MarGin will deliver only the highest quality

Paralegal Nurse Consulting services to our clients.

Profitably, if we are able;

At a loss if we must;

Only the highest quality product will reach our clients.

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Legal Nurse Consulting Services:

- Secure medical record retrieval and document transfer;
- Organize medical records by type with Bates stamping where required for easy reference;
- Identify potential issues of tampering with the medical records;
- Interpret and Summarize relevant medical records;
- Prepare a detailed chronology of the events recorded in the matter;
- Screen cases for merit, including both a nursing and at least two qualified medical expert opinions;
- Evaluate case economics;
- Identify, summarize, and interpret standard of care issues across professions;
- Identify causation issues for medical review;
- Search for and screen testifying experts;
- Fully vet opposing experts, including reports of disciplinary actions, license restrictions, litigation and testimony history, nationwide civil or criminal proceedings as party, and motor vehicle records;
- Healthcare facility demographic and financial analysis;
- Assess damages/injuries and identify contributing factors;
- Identify and recommend potential defendants;
- Develop oral and written reports for the attorney.

Paralegal and Office Management Services:

- Telephonic client intake.
- Shepardized legal research, both general and medical/healthcare related case law;
- Expert witness location and vetting;
- Drafting documents ready for in-house paralegal completion:
    - Expert witness location and vetting;
    - Petitions/complaints, responses/answers;
    - Motions;
    - Questions outlined for Depositions;
    - Interrogatories per local rules;
    - Subpoenas;
    - Correspondence;
- Deposition summaries.

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Detailed Medical Record Review

1) **Chronology and Nursing Summary to include:**
   a) Categorization and sorting of medical records;
   b) Identification of missing and incomplete records;
      i) A detailed list of missing records, including their importance to case evaluation is produced and identifies records by type, provider, and date;
      ii) Document review captures provider name, date of service, next appointment, medical bills and gaps in treatment which are matched against provided records;
   c) Search for documents common to case type;
   d) Identification of suspect records;
   e) Detailed Chronology of events;
   f) Extraction and logging of duplicate records;
   g) Medication review for indications/contraindications/interactions;
   h) Highlighting and linking (in Adobe Acrobat product) of potentially significant medical information related to litigation;
   i) Comprehensive nursing summary of record.
2) **Causation Evaluation to include:**
   a) Chronology with comprehensive nursing summary billed separately as above, if needed;
   b) Review of record from perspective of torts with focus on the elements of torts;
   c) Critical issues related to potential case strengths and weaknesses are identified and discussed;
      i) MarGin reviews records from a party neutral position to ensure capture of all relevant information supporting or refuting clients' position;
   d) Annotated medical literature provided with links to chronology/timeline;
   e) Draft of Demand Letter in meritorious matters for attorney review.
3) **MarGin will, upon request; submit the client's case summary to at least two qualified experts for review:**

a) This option represents an opportunity to have a qualified medical opinion produced in conjunction with a chronology/timeline and nursing summary prepared to identify breaches in medical, nursing, and allied health professions and avoid the cost of a comprehensive Causation Evaluation in cases where malpractice is not otherwise apparent.

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MEMORANDUM

TO: Attorney of Record
FROM: Martin A. Ginsburg, RN, LNC
SUBJECT: Wrongful Death – Compressive Asphyxia
DATE: 09NOV15

Mr. Attorney,

Per your instructions and at your request; this memorandum is a summary of the information contained in the Medical Examiner's report, defense witness depositions and their correlation to the discussions with your expert witness preparatory to the witness' deposition.

As you mentioned in our initial discussion of this tragic case, this matter presented substantial challenges related to identifying on-point research available. As your expert has noted, there is little quality research information available, owing to the nature of the manner of death in this case.

Your expert has indicated that the mechanism of injury in this matter is similar to strangulation. I would caution in the strongest terms against permitting that analogy to be proffered by the expert. The rationale for this admonishment is as follows:

1. Strangulation occurs when either or both of blood flow or air flow are disrupted in the region of the neck:
   1.1. In the case of air flow disruption, blood flow disruption is frequently concurrent;
   1.2. With blood flow disruption – nearly universal in strangulations – there is no more than 9 seconds of consciousness following application of strangulation pressures.
2. Compressive asphyxia, as described in the Medical Examiner's findings, is not analogous to strangulation:

2.1. Compression of the thoracic (chest) cavity results in a progressive decrease in tidal volumes (air breathed in);

2.2. This progressive decrease in volume results, after time, in a lack of sufficient air movement to sustain life;

2.3. Compressive asphyxia is the manner of death applied by reptiles such as snakes known as constrictors;

2.3.1. This includes boa constrictors, corn snakes, rat snakes, and anacondas;

3. While strangulation typically results in near immediate unconsciousness and little suffering, compressive asphyxia can take several minutes to render a victim unconscious while recognizing throughout this protracted process that death is both certain and imminent.

The fear, anxiety, panic, and pain of such a manner of death ought be highlighted by your expert.

I have included as attachments the two chapters from the most definitive text on the subject I have encountered and highlighted the relevant portions to review with your expert. I feel confident that when presented with the descriptions of differentiation your expert will agree that this argument will better serve your client's interests.

Additionally, in reviewing the deposition transcripts of the two witnesses I find the linguistic nuance of that testimony troubling. While I recognize that an attorney may suggest phrasing or otherwise "coach" a witness when seeking a description, the terminology used is not one generally seen in regular use – it is reserved for persuasive speech settings or dialogue in a script. This scripting is troubling not only in that the description may not fully comport with the witnessed events or opinions at the time but that, as has been widely recognized in both criminal and civil courts, this scripted response may have overcome and supplanted the witness' memory of events.

Specifically the phrase "looked right through me" is one not heard in conversational settings but, rather, in scripted speech. If this is simply a case of mimicry it may be overcome during later examinations of these witnesses. If, however, this is

“coached” testimony that has already degraded the witness’ ability to independently recall events, that issue is one solely within your purview and for which I have no recommendation likely to be of assistance.

Understanding that this review is preparatory to a deposition and time is short; it would likely be helpful to secure a full and detailed review of the complete record, including video captured at the scene by security cameras as well as EMS run records to better delineate time frames for onset of injury to loss of consciousness, the critical argument you have identified. Despite the added time required, more detail is likely to support this cause of action. If seasonal supplementation is appropriate, such a summary – including medical literature review for future implications – may be of benefit.

Please advise of additional information needed or questions I can answer.

Respectfully,

Martin A. Ginsburg, RN, LNC
Paralegal

Enc: CH 14 Textbook on Mechanics of Death in Trauma
CH 17 Textbook on Mechanics of Death in Trauma

MEMORANDUM

TO: Attorney of Record
FROM: Martin A. Ginsburg, RN, LNC
SUBJECT: Requested Select Medical Record Review and Summary
DATE: 07OCT14

Mr. Attorney,

Per your instructions and at your request, this memorandum is a summary of injuries, treatments, consults, and potential future medical concerns related to the motor vehicle crash of 07JUN10 injuring your client.

WakeMed admitted Ms. Client with diagnoses of:

1. Sigmoid colon injury – this is the "S" shaped portion of the large bowel connecting the colon to the rectum;
2. Rent in small bowel mesentery – a fold of membranous tissue that arises from the posterior wall of the attaching to the intestinal tract. Within it are the arteries and veins that supply the intestine;
3. Cecal serosal tears – The cecum is the connecting point between the small and large bowels and the point from which the appendix arises. Serosal tissue connects and contacts only internal body structures with no natural path to the external environment;
4. Large abdominal wound traumatic hernia with defect – Abdominal hernias are protrusions through muscle by a portion of the intestine. This repair required placement of a mesh device to permit healing;
5. Right upper extremity fracture – The right forearm suffered a complex comminuted fracture where the bones of the forearm broke into multiple pieces with the remaining shafts protruding through the skin;

6. Right knee laceration – A traumatic cutting of the skin that in this situation was approximately 5.5 inches in length requiring irrigation and complex repair;

Surgical intervention was required to affect repairs of the injuries Ms. Client sustained in the crash. Rehabilitative treatment was ordered to increase the likelihood of a return to baseline. An infection required additional surgery and led to a delay in the rehabilitative process. The following are interventions required by injuries sustained in the collision and recovery:

1. Sigmoid colon – Exploratory laparotomy where the abdomen is opened from the area just below the breast bone to just above the pelvic bone (epigastric to symphysis pubis) – the sigmoid colon had a near perforation with an injury to the mesentery. This required a portion of the mesentery to be drawn over the injured area and stapled in place;
2. Rent in small bowel mesentery – a fold of membranous tissue that arises from the posterior wall of the peritoneal cavity and attaches to the intestinal tract. Within it are the arteries and veins that supply the intestine which suffered a small arterial tear requiring sutures;
3. Cecal serosal tears – Two separate areas of the cecum were found to have suffered injury and were repaired with sutures;
4. Large abdominal wound traumatic hernia with defect – The abdomen from the groin on both sides to the umbilicus (belly button) was degloved. This is a separation of the skin from the underlying tissue much like peeling a banana skin away from the banana or skin in a stubbed toe. The intestine that protruded through the injured muscle under the skin twisted and was drawn back into the abdomen and repositioned. A mesh screen to support the muscle as it heals from this injury was placed;
5. Right upper extremity fracture – In a detailed surgery the bone protruding from the right forearm was debrided, the skin wound was extended to permit access to the area and the radius and ulna were returned to an

anatomically correct position and secured in place with a plate and multiple screws. The wound was then sutured for closure;

6. Right knee laceration – A 5.5" slicing wound to the right knee was debrided and inspected before being closed with sutures;
7. Wound infection – Drainage coupled with increased temperature and white blood cell count led Ms. Client to be readmitted to WakeMed from the rehabilitation facility. She was found to have an active infection suspicious for an abnormal opening between her bowel and skin (enterocutaneous fistula) because of foul smelling pus (purulent drainage). The left groin wound was re-opened and drainage was noted from the midline. The midline incision was re-opened and abdominal contents were expressed. The wounds were irrigated and in the operating room and cleaning continued with wet-to-dry dressings over several days. A negative pressure wound closure device was used to assist in wound healing.

Medical consultations included trauma, orthopaedic, infectious disease, and rehabilitation physicians. Physical, occupational therapists were both likely consulted during rehabilitation. Upon readmission to WakeMed for her second surgery Ms. Client was still in need of substantial assistance with activities of daily living including; bed mobility, transfers (bed to chair), ambulating distances of 100 feet, and requiring standby assistance for safety.

Infection is a known complication of surgery despite the best of efforts to reduce the risk. Adhesions anywhere along the bowel or between the bowel and the mesh used to secure the herniated bowel in place are potential complications, though the further out from surgery, the risks become less definable. There is insufficient information in the provided records allowing an estimation of level of function after completion of all interventions.

Understanding that this review is preparatory to a discovery response and time is short; it would likely be helpful to secure a full and detailed review of the complete

record to better estimate likely long-term effects of this trauma. Despite the added time required, more detail is likely to support this cause of action. If seasonal supplementation is appropriate, such a summary – including medical literature review for future implications – may be of benefit.

Please advise of additional information needed or questions I can answer.

Respectfully,

Martin A. Ginsburg, RN, LNC
Paralegal

MEMORANDUM

TO: Janet Simpson
FROM: Martin A. Ginsburg, RN, LNC
SUBJECT: Requested Medical Chronology with supplements
CLIENT: Michael Biggs Law, P.C.
DOCKET: 15-254-0857
DATE: 02OCT15

Ms. Simpson,

Per your instructions and at your request, this memorandum is a summary of the medical record chronology developed to address concerns and issues in the matter of Michael Biggs Law client Mr. Robert Seeger.

Mr. Seeger was hospitalized 09/22/2014 through 10/08/2014 and treated for sepsis secondary to Acute Respiratory Distress Syndrome (ARDS). Statewide Regional Medical Center (SWRMC) admitted Mr. Seeger with diagnoses of:

1. Probable Bacterial healthcare-associated pneumonia, procalcitonin pending;
2. Severe sepsis;
3. Metabolic encephalopathy, "improving with bi-level positive airway pressure and fluid resuscitation";
4. Probable diabetes, unknown control. A1c pending;
5. Hypertension;
6. Bipolar disorder with anxiety;
7. Leukocytosis;
8. Chronic pain syndrome;
9. Abdominal pain;
10. Lactic acidosis secondary to acute illness;
11. Known coronary artery disease (CAD);
12. Obesity;
13. Probable chronic obstructive pulmonary disease (COPD). No pulmonary function testing available in the computer;
14. Chronic diastolic congestive heart failure with most recent echocardiogram on August 4, 2014;
15. Acute respiratory failure.

Mr. Seeger was admitted to the Intensive Care Unit (ICU) for close monitoring with a belief that despite his improvement with non-invasive ventilator support he might require more intrusive intervention. Mr. Seeger was subsequently intubated by Respiratory Therapy on 09/23/2014 at 0630. At this point sedation and restraints, common protocol in many hospitals for both patient comfort and safety, were initiated.

It was the declining condition of Mr. Seeger leading to invasive ventilatory support, sedation, and restraint use for safety that combined to create what is sometimes referred to as a "perfect storm" of risk factors for pressure ulcer and heralded the need for strict adherence to best practices to prevent skin wounds. Patients in this situation require their caregivers to anticipate needs, be vigilant for signs of unmet needs and exercise due diligence in executing necessary interventions to prevent patient injury.

"Never Events", as they are frequently referred to by healthcare professionals; including pressure ulcers, are sometimes thought of as res ipsa loquitor evidence of negligence; this is not always the case. The Centers for Medicare and Medicaid Services (CMS) more accurately terms these "never events" "Serious Reportable Events" (SRE) and considers these events in reimbursement decisions. Concurring with the Institute of Medicine recommendation for better and greater reporting of healthcare associated adverse events and errors, the Federal Government's Quality Interagency Coordination Committee requested National Quality Forum (NQF) to promulgate a standardized listing of serious adverse events to enhance the accuracy and detail of available information related to preventable illness and injury associated with healthcare delivery.

In Mr. Seeger's case, inadequate, insufficient, inaccurate, and sometimes conflicting documentation leave little room for a presumption of unavoidability. The chronology details the flaws in the documentation and omissions therein. The medical records reflect that a pressure relieving mattress was not ordered until approximately 72 hours after the initiation of sedation and restraints. Skin frequently documented as dry or cracked lacks documentation of interventions. There are approximately five identified wound site specifically referred to as ulcerations without explanation of documentation errors found in the record. If these were not documentation error, there

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is no documentation of interventions undertaken to address these additional wounds. In fact, the wounds are not universally documented by any one provider; this is the basis for a suspicion the documentation is erroneous, rather than lacking.

After discontinuation of restraints and sedation there are identified several lapses in the standard of care for Mr. Seeger. Following discharge from SWRMC Mr. Seeger was admitted to Local Center Health and Rehabilitation (LCHR). During this admission there continued inadequate and errant documentation of wound assessment and care with the wound subsequently deteriorating until bone was exposed and requiring surgical repair of what is widely recognized as a preventable condition.

During the course of rehabilitation at LCHR, despite a specific medical order for both bed and chair pressure relief/reduction surfaces, Mr. Seeger was not provided pressure relief/reduction surfaces for chair and was provided an "air mattress" for her sleep surface. Air mattresses are not generally specifically designed as pressure relieving or reducing surfaces and are not interchangeable with such a surface as bariatric bed surfaces most frequently employ alternating pressure low-loss capabilities not found in conventional air mattresses. Therapeutic surfaces for beds vary widely in features but all share some common traits, among which are; low air loss; pressure control zones; surface material; and alternating pressure, among others. These are not available in what many frequently refer to as "air mattresses". For this reason, documentation of a particular surface and its settings, if appropriate, are critical to understanding wound development and efficacy of prevention or corrective measures.

Pressure related wounds are a known and preventable risk of hospitalization, especially in patients with co-morbid conditions related to tissue perfusion, such as coronary artery disease, diabetes, or systemic infections. Added to these underlying factors; the need for mechanical ventilation and sedation, risk increases significantly. Risk factors and risk reduction strategies are well documented and widely known.

Implementation of appropriate preventive strategies in a timely manner is essential in the prevention of pressure related wounds in patients during enforced bed rest. There is a duty of care that in this case was breached; leading inexorably to the

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formation of the wounds suffered by Mr. Seeger. While these injuries cause patients appreciable pain until fully resolved the psychological toll on a patient affected by physical de-conditioning and pain would be immeasurable. This suffering could only be exacerbated in one suffering underlying mental health issues where chronic or enduring acute pain is an aggravating factor for that underlying illness.

While there are contributing factors to the risk for pressure ulcer, such as; obesity, diabetes mellitus (Type II), coronary artery disease, hypertension, and malnutrition, these are better seen as pre-disposing in the context of law. This being so, and with no other information available, I see no mitigating or militating factors from the record reviewed.

Thank you for your confidence in MarGin and permitting us to be of service in this rather complex matter. As we discussed via telephone 10/01/2015 I will hand deliver hard copies and the electronic files for this matter to your office in the coming week.

Please advise of additional information needed or questions I can answer.

Respectfully,

Martin A. Ginsburg, RN, LNC
Paralegal Nurse Consultant

MEMORANDUM

TO: Attorney of Record
FROM: Martin A. Ginsburg, RN, LNC
SUBJECT: Closed Head Injury Sequelae Review
DATE: 05OCT15

Mr. Attorney,

Per your instructions and at your request, this memorandum is a summary of information noted during a perusal of available records relating to your client including; injuries, treatments, consultations and evaluations, and potential future medical concerns related to the motor vehicle crash of 20AUG11 injuring your client.

WakeMed admitted Mrs. Client with diagnoses of:

1. Closed head injury with severe concussive symptoms
2. C6 spinous process fracture

Surgical intervention was not required to repair a non-displaced (or minimally displaced) vertebral spinous process fracture as this fracture did not threaten the spinal cord and is routinely managed without surgical intervention and has an excellent prognosis for full recovery.

The client completed all recommended therapies and is reported to suffer no residual effect related to this fracture.

During deposition the client reported anxiety related to stress, including while a passenger in or operator of a motor vehicle. This seems to have substantially resolved, though that is not entirely clear from the records available. If resolved the issue is one of emotional distress in the past and therefore, despite its relevance to this cause of action, it is moot in this review. If not fully resolved the presentation may be akin to that of post-traumatic stress disorder and necessitate further medical or psychological intervention. This would present a troubling time for the client and her family as well as a difficult to assess cost burden for that course of treatment.

Mrs. Client's closed head injury, however, presents a greater challenge to adequately summarize or predict with certainty its impact on her life.

The client underwent a number of neuropsychological tests used to assess, among other things, cognition. This testing indicated no statistically significant deviation from normal findings across a range of cognitive skills. Memory was also tested, including working memory (sometimes referred to as "immediate memory") and no statistically significant deviations from the norm were identified.

Please note that all findings reported are reported as "within expected range"; "no statistically significant deviation from normal values (or the norm)"; or that performance during testing failed to indicate below "average" or "normal" ranges. This phrasing is significant in the Mrs. Client's baseline test results cannot be known and, therefore the impact on her performance cannot be assessed. As mentioned to your associate attorney; a severe concussive event may result in an intellect equivalent to Albert Einstein's to post-trauma test within normal or expected ranges. It is impossible to know pre-event performance in the absence of the test having been conducted.

The significance here is that Mrs. Client's reported losses, while testing within expected ranges are not entirely possible to estimate. Extrapolation based upon the information provided by co-workers and her supervisor are the only evidence included in the shared materials that demonstrate a substantial degradation in her baseline abilities.

Of concern in this client is mathematical calculation ability. A discrete sub- function of other cognitive and executive capacities, this is reported by Mrs. Client to have not returned to baseline. In fact; Mrs. Client reports using memory aids to complete tasks more slowly than prior to the crash as well as difficulty with. While this client, whose pre-morbid capacities are reported to have been above average across myriad fields of intellection, may not show signs of significant impairment following her trauma, the comparison to norms may now show all internal changes.

The Wechsler Test of Adult Reading is designed to assist in assessing a patient's pre-morbid cognitive abilities. This test does not demonstrate but, rather estimates, capabilities prior to a trauma such as the one sustained in this crash. This estimate is the basis for degrees of change reported following testing.

Test results such as those reported in this case, less than three months post-crash, are highly encouraging and show a patient progressing well toward potentially full recovery. The detail of investigation available allows a reviewer to recognize both the severity of the initial injury as well as the breadth of recovery accomplished even at the early stage of

October 2011.

With the exception of calculation ability which in this client may prove significant, owing to the complexity of her employment situation, there are no long term deficits identified. Further; in the absence of a diagnosed or imaged organic or structural brain injury I am unable to identify additional ongoing adverse effects of this injury.

The interesting thing related to difficulty with mathematical calculation is that my preliminary search has yielded at least some reports relating this particular function to the left hemisphere of the brain. Coincidentally, the receptive and expressive language functions of the brain are also in the left hemisphere. This will require a more investigation to fully explore the potential and may not overcome a cost/benefit inspection given the nature of the ongoing reported deficit.

I am attaching the deposition summary you were kind enough to share with comments and mark-ups of both the summary and the neuropsychology reports from October 2011.

Understanding that this review is preparatory to a discovery phase and further insights are required to fully address this issue MarGin will submit our full review not later than close of business Monday 12OCT15.

Please advise of additional information needed or questions I can answer.

Respectfully,

Martin A. Ginsburg, RN, LNC
Paralegal Nurse Consultant

PHYSICIAN

Source:	Mississippi State Board of Medical Licensure, NEWSLETTER
Issue:	Vol. 9, No. 4; Winter 2013; Downloaded from: www.msbml.state.ms.us/newsletters/
Name:	
Title:	M.D.
License #:	
Provider Type:	M.D.
Provider Cat.:	PHYSICIANS/SURGEONS & PHYSICIAN ASSISTANTS
City:	Starkville
State:	MS
Findings:	due to conviction of a felony or misdemeanor involving moral turpitude, to wit, arson.
Action:	ACTIONS BY THE BOARD: April 1, 2012 through December 31, 2013: License revoked; Action August 20, 2013.
Licensing State:	MS
Reporting State:	MS
Authority:	Mississippi State Board of Medical Licensure
Run Date:	12/31/2013
Note 2:	Mississippi State Board of Licensure, 1867 Crane Ridge Drive, Suite 200-B, Jackson, MS 39216; Post Office Box 9268, Jackson, MS 39286-9268; Phone: (601) 987-3079, Fax: (601) 987-4159; Website: www.msbml.state.ms.us/

CHIROPRACTOR

Source:	Kansas State Board of Healing Arts - Board Actions
Name:	
Title:	DC
License:	
Provider	DC
Provider Category:	CHIROPRACTIC MEDICINE
City:	Garden City
State:	KS
Action:	Fine; Action Date: 02-15-14
Licensing	KS
Reporting State:	KS
Authority:	Kansas State Board of Healing Arts
Run Date:	02/15/2014
Note 1:	Kansas State Board of Healing Arts, 235 S. Topeka Boulevard, Topeka,
Note 2:	PLEASE NOTE: The Run Date is set to correspond with the date the action was taken.

NURSE

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Source:	DHHS Office of Inspector General; 2013 LIST OF EXCLUDED INDIVIDUALS/ENTITIES
Issue:	Reinstatement Actions Downloaded From: http://oig.hhs.gov/fraud/exclusions/database.html#1
Name:	
Birth Date:	
Provider Type:	GENERAL: HOSPITAL ; SPECIALTY: EMPLOYEE
Provider Cat.:	NURSING
Address:	aaaaaaaaaaaaaaaaaaaaaaaaaaaaaa
City:	CAPE CORAL
State:	FL
Zip:	33904
Action Code:	1128a1
Action:	REINSTATEMENT: 1128(a)(1) Conviction of program-related crimes. Minimum Period: 5 years
Effective Start:	06/06/2008
Reinstate Date:	05/07/2013
Reporting State:	US
Authority:	DHHS Office of Inspector General
Run Date:	06/01/2013
Note 1:	The OIG imposes exclusions under the authority of sections 1128 and 1156 of the Social Security Act.
Note 2:	PLEASE NOTE: The Provider_Num field contains the UPIN as reported by the Office of Inspector. Also, the Provider_Type field contains two items. The first description, 'GENERAL', is the basic subject type. The second description, called 'SPECIALTY', is more specific. For example, if 'HOSPITAL' is listed as 'GENERAL' and 'NURSE/NURSE AIDE' is listed as the 'SPECIALTY', the excluded individual was a nurse or nurse aide in a

HOSPITAL

Source:	New Jersey Department of Health and Senior Services, Hospital Fines & Enforcement Actions
Issue:	As of September 30, 2011; From: www.state.nj.us/health/hcsa/hospfines/summaries.htm
Organization:	
Provider Cat.:	HOSPITALS/CLINICS
Address:	
City:	Montclair
Zip:	07043
Findings:	Failure to implement an appropriate complaint procedure for patients. Inaccurate/incomplete medical record. Failure to decontaminate and sterilize equipment used in patient care. Inappropriate cleaning of reusable patient care items. Inadequate review by infection control committee of salaries and procedures for decontamination, disinfection, sterilization, and handling of waste materials. Inadequate equipment for waste drainage. Inadequate building maintenance policies and procedures; inadequate preventive maintenance program. Failure to employ appropriate patient discharge criteria. Inadequate preoperative checklist prior to surgery. Lacking Quality Assurance program for Same Day Surgery. No formal program to monitor infections after discharge from ambulatory care. Based on: March 17, 2011 visit to conduct a complaint investigation.
Action:	Enforcement Date: August 10, 2011; Enforcement Action: $40,500; Issue: 21 various violations; Hospital's Plan of Correction: Corrective actions outlined in a plan accepted by the Department on September 5, 2011; Hospital Appeal Status: $40,400 fine paid in full on September 10, 2001.
Licensing State:	NJ
Reporting State:	NJ
Authority:	New Jersey Department of Health and Senior Services
Run Date:	09/30/2011
Note 1:	New Jersey Department of Health and Senior Services, P.O. Box 360, John Fitch Plaza, Trenton, NJ 08625-0360; Phone: (609) 292-7837, Fax: (609) 292-0053, Website: http://www.state.nj.us/health/hcsa/hospfines/hfines.htm
Note 2:	Enforcement Actions: The information that follows on state licensure inspections and complaint investigations during the past 15 months is in summary form and has been taken from penalty letters sent by the department to each hospital fined. The violations cited here are ones

	hospital.
Note 3:	CONTACT US: There are several ways you can contact the Office of Inspector General at the Department of Health and Human Services: By Phone: 202 619-1343, By Fax: 202 260-8512, By E-Mail: eaffairs@os.dhhs.gov, By Mail: Office of Inspector General, Office of Public Affairs, Department of Health and Human Services, Room 5541 Cohen Building, 330 Independence Avenue, S.W., Washington, D.C. 20201. OTHER INFORMATION: If you have questions about or need to request specific OIG information, please contact the OIG Executive Secretariat at esec@os.dhhs.gov. TO OBTAIN DOCUMENTATION ON EXCLUDED INDIVIDUALS OR ENTITIES: If you have verified the identity of an excluded party and are seeking documentation of this action, you may submit a written request to the address listed above. Your request should include a copy of the LEIE page identifying the individual or entity. Requests without this information from the LEIE will be returned. In most instances, the only documentation available will be the exclusion notice, which notifies the party of the exclusion, its effect and information concerning appeal rights. It does not contain specific details regarding the basis for the exclusion. If the excluded party has been reinstated, that notice may also be available. We recommend contacting an excluded individual or entity for additional information concerning any of these actions.

MEDICAL CHRONOLOGY

Overview and Usage Guides:

Brief Summary/Flow of Events:
In the beginning of the chronology, a Brief Summary/Flow of Events outlining significant medical events is provided which gives general picture of the focus points in the case.

Patient History:
Details related to the patient's past history (medical, surgical, social and family history) present in the medical records.

Detailed Medical Chronology:
Information captured "as it is" in the medical records without alteration of the meaning. Type of information captured (all details/zoom-out model and relevant details/zoom-in model) is per the demands of the case elaborated under 'Specific Instructions'

Reviewer's Comments:
Comments on contradictory information and misinterpretations in the medical record, illegible handwritten notes, missing records, clarifications needed etc. are given in bold italics and red font color and will appear as **** Reviewer's Comment.*** *Definitions of medical terminology are available as pop-up balloon text over blue font color and appear as* definition. *In situ commentary is also displayed in blue font color and is further bolded appearing as* **Reviewer inline commentary.**

Illegible Dates: *Illegible and missing dates are presented as "00/00/0000"(mm/dd/yyyy format)*

Illegible Notes: *Illegible handwritten notes are left as a blank space "_____" with a note as "Illegible Notes" in the heading of the particular consultation/report.*

Specific Instructions:

Prior records:
The prior records are reviewed and the skin condition alone was included if there are any predisposing factors for pressure ulcer.

09/22/2014-10/17/2014:
During this time period the records are summarized in detail to show co-morbid conditions, pressure ulcer prevention protocol followed, daily shift/skin assessments, pressure ulcer evaluation and its management. The details pertinent to other medical conditions are included in brief.

10/17/2014-04/02/2015:
During this time period the records are summarized in detail to show the treatment and progress of the pressure ulcer, including detailed physician progress notes and wound assessments with treatment. The details pertinent to other medical conditions are included in brief. The rehab records are included in brief to show the continued complications and suffering. Only the records which contain the wound details are elaborated; other hospitalization and rehab records are not included in the chronology.

If the name or signature of the provider is not decipherable, an image is captured and included in place or the provider's name in the chronology.

For ease of reference the treatment records are presented in snapshot.

Brief Summary/Flow of Events

09/22/2014-10/08/2014

Hospitalization for Acute Respiratory Distress Syndrome (ARDS)

09/22/2014: Presented with symptoms of sepsis – Intubated – Skin intact and warm – Started on Levaquin and Cefepime

09/23/2014: Braden scale 14/23 – Bilateral heels dry and scaly – Mepilex border ordered

09/26/2014: Sacral **stage I** pressure ulcer – Bariatric bed ordered – Mepilex dressing ordered

09/27/2014: Braden scale 11/23

09/28/2014: Dressing removed – Skin noted to be boggy, dark purple with broken fluid filled blisters – Area cleansed and large Mepilex applied

10/01/2014: Sacral ulcer **stage III** – Broken blister with serous drainage Mepilex border applied

10/02/2014: Mepilex replaced

From 10/03/2014 to 10/08/2014 wound details are not available for review.

10/08/2014: Discharged to rehab

* *

10/08/2014-10/17/2014

Rehabilitation stay status post respiratory failure

10/08/2014: 10 x 8 cm sacral ulcer

10/15/2014: 8.3 x 13.4 x 3.9 cm – Foul purulent with odor – Ordered **Dakin's** wet to dry dressing twice daily

10/8/2014-10/17/2014: On wound care as ordered

10/17/2014: Planned to send to Statewide for surgical debridement of **sacrococcygeal** decubitus

* *

10/17/2014-10/24/2014

Hospitalization for sacral wound

10/17/2014: Placed on Zosyn –**Stage IV** 21 x 15 x 6 cm – **Plavix** stopped

10/20/2014: 21 x 15 x 9 cm sacral ulcer

10/21/2014: Underwent debridement of sacral decubitus ulcer – **Wound vac** placed

10/24/2014: 9.5 x 13 x 6.6 cm sacral decubitus ulcer – Discharged to rehab

* *

10/24/2014-10/29/2014

Rehabilitation stay for wound management

On wound vac – Transferred to Statewide for bleeding from wound vac

* *

10/29/2014-11/26/2014

Hospitalization for bleeding from wound vac

Wound was managed as ordered – Hemoglobin and hematocrit were corrected – **Nicotine** patch discontinued – Plastic Surgery consulted – Planned for wound closure after 6 weeks as of 11/20/2014 visit – Discharged on home health care

* *

12/06/2014: Wound culture with **MRSA**
01/08/2014: Plastic Surgery office visit – Scheduled OR debridement on 01/16/2015

* * * * * * * * * * * * * * * * * * * *

01/15/2015-02/19/2015
Hospitalization for wound closure
01/16/2015: Underwent sacral soft tissue biopsy for culture – Culture with no growth – Placed on **KinAir bed**
01/23/2015: Underwent bilateral **fasciocutaneous flaps** for closure of sacral ulcer
01/23/2015-02/19/2015: On antibiotics – Wound **dehisced inferiorly** which was packed – Discharged home

* * * * * * * * * * * * * * * * * * * *

02/20/2015-02/27/2015
Hospitalization for wound care – Wound culture with **E. coli**– Placed on antibiotics

* * * * * * * * * * * * * * * * * * * *

03/06/2015-04/02/2015
Hospitalization for depression, suicidal ideation and wound management
On wound care per order - **Wound VAC** discontinued
Discharged to Very Skilled Nursing Facility

* * * * * * * * * * * * * * * * * * * *

Patient History

Past Medical History: Coronary artery disease, chronic obstructive pulmonary disease (COPD), hypertension, diabetes mellitus (Type II), chronic back pain, neuropathy, obesity, allergic rhinitis.

Surgical History: Cardiac catheterization, back operations, multiple fractures left ankle and leg requiring plating.

Family History: Mother had cancer (possibly pancreatic). Two sisters died of lung cancer. Father is diabetic with heart disease.

Social History: Smokes half a pack day as of 08/02/2014. No drugs or alcohol abuse.

Allergy: No known drug allergies.

Detailed Chronology

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
06/23/2012 - 08/03/2014	*Multiple Providers*	**Multiple hospitalizations for abdominal pain and chest pain, office visits for labs and radiographs:** **06/23/2012-06/28/2012:** Hospitalization for perforated appendix. Presented with abdominal pain. Secondary diagnoses include bipolar disorder, depression and other psychiatric issues. *(Ref 4292)* **08/02/2014-08/03/2014:** Hospitalization for atypical chest pain, possibly pleuritic, community acquired pneumonia, chronic obstructive pulmonary disease exacerbation, chronic pain. ***(Ref 4103-4104)*** ****Reviewer's comment: These records reviewed and the skin remained intact without any lesions except for tattoos.***	4100-4426
		Statewide Regional Medical Center	
09/22/2014	David Crosby, M.D.	**Admission for cough, shortness of breath:** She states she had been doing well up until this last week where she has been constantly coughing. She has had productive sputum. Her breathing has been getting steadily worse to the point where most recently she has not been able to use her Continuous Positive Airway Pressure (CPAP) secondary to the cough. She has been kept up all night. She has also noted some belly pain in the middle of her belly, in the epigastrium. She has also noted chills and sweats. She states she has had diarrhea constantly for the last 3 months and has seen her primary for this and a colonoscopy is set up in October. Her shortness of breath is severe in intensity. The patient was seen in Emergency Room (ER) for shortness of breath and initially was minimally responsive. She was placed on Biphasic Positive Airway Pressure (BiPAP) and is now more able to contribute to history, as above. She is referred for admission with chest X-ray consistent with pneumonia by Dr. Martin Short. **Review of systems:** The patient has had chills and sweats, but no noted fevers. Her appetite has been poor. She only eats once a day, she states. She has had some sternal chest pains over the last couple days, but thinks it might be related to the cough. She has had severe cough and shortness of breath. She has had some epigastric and periumbilical abdominal pain. Stable diarrhea. No dysuria, but she notes, "my nuts hurt when I cough". Chronic back pain. Borderline diabetic. **Physical examination:** **Vital signs:** Temperature 101.6, BP 198/86, HR 97, RR 24, O2 saturation 78%. Weight 154.2 kg. **Respiratory:** Decreased breath sounds throughout with prolonged expiratory phase, diffuse expiratory wheezes, bibasilar rales, scattered rhonchi. **Abdomen:** Soft, moderate **periumbilical** pain, but no rebound or guarding, no bruit. Bowel sounds are hypoactive but present. **Extremities:** Warm and dry, 1+ bilateral lower extremity pitting edema. **Skin:** No suspicious rash, palpable nodule or induration. Numerous tattoos.	3332-3335

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Assessment and plan: **A 53-year-oldwhite male:** 1. Probable bacterial healthcare-associated pneumonia, **procalcitonin** pending. 2. Severe sepsis. 3. Metabolic encephalopathy, improving with bi-level positive airway pressure and fluid resuscitation. 4. Probable diabetes, unknown control, **A1C** pending. 5. Hypertension. 6. Bipolar disorder with anxiety. 7. Leukocytosis. 8. Chronic pain syndrome. 9. Abdominal pain. 10. **Lactic acidosis** secondary to acute illness. 11. Known coronary artery disease. 12. Obesity. 13. Probable chronic obstructive pulmonary disease. No pulmonary function testing available in the computer. 14. Chronic diastolic congestive heart failure with most recent echocardiogram on August 4, 2014, showing an Ejection Fraction (EF) of 50% to 55% and a normal Right Ventricular Systolic Pressure (RVSP). No significant valvular abnormalities. 15. Acute respiratory failure. **Plan:** The patient's breathing remains tenuous and she may need intubation. She remains in critical condition. We will treat her as a healthcare-associated bacterial pneumonia given her recent hospitalization here 6 weeks ago. She will be placed on Levaquin and Cefepime, as there has been some influenza in the area. We will also add a rapid influenza swab, sputum culture, blood culture, Legionella. With her abdominal pains, I suspect that this may be related to her cough; however, her lactate is fairly elevated, and we will obtain a CT scan renal stone protocol. Okay Oxycodone orally for pain relief. We will monitor accu-checks and with her probable diabetes, check a Thyroid Stimulating Hormone (TSH) and A1C. Use nicotine patch for withdrawal and provide smoking cessation education. We will use Lovenox and sequential compression devices for deep venous thrombosis prophylaxis. As the patient normally uses continuous positive airway pressure at home, we will continue noninvasive ventilator support, but here bi-level positive airway pressure. Check a **procalcitonin** tonight and in the morning and monitor serial lactates with her sepsis. We will aggressively fluid resuscitate. **Addendum:** The patient's procalcitonin has now returned back and is less than 0.05. Her influenza swab has also returned negative. Her lactic acid is improving, down to 2.5, possible viral pneumonia. For now, we will continue her current antibiotics and we will consult Pulmonology in the morning. She continues to have the severe cough and codeine cough syrup is being added as well.	
09/22/2014	Beth W. Davis, R.N.	**Positioning assessment:**	3476

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Date **Time** **Observation** **09/22/2014** 2235 hrs Independent	
09/22/2014		**Labs:** **High:** Lactate (2.5-4.7), White Blood Cells (WBC) (17.6), Red Blood Cells (RBC) (4.47), Hemoglobin (13.9), Hematocrit (40.9)	3349, 3353
09/23/2014	Angela Kennedy, M.D.	**Consultation for severe acute respiratory distress syndrome and likely healthcare-associated pneumonia:** *History reviewed.* **Physical examination:** **Vital signs:** Temperature 100.6, heart rate 74-129, BP 93-154/48-87. Ins and outs: 449 in, 1290 out. **Neurologic:** Intubated and sedated. Currently on Propofol at 45 mcg per hour and Fentanyl at 50 mcg per hour. The patient still opens her eyes to voice and becomes extremely tachypneic. No focal deficits appreciated. **Respiratory:** Coarse breath sounds bilaterally. **Plan:** **Neurologic:** The patient is quite agitated at times. We will attempt to keep her comfortable while on the ventilator. Have recommended as needed Versed usage between when agitated with Propofol. Additionally, we will increase analgesia to 100 mcg per hour. **Cardiovascular:** Currently, no acute issues. Appears to be well-resuscitated, her lactate has cleared and she has good urine output. Echocardiogram performed today showed good cardiac function with an ejection fraction of 50% to 55%. We will continue to monitor, likely hold blood pressure medications as long as she is on Propofol, secondary to hypotensive effects of Propofol. **Pulmonary:** Likely healthcare-associated pneumonia. She does have an elevated white blood cell count on admission as well as a cough with productive sputum. Given her recent hospitalization, agree with covering for healthcare-associated pneumonia. She is currently on Levaquin and Cefepime. I have obtained a sputum culture, and we will send this to microbiology. We can taper antibiotics appropriately when this returns. Additionally, the patient meets criteria for acute respiratory distress syndrome. She has bilateral infiltrates as well as a **P/F ratio** of less than 200. We will proceed with ventilator management based on **ARDSNet** recommendations with low tidal volumes (6 to 8 ml/kg) and high positive end-expiratory pressure (**PEEP**) as needed. She is currently on a tidal volume of 500 and a positive end-expiratory pressure of 8. We could increase her tidal volume to even 600 based on her ideal body weight, but her pCO2 is trending down currently. Additionally, her positive end-expiratory pressure is currently at 8 and her pO2 appears much improved on her most recent gas. We will continue to titrate ventilator settings based on arterial blood gases. Chronic obstructive pulmonary disease. Agree with steroids given her recent hospitalization with Prednisone. Unsure if she was taking Prednisone recently or if she tapered off of this fairly quickly in August. **Gastrointestinal**, we will continue nasogastric tube to low continuous wall suction, currently secondary to a distended stomach seen on post-intubation	3336-3338

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		chest X-ray and recent use of bi-level positive airway pressure. Suspect that she had some gastric distention from bi-level positive airway pressure. If minimal output is obtained overnight, we will consider starting tube feeds on 09/24/2014. **Fluids, electrolytes, nutrition.** Currently on maintenance intravenous fluids. As mentioned above, feel that she is well resuscitated, given the fact that her lactate has cleared and her urine output has been good. I suspect that her lactic acidosis was secondary to sepsis. Currently, her electrolytes are within normal limits. We will continue to monitor. As mentioned above, we will consider starting tube feeds tomorrow. We will consult nutrition for goal tube feeds, given the caloric input she is receiving from the Propofol. **Genitourinary:** No acute issues. We will continue to monitor. Continue Foley for strict ins and outs. **Hematologic and Oncologic:** **Leukocytosis**, likely secondary to underlying infection with healthcare-associated pneumonia. We will continue to tend this; however, I suspect that she may have continued leukocytosis secondary to steroid use. **Infectious Disease.** Likely healthcare-associated pneumonia, as mentioned above. We will follow up cultures and taper antibiotics as needed. Agree with broad spectrum coverage with Levaquin and Cefepime. **Endocrine:** History of diabetes and steroid usage. We will check finger-stick blood sugars every 6 hours and use moderate sliding scale Insulin to correct. Prophylaxis: Gastrointestinal is Pepcid, deep venous thrombosis is Lovenox.	
09/23/2014	Daniel J. Glover, M.D.	**Hospitalist progress note:** **Vital signs:** Temperature max 100.6. BP 93/68, pulse 90, RR 22, O2 saturation 95%. Sedated. Expiratory wheezing bilaterally. Some erythema on the right lower extremity – indurations on the heels bilaterally. Patient with acute respiratory failure requiring intubation on Tuesday morning 09/23/2014 after failing BiPAP trial with high respiratory rates with associated cough. Chest X-ray of 09/23/2014 demonstrates diffuse **bilateral infiltrates.** Consult wound care.	3442-3446
09/23/2014	**?Lisa A. Bragg, R.N.?**	**Wound care treatment plan:** ***(Illegible notes)*** Wound location/type: Bilateral dry, cracked heels. Apply __________*(?Sween 24?)*. Cover with Mepilex border. Change dressing Tuesday and Friday and as needed for excess soiling. Recommend sof-care heel lift boots from storeroom.	3449
09/23/2014	Katy W. Bray, R.N. Katy W. Bray, R.N. Lisa A. Bragg, R.N.	**Nursing daily assessment:** **@ 0730 hrs:** Braden scale for risk: 14/23. **Skin:** Dry, warm, intact. **Skin color:** Race appropriate. **Turgor:** Elastic. No lesions noted. @ **0730 hrs, 1000 hrs:** Fall precautions. Pressure prevention measures. Head of Bed elevated. @ **1432 hrs:** Wound care #1: **Location:** Bilateral heels. **Type of wound:** Other. Dry, scaly skin.	3484, 3494, 3485, 3488, 3503

<table>
<tr><th>DATE</th><th>PROVIDER</th><th>OCCURRENCE/TREATMENT</th><th>PDF REF</th></tr>
<tr><td></td><td></td><td>Periwound skin: Dry, scaly skin throughout heels.
Treatment: Topical Sween 24. Cover with Mepilex border heel dressing. Treatment plan initiated. Recommend sof-care heel boots.</td><td></td></tr>
<tr><td>09/23/2014</td><td></td><td>Positioning assessment:
<table>
<tr><th>Date</th><th>Time (Documented)</th><th>Observation</th><th>Pdf Ref</th></tr>
<tr><td>09/23/2014</td><td>0030 hrs</td><td>Independent</td><td>3478</td></tr>
<tr><td></td><td>0200 hrs</td><td>Independent</td><td>3479</td></tr>
<tr><td></td><td>0218 hrs</td><td>Independent</td><td>3480</td></tr>
<tr><td></td><td>1000 hrs</td><td>Turned/positioned for comfort</td><td>3494</td></tr>
<tr><td></td><td>1200 hrs</td><td>Turned/positioned for comfort</td><td>3497</td></tr>
<tr><td></td><td>1400 hrs</td><td>Turned/positioned for comfort</td><td>3500</td></tr>
<tr><td></td><td>1545 hrs</td><td>Turned/positioned for comfort</td><td>3504</td></tr>
<tr><td></td><td>1800 hrs</td><td>Turned/positioned for comfort</td><td>3506</td></tr>
<tr><td></td><td>1930 hrs</td><td>Turned/positioned for comfort</td><td>3508</td></tr>
<tr><td>3.75 hrs</td><td>2315 hrs</td><td>Turned/positioned for comfort</td><td>3517
D W Davis</td></tr>
</table></td><td>3478-3517</td></tr>
<tr><td>09/23/2014</td><td></td><td>Labs:
High: Cortisol PM (20.7)
Low: Total protein (5.6), Albumin (2.9), Lactate (1)</td><td>3347-3348, 3355</td></tr>
<tr><td>09/24/2014</td><td>?Angela Kennedy, M.D.?</td><td>Critical care progress note:
No overnight events. Sedated and calm on Propofol/Fentanyl.

Vital signs: Temperature 100.3, Pulse 66-94, BP 104-138/50-65. Improved breath sounds with decreased rhonchi.

Continue Fentanyl, Propofol, as needed Versed for sedation/analgesia. Titrate to SAS 4. Well resuscitated. Keep on dry side secondary to ARDS. HCAP and ARDS. Continue Levaquin and Cefepime. Follow-up cultures. WBC improved. Continue vent. Start TFs at trickle via Nasogastric Tube (NGT). Lactate within normal limits. Leukocytosis improving. On Gastrointestinal (GI) and Deep Vein Thrombosis (DVT) prophylaxis.</td><td>3389</td></tr>
<tr><td>09/24/2014</td><td>Katy W. Bray, R.N.

Nancy E. Holmes, R.N.</td><td>Daily nursing assessment:
@ 0700 hrs: Braden score: 13/23.
Skin: Dry, warm and intact.
Skin color: Race appropriate.
Turgor: Elastic.

@ 1955 hrs: Braden score: 12/23.
Skin: Dry, warm and intact.
Skin color: Race appropriate.
Turgor: Elastic.</td><td>3526, 3550</td></tr>
<tr><td>09/24/2014</td><td></td><td>Positioning assessment:
<table>
<tr><th>Date</th><th>Time (Documented)</th><th>Observation</th><th>Pdf Ref</th></tr>
<tr><td>09/24/2014</td><td>0700 hrs</td><td>Turned/positioned for</td><td>3526</td></tr>
</table></td><td>3526-3557</td></tr>
</table>

<table>
<tr><th>DATE</th><th>PROVIDER</th><th>OCCURRENCE/TREATMENT</th><th>PDF REF</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td></td><td>(0849)</td><td>comfort</td><td>C L Bray</td></tr>
<tr><td></td><td>0900 hrs
(1226)</td><td>Turned/positioned for
comfort</td><td>3533
C L Bray</td></tr>
<tr><td></td><td>1000 hrs
(1228)</td><td>Turned/positioned for
comfort</td><td>3537
C L Bray</td></tr>
<tr><td></td><td>1200 hrs
(1234)</td><td>Turned/positioned for
comfort</td><td>3540
C L Bray</td></tr>
<tr><td></td><td>1400 hrs
(1523)</td><td>Turned/positioned for
comfort</td><td>3543
C L Bray</td></tr>
<tr><td></td><td>1600 hrs
(1837)</td><td>Turned/positioned for
comfort</td><td>3546
C L Bray</td></tr>
<tr><td></td><td>1800 hrs
(1842)</td><td>Turned/positioned for
comfort</td><td>3548
C L Bray</td></tr>
<tr><td></td><td>2200 hrs
(2237)</td><td>Turned/positioned for
comfort</td><td>3557
N E Holmes</td></tr>
</table>
</td><td></td></tr>
<tr><td>09/24/2014</td><td></td><td>**Labs:**
High: CRP (270), WBC (12.4), Cortisol AM (21)
Low: Total protein (8.3), Albumin (3), Lactate (1), RBC (3.71), Hemoglobin (11.4), Hematocrit (34.3)</td><td>3347-3348, 3352, 3354</td></tr>
<tr><td>09/25/2014</td><td>Nancy E. Holmes, R.N.</td><td>**Daily nursing assessment:**
@ **1935 hrs: Braden score:** 10/23.
Skin: Dry, warm and intact.
Skin color: Race appropriate.
Turgor: Elastic.</td><td>3589</td></tr>
<tr><td>09/25/2014</td><td></td><td>**Positioning assessment:**
<table>
<tr><th>Date</th><th>Time (Documented)</th><th>Observation</th><th>Pdf Ref</th></tr>
<tr><td>**09/25/2014**</td><td>0210 hrs
(0244)</td><td>Turned/positioned for
comfort</td><td>3562
N E Holmes</td></tr>
<tr><td>**>4 hrs since last**</td><td>0700 hrs
(1440)</td><td>Turned/positioned for
comfort</td><td>3571
J L Scott</td></tr>
<tr><td>**12 hrs since last**</td><td>1900 hrs
(1920)</td><td>Turned/positioned for
comfort</td><td>3588
J L Scott</td></tr>
<tr><td></td><td>2100 hrs
(2104)</td><td>Turned/positioned for
comfort</td><td>3596
N E Holmes</td></tr>
<tr><td></td><td>2300 hrs
(2320)</td><td>Turned/positioned for
comfort</td><td>3599
A S Davis, CN</td></tr>
</table>
</td><td>3562-3599

Note gaps in notation of positioning for comfort. This is outside the standard of care for nursing.</td></tr>
<tr><td>09/25/2014</td><td></td><td>**Labs:**
High: CRP (214.3), WBC (16.9)
Low: Albumin (3.1), RBC (3.68), Hemoglobin (11.4), Hematocrit (33.5)</td><td>3346-3347, 3352</td></tr>
<tr><td>09/26/2014</td><td>**?Daniel J. Glover, M.D.?**</td><td>**@ 0730 hrs: Physician order:**
Order Bariatric bed with turning capabilities.</td><td>3099</td></tr>
<tr><td>09/26/2014</td><td>Nancy E. Holmes, R.N.</td><td>**Daily nursing assessment:**
@ **0200 hrs:** Mepilex sacral dressing placed on coccyx area that is reddened.</td><td>3603, 3610-3611, 3617,</td></tr>
</table>

<table>
<tr><th>DATE</th><th>PROVIDER</th><th>OCCURRENCE/TREATMENT</th><th>PDF REF</th></tr>
<tr><td></td><td>

Jeanie D. Scott, R.N.

Jeanie D. Scott, R.N.
Jeanie D. Scott, R.N.
Lori Robinson, R. N.</td><td>Right hip stage I pressure ulcer. Stage I pressure ulcers to coccyx AND right hip described.

@ 0800 hrs: Braden scale: 12/23.
Skin: Dry, warm.
Skin color: Race appropriate.
Turgor: Elastic.

@ 1000 hrs: Moved to bariatric bed.

@ 1100 hrs: Rotational bed.

@ 1930 hrs: Braden scale 15/23. Sacral dressing dry and intact. Braden Scale assessment indicates this intubated and sedated patient's nutritional intake is adequate and friction and shear are no apparent problem. This is inconsistent with Braden Scale instructions.</td><td>3619, 3630, 3634</td></tr>
<tr><td>09/26/2014

09/26/2014</td><td></td><td>Positioning assessment:

<table>
<tr><th>Date</th><th>Time (Documented)</th><th>Observation</th><th>Pdf Ref</th></tr>
<tr><td>09/26/2014</td><td>0100 hrs (0122)</td><td>Turned/positioned for comfort</td><td>3602 N E Holmes</td></tr>
<tr><td></td><td>0300 hrs (0328)</td><td>Turned/positioned for comfort</td><td>3604 A S Davis</td></tr>
<tr><td></td><td>0410 hrs (0635)</td><td>Turned/positioned for comfort</td><td>3605 N E Holmes</td></tr>
<tr><td></td><td>0500 hrs (0541)</td><td>Turned/positioned for comfort</td><td>3609 A S Davis</td></tr>
<tr><td></td><td>0617 hrs (0617)</td><td>Turned/positioned for comfort</td><td>3609 C R Rivers</td></tr>
<tr><td>>5 hrs since last</td><td>1200 hrs (1633)</td><td>Rotational bed</td><td>3620 J L Scott</td></tr>
<tr><td></td><td>1300 hrs (1659)</td><td>Rotational bed</td><td>3622 J L Scott</td></tr>
<tr><td></td><td>1400 hrs (1700)</td><td>Rotational bed</td><td>3623 J L Scott</td></tr>
<tr><td></td><td>1450 hrs (1703)</td><td>Rotational bed</td><td>3624 J L Scott</td></tr>
<tr><td></td><td>1600 hrs (1706)</td><td>Rotational bed</td><td>3625 J L Scott</td></tr>
<tr><td></td><td>1700 hrs (1756)</td><td>Rotational bed</td><td>3628 J L Scott</td></tr>
<tr><td></td><td>1757 hrs (1757)</td><td>Rotational bed - Independent</td><td>3628 J L Scott</td></tr>
<tr><td></td><td>1900 hrs (1918)</td><td>Turned/positioned for comfort</td><td>3629 A S Davis</td></tr>
<tr><td></td><td>1930 hrs (2052)</td><td>Turned/positioned for comfort</td><td>3630 L Robinson</td></tr>
</table>
</td><td>3602-3639</td></tr>
</table>

<table>
<tr><th>DATE</th><th>PROVIDER</th><th>OCCURRENCE/TREATMENT</th><th>PDF REF</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td></td><td>2000 hrs
(2206)</td><td>Turned/positioned for comfort</td><td>3636
L Robinson</td></tr>
<tr><td></td><td>2100 hrs
(2105)</td><td>Turned/positioned for comfort</td><td>3637
A S Davis</td></tr>
<tr><td></td><td>2211 hrs
(2211)</td><td>Turned/positioned for comfort</td><td>3639
L Robinson</td></tr>
<tr><td></td><td>2300 hrs
(2306)</td><td>Turned/positioned for comfort</td><td>3639
A S Davis</td></tr>
</table>
</td><td></td></tr>
<tr><td>09/26/2014</td><td></td><td>Labs:
High: CRP (87.6)
Low: Total protein (6.1), Albumin (2.9), RBC (3.69), Hemoglobin (11.3), Hematocrit (33.6)</td><td>3346-3347, 3352</td></tr>
<tr><td>09/27/2014</td><td>
Debra L. Franks, R.N.

Debra L. Franks, R.N.

Debra L. Franks, R.N.
Rebekah C. Nashten, R.N.

Rebekah C. Nashten, R.N.</td><td>Daily nursing assessment:
@ 0748 hrs: Bari-Maxx II air bed turning patient every 15 minutes.
Braden scale 13/23. Skin dry, warm and intact.
Mepilex dressing to sacral area clean, dry, and intact.

@ 1418 hrs: Bariatric bed continues to turn patient from left to right to back every 15 minutes.

@ 1615 hrs: Skin moist/diaphoretic.

@ 1940 hrs: Sacral wound. Braden scale 11/23. Skin dry, warm, reddened and ecchymosis. NOT DOCUMENTED UNTIL 09/29/2015 @ 0152

@ 2200 hrs: Bari-Maxx II air bed turning patient every 15 minutes.</td><td>3653, 3655, 3667, 3669, 3676-3677</td></tr>
<tr><td>09/27/2014</td><td></td><td>Positioning assessment:
<table>
<tr><th>Date</th><th>Time (Documented)</th><th>Observation</th><th>Pdf Ref</th></tr>
<tr><td>09/27/2014</td><td>0031 hrs
(0031)</td><td>Turned/positioned for comfort</td><td>3641
L Robinson</td></tr>
<tr><td></td><td>0100 hrs
(0118)</td><td>Turned/positioned for comfort</td><td>3643
A S Davis</td></tr>
<tr><td></td><td>0201 hrs
(0201)</td><td>Turned/positioned for comfort</td><td>3644
L Robinson</td></tr>
<tr><td></td><td>0300 hrs
(0321)</td><td>Turned/positioned for comfort</td><td>3646
A S Davis</td></tr>
<tr><td></td><td>0406 hrs
(0406)</td><td>Turned/positioned for comfort</td><td>3648
L Robinson</td></tr>
<tr><td></td><td>0500 hrs
(0502)</td><td>Turned/positioned for comfort</td><td>3651
A S Davis</td></tr>
<tr><td></td><td>0558 hrs
(0558)</td><td>Turned/positioned for comfort</td><td>3652
L Robinson</td></tr>
<tr><td></td><td>0748 hrs
(0748)</td><td>Turned/positioned for comfort</td><td>3652
D L Franks</td></tr>
<tr><td></td><td>1016 hrs</td><td>Turned/positioned for</td><td>3661</td></tr>
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<tr><th>DATE</th><th>PROVIDER</th><th>OCCURRENCE/TREATMENT</th><th>PDF REF</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>2.5 hrs</td><td>(1017)</td><td>comfort</td><td>J D Stiles</td></tr>
<tr><td>4 minutes after last</td><td>1020 hrs
(1028)</td><td>Turned/positioned for comfort</td><td>3661
D L Franks</td></tr>
<tr><td></td><td>1200 hrs
(1426)</td><td>Turned/positioned for comfort</td><td>3664
D L Franks</td></tr>
<tr><td></td><td>1418 hrs
(1418)</td><td>Turned/positioned for comfort</td><td>3667
D L Franks</td></tr>
<tr><td></td><td>1615 hrs
(1814)</td><td>Turned/positioned for comfort</td><td>3669
D L Franks</td></tr>
<tr><td></td><td>1818 hrs
(1818)</td><td>Turned/positioned for comfort</td><td>3672
D L Franks</td></tr>
<tr><td></td><td>2200 hrs
(2218)</td><td>Turned/positioned for comfort</td><td>3681
R C Nashten</td></tr>
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</td><td></td></tr>
<tr><td>09/27/2014</td><td></td><td>Labs:
Low: Total protein (5.1), Albumin (2.4), RBC (3.65), Hemoglobin (11.1), Hematocrit (33)</td><td>3345, 3352</td></tr>
<tr><td>09/28/2014</td><td>
Debra L. Franks, R.N.

