Medical Chronology/Summary

Confidential and privileged information

Usage guidelines/Instructions

Verbatim summary: All the medical details have been included "word by word' or "as it is" from the provided medical records to avoid alteration of the meaning and to maintain the validity of the medical records. The sentence available in the medical record will be taken as it is without any changes to the tense.

Case synopsis/Flow of events: For ease of reference and to know the glimpse of the case, we have provided a brief summary including the significant case details.

Injury report: Injury report outlining the significant medical events/injuries is provided which will give a general picture of the case.

Comments: We have included comments for any noteworthy communications, contradictory information, discrepancies, misinterpretation, missing records, clarifications, etc for your notification and understanding. The comments will appear in red italics as follows: **"**Comments*".**

Indecipherable notes/date: Illegible and missing dates are presented as "00/00/0000" (mm/dd/yyyy format). Illegible handwritten notes are left as a blank space "_____" with a note as ***"Illegible Notes"*** in heading reference.

Patient's History: Pre-existing history of the patient has been included in the history section.

Snapshot inclusion: If the provider name is not decipherable, then the snapshot of the signature is included. Snapshots of significant examinations and pictorial representation have been included for reference.

De-Duplication: Duplicate records and repetitive details have been excluded.

General Instructions:

- *The medical summary focuses on heatstroke on MM/DD/YYYY at ABC Nursing and Rehabilitation and subsequent transfer to ABC Center Hospital and care/management provided from MM/DD/YYYY to 07/29/YYYY in detail.*

- *Nursing home records and hospitalization records prior to MM/DD/YYYY are presented narratively/briefly to evaluate the condition of the patient and the management provided.*

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Flow of events

ABC Center
08/20/YYYY-07/19/YYYY

Resident was monitored periodically. He received ADL care, medication management, incontinent care, and nutrition care. He also had regular physician evaluation for his medical management. He had episodes of physical and verbal altercations and combative behaviors. He also had episodes of confusion and agitation, and aggressive behaviors with other residents and staff nurse. He received physical therapy and occupational therapy. He also underwent ER visits and hospitalization visits for management of fall, AMS, seizure like activity. He was noted to be COVID positive on January 05, YYYY. Transferred to hospital on MM/DD/YYYY after heatstroke

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ABC Center Hospital
07/19/YYYY-07/29/YYYY

Admitted due to heatstroke after being left outside at the nursing home in the wheelchair, initial temperature of 107 with GCS of 6 required intubation and rapid ice water immersion followed by cooling blanket transition. Course complicated with ESBL pneumonia treated with meropenem as well as seizures requiring restarting of Keppra, Dr. XXX following along. Successfully extubated to nasal cannula on 07/24/YYYY without any complications, possible evaluation on 07/25/YYYY and started on clear liquid diet with close monitoring for aspiration risk. Echocardiogram showed ejection fraction 60 to 65% with trace MR and TR and no pericardial effusion. Speech pathology evaluation advance to puréed diet. Patient condition gradually improved. Other conditions management as above. Patient was referred to focus care per family preference. Social services consulted. Patient was accepted at skilled nursing facility focus care on 07/29/YYYY and discharged in stable condition.

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ABC Center Hospital
04/28/YYYY

Date of death: 04/22/YYYY at 1130 hours; Cause of death: Sepsis unspecified organism, unspecified dementia, essential hypertension

Patient History

Past Medical History: Acute right-sided weakness, dementia, diabetes, hypertension, impaired mobility and ADLs, history of seizures, TIA ***(PDF Ref:** 5682, 5690)*

Surgical History: *Not available*

Family History: *Not available*

Social History: As on MM/DD/YYYY: Current some day smoker ***(PDF Ref:** 5682)*

Allergy: No known allergies ***(PDF Ref:** 5691)*

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Detailed Summary

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		ABC Center ***08/20/YYYY-MM/DD/YYYY***	
		**Reviewer's Comments: Medical records pertinent to nursing home prior to MM/DD/YYYY are summarized narratively/briefly to evaluate the medical condition and management rendered. These records are not summarized in detail as they are not significant for case focus. We will elaborate these records in detail upon request.*	
12/09/YYYY	Hospital/ Provider Name	**Follow-up Visit:** **Nursing Home Visit:** This man is seen for follow-up. He has progressive worsening dementia, history of alcoholism, history of traumatic brain injury, diabetes, hypertension, polyarticular osteoarthritis. Since admission, the patient has been fairly stable. He is comfortable. No new acute complaints or problems. No falls. No injuries. No aspiration. No recent seizures. No skin breakdown. He needs help with medication. He needs help with feeding. **Physical examination:** **Vital signs:** Stable. **Musculoskeletal:** He has fairly good strength and range of motion. He has no focal neurological deficits. No meningeal signs. He has very poor concentration and recall. **Diagnostic impression:** • Progressive worsening dementia. • History of alcoholism. • TBI in the past. • Diabetes. • Hypertension. • Polyarticular osteoarthritis. The patient is full code status. He has no known allergies. He is on lisinopril 40 mg daily for hypertension, Hydralazine 10 mg QID, Melatonin 10 mg daily for insomnia. O2 PRN. Recently on Keflex for infection. He seems to be stable. Prognosis is unchanged. The patient is full code.	1254-1255
01/20/YYYY	Hospital/ Provider Name	**Follow-up Visit:** **Nursing Home Visit:** This patient is seen for re-evaluation. He has had recurrent hospitalization for change in mental status, worsening dementia, history of alcohol abuse, hypertension, episodic disorientation. APS is involved.	4146

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		The patient has diabetes, hypertension. He is fairly comfortable. No recent falls. No injuries. No aspiration. No paroxysmal nocturnal dyspnea or orthopnea. No skin breakdown. Intake is fair. Weight is stable. He responds to nam5otwell oriented. He does not have any focal neurological deficits. OA changes in extremities. **Diagnostic impression:** • Worsening dementia. • History of TBI. • Hypertension. • Diabetes. • Osteoarthritis with polyarthralgia. • History of alcoholism. • History of right eye surgery. The patient is full code status. No known allergies. Continue Lisinopril 40 mg daily, Hydralazine 10 mg QID, Melatonin 10 mg at bedtime. O2 PRN Supportive symptomatic care. Plan and medications reviewed. Prognosis guarded.	
03/04/YYYY	Hospital/ Provider Name	**Team Conference Note:** **Subjective:** Patient was seen on rounds today with the rounding team. He has history of dementia with hypertension. **Interval review of systems:** *Unremarkable.* **Review of medical strategies:** Medically, I initiated Aricept for dementia, Melatonin to help with sleep, and Lisinopril with hypertension along with Hydralazine. **Objective:** **Vital Signs:** Temperature 98. Pulse 66. Respiration 18. Blood pressure 101/83. **Functional data:** He is ambulating freely. He struggles with some dressing skills. **Assessment & problem list:** We will run Aricept 10 mg daily for approximately two to three weeks' time and then make it through adding Namenda if it is warranted.	4187
03/17/YYYY	Hospital/ Provider Name	**Follow-up Visit:** **Nursing Home Visit:** The patient is seen at Sienna Nursing Center.	4136-4137

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		The patient is doing fairly well. No new acute complaints or problems. He has history of worsening dementia, history of traumatic brain injury, hypertension, diabetes, osteoarthritis, right eye surgery, polyarthralgia. The patient is fairly comfortable. No new acute complaints or problems. No falls. No injuries. No aspirations. Intake is fair. No skin breakdown. **Physical examination:** **Vital signs:** Stable. **General:** Appears slightly pale. No jaundice or petechiae. **Musculoskeletal:** He has osteoarthritic changes. **Neuropsychiatric:** Responds to name, not well oriented. He can be directed. Needs help with ADLs. No meningeal signs. **Diagnostic impression:** • Worsening dementia with cognitive impairment. • History of traumatic brain injury. • Hypertension. • Diabetes. • Osteoarthritis with polyarthralgia. • History of alcoholism. • History of right eye surgery. He is on Tylenol 650 q.4h., Hydralazine 10 mg QID, Lisinopril 40 mg daily, Melatonin 10 mg at bedtime. Supportive symptomatic care. Redirection. Prognosis is poor. The patient is full code status.	
05/14/YYYY	Hospital/ Provider Name	**Follow-up Visit:** **Nursing Home Visit:** This patient is seen for follow-up. He has cognitive impairment, dementia, traumatic brain injury in the past, hypertension, diabetes, osteoarthritis, history of alcoholism, history of right eye surgery. This man is fairly comfortable, not very communicative, sleepy at times. Intake is fair. No recent falls. No injuries. No aspirations. No paroxysmal nocturnal angina, dyspnea or orthopnea. No skin breakdown. **Physical examination:** **Vital signs:** Stable. Appears pale. No jaundice or petechiae. **Musculoskeletal:** He has osteoarthritic changes. **Neuropsychiatric:** Responds to name. Not well oriented. Needs help with ADLs. No focal meningeal signs. No focal neurologic deficits. Poor concentration and recall. **Diagnostic impression:** • Traumatic brain injury in the past. • Worsening dementia with cognitive impairment.	4138-4139

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		• Hypertension. • Diabetes. • Osteoarthritis. • History of alcoholism. • History of right eye surgery. No allergies. Full code status. Prognosis is guarded. Tylenol 650 q.4h., hydralazine 10 mg QID, Lisinopril 40 mg, Melatonin 10 mg at bedtime.	
06/09/YYYY	Hospital/ Provider Name	**Follow-up Visit:** **Nursing Home Visit:** This patient is seen for re-evaluation. He has history of traumatic brain injury in the past, diabetes, dementia, history of alcoholism, history of right eye surgery. This patient is fairly stable, comfortable. No new acute complaints or problems. No falls. No injuries. No aspirations. No paroxysmal nocturnal angina, dyspnea or orthopnea. No skin breakdown. Weight is stable. No seizures. No aspiration. **Physical examination:** **Vital signs:** Stable. Appears pale. No jaundice or petechiae. **Musculoskeletal:** He has stiffness, swelling in ___ *(Text missing in record)* joint. Some periarticular swelling in the knee. He has crepitation. No signs of infection. Responds to name, not well oriented. Needs help with ADLs. No focal meningeal signs. No focal neurological deficits. Poor concentration and recall. **Diagnostic impression:** • Remote TBI. • Worsening dementia with cognitive impairment. • Hypertension. • Diabetes. • Osteoarthritis. • History of alcoholism. • Right eye surgery. Poor prognosis. Full code status. He is on Tylenol 650 q.4h. Hydralazine 10 mg QID for blood pressure. Lisinopril 40 mg daily, Melatonin 10 mg at bedtime. Prognosis is guarded.	4140-4141
08/10/YYYY	Hospital/ Provider	**Annual History and Physical Examination:** This man is seen for follow-up. He has had organic brain syndrome, history of traumatic brain injury, dementia, history of alcoholism, right eye surgery,	4142-4143

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
	Name	diabetes. The patient since admission here is fairly comfortable, stable. No new acute complaints or problems. No falls. No injuries. No aspiration. No skin breakdown. No recent seizures. Does not smoke or drink. **Physical examination:** **Vital signs:** Temperature 98, heart rate 82, respirations 16, blood pressure 136/72. Appears pale. No jaundice or petechiae. **Musculoskeletal/neurological:** He has osteoarthritic changes. He has ___ *(Text missing in record)*. **Neuropsychiatric:** Responds to name. Poor concentration and recall. No meningeal deficits. There has been no change in personal, family, or social history. No recent hospitalization. **Diagnostic impression:** • Remote traumatic brain injury. • Worsening dementia with cognitive impairment. • Hypertension. • Diabetes. • Polyarticular osteoarthritis. • History of alcoholism. • History of right eye surgery. Prognosis is poor and guarded. The patient is full code status. He is on Tylenol 650 q.4h., Aspirin 81 mg, Crestor 20 mg, Hydralazine 25 mg, Lisinopril 40 mg daily, Melatonin 10 mg daily.	
09/10/YYYY	Hospital/ Provider Name	**Follow-up Visit:** **Nursing Home Visit:** This patient is seen for follow-up. He has organic brain syndrome, history of traumatic brain injury, progressive dementia, history of alcoholism, diabetes, hypertension, polyarticular osteoarthritis. The patient is doing fairly well. He is stable. No new acute complaints or problems. No falls. No injuries. No aspiration. No paroxysmal nocturnal dyspnea or orthopnea. No skin breakdown. Intake is fair. No weight changes. **Physical examination:** **Vital signs:** Stable. Appears pale. No jaundice or petechiae. **Musculoskeletal:** No new focal neurological deficits. No meningeal signs. Rest of the examination is unchanged. **Diagnostic impression:**	4183-4184

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		• Remote traumatic brain injury. • Worsening dementia with cognitive impairment. • Hypertension. • Diabetes. • Polyarticular osteoarthritis. • History of alcoholism. • History of right eye problems post-surgery. Full code status. Poor prognosis. Continue Crestor 10 mg, Hydralazine 25 BID, Lisinopril 40 mg daily, Melatonin 10 mg daily.	
	Hospital/ Provider Name	***ABC Center Hospital*** ***10/21/YYYY-10/22/YYYY***	
10/21/YYYY	Hospital/ Provider Name	**ER Physician Record:** **Chief complaint:** Patient coming from Sienna via EMS, sent for AMS and seizure like activity. **History of Present Illness:** 66-year-old male with history of dementia, diabetes, hypertension presents via EMS from sienna nursing home for evaluation of seizure-like activity and altered mental status. Per EMS report patient had 3 episodes today of shaking which they think was generalized but more pronounced in the upper extremities and seemed confused afterwards. No known history of seizures per EMS report. Apparently the nursing home "system" was down and they are not able to provide us with any paperwork. EMS reports CBG within normal limits. History is limited due to the condition of the patient. EMS reports grossly negative stroke scale but patient not completely compliant with exam. Patient able to answer some questions but does not answer consistently. **Review of Systems:** Unable to obtain review of systems secondary to dementia **Physical examination:** **Vitals**: Temperature: 37.2C, HR: 72, RR: 20, BP: 126/88, SpO2: 97% Height: 170 cm, weight: 80 kg, BMI: 27.7 **General appearance:** Well developed, well-nourished, alert, no acute distress **HEENT:** Normocephalic, atraumatic. Pupils equal, round, and reactive to light, extraocular muscles intact. Moist mucous membranes. **Neck:** Normal inspection. Neck supple, normal range of motion. **Respiratory:** Chest nontender. No respiratory distress. Breath sounds clear and equal bilaterally. **Cardiovascular:** Regular rate and rhythm. No murmurs, rubs, or gallops. Strong distal pulses with good perfusion. **Abdomen:** Soft, nontender, nondistended. No organomegaly. No palpable masses. **Back:** Normal inspection, no CVA tenderness. **Skin:** Warm, dry, intact with normal color and no rash. No embolic lesions. No petechiae.	5791-5798

