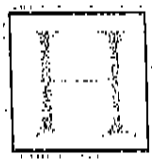

HOMESTEAD
POST ACUTE

1608 Versailles Road
Lexington, KY 40504
Phone: 859-252-0871
Fax: 859-255-2467

To: McGrath Inland Care Date: 8/20/25

From: Elvia T. Fax: 859-399-6697

Re: E. Bates No. of Pages (a/s+)

☐ Urgent ☑ For Review ☐ Please Comment ☐ Please Reply

Notes: will be d/c Monday 25th

ADMISSION RECORD

Homestead Post Acute
1608 Versailles Road
Lexington, KY 40504-2402
United States
TEL: (859) 252-0871
FAX: (859) 255-2467

Aug 20, 2025 11:05:28 ET

RESIDENT INFORMATION

Resident Name	Preferred Name	Unit	Room / Bed	Admission Date	Init. Adm. Date	Orig. Adm. Date	Resident #
Bates, Eddie		500-A	509-1	08/08/2025	06/24/2025	06/24/2025	10012

Previous address	Previous Phone #	Legal Mailing address
254 Ridgeway dr, Winchester, KY, 40391	(859) 213-1966	Same as Previous Address

Sex	Birthdate	Age	Marital Status	Religion	Race	Occupation(s)	Primary Lang.
M	01/03/1957	68	Divorced		White	Disabled	English

Admitted From	Admission Location	Birth Place	Citizenship	Maiden Name
			U.S.	

Medicare (HIC) #	Medicare Beneficiary ID	Social Security #	Advantage Plan #
	9MD4EF7GD02	***-**-1125	102155039900
Advantage Plan Name	**Medicaid #**	**Managed Medi-Cal #**	**Coins Policy #**
Aetna	0031966741		
Coinsurance Name	**LTC Insurance Name**	**LTC Insurance Policy #**	**Insurance**
Policy #	**Medical Record #**		

PAYER INFORMATION

Payer							
Primary Payer	Medicaid - KY (MCD-KY)	Medicaid #	0031966741	Group #		Ins. Company	MEDICAID KY
Second Payer	Share of Cost (SOC)						
Third Payer	Managed Care B (MGB)	Policy #	102155039900	Group #		Ins. Company	AETNA ADVANTAGE PLAN
Fourth Payer	Managed Care Coins-Medicaid	Medicaid #	0031966741				

OTHER INFORMATION

Most Recent Hospital Stay		Allergies
06/13/2025	06/24/2025	Cyclobenzaprine, diphenhydrAMINE, Tramadol

07000	**Admission Type**	**Admitted from County?**	**Arbitration Agreement Signed?**
	Short Term	Fayette	Signed
Authorization Expires	**Bariatric Recertification**	**Birthplace**	**Colonization Status/Pathogen**
Community Pharmacy	**Consent for Dental Services**	**Consent for Ophthalmology Services**	**Consent for Podiatry Services**
Consent for Psychiatric Services	**Consent for Psychological Services**	**County admitted from?**	**County of Residence**
		Clark	Clark
Date Medicare should be applied for	**Denti?**	**Director of Nursing**	**Facility Name**
			Homestead
Family does Laundry?	**Financial Resources**	**Funeral Home**	**Gender Identification**
No			Male
Gender Identification Preference	**Hospice Company**	**Insulin Insights Glucose Targets**	**Laundry done by?**
Male			Facility
Loc	**Managed Care Plan?**	**Managed Medi-Cal Recertification Date**	**MC 171 Date**
MCHC/MW Name & Phone	**Medi-Cal Redetermination Date**	**Medical worker and case #**	**Medicare A Coverage MBI#**
Medicare Advantage?	**Medicare B Coverage MBI#**	**Military Status**	**Mortician Signature**
Mother's Maiden Name	**Optum patient?**	**Part D Carrier**	**Personal Information Ind**
			Yes
Pet	**Physician**	**Preferred Hospital**	**Preferred Pronoun**
		Baptist	
Preferred Provider	**Prescription Drug Coverage - Ins Name**	**Resident Care Manager**	**Resident on Hemodialysis**
Social Security Number	**TAR Expiration Date**	**Trust Account?**	**ULTC End Date**
307-58-1125			
Under 65	**Uses Facility Wheelchair?**	**Uses Wheelchair?**	**Veteran**
no			
Veteran	**Veteran?**	**Voting Status**	**Wheelchair?**
No	No		