Debra L. Franks, R.N.

Debra L. Franks, R.N.

Ibid.

Debra L. Franks, R.N.
Rebekah C. Nashten, R.N.</td><td>Daily nursing assessment:
@ 0719 hrs: Bari-Maxx II air bed rotating patient in bed every 16 minutes from left to back to right and so forth. Braden scale 12/23. Skin intact and moist.
Sacral area covered with Mepilex.

@ 0820 hrs: Automatic turn stopped on bed and patient turned by nursing onto left side.
Sacral stage II pressure ulcer: Dressing removed and skin is noted to be boggy, dark purple with broken fluid filled blisters. Area cleansed with saline and large Mepilex applied to cover area.

@ 0940 hrs: Patient turned to right side.

@ 1206 hrs: Patient turned well over onto left side off of sacral area. Arms elevated on pillows.

@ 1449 hrs: Patient turned on right side.

@ 2004 hrs: Repositioned on right side. Braden scale 11/23. Skin dry, warm, reddened and ecchymosis. Dressing to pressure ulcer is clean, dry and intact.
Documented @ 0141</td><td>3693-3694, 3696, 3701-3702, 3707, 3709, 3717, 3720</td></tr>
<tr><td>09/28/2014</td><td></td><td>Positioning assessment:

<table>
<tr><th>Date</th><th>Time (Documented)</th><th>Observation</th><th>Pdf Ref</th></tr>
<tr><td>09/28/2014</td><td>0219 hrs
(0802)</td><td>Turned/positioned for comfort</td><td>3687
R C Nashten</td></tr>
<tr><td></td><td>0440 hrs
(0800)</td><td>Turned/positioned for comfort</td><td>3690
R C Nashten</td></tr>
<tr><td></td><td>0600 hrs
(0757)</td><td>Turned/positioned for comfort</td><td>3692
R C Nashten</td></tr>
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<tr><td></td><td>0719 hrs
(0719)</td><td>Turned/positioned for comfort</td><td>3693
D L Franks</td></tr>
<tr><td></td><td>0820 hrs
(0854)</td><td>Turned/positioned for comfort – Left side</td><td>3701
D L Franks</td></tr>
<tr><td>5 minutes after last</td><td>0825 hrs
(0834)</td><td>Turned/positioned for comfort</td><td>3701
J D Stiles</td></tr>
<tr><td></td><td>0940 hrs
(0940)</td><td>Turned/positioned for comfort - Right side</td><td>3702
D L Franks</td></tr>
<tr><td>>2.25 hrs</td><td>1206 hrs
(1206)</td><td>Turned/positioned for comfort – Left side</td><td>3707
D L Franks</td></tr>
<tr><td>>2.5 hrs</td><td>1449 hrs
(1450)</td><td>Turned/positioned for comfort – Right side</td><td>3709
D L Franks</td></tr>
<tr><td>11 minutes after last</td><td>1500 hrs
(1617)</td><td>Turned/positioned for comfort</td><td>3710
J D Stiles</td></tr>
<tr><td></td><td>1755 hrs
(1756)</td><td>Turned/positioned for comfort - Back</td><td>3713
D L Franks</td></tr>
<tr><td></td><td>2004 hrs
(0141)</td><td>Turned/positioned for comfort – Right side</td><td>3717
R C Nashten</td></tr>
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</td><td></td></tr>
<tr><td>09/28/2014</td><td></td><td>Labs:
Low: Total protein (5.9), Albumin (2.7), RBC (3.7), Hemoglobin (11.5), Hematocrit (33.3)</td><td>3345, 3352</td></tr>
<tr><td>09/29/2014</td><td>Multiple Providers</td><td>Daily nursing assessment:
@ 0015 hrs: Turned on left side.

@ 0630 hrs: Turned to right side.

@ 0745 hrs: Braden scale 14/23. Braden assessment by C L Bray, R.N. shows scoring of 4 defined as: No impairment: Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort. (Ref 3735) Neurological assessment note shows patient with Glasgow Coma Score of 5, and sedated; opens eyes, does not follow commands. (Ref 3736)

@ 1931 hrs: Braden scale 10/23. Skin dry, warm, reddened and ecchymosis. Mepilex dressing in place.

@ 2220 hrs: Mepilex dressing clean, dry and intact. Turned to left side.</td><td>3727, 3733, 3735, 3754, 3757, 3761</td></tr>
<tr><td>09/29/2014</td><td></td><td>Positioning assessment:
<table>
<tr><th>Date</th><th>Time (Documented)</th><th>Observation</th><th>Pdf Ref</th></tr>
<tr><td>09/29/2014</td><td>0015 hrs</td><td>Turned/positioned for comfort</td><td>3727</td></tr>
<tr><td></td><td>0225 hrs</td><td>Turned/positioned for comfort</td><td>3728</td></tr>
<tr><td>>4 hrs</td><td>0630 hrs</td><td>Turned/positioned for comfort</td><td>3733
R C Nashten</td></tr>
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</td><td>3727-3761</td></tr>
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<tr><td></td><td>0745 hrs</td><td>Turned/positioned for comfort</td><td>3735</td></tr>
<tr><td></td><td>0957 hrs</td><td>Turned/positioned for comfort</td><td>3741
J D Stiles</td></tr>
<tr><td>3 minutes after last</td><td>1000 hrs</td><td>Turned/positioned for comfort</td><td>3742
C L Bray</td></tr>
<tr><td></td><td>1200 hrs</td><td>Turned/positioned for comfort</td><td>3745</td></tr>
<tr><td></td><td>1400 hrs</td><td>Turned/positioned for comfort</td><td>3747</td></tr>
<tr><td></td><td>1500 hrs</td><td>Turned/positioned for comfort</td><td>3749</td></tr>
<tr><td></td><td>1600 hrs</td><td>Turned/positioned for comfort</td><td>3750</td></tr>
<tr><td></td><td>1800 hrs</td><td>Turned/positioned for comfort</td><td>3752</td></tr>
<tr><td></td><td>2015 hrs</td><td>Turned/positioned for comfort</td><td>3759</td></tr>
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<tr><td>09/29/2014</td><td></td><td>Labs:
High: Glucose (111), WBC (11)
Low: Total protein (6), Albumin (2.9), RBC (3.97), Hemoglobin (11.7), Hematocrit (35.9)</td><td>3345, 3352</td></tr>
<tr><td>09/30/2014</td><td>Multiple Providers</td><td>Daily nursing assessment:
@ 0148 hrs: Turned on back.

@ 0405 hrs: Turned right side.

@ 0600 hrs: Turned on back.

@ 0730 hrs: Braden scale 14/23. Skin warm and diaphoretic.

@ 2049 hrs: Braden scale 14/23. Skin dry and warm. Mepilex in place.</td><td>3768, 3770, 3773-3774, 3795-3797</td></tr>
<tr><td>09/30/2014</td><td></td><td>Positioning assessment:
<table>
<tr><th>Date</th><th>Time (Documented)</th><th>Observation</th><th>Pdf Ref</th></tr>
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<tr><td></td><td>0405 hrs</td><td>Turned/positioned for comfort</td><td>3770</td></tr>
<tr><td></td><td>0600 hrs</td><td>Turned/positioned for comfort</td><td>3773</td></tr>
<tr><td></td><td>0730 hrs</td><td>Turned/positioned for comfort</td><td>3774</td></tr>
<tr><td></td><td>0900 hrs</td><td>Turned/positioned for comfort</td><td>3781</td></tr>
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</td><td>3768-3800</td></tr>
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<tr><th>DATE</th><th>PROVIDER</th><th>OCCURRENCE/TREATMENT</th><th>PDF REF</th></tr>
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<tr><td></td><td>1000 hrs</td><td>Turned/positioned for comfort</td><td>3782</td></tr>
<tr><td></td><td>1200 hrs</td><td>Turned/positioned for comfort</td><td>3784</td></tr>
<tr><td></td><td>1400 hrs</td><td>Turned/positioned for comfort</td><td>3787</td></tr>
<tr><td></td><td>1800 hrs</td><td>Turned/positioned for comfort</td><td>3792</td></tr>
<tr><td>>5.5 hrs</td><td>2338 hrs</td><td>Turned/positioned for comfort</td><td>3800
D W Davis</td></tr>
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</td><td></td></tr>
<tr><td>09/30/2014</td><td></td><td>Labs:
Low: Albumin (2.8), RBC (4.05), Hemoglobin (12.4), Hematocrit (36.6)</td><td>3344, 3351</td></tr>
<tr><td>10/01/2014</td><td>Multiple Providers</td><td>Daily nursing assessment:
@ 0700 hrs: Braden scale 11/23. Skin warm and diaphoretic. Pressure ulcer stage III, right hip and sacral.

@ 0900 hrs: Dressing change on coccyx. Has purple areas with large broken blisters, draining serous fluid, Mepilex border sacrum applied.

@ 1940 hrs: Braden scale 13/23. Skin warm and moist. Dressing to coccyx in place.

@ 2230 hrs: Complaining of buttocks and sacral pain, repositioned in bed, Fentanyl given as ordered.

@ 2358 hrs: Refused to be turned at this time.</td><td>3810, 3813, 3818, 3828, 3830-3832</td></tr>
<tr><td>10/01/2014

10/01/2014</td><td></td><td>Positioning assessment:
<table>
<tr><th>Date</th><th>Time (Documented)</th><th>Observation</th><th>Pdf Ref</th></tr>
<tr><td>10/01/2014</td><td>0030 hrs (0129)</td><td>Turned/positioned for comfort</td><td>3802
D W Davis</td></tr>
<tr><td></td><td>0239 hrs (0239)</td><td>Turned/positioned for comfort</td><td>3804
D W Davis</td></tr>
<tr><td></td><td>0408 hrs (0408)</td><td>Turned/positioned for comfort</td><td>3806
D W Davis</td></tr>
<tr><td></td><td>0800 hrs</td><td>Independent</td><td>3817</td></tr>
<tr><td></td><td>0900 hrs</td><td>Independent</td><td>3818</td></tr>
<tr><td></td><td>1000 hrs</td><td>Independent</td><td>3819</td></tr>
<tr><td></td><td>1500 hrs</td><td>Independent</td><td>3824</td></tr>
<tr><td></td><td>1600 hrs</td><td>Independent</td><td>3824</td></tr>
<tr><td></td><td>1700 hrs</td><td>Independent</td><td>3826</td></tr>
<tr><td></td><td>1800 hrs</td><td>Independent</td><td>3826</td></tr>
<tr><td></td><td>1940 hrs</td><td>Turned/positioned for comfort</td><td>3827</td></tr>
<tr><td></td><td>2358 hrs</td><td>Refused to be turned</td><td>3832</td></tr>
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<tr><th>DATE</th><th>PROVIDER</th><th>OCCURRENCE/TREATMENT</th><th>PDF REF</th></tr>
<tr><td>10/01/2014</td><td></td><td>Labs:
High: Glucose (107), WBC (11.4)
Low: Albumin (2.7), RBC (4.13), Hemoglobin (12.5), Hematocrit (37.2)</td><td>3344, 3351</td></tr>
<tr><td>10/02/2014</td><td></td><td>@ 0835 hrs: Physician order:
Full liquid diet advance to diabetic as tolerated. Up to chair as tolerated with PT.</td><td>3055</td></tr>
<tr><td>10/02/2014</td><td>Katy W. Bray, R.N.

Nancy E. Holmes, R.N.

Nancy E. Holmes, R.N.</td><td>Daily nursing assessment:
@ 0710 hrs: Braden scale 12/23. Skin warm and diaphoretic.

@ 2002 hrs: Braden scale 13/23. Skin dry and warm. Sacral stage II pressure ulcer.

@ 2205 hrs: Patient has large area on her coccyx are that has broken skin and is purple in color. Mepilex replaced.</td><td>3835-3836, 3851-3852, 3854, 3857</td></tr>
<tr><td>10/02/2014</td><td></td><td>Positioning assessment:
<table>
<tr><th>Date</th><th>Time (Documented)</th><th>Observation</th><th>Pdf Ref</th></tr>
<tr><td>10/02/2014</td><td>0230 hrs (0230)</td><td>Turned/positioned for comfort</td><td>3833
D W Davis</td></tr>
<tr><td></td><td>0415 hrs (0607)</td><td>Turned/positioned for comfort</td><td>3834
D W Davis</td></tr>
<tr><td></td><td>0710 hrs</td><td>Independent</td><td>3835</td></tr>
<tr><td></td><td>0800 hrs</td><td>Independent</td><td>3840</td></tr>
<tr><td></td><td>0900 hrs</td><td>Independent</td><td>3841</td></tr>
<tr><td></td><td>1000 hrs</td><td>Independent</td><td>3842</td></tr>
<tr><td></td><td>1120 hrs</td><td>Independent</td><td>3843</td></tr>
<tr><td></td><td>1200 hrs</td><td>Independent</td><td>3844</td></tr>
<tr><td></td><td>1300 hrs</td><td>Independent</td><td>3845</td></tr>
<tr><td></td><td>1400 hrs</td><td>Independent</td><td>3846</td></tr>
<tr><td></td><td>1500 hrs</td><td>Independent</td><td>3847</td></tr>
<tr><td></td><td>1600 hrs</td><td>Independent</td><td>3848</td></tr>
<tr><td></td><td>1700 hrs</td><td>Independent</td><td>3849</td></tr>
<tr><td></td><td>1800 hrs</td><td>Independent</td><td>3849</td></tr>
<tr><td></td><td>1900 hrs</td><td>Turned/positioned for comfort</td><td>3851</td></tr>
<tr><td></td><td>2002 hrs</td><td>Independent</td><td>3851</td></tr>
<tr><td></td><td>2100 hrs</td><td>Turned/positioned for comfort</td><td>3856</td></tr>
<tr><td></td><td>2205 hrs</td><td>Independent</td><td>3856</td></tr>
<tr><td></td><td>2300 hrs</td><td>Turned/positioned for comfort</td><td>3857</td></tr>
</table></td><td>3833-3857</td></tr>
<tr><td>10/02/2014</td><td></td><td>Labs:
High: Glucose (127), WBC (18)</td><td>3344, 3351</td></tr>
<tr><td>10/03/2014</td><td></td><td>Positioning assessment:
<table>
<tr><th>Date</th><th>Time</th><th>Observation</th><th>Pdf Ref</th></tr>
<tr><td>10/03/2014</td><td>0015 hrs</td><td>Independent</td><td>3858</td></tr>
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DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Reviewer's comment: The daily nursing notes from 10/03/2014 0015 hrs to the discharge dated 10/08/2014 are not available for review to know the repositioning, Braden score and the skin assessments done during the time period.	
		Reviewer's comment: All the physician progress notes are reviewed and there are no significant details related to the pressure ulcer, therefore not detailed chronology. Wound assessment records are not available for review.	
10/03/2014		**Labs:** **High:** (Glucose (140), WBC (17.8) **Low:** Albumin (3.3)	3343, 3350
10/04/2014		**Labs:** **High:** Glucose (116), WBC (17.3)	3343, 3350
10/05/2014		**Labs:** **High:** Glucose (119), WBC (16.4) **Low:** Albumin (3.3) **Urinalysis:** Urine protein (75), Urine ketones (5), Urine urobilinogen (4), Urine bilirubin (1), Urine blood (250), Urine WBC (6-10), Urine RBC (25-50), Urine bacteria (Trace), Urine mucus (Slight), Squamous epithelial (2-5)	3343, 3350, 3362
10/06/2014	Barry White, M.D.	**Hospitalist progress note:** Discharge summary done today. She will need to go to rehabilitation from here. Seeing as how she is walking a little bit she is not quite ready for discharge home but it is certain that she will not need even a 30 days of rehabilitation. She has been encouraged to get up move around without help with healing from her ulcer or from keeping pressure off of it.	3396-3398
10/06/2014	[signature] **?Lisa A. Bragg, RN?**	**@ 1211 hrs: Wound care treatment plan:** **Wound location/Type:** Bilateral **ischium**/Deep tissue injury. **Cleanse with:** Normal saline. **Apply barrier up to edge of wound:** Skin Prep. **Cover wound with:** Two Mepilex border sacrum. **Change dressing:** Every Monday and as needed excess soiling. **Additional instructions:** Offloading at all times, chair cushion given.	5815
10/06/2014	[signature]	**Long term care services review:** **Admission date:** 09/22/2014. **Current level of care:** Hospital. **Recommended level of care:** SNF. **Discharge plan:** Skilled Nursing Facility (SNF). Semi ambulatory with assistance. Bilateral ischial deep tissue injury. Dressing with Mepilex. Diabetic diet. On CPAP. PT 2 times daily for 5-7 days a week.	5813-5814
10/06/2014	Barry White, M.D.	**Discharge summary:** **Discharge diagnoses:** Health care associated pneumonia with severe sepsis. Acute on chronic respiratory failure with ARDS had home oxygen recently. Volume overload. Hypokalemia. Hyperglycemia with A1C 5.5. Bipolar disorder.	5649-5653

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Coronary artery disease. Chronic Obstructive Pulmonary Disease (COPD). Obstructive sleep apnea on CPAP. Patient admitted through the Emergency Room on 09/22 with possible viral pneumonia versus ARDS, et cetera. She failed BiPAP therapy, was intubated. It was felt that this was at possibly help care associated pneumonia and very broad-spectrum antibiotics initiated. Her sputum culture grew out light growth normal flora. She did have severe sepsis and systemic inflammatory response with the pneumonia. She received significant fluids which caused overload which is now improving with diuresis. She is restarted on her home diuretics at discharge. Patient was monitored with serial pro-Calcitonin is in with a brick came undetectable; her IV antibiotics were stopped and placed on Bactrim. She will received a couple doses of Bactrim which is stopped as she had had adequate therapy with the new recommendations to use short course therapy for pneumonia. Just really stable for discharge to rehabilitation having completed antibiotics. Patient with prolonged ventilation but has been able to be extubated several days ago. After extubation she has done well and is down to 4 L nasal cannula. She does wear CPAP at night which will need to continue. Patient has developed a sacral decubitus ulcer after being on the ventilator. Wound care is consulted for that and will need to have continued therapy as an outpatient. **Discharge diet:** Regular. **Discharge activity:** As tolerated. **Follow-up:** Dr. Ward after rehabilitation. Facility provider within 2 weeks. Wound care consult for sacral decubitus ulcer.	
10/06/2014		**Labs:** **High:** WBC (12.5) **Low:** Albumin (3.2)	3343, 3349
09/23/2014 - 10/06/2014		**Vital signs:**	3396-3446 09/26/2014

Date	BP	Pulse	Temp	RR	O2 Sat
09/23/2014	93/66	90	100.6	22	96
09/24/2014	107/57	60	98.2	32	96
09/25/2014	119/64	57	99	32	96
09/26/2014	109/80	55	98.1	4	90
09/27/2014	111/42	67	99.8	22	90
09/28/2014	121/58	73	99.8	21	91
09/29/2014	145/89	65	99.5	24	96
10/01/2014	110/58	97	98.8	24	100
10/02/2014	138/83	102	99.8	18	97
10/03/2014	152/91	77	98.1	25	96
10/04/2014	131/72	72	98.4	27	95
10/05/2014	121/74	59	98.1	18	95

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		10/06/2014 136/77 56 97.8 18 93 ****Reviewer's comment: Respiratory rate of four breaths per minute recorded 09/26/2014. Patient intubated and on ventilator support. This is likely errant charting though many EMR systems require either correction of such a deviation from expected findings or explanatory note detailing interventions undertaken.***	
10/07/2014	David Crosby, M.D.	**Hospitalist progress note:** No new complaints. Still some dysuria. Eating better. Motivated to get stronger. **Vital signs:** Temperature max 98.4, BP 123/80, Pulse 68, Temperature 98.4, RR 18, O2 saturations 93% on 3L Nasal Cannula (NC). Antibiotics now completed. Continue supplemental O2. Hyperglycemia stress induced with A1C 5.5. Continue CPAP every night. Potassium replaced. Decub ulceration discussed with wound care. Related to her recent near death critical illness. MRSA in sputum. Now off antibiotics. Unclear if colonization, or related to recent pneumonia. No further fevers. Breathing well. Discussed with discharge planner. Probable discharge to Care Partners or Brian Center 10/08/2014.	3393-3395
10/07/2014		**Positioning assessment:** @ **0610 hrs:** Positioning independent. @ **0719 hrs:** Positioning independent. Pressure ulcer. @ **0727 hrs:** Turned and positioned for comfort. @ **0900 hrs:** Turned and positioned for comfort. @ **1100 hrs:** Turned and positioned for comfort. @ **1142 hrs:** Positioning independent.	5820, 5822
10/07/2014		**Labs:** **High:** WBC (12.5). **Low:** Albumin (3.4)	3343, 3349
10/08/2014	[signature]	**Wound care treatment plan:** **Wound location/Type:** Bilateral ischemia/Pressure ulcer **DTI** healing. Discontinue previous wound care treatment plan. Cleanse with normal saline. Apply barrier up to edge of wound Skin Prep. Lightly fill wound with wound dress. Cover wound with border foam dressing (currently has Mepilex border secure) Offloading at all times.	3447
10/08/2014		**Labs:** **High:** WBC (11.5). **Low:** Albumin (3.4)	3343, 3349
09/22/2014 - 10/08/2014		**Other hospitalization records:** Labs, physician progress notes, medication administration records, physician orders, consent and authorizations, ER record, radiology reports, nursing assessment, EKG ****Reviewer's comment: These records reviewed and the significant details related to the pressure ulcer are included in the chronology above from these records, therefore these records are not detailed here.***	3475-4066, 4069-4099, 3026-3170, 3173-3318, 5816-5822
		Brian Center Health & Rehabilitation/Waynesville	

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
10/08/2014		**Nursing admission intake form:** **Vital signs:** Temperature 98.4, Pulse 80, RR 18, BP 114/74, Weight 357.28. Bed rest. Weak balance. ADL with limited assistance for transfers, extensive assistance for locomotion and bathing. Independent for bed mobility and eating. Resident arrived on SouthWing at 1500 hrs via ambulance with 2 EMTs. She is alert and oriented. She complains of left hip discomfort. Her vital signs were stable. She expressed help desires from PT to walk again. She is pleasant and cooperative.	5732-5735
10/08/2014		**Plan of care – Wound:** Skin potential for skin break down. Pressure ulcer hips. **Interventions initiated:** Provide wound care/preventive skin care per order. Observe wound healing. Skin checks weekly per facility protocol, document findings. Notify MD of changes in wound, or emerging wounds.	5731
10/08/2014		**Head to toe skin assessment:** **Skin intact:** No, buttocks 10 x 8 cm, surrounding area red. **Bruises:** Yes. Arms from injections. **Previously identified area:** No. Preventive measures in place: Yes.	5795
10/08/2014	*Provider not available – Notes unsigned*	**Wound assessment:** **Site/location:** Sacral both buttock cheeks. **Wound #: 1.** **Stage:** Unstageable. **Size in cm:** 10 x 8 cm. **Depth:** <0.5 cm. **Undermining:** Undermining. **Exudate type:** None. **Exudate amount:** None. **Wound bed:** Red, yellow and black. **Surrounding skin color:** Bright red. **Surrounding skin:** Peripheral tissue edema. **Pain related to wound:** Yes Cleanse sacral decubitus with normal saline, pat dry. Apply skin prep to edges, cover with Mepilex Ag and border gauze and CDD every Monday and as needed. (Reddened area 12 x 12 cm surrounding WB)	5796
10/08/2014		**Evaluation for bowel and bladder training:** **Present bladder status:** No incontinence. **Present bowel status:** No incontinence.	5797
10/08/2014		**Daily nursing assessment:** Balance and gait unsteady. Urine dark yellow. Decubitus ulcer on buttocks.	5760
10/08/2014		**Nurse notes:** **@ 2230 hrs:** Admit note: Resident arrived approximately at 1330 hrs via ambulance and 2 attendants and gurney. Resident continent of bowel and bladder, voided 500 cc dark yellow urine this shift. Appetite fair. Moderate assistance with Activities of Daily Living (ADLs). Resident easily agitated.	5761

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Complaining of severe pain. Pain medications given x 2 this shift with only small results. Resident easily agitated, now cooled to calm resident and 1:1. Skin check to wait till morning till resident pain and resident less tired and agitated, resident medications arrived and resident took night medications and Bipap on. Resting at this time.	
10/09/2014	Michael Pass, M.D.	**Rehabilitation admission status post sepsis:** *History reviewed.* **Review of systems:** Positive for the patient having some back discomfort but it is more related to the sacral decubitus that developed in the hospital while she was on the ventilator. This is being evaluated by physical therapy and wound care. The patient was concerned that she was not signed up for the right therapy. Her main reason for being here was to get physical therapy to get her strength back in her legs and get back on her feet so she can take care of himself and get home. She has no other concerns. She is somewhat agitated at the time of my arrival because everything was not being done exactly the way she wanted and she misunderstood some communications from the administration. Nurses knew of no other specific problems except they were concerned that her mania from bipolar may be getting out of control with the amount of agitation they were witnessing. **Physical examination:** The physical exam shows a blood pressure of 114/74, temperature 98.4 orally. Pulse of 80 and regular, respirations 18 and unlabored and weight 357 pounds. Her oxygen saturation was 94% on 4 liters per nasal cannula. **In general**, she is a well-developed, obese, very large. I think 6 feet 7 inches white male, in no acute distress, but somewhat agitated but calm fairly quickly once she was able to vent some of her frustrations and get some degree of reassurance. **HEENT** exam showed no evidence of trauma. Mucous membranes are moist. Neck is negative for adenopathy and Jugular Venous Distention (JVD). **Chest** is clear to percussion. Auscultation reveals diminished breath sounds diffusely. Some rhonchi. No rales, wheezes, or rubs. **Heart** has regular rate and rhythm without significant murmur. **Abdomen** is obese but benign. No real tenderness. No masses or organomegaly. Bowel sounds are within normal limits. **Extremities** show no significant clubbing, cyanosis, or edema. She has just had her sacral wound redressed and was not examined specifically by myself. **Assessment and plan:** Healthcare associated pneumonia and sepsis, acute on chronic respiratory failure and ARDS, complicating her COPD and obstructive sleep apnea, now extubated and on CPAP with naps and bedtime 4 liters of oxygen per nasal cannula. Is pretty adequate while she is off of CPAP. Bipolar disorder, may not be adequately controlled. We will have to watch and see how her agitation and manic tendency is controlled from here on and decide about further medications and intervention. Coronary disease, asymptomatic. Diabetes, will be followed closely. Obesity, certainly would help all of her problems if she had significant weight loss but she reports she not had much hunger at this time and may be losing	5676-5677

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		some weight just since hospitalization. Sacral decubitus. We will have wound care help take care of this and she knows to move frequently to keep the pressure off of that area while here. Chronic back pain and chronic narcotics, we will have adequate pain control for the back and the sacrum wound. The patient will work with therapy to try and regain strength and better ambulation. We did clarify some of-her medications that were being given to her at Practice Center but had been discontinued somewhere along the line through hospitalization including Trileptal, which she had been on for sometime, Trazodone 300 mg every night and Neurontin 600 mg three times daily instead of 100 mg every night, that she came to the facility on. We will watch closely with these medications to make sure there is not excessive sedation that might have caused pneumonia to start with. The patient will be rechecked at least within a month, sooner if things are not improving well.	
10/09/2014		**Nurse notes:** Resident well this shift. No acute distress noted. Temperature 98.2, pulse 78, RR 20, BP 120/74, O2 94%.	5761
10/09/2014		**Nurse notes:** **Time arrived:** 1500 hrs. **Complaints:** Hip and back pain from prior surgery. **Notes:** Resident is alert and oriented and cooperative. Her vital signs are stable. She has a wound to her buttocks to be referred to wound care. She expressed the desire to walk again although she complains of leg weakness	5762
10/10/2014		**Daily nursing assessment:** Alert and anxious. Balance and gait unsteady. Temperature 98.8, Pulse 82, RR 20, BP 120/72. Bed mobility with extensive assist. Transfer with extensive assist. Decubitus buttock wound VAC. ***Reviewer's comment: The placement of wound VAC is not found in the record prior to 10/21/2014.*** Wound care and management.	5759
10/10/2014		**Nurse notes:** Temperature 98, pulse 80, RR 22, BP 118/60, O2 saturation 95%. Resident weaning CPAP. Tolerating well. No acute distress noted. Call light within reach.	5761
10/11/2014		**Daily nursing assessment:** Often incontinence. Urine yellow. Temperature 99.2, pulse 74, RR 18, BP 115/60. SpO2 96%. Bed mobility and transfers with extensive assistance. Decubitus ulcer buttocks. Wound care and management.	5758
10/11/2014		**Nurse notes:** Remains on antibiotics without problems. Temperature 99.2.	5761
10/12/2014		**Daily nursing assessment:** Vital signs: Temperature 98.2, pulse 74, RR 18, BP 115/60. SpO2 96%. Other assessment remains unchanged from previous day.	5756
10/12/2014		**Daily nursing assessment:** Temperature 99.8, pulse 84, RR 18, BP 130/65. O2 sat 92%. Other assessment	5757

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		remains unchanged from previous day.	
10/13/2014		**Initial nutritional assessment:** **Diet order:** **RCS**. **Physical condition:** Height 81 inches, weight 357.3 lbs, Body Mass Index (BMI) 38. States 70# loss while hospitalized. **Skin condition:** Pressure ulcer. Admitted with wound from hospital. Dentition complete. Comprehension alert and verbal. Activity wheel chair. Feeding independent. **Nutrient needs:** Estimate needs >3000 calorie. Estimate intake calorie >2100. Estimate protein needs >110, estimated protein intake >100 gram. Estimated fluid needs >2500. Admitted for rehab, has wound on buttock; states wound came from "being in a coma at the hospital and I did not get turned". Discussed importance of protein intake; requested liquid diet related to complaining of gastric pain, agreeable to protein supplements. States she lost nearly 75 # at hospital and would like to maintain the loss. Agreed to add protein and supplements for wound healing. Will consume diet as ordered focusing on protein for healing. Monitor weights per protocol, monitor for lab results. ***Reviewer's comment: The patient is elsewhere reported as approximately 72" in height (6 ft) this notation appears to be erroneous.***	5793-5794
10/14/2014		**Daily nursing assessment:** Temperature 97.6, pulse 95, RR 20, BP 98/45. Decubitus buttocks. O2 saturations 93%. I and E program in place and wound care in place.	5753
10/14/2014		**Nursing weekly summary:** Bowel and bladder continent. Alert and wanders. Understands information conveyed without difficulty. Skin turgor poor. Preventive skin care, pressure relieving or reduction mattress. Pressure relieving/reduction chair pad. Eating habits usually good. Vision adequate. Hearing adequate. Ambulation with assistance. Bed to chair. Transfers assist of 2. Resident continues to turn and position self routinely.	5754-5755
10/08/2014 - 10/15/2014		**Assessment:** **10/08/2014: Pain evaluation:** On pain management. Pain is constant. Hard to sleep at night. Limited activities due to pain. **Location of pain:** Bone, bilateral buttock. **Potential underlying cause:** Ulcer/wound. Neuropathy. Mental illness. **Braden scale:** 10/08/2014: Braden scale: 17 (Mild risk) 10/15/2014: Braden scale: 17 (Mild risk)	5715-5719

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		Fall risk assessment: 10/08/2014: 7 10/15/2014: 11 **10/15/2014:** Weight: 359.2 lbs.	
10/15/2014		**Wound assessment:** ***(Illegible notes)*** **Location:** Buttock. Necrotic open area. **Stage:** Unstageable. **Size in cms:** 8.3 x 13.4 cm. **Depth:** 3.9 cm. **Undermining:** Undermining. **Exudate type:** Foul purulent. Odor present. **Exudate amount:** Moderate. **Wound bed:** Red, yellow and black. **Surrounding skin color:** Bright red. **Surrounding skin:** Induration. **Pain related to wound:** Yes. Wound care consult in morning and twice daily Dakin's wet to dry dressing. Patient _______________ debridement treatment 3x/week ________________. **Speciality interventions:** Air mattress bed. Positioning devices pillows.	5765
10/16/2014		**Daily nursing assessment:** Temperature 98.2, pulse 78, RR 78, BP 132/70. Balance and gait unsteady. Weakness. Bed mobility with extensive assistance and 2 person assist. Transfer with extensive assistance and 2 person assist. Feeding ability independent. Decubitus coccyx/buttocks. Wound care and management. Turn and position program in place; wound care in place.	5752
10/17/2014		**Nurse notes:** Order received from Dr. Pass to send to Statewide Regional Hospital to be seen for surgical debridement of sacrococcygeal decubitus that recently reopened and presents with necrotic tissue and depth. EMS transport contacted and report called to ER.	5761
10/08/2014 - 10/17/2014		**Treatment flow sheet:** **Wound care sacral decub cleanse with normal saline. Apply skin prep to edge of wound. Cover with 2 Mepilex border gauze change every Monday and as needed:** Wound Care Sacral Decub cleanse c N.S. apply skin prep to edge of wound Cover c 2 Mepilex border gauze change every Mon + Prn	5775, 5777, 5764

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Cleanse sacral decub, tx3 w/ NS, pat dry, Apply skin prep and medihoney AG & cover w/ border gauze D/c 10/15/14 (3-11) 10/15/14 New order [illegible] dressing c Dakins .25% solution for cleansing Wet to Dry dressing (7-3, 3-11) [illegible] **Pressure reducing mattress every shift:** Pressure Reducing Mattress q. shift **Pressure reducing cushion every shift:** Pressure Reducing cushion q. shift **Turn and reposition every 2 hours every shift:** Turn + Reposition q. 2° q. shift **Promod, Juven and MVI:** Promod 30 cc. po BID x 14 days 10/13/14 (0800, 2000) Juven 1 pkg. BID x 14 days 10/13/14 (0800, 2000) MVI 1 tab po qd x 30 days 10/13/14 (0800) ****Reviewer's comment: For ease of reference the snap shot for the protein supplementation and treatment records is provided abovey.***	
10/17/2014	Briggs Healthcare	**Transfer report:** **Reason for transfer:** Newly opened sacral/coccygeal decubitus with necrotic tissue.	5636
		Statewide Regional Medical Center	
10/17/2014	Ben Jackson, M.D.	**ER visit for pressure ulcer:** Pressure ulcer much worse. This started yesterday. She had sacral decub that	2715-2720

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		worsened when recently on vent for pneumonia and respiratory failure. Has been at the Brian Center but it has worsened, opened and now has foul odor, and is still present and worsening. It was gradual in onset. No loss of appetite, weight loss, headache, visual disturbance or muscle aches. Denies sleep problem. No decreased urine output. **Similar symptoms previously:** Milder. **Review of systems:** She has had nausea. She has had vomiting (yesterday episode resolved). **Physical examination:** **Vital signs:** BP 112/51, HR 88, RR 18, O2 saturation 81% on room air. Weight 147.4 kg. Temperature 98.1. Pain level 10/10. BMI 36.6. Respiratory: Mild rales present bilaterally. **Back:** Probable grade 4 foul smelling ulcer with damage down to muscle. Located on sacral area. **General orders:** Wound culture. Complete Blood Count (CBC) with differentials. Comprehensive Metabolic Panel (CMP) stat. Lactate. Blood culture. Urinalysis. **Progress and procedures:** **Disposition:** Admitted. **Clinical impression:** Sacral decubitus – severe.	
10/17/2014	Daniel J. Glover, M.D.	**Admission for draining sacral wound:** *History reviewed.* She was later extubated, but she states she developed a wound after being in bed for that period of time. She states that it was addressed while she was at Statewide Medical Center and in the Brian Center as well; however, it worsened and it worsened to the point where it was foul smelling at the Brian center. Because of the worsening smell and because the wound itself had progressed she was sent back to the Emergency Room here at Statewide Hospital, where it was evaluated and it was felt that it needed surgical debridement intervention. The patient states that the wound was draining. She states that she had some pain from the wound, but she has pain also because of, for the most part, deconditioning. She states that she has not walked. She has only stood with assistance. **Review of systems:** **Constitutional:** The patient states that she had a temperature up to 101.1 at the Brian Center. She has also admitted to constant sweating. The patient received a pneumonia and influenza shot prior to being discharged recently from Statewide Hospital following her previous Intensive Care Unit (ICU) stay. **ENMT:** She admits to cotton dry, cotton type mouth. **Neck:** Pain along with her other symptoms. **Pulmonary:** Dyspnea this morning upon awakening this morning. **Cardiovascular:** No reported chest pain in the central part of her chest, but	2722-2725

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		she does admit to rib pain on the left and she cannot lie on her left. She states that it hurts on the left. **Gastrointestinal:** Nausea and vomiting this morning. **Genitourinary:** Some dysuria, which she feels is from having the catheter in long-term earlier doing her ICU stay. She admits to having improved, clear urine, but now it is dark. **Musculoskeletal:** The patient admits to left-sided rib pain, for which it hurts for her to lie on her left side. She states she has been unable to walk for 3 weeks now. **Neurological:** She is weak in her legs. **Psychiatric:** Bipolar disorder with, she states, a lot episodes and recurrences of anxiety. **Endocrine:** Diabetes mellitus type 2. **Skin:** No rash or skin condition such as psoriasis. **Physical examination:** **Vital signs:** Temperature is 98.1, heart rate is 90, respirations are 18, blood pressure is 112/50. O2 saturation is 96% on room air. **Constitutional:** The patient is in no acute distress. She is uncomfortable from many of her body aches from cramping and weak muscles. She is alert and oriented to person, place and time and situation. **Gastrointestinal:** Positive bowel sounds, soft, mild diffuse tenderness. Bowel sounds are present. No organomegaly. **Psychiatric:** The patient admits to anxiety, but she is cooperative, she is calm and she is appropriate. **Assessment and plan:** Acute cellulitis with sacral decubitus. We will place the patient on Zosyn. Diabetes mellitus type 2. We will check a hemoglobin A1C. We will place the patient on sliding scale regimen. Hyperlipidemia. We will continue the patient's statin. Hypertension. We will continue the patient's antihypertensive medicines. Bipolar disorder. We will continue the patient's mood medicines. Coronary artery disease. We will continue Plavix and Lisinopril. It does not look like the patient has a beta blocker, likely due to underlying lung disease. Peripheral neuropathy. We will continue Neurontin. Insomnia. We will continue melatonin. **CODE STATUS:** The patient's code status is FULL CODE.	
10/17/2014	Statewide Regional Medical Center	**Admission assessment:** @ **1519 hrs:** Temperature 98.4, Pulse 86, RR 18, BP 95/53. Weight 146.90 kg. @ **1544 hrs:** SpO2 92%. *(Ref 2780)* @ **1641 hrs:** Left buttock acute pain. 10/10. *(Ref 2775)* **Braden scale:** 13/23. *(Ref 2775-2776)* Requires assistance with positioning. *(Ref 2779)*	2768-2780
10/17/2014	Lisa Bragg, R.N.	**Wound assessment:** **Location of wound:** Bilateral **ischium**. **Type of wound:** Pressure ulcer. **Wound size in cm:** 21 x 15 x 6 cm.	2781

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		Undermining: From 3 to 6 o clock measuring 3.5. **Odor:** Foul. **Staging:** Stage IV. **Drainage:** Large, other. (Grey, malodorous) **Wound appearance pre-debridement:** (Surgical consult recommended for large amount of grey slough throughout depth of wound and distal aspect). **Periwound skin:** Intact. **Treatment:** Cleanse with normal saline, antiseptic other Anasept. Fill with Maxorb ES Ag. Cover with Alleyn sacrum with two Mepilex border 6 x 6. **Debridement:** Non selective. **Other interventions:** Nurse, Sally, informed this nurse that Dr. Tucci is currently in surgery and will be seeing this patient after said surgery.	
10/17/2014		**Wound care treatment plan:** **Wound location/type:** Bilateral ischium stage IV pressure ulcer. Cleanse with normal saline and Anasept wound cleanser. Lightly fill wound with Aquacel Ag. Cover wound with Mepilex border 6 x 6 (3). Change dressing daily. **Additional instructions:** Recommend surgical debridement and wound VAC placement. Recommend silver wound VAC granufoam.	2767
10/17/2014		**Daily nursing assessment:** @ **1700 hrs:** Transferred to bariatric air flo bed. @ **1854 hrs:** Pain 3/10 left buttock. @ **2000 hrs:** Braden scale: 18/23. @ **2054 hrs:** Pain 10/10, left buttock. @ **2100 hrs:** Positioning independent. @ **2154 hrs:** Pain reassessment 5/10, left buttock.	2781, 2783-2784, 2786-2787
10/17/2014		**Labs:** **High:** C Reactive Protein **(**CRP) (196.1), WBC (13.3) **Low:** Total protein (5.9), Albumin (2.8), Prealbumin (10.1), RBC (4.27), hemoglobin (12.9), Hematocrit (37.6)	2728, 2730
10/18/2014		@ **1320 hrs: Surgery progress note:** Met with patient regarding decubitus and she clearly needs debridement. On Plavix, however, and will prefer to wait a few days before surgery. Will discontinue Plavix.	2741
10/18/2014	Daniel J. Glover, M.D.	**Hospitalist progress note:** Patient with draining sacral stage 4 decubitus. Tolerating diet. **Vital signs:** Temperature max 98.6. BP 102/55, Pulse 92, Temperature 98.6, RR 18. O2 saturation 96%. **Abdomen:** Mild right sided abdominal tenderness to palpation. **Extremities:** Trace edema bilaterally in the lower extremities. **Skin:** Stage 4 sacral decubitus with treatment application over the wound. **Assessment and plan:** Acute stage 4 sacral decubitus. General Surgery consulted for debridement and management. Wound care team consulted and also involved. On IV Zosyn until debridement with antibiotic day #2 on Saturday 10/18/2014.	2763-2766

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Recent prolonged hospital stay last month with acute severe sepsis, severe ARDS, acute healthcare acquired pneumonia. Leukocytosis. Severe protein calorie malnutrition with prealbumin of 10.1. On Lovenox 40 mg subcutaneous daily for DVT prophylaxis.	
10/18/2014		**Daily nursing assessment:** @ **0100 hrs:** Positioning independent. Pain score 10/10, left buttock. @ **0200 hrs, 0240 hrs:** Pain reassessment: 6/10, left buttock. @ **0300 hrs:** Positioning independent. @ **0340 hrs:** Pain assessment: 4/10, left buttock. @ **0745 hrs:** Positioning independent. Pain 10/10, left buttock. Braden scale 19/23. Decubitus sacral ulcer, dressing with some noted drainage, surgery consult ordered. Heels dry, scaly. @ **0845 hrs, 0925 hrs:** Pain 7/10, left buttock. @ **1142 hrs:** Pain 10/10, left buttock. @ **1226 hrs:** Dressing change performed. @ **1323 hrs:** Pain 10/10 left buttock. @ **1421 hrs:** Pain 4/10, left buttock. @ **1758 hrs:** Pain 10/10, left buttock. @ **1825 hrs:** Pain 7/10, Left buttock. @ **2000 hrs:** Braden scale: 18/23.	2788-2791, 2795, 2802-2804
10/18/2014		**Labs:** **High:** WBC (15) **Low:** Total protein (5.8), Albumin (2.6), RBC (4.07), Hemoglobin (11.9), Hematocrit (36.9)	2728, 2730
10/19/2014	[signature]	@ **0850 hrs: Surgery progress note:** Patient aware of delay reason. Will attempt debridement Tuesday.	2741
10/19/2014	Daniel J. Glover, M.D.	**Hospitalist progress note:** Foul smelling draining sacral decubitus. Abdominal pain. Tolerating diet. **Vital signs:** Temperature max 98.6, BP 105/55, Pulse 88, Temperature 98.4, RR 16, O2 saturation 93%. **Physical examination:** Patient is worried about her sacral decubitus. Abdominal mild diffuse tenderness. Stage 4 sacral decubitus with treatment application over the wound. **Assessment and plan:** Dr. Tucci General Surgery to debride soon after patient has been off Plavix for several days. Plavix stopped by Dr. Tucci on Saturday. Wound care team consulted and also involved. On IV Zosyn until debridement with antibiotic day #3 on Sunday. On nicotine patch. Tobacco cessation recommended. Persistently elevated LFTs. On Pepcid 20 mg orally twice daily.	2759-2762
10/19/2014		**Daily nursing assessment:** @ **0915 hrs:** Positioning independent. Pain 10/10, left buttock. Braden scale 21/23. Dressing to sacrum, buttock intact with noted drainage. Appetite good. @ **1020 hrs:** Pain 6/10, left buttock. @ **1315 hrs:** Pain 10/10, left buttock. @ **1409 hrs:** Dressing change performed as ordered. Drainage with foul odor.	2808-2809, 2811, 2813, 2815-2818, 2820-2821

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Pain 6/10, left buttock. @ **1620 hrs:** Pain 10/10, left buttock. @ **1720 hrs, 1728 hrs:** Pain 9/10, left buttock. @ **1830 hrs:** Pain 6/10, left buttock. @ **1905 hrs:** Positioning independent. @ **2000 hrs:** Braden scale 20/23. @ **2118 hrs:** Positioning independent. @ **2332 hrs:** Positioning independent.	
10/19/2014		**Labs:** **High:** WBC (12.7) **Low:** Total protein (5.8), Albumin (2.6), RBC (3.93), Hemoglobin (11.6), Hematocrit (35) **Wound culture:** **Collected date:** 10/17/2014. **Source:** Buttocks. **Direct exam:** White blood cells seen on smear. Moderate amount of gram negative rods seen on smear. Light amount of gram positive cocci seen on smear. Acceptable specimen, culture results to follow. **Culture exam:** Heavy growth Escherichia coli. **Susceptibility:** Sensitive to Amikacin, Cefepime, Cefotaxime, Ceftazidime, Cefuroxime, Gentamicin, Imipenem, Tobramycin. Resistant to Ampicillin/Sulbactam, Cefazolin, Ciprofloxacin, Levofloxacin, Piperacillin, Piperacillin/Tazobactam, Tetracycline, Ticarcillin/K Clavulanate, Amoxicillin, Ampicillin.	2727, 2729, 2731-2732
10/20/2014		@ **1220 hrs: PICC double lumen insertion procedure report:** **Indication for line:** Inadequate peripheral access. **Type of line:** PICC double lumen. **Site of insertion:** Right central placement. Basilic. **Catheter size:** 5 Fr. **Catheter length:** 55 cm, not trimmed. **Secure at cm:** 50 cm. **Notes:** Statseal powder to insertion site. **Complications:** No complications.	2739-2740
10/20/2014	Daniel J. Glover, M.D.	**Hospitalist progress note:** Draining sacral decubitus. Abdominal pain. Tolerating diet. **Vital signs:** Temperature 98.8, BP 112/57, Pulse 68, Temperature 98.6, RR 16, O2 saturation 96%. Mild upper abdominal discomfort to palpation predominantly in the muscle tissue. Bowel sound present. Trace edema bilaterally in the lower extremities. Stage 4 sacral decubitus with treatment application over the wound. Day #4 antibiotics. Decrease Lasix to 20 mg orally daily. Hold for systolic BP less than 130 mmHg. Decrease Lisinopril 10 mg orally daily. Hold for systolic BP less than 120 mmHg.	2755-2758
10/20/2014	Lisa Bragg, R.N.	**Wound assessment:** **Location of wound:** Bilateral ischium. **Type of wound:** Pressure ulcer.	2824

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Wound size in cms: 21 x 15 x 9. **Odor:** Foul. **Staging:** Stage IV. **Drainage:** Large. Grey, tan, malodorous. Dr. Tucci to see patient. Not able to go to surgery for debridement until lab values stabilize – has been on Plavix. **Periwound skin: Macerated, erythemic, denuded.** **Treatment:** Cleanse with normal saline, antiseptic – Anasept. Periwound with skin prep, fill with Aquacel Ag, cover with Mepilex sacrum and two Mepilex borders 6 x 6. **Treatment plan:** Continue treatment plan. **Other interventions:** Dressing change. Mepilex border 6 x 6 placed on both hips prophylactic ally. Patient repositions frequently to keep pressure off her sacrum and ischemia.	
10/20/2014		**Daily nursing assessment:** @ **0127 hrs:** Positioning independent. @ **0304 hrs:** Positioning independent. @ **0506 hrs:** Positioning independent. @ **0722 hrs:** Turned and positioned for comfort. @ **0900 hrs:** Positioning independent. @ **1100 hrs:** Positioning independent. @ **1300 hrs:** Turned and positioned for comfort. @ **1506 hrs:** Referral made to care partner rehab. Patient for debridement and wound VAC application 10/21/2014 (had to be held as patient had been on Plavix). @ **1700 hrs:** Turned and positioned for comfort. @ **1930 hrs:** Positioning independent. Patient on bariatric bed. Turns self side to side. Has trapeze. Pain 9/10, left buttock. Braden scale 18/23. Dressing changed, removed soiled packing and cleaned with normal saline and repacked with Aquacel Ag and recovered with Mepilex border 6x 6. Area is bilateral ischium. @ **2125 hrs:** Pain 9/10, left buttock. @ **2225 hrs:** Pain 9/10, left buttock. Positioning independent. Braden scale 18/23. @ **2253 hrs:** Pain 10/10, left buttock. @ **2342 hrs:** Positioning independent. Pain 8/10. Braden scale 18/23.	2821-2823, 2826-2830, 2832, 2834-2838
10/20/2014		**Labs:** **Low:** Total protein (5.8), Albumin (2.6), RBC (3.98), Hemoglobin (11.9), Hematocrit (35.3)	2727, 2729
10/21/2014	Daniel J. Glover, M.D.	**Hospitalist progress note:** Debridement today. Abdominal pain. Tolerating diet. **Vital signs:** Temperature max 98.3, BP 124/73, Pulse 77, Temperature 98.1, RR 18, O2 saturation 92%. Generalized abdominal tenderness likely from this past month's Lovenox injections. Stage 4 sacral decubitus with treatment application over the wound. Decreased the doses of both Lasix and Lisinopril.	2751-2754
10/21/2014	George Hanson	**Anesthesia record:** **Diagnosis:** Buttock lesion.	2987

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Procedure: I &D exploration right buttock lesion.	
10/21/2014		**Operative note:** **Pre and post operative diagnosis:** Decubitus ulcer. **Procedure:** Buttocks I & D/Exploration. **Drains:** Unknown. **Case notes:** Decubitus ulcer I & D. ***Reviewer's comment: The operative report is dated as 10/23/2014 (Ref 2989) and is summarized below with same date.***	2988
10/21/2014		**Daily nursing assessment:** @ **0200 hrs:** Positioning independent. Braden scale 18/23. @ **0305 hrs:** Dressing changed. Pain 9/10, left buttock. Bleed through old dressing. Noted 2 blood clots in old dressing. Cleansed with saline and packed with Aquacel Ag. Applied Mepilex with borders 6/6 x3. Patient given Ativan 1 mg with a sip of water for dressing change. @ **0405 hrs:** Positioning independent. Pain 8/10, left buttock. Braden scale 18/23. @ **0600 hrs:** Positioning independent. Pain 8/10, left buttock. Braden scale 17/23. @ **0700 hrs:** Pain 10/10, left buttock. @ **0719 hrs:** Positioning independent. @ **0847 hrs:** Braden scale 16/23. @ **0936 hrs:** Positioning independent. @ **1415 hrs:** Pain 8/10, left buttock. @ **1517 hrs:** Turned and positioned for comfort. @ **1611 hrs:** Turned and positioned for comfort. Pain 4/10, left buttock. @ **1700 hrs:** Turned and positioned for comfort. @ **1825 hrs:** Pain 8/10, left buttock. @ **1949 hrs:** Wound VAC in place to 125 mmHg suction. Dressing intact. Positioning independent. Pain 10/10, left buttock. Braden scale 18/23. @ **2049 hrs:** Pain 9/10, left buttock. @ **2132 hrs:** Turned and positioned for comfort. Pain 10/10, left buttock. Braden scale 17/23. @ **2230 hrs:** Pain 9/10, left buttock. @ 2334 hrs: Positioning independent. Pain 10/10 left buttock. Braden scale 17/23.	2840-2843, 2845, 2847-2848, 2853-2858, 2862-2867
10/21/2014		**Labs:** **Low:** Total protein (6.1), Albumin (2.8), RBC (4.08), hemoglobin (12.4), hematocrit (36.1)	2727, 2729
10/22/2014	Daniel J. Glover, M.D.	**Hospitalist progress note:** Draining sacral decubitus status post debridement by Dr. Tucci on yesterday. Vital signs: Temperature max 98.9, BP 117/60, Pulse 72, Temperature 98.3, RR 18, O2 saturation 94%. Anxious concerning her sacral wound. Wound VAC is present. Dr. Tucci recommended continuing antibiotic therapy.	2746-2750
10/22/2014	Lisa Bragg, R.N.	**Wound assessment:** **Location of wound:** Bilateral ischium. **Type of wound:** Surgical wound. **Wound size in cms:** 13 x 10 x 6.	2886-2887

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Undermining: From 0930 to 0400 o'clock measures 7.5 cm. **Drainage:** Large, serosanguineous. **Wound appearance:** 95% pale pink, 5% slough. Wound appearance post debridement 100% pale pink. Periwound skin erythemic and denuded. **Treatment:** Cleanse with normal saline and Anasept. Periwound with skin prep and Marathon. Fill with white foam. Cover with silver granulofoam. Secure with KCl drape. Debridement non selective. Wound VAC therapy ongoing set at 125 mmHg continuous.	
10/22/2014		**Daily nursing assessment:** @ **0034 hrs:** Pain 9/10, left buttock. @ **0248 hrs:** Pain 9/10, left buttock. Positioning independent. Braden scale 17/23. @ **0333 hrs:** Pain 9/10, left buttock. @ **0430 hrs:** Positioning independent. Pain 8/10 left buttock. Braden scale 17/23. @ **0539 hrs:** Pain 9/10, left buttock. @ **0623 hrs:** Positioning independent. Pain 8/10, left buttock. Braden scale 17/23. @ **0729 hrs:** Positioning independent. @ **0743 hrs:** Pain 10/10, left buttock. Braden scale 21/23. Wound VAC to sacral wound. @ **0842 hrs:** Pain 7/10, left buttock. @ **0907 hrs:** Positioning independent. @ **1048 hrs:** Pain 9/10, left buttock. @ **1052 hrs:** Weight 1445.9 kgs. @ **1126 hrs:** Positioning independent. @ **1139 hrs:** 10/10, left buttock pain. @ **1226 hrs:** 7/10, left buttock pain. @ **1319 hrs:** Wound care nurses in with patient to perform wound VAC dressing change. Patient pre-medicated with Morphine IV as ordered. @ **1357 hrs:** Positioning independent. @ **1500 hrs:** Positioning independent. @ **1547 hrs:** Pain 9/10, left buttock. @ **1648 hrs:** Pain 9/10, left buttock. @ **1700 hrs:** Positioning independent. @ **1753 hrs:** Pain 7/10, left buttock. @ **1920 hrs:** Positioning independent. Patient has a bariatric bed with a trapeze and turns well and often. Pain 7/10, left buttock. Braden scale 18/23. @ **2059 hrs:** Pain 9/10, left buttock. @ **2120 hrs:** Pain 7/10, left buttock. Positioning independent. @ **2300 hrs:** Positioning independent.	2868-2870, 2872-2875, 2877-2878, 2882-2886, 2888-2892, 2896-2897
10/22/2014		**Labs:** **Low:** Total protein (5.6), Albumin (2.6), RBC (3.58), Hemoglobin (10.8), Hematocrit (31.6)	2726, 2729
10/23/2014	Robin Benz, M.D.	**Hospitalist progress note:** Patient notes that she has pain in the wound region. Vital signs: Temperature max 97.8, BP 102/50, Pulse 65, Temperature 97.8,	2742-2745

