**Expert Medical Opinion for RRR CCC**

**DOB: 06/27/YYYY**

**Summary of Merit:**

From the available medical records, it is with a degree of reasonable medical certainty; I professionally opine that there were deviations from the standard of care provided to Ms. CCC in San Antonio Regional Medical Center and HH PP Nursing Center. Since so many facilities were involved in the care of Ms. CCC, I will discuss the opinion under each facility header.

**PVC Hospital (03/30/YYYY to 04/26/YYYY):**

On 03/30/YYYY, the patient was admitted in PVCH. Patient was found to have diffuse SAH (Subarachnoid hemorrhage), IVH (Intraventricular hemorrhage), and right frontal lobe hemorrhage. Patient was transferred to PVMC for higher level of care.

The patient developed few excoriations in the skin while she was admitted in PVCH. On 04/20/YYYY, the patient was seen for wound care follow up to MASD (Moisture Associated Skin Damage) to bilateral buttocks and skin tear to right ischial area. Patient has no improvement to MASD to bilateral buttocks. Recommend to increase Venelex to q 6hrs. Leave open to air. Patient had skin tear to right ischial area that has now healed.

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| --- | --- | --- | --- |
|  |  |  | **Status** |
| **04/24** | **Left buttocks** | MASD (Moisture associated skin damage) | No progress |
| **Scalp** | Surgical incision | Improving |
| **Right buttocks** | MASD  | Improving |
| **Right posterior buttock/ischium** | MASD  | Improving |

The pressure ulcers were just excoriation and in stage I/stage II. Hence they are no never events in a hospital stay. There was no breach in the standard of care in PVCH. Pressure ulcer precautions were adequately documented and implemented PVCH treating team.

Patient was found to have 2 mm anterior communicating artery aneurysm, left MCA bifurcating aneurysm approximately 1.5 mm, left MCA M2 M3 segment aneurysm approximately 2.5 mm and left ICA supraclinoid aneurysm and possible right ICA supraclinoid aneurysm. Patient was put on 3% Normal Saline to help for cerebral swelling, Keppra 500 twice daily to prevent seizures, Nimodipine to prevent vasospasm. Patient had complication with EVD where tPA had been pushed through and showed that the CSF spaces were improved. After few days of being intubated patient's mental status improved and was eventually extubated and eventually transition from high flow to room air. It was noted that patient had a lower bicarb due to non-anion gap metabolic acidosis and she was placed on Bicarb drip initially which helped improve this. TCD's showed evidence of intracerebral arterial vasospasm, on angiogram she had had a left and right ACA vasospasm noted for which she received Verapamil. She had a second procedure about a week later for vasospasm treatment again for bilateral anterior communicating artery vasospasms. Patient had somnolent mental status and therefore had multiple repeat CT scans of the brain but they were overall unchanged showing intraparenchymal hematomas of the right frontal lobe, scattered areas of subarachnoid hemorrhage, evidence of EVD catheter, also an unchanged 4 mm right to left midline shift.

During the course of the stay patient did have blood cultures which showed Streptococcus constellatus which was suspected to be a contaminant but was treated empirically with the Rocephin anyways. She finished her course. Patient finished full course of Nimodipine and was more awake. She was transferred down to the floor eventually and it was noted that she would require intensive rehab as her whole left side was flaccid. Patient also passed swallow eval and therefore was started on an appropriate diet. It was also noted that her bicarb was becoming worse as she was no longer on the Bicarb drip and therefore Sodium Bicarb tablets were started which showed improvement. Nephrology was consulted who suspected that patient had an RTA was likely secondary to her diabetes and agreed that the patient would require Sodium Bicarb tablets. Patient qualified for skilled nursing facility for rehab at Creekside nursing home. Patient was stable for discharge. The patient was seen and examined by me on the day of discharge. The patient was discharged on 04/26/YYYY.

***Reviewing the records from PVCH we can see that the patient developed few excoriations in sacrum and ischium. They were either in stage I or stage II. We must note that stage I and II pressure ulcers are not never events in a hospital or nursing home. Usually a good standard of care involves identifying these pressure ulcers and preventing them progressing. PVCH did not let the pressure ulcer progress to advanced stages and the pressure ulcers were identified in early stages.***

***I conclude that there was no deviation from the standard of care provided in terms of pressure ulcer prevention and management at PVCH.***

**Creekside Nursing Home (04/26/YYYY to 05/06/YYYY):**

On 04/26/YYYY, the patient was received at CRRK Care Center. On admission, the patient had a Braden score of 13 which means she was at moderate risk of pressure ulcer.

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|  |  |  | **Status** |
| **04/26** | **Left buttocks** | MASD (Moisture associated skin damage) | No progress |
| **Scalp** | Surgical incision | Improving |
| **Right buttocks** | MASD  | Improving |
| **Right posterior buttock/ischium** | MASD  | Deteriorating |

Resident was newly admitted. Breathing even, nonlabored on room air. Noted to have a top of head surgical wound. Stage 2 coccyx, (Left) hand pitting edema +1, lower abdominal bruising. Bilateral big toe hyper tropic toenail growth. Upper and lower extremity bruising/ discoloration. On 04/27/YYYY, Patient had MASD to buttock and bilateral ischium.

Stage 2 - Number of Stage 2 pressure ulcers: 1. Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry: 1.

**Skin and Ulcer/Injury Treatments:**

* Pressure reducing device for bed
* Nutrition or hydration intervention to manage skin problems
* Pressure ulcer/injury care
* Surgical wound care
* Applications of ointments/medications other than to feet.