CARE PROVIDERS

Provider	Phone	Address	UPIN	NPI
Attending Physician (Primary) Doodnauth, Davanand	Office:(859) 286-9951 Fax:(859) 286-9952	1050Monarch St Suite 300 Lexington, KY 40573	157254	1568499804

Bates, Eddie(10012) -- Continued on Page 2

CARE PROVIDERS

Physiatrist Ilkanich, Paul	Office:(872) 231-3162	401Michigan Avenue Chicago, IL 60611		1639674500

PHARMACY

Pharmacy	Phone/Fax	Address
Med Care Pharmacy (Primary)	Phone: (859) 689-7130 Fax: (859) 689-6212	350 Aristocrat Drive Suite B Florence, KY, 41042

EXTERNAL FACILITIES

Facility Name	Phone	Facility Type
Baptist Health	Phone: (859) 260-6100	Hospital
Scobee Funeral Home	Phone: (859) 744-2422	Funeral Home
Solaris Diagnostics	Phone: (844) 550-0306	Laboratory

CONTACTS

Name	Contact Via	Relationship	Address	Phone/Email
Bates, Eddie	Resident Responsible Party Self	Self	254 Ridgeway dr Winchester, KY, 40391	Home:(859) 213-1966

DIAGNOSIS INFORMATION

Code	Description	On-Set Date	Rank	Classification
I69.398	OTHER SEQUELAE OF CEREBRAL INFARCTION	06/24/2025	Primary	Admission
J44.9	CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED	06/24/2025	A	Admission
E11.40	TYPE 2 DIABETES MELLITUS WITH DIABETIC NEUROPATHY, UNSPECIFIED	06/24/2025	B	Admission
J90	PLEURAL EFFUSION, NOT ELSEWHERE CLASSIFIED	06/24/2025	C	Admission
M86.9	OSTEOMYELITIS, UNSPECIFIED	06/24/2025	D	Admission
L89.154	PRESSURE ULCER OF SACRAL REGION, STAGE 4	06/24/2025	E	Admission
S72.001D	FRACTURE OF UNSPECIFIED PART OF NECK OF RIGHT FEMUR, SUBSEQUENT ENCOUNTER FOR CLOSED FRACTURE WITH ROUTINE HEALING	06/24/2025	F	Admission
R29.3	ABNORMAL POSTURE	06/24/2025	G	Admission
M62.81	MUSCLE WEAKNESS (GENERALIZED)	06/23/2025	H	Active Dx
Z89.611	ACQUIRED ABSENCE OF RIGHT LEG ABOVE KNEE	06/24/2025	I	Admission
Z89.512	ACQUIRED ABSENCE OF LEFT LEG BELOW KNEE	06/24/2025	J	Admission
D64.9	ANEMIA, UNSPECIFIED	06/24/2025	K	Admission
E78.5	HYPERLIPIDEMIA, UNSPECIFIED	06/24/2025	Rank N/A	Admission
F32.A	DEPRESSION, UNSPECIFIED	06/24/2025	Rank N/A	Admission
F41.9	ANXIETY DISORDER, UNSPECIFIED	06/24/2025	Rank N/A	Admission
I10	ESSENTIAL (PRIMARY) HYPERTENSION	06/24/2025	Rank N/A	Admission
I73.9	PERIPHERAL VASCULAR DISEASE, UNSPECIFIED	06/24/2025	Rank N/A	Admission
M85.89	OTHER SPECIFIED DISORDERS OF BONE DENSITY AND STRUCTURE, MULTIPLE SITES	06/24/2025	Rank N/A	Admission
N31.9	NEUROMUSCULAR DYSFUNCTION OF BLADDER, UNSPECIFIED	06/24/2025	Rank N/A	Admission
N40.1	BENIGN PROSTATIC HYPERPLASIA WITH LOWER URINARY TRACT SYMPTOMS	06/24/2025	Rank N/A	Admission