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		RR 20, O2 saturation 98%. **Assessment and plan:** Sacral decubitus – debrided by Dr. Tucci on 10/21/2014, wound care team involved – case management working on placement. The patient continues to be on Zosyn we will discuss with Dr. Tucci.	
10/23/2014	Statewide Regional Medical Center Eric Tucci, M.D.	**Wound debridement operative report:** **Pre and postoperative diagnosis:** Sacral decubitus ulcer. **Indication:** The patient is a 53-year-old gentleman who has returned to the hospital with a worsening sacral decubitus ulcer. The exact cause is unclear, but apparently several weeks or a month earlier, she had had a severe pneumonia requiring prolonged ventilator support, possibly developing it at that time only to have it worsen once she had gone to rehabilitation or a nursing home. **Findings at surgery:** A very large, deep, widespread sacral decubitus ulcer, one of the worst that I have ever seen. **Description of procedure:** After receiving her informed consent, she was brought to the Operating Room, placed under satisfactory general anesthetic then rolled into the prone jackknife position. She was already on therapeutic antibiotics. The area of external skin breakdown measured about 10 to 12 cm in diameter and was irregular and just to the left of center, but as I debrided deeply through the necrotic fat as well as even muscle it tunneled out in all directions for a good 4 to 6 inches. After debriding, several bleeding points were found requiring suture ligature but most were controlled with pressure and cautery. Once I had debrided a good 90% or so of the necrotic material, we then placed a silver sponge wound VAC into the cavity. The wound VAC was then assembled and put to suction. She tolerated this well with perhaps only 100 ml or so of blood loss and went back to recovery in good condition. **Reviewer's comment: The sacral debridement was carried out on 10/21/2014, but in the medical records it was documented as 10/23/2014. We have the brief operative note, the anesthesia record, and procedure flow sheets dated 10/21/2014.*	2989-2990
10/23/2014		**Assessment:** Braden scale: 19. Wound VAC to lower left buttocks. Only skin deformity noted	5712-5714
10/23/2014		**Daily nursing assessment:** @ **0002 hrs:** Positioning independent. @ **0006 hrs:** Pain 9/10, left buttock. @ **0109 hrs:** Pain 8/10, left buttock. @ **0156 hrs:** Pain 9/10, left buttock. @ **0209 hrs:** Positioning independent. @ **0215 hrs:** Pain 8/10, left buttock. @ **0302 hrs:** Positioning independent. @ **0402 hrs:** Positioning independent. @ **0603 hrs:** Positioning independent. Pain 10/10, left buttock.	2897-2904, 2910-2913, 2915-2917, 2921-2922

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		@ **0620 hrs:** Pain 9/10, left buttock. @ **0700 hrs:** Positioning independent. @ **0813 hrs:** Pain 9/10, left buttock. @ **0830 hrs:** Turned and positioned for comfort. Braden scale 18/23. Wound VAC in place functioning appropriately. @ **0900 hrs:** Positioning independent. @ **0912 hrs:** Pain 7/10, left buttock. @ **1051 hrs:** Turned and positioned for comfort. Pain 9/10, left buttock. @ **1100 hrs:** Positioning independent. @ **1122 hrs:** Pain 6/10, left buttock. @ **1220 hrs:** Turned and positioned for comfort. @ **1315 hrs:** Positioning independent. Turned and positioned for comfort. @ **1438 hrs:** Pain 9/10, left buttock. @ **1510 hrs:** Out of bed in chair. Turned and positioned for comfort. @ **1536 hrs:** Pain 5/10, left buttock. @ **1702 hrs:** Positioning independent. @ **1839 hrs:** Turned and positioned for comfort. Pain 8/10, left buttock. @ **1912 hrs:** Positioning independent. Braden scale 17/23. Patient is quite down concerning her SNF placement, as her first choice will not take her with her wound VAC. The only place that has accepted her is the Brian Center which she is adamant that she does not want to go back there. @ **2001 hrs:** Positioning independent. @ **2100 hrs:** Positioning independent. @ **2202 hrs:** Positioning independent. @ **2245 hrs:** Pain 9/10, left buttock. @ **2300 hrs:** Positioning independent.	
10/23/2014		**Labs:** **Low:** Total protein (5.7), Albumin (2.7), RBC (3.56), hemoglobin (10.5), Hematocrit (31.2)	2726, 2729
10/24/2014	Jill Young, R.N.	**Wound assessment:** **Location of wound:** Bilateral ischium. **Type of wound:** Surgical wound. **Wound in size:** 9.5 x 13 x 6.6 cm. **Undermining:** 2-4 o'clock at 7 cm and 10-11 5 cm. **Drainage:** Large. Serosanguineous. **Wound appearance:** 100% slough. Pre debridement; post debridement 25% pale pink and 75% slough. **Periwound skin:** Erythemic, denuded. **Treatment:** Cleanse with normal saline, antiseptic and periwound with skin prep. Applied Aquacel Ag to outer areas of wound. Fill with white foam. Cover with black granufoam. Secure with drape. Debridement non selective. **Wound VAC therapy:** Ongoing set 125 mmHg continuous. Patient was medicated for pain prior to dressing change.	2935
10/24/2014		**Daily nursing assessment:** @ **0020 hrs:** Pain 9/10, left buttock. @ **0040 hrs:** Pain 0/10, left buttock. @ **0100 hrs:** Positioning independent. @ **0204 hrs:** Positioning independent.	2923-2927, 2931-2938

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		@ **0300 hrs:** Positioning independent. @ **0352 hrs:** Positioning independent. Pain 8/10, left buttock. @ **0500 hrs:** Positioning independent. @ **0615 hrs:** Positioning independent. @ **0700 hrs:** Positioning independent. @ **0759 hrs:** Positioning independent. Pain 9/10, left buttock. Braden scale 20/23. @ **0853 hrs**: Pain 7/10, left buttock. @ **0900 hrs:** Turned and positioned for comfort. @ **1043 hrs:** Patient expressed desire to go to Mountain Trace instead of Brian Center. Called Mountain Trace, no medicare beds available at facility. Patient instructed she could be transferred to Mountain Trace from Brian Center when a bed became available if she desired. @ **1055 hrs:** Pain 10/10, left buttock. @ **1100 hrs:** Positioning independent. @ **1211 hrs, 1230 hrs:** Pain 8/10, left buttock. @ **1317 hrs:** Turned and positioned for comfort. @ **1500 hrs:** Turned and positioned for comfort.	
10/24/2014		**Labs:** **Low:** Albumin (2.9), Total protein (5.9), RBC (3.56), Hemoglobin (10.7), Hematocrit (31.3)	2726, 2729
10/24/2014	Robin Benz, M.D.	**Discharge summary:** **Final diagnoses:** Sacral decubitus with wound infection. **Hospital course:** The patient was admitted. She was seen by the general surgery team management. Due to being on Plavix, they wanted to hold off on doing surgery and was not begun until October 23, 2014. The patient was placed on IV Zosyn. Wound care team was involved. Again, the patient had a sacral decubitus. Operative procedure done on October 23, 2014, noting that there was some tunneling and it was debrided. For additional discussion of the surgical debridement/wide debridement, please see the operative report from October 23, 2014. The patient was subsequently felt to be stabilized and we have arranged for her to go back to the Brian Center for treatment of her continued treatment of her wound. Antibiotics have been discontinued. ***Reviewer's comment: The wound debridement was done on 10/21/2014, but it was given as 10/23/2014.***	2599-2600
		Brian Center Health & Rehabilitation/Waynesville	
10/24/2014 - 10/29/2014	*Multiple Providers*	**Rehabilitation stay for wound care:** **10/24/2014:** Braden scale 19. *(Ref 5711)* Vital signs: Temperature 98.7, Pulse 76, RR 18, BP 118/91. *(Ref 5746)* Wound plan of care: Skin: Actual surgical site, pressure ulcer – history of ulcers. **Interventions:** Provide wound care/preventive skin care per order. Observe wound healing. Skin checks weekly per facility protocol, document findings. Notify MD of changes in wound, or emerging wounds. Turn and reposition frequently to decrease pressure.	5711, 5746, 5729, 5744, 5743, 5742, 5748, 5635, 5771

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Encourage participation in daily care needs as able. *(Ref 5729)* **10/25/2014:** Wound vac to coccyx. Temperature 98.6, Pulse 80, RR 22, BP 130/74. *(Ref 5744)* **10/26/2014:** Temperature 98.6, Pulse 78, RR 20, BP 116/66. Wound vac to coccyx. *(Ref 5743)* **10/27/2014:** Temperature 98, Pulse 84, RR 20, BP 104/56, SpO2 96%. Wound vac to coccyx. *(Ref 5748)* **10/28/2014:** Temperature 97.4, Pulse 75, RR 18, BP 135/74. Wound vac to coccyx. *(Ref 5742)* **10/29/2014:** Tramic copious blood coming around wound VAC. *(Ref 5635)* **Treatment sheets:** **10/25/2014-10/29/2014:** *(Ref 5771)* Pressure reducing mattress every shift while in bed. Pressure relieving cushion when out of bed in wheel chair every shift. Turn and reposition every 2 hours every shift. Head to toe skin assessment every Wednesday 3-11 shift.	
10/29/2014	[signature]	**Discharge summary:** Large amount bright blood, tramic, blood coming around wound vac to left buttock. Discharged to Medwest Statewide.	5634
		Statewide Regional Medical Center	
10/29/2014 - 10/30/2014	Marvin Williams, M.D.	**ER visit fro hemorrhage from wound:** Complaints of hemorrhage from wound. This started just prior to arrival. Patient had recent debridement of sacral decubitus. She ha s a wound vac in place. Patient reports that she had a bowel movement tonight and trained, and had sudden onset of copious bleeding from wound, and is still present. At its maximum, severity described as moderate. When seen in the ED, severity described as moderate. Modifying factors. Not worsened by anything. Not relieved by anything. **Physical examination:** **Rectal:** Large amount of blood present. Bleeding appears controlled with clamping of wound VAC at this time. Weight 120.2 kgs. **Progress and procedures:** **Course of care:** Discussed patient with surgeon, Dr. Tucci and hospitalist. Patient hemoglobin is decreased about 2 grams since 09/22/2014. Patient is on Plavix. Decision is made to admit for monitoring of hemoglobin/hematocrit. **Disposition:** Admitted to the medical/surgical unit. A medical screening exam was performed. The patient should continue through the ED for further evaluation. **Clinical impression:** Post operative wound hemorrhage.	2369-2376

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		10/29/2014: Labs: *(Ref 2388, 2394)* **High:** WBC (15.8) **Low:** Total protein (6), Albumin (3), RBC (3.79), Hemoglobin (11.3), Hematocrit (33.1)	
10/30/2014	Robert Planck, M.D.	**Admission for wound bleeding:** Massive gross prevalent bleeding from her wound VAC and sacral decubitus ulcer. Bleeding was bright red and also cherry-colored. *History reviewed.* She returns tonight with report of "massive bleeding" from her wound VAC and sacral decubitus ulcer. Reportedly, the wound VAC had to be cut off and dis-applied and, after the wound VAC was stopped, the bleeding was subsequently significantly decreased. The area of the sacral decubitus ulcer is still quite moist and bloody, but I do not see any obvious active bleeding. Her hemoglobin has dropped from 13.9 to 11.3. Will go ahead and admit for further observation, and will request surgical consultation in the morning obviously, her Plavix and Aspirin will be on hold for the moment given her active bleeding. Will continue to monitor closely and if her hemoglobin drops anywhere below 10 or 9.0, could consider a blood transfusion to optimize oxygen delivery given her history of coronary artery disease. Will continue to monitor. Wound care consultation will be requested. **Admitting diagnoses:** Active bleeding from sacral decubitus ulcer. Active bleeding from wound VAC and sacral decubitus ulcer. Sacral decubitus ulcer pain. Sacral decubitus ulcer, status post wound VAC. wound VAC stopped given active bleeding. Coronary artery disease with a history of coronary artery stenting. obviously, Aspirin and Plavix will have to be on hold for the moment given her active bleed. **Physical examination:** **Vital signs:** Blood pressure is 150/59. Heart rate is 94, respirations 18, temperature is 98.5, oxygen saturation is 96%. **Skin:** There is evidence of a large sacral decubitus ulcer which looks moist and bloody all around both with bright red blood and also cherry-colored blood. I do not see any obvious active bleeding at the moment. I do not see any pus or significant purulent secretions. **Assessment and plan:** The patient is a 53-year-old male who comes to the Emergency Department referred from skilled nursing facility due to what was described as "a massive amount" of active bright red blood bleeding from her wound VAC and sacral decubitus ulcer that reportedly started a few hours ago. Wound VAC was turned off and the patient was sent to the Emergency Department for further evaluation. Her hemoglobin at the present time is 11.3. Actually, her post-discharge hemoglobin from October 24, 2014, was only 10.7, so no significant blood drop so far; will continue serial hemoglobins overnight. Given her active	2378-2382

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		bleeding, ER physician called surgery on call, Dr. Tucci, who is the surgeon who performed the original debridement and so Dr. Tucci will consult with the patient in the morning will request wound care consultation as well. Obviously, wound VAC will be on hold as well as her blood thinners, including Aspirin and Plavix. Will continue to monitor. Of Note, per Dr. Tucci's operative report from 7 days ago, it noted after debriding, the patient actually had several acute bleeding points that on occasion required ligature suture, but mostly were controlled with pressure and cautery. Will continue to monitor closely and if re-bleeding starts again, could consider calling Dr. Tucci emergently for evaluation. Obviously, for the moment her Plavix and Aspirin will be on hold. She takes those chronically given her history of coronary artery disease, myocardial infarction and coronary artery stenting. Will place on sequential compression devices for deep venous thrombosis prophylaxis. Will request wound care consultation. She is currently afebrile.	
10/30/2014		**PICC placement note:** Indication: Inadequate peripheral access and GI bleed. Type of line: PICC double lumen. Site of insertion: Right central placement. Brachial. 5Fr catheter size, 50 cm length, secured at 46 cm.	2402-2403
10/30/2014	Robin Benz, M.D.	**Hospitalist progress note:** Temperature max 98.3, BP 100/52, Pulse 85, Temperature 98, RR 18, O2 saturation 5%. 8 x 6 x 6 cm stage IV sacral decubitus now without active bleeding. **Assessment and plan:** Bleeding from wound VAC pump sacral decubitus. She returned this evening with large amount of bleeding. Hemoglobin dropped from 13.9 to 11.3. Plavix and Aspirin were held.	2496-2498
10/30/2014		**Labs:** **Low:** Hemoglobin (10.5-10.6), Hematocrit (31.4-32.1)	2393-2394
10/31/2014		**Surgery progress note:** Concerns of bleeding this morning and decreased hemoglobin. Wound checked with wound care, some clots, no active fresh bleeding. Somewhat cleaner. Continue same.	2403
10/31/2014	Robin Benz, M.D.	**Hospitalist progress note:** Patient noted to be still miserable, she started having more brisk bleeding from her wound. **Vital signs:** Temperature max 98.2, BP 107/55, Pulse 66, Temperature 98, RR 18, O2 saturation 95%. Wound VAC was restarted yesterday. This morning she began developing more brisk bleeding. Her hemoglobin dropped a half a point from previous check less than 2 hours previous. Surgery is aware and will come to see the patient shortly we will go ahead and transfuse the patient. We are stopping the wound VAC. Severity is severe. Without hospitalization the patient might bleed to death.	2492-2495, 2491

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
10/31/2014	Lisa A. Bragg, R.N.	**Wound care treatment plan:** *(Illegible notes)* **Wound location/Type:** Bilateral ischial surgical wound. Discontinue previous wound care treatment plan – Used wound VAC. Cleanse with normal saline. Apply barrier up to edge of wound: Mepitel (can be ________ unless soiled). Lightly fill wound with saline soaked Kerlix. Cover wound with ABD x3. Secure dressing with Tegaderm. Change dressing daily and as needed dressing saturated. Additional instructions: Sween 24 to bilateral heels and all dry skin areas daily.	2501
10/31/2014		**Labs:** **Low:** Hemoglobin (7.8-9.7), Hematocrit (22.1-27.7), RBC (3.14)	2393
11/01/2014	[signature]	**Surgery progress note:** *(Illegible notes)* Complaining of ___ pain. No drainage. H/H pending. Status post 2 units transfusion.	2403
11/01/2014	Daniel J. Glover, M.D.	**Hospitalist progress note:** Bleeding sacral decubitus wound. Temperature max 98.9, BP 118/68, Pulse 65, Temperature 98, RR 17, O2 saturation 98%. Abdomen mild diffuse tenderness. Skin with rash and cellulitis. Transfused 3 units PRBCs on Friday morning 10/31/2014. Wound VAC stopped. Plan to discuss this case with Dr. Tucci General Surgery on Monday 11/03/2014.	2487-2490
11/01/2014		**Labs:** **Low:** RBC (3.68), Hemoglobin (10.9), Hematocrit (31.9)	2393
11/02/2014	Daniel J. Glover, M.D.	**Hospitalist progress note:** Abdominal pain and tolerating diet. Temperature max 98.7, BP 101/51, Pulse 68, RR 17, O2 saturation 92%. Anxious about her stage 4 sacral decubitus wound. Very mild abdominal tenderness diffusely. Plan to discuss with Dr. Almina General Surgery (covering for Dr. Tucci) today 11/02/2014. Checking H/H every 6 hours. Keeping 4 units of PRBC on hold.	2483-2486
11/02/2014	[signature]	**@ 1900 hrs: Surgery progress note:** Brisk bleeding from wound bed this morning. Hemoglobin 12.5. Dressing changed. Clot intact without no visible vessel bleeding. Cleaned and cauterized with silver nitrate. No current bleeding noted. Repacked and told patient to be flat on back for 1 hour.	2401
11/02/2014		**Labs:** **Low:** Hemoglobin (8.1-10.9), Hematocrit (23.5-28.6)	2392-2393
11/03/2014	Daniel J. Glover, M.D.	**Hospitalist progress note:** Tolerating diet. Vital signs: Temperature max 98.2, BP 126/58, Pulse 88, Temperature 97.8, RR 16, O2 saturation 98%. Stage 4 sacral decubitus examined today 11/03/2014 measuring 9 cm by 7 cm by 5cm with clot and no bleeding and good granulation tissue. **Assessment and plan:** I discussed this case with Dr. Tucci General Surgery	2479-2482

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		on today 11/03/2014. Patient will need intervention from Plastic Surgery.	
11/03/2014		**Labs:** **Low:** Hemoglobin (9.3-9.8), Hematocrit (28-28.5)	2392
11/04/2014	Daniel J. Glover, M.D.	**Hospitalist progress note:** Tolerating diet. Vital signs: Temperature max 98, BP 95/48, Pulse 75, Temperature 97.7, RR 16, O2 saturation 98%. Large stage 4 sacral decubitus wound on the buttock with wound VAC. Wound VAC back in place again after the bleeding has stopped. I spoke with Dr. Simms at Sleepy Hollow Medical Center in Winston Salem, NC. She believes that the patient will be a candidate in the next 3 to 6 weeks but not today. Patient needs to be evaluated and treated for any MRSA infection. I will call other North Carolina tertiary centers with Plastic Surgeons. I plan to discuss this situation with Dr. Tucci. Discontinued tobacco patch on 11/04/2014. Patient will need to be off any nicotine for any plastic surgery flap procedure.	2475-2478
11/04/2014		**Labs:** **Low:** Hemoglobin (9.2-9.5), Hematocrit (27.6-29.4)	2392
11/05/2014	Daniel J. Glover, M.D.	**@ 1400 hrs: Hospitalist progress note:** Patient has a complex stage 4 extensive deep stage 4 sacral decubitus. She will need a short term rehabilitation stay of less than a month with a wound care nurse or team where her wound can be treated. She will need an appointment with a specialized Plastic Surgeon who can perform a complex bilateral flap procedure.	2400
11/05/2014	Daniel J. Glover, M.D.	**Hospitalist progress note:** Patient with large stage 4 sacral decubitus wound. Patient complains of consistent burning pain from the sacral decubitus. Abdominal pain and tolerating diet. **Vital signs:** Temperature max 98.3, BP 112/57, Pulse 65, Temperature 97.7, RR 16, O2 saturation 98%. Anemia resolved.	2470-2474
11/05/2014		**Labs:** **Low:** Total protein (5.6), Albumin (2.9), Hemoglobin (9.3-10.1), Hematocrit (28.7-30.4), RBC (3.23)	2387, 2390-2391
11/06/2014	Daniel J. Glover, M.D.	**Hospitalist progress note:** Abdominal pain and tolerating diet. **Vital signs:** Temperature max 97.7, BP 106/54, Pulse 68, Temperature 97.6, RR 16, O2 saturation 95%.	2466-2469
11/06/2014		**Labs:** **Low:** Total protein (5.9), Albumin (3), Hemoglobin (9.4-9.8), Hematocrit (27.9-29.6), RBC (3.39)	2387, 2390
11/07/2014	Daniel J. Glover, M.D.	**Hospitalist progress note:** Patient had some foul smell to her sacral decubitus. Abdominal pain and tolerating diet.	2461-2465

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Vital signs: Temperature max 97.9, BP 102/50, Pulse 60, RR 17, saturation 95%. Foul smell to sacral wound. Requested that Dr. Tucci and the wound care nurse reevaluate the wound. Today called East Carolina University Medical/Vidant Medical Center for transfer but it was not felt to be an appropriate inpatient transfer. I discuss this situation with Dr. Tucci. Case management is now helping with other options for treatment of patient's large decubitus.	
11/07/2014		**Labs:** **Low:** Total protein (5.5), Albumin (2.8), RBC (3.27), Hemoglobin (9.6), Hematocrit (28.3)	2386, 2390
11/08/2014	Pincus Samuel, M.D.	**Hospitalist progress note:** Patient admits to increased anxiety and wants to know if she can be put back on her home medications Xanax. **Vital signs:** Temperature max 98.7, BP 112/72, Pulse 68, Temperature 98.3, RR 17, O2 saturation 97%. Vacuum noted on the sacral wound. Wound vacuum is noted with extensive amount of odor. We will continue current treatment. I am going to speak to the surgeon on Monday so that we can decide what will be the long term plan. At this time we do not have a place for transfer. Anemia stable at this time. Start her back on Xanax for general anxiety.	2458-2460
11/08/2014		**Labs:** **Low:** Total protein (5.6), Albumin (2.8), RBC (3.39), Hemoglobin (9.8), Hematocrit (29.6)	2386, 2389
11/09/2014	Pincus Samuel, M.D.	**Hospitalist progress note:** Patient admitted to mild pain in the sacral region this morning. **Vital signs:** Temperature max 98.3, BP 116/65, Pulse 61, Temperature 97.2, RR 16, O2 saturation 99%. Wound vacuum is noted with extensive amount of odor. Plan is to discharge her to another Nursing Facility. I am going to speak to case management in the morning to see if patient is scheduled to follow-up with Wake Plastic Surgeon in 3 weeks. Continue to follow hemoglobin and hematocrit.	2455-2457
11/09/2014		**Labs:** **Low:** Total protein (5.3), Albumin (2.6), RBC (3.31), Hemoglobin (9.7), Hematocrit (28.8)	2386, 2389
11/10/2014	Pincus Samuel, M.D.	**Hospitalist progress note:** She is complaining of a right sided chest pain. **Vital signs:** Temperature max 98.4, BP 105/83, Pulse 75, Temperature 97.8, RR 18, O2 saturation 96%. Ulceration noted in the sacrum area that still size of the boxing glove and can see the sacrum.	2452-2454

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Give Toradol times one. Wound vacuum changed today. Anemia stable.	
11/10/2014		**Labs:** **Low:** Total protein (5.7), Albumin (2.9), RBC (3.42), Hemoglobin (9.9), Hematocrit (29.8)	2385, 2389
11/11/2014	Pincus Samuel, M.D.	**Hospitalist progress note:** She is complaining of sacral pain this morning. **Vital signs:** Temperature max 100.4, BP 119/65, Pulse 67, RR 16, saturation 93%. Vac on the sacral wound. Fever. Get procalcitonin level and follow temperature. Adjust pain medications. We have still waiting on discharge planning and disposition of her outpatient care.	2449-2451
11/11/2014		**Labs:** **Low:** Total protein (5.6), Albumin (2.8), RBC (3.46), Hemoglobin (10.1), Hematocrit (30.2)	2385, 2388
11/12/2014	Pincus Samuel, M.D.	**Hospitalist progress note:** Patient is complaining about sacrum pain this morning. She denies any shortness of breath, fever, or chills. **Vital signs:** Temperature max 98, BP 117/71, Pulse 73, Temperature 97.5, RR 18, O2 saturation 99%. Ulceration of the sacrum area with vac present. No fever in the last 24 hours. I am going to change her to oral medication for transition to outpatient setting. Patient was able to get an appointment Wake Forest Plastic Surgeon on 11/20/2014. Case manager to stay working on a long term facility for her that is close Wake Forest.	2446-2448
11/13/2014	Pincus Samuel, M.D.	**Hospitalist progress note:** Patient admitted that she did not sleep last night do to the pain with in her sacrum. She denies any fever or chills. **Vital signs:** Temperature max 98.6, BP 128/68, Pulse 76, Temperature 97.9, RR 18, O2 saturation 99%. Vac present on sacrum wound. Insomnia as needed medication for sleeping. Continue wound care and continue pain controlled. No new recommendation for today. We are stay waiting on placement.	2443-2445
11/14/2014	Pincus Samuel, M.D.	**Hospitalist progress note:** Patient admitted to trouble sleeping last night due to the pain in the sacrum area. **Vital signs:** Temperature max 98.4, BP 128/67, Pulse 68, Temperature 97.5, RR 20, O2 saturation 92%. Vac in sacrum region. Insomnia. As needed medication for sleeping and pain control. Continue	2440-2442

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		wound care and continue pain controlled. Get CMP and CBC. No new recommendation for today. We are stay waiting on placement.	
11/15/2014	Kristen Crosby, M.D.	**Hospitalist progress note:** Doing well overall but pain poorly controlled currently. **Vital signs:** Temperature max 98, BP 118/77, Pulse 65, RR 15, saturation 95%. Glucose have been good. Will discontinue Insulin sliding scale and glucometer. Continue with wound care, wound vac. Appointment at Wake Forest 11/20/2014. Pain is not controlled by oral Dilaudid; will add back IV Dilaudid as needed breakthrough pain. Patient states she has been on Norco 10/325 x 20 years for back pain so she has a high tolerance for narcotics. As needed Melatonin. Await appointment on Thursday, SNF placement sooner if able.	2437-2439
11/15/2014		**Labs:** **Low:** Total protein (6.1), Albumin (3.1), RBC (3.79), Hemoglobin (10.9), Hematocrit (32.8)	2385, 2388
11/16/2014	Kristen Crosby, M.D.	**Hospitalist progress note:** Reports pain is still severe and Dilaudid helps but pain still significant. Feels anxious about transfer on Thursday. **Vital signs:** Temperature max 98.3, BP 119/61, Pulse 76, Temperature 97.7, RR 20, O2 saturation 92%. Plan at this time is for patient stay here until she can be transferred to Wake Forest for surgical intervention, chronic narcotic use so tolerates high doses of narcotics without sedation or other side effects.	2434-2436
11/17/2014	Barry White, M.D.	**Hospitalist progress note:** Having sacral pain at times. Mild nausea. No new complaints. **Vital signs:** Temperature max 98.3, BP 142/79, Pulse 66, Temperature 97.5, RR 20, O2 saturation 97%. Plan is to go to Wake Forest Thursday; will contact provider before transfer/visit. Pain control. Sugars well controlled so stopped checks. Stable mood.	2431-2433
11/18/2014	Barry White, M.D.	**Hospitalist progress note:** Some sacral pain and getting IV narcotics a lot. Minimal nausea. Some feeling that she is hoarse. No shortness of breath. **Vital signs:** Temperature max 97.6, BP 112/58, Pulse 91, RR 18, saturation 97%. Plan is to go to Wake in 2 days; long talk 11/18/2014 about her pain and need to move to oral medications. She as titrated himself down from long acting medications for back pain in past. I told her my concern about tolerance balanced with pain control. Discussed with pharmacy and 12 mg Dilaudid is equigesic to Oxycontin 80 twice daily. Will use half of that but she will be on	2427-2430

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		narcotics for some time with wound. Stable mood.	
11/19/2014	Barry White, M.D.	**Hospitalist progress note:** Pain not that bad. Nausea improved. No shortness of breath. No cough. Able to ambulate a bit. **Vital signs:** Temperature max 98.5, BP 116/68, Pulse 63, Temperature 98.5, RR 16, O2 saturation 94%. Now on oral pain medications that she is doing okay with. Setting up for transport to Wake Forest. I called the office and her first OR date is 12/05/2014. Having to use IV medications as needed enroute.	2423-2426
11/20/2014	Sleepy Hollow Medical Center Anthony Simms, M.D.	**Plastic Surgery office visit for sacral stage 4 ulcer:** Large sacral pressure sore grade 4 sacral with 10 x 10 cm opening and 10 cm of undermining to right; 5 cm deep. Stopped nicotine patches 2 weeks ago. VAC in place; wound has been debrided well. **Plan:** Continue wound management with VAC and wound care debridement as currently being done. Vac may close wound to a smaller size to make flap easier. Must be off nicotine for 8 weeks to be a good flap candidate. This flap is already compromised by undermining. Discontinuation of nicotine is very important in this case for maximum flap survival.	4437-4462
11/21/2014	Case Manager Signature image	**Multidisciplinary care conference note:** Patient evaluated by Plastic/Reconstructive Surgeon at Sleepy Hollow Hospital yesterday and will need 4-6 more weeks before re-evaluation. Patient wants to go home at this time. Rehab reevaluated patient today and she is walking 150 feet independently with and without walker and recommends patient to have homecare but safe to go home. Will need hospital bed with air mattress and evaluation for other equipment. Also cushion for seating. Care coordination will begin referrals for DME. Lisa Bragg will begin process and prior approval for Medicaid for wound VAC. Home care will be able to provide HH Nurse, physical therapist, aide and social work. Plan is to have a therapy in home daily if possible. Goal is to have patient home prior to thanksgiving if possible.	2398
11/21/2014	Barry White, M.D.	**Hospitalist progress note:** She is still having pain. She says she can walk. Intermittent nausea. No shortness of breath. **Vital signs:** Temperature max 99.1, BP 127/74, Pulse 71, Temperature 97.8, RR 17, O2 saturation 95%. Seen at Wake Forest 11/20/2014 and Plastic Surgeon recommended wound vac and follow-up in 6 weeks. Work on getting her home or to rehab. Stable.	2420-2422
11/22/2014	Samuel Pincus, M.D.	**Hospitalist progress note:** Patient admitted that her pain is not controlled. **Vital signs:** Temperature max 98.1, BP 110/77, Pulse 68, Temperature 97.9, RR 17, O2 saturation 95%. Adjust her pain medications. Stop IV Ativan. Increased duration of Xanax. Continue other treatment.	2416-2419

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11/23/2014	Samuel Pincus, M.D.	**Hospitalist progress note:** She admitted having trouble sleeping at night. She denies any other acute medical symptom at this time. **Vital signs:** Temperature max 98.9, BP 109/56, Pulse 60, temperature 97.6, RR 16, O2 saturation 95%. Wound vac located on sacral area. Add Benadryl for insomnia. Continue current treatment. Waiting for placement at this time.	2413-2415
11/24/2014	Samuel Pincus, M.D.	**Hospitalist progress note:** Patient states a mild pain in the sacrum area. She denies any fevers or chills. **Vital signs:** Temperature max 99.1, BP 109/54, Pulse 73, Temperature 98.5, RR 18, O2 saturation 95%. Wound vac present in this sacrum area. No new recommendations today. We are still waiting for placement and wait home healthcare.	2410-2412
11/25/2014	Samuel Pincus, M.D.	**Hospitalist progress note:** She still complains about pain in the sacrum area. **Vital signs:** Temperature max 98.1, BP 113/66, Pulse 65, RR 18, saturation 95%. Get CBC and consider putting her back on Plavix.	2407-2409
11/25/2014		**Labs:** **High:** WBC (10.9) **Low:** RBC (4.14), Hemoglobin (11.6), Hematocrit (35)	2388
11/26/2014	Samuel Pincus, M.D.	**Hospitalist progress note:** Denies any acute problems at this time. **Vital signs:** Temperature max 98, BP 120/62, Pulse 62, Temperature 97.4, RR 18, O2 saturation 95%. Still waiting on placement.	2404-2406
11/26/2014	Samuel Pincus, M.D.	**Discharge summary:** **Discharge diagnoses:** Acute decubitus sacral ulcer bleed. Coronary artery disease, status post stent. Anxiety disorder. Acute blood loss secondary to sacrum wound bleeding. **Brief hospital course:** The patient was admitted. She was taken for surgical intervention by Dr. Mina, who was able to control the extensive nature of the bleeding. The patient did receive some blood transfusion while she was in the hospital. Within 7 to 8 days of admission her symptoms were relatively controlled. Due to the extensive degree of wound to the sacrum area, vacuum therapy was restarted.	2019-2020

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		Surgery believed that the patient may need plastic. She was referred to a Wake Forest plastic surgeon on November 20, 2014, and felt that the patient needed to be off nicotine for at least 6 months before they could do any intervention. The patient was brought back and has been in the hospital simply due to logistics reason. She has been relatively stable. Pain is relatively now controlled with pain medication. Had anxiety, which was treated with Xanax. **Discharge instructions:** The patient will be discharged home with home health care. She will be discharged with physical therapy, occupation therapy, social worker, nursing and aides. The patient will see Wake Forest plastic surgeon as required. The patient is advised the importance of not using any nicotine based product due to the fact that she has to undergo plastic surgery after being free of nicotine. ***Reviewer's comment: The nursing daily assessment flow sheets are not available for this hospitalization to assess the Braden scale, positioning assessment and wound assessment.***	
		Multiple ER visits for abdominal pain, decubitus ulcer and Plastic Surgery office visit	
12/05/2014	Statewide Regional Medical Center Marvin Williams, M.D.	**ER visit for abdominal pain:** Patient infiltrates have improved, but not resolved completely. Discussed patient with hospitalist, and patient does not meet any criteria for inpatient admission. Will check influenza swab, but patient will likely be discharged to home. She states that she has not been on outpatient antibiotics since previous discharge. Will restart antibiotics. **Disposition:** Discharged home in stable condition. A medical screening exam was performed: the patient should continue through the ED for further evaluation. **Clinical impression:** Abdominal pain of unknown cause. Bacterial pneumonia. Vital signs recorded and reviewed, empiric antibiotics (Levaquin 500 mg every 24 hours for 10 days) given. Sacral decubitus.	1980-1993
12/06/2014	Statewide Regional Medical Center	**Wound culture:** **Site:** Buttock wound. **Collected date:** 12/04/2014. **Direct exam:** White blood cells seen in smear. Light amount of gram positive cocci seen on smear. Acceptable specimen, culture results to follow. **Culture exam:** Moderate growth MRSA. **Susceptibility:** Resistant to Ciprofloxacin, Clindamycin, Erythromycin, Levofloxacin, Oxacillin, Penicillin. Sensitive to Daptomycin, Linezolid, Rifampin, Tetracycline, Trimethoprim/Sulfamethoxazole and Vancomycin.	2010
12/18/2014	Statewide Regional Medical Center Marvin Williams, M.D.	**ER visit for decubitus ulcer:** This started weeks; patient states that her home health nurse was there today, and reported that her sacral decubitus appeared to be getting infected. Patient states that she has been taking antibiotics, but she does not know name of antibiotic she has been taking. She states that her local MD was called, and stated to send patient to ER. She states that her O2 level has been going up and	1956-1966

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		down. She is prescribed home O2, but reports that she has been out of this for a couple of days, and that it has not yet been reviewed and is still present. At its maximum, severity described as moderate. When seen in the ED, severity described as moderate. Patient has sacral decubitus. Currently dressing and wound vac are in place. Patient with low O2 saturation on room air. She uses home O2, and saturation is normal on O2. She has been out of her O2 for 2-3 days. Will try to contact O2 supply company and arrange for patient to continue O2 at home. Patient has been taking Bactrim for sacral decubitus. Will change patient to Doxycycline pending culture result. Patient WBC is normal, and patient is afebrile. Will discharge to home and patient to continue wound care with home health. **Impression:** Single pressure ulcer: Sacrum right buttock. Stage 4.	
01/02/2015	Statewide Regional Medical Center	**ER visit for depression:** **Impression:** Depression and suicidal ideation. Course improved in ED. Transferred to Psychiatric facility.	1914-1934
01/02/2015		**Wound assessment:** Removed wound vac dressing and cleaned wound bed with Anasept wound cleanser. Wound bed is pink and moist, granulation tissue present throughout wound bed. Wound measurement are 5.3 x 6 x 1.5 cm. undermining present at 9 o'clock to 3 o'clock with deepest measurement 3.5 at 9 o'clock. Placed black granufoam with Mepitel into site and covered with KCI drape. Resumed negative pressure at 125 mmHg continuous suction. Leak verified.	1947
01/08/2015	Baptist Medical Center Anthony Simms, M.D.	**Plastic Surgery office visit:** 6 x 6 cm sacral stage 4 ulcer. Odor with vac. Discontinue vac, Dakin's three times daily, scheduled for OR debridement.	4463-4486
		Sleepy Hollow Medical Center	
01/15/2015	Peter Tork, M.D.	**Admission for incision and debridement of wound:** Presents for surgery tomorrow. She will be admitted as inpatient for IV Ancef due to concern of osteomyelitis. *History reviewed.* **Physical examination:** Vital signs: Temperature 97.4, BP 114/58, Pulse 58, RR 20, SpO2 91%, Weight 136.079 kg. **Skin:** A stage 4 on sacral area, measuring about 5 x 5 x 5 cm. with Dakin dressing. **Assessment:** Presents for I & D tomorrow with Dr. Simms. **Plan:** Morphine orally and Dilaudid IV for pain management. HS diet and mIVF. Follow-up CMP, CBC and PT/PTT. Ancef IV. Nil per oral after midnight for surgery. Admit to the floor, Dr. Simms attending.	4492-4496
01/16/2015	Anthony Simms, M.D.	**Excision of sacral ulcer and biopsy operative report:** **Pre and postoperative diagnosis:** Sacral ulcer, stage IV.	4498-4499

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	Michael Nesmith, M.D.	**Procedures:** Excision of sacral pressure ulcer dimensions 7 x 6.5 x 4 cm with 4 cm of undermining from 9 o'clock to 12 o'clock in preparation for flap closure Intraoperative soft tissue biopsy for culture, Gram stain, and sensitivity of sacrum. **Specimens:** Sacral soft tissue biopsy for culture **Indications for procedure:** Patient is a 53-year-old male with a sacral ulcer. She is brought to the Operating Room today for surgical excision and in preparation for flap closure. **Operative findings:** No exposed bone but the wound extended into muscle. **Description of procedure:** The patient was identified and brought to operating room two by Anesthesia Service, laid prone on the operating table after placing under general tracheal anesthetic. She was then prepped and draped in sterile fashion. Time out was performed for patient safety, appropriate antibiotics were given. A #10 blade was used to sharply incise the skin around the ulcer and dissection was carried down to subcutaneous tissue with Bovie Electrocautery. The complete contents of the ulcer cavity were excised with Bovie electrocautery. Care was taken to ensure hemostasis as bleeding vessels were encountered. Following excision of the cavity the soft tissue of the sacrum was debrided with rongeur and then a specimen was taken and sent for culture, Gram stain and sensitivities. Following complete excision, the wound was thoroughly irrigated Bacitracin containing saline and the wound was made hemostatic with electrocautery and the wound was excised down to bleeding healthy tissue in all directions. The wound was then thoroughly packed after ensuring hemostasis. The wound was packed with epinephrine saline gauze and this concluded the procedure. The patient tolerated the procedure very well with no immediate complications. **Disposition:** The patient was extubated and taken to the PACU in stable condition. She will be admitted for inpatient care including wound care and awaiting cultures while we anticipate coverage of the ulcer. She will be on positive pressure reduction at all times.	
01/16/2015	Graham Nash, R.D.	**Nutrition assessment:** **Assessment:** Status post I & D for stage IV sacral ulcer. Endorses significant weight loss during prior hospital stay. It just advanced, patient yet to eat. Reports normally good appetite. Endorses some nausea and diarrhea, now resolved. Denies difficulty chewing/swallowing. **Recommendations:** Added high protein Ice Cream twice daily and Ensure muscle health once daily. RD discussed protein food sources and encouraged good protein intake with all meals/snacks. Suggest daily MVI for wound healing.	4510-4512

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		Nutritional diagnosis: Increased protein need related to healing, as evidenced by stage IV sacral pressure ulcer 7 x 6.5 x 4 cm with undermining. The status of this diagnosis is new.	
01/17/2015	Peter Tork, M.D.	**Surgery progress note:** Pain well controlled. On Cefazolin. **Vital signs:** Temperature 96.4-98.8; Pulse 51-162, RR 11-23, BP 109-160/54-89, SpO2 96%. Pain score 8. Wound: On sacral area is clean, dry and intact. Packed with Dakin dressing. **Assessment and plan:** She is recovering well on the floor and getting ready to get her flap closure in few days. Continue current pain medications. Dilaudid 1 mg IV every 6 hours and MSIR 30 mg orally every 4 hours as needed. Hemodynamically stable. Continue routine VS. Encourage deep breathing, ambulation and the use of IS. On house select diet. Phenergan and Zofran as needed for nausea. On Cefazolin. Afebrile with no current infectious concerns. NS at 50 ml/hour. Well hydrated. Monitor BS. Adequate UOP. Dakin's dressing changed three times daily. Stable on the floor. Planned for a flap covering of the ulcer in few days.	4640-4642
01/18/2015	Peter Tork, M.D.	**Surgery progress note:** Patient complaining of pain at the surgery site today. Her pain is increased with movement. **Physical examination:** Temperature 96.8-98.5; Pulse 52-54; RR 15-20; BP 98-109/54-56; SpO2 94-97%. Sacral area dry, clean and intact, packed with Dakin dressing. **Assessment and plan:** Remains unchanged from previous day progress note. Kin Air bed requested for the room. Will need SNF placement in a facility with a KinAir bed.	4637-4640
01/19/2015	Stephen Stills, R.D.	**Nutrition notes:** Patient reports that her appetite is good. Encouraged good oral intake of meals and supplements. **Recommendations:** Encouraged good oral intake of protein rich foods and supplements. Consider supplementing with Vitamin C and inc sulfate. **Nutrition risk:** High.	4508-4510
01/19/2015	Peter Tork, M.D.	**Surgery progress note:** She states she feels more comfortable in the KinAir bed. **Vital signs:** Temperature 96-98; Pulse 53-68; RR 14-18; BP 100-134/59-64; SpO2 94-98%. On Dakin's three times daily. Will need SNF placement in a facility with a KinAir bed.	4634-4637
01/20/2015	Peter Tork, M.D.	**Surgery progress note:** Temperature 96.9-97.6; Pulse 51-59; RR 17-18; BP 114-129/56-63; SpO2 94-98%. Surgery scheduled on 01/23/2014. On Cefazolin. On **Dakins** three times	4631-4634

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		daily. Per dietary recommendations started Zinc and Vitamin C today.	
01/21/2015	Joni Mitchell, M.D.	**Surgery progress note:** Patient reports improved pain control with change in pain medications. Temperature 96.5-97.5; Pulse 51-61; RR 16-20; SpO2 96-98%. Home **MSIR** with oral Oxy and IV Dilaudid for breakthrough pain. On Cefazolin. **Dakins** dressing three times daily.	4627-4629
01/22/2015	Allison Krauss, M.D.	**Surgery progress notes:** States ready for surgery tomorrow. Temperature 96-98.7; Pulse 54-62; RR 16-20; BP 98-103/51-57; SpO2 94-95%. Sacral wound packed with moistened gauze. Continue pain medications. Restart psych medications. On Cefazolin. **Dakin's** dressing three times daily.	4620-4623
01/23/2015	Anthony Simms, M.D.	**Flap for closure of sacral ulcer operative report:** **Pre and post operative diagnosis:** Sacral ulcer. **Procedure:** Bilateral **fasciocutaneous flaps** for closure of sacral ulcer, **Description of procedure:** The patient was brought in the room, anesthesia was induced. The patient was then placed in a prone position. The skin edge was excised with a scalpel as well as some of the remaining scar tissue. The flaps were designed by extending incision and at the midline of her back as a rotation flaps. The incision was brought down with dissection with cautery down to the fascial layer. At that point, the flaps were raised laterally. The lateral aspect of the pressure ulcer was also elevated including fascia and a back cut was made at the superior aspect of the incisions on each side to rotate the two flaps down, Also, it was extended at the midline and raised for rotation of the inferior skin. At that point, once it was adequately raised released, and hemostasis was achieved and was irrigated with copious amount of antibiotic solution. At that point, the flap was inset with 0 PDS, tacking it together as well as into the deep soft tissue to keep it down in place and eliminate dead space as well as tension. A deep layer of 0 PDS was used sewing the flaps together down to the deep tissue of the midline along the entire length. At that point, deep 0 PDS was placed in the Scarpa's layer. At that point, once the deep layers were closed including the back, 2-0 nylon vertical mattress sutures were placed in the entirety of the skin. Dermabond was then placed over the entirety of the wound. The patient tolerated the procedure well without apparent complications. Blood loss 100 ml. Two drains were placed coming out laterally on each side. The patient tolerated the procedure well without apparent complications,	4497
01/24/2015	Adam Mucci, M.D.	**Surgery progress note:** Doing well. Temperature 96.9-98.7; Pulse 58-89; RR 15-18; BP 100-126/53-81; SpO2 93-100%. Drains with serosanguineous drainage. Continue Cefazolin, dry dressing as needed. Stable on the floor. Working on placement after surgery.	4613-4616
01/25/2015	Adam Mucci, M.D.	**Surgery progress note:** Doing well. Temperature 96.9-98.9; Pulse 59-75; RR 16-20; BP 113-118/53-	4610-4613

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		58; SpO2 92-95%. Assessment and plan remains unchanged from previous day progress note.	
01/26/2015	Peter Tork, M.D.	**Surgery progress note:** Doing well. Temperature 96.8-98.5; Pulse 59-73; RR 14-20; BP 110-126/54-71; SpO2 92-96%. Drains with serosang drainage. Output 120 ml. on low residue diet. Dry dressing as needed. On Cefazolin.	4607-4610
01/27/2015	Peter Tork, M.D.	**Surgery progress note:** Doing well with better pain control. Temperature 96.9-97.8; Pulse 65-74; RR 16-19; BP 113-126/56-59; SpO2 94-97%. Drains with serosang drainage. Output 165 ml. on pain medications. On Cefazolin. Dry dressing as needed.	4603-4606
01/28/2015	Peter Tork, M.D.	**Surgery progress note:** Pain well controlled. Temperature 96.8-97; Pulse 67-68; RR 17-18; BP 105-127/54-60; SpO2 96-99%. Drains with serosang drainage. Output 90 ml. stable on floor. Patient now wanted to go home instead of SNF. Will set up to go home with a KinAir bed. On Cefazolin and dry dressing change as needed.	4600-4603
01/29/2015	Peter Tork, M.D.	**Surgery progress note:** Pain well controlled. Had some trouble having a BM and tried two different enemas then Sorbitol which then helped her to move her bowels. Temperature 97.2-99.7; Pulse 60-85; RR 16-20; BP 104-123/56-61; SpO2 94-97%. Drain output 200 ml. on Cefazolin, dry dressing as needed. Stable on floor. Will be discharged home next week on Friday if clinically stable.	4597-4599
01/30/2015	Joni Mitchell, M.D.	**Surgery progress note:** No complaints. Having bowel movements but reports some straining. Temperature 96.3-97.2; Pulse 67-74; RR 15-20; BP 110-130/59-69; SpO2 94-98%. Wound with small amount of fibrinous exudate, drains with serosang drainage. On Cefazolin, dry dressing as needed.	4594-4596
01/31/2015	Peter Tork, M.D.	**Surgery progress note:** Still feels constipated. Temperature 96.2-97.9; Pulse 61-71; RR 18-20; BP 119-125/57-77; SpO2 94-98%. Will try milk of molasses to help with having a bowel movement. On Cefazolin, dry dressing as needed. Dial soap 3-4 times daily on the wound.	4591-4593
02/01/2015	Adam Mucci, M.D.	**Surgery progress note:** Still feels constipated – some relief but does not feel completely empty. Temperature 96.2-97.2; Pulse 61-65; RR 18-20; BP 118-135/65-71; SpO2 96-98%. Small **dehiscence inferiorly** to the wound. Will try milk of molasses enema again to help with having a bowel movement. On Cefazolin. Skin wound with NS wet to moist started inferiorly. Dial soap 3-4 times daily on the wound.	4588-4590
02/02/2015	Peter Tork, M.D.	**Surgery progress note:** Still feels constipated but had 2 bowel movements yesterday. Temperature 97.1-97.9; Pulse 67-106; RR 19-22; BP 106-121/49-78; SpO2 95-97%. Small dehiscence inferiorly to wound. Assessment and plan remains unchanged from previous day progress note.	4585-4588
02/03/2015	Peter Tork, M.D.	**Surgery progress note:** No complaints this morning. Temperature 96.3-96.9; Pulse 68-71; RR 18; BP 118-128/59-84; SpO2 94-96%. Small dehiscence inferiorly to wound that is packed. Assessment and plan remains unchanged from previous day progress note.	4583-4585
02/04/2015	Peter Tork, M.D.	**Surgery progress note:**	4580-4582

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		No complaints. Temperature 96.5-97.1; Pulse 71-79; RR 16-17; BP 120-142/61-77; SpO2 94-99%. Small dehiscence inferiorly that is packed. On Cefazolin, started Cipro for UTI. NS wet to moist started inferiorly. Dial soap 3-4 times daily on the wound.	
02/05/2015	Peter Tork, M.D.	**Surgery progress note:** Patient is complaining of subjective fever and night sweats. Temperature 96.9-97.8; Pulse 72; RR 17-18; BP 110-118/55-67; SpO2 94-96%. Small dehiscence inferiorly that is packed. On Bactrim, afebrile. CBC and CMP ordered. NS wet to moist started inferiorly. Dial soap 3-4 times daily on the wound.	4577-4580
02/07/2015	Peter Tork, M.D.	**Surgery progress note:** Temperature 95.4-98.2; Pulse 69-72; RR 16-20; BP 93-126/66-73; SpO2 95-97%. Small dehiscence inferiorly that is packed. Home MSIR with oral Oxy for breakthrough pain. On **Cipro** and **Keflex**.Afebrile. NS wet to moist started inferiorly. Dial soap 3-4 times daily on the wound.	4573-4577
02/08/2015	Peter Tork, M.D.	**Surgery progress note:** Temperature 97.1-98.2; Pulse 66-78; RR 16-18; BP 110-116/68-72; SpO2 94-98%. Small dehiscence inferiorly that is packed. On probiotics. Other assessment and plan remains unchanged from previous day progress note.	4564-4567
02/09/2015	Peter Tork, M.D.	**Surgery progress note:** Temperature 96.7-98.1; Pulse 68-99; RR 16-18; BP 119-142/64-71; SpO2 95%. Small dehiscence inferiorly that is packed. Assessment and plan remains unchanged from previous day progress note.	4553-4556
02/10/2015	Jonathan Edwards, M.D.	**Surgery progress note:** Patient with complaints of uncontrolled pain this morning, afebrile. Temperature 96-98; Pulse 77-82; RR 16-18; BP 117-128/63-71; SpO2 90-96%. Last day of Cipro. On Keflex and probiotics. NS wet to moist started inferiorly. Dial soap 3-4 times daily on the wound.	4551-4553
02/11/2015	Jonathan Edwards, M.D.	**Surgery progress note:** Afebrile, hemodynamically stable. Good urine output. Temperature 96.9-98.2; Pulse 69-82; RR 16; BP 127-135/61-75; SpO2 95-97%. Assessment and plan remains unchanged from previous day progress note.	4548-4551
02/12/2015	Jonathan Edwards, M.D.	**Surgery progress note:** Patient complaining of sore throat. Temperature 97.1-97.8; Pulse 81-88; RR 16; BP 126-138/73-83; SpO2 93-94%. Assessment and plan remains unchanged from previous day progress note. Will need chloraseptic spray for sore throat.	4544-4546
02/13/2015	Jonathan Edwards, M.D.	**Surgery progress note:** Concerned for discharge problems. Temperature 97.2-98; Pulse 70-85; RR 16-17; BP 114-139/55-74; SpO2 94-97%. Previously started on Cipro for suspected UTI, however subsequent culture was negative, therefore no UTI diagnosed during this admission. On Keflex and probiotics. Aquacel Ag to open part of wound inferiorly. Dial sop 3-4 times daily on the wound.	4538-4540
02/14/2015	Adam Mucci, M.D.	**Surgery progress note:** Temperature 96.3-97.8; Pulse 72-80; RR 16; BP 98-134/53-75; SpO2 92-97%. Small dehiscence inferiorly that is packed with Aquacel Ag. Assessment and plan remains unchanged from previous day progress note.	4535-4537
02/15/2015	Adam Mucci, M.D.	**Surgery progress note:** Temperature 96.8-98.7; Pulse 77-91; RR 16-19; BP 119-145/62-75; SpO2 93-	4532-4535

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		97%. Assessment and plan remains unchanged from previous day progress note.	
02/16/2015	Jonathan Edwards, M.D.	**Surgery progress note:** Temperature 96.9-98.3; Pulse 74-84; RR 14-18; SpO2 91-98%. Assessment and plan remains unchanged from previous day progress note.	4530-4532
02/17/2015	Jonathan Edwards, M.D.	**Surgery progress note:** Sutures removed at bedside today, patient tolerated well. Temperature 96.8-97.3; Pulse 86-89; RR 17; BP 114-150/61-74; SpO2 93-94%. Assessment and plan remains unchanged from previous day progress note.	4527-4529
02/18/2015	Jonathan Edwards, M.D.	**Surgery progress note:** Discussed with patient possibility of home disposition and she was amenable. No other complaints. Temperature 97.2-97.6; Pulse 79-89; RR 16-18; BP 122-131/67-68; SpO2 93-95%. Assessment and plan remains unchanged from previous day progress note.	4524-4527
02/19/2015	Baptist Medical Center Jonathan Edwards, M.D.	**Discharge summary:** She was admitted to our service several days before debridement of sacral ulcer due to concern for infection surrounding the ulcer. During that time, she did well and had no problems or complications. On 01/16/2015, she underwent excision of her sacral pressure ulcer. She tolerated the procedure well with no complications. For a week following surgery, she underwent Dakin's dressing changes to the wound until 01/23/2015 when she underwent bilateral fasciocutaneous flaps for definitive closure of her sacral pressure ulcer. She tolerated this procedure well with no complications. Following this, she was admitted to our service for pressure offloading and wound monitoring. She was on a KinAir bed and did very well during this hospitalization. About a week following her fasciocutaneous closure, it was noted that a very small part of her sacral wound had reopened at the inferior aspect. This was begun on wet-to-dry dressings three times a day and was eventually transitioned to Aquacel AG one time a day. Over the course of this hospitalization, she did very well and had no significant complications. She did, however, have a prolonged hospital stay due to an inability to find her appropriate disposition, given her wound care needs. Eventually, her pain with dressing changes subsided, and she was able to teach himself how to perform her once a day dressing changes and was able to go home. On the date of discharge, she was afebrile, ambulating, taking solids and liquids p.o., voiding, and having bowel movements without difficulty. She was aware of all pressure offloading needs and did have a pressure offloading mattress at home. At that point, she was discharged to home without any further needs. She was discharged to home with by mouth pain medication and stool softener. She will follow up with our team in two weeks following discharge. **Wound:** Posterior sacral wound clean, dry, and intact. An approximately 1 inch long area of wound still open at the inferior aspect. Packed with Aquacel AG, clean, and dry with no evidence of tracking or undermining. No surrounding erythema, induration, or purulence from the wound.	4488-4491
		Statewide Regional Medical Center	
02/20/2015		**ER visit for tender area:**	1675-1678

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	Rene Russo, M.D.	This started 6 months ago and is still present. It was gradual in onset and has been constant. It is described as painful. It has been located on the buttocks. Cause has been identified (pressure ulcer). (Patient had recent surgical debridement of wound, was sent home with home health to assist with wound care. Patient's wound care nurse today advised her to come to ER, with note from her stating that wound is too deep and complicated and too high risk for her to manage in home health setting, with no other caregiver for patient). **Skin:** Rash present on the trunk (superior gluteal cleft, deep full thickness wound with granulation tissue). The rash is erythematous. No warmth or swelling. There is tenderness. **Course of care:** Care transferred at shift change with labs pending and plan for surgical consultation. **Disposition:** Admitted to the Medical/Surgical unit. Condition stable. **Clinical impression:** Single pressure ulcer: Sacrum, stage unstageable.	
02/20/2015	Robert Planck, M.D.	**Admission for wound care:** Per outpatient wound care is postoperative wound drainage and possible wound infection. The patient states that she has had a malodorous yellow discharge from the wound since her discharge from Wake Forest the day before yesterday. She has also had some chills, although no specific report of fever. Her white count is elevated in the Emergency Department. **Admitting diagnoses:** 1. Possible sacral decubitus ulcer infection. 2. Sacral decubitus ulcer. 3. Leukocytosis. 4. Sacral decubitus ulcer pain 5. Coronary artery disease with a history of coronary artery stenting, on aspirin and Plavix. 6. History of plastic surgery intervention of the decubitus ulcer. Reportedly this occurred 1-1/2 weeks ago. The patient was discharged from Wake Forest just a couple of days ago. 7. Anxiety disorder. 8. Peripheral neuropathy. 9. Chronic low back pain, 10. Diabetes mellitus type 2, reportedly non-insulin dependent, 11. History of tobacco abuse. Reportedly, she quit smoking several months ago. 12. Obesity. 13. Bi-polar disorder. 14. Chronic obstructive pulmonary disease. 15. Appendectomy. 16. History of carpal tunnel release.	1686-1689