On 05/06/YYYY, cleanse stage 2 coccyx with saline, pat dry, apply barrier cream daily and prn, every 4 hours as needed, every day shift was documented. Stage 2 - Number of Stage 2 pressure ulcers: 1. Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry: 1. The patient was discharged to HH PP Nursing Center on 05/06/YYYY.

***Reviewing CRRK records, we can see that the pressure ulcers did not greatly progress in the nursing home. They remained in either stage I or II. Again stage I and II pressure ulcers are not never events in a nursing home stay. The patient did not develop any new pressure ulcers and the preexisting pressure ulcers did not progress or worsen. With all that said, I conclude that there was no deviation from the standard of care provided to Ms. CCC in CRRK in terms of pressure ulcer management.***

**SAR Hospital (05/07/YYYY to 05/16/YYYY):**

On 05/07/YYYY, the patient was admitted in SAR Hospital. Patient with history of CVA, DM and HTN. BIBA (Brought in by ambulance), presented to the ED due to AMS. Per EMS, the patient has a history of a recent hemorrhagic stroke which has left her nonverbal and altered at baseline, however earlier that at the patient's SNF, the staff noticed that she was "harder to arouse' and unresponsive to her name. EMS indicated that the patient was normally more responsive to her name and painful stimuli at baseline. Additionally, on scene, the patient's O2 saturation level was 83%, prompting the patient to be placed on O2 on scene. The patient was recently discharged from Pomona Valley yesterday.

It is during this hospitalization, the patient developed progression of pressure ulcers. Stage I/II pressure ulcer in the sacrum progressed to stage IV. The patient also developed new pressure ulcers in both the heels. This is because pressure ulcer precautions were not strictly documented and implemented. The patient was at a risk of pressure ulcer progression given her high risk Braden score and reduced mobility due to intracranial hemorrhage and acute sepsis on presentation. The facility failed to provide proper pressure ulcer care and this resulted in development of stage IV pressure ulcer in the sacrum and DTI (Deep Tissue Injury) in the bilateral heels.

The patient was discharge to HH PP Nursing Home on 05/16/YYYY after her UTI and sepsis resolved.

**Defendant:** SAR Hospital Nursing Team

**Deviations from the standard of care:**

* Failure to strictly document and implement pressure ulcer precautions
* Failure to document turning and repositioning every 2nd hourly
* Failure to prevent development of new pressure ulcers - the patient developed DTI in the bilateral heels
* Failure to document offloading of heel or use of heel protection such as waffle boots
* Failure to prevent the progression of preexisting pressure ulcers
* Failure to document regular wound care and management

**General pressure ulcer precautions that were not strictly documented and followed in SAR Hospital:**

* Failure to implement systematic screening for pressure with scoring such as Braden scoring
* Failure to stratify risk of pressure ulcer development
* Failure to meticulously implement turning and repositioning of patient every second hourly
* Failure to document development of pressure ulcer in stage I. The treatment of pressure ulcer when identified in stage 1 is easier than treatment initiated later. Pressure ulcer is better prevented than treated.
* Failure to protect and pad bony structures such as sacrum, nape of the neck, etc
* Failure to offload pressure on bony areas and regions of the body where common pressure load is high
* Failure to document use of pressure relieving devices such as air beds, alpha beds, water beds or egg crate beds. There are special types of mattress that are specially designed to prevent the incidence of pressure ulcer.
* Failure to offload heels or use waffle boots to prevent pressure wounds to heels
* Failure to regularly mobilize the patient to chair and implement use of roho cushions or Geri chairs
* Failure to document continence care – the patient was on Foley’s catheter so there was no major risk of urine related moisture however bowel incontinence was not properly documented and prevented using bowel care program.
* Failure to regularly assess nutritional markers such as albumin and prealbumin and make sure patient was receiving regular nutritional supplements according to needs
* Failure maintain adequate moisture of skin to prevent any breakdown of the skin
* Failure document regular skin assessments – shift based, daily and weekly statuses
* Failure to document a minimal data assessment for a systematic skin checks and wound improvement
* Failure to document regular wound checks and wound care that was given – treatment including dressings and wound debridement **(**[**Ref 1)**](#_Hlk152152655)

**Damages:**

* Stage IV pressure ulcer in the sacral area
* DTI in the bilateral heels
* Pain and suffering
* Emotional distress
* Need for wound care
* Prolonged hospitalization and recovery period
* Financial implications
* Morbidity from all the above

**HH PP Nursing Center (05/16/YYYY to 08/15/YYYY):**

On 05/16/YYYY, the patient was again transferred back to HH PP Nursing Center. On admission her Braden score was 11 - the patient was at a high risk of developing pressure ulcer.

**Pressure ulcer details:**

* UTD - Coccyx + Right ischium.
* DTI Bilateral heels.

The patient was a long term resident of HH PP. She was admitted there for rehabilitation and treatment of pressure ulcers. The patient received good pressure ulcer care at HH PP. The size of sacral pressure ulcers reduced due to appropriate wound care. The pressure ulcer did not progress or worsen during the 3 month stay at HH PP. The patient also did not develop any new pressure ulcer while in HH PP. The pressure ulcers remained stable and they improved in condition due to appropriate wound care and implementation of pressure ulcer precautions.