ADVANCE DIRECTIVE

DNR

MISCELLANEOUS INFORMATION

Date of Discharge	Time	Length of Stay	Discharged to(Medicaid Name and Update No)
		12	

Signature	Date	Time

Person Verified Sent With	Relationship	Date	Time

TRANSFER / DISCHARGE REPORT

20 Aug, 2025

Homestead Post Acute
1608 Versailles Road
Lexington KY 40504-2402 United States
(859) 252-0871

RESIDENT INFORMATION

Resident Name	Unit	Room/Bed	Admission Date	Resident No.
Bates, Eddie	500-A	509 1	08/08/2025	10012

Sex	Birthdate	Age	Marital Status	Religion	Primary Language	Secondary Language
M	01/03/1957	68	Divorced		English	

Medicare (HIC) #	Medicare Beneficiary ID	Social Security #	Advantage Plan #
	9MD4EF7GD02	***-**-1125	102155039900

Advantage Plan Name	Medicaid #	Managed Medicaid #	Other Policy #
Aetna	0031966741		

Co-Insurance Name	LTC Insurance Name	LTC Insurance Policy #	Insurance

Policy #	Medical Record #

OTHER INFORMATION

Allergies
Cyclobenzaprine, diphenhydrAMINE, Tramadol

Advance Directive	Copy Advance Directive/Living Will Enclosed	Diet Type	Diet Texture	Fluid Consistency
DNR	YES NO	CCHO, NAS	Regular	Thin Liquids

PRIMARY CONTACT

Name	Notified	Relationship	Address	Phone

Error: The primary contact type has not been specified.
A contact type to be used for Primary Contact must be selected in the Admin General Configuration section.

PRIMARY PHYSICIAN

Physician	Phone	Address
Doodnauth, Davanand	Office:(859) 286-9951	1050Monarch St Lexington,KY

DIAGNOSES

ABNORMAL POSTURE (R29.3)	ACQUIRED ABSENCE OF LEFT LEG BELOW KNEE (Z89.512)
ACQUIRED ABSENCE OF RIGHT LEG ABOVE KNEE (Z89.611)	ANEMIA, UNSPECIFIED (D64.9)
ANXIETY DISORDER, UNSPECIFIED (F41.9)	BENIGN PROSTATIC HYPERPLASIA WITH LOWER URINARY TRACT SYMPTOMS (N40.1)
CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED (J44.9)	DEPRESSION, UNSPECIFIED (F32.A)
ESSENTIAL (PRIMARY) HYPERTENSION (I10)	FRACTURE OF UNSPECIFIED PART OF NECK OF RIGHT FEMUR, SUBSEQUENT ENCOUNTER FOR CLOSED FRACTURE WITH ROUTINE HEALING (S72.001D)
HYPERLIPIDEMIA, UNSPECIFIED (E78.5)	MUSCLE WEAKNESS (GENERALIZED) (M62.81)
NEUROMUSCULAR DYSFUNCTION OF BLADDER, UNSPECIFIED (N31.9)	OSTEOMYELITIS, UNSPECIFIED (M86.9)
OTHER SEQUELAE OF CEREBRAL INFARCTION (I69.398)	OTHER SPECIFIED DISORDERS OF BONE DENSITY AND STRUCTURE, MULTIPLE SITES (M85.89)
PERIPHERAL VASCULAR DISEASE, UNSPECIFIED (I73.9)	PLEURAL EFFUSION, NOT ELSEWHERE CLASSIFIED (J90)
PRESSURE ULCER OF SACRAL REGION, STAGE 4 (L89.154)	TYPE 2 DIABETES MELLITUS WITH DIABETIC NEUROPATHY, UNSPECIFIED (E11.40)

LAST VITAL SIGNS

Blood Pressure	Pulse	Temperature	Respirations	Date of last Tetanus Shot
177/94 Date: 08/20/2025	80 Date: 08/19/2025	97.9 Date: 08/19/2025	18 Date: 08/19/2025	

CHIEF COMPLAINT(reason for transfer)