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		17. History of rotator cuff surgery. *History reviewed.* She was actually discharged from the hospital just the day before yesterday. She reports she has been having chills and she reports a malodorous yellow secretion discharge from the ulcer area. She was discharged with home health but after evaluation by the home health wound care nurse, thought the patient needed more assertive and complex interventions, so she was brought over to the Emergency Department for further evaluation. I have discussed the case with the case manager in the Emergency Department. The patient does meet inpatient criteria for the possibility of a sacral decubitus ulcer infection in the postop setting, so we will request a procalcitonin level and we will go ahead and request a wound culture and also blood cultures. Will cover with Unasyn IV for the moment and I will request a consultation with wound care service in the hospital and also a consultation with general surgery. Apparently, the patient does not meet criteria per insurance to go back to a skilled nursing facility, but she could perhaps qualify for assisted living, so the plan will be after discharge from the hospital will be to discharge her to assisted living where she will follow up with outpatient wound care. Will go ahead and admit at present time, given that the patient will be admitted as an inpatient. I anticipate a greater than 2-day hospital stay at least over the weekend and will go ahead and request consultation with general surgery and wound care. The risks of not hospitalizing this patient as an inpatient at present time, given that she really has no help at home, involve worsening of the wound and even development of sepsis from wound infection. Will request wound care and surgical consultations for further recommendations. **Assessment and plan:** The patient is a 53-year-old male with the above acute-on-chronic medical conditions who comes to the Emergency Department referred by home health nurse to the Emergency Department due to postoperative wound drainage and suspicion of wound infection in the setting after plastic surgery due to a sacral decubitus ulcer. Will continue workup in the Emergency Department. Will request a wound culture. Will request a wound care consultation and also a surgical consultation. Will admit as an inpatient for the moment. The plan, per discussion with the case manager, will be perhaps to discharge to an assisted living facility with outpatient wound care. Will continue to monitor closely.	
02/21/2015	Angela Kennedy, M.D.	**General Surgery progress note:** Admitted with possible decub wound infection. Temperature 97.8, Pulse 93, RR 16, BP 116/89. **Assessment and plan:** Patient with sacral decubitus status post flap rearrangement. Wound dressing with Aquacel, 4 x 4 s, Mepilex every day and as needed. Wound care culture and sensitivity. May benefit from wound vac at this point. Follow-up wound culture and taper antibiotics.	1695
02/21/2015	Daniel J. Glover, M.D.	**Hospitalist progress note:** Drainage from her wound. Patient requests IV narcotics. Patient with fatigue, ambulating, abdominal pain and tolerating diet.	1716-1719

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		Vital signs: Temperature max 97.8, BP 82/50, Pulse 86, RR 16, Temperature 97.7. Patient has a small area of drainage. Area cultured. Continued antibiotics.	
02/22/2015	Daniel J. Glover, M.D.	**Hospitalist progress note:** Drainage from sacral wound. With fatigue, ambulating and tolerating diet. Vital signs: Temperature max 98.1, BP 91/50, Pulse 98, RR 16, O2 sat 92%. On IV Unasyn. Continue antibiotics and taper according to the wound culture growth.	1712-1715
02/23/2015	Angela Kennedy, M.D.	**General Surgery progress note:** OOB ambulating with PT earlier. Afebrile, pulse 74-91, BP 106-120/55-62. Sacrum incision healed except at midportion. **Micro: Wound NGTD**. Wound care to make recommendations. Follow-up cultures and taper accordingly. Follow-up at Wake outpatient.	1694
02/23/2015	Barry White, M.D.	**Hospitalist progress note:** She says her pain is inadequately controlled. She is able to ambulate. No new complaints. She desires to go home rather than rehabilitation. Temperature max 98, BP 107/59, Pulse 76, RR 16, Temperature 97.9, O2 saturation 98%. Dressed sacral wound. No erythema beyond edges. Discussed with wound care. Awaiting decision about if she needs a wound vac. She wants to go home with home health rather than to rehabilitation. Able to ambulate in the hall. Continue same therapy today. Increased pain medications a bit.	1708-1711
02/23/2015	Lisa Bragg, R.N.	**Wound assessment:** **Location of wound #1:** Coccyx. **Type of wound:** Surgical wound. **Wound size:** 2.3 x 1 x 2.7 cm. **Tunneling:** @ 1130 o'clock measures 3.4 cm. **Drainage:** Moderate. Serosanguineous. **Periwound skin:** Intact. **Treatment:** Cleanse with normal saline. Periwound with skin prep. Fill with Aquacel Ag, cover with Mepilex border 6x6. **Location of wound #2:** Left hip. **Type of wound:** Surgical wound. **Wound size:** 1 x 0.6 x 0.3 cm. **Drainage:** Scant, serous. **Periwound skin:** Intact. **Treatment:** Cleanse with normal saline. Periwound with skin prep. Fill with Aquacel Ag, cover with extra thin Duoderm. **Location of wound #3:** Right hip. **Type of wound:** Surgical wound. **Wound size:** 0.6 x 0.9 x 0.1 cm.	1789-1790

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		Drainage: Scant, serous. **Periwound skin:** Intact. **Treatment:** Cleanse with normal saline, periwound with skin prep. Fill with Aquacel AG, cover with extra thin Duoderm.	
02/24/2015	Barry White, M.D.	**Hospitalist progress note:** Ambulating, no fever. Temperature max 98.2, BP 98/53, Pulse 81, RR 20, O2 saturation 99%. Dressed sacral wound. Await wound cultures. Changed medications. Stopped SSI.	1704-1707
02/25/2015	Barry White, M.D.	**Hospitalist progress note:** Complaining of lot of pain. Next day she is getting some confusion confirm with nursing. She thinks she is holding her pain medications. She has had some nausea no emesis. She noted some drainage from her wound. Temperature max 98.8, BP 121/70, Pulse 83, RR 16, Temperature 97.9, O2 saturation 93%. Still waiting on her wound culture. Not comfortable sending her home without knowing that data as she make it worse. Confusion for medications. She does need continued pain control. She states it is not her pain medicines but her bipolar disorder. Am not excited about titrating up her pain medications with the confusion. Just try to use what she is getting. We will go with pain medicines she was receiving at outside hospital. Discussed with nursing. Stopped SSI. Good control at baseline.	1700-1703
02/26/2015	Barry White, M.D.	**Hospitalist progress note:** She still notes drainage. She states that she is no longer having thoughts of suicide. Apparently had told home health nursing or wound care that she was being suicidal. Notes it that was not serious and that she does not have those thoughts anymore. She is reluctant to go to an assisted living facility or nursing facility as she is afraid her check will be taken after some time and she cannot pay for her car, house, etc. Temperature max 97.9, BP 115/59, Pulse 87, RR 16, O2 saturation 93%. Dressing over sacral wound, no redness beyond the edges. Changed to **Cefuroxime**. She will be stable for discharge once we can ensure that she gets wound care. Confusion seems to resolve. We are giving her some medications. Not complaining of more back pain today. Diet controlled diabetes for now. Patient not safe for discharge as to have a disposition on her wound care. We will work that out tomorrow see how she does on oral therapy.	1696-1699
02/26/2015		**Wound culture:** **Source:** Coccyx. **Collected date:** 02/22/2015. **Final report:** E. coli. **Susceptibility:** Sensitive to Amikacin, Cefepime, Cefotaxime, Ceftazidime, Ceftriaxone, Cefuroxime, Gentamicin, Imipenem, Tobramycin. Resistant to Amoxicillin, Ampicillin, Ampicillin/Sulbactam, Cefazolin, Ciprofloxacin, Levofloxacin, Piperacillin, Piperacillin/Tazobactam, Tetracycline and Trimethoprim/Sulfamethoxazole.	1691-1692

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02/27/2015	Barry White, M.D.	**Discharge summary:** **Discharge diagnoses:** Stage 4 sacral decubitus, Infected with E coli and Coag neg staph. Confusion; suspect from pain medications Patient had spent one month at Wake Forest for sacral decubitus ulcer therapy. Discharged 2 days prior to admission here. Home health nursing came out evaluated her weight at doctor was worse was sent to the ER. Wake Forrest would not take her back so it appears an inpatient. Here general surgery evaluated her and did not think she needed further debridement. Wound care is been following her. Placed on empiric antibiotics of with wound cultures pending. Consideration of a wound VAC done however decision made to avoid that for now as it looks that we will heal without it. She will complete oral antibiotics 7 days more.	1531-1534
		Statewide Regional Medical Center ***Hospitalization for small bowel obstruction***	
03/02/2015 - 03/06/2015	Statewide Regional Medical Center	**Hospitalization for small bowel obstruction versus ileus:** Admission date: 03/02/2015. Discharge date: 03/06/2015. **Discharge diagnoses:** Acute ileus versus partial small-bowel obstruction. These conditions have resolved. The patient is on a normal diet. Suicidal ideation with severe major depression. The patient is being admitted to the Behavioral Health Unit tonight. Bipolar depression. Anxiety disorder. Stage IV sacral decubitus, status post repair. The patient went to Sleepy Hollow Medical Center in Winston-Salem, North Carolina for repair and her decubitus has resolved. She has some surface wound drainage which had heavy growth of Escherichia coli but has been treated and she is undergoing basic wound care currently. **Procedures:** CT scan of the abdomen and pelvis without IV contrast on March 2, 2015, demonstrates bibasilar interstitial changes in the lower lung fields. There was surgical absence of the appendix. There were a few mildly dilated small bowel loops present in the left upper quadrant with otherwise normal bowel loops. This raised the possibility of earlier or partial small-bowel obstruction. There were 2 chronic adjacent supraumbilical fat areas containing midline ventral abdominal wall hernias measuring 5.2 cm and 2.2 cm. There is a decubitus ulcer with adjacent inflammatory changes seen posteriorly at the midline within the soft tissue superimposing at the level of the coccyx. No organizing fluid collections are seen. NG tube placement on admission. **Hospital course:** The patient was followed by surgery. It was thought that the NG tube had relieved any signs of any partial small-bowel obstruction and ileus. The patient still complained of abdominal pain, but improved. There was	1237-1239

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		no vomiting. She did not significantly complain of nausea. She more complained of the fact that she did not want to go home and she did not feel that she could live at home and live with himself with her current mood. The patient was gradually started on clear liquids and later advanced to solid foods. She had no nausea or vomiting. She still complained of abdominal pain, but that improved. The patient had had some chronic abdominal pain related to multiple subcutaneous Heparin injections, given the amount of time the patient has spent in the hospital. It is felt that her partial small-bowel obstruction had resolved. She was placed back on her home medications. The Behavioral Health Unit evaluated the patient and felt that she was a candidate for the Behavioral Health unit and the patient is being discharged there tonight with continued aggressive interventions for her significantly depressed mood. It is felt that the patient is a very good candidate for inpatient admission and the patient was agreeable to inpatient admission. **Discharge diet:** Regular diet. **Discharge activity:** As tolerated. **Discharge instructions:** The patient will transfer to the Behavioral Health unit tonight for the treatment of her mood as she requests.	
		Statewide Regional Medical Center ****Reviewer's comment: For this hospitalization only the significant records related to the wound assessment and patient's condition are elaborated. Other records have been reviewed and are not significant, therefore not included in chronology.***	
03/06/2015 - 03/09/2015	Statewide Regional Medical Center	**Hospitalization for depression:** Gabapentin decreased and Trileptal increased – On day of discharge continues to endorse suicidal ideation and states that if she went home she would commit suicide by overdose. Reports chronic pain issues even though she is being treated with pain medications. Transferred to the ICU.	1049-1054
03/09/2015	Jill Young, R.N.	**Wound assessment:** Location of wound #1: Sacral. Type of wound: Surgical wound. Wound size: 1.3 x 0.4 x 1.2 cm. Tunneling: 3 o'clock – 2.2, 6 o'clock 4 cm, 9 o'clock 3 cm. Drainage: Large, serosanguineous. Wound appearance: 100% red. Periwound skin: Intact. Treatment: Cleanse with antiseptic, periwound skin prep. Fill with Aquacel Ag, cover with Aquacel extra/secured with Duoderm extra thin, also placed abd pad in patient undergarment for added protection. Debridement non selective. With increased drainage over weekend.	1208-1209
03/13/2015	Lisa Bragg, R.N.	**Wound assessment:** Location of wound: Sacral. Type of wound: Surgical wound. Wound size: 1.1 x 0.9 x 2 cm. Tunneling: 12 o'clock measures 3.5 cm, at 11 o'clock measures 6.5 cm, and at	909-909

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		3 o'clock measures 3.5 cm. Drainage: Moderate, serous. Wound appearance: Pre debridement 50% pale pink, 50% slough; Post debridement 90% pale pink and 10% slough. Periwound skin: Intact. Treatment: Cleanse with antiseptic Anasept. Periwound with skin prep, Benzoin and extra thin Duoderm. Treatment: Topical Lidocaine 2% x1. Fill with white foam. Cover with black granufoam. Secure with KCl drape. Debridement nonselective. Mechanical debridement of nonviable non adherent yellow slough with wound cleansing. Wound vac therapy: At 125 mmHg continuous.	
03/16/2015	Lisa Bragg, R.N.	**Wound assessment:** Location of wound: Sacral. Type of wound: Surgical wound. Wound size: 1.5 x 1 x 2.1 cm. Tunneling: 12 o'clock measures 4.8 cm, t 6 o'clock measures 2.8 cm, at 9 o'clock measures 4.3 cm, and at 3 o'clock measures 3.1 cm. Drainage: Moderate, serous. Periwound skin: Intact. Treatment: Cleanse with antiseptic Anasept. Periwound with skin prep, Benzoin and extra thin Duoderm. Treatment: Topical Lidocaine 2% x1. Fill with white foam. Cover with black granufoam. Secure with KCl drape and Duoderm at 6 o'clock. Wound vac therapy: At 125 mmHg continuous. Discontinued Infovac and connected patient to freedom VAC.	971
03/09/2015 - 03/16/2015	Statewide Regional Medical Center	**ICU stay for wound drainage:** Patient transferred to a medical unit due to more drainage from her sacral wound then was able to be dealt with appropriately on the behavioral health unit: **Hospital course:** Decubitus ulcer of sacrum. The patient was treated by wound care. Wound VAC was placed. Once the wound VAC drainage was at an acceptable level. She was thought to be appropriate for return to the behavioral health unit. Diarrhea. Clostridium difficile testing was performed and was negative. The diarrhea resolved. Bipolar disorder. The patient was maintained on her usual medications as recommended by BHU. Chronic back pain. Pain management was somewhat of an issue. The patient did consistently rate her pain at 10/10 no matter the amount of pain medication that was being administered. We did try to decrease this to a level that would be manageable on the BHU prior to her transfer back up there. **Discharge disposition:** Behavioral health unit in stable condition.	620-621
03/23/2015	Lisa Bragg, R.N.	**Wound assessment:** **Location of wound#1:** Sacral. Type of wound: Surgical wound. Wound size: 1.2 x 1 x 2.9 cm. Difficult to fully visualize wound bed due to small opening.	450-451

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		Tunneling: 12 o'clock measures 0.4 cm, at 6 o'clock measures 5.2 cm, at 9 o'clock measures 2.7 cm, and at 3 o'clock measures 3 cm, 11 o'clock measures 4 cm. Odor: Typical Vac odor. Drainage: Moderate, serous. Wound appearance: Pre debridement 100% pale pink. Periwound skin: Intact. Treatment: Cleanse with normal saline. Periwound with skin prep, Benzoin and extra thin Duoderm. Treatment: Topical Lidocaine 2% x1. Fill with white foam. Cover with black granufoam. Secure with KCI drape. Wound vac therapy: At 125 mmHg continuous. **Location of wound #2:** Right hip. Type of wound: Surgical wound. Wound size: 0.4 x 2 x 0.1 cm. Drainage: Minimal, serous. Wound appearance: Pre debridement 95% red and 5% slough. Post debridement 100% red. Periwound skin: Intact. Treatment: Cleanse with normal saline. Periwound skin prep. Fill with Aquacel Ag. Cover with extra thin Duoderm. Mechanical debridement of noninvasive tissue with wound cleansing.	
03/24/2015	Doris Smith, R.N.	**Nurse notes:** Called to social worker's office because patient's wound VAC was alarming. Patient states "I have a leak because I can feel it at the base of my spine. Site appeared sealed, but, I could not see between the gluteal fold. When patient went to her room she state "You don't have to call wound care because it sealed itself. Wound care was called to room again and there was a small area in the gluteal fold where the clear sheath had lifted. Duoderm placed in the gluteal fold to secure the air leak. Patient tolerated it well. Wound VAC setting was on 125 mmHg with a 6 intensity. Patient resting quietly in bed.	568
03/25/2015	Patricia Condon, R.N.	**Nurse notes:** Patient's wound VAC screen observed to be running properly at 125 mmHg continuous pressure.	568
04/02/2015	Lisa Bragg, R.N.	**Wound assessment:** Location of wound #1: Sacrum. Type of wound: Surgical wound. Wound size: 0.9 x 0.8 x 2 cm. Small wound opening difficult to place foam/alternate wound dressing today. Tunneling: At 9 o'clock measures 3 cm, at 3 o'clock measures 3.3 cm, at 12 o'clock measures 2.4 cm, at 11 o'clock measures 2.8 cm. Drainage: Large serous. Wound appearance: Pre debridement 100% pal pink. No debridement warranted today. Periwound skin: Intact. Treatment: Cleanse with normal saline, soap/cleanser, Seaclenz. Periwound with Benzoin. Fill with Aquacel Ag extra, cover with Aquacel Ag extra.	536

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		Secure with Duoderm. Vac on hold. Patient may be transferring to a facility today. Treatment plan revised.	
04/02/2015	[signature] Appears to be Lisa A. Bragg, R.N.	**Wound care treatment plan:** Discontinue previous wound care order. Cleanse with normal saline to irrigate wound and tunnels. Apply barrier up to edge of wound. Skin prep and Benzoin. Lightly fill with Aquacel Ag extra. Cover wound with Aquacel Ag extra. Secure dressing with Duoderm. Change dressing every other day and as needed excess soiling. Please send wound vac supplies with patient to facility. May need to have vac again in future.	372
04/02/2015	*Multiple Providers*	**Nurse notes:** Nursing Supervisor states wound care nurse will be in at 0800 hrs and she will leave note for her to see patient as soon as possible related to wound area leaking and foul smell. NS states have client stay in room and not to change dressing at this time because it will probably need to be cultured when wound nurse arrives. Wound VAC remains in place and on normal settings 125 mmHg. Patient came to Medical room door to ask for pain medications and stated, “my dressing is leaking. I can smell my wound and when I got up my bed was wet where it had leaked. Patient taken back to her room to observe her dressing. I could smell patient’s wound prior to reaching her doorway. I observed fresh serosanguinous drainage on her bed linens that had a foul odor. Patient’s wound VAC was still running at 125 continuous without alarming. Patient’s wound drape remains intact with scant drainage noted at superior aspect of perianal crack area. Patient has a towel in place to cover dressing for now. Patient states, “the wound care nurse is supposed to change the dressing this morning before I leave. I would rather just leave it alone until she comes to change it”. NS called for assistance.	568
03/10/2015 - 04/02/2015	Statewide Regional Medical Center	**Hospitalization for depression and suicidal ideation:** **Discharge diagnoses:** Bipolar disorder type II; Borderline personality disorder; Generalized anxiety disorder; stage IV sacral decubitus ulcer with some drainage (patient on a wound VAC, status post repair at Sleepy Hollow Hospital Center in Winston Salem, North Carolina), chronic low back pain, hypertension, diabetes mellitus Type 2, COPD, chronic respiratory failure, obstructive sleep apnea uses CPAP machine at home, previous tobacco use, Gastroesophageal Reflux Disease (GERD), morbid obesity, Coronary Artery Disease (CAD), ataxia, pernicious anemia, low High Density Lipoprotein (HDL) **Hospital course:** **Notes from treatment on medical unit:** 03/10/2015: Discussed medication options with patient. She's never been tried on Seroquel. Discontinue Geodon and begin Seroquel 100 mg every night and titrate up as tolerated. Hopefully she'll be able to tolerate at least 200-300 mg. This can increase efficacy of her antidepressant as well as work as a mood stabilizer. I will continue to round on the patient and work on her psychotropic medications while she is in ICU. Once she is medically stable then she can be	24-33

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		transferred to the BHU for further psychiatric treatment No other changes with her psychotropic medications at this time. 03/12/2015: The patient appears oversedated which could be from not sleeping last night or from pain medication. There is a big change from 03/11/2015 to 03/12/2015 and the only change I can see in medication besides what I've changed is the IV Morphine. I will continue to adjust her psychotropic medications to try and improve mood and decrease/resolve suicidal ideation. My impression of her mood is a 9 on scale of 1 to 10 with 1 being the best mood. She isn't harming himself in the hospital but continues to state she is suicidal with plan and intent should she be discharged. My impression of her response to medication and treatment for psychiatric illness at this time is also 9. Increase Seroquel, decrease and continue to taper Trileptal. Decrease Prozac as it's a once a day medication and the high dose of 80 mg could interfere with electrical activity of the heart and increase risk for serotonin syndrome. I will continue to round on this patient until she is either discharged or transferred to the BHU. 03/13/2015: The patient can speak more fluidly today now that her IV Morphine has been reduced. I educated the patient about being able to get up and walk around so that she can show us that she will be able to ambulate once she comes up to the behavioral health unit again. When the patient was in the ICU only receiving opiate pain medication by mouth her affect was much brighter and she was able to move around better. I will continue to taper Trileptal. Also the patient continues to have diarrhea and have noticed that she is on scheduled Colace and Simethicone 50 I will move those to when necessary. I met with a discharge team including Dr. White. The wound care nurse has ordered a portable wound VAC which the patient can wear under her close. The wound care nurse will come up as needed to care for it. Hopefully they will have this in sometime early next week. I will continue to round on this patient throughout the weekend and until she can be admitted to the behavioral health unit. She contracts for safety stating that she will not harm himself. She states that if she has any type of urges to do so that she will reach out for help. The patient has been able to keep himself safe in the hospital since she's been here. Dr. White is going to taper the IV Morphine. 03/14/2015: Patient continues to be severely depressed. She does not appear to be in any pain but continues to report pain. She is currently on oral pain medications. I reminded her that she cannot be on any IV, and she will need to wear is a portable wound VAC when she comes up to the unit. I have asked her to make sure that she is getting out of bed and walking as much as she can now because when she was on the behavioral health unit she complained of her legs being sore having to walk and be up so much. I reminded her that she is not going to be able to just stay in bed once she comes up toward unit. The patient states that she is looking forward to engaging in the groups. She'll have her last dose of Trileptal tonight. 03/15/2015: As stated above I have educated the patient concerning her inability to articulate her perception of pain. I am concerned that she is at this	

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		level of pain and has had 25 mg of Oxycodone since 5 AM this morning. About 5 AM she received her breakthrough pain medication of 5 mg of Oxycodone. Then at 9:39 AM she received another 5 mg, 10:43 AM she received 5 mg, and at 10:41 AM she received 10 mg of Oxycodone. I came to see her about 15-20 minutes after her last dose of pain medicine and she is still rating her pain to be at a "10." I taught her a visualization technique to help reduce her pain, and I have asked her to practice this and build upon it. I have educated her that we cannot handle someone on our psychiatric unit with severe pain issues that she would need to receive care on a medical/psychiatric unit, were that to be the case. The patient seems confident that she will do okay on the unit again however I have my reservations. The patient needs to be ambulating more during the day then she is right now. My impression of this patient is that no matter how much pain medicine she receives she will still report her pain to be a 10. While she was on the IV Morphine she could barely wake up and still reported her pain to be at 10. I believe that the patient is treating her emotional pain through the use of opiate pain medication. I have educated the patient concerning this but she has not developed any insight so far. With all of this said, it should be noted that if the patient continues to have to receive extra pain medicine by mouth she will not be an appropriate candidate for the behavioral health unit here. If that's the case then the utilization nurse needs to search for a medical psychiatric unit can handle that level of care. I will check the patient's MAR tomorrow morning to see if she has received any extra pain medication and make that decision then. We will have beds available tomorrow and I believe that they have received the portable wound VAC unit. I will get in touch with the hospitalist who is covering her now and also let them know my concerns. 03/17/2015: **Initial treatment plan with current BHU admission:** I reviewed the patient's labs. She will remain on Prozac 40 mg daily, Seroquel 300 mg by mouth each bedtime, and Lamictal 200 mg by mouth twice a day. We'll start to taper her off of Neurontin and we will reduced to 300 mg by mouth 3 times a day. Xanax will increase to 1 mg by mouth 3 times a day due to the patient's high level of agitation. I will continue with extended release OxyContin 30 mg by mouth twice a day. I will increase her Oxycodone IR to 20 mg every 6 hours when necessary for breakthrough pain. All of her other medications will remain the same. She believes that she might be getting constipated ***sialoadenectomy*** Colace 50 mg daily. When she was on the medical floor she was on Colace 100 mg twice a day with Simethicone scheduled 3 times a day and that's when she ended up with diarrhea. Once I stopped this the diarrhea resolved. I believe that this will be a balancing act do to all of the sedating medications that she is currently on which can cause constipation. The wound care nurse will come twice a week to attend to her wound VAC and to check the wound. If we need any help with medical management we will get the hospitalist's involved however right now I think I can manage. I will recheck her sodium level as well as hemoglobin in a day or 2. I've ordered a dietary consult as she was receiving some type of extra protein on the medical floor, for better wound healing. I have encouraged the patient to engage in the milieu and to attend groups. Currently she is using a wheelchair but once her strength	

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		regains we will encourage her to use a walker. Social worker will coordinate with outside agencies to try to place the patient in an assisted living home where she can be safe and continue to heal. 03/18/2015: I again educated the patient about her perception of pain. We also talked about ways that she can distract himself from her pain including visualization. No medication changes today. My impression of the patient's mood is 9, and my impression of her response to treatment and medication is also a 9. will increase Colace and add Miralax for constipation. Will continue to taper Neurontin. 03/19/2015: I reviewed the patient's labs. Hyponatremia has resolved. She has low B12 and appears to have pernicious anemia. Patient's HDL is very low. Even though the patient keeps stating that she will kill himself if she is discharged home she has kept himself safe here on our unit and on each medical unit that she has stayed on here in the hospital. She is trying to attend groups, but it's been difficult with her still being in a wheelchair. I will order physical therapy, evaluate her to try to help her slowly get out of the wheelchair and use walker. This will also help with wound healing. I have coordinated with the wound care nurse who continues to see her each day. She is going to try a new type of dressing and may remove the wound VAC even if this is for short time. The patient has had her dietary consult I believe that today is her last dose of Gabapentin SW to speak to Trish From ACS. I will order B12 1000 mcg IM daily x7 days then we'll go to once a week, also fish oil capsule 1 gm with each meal. I have asked the patient what we would see when she is safe to go to a nursing facility. She has said repeatedly that she needs to go to some type of nursing facility otherwise if she was discharged home she would kill himself. The patient does not answer my question and just says that we need to talk to "Trish." 03/20/2015: The patient reports that she would gladly go to a nursing home and she feels that she could keep himself safe and would not want to kill himself. She understands that she will not be able to keep her home or her vehicle. The patient continues to report her pain at a "10" however does not appear to be in severe pain. I'm sure she deals with some pain issues with the decubitus ulcer which has been healing however she actually reports more pain in her back from other issues when she tries to use the walker. Even when the patient was receiving IV Morphine and at that time was difficult to wake up she still reported her pain at a "10. In my impression of the patient's dangerousness is a 6 and my impression of her response to treatment and medication is a 7. 03/21/2015-03/22/2015: Patient was seen by the weekend provider on both Saturday and Sunday. No medication changes. 03/23/2015: The patient verbalizes that she can keep himself safe on our unit and she has kept himself safe the entire time that she's been in the hospital. She reports that she would be able to keep himself safe in a nursing home as well. Social work is currently working on placement. The patient was seen by the	

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		wound care nurse who recommends that the patient be up and walking with the walker for healing purposes. Also physical therapy has reported that the patient has no problems walking using a walker. I've explained to the patient again that she needs to be using the walker and not to wheelchair in order to help the healing process. I will go ahead and increase the frequency of her Oxycodone for breakthrough pain to every 4 hours as needed. I've explained to the patient that if she is over sedated or cannot walk well with the increase of frequency of the opiate pain medication then we will have to reduce it and she verbalizes understanding of this. She continues to be on extended release Morphine 30 mg twice a day schedule. No change in the patient's psychotropic medications as these medications here to be helping with her depression. My impression of the patient's mood is 4, and my impression of her response to treatment and medication is 5. Also there has been an overlay put on the patient's mattress in order to reduce pressure. Patient remains on a wound VAC. 03/24/2015: My impression of the patient's mood is a 7 and response 10 treatment and medications a 5. Have educated the patient as to why she should not be using the wheelchair and we need for her to walk using a walker. I've also educated her concerning her medications reminding her that there is medication for breakthrough pain that she needs to utilize. I've reminded her that the staff and myself included here to help her get better psychiatrically as well as physically and even though she may not agree with our recommendations she needs to follow those recommendations in order to get better. I'm sure that it is very frustrating going through what she has gone through and I have listened to her and allow her to attend her frustrations. I will schedule her Miralax' twice daily and add magnesium citrate as needed for constipation. I've educated her that it's a delicate balance between her stools becoming too soft increasing diarrhea which will put her at a higher risk of contaminating the wound site, and also keeping her out of constipation which is not good for her to strain either. Patient verbalizes understanding of this. 03/25/2015: Patient continues to complain and report mood and pain at a "10." She is unwilling to get out of bed for groups or to socialize but will get up for meals. She declines any suggestions of how to try and make improvements in her mood by engagement in our program in partnering with staff in a mutual relationship for recovery. Her expectation is that medication will fix her mood and her pain. She declines to take an active role in helping her wound to heal. SW has spoken to her peer support specialist at ACS and she reports that the patient is telling untruths about her providers and staff here on the unit. I encourage the patient and continue to educate her as to the steps she needs to take in order to become physically and mentally healthy again. I offered the patient to have her breakthrough pain medication early so she can go sit in group because she states she can't go to group because it "hurts too much to sit out there." I told her that the expectation is for her to get out of bed and go to the medication window to receive the early pain medication and then go to group even if for only 20 or 30 minutes. She states she is going to do that. 03/26/2015: Patient is not as irritable today and she has been out of her room. I think that her support system from Appalachian community services have been	

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		able to convince her to participate more. Social work is actively trying to seek out a nursing home. No changes in medications today. My impression of the patient's response to treatment and medications is 5. My impression that the patient's dangerousness and mood is 7. 03/27/2015-04/01/2015: During this time the patient's extended release Oxycodone was increased to 60 mg 3 times a day. Immediate release Oxycodone was decreased to 10 mg every 6 hours when necessary breakthrough pain. Doxepin was added at night for sleep last night however the patient states that it did not help and was discontinued. 04/02/2015: Day of discharge - Even though the patient's pain medicine has been significantly increased she continues to report her pain at a "10: The patient reports more draining from her decubitus ulcer however the wound care nurse did come up and redress as well as clean the wound. I pulled labs on the patient and there are no signs indicated that there is any infection. The patient's white blood cell count is within normal limits and procalcitonin is negative. The patient's vitamin B12 is now greater than 1000 so I will go ahead and discontinue the injections of 1000 mcg weekly. The patient's B12 level should be checked in another week or 2 and if it starts to decrease significantly then I would recommend starting vitamin B12 by mouth 500 mcg daily. The patient reports that she will be able to keep himself safe in a nursing home environment and has kept himself safe the entire time she has been here at the hospital. The patient has not engaged in any of the groups for the past several days and she should be encouraged moving forward to engage in any type of group activity that is allowed at the nursing home. **Recommendations:** It's recommended that the patient be treated at the Very Skilled Nursing home. It's recommended that she see someone for psychiatry at the nursing home as well as her medical care. The patient will continue to need attention for her decubitus ulcer with wound care. Appalachian community services have also continued to see this patient and I believe will continue to follow her at the nursing home. **Condition on discharge and prognosis:** Patient will be discharged in improved mood and condition to the nursing home. Patient's medications have been called to the pharmacy that the nursing home uses which is Stanley labs. A prescription of OxyContin was given to the patient to give to the nursing home as this prescription needs to be written out on a prescription pad. The patient will need close follow-up in the outpatient setting for her decubitus ulcer as well as her psychiatric care. She will be living in a nursing home environment in order to receive the care needed particularly for her psychiatric condition. The patient states that if she were to go home she would become suicidal again, but she states she can keep himself safe at a nursing home in a structured environment. **Disposition:** The Very Skilled nursing home will be coming to transport the patient.	

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
04/29/2015	Statewide Regional Medical Center Laboratory	**Labs:** **High:** Alkaline phosphatase (127), CRP (25.5), Erythrocyte Sedimentation Rate (ESR) (21) **Low:** Total protein (6), Albumin (3.3)	15
05/01/2015	Statewide Regional Medical Center Laboratory	**Labs:** **High:** CRP (20.2), Red Cell Distribution Width (RDW) (15.6), ESR (24) **Low:** Hemoglobin (13.2), Hematocrit (39.8), Mean Cell Hemoglobin (MCH) (27.3), % Lymphocytes (19.6)	10
05/06/2015	Statewide Regional Medical Center Laboratory	**Labs:** A1C (5.4)	5-6

Causation Evaluation – Mitchell Lightfoot

DOB: 06/25/1957

Evaluation Formulation:

1. **What were the patient's risk factors for pressure ulcer formation?**
    - Period of ventilation for healthcare associated pneumonia
    - Diabetes mellitus Type II
    - Hypertension
    - Peripheral Neuropathy
    - Chronic diastolic congestive heart failure
    - MRSA in sputum
    - Severe protein calorie malnutrition with prealbumin of 10.1
    - Albumin level of 2.9 g/dl on 9/23/2014

    Comment: These are well described risk factors for pressure ulcer formation **(REF-1)**.

2. **What, if any, were the deviations from the standard of care which led to the formation of pressure ulcers at Local Regional Medical Center?**

    There were four deviations from the standard of care which led to pressure ulcer formation:

    a) The bariatric bed (Bari-Maxx II air bed) with turning capabilities (every 15 minutes) was ordered only after the development of the pressure ulcers over the sacrum and right hip on 9/26/2014 and three days into ventilatory support with sedation in at-risk patient.
    b) There was failure to use a gel cushion or a Roho cushion for the chair on 10/02/2014. The chair cushion was provided on 10/06/2014. By this time, bilateral ischial deep tissue injury had developed.
    c) There was failure to turn and re-position the patient every 2 hours on 9/22/2014 and 9/23/204 prior to use of the Bariatric bed.
    On 9/23/2014, the patient is not turned between 0218 hours and 1000 hours.
    On 9/24/2014, the patient is not turned between 1800 and 2200 hours.
    On 9/25/2014, the patient is not turned between 0700 and 1900 hours.
    In the Pressure Ulcer Prevention Quick Reference Guide by the European Pressure Ulcer Advisory Panel and the National Pressure Ulcer Pressure Panel, it is recommended that the patient be repositioned in such a way that the pressure is redistributed and to avoid positioning the individual on bony prominences. As for documentation, the guidelines recommend to record the specific timeframe and position adopted as well as the outcome of the intervention.
    d) There was failure to moisturize the skin at least once daily in spite of the skin being repeatedly assessed as being dry. In the Pressure Ulcer Prevention Quick Reference Guide by the European Pressure Ulcer Advisory panel and National Pressure Ulcer Pressure Panel, it is recommended that skin emollients be used to help reduce skin damage.

*There is an allegation of weight loss: Mr. Lightfoot reported on 10/13/2014 that he suffered a weight loss of 75 lbs in hospital. However, this cannot be substantiated as his admission weight on 9/22/2014 was 154.2kg and his weight on 10/08/2014 was 357.28 lbs (162Kg).

Comment: Pressure reducing surfaces and two hourly turning and re-positioning are the most important measures to prevent pressure ulcer formation **(REF-2)**.

3. **What, if any, were the deviations in the standard of care at Smith's Center Health and Rehabilitation from 10/08/2014 onward where the wounds deteriorated into stage IV decubitus ulcers?**

There were two deviations in the standard of care which led to worsening of the pre-existing pressure ulcer:

a) There was a failure to turn and reposition the patient every two hours. Michael Jordan, M.D. documented "he (the patient) knows to move frequently to keep the pressure off of that area while here." The nursing staff documented on 10/10/2014, 10/11/2014 and 10/16/2014 that the patient had "Bed mobility with extensive assist."
b) There was failure to provide pressure reducing surfaces for the bed and chair. There is documentation dated 10/14/2014 stating there was an order for a "pressure relieving or reduction mattress… Pressure relieving/reduction chair pad." An air mattress bed was in place on 10/15/2014.

4. **Who are identified as potential defendants?**
- Local Regional Medical Center (admission 9/22/2014)
- Smith's Center Health and Rehabilitation the wound worsened considerably

5. **What damages resulted from deviation from the standard of care?**
- Pressure ulcers
- Acute cellulitis around sacral decubitus ulcer
- Surgical Debridement on 10/21/2014
- Acute decubitus sacral ulcer bleeding on 10/30/2014
- Excision of sacral ulcer and biopsy on 01/16/2015
- Bilateral fasciocutaneous flaps for definitive closure of his sacral pressure ulcer on 1/23/2015
- Confusion from pain medications
- Blood transfusion
- Wound VAC
- PICC line
- Pain and suffering (needing Dilaudid)
- Emotional distress
- Financial cost
- Morbidity from all the above

6. Summary

The patient is a 53-year-old gentleman who was ventilated for ARDS (Acute Respiratory Distress Syndrome) at Local Regional Medical Center from 09/22/2014 forward. There were multiple deviations from the standard of care which led to the formation of multiple pressure ulcers at this facility.

For rehabilitation, he was transferred on 10/08/2014 to Smith's Center Health and Rehabilitation/Waynesville, where the pressure ulcer worsened considerably and deteriorated into stage IV pressure ulcer. This deterioration of the pressure ulcer prompted Eric Mucci, M.D. surgeon, to document his findings at the time of surgery as "a very large, deep, widespread sacral decubitus ulcer, ***one of the worst that I have ever seen".*** There were deviations in the standard of care at Smith's Center Health and Rehabilitation/Waynesville which led to deterioration of the sacral pressure ulcer.

References
REF-1:

http://www.researchbyMarGin.com/contents/pressureulcerepidemiology&pathogenesis&sstaging?source=see_link&anchor=H4#H4

Pressure ulcers are lesions caused by unrelieved pressure that results in damage to the underlying tissue. Generally, these are the result of soft tissue compression between a bony prominence and an external surface for a prolonged period of time.
In one report in an intensive care unit, over 50 percent of patients developed a stage 1 or larger ulcer when managed with a standard mattress bed.
Pressures are greatest over bony prominences where weight-bearing points come in contact with external surfaces. A patient lying on a standard hospital mattress may generate pressures of 150 mmHg; sitting produces pressures as high as 300 mmHg over the ischial tuberosities. Pressure in excess of 70 mmHg for two hours results in irreversible tissue damage in animal models.
Moisture — Exposure to moisture in the form of perspiration, feces, or urine may lead to skin maceration and predispose to superficial ulceration.
Host factors — A number of host factors may contribute to pressure ulcer development including immobility, incontinence, nutritional status, circulatory factors, and neurologic disease.
Immobility — Immobility is the most important host factor that contributes to pressure ulcer development. There is a high correlation between a lack of spontaneous nocturnal movements and pressure ulcer development in studies using devices that measure body movement.
Incontinence — Urinary incontinence is frequently cited as a predisposing factor for pressure ulcers. Some studies suggest that incontinent patients have up to a five-fold higher risk for pressure ulcer development. Several studies have also suggested that fecal incontinence is a predictor of pressure ulcers.
Nutritional compromise — ***Impaired nutritional status*** is a risk factor for the development of pressure ulcers. The strongest nutritional measure predicting pressure ulcer development may simply be whether the patient has adequate dietary intake.
Neurologic diseases — Neurologic diseases such as dementia, delirium, spinal cord injury, and ***neuropathy*** are important contributors to pressure ulcer development. This may be related to immobility, spasticity, and contractures that are common in these conditions. Sensory loss is also common, suggesting that patients may not perceive pain or discomfort arising from prolonged pressure.
Other factors - A partial list includes sepsis and hypotension.

REF-2:

http://www.researchbyMarGin.com/contents/pressurewoundprevention?source=see_link

Pressure relief — Pressure relief is the most important factor in preventing pressure ulcers and may be accomplished in two ways: proper patient positioning and appropriate use of ***pressure-reducing devices and surfaces***.

Patient positioning — Proper positioning of bed-bound individuals is recommended, including a regular turning and repositioning schedule, with particular attention to vulnerable tissue covering bony prominences such as the sacrum. Typically, a two-hour interval is recommended although this is based upon expert opinion in the absence of randomized trials.

Pressure-reducing products for patients at increased risk (identified by clinical assessment or risk scales) for developing pressure ulcers. The choice of product, including overlays, foam, and gel supports, or dynamic devices, will depend upon patient risk factors and the availability of resources. Dynamic supports, such as air fluidized beds, may be cost-effective in high-risk patients.

Other measures that may be helpful for pressure ulcer prevention in selected patients include limiting immobility (with physical therapy and decreased use of sedatives), nutritional supplementation, and meticulous skin care.

Screening Date: 05/01/2013
Prepared for: Your Law Firm
Re: Randolph Mantooth

Expert Document Availability Estimate *

SEARCH STRING USED:

(Randolph w/2 Mantooth) w/100 (Expert or Professor or Biostatistic! or Statistic! or Biometric!)

SOURCE	TOTAL DOCUMENTS
Challenges/ Exclusions	**4**
Affidavits and Reports	**8**
Docket Databases	**93**
Motions, Pleadings, Briefs and Orders Databases	**57**
Opinions/ Case Law Databases	**20**
Verdict Report Databases	**38**
Transcripts and Depositions Databases	**32**
Federal Agency Decisions	**11**
State Agency Decisions	**3**
Curricula Vitae and Resumes	**3**

*This Report was prepared to assist you in deciding whether ordering a more in-depth Litigation & Testimony History or Comprehensive Expert Vetting Report is warranted. The screening results were obtained by the use of the search string(s) referenced above. We made no attempts to expand or contract query language to broaden or limit findings, as would be the case if a full Litigation & Testimony History or Comprehensive Expert Vetting Report were requested. No attempts were made to verify that the data is relevant to the particular expert in question in the event there is more than one expert with this name, as would also be the case if a full Profile report were to be ordered. N.B.; Final document availability results may vary from those in this Preliminary Profile Screening Report.

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Richardson v. Methodist Hosp. of Hattiesburg, Inc.
807 So. 2d 1244 (Miss. 2002)

Experts Challenged:

Name	Discipline	Area of Expertise	Disposition
Crystal Keller	Nursing;Nursing (Unspec.)		Testimony was sufficient to create a genuine issue of fact regarding pain and suffering, thus the trial court erred in granting summary judgment on that issue, however, the Court held that the trial court properly concluded that Keller lacked the requisite education and experience to testify regarding causation, thus the trial court properly granted summary judgment for the wrongful death claim.

Gatekeeping Authorities: Federal;Rule 702

Jurisdiction: State

Court: Mississippi, Supreme Court

Plaintiff(s): LINDA RICHARDSON, INDIVIDUALLY AND ON BEHALF OF THE WRONGFUL DEATH HEIRS OF VIVIAN WHEELESS, DECEASED

Defendant(s): METHODIST HOSPITAL OF HATTIESBURG, INC., NOW KNOWN

AS WESLEY HEALTH CENTER

Docket No(s).:	1999-CA-02001-SCT
Citations:	807 So. 2d 1244
Year of Decision:	2002
Area of Law:	Medical Malpractice
Counsel:	ATTORNEYS FOR APPELLANT: J. ANDREW PHELPS MARK THOMAS FINCH. ATTORNEYS FOR APPELLEE: J. ROBERT RAMSAY GEORGE F. GATES.
Judges:	WALLER, JUSTICE, PITTMAN, C.J., SMITH, P.J., COBB AND CARLSON, JJ., CONCUR. McRAE, P.J., CONCURS IN PART AND DISSENTS IN PART WITH SEPARATE WRITTEN OPINION JOINED BY DIAZ, EASLEY AND GRAVES, JJ.
Opinion By:	WALLER

OPINION:

NATURE OF THE CASE: CIVIL WRONGFUL DEATH

EN BANC.

WALLER, JUSTICE, FOR THE COURT:

P1. The motion for rehearing filed by Wesley Health Center is denied. The original opinions are withdrawn, and these opinions are substituted therefor.

P2. Linda Richardson, the daughter of Vivian Wheeless, filed a personal injury and wrongful death action against Methodist Hospital of Hattiesburg, Inc., now known as Wesley Health Center, alleging that Wheeless died as a result of Wesley Health Center's negligent failure to provide adequate care. Summary judgment was granted to Wesley Health Center, from which Richardson seeks our review. Finding there is a genuine issue of material fact concerning whether negligent nursing care caused or contributed to the decedent's pain and suffering during her hospitalization, we reverse the summary judgment in part and remand for a jury trial on that claim. However, we affirm the summary judgment in favor of Wesley Health Center on the wrongful death claim because Richardson failed to present proof sufficient to causally connect the death of Wheeless to deficient care.

FACTS

P3. After complaining of nausea and vomiting blood, Wheeless was admitted to Wesley Health Center where she was originally diagnosed with upper gastrointestinal hemorrhage. Wheeless had a history of poor health, which included a stroke, delirium tremens secondary to alcohol abuse, elevated heart rate, fast breathing, and high blood pressure. During her stay at Wesley, Wheeless suffered a second stroke and subsequently died. The cause of Wheeless's death was recorded on the death certificate as cerebral vascular accident (stroke) secondary to artherosclerotic vascular disease as a consequence of hypertension. Wheeless's physicians concluded the stroke was caused by a totally blocked left carotid artery. Wheeless was a patient at Wesley from December 5, 1996, until her death on January 8, 1997.

P4. Richardson alleges that Wesley caused or contributed to her mother's pain, suffering, and death by providing negligent and sub-standard nursing care. Richardson's expert was Crystal D. Keller, a Registered Nurse and Certified Legal Nurse Consultant, who was designated to testify to the appropriate nursing standards of care and deviations therefrom committed by the hospital staff. In her report, Keller set out in detail areas of failure attributable to the nursing staff at Wesley, which included: failure to monitor adequately; failure to inform physicians of significant changes in the patient's status; failure to follow physician's orders; failure to safeguard adequately; failure to provide adequate care; failure to document properly, accurately, and consistently; failure to assess and reassess adequately; failure to implement an appropriate plan of care; failure to evaluate the patient appropriately; failure to use critical thinking in the nursing process; and failure to assess adequately the patient's risk for injury.

Keller's proffered testimony cites there were noted instances during Wheeless's hospitalization where she exhibited signs of gastrointestinal bleeding (black tarry stools), decreased laboratory values, changes in mental status and confusion, decreased blood pressure, increased heart and respiratory rates, restlessness, and agitation, all of which either were not reported to the physician or documented appropriately. Keller opined that the deviations from the requisite standard of nursing care led to Wheeless's suffering and subsequent death.

STANDARD OF REVIEW

P5. This Court conducts a de novo review of summary judgment motions and, therefore, considers facts without any deference to the trial court and applies its own interpretation of the law. *Daniels v. GNB, Inc.*, 629 So. 2d 595, 599 (Miss. 1993).

P6. Rule 56(c) of the Mississippi Rules of Civil Procedure allows summary judgment where there is no genuine issue of material fact and the moving party is entitled to summary judgment as a matter of law. M.R.C.P. 56(c). The standard of review for granting or denying summary judgment is that summary judgment must be denied unless the moving party has shown it is entitled to judgment as a matter of law after the trial court has reviewed all evidentiary matters in the light most favorable to the non-moving party. This was set out by this Court in *Aetna Cas. & Sur. Co. v. Berry*, 669 So. 2d 56, 70 (Miss. 1996), as follows:

The standard for reviewing the granting or the denying of summary judgment is the same standard as employed by the trial court under Rule 56(c). This Court conducts de novo review of orders granting or denying summary judgment and looks at all the evidentiary matters before it -- admissions in pleadings, answers to interrogatories, depositions, affidavits, etc. The evidence must be viewed in the light most favorable to the party against whom the motion has been made. If, in this view, the moving party is entitled to judgment as a matter of law, summary judgment should forthwith be entered in his favor. Otherwise, the motion should be denied.

DISCUSSION

A. Testimony as to Pain and Suffering

P7. Richardson argues that summary judgment should not have been granted because there was a genuine issue of fact concerning Wheeless's pain, suffering, and death, established through the expert testimony of Keller. In support, Richardson offers Keller's education and sixteen years experience as a registered nurse and six years work as a legal consultant. Richardson believes that Keller's expert opinion is admissible as it is "helpful to the trier of fact," which is the relevant inquiry to be made pursuant to Mississippi Rule of Evidence 702.

P8. We set the standard for expert witnesses in medical malpractice cases in *Hall v. Hilbun*, 466 So. 2d 856 (Miss. 1983), where we said expert opinion testimony should be allowed where the witness is

qualified and independent, and the testimony will assist the trier of fact. We find the trial court's ruling was overly restrictive in not allowing Keller to testify concerning the appropriate standard of nursing care and the deviations from that standard. There is sufficient proffered evidence from Keller for a jury to consider whether the inadequate nursing care resulted in worsening Wheeless's physical pain and suffering.

P9. Wheeless's treating physician provided further support to the deficiencies outlined by Keller. Steven Farrell, M. D., treated Wheeless while she was hospitalized at Wesley and was deposed concerning his treatment and observations of Wheeless. Dr. Farrell expressed concern over the standard of nursing care that Wheeless received, stating that he believed the nurses were deficient in failing to timely notify him and the other treating physician concerning melenic (bloody) stools that were observed after Wheeless's admittance to the hospital. Even though Dr. Farrell did not opine that the gastrointestinal bleeding was in any way associated with the stroke that ultimately caused Wheeless's death, he did testify that the unreported bleeding could have negatively affected her condition. Dr. Farrell explained that the melenic stools would indicate either continued or repeat gastrointestinal bleeding and that there were also notations in the treatment records of low hemoglobin counts which could be indicative of significant hemorrhaging. Dr. Farrell stated "the loss of blood contributed to angina that she had, the chest pain that she had, and reflected poor blood flow to her heart." He went on to say that the continued bleeding could have led to heart problems and may have led to Wheeless's confusion because of poor blood flow to the brain.

P10. In ***Drummond v. Buckley,*** 627 So. 2d 264 (Miss. 1993), the plaintiff filed a medical malpractice action after suffering pain and swelling in his lower back following surgery for a herniated disc. In *Drummond,* the plaintiff did not have an expert witness to show proximate causation; however, we ruled summary judgment was precluded. The facts of *Drummond* reflect there was a dispute over a conversation between the physician and patient over the doctor's recommendation that the patient enter the hospital for treatment of his back infection. We noted that *Clayton v. Thompson*, 475 So. 2d 439, 445 (Miss. 1985), stated "proximate cause arises when omission of a duty contributes to cause an injury." *Drummond*, 627 So. 2d at 270. Here there is substantial evidence documenting deficient nursing care that may have contributed to Wheeless's suffering.

P11. The fact that Keller is not a physician does not bar her right to testify concerning the standard of care for the nursing staff, but more appropriately may affect the weight of her testimony, which is an issue for the trier of fact. Considering all of the evidence in the light most favorable to Richardson, we find there is a genuine issue of fact concerning whether Wheeless suffered more physically and incurred more expense from the failures of the nursing staff documented by Wheeless's expert and that the circuit court improperly granted summary judgment as to pain and suffering.

P12. Wesley argues that the claim for the pain and suffering as an element of the wrongful death action should likewise be denied pursuant to *Wilks v. American Tobacco Co.*, 680 So. 2d 839 (Miss. 1996). In *Wilks*, the jury found that cigarette smoking did not proximately cause the decedent's death. The heirs contended on appeal they were at least entitled to the decedent's lifetime damages that the heirs

believed were overwhelmingly proven to be caused by cigarette smoking. The heirs' cause of action was exclusively under Mississippi's wrongful death statute. We held the personal injury action could not be maintained where it was not alternatively claimed under Mississippi's survival statute. *Id.* at 843.

P13. The facts in Richardson's case reflect that the nurses' negligent actions exacerbated Wheeless's condition and caused pain and suffering, even if that negligence was not determined to be the ultimate cause of death. Though the survival statute is not specifically cited in the complaint, the pleadings in this case delineate two specific causes of action and are sufficient under our system of notice pleadings. We hold that Richardson demonstrated a genuine issue of material fact requiring a trial on her separate cause of action for Wheeless's pain and suffering. Therefore, the circuit court erred in granting summary judgment as to that claim.

B. Testimony as to the Cause of Death

P14. While Keller is qualified to testify concerning deviations in nursing care and resultant pain and suffering, she is not qualified to testify concerning the causal nexus between these deviations and Wheeless's death.

P15. Richardson has cited other cases involving personal injuries where medical testimony was not required for proof of causation, including our decision in *Sonford Prods. Corp. v. Freels*, 495 So. 2d 468 (Miss. 1986), *overruled on other grounds, Bickham v. Department of Mental Health*, 592 So. 2d 96, 98 (Miss. 1991). In *Sonford,* we held that a toxicologist should have been able to render expert testimony that prolonged exposure to toxic chemicals caused injury and death to a workers' compensation claimant. We further held that there need not be expert testimony from a medical doctor to establish causation. 495 So. 2d at 474.

P16. While we do not require expert testimony by a medical doctor in order to establish the cause of death, the plaintiff must show that there is causation in fact. *Trapp v. Cayson,* 471 So. 2d 375, 383 (Miss. 1985). It is not enough to show that there were deviations from the requisite standard of care for nursing. Here, Richardson has failed to make a required showing that the nurses' negligent failure to abide by the standard of care in fact caused or contributed to Wheeless's death.

P17. The cause of a stroke or, in Wheeless's case, a second stroke, is a complex medical issue. Wheeless's doctors discussed the cause of death in detail, and none were supportive of Richardson's theory of wrongful death.

P18. The trial court ruled that Richardson's designated expert witness, Keller, was not "qualified by education or experience to render relevant testimony with regard to the mechanism of Ms. Wheeless's death and/or causal connection between these alleged deviations and Ms. Wheeless's multiple severe medical problems," and therefore "would not be allowed to render medical opinions as to the multiple medical diseases and/or conditions suffered by the Plaintiff during this lengthy hospitalization at Wesley or the cause of these conditions and/or the cause of her death."

P19. We agree with the circuit court that Keller lacks the requisite education and experience as an expert to testify concerning the causal link between Wheeless's death and the alleged deviations in nursing care and further that her proffered testimony does not specify such a link. Therefore, the circuit court did not err in granting summary judgment for Wesley on the charge of causing her wrongful death.

CONCLUSION

P20. The trial court erred in granting summary judgment to Wesley on Richardson's claim for Wheeless's pain and suffering. We therefore reverse the judgment below in part and remand to the Circuit Court of Lamar County for a jury trial on the claim for Wheeless's pain and suffering. In all other respects, we affirm the judgment below.

P21. AFFIRMED IN PART AND REVERSED AND REMANDED IN PART.

PITTMAN, C.J., SMITH, P.J., COBB AND CARLSON, JJ., CONCUR. McRAE, P.J., CONCURS IN PART AND DISSENTS IN PART WITH SEPARATE WRITTEN OPINION JOINED BY DIAZ, EASLEY AND GRAVES, JJ.

CONCURBY: MCRAE (In Part)

DISSENTBY: McRAE (In Part)

DISSENT:

McRAE, PRESIDING JUSTICE, CONCURRING IN PART AND DISSENTING IN PART:

P22. The majority is "splitting hairs" in reversing the summary judgment for Wesley on the claim for Wheeless's pain and suffering and any extra damages that may have occurred for the pain and suffering but upholding the judgment on the wrongful death claim. I agree that this case should be sent back for trial, but I would send it back for trial, not only for pain and suffering, but also for the wrongful death as there is ample evidence and opinions to support the denial of summary judgment and for trial and to allow a trial to occur and let the trier of fact determine the credibility of the expert. The majority has concluded that Keller was qualified to testify concerning deviations in nursing care and resulting pain and suffering, but it refuses to allow her to testify as to causal nexus between deviation and Wheeless's death. This is a "splitting of hairs" when one is allowed to testify and she has expert qualification, enough to testify as to pain and suffering, but not go the one step forward, that leads to death. More importantly, there are additional matters that are sufficient enough to allow this case to go to trial that will be later discussed.

P23. The record before us reveals evidence that Vivian Wheeless was allowed to continue bleeding internally due to negligent nursing care. This bleeding caused the low blood count that is associated with high output congestive heart failure, of which she suffered, and further restricted the already severely

limited blood flow to her brain. Because there exists evidence sufficient to support a finding that the negligent nursing care contributed to her suffering and probably her death, I would reverse the grant of summary judgment and remand this case for a jury to determine the credibility of the expert and the cause of the stroke. Accordingly, I concur in part and dissent in part.

P24. Nurses are trained to be the eyes of the doctor and to monitor the patient's condition or changes for the doctor while he or she is not there. Nurses are trained to recognize symptoms and injuries. They are also trained as to the reason why they have to specifically recognize these symptoms, illnesses, and injuries. Their training also consists of what happens when the symptoms are not recognized. Thus, they should be allowed to state an opinion of causation, and the jury can decide the weight of their testimony. The witness, Crystal Keller, has been a registered nurse since 1986 in Louisiana, and since 1987 in Virginia. Her application for registered nurse status in Mississippi was pending at the time this appeal was taken. She was employed as a nurse by various hospitals from 1986 through 1997. From 1993 to present, Keller served as director of Medical-Legal Consulting Services, an organization she founded to provide expert nursing opinions in expectation of litigation. These qualifications are hardly "meager," as the hospital contends.

P25. In her report, Keller stated that "the nurses failed to recognize signs and symptoms associated with a GI bleed and decreased laboratory values which affect the cardiovascular system and alter the mental status." She concluded that the failure of the nurses to notify the doctors of these symptoms, along with other deviations from the nursing standard of care, ultimately led to Wheeless's death.

P26. In ***Hooten v. State***, 492 So. 2d 948 (Miss. 1986), we held that the trial court abused its discretion in failing to qualify a handwriting witness as an expert. The witness's formal education consisted entirely of correspondence courses taken through the International Graph-Analysis Society Institute of Chicago, where she completed an eighteen-month course of twenty lessons in less than a year. After voir dire, the judge determined that she lacked the educational background to qualify as an expert. ***Id.***

P27. We reversed, holding that her fifteen years of experience and testimony in 300 trials "places her clearly within the ambit of our rules regarding experts." ***Id.*** "We emphasize that in situations such as this, attacks on the expert's qualifications and methods are better directed toward the weight of the testimony than its admissibility." ***Id.*** (citing *Henry v. State* (emphasis added)).

