aware of psych order. SS also made her nurse aware of her s/s of depression. Ms. Parrott's BIM score does not indicate cognitive impairment. It was noted on 7/7/14 she told her daughter that it was an emergency. She told her that people were coming from the woods and leaving things in her room. Ms. Parrott is slowly progressing in therapy with encouragement. Ms. Parrott is taking Celexa and Vallum PRN. Will continue to monitor mood, behavior and cognition.
Signed by: Carl Jo Merwin *Co-signed by:*

7/9/2014 4:39 PM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE
RESIDENT REMAINS ALERT AND ORIENTED X 3. PLEASANT IN MOOD TODAY. COOPERATIVE WITH CARSE. CONTINENT OF BOWEL AND BLADDER. REPORTS REGULAR BMS. ATE 25% OF LUNCH WITH SET UP HELP ONLY. DRANK 100% OF ENSURE. DENIES GI UPSET, NO NAUSEA, VOMITTING OR LOOSE STOOLS NOTED. REQUIRES ONE ASSIST TO SET UP HELP WITH ADLS. TWO ASSIST WITH TRANSFERS. ONE ASSIST WITH MOBILITY. USES W/C. CARDIOVASCULAR SYSTEM STABLE. SKIN IS WARM AND DRY. DRESSING TO RIGHT HIP, LEFT HIP AND LEFT ANTICUBITAL REMAIN CLEAN, DRY AND INTACT. RESPIRATIONS EVEN AND UNLAOBRED WITH NO C/O SOB. RESIDENT CONTINUES WITH THERAPY PER ORDER WITH GOOD PARTICPATION.
Signed by: Cora Cunningham *Co-signed by:*

7/8/2014 11:46 PM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE
RES IS ALERT AND ORIENTED X3 VERBALLY RESPONSIVE NO COMPLAINTS OF PAIN AT THIS TIME. CONTINUES SCHEDULED NORCO FOR PAIN MAINTENANCE. NO RESPIRATORY DISTRESS NOTED NO CARDIAC ISSUES NO GASTROINTESTINAL ISSSUES NOTED NOP N/V INCONTINENT OF BOWEL AND BLADDER ADLS WITH MODERATE ASSIST OF ONE. TRANSFERS ONE ASSIST USING W/C FOR TRANSPORT. CONTINUES PT/OT/ST SERVICES AS DIRECTED. WEDGE IN PLACE BETWEEN LEGS WHEN IN BED. SKIN DRY AND WARM DRESSING TO LOWER EXTREMITIES INTACT. RESTING QUIETLY CALL LIGHT AND FLUIDS IN REACH VS 98.2 64 18 150/58 O2 96% ROOM AIR
Signed by: Michelle McCarley *Co-signed by:*

7/8/2014 8:14 PM *Role:* LICENSED NURSE *Category:* NURSING NOTE
NEW ORDERS: AMOXICILLIN 1 G PO BID; CLARTHROMYCIN 500 MG PO BID IF FAMILY DESIRES. DAUGHTER JOAN, RESPONSIBLE PARTY, DECLINES AND STATES SHE WISHES TO WAIT FOR ENDOSCOPY RESULTS (SCOPE SCHEDULED FOR 7/15) BEFORE PROCEEDING WITH TREATMENT. DR. MURK CANCELLED ORDER.
Signed by: Dawn Thomas *Co-signed by:*

7/7/2014 11:59 AM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE
RESIDENT IS ALERT AND ORIENTED X 3. TEARFUL TODAY. REASSURACNE PROVIDED WITH EFFECTIVE RESULTS. DENIES PAIN. CONTINUES WITH SCHED NORCO. CONTINENT OF BOWEL AND BLADDER WITH INCONTINENT EPISODES. C/O DYSURIA. W. GREENE PA NOTIFIED WITH NEW ORDER. DAUGHTER, JOAN, AWARE. CARDIOVASCULAR SYSTEM STABLE : S1 AND S2 ASCULATATED. LUNG SOUNDS CLEAR BUT DIMINISHED THROUGHOUT. ABD SOFT WITH BS + X 4. CONTINUES WITH ENSURE BID WITH GOOD INTAKE. RESIDENT DENIES

Parrott, Delila (80987) *Room:* *Medical Record no: 80987*

THIS IS THE DAILY MEDICARE NOTE FOR 7/24/2014. VS: 147/52, 68, 98.1, 18, 100% ON RA. RESIDENT IS ALERT AND ORIENTED X3, ABLE TO VOICE WANTS AND NEEDS. PLEASANT AND COOPERATIVE WITH CARE. RESIDENT HAD COMPLAINTS OF PAIN TO HIP THIS EVENING, PRN NORCO ADMINISTERED WITH POSITIVE EFFECT. RESIDENT REQUIRES ASSIST X1 WITH ADL'S AND TRANSFERS. RESIDENT USES WHEELCHAIR FOR AMBULATION. RESIDENT IS CONTINENT OF BOWEL AND BLADDER. BOWEL SOUNDS PRESENT X4, ABDOMEN IS SOFT, NONTENDER, NONDISTENDED. RESIDENT CONTINUES TO HAVE A GOOD APPETITE.NEUROLOGICAL AND GASTROINTESTINAL SYSTEM IN STABLE CONDITION. NO COMPLAINTS OF N/V, CONSTIPATION OR LOOSE STOOLS NOTED. NO SIGNS OR SYMPTOMS OF ACUTE CARDIAC OR RESPIRATORY DISTRESS NOTED. RESPIRATIONS ARE EVEN AND UNLABORED. LUNG SOUNDS ARE CLEAR BILATERALLY. NO SOB NOTED. NO COMPLAINTS OF CHEST PAIN NOTED. SKIN IS WARM AND DRY. RESIDENT CONTINUES WITH THERAPY AS ORDERED WITH GOOD PARTICIPATION. RESIDENT CURRENTLY RESTING IN BED, CALL LIGHT WITHIN REACH. NO SIGNS OR SYMPTOMS OF DISTRESS NOTED.

Signed by: Jenna Donovan *Co-signed by:*

7/23/2014 4:28 PM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE

RESIDENT REMAINS ALERT AND ORIENTED X 2. PLEASANT IN MOOD TODAY AND COOPERATIVE WITH CARES. DENIES PAIN. CONTINENT/INCONTINENT OF BOWEL AND BLADDER: ABD SOFT: REPORTS RECENT BM. ATE 60% OF LUNCH WITH SET UP HELP ONLY. 100% OF ENSURE. CONTINUES WITH ENSURE EVERY MEAL. CARDIOVASCULAR SYSTEM STABLE: DENIES CHEST PAIN. SKIN IS WARM AND DRY. RESPIRATIONS EVEN AND UNLABORED. NO C/O SOB. RESIDENT CONTINUES WITH THERAPY PER ORDER WITH GOOD PARTICPATION. CONTINUES WITH BOOT TO LEFT LOWER LEG PER ORDER. VS: 111/51, 75, 98.2 ORAL TEMP, 20, 100% ON ROOM AIR

Signed by: Cora Cunningham *Co-signed by:*

7/23/2014 2:34 AM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE

NOTE FOR 7/22/2014 RES IS PRESENTLY RESTING IN LONG INTERVALS COMPLAINTS OF PAIN BOTH LOWER EXTREMITIES AT 11PM ULTRAM GIVEN AS ORDERED PRN AND EFFECTIVE. NO SOB OR COUGH PRESENT LUNGS CLEAR BILATERALLY. NO CARDIAC ISSUES NOTED. ABD IS SOFT NONTENDER POSITIVE BOWEL SOUNDS PRESENT ALL QUADS. INCONTINENT OF BOWEL AND BLADDER INCONTINENT CARE PROVIDED AS NEEDED. ADLS WITH MODERATE ASSIST OF ONE. TRANSFERS ONE ASSIST USES W/C FOR MOBILITY. CONTINUES PARTICIPATION IN OT/PT SERVICES. SKIN IS DRY AND WARM TO TOUCH NO EDEMA PRESENT. PLEASANT AND COOPERATIVE DURING CARE ALERT AND ORIENTED X2 WHEN AWAKE. VS 98.9 83 18 140/68 O2 100% ROOM AIR

Signed by: Michelle McCarley *Co-signed by:*

7/21/2014 10:38 AM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE

RESIDENT ALERT AND ORIENTED X 3. RESIDENT IS ON SCHEDULED NORCO, BUT REFUSED "BECAUSE I'M NOT IN ANY PAIN." ORDER SUBSEQUENTLY CHANGED TO PRN; DAUGHTER JOAN NOTIFIED. BACITRACIN APPLIED PER ORDER. CONTINUES WITH MULTIPODUS BOOT TO LEFT FOOT IN BED FOR POSITIONING. ABLE TO VERBALIZE NEEDS. VERY NICE AND PLEASANT. NO SIGNS OR SYMPTOMS OF RESPIRATORY DISTRESS. CONTINENT OF BOWEL AND BLADDER. SET UP FOR MEALS, AND ASSIST X 1 IN ADLS AND TRANSFERS. USES WHEELCHAIR FOR MOBILITY WITH ASSIST. SKIN WARM AND DRY. NO COMPLAINTS OF NAUSEA, VOMITING, OR DIARRHEA. RESIDENT HAS GOOD APPETITE TODAY; ATE 80%% OF BREAKFAST. NEUROLOGICAL SYSTEM IN STABLE CONDITION. CARDIAC STATUS IN STABLE CONDITION. CONTINUES WITH PT/OT WITH GOOD RESPONSE.

Signed by: Dawn Thomas *Co-signed by:*

7/21/2014 2:38 AM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE

THIS IS THE DAILY MEDICARE NOTE FOR 7/20/2014. VS: 121/59, 68, 97.5, 16, 96% ON RA. RESIDENT IS ALERT AND ORIENTED X3, ABLE TO VOICE WANTS AND NEEDS. PLEASANT AND COOPERATIVE WITH CARE. RESIDENT DENIES ANY PAIN OR DISCOMFORT AT THIS TIME. RESIDENT REQUIRES ASSIST X1 WITH ADL'S AND TRANSFERS. RESIDENT USES WHEELCHAIR FOR MOBILITY, ABLE TO PROPEL SELF. RESIDENT CONTINUES ON A REGULAR DIET, TOLERATING WELL. RESIDENT IS ABLE TO FEED SELF WITH SET UP. RESIDENT IS CONTINENT OF BOWEL AND BLADDER WITH INCONTINENT EPISODES, KEPT CLEAN AND DRY BY STAFF. BOWEL SOUNDS PRESENT X4. ABDOMEN IS SOFT, NONTENDER, NONDISTENDED. NEUROLOGICAL AND GASTROINTESTINAL SYSTEM IN STABLE CONDITION. NO COMPLAINTS OF N/V, LOOSE STOOL OR CONSTIPATION NOTED. NO SIGNS OR SYMPTOMS OF ACUTE RESPIRATORY OR CARDIAC DISTRESS NOTED. RESPIRATIONS ARE EVEN AND UNLABORED. LUNG SOUNDS ARE CLEAR BILATERALLY. NO SOB NOTED. NO COMPLAINTS OF CHEST PAIN NOTED. SKIN IS WARM AND DRY. RESIDENT CONTINUES WITH PODUS BOOT TO LEFT FOOT PER ORDER, TOLERATING WELL. RESIDENT CONTINUES WITH THERAPY PER ORDER WITH GOOD PARTICIPATION. RESIDENT CURRENTLY RESTING IN BED. CALL LIGHT WITHIN REACH. NO SIGNS OR SYMPTOMS OF DISTRESS NOTED.

Signed by: Jenna Donovan *Co-signed by:*

Parrott, Della (80987) *Room:* *Medical Record no: 80987*

RESIDENT IS ALERT AND ORIENTED X 3 WITH OCCASIONAL CONFUSION. NO COMPLAINTS OF PAIN AS OF ASSESSMENT. RESIDENT IS WEIGHT BEARING AS TOLERATED TO LEFT LOWER EXTREMITY. ABLE TO VERBALIZE NEEDS. VERY NICE AND PLEASANT. NO SIGNS OR SYMPTOMS OF RESPIRATORY DISTRESS. CONTINENT OF BOWEL AND BLADDER. SET UP TO ASSIST X 1 IN ADLS AND TRANSFERS. USES WHEELCHAIR FOR MOBILITY WITH ASSIST OR INDEPENDENTLY. SKIN WARM AND DRY. NO COMPLAINTS OF NAUSEA, VOMITING, OR DIARRHEA. RESIDENT HAS MODERATE APPETITE TODAY; ATE 60% OF BREAKFAST AND 60% OF LUNCH. NEUROLOGICAL SYSTEM IN STABLE CONDITION. CARDIAC STATUS IN STABLE CONDITION. CONTINUES WITH PT/OT WITH GOOD

RESPONSE. VS 135/72, 66, 18, 98.0, 97%.
Signed by: Dawn Thomas *Co-signed by:*

8/7/2014 3:37 PM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE

RESIDENT ALERT AND ORIENTED X 3. PLEASANT IN MOOD. RESIDENT REFUSING TO WEAR MULTIPODUS BOOT; BOOT D/C PER PT AND DR. MURK; RESIDENT AND DAUGHTER MADE AWRES. RESIDENT DENIES PAIN. CONTINENT OF BOWEL AND BLADDER. BOWEL MOVEMENT TODAY. ATE 50% OF LUNCH WITH SET UP HELP ONLY. REQUIRES SET UP HELP TO ONE ASSIST WITH ADLS, TRANSFERS AND MOBILITY; USES W/C. CARDIOVASCULAR SYSTEM STABLE. SKIN IS WARM AND DRY. RESPIRATIONS EVEN AND UNLABORED. NO C/O SOB. RESIDENT CONTINUES WITH THERAPY PER ORDER WITH GOOD PARTICPATION. VS: 136/69, 63, 98.0 ORAL TEMP, 18, 95% ON ROOM AIR.
Signed by: Cora Cunningham *Co-signed by:*

8/7/2014 4:19 AM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE

THIS IS THE DAILY MEDICARE NOTE FOR 8/6/2014. VS: 112/61, 72, 98.0, 20, 98% ON RA. RESIDENT IS ALERT AND ORIENTED X3, ABLE TO VOICE WANTS AND NEEDS. RESIDENT IS PLEASANT AND COOPERATIVE WITH CARE. RESIDENT DENIES ANY PAIN OR DISCOMFORT AT THIS TIME. RESIDENT REQUIRES ASSIST X1 WITH TRANSFERSCAND ADL'S. RESIDENT USES WHEELCHAIR FOR MOBILITY. RESIDENT IS CONTINENT OF BOWEL AND BLADDER WITH INCONTINENT EPISODES, KEPT CLEAN AND DRY BY STAFF. RESIDENT CONTINUES TO HAVE A GOOD APPETITE, ABLE TO FEED SELF WITH SET UP; BOWEL SOUNDS PRESENT X4, ABDOMEN IS SOFT, NONTENDER, NONDISTENDED. NEUROLOGICAL AND GASTROINTESTINAL SYSTEM IN STABLE CONDITION. RESIDENT DENIES ANY N/V, CONSTIPATION OR LOOSE STOOLS. NO SIGNS OR SYMPTOMS OF ACUTE RESPIRATORY DISTRESS NOTED. RESPIRATIONS ARE EVEN AND UNLABORED. LUNG SOUNDS ARE CLEAR BILATERALLY. NO SOB NOTED. NO COMPLAINTS OF CHEST PAIN NOTED. SKIN IS WARM AND DRY. RESIDENT CONTINUES WITH THERAPY PER ORDER WITH GOOD PARTICIPATION. NO SIGNS OR SYMPTOMS OF DISTRESS NOTED. RESIDENT CURRENTLY RESTING IN BED, CALL LIGHT WITHIN REACH.
Signed by: Jenna Donovan *Co-signed by:*

8/5/2014 4:03 PM *Role:* Resident Interviewer *Category:* MDS

a pain assessment interview was done.
Signed by: Cassandra Gibbs *Co-signed by:*

8/5/2014 8:30 AM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE

NOTE FOR 8/04/2014 RES IS ALERT AND ORIENTED X2 VERBALLY RESPONSIVE NO COMPLAINTS OF PAIN NO RESPIRATORY DISTRESS NO SOB NO CARDIAC ISSUES. NO GASTROINTESTINAL ISSUES NOTED NO N/V OR LOOSE STOOLS NOTED. SKIN DRY AND WARM NO SKIN ISSUES NOTED NO EDEMA PRESENT INCONTINENT OF BOWEL AND BLADDER INCONTINENT CARE PROVIDED AS NEEDED. TRANSFERS ONE ASSIST W/C FOR TRANSPORT CONTINUES PT/OT SERVICES VS 98.4 67 16 160/75 O2 95% ROOM AIR
Signed by: Michelle McCarley *Co-signed by:*

8/3/2014 2:43 PM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE

VS: 119/59, P71, R18, T97.5 RESIDENT A&OX2-3 ABLE TO MAKE NEEDS KNOWN. RESIDENT PLEASANT AND COOPERATIVE DURING NURSING CARES. RESIDENT AMBULATORY WITH WALKER AND ASSIST X1. ASSIST X1 FOR ADLS. RESIDENT ABLE TO FEED SELF WITH STAFF SETTING UP TRAY. CONTINUES WITH ADEQUATE PO INTAKE. NO C/O PAIN THIS SHIFT. NO C/O NAUSEA/DIARRHEA NOTED. SKIN WARM DRY AND INTACT AND OF NORMAL COLOR FOR THIS RESIDENT. CURRENTLY RESTING WITH NO S/S DISTRESS NOTED. LUNGS CLEAR TO AUSCULTATION. RESPIRATIONS EVEN AND UNLABORED CV SYSTEMS INTACT. BED LOW, CALL BELL IN REACH.
Signed by: Amanda Morgan *Co-signed by:*

8/3/2014 2:16 AM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE

THIS IS A DAILY MEDICARE NOTE FOR 08/02/14. RESIDENT ALERT AND ORIENTED X 3. PLEASANT AND COOPERATIVE. ABLE TO MAKE NEEDS KNOWN. CARDIOVASCULAR SYSTEM STABLE. NO COMPLAINTS OF CHEST

ROPER ST. FRANCIS PHYSICIAN PARTNERS

PARROTT, DELILA W
80 Y old Female, DOB: REDACT
Account Number: 0000127282
2933 ASHLEY RIVER ROAD, CHARLESTON, SC-29414
Home: 843-881-1692
Guarantor: PARROTT, DELILA W Insurance: MEDICARE
Payer ID: PAPER
Appointment Facility: East Cooper Internal Medicine

10/09/2014

Progress Notes: Richard E. Mills MD

Current Medications

Taking
- MiraLax -- Packet 1 packet mixed with 8 ounces of fluid Once a day prn for constipation; stop date 12/22/2014
- Lasix 40 MG Tablet 1 tablet daily prn
- Nexium 40 MG Capsule Delayed Release 1 capsule Once a day
- Colace 100 MG Capsule 1 capsule as needed Once a day
- Celexa 10 MG Tablet 2 tablets Once a day
- Dilacor XR 180 MG Capsule Extended Release 24 Hour 1 capsule on an empty stomach in the morning Once a day
- Inderal LA 60 MG Capsule Extended Release 24 Hour
- Ultram 50 MG Tablet 1 tablet as needed every 6 hrs
- Norco 7.5-325 MG Tablet 1 to 2 tablets every 4 hours
- Xanax 0.25 MG Tablet 1 tablet Three times a day
- Macrobid 100 MG Capsule 1 capsule with food every 12 hrs; stop date 10/25/2014
- Docusate Sodium 100 MG Capsule 1 capsule as needed Once a day

Discontinued
- Vitamin B 12 100 MCG Lozenge
- Lumoil 2.5-0.025 MG Tablet 1 tablet as needed Four times a day
- Mylanta 200-200-20 MG/5ML Suspension 10 ml as needed Four times a day
- Medication List reviewed and reconciled with the patient

Past Medical History

Macular degeneration
HTN
GERD
Sleep apnea
OA
PAF 2008
Colonoscopy August 2013 - Dr. Joyner
Zostavax 2007
Pneumovax 2004

Surgical History

breast biopsy - left breast
left wrist Fx

Reason for Appointment

1. F/U MEDS
2. NERDS PAIN CONTRACT IF CONTINUE W/ NORCO
3. PARANOIA, AGITATION, SHORT TERM MEMORY LOSS, CONFUSION

History of Present Illness

Mrs. Parrot has not been here since January. She had a bad fall at home in June and was on the floor for 3 days until she was found. She is now in assisted living and doing better. Her daughter is with her today and expresses several concerns about her mood and mental status. Her daughter is concerned that she had a brain injury with the fall or a stroke because she has speech and memory trouble. She is not the same since the fracture. She is often agitated and irritable. She does not have any focal weakness since the fall.

Vital Signs

Ht 65 in, Temp 97.8, Pulse Sitting 70, BP 140/78 mm Hg, RR 18 /min, Oxygen saturation 95 %.

Examination

General Examination:

GENERAL APPEARANCE: alert, well hydrated, in no distress, elderly white female who is sitting in wheelchair, accompanied by daughter.

HEAD: normocephalic, atraumatic.

EYES: no lid lag, stare or proptosis, extraocular movement intact (EOMI), pupils equal, round, reactive to light.

ORAL CAVITY: tongue in midline, mucosa moist.

THROAT: uvula midline, pharynx normal.

NECK: neck supple, full range of motion.

HEART: S1, S2 normal.

LUNGS: clear to auscultation bilaterally, good air movement.

ABDOMEN: soft, nontender, nondistended, no masses palpable.

SKIN: good turgor, warm and dry.

MUSCULOSKELETAL: strength 4/5 in bilateral quadriceps, 4/5 strength on plantar flexion.

EXTREMITIES: 2+ pitting edema of LLE with compression stocking in place, 1+ edema of RLE.

NEUROLOGIC: alert, oriented to person, cooperative with exam.

multiple eye surgeries OU
Open reduction internal fixation left subtrochanteric femur fracture DR MURRAY 06/07/2014

Family History
Father: deceased, stroke
Mother: alive, childbirth
Spouse: deceased, arrhythmia
Adopted at 2 yrs. .

Social History
Tobacco Use:
Tobacco Use/Smoking Are you a: nonsmoker .
Tobacco Use/Smokeless: Denies
Smokeless Tobacco: No
Tobacco cessation
Patient counselled on the dangers of tobacco 10/29/2013
Cessation: Not applicable

Allergies
NSAIDS
sulfa
ASA
Altace
Diovan

Hospitalization/Major Diagnostic Procedure
see above

Review of Systems
General/Constitutional:
Fever denies. Chills denies. Headache denies. Fatigue denies. Night sweats denies. Change in appetite denies.

Respiratory:
Shortness of breath denies. Chest pain denies. Cough denies. Shortness of breath with exertion denies. Sputum production denies. Wheezing denies.

Cardiovascular:
Chest Pain denies. Dizziness denies. Palpitations denies.

Gastrointestinal:
Patient denies blood in stool, constipation, difficulty swallowing, rectal bleeding, weight loss. Abdominal pain denies. Exposure to hepatitis denies.

Musculoskeletal:
Fracture admits, left femur. Leg swelling admits, left.

Neurologic:
Patient denies balance difficulty, difficulty speaking, loss of strength, dysphagia. Patient complaining short term memory loss, no tremor, normal sensory exam.

PSYCH: good eye contact, mood/affect appropriate, speech clear, confused at times.

Assessments
1. HTN - 401.9 (Primary)
2. Confusion - 298.9
3. Short-term memory loss - 780.93
4. Fall - E888.9
5. Subtrochanteric fracture of femur - 820.22, Left
6. Hypoalbuminemia - 273.8
7. Hypocalcemia - 275.41
8. Anemia - 285.9

Treatment
1. HTN

LAB: COMP METABOLIC PANEL (CMP)		Normal result
ANION GAP CALC	11.0	7.0-16.0 - calc
ALBUMIN	3.7	3.5-5.0 - g/dL
ALK PHOS	140	40-150 - IU/L
B/C RATIO CALC	17.1	3.0-40.0 - calc
BILI TOTAL	0.4	0.2-1.2 - mg/dL
BUN	12.0	9.8-20.1 - mg/dL
CALCIUM	9.5	8.8-10.5 - mg/dL
Cl	100	99-110 - mmol/L
CO_2	30	21-32 - mmol/L
CREATININE	0.7	0.6-1.1 - mg/dL
GLUCOSE	87	70-105 - mg/dL
K	4.1	3.7-5.5 - mmol/L
NA	141	135-145 - mmol/L
PROTEIN	7.0	6.0-8.3 - g/dL
SGOT	21	5-34 - IU/L
SGPT	16	0-55 - IU/L

2. Confusion
Start QUEtiapine Fumarate ER Tablet Extended Release 24 Hour, 50 mg, 1 tablet in the evening, Orally, Once a day, 30 day(s), 30, Refills 03
IMAGING: CT HEAD W/O CONTRAST

3. Short-term memory loss
Start Aricept Tablet, 5 MG, 1 tablet at bedtime, Orally, Once a day, 30 day(s), 30, Refills 05
IMAGING: CT HEAD W/O CONTRAST

4. Fall
IMAGING: CT HEAD W/O CONTRAST

5. Hypoalbuminemia

LAB: COMP METABOLIC PANEL (CMP)		Normal result
ANION GAP CALC	11.0	7.0-16.0 - calc
ALBUMIN	3.7	3.5-5.0 - g/dL
ALK PHOS	140	40-150 - IU/L
B/C RATIO CALC	17.1	3.0-40.0 - calc
BILI TOTAL	0.4	0.2-1.2 - mg/dL

of daughter reports memory loss, confusion.
Psychiatric:
Patient complaining of daugher reports anxiety, agitation.

BUN	12.0	9.8-20.1 - mg/dL
CALCIUM	9.5	8.8-10.5 - mg/dL
CL	100	99-110 - mmol/L
CO2	30	21-32 - mmol/L
CREATININE	0.7	0.6-1.1 - mg/dL
GLUCOSE	87	70-105 - mg/dL
K	4.1	3.7-5.5 - mmol/L
NA	141	135-145 - mmol/L
PROTEIN	7.0	6.0-8.3 - g/dL
SGOT	21	5-34 - IU/L
SGPT	16	0-55 - IU/L

Notes: Her albumin level has significantly improved.

6. Hypocalcemia

LAB: COMP METABOLIC PANEL (CMP) Normal result

ANION GAP CALC	11.0	7.0-16.0 - calc
ALBUMIN	3.7	3.5-5.0 - g/dL
ALK PHOS	140	40-150 - IU/L
B/C RATIO CALC	17.1	3.0-40.0 - calc
BILI TOTAL	0.4	0.2-1.2 - mg/dL
BUN	12.0	9.8-20.1 - mg/dL
CALCIUM	9.5	8.8-10.5 - mg/dL
CL	100	99-110 - mmol/L
CO2	30	21-32 - mmol/L
CREATININE	0.7	0.6-1.1 - mg/dL
GLUCOSE	87	70-105 - mg/dL
K	4.1	3.7-5.5 - mmol/L
NA	141	135-145 - mmol/L
PROTEIN	7.0	6.0-8.3 - g/dL
SGOT	21	5-34 - IU/L
SGPT	16	0-55 - IU/L

Notes: Calcium is now WNL.

7. Anemia

LAB: CBC (COMPLETE BLOOD COUNT) Normal result

WBC	5.2		3.8-10.6 - K/uL
RBC	4.79		3.60-5.20 - M/uL
HGB	12.3		11.5-15.7 - g/dL
HCT	37.8		34.0-47.0 - %
MCV	78.9	L	81.0-99.0 - fL
MCH	25.6	L	27.0-34.5 - pg
MCHC	32.5		32.0-36.0 - g/dL
RDW	17.7	H	11.0-16.0 - %
MPV	7.6		7.2-11.2 - fL
PLATELET	269		140-440 - K/uL

Notes: Anemia resolved since acute postoperative blood loss.

Follow Up

4 Weeks

Images

Patient Letter 2014-10-9 23:17:38



Electronically signed by RICHARD MILLS MD on 10/10/2014 at 08:32 PM EDT

Sign off status: Completed

East Cooper Internal Medicine
180 WINGO WAY SUITE 306
MT PLEASANT, SC 29464-1812
Tel: 843-884-1777
Fax: 843-606-8000

Patient: PARROTT, DELILA W DOB: REDACTE Progress Note: Richard E. Mills MD 10/09/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

ROPER ST. FRANCIS

MRN: 001787037 DOB: REDACT
PARROTT,DELILA W IPD 3125-01
Mt Pleasant
PHYS:MILLS-MD,RICHARD E
ACCT#: 14284-00218 10/11/14

PARROTT, DELILA W

80 Y old Female, DOB: REDACT
Account Number: 0000127282
2333 ASHLEY RIVER ROAD, CHARLESTON, SC-29414
Home: 843-881-1692
Guarantor: PARROTT, DELILA W Insurance: MEDICARE
Payer ID: PAPER
Appointment Facility: East Cooper Internal Medicine

10/09/2014

Progress Notes: Richard E. Mills MD

Current Medications

Taking
- MiraLax – Packet 1 packet mixed with 8 ounces of fluid Once a day prn for constipation, stop date 12/22/2014
- Lasix 40 MG Tablet 1 tablet daily prn
- Nexium 40 MG Capsule Delayed Release 1 capsule Once a day
- Colace 100 MG Capsule 1 capsule as needed Once a day
- Celexa 10 MG Tablet 2 tablets Once a day
- Dilacor XR 180 MG Capsule Extended Release 24 Hour 1 capsule on an empty stomach in the morning Once a day
- Inderal LA 60 MG Capsule Extended Release 24 Hour
- Ultram 50 MG Tablet 1 tablet as needed every 6 hrs
- Norco 7.5-325 MG Tablet 1 to 2 tablets every 4 hours
- Xanax 0.25 MG Tablet 1 tablet Three times a day
- Macrobid 100 MG Capsule 1 capsule with food every 12 hrs, stop date 10/25/2014
- Docusate Sodium 100 MG Capsule 1 capsule as needed Once a day

Discontinued
- Vitamin B 12 100 MCG Lozenge
- Lomotil 2.5-0.025 MG Tablet 1 tablet as needed Four times a day
- Mylanta 200-200-20 MG/5ML Suspension 10 ml as needed Four times a day
- Medication List reviewed and reconciled with the patient.

Past Medical History

Macular degeneration
HTN
GERD
Sleep apnea
OA
PAP 2008
Colonoscopy August 2013 - Dr. Joyner
Zostavax 2007
Pneumovax 2004

Surgical History

breast biopsy - left breast
left wrist Px

Reason for Appointment

1. F/U MEDS
2. NEEDS PAIN CONTRACT IF CONTINUE W/ NORCO
3. PARANOIA, AGITATION, SHORT TERM MEMORY LOSS; CONFUSION

History of Present Illness

Mrs. Parrot has not been here since January. She had a bad fall at home in June and was on the floor for 3 days until she was found. She is now in assisted living and doing better. Her daughter is with her today and expresses several concerns about her mood and mental status. Her daughter is concerned that she had a brain injury with the fall or a stroke because she has speech and memory trouble. She is not the same since the fracture. She is often agitated and irritable. She does not have any focal weakness since the fall.

Vital Signs

Ht 65 in, Temp 97.8, Pulse Sitting 70, BP 140/78 mm Hg, RR 18 /min, Oxygen saturation 95 %.

Examination

General Examination:

GENERAL APPEARANCE: alert, well hydrated, in no distress, elderly white female who is sitting in wheelchair, accompanied by daughter.

HEAD: normocephalic, atraumatic.

EYES: no lid lag, stare or proptosis. extraocular movement intact (EOMI), pupils equal, round, reactive to light.

ORAL CAVITY: tongue in midline, mucosa moist.

THROAT: uvula midline, pharynx normal.

NECK: neck supple, full range of motion.

HEART: S1, S2 normal.

LUNGS: clear to auscultation bilaterally, good air movement.

ABDOMEN: soft, nontender, nondistended, no masses palpable.

SKIN: good turgor, warm and dry.

MUSCULOSKELETAL: strength 4/5 in bilateral quadriceps, 4/5 strength on plantar flexion.

EXTREMITIES: 2+ pitting edema of LLE with compression stocking in place, 1+ edema of RLE.

NEUROLOGIC: alert, oriented to person, cooperative with exam,

multiple eye surgeries OU
Open reduction internal fixation left subtrochanteric femur fracture DR MURRAY 06/07/2014

Family History

Father: deceased, stroke
Mother: alive, childbirth
Spouse: deceased, arrhythmia
Adopted at 2 yrs.

Social History

Tobacco Use:
Tobacco Use/Smoking: Are you a: nonsmoker.
Tobacco Use/Smokeless: Denies
Smokeless Tobacco: No
Tobacco cessation
Patient counselled on the dangers of tobacco 10/29/2013
Cessation: Not applicable

Allergies

NSAIDS
sulfa
ASA
Altace
Diovan

Hospitalization/Major Diagnostic Procedure

see above

Review of Systems

General/Constitutional:
Fever denies. Chills denies. Headache denies. Fatigue denies. Night sweats denies. Change in appetite denies.

Respiratory:
Shortness of breath denies. Chest pain denies. Cough denies. Shortness of breath with exertion denies. Sputum production denies. Wheezing denies.

Cardiovascular:
Chest Pain denies. Dizziness denies. Palpitations denies.

Gastrointestinal:
Patient denies blood in stool, constipation, difficulty swallowing, rectal bleeding, weight loss. Abdominal pain denies. Exposure to hepatitis denies.

Musculoskeletal:
Fracture admits, left femur. Leg swelling admits, left.

Neurologic:
Patient denies balance difficulty, difficulty speaking, loss of strength, dysphagia. Patient complaining short term memory loss, no tremor, normal sensory exam.

PSYCH: good eye contact, mood/affect appropriate, speech clear, confused at times.

Assessments

1. HTN - 401.9 (Primary)
2. Confusion - 298.9
3. Short-term memory loss - 780.93
4. Fall - E888.9
5. Subtrochanteric fracture of femur - 820.22, Left
6. Hypoalbuminemia - 273.8
7. Hypocalcemia - 275.41
8. Anemia - 285.9

Treatment

1. HTN

LAB: COMP METABOLIC PANEL (CMP)		Normal result
ANION GAP CALC	11.0	7.0-16.0 - calc
ALBUMIN	3.7	3.5-5.0 - g/dL
ALK PHOS	140	40-150 - IU/L
B/C RATIO CALC	17.1	3.0-40.0 - calc
BILI TOTAL	0.4	0.2-1.2 - mg/dL
BUN	12.0	9.8-20.1 - mg/dL
CALCIUM	9.5	8.8-10.5 - mg/dL
CL	100	99-110 - mmol/L
CO2	30	21-32 - mmol/L
CREATININE	0.7	0.6-1.1 - mg/dL
GLUCOSE	87	70-105 - mg/dL
K	4.1	3.7-5.5 - mmol/L
NA	141	135-145 - mmol/L
PROTEIN	7.0	6.0-8.3 - g/dL
SGOT	21	5-34 - IU/L
SGPT	16	0-55 - IU/L

2. Confusion

Start QUEtiapine Fumarate ER Tablet Extended Release 24 Hour, 50 mg, 1 tablet in the evening, Orally, Once a day, 30 day(s), 30, Refills 03
IMAGING: CT HEAD W/O CONTRAST

3. Short-term memory loss

Start Aricept Tablet, 5 MG, 1 tablet at bedtime, Orally, Once a day, 30 day(s), 30, Refills 05
IMAGING: CT HEAD W/O CONTRAST

4. Fall

IMAGING: CT HEAD W/O CONTRAST

MRN: 001787037 DOB: REDA
PARROTT,DELILA W
Mt Pleasant IPD 3129-01
PHYS: MILLS-MD,RICHARD B
ACCT#: 14284-00216 10/11/14

5. Hypoalbuminemia

LAB: COMP METABOLIC PANEL (CMP)		Normal result
ANION GAP CALC	11.0	7.0-16.0 - calc
ALBUMIN	3.7	3.5-5.0 - g/dL
ALK PHOS	140	40-150 - IU/L
B/C RATIO CALC	17.1	3.0-40.0 - calc
BILI TOTAL	0.4	0.2-1.2 - mg/dL

of daughter reports memory loss, confusion.

Psychiatric

Patient complaining of daugher reports anxiety, agitation.

BUN	12.0	9.8-20.1 - mg/dL
CALCIUM	9.5	8.8-10.5 - mg/dL
CL	100	99-110 - mmol/L
CO2	30	21-32 - mmol/L
CREATININE	0.7	0.6-1.1 - mg/dL
GLUCOSE	87	70-105 - mg/dL
K	4.1	3.7-5.5 - mmol/L
NA	141	135-145 - mmol/L
PROTEIN	7.0	6.0-8.3 - g/dL
SGOT	21	5-34 - IU/L
SGPT	16	0-55 - IU/L

Notes: Her albumin level has significantly improved.

6. **Hypocalcemia**

LAB: COMP METABOLIC PANEL (CMP) Normal result

ANION GAP CALC	11.0	7.0-16.0 - calc
ALBUMIN	3.7	3.5-5.0 - g/dL
ALK PHOS	140	40-150 - IU/L
B/C RATIO CALC	17.1	3.0-40.0 - calc
BILI TOTAL	0.4	0.2-1.2 - mg/dL
BUN	12.0	9.8-20.1 - mg/dL
CALCIUM	9.5	8.8-10.5 - mg/dL
CL	100	99-110 - mmol/L
CO2	30	21-32 - mmol/L
CREATININE	0.7	0.6-1.1 - mg/dL
GLUCOSE	87	70-105 - mg/dL
K	4.1	3.7-5.5 - mmol/L
NA	141	135-145 - mmol/L
PROTEIN	7.0	6.0-8.3 - g/dL
SGOT	21	5-34 - IU/L
SGPT	16	0-55 - IU/L

Notes: Calcium is now WNL.

7. **Anemia**

LAB: CBC (COMPLETE BLOOD COUNT) Normal result

WBC	5.2		3.8-10.6 - K/uL
RBC	4.79		3.60-5.20 - M/uL
HGB	12.3		11.5-15.7 - g/dL
HCT	37.8		34.0-47.0 - %
MCV	78.9	L	81.0-99.0 - fL
MCH	25.6	L	27.0-34.5 - pg
MCHC	32.5		32.0-36.0 - g/dL
RDW	17.7	H	11.0-16.0 - %
MPV	7.6		7.2-11.2 - fL
PLATELET	269		140-440 - K/uL

Notes: Anemia resolved since acute postoperative blood loss.

Follow Up

MRN: 001787037 DOB: REDA
PARROTT,DELILA W
Mt Pleasant IPO 3125-01
PHYS: MILLS-MD,RICHARD E
ACCT#: 14284-00216 10/11/14

Physician Documentation

Roper St. Francis HealthCare Mount Pleasant

Name: Delila Parrott
Age: 80 years Sex: Female DOB: REDACT
Arrival Date: 10/11/2014 Time: 11:08
Bed 11
ED Physician Blanco, Joseph

MRN: 001787037
Account#: 1428400216
Private MD:

HPI:

10/11 15:03 This 80 years old White Female presents to ED via EMS with complaints of Psych Problem. |br2

15:03 The patient presents to the emergency department with paranoia. Onset: The symptoms/episode began/occurred gradually. Timing is constant. Past psychiatric history: Prior diagnosis: schizophrenia. Associated signs and symptoms: The patient has no apparent associated signs or symptoms. Severity of symptoms: At their worst the symptoms were severe just prior to arrival, in the emergency department the symptoms are unchanged. The patient has experienced similar episodes in the past. several times, but today's symptoms are worse. The patient has been recently seen by a physician: the patient's primary care provider, 5 day(s) ago, with similar presenting complaints. The patient is an 80-year-old female who presents to the ER from an assisted living center complaining of paranoid delusions. Patient states that someone is trying to kill her. Patient states that they've been giving her medicines and she knows when she wakes up she doesn't know what is happening. Patient has some confusion and a slightly altered per the nursing home.. |br2

15:05 Unable to obtain HPI due to altered mental status. |br2

Historical:

- **Allergies:** green vegetables; NSAIDS; all nasal sprays; Chocolate; Aspirin; ACE INHIBITORS; Toradol;
- **Home Meds:**
  1. Tylenol-Codeine Unknown
  2. Estrace Unknown
  3. Ultram Oral Unknown as needed, every 6 hours
  4. Norco Oral 7.5/325 1-2 tabs as needed, every 4 hours
  5. Inderal LA Oral Unknown every 8 hours
  6. Colace oral 100 mg as needed
  7. Celexa Oral Unknown daily
  8. Nexium Oral 40 mg daily
  9. Lasix oral 40 mg daily, as needed
  10. Dilacor XR oral 180 mg daily
  11. Miralax Oral 1 packet as needed
  12. Macrobid Oral 1 capsule twice a day
  13. Xanax Oral 0.25 mg three times a day
  14. Seroquel Oral Unknown daily
  15. Aricept Oral 5 mg daily, nightly
- **PMHx:** phobias; Schizophrenia
- **PSHx:** Breast biopsy; Fracture repair; ORIF 6/7/2014- lt hip
- **Social history:** unknown, Smoking status: unknown.
- **Advanced Directives:** Unable to obtain information.
- **History obtained from:** daughter, EMS.

ROS:

15:05 |br2

Constitutional: NO FEVER OR CHILLS.
Psych: Positive for anxiety, auditory hallucinations, visual hallucinations. All other systems reviewed and are negative.

Exam:

15:08 |br2

Constitutional: Awake and in NAD, resting comfortably.
Head/Face: d
Eyes: Pupils equal round and reactive to light, extra-ocular motions intact. Lids and lashes normal. Conjunctiva and sclera are non-icteric and not injected. Periorbital areas with no swelling, redness, or

OneContent: Generated By coffje1

DATE OF ADMISSION: 10/11/2014

DATE OF DISCHARGE: 10/15/2014

PRIMARY CARE PHYSICIAN: Dr. Richard Mills

PRINCIPAL DISCHARGE DIAGNOSES: Delirium and paranoia.

SECONDARY DISCHARGE DIAGNOSES:
1. Hypertension.
2. Osteoarthritis.
3. Dementia.
4. GERD.
5. Deconditioning.

DIAGNOSTIC STUDIES:
1. CT head without contrast on 10/11/2014 showed no evidence of acute intracranial abnormality, diffuse chronic microangiopathic changes including several previous lacunar infarction.

HOSPITAL COURSE: Ms. Parrott is a patient with a known psychiatric history and known cognitive decline who presented after a precipitous decline over the preceding two weeks with worsening cognitive function, as well as worsening in her physical abilities to do activities of daily living.
1. Delirium and paranoia. An infectious workup was pursued, which was negative as the precipitant. Looking at her current medications her Citalopram and Tramadol were discontinued due to concern for possible serotonin syndrome. Her hydrocodone was also discontinued as this could have contributed to her decline. Laboratory testing including a serum ammonia, B-12, folate and thyroid function were all normal. The patient was started on Risperdal 0.5 mg at bedtime and 0.25 twice a day with meals with much improvement in her mental status. At the time of discharge the patient's paranoia seemed to have improve significantly. She still gets confused at times and still does require two people to assist her with movement, but overall is much improved.
2 Hypertension. Her blood pressure was elevated during her stay; however, no adjustments in her antihypertensives was made as this could have been contributed to IV fluids that she received early during her hospitalization. She was continued on her home antihypertensives. She has a follow up

appointment scheduled with Dr. Mills and if her blood pressure remains elevated at that time an adjustment could be made.
3. Dementia. She was continued on her home Donepezil. Her daughter reports that she has significant anxiety associated with her dementia. She was continued on her home Alprazolam. Her Citalopram was restarted on 10/14/2014 due to her daughter's significant concern about her underlying anxiety. She seems to be tolerating that medication well on the day of discharge.
4. GERD. The patient was continued on a PPI with no complaints of abdominal pain.
5. Deconditioning. Physical therapy worked with the patient during her hospital stay and this will be continued as an outpatient at Ashley River Plantation.

DISCHARGE MEDICATIONS: Please see med rec.

CHANGES TO HOME MEDICATIONS: Discontinuation of Macrobid, Norco, Tramadol and Seroquel. Addition of Risperdal.

DISPOSITION: The patient will be discharged back to Ashley River Plantation to continue physical therapy and occupational therapy.

DIET: Regular.

ACTIVITY: As tolerated and as directed by physical therapy.

CODE STATUS: Full code.

FOLLOW UP: Appointment with Dr. Mills on 10/29/2014 at 11:45 a.m.

Abby E Gass, MD
TR: pn DD: 10/15/2014 08:36 TD: 10/15/2014 09:09 Job#: 330260
DOC#: 433064

SPECIAL ARTICLE

PERSONS FOUND IN THEIR HOMES HELPLESS OR DEAD

R. JAN GURLEY, M.D., NANCY LUM, M.S., MERLE SANDE, M.D., BERNARD LO, M.D., AND MITCHELL H. KATZ, M.D.

Abstract *Background.* Health care providers and providers of emergency services are sometimes called to help with people who are found alone in their homes either helpless or dead. It is not known who is at risk for being found helpless or dead, what the mortality rates are among those found alive, or how frequently this situation occurs.

Methods. We conducted a population-based study of patients who were found in their homes either helpless or dead. Over 12 weeks, paramedics employed by the city of San Francisco identified 387 such events involving 367 persons. We obtained information on these patients from the emergency-medical-services department or the hospitals to which they were taken and determined their outcomes.

Results. The median age of the persons found helpless or dead was 73 years; 61 percent were women. The frequency of such incidents increased sharply with age, from a rate of 3 per 1000 per year among those 60 to 64 years of age to 27 per 1000 per year among those 85 years of age or older. The highest rate was among men 85 years and older who were living alone (123 per 1000 per year). In 23 percent of the cases, the person was found dead; an additional 5 percent died in the hospital. Thus, total mortality was 28 percent. Of the patients found alive, 62 percent were admitted to the hospital. The average hospital stay was eight days, and 52 percent of those admitted required intensive care. Of the survivors, 62 percent were unable to return to living independently. The total mortality was 67 percent for patients who were estimated to have been helpless for more than 72 hours, as compared with 12 percent for those who had been helpless for less than 1 hour.

Conclusions. For elderly people who live alone, becoming incapacitated and unable to get help is a common event, which usually marks the end of their ability to live independently. (N Engl J Med 1996;334:1710-6.)

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HEALTH care providers and emergency-medical-services personnel are sometimes called on to assist when elderly people are found in their homes in need of emergency attention and unable to summon help. In a typical case, a neighbor notices an elderly person's absence or the fact that mail has piled up and calls emergency services. The precipitating incident can be a fall, a stroke, failure to thrive, or some other event. The clinical course for persons found alive but incapacitated can be complicated by factors related to the duration of time since the person became helpless, such as severe dehydration or decubitus ulcers.[1] The prognosis for such elderly patients is thought to be poor. Because of the variety of possible causes of these events, some health care providers refer to patients found in these circumstances as "found down," with the amount of time that the patient is helpless referred to as "down time." In this article, we refer to such patients as found helpless or dead, and we refer to the down time as the time spent incapacitated.

It is unknown who is at risk for being found helpless or dead in the home, how often such events occur, and what the mortality rate is among patients found alive but helpless. We undertook a prospective, population-based study of this phenomenon in San Francisco. Our goals were to determine how often elderly people are found helpless or dead in their homes and to assess the demographic characteristics of such patients and the outcomes of those found alive but incapacitated.

From the Robert Wood Johnson Clinical Scholars Program, University of California, San Francisco (R.J.G., B.L.); the Department of Public Health, City and County of San Francisco (R.J.G., M.H.K.); the Joint Medical School Program, University of California, San Francisco and Berkeley (N.L.); and the Department of Medicine, San Francisco General Hospital, San Francisco (M.S.). Address reprint requests to Dr. Gurley at the Department of Public Health, AIDS Office, Suite 500, 25 Van Ness Ave., San Francisco, CA 94102.

Supported in part by a grant from the Walter and Evelyn Haas, Jr., Foundation. Dr. Gurley is a Robert Wood Johnson Clinical Scholar.

METHODS

During a 12-week period, from March through May 1993, paramedics employed by the city of San Francisco responded to 88 percent of all calls for emergency medical assistance (10,402 total calls). Persons encountered by paramedics in responding to these calls were included in this study if they lived alone and had been reported missing or were found helpless or dead in their homes. There were no other criteria for inclusion based on age, residence, or presentation. The case definition was designed to exclude people who were found helpless or dead outside their homes, who did not live alone, or whose illness did not warrant involvement of the emergency medical system. Persons who did not live alone were excluded under the assumption that those living with them would be able to provide them with assistance. Persons found dead were not excluded from our study if the other case criteria were met. Paramedics estimated the length of time the patient had been incapacitated, choosing from several categories ranging from less than 1 hour to more than 72 hours.

Data were abstracted from the records of the emergency medical system and from the hospital charts of patients transported to 13 hospitals. Information on medications taken by the patients before the emergency call was also obtained from the records of the emergency medical system and the hospitals. We also obtained diagnostic and procedural codes (from the *International Classification of Diseases, 9th revision* [ICD-9][2]) from hospital records. Death certificates were obtained for all persons who were found dead, and demographic information was recorded from these certificates, from hospital records, or from the paramedics' records (in descending order of priority).

Data on persons found dead were excluded from the analyses of outcomes and costs of care. Rates of incidence were calculated with the use of 1990 U.S. Census data for the population of San Francisco, both overall and according to age, race, and sex. The annual number of cases was determined, assuming a constant rate over time. Proportions were compared with two-tailed chi-square analyses. Rates were compared with an indirect method of standardization based on the 95 percent confidence intervals for Poisson distributions. An average community income was assigned to each patient on the basis of housing-tract data from the 1990 Census.

The outcomes we studied included survival, duration of hospitalization, and return to independent living. Patients who were evaluated by

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ROA 1513

Table 1. Characteristics of Persons Found Helpless or Dead in Their Homes.

Characteristic	Found Alive (N=297)	Found Dead (N=90)
Race or ethnic group — no. (%)		
Non-Hispanic white	191 (64)	54 (60)
Black	38 (13)	19 (21)
Asian	27 (9)	9 (10)
Unknown	26 (9)	0
Hispanic	13 (4)	7 (8)
Other	1 (<1)	1 (1)
Native American	1 (<1)	0
Age — yr		
Median	75	65
Range	26–101	25–93
Female sex — no. (%)	170 (57)	29 (32)
Median community income — $	31,966	30,247
Estimated time spent incapacitated — no. (%)		
<1 hr	92 (31)	8 (9)
1 to <3 hr	47 (16)	5 (6)
3 to <6 hr	25 (8)	6 (7)
6 to <12 hr	22 (7)	15 (17)
12 to <24 hr	33 (11)	11 (12)
24 to <48 hr	14 (5)	6 (7)
48 to 72 hr	12 (4)	5 (6)
>72 hr	13 (4)	26 (29)
Unknown	39 (13)	8 (9)
Median time spent incapacitated — hr	2	18
Insurance — no. (%)		
Private	152 (51)	
Medicaid	72 (24)	
Medicare only	36 (12)	
None	11 (4)	
Unknown	26 (9)	
Reason for incapacitation — no. (%)		
Inability to get up or weakness	88 (30)	
Fall	67 (23)	
Shortness of breath or chest pain	21 (7)	
Altered mental status	18 (6)	
Found unresponsive	16 (5)	
Cerebrovascular accident	13 (4)	
Miscellaneous*	74 (25)	

*Includes overdose, suicide or attempted suicide, seizures, no identified problem, syncope, severe pain, diabetes with hypoglycemia, and previous assault. Each category included eight or fewer patients.

paramedics but not transported to a hospital or who were seen in emergency departments and discharged were assumed to have survived and continued living independently. Patients who were discharged to a nursing home, a family member's home, a rehabilitation facility, a board-and-care facility, or a skilled-nursing facility were considered discharged to "other care." Information on who contacted the paramedics was obtained from the records of the emergency medical system or the hospitals. In cases in which no family member was mentioned, the contact person was categorized as "not family." All patients 65 years of age or older were assumed to be covered by Medicare. Patients covered by both Medicare and private supplemental insurance were classified as having private insurance. We estimated costs by calculating 70 percent of 1993 charges for evaluation and transport by paramedics, number of days in the hospital, and number of days in the intensive care unit.

Results

Characteristics of the Patients

During a 12-week period, paramedics were called on to assist 367 persons found incapacitated or dead in their homes; these people accounted for 387 episodes of being found helpless or dead and 3.7 percent of all calls to the emergency-medical-services department (Table 1 and Fig. 1). The median age of the women (78 years) was significantly higher than that of the men (65 years). Women made up only 27 percent of the patients under 65, but 63 percent of those 65 years of age or older. A typical patient was an 82-year-old white woman who was found by a neighbor during a routine check. She was lying on the floor, soiled by dirt, feces, and urine, and had garbled speech. She was estimated to have been incapacitated for more than 72 hours. She was admitted with decubitus ulcers and dehydration. After 21 days, she was discharged to a skilled-nursing facility.

Clinical Presentation

The people found helpless had a variety of precipitating problems (Table 2). The most frequently cited precipitating causes of incapacitation among those who survived were weakness or inability to get up and falls. There was some variation according to age; weakness or inability to get up was the most frequent cause of incapacitation among patients 65 and older (n=72). For example, one 78-year-old woman was found on her bed by the paramedics after a neighbor called for help. She stated that she had been unable to get up for two days. She denied falling. She appeared dehydrated, and her lips had cracked and bled. She spent nine days in the intensive care unit and was then discharged to a skilled-nursing facility.

There were no patients under 65 who had multiple falls or who fell and became lodged in place. Overdose (n=7) and suicide attempts (n=5) occurred only in the cases of patients less than 65 years of age. Contributing factors included gastrointestinal symptoms (n=31; mean age, 62 years) and alcohol or drug use (n=32; mean age, 51 years). Twenty patients (16 percent of those under 65; mean age, 43 years) were identified as having the acquired immunodeficiency syndrome (AIDS) as a contributing condition.

Ratings on the Glasgow coma scale were available for 295 of the 297 patients found alive (99 percent). For-

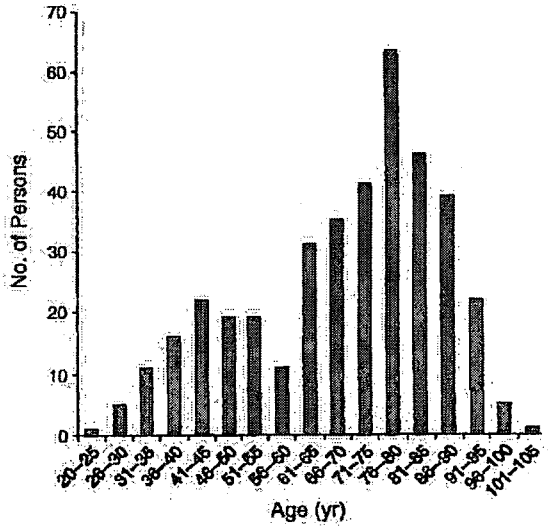


Figure 1. Distribution of Persons Found Helpless or Dead in Their Homes, According to Age.

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ROA 1514

Table 2. Examples of Patients' Clinical Presentations and Chief Causes of Immobilization.*

Inability to get up or weakness

General weakness and confusion for 2 to 3 days; found on well-being check; questionable food and liquid intake for 2 days.

Patient could not get up from toilet, moved to the ground, and became wedged between toilet and bathtub for 9½ hours.

Person found dead

Family unable to contact patient for 24 hours; patient found extremely cold in heaps of garbage and feces at home.

Patient not seen in 10 days; found decomposed in bathroom by apartment manager. Blood covering bed with trail to bathroom where patient was lying.

Patient not seen for 3 to 4 days; younger brother found patient prone on floor by bed with questionable coffee-ground emesis, diarrhea, or blood.

Falls

Caretaker found patient supine on floor, complaining of occipital pain; left shoulder abrasion from fall.

Recurrent falls for 24 hours; fire department there earlier today; evidence of diarrhea in clothing, bedroom, bathroom.

Patient with a dislocated left hip causing fall; dislocation several times per year.

Shortness of breath or chest pain

Extreme respiratory distress; white frothy sputum from mouth; complaining of severe shortness of breath, nausea, and vomiting; extremely drowsy, unresponsive to verbal stimulation.

Altered mental status

Patient found on bedroom floor by manager; speech incomprehensible.

Home nurse found patient shivering and defecating while standing, possibly over- or undermedicated.

Psychiatric history; patient has been noncompliant with medications; sequestered in apartment; increased depression for 1 month after losing job; last seen by family several days ago; found supine.

Patient found sitting on floor, conscious, but no verbal response, not following simple commands, incontinent of urine, poor skin turgor.

Person found unresponsive

Patient with end-stage acquired immunodeficiency syndrome found unconscious in bed, incontinent of urine and feces.

Patient unconscious, unresponsive, clothes soaked in urine, supine on floor, dinner untouched on table.

Patient emaciated, dehydrated, found unconscious on toilet for unknown duration; ecchymoses on buttocks.

Cerebrovascular accident

Patient found by friend on living-room floor with right-sided weakness and aphasia.

Patient found supine on floor, nonverbal, left side flaccid; San Francisco Fire Department came to check smoke alarm (teakettle boiled dry).

Overdose

Patient found unconscious, unresponsive, dragged to cold shower before arrival of paramedics; found sitting on stairs, agitated; took heroin, codeine, alcohol.

Suicide attempt

Patient lacerated wrists and ankles; found unconscious in bathtub by friend.

Seizures

Two seizures this p.m., patient postictal, oriented to self only.

No identified problem

Patient with tender hips, ecchymoses on hands; pale, cool, dehydrated; found on floor.

Syncope

Patient found prone on floor with respiratory distress following syncope, scheduled for pacemaker tomorrow.

Severe pain

Patient unable to urinate or defecate for 5 days; burning pain in lower abdomen for 1 week.

Diabetic patient with hypoglycemia

Friend heard patient fall out of bed; patient with insulin-dependent diabetes mellitus, unable to speak but became alert and oriented after the administration of dextrose solution.

Previous assault

Assault yesterday; patient had facial trauma with massive bleeding, eyes open to voice.

*These examples have been condensed from the paramedics' records. The categories appear in descending order of frequency.

ty-four patients (15 percent) had moderately to severely depressed scores (1 through 16). Fifty-four patients (18 percent) had scores of 17 through 19, with 74 percent of this group exhibiting "confused verbal response." The remaining 197 patients (67 percent) had a normal score (20).

In the 387 cases in which persons were found incapacitated or dead in their homes, paramedics found 90 persons (23 percent) dead (Fig. 2). Patients who were found dead were significantly more likely than the patients found alive to be male (68 percent vs. 43 percent, $P<0.01$), younger (median age, 65 vs. 75 years; $P<0.01$), and black (21 percent vs. 13 percent, $P=0.08$). Before being found incapacitated, the patients were taking an average of 3 medications (range, 0 to 17); 21 percent (median age, 70 years) were taking sedative–hypnotic agents.

Insurance and Income

Information on insurance coverage was available for 91 percent of the patients found alive. Those under 65 were most commonly covered by Medicaid, which was the sole form of insurance for 27 percent, whereas persons 65 and older most commonly had private insurance (70 percent). Medicare was the sole form of insurance for only 16 percent of those 65 and older.

Community income varied according to race; the vast majority of whites lived in middle-to-high-income communities, the majority of blacks lived in low-income communities, and the majority of Asians lived in either the very-lowest-income or middle-income communities.

Who Called the Paramedics?

Only 11 percent (n=42) of the patients were found by family members. The most common category of contact person was "other" (n=76), which included visiting nurses, caretakers, housekeepers, and home health aides. In one typical case, a 95-year-old white man was found by his caretaker wedged between the toilet and the bathtub. The patient said that he had sat on the toilet at noon the day before and was unable to get up. He tried to move to the floor but mistakenly lowered himself between the toilet and the bathtub. He refused transportation to the hospital. The remaining categories of persons who contacted the emergency medical services were friends (n=41), neighbors (n=36), landlords (n=3), and unidentified persons (n=169).

Calls made to the paramedics by friends resulted in shorter lengths of time spent helpless than any other category (median, 4.5 hours), except for patients who were eventually able to call for help themselves (median, 2 hours). Calls by family members (9 hours), neighbors (9 hours), landlords (more than 72 hours), and

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ROA 1515

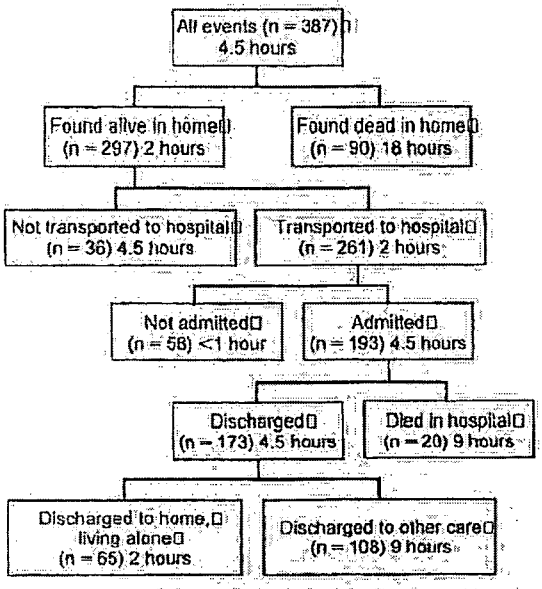


Figure 2. Outcomes of Persons Found Helpless or Dead in Their Homes.

For each group of patients, the median time spent incapacitated, as estimated by the paramedics, is indicated. Data on admission and hospital outcomes are shown for only 251 of the 261 persons transported to the hospital, since the records of 10 persons could not be found.

others (18 hours) were associated with much longer estimated times spent incapacitated.

Frequency of Incidents

The age-specific frequency of incidents of persons being found incapacitated or dead in the city of San Francisco reached a peak of 27 per 1000 persons per year among those 85 years of age or older (Fig. 3). Overall, the rates for men and women were similar. However, among blacks, the rate for men 85 and older was more than twice that for women (36 per 1000 vs. 16 per 1000, $P<0.05$). The rates among non-Hispanic whites and blacks were generally about twice those among Asians and Hispanics. The rates varied according to the average annual income in the community, with the highest rates (27 per 1000) among patients living in communities with incomes between $30,000 and $40,000.

We recalculated the frequency of incidents with the number of persons living alone as the denominator. The annual rate per 1000 persons living alone was 14.0. The annual rates for men and women living alone were 14.3 per 1000 and 13.6 per 1000, respectively. Annual rates were 10.1 per 1000 for Hispanics, 10.6 per 1000 for Asians, 11.6 per 1000 for non-Hispanic whites, and 22.3 per 1000 for blacks.

The annual rates among people 65 or older who lived alone were 31.6 per 1000 overall, 42.2 per 1000 for men, and 27.6 per 1000 for women. Rates continued to rise with age, even when adjusted for the number of people living alone (Fig. 4). The peak rate — among persons 85 years of age or older who were living alone — was 123 per 1000 for men and 59 per 1000 for women (P not significant).

Outcomes

Duration of Hospital Stay, Survival, and Return to Independent Living

In the 297 episodes in which patients were found alive, 261 patients (88 percent) were transported to the hospital (Fig. 2). When patients were not taken to the hospital, the most frequent reason was the patient's refusal (n = 29). Seventy-four percent of the 261 patients transported to a hospital (n = 193) were admitted. Those who were admitted were older than those not admitted (median age, 77 years vs. 67 years; $P<0.01$) and significantly more likely to be women (64 percent, $P<0.05$).

ICD-9 disease and procedure codes were available for 82 percent of the patients transported to a hospital and 97 percent of those admitted (Table 3). Patients frequently had altered mental status (39 percent of all transported patients); central nervous system imaging was performed in 69 patients. Many patients (25 percent) had acute injuries; 36 had fractures. Alcohol or drug abuse was diagnosed in 38 patients, sepsis or hypotension in 20, decubitus ulcers in 10, and aspiration pneumonia in 10. Dehydration occurred in 42 patients.

For patients admitted to hospitals, the average duration of stay was eight days. Intensive care was required for 52 percent (n = 100), with an average stay in the intensive care unit of seven days. In-hospital mortality was 10 percent overall and 16 percent among those requiring intensive care.

Among those who survived until discharge, 62 percent did not return to independent living. Patients discharged to supportive care were significantly older (me-

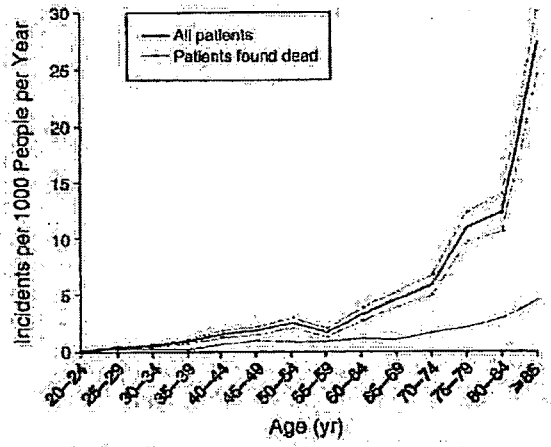


Figure 3. Frequency of Incidents According to Age.

This graph shows the rate at which persons were found helpless or dead in their homes (per 1000 population per year) according to age. The rate for those found dead is also shown. The dotted lines show the 85 percent confidence intervals for all patients.

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dian age, 79 years; $P<0.01$), were more likely to be female (64 percent; $P=0.07$), and were commonly discharged to institutions (77 percent to nursing homes or skilled-nursing or rehabilitation facilities, with only 4 percent discharged to live with family or friends). Of those who were hospitalized, two thirds either died or did not return to independent living.

Estimated Time Spent Incapacitated In Relation to Outcome

Longer times spent helpless, as estimated by the paramedics, were associated with the person's being found dead or being transported to the hospital, being admitted, and being discharged to other care rather than to independent living ($P<0.05$ for all these comparisons). Male sex was significantly associated with estimated times of more than 12 hours spent helpless ($P<0.05$), but age, race or ethnic group, and insurance status were not significantly associated with the length of time spent incapacitated.

The number of deaths, both in the home and in the hospital, varied according to the estimated time since the person had become incapacitated. Of the people for whom this time was estimated to be less than one hour, 10 percent were found dead and 2 percent died in the hospital, for a total mortality rate of 12 percent. Of this group, 11 percent were black, 58 percent were women, and the median age was 75 years. Of those estimated to have been immobilized for more than 72 hours, 62 percent were found dead and 5 percent died in the hospital, for a total mortality rate of 67 percent. Of this group, 28 percent were black, 36 percent were women, and the median age was 64 years.

Costs

The estimated average cost of care for each patient was $9,985.

Discussion

The number of people 85 years of age or older in the United States is expected to increase from 3.1 million in 1990 to 17.7 million by 2050.[3] Longer life spans, declining birth rates, the expanding role of women in the work force, and the breakdown of the extended family have all been cited as reasons for the increasing number of elderly people at risk for institutionalization.[4-7] Yet elderly people clearly prefer independent living to institutionalization.[8,9]

Elderly people who live alone may fear being unable to obtain help if they are injured or ill. For many families, the specter of such an event can dominate decisions about living arrangements. This fear has generated an industry marketing automatic alarm-and-notification systems. Health care professionals who counsel those who are concerned about being incapacitated or those who have survived such an event have little or no information on which to base recommendations.

Our results indicate that it is common for elderly people living alone to be found helpless or dead in their homes. Among men who were 65 or older and lived alone, there were an estimated 123 such incidents per 1000 persons per year in San Francisco in 1993. For comparison, the incidence of myocardial infarction among people 65 years of age or older is estimated to be between 1.7 per 1000 and 4.4 per 1000 persons per year,[10] and the incidence of hip fracture among 85-year-old white women is estimated to be 35 per 1000 per year.[11]

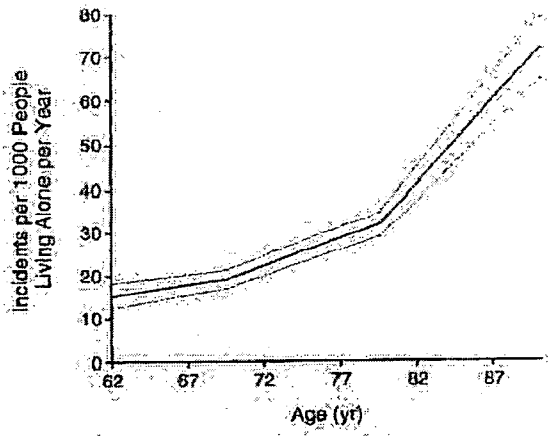


Figure 4. Frequency of Incidents among Elderly People Living Alone.

This graph shows the rate at which persons 62 years of age or older were found helpless or dead in their homes (per 1000 persons living alone per year) according to age. The dotted lines show the 95 percent confidence intervals.

The outcomes of such incidents are often poor. In 23 percent of the cases in which the paramedics were called on for aid, the patients were found dead, and an additional 5 percent died in the hospital, for a total mortality rate of 28 percent. Consideration also must be given to the suffering of those who are unable to get help for prolonged periods. Ten percent of the patients were estimated to have been unable to summon help for more than three days; 38 percent of them survived the experience. For those who survive, being found incapacitated and helpless usually leads to a loss of independence; the majority of those who are hospitalized do not return to independent living.

Although the incidence of such episodes is highest among very elderly men, members of all races and ethnic groups and all socioeconomic groups are susceptible to becoming incapacitated in their homes. The rate of such incidents increases dramatically with age. Most of the persons encountered by paramedics were elderly white women from fairly well-to-do communities, as indicated by a high community income and private health insurance coverage. Large differences among non-Hispanic whites, Asians, and Hispanics were eliminated when the rates were adjusted for the proportion of elderly people living alone. Elderly blacks, however, continued to have higher rates than the other racial and ethnic groups; black men were more likely than black women to be found helpless or dead by paramedics.

Our study identified a subgroup of patients found in-

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capacitated in their homes, who tended to be relatively young, male, poor, and black and who were frequently found dead. Drug overdoses, suicide, alcohol or drug abuse, and AIDS were contributing factors that predominantly affected people younger than 65.

In only a few cases was there any mention of family members in the records of the emergency medical system, a fact that suggests that patients found helpless or dead may be somewhat isolated socially. Neighbors and others were more likely to call the paramedics with requests for assistance than were friends and family.

Our study has several limitations. By design, we did not include patients who were found incapacitated or dead on the street or who lived with others. Our case definition was chosen to focus on people who were elderly and potentially isolated. Although the study was also designed to include all patients identified as meeting the inclusion criteria by paramedics employed by the city of San Francisco, the magnitude of the problem may have been underestimated because of patients who were seen by paramedics but not enrolled or who were transported to hospitals by private ambulances or by other means. Our assumptions about patients who were not admitted may have caused us to underestimate the mortality rate or the frequency of loss of independence associated with being found helpless in the home. We were unable to assess whether such incidents followed any seasonal pattern.

In this descriptive study, we assessed the magnitude of the phenomenon of patients' being found helpless or dead in their homes, the demographic features of the patients found in this condition, and their outcomes. We did not attempt to determine relative risks or to generalize our results to groups other than those living in San Francisco. Therefore, some important questions that arise from our results cannot be reliably answered on the basis of our data. For example, we were unable to assess whether the patients who were found dead represented a distinctly different group from those found alive or, on the contrary, whether the two groups were similar but those found dead had been left a longer time without help. Our results indicate that the majority of persons who are not accounted for for more than three days are found dead. We were also unable to determine which deaths were preventable. Although some of the people in our study group may have died peacefully at home,

Table 3. Diagnoses of 261 Patients Transported to Hospitals, with Associated Procedures.*

Diagnosis	No. (%)†	Procedure	No.†
CNS events and alterations in consciousness	101 (39)	**CNS procedures**	107
Strokes, TIAs, syncope, seizures	71	CT or MRI	69
Paralysis, movement disorders, neuropathy	37	Lumbar puncture	13
Dementia, psychoses, delirium	22	EEG	9
CNS injuries, hemorrhage, infection	17		
Coma	5		
Cardiac disorders	96 (37)	**Cardiac procedures**	71
Dysrhythmias	42	Echocardiography	23
Heart failure	34	Cardiac catheterization	11
Acute MI and ischemic heart disease	26	PCWP monitoring	6
Infectious diseases	84 (32)		
Septicemia, shock	20		
HIV/AIDS	14		
Acute injury	64 (25)	**Orthopedic procedures**	65
Fractures	36	OR, femur or tibia–fibula	21
Wounds, abrasions, dislocations, sprains	30	Reduction of hip dislocation	4
		Fasciotomy	3
Electrolyte disorders	64 (25)		
Volume depletion	42		
Hypokalemia	21		
Acidosis	7		
Respiratory disorders	59 (23)	**Pulmonary procedures**	41
Pneumonia	25	Ventilation ≥96 hr	16
COPD	23	Ventilation <96 hr	9
Respiratory failure	13	Other oxygen supplementation	5
Urinary tract disorders	50 (19)	**Urinary procedures**	16
UTI	31	Renal dialysis	4
Renal failure	11	Renal ultrasonography	3
Joint, bone, and muscle disorders	47 (18)		
Arthritis, osteoporosis	35		
Hematologic disorders	43 (16)		
Alcohol or drug abuse	38 (15)		
Endocrine disorders	34 (13)		
Diabetes	25		
Gastrointestinal disorders	30 (11)	**Gastrointestinal procedures**	28
GI bleeding (not occult)	10	Abdominal ultrasonography	8
Psychiatric disorders	26 (10)		
Nonorganic psychoses	10		
Depressive disorders	7		
Skin disorders	25 (10)		
Cellulitis	14		
Decubitus ulcers	10		
Miscellaneous		**Radiographic procedures**	26
Cancer	18	CT of abdomen	8
Malnutrition	9	CT of area other than abdomen or thorax	5
Poisoning	8	Bone scanning	4
Gangrene	3	CT of thorax	3

*These data on diagnoses and procedures are based on the ICD-9 codes in the hospital records of 261 patients transported to the hospital after being found helpless in their homes. CNS denotes central nervous system, TIA transient ischemic attack, CT computed tomography, MRI magnetic resonance imaging, EEG electroencephalography, MI myocardial infarction, PCWP pulmonary-capillary wedge pressure, HIV human immunodeficiency virus, AIDS acquired immunodeficiency syndrome, OR open reduction, COPD chronic obstructive pulmonary disease, UTI urinary tract infection, and GI gastrointestinal.

†Major categories, in boldface type, include the numbers of patients and percentages. Selected subcategories are also shown, with the numbers of diagnoses.

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most cases seem to represent deaths or suffering that could have been prevented.

In this study, working with paramedics employed by the city of San Francisco, we examined a common set of circumstances that result in adverse outcomes. We were not able, however, to determine the independent influence of functional status, the length of time spent helpless, the extent of social support, diagnosis, demographic variables, or a number of other factors on the outcomes of persons found dead or helpless in their homes. We were also unable to determine the independent relative risk of being found incapacitated among people who live alone as compared with those who do not. For patients who survive prolonged periods of time spent helpless in their homes, our study suggests that tremendous suffering could be reduced by earlier intervention. The correlation between the estimated length of time since incapacitation and outcome implies that future studies should attempt to reduce mortality and suffering by devising ways for others to intervene earlier.

The results of this study also raise several important policy questions. Who can undertake the monitoring necessary to ensure the safety of relatively isolated, very elderly people living alone in the community? Many of the patients were already known to the health care system and were discovered by other health care professionals after prolonged periods spent helpless. Assisting such patients might require more frequent checks, perhaps every 12 to 24 hours. When is periodic monitoring cost effective or ethically justified? How can it be carried out in a way that is supportive of the individual person's wish for independence and not coercive or intrusive? An important first step would be to raise public awareness of the likelihood that elderly people may become helpless in their homes and to promote activism within a community. Checking on someone requires no specific training. Our finding that notification of the paramedics by patients' friends resulted in a significantly shorter time spent helpless than notification by others implies that the best preventive measure (as simple as it may sound) is the existence of active social relationships. Identifying, facilitating, and assisting in the maintenance of such friendships for relatively isolated elderly people may require creative social responses. Other possibilities for intervention include electronic telephone checks, calling circles among elderly people at risk, and the use of devices that are commercially available to summon help (only one patient in our study possessed such a device). How can limited resources be targeted to those at greatest risk? Our study indicates that very elderly men living alone, particularly black men, are especially in need of intervention.

This study may help health care providers to counsel patients at risk, but further research is needed to adequately address the fears of elderly people who live alone. Future studies should evaluate interventions to prevent elderly people from becoming helpless in their homes, lessen morbidity, and maintain independent living for patients who desire it.

We are indebted to the men and women of the San Francisco Department of Public Health Paramedic Division, who with diligence and compassion found and cared for each of the patients we studied; to Owen Linderholm, without whom the study could not have been conducted; to Charles Saunders and Tom Newman for their assistance; and to Ramona Doyle for her sharp eye and quick pen.

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Q. **Okay. Seated at the front desk there is -- let me show you something. You may or may not recognize this. This is a -- an aerial view of Sandpiper. Are you able to identify that at all?**

A. Yes.

Q. **Okay. There's a building with number one on it?**

A. Uh-huh.

Q. **Do you see that?**

A. Uh-huh.

Q. **You need to say yes, okay?**

A. Yes.

Q. **Okay. All right. Is that the place where you worked?**

A. No.

Q. **Okay. Where --**

A. Yes. Yes.

Q. **Okay. All right.**

A. The Community Center.

Q. **Yes. All right. And would the residents in order to get to the dining room would they pass by where you worked or where you were seated?**

A. Yes.

Q. **All right. And if they were going to do activities in this particular building would they pass by the place where you were seated?**

A. Not necessarily, no.

Q. Okay. What activities might they be involved in that would cause them to pass by where you worked?

A. Okay. Well, in -- in the building they have the activity area so it depended on where they lived.

Q. Okay. All right.

A. If they came through the door over here then I would see them. If they came in through the door here I would see them. If they came in by the pool then I -- wouldn't necessarily see them.

Q. Okay. Well, would you mark then -- and I'm going to give you a pen. And just put a big X where your -- approximately your desk was located?

A. Okay.

Q. Okay. You just put your initials under that.

A. Okay.

Q. Okay. So, I can -- all right. So, if they came by the pool you wouldn't see them? If they came in from, I guess, to the top of the page they -- you wouldn't see them, correct?

A. Right here.

Q. Okay. Yes. You're -- you're locating where the pool is?

A. Yes.

Q. Or, excuse me, where the pool is? Okay.

MR. REEVES: I'll mark that as an Exhibit.