**Fall event:**

However, the facility failed to prevent fall events while the patient was a resident there. We can see that the patient was at a high risk of fall due to her condition and reduced motility. The patient sustained two fall events while she was a resident of HH PP.

On 07/01/YYYY, prior to incident resident resting in bed laying on her. At that time she had no complains of pain no distress or discomfort, no SOB. CNA reported to charge nurse that resident lying on floor on her left side of the bed body. Assessment rendered no apparent injury noted, no bruising noted. Resident was able to move all extremities without limitations. Neurocheck rendered, resident assisted back to bed. No complains of pain at that time. Just feeling anxious. Asked resident how incident occurred she stated that she was trying to put her bed control in her drawer and slipped out. Dr Wu made aware just to monitor resident for 72 hrs, Katherine resp. party made aware reminded resident to use call light for assistance and any other needs she may have bed low call light in reach will continue to monitor.

On 07/08/YYYY, the resident was about to be transferred from wheelchair to bed when suddenly fell forward but CNA was able to grab by underarm but still hit left knee on the floor. Was assisted to floor. No apparent injury, denies of pain, no bruising, no bump. Monitor.

I believe that fall precautions were not strictly documented and implemented in HH PP Nursing Center.

**Defendant:** HH PP Nursing Center

**Breaches in the standard of care:**

* Failure to prevent fall event while the patient was a resident of HH PP
* Failure to document and implement fall precautions
* Failure to keep side rails half raised
* Failure to document use of call bell and bed alarm and bed set in lowest position - this was implemented only after the patient had the first fall
* Failure to lock the wheel chair while transferring the patient
* Failure to prevent subsequent fall event which happened in 2 days after the initial fall event

**Fall precautions that were not strictly documented and implemented in HH PP Nursing Center:**

* Rearrange room to make better pathways to meet resident’s needs (like bathroom)
* Change roommates to one with less medical equipment or "stuff" (clutter)
* Move personal items closer Relocate to room closer to nurses’ station
* Add verbal warning alarm using the resident's or family members’ voice
* Add non-skid strips on chair or floor in slick spots; non-skid tips on assistive devises
* Non-skid socks or slippers Proper fitting shoes
* Add bed/chair/floor alarm Padded side rails with colored noodles
* Wander guard alarm system
* Add body or sensor pad alarm or self-release belt alarm
* Utilize mechanical lifts Use top 1/2 bed rails as enablers
* Eliminate decorative tile in middle of floors as they can be perceived as "holes"
* Improve lighting and reduce glare in corridors, patient rooms, showers, and bath rooms
* Add night lights or motion lights
* Beside commode or bed pan or raised toilet seat
* Place picture of toilet on the bathroom door
* Add resting stations (bench) on long corridors, but be cautious not to create trip hazard
* Reduce or eliminate clutter in common areas
* Eliminate low obstacles that can be trip hazards
* Make regular rounds looking for discarded clothing or wet spots
* Add grab bars or other assistive devices for bed, toilet or shower
* Non-skid rubber backed bath mats
* Elevate chair to facilitate getting up
* Evaluate housekeeping practices—are cleaning technique or chemicals creating slip hazards
* Create adequate spacing between tables in dining room
* Always "lock" wheels of equipment if possible in hall as residents may use to steady
* Wheel back rolling prevention device
* Built-up or colored wheel chair brakes
* High back wheel chair Back weighted wheel chair to prevent tipping
* Add or remove leg rest on wheel chair
* Add or remove low bed, add or remove mat beside bed, front and back tippers
* Assess for perimeter defining mattress, bolsters to bed, wedge Cushion, helmet and hip/knee/shoulder pads
* Add Merry Walker or other equipment such as stroller or wheel chair, lateral supports and stabilizers/arm troughs, pommel cushion, hip thrust cushion, prosthetic devices/splints, quad cane and drop seat in wheel chair
* Self-releasing Velcro belt/seat belt, hip clip belt, orthotic chair, lab buddy, tray table, recliner/lounge chair and recliner chair with tray table
* Stop signs or door exits or other patient rooms
* Dycem matting to stabilize seating, utilization of a rocking chair
* Make doors and exits look like something else or have mirrors on exits **(**[**Ref 2**](#_Hlk152164577)**)**

**Damages:**

* Injury to the left knee
* Pain and suffering
* Emotional distress
* Prolonged hospitalization
* Financial implications
* Morbidity from all the above

**Weakness in the case in terms of fall event:**

The patient did not sustain any major injury due to the first fall. During the second fall, the patient had an injury to the left knee which was also not major. Hence, in terms of damages, there is not much weightage in this case. Both the falls did not result in any major injuries or damages.

**Case overview:**

Ms. CCC is a 62 year old female with medical history significant for acid reflux, anemia, anxiety, at risk for falls, cirrhosis of liver, COVID-19 virus detected 08/06/2020, diabetes mellitus type 2, alcohol addiction, depression, hypertension, heartburn, kidney stones, panic attack, GERD (Gastro Esophageal Reflux Disease) and MRSA (Methicillin Resistant Staphylococcus aureus) infection. She did not have any significant past surgical history. Her father and mother had Diabetes mellitus and hypertension. Patient denied tobacco, alcohol or substance abuse. Work History: Retired. She is allergic to Hydrocodone.

On 03/30/YYYY, Ms. CCC presented to SAR Hospital. EMS brought in by ambulance to the ED with altered mental status. EMS stated that the patient was last seen normal by her family members at 0200hrs this morning. She was found to be altered and stumbling by her family at 1000hrs this morning. EMS noted that the patient was only responsive to painful stimuli, her blood sugar was 410, and her blood pressure was in the 200s.