P28. Nurses are not laypersons. They are trained to recognize symptoms and injuries that are life-threatening. They are trained to monitor patients and notify doctors of any adverse changes in their condition. The college that Keller attended and the conclusions that she reached in her report should be challenged on cross-examination, and the weight to be given her testimony should be determined by a jury, rather than dismissed on summary judgment.

P29. Based on our holding in ***Hooten***, Keller should be allowed to testify in light of her training and more than 16 years of experience as a registered nurse including six years of experience as a legal consultant. Because of her experience and work background, she is able to testify as to what led up to the death,

not just pain and suffering.

P30. The majority cites *Trapp v. Cayson* 1985), for the well-established rule that "the plaintiff must show that there is causation in fact." In ***Trapp***, we held that a "jury must believe by a preponderance of evidence Dr. Trapp violated that duty and negligently did, or failed to do, certain acts, which proximately caused or contributed to Cayson's injuries." ***Id.*** We went on to cite another well-established rule in that case, that the credibility of medical experts is for a jury to determine. *Id.* at 380.

P31. While the majority recognized Dr. Stephen Farrell, who treated Wheeless and noted some of his opinions, it failed to recognize that Dr. Farrell's testimony further bolstered the testimony of Keller as to causation. While there is no question that he was a reluctant witness, his testimony alone is enough to send the case to a jury without Keller's testimony, but with the combination of both, it is sufficient enough for the testimony to go forward on all issues.

P32. Dr. Farrell treated Wheeless at the hospital. He testified in his deposition that after she was admitted in the Intensive Care Unit, family members told him that they were concerned because she experienced some "melenic" (black, tarry) stool that was not reported to the doctors. He testified that he would expect the nursing staff to report this condition to doctors "because if we believe a person to be stable from having had gastrointestinal bleeding . . . if they have recurrent melenic stool, then it could indicate a recurring bleed." He further stated, "that should be reported emergently to the physician because she could be bleeding again significantly when she was presumed to be stable."

P33. Dr. Farrell testified that internal bleeding could have exacerbated Wheeless's congestive heart failure. "The presumption was by Dr. Wilkins, the cardiologist, that she could have a form of congestive heart failure called high output failure which was associated with a low blood count." He further stated that a low blood count could be caused by excessive bleeding and that a recurring bleed could cause her hemoglobin hematocrits to become unstable. This means the volume percentage of oxygen-carrying hemoglobin in her blood would fall. In other words, her heart was already impaired in its ability to maintain adequate blood flow, and internal bleeding would further impede the amount of oxygen that her heart was able to deliver to her brain.

P34. The death certificate stated that Wheeless's death was caused by a "cerebral vascular accident," or apoplectic stroke, due to atherosclerosis caused by high blood pressure. Her treating physicians determined that Wheeless suffered from a completely blocked left carotid artery. As a result, the entire left hemisphere of her brain was being provided with blood only through the development of new vasculature from the right hemisphere. She also suffered a stroke on December 11, while in the hospital.

P35. In spite of her delicate condition, at no time was Dr. Farrell notified by the nursing staff that Wheeless was exhibiting symptoms of internal bleeding. He testified that "I believe the loss of blood contributed to [the] angina that she had, the chest pain that she had, and reflected poor blood flow to her heart . . . It could have led to some of her confusion that she was having and poor blood flow to her brain."

P36. Wheeless suffered from numerous conditions which caused her to have severely restricted blood flow to her brain. The nursing staff was aware of this. Whether her internal bleeding, which further limited what was already considered "poor blood flow to her brain" and created fluctuations in her blood pressure, caused her fatal stroke is a question for a jury to determine. The qualifications of the causation experts "are better directed toward the weight of the testimony than its admissibility." *Hooten*, 492 So. 2d at 949.

P37. In her report, Keller cited numerous "deviations from the Nursing Standards of Care which lead to the injury and subsequent death of Ms. Vivian Wheeless." She concluded that there were deviations throughout Wheeless's stay in the hospital, but that the deviations of the nurses on floor 2E are what led to her injury and subsequent death on January 8. On December 20, Dr. Farrell had Wheeless transferred to a different room and ordered that she not be returned to the nursing staff on floor 2E.

P38. The testimony of Dr. Farrell, along with the proffered testimony of Crystal Keller, are sufficient to create a jury question as to the causation between the treatment of Vivian Wheeless and her injuries. Due to Keller's education, training, experience as a nurse, and experience in litigation consultation, she should not have been disqualified as an expert, and her credibility should be weighed by the jury. The burden is on the movant to prove there are no triable issues. There is sufficient evidence for this case to be tried by a jury. As the majority notes, the cause of a stroke is a complex medical issue, and it should not be determined by this Court. I would reverse the grant of summary judgment and remand this case for a jury trial on all issues including causation on death and not just pain and suffering prior to death. Accordingly, I concur in part and dissent in part.

DIAZ, EASLEY AND GRAVES, JJ., JOIN THIS OPINION.

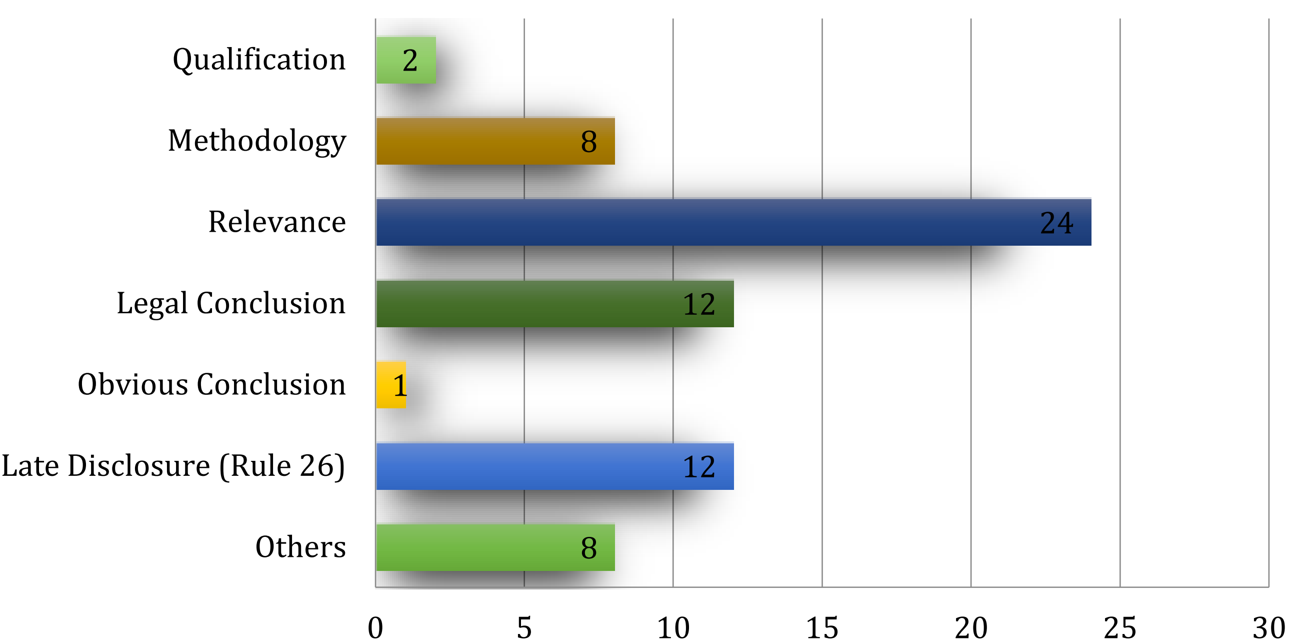
EXPERT CHALLENGE HISTORY

DR. JOHN R. DOE, PH.D.

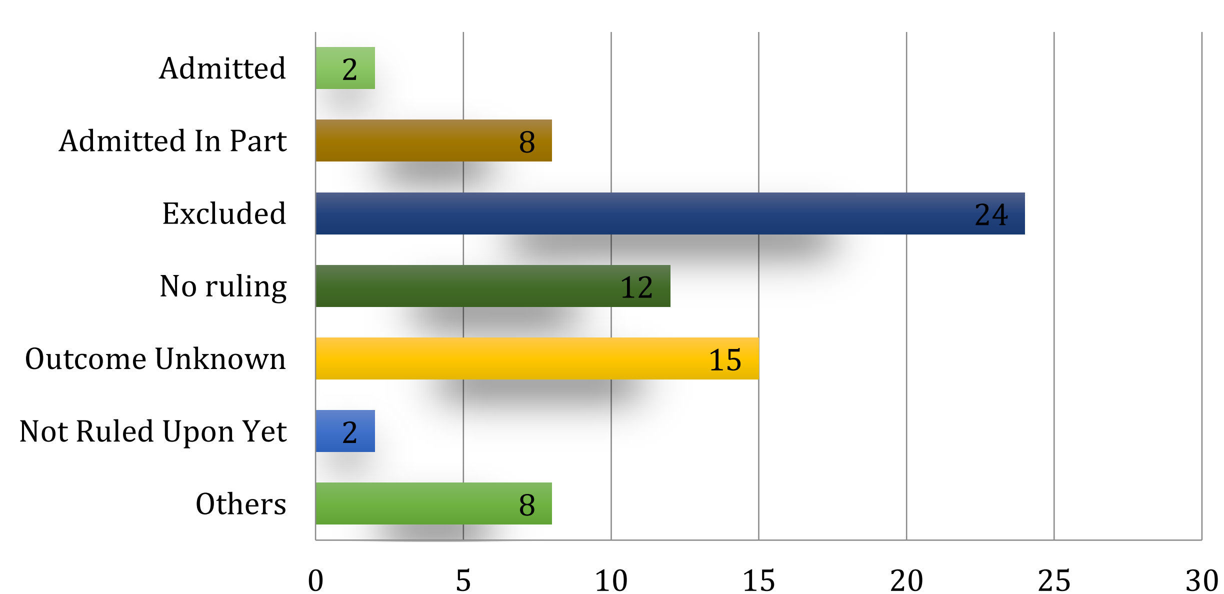
MARKETING EXPERT WITNESS

PREPARED ON MAY 29, 2015

Grounds of Challenge



Challenge Disposition



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EXPERT CHALLENGES

This section provides references to an expert who has been cited or mentioned in case opinions (reported and unreported), briefs (where available), jury verdicts, dockets, and expert challenges for both state and federal courts. It is again noted that not every jurisdiction and every court makes their case law available, and this profile is limited as such.

The following search strings were run to ensure that all available cases and briefs are captured.

1. ((John w/2 Doe) w/100 Expert and (Professor or Psycholog! Or "Marketing" or "Damages Expert" or Econom! or "Product Management" or Analys! or Licensing)

The following legal databases were looked at during the preparation of this report:

1. Federal and State Cases Combined, Jury Verdicts and Settlements, Federal Agency Decisions, State Agency Decisions
2. Court Documents – Trial Filings, Appellate Briefs, Trial Orders, Dockets
3. PACER was searched to retrieve original documents, if available.
4. Google Scholar – Legal Opinion Search

Availability of Supporting Documents

In the course of research, many relevant documents such as opinions, briefs, pleadings, deposition transcripts, motions to exclude, rulings, expert reports, expert CVs etc. are retrieved from various sources. These documents are divided into three categories:

1. Available for Download for no additional cost (These are mainly opinions for which no cost is incurred on the part of MarGin Consulting, LLC.)

2. Available for Instant Delivery (These are documents which can be delivered within one business day after payment.) To know the cost of these documents and to order, click on **(Request Document)** next to the document to send an email with the relevant document title and the Case Caption.

3. These are documents which cannot be procured electronically and can be obtained only from the court. These documents do not have **(Request Document)** mentioned against them. To know how these documents can be procured, please send a mail to **Doc_Request@MarGin-Consulting.com** with the relevant document title and the Case Caption.

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DIRECT CHALLENGES

This section includes reported, and numerous unreported cases from both state and federal jurisdictions where a "gatekeeping authority" has been cited or mentioned in a decision and the testifying expert's methodology or qualifications have been challenged. Gatekeeping authority is defined as a seminal decision or rule of evidence that defines or interprets the standards for admissibility or expert witness testimony for the corresponding jurisdiction. This section includes results from over 165 gatekeeping authorities, including but not limited to *Daubert v. Merrell Dow*, *Frye v. United States*, and their progeny. Sources for unreported decisions include docket sheets, litigation reports, jury verdicts, and other online resources. Although care has been followed to gather this information, not all cases involving expert challenges are reported.

Testimony admitted in part and excluded in part.

Case Source: Opinion, Trial Pleading, Docket

Case Caption: **Brighton Collectibles, Inc. v. Renaissance Group**

Docket Number: 06-CV-1115, 306CV01584, 06 CV 01848

Case Cite(s): 2008 U.S. Dist. LEXIS 39707, 2006 Misc. Filings 1115; 2007 Misc. Filings LEXIS 4582; 2007 Misc. Filings LEXIS 4583, 2008 WL 2546408, 2008 WL 2546407, 2008 WL 2546426, 2008 WL 5455245, 2007 WL 7631415

Grounds of Challenge: Methodology

Area of Law: Trademark Law

Jurisdiction: Federal

State: California

Court Name: United States District Court For The Southern District Of California

Retained By: Plaintiff

Plaintiff's Attorney(s): Peter W Ross, Keith J Wesley , Marta B Almli , Dreier Stein Kahan Browne Woods George LLP, Beverly Hills, CA; Steven W Winton, Winton and Larson, San Diego, CA

Defendant's Attorney(s): Jessica Marie Helliwell, Michelle M McCliman, Wang, Hartmann, Gibbs & Cauley, P.C., Newport Beach, CA

Judge(s): Marilyn L. Huff

Date(s): 04/01/2009

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Summary of Involvement: Doe was retained by the Plaintiff to provide expert analysis and testimony on surveys conducted regarding the public perception of Plaintiff's products and/or the likelihood that consumers will confuse Defendant's goods with Plaintiff's goods in the instant case. Defendant filed a motion in limine to exclude his testimony. The Court concluded that the Plaintiff had failed to establish that his testimony regarding lost sales satisfied the FRE- Rule 702 standard and failed to demonstrate that his testimony was "based on sufficient facts or data" or that it was "the product of reliable principles and methods" that had been applied "reliably" to the facts of this case. The Court concluded that the challenged portion of his proposed testimony was too speculative to merit admission and accordingly granted Defendant's motion to preclude Plaintiff from presenting his testimony that Plaintiff lost one customer transaction for each Langdon Leather product sold by Defendant. However, the Court declined to exclude his testimony in its entirety.

Supporting Document(s):

1. Expert Report of John Doe (**Request Document**)
2. Ralphs' Memorandum In Support Of Motion In Limine No. 4, To Exclude “Expert” Opinion Testimony (**Request Document**)
3. Defendant's Memorandum Of Points And Authorities In Support Of Its Motion For Summary Judgment (**Request Document**)
4. Order Regarding Motions In Limine: Finding As Moot Motion In Limine (**Request Document**)
5. Order Regarding Motions In Limine: Finding As Moot Motion In Limine (**Request Document**)
6. Brighton's Notice Of Motion To Amend Judgment To Include A Permanent Injunction; Memorandum Of Points And Authorities; Declaration In Support Thereof

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Trial court did not allow the expert to testify; affirmed.

Case Source: Brief Bank

Case Caption: **Loughert vs. The Reagan Hospital And Medical Center**

Docket Number: 02588EDA9942

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Case Cite(s):	1999 WL 033887609 (Pa.Super.); 1999 WL 033888608 (Pa.Super.)
Grounds of Challenge:	Obvious Conclusion
Area of Law:	Insurance Law
Jurisdiction:	State
State:	Pennsylvania
Court Name:	Superior Court of Pennsylvania
Retained By:	Plaintiff
Plaintiff's Attorney(s):	Derek R. Lassiter, Klone & Specter, P.C.
Defendant's Attorney(s):	Edward L. Stork, Esquire, Roland & Schlegel, P.C.
Judge(s):	Marilyn L. Huff
Date(s):	04/01/2009
Summary of Involvement:	Doe was retained by the Plaintiff as an expert. On appeal, the Plaintiff argued that the trial court erred in refusing to allow Doe to testify to the non-effectiveness of unsigned insurance policy. However, the judgment was affirmed.
Supporting Document(s):	1. Brief for Appellants (**Request Document**) 2. Brief of Appellee (**Request Document**)

Testimony unpersuasive.

Case Source:	Opinion, Trial Order, Brief Bank
Case Caption:	**Jenkins v. McCarthy**
Docket Number:	B297993, BC 309975
Case Cite(s):	2009 Cal. App. Unpub. Lexis 9777, 2005 WL 7237970, 2005 WL 7237259, 2009 WL 5707527, 2009 WL 5555529

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Grounds of Challenge: Methodology

Area of Law: Business Laws

Jurisdiction: State

State: New York

Court Name: Court Of Appeal Of New York, Second Appellate District, Division Two

Retained By: Defendant

Plaintiff's Attorney(s): Not Applicable

Defendant's Attorney(s): Winston & Strawn, Rebecca Lawlor Calkins and Erin R. Ranahan

Judge(s): Ashmann-Gerst, J.; Boren, P. J., Doi Todd, J. concurred

Date(s): 02/27/2009

Summary of Involvement: Doe was retained by the Defendant as an expert in the instant case. The Court observed that Doe had admitted in his testimony that Plaintiff had failed to conduct any independent work and relied on the Defendant's testimony. The Court found his testimony unpersuasive.

Supporting Document(s):

1. Opinion dated 27th February 2009 (**Request Document**)
2. Statement of Decision (**Request Document**)
3. Expert Report of John Doe (**Request Document**)

Testimony was improperly excluded at trial; outcome of appeal is unknown.

Case Source: Brief Bank

Case Caption: **Investments v. Del Curto**

Docket Number: B5555555

Case Cite(s): 2000 WL 555555, 2000 WL 111111, 1997 WL 222222

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Grounds of Challenge: Qualification

Area of Law: Business Law

Jurisdiction: State

State: New York

Court Name: Court of Appeal, Second District, Division 5, New York

Retained By: Defendant

Plaintiff's Attorney(s): David M. Sine, Sanborn & Sine

Defendant's Attorney(s): Neil Papiani

Judge(s): Honorable Reginald A. Dunn

Date(s): 02/05/1987

Summary of Involvement: Doe was retained by the Defendant as an expert in valuation. In the instant case, Defendant argued that the trial court had improperly excluded Doe's testimony. The outcome of appeal is unknown.

Supporting Document(s):

1. Appellants' Supplemental Brief Regarding Prejudicial Effect of Trial Court's Exclusion of Expert (**Request Document**)
2. Appellants' Reply Brief and Opposition to Respondents Cross-Appeal (**Request Document**)
3. Respondents' Reply Brief and Cross-Appeal (**Request Document**)

Testimony rejected by the trial court; outcome of appeal is unknown.

Case Source: Brief Bank

Case Caption: **Wetzel v. Gratzer**

Docket Number: G0666666

Case Cite(s): 2002 WL 555555

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Grounds of Challenge: Methodology

Area of Law: Labour Law

Jurisdiction: State

State: New York

Court Name: Court of Appeal, Fourth District, Division 3, New York

Retained By: Not Applicable

Plaintiff's Attorney(s): Not Applicable

Defendant's Attorney(s): Not Applicable

Judge(s): Honorable Kim G. Dunning

Date(s): 09/22/2002

Summary of Involvement: Doe was an independent appraiser in the instant case. Doe prepared a report on fair value which the trial court had rejected. The outcome of appeal is unknown.

Supporting Document(s): 1. Appellant's Opening Brief (**Request Document**)

Testimony disregarded by arbitrator, affirmed at trial; outcome unknown on appeal.

Case Source: Brief Bank

Case Caption: **Todisco v. Cable**

Docket Number: G055555

Case Cite(s): 2000 WL 555555, 2000 WL 111111, 1997 WL 222222

Grounds of Challenge: Qualification

Area of Law: Negligence

Jurisdiction: State

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State:	New York
Court Name:	Court of Appeal, Fourth District, Division 3, New York
Retained By:	Defendant
Plaintiff's Attorney(s):	David M. Sine, Sanborn & Sine
Defendant's Attorney(s):	Sylvia L. Paoli #55555, Paoli & Paoli, Inc.
Judge(s):	Hon. Raymond Ikola
Date(s):	07/29/2000
Summary of Involvement:	Doe was retained by the Defendant as an expert in accountancy. The arbitrator found his testimony credible but disregarded it at trial. The outcome of the appeal is unknown.
Supporting Document(s):	1. Appellant's Reply Brief (**Request Document**) 2. Respondent's Brief (**Request Document**) 3. Appellant's Opening Brief (**Request Document**)

Indirect Challenges

This section includes reported, and numerous unreported cases from both state and federal jurisdictions where the expert's testimony has been cited or mentioned in a decision and the testifying expert's testimony has been offered in support of, in response to, or in opposition to motion for summary judgment, class certification, preliminary injunction, motion for a new trial or judgment notwithstanding the verdict. Sources for unreported decisions include docket sheets, litigation reports, jury verdicts, and other online resources. Although care has been followed to gather this information, not all cases involving such indirect expert challenges are reported.

Testimony filed in support of motion for class certification; outcome unknown.

Case Source:	Docket
Case Caption:	**Loughert v. Demetrius**
Docket Number:	6:93cv254
Case Cite(s):	Not Applicable
Grounds of Challenge:	Others

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Area of Law: Insurance Law

Jurisdiction: Federal

State: Texas

Court Name: US District Court for the Western District of Texas

Retained By: Plaintiff

Plaintiff's Attorney(s): John P. Germani, Richard D. Martemucci And Germani Martemucci Riggle

Defendant's Attorney(s): Elizabeth A. Flynn, James F. Tucker, J. Tucker LLP

Judge(s): S. Gonzalez-Villamil

Date(s): 08/01/2012

Summary of Involvement: Doe was retained by the Plaintiff as an expert in the instant case. Plaintiff filed his testimony in support of its motion for class certification. The outcome of Plaintiff's motion for class certification is unknown.

Supporting Document(s):

1. Testimony of John Doe in support of Plaintiff's Motion for Class Certification (**Request Document**)

2. Reply and Response to Plaintiff's Motion for Class Certification by Doe (**Request Document**)

Testimony insufficient to avoid grant of motion for preliminary injunction.

Case Source: Opinion, Trial Order

Case Caption: **Mercy v. McCarthy**

Docket Number: B297955, BC 309970

Case Cite(s): 2009 Cal. App. Unpub. Lexis 9873; 2005 WL 7237955

Grounds of Challenge: Others

Area of Law: Products Liability

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Jurisdiction:	State
State:	New York
Court Name:	Court Of Appeal Of New York, Second Appellate District, Division Two
Retained By:	Defendant
Plaintiff's Attorney(s):	David Caspi
Defendant's Attorney(s):	Robert McDonald
Judge(s):	William B. Stock
Date(s):	02/22/2002
Summary of Involvement:	Doe was retained by the Defendant as an expert in the instant case. Defendant filed his testimony in opposition to Plaintiff's motion for preliminary injunction. The Court granted Plaintiff's motion for preliminary injunction.
Supporting Document(s):	1. Opinion dated February 22, 2002 (**Request Document**) 2. Statement of Decision (**Request Document**) 3. Expert Report of John Doe (**Request Document**)

Testimony sufficient to win grant of motion for judgment notwithstanding the verdict at trial; outcome of appeal is unknown.

Case Source:	Brief Bank
Case Caption:	**Abreu v. CHP Corp.**
Docket Number:	113660-06
Case Cite(s):	2010 WL 9615418; 2010 WL 9615423; 2010 WL 8425185
Grounds of Challenge:	Others
Area of Law:	Negligence

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Jurisdiction: State

State: New York

Court Name: Court of Appeal, Fourth District, Division 3, New York

Retained By: Defendant

Plaintiff's Attorney(s): Sandra L. Flushman

Defendant's Attorney(s): Kenneth L. Thompson

Judge(s): Robert Wooten

Date(s): 07/29/2001

Summary of Involvement: Doe was retained by the Defendant as an expert in accountancy. According to the "Appellant's Reply Brief" it was stated that Defendant had cited his testimony in support of its motion for judgment notwithstanding the verdict. The trial court had granted Defendant's motion for judgment notwithstanding the verdict. The outcome of appeal is unknown.

Supporting Document(s):

1. Appellant's Reply Brief (**Request Document**)
2. Respondent's Brief (**Request Document**)
3. Appellant's Opening Brief (**Request Document**)

Testimony sufficient to win grant of motion for summary judgment.

Case Source: Opinion, Trial Pleading

Case Caption: **Lee v. Hendrick**

Docket Number: 3:95cv1284

Case Cite(s): 2007 Misc. Filings LEXIS 4545; 2008 WL 2546302; 2008 WL 2546409

Grounds of Challenge: Others

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Area of Law:	Personal Injury
Jurisdiction:	Federal
State:	New York
Court Name:	United States District Court For The Southern District Of New York
Retained By:	Defendant
Plaintiff's Attorney(s):	Soberson Halley, Robert & Soberson, LLP, New York
Defendant's Attorney(s):	Marina L. Kaufman, Robert K. Luther
Judge(s):	Jill Barschi
Date(s):	04/01/2014
Summary of Involvement:	Doe was retained by the Defendant to provide expert analysis and testimony on surveys conducted regarding the public perception of Plaintiff's products and/or the likelihood that consumers will confuse Defendant's goods with Plaintiff's goods in the instant case. Defendant filed his testimony in support of its motion for summary judgment. The Court granted Defendant's motion for summary judgment.
Supporting Document(s):	1. Opinion dated April 01, 2014 (**Request Document**) 2. Ralphs' Memorandum In Support Of Motion For Summary Judgment (**Request Document**) 3. Defendant's Memorandum Of Points And Authorities In Support Of Its Motion For Summary Judgment (**Request Document**)

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COMPREHENSIVE EXPERT VETTING REPORT

DR. JOHN R. DOE, PH.D.

MARKETING EXPERT WITNESS

REPORT PREPARED ON JUNE 1, 2015

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MarGin Consulting, LLC requires the purchase of additional copies.

Dr. John R. Doe, Ph.D.
Marketing and Public Policy Expert Witness
Doe College of Business Administration
Address: Suite 123, 6 Street Drive
Los Angeles
California 55555
P: (555) 555-5555 | E: john.doe@doe.edu
Web: www.johndoe.com

Introduction

Dr. John Doe's professional interest lies in Advertising Management, Media Marketing, Marketing Strategy and Planning and Management. He has appeared on numerous television and radio programs, including the NBC Evening News, CBS Evening News, ABC Evening News, CBS News' America Tonight, CNN News, ABC's Nightline, History Channel, Financial News Network, Money Radio, Financial Broadcasting Network, The Parenting Network, Senior Report, National Public Radio, the Copley Radio Network, and several other local radio and television stations.

Areas of Expertise

Marketing and Public Policy
Marketing Strategy
Marketing Communication
New Product Development
Psychology

Additional Contact Information

Home Address

Address: 111 Main St., Any City, USA 99999
Phone: (555) 555-5555
Email: johndoe@expertsample.com
Source: CV | View on Map

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CV/ Resumes

Available Online

1. Expert Resume | University of Illinois at Chicago Website
2. Expert Resume | From Expert's Website

Court Filed Resumes

1. Roger v. Smith, USDC – Texas (Southern) | Request Document
2. American Liability Insurance Co. vs. McRonald Corp. | USDC – California Eastern | Request Document
3. Apple, Inc. v. Samsung Electronics | USDC – Delaware | Request Document

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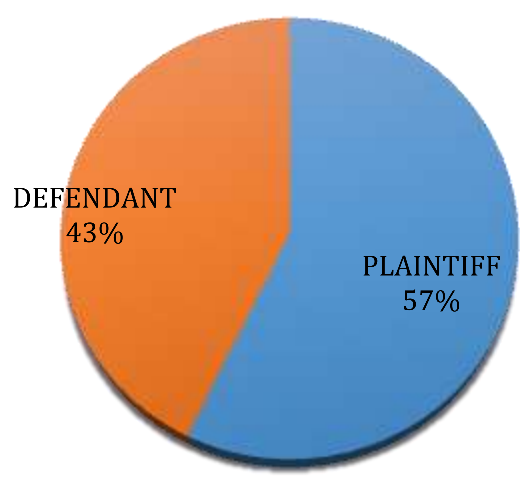
OVERVIEW

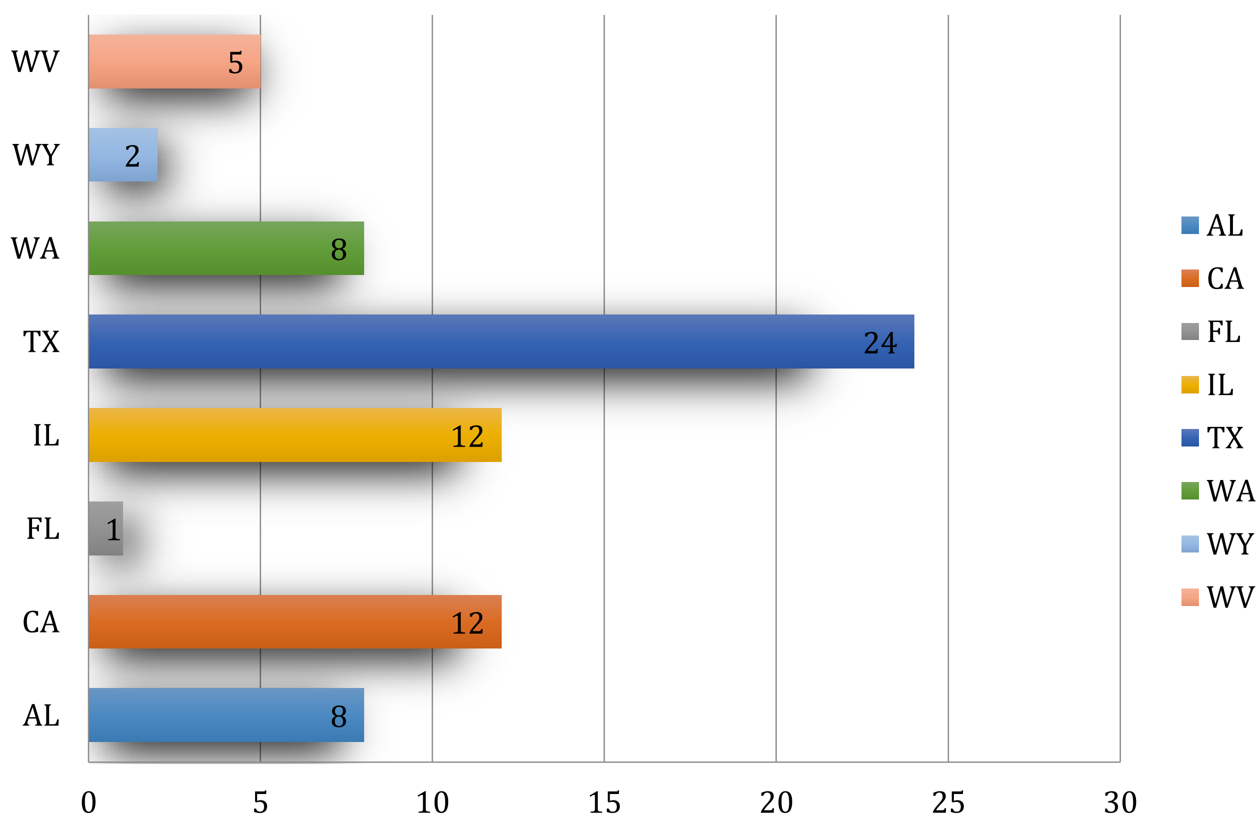
Time Period Covered: 1981 to 2013

RETAINED BY (OVERALL)



CASE INVOLVEMENT

By State:



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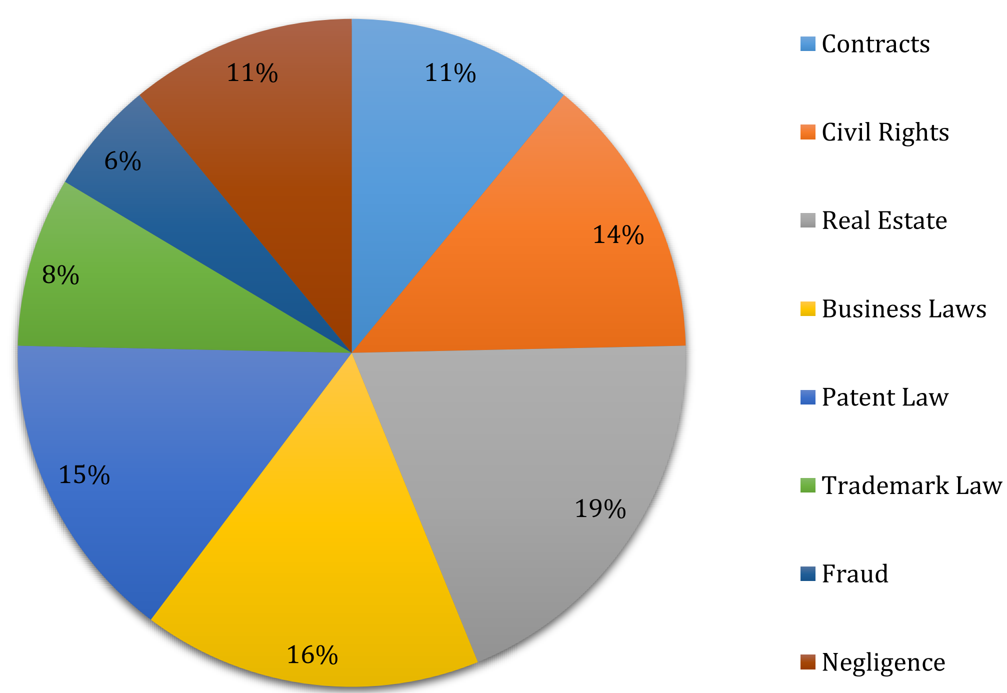
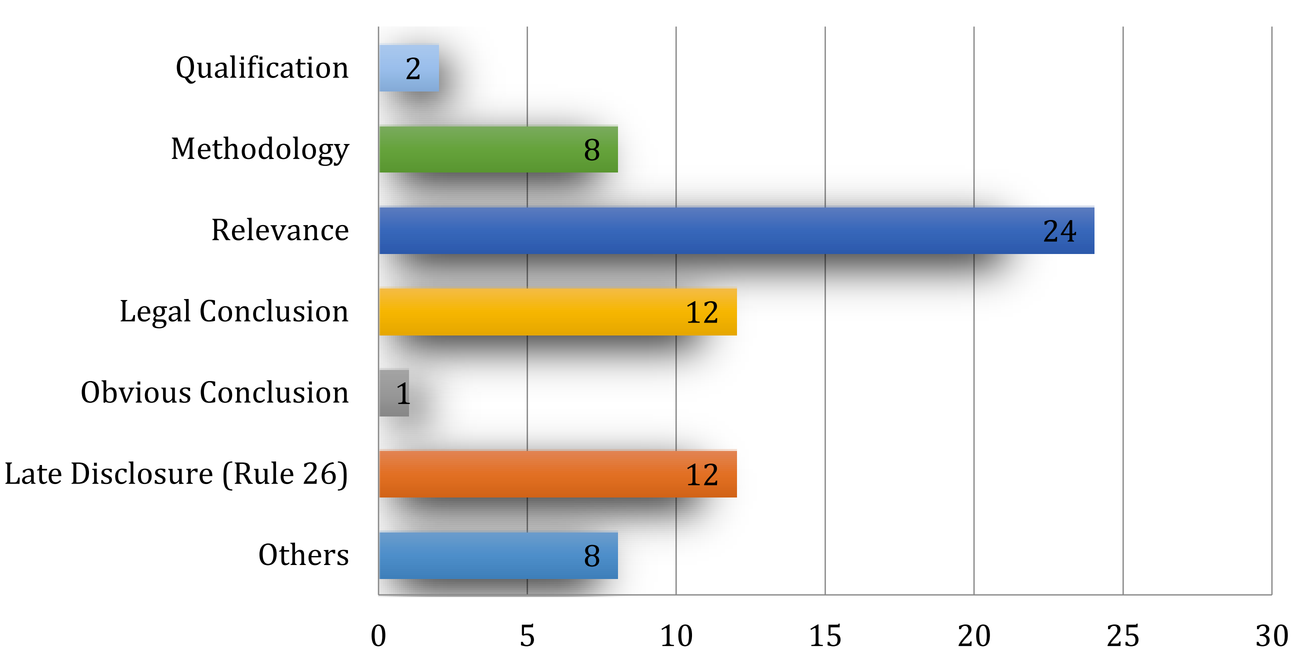
BY AREA OF LAW



GROUNDS OF CHALLENGE



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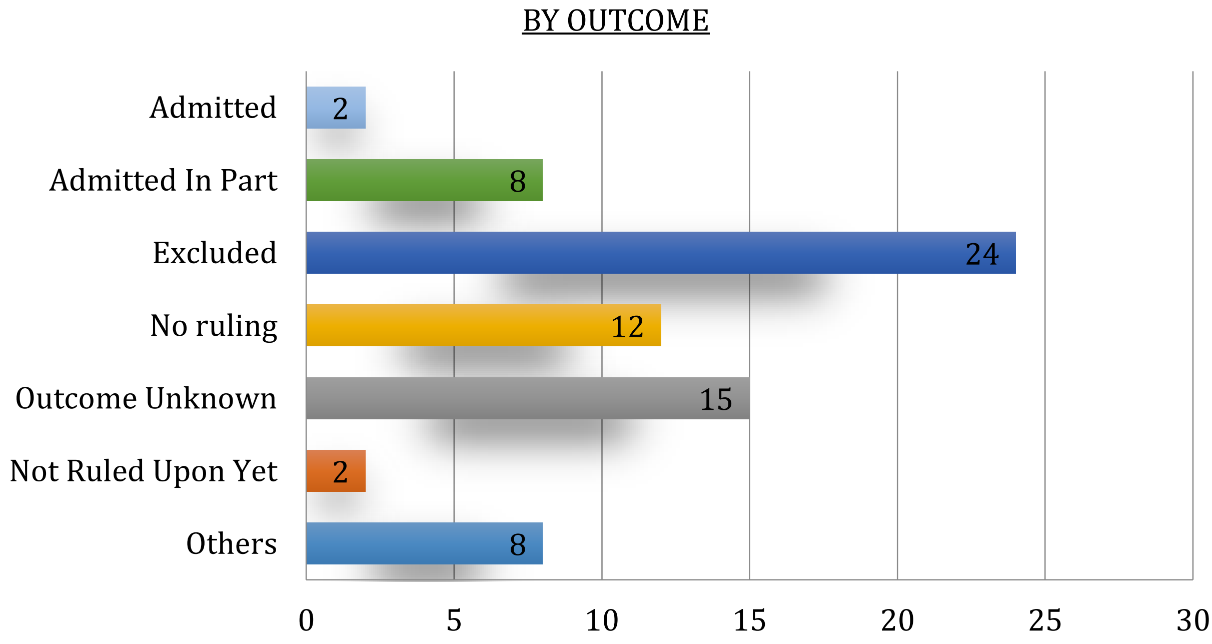
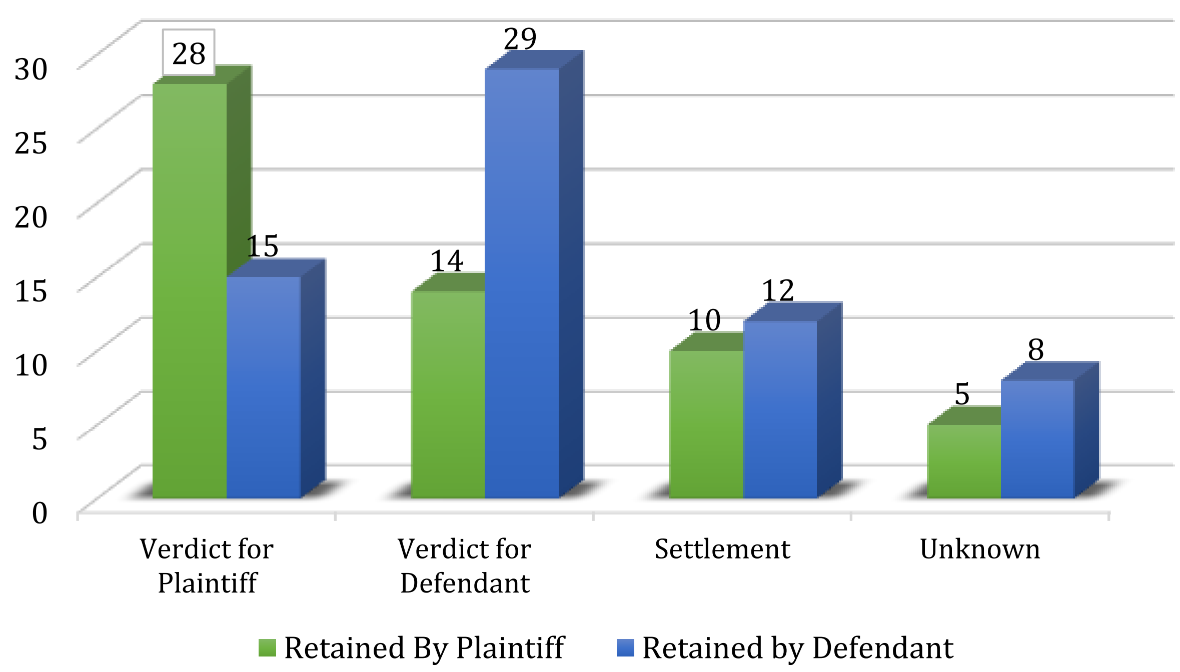
Challenge Disposition

BY OUTCOME



Jury Verdict Analysis

OUTCOME BY RETAINING PARTY



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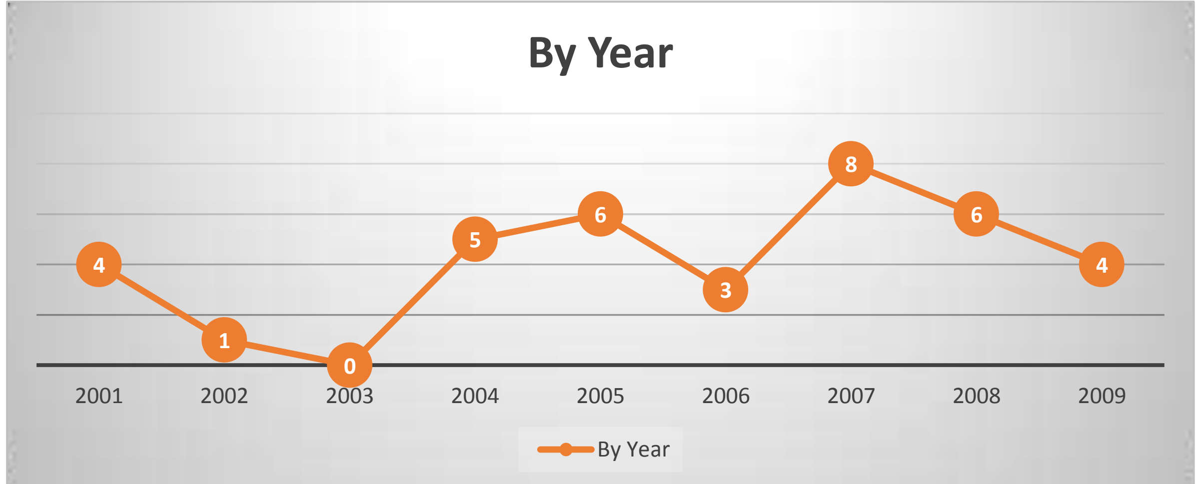
PUBLICATIONS



OTHER DOCUMENTS AVAILABLE

Direct link to documents available for immediate access have been provided. For documents listed in this report and appended with a Request Document link, a procurement fee of $15 per document is applicable. All other documents listed which do not have the Request Document link may not be available through MarGin Consulting, LLC.

Deposition Transcripts/ Excerpts: 2
Trial Transcripts: 1
Full Text Opinions: 25

Federal Agency Decisions: 3
State Agency Decisions: 1
Expert Reports/ Affidavits: 6

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CASE LAW

This case law section provides references to an expert who has been cited or mentioned in case opinions (reported and unreported), briefs (where available), jury verdicts, dockets, and expert challenges for both state and federal courts. It is again noted that not every jurisdiction and every court makes their case law available, and this report is limited as such.

The following search strings were run to ensure that all available cases and briefs are captured.

1. ((John w/2 Doe) w/100 Expert and (Professor or Psycholog! Or "Marketing" or "Damages Expert" or Econom! or "Product Management" or Analys! or Licensing)

The following legal databases were looked at during the preparation of this report:

1. Federal and State Cases Combined, Jury Verdicts and Settlements, Federal Agency Decisions, State Agency Decisions
2. Court Documents – Trial Filings, Appellate Briefs, Trial Orders, Dockets
3. PACER was searched to retrieve original documents, if available.
4. Google Scholar – Legal Opinion Search

Availability of Supporting Documents

In the course of research, many relevant documents such as opinions, briefs, pleadings, deposition transcripts, motions to exclude, rulings, expert reports, expert CVs etc. are retrieved from various sources. These documents are divided into three categories:

1. Available for Download for no additional cost (These are mainly opinions for which no cost is incurred on the part of MarGin Consulting, LLC.)
2. Available for Instant Delivery (These are documents which can be delivered within one business day after payment.) To know the cost of these documents and to order, click on **(Request Document)** next to the document to send an email with the relevant document title and the Case Caption.
3. These are documents which cannot be procured electronically and can be obtained only from the court. These documents do not have **(Request Document)** mentioned against them. To know how these documents can be procured, please send a mail to **Doc_Request@MarGin-Consulting.com**with the relevant document title and the Case Caption.

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DIRECT CHALLENGES

This section includes reported, and numerous unreported cases from both state and federal jurisdictions where a "gatekeeping authority" has been cited or mentioned in a decision and the testifying expert's methodology or qualifications have been challenged. Gatekeeping authority is defined as a seminal decision or rule of evidence that defines or interprets the standards for admissibility or expert witness testimony for the corresponding jurisdiction. This section includes results from over 165 gatekeeping authorities, including but not limited to *Daubert v. Merrell Dow*, *Frye v. United States*, and their progeny. Sources for unreported decisions include docket sheets, litigation reports, jury verdicts, and other online resources. Although care has been followed to gather this information, not all cases involving expert challenges are reported.

Testimony admitted in part and excluded in part.

Case Source: Opinion, Trial Pleading, Docket

Case Caption: **Brighton Collectibles, Inc. v. Renaissance Group**

Docket Number: 06-CV-1115, 306CV01584, 06 CV 01848

Case Cite(s): 2008 U.S. Dist. LEXIS 39707, 2006 Misc. Filings 1115; 2007 Misc. Filings LEXIS 4582; 2007 Misc. Filings LEXIS 4583, 2008 WL 2546408, 2008 WL 2546407, 2008 WL 2546426, 2008 WL 5455245, 2007 WL 7631415

Grounds of Challenge: Methodology

Area of Law: Trademark Law

Jurisdiction: Federal

State: California

Court Name: United States District Court For The Southern District Of California

Retained By: Plaintiff

Plaintiff's Attorney(s): Peter W Ross, Keith J Wesley , Marta B Almli , Dreier Stein Kahan Browne Woods George LLP, Beverly Hills, CA; Steven W Winton, Winton and Larson, San Diego, CA

Defendant's Attorney(s): Jessica Marie Helliwell, Michelle M McCliman, Wang, Hartmann, Gibbs & Cauley, P.C., Newport Beach, CA

Judge(s): Marilyn L. Huff

Date(s): 04/01/2009

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Summary of Involvement: Doe was retained by the Plaintiff to provide expert analysis and testimony on surveys conducted regarding the public perception of Plaintiff's products and/or the likelihood that consumers will confuse Defendant's goods with Plaintiff's goods in the instant case. Defendant filed a motion in limine to exclude his testimony. The Court concluded that the Plaintiff had failed to establish that his testimony regarding lost sales satisfied the FRE- Rule 702 standard and failed to demonstrate that his testimony was "based on sufficient facts or data" or that it was "the product of reliable principles and methods" that had been applied "reliably" to the facts of this case. The Court concluded that the challenged portion of his proposed testimony was too speculative to merit admission and accordingly granted Defendant's motion to preclude Plaintiff from presenting his testimony that Plaintiff lost one customer transaction for each Langdon Leather product sold by Defendant. However, the Court declined to exclude his testimony in its entirety.

Supporting Document(s):

1. Expert Report of John Doe (**Request Document**)
2. Ralphs' Memorandum In Support Of Motion In Limine No. 4, To Exclude "Expert" Opinion Testimony (**Request Document**)
3. Defendant's Memorandum Of Points And Authorities In Support Of Its Motion For Summary Judgment (**Request Document**)
4. Order Regarding Motions In Limine: Finding As Moot Motion In Limine (**Request Document**)
5. Order Regarding Motions In Limine: Finding As Moot Motion In Limine (**Request Document**)
6. Brighton's Notice Of Motion To Amend Judgment To Include A Permanent Injunction; Memorandum Of Points And Authorities; Declaration In Support Thereof

---

Trial court did not allow the expert to testify; affirmed.

Case Source: Brief Bank

Case Caption: **Loughert vs. The Reagan Hospital And Medical Center**

Docket Number: 02588EDA9942

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Case Cite(s): 1999 WL 033887609 (Pa.Super.); 1999 WL 033888608 (Pa.Super.)

Grounds of Challenge: Obvious Conclusion

Area of Law: Insurance Law

Jurisdiction: State

State: Pennsylvania

Court Name: Superior Court of Pennsylvania

Retained By: Plaintiff

Plaintiff's Attorney(s): Derek R. Lassiter, Klone & Specter, P.C.

Defendant's Attorney(s): Edward L. Stork, Esquire, Roland & Schlegel, P.C.

Judge(s): Marilyn L. Huff

Date(s): 04/01/2009

Summary of Involvement: Doe was retained by the Plaintiff as an expert. On appeal, the Plaintiff argued that the trial court erred in refusing to allow Doe to testify to the non-effectiveness of unsigned insurance policy. However, the judgment was affirmed.

Supporting Document(s):

1. Brief for Appellants (**Request Document**)
2. Brief of Appellee (**Request Document**)

Testimony unpersuasive.

Case Source: Opinion, Trial Order, Brief Bank

Case Caption: **Jenkins v. McCarthy**

Docket Number: B297993, BC 309975

Case Cite(s): 2009 Cal. App. Unpub. Lexis 9777, 2005 WL 7237970, 2005 WL 7237259, 2009 WL 5707527, 2009 WL 5555529

Grounds of Challenge: Methodology

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Area of Law:	Business Laws
Jurisdiction:	State
State:	New York
Court Name:	Court Of Appeal Of New York, Second Appellate District, Division Two
Retained By:	Defendant
Plaintiff's Attorney(s):	Not Applicable
Defendant's Attorney(s):	Winston & Strawn, Rebecca Lawlor Calkins and Erin R. Ranahan
Judge(s):	Ashmann-Gerst, J.; Boren, P. J., Doi Todd, J. concurred
Date(s):	02/27/2009
Summary of Involvement:	Doe was retained by the Defendant as an expert in the instant case. The Court observed that Doe had admitted in his testimony that Plaintiff had failed to conduct any independent work and relied on the Defendant's testimony. The Court found his testimony unpersuasive.
Supporting Document(s):	1. Opinion dated 27th February 2009 (**Request Document**) 2. Statement of Decision (**Request Document**) 3. Expert Report of John Doe (**Request Document**)

Testimony disregarded by arbitrator, affirmed at trial; outcome unknown on appeal.

Case Source:	Brief Bank
Case Caption:	**Todisco v. Cable**
Docket Number:	G055555
Case Cite(s):	2000 WL 555555, 2000 WL 111111, 1997 WL 222222
Grounds of Challenge:	Qualification
Area of Law:	Negligence

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Jurisdiction:	State
State:	New York
Court Name:	Court of Appeal, Fourth District, Division 3, New York
Retained By:	Defendant
Plaintiff's Attorney(s):	David M. Sine, Sanborn & Sine
Defendant's Attorney(s):	Sylvia L. Paoli #55555, Paoli & Paoli, Inc.
Judge(s):	Hon. Raymond Ikola
Date(s):	07/29/2000
Summary of Involvement:	Doe was retained by the Defendant as an expert in accountancy. The arbitrator found his testimony credible but disregarded it at trial. The outcome of the appeal is unknown.
Supporting Document(s):	1. Appellant's Reply Brief (**Request Document**) 2. Respondent's Brief (**Request Document**) 3. Appellant's Opening Brief (**Request Document**)

Testimony rejected by the trial court; outcome of appeal is unknown.

Case Source:	Brief Bank
Case Caption:	**Wetzel v. Gratzer**
Docket Number:	G0666666
Case Cite(s):	2002 WL 555555
Grounds of Challenge:	Methodology
Area of Law:	Labour Law
Jurisdiction:	State
State:	New York

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Court Name:	Court of Appeal, Fourth District, Division 3, New York
Retained By:	Not Applicable
Plaintiff's Attorney(s):	Not Applicable
Defendant's Attorney(s):	Not Applicable
Judge(s):	Honorable Kim G. Dunning
Date(s):	09/22/2002
Summary of Involvement:	Doe was an independent appraiser in the instant case. Doe prepared a report on fair value which the trial court had rejected. The outcome of appeal is unknown.
Supporting Document(s):	1. Appellant's Opening Brief (**Request Document**)

Testimony was improperly excluded at trial; outcome of appeal is unknown.

Case Source:	Brief Bank
Case Caption:	**Investments v. Del Curto**
Docket Number:	B5555555
Case Cite(s):	2000 WL 555555, 2000 WL 111111, 1997 WL 222222
Grounds of Challenge:	Qualification
Area of Law:	Business Law
Jurisdiction:	State
State:	New York
Court Name:	Court of Appeal, Second District, Division 5, New York
Retained By:	Defendant
Plaintiff's Attorney(s):	David M. Sine, Sanborn & Sine
Defendant's Attorney(s):	Neil Papiani

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Judge(s): Honorable Reginald A. Dunn

Date(s): 02/05/1987

Summary of Involvement: Doe was retained by the Defendant as an expert in valuation. In the instant case, Defendant argued that the trial court had improperly excluded Doe's testimony. The outcome of appeal is unknown.

Supporting Document(s):

1. Appellants' Supplemental Brief Regarding Prejudicial Effect of Trial Court's Exclusion of Expert (**Request Document**)

2. Appellants' Reply Brief and Opposition to Respondents Cross-Appeal (**Request Document**)

3. Respondents' Reply Brief and Cross-Appeal (**Request Document**)

Indirect Challenges

This section includes reported, and numerous unreported cases from both state and federal jurisdictions where the expert's testimony has been cited or mentioned in a decision and the testifying expert's testimony has been offered in support of, in response to, or in opposition to motion for summary judgment, class certification, preliminary injunction, motion for a new trial or judgment notwithstanding the verdict. Sources for unreported decisions include docket sheets, litigation reports, jury verdicts, and other online resources. Although care has been followed to gather this information, not all cases involving such indirect expert challenges are reported.

Testimony sufficient to win grant of motion for summary judgment.

Case Source: Opinion, Trial Pleading

Case Caption: **Lee v. Hendrick**

Docket Number: 3:95cv1284

Case Cite(s): 2007 Misc. Filings LEXIS 4545; 2008 WL 2546302; 2008 WL 2546409

Grounds of Challenge: Others

Area of Law: Personal Injury

Jurisdiction: Federal

State: New York

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Court Name:	United States District Court For The Southern District Of New York
Retained By:	Defendant
Plaintiff's Attorney(s):	Soberson Halley, Robert & Soberson, LLP, New York
Defendant's Attorney(s):	Marina L. Kaufman, Robert K. Luther
Judge(s):	Jill Barschi
Date(s):	04/01/2014
Summary of Involvement:	Doe was retained by the Defendant to provide expert analysis and testimony on surveys conducted regarding the public perception of Plaintiff's products and/or the likelihood that consumers will confuse Defendant's goods with Plaintiff's goods in the instant case. Defendant filed his testimony in support of its motion for summary judgment. The Court granted Defendant's motion for summary judgment.
Supporting Document(s):	1. Opinion dated April 01, 2014 (**Request Document**) 2. Ralphs' Memorandum In Support Of Motion For Summary Judgment (**Request Document**) 3. Defendant's Memorandum Of Points And Authorities In Support Of Its Motion For Summary Judgment (**Request Document**)

Testimony filed in support of motion for class certification; outcome unknown.

Case Source:	Docket
Case Caption:	**Loughert v. Demetrius**
Docket Number:	6:93cv254
Case Cite(s):	Not Applicable
Grounds of Challenge:	Others
Area of Law:	Insurance Law

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Jurisdiction:	Federal
State:	Texas
Court Name:	US District Court for the Western District of Texas
Retained By:	Plaintiff
Plaintiff's Attorney(s):	John P. Germani, Richard D. Martemucci And Germani Martemucci Riggle
Defendant's Attorney(s):	Elizabeth A. Flynn, James F. Tucker, J. Tucker LLP
Judge(s):	S. Gonzalez-Villamil
Date(s):	08/01/2012
Summary of Involvement:	Doe was retained by the Plaintiff as an expert in the instant case. Plaintiff filed his testimony in support of its motion for class certification. The outcome of Plaintiff's motion for class certification is unknown.
Supporting Document(s):	1. Testimony of John Doe in support of Plaintiff's Motion for Class Certification (**Request Document**) 2. Reply and Response to Plaintiff's Motion for Class Certification by Doe (**Request Document**)

Testimony insufficient to avoid grant of motion for preliminary injunction.