(PLAINTIFF'S EXHIBIT 1 MARKED FOR IDENTIFICATION PURPOSES (1 page) - Google Map color photo - aerial view of Sandpiper)

(Off the Record)

Q. Ms. Munoz, did your occupation keep you at this desk or did your requirements cause you to have leave that location?

A. I -- during the whole shift I'd be all over that community.

Q. Okay. All right. And was there a mechanism or a manner in which you would communicate with other staff people while you were there?

A. No. Just --

Q. Okay.

A. -- person to person.

Q. All right. And what -- again, I'm not trying to trick you. Just sometimes people carry walkie talkies or something that kind of thing, so.

A. Got you.

Q. You -- you would just communicate either by phone at your desk or by personal communication face to face?

A. Yes.

Q. **All right. Okay. Do you know or do you recall on Exhibit Number 1 where Ms. Parrott's residence was?**

A. Building with the number two on it.

Q. **Okay.**

A. She was six.

Q. **Okay.**

A. S6.

Q. **All right. How far would you estimate your desk would have been from then entrance to her apartment at S6?**

A. I have no idea.

Q. **Okay. How long would it take you to walk there? Less than 30 seconds or more than 30 seconds?**

A. I'd say a minute or less.

Q. **Okay. All right. Was that her apartment for the entire time of her stay up until this event happened during the week of June 2nd?**

A. Yes.

Q. **All right. Okay. Did you know her, Ms. Parrott, by sight?**

A. Yes.

Q. **All right. And I'm -- I'm assuming based on her lease that she lived alone as far as you know?**

A. Uh-huh.

Roper St. Francis Healthcare
Department of Laboratory Medicine
Charleston, South Carolina 29401

PATIENT: PARROTT, DELILA WILSON
DOB: REDACT
PID: D001787037
ACCT # : D1415701389

LOCATION: D3D 3109-01
PHYSICIAN: MILLS-MD, RICHARD E
PRINTED: 06/11/14 02:43

ADMITTED: 06/06/14

DISCHARGED: 06/10/14

CARDIAC MARKERS

Collected	06/06 22:35		06/09 22:35		Units	Reference
TROPONIN I	<0.015[1]				ng/mL	
CPK	660	H	673	H	IU/L	26-192

06/06/14 22:35 : Performed at RSFH Mount Pleasant Hospital, 3500 Highway 17 North, MT PLEASANT, SC, United States, 29466

1
TROPONIN INTERPRETATION:

TROPONIN methodology change effective 7/27/2010
Note revised reference ranges and interpretation.

Siemens TROPONIN (Roper St. Francis Hospital Laboratories Methodology) Interpretation:

A joint committee from the European Society of Cardiologists (ESC) and the American College of cardiology (ACC) has recommended a redefinition of myocardial infarction (NI). The committee defines MI as the typical rise and gradual fall of troponin or more rapid rise and fall of CK-MB in conjunction with ischemic symptoms, pathologic ECG Q waves, ECG ST segment elevation/depression, and/or coronary artery intervention.

REVISED TROPONIN interpretation:
Based on the committee's recommendations, an increased Siemens Troponin is defined as measurement exceeding *0.045* ng/mL

Previous TROPONIN interpretation:
Based on the committee's recommendations, an increased Siemens Troponin is defined as measurement exceeding 0.07 ng/mL.

LEGEND
L = LOW, H = HIGH, LC = LOW CRITICAL, HC = HIGH CRITICAL, <> = ABNORMAL, C = CRITICAL

Q. Okay. All right. So, in -- in this case then at least Ms. Auld knew before June of 2014 --

A. Yes, sir.

Q. -- there was a different key?

A. Yes, sir.

Q. Do you know whether Rebecca knew?

A. I asked her to please inform Rebecca.

Q. Okay. All right.

A. Whether she did, I did not -- I don't know.

Q. Okay. Ms. Munoz indicated that her routine -- maybe everybody's but at least her routine was if she had not been able to sign off or check off a resident that she would then call. If there was no answer she would go to the apartment and knock on the door?

A. Yes, sir.

Q. And is that your understanding what the protocol should have been?

A. Yes.

Q. All right. Was -- was what to do if a resident wasn't checked off was it written down in some --

A. Yes.

Q. -- policy or protocol?

A. They were to notify the family.

Q. Okay. Was there anything -- I mean, was that

The patient was also noted to have a history of chronic stools with loose bowels during admission, and therefore, she was seen in consultation by the GI team who felt that her chronic diarrhea could be due to microscopic/collagenous colitis. Other etiologies include inflammatory bowel disease or infection. Therefore, they recommended checking stool studies. Her C. diff toxin was negative. Prior to discharge. Stool studies are still pending. She was treated empirically with p.r.n. Imodium and Lomotil and plans to follow up with Dr. Yantis and/or Joynet as an outpatient as she will likely need a repeat colonoscopy with biopsies.

The patient was able to work with physical therapy and occupational therapy, and it was felt that she would benefit from subacute rehabilitation at a skilled nursing part of Sandpiper. She will be transferred there today in stable condition.

DISCHARGE LABORATORY DATA: BNP 169. Magnesium 2.5. CPK 673. Negative C. diff toxin. Urine culture 1000 colony counts of E. coli. Stool Hemoccult negative. White count of 8.3, hemoglobin of 9, hematocrit of 27.3, and platelets of 156. Sodium of 145, potassium of 39, chloride of 112, bicarbonate of 20, BUN of 10, creatinine 0.5, and a glucose of 105. LFTs normal except for a slight elevation of her SGOT of 38.

DISCHARGE MEDICATIONS: Please see attached medication list.

DISCHARGE INSTRUCTIONS: The patient can increase activity as tolerated. She has been instructed to use toe-touch weightbearing with the assistance of physical therapy and occupational therapy. She should resume a low sodium diet. Her current dressing will be able to stay on for 1 week. Staple removal will be at her followup appointment with Dr. Murray in approximately 2 weeks. Followup appointment has been made to see Dr. Richard Mills on Wednesday 07/02/2014 at 3:00 p.m. Any questions or concerns regarding the patient's hospital course can be addressed to Dr. Omraju at 884-1777.

Nicole Perrin Ketchin, PA-C
TR: en DD: 06/10/2014 13:32 TD: 06/10/2014 14:26 Job#: 284102
DOC#: 386658

Authenticated by OMRAJU-MD,SWAPNA on 06/11/2014 05:21:51 PM

FAX COVER SHEET

TO	
COMPANY	
FAX NUMBER	18437208323
FROM	Joan Acosta
DATE	2018-05-21 09:31:51 EDT
RE	Delila Wilson Parrott REDACTED

COVER MESSAGE

I am the personal representative for the estate of Delila Wilson Parrott. I am requesting the complete medical record on behalf of the estate. Please find attached your form for request of protected health information, the death certificate, certificate of appointment by the Probate Court Judge in Charleston County, South Carolina and a copy of my picture ID, my SC Driver's License.

Please contact me for call at 803-331-6342 or by email to the address listed below or my personal email jacosta612@yahoo.com. Please contact me for any questions or concerns. Thank you for your attention in this matter.

–
Joan Acosta, RN, CCM
Rehabilitation Nurse Consultant
800-242-8856 Toll Free
803-331-6342 Cell
843-628-2475 Fax

Visit us at www.TheDirectionsGroup.com

This communication is intended only for the use of the individual or entity to which it is addressed and may contain information that is privileged and/or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking any action in reliance on the content of this email information is strictly prohibited. If you have received this email in error, please immediately notify me via telephone or email.

WWW.EFAX.COM

178037

Internal Use Only:
Request Number:
Date ROI Received:
Name & Title Verified ROI & ID:
Date Released:
Name & Title Processed ROI:

Jacosta612@yahoo.com

ROPER ST. FRANCIS

Authorization for Release of Protected Health Information

PLEASE PRINT CLEARLY AND COMPLETE

PT

Patient Full Legal Name: Delta Allison Acosta [REDACTED] Date of Birth:
Street Address: 2221 Bishop River Rd Social Security #:
City, State, Zip: Chas SC 29414 Best Contact #: 803 331-6342
Email Address: jacosta612@yahoo.com May we leave a message at this number: ☑ Yes ☐ No

RELEASE INFORMATION FROM:
Roper Hospital
Name of Facility or Person: Ch. Main St. Chas
City, State, Zip: Mt. Pleasant only
Phone Number / Fax Number

RELEASE INFORMATION TO:
Joan Acosta
Name of Facility, Person or Company: PO Box 1564 Murrells Inlet, SC 29576
City, State, Zip
803-331-6342
Phone Number / Fax Number

Bill To

PURPOSE OF RELEASE (check reason): ☐ Request of Individual/Personal Use ☐ Continued Patient Care ☐ Insurance
☑ Legal Purpose (including disposition & proceedings) ☐ Other:

DATES OF TREATMENT OR DATE RANGE OF RECORDS TO BE RELEASED: From 10-7-2014 To 12-9-2014

RECEIVED BY
MAY 21 2018
ROI DEPARTMENT

HOSPITAL INFORMATION TO BE RELEASED (check all that apply):
☐ Hospital Summary (may include H&P, discharge summary, operative notes, consults, diagnostic test results, medication list and allergies)
☐ Discharge Summary
☐ History and Physical
☐ Consultation Reports
☑ Entire Record (not including psychotherapy notes)
☐ Cardiac Reports
☐ Emergency Record
☐ Operative Reports
☐ Laboratory Reports
☐ Radiology/X-Ray Reports
☐ Pathology Reports
☑ Other: Can't Asych records

Fees May Apply. Requests for more than ten pages will be processed by our copy service who will contact you about charges that may apply pursuant to SC Code Section 44-115-60.

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DELIVERY METHOD (check one):
☐ Reg. US Mail
☐ Pick-up:
☐ Fax, where permitted
☑ Secure Email, where permitted
☐ Other:

PATIENT'S RIGHTS – I understand that:
- I can cancel this permission at any time. I must cancel in writing and send or deliver the cancellation to the releasing facility or practice named above. Any cancellation will apply only to information not yet released by the facility or practice.
- This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetics, HIV/AIDS, and other sexually transmitted diseases.
- Once my health information is released, the recipient may disclose or share my information with others and my information may be longer be protected by federal and state privacy protections.
- Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in a health plan, or eligibility for benefits.
- ROPER will not share or use my health information without my permission other than by ways listed in ROPER's Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at www.roper.com.
- A fee may be charged for providing the protected health information.
- I have a right to receive a copy of this form upon request.

This permission continues until you enter the date of expiration or event listed below or I revoke it.

Print Name: Joan Acosta Patient Signature: Joan Acosta Date: 5-21-18

NOTE: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form. Check relationship/authority if signature is not that of the patient (written proof may be required):
☐ Healthcare Agent/POA ☐ Guardian ☐ Executor/Administrator/Attorney in Fact ☐ Spouse
☐ Parent ☐ Adult Child ☐ Affidavit/ Next of Kin ☑ Other: Personal Rep

RETURN COMPLETED FORM IN PERSON, BY MAIL, OR BY FAX WITH A COPY OF YOUR PHOTO ID.

Roper Hospital
Attn: Medical Records Department
316 Calhoun Street, Charleston, SC 29401
Ph: (843) 724-2230 Fax: (843) 720-8328

Roper St. Francis Mount Pleasant
Attn: Medical Records Department
2095 Henry Tecklenburg Drive, Charleston, SC 29414
Ph: (843) 402-2022 Fax: (843) 881-1944

Roper St. Francis Hospital
Attn: Medical Records Department
3500 Hwy 17 N, Mt. Pleasant, SC 29464
Ph: (843) 606-7675 Fax: (843) 606-7914

Origin: I/O2 Section: 1000

PO Box 1564
Murrells Inlet, SC 29576
↑ Send to

Le 1/14-2/9/15

8362 Ulsa.

STATE OF SOUTH CAROLINA)
) IN THE PROBATE COURT
COUNTY OF CHARLESTON)

CERTIFICATE OF APPOINTMENT

IN THE MATTER OF

DELPHA WILSON HARRIOTT
(Deceased)

CASE NUMBER: 2015ES1000592

This is to certify that

JOAN ACOSTA

is/are the duly qualified

PERSONAL REPRESENTATIVE
SUCCESSOR PERSONAL REPRESENTATIVE
SPECIAL ADMINISTRATOR
TRUSTEE

of the above-named decedent having received letters on the 2nd day of APRIL 2015 and has/have qualified.

RESTRICTIONS: NONE

Executed this 14th day of APRIL 2015.

Probate Court Judge
LYNN A. TAFT, CLERK

Do not accept a copy of this certificate without the raised seal of the Probate Court.

CRM-1(PRS) (7/13)

STATE OF SOUTH CAROLINA

CERTIFICATION OF VITAL RECORD

DEATH CERTIFICATION

STATE FILE NUMBER: [redacted]
DECEDENT'S NAME: DELLA W PARROTT
AKA: NA
ARMED FORCES: NO
DATE OF BIRTH: REDACT
TYPE OF ACCEPTABLE DEATH: HOSPICE FACILITY
NAME AND ADDRESS OF PLACE OF DEATH: HOSPICE CENTER OF HOSPICE OF CHARLESTON, MOUNT PLEASANT, SC 29464
PLACE OF DISPOSITION: LAMAR CEMETERY
DISPOSITION LOCATION: LAMAR, SOUTH CAROLINA
METHOD OF DISPOSITION: BURIAL
DECEDENT'S RESIDENCE: [redacted] RIVER ROAD, CHARLESTON, CHARLESTON COUNTY, SC 29414
PLACE OF BIRTH: SOUTH CAROLINA
SEX: FEMALE
SOCIAL SECURITY NUMBER: REDACT
AGE: 80 YEARS
COUNTY OF DEATH: CHARLESTON
MARITAL STATUS: WIDOWED (AND NOT REMARRIED)
SURVIVING SPOUSE'S NAME: NA
FATHER'S NAME: CLARENCE OSCAR WILSON
MOTHER'S MAIDEN NAME PRIOR TO FIRST MARRIAGE: ETHAMAE STRICKLAND
INFORMANT'S NAME: JOAN ACOSTA
RELATIONSHIP: DAUGHTER
MAILING ADDRESS: 129 VESCOTT PLACE, COLUMBIA, SC 29210
FUNERAL HOME: ESCALIER-SMITH FUNERAL HOME, 2701 RIVERS AVENUE, CHARLESTON, SC 29414
FUNERAL DIRECTOR: ARCHIE D. WILLIS III
LICENSE NUMBER: 1618
EMBALMER'S NAME: AMANDA M. BRUCE III
LICENSE NUMBER: 2118
ACTUAL OR PRESUMED DATE OF DEATH: FEBRUARY 09, 2015
MANNER OF DEATH: NATURAL
ACTUAL OR PRESUMED TIME OF DEATH: 2024
CAUSE OF DEATH: PART I
CHRONIC CONDITION: [redacted]
OTHER SIGNIFICANT CONDITIONS: PART II
ADULT FAILURE TO THRIVE OSTEOPOROSIS
CORONER CONTACTED: NO
AUTOPSY PERFORMED: NO
AUTOPSY AVAILABLE: NA
DATE OF INJURY: NA
TIME OF INJURY: NA
INJURY AT WORK: NA
PLACE OF INJURY: NA
LOCATION OF INJURY: NA
HOW THE INJURY OCCURRED: NA
CERTIFIER'S NAME AND TITLE: MD DOLORES V. TRIBEAUCI
LICENSE NUMBER: 31970
CERTIFIER'S ADDRESS: 1015 BANNAMAN BLVD, MOUNT PLEASANT, SC 29464
DATE FILED: FEBRUARY 11, 2015
DATE OF ISSUANCE: FEBRUARY 12, 2015
SPECIAL INSTRUCTIONS:

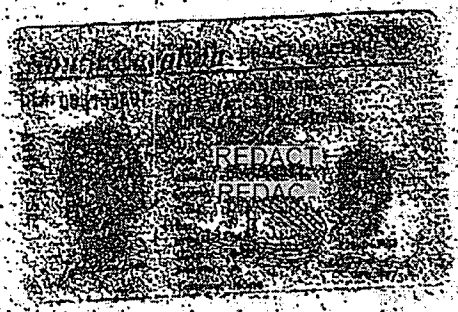
SC0539371

This is a true certification of the facts of death as filed in the Vital Records SC Department of Health and Environmental Control.

Deborah E. Derrick
Director and State Registrar

This copy not valid unless prepared on engraved border displaying the state seal and security logo.

DHEC


REDACT
REDAC

Mount Pleasant Hospital

ADMISSION RECORD

PATIENT

MED REC #	ADMISSION DATE/TIME	DISCHARGE DATE/TIME		SERVICE	STATION	ROOM NO	PAT TYPE	F.C.	ACCT #
001787037	10/11/14 1836			MED	D3C	3125-01	IPD	1	14284-00216

LOCATION(S)	RR.	PAT. CLA	PUBVAL	LNG	SEX	RACE	MS	DATE OF BIRTH	AGE
MED	PVT		I N	E	F	W	W	REDA	BOI

PATIENT NAME AND ADDRESS	SOC SEC NO	PATIENT EMPLOYER	TELEPHONE NO.
PARROTT,DELILA W 2333 ASHLEY RIVER ROAD CHARLESTON SC 29414	REDACT PATIENT TELEPHONE NO. (843)881-1692	RETIRED EMP STAT SC	

GUARANTOR

GUARANTOR NAME AND ADDRESS	SOC SEC NO	GUARANTOR EMPLOYER	TELEPHONE NO.
PARROTT,DELILA W 2333 ASHLEY RIVER ROAD CHARLESTON SC 29414	REDACT TELEPHONE NO. (843)881-1692 SELF	RETIRED SC	

EMPLOYERS

INSURANCE

INSURANCE 1	INSURANCE 2
MEDICARE 2300 SPRINGDALE DRIVE CAMDEN SC 29020 PO BOX 7004 REDAC PARROTT,DELILA W	STATE FARM PO BOX 3070 MINARK OH 43058-3070 PLAN # HB913702404G PARROTT,DELILA/W

MISC

IN CASE OF EMERGENCY NOTIFY	SPOUSE	ARRIVAL MODE	ADM TYPE/SOURCE
CONNOR,JUNE DAUGHTER HM: (843)814-1696 WK:	SCOPA,JOAN DAUGHTER HM: (803)331-6342 WK: (803)331-6342	AMBULANC	2 / 1

ADM DIAG/PRESENTING COMPLAINT: ALTERED MENTAL STATUS

ADMITTING DOCTOR	ATTENDING DOCTOR	REFERRING DOCTOR	PRIMARY CARE DOCTOR
MILLS-MD,RICHARD P	MILLS-MD,RICHARD P	BLANCO-MD,ROBERT	MILLS-MD,RICHARD P

ALERTS	PREVIOUS ADM DATE	OPT OUT	Dth	W40	WKT	PHN MSG	PRIMARY	ALT.	BY
NO KNOWN	07/15/14		No		XXX		Yes		EDH

FOR EMERGENCY DEPARTMENT USE ONLY — ALLERGIES | LMP# | TEMP # | RESP# | PULSE# | BP# | TIME | SIGNATURE

PRINCIPLE DIAGNOSIS — DRG

OTHER DIAGNOSIS(ES) — CODE(S)

PRINCIPAL OPERATION/PROCEDURE:

OTHER OPERATION(S)/PROCEDURE(S):

Inpatient MP

EBT D0001787037 D14284-00216

☐ OPERATIVE SUMMARY DICTATED ☐ DISCHARGE SUMMARY DICTATED PHYSICIAN SIGNATURE: _____ DATE _____

MRN: 001787037 DOB: REDA
PARROTT,DELILA W
Mt Pleasant ERD
PHYS: BIANCO-MD,JOSEPH
ACCT#: 14288-00210 10/11/14

Consent for Treatment
Mt. Pleasant Hospital

Before Roper Hospital and any of its departments (the **HOSPITAL**) may provide you inpatient or outpatient services **YOU** must know what services **YOU** will receive, consent to them, agree to how to pay for them, and accept how the **HOSPITAL** will use your medical record. The **HOSPITAL** requests your consent to **TWO** (2) different parts of this form. Please carefully read Part I on treatment and other important matters **AND** Part II on the use of your patient information. **YOU** may request that this form be read to **YOU**. Be sure to ask any questions **YOU** may have about it. When **YOU** fully understand the form's content, please sign in the places indicated.

PART I

CONSENT TO TREATMENT

YOU authorize your physician or a designated qualified assistant to provide **YOU** medical treatment. This may include physicians of a distant site telemedicine entity. **YOU** consent to all **HOSPITAL** medical or diagnostic care ordered for **YOU** during this visit as an outpatient or stay in the **HOSPITAL**. This consent includes testing for infections such as hepatitis B and HIV and providing blood or body fluids for such tests in order to protect **YOU** and/or those who provide **YOU** services.

PAYMENT FOR SERVICES AND INSURANCE

YOU are directly responsible for paying for all provided services. The **HOSPITAL** will accept assignment of your payment responsibility to others. This includes health insurers, Medicare, Medicaid, workers' comp, and different types of liability, accident, and disability insurance policies. **YOU** agree that the assigned payment responsibility is covered by current, valid and in effect insurance arrangements and that **YOU** will promptly pay any required co-pay amounts and unpaid deductibles. If **YOU** are receiving Medicare benefits for the services provided, an assignment of benefits includes those for physician services that were part of the **HOSPITAL**'s services to **YOU**.

YOU (patient or agent accepting financial responsibility) *guarantee payment* to the **HOSPITAL** for **ALL NONCOVERED SERVICES** and any unpaid, billed amounts not covered by insurance if the applicable benefit plan allows collection of the unpaid balance. **YOU** understand and accept that your physician's orders may include services not paid by benefit plans but will be provided to you by the **HOSPITAL**. Also, **YOU** accept that benefit plans may deny payment for what **YOU** believed were covered services resulting in your responsibility for paying for these services. **YOU** may be billed for the professional component of any hospital services, such as the professional component for clinical laboratory tests. If it becomes necessary, the Hospital can assist you in applying for financial assistance through Federal, State and Local Programs.

Should any remaining account balance produce a financial burden to **YOU**, please inform the **HOSPITAL** of your hardship.

VALUABLES

YOU accept full responsibility for your valuables especially money or jewelry. The **HOSPITAL** does not accept any liability for your valuables. The **HOSPITAL** expects **YOU** will entrust any valuables to family or friends for safekeeping or deposit them in the **HOSPITAL** safe provided for that purpose. This is especially important when you are an inpatient, but this responsibility also extends to when **YOU** are an outpatient and must change into a **HOSPITAL** gown, remove jewelry or be sedated for a procedure.

SPECIAL NOTE FOR MEDICARE OR CHAMPUS PATIENTS

YOU acknowledge and certify by your signature that all your information provided to the **HOSPITAL** for Medicare or Champus benefits is correct and **YOU** agree to allow the **HOSPITAL OR OTHERS** that have information on your Medicare or Champus benefits claim to provide the information to Medicare, Champus, or their agents in order for them to determine your eligibility for benefits. To carry out this activity, the **HOSPITAL** may use a copy rather than the original of this consent form. **YOU** also, acknowledge receipt of the "Important Message from Medicare" or "Important Message from Champus" forms, which does not waive any of your rights for a review or make **YOU** liable for any payment.

I CERTIFY THAT I HAVE READ (OR HAD READ TO ME) PART I AND FULLY UNDERSTAND AND AGREE TO THE CONTENT.

Patient/Agent Signature: Delila Parrott Date of Birth: 4/[illegible]/[illegible]

Print Name: Delila Parrott Date/Time: 10/11/14 11:16am

If agent, what is relationship to patient (parent, guardian, legal representative):

Reason Patient Unable/Unwilling to Sign:

Witness (when form is accepted verbally, by telephone or by electronic means):

Original 3/06; Revised 3/14; 5/14

OneContent: Generated By colfja1

Consent for Treatment
Mt. Pleasant Hospital

PART II

Consent to the Use and Disclosure of Protected Health Information

YOU agree to honestly, completely, and correctly provide all requested information and permit the HOSPITAL to share your medical record as applicable under the law with your physician, your insurers, Medicare, Medicaid or their designated agents. They may review your record, copy it in full or in part in order to obtain billing and payment information and for insurers (private or government) to determine whether your services are covered by them. YOU agree to allow the HOSPITAL to use your record made during this visit at this time or later to meet its required reporting duties regarding your care and to collect payment for the services YOU received. YOU agree for your doctor to direct copies of your medical records to other physicians, hospitals, and other healthcare facilities, as they deem necessary for continuity of care. YOU also agree to have your name posted on scheduling boards and outside your hospital room.

Specific Uses of Your Protected Information

The HOSPITAL originates and maintains health records describing your health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. This information serves as:

- A basis for planning care and treatment
- A means of communication among the many health professionals who contribute to your care (this includes posting your name on scheduling boards or outside your patient room)
- A source of information for applying diagnosis and surgical information to your bill
- A means by which a third-party payer (usually your insurance company or the government) can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

Your signature below acknowledges that YOU received the Roper St. Francis Notice of Information Practices that provides a description of information uses and disclosure practices. YOU accept and understand that YOU:

- Have the right to review the NOTICE prior to signing this consent.
- Accept that the HOSPITAL reserves the right to change the NOTICE and its information practices, for past, current, or future information. The new notice will contain the effective date on its first page and be made available on our Web site.
- Have the right to object to the use of your health information for the HOSPITAL's patient directory.
- Have the right to request restrictions on the use or disclosure of your health information to carry out treatment, payment, or healthcare operations and to correct error(s) in your record. The HOSPITAL, however, is not required to agree to the restrictions requested.
- May revoke this consent in writing that YOU provide to the HOSPITAL. The revocation does not apply to any uses of your information made by the HOSPITAL in reliance upon this consent form and on the belief that your consent was still effective.
- Your signature acknowledges that YOU have been provided with information regarding the Lewis Blackman Patient Safety Act and the HOSPITAL's Patient Assistance Program as found in the RSF Patient Handbook.

I HAVE BEEN PROVIDED A COPY OF RSF's NOTICE OF PRIVACY PRACTICES.

Patient/Agent Signature: Delila Parrott Date of Birth 4/18/[illegible]

Print Name: Delila Parrott Date/Time: 10/11/14 11:16am

If agent, what is relationship to patient (parent, guardian, legal representative): _____

Reason Patient Unable/Unwilling to Sign: _____

Witness (when form is accepted verbally, by telephone or by electronic means): _____

Original 5/06; Revised 2/14; 5/14

Mt. Pleasant
3500 Highway 17 North Mt Pleasant,SC 29466

Date:	Name	Acct. #	Financial Class	
10/22/14	PARROTT,DELILA W	14284-00216	M - MEDICARE	
Sex	Birth Date Age	Adm Date	Dsch Date	LOS
F	REDA 80Y	10/11/14	10/15/14	4

Attending Physician
HILLS-MD,RICHARD E
Coder: HM

Discharge Status
03 - 03_SKILLED NURSING FACILITY

MDC: 19 MENTAL DISEASES AND DISORDERS
DRG: V32.0 (P) 885 PSYCHOSES

OUTLIER STATUS: N/A

	DIAGNOSIS	DESCRIPTION/POA		DIAGNOSIS	DESCRIPTION/POA
1.	(P) 297.1	DELUSIONAL DISORDER/Y	12.	V54.13	AFTRCR TRAMATIC FX R/E
2.	294.20	DEMEN NOS W/O BEHV DST/Y	13.	780.57	SLEEP APNEA NOS/Y
3.	780.09	OTHER ALTER CONSCIOUSN/Y	14.	362.50	MACULAR DEGENERATION N/Y
4.	401.9	HYPERTENSION NOS/Y	15.	V14.2	HX-SULFONAMIDES ALLERG/Z
5.	715.90	OSTEOARTHROS NOS-UNSPE/Y	16.	V14.9	HX-DRUG ALLERGY NEC/Z
6.	530.81	ESOPHAGEAL REFLUX/Y	17.	V14.6	HX-ANALGESIC ALLERGY/Z
7.	V04.81	VACCIN FOR INFLUENZA/E	18.	V15.82	HISTORY OF TOBACCO USE/E
8.	311	DEPRESSIVE DISORDER NE/Y	19.	300.00	ANXIETY STATE NOS/Y
9.	781.2	ABNORMALITY OF GAIT/Y	20.	V13.02	PERSONAL HISTORY UTI/E
10.	V12.54	HX TIA/STROKE W/O RESI/E	21.	E935.9	ADV EFF ANALGESIC NOS/Y
11.	V58.69	LONG-TERM USE MEDS NEC/Z			

Reason for Visit:

PROCEDURE	DESCRIPTION	DATE	SURGEON NAME

PARROTT,DELILA W
001787037 00913109
10/22/14

DIAGNOSIS SUMMARY WORKSHEET

OneContent: Generated By coffje1

Patient DOB: REDAC

CHIEF COMPLAINT: Per daughter, increased agitation, confusion, hallucinations and altered mental status.

HISTORY OF PRESENT ILLNESS: This 80-year-old white female is followed long-term by Dr. Richard Mills and was seen in his office 2 days prior to this admission. She had not been seen previously since January but has had multiple episodes of care since that time. She presented with decline over the past 2 weeks according to her daughter, with inability to do things as simple as picking up a glass and drinking from it. She also has frequently had paranoid ideations that people and things come into her room at night and cause her harm. Daughter reports that she has also previously had hallucinations, insisting bedbugs were all over her and were her biting her. She has had progressive memory loss and cognitive decline over several years. Daughter indicates that she had a single psychiatric hospitalization at a geriatric psychiatry unit in Columbia about 5 or 6 years ago. The daughter indicates that she had noticed some memory loss and decline and increased anxiety predating this; but after the financial downturn, she became very concerned about money and very fearful that she would run out of money. Daughter reports that she was treated at that time with Seroquel and seemed to tolerate it well and believes that she has stopped it on her own.

The patient had a fairly severe fall in June and suffered a left hip fracture. She underwent ORIF of the left subtrochanteric femur fracture by Dr. Murray in early June and then was discharged to rehabilitation at the Sandpiper nursing facility. She subsequently has been admitted to Ashley River Plantation assisted living facility and daughter feels that, with her recent decline, she is probably not safe in the assisted living environment. She did have reasonably good rehab after her hip fracture but walks only with a walker and assistance of 1 person standing by according to the daughter.

Dr. Mills had, on October 10th at that evaluation, scheduled her for a CT brain scan, which had not been done prior to her presentation to the Emergency Department. He also did a CMP and CBC and these were unremarkable with a totally normal CMP and CBC with a normal white count, hemoglobin of 12.9 and slightly microcytic indices, which showed resolution of her postoperative blood loss, which occurred after her hip fracture.

The patient denies any history of any recent cough or chest congestion, fever or

chills, abdominal pain, nausea or vomiting. She does complain of a mild headache today and indicates that she is having some back pain.

PAST MEDICAL HISTORY: Notable for macular degeneration with significant decline in vision, hypertension, gastroesophageal reflux disease, sleep apnea and osteoarthritis.

PAST SURGICAL HISTORY: Breast biopsy, left wrist fracture, multiple eye surgeries and the repair of the hip fracture in June 2014.

MEDICATIONS ON ADMISSION: MiraLax, Lasix 40 mg daily, Nexium 40 mg daily, Colace 100 mg daily p.r.n., Celexa 10 mg daily, Dilacor XR 180 mg extended release daily, Inderal-LA 60 mg daily, Ultram 50 mg 1 tablet every 6 hours as needed, Norco 7.5/325 mg 1-2 tablets every 4 hours, Xanax 0.25 mg 3 times a day, Macrobid 100 mg every 12 hours with a scheduled stop date of October 25th.

ALLERGIES: NONSTEROIDAL ANTI-INFLAMMATORIES, SULFA, ASPIRIN, ALTACE AND DIOVAN.

SOCIAL HISTORY: The patient is a nonsmoker, having smoked in the distant past but stopping about age 40. She does not use alcohol at all. She was a certified registered nurse anesthetist for 40 years.

FAMILY HISTORY: Significant for a daughter with unknown mental issues. Her mother died in childbirth when the patient was 18 months old. Spouse deceased from an arrhythmia.

REVIEW OF SYSTEMS: GENERAL CONSTITUTIONAL REVIEW: Denies fever, chills, night sweats, change in appetite. Admits headache and decline in function. RESPIRATORY REVIEW: Denies shortness of breath, cough, chest pain and sputum production. CARDIOVASCULAR REVIEW: Denies dyspnea, dizziness or lightheadedness, palpitations. GASTROESOPHAGEAL REVIEW: Denies abdominal pain, change in bowel habits, constipation, weight loss. MUSCULOSKELETAL REVIEW: Admits to lower back pain and recent fracture of the left femur. NEUROLOGIC: History is obtained from daughter of significant memory loss. PSYCHIATRIC: Anxiety, agitation, hallucinations, paranoia with uncertain prior psychiatric diagnosis.

PHYSICAL EXAMINATION: GENERAL: Reveals a frail, somewhat disheveled elderly white female who is calm and cooperative to exam. CONSTITUTIONAL: Temperature

OneContent: Generated By coffje1

97.7, pulse 67, respiratory rate 20, O2 saturation on room air 97%, blood pressure 180/74. HEENT: Pupils are equal and reactive. Extraocular movements are intact. Nose and oropharynx are clear. Oral mucosa is moist. The face is symmetrical. NECK: Supple, with full range of motion, no thyromegaly, no bruits. CHEST: Clear, full bilateral breath sounds are noted. No rales or wheezing present. HEART: Regular rate and rhythm, normal S1 and S2, no murmur, gallop or rub. ABDOMEN: Soft, active bowel sounds throughout. No guarding or rigidity. No direct tenderness, no mass or hepatosplenomegaly. LOWER EXTREMITIES: Trace pedal edema bilaterally. Good muscle tone. Range of motion relatively well preserved in the large joints bilaterally. NEUROLOGIC: Cranial nerves II-XII are grossly intact. There is no focal motor or sensory deficit. The patient is confused and follows some simple commands but at other times is unable to do this. Gait is not tested.

ADMISSION LABORATORY EVALUATION: Potassium 4.2. Electrolytes are normal. Creatinine 0.6, BUN 13. White count is 5400, hemoglobin 12.5. Urinalysis shows negative for leukocytes but moderate blood. CT brain scan was obtained in the Emergency Department and it showed no evidence of acute intracranial abnormality or bleed, but did show diffuse chronic microangiopathic changes, including several previous lacunar infarcts.

ASSESSMENT:
1. A patient with known psychiatric history and known cognitive decline who presents after a precipitous decline over the past 2 weeks with worsening cognitive function, but also worsening in her physical ability to do activities of daily living. She is currently receiving Macrobid, presumably for a urinary tract infection; although, her current urine is benign. Evaluation for an underlying delirium is initiated with further laboratory tests to include serum ammonia, B12, folate and thyroid function. Additionally, consideration for serotonin syndrome, in that she has been on both citalopram and tramadol. Consideration of altered mental status secondary to her pain medication is also in the differential. Other problems include hypertension and we will maintain her on Dilacor for this. Gastroesophageal reflux, for which Nexium will be continued. We will discontinue Seroquel, as daughter is concerned that this will not be effective, and try Risperdal 0.5 mg at bedtime daily and 0.25 mg b.i.d. Consider neurology and/or a psychiatric evaluation depending on her clinical course during this hospital stay. Physical therapy and occupational therapy evaluations are ordered. A PPD is placed, anticipating that she may need to go to a skilled nursing facility, either for short-term rehabilitation

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or potentially for long-term care.

Update to the History and Physical if appropriate
[] I have reviewed the H&P and re-examined the patient and there are no changes to the physical examination and/or history of present illness.
[] I have reviewed the H&P and re-examined the patient and the following changes have occurred to the physical examination and /or history of present illness:

---

[x] Refer to the Admission Home Medication Orders (inpatient) or Outpatient/OBSERVATION medication list (outpatient) for current medications.
Physician Signature: _____ Date: _____ Time:

R. Levern Livingston, MD
TR: sa DD: 10/11/2014 17:39 TD: 10/11/2014 18:33 Job#: 329067
DOC#: 431646

Authenticated by R LEVERN LIVINGSTON MD On 10/13/2014 09:05:59 AM

OneContent: Generated By coffje1

MRN: 001787037 DOB REDA
PARROTT,DELILA W
Mt Pleasant ERD
PHYS: GIANCO-MD,JOSEPH

Patient Name
DOB / /
MD
ACCT#: 14284-00216 10/11/14
Room # Bed Type: Med/Surg Tele ICU
Fax Numbers: Roper/ MPH 724-1949
BSSP 402-1550

Patient Status - Certification Physician Order

FAXED

Questions contact Utilization Review at: Roper 286-0462 / BSSF 729-1654 / MPH 991-2329 or 296-0462

☑ **Inpatient Order & Certification** (In accordance with 42 CFR 412.3)
Expected LOS is 2 midnights or greater due to medical necessity.

Diagnoses: ~~[illegible]~~ Altered mental Status med surg

Admit to:

Clinical Reasons for Inpatient admission:

Signs/Symptoms:

Significant History: see H + P

Co-Morbidities:

Risk for adverse outcomes:

Discharge plans/instructions will be delivered to the patient prior to discharge and include appropriate follow up services, medication instructions and care transition instructions as needed.

☐ **Outpatient with Observation Services Order**

Diagnoses:

Admit to:
ER or Direct Admissions whose LOS based on medical necessity is NOT anticipated to span 2 midnights

☐ **Outpatient Order**
All procedures NOT designated as inpatient only.

Universal Patient Care Orders
- ☑ Initiate Rapid Response Team/Stroke Team as appropriate & notify MD of patient's condition
- ☑ Initiate Emergency Resuscitation per ACLS guidelines until Code Team arrives, unless otherwise indicated.
- ☑ Initiate Hypoglycemia Protocol for blood glucose < 70 mg/dL
- ☑ Initiate Naloxone (Narcan) Protocol for reversal of opioid induced respiratory depression

COMPLETE A "NEW" PATIENT STATUS ORDER FORM IF CHANGING STATUS ORDER

Physician Signature: [illegible] Date & Time: 10/11/14 1530

Nursing Signature: [illegible] Date & Time: 10/11/14 1530

[illegible] (Gass)

Revised 12/08 ;10/10,9/13; 11/13; 3/14, 7/14

3121

ROPER ST. FRANCIS PHYSICIAN PARTNERS

PARROTT, DELILA W

80 Y old Female, DOB: REDACT
Account Number: 00000127282
2333 ASHLEY RIVER ROAD, CHARLESTON, SC-29414
Home: 843-881-1692
Guarantor: PARROTT, DELILA W Insurance: MEDICARE
Payer ID: PAPER
Appointment Facility: East Cooper Internal Medicine

10/09/2014 Progress Notes: Richard E. Mills MD

Current Medications

Taking
- MiraLax – Packet 1 packet mixed with 8 ounces of fluid Once a day prn for constipation, stop date 12/22/2014
- Lasix 40 MG Tablet 1 tablet daily prn
- Nexium 40 MG Capsule Delayed Release 1 capsule Once a day
- Celece 100 MG Capsule 1 capsule as needed Once a day
- Celexa 10 MG Tablet 2 tablets Once a day
- Diltiazem XR 180 MG Capsule Extended Release 24 Hour 1 capsule on an empty stomach in the morning Once a day
- Inderal LA 60 MG Capsule Extended Release 24 Hour
- Ultram 50 MG Tablet 1 tablet as needed every 6 hrs
- Norco 7.5-325 MG Tablet 1 to 2 tablets every 4 hours
- Xanax 0.25 MG Tablet 1 tablet Three times a day
- Macrobid 100 MG Capsule 1 capsule with food every 12 hrs, stop date 10/25/2014
- Docusate Sodium 100 MG Capsule 1 capsule as needed Once a day
Discontinued
- Vitamin B 12 100 MCG Lozenge
- Lamotil 2.5-0.025 MG Tablet 1 tablet as needed Four times a day
- Mylanta 200-200-20 MG/5ML Suspension 10 ml as needed Four times a day
- Medication List reviewed and reconciled with the patient

Past Medical History

Macular degeneration
HTN
GERD
Sleep apnea
OA
PAP 2008
Colonoscopy August 2013 - Dr. Joyner
Zostavax 2007
Pneumovax 2004

Surgical History

breast biopsy - left breast
left wrist Fx

Reason for Appointment

1. F/U MEDS
2. NEEDS PAIN CONTRACT IF CONTINUE W/ NORCO
3. PARANOIA, AGITATION, SHORT TERM MEMORY LOSS, CONFUSION

History of Present Illness

Mrs. Parrot has not been here since January. She had a bad fall at home in June and was on the floor for 3 days until she was found. She is now in assisted living and doing better. Her daughter is with her today and expresses several concerns about her mood and mental status. Her daughter is concerned that she had a brain injury with the fall or a stroke because she has speech and memory trouble. She is not the same since the fracture. She is often agitated and irritable. She does not have any focal weakness since the fall.

Vital Signs

Ht 65 in, Temp 97.8, Pulse Sitting 70, BP 140/78 mm Hg, RR 18 /min, Oxygen saturation 95 %.

Examination

General Examination:

GENERAL APPEARANCE: alert, well hydrated, in no distress, elderly white female who is sitting in wheelchair, accompanied by daughter.

HEAD: normocephalic, atraumatic.

EYES: no lid lag, stare or proptosis, extraocular movement intact (EOMI), pupils equal, round, reactive to light.

ORAL CAVITY: tongue in midline, mucosa moist.

THROAT: uvula midline, pharynx normal.

NECK: neck supple, full range of motion.

HEART: S1, S2 normal.

LUNGS: clear to auscultation bilaterally, good air movement.

ABDOMEN: soft, nontender, nondistended, no masses palpable.

SKIN: good turgor, warm and dry.

MUSCULOSKELETAL: strength 4/5 in bilateral quadriceps, 4/5 strength on plantar flexion.

EXTREMITIES: 2+ pitting edema of LLE with compression stocking in place, 1+ edema of RLE.

NEUROLOGIC: alert, oriented to person, cooperative with exam,

multiple eye surgeries OU
Open reduction internal fixation left subtrochanteric femur fracture DR MURRAY 06/07/2014

Family History
Father: deceased, stroke
Mother: alive, childbirth
Spouse: deceased, arrhythmia
Adopted at 2 yrs. .

Social History
Tobacco Use:
Tobacco Use/Smoking Are you a: nonsmoker .
Tobacco Use/Smokeless: Denies
Smokeless Tobacco: No
Tobacco cessation
Patient counselled on the dangers of tobacco 10/29/2013
Cessation: Not applicable

Allergies
NSAIDS
sulfa
ASA
Altace
Diovan

Hospitalization/Major Diagnostic Procedure
see above

Review of Systems

General/Constitutional:
Fever denies. Chills denies. Headache denies. Fatigue denies. Night sweats denies. Change in appetite denies.

Respiratory:
Shortness of breath denies. Chest pain denies. Cough denies. Shortness of breath with exertion denies. Sputum production denies. Wheezing denies.

Cardiovascular:
Chest Pain denies. Dizziness denies. Palpitations denies.

Gastrointestinal:
Patient denies blood in stool, constipation, difficulty swallowing, rectal bleeding, weight loss. Abdominal pain denies. Exposure to hepatitis denies.

Musculoskeletal:
Fracture admits, left femur. Leg swelling admits, left.

Neurologic:
Patient denies balance difficulty, difficulty speaking, loss of strength, dysphagia. Patient complaining short term memory loss, no tremor, normal sensory exam.

PSYCH: good eye contact, mood/affect appropriate, speech clear, confused at times.

Assessments
1. HTN - 401.9 (Primary)
2. Confusion - 298.9
3. Short-term memory loss - 780.93
4. Fall - E888.9
5. Subtrochanteric fracture of femur - 820.22, Left
6. Hypoalbuminemia - 273.8
7. Hypocalcemia - 275.41
8. Anemia - 285.9

Treatment

1. **HTN**
LAB: COMP METABOLIC PANEL (CMP) Normal result

ANION GAP CALC	11.0	7.0-16.0 - calc
ALBUMIN	3.7	3.5-5.0 - g/dL
ALK PHOS	140	40-150 - IU/L
B/C RATIO CALC	17.1	3.0-40.0 - calc
BILI TOTAL	0.4	0.2-1.2 - mg/dL
BUN	12.0	9.8-20.1 - mg/dL
CALCIUM	9.5	8.8-10.5 - mg/dL
CL	100	99-110 - mmol/L
CO2	30	21-32 - mmol/L
CREATININE	0.7	0.6-1.1 - mg/dL
GLUCOSE	87	70-105 - mg/dL
K	4.1	3.7-5.5 - mmol/L
NA	141	135-145 - mmol/L
PROTEIN	7.0	6.0-8.3 - g/dL
SGOT	21	5-34 - IU/L
SGPT	16	0-55 - IU/L

2. **Confusion**
Start QUEtiapine Fumarate ER Tablet Extended Release 24 Hour, 50 mg, 1 tablet in the evening, Orally, Once a day, 30 day(s), 30, Refills 03
IMAGING: CT HEAD W/O CONTRAST

3. **Short-term memory loss**
Start Aricept Tablet, 5 MG, 1 tablet at bedtime, Orally, Once a day, 30 day(s), 30, Refills 05
IMAGING: CT HEAD W/O CONTRAST

4. **Fall**
IMAGING: CT HEAD W/O CONTRAST

5. **Hypoalbuminemia**
LAB: COMP METABOLIC PANEL (CMP) Normal result

ANION GAP CALC	11.0	7.0-16.0 - calc
ALBUMIN	3.7	3.5-5.0 - g/dL
ALK PHOS	140	40-150 - IU/L
B/C RATIO CALC	17.1	3.0-40.0 - calc
BILI TOTAL	0.4	0.2-1.2 - mg/dL

of daughter reports memory loss, confusion.

Psychiatric:

Patient complaining of daugher reports anxiety, agitation.

BUN	12.0	9.8-20.1 - mg/dL
CALCIUM	9.5	8.8-10.5 - mg/dL
CL	100	99-110 - mmol/L
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PROTEIN	7.0	6.0-8.3 - g/dL
SGOT	21	5-34 - IU/L
SGPT	16	0-55 - IU/L

Notes: Her albumin level has significantly improved.

6. Hypocalcemia

LAB: COMP METABOLIC PANEL (CMP) Normal result

ANION GAP CALC	11.0	7.0-16.0 - calc
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SGOT	21	5-34 - IU/L
SGPT	16	0-55 - IU/L

Notes: Calcium is now WNL.

7. Anemia

LAB: CBC (COMPLETE BLOOD COUNT) Normal result

WBC	5.2		3.8-10.6 - K/uL
RBC	4.79		3.60-5.20 - M/uL
HGB	12.3		11.5-15.7 - g/dL
HCT	37.8		34.0-47.0 - %
MCV	78.9	L	81.0-99.0 - fL
MCH	25.6	L	27.0-34.5 - pg
MCHC	32.5		32.0-36.0 - g/dL
RDW	17.7	H	11.0-16.0 - %
MPV	7.6		7.2-11.2 - fL
PLATELET	269		140-440 - K/uL

Notes: Anemia resolved since acute postoperative blood loss.

Follow Up

4 Weeks

Images

Patient Letter 2014-10-9 23:17:38



Electronically signed by RICHARD MILLS MD on 10/10/2014 at 08:32 PM EDT

Sign off status: Completed

East Cooper Internal Medicine
180 WINGO WAY SUITE 306
MT PLEASANT, SC 29464-1812
Tel: 843-884-1777
Fax: 843-606-8000

ROPER ST FRANCIS

MRN: 001787037 DOB: REDACT
PARROTT,DELILA W IPD 3125-01
Mt Pleasant
PHYS:MILLS-MD,RICHARD E
ACCT#: 14284-00216 10/11/14

PARROTT, DELILA W

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Guarantor: PARROTT, DELILA W Insurance: MEDICARE
Payer ID: PAPER
Appointment Facility: Rust Cooper Internal Medicine

10/09/2014

Progress Notes: Richard E. Mills MD

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Discontinued
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HTN
GERD
Sleep apnea
OA
PAP 2008
Colonoscopy August 2013 - Dr. Joyner
Zostavax 2007
Pneumovax 2004

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breast biopsy - left breast
left wrist Fx

Reason for Appointment

1. F/U MEDS
2. NEEDS PAIN CONTRACT IF CONTINUE W/ NORCO
3. PARANOIA, AGITATION, SHORT TERM MEMORY LOSS, CONFUSION

History of Present Illness

Mrs. Parrot has not been here since January. She had a bad fall at home in June and was on the floor for 3 days until she was found. She is now in assisted living and doing better. Her daughter is with her today and expresses several concerns about her mood and mental status. Her daughter is concerned that she had a brain injury with the fall or a stroke because she has speech and memory trouble. She is not the same since the fracture. She is often agitated and irritable. She does not have any focal weakness since the fall.

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SKIN: good turgor, warm and dry.

MUSCULOSKELETAL: strength 4/5 in bilateral quadriceps, 4/5 strength on plantar flexion.

EXTREMITIES: 2+ pitting edema of LLE with compression stocking in place, 1+ edema of RLE.

NEUROLOGIC: alert, oriented to person, cooperative with exam,

multiple eye surgeries OU
Open reduction internal fixation left subtrochanteric femur fracture DR MURRAY 06/07/2014

Family History
Father: deceased, stroke
Mother: alive, childbirth
Spouse: deceased, arrhythmia
Adopted at 2 yrs. .

Social History
Tobacco Use:
Tobacco Use/Smoking: Are you a: nonsmoker .
Tobacco Use/Smokeless: Denies
Smokeless Tobacco: No
Tobacco cessation
Patient counselled on the dangers of tobacco 10/29/2013
Cessation: Not applicable

Allergies
NSAIDS
sulfa
ASA
Altace
Diovan

Hospitalization/Major Diagnostic Procedure
see above

Review of Systems
General/Constitutional:
Fever denies. Chills denies. Headache denies. Fatigue denies. Night sweats denies. Change in appetite denies.

Respiratory:
Shortness of breath denies. Chest pain denies. Cough denies. Shortness of breath with exertion denies. Sputum production denies. Wheezing denies.
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Gastrointestinal:
Patient denies blood in stool, constipation, difficulty swallowing, rectal bleeding, weight loss. Abdominal pain denies. Exposure to hepatitis denies.
Musculoskeletal:
Fracture admits, left femur. Leg swelling admits, left.
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Patient denies balance difficulty, difficulty speaking, loss of strength, dysphagia. Patient complaining short term memory loss, no tremor, normal sensory exam.
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4. Fall - E888.9
5. Subtrochanteric fracture of femur - 820.22, Left
6. Hypoalbuminemia - 273.8
7. Hypocalcemia - 275.41
8. Anemia - 285.9

Treatment
1. HTN

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PROTEIN	7.0	6.0-8.3 - g/dL
SGOT	21	5-34 - IU/L
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2. Confusion
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IMAGING: CT HEAD W/O CONTRAST

3. Short-term memory loss
Start Aricept Tablet, 5 MG, 1 tablet at bedtime, Orally, Once a day, 30 day(s), 30, Refills 05
IMAGING: CT HEAD W/O CONTRAST

4. Fall
IMAGING: CT HEAD W/O CONTRAST

MRN: 001787037 DOB: REDACTED
PARROTT,DELILA W
Mt Pleasant IPD 3125-01
PHYS: MILLS-MD,RICHARD E
ACCT#: 14284-00218 10/11/14

5. Hypoalbuminemia

LAB: COMP METABOLIC PANEL (CMP) Normal result

ANION GAP CALC	11.0	7.0-16.0 - calc
ALBUMIN	3.7	3.5-5.0 - g/dL
ALK PHOS	140	40-150 - IU/L
B/C RATIO CALC	17.1	3.0-40.0 - calc
BILI TOTAL	0.4	0.2-1.2 - mg/dL

of daughter reports memory loss, confusion.
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Patient complaining of daughter reports anxiety, agitation.

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PROTEIN	7.0	6.0-8.3 - g/dL
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SGPT	16	0-55 - IU/L

Notes: Her albumin level has significantly improved.

6. Hypocalcemia

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Notes: Calcium is now WNL.

7. Anemia

LAB: CBC (COMPLETE BLOOD COUNT) Normal result

WBC	5.2		3.8-10.6 - K/uL
RBC	4.79		3.60-5.20 - M/uL
HGB	12.3		11.5-15.7 - g/dL
HCT	37.8		34.0-47.0 - %
MCV	78.9	L	81.0-99.0 - fL
MCH	25.6	L	27.0-34.5 - pg
MCHC	32.5		32.0-36.0 - g/dL
RDW	17.7	H	11.0-16.0 - %
MPV	7.6		7.2-11.2 - fL
PLATELET	269		140-440 - K/uL

Notes: Anemia resolved since acute postoperative blood loss.

Follow Up

MRA 001787037 DOB: REDA
PARROTT,DELILA W
Mt Pleasant IPO 3125-01
PHYS: MILLS MD,RICHARD E
ACCT#: 14284-00216 10/11/14

4 Weeks

Images

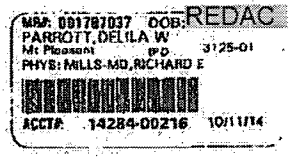
Patient Letter 2014-10-9 23:17:38



Electronically signed by RICHARD MILLS MD on 10/10/2014 at 08:32 PM EDT

Sign off status: Completed

East Cooper Internal Medicine
180 WINGO WAY SUITE 306
MT PLEASANT, SC 29464-1812
Tel: 843-884-1777
Fax: 843-606-8000



OneContent: Generated By coffje1

PHYSICIAN'S ORDER SHEET

Patient Label: REDA
MRN: 001787037 DOB:
PARROTT,DELILA W
Mt Pleasant ERD
PHYS: BIANCO-MD,JOSEPH
ACCT#: 14284-00216 10/11/14

Do Not Use Abbreviations

DO NOT USE

USE

Daily

Every Other Day

2 mg

0.2 mg

Morphine Sulfate
Magnesium Sulfate

Morphine Sulfate

Date and Time	
	Dr Livingston
1458	
	Admit to Dr Mills
	DX - altered mental status / paranoia
	Vitals q4
	Bedrest - BR with assistance
	Type PTD
	regular diet
FAXED	VO Dr Livingston / Ramsey
	AFH by 10/11/14 1700
	Noted 10/11/14 1840 Jamie Livingston, PA
10-11-14 1700	Risperdal 0.5 mg at hs daily and 0.25 mg po bid
	Lofexa Colace to soft/liquid bid
	Am Lab: Serum ammonia, TSH, Folate, RPR, Serum B12, Sed rate
	PT and OT evaluation - 10/12/14 10:45 am
FAXED	Noted 10/12/14 at 0145 AFH by 10/13/14 1512 Jamie Livingston, PA
1744	D5 1/2 NS at 80cc/hr x 1 bl, then 50/hr
	D/C Citalopram & Trazodone
	Clonidine 0.1 mg po q 4hrs prn SYS > 175 or Diast > 100
FAXED	D/C Seroquel
	Change Lorazepam to daily
	Noted 10/11/14 2020 Jamie Livingston, PA

Originated: 2/08
Revised: 3/09 8/09

Patient Identifier

PHYSICIAN'S ORDER SHEET

MRN: 001787037 DOB: REDA
PARROTT,DELILA W
Mt Pleasant IPD 3125-01
PHYS: MILLS-MD,RICHARD E
ACCT#: 14284-00216 10/11/14

Do Not Use Abbreviations	Date and Time	
DO NOT USE	10/11/14 1905	ALL ELECTRONIC AND WRITTEN ORDERS REVIEWED Julia Lunn, RN/Candy S. RN
Daily	10/12/14 @ 0110	ALL ELECTRONIC AND WRITTEN ORDERS REVIEWED Candy S. RN/Julia Lunn, RN
Every Other Day		
Units	10/12/14 1030	Lotrisone lotion - cleanse 10% only BMP, CBC in AM Tylenol tabs 2 prn FAXED
2 mg	10/12/14 @ 1920	ALL ELECTRONIC AND WRITTEN ORDERS REVIEWED Julia Lunn, RN/Candy S. RN
0.2 mg	10/13/14 0705	ALL ELECTRONIC AND WRITTEN ORDERS REVIEWED Candy S. RN/Julia Lunn, RN
Morphine Sulfate Magnesium Sulfate	10/13/14 0800	BMP, Mg, CBC in am Tylenol 500mg q6h prn pain KCl 40meq IV once FAXED @ 0804
Morphine Sulfate		Noted 10/13/14 0835 Julia Lunn, RN
Magnesium Sulfate		

Originated: 2/09
Revised: 3/09 8/09

MRN: 001787037 DOB: REDA
PARROTT,DELILA W
Mt Pleasant IPD 3126-01
PHYS: MILLS-MD,RICHARD E
ACCT#: 14284-00216 10/11/14

Venous Thromboembolism (VTE) Prevention Orders

Page

Abbreviations	
DO NOT USE	USE
QD or q.d. qd	Daily
QOD or q.o.d. qod	Every Other Day
units	Units
No trailing zero	2 mg
Leading zero	0.2 mg
MSO4	Morphine Sulfate Magnesium Sulfate
MSO4	Morphine Sulfate
MgSO4	Magnesium Sulfate

1. INDICATE RISK ASSESSMENT

☐ LOW RISK ⟶ Ambulate 150 feet 4 X Daily
■ Begin in: ☐ 8 hrs ☐ 12 hrs ☐ 24 hrs

☒ MODERATE RISK ⟶ continue through order set

☐ HIGH RISK ⟶ continue through order set

2. PHARMACOLOGIC PREVENTION †

☒ Enoxaparin (Lovenox) 40 mg SQ q 24 hrs

☐ Heparin 5000 units SQ q 12 hrs (moderate risk)

☐ Heparin 5000 units SQ q 8 hrs (moderate and high risk)

☐ Warfarin (Coumadin) _____ mg PO daily, 1st dose _____
- PT/INR now (if not done within 24 hrs)
- Hold warfarin for INR > 3.5, and clarify dosing with MD
- PT/INR q am
- No IM injections
- Notify MD if there is any evidence of bleeding

☐ CONTRAINDICATED: Pharmacologic prophylaxis because:
- ☐ Increased risk of bleeding
- ☐ On therapeutic anticoagulation
- ☐ Other:

3. MECHANICAL PREVENTION

☐ SCDs (Sequential Compression Devices)

Note to MD: Use if medications contraindicated in Moderate or High Risk and add to medications in surgical patients with multiple risk factors

☐ CONTRAINDICATED Mechanical prophylaxis

4. ORDERS only if Heparin or Enoxaparin ordered . . .

■ CBC every other day (Notify MD if platelet count < 150,000 mm³ or if count Drops > 50% from initial count (baseline).

5. CONSIDER CONSULTATION Re: VTE Prevention Recommendations

- ☐ Hx of HIT: Consult Hematologist re: VTE prevention
- ☐ Indwelling/epidural catheter: Consult Anesthesiology
- ☐ Consult Pharmacy for monitoring LMWH guidelines>thrombosis prevention (weight of < 50kg or > 120kg)

GROUP SPECIFIC RISK ASSESSMENT

LOW
- Minor surgery in mobile patients
- Medical patients who are fully mobile

MODERATE
- Major general surgery
- Open gynecologic or urologic surgery
- Medical patients "at bedrest or sick"
- Rx: LMWH / UFH bid / tid

HIGH
- Hip or knee arthroplasty
- Hip fracture surgery
- Major trauma or spinal cord injury
- Rx: LMWH / Warfarin

- Acutely ill medical patients
- Admitted with CHF
- Admitted with severe respiratory disease
- Confined to bed and have one or more additional risk factors including:
  - active cancer
  - previous VTE
  - acute neurologic disease
  - inflammatory bowel disease
- Rx: LMWH / UFH bid / tid

PATIENT SPECIFIC FACTORS THAT INCREASE RISK OF VTE
- Age > 40
- Major trauma or lower extremity injury
- Immobility, lower extremity
- Surgery
- Cancer (active or occult)
- Cancer therapy
- Venous compression
- Tumor compressing veins
- Previous VTE
- Increasing age
- Pregnancy and postpartum period
- Estrogen-containing oral contraceptives
- Hormone replacement therapy
- Selective estrogen receptor modulators
- Erythropoiesis-stimulating agents
- Acute medical illness
- Inflammatory bowel disease
- Nephrotic syndrome
- Myeloproliferative disorders
- Paroxysmal nocturnal hemoglobinuria
- Obesity
- Smoking
- Central venous catheterization
- Inherited or acquired thrombophilia

† For more specific studies pertaining to risk assessment and treatment recommendations, please refer to: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines (8th Edition) Prevention of Venous Thromboembolism, Chest – Volume 133, Issue 6 (June 2008). http://www.chestjournal.org/content/133/6_suppl/381S.full.pdf

MD Signature: _____ Date: 10/14/14 Time: 0945

RN Signature: _____ Date: 10/14/14 Time: 0722

Originated: 8/09
Revised: 4/07, 1/10, 3/10, 8/12

FAXED

OneContent: Generated By coffje1

PHYSICIAN'S ORDER SHEET

Patient Identifier
MRN: 001787037 DOB: 3/25/1951
PARROTT, DELILA W
Mt Pleasant IPD 3125-01
PHYS: MILLS-MD, RICHARD G
ACCT#: 14284-00216 10/11/14

Do Not Use Abbreviations	Date and Time	
DO NOT USE	10/14/14 0647	PLC IVF KCl 40mEq IR once Celexa 20mg po daily FAXED Lasix 40mg
USE		
Daily		
Every Other Day		NOTED C. Parrott 10-14-14 @ 0727
Units	10-14-14 @0830	ALL ELECTRONIC AND WRITTEN ORDERS REVIEWED
2 mg	10/14/14 2011	ALL ELECTRONIC AND WRITTEN ORDERS REVIEWED
0.2 mg	10.15.14 @0830	ALL ELECTRONIC AND WRITTEN ORDERS REVIEWED
Morphine Sulfate Magnesium Sulfate	10/15/14 0830	Discharge to Ashley River Plantation Lasix 40mg Rxed 10/15/14 @ 1125
Morphine Sulfate		
Magnesium Sulfate		

Originated: 8/09
Revised: 3/09,8/09



PARROTT, DELILA W
Rose St Francis Al Pleasant Hospital
FROM: 10/10/14 19:45 TO: 10/11/14 19:45
ROOM: 3125 01 ADM: 10/11/14 15:36
AGE: 86Y SEX: F DID: MILLIGAN, RICHARD E
DOB: RED ID: 1428400216 MR: 001787037
REQUESTED: 10/11/14 16:45 (CWH)
OPT OUT:

OCR - PARROTT, DELILA W
DEPT: D3C ROOM: 3125-01 MR: 001787037
Ordered by: MD LIVINGSTON-MD, R LE
Entered by: PCT PETERSON, CONTESSA W - 10/11/14 16:46
Order mode: Written - Session Id:23333392

ALLERGY

Started	Allergy Name	Type	Reaction	Severity	Comment
10/11 11:17	Doradol	Drug Allergy		Unknown	UNKN. Charted by: carvaja,Carman Jackie
06/06 21:33	all meat sprays	Miscellaneous Allergy		Unknown	UNKN. Charted by: carvaja,Carman Jackie
06/06 21:33	ACE Inhibitors	Drug Allergy		Unknown	UNKN. Charted by: carvaja,Carman Jackie
06/06 21:33	aspirin	Drug Allergy		Unknown	UNKN. Charted by: carvaja,Carman Jackie
06/06 21:33	Chocolate	Food Allergy		Unknown	UNKN. Charted by: carvaja,Carman Jackie
06/06 21:33	green vegetables	Miscellaneous Allergy		Unknown	UNKN. Charted by: carvaja,Carman Jackie
03/28 09:43	NSAIDS	Drug Allergy		Unknown	UNKN. Charted by: carvaja,Carman Jackie

DIAGNOSIS
NONE/WNL PROBLEMS

DFN

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
17	Started	REGULAR	MEALS	MEALS		10/11 16:36	Indefinite
		Diet Modifier #1: NO MODIFIER					
		Diet Modifier #2: NO MODIFIER					
		Diet Modifier #3: NO MODIFIER					
		Send Tray Now?: No					

NEODEPT

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
12	Started	DIAGNOSIS:	CONTIN	ROUTINE		06/06 21:33	Indefinite
		Category: Medical					
		Enter a diagnosis search (part of a name or an ICD9 code): Closed fracture of hip (820.8)					
13	Started	DIAGNOSIS:	CONTIN	ROUTINE		06/06 23:54	Indefinite
		Category: Medical					
		Enter a diagnosis search (part of a name or an ICD9 code): Urinary tract infectious disease (599.0)					
14	Started	DIAGNOSIS:	CONTIN	ROUTINE		10/11 16:06	Indefinite
		Category: Medical					
		Enter a diagnosis search (part of a name or an ICD9 code): Impaired cognition (780.97)					
15	Started	DIAGNOSIS:	CONTIN	ROUTINE		10/11 16:08	Indefinite
		Category: Medical					
		Enter a diagnosis search (part of a name or an ICD9 code): Paranoid schizophrenia (295.30)					
16	Started	DIAGNOSIS:	CONTIN	ROUTINE		06/06 23:53	Indefinite
		Category: Medical					
		Enter a diagnosis search (part of a name or an ICD9 code): Dehydration (276.51)					

NSG

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
18	Started	VITAL SIGNS	Q4H	ROUTINE		10/11 16:37	Indefinite
19	Started	BED REST with assistance	CONTINUOUS	ROUTINE		10/11 16:37	Indefinite
		Select option(s) from list below: to bathroom					
20	Started	COMPLETE PPD ASSESSMENT FOR FACILITY PLACEMENT PROTOCOL	ONCE	ROUTINE	1 time	10/11 16:38	10/11 16:38

LAST PAGE



PATIENT ID: 1420400216

PARROTT, DELILA W
Roper St. Francis Mt Pleasant Hospital
FROM: 10/10/14 17:55 TO: 10/11/14 17:55
ROOM: 0125-01 ADM: 10/11/14 16:26
AGE: 80Y SEX: F MD: MELLGRAD, RICHARD E
DOB: RED ID: 1420400216 MR: 001787037
ADMIT STATUS: On 10/4 17:55 (CWH)
OPT OUT:

OGR - PARROTT, DELILA W
DEPT: D3C ROOM: 3125-01 MR: 001787037
Ordered by: MD LIVINGSTON-MD, R LE
Entered by: PCT PETERSON, CONTESSA W - 10/11/14 17:55
Order mode: Written - Session Id:23333820

ALLERGY

Charted	Allergy Name	Type	Reaction	Severity	Comment
10/11 16:17	Toradol	Drug Allergy		Unknown	DNUK. Charted by: Carvajal,Carmen Jackie
06/06 21:13	all nasal sprays	Miscellaneous Allergy		Unknown	DNUK. Charted by: carvajal,carmen jackie
06/06 21:13	ACE inhibitors	Drug Allergy		Unknown	DNUK. Charted by: carvajal,carmen jackie
06/06 21:13	aspirin	Drug Allergy		Unknown	DNUK. Charted by: carvajal,carmen jackie
06/06 21:13	Chocolate	Food Allergy		Unknown	DNUK. Charted by: carvajal,carmen jackie
06/06 21:13	green vegetables	Miscellaneous Allergy		Unknown	DNUK. Charted by: carvajal,carmen jackie
05/20 09:43	Nuprin	Drug Allergy		Unknown	DNUK. Charted by: Carvajal,Carmen Jackie

DIAGNOSIS

ENT/PSYCH PROBLEMS

DCO

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
23	Started	PHISICAL THERAPY CONSULT evaluation	ONCE	ROUTINE	1 Time	10/11 17:53	10/11 17:53
24	Started	OCCUPATIONAL THERAPY CONSULT evaluation	ONCE	ROUTINE	1 Time	10/11 17:53	10/11 17:53

Please choose a consult reason.: OTHER - USE THE COMMENT FIELD

DMP

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
25	Active	RPR QUAL	IN AM	ROUTINE	1 Time	10/12 06:00	10/12 06:00
		Specimen Source: Blood NURSE COLLECT: No					
26	Active	SEDIMENTATION RATE AUTO	IN AM	ROUTINE	1 Time	10/12 06:00	10/12 06:00
		Specimen Source: Blood NURSE COLLECT: No					
27	Active	FOLATE SERUM	IN AM	ROUTINE	1 Time	10/12 06:00	10/12 06:00
		Specimen Source: Blood NURSE COLLECT: No					
28	Active	TSH-3RD GENERATION	IN AM	ROUTINE	1 Time	10/12 06:00	10/12 06:00
		Specimen Source: Blood NURSE COLLECT: No					
29	Active	AMONNIA	IN AM	ROUTINE	1 Time	10/12 06:00	10/12 06:00
		Specimen Source: Blood NURSE COLLECT: No					
30	Active	VITAMIN B12	IN AM	ROUTINE	1 Time	10/12 06:00	10/12 06:00
		Specimen Source: Blood NURSE COLLECT: No					

NRODEPT

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
31	Started	PATIENT SPECIFIC DATA	CONTINUOUS	ROUTINE		10/11 16:10	Indefinite
		Patient's height (cms or ins): 168.91 Instructions: height: 168.91cm/66.5in;					
32	Started	PATIENT SPECIFIC DATA	CONTIN	ROUTINE		10/11 16:10	Indefinite
		Patient's weight (kgs or lbs): 61.5 Instructions: weight: 61.5kg/135.6lb;					

LAST PAGE

FORM: PERM



PARROTT, DELILA W
Roper St Francis Mt Pleasant Hospital
FROM: 10/11/14 10:39 TO: 10/12/14 10:39
ROOM: 3125-01 ADM: 10/11/14 10:38
AGE: 68Y SEX: F REG: DELILA W RICHARD E
DOB: RED ID: 1420400216 MR: 001787037
PRODUCED: 10/12/14 10:39 (EST)
OPT OUT:

OCR - PARROTT, DELILA W
DEPT: D3C ROOM: 3125-01 MR: 001787037
Ordered by: MD LIVINGSTON-MD, R LE
Entered by: PCT PETERSON, CONTESSA W - 10/12/14 10:38
Order mode: Written - Session Id:29937435

ALLERGY

Charted	Allergy Name	Type	Reaction	Severity	Comment
10/11 11:17	Toradol	Drug Allergy		Unknown	SNOM. Charted by: carmaja,Carman Jackie
06/06 21:23	all nasal sprays	Miscellaneous Allergy		Unknown	SNOM. Charted by: carmaja,Carman Jackie
06/06 21:23	ACE Inhibitors	Drug Allergy		Unknown	SNOM. Charted by: carmaja,Carman Jackie
06/06 21:23	aspirin	Drug Allergy		Unknown	SNOM. Charted by: carmaja,Carman Jackie
06/06 21:23	Chocolate	Food Allergy		Unknown	SNOM. Charted by: carmaja,Carman Jackie
06/06 21:23	green vegetables	Miscellaneous Allergy		Unknown	SNOM. Charted by: carmaja,Carman Jackie
03/28 09:43	BACLOF	Drug Allergy		Unknown	SNOM. Charted by: carmaja,Carman Jackie

DIAGNOSIS

ENS/TYPED PROBLEM

DMP

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
51	Active	BASIC METABOLIC PANEL (FOR CA) Specimen Source: Blood NURSE COLLECT: No	IN AM	ROUTINE	1 Time	10/13 06:00	10/13 06:00
52	Active	CBC (COMPLETE BLOOD COUNT) Specimen Source: Blood NURSE COLLECT: No	IN AM	ROUTINE	1 Time	10/13 05:00	10/13 05:00

NSG

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
53	Started	URINE CULTURE COLONY COUNT (COLLECT SPECIMEN)	CONTINUOUS	ROUTINE		10/12 10:39	End of Unico

LAST PAGE



PATIENT ID: 1420400216

PARROTT, DELILA W
Roper St Francis Mt Pleasant Hospital
FROM: 10/11/14 09:20 TO: 10/12/14 10:20
ROOM: 3125-01 ADM: 10/11/14 15:36
AGE: 39Y SEX: F DOB: RED ID: 1420400216 MR: 001787037
RECONCILIATED: 10/11/14 09:20 (MP)
OPT OUT:

OCR - PARROTT, DELILA W
DEPT: D3C ROOM: 3125-01 MR: 001787037
Ordered by: MD LIVINGSTON-MD, R LE
Entered by: THERAPIST WALTERS, JESSICA - 10/12/14 09:20
Order mode: Written - Session Id:23337100

ALLERGY

Charted	Allergy name	Type	Reaction	Severity	Comment
10/12 11:57	Toradol	Drug Allergy		Unknown	UNUK. Charted by: carvaja,Carmen Jackie
06/06 21:33	oil nasal spray	Miscellaneous Allergy		Unknown	UNUK. Charted by: carvaja,Carmen Jackie
06/06 21:33	ACE Inhibitors	Drug Allergy		Unknown	UNUK. Charted by: carvaja,Carmen Jackie
06/06 21:33	aspirin	Drug Allergy		Unknown	UNUK. Charted by: carvaja,Carmen Jackie
06/06 21:33	Chocolate	Food Allergy		Unknown	UNUK. Charted by: carvaja,Carmen Jackie
06/06 21:33	green vegetables	Miscellaneous Allergy		Unknown	UNUK. Charted by: carvaja,Carmen Jackie
03/20 09:43	NSAIDS	Drug Allergy		Unknown	UNUK. Charted by: carvaja,Carmen Jackie

DIAGNOSIS

EMS/PSYCH PROBLEM*

NSG

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
48	Started	PHYSICAL THERAPY IN PROGRESS	CONTINUOUS	ROUTINE		10/12 09:20	Indefinite

LAST PAGE

PERM

PATIENT ID: 1420400216

PARROTT, DELILA W
Roper St Francis Mt Pleasant Hospital
FROM: 10/12/14 08:10 TO: 10/21/14 08:10
ROOM: 3125-01 ADM: 10/11/14 15:36
AGE: 68Y SEX: F MD: HALLIGAN, RICHARD E
DOB: [redacted] ID: 1420400216 MR: 001787037
HEIGHT: 157.5 cm (10/13/14 08:10) [illegible]
OPT OUT:

OCR - PARROTT, DELILA W
DEPT: D3C ROOM: 3125-01 MR: 001787037
Ordered by: MD GASS-MD, ABIGAIL E
Entered by: US RAGLAND, DELLA - 10/13/14 08:19
Order mode: Written : Session Id:23342983

ALLERGY

Charted	Allergy Name	Type	Reaction	Severity	Comment
10/1: 11:57	Toradol	Drug Allergy		Unknown	DHUM. Charted by: carnaja,Carlan Jackie
06/06 21:33	all nasal sprays	Miscellaneous Allergy		Unknown	DHUM. Charted by: carnaja,Carlan Jackie
06/06 21:33	ACE inhibitors	Drug Allergy		Unknown	DHUM. Charted by: carnaja,Carlan Jackie
06/06 21:33	aspirin	Drug Allergy		Unknown	DHUM. Charted by: carnaja,Carlan Jackie
06/06 21:33	chocolate	Food Allergy		Unknown	DHUM. Charted by: carnaja,Carlan Jackie
06/06 21:33	green vegetables	Miscellaneous Allergy		Unknown	DHUM. Charted by: carnaja,Carlan Jackie
03/28 09:47	NSAIDS	Drug Allergy		Unknown	DHUM. Charted by: carnaja,Carlan Jackie

DIAGNOSIS

DMS/PSYCH PROBLEM*

DMP

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
58	Active	BASIC METABOLIC PANEL (FOR CA) Specimen Source: Blood NURSE COLLECT: No	IN AM	ROUTINE	1 time	10/14 06:00	10/14 06:00
59	Active	CBC (COMPLETE BLOOD COUNT) Specimen Source: Blood NURSE COLLECT: No	IN AM	ROUTINE	1 time	10/14 06:00	10/14 06:00
60	Active	MAGNESIUM BLOOD Specimen Source: Blood NURSE COLLECT: No	IN AM	ROUTINE	1 time	10/14 06:00	10/14 06:00

LAST PAGE

FORM: PRINT

PATIENT ID: 142D400216

PARROTT, DELILA W
Room: St Francis At Pleasant Hospital
FROM: 10/09/14 08:56 TO: 10/14/14 08:56
ROOM: 3125-01 ADM: 10/11/14 15:35
AGE: 80Y SEX: F MD: MULLO MD, RICHARD E
DOB: RED ID: 142D400216 MR: 001787037
DCT OUT:

OCR - PARROTT, DELILA W
DEPT: 03C ROOM: 3125-01 MR: 001787037
Ordered by: MD GASS-MD, ABIGAIL E
Entered by: US RAGLAND, DELLA - 10/14/14 06:56
Order mode: Written - Session Id:23352509

ALLERGY

Started	Allergy name	Type	Reaction	Severity	Comment
10/12 11:57	Toradol	Drug Allergy		Unknown	DNUR. Charted by: carnaje,Carman Jackie
06/06 21:33	all nasal sprays	Miscellaneous Allergy		Unknown	DNUR. Charted by: carnaje,Carman Jackie
06/06 21:33	ACE inhibitors	Drug Allergy		Unknown	DNUR. Charted by: carnaje,Carman Jackie
06/06 21:33	aspirin	Drug Allergy		Unknown	DNUR. Charted by: carnaje,Carman Jackie
06/06 21:33	Chocolate	Food Allergy		Unknown	DNUR. Charted by: carnaje,Carman Jackie
06/06 21:33	green vegetables	Miscellaneous Allergy		Unknown	DNUR. Charted by: carnaje,Carman Jackie
01/29 09:43	NSAIDS	Drug Allergy		Unknown	ANUR. Charted by: carnaje,Carman Jackie

DIAGNOSIS
KMS/PSYCH PROBLEMS

DMP

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
65	Active	CBC (COMPLETE BLOOD COUNT)	QOD	TIMED		10/16 06:00	Indefinite
		Specimen Source: Blood					
		NURSE COLLECT: No					

NSG

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
64	Started	**AVTE PREVENTION INSTRUCTIONS	CONTINUOUS	ROUTINE		10/14 06:53	Indefinite
		Risk Level: MODERATE RISK (2)					
		Contraindication(s) if any: NO CONTRAINDICATION					
		Mechanical Prevention: BILATERAL SCDs					
66	Started	CALL MD:	PRN	PRN		10/14 06:55	Indefinite
		MD IF PLATELET COUNT >150,000 MM3 OR IF COUNT DROPS >50% FROM INITIAL COUNT (BAGBLIDZ)					

LAST PAGE



PARROTT, DELILA W
Hope St Fresno MJ Pleasant Hospital
FROM: 10/14/14 00:26 TO: 10/15/14 00:26
ROOM: 3125-01 ADM: 10/11/14 15:26
AGE: 62Y SEX: F MD: MILLS-MD, RICHARD C
DOB: RED ID: 1428400216 MR: 001787037
LOCATION: Fen Sn 4 00:26 (DH)
OPT OUT:

OCR - PARROTT, DELILA W
DEPT: D3C ROOM: 3125-01 MR: 001787037
Ordered by: MD GASS-MD, ABIGAIL E
Entered by: US RAGLAND, DELLA - 10/15/14 09:26
Order mode: Written - Session Id:23864860

ALLERGY

Charted	Allergy name	Type	Reaction	Severity	Comment
10/11 11:57	Toradol	Drug Allergy		Unknown	DRUG. Charted by: carnaje,Carman Jackie
06/06 21:33	all nasal sprays	Miscellaneous Allergy		Unknown	DRUG. Charted by: carnaje,Carman Jackie
06/06 21:33	ACE Inhibitors	Drug Allergy		Unknown	DRUG. Charted by: carnaje,Carman Jackie
06/06 21:33	aspirin	Drug Allergy		Unknown	DRUG. Charted by: carnaje,Carman Jackie
06/06 21:33	Chocolate	Food Allergy		Unknown	DRUG. Charted by: carnaje,Carman Jackie
06/06 21:33	green vegetables	Miscellaneous Allergy		Unknown	DRUG. Charted by: carnaje,Carman Jackie
03/28 09:43	MSAJOG	Drug Allergy		Unknown	DRUG. Charted by: carnaje,Carman Jackie

DIAGNOSIS

MHS/PYSCH PROBLEM*

NSG

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
67	Started	DISCHARGE PATIENT	CONTINUOUS	ROUTINE		10/15 09:26	Indefinite
	To: OTHER: (USE COMMENTS)						

LAST PAGE





PARROTT, DELILA W
Hopa 01 Francis Mi Pleasures Hospital
FROM: 10/11/14 11:53 TO: 10/18/14 08:00
ROOM: *3125-01* ADM: 10/11/14 05:38
AGE: 89Y SEX: F MD: HELLS MD, RICHARD E
DOB: RED ID: 1420400210 MR: 001787037
ROOM TRANSFER 10/14 07:40
OFF OUT:

OCR - PARROTT, DELILA W
DEPT: ROOM: *3125-01* MR: 001787037
Ordered by:
Entered by: -
Order mode: - Session Id:

ALLERGY

Charted	Allergy Name	Type	Reaction	Severity	Comment
10/11 11:57	Toradol	Drug Allergy		Unknown	DNUK. Charted by: carnaje,Carman Jackie
06/06 21:33	all nasal sprays	Miscellaneous Allergy		Unknown	DNUK. Charted by: carnaje,Carman Jackie
06/06 21:33	ACE inhibitors	Drug Allergy		Unknown	DNUK. Charted by: carnaje,Carman Jackie
06/06 21:33	Aspirin	Drug Allergy		Unknown	DNUK. Charted by: carnaje,Carman Jackie
06/06 21:33	Chocolate	Food Allergy		Unknown	DNUK. Charted by: carnaje,Carman Jackie
06/06 21:33	green vegetables	Miscellaneous Allergy		Unknown	DNUK. Charted by: carnaje,Carman Jackie
03/28 09:43	NSAIDS	Drug Allergy		Unknown	DNUK. Charted by: carnaje,Carman Jackie

DIAGNOSIS

ENC/VISIT PROBLEM*

No orders for stored order id:

LAST PAGE



[Patient Identifier]
MRN: 001787037 DOB: REDA
PARROTT,DELILA W
Mt Pleasant IPD 3125-01
PHYS: MILLS-MD,RICHARD E
ACCT#: 14284-00216 10/11/14

PROGRESS RECORD

Date/ Time	
10/11/14 1025	Sitting in chair. Indicates feeling a little better. "I can talk" "Someone is trying to kill me because of something I found out. Asks the "desk" not let anyone know that she is here" Tearful Sattar, VA) 98 58 17 96% RS/21 Chest- clear Heart- RRR Abd- active BS, tender Ecchymosis Staff report very unsteady on feet. PT to see New Lab: ammonia 25 Folate 12 B12 525 TSH 3.188 ESR 17 A- Psychosis, ? delusional Hematoma Depression, agitation S/P ORIF hip fx 6/2014 Unstable gait GERD P- Cont suspension D/C planning Consider geriatric psych input when K Taylor

05/06

[Patient Id]

MRN: 001787037 DOB: REDA
PARROTT,DELILA W
Mt Pleasant IPD 3125-01
PHYS: MILLS-MD,RICHARD E
ACCT#: 14284-00216 10/11/14

PROGRESS RECORD

Date/ Time	Int. Med
10/13/14 0800	S: feeling this am. Conversant. "Feels safe here." O: 98.2 70 20 94/LA 154/74 Gen - NAD CV - RRR ϕm Pulm - bibasilar crackles 4+ 102 201 142 | 102 | 8 | 103 32 | 31 | 0.6 GI - S/NT +BS Ext - ϕ edema A/P: (1) Delirium, paranoia - ϕ obvious precipitants identified. Cont Risperdal. Would benefit from geriatric psych stay. Will discuss w/ CM. PPD has already been placed. Cont Aricept. (2) HTN - cont clonidine, d.lt, lasix, propranolol. (3) GERD - cont. omeprazole. (4) OA - complaints of back pain today. Vitram 1 norco d/c'd on admission due to concern of pPt AMS. Will give tylenol prn. (5) ambulation - cont work w/ PT. Lyle Ann

08/06

[Patient Iden
MRN: 001787037 DOB: REDA
PARROTT, D W
Mt Pleasant IPD 3125-01
PHYS: MILLS-MD,RICHARD E
ACCT#: 14294-00216 10/11/14

PROGRESS RECORD

Date/ Time	
10/14/14 0650	S: No complaints this am per nursing much brighter and oriented overnight O: 98 162 18 95% RA 170/69 Gen- NAD, alert, conversant GI- SINT +BS CV- RRR ϕ m Ext- ϕ edema Pulm- CTA Bilaterally $\frac{10^2}{35}$ | 140 | 141 | 104 | 8 | 107 mg 1.8 | 35 | 30 | 0 A/P: (1) Delirium / paranoia - much improved over past 2 days. cont risperdal, aricept. will restart celexa as daughter Joan is very concerned about anxiety ~~worsening~~ emerging. will plan on d/c back to Achiev River Plantation tomorrow. (2) HTN - no changes to meds today. (3) OA - cont tylenol. Lana Ann
10/15/14 0800	S: No complaints. Ready to go home. O: 97.8 WD 16 99% RA 143/69 Gen- NAD, alert, conversant GI- SINT +BS CV- RRR ϕ m Ext- mild RLE pitting edema Pulm- bibasilar crackles A/P: (1) Delirium / paranoia- much improved on current meds restarted celexa Yday (2) HTN- BP has been up & down. Some elevation could be related to IVF she had been getting. will not elect to start new antihypertensive until fly to see what her blood pressure does P discharge. Lana Ann

DMR
MRN: 001787037 DOB:
PARROTT, DELILA W
Mt Pleasant IPD 3125-01
PHYS: MILLS-MD,RICHARD E
ACCT#: 14294-00216 10/11/14

08/06

Mt. Pleasant Hospital Imaging Services

Name: PARROTT,DELILA W
Exam Date: 10/11/14 1224
Ord. Phy.: BIANCO-MD,JOSEPH

MRN: 001787037
DOB: REDA
Pt. Phone#: (843)881-1692
Ord. Phy.#: (843)724-2010
Phy. Fax #: (843)720-8345

BIANCO-MD.JOSEPH
** 316 CALHOUN STREET
ER DEPT
CHARLESTON SC 29401

Acct Nbr : D1428400216
Pat Typo : ERD

Chk-in #	Order	Exam	
3715118	0004	35140	CT HEAD W/O CONTRAST

Ord Diag: AMS

CT HEAD WITHOUT CONTRAST

DATE: 10/11/14

INDICATION: AMS.