Patient presented with altered mental status, last seen normal by family members at 2 AM, then discovered with altered mental status that morning at 10 AM, arrived by EMS. According to Medics blood pressure was above 200 systolic. With vigorous stimulation the patient follows command to weakly squeeze hand grips. She was nonverbal. Eyes showed disconjugate gazes with mid position pupils. On my exam the patient was comatose, disconjugate gaze, unresponsive to voice or vigorous stimulation, spontaneous respiration, clear lungs, normal heart tones. No clinical evidence of trauma was seen.

Head CT showed an extensive subarachnoid hemorrhage, radiologist believes localized to the right frontal with communicating hydrocephalus, ventricles enlarged greater than last head CT 1 year ago. Dr. James Fisgus discussed about the patient with Dr. Young, neurosurgeon, who recommended transfer to Pomona Valley Hospital for aneurysm coiling. Dr. Young has contacted PVCH (PVC Hospital) and the patient had been accepted for transfer by Dr. Goldman. CTA head and neck with IV contrast shows a 4mm saccular aneurysm at the right anterior communicating artery, a likely source of the hemorrhage according to Dr. Ong (radiology). The patient was premedicated with Zofran, Etomidate and Rocuronium and then intubated in a single attempt using Glidescope. A Nicardipine infusion is being titrated for BP >140 systolic. Propofol IV sedation. The patient was transferred by ALS (Advanced Life Support) accompanied by an ED nurse.

On 03/30/YYYY, the patient was admitted in PVCH. Patient was found to have diffuse SAH (Subarachnoid hemorrhage), IVH (Intraventricular hemorrhage), and right frontal lobe hemorrhage. Patient was transferred to PVMC for higher level of care.

Neurosurgery with Dr. Young was contacted for transfer to Pomona Valley Hospital Medical Center for higher level of care to undergo cerebral angiogram. Patient also already had a EVD placed. Cerebral angiogram was performed by Dr. Young and patient had successful embolization of AcomA aneurysm. Patient was found to have a 2 mm AcomA aneurysm, left MCA bifurcation aneurysm approximately 1.5 mm, left MCA M2 M3 segment aneurysm approximately 2.5 mm, left ICA supraclinoid aneurysm, and possible right ICA supraclinoid aneurysm. The patient was intubated and on Propofol drip. Patient was unresponsive with GCS 3T. According to neurosurgery and previous documentation patient had GCS of 7T.

Patient was initially admitted to the ICU and monitored closely. She was taken to the operating room for embolization of aneurysm and then also an EVD was placed. She remained in the ICU while the drain was then. She was seen by Physical Therapy, Occupational Therapy and Speech Therapy. She required Amlodipine and transcranial Dopplers for vasospasm. She passed swallow evaluation and was started on diet. She was treated for a UTI. She remained stable and was transferred to the telemetry floor. She completed 21 days of Nimodipine. She was on Keppra for seizure prophylaxis. She was on Modafinil to try to keep her more alert. She was able to eat and move her right hand and talk to you. She was going to require extensive physical and occupational therapy and is going be discharged to skilled nursing facility for further therapy. Her labs show non-anion gap metabolic acidosis, seems to be renal tubular acidosis and the doctor started her on Sodium Bicarb. She was started on Lisinopril and Amlodipine for hypertension and advised to increase medications as needed.

The patient developed few excoriations in the skin while she was admitted in PVCH. On 04/20/YYYY, the patient was seen for wound care follow up to MASD (Moisture Associated Skin Damage) to bilateral buttocks and skin tear to right ischial area. Patient has no improvement to MASD to bilateral buttocks. Recommend to increase Venelex to q 6hrs. Leave open to air. Patient had skin tear to right ischial area that has now healed.

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| **Right buttocks** | MASD  | Improving |
| **Right posterior buttock/ischium** | MASD  | Improving |

**The pressure ulcers were just excoriation and in stage I/stage II. Hence they are no never events in a hospital stay. There was no breach in the standard of care in PVCH. Pressure ulcer precautions were adequately documented and implemented PVCH treating team.**

Patient also was found to have 2 mm anterior communicating artery aneurysm, left MCA bifurcating aneurysm approximately 1.5 mm, left MCA M2 M3 segment aneurysm approximately 2.5 mm and left ICA supraclinoid aneurysm and possible right ICA supraclinoid aneurysm. Patient was put on 3% Normal Saline to help for cerebral swelling, Keppra 500 twice daily to prevent seizures, Nimodipine to prevent vasospasm. Patient had complication with EVD where tPA had been pushed through and showed that the CSF spaces were improved. After few days of being intubated patient's mental status improved and was eventually extubated and eventually transition from high flow to room air. It was noted that patient had a lower bicarb due to non-anion gap metabolic acidosis and she was placed on Bicarb drip initially which helped improve this. TCD's showed evidence of intracerebral arterial vasospasm, on angiogram she had had a left and right ACA vasospasm noted for which she received Verapamil. She had a second procedure about a week later for vasospasm treatment again for bilateral anterior communicating artery vasospasms. Patient had somnolent mental status and therefore had multiple repeat CT scans of the brain but they were overall unchanged showing intraparenchymal hematomas of the right frontal lobe, scattered areas of subarachnoid hemorrhage, evidence of EVD catheter, also an unchanged 4 mm right to left midline shift.