Case Source:	Opinion, Trial Order
Case Caption:	**Mercy v. McCarthy**
Docket Number:	B297955, BC 309970
Case Cite(s):	2009 Cal. App. Unpub. Lexis 9873; 2005 WL 7237955
Grounds of Challenge:	Others
Area of Law:	Products Liability
Jurisdiction:	State

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State:	New York
Court Name:	Court Of Appeal Of New York, Second Appellate District, Division Two
Retained By:	Defendant
Plaintiff's Attorney(s):	David Caspi
Defendant's Attorney(s):	Robert McDonald
Judge(s):	William B. Stock
Date(s):	02/22/2002
Summary of Involvement:	Doe was retained by the Defendant as an expert in the instant case. Defendant filed his testimony in opposition to Plaintiff's motion for preliminary injunction. The Court granted Plaintiff's motion for preliminary injunction.
Supporting Document(s):	1. Opinion dated February 22, 2002 (**Request Document**) 2. Statement of Decision (**Request Document**) 3. Expert Report of John Doe (**Request Document**)

Testimony sufficient to win grant of motion for judgment notwithstanding the verdict at trial; outcome of appeal is unknown.

Case Source:	Brief Bank
Case Caption:	**Abreu v. CHP Corp.**
Docket Number:	113660-06
Case Cite(s):	2010 WL 9615418; 2010 WL 9615423; 2010 WL 8425185
Grounds of Challenge:	Others
Area of Law:	Negligence
Jurisdiction:	State
State:	New York

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Court Name:	Court of Appeal, Fourth District, Division 3, New York
Retained By:	Defendant
Plaintiff's Attorney(s):	Sandra L. Flushman
Defendant's Attorney(s):	Kenneth L. Thompson
Judge(s):	Robert Wooten
Date(s):	07/29/2001
Summary of Involvement:	Doe was retained by the Defendant as an expert in accountancy. According to the "Appellant's Reply Brief" it was stated that Defendant had cited his testimony in support of its motion for judgment notwithstanding the verdict. The trial court had granted Defendant's motion for judgment notwithstanding the verdict. The outcome of appeal is unknown.
Supporting Document(s):	1. Appellant's Reply Brief (**Request Document**) 2. Respondent's Brief (**Request Document**) 3. Appellant's Opening Brief (**Request Document**)

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OTHER CASES INVOLVING JOHN R. DOE

These are cases where the expert was retained. However, no challenge or credibility assessment activity for the expert was found in these cases. Please note that not all cases where an expert is retained mention the name of the expert and hence, these cases do not constitute an exhaustive list of the expert's testimonial history.

Case Source:	Jury Verdict Report
Case Caption:	**Decker v. Chen**
Docket Number:	N777777
Case Cite(s):	Not Mentioned
Area of Law:	Trademark Law
Jurisdiction:	State
State:	New York
Court Name:	Los Angeles Superior Court - Long Beach, New York
Retained By:	Plaintiff
Plaintiff's Attorney(s):	George T. Kelly; Law Offices of George T. Kelly; Long Beach, CA
Defendant's Attorney(s):	Margaret M. Holm; Bonne, Bridges, Mueller, O'Keefe and Nichols; Santa Ana, CA
Judge(s):	Not Mentioned
Date(s):	02/25/2005
Summary of Involvement:	Doe was retained by the Plaintiff as an expert in economics. The jury returned a verdict in favor of the Defendant.
Supporting Document(s):	1. Jury Verdict Report dated February 25, 2005

Case Source:	Trial Order
Case Caption:	**Simmons v. Mitchell**
Docket Number:	EDCV 55-5555

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Case Cite(s): 2009 WL 555555

Area of Law: Maritime Law

Jurisdiction: Federal

State: New York

Court Name: United States District Court, C.D. New York

Retained By: Plaintiff

Plaintiff's Attorney(s): Law Offices of Brian C. Ostler, Sr., A Professional Corporation, Brian C. Ostler, Sr., Esq. Bar #55555, William L. Smith, Jr., Esq. Bar #444444, 555 Any Street, USA 55555, Telephone: (555) 555-5555 Fax: (555) 555-5555

Defendant's Attorney(s): Adam Johnson

Judge(s): Honorable Paul Abrams

Date(s): 05/30/2005

Summary of Involvement: Doe was retained by the Plaintiff as an expert in the instant case.

Supporting Document(s): 1. Joint Witness List (**Request Document**)

Case Source: Trial Order

Case Caption: **Campbell Advisors, P.C. v. Sundog International, Inc.**

Docket Number: 03CC25555

Case Cite(s): 2007 WL 5555555

Area of Law: Labour Law

Jurisdiction: State

State: New York

Court Name: Superior Court of New York

Retained By: Defendant

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Plaintiff's Attorney(s): Brian C. Ostler, Sr., Esq.

Defendant's Attorney(s): Not Mentioned

Judge(s): Robert J. Moss

Date(s): 07/30/2007

Summary of Involvement: Doe was retained by the Defendant. He submitted a declaration stating deficiencies in the Plaintiff's declaration in the instant case.

Supporting Document(s):

1. Defendants Lori Gulsvig and Sundog International, Inc.'s Reply to Plaintiff's Opposition to Defendant's Motion for Summary Judgment or, In the Alternative, Summary Adjudication; Declaration of Brian C. Ostler, Sr. (**Request Document**)

Case Source: Brief Bank, Trial Order

Case Caption: **Parlour Enterprises, LLC v. The Kirin Group, Inc.**

Docket Number: G037525, 05CC02399

Case Cite(s): 2007 WL 5555555, 2007 WL 444444

Area of Law: Insurance Law

Jurisdiction: State

State: New York

Court Name: Court of Appeal, Fourth District, Division 3, New York

Retained By: Defendant

Plaintiff's Attorney(s): Law Offices of William B. Hanley, William B. Hanley (SBN 555555), 123, Any City, USA 55555, Telephone: (555) 555-5555, Facsimile: (555) 555-5555

Defendant's Attorney(s): Smith, Chapman & Campbell, John C. Smith, SBN 5555, William D. Chapman, SBN 44444

Judge(s): Robert H. Gallivan

Date(s): 07/29/2007

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Summary of Involvement: Doe was retained by the Defendant. Plaintiff had argued that although Doe was retained to refute Plaintiff's expert's testimony he had admitted that his calculations had errors.

Supporting Document(s):

1. Appellants' Reply Brief
2. Respondents' Brief
3. Plaintiffs' Opposition to Defendants' Motion for New Trial
4. Plaintiffs' Opposition to Defendants' Motion for Judgment Notwithstanding the Verdict
5. Cross-Defendants, Parlour Enterprises, Inc., Paul Kramer, and Mike Fleming's Motion for Nonsuit [CCP §555c]

Case Source: Docket

Case Caption: **CASC Environmental Et Al V. The Foxboro Co Et Al**

Docket Number: SCVSS72537

Case Cite(s): Not Mentioned

Area of Law: Trademark Law

Jurisdiction: State

State: New York

Court Name: Los Angeles Superior Court - Long Beach, New York

Retained By: Plaintiff

Plaintiff's Attorney(s): William Coffee

Defendant's Attorney(s): Richard Decker

Judge(s): Not Mentioned

Date(s): 02/25/2005

Summary of Involvement: Doe was retained by the Plaintiff. He deposed in the instant case.

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Supporting Document(s):

1. Ex-Parte Motion Re: Order Shortening Time To Hear Motion Disposition: Action Dispo: Complete - Proceedings: Defendants Joint Application To Depose Plaintiffs Expert, John C. Doe, Is Heard. Ex-Parte Hearing Is Held. Ex Parte Application Argued. Per Parties Agreement, The Court Finds No Need For Further Motion On The Above Matter. Ex Parte Orders Granted. Expert depositions are to go forward and be completed prior to the new trial dates. Court Ruling Is Made As To The Issues Addressed In The Ex Parte Application Only. Notice Waived

Personal Litigation History

If the expert has been a party to a litigation, such cases are documented in this section.

Case Source: Brief Bank

Case Caption: **Hetro-Risk, Inc. v. Marsh-Macmillan. Inc.**

Docket Number: 03125

Case Cite(s): 1997 WL 03817790, 1997 WL 03817791, 1997 WL 03817792

Area of Law: Contract

Jurisdiction: State

State: California

Court Name: Court of Appeal, First District, Division 1, California

Judge(s): H Bruce Guyton

Date(s): 08/07/2005

Summary of Involvement: Plaintiff sued Doe in the instant contracts suit.

Supporting Document(s):

1. Appellants' Reply Brief
2. Respondents' Brief

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Case Source:	Docket
Case Caption:	**John Doe v. First Cry Express**
Docket Number:	03CV25555
Case Cite(s):	Not Mentioned
Area of Law:	Business Law
Jurisdiction:	State
State:	California
Court Name:	Court of Appeal, First District, Division 1, California
Judge(s):	Robert Field
Date(s):	08/07/2003
Summary of Involvement:	Doe sued the Defendant in the instant business law suit.
Supporting Document(s):	1. Docket Summary

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PROFESSIONAL HISTORY

The expert's professional information is assembled from the curriculum vita, where available, or online resources such as websites, directories, and public databases.

EMPLOYMENT / TEACHING / RESEARCH

Employment History

Employment history is gathered from the expert's curriculum vita, directories, employer websites and other online resources.

Intelligent Insurance Company

Job / Position: President

Years: Sep 2008 – Present

Source: www.EVRsample.com

HETRO/RISK, Inc. Insurance Brokers (Now Smithedges Insurance Center)

Job / Position: Founder and Chief Executive Officer

Years: March 1992 – May 2009

Source: www.EVRsample.com

Teaching / Research History

Teaching/ Research history is gathered from the expert's curriculum vita, directories, university websites and other online resources.

Harvard Business School

Job / Position: Professor of Business Administration

Years: 2004 – 2008

Source: www.EVRsample.com

EDUCATION

Educational history is gathered from the expert's curriculum vita, university websites, the National Student Clearinghouse and other online resources. The expert's attendance and degrees granted is not independently verified unless the expert's date of birth is known, and the school's registrar will release that information.

University of San Diego

Degree: BA, Economics

Years: Sep 1971 – June 1974

Sources:

1. www.EVRsample.com/john_doe
2. National Student Clearinghouse

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NATIONAL STUDENT CLEARINGHOUSE INFORMATION

Name On School's Records: JOHN R. DOE

Date Awarded: 06/18/1974

Degree Title: BACHELOR OF ARTS

Official Name of School: DOE UNIVERSITY

Major Course(s) of Study: ECONOMICS

Major Option: APPLIED ECONOMICS

Dates of Attendance: 09/17/1971 to 06/18/1974

REFERENCES

In some instances, an expert will list the names of references to parties or law firms with whom the expert has worked. These can often be found through online resources. These references are provided when available.

Myles Levin

111 Main St.

Any City

USA 99999

Ph: (555) 555-5555

Source: www.EVRsample.com/john_doe

ASSOCIATION MEMBERSHIPS

Information about an expert's membership in associations is found in this section. This may include the association name, the location, information about the association, any committee or positions held, and the years the expert has been a member.

1. Vice President, The Hobos Club, New York
   Years: 1999 to 2008

2. Member, Business Valuation Section and Economic Damages Section, New York Society of CPAs Litigation Services Section
   Years: 1995 – Present

3. Member, Litigation Sections Steering Committee, New York Society of CPAs Litigation Services Section
   Years: 1997 – Present

4. Member, Board of Directors, and President, Forensic Consultants Association of Orange County
   Years: 2008 – 2010

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BOARD MEMBERSHIPS

1. Chairman, Brigham Young University Board of Advisors to Institute of Professional Accountancy
   Years: 2001- 2003

2. Member, Board of Directors, International Group of Accounting Firms
   Years: 1992 – 1995

3. Director, Cardium Therapeutics Inc.
   Year: 2006 – Present

AWARDS AND HONORS

1. Edmund James Scholar from the University of Illinois, Urbana, IL | 1973

CONFERENCES / PRESENTATIONS / SEMINARS

1. College of American Pathologists, Inspector of National Institutes of Health Clinical Laboratories | June 1996

2. Genetic Epidemiology of Lung Cancer Consortium, National Cancer Institute | September 1997

INTELLECTUAL PROPERTY OWNED

Patents

1. Controlled modification of semiconductor nanocrystals
2. Medicine delivery device and medicine filling device

Trademarks

1. DECPAGE
2. PAGEDEC

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Expert Rates

If an expert has posted his or her rates on their website, published their fee schedule, or otherwise made public their expert rates, then that information is provided in this section.

Consulting with an attorney: $250 per hour

Reviewing documents: $250 per hour

Providing deposition testimony: $250 per hour

Providing testimony at trial: $250 per hour

Other Charges:

- Work which requires travel, other than local travel, is billed at $3,000 per day.
- No charge for normal office expenses such as copies, telephone, and mail.
- Outside copy services, FedEx delivery is billed at cost.
- Travel expenses at cost.

Source: Expert Affidavit Filed in Abrahams v. Bush | June 12, 2012 (Request Document)

Publications

Search results of over 10 million expert authored books, articles, newsletters, law reviews, and/or other scholarly papers and journals are included here. This section may include summaries, source information, dates, and any co-authors (if applicable).

Books

1. Living the Future Not Too Long
2. How to Kill a Mockingbird
3. A Hitchhiker's Guide to the Galaxy

Articles

1. How to research an expert witness.
2. How not to research an expert witness.

Book Reviews

1. Intuition Pumps and Other Tools for Thinking
2. The Dark Side of Liberation

Abstracts

1. Distinct epithelial gene expression phenotypes in childhood respiratory allergy
2. Climate change, air pollution and extreme events leading to increasing prevalence of allergic respiratory diseases

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Editorials

1. Editorial Review Board, The Journal Of The American College of Certified Wound Specialists
2. Editorial Board, Journal Of The American Medical Directors Association

CERTIFICATES AND LICENSES

If the expert has listed any licenses or certifications, that information has been researched, and the result of the investigation is included here. This section may include the expert's occupation, the state, the authority, the license or certification number, the date acquired, and the date of expiration.

1. Licensed Attorney, State Bar of California
2. Licensed Attorney, State Bar of Texas
3. Licensed Physician, Medical Board of California

WEBSITES AND LINKS

Besides the current website, this section includes archived website and web pages to track any change to the expert's website. If there are any sites that link to or from the expert's website, those are included in this section.

Current Websites

1. http://evrsample.com/Content/yoursociety/lit/economicdamages.aspx
2. http://www.example.com/article1

Archived Websites

http://evrsample.com/Content/yoursociety/lit/economicdamages.aspx

Date of Cached Page: 24th June, 2009

Site linked from Current Website

URL: https://www.margin-consulting.com/

Site linked to Current Website

URL: https://www.margin-consulting.com/

EXPERT DIRECTORIES

Expert directories provide a wealth of information about experts, and this information can be compared to the information that expert has provided through formal discovery efforts as well as on his/her website. A simple comparison of the information provided by the expert with his/her directory listing might reveal discrepancies. A list of the expert's directory listings is provided in this section.

1. Expert Profile on JurisPro Expert Witness Directory

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2. Expert Profile on FindLaw Expert Witness Directory
3. Expert Profile on All Law Expert Witness Directory
4. Expert Profile on ALM Experts Expert Witness Directory
5. Expert Profile on ARC Expert Witness Directory
6. Expert Profile on CA Experts Expert Witness Directory
7. Expert Profile on Exify Expert Witness Directory
8. Expert Profile on Expert Law Expert Witness Directory
9. Expert Profile on Expert Pages Expert Witness Directory
10. Expert Profile on Experts.com Expert Witness Directory
11. Expert Profile on FEWA Expert Witness Directory
12. Expert Profile on HG Experts Expert Witness Directory
13. Expert Profile on Martindale Expert Witness Directory
14. Expert Profile on LA County Bar Association Expert Witness Directory
15. Expert Profile on Rominger Legal Expert Witness Directory
16. Expert Profile on SEAK Expert Witness Directory
17. Expert Profile on SF Bar Association Expert Witness Directory
18. Expert Profile on LexVisio Expert Witness Directory

SOCIAL NETWORKING

This section includes any results for the expert's posts, and references to the expert, in blogs and major social networking sites up to the date and time listed. These social networking sites include, but are not limited to, LinkedIn, Facebook, and Twitter.

LinkedIn
www.linkedin.com/john-doe

Facebook
www.facebook.com/ John Doe

Twitter
http://www.twitter.com/john-doe

Google +
https://plus.google.com/John Doe

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Public Profiles

There are several websites which create public profiles of individuals based on information gathered from the internet. Such public profiles of the expert are listed in this section.

Zoominfo
www.zoominfo.com/John Doe/18/178a0/638

Vitals
www.vitals.com/John Doe/17/168a1/618

Manta
www.manta.com/John Doe/16/158a2/698

Healthgrades
www.healthgrades.com/John Doe/15/148a3/688

Corporation Wiki
www.corporationwiki.com/John Doe/14/138a4/678

Superpages
www.superpages.com/John Doe/13/128a5/668

Healthtap
www.healthtap.com/John Doe/12/118a/658

Groups

Some experts will join an online discussion group, or will be mentioned in such a group. Results of an archive of more than 700 million Usenet postings from a period of more than 20 years are included here.

1. South Bay Cycling Group
2. American College of Radiology

Blogs

If an expert maintains a blog, or has been mentioned in a blog post, those results are included here.

Obama responds to Palin in red state
The Washington Bureau- The Scoop | 01/21/2011

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Obama Denies Role In Government
New Yorker | 06/02/2013

Obama to hand over some CIA drone operations to Pentagon
RT Question More | 09/22/2012

Senator accuses former IRS head of engaging in "lie of omission"
Prison Planet | 04/12/2013

Michael Jackson's Alleged Molestation Victim Wade Robson Calls Popstar "Pedophile" On Today!
Perez Hilton | 08/11/2013

MULTIMEDIA

When located, the source for the audio, video, and podcasts (audio programs distributed over the Internet) are included here.

Audio

Audio File containing speech given at National Insurance Forum, 2010

Video

Video File containing speech given at National Insurance Forum, 2010

Podcasts

Doe's weekly podcast

NEWS ARTICLES

Thousands of publications, newspapers, and articles have been searched to locate information, quotes, or references about this expert. It should be noted that not every publication and newspaper is available to be searched for every year. If information about the expert has been located, then this section includes the headline, name and location of the publication, date, and excerpt regarding this expert.

Press Release: Smithedges Announces Acquisition of HETRO/RISK
Smithedges Insurance Centre website
08/11/2013

BrahMos supersonic cruise missile successfully test-fired
The San Francisco Chronicle
04/12/2013

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Oklahoma tornado: family pictured round the world identified
The Sun Sentinel
09/22/2012

Microsoft Xbox One launched with Kinect, Live Tv: All you need to know
The Business Chronicle
06/02/2013

Larsen & Toubro Posts Lower January-March Profit
The Wall Street Journal
01/21/2011

Disciplinary Actions

All state governments and some professional associations maintain records of professional misconduct. When located, the type of misconduct, the action take, the date of the action, and the authority are included.

Name of Authority: Insurance Certification Board of San Diego, California
Type of Action: Suspension of CPCU License for three months.
Reason: Bad faith insurance claim handling
Date: December 1, 2010
Source: www.EVRsample.com/disciplinary/december2010/doe.html

Personal Information

Personal information about this expert, if found, is included in this section. This includes the expert's family history, political contributions, and public information such as bankruptcies, liens, and UCC filings, if any.

Relations

Wife: Jane Doe
Source: www.EVRsample.com-1973-transcription.txt

*A search on December 3, 2010 of online resources revealed that Jane Doe, the wife of John Doe died in a traffic accident in San Francisco at the age of 39. It also stated that John Doe was also severely injured in the accident.
Source: www.EVRsample.com-1973-transcription.txt

Sons: William Doe and Harry Doe
Daughter: Amy Doe

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Source: www.ReportSample.com-1973-transcription.txt

Bankruptcies

If the expert, or his company, has participated in a bankruptcy proceeding, then information about that proceeding can be found here. This information is taken from public records and court filings.

Debtor Name: John Doe
Debtor Company: Hetro Risk, LLC
Debtor Address: 111 Main St., Any City, USA 99999
Debtor Phone: (555) 555-5555
Date of Filing: July 12, 2008
Court: United States Bankruptcy Court for the Southern District of California
Bankruptcy Judge: Myles Robinson
Case # 0773H
Debtor's Attorney Name: Mark Anthony, Esq.
Debtor's Attorney Firm: Mark Anthony Law Offices
Debtor's Attorney Firm Address: 111 Main St., Any City, USA 99999
Debtor's Attorney Firm Phone: (555) 555-5555
Type of bankruptcy (Chapter #): Chapter 13
Date discharged: Undischarged
Creditors: Punyark Legal, LLC
Assets: $10 million
Other parties of interest: None
Source: http://EVRsample.com/bankruptcy/california/sandiego/johndoe.html

Judgments and Liens

If a judgment or lien has been filed by or against the expert, then this information is found here. Drawn from public records, the information includes the claimant information, type of lien or judgment, amount, and date.

Claimant Name: Bank of America
Lien holder Company: Bank of America
Lien holder Address: 111 Main St., Any City, USA 99999
Lien holder Phone: (555) 555-5555
Lien filed against (Name): John Doe
Lien filed against (Address): 111 Main St., Any City, USA 99999
Lien filed against (Phone): (555) 555-5555
Type of claim/lien: Banker's Lien
Amount of the lien: $450000
Reason for claim/lien: Unpaid Mortgage
Court (if applicable): Not Applicable
City: San Diego
State: California
Case title (if applicable): Not Applicable
Case cite (if applicable): Not Applicable
Date: May 21, 2006

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Plaintiff's Attorney: Mark Anthony
Plaintiff's Firm: Mark Anthony Law Offices
Defendant's Attorney: Michael Bengelsdorf, Esq
Defendant's Firm: Bengelsdorf and Stevenson, LLC
Excerpt/Summary (including expert's name):
A lien was put on John Doe's deposits with the Bank of America for failure to pay the mortgage of this house.
Source: http://MarGinConsultingSample.com/liens/california/johndoe.html

UCC Filings

If a UCC filing has been made involving the expert, then this information is found here. Drawn from public records, the information includes the claimant information, description of filing, amount, and date.

Filed By: John Doe and America Loan Givers, LLC
Date of Filing: April 10, 2005
Description: The filing was made on a home loan given by America Loan Givers, LLC to John Doe
Amount: $500,000
Source: www.MarGinConsultingSample.com/templogin.asp

SEC Filings

If an SEC filing has been made involving the expert, then this information is found here. Drawn from public records, the information includes the form type, filing no., and date.

Filing Date: 03/17/2009
Form Type: 4
Company: Cardium Therapeutics, Inc.
Filing No.: 633
Source:
www.EVRsample.com/Archives/edgar/data/772320/000118143309016151/0001181431-09-016151.txt

Properties Owned

If the expert owns a property, that information can be found here. The information is drawn from public records and includes the description, location and consideration paid for the property.

111 Main St., Any City, USA 99999
Lot Size: 135X184.2IRR
Consideration: $45,500.00 as of 01/01/1982

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Source: www.MarGinConsultingSample.com

POLITICAL CONTRIBUTIONS

Political contributions, and the expert's likely political persuasion, are generally gathered from the Federal Election Commission (FEC), an independent regulatory agency that tracks federal campaign contributions over $200. Information about this section may have also been gathered through other government public records.

Political Persuasion: Republican

Cause/ Campaign: BRADY, KEVIN VIA BRADY FOR CONGRESS

Date: 06/29/1998

Donation Amount: $500

Source: http://images.nictusa.com/cgi-bin/fecimg/?98033373995

DONATIONS

This section contains all non-political donations made by the expert. The information may be procured from various sources found on the internet, such as donor's directory, event brochures etc.

Name of Organization: California Aquarium

Date of Donation: 09/21/1985

Amount of Donation: $200

Source: www.MarGinConsultingSample.com

CRIMINAL HISTORY

Not every criminal record is available for public viewing. As such, the information included here is not exhaustive. If any information from criminal records is located about this expert, then this information is found here.

Name: John Doe
Date of Birth: November 16, 1951
Type of charge (Felony or Misdemeanor): Assault and Battery
Charge: Aggravated Assault
Jurisdiction / Location: San Diego, California
Case Number: 01-cr-1895676
Offense Date: January 29, 2001
Arrest Date: February 2, 2001
File Date: February 28, 2001
Disposition Date: March 12, 2001

Other Case Information*:* The accused was found to be guilty of the charges and served a sentence of 6 months of imprisonment.
Source: Criminal Records (Subscription Database)

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SEXUAL OFFENSES

Information about any sexual offenses is derived from public information found through the Dru Sjodin National Sex Offender Public Website (NSOPW). Coordinated by the U.S. Department of Justice, The NSOPW is a cooperative effort between Jurisdictions hosting public sex offender registries and the federal government.

Name: John Doe
Aliases: Johnny
Tier Level: Community Notification: Tier Level 2
Race: White
Hair Color: Blond or Strawberry
Eye Color: Green
Height: 5'10"
Weight: 180 lbs
Conviction Date: 1989-10-24
Court: First Judicial District Court
Conviction Location: Carson City, NV
Conviction State: NV
Statute: NRS201.230
Conviction Description: Lewdness with a Child Under 14
Incarceration: Hospital: Carson City Jail – Carson
Source: www.MarGinConsultingSample.com

INTERESTS / HOBBIES

If the expert has made public any interests or hobbies, that information is included here. Information about the expert's interests and hobbies is derived from the expert's website, curriculum vitae, and other online sources.

A search on May 19, 2013 of the expert's memberships revealed that he has a keen interest in arts and music especially musical compositions by Beethoven.

Sources:

1. www.EVRsample.com/john-doe1
2. www.ReportSample.com/john-doe2

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People	Haywood County, North Carolina	Madison County, North Carolina	Jackson County, North Carolina	Buncombe County, North Carolina
Population				
Population estimates, July 1, 2014, (V2014)	59471	21157	40981	250539
Population estimates base, April 1, 2010, (V2014)	59036	20774	40271	238307
Population, percent change - April 1, 2010 (estimates base) to July 1, 2014, (V2014)	0.7	1.8	1.8	5.1
Population, Census, April 1, 2010	59036	20764	40271	238318
Age and Sex				
Persons under 5 years, percent, July 1, 2014, (V2014)	4.4	4.9	4.7	5.3
Persons under 5 years, percent, April 1, 2010	4.9	4.5	5.1	5.7
Persons under 18 years, percent, July 1, 2014, (V2014)	18.4	19.1	17.1	19.4
Persons under 18 years, percent, April 1, 2010	19.5	19.7	17.7	20.5
Persons 65 years and over, percent, July 1, 2014, (V2014)	23.7	19.8	17.7	18.1
Persons 65 years and over, percent, April 1, 2010	21	17.7	15.1	16
Female persons, percent, July 1, 2014, (V2014)	51.9	50.3	50.9	52
Female persons, percent, April 1, 2010	51.7	50.5	50.2	51.8
Race and Hispanic Origin				
White alone, percent, July 1, 2014, (V2014) (a)	96.5	95.9	85.2	89.6
White alone, percent, April 1, 2010 (a)	95.5	96.5	83.2	87.4
Black or African American alone, percent, July 1, 2014, (V2014) (a)	1.2	1.8	2.3	6.5
Black or African American alone, percent, April 1, 2010 (a)	1.1	1.2	1.8	6.4
American Indian and Alaska Native alone, percent, July 1, 2014, (V2014) (a)	0.6	0.5	9.6	0.5
American Indian and Alaska Native alone, percent, April 1, 2010 (a)	0.5	0.2	9.4	0.4
Asian alone, percent, July 1, 2014, (V2014) (a)	0.5	0.5	1	1.2
Asian alone, percent, April 1, 2010 (a)	0.4	0.3	0.9	1

Native Hawaiian and Other Pacific Islander alone, percent, July 1, 2014, (V2014) (a)	0	0	0.1	0.2
Native Hawaiian and Other Pacific Islander alone, percent, April 1, 2010 (a)	Z	Z	Z	0.1
Two or More Races, percent, July 1, 2014, (V2014)	1.1	1.3	1.9	2
Two or More Races, percent, April 1, 2010	1.1	1.3	1.9	2.1
Hispanic or Latino, percent, July 1, 2014, (V2014) (b)	3.7	2.7	5.1	6.5
Hispanic or Latino, percent, April 1, 2010 (b)	3.4	2	5.1	6
White alone, not Hispanic or Latino, percent, July 1, 2014, (V2014)	93.2	93.6	81.4	83.7
White alone, not Hispanic or Latino, percent, April 1, 2010	93.8	95	81.4	84.4
Population Characteristics				
Veterans, 2010-2014	6148	1420	2977	19596
Foreign born persons, percent, 2010-2014	2.4	2.8	4.2	5.4
Housing				
Housing units, July 1, 2014, (V2014)	35087	10684	26574	115680
Housing units, April 1, 2010	34954	10608	25948	113365
Owner-occupied housing unit rate, 2010-2014	72.9	72.7	66.4	63.9
Median value of owner-occupied housing units, 2010-2014	157200	158100	173200	189500
Median selected monthly owner costs -with a mortgage, 2010-2014	1182	1176	1143	1287
Median selected monthly owner costs -without a mortgage, 2010-2014	335	299	300	374
Median gross rent, 2010-2014	726	631	620	828
Building permits, 2014	122	59	211	1312
Families and Living Arrangements				
Households, 2010-2014	26261	8353	15872	101645
Persons per household, 2010-2014	2.22	2.38	2.33	2.34
Living in same house 1 year ago, percent of persons age 1 year+, 2010-2014	86.2	88.6	83.6	83.6
Language other than English spoken at home, percent of persons age 5 years+, 2010-2014	3.1	3.3	6.9	7.3
Education				

High school graduate or higher, percent of persons age 25 years+, 2010-2014	86.5	80.3	86.4	90
Bachelor's degree or higher, percent of persons age 25 years+, 2010-2014	23.8	20.3	29.3	35.1
Health				
With a disability, under age 65 years, percent, 2010-2014	11	11.4	9.4	9.5
Persons without health insurance, under age 65 years, percent	18.6	17.7	24.5	20
Economy				
In civilian labor force, total, percent of population age 16 years+, 2010-2014	53.9	56	55.8	62.4
In civilian labor force, female, percent of population age 16 years+, 2010-2014	47.9	52	53	59.2
Total accommodation and food services sales, 2007 ($1,000) (c)	99102	12110	74029	684287
Total health care and social assistance receipts/revenue, 2007 ($1,000) (c)	230725	33190	181050	2071233
Total manufacturers shipments, 2007 ($1,000) (c)	D	FN(1)	FN(1)	3211724
Total merchant wholesaler sales, 2007 ($1,000) (c)	174370	26489	52919	1162902
Total retail sales, 2007 ($1,000) (c)	821787	76045	433723	3597871
Total retail sales per capita, 2007 (c)	14501	3757	11900	15862
Transportation				
Mean travel time to work (minutes), workers age 16 years+, 2010-2014	22.9	28.2	18.9	20.4
Income and Poverty				
Median household income (in 2014 dollars), 2010-2014	41795	38251	36705	45642
Per capita income in past 12 months (in 2014 dollars), 2010-2014	24870	20791	21033	26930
Persons in poverty, percent	20.4	19.9	24.2	15.7
Businesses	Haywood County, North Carolina	Madison County, North Carolina	Jackson County, North Carolina	Buncombe County, North Carolina
Total employer establishments, 2013	1375	301	925	7399
Total employment, 2013	13662	3058	10727	101093
Total annual payroll, 2013	423533	73840	324577	3702007
Total employment, percent change, 2012-2013	1.9	1	7.5	2.8
Total nonemployer establishments, 2013	4603	1729	3003	23896

All firms, 2007	5740	2214	3866	29566
Men-owned firms, 2007	2913	S	2229	15857
Women-owned firms, 2007	1454	S	810	8247
Minority-owned firms, 2007	S	F	173	1414
Nonminority-owned firms, 2007	5364	S	3516	26686
Veteran-owned firms, 2007	508	S	840	3331
Nonveteran-owned firms, 2007	4714	1733	2601	23802
Geography	Haywood County, North Carolina	Madison County, North Carolina	Jackson County, North Carolina	Buncombe County, North Carolina
Population per square mile, 2010	106.6	46.2	82.1	362.9
Land area in square miles, 2010	553.69	449.57	490.76	656.67
FIPS Code	"37087"	"37115"	"37099"	"37021"

This geographic level of poverty and health estimates are not comparable to other geographic levels of these estimates

Some estimates presented here come from sample data, and thus have sampling errors that may render some

The vintage year (e.g., V2014) refers to the final year of the series (2010 thru 2014). Different vintage years of

(1) Data may be subject to publication minimums that varyÂ byÂ industryÂ and geography.

(a) Includes persons reporting only one race

(b) Hispanics may be of any race, so also are included in applicable race categories

(c) Economic Census - Puerto Rico data are not comparable to U.S. Economic Census data

D: Suppressed to avoid disclosure of confidential information

F: Fewer than 25 firms

FN: Footnote on this item in place of data

NA: Not available

S: Suppressed; does not meet publication standards

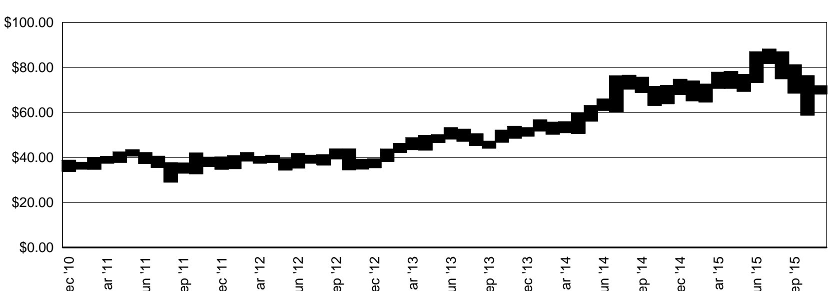
X: Not applicable

Z: Value greater than zero but less than half unit of measure shown

QuickFacts data are derived from: Population Estimates, American Community Survey, Census of Population

LifePoint Health Inc (Nasdaq: LPNT) $71.890 ($88.180-$58.610)

Web	http://www.lifepointhealth.net/
Sector	08 Health Care
Industry	0806 Healthcare Facilities



S&P Index	MidCap 400	Shrs Outst'g (M)	44.0
Market Cap ($M)	3,129.0	Float (M)	42.6
Employees	38,000	Daily Vol (K)	500.0
Beta	0.78	Insd'r Hlds %	1.5
		Inst Hlds %	97.7
EPS TTM ($)	3.27	EPS Est 2015 ($)	4.02
P/E TTM	22.0	P/E Est EPS	17.9
PEG	27.5	PEG Est EPS & Grth	2.2
5yr EPS Grth (%)	0.8	Est EPS Grth (%)	8.2
Yield (%)	0.0	Ind Dividend ($)	0.00
Split Date	NA	Next Qtrly Dividend ($)	0.00
Split Factor	0.0000	Ex. Dividend Date	0/00/0
		Dividend Pmt. Date	0/00/0

LifePoint Health, Inc., formerly LifePoint Hospitals, Inc. provides healthcare services. Through its subsidiaries, the Company operates general acute care hospitals primarily in non-urban communities in the United States. Its hospitals provide a range of medical and surgical services in hospitals in non-urban markets. The Company's services include general surgery, internal medicine, obstetrics, emergency room care, radiology, oncology, diagnostic care, coronary care, rehabilitation services and pediatric services. In some of its hospitals, the Company offers services, such as open-heart surgery, skilled nursing, psychiatric care and neuro-surgery. LifePoint provides outpatient services, such as same-day surgery, laboratory, x-ray, respiratory therapy, imaging, sports medicine and lithotripsy. The Company operates approximately 67 hospital campuses in 21 states, having a total of approximately 8,254 licensed beds.

	Price Chg	Rel Strgth vs S&P	Rel Strgth Rank
4 Week (%)	(3)	(7)	35
13 Week (%)	(11)	(12)	31
26 Week (%)	(0)	(0)	62
52 Week (%)	4	0	67

Growth (%)	TTM	3 Year	5 Year
Sales	22.4	14.0	11.6
Gross Income	19.4	11.4	10.4
Net Income	8.6	(8.2)	(1.2)
EPS Basic	11.7	(5.2)	2.0
EPS Diluted	10.8	(5.9)	1.6
EPS Diluted Cont	10.5	(5.8)	0.8
Dividends	NA	NA	NA
Cash Flow	(17.4)	(80.8)	(45.8)
Free Cash Flow	59.5	6.8	5.1

EPS Surprise	Reported EPS	% Surprise	SUE Score
10/30/2015	$0.97	8.30%	1.9
07/31/2015	$1.00	1.20%	0.2

Earnings Estimates	Quarterly 12/2015	Quarterly 3/2016	Annual 12/2015	Annual 12/2016
Average	1.07	1.08	4.02	4.32
High Est.	1.29	1.19	4.17	4.66
Low Est.	0.93	0.94	3.92	3.92
Std. Dev.	0.09	0.06	0.07	0.16
# of Est.	22	15	17	22
Month Ago	1.09	1.04	3.96	4.27
Rev Up.	6	9	14	10
Rev. Down	10	2	1	4
3 Months Ago	1.08	1.06	3.96	4.29
Report Date	02/15/2016	04/28/2016		

Quarterly EPS	9/30/15	6/30/15	3/31/15	12/31/14	Total
TTM	0.94	1.00	0.84	0.48	3.26
1 Year Ago	0.59	0.84	0.78	0.75	2.96

Quarterly Sales	9/30/15	6/30/15	3/31/15	12/31/14	Total
TTM	1,309.5	1,270.4	1,263.7	1,262.9	5,106.5
1 Year Ago	1,166.0	1,047.0	1,007.2	952.6	4,172.8

Financial Statements	Current	12/2014	12/2013	12/2012	12/2011	12/2010
Sales ($M)	5,106.5	4,483.1	3,678.3	3,391.8	3,026.1	2,818.6
Gross Income ($M)	1,854.3	1,649.6	1,373.8	1,312.7	1,191.9	1,105.3
Research/Dev ($M)	NA	NA	NA	NA	NA	NA
Unusual/Extra ($M)	59.3	57.7	0.3	8.4	0.0	2.4
Operating Income ($M)	255.5	203.0	211.5	244.1	263.3	241.1
Interest Expense ($M)	113.9	123.0	97.0	100.0	107.1	108.1
Pretax Income ($M)	255.5	203.0	211.5	244.1	263.3	241.1
Net Income ($M)	151.3	126.1	128.2	151.9	162.9	155.5
Operat'g Cash Flw ($M)	646.7	412.3	354.0	382.2	401.5	374.1
Cap Expenditures ($M)	269.8	207.1	185.2	221.4	219.9	168.7
EPS Basic ($)	3.43	2.81	2.77	3.22	3.30	2.98
EPS Diluted ($)	3.27	2.69	2.69	3.14	3.23	2.91
EPS Diluted Cont ($)	3.27	2.69	2.68	3.14	3.22	2.91
Dividends/Share ($)	0.00	0.00	0.00	0.00	0.00	0.00
Cash Flow/Share ($)	1.09	(9.52)	11.62	(0.85)	(1.61)	0.38
Free Cash Flow/Share ($)	8.15	4.38	3.55	3.32	3.60	3.84
Cash & ST Inv ($M)	313.2	191.5	637.9	85.0	126.2	207.4
Goodwill/Intgble ($M)	1,739.8	1,705.2	1,723.6	1,696.3	1,658.2	1,623.8
Total Assets ($M)	5,599.0	5,457.0	5,586.8	4,722.2	4,370.1	4,162.9
Long Term Debt ($M)	2,181.2	2,199.3	1,793.8	1,696.5	1,595.4	1,570.5
Total Liabilities ($M)	3,363.3	3,302.4	3,376.7	2,671.7	2,424.9	2,275.4
Book Value/Share ($)	50.81	47.99	47.73	43.44	39.46	36.16
Avg Shares Outst'g (M)	44.0	44.9	46.3	47.2	49.3	52.2

Multiples	Current	12/2014	12/2013	12/2012	12/2011	12/2010
Price/Earnings	22.0	23.5	17.2	12.5	11.2	11.7
Price/Book Value	1.4	1.3	0.9	0.9	0.9	0.9
Price/Sales	0.6	0.6	0.5	0.5	0.5	0.6
Price/Cash Flow	66.0	NA	4.0	NA	NA	89.6
Price/Free Cash Flow	8.8	14.5	13.0	11.8	10.1	8.9
Yield (%)	0.0	NA	NA	NA	NA	NA

Ratios	Current	12/2014	12/2013	12/2012	12/2011	12/2010
Gross Margin (%)	36.3	36.8	37.3	38.7	39.4	39.2
Operating Margin (%)	5.0	4.5	5.7	7.2	8.7	8.6
Net Margin (%)	3.0	2.8	3.5	4.5	5.4	5.5
ROE (%)	6.9	5.8	6.0	7.6	8.5	8.4
ROA (%)	2.7	2.3	2.5	3.3	3.8	3.9
Current Ratio (%)	2.1	2.2	1.5	2.1	2.3	2.5
Payout Ratio (%)	0.0	0.0	0.0	0.0	0.0	0.0
Liabilities to Assets (%)	60.1	60.5	60.4	56.6	55.5	54.7
Asset Turnover (X)	0.9	0.8	0.7	0.7	0.7	0.7

Profile - December 9, 2015

Haywood Regional Medical Center
Clyde, NC 28721
CMS Certification Number: 340184

- Financial data for hospital cost report period ending 07/31/2014 (HCRIS 552206 - 2010).
- Medicare IPPS claims data are for federal fiscal year ending 09/30/2014 (Final rule MedPAR).
- Medicare OPPS claims data are for calendar year ending 12/31/2014 (Proposed rule OPPS).
- Data from other sources and their effective periods are identified within report headers.

Identification and Characteristics

- Last updated 10/28/2015. Definitions

Name and Address: **Haywood Regional Medical Center**
262 Leroy George Drive
Clyde, NC 28721
Telephone number: (828) 456-7311
Hospital Website:
www.haymed.org/
CMS Certification Number: 340184

Type of Facility: Short Term Acute Care
Type of Control: Governmental, County
Health Care System: Duke LifePoint Healthcare
Brentwood, TN
System Website:
www.dukelifepointhealthcare.com

General Med/Surg Beds: 110
Special Care Beds: 12

Total Employees: 572
Total Discharges: 4,022
Total Patient Days: 13,009
Total Patient Revenue: $316,484,566

County (FIPS code): NC087 - Haywood, NC
CBSA (formerly MSA): 11700 - Asheville, NC
Latitude / Longitude: 35°31'N / 82°56'W

NOTES

Formerly known as Haywood Regional Medical Center.

This facility used to report under Provider ID 340025.

Duke Lifepoint Healthcare acquired WestCare Health System on August 1 2014.

Source:WestCare Health System WebsiteAugust 1 2014

Fiscal Intermediary: Palmetto GBA
Urban / Rural Designation: Urban
Medicare Certified Beds: 178

Key Contacts

- Contact information is copyrighted and is not included in downloads of this page.
- Contact information available last updated 08/17/2015.)

Components (Medicare Certified)

- NPI information last Updated 09/13/2015 / Definitions

Type of Component	Provider Number	Medicare Payment System	Medicaid Payment System	Certified	NPI
Hospital	340184	PPS	None	06/06/2008	1811158215
Psych Subprovider	34S184	PPS	None	10/01/2009	1568618379
Hospital-Based HHA	347035	PPS	None	12/09/1971	1225012172
Hospital-Based Hospice	341550			11/08/1990	1164407649

Associated

- NPI information last Updated 09/13/2015 / Definitions

NPI	Name	Address	Telephone
1164407649	DLP HAYWOOD REGIONAL MEDICAL CENTER LLC HAYWOOD HOSPICE & PALLIATIVE CARE	243 JONES COVE RD CLYDE, NC 28721-9483	(828) 452-8811
1225012172	DLP HAYWOOD REGIONAL MEDICAL CENTER LLC HOME CARE SERVICES OF HAYWOOD REGIONAL MEDICAL CENTER	560 LEROY GEORGE DR CLYDE, NC 28721-7408	(828) 452-8292
1225299480	HAYWOOD REGIONAL MEDICAL CENTER	262 LEROY GEORGE DR CLYDE, NC 28721-7430	(828) 456-7311
1316041577	HAYWOOD REGIONAL MEDICAL CENTER HRMC UCC PRO FEES	262 LEROY GEORGE DR CLYDE, NC 28721-7430	(828) 452-8139
1326142670	HAYWOOD REGIONAL MEDICAL CENTER HRMC PRO FEES	262 LEROY GEORGE DR	(828) 452-8139

NPI	Name	Address	Phone
		CLYDE, NC 28721-7430	
1528018884	HAYWOOD REGIONAL IN HOME AIDE PROGRAM HAYWOOD REGIONAL MEDICAL CENTER HOME HEALTH	560 LEROY GEORGE DR CLYDE, NC 28721-7408	(828) 452-8292
1568618379	DLP HAYWOOD REGIONAL MEDICAL CENTER LLC HAYWOOD REGIONAL MEDICAL CENTER BEHAVIORAL HEALTH UNIT	262 LEROY GEORGE DR CLYDE, NC 28721-7430	(828) 456-7311
1811158215	DLP HAYWOOD REGIONAL MEDICAL CENTER LLC. HAYWOOD REGIONAL MEDICAL CENTER	262 LEROY GEORGE DR CLYDE, NC 28721-7430	(828) 456-7311
1972764132	DLP HAYWOOD REGIONAL MEDICAL CENTER LLC HAYWOOD REGIONAL MEDICAL CENTER URGENT CARE CENTERS	576 LEROY GEORGE DR CLYDE, NC 28721-7497	(828) 456-7311

Group Purchasing Organizations

- Last updated 03/01/2015 / Definitions

Data are not available.

Acute Utilization Statistics by Payor

- Definitions

	Beds	Revenue	Inpatient Days			
			Medicare	Medicaid	Other	Total
Routine Services	110	$14,895,297	5,635	1,330	3,920	10,885
Intensive Care Unit	12	$2,982,293	833	194	530	1,557
Nursery		$488,209	N/A	413	153	566
Total Acute	**122**	**$18,365,799**	**6,468**	**1,937**	**4,603**	**13,008**

	Discharges / ALOS / ADC			
	Medicare	Medicaid	Other	Total
Discharges	1,948	589	1,485	4,022
Average Length of Stay	3.3	3.3	3.1	3.2
Average Daily Census	17.7	5.3	12.6	35.6

Other Utilization Statistics by Payor

	Beds	Revenue	Inpatient Days			
			Medicare	Medicaid	Other	Total
Psychiatric Unit	16	$5,002,538	1,016	70	4,176	5,262

Total Other	**16**	**$5,002,538**	**1,016**	**70**	**4,176**	**5,262**
Total Complex	**138**	**$23,368,337**	**7,484**	**2,007**	**8,779**	**18,270**

	Gross Patient Revenue			
	Medicare	Medicaid	Other	Total
Total Hospital Patient Revenue	$90,102,841	$37,175,766	$189,205,959	$316,484,566

Utilization

- Definitions

	Medicare/ Medicaid HMO (not included above)			
	Medicare Days	Medicaid Days	Medicare Discharges	Medicaid Discharges
HMO Acute	1,894	145	519	
HMO Inpatient Psychiatric Facility	0	0		
HMO Inpatient Rehab Facility	0	0		

Estimated Patient Volumes

- Definitions

Inpatient Surgeries:	900
Outpatient Surgeries:	3,900
Births:	300
Outpatient Visits:	94,100
Emergency Room (Not Admitted):	20,100
Emergency Room (Admitted):	3,600

Clinical Services

- Definitions

Cardiovascular Services
- Cardiac Cath Lab
- Cardiac Rehab

Emergency Services
- Emergency Department

Neurosciences
- Electroencephalography (EEG)
- Sleep Studies

Oncology Services
- Chemotherapy

Orthopedic Services

Radiology / Nuclear Medicine / Imaging
- Computed Tomography (CT)
- Computed Tomography-Angiography (CTA)
- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance Imaging (MRI)
- Single Photon Emission Computerized Tomography (SPECT)

Rehabilitation Services
- Physical Therapy

Special Care
- Intensive Care Unit (ICU)

Subprovider Units

Joint Replacement
Spine Surgery
Other Services
Home Health
Hospice
Lithotripsy (ESWL)
Obstetrics
Psychiatric
Surgery
Inpatient Surgery
Wound Care
Wound Care

Joint Commission Accreditation

- Accreditation status licensed from The Joint Commission
- Last updated 10/01/2015 / Definitions and Terms of Use

- Current Status: 03/07/2015 - Accreditation with Full Standards Compliance

Verified Trauma Program

- Verification status provided by The American College of Surgeons (ACS) Committee on Trauma (COT) Verification Program.
- See ACS/COT website for more / Last updated 09/11/2015 / Definitions

- Type: No data are available

Teaching Status

- Data are from multiple sources / Definitions
- COTH data are from the Association of American Medical Colleges / Division of Health Care Affairs / Council of Teaching Hospitals
- See COTH website for more / Last Updated 06/15/2014

- Major teaching hospital; member of the Council of Teaching Hospitals and Health Systems (COTH)

Departments - December 9, 2015

Haywood Regional Medical Center
Clyde, NC 28721
CMS Certification Number: 340184

- The hospital's most recent cost reporting period is for their period ending 07/31/2014.
- Data from other sources and their effective periods are identified within report headers.

Cost Center Statistics

- Definitions

Inpatient Routine Service Cost Centers

	Beds	Square Feet	Gross Salaries	Total Costs	IP Charges	Ratio Cost/Chg	Days	Cost/Day
General Med/Surg	110	43,251	$4,166,280	$10,101,908	$14,895,297	0.6782	10,885	$928
Intensive Care Unit	12	4,975	$838,462	$1,898,073	$2,982,293	0.6364	1,557	$1,219
Psych Subprovider	16	9,617	$1,584,858	$2,788,551	$5,002,538	0.5574	5,262	$530
Nursery		1,496	$76,744	$230,240	$488,209	0.4716	566	$407
TOTAL	138	59,339	$6,666,344	$15,018,772	$23,368,337	0.6427	18,270	$822

Ancillary Service Cost Centers

	Square Feet	Gross Salaries	Total Costs	IP Charges	OP Charges	Ratio Cost/Chg
Operating Room	19,706	$2,187,499	$7,692,840	$9,632,151	$26,516,198	0.2128

Recovery Room	0	$0	$0	$0	$0	0.0000
Delivery Room / Labor Room	492	$36,977	$928,489	$1,870,680	$299,767	0.4278
Anesthesiology	0	$40,756	$495,929	$8,003,562	$13,688,579	0.0229
Radiology - Diagnostic	11,888	$1,488,183	$4,349,012	$2,078,429	$13,553,089	0.2782
Radiology - Therapeutic	0	$0	$0	$0	$0	0.0000
Radioisotope	0	$0	$0	$0	$0	0.0000
Computed Tomography (CT) Scan	1,351	$369,556	$1,228,018	$3,077,766	$12,555,936	0.0785
Magnetic Resonance Imaging (MRI)	1,616	$148,563	$703,090	$685,994	$5,469,331	0.1142
Cardiac Catheterization	0	$167,412	$386,552	$1,903,557	$4,154,671	0.0638
Laboratory	6,868	$996,651	$4,497,975	$6,075,647	$10,856,883	0.2656
PBP Clinical Lab Services	0	$0	$0	$0	$0	0.0000
Whole Blood / Packed RBC	0	$0	$0	$0	$0	0.0000
Blood Stor, Process, Trans	0	$0	$0	$0	$0	0.0000
IV Therapy	0	$0	$0	$0	$0	0.0000
Respiratory Therapy	1,686	$563,693	$1,126,096	$3,924,246	$669,803	0.2451
Physical Therapy	8,657	$1,558,626	$3,385,394	$1,356,272	$7,970,407	0.3630
Occupational Therapy	0	$0	$0	$0	$0	0.0000
Speech Pathology	0	$0	$0	$0	$0	0.0000
Electrocardiology	1,006	$381,975	$746,464	$1,984,445	$3,542,922	0.1350
Electroencephalography	0	$0	$0	$0	$0	0.0000
Medical Supplies (charged)	0	$0	$3,788,206	$1,441,471	$3,033,808	0.8465
Implantable Devices (charged)	0	$0	$5,274,485	$16,318,681	$5,083,036	0.2465
Drugs (charged)	0	$0	$6,695,979	$8,683,960	$11,119,224	0.3381
Renal Dialysis	0	$0	$0	$0	$0	0.0000
ASC (non-distinct part)	0	$0	$0	$0	$0	0.0000
Other	0	$55,750	$86,089	$174	$42,562	2.0144
TOTAL	53,270	$7,995,641	$41,384,618	$67,037,035	$118,556,216	0.2230

Outpatient Service Cost Centers

	Square Feet	Gross Salaries	Total Costs	IP Charges	OP Charges	Ratio Cost/Chg
Clinic	0	$1,521,651	$7,880,605	$0	$17,067,406	0.4617
Emergency	18,261	$2,898,346	$7,349,657	$5,698,031	$32,665,632	0.1916
Observation Beds	0	$0	$1,372,156	$240,131	$3,914,721	0.3303
Other	0	$967,653	$2,708,990	$307	$5,544,671	0.4885
TOTAL	18,261	$5,387,650	$19,311,408	$5,938,469	$59,192,430	0.2965

Other Reimbursable Cost Centers

	Square Feet	Gross Salaries	Total Costs	IP Charges	OP Charges	Ratio Cost/Chg
Home Program Dialysis	0	$0	$0	$0	$0	0.0000
Ambulance Services	0	$0	$0	$0	$0	0.0000
Durable Medical Equipment - rented	0	$0	$0	$0	$0	0.0000
Durable Medical Equipment - sold	0	$0	$0	$0	$0	0.0000
Other Reimbursable	0	$0	$0	$0	$0	0.0000
TOTAL	0	$0	$0	$0	$0	0.0000

Overall Cost to Charge Ratio

	Total Costs	Total Charges	Ratio Cost/Chg
Inpatient Routine Services	$15,018,772	$23,368,337	0.6427
Ancillary Services	$41,384,618	$185,593,251	0.2230
Outpatient Services	$19,311,408	$65,130,899	0.2965
Other Reimbursable Cost Centers	$0	$0	0.0000
TOTAL	$75,714,798	$274,092,487	0.2762

General Service Costs

- Definitions

Salaries and Other Costs

	Direct Salaries	Other Costs	Total Costs	Paid Hours	Average Hourly
Employee Benefits	$352,184	$9,488,362	$9,840,546	12,144	$29.00
Administrative and General	$3,714,435	$13,479,843	$17,194,278	200,833	$18.50
Maintenance and Repairs	$0	$0	$0	0	$0.00
Operation of Plant	$529,849	$3,195,599	$3,725,448	35,377	$14.98
Laundry and Linen Service	$13,115	$218,426	$231,541	1,587	$8.26
Housekeeping	$616,976	$403,134	$1,020,110	58,191	$10.60
Dietary	$392,455	$730,586	$1,123,041	34,911	$11.24
Cafeteria	$0	$0	$0	0	$0.00
Maintenance of Personnel	$0	$0	$0	0	$0.00
Nursing Administration	$510,137	$117,054	$627,191	15,803	$32.28
Central Services and Supply	$272,495	$-1,465,730	$-1,193,235	22,509	$12.11
Pharmacy	$1,376,117	$3,775,924	$5,152,041	38,724	$35.54
Medical Records	$1,004,826	$376,245	$1,381,071	47,825	$21.01
Social Service	$0	$0	$0	0	$0.00
Other General Service	$0	$0	$0	0	$0.00

Staffing

- Provider of Services file for cutoff 09/30/2015 / Definitions

Positions	FTEs

Haywood Regional Medical Center

Certified Registered Nurse Anesthetists (CRNAs):	0
Dieticians:	0
Inhalation Therapists:	10
Licensed Practical Nurses (LPNs):	21
Occupational Therapists:	2
Pharmacists:	6
Physical Therapists:	8
Physician Assistants:	4
Registered Nurses (RNs):	143
Speech Pathologists, Audiologists:	2
Social Workers:	5
Other Personnel:	547

Financial - December 9, 2015

Haywood Regional Medical Center
Clyde, NC 28721
CMS Certification Number: 340184

- See column headings for cost reporting periods. / Definitions

Balance Sheet

Period ending date	7/31/2014	9/30/2013	9/30/2012	9/30/2011	9/30/2010
Number of months in period	10	12	12	12	12
Cost report status	As Submitted	As Submitted	As Submitted	Settled With Audit	Settled Without Audit
Assets					
Current Assets	$17,681,710	$18,385,066	$19,011,680	$21,795,132	$26,421,577
Fixed Assets	$26,210,876	$30,315,257	$36,232,490	$34,215,199	$22,770,393
Other Assets	$6,730,620	$6,472,096	$7,226,756	$1,503,890	$839,601
Total Assets	**$50,623,206**	**$55,172,419**	**$62,470,926**	**$57,514,221**	**$50,031,571**
Liabilities and Fund Balances					
Current Liabilities	$24,936,274	$27,911,580	$31,659,702	$20,852,915	$16,640,456
Long-Term Liabilities	$3,055,606	$3,315,182	$4,599,687	$5,573,923	$2,356,436
Total Liabilities	**$27,991,880**	**$31,226,762**	**$36,259,389**	**$26,426,838**	**$18,996,892**
Total Fund Balances	$22,631,326	$23,945,657	$26,211,537	$31,087,383	$31,034,679
Total Liabilities & Fund Balances	**$50,623,206**	**$55,172,419**	**$62,470,926**	**$57,514,221**	**$50,031,571**

Income Statement

- Data are annualized for periods other than twelve months.