TECHNIQUE: Noncontrast axial images obtained from the skull base through the vertex.

COMPARISON: None.

FINDINGS: There is no acute intracranial hemorrhage, mass effect, abnormal extra-axial fluid collection, or hydrocephalus. There are diffuse chronic microangiopathic changes. There is old lacunar infarction in the right thalamus, which also be faintly seen on a maxillofacial CT from 7/12/2012. Probable additional prior lacunar infarctions are present in the left thalamus.

There is no evidence of aggressive osseous lesion.

Included paranasal sinuses are predominantly clear. The included mastoid air cells are clear.

IMPRESSION:

1. There is no evidence of acute intracranial abnormality.

2. Diffuse chronic microangiopathic changes, including several previous lacunar infarctions.

Transcriptionist- ANDREW K ANDERSON-MD

FINAL Page 1

3500 HIGHWAY 17 NORTH MT PLEASANT, SC 29466 (843) 724-2150

Nurse's Notes — *Roper St. Francis HealthCare Mount Pleasant*

Name: Delila Parrott
Age: 80 years **Sex:** Female **DOB:** REDACT
Arrival Date: 10/11/2014 **Time:** 11:08
Bed I1
Diagnosis: Altered Mental Status; Paranoid Schizophrenia

MRN: 001787037
Account#: 1428400216
Private MD:

Inbound Details:
Referred by:
Who will see patient? ED Physician
Notes:
Notify referring provider: Do not notify

Arriving by: EMS

ETA: 11:02

Presentation:
10/11 11:23 Transition of care: Patient was received from long-term care facility. jmc2
11:23 Method Of Arrival: EMS. jmc2

Triage Assessment:
11:10 Presenting complaint per patient: Couldn't get up this morning.Paramedic states that they they were called because pt complained that there were criminals were she lived and that she was being mistreated .Family weas called and that was her normal but staff said her symptoms have been increased. Patient appears awake, alert, oriented. Skin warm and dry. Moves all extremities. Respirations even and unlabored. Behavior is confused. **Pain:** Denies pain. jmc2

Historical:
Allergies:
11:14 green vegetables; NSAIDS; all nasal sprays; Chocolate; Aspirin; ACE INHIBITORS; jmc2
11:30 Toradol; jmc2
Home Meds:
11:14 Tylenol-Codeine Unknown ; Estrace Unknown ; Ultram Oral Unknown as needed, every 6 hours; Norco Oral 7.5/325 1-2 tabs as needed, every 4 hours; Inderal LA Oral Unknown every 8 hours; Colace oral 100 mg as needed; Celexa Oral Unknown daily; Nexium Oral 40 mg daily; Lasix oral 40 mg daily, as needed; Dilacor XR oral 180 mg daily; Miralax Oral 1 packet as needed; Macrobid Oral 1 capsule twice a day; Xanax Oral 0.25 mg three times a day; Seroquel Oral Unknown daily; Aricept Oral 5 mg daily, nightly; jmc2
PMHx:
11:14 phobias; jmc2
11:30 Schizophrenia; jmc2
PSHx:
11:14 Breast biopsy; Fracture repair; jmc2
11:30 ORIF 6/7/2014- lt hip; jmc2

- **Social history:** unknown, Smoking status: Unknown.
- **Advanced Directives:** Unable to obtain information,.
- **History obtained from:** daughter, EMS,.

Screening:
11:22 jmc2
Abuse screen:
unknown.
Fall Risk
None identified.
Suicide Screening:

Physician Documentation

Roper St. Francis HealthCare Mount Pleasant

Name: Delila Parrott
Age: 80 years Sex: Female DOB REDACT
Arrival Date: 10/11/2014 Time: 11:08
Bed 11
ED Physician Blanco, Joseph

MRN: 001787037
Account#: 1428400216
Private MD:

HPI: |br2

10/11 15:03 This 80 years old White Female presents to ED via EMS with complaints of Psych Problem. |br2

15:03 The patient presents to the emergency department with paranoia. Onset: The symptoms/episode began/occurred gradually. Timing is constant. Past psychiatric history: Prior diagnosis: schizophrenia. Associated signs and symptoms: The patient has no apparent associated signs or symptoms. Severity of symptoms: At their worst the symptoms were severe just prior to arrival, in the emergency department the symptoms are unchanged. The patient has experienced similar episodes in the past several times, but today's symptoms are worse. The patient has been recently seen by a physician: the patient's primary care provider, 5 day(s) ago, with similar presenting complaints. The patient is an 80-year-old female who presents to the ER from an assisted living center complaining of paranoid delusions. Patient states that someone is trying to kill her. Patient states that they've been giving her medicines and she knows when she wakes up she doesn't know what is happening. Patient has some confusion and a slightly altered per the nursing home.. |br2

15:05 Unable to obtain HPI due to altered mental status.

Historical:

- **Allergies:** green vegetables; NSAIDS; all nasal sprays; Chocolate; Aspirin; ACE INHIBITORS; Toradol;
- **Home Meds:**
  1. Tylenol-Codeine Unknown
  2. Estrace Unknown
  3. Ultram Oral Unknown as needed, every 8 hours
  4. Norco Oral 7.5/325 1-2 tabs as needed, every 4 hours
  5. Inderal LA Oral Unknown every 8 hours
  6. Colace oral 100 mg as needed
  7. Celexa Oral Unknown daily
  8. Nexium Oral 40 mg daily
  9. Lasix oral 40 mg daily, as needed
  10. Dilacor XR oral 180 mg daily
  11. Miralax Oral 1 packet as needed
  12. Macrobid Oral 1 capsule twice a day
  13. Xanax Oral 0.25 mg three times a day
  14. Seroquel Oral Unknown daily
  15. Aricept Oral 5 mg daily, nightly
- **PMHx:** phobias; Schizophrenia
- **PSHx:** Breast biopsy; Fracture repair; ORIF 6/7/2014- lt hip
- **Social history:** unknown, Smoking status: unknown.
- **Advanced Directives:** Unable to obtain information,.
- **History obtained from:** daughter, EMS,.

ROS: |br2

15:05

Constitutional: NO FEVER OR CHILLS.
Psych: Positive for anxiety, auditory hallucinations, visual hallucinations. All other systems reviewed and are negative.

Exam: |br2

15:06

Constitutional: Awake and in NAD, resting comfortably.
Head/Face: d
Eyes: Pupils equal round and reactive to light, extra-ocular motions intact. Lids and lashes normal. Conjunctiva and sclera are non-ictoric and not injected. Periorbital areas with no swelling, redness, or

Print Time: 10/12/2014 08:05:46 *** CHART COMPLETE *** Page 1 of 4

Physician Documentation Con't.

edema.
ENT: Nares patent. No nasal discharge. Tympanic membranes without erythema or bulging. Oropharynx with no redness, swelling, or masses, exudates, or evidence of obstruction, uvula midline. Mucous membranes moist.
Neck: Trachea midline and no cervical lymphadenopathy. Supple, full range of motion without nuchal rigidity, or vertebral point tenderness. No Meningismus.
Chest/axilla: Normal chest wall appearance and motion.
Cardiovascular: Regular rate and rhythm. No gallops, murmurs, or rubs appreciated. No pulse deficits.
Respiratory: Lungs have equal breath sounds bilaterally, clear to auscultation. No rales, rhonchi or wheezes noted. No increased work of breathing, no retractions or nasal flaring.
Abdomen/GI:
Back: No spinal tenderness. No costovertebral tenderness.
Skin: Warm and dry, with no significant rashes noted.
MS/ Extremity: Pulses equal and no obvious deformity noted. Neurovascular intact. Normal range of motion per patients baseline.
Neuro: Awake and alert, GCS 15, oriented to person, place and time. Cranial nerves grossly intact. Reasonable motor strength in all extremities. Sensory grossly intact. Cerebellar exam without abnormality or past pointing.
Psych: Behavior/mood is cooperative, anxious, Affect is flat, Oriented to person, only. Not oriented to place, time. Patient has no thoughts/intents to harm self or others. Judgement / Insight is impaired. Delusions/hallucinations are present and described as Patient believes someone is out to kill her..

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Pain	Staff
11:13		60	20	97.7	99%		0/10	jmc2
12:58	171 / 58	60	20		97%		0/10	jmc2
15:49	173 / 83	67	20		97%		0/10	jmc2

MDM:

11:10 Medical screening evaluation initiated. jbr2

15:08 jbr2

Data reviewed: vital signs, nurses notes, old medical records obtained and reviewed, lab test result(s), radiologic studies, CT scan.
Counseling: I had a detailed discussion with the patient and/or guardian regarding: the historical points, exam findings, and any diagnostic results supporting the discharge/admit diagnosis, lab results, radiology results, the need for further work-up and treatment in the hospital.
ED course: Patient recently had her medications changed. In the emergency department she is clearly altered and paranoid. Patient is going to be admitted..

Time	Order name	Complete Time	Staff
10/11 11:27	BMP	12:38	jbr2
10/11 11:27	CBC	12:38	jbr2
10/11 11:52	URINALYSIS POC MP ED	12:38	EDMS
10/11 12:05	Potassium Blood Level	12:38	bj
10/11 11:59	Head CT w/o contrast	12:38	jbr2
10/11 11:27	INT	11:40	jbr2
10/11 11:27	POC - Urine dip (collect)	11:55	jbr2

Name: Delila Parrott **MRN:** 001787037
Account#: 1428400216
Page 2 of 4

Print Time: 10/12/2014 08:05:40

OneContent: Generated By coffje1

DATE OF ADMISSION: 10/11/2014

DATE OF DISCHARGE: 10/15/2014

PRIMARY CARE PHYSICIAN: Dr. Richard Hills

PRINCIPAL DISCHARGE DIAGNOSES: Delirium and paranoia.

SECONDARY DISCHARGE DIAGNOSES:
1. Hypertension.
2. Osteoarthritis.
3. Dementia.
4. GERD.
5. Deconditioning.

DIAGNOSTIC STUDIES:
1. CT head without contrast on 10/11/2014 showed no evidence of acute intracranial abnormality, diffuse chronic microangiopathic changes including several previous lacunar infarction.

HOSPITAL COURSE: Ms. Parrott is a patient with a known psychiatric history and known cognitive decline who presented after a precipitous decline over the preceding two weeks with worsening cognitive function, as well as worsening in her physical abilities to do activities of daily living.
1. Delirium and paranoia. An infectious workup was pursued, which was negative as the precipitant. Looking at her current medications her Citalopram and Tramadol were discontinued due to concern for possible serotonin syndrome. Her hydrocodone was also discontinued as this could have contributed to her decline. Laboratory testing including a serum ammonia, B-12, folate and thyroid function were all normal. The patient was started on Risperdal 0.5 mg at bedtime and 0.25 twice a day with meals with much improvement in her mental status. At the time of discharge the patient's paranoia seemed to have improve significantly. She still gets confused at times and still does require two people to assist her with movement, but overall is much improved.
2. Hypertension. Her blood pressure was elevated during her stay; however, no adjustments in her antihypertensives was made as this could have been contributed to IV fluids that she received early during her hospitalization. She was continued on her home antihypertensives. She has a follow up

appointment scheduled with Dr. Mills and if her blood pressure remains elevated at that time an adjustment could be made.
3. Dementia. She was continued on her home Donepezil. Her daughter reports that she has significant anxiety associated with her dementia. She was continued on her home Alprazolam. Her Citalopram was restarted on 10/14/2014 due to her daughter's significant concern about her underlying anxiety. She seems to be tolerating that medication well on the day of discharge.
4. GERD. The patient was continued on a PPI with no complaints of abdominal pain.
5. Deconditioning. Physical therapy worked with the patient during her hospital stay and this will be continued as an outpatient at Ashley River Plantation.

DISCHARGE MEDICATIONS: Please see med rec.

CHANGES TO HOME MEDICATIONS: Discontinuation of Macrobid, Norco, Tramadol and Seroquel. Addition of Risperdal.

DISPOSITION: The patient will be discharged back to Ashley River Plantation to continue physical therapy and occupational therapy.

DIET: Regular.

ACTIVITY: As tolerated and as directed by physical therapy.

CODE STATUS: Full code.

FOLLOW UP: Appointment with Dr. Mills on 10/29/2014 at 11:45 a.m.

Abby Z Gass, MD
TR: pn DD: 10/15/2014 08:34 TD: 10/15/2014 09:09 Job#: 530260
Doc#: 435064

Ancillary Chartin	10/12				
PT Eval Cont	12:07	12:43	15:47	19:53	23:27
Funct mobility 2		chair to bed 2 persons minimal assist JW			
Gait/Amb 1		roll walker incr dist on level surface of one min JW			
Distance 1		25ft JW			
Time frame		6 sessions JW			
LTG 1 LTG 2		JW JW			
Plan		func mobility pt/fam train/edu safety JW			
Bed Mobility		4 = min ass JW			
Trans: bed to		3=mod ass JW			
Gait:walking lev		0=cannot assess JW			
Walking distance		0 = cannot asses JW			
Funct outcome		7 JW			
G-code modifier		C L JW			
Current G-Code		G8978 JW			
Goal G-Code		G8979 JW			
Goal status		cj JW			
Rehab Potential		Fair JW			

10/12/14 12:43 Treatment reqstd(JW): PT evaluation
10/12/14 12:43 Treatment Dx(JW): weakness
10/12/14 12:43 Special equipmt(JW): IV
10/12/14 12:43 Prior lvl functn(JW): lives in assisted-living memory care unit. usually uses a walker
10/12/14 12:43 Precautions(JW): Fall risk/HOH
10/12/14 12:43 Prev Med Hx(JW): paranoid shizophrenia, hip fracture (L), aortic insufficiency, HTN, sleep apnea, GERD,OA, anxiety, phobias

WALTERS, JESSICA(JW)1THERAPIST

CONTINUED

Ancillary Charting	10/12				
PT Eval Cont	12:07	12:43	15:47	19:53	21:32
Distance 1		of one min JW 250 JW			
Time frame		6 sessions JW			
LTG 1		JW &			
LTG 2		JW &			
Plan		func mobility pt/fam train/edu safety JW			
Bed Mobility		4 = min ass JW			
Trans: bed to		3=mod ass JW			
Gait:walking lev		0=cannot assess JW			
Walking distance		0 = cannot asses JW			
Funct outcome		7 JW			
G-code modifier		C L JW			
Current G-Code		G8978 JW			
Goal G-Code		G8979 JW			
Goal status		cj JW			
Rehab Potential		Fair JW			

10/12/14 12:42 Treatment reqstd(JW): PT evaluation
10/12/14 12:43 Treatment Dx(JW): weakness
10/12/14 12:43 Special equipmt(JW): IV
10/12/14 12:43 Prior lvl functn(JW): lives in assisted-living memory care unit. usually uses a walker
10/12/14 12:43 Precautions(JW): Fall risk/HOH
10/12/14 12:43 Prev Med Hx(JW): paranoid shizophrenia, hip fracture (L), aortic insufficiency. HTN, sleep apnea, GERD,OA, anxiety, phobias
10/12/14 12:43 Subjective(JW): "I don't want anyone to know I am here"
10/12/14 12:43 PT eval pain(JW): tearful
10/12/14 12:43 Func bed to char(JW): 1-2 step cues
10/12/14 12:43 Other(JW): PT evaluation
WALTERS, JESSICA(JW)THERAPIST

CONTINUED

OneContent: Generated By coffje1

PARROTT, DELILA W
Roper St. Francis Mt Pleasant Hospital
Case Mgmt (cm_hsd_hpf)

ROOM: *3125-01* ADM: 10/11/14 15:30
AGE: 69Y SEX: F RPT MILLS-MIT, RICHARD F
DOB: RED ID: 1428400216 MR: 001787037
RECEIVED: 10/14/14 07:49
OFT OUT

Page: 1

Case Mgmt Chartin	10/13
Cm Initl Assess	15:22
Primary Contact	joan acosta, dtr MV
Phone Number	803-331-8342 MV
Info From	pt, chart, dtr MV
Primary Care Phy	dr. mills MV
Hosp In last 30d	no MV
Referral Reason	case coord. DC needs MV
Finan Resources	insurance medicare MV
Living Situation	assisted living MV R
Number of Steps	0 MV
SNF	Sandppr Rhb Nsg MV
Support System	family MV
Coping	
Coping/Patient	adequate MV
Coping/Family	adequate MV
Verbal Skills	adequate MV
Caregiver	other MV R
Caregiver Info	manages well MV
Pre Hosp LOC	alert oriented MV
Current LOC	alert confsd/disornted MV
Pre Hosp Cmplian	adequate MV
Current Complian	adequate MV

VANSICKLE-BONNEY, MARY(MV)Case Mgr

OneContent: Generated By coffje1

Case Mgmt Charting	10/15
CM Goals/Notes Cont.	11:58
	discussed w/Pt DCP Disc w crgvr IM letter given MD agrd with DCP MV
Progress Note 1 Progress Note 2 Progress Note 3	MV & MV & MV &
Prim Care Givers	MV &
Transportation	ambulance MV

10/15/14 11:58 Plan A(MV): return to Ashley River Plantation ALF

10/15/14 11:58 Progress Note 1(MV): CM Note: Pt is stable for dc back to Ashley River Plantation today. I spoke with Kathy Black from the ALF and she requested Dr. Gass complete a ALF form as per their requirements. This was completed and faxed to the ALF along with a dc summary, med rec.

10/15/14 11:58 Progress Note 2(MV): and prescription for Reseperidol. The ALF also requested a prescription signed by Dr. Gass, stating the specific meds that need to be discontinued. Nursing called the office of Dr. Gass and they agreed to fax this prescription to the ALF today. Pt is

10/15/14 11:58 Progress Note 3(MV): being transported back to Ashley River Plantation via Lifelink. I spoke with pts dtr, Joan Acosta, via telephone and she is in agreement with pts dc plan.

10/15/14 11:58 Prim Care Givers(MV): ALF staff

VANSICKLE-BONNEY, MARY(MV)Case Mgr

OneContent: Generated By coffje1

DICTATED BY: Nicole Perrin Natchin, PA-C.

PRIMARY CARE PHYSICIAN: Dr. Richard Ellis.

CONSULTING PHYSICIANS:
1. Dr. Patrick Murray, orthopedist.
2. Dr. Paul Yantis, gastroenterologist.

DISCHARGE DIAGNOSES:
1. Left hip fracture status post open reduction and internal fixation.
2. Anemia of acute blood loss superimposed on chronic anemia.
3. Hypertension.
4. Acute delirium, improving.
5. Chronic diarrhea.
6. History of atrial fibrillation.
7. Anxiety.

HISTORY OF PRESENT ILLNESS: Ms. Parrott is an 80-year-old Caucasian female who sustained a fall at her residence and was discovered 2 days after the incident by a friend. The patient complained of left hip pain and was unable to ambulate. In the Emergency Room, x-ray revealed a left femoral intertrochanteric and subtrochanteric fracture. Her urinalysis also revealed that she was dehydrated. She was also noted to have some skin breakdown. The patient was then admitted for further workup and management of her acute concerns.

RADIOLOGICAL STUDIES:
1. Chest x-ray: No acute process.
2. X-ray of the hip: Acute comminuted fracture in the left femoral intertrochanteric/subtrochanteric region.

HOSPITAL COURSE: For the patient's hip fracture, she was seen in consultation by Dr. Patrick Murray who brought her to the operating room on 06/07/2014 performing an open reduction and internal fixation of the left subtrochanteric femur fracture. The patient tolerated the operation well; however, she did have postoperative complications of acute delirium. The patient was also noted to have anemia of acute blood loss, and therefore, she required a transfusion of 2 units of packed red blood cells.

The patient was also noted to have a history of chronic stools with loose bowels during admission, and therefore, she was seen in consultation by the GI team who felt that her chronic diarrhea could be due to microscopic/collagenous colitis. Other etiologies include inflammatory bowel disease or infection. Therefore, they recommended checking stool studies. Her C. diff toxin was negative. Prior to discharge. Stool studies are still pending. She was treated empirically with p.r.n. Imodium and Lomotil and plans to follow up with Dr. Yantis and/or Joyner as an outpatient as she will likely need a repeat colonoscopy with biopsies.

The patient was able to work with physical therapy and occupational therapy, and it was felt that she would benefit from subacute rehabilitation at a skilled nursing part of Sandpiper. She will be transferred there today in stable condition.

DISCHARGE LABORATORY DATA: BNP 169. Magnesium 2.5. CPK 673. Negative C. diff toxin. Urine culture 1000 colony counts of E. coli. Stool Hemoccult negative. White count of 8.3, hemeglobin of 9, hematocrit of 27.3, and platelets of 156. Sodium of 145, potassium of 39, chloride of 112, bicarbonate of 26, BUN of 10, creatinine 0.8, and a glucose of 105. LFTs normal except for a slight elevation of her SGOT of 30.

DISCHARGE MEDICATIONS: Please see attached medication list.

DISCHARGE INSTRUCTIONS: The patient can increase activity as tolerated. She has been instructed to use toe-touch weightbearing with the assistance of physical therapy and occupational therapy. She should resume a low sodium diet. Her current dressing will be able to stay on for 1 week. Staple removal will be at her followup appointment with Dr. Murray in approximately 2 weeks. Followup appointment has been made to see Dr. Richard Hills on Wednesday 07/02/2014 at 3:00 p.m. Any questions or concerns regarding the patient's hospital course can be addressed to Dr. Omraju at 884-1777.

Nicole Forrin Ketchin, PA-C
TR: en DD: 06/10/2014 13:32 TD: 06/10/2014 14:26 Job#: 284102
DOC#: 386680

Authenticated by OMRAJU-MD,SWAPNA On 06/11/2014 05:21:51 PM

Acct# 1415701389

PRID:30486302 RPT#:0483361 Response District:S

Service: Charleston County EMS
Base: Medic 11
Unit: M11
Shift: 8B-night
Tail/Reg: 4663
END: Yes, With Pre-Arrival Instructions 17003
Type of Svc: Scene Unscheduled
Response Code: Delta
Mode to Ref: Lights / Sirens
Moved Via: Stretcher
Position: Supine
Outcome: Transported

Date: June 6, 2014
Team: ALS
Crew 1: Secondary Caregiver
*Broccolo, Frank
EMT-P (SC0142I7)
Crew 2: Primary Caregiver
McCarney, Anthony
EMT-P (SC0218961
* designates an ALS Provider
Mode to Rec: No Lights/Sirens
Moved From: Stretcher
Pt. Condition: Improved

Ref Other Type: Assisted Living
Location: SANDPIPER VILLAGE CARE
1224 Village Creek Ln
S6
MOUNT PLEASANT, SC 29464
Requestor: Neighbor
Ref. GPS: 32.83880,-79.8609

Receiving: Hospital
Mount Pleasant Hospital
Emergency Department
3500 Highway 17 North
Mount Pleasant, SC 29466-9123

843-606-7000
Dest. GPS: 32.877622,-79.767207
Rec. RN: Tammy

Last Name: Parrot First: Delila
Address: 1224 village creek ln
S6
City: Mount Pleasant ST:SC Zip:29464
County: Charleston
Citizenship: United States
Phone: (843) 216-1816
DOB: REDACT SSN: REDACTE
Age: 80y Sex: F Weight: 170 lb
Height:
Subscriber: No
Race: White, non-Hispanic
DNR Orders: None
Billing Information:

Company	Group	ID
medicare		REDAC A & B
State Farm		HB9137026040

Odometer		Times	
Start:	0.0	Received:	19:54
At Ref:	0.0	Dispatch:	19:55
At Rec:	7.9	EnRoute:	19:57
End:	7.9	First Resp:	20:06
Ld Miles:	7.9	At Ref:	20:04
Tot Miles:	7.9	Leave Ref:	20:46
		At Rec:	21:10
		Available:	21:23
		Med control:	20:20

Notice of Privacy Practices Given: None
Consent Signed: No
PCS / Medical Necessity Signed: No
Primary Method of Payment: Medicare

Scene Information

Description: PT found laying R recovery position with incontinence and feces covering PT. PT is unable to extend her L leg.
Patient Belongings: Paperwork, 2 pillows left in ER with PT.
Other Agencies: Fire Fire Number: MPFD

Chief Complaint (Category: Fall Victim)

L Hip Pain 8-10

Duration: 1 Days
Anatomic Location: Extremity - Lower

Secondary Complaint

Fall

Duration: 1 Days

Chief Complaint (Category: Fall Victim)

History of Present Illness

D/A EMS Found 80yo F AAOx3 laying on the floor between her bed and a dresser. PT shows no signs of distress and is able protect her airway with adequate respirations. CC L Hip pain secondary to a fall. PT states she was attempting to hanging her curtains and fell. Unknown if PT was standing on the lazy boy chair under the window where she was hanging curtains. PT states she is unable to straighten her L leg due to Pain in her Hip an thigh. PT states she has been on the floor since Tuesday but neighbors state they saw her walking around yesterday. PT denies any CP, SOB, weakness, dizziness, neck or back pain. No pain upon palpation of neck and back. Pain upon palpation of hip and leg with no creptius. EMS is unable to move leg without pt screaming in pain. Vitals above. 20g IV established in L forearm by fire personnel, 4 lead EKG indicates NSR with no ectopy,. PT has Allergy to ASA, and Ace inhibitors. RMPH contacted for med order. Per Dr John Walters, 50mcg Fentanyl approved via IV push with second dose of 50mcg Fentanyl if needed. 12 lead EKG indicates NSR with no ST elevation or Ectopy. PT administered 50mcg Fentanyl with TKO flush NS. Pain improves to 5-10. PT picked up with Scoop stretcher. Voids padded with 2 pillows and blankets. PT carried to Stretcher, Secured with 3 straps. PT placed on Oxygen at 2 LPM via NC. PT transported in position of comfort to RMPH. En route second dose of 50mcg Fentanyl administered IV push with TKO flush NS. Pain drops to 2-10. En route hospital updated with no additional questions or orders. U/A PT moved to ER bed 6 where turnover conducted and PT care transferred to ER staff. PT is unable to sign PCR, witnessed by nurse. Dr. Walters Signs drug order. ASM

Medical History	Current Medications	Allergies
Hypertension Unknown Cardiac	Acetaminophen Cefuroxime Citalopram Cyanocobalamin Diltiazem Furosemide Nexium Propranolol	ACE Inhibitors All Insids ase Chocolate nasal sprays

Neurological Exam

Level of Consciousness: Alert
Loss of Consciousness: Unknown
Chemically Paralyzed: No
Stroke Scale: Cincinnati Negative
Neurological Present: Normal
Mental Present: Normal

Glasgow Coma Scale			
	E	V	M	Tot
Int:	4	5	6	= 15

Revised Trauma Score: 12.00

	Motor	Sensory
LA:	Normal	Normal
RA:	Normal	Normal
LL:	Flaccid	Normal
RL:	Flaccid	Normal

Airway
Status: Patent

Respiratory
Effort: Normal

Cardiovascular

Pulses	Left	Right
Carotid:		
Radial:	Normal	
Femoral:		

Injury Details

Reason for Encounter: Injury/Trauma

Physician Documentation

Roper St. Francis HealthCare Mount Pleasant

Name: Delila Parrott
Age: 80 years Sex: Female DOB: REDAC
Arrival Date: 06/06/2014 Time: 21:14
Bed 2
ED Physician Walters, John

MRN: 001787037
Account#: 1415701369
Private MD:

HPI: jwf1

06/06
23:07 This 80 years old White Female presents to ED via EMS with complaints of Hip Pain. jwf1

23:07 The patient or guardian reports an injury, that occurred at home, sustained from a fall, the left lower extremity is shortened, left leg is externally rotated. The patient is not able to ambulate. Patient is not able to bear weight. The patient was discovered 2 daysafter the incident. The complaints affect the left hip. Onset: The symptoms/episode began/occurred 2 day(s) ago. Associated signs and symptoms: Pertinent positives: Patient was on the floor for 2 days before being discovered. The patient laid on the floor without any food or water. Patient complains of pain in the hip without numbness or tingling or weakness or sensory loss. No chest pain or shortness of breath. She is extremely thirsty. Severity of symptoms: At their worst the symptoms were severe, incapacitating.

Historical:
- **Allergies:** green vegetables; Chocolate; Aspirin; ACE INHIBITORS; all nasal sprays; NSAIDS;
- **Home Meds:**
  1. Diltiazem Oral
  2. Lomotil oral
  3. Propranolol Oral
  4. citalopram oral
  5. Tylenol #3 Oral
  6. Nexium Oral
  7. Furosemide Oral
  8. cyanocobalamin (vitamin B-12) oral
  9. Celtin Oral
- **PMHx:** Atrial Fib; Hypertension; Anxiety
- **Social history::** Smoking status: Patient/guardian denies using tobacco, but has a distant history of tobacco abuse,.
- **Advanced Directives::** Patient has healthcare power of attorney, documentation unavailable. Patient/legal representative advised of need for copy to be obtained and placed on chart for Advance Directive to be honored. The patient has a living will, documentation unavailable. Patient/legal representative advised of need for copy to be obtained and placed on chart or Advance Directive to be honored.

ROS: jwf1

23:09
Constitutional: Negative for fever, malaise, vomiting or weight loss
Eyes: Negative for injury, pain, redness, and discharge.
ENT: no rhinorea, sore throat, earache or toothache
Neck: Negative for injury, pain, swelling or stiffness
Cardiovascular: Negative for chest pain, palpitations, and edema.
Respiratory: Negative for shortness of breath, cough, wheezing, and pleuritic chest pain.
Abdomen/GI: Negative for abdominal pain, nausea, vomiting, diarrhea, and constipation.
Back: Negative for injury and pain.
Skin: Positive for breakdown - seen by nurse.

Exam: jwf1

23:09

Eyes: Pupils equal round and reactive to light, extra-ocular motions intact. Lids and lashes normal. Conjunctiva and sclera are non-icteric and not injected. Cornea within normal limits. Periorbital areas with no swelling, redness, or edema.Fundi are normal. discs are sharp.
Neck: Trachea midline, no thyromegaly or masses palpated, and no cervical lymphadenopathy. Supple, full range of motion without nuchal rigidity, or vertebral point tenderness. No Meningismus.
Chest/axilla: Normal chest wall appearance and motion. Normandar with no deformity. No lesions are appreciated.
Cardiovascular: Regular rate and rhythm with a normal S1 and S2. No gallops, murmurs, or rubs. Normal PMI, no JVD. Pulses equal and strong bilaterally.
Respiratory: Lungs have equal breath sounds bilaterally, clear to auscultation and percussion. No rales, rhonchi or wheezes noted. No increased work of breathing, no retractions or nasal flaring.

*** CHART COMPLETE ***

Print Time: 06/7/2014 07:40:32

Physician Documentation Con't.

Abdomen/GI: Soft, non-tender, with normal bowel sounds. No distension or tympany. No guarding or rebound. No evidence of tenderness throughout.
Back: No spinal tenderness. No costovertebral tenderness. Full range of motion.
Neuro: Awake and alert, oriented to person, place, time and situation. Neuro grossly intact. Normal gait.
Psych: Affect appropriate, memory intact.
Constitutional: The patient appears alert, awake, frail, uncomfortable.
ENT: Mouth: Lips: dry, cracked, Oral mucosa: dry.
Musculoskeletal/extremity: Circulation is intact in all extremities. Sensation intact. Joints: the left hip displays deformity, pain at rest, painful range of motion, tenderness.
Skin: breakdown from pressure on right buttock hip.

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Height	Pain	Staff
21:18	182 / 77	86	17	97.7	93%	68.04 kg	5 ft. 7 in. (170 cm)	9/10	tm7
22:00	145 / 67 (auto)								ekk
22:00		77 MON	16		95%				ekk
22:15	149 / 67 (auto)								ekk
22:15		79 MON	17		95%				ekk
22:30	156 / 66 (auto)								ekk
22:31		83 MON	16		95%				ekk
23:27		83 MON	13		95%				ekk
23:30	141 / 64 (auto)								ekk
23:38		83 MON	18		95%			7/10	ekk
23:45	149 / 69 (auto)								ekk
23:45		82 MON	14		94%				ekk

23:45 Body Mass Index 23.5 (68.04 kg, 170 cm) ekk
23:38 Normal Sinus Rhythm ekk

Glasgow Coma Score:

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
21:18	spontaneous(4)	oriented(5)	obeys commands(6)		15	tm7

MDM:
21:11 Medical screening evaluation initiated. jwf1
23:11 jwf1
Data reviewed: vital signs, nurses notes, old medical records obtained and reviewed, lab test result(s), radiologic studies, X-ray.
Physician consultation (by phone and in detail): Richard Mills MD and will see patient in hospital.

Time	Order name	Complete Time	Staff
06/06 22:18	CBC	22:58	jwf1
06/06 22:18	BMP	22:58	jwf1
06/06	Mg Level	23:07	jwf1

Physician Documentation Con't.

22:18			
06/06 22:18	CPK Total	23:07	jwf1
06/06 22:18	Troponin I Lab	23:07	jwf1
06/06 23:15	Add On Test-Spec in Lab		ekk
06/06 23:15	UA Lab		ekk
06/06 23:15	Urine Culture - Cath		ekk
06/06 23:33	CPK TOTAL		EDMS
06/06 21:31	HIP XR UNILATERAL (COM) 2 VIEW MIN		jwf1
06/06 22:18	PCXR		jwf1
06/06 21:43	Foley	21:44	ekk

Dispensed Medications:

Time	Drug & Dose	Route	Rate	Duration	Site	Delivery	Staff
22:41	NS 0.9% * 1000 ml	IV	bolus		existing IV site		ekk
23:00	Dilaudid [2 mg/mL] 0.5 mg	IVP			existing IV site		ekk
23:43	Follow up: Response: Pain is unchanged, physician notified						ekk
23:41	NS 0.9% * 1000 ml	IV	125 ml/hr		existing IV site		ekk
23:41	Follow up: IV Status: Completed infusion; IV intake: 1000ml						ekk
06/07 00:16	Follow up: IV Status: Infusion continued upon admission/transfer						ekk
06/06 23:41	Rocephin (ADM) 1 grams	IVPB			existing IV site		ekk
06/07 00:16	Follow up: IV Status: Infusion continued upon admission/transfer						ekk
06/06 23:43	Dilaudid [2 mg/mL] 0.5 mg	IVP			existing IV site		ekk
23:51	Follow up: Response: Pain is decreased						ekk

1 - Note: PER DR. MILLS ORDERS.

Disposition:
06/06/14 23:12 Admit ordered for Mills, Richard. Preliminary diagnosis are Hip Fracture, Dehydration, Decubitus Ulcer, Pressure, (Buttock), Decubitus Ulcer, Pressure, (Hip), Bladder Infection (UTI).

- Condition is Serious.
- Problem is new.
- Symptoms have improved.

Signatures:

Dispatcher MedHost	EDMS	MACBRIDE, TAMARA, RN	RN tm7
Walters, John, MD	MD jwf1	Kell, Erin, RN	RN ekk

Name: Delila Parrott

MRN: 001787037
Account#: 1415701389
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Print Time: 6/6/2014 07:40:32

Physician Documentation Con't.

Order	Status	Time	By	For
HIP XR UNILATERAL (COM) 2 VIEW MIN	Ordered	06/06/14 21:31	jwl1	jwl1
	Returned	06/06/14 23:18	Dispatcher MedHost	
Notes: Bed Name: 2	Order Method: Electronic			
Specify View other than AP, Frogleg: NONE				
Transportation: STRETCHER				
Ask Left/Right?: Left				
Bed Reason - Ortho: *Pain with Trauma/Injury				
Special Instructions:				

Order	Status	Time	By	For
Foley	Ordered	06/06/14 21:43	ekk	jwl1
	Completed	06/06/14 21:44	Erin Kell	
Notes:	Order Method: Verbal - Read back			
	Sign off: Walters, John, MD 06/06/14 23:12			
Foley Indications: Required prolonged immobilization				

Order	Status	Time	By	For
PCXR	Ordered	06/06/14 22:18	jwl1	jwl1
	In Process Unspecified	06/06/14 22:19	Dispatcher MedHost	
Notes: Bed Name: 2	Order Method: Electronic			
PORTABLE: PORTABLE				
Bed Reason- CXR: Weakness				
Special Instructions:				

Order	Status	Time	By	For
CBC	Ordered	06/06/14 22:18	jwl1	jwl1
	Reviewed	06/06/14 22:56	John Walters	
Notes:	Order Method: Electronic			
Specimen Source Blood: BLOOD				
Nurse collected- YES: YES				

Order	Status	Time	By	For
BMP	Ordered	06/06/14 22:18	jwl1	jwl1
	Reviewed	06/06/14 22:56	John Walters	
Notes:	Order Method: Electronic			
Specimen Source Blood: BLOOD				
Nurse collected- YES: YES				

Order	Status	Time	By	For
Mg Level	Ordered	06/06/14 22:18	jwl1	jwl1
	Reviewed	06/06/14 23:07	John Walters	
Notes:	Order Method: Electronic			
Specimen Source Blood: BLOOD				
Nurse collected- YES: YES				

Name: Delila Parrott

MRN: 001787037
Account#: 1415701389
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Print Time: 6/8/2014 07:40:32

Physician Documentation Con't.

Order	Status	Time	By	For
CPK Total	Ordered	06/06/14 22:18	jwf1	jwf1
	Reviewed	06/06/14 23:07	John Walters	
Notes:	Order Method: Electronic			
Specimen Source Blood: BLOOD				
Nurse collected-YES: YES				

Order	Status	Time	By	For
Troponin I Lab	Ordered	06/06/14 22:18	jwf1	jwf1
	Reviewed	06/06/14 23:07	John Walters	
Notes:	Order Method: Electronic			
Specimen Source Blood: BLOOD				
Nurse collected-YES: YES				

Order	Status	Time	By	For
NS 0.9% * 1000 ml IV at bolus once; []	Ordered	06/06/14 22:18	jwf1	jwf1
	Administered	06/06/14 22:41	ekk	
	Administered	06/06/14 23:41	ekk	
Notes:	Order Method: Electronic			
06/06/14 22:41 Administration: NS 0.9% * 1000 ml IV in existing IV site				ekk
06/06/14 23:41 Administration: NS 0.9% * 1000 ml IV at 125 ml/hr in existing IV site				ekk
06/06/14 23:41 Follow Up: IV Status: Completed infusion; IV Intake: 1000ml				ekk
06/07/14 00:16 Follow Up: IV Status: Infusion continued upon admission/transfer				ekk
No documented allergy; have you verified allergies?: green vegetables, Chocolate, Aspirin, ACE INHIBITORS, a! na				

Order	Status	Time	By	For
Dilaudid [2 mg/mL] 0.5 mg IVP once; []	Ordered	06/06/14 23:00	ekk	jwf1
	Administered	06/06/14 23:00	ekk	
Notes:	Order Method: Verbal - Read back			
	Sign off: Walters, John, MD 06/06/14 23:12			
06/06/14 23:00 Administration: Dilaudid [2 mg/mL] 0.5 mg IVP in existing IV site				ekk
06/06/14 23:43 Follow Up: Response: Pain is unchanged, physician notified				ekk
No documented allergy; have you verified allergies?: green vegetables, Chocolate, Aspirin, ACE INHIBITORS, a! na				

Order	Status	Time	By	For
Rocephin (ADM) 1 grams IVPB once; []	Ordered	06/06/14 23:15	ekk	rmo
	Administered	06/06/14 23:41	ekk	
Notes:	Order Method: Telephone - Read back			
	Sign off:			
06/06/14 23:41 Administration: Rocephin (ADM) 1 grams IVPB in existing IV site				ekk
06/07/14 00:10 Follow Up: IV Status: Infusion continued upon admission/transfer				ekk
No documented allergy; have you verified allergies?: green vegetables, Chocolate, Aspirin, ACE INHIBITORS, a! na				

Order	Status	Time	By	For
Add On Test-Spec In Lab	Ordered	06/06/14 23:15	ekk	jwf1
	Sent	06/06/14 23:50	Erin Keil	

Name: Delila Parrott
MRN: 001787037
Account#: 1415701389
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Print Time: 6/9/2014 07:40:32

Physician Documentation Con't.

Notes:	Order Method: Verbal - Read back			
	Sign off:			
Add On Test 05:				
Specimen Source Blood: BLOOD				
Nurse Collect- NO: NO				
Add On Test 01: CPK				
Add On Test 02:				
Add On Test 03:				
Add On Test 04:				

Order	Status	Time	By	For
UA Lab	Ordered	06/06/14 23:15	ekk	jwf1
	Returned	06/06/14 23:47	Dispatcher MedHost	
Notes:	Order Method: Verbal - Read back			
	Sign off:			
Specimen Source Non-Blood: URINE				
Method of Urine Collection: Clean Catch				
Nurse collected- YES: YES				

Order	Status	Time	By	For
Urine Culture - Cath	Ordered	06/06/14 23:15	ekk	jwf1
	Returned	06/06/14 07:40	Dispatcher MedHost	
Notes:	Order Method: Verbal - Read back			
	Sign off:			
Specimen Source Non-Blood: URINE				
*Urine Collection-Female: Cath				
Nurse collected- YES: YES				

Order	Status	Time	By	For
CPK TOTAL	Ordered	06/06/14 23:33	EDMS	
	Returned	06/06/14 23:33	Dispatcher MedHost	
Notes:	Order Method:			
	Sign off:			

Order	Status	Time	By	For
Dilaudid [2 mg/mL] 0.5 mg IVP once; ‖	Ordered	06/06/14 23:43	ekk	jwf1
	Administered	06/06/14 23:43	ekk	
Notes:	Order Method: Verbal - Read back			
	Sign off:			
06/06/14 23:43 Administration: Dilaudid [2 mg/mL] 0.5 mg IVP in existing IV site				ekk
06/06/14 23:51 Follow Up: Response: Pain is decreased				ekk
No documented allergy; have you verified allergies?: green vegetables, Chocolate, Aspirin, ACE INHIBITORS, a'l na				

Order Signatures:

Walters, John, MD	MD	jwf1	Kell, Erin, RN	RN	ekk
Dispatcher MedHost		EDMS	Mills, Richard, MD	MD	rme

Name: Delila Parrott

MRN: 001787037
Account#: 1415701389
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Print Time: 6/6/2014 07:40:32

PARROTT, DELILA W. Opt Out: No
MJ Pleasant
Site Management (shwmgmt_hpi)
Rm-Bed: 3109 - 01 Admit Dt: 06/06/2014 23:20
Age: 65 yr Gender: F MD: Mills-Mc, Richard B., MD
DOB REDA Acct: 1415701389
MRN: 001787037
Requested: 06/11/2014 10:36
Page 1 of 8

Active Sites

abrasion (1) right hip

Start Date = 06/06/2014; Time = 23:00 [Charted by: Carter, Sara P., RN at 06/07/2014 04:22]; Timing = prior to admit [Charted by: Carter, Sara P., RN at 06/07/2014 04:22]; Type = abrasion [Charted by: Carter, Sara P., RN at 06/07/2014 04:22]; Location = right hip [Charted by: Carter, Sara P., RN at 06/07/2014 04:22]

blister (1) right lower hip

Start Date = 06/07/2014; Time = 21:30 [Charted by: Carter, Sara P., RN at 06/08/2014 06:53]; Timing = prior to admit [Charted by: Carter, Sara P., RN at 06/08/2014 06:53]; Type = blister [Charted by: Carter, Sara P., RN at 06/08/2014 06:53]; Location = right lower hip [Charted by: Carter, Sara P., RN at 06/08/2014 06:53]

laceration (1) left wrist

Start Date = 06/06/2014; Time = 23:00 [Charted by: Carter, Sara P., RN at 06/07/2014 04:25]; Timing = prior to admit [Charted by: Carter, Sara P., RN at 06/07/2014 04:25]; Type = laceration [Charted by: Carter, Sara P., RN at 06/07/2014 04:25]; Location = left wrist [Charted by: Carter, Sara P., RN at 06/07/2014 04:25]; Wound Comment = scratch [Charted by: Carter, Sara P., RN at 06/07/2014 04:25]

surgical incision (1) left hip

Start Date = 06/07/2014; Timing = prior to arrival on unit [Charted by: Kirk, Julia P., RN at 06/09/2014 10:21]; Type = surgical incision [Charted by: Kirk, Julia P., RN at 06/09/2014 10:21]; Location = left hip [Charted by: Kirk, Julia P., RN at 06/09/2014 10:21]

Ended Sites

Foley (1) 16fr

Start Date = 06/06/2014 [Charted by: Carter, Sara P., RN at 06/07/2014 04:18]; Time = 23:00 [Charted by: Carter, Sara P., RN at 06/07/2014 04:18]; Timing = prior to admit [Charted by: Carter, Sara P., RN at 06/07/2014 04:18]; Reported Pt Location @ Insertion = ER [Charted by: Carter, Sara P., RN at 06/07/2014 04:18]; Type = Foley [Charted by: Carter, Sara P., RN at 06/07/2014 04:18]; Size (Fr) = 16fr [Charted by: Carter, Sara P., RN at 06/07/2014 04:18]; End Date = 06/09/2014 [Charted by: Kirk, Julia P., RN at 06/09/2014 10:38]; Time = 10:10 [Charted by: Kirk, Julia P., RN at 06/09/2014 10:38]; Removed By = jk [Charted by: Kirk, Julia P., RN at 06/09/2014 10:38]

done (1) orm 20 gauge

Start Date = 06/06/2014; Time = 23:30 [Charted by: Carter, Sara P., RN at 06/07/2014 03:55]; IV Timing = prior to admit [Charted by: Carter, Sara P., RN at 06/07/2014 03:55]; Reported Pt Location @ Insertion = ER [Charted by: Carter, Sara P., RN at 06/07/2014 03:55]; Size (Ga) = 20 gauge [Charted by: Carter, Sara P., RN at 06/07/2014 03:55]; Site = rfa [Charted by: Carter, Sara P., RN at 06/07/2014 03:55]; Location = arm [Charted by: Carter, Sara P., RN at 06/07/2014 03:55]; End Date = 06/10/2014 [Charted by: Swan, Dolly, RN at 06/10/2014 10:49]; Time = 1024 [Charted by: Swan, Dolly, RN at 06/10/2014 10:59]; Removed By = pa [Charted by: Swan, Dolly, RN at 06/10/2014 10:59]; Dressing Applied = dsg [Charted by: Swan, Dolly, RN at 06/10/2014 10:59]; Removal Comments = Pulled with sterile technique by RT Swan, Dolly, RN at [06/10/2014 10:59]

narrative

06/07/2014 00:00 - TO - 06/07/2014 23:59

Legend Charting

06/07/2014 00:10

done (1) orm 20 gauge

done (1) ended) left arm

Check Pain / Reliefs & Re-eval

Carter, Sara P., RN 06/07/2014 04:26

Intervention = other-comment

Carter, Sara P., RN 06/07/2014 04:00

Notes: IVF

Site Assessment = WNL

Carter, Sara P., RN 06/07/2014 04:26

Foley (1) 16fr

Foley(1)(ended)

Intervention: (N/A)

Carter, Sara P., RN 06/07/2014 04:26

Necessity = requires prolonged immobilization

Carter, Sara P., RN 06/07/2014 04:26

Status = patient bedified to toilet, unattended

Carter, Sara P., RN 06/07/2014 04:26

PARROTT, DELILA W. Opt Out: No
Mt Pleasant
Site Management (sfomgmt_ipf)
Rm-Bed: 3109 - 01 Admit D.: 06/06/2014 23:29
Age: 80 yr. Gender: F MD: Uhle Md, Richard E., MD
DOB: REDA Acct: 1415701389
MRN: 001787037
Requested: 06/11/2014 10:36
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narrative

06/07/2014 00:00 TO 06/07/2014 23:59

Legend Charting

06/07/2014 00:10

Foley (1) 16fr

Intake Assessment = Clear — Carter, Sara P., RN 06/07/2014 04:26

Urine Color = amber — Carter, Sara P., RN 06/07/2014 04:26

abrasion (1) right hip

Abrasion (1) right hip

Inpatient Documentation,Appearance = clean, reddened, other-comment — Carter, Sara P., RN 06/07/2014 04:26

Noted: bruise

Inpatient Documentation,Wound drainage = none — Carter, Sara P., RN 06/07/2014 04:26

Inpatient Documentation,Interventions = open to air — Carter, Sara P., RN 06/07/2014 04:26

Location (1) right wrist

Inpatient Documentation,Appearance = approximated, reddened — Carter, Sara P., RN 06/07/2014 04:26

Inpatient Documentation,Wound drainage = none — Carter, Sara P., RN 06/07/2014 04:26

Inpatient Documentation,Interventions = open to air — Carter, Sara P., RN 06/07/2014 04:26

06/07/2014 10:33

done (1) arm 20 gauge

Abrasion (1) right hip

Intervention = other-comment — Kirk, Julia P., RN 06/07/2014 15:27

Noted: IV infusing

Site Assessment = WNL — Kirk, Julia P., RN 06/07/2014 15:27

Foley (1) 16fr

Foley (1) (sealed)

Necessity = Need accurate Urine Output measurement / Patient unresponsive — Kirk, Julia P., RN 06/07/2014 15:27

Status = patent, secured to leg, undamped — Kirk, Julia P., RN 06/07/2014 15:27

Urine Assessment = Clear — Kirk, Julia P., RN 06/07/2014 15:27

Urine Color = amber — Kirk, Julia P., RN 06/07/2014 15:27

abrasion (1) right hip

Abrasion (1) right hip

Inpatient Documentation,Appearance = open, reddened — Kirk, Julia P., RN 06/07/2014 15:27

Inpatient Documentation,Wound drainage = serosanguinous — Kirk, Julia P., RN 06/07/2014 15:27

Noted: scant amount

Inpatient Documentation,Interventions = open to air — Kirk, Julia P., RN 06/07/2014 15:27

Location (1) left wrist

Inpatient Documentation,Appearance = approximated, reddened — Kirk, Julia P., RN 06/07/2014 15:27

PARROTT, DELILA W. Opt Out: No
MI Present
Site Management (sitemgmt_hpf)
Rm-Bed: 3109 - 01 Admit D.: 08/08/2014 23:00
Age: 60 yr Gender: F MD: Mills Md, Richard E., MD
DOB: RED Acct: 1415701039
MRN: 001787037
Requested: 08/11/2014 10:38
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narrative
08/07/2014 00:00 TO 08/07/2014 23:59
Legend Charting
08/07/2014 10:33
laceration (1) - left wrist
Inpatient Documentation,Wound drainage = none — Kirk, Julia P., RN 08/07/2014 15:27
Inpatient Documentation,Intervention = open to air — Kirk, Julia P., RN 08/07/2014 15:27
Inpatient Documentation,Topical = antibiotic — Kirk, Julia P., RN 08/07/2014 15:27
08/07/2014 10:56
surgical incision (1) - left hip
surgical incision(1) left hip
Inpatient Documentation,Dressing condition = drainage/stable — Kirk, Julia P., RN 08/08/2014 10:22
Inpatient Documentation,Wound drainage = bloody, serous — Kirk, Julia P., RN 08/08/2014 10:22
Inpatient Documentation,Dressing/Cover = other comment — Kirk, Julia P., RN 08/08/2014 10:22
Notes: honeycomb islanf dressing
08/07/2014 21:27
done (1) ans 20 gauge
done(1)ended(left arm)
Intervention = other comment — Carter, Sara P., RN 08/08/2014 00:20
Notes, IVF
Skin Assessment = Wnl — Carter, Sara P., RN 08/08/2014 00:20
Foley (1) 16fr
Foley(1)(ended)
Necessity = have accurate urine output measurements; requires prolonged instrumentation — Carter, Sara P., RN 08/08/2014 00:20
Status = patent, secured to leg, unclamped — Carter, Sara P., RN 08/08/2014 00:29
Urine Appearance = clear — Carter, Sara P., RN 08/08/2014 00:29
Urine Color = amber — Carter, Sara P., RN 08/08/2014 00:20
abrasion (1) - right hip
abrasion(1) left hip
Inpatient Documentation,Appearance = open, reddened — Carter, Sara P., RN 08/08/2014 00:29
Inpatient Documentation,Wound drainage = none — Carter, Sara P., RN 08/08/2014 00:29
Inpatient Documentation,Intervention = open to air — Carter, Sara P., RN 08/08/2014 00:29
Inpatient Documentation,Topical = other comment — Carter, Sara P., RN 08/08/2014 00:29
Notes: Bacitracin
laceration(1) left wrist
Inpatient Documentation,Appearance = approximated — Carter, Sara P., RN 08/08/2014 00:29
Inpatient Documentation,Wound drainage = none — Carter, Sara P., RN 08/08/2014 00:29

narrative

08/07/2014 00:00 TO 08/07/2014 23:59

Legend Charting

08/07/2014 01:27

laceration (1) left wrist

Inpatient Documentation,Interventions = open to air — Carter, Sara P., RN 08/06/2014 00:20

abrasion(1) right lower hip

Inpatient Documentation,Wound drainage = none — Carter, Sara P., RN 08/06/2014 05:53

Inpatient Documentation,Interventions = open to air — Carter, Sara P., RN 08/06/2014 05:53

08/08/2014 00:00 TO 08/08/2014 23:59

Legend Charting

08/08/2014 00:00

clone (1) arm 20 gauge

dose(1) (ended) left arm

Intervention = other comment — Kirk, Julia P., RN 08/08/2014 16:22

NOS: (Initiating)

Site Assessment = WNL — Kirk, Julia P., RN 08/08/2014 16:22

Foley (1) 16fr

Foley(1)(ongoing)

Necessity = need accurate urine output measurements, requires prolonged immobilization — Kirk, Julia P., RN 08/08/2014 16:22

Output = patient scheduled to toilet, incontinent — Kirk, Julia P., RN 08/08/2014 16:22

Urine Assessment = clear — Kirk, Julia P., RN 08/08/2014 16:22

Urine Color = Amber — Kirk, Julia P., RN 08/08/2014 16:22

abrasion (1) right hip

abrasion(1) right hip

Inpatient Documentation,Appearance = other (add detail) — Kirk, Julia P., RN 08/08/2014 16:22

Inpatient Documentation,Wound drainage = none — Kirk, Julia P., RN 08/08/2014 16:22

Inpatient Documentation,Interventions = open to air — Kirk, Julia P., RN 08/08/2014 16:22

Inpatient Documentation,Topical = other comment — Kirk, Julia P., RN 08/08/2014 16:22

Notes, bactroban

laceration(1) left wrist

Inpatient Documentation,Appearance = reddened — Kirk, Julia P., RN 08/08/2014 16:22

Inpatient Documentation,Wound drainage = none — Kirk, Julia P., RN 08/08/2014 16:22

Inpatient Documentation,Interventions = open to air — Kirk, Julia P., RN 08/08/2014 16:22

bruise(1) right lower hip

Inpatient Documentation,Wound drainage = none — Kirk, Julia P., RN 08/08/2014 16:22

Inpatient Documentation,Interventions = open to air — Kirk, Julia P., RN 08/08/2014 16:22

surgical incision(1) left hip

narrative

06/08/2014 00:00 TO 06/08/2014 23:59

Legend Charting

06/08/2014 00:00

surgical incision (1) left hip

Inpatient Documentation,Dressing condition = drainage/stable — Kirk, Julia P., RN 06/08/2014 16:22

Inpatient Documentation,Wound drainage = (blood), scant (qty) — Kirk, Julia P., RN 06/08/2014 16:23

Inpatient Documentation,Dressing/Cover = other comment — Kirk, Julia P., RN 06/08/2014 16:22

Notes: honeycomb island dressing

06/08/2014 20:00

done (1) arm 20 gauge

done (1) (ended) left arm — Site Assessment = WNL — Muller, Gretchen A., RN 06/09/2014 00:14

Foley (1) 16fr

Foley (1) (ended) — Status = patent, secured to leg, unclamped — Muller, Gretchen A., RN 06/09/2014 01:37

abrasion (1) right hip

abrasion (1) right hip — Inpatient Documentation,Appearance = open, reddened — Muller, Gretchen A., RN 06/09/2014 01:37

Inpatient Documentation,Wound drainage = none — Muller, Gretchen A., RN 06/09/2014 01:37

Inpatient Documentation,Interventions = open to air — Muller, Gretchen A., RN 06/09/2014 01:37

Inpatient Documentation,Topical = other comment — Muller, Gretchen A., RN 06/09/2014 01:37

Notes: bacitracin

laceration (1) left wrist

Inpatient Documentation,Appearance = reddened — Muller, Gretchen A., RN 06/09/2014 01:37

Inpatient Documentation,Wound drainage = none — Muller, Gretchen A., RN 06/09/2014 01:37

Inpatient Documentation,Interventions = open to air — Muller, Gretchen A., RN 06/09/2014 01:37

bruise (1) right lower hip

Inpatient Documentation,Wound drainage = none — Muller, Gretchen A., RN 06/09/2014 01:37

Inpatient Documentation,Interventions = open to air — Muller, Gretchen A., RN 06/09/2014 01:37

surgical incision (1) left hip

Inpatient Documentation,Dressing condition = drainage/stable — Muller, Gretchen A., RN 06/09/2014 01:37

Inpatient Documentation,Wound drainage = (blood), scant (qty) — Muller, Gretchen A., RN 06/09/2014 01:37

Inpatient Documentation,Dressing/Cover = other comment — Muller, Gretchen A., RN 06/09/2014 01:37

Notes: honeycomb

06/09/2014 00:00 TO 06/09/2014 23:59

Legend Charting

06/09/2014 10:08

corrective
06/09/2014 00:00 TO 06/09/2014 23:59
Legend Charting
06/09/2014 10:09
done (1) arm 20 gauge
done (1) (ended) left arm
Site Assessment = WNL — Kirk, Julia P., RN 06/09/2014 13:10
Foley (1) 16fr
Foley (1) (ongoing)
Status = patent, secured to leg, undamped — Kirk, Julia P., RN 06/09/2014 13:10
abrasion (1) right hip
abrasion (1) right hip
Inpatient Documentation,Appearance = open, reddened — Kirk, Julia P., RN 06/09/2014 13:10
Inpatient Documentation,Wound drainage = none — Kirk, Julia P., RN 06/09/2014 13:10
Inpatient Documentation,Interventions = open to air — Kirk, Julia P., RN 06/09/2014 13:10
Inpatient Documentation,Topical = other comment — Kirk, Julia P., RN 06/09/2014 13:10
Notes: betadine
laceration (1) left wrist
Inpatient Documentation,Appearance = approximated — Kirk, Julia P., RN 06/09/2014 13:10
Inpatient Documentation,Wound drainage = none — Kirk, Julia P., RN 06/09/2014 13:10
Inpatient Documentation,Interventions = open to air — Kirk, Julia P., RN 06/09/2014 13:10
bites (1) right lower hip
Inpatient Documentation,Wound drainage = moderate — Kirk, Julia P., RN 06/09/2014 13:10
Inpatient Documentation,Interventions = open to air — Kirk, Julia P., RN 06/09/2014 13:10
surgical incision (1) left hip
Inpatient Documentation,Dressing condition = drainage/staples — Kirk, Julia P., RN 06/09/2014 13:10
Inpatient Documentation,Wound drainage = bloody, scant, old — Kirk, Julia P., RN 06/09/2014 13:10
Inpatient Documentation,Dressing/Cover = other comment — Kirk, Julia P., RN 06/09/2014 13:10
Notes: honeycomb
06/09/2014 10:50
done (1) arm 20 gauge
done (1) (ended) left arm
Check Blood Return = positive — Carter, Sara P., RN 06/10/2014 01:55
Intervention = flush/monitor — Carter, Sara P., RN 06/10/2014 01:55
Notes: IVF
Site Assessment = WNL — Carter, Sara P., RN 06/10/2014 01:55
abrasion (1) right hip
abrasion (1) (ongoing)

narrative

08/09/2014 00:00 TO 08/09/2014 23:59

Legend Charting

08/09/2014 19:58

abrasion (1) right hip

Inpatient Documentation,Appearance = reddened — Carter, Sara P., RN 08/10/2014 01:55

Inpatient Documentation,Wound drainage = none — Carter, Sara P., RN 08/10/2014 01:55

Inpatient Documentation,Interventions = open to air — Carter, Sara P., RN 08/10/2014 01:55

Inpatient Documentation,Topical = other-comment — Carter, Sara P., RN 08/10/2014 01:55

Notes: Bactroban

laceration (1) left wrist

Inpatient Documentation,Appearance = reddened — Carter, Sara P., RN 08/10/2014 01:55

Inpatient Documentation,Wound drainage = none — Carter, Sara P., RN 08/10/2014 01:55

Inpatient Documentation,Interventions = open to air — Carter, Sara P., RN 08/10/2014 01:55

ulcer(1) right lower (1)

Inpatient Documentation,Wound drainage = none — Carter, Sara P., RN 08/10/2014 01:55

Inpatient Documentation,Interventions = open to air — Carter, Sara P., RN 08/10/2014 01:55

surgical incision(1) left hip

Inpatient Documentation,Wound Drainage Amount = small — Carter, Sara P., RN 08/10/2014 01:55

Inpatient Documentation,Wound drainage = bloody, moderate, old — Carter, Sara P., RN 08/10/2014 01:55

Inpatient Documentation,Dressing Comment = clean/dry/intact — Carter, Sara P., RN 08/10/2014 01:55

Notes: bonecon3

05/10/2014 00:00 TO 05/10/2014 23:59

Legend Charting

05/10/2014 09:50

done (1) arm 20 gauge

done(1) forehead left arm

Site Assessment = WNL — Swan, Betty , RN 05/10/2014 14:34

abrasion (1) right hip

abrasion(1) right hip

Inpatient Documentation,Appearance = clean, dry — Swan, Betty , RN 05/10/2014 14:34

Inpatient Documentation,Wound drainage = none — Swan, Betty , RN 05/10/2014 14:34

laceration(1) left wrist

Inpatient Documentation,Appearance = clean — Swan, Betty , RN 05/10/2014 14:34

Inpatient Documentation,Wound drainage = none — Swan, Betty , RN 05/10/2014 14:34

Inpatient Documentation,Interventions = open to air — Swan, Betty , RN 05/10/2014 14:34

ulcer(1) right lower hip

Inpatient Documentation,Wound drainage = none — Swan, Betty , RN 05/10/2014 14:34

OneContent: Generated By coffje1

PARROTT, DELILA W. Opt Out: No
HI Pleasant
Site Management (sitemgmt_hpl)
Rm-Bed: 3109 - 01 Admit Dt: 06/09/2014 23:29
Age: 60 Gender: F MD: Mele Md, Richard E., MD
DOB: REDACTED Acct: 1416701389
MRN: 001787037
Requested: 06/11/2014 10:36
Page 6 of 8

narrative

06/10/2014 00:00 TO 06/10/2014 23:59

Legend Charting

06/10/2014 00:50

blister (1) right lower hip

Inpatient Documentation,Intervantions = other-comment — Swan, Betty , RN 06/10/2014 14:34

Notes: mepelix applied

surgical incision (1) left hip

Inpatient Documentation,Dressing condition = intact, dry — Swan, Betty , RN 06/10/2014 14:34

Inpatient Documentation,Wound drainage = scant — Swan, Betty , RN 06/10/2014 14:34

Inpatient Documentation,Dressing/Cover = other-comment — Swan, Betty , RN 06/10/2014 14:34

Notes: aquacel

06/10/2014 14:17

surgical incision (1) left hip

surgical incision (1) left hip

Inpatient Documentation,Dressing condition = intact, dry — Swan, Betty , RN 06/10/2014 14:10

Inpatient Documentation,Wound drainage = scant — Swan, Betty , RN 06/10/2014 14:10

Inpatient Documentation,Dressing/Cover = other-comment — Swan, Betty , RN 06/10/2014 14:10

Notes: aquacel dressing

Inpatient Documentation,Intervantions = dressing changed — Swan, Betty , RN 06/10/2014 14:10

Resident Service Notes
Resident Name: Delilia Parrot
Apt. Number: 808

FIVESTAR SENIOR LIVING, INC.

DATE	COMMENTS	SIGNATURE/TITLE
9/18/14	Resident moved into the facility this afternoon her family helped resident move in the facility. resident ambulates and transfers with a wheelchair. resident will need stand by assist with transfers and ambulation. resident is a retired nurse and enjoys being around other people	RJ Simmons SRSD
10-10-14	Resident can not stand up if I took 2 CNA to put her in bed Tonight,	A. Grant
10/11/14	RESIDENT BACK FROM HOSPITAL, EXITED ROOM TWICE TONIGHT CONVINCED HER ROOM & CLOTHES WERE FLOODED. DURING	
10/18/14	During first shift Mrs Parrot locked herself in the facility discovery room and was crying say someone entered her room at 1am and was standing over her she then went outside and attempted to leave; she was brought back in by care manger and med tech and called her daughter when she then calmed down and went in her room. R.S.D and physician on call has been notified/continued→	

Resident Service Notes
Resident Name: Delilia Parrott
Apt. Number: 808

FIVESTAR SENIOR LIVING, INC.

DATE	COMMENTS	SIGNATURE/TITLE
10/18/14	continued - and currently waiting on physician to respond to request for a psh anxiety medication. Resident have also been put on 24° alert — Jellegler	
10/19/14	Ms Parrott was in a much better mood today happy and smiling. Resident was organizing a bridge card game group she is in a pleasant mood. — Jellegler	
10/20/14	Resident was sent out to the ER this morning. Complaining of chest pains and couldn't breath. Notified daughter and physician.	gh
10/25/14	Resident ambulates with wheel-chair. Normally has 1 staff member assist but can do a lot for herself. Resident has had an up and down road. Each day is different - some days worse/better than others. Since she's been back from the hospital, everything seems OK. she had a fall yesterday but just appeared to slip off couch, she was OK. Family & Dr notified. No other concerns at this time.	gh
10-27-14	Resident complaining of left side hurting after her fall on Friday. Notified Dr.	gh

Resident Service Notes

Resident Name: Delilia Parrot

Apt. Number: 808

FIVESTAR SENIOR LIVING, INC.

DATE	COMMENTS	SIGNATURE/TITLE
10/20	TOOK RESIDENT HOME LUNCH AND RESIDENTS JUST STARTED YELLING AND STATING SHE WAS VERY UPSET. ~~TO~~ RESIDENT ASK WHY DIDN'T I WAKE HER UP FOR LUNCH I STATED TO THE RESIDENT SHE NEEDED HER REST AND I HAVE HER FOOD WHEN EVER SHE WANTS IT. RESIDENT STATED SHE WAS UPSET AND SHE WANTED HER DAUGHTER STARTED PICKING UP HER WALKER AND SAYING SHE'S GOING TO THROW IT AT ME AND SHE CAN TAKE CARE OF HERSELF SO I PLACED HER FOOD DOWN AND STARTED WALKING TOWARDS THE DOOR AND SHE STARTED APOLOGIZING. RESIDENT CALMED DOWN AFTER NOTICING I WAS GOING TO LEAVE OUT HER ROOM.	KB nurse

Resident Service Notes
Resident Name: Delila Parrott
Apt. Number: 804

FIVE STAR SENIOR LIVING, INC

DATE	COMMENTS	SIGNATURE/TITLE
11-22-14	Resident continues to ambulate with wheelchair & 1 staff member assist. She has declined a bit as she was doing almost everything by herself last month, now needs help with a lot. Comes out for all meals & eats well. Doesn't participate in any activities or go on any outings. Enjoys spending time with Mr. Hoskinson.	gh

Resident Service Notes 3-21-06

Resident Service Notes

FIVESTAR SENIOR LIVING, INC.

Resident Name: DELILA PARRETT

Apt. Number: 808

DATE	COMMENTS	SIGNATURE/TITLE
12/4/14	RESIDENT SAID WESLEY & PAM KILLED 2 PEOPLE AND BURIED THEM OUTSIDE OF HER WINDOW IN JUNE & SINCE SHE WITNESSED IT, THEY ARE TRYING TO KILL HER BY CHRISTMAS BY LEAKING GAS INTO HER ROOM AT NIGHT WHILE SHE IS SLEEPING. THAT IS WHY THERE IS A HISSING NOISE BEHIND HER COUCH	Denise Williams MT
12-23-14	Resident is leaning towards her left side more today. She said she was very weak and couldn't really move herself. She went to the Dr. and they're going to check her out.	
12-26-14	Resident continues to ambulate with wheelchair. Needs a lot more assitance with toileting. She's having a hard time doing things on her own. She's getting weaker where staff has to more or less lift her up. Therapy is currently working with her. Comes out for all meals and doesn't participate in any activities. Enjoys spending time with Mr. Hoskinson.	

Resident Service Notes
Resident Name: Delila Parrott
Apt. Number: 808

FIVESTAR SENIOR LIVING, INC.

DATE	COMMENTS	SIGNATURE/TITLE
12-29-14	Resident said that she needs to go to the bathroom more because the evil spirits need to come out of her. Daughter was very concerned & requested for her miralax to be D/C. Sent a request to the Dr.	
1/14/15	Resident said she feels nervous but does not know why. Resident says "Something is going on and I can't put my finger on it." Resident stated to med tech that due to her feeling nervous she can't pick up her utensils to eat — Jennifer	
1/18/15	Resident cannot grab with her hands. med tech has to put the cup of pills to her mouth and put the water to her mouth bcus she couldn't grab the cup. She didn't eat anything for breakfast bcus she couldn't pick up the utensils. Dr was notified.	
1/19/15	Resident still has not eaten today. Daughter & Dr notified.	

Parrott, Delila MRN: 710111
DOB: REDACTE 80y/o MPIPU
ADM: 1/31/2015 DX: Schizophrenia
GTV: 1484684

HOSPICE *PHYSICIAN* MEDICAL GUIDELINES

(* other than Adult Failure to Thrive, Debility, Alzheimer's, Cancer, COPD, HIV, I

Patient Name: _____ Age: ____ MR #: _____ Benefit Period: ☐ 1st ☐ 2nd ☐ 3rd ☐* _____ / ☐ Diagnosis Change

Hospice Dx: _____ Start of Care: 1/31/15 Benefit Period Dates: 1/31/15 to 4/30/15 ☐* Face-to-Face Completed on _____

GENERAL GUIDELINES

☑ Life limiting condition | ☑ Patient / family have elected course of palliative care | ☑ Patient / caregiver / physician are in agreement on a course of palliative care

☑ Palliative Performance Scale (PPS) 30 Previous PPS 80 (7 months ago)

☐ Pain requiring increasing doses of (opioid) analgesics _____ Explain: _____

☑ Increasing emergency room visits, hospitalizations, or physician's visits over previous 6 months & / or last benefit period *related to the hospice diagnosis*

All Patients – Dependence in Activities of Daily Living – Evidenced by (narrative should show considerable effort required):

☐ Bathing ☑ Dressing ☐ Feeding ☑ Transfers ☐ Toileting ☐ Ambulation needs assistance

Other Indicators of Decline: ☐ Sleeps > _____ hours in 24 hours

All Patients – Recent Impaired nutritional status – Evidenced by:

Maximum Adult Height 65" Current Weight 41 kg BMI 21.6 Previous Weight _____ (_____ months ago)

Mid Arm Circumference (non-dominant arm)_____ ☐ Unintentional progressive weight loss of 10% or more over past six months ☐ Serum albumin _____

☐ Cholesterol < 150 _____ ☐ Dysphagia, choking, poor oral intake ☐ Impaired nutrition despite PEG / Tube Feeding

Co-morbidities: If not the primary hospice diagnosis, the presence of disease such as the following, the severity of which is likely to contribute to a life expectancy of six months or less, should be considered in determining hospice eligibility:

☐ COPD ☐ CHF ☐ Ischemic heart disease ☐ Diabetes mellitus ☑ Neurologic disease (☐ CVA ☐ ALS ☑ MS ☐ Parkinson's) ☐ Renal failure

☐ Liver Disease ☐ Neoplasia ☐ Dementia (FAST _____) ☐ Other _____

OTHER TERMINAL ILLNESS

Observable and documented deterioration in overall clinical condition in the past 6 months as evidenced by *any* of the following:

☐ Serial physician assessments ☐ Multiple hospital / ER visits ☐ Progressive pressure ulcers ☑ Decline in functional status with a PPS of 40% ☐ Systolic BP 80

☑ Progressive dependence in ADL's ☐ Persistent nausea and vomiting ☐ Recent impaired nutritional status ☐ Weight loss ☐ Decreasing serum albumin (< 2.5)

☐ Malnutrition with BMI < 22 kg/m² ☑ *Combination of disease processes which, reviewed together, presents a picture of structural and functional impairment*

☐ Requires O₂ at rest ☐ declines artificial ventilation

NARRATIVE SUMMARY

To include History of Disease Progression to Date and effect of co-morbid conditions(If the patient does not meet the guidelines above, your summary must include the alternative factors that support the terminal prognosis):

AD c/o widow c progressive, accelerating Schizophrenia requiring 24° care c aphasia, dysarthria, admitted for failure to thrive c pt eating / drinking less over last several weeks & activity p hip fx 6/14 now c worsening sacral decubitus ulcer causing pain ? c diffuse bone pain ? anemia of ? etiology

HOSPICE PHYSICIAN ATTESTATION

Based on these findings, it is my clinical judgment that this patient's prognosis is for a life expectancy of six months or less if the disease runs the normal course.