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Extremities: Nontender, full range of motion, no calf tenderness. No pedal edema. **Neuro:** Awake, alert, disoriented. Cranial nerves II through XII grossly intact. Motor and sensation grossly intact. Slightly agitated **Medical Decision Making** Differential diagnosis includes but is not limited to: Seizure, syncope with myoclonic jerks, renal failure, electrolyte abnormality, pseudoseizure, tremor, ICH, brain mass Reviewed prior records. Patient was previously admitted in July of this year after being seen in the ED for syncopal episode by myself. Ultimately discharged back to nursing home. Patient given 1 mg Ativan to prevent further seizure and loaded with 1 g Keppra. CT scan of the head is negative. Work-up is all reassuring. Discussed with Dr. XXX who agrees with admission for MRI and EEG. He will consult. We will continue Keppra at this point time. Discussed with the hospitalist will admit for further care. **Assessment/Plan** • Seizure-like activity • Dementia • Acute right-sided weakness • Altered mental status • CVA (cerebrovascular accident)	
10/22/YYYY	Hospital/ Provider Name	**Discharge Summary:** **Final Diagnosis and Management Plan** **AMS, improved sec to Reported seizure-like activity at sienna nursing home** EEG normal per Dr XXX, recommended Keppra 500mg BID **Hypertension** Continue Lisinopril Continue Hydralazine **History of TIA** Continue Crestor Continue Aspirin. **Insomnia** Melatonin as needed. **Dementia** Fall precaution. **Follow-Up Appointments** No qualifying data available	5787-5791

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		PCP Dr. XXX **Consultants** Dr. XXX **Brief Hospital Course** This patient 66-year-old Caucasian man with known history of hypertension and dementia and is a nursing home resident. Patient was admitted for observation secondary to alleged seizure-like activity in the nursing home. Patient had a CT of the head done which was appropriate for age and did not reveal any acute abnormality. EEG done was normal. Dr. XXX was consulted and recommended continuation of Keppra. Patient is altered mental status is improved today, he is easily arousable, tolerating breakfast and PO medication. He is now being discharged back to the nursing home. **Physical examination:** **Vitals:** Temperature: 98 F, HR: 57, RR: 18, BP: 122/77, SpO2: 96%, height: 170 cm, weight: 75.5 kg, BMI: 26.1 **General:** Comfortable in bed, NAD, mildly drowsy but easily arousable, demented **HEENT:** Normocephalic, atraumatic, pink palpebral conjunctivae, anicteric sclerae **CVS:** Adynamic precordium, NRRR, normal S1 and S2, no S3/4, no murmurs appreciated **Respiratory:** Symmetrical expansion, no retractions, clear to auscultation, bilaterally **Abdomen:** Flat, soft, normoactive bowel sounds, non-tender, no hepatosplenomegaly, no hernias noted **Extremities:** No pitting bipedal edema, no cyanosis, DP/radial pulses are full and equal **Skin:** Warm, moist, no active skin lesions, cap refill <2s **Condition at Discharge:** Improved and stable. **Related records:** Admission record, history and physical, EEG, nursing notes, diagnostic reports, labs *(PDF Ref: 5786, 5798-5812)*	
11/12/YYYY	Hospital/ Provider Name	**Follow-up Visit:** **Nursing Home Visit:** This man has organic brain syndrome, remote traumatic brain injury, worsening dementia with cognitive impairment, hypertension, diabetes, osteoarthritis, history of alcoholism. He has done fairly well. He is comfortable. No new acute complaints or problems. No falls. No injuries. No aspirations. Intake is fair. No new skin breakdown.	4144-4145

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Physical examination: **Vital signs:** Stable. Appears pale. No jaundice or petechiae. **Musculoskeletal:** He has osteoarthritic changes. **Neuropsychiatric:** Responds to name. No focal meningeal signs. No focal neurologic deficits. Poor concentration and recall. He is able to ambulate. He needs to be monitored. **Diagnostic impression:** • Remote traumatic brain injury. • Worsening dementia with cognitive impairment. • Hypertension. • Diabetes. • Osteoarthritis. • History of alcoholism. Poor prognosis. Full code status. He is on Tylenol 650 q.4h., Aspirin 81 mg daily, Lipitor 20 mg daily, Hydralazine 25 mg TID, Keppra 500 mg BID. Melatonin 10 mg daily and he is also on Lisinopril 40 mg daily and Namenda 10 mg BID. Full code status.	
		ABC Center Hospital ***11/27/YYYY***	
11/27/YYYY	Hospital/ Provider Name	**ER Physician Record:** **Chief complaint:** Patient presents via EMS from Sienna after being hit in head with a stick. **History of present illness:** 66-year-old male with past medical history of unspecified dementia without behavioral disturbances presents to the emergency department after an altercation in the nursing home. Arrives via Odessa fire rescue. Per report patient was hit in the head with a stick. Nurses attempted sternal rub at the scene and did chest compressions however there was no documented loss of pulse. Patient became more responsive immediately afterward. EMS vital signs stable. Patient also reports mild neck pain mild to moderate in severity, non-radiating. Patient reports dull headache, non-radiating, moderate in severity. Nursing home paperwork reviewed. **Review of systems:** **Musculoskeletal:** Neck pain **Neuro:** Headache Except as noted above and in HPI all other systems reviewed and negative. **Physical examination:** *Unremarkable.*	5848-5851

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Medical Decision Making Old chart reviewed to include 10/22/YYYY hospitalist discharge by Dr. Caparas, altered mental status and negative EEG. Head CT negative. NIH score 0. No neuro-focal deficits on examination. Patient hemodynamically stable. Patient medically clear for discharge. Case and plan discussed with patient, who voiced understanding and is in agreement with plan for discharge. Instructed to follow-up PCP in the next few days. Instructed return to the emergency room if symptoms persist or get worse. **Assessment/Plan:** Head contusion **Ordered:** • Discharge patient to • Headache **Attending Attestation** The patient was independently seen, interviewed, and examined by me. I agree with the assessment and care plan as documented by the fellow. Head contusion after minor head injury at nursing home after altercation. Head CT negative and discharged.	
11/27/YYYY	Hospital/ Provider Name	**CT of Head/Brain without Contrast:** **Ordering Physician:** XXX, M.D. **Clinical indication:** Injury or trauma; Fall **Impression:** No acute post-traumatic brain injury.	5852
12/03/YYYY	Hospital/ Provider Name	**Follow-up Visit:** **Nursing Home Visit:** This man has organic brain syndrome with confusion, history of traumatic brain injury. He has hypertension, diabetes, osteoarthritis, and history of alcoholism. He has occasional spells of anxiety, agitation. He occasionally acts out. No recent falls. No injuries. No aspirations. No paroxysmal nocturnal angina, dyspnea or orthopnea. No skin breakdown. **Physical examination:** **Vital signs:** Stable. Appears pale. No jaundice or petechiae. **Musculoskeletal:** He has osteoarthritic changes. **Neuropsychiatric:** Responds to name, not well oriented. Needs help with ADLs. No focal neurological deficits. No meningeal signs. **Diagnostic impression:** • Remote traumatic brain injury. • Worsening dementia with cognitive impairment. • Hypertension. • Diabetes. • Polyarticular osteoarthritis.	4185-4186

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		• History of alcoholism. Prognosis is poor. The patient is full code status. He is on Melatonin 10 mg at bedtime, Namenda 10 mg daily. The patient is examined. Plans are reviewed. Prognosis is unchanged.	
		ABC Center Hospital ***12/19/YYYY-12/21/YYYY***	
12/19/YYYY	Hospital/ Provider Name	**ER Physician Record:** **Chief complaint:** Patient arrived via EMS from Sienna NH C/O right sided weakness; LKW 0530 this AM **History of present illness:** 66-year-old male with past medical history of hypertension, seizure, dementia presents from Sandy nursing home. As per nursing staff report, patient was walking around 530 when he began stumbling to the right, subsequently had an assisted fall. She has been reported he was thirsty, was given a glass of water with reports that patient was unable to hold onto cup of water. Upon EMS arrival, EMS reports patient was less responsive with decreased grip strength in the left. Upon ED arrival, stroke alert was called. As per ED nursing report, patient was more awake and alert during CT, answering questions, moving all extremities. During interview, patient denies any complaints at this time. **Review of systems:** Except as noted above and in HPI all other systems reviewed and negative. **Physical examination:** **Vitals:** Temperature: 36.4C, HR: 67, RR: 19, BP: 136/86, SpO2: 100% Height: 180 cm, weight: 82.5 kg, BMI: 25.5 **Extremities:** Nontender, full range of motion, no calf tenderness. No pedal edema. **Neuro:** Awake, alert, oriented ×1 (person). Cranial nerves II through XII grossly intact. Motor and sensation grossly intact. Mood and affect normal. **Medical Decision Making** Patient is afebrile, nontoxic-appearing, hemodynamically stable. NIH score 0. CT head, CTA head, CTA neck showed no acute findings. No neuro-focal deficits on examination. On reexamination, patient found to be walking around the bed. tPA not given as last well-known was at 5:30 AM, along with resolvent of any reported deficits. Patient appears to be back at baseline. Patient will be admitted for weakness likely secondary to TIA. Patient is currently on Aspirin and atorvastatin along with antihypertensive medications. Case and findings discussed with patient, along with plan for admission. Case discussed with Dr. XXX, neurology, who agrees to be consulted. Case and findings discussed with hospitalist, who accepts admission.	5816-5823

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Assessment/Plan • TIA (transient ischemic attack) • History of dementia • Bradycardia, sinus • Left-sided weakness • Weakness - Right sided **Attending Attestation** The patient was independently seen, interviewed, and examined by me. I agree with the assessment and care plan as documented by the ER fellow Jariwala. 66-year-old nursing home patient was sent in for possible stroke. Apparently patient was noted to be falling to the right this morning while walking. EMS thought he had left-sided weakness upon their initial evaluation. On our evaluation the patient demonstrated no significant weakness. CT scans all negative. Discussed with neurology, will admit for MRI.	
12/21/YYYY	Hospital/ Provider Name	**Discharge Summary:** **Brief hospital course:** 66-year-old male with past medical history of diabetes, hypertension, dementia, history of seizures on Keppra who lives at Siena nursing home was brought in via EMS with staff witnessing right-sided weakness and stumbling, last known well was at 530 a.m. 12/19. Upon arrival in ER there was a question for left-sided weakness which was witnessed by admitting NP however later on my examination no weakness of any side was noted. All imagings of the brain were negative. EEG was okay as well per Dr. XXX-neurologist on board. He was found to have agitation for which he responded well to antipsychotic. Patient is now being discharged back to nursing home. **Physical examination:** **Vitals:** Temperature: 97.7F, HR: 56, BP: 150/95, SpO2: 95%, height: 180 cm, weight: 82.5 kg, BMI: 25.5 **General:** Not pale, jaundiced or cyanotic. No apparent distress **HEENT:** Normo-cephalic, Atraumatic **Neck:** Supple, **Neuro:** Non focal. GCS 14/15 **Lungs:** VB, CTA BL. **Heart:** S1S2 normal, RRR. **Abdomen:** Soft, No tendernes, No guarding or rigidity. No appreciable organomegaly, BS-normoactive **Skin:** No erythema or lesions noted **Extremities:** No Peripheral edema. **Discharge A/P:** **Acute:** Right versus left-sided transient hemiparesis secondary to TIA? Versus postictal? All imagings of brain including MRI is WNL	5814-5815

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Pending EEG Continue Keppra Agitation likely secondary to worsening of possible dementia-antipsychotic **Chronic:** Diabetes mellitus type 2-APRN consult, Hypoglycemia protocol, CBG Checks. Dementia with possible behavioral disorder-continue home dose of all medications, including memantine donepezil, Seizure disorder-continue Keppra **VTE prophylaxis:** SCDs, chemoprophylaxis with Lovenox **Related records:** Admission record, history and physical, consultation report, progress notes, CT, labs *(PDF Ref: 5813, 5823-5847)*	
01/07/YYYY	Hospital/ Provider Name	**Follow-up Visit:** **Nursing Home Visit:** This man, a long-term resident is now in the secure unit. He is also on isolation. He recently had positive COVID-19 antigen testing. He has history of organic brain syndrome, traumatic brain injury, worsening dementia, cognitive impairment, diabetes, hypertension, osteoarthritis, and alcoholism. Since he is positive for COVID, he is in the isolated status. No recent fevers. No cough. No wheezing. No chest pain. No paroxysmal nocturnal angina, dyspnea or orthopnea. No skin breakdown. **Physical examination:** **Vital signs:** Stable. Appears pale. No jaundice or petechiae. **Musculoskeletal:** He has osteoarthritic changes. **Neuropsychiatric:** Responds to name, not well oriented. He can be directed. Needs help with ADLs. No other focal findings. **Diagnostic impression:** • Remote brain injury. • Worsening dementia with cognitive impairment. • Recent COVID-positive status. • Hypertension. • Diabetes. • Alcoholism. • Osteoarthritis. Prognosis is poor. Full code status.	5367-5368

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		He is on Tylenol 650 q.4h., aspirin 81 mg daily. Lipitor 20 mg, Hydralazine 25 TID, Keppra 500 BID, Lisinopril 40 mg, Melatonin 10 mg daily, Namenda 10 BID, Plavix 75 mg, Seroquel 25 mg daily. Prognosis is guarded. Isolation precautions will be carried out. He will be monitored for oxygen desaturation and any signs of infection. No new medications at the present time.	
02/02/YYYY	Hospital/ Provider Name	**Follow-up Visit:** **Nursing Home Visit:** This man is seen for re-evaluation and follow-up. He has had some decrease in appetite. Minimal weight loss. No hematemesis. No melena. No vomiting. No diarrhea. No weight changes. He does have organic brain syndrome with traumatic brain injury, worsening dementia, cognitive impairment, diabetes, hypertension, osteoarthritis, alcoholism. No vomiting. No bleeding. No skin breakdown. He seems to recover from his COVID-19 infection. However, he has poor appetite. He can be directed. **Physical examination:** **Vital signs:** Temperature is 97.9, respiration 18, blood pressure is 126/70. Appears pale. No jaundice or petechiae. **Lungs:** Air entry is fair. Scattered rhonchi. **Musculoskeletal:** He has osteoarthritic changes. **Neuropsychiatric:** Responds to name, not well oriented. He can be directed. He is sleepy. No focal neurologic deficits. No meningeal signs. **Diagnostic impression:** • Recent anorexia. • Remote brain injury. • Worsening dementia with cognitive impairment. • Recent COVID-19 infection. • Hypertension. • Diabetes. • History of alcoholism. • Osteoarthritis. Prognosis is poor. He is full code status. We will place him on Megace 200 mg daily for 1 month to improve his appetite. Continue Plavix 75 mg, aspirin 81 mg, Lipitor 40 mg daily, Keppra 500 BID for history of seizures, melatonin 9 mg at bedtime, Namenda 10 BID, Seroquel 25 BID, Hydralazine 25 mg TID, Lisinopril 40 mg daily. Prognosis is guarded.	5389-5390