Period ending date	7/31/2014	9/30/2013	9/30/2012	9/30/2011	9/30/2010
Number of months in period	10	12	12	12	12
Cost report status	As Submitted	As Submitted	As Submitted	Settled With Audit	Settled Without Audit
Inpatient Revenue	$97,959,327	$109,166,562	$121,103,553	$119,437,186	$88,029,961
Outpatient Revenue	$218,525,239	$212,133,708	$191,716,857	$153,730,933	$114,802,658
Total Patient Revenue	$316,484,566	$321,300,270	$312,820,410	$273,168,119	$202,832,619
Contractual Allowance (Discounts)	$212,711,279	$220,008,689	$212,710,740	$178,882,519	$121,227,033

Net Patient Revenues	$103,773,287	$101,291,581	$100,109,670	$94,285,600	$81,605,586
Total Operating Expense1	$109,877,245	$107,343,336	$113,549,520	$97,868,853	$89,143,145
Operating Income	**$-6,103,958**	**$-6,051,755**	**$-13,439,850**	**$-3,583,253**	**$-7,537,559**
Other Income (Contributions, Bequests, etc.)	$520,938	$400	$1,424,302	$0	$0
Income from Investments	$2,176	$12,509	$516	$2,265,595	$261,386
Governmental Appropriations	$0	$0	$0	$0	$0
Miscellaneous Non-Patient Revenue	$7,169,549	$4,188,664	$7,155,368	$989,081	$5,269,139
Total Non-Patient Revenue	$7,692,663	$4,201,573	$8,580,186	$3,254,676	$5,530,525
Total Other Expenses	$0	$715,171	$4	$-3	$0
Net Income or (Loss)	**$1,588,705**	**$-2,565,353**	**$-4,859,668**	**$-328,574**	**$-2,007,034**

1 Depreciation Expense (included above)	$5,524,541	$5,680,663	$5,351,521	$4,722,199	$3,892,995

Please note:
Hospitals receiving 100% Federal prospective payment for capital were not required to complete Parts III - IV of Worksheet A-7 for cost reports beginning on or after October 1, 2001 and ending before February 29, 2004. All other hospitals must complete Parts III and IV for all cost reporting periods ending on or after April 30, 2005. This worksheet is the source of interest, depreciation, and amortization expense.

Uncompensated Care

- This hospital's most recent cost reporting period is for the period ending 7/31/2014

	Revenue	Estimated Cost
Medicaid	$37,175,766	$10,619,963
State Children's Health Insurance Program (SCHIP)	$0	$0
State and local indigent care programs	$0	$0
TOTAL Governmental Programs	**$37,175,766**	**$10,619,963**
Other uncompensated care	$5,104,107	$1,458,084
Restricted grants	$0	N/A
Unrestricted grants	$0	N/A

Financial Indicators - December 9, 2015

Haywood Regional Medical Center
Clyde, NC 28721
CMS Certification Number: 340184

- See column headings for cost reporting periods. / Definitions

Period ending date	07/31/2014	09/30/2013	09/30/2012	09/30/2011	09/30/2010
Number of months in period	10	12	12	12	12
Cost report status	As Submitted	As Submitted	As Submitted	Settled With Audit	Settled Without Audit

EBITDAR - Earnings Before Interest, Taxes, Depreciation, Amortization, and Rent	**$6,433,468**	**$3,951,525**	**$1,373,809**	**$4,562,164**	**$3,052,383**
Definition: net income + interest + depreciation and amortization + lease cost					
net income (before taxes)	$1,323,195	$-2,565,353	$-4,859,668	$-328,574	$-2,007,034
interest expense1	$509,015	$836,215	$881,956	$168,539	$28,729
depreciation and amortization expense1	$4,601,258	$5,680,663	$5,351,521	$4,722,199	$3,892,995
lease cost	$0	$0	$0	$0	$1,137,693

Operating Margin	**-5.9%**	**-6.0%**	**-13.4%**	**-3.8%**	**-9.2%**
Definition: (tot oper rev - tot oper exp) / tot oper rev * 100					
total operating revenue (net patient revenue)	$86,430,280	$101,291,581	$100,109,670	$94,285,600	$81,605,586
total operating expense	$91,514,121	$107,343,336	$113,549,520	$97,868,853	$89,143,145

Excess Margin	1.4%	-1.8%	-4.5%	-0.3%	-2.3%
Definition: (tot oper rev - tot oper exp + non-oper rev) / (tot oper rev + non-oper rev) * 100					
total operating revenue (net patient revenue)	$86,430,280	$101,291,581	$100,109,670	$94,285,600	$81,605,586
total operating expense	$91,514,121	$107,343,336	$113,549,520	$97,868,853	$89,143,145
non-operating revenue (non-patient revenue)	$6,407,036	$4,201,573	$8,580,186	$3,254,676	$5,530,525

Personnel Expense as a percent of Total Operating Revenue	43.8%	47.8%	55.8%	58.6%	57.9%
Definition: (salary expense + contract labor + fringe benefits) / total operating rev * 100					
salary expense	$28,198,263	$35,695,982	$42,147,796	$42,787,130	$37,279,611
contract labor	$1,715,107	$2,768,847	$4,046,930	$3,034,886	$1,264,248
fringe benefits	$7,902,629	$9,929,051	$9,701,812	$9,460,715	$8,744,635
total operating revenue (net patient revenue)	$86,430,280	$101,291,581	$100,109,670	$94,285,600	$81,605,586

Return on Equity	5.8%	-10.7%	-18.5%	-1.1%	-6.5%
Definition: net income / (total assets - total liabilities) * 100					
net income (before taxes)	$1,323,195	$-2,565,353	$-4,859,668	$-328,574	$-2,007,034
total assets (general fund only)	$50,623,206	$55,172,419	$62,470,926	$57,514,221	$50,031,571
total liabilities (general fund only)	$27,991,880	$31,226,762	$36,259,389	$26,426,838	$18,996,892

Return on Assets (ROA)	2.6%	-4.6%	-7.8%	-0.6%	-4.0%
Definition: net income / total assets * 100					
net income (before taxes)	$1,323,195	$-2,565,353	$-4,859,668	$-328,574	$-2,007,034
total assets (general fund only)	$50,623,206	$55,172,419	$62,470,926	$57,514,221	$50,031,571

Current Ratio	0.7	0.7	0.6	1.0	1.6
Definition: total current assets / total current liabilities					
total current assets (general fund only)	$17,681,710	$18,385,066	$19,011,680	$21,795,132	$26,421,577
total current liabilities (general fund only)	$24,936,274	$27,911,580	$31,659,702	$20,852,915	$16,640,456

Quick Ratio	0.7	0.6	0.6	1.0	1.5
Definition: (total current assets - inventory) / total current liabilities					
total current assets (general fund only)	$17,681,710	$18,385,066	$19,011,680	$21,795,132	$26,421,577
inventory (general fund only)	$1,366,008	$1,431,151	$1,249,588	$0	$1,863,783
total current liabilities (general fund only)	$24,936,274	$27,911,580	$31,659,702	$20,852,915	$16,640,456

Days Cash on Hand	17.0	6.4	7.5	7.3	27.4
Definition: (cash on hand + market securities) / [(total operating expenses - depreciation) / 365]					
cash on hand (general fund only)	$4,057,812	$1,782,797	$2,215,801	$1,681,666	$3,716,193
market securities (temporary investments) (general fund only)	$0	$0	$0	$171,061	$2,675,818
total operating expense	$91,514,121	$107,343,336	$113,549,520	$97,868,853	$89,143,145
depreciation expense1	$4,601,258	$5,680,663	$5,351,521	$4,722,199	$3,892,995

Days Cash on Hand - All Sources	17.0	6.4	7.5	7.3	27.4
Definition: (cash on hand + mkt securities + investments) / [(total operatingexp - depreciation exp) / 365]					
cash on hand (general fund only)	$4,057,812	$1,782,797	$2,215,801	$1,681,666	$3,716,193
market securities (temporary investments) (general fund only)	$0	$0	$0	$171,061	$2,675,818
investments (general fund only)	$0	$0	$0	$0	$0
total operating expense	$91,514,121	$107,343,336	$113,549,520	$97,868,853	$89,143,145
depreciation expense1	$4,601,258	$5,680,663	$5,351,521	$4,722,199	$3,892,995

Days in Net Patient Accounts Receivable	45.3	50.3	52.1	62.0	73.7
Definition: (accounts receivable - allowances for uncollectible) / (total operating revenue / 365)					
accounts receivable (general fund only)	$10,717,928	$13,972,139	$14,292,062	$16,020,732	$16,482,404
allowances for uncollectible (general fund only)	$0	$0	$0	$0	$0
total operating revenue (net patient revenue)	$86,430,280	$101,291,581	$100,109,670	$94,285,600	$81,605,586

Days in Net Total Receivable	48.9	53.3	55.3	62.0	75.5
Definition: (accounts receivable + notes receivable + other receivables - allowances for uncollectible) / (total operating revenue / 365)					
accounts receivable (general fund only)	$10,717,928	$13,972,139	$14,292,062	$16,020,732	$16,482,404
notes receivable (general fund only)	$0	$0	$0	$0	$0
other receivables (general fund only)	$860,703	$827,411	$871,945	$0	$389,388
allowances for uncollectible (general fund only)	$0	$0	$0	$0	$0
total operating revenue (net patient revenue)	$86,430,280	$101,291,581	$100,109,670	$94,285,600	$81,605,586

Average Payment Period (days)	104.7	99.5	106.8	81.7	71.2
Definition: total current liabilities / [(total operating expenses + total other expenses - depreciation) / 365]					
total current liabilities (general fund only)	$24,936,274	$27,911,580	$31,659,702	$20,852,915	$16,640,456
total operating expense	$91,514,121	$107,343,336	$113,549,520	$97,868,853	$89,143,145
total other expense	$0	$715,171	$4	$-3	$0
depreciation expense1	$4,601,258	$5,680,663	$5,351,521	$4,722,199	$3,892,995

Inventory Turnover	68.0	73.7	87.0	0.0	46.8
Definition: (total operating revenue + non-operating revenue) / inventory					
total operating revenue (net patient revenue)	$86,430,280	$101,291,581	$100,109,670	$94,285,600	$81,605,586
non-operating revenue (non-patient revenue)	$6,407,036	$4,201,573	$8,580,186	$3,254,676	$5,530,525

inventory (general fund only)	$1,366,008	$1,431,151	$1,249,588	$0	$1,863,783

Total Asset Turnover	**1.8**	**1.9**	**1.7**	**1.7**	**1.7**
Definition: (total operating revenue + non-operating revenue) / total assets					
total operating revenue (net patient revenue)	$86,430,280	$101,291,581	$100,109,670	$94,285,600	$81,605,586
non-operating revenue (non-patient revenue)	$6,407,036	$4,201,573	$8,580,186	$3,254,676	$5,530,525
total assets (general fund only)	$50,623,206	$55,172,419	$62,470,926	$57,514,221	$50,031,571

Long Term Debt to Net Assets	**0.14**	**0.14**	**0.18**	**0.18**	**0.08**
Definition: total long term liabilities / (total assets - total liabilities)					
total long term liabilities (general fund only)	$3,055,606	$3,315,182	$4,599,687	$5,573,923	$2,356,436
total assets (general fund only)	$50,623,206	$55,172,419	$62,470,926	$57,514,221	$50,031,571
total liabilities (general fund only)	$27,991,880	$31,226,762	$36,259,389	$26,426,838	$18,996,892

Total Debt to Net Assets	**1.24**	**1.30**	**1.38**	**0.85**	**0.61**
Definition: total liabilities / (total assets - total liabilities)					
total assets (general fund only)	$50,623,206	$55,172,419	$62,470,926	$57,514,221	$50,031,571
total liabilities (general fund only)	$27,991,880	$31,226,762	$36,259,389	$26,426,838	$18,996,892

Average Age of Plant	**18.7**	**14.3**	**13.9**	**14.8**	**16.7**
Definition: accumulated depreciation / depreciation expense					
accumulated depreciation1	$86,047,088	$81,129,803	$74,498,262	$70,109,199	$65,127,023
depreciation expense1	$4,601,258	$5,680,663	$5,351,521	$4,722,199	$3,892,995

1. **Please note:**
Hospitals receiving 100% Federal prospective payment for capital were not required to complete Parts III - IV of Worksheet A-7 for cost reports beginning

on or after October 1, 2001 and ending before February 29, 2004. All other hospitals must complete Parts III and IV for all cost reporting periods ending on or after April 30, 2005. This worksheet is the source of interest, depreciation, and amortization expense.

Inpatient Utilization - December 9, 2015

Based on Medicare IPPS claims data

Haywood Regional Medical Center
Clyde, NC 28721
CMS Certification Number: 340184

- Medicare IPPS claims data are for federal fiscal year ending 09/30/2014 (Final rule MedPAR).
- These reports are consistent with CMS cell size suppression policy.
- The Case Mix Index (CMI) for LTAC hospitals reflects LTAC regulations.

Patient Origin

- Medicare Hospital Market Service Area file for calendar year ending 12/31/2014 / Definitions

ZIP Code of Residence	Discharges	Days of Care	Charges	Discharges Inc/(Dec)	Market Share
28786	877	3,173	18,036,550	-12.5%	55.2%
28716	538	1,798	10,804,618	-8.8%	48.6%
28721	345	1,220	6,695,106	3.3%	51.7%
28785	235	761	4,692,472	-13.6%	55.7%
28751	172	582	3,533,247	7.5%	55.7%
28745	50	152	993,086	-21.9%	44.2%
28779	39	242	954,916	-29.1%	4.7%
28715	29	116	474,495	16.0%	2.3%
28738	26	78	488,945	8.3%	70.3%
28734	24	133	779,585	-38.5%	1.6%
All other ZIP Codes	345	1,360	9,592,787		
Total	2,680	9,615	57,045,807	-11.1%	

Trend Report

- Definitions

Inpatient Utilization Statistics	FY 2014	FY 2013	FY 2012	FY 2011	FY 2010
Case Mix Index	1.4012	1.3506	1.3105	1.3133	1.2797
Medical MS-DRGs	78.89%	80.75%	79.03%	74.28%	77.28%
Surgical MS-DRGs	21.11%	19.25%	20.97%	25.72%	22.72%

Routine Discharges to home	1,255	1,549	1,714	1,659	1,460
Discharges to other acute care hospitals	77	90	91	88	86
Discharges to Skilled Nursing Facilities (SNF)	517	585	667	613	536
Deaths	17	47	46	56	47
Other Discharges	247	327	358	383	415
Total Discharges	2,113	2,598	2,876	2,799	2,544
Psychiatric Discharges (DPU, included in Total)	108	106	97	142	110
Medicare Advantage (HMO) Discharges (NOT included in Total)	551	513	438	262	N/A

Statistics for the Top 20 Base MS-DRGs

- Costs calculated per hospital's cost report for the period ending 07/31/2014. / Definitions

Base MS-DRG	Base MS-DRG Description	IPPS Cases	ALOS	Average Charges	Average Payment	Average Cost	Case Mix Index	CC/MCC Rate	MCC Rate
293-292-291	Heart failure & shock	120	3.5	$13,477	$5,917	$5,435	1.0743	77.5%	30.0%
872-871	Septicemia or severe sepsis w/o MV 96+ hours	118	4.4	$19,563	$8,757	$7,632	1.6534	74.6%	74.6%
470-469	Major joint replacement or reattachment of lower extremity	104	3.1	$41,481	$11,962	$11,524	2.2084	4.8%	4.8%
195-194-193	Simple pneumonia & pleurisy	104	3.1	$13,254	$5,888	$5,217	1.0747	78.8%	32.7%
885	Psychoses	102	9.8	$13,330	$6,539	$7,409	1.0048	0.0%	0.0%
310-309-308	Cardiac arrhythmia & conduction disorders	87	2.8	$11,968	$4,297	$4,629	0.7572	58.6%	16.1%
192-191-190	Chronic obstructive pulmonary disease	87	2.8	$13,455	$5,539	$5,053	1.0093	88.5%	42.5%
392-391	Esophagitis, gastroent & misc digest disorders	65	2.4	$11,651	$4,581	$4,159	0.8019	13.8%	13.8%
379-378-377	G.I. hemorrhage	58	2.9	$15,162	$6,029	$5,769	1.1068	82.8%	20.7%
460-459	Spinal fusion except cervical	55	3.0	$95,166	$22,425	$24,430	4.2253	7.3%	7.3%
482-481-480	Hip & femur procedures except major joint	53	3.9	$35,705	$10,475	$10,985	2.0139	69.8%	13.2%
690-689	Kidney & urinary tract infections	47	3.3	$11,523	$5,013	$4,767	0.9458	48.9%	48.9%
066-065-064	Intracranial hemorrhage or cerebral infarction	46	3.3	$15,559	$6,147	$5,565	1.1327	58.7%	28.3%
189	Pulmonary edema & respiratory failure	43	3.5	$16,408	$6,876	$6,194	1.2184	0.0%	0.0%
390-389-388	G.I. obstruction	38	3.1	$11,362	$4,759	$4,405	0.8441	57.9%	10.5%
641-640	Misc disorders of nutrition,metabolism,fluids/electrolytes	37	3.6	$13,036	$4,785	$5,242	0.8439	35.1%	35.1%
473-472-471	Cervical spinal fusion	30	1.2	$47,445	$12,045	$13,066	2.4052	23.3%	0.0%
282-281-280	Acute myocardial infarction, discharged alive	28	2.4	$12,930	$5,742	$4,449	1.1589	60.7%	32.1%
684-683-682	Renal failure	28	2.5	$10,919	$5,837	$4,166	1.1503	82.1%	42.9%

603-602	Cellulitis	28	4.0	$13,352	$5,458	$5,699	1.0175	28.6%	28.6%
	All Other Base MS-DRGs	835	3.5	$22,212	$7,568	$7,483	1.4444		
	T O T A L S	2,113	3.6	$21,695	$7,519	$7,369	1.4012		

Statistics by Medical Service

- Costs calculated per hospital's cost report for the period ending 07/31/2014. / Definitions

	Number Medicare Inpatients	Average Length of Stay	Average Charges	Average Cost	Medicare CMI	CMI Adjusted Avg. Cost
Cardiology	331	2.9	$13,130	$4,864	0.9352	$5,201
Medicine	556	3.4	$15,052	$5,746	1.1173	$5,142
Neurology	130	3.3	$16,177	$5,857	1.0554	$5,549
Oncology	24	3.6	$15,961	$5,876	1.3904	$4,226
Orthopedic Surgery	314	3.1	$51,486	$14,101	2.5655	$5,496
Orthopedics	65	3.4	$13,455	$5,208	0.9828	$5,299
Psychiatry	123	8.9	$12,985	$7,003	0.9831	$7,123
Pulmonology	330	3.2	$14,932	$5,699	1.1928	$4,778
Surgery	100	5.5	$42,941	$14,085	2.9142	$4,833
Urology	113	3.3	$15,024	$5,731	1.1562	$4,957
TOTAL	2,113	3.65	$21,695	$7,369	1.4012	$5,259

Outpatient Utilization - December 9, 2015

Based on Medicare OPPS claims data

Haywood Regional Medical Center
Clyde, NC 28721
CMS Certification Number: 340184

- Medicare OPPS claims data are for calendar year ending 12/31/2014 (Proposed rule OPPS).
- These reports are consistent with CMS cell size suppression policy.

Statistics for the Top 20 Medical Diagnoses

- ICD-9 diagnosis codes / Definitions

ICD-9 Code	ICD-9 Description	Total Payment	Number Patient Claims	Average Charge	Average Cost	Average Payment	Total Outlier Amount	National Average Charge
7140	Rheumatoid arthritis	$870,761	637	$3,854	$1,062	$1,367	$0	$3,797
36619	Senile cataract NEC	$616,776	393	$4,204	$1,335	$1,569	$0	$5,729
78650	Chest pain NOS	$276,003	371	$3,159	$1,073	$744	$0	$5,470
78659	Chest pain NEC	$261,032	285	$4,430	$1,490	$916	$0	$8,487
7244	Lumbosacral neuritis NOS	$234,969	391	$2,318	$953	$601	$0	$2,833
V072	Prophylact immunotherapy	$219,645	72	$7,236	$1,955	$3,051	$0	$5,233
V7651	Screen malig neop-colon	$219,500	316	$3,980	$1,038	$695	$0	$4,124
V5789	Rehabilitation proc NEC	$218,070	412	$1,367	$618	$529	$0	$1,624
73313	Path fx vertebrae	$207,962	197	$6,491	$1,692	$1,056	$13,327	$12,671
72402	Spin sten,lumbr wo claud	$199,691	249	$3,693	$1,285	$802	$0	$3,693
42731	Atrial fibrillation	$191,824	1,687	$392	$128	$114	$0	$1,232
7242	Lumbago	$184,044	775	$1,021	$230	$237	$0	$1,798
4019	Hypertension NOS	$141,308	1,720	$212	$74	$82	$0	$658
5921	Calculus of ureter	$135,562	91	$8,083	$1,657	$1,490	$873	$9,389
7202	Sacroiliitis NEC	$131,617	198	$1,340	$327	$665	$8,030	$2,348
V5869	Long-term use meds NEC	$124,881	839	$447	$130	$149	$0	$416
7802	Syncope and collapse	$123,345	186	$3,282	$1,010	$663	$0	$6,583
5990	Urin tract infection NOS	$116,372	1,307	$295	$77	$89	$0	$1,249
V5861	Long-term use anticoagul	$109,121	1,831	$61	$24	$60	$0	$127
185	Malign neopl prostate	$101,614	602	$473	$125	$169	$0	$3,540
	All Other	$8,960,511	36,139	-	-	-	-	-

Unclassified Services	$0	0	-	-	-	-	-
TOTAL FOR ALL CLAIMS	$13,644,608	48,698	-	-	-	-	-

Statistics for the Top 20 Ambulatory Payment Classifications (APCs)

- APC descriptions / Definitions
- Please note: APC Statistics reflect composite APCs.

APC Number	APC Description	Total Payment	Number Patient Claims	Units of Service	Average Charge	Average Cost	Average Payment	National Average Charge
0634	Hospital Clinic Visits	$1,810,512	21,598	22,026	$144	$59	$82	$152
7043	Infliximab injection	$709,181	237	10,132	$209	$57	$70	$290
0616	Level 5 Type A Emergency Visits	$692,708	1,717	1,719	$1,386	$295	$403	$1,853
0246	Cataract Procedures with IOL Insert	$656,571	420	420	$1,013	$211	$1,563	$4,303
0207	Level III Nerve Injections	$612,331	962	1,053	$1,659	$765	$582	$1,902
8009	Extended Assessment & Management Composite	$417,090	395	395	$3,396	$2,030	$1,056	$4,485
0615	Level 4 Type A Emergency Visits	$387,668	1,487	1,490	$895	$191	$260	$1,306
0260	Level I Plain Film Including Bone Density Measurement	$326,343	5,418	6,403	$162	$46	$51	$360
0377	Level II Cardiac Imaging	$283,272	278	278	$1,804	$512	$1,019	$4,022
0143	Lower GI Endoscopy	$257,857	377	417	$2,372	$617	$618	$2,526
0943	Octagam injection	$247,540	91	7,930	$68	$18	$31	$168
0131	Level II Laparoscopy	$209,563	61	62	$5,297	$1,101	$3,380	$9,650
0336	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contr	$187,964	717	718	$1,350	$155	$262	$2,869
0269	Level I Echocardiogram Without Contrast	$185,022	489	489	$1,032	$268	$378	$2,160
0337	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contr	$165,958	379	380	$2,081	$240	$437	$4,163
0438	Level III Drug Administration	$153,401	1,610	1,640	$166	$43	$94	$274
0050	Level II Musculoskeletal Procedures Except Hand and Foot	$149,885	64	72	$7,393	$1,536	$2,082	$4,795
0141	Level I Upper GI Procedures	$141,903	273	274	$2,277	$592	$518	$2,254
0437	Level II Drug Administration	$139,685	2,734	3,607	$108	$32	$39	$189
0208	Laminotomies and Laminectomies	$136,920	35	36	$6,916	$1,437	$3,803	$11,070
	TOTAL FOR TOP 20	$7,871,374	39,342	59,541	-	-	-	-
	SERVICE MIX INDEX = 2.766							

Search for Other APCs

- **Enter APC desired and statistics will appear in a new window.**
- (Only APCs representing more than 10 patients are reported.)

CPT information is currently not enabled for your subscription.

Service Statistics

- Services by Revenue Code / Definitions

Service	Number Patient Claims	Units of Service	Average Charge	Average Cost	Average Payment	Service Mix Index - SMI
Pharmacy	4,312	27,310	$28	$8	$0	0.00
IV Therapy	1,445	2,538	$232	$60	$70	1.11
Medical Surgical Supplies	4,586	9,183	$325	$148	$0	0.00
Laboratory	66,505	70,837	$49	$13	$5	1.16
Laboratory - Pathological	1,746	2,573	$146	$41	$30	2.15
Radiology - Diagnostic	9,210	9,467	$216	$61	$61	0.97
Radiology - Therapeutic	730	858	$221	$57	$150	2.27
Nuclear Medicine	847	1,122	$766	$218	$294	12.02
CT Scan	3,140	3,152	$1,161	$74	$180	3.17
Operating Room Services	2,016	2,039	$3,052	$634	$1,445	24.31
Anesthesia	1,193	1,195	$2,939	$66	$0	0.00
Blood Storage and Processing	80	134	$1,005	$261	$230	3.23
Other Imaging Services	1,554	1,554	$286	$81	$80	1.73
Respiratory Services	489	1,115	$125	$33	$58	2.30
Physical Therapy	1,423	1,979	$110	$39	$26	1.72
Occupational Therapy	35	39	$67	$18	$21	0.00
Speech-Language Pathology	142	146	$93	$24	$21	0.00
Emergency Room	10,400	10,423	$576	$123	$204	3.56
Pulmonary Function	1,845	2,277	$117	$30	$14	4.45
Cardiology	1,162	1,163	$601	$156	$193	3.77
Cardiac Cath Lab	48	48	$10,375	$600	$2,269	34.45
Clinic	2,757	2,811	$171	$83	$92	1.58
Magnetic Resonance Technology (MRT)	1,387	1,392	$1,607	$185	$323	5.35
Drugs Requiring Specific Identification	27,052	326,623	$21	$6	$5	0.00

Recovery Room	1,586	100,577	$18	$5	$0	1.30
EKG/ECG (Electrocardiogram)	2,735	3,153	$102	$13	$25	1.06
EEG (Electroencephalogram)	109	109	$2,231	$580	$665	10.09
Gastrointestinal Services	898	898	$2,381	$619	$607	10.68
Observation Room	971	14,625	$106	$90	$0	12.84
Treatment Room	16,848	17,677	$236	$114	$111	1.78
Lithotripsy	23	23	$10,800	$2,808	$2,780	0.00
Other Diagnostic Services	894	897	$410	$116	$140	2.30
Other Therapeutic Services	3,341	4,106	$137	$36	$55	1.09
Other Therapeutic - Education / Training	46	46	$20	$10	$21	0.35
Other Therapeutic - Cardiac Rehab	208	1,381	$148	$72	$91	1.39
Unclassified	566	566	$73	$35	$34	0.62

Quality Report - December 9, 2015

Haywood Regional Medical Center
Clyde, NC 28721
CMS Certification Number: 340184

- Posted on 10/07/2015
- Collection Periods
- Report is based on information from Hospital Compare, a website created through the efforts of the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (DHHS) along with the Hospital Quality Alliance (HQA). The HQA is a public-private collaboration established to promote reporting on hospital quality of care.

Quality Measures Linked to Payment

- Definitions

Value-Based Purchasing Program

Federal Fiscal Year	Clinical Process of Care Domain	Patient Experience of Care Domain	Outcome Domain	Total Performance Score	National Percentile	Payment Adjustment
2014	25.56	48.00	20.00	35.51	33%	-0.10%
2013	45.00	57.00	26.67	44.02	41%	0.23%

Readmission Reduction Program

Federal Fiscal Year	Heart Attack		Heart Failure		Pneumonia		COPD		Hip/Knee		Readmiss Adjustm Facto
	Excess Readmission Ratio	Cases	Excess Readmission Ratio	Cases	Excess Readmission Ratio	Cases	Excess Readmission Ratio	Cases	Excess Readmission Ratio	Cases	
2015	0.9705	73	0.9150	287	1.0121	426	0.8824	335	0.9463	247	0.
2014	1.0710	61	0.8803	266	0.9323	382	N/A	N/A	N/A	N/A	0.
2013	0.9536	46	0.9272	231	0.9118	380	N/A	N/A	N/A	N/A	1.

Hospital-Acquired Condition (HAC) Reduction Program

Federal Fiscal Year	Domain 1 Serious Complications (AHRQ PSI 90 Composite Score)			Domain 2 Central Line-Associated Blood Stream Infections (CLABSI) Catheter-Associated Urinary Tract Infections (CAUTI)					Total HAC Score	Payment Adjustment
	From	To	Score	From	To	Score	CLABSI Score	CAUTI Score		
2015	07/01/2011	06/30/2013	8.0000	01/01/2012	12/31/2013	2.5000	1	4	4.4250	0%

Timely & Effective Care

- Definitions

Timely Heart Attack Care

- Collection Periods

Measure	Number of Patients	Hospital Footnotes	Hospital Score	National Average	State Average
AMI-7a. Fibrinolytic Medication Within 30 Minutes Of Arrival	N/A	7	N/A	60%	50%
AMI-8a. PCI Within 90 Minutes Of Arrival	N/A	7	N/A	96%	99%
OP-2. Fibrinolytic Therapy received within 30 minutes	N/A	7	N/A	60%	64%
OP-3b. Median Time to transfer patients for Acute Coronary Intervention	16		48 minutes	58 minutes	46 minutes
OP-4. Aspirin at Arrival	71		100%	97%	98%
OP-5. Median Time to ECG	72		11 minutes	7 minutes	7 minutes

Effective Heart Attack Care

- Collection Periods

Measure	Number of Patients	Hospital Footnotes	Hospital Score	National Average	State Average
AMI-2. Aspirin at Discharge	20		100%	99%	100%
AMI-10. Heart Attack Patients Given a Prescription for a Statin at Discharge	16		100%	99%	99%

Effective Heart Failure Care

- Collection Periods

Measure	Number of Patients	Hospital Footnotes	Hospital Score	National Average	State Average
HF-1. Discharge Instructions	N/A	5	N/A	92%	98%
HF-2. Evaluation of Left Ventricular Systolic (LVS) Function	166		100%	99%	100%
HF-3. ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD)	31		97%	97%	99%

Effective Pneumonia Care

- Collection Periods

Measure	Number of Patients	Hospital Footnotes	Hospital Score	National Average	State Average
PN-6. Appropriate Initial Antibiotic Selection	92		100%	96%	98%

Emergency Department: Cardiac Care

- Collection Periods

Measure	Number of Patients	Hospital Footnotes	Hospital Score	National Average	State Average
OP-1. Median Time to Fibrinolysis	N/A	7	N/A	28 minutes	26 minutes

Timely Surgical Care

- Collection Periods

Measure	Number of Patients	Hospital Footnotes	Hospital Score	National Average	State Average
OP-6. Timing of Antibiotic Prophylaxis	238		100%	98%	99%
SCIP-INF-1. Prophylactic Antibiotic Received Within 1 Hour Prior to Surgical Incision	207		100%	99%	99%
SCIP-INF-3. Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time	198		98%	98%	99%
SCIP-VTE-2. Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery	274		100%	100%	100%

Effective Surgical Care

- Collection Periods

Measure	Number of Patients	Hospital Footnotes	Hospital Score	National Average	State Average
OP-7. Prophylactic Antiobiotic Selection	238		100%	98%	98%
SCIP-CARD-2. Patients on beta blocker at admission who received beta blocker during perioperative period	70		100%	98%	99%
SCIP-INF-2. Prophylactic Antibiotic Selection	207		100%	99%	99%
SCIP-INF-9. Urinary catheter removed within two days following surgery	59		95%	98%	99%
	N/A	5	N/A	100%	100%

SCIP-INF-10. Patients having surgery who were actively warmed in the operating room or whose body temperature was near normal by the end of surgery

Timely Emergency Department Care

- Collection Periods

Measure	Number of Patients	Footnotes	Hospital Score	National Average	State Average
ED-1b. Average (median) time patients spent in the emergency department, before they were admitted to the hospital as an inpatient	614	2	250 minutes	275 minutes	288 minutes
ED-2b. Average (median) time patients spent in the emergency department, after the doctor decided to admit them as an inpatient before leaving the emergency department for their inpatient room	601	2	117 minutes	96 minutes	96 minutes
OP-18b. Average time patients spent in the emergency department before being sent home	374		120 minutes	140 minutes	150 minutes
OP-20. Average time patients spent in the emergency department before they were seen by a healthcare professional	398		24 minutes	24 minutes	31 minutes
OP-21. Average time patients who came to the emergency department with broken bones had to wait before receiving pain medication	111		60 minutes	54 minutes	58 minutes
OP-22. Percentage of patients who left the emergency department before being seen	25,164		1%	2%	2%
OP-23. Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival	11		64%	65%	67%

Preventive Care

- Collection Periods

Measure	Number of Patients	Footnotes	Hospital Score	National Average	State Average
IMM-2. Patients assessed and given influenza vaccination	429	2	94%	93%	95%
IMM-3-OP-27-FAC-ADHPCT. Healthcare workers given influenza vaccination	1,545		96%	84%	94%

Effective Children's Asthma Care

- Collection Periods

Measure	Number of	Hospital Footnotes	Hospital Score	National Average	State Average

Patients

No Data are available for this hospital.

Timely Stroke Care

- Collection Periods

Measure	Number of Patients	Hospital Footnotes	Hospital Score	National Average	State Average
STK-1. Ischemic or hemorrhagic stroke patients who received treatment to prevent venous thromboembolism within 2 days of arrival	69		100%	97%	98%
STK-4. Ischemic stroke patients who received t-PA within 3 hours of symptoms	N/A	1	N/A	80%	83%
STK-5. Ischemic stroke patients who received antithrombotic therapy within 2 days of arrival	67		100%	98%	99%

Effective Stroke Care

- Collection Periods

Measure	Number of Patients	Hospital Footnotes	Hospital Score	National Average	State Average
STK-2. Ischemic stroke patients who received a prescription for an antithrombotic prior to discharge	72		100%	99%	100%
STK-3. Ischemic stroke patients with an irregular heartbeat who received a prescription for an anticoagulant prior to discharge	12		100%	96%	96%
STK-6. Ischemic stroke patients with high cholesterol who were given a prescription for a statin prior to discharge	53		98%	96%	98%
STK-8. Ischemic or hemorrhagic stroke patients who received educational materials about stroke care during their stay	42		95%	93%	95%
STK-10. Ischemic or hemorrhagic stroke patients who were evaluated for rehabilitation services	72		100%	98%	99%

Blood Clot Prevention

- Collection Periods

Measure	Number of Patients	Hospital Footnotes	Hospital Score	National Average	State Average
VTE-1. Patients who received treatment to prevent blood clots within one day of admission or the day after surgery	428	2	100%	92%	94%
	82	2	94%	96%	96%

VTE-2. ICU patients who received treatment to prevent blood clots within one day of admission, within one day of transfer to the ICU, or within one day following surgery					
VTE-6. Patients who developed blood clots who did not receive preventative treatment	N/A	1, 2	N/A	6%	5%

Blood Clot Treatment

- Collection Periods

Measure	Number of Patients	Hospital Footnotes	Hospital Score	National Average	State Average
VTE-3. Patients with blood clots who received recommended treatment with two blood thinners	27	2	100%	95%	96%
VTE-4. Patients with blood clots who were treated with unfractionated IV heparin and had their blood checked using recommended procedures	13	2	100%	99%	99%
VTE-5. Patients with blood clots who were discharged on blood thinners and received educational instructions at discharge	15	2	93%	89%	89%

Pregnancy and Delivery Care

- Collection Periods

Measure	Number of Patients	Hospital Footnotes	Hospital Score	National Average	State Average
PC-01. Women who had elective deliveries 1-3 weeks early when not medically necessary	N/A	1	N/A	4%	2%

Patient Survey Results

Hospital Consumer Assessment of Healthcare Providers and Systems ()

- Collection Periods / Definitions

Survey question	Measure	Percent	Measure	Percent	Measure	Percent	Star Rating
Nurses communicated well	Always	78%	Usually	17%	Sometimes	5%	
Doctors communicated well	Always	86%	Usually	11%	Sometimes	3%	
Help received quickly	Always	66%	Usually	25%	Sometimes	9%	
Pain controlled well	Always	69%	Usually	22%	Sometimes	9%	
Staff explained medicines	Always	62%	Usually	18%	Sometimes	20%	
Room and bath kept clean	Always	63%	Usually	21%	Sometimes	16%	
Area quiet at night	Always	58%	Usually	31%	Sometimes	11%	
Given discharge instructions	Yes	84%	No	16%			

Patient understood care	Strongly Agree	53%	Agree	39%	Disagree	8%
Overall hospital rating	High	66%	Medium	27%	Low	7%
Would recommend hospital	Definitely	67%	Probably	27%	No	6%

Summary Star Rating

Readmissions, Complications and Deaths

- Collection Periods / Definitions

30-Day Risk Adjusted Mortality Rates

Measure	Hospital		Predicted Range		National Average
	Number Patients	Mortality Rate	from	to	
CABG	N/A	N/A	N/A	N/A	3.2%
Heart Attack	88	13.8%	10.7%	17.7%	14.2%
Heart Failure	266	12.3%	9.6%	15.5%	11.6%
Pneumonia	353	10.4%	8.1%	13.2%	11.5%
COPD	251	7.4%	5.4%	10.0%	7.7%
Stroke	133	12.9%	9.9%	16.6%	14.8%

30-Day Risk Adjusted Readmission Rates

Measure	Hospital		Predicted Range		National Average
	Number Patients	Readmission Rate	from	to	
CABG	N/A	N/A	N/A	N/A	14.9%
Heart Attack	66	16.6%	13.5%	20.3%	17.0%
Heart Failure	305	19.2%	16.2%	22.5%	22.0%
Pneumonia	388	17.6%	15.2%	20.4%	16.9%
COPD	302	17.8%	15.0%	20.9%	20.2%
Hip/Knee Surgery	246	4.6%	3.3%	6.6%	4.8%
Stroke	128	12.4%	9.6%	16.0%	12.7%
Hospital-wide	1,590	14.3%	13.3%	15.5%	15.2%

Surgical Complications

- Collection Periods

Measure	Hospital		Predicted Range		National Average
	Number Patients	Rate	from	to	
Complications for Hip/Knee Replacements	234	3.00%	1.90%	4.70%	3.10%
PSI-4. Death from serious treatable complications after surgery	36	9.74%	4.72%	14.77%	11.78%
PSI-6. Collapsed lung due to medical treatment	4,456	0.33%	0.05%	0.60%	0.39%
PSI-12. Serious blood clots after surgery	954	5.29%	2.43%	8.16%	4.35%

PSI-14. A wound that splits open after surgery	103	2.06%	0.20%	3.92%	1.70%
PSI-15. Accidental cuts and tears from medical treatment	4,317	2.18%	0.72%	3.63%	1.81%
PSI-90. Serious Complications	N/A	0.92%	0.56%	1.28%	0.81%

Healthcare Associated Infections

- Collection Periods

Measure	Hospital Score	State Score
HAI-1-SIR. Central Line Associated Blood Stream Infections (CLABSI)	N/A	0.384
HAI-2-SIR. Catheter Associated Urinary Tract Infections (CAUTI)	N/A	1.267
HAI-3-SIR. Surgical Site Infections from colon surgery (SSI: Colon)	0.702	0.816
HAI-4-SIR. Surgical Site Infections from abdominal hysterectomy (SSI: Hysterectomy)	N/A	0.871
HAI-5-SIR. Methicillin-resistant Staphylococcus aureus (or MRSA) blood infections	N/A	0.865
HAI-6-SIR. Clostridium difficile (or C.diff.) Infections (intestinal infections)	0.768	0.912

Efficiency Measures

Use of Medical Imaging

- Collection Periods

Measure	Hospital Footnotes	Hospital Score	National Average	State Average
OP-8. MRI Lumbar Spine for Low Back Pain	4	N/A	N/A	N/A
OP-9. Mammography Follow-up Rates		7.5%	8.9%	7.9%
OP-10. Abdomen CT - Use of Contrast Material		10.2%	9.4%	5.4%
OP-11. Thorax CT - Use of Contrast Material		5.1%	2.4%	1.4%
OP-13. Outpatients who got cardiac imaging stress tests before low-risk outpatient surgery		3.8%	5.0%	4.8%
OP-14. Outpatients with brain CT scans who got a sinus CT scan at the same time		2.8%	2.8%	2.5%

Medicare Spending Per Patient

- Collection Periods

Measure	Hospital Score	National Average	State Average
SPP-1. Spending per Hospital Patient with Medicare (displayed in ratio)	0.92	0.98	0.94

Measures of Psychiatric Facilities

Inpatient Psychiatric Facility Quality Reporting ()

Measure	Hospital Score	National Average	State Average

HBIPS-2. Hours of physical-restraint use	0.00	0.66	1.78
HBIPS-3. Hours of seclusion	0.00	0.30	0.20
HBIPS-4. Patients discharged on multiple antipsychotic medications	N/A	9.42	7.84
HBIPS-5. Patients discharged on multiple antipsychotic medications with appropriate justification	N/A	29.69	61.69
HBIPS-6. Post-discharge continuing care plan created	100.00	77.19	90.63
HBIPS-7. Post-discharge continuing care plan transmitted to the next level of care provider upon discharge	81.70	69.92	80.52

Medicare.gov | Nursing Home Compare
The Official U.S. Government Site for Medicare

General information

	x	x	x
	BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE	SMOKY MOUNTAIN HEALTH AND REHABILITATION CENTER	MAGGIE VALLEY NURSING AND REHABILITATION
	516 WALL STREET WAYNESVILLE, NC 28786 (828) 452-3154	1349 CRABTREE ROAD WAYNESVILLE, NC 28785 (828) 454-9260	75 FISHER LOOP MAGGIE VALLEY, NC 28751 (828) 926-4326
	Distance: 0.6 miles	**Distance**: 5.1 miles	**Distance**: 8.1 miles

Overall rating	1 out of 5 stars **Much Below Average**	4 out of 5 stars **Above Average**	4 out of 5 stars **Above Average**
Health inspection	2 out of 5 stars **Below Average**	2 out of 5 stars **Below Average**	4 out of 5 stars **Above Average**
Staffing	1 out of 5 stars **Much Below Average**	5 out of 5 stars **Much Above Average**	2 out of 5 stars **Below Average**
Quality measures	3 out of 5 stars **Average**	5 out of 5 stars **Much Above Average**	2 out of 5 stars **Below Average**
Health inspections summary	Health Inspections Summary	Health Inspections Summary	Health Inspections Summary
Number of certified beds	90	50	114
Participation: (Medicare/Medicaid)	Medicare and Medicaid	Medicare and Medicaid	Medicare and Medicaid
Automatic sprinkler systems: in all required areas	Yes	Yes	Yes

Within a Continuing Care Retirement Community (CCRC)	No	No	No
Within a hospital	No	No	No
With a resident and family council	RESIDENT	RESIDENT	RESIDENT
Ownership	For profit - Corporation Get More Ownership Information	For profit - Corporation Get More Ownership Information	For profit - Corporation Get More Ownership Information

Health & fire safety inspections

	BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE 516 WALL STREET WAYNESVILLE, NC 28786 (828) 452-3154 **Distance** : 0.6 miles	SMOKY MOUNTAIN HEALTH AND REHABILITATION CENTER 1349 CRABTREE ROAD WAYNESVILLE, NC 28785 (828) 454-9260 **Distance** : 5.1 miles	MAGGIE VALLEY NURSING AND REHABILITATION 75 FISHER LOOP MAGGIE VALLEY, NC 28751 (828) 926-4326 **Distance** : 8.1 miles
Overall rating	1 out of 5 stars **Much Below Average**	4 out of 5 stars **Above Average**	4 out of 5 stars **Above Average**
Health inspection	2 out of 5 stars **Below Average**	2 out of 5 stars **Below Average**	4 out of 5 stars **Above Average**

Total number of health deficiencies for this nursing home	8	6	2
Average number of health deficiencies in North Carolina	3.93.9	3.93.9	3.93.9
Date of last standard health inspection	02/27/2015	08/27/2015	08/06/2015
Health inspection details	Health inspection details	Health inspection details	Health inspection details
Number of complaints	3	0	0
Number of facility-reported incidents	0	0	0
Fire safety deficiencies			
Total number of fire deficiencies for this nursing home	0	1	2
Date of last standard fire inspection	10/24/2013	09/25/2015	09/03/2015
Range of fire safety deficiencies in North Carolina	0-150-15	0-150-15	0-150-15

Fire safety inspection details	Fire safety inspection details	Fire safety inspection details	Fire safety inspection details
	x BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE 516 WALL STREET WAYNESVILLE, NC 28786 (828) 452-3154 **Distance**: 0.6 miles	x SMOKY MOUNTAIN HEALTH AND REHABILITATION CENTER 1349 CRABTREE ROAD WAYNESVILLE, NC 28785 (828) 454-9260 **Distance**: 5.1 miles	x MAGGIE VALLEY NURSING AND REHABILITATION 75 FISHER LOOP MAGGIE VALLEY, NC 28751 (828) 926-4326 **Distance**: 8.1 miles
Overall rating	1 out of 5 stars **Much Below Average**	4 out of 5 stars **Above Average**	4 out of 5 stars **Above Average**
Health inspection	2 out of 5 stars **Below Average**	2 out of 5 stars **Below Average**	4 out of 5 stars **Above Average**
Total number of health deficiencies for this nursing home	8	6	2
Average number of health deficiencies in North Carolina	3.93.9	3.93.9	3.93.9
Date of last standard health inspection	02/27/2015	08/27/2015	08/06/2015

Health inspection details	Health inspection details	Health inspection details	Health inspection details
Number of complaints	3	0	0
Number of facility-reported incidents	0	0	0
Fire safety deficiencies			
Total number of fire deficiencies for this nursing home	0	1	2
Date of last standard fire inspection	10/24/2013	09/25/2015	09/03/2015
Range of fire safety deficiencies in North Carolina	0-150-15	0-150-15	0-150-15
Fire safety inspection details	Fire safety inspection details	Fire safety inspection details	Fire safety inspection details

Staffing

	BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE 516 WALL STREET WAYNESVILLE, NC 28786 (828) 452-3154 **Distance**: 0.6 miles	SMOKY MOUNTAIN HEALTH AND REHABILITATION CENTER 1349 CRABTREE ROAD WAYNESVILLE, NC 28785 (828) 454-9260 **Distance**: 5.1 miles	MAGGIE VALLEY NURSING AND REHABILITATION 75 FISHER LOOP MAGGIE VALLEY, NC 28751 (828) 926-4326 **Distance**: 8.1 miles
Overall rating	1 out of 5 stars **Much Below Average**	4 out of 5 stars **Above Average**	4 out of 5 stars **Above Average**
Staffing	1 out of 5 stars **Much Below Average**	5 out of 5 stars **Much Above Average**	2 out of 5 stars **Below Average**
RN staff only	2 out of 5 stars **Below Average**	5 out of 5 stars **Much Above Average**	3 out of 5 stars **Average**

	BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE	SMOKY MOUNTAIN HEALTH AND REHABILITATION CENTER	MAGGIE VALLEY NURSING AND REHABILITATION	NORTH CAROLINA AVERAGE	NATIONAL AVERAGE
Total number of residents	76	33	100	86.5	87.0
Total number of licensed nurse staff hours per resident per day	1 hour and 13 minutes	2 hours and 29 minutes	1 hour and 22 minutes	1 hour and 38 minutes	1 hour and 41 minutes
RN hours per resident per day	37 minutes	1 hour and 54 minutes	43 minutes	45 minutes	51 minutes
LPN/LVN hours per resident per day	36 minutes	34 minutes	39 minutes	54 minutes	50 minutes
CNA hours per resident per day	2 hours and 12 minutes	2 hours and 54 minutes	2 hours	2 hours and 25 minutes	2 hours and 28 minutes
Physical therapy staff hours per resident per day	4 minutes	9 minutes	3 minutes	6 minutes	6 minutes

How to read staffing charts | About staff roles

How to read staffing charts | About staff roles

	BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE 516 WALL STREET WAYNESVILLE, NC 28786 (828) 452-3154 **Distance**: 0.6 miles	SMOKY MOUNTAIN HEALTH AND REHABILITATION CENTER 1349 CRABTREE ROAD WAYNESVILLE, NC 28785 (828) 454-9260 **Distance**: 5.1 miles	MAGGIE VALLEY NURSING AND REHABILITATION 75 FISHER LOOP MAGGIE VALLEY, NC 28751 (828) 926-4326 **Distance**: 8.1 miles
Overall rating	1 out of 5 stars **Much Below Average**	4 out of 5 stars **Above Average**	4 out of 5 stars **Above Average**
Staffing	1 out of 5 stars **Much Below Average**	5 out of 5 stars **Much Above Average**	2 out of 5 stars **Below Average**
RN staff only	2 out of 5 stars **Below Average**	5 out of 5 stars **Much Above Average**	3 out of 5 stars **Average**

	BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE	SMOKY MOUNTAIN HEALTH AND REHABILITATION CENTER	MAGGIE VALLEY NURSING AND REHABILITATION	NORTH CAROLINA AVERAGE	NATIONAL AVERAGE
Total number of residents	76	33	100	86.5	87.0
Total number of licensed nurse staff hours per resident per day	1 hour and 13 minutes	2 hours and 29 minutes	1 hour and 22 minutes	1 hour and 38 minutes	1 hour and 41 minutes
RN hours per resident per day	37 minutes	1 hour and 54 minutes	43 minutes	45 minutes	51 minutes
LPN/LVN hours per resident per day	36 minutes	34 minutes	39 minutes	54 minutes	50 minutes
CNA hours per resident per day	2 hours and 12 minutes	2 hours and 54 minutes	2 hours	2 hours and 25 minutes	2 hours and 28 minutes
Physical therapy staff hours per resident per day	4 minutes	9 minutes	3 minutes	6 minutes	6 minutes

Quality measures

	x BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE 516 WALL STREET WAYNESVILLE, NC 28786 (828) 452-3154 **Distance**: 0.6 miles	x SMOKY MOUNTAIN HEALTH AND REHABILITATION CENTER 1349 CRABTREE ROAD WAYNESVILLE, NC 28785 (828) 454-9260 **Distance**: 5.1 miles	x MAGGIE VALLEY NURSING AND REHABILITATION 75 FISHER LOOP MAGGIE VALLEY, NC 28751 (828) 926-4326 **Distance**: 8.1 miles
Overall rating	1 out of 5 stars **Much Below Average**	4 out of 5 stars **Above Average**	4 out of 5 stars **Above Average**
Quality measures	3 out of 5 stars **Average**	5 out of 5 stars **Much Above Average**	2 out of 5 stars **Below Average**

	BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE 516 WALL STREET WAYNESVILLE, NC 28786 (828) 452-3154 **Distance**: 0.6 miles	SMOKY MOUNTAIN HEALTH AND REHABILITATION CENTER 1349 CRABTREE ROAD WAYNESVILLE, NC 28785 (828) 454-9260 **Distance**: 5.1 miles	MAGGIE VALLEY NURSING AND REHABILITATION 75 FISHER LOOP MAGGIE VALLEY, NC 28751 (828) 926-4326 **Distance**: 8.1 miles
Overall rating	1 out of 5 stars **Much Below Average**	4 out of 5 stars **Above Average**	4 out of 5 stars **Above Average**
Quality measures	3 out of 5 stars **Average**	5 out of 5 stars **Much Above Average**	2 out of 5 stars **Below Average**

Short-stay residents

Find out why these measures are important.

Get more information about the data.

Get the current data collection period.

	BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE	SMOKY MOUNTAIN HEALTH AND REHABILITATION CENTER	MAGGIE VALLEY NURSING AND REHABILITATION	NORTH CAROLINA AVERAGE	NATIONAL AVERAGE
Percent of short-stay residents who self-report moderate to severe pain. ***Lower*** *percentages are better.*	20.0%	10.4%	29.1%	18.7%	17.6%
Percent of short-stay residents with pressure ulcers that are new or worsened. ***Lower*** *percentages are better.*	0.8%	0.6%	0.7%	1.0%	1.0%
Percent of short-stay residents assessed and given, appropriately, the seasonal influenza vaccine. ***Higher*** *percentages are better.*	90.1%	100.0%	84.8%	82.2%	81.9%

Percent of short-stay residents assessed and given, appropriately, the pneumococcal vaccine. ***Higher*** *percentages are better.*	95.8%	99.4%	98.9%	82.5%	82.3%
Percent of short-stay residents who newly received an antipsychotic medication. ***Lower*** *percentages are better.*	2.7%	0.0%	1.1%	2.2%	2.3%

Find out why these measures are important.

Get more information about the data.

Get the current data collection period.

	BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE	SMOKY MOUNTAIN HEALTH AND REHABILITATION CENTER	MAGGIE VALLEY NURSING AND REHABILITATION	NORTH CAROLINA AVERAGE	NATIONAL AVERAGE
Percent of short-stay residents who self-report moderate to severe pain. ***Lower*** *percentages are better.*	20.0%	10.4%	29.1%	18.7%	17.6%
Percent of short-stay residents with pressure ulcers that are new or worsened. ***Lower*** *percentages are better.*	0.8%	0.6%	0.7%	1.0%	1.0%

	BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE	SMOKY MOUNTAIN HEALTH AND REHABILITATION CENTER	MAGGIE VALLEY NURSING AND REHABILITATION	NORTH CAROLINA AVERAGE	NATIONAL AVERAGE
Percent of short-stay residents assessed and given, appropriately, the seasonal influenza vaccine. ***Higher*** *percentages are better.*	90.1%	100.0%	84.8%	82.2%	81.9%
Percent of short-stay residents assessed and given, appropriately, the pneumococcal vaccine. ***Higher*** *percentages are better.*	95.8%	99.4%	98.9%	82.5%	82.3%
Percent of short-stay residents who newly received an antipsychotic medication. ***Lower*** *percentages are better.*	2.7%	0.0%	1.1%	2.2%	2.3%

Long-stay residents

Find out why these measures are important.

Get more information about the data.

Get the current data collection period.

	BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE	SMOKY MOUNTAIN HEALTH AND REHABILITATION CENTER	MAGGIE VALLEY NURSING AND REHABILITATION	NORTH CAROLINA AVERAGE	NATIONAL AVERAGE
Percent of long-stay residents experiencing one or more falls with major injury. ***Lower*** *percentages are better.*	1.8%	3.3%	4.0%	3.2%	3.3%
Percent of long-stay residents with a urinary tract infection. ***Lower*** *percentages are better.*	0.9%	1.8%	9.3%	6.2%	5.3%
Percent of long-stay residents who self-report moderate to severe pain. ***Lower*** *percentages are better.*	5.8%	11.5%	9.7%	8.5%	7.6%
Percent of long-stay high-risk residents with pressure ulcers. ***Lower*** *percentages are better.*	6.7%	18.4%	7.0%	7.5%	5.9%

Percent of long-stay low-risk residents who lose control of their bowels or bladder. ***Lower*** *percentages are better.*	36.3%	23.1%	54.9%	54.6%	45.8%
Percent of long-stay residents who have/had a catheter inserted and left in their bladder. ***Lower*** *percentages are better.*	1.8%	10.1%	4.5%	2.9%	3.1%
Percent of long-stay residents who were physically restrained. ***Lower*** *percentages are better.*	0.0%	0.0%	1.3%	0.8%	1.0%
Percent of long-stay residents whose need for help with daily activities has increased. ***Lower*** *percentages are better.*	30.4%	8.6%	9.2%	18.9%	15.8%
Percent of long-stay residents who lose too much weight. ***Lower*** *percentages are better.*	16.0%	0.0%	9.7%	9.0%	7.4%
Percent of long-stay residents who have depressive symptoms. ***Lower*** *percentages are better.*	12.1%	7.7%	0.0%	4.1%	5.7%

Percent of long-stay residents assessed and given, appropriately, the seasonal influenza vaccine. ***Higher*** *percentages are better.*	99.6%	100.0%	86.7%	92.1%	93.6%
Percent of long-stay residents assessed and given, appropriately, the pneumococcal vaccine. ***Higher*** *percentages are better.*	99.5%	100.0%	100.0%	92.8%	93.6%
Percent of long-stay residents who received an antipsychotic medication. ***Lower*** *percentages are better.*	32.8%	13.1%	14.9%	14.9%	18.6%

Find out why these measures are important.

Get more information about the data.

Get the current data collection period.

	BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE	SMOKY MOUNTAIN HEALTH AND REHABILITATION CENTER	MAGGIE VALLEY NURSING AND REHABILITATION	NORTH CAROLINA AVERAGE	NATIONAL AVERAGE
Percent of long-stay residents experiencing one or more falls with major injury. ***Lower*** *percentages are better.*	1.8%	3.3%	4.0%	3.2%	3.3%

	BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE	SMOKY MOUNTAIN HEALTH AND REHABILITATION CENTER	MAGGIE VALLEY NURSING AND REHABILITATION	NORTH CAROLINA AVERAGE	NATIONAL AVERAGE
Percent of long-stay residents with a urinary tract infection. ***Lower*** *percentages are better.*	0.9%	1.8%	9.3%	6.2%	5.3%
Percent of long-stay residents who self-report moderate to severe pain. ***Lower*** *percentages are better.*	5.8%	11.5%	9.7%	8.5%	7.6%
Percent of long-stay high-risk residents with pressure ulcers. ***Lower*** *percentages are better.*	6.7%	18.4%	7.0%	7.5%	5.9%
Percent of long-stay low-risk residents who lose control of their bowels or bladder. ***Lower*** *percentages are better.*	36.3%	23.1%	54.9%	54.6%	45.8%
Percent of long-stay residents who have/had a catheter inserted and left in their bladder. ***Lower*** *percentages are better.*	1.8%	10.1%	4.5%	2.9%	3.1%
Percent of long-stay residents who were physically restrained. ***Lower*** *percentages are better.*	0.0%	0.0%	1.3%	0.8%	1.0%

	BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE	SMOKY MOUNTAIN HEALTH AND REHABILITATION CENTER	MAGGIE VALLEY NURSING AND REHABILITATION	NORTH CAROLINA AVERAGE	NATIONAL AVERAGE
Percent of long-stay residents whose need for help with daily activities has increased. ***Lower*** *percentages are better.*	30.4%	8.6%	9.2%	18.9%	15.8%
Percent of long-stay residents who lose too much weight. ***Lower*** *percentages are better.*	16.0%	0.0%	9.7%	9.0%	7.4%
Percent of long-stay residents who have depressive symptoms. ***Lower*** *percentages are better.*	12.1%	7.7%	0.0%	4.1%	5.7%
Percent of long-stay residents assessed and given, appropriately, the seasonal influenza vaccine. ***Higher*** *percentages are better.*	99.6%	100.0%	86.7%	92.1%	93.6%
Percent of long-stay residents assessed and given, appropriately, the pneumococcal vaccine. ***Higher*** *percentages are better.*	99.5%	100.0%	100.0%	92.8%	93.6%

	BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE	SMOKY MOUNTAIN HEALTH AND REHABILITATION CENTER	MAGGIE VALLEY NURSING AND REHABILITATION	NORTH CAROLINA AVERAGE	NATIONAL AVERAGE
Percent of long-stay residents who received an antipsychotic medication. ***Lower** percentages are better.*	32.8%	13.1%	14.9%	14.9%	18.6%

Short-stay residents

Long-stay residents

Penalties

	x BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE 516 WALL STREET WAYNESVILLE, NC 28786 (828) 452-3154 **Distance**: 0.6 miles	x SMOKY MOUNTAIN HEALTH AND REHABILITATION CENTER 1349 CRABTREE ROAD WAYNESVILLE, NC 28785 (828) 454-9260 **Distance**: 5.1 miles	x MAGGIE VALLEY NURSING AND REHABILITATION 75 FISHER LOOP MAGGIE VALLEY, NC 28751 (828) 926-4326 **Distance**: 8.1 miles
Overall rating	1 out of 5 stars **Much Below Average**	4 out of 5 stars **Above Average**	4 out of 5 stars **Above Average**
Federal fines in the last 3 years	0 Fines	0 Fines	0 Fines
Federal payment denials in the last 3 years	0 Payment Denials	0 Payment Denials	0 Payment Denials

Ownership Information

BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE
516 WALL STREET
WAYNESVILLE, NC 28786
(828) 452-3154
Ownership: For profit - Corporation
Legal Business Name: SSC WAYNESVILLE OPERATING COMPANY LLC
Owners and Managers of BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE

5% OR GREATER DIRECT OWNERSHIP INTEREST
PROTO EQUITY HOLDINGS, LLC (NO PERCENTAGE PROVIDED), since 10/11/2013
SAVA SENIORCARE LLC (NO PERCENTAGE PROVIDED), since 12/01/2005
SPECIAL HOLDINGS PARENT HOLDCO, LLC (NO PERCENTAGE PROVIDED), since 10/11/2013
SSC SPECIAL HOLDINGS LLC (NO PERCENTAGE PROVIDED), since 12/01/2005
TERPAX, INC. (NO PERCENTAGE PROVIDED), since 10/11/2013
OGLESBY, TONY (NO PERCENTAGE PROVIDED), since 10/11/2013

DIRECTOR
HORNE, JERRY, since 12/01/2005
ROBERTSON, GAIL, since 12/01/2005

OFFICER
HAUPT-MORROW, BRIDGET, since 04/03/2014
SCHRANK, HARRY, since 01/10/2006
SIMS, WYNN, since 08/13/2009

MANAGING EMPLOYEE
HAUPT-MORROW, BRIDGET, since 04/03/2014
HORNE, JERRY, since 12/01/2005
ROBERTSON, GAIL, since 12/01/2005

Health Inspection Summary

BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE

516 WALL STREET
WAYNESVILLE, NC 28786
(828) 452-3154

Deficiency Category	Inspection Date: 02/27/2015 Complaint Reporting Period: 11/1/2014 - 10/31/2015	Inspection Date: 10/24/2013 Complaint Reporting Period: 11/1/2013 - 10/31/2014	Inspection Date: 08/09/2012 Complaint Reporting Period: 11/1/2012 - 10/31/2013
Mistreatment Deficiencies	0	0	0
Quality Care Deficiencies	1	0	1
Resident Assessment Deficiencies	0	0	1
Resident Rights Deficiencies	1	0	0
Nutrition and Dietary Deficiencies	0	0	1
Pharmacy Service Deficiencies	2	0	1
Environmental Deficiencies	3	0	1
Administration Deficiencies	1	0	0

Detailed Result for Inspection on 02/27/2015

Date of last standard health inspection:	02/27/2015	View Full Report
Date(s) of complaint inspection(s) between 11/1/2014 - 10/31/2015:	02/27/2015	View Full Report
Total number of Health Deficiencies for this nursing home:	8	
Average number of Health Deficiencies in North Carolina:	3.9	

Average number of Health Deficiencies in the United States:	6.8
Range of Health Deficiencies in North Carolina:	0-27

Mistreatment Deficiencies

No Mistreatment Deficiencies were found during this inspection period.

Quality Care Deficiencies

Inspectors determined that the nursing home failed to:	Inspection Date	Date of Correction	Level of Harm (Least to Most)	Residents Affected (Few, Some, Many)
Assist those residents who need total help with eating/drinking, grooming and personal and oral hygiene.	02/27/2015	03/27/2015	2 = Minimal harm or potential for actual harm	Few

Resident Assessment Deficiencies

No Resident Assessment Deficiencies were found during this inspection period.

Resident Rights Deficiencies

Inspectors determined that the nursing home failed to:	Inspection Date	Date of Correction	Level of Harm (Least to Most)	Residents Affected (Few, Some, Many)
Make sure each resident has the right to have a choice over activities, their schedules and health care according to his or her interests, assessment, and plan of care.	02/27/2015	03/27/2015	2 = Minimal harm or potential for actual harm	Few

Nutrition and Dietary Deficiencies

No Nutrition and Dietary Deficiencies were found during this inspection period.

Pharmacy Service Deficiencies

Inspectors determined that the nursing home failed to:	Inspection Date	Date of Correction	Level of Harm (Least to Most)	Residents Affected (Few, Some, Many)

Keep the rate of medication errors (wrong drug, wrong dose, wrong time) to less than 5%.	02/27/2015	03/27/2015	2 = Minimal harm or potential for actual harm	Some
Make sure that residents are safe from serious medication errors.	02/27/2015	03/27/2015	2 = Minimal harm or potential for actual harm	Some

Environmental Deficiencies

Inspectors determined that the nursing home failed to:	Inspection Date	Date of Correction	Level of Harm (Least to Most)	Residents Affected (Few, Some, Many)
Provide a safe, clean, comfortable and homelike environment.	02/27/2015	03/27/2015	2 = Minimal harm or potential for actual harm	Few
Provide housekeeping and maintenance services.	02/27/2015	03/27/2015	2 = Minimal harm or potential for actual harm	Few
Have a program that investigates, controls and keeps infection from spreading.	02/27/2015	03/27/2015	2 = Minimal harm or potential for actual harm	Some

Administration Deficiencies

Inspectors determined that the nursing home failed to:	Inspection Date	Date of Correction	Level of Harm (Least to Most)	Residents Affected (Few, Some, Many)
Keep accurate, complete and organized clinical records on each resident that meet professional standards	02/27/2015	03/27/2015	2 = Minimal harm or potential for actual harm	Some

Detailed Result for Inspection on 10/24/2013

Date of standard health inspection:	10/24/2013 View Full Report
Date(s) of complaint inspection(s) between 11/1/2013 - 10/31/2014:	No Complaint Inspections
Total number of Health Deficiencies for this nursing home:	0

Average number of Health Deficiencies in North Carolina:	3.8
Average number of Health Deficiencies in the United States:	7.0
Range of Health Deficiencies in North Carolina:	0-33

Mistreatment Deficiencies

No Mistreatment Deficiencies were found during this inspection period.

Quality Care Deficiencies

No Quality Care Deficiencies were found during this inspection period.

Resident Assessment Deficiencies

No Resident Assessment Deficiencies were found during this inspection period.

Resident Rights Deficiencies

No Resident Rights Deficiencies were found during this inspection period.

Nutrition and Dietary Deficiencies

No Nutrition and Dietary Deficiencies were found during this inspection period.

Pharmacy Service Deficiencies

No Pharmacy Service Deficiencies were found during this inspection period.

Environmental Deficiencies

No Environmental Deficiencies were found during this inspection period.

Administration Deficiencies

No Administration Deficiencies were found during this inspection period.

Detailed Result for Inspection on 08/09/2012

Date of standard health inspection:	08/09/2012	View Full Report
Date(s) of complaint inspection(s) between 11/1/2012 - 10/31/2013:	06/17/2013	View Full Report
	03/08/2013	View Full Report

Total number of Health Deficiencies for this nursing home:	5
Average number of Health Deficiencies in North Carolina:	3.3
Average number of Health Deficiencies in the United States:	7.1
Range of Health Deficiencies in North Carolina:	0-19

Mistreatment Deficiencies

No Mistreatment Deficiencies were found during this inspection period.

Quality Care Deficiencies

Inspectors determined that the nursing home failed to:	Inspection Date	Date of Correction	Level of Harm (Least to Most)	Residents Affected (Few, Some, Many)
Provide necessary care and services to maintain the highest well being of each resident .	06/17/2013	07/15/2013	2 = Minimal harm or potential for actual harm	Few

Resident Assessment Deficiencies

Inspectors determined that the nursing home failed to:	Inspection Date	Date of Correction	Level of Harm (Least to Most)	Residents Affected (Few, Some, Many)
Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.	08/09/2012	09/06/2012	2 = Minimal harm or potential for actual harm	Few

Resident Rights Deficiencies

No Resident Rights Deficiencies were found during this inspection period.

Nutrition and Dietary Deficiencies

Inspectors determined that the nursing home failed to:	Inspection Date	Date of Correction	Level of Harm (Least to Most)	Residents Affected (Few, Some, Many)
Store, cook, and serve food in a safe and clean way.	08/09/2012	09/06/2012	2 = Minimal harm or potential for actual harm	Some

Pharmacy Service Deficiencies

Inspectors determined that the nursing home failed to:	Inspection Date	Date of Correction	Level of Harm (Least to Most)	Residents Affected (Few, Some, Many)
Maintain drug records and properly mark/label drugs and other similar products according to accepted professional standards.	03/08/2013	04/05/2013	2 = Minimal harm or potential for actual harm	Some

Environmental Deficiencies

Inspectors determined that the nursing home failed to:	Inspection Date	Date of Correction	Level of Harm (Least to Most)	Residents Affected (Few, Some, Many)
Have a program that investigates, controls and keeps infection from spreading.	03/08/2013	04/05/2013	2 = Minimal harm or potential for actual harm	Some

Administration Deficiencies

No Administration Deficiencies were found during this inspection period.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345411	A. BUILDING ______ B. WING _____	**02/27/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE	**516 WALL STREET WAYNESVILLE, NC 28786**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0242 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure each resident has the right to have a choice over activities, their schedules and health care according to his or her interests, assessment, and plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews and record reviews the facility failed to honor food preferences for 2 of 3 residents reviewed for choices (Resident # 95 and Resident #115). The findings included: 1. Resident #95 was admitted to the facility 09/04/14 with [DIAGNOSES REDACTED]. The most recent Minimum Data Set (MDS) 30 day admission assessment dated [DATE] revealed resident #95 was cognitively intact and able to make decisions of daily living. Review of Resident #95's tray card on 02/23/15 at 12:29 PM revealed no dislikes recorded on the tray card. Review of Resident #95's care conference notes revealed he was invited and attended care conferences and was involved in the plan of care. The weight loss and nutritional care plan dated 09/15/14 identified the potential risk for weight loss related to chronic illness with approaches which included provide diet as ordered and determine the resident's individual likes and dislikes. The food preference list in the medical record of Resident #95 dated 09/05/14 noted Resident #95 was on a consistent carbohydrate, no added salt diet and that he disliked liver, and cooked or raw onions. A follow up preference list dated 02/26/15 revealed Resident #95 also indicated he disliked carrots, corn and peas. On 02/23/15 at 12:29 PM Resident #95's lunch tray and tray card were observed. The tray card revealed no dislikes and the lunch meal consisted of turkey, mashed potatoes, peas and fruit cocktail. Resident #95 stated, see here they gave me peas again, I hate peas and I have told them that. Resident #95 did not eat the peas served with the lunch meal on 02/23/15. On 02/25/15 at 12:25 PM Resident #95's lunch tray and tray card were observed. The tray card revealed no dislikes and the meal consisted of ham, macaroni and cheese and peas. Resident #95 stated, I will tell you right now I won't eat these peas, they give them to me all the time and I don't like peas. On 02/26/15 at 12:28 PM Resident #95's lunch tray and tray card were observed. The tray card revealed no dislikes and the meal consisted of cooked cabbage, corn bread, and a bowl of ground meat with kidney beans and onions in a tomato sauce. Resident #95 stated, I don't eat onions raw or cooked and they know this. It was reviewed during the admission when they filled out a preference list. See this bowl of meat and beans, it has cooked onions in it, I will not eat this and they know I don't eat onions. Resident 95# stated his food likes and dislikes were reviewed when he was admitted and it was upsetting that he kept receiving food he disliked at his meals. Resident #95 revealed he spoke to someone in the dietary department about a month ago and told them then he did not like raw or cooked onions, and peas and carrots. Resident #95 stated he was told they would fix it so he would not be given these foods. On 02/27/15 at 10:14 AM the District Dietary Manager (DDM) confirmed peas and carrots were not on Resident #95's preference list but that raw and cooked onions were on the list. The DDM revealed that dislikes are not listed on each individual residents tray card that the dietary staff use to prepare meal trays. The DDM stated preferences for likes and dislikes were listed in each residents profile in the computer. The DDM explained tray cards were generated for each meal based on each residents profile and preferences with alternates substituted for any known dislikes. The DDM stated she was not aware of a problem of Resident #95 receiving food he did not like. The DDM confirmed it was her expectation that any time a preference or dislike was communicated it should be documented and placed in the meal tracker system so residents food preferences were honored. On 02/27/15 at 1:35 PM the Dietary Manager (DM) confirmed that residents dislikes are not listed on the tray cards which dietary staff use to prepare resident meal trays. The DM stated the meal tracker system was a new system put into place and was a work in progress. The DM stated resident food preferences were noted in the system under each residents profile and used to generate the tray card. The DM revealed she was not aware Resident #95 was served items he did not like. The DM explained that food preferences were reviewed at the time of a residents admission, yearly and as needed. The DM further explained her expectation was that resident food preferences were honored and items residents did not like were not served. The DM confirmed because Resident #95 received food he had communicated as a dislike, the facility was not honoring his food preferences. An interview was conducted on 02/26/15 at 4:49 PM with the Director of Nursing (DON). The DON stated she expected residents food preferences were reviewed on admission, updated yearly and as needed. The DON stated residents should receive the foods they like and dietary staff should ensure resident food preferences were honored and the correct foods were served on their meal tray. 2. Resident #115 was re-admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The most recent Minimum Data Set (MDS) 5 day admission assessment dated [DATE] revealed resident #115 was cognitively intact and able to make decisions of daily living. Review of Resident #115's tray card on 02/23/15 at 12:29 PM revealed no dislikes recorded on the tray card. Review of Resident #115's individual preferences care plan dated 02/18/15 identified his choice to be highly involved in daily care decisions regarding suggested or recommended interventions and specific preferences. The goal was for Resident #115 to have his preferences honored after individual consultation throughout the review. The approaches listed revealed recommended treatments of interventions to allow his individual preferences and choices, and to honor his individual choices and preferences as able within parameters of the facility. The weight loss and nutritional care plan dated 02/18/15 identified the potential risk for weight loss related to chronic illness with approaches which included providing diet as ordered and determining Resident #115's individual likes and dislikes. Review of the 10/10/14 food preference list in the medical record of Resident #115 revealed a dislike for rice. The updated preference list dated 01/23/15 revealed the resident interview for likes and dislikes was completed with no other documented changes. The preference list revealed Resident #115 was on a consistent carbohydrate renal diet. Review of the Group food item detail list provided by the District Dietary Manager (DDM) on 02/27/15 at 10:14 AM revealed macaroni and cheese should not be served on a renal diet. During an observation on 02/23/15 at 12:29 PM Resident #115 was observed eating his lunch which consisted of turkey, mashed potatoes,stuffing and peas and carrots. Resident #115 only ate the turkey and potatoes and stated, I don't like the carrots and they know this. During an observation on 02/26/15 at 12:48 PM Resident #115 was observed with his lunch tray which consisted of the alternate menu item of chicken with peas/carrots/biscuit dumpling and spiced apple dessert. Resident #115 stated, see look at this again they give me this alternative but it has carrots in it which I told them I do not like. I get frustrated by

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **345411**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **02/27/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE	**516 WALL STREET WAYNESVILLE, NC 28786**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0242 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) having to tell this all the time so I either don't eat or I order grilled cheese sandwiches. Resident #115 was observed to eat only the spiced apple dessert. An interview was conducted on 02/25/15 at 12:25 PM with Resident #95 (the roommate of Resident #115). Resident #95 was observed eating his lunch of ham and macaroni and cheese. Resident #95 stated, you see this macaroni and cheese? My roommate will be glad he was at [MEDICAL TREATMENT] today because he hates mac and cheese. I can tell you right now he gets it on his plate all the time, he gets mad about it and he won't eat it. I know because I heard him tell the dietary people he doesn't like it. An interview was conducted on 02/25/15 at 3:37 PM with Nurse #2 who was familiar with Resident #115. Nurse #2 stated Resident #115 was very independent and was cognitively able to make his own choices and voice his concerns. Nurse #2 revealed Resident #115 had complained about being given foods that he did not prefer which were communicated to the dietary department. Nurse #2 further revealed that Resident #115 frequently requested grilled cheeses sandwiches because he wasn't given foods that he liked. An interview was conducted on 02/26/15 at 12:34 PM with Resident #115. He stated that he talked to the dietary staff when he was admitted to the facility and they came and did updates to his preference list. Resident #115 stated he told them he did not like rice, carrots, and macaroni and cheese. Resident #115 revealed the dietary staff assured him he would not receive food items he did not like on his meal plates. On 02/27/15 at 10:14 AM the DDM stated Resident #115 received a Consistent Carbohydrate Diet (CCD) renal diet. The DDM explained the diet he received was a more liberalized diet for quality of life and that it included some of the renal diet restrictions. The DDM confirmed that rice was on the food preference list of Resident #115 but that macaroni and cheese was not on the list. The DDM stated dislikes were not listed on individual resident tray cards that the dietary staff use to prepare meal trays. The DDM further revealed preferences for likes and dislikes were listed in each residents profile in the computer. The DDM explained tray cards were generated for each meal based on each residents profile and preferences with alternates substituted for any known dislikes. The DDM further stated she was not aware Resident #115 received food he did not like. The DDM confirmed it was her expectation that any time a preference or dislike was communicated it should be documented and placed in the meal tracker system so residents food preferences were honored. On 02/27/15 at 1:35 PM the Dietary Manager (DM) confirmed that residents dislikes were not listed on the tray cards which dietary staff used to prepare residents meal trays. The DM stated the meal tracker system was a new system put into place and was a work in progress. The DM stated that resident food preferences were in the system under each residents profile. The DM revealed she was not aware Resident #115 was served items he did not like. The DM explained that food preferences were reviewed at the time of a residents admission, yearly and as needed. The DM further explained her expectation was that resident food preferences were honored and items they did not like were not served at meals. The DM further confirmed that based on this and the fact that Resident #115 was still receiving foods that were on his dislike list, the facility was not honoring his food preferences. On 02/26/15 at 4:49 PM the Director of Nursing (DON) stated she expected residents preferences were reviewed on admission, updated yearly and as needed. The DON stated residents should receive food they like and dietary staff should ensure all residents likes and dislikes were honored and the correct foods were served on their trays.
F 0252 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide a safe, clean, comfortable and homelike environment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and staff interviews the facility failed to provide a homelike environment with sensory stimulation for 1 of 35 residents reviewed for homelike environment (Resident #57). The findings included: Resident #57 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the most recent quarterly Minimum Data Set ((MDS) dated [DATE] revealed Resident #57 had short term and long term memory problems and was severely impaired in cognition for daily decision making skills. The MDS further revealed Resident #57 required extensive assistance with activities of daily living (ADLs) which included mobility, transfers, walking, toileting and personal hygiene. The MDS coded Resident #57 with behavior symptoms of inattention, disorganized thinking, and decreased level of activity. The MDs further coded Resident #57 as not exhibiting behaviors of rejected care. A review of a care plan dated 07/08/14 last revised on 12/09/14 revealed Resident #57 required assistance with ADLs related to his progressing dementia. The goals indicated Resident #57 would have his daily needs met with staff support and with interventions to assist as needed with ADLs. The care plan for altered communication related to dementia dated 07/08/14 included interventions to provide a calm environment, to promote effective communication and attempt to keep the resident occupied in activities. The care plan for activities dated 10/08/14 identified Resident #57' s potential for decreased participation in activities related to his choice to spend time in his room. The goals indicated Resident #57 enjoyed TV, music and special events. The interventions were designed to draw on Resident #57's strengths and provide 1 on 1 activities as needed throughout the week. The care plan dated 10/08/14 identified the problem area of potential for wandering related to dementia. The interventions revealed offering emotional and psychological support, provide and involve the resident in activities directed at his specific interests, provide supervised walks, and to observe for increased safety risks. A review of the physician progress notes [REDACTED].#57 with significant dementia, anxiety, depression and debility which required a lot of help with ADLs. The exam and observations further revealed Resident #57 was in no acute distress, sitting in his chair uninterested in any interactions except wanting to watch and listen to his TV. During an observation on 02/23/15 at 11:56 AM Resident #57 was sitting in his chair, beside the bed, looking at the floor. His wheelchair and walker were noted to be on the opposite side of the room. No personal objects were noted in room, on his tables or on the walls. There was no radio or TV in the room and no pictures on the walls. There was no bird feeder or anything outside the window beside his bed. During an observation on 02/25/15 at 11:54 AM Resident #57 was sitting in his chair, beside his bed. There were 4 photos on his side table across the room from where he was sitting. His wheelchair and walker remained on the opposite side of the room next to the table with the photos. There was no radio or TV in the room and no pictures on the walls. There was no bird feeder or anything outside the window beside his bed. During an observation on 02/26/15 at 9:43 AM Resident #57 was sitting in his chair, next to his bed, looking at the floor. Resident #57 had a tray table in front of him with 2 wildlife bird magazines one dated March 2007 and one dated [DATE]. There was no bird feeder outside the window beside his bed. His wheelchair and walker were noted to be on the opposite side of the room . No personal objects were noted in room, on his tables or on the walls. There was no radio or TV in the room and no pictures on the walls. An interview was conducted on 02/25/15 at 2:51 PM with NA #1. NA#1 stated Resident #57 stayed in his room most days but sometimes he would get up and walk out into the halls. NA#1 further stated Resident #57 rarely attended any activities An interview was conducted on 02/26/15 at 4:49 PM with the Director of Nursing (DON). The DON revealed Resident #57 rarely attended activities out of his room. The DON further stated the Activity Director normally visited with residents in their rooms. The DON confirmed Resident #57 needed a more homelike environment and some sensory stimulation. The DON stated it was her expectation that residents were provided in room stimulation and activities that met their interest. An interview was conducted on 02/26/15 at 5:26 PM with the Activities Director (AD). The AD stated that Resident #57 enjoyed watching TV and listening to music. The AD further stated Resident #57 enjoyed listening and watching the gospel music channel on TV. The AD revealed Resident #57 had attended music group activities in the past. The AD confirmed he was unaware Resident #57 did not have a TV or a radio in his room.
F 0253 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide housekeeping and maintenance services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and staff interviews the facility failed to repair furniture in a resident's room for 1 of 35 residents reviewed for safe environment and furniture in good repair (Resident #57). The findings included: Resident #57 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the most recent quarterly Minimum Data Set ((MDS) dated [DATE] revealed Resident #57 had short term and long term memory problems and was severely impaired in cognition for daily decision making skills. The MDS further revealed

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NAME OF PROVIDER OF SUPPLIER **BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE**		STREET ADDRESS, CITY, STATE, ZIP **516 WALL STREET WAYNESVILLE, NC 28786**	

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F 0253 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) Resident #57 required extensive assistance with activities of daily living (ADLs) which included mobility, transfers, walking, toileting and personal hygiene. The MDS coded Resident #57 with behavior symptoms of inattention, disorganized thinking, and decreased level of activity. The MDs further coded Resident #57 as not exhibiting behaviors of rejected care. A review of a care plan dated 07/08/14 last revised on 12/09/14 revealed Resident #57 required assistance with ADLs related to his progressing dementia. The goals indicated Resident #57 would have his daily needs met with staff support and with interventions to assist as needed with ADLs. The care plan dated 10/08/14 identified the problem area of potential for wandering related to dementia. The interventions revealed offering emotional and psychological support, provide and involve the resident in activities directed at his specific interests, provide supervised walks, and to observe for increased safety risks. During an observation on 02/23/15 at 11:56 AM Resident #57 was sitting in his chair, beside the bed, looking at the floor. His wheelchair and walker were noted to be on the opposite side of the room. The drawer handle on the bedside table and on the closet drawer was broken and hanging from one screw on the bottom drawers that was 6-8 from the floor. The veneer was peeling off the closet door at waist height on the right hand side of the door and on the right hand side of the base of the closet unit. During an observation on 02/25/15 at 11:54 AM Resident #57 was sitting in his chair, beside his bed. His wheelchair and walker remained on the opposite side of the room. The drawer handle on the bedside table and on the closet drawer was broken and hanging from one screw on the bottom drawers that was 6-8 from the floor. The veneer was peeling off the closet door at waist height on the right hand side of the door and on the right hand side of the base of the closet unit. During an observation on 02/26/15 at 9:43 AM Resident #57 was sitting in his chair, next to his bed, looking at the floor. His wheelchair and walker were noted to be on the opposite side of the room. The drawer handle on the bedside table and on the closet drawer was broken and hanging from one screw on the bottom drawers that was 6-8 from the floor. The veneer was peeling off the closet door at waist height on the right hand side of the door and on the right hand side of the base of the closet unit. An interview was conducted on 02/26/15 at 4:49 PM with the Director of Nursing (DON). The DON verified the drawer handles were broken and needed to be repaired. The DON further verified the closet veneer was in need of repair. The DON stated it was her expectation that residents were provided an environment that was safe and she expected furniture in good working order to prevent injuries. An interview was conducted on 02/26/15 at 4:21 PM with the Maintenance Manager (MM). The MM explained that staff and residents and their family members report any maintenance problems to him directly or they are written on a maintenance log that is kept at the nurse's station. The MM further explained he reviewed the repair log daily and prioritized the jobs according to urgency and safety. The MM stated he was unaware of the repairs needed in Resident #57's room to the drawer handles and the veneer on the closet. The MM verified the drawer handles were broken and needed to be repaired and the closet veneer was in need of repair. The MM stated it was his expectation that residents were provided an environment that was safe and he expected to be notified of needed repairs in order to provide maintenance to prevent injuries.
F 0312 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Assist those residents who need total help with eating/drinking, grooming and personal and oral hygiene.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and staff interviews the facility failed to provide nail care for 1 of 2 dependent residents reviewed for activities of daily living (Resident #57). The findings included: Resident #57 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the most recent quarterly Minimum Data Set ((MDS) dated [DATE] revealed Resident #57 had short term and long term memory problems and was severely impaired in cognition for daily decision making skills. The MDS further revealed Resident #57 required extensive assistance with activities of daily living (ADLs) which included mobility, transfers, walking, toileting and personal hygiene. The MDS coded Resident #57 with behaviors and symptoms of inattention, disorganized thinking, and decreased level of activity. The MDs also coded Resident #57 with no behaviors of rejected care. A review of a care plan dated 07/08/14 and last revised 12/09/14 revealed Resident #57 required assistance with ADLs related to progressing dementia. The goals indicated Resident #57 would have his daily needs met with staff support and with interventions as needed to assist Resident #57 with ADLs. The behavior care plan dated 07/08/14 identified the problem of Resident #57 eating with his hands and addressed interventions for staff to wash his hands before and after meals. A review of an ADL sheet (which was identified as the daily care guide for Nurse Aides (NAs) to provide resident care) indicated Resident #57 required assistance with grooming. The special instructions section on the ADL sheet did not indicate that Resident #57 had refused nail care. On 02/23/15 at 11:56 AM, 2/23/15 at 4:04 PM and 2/24/15 at 2:53 PM Resident #57 was observed seated in a chair, in his room, and all ten fingernails were noted to be long with ragged edges. The fingernails extended approximately ¼ inch at the end of each finger and had whitish/brown debris under the nails on both hands. On 02/25/15 at 8:17 AM Resident #57 was observed seated in a chair, in his room, eating breakfast which consisted of eggs, ground meat and oatmeal. Resident #57 was observed using his fingers to eat the oatmeal and the fingernails on both hands were long with ragged edges. The resident's fingernails extended approximately ¼ inch at the end of each finger and had whitish/brown debris under the nails on both hands. In addition there was oatmeal observed on the thumb and index finger of his right hand. On 02/26/15 at 12:45 PM Resident #57 was observed seated in a chair, in his room, eating lunch. The lunch meal consisted of a mechanical soft meal which included ground cabbage. Resident #57 was observed holding a spoon in his right hand and pushed the food onto the spoon with his left hand. The fingernails on both of Resident #57's hands were long with ragged edges. The resident's fingernails extended approximately ¼ inch at the end of each finger and had whitish/brown debris under the nails on both hands. An interview was conducted on 02/26/15 at 2:51 PM with Nurse Aide (NA) #1. NA #1 stated she had taken care of Resident #57 in the past and was familiar with his needs. NA #1 stated NAs were expected to check residents' nails every day and to clean and trim them not only during their shower but on a daily basis as needed. NA #1 confirmed Resident #57 was cooperative with his care but she had not trimmed his nails during her shift on 02/26/15. NA # 1 further explained they were provided a daily duty paper listing the residents and their needed care. NA # 1 revealed that Resident #57 required total care for most ADLs, but that he ate well without assistance and needed only tray set-up. NA # 1 further revealed Resident #57 ate using his hands at times. An interview was conducted on 02/25/15 at 3:37 PM with Nurse # 2 who was familiar with the care required for Resident #57. Nurse # 2 confirmed Resident #57 required total care for most ADLs but was able to feed himself with tray set up. Nurse #2 revealed nail care was provided for residents on their shower days, and as needed before and after meals. An interview was conducted on 02/26/15 at 4:49 PM with the Director of Nursing (DON). The DON revealed Resident #57 required total assistance for most ADLs but he was able to feed himself with tray set-up only. The DON further revealed she was aware that Resident #57 often ate with his hands. The DON stated it was her expectation that nail care was provided for residents on their shower days and as needed. The DON further stated that Resident #57 should have his nails and hands cleaned before and after each meal due to his eating with his hands.
F 0332 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Keep the rate of medication errors (wrong drug, wrong dose, wrong time) to less than 5%.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff interview the facility medication error rate was greater than 5 percent (%) as evidenced by 4 medication errors out of 26 opportunities for error which resulted in a medication error rate of 15.38% for 2 of 9 residents observed during medication administration who were administered sliding scale insulin without current physician's orders [REDACTED].# 125). The findings include: 1. Resident # 31 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. His most recent care plan dated 12/26/14

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F 0332 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) addressed his need for monitoring of blood glucose levels with daily capillary blood glucose (CBG)) tests and sliding scale insulin as ordered. Review of Resident # 31's medical record revealed a document titled Blood Glucose Tracking/Sliding Scale Insulin Administration Record dated February 2015 which indicated Resident # 31 received daily CBG tests before meals and at bedtime and sliding scale insulin injections. Instructions were written at the top of the document to administer sliding scale [MEDICATION NAME]before meals and at bedtime with the following parameters: 0 - 150 = 0 units, 151 - 200 = 2 units, 201 - 250 = 4 units, 251 - 300 = 6 units, 301 - 350 = 8 units and 351 - 400 = 10 units. Nursing documentation on the record revealed Resident # 31 had received sliding scale insulin injections four times every day in February 2015. There was no place designated on the document for a physician signature to indicate the dosage parameters were reviewed and approved by the physician. Review of Resident # 31's January and February 2015 summary of physician's orders [REDACTED]. Further review of the medical record did not reveal any orders on the current chart for CBG tests or sliding scale insulin before meals and at bedtime. Nurse # 1 was observed on 02/26/15 at 11:41 AM performing a CBG test on Resident # 31 and obtained a result of 246. Nurse # 1 was observed checking the dosage parameters on the Sliding Scale Insulin Administration Record, then administering [MEDICATION NAME]4 units to Resident # 31 and documenting the CBG and insulin administration on the record. An interview with Unit Coordinator (UC) # 1 on 02/26/15 at 3:01 PM revealed she was unable to locate a signed physician's orders [REDACTED]. UC # 1 stated the parameters for the sliding scale insulin were listed on the Blood Glucose Tracking/Sliding Scale Insulin Administration Record. When asked if the physician reviewed the document and approved the dosage parameters, UC # 1 stated the physician didn't review or sign the document to approve the dosage parameters. An interview with the Medical Records coordinator on 02/26/15 at 3:20 PM revealed she located a telephone order dated 05/22/14 for CBG's and sliding scale insulin in Resident # 31's archived records, which was signed by the physician. When asked why the order for CBG's and sliding scale insulin was not included in the January or February 2015 summary of current physician orders, she stated the facility stopped including the CBG and sliding scale insulin orders on the monthly summary of orders about 6 months ago. When asked what the system was for the physician reviewing and approving those orders, she acknowledged there was not a system in place for the physician to review the orders. An interview with the Director of Nursing (DON) on 02/27/15 at 2:45 PM revealed the monthly summary of physician's orders [REDACTED]. The DON stated the nurses were not instructed to omit orders for CBG's and sliding scale insulin from the monthly summary of physician's orders [REDACTED]. 2. Resident # 125 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. His most recent care plan dated 12/31/14 addressed his need for monitoring of blood glucose levels with daily capillary blood glucose (CBG)) tests and sliding scale insulin as ordered. Review of Resident # 125's medical record revealed a document titled Blood Glucose Tracking/Sliding Scale Insulin Administration Record dated February 2015 which indicated Resident # 125 received daily CBG tests before meals and at bedtime and sliding scale insulin injections. Instructions were written at the top of the document to administer sliding scale [MEDICATION NAME]before meals and at bedtime with the following parameters: 0 - 150 = 0 units, 151 - 200 = 2 units, 201 - 250 = 4 units, 251 - 300 = 6 units, 301 - 350 = 8 units and 351 - 400 = 10 units. Nursing documentation on the record revealed Resident # 125 had received sliding scale insulin injections usually three times every day in February 2015. There was no place designated on the document for a physician signature to indicate the dosage parameters were reviewed and approved by the physician. Review of Resident # 125's January and February 2015 summary of physician's orders [REDACTED]. Further review of the medical record revealed an admission order dated 12/19/14 which listed Insulin [MEDICATION NAME] sliding scale before meals and at bedtime but did not include the type of insulin or dosage parameters for the sliding scale insulin. Nurse # 3 was observed on 02/25/15 at 4:28 PM performing a CBG test on Resident # 125 and obtained a result of 296. Nurse # 3 was observed checking the dosage parameters on the Sliding Scale Insulin Administration Record, then administering [MEDICATION NAME]6 units to Resident # 125 and documenting the CBG and insulin administration on the record. Nurse # 2 was observed on 02/26/15 at 12:00 PM performing a CBG test on Resident # 125 and obtained a result of 284. Nurse # 2 was observed checking the dosage parameters on the Sliding Scale Insulin Administration Record, then administering [MEDICATION NAME]6 units to Resident # 125 and documenting the CBG and insulin administration on the record. An interview with Unit Coordinator (UC) # 1 on 02/26/15 at 3:01 PM revealed she was unable to locate a signed physician's orders [REDACTED]. UC # 1 stated the parameters for the sliding scale insulin were listed on the Blood Glucose Tracking/Sliding Scale Insulin Administration Record. When asked if the physician reviewed the document and approved the dosage parameters, UC # 1 stated the physician didn't review or sign the document to approve the dosage parameters. UC # 1 stated the specific dosage parameters for the sliding scale insulin should have been included on the admission orders [REDACTED] An interview with the Medical Records coordinator on 02/26/15 at 3:20 PM revealed she located a hospital discharge summary for Resident # 125 with a discharge medication list dated 12/19/14 which included CBG's and sliding scale insulin. She was unable to locate a signed physician's orders [REDACTED]. When asked why the order for CBG's and sliding scale insulin was not included in the January or February 2015 summary of current physician orders, she stated the facility stopped including the CBG and sliding scale insulin orders on the monthly summary of orders about 6 months ago. When asked what the system was for the physician reviewing and approving those orders, she acknowledged there was not a system in place for the physician to review the orders. An interview with the Director of Nursing (DON) on 02/27/15 at 2:45 PM revealed the monthly summary of physician's orders [REDACTED]. The DON stated the nurses were not instructed to omit orders for CBG's and sliding scale insulin from the monthly summary of physician's orders [REDACTED].
F 0333 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure that residents are safe from serious medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff interview the facility failed to accurately transcribe physician's orders which resulted in 3 of 6 residents not receiving the correct dosage of medication (Residents #24, #80 and #130). The findings included: 1. Resident #24 was admitted to the facility 07/12/13 with [DIAGNOSES REDACTED]. The current care plan for Resident #24 last updated 01/14/15 included the following problem area: -Resident on Proton Pump Inhibitor ([MEDICATION NAME]) due to associated [DIAGNOSES REDACTED]. Approaches to address this problem area included to administer medication per order. Review of physician orders in the medical record of Resident #24 noted [MEDICATION NAME] (a medication used to treat [MEDICAL CONDITION] reflux) had been ordered 20 milligrams (mg) twice a day on 03/20/14. A physician's progress note dated 03/20/14 noted Resident #24 was having continual issues with abdominal pain and nausea and had been on multiple medications to treat this, including [MEDICATION NAME]. The note referenced a recent gastrointestinal consult with recommendation to increase the dose of the [MEDICATION NAME] secondary to the continued symptomatology. The physician wrote an order on 03/20/14 for [MEDICATION NAME] 20 mg, twice a day. Review of Medication Administration Records (MARs) from March 2014-November 2014 noted the [MEDICATION NAME] was administered to Resident #24 twice a day as ordered. On 12/09/14 a handwritten entry on the December 2014 MAR for Resident #24 noted a change in the [MEDICATION NAME] from twice a day to once a day. There was not a subsequent physician order in the medical record of Resident #24 to correspond with the decrease in the [MEDICATION NAME]. On 02/27/15 at 10:30 AM Unit Coordinator #2 reviewed the medical record of Resident #24 and found a pharmacy Consultation Report dated 12/01/14 with a recommendation to decrease the [MEDICATION NAME] from 20 mg twice a day to 20 mg once a day. A handwritten response by the Geriatric Nurse Practitioner (GNP) for Resident #24 dated 12/05/14 noted a decline in the recommendation noting the resident has severe [MEDICAL CONDITION] reflux disease and needs this for treatment management. Unit Coordinator #2 stated that Nurse #2 noted this recommendation on 12/09/14 and felt Nurse #2 mistakenly read the response as an approval and changed the order on the MAR from twice a day to once a day. Unit Coordinator #2 stated the [MEDICATION NAME] order should not have been changed, that it was a medication error and would be reported to the resident's GNP. Attempts were made to contact Nurse #2 for a phone interview but the attempts were unsuccessful. On 02/27/15 at 12:50 PM the GNP for Resident #24 stated she had declined the order to decrease the [MEDICATION NAME] when

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F 0333

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 4)
requested by the consultant pharmacist 12/01/14. The GNP stated she had just been informed of the medication error and increased the [MEDICATION NAME] dose back to twice a day for Resident #24.
On 02/27/15 at 1:30 PM the Director of Nursing (DON) stated the [MEDICATION NAME] should not have been decreased for Resident #24 on 12/09/14. The DON stated that it was most likely not identified by staff when the January 2015 MAR/physician orders were reconciled. The DON stated she suspected the staff member that typed the January 2015 physician orders and January 2015 MAR for Resident #24 used the December MAR indicated [REDACTED].

2. Resident # 130 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Her most recent care plan dated 02/24/15
addressed her need for a proton pump inhibitor for treatment of [REDACTED].
Admission physician's orders for Resident # 130 dated 02/11/15 included [MEDICATION NAME] (a proton pump inhibitor) 20 milligrams (mg) one tablet twice a day. Review of the February 2015 Medication Administration Record [REDACTED]. Nursing documentation on the MAR indicated [REDACTED].
Visual inspection of the medication package of [MEDICATION NAME] 20 mg for Resident # 130 revealed it was labeled as dispensed from the pharmacy on 02/11/15 and the package label indicated the medication was to be administered twice a day.
An interview on 02/26/15 at 4:07 PM with Unit Coordinator (UC) # 1 about the process for transcribing physicians orders revealed the charge nurse transcribed new orders onto the MAR. When asked if the facility had a system for verifying accuracy of the transcription of orders, UC # 1 stated the facility did not have a formal system for double checking the accuracy of transcription of physicians orders. UC # 1 stated she checked the transcription of orders when requested by the charge nurse but didn't verify the accuracy of transcription on a routine basis.
During an interview on 02/27/15 at 1:33 PM with the Geriatric Nurse Practitioner (GNP), the GNP was asked if there was any adverse effect on Resident # 130 from receiving half the prescribed dosage of [MEDICATION NAME] for the first 15 days of her admission to the facility. The GNP stated she didn't think Resident # 130 suffered any harm but she expected the medication to be administered as prescribed.
An interview on 02/27/15 at 3:18 PM with the Director of Nursing (DON) about the facility's process for verifying the accuracy of transcription of MEDICATION ORDERS FOR [REDACTED].
3. Resident # 80 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated she had moderately impaired cognitive skills for daily decision making and impaired short term and long term memory. Her most recent care plan dated 11/12/14 addressed the resident's chronic pain with need for administration of [MEDICATION NAME], a medication used to treat pain, on an as needed (PRN) basis.
Review of Resident # 80's October 2014 summary of physician's orders, which was signed as reviewed by Unit Coordinator (UC) # 1 on 09/30/14, revealed the list of medications included [MEDICATION NAME] 50 milligrams (mg) by mouth every 6 hours PRN pain with an origination date of 11/05/12.
Review of Resident # 80's October 2014 Medication Administration Record [REDACTED]. Nursing documentation on the MAR indicated [REDACTED].
Review of Resident # 80's November 2014 summary of physician's orders, which was signed as reviewed by UC # 1 on 10/31/14, revealed [MEDICATION NAME] was not included with the medications listed. The summary of orders was signed by the physician on 11/06/14.
Review of Resident # 80's November 2014 MAR indicated [REDACTED].
Review of Resident # 80's December 2014 summary of physician's orders, which was signed as reviewed by UC # 1 on 11/30/14, revealed [MEDICATION NAME] was not included with the medications listed. The summary of orders was signed by the physician on 12/08/14.
Review of Resident # 80's December 2014 MAR indicated [REDACTED]. Nursing documentation on the MAR indicated [REDACTED].
Review of Resident # 80's January 2015 summary of physician's orders, which was signed as reviewed by UC # 1 on 12/31/14, revealed [MEDICATION NAME] was not included with the medications listed. The summary of orders was signed by the physician on 01/11/15.
Review of Resident # 80's January 2015 MAR indicated [REDACTED]. Nursing documentation on the MAR indicated [REDACTED].
Further review of Resident # 80's physician's orders revealed a telephone order dated 01/28/15 for [MEDICATION NAME] 50 mg one tablet by mouth every 6 hours as needed for back pain.
Review of Resident # 80's February 2015 summary of physician's orders, which was signed as reviewed by UC # 1 on 01/31/15, revealed [MEDICATION NAME] was not included with the medications listed.
Review of Resident # 80's February 2015 MAR indicated [REDACTED]. Nursing documentation on the MAR indicated [REDACTED].
Further review of Resident #80's medical record revealed there was not a physician's order to discontinue the [MEDICATION NAME] after it was ordered on [DATE]. There was also not an order to resume the [MEDICATION NAME] after it was omitted from
the November 2014 summary of physician's orders and the November 2014 MAR indicated [REDACTED]. Review of the February 2015
summary of physician orders revealed the [MEDICATION NAME] 50 mg one tablet by mouth every 6 hours PRN pain was not included on the summary.
An interview with the Director of Nursing (DON) on 02/17/15 at 2:45 PM revealed she did not have an explanation for the [MEDICATION NAME] being omitted from November 2014 through February 2015 summary of physician's orders and from the November 2014 MAR. The DON stated once the physician signed the monthly summary of physician's orders they were considered the current orders unless another order was written after that date. The DON stated the Medical Records coordinator entered physician's orders into the computer program that was used to generate the monthly summary of physician's orders and MARs and she must have overlooked the [MEDICATION NAME].

F 0441

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

Have a program that investigates, controls and keeps infection from spreading.

Based on observation and staff interviews the facility failed to sanitize contaminated wound care supplies before placing them in a common storage area for 1 of 1 residents. (Resident #70)
The findings included:
Wound care was observed being performed by Nurse #4 on Resident #70 on 02/25/2015 at 3:57 PM. Nurse #4 cleansed the wound with normal saline and applied medicated cream to the wound bed with gloved hands then handled the tube of medicated cream and container of normal saline without changing gloves or washing hands. Nurse #4 did not sanitize the tube of medicated cream or container of normal saline after the tube of medicated cream and container of normal saline were handled by Nurse #4's gloved hands while she was performing wound care, applying medicated cream on resident's wound and dressing resident's wound prior to replacement in wound care supply cart. Nurse #4's gloved hands had been in contact with the bed of Resident #70's wound which was described as a stage 3 pressure ulcer in the medical record. The wound bed was beefy red. No drainage, bleeding or odor related to Resident #70's wound was observed.
Nurse #4 verbalized that she does not sanitize wound care supplies prior to placing them back in the wound care supply cart during a staff interview immediately following wound care procedure.
On 02/25/2015 at 4:19 PM Nurse #4 was observed placing the wound care supplies which had just been used to treat Resident #70 in a wound care cart drawer with supplies for use with other residents. Nurse #4 was observed placing the tube of contaminated, unlabeled medicated cream into an unlabeled box with other tubes of the medicated cream. Nurse #4 was observed placing the contaminated container of normal saline into a drawer with wound care supplies intended for use treating other residents. Nurse #4 had not labeled the container of normal saline with the resident's name or dated the container of normal saline after she had opened it in preparation to perform wound care.
A staff interview was conducted with Director of Nurses and Unit Coordinator #2 on 02/25/2015 at approximately 5:00 PM. The Director of Nurses and Unit Coordinator #2 both verbalized that the facilities in-service and training materials did not instruct staff to sanitize wound care supplies and equipment prior to placing them back into the wound care cart and that resident's wound care supplies and equipment were commonly stored together in the wound care carts throughout the facility.

F 0514 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** **Keep accurate, complete and organized clinical records on each resident that meet professional standards**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **345411**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **02/27/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE	**516 WALL STREET WAYNESVILLE, NC 28786**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0514

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 5)
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on medical record review and staff interview the facility failed to ensure physician's orders and Medication Administration Records (MARs) were complete and accurate for 5 of 6 residents reviewed for unnecessary medications (Residents # 31, 53, 80, 125 and 130).
The findings included:
1. Resident # 31 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. His most recent care plan dated 12/26/14 addressed his need for monitoring of blood glucose levels with daily capillary blood glucose (CBG) tests and sliding scale insulin as ordered.
Review of Resident # 31's January and February 2015 summary of physician's orders, which were signed as approved by the physician, revealed there were no orders for CBG tests or sliding scale insulin before meals and at bedtime. Further review of the medical record did not reveal any orders on the current chart for CBG tests or sliding scale insulin before meals and at bedtime.
Nurse # 1 was observed on 02/26/15 at 11:41 AM performing a CBG test on Resident # 31 and obtained a result of 246. Nurse # 1 was observed checking the dosage parameters on the Sliding Scale Insulin Administration Record, then administering [MEDICATION NAME]4 units to Resident # 31 and documenting the CBG and insulin administration on the record.
An interview with Unit Coordinator (UC) # 1 on 02/26/15 at 3:01 PM revealed she was unable to locate a signed physician's order on Resident # 31's chart for CBG tests or sliding scale insulin. UC # 1 stated the parameters for the sliding scale insulin were listed on the Blood Glucose Tracking/Sliding Scale Insulin Administration Record. When asked if the physician reviewed the document and approved the dosage parameters, UC # 1 stated the physician didn't review or sign the document to approve the dosage parameters.
An interview with the Medical Records coordinator on 02/26/15 at 3:20 PM revealed the facility stopped including the CBG and sliding scale insulin orders on the monthly summary of orders about 6 months ago. When asked what the system was for the physician reviewing and approving those orders, she acknowledged there was not a system in place for the physician to review the orders.
An interview with the Director of Nursing (DON) on 02/27/15 at 2:45 PM revealed the monthly summary of physician's orders was considered the currently approved orders after they were signed by the physician and should include all current orders for medication and treatment. The DON stated the nurses were not instructed to omit orders for CBG's and sliding scale insulin from the monthly summary of physician's orders and those orders should have been included on the January and February 2015 orders.
2. Resident # 53 was originally admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED].
Review of Resident # 53's readmission orders [REDACTED].
Review of Resident # 53's February 2015 Medication Administration Record (MAR) revealed an entry which read: artificial tears 1 drop three times a day and did not specify the eye(s) to which they were to be administered.
During observation of administration of Resident #53's medication on 02/26/15 at 2:25 PM, Certified Medication Aide (CMA) # 1 removed a bottle of artificial tears labeled for Resident # 53 from the medication cart. CMA # 1 read the MAR and stated: he's always gotten drops in both eyes but it doesn't list it on the MAR. CMA then approached Unit Coordinator (UC) # 2 to ask for clarification.
UC # 2 checked the readmission orders [REDACTED]. UC # 2 then checked the list of discharge medications on the hospital discharge summary which indicated 1 drop was to be administered to each eye. UC # 2 stated she wrote the readmission orders [REDACTED]. UC # 2 then wrote a clarification order and added the instructions to the MAR.
3. Resident # 80 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated she had moderately impaired cognitive skills for daily decision making and impaired short term and long term memory. Her most recent care plan dated 11/12/14 addressed the resident's chronic pain with need for administration of [MEDICATION NAME], a medication used to treat pain, on an as needed (PRN) basis.
Review of Resident # 80's October 2014 summary of physician's orders revealed the list of medications included [MEDICATION NAME] 50 milligrams (mg) by mouth every 6 hours PRN pain with an origination date of 11/05/12.
Review of Resident # 80's October 2014 Medication Administration Record (MAR) revealed the following entry: [MEDICATION NAME] 50 mg one tablet by mouth every 6 hours PRN pain. Nursing documentation on the MAR indicated the [MEDICATION NAME]
had been given all but 5 days in October 2014 and was given twice on 10/01/14.
Review of Resident # 80's November 2014 summary of physician's orders revealed [MEDICATION NAME] was not included with the
medications listed. The summary of orders was signed by the physician on 11/06/14.
Review of Resident # 80's November 2014 MAR revealed [MEDICATION NAME] was not listed on the MAR.
Review of Resident # 80's December 2014, January and February 2015 summary of physician's orders revealed [MEDICATION NAME]
was not included with the medications listed.
Review of Resident # 80's December 2014 MAR revealed the following entry: [MEDICATION NAME] 50 mg one tablet by mouth every
6 hours PRN pain. Nursing documentation on the MAR indicated the [MEDICATION NAME] had been given all but 3 days in December 2014 and was given twice on 12/19/14 and 12/28/14.
Review of Resident # 80's January 2015 MAR revealed the following entry: [MEDICATION NAME] 50 mg one tablet by mouth every 6
hours PRN pain. Nursing documentation on the MAR indicated the [MEDICATION NAME] had been given all but 3 days in January 2015 and was given twice on 01/04/15 and 01/07/15.
Further review of Resident # 80's physician's orders revealed a telephone order dated 01/28/15 for [MEDICATION NAME] 50 mg one tablet by mouth every 6 hours as needed for back pain.
Review of Resident # 80's February 2015 MAR revealed the following entry: [MEDICATION NAME] 50 mg one tablet by mouth every
6 hours PRN pain. Nursing documentation on the MAR indicated the [MEDICATION NAME] had been given all but 3 days in February 2015 beginning 02/01/15.
Further review of Resident #80's medical record revealed there was not a physician's order to discontinue the [MEDICATION NAME] after it was ordered on [DATE]. There was also not an order to resume the [MEDICATION NAME] after it was omitted from
the November 2014 summary of physician's orders and the November 2014 MAR as well as the December 2014, January 2015 and February 2015 summary of physician's orders.
An interview with the Director of Nursing (DON) on 02/17/15 at 2:45 PM revealed she did not have an explanation for the [MEDICATION NAME] being omitted from November 2014 through February 2015 summary of physician's orders and from the November 2014 MAR. The DON stated once the physician signed the monthly summary of physician's orders they were considered the current orders unless another order was written after that date. The DON stated there should have been an order to discontinue the [MEDICATION NAME] before it was omitted from the November 2014 summary of physician's orders and MAR. She
stated there should have been an order to resume the [MEDICATION NAME] before it was added to the December 2014 MAR. The DON stated she expected the physician's orders to correspond with the medications listed on the MAR and for both documents to be complete and accurate.
4. Resident # 125 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. His most recent care plan dated 12/31/14
addressed his need for monitoring of blood glucose levels with daily capillary blood glucose (CBG)) tests and sliding scale insulin as ordered.
Review of Resident # 125's January and February 2015 summary of physician's orders, which were signed as approved by the physician, revealed there were no orders for CBG tests or sliding scale insulin before meals and at bedtime. Further review of the medical record revealed an admission order dated 12/19/14 which listed Insulin [MEDICATION NAME] sliding scale before meals and at bedtime but did not include the type of insulin or dosage parameters for the sliding scale insulin.
Nurse # 3 was observed on 02/25/15 at 4:28 PM performing a CBG test on Resident # 125 and obtained a result of 296. Nurse # 3 was observed checking the dosage parameters on the Sliding Scale Insulin Administration Record, then administering [MEDICATION NAME]6 units to Resident # 125 and documenting the CBG and insulin administration on the record.
Nurse # 2 was observed on 02/26/15 at 12:00 PM performing a CBG test on Resident # 125 and obtained a result of 284. Nurse # 2 was observed checking the dosage parameters on the Sliding Scale Insulin Administration Record, then administering [MEDICATION NAME]6 units to Resident # 125 and documenting the CBG and insulin administration on the record.
An interview with Unit Coordinator (UC) # 1 on 02/26/15 at 3:01 PM revealed she was unable to locate a signed physician's order on Resident # 125's chart that listed specific parameters for sliding scale insulin. UC # 1 stated the parameters for the sliding scale insulin were listed on the Blood Glucose Tracking/Sliding Scale Insulin Administration Record. When asked

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE	**516 WALL STREET WAYNESVILLE, NC 28786**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0514 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 6) if the physician reviewed the document and approved the dosage parameters, UC # 1 stated the physician didn't review or sign the document to approve the dosage parameters. UC # 1 stated the specific dosage parameters for the sliding scale insulin should have been included on the admission orders [REDACTED] An interview with the Medical Records coordinator on 02/26/15 at 3:20 PM revealed the facility stopped including the CBG and sliding scale insulin orders on the monthly summary of orders about 6 months ago. When asked what the system was for the physician reviewing and approving those orders, she acknowledged there was not a system in place for the physician to review the orders. An interview with the Director of Nursing (DON) on 02/27/15 at 2:45 PM revealed the monthly summary of physician's orders was considered the currently approved orders after they were signed by the physician and should include all current orders for medication and treatment. The DON stated the nurses were not instructed to omit orders for CBG's and sliding scale insulin from the monthly summary of physician's orders and those orders should have been included on the January and February 2015 orders. 5. Resident # 130 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Her most recent care plan dated 02/24/15 addressed her need for a proton pump inhibitor for treatment of [REDACTED]. Her admission physician's orders dated 02/11/15 included [MEDICATION NAME] (a proton pump inhibitor) 20 milligrams (mg) one tablet twice a day. Review of the February 2015 Medication Administration Record (MAR) revealed [MEDICATION NAME] 20 mg one tablet twice a day was listed on the MAR but the administration time was listed for once a day at 5:00 PM. Nursing documentation on the MAR indicated the [MEDICATION NAME] was administered once a day from 02/11/15 through 02/26/15 when the surveyor brought the medication error to staff's attention. Visual inspection of the medication package for [MEDICATION NAME] 20 mg revealed it was labeled as dispensed from the pharmacy on 02/11/15 and the package label indicated the medication was to be administered twice a day. An interview on 02/26/15 at 4:07 PM with Unit Coordinator (UC) # 1 about the process for transcribing physicians orders revealed the charge nurse transcribed new orders onto the MAR. When asked if the facility had a system for verifying accuracy of the transcription of orders, UC # 1 stated the facility did not have a formal system for double checking the accuracy of transcription of physician's orders. UC # 1 stated she checked the transcription of orders when requested to do so by the charge nurse but didn't verify the accuracy of transcription on a routine basis. During an interview on 02/27/15 at 1:33 PM with the Geriatric Nurse Practitioner (GNP), the GNP was asked if there was any adverse effect on Resident # 130 from receiving half the prescribed dosage of [MEDICATION NAME] for the first 15 days of her admission to the facility. The GNP stated she didn't think Resident # 130 suffered any harm but she expected the medication to be administered as prescribed. An interview on 02/27/15 at 3:18 PM with the Director of Nursing (DON) about the facility's process for verifying the accuracy of transcription of medication orders for newly admitted residents revealed the facility protocol was to complete a chart audit the day after a resident was admitted but the person who did the audit failed to identify the error on Resident # 130's MAR.