During the course of the stay patient did have blood cultures which showed Streptococcus constellatus which was suspected to be a contaminant but was treated empirically with the Rocephin anyways. She finished her course. Patient finished full course of Nimodipine and was more awake. She was transferred down to the floors eventually and it was noted that she would require intensive rehab as her whole left side was flaccid. Patient also passed swallow eval and therefore was started on an appropriate diet. It was also noted that her bicarb was becoming worse as she was no longer on the Bicarb drip and therefore Sodium Bicarb tablets were started which showed improvement. Nephrology was consulted who suspected that patient had an RTA was likely secondary to her diabetes and agreed that the patient would require Sodium Bicarb tablets.

Patient qualified for skilled nursing facility for rehab at CRRK nursing home. Patient was stable for discharge. The patient was seen and examined by me on the day of discharge. The patient was discharged on 04/26/YYYY.

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| --- | --- | --- | --- |
|  |  |  | **Status** |
| **04/26** | **Left buttocks** | MASD (Moisture associated skin damage) | No progress |
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| **Right buttocks** | MASD  | Improving |
| **Right posterior buttock/ischium** | MASD  | Deteriorating |

On 04/26/YYYY, the patient was received at CRRK Care Center. On admission, the patient had a Braden score of 13 which means she was at moderate risk of pressure ulcer.

Site: Right buttock

Select Stage of Pressure Ulcer: Stage 2

Size in centimeters (length x width): 5 x 5

Depth: 0.1

Tunneling in centimeters: 0

Undermining in centimeters: 0

Exudate Type: None

Exudate Amount: None

Odor: None

Wound Bed: Pink

Wound Edges: Undefined

Surrounding Tissue: Normal for skin

Resident was newly admitted. Breathing even, nonlabored on room air. Noted to have a top of head surgical wound. Stage 2 coccyx, (Left) hand pitting edema +1, lower abdominal bruising. Bilateral big toe hyper tropic toenail growth. Upper and lower extremity bruising/ discoloration. On 04/27/YYYY, Patient had MASD to buttock and bilateral ischium.

**Interventions:**

- Follow facility protocols for treatment of injury.

- Keep skin clean and dry. Use lotion on dry skin.

- Keep skin clean and dry. Use lotion on dry skin. Do not apply on (Specify: site of injury).

- Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx of infection, maceration etc. to MD.

- Use a draw sheet or lifting device to move resident.

- Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface.

On 05/01/YYYY, the patient was with alteration in nutrition and hydration status and at risk for malnutrition r/t (related to): Cerebral infarction due to embolism, hemiplegia and hemiparesis, dysphagia following cerebral infarction, obstructive hydrocephalus, acute and chronic respiratory failure, type 2 diabetes mellitus with hyperglycemia, acute metabolic acidosis, CKD, intracerebral hemorrhage, type 2 diabetes mellitus with diabetic chronic kidney disease.

**Activities of Daily Living (ADL) Assistance:**

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| --- | --- | --- |
| **ADL** | **Self-Performance** | **Support Provided** |
| Bed mobility, Locomotion on unit, Locomotion off unit, Dressing, Toilet use, Personal hygiene, Bathing | Total dependence | One person physical assist |
| Transfer | Total dependence | Two+ persons physical assist |
| Eating | Extensive assistance | One person physical assist |
| Walk in room, Walk in corridor | Activity did not occur | ADL activity itself did not occur |

Stage 2 - Number of Stage 2 pressure ulcers: 1. Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry: 1.

**Skin and Ulcer/Injury Treatments:**

* Pressure reducing device for bed
* Nutrition or hydration intervention to manage skin problems
* Pressure ulcer/injury care
* Surgical wound care
* Applications of ointments/medications other than to feet.

Braden score on 05/02/YYYY was 10. The patient was at a high risk of pressure ulcer. Braden score had reduced compared to initial admission.

On 05/03/YYYY, the resident was to be discharged to HH PP 275N Garnet Way A, Upland, CA 91786 per family request. Resident’s family was requesting for resident to transferred to a facility closer to them. They stated that they were happy with the care she was receiving there, but they would like her to be transferred closer to them and her primary doctors. Resident would be discharge once arrangements are made and authorization has been approved from insurance.

On 05/06/YYYY, cleanse stage 2 coccyx with saline, pat dry, apply barrier cream daily and prn, every 4 hours as needed, every day shift was documented. Stage 2 - Number of Stage 2 pressure ulcers: 1. umber of these Stage 2 pressure ulcers that were present upon admission/entry or reentry: 1. The patient was discharged to HH PP Nursing Center on 05/06/YYYY.

**Diagnosis Information:**

* Cerebral infarction due to embolism of right anterior cerebral artery (Principal diagnosis) (Admitting diagnosis)
* Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (Secondary)
* Dysphagia following cerebral infarction (Primary diagnosis)
* Muscle weakness (generalized) (during stay)
* Other abnormalities of gait and mobility (during stay)
* Obstructive hydrocephalus
* Acute and chronic respiratory failure, unspecified whether with hypoxia or hypercapnia
* Type 2 diabetes mellitus with hyperglycemia
* Epilepsy, unspecified, intractable, without status epilepticus
* Weakness
* Type 2 diabetes mellitus with diabetic chronic kidney disease
* Acute metabolic acidosis
* Cerebral edema
* Hypertensive heart disease without heart failure
* Nontraumatic subarachnoid hemorrhage from other intracranial arteries
* Nontraumatic subarachnoid hemorrhage from other intracranial arteries
* Nontraumatic intracerebral hemorrhage, intraventricular
* Nontraumatic intracerebral hemorrhage, multiple localized
* Nontraumatic intracranial hemorrhage, unspecified
* Cerebral infarction due to thrombosis of unspecified cerebellar artery
* Irritant contact dermatitis due to friction or contact with body fluids, unspecified
* Chronic kidney disease, unspecified
* Urinary tract infection, site not specified
* Laceration with foreign body of scalp, initial encounter
* Unspecified subluxation of left shoulder joint, initial encounter
* Long term (current) use of Anticoagulants
* Long term (current) use of Insulin