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Monitor his weight. Monitor his intake.	
02/02/YYYY	Hospital/ Provider Name	**Follow-up Visit:** **Re-dictation:** This man is seen for re-evaluation. He is doing fairly well. He has recovered from his COVID-19. He has organic brain syndrome, history of traumatic brain injury, dementia, cognitive impairment, diabetes, hypertension, osteoarthritis, alcoholism. Intake is fair. No recent falls. No injuries. He does not have anorexia. Appetite is good. He is not on Megace. **Physical examination:** **Vital signs:** Temperature is 98, heart rate 82, respiration is 17, blood pressure 136/70. Appears pale. No jaundice or petechiae. **Musculoskeletal/neurological:** He has osteoarthritic changes. There are no focal neurological deficits. **Diagnostic impression:** • Remote brain injury. • Worsening dementia with cognitive impairment. • Hypertension. • Diabetes. • History of alcoholism. • Osteoarthritis. Full code status. The patient is examined. Plans are reviewed. Medications include Plavix 75 mg, Aspirin 81 mg, Lipitor 40 mg daily, Keppra 1000 mg BID, melatonin 3 mg 3 tablets at bedtime, Namenda 10 BID, Seroquel 25 mg, Hydralazine 25 TID, Lisinopril 40 mg daily. He is not on Megace. Continue medications.	5395-5396
03/04/YYYY	Hospital/ Provider Name	**Follow-up Visit:** **Nursing Home Visit:** This man has history of remote brain injury with worsening dementia and cognitive impairment, hypertension, diabetes, history of alcoholism, osteoarthritis. He is in the secure care unit. He is doing fairly well. Responds to name, not well oriented. Needs help with ADLs. He can be directed. No new complaints. No falls. No injuries. No aspirations. No paroxysmal nocturnal angina, dyspnea, or orthopnea. **Physical examination:**	5379-5380

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		Vital signs: Temperature is 97.8, respiration is 17, blood pressure 138/70, pulse is 82. Appears pale. No jaundice or petechiae. **Musculoskeletal/Neurological:** He has osteoarthritic changes. He has fairly good strength and range of motion. No focal neurologic deficits. No meningeal signs. Poor concentration and recall. Responds to name. Not oriented. Needs help with direction. Needs help with activities of daily living and medication. **Diagnostic impression:** • Remote brain injury. • Worsening dementia with cognitive impairment. • Hypertension. • Diabetes. • History of alcoholism. • Osteoarthritis. The patient's status is about the same. He is full code status. He is on Tylenol 650 q.4h., aspirin 81 mg daily, Lipitor 20 mg, Hydralazine 25 TID, Keppra 500 BID for seizures and intermittent explosive disorder, Lisinopril 40 mg daily, Melatonin 10 mg at bedtime, Namenda 10 BID, Plavix 75 mg daily, Seroquel 25 BID for psychosis. The patient is examined. Plans are reviewed. Prognosis is unchanged. Full code status.	
04/01/YYYY	Hospital/ Provider Name	**Follow-up Visit:** **Nursing Home Visit:** This patient has a remote history of brain injury. He has progressive dementia and cognitive impairment, hypertension, diabetes, history of alcoholism, osteoarthritis. He is in the secure unit at Sienna Nursing Center. He has done fairly well. No new acute complaints or problems. No falls. No injuries. No aspirations. No paroxysmal nocturnal angina, dyspnea or orthopnea. No skin breakdown. **Physical examination:** **Vital signs:** Temperature is 96.9, respiration 16, blood pressure is 128/72, pulse is 76. Appears pale. No jaundice or petechiae. **Musculoskeletal:** He has osteoarthritic changes. **Neuropsychiatric:** Responds to name. Not well oriented. He can be directed. Poor concentration and recall. He needs help with medication. Needs help with directions. No focal neurologic deficits. No meningeal signs. **Diagnostic impression:**	5381-5382

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		• Remote brain injury. • Worsening dementia with cognitive impairment. • Hypertension. • Diabetes. • History of alcoholism. • Osteoarthritis. Full code status. Continue aspirin 81 daily Lipitor 20 mg daily, Hydralazine 25 TID, Keppra 500 BID, Lisinopril 40 mg daily, Melatonin 10 mg at bedtime, Namenda 10 BID, Plavix 75 mg daily, Seroquel 25 mg at bedtime. Prognosis is unchanged. Full code status.	
05/04/YYYY	Hospital/ Provider Name	**Follow-up Visit:** This man seen for follow-up. He has remote history of brain injury. He has progressive dementia with cognitive impairment, hypertension, diabetes, history of alcoholism and osteoarthritis. The patient has done fairly well. He is comfortable. No new acute complaints or problems. Intake is fair. No falls. No injuries. No aspiration. No paroxysmal nocturnal dyspnea or orthopnea. No skin breakdown. **Physical examination:** **General:** His temperature is 97.8, respiration 16, blood pressure 134/82, pulse is 70. Appears pale. No jaundice or petechiae. **Musculoskeletal/neurological:** Responds to name, not oriented. Poor concentration and recall. Poor memory. He can be directed. Needs help with activity and medication and direction. Unable to meet his needs by himself. No meningeal signs. **Diagnostic impression:** • Remote brain injury. • Worsening dementia with cognitive impairment. • Hypertension. • Diabetes. • History of alcoholism. • Osteoarthritis. The patient is full code status. He is on Aspirin 81 mg, Lipitor 20 mg, Hydralazine 25 TID, Keppra 500 BID, Lisinopril 40 mg, Melatonin 10 mg, Namenda 10 BID, Plavix 75 mg daily, Seroquel 25 mg BID. Prognosis is unchanged. Full code status.	5383-5384
06/01/YYYY	Hospital/ Provider	**Follow-up Visit:** **Nursing Home Visit:** This man has history remote brain injury with worsening dementia and cognitive	5385-5386

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	Name	impairment. He also has diabetes, hypertension, history of alcoholism, and osteoarthritis. He has done fairly well. He is comfortable. No new acute complaints or problems. No falls. No injuries. No aspirations. No paroxysmal nocturnal dyspnea or orthopnea. No skin breakdown. **Physical examination:** **General:** The patient is sitting in the wheelchair. **Vital signs:** Temperature is 97, respiration is 16, heart rate is 74, blood pressure 116/70. **General:** Appears slightly pale. Mild edema . No jaundice or petechiae. **Musculoskeletal/neurological:** Responds to name. He has osteoarthritic changes. Not oriented. He can be directed. Needs help with ADLs. No focal findings. Poor concentration and recall. No meningeal signs. **Diagnostic impression:** • Dementia with cognitive impairment. • History remote brain injury. • Hypertension. • Diabetes. • History of alcoholism. • Osteoarthritis. Poor prognosis. Full code status. He is on Tylenol 650 q.4., aspirin 81 mg, Lipitor 20 mg daily. Hydralazine 25 mg TID, Keppra 500 mg BID, Lisinopril 40 mg daily, Melatonin 10 mg at bedtime, Namenda 10 mg BID, Zofran 4 mg q.6h PRN, Plavix 75 mg daily, Seroquel 25 mg BID. The patient is examined and plans are reviewed. Prognosis is unchanged. Full code status.	
07/06/YYYY	Hospital/ Provider Name	**Follow-up Visit:** **Nursing Home Visit:** The patient with dementia in the Secure Unit. Recently noted to have some instability and discomfort in the right ankle, he had a fall. No acute injuries. He is fairly comfortable at the present time. He is known to have remote brain injury, dementia, cognitive impairment, hypertension, osteoarthritis. No GI or GU incontinence. No new skin breakdown.	5387-5388

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Physical examination: **General:** Today, the patient is sitting in the wheelchair. Appears pale. No jaundice or petechiae. **Vital signs:** Temperature 98, heart rate 76, respirations 16, blood pressure 116/70. **Musculoskeletal:** He does have some minimal swelling on the right ankle. Strength and range of motion fairly good. Peripheral pulses are okay. No focal neurologic deficits. No meningeal signs. No skin breakdown. **Diagnostic impression:** • Weakness, right ankle. • Fall. • Dementia with cognitive impairment. • Remote brain injury. • Hypertension. • Diabetes. • Alcoholism by history. • Osteoarthritis. **Plan:** We will get an X-ray of the right knee. Monitor for strength. Encourage range of motion. Full code status. Continue Tylenol 650 q.4h, Aspirin 81 mg, Lipitor 20 mg daily, Hydralazine 25 TID, Keppra 500 BID, Lisinopril 40 mg daily, Melatonin 10 mg at bedtime, Namenda 10 BID, Plavix 75 mg daily, Seroquel 25 mg BID. The patient is examined. Plans are reviewed. Prognosis unchanged. Await X-ray report.	
07/06/YYYY	Hospital/ Provider Name	**@ 2256 hours: X-Ray of Right Ankle:** **Ordering provider:** XXX, M.D. **Conclusion:** Intact right ankle.	5405, 3403-3404
08/20/YYYY-MM/DD/YYYY	Hospital/ Provider Name	**Narrative nursing notes:** Resident was monitored periodically. He received ADL care, medication management, incontinent care, and nutrition care. He also had regular physician evaluation for his medical management. He had episodes of physical and verbal altercations and combative behaviors. He also had episodes of confusion and agitation, and aggressive behaviors with other residents and staff nurse. He received physical therapy and occupational therapy. He also underwent ER visits and hospitalization visits for management of fall, AMS, seizure like activity. He was noted to be COVID positive on January 05, YYYY.	1144-1181, 3915-3949, 5229-5246
MM/DD/YYYY	Hospital/ Provider Name	**Nursing Notes:** This Nurse was doing rounds on 500 Hall, when she looked through the blinds and saw this resident lying in the Sun face up. Nurse started yelling to other Nurses to call 911 and rushed out to resident. Resident was unresponsive, Body was heated and he had apparently been outside for a while. BP-95/57mmHg, pr-89, RR-24. 911 arrived in 6minutes and resident was taken to the ER. **Reviewer's Comments: The corresponding EMS report is not available for review.*	5229-5230

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
MM/DD/YYYY	Hospital/ Provider Name	**@ 1550 hours: Transfer Notification:** Patient was transferred to a hospital on MM/DD/YYYY at 1550 hours related to unresponsive patient.	5229
MM/DD/YYYY	Hospital/ Provider Name	**Discharge Note:** **Brief history:** Resident on male secure unit was found non-responsive out in the secure yard sent to ER via 911. **Pertinent physical and laboratory findings:** Non-responsive **Course of treatment:** Resident sent to ER via 911 for treatment. Resident then sent to another facility in Midland at time of hospital DC. **Condition on discharge:** Poor **Rehabilitative potential:** Fair **Follow-up and discharge medication:** None	5195
MM/DD/YYYY	Hospital/ Provider Name	**Transfer Note:** **Reason for transfer:** **Where is the resident transferring to?** Hospital **What hospital?** ABC Center Hospital **Describe the reason for transfer:** Unresponsive patient **Date and time of transfer:** MM/DD/YYYY at 1550 hours **Vitals:** BP: 95/57, temperature: 98.4F, pulse: 89, RR: 24, O2 sat: 95.0%, glucose: 256.0 **Current resident status:** **Current primary diagnosis:** Dementia **Level of consciousness:** Lethargic **Orientation:** Person **Communication:** Clear speech **Date of last BM:** MM/DD/YYYY **ADL assistance:** **Bathing, dressing:** 1 person assist **Transfers, toileting, ambulation, eating:** Independent **What is the resident's weight bearing status?** Full weight bearing **Swallowing problem?** No **Diet type:** Regular **Fluids:** Regular **Is the resident's current status different from their baseline?** No **Resident baseline status:** The resident's current status in section 3 is the same as their baseline. **Behaviors:** **Does the resident have any of the following advanced directives?** None of the above **Special treatments and precautions:**	5197-5201

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		The resident is at risk for the following: Elopement, seizures **Does the resident have any infection control precautions?** No special precautions **Devices used by the resident:** **Select all the devices normally used by the resident** Other. None is being used **Contact information:** **Primary physician:** Dr. XXX	
08/20/YYYY-MM/DD/YYYY	Hospital/ Provider Name	**Related records:** Cover pages, admission record, transfer report, assessment, medication sheets, orders, weight records/vital signs, nursing daily assessment, minimum data set, nutritional assessment, plan of care, ADL/PCR sheet, physical therapy records, occupational therapy records, nursing notes/records, labs, others. ***PDF Ref:*** *1-1143, 1182-1253, 1256-3914, 3950-4135, 4147-4182, 4188-5228* **Reviewer's Comments: All the significant details are included in the chronology. These records have been reviewed and do not contain any significant information. Hence they are not elaborated.*	
		ABC Center Hospital ***MM/DD/YYYY-07/29/YYYY***	
MM/DD/YYYY	Hospital/ Provider Name	**@ 1611 hours: ER Physician Record:** **Chief complaint:** Patient found outside of Sienna nursing home in the grass, reports minimum of an hour from staff **History of present illness:** 66-year-old male brought in by EMS code 3 for altered mental status. Patient is a resident at Siena nursing home. Per EMS the patient had been taken outside in his wheelchair by staff around 2 PM to get some fresh air. Apparently staff forgot about the patient for at least 2 hours, and when they went to check on him he was found lying on the ground next to his wheelchair unconscious. EMS arrived to find the patient hypotensive, tachycardic, and hyperthermic. EMS started a line and initiated fluids and brought the patient here emergently. Upon arrival the patient has a GCS of 3, no gag, this demonstrated agonal respirations. Patient intubated shortly after arrival. Per nursing home records he is a full code. History and physical exam limited due to patient's clinical condition. **Review of systems:** Unable to obtain adequate review of systems due to patient's clinical condition **Physical examination:** **Vitals:** Temperature: 95.5 F, HR: 76, RR: 25, BP: 92/71 (99/55), SpO2: 100% Height: 178 cm, weight: 76.4 kg, BMI: 24.1 **Nursing assessment reviewed.** Vitals reviewed.	5681-5689

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		General appearance: Well developed, well-nourished, hot, obtunded, GCS 3 **HEENT:** Normocephalic, atraumatic. Pupils equal, round, and reactive to light, extraocular muscles intact. Pharynx normal. No oral lesions. Dry mucous membranes. **Neck:** Normal inspection, no thyromegaly, no lymphadenopathy. Neck supple. C-collar in place **Respiratory:** Chest nontender. No respiratory distress. Breath sounds clear and equal bilaterally. **Cardiovascular:** Tachycardia. No murmurs, rubs, or gallops. Strong distal pulses with good perfusion. **Abdomen:** Soft, nontender, nondistended. No organomegaly. No palpable masses. Normal bowel sounds. **Back:** Normal inspection, no CVA tenderness. **Skin:** Warm, dry, and intact.. No embolic lesions. No petechiae. **Extremities:** Nontender, full range of motion, no calf tenderness. No pedal edema **Neuro:** GCS 3. No purposeful movements noted *Labs and images reviewed.* **Medical decision making:** Patient intubated shortly after arrival for airway protection. 2 L of cold fluids were initiated and aggressive cooling measures started. Patient started on Levophed due to persistent hypotension after 2 L fluid bolus and left central line placed. Patient has been cooled considerably, core temp now 100.0. Arterial line placed on the right wrist. Heart rate now 105 with blood pressure 119/81. Will admit to ICU for further management. **Assessment/Plan** • Hyperthermia associated with heat • Acute renal failure • Unresponsive **Orders:** Norepinephrine 4 mg [2 mcg/min] + Premix Dextrose 5% in Water 250 mL, IV Drip Order Rate: 7.5 mL/hr Starting Rate: 2 mcg/min Max Rate: 200 mcg/min Titrate Instructions: Titrate by 5 mCg/min every 5 minutes, MAP >/= 65 mmHg Order Weight: 87.9 kg Start Date: MM/DD/YYYY 16:35:00 CDT, Total Volume (mL): 250 Propofol 1,000 mg [2 mg/kg/hr] + premix 100 mL, IV Drip Order Rate: 17.58 mL/hr Starting Rate: 2 mg/kg/hr Max Rate: 5 mg/kg/hr Titrate Instructions: Titrate by 1 mg/kg/hr every 5 minutes to target RASS; Order Weight: 87.9 kg Start Date: MM/DD/YYYY 16:37:00 CDT Target RASS -1 to -2, Total Volume (mL) Request for Admit.	
MM/DD/YYYY	Hospital/ Provider Name	**@ 1616 hours: Labs:** **High:** Glucose: 138, creatinine: 2.0, potassium: 110, anion gap: 20, lipase: 131, proBNP: 342, PT: 17.1, MPV: 12.8, lymphocyte auto: 50, lymphocyte absolute:	5773-5775, 5778