Other

TRANSFER / DISCHARGE REPORT

20 Aug, 2025

Homestead Post Acute
1608 Versaillee Road
Lexington KY 40504-2402 United Statee
(859) 252-0871

RESIDENT INFORMATION

Resident Name	Unit	Room/Bed	Admission Date	Resident No.
Bates, Eddie	500-A	509 1	08/08/2025	10012

RELEVANT INFORMATION

Behavior(s)	Ambulation	Bladder	Bowel	Feeding

Usual Level of Functioning

MISCELLANEOUS INFORMATION

Date of Transfer/Discharge	Time	Transferred/Discharged to
08/19/2025	23:05	Acute care hospital: ST. JOSEPH HOSPITAL

Signature	Date	Time

Personal Effects Sent With	Relationship	Date	Time

TRANSFER / DISCHARGE REPORT

20 Aug, 2025

Homestead Post Acute
1608 Versailles Road
Lexington KY 40504-2402 United States
(859) 252-0871

RESIDENT INFORMATION

Resident Name	Unit	Room/Bed	Admission Date	Resident No.
Bates, Eddie	500-A	509 1	08/08/2025	10012

CURRENT MEDICATIONS

The Last Administered column only includes medications with a Chart Code of 0 - Administered. For complete details, see the Medication Administration Record (MAR).

Medication	Last Administered	Diagnosis Related Diagnoses	Start Date	End Date
Advair Diskus Inhalation Aerosol Powder Breath Activated 250-50 MCG/ACT. Directions: 1 Inhalation inhale orally two times a day for COPD	08/20/2025 10:31		06/24/2025	
Zinc Oral Tablet 50 MG. Directions: Give 1 tablet by mouth one time a day for wound healing	08/20/2025 10:31		07/03/2025	
Calcium Carbonate Oral Tablet. Directions: Give 500 mg by mouth three times a day for bone healing	08/20/2025 10:31		07/10/2025	
Polyethylene Glycol 3350 Powder. Directions: Give 17 gram by mouth one time a day for constipation hold for loose stool	08/20/2025 10:31		08/08/2025	
Bactrim DS Oral Tablet 800-160 MG. Directions: Give 1 tablet by mouth two times a day for Prophylaxis	08/20/2025 10:31		08/07/2025	
Ascorbic Acid Oral Tablet 500 MG. Directions: Give 1 tablet by mouth one time a day for supplement	08/20/2025 10:31		06/25/2025	
Vitamin D-3 Oral Tablet. Directions: Give 2000 unit by mouth one time a day for bone healing	08/20/2025 10:31		07/10/2025	
Carvedilol Oral Tablet 3.125 MG. Directions: Give 1 tablet by mouth two times a day for HTN hold for SBP less than 110	08/20/2025 10:31		06/24/2025	
Enalapril Maleate Oral Tablet 5 MG. Directions: Give 1 tablet by mouth one time a day for HTN	08/20/2025 10:30		08/13/2025	
FeroSul Oral Tablet 325 (65 Fe) MG. Directions: Give 1 tablet by mouth one time a day for anemia	08/20/2025 10:30		08/25/2025	
Gabapentin Oral Tablet 100 MG. Directions: Give 2 tablet by mouth three times a day for neuropathy pain	08/20/2025 10:30		06/24/2025	
buPROPion HCl ER (XL) Oral Tablet Extended Release 24 Hour 300 MG. Directions: Give 1 tablet by mouth one time a day for depression	08/20/2025 10:30		06/25/2025	
Bumetanide Oral Tablet 1 MG. Directions: Give 1 tablet by mouth one time a day for urinary retention	08/20/2025 10:30		06/25/2025	
Nystatin External Cream 100000 UNIT/GM. Directions: Apply to back topically two times a day for Candidiasis	08/20/2025 10:30		08/05/2025	
cloNIDine HCl Oral Tablet 0.1 MG. Directions: Give 1 tablet by mouth one time a day for HTN hold for SBP less than 110	08/20/2025 09:30		06/25/2025	
Venelex External Ointment. Directions: Apply to penis topically every shift for Traumatic injury Cleanse wound with NS, Pat dry, apply venelex oint	08/20/2025 02:51		06/25/2025	
Atorvastatin Calcium Oral Tablet 40 MG. Directions: Give 1 tablet by mouth at bedtime for HLD	08/16/2025 21:26		06/24/2025	
HYDROcodone-Acetaminophen Oral Tablet 5-325 MG. Directions: Give 1 tablet by mouth every 6 hours as needed for severe pain	08/08/2025 14:28		08/24/2025	
Acetaminophen Oral Tablet 325 MG. Directions: Give 2 tablet by mouth every 4 hours as needed for moderate pain	08/07/2025 21:53		06/24/2025	