By signing my signature, I attest that I composed the above narrative based on my review of the medical record or, if applicable, my examination of the patient.

BRYNA KRAMER HALL MD — Hospice Physician's Printed Name

Hospice Physician's Signature — 1.30.15 Date by Physician

☐ FAXed to Attending Physician _____ on _____ by _____

Parrott, Delila MRN: 710111
DOB: REDACTE 80y/o MPIPU
ADM: 1/31/2015 DX: Schizophrenia
GTV: 1484684

NURSING REV (* other than Adult Failure to Th

OTHER TERMINAL ILLNESS* (es, Parkinson's, Renal Disease, Stroke or Coma)

Patient Name: Delila Parrott Age: ____ MR #: ____ ☒ Certification / ☐ Re-Certification / ☐ Diagnosis Change

Hospice Dx: Schizophrenia Start of Care: 1-31-15 Benefit Period: 1 Dates: 1-31-15 to 4/30/15

OTHER TERMINAL ILLNESS GUIDELINES

History of Disease Progression to Date:
80 y/o F dx'd schizophrenic + worsening dementia. Symptoms have been uncontrolled for 5 years. She is currently experiencing insomnia, hallucinations, paranoia, delusions + failure to thrive. She has been refusing to eat as much - 2-3 wks. She c/o poorly managed pain in shoulders, (L) hip + RUE. Comorbidities include HTN, OA (R) hip, macular degeneration, sleep apnea, OA.

Observable and documented deterioration in overall clinical condition in the past 6 months as evidenced by *any* of the following:
☐ Serial physician assessments ☒ Progressive pressure ulcers ☐ Systolic BP 80 ☐ Persistent nausea and vomiting ☐ Requires O2 at rest ☐ Declines artificial ventilation
☒ Palliative Performance Scale (PPS) ____ (should be ≤ 40%) Previous PPS ____ (____ months ago)
☒ Pain requiring increasing doses of (opioid) analgesics ____ Explain: ____
☒ Increasing emergency room visits, hospitalizations, or physician's visits over previous 6 months & / or last benefit period *related to the hospice diagnosis*

Dependence in Activities of Daily Living – Evidenced by (*narrative below should show considerable effort required & progressive dependence*):
☐ Bathing ☒ Dressing ☐ Feeding ☒ Transfers ☐ Toileting ☐ Ambulation
Other Indicators of Decline: ☐ Sleeps > ____ hours in 24 hours
Recent Impaired nutritional status evidenced by:
Maximum Adult Height 65" Current Weight 67 kg BMI ____ Previous Weight ____ Previous BMI ____ (____ months ago)
Mid Arm Circumference (non-dominant arm) ____ ☐ Serum albumin ____ ☐ Cholesterol < 160 ____
☐ Unintentional progressive weight loss of 10% or more over past six months ☐ Impaired nutrition despite PEG / Tube Feeding
☐ Choking ☒ Poor / Decreased oral intake (currently ____ % of ____ meals per day / was ____ % of ____ meals / day ____ ago)
Co-morbid and secondary conditions that *directly* impact the terminal illness:
☐ *Combination of disease processes which, reviewed together, presents a picture of structural and functional impairment* ☐ COPD ☐ CHF ☐ Ischemic heart disease
☐ Diabetes mellitus ☐ Neurologic disease (☐ CVA ☐ ALS ☐ MS ☐ Parkinson's) ☐ Renal failure ☐ Dysphagia
☐ Liver Disease ☐ Neoplasia ☐ Dementia ☐ Other Schizophrenia, depression
IF PT TO BE RE-CERTIFIED: Memory re-call words "ball", "pencil", "brush"; ____ / 3 recalled after 5 minutes; ☐ result of 0 or 1 – pt referred to MSW for MMSE
Documentation of structural / functional impairments related to co-morbidities:

CURRENT CLINICAL PICTURE

(To include weight loss/ gain in time period, vital signs, shortness of breath, decreased level of consciousness, heart rhythms, rales, edema, etc in order to illustrate how the patient meets criteria qualifying for hospice care)
Awake, eyes open + focusing on arrival. Minimal verbal response due to expressive aphasia. Recognizes family. No signs of discomfort present. Resp. unlabored on RA. Daughter describes increased anxiety + confusion c visual + auditory hallucinations. Paranoid. Dx. Increasing pain in RUE, (L) hip + shoulders. Requires total care ADL's. Bedbound. Decreased appetite. Incont of bowel + bladder. Ht 22 H.L. (R) arm + (R) foot drop. Stage II decub on sacrum + (R) buttock + skin tear.

RN Signature: [signature] Date: 1-31-15 11/04/10

Parrott, Delila MRN: 710111
DOB: REDACT 80y/o MPIPU
ADM: 1/31/2015 DX: Schizophrenia
GTV: 1484684

DIAGNOSES LIST

Pa_____ MRN#: _____ Date: _____

Terminal Diagnosis: INCLUDE IN LIST BELOW ☐ Initial IDG Meeting ☐ Diagnosis Change ☐ Additional Diagnosis

All of the patient's diagnoses (related and unrelated to the terminal prognosis) should be provided in the spaces below.

DIAGNOSIS	NOT RELATED* TO TERMINAL PROGNOSIS (Must be explained below)	RELATED* TO TERMINAL PROGNOSIS (Provide ICD Code◆)	CODE ENTERED ON CLAIM▲
1) SCHIZOPHRENIA L DIAGNOSIS		295.80	✓
2) DECUBITUS ULCER	✓		1
3) ANEMIA	✓		
4) HTN	✓		
5)	☐		
6)	☐		
7)	☐		
8)	☐		
9)	☐		
10)	☐		

HOSPICE PHYSICIAN'S DOCUMENTATION OF REASON NOT RELATED TO THE TERMINAL PROGNOSIS

DIAGNOSIS #: 2
REASON: 2° bed (wheelchair confined; not associated w/ the schizophrenia

DIAGNOSIS #: 3
REASON: ? etiology; not associated w/ schizophrenia

DIAGNOSIS #: 4
REASON: not contributing to the schizophrenia

DIAGNOSIS #:
REASON:

DIAGNOSIS #:
REASON:

*Related/Not Related is determined by the Hospice Physician ▲ Initial once Physician has signed & ICD Code of Related Diagnosis has been entered into the system

I have reviewed diagnoses and determined relatedness to the prognosis. 15 min
Signature of Hospice Physician — Date: 1.31.15

◆ Signature of Coder — Date: 2/2/15

HOS4240 09/2013

Page _____ of _____

If additional space is needed, use second Diagnoses List (HOS4240)
White copy - Chart Yellow Copy - On-Call Pink Copy - RNCM

Hospice 032

Parrott, Delila MRN: 710111
DOB: REDACT 80y/o MPIPU
ADM: 1/31/2015 DX: Schizophrenia
GTV: 1484684

ESTABLISHMENT OF THE HOSPICE PLAN OF CARE

Patient Name: _____ MR#: _____

Hospice Plan of Care established & coordinated with the following Interdisciplinary Group members:

	In Person	By Telephone
Attending Physician	☐	☑
Hospice Physician	☑	☐
Social Worker	☑	☐
Spiritual Care Coordinator	☑	☐
Bereavement Coordinator	☑	☐
Manager of Volunteer Services	☑	☐
Patient	☐	☒
Family / Caregiver: Joan (daughter)	☐	☐

Plan of Care Discussed & Coordinated with Facility Nurse: _____

Visit Frequencies will be: SN: 24° Phy: 24/wk HA: 24° SW: 1 x wk SCC: 1 x wk MVS: 1 x wk Other: _____

☐ IDG approves unscheduled visits provided at the request of pt/family/caregiver

Signature/Title: Connie Kpatek RN — Date Established: 1-31-15

INFORMATION BELOW TO BE COMPLETED AT FIRST IDG FOLLOWING ADMISSION OF PATIENT

INITIAL IDG PLAN OF CARE REVIEW

IDG Meeting Date: 2-4-15

The following Plans of Care are open:

- ☐ Admission
- ☐ Communication
- ☑ Pain Management
- ☐ Cardiopulmonary
- ☑ Neuro/Cognitive/Behavioral
- ☐ Skin/Pressure Ulcer
- ☐ Nutrition/Fluid Maintenance/Upper GI
- ☐ Genitourinary/Lower GI
- ☑ Functional Status
- ☑ Psychosocial Well-Being
- ☐ Spiritual
- ☐ Safety/Falls
- ☐ Knowledge Deficit
- ☐ Pre-Bereavement
- ☐ Volunteer
- ☐ Other

RN Case Manager Summary: PPS 10%, NPO minimally responsive still having hallucinations, Family aware of decline.

Spiritual Care/Bereavement Coordinator Summary: Pt's daughter is emotional person but pt has remained NC will continue to follow-up as req

Social Worker Summary: Pt declining. Dtr thought SNF placement would be needed but pt at end of life & will remain at IPU. Emotional support will be provided

Scope of Services *(frequency of visits)*:

Skilled Nurse: 24° — Physician: daily — Hospice Aide: 24°

Social Worker: 2 x wk — Spiritual Care Coordinator: 3-7 x wk — Bereavement Coordinator: prn

Volunteer: As needed — Dietician: _____ — Occupational Therapy: _____

Physical Therapy: _____ — Speech Therapy: _____

Plan of Care (including unscheduled visits provided at the request of pt/family/caregiver) Reviewed and Approved by:

RN Case Manager: _____

Hospice Physician: _____

Social Worker: _____

Spiritual Care/Bereavement Coordinator: _____

Manager of Volunteer Services: _____

☐ Copy to Attending Physician for review of the Plan of Care Date Sent: _____ Initial: _____

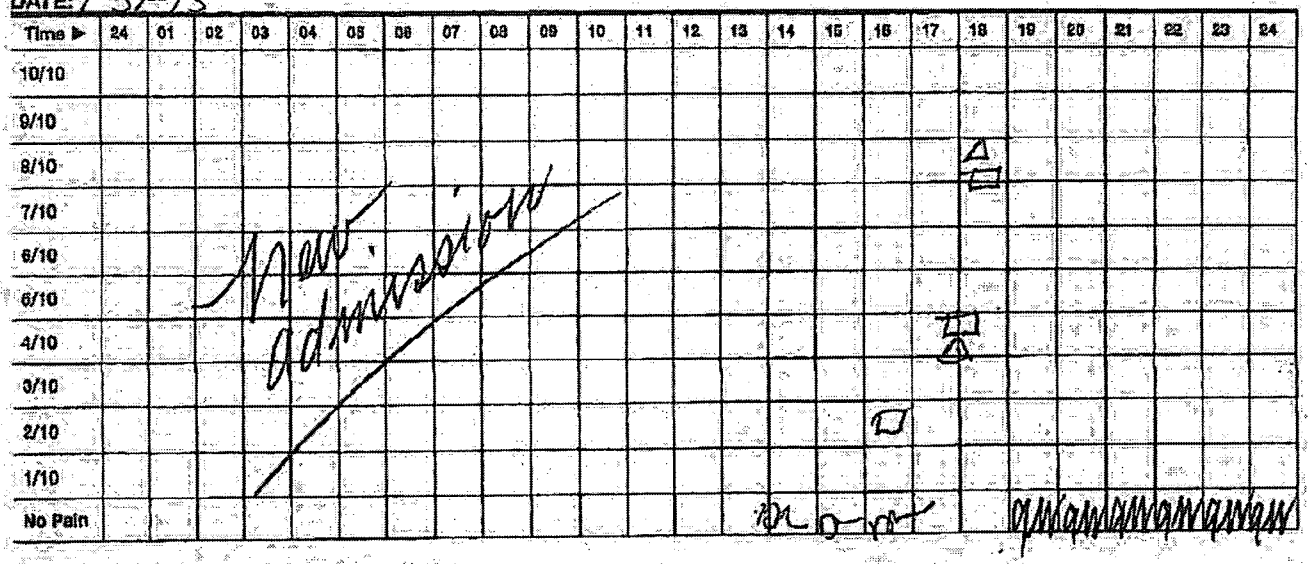
Rev. 7/2011 (Est. of POC) 220-CHS — WHITE COPY - HOSPICE RECORD AFTER SIGNED BY IDG — YELLOW COPY - FACILITY/HOME AFTER SIGNED BY IDG — PINK COPY - FACILITY/HOME UNTIL SIGNED BY IDG

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Parrott, Delila MRN: 710111
DOB: REDACT 80y/o MPIPU
ADM: 1/31/2015 DX: Schizophrenia
GTV: 1484684

IPU NARRATIVE NURSES NOTES

DATE: 1-31-15



Legend: △=Pain; O=Nausea; □=Anxiety; X=

Initial	Signature	Initial	Signature
DA	DAYCHER RN	AW	Anna Williams, RN

1340 Pt admitted to IPU. See adm assessment —— DA
1615 medicated c Ativan 1g PO for anxiety & daughters request. Pt restless & furrowed brow. shakes her head no when asked if she is having pain —— A
1620 Dr Hall in to eval. —— DA
1735 Pt trembling, anxious. numbing incoherently. medicated c morphine 2g IV for pain. Family to bs. —— A
1800 med ineffective. Pt yelling out loud c eyes closed. Incoherent. Discussed c Dr Hall. Additional 5g morphine given IV. Daughter wonders if she is having an adverse reaction to ativan but states Pt has never happened before when she had it —— A
1830 Assumed care for patient. Complete physical assessment performed. PPS = 20% hx admission; Symptoms and POC evaluation on-going. prn Ativan 1mg given x1. Prn Morphine given x2; 2mg and 5mg respectively —— A

on day shift. ~~~~~ Ann Williams, RN

Parrott, Delila MRN: 710111
DOB: REDACTE 80y/o MPIPU
ADM: 1/31/2015 DX: Schizophrenia

PREHENSIVE ADMISSION ASSESSMENT

Patient GTV: 1484684 | MR # | Date (mm/dd/yyyy) 1-31-15

Other Specific Education/Instruction Provided	Pt	*Cg/PS	Understanding Verbalized	Further/On-Going Teaching Needed, See POC
Medication	☐	☑	☑	☐
Administration	☐	☑	☑	☐
Side Effects	☐	☑	☑	☐
Risks & Benefits	☐	☑	☑	☐
Effectiveness	☐	☐	☐	☐
Drug Disposal	☐	☑	☑	☐
BM Regimen for Opioid Use	☐	☐	☐	☐
Skin/Wound Care	☐	☐	☐	☐
Appropriate use of Supplies	☐	☐	☐	☐
Encourage to call hospice for change in condition	☐	☐	☐	

Additional teaching not included in the body of the note:

*CG Name: *PS Name:

Comments:

SPECIFIC PREFERENCES

Preference Discussed	Preference Yes	Preference No	Undecided*	Refused to Discuss*
DNR	☑	☐	☐	☐
Antibiotics	☐	☑	☐	☐
Artificial Feedings	☐	☑	☐	☐
Infusions	☐	☑	☐	☐
Lab/Diagnostics	☐	☑	☐	☐
ICD Deactivated ☑ NA	☐	☐	☐	☐

CURRENT CODE STATUS

☑ No Code
☐ Full Code

"Do you want cardiopulmonary resuscitation if your heart and lungs stop working?" ☐ Y ☑ No ☐ Refused to discuss
"Do you want life-sustaining treatments other than CPR if your heart and lungs stop working?" ☐ Y ☑ No ☐ Refused to discuss
"Do you want to avoid hospitalization if your condition worsens?" ☐ Y ☐ No ☐ Refused to discuss

Was the patient/responsible party asked about preferences regarding the use of cardiopulmonary resuscitation (CPR)? ☐ No ☑ Yes ☐ Yes, but the patient/responsible party refused to discuss.
Information provided by: ☐ Pt ☑ Responsible Party Joan (daughter)
☐ Cultural preferences
☐ Comfort measures, specifically
☐ Other
☐ Benefit/burden of preference discussed, explain outcomes
☐ Benefit/burden of preference not discussed, explain
*Document conversation and follow-up plan

☐ Completed on Initial Assessment

REASON FOR ADMISSION

What prompted this admission? declining condition
How has the patient changed in the last 3-12 months? requires total care c ADLs
What could the patient do previously that now requires assistance?
Has the patient's "home" changed due to care-related needs?
Multiple ER visits/hospitalizations over previous 6 months (include dates, reasons and locations of visits/admissions)

Additional Comments:

SERVICES EXPLAINED AND OFFERED

Service	Yes	No	Accepted	Declined at this Time	Service	Yes	No	Accepted	Declined at this Time
Hospice Aide	☐	☐	☐	☐	Bereavement	☐	☐	☐	☐
Volunteer	☐	☐	☐	☐	Other	☐	☐	☐	☐

ASSESSMENT SUMMARY: 80y/o F c/o SOB & focus on arrival, minimal verbal response due to expressive aphasia. Daughter reports increased agitation, hallucinating & paranoid behavior. (+) confusion but recognizes family. Requires total care c ADL's. Bedbound. Incontinent. Decreased appetite - refusing to eat. Stage II wound on sacrum. Occasional pain in (L) hip, RUE + shakes. (+) footdrop. Travel in area

1/31/15
RN Signature/Title Date

White: Medical Record
Yellow: Patient
Pink: Facility

Nursing Comprehensive Admission Assessment
Page 1 Out 10

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Form HOS4178-HC

NURSING NUTRITIONAL SCREENING

Parrott, Delila MRN: 710111
DOB: REDACTED 80y/o MPIPU
Pa ADM: 1/31/2015 DX: Schizophrenia
GTV: 1484684
Terminal Diagnosis: _____

_____ MR# _____ Date: 1-31-15

Clinical Assessment

One (1) Point

____ Diabetes - controlled
____ GI motility or absorption disorder
____ Renal failure - only abnormal lab
K 5.5, Phos 5.5, BUN 100
____ Severe Anemia; only abnormal labs
HGB <9.0, depressed HCT, MCV, MCHC
____ Shortness of breath, decreased ability to eat or drink
____ Dry mouth, sore mouth, alteration in smell or taste
____ Special diet (specify)_____
____ Diarrhea lasting more than 5 days
____ Nausea or vomiting more than 3 days per week
____ Oral intake less than 50% of usual for 10 days
____ Involuntary weight loss in past 6 months
✓ Pressure ulcers/wounds (Stage I & II)
____ Chewing difficulties
____ Impaired swallowing

Two (2) Points

____ Diabetes - uncontrolled
____ Active AIDS
____ Pressure ulcers/wounds (stage III & IV)
____ Cancer of oral pharynx and/or GI tract
____ Major burns (recent)
____ Lab: Albumin 3.0 or less
____ COPD dependent on oxygen
____ Pitting edema (3+ - 4+)

Three (3) Points

____ Lab: Albumin 2.6
____ Enteral nutrition
____ TPN
____ Other_____

_____ **Total Points**

Guidelines for Referral

Key for Points

Less than 5 points
No Dietician referral at this time

5-6 Points
Nurse/Dietician telephone consult.
Dietician will make recommendations

7 Points
Refer to Dietician to make visit per IDG discussion

- Refer to Dietician at patient request

☐ Patient/Family decline dietary consult

Comments: pt c schizophrenia, depression. stopped eating for 2-3 wks

Plan: Diet as tolerated

RN Signature: Denise Kramer Date: 1-31-15

Hospice 121

Rev. 10/2011 (Nrsng Nut'l Screening) 108-CHS WHITE COPY - HOSPICE YELLOW COPY - FACILITY/HOME

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Patient Name: Delila Parrott MR#: 710111 Date: 2/1/15

INITIAL BEREAVEMENT RISK ASSESSMENT (*see HETB)
(Factors to include social, spiritual & cultural)

1 Primary Caregiver: Joan Acosta Relationship to Pt: dtr/POA Address for Contact: 12 Arrowcrest Pl. Columbia SC 29229
Phone Number: 803-331-6342

2 Primary Caregiver: Bert Chestnut Relationship to Pt: Son Address for Contact: Florence SC
Phone Number: 843-615-5030

	1	2
# of Strengths	7	
# of Complicators	4	
Risk Level	Mod	

*Risk Levels

Low	Complicators < Strengths
Moderate	Complicators ≥ Strengths
High	Complicators 2x ≥ Strengths

Complicated Grief Describe: (i.e., multiple/recent losses, ambivalence towards Pt, low self-worth, depression, etc.)
Cg seems to have an interdependent relationship w/ pt. per staff observations. Pt wants to die, but Cg plans to look for SNF placement

Volunteer Services

☐ Requested Purpose:

ADDITIONAL CONSIDERATIONS:
☐ Dependent Children In Home
☐ Dependent Elderly In Home
☐ Disabled Adult In Home
☐ Unsafe Social/Emotional Environment
☐ Pt placement needs (i.e., nursing home, IP, DC, etc.)
☐ None identified

SELF-DETERMINATION OF LIFE CLOSURE:
(Pt-Elected Healthcare Decision Maker, i.e., POA**/Proxy**/Surrogate**, etc.)
☐ Pt has an elected healthcare decision maker
☑ Pt does not have an elected healthcare decision maker — None identified
☐ Assistance requested
☐ Assistance declined
☐ Pt lacks capacity to elect healthcare decision maker
☐ Funeral Home: McAllister ☐ Burial ☐ Cremation ☐ Assistance Needed:

ADVANCE DIRECTIVE**/LIVING WILL**
☐ Pt has an Advance Directive/Living Will
☑ Pt does not have an Advance Directive/Living Will — None identified
☐ Assistance requested
☐ Assistance declined
☐ Pt lacks capacity to execute an Advance Directive/Living Will

CODE STATUS:
☑ Pt has a completed DNR**
☐ Pt does not have a completed DNR
☐ Assistance requested
☐ Assistance declined
☐ Pt lacks capacity to complete DNR process

**Copy must be obtained

NARRATIVE SUMMARY OF FINDINGS: Pt is 80 yo old white female admitted to IPU for management of pain & anxiety. Pt lives previously living in Cobblestone Plantation ALF but has had 1 weakness, decreased appetite and general wanting to die. Pt has hx of schizophrenia & unverbalized symptoms for 5+ yrs. Pt may need LTCF placement, but Cg wants to visit some places before making decision. Pt has 3 children, but primary decision maker is Joan

☑ The Plan of Care was reviewed, and understanding and agreement was verbalized by the Pt/Primary Caregiver/Facility staff: Joan Acosta / dtr (Name) (Relationship to Pt/Title)

☑ Visit frequency will be 2 x wk

Catherine Kelly Mahon Rogers LMSW — 2/1/15
Signature/Title — Date

Hospice 124

Page 2 of 2

Rev. 10/2011 (SW Comp Assess 2) 229.2-CHS WHITE COPY - HOSPICE YELLOW COPY - FACILITY/HOME PINK COPY - HOSPICE STAFF

124

ROA 1608

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SOCIAL WORK COMPREHENSIVE ASSESSMENT

When completing this assessment, refer to the Hospice Eligibility Toolbox (HETB)

Patient Name: Delila Parrott MR#: 71011 Date: 2/4/15 Time In: 1145 Time Out: 1230

Terminal Diagnosis: Schizophrenia Age: 80 Sex: ☐ M ☒ F Ethnic Identity: W

Patient Location: ☐ Home ☒ Inpatient Facility ☐ SNF ☐ ALF Level of Care: ☐ Routine ☐ Inpatient (GIP) ☐ Respite ☐ Continuous Care (CC)

Attending Physician: Delnes Detrault Life Occupation:

PAIN *see HETB

*PAINAD Scale Score: 0

(circle highest acceptable to Pt)

0 (None) 1 2 3 4 5 6 7 8 9 10 (Worst)

___ Now ___ Worst in past 24 hrs ___ Avg in past 24 hrs

☐ Pain is > pt's highest acceptable level, RN notified

Comments: Pt unresponsive for assessment, no s/s of pain at time of visit

SYMPTOMS AFFECTING THE PTS QUALITY OF LIFE (check all that apply)

CIRCLE RATER: Patient / Caregiver / Hospice Clinician

Nausea ___ Anxiety ___ SOB ___

Behavior ___ Patient Well-Being ___

Caregiver Well-Being ___ Vomiting ___

Fatigue ___ Depression ___ Drowsiness ___

Sleep ___ Appetite ___ Level of Acceptance ___

None Identified ___

Other ___

NEURO/COGNITIVE/BEHAVIORAL *see HETB

*Mental Status: Oriented to: ☐ person ☐ place ☐ time ☐ season

☐ Inattention ☐ Disorganized thinking

☐ Altered LOC ☐ Psychomotor Retardation

Behavior: (If these behaviors are observed, report to RN)

☐ hitting ☐ kicking ☐ pushing ☐ scratching

☐ grabbing ☒ No problem noted at this

☐ threatening others ☐ screaming ☐ cursing

☒ No problem noted at this

*Cognitive Skills for Daily Decision Making

☐ Independent ☐ Modified Independence

☐ Moderately Impaired ☒ Severely Impaired

PSYCHOSOCIAL WELL-BEING – SOCIAL/EMOTIONAL FACTORS

COPING:

Patient		Caregiver
☐	Denial	☐
☐	Anger	☐
☐	Avoidance	☐
☐	Mixed Emotions	☐
☐	Suicidal Ideation	☐
☐	Loss of Interest in Life	☐
☐	Unprepared for Approaching Death	☐
☐	Lack of Emotion	☐
☐	Dependent Personality	☐
☐	Lack of Tolerance	☐
☐	Multiple Losses	☐
☐	Substance Abuse	☐
☐	Mental Health Problems	☐

Describe healthy coping strategies:

(Pt/Cg) ___

COMMUNICATION:

Patient		Caregiver
☐	Withdrawn	☐
☐	Irritable	☐
☐	Overwhelmed	☐
☐	Adequate Methods (see below)	☒

Describe healthy communication exhibited:

(Pt/Cg) Cg is meeting appropriate communication, but has reported

ADJUSTMENT:

Patient		Caregiver
☐	Sad	☐
☐	Depressed	☐
☐	Lonely	☐
☐	Afraid	☐
☐	Stressed	☒
☐	Tearful	☒
☐	Anxious	☐
☐	Withdrawn	☐
☐	Overwhelmed	☐
☐	Realistic Adjustment (see below)	☐

Describe current functional adjustment exhibited:

(Pt/Cg) Cg seems to understand pt's needs and limitations but is unsure how to proceed

FAMILY DYNAMICS

Patient		Caregiver
☐	Marital Discord	☐
☐	Estranged	☐
☐	Unavailable	☐
☐	Domestic Violence	☐
☐	Closed Family System	☐
☐	Functional (see below)	☐

Describe supportive family dynamics exhibited:

(Pt/Cg) Pt's 3 children were gathered at Pt's request. At least 1 dtr has psychiatric issues of her own

FAMILY SUPPORT SYSTEM

☐ No Primary Caregiver ☐ Private Caregiver

☐ No Local Family Available ☐ Guardian

☐ Other: ___

Describe active family support system in place:

Pt's 3 children were at bedside

SOCIAL SUPPORT SYSTEM

☒ Faith-based affiliation Baptist

☐ None

☐ No social network

☐ No community involvement

☐ Cultural Isolation

Describe Pt/family report of satisfactory social support system(s): Pt unresponsive

FINANCIAL ISSUES

☐ Lack of income to meet basic needs

☒ Other: Pt has LTC insurance but will need SNF placement possible

Describe Pt/family report of adequate financial resources: ___

Parrott, Delila MRN: 710111 MR#: Date: 2-2-15
DOB: REDACTE 80 y/o MPIPU
ADM: 1/31/2015 GTV: 1484684
Dx: Schizophrenia

pt was resting comfortably in bed this morning requested prayer for the mental pain she is suffering. She said pt was raised with pt in the Baptist church and her mother Kenneth was a Baptist minister. pts daughter was very tearful and said she is not prepared for her mothers to die. I talked with her about prayer with pt and strength. She was encouraged to pray and continue to believe up to the very end for pt and daughter.

The Plan of Care was reviewed, and understanding and agreement was verbalized by the Pt/Primary Caregiver/Facility staff

Visit frequency will be 2-3 x/ wk

[Name] / dtr [Relationship to Pt/Title]

Signature/Title OCC

2/2/15 Date

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Parrott, Delila MRN: 710111
DOB: REDACTE 80y/o MPIPU
ADM: 1/31/2015 DX: Schizophrenia
GTV: 1484684

INPATIENT PHYSICIAN ORDER

MR#: _____ DATE: _____ TIME: _____

	Indication	Hospice Covers
1/31/15 0305 24 hour chart audit — Robinson, RN		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

24° CHART CHECK DATE: _____ TIME: _____ INITIALS: _____

☐ TELEPHONE ☐ VERBAL ORDER OF: DR. _____ DATE: _____
REC'D BY: _____
☐ TELEPHONE/VERBAL ORDER RECEIVED & READ BACK _____ (NURSE INITIALS)
A review of medications was performed including prescription, over the counter, herbal remedies and other alternative treatments, both related and non-related, regarding: effectiveness of the drug therapy, side effects, actual or potential drug interactions, duplicate drug therapy, those associated with laboratory monitoring and noncompliance with drug therapy.
PHYSICIAN'S SIGNATURE: _____ DATE: _____

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Parrott, Delila MRN: 710111
DOB: REDACTE 80 y/o MPIPU
ADM: 1/31/2015 GTV: 1484684
Patient Name: Dx: Schizophrenia

INPATIENT PHYSICIAN ORDER

MR#: _____ DATE: _____ TIME: _____
Allergies: _____

	Indication	Hospice Covers
02/03/15 D/c all PO meds		☐ Yes ☐ No
810 AM Morphine 5 mg IV/SQ Q4hº ATC	Y	☐ Yes ☐ No
Morphine 5-10 mg IV/SQ Q1hº PRN pain or dyspnea	Y	☐ Yes ☐ No
Lorazepam 1 mg IV/SQ Q1hº ATC	Y	☐ Yes ☐ No
Lorazepam 1-2 mg IV/SQ Q1hº PRN anxiety or agitation	Y	☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

24° CHART CHECK DATE: _____ TIME: _____ INITIALS: _____

☐ TELEPHONE ☐ VERBAL ORDER OF: DR. _____ DATE: _____
REC'D BY: _____
☐ TELEPHONE/VERBAL ORDER RECEIVED & READ BACK _____ (NURSE INITIALS)
A review of medications was performed including prescription, over the counter, herbal remedies and other alternative treatments, both related and non-related, regarding: effectiveness of the drug therapy, side effects, actual or potential drug interactions, duplicate drug therapy, those associated with laboratory monitoring and noncompliance with drug therapy.
PHYSICIAN'S SIGNATURE: _____ DATE: _____

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INPATIENT PHYSICIAN ORDER

Patient Name: _____ MR#: _____ DATE: _____ TIME: _____
Allergies: _____

	Indication	Hospice Covers
2-4-15 0305 24 hour chart audit — Robinson, RN		☐ Yes ☐ No
02/04/15 A Morphine to 10 mg IV/SQ Q4hº ATC		☐ Yes ☐ No
1010 A Morphine to 10-15 mg IV/SQ Q1hº PRN pain or dyspnea		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

24° CHART CHECK DATE: _____ TIME: _____ INITIALS: _____

Orders Checked
2/4/15 1845

☐ TELEPHONE ☐ VERBAL ORDER OF: DR. _____ DATE: _____
REC'D BY: _____
☐ TELEPHONE/VERBAL ORDER RECEIVED & READ BACK _____ (NURSE INITIALS)
A review of medications was performed including prescription, over the counter, herbal remedies and other alternative treatments, both related and non-related, regarding: effectiveness of the drug therapy, side effects, actual or potential drug interactions, duplicate drug therapy, those associated with laboratory monitoring and noncompliance with drug therapy.
PHYSICIAN'S SIGNATURE: _____ Hospice 041 DATE: _____

Rev. 8/2011

Parrott, Delila MRN: 710111
DOB: REDACTE 80y/o MPIPU
ADM: 1/31/2015 DX: Schizophrenia
GTV: 1484684

HOSPICE *PHYSICIAN* MEDICAL GUIDELINES

(* other than Adult Failure to Thrive, Debility, Alzheimer's, Cancer, COPD, HIV, I

Patient Name: _____ Age: _____ MR #: _____ Benefit Period: ☐ 1st ☐ 2nd ☐ 3rd ☐ _____ / ☐ Diagnosis Change

Hospice Dx: _____ Start of Care: 1/31/15 Benefit Period Dates: 1/31/15 to 4/30/15 ☐* Face-to-Face Completed on _____

GENERAL GUIDELINES

☑ Life limiting condition | ☑ Patient / family have elected course of palliative care | ☑ Patient / caregiver / physician are in agreement on a course of palliative care

☑ Palliative Performance Scale (PPS) 30 Previous PPS 80 (7 months ago)

☐ Pain requiring increasing doses of (opioid) analgesics _____ Explain: _____

☑ Increasing emergency room visits, hospitalizations, or physician's visits over previous 6 months & / or last benefit period *related to the hospice diagnosis*

All Patients – Dependence in Activities of Daily Living – Evidenced by (narrative should show considerable effort required):

☑ Bathing ☑ Dressing ☑ Feeding ☑ Transfers ☑ Toileting ☐ Ambulation need assistance

Other Indicators of Decline: ☐ Sleeps > _____ hours in 24 hours

All Patients – Recent Impaired nutritional status – Evidenced by:

Maximum Adult Height 65" Current Weight 61 kg BMI 24.6 Previous Weight _____ (_____ months ago)

Mid Arm Circumference (non-dominant arm) _____ ☐ Unintentional progressive weight loss of 10% or more over past six months ☐ Serum albumin _____

☐ Cholesterol < 150 _____ ☐ Dysphagia, choking, poor oral intake ☐ Impaired nutrition despite PEG / Tube Feeding

Co-morbidities: If not the primary hospice diagnosis, the presence of disease such as the following, the severity of which is likely to contribute to a life expectancy of six months or less, should be considered in determining hospice eligibility:

☐ COPD ☐ CHF ☐ Ischemic heart disease ☐ Diabetes mellitus ☑ Neurologic disease (☐ CVA ☐ ALS ☑ MS ☐ Parkinson's) ☐ Renal failure

☐ Liver Disease ☐ Neoplasia ☐ Dementia (FAST _____) ☐ Other _____

OTHER TERMINAL ILLNESS

Observable and documented deterioration in overall clinical condition in the past 6 months as evidenced by any of the following:

☐ Serial physician assessments ☐ Multiple hospital / ER visits ☑ Progressive pressure ulcers ☑ Decline in functional status with a PPS of 40% ☐ Systolic BP 90

☑ Progressive dependence in ADL's ☐ Persistent nausea and vomiting ☑ Recent impaired nutritional status ☐ Weight loss ☐ Decreasing serum albumin (< 2.5)

☐ Malnutrition with BMI < 22 kg/m² ☑ *Combination of disease processes which, reviewed together, presents a picture of structural and functional impairment*

☐ Requires O_2 at rest ☐ declines artificial ventilation

NARRATIVE SUMMARY

To include History of Disease Progression to Date and effect of co-morbid conditions(if the patient does not meet the guidelines above, your summary must include the alternative factors that support the terminal prognosis):

80yo w/hx of progressive, accelerating schizophrenia requiring 24° care c aphasia, paranoia, admitted for failure to thrive c pt eating/drinking less over last several weeks & activity p hip fx 6/14 now c worsening sacral decubitus ulcer causing pain & diffuse bone pain & anemia of ? etiology

HOSPICE PHYSICIAN ATTESTATION

Based on these findings, it is my clinical judgment that this patient's prognosis is for a life expectancy of six months or less if the disease runs the normal course.

By signing my signature, I attest that I composed the above narrative based on my review of the medical record or, if applicable, my examination of the patient.

BRYNA KUCHAR HALL MD — Hospice Physician's Printed Name

Bryna Kuchar Hall MD — Hospice Physician's Signature

1.31.15 — Date by Physician

☐ FAXed to Attending Physician _____ on _____ by _____

01/01/11

Parrott, Delila MRN: 710111
DOB: REDACTED 80y/o MPIPU
ADM: 1/31/2015 DX: Schizophrenia
GTV: 1484684

NURSING REV (* other than Adult Failure to Th

OTHER TERMINAL ILLNESS* (ss, Parkinson's, Renal Disease, Stroke or Coma)

Patient Name: Delila Parrott Age: ___ MR #: ___ ☑ Certification / ☐ Re-Certification / ☐ Diagnosis Change

Hospice Dx: Schizophrenia Start of Care: 1-31-15 Benefit Period: 1 Dates: 1-31-15 to 4/30/15

OTHER TERMINAL ILLNESS GUIDELINES

History of Disease Progression to Date:
80 y/o F dx'd schizophrenia + worsening depression. Symptoms have been uncontrolled for 5 years. She is currently experiencing insomnia, hallucinations, paranoia, delusions + failure to thrive. She has been refusing to eat or rest 2-3 hrs. She c/o daily increased pain in shoulders, L hip + RUE. Comorbidities include HTN, ORIF (L) hip, macular degeneration, sleep apnea, DM.

Observable and documented deterioration in overall clinical condition in the past 6 months as evidenced by any of the following:
☐ Serial physician assessments ☑ Progressive pressure ulcers ☐ Systolic BP 90 ☐ Persistent nausea and vomiting ☐ Requires O2 at rest ☐ Declines artificial ventilation
☑ Palliative Performance Scale (PPS) ___ (should be ≤ 40%) Previous PPS ___ (___ months ago)
☑ Pain requiring increasing doses of (opioid) analgesics ___ Explain: ___
☑ Increasing emergency room visits, hospitalizations, or physician's visits over previous 6 months & / or last benefit period *related to the hospice diagnosis*

Dependence in Activities of Daily Living – Evidenced by (*narrative below should show considerable effort required & progressive dependence*):
☐ Bathing ☑ Dressing ☐ Feeding ☑ Transfers ☐ Toileting ☐ Ambulation
Other Indicators of Decline: ☐ Sleeps > ___ hours in 24 hours
Recent impaired nutritional status evidenced by:
Maximum Adult Height 5'1" Current Weight 67 kg BMI ___ Previous Weight ___ Previous BMI ___ (___ months ago)
Mid Arm Circumference (non-dominant arm) ___ ☐ Serum albumin ___ ☐ Cholesterol < 150 ___
☐ Unintentional progressive weight loss of 10% or more over past six months ☐ Impaired nutrition despite PEG / Tube Feeding
☐ Choking ☑ Poor / Decreased oral intake (currently ___ % of ___ meals per day / was ___ % of ___ meals / day ___ ago)
Co-morbid and secondary conditions that *directly* impact the terminal illness:
☐ *Combination of disease processes which, reviewed together, presents a picture of structural and functional impairment* ☐ COPD ☐ CHF ☐ Ischemic heart disease
☐ Diabetes mellitus ☐ Neurologic disease (☐ CVA ☐ ALS ☐ MS ☐ Parkinson's) ☐ Renal failure ☐ Dysphagia
☐ Liver Disease ☐ Neoplasia ☐ Dementia ☐ Other Schizophrenia, depression
IF PT TO BE RE-CERTIFIED: Memory re-call words "ball", "pencil", "brush"; ___/3 recalled after 5 minutes; ☐ result of 0 or 1 – pt referred to MSW for MMSE
Documentation of structural / functional impairments related to co-morbidities:

CURRENT CLINICAL PICTURE

(To include weight loss/ gain in time period, vital signs, shortness of breath, decreased level of consciousness, heart rhythms, rales, edema, etc in order to illustrate how the patient meets criteria qualifying for hospice care)
Alert, person + focusing on arrival. Minimal verbal response due to expressive aphasia. Recognizes family. NO signs of discomfort present. Resp. unlabored on RA. Daughter describes increased anxiety + confusion c visual + auditory hallucinations. Paranoid. Hx. Increasing pain in RUE, (L) hip + shoulders. Requires total care ADL's. Bradbound. Decreased appetite. Incont of bowel + bladder. #22 HL (D) AC. Hx of fx (L) hip. Fair ROM to sacrum + (R) buttock c skin tear.

RN Signature: Denise Kerr Date: 1-31-15 11/09/10

Parrott, Delila MRN: 710111
DOB: REDACTE 80y/o MPIPU
ADM: 1/31/2015 DX: Schizophrenia
GTV: 1484684

DIAGNOSES LIST

Pa _____ MRN#: _____ Date: _____

Terminal Diagnosis: INCLUDE IN LIST BELOW ☐ Initial IDG Meeting ☐ Diagnosis Change ☐ Additional Diagnosis

ALL of the patient's diagnoses (related and unrelated to the terminal prognosis) should be provided in the spaces below.

DIAGNOSIS	*NOT* RELATED* TO TERMINAL PROGNOSIS *(Must be explained below)*	RELATED* TO TERMINAL PROGNOSIS *(Provide ICD Code◆)*	CODE ENTERED ON CLAIM♦
1) SCHIZOPHRENIA DIAGNOSIS		295.80	✓
2) DECUBITUS ULCER	☑		
3) ANEMIA	☑		
4) HTN	☑		
5)	☐		
6)	☐		
7)	☐		
8)	☐		
9)	☐		
10)	☐		

HOSPICE PHYSICIAN'S DOCUMENTATION OF REASON NOT RELATED TO THE TERMINAL PROGNOSIS

DIAGNOSIS #: 2
REASON: 2° bed/wheelchair confined; not associated w the schizophrenia

DIAGNOSIS #: 3
REASON: ? etiology; not associated w schizophrenia

DIAGNOSIS #: 4
REASON: not contributing to the schizophrenia

DIAGNOSIS #:
REASON:

DIAGNOSIS #:
REASON:

*Related/Not Related is determined by the Hospice Physician ♦ Initial once Physician has signed & ICD Code of Related Diagnosis has been entered into the system

I have reviewed diagnoses and determined relatedness to the prognosis.
IS
Signature of Hospice Physician — Date: 1.31.15

♦ Signature of Coder — Date: 2/2/15

HOS4240 09/2013

Page ____ of ____

If additional space is needed, use second Diagnoses List (HOS4240)
White copy - Chart Yellow Copy - On-Call Pink Copy - RNCM

A. Okay. Yes. I believe she has been down for longer than that period of time. To get that level of BUN and creatinine, to start some skin breakdown and have that elevated a CPK, particularly if she was inside, it would take longer than 24 hours.

Q. Okay. Ultimately, the skin breakdown was

narrative

08/07/2014 00:00 TO 08/07/2014 23:59

Legend Charting

08/07/2014 00:10

Foley (1) 16fr

Urine Assessment = clear
Carter, Sara P., RN 08/07/2014 04:26

Urine Color = amber
Carter, Sara P., RN 08/07/2014 04:26

abrasion (1) right hip

abrasion (1) right hip
Inpatient Documentation,Appearance = clean, reddened, other-comment
Carter, Sara P., RN 08/07/2014 04:26

Notes: bruise

Inpatient Documentation,Wound drainage = none
Carter, Sara P., RN 08/07/2014 04:26

Inpatient Documentation,Interventions = open to air
Carter, Sara P., RN 08/07/2014 04:26

laceration (1) left wrist

Inpatient Documentation,Appearance = approximated, reddened
Carter, Sara P., RN 08/07/2014 04:26

Inpatient Documentation,Wound drainage = none
Carter, Sara P., RN 08/07/2014 04:26

Inpatient Documentation,Interventions = open to air
Carter, Sara P., RN 08/07/2014 04:26

08/07/2014 10:33

done (1) arm 20 gauge

done (1) [ended] left arm
Intervention = other-comment
Kirk, Julie P., RN 08/07/2014 15:27

Notes: iv infusing

Site Assessment = WNL
Kirk, Julie P., RN 08/07/2014 15:27

Foley (1) 16fr

Foley (1) [ended]

Necessity = need accurate urine output measurement, requires catheterization
Kirk, Julie P., RN 08/07/2014 15:27

Status = patent, secured to leg, unclamped
Kirk, Julie P., RN 08/07/2014 15:27

Urine Assessment = clear
Kirk, Julie P., RN 08/07/2014 15:27

Urine Color = amber
Kirk, Julie P., RN 08/07/2014 15:27

abrasion (1) right hip

abrasion (1) right hip
Inpatient Documentation,Appearance = open, reddened
Kirk, Julie P., RN 08/07/2014 15:27

Inpatient Documentation,Wound drainage = moderate amount
Kirk, Julie P., RN 08/07/2014 15:27

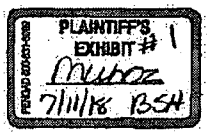
Notes: scant amount

Inpatient Documentation,Interventions = open to air
Kirk, Julie P., RN 08/07/2014 15:27

laceration (1) left wrist

Inpatient Documentation,Appearance = approximated, reddened
Kirk, Julie P., RN 08/07/2014 15:27


1224 Village Brook Ln
Google


PLAINTIFF'S
EXHIBIT # 1
Munoz
7/11/18 BSH

concerned?

A. That's all I remember --

Q. Okay.

A. -- right there.

Q. All right. When you came in at 5:00 PM on Wednesday, June 4th did anyone speak with you about Ms. Parrott?

A. No.

Q. All right. When you did not sign off on her would you just explain to me what that means? Or just tell me what that means?

A. It meant I couldn't get in touch with her. I couldn't get in her apartment. So, I did not see her and was not able to sign off on her.

Q. Okay. Do you recall after you did not see her did you go to her apartment on Wednesday, June 4th?

A. Yes.

Q. All right. Did you knock on the door?

A. Yes.

Q. Did you go into the apartment?

A. No, I couldn't get in.

Q. Okay. Why not?

A. The master key would not work.

Q. Okay. Had anyone told you that Ms. Parrott had a

different master key for her apartment?

A. At that time, no.

Q. Okay. All right. When the master key did not work did you make any other contact with anyone else about your inability to enter the apartment?

A. My mother.

Q. Okay. And that's Ms. Auld?

A. Beth Auld.

Q. And what -- how did you reach her or how did you speak with her about that situation?

A. I called her.

Q. Okay. And what did she say, if anything?

A. That Ms. Parrott had changed her locks.

Q. Okay. Did she mention anything about an additional key?

A. No.

Q. Okay. At the time, did you know that Premier/Sandpiper had a key to the apartment?

A. No.

Q. And obviously your mother as June -- as of June 4th did not know that there was a key to Ms. Parrott's apartment?

A. Correct.

Q. All right. Did you later find out there was a key to Ms. Parrott's apartment?

A. Yes.
Q. And where was that key located?
A. In the key box in the main building.
Q. All right. And who has -- did you have access to the key box?
A. Yes.
Q. All right. And was that key -- how was it marked, if any?
A. I think there were labeled by numbers. And there was a sheet on top of the key box that had the numbers -- the apartments with the numbers.
Q. Okay. Did either, excuse me, During your conversation with your mother did either one of you talk about following up with anyone else since the master key did not work?
A. I believe -- yes. I would've asked her to check on her the next day because she was working.
Q. Okay.
A. To make sure she checked on her the next day.
Q. All right. And do you know your mother's schedule on June 5th, Thursday?
A. I would assume, at that time, it would have been her regular schedule of 10:00 to 9:00 --
Q. Okay.
A. -- 10:30 to 9:00. I can't remember if it was

A. Or she went in the hallway and marked everybody off that she saw.

Q. Okay.

A. Or saw her walk by on her way to lunch.

Q. Okay. Are you aware that Ms. Parrott reported that she had fallen on Tuesday evening?

A. No.

Q. Okay. When you found Ms. Parrott what room was she in --

A. Her --

Q. -- when you --

A. -- bedroom.

Q. Okay. And was there a phone near by?

A. I don't remember.

Q. Okay. Did you notice a cell phone near by?

A. I don't remember.

Q. All right. She was not wearing her panic button?

A. I do remember that. Yes.

Q. All right. Okay. Did you ever speak with Ms. Waters about any concerns that she had about Ms. Parrott?

A. No.

Q. Okay. On Friday, June 5th what time did you eventually get to Ms. Parrott's room?

A. Around seven.

Nurse's Notes — *Roper St. Francis HealthCare Mount Pleasant*

Name: Delila Parrott
Age: 80 years Sex: Female DOB: REDACT
Arrival Date: 06/06/2014 Time: 21:14
Bed 2

MRN: 001787037
Account#: 1415701389
Private MD:

Diagnosis: Hip Fracture; Dehydration; Decubitus Ulcer, Pressure, (Buttock); Decubitus Ulcer, Pressure, (Hip); Bladder Infection (UTI)

Inbound Details:
Referred by: **Arriving by:** EMS **ETA:**
Who will see patient? ED Physician
Notes:
Notify referring provider: Do not notify

Presentation:

06/06 21:32 Transition of care: patient was received from home. — tm7

21:32 Method Of Arrival: EMS. — tm7

21:45 Care prior to arrival: See EMS report. Medication(s) given: 100 MCG OF FENTANYL ADMINISTERED PTA IV initiated. 20 LEFT FA Glucose check. 108. Mechanism of Injury: Fall PT WAS STANDING ON LAZY BOY TRYING TO FIX CURTIN. FELL TO THE FLOOR. DENIES LOC OR STRIKING HEAD. — ekk

Triage Assessment:

21:18 Presenting complaint per patient: Pt was found on the floor by a neighbor who checked on her. Unknown how long she was on the floor. Complains of left hip pain. Appears unkempt, Behavior is crying. **Pain:** Complains of pain in left hip. — tm7

21:36 Presenting complaint per patient: pt was given 100 mcg IV fentanyl by EMS prior to arrival. — tm7

Historical:

Allergies:

21:30 green vegetables; Chocolate; Aspirin; ACE INHIBITORS; all nasal sprays; NSAIDS; — tm7

Home Meds:

21:34 Diltiazem Oral ; Lomotil oral ; Propranolol Oral ; citalopram oral ; Tylenol #3 Oral ; Nexium Oral ; Furosemide Oral ; cyanocobalamin (vitamin B-12) oral ; Ceftin Oral ; — tm7

PMHx:

21:34 Atrial Fib; Hypertension; Anxiety; — tm7

- **Social history:** Smoking status: Patient/guardian denies using tobacco, but has a distant history of tobacco abuse.,.
- **Advanced Directives:** Patient has healthcare power of attorney, documentation unavailable. Patient/legal representative advised of need for copy to be obtained and placed on chart for Advance Directive to be honored The patient has a living will, documentation unavailable. Patient/legal representative advised of need for copy to be obtained and placed on chart or Advance Directive to be honored.

Screening:

21:32 **Abuse screen:** — tm7
Denies threats or abuse.
Fall Risk
Fall in past 12 months (25 points). Secondary diagnosis (15 points) No IV (0 pts). Ambulatory Aid- Crutches/Cane/Walker (15 pts). Gait- Impaired (20 pts.). Mental Status- Oriented to own ability (0 pts).
Suicide Screening:
Patient denies thoughts of harming self or others.
Tuberculosis screening:
No symptoms or risk factors identified. Denies unexplained cough, fever, night sweats, weight loss, or exposure to anyone with know TB infection.
C-Diff Screening:
Patient has not had any watery stools in the past 24 hours.

Assessment:

21:38 Appears uncomfortable, Behavior is cooperative, "I fell down on Tuesday and have been laying in the floor just hoping someone would find me. I think I broke my hip". — ekk

Print Time: 6/6/2014 07:40:30 *** CHART COMPLETE *** Page 1 of 3

Nurse's Notes Con't

21:39 GU: Noted on inspection; on arrival pt was saturated in foul smelling urine. Her underwear was stuck to her skin. Cleaned of incontinence, yellow and green think liquid coming from vaginal area. ekk

21:41 Musculoskeletal: Noted on Inspection: Deformity Bony deformity noted of pelvis and left hip. Skin: Bruising that is dark purple, on left leg. ekk

21:43 Skin: Decubitus located on right hip(s) approximately 7.6 cm to 20 cm other top layer of skin broken down, pt states she was in that same position since she fell tuesday. ekk

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Height	Pain	Staff
21:18	162 / 77	86	17	97.7	93%	68.04 kg	5 ft. 7 in. (170 cm)	9/10	lm7
22:00	149 / 67 (auto/)								
22:00		77 I:ON	16		95%				okk
22:15	148 / 67 (auto/)								ekk
22:15		79 I:ON	17		95%				ekk
22:30	155 / 65 (auto/)								ekk
22:31		83 I:ON	16		95%				ekk
23:27		83 I:ON	13		95%				ekk
23:30	151 / 64 (auto/)								ekk
23:38		83 I:ON	18		95%				okk
23:45	149 / 59 (auto/)							7/10	ekk
23:45		82 I:ON	14		94%				okk
									ekk

23:45 Body Mass Index 23.6 (68.04 kg, 170 cm)
23:38 Normal Sinus Rhythm ekk

Vitals: ekk
21:18 Acuity: Urgent.

lm7

Glasgow Coma Score:

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
21:18	spontaneous(4)	oriented(5)	obeys commands(6)		15	lm7

ED Course:

21:14 Patient arrived in ED.
21:16 Walters, John, MD is Attending Physician. ds8
21:18 Triage completed. jwf1
21:34 Patient has correct armband on for positive identification, for Fall Risk, Placed in gown. Bed in low position. Call light in reach. Side rails up X2. Verbal reassurance given. Pillow given. Elevated left hip Turned to right side. Repositioned patient. Assisted with dressing. Cleaned of incontinence. Linen changed. lm7 rs
21:36 Cardiac/NIBP/Pulse Ox monitor on. rs
21:38 Kell, Erin, RN is Primary Nurse. ekk
21:42 Maintain field IV. Dressing intact. Good blood return noted. Site clean & dry. Gauge & site: left forearm . ekk
21:42 Foley cath inserted 16 Fr. Balloon inflated. To gravity drainage. ekk
22:01 HIP XR UNILATERAL (CO M) 2 VIEW MIN In Process Unspecified. ED I:S
22:19 PCXR In Process Unspecified. ED I:S

Name: Delila Parrott MRN: 001787037
Account#: 1415701389

Print Time: 6/6/2014 07:40:00

Roper 6/6/2014 - 061

Nurse's Notes Con't

23:00 Call/page placed to Dr Mills. Time called 23:00. rs
23:00 Noise minimized. Lights dimmed. PO fluids given. Verbal reassurance given. Warm blanket given. ekk
23:01 Dr Mills. Returned call at 23:01. rs
23:41 UA Lab Sent. ekk
23:41 Urine Culture - Cath Sent. ekk
23:50 Add On Test-Spec In Lab Sent. ekk

Administered Medications:

Time	Drug & Dose	Route	Rate	Duration	Site	Delivery	Staff
22:41	NS 0.9% * 1000 ml	IV	bolus		existing IV site		ekk
23:00	Dilaudid [2 mg/mL] 0.5 mg	IVP			existing IV site		ekk
23:43	Follow up: Response: Pain is unchanged, physician notified						ekk
23:41	NS 0.9% * 1000 ml [1]	IV	125 ml/hr		existing IV site		ekk
23:41	Follow up: IV Status: Completed Infusion; IV Intake: 1000ml						ekk
06/07 00:16	Follow up: IV Status: Infusion continued upon admission/transfer						ekk
06/08 23:41	Rocephin (ADM) 1 grams	IVPB			existing IV site		ekk
06/07 00:16	Follow up: IV Status: Infusion continued upon admission/transfer						ekk
06/08 23:43	Dilaudid [2 mg/mL] 0.5 mg	IVP			existing IV site		ekk
23:51	Follow up: Response: Pain is decreased						ekk

1 - Note: PER DR. MILLS ORDERS.

Intake:

Time	PO	IV	Tubes	Total	Staff
23:41		1000ml		1000ml	ekk

Outcome:

23:12 Decision to Admit by physician. jwf1
23:46 ekk
Disposition pain rating: 2 / 10.
23:52 Patient left the ED. ekk
23:52 ekk
IVF Stop Time Documentation: IVF stop time already documented in Meds followup section. Admitted to Tele, accompanied by nurse, accompanied by tech, family with patient, via stretcher, on monitor, with chart, with SBAR form and copy of orders, Report called to SARAH, RN Pt. belongings with patient.
Condition: stable Instructed on need for admit. Demonstrated understanding of instructions, medications, verbalized understanding.

Signatures:

Dispatcher MedHost		EDMS	MACBRIDE, TAMARA, RN	RN	lm7
SMITH, RACHEL, EDT	EDT	rs	Walters, John, MD	MD	jwf1
STEPHENS, DANA, Reg	Reg	ds6	Kell, Erin, RN	RN	ekk

Name: Delila Parrott **MRN:** 001787037
Account#: 1415701369
Print Time: 6/6/2014 07:40:20 Page 3 of 3

Acct# 141570 1389

PRID:30486302 RPT#:0483361 Response District:5

Service: Charleston County EMS
Base: Medic 11
Unit: M11
Shift: AB-night
Tail/Reg: 4663
EMD: Yes, With Pre-Arrival Instructions - 17D03
Type of Svc: Scene/Unscheduled
Response Code: Delta
Mode to Ref: Lights / Sirens
Moved Via: Stretcher
Position: Supine
Outcome: Transported

Ref Other Type: *Assisted Living*
Location: SANDPIPER VILLAGE CARE
1224 Village Creek Ln
S6
MOUNT PLEASANT, SC 29464
Requester: Neighbor
Ref. GPS: 32.80E00,-79.8409

Date: June 6, 2014
Team: ALS
Crew 1: *Secondary Caregiver*
*Broccolo, Frank
EMT-P (SC0142127)
Crew 2: *Primary Caregiver*
McCarney, Anthony
EMT-P (SC0218961)

* designates an ALS Provider

Mode to Rec: No Lights/Sirens
Moved From: Stretcher
Pt. Condition: Improved

Receiving: *Hospital*
Mount Pleasant Hospital
Emergency Department
3500 Highway 17 North
Mount Pleasant, SC 29466-9123

843-606-7000
Dest. GPS: 32.877622,-79.767207
Rec. RN: Tammy

Last Name: Parrot First: Delila
Address: 1224 village creek ln
S6
City: Mount Pleasant ST:SC Zip:29464
County: Charleston
Citizenship: United States
Phone: (843) 216-1016
DOB: REDACT SSN: REDACTE
Age: 80y Sex: F Weight: 170 lb
Height:
Subscriber: No
Race: White, non-Hispanic
DNR Orders: None
Billing Information:

Company	Group	ID
medicare		REDAC A & B
State Farm		HB9137024040

Odometer		Times	
Start:	0.0	Received:	19:54
At Ref:	0.0	Dispatch:	19:55
At Rec:	7.9	EnRoute:	19:57
End:	7.9	First Resp:	20:04
Ld Miles:	7.9	At Ref:	20:04
Tot Miles:	7.9	Leave Ref:	20:46
		At Rec:	21:10
		Available:	21:23
		Med Control:	20:20

Notice of Privacy Practices Given: None
Consent Signed: No
PCS / Medical Necessity Signed: No
Primary Method of Payment: Medicare

Scene Information

Description: PT found laying R recovery position with incontinence and feces covering PT. PT is unable to extend her L leg.
Patient Belongings: Paperwork, 2 pillows left in ER with PT.
Other Agencies: Fire Fire Number: MPFD

Chief Complaint (Category: Fall Victim)

L Hip Pain 8-10

Duration: 1 Days
Anatomic Location: Extremity - Lower

Secondary Complaint

Fall

Duration: 1 Days

Chief Complaint (Category: Fall Victim)

History of Present Illness

U/A EMS Found 80yo F AAOx3 laying on the floor between her bed and a dresser. PT shows no signs of distress and is able protect her airway with adequate respirations. CC L Hip pain secondary to a fall. PT states she was attempting to hanging her curtains and fell. Unknown if PT was standing on the lazy boy chair under the window where she was hanging curtains. PT states she is unable to straighten her L leg due to Pain in her Hip an thigh. PT states she has been on the floor since Tuesday but neighbors state they saw her walking around yesterday. PT denies any CP, SOB, weakness, dizziness, neck or back pain. No pain upon palpation of neck and back. Pain upon palpation of hip and leg with no crepitus. EMS is unable to move leg without pt screaming in pain. Vitals above. 20g IV established in L forearm by Fire personnel. 4 lead EKG indicates NSR with no ectopy,. PT has Allergy to ASA, and Ace inhibitors. RMPH contacted for med order. Per Dr John Walters, 50mcg Fentanyl approved via IV push with second dose of 50mcg Fentanyl if needed. 12 lead EKG indicates NSR with no ST elevation or Ectopy. PT administered 50mcg Fentanyl with TKO flush NS. Pain improves to 5-10. PT picked up with Scoop stretcher. Voids padded with 2 pillows and blankets. PT carried to stretcher, Secured with 3 straps. PT placed on Oxygen at 2 LPM via NC. PT transported in position of comfort to RMPH. En route second dose of 50mcg Fentanyl administered IV push with TKO flush NS. Pain drops to 2-10. En route hospital updated with no additional questions or orders. U/A PT moved to ER bed 8 where turnover conducted and PT care transferred to ER staff. PT is unable to sign PCR, witnessed by nurse, Dr. Walters Signs drug order. ASM

Medical History	Current Medications	Allergies
Hypertension Unknown Cardiac	Acetaminophen Cefuroxime Citalopram Cyanocobalamin Diltiazem Furosemide Nexium Propranolol	ACE Inhibitors All Insids asa Chocolate nasal sprays

Neurological Exam

Level of Consciousness: Alert
Loss of Consciousness: Unknown
Chemically Paralyzed: No
Stroke Scale: Cincinnati Negative
Neurological Present: Normal
Mental Present: Normal

Glasgow Coma Scale			
	E	V	M	Tot
Int:	4	5	6	= 15

Revised Trauma Score: 12.00

	Motor	Sensory
LA:	Normal	Normal
RA:	Normal	Normal
LL:	Flaccid	Normal
RL:	Flaccid	Normal

Airway

Status: Patent

Respiratory

Effort: Normal

Cardiovascular

Pulses	Left	Right
Carotid:		
Radial:	Normal	
Femoral:		

Injury Details

Reason for Encounter: Injury/Trauma

Drugs/Alcohol?: None
Fall Height: 0 FT
Fall Surface: Hard
Injury Cause: Fall

Initial Physical Findings

Assessment Tubes/Drains:

Skin Findings:

Impression / Diagnosis

System: Musculoskeletal
Symptoms: Pain
Impression: Traumatic injury
Initial Patient Acuity: Lower Acuity (Green)

Activity

Time	H.R.	B.P.	MAP	SpO2	Resp	Rhythm	GCS	ECG Method	Prtcl	Pain	CRM*
	H.R. Method	Method	LOC		Resp Effort	Stroke Scale					
Action	Comment										
20:15									General Medical	8	#1
Cardiac	Current Lead: II Cardiac Monitor performed by Anthony McCarney. Successful. Authorization: Via Protocol. Pt. Response: Unchanged.										
20:17	95	150 / 70		97	20		4/5/6		General Medical	8	#1
	Electric Monitor - Cardiac	Auto. Cuff	Alert		Normal	Cincinnati Negative					
Vitals Signs											
20:18									General Medical		#1
Initiate IV	Peripheral IV initiated by Other with 20ga. at left Forearm. Attempts: 1, successful. Authorization: Via Protocol. Pt. Response: Unchanged. Fire personnel										
20:19									General Medical		#1
Labs	Lab Values obtained by Frank Broccolo. GLU: 108. Authorization: Via Protocol.										
20:20									General Medical		#1
Resp. Notify	Alert sent by Anthony McCarney via Sonic. Requesting Med orders 50mcg fentanyl to max 300mcg if needed.										
20:25									General Medical		#1
Cardiac	12-lead Analysis Status: Started 12-Lead EKG performed by Frank Broccolo. Successful. Authorization: Via Protocol.										
20:30									General Medical	8	#2
Med.	Dr Walters Fentanyl, 50 MCG via IV - Push given by Anthony McCarney. Authorization: Pt. Response: Improved. Dr Walters approved 50mcg Fentanyl										
20:31	96	148 / 75			20		4/5/6		General Medical	5	#1
			Alert		Normal						
Vitals Signs											
20:43	93	158 / 75		95					General Medical	5	#1
Vitals Signs											
20:53									General Medical	5	
Med.	Fentanyl, 50 MCG via IV - Push given by Anthony McCarney. Authorization: Pt. Response: Improved. Dr Walters approved 50mcg Fentanyl										
20:55	90	154 / 67		93	18		4/5/6		General Medical	2	#1
					Normal						
Vitals Signs											
21:00									General Medical	2	
Airway	Oxygen Initiated at 2 via NC. Performed by Anthony McCarney. Authorization: Protocol.										
21:05	90	150 / 70	97	97	18				General Medical	2	#1
		Auto. Cuff			Normal						

* Assessment made by

Mount Pleasant Hospital

ADMISSION RECORD

MED REC #	ADMISSION DATE/TIME	DISCHARGE DATE/TIME		SERVICE	STATION	ROOM NO	PAT TYPE	F.C.	G/ACCT #
001787037	08/06/14 2320			MED	DRD	3109-01	IND	4	01157-01389

PATIENT

LOCATION(S)	REG.	PAT. CLA	PUBLICITY	LNG	SEX	RACE	MAR	DATE OF BIRTH	AGE
ERD	PVT		I N	E	F	W	M	REDA	80

PATIENT NAME AND ADDRESS
PARROTT,DELILA WILSON
1224 VILLAGE CREEK LANE
APT 86
MT PLEASANT SC 29464

SOC SEC NO: REDACT
PATIENT TELEPHONE NO.: (843)881-1692

EMPLOYERS

PATIENT EMPLOYER: RETIRED
EMP. STAT: SS
TELEPHONE NO.:

GUARANTOR

GUARANTOR NAME AND ADDRESS
PARROTT,DELILA WILSON
1224 VILLAGE CREEK LANE
APT 86
MT PLEASANT SC 29464

SOC SEC NO: REDACTE
TELEPHONE NO.: (843)881-1692
SELF

GUARANTOR EMPLOYER: RETIRED
SC
TELEPHONE NO.:

INSURANCE

INSURANCE 1
MEDICARE
2300 SPRINGDALE DRIVE PO BOX 7004
CAMDEN SC 29020
REDAC
PARROTT,DELILA W HA

INSURANCE 2
STATE FARM
PO BOX 3070
NEWARK OH 43058-3070
PLAN #
HB9157026040
PARROTT,DELILA;W HA

MISC

IN CASE OF EMERGENCY NOTIFY
CONNOR,JUNE DAUGHTER
HM: (843) 814-1696 WK:

SPOUSE
ACOSTA,JOAN DAUGHTER
(H: (803)331-6242 WK: (803)331-6342

ADM DIAGNOSIS/PRESENTING COMPLAINT: LEFT HIP PX & DISLOCATION
ARRIVAL MODE: AMBULANC
ADM TYPE/SOURCE: 1 / 1

ADMITTING DOCTOR	ATTENDING DOCTOR	REFERRING DOCTOR	PRIMARY CARE DOCTOR
MILLS-MD,RICHARD R	MILLS-MD,RICHARD R	MILLS-MD,RICHARD R	MILLS-MD,RICHARD R

ALERTS	PREVIOUS ADM DATE	OPT OUT	DR	PHD	MKT	PHN MSG	PRIMARY	ALT.		BY
NO KNOWN	10/10/13		No		XX		Yes			CEB

FOR EMERGENCY DEPARTMENT USE ONLY
ALLERGIES | LMP# | TEMP # | RESP# | PULSE# | BP# | TIME | SIGNATURE

PRINCIPLE DIAGNOSIS | DRG

OTHER DIAGNOSIS(ES) | CODE(S)

PRINCIPAL OPERATION/PROCEDURE

OTHER OPERATION(S)/PROCEDURE(S)

Inpatient MP

003 D001787037 D14157-01389

☐ OPERATIVE SUMMARY DICTATED ☐ DISCHARGE SUMMARY DICTATED PHYSICIAN SIGNATURE: _____ DATE _____

MRN: 001787037 DOB: REDACTED
PARROTT,DELILA WILSON
Mt Pleasant ERD
PHYS: WALTERS-MD,JOHN

ACCT#: 14167-01389 06/06/14

Consent For Treatment
Mt. Pleasant Hospital

PART II

Consent to the Use and Disclosure of Protected Health Information

YOU agree to honestly, completely, and correctly provide all requested information and permit the **HOSPITAL** to share your medical record as applicable under the law with your physician, your insurers, Medicare, Medicaid or their designated agents. They may review your record, copy it in full or in part in order to obtain billing and payment information and for insurers (private or government) to determine whether your services are covered by them. YOU agree to allow the **HOSPITAL** to use your record made during this visit at this time or later to meet its required reporting duties regarding your care and to collect payment for the services YOU received. YOU agree for your doctor to direct copies of your medical records to other physicians, hospitals, and other healthcare facilities, as they deem necessary for continuity of care. YOU also agree to have your name posted on scheduling boards and outside your hospital room.

Specific uses of your protected information

The **HOSPITAL** originates and maintains health records describing your health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. This information serves as:

- A basis for planning care and treatment.
- A means of communication among the many health professionals who contribute to your care (this includes posting your name on scheduling boards or outside your patient room)
- A source of information for applying diagnosis and surgical information to your bill
- A means by which a third-party payer (usually your insurance company or the government) can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

Your signature below acknowledges that YOU received the Roper St. Francis Healthcare Notice of Information Practices that provides a description of information uses and disclosure practices. YOU accept and understand that YOU:

- Have the right to review the NOTICE prior to signing this consent.
- Accept that the **HOSPITAL** reserves the right to change the NOTICE and its information practices, for past, current, or future information. The new notice will contain the effective date on its first page and be made available on our Web site.
- Have the right to object to the use of your health information for the **HOSPITAL**'s patient directory.
- Have the right to request restrictions on the use or disclosure of your health information to carry out treatment, payment, or healthcare operations and to correct error(s) in your record. The **HOSPITAL**, however, is not required to agree to the restrictions requested.
- May revoke this consent in writing that YOU provide to the HOSPITAL. The revocation does not apply to any uses of your information made by the **HOSPITAL** in reliance upon this consent form and on the belief that your consent was still effective.
- Your signature acknowledges that YOU have been provided with information regarding the Lewis Blackman Patient Safety Act and the **HOSPITAL**'s Patient Assistance Program as found in the RSFH Patient Handbook.

I CERTIFY THAT I HAVE READ (OR HAD READ TO ME) PART I AND PART II AND FULLY UNDERSTAND AND AGREE TO THE CONTENT.

Patient/Agent Signature: _____ Date/Time 6/6/14 9:19pm

Print Name: _____

If agent, what is relationship to patient? _____
Parent, guardian, legal representative

_____ Date/Time _____
Witness (when form is accepted verbally, by telephone or by electronic means)

Revised 3/06; 1/09; 1/10; 9/10; 1/11; 4/11; 3/12; 11/13

Patient arrived via EMS. Patient is unable to sign. Family not present. DS

OneContent: Generated By coffje1

FAXED

PARROTT,DELILA WILSON
Pati PHYS: WALTERS-MD,JOHN
DO
MD ACCT#: 14157-01388 DSR:9/14
Rm: Tele ICU
Fax Numbers: Roper / MPH 724-1040
USSF 402-1550

Patient Status - Certification
Physician Order

Questions contact Utilization Review at: Roper 286-0462 / BSSF 729-1654 / MPH 991-2329 or 286-0462

☒ **Inpatient Order & Certification** (In accordance with 42 CFR 412.3)
Expected LOS is 2 midnights or greater due to medical necessity.

Diagnoses: hip fx ; dehydration

Admit to: med / tele

Clinical Reasons for Inpatient admission:

Signs/Symptoms:
Significant History: see H&P
Co-Morbidities:
Risk for adverse outcomes:

Discharge plans/instructions will be delivered to the patient prior to discharge and include appropriate follow up services, medication instructions and care transition instructions as needed.

☐ **Outpatient with Observation Services Order**

Diagnoses:

Admit to:
ER or Direct Admissions whose LOS based on medical necessity is NOT anticipated to span 2 midnights.

☐ **Outpatient Order**
All procedures NOT designated as inpatient only.

Universal Patient Care Orders
- ✓ Initiate Rapid Response Team/Stroke Team as appropriate & notify MD of patient's condition
- ✓ Initiate Emergency Resuscitation per ACLS guidelines until Code Team arrives, unless otherwise indicated.
- ✓ Initiate Hypoglycemia Protocol for blood glucose < 70 mg/dL

COMPLETE A "NEW" PATIENT STATUS ORDER FORM IF CHANGING STATUS ORDER

Physician Signature: Date & Time: 6/7/14 0730
Nursing Signature: RRV T.O. Dr. Hall Date & Time: 6/7/14 0835

Revised 12/08 ;10/10,9/13; 11/13; 3/14

6/10/14 8am

PHYSICIAN'S ORDER SHEET 3109

MR#: U[redacted] DOB: REDA
PARROTT[redacted]ILA WILSON
Mt Pleasant ERD
PHYS: WALTDAS-MD,JOHN
ACCT#: 14157-01389 06/06/14

Do Not Use Abbreviations		Date and Time
DO NOT USE	USE	
Q.D. QD	Daily	
Q.O.D. QOD	Every Other Day	
Trailing Zero	Units	
Lack of Leading Zero	2 mg	
MS	2.2 mg	
MSO4	Morphine Sulfate Magnesium Sulfate	
	Morphine Sulfate	
	Magnesium Sulfate	

6/6/14 2315 "Admit to floor - Inpatient, Medicine, Service of DR Mills
Dx: Left hip fracture & Dehydration). Consult Dr. Graham in AM R/G Hip fracture.
Foley to gravity - Send UA & Culture. Send CPK now. Send CBC, BMP, INR in AM"
Clear liquid Diet
Call for Temp > 101
Apply 5lbs Buck traction.
See attached med List."
RBLV T.O. DR. Mills/
Erin Kell (RN) 6/6/14
6/7/14 Note dc 01:45 Sn 6/7/14 0700

Obphisted: 2/09
Revised: 3/08/2009

OneContent: Generated By coffje1

REDA

MRN: 001787037 DOB:
PA T, DELILA WILSON
PHYS: MILLS-MD,RICHARD E
ACCT#: 14167-01388 06/06/14

ANESTHESIA POST OP ORDERS - ***PACU USE ONLY***

PAIN CONTROL - IV AS NEEDED FOR PAIN

☐ FENTANYL 12.5 micrograms - 50 micrograms	☐ MORPHINE: 1 mg - 5 mg
Frequency (check 1) : ☐ q 5 min ☐ q 10 min ☐ q ____ min	Frequency: (check 1) ☐ q 5 min ☐ q 10 min ☐ q 15 min
Maximum dosage ____ micrograms	Maximum dosage ____ mg
☑ DILAUDID 0.2 mg - 0.5 mg	☐ Other:
Frequency (check 1) ☐ q 5 min ☐ q 10 min ☐ q ____ min	Dosage:
Maximum dosage ____ mg	Frequency:

ANTIEMETIC - IV AS NEEDED FOR NAUSEA / VOMITING

☑ ZOFRAN (check 1) ☐ 2 mg OR ☑ 4 mg	☐ DROPERIDOL 0.625 mg
Frequency: times 1 dose	Frequency: times 1 dose
☐ PHENERGAN 6.25 mg - 12.5 mg	☐ Other:
Frequency (check 1) ☐ q 5 min ☐ q 10 min ☐ Other	Dosage:
Maximum dosage ____ mg	Frequency:

☐ DEMEROL 12.5 mg IV may repeat ____ times for Shivers

☐ O_2 3 LNC for O_2 Sat < ____ for 24 hours

Diagnostic Studies: ☐ Chest Xray ☐ ABGs ☐ Hbg/Hct ☐ Bedside Glucose ☐ BMP ☐ ____

■ If Peripheral Nerve Catheter present, see Anesthesia Continuous Peripheral Nerve Catheter Post-Op Orders.