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		4.9, monocyte absolute: 0.7 **Low:** CO2: 14, calcium: 8.6, total protein: 5.8, EGFR AA: 40.48, EGFR non-AA: 33.40, RBC: 4.14, hemoglobin: 12.8, hematocrit: 38.0 **Normal:** INR: 1.41, PTT: 31.2, WBC: 9.7	
MM/DD/YYYY	Hospital/ Provider Name	**@ 1638 hours: Urinalysis:** **Abnormal:** pH: 6.0 Specific gravity: 1.020 Protein: 30 Urobilinogen: 2 RBC: 7	5779
MM/DD/YYYY	Hospital/ Provider Name	**@ 1643 hours: X-Ray of Chest:** **Ordering provider:** XXX, M.D. **Clinical information:** Chest pain Comparison is made to December 19, YYYY. Heart size normal. ET tube and orogastric tube have been present on good position. The lungs remain clear. There is no effusion or pneumothorax. **Impression:** • ET tube and orogastric tube are in good position. • No active cardiopulmonary disease.	5767
MM/DD/YYYY	Hospital/ Provider Name	**@ 1710 hours: ABG:** **High:** PO2: 346.0, SO2: 100 **Low:** PCO2: 27.7, HCO3: 16.3, TCO2: 17	5769
MM/DD/YYYY	Hospital/ Provider Name	**@ 1731 hours: X-Ray of Chest:** **Ordering Physician:** XXX, M.D. **Clinical information:** Line placement **Comparison:** Comparison is made to the exam of the same day obtained at 4:45 PM. Support lines and tubes remain in place with addition of a left subclavian central venous line. It terminates in lower SVC. There is no pneumothorax. The lungs remain clear. **Impression:** There has been interval addition of a well-positioned central line. There is no pneumothorax. There has been no other change.	5767
MM/DD/YYYY	Hospital/ Provider Name	**@ 1915 hours: Labs:** **High:** Lactic acid: 5.5	5773-5774
MM/DD/YYYY	Hospital/ Provider Name	**@ 1958 hours: CT of Cervical Spine without Contrast:** **Ordering physician:** XXX, M.D. **Clinical information:** Trauma **Findings:** ET tube and orogastric tube are present. There is no fracture or dislocation. There is mild osteopenia. There has been no change since the exam of July 19, YYYY. There are stable degenerative changes. At C3-C4, there is mild-to-moderate	5760-5761

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		foraminal narrowing due to moderate uncinate hypertrophy. There is also mild central stenosis. At C4-C5 there is mild uncinate and mild to moderate facet hypertrophy with moderate bilateral foraminal narrowing and mild central stenosis. At C5-C6 there is moderate posterior annular bulging and osteophytic ridging with anterior osteophytes. There are moderate degenerative uncinate changes. There is mild to moderate left and moderate to severe right foraminal narrowing. There is mild central stenosis. At C6-C7, there is mild posterior annular bulging. **Impression:** • No fracture or dislocation. • Probable osteopenia. • Stable degenerative changes since July 19, YYYY as described. • ET tube and orogastric tube present.	
MM/DD/YYYY	Hospital/ Provider Name	**@ 1958 hours: CT of Head/Brain without Contrast:** **Ordering physician:** XXX, M.D. **Clinical information:** Altered level of consciousness **Findings:** The calvarium, skull base, orbits and the visualized paranasal and mastoid sinuses are unremarkable. There is no extra-axial fluid collection, mass effect, midline shift or intracranial hemorrhage. No acute infarct is demonstrated. Please note that a hyperacute infarct may be occult by CT. The posterior fossa is unremarkable. There is no mass or cyst. There is no suggestion of chronic ischemic disease of any significance. There is mild volume loss at the age of 66. **Impression:** • No acute abnormality. • Mild volume loss at the age of 66. • No significant change since MRI of December 19, YYYY.	5760
MM/DD/YYYY	Hospital/ Provider Name	**@ 2109 hours: ABG:** **High:** PO2: 161.0, SO2: 99 **Low:** pH: 7.307, PCO2: 27.4, HCO3: 13.7, TCO2: 15	5769
MM/DD/YYYY	Hospital/ Provider Name	**@ 2140 hours: Labs:** **High:** Glucose: 179, BUN: 25, creatinine: 2.0, chloride: 114, anion gap: 15, lactic acid: 5.1, CK: 617 **Low:** Potassium: 3.4, CO2: 14, calcium: 7.7, EGFR AA: 39.80, EGFR non-AA: 32.84, phosphorus: < 0.4	5773, 5775
MM/DD/YYYY	Hospital/ Provider Name	**TTCC Admission History and Physical:** **PCP:** Sienna nursing home resident, Dr. XXX **Code status:** Full code, patient is unable to answer, tried to contact the daughter but unable to **Source of information:** EMR and nursing staff **Chief complaint:** Altered mental status **History of present illness:**	5689-5694

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		Patient is a 66-year-old male nursing home resident with past medical history of dementia, diabetes mellitus, impaired mobility, hypertension, history of seizures when taken by EMS to ED for altered mental status. Per nursing staff patient was taken to the outside on wheelchair, but he was forgotten for unknown period of time. Patient was found lying on the grass. EMS took the patient to ED. History is limited because patient is intubated/sedated, tried to contact daughter but unfortunately was not able to **ED course:** On arrival to ED blood pressure was 76/54, heart rate was 144, temperature was 107 Fahrenheit, respiratory rate 30, saturation 98% Patient was unresponsive, GCS less than 6 Patient was intubated, central line was placed, A-line was placed, rapid ice water immersion was done which was later transitioned to cooling blanket Patient was given LR 1 L bolus **Review of systems:** Unable to assess **Physical examination:** **At 2006 hours: Vitals:** BP: 123/74, BP invasive: 119/69, HR monitored: 88, RR: 36, MAP: 90, MAP invasive: 84 **At 1608 hours:** Temperature: 41.3 C, pulse: 144 **At 1935 hours:** Temperature: 97 F **At 2032 hours:** Height: 178 cm, weight: 76.4 kg, BMI: 24.1, BSA measured - Hemodynamic: 1.9 **Physical examination:** **General:** Caucasian male intubated sedated **Eyes:** Pupils sluggishly reactive **HENT:** No scleral icterus, no sinus tenderness. **Neck:** No JVD, no cervical lymphadenopathy. **Lungs:** Normal vesicular breath sounds bilaterally, no added sounds. **Heart:** S1, S2 normal, Normal rate, regular rhythm, no murmur, rub or gallop. **Abdomen:** Soft, non-tender, non-distended, normal bowel sounds, no masses. **Skin:** Skin is warm, dry and pink, no rashes or lesions. **Musculoskeletal:** Unable to assess, no tenderness or swelling. **Neurologic:** Intubated sedated *Images reviewed.* **Assessment:** **Acute:** • Altered mental status 2/2 heatstroke • Acute hypoxic hypercapnic respiratory failure 2/2 intubated • Increased anion gap metabolic acidosis 2/2 lactic acidosis • Prerenal AKI on CKD Baseline creatinine 1-1.5	

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		Chronic: • Dementia • Diabetes mellitus • Impaired mobility • Hypertension • Nursing home resident • History of seizures • TIA **Plan:** Continue in the ICU under the care of IM TTUHSC. Attending physician Dr. XXX **Neuro:** • Neuro checks per protocol • RASS goal: • Sedation with Propofol and Precedex - titrate to achieve RASS and BPS goals • Breakthrough analgesia with Fentanyl • Seizure prophylaxis with Keppra 500 mg twice daily • Physical therapy consult **Respiratory:** • Intubated and respiratory support with CMV • Titrate FiO2 to achieve goal SpO2 of 91-94% • Aspiration precautions **Cardiovascular:** • MAP goal > 65 • Titrate Levophed to achieve MAP goal • Last echo in December YYYY, LVEF 60 to 65% ejection fraction mild LV systolic dysfunction • We will resume aspirin, because CT scan is negative for any bleed **GI:** • NPO for now • GI prophylaxis with Protonix **Renal:** • Strict Intake and output measurement • Replace electrolyte as needed • IVF NS / LR at 75 mL/h • Given 1 L bolus, follow CK if elevated can give more **ID:** • Patient was lying straight with unknown period of time,	

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		• Giving aspiration prophylaxis with Zosyn can DC if deemed necessary, sent LR culture **Endo:** • Check CBGs q4h + correctional scale + hypoglycemia protocol as needed **Heme:** • DVT prophylaxis with SCDs with Heparin	
07/20/YYYY	Hospital/ Provider Name	**@ 0042 hours: Gram stain report:** **Collected date:** MM/DD/YYYY at 1841 hours **Source:** Tracheal aspirate **Result:** • Rare gram positive cocci in pairs • Few gram negative bacilli • No polymorphonuclear cells seen	5781
07/20/YYYY	Hospital/ Provider Name	**@ 0302 hours: Labs:** **High:** Glucose: 218, BUN: 30, creatinine: 2.1, chloride: 110, anion gap: 14, AST: 91, lactic acid: 4.5, WBC: 13.8, MCH: 31.5, MPV: 12.5, neutrophil auto: 82, monocyte auto: 13, neutrophil absolute: 11.4, monocyte absolute: 1.8 **Low:** CO2: 17, chloride: 8.0, total protein: 5.6, albumin: 3.1, EGFR AA: 38.92, EGFR non-AA: 32.11, phosphorus: 0.8, RBC: 4.48, hematocrit: 40.7, platelets: 119, lymphocytes auto: 5, eosinophils auto: 0, lymphocyte absolute: 0.7 **Normal:** Hemoglobin: 14.1	5772, 5777
07/20/YYYY	Hospital/ Provider Name	**@ 0805 hours: ABG:** **High:** PO2: 177.0, SO2: 100 **Low:** PCO2: 28.9	5769
07/20/YYYY	Hospital/ Provider Name	**@ 0809 hours: Labs:** **High:** Glucose: 156, BUN: 30, creatinine: 1.9, chloride: 112, anion gap: 14, AST: 106, ALT: 73 **Low:** Potassium: 3.2, CO2: 16, calcium: 7.7, total protein: 5.0, albumin: 2.9, EGFR AA: 43.20, EGFR non-AA: 35.64	5771-5772
07/20/YYYY	Hospital/ Provider Name	**@ 0817 hours: X-Ray of Chest:** **Ordering provider:** Brian Griffin, NP **Clinical information:** ET tube placement **Comparison:** Single view chest dated 7/19/YYYY **Findings:** Endotracheal tube tip projects at the mid trachea. Enteric tube appears in good position. Left-sided CVC appears unchanged. No focal airspace consolidation is demonstrated. There is mild central bronchial wall thickening and hazy perihilar airspace disease. There is no evidence of pneumothorax. No large pleural effusion is demonstrated. Heart size and mediastinal silhouette appear unchanged. **Impression:** No significant interval change.	5765-5766

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07/20/YYYY	Hospital/ Provider Name	**@ 0848 hours: Critical Care Progress Notes:** **Subjective/Chief complaint:** Admitted yesterday from the emergency department following episode of altered mental status with hyperthermic etiology. Intubated yesterday due to mentation. No acute, critical events overnight. Hemodynamically unstable on low-dose Levophed to achieve MAP greater 65. Mechanically ventilated 45% FiO2 with a PEEP of 5. Propofol for sedation. Afebrile Leukocytosis Hemoglobin hematocrit stable Thrombocytopenia Hyperglycemia AKI on CKD Hyperchloremia High anion gap metabolic acidosis, lactic Corrected calcium normal Hypoproteinemia Hypoalbuminemia Transaminitis, ALT 91 from 23 Hypophosphatemia **Brief course hospital stay** Patient is a 66-year-old male nursing home resident with past medical history of dementia, diabetes mellitus, impaired mobility, hypertension, history of seizures when taken by EMS to ED for altered mental status. Per nursing staff patient was taken to the outside on wheelchair, but he was forgotten for unknown period of time. Patient was found lying on the grass. EMS took the patient to ED. Altered mental status while in the ED subsequently patient was intubated. CT of the head negative. Transferred to ICU for further management of hyperthermia. **Vitals:** Temperature: 98.6F, HR: 68, RR: 21, BP: 124/80, BP (Line): 133/69, SpO2: 100%, height: 178 cm, weight: 76.4 kg, BMI: 24.1 **Physical examination:** **General:** Caucasian male intubated sedated **Eyes:** Pupils sluggishly reactive **Musculoskeletal:** Unable to assess, no tenderness or swelling. **Neurologic:** Intubated sedated *Labs and images reviewed.* **Assessment/Plan:** • Hyperthermia associated with heat • Acute renal failure • Unresponsive	5749-5758

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Orders: Dexmedetomidine 400 mcg [0.2 mcg/kg/hr] + Premix Sodium Chloride 0.9% 100 mL, IV Drip Order Rate: 3.82 mL/hr Starting Rate: 0.2 mcg/kg/hr Max Rate: 1.5 mcg/kg/hr Titrate Instructions: Titrate by 0.2 mCg/kg/hr every 5 mins to a target RASS Order Weight: 76.4 kg Start Date: 07/20/22 7:28:00 CDT Target RASS 0 to -1, Total Volume Arterial Blood Gas w/o Co-Ox POC XR Chest 1 View Frontal **Plan:** Continue in the ICU under the care of IM TTUHSC. Attending physician Dr. XXX **Neuro:** • Neuro checks per protocol • Propofol for sedation • RASS goal: 0 to -1 • SAT, patient responds to pain but does not follow commands • Breakthrough analgesia with Fentanyl • Seizure prophylaxis with Keppra 500 mg twice daily • Physical therapy consult **Respiratory:** • Maintain oxygen saturations greater than 92% • Vent bundle • AC/400/45%/PEEP of 5 • ABG 7.43/29/170/3 • Decreased FiO2 35% • LTVV • SBT 35% 8/5 • Titrate FiO2 to achieve goal SpO2 of 91-94% • Aspiration precautions **Cardiovascular:** • MAP goal > 65 • Levophed DC'd this a.m. after propofol turned off • Last echo in December YYYY, LVEF 60 to 65% ejection fraction mild LV systolic dysfunction • ASA • Hold Atorvastatin **GI:** • NPO for now • GI prophylaxis with Protonix **Renal:**	