*On 05/06/YYYY, the patient was admitted in HH PP Nursing Center. The detailed medical records pertaining to HH PP Nursing Center are not available for review.*

On 05/07/YYYY, the patient was admitted in SAR Hospital. Patient with history of CVA, DM and HTN. BIBA (Brought in by ambulance), presented to the ED due to AMS. Per EMS, the patient has a history of a recent hemorrhagic stroke which has left her nonverbal and altered at baseline, however earlier that at the patient's SNF, the staff noticed that she was "harder to arouse' and unresponsive to her name. EMS indicated that the patient was normally more responsive to her name and painful stimuli at baseline. Additionally, on scene, the patient's O2 saturation level was 83%, prompting the patient to be placed on O2 on scene. The patient was recently discharged from Pomona Valley yesterday. EMS denied any recent injury, trauma, or fall, fever, chills, vomiting, diarrhea, hematuria, hematochezia, hematemesis, or any other concerns.

Patient with recent intracranial hemorrhage status post craniotomy presented with altered mentation. She was discharged to SNF from Pomona Valley Medical Center. Staff at facility noted even more altered mentation so she was transferred here for further care. Patient was noted to be hypotensive and tachycardic, concern for acute sepsis. She was fluid resuscitated with minimal improvement in her vital signs. Extensive work-up revealed uremia with acute renal failure and severe dehydration. She was hyponatremic as well. She was started on Levophed with good improvement of her blood pressure. She was started on broad-spectrum IV Antibiotics. She was placed on a central line for pressor administration. The case was discussed with the hospitalist who admitted for further care. The nephrology group and the neurosurgery group both were contacted of which agreed to evaluate the patient in house. Still pending urinalysis results but highly suspicious for UTI sepsis.

Noted that no records from HH PP were in patient's hard chart. So medical records could not be completed. Per patient’s sister, patient was at PVMC for SAH with aneurysm clipping -> CRRK SNF -> HH PP SNF for less than on (one) day.

**On 05/10/YYYY:**

**Skin Abnormality Information:**

|  |  |
| --- | --- |
| **Procedure** | **Findings** |
| **@0800hrs** | **@2000hrs** |
| **Minor Skin Abnormality** | Bruising, Denuded, Rash | Bruising, Denuded |
| **Bruising Details** | RUE, Right lower abdomen | BUE, Abdomen |
| **Denuded Details** | Peri area | Peri area |
| **Rash Details** | Scattered Middle chest |  |

**Urine Culture Report:** (Collected Date: 05/07/YYYY)

**Result:** >100000 cfu/ml Escherichia coli. >100000 cfu/ml Enterococcus faecalis. Serious enterococcal infections need Ampicillin, Penicillin or Vancomycin plus an Aminoglycoside.

**On 05/14/YYYY:**

**Skin Abnormality Information:**

|  |  |
| --- | --- |
| **Procedure** | **Findings** |
| **@0800hrs** | **@2000hrs** |
| **Minor Skin Abnormality** | Bruising, erythema | Bruising, erythema |
| **Bruising Details** | Bilateral upper extremities | Bilateral upper extremities |
| **Erythema Details** | Rightfoot, tip of big toe |  |
| **Other Skin Abnormality Details** |  | Stitches on head |

DTI noted to bilateral heels, and unstageable wounds noted to buttocks and left ischium.

|  |  |
| --- | --- |
| **Procedure** | **Findings** |
| **05/08/YYYY** | **05/09/YYYY** | **05/10/YYYY** | **05/11/YYYY** | **05/12/YYYY** |
| **Skin Integrity** | Pressure ulcer present, drain/tube present, minor skin abnormality present | Pressure ulcer present | Pressure ulcer present, wound present, minor skin abnormality present | Pressure ulcer present, wound present, minor skin abnormality present | Pressure ulcer present, Incision present, Drain/Tube present, Minor skin abnormality present |
| **Skin Turgor** | Elastic | Decreased | @0800hrs Decreased, @2000hrs Elastic | Elastic | Elastic |
| **Heel Inspection**  | @0200hrs Heels intact, @0800hrs Heels not intact | Heels intact | Heels not intact. DTI since admission | Heels not intact | Heels not intact |

|  |  |
| --- | --- |
| **Procedure** | **Findings** |
| **05/13/YYYY** | **05/14/YYYY** | **05/15/YYYY** | **05/16/YYYY** |
| **Skin Integrity** | Pressure ulcer present, Drain/Tube present, Minor skinabnormality present | Pressure ulcer present, Drain/Tube present, Minor skinabnormality present | @0800hrs Pressure ulcer present, minor skin abnormality present; @2000hrs Intact (no broken skin) | Pressure ulcer present, minor skin abnormality present |
| **Skin Turgor** | Elastic | Elastic | Elastic | Elastic |
| **Heel Inspection**  | Heels not intact | Heels not intact | Heels intact |  |

Her imaging demonstrated right frontal cranial infarct with residual brain edema. Her chest x-ray demonstrated mild left lower lobe atelectasis. Her labs are significant for a hypernatremia, leukocytosis, transaminitis, mildly elevated troponin level, and acute kidney injury with metabolic acidosis. She was started on broad-spectrum antibiotics in the emergency department. Per nursing home documentation, patient is verbal, eats regular diet. At the time of Dr. Elbert Chang examination patient was on 6 L/min oxygen via nasal cannula.