Discharge from PACU per Phase 1 & 2 Recovery PACU Protocol
AND
Anesthesiologist Post Procedure Assessment completed

Other Orders

Physician Signature [signature] Date 6/7/14 Time 1722

Nurse Signature MBarrett RN Date 6/7/14 Time 1726

ADDITIONAL PACU ORDERS

DATE	TIME	

Revised: 10/09, 1/10, 9/10, 4/12, 6/13a, 6/13b

Patient Identifier

PHYSICIAN'S ORDER SHEET

MRN: 001787037 DOB: REDA
PARROTT,DELILA WILSON
MI Pleasant PD 3109-01
PHYS: MILLS-MD,RICHARD E
ACCT#: 14157-01389 06/06/14

Do Not Use Abbreviations

DO NOT USE	USE
QD/QOD	Daily
QOD	Every Other Day
U	Units
1 mg	
0.2 mg	
MS	Morphine Sulfate Magnesium Sulfate
MSO4	Morphine Sulfate
MgSO4	Magnesium Sulfate

Date and Time

6/7/14 Referred to Dr. Mills
5 pm Regular diet
PT/OT - toe touch WB on LLE
X-ray in PACU (L) hip AP & lateral
Morphine 2mg IV Q2hrs prn pain
Norco 7.5/325 1-2 po Q4hrs prn pain
ASA 325mg po BID, 1st dose in AM
SCDs to BLE

6/7/14 1930 ALL ELECTRONIC AND WRITTEN ORDERS REVIEWED Julia Kink, RN
6/7/14 D/C aspirin
1941 Lovenox 40mg SQ daily 1st 6/8 AM
Continue NS @ 125/hr
T.O. Dr. Murray / RBV Julia Kink, RN
FAXED FAXED
Noted 6/7/14 1955
6/9/14 0710 ALL ELECTRONIC AND WRITTEN ORDERS REVIEWED Julia Kink, RN
Authenticated by MURRAY-MD,PATRICK
On 6/12/2014 11:06:07 AM

Originated: 2/09
Revised: 3/09&09

PHYSICIAN'S ORDER SHEET

MRN: 001787037 DOB: REDA
PARROTT,DELILA WILSON
Mt Pleasant IPD 3109-01
PHYS: MILLS-MD,RICHARD E
ACCT#: 74157-01389 08/08/14

Do Not Use Abbreviations	
DO NOT USE	USE
q.d., qd	Daily
q.o.d., qod	Every Other Day
Units	Units
2 mg	2 mg
0.3 mg	0.3 mg
Morphine Sulfate Magnesium Sulfate	Morphine Sulfate
Morphine Sulfate	Magnesium Sulfate

Date and Time	
6/9/14 0700	ALL ELECTRONIC AND WRITTEN ORDERS REVIEWED Julia Hill, RN/S. Cato RN
6/10/14 Gain	CBC, comp - am
	6/10/14
	6/10/14 Notified OB-Lle & Ltt. RN
6/10/14 10:10	Aquacel Dressing Change this Morning. after Dressing change the Dressing can stay on for one week. T.O./R.B. Dr. Murray / Betty Swanson Authenticated by MURRAY-MD,PATRICK J On 06/12/2014 11:06:44 AM
6/10/14 10:10	O/C to Discharge from ortho standpoint. O/C to Shower with Aquacel Dressing on. Follow up visit with Dr. Murray in 2 weeks. Authenticated by MURRAY-MD,PATRICK J On 06/12/2014 11:07:41 AM
	T.O./R.B. Dr. Murray / Betty Swanson
6/10/14 13:19	Discharge to SNF ✓ T.O./R.B. Nikki PA Dr. Omraju / Betty Swanson Authenticated by OMRAJU-MD,SWAPNA On 06/16/2014 09:10:17 AM

Originated: 2/09
Revised: 0/99,8/09

MRN: 001787037 DOB: REDA
PARROTT,DELILA WILSON
Mt Pleasant IPD 3103-01
PHYS: MILLS-MD,RICHARD E
ACCT#: 14157-01389 08/06/14

PROGRESS RECORD

Date

6/6/14 Pt fell 2 days ago. Hit head. Pain and Rt hip. Has Rt hip pain. Has Rt groin pain. Has Rt knee pain. Has Rt ankle pain. Has Rt foot pain. Has Rt shoulder pain. Has Rt arm pain. Has Rt hand pain. Has Rt wrist pain. Has Rt elbow pain. Has Rt forearm pain. Has Rt upper arm pain. Has Rt shoulder pain. Has Rt neck pain. Has Rt head pain. Has Rt face pain. Has Rt eye pain. Has Rt ear pain. Has Rt nose pain. Has Rt mouth pain. Has Rt chin pain. Has Rt jaw pain. Has Rt throat pain. Has Rt chest pain. Has Rt abdomen pain. Has Rt back pain. Has Rt buttock pain. Has Rt groin pain. Has Rt thigh pain. Has Rt knee pain. Has Rt leg pain. Has Rt ankle pain. Has Rt foot pain.

Allergic to ASA ACE

Home Meds: Dr Hagen 1400
Nexium 40
Celexa 10
Lisinopril 10 PO
Lasix PO
London

6/7 9:15 A.O. to ED via EMS 16 9/14
Tearful upset
Needs oriented
Client c/o Rt
c/o Rt
Rt leg ext rotated
c/o to communicate
Rt & Lt leg
Intermittent

Over

L K 6
SPPAC
Burn
40.7
No CT
daughter
Gina
803-331-6312
6/6 16.5 10.8 3.5
6/7 13.6 19.2 26.5
Plat 165K
147/110/179 0.6
4/89/38
6/6 WA Hbet
CPK 673
MG 2.5

08/06

SIDE TWO
(2)

MRN: 001787037 DOB: REDA
PARROTT, DELILA WILSON
Mi Preferred IPO 2109-01
PHYS: MILLS-MD, RICHARD E
ACCT#: 14157-01389 06/06/14

Date

PMH Atrial fib Macular Degen
HTN CAD
Anxiety Sleep apnea

Uridine Fatty liver + CVA
distant HX Cerebellar
Colonoscopy Dr Ingram Aug 2013
Endoscopy 2007
Pneumonia 2004

PSH
Lt breast bx
Lt wrist fx
Multiple dig surgeries

A/P: 1. HTN Ex for surgical clearance
2. HCV positive
3. Anemia w/u in HP
4. Anxiety Xanax prn Ativan
5. Hx right cord DVT.
6. Chronic diarrhea

(DO NOT WRITE BELOW THIS LINE)

PROGRESS RECORD

[Patient Identifier]
MRN: 001787037 DOB: REDA
PARROTT,DELILA WILSON
Mr Resident PD 3109-01
PHYS: MILLS-MD,RICHARD E
ACCT#: 14167-01389 05/05/14

PROGRESS RECORD

Date | Title of Note

6/4/14 5pm
- (L) subtroch fx
ORIF (L) subtroch fx
- Dr Mon
Anesthesia: General
EBL: 200 ml
Implant: Synthes TFN nail
Stable

6/6/14 9:45 Post Op
Pt pain controlled, pt denies CP, SOB, dizziness, lightheadedness, or dizziness. Pt agrees to call for assistance and to take Foley out.

qd, bid, prn, 12/5, 2, 100%
Pain well controlled
Chest clear
CBC added 6/6 appt
A/P: Post op H/O Stable
1. Anemia Transfuse 2 U PRBC
3. Dehydration cont IVF
4. Diarrhea, consult GI dr

BNP 167
7.9 / 178
23.9
146 / 112 / 150 1.0
4.2 / 9.7 / 53

08/06

[Patient Identifier] REDA

MRN: 001787037 DOB:
PARROTT,DELILA WILSON
Mt Pleasant IPD 3109-01
PHYS: MILLS-MD,RICHARD E
ACCT#: 14157-01389 06/06/14

PROGRESS RECORD

Date	
6/10/14 Sun	Int. med :- NO acute overnight events. Delirium improving. VS - 98.1 67 16 93% 160/72 (on meds) Neuro - clear, ↓ secretions CVS - S, pace, RRR Resp - RA, bilat entry good Abdo - soft, non-tender, BS+ CNS - AAOx , ↓ gross neuro deficits Labs :- 8.3 / 9.0 / 27.3 / 156 145 / 112 / 18 / 105 3.9 / 28 / 0.5 8700/cu - (P) Cdiff toxin - pve dce stool stool - pve A/P :- (1) (L) hip fracture S/P ORIF - cont. Pain Rx Ortho fu ! (P) - cont. PT. (2) Anemia (Stable) - S/P transfusion. NVO bulkx intervention as per GI (3) HTN - cont. Antihypertensive / propranolol (4) Chronic diarrhea - Stool C/S pve. CX (P) (5) DVT prophy/abx - SCDs / oversox. Appre c SNF placement. So 6/10/14.

08/06

Patient DOB: REDAC

CHIEF COMPLAINT: Left hip pain.

HISTORY OF PRESENT ILLNESS: This is an 80-year-old female who per her daughters fell several days ago at home and was left lying on the floor until somebody discovered her after supposedly suffering a fall. She was unable to bear weight and had extreme pain in her left hip. She was brought to the Emergency Room and found to have a left comminuted subtrochanteric and intertrochanteric femur fracture. She was admitted to the medical service and cleared for surgical management.

PAST MEDICAL HISTORY: Atrial fibrillation, hypertension, anxiety, macular degeneration, gastroesophageal reflux disease, and sleep apnea.

PAST SURGICAL HISTORY: Includes: Breast biopsy, left wrist fracture, multiple eye surgeries.

FAMILY HISTORY: Father died of stroke.

HOME MEDICATIONS: Diltiazem, Nexium, Colace, propranolol, Tylenol.

ALLERGIES: INCLUDE ACE INHIBITORS AND ASPIRIN.

SOCIAL HISTORY: She is a widow. She has a distant history of smoking more than 30 years ago.

PHYSICAL EXAMINATION: She is awake and in no acute distress. She has pain with leg roll of her left hip. No pain with right hip leg roll. No bilateral knee, ankle, shoulder, elbow, wrist tenderness. No cervical neck tenderness. Brisk capillary refill in all 4 extremities. Sensation intact to light touch throughout all 4 extremities. ABDOMEN: Soft. Nonlabored breathing. CARDIOVASCULAR: Regular rate and rhythm.

Review of x-rays shows comminuted subtrochanteric and intertrochanteric femur fracture on the left.

ASSESSMENT AND PLAN: Admitted by the hospitalist service and taken to the OR for open reduction internal fixation.

OneContent: Generated By coffje1

Patient DOB: REDAC

REFERRING PHYSICIAN: Dr. Richard Mills

REASON FOR CONSULTATION: Diarrhea.

HISTORY OF PRESENT ILLNESS: Ms Parrott is a pleasant, 80-year-old white female well known to me for many years and is a retired nurse anesthetist. I saw her last summer when she had a routine colonoscopy here at Roper Mount Pleasant Hospital that was negative except for a small benign polyp in the mid sigmoid colon. The best I can tell, the patient has had problems now with chronic diarrhea since the first of the year. A referral was sent to our office, and we contacted the patient but she refused to make an appointment at that time. Anyway, she says she had anywhere between 2-5 loose bowel movements a day, without blood. She thinks she has slowly gotten better over the last couple months down to maybe 2 bowel movements a day. She is in the hospital now because she fell approximately 2 days prior to admission while living Sandpiper, and was not seen because the caregivers at Sandpiper thought she was out of town. Anyway, she was found by one of her bridge partners and sent to the Emergency Room here at Roper Mount Pleasant Hospital on 06/05/2014, and was discovered to have a left femoral intratrochanteric fracture. She was admitted to the hospital at that time.

PAST MEDICAL HISTORY:
1. Atrial fibrillation.
2. Hypertension.
3. Anxiety.
4. GERD.
5. Sleep apnea.

PAST SURGICAL HISTORY:
1. Left wrist fracture.
2. Multiple eye surgeries.
3. Colonoscopy 08/20/2013, by myself.

SOCIAL HISTORY: The patient is a retired nurse anesthetist and she denies using alcohol and quit smoking 30 years ago.

FAMILY HISTORY: Negative for gastrointestinal disease.

OneContent: Generated By coffje1

DRUG ALLERGIES: ACE INHIBITORS AND ASPIRIN.

SYSTEMS REVIEW: Gastrointestinal review of systems discussed in detail in the history of present illness. All other pertinent review of systems are negative.

ADMISSION MEDICATIONS:
1. Diltiazem 180 mg daily.
2. Valium 10 mg daily.
3. Celexa 10 mg daily.
4. Propranolol 10 mg twice daily.
5. Tylenol #3 p.r.n. pain.
6. Lasix 40 mg daily.

PHYSICAL EXAMINATION: GENERAL: The patient is a well-developed, well-nourished, somewhat upset white female, lying comfortably in bed in no acute distress. VITAL SIGNS: Blood pressure 170/76, pulse 80 and regular, respirations 16, temperature 98.4. HEENT: Head normocephalic, atraumatic. Throat: Posterior pharynx is not injected. Pupils are equally round and reactive to light and accommodation. There is no scleral icterus. NECK: Supple, without masses, thyromegaly, or bruits. LUNGS: Clear to auscultation bilaterally without rhonchi, rales, wheezes. HEART: Normal sinus rhythm without murmurs or gallops. ABDOMEN: Soft with positive bowel sounds. There is no tenderness to palpation. The liver is not enlarged. Spleen is not palpated. No masses are felt. EXTREMITIES: The patient moves all 4 without difficulty and there is no edema, clubbing, or cyanosis. NEUROLOGIC: The patient is somewhat confused both to date and previous events. There are no focal neurologic deficits.

LABORATORY: Admission laboratory hemoglobin 9.2, hematocrit 28.3, platelet count 165,000.

IMPRESSION:
1. Chronic diarrhea with 6 months' duration. This could easily be due to microscopic/collagenous colitis with her advanced age. Inflammatory bowel disease or infection would be much less likely over 6 months.
2. Status post left hip fracture repair.
3. Anemia, questionable chronic.
4. Confusion/dementia.
5. History of atrial fibrillation.

Nurse's Notes

Roper St. Francis HealthCare Mount Pleasant

Name: Delila Parrott
Age: 80 years **Sex:** Female **DOB:** REDAC
Arrival Date: 06/06/2014 **Time:** 21:14
Bed 2
MRN: 001787037
Account#: 1415701389
Private MD:
Diagnosis: Hip Fracture; Dehydration; Decubitus Ulcer, Pressure, (Buttock); Decubitus Ulcer, Pressure, (Hip); Bladder Infection (UTI)

Inbound Details:
Referred by:
Who will see patient? ED Physician
Notes:
Notify referring provider: Do not notify

Arriving by: EMS

ETA:

Presentation: tm7

06/06 21:32 Transition of care: patient was received from home. tm7

21:32 Method Of Arrival: EMS. ekk

21:45 Care prior to arrival: See EMS report. Medication(s) given: 100 MCG OF FENTANYL ADMINISTERED PTA IV initiated. 20 LEFT FA Glucose check. 108. Mechanism of Injury: Fall PT WAS STANDING ON LAZY BOY TRYING TO FIX CURTIN. FELL TO THE FLOOR. DENIES LOC OR STRIKING HEAD.

Triage Assessment: tm7

21:15 Presenting complaint per patient: Pt was found on the floor by a neighbor who checked on her. Unknown how long she was on the floor. Complains of left hip pain. Appears unkempt, Behavior is crying. **Pain:** Complains of pain in left hip.

21:36 Presenting complaint per patient: pt was given 100 mcg IV fentanyl by EMS prior to arrival. tm7

Historical:

Allergies:
21:30 green vegetables; Chocolate; Aspirin; ACE INHIBITORS; all nasal sprays; NSAIDS; tm7

Home Meds:
21:34 Diltiazem Oral ; Lomotil oral ; Propranolol Oral ; citalopram oral ; Tylenol #3 Oral ; Nexium Oral ; Furosemide Oral ; cyanocobalamin (vitamin B-12) oral ; Ceftin Oral ; tm7

PMHx:
21:34 Atrial Fib; Hypertension; Anxiety; tm7

- **Social history::** Smoking status: Patient/guardian denies using tobacco, but has a distant history of tobacco abuse.
- **Advanced Directives::** Patient has healthcare power of attorney, documentation unavailable. Patient/legal representative advised of need for copy to be obtained and placed on chart for Advance Directive to be honored. The patient has a living will, documentation unavailable. Patient/legal representative advised of need for copy to be obtained and placed on chart or Advance Directive to be honored.

Screening: tm7

21:32 **Abuse screen:**
Denies threats or abuse.
Fall Risk
Fall in past 12 months (25 points). Secondary diagnosis (15 points) No IV (0 pts). Ambulatory Aid-Crutches/Cane/Walker (15 pts). Gait- Impaired (20 pts.). Mental Status- Oriented to own ability (0 pts).
Suicide Screening:
Patient denies thoughts of harming self or others.
Tuberculosis screening:
No symptoms or risk factors identified. Denies unexplained cough, fever, night sweats, weight loss, or exposure to anyone with know TB infection.
C-Diff Screening:
Patient has not had any watery stools in the past 24 hours.

Assessment: ekk

21:38 Appears uncomfortable, Behavior is cooperative, "I fell down on Tuesday and have been laying in the floor just hoping someone would find me. I think I broke my hip".

*** CHART COMPLETE ***

Page 1 of 3

Print Time: 6/6/2014 07:40:30

Physician Documentation

Roper St. Francis HealthCare Mount Pleasant

Name: Delila Parrott
Age: 80 years **Sex:** Female **DOB:** REDAC
Arrival Date: 06/06/2014 **Time:** 21:14
Bed 2
ED Physician Walters, John

MRN: 001787037
Account#: 1415701389
Private MD:

HPI:

06/06 23:07 This 80 years old White Female presents to ED via EMS with complaints of Hip Pain. jwf1

23:07 The patient or guardian reports an injury, that occurred at home, sustained from a fall, the left lower extremity is shortened, left leg is externally rotated, The patient is not able to ambulate. Patient is not able to bear weight. The patient was discovered 2 daysafter the incident. The complaints affect the left hip. Onset: The symptoms/episode began/occurred 2 day(s) ago. Associated signs and symptoms: Pertinent positives: Patient was on the floor for 2 days before being discovered. The patient laid on the floor without any food or water. Patient complains of pain in the hip without numbness or tingling or weakness or sensory loss. No chest pain or shortness of breath. She is extremely thirsty. Severity of symptoms: At their worst the symptoms were severe, incapacitating. jwf1

Historical:

- **Allergies:** green vegetables; Chocolate; Aspirin; ACE INHIBITORS; all nasal sprays; NSAIDS;
- **Home Meds:**
  1. Diltiazem Oral
  2. Lomotil oral
  3. Propranolol Oral
  4. citalopram oral
  5. Tylenol #3 Oral
  6. Nexium Oral
  7. Furosemide Oral
  8. cyanocobalamin (vitamin B-12) oral
  9. Coffin Oral
- **PMHx:** Atrial Fib; Hypertension; Anxiety
- **Social history::** Smoking status: Patient/guardian denies using tobacco, but has a distant history of tobacco abuse,.
- **Advanced Directives::** Patient has healthcare power of attorney, documentation unavailable. Patient/legal representative advised of need for copy to be obtained and placed on chart for Advance Directive to be honored The patient has a living will, documentation unavailable. Patient/legal representative advised of need for copy to be obtained and placed on chart or Advance Directive to be honored.

ROS:

23:09 jwf1

Constitutional: Negative for fever, malaise, vomiting or weight loss
Eyes: Negative for injury, pain, redness, and discharge.
ENT: no rhinorea, sore throat, earache or toothache
Neck: Negative for injury, pain, swelling or stiffness
Cardiovascular: Negative for chest pain, palpitations, and edema.
Respiratory: Negative for shortness of breath, cough, wheezing, and pleuritic chest pain.
Abdomen/GI: Negative for abdominal pain, nausea, vomiting, diarrhea, and constipation.
Back: Negative for injury and pain.
Skin: Positive for breakdown - seen by nurse.

Exam:

23:09 jwf1

Eyes: Pupils equal round and reactive to light, extra-ocular motions intact. Lids and lashes normal. Conjunctiva and sclera are non-icteric and not injected. Cornea within normal limits. Periorbital areas with no swelling, redness, or edema.Fundi are normal. discs are sharp.
Neck: Trachea midline, no thyromegaly or masses palpated, and no cervical lymphadenopathy. Supple, full range of motion without nuchal rigidity, or vertebral point tenderness. No Meningismus.
Chest/axilla: Normal chest wall appearance and motion. Nontender with no deformity. No lesions are appreciated.
Cardiovascular: Regular rate and rhythm with a normal S1 and S2. No gallops, murmurs, or rubs. Normal PMI, no JVD. Pulses equal and strong bilaterally.
Respiratory: Lungs have equal breath sounds bilaterally, clear to auscultation and percussion. No rales, rhonchi or wheezes noted. No increased work of breathing, no retractions or nasal flaring.

Physician Documentation Con't.

Abdomen/GI: Soft, non-tender, with normal bowel sounds. No distension or tympany. No guarding or rebound. No evidence of tenderness throughout.
Back: No spinal tenderness. No costovertebral tenderness. Full range of motion.
Neuro: Awake and alert, oriented to person, place, time and situation. Neuro grossly intact. Normal gait.
Psych: Affect appropriate, memory intact.
Constitutional: The patient appears alert, awake, frail, uncomfortable.
ENT: Mouth: Lips: dry, cracked. Oral mucosa: dry.
Musculoskeletal/extremity: Circulation is intact in all extremities. Sensation intact. Joints: the left hip displays deformity, pain at rest, painful range of motion, tenderness.
Skin: breakdown from pressure on right buttock hip.

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Height	Pain	Staff
21:18	182 / ??	86	17	97.7	93%	68.04 kg	5 ft. 7 in. (170 cm)	9/10	tm7
22:00	145 / 67 (auto)								ekk
22:00		77 MON	16		95%				ekk
22:15	149 / 67 (auto)								ekk
22:15		79 MON	17		95%				ekk
22:30	158 / 65 (auto)								ekk
22:31		83 MON	16		95%				ekk
23:27		83 MON	13		95%				ekk
23:30	181 / 64 (auto)								ekk
23:38		83 MON	18		95%			7/10	ekk
23:45	183 / 59 (auto)								ekk
23:45		82 MON	14		94%				ekk

23:45 Body Mass Index 23.5 (68.04 kg, 170 cm) ekk
23:38 Normal Sinus Rhythm ekk

Glasgow Coma Score:

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
21:18	spontaneous(4)	oriented(5)	obeys commands(6)		15	tm7

MDM:
21:11 Medical screening evaluation initiated. jwf1
23:11 jwf1
Data reviewed: vital signs, nurses notes, old medical records obtained and reviewed, lab test result(s), radiologic studies, X-ray.
Physician consultation (by phone and in detail): Richard Mills MD and will see patient in hospital.

Time	Order name	Complete Time	Staff
06/06 22:18	CBC	22:58	jwf1
06/06 22:18	BMP	22:58	jwf1
06/06	Mg Level	23:07	jwf1

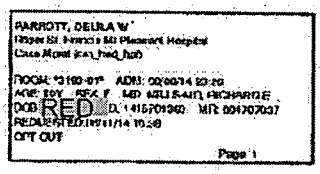
Name: Delila Parrott **MRN:** 001787037
Account#: 1415701389
Print Time: 6/6/2014 07:40:32 Page 2 of 6

Ancillary Chartin	06/09			
PT Eval-Cont	11:11	14:07	16:53	19:37
	AD77			
Time frame	7 sessions AD77			
LTG 1	AD77 B			
LTG 2	AD77 B			
Plan	balance training bed/mat mobility func mobility gait training pt/fam train/edu safety ther Ex transfer train AD77			
Bed Mobility	2 = max assist AD77			
Trans: bed to	2 = max assist AD77			
Gait:walking lev	0=cannot assess AD77			
Walking distance	0 = cannot asses AD77			
Funct outcome	4 AD77			
G-code modifier	C M AD77			
Current G-Code	G8978 AD77			
Goal G-Code	G8979 AD77			
Goal status	cm AD77			
Rehab Potential	Good AD77			

06/09/14 11:11 Surgery (type)(AD77): L ORIF femur
06/09/14 11:11 Treatment reqstd(AD77): PT consult
06/09/14 11:11 Treatment Dx(AD77): difficulty in walking
06/09/14 11:11 Special equipmt(AD77): cane
06/09/14 11:11 Prior lvl functn(AD77): MOD I c cane; lives in Sandpiper independent living - per daughter has had multiple falls
06/09/14 11:11 Precautions(AD77): falls, TTWB on L LE
06/09/14 11:11 Prev Med Hx(AD77): fall c L femoral fx s/p ORIF, anxiety, afib, aortic insufficiency, SVT, HTN, sleep apnea, arthritis, HOH
06/09/14 11:11 Subjective(AD77): "I just need someone that can pick me up."
06/09/14 11:11 ROM l lower ext(AD77): see pain
06/09/14 11:11 Coord/Propriocep(AD77): decreased c all functional mobility
DOOSSCHE, AMANDA(AD77)THERAPIST

CONTINUED

OneContent: Generated By coffje1



Case Mgmt Chartin	06/09
CM Initl Assess	14:48
Primary Contact	june connor dtr LD77
Phone Number	843-897-1686 LD77
Info From	chart, dtr LD77
Primary Care Phy	dr. mills LD77
Hosp in last 30d	no LD77
Referral Reason	case coord DC needs LD77
Finan Resources	insurance medicare LD77
Living Situation	home alone LD77
Decision Maker	financial health care legal LD77
Rel Declsn Maker	self LD77
ELOS	4 LD77
Pt Fam notified	yes LD77
Support System	family LD77
Coping	
Coping/Patient	adequate LD77
Coping/Family	adequate LD77
Verbal Skills	adequate LD77
Caregiver	self LD77
Caregiver Info	manages well LD77
Pre Hosp LOC	alert oriented LD77

DUNNE, LINDA(LD77)Case Mgr

Case Mgmt Chartin	08/09
CM Initial Asses Cont	**14:48**
Currnt Assis Dev	bedrails hospital bed LD77
Transportation	family LD77
Intervention	discussed w/Fam discussed w/Pt LD77
Plan of Options	agreed to by Fam agreed to by Pt LD77
CM DC Planning	**14:48**
DC Planning Rnds	done LD77
CM Goals/Notes	**14:48**
Current LOS	3 LD77
Expected DC date	08/10/2014 LD77
Plan A	LD77 B
Plan B	LD77 B
Intervention	CM brochure prov dly introdis rnds discussed w/Fam DCP Disc w crgvr MD agrd with DCP PPD given SNF list pvd SNF referral LD77
Progress Note 1	LD77 B
Progress Note 2	LD77 B
Progress Note 3	LD77 B

08/09/14 14:48 Plan A(LD77): SNF for rehab

08/09/14 14:48 Plan B(LD77): home with support services

08/09/14 14:48 Progress Note 1(LD77): CM: Pt is alert, oriented and independent in ADL's. She lives in independent living at Sandpiper. Pt fell and fractured her hip. She had surgery and will need rehab at dc. Dtr June stated she wanted Sandpiper rehab for her first choice and Savannah

08/09/14 14:48 Progress Note 2(LD77): Grace for her second choice. Information faxed to Sandpiper and they have accepted her. PPD done on 8/8/14 and she will be ready for dc in the morning after PPD read. Family aware. Pt is low risk for readmit. CM will continue to follow for any dc

08/09/14 14:48 Progress Note 3(LD77): needs that may arise and assist with dc to SNF. She will need dc summary done prior to dc.

DUNNE, LINDA(LD77)Case Mgr

PARROTT, DELILA W. Opt Out: No
Mi Plossert
Site Management (sitemgmt_hpf)
Rm-Bed: 3109 - 01 Admit Dt: 06/06/2014 23:20
Age: 69 yr Gender: F MD: Mills-Md, Richard E., MD
DOB: REDA Acct: 1415701389
MRN: 001787037
Requested: 06/11/2014 10:38
Page 1 of 8

Active Sites

abrasion (1) right hip

Start Date = 06/06/2014; Time = 23:00 [Charted by: Carter, Sara P., RN at 06/07/2014 04:22]; Timing = prior to admit [Charted by: Carter, Sara P., RN at 06/07/2014 04:22]; Type = abrasion [Charted by: Carter, Sara P., RN at 06/07/2014 04:22]; Location = right hip [Charted by: Carter, Sara P., RN at 06/07/2014 04:22]

bilator (1) right lower hip

Start Date = 06/07/2014; Time = 21:27 [Charted by: Carter, Sara P., RN at 06/08/2014 06:53]; Timing = prior to admit [Charted by: Carter, Sara P., RN at 06/08/2014 06:53]; Type = bilator [Charted by: Carter, Sara P., RN at 06/08/2014 06:53]; Location = right lower hip [Charted by: Carter, Sara P., RN at 06/08/2014 06:53]

laceration (1) left wrist

Start Date = 06/06/2014; Time = 23:00 [Charted by: Carter, Sara P., RN at 06/07/2014 04:25]; Timing = prior to admit [Charted by: Carter, Sara P., RN at 06/07/2014 04:25]; Type = laceration [Charted by: Carter, Sara P., RN at 06/07/2014 04:25]; Location = left wrist [Charted by: Carter, Sara P., RN at 06/07/2014 04:25]; Wound Comment = scratch [Charted by: Carter, Sara P., RN at 06/07/2014 04:25]

surgical incision (1) left hip

Start Date = 06/07/2014; Timing = prior to arrival at ont [Charted by: Kirk, Julia P., RN at 06/09/2014 16:21]; Type = surgical incision [Charted by: Kirk, Julia P., RN at 06/09/2014 16:21]; Location = left hip [Charted by: Kirk, Julia P., RN at 06/09/2014 16:21]

Ended Sites

Foley (1) 16fr

Start Date = 06/06/2014 [Charted by: Carter, Sara P., RN at 06/07/2014 04:18]; Time = 23:00 [Charted by: Carter, Sara P., RN at 06/07/2014 04:18]; Timing = prior to admit [Charted by: Carter, Sara P., RN at 06/07/2014 04:18]; Reported Pt Location @ Insertion = ER [Charted by: Carter, Sara P., RN at 06/07/2014 04:18]; Type = Foley [Charted by: Carter, Sara P., RN at 06/07/2014 04:18]; Size (Fr) = 16fr [Charted by: Carter, Sara P., RN at 06/07/2014 04:18]; End Date = 06/09/2014 [Charted by: Kirk, Julia P., RN at 06/09/2014 10:38]; Time = 10:10 [Charted by: Kirk, Julia P., RN at 06/09/2014 10:38]; Removed By = jk [Charted by: Kirk, Julia P., RN at 06/09/2014 10:38]

done (1) arm 20 gauge

Start Date = 06/05/2014; Time = 23:10 [Charted by: Carter, Sara P., RN at 06/07/2014 03:55]; IV Timing = prior to admit [Charted by: Carter, Sara P., RN at 06/07/2014 03:55]; Reported Pt Location @ Insertion = ER [Charted by: Carter, Sara P., RN at 06/07/2014 03:55]; Site (Ga) = 20 gauge [Charted by: Carter, Sara P., RN at 06/07/2014 03:55]; Site = left [Charted by: Carter, Sara P., RN at 06/07/2014 03:55]; Location = arm [Charted by: Carter, Sara P., RN at 06/07/2014 03:55]; End Date = 06/10/2014 [Charted by: Swain, Betty , RN at 06/10/2014 16:59]; Time = 15:24 [Charted by: Swain, Betty , RN at 06/10/2014 16:59]; Removed By = pcl [Charted by: Swain, Betty , RN at 06/10/2014 16:59]; Dressing Applied = dsite [Charted by: Swain, Betty , RN at 06/10/2014 16:59]; Removal Comment = iv dcd with cellula intact [Charted by: Swain, Betty , RN at 06/10/2014 16:59]

narrative

06/07/2014 00:00 TO 06/07/2014 23:59

Legend Charting

06/07/2014 00:10

done (1) arm 20 gauge

done(1)(ended) left arm

Clinical Blood Return = positive — Carter, Sara P., RN 06/07/2014 04:26

Intervention = other-comment — Carter, Sara P., RN 06/07/2014 04:26

Notes: IVF

Site Assessment = WNL — Carter, Sara P., RN 06/07/2014 04:26

Foley (1) 16fr

Foley(1)(ended)

Intervention = RN — Carter, Sara P., RN 06/07/2014 04:26

Necessity = requires prolonged immobilization — Carter, Sara P., RN 06/07/2014 04:26

Safety = patient secured to leg, restraints used — Carter, Sara P., RN 06/07/2014 04:26

narrative
06/07/2014 00:00 TO 06/07/2014 23:59
Legend Charting
06/07/2014 00:10
Foley (1) 16fr
Urine Assessment = diguric — Carter, Sara P., RN 06/07/2014 04:26
Urine Color = amber — Carter, Sara P., RN 06/07/2014 04:26

abrasion (1) right hip
abrasion(1): right hip
Inpatient Documentation,Appearance = clean, reddened, other-comment — Carter, Sara P., RN 06/07/2014 04:26

Notes: bruise
Inpatient Documentation,Wound drainage = none — Carter, Sara P., RN 06/07/2014 04:26
Inpatient Documentation, interventions = open to air — Carter, Sara P., RN 06/07/2014 04:26

laceration(1): left wrist
Inpatient Documentation,Appearance = approximated, reddened — Carter, Sara P., RN 06/07/2014 04:26
Inpatient Documentation,Wound drainage = none — Carter, Sara P., RN 06/07/2014 04:26
Inpatient Documentation, interventions = open to air — Carter, Sara P., RN 06/07/2014 04:26

06/07/2014 10:33
done (1) arm 20 gauge
done(1)(ended) left arm
Intervention = other-comment — Kirk, Julia P., RN 06/07/2014 15:27

Notes: ivf infusing
Site Assessment = WNL — Kirk, Julia P., RN 06/07/2014 15:27

Foley (1) 16fr
Foley(1)(ended)
Necessity = need accurate urinal output measurements, requires prolonged immobilization — Kirk, Julia P., RN 06/07/2014 15:27
Status = patent, secured to leg, unclamped — Kirk, Julia P., RN 06/07/2014 15:27
Urine Assessment = clear — Kirk, Julia P., RN 06/07/2014 15:27
Urine Color = amber — Kirk, Julia P., RN 06/07/2014 15:27

abrasion (1) right hip
abrasion(1): right hip
Inpatient Documentation,Appearance = open, reddened — Kirk, Julia P., RN 06/07/2014 15:27
Inpatient Documentation,Wound drainage = serosanguinous — Kirk, Julia P., RN 06/07/2014 15:27

Notes: scant amount
Inpatient Documentation, interventions = open to air — Kirk, Julia P., RN 06/07/2014 15:27

laceration(1): left wrist
Inpatient Documentation,Appearance = approximated, reddened — Kirk, Julia P., RN 06/07/2014 15:27

narrative

06/07/2014 00:00 TO 06/07/2014 23:59

Legend Charting

06/07/2014 10:33

laceration (1) left wrist

Inpatient Documentation,Wound drainage = none	Kirk, Julia P., RN 06/07/2014 15:27
Inpatient Documentation,Interventions = open to air	Kirk, Julia P., RN 06/07/2014 15:27
Inpatient Documentation,Topical = antibiotic	Kirk, Julia P., RN 06/07/2014 15:27

06/07/2014 18:55

surgical incision (1) left hip

vertical incision(3) left hip

Inpatient Documentation,Dressing condition = drainage/stable	Kirk, Julia P., RN 06/08/2014 16:22
Inpatient Documentation,Wound drainage = bloody, scant	Kirk, Julia P., RN 06/08/2014 16:22
Inpatient Documentation,Dressing Cover = other-comment	Kirk, Julia P., RN 06/08/2014 16:22

Notes: honeycomb island dressing

06/07/2014 21:27

done (1) arm 20 gauge

dose(s) (ended) left arm

Intervention = other-comment	Carter, Sara P., RN 06/08/2014 00:29

Notes: IVF

Site Assessment = WNL	Carter, Sara P., RN 06/08/2014 00:29

Foley (1) 16fr

Foley(1)(ended)

Necessity = need accurate urine output measurements, requires pt to be immobilization	Carter, Sara P., RN 06/08/2014 00:29
Status = patent, secured to leg, unclamped	Carter, Sara P., RN 06/08/2014 00:29
Urine Assessment = clear	Carter, Sara P., RN 06/08/2014 00:29
Urine Color = amber	Carter, Sara P., RN 06/08/2014 00:29

abrasion (1) right hip

abrasion(1) right hip

Inpatient Documentation,Appearance = open, reddened	Carter, Sara P., RN 06/08/2014 00:29
Inpatient Documentation,Wound drainage = none	Carter, Sara P., RN 06/08/2014 00:29
Inpatient Documentation,Interventions = open to air	Carter, Sara P., RN 06/08/2014 00:29
Inpatient Documentation,Topical = other-comment	Carter, Sara P., RN 06/08/2014 00:29

Notes: bacitracin

laceration(1) left wrist

Inpatient Documentation,Appearance = reddened	Carter, Sara P., RN 06/08/2014 00:29
Inpatient Documentation,Wound drainage = none	Carter, Sara P., RN 06/08/2014 00:29

OneContent: Generated By coffje1

Patient ssn: REDAC

HISTORY OF PRESENT ILLNESS: Ms. Wilson is a white female who was found with a fractured hip, unable to get up. She gives a history that she fell about 2 days ago, hit her on the bed frame and fell. She apparently was Sandpiper. By her history, they apparently thought that she was out of town, but she was not. Finally, she was found by one of her bridge partners and brought to the Emergency Room here last night. In the Emergency Room, she was found on x-ray to have a left femoral intratrochanteric/subtrochanteric fracture. Her urine was abnormal. She was dehydrated and was cultured as far as the urine and started on Rocephin in the Emergency Room. She was also noted to have some skin breakdown. EKG was done which showed sinus rhythm, PACs. She had an elevated BUN creatinine ratio of 40/0.7. Sodium was 147. Daughter is June, telephone number 803-931-6342. White count on June 6th was 16.5 with hemoglobin of 10.8, hematocrit of 32.5.

ALLERGIES: ACE INHIBITORS AND ASPIRIN.

HOME MEDICATIONS: Include diltiazem 180, Nexium 40, Celexa 10, propranolol 10 b.i.d., Tylenol 3, monthly B12 shots, Lasix 40.

PAST MEDICAL HISTORY: Includes atrial fibrillation, hypertension, anxiety, macular degeneration, gastroesophageal reflux disease, sleep apnea.

FAMILY HISTORY: Father died of a stroke.

PAST SURGICAL HISTORY: Includes left breast biopsy, left wrist fracture, multiple eye surgeries. She had a colonoscopy by Dr. Joyner in August 2013, had a Zostavax vaccination in 2007 and a pneumonia vaccine in 2004.

SOCIAL HISTORY: She is a widow. Her husband was a former pharmacist. She has a distant history of smoking more than 30 years ago.

CURRENT LABORATORY DATA: From this morning, June 7th, show white count of 13.6, hemoglobin 9.2, hematocrit 28.5, platelet count 169,000. Sodium 147, potassium 4, chloride 110.

PHYSICAL EXAMINATION: Temperature 97.8, pulse 81, respiratory rate 16, blood pressure 169/74, tearful, upset. NECK: Supple. CHEST: Shallow breath sounds. CARDIOVASCULAR: Regular rate. ABDOMEN: Bowel sounds present. Left leg is

externally rotated. Skin breakdown on the right hip.

ADMITTING DIAGNOSES:
1. Hip fracture for surgical repair.
2. Hypertension, systolic, follow.
3. Anemia, follow.
4. Anxiety.
5. History of a-fib, continue diltiazem.
6. Chronic diarrhea. Check stool studies.

Update to the History and Physical if appropriate
[] I have reviewed the H&P and re-examined the patient and there are no changes to the physical examination and/or history of present illness.
[] I have reviewed the H&P and re-examined the patient and the following changes have occurred to the physical examination and /or history of present illness:

---

[x] Refer to the Admission Home Medication Orders (Inpatient) or Outpatient/OBSERVATION medication list (outpatient) for current medications.
Physician Signature: _____ Date: _____ Time:

Richard E Mills, MD
TR: dn DD: 06/07/2014 09:30 TD: 06/07/2014 10:14 Job#: 283131
DOC#: 396607

Authenticated by RICHARD E MILLS MD On 06/07/2014 11:10:18 AM

Roper St. Francis Healthcare
Department of Laboratory Medicine
Charleston, South Carolina 29401

PATIENT: PARROTT, DELILA WILSON
DOB: REDAC
PID: D001787037
ACCT # : D1415701389

LOCATION: D3D 3109-01
PHYSICIAN: MILLS-MD, RICHARD E
PRINTED: 06/11/14 06:53

ADMITTED: 06/06/14

DISCHARGED: 06/10/14

CHEMISTRY

Collected	06/10 05:30		06/09 05:40		06/08 05:45		06/07 05:40		06/06 22:35		Units	Reference
NA	145		146	H	146	H	147	H	147	H	mmol/L	135-145
K	3.9		3.4	L	4.2		4.0		3.8		mmol/L	3.5-5.1
CL	112	H	112	H	112	H	110	H	108	H	mmol/L	98-107
CO2	28		26		27		29		29		mmol/L	21-32
GLUCOSE	105	H	104	H	139	H	129	H	131	H	mg/dL	70-99
BUN	18		22		33	H	38	H	40	H	mg/dL	7-22
CREATININE	0.5	L	0.5	L	0.6		0.6		0.7		mg/dL	0.6-1.0
B/C RATIO CALC	36.0	H	44.0	H	55.0	H	63.3	H	57.1	H		6.0-17.0
ANION GAP CALC	5		8		7		6		10		mmol/L	2-17
OSMO CALC	291		294		300		303		304		mOsm/kg	286-309
CALCIUM	7.5	L	7.6	L	7.6	L	8.0	L	9.0		mg/dL	8.5-10.1
PROTEIN	4.1	L									g/dL	6.4-8.2
ALBUMIN	1.6	L									g/dL	3.4-5.0
GLOBULIN	2.5										g/dL	1.8-4.4
A/G RATIO CALC	0.64	L										1.00-2.20
BILI TOTAL	0.57										mg/dL	0.00-1.00
ALK PHOS	79										U/L	45-117
SGOT	36	H									U/L	15-37
SGPT	39										U/L	30-65
GLOM FILT RATE	126		126		102		102		86			

ALKALINE PHOSPHATASE INTERPRETATION:

effective 4/7/2014, revised Alkaline Phosphatase method.

Note revised adult reference range.

SGPT methodology change effective 2-4-2013.

Average GFR based on this patient's Age Group: 75 ml/min/1.73 sq.m.

LEGEND
L = LOW, H = HIGH, LC = LOW CRITICAL, HC = HIGH CRITICAL, <> = ABNORMAL, C = CRITICAL

Roper St. Francis Healthcare
Department of Laboratory Medicine
Charleston, South Carolina 29401

PATIENT: PARROTT, DELILA WILSON
DOB: REDACT
PID: D001787037
ACCT # : D1415701389

LOCATION: D3D 3109-01
PHYSICIAN: MILLS-MD, RICHARD E
PRINTED: 06/11/14 06:31

ADMITTED: 06/06/14

DISCHARGED: 06/10/14

HEMATOLOGY

Collected	06/10 05:30		06/09 05:40		06/08 05:45		06/07 05:40		Units	Reference
WBC	8.3[1]		7.8[1]		7.9[1]		13.6[1]	H	x10E3/uL	3.8-10.8
RBC	3.28	L	3.26	L	2.91	L	3.44	L	x10E6/uL	3.80-5.20
HGB	9.0	L	9.1	L	7.8	L	9.2	L	g/dL	11.5-15.7
HCT	27.3	L	27.6	L	23.9	L	28.5	L	%	34.0-47.0
MCV	83.1		83.9		82.0		82.9		fL	81.0-99.0
MCH	27.6		27.8		26.8	L	26.8	L	pg	27.0-34.5
MCHC	33.2		33.1		32.7		32.4		g/dL	32.0-36.0
RDW	14.6		14.6		14.1		14.3		%	11.0-16.0
PLATELET	158		140		168		165		x10E3/uL	140-440
MPV	7.3		7.5		7.6		7.7		fL	7.2-11.2

Collected	06/06 22:35		Units	Reference
WBC	16.5[1]	H	x10E3/uL	3.8-10.8
RBC	3.95		x10E6/uL	3.80-5.20
HGB	10.8	L	g/dL	11.5-15.7
HCT	32.5	L	%	34.0-47.0
MCV	82.4		fL	81.0-99.0
MCH	27.4		pg	27.0-34.5
MCHC	33.2		g/dL	32.0-36.0
RDW	13.9		%	11.0-16.0
PLATELET	175		x10E3/uL	140-440
MPV	8.3		fL	7.2-11.2

06/10/14 05:30 : Performed at RSFH Mount Pleasant Hospital, 3500 Highway 17 North, MT PLEASANT, SC, United States, 29466
06/09/14 05:40 : Performed at RSFH Mount Pleasant Hospital, 3500 Highway 17 North, MT PLEASANT, SC, United States, 29466
06/08/14 05:45 : Performed at RSFH Mount Pleasant Hospital, 3500 Highway 17 North, MT PLEASANT, SC, United States, 29466
06/07/14 05:40 : Performed at RSFH Mount Pleasant Hospital, 3500 Highway 17 North, MT PLEASANT, SC, United States, 29466
06/06/14 22:35 : Performed at RSFH Mount Pleasant Hospital, 3500 Highway 17 North, MT PLEASANT, SC, United States, 29466

[1]Review of peripheral smear and/or differential may be indicated if clinically appropriate.

LEGEND
L = LOW, H = HIGH, LC = LOW CRITICAL, HC = HIGH CRITICAL, <> = ABNORMAL, C = CRITICAL

OneContent: Generated By coffje1

Roper St. Francis Healthcare
Department of Laboratory Medicine
Charleston, South Carolina 29401

PATIENT: PARROTT, DELILA WILSON
DOB: REDACT
PID: D001787037
ACCT # : D1415701389

LOCATION: D3D 3109-01
PHYSICIAN: MILLS-MD, RICHARD E
PRINTED: 06/11/14 03:39

ADMITTED: 06/06/14

DISCHARGED: 06/10/14

URINALYSIS

Collected	06/09 23:15	Units	Reference
METHOD OF COLLECTION	CATH		
COLOR	YELLOW		YELLOW,STRAW,COLORLESS,LIGHT YELLOW,DARK YELLOW
APPEARANCE	CLEAR		CLEAR
GLUCOSE URINE	NEGATIVE		NEGATIVE
BILIRUBIN URINE	NEGATIVE		NEGATIVE
KETONES URINE	TRACE <>		NEGATIVE
SPECIFIC GRAVITY	1.030		1.003-1.035
BLOOD URINE	MODERATE <>		NEGATIVE
PH URINE	6.0		4.6-8.0
PROTEIN URINE	100 <>		NEGATIVE
UROBILINOGEN	0.2	EU/dL	0.2,1.0
NITRITE URINE	NEGATIVE		NEGATIVE
LEUKOCYTE ESTER	NEGATIVE		NEGATIVE
WBC URINE	6-10 <>		NOT SEEN
RBC URINE	21-50 <>		NOT SEEN
MUCUS URINE	4+ <>		NOT SEEN,RARE
BACTERIA URINE	1+ <>		NOT SEEN,RARE

Performed at: RSFH Mount Pleasant Hospital, 3500 Highway 17 North, MT PLEASANT, SC, United States, 29466

LEGEND
L = LOW, H = HIGH, LC = LOW CRITICAL, HC = HIGH CRITICAL, <> = ABNORMAL, C = CRITICAL

Mt. Pleasant
3500 Highway 17 North Mt Pleasant,SC 29466

Date:	Name	Acct. #	Financial Class	
06/24/14	PARROTT,DELILA WILSON	14137-01389	M - MEDICARE	
Sex	Birth Date Age	Adm Date	Dsch Date	LOS
F	REDA 80Y	06/06/14	06/10/14	4

Attending Physician
OKRAJU-MD,SWAPNA
Coder: GSR

Discharge Status
03 - 03_SKILLED NURSING FACILITY

MDC: 8
DRG: V01.0 (I9) 481 HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W CC

OUTLIER STATUS: N/A

	DIAGNOSIS	DESCRIPTION/POA		DIAGNOSIS	DESCRIPTION/POA
1.	(P) 820.21	INTERTROCHANTERIC FX-C/Y	14.	401.9	HYPERTENSION NOS/Y
2.	s 293.8	TRANSIENT MENTAL DIS N/W	15.	311	DEPRESSIVE DISORDER NE/Y
3.	707.04	PRESSURE ULCER, HIP/Y	16.	300.00	ANXIETY STATE NOS/Y
4.	707.05	PRESSURE ULCER, BUTTOC/Y	17.	530.81	ESOPHAGEAL REFLUX/Y
5.	276.51	DEHYDRATION/Y	18.	780.57	SLEEP APNEA NOS/Y
6.	427.31	ATRIAL FIBRILLATION/Y	19.	707.20	PRESSURE ULCER,STAGE U/Y
7.	280.0	CHR BLOOD LOSS ANEMIA/Y	20.	276.0	HYPOOSTASEMIA/N
8.	903.82	MD VAC STRPTCS PNEUMOL/E	21.	V15.82	HISTORY OF TOBACCO USE/Z
9.	294.20	DEMEN NOS W/O BEHV DST/Y	22.	E880.1	FALL STRIKING OBJECT N/Y
10.	s 997.99	SURG COMPL-BODY SYST N/N	23.	E849.0	ACCIDENT IN HOME/E
11.	285.1	AC POSTHEMORRHAG ANEMI/N	24.	E878.8	ABN REACT-SURG PROC NE/N
12.	820.22	SUBTROCHANTERIC FX-CLO/Y	25.	E849.7	ACCID IN RESIDENT INST/Y
13.	558.9	NONINF GASTROENTERIT N/Y			

Reason for Visit:

	PROCEDURE	DESCRIPTION	DATE	SURGEON NAME
1.	(P) 79.35	OPEN REDUC-INT FIX FEMUR	06/07/14	MURRAY-MD,PATRICK J
2.	99.04	PACKED CELL TRANSFUSION	06/08/14	MURRAY-MD,PATRICK J
3.	00.33	CAS W FLUOROSCOPY	06/07/14	MURRAY-MD,PATRICK J

PARROTT,DELILA WILSON
001787037 00913109
06/24/14

DIAGNOSIS SUMMARY WORKSHEET

Mt Pleasant Hospital
Discharge Summary
ADMISSION: 06/06/2014
DISCHARGE: 06/10/2014
Patient DOB: REDACTED

PARROTT, DELILA W
1416701389
Swapna Omraju MD
Page 1

DICTATED BY: Nicole Perrin Ketchin, PA-C.

PRIMARY CARE PHYSICIAN: Dr. Richard Mills.

CONSULTING PHYSICIANS:
1. Dr. Patrick Murray, orthopedist.
2. Dr. Paul Tantis, gastroenterologist.

DISCHARGE DIAGNOSES:
1. Left hip fracture status post open reduction and internal fixation.
2. Anemia of acute blood loss superimposed on chronic anemia.
3. Hypertension.
4. Acute delirium, improving.
5. Chronic diarrhea.
6. History of atrial fibrillation.
7. Anxiety.

HISTORY OF PRESENT ILLNESS: Ms. Parrott is an 80-year-old Caucasian female who sustained a fall at her residence and was discovered 2 days after the incident by a friend. The patient complained of left hip pain and was unable to ambulate. In the Emergency Room, x-ray revealed a left femoral intertrochanteric and subtrochanteric fracture. Her urinalysis also revealed that she was dehydrated. She was also noted to have some skin breakdown. The patient was then admitted for further workup and management of her acute concerns.

RADIOLOGICAL STUDIES:
1. Chest x-ray: No acute process.
2. X-ray of the hip: Acute comminuted fracture in the left femoral intertrochanteric/subtrochanteric region.

HOSPITAL COURSE: For the patient's hip fracture, she was seen in consultation by Dr. Patrick Murray who brought her to the operating room on 06/07/2014 performing an open reduction and internal fixation of the left subtrochanteric femur fracture. The patient tolerated the operation well; however, she did have postoperative complications of acute delirium. The patient was also noted to have anemia of acute blood loss, and therefore, she required a transfusion of 2 units of packed red blood cells.

The patient was also noted to have a history of chronic stools with loose bowels during admission, and therefore, she was seen in consultation by the GI team who felt that her chronic diarrhea could be due to microscopic/collagenous colitis. Other etiologies include inflammatory bowel disease or infection. Therefore, they recommended checking stool studies. Her C. diff toxin was negative. Prior to discharge. Stool studies are still pending. She was treated empirically with p.r.n. Imodium and Lomotil and plans to follow up with Dr. Yantis and/or Joyner as an outpatient as she will likely need a repeat colonoscopy with biopsies.

The patient was able to work with physical therapy and occupational therapy, and it was felt that she would benefit from subacute rehabilitation at a skilled nursing part of Sandpiper. She will be transferred there today in stable condition.

DISCHARGE LABORATORY DATA: BNP 169. Magnesium 2.8. CPK 673. Negative C. diff toxin. Urine culture 1000 colony counts of E. coli. Stool Hemoccult negative. White count of 8.3, hemoglobin of 9, hematocrit of 27.3, and platelets of 156. Sodium of 145, potassium of 39, chloride of 112, bicarbonate of 20, BUN of 10, creatinine 0.5, and a glucose of 105. LFTs normal except for a slight elevation of her SGOT of 38.

DISCHARGE MEDICATIONS: Please see attached medication list.

DISCHARGE INSTRUCTIONS: The patient can increase activity as tolerated. She has been instructed to use toe-touch weightbearing with the assistance of physical therapy and occupational therapy. She should resume a low sodium diet. Her current dressing will be able to stay on for 1 week. Staple removal will be at her followup appointment with Dr. Murray in approximately 2 weeks. Followup appointment has been made to see Dr. Richard Mills on Wednesday 07/02/2014 at 3:00 p.m. Any questions or concerns regarding the patient's hospital course can be addressed to Dr. Omraju at 884-1777.

Nicole Perrin Ketchin, PA-C
TR: en DD: 06/10/2014 13:32 TD: 06/10/2014 14:26 Job#: 284102
DOC#: 386658

Authenticated by OMRAJU-MD,SWAPNA On 06/11/2014 05:21:51 PM

MUSC Health

"CONSULT"

PHYSICIAN CONSULTATION REPORT

Page 1 of 2

Form Origination Date: 1/00
Version: 4 Version Date: 1/10

SP-Magnolia 125

Patient Name Parrott, Delila
MRN

PATIENT IDENTIFICATION LABEL

Physician / Service notified by: _____ Date: 7-10-14
Requested by Attending Dr. _____ Pager ID: _____ Service being consulted: psych
CC / Reason for Request: flashbacks

HPI: 80 yo WLOF at SP since 6/10/14 following hosp. at MUSC for LWI, fx s/p ORIF. Pt fell at Sandpiper Village & was discovered by a friend 2 days later. She was dehydrated & had some skin breakdown, also UTI. & needs at home - Celexa 10 QD & B12 injections - keep pt & pt's sensory notes delirium & anxiety & problems. At SP per Valium started on 6/10/14. Chart review shows pt continued on 2/2 - stated people capture & keep her from leaving. Pt's daughter - she received per Valium - she was fearful & expressed wishes she wanted the Valium off d/c'd. Intrusive she recalls the fall, her fear & hanging Hoover/wide for 2 days. memories

Allergies: ace/nabib, NSAID, ASA, nasal spray Medications: Lasix, Nexium, Colace, Celexa 10 QD, Diflucan, Vit B12 IM monthly, Norco PRN, Valium 2 QHS PRN, Tramadol PRN, Inderal, Norco, 7.5/325 BID
PMH: HTN, fx s/p ORIF, chronic diarrhea/possible colitis, anemia of acute
SH: CVA - psychiatric Disorder SH: widow (H) with pharmacist.

ROS: Constitutional PCP Dr. Wills in Mt P.
Eyes
ENT
Cardio
Resp
GI chronic diarrhea - colonoscopy sched. for July 8th
GU
Integument
Muscl / skeletal ϕ pain in LLE. Good PT effort.
Endo
Psych sleep well, avg anxiety, ↓ conc, ↓ appetite
Neuro
Heme / Lymph anemia s/p 2 units RBC's.
Allerg / Immun
☑ All others reviewed and negative ☐ UNABLE TO OBTAIN HISTORY DUE TO:

PHYSICAL EXAMINATION: T 97.8 °C P 104 RR 18 BP 146/63 O2 Sat 96 %

Area	WNL	Area	WNL	Labs / Xrays
Genl appearance	☐ Meds (cont)	Heart	☐ At SP	Recent Pt -
Skin	☐ —	GI / Abdomen	☐ H Pylori IgG ↑	CXR - ϕ acute process
Head	☐	Genitourinary	☐ 1.16 - will	BC C diff (-)
Eyes	☐	MS / Extremities	☐ Hx ↓ Gt.	Na 143, K 3.9, Cl 112,
ENT	☐	Neuro	☐ 10/10/14 -	CO2 28, BUN 18, cr 0.5
Neck	☐	Heme / Lymph	☐ 8.9/32.7	glc 105
Breasts	☐	Psych	☐	LFT's WNL ↑ SGOT 37
Lung / Chest	☐	Other	☐ 6/16 - unreviewed (-).	EKG - SR PAC's.

Abnormal findings / Additional comments:
PMH (cont) - blood loss, HTN, AFib, chronic anemia, UTI (E coli) s/p fx, B12 deficiency, macular degeneration, GERD, OSA

SH - remote H/O smoking (H) in Columbia. College edu. married twice, divorced from 1st (H) nurse anesthetist. Caregiver for 2nd (H) who died from cancer at home in 2008. 1 son in Florence, (H) at Folly Beach, 1 GD in Columbia (nurse/RN). Pt adopted - mother died in childbirth, father abandoned. Adopted c 1 sister, 3 other sibs. ϕ childhood abuse or trauma.

Clinician Signature _____ Pager ID _____ Date of consult _____ Time _____
all all consult medconsult
Lived in Sandpiper until 1 yr ago - then SP Village. Quit driving 1 yr ago. Lived in Florence a few months ago. ϕ etoh/Drugs/tobacco

MUSC Health

"CONSULT"

PHYSICIAN CONSULTATION REPORT

Page 2 of 2

Form Origination Date: 1/00
Version: 3 Version Date: 2/08

SP - Maquova 125

Patient Name Parrott, Delila
MRN

PATIENT IDENTIFICATION LABEL

ASSESSMENT / PLAN:

4 Hx - (per pt + also (P) game collateral). no formal Dx + Tx until 2009 when she was hosp. at Baptist geriatric unit in Columbia for SI + delirium of paranoia's. briefly took seroquel but never compliant. Has taken celexa for years per PCP + also W/O Xanax IRN for anxiety (helpful). Long Hx paranoia + delusions. For ex., sees a van parked near house + thinks it is photographing her. No clear Hx AVH. Somatic delusions since her 40's - thinks washing + peroxide can control her BP, for ex. Delusion of bad insertion more recent (since 2009 I (P) d/c'd). Has caked up her vagina/anus + keep bugs out + excessively used enemas + douches. + insight into psychosis. + formal suicide attempts.

MSE - Pt is seen c 5-in-law visiting. Appears dressed + groomed. Good eye contact. + tremor or abn. movements. Speech soft but otherwise normal. Mild word finding difficulty. Mood "up + down stay upbeat + hopeful". Affect constricted, tearful. TC OSI/PHI/AOX3 + delirium of people in woods by her room + child, mother died. TP - Linear; coherent. Attn - mildly impaired SIM/LTM - grossly intact + Blessed - 2/3

A+O x 3 J/I - mild - mod impaired.

10/28

Clinician Signature _____ Pager ID _____ Date of consult _____ Time _____

ATTENDING PHYSICIAN COMMENTS:

I have reviewed the history, physical exam and plan of care and after my examination and interview of the patient, I agree with the findings. I have the following additional findings:

A/P - Delirium 2° opiates/dehydration/UTI resolving
Depression NOS
Psychosis NOS (Delusional D/O v. MDD c ψ sis) most likely

① Depression - worsened - acute trauma + health decline. + Celexa 20 mg QD. For acute anxiety use Xanax 0.25 Q8 prn. Dc Xanax.
② Psychosis - chronic, non-compliant c Tx, refuses antipsychotic - likely delusional D/O.
③ Cognition - no W/O dementia or decline. ~~Deficit~~ Deficits on

Attending Signature _____ Pager ID _____ Date of consult _____ Time _____ W/O
all_all_consult_medconsult

OTE 700321 Rev. 2/08

plan may be 2° depression/delirium, but needs to be tracked over time for improvement. may need AL level care
ran F.U in geriatric + clinic - 792-5567 [illegible] 7/10/

Sandpiper PT0006

176

ROA 1660

A. No.

Q. Where did you find Ms. Delila when you came into the room?

A. She was on the floor.

Q. Can you describe where in the apartment she was on the floor?

A. Well, yes. Like if this is the wall, there's a window here and the chair was there. There was a big chest of drawers here, one of those great big ones. The four-poster bed was here and she was between the bed and chester drawers.

Q. Okay. What did you notice about her appearance? Did she appear to be injured?

MR. BUCKNER: Object to the form.

BY MR. REEVES:

A. She was lucid. She was fine.

Q. Okay.

A. I mean, she just said, oh, I'm so glad to see you, don't leave me, don't leave me. I said, I've got to call an ambulance.

Q. Did you call the ambulance, Ms. Lila?

A. No. She said, my phone's over there. But I didn't. I went back and asked Rebecca to call the ambulance. And then she did and then Becca came and the ambulance people came.

A. Yes.

Q. All right. Did you see Ms. Delila on June 4th?

A. No.

Q. Okay. And she left you the birthday wish message on Tuesday evening?

A. Yes.

Q. All right. Did you know you were not going to see her on June 4th?

A. I didn't -- if she didn't come to dinner I would not see her.

Q. Okay. Did you see her on June 5th?

A. On Tuesday?

Q. No. That would be Thursday.

A. On Thursday? No.

Q. Okay. What, if any, concerns did you have about not seeing her on Thursday? Did you expect to see her?

A. Yes.

Q. All right. And what did you do, if anything, once you did not see her?

A. I called her, went down and knocked on the door. And the lady at the desk called her several times and went down and knocked on the door.

Q. Do you know the name of the lady at the desk?

A. Rebecca.

Q. And did you ask Rebecca to call and check on

Ms. Delila?

A. Yes.

Q. **All right. Did she receive an answer to your knowledge?**

A. She said she didn't have her name and telephone number -- her address and telephone number.

Q. **Repeat that, Ms. Lila? I'm sorry.**

A. She did not have her address and telephone number.

Q. **What did Rebecca do to try to -- she just tried to call her from what you observed?**

MR. BUCKNER: Object to the form.

BY MR. REEVES:

A. What did she do? Well, she -- she went down there and knocked on the door and rang the phone.

Q. **Okay. All right. And did she get any response to your knowledge?**

A. No.

Q. **Did you do anything else on Thursday to determine -- let me rephrase that.**

What, if anything, did you do on Thursday to try to check on Ms. Delila other than talk to Rebecca?

A. I went down there and went on the front porch and moved a rocking chair over and made a little bit of noise, and nothing.

Q. Okay. Did you try to call her telephone number?

A. Oh, yeah. Several times.

Q. Did you ever receive an answer?

A. No.

Q. On Friday morning, this would be June 6th, did you see Ms. Delila that morning?

A. No.

Q. Did you do anything as a result of not seeing her?

A. We did the same routine, Rebecca and I.

Q. Okay. And did she call again?

A. Oh, yeah.

Q. Do you know if she received an answer?

A. No. Nobody -- we didn't.

Q. Okay. Did you go to Ms. Delila's room or her apartment?

A. Oh, yes.

Q. And you did not receive any notice or any --

A. I knocked on both doors, nothing.

Q. Did you speak with Rebecca again that day about trying to get into Ms. Delila's apartment?

MR. BUCKNER: Object to the form.

BY MR. REEVES:

A. No.

Q. Okay. What happened next on Friday then?

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

DAY SHIFT color ink ▶ EVENING SHIFT color ink ▶ NIGHT SHIFT color ink ▶

DATE/TIME GIVEN	TIME NOTED	MEDICATION & DOSAGE	REASON	RESULTS OR RESPONSE	TIME NOTED	NURSE'S SIGNATURE & TITLE
9-18-14 1120p	PP	Xanax 0.25mg	anxious	resting	1230	
9-19-14 945	PP	Xanax 0.25mg	anxious	resting	015	
9/21/14 2am	PP	Xanax 0.25mg	anxious	helped	130	
9/23/14 230pm	PP	Xanax 0.25mg	anxious	helped	130pm	
9-22-14 8P	PP	Xanax 0.25mg	anxiety	effective	100	
9-24-14 8P	PP	Xanax 0.25mg	anxiety	effective	10p	
9-25-14 8P	PP	Xanax 0.25mg	anxiety	effective	9p	
9-26-14 8P	PP	Xanax 0.25mg	anxiety	effective	9p	
9-29-14 8P	PP	Xanax 0.25mg	anxiety	effective	9p	
9-30-14 8P	PP	Xanax 0.25mg	anxiety	effective	9p	

DATE/TIME GIVEN	TIME NOTED	MEDICATION & DOSAGE	REASON	RESULTS OR RESPONSE	TIME NOTED	NURSE'S SIGNATURE & TITLE

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

DAY SHIFT color ink ▶ EVENING SHIFT color ink ▶ NIGHT SHIFT color ink ▶

INSTRUCTIONS

MEDICATION RECORD

FiveStar 258

OneContent: Generated By coffje1

The patient was also noted to have a history of chronic stools with loose bowels during admission, and therefore, she was seen in consultation by the GI team who felt that her chronic diarrhea could be due to microscopic/collagenous colitis. Other etiologies include inflammatory bowel disease or infection. Therefore, they recommended checking stool studies: Ber C. diff toxin was negative. Prior to discharge. Stool studies are still pending. She was treated empirically with p.r.n. Imodium and Lomotil and plans to follow up with Dr. Yantis and/or Joyner as an outpatient as she will likely need a repeat colonoscopy with biopsies.

The patient was able to work with physical therapy and occupational therapy, and it was felt that she would benefit from subacute rehabilitation at a skilled nursing part of Sandpiper. She will be transferred there today in stable condition.

DISCHARGE LABORATORY DATA: BNP 169. Magnesium 2.5. CPK 673. Negative C. diff toxin. Urine culture 1000 colony counts of E. coli. Stool Hemoccult negative. White count of 8.3, hemoglobin of 9, hematocrit of 27.3, and platelets of 155. Sodium of 145, potassium of 39, chloride of 112, bicarbonate of 20, BUN of 10, creatinine 0.5, and a glucose of 105. LFTs normal except for a slight elevation of her SGOT of 36.

DISCHARGE MEDICATIONS: Please see attached medication list.

DISCHARGE INSTRUCTIONS: The patient can increase activity as tolerated. She has been instructed to use toe-touch weightbearing with the assistance of physical therapy and occupational therapy. She should resume a low sodium diet. Her current dressing will be able to stay on for 1 week. Staple removal will be at her followup appointment with Dr. Murray in approximately 2 weeks. Followup appointment has been made to see Dr. Richard Mills on Wednesday 07/02/2014 at 3:00 p.m. Any questions or concerns regarding the patient's hospital course can be addressed to Dr. Omraju at 884-1777.

Nicole Perrin Ketchin, PA-C
TR: en DD: 06/10/2014 13:32 TD: 06/10/2014 14:26 Job#: 284102
DOC#: 386658

Authenticated by OMRAJU-MD,SWAPNA On 06/11/2014 05:21:51 PM

OneContent: Generated By coffje1

Patient DOB: REDACTE

CHIEF COMPLAINT: Left hip pain.

HISTORY OF PRESENT ILLNESS: This is an 80-year-old female who per her daughters fell several days ago at home and was left lying on the floor until somebody discovered her after supposedly suffering a fall. She was unable to bear weight and had extreme pain in her left hip. She was brought to the Emergency Room and found to have a left comminuted subtrochanteric and intertrochanteric femur fracture. She was admitted to the medical service and cleared for surgical management.

PAST MEDICAL HISTORY: Atrial fibrillation, hypertension, anxiety, macular degeneration, gastroesophageal reflux disease, and sleep apnea.

PAST SURGICAL HISTORY: Includes: Breast biopsy, left wrist fracture, multiple eye surgeries.

FAMILY HISTORY: Father died of stroke.

HOME MEDICATIONS: Diltiazem, Nexium, Celexa, propranolol, Tylenol.

ALLERGIES: INCLUDE ACE INHIBITORS AND ASPIRIN.

SOCIAL HISTORY: She is a widow. She has a distant history of smoking more than 30 years ago.

PHYSICAL EXAMINATION: She is awake and in no acute distress. She has pain with log roll of her left hip. No pain with right hip log roll. No bilateral knee, ankle, shoulder, elbow, wrist tenderness. No cervical neck tenderness. Brisk capillary refill in all 4 extremities. Sensation intact to light touch throughout all 4 extremities. ABDOMEN: Soft. Nonlabored breathing. CARDIOVASCULAR: Regular rate and rhythm.

Review of x-rays shows comminuted subtrochanteric and intertrochanteric femur fracture on the left.

ASSESSMENT AND PLAN: Admitted by the hospitalist service and taken to the OR for open reduction internal fixation.

OneContent: Generated By coffje1

Patient DOB: REDACTED

REFERRING PHYSICIAN: Dr. Richard Mills

REASON FOR CONSULTATION: Diarrhea.

HISTORY OF PRESENT ILLNESS: Ms Parrott is a pleasant, 80-year-old white female well known to me for many years and is a retired nurse anesthetist. I saw her last summer when she had a routine colonoscopy here at Roper Mount Pleasant Hospital that was negative except for a small benign polyp in the mid sigmoid colon. The best I can tell, the patient has had problems now with chronic diarrhea since the first of the year. A referral was sent to our office, and we contacted the patient but she refused to make an appointment at that time. Anyway, she says she had anywhere between 2-5 loose bowel movements a day, without blood. She thinks she has slowly gotten better over the last couple months down to maybe 2 bowel movements a day. She is in the hospital now because she fell approximately 2 days prior to admission while living Sandpiper, and was not seen because the caregivers at Sandpiper thought she was out of town. Anyway, she was found by one of her bridge partners and sent to the Emergency Room here at Roper Mount Pleasant Hospital on 06/05/2014, and was discovered to have a left femoral intratrochanteric fracture. She was admitted to the hospital at that time.

PAST MEDICAL HISTORY:
1. Atrial fibrillation.
2. Hypertension.
3. Anxiety.
4. GERD.
5. Sleep apnea.

PAST SURGICAL HISTORY:
1. Left wrist fracture.
2. Multiple eye surgeries.
3. Colonoscopy 08/20/2013, by myself.

SOCIAL HISTORY: The patient is a retired nurse anesthetist and she denies using alcohol and quit smoking 30 years ago.

FAMILY HISTORY: Negative for gastrointestinal disease.

Chief Complaint (Category: Fall Victim)

History of Present Illness

O/A EMS found 80yo F AAOx3 laying on the floor between her bed and a dresser. PT shows no signs of distress and is able protect her airway with adequate respirations. CC L Hip pain secondary to a fall. PT states she was attempting to hanging her curtains and fell. Unknown if PT was standing on the lazy boy chair under the window where she was hanging curtains. PT states she is unable to straighten her L leg due to Pain in her Hip an thigh. PT states she has been on the floor since Tuesday but neighbors state they saw her walking around yesterday. PT denies any CP, SOB, weakness, dizziness, neck or back pain. No pain upon palpation of neck and back. Pain upon palpation of hip and leg with no crepitus. EMS is unable to move leg without pt screaming in pain. Vitals above. 20g IV established in L forearm by Fire personnel. 4 lead EKG indicates NSR with no ectopy. PT has Allergy to ASA, and Ace Inhibitors. RMPH contacted for med order. Per Dr John Walters, 50mcg Fentanyl approved via IV push with second dose of 50mcg Fentanyl if needed. 12 lead EKG indicates NSR with no ST elevation or Ectopy. PT administered 50mcg Fentanyl with TKO flush NS. Pain improves to 5-10. PT picked up with Scoop stretcher. Voids padded with 2 pillows and blankets. PT carried to stretcher, Secured with 3 straps. PT placed on Oxygen at 2 LPM via NC. PT transported in position of comfort to RMPH. En route second dose of 50mcg Fentanyl administered IV push with TKO flush NS. Pain drops to 2-10. En route hospital updated with no additional questions or orders. O/A Pt moved to ER bed 6 where turnover conducted and PT care transferred to ER staff. PT is unable to sign PCR, witnessed by nurse. Dr. Walters signs drug order. ASM

Medical History	Current Medications	Allergies
Hypertension Unknown Cardiac	Acetaminophen Cefuroxime Citalopram Cyanocobalamin Diltiazem Furosemide Nexium Propranolol	ACE Inhibitors All Insids Asa Chocolate nasal sprays

Neurological Exam

Level of Consciousness: Alert

Loss of Consciousness: Unknown

Chemically Paralyzed: No

Stroke Scale: Cincinnati Negative

Neurological Present: Normal

Mental Present: Normal

Glasgow Coma Scale				
	E	V	M	Tot
Int:	4	5	6	= 15

Revised Trauma Score: 12.00

	Motor	Sensory
LA:	Normal	Normal
RA:	Normal	Normal
LL:	Flaccid	Normal
RL:	Flaccid	Normal

Airway

Status: Patent

Respiratory

Effort: Normal

Cardiovascular

Pulses	Left	Right
Carotid:		
Radial:	Normal	
Femoral:		

Injury Details

Reason for Encounter: Injury/Trauma

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Nurse's Notes — *Roper St. Francis HealthCare Mount Pleasant*

Name: Delila Parrott
Age: 80 years **Sex:** Female **DOB:** REDACTE
Arrival Date: 06/06/2014 **Time:** 21:14
Bed 2
MRN: 001787037
Account#: 1415701389
Private MD:
Diagnosis: Hip Fracture; Dehydration; Decubitus Ulcer, Pressure, (Buttock); Decubitus Ulcer, Pressure, (Hip); Bladder Infection (UTI)

Inbound Details:
Referred by: Arriving by: EMS ETA:
Who will see patient? ED Physician
Notes:
Notify referring provider: Do not notify

Presentation:

06/06 21:32 Transition of care: patient was received from home. tm7

21:32 Method Of Arrival: EMS. tm7

21:45 Care prior to arrival: See EMS report. Medication(s) given: 100 MCG OF FENTANYL ADMINISTERED PTA IV initiated. 20 LEFT FA Glucose check. 108. Mechanism of Injury: Fall PT WAS STANDING ON LAZY BOY TRYING TO FIX CURTIN. FELL TO THE FLOOR. DENIES LOC OR STRIKING HEAD. ekk

Triage Assessment:

21:15 Presenting complaint per patient: Pt was found on the floor by a neighbor who checked on her. Unknown how long she was on the floor. Complains of left hip pain. Appears unkempt. Behavior is crying. **Pain:** Complains of pain in left hip. tm7

21:36 Presenting complaint per patient: pt was given 100 mcg IV fentanyl by EMS prior to arrival. tm7

Historical:

Allergies:
21:30 green vegetables; Chocolate; Aspirin; ACE INHIBITORS; all nasal sprays; NSAIDS; tm7

Home Meds:
21:34 Diltiazem Oral ; Lomotil oral ; Propranolol Oral ; citalopram oral ; Tylenol #3 Oral ; Nexium Oral ; Furosemide Oral ; cyanocobalamin (vitamin B-12) oral ; Celtin Oral ; tm7

PMHx:
21:34 Atrial Fib; Hypertension; Anxiety; tm7

- **Social history::** Smoking status: Patient/guardian denies using tobacco, but has a distant history of tobacco abuse..
- **Advanced Directives::** Patient has healthcare power of attorney, documentation unavailable. Patient/legal representative advised of need for copy to be obtained and placed on chart for Advance Directive to be honored. The patient has a living will, documentation unavailable. Patient/legal representative advised of need for copy to be obtained and placed on chart or Advance Directive to be honored.

Screening:

21:32 **Abuse screen:** tm7
Denies threats or abuse.
Fall Risk
Fall in past 12 months (25 points). Secondary diagnosis (15 points) No IV (0 pts). Ambulatory Aid-Crutches/Cane/Walker (15 pts). Gait- Impaired (20 pts.). Mental Status- Oriented to own ability (0 pts).
Suicide Screening:
Patient denies thoughts of harming self or others.
Tuberculosis screening:
No symptoms or risk factors identified. Denies unexplained cough, fever, night sweats, weight loss, or exposure to anyone with know TB infection.
C-Diff Screening:
Patient has not had any watery stools in the past 24 hours.

Assessment:

21:38 Appears uncomfortable. Behavior is cooperative, "I fell down on Tuesday and have been laying in the floor just hoping someone would find me. I think I broke my hip". ekk

Print Time: 6/6/2014 07:40:30 *** **CHART COMPLETE** *** Page 1 of 3

Nurse's Notes Con't

21:39 **GU:** Noted on inspection: on arrival pt was saturated in foul smelling urine. Her underwear was stuck to her skin. Cleaned of incontinence. yellow and green think liquid coming from vaginal area. ekk

21:41 **Musculoskeletal:** Noted on inspection: Deformity Bony deformity noted of pelvis and left hip. **Skin:** Bruising that is dark purple, on left leg. ekk

21:43 **Skin:** Decubitus located on right hip(s) approximately 7.6 cm to 20 cm other top layer of skin broken down. pt states she was in that same position since she fell tuesday. ekk

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Height	Pain	Staff
21:18	162 / 77	86	17	97.7	93%	68.04 kg	5 ft. 7 in. (170 cm)	9/10	tm7
22:00	149 / 67 (auto)								ekk
22:00		77 HON	16		95%				ekk
22:15	149 / 67 (auto)								ekk
22:15		79 HON	17		95%				ekk
22:30	156 / 68 (auto)								ekk
22:31		83 HON	16		95%				ekk
23:27		83 HON	13		95%				ekk
23:30	161 / 64 (auto)								ekk
23:38		83 HON	18		95%			7/10	ekk
23:45	149 / 58 (auto)								ekk
23:45		82 HON	14		94%				ekk

23:45 Body Mass Index 23.5 (68.04 kg, 170 cm) ekk
23:38 Normal Sinus Rhythm ekk

Vitals:
21:18 Acuity: Urgent. tm7

Glasgow Coma Score:

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
21:18	spontaneous(4)	oriented(5)	obeys commands(6)		15	tm7

ED Course:

21:14 Patient arrived in ED. ds6
21:16 Walters, John, MD is Attending Physician. jwf1
21:18 Triage completed. tm7
21:34 Patient has correct armband on for positive identification, for Fall Risk, Placed in gown. Bed in low position. Call light in reach. Side rails up X2. Verbal reassurance given. Pillow given. Elevated left hip Turned to right side. Repositioned patient. Assisted with dressing. Cleaned of incontinence. Linen changed. rs
21:36 Cardiac/NIBP/Pulse Ox monitor on. rs
21:38 Kell, Erin, RN is Primary Nurse. ekk
21:42 Maintain field IV. Dressing intact. Good blood return noted. Site clean & dry. Gauge & site: left forearm . ekk
21:42 Foley cath inserted 16 Fr. Balloon inflated. To gravity drainage. ekk
22:01 HIP XR UNILATERAL (CO1) 2 VIEW RIN In Process Unspecified. ED IS
22:19 PCXR In Process Unspecified. ED IS

Name: Delila Parrott **MRN:** 001787037
Account#: 1415701389

Print Time: 6/6/2014 07:40:30 Page 2 of 3

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Physician Documentation

Roper St. Francis HealthCare Mount Pleasant

Name: Delila Parrott
Age: 80 years **Sex:** Female **DOB:** REDACTED
Arrival Date: 06/06/2014 **Time:** 21:14
Bed 2
ED Physician Walters, John
HPI:

MRN: 001787037
Account#: 1415701389
Private MD:

06/06 23:07 This 80 years old White Female presents to ED via EMS with complaints of Hip Pain. jwf1

23:07 The patient or guardian reports an injury, that occurred at home, sustained from a fall, the left lower extremity is shortened, left leg is externally rotated, The patient is not able to ambulate. Patient is not able to bear weight. The patient was discovered 2 daysafter the incident. The complaints affect the left hip. Onset: The symptoms/episode began/occurred 2 day(s) ago. Associated signs and symptoms: Pertinent positives: Patient was on the floor for 2 days before being discovered. The patient laid on the floor without any food or water. Patient complains of pain in the hip without numbness or tingling or weakness or sensory loss. No chest pain or shortness of breath. She is extremely thirsty. Severity of symptoms: At their worst the symptoms were severe, incapacitating. jwf1

Historical:

- **Allergies:** green vegetables; Chocolate; Aspirin; ACE INHIBITORS; all nasal sprays; NSAIDS;
- **Home Meds:**
  1. Diltiazem Oral
  2. Lomotil oral
  3. Propranolol Oral
  4. citalopram oral
  5. Tylenol #3 Oral
  6. Nexium Oral
  7. Furosemide Oral
  8. cyanocobalamin (vitamin B-12) oral
  9. Coffin Oral
- **PMHx:** Atrial Fib; Hypertension; Anxiety
- **Social history::** Smoking status: Patient/guardian denies using tobacco, but has a distant history of tobacco abuse,.
- **Advanced Directives::** Patient has healthcare power of attorney, documentation unavailable. Patient/legal representative advised of need for copy to be obtained and placed on chart for Advance Directive to be honored The patient has a living will, documentation unavailable. Patient/legal representative advised of need for copy to be obtained and placed on chart or Advance Directive to be honored.