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		• Strict Intake and output measurement • AKI on CKD • Oliguria 250 mL last 24 hours • Replace electrolyte as needed • Hypokalemia • Hypophosphatemia • 30 mmol of K-Phos • 20 mEq potassium chloride IV • IVF NS / LR at 125 mL/h • CK 680; will continue to try to clear CK with intermittent fluid boluses • 1.5 L bolus LR • BMP, mag and Phos q. 6 **ID:** • Leukocytosis, no bandemia, hemodynamically stable without any vasoactive medication, afebrile • Pancultures with no growth • Zosyn day 2, no indication for infection at this point in time but will continue Zosyn for 1 more day • Chest X-ray shows no suspicion for aspiration pneumonia **Endo:** • Check CBGs q4h + correctional scale + hypoglycemia protocol as needed • CBGs ranged from 138-179 requiring 3 units correctional sliding scale insulin • TSH normal **Heme:** • DVT prophylaxis with SCDs with Heparin *XXX, M.D.* **Addendum:** The patient was seen and examined during am ICU rounds • I personally reviewed all available clinical data, all labs and imaging. • I was physically present during the key and critical portions of PE and the service to include history, events, exam and plan, when performed by the resident, • I directly participated in the management of this patient as noted in the noted, treatment and plan • I personally formulated pt's plan of care and d/w ICU rounding team, bedside RT and RN+ICU PharmD during am multi-disciplinary rounds • I personally made necessary adjustments on Vent to improve the patient - vent synchrony and oxygenation. • Mechanical ventilation in accordance with the latest evidence-based medicine • Low tidal volume with a lung protective strategy 6 cc/kg ideal body	

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		weight • Peak and plateau airway pressure target less than 30 • SPO2 target 92% + wean FiO2 for lowest to maintain it • Empiric coverage Broad - Spectrum Abx Rx is warranted • Sedation analgesia protocols • DVT/GI prophylaxis • Further data, please see ICU resident progress note above • I have reviewed all, documented by the resident and I agree with A/P and PE • I attest to note above Heat stroke, AMS, Acute hypoxemic respiratory failure, AKI Agree with above Vent support wean as tolerated IVF Monitor renal function	
07/20/YYYY	Hospital/ Provider Name	**@ 1015 hours: Wound Care Nurse's Note:** Unable to perform skin assessment due to patient having echocardiogram done at bed side. Admission pictures in chart. Patient to be repositioned Q2H per protocol.	5759
07/20/YYYY	Hospital/ Provider Name	**@ 1020 hours: Labs:** **High:** CK: 638	5775
07/20/YYYY	Hospital/ Provider Name	**@ 1606 hours: ABG:** **High:** PO2: 115.0, SO2: 99 **Low:** PCO2: 26.4, HCO3: 17.4, TCO2: 18	5769
07/20/YYYY	Hospital/ Provider Name	**@ 1842 hours: Labs:** **High:** Glucose: 120, BUN: 26, creatinine: 1.8, chloride: 110, anion gap: 15 **Low:** CO2: 16, calcium: 7.7, EGFR AA: 44.55, EGFR non-AA: 36.76	5771-5772
07/20/YYYY	Hospital/ Provider Name	**@ 2302 hours: Labs:** **High:** Phosphorus: 5.1	5771-5772
07/21/YYYY	Hospital/ Provider Name	**@ 0340 hours: Labs:** **High:** Creatinine: 1.7, chloride: 110, AST: 472, ALT: 604, total bilirubin: 1.3, phosphorus: 4.7, WBC: 12.6, MPV: 12.8, neutrophil auto: 81, neutrophil absolute: 12.4, monocyte absolute: 1.2 **Low:** CO2: 19, calcium: 7.6, total protein: 4.8, albumin: 2.8, EGFR AA: 49.79, EGFR non-AA: 41.08, RBC: 3.90, hemoglobin: 12.0, hematocrit: 35.7, platelets: 77, lymphocyte auto: 10, eosinophil auto: 0	5770-5771, 5777
07/21/YYYY	Hospital/ Provider Name	**@ 0450 hours: ABG:** **High:** PO2: 106.0 **Low:** PCO2: 31.1	5769
07/21/YYYY	Hospital/ Provider Name	**@ 0505 hours: X-Ray of Chest:** **Ordering physician:** XXX, M.D. **Clinical information:** Difficulty breathing **Comparison:** Single view chest dated 07/20/YYYY	5765

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Findings: Endotracheal tube tip projects at the mid trachea. Enteric tube descends below the inferior margin of image. Left subclavian CVC appears unchanged. There may be underlying emphysema and there is residual mild hazy perihilar and basilar airspace disease, probably atelectasis. There is no evidence of pneumothorax or pleural effusion. Heart size and mediastinal silhouette appear unchanged. **Impression:** No significant interval change.	
07/21/YYYY	Hospital/ Provider Name	**@ 0653 hours: Labs:** **High:** CK: 1765	5775
07/21/YYYY	Hospital/ Provider Name	**@ 0734 hours: Lower Respiratory Culture Report:** **Collected date:** MM/DD/YYYY at 1841 hours **Source:** Tracheal aspirate **Final report:** • Rare Escherichia coli • Moderate normal oropharyngeal flora **Susceptibility for Escherichia coli:** Amikacin, Ampicillin, Ampicillin/Sulbactam, Aztreonam, Cefazolin, Cefepime, Ceftriaxone, Cefuroxime, Ciprofloxacin, Gentamicin, Levofloxacin, Meropenem, Piperacillin/Tazobactam, Tetracycline, Tobramycin, Trimethoprim/Sulfa	5781-5782
07/21/YYYY	Hospital/ Provider Name	**@ 0945 hours: Nutrition Notes:** **Nutrition Risk Level:** High **Assessment and Monitoring:** **Reason for visit:** Length of stay **Reason for admit:** Taken by EMS to ED for altered mental status **Dx:** Altered mental status 2/2 heatstroke, acute hypoxic hypercapnic respiratory failure 2/2 intubated, Increased anion gap metabolic acidosis 2/2 lactic acidosis, Prerenal AKI on CKD **Past medical history:** Dementia, diabetes mellitus, impaired mobility, hypertension, history of seizures, Sienna nursing home resident Per H&P note pt was taken outside Sienna nursing home on wheelchair but he was forgotten for unknown period of time. Pt was found lying on the grass, brought by EMS to ED. History is limited because patient is intubated/sedated, tried to contact daughter but unfortunately was not able to. On arrival to ED blood pressure was 76/54, heart rate was 144, temperature was 107 Fahrenheit, respiratory rate 30, saturation 98%. Pt was unresponsive, GCS less than 6. Pt was intubated, central line was placed, A-line was placed, rapid ice water immersion was done which was later transitioned to cooling blanket. Pt was given LR 1 L bolus. As on 07/20/YYYY-patient was not responding to pain/verbal commands, continues to	5728-5730

MEDACUITY LLC

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		be intubated, had a temperature of 102 °F, cooling blanket was used. 07/21/YYYY pt had an episode of seizures with opening of eyes, diazepam IV was given, started on Propofol drip, EEG and MRI brain were ordered, started on prophylactic antibiotics for meningitis, consulted neurologist Dr. XXX. Pt is currently hemodynamically unstable, intubated and sedated, on NPO day 3. **RD/Intern visit:** Discussed with pt nurse the plan of care for the pt moving forward with neurologic concerns. Pt was started on Propofol during rounds when they appeared to have a seizure episode. Pt will likely continue to be sedated and intubated. Informed nurse following that we could put in EN recommendations. **Diet Order:** NPO **Last BM:** 07/20/YYYY **Labs:** BG: 95, CBG: 86 - 97, HbA1c: 5.8, Cr: 1.7 (H), BUN: 22, eGFR: 49.79 (L), Na, K, Mg WNL, Phos: 4.7 (H), AST: 472 (H), ALT: 604 (H), bili: 1.3 (H), Cl: 110 (H), Ca: 7.6 (L) **Meds:** Insulin, antibiotics, Protonix, heparin, Mg sulfate PRN, KCl PRN, lactated ringers drip 125mL/hr, propofol at 19.1mL/hr (provides 504kcal in 24hrs) **BR:** 12 **Skin:** Blister/tear to upper right arm, tear to left calf, blister to right heel **Edema:** None **I/O:** 4536.05/2028 (+2508.05mL) 24hr GI tube (NG/OG) output 225mL **Nutrition Diagnosis** Altered nutrition related lab values related to AKI on CKD as evidenced by Cr: 1.7 (H), BUN: 22, eGFR: 49.79 (L), Phos: 4.7 (H). - new Inadequate protein and energy intake related to NPO status as evidenced by 0% estimated needs met. - new Increased protein needs related to critical illness as evidenced by estimated protein needs of 1.2-2g/kg. - new **Nutrition Goals:** Maintain lean body mass Comply with MNT during admission Intakes to meet greater than 75% of est. needs Maintain body weight +/-1% Maintain BG within 100-180mg/dL during admit. **Nutrition Interventions/Education** Monitor intake, weight, skin, and labs Recommend initiation of EN as soon as medically feasible Monitor for tolerance of EN; vomiting, abdominal distention, diarrhea (5+ stools or greater than 750mL in 24hr), constipation, GRV greater than 500mL	

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		No education needs at this time **Estimated Needs** Kcal: PSU 1959 (MSJ 1556kcal, Ve: 10.7L/min, Tmax: 38 degrees celsius) - 26 kcal/kg Protein: 91-152g - 1.2-2g/kg Fluid: 1910mL (25mL/kg for adults over 65) or per MD **Anthropometrics** Height/Length Measured: 178 cm (MM/DD/YYYY at 2032 hours) Dosing weight: 76.4kg Daily weight: 79.2kg BMI: 24.1 IBW: 75.5kg %IBW: 101.2% **Nutrition Recommendations:** Recommend initiation of EN infusions as soon as medically feasible If EN infusions are initiated then recommend Vital High Protein at trophic rate to advance as tolerated to goal rate of 60mL/hr (1440mL) with 30mL water flush q4 Recommendation provides 1440kcal (1944kcal with propofol), 126g protein, and 1203mL free water (1383mL total fluids) to meet greater than 90% of estimated needs Monitor for tolerance of EN; vomiting, abdominal distention, diarrhea (5+ stools or greater than 750mL in 24hr), constipation, GRV greater than 500mL **Disposition planning:** Dependent on pt clinical improvement.	
07/21/YYYY	Hospital/ Provider Name	**@ 1027 hours: Critical Care Progress Notes:** **Subjective** The patient was seen and examined at the bed side with the attending physician during the morning rounds and considerable amount was spent in evaluation and assessment. Overnight patient has been agitated, started on Precedex, had hypotension, Precedex drip discontinued, started on Levophed which was discontinued today morning at 3 AM Patient is spontaneously opening eyes, moving extremities, withdrawing extremities to pain, on SBT trial BiPAP 8/5, 35% FiO2 Patient had an episode of seizures during the rounds, out-rolling of eyes, started on Propofol drip, consulted Dr. XXX Patient had a T-max of 102 °F yesterday, managed with cooling blanket Sputum cultures grew E. coli, started on Ceftriaxone Vitals hemodynamically stable with heart rate 96 blood pressure 132/90,	5716-5722

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		respiratory rate 18, maintaining saturation 97% on BiPAP ABG-7.43/31.1/106/98 on AC/CMV-18/420/35/5 **Labs reviewed:** CBC shows low platelet count 77 from 119, probable heparin-induced thrombocytopenia CMP shows hypokalemia potassium 3.7, hypomagnesemia magnesium 1.7, improving renal function with creatinine 1.7 from 2.1 LFT shows bilirubin 1.3 Creatinine kinase increased to 1735 from 650 CBGs ranging between 86-1 20 Sputum cultures growing E. coli, pansensitive Blood cultures-negative Chest X-ray-normal **Brief Hospital course:** A 66-year-old male, nursing home resident with PMH dementia, diabetes mellitus, impaired mobility, hypertension, history of seizures was brought to ED for altered mental status. Per nursing staff patient was taken to the outside on wheelchair, but he was forgotten for unknown period of time. At the time of admission, patient's temperature was 107 °F, GCS less than 6, intubated, central line was placed, A-line was placed, rapid ice water immersion was done which was later transitioned to cooling blanket Patient had mild coagulopathy with INR 1.4, elevated creatinine kinase. As on 07/20/YYYY - Patient was not responding to pain/verbal commands, continues to be intubated, had a temperature of 102 °F, cooling blanket was used. Has on 07/21/YYYY - Patient had an episode of seizures with opening of eyes, Diazepam IV was given, started on Propofol drip, EEG and MRI brain were ordered, started on prophylactic antibiotics for meningitis, consulted neurologist Dr. XXX. Patient is a 66-year-old male nursing home resident with past medical history of dementia, diabetes mellitus, impaired mobility, hypertension, history of seizures when taken by EMS to ED for altered mental status. **Objective** **General:** Caucasian male, intubated, spontaneous eye opening **Eyes:** Pupils sluggishly reactive **Musculoskeletal:** Withdrawing extremities to pain **Neurologic:** Intubated, spontaneous eye opening, squeezing fingers on verbal command, withdrawing extremities to pain **Vitals:** Temperature: 100.2F, HR: 96, RR: 21, BP: 152/88, BP (Line): 152/70, SpO2: 99%, height: 178 cm, weight: 76.4 kg, BMI: 24.1 *Labs and images reviewed.* **Assessment/Plan:**	

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Acute: • Altered mental status 2/2 heatstroke • Seizures 2/2 above • Acute hypoxic hypercapnic respiratory failure 2/2 intubated • Sputum cultures growing E. coli, pansensitive • Increased anion gap metabolic acidosis 2/2 lactic acidosis-improving • Prerenal AKI on CKD Baseline creatinine 1-1.5-improving • Elevated creatinine kinase 2/2 rhabdomyolysis 2/2 above **Plan:** **Neuro:** • Neuro checks per protocol • RASS goal: • Sedation with Propofol • Breakthrough analgesia with Fentanyl • Seizure prophylaxis with Keppra 500 mg twice daily • Physical therapy consulted • Order EEG, MRI brain without contrast • Diazepam 10 Mg IV every 10 minutes for a maximum of 30 Mg for seizures • Consulted neurologist, Dr. XXX • Started empiric antibiotics for meningitis-Ceftriaxone, Vancomycin, Ampicillin, Acyclovir **Cardiovascular:** • Continue Aspirin 81 mg daily. **Renal:** • IVF NS/LR at 125 ml/h • CK increased today, follow in AM **ID:** • Started on empiric antibiotics for meningitis-Ceftriaxone, Vancomycin, Ampicillin, Acyclovir-day 1 • Follow blood cultures, sputum cultures **Heme:** • DVT prophylaxis with SCDs • Heparin discontinued, probable HIT • Follow serotonin release assay Follow AM labs *XXX, M.D.* **Addendum:** Heat stroke, AMS, Acute hypoxemic respiratory failure, AKI Seizure episode propofol started, EEG, stat MRI, neuro consult	