IMMUNIZATIONS

Immunization	Date Given
TB 2 Step Mantoux Skin Test (Step2)	07/09/2025
TB 2 Step Mantoux Skin Test (Step1)	06/24/2025
Influenza (high dose)	10/01/2024
Moderna COVID-19 (Spikevax) Seasonal 2024-2025	10/01/2024
Pneumovax	01/02/2024

Resident: Bates, Eddie (10012)

Order Details

Order Date: 8/20/2025 | 11 | 16 *

Order Category: Other *

Communication Method: (●) Phone ( ) Verbal ( ) Prescriber written ( ) Prescriber entered *

Ordered By: Doodnauth, Davanand *

(Current Primary Physician: Davanand Doodnauth)

Order Template Search: clear

Description:

```
DISCHARGE resident to home with homehealth to eval and tx for
PT, SN, and OT.
```

*

Order Type: *PACS-Ancillary Orders (non-MAR/TAR) - [] *

▫ Scheduling Details

▫ Audit Details

Physical Therapy
Treatment Encounter Note(s)

Provider: Homestead Post Acute

Bates, Eddie

Identification Information

Patient:	Bates, Eddie		
MRN:	10012	**DOB:**	1/3/1957

Date of Service: 8/19/2025 **Completed Date: 8/19/2025**

Summary of Daily Skilled Services

Precautions	Precautions: fall risk, RLE AKA, LLE BKA, NWB R LE, power w/c level baseline, foley, lift, pressure injury sacral region
97110	97110: PT assessed ROM/strength for progress note. Downgraded trunk strength goal. Incorporated trunk/hip flexion exercises in sitting and side lye positioning.
97530	97530: PT assessed functional mobility goals for progress note. Time spent educating patient on safety concerns with current d/c plans of returning home. Pt has agreed to remain in facility for 1 month. Pt's personal goal of returning home unrealistic. Complexity of condition and level of chronic debility impacts ability to progress to PLOF. Pt has been in/out of LTC facilities for >1.5 years. Loss of spinal and pelvic mobility coupled with gross trunk weakness and lack of counterweight with bil LE amputations impacts his ability to sit upright. Pt is not a candidate for new prothesis r/t level of debility. Pt also with wound on buttock region impacting tolerance to sitting in w/c. At this time, PT has downgraded goals; however will need to move toward d/c if progress continues to plateau.
97542	97542: PT assessed positioning in manual w/c requiring TD for repositioning hips for upright sitting. W/c level mobility limited r/t anti tippers engaging and front casters lifting. Recommend trial with lowering front caster wheel setting to reduce dumped position and improve safety w/ propulsion.
Response to Tx	Response to Treatment: Motivated and cooperative but physical limitations are profound.

Functional Status as a Result of Skilled Interventions

Bed Mobility	Rolling Right = Mod (A); Sit to Supine / Supine to sit = Max x 2
Transfers	Sit --> Stand = DNT; Chair / Bed / Chair Transfer = Total Dependence without attempts to initiate; Car Transfers = DNT
Gait	Gait: Level Surfaces = N/A - Not Applicable at this time
Other Areas	Stairs = N/A - Not Applicable at this time; Number of Stairs = 0 steps
	Curb Step = N/A - Not Applicable at this time
Sitting Balance	Static Sitting = Poor; Dynamic Sitting = Unable
Standing Balance	Static Standing = DNT; Dynamic Standing = DNT; Picking up object from floor = N/A - Not Applicable at this time

I accept responsibility for the content I documented in this patient's record and attest, to the best of my knowledge, that it accurately reflects the current performance, condition and medically necessary, skilled services provided per this patient's current treatment plan.