ROS:

23:09 jwf1

Constitutional: Negative for fever, malaise, vomiting or weight loss
Eyes: Negative for injury, pain, redness, and discharge.
ENT: no rhinorea, sore throat, earache or toothache
Neck: Negative for injury, pain, swelling or stiffness
Cardiovascular: Negative for chest pain, palpitations, and edema.
Respiratory: Negative for shortness of breath, cough, wheezing, and pleuritic chest pain.
Abdomen/GI: Negative for abdominal pain, nausea, vomiting, diarrhea, and constipation.
Back: Negative for injury and pain.
Skin: Positive for breakdown - seen by nurse.

Exam:

23:09 jwf1

Eyes: Pupils equal round and reactive to light, extra-ocular motions intact. Lids and lashes normal. Conjunctiva and sclera are non-icteric and not injected. Cornea within normal limits. Periorbital areas with no swelling, redness, or edema. Fundi are normal, discs are sharp.
Neck: Trachea midline, no thyromegaly or masses palpated, and no cervical lymphadenopathy. Supple, full range of motion without nuchal rigidity, or vertebral point tenderness. No Meningismus.
Chest/axilla: Normal chest wall appearance and motion. Nontender with no deformity. No lesions are appreciated.
Cardiovascular: Regular rate and rhythm with a normal S1 and S2. No gallops, murmurs, or rubs. Normal PMI, no JVD. Pulses equal and strong bilaterally.
Respiratory: Lungs have equal breath sounds bilaterally, clear to auscultation and percussion. No rales, rhonchi or wheezes noted. No increased work of breathing, no retractions or nasal flaring.

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PARROTT, DELILA W. Opt Out: No
Mt Pleasant
Site Management (sitemgmt_hpf)
Rm-Bed: 3109 - 01 Admit Dt: 06/06/2014 23:20
Age: 85 yr. Gender: F MD: Mills-Md, Richard E., MD
DOB: REDACTED Acct: 1415701389
MRN: 001787037
Requested: 06/11/2014 10:38
Page 1 of 8

Active Sites

abrasion (1) right hip

Start Date = 06/06/2014; Time = 23:00 [Charted by: Carter, Sara P., RN at 06/07/2014 04:22]; Timing = prior to admit [Charted by: Carter, Sara P., RN at 06/07/2014 04:22]; Type = abrasion [Charted by: Carter, Sara P., RN at 06/07/2014 04:22]; Location = right hip [Charted by: Carter, Sara P., RN at 06/07/2014 04:22]

blister (1) right lower hip

Start Date = 06/07/2014; Time = 21:27 [Charted by: Carter, Sara P., RN at 06/08/2014 06:53]; Timing = prior to admit [Charted by: Carter, Sara P., RN at 06/08/2014 06:53]; Type = blister [Charted by: Carter, Sara P., RN at 06/08/2014 06:53]; Location = right lower hip [Charted by: Carter, Sara P., RN at 06/08/2014 06:53]

laceration (1) left wrist

Start Date = 06/06/2014; Time = 23:00 [Charted by: Carter, Sara P., RN at 06/07/2014 04:25]; Timing = prior to admit [Charted by: Carter, Sara P., RN at 06/07/2014 04:25]; Type = laceration [Charted by: Carter, Sara P., RN at 06/07/2014 04:25]; Location = left wrist [Charted by: Carter, Sara P., RN at 06/07/2014 04:25]; Wound Comment = scratch [Charted by: Carter, Sara P., RN at 06/07/2014 04:25]

surgical incision (1) left hip

Start Date = 06/07/2001; Timing = prior to arrival on unit [Charted by: Kirk, Julia P., RN at 06/09/2014 10:21]; Type = surgical incision [Charted by: Kirk, Julia P., RN at 06/09/2014 10:21]; Location = left hip [Charted by: Kirk, Julia P., RN at 06/09/2014 10:21]

Ended Sites

Foley (1) 16fr

Start Date = 06/06/2014 [Charted by: Carter, Sara P., RN at 06/07/2014 04:18]; Time = 23:00 [Charted by: Carter, Sara P., RN at 06/07/2014 04:18]; Timing = prior to admit [Charted by: Carter, Sara P., RN at 06/07/2014 04:18]; Reported PI Location @ Insertion = ER [Charted by: Carter, Sara P., RN at 06/07/2014 04:18]; Type = Foley [Charted by: Carter, Sara P., RN at 06/07/2014 04:16]; Size (Fr) = 16fr [Charted by: Carter, Sara P., RN at 06/07/2014 04:18]; End Date = 06/09/2014 [Charted by: Kirk, Julia P., RN at 06/09/2014 10:38]; Time = 10:10 [Charted by: Kirk, Julia P., RN at 06/09/2014 10:38]; Removed By = jk [Charted by: Kirk, Julia P., RN at 06/09/2014 10:38]

done (1) arm 20 gauge

Start Date = 06/06/2014; Time = 23:30 [Charted by: Carter, Sara P., RN at 06/07/2014 03:55]; IV Timing = prior to admit [Charted by: Carter, Sara P., RN at 06/07/2014 03:55]; Reported PI Location @ Insertion = ER [Charted by: Carter, Sara P., RN at 06/07/2014 03:55]; Size (Ga) = 20 gauge [Charted by: Carter, Sara P., RN at 06/07/2014 03:55]; Side = left [Charted by: Carter, Sara P., RN at 06/07/2014 03:55]; Location = arm [Charted by: Carter, Sara P., RN at 06/07/2014 03:55]; End Date = 06/10/2014 [Charted by: Swan, Betty , RN at 06/10/2014 16:59]; Time = 15:24 [Charted by: Swan, Betty , RN at 06/10/2014 16:59]; Removed By = pcl [Charted by: Swan, Betty , RN at 06/10/2014 16:59]; Dressing Applied = done [Charted by: Swan, Betty , RN at 06/10/2014 16:59]; Removal Comment = iv dc'd w/pt cathda intact [Charted by: Swan, Betty , RN at 06/10/2014 16:59]

narrative

06/07/2014 00:00 TO 06/07/2014 23:59

Legend Charting

06/07/2014 00:10

done (1) arm 20 gauge

done(1)(ended) left arm

Check Blood Return = positive	Carter, Sara P., RN 06/07/2014 04:26
Intervention = other comment	Carter, Sara P., RN 06/07/2014 04:26
Notes: IVF	
Site Assessment = WNL	Carter, Sara P., RN 06/07/2014 04:26

Foley (1) 16fr

Foley(1)(ended)

Intervention = RN	Carter, Sara P., RN 06/07/2014 04:26
Necessity = requires prolonged immobilization	Carter, Sara P., RN 06/07/2014 04:26
Status = patient secured to leg; undamaged	Carter, Sara P., RN 06/07/2014 04:26

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narrative

06/07/2014 00:00 TO 06/07/2014 23:59

Legend Charting

06/07/2014 00:10

Foley (1) 16fr

Urine Assessment = oliguric — Carter, Sara P., RN 06/07/2014 04:26

Urine Color = amber — Carter, Sara P., RN 06/07/2014 04:26

abrasion (1) right hip

abrasion(1) right hip

Inpatient Documentation,Appearance = clean, reddened, other-comment — Carter, Sara P., RN 06/07/2014 04:26

Notes: bruise

Inpatient Documentation,Wound drainage = none — Carter, Sara P., RN 06/07/2014 04:26

Inpatient Documentation,Interventions = open to air — Carter, Sara P., RN 06/07/2014 04:26

laceration(1) left wrist

Inpatient Documentation,Appearance = approximated, reddened — Carter, Sara P., RN 06/07/2014 04:26

Inpatient Documentation,Wound drainage = none — Carter, Sara P., RN 06/07/2014 04:26

Inpatient Documentation,Interventions = open to air — Carter, Sara P., RN 06/07/2014 04:26

06/07/2014 10:33

done (1) arm 20 gauge

done(1) (ended) left arm

Intervention = other-comment — Kirk, Julia P., RN 06/07/2014 15:27

Notes: ivf infusing

Site Assessment = WNL — Kirk, Julia P., RN 06/07/2014 15:27

Foley (1) 16fr

Foley(1)(ended)

Necessity = need accurate urine output measurements, requires prolonged immobilization — Kirk, Julia P., RN 06/07/2014 15:27

Status = patent, secured to leg, unclamped — Kirk, Julia P., RN 06/07/2014 15:27

Urine Assessment = clear — Kirk, Julia P., RN 06/07/2014 15:27

Urine Color = amber — Kirk, Julia P., RN 06/07/2014 15:27

abrasion (1) right hip

abrasion(1) right hip

Inpatient Documentation,Appearance = open, reddened — Kirk, Julia P., RN 06/07/2014 15:27

Inpatient Documentation,Wound drainage = serosanguinous — Kirk, Julia P., RN 06/07/2014 15:27

Notes: scant amount

Inpatient Documentation,Interventions = open to air — Kirk, Julia P., RN 06/07/2014 15:27

laceration(1) left wrist

Inpatient Documentation,Appearance = approximated, reddened — Kirk, Julia P., RN 06/07/2014 15:27

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narrative

06/07/2014 00:00 TO 06/07/2014 23:59

Legend Charting

06/07/2014 10:33

laceration (1) left wrist

Inpatient Documentation,Wound drainage = none	Kirk, Julia P., RN 06/07/2014 15:27
Inpatient Documentation,Interventions = open to air	Kirk, Julia P., RN 06/07/2014 15:27
Inpatient Documentation,Topical = antibiotic	Kirk, Julia P., RN 06/07/2014 15:27

06/07/2014 18:56

surgical incision (1) left hip

surgical incision(1) left hip

Inpatient Documentation,Dressing condition = drainage/stable	Kirk, Julia P., RN 06/08/2014 16:22
Inpatient Documentation,Wound drainage = bloody, scant	Kirk, Julia P., RN 06/08/2014 16:22
Inpatient Documentation,Dressing/Cover = other comment	Kirk, Julia P., RN 06/08/2014 16:22

Notes: honeycomb island dressing

06/07/2014 21:27

done (1) arm 20 gauge

done(1)(ended) left arm

Intervention = other-comment	Carter, Sara P., RN 06/08/2014 00:29

Notes: IVF

Site Assessment = WNL	Carter, Sara P., RN 06/08/2014 00:29

Foley (1) 16fr

Foley(1)(ended)

Necessity = need accurate urine output measurements, requires prolonged immobilization	Carter, Sara P., RN 06/08/2014 00:29
Status = patient, secured to leg, unclamped	Carter, Sara P., RN 06/08/2014 00:29
Urine Assessment = clear	Carter, Sara P., RN 06/08/2014 00:29
Urine Color = amber	Carter, Sara P., RN 06/08/2014 00:29

abrasion (1) right hip

abrasion(1) right hip

Inpatient Documentation,Appearance = open, reddened	Carter, Sara P., RN 06/08/2014 00:29
Inpatient Documentation,Wound drainage = none	Carter, Sara P., RN 06/08/2014 00:29
Inpatient Documentation,Interventions = open to air	Carter, Sara P., RN 06/08/2014 00:29
Inpatient Documentation,Topical = other comment	Carter, Sara P., RN 06/08/2014 00:29

Notes: bactroban

laceration(1) left wrist

Inpatient Documentation,Appearance = reddened	Carter, Sara P., RN 06/08/2014 00:29
Inpatient Documentation,Wound drainage = none	Carter, Sara P., RN 06/08/2014 00:29

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Mt Pleasant Hospital
History and Physical
06/06/2014

PARROTT, DELILA W
1418701389
Richard E Mills MD
Page 1

Patient DOB REDACT

HISTORY OF PRESENT ILLNESS: Ms. Wilson is a white female who was found with a fractured hip, unable to get up. She gives a history that she fell about 2 days ago, hit her on the bed frame and fell. She apparently was Sandpiper. By her history, they apparently thought that she was out of town, but she was not. Finally, she was found by one of her bridge partners and brought to the Emergency Room here last night. In the Emergency Room, she was found on x-ray to have a left femoral intratrochanteric/subtrochanteric fracture. Her urine was abnormal. She was dehydrated and was cultured as far as the urine and started on Rocephin in the Emergency Room. She was also noted to have some skin breakdown. EKG was done which showed sinus rhythm, PACs. She had an elevated BUN creatinine ratio of 40/0.7. Sodium was 147. Daughter is June, telephone number 803-331-6342. White count on June 6th was 16.5 with hemoglobin of 10.6, hematocrit of 32.5.

ALLERGIES: ACE INHIBITORS AND ASPIRIN.

HOME MEDICATIONS: Include diltiazem 180; Nexium 40, Celexa 10, propranolol 10 b.i.d., Tylenol 3, monthly B12 shots, Lasix 40.

PAST MEDICAL HISTORY: Includes atrial fibrillation, hypertension, anxiety, macular degeneration, gastroesophageal reflux disease, sleep apnea.

FAMILY HISTORY: Father died of a stroke.

PAST SURGICAL HISTORY: Includes left breast biopsy, left wrist fracture, multiple eye surgeries. She had a colonoscopy by Dr. Joyner in August 2013, had a Zostavax vaccination in 2007 and a pneumonia vaccine in 2004.

SOCIAL HISTORY: She is a widow. Her husband was a former pharmacist. She has a distant history of smoking more than 30 years ago.

CURREN LABORATORY DATA: From this morning, June 7th, show white count of 13.6, hemoglobin 9.2, hematocrit 28.5, platelet count 165,000. Sodium 147, potassium 4, chloride 110.

PHYSICAL EXAMINATION: Temperature 97.8, pulse 81, respiratory rate 16, blood pressure 169/74, tearful, upset. NECK: Supple. CHEST: Shallow breath sounds. CARDIOVASCULAR: Regular rate. ABDOMEN: Bowel sounds present. Left leg is

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Mt. Pleasant Page: 1
3500 Highway 17 North Mt Pleasant,SC 29466

Date:	Name	Acct. #	Financial Class
06/26/14	PARROTT,DELILA WILSON	14157-01389	M - MEDICARE
Sex	Birth Date Age	Adm Date	Dsch Date LOS
F	REDAC 80Y	06/06/14	06/10/14 4

Attending Physician
CNRAJU-MD,SWAPNA
Coder: GSK

Discharge Status
03 - 03_SKILLED NURSING FACILITY

MDC: 8
DRG: v31.0 (19) 481 HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W CC

OUTLIER STATUS: N/A

	DIAGNOSIS	DESCRIPTION/POA		DIAGNOSIS	DESCRIPTION/POA
1.(P)	820.21	INTERTROCHANTERIC FX-C/Y	14.	401.9	HYPERTENSION NOS/Y
2. s	293.9	TRANSIENT MENTAL DIS N/H	15.	311	DEPRESSIVE DISORDER NE/Y
3.	707.04	PRESSURE ULCER, HIP/Y	16.	300.00	ANXIETY STATE NOS/Y
4.	707.05	PRESSURE ULCER, BUTTOC/Y	17.	530.81	ESOPHAGEAL REFLUX/Y
5.	276.51	DEHYDRATION/Y	18.	780.57	SLEEP APNEA NOS/Y
6.	427.31	ATRIAL FIBRILLATION/Y	19.	707.20	PRESSURE ULCER,STAGE U/Y
7.	280.0	CHR BLOOD LOSS ANEMIA/Y	20.	276.8	HYPOPOTASSEMIA/N
8.	V03.82	ND VAC STRPTCS PNEUMONI/E	21.	V15.82	HISTORY OF TOBACCO USE/E
9.	294.20	DEMEN NOS W/O BEHV DST/Y	22.	E888.1	FALL STRIKING OBJECT N/Y
10. s	997.99	SURG COMPL-BODY SYST N/N	23.	E849.0	ACCIDENT IN HOME/E
11.	285.1	AC POSTHEMORRHAG ANEMI/N	24.	E878.0	ABN REACT-SURG PROC NE/E
12.	820.22	SUBTROCHANTERIC FX-CLO/Y	25.	E849.7	ACCID IN RESIDENT INST/Y
13.	558.9	NONINF GASTROENTERIT N/Y			

Reason for Visit:

	PROCEDURE	DESCRIPTION	DATE	SURGEON NAME
1.(P)	79.35	OPEN REDUC-INT FIX FEMUR	06/07/14	MURRAY-MD,PATRICK J
2.	99.04	PACKED CELL TRANSFUSION	06/08/14	MURRAY-MD,PATRICK J
3.	00.33	CAS W FLUOROSCOPY	06/07/14	MURRAY-MD,PATRICK J

PARROTT,DELILA WILSON
001787037 00913109
06/24/14

DIAGNOSIS SUMMARY WORKSHEET

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Mt Pleasant Hospital
Discharge Summary
ADMISSION: 06/06/2014
DISCHARGE: 06/10/2014
Patient DOB: REDACTE

PARROTT, DELILA W
1415701389
Swapna Omraju MD
Page 1

DICTATED BY: Nicole Perrin Ketchin, PA-C.

PRIMARY CARE PHYSICIAN: Dr. Richard Mills.

CONSULTING PHYSICIANS:
1. Dr. Patrick Murray, orthopedist.
2. Dr. Paul Yantis, gastroenterologist.

DISCHARGE DIAGNOSES:
1. Left hip fracture status post open reduction and internal fixation.
2. Anemia of acute blood loss superimposed on chronic anemia.
3. Hypertension.
4. Acute delirium, improving.
5. Chronic diarrhea.
6. History of atrial fibrillation.
7. Anxiety.

HISTORY OF PRESENT ILLNESS: Ms. Parrott is an 80-year-old Caucasian female who sustained a fall at her residence and was discovered 2 days after the incident by a friend. The patient complained of left hip pain and was unable to ambulate. In the Emergency Room, x-ray revealed a left femoral intertrochanteric and subtrochanteric fracture. Her urinalysis also revealed that she was dehydrated. She was also noted to have some skin breakdown. The patient was then admitted for further workup and management of her acute concerns.

RADIOLOGICAL STUDIES:
1. Chest x-ray: No acute process.
2. X-ray of the hip: Acute comminuted fracture in the left femoral intertrochanteric/subtrochanteric region.

HOSPITAL COURSE: For the patient's hip fracture, she was seen in consultation by Dr. Patrick Murray who brought her to the operating room on 06/07/2014 performing an open reduction and internal fixation of the left subtrochanteric femur fracture. The patient tolerated the operation well; however, she did have postoperative complications of acute delirium. The patient was also noted to have anemia of acute blood loss, and therefore, she required a transfusion of 2 units of packed red blood cells.

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Nurse's Notes Con't

23:00 Call/page placed to Dr Mills. Time called 23:00. rs
23:00 Noise minimized. Lights dimmed. PO fluids given. Verbal reassurance given. Warm blanket given. ekk
23:01 Dr Mills. Returned call at 23:01. rs
23:41 UA Lab Sent. ekk
23:41 Urine Culture - Cath Sent. ekk
23:50 Add On Test-Spec In Lab Sent. ekk

Administered Medications:

Time	Drug & Dose	Route	Rate	Duration	Site	Delivery	Staff
22:41	NS 0.9% * 1000 ml	IV	bolus		existing IV site		ekk
23:00	Dilaudid [2 mg/mL] 0.5 mg	IVP			existing IV site		ekk
23:43	Follow up: Response: Pain is unchanged, physician notified						ekk
23:41	NS 0.9% * 1000 ml [1]	IV	125 ml/hr		existing IV site		ekk
23:41	Follow up: IV Status: Completed infusion: IV Intake: 1000ml						ekk
06/07 00:16	Follow up: IV Status: Infusion continued upon admission/transfer						ekk
06/06 23:41	Rocephin (ADM) 1 grams	IVPB			existing IV site		ekk
06/07 00:16	Follow up: IV Status: Infusion continued upon admission/transfer						ekk
06/06 23:43	Dilaudid [2 mg/mL] 0.5 mg	IVP			existing IV site		ekk
23:51	Follow up: Response: Pain is decreased						ekk

1 - Note: PER DR. MILLS ORDERS.

Intake:

Time	PO	IV	Tubes	Total	Staff
23:41		1000ml		1000ml	ekk

Outcome:

23:12 Decision to Admit by physician. jwf1
23:45 ekk
Disposition pain rating: 2 / 10.
23:52 Patient left the ED. ekk
23:52 ekk
IVF Stop Time Documentation: IVF stop time already documented in Meds followup section. Admitted to Tele, accompanied by nurse, accompanied by tech, family with patient, via stretcher, on monitor, with chart, with SBAR form and copy of orders, Report called to SARAH, RN Pt. belongings with patient.
Condition: stable Instructed on need for admit. Demonstrated understanding of instructions, medications, verbalized understanding.

Signatures:

Dispatcher MedHost		EDMS	MACBRIDE, TAMARA, RN	RN	tm7
SMITH, RACHEL, EDT	EDT	rs	Walters, John, MD	MD	jwf1
STEPHENS, DANA, Reg	Reg	ds6	Kell, Erin, RN	RN	ekk

Name: Delila Parrott

Print Time: 6/6/2014 07:40:30

MRN: 001787037
Account#: 1415701389
Page 3 of 3

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Physician Documentation

Roper St. Francis HealthCare Mount Pleasant

Name: Delila Parrott
Age: 80 years **Sex:** Female **DOB:** REDACTED
Arrival Date: 06/06/2014 **Time:** 21:14
Bed 2
ED Physician Walters, John
HPI:

MRN: 001787037
Account#: 1415701389
Private MD:

06/06 23:07 This 80 years old White Female presents to ED via EMS with complaints of Hip Pain. jwf1

23:07 The patient or guardian reports an injury, that occurred at home, sustained from a fall, the left lower extremity is shortened, left leg is externally rotated. The patient is not able to ambulate. Patient is not able to bear weight. The patient was discovered 2 daysafter the incident. The complaints affect the left hip. Onset: The symptoms/episode began/occurred 2 day(s) ago. Associated signs and symptoms: Pertinent positives: Patient was on the floor for 2 days before being discovered. The patient laid on the floor without any food or water. Patient complains of pain in the hip without numbness or tingling or weakness or sensory loss. No chest pain or shortness of breath. She is extremely thirsty. Severity of symptoms: At their worst the symptoms were severe, incapacitating. jwf1

Historical:

- **Allergies:** green vegetables; Chocolate; Aspirin; ACE INHIBITORS; all nasal sprays; NSAIDS;
- **Home Meds:**
  1. Diltiazem Oral
  2. Lomotil oral
  3. Propranolol Oral
  4. citalopram oral
  5. Tylenol #3 Oral
  6. Nexium Oral
  7. Furosemide Oral
  8. cyanocobalamin (vitamin B-12) oral
  9. Ceftin Oral
- **PMHx:** Atrial Fib; Hypertension; Anxiety
- **Social history::** Smoking status: Patient/guardian denies using tobacco, but has a distant history of tobacco abuse..
- **Advanced Directives::** Patient has healthcare power of attorney, documentation unavailable. Patient/legal representative advised of need for copy to be obtained and placed on chart for Advance Directive to be honored The patient has a living will, documentation unavailable. Patient/legal representative advised of need for copy to be obtained and placed on chart or Advance Directive to be honored.

ROS:

23:09 jwf1

Constitutional: Negative for fever, malaise, vomiting or weight loss
Eyes: Negative for injury, pain, redness, and discharge.
ENT: no rhinorea, sore throat, earache or toothache
Neck: Negative for injury, pain, swelling or stiffness
Cardiovascular: Negative for chest pain, palpitations, and edema.
Respiratory: Negative for shortness of breath, cough, wheezing, and pleuritic chest pain.
Abdomen/GI: Negative for abdominal pain, nausea, vomiting, diarrhea, and constipation.
Back: Negative for injury and pain.
Skin: Positive for breakdown - seen by nurse.

Exam:

23:09 jwf1

Eyes: Pupils equal round and reactive to light, extra-ocular motions intact. Lids and lashes normal. Conjunctiva and sclera are non-icteric and not injected. Cornea within normal limits. Periorbital areas with no swelling, redness, or edema.Fundi are normal, discs are sharp.
Neck: Trachea midline, no thyromegaly or masses palpated, and no cervical lymphadenopathy. Supple, full range of motion without nuchal rigidity, or vertebral point tenderness. No Meningismus.
Chest/axilla: Normal chest wall appearance and motion. Nontender with no deformity. No lesions are appreciated.
Cardiovascular: Regular rate and rhythm with a normal S1 and S2. No gallops, murmurs, or rubs. Normal PMI, no JVD. Pulses equal and strong bilaterally.
Respiratory: Lungs have equal breath sounds bilaterally, clear to auscultation and percussion. No rales, rhonchi or wheezes noted. No increased work of breathing, no retractions or nasal flaring.

Physician Documentation Con't.

Abdomen/GI: Soft, non-tender, with normal bowel sounds. No distension or tympany. No guarding or rebound. No evidence of tenderness throughout.
Back: No spinal tenderness. No costovertebral tenderness. Full range of motion.
Neuro: Awake and alert, oriented to person, place, time and situation. Neuro grossly intact. Normal gait.
Psych: Affect appropriate; memory intact.
Constitutional: The patient appears alert, awake, frail, uncomfortable.
ENT: Mouth: Lips: dry, cracked, Oral mucosa: dry.
Musculoskeletal/extremity: Circulation is intact in all extremities. Sensation intact. Joints: the left hip displays deformity, pain at rest, painful range of motion, tenderness.
Skin: breakdown from pressure on right buttock hip.

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Height	Pain	Staff
21:18	162 / 77	86	17	97.7	93%	68.04 kg	5 ft. 7 in. (170 cm)	9/10	tm7
22:00	145 / 67 (auto)								ekk
22:00		77 MON	16		95%				ekk
22:15	149 / 67 (auto)								ekk
22:15		79 MON	17		95%				ekk
22:30	156 / 68 (auto)								ekk
22:31		83 MON	16		95%				ekk
23:27		83 MON	13		95%				ekk
23:30	161 / 64 (auto)								ekk
23:38		83 MON	18		95%			7/10	ekk
23:45	149 / 68 (auto)								ekk
23:45		82 MON	14		94%				ekk

23:45 Body Mass Index 23.5 (68.04 kg, 170 cm) ekk
23:38 Normal Sinus Rhythm ekk

Glasgow Coma Score:

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
21:18	spontaneous(4)	oriented(5)	obeys commands(6)		15	tm7

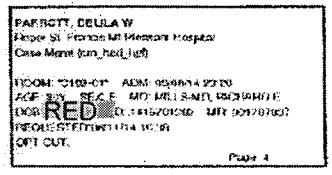
MDM:

21:11 Medical screening evaluation initiated. jwf1
23:11 jwf1
Data reviewed: vital signs, nurses notes, old medical records obtained and reviewed, lab test result(s), radiologic studies, X-ray.
Physician consultation (by phone and in detail): Richard Mills MD and will see patient in hospital.

Time	Order name	Complete Time	Staff
06/06 22:18	CBC	22:58	jwf1
06/06 22:18	BMP	22:58	jwf1
06/06	Mg Level	23:07	jwf1

Name: Delila Parrott **MRN:** 001787037
Account#: 1415701389
Print Time: 6/6/2014 07:40:32 Page 2 of 6

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Case Mgmt Chartin	06/09
CM Initial Asses-Cont	**14:48**
Currnt Assis Dev	bedrails hospital bed LD77
Transportation	family LD77
Intervention	discussed w/Fam discussed w/Pt LD77
Plan of Options	agreed to by Fam agreed to by Pt LD77
CM DC Planning	**14:48**
DC Planning Rnds	done LD77
CM Goals/Notes	**14:48**
Current LOS	3 LD77
Expected DC date	06/10/2014 LD77
Plan A	LD77 &
Plan B	LD77 &
Intervention	CM brochure prov dly intrdis rnds discussed w/Fam DCP Disc w crgvr MD agrd with DCP PPD given SNF list pvd. SNF referral LD77
Progress Note 1	LD77 &
Progress Note 2	LD77 &
Progress Note 3	LD77 &

06/09/14 14:48 Plan A(LD77): SNF for rehab

06/09/14 14:48 Plan B(LD77): home with support services

06/09/14 14:48 Progress Note 1(LD77): CM: Pt is alert, oriented and independent in ADL's. She lives in independent living at Sandpiper. Pt fell and fractured her hip. She had surgery and will need rehab at dc. Dtr June stated she wanted Sandpiper renab for her first choice and Savannah

06/09/14 14:48 Progress Note 2(LD77): Grace for her second choice. Information faxed to Sandpiper and they have accepted her. PPD done on 6/6/14 and she will be ready for dc in the morning after PPD read. Family aware. Pt is low risk for readmit. CM will continue to follow for any dc

06/09/14 14:48 Progress Note 3(LD77): needs that may arise and assist with dc to SNF. She will need dc summary done prior to dc.

DUNNE, LINDA(LD77)Case Mgr

CONTINUED

PARROTT, DELILA W MR: 001787037 ID: 14157013[illegible] DOB: REDACTED Case Mgmt (crn_hsd_hpf)
ROOM: [illegible] Page: 4

FERM

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externally rotated. Skin breakdown on the right hip.

ADMITTING DIAGNOSES:
1. Hip fracture for surgical repair.
2. Hypertension, systolic, follow.
3. Anemia, follow.
4. Anxiety.
5. History of a-fib, continue diltiazem.
6. Chronic diarrhea. Check stool studies.

Update to the History and Physical if appropriate
[] I have reviewed the H&P and re-examined the patient and there are no changes to the physical examination and/or history of present illness.
[] I have reviewed the H&P and re-examined the patient and the following changes have occurred to the physical examination and /or history of present illness:

---

[x] Refer to the Admission Home Medication Orders (inpatient) or Outpatient/OBSERVATION medication list (outpatient) for current medications.
Physician Signature: _____ Date: _____ Time:

Richard E Mills, MD
TR: dn DD: 06/07/2014 09:30 TD: 06/07/2014 10:14 Job#: 283131
DOC#: 385697

Authenticated by RICHARD E MILLS MD On 06/07/2014 11:10:18 AM.

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Patient DOB: REDACT

DRUG ALLERGIES: ACE INHIBITORS AND ASPIRIN.

SYSTEMS REVIEW: Gastrointestinal review of systems discussed in detail in the history of present illness. All other pertinent review of systems are negative.

ADMISSION MEDICATIONS:
1. Diltiazem 180 mg daily.
2. Nexium 40 mg daily.
3. Celexa 10 mg daily.
4. Propranolol 10 mg twice daily.
5. Tylenol #3 p.r.n. pain.
6. Lasix 40 mg daily.

PHYSICAL EXAMINATION: GENERAL: The patient is a well-developed, well-nourished, somewhat upset white female, lying comfortably in bed in no acute distress. VITAL SIGNS: Blood pressure 170/76, pulse 80 and regular, respirations 16, temperature 98.4. HEENT: Head normocephalic, atraumatic. Throat: Posterior pharynx is not injected. Pupils are equally round and reactive to light and accommodation. There is no scleral icterus. NECK: Supple, without masses, thyromegaly, or bruits. LUNGS: Clear to auscultation bilaterally without rhonchi, rales, wheezes. HEART: Normal sinus rhythm without murmurs or gallops. ABDOMEN: Soft with positive bowel sounds. There is no tenderness to palpation. The liver is not enlarged. Spleen is not palpated. No masses are felt. EXTREMITIES: The patient moves all 4 without difficulty and there is no edema, clubbing, or cyanosis. NEUROLOGIC: The patient is somewhat confused both to date and previous events. There are no focal neurologic deficits.

LABORATORY: Admission laboratory hemoglobin 9.2, hematocrit 28.5, platelet count 155,000.

IMPRESSION:
1. Chronic diarrhea with 6 months' duration. This could easily be due to microscopic/collagenous colitis with her advanced age. Inflammatory bowel disease or infection would be much less likely over 6 months.
2. Status post left hip fracture repair.
3. Anemia, questionable chronic.
4. Confusion/dementia.
5. History of atrial fibrillation.

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RECOMMENDATIONS:
1. We will check stool studies. C. difficile study is already returned and it is negative.
2. The patient is still somewhat confused and disoriented, as she insists that Dr Joyner has done all of her procedures instead of me, in spite of showing her documentation to the otherwise. Anyway, I suspect that the patient should probably be treated empirically now with Imodium, Lomotil, and if her dementia/confusion clears, I will be happy to work with her further on her diarrhea and possibly repeat her colonoscopy and do biopsies as necessary.

Thank you for allowing me the opportunity to participate in Ms. Parrott's care.

Paul L Yantis, III, MD
TR: hn DD: 06/09/2014 17:07 TD: 06/09/2014 18:07 Job#: 283729
DOC#: 286345

Authenticated by PAUL L YANTIS III MD on 06/28/2014 11:46:07 AM

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Mt. Pleasant
3500 Highway 17 North Mt Pleasant,SC 29466

Date:	Name	Acct. #	Financial Class	
10/22/14	PARROTT,DELILA W	14284-00216	M - MEDICARE	
Sex	Birth Date Age	Adm Date	Dsch Date	LOS
F	REDA 80Y	10/11/14	10/15/14	4

Attending Physician
MILLS-MD,RICHARD E
Coder: MH

Discharge Status
03 - 03_SKILLED NURSING FACILITY

MDC: 19 MENTAL DISEASES AND DISORDERS
DRG: 432.0 (19) 885 PSYCHOSES

CUTLIER STATUS: S/A

	DIAGNOSIS	DESCRIPTION/POA		DIAGNOSIS	DESCRIPTION/POA
1.	(P) 297.1	DELUSIONAL DISORDER/Y	12.	V54.13	AFTRCRE TRAUMATIC FX H/E
2.	294.20	DEMEN NOS W/O BEHV DST/Y	13.	780.57	SLEEP APNEA NOS/Y
3.	780.09	OTHER ALTER CONSCIOUSN/Y	14.	362.50	MACULAR DEGENERATION H/Y
4.	401.9	HYPERTENSION NOS/Y	15.	V14.2	HX-SULFONAMIDES ALLERG/E
5.	715.90	OSTEOARTHROS NOS-UNSPE/Y	16.	V14.8	HX-DRUG ALLERGY NEC/E
6.	530.81	ESOPHAGEAL REFLUX/Y	17.	V14.6	HX-ANALGESIC ALLERGY/E
7.	V04.81	VACCIN FOR INFLUENZA/E	18.	V15.82	HISTORY OF TOBACCO USE/E
8.	311	DEPRESSIVE DISORDER NE/Y	19.	300.00	ANXIETY STATE NOS/Y
9.	781.2	ABNORMALITY OF GAIT/Y	20.	V13.02	PERSONAL HISTORY UTI/E
10.	V12.54	HX TIA/STROKE W/O RESI/E	21.	E935.9	ADV EFF ANALGESIC NOS/Y
11.	V58.69	LONG-TERM USE MEDS NEC/E			

Reason for Visit:

PROCEDURE	DESCRIPTION	DATE	SURGEON NAME

PARROTT,DELILA W
001787037 00913109
10/22/14

DIAGNOSIS SUMMARY WORKSHEET

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Mt Pleasant Hospital
History and Physical
10/11/2014

PARROTT, DELILA W
1628400216
R. Leverm Livingston MD
Page 1

Patient DOB REDACT

CHIEF COMPLAINT: Per daughter, increased agitation, confusion, hallucinations and altered mental status.

HISTORY OF PRESENT ILLNESS: This 80-year-old white female is followed long-term by Dr. Richard Mills and was seen in his office 2 days prior to this admission. She had not been seen previously since January but has had multiple episodes of care since that time. She presented with decline over the past 2 weeks according to her daughter, with inability to do things as simple as picking up a glass and drinking from it. She also has frequently had paranoid ideations that people and things come into her room at night and cause her harm. Daughter reports that she has also previously had hallucinations, insisting bedbugs were all over her and were her biting her. She has had progressive memory loss and cognitive decline over several years. Daughter indicates that she had a single psychiatric hospitalization at a geriatric psychiatry unit in Columbia about 5 or 6 years ago. The daughter indicates that she had noticed some memory loss and decline and increased anxiety predating this; but after the financial downturn, she became very concerned about money and very fearful that she would run out of money. Daughter reports that she was treated at that time with Seroquel and seemed to tolerate it well and believes that she has stopped it on her own.

The patient had a fairly severe fall in June and suffered a left hip fracture. She underwent ORIF of the left subtrochanteric femur fracture by Dr. Murray in early June and then was discharged to rehabilitation at the Sandpiper nursing facility. She subsequently has been admitted to Ashley River Plantation assisted living facility and daughter feels that, with her recent decline, she is probably not safe in the assisted living environment. She did have reasonably good rehab after her hip fracture but walks only with a walker and assistance of 1 person standing by according to the daughter.

Dr. Mills had, on October 10th at that evaluation, scheduled her for a CT brain scan, which had not been done prior to her presentation to the Emergency Department. He also did a CMP and CBC and these were unremarkable with a totally normal CMP and CBC with a normal white count, hemoglobin of 12.3 and slightly microcytic indices, which showed resolution of her postoperative blood loss, which occurred after her hip fracture.

The patient denies any history of any recent cough or chest congestion, fever or

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chills, abdominal pain, nausea or vomiting. She does complain of a mild headache today and indicates that she is having some back pain.

PAST MEDICAL HISTORY: Notable for macular degeneration with significant decline in vision, hypertension, gastroesophageal reflux disease, sleep apnea and osteoarthritis.

PAST SURGICAL HISTORY: Breast biopsy, left wrist fracture, multiple eye surgeries and the repair of the hip fracture in June 2014.

MEDICATIONS ON ADMISSION: MiraLax, Lasix 40 mg daily, Nexium 40 mg daily, Colace 100 mg daily p.r.n., Celexa 10 mg daily, Diltcor XR 180 mg extended release daily, Inderal-LA 60 mg daily, Ultram 50 mg 1 tablet every 6 hours as needed, Norco 7.5/325 mg 1-2 tablets every 4 hours, Xanax 0.25 mg 2 times a day, Macrobid 100 mg every 12 hours with a scheduled stop date of October 25th.

ALLERGIES: NONSTEROIDAL ANTI-INFLAMMATORIES, SULFA, ASPIRIN, ALTACE AND DIOVAN.

SOCIAL HISTORY: The patient is a nonsmoker, having smoked in the distant past but stopping about age 40. She does not use alcohol at all. She was a certified registered nurse anesthetist for 40 years.

FAMILY HISTORY: Significant for a daughter with unknown mental issues. Her mother died in childbirth when the patient was 18 months old. Spouse deceased from an arrhythmia.

REVIEW OF SYSTEMS: GENERAL CONSTITUTIONAL REVIEW: Denies fever, chills, night sweats, change in appetite. Admits headache and decline in function. RESPIRATORY REVIEW: Denies shortness of breath, cough, chest pain and sputum production. CARDIOVASCULAR REVIEW: Denies dyspnea, dizziness or lightheadedness, palpitations. GASTROESOPHAGEAL REVIEW: Denies abdominal pain, change in bowel habits, constipation, weight loss. MUSCULOSKELETAL REVIEW: Admits to lower back pain and recent fracture of the left femur. NEUROLOGIC: History is obtained from daughter of significant memory loss. PSYCHIATRIC: Anxiety, agitation, hallucinations, paranoia with uncertain prior psychiatric diagnosis.

PHYSICAL EXAMINATION: GENERAL: Reveals a frail, somewhat disheveled elderly white female who is calm and cooperative to exam. CONSTITUTIONAL: Temperature

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97.7, pulse 67, respiratory rate 20, 02 saturation on room air 97%, blood pressure 180/74. HEENT: Pupils are equal and reactive. Extraocular movements are intact. Nose and oropharynx are clear. Oral mucosa is moist. The face is symmetrical. NECK: Supple, with full range of motion, no thyromegaly, no bruits. CHEST: Clear, full bilateral breath sounds are noted. No rales or wheezing present. HEART: Regular rate and rhythm, normal S1 and S2, no murmur, gallop or rub. ABDOMEN: Soft, active bowel sounds throughout. No guarding or rigidity. No direct tenderness, no mass or hepatosplenomegaly. LOWER EXTREMITIES: Trace pedal edema bilaterally. Good muscle tone. Range of motion relatively well preserved in the large joints bilaterally. NEUROLOGIC: Cranial nerves II-XII are grossly intact. There is no focal motor or sensory deficit. The patient is confused and follows some simple commands but at other times is unable to do this. Gait is not tested.

ADMISSION LABORATORY EVALUATION: Potassium 4.2. Electrolytes are normal. Creatinine 0.6, BUN 13. White count is 5400, hemoglobin 12.5. Urinalysis shows negative for leukocytes but moderate blood. CT brain scan was obtained in the Emergency Department and it showed no evidence of acute intracranial abnormality or bleed, but did show diffuse chronic microangiopathic changes, including several previous lacunar infarcts.

ASSESSMENT:
1. A patient with known psychiatric history and known cognitive decline who presents after a precipitous decline over the past 2 weeks with worsening cognitive function, but also worsening in her physical ability to do activities of daily living. She is currently receiving Macrobid, presumably for a urinary tract infection; although, her current urine is benign. Evaluation for an underlying delirium is initiated with further laboratory tests to include serum ammonia, B12, folate and thyroid function. Additionally, consideration for serotonin syndrome, in that she has been on both citalopram and tramadol. Consideration of altered mental status secondary to her pain medication is also in the differential. Other problems include hypertension and we will maintain her on Dilacor for this. Gastroesophageal reflux, for which Nexium will be continued. We will discontinue Seroquel, as daughter is concerned that this will not be effective, and try Risperdal 0.5 mg at bedtime daily and 0.25 mg b.i.d. Consider neurology and/or a psychiatric evaluation depending on her clinical course during this hospital stay. Physical therapy and occupational therapy evaluations are ordered. A PPD is placed, anticipating that she may need to go to a skilled nursing facility, either for short-term rehabilitation

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or potentially for long-term care.

Update to the History and Physical if appropriate
[] I have reviewed the H&P and re-examined the patient and there are no changes to the physical examination and/or history of present illness.
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[X] Refer to the Admission Home Medication Orders (inpatient) or Outpatient/OBSERVATION Medication list (outpatient) for current medications.
Physician Signature: _____ Date: _____ Time:

R. Levern Livingston, MD
TR: sn DD: 10/11/2014 17:33 TD: 10/11/2014 18:33 Job#: 329047
DOC#: 431846

Authenticated by R LEVERN LIVINGSTON MD On 10/13/2014 09:05:53 AM

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ROPER ST. FRANCIS PHYSICIAN PARTNERS

PARROTT, DELILA W

80 Y old Female, DOB REDACTE
Account Number: 00000127282
2333 ASHLEY RIVER ROAD, CHARLESTON, SC 29414
Home: 843-881-1692
Guarantor: PARROTT, DELILA W Insurance: MEDICARE
Payer ID: PAPER
Appointment Facility: East Cooper Internal Medicine

10/09/2014

Progress Notes: Richard E. Mills MD

Current Medications

Taking
- MiraLax -- Packet 1 packet mixed with 8 ounces of fluid Once a day prn for constipation, stop date 12/22/2014
- Lasix 40 MG Tablet 1 tablet daily prn
- Nexium 40 MG Capsule Delayed Release 1 capsule Once a day
- Colace 100 MG Capsule 1 capsule as needed Once a day
- Celexa 10 MG Tablet 2 tablets Once a day
- Dilacor XR 180 MG Capsule Extended Release 24 Hour 1 capsule on an empty stomach in the morning Once a day
- Inderal LA 60 MG Capsule Extended Release 24 Hour
- Ultram 50 MG Tablet 1 tablet as needed every 6 hrs
- Norco 7.5-325 MG Tablet 1 to 2 tablets every 4 hours
- Xanax 0.25 MG Tablet 1 tablet Three times a day
- Macrobid 100 MG Capsule 1 capsule with food every 12 hrs, stop date 10/25/2014
- Docusate Sodium 100 MG Capsule 1 capsule as needed Once a day

Discontinued
- Vitamin B 12 100 MCG Lozenge
- Lumigan 0.3-0.025 MG Tablet 1 tablet as needed Four times a day
- Mylanta 200-200-20 MG/5ML Suspension 10 ml as needed Four times a day
- Medication List reviewed and reconciled with the patient

Past Medical History

Macular degeneration
HTN
GERD
Sleep apnea
OA
PAP 2008
Colonoscopy August 2013 - Dr. Joyner
Zostavax 2007
Pneumovax 2004

Surgical History

breast biopsy - left breast
left wrist Fx

Reason for Appointment

1. F/U MEDS
2. NEEDS PAIN CONTRACT IF CONTINUE W/ NORCO
3. PARANOIA, AGITATION, SHORT TERM MEMORY LOSS, CONFUSION

History of Present Illness

Mrs. Parrot has not been here since January. She had a bad fall at home in June and was on the floor for 3 days until she was found. She is now in assisted living and doing better. Her daughter is with her today and expresses several concerns about her mood and mental status. Her daughter is concerned that she had a brain injury with the fall or a stroke because she has speech and memory trouble. She is not the same since the fracture. She is often agitated and irritable. She does not have any focal weakness since the fall.

Vital Signs

Ht 65 in, Temp 97.8, Pulse Sitting 70, BP 140/78 mm Hg, RR 18 /min, Oxygen saturation 95 %.

Examination

General Examination:

GENERAL APPEARANCE: alert, well hydrated, in no distress, elderly white female who is sitting in wheelchair, accompanied by daughter.
HEAD: normocephalic, atraumatic.
EYES: no lid lag, stare or proptosis, extraocular movement intact (EOMI), pupils equal, round, reactive to light.
ORAL CAVITY: tongue in midline, mucosa moist.
THROAT: uvula midline, pharynx normal.
NECK: neck supple, full range of motion.
HEART: S1, S2 normal.
LUNGS: clear to auscultation bilaterally, good air movement.
ABDOMEN: soft, nontender, nondistended, no masses palpable.
SKIN: good turgor, warm and dry.
MUSCULOSKELETAL: strength 4/5 in bilateral quadriceps, 4/5 strength on plantar flexion.
EXTREMITIES: 2+ pitting edema of LLE with compression stocking in place, 1+ edema of RLE.
NEUROLOGIC: alert, oriented to person, cooperative with exam,

multiple eye surgeries OU
Open reduction internal fixation left subtrochanteric femur fracture DR MURRAY 06/07/2014

Family History
Father: deceased, stroke
Mother: alive, childbirth
Spouse: deceased, arrhythmia
Adopted at 2 yrs. .

Social History
Tobacco Use:
Tobacco Use/Smoking: Are you a: nonsmoker .
Tobacco Use/Smokeless: Denies
Smokeless Tobacco: *No*
Tobacco cessation
Patient counselled on the dangers of tobacco *10/29/2013*.
Cessation: *Not applicable*

Allergies
NSAIDS
sulfa
ASA
Altace
Diovan

Hospitalization/Major Diagnostic Procedure
see above

Review of Systems
General/Constitutional:
Fever denies. Chills denies. Headache denies. Fatigue denies. Night sweats denies. Change in appetite denies.

Respiratory:
Shortness of breath denies. Chest pain denies. Cough denies. Shortness of breath with exertion denies. Sputum production denies. Wheezing denies.
Cardiovascular:
Chest Pain denies. Dizziness denies. Palpitations denies.
Gastrointestinal:
Patient denies blood in stool, constipation, difficulty swallowing, rectal bleeding, weight loss. Abdominal pain denies. Exposure to hepatitis denies.
Musculoskeletal:
Fracture admits, left femur. Leg swelling admits, left.
Neurologic:
Patient denies balance difficulty, difficulty speaking, loss of strength, dysphagia. Patient complaining short term memory loss, no tremor, normal sensory exam.
PSYCH: good eye contact, mood/affect appropriate, speech clear, confused at times.

Assessments
1. HTN - 401.9 (Primary)
2. Confusion - 298.9
3. Short-term memory loss - 780.93
4. Fall - E888.9
5. Subtrochanteric fracture of femur - 820.22, Left
6. Hypoalbuminemia - 273.8
7. Hypocalcemia - 275.41
8. Anemia - 285.9

Treatment
1. HTN

LAB: COMP METABOLIC PANEL (CMP) Normal result

ANION GAP CALC	11.0	7.0-16.0 - calc
ALBUMIN	3.7	3.5-5.0 - g/dL
ALK PHOS	140	40-150 - IU/L
B/C RATIO CALC	17.1	3.0-40.0 - calc
BILI TOTAL	0.4	0.2-1.2 - mg/dL
BUN	12.0	9.8-20.1 - mg/dL
CALCIUM	9.5	8.8-10.5 - mg/dL
CL	100	99-110 - mmol/L
CO2	30	21-32 - mmol/L
CREATININE	0.7	0.6-1.1 - mg/dL
GLUCOSE	87	70-105 - mg/dL
K	4.1	3.7-5.5 - mmol/L
NA	141	135-145 - mmol/L
PROTEIN	7.0	6.0-8.3 - g/dL
SGOT	21	5-34 - IU/L
SGPT	16	0-55 - IU/L

2. Confusion
Start QUEtiapine Fumarate ER Tablet Extended Release 24 Hour, 50 mg, 1 tablet in the evening, Orally, Once a day, 30 day(s), 30, Refills 03
IMAGING: CT HEAD W/O CONTRAST

3. Short-term memory loss
Start Aricept Tablet, 5 MG, 1 tablet at bedtime, Orally, Once a day, 30 day(s), 30, Refills 05
IMAGING: CT HEAD W/O CONTRAST

4. Fall
IMAGING: CT HEAD W/O CONTRAST

5. Hypoalbuminemia

LAB: COMP METABOLIC PANEL (CMP) Normal result

ANION GAP CALC	11.0	7.0-16.0 - calc
ALBUMIN	3.7	3.5-5.0 - g/dL
ALK PHOS	140	40-150 - IU/L
B/C RATIO CALC	17.1	3.0-40.0 - calc
BILI TOTAL	0.4	0.2-1.2 - mg/dL

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PHYSICIAN'S ORDER SHEET

Patient Jo... REDAC
MRN: 001787037 DOB
PARROTT,DELILA W
Mt Pleasant ER3
PHYS: BIANCO-MD,JOSEPH
ACCT#: 14284-00216 10/11/14

Do Not Use Abbreviations

DO NOT USE | USE
Q.D. QD q.d. qd | Daily
Q.O.D. QOD q.o.d. qod | Every Other Day
No Trailing Zero | 2 mg
Lack of Leading Zero | 0.2 mg
MS | Morphine Sulfate Magnesium Sulfate
MSO4 | Morphine Sulfate
MgSO4 | Magnesium Sulfate

Date and Time	
	Dr Livingston
1458	
	Admit to Dr Mills
	DX - altered mental status / paranoia
	Vitals Q4
	Bedrest - BR with assistance
	Type PTO
	Seroquel
	VO Dr Livingston / Ramsey
	ATT M 10/11/14 1700
	Noted 10/11/14 1840 Jolena Lewis, RN
10-11-14 1700	Resperdal 0.5 mg at hs daily and 0.25 mg po b.i.d
	Lofexa lotion to feet/trunk b.i.d
	Am lab: Serum ammonia, TSH, Folate, RPR, Serum B12, Sed rate
	PT and OT evaluation - 10/12/14 Thursday
	Noted 10/12/14 at 0715 ATT M Jolena Lewis, RN
1740	D5 1/2 NS at 80cc/hr x 1 liter, then 50/hr
	D/c Lithogram & tramadol
	Clonidine 0.1 mg po q 4hrs prn SYS > 175 or Diast > 100
	D/c Seroquel
	Change Lovenox to daily ATT
	Noted 10/11/14 2020 Jolena Lewis, RN

FAXED
FAXED
FAXED

Originated: 2/09
Revised: 3/09 EW3

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[Patient Identifier]

MRN: 001787037 DOB: REDAC
PARROTT,DELILA W
Mt Pleasant IPD 3125-01
PHYS: MILLS-MD,RICHARD E
ACCT#: 14284-00216 10/11/14

PROGRESS RECORD

Date/ Time	
	Sitting in chair. Indicates feeling a little better. "I can walk".
10/11/14 1025	"Someone is trying to kill me because of something I found out. After the "desk" not let anyone know that she is here." Tearful Sitting up. VSS 98 58 17 96% RA/RT Chest: clear Heart: RRR Abd: active BS, benign Edema Staff report very unsteady on feet. PT to see New labs: ammonia 25 Folate 12 B12 525 TSH 3.188 ESR 17 A: Psychosis, ? delusional disorder Depression, agitation S/P orif hip fx 6/2014 Unstable gait (FERD) P: Cont dependent D/C plan Consider geriatric psych input when K.T. Fogt

08/06

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[Patient Id] MR#: 001787037 DOB: REDA
PARROTT, DELILA W
Mt Pleasant IPD 3125-01
PHYS: MILLS-MD, RICHARD E
ACCT#: 14284-00216 10/11/14

PROGRESS RECORD

Date/ Time	Int. Med
10/13/14 0800	S: resting this am. Conversant. Feels safe here. O: 98.2 70 20 94/RA 154/79 Gen - NAD Ei - SINT + BS CV - RRR ϕ m Ext - ϕ edema Pulm - bibasilar crackles 10² / 4⁵ / 20¹ 142 | 102 | 8 < 103 (3²) 31 0⁴ A/P: ① Delirium, paranoia - ϕ obvious precipitant identified. Cont Risperdal. Would benefit from geriatric psych stay. Will discuss c rn. PPD has already been placed. Cont. Aricept ② HTN - cont clonidine, d.t, lasix, propranolol. ③ GERD - cont omeprazole ④ OA - complaints of back pain today. Vicoprn + norco d/c'd on admission due to concern of ppt AMS. Will give tylenol prn. ⑤ Deconditioning - cont work 2 PT. John Gam

08/06

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[Patient Iden
MRN: 001787037 DOB: REDACT
PARROTT, D[illegible] W
Mt Pleasant IPD 3125-01
PHYS: MILLS-MD,RICHARD E
ACCT#: 14284-00216 10/11/14

PROGRESS RECORD

Date/ Time	
10/14/14 0630	S: NO complaints this am per nursing much brighter and oriented overnight O: 98 162 18 95% RA 170/104 Gen- NAD, alert, conversant GI- SINT +BS CV- RRR ϕm Ext- ϕ edema Pulm- CTAB anteriorly 10^2 / 3^2 TAU 141 / 3^C 109 / 30 8 / 107 / 0^V mg 1.8 A/P: (1) Delirium/paranoia - much improved over past 2 days. cont risperdal, aricept. will restart celexa as daughter Joan is very concerned about anxiety ~~[illegible]~~ re-emerging. will plan on dc back to Ashley River Plantation tomorrow. (2) HTN - no changes to meds today. (3) OA - cont tylenol. Lam 9am
10/15/14 0800	S: No complaints. Ready to go home. O: 97.8 60 16 99% RA 143/68 Gen- NAD, alert, conversant GI- SINT +BS CV- RRR ϕm Ext- mild RLE pitting edema Pulm- bibasilar crackles A/P: (1) Delirium/paranoia- much improved on current meds. Restarted celexa ydsy (2) HTN- bp has been up & down. Some elevation could be related to IVF she had been getting will not elect to start new antihypertensive unless flu to see what her blood pressure does p discharge. Lam 9am

REDACTED
MRN: 001787037 DOB: 3125-01
PARROTT, DELILA W
Mt Pleasant IPD
PHYS: MILLS-MD,RICHARD E
ACCT#: 14284-00216 10/11/14

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Mt. Pleasant Hospital Imaging Services

Name: PARROTT,DELILA W
Exam Date: 10/11/14 1224
Ord. Phy.: BIANCO-MD,JOSEPH

MR#: 001787037
DOB: REDA
Pt. Phone#: (843)881-1692
Ord. Phy.#: (843)724-2010
Phy. Fax #: (843)720-8345

BIANCO-MD,JOSEPH
** 316 CALHOUN STREET
ER DEPT
CHARLESTON SC 29401

Acct Nbr : D1429400216
Pat Type : ERD

Chk-in #	Order	Exam	
3715118	0004	35140	CT HEAD W/O CONTRAST

Ord Diag: AMS

CT HEAD WITHOUT CONTRAST

DATE: 10/11/14

INDICATION: AMS.

TECHNIQUE: Noncontrast axial images obtained from the skull base through the vertex.

COMPARISON: None.

FINDINGS: There is no acute intracranial hemorrhage, mass effect, abnormal extra-axial fluid collection, or hydrocephalus. There are diffuse chronic microangiopathic changes. There is old lacunar infarction in the right thalamus, which also be faintly seen on a maxillofacial CT from 7/12/2012. Probable additional prior lacunar infarctions are present in the left thalamus.

There is no evidence of aggressive osseous lesion.

Included paranasal sinuses are predominantly clear. The included mastoid air cells are clear.

IMPRESSION:

1. There is no evidence of acute intracranial abnormality.

2. Diffuse chronic microangiopathic changes, including several previous lacunar infarctions.

Transcriptionist- ANDREW K ANDERSON-MD
FINAL

3500 HIGHWAY 17 NORTH MT PLEASANT, SC 29466 * (843) 724-2150

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Nurse's Notes — *Roper St. Francis HealthCare Mount Pleasant*

Name: Delila Parrott
Age: 80 years **Sex:** Female **DOB:** REDACT
Arrival Date: 10/11/2014 **Time:** 11:08
Bed I1
Diagnosis: Altered Mental Status; Paranoid Schizophrenia

MRN: 001787037
Account#: 1428400216
Private MD:

Inbound Details:
Referred by: Arriving by: EMS ETA: 11:02
Who will see patient? ED Physician
Notes:
Notify referring provider: Do not notify

Presentation:
10/11 11:23 Transition of care: Patient was received from long-term care facility. jmc2
11:23 Method Of Arrival: EMS. jmc2

Triage Assessment:
11:10 Presenting complaint per patient: Couldn't get up this morning.Paramedic states that they they were called because pt complained that there were criminals were she livec and that she was being mistreated. Family weas called and that was her normal but staff said her symptoms have been increased. Patient appears awake, alert, oriented. Skin warm and dry. Moves all extremities. Respirations even and unlabored. Behavior is confused. **Pain:** Denies pain. jmc2

Historical:
Allergies:
11:14 green vegetables; NSAIDS; all nasal sprays; Chocolate; Aspirin; ACE INHIBITORS; jmc2
11:30 Toradol; jmc2
Home Meds:
11:14 Tylenol-Codeine Unknown ; Estrace Unknown ; Ultram Oral Unknown as needed, every 6 hours; Norco Oral 7.5/325 1-2 tabs as needed, every 4 hours; Inderal LA Oral Unknown every 8 hours; Colace oral 100 mg as needed; Celexa Oral Unknown daily; Nexium Oral 40 mg daily; Lasix oral 40 mg daily, as needed; Dilacor XR oral 180 mg daily; Miralax Oral 1 packet as needed; Macrobid Oral 1 capsule twice a day; Xanax Oral 0.25 mg three times a day; Seroquel Oral Unknown daily; Aricept Oral 5 mg daily. nightly; jmc2
PMHx:
11:14 phobias; jmc2
11:30 Schizophrenia; jmc2
PSHx:
11:14 Breast biopsy; Fracture repair; jmc2
11:30 ORIF 6/7/2014- l hip; jmc2

- **Social history::** unknown. Smoking status: unknown.
- **Advanced Directives::** Unable to obtain information,.
- **History obtained from:** daughter, EMS,.

Screening:
11:22 jmc2
Abuse screen:
unknown.
Fall Risk
None identified.
Suicide Screening:

Print Time: 10/12/2014 06:06:44 *** CHART COMPLETE *** Page 1 of 3

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Physician Documentation

Roper St. Francis HealthCare Mount Pleasant

Name: Delila Parrott
Age: 80 years **Sex:** Female **DOB:** REDACT
Arrival Date: 10/11/2014 **Time:** 11:08
Bed 11
ED Physician Bianco, Joseph
HPI:

MRN: 001787037
Account#: 1428400216
Private MD:

10/11
15:03 This 80 years old White Female presents to ED via EMS with complaints of **Psych Problem**. jbr2

15:03 The patient presents to the emergency department with paranoia. Onset: The symptoms/episode began/occurred gradually. Timing is constant. Past psychiatric history: Prior diagnosis: schizophrenia. Associated signs and symptoms: The patient has no apparent associated signs or symptoms. Severity of symptoms: At their worst the symptoms were severe just prior to arrival, in the emergency department the symptoms are unchanged. The patient has experienced similar episodes in the past several times, but today's symptoms are worse. The patient has been recently seen by a physician: the patient's primary care provider, 5 day(s) ago, with similar presenting complaints. The patient is an 80-year-old female who presents to the ER from an assisted living center complaining of paranoid delusions. Patient states that someone is trying to kill her. Patient states that they've been giving her medicines and she knows when she wakes up she doesn't know what is happening. Patient has some confusion and a slightly altered per the nursing home. jbr2

15:05 Unable to obtain HPI due to altered mental status. jbr2

Historical:

- **Allergies:** green vegetables; NSAIDS; all nasal sprays; Chocolate; Aspirin; ACE INHIBITORS; Toradol;
- **Home Meds:**
  1. Tylenol-Codeine Unknown
  2. Estrace Unknown
  3. Ultram Oral Unknown as needed, every 6 hours.
  4. Norco Oral 7.5/325 1-2 tabs as needed, every 4 hours
  5. Inderal LA Oral Unknown every 8 hours
  6. Colace oral 100 mg as needed
  7. Celexa Oral Unknown daily
  8. Nexium Oral 40 mg daily
  9. Lasix oral 40 mg daily, as needed
  10. Dilacor XR oral 180 mg daily
  11. Miralax Oral 1 packet as needed
  12. Macrobid Oral 1 capsule twice a day
  13. Xanax Oral 0.25 mg three times a day
  14. Seroquel Oral Unknown daily
  15. Aricept Oral 5 mg daily, nightly
- **PMHx:** phobias; Schizophrenia
- **PSHx:** Breast biopsy; Fracture repair; ORIF 6/7/2014- lt hip
- **Social history:** unknown. Smoking status: unknown.
- **Advanced Directives:** Unable to obtain information,.
- **History obtained from:** daughter, EMS,.

ROS:

15:05 jbr2

Constitutional: NO FEVER OR CHILLS.
Psych: Positive for anxiety; auditory hallucinations, visual hallucinations. All other systems reviewed and are negative.

Exam:

15:06 jbr2

Constitutional: Awake and in NAD, resting comfortably.
Head/Face: d
Eyes: Pupils equal round and reactive to light, extra-ocular motions intact. Lids and lashes normal. Conjunctiva and sclera are non-icteric and not injected. Periorbital areas with no swelling, redness, or

Physician Documentation Con't.

edema.
ENT: Nares patent. No nasal discharge. Tympanic membranes without erythema or bulging. Oropharynx with no redness, swelling, or masses, exudates, or evidence of obstruction, uvula midline. Mucous membranes moist.
Neck: Trachea midline and no cervical lymphadenopathy. Supple, full range of motion without nuchal rigidity, or vertebral point tenderness. No Meningismus.
Chest/axilla: Normal chest wall appearance and motion.
Cardiovascular: Regular rate and rhythm. No gallops, murmurs, or rubs appreciated. No pulse deficits.
Respiratory: Lungs have equal breath sounds bilaterally, clear to auscultation. No rales, rhonchi or wheezes noted. No increased work of breathing, no retractions or nasal flaring.
Abdomen/GI:
Back: No spinal tenderness. No costovertebral tenderness.
Skin: Warm and dry, with no significant rashes noted.
MS/ Extremity: Pulses equal and no obvious deformity noted. Neurovascular intact. Normal range of motion per patients baseline.
Neuro: Awake and alert, GCS 15, oriented to person, place and time. Cranial nerves grossly intact. Reasonable motor strength in all extremities. Sensory grossly intact. Cerebellar exam without abnormality or past pointing.
Psych: Behavior/mood is cooperative, anxious, Affect is flat, Oriented to person, only. Not oriented to place, time. Patient has no thoughts/intents to harm self or others. Judgement / Insight is impaired. Delusions/hallucinations are present and described as Patient believes someone is out to kill her..

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Pain	Staff
11:13		60	20	97.7	99%		0/10	jmc2
12:58	171 / 58	60	20		97%		0/10	jmc2
15:49	170 / 68	67	20		97%		0/10	jmc2

MDM:

11:10 Medical screening evaluation initiated. jbr2

15:08 jbr2

Data reviewed: vital signs, nurses notes, old medical records obtained and reviewed, lab test result(s), radiologic studies, CT scan.
Counseling: I had a detailed discussion with the patient and/or guardian regarding the historical points, exam findings, and any diagnostic results supporting the discharge/admit diagnosis, lab results, radiology results, the need for further work-up and treatment in the hospital.
ED course: Patient recently had her medications changed. In the emergency department she is clearly altered and paranoid. Patient is going to be admitted..

Time	Order name	Complete Time	Staff
10/11 11:27	BMP	12:38	jbr2
10/11 11:27	CBC	12:38	jbr2
10/11 11:52	URINALYSIS POC MP ED	12:38	EDMS
10/11 12:05	Potassium Blood Level	12:38	bj
10/11 11:59	Head CT w/o contrast	12:38	jbr2
10/11 11:27	INT	11:40	jbr2
10/11 11:27	POC - Urine dip (collect)	11:55	jbr2

Name: Delila Parrott **MRN:** 001787037
Account#: 1428400216
Print Time: 10/12/2014 06:05:46 Page 2 of 4

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DATE OF ADMISSION: 10/11/2014

DATE OF DISCHARGE: 10/15/2014

PRIMARY CARE PHYSICIAN: Dr. Richard Mills

PRINCIPAL DISCHARGE DIAGNOSES: Delirium and paranoia.

SECONDARY DISCHARGE DIAGNOSES:
1. Hypertension.
2. Osteoarthritis.
3. Dementia.
4. GERD.
5. Deconditioning.

DIAGNOSTIC STUDIES:
1. CT head without contrast on 10/11/2014 showed no evidence of acute intracranial abnormality, diffuse chronic microangiopathic changes including several previous lacunar infarction.

HOSPITAL COURSE: Ms. Parrott is a patient with a known psychiatric history and known cognitive decline who presented after a precipitous decline over the preceding two weeks with worsening cognitive function, as well as worsening in her physical abilities to do activities of daily living.
1. Delirium and paranoia. An infectious workup was pursued, which was negative as the precipitant. Looking at her current medications her Citalopram and Tramadol were discontinued due to concern for possible serotonin syndrome. Her hydrocodone was also discontinued as this could have contributed to her decline. Laboratory testing including a serum ammonia, B-12, folate and thyroid function were all normal. The patient was started on Risperdal 0.5 mg at bedtime and 0.25 twice a day with meals with much improvement in her mental status. At the time of discharge the patient's paranoia seemed to have improve significantly. She still gets confused at times and still does require two people to assist her with movement, but overall is much improved.
2. Hypertension. Her blood pressure was elevated during her stay, however, no adjustments in her antihypertensives was made as this could have been contributed to IV fluids that she received early during her hospitalization. She was continued on her home antihypertensives. She has a follow up

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appointment scheduled with Dr. Mills and if her blood pressure remains elevated at that time an adjustment could be made.
3. Dementia. She was continued on her home Donepezil. Her daughter reports that she has significant anxiety associated with her dementia. She was continued on her home Alprazolam. Her Citalopram was restarted on 10/14/2014 due to her daughter's significant concern about her underlying anxiety. She seems to be tolerating that medication well on the day of discharge.
4. GERD. The patient was continued on a PPI with no complaints of abdominal pain.
5. Deconditioning. Physical therapy worked with the patient during her hospital stay and this will be continued as an outpatient at Ashley River Plantation.

DISCHARGE MEDICATIONS: Please see med rec.

CHANGES TO HOME MEDICATIONS: Discontinuation of Macrobid, Norco, Tramadol and Seroquel. Addition of Risperdal.

DISPOSITION: The patient will be discharged back to Ashley River Plantation to continue physical therapy and occupational therapy.

DIET: Regular.

ACTIVITY: As tolerated and as directed by physical therapy.

CODE STATUS: Full code.

FOLLOW UP: Appointment with Dr. Mills on 10/29/2014 at 11:45 a.m.

Abby E Gass, MD
TR: pn DD: 10/15/2014 08:34 TD: 10/15/2014 09:09 Job#: 330250
DOC#: 433064

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PARROTT, DELILA W
Roper St. Francis Mt Pleasant Hospital
Ancillary Charting (anc_hpf)

ROOM: *3125-01* ADM: 10/11/14 15:36
ADMIT PHY: ST OF MD: MILLS MD, RICHARD E
DOB: RED ID: 1428400216 MR: 001787037
REQUESTED: 10/14/14 07:49
OPT OUT:

Page: 3

Ancillary Chartin	10/12				
PT Eval-Cont	12:07	12:43	15:47	19:53	23:32
Funct mobility 2		chair to bed 2 persons minimal assist JW			
Gait/Amb 1		roll walker incr dist on level surface of one min JW			
Distance 1		25ft JW			
Time frame		6 sessions JW			
LTG 1		JW			
LTG 2		JW			
Plan		func mobility pt/fam train/edu safety JW			
Bed Mobility		4 = min ass JW			
Trans: bed to		3=mod ass JW			
Gait/walking lev		0=cannot assess JW			
Walking distance		0 = cannot asses JW			
Funct outcome		7 JW			
G-code modifier		C L JW			
Current G-Code		G8978 JW			
Goal G-Code		G8979 JW			
Goal status		cj JW			
Rehab Potential		Fair JW			

10/12/14 12:43 Treatment reqstd(JW): PT evaluation
10/12/14 12:43 Treatment Dx(JW): weakness
10/12/14 12:43 Special equipmt(JW): IV
10/12/14 12:43 Prior lvl functn(JW): lives in assisted-living memory care unit. usually uses a walker
10/12/14 12:43 Precautions(JW): Fall risk/HOH
10/12/14 12:43 Prev Med Hx(JW): paranoid shizophrenia, hip fracture (L), aortic insufficiency, HTN, sleep apnea, GERD,OA, anxiety, phobias

WALTERS, JESSICA(JW) THERAPIST

CONTINUED

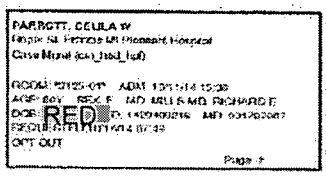
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PARROTT, DELILA W
Roper St. Francis Mt Pleasant Hospital
Ancillary Charting (anc_hst)
ROOM: *3125-01* ADM: 10/11/14 15:35
ADF: 93W ASC: E MD: MILLS-MD, RICHARD F
DOB: REDACTED ID: 1428400216 MR: 001787037
REQUESTED:10/16/14 07:49
OPT OUT
Page: 6

Ancillary Chartin	10/12				
PT Eval-Cont	12:07	12:43	15:47	19:53	23:32
Distance 1		of one min JW 25ft JW			
Time frame LTG 1 LTG 2		6 sessions JW JW JW			
Plan		func mobility pt/fam train/edu safety JW			
Bed Mobility Trans: bed to Gait:walking lev Walking distance Funct outcome G-code modifier Current G-Code Goal G-Code Goal status		4 = min ass JW 3=mod ass JW 0=cannot assess JW 0 = cannot asses JW 7 JW C L JW G8978 JW G8979 JW 0j JW			
Rehab Potential		Fair JW			

10/12/14 12:43 Treatment reqstd(JW): PT evaluation
10/12/14 12:43 Treatment Dx(JW): weakness
10/12/14 12:43 Special equipmt(JW): IV
10/12/14 12:43 Prior lvl functn(JW): lives in assisted-living memory care unit, usually uses a walker
10/12/14 12:43 Precautions(JW): Fall risk/HOH
10/12/14 12:43 Prev Med Hx(JW): paranoid shizophrenia, hip fracture (L), aortic insufficiency, HTN, sleep apnea, GERD,OA, anxiety, phobias
10/12/14 12:43 Subjective(JW): "I don't want anyone to know I am here"
10/12/14 12:43 PT eval pain(JW): fearful
10/12/14 12:43 Func bed to chair(JW): 1-2 step cues
10/12/14 12:43 Other(JW): PT evaluation
WALTERS, JESSICA(JW)THERAPIST

OneContent: Generated By coffje1


PARROTT, DELILA W
Roper St. Francis Mt Pleasant Hospital
Case Mgmt (cm_hed_hpf)

ROOM: 3125-01 ADM: 10/11/14 15:38
ACP: SELF MD: MILLS MD, RICHARD E
DOB: REDACTED ID: 1428400216 MR: 001787037
PRINTED: 10/17/14 07:39
OPT OUT

Page 1

Case Mgmt Chartin	10/13
CM Initl Assess-Com.	**15:22**
PreHsp Phys Stat	independ amb MV
Currnt Phys Stat	amb with assist MV
Pre Hospital ADL	partial assist MV
Current ADL	partial assist MV
PreHsp Asst Dev	walker wheelchair MV
Currnt Assis Dev	hospital bed walker MV
Transportation	ambulance MV
Intervention	discussed w/Fam discussed w/Pt is indicated MV

10/13/14 15:22 Living Situation(MV): Ashley River
10/13/14 15:22 Caregiver(MV): assisted living staff

CM Initial Assess	**15:22**
Primary Contact	joan acosta, dtr MV
Phone Number	803-331-6342 MV
Info From	pt, chart, dtr MV
Primary Care Phy	dr. mills MV
Hosp in last 30d	no MV
Referral Reason	case coord DC needs MV
Finan Resources	insurance medicare MV
Living Situation	assisted living MV
Number of Steps	0 MV
SNF	Sandpipr Rhb Nsg MV

VANSICKLE-BONNEY, MARY(MV)Case Mgr

Parrott, Delila (80987) *Room:* *Medical Record no: 80987*

8/21/2014 7:47 PM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE
VS: 121/57, 75, 97.8 ORAL TEMP, 17, 94% ON ROOM AIR.
Signed by: Cora Cunningham *Co-signed by:*

8/21/2014 3:59 PM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE
RESIDENT ALERT AND ORIENTED X 3. PLEASANT IN MOOD TODAY. RESIDENT IN HALL TODAY VISITING WITH OTHER RESIDENTS AND STAFF: HAPPY AFFECT. RESIDENT DENIES PAIN. CONTINENT OF BOWEL AND BLADDER. ABD SOFT WITH BS + X 4. ATE 50% OF LUNCH. CONTINES WITH ENSRE PER ORDERS. RESIDENT REQUIRE SET UP HELP WITH MEALS. REQUIRES SET UP HELP TO ONE ASSIST WITH ADLS, TRANSFERS AND MOBILITY: USES W/C: ABLE TO SELF PROPEL. CARDIOVASCULAR SYSTEM STABLE: DENIES CHEST PAIN. SKIN IS WARM AND DRY. RESPIRATIONS EVEN AND UNLABORED. NO C/O SOB. RESIDENT CONTINUES WITH THERAPY PER ORDER WITH GOOD PARTICPATION.
Signed by: Cora Cunningham *Co-signed by:*

8/21/2014 4:00 AM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE
THIS IS THE DAILY MEDICARE NOTE FOR 8/20/2014. VS: 142/52, 63, 98.9, 16, 94% ON RA. RESIDENT IS ALERT AND ORIENTED X3 WITH OCCASSIONAL PERIODS OF CONFUSION. RESIDENT ABLE TO VOICE WANTS AND NEEDS. RESIDENT IS PLEASANT AND COOPERATIVE WITH CARE. RESIDENT DENIES ANY PAIN OR DISCOMFORT AT THIS TIME. RESIDENT REQUIRES ASSIST X1 WITH ADL'S AND TRANSFERS. RESIDENT USES WHEELCHAIR FOR MOBILITY. RESIDENT IS CONTINENT OF BOWEL AND BLADDER WITH INCONTINENT EPSIODES, KEPT CLEAN AND DRY BY STAFF. RESIDENT CONTINUES TO HAVE A FAIR APPETITE, ABLE TO FEED SELF WITH SET UP ASSIST. RESIDENT IS CONTINENT OF BOWEL AND BLADDER. BOWEL SOUNDS PRESENT X4, ABDOMEN IS SOFT, NONTENDER, NONDISTENDED. NEUROLOGICAL AND GASTROINTESTINAL SYSTEM IN STABLE CONDITION. NO COMPLAINTS OF N/V, CONSTIPATION OR LOOSE STOOLS NOTED. NO SIGNS OR SYMPTOMS OF ACUTE CARDIAC OR RESPIRATORY DISTRESS NOTED. RESPIRATIONS ARE EVEN AND UNLABORED, LUNG SOUNDS DIMINISHED IN THE BASES. NO SOB NOTED. NO COMPLAINTS OF CHEST PAIN NOTED. SKIN IS WARM AND DRY. RESIDENT CONTINES WITH THERAPY PER ORDER WITH GOOD PARTICIPATION. RESIDENT CURRENTLY RESTING IN BED, CALL LIGHT WITHIN REACH. NO SIGNS OR SYMPTOMS OF DISTRESS NOTED.
Signed by: Jenna Donovan *Co-signed by:*

8/20/2014 11:12 AM *Role:* Social Service Assistant *Category:* SOCIAL SERVICES
Sixty Day Assessment - Mrs. Parrott's BIMS' score did not show any cognitive impairment. The Mood Interview showed mild depression. She did admit to feeling depressed at times and feeling negative about herself. She still has flashbacks "all the time" about her experience at the Village. At times, she can be confused and anxious. She was seen by our psychiatrist, Dr. Craig on 7-10-14. She increased Mrs. Parrot's Celexa , discontinued her Valium and added PRN Xanax. Therapy reports that Mrs. Parrot is making good progress. Will continue to monitor her mood and behavior and to provide support if needed.
Signed by: Carole Harvey *Co-signed by:*

8/20/2014 3:00 AM *Role:* LICENSED NURSE *Category:* NURSING NOTE
ADMINISTERED VITAMIN B-12 IM INJECTION TO THE RIGHT DELTOID ON 8/19/2014 AT 930 PM. NO ADVERSE REACTIONS NOTED.
Signed by: Arianne Easton *Co-signed by:*

8/20/2014 12:08 AM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE
THIS IS A LATE ENTRY DAILY MEDICARE NOTE FOR 8/5/14. RESIDENT IS ALERT AND ORIENTED X 3 WITH INTERMITTENT CONFUSION. NO COMPLAINTS OF PAIN AS OF ASSESSMENT. RESIDENT IS WEIGHT BEARING AS TOLERATED TO LEFT LOWER EXTREMITY. ABLE TO VERBALIZE NEEDS. VERY NICE AND PLEASANT. NO SIGNS OR SYMPTOMS OF RESPIRATORY DISTRESS. CONTINENT OF BOWEL AND BLADDER WITH INTERMITTENT BLADDER INCONTINENCE. SET UP TO ASSIST X 1 IN ADLS AND TRANSFERS. USES WALKER WITH ASSIST X1 FOR AMBULATION. USES WHEELCHAIR FOR LONG DISTANCE MOBILITY INDEPENDENTLY. SKIN WARM AND DRY. NO COMPLAINTS OF NAUSEA, VOMITING, OR DIARRHEA. RESIDENT HAS MODERATE APPETITE TODAY; ATE 40% OF BREAKFAST AND 60% OF LUNCH. NEUROLOGICAL SYSTEM IN STABLE CONDITION. CARDIAC STATUS IN STABLE CONDITION. CONTINUES WITH PT/OT WITH GOOD RESPONSE. VS 98.7, 67, 118/68, 18, 97%.
Signed by: Dawn Thomas *Co-signed by:*

8/19/2014 2:49 PM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE
THIS IS A LATE ENTRY DAILY MEDICARE NOTE FOR 8/8/14. RESIDENT IS ALERT AND ORIENTED X 3 WITH OCCASIONAL CONFUSION. NO COMPLAINTS OF PAIN AS OF ASSESSMENT. RESIDENT IS WEIGHT BEARING AS

Parrott, Delila (80987) *Room:* *Medical Record no: 80987*

Addendum 6/21/2014 3:48 PM

RESIDENT C/O BLISTER TO BOTTOM LIP. NEW ORDER ALSO RECEIVED FOR ABREVA CREAM TO AREA QID: RESIDENT AND FAMILY AWARE. ORDER IMPLAMENTED.