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Vent support IVF Monitor renal function Expand ABX to CNS dosing Remains critical not ready for CPAP *Others remain same.*	
07/21/YYYY	Hospital/ Provider Name	**Electroencephalography:** **Referring Physician:** Dr. XXX **Reason for Procedure:** Mental status change, and single seizure. **Procedure Summary:** 30-minute EEG **Condition of Recording:** Intubated and sedated **Description:** Background rhythm was diffusely slow at some 4 cps and low amplitude at 25 µV. EKG appeared to be normal sinus rhythm. **Impression:** Abnormal EEG secondary to diffuse slowing and low amplitude compatible with encephalopathy but no evidence of any ongoing seizure activity.	5694
07/21/YYYY	Hospital/ Provider Name	**Electroencephalography:** **Referring Physician:** Dr. XXX **Reason for Procedure:** Mental status change **Procedure Summary:** 30-minute EEG **Condition of Recording:** Intubated **Description:** Background rhythm was diffusely slow at 4 cps and low amplitude of 25 µV. No paroxysmal activity or asymmetries were noted. EKG appeared to be sinus rhythm throughout. **Impression:** Abnormal EEG secondary to diffuse slowing and low amplitude compatible with encephalopathy.	5695
07/21/YYYY	Hospital/ Provider Name	**@ 1142 hours: Gram stain report:** **Collected date:** 07/21/YYYY at 1022 hours **Source:** Tracheal aspirate **Result:** • Rare polymorphonuclear leukocytes • No organisms seem	5780
07/21/YYYY	Hospital/ Provider Name	**@ 1143 hours: Vancomycin New Start Note:** **Indication:** Empiric, possible meningitis **Target trough:** 15-20 mcg/mL **Objective:** Height: 178 cm Weight: 76.4 kg BMI: 24.1 Micro: MM/DD/YYYY Sputum Culture - Pansensitive E.coli	5731-5732

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Loading dose: 1750 mg IV scheduled at 1200 on 7/21 **Initial ordered dose:** Pulse dosing **Pharmacokinetics:** Variable; AKI **Assessment:** WBC: 12.8 Temperature: Afebrile; Tmax 100.2 F SCr: 1.7 **Other Abx:** Acyclovir Ampicillin Ceftriaxone **Plan:** • Start Vancomycin pulse dosing to achieve an estimated trough of 15-20 mcg/mL. • Vancomycin random level is ordered for 0300 on 7/22. • Will follow patient clinically and make adjustments to Vancomycin dosing as necessary. • Please contact pharmacist with questions or concerns.	
07/21/YYYY	Hospital/ Provider Name	**@ 1601 hours: Wound Care Nurse's Notes:** R Heel Unstageable, L Heel DTI: Cleanse with ns then apply bacitracin to Xeroform and place on wound then cover with dry dressing. Nursing to change daily. Wound care to check patient daily. Bilateral Arms ruptured blisters: Cleanse with ns then apply foams. Nursing to change weekly.	5759
07/22/YYYY	Hospital/ Provider Name	**@ 0304 hours: Labs:** **High:** Creatinine: 1.5, chloride: 110, AST: 305, ALT: 577, CK: 1322, WBC: 14.7, MCH: 31.3, MPV: 12.8, neutrophil auto: 85, neutrophil absolute: 12.4, monocyte absolute: 1.2 **Low:** CO2: 20, calcium: 7.9, total protein: 5.5, albumin: 2.9, EGFR AA: 56.75, EGFR non-AA: 46.82, RBC: 4.03, hemoglobin: 12.6, hematocrit: 36.8, lymphocyte absolute: 1.0, Vancomycin level: 8.2	5770-5771, 5775, 5778
07/22/YYYY	Hospital/ Provider Name	**@ 0413 hours: ABG:** **Low:** PCO2: 32.9	5769
07/22/YYYY	Hospital/ Provider Name	**@ 0532 hours: X-Ray of Chest:** **Ordering physician:** XXX, M.D. **Clinical information:** Difficulty breathing **Comparison:** Frontal view of the chest dated July 21, YYYY. **Findings:** A single frontal view of the chest is submitted. Endotracheal tube, esophageal pH probe, left subclavian central venous catheter, and partially visualized enteric catheter coursing below the diaphragm with tip excluded from view remain in place. Monitor leads overlie the chest.	5764-5765

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		No pneumothorax is seen. A small left pleural effusion may be present. No definite new or increasing focal consolidation is identified. Cardiac silhouette and pulmonary vasculature appear similar. Osseous structures appear unchanged. **Impression:** Questionable small left pleural effusion. No definite new or increasing focal consolidation.	
07/22/YYYY	Hospital/ Provider Name	**@ 1029 hours: Neurology Progress Notes:** **Consult Reason:** Mental status change. **History of present illness:** Patient is a nursing home resident because of dementia. He was placed in his wheelchair and apparently wheeled to an outside area where he remained for prolonged period of time, and was later found on the ground unresponsive. He was brought to the emergency room where his initial temperature was noted to be 107. He was hypotensive at 76/54 and unresponsive. He was intubated to protect his airway and remained so. He did have a seizure in the emergency room and was loaded with Keppra and continues on 500 twice daily. He did undergo CT brain which was normal. His laboratory studies showed elevated CPK at 1765 liver enzymes were significantly elevated as well. He did undergo EEG read by myself which showed diffuse slowing and low amplitude at 4 cps 25 µV, but no evidence of any ongoing seizure activity. **Physical examination:** **Vitals:** Temperature: 98.6F, HR: 86, RR: 4, BP: 133/81, BP (line): 146/68, SpO2: 100%, height: 178 cm, weight: 76.4 kg, BMI: 24.1 Patient is intubated and sedated. When the sedation is decreased patient does have bilateral movements. Pupils are symmetric and sluggish and there is no evidence of localized neurologic deficit. **Assessment/Plan** • Hyperthermia associated with heat • Acute renal failure • Unresponsive **Impressions:** • Heat injury with severe hyperthermia and possible heatstroke. • Baseline dementia. • Single seizure on admission likely related to the acute injury. **Recommendations** • Would do MRI when possible to evaluate for any localized structural injury/stroke. • Continue Keppra 500 twice daily.	5722-5726
07/22/YYYY	Hospital/	**@ 1331 hours: Critical Care Progress Notes:**	5742-5749

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
	Provider Name	**Subjective/CC:** No acute, critical events overnight. No seizure activity noted on Propofol. Hemodynamically stable no vasoactive medication. Mechanically ventilated AC 45% PEEP of 5. Peak and plateau pressures below 20. And cannot extubate yesterday during spontaneous awakening trial patient had what seemed to be some seizure activity complicating extubation. Attempted to have the patient undergo MRI last night complicated by inability to satisfactorily fill out MRI checklist for patient safety. Attempts were made to contact family member /nursing home residence but unsuccessful. Therefore no MRI last night. Afebrile Leukocytosis Decrease in hemoglobin likely related to fluid Thrombocytopenia, stable AKI on CKD, improving Hyperchloremia Corrected calcium normal Hypoproteinemia Hypoalbuminemia Transaminitis downtrending CK downtrending **07/21/YYYY:** Sputum culture with few gram-negative bacilli susceptibility identification pending s rare normal oropharyngeal flora **MM/DD/YYYY:** Sputum culture with E. coli pansensitive patient on Ampicillin Chest X-ray with no obvious bilateral airspace disease, blunted hemidiaphragm. ET tube projects mid trachea. OGT tip below the level of diaphragm. No pneumothorax soft tissue gas or pneumomediastinum EEG shows diffuse slowing and low amplitude compatible with encephalopathy **Brief course hospital stay** *Reviewed.* EEG showed diffuse slowing and low amplitude compatible with encephalopathy. **Assessment/Plan:** **Neuro:** • MRI pending, able to obtain checklist. MRI scheduled for 1700. • EEG demonstrates slowing and low amplitude consistent with encephalopathy **Respiratory:** • No SBT today due to patient's history of seizure activity	

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		GI: • Trickle tube feeds **Renal:** • AKI on CKD, improving • Hyperchloremia • Corrected calcium normal **ID:** • Started empiric antibiotics for meningitis - Ceftriaxone, Vancomycin, Ampicillin, Acyclovir • Continue Rocephin • Continue Ampicillin • Continue Acyclovir • Continue Vancomycin **Endo:** • CBGs ranged from 95 requiring 3 units correctional sliding scale Insulin **Heme:** • Thrombocytopenia *XXX, M.D.* **Addendum:** Heat stroke, AMS, Acute hypoxemic respiratory failure, AKI Seizure episode resolved Pending MRI brain Vent support IVF Monitor renal function Expand ABX to CNS dosing Wean sedation as tolerated E.coli in sputum on appropriate ABX *Others remain same.*	
07/22/YYYY	Hospital/ Provider Name	**@ 1750 hours: MRI of Brain without Contrast:** **Ordering Physician:** XXX, M.D. **Reason for exam:** Seizure, abnormal neuro exam, other **Clinical information:** Seizures. **Comparison:** Cranial CT without IV contrast dated MM/DD/YYYY. **Findings:** Cerebral ventricles are symmetrical in configuration and appropriate in size for the patient's chronological age of 66. There is no evidence of intra-axial susceptibility lesions in the supratentorial or infratentorial compartments. Axial DWI trace images demonstrate no evidence of intra-axial restricted diffusion. ADC maps are normal. There is no evidence of hydrocephalus. Brainstem and cerebellum are unremarkable. Pituitary gland is physiologic. Optic chiasm and	5768

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		cisternal segments of bilateral optic nerves are normal. Bilateral mastoid effusions are demonstrated. Small quantity of fluid is noted in the nasopharynx, a normal finding in a patient on mechanical ventilation. **Impression:** • No evidence of intracranial pathology. • Bilateral mastoid effusions, likely due to mechanical ventilation and stasis of fluid in the nasopharynx.	
07/23/YYYY	Hospital/ Provider Name	**@ 0434 hours: Labs:** **High:** Glucose: 121, chloride: 111, AST: 153, ALT: 351, WBC: 11.9, MPV: 12.8, neutrophil auto: 84, neutrophil absolute: 10.1, monocyte absolute: 0.9 **Low:** Calcium: 7.6, total protein: 5.0, albumin: 2.5, phosphorus: 2.2, RBC: 3.45, hemoglobin: 10.6, hematocrit: 31.8, platelets: 64, lymphocytes auto: 8, eosinophil auto: 0, lymphocyte absolute: 0.9	5770-5771, 5777
07/23/YYYY	Hospital/ Provider Name	**@ 0508 hours: ABG:** **High:** PO2: 102.0 **Low:** PCO2: 34.8	5769
07/23/YYYY	Hospital/ Provider Name	**@ 0809 hours: X-Ray of Chest:** **Ordering Physician:** XXX, M.D. **Clinical indication:** Device placement; Patient HX: Ng tube placement. **Comparison:** CR XR chest 1 view frontal 07/21/YYYY at 0439 hours **Findings:** Tubes, catheters and devices: Left subclavian central venous line is in distal SVC. Endotracheal tube is above the carina. The feeding tube is difficult to visualize due to overlying object. There is around button like object which is now projected at the GE junction when compared to prior examination. The NG tube is difficult to see which was better seen on prior examination. Correlation with abdominal X-ray is recommended. **Lungs:** No consolidation in the right lung. Left lower lobe and lingular parenchymal infiltrate and consolidation with volume loss representing atelectasis versus pneumonia. **Pleural spaces:** Moderate left pleural effusion. **Heart/Mediastinum:** Enlarged cardiac silhouette. **Bones/joints:** Unremarkable. **Impression:** • The feeding tube is difficult to visualize due to overlying object. There is around button like object which is now projected at the GE junction when compared to prior examination. The NG tube is difficult to see which was better seen on prior examination. Correlation with abdominal x-ray is recommended. • Moderate left pleural effusion. • Left lower lobe and lingular parenchymal infiltrate and consolidation with volume loss representing atelectasis versus pneumonia.	5763-5764
07/23/YYYY	Hospital/ Provider	**@ 0901 hours: Lower Respiratory Culture Report:** **Collected date:** 07/21/YYYY at 1022 hours	5780

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
	Name	**Source:** Tracheal aspirate **Result:** • Few Klebsiella pneumoniae ESBL producing organism • Rare normal oropharyngeal flora **Susceptibility for Klebsiella pneumoniae:** Amikacin, Ciprofloxacin, Gentamicin, Levofloxacin, Meropenem, Piperacillin/Tazobactam, Tobramycin, Trimethoprim/Sulfa	
07/23/YYYY	Hospital/ Provider Name	**@ 0945 hours: Critical Care Progress Notes:** **Subjective:** No major overnight events have been reported. Nurse reported of 10-second seizure activity yesterday afternoon. Patient is wiggling toes to commands, not obeying any other commands, does not withdraw extremities to pain, does not open eyes spontaneously/to command , cough infection reflexes present 07/21/YYYY - Sputum cultures grew Klebsiella, ESBL, discontinued Ceftriaxone, started on Meropenem. Vitals hemodynamically stable with heart rate 64, blood pressure 111/70, respiratory rate 18, 97.8 °F, maintaining saturation 100% on AC/CMV ABG-7.42/34 point 8/102/90 8% on AC/CMV-18/420/30 percent/5, FiO2 decreased to 30% **Brief Hospital course:** As on 07/23/YYYY - Sputum cultures grew Klebsiella, ESBL, discontinued ceftriaxone, started on meropenem. Chest x-ray shows moderate left pleural effusion, left pleural consolidation/atelectasis. EEG showed diffuse slowing and low amplitude compatible with encephalopathy, MRI brain showed bilateral mastoid effusion, status of fluid in the nasopharynx, no acute intracranial abnormality. Patient neurological status continues to be the same, not responding to commands, not withdrawing to pain, not opening the eyes. **Objective:** **General:** Caucasian male, intubated, not opening eyes **Eyes:** Pupils briskly reactive **Lungs:** Left lower lobe decreased breath sounds, no added sounds. **Musculoskeletal:** Not withdrawing extremities to pain, occasionally wiggles toes on commands **Neurologic:** Intubated, no spontaneous eye opening, occasionally follows commands and wiggles toes **Vitals:** Temperature: 97.5F, HR: 54, RR: 18, BP: 111/70, BP (line): 118/65, SpO2: 100% Height: 178 cm, weight: 76.4 kg, BMI: 24.1 **Assessment/plan:** **Acute:** • Acute hypoxic hypercapnic respiratory failure 2/2 above s/p intubation	5709-5716

MEDACTY LLC

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		• Sputum cultures growing E. coli, Klebsiella-ESBL, 22 • Prerenal AKI on CKD Baseline creatinine 1-1.5-resolved • Thrombocytopenia 2/2 probable HIT **Plan:** Continue care with Texas tech critical care team, with attending Dr. XXX. **Neuro:** • Continue empiric antibiotics for meningitis - Vancomycin, Ampicillin, Acyclovir-day 3, ceftriaxone discontinued • Started on Meropenem for ESBL Klebsiella-day 1 **Respiratory:** • ABG and chest X-ray in AM **Renal:** • IVF NS / LR at 125 mL/h for rhabdomyolysis • Follow CK in AM **ID:** • Started on empiric antibiotics for meningitis - Vancomycin, Acyclovir-day 3 • Ceftriaxone and Ampicillin discontinued-on day 3 as her sputum cultures were growing ESBL Klebsiella • Started on Meropenem-day 1 **Endo:** • Check CBGs q4h + correctional scale + hypoglycemia protocol as needed *XXX, M.D.* **Addendum:** Heat stroke , AMS , Acute hypoxemic respiratory failure , AKI Seizure episode resolved Normal MRI brain Vent support IVF Monitor renal function Expand ABX to CNS dosing Off sedation E.coli MDRO change to meropenem Precedex as needed Very drowsy altered not following commands limiting extubation *Others remain same.*	
07/23/YYYY	Hospital/ Provider	**@ 1020 hours: X-Ray Chest:** **Ordering Physician:** XXX, M.D. **Clinical information:** Feeding tube placement	5762-5763