**05/9:** Patient was off pressor support, renal function has improved. Noted continued hypernatremia.

**05/10:** Remained off pressors, tolerating diet well.

**05/11:** On tele floor, off pressors. Passed swallow eval, Hypernatremia improving, Renal function improving.

**05/12:** Patient remained afebrile, vital stable. Tolerating diet well. Renal function continues to improve.

**05/13:** Patient remained medically stable, renal function is also stable. Tolerating diet.

**05/14:** Patient remained afebrile, vital signs stable. Renal function stable.

**05/15:** Patient remained afebrile, vital signs stable. Discharge planning back to SNF planned for tomorrow.

**05/16:** Patient cleared for discharge back to SNF.

On 05/16/YYYY, the patient was again transferred back to HH PP Nursing Center. On admission her Braden score was 11 - the patient was at a high risk of developing pressure ulcer.

**Pressure ulcer details:**

* UTD - Coccyx + Right ischium.
* DTI Bilateral heels.

On 05/17/YYYY, resident’s skin reassessment was done around 0454hrs. Resident alert/oriented x 4, able to verbalize needs. Resident demonstrated Foley Catheter Fr. 16 with 10 cc Balloon. Multiple Purplish Discolorations at bilateral Upper Extremities, Surgical incision at Top of Scalp (1 x 1 x UTD = 2 Sutures), and DTI at Left Heel (2.5 x 4 x UTD) and Right Heel (2 x 2 x UTD) and Sacrum Extending to Right Buttocks (13 x 10 x UTD), treatment was prescribed and carried out. All needs were met.

The patient required 1 person extensive assist with bed mobility and dressing. Incontinent of B/B (Bowel/Bladder) with F/C (Foley Catheter). F/C patent with 350cc of yellow/clear urine noted. Good F/C care rendered. Resident has F/C due to DTI (Deep Tissue Injury) to sacrococcyx. Turned/repositioned Q2H with pillows. To continue with tx orders per in house wound Dr. To begin PT/OT services during stay at facility. Extra fluids encouraged. Adjusting to facility well at this time with no roommate.

On 05/18/YYYY, the patient was alert to name verbal, in bed resting, no s/s of acute distress, able to make simple needs known, continues on Rehab PT/OT therapy, required extensive assistance with ADLs, toileting and reposition. Resident was self PO (Per Oral) feeder, with min assist to during meals to increase PO intake. Continued on PO ABX for UTI, no reported ASE at that time. Hydration encouraged as tolerated, ongoing wound care reposition Q 2 and PRN as tolerated. Resident had call light within reach, all needs meet by staff will continue to monitor resident.

On 05/25/YYYY, resident’s wound at bilateral heels reclassified from DTI (Deep Tissue Injury) to diabetic ulcer by Sophia Antillon, NP. Resident’s unstageable pressure injury at sacrococcyx stayed the same classification as per NP.

**On 05/29/YYYY:**

**Wound 1: Left foot/heel**

|  |  |
| --- | --- |
| **Location** | Left foot/heel |
| **Etiology** | DM ulcer |
| **Progress** | Deteriorating |
| **Length**  | 3cm |
| **Width** | 3cm |
| **Total Surface Area** | 9cm2 |
| **Depth** | UTD |
| **Quality** | 100% Eschar |
| **Periwound** | Dry |
| **Wound Dressing** | Continue same treatment |

**Wound 2: Right foot/heel**

|  |  |
| --- | --- |
| **Location** | Right foot/heel |
| **Etiology** | DM ulcer |
| **Progress** | Deteriorating |
| **Length**  | 1.5cm |
| **Width** | 1.5cm |
| **Total Surface Area** | 2.25cm2 |
| **Depth** | UTD |
| **Quality** | 100% Eschar |
| **Periwound** | Dry |
| **Wound Dressing** | Continue same treatment, off loading |

**Wound 3: Sacro Coccyx**

|  |  |
| --- | --- |
| **Location** | Sacro coccyx |
| **Etiology** | Pressure unstageable |
| **Progress** | Deteriorating |
| **Length**  | 10.7cm |
| **Width** | 8.5cm |
| **Total Surface Area** | 90.95cm2 |
| **Depth** | UTD |
| **Quality** | 100% Eschar |
| **Stage**  | UTD |
| **Drainage** | Scant |
| **Periwound** | Dry |
| **Procedure Performed** | 100% debridement to muscle |
| **Wound Dressing** | Continue same treatment, Silvadene cream. Daily with foam dressing. |

On 06/15/YYYY, the resident had diabetic ulcer to left heel, diabetic ulcer to right heel, and unstageable pressure injury to sacrococcyx with ongoing treatment. Resident was receiving vitamin and nutrition therapy to aid skin. She remained at high nutritional risk.