Original Signature: Electronically signed by Carrie Reuss (PT) 8/19/2025 05:49:25 PM EDT

Date

Occupational Therapy
Treatment Encounter Note(s)

Provider: Homestead Post Acute

Bates, Eddie

Identification Information

Patient:	Bates, Eddie		
MRN:	10012	**DOB:**	1/3/1957

Date of Service: 8/19/2025 **Completed Date: 8/19/2025**

Summary of Daily Skilled Services

Precautions	Precautions: fall risk, NWB R LE, power w/c level baseline, foley catheter
97530	97530: Facilitated transfer training via slide board approach from wheelchair to mat table (max assistX2/total assist required; poor trunk strength and BLE amputations impacting). Facilitated patient in sitting balance and tolerance training on mat table, instructing in achievement and sustainment of upright posture with COG over BOS, as well as attempts of dynamic sitting balance tasks (static sitting balance Fair-/Poor+ with UE support on grab bar; Dynamic balance Absent overall, presenting with immediate LOB without UE support). Trained on transfer back to wheelchair slide baord level (caution with sacral region due to skin integrity issues) with patient requiring total assist, with assist for optimal positioning in wheelchair. Discussed status/goals/plans. Patient adamant about returning back to his apartment, declining interest/pursuit of LTC residency. OT educated on benefits of 24/7 care at this time due to debility level, with patient expressing understanding.
Response to Tx	Response to Treatment: Fair-.....cooperative; complex issues, high debility level

Functional Status as a Result of Skilled Interventions

Standing Balance	Standing During ADLs = DNT
Sitting Balance	Sitting During ADLs = Poor

I accept responsibility for the content I documented in this patient's record and attest, to the best of my knowledge, that it accurately reflects the current performance, condition and medically necessary, skilled services provided per this patient's current treatment plan.

Original Signature: Electronically signed by Kyle Marcum (OT) 8/19/2025 06:03:18 PM EDT

Date

Skin & Wound Evaluation V7.0

Resident: Bates, Eddie (10012)	**Effective Date:** 08/12/2025 08:06	**Location:** 500-A 509 1
Initial Admission: 06/24/2025	**Admission:** 08/08/2025	**Date of Birth:** 01/03/1957
Score: NA	**Category:** NA	**Physician:** Doodnauth, Devanand

A. Describe

1. Type:
   - ○ 1. Abrasion
   - ○ 2. Abscess
   - ○ 3. Arterial
   - ○ 4. Blister
   - ○ 5. Bruise
   - ○ 6. Burn
   - ○ 7. Cancer Lesion
   - ○ 8. Diabetic
   - ○ 9. Hematoma
   - ○ 10. Hidradenitis Suppurativa
   - ○ 11. Laceration
   - ○ 12. Moisture Associated Skin Damage (MASD)
   - ○ 13. Mole
   - ○ 14. Open Lesion
   - ◉ 15. Pressure
   - ○ 16. Pressure - Kennedy Terminal Ulcer
   - ○ 17. Pressure - Medical Device Related Pressure Injury
   - ○ 18. Rash
   - ○ 19. Skin Tear
   - ○ 20. Surgical
   - ○ 21. Venous
   - ○ 22. Other

15a. Stage:
   - ○ 1. Stage 1: Non-blanchable erythema of intact skin
   - ○ 2. Stage 2: Partial-thickness skin loss with exposed dermis
   - ○ 3. Stage 3: Full-thickness skin loss
   - ◉ 4. Stage 4: Full-thickness skin and tissue loss
   - ○ 5. Deep Tissue Injury: Persistent non-blanchable deep red, maroon or purple discoloration
   - ○ 6. Mucosal Membrane: found on mucous membrane
   - ○ 7. Unstageable: Obscured full-thickness skin and tissue loss