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
	Name	**Comparison:** Frontal view of the chest performed earlier the same day at 0757 hours. **Findings:** A single frontal view of the lower chest and upper abdomen is submitted. An enteric catheter is in place, with sidehole and tip overlying the region of the gastric body. Esophageal pH probe tip overlies the region of the distal thoracic esophagus. Vascular catheter tip overlies the cavoatrial region. The visualized lungs appear grossly similar to chest radiograph performed earlier the same day. The visualized abdomen demonstrates no definite pneumoperitoneum and a nonspecific bowel gas pattern. **Impression:** Enteric catheter sidehole and tip overlie the region of the gastric body.	
07/23/YYYY	Hospital/ Provider Name	**@ 1223 hours: Labs:** **High:** CK: 899	5775
07/24/YYYY	Hospital/ Provider Name	**@ 0311 hours: Labs:** **High:** Glucose: 112, chloride: 111, AST: 112, ALT: 243, CK: 641, neutrophil absolute: 7.5, monocyte absolute: 1.0 **Low:** Calcium: 7.4, total protein: 4.9, albumin: 2.5, phosphorus: 1.8, RBC: 3.37, hemoglobin: 10.6, hematocrit: 31.1, platelets: 76, lymphocytes auto: 10, lymphocyte absolute: 1.0 **Normal:** WBC: 9.6	5770, 5775-5777
07/24/YYYY	Hospital/ Provider Name	**@ 0504 hours: X-Ray of Chest:** **Ordering Physician:** XXX, M.D. **Clinical information:** Difficulty breathing **Comparison:** Frontal views of the chest dated July 23, YYYY. **Findings:** A single frontal view of the chest is submitted. Endotracheal tube and left subclavian central venous catheter remain in place. There has been slight interval retraction of the esophageal pH probe, with tip now overlying the region of the mid thoracic esophagus. An enteric catheter remains in place, coursing below the diaphragm with tip excluded from view. Monitor leads overlie the chest. No pneumothorax or significant increasing pleural effusion is seen. Aeration at the left lung base appears improved. No new or increasing consolidation is identified. Cardiac silhouette and pulmonary vasculature appear similar. Osseous structures appear unchanged. **Impression:** Improved aeration at the left lung base. No new or increasing consolidation.	5762

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
07/24/YYYY	Hospital/ Provider Name	**@ 0801 hours: Critical Care Progress Notes:** **Subjective:** The patient was seen and examined at the bed side with the attending physician during the morning rounds and considerable amount was spent in evaluation and assessment. No major overnight events have been reported. Patient is responding to verbal commands, opening eyes, moving all extremities Creatinine kinase downtrending, renal function improved, started on CPAP trial, discontinued Acyclovir, Vancomycin Vitals hemodynamically stable with heart rate 66, blood pressure 130/68, respiratory 18, temperature 98.8 °F, maintaining a saturation of 99% on AC/CMV heart rate 64, blood pressure 111/70, respiratory rate 18, 97.8 °F, maintaining saturation 100% on AC/CMV ABG-7.42/35 point 2/83/97% on AC/CMV-18/420/30 percent/5 **Labs reviewed:** CBC shows improving leukocytosis 9.6 11.1, hemoglobin stable at 10.6, platelet count improved from 64-76 CMP shows improved renal function with creatinine 1.1, LFTs improving AST 112 from 153, ALT 253 from 351, phosphorus 1.8 CK 641 from 899 CBGs ranging between 109-1 30 07/21/YYYY sputum cultures growing Klebsiella , ESBL 07/20/YYYY - Blood cultures - negative MM/DD/YYYY - Sputum cultures grew E. coli 07/23/YYYY - Chest X-ray shows mild pleural effusion on left 07/22/YYYY - MRI brain shows bilateral mastoid effusion, stasis of fluid in the nasopharynx, no acute intracranial abnormality 07/21/YYYY - EEG shows diffuse slowing and low amplitude compatible with encephalopathy **Brief hospital course:** AS on 07/24/YYYY, Patient is responding to verbal commands, opening eyes, moving all extremities, started on CPAP trial, discontinued Acyclovir, Vancomycin. **Objective:** **General:** Caucasian male, intubated, opening eyes on verbal commands **Musculoskeletal:** Moving all extremities on commands bilaterally, symmetrically **Neurologic:** Intubated, opening eyes on verbal commands, Moving all extremities on commands bilaterally, symmetrically **Vitals:** Temperature: 98.6F, HR: 69, RR: 18, BP: 120/66, BP (line): 126/62, SpO2: 99% Height: 178 cm, weight: 76.4 kg, BMI: 24.1	5702-5708

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Assessment/plan: • Elevated creatinine kinase 2/2 rhabdomyolysis 2/2 above - Improving **Plan:** **Neuro:** • Seizure prophylaxis with Keppra 500 mg IV twice daily • Diazepam 10 Mg IV every 10 minutes for a maximum of 30 Mg for seizures • Consulted neurologist, Dr. XXX • Discontinued Acyclovir, Vancomycin • Continue Meropenem for ESBL Klebsiella-day 2 **Respiratory:** • Started on CPAP trial for probable extubation **GI:** • Tube feeds held for extubation **ID:** • Discontinued Vancomycin, Acyclovir • Started on Meropenem - day 2 **Heme:** • DVT prophylaxis with SCDs • Heparin discontinued, probable HIT • Follow Serotonin release assay *XXX, M.D.* **Addendum:** • Extubated to NC • Stop Acyclovir, Vancomycin • Swallow evaluation *Others remain same.*	
07/25/YYYY	Hospital/ Provider Name	**@ 0214 hours: Labs:** **High:** Chloride: 108, AST: 102, ALT: 210, CK: 430, MPV: 12.6, neutrophil auto: 76, neutrophil absolute: 8.3, monocyte absolute: 1.1 **Low:** Calcium level: 7.7, total protein: 5.4, albumin level: 2.7, phosphorus: 2.4, RBC: 3.82, hemoglobin: 11.7, hematocrit: 35.4, platelets: 125, lymphocyte auto: 12, eosinophil auto: 0 **Normal:** WBC: 10.8	5770, 5775-5777
07/25/YYYY	Hospital/ Provider Name	**@ 0545 hours: X-Ray of Chest:** **Ordering Physician:** XXX, M.D. **Clinical information:** Difficulty breathing **Comparison:** Single view chest dated 07/24/YYYY	5761

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Findings: There has been interval extubation and enteric tube removal. Left jugular CVC appears unchanged. Hazy perihilar and basilar airspace disease is seen with probable small pleural effusions. Arch size and mediastinal silhouette appear unchanged. **Impression:** No significant interval change.	
07/25/YYYY	Hospital/ Provider Name	**@ 0835 hours: Critical Care Progress Notes:** **Subjective:** The patient was seen and examined at the bed side with the attending physician during the morning rounds and considerable amount was spent in evaluation and assessment. Patient had 1 episode of fever with temperature 100.9 °F, acetaminophen was given. No other overnight events have been reported. Patient was extubated yesterday to nasal cannula Patient is spontaneously opening eyes, responding to verbal commands. Patient passed swallow test, started on clear liquid diet Vitals hemodynamically stable , maintaining a saturation of 97% on 2 L of oxygen to nasal cannula Input 2.3 L, output 3.7 L, cumulative fluid balance +4.3 L **Brief hospital course:** AS on 07/24/YYYY, Patient is responding to verbal commands, opening eyes, moving all extremities, started on CPAP trial, discontinued Acyclovir, Vancomycin. Patient is extubated to nasal cannula. As on 07/25/YYYY, patient is hemodynamically stable, passed swallow test, started on clear liquid diet, advance diet as tolerated. Strict residents order for the nurse has been placed to ED, patient is having his knee as he has baseline dementia needs to be reoriented to eat often and for prevention of aspiration. Dr. XXX, hospitalist was informed about the patient, transferred to floor with hospitalist team for further care. **Objective:** **General:** Caucasian male, spontaneously opening eyes **Skin:** Skin is warm, dry and pink, patient has multiple blisters in different sites, had blisters bilaterally in the heels which were ruptured, dressing done daily by wound care **Musculoskeletal:** Moving all extremities on commands bilaterally, symmetrically **Neurologic:** Awake, alert, could not elicit orientation due to baseline dementia , moving all EXTR, no focal neurologic deficits **Vitals:** Temperature: 99.5F, HR: 67, RR: 14, BP: 134/81, BP (line): 166/78, SpO2: 93%, height: 178 cm, weight: 76.4 kg, BMI: 24.1 **Assessment/plan:**	5695-5701

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Acute: • Altered mental status 2/2 heatstroke-improving • Seizures/shivering 2/2 above • Acute hypoxic hypercapnic respiratory failure 2/2 above s/p extubation • Sputum cultures growing E. coli, Klebsiella-ESBL, 07/22/YYYY • Prerenal AKI on CKD Baseline creatinine 1-1.5-resolved • Elevated creatinine kinase 2/2 rhabdomyolysis 2/2 above-improving • Thrombocytopenia 2/2 probable HIT **Plan:** Transfer patient to hospitalist team, with hospitalist Dr. XXX. **Neuro:** • Continue aspiration precautions, physical therapy • Consulted neurologist, Dr. XXX, further recommendations • Memantine 10 mg twice daily • Held home medication Seroquel, can be started when patient was agitated • Continue Aspirin, patient does not need clopidogrel started for TIA which was few years back • DuoNebs as needed as needed started on home medication Melatonin 10 Mg at bedtime, **Cardiovascular:** • Started on Home medication Lisinopril 20 Mg daily • Atorvastatin can be started when LFTs are less than **GI:** • Patient passed swallow test • Started on clear liquid diet, advance as tolerated • Strict communication order for the nurse to be present patient is eating, to prevent aspiration, to reorient the patient. **Renal:** • Strict Intake and output measurement • Replace electrolyte as needed • Discontinue IV fluids once patient tolerates clear liquid diet **ID:** • Started on empiric antibiotics for meningitis- Vancomycin, Acyclovir- day 3 • D/c'd Vancomycin, Acyclovir • Started on Meropenem -day 3 for ESBL Klebsiella in sputum • Follow sputum cultures ordered yesterday • Wound care to follow the patient daily for daily dressing of the blisters on bilateral heels	

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Endo: • Check CBGs q4h + correctional scale + hypoglycemia protocol as needed **Heme:** • DVT prophylaxis with SCDs • Heparin discontinued, probable HIT • Follow serotonin release assay • Not started him on Argatroban/Fondaparinux as bleeding risk greater than benefits Follow AM lab. *XXX, M.D.* **Addendum:** **Attending statements:** I saw and examined this patient during ICU morning rounds. I performed a detailed history and physical examination of the patient in ICU with the resident at the bedside. I personally reviewed the patient's chart, hospital course, all clinical data, labs and radiologic data. I discussed, supervised and guided comprehensive plan of patient's ICU care with resident/NP, RN, and RT I have personally examined the patient and together with the resident discussed and developed the plan of care as outlined by the resident note. The patient was seen by me and discussed extensively in multidisciplinary rounds Patient was seen and examined during morning and afternoon ICU rounds I personally saw and examined the patient I personally reviewed all available clinical data, all labs and imaging I personally formulated and coordinated patient's plan of care and discussed with the ICU rounding team, bedside RN, RT and Pharm.D. I agree with the ICU residents assessment plan and physical exam For documentation of vital signs and physical exam findings please refer to resident's/NP's note **In addition:** Patient is a 66-year-old male nursing home resident with prior medical history of multiple comorbid conditions who was initially admitted due to heatstroke after being left outside at the nursing home in the wheelchair, initial temperature of 107 with GCS of 6 required intubation and rapid ice water immersion followed by cooling blanket transition. Course complicated with ESBL pneumonia treated with meropenem as well as seizures requiring restarting of Keppra, Dr. XXX following along. Successfully extubated to nasal cannula on 07/24/YYYY without any complications, possible evaluation on 07/25/YYYY and started on clear liquid diet with close monitoring for aspiration risk.	

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Patient was seen and examined this morning, overnight no major events had a low-grade temperature of 100.9 currently on antibiotics and rest of the cultures have remained unchanged. Mildly hypertensive, I's and O's 3.5/3.8 positive fluid balance of 5 L, 1 bowel movement in the last 24 hours. Glucose well controlled no insulin required. On 2 L nasal cannula. Able to communicate basic answers appropriately and follows commands consistently. On review of the labs white count downtrending, stable hemoglobin and platelets improving no bands. Chemistry with hypokalemia and hypophosphatemia repleted this morning, continue to improve renal function, downtrending liver function test with normal bilirubin and hypoalbuminemia. Echocardiogram showed ejection fraction 60 to 65% with trace MR and TR and small pericardial effusion. Chest x-ray looks stable compared to prior with bibasilar atelectasis will need aggressive chest physiotherapy. **Assessment and plan:** Altered mental status secondary to heatstroke, improving Episode of seizures weakness on Keppra, following with Dr. XXX Acute hypoxemic hypercarbic respiratory failure secondary to altered mental status due to #1, improving Bacterial pneumonia secondary to Klebsiella ESBL as well as E. coli on meropenem therapy Prerenal AKI on baseline CKD, resolved Rhabdomyolysis, resolved Thrombocytopenia possibly HIT pending antibodies Dementia moderate Dependent for activities of daily living and wheelchair-bound at baseline Type 2 diabetes Impaired mobility Hypertension Nursing home resident History of seizures History of TIA. I will continue preventive measures for: VTE, SRMD, VAP/VAC/VALI, CAUTI, Skin DTI, CVC related infections I will continue Multisystem Support/Monitoring **System plan:** • I personally reviewed all available clinical data, all labs and imaging. • I was physically present during the key and critical portions of PE and the service to include history, events, exam and plan, when performed by the resident • I directly participated in the management of this patient as noted in the noted, treatment and plan • I personally formulated pt's plan of care and d/w ICU rounding team, bedside RT and RN+ICU PharmD during am multi-disciplinary rounds • Mentation slowly improving, restart prior to admission memantine and melatonin to sleep at night. Continue Tylenol as needed as well as	