**On 06/29/YYYY:**

**Wound 1: Left foot/heel**

|  |  |
| --- | --- |
| **Location** | Left foot/heel |
| **Etiology** | Diabetic ulcer |

**Wound 2: Right foot/heel**

|  |  |
| --- | --- |
| **Location** | Right foot/heel |
| **Etiology** | Diabetic ulcer |

**Wound 3: Sacro Coccyx**

|  |  |
| --- | --- |
| **Location** | Sacro coccyx |
| **Etiology** | Pressure  |
| **Progress** | Improving |
| **Length**  | 10cm |
| **Width** | 6cm |
| **Total Surface Area** | 60cm2 |
| **Depth** | 1.5 |
| **Quality** | 80% Granulation, 20% Slough |
| **Stage**  | 4 |
| **Drainage** | Moderate |
| **Periwound** | Erythematous |
| **Procedure Performed** | 100% surgical debridement to muscle |
| **Wound Dressing** | +Tendon white started Medi honey and alginate daily on LAL/FC |

On 07/01/YYYY, prior to incident resident resting in bed laying on her. At that time she had no complains of pain no distress or discomfort, no sob. CNA reported to charge nurse that resident lying on floor on her left side of the bed body. Assessment rendered no apparent injury noted, no bruising noted. Resident was able to move all extremities without limitations. Neurocheck rendered, resident assisted back to bed. No complains of pain at that time. Just feeling anxious. Asked resident how incident occurred she stated that she was trying to put her bed control in her drawer and slipped out. Dr Wu made aware just to monitor resident for 72 hrs, Katherine resp. party made aware reminded resident to use call light for assistance and any other needs she may have bed low call light in reach will continue to monitor.

On 07/08/YYYY, the resident was about to be transferred from wheelchair to bed when suddenly fell forward but CNA was able to grab by underarm but still hit left knee on the floor. Was assisted to floor. No apparent injury, denies of pain, no bruising, no bump. Monitor.

On 07/12/YYYY, Site: Sacral coccyx

**Description:** Sacral coccyx PI stage 4: 9.5 x 5. 7 x 1.5, undermining 9:00-1:00 deepest @ 12:00: 2cm, 90% granulation, 10% slough, moderate drainage, erythematous periwound.

On 07/20/YYYY, wound care progress note by Dr. Akil Simon.

**Wound Assessment:**

**Wound #1:** Sacral is a Pressure Ulcer and has received a status of Not Healed. Measurements are 8.5cm length x 5.2cm width x 1.3cm depth with an area of 44.2 sq cm and a volume of 57.46 cubic cm. Undermining has been noted at 7:00 and ends at 12:00 with a maximum distance of 2cm. There is a Moderate amount of drainage noted. Wound bed has 76-100%, granulation, 1-25% slough. The wound is improving.

The periwound skin texture is normal. The periwound skin moisture is normal. The periwound skin color is normal.

**Procedures:**

**Wound #1:**

Wound #1 (Pressure Ulcer) is located on the sacral. A skin/subcutaneous tissue/muscle/fascia level excisional surgical debridement with a total area debrided of 44.72 sq cm was performed by Simon, Akil P., MD. Fascia, muscle and subcutaneous were removed to remove devitalized tissue: biofilm and slough. The following instrument(s) were used: curette. Pain control was achieved using Topical Benzocaine. A minimal amount of bleeding was controlled with pressure. The procedure was tolerated well. Post Debridement Measurements: 8.6cm length x 5.2cm width x 1.3cm depth; with an area of 44.72 sq cm and a volume of 58.136 cubic cm. Post debridement Stage noted as Stage 4 Pressure Injury.

**On 08/07/YYYY:**

|  |  |
| --- | --- |
| **Site** | Sacrum |
| **Type** | Pressure |
| **Length** | 8cm |
| **Width** | 5cm |
| **Depth** | 1.2cm |
| **Stage** | IV |
| **Shape** | Round/Oval |
| **Size Score** | Length x Width = 36.1-80 sq.cm |
| **Stage/Depth** | Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (tendon) |
| **Edges**  | Well-defined , not attached wound base |
| **Undermining** | Undermining 2- 4 cm involving < 50% of wound margins |
| **Necrotic Tissue Type** | Loosely adherent yellow slough |
| **Necrotic Tissue Amount** | <25% of wound bed covered |
| **Exudate Type** | Serosanguineous; thin, watery, pale red/pink |
| **Exudate Amount** | Moderate |
| **Skin Color Surrounding Wound** | Pink or normal for ethnic group |
| **Peripheral Tissue Edema** | None |
| **Peripheral Tissue Induration** | None |
| **Granulation Tissue** | Bright, beefy red ; 75% to 100% of wound filled or tissue overgrowth |
| **Epithelialization** | <25% wound covered |

On 08/14/YYYY, the resident was seen in bed awake, alert, and verbally responsive. Able to make needs known. Skin was clean and dry. Frequent visual checks rendered. Wound care treatment done, tolerated well. All due meds given as ordered, tolerated well no adverse reaction noted. All needs met and attended. Bed in low safe position. Call light in reach. Continue with plan of care. On 08/15/YYYY, the patient was discharged from HH PP Nursing Center.

**References:**

**Ref 1:**

<https://www.mayoclinic.org/diseases-conditions/bed-sores/symptoms-causes/syc-20355893>

<https://www.mayoclinic.org/diseases-conditions/bed-sores/diagnosis-treatment/drc-20355899>

**Ref 2:**

<https://www.mayoclinic.org/healthy-lifestyle/healthy-aging/in-depth/fall-prevention/art-20047358>

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