Addendum signed by: Cora Cunningham *Co-signed by:*

6/20/2014 10:39 AM *Role:* **Activities** *Category:* **ACTIVITIES**

MRS.DELILA PARROTT WAS ADMITTED TO THE FACILITY ON 06/10/2014 FOLLOWING HOSPITALIZATION. RESIDENT WAS PLEASANT AND COOPERATIVE TOWARDS STAFF. SHE IS ALERT AND IS ABLE TO MAKE ALL OF HER NEEDS KNOWN AND MET.MRS. PARROTT LIVED AT SANDPIPER VILLAGE PRIOR TO COMING HERE AND HAS PLAN TO RETURN AFTER THERAPY. MRS. PARROTT IS BAPTIST, HER HOBBIES ARE PLAYING CARD, AND BINGO. RESIDENT STATED SHE USE TO READ AND DO LOTS OF CRAFTS IN THE PAST HOWEVER HER VISION IS POOR AT THIS TIME SO SHE SPENDS MOST OF HER DAY WATCHING TELEVISION. MRS. PARROTT WAS PROVIDED WITH A MONTHLY ACTIVITY CALENDAR FOR HER VIEWING. SHE ALSO COMPLETED AND ACTIVITY EVALUATION WITH STAFF ON 06/20/2014 AND DISCUSSED ACTIVITY PREFERENCES. MRS. PARROTT IS INTERESTED IN WEEKLY CHURCH, BINGO AND SOCIALS. SHE DOES REQUIRE REMINDERS AND NEED ASSIST WITH TRANSPORTING TO AND FROM ACTIVITIES. STAFF WILL CONTINUE TO ENCOURAGE AND INVITE RESIDENT TO ACTIVITIES OF INTEREST ASSISTING AS NEEDED. STAFF WILL ALSO ENCOURAGE FAMILY INVOLVEMENT IN GROUP ACTIVITIES FOR SUPPORT TO RESIDENT AS SHE ADJUST TO NEW FACILITY.

Signed by: Marva Bland *Co-signed by:*

6/19/2014 2:47 PM *Role:* **LICENSED NURSE** *Category:* **DAILY MEDICARE NOTE**

RESIDENT IS ALERT AND ORIENTED X3. PLEASANT AND COOPERATIVE; SITTING IN WHEELCHAIR IN ROOM READY FOR THERAPY. COMPLAINTS OF PAIN TO LEFT LOWER EXTREMITY; PRN ULTRAM ADMINISTERED AT 8:35 AM AND PRN NORCO ADMINISTERED AT 12:45 PM, BOTH WITH POSITIVE RESULTS. WOUND CARE TREATMENT PROVIDED PER ORDERS. RESIDENT REQUIRES SET UP ASSIST WITH MEALS, AND ASSIST X1 WITH ADL'S ,AND TRANSFERS; UTILIZES WHEELCHAIR FOR MOBILITY. CONTINENT OF BOWEL AND BLADDER. BOWEL SOUNDS X4 QUADRANTS. NO COMPLAINTS OF NAUSEA, VOMITING, OR CONSTIPATION. NO SIGNS OF CARDIAC DISTRESS. RESPIRATIONS EVEN AND UNLABORED; NO COMPLAINTS OF SHORTNESS OF BREATH. SKIN IS WARM AND DRY. ADEQUATE INTAKE OF FOOD AND FLUIDS. CONTINUES WITH THERAPY PER ORDER. ABLE TO MAKE NEEDS KNOWN. CALL BELL WITHIN REACH. VS 120/65, 60, 18, 96%, 96.6. NEW ORDER FOR PYRIDIUM 200 MG BID X 3 DAYS; D/C ORDER FOR CIPRO. DAUGHTER JOAN AWARE.

Signed by: Dawn Thomas *Co-signed by:*

6/18/2014 11:32 PM *Role:* **LICENSED NURSE** *Category:* **DAILY MEDICARE NOTE**

RES IS ALERT AND ORIENTED X2-3 VERBALLY RESPONSIVE NORCO GIVEN AT HS FOR LEFT HIP PAIN EFFECTIVE RESTING AT THIS TIME. NO RESPIRATORY DISTRESS NOTED LUNGS CLEAR ALL FIELDS NO SOB OR COUGH NO CARDIAC ISSUES NOTED NO N/V ABD SOFT NONTENDER NONDISTENDED POSITIVE BOWEL SOUNDS PRESENT ALL QUADS CONTINENT OF BOWEL AND BLADDER. USE BEDPAN AS NEEDED. SKIN DRY AND WARM TO TOUCH DRESSING CHANGES DONE TO BOTH LOWER EXTREMITIES AS ORDERED NO DRAINAGE NOTED. NO S/SX OF INFECT. NOTED. CONTINUES CIPRO NO ADVERSE REACTION NOTED. CONTINUES PT/OT SERVICES AS DIRECTED ADLS WITH MODERATE ASSIST. W/C FOR TRANSPORT. CALL LIGHT AND FLUIDS IN REACH VS 98.5 69 19 126/61 O2 95% ROOM AIR

Signed by: Michelle McCarley *Co-signed by:*

6/18/2014 2:40 PM *Role:* **LICENSED NURSE** *Category:* **NURSING NOTE**

URINE C&S RETURNED AND IS NEGATIVE. DR. MURK NOTIFIED AND RESIDENT AWARE.

Signed by: Dawn Thomas *Co-signed by:*

6/17/2014 11:38 PM *Role:* **LICENSED NURSE** *Category:* **NURSING NOTE**

VS: 142/63, 67, 98.0, 18, 95% ON RA. RESIDENT BEGAN CIPRO 250MG FOR UTI THIS EVENING. NO SIGNS OR SYMPTOMS OF ADVERSE REACTIONS NOTED. RESIDENT RESTING IN BED, CALL LIGHT WITHIN REACH. NO SIGNS OR SYMPTOMS OF DISTRESS NOTED. WILL CONTINUE TO MONITOR.

Signed by: Jenna Donovan *Co-signed by:*

6/17/2014 7:35 PM *Role:* **LICENSED NURSE** *Category:* **NURSING NOTE**

U/A RETURNED. VIEWED BY DR. MURK WITH NEW ORDERS FOR CIPRO 250MG PO BID X 7 DAYS. ORDERS IMPLAMENTED. VOICE MAIL LEFT FOR RESIDENT'S DAUGHTER REQUESTING RETURN PHONE CALL. RESIDENT ENCOURAGED TO INCREASE FLUID INTAKE. CURRENTLY RESTING QUIETLY WITH CALL LIGHT IN REACH.

Signed by: Cora Cunningham *Co-signed by:*

Parrott, Delila (80987) *Room:* *Medical Record no: 80987*

ADVERSE REACTIONS NOTED. CARDIOVASCULAR SYSTEM STABLE. SKIN IS WARM AND DRY. RESPIRATIONS EVEN AND UNLABORED. NO C/O SOB. RESIDENT CONTINUES WITH THERAPY PER ORDER WITH GOOD PARTICPATION. VS: 146/66, 70, 98.2 ORAL TEMP, 18, 99% ON ROOM AIR.
Signed by: Cora Cunningham *Co-signed by:*

6/21/2014 4:00 PM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE
RESIDENT ALERT AND ORIENTED X 3. PLEASANT IN MOOD AND COOPERATIVE WITH CARES. NO C/O PAIN AT PRESENT: RECEIVED SCHED NORCO 7.5 THIS A.M. PER ORDER. CONTINENT OF BOWEL AND BLADDER WITH EPISODES OF INCONTINENCE: PERI CARE RECEIVED. CONTINENT BM TODAY X 2: SOFT/FORMED. POOR APPETITE TODAY: ATE 25% OF LUNCH WITH SET UP HELP: ENCOURAGMENT PROVIDED BY STAFF. CARDIDOVASCULAR SYSTEM STABLE: DENIES CHEST PAIN. SKIN IS WARM AND DRY. DRESSING TO RIGHT HIP, LEFT HIP AND LEFT POSTERIOR KNEE ARE ALL CLEAN, DRY AND INTACT. CONTINUES WITH ABREVA CREAM TO FEVER BLISTER TO BOTTOM LIP: BLISTER RESOLVING. NEW ORDER FOR FOAM WEDGE BETWEEN LEGS EVERY HS PER PT RECOMMENDATION. ORDER IMPLAMENTED. RESIDENT MADE AWARE. DAUGHTER, JOAN ALSO AWARE. RESPIRATIONS EVEN AND UNLABORED WITH NO C/O SOB. RESIDENT CONTINUES WITH THERAPY PER ORDER WITH GOOD PARTICPATION. VS: 116/59, 72, 97.1 ORAL TEMP, 18, 99% ON ROOM AIR.
Signed by: Cora Cunningham *Co-signed by:*

6/21/2014 3:02 AM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE
THIS IS THE DAILY MEDICARE NOTE FOR 6/20/14. VS: 152/66, 93, 98.0, 20, 95% ON RA. RESIDENT IS ALERT AND ORIENTED X3. PLEASANT AND COOPERATIVE WITH CARE. RESIDENT IS ABLE TO VOICE WANTS AND NEEDS. RESIDENT DENIES ANY BREAKTHROUGH PAIN OR DISCOMFORT AT THIS TIME. NORCO ADMINISITERED PER ORDER WITH EFFECTIVE RELIEF OF PAIN. RESIDENT REQUIRES ASSIST X1 WITH ADLS AND TRANSFERS. RESIDENT USES WHEELCHAIR FOR MOBILITY. RESIDENT IS ABLE TO FEED SELF WITH SET UP ASSIST. RESIDENT IS CONTINENT OF BOWEL AND BLADDER WITH INCONTINENT EPISODES, KEPT CLEAN AND DRY BY STAFF. NO COMPLAINTS OF CONSTIPATION OR LOOSE STOOLS NOTED. BOWEL SOUNDS PRESENT X4, ABDOMEN IS SOFT, NONTENDER, NONDISTENDED. NEUROLOGICAL AND GASTROINTESTINAL SYSTEM IN STABLE CONDITION. NO COMPLAINTS OF N/V NOTED. NO SIGNS OR SYMPTOMS OF ACUTE RESPIRATORY OR CARDIAC DISTRESS NOTED. RESPIRATIONS ARE EVEN AND UNLABORED. LUNG SOUNDS ARE CLEAR BILATERALLY. NO SOB NOTED. NO COMPLAINTS OF CHEST PAIN NOTED. CARDIAC SYSTEM IN STABLE CONDITION. SKIN IS WARM AND DRY. DRESSING CHANGES COMPLETED TO BILATERAL LOWER EXTREMITIES AS ORDERED. DRESSINGS ARE CLEAN, DRY AND INTACT WITH NO DRAINAGE NOTED. NO SIGNS OR SYMPTOMS OF INFECTION NOTED. RESIDENT CONTINUES TO PARTICIPATE IN THERAPY PER ORDER WITH GOOD PARTICIPATION. RESIDENT CURRENTLY RESTING IN BED, CALL LIGHT WITHIN REACH. NO SIGNS OR SYMPTOMS OF DISTRESS NOTED.
Signed by: Jenna Donovan *Co-signed by:*

6/20/2014 2:38 PM *Role:* Social Service Assistant *Category:* SOCIAL SERVICES
SW requested physician to complete medical decisional capacity form.
Signed by: Carole Harvey *Co-signed by:*

6/20/2014 2:23 PM *Role:* Social Service Assistant *Category:* SOCIAL SERVICES
Admission Assessment -Mrs. Parrott is an 80 year old Caucasian female who was admitted to our facility following hospitalization. Discharge diagnoses include: left hip fracture, anemia, hypertension, acute delirium, chronic diarrhea, hx.of a-fib and anxiety. Mrs. Parrot sustained a fall in her apartment at the Village and was discovered 2 days after the incident by a friend. The Mood Interview revealed moderate depression. She told me she felt that she would be better off dead while she was one the floor after the fall. It was a very traumatic experience. She yelled and banged on the wall for two days.She also states that she feels depresed, tired, has a poor appetite and has difficuty concentrating. She is taking Celexa and PRN Valium. Mrs. Parrott's BIMS' score did not reveal cognitive impairment. Mrs. Parrott plans to return to independent living after rehab. She has a daughter who is a RN and lives in Columbia, S.C. Her daughter visits frequently. Will continue to monitor her mood and behavior.
Signed by: Carole Harvey *Co-signed by:*

6/20/2014 10:59 AM *Role:* LICENSED NURSE *Category:* NURSING NOTE
RESIDENT SEEN BY W. GREENE PA THIS MORNING WITH NEW ORDERS FOR SCHED NORCO 7.5/325MG PO BID FOR PAIN MANAGMENT. RESIDENT AND DAUGHTER, JOAN, MADE AWARE.
Signed by: Cora Cunningham *Co-signed by:*

Parrott, Delila (80987) *Room:* *Medical Record no: 80987*

Signed by: Jenna Donovan *Co-signed by:*

6/25/2014 1:51 PM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE

RESIDENT NOTED TO HAVE A 5LB WIEGHT LOSS IN LAST WEEK. DIETICIAN CONSULTED: NEW ORDER FOR NUTRITIONAL SUPPLEMENT BID: RESIDENT IS NOW A WEEKLY WIEGHT. RESIDENT AND DAUGHTER JOAN MADE AWARE: RESIDENT REQUEST H.PYLORI TEST R/T C/O HEARTBURN. ORDER RECEIVED TO DRAW IN AM. RESIDENT AND DAUGHTER, JOAN, AWARE. REMAINS ALERT AND ORIENTED X 3. PLEASANT IN MOOD AND COOPERATIVE WITH CARES. DENIES PAIN AT TIME OF ASSESSMENT. CONTINUES WITH SCHED NORCO BID WITH EFFECTIVE RESULTS. CONTINENT OF BOWEL AND BLADDER: ABD SOFT WITH BS + X 4. GOOD APPETITE THIS AFTERNOON: ATE 100% OF LUNCH WITH SET UP HELP ONLY. DRANK 100% OF ENSURE. REQUIRES SET UP HELP TO ONE ASSIST WITH ADLS. ONE ASSIST WITH TRANSFERS AND MOBILTY: USES W/C. DRESSINGS TO RIGHT HIP, LEFT HIP AND LEFT POPLITEAL ARE CLEAN, DRY AND INTACT. CONTINUES WITH SMALL FEVER BLISTER IMMEDIATLEY BELOW BOTTOM LIP: ABREVA APPLIED PER ORDER. CARDIOVASCULAR SYSTEM STABLE: DENIES CHEST PAIN. 2+ EDEMA TO RIGHT LOWER EXTREMITY. TRACE EDEMA TO LLE. LEGS ELEVATED WHILE IN BED. PRN LASIX ADMINSITERED. RESPIRATIONS EVEN AND UNLABORED. NO C/O SOB. CONTINUES WITH THERAPY PER ORDER WITH GOOD PARTICIPATION. VS: 120/66, 68, 97.6 ORAL TEMP, 18, 97% ON ROOM AIR.

Signed by: Cora Cunningham *Co-signed by:*

6/25/2014 12:55 AM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE

NOTE FOR 6/24/2014 RES IS ALERT AND ORIENTED X2 VERBALLY RESPONSIVE NO COMPLAINTS OF PAIN AT THIS TIME. NO RESPIRATORY DISTRESS NOTED LUNGS CLEAR BILATERALLY. NO CARDIAC ISSUES NOTED. NO GASTROINTESTINAL ISSUES NOTED. ABD SOFT NONTENDER NONDISTENDED NORMOACTIVE BOWELSOUNDS PRESENT ALL QUADS. INCONTINENT OF BOWEL AND BLADDER WEARS BRIEFS. SKIN DRY AND WARM DRESSING S INTACT TO BOTH LOWER EXTREMITIES. NO EDEMA NOTED WEDGE IN PLACE BETWEEN LOWER EXTREMITIES WHILE IN BED. TRANSFERS WITH ONE ASSIST ADLS WITH MODERATE ASSIST OF ONE. USES W/C FOR MOBILITY. CONTINUES PARTICIPATION IN PT/OT/ST SERVICES AS DIRECTED. RESTING IN LONG INTERVALS CALL LIGHT AND FLUIDS IN REACH VS 98.3 62 18 120/62 O2 94% ROOM AIR

Signed by: Michelle McCarley *Co-signed by:*

6/24/2014 7:59 PM *Role:* LICENSED NURSE *Category:* NURSING NOTE

2ND STEP PPD READ. NO REACTION; NEGATIVE.

Signed by: Dawn Thomas *Co-signed by:*

6/24/2014 6:17 PM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE

THIS IS A LATE ENTRY DAILY MEDICARE NOTE FOR 6/23/14. RESIDENT IS ALERT AND ORIENTED X3. PLEASANT AND COOPERATIVE; LYING IN BED RELAXING. CONTINUES ON SCHEDULED NORCO. COMPLAINTS OF BREAKTHROUGH PAIN TO LEFT LOWER EXTREMITY; PRN NORCO ADMINISTERED AT 3PM WITH POSITIVE RESULTS. WOUND CARE TREATMENT PROVIDED PER ORDERS. NO SIGNS OR SYMPTOMS OF INFECTION AT INCISION OR PREVIOUSLY BLISTERED SITES. RESIDENT REQUIRES ASSIST X1 WITH ADL'S TRANSFERS; SET UP FOR MEALS. CONTINENT OF BOWEL AND BLADDER TODAY. BOWEL SOUNDS X4 QUADRANTS. NO COMPLAINTS OF NAUSEA, VOMITING, OR CONSTIPATION. NO SIGNS OF CARDIAC DISTRESS. RESPIRATIONS EVEN AND UNLABORED; NO COMPLAINTS OF SHORTNESS OF BREATH. SKIN IS WARM AND DRY. POOR APPETITE TODAY; DAUGHTER ATTRIBUTES TO RESIDENT'S FEAR OF FOOD TRIGGERING HER COLITIS AND BECOMING INCONTINENT OF BOWEL WHILE IN REHAB. DAUGHTER HAS REQUESTED TEST FOR H. PYLORI BACTERIA; CONCERN RELAYED TO DR. MURK. CONTINUES WITH THERAPY PER ORDER. ABLE TO MAKE NEEDS KNOWN. CALL BELL WITHIN REACH. VS 145/74, 72, 18, 98.0, 99%.

Signed by: Diana Ingle *Co-signed by:*

6/24/2014 12:52 PM *Role:* LICENSED NURSE *Category:* NURSING NOTE

RESOURCE BREEZE BID @ BREAKFAST AND LUNCH AND DOCUMENT INTAKE PERCENTAGE. OBTAIN WEEKLY WT X 4WEEKS AS PER RD RECOMMENDATION

Signed by: JENIFFER GALVAN *Co-signed by:*

6/22/2014 10:21 PM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE

PPD PLACED TO RIGHT FOREARM PER ORDER: RESIDENT TOLERATED WELL. REMAINS ALERT AND ORIENTED X 3. PLEASANT IN MOOD AND COOPERATIVE WITH CARES. DENIES PAIN: CONTINUES WITH SCHED NORCO 7.5/325MG PO BID. C/O HEARTBURN THIS EVENING: PRN MYLANTA ADMINISTERED PER ORDER WITH EFFECTIVE RESULTS: RESIDENT CURRENTLY SLEEPING QUIELTY. CONTINENT OF BOWEL AND BLADDER. ABD SOFT WITH BS + X 4. OCCASIONAL INCONTINENT EPISODES: PERI CARE RECEIVED. RESIDENT CONTINUES ON PYRIDIUM WITH NO

Sandpiper R&N0111

Parrott, Delila (80987) *Room:* *Medical Record no: 80987*

WHERE SHE IS PROPELLED BY STAFF. RESIDENT REMAINS ACTIVE ON THERAPY CASELOAD. CURRENTLY SHE IS IN BED WITH EYES CLOSED AND IN NO ACUTE DISTRESS.
Signed by: Aziza Gary *Co-signed by:*

Addendum 7/7/2014 12:33 AM

THIS IS THE DAILY MEDICARE NOTE FOR 7/4/14.
Addendum signed by: Aziza Gary *Co-signed by:*

7/3/2014 5:23 PM *Role:* **Social Service Assistant** *Category:* SOCIAL SERVICES

Fourteen Day Assessment - Mrs. Parrot's BIMS' score did not show cognitive impairment. The Mood Interview showed severe depression. Mrs. Parrott was tearful during the interview and stated, "I am not happy at all." She has thoughts that she would be better off dead. She feels that she will " not be able to be a full person again". She continues on Celexa and Valium PRN. SW requested psych eval after last assessment. An order for a psych consult was written on 6-26-2014. Mrs. Parrott told me that she is not thinking about returning to her condo at this time. Will continue to monitor her mood and behavior and to provide support if needed. Unit Manager was told of her negative thoughts.
Signed by: Carole Harvey *Co-signed by:*

7/2/2014 10:18 PM *Role:* **LICENSED NURSE** *Category:* DAILY MEDICARE NOTE

RES IS ALERT AND ORIENTED X2 VERBALLY RESPONSIVE NO COMPLAINTS OF PAIN AT THIS TIME SCHEDULED NORCO GIVEN AS ORDERED FOR PAIN MAINTENANCE. NO RESIPRATORY DISTRESS NOTED NO SOB NO COUGH. NO CARDIAC ISSUES NOTED. NO N/V OR LOOSE STOOLS NOTED. ABD SOFT NONTENDER WITH POSITIVE BOWEL SOUNDS PRESENT ALL QUADS. INCONTINENT OF BOWEL AND BLADDER. SKIN DRY AND WARM DRESSINGS INTACT BOTH LOWER EXTREMITIES. TRANSFERS WITH ONE ASSIST USES W/C FOR TRANSPORT. CONTINUES PT/OT SERVICES ADLS WITH MODERATE ASSIST OF ONE. WEDGE PRESENT BETWEEN LOWER EXTRMITIES WHILE IN BED. PRESENTLY RESTING IN LONG INTERVALS NO DISTRESS CALL LIGHT AND FLUIDS IN REACH. VS 98.1 71 18 114/60 O2 95% ROOM AIR
Signed by: Michelle McCarley *Co-signed by:*

7/1/2014 5:56 PM *Role:* **LICENSED NURSE** *Category:* DAILY MEDICARE NOTE

FAIR TO POOR APPETITE: ATE 25% OF BREAKFAST AND 40% OF LUNCH WITH SET UP HELP ONLY. RESIDENT C/O STOMACH PAIN WHILE EATING. APPOINTMENT SCHEDULED WITH DR. YANTIS WHO SUGGEST AN UPPER ENDOSCOPY: RESIDENT STATSE SHE WANTS THIS PROCEDURE: DAUGHTER AWARE AND AGREES. RESIDENT ALERT AND ORIENTED X 3. PLEASANT AND COOPERATIVE WITH CARES. CONTINENT OF BOWEL AND BLADDER. ABD SOFT WITH BS + X 4. CARDIOVASCULAR SYSTEM STABLE. SKIN IS WARM AND DRY: DRESSING TO RIGHT HIP, LEFT HIP AND LEFT UPPER CALF ARE CLEAN, DRY AND INTACT. 1+ EDEMA NOTED TO BILATEARL LOWER EXTREMITY: LEGS ELEVATED WHILE IN BED. RESPIRSTIONS EVEN AND UNLABORED: DENIES SOB. CONTINUES WITH THERAPY PER ORDER WITH GOOD PARTICPATION. VS: 104/59, 70, 18, 97.0 ORAL TEMP, 94% ON ROOM AIR.
Signed by: Cora Cunningham *Co-signed by:*

7/1/2014 2:46 AM *Role:* **LICENSED NURSE** *Category:* DAILY MEDICARE NOTE

THIS IS THE DAILY MEDICARE NOTE FOR 6/30/14. VS: 149/73, 69, 97.5, 18, 96% ON RA. RESIDENT IS ALERT AND ORIENTED X3, ABLE TO VOICE WANTS AND NEEDS. PLEASANT AND COOPERATIVE WITH CARE. RESIDENT DENIES ANY BREAKTHROUGH PAIN NOTED. RESIDENT CONTINUES ON SCHEDULE NORCO WITH EFFECTIVE PAIN RELIEF NOTED. RESIDENT REQUIRES ASSIST X1 WITH ADL'S AND TRANSFERS. RESIDENT USES WHEELCHAIR FOR MOBILITY, ABLE TO PROPEL SELF. RESIDENT CONTINUES ON A NAS DIET, TOLERATING WELL. RESIDENT IS ABLE TO FEED SELF WITH SET UP, CONTINUES TO HAVE GOOD APPETITE.RESIDENT IS CONTINENT OF BOWEL AND BLADDER, WITH INCONTINENT EPISODES, KEPT CLEAN AND DRY BY STAFF. BOWEL SOUNDS PRESENT X4. ABDOMEN IS SOFT, NONTENDER, NONDISTENDED. NEUROLOGICAL AND GASTROINTESTINAL SYSTEM IN STABLE CONDITION. NO COMPLAINTS OF N/V NOTED. NO SIGNS OR SYMPTOMS OF ACUTE RESPIRATORY OR CARDIAC DISTRESS NOTED. RESPIRATIONS ARE EVEN AND UNLABORED. LUNG SOUNDS ARE CLEAR BILATERALLY. NO SOB NOTED. NO COMPLAINTS OF CHEST PAIN NOTED. SKIN IS WARM AND DRY. DRESSINGS IN PLACE TO BILATERAL LOWER EXTREMITIES. DRESSINGS ARE CLEAN, DRY AND INTACT. RESIDENT CONTINUES WITH THERAPY PER ORDER WITH GOOD PARTICIPATION. RESIDENT IS CURRENTLY RESTING IN BED. CALL LIGHT WITHIN REACH. NO SIGNS OR SYMPTOMS OF DISTRESS NOTED.
Signed by: Jenna Donovan *Co-signed by:*

6/30/2014 10:46 AM *Role:* **LICENSED NURSE** *Category:* NURSING NOTE

VOICE MAIL LEFT FOR DAUGHTER, JOAN, REQUESTING RETURN CALL R/T H.PYLORI TEST
Signed by: Cora Cunningham *Co-signed by:*

Parrott, Delila (80987) *Room:* *Medical Record no: 80987*

PAIN. CURRENTLY IN GYM WITH THERAPY. CONTINUES WITH THEARPY PER ORDERS WITH GOOD PARTICPATION. VS: 146/63, 64, 97.8 ORAL TMEP, 18, 96% ON ROOM AIR.
Signed by: Cora Cunningham *Co-signed by:*

Addendum 7/10/2014 1:47 PM

FROM 7/7/14: FEVER SORE TO LOWER LIP WELL HEALED. RESIDENT REQUEST TO D/C ABREVA CREAM: W. GREENE PA MADE AWARE WITH NEW ORDER TO D/C. ORDER IMPLAMENTED. RESIDENT AND FAMILY AWARE.
Addendum signed by: Cora Cunningham *Co-signed by:*

7/7/2014 3:26 AM *Role:* **LICENSED NURSE** *Category:* **DAILY MEDICARE NOTE**

THIS IS THE DAILY MEDICARE NOTE FOR 7/6/14. VS: 139/60, 68, 98.4, 18, AND 96% ON ROOM AIR. SHE IS ALERT AND ORIENT X 2 WITH EPISODES OF CONFUSION/HALLUCINATIONS. SHE IS VERBAL AND ABLE TO MAKE MOST NEEDS KNOWN, NEEDS ARE ALSO ANTICIPATED AND MET BY STAFF. SHE IS PLEASANT AND COOPERATIVE WITH CARE, ALTHOUGH SHE OCCASIONALLY REFUSES ORDERED MEDS AND TX.SKIN IS WARM, DRY, AND INTACT WITH EXCEPTION OF DRESSINGS TO LEFT AND RIGHT THIGH; DRY DRESSINGS ARE INTACT AND DRY. NO CARDIAC, RESPIR., OR GU DISTRESS NOTED THIS SHIFT. RESIDENT C/O OF UPSET STOMACH THIS SHIFT AND ADMINISTRED PRN MAALOX WITH POSITIVE EFFECTIVENESS. RESIDENT RQST THIS NURSE CALL HER DAUGHTER VIA RES OWN CELL. RES STATED TO DAUGHTER THAT THIS WAS AN "EMERGENCY" AND THAT PEOPLE WERE COMING FROM THE WOODS AND LEAVING THINGS IN HER ROOM. ATTEMPTED TO REDIRECT RESIDENT-PARTIALLY SUCCESSFUL. DAUGHTER CALLED NURSE STATION AND RQST RESIDENT BE ADMINISTRED PRN VALIUM R/T ANXIETY. ADMINISTRED DOSE WITH POSITIVE EFFECTIVENESS. RESIDENT IS CONTINENT OF BOWEL AND BLADDER WITH OCCASIONAL ACCIDENTS. SHE ASSIST X 1 WITH ADLS AND TRANSFER AND IS ABLE TO FEED SELF WITH SET-UP ASSISTANCE FROM STAFF. CURRENTLY RESIDENT IS IN BED WITH EYES CLOSED AND IN NO ACUTE DISTRESS. SHE IS ACTIVE ON THERAPY CASELOAD.
Signed by: Aziza Gary *Co-signed by:*

7/5/2014 6:26 PM *Role:* **LICENSED NURSE** *Category:* **DAILY MEDICARE NOTE**

RESIDENT ALERT AND ORIENTED X 3. NO COMPLAINST OF BREAKTHROUGH PAIN; RESIDENT IS ON SCHEDULED

NORCO. DRESSINGS CHANGED AND BACITRACIN APPLIED PER ORDER. LEGS ELEVATED TODAY WHILE IN BED.

ABLE TO VERBALIZE NEEDS. VERY NICE AND PLEASANT. COMPLIANT WITH CARE AND MEDICATIONS. NO S/S

OF RESPIRATORY DISTRESS; LUNG SOUNDS CLEAR AND PRESENT IN ALL LOBES. CONTINENT OF B AND B. RESIDENT REQUIRES SET UP FOR MEALS, AND ASSIST X 1 IN ADLS AND TRANSFERS. USES WHEELCHAIR FOR MOBILITY WITH ASSIST. SKIN WARM AND DRY. NO COMPLAINTS OF NAUSEA, VOMITING, OR DIAHRREA. RESIDENT HAS MODERATE APPETITE TODAY; ATE 40% OF BREAKFAST AND 50% OF LUNCH. NEUROLOGICAL SYSTEM IN STABLE CONDITION. CARDIAC STATUS IN STABLE CONDITION.

CONTINUES WITH PT/OT WITH GOOD RESPONSE. VS 106/56, 97.7, 60, 94%, 18.
Signed by: Dawn Thomas *Co-signed by:*

7/5/2014 1:16 PM *Role:* **LICENSED NURSE** *Category:* **DAILY MEDICARE NOTE**

THIS IS A LATE ENTRY DAILY MEDICARE NOTE FOR 7/3/14. RESIDENT IS ALERT AND ORIENTED X3. NO COMPLAINTS OF BREAKTHROUGH PAIN AT TIME OF ASSESSMENT IN AFTERNOON. RESIDENT HAS FOAM WEDGE BETWEEN LEGS WHILE IN BED PER ORDERS. BACITRACIN AND DRESSING APPLIED PER ORDERS. RESIDENT REQUIRES SET UP FOR MEALS, ASSIST X1 FOR ADL'S AND TRANSFERS, AND USES WHEELCHAIR FOR MOBILITY. RESIDENT IS CONTINENT OF BOWEL AND INCONTINENT OF BLADDER X2; PERI CARE PROVIDED. BOWEL SOUNDS X 4 QUADRANTS. LUNG SOUNDS CLEAR AND PRESENT IN ALL LOBES. RESIDENT HAS NO COMPLAINTS OF SHORTNESS OF BREATH. S1 AND S2 AUSCULATED; NO SIGNS OF CARDIAC DISTRESS; NO COMPLAINTS OF CHEST PAIN. SKIN IS WARM AND DRY. POOR APPETITE TODAY, BUT COPIOUS FLUID CONSUMPTION, INCLUDING ENSURE PER ORDERS. RESIDENT IS ABLE TO MAKE NEEDS KNOWN. CONTINUES WITH THERAPY PER ORDERS WITH GOOD PARTICIPATION. VS 97.7, 18, 108/57, 67, 95%.
Signed by: Dawn Thomas *Co-signed by:*

7/5/2014 3:50 AM *Role:* **LICENSED NURSE** *Category:* **DAILY MEDICARE NOTE**

VS: 128/67, 62, 97.7, 18, AND 97% ON ROOM AIR. RESIDENT IS ALERT AND ORIENT X 3 WITH WITH CONFUSION AT TIMES. SHE IS VERBAL AND ABLE TO MAKE NEEDS KNOWN. RESIDENT INCONT. OF BOWEL AND BLADDER WEARS ADULT BRIEFS AND IS KEPT CLEAN AND DRY BY STAFF. NO S/S OF CARDIAC, RESPIR., GI, AND GU DISTRESS AT THIS TIME. RESIDENT C/O PAIN ONCE THIS SHIFT, WAS IN TEARS, RES WAS ADMINISTERED SCHEDULED PAIN MED AND PRN VALIUM WITH POSITIVE EFFECTIVENESS. RESIDENT IS ASSIST X 1 WITH ADLS AND TRANSFERS TO W/C

Sandpiper R&N0114

Parrott, Delila (80987) *Room:* *Medical Record no: 80987*

SKIN IS WARM AND DRY. DRESSINGS IN PLACE TO BILATERAL LOWER EXTREMITIES. DRESSINGS ARE CLEAN, DRY AND INTACT. RESIDENT CONTINUES WITH THERAPY PER ORDER WITH GOOD PARTICIPATION. RESIDENT IS CURRENTLY RESTING IN BED, CALL LIGHT WITHIN REACH. NO SIGNS OR SYMPTOMS OF DISTRESS NOTED.
Signed by: Jenna Donovan *Co-signed by:*

7/10/2014 7:58 PM *Role:* LICENSED NURSE *Category:* NURSING NOTE
WEDGE D/C PER PT RECOMENDATION. NEW ORDER FOR L MULTIPODUS BOOT WHILE IN BED FOR POSITIONING WHILE IN BED. ORDER IMPLAMENTED. DAUGHTER, JOAN, MADE AWARE.
Signed by: Cora Cunningham *Co-signed by:*

7/10/2014 4:28 PM *Role:* Social Service Assistant *Category:* SOCIAL SERVICES
SS requested that MD evaluate Ms. Parrot's mental capacity.
Signed by: Cari Jo Merwin *Co-signed by:*

7/10/2014 3:59 PM *Role:* Social Service Assistant *Category:* SOCIAL SERVICES
30 Day Assessment
Ms. Parrott can be pleasant, has a very flat affect and it has been noted she can become tearful. She admits to depression, little pleasure in doing things, and little energy daily. When SS asked Ms. Parrott if she had any negative thoughts lately, she answered, "now that's a stupid question" and would not answer the question. SS asked her if she had any plan and she stated, "no." She also stated, "I don't have anything to be happy about." A psych consult was ordered on 6/26/14 and SS made DON aware of psych order. SS also made her nurse aware of her s/s of depression. Ms. Parrott's BIM score does not indicate cognitive impairment. It was noted on 7/7/14 she told her daughter that it was an emergency. She told her that people were coming from the woods and leaving things in her room. Ms. Parrott is slowly progressing in therapy with encouragement. Ms. Parrott is taking Celexa and Valium PRN. Will continue to monitor mood, behavior and cognition.
Signed by: Cari Jo Merwin *Co-signed by:*

7/9/2014 4:39 PM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE
RESIDENT REMAINS ALERT AND ORIENTED X 3. PLEASANT IN MOOD TODAY. COOPERATIVE WITH CARSE. CONTINENT OF BOWEL AND BLADDER. REPORTS REGULAR BMS. ATE 25% OF LUNCH WITH SET UP HELP ONLY. DRANK 100% OF ENSURE. DENIES GI UPSET. NO NAUSEA, VOMITTING OR LOOSE STOOLS NOTED. REQUIRES ONE ASSIST TO SET UP HELP WITH ADLS. TWO ASSIST WITH TRANSFERS. ONE ASSIST WITH MOBILITY: USES W/C. CARDIOVASCULAR SYSTEM STABLE. SKIN IS WARM AND DRY. DRESSING TO RIGHT HIP, LEFT HIP AND LEFT ANTICUBITAL REMAIN CLEAN, DRY AND INTACT. RESPIRATIONS EVEN AND UNLAOBRED WITH NO C/O SOB. RESIDENT CONTINUES WITH THERAPY PER ORDER WITH GOOD PARTICPATION.
Signed by: Cora Cunningham *Co-signed by:*

7/8/2014 11:46 PM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE
RES IS ALERT AND ORIENTED X3 VERBALLY RESPONSIVE NO COMPLAINTS OF PAIN AT THIS TIME. CONTINUES SCHEDULED NORCO FOR PAIN MAINTENANCE. NO RESPIRATORY DISTRESS NOTED NO CARDIAC ISSUES NO GASTROINTESTINAL ISSSUES NOTED NOP N/V INCONTINENT OF BOWEL AND BLADDER ADLS WITH MODERATE ASSIST OF ONE. TRANSFERS ONE ASSIST USING W/C FOR TRANSPORT. CONTINUES PT/OT/ST SERVICES AS DIRECTED. WEDGE IN PLACE BETWEEN LEGS WHEN IN BED. SKIN DRY AND WARM DRESSING TO LOWER EXTREMITIES INTACT. RESTING QUIETLY CALL LIGHT AND FLUIDS IN REACH VS 98.2 64 18 150/56 O2 96% ROOM AIR
Signed by: Michelle McCarley *Co-signed by:*

7/8/2014 8:14 PM *Role:* LICENSED NURSE *Category:* NURSING NOTE
NEW ORDERS: AMOXICILLIN 1 G PO BID; CLARTHROMYCIN 500 MG PO BID IF FAMILY DESIRES. DAUGHTER JOAN, RESPONSIBLE PARTY, DECLINES AND STATES SHE WISHES TO WAIT FOR ENDOSCOPY RESULTS (SCOPE SCHEDULED FOR 7/15) BEFORE PROCEEDING WITH TREATMENT. DR. MURK CANCELLED ORDER.
Signed by: Dawn Thomas *Co-signed by:*

7/7/2014 11:59 AM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE
RESIDENT IS ALERT AND ORIENTED X 3. TEARFUL TODAY. REASSURACNE PROVIDED WITH EFFECTIVE RESULTS. DENIES PAIN. CONTINUES WITH SCHED NORCO. CONTINENT OF BOWEL AND BLADDER WITH INCONTINENT EPISODES. C/O DYSURIA. W. GREENE PA NOTIFIED WITH NEW ORDER. DAUGHTER, JOAN, AWARE. CARDIOVASCULAR SYSTEM STABLE : S1 AND S2 ASCULATATED. LUNG SOUNDS CLEAR BUT DIMINISHED THROUGHOUT. ABD SOFT WITH BS + X 4. CONTINUES WITH ENSURE BID WITH GOOD INTAKE. RESIDENT DENIES

Parrott, Delila (80987) *Room:* *Medical Record no: 80987*

THIS IS THE DAILY MEDICARE NOTE FOR 7/24/2014. VS: 147/52, 68, 98.1, 18, 100% ON RA. RESIDENT IS ALERT AND ORIENTED X3, ABLE TO VOICE WANTS AND NEEDS. PLEASANT AND COOPERATIVE WITH CARE. RESIDENT HAD COMPLAINTS OF PAIN TO HIP THIS EVENING, PRN NORCO ADMINISTERED WITH POSITIVE EFFECT. RESIDENT REQUIRES ASSIST X1 WITH ADL'S AND TRANSFERS. RESIDENT USES WHEELCHAIR FOR AMBULATION. RESIDENT IS CONTINENT OF BOWEL AND BLADDER. BOWEL SOUNDS PRESENT X4, ABDOMEN IS SOFT, NONTENDER, NONDISTENDED. RESIDENT CONTINUES TO HAVE A GOOD APPETITE.NEUROLOGICAL AND GASTROINTESTINAL SYSTEM IN STABLE CONDITION. NO COMPLAINTS OF N/V, CONSTIPATION OR LOOSE STOOLS NOTED. NO SIGNS OR SYMPTOMS OF ACUTE CARDIAC OR RESPIRATORY DISTRESS NOTED. RESPIRATIONS ARE EVEN AND UNLABORED. LUNG SOUNDS ARE CLEAR BILATERALLY. NO SOB NOTED. NO COMPLAINTS OF CHEST PAIN NOTED. SKIN IS WARM AND DRY. RESIDENT CONTINUES WITH THERAPY AS ORDERED WITH GOOD PARTICIPATION. RESIDENT CURRENTLY RESTING IN BED, CALL LIGHT WITHIN REACH. NO SIGNS OR SYMPTOMS OF DISTRESS NOTED.

Signed by: Jenna Donovan *Co-signed by:*

7/23/2014 4:28 PM *Role:* **LICENSED NURSE** *Category:* **DAILY MEDICARE NOTE**

RESIDENT REMAINS ALERT AND ORIENTED X 2. PLEASANT IN MOOD TODAY AND COOPERATIVE WITH CARES. DENIES PAIN. CONTINENT/INCONTINENT OF BOWEL AND BLADDER: ABD SOFT: REPORTS RECENT BM. ATE 60% OF LUNCH WITH SET UP HELP ONLY. 100% OF ENSURE. CONTINUES WITH ENSURE EVERY MEAL. CARDIOVASCULAR SYSTEM STABLE: DENIES CHEST PAIN. SKIN IS WARM AND DRY. RESPIRATIONS EVEN AND UNLABORED. NO C/O SOB. RESIDENT CONTINUES WITH THERAPY PER ORDER WITH GOOD PARTICPATION. CONTINUES WITH BOOT TO LEFT LOWER LEG PER ORDER. VS: 111/51, 75, 98.2 ORAL TEMP, 20, 100% ON ROOM AIR.

Signed by: Cora Cunningham *Co-signed by:*

7/23/2014 2:34 AM *Role:* **LICENSED NURSE** *Category:* **DAILY MEDICARE NOTE**

NOTE FOR 7/22/2014 RES IS PRESENTLY RESTING IN LONG INTERVALS COMPLAINTS OF PAIN BOTH LOWER EXTREMITIES AT 11PM ULTRAM GIVEN AS ORDERED PRN AND EFFECTIVE. NO SOB OR COUGH PRESENT LUNGS CLEAR BILATERALLY. NO CARDIAC ISSUES NOTED. ABD IS SOFT NONTENDER POSITIVE BOWEL SOUNDS PRESENT ALL QUADS. INCONTINENT OF BOWEL AND BLADDER INCONTINENT CARE PROVIDED AS NEEDED. ADLS WITH MODERATE ASSIST OF ONE. TRANSFERS ONE ASSIST USES W/C FOR MOBILITY. CONTINUES PARTICIPATION IN OT/PT SERVICES. SKIN IS DRY AND WARM TO TOUCH NO EDEMA PRESENT. PLEASANT AND COOPERATIVE DURING CARE ALERT AND ORIENTED X2 WHEN AWAKE. VS 98.9 83 18 140/68 O2 100% ROOM AIR

Signed by: Michelle McCarley *Co-signed by:*

7/21/2014 10:38 AM *Role:* **LICENSED NURSE** *Category:* **DAILY MEDICARE NOTE**

RESIDENT ALERT AND ORIENTED X 3. RESIDENT IS ON SCHEDULED NORCO, BUT REFUSED "BECAUSE I'M NOT IN ANY PAIN." ORDER SUBSEQUENTLY CHANGED TO PRN; DAUGHTER JOAN NOTIFIED. BACITRACIN APPLIED PER ORDER. CONTINUES WITH MULTIPODUS BOOT TO LEFT FOOT IN BED FOR POSITIONING. ABLE TO VERBALIZE NEEDS. VERY NICE AND PLEASANT. NO SIGNS OR SYMPTOMS OF RESPIRATORY DISTRESS. CONTINENT OF BOWEL AND BLADDER. SET UP FOR MEALS, AND ASSIST X 1 IN ADLS AND TRANSFERS. USES WHEELCHAIR FOR MOBILITY WITH ASSIST. SKIN WARM AND DRY. NO COMPLAINTS OF NAUSEA, VOMITING, OR DIARRHEA. RESIDENT HAS GOOD APPETITE TODAY; ATE 80%% OF BREAKFAST. NEUROLOGICAL SYSTEM IN STABLE CONDITION. CARDIAC STATUS IN STABLE CONDITION. CONTINUES WITH PT/OT WITH GOOD RESPONSE.

Signed by: Dawn Thomas *Co-signed by:*

7/21/2014 2:38 AM *Role:* **LICENSED NURSE** *Category:* **DAILY MEDICARE NOTE**

THIS IS THE DAILY MEDICARE NOTE FOR 7/20/2014. VS: 121/59, 68, 97.5, 18, 96% ON RA. RESIDENT IS ALERT AND ORIENTED X3, ABLE TO VOICE WANTS AND NEEDS. PLEASANT AND COOPERATIVE WITH CARE. RESIDENT DENIES ANY PAIN OR DISCOMFORT AT THIS TIME. RESIDENT REQUIRES ASSIST X1 WITH ADL'S AND TRANSFERS. RESIDENT USES WHEELCHAIR FOR MOBILITY, ABLE TO PROPEL SELF. RESIDENT CONTINUES ON A REGULAR DIET, TOLERATING WELL. RESIDENT IS ABLE TO FEED SELF WITH SET UP. RESIDENT IS CONTINENT OF BOWEL AND BLADDER WITH INCONTINENT EPISODES, KEPT CLEAN AND DRY BY STAFF. BOWEL SOUNDS PRESENT X4. ABDOMEN IS SOFT, NONTENDER, NONDISTENDED. NEUROLOGICAL AND GASTROINTESTINAL SYSTEM IN STABLE CONDITION. NO COMPLAINTS OF N/V, LOOSE STOOL OR CONSTIPATION NOTED. NO SIGNS OR SYMPTOMS OF ACUTE RESPIRATORY OR CARDIAC DISTRESS NOTED. RESPIRATIONS ARE EVEN AND UNLABORED. LUNG SOUNDS ARE CLEAR BILATERALLY. NO SOB NOTED. NO COMPLAINTS OF CHEST PAIN NOTED. SKIN IS WARM AND DRY. RESIDENT CONTINUES WITH PODUS BOOT TO LEFT FOOT PER ORDER, TOLERATING WELL. RESIDENT CONTINUES WITH THERAPY PER ORDER WITH GOOD PARTICIPATION. RESIDENT CURRENTLY RESTING IN BED. CALL LIGHT WITHIN REACH. NO SIGNS OR SYMPTOMS OF DISTRESS NOTED.

Signed by: Jenna Donovan *Co-signed by:*

Parrott, Delila (80987) *Room:* *Medical Record no: 80987*

RESIDENT IS ALERT AND ORIENTED X 3 WITH OCCASIONAL CONFUSION. NO COMPLAINTS OF PAIN AS OF ASSESSMENT. RESIDENT IS WEIGHT BEARING AS TOLERATED TO LEFT LOWER EXTREMITY. ABLE TO VERBALIZE NEEDS. VERY NICE AND PLEASANT. NO SIGNS OR SYMPTOMS OF RESPIRATORY DISTRESS. CONTINENT OF BOWEL AND BLADDER. SET UP TO ASSIST X 1 IN ADLS AND TRANSFERS. USES WHEELCHAIR FOR MOBILITY WITH ASSIST OR INDEPENDENTLY. SKIN WARM AND DRY. NO COMPLAINTS OF NAUSEA, VOMITING, OR DIARRHEA. RESIDENT HAS MODERATE APPETITE TODAY; ATE 60% OF BREAKFAST AND 60% OF LUNCH. NEUROLOGICAL SYSTEM IN STABLE CONDITION. CARDIAC STATUS IN STABLE CONDITION. CONTINUES WITH PT/OT WITH GOOD

RESPONSE. VS 135/72, 66, 18, 98.0, 97%.
Signed by: Dawn Thomas *Co-signed by:*

8/7/2014 3:37 PM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE

RESIDENT ALERT AND ORIENTED X 3. PLEASANT IN MOOD. RESIDENT REFUSING TO WEAR MULTIPODUS BOOT. BOOT D/C PER PT AND DR. MURK. RESIDENT AND DAUGHTER MADE AWRES. RESIDENT DENIES PAIN. CONTINENT OF BOWEL AND BLADDER. BOWEL MOVEMENT TODAY. ATE 50% OF LUNCH WITH SET UP HELP ONLY. REQUIRES SET UP HELP TO ONE ASSIST WITH ADLS, TRANSFERS AND MOBILITY. USES W/C. CARDIOVASCULAR SYSTEM STABLE. SKIN IS WARM AND DRY. RESPIRATIONS EVEN AND UNLABORED. NO C/O SOB. RESIDENT CONTINUES WITH THERAPY PER ORDER WITH GOOD PARTICPATION. VS: 136/69, 63, 98.0 ORAL TEMP, 18, 95% ON ROOM AIR.
Signed by: Cora Cunningham *Co-signed by:*

8/7/2014 4:19 AM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE

THIS IS THE DAILY MEDICARE NOTE FOR 8/6/2014. VS: 112/61, 72, 98.0, 20, 98% ON RA. RESIDENT IS ALERT AND ORIENTED X3, ABLE TO VOICE WANTS AND NEEDS. RESIDENT IS PLEASANT AND COOPERATIVE WITH CARE. RESIDENT DENIES ANY PAIN OR DISCOMFORT AT THIS TIME. RESIDENT REQUIRES ASSIST X1 WITH TRANSFERSCAND ADL'S. RESIDENT USES WHEELCHAIR FOR MOBILITY. RESIDENT IS CONTINENT OF BOWEL AND BLADDER WITH INCONTINENT EPISODES, KEPT CLEAN AND DRY BY STAFF. RESIDENT CONTINUES TO HAVE A GOOD APPETITE, ABLE TO FEED SELF WITH SET UP. BOWEL SOUNDS PRESENT X4; ABDOMEN IS SOFT, NONTENDER, NONDISTENDED. NEUROLOGICAL AND GASTROINTESTINAL SYSTEM IN STABLE CONDITION. RESIDENT DENIES ANY N/V, CONSTIPATION OR LOOSE STOOLS. NO SIGNS OR SYMPTOMS OF ACUTE RESPIRATORY DISTRESS NOTED. RESPIRATIONS ARE EVEN AND UNLABORED. LUNG SOUNDS ARE CLEAR BILATERALLY. NO SOB NOTED. NO COMPLAINTS OF CHEST PAIN NOTED. SKIN IS WARM AND DRY. RESIDENT CONTINUES WITH THERAPY PER ORDER WITH GOOD PARTICIPATION. NO SIGNS OR SYMPTOMS OF DISTRESS NOTED. RESIDENT CURRENTLY RESTING IN BED, CALL LIGHT WITHIN REACH.
Signed by: Jenna Donovan *Co-signed by:*

8/5/2014 4:03 PM *Role:* Resident Interviewer *Category:* MDS

a pain assessment interview was done.
Signed by: Cassandra Gibbs *Co-signed by:*

8/5/2014 8:30 AM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE

NOTE FOR 8/04/2014 RES IS ALERT AND ORIENTED X2 VERBALLY RESPONSIVE NO COMPLAINTS OF PAIN NO RESPIRATORY DISTRESS NO SOB NO CARDIAC ISSUES. NO GASTROINTESTINAL ISSUES NOTED. NO N/V OR LOOSE STOOLS NOTED. SKIN DRY AND WARM NO SKIN ISSUES NOTED. NO EDEMA PRESENT INCONTINENT OF BOWEL AND BLADDER INCONTINENT CARE PROVIDED AS NEEDED. TRANSFERS ONE ASSIST W/C FOR TRANSPORT CONTINUES PT/OT SERVICES VS 98.4 67 16 160/75 O2 95% ROOM AIR
Signed by: Michelle McCarley *Co-signed by:*

8/3/2014 2:43 PM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE

VS: 119/59, P71, R18, T97.5 RESIDENT A&OX2-3 ABLE TO MAKE NEEDS KNOWN. RESIDENT PLEASANT AND COOPERATIVE DURING NURSING CARES. RESIDENT AMBULATORY WITH WALKER AND ASSIST X1. ASSIST X1 FOR ADLS. RESIDENT ABLE TO FEED SELF WITH STAFF SETTING UP TRAY. CONTINUES WITH ADEQUATE PO INTAKE. NO C/O PAIN THIS SHIFT. NO C/O NAUSEA/DIARRHEA NOTED. SKIN WARM DRY AND INTACT AND OF NORMAL COLOR FOR THIS RESIDENT. CURRENTLY RESTING WITH NO S/S DISTRESS NOTED. LUNGS CLEAR TO AUSCULTATION. RESPIRATIONS EVEN AND UNLABORED CV SYSTEMS INTACT. BED LOW, CALL BELL IN REACH.
Signed by: Amanda Morgan *Co-signed by:*

8/3/2014 2:16 AM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE

THIS IS A DAILY MEDICARE NOTE FOR 08/02/14. RESIDENT ALERT AND ORIENTED X 3. PLEASANT AND COOPERATIVE. ABLE TO MAKE NEEDS KNOWN. CARDIOVASCULAR SYSTEM STABLE. NO COMPLAINTS OF CHEST

Parrott, Delila (80987) *Room:* *Medical Record no: 80987*

DEMEANOR. RESIDENT IS AN ASSIST OF ONE WITH ADL'S AND TRANSFERS. ASSIST OF ONE WITH MOBILITY. WEIGHT BEARING AS TOLERATED AS PER ORDER. CARDIOVASCULAR SYSTEM STABLE. NO COMPLAINTS OF CHEST PAIN AT CURRENT TIME. SKIN WARM AND DRY. RESPIRATORY SYSTEM STABLE. LUNGS CTA, RESPIRATIONS EVEN AND NONLABORED. NO SOB OR COUGH NOTED. NEUROLOGICAL AND GASTROINTESTINAL SYSTEM STABLE. ABDOMEN SOFT, NONTENDER. INCONTINENT AT TIMES, PERICARE PROVIDED. ADEQUATE INTAKE, 75-100% OF MEALS. CONTINUES ON NAS DIET. CONTINUES IN THERAPY AS PER ORDER WITH GOOD PARTICIPATION. ENCOURAGED TO USE THE CALL BELL FOR ASSISTANCE AS NEEDED. CALL BELL WITHIN REACH.
Signed by: Arianne Easton *Co-signed by:*

8/13/2014 3:05 PM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE

RESIDENT IS ALERT AND ORIENTED X 3 WITH OCCASIONAL CONFUSION. NO COMPLAINTS OF PAIN AS OF ASSESSMENT. RESIDENT IS WEIGHT BEARING AS TOLERATED TO LEFT LOWER EXTREMITY. ABLE TO VERBALIZE NEEDS. VERY NICE AND PLEASANT. NO SIGNS OR SYMPTOMS OF RESPIRATORY DISTRESS. CONTINENT OF BOWEL AND BLADDER WITH INTERMITTENT BLADDER INCONTINENCE. SET UP TO ASSIST X 1 IN ADLS AND TRANSFERS. USES WALKER WITH ASSIST X1 FOR AMBULATION. USES WHEELCHAIR FOR LONG DISTANCE MOBILITY INDEPENDENTLY. SKIN WARM AND DRY. NO COMPLAINTS OF NAUSEA, VOMITING, OR DIARRHEA. RESIDENT HAS MODERATE APPETITE TODAY; ATE 50% OF BREAKFAST AND 70% OF LUNCH. NEUROLOGICAL SYSTEM IN STABLE CONDITION. CARDIAC STATUS IN STABLE CONDITION. CONTINUES WITH PT/OT WITH GOOD RESPONSE. VS 97.8, 18, 141/70, 62, 95%.
Signed by: Dawn Thomas *Co-signed by:*

8/13/2014 2:56 AM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE

THIS IS THE DAILY MEDICARE NOTE FOR 8/12/2014. VS: 132/67, 61, 98.2, 18, 97% ON RA. RESIDENT IS ALERT AND ORIENTED X3, OCCASIONAL CONFUSION NOTED. RESIDENT IS ABLE TO VOICE WANTS AND NEEDS. RESIDENT IS PLEASANT AND COOPERATIVE WITH CARE. RESIDENT DENIES ANY PAIN OR DISCOMFORT AT THIS TIME. RESIDENT REQUIRES ASSIST X1 WITH TRANSFERS AND ADL'S. RESIDENT USES WHEELCHAIR FOR MOBILITY. RESIDENT CONTINUES WITH WEIGHT BEARING AS TOLERATED TO LEFT LOWER EXTREMITY. RESIDENT IS CONTINENT OF BOWEL AND BLADDER WITH INCONTINENT EPISODES, KEPT CLEAN AND DRY BY STAFF. RESIDENT CONTINUES TO HAVE A FAIR APPETITE, ABLE TO FEED SELF WITH SET UP. BOWEL SOUNDS PRESENT X4, ABDOMEN IS SOFT, NONTENDER, NONDISTENDED. NEUROLOGICAL AND GASTROINTESTINAL SYSTEM IN STABLE CONDITION. NO COMPLAINTS OF N/V, CONSTIPATION OR LOOSE STOOLS NOTED. NO SIGNS OR SYMPTOMS OF ACUTE CARDIAC OR RESPIRATORY DISTRESS NOTED. NO SOB NOTED. NO COMPLAINTS OF CHEST PAIN NOTED. SKIN IS WARM AND DRY. SLIGHT EDEMA NOTED TO LEFT LOWER EXTREMITY, CONTINUES TO IMPROVE.LEG REMAINS ELEVATED WHILE IN BED. RESIDENT CONTINUES WITH THERAPY PER ORDER WITH GOOD PARTICIPATION. RESIDENT CURRENTLY RESTING IN BED, CALL LIGHT WITHIN REACH. NO SIGNS OR SYMPTOMS OF DISTRESS NOTED.
Signed by: Jenna Donovan *Co-signed by:*

8/11/2014 10:14 AM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE

RESIDENT ALERT AND ORIENTED X 3. PLEASANT IN MOOD THIS MORNING. RESIDENT DENIES PAIN. CONTINENT OF BOWEL AND BLADDER. ABD SOFT WITH BS + X 4. ATE 50% OF BREAKFAST WITH SET UP HELP ONLY. REQUIRES SET UP HELP TO ONE ASSIST WITH ADLS, TRANSFERS AND MOBILITY: USES W/C. CARDIOVASCULAR SYSTEM STABLE: DENIES CHEST PAIN. 1+ EDEMA NOTED TO LEFT LOWER EXTREMITY: LEG ELEVATED WHILE IN BED. PRN LASIX ADMINISTERED: EFFECTINESS TO BE EVALUATED. SKIN IS WARM AND DRY. RESPIRATIONS EVEN AND UNLABORED. NO C/O SOB. RESIDENT CONTINUES WITH THERAPY PER ORDER WITH GOOD PARTICPATION.
Signed by: Cora Cunningham *Co-signed by:*

8/11/2014 1:25 AM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE

VITAL SIGNS: 151/72 18 97.4 98%. RESIDENT ALERT AND ORIENTED 2-3, WITH OCCASIONAL TIMES OF CONFUSION. ABLE TO VERBALIZE NEEDS. CALM AND COOPERATIVE; WITH PLEASANT DEMEANOR. ASSIST OF 1 FOR TRANSFERS AND ADL'S. USES WHEELCHAIR WHEN OUT OF BED. WEIGHT BEARING AS TOLERATED TO LEFT LOWER EXTREMITY. ASSISIT WITH MEAL SET UP. CONSUMED 75-100% OF MEALS. CONTINUES ON NAS DIET. CARDIOVASCULAR SYSTEM STABLE. NO EDEMA NOTED TO EXTREMITIES. SKIN DRY AND WARM. RESPIRATORY SYSTEM STABLE. LUNG FIELDS CTA. RESPIRATIONS EVEN AND UNLABORED. NO SOB OR COUGH NOTED. NEUROLOGICAL AND GASTROINTESTINAL SYSTEMS STABLE. CONTINENT OF BOWEL AND BLADDER. CONTINUES WITH PT/OT PER ORDER WITH GOOD PARTICIPATION. ENCOURAGED TO USE CALL BELL WHEN NEEDED FOR ASSISTANCE. CALL BELL WITHIN REACH.
Signed by: Arianne Easton *Co-signed by:*

8/9/2014 5:42 PM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE

PN1000

Departmental Notes

Parrott, Delila (80987) *Room:* *Medical Record no: 80987*

8/21/2014 7:47 PM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE
VS: 121/57, 75, 97.8 ORAL TEMP, 17, 94% ON ROOM AIR.
Signed by: Cora Cunningham *Co-signed by:*

8/21/2014 3:59 PM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE
RESIDENT ALERT AND ORIENTED X 3. PLEASANT IN MOOD TODAY. RESIDENT IN HALL TODAY VISITING WITH OTHER RESIDENTS AND STAFF: HAPPY AFFECT. RESIDENT DENIES PAIN. CONTINENT OF BOWEL AND BLADDER. ABD SOFT WITH BS + X 4. ATE 50% OF LUNCH. CONTINES WITH ENSRE PER ORDERS. RESIDENT REQUIRE SET UP HELP WITH MEALS. REQUIRES SET UP HELP TO ONE ASSIST WITH ADLS, TRANSFERS AND MOBILITY: USES W/C: ABLE TO SELF PROPEL. CARDIOVASCULAR SYSTEM STABLE: DENIES CHEST PAIN. SKIN IS WARM AND DRY. RESPIRATIONS EVEN AND UNLABORED. NO C/O SOB. RESIDENT CONTINUES WITH THERAPY PER ORDER WITH GOOD PARTICPATION.
Signed by: Cora Cunningham *Co-signed by:*

8/21/2014 4:00 AM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE
THIS IS THE DAILY MEDICARE NOTE FOR 8/20/2014. VS: 142/52, 63, 98.9, 16, 94% ON RA. RESIDENT IS ALERT AND ORIENTED X3 WITH OCCASSIONAL PERIODS OF CONFUSION. RESIDENT ABLE TO VOICE WANTS AND NEEDS. RESIDENT IS PLEASANT AND COOPERATIVE WITH CARE. RESIDENT DENIES ANY PAIN OR DISCOMFORT AT THIS TIME. RESIDENT REQUIRES ASSIST X1 WITH ADL'S AND TRANSFERS. RESIDENT USES WHEELCHAIR FOR MOBILITY. RESIDENT IS CONTINENT OF BOWEL AND BLADDER WITH INCONTINENT EPSIODES, KEPT CLEAN AND DRY BY STAFF. RESIDENT CONTINUES TO HAVE A FAIR APPETITE, ABLE TO FEED SELF WITH SET UP ASSIST. RESIDENT IS CONTINENT OF BOWEL AND BLADDER. BOWEL SOUNDS PRESENT X4, ABDOMEN IS SOFT, NONTENDER, NONDISTENDED. NEUROLOGICAL AND GASTROINTESTINAL SYSTEM IN STABLE CONDITION. NO COMPLAINTS OF N/V, CONSTIPATION OR LOOSE STOOLS NOTED. NO SIGNS OR SYMPTOMS OF ACUTE CARDIAC OR RESPIRATORY DISTRESS NOTED. RESPIRATIONS ARE EVEN AND UNLABORED, LUNG SOUNDS DIMINISHED IN THE BASES. NO SOB NOTED. NO COMPLAINTS OF CHEST PAIN NOTED. SKIN IS WARM AND DRY. RESIDENT CONTINES WITH THERAPY PER ORDER WITH GOOD PARTICIPATION. RESIDENT CURRENTLY RESTING IN BED, CALL LIGHT WITHIN REACH. NO SIGNS OR SYMPTOMS OF DISTRESS NOTED.
Signed by: Jenna Donovan *Co-signed by:*

8/20/2014 11:12 AM *Role:* Social Service Assistant *Category:* SOCIAL SERVICES
Sixty Day Assessment - Mrs. Parrott's BIMS' score did not show any cognitive impairment. The Mood Interview showed mild depression. She did admit to feeling depressed at times and feeling negative about herself. She still has flashbacks "all the time" about her experience at the Village. At times, she can be confused and anxious. She was seen by our psychiatrist, Dr. Craig on 7-10-14. She increased Mrs. Parrot's Celexa , discontinued her Valium and added PRN Xanax. Therapy reports that Mrs. Parrot is making good progress. Will continue to monitor her mood and behavior and to provide support if needed.
Signed by: Carole Harvey *Co-signed by:*

8/20/2014 3:00 AM *Role:* LICENSED NURSE *Category:* NURSING NOTE
ADMINISTERED VITAMIN B-12 IM INJECTION TO THE RIGHT DELTOID ON 8/19/2014 AT 930 PM. NO ADVERSE REACTIONS NOTED.
Signed by: Arianne Easton *Co-signed by:*

8/20/2014 12:08 AM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE
THIS IS A LATE ENTRY DAILY MEDICARE NOTE FOR 8/5/14. RESIDENT IS ALERT AND ORIENTED X 3 WITH INTERMITTENT CONFUSION. NO COMPLAINTS OF PAIN AS OF ASSESSMENT. RESIDENT IS WEIGHT BEARING AS TOLERATED TO LEFT LOWER EXTREMITY. ABLE TO VERBALIZE NEEDS. VERY NICE AND PLEASANT. NO SIGNS OR SYMPTOMS OF RESPIRATORY DISTRESS. CONTINENT OF BOWEL AND BLADDER WITH INTERMITTENT BLADDER INCONTINENCE. SET UP TO ASSIST X 1 IN ADLS AND TRANSFERS. USES WALKER WITH ASSIST X1 FOR AMBULATION. USES WHEELCHAIR FOR LONG DISTANCE MOBILITY INDEPENDENTLY. SKIN WARM AND DRY. NO COMPLAINTS OF NAUSEA, VOMITING, OR DIARRHEA. RESIDENT HAS MODERATE APPETITE TODAY; ATE 40% OF BREAKFAST AND 60% OF LUNCH. NEUROLOGICAL SYSTEM IN STABLE CONDITION. CARDIAC STATUS IN STABLE CONDITION. CONTINUES WITH PT/OT WITH GOOD RESPONSE. VS 98.7, 67, 118/68, 18, 97%.
Signed by: Dawn Thomas *Co-signed by:*

8/19/2014 2:49 PM *Role:* LICENSED NURSE *Category:* DAILY MEDICARE NOTE
THIS IS A LATE ENTRY DAILY MEDICARE NOTE FOR 8/8/14. RESIDENT IS ALERT AND ORIENTED X 3 WITH OCCASIONAL CONFUSION. NO COMPLAINTS OF PAIN AS OF ASSESSMENT. RESIDENT IS WEIGHT BEARING AS

INSTRUCTIONS

INJECTION SITE CODE

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
TEMP.																															
PULSE																															
RESP.																															
BLOOD PRESSURE																															

DAY SHIFT color ink ▶ | EVENING SHIFT color ink ▶ | NIGHT SHIFT color ink ▶

INITIALS	NURSE'S SIGNATURE	INITIALS	NURSE'S SIGNATURE	INITIALS	NURSE'S SIGNATURE

DATE / TIME GIVEN	INJ SITE	MEDICATION & DOSAGE	REASON	RESULTS OR RESPONSE	TIME NOTED	NURSE'S SIGNATURE & TITLE
9·18·14 1120p	PO	Xanax 0.25mg	anxious	resting	1220	
9·19·14 945	PO	Xanax 0.25mg	anxious	resting	1015	
9/21/14 2pm	PO	Xanax 0.25mg	anxious	helped	130	
9/22/14 230p	PO	Xanax 0.25mg	anxious	helped	1330	
9·22·14 8p	PO	Xanax 0.25mg	anxiety	effective	10p	
9·24·14 8p	PO	Xanax 0.25mg	anxiety	effective	10p	
9·25·14 8p	PO	Xanax 0.25mg	anxiety	effective	9p	
9·26·14 8p	PO	Xanax 0.25mg	anxiety	effective	9p	
9·29·14 8p	PO	Xanax 0.25mg	anxiety	effective	9p	
9·30·14 8p	PO	Xanax 0.25mg	anxiety	effective	9p	

DATE / TIME GIVEN	INJ SITE	MEDICATION & DOSAGE	REASON	RESULTS OR RESPONSE	TIME NOTED	NURSE'S SIGNATURE & TITLE

INITIALS	NURSE'S SIGNATURE	INITIALS	NURSE'S SIGNATURE	INITIALS	NURSE'S SIGNATURE

DAY SHIFT color ink ▶ | EVENING SHIFT color ink ▶ | NIGHT SHIFT color ink ▶

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

INSTRUCTIONS

INJECTION SITE CODE

Resident Service Notes

Resident Name: Delia Parrot

Apt. Number: 808

FIVESTAR SENIOR LIVING, INC.

DATE	COMMENTS	SIGNATURE/TITLE
9/18/14	Resident moved into the facility this afternoon-her family helped resident move in the facility-resident ambulates and transfers with a wheelchair-resident will need stand by assist with transfers and ambulation-resident is a retired nurse and enjoys being around other people	Dominique SAS/P
10-10-14	Resident can not stand up if took 2 cm to put her in bed tonight,	A. Grant
10/16/14	RESIDENT BACK FROM HOSPITAL, EXITED ROOM TWICE TONIGHT CONVINCED HER ROOM & CLOTHES WERE FLOODED. Dunn
10/18/14	During first shift ms Parrot locked herself in the facility discovery room and was crying say someone entered her room at 1am and was standing over her she then went outside and attempted to leave; she was brought back in by care manger and med tech and called her daughter when she then calmed down and went in her room. R.S.D and physician on call has been notified/continued→	

FIVESTAR SENIOR LIVING, INC.

Resident Service Notes

Resident Name: Delilia Parrot

Apt. Number: 808

DATE	COMMENTS	SIGNATURE/TITLE
10/20	TOOK RESIDENT SOME LUNCH AND RESIDENTS JUST STARTED YELLING AND STATING SHE WAS VERY UPSET. ~~TO~~ RESIDENT ASK WHY DIDN'T I WAKE HER UP FOR LUNCH I STATED TO THE RESIDENT SHE NEEDED HER REST AND I HAVE HER FOOD WHEN EVER SHE WANTS IT. RESIDENT STATED SHE WAS UPSET AND SHE WANTED HER DAUGHTER STARTED PICKING UP HER WALKER AND SAYING SHE'S GOING TO THROW IT AT ME AND SHE CAN TAKE CARE OF HERSELF SO I PLACED HER FOOD DOWN AND STARTED WALKING TOWARDS THE DOOR AND SHE STARTED APOLOGIZING. RESIDENT CALMED DOWN AFTER NOTICING I WAS GOING TO LEAVE OUT HER ROOM.	KO [illegible]

Resident Service Notes

Resident Name: Delila Parrott

Apt. Number: 801

FIVE STAR SENIOR LIVING, INC.

DATE	COMMENTS	SIGNATURE/TITLE
11-22-14	Resident continues to ambulate with wheelchair & 1 staff member assist. She has declined a bit as she was doing almost everything by herself last month, now needs help with a lot. Comes out for all meals & eats well. Doesn't participate in any activities or go on any outings. Enjoys spending time with Mr. Hoskinson.	gh

Resident Service Notes

FIVESTAR SENIOR LIVING, INC.

Resident Name: DELILA PARROTT

Apt. Number: 808

DATE	COMMENTS	SIGNATURE/TITLE
12/14/14	RESIDENT SAID WESLEY & PAM KILLED 2 PEOPLE AND BURIED THEM OUTSIDE OF HER WINDOW IN JUNE & SINCE SHE WITNESSED IT, THEY ARE TRYING TO KILL HER BY CHRISTMAS BY LEAKING GAS INTO HER ROOM AT NIGHT WHILE SHE IS SLEEPING. THAT IS WHY THERE IS A HISSING NOISE BEHIND HER COUCH	DeLaine Mellmont
12-23-14	Resident is leaning towards her left side more today. She said she was very wear and couldn't really move herself. She went to the Dr. and they're going to check her out.	
12-26-14	Resident continues to ambulate with wheelchair. Needs a lot more assitance with toileting. She's having a hard time doing things on her own. She's getting weaker where staff has to more or less lift her up. Therapy is currently working with her. Comes out for all meals and doesn't participate in any activities. Enjoys spending time with Mr. Hoskinson.	

Resident Service Notes

Resident Name: Delila Parrott

Apt. Number: 808

FIVESTAR SENIOR LIVING, INC.

DATE	COMMENTS	SIGNATURE/TITLE
12-29-14	Resident said that she needs to go to the bathroom more because the evil spirits need to come out of her. Daughter was very concerned & requested for her miralax to be D/C. Sent a request to the Dr.	
1/16/15	Resident said she feels nervous but does not know why. Resident says "Something is going on and can't put my finger on it." Resident stated to med tech that due to her feeling nervous she can't pick up her utensils to eat. — Illegible	
1/18/15	Resident cannot grab with her hands. med tech has to put the cup of pills to her mouth and put the water to her mouth bcus she couldn't grab the cup. She didn't eat anything for breakfast bcus she couldn't pick up the utensils. Dr was notified.	
1/19/15	Resident still has not eaten today. Daughter & Dr notified.	

OneContent: Generated By coffje1

Physician Documentation ***Roper St. Francis HealthCare Mount Pleasant***

Name: Delila Parrott
Age: 80 years **Sex:** Female **DOB** REDACTE
Arrival Date: 10/11/2014 **Time:** 11:08
Bed 11
ED Physician Bianco, Joseph
HPI:

MRN: 001787037
Account#: 142840021 6
Private MD:

10/11 15:03 This 80 years old White Female presents to ED via EMS with complaints of **Psych Problem**. jbr2

15:03 The patient presents to the emergency department with paranoia. Onset: The symptoms/episode began/occurred gradually. Timing is constant. Past psychiatric history: Prior diagnosis: schizophrenia. Associated signs and symptoms: The patient has no apparent associated signs or symptoms. Severity of symptoms: At their worst the symptoms were severe just prior to arrival, in the emergency department the symptoms are unchanged. The patient has experienced similar episodes in the past several times, but today's symptoms are worse. The patient has been recently seen by a physician: the patient's primary care provider, 5 day(s) ago, with similar presenting complaints. The patient is an 80-year-old female who presents to the ER from an assisted living center complaining of paranoid delusions. Patient states that someone is trying to kill her. Patient states that they've been giving her medicines and she knows when she wakes up she doesn't know what is happening. Patient has some confusion and a slightly altered per the nursing home. jbr2

15:05 Unable to obtain HPI due to altered mental status. jbr2

Historical:

- **Allergies:** green vegetables; NSAIDS; all nasal sprays; Chocolate; Aspirin; ACE INHIBITORS; Toradol;
- **Home Meds:**
  1. Tylenol-Codeine Unknown
  2. Estrace Unknown
  3. Ultram Oral Unknown as needed, every 6 hours
  4. Norco Oral 7.5/325 1-2 tabs as needed, every 4 hours
  5. Inderal LA Oral Unknown every 8 hours
  6. Colace oral 100 mg as needed
  7. Celexa Oral Unknown daily
  8. Nexium Oral 40 mg daily
  9. Lasix oral 40 mg daily, as needed
  10. Dilacor XR oral 180 mg daily
  11. Miralax Oral 1 packet as needed
  12. Macrobid Oral 1 capsule twice a day
  13. Xanax Oral 0.25 mg three times a day
  14. Seroquel Oral Unknown daily
  15. Aricept Oral 5 mg daily, nightly
- **PMHx:** phobias; Schizophrenia
- **PSHx:** Breast biopsy; Fracture repair; ORIF 6/7/2014- lt hip
- **Social history:** unknown, Smoking status: unknown,
- **Advanced Directives:** Unable to obtain information,
- **History obtained from:** daughter, EMS,

ROS:

15:05 jbr2

Constitutional: NO FEVER OR CHILLS.
Psych: Positive for anxiety, auditory hallucinations, visual hallucinations. All other systems reviewed and are negative.