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Keppra for seizures, appreciate Dr. XXX help in the management of this patient. • Hemodynamically stable on the hypertensive side, start Lisinopril prior to admission medication 20 mg which is half of his home dose daily, continue Aspirin and Statin to be held so far due to elevated liver function test but they have been decreasing consider restarting in the near future. • SPO2 target 92% + wean FiO2 for lowest to maintain it, on 2 L nasal cannula, encourage I-S. DuoNebs only as needed. • Swallow evaluation performed today and patient was cleared for clear liquid diet with plans to advance to puréed diet not advancing further than that, speech to continue to follow. Patient needs to be fed for every meal and needs constant supervision during meals, high risk for aspiration head of the bed elevated and aspiration precautions in place. No indication for GI prophylaxis discontinue PPI. • Discontinue LR once tolerating PO intake consistently. Potassium repleted. Discontinue CK. • Empiric coverage Broad - Spectrum Abx Rx is warranted, ESBL Klebsiella growing in sputum, continue meropenem day 3/7-10. Wound care to continue to follow for blisters on upper and lower extremities from burns. • Sliding scale insulin to assure euglycemia. • DVT prophylaxis with SCDs only due to concerns for HIT, HIT panel sent and results still pending. • Further data, please see ICU resident progress note above • I have reviewed all, documented by the resident and I agree with A/P and PE • I attest to note above Patient no longer requiring ICU level of care will transfer to floors *Others remain same.*	
07/25/YYYY	Hospital/ Provider Name	@ **1025 hours: Speech Therapy Progress Notes:** 07/25/YYYY: TY: Chart reviewed, spoke w/ RN. Pt admitted MM/DD/YYYY after being found in the grass at Sienna SNF. Pt intubated MM/DD/YYYY-07/24/YYYY (4 days; 18hrs). Pt w/ PMhx of dementia, DM, HTN, seizures. MRI w/ no acute findings. Pt currently NPO, compensated on 2L via NC. Bedside swallow evaluation completed this date. Pt awake, verbally responding - altered. HOB elevated. Attempted ice chips with pt spitting them out. Pt accepted thin liquid via straw and applesauce with simple step by step instructions for intake (open mouth, close mouth, etc). Pt w/ no overt s/s any consistencies assessed. No coughing/choking/wet vocal quality indicated. No drop in O2 and HLE appeared adequate via palpation. ST to continue to monitor for diet tolerance. Pt would benefit from 1:1 assistance (feeder) and simple step by step instructions. Recommend thin liquids/pureed diet due to mentation. RN notified and will notify MD of results. **Recommendation:**	5758

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Thin liquid Puree diet Medications crushed w/ puree Daily oral care	
07/25/YYYY	Hospital/ Provider Name	**@ 1303 hours: Wound Care Nurse's Note:** Wound care did not change patient's dressings to heels d/t dressing changed at 0300-0400 07/25/YYYY per date on dressing. Dressing is ordered to be changed daily unless Soiled/Falling off.	5759
07/25/YYYY	Hospital/ Provider Name	**@ 1456 hours: Nutrition Notes:** **Nutrition Risk Level:** Moderate **Assessment and Monitoring** RD follow up Pt is extubated and passed BSE with SLP recommendations for Pureed diet and thin liquids. Currently on CLD and tolerating. No issues with n/v at this time. Patient is spontaneously opening eyes, responding to verbal commands. Pt to transfer to the floor - RD to adjust estimated needs once that happens and pt is no longer critical. **Nutrition Diagnosis** Altered nutrition related lab values related to AKI on CKD as evidenced by Cr: 1.7 (H), BUN: 22, eGFR: 49.79 (L), Phos: 4.7 (H). Resolving with only phos levels not WNL Inadequate protein and energy intake related to NPO status/CLD as evidenced by <90% estimated needs met. - ongoing Increased protein needs related to critical illness as evidenced by estimated protein needs of 1.2-2g/kg. - ongoing **Nutrition Goals** Maintain weight +/- 1% during admission PO intake >75% Comply with MNT during admission **Nutrition Interventions/Education** Monitor intake, weight, skin, and labs Advance PO diet as medically feasible **Estimated Needs** Kcal: 1910 kcal (25 kcal/kg) Protein: 91-152g (1.2-2g/kg) Fluid: 1910mL (25mL/kg for adults over 65) or per MD **Nutrition Recommendations:** Pureed/Cardiac diet per SLP Monitor PO as diet advanced and add Ensure Enlive is PO is not meeting >75% estimated needs	5726-5728

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Disposition plans: Cardiac diet with textures per SLP and as tolerated. Recommend low K+/phos foods for renal protection. *Kerryn Cannan, Clinical Dietitian* **Addendum:** Monitor BG and add ADA 1800 kcal restriction of BG > 180 mg/dl. *Others remain same.*	
07/26/YYYY	Hospital/ Provider Name	**@ 0000 hours: Blood Culture Report:** **Collected date:** 07/20/YYYY at 2029 hours **Source:** Venous central line **Final report:** No growth at 5 days.	5781
07/26/YYYY	Hospital/ Provider Name	**@ 0000 hours: Blood Culture Report:** **Collected date:** 07/20/YYYY at 2029 hours **Source:** Peripheral venous stick **Final report:** No growth at 5 days.	5781
07/26/YYYY	Hospital/ Provider Name	**@ 2145 hours: Progress Notes:** **Subjective:** Patient spontaneously opening eyes but not following any commands. Moving all extremities. Low-grade fever T-max 100.2.Good urine output. Heart rate controlled. Blood pressure intermittently elevated **Objective:** **Vitals:** Temperature: 99.5F, HR: 70, RR: 16, BP: 156/BP (line): 166/78, SpO2: 97%, height: 178 cm, weight: 76.4 kg, BMI: 24.1 **Physical examination:** **Lungs:** Bilateral decreased basal sounds on auscultation non-labored respiration. **Neuro:** Spontaneously opening eyes and moving all extremities **Assessment:** **Acute:** • Altered mental status secondary to heatstroke, improving • Episode of seizures weakness on Keppra, following with Dr. XXX • Acute hypoxemic hypercarbic respiratory failure secondary to altered mental status due to #1, improving • Bacterial pneumonia secondary to Klebsiella ESBL as well as E. coli on meropenem therapy • Prerenal AKI on baseline CKD, resolved • Rhabdomyolysis, resolved • Thrombocytopenia possibly HIT pending antibodies **Plan:** **Neuro:** • Consulted neurologist, Dr. XXX, further recommendations MRI brain	5739-5742

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		no evidence of any stroke. • Speech therapy consult for swallow evaluation recommending thin liquid and puree diet aspiration precautions **ID:** • Sputum culture ESBL Klebsiella. On Meropenem. Cultures negative so far • Wound care consult. **Cardiology:** • Not started him on Argatroban/Fondaparinux as bleeding risk greater than benefits *Others remain same.*	
07/27/YYYY	Hospital/ Provider Name	**@ 0723 hours: Labs:** **High:** AST: 67, ALT: 139, CK: 208, MCH: 31.3, MPV: 12.7, monocyte auto: 15, monocyte absolute: 1.3 **Low:** Calcium level: 8.5, total protein: 5.9, albumin: 3.0, RBC: 4.02, hemoglobin: 12.6, hematocrit: 37.1, lymphocyte auto: 18 **Normal:** WBC: 8.7	5770, 5775-5777
07/27/YYYY	Hospital/ Provider Name	**@ 1945 hours: Progress Notes:** **Subjective:** Patient drowsy this am . Discussed with RN . Patient was given Seraquel and Morphine . Moving all extremities spontaneously Afebrile this AM. Good urine output. Heart rate controlled. Blood pressure stable. **Objective:** **Vitals:** Temperature: 98.5F, HR: 67, RR: 16, BP: 147/90, BP (line): 166/78, SpO2: 99%, height: 178 cm, weight: 76.4 kg, BMI: 24.1 **Assessment:** **Acute:** • Altered mental status secondary to heatstroke, improving • Episode of seizures on Keppra, following with Dr. XXX • Generalized weakness • Acute hypoxemic hypercarbic respiratory failure secondary to altered mental status due to #1, improving • Bacterial pneumonia secondary to Klebsiella ESBL as well as E. coli on meropenem therapy • Prerenal AKI on baseline CKD, resolved • Rhabdomyolysis, resolved • Thrombocytopenia possibly HIT pending antibodies • Pressure wounds **Plan:** **Therapy:**	5736-5739

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		• PT/OT consult • Rehab referral per request from family. SS consult *Others remain same.*	
07/28/YYYY	Hospital/ Provider Name	**@ 0811 hours: Labs:** **High:** Glucose: 110, AST: 66, ALT: 125, MCH: 31.4, MPV: 12.9, neutrophil auto: 75, monocyte auto: 13, monocyte absolute: 1.0 **Low:** Calcium level: 8.3, total protein: 6.1, albumin level: 3.2, RBC: 3.98, hemoglobin: 12.5, hematocrit: 36.4, lymphocyte auto: 9, lymphocyte absolute: 0.7 **Normal:** WBC: 8.0	5770, 5776-5777
07/28/YYYY	Hospital/ Provider Name	**@ 1921 hours: Progress Notes:** **Subjective:** Patient more awake today . Moving all extremities spontaneously. Afebrile. Blood pressure normotensive to hypertensive. On room air this morning. Urine output 3100 cc. No bowel movement reported. Review of labs this morning CBC no leukocytosis Hemoglobin stable, no bands, platelets within normal limits. CMP LFTs downtrending. Bilirubin within normal limits. Electrolytes within normal limits. CPK level downtrending. **Vitals:** Temperature: 98.4F, HR: 63, RR: 16, BP: 158/89, BP (line): 166/78, SpO2: 98%, height: 178 cm, weight: 76.4 kg, BMI: 24.1 *Others remain same.*	5732-5735
07/29/YYYY	Hospital/ Provider Name	**@ 1311 hours: Wound Care Nurse's Note:** R Heel Unstageable, L Heel DTI: Cleanse with ns then apply Aquacel AG and cover with dry dressing. Wound care to change MWF nursing to change on Sundays/PRN/Soiled Bil Arms ruptured blisters: Cleanse with ns then apply foams. Nursing to change weekly.	5758
07/29/YYYY	Hospital/ Provider Name	**Discharge summary:** **Brief hospital course:** 66-year-old male nursing home resident with prior medical history of multiple comorbid conditions who was initially admitted due to heatstroke after being left outside at the nursing home in the wheelchair, initial temperature of 107 with GCS of 6 required intubation and rapid ice water immersion followed by cooling blanket transition. Course complicated with ESBL pneumonia treated with meropenem as well as seizures requiring restarting of Keppra, Dr. XXX following along. Successfully extubated to nasal cannula on 07/24/YYYY without any complications, possible evaluation on 07/25/YYYY and started on clear liquid diet with close monitoring for aspiration risk. Echocardiogram showed ejection fraction 60 to 65% with trace MR and TR and no pericardial effusion. Speech pathology evaluation advance to puréed diet. Patient condition gradually improved. Other conditions management as above. Patient was	5679-5681

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		referred to focus care per family preference. Social services consulted. Patient was accepted at skilled nursing facility focus care on 07/29/YYYY and discharged in stable condition. **Physical examination:** **Vitals:** Temperature: 97.6F, HR: 61, RR: 16, BP: 128/75, BP (line): 166/78, SpO2: 94%, height: 178 cm, weight: 76.4 kg, BMI: 24.1 **Lungs:** Bilateral decreased basal sounds on auscultation non-labored respiration **Heart:** Normal rate, regular rhythm, no murmur, gallop or edema. **Abdomen:** Soft, non-tender, non-distended, normal bowel sounds, no masses. **Neuro:** Spontaneously opening eyes and moving all extremities **Assessment:** **Acute:** • Altered mental status secondary to heatstroke, improving • Episode of seizures on Keppra, following with Dr. XXX • Generalized weakness • Acute hypoxemic hypercarbic respiratory failure secondary to altered mental status due to #1, improving • Bacterial pneumonia secondary to Klebsiella ESBL as well as E. coli. Treated with meropenem. • Prerenal AKI on baseline CKD, resolved • Rhabdomyolysis, resolved • Thrombocytopenia possibly HIT pending antibodies • Pressure wounds • Hypertension uncontrolled. **Chronic:** • Dementia moderate • Dependent for activities of daily living and wheelchair-bound at baseline • Type 2 diabetes • Impaired mobility • Hypertension • Nursing home resident • History of seizures • History of TIA. **Plan:** • Neurochecks per protocol. • Seizure precautions • Seizure prophylaxis with Keppra 500 mg oral twice daily • Continue aspiration precautions, physical therapy • Consulted neurologist, Dr. XXX, further recommendations MRI brain no evidence of any stroke. • Memantine 10 mg twice daily	

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		• Seroquel, as needed for agitation. • Continue aspirin, patient does not need clopidogrel started for TIA which was few years back. Restarted statin. LFTs downtrending. • Blood pressure elevated. Resume home medication Lisinopril and Hydralazine. • Speech therapy consult for swallow evaluation, recommending thin liquid and purée diet aspiration precautions • Sputum culture ESBL Klebsiella. On meropenem D#7 started on 07/23/YYYY . Cultures negative so far. Pro-Cal negative. • Wound care consult. • PT/OT consult • Discharge planning. SNF placement. SS consult • DVT prophylaxis with SCDs • Heparin discontinued, probable HIT • Not started him on Argatroban/Fondaparinux as bleeding risk greater than benefits placement at focus care. **Follow-up appointments:** Follow-up with primary care provider in 1 week 08/05/YYYY **Consultants:** Dr. XXX. **Condition at Discharge:** Stable and discharged home **Diagnostic Studies:** Lab Results: Review patient's chart **Radiology (Last 24 Hours):** No qualifying data available. Review patient's chart **Pending Lab Work and other Tests:** No qualifying data available. **Patient Education Given:** Heat Exhaustion **Documentation of Patient Education:** ER precautions given	
	Hospital/ Provider Name	**Reviewer's Comments: Interim significant medical records are not available for review. Available labs are summarized below.*	
11/18/YYYY	Hospital/ Provider Name	**@ 0317 hours: Labs:** **High:** MPV: 14.4, BUN: 32, sodium: 152, chloride: 118 **Low:** RBC: 4.18, hemoglobin: 12.7, hematocrit: 39.1, total protein: 5.9, albumin: 3.2, EGFR non-AA: 55.06, prealbumin: 13, HDL cholesterol: 26	5855-5857

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Normal: WBC: 6.6	
11/22/YYYY	Hospital/ Provider Name	**@ 1249 hours: Labs:** **High:** BUN: 30, sodium: 151, chloride: 115, anion gap: 15 **Low:** CO2: 21, total protein: 6.1, albumin: 3.4, EGFR non-AA: 56.06	5858
11/28/YYYY	Hospital/ Provider Name	**@ 0337 hours: Labs:** **High:** Sodium: 146, chloride: 114 **Low:** Calcium: 8.7, total protein: 5.2, albumin: 3.1	5859
04/04/YYYY	Hospital/ Provider Name	**@ 0420 hours: Labs:** **High:** WBC: 10.9, MCH: 31.4, neutrophil auto: 82, neutrophil absolute: 9.0, BUN: 37, chloride: 109 **Low:** RBC: 4.04, hemoglobin: 12.7, hematocrit: 37.7, lymphocytes auto: 10, eosinophil auto: 0, lymphocyte absolute: 1.0, total protein: 6.2, albumin: 3.3, EGFR non-AA: 58.15	5860-5861
04/28/YYYY	Hospital/ Provider Name	**Death Certificate:** **Date of Death:** 04/22/YYYY at 1130 hours **Place of death:** **Death occurred somewhere other than a hospital:** Nursing Home **Facility name:** Focused care at Midland **Cause of death:** • Sepsis unspecified organism • Unspecified dementia • Essential hypertension **Was an autopsy performed?** No **Manner of death:** Natural	5677

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