22. Location
   Sacrum

23. Acquired:
   - ○ 1. In-House Acquired
   - ◉ 2. Present on Admission

24. How long has the wound been present? (wound age when first assessed, after that it is auto calculated):
   - ○ 1. New
   - ○ 2. Exact Date
   - ○ 3. 1 week
   - ○ 4. 2 weeks
   - ○ 5. 1 month
   - ○ 6. 1-3 months
   - ○ 7. 3-6 months
   - ○ 8. 6-9 months
   - ○ 9. 9-12 months
   - ○ 10. 1-2 years
   - ○ 11. Over 2 years

12. Unknown

24a. Exact Date:

25. Staged by
- 1. N/A
- 2. In-house nursing
- 3. Home Health
- 4. Hospice
- 5. Health Care Provider
- 6. Wound Care Clinic
- 7. Other

B. Wound Measurements

1. Area

1.2 cm2

2. Length

2.8 cm

3. Width

0.5 cm

4. Depth

0.1 cm

5. Undermining

Not Applicable

6. Tunneling

Not Applicable

C. Wound Bed

1. ☒ Epithelial
2. ☒ Granulation

2a. % Granulation
- 1. 100% of wound filled
- 2. 90% of wound filled
- 3. 80% of wound filled
- 4. 70% of wound filled
- 5. 60% of wound filled
- 6. 50% of wound filled
- 7. 40% of wound filled
- 8. 30% of wound filled
- 9. 20% of wound filled
- 10. 10% of wound filled
- 11. 0% of wound filled

3. ☐ Slough
4. ☐ Eschar

5. Evidence of Infection
- ☐ 1. Fever
- ☐ 2. Increased drainage
- ☐ 3. Increased pain

- [ ] 4. Malaise
- [ ] 5. Redness/inflammation
- [ ] 6. Streaking
- [ ] 7. Warmth
- [x] 8. None
- [ ] 9. Not applicable

6. Other

- [ ] 1. Bleeding
- [ ] 2. Bone
- [ ] 3. Fibrin
- [ ] 4. Gangrene
- [ ] 5. Hematoma
- [ ] 6. Hypergranulated
- [ ] 7. Intact blister
- [ ] 8. Islands of epithellum
- [ ] 9. Pink or red
- [ ] 10. Ruptured blister
- [ ] 11. Scab
- [ ] 12. Sutured
- [x] 13. None
- [ ] 14. Not applicable
- [ ] 15. Other

D. Exudate

1. Amount

- ( ) 1. None
- ( ) 2. Light
- ( ) 3. Moderate
- ( ) 4. Heavy

2. Type

- ( ) 1. None
- ( ) 2. Serous
- ( ) 3. Sanguineous/Bloody
- ( ) 4. Serosanguineous
- ( ) 5. Purulent
- ( ) 6. Seropurulent

3. Odor noted after cleansing

- ( ) 1. None
- ( ) 2. Faint
- ( ) 3. Moderate
- ( ) 4. Strong

E. Periwound

1. Edges:

- [ ] 1. Attached: Edge appears flush with wound bed or as a sloping edge
- [ ] 2. Non-Attached: Edge appears as a cliff
- [ ] 3. Rolled Edge (Epibole): Edge appears curled under
- [ ] 4. Epithelialization: New, pink to purple, shiny skin tissue

2. Surrounding Tissue:

- [ ] 1. Blanching (whitening of external tissue)
- [ ] 2. Blister
- [ ] 3. Calloused – Fibrotic or Hyper-keratotic

- ☑ 4. Dark reddish brown
- ☑ 5. Denuded – loss of epidermis caused by exposure to urine, feces, body fluids, wound exudate or friction.
- ☑ 6. Discoloration - black/blue
- ☑ 7. Dry/Flaky
- ☑ 8. Eczematous
- ☑ 9. Erythema: Redness of the skin - may be intense bright red to dark red or purple
- ☑ 10. Excoriated: Superficial loss of tissue
- ☑ 11. Fragile: Skin that is at risk for breakdown
- ☑ 12. Intact: Unbroken skin
- ☑ 13. Macerated: Wet, white, waterlogged tissue
- ☑ 14. Normal in color
- ☑ 15. Scarring
- ☑ 16. Other

3. Induration

- ◉ 1. None present
- ○ 2. Induration, < 2cm around wound
- ○ 3. Induration 2-4 cm extending < 50% around wound
- ○ 4. Induration 2-4 cm extending > 50% around wound
- ○ 5. Induration > 4 cm in any area around wound

4. Edema

- ◉ 1. No swelling or edema
- ○ 2. Non-pitting edema extends < 4cm around wound
- ○ 3. Non-pitting edema extends > 4 cm around wound
- ○ 4. Pitting edema extends < 4 cm around wound
- ○ 5. Crepitus and/or pitting edema extends > 4 cm around wound

5. Periwound Temperature:

- ○ 1. Cool
- ◉ 2. Normal
- ○ 3. Warm
- ○ 4. Hot (localized heat)

F. Wound Pain

1. ☑ Cognitively Impaired

8. Pain:

0	1	2	3	4	5	6	7	8	9	10

9. Pain Frequency:

- ◉ 1. None
- ○ 2. Intermittent
- ○ 3. At Dressing
- ○ 4. Continuous

10. Notes on Pain:

n/a

G. Orders

1. Goal of Care:

- ○ 1. Healable
- ◉ 2. Slow to Heal: wound healing is slow or stalled but stable, little/no deterioration
- ○ 3. Monitor/Manage: Wound healing not achievable due to untreatable underlying condition

H. Treatment

Skin & Wound Evaluation V7.0

Resident: Bates, Eddie (10012)

1. Dressing appearance:
   - [x] 1. Intact
   - [ ] 2. Missing
   - [ ] 3. Dry
   - [ ] 4. Saturated
   - [ ] 5. Leaking
   - [ ] 6. None
2. Cleansing Solution
   - [ ] 1. Acetic Acid
   - [ ] 2. Cetrimide
   - [ ] 3. Chlorhexidine
   - [ ] 4. Hydrogen peroxide
   - [x] 5. Normal Saline
   - [ ] 6. Povidone iodine
   - [ ] 7. Soap & Water
   - [ ] 8. Sodium hypochlorite
   - [ ] 9. Sterile Water
   - [ ] 10. Water
   - [ ] 11. Generic wound cleanser
   - [ ] 12. Other
   - [ ] 13. None
3. Debridement
   - ( ) 1. Autolytic
   - ( ) 2. Biologic
   - ( ) 3. Enzymatic
   - ( ) 4. Mechanical
   - ( ) 5. Polyacrylate
   - ( ) 6. Sharp
   - ( ) 7. Surgical-outpatient
   - (•) 8. None
4. Primary Dressing:
   - [ ] 1. Antimicrobial
   - [ ] 2. Antifungal
   - [ ] 3. Biologic
   - [x] 4. Calcium Alginate
   - [ ] 5. Charcoal
   - [ ] 6. Clear Acrylic
   - [ ] 7. Composite Dressing
   - [ ] 8. Film/Membrane
   - [ ] 9. Foam
   - [ ] 10. Hydrocolloid
   - [ ] 11. Hydrogel
   - [ ] 12. Hydrophilic Fiber
   - [ ] 13. Hypertonic
   - [ ] 14. Negative Pressure Wound Therapy
   - [ ] 15. Non-Adherent Synthetic
   - [ ] 16. Pain controlling
   - [ ] 17. Other
   - [ ] 18. No dressing applied
5. Secondary Dressing:
   - [ ] 1. Composite
   - [ ] 2. Compression wrap

- [x] 3. Dry
- [ ] 4. Film/Membrane
- [ ] 5. Foam
- [ ] 6. Hydrocolloid
- [ ] 7. Silicone
- [ ] 8. Other
- [ ] 9. No secondary dressing

6. Modalities

- [ ] 1. Electrical stimulation
- [ ] 2. Electromagnetic therapy
- [ ] 3. Ultrasound mist
- [ ] 4. Other
- [x] 5. None

7. Additional Care

- [ ] 1. Air Flow Pad
- [ ] 2. Compression
- [x] 3. Cushion
- [ ] 4. Customized shoe wear
- [ ] 5. Foam Mattress
- [ ] 6. Foot cradle
- [ ] 7. Heel