Exam:

15:06 jbr2

Constitutional: Awake and in NAD, resting comfortably.
Head/Face: d
Eyes: Pupils equal round and reactive to light, extra-ocular motions intact. Lids and lashes normal. Conjunctiva and sclera are non-icteric and not injected. Periorbital areas with no swelling, redness, or

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Mt Pleasant Hospital
Discharge Summary
ADMISSION: 10/11/2014
DISCHARGE:
Patient DOB: REDACT

DATE OF ADMISSION: 10/11/2014

DATE OF DISCHARGE: 10/15/2014

PRIMARY CARE PHYSICIAN: Dr. Richard Mills

PRINCIPAL DISCHARGE DIAGNOSES: Delirium and paranoia.

SECONDARY DISCHARGE DIAGNOSES:
1. Hypertension.
2. Osteoarthritis.
3. Dementia.
4. GERD.
5. Deconditioning.

DIAGNOSTIC STUDIES:
1. CT head without contrast on 10/11/2014 showed no evidence of acute intracranial abnormality, diffuse chronic microangiopathic changes including several previous lacunar infarction.

HOSPITAL COURSE: Ms. Parrott is a patient with a known psychiatric history and known cognitive decline who presented after a precipitous decline over the preceding two weeks with worsening cognitive function, as well as worsening in her physical abilities to do activities of daily living.
1. Delirium and paranoia. An infectious workup was pursued, which was negative as the precipitant. Looking at her current medications her Citalopram and Tramadol were discontinued due to concern for possible serotonin syndrome. Her hydrocodone was also discontinued as this could have contributed to her decline. Laboratory testing including a serum ammonia, B-12, folate and thyroid function were all normal. The patient was started on Risperdal 0.5 mg at bedtime and 0.25 twice a day with meals with much improvement in her mental status. At the time of discharge the patient's paranoia seemed to have improve significantly. She still gets confused at times and still does require two people to assist her with movement, but overall is much improved.
2 Hypertension. Her blood pressure was elevated during her stay; however, no adjustments in her antihypertensives was made as this could have been contributed to IV fluids that she received early during her hospitalization. She was continued on her home antihypertensives. She has a follow up

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appointment scheduled with Dr. Mills and if her blood pressure remains elevated at that time an adjustment could be made.
3. Dementia. She was continued on her home Donepezil. Her daughter reports that she has significant anxiety associated with her dementia. She was continued on her home Alprazolam. Her Citalopram was restarted on 10/14/2014 due to her daughter's significant concern about her underlying anxiety. She seems to be tolerating that medication well on the day of discharge.
4. GERD. The patient was continued on a PPI with no complaints of abdominal pain.
5. Deconditioning. Physical therapy worked with the patient during her hospital stay and this will be continued as an outpatient at Ashley River Plantation.

DISCHARGE MEDICATIONS: Please see med rec.

CHANGES TO HOME MEDICATIONS: Discontinuation of Macrobid, Norco, Tramadol and Seroquel. Addition of Risperdal.

DISPOSITION: The patient will be discharged back to Ashley River Plantation to continue physical therapy and occupational therapy.

DIET: Regular.

ACTIVITY: As tolerated and as directed by physical therapy.

CODE STATUS: Full code.

FOLLOW UP: Appointment with Dr. Mills on 10/29/2014 at 11:45 a.m.

Abby Z Gass, MD
TR: pn DD: 10/15/2014 08:34 TD: 10/15/2014 09:09 Job#: 330260
DOC#: 433064

Parrott, Delila MRN: 710111
DOB: REDACTE 80y/o MPIPU
ADM: 1/31/2015 DX: Schizophrenia
GTV: 1484684

HOSPICE *PHYSICIAN* MEDICAL GUIDELINES

(* other than Adult Failure to Thrive, Debility, Alzheimer's, Cancer, COPD, HIV, I

Patient Name: _____ Age: _____ MR #: _____ Benefit Period: ☐ 1st ☐ 2nd ☐ 3rd ☐ _____ / ☐ Diagnosis Change

Hospice Dx: _____ Start of Care: 1/31/15 Benefit Period Dates: 1/31/15 to 4/30/15 ☐ Face-to-Face Completed on _____

GENERAL GUIDELINES

☑ Life limiting condition | ☑ Patient / family have elected course of palliative care | ☑ Patient / caregiver / physician are in agreement on a course of palliative care

☑ Palliative Performance Scale (PPS) 30 Previous PPS 80 (7 months ago)

☐ Pain requiring increasing doses of (opioid) analgesics _____ Explain: _____

☑ Increasing emergency room visits, hospitalizations, or physician's visits over previous 6 months & / or last benefit period *related to the hospice diagnosis*

All Patients – Dependence in Activities of Daily Living – Evidenced by (narrative should show considerable effort required):
☑ Bathing ☑ Dressing ☑ Feeding ☑ Transfers ☑ Toileting ☐ Ambulation needs assistance
Other Indicators of Decline: ☐ Sleeps > _____ hours in 24 hours

All Patients – Recent impaired nutritional status – Evidenced by:
Maximum Adult Height 65" Current Weight 61 kg BMI 24.6 Previous Weight _____ (_____ months ago)
Mid Arm Circumference (non-dominant arm) _____ ☐ Unintentional progressive weight loss of 10% or more over past six months ☐ Serum albumin _____
☐ Cholesterol < 150 _____ ☐ Dysphagia, choking, poor oral intake ☐ Impaired nutrition despite PEG / Tube Feeding

Co-morbidities: If not the primary hospice diagnosis, the presence of disease such as the following, the severity of which is likely to contribute to a life expectancy of six months or less, should be considered in determining hospice eligibility:
☐ COPD ☐ CHF ☐ Ischemic heart disease ☐ Diabetes mellitus ☑ Neurologic disease (☐ CVA ☐ ALS ☑ MS ☐ Parkinson's) ☐ Renal failure
☐ Liver Disease ☐ Neoplasia ☐ Dementia (FAST _____) ☐ Other _____

OTHER TERMINAL ILLNESS

Observable and documented deterioration in overall clinical condition in the past 6 months as evidenced by *any* of the following:
☐ Serial physician assesments ☐ Multiple hospital / ER visits ☑ Progressive pressure ulcers ☑ Decline in functional status with a PPS of 40% ☐ Systolic BP 90
☑ Progressive dependence in ADL's ☐ Persistent nausea and vomiting ☑ Recent impaired nutritional status ☐ Weight loss ☐ Decreasing serum albumin (< 2.5)
☐ Malnutrition with BMI < 22 kg/m² ☑ *Combination of disease processes which, reviewed together, presents a picture of structural and functional impairment*
☐ Requires O_2 at rest ☐ declines artificial ventilation

NARRATIVE SUMMARY

To include History of Disease Progression to Date and effect of co-morbid conditions(if the patient does not meet the guidelines above, your summary must include the alternative factors that support the terminal prognosis):

80yo widow c progressive, accelerating schizophrenia requiring 24° care c apriaty ' paranoia, admitted for failure to thrive c pt eating / drinking less over last several weeks ? ↓ activity p hip fx 6/14 now c worsening sacral decubitus ulcer causing pain ? c diffuse bone pain ? anemia of ? etiology

HOSPICE PHYSICIAN ATTESTATION

Based on these findings, it is my clinical judgment that this patient's prognosis is for a life expectancy of six months or less if the disease runs the normal course.

By signing my signature, I attest that I composed the above narrative based on my review of the medical record or, if applicable, my examination of the patient.

RAYNA KNEUPER HALL MD — Rayna Kneuper Hall MD — 1-31-15

Hospice Physician's Printed Name | Hospice Physician's Signature | Date by Physician

☐ FAXed to Attending Physician _____ on _____ by _____ 01/01/11

Parrott, Delila MRN: 710111
DOB: REDACTE 80y/o MPIPU
ADM: 1/31/2015 DX: Schizophrenia
GTV: 1484684

NURSING REV (* other than Adult Failure to Th

OTHER TERMINAL ILLNESS*
(es, Parkinson's, Renal Disease, Stroke or Coma)

Patient Name: Delila Parrott Age: ____ MR #: ____ ☑ Certification / ☐ Re-Certification / ☐ Diagnosis Change

Hospice Dx: Schizophrenia Start of Care: 1-31-15 Benefit Period: 1 Dates: 1-31-15 to 4/30/15

OTHER TERMINAL ILLNESS GUIDELINES

History of Disease Progression to Date:

80 yo F dx w schizophrenia + worsening depression. Symptoms have been uncontrolled for 5 years. She is currently experiencing insomnia, hallucinations, paranoia, delusions + failure to thrive. She has been refusing to eat approx 2-3 wks. She c/o poorly managed pain in shoulders, (L) hip + RUE. Comorbidities include HTN, ORIF (L) hip, macular degeneration, sleep apnea, OA.

Observable and documented deterioration in overall clinical condition in the past 6 months as evidenced by any of the following:

☐ Serial physician assessments ☑ Progressive pressure ulcers ☐ Systolic BP 90 ☐ Persistent nausea and vomiting ☐ Requires O_2 at rest ☐ Declines artificial ventilation

☑ **Palliative Performance Scale (PPS)** ____ (should be ≤ 40%) **Previous PPS** ____ (____ months ago)

☑ Pain requiring increasing doses of (opioid) analgesics ____ Explain: ____

☑ Increasing emergency room visits, hospitalizations, or physician's visits over previous 6 months & / or last benefit period *related to the hospice diagnosis*

Dependence in Activities of Daily Living – Evidenced by (*narrative below should show considerable effort required & progressive dependence*):

☐ Bathing ☑ Dressing ☐ Feeding ☑ Transfers ☐ Toileting ☐ Ambulation

Other Indicators of Decline: ☐ Sleeps > ____ hours in 24 hours

Recent impaired nutritional status evidenced by:

Maximum Adult Height 65" Current Weight 67 kg BMI ____ Previous Weight ____ Previous BMI ____ (____ months ago)

Mid Arm Circumference (non-dominant arm) ____ ☐ Serum albumin ____ ☐ Cholesterol < 150 ____

☐ Unintentional progressive weight loss of 10% or more over past six months ☐ Impaired nutrition despite PEG / Tube Feeding

☐ Choking ☑ Poor / Decreased oral intake (currently ____% of ____ meals per day / was ____% of ____ meals / day ____ ago)

Co-morbid and secondary conditions that *directly* impact the terminal illness:

☐ *Combination of disease processes which, reviewed together, presents a picture of structural and functional impairment* ☐ COPD ☐ CHF ☐ Ischemic heart disease

☐ Diabetes mellitus ☐ Neurologic disease (☐ CVA ☐ ALS ☐ MS ☐ Parkinson's) ☐ Renal failure ☐ Dysphagia

☐ Liver Disease ☐ Neoplasia ☐ Dementia ☐ Other Schizophrenia, depression

IF PT TO BE RE-CERTIFIED: Memory re-call words "ball", "pencil", "brush"; ____/3 recalled after 5 minutes; ☐ result of 0 or 1 – pt referred to MSW for MMSE

Documentation of structural / functional impairments related to co-morbidities:

CURRENT CLINICAL PICTURE

(To include weight loss/ gain in time period, vital signs, shortness of breath, decreased level of consciousness, heart rhythms, rales, edema, etc in order to illustrate how the patient meets criteria qualifying for hospice care)

Awake, expressive + focusing on arrival. Minimal verbal response due to expressive aphasia. Recognizes family, no signs of discomfort present. Resp. unlabored on RA. Daughter describes increased anxiety + confusion c visual + auditory hallucinations, paranoid. Dx. Increasing pain in RUE, (L) hip + shoulder. Requires total care c ADL's. Bedbound. Decreased appetite. Incont of bowel + bladder. Hx of HTN, (L) arm, + foot drop. Stage II decub on sacrum + (R) buttock c skin tear.

RN Signature: Denise Hyer Date: 1-31-15

11/08/10

Parrott, Delila MRN: 710111
DOB: REDACTE 80y/o MPIPU
ADM: 1/31/2015 DX: Schizophrenia
GTV: 1484684

DIAGNOSES LIST

Pa_____ MR#: _____ Date: _____

Terminal Diagnosis: INCLUDE IN LIST BELOW ☐ Initial IDG Meeting ☐ Diagnosis Change ☐ Additional Diagnosis

ALL of the patient's diagnoses (related and unrelated to the terminal prognosis) should be provided in the spaces below.

DIAGNOSIS	*NOT* RELATED* TO TERMINAL PROGNOSIS *(Must be explained below)*	RELATED* TO TERMINAL PROGNOSIS *(Provide ICD Code❖)*	CODE ENTERED ON CLAIM▲
1) SCHIZOPHRENIA PRINCIPAL DIAGNOSIS		295.80	▲
2) DECUBITUS ULCER	☑		▲
3) ANEMIA	☑		
4) HTN	☑		
5)	☐		
6)	☐		
7)	☐		
8)	☐		
9)	☐		
10)	☐		

HOSPICE PHYSICIAN'S DOCUMENTATION OF REASON NOT RELATED TO THE TERMINAL PROGNOSIS

DIAGNOSIS #: 2
REASON: 2° bed/wheelchair confined; not associated c the schizophrenia

DIAGNOSIS #: 3
REASON: ? etiology; not associated c schizophrenia

DIAGNOSIS #: 4
REASON: not contributing to the schizophrenia

DIAGNOSIS #:
REASON:

DIAGNOSIS #:
REASON:

*Related/Not Related is determined by the Hospice Physician ▲ Initial once Physician has signed & ICD Code of Related Diagnosis has been entered into the system

I have reviewed diagnoses and determined relatedness to the prognosis.

Signature of Hospice Physician: [signature] Date: 1.31.15

❖ Signature of Coder: [signature] Date: 2/2/15

HOS4240 09/2013

Page _____ of _____

If additional space is needed, use second Diagnoses List (HOS4240)
White copy - Chart Yellow Copy - On-Call Pink Copy - RNCM

Parrott, Delila MRN: 710111
DOB: REDACTED 80y/o MPIPU
ADM: 1/31/2015 DX: Schizophrenia
GTV: 1484684
Patient Name: _____ MR#: _____

ESTABLISHMENT OF THE HOSPICE PLAN OF CARE

Hospice Plan of Care established & coordinated with the following Interdisciplinary Group members:

	In Person	By Telephone
Attending Physician	☐	☒
Hospice Physician	☒	☐
Social Worker	☒	☐
Spiritual Care Coordinator	☒	☐
Bereavement Coordinator	☒	☐
Manager of Volunteer Services	☒	☐
Patient	☐	☐
Family / Caregiver: Joan (daughter)	☐	☒

Plan of Care Discussed & Coordinated with Facility Nurse: _____

Visit Frequencies will be: SN: PRN Phy: 7/wk HA: 24° SW: 1 x wk SCC: 1 x wk MVS: 1 x wk Other: _____

☐ IDG approves unscheduled visits provided at the request of pt/family/caregiver

Signature/Title: Daniel Kletzkin — Date Established: 1-31-15

INFORMATION BELOW TO BE COMPLETED AT FIRST IDG FOLLOWING ADMISSION OF PATIENT

INITIAL IDG PLAN OF CARE REVIEW

The following Plans of Care are open: IDG Meeting Date: 2-4-15

☐ Admission	☐ Nutrition/Fluid Maintenance/Upper GI	☐ Knowledge Deficit
☐ Communication	☐ Genitourinary/Lower GI	☐ Pre-Bereavement
☒ Pain Management	☒ Functional Status	☐ Volunteer
☐ Cardiopulmonary	☒ Psychosocial Well-Being	☐ Other
☒ Neuro/Cognitive/Behavioral	☐ Spiritual	
☐ Skin/Pressure Ulcer	☐ Safety/Falls	

RN Case Manager Summary: PPS 10%, NPO, minimally responsive, still having hallucinations, Family aware of decline.

Spiritual Care/Bereavement Coordinator Summary: Pt's daughter Joan is supportive of pt. Joan plans to be present when pt passes. Will continue to follow up with family.

Social Worker Summary: Pt declining. DR thought SNF placement would be needed but pt at end of life & will remain at IPU. Emotional support will be provided.

Scope of Services *(frequency of visits)*:

Skilled Nurse: 24°	Physician: daily	Hospice Aide: 24°
Social Worker: 2 x wk	Spiritual Care Coordinator: 3-7 x wk	Bereavement Coordinator: prn
Volunteer: as needed	Dietician: _____	Occupational Therapy: _____
Physical Therapy: _____	Speech Therapy: _____	

Plan of Care (including unscheduled visits provided at the request of pt/family/caregiver) Reviewed and Approved by:

RN Case Manager: _____

Hospice Physician: _____

Social Worker: _____

Spiritual Care/Bereavement Coordinator: _____

Manager of Volunteer Services: _____

☐ Copy to Attending Physician for review of the Plan of Care Date Sent: _____ Initial: _____

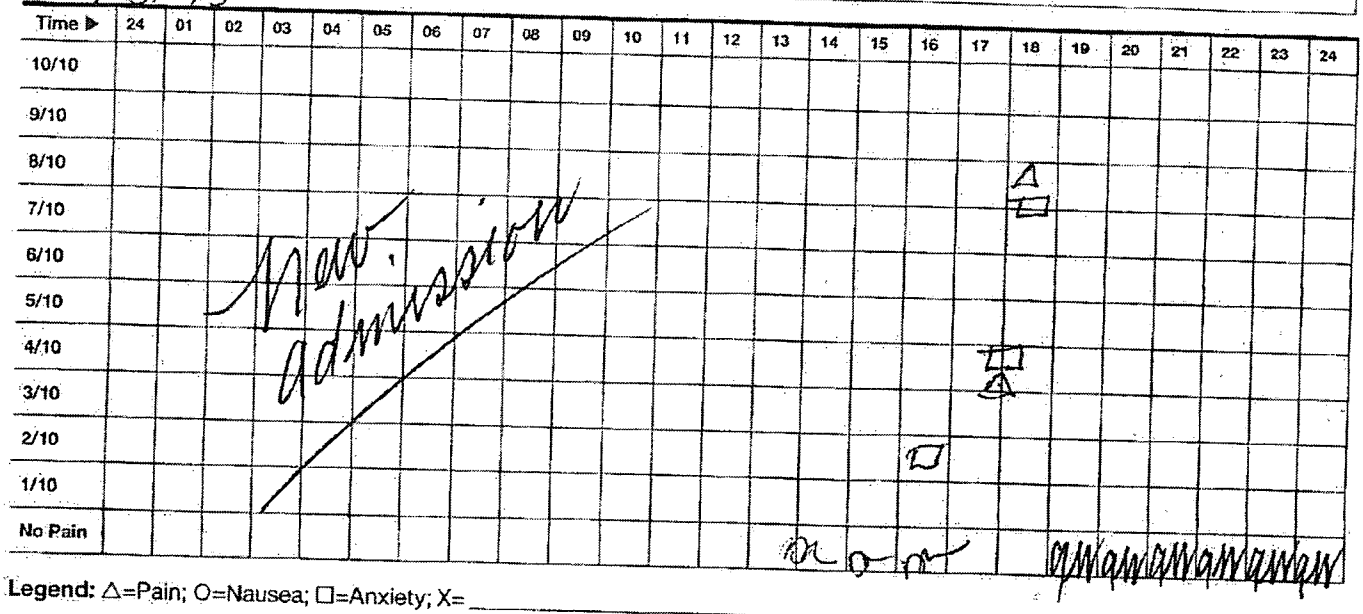
Rev. 7/2011 (Est. of POC) 220-CHS WHITE COPY - HOSPICE RECORD AFTER SIGNED BY IDG YELLOW COPY - FACILITY/HOME AFTER SIGNED BY IDG PINK COPY - FACILITY/HOME UNTIL SIGNED BY IDG

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Parrott, Delila MRN: 710111
DOB: REDACTE 80y/o MPIPU
ADM: 1/31/2015 DX: Schizophrenia
GTV: 1484684

IPU NARRATIVE NURSES NOTES

DATE: 1-31-15



Legend: △=Pain; O=Nausea; □=Anxiety; X= _____

Initial	Signature	Initial	Signature
DR	DR OTHER RN	AW	Anne Williams, RN

1340 Pt admitted to IPU. See adm assessment ——— DR

1615 medicated c Ativan 1g PO for anxiety & daughter's request. Pt restless & furrowed brow. shakes her head no when asked if she is having pain ——— DR

1620 Dr Hall in to eval ——— DR

1735 Pt trembling, anxious. numbling incoherently, medicated c morphine 2g IV for pain, Family hx. ——— DR

1800 med ineffective. Pt yelling out loud & eyes closed. Inconsolable. Discussed c Dr Hall. Additional 5g morphine given IV. Daughter wonders if she is having an adverse reaction to ativan but states this has never happened before when she had it ——— DR

1838 Assumed care for patient. Complete physical assessment performed. PPS= 20% Post admission symptoms and POC evaluation on-going. prn Ativan 1mg given x1. Prn Morphine given x2; 2mg and 5mg respectively ——— AW

Parrott, Delila MRN: 710111
DOB REDACTE 80y/o MPIPU
ADM: 1/31/2015 DX: Schizophrenia
GTV: 1484684

COMPREHENSIVE ADMISSION ASSESSMENT

Patient | MR # | Date (mm/dd/yyyy) 1-31-15

Other Specific Education/Instruction Provided

Medication	Pt	*Cg/FS	Understanding Verbalized	Further/On-Going Teaching Needed, See POC
Administration	☐	☑	☑	☐
Side Effects	☐	☑	☑	☐
Risks & Benefits	☐	☑	☑	☐
Effectiveness	☐	☑	☑	☐
Drug Disposal	☐	☐	☐	☐
BM Regimen for Opioid Use	☐	☑	☑	☐
Skin/Wound Care	☐	☐	☐	☐
Appropriate use of Supplies	☐	☐	☐	☐
Encourage to call hospice for change in condition	☐	☐	☐	☐

Additional teaching not included in the body of the note: _____

*CG Name: _____ *FS Name: _____

Comments: _____

SPECIFIC PREFERENCES

Preference Discussed	Preference Yes	Preference No	Undecided*	Refused to Discuss*
DNR	☑	☐	☐	☐
Antibiotics	☐	☑	☐	☐
Artificial Feedings	☐	☑	☐	☐
Infusions	☐	☑	☐	☐
Lab/Diagnostics	☐	☑	☐	☐
ICD Deactivated ☑ NA	☐	☐	☐	☐

CURRENT CODE STATUS

☑ No Code _____
☐ Full Code _____

"Do you want cardiopulmonary resuscitation if your heart and lungs stop working?" ☐ Y ☑ No ☐ *Refused to discuss*
"Do you want life-sustaining treatments other than CPR if your heart and lungs stop working?" ☐ Y ☑ No ☐ *Refused to discuss*
"Do you want to avoid hospitalization if your condition worsens?" ☐ Y ☐ No ☐ *Refused to discuss*

Was the patient/responsible party asked about preferences regarding the use of cardiopulmonary resuscitation (CPR)? ☐ No ☑ Yes ☐ Yes, but the patient/responsible party refused to discuss.
Information provided by: ☐ Pt ☑ Responsible Party Joan (daughter)
☐ Cultural preferences _____
☐ Comfort measures, specifically _____
☐ Other _____
☐ Benefit/burden of preference discussed, explain outcomes _____
☐ Benefit/burden of preference not discussed, explain _____
*Document conversation and follow-up plan _____

REASON FOR ADMISSION ☐ *Completed on Initial Assessment*

What prompted this admission? declining condition
How has the patient changed in the last 3-12 months? _____
What could the patient do previously that now requires assistance? Requires total care 2 ADL's
Has the patient's "home" changed due to care-related needs? _____
Multiple ER visits/hospitalizations over previous 6 months (include dates, reasons and locations of visits/admissions) _____
Additional Comments: _____

SERVICES EXPLAINED AND OFFERED

Service	Yes	No	Accepted	Declined at this Time	Service	Yes	No	Accepted	Declined at this Time
Hospice Aide	☐	☐	☐	☐	Bereavement	☐	☐	☐	☐
Volunteer	☐	☐	☐	☐	Other _____	☐	☐	☐	☐

ASSESSMENT SUMMARY: 80y/o F to eyes open & focusing on arrival, minimal verbal response due to expressive aphasia. Daughter reports increased agitation, hallucinating & paranoid by. ⊕ confusion but recognizes family. Requires total care 2 ADL's. Bedbound. Incontinent; Decreased appetite — refusing to eat. Stage II wound on sacrum. Occasional pain in ⊕ hip, RUE + shoulders. ⊕ footdrop. ↓ wt 22# in DEC

RN Signature/Title Denise Tyler — Date 1/31/15

White: Medical Record
Yellow: Patient
Pink: Facility

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Form HOS4178-HC

Parrott, Delila MRN: 710111
DOB REDACTED 80y/o MPIPU
Pa ADM: 1/31/2015 DX: Schizophrenia
GTV: 1484684
Terminal Diagnosis: _____

ɔn NURSING NUTRITIONAL SCREENING

_____ MR# _____ Date: 1-31-15

Clinical Assessment

One (1) Point

____ Diabetes - controlled
____ GI motility or absorption disorder
____ Renal failure - only abnormal lab
K 5.5, Phos 5.5, BUN 100
____ Severe Anemia; only abnormal labs
HGB <9.0, depressed HCT, MCV, MCHC
____ Shortness of breath, decreased ability to eat or drink
____ Dry mouth, sore mouth, alteration in smell or taste
____ Special diet (specify)_____
____ Diarrhea lasting more than 5 days
____ Nausea or vomiting more than 3 days per week
____ Oral intake less than 50% of usual for 10 days
____ Involuntary weight loss in past 6 months
✓ Pressure ulcers/wounds (Stage I & II)
____ Chewing difficulties
____ Impaired swallowing

Two (2) Points

____ Diabetes - uncontrolled
____ Active AIDS
____ Pressure ulcers/wounds (stage III & IV)
____ Cancer of oral pharynx and/or GI tract
____ Major burns (recent)
____ Lab: Albumin 3.0 or less
____ COPD dependent on oxygen
____ Pitting edema (3+ - 4+)

Three (3) Points

____ Lab: Albumin 2.6
____ Enteral nutrition
____ TPN
____ Other_____

_____ **Total Points**

Guidelines for Referral

Key for Points

Less than 5 points
No Dietician referral at this time

5-6 Points
Nurse/Dietician telephone consult.
Dietician will make recommendations

7 Points
Refer to Dietician to make visit per IDG discussion

- Refer to Dietician at patient request

☐ Patient/Family decline dietary consult

Comments: PTC schizophrenia, depression. Stopped eating for 2-3 wks

Plan: Diet as tolerated

RN Signature: Denise Kpotsawo RN Date: 1-31-15

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SOCIAL WORK COMPREHENSIVE ASSESSMENT

When completing this assessment, refer to the Hospice Eligibility Toolbox (HETB)

Patient Name: Delila Parrott MR#: 710111 Date: 2/1/15 Time In: 1145 Time Out: 1230

Terminal Diagnosis: Schizophrenia Age: 80 Sex: ☐ M ☒ F Ethnic Identity: W

Patient Location: ☐ Home ☒ Inpatient Facility ☐ SNF ☐ ALF Level of Care: ☐ Routine ☐ Inpatient (GIP) ☐ Respite ☐ Continuous Care (CC)

Attending Physician: Delores Letreault Life Occupation: _____

PAIN *see HETB

*PAINAD Scale Score: 0

(circle highest acceptable to Pt)

0 (None) 1 2 3 4 5 6 7 8 9 10 (Worst)

___ Now ___ Worst in past 24 hrs ___ Avg in past 24 hrs

☐ Pain is > pt's highest acceptable level, RN notified

Comments: Pt unresponsive to assessment, no s/s of pain at time of visit

SYMPTOMS AFFECTING THE PTS QUALITY OF LIFE (check all that apply)

CIRCLE RATER: Patient / Caregiver / Hospice Clinician

Nausea ___ Anxiety ___ SOB ___

Behavior ___ Patient Well-Being ___

Caregiver Well-Being ___ Vomiting ___

Fatigue ___ Depression ___ Drowsiness ___

Sleep ___ Appetite ___ Level of Acceptance ___

None Identified ___

Other _____

NEURO/COGNITIVE/BEHAVIORAL *see HETB

*Mental Status: Oriented to: ☒ person ☐ place ☐ time ☐ season

☐ Inattention ☒ Disorganized thinking

☐ Altered LOC ☐ Psychomotor Retardation

Behavior: (If these behaviors are observed, report to RN)

☐ hitting ☐ kicking ☐ pushing ☐ scratching

☐ grabbing ☒ No problem noted chart

☐ threatening others ☐ screaming ☐ cursing

☐ No problem noted chart

*Cognitive Skills for Daily Decision Making

☐ Independent ☐ Modified Independence

☐ Moderately Impaired ☒ Severely Impaired

PSYCHOSOCIAL WELL-BEING – SOCIAL/EMOTIONAL FACTORS

COPING:

Patient		Caregiver
☐	Denial	☐
☐	Anger	☐
☐	Avoidance	☐
☐	Mixed Emotions	☐
☐	Suicidal Ideation	☐
☐	Loss of Interest in Life	☐
☐	Unprepared for Approaching Death	☐
☐	Lack of Emotion	☐
☐	Dependent Personality	☐
☐	Lack of Tolerance	☐
☐	Multiple Losses	☐
☐	Substance Abuse	☐
☐	Mental Health Problems	☐

Describe healthy coping strategies:

(Pt/Cg) _____

COMMUNICATION:

Patient		Caregiver
☐	Withdrawn	☐
☐	Irritable	☐
☐	Overwhelmed	☐
☐	Adequate Methods (see below)	☒

Describe healthy communication exhibited:

(Pt/Cg) Cg is mostly appropriate conversation, but staff has reported unresponsiveness at times of her own choosing that always will be [illegible]

ADJUSTMENT:

Patient		Caregiver
☐	Sad	☐
☐	Depressed	☐
☐	Lonely	☐
☐	Afraid	☐
☐	Stressed	☒
☐	Tearful	☒
☐	Anxious	☐
☐	Withdrawn	☐
☐	Overwhelmed	☐
☐	Realistic Adjustment (see below)	☐

Describe current functional adjustment exhibited:

(Pt/Cg) Cg seems to understand pt's needs and limitations but would look to want pt removed in SNF

FAMILY DYNAMICS

Patient		Caregiver
☐	Marital Discord	☐
☐	Estranged	☐
☐	Unavailable	☐
☐	Domestic Violence	☐
☐	Closed Family System	☐
☐	Functional (see below)	☐

Describe supportive family dynamics exhibited:

(Pt/Cg) Pt's 3 children were gathered at pt's request. At least 1 dtr has psychiatric issues

FAMILY SUPPORT SYSTEM

☐ No Primary Caregiver ☐ Private Caregiver

☐ No Local Family Available ☐ Guardian

☐ Other: _____

Describe active family support system in place:

Pt's 3 children were at bedside

SOCIAL SUPPORT SYSTEM

☒ Faith-based affiliation Baptist

☐ None

☐ No social network

☐ No community involvement

☐ Cultural Isolation

Describe Pt/family report of satisfactory social support system(s): Pt lives in ALF

FINANCIAL ISSUES

☐ Lack of income to meet basic needs

☒ Other: Pt has LTC insurance but will need SNF placement approved

Describe Pt/family report of adequate financial resources:

Hospice of Charleston
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Patient Name: Delila Parrott MR#: 710111 Date: 2/1/15

INITIAL BEREAVEMENT RISK ASSESSMENT (*see HETB)
(Factors to include social, spiritual & cultural)

1 Primary Caregiver Joan Acosta Relationship to Pt dtr/POA Address for Contact: 129 Wisteria Pl. Columbia SC 29229
Phone Number 803-331-6342

2 Primary Caregiver Bev Chastain Relationship to Pt SW Address for Contact: Florence SC
Phone Number 843-615-5030

	1	2
# of Strengths	7	
# of Complicators	4	
Risk Level	Mod	

*Risk Levels

Low	Complicators < Strengths
Moderate	Complicators ≥ Strengths
High	Complicators 2x ≥ Strengths

Complicated Grief Describe: (i.e., multiple/recent losses, ambivalence towards Pt, low self-worth, depression, etc.)
Cg seems to have an interdependent relationship w/ pt. per staff observations. Pt wants to die, but cg plans to look for SNF placement

Volunteer Services

☐ Requested Purpose:

ADDITIONAL CONSIDERATIONS:
☐ Dependent Children in Home
☐ Dependent Elderly in Home
☐ Disabled Adult in Home
☐ Unsafe Social/Emotional Environment
☐ Pt placement needs (i.e., nursing home, IP, DC, etc.)
☒ None Identified

ADVANCE DIRECTIVE/LIVING WILL ****
☐ Pt has an Advance Directive/Living Will
☑ Pt does not have an Advance Directive/Living Will — None identified
☐ Assistance requested
☐ Assistance declined
☐ Pt lacks capacity to execute an Advance Directive/Living Will

SELF-DETERMINATION OF LIFE CLOSURE:
(Pt-Elected Healthcare Decision Maker, i.e., POA**/Proxy**/Surrogate**, etc.)
☐ Pt has an elected healthcare decision maker
☑ Pt does not have an elected healthcare decision maker — None identified
☐ Assistance requested
☐ Assistance declined
☐ Pt lacks capacity to elect healthcare decision maker
☐ Funeral Home: McAllister ☐ Burial ☐ Cremation ☐ Assistance Needed:

CODE STATUS:
☒ Pt has a completed DNR**
☐ Pt does not have a completed DNR
☐ Assistance requested
☐ Assistance declined
☐ Pt lacks capacity to complete DNR process

**Copy must be obtained

NARRATIVE SUMMARY OF FINDINGS: Pt is 80 yr old white female admitted to IPU for management of pain & anxiety. Pt was previously living in Ashley River Plantation ALF but has had ↑ weakness, ↓ in appetite and general wasting & desire to die. Pt has hx of schizophrenia & unverified hallucinations for 5+ yrs. Pt may need LTCF placement, but Cg wants to visit some places before making decision. Pt has 3 children, but primary decision maker is Joan.

☑ The Plan of Care was reviewed, and understanding and agreement was verbalized by the Pt/Primary Caregiver/Facility staff.

☑ Visit frequency will be 2 x/wk

Joan Acosta / dtr
(Name) (Relationship to Pt/Title)

Catherine Kelly Mahon Rogers LMSW
Signature/Title

2/1/15
Date

Parrott, Delila MRN: 710111
DOB REDACTED 80 y/o MPIPU
ADM: 1/31/2015 GTV: 1484684
Dx: Schizophrenia

MR#: Date: 2-2-15

pt was resting comfortably in bed pts daughter requested prayer for the mother for comfort. She said her mothy was raised in the baptist church and her mother fourth was a baptist minister. pts daughter was very tearful and said she is not prepared for her mothy to die. I talked with her and prayed with her and daughter. She was encouraged by prayer & will continue to keep up to pray w/ pt and daughter.

The Plan of Care was reviewed, and understanding and agreement was verbalized by the Pt/Primary Caregiver/Facility staff

Visit frequency will be 2-3 x/ wk

Name (Name) / dtr (Relationship to Pt/Title)

Signature/Title OCC

2/2/15 Date

Parrott, Delila MRN: 710111
DOB: REDACTE 80y/o MPIPU
ADM: 1/31/2015 DX: Schizophrenia
GTV: 1484684

INPATIENT PHYSICIAN ORDER

MR#: _____ DATE: _____ TIME: _____

	Indication	Hospice Covers
2/4/15 0515 24° chart audit — Ritchison, RN		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
24° CHART CHECK DATE: _____ TIME: _____ INITIALS: _____		☐ Yes ☐ No

☐ TELEPHONE ☐ VERBAL ORDER OF: DR. _____
REC'D BY: _____ DATE: _____
☐ TELEPHONE/VERBAL ORDER RECEIVED & READ BACK _____ (NURSE INITIALS)
A review of medications was performed including prescription, over the counter, herbal remedies and other alternative treatments, both related and non-related, regarding: effectiveness of the drug therapy, side effects, actual or potential drug interactions, duplicate drug therapy, those associated with laboratory monitoring and noncompliance with drug therapy.
PHYSICIAN'S SIGNATURE: _____ DATE: _____

IPU-114-CHS — RD AFTER SIGNED BY PHYSICIAN YELLOW COPY - PHYSICIAN — Rev. 8/2011

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Parrott, Delila MRN: 710111
DOB: REDACTE 80 y/o MPIPU
ADM: 1/31/2015 GTV: 1484684
Patient Nar Dx: Schizophrenia

INPATIENT PHYSICIAN ORDER

MR#: _____ DATE: _____ TIME: _____
Allergies: _____

	Indication	Hospice Covers
02/03/15 Dc all P.O. meds		☐ Yes ☐ No
8:10 AM Morphine 5 mg IV/SQ Q4h° ATC	Y	☐ Yes ☐ No
Morphine 5-10 mg IV/SQ Q1h° PRN pain or dyspnea	Y	☐ Yes ☐ No
Lorazepam 1 mg IV/SQ Q6h° ATC	Y	☐ Yes ☐ No
Lorazepam 1-2 mg IV/SQ Q1h° PRN anxiety or agitation	Y	☐ Yes ☐ No
		☐ Yes ☐ No
24° CHART CHECK DATE: _____ TIME: _____ INITIALS: [signature] 2/3/15 1000		☐ Yes ☐ No

☐ TELEPHONE ☐ VERBAL ORDER OF: DR. _____
REC'D BY: _____ DATE: Ritchison RN
☐ TELEPHONE/VERBAL ORDER RECEIVED & READ BACK _____ (NURSE INITIALS)
A review of medications was performed including prescription, over the counter, herbal remedies and other alternative treatments, both related and non-related, regarding: effectiveness of the drug therapy, side effects, actual or potential drug interactions, duplicate drug therapy, those associated with laboratory monitoring and noncompliance with drug therapy.
PHYSICIAN'S SIGNATURE: _____ DATE: _____

IPU-114-CHS — WHITE COPY - HOSPICE RECORD AFTER SIGNED BY PHYSICIAN YELLOW COPY - PHYSICIAN — Rev. 8/2011

Hospice of Charleston
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INPATIENT PHYSICIAN ORDER

Patient Name: _____ MR#: _____ DATE: _____ TIME: _____
Allergies: _____

	Indication	Hospice Covers
2-4-15 0515 24° chart audit — Ritchison, RN		☐ Yes ☐ No
02/04/15 Δ Morphine to 10 mg IV/SQ Q4h° ATC		☐ Yes ☐ No
1010 Δ Morphine to 10-15 mg IV/SQ Q1h° PRN pain or dyspnea	Y	☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
24° CHART CHECK DATE: _____ TIME: _____ INITIALS: [signature] 2/4/15 1020		☐ Yes ☐ No

Orders Checked
Date 2/4/15 1845

☐ TELEPHONE ☐ VERBAL ORDER OF: DR. _____
REC'D BY: _____ DATE: _____
☐ TELEPHONE/VERBAL ORDER RECEIVED & READ BACK _____ (NURSE INITIALS)
A review of medications was performed including prescription, over the counter, herbal remedies and other alternative treatments, both related and non-related, regarding: effectiveness of the drug therapy, side effects, actual or potential drug interactions, duplicate drug therapy, those associated with laboratory monitoring and noncompliance with drug therapy.
PHYSICIAN'S SIGNATURE: _____ DATE: _____

Hospice 041

Rev. 8/2011

Sandpiper Village
1224 Village Creek Lane
Mount Pleasant, SC 29464

Date: 04/26/2013

Occupant Name: Ms. Delila Parrott

Subject: Lease Agreement ("Agreement")

THIS AGREEMENT MAY BE SUBJECT TO BINDING ARBITRATION

Dear Ms. Parrott,

Sandpiper Village Independent and Assisted Living, LLC (Sandpiper) is pleased to welcome you to our Sandpiper. This Lease Agreement (Agreement) explains the responsibilities of all parties. This Agreement refers to you as "Occupant." That term also includes any other person who may be living with you (subject to Sandpiper's knowledge and approval). When the term Parties is used, that means Sandpiper, Occupant and your guests.

Once signed by all Parties, this Agreement becomes an enforceable contract. Therefore, if anything in this Agreement is confusing or different from what has been previously explained, you are encouraged to ask for a written explanation and to seek legal counsel before signing.

Sandpiper has agreed and you have accepted to lease Unit number **S6** (Unit). In addition, Sandpiper will provide the following services: (1) two meals per day per each Occupant; (2) weekly housekeeping services; (3) weekly flat laundry service; (4) availability of laundry facilities; (5) water and sewer service; (6) general maintenance service; (7) planned activities—social, cultural, recreational; (8) the services of a social-recreational director; (9) free parking at Sandpiper for one automobile owned or leased by the Occupant; (10) carpeting throughout your Unit excluding kitchen and bathrooms; (11) scheduled local transportation; and (12) a kitchen in the Unit, including stove top and refrigerator.

Entrance Fees, Closing Date and Limitations on Refunds

As a condition to occupying the Unit and receiving the services described above, you agree to pay Sandpiper a one-time, non-refundable Entrance Fee (Entrance Fee). The Entrance Fee must be paid prior to or at the time this Agreement is signed and delivered to the Village. Your Entrance Fee is $0.

Your Closing Date is the date you have been given a key that gives you the right to take possession and occupy your Unit. The Closing Date follows acceptance of your application and receipt of your Entrance Fee. The date you actually move in may vary or be delayed based on your own moving schedule and personal challenges. The Closing Date is also the date when the Monthly Service Fee (described below) begins.

Occupant initial: Delila Parrott
Village initial: _____

By signing this Agreement you acknowledge that the Entrance Fee has been fully earned by Sandpiper on your Closing Date and will not be returned to you under any circumstances or for any reasons regardless of the term of this Agreement or the actual length of your stay.

No Cause Termination by Occupant or Sandpiper

Subject to Default as described below which provides shorter notice period, either Party may terminate this Agreement for no cause by delivering at least thirty (30) days advance written notice. However, in no event shall the last day of the notice end prior to the last day of a full calendar month. For instance, if written notice of termination is delivered on November 15, the last day of the Agreement would be December 31. During this notice period you will continue to be responsible for the Monthly Service Fee and fees and complying with all other obligations under this Agreement.

Monthly Service Fee

In addition to your Entrance Fee, you agree to pay a Monthly Service Fee through the term of your occupancy. This fee includes both rental of your Unit and the services listed above. Your Monthly Service Fee will be $1650 per month. If two persons are occupying the Unit, your Monthly Service Fee is an additional $495 per month.

The Monthly Service Fee is due and payable in advance on the first (1st) day of each month. Your first Monthly Service Fee should be paid on your Closing Date and will be prorated on a daily basis for any partial calendar month.

A late charge of 10% of your Monthly Service Fee will be assessed if your Monthly Service Fees is not paid by the 5th day of the month in which it is due. Monthly Service Fees not paid by the 10th day of the month will be subject to a late charge of 25%. Late charges are due and payable when the corresponding Monthly Service Fee is paid or, if earlier, upon written demand by the Village.

Each July 1st, your Monthly Service Fee will automatically increase. The exact amount of this increase will be determined at the sole discretion of Sandpiper, but it will not increase by more than eight (8%) percent. Sandpiper will strive to keep increases at a minimum based on the actual and projected operating costs, cost of ownership, future needs and other economic factors. This increase will not apply if contrary to federal or state laws or regulations. Further, Sandpiper may decide to either not increase the Monthly Service Fee in any particular year or withhold applying a yearly increase for one or more months following July of any given year. If either occurs, this should not be considered a waiver of Sandpiper's right to increase the Monthly Service Fee in the future as described above.

Responsible Party – Personal Financial Responsibility

By signing this Agreement, either as a new Occupant or on behalf of a new Occupant, you are accepting personal financial responsibility and guaranteeing the payment of all charges incurred while occupying a Unit at Sandpiper. This is also referred to as Responsible Party. This includes the Monthly Rental Fee and all additional

Occupant initial: MJP
Village initial: G

fees, costs, damages and all other charges including attorney's fees, costs of collection, interest and court costs. If you are signing this Agreement on behalf of another and if you are receiving money from a third party that is intended to be used for that person, you agree to pay any and all of that amount to Sandpiper. You also agree to take all steps necessary to change the payee to Sandpiper if allowed by the third party insurer, trust or other payment source.

Pet Fee and Continuing Pet Obligations

If authorized by Sandpiper in writing, you agree to pay a non-refundable pet fee of $350 to Sandpiper. Your pet must be pre-approved by Sandpiper for your Unit. This fee is by no means a limitation on your obligation to cover all costs for damages that may result from your pet. You agree to pay for any damages that exceed this non-refundable fee including the possible cost of new carpet and other interior and exterior items. You also agree to keep in force insurance such as rental that will include damages and liability protection in the event your pet injures another Occupant, a Village employee or agent or other individual.

When walking your pet, a leash must be used at all times. You are also responsible for cleaning after your pet while on pet walks. If at any time your pet becomes a nuisance to other tenants, you may be asked to remove your pet completely from the Sandpiper and you agree to do so.

Right to Occupy Your Unit, Limitations on Ownership and Changes of Unit

Your right to occupy your Unit will exist and continue for an indefinite period of time unless or until cancelled or terminated as provided in this Agreement. It is expressly understood and agreed that this Agreement grants to you a revocable license to occupy and use the Unit in accordance with, and subject to, the terms of this Agreement. However, this does not give you the exclusive possession or ownership of the Unit as against the Village. Because this Agreement is a lease, it does not transfer or grant to you any interest in real or personal property owned by Sandpiper or any other person or entity. Your rights under this Agreement are not assignable and no right or benefit will pass on to the use or benefit of your heirs, your estate, your assignees, or your representatives.

Regardless of any other item in this Agreement, Sandpiper may move you from one Unit to another to meet the requirements of any applicable statute, law, or regulation. Your Unit may not be used for any business or profession or any manner in violation of applicable zoning or other laws, rules or regulations.

No person other than you may occupy the Unit without the express written approval of the Village. If your spouse or other person who is not an original party to this Agreement is later accepted for occupancy of the Unit, your Monthly Service Fee will be increased from the date that person initially moves in. If a spouse or other person does not meet the requirements for occupancy, that person will not be permitted to occupy the Unit for more than thirty (30) days (except with the express written approval of Sandpiper).

Occupant initial: MM
Village initial: _____

You agree that your license to occupy the Unit will at all times be subject to any liens of any and all mortgages and other documents creating liens or security interests in or to the assets that make up Sandpiper, whether now or hereafter existing. Upon request by the Village, you agree to execute, acknowledge, and deliver to such mortgagee, lender or lien holder such further written evidence of such subordination as such lender(s) may require. However, you will not be liable for any such other indebtedness.

Limitation of Liability and Personal Property / Rental Insurance

Sandpiper is not responsible for the negligence of its Occupants including acts or omissions that cause injury or death to other persons or damage to property. This includes acts or omissions on the part of Village occupants, guests or invitees. You agree to be responsible, defend, and hold Sandpiper and its owners, managers, officers, employees and agents harmless from and against, any and all claims, damages, suits, actions, judgments, fines, penalties, costs and/or expenses, including attorney's fees and court costs, resulting from any injury to or death of any person and/or any damage to property caused by, resulting from, attributable to, or in any way connected with acts or omissions of or on the part of you as occupant or any of your guests or invitees.

Sandpiper will not be responsible for the loss of any personal property of others resulting from his/her negligence. Each Occupant will have personal liability insurance and will maintain personal property and/or rental insurance coverage. Further, firearms are not permitted at Sandpiper. Sandpiper is also not responsible for fire, theft, injury or other damages to persons or personal property including automobiles.

Assumption of Risk

Both Sandpiper and you agree that your freedom to make personal health and non-health related decisions, the freedom to travel, to come and go as you please, the decisions that effect and control your day-to-day activities should all remain within your sole decision so long as it does not adversely affect other occupants. As such, both Sandpiper and you understand and realize that such decision making ability carries an inherent possibility of adversity that may directly or indirectly affect you as occupant. Therefore, you and your representative, if appropriate, agree to assume such risk and the related consequences and, as it relates to Sandpiper and its agents, officers and assigns, waive any and all liability against such individuals and entities from any and all damages, both direct and indirect, that may result from such activities, the risks and the resulting damages resulting from such activities.

Resolution of Legal Disputes – Agreement to Binding Arbitration

You will be asked to sign an Agreement to Binding Arbitration, This is **Attachment A** to this Agreement. Signing the Agreement to Binding Arbitration is **not** a condition of acceptance or admission. **If you do sign, however, you should know that any legal controversy, dispute, disagreement, or claim of any kind and of any nature arising out of, or related to this Lease Agreement, or breach thereof, including but not limited, policies and procedures, rules and regulations referred to by reference herein or the breach thereof, and also including your Responsible Party shall be adjudicated as provided in the Agreement to Binding Arbitration. This shall**

Occupant initial: AY

Village initial: _____

include any controversy, dispute, disagreement, or claim arising between the Occupant and Sandpiper after the execution of this Agreement in which you or a person on your behalf acting as executor or administrator of your estate alleges a violation of any right granted to you under law. That includes personal injury, malpractice, or wrongful death. This paragraph and the Agreement to Binding Arbitration shall not limit in any way your right to file formal grievances with Sandpiper as may be provided by rule or regulation, nor shall it apply to Sandpiper for instances involving non-payment of Monthly Fees and an alleged breach of house rules and Sandpiper posted rules and regulations. If there are any conflicts in language and terminology between this Agreement and the Agreement to Binding Arbitration, the later will control.

Furnishing Your Unit, Removal of Personal Property and Occupancy

Unless otherwise agreed, you agree to furnish your own unit. Your furnishings and other property should not interfere with the health, safety or general welfare of any other occupant or any other unit at Sandpiper, as determined by Sandpiper in its sole discretion.

In the event that removal of your property is not accomplished within thirty (30) days after your death or the termination of this Agreement as provided in below, then Sandpiper may remove and/or store such furniture, possessions and property at your expense or the expense of your estate. After sixty (60) days in storage, Sandpiper may sell your belongings at a private sale. The proceeds of such sale will first be used to pay storage and sale expenses and any balance due on your account. If any proceeds from the sale remain, the balance will be paid to you or your estate within a reasonable time after the sale.

In the event two (2) people occupy a Unit under this Agreement, upon the death, or other inability of one such person to occupy the Unit, the second person will continue to be allowed to occupy the Unit under the terms of this Agreement. Nonetheless, you agree not add a second occupant unless that other person has signed an occupancy agreement with Sandpiper (or an amendment to this Agreement has been entered into by the parties hereto).

Repairs and Maintenance

Sandpiper will provide replacements and perform necessary repairs and maintenance associated with normal wear and tear to property and equipment owned by the Village. You will be responsible for the repair, maintenance and replacement of property you own and for any extraordinary maintenance and/or any damage to the Unit due to any act or omission by you, your guests or invitees. You may not make any structural or physical change of any kind within or about the Unit without the express written consent of Sandpiper. In the event permission is granted, the cost of any change you request will be at your expense, unless otherwise agreed in advance in writing by the Village. Any approval of such change may be conditioned upon your undertaking to bear the cost of a later restoration of the Unit to its original condition.

Occupant initial: AP
Village initial: _____

Village's Right to Transfer Occupants Due to Medical or Mental Status

Sandpiper strives to foster an independent living Sandpiper. During your occupancy, a change in your medical or mental status may require that you obtain additional assistance to meet your daily living needs. You will at that time have several options, which may include transferring to an alternate setting as directed by your personal physician or hiring a private sitter to provide services at your Unit. Any arrangements for a personal sitter are strictly your responsibility. Sandpiper reserves the right to require a transfer to an alternate setting if your health should decline to the level where remaining in independent living may endangering your own well-being or that of other Occupants.

Promises Made by You as Occupant

You represent and warrant to Sandpiper that all facts stated in your application for occupancy at Sandpiper are true and complete. You further covenant and agree with Sandpiper (a) to comply with all reasonable operating procedures of Sandpiper as now existing or as hereafter amended or enacted, (b) to timely pay the Monthly Service Fee, as provided in this Agreement, (c) not to impair your ability to meet your financial obligations under this Agreement by transferring assets or properties for less than full and adequate consideration in money or money's worth, and (d) to abide by all other terms and conditions of this Agreement. You also represent and affirm that you have never been convicted of a felony for a sexual offense and, should it be later found that a prior felony was committed or is thereafter is committed by you, such allegation or conviction will be grounds for immediate termination of this Agreement at the sole discretion of the Village.

Default, Termination and Opportunity to Cure Default

Sandpiper may, upon notice and after giving you the opportunity to cure, revoke your license to occupy the Unit and terminate this Agreement upon the occurrence of any of the following events, referred to as Default: (1) the failure to comply with reasonable operating procedures for Sandpiper as now existing or as may hereafter amended or enacted; or (2) the failure to pay any Monthly Service Fee or any other fees when due; or (3) where you, your co-tenant or your guests create a disturbance within Sandpiper that is detrimental to the health, safety or peaceful lodging of other occupants at Sandpiper, as determined by Sandpiper in its sole discretion.

Prior to the termination of this Agreement for any Default except as otherwise provided in this Agreement, Sandpiper will give you notice, in writing, of such Default and you will have ten (10) days thereafter within which to cure such Default. No Default will eliminate your obligation to pay the Monthly Service Fee until termination. If you fail to cure such Default within such time, this Agreement and your license to occupy the Unit will terminate at the expiration of that ten (10) day period.

Additional Conditions

This Agreement will be binding upon the successor and assigns of Sandpiper. No amendment of this Agreement, other than an increase of the Monthly Service Fee, a

Occupant initial: AP

Village initial: _____

change in Sandpiper's posted rules and regulations or a change in the Services to be provided, will be valid unless in writing and executed by Sandpiper and you. Sandpiper may change its posted rules and regulations at any time and at its sole discretion. The invalidity of any restriction, condition, or other provision of this Agreement or any part will not impair or affect in any way the validity of enforceability of the remainder of this Agreement.

The Sections above titled "*Limitation of Liability and Personal Property / Rental Insurance*" and "*Assumption of Risk*" and the attached "*Agreement to Binding Arbitration*", if signed, are all a material part of this Agreement and incorporated by reference herein. Notwithstanding anything in this Agreement to the contrary, the terms and conditions of those sections and attachment shall survive the termination, cancelation and/or expiration of this Occupant Admission Agreement.

Any waiver by Sandpiper of a breach of any provision of this Agreement or of a violation of Sandpiper's posted rules and regulations will not operate or be construed as a waiver of any subsequent breach. The failure or any delay by Sandpiper in exercising any right in this Agreement or of enforcing a violation of Sandpiper's posted rules and regulations will not operate as a waiver of such right in the future.

This Agreement will be interpreted according to the laws of the State of South Carolina. It has been executed on behalf of Sandpiper by its duly authorized staff. No officer, director, agent, or employee of Sandpiper will have personal liability to you under any circumstances. This includes its officers, directors, agents, employees, parent, subsidiaries, successors and assigns If there is more than one occupant, the rights and obligations of each such person will be joint and several.

If either Sandpiper or you desire to give any notice based on this Agreement, it is official when delivered by hand, or sent by FedEx, UPS or U.S. certified mail, return receipt requested. For delivery to Sandpiper, the address on this letter should be used. For you, your Unit will be used or notice may be sent to other addresses as you may provide with written notification of the same.

By signing this Agreement, you are stating and certifying that they have read and understand the foregoing and agree to the terms and conditions of this Agreement and all posted rules and regulations (which may change from time to time). You also acknowledge receipt of **Attachment A.** We look forward to having you as a member of our Sandpiper.

Sincerely yours,

Corinne Carrington

Corinne Carrington
Executive Director

Occupant initial: UP
Village initial: C

Acknowledgement and Agreement

By signing below, I ("We" if signed by more than one person) agree to the terms and conditions as stated in this Lease Agreement and all Sandpiper posted rules and regulations and **Attachment A**, if signed. I ("We" if signed by more than one person) further acknowledge that I am and will continue to be a Responsible Party as defined in this Agreement even though I may be signing on behalf of another individual or individuals in order to secure that individual or individual's acceptance at Sandpiper as set forth in this Agreement and Attachment.

Melissa Parrett
Occupant/Responsible Party

Occupant/Responsible Party

4-26-13
Date

Date

Responsible Party (if not occupant)

Date

Address for billing and notification purposes:

1224 Village Creek Lane 3b
Mt Pleasant SC 29464
(843) 881-1692
(Telephone Number)

Occupant initial: ____
Village initial: CL

Attachment A

AGREEMENT TO BINDING ARBITRATION

PLEASE NOTE: **SIGNING THIS AGREEMENT IS NOT A CONDITON OF ADMISSION.** The Occupant and/or Occupant's Responsible Party understand(s) that agreeing to binding arbitration of legal disputes means that Occupant is waiving Occupant's right to sue in a court of law and to a trial by jury. If the Occupant or Occupant's Responsible Party does not wish to agree to arbitration, then the Occupant should so inform Sandpiper.

This Agreement to Binding Arbitration ("Agreement") is made between Sandpiper Village Independent and Assisted Living, LLC, which includes and is mutually affective against its officers, directors, agents, employees, parent, subsidiaries, successors and assigns ("Sandpiper"), and Delila Parrott, including and is mutually effective against his or her heirs, executors, administrators, and assigns ("Occupant"). The term shall begin at the date signed below and continue during Occupants' length of stay at Sandpiper.

Any legal controversy, dispute, disagreement or claim of any kind arising out of, or related to the Occupant Admission Agreement, or the breach thereof, (other than non-payment by Occupant, where the party is seeking remedies in small claims court for disputes or claims within the scope of its jurisdiction, or Occupants' rights to file formal grievances with the Sandpiper or the State or Federal Government), shall be settled first through mediation and, if not resolved within three (3) months, exclusively by binding arbitration. This includes all controversies, disputes, disagreements, or claims including, but not limited to, all breach of contract claims, all negligence and malpractice claims, all tort claims, and all allegations of fraud in the inducement or requests for rescission of the Agreement.

This Agreement and the rights of the parties hereunder shall be governed by and construed in accordance with the laws of the State of South Carolina, exclusive of conflict or choice of law rules. However, the parties acknowledge that this Agreement evidences a transaction involving interstate commerce. Therefore, notwithstanding the application of substantive law, any arbitration conducted pursuant to the terms of this Agreement shall be governed and interpreted under the Federal Arbitration Act, 9 U.S.C. §§ 1-16, as may be amended ("FAA").

Mediation and Arbitration shall be administered by JAMS pursuant to its applicable rules and procedures depending on the claim including either its Expedited Procedures or Streamlined Arbitration Rules and Procedures in which event JAMS' "Consumer Arbitrations Pursuant to Pre-Dispute Clauses Minimum Standards of Procedural Fairness" shall also apply. More information about JAMS can be obtained at www.jamsadr.com. Administration by JAMS is not a material condition of this Agreement and an alternative arbitration panel may be selected either by mutual agreement of the parties, should JAMS not be available as a arbitration forum, or as otherwise ordered by a court of competent jurisdiction and in accordance with the FAA. Judgment on an award may be entered in any court having jurisdiction. This clause shall not preclude parties from seeking provisional remedies in aid of arbitration from a court of appropriate jurisdiction.

Arbitration shall take place in the state and county in which the breach is claimed to have arisen before three arbitrators. Each party shall select one person to act as arbitrator, and the two so selected shall select a third arbitrator. If the arbitrators selected by the parties are unable or fail to agree upon the third arbitrator, the third arbitrator shall be appointed by JAMS or other arbitration

9

Occupant initial: DP

Village initial: tw

panel, as the case may be. All shall serve as neutral, independent and impartial arbitrators.

The parties shall maintain the confidential nature of the arbitration proceeding and the award, including the hearing, except as may be necessary to prepare for or conduct the arbitration hearing on the merits, or except as may be necessary in connection with a court application for a preliminary remedy, a judicial challenge to an award or its enforcement, or unless otherwise required by law or judicial decision.

In any arbitration arising out of or related to this Agreement, the arbitrators are ***not empowered to award punitive or exemplary damages***, except where permitted by statute, and the parties waive any right to recover any such damages. The award will provide a concise written statement of the essential findings and conclusions on which the award is based.

I acknowledge reading this **Agreement to Binding Agreement** and agree with its terms. I understand that this Agreement includes all care and services which previously have been or will in the future be provided to me. I further understand that this Agreement also is binding on any individual or entity claiming by or through me or on my behalf including my estate. I further understand that this Agreement is voluntary and not a precondition to receiving care and services and that I am **giving up the right for a trial by jury and agreeing to binding arbitration**.

If the individual signing this Agreement is the Responsible Party, he or she is doing so on behalf of any person for whom he or she is legally responsible for all fiduciary obligations, the signature below affirms that he or she has the authority to contract with the Sandpiper, and that his or her execution of this agreement is in furtherance of that authority including the authority to enter into this **Agreement to Binding Arbitration.**

THIS AGREEMENT MAY BE REVOKED FOR ANY REASON BY THE OCCUPANT OR AUTHORIZED OR RESPONSIBLE PARTY BY GIVING SANDPIPER WRITTEN NOTICE OF SUCH INTENT PROVIDED SUCH NOTICE IS DELIVERED TO SANDPIPER WITHIN 30 DAYS FROM THE DATE OF SIGNING SET FORTH BELOW.

Melba Parrott	
Occupant/Responsible Party	Occupant/Responsible Party
4-24-13	
Date	Date
Print Name: Occupant or Responsible Party	Print Name: Occupant or Responsible Party

Nature of Responsible Party: ✓ Occupant/Applicant ___ Healthcare Power of Attorney
___ General Power of Attorney ___ Durable Power of Attorney _____ Guardian

Occupant initial: MP
Village initial: _____

Witness or Acknowledgment by:

I acknowledge that the above party(ies) has (have) signed this Agreement to Binding Arbitration in my presence, or they have represented to me that they have signed, and that they understand and agree to its terms. My signature also represents acceptance by Sandpiper of this Agreement to Binding Arbitration.

Connie Carlton — 4-24-13

Signature: Sandpiper Representative — Date

Occupant initial: CC

Village initial: CW

Front Desk Procedures and Duties:

Answer the phone "Sandpiper Retirement Community; this is "your name"; how may I help you?"

Calls for other extensions may be transferred by pressing the button for that extension, or by pressing the TRANSFER button and dialing the number for that extension. Should a line be busy, and you wish to transfer to their voicemail, press the "VM/XFR" button, then the extension number. Extension numbers, direct lines, and frequently used numbers are posted near the phone along with numbers for the Courtyard and Rehab and Nursing. To transfer a call to Rehab and Nursing or the Courtyard, you must press the TRANSFER button and then the extension you are calling. Other numbers that you may need, including residents and staff, are kept on the desk. We do not give resident numbers out to non-residents.

If you notice the VMAIL button is lit, you have a message. You may retrieve it by doing the following:

Pick up the receiver
Press the VMAIL button
Enter the password (1234)

To pick up a call on hold from another extension press 12 and the extension number that the call is originating from. The front desk is 2421.
To answer an incoming call from an extension, press 65 then 2421.
To get an outside line you must dial nine.

The cordless phone can be answered by pressing the "talk" button on the receiver. Calls may be transferred by pressing the "talk" button and then dialing the extension number of the person to which you wish to transfer, and then hanging up. To place someone on hold press the "talk" button, to resume conversation press the "talk" button again. On this phone, when you have someone on hold or on the line you cannot answer other incoming calls.
To make a call from the cordless phone you must dial nine for an outside line.

Messages: Messages should be written in the phone message book kept at the front desk. Please leave a detailed message. Make sure you put the

name of the person the message is for at the top and your name at the bottom. Tear off the top copy and put it in the appropriate person's box. Please do not leave messages scribbled on slips of paper at the front desk. You may email messages to anyone with an email address.

Marketing Calls:

Linda and Tina both take marketing calls and give tours. If someone calls for information try Linda first and then Tina. If neither one is available ask if you can transfer them to voicemail. If the caller does not want voicemail ask if you can take a name and number to have someone call them back or offer to mail them a packet of information. If someone walks in and wants information or a tour, again, try Linda first then Tina. If they are not available offer them a packet of information and get their name and phone number for Linda to call them later. We have information packets at the front desk (to the right of the phone).

The Top Desk Drawer Contains Things That We Need To Lock Up:

KEYS:

There is a key box located to the left of the front desk. It contains keys for each apartment and it's mailbox. Residents may borrow apartment keys if they need to, but it is your responsibility to make sure the key is returned. All apartment keys are coded with a number. Check the sheet in the bottom of key box one to see which code number corresponds to the apartment key that you want.

There is a sign out sheet at the front desk. Please sign all keys out and back in.

Always hang keys back in the box. Please do not leave keys thrown in the top drawer or the bottom of the key box.

STAMPS, COPIES, AND FAXES:

We have stamps for **office mail only** in the top drawer. **(We do not sell stamps.)**

If someone wants to buy stamps, we have envelopes in the second drawer for ordering from the Post Office. Stamps may also be purchased at Publix.

DAILY CHECK SHEET:

All residents must be seen by staff and initialed off every day. If you do not see someone call them, if you can't get them on the phone, go to the apartment and check on them.

MEAL TICKETS:
The binder in the top desk drawer contains meal tickets and money to make change. When a resident has a guest we fill out a meal ticket for them to give to dietary and either charge it or collect cash. There is a sheet to record guest meal charges, and cash paid for meals. Prices for all meals are listed inside the binder. Delivery charges are $2.00 per meal (lunch only). We do not need to record delivery charges.
Some guests may want to charge meals on their charge card also.

RENT CHECKS:
The rent checks should be put in the rent check box located on the wall outside of the sliding glass doors to Linda's office.

MENUS:
We keep extra daily menus in the bottom drawer as they are always needed for deliveries and extras. We also start out the week with extra weekly menus as well as an original should you need to make extra copies. When filling out a menu for a delivery make sure to put the name and apt number on it. If it's for lunch place the menu on the spindle for dietary to pick up, place dinner menus in the basket for later. Only send lunch menus at lunch and dinner menus at dinner. Some residents will send over a week's worth of menus at a time. We keep them in the bottom drawer with the other menus. Please keep an eye out for them, and make sure they make it to the kitchen. It's a good idea to check the spindle a little after 12:00pm and 5:00pm, as sometimes late call-ins do not get picked up.
Before leaving at night, put out menus for the next day and put one on the menu board in hallway.

MAIL AND PACKAGES:
The mailman will leave office mail and packages too big for the mailboxes at the front desk. All packages, prescriptions, and flowers need to be logged in and signed out when picked up or delivered. Please put the date it is delivered and the date it is picked up or delivered.
Office mail can be sorted and put in the appropriate mailboxes located in the copy room. It is up to the front desk staff to make sure that the residents get any packages left at the desk. If it is small enough, give it to them when they come for meals. Large ones can be delivered by staff. All mail and packages must be put in the break room when we close the desk at night. Fill out a package notice for any packages left and tape it to the outside of

the appropriate mailbox. We are allowed to sign for mail and packages for the residents.

CHANGE OF STATUS FORMS: We fill out a change of status whenever a resident moves-in, moves out, goes to the hospital or rehab, returns from the hospital or rehab, or passes away. A copy is then put in the appropriate staff's mailbox as well as the binder labeled "Residents' Change of Status". Staff that should get one are the director, activities, and security. Also, when a former resident or their family turn in the keys to an apartment, fill out a change of status and put a copy in the COS binder. When we have a new move-in please always give a copy to Traylor Rucker and one to Elinor Kessel if it's a woman .

MAINTENANCE:

After hours, our maintenance staff is on call for emergencies only. There is an after hours maintenance pager number posted at the desk. For routine maintenance a work order must be filled out. If some one has a stopped up toilet, there should be a plunger in the activities office behind the curtain. **Please return the plunger to the closet.**

EMERGENCY CALL SYSTEM:

Each resident is issued a panic button which is monitored off campus. Occasionally the monitoring company will call us to check on a resident. The dark gray cell phone is the emergency phone and that is the phone they call on. Whenever you have to leave the front desk make sure you take this phone with you.

Locate the resident and make sure they are OK.

Anytime a resident is sent to the hospital make sure to make a copy of the emergency contact sheet for EMS. Also call the resident's emergency contact. This information is in the white binders labeled Emergency Profiles.

FIRE ALARM:

The keypad for the fire alarm is on the left side of the back wall. When the alarm sounds, check the display to see which building is going off. The first letter in the last word is the building in question. (Example: Echo means E

building) Immediately call someone in maintenance to check that building. If there is no maintenance man on campus, take the portable phone and go check it. Check each apartment. Censignal Fire Alarm needs to be notified as soon as possible if there is not a fire as they call the fire department as soon as the alarm goes off. Their number is 1 800-554-1101 (code 6445). Whenever you speak with them you will need to give them the code.

MISC:

Doctor's appointments – To avoid mistakes and confusion The Transportation Department would prefer that no one else schedule doctor's appointments. If a resident needs to have an appointment scheduled or to put an existing appointment on the schedule, we ask that you take a detailed message and leave it for one of us on the clipboard by the phone.

Most office supplies are kept in the closet to the left of the mailboxes or in the closets in the copy room. The key to the closet is in the key box.

The front desk staff are responsible for keeping the lobby, the library, the bathrooms, and the copy rooms clean and tidy when the housekeeping staff is not here. There are some cleaning supplies under the sink in the copy room. Extra paper towels and toilet paper are kept in a closet behind the kitchen. Also, please, make sure to return all dirty dishes, glasses, and silverware to the kitchen before you go home. **Do not leave them in the sink in the back.**

When you close the desk at night remember to:

Make sure all mail and packages are put back in the copy room.
The top desk drawer is locked and key is put up.
Phones are put on chargers.
Emergency phone is given to the guard.

Remember, we are not permitted to give resident's phone numbers to anyone outside of the Village, nor are we permitted to give staff home numbers to anyone. Do not give out staff cell phone numbers unless the staff member approves. At this time you may give out the cell number for Transportation

I have read and understand the front desk procedures and duties.

_____

Date: _____

SANDPIPER
Premier Senior Living

FREQUENTLY ASKED QUESTIONS= HELPFUL HINTS

Utilities: Resident pays their own utilities except for water. We pay the water bill. For those that want internet, cable, and cell phone-Comcast offers a bundled package at a discounted rate.

Trash: Trash is picked up from each "pod" on Mondays, Wednesdays, and Fridays.

Housekeeping: Weekly housekeeping service includes bed linens and bath towels washed once weekly. Personal laundry is the resident's responsibility.
There are 6-7 apartments per pod with a common courtyard in the center.
Each pod has their own laundry room and is shared with the residents of that pod.

Pets: Pets are welcome but the owner must be able to manage their pet.
Leash law is in effect for dogs.
Residents are expected to bag their dog's waste.
A $5 fine can be assessed if management notices owner not picking up after their dog.

Guests: Guest apartments are available to family members on a reservation basis.
$65 for a one bedroom cottage
$85 for a two bedroom cottage
- please see Beth Jacobs or Corinne Carrington to reserve a guest cottage.

Delivery: You can request your meal delivered for a $2.00 delivery charge.

Security: We are a gated community. Entrance gate closes by 8:00 p.m., Security guard comes on duty right before 9:00 p.m. and remains until 7:00 a.m. Every resident can purchase a remote for the front gate ($35).

Emergency Response System: Every resident is issued a portable monitor on a pendant or bracelet. This ERS works like a GPS system ***on our campus*** when the alarm button is pushed on the portable monitor. This shows us who has pushed their button and what location they are on the campus.
If you are experiencing chest pains or difficulty breathing, CALL 911 immediately

On 6/7/14 received a call from Rebecca Whitfield stating the Mrs. Parrott fell at some point and she found her with what she thought was a broken him on Friday night around 7pm.

States she fell hanging curtains standing on a rocking chair. She was not wearing her panic alarm. Added that she told EMS she was down since Tuesday.

Came into work to investigate on 6/7/2014

Wednesday Mrs. Watters stated that she received a call from Mrs. Parrott to wish her a happy birthday. Was not signed off by Rebecca on Wednesday 6/4/ 2014 and she stated that she told her mother to make sure she saw her on Thursday. Beth Auld signed her as being seen on the 6/5/14. Called Beth and she was adamant that she would not sign anyone off unless she had seen them.

Mrs. Parrott did not show at Bingo on Friday 6/6/2014 as regular and so her friend Mrs. Watters came to Rebecca Mrs. Parrot's apartment without answer. While Rebecca called Mrs. Watters went to the unit and found her on the floor. 911 was called by Rebecca Whitfield.

Talked with daughter Joan Acosta and she also stated that her sister had called Mrs. Parrott without answer since Tuesday. The family never called here for us to check on her. Explained to the daughter that mother was very private and had personally told me on at least one occasion that she did not want anyone in her apartment.

Cousin Carrington
6/7/14

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THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

Appeal from Charleston County
Court of Common Pleas

Bentley D. Price, Circuit Court Judge

Circuit Court Case No. 2016-CP-10-05379

The Estate of Delila Parrott,

Respondent

v.

Sandpiper Independent and Assisted Living-Delaware, LLC,

Appellant.

NOTICE OF APPEAL

YOUNG CLEMENT RIVERS, LLP
Stephen L. Brown (SC Bar No. 66468)
D. Jay Davis, Jr. (SC Bar No. 12084)
Russell G. Hines (SC Bar No. 72100)
Matthew O. Riddle (SC Bar No. 76650)
25 Calhoun Street, Suite 400 (29401)
P.O. Box 993
Charleston, South Carolina 29402
(843) 720-5488
Attorneys for Appellant

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Other Counsel of Record:

Paul L. Reeves, Esquire (SC Bar No. 4671)
Todd R. Lyle, Esquire (SC Bar No. 102308)
Reeves & Lyle, LLC
P. O. Box 11126
Columbia, SC 29211
(803) 929-0001

and

John G. Boswell, Esquire (SC Bar No. 778)
211 Hawthorne Rd
Raleigh, NC 27605
john.boswell.us@gmail.com

Attorneys for Respondent

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Defendant, Sandpiper Independent and Assisted Living-Delaware, LLC ("Appellant"), hereby appeals the following orders of the Honorable Bentley D. Price, Circuit Court Judge:

- Form 4 Order, filed October 16, 2020
- Order Awarding Judgment in Favor of Plaintiff, filed October 16, 2020
- Order denying Motion to Reconsider, filed November 18, 2020

Copies of the appealed orders are attached hereto and incorporated herein by reference. Appellant received written notice of entry of the most recent order on November 18, 2020.

Respectfully submitted,

YOUNG CLEMENT RIVERS, LLP

By: *s/Stephen L. Brown*

Stephen L. Brown (SC Bar No. 66468)
D. Jay Davis, Jr. (SC Bar No. 12084)
Russell G. Hines (SC Bar No. 72100)
Matthew O. Riddle (SC Bar No. 76650)
25 Calhoun Street, Suite 400 (29401)
P.O. Box 993
Charleston, South Carolina 29402
(843) 720-5488
Attorneys for Appellant

Charleston, South Carolina

Dated: December 17, 2020

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THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

Appeal from Charleston County
Court of Common Pleas

Bentley D. Price, Circuit Court Judge

Appellate Case No. 2020-
Circuit Court Case No. 2016-CP-10-05379

The Estate of Delila Parrott,

Respondent

v.

Sandpiper Independent and Assisted Living-Delaware, LLC,

PROOF OF SERVICE

YOUNG CLEMENT RIVERS, LLP
Stephen L. Brown (SC Bar No. 66468)
D. Jay Davis, Jr. (SC Bar No. 12084)
Russell G. Hines (SC Bar No. 72100)
Matthew O. Riddle (SC Bar No. 76650)
25 Calhoun Street, Suite 400 (29401)
P.O. Box 993
Charleston, South Carolina 29402
(843) 720-5488
Attorneys for Appellant

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I, Stephen L. Brown, of Young Clement Rivers, LLP, counsel for the Appellant above named, do hereby certify that I have served **NOTICE OF APPEAL** on the above-named Respondent by depositing a copy of the same in the United States Mail, postage prepaid, on December 17, 2020, addressed as follows to Respondent's counsel (as well as via email to paul@reevesandlyle.com, todd@reevesandlyle.com, and john.boswell.us@gmail.com, see attached copy of the sent email):

Paul L. Reeves, Esquire
Todd R. Lyle, Esquire
Reeves & Lyle, LLC
P. O. Box 11126
Columbia, SC 29211

and

John G. Boswell, Esquire
211 Hawthorne Rd
Raleigh, NC 27605

Attorneys for Respondent

I further certify that a copy of this **NOTICE OF APPEAL** is this day, December 17, 2020, being E-filed with the lower court (which will also, i.e., in addition to service by mail, effect service of this notice electronically on counsel of record for all parties to this matter).

YOUNG CLEMENT RIVERS, LLP

By: *s/Stephen L. Brown*
Stephen L. Brown
Attorneys for Appellant

Charleston, South Carolina

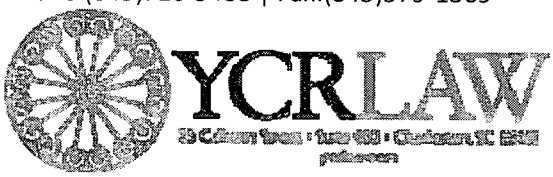
Dated: December 17, 2020

Bell, Pollyana (Polly)

From: Bell, Pollyana (Polly)
Sent: Thursday, December 17, 2020 1:36 PM
To: 'Paul@ReevesandLyle.com'; 'jennifer@reevesandlyle.com'; 'john.boswell.us@gmail.com'; 'todd@reevesandlyle.com'
Cc: 'Stephen Brown (sbrown@ycrlaw.com)'; Hines, Russell; Justman, Aimee
Subject: The Estate of Delila Parrott v. Sandpiper Appeal; 2016-CP-10-5379
Attachments: Filed 10-16-20- Form 4 Order Ending Case.PDF; Filed 10-16-20- Order Parrott matter.PDF; Filed 11-18-20 Order denying MTR.PDF; Notice of Appeal.pdf

Enclosed please find a Notice of Appeal and the documents referenced therein in the above-referenced matter. These are being electronically filed and mailed out today.

Thank you,
Pollyana Bell
Project Assistant
Commercial Litigation Practice Group
Phone:(843)720-5488 | Fax:(843)579-1369



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Certificate of Counsel

The undersigned counsel for Appellant certifies that, in accordance with Rule 210(c), SCACR, this **Record on Appeal** contains all material proposed to be included by any party that was presented to the lower court and not any other material. The undersigned also certifies that this **Record on Appeal** complies with the Supreme Court of South Carolina's Revised Order Concerning Personal Identifying Information and Other Sensitive Information in Appellate Court Filings issued April 15, 2014.

Respectfully submitted,

CLEMENT RIVERS, LLP

By: _____

Stephen L. Brown (SC Bar No. 66468)
Russell G. Hines (SC Bar No. 72100)
25 Calhoun Street, Suite 400
Charleston, South Carolina 29401
P.O. Box 993 (29402)
(843) 720-5488

Attorneys for Appellant

Charleston, South Carolina

Dated: 1-12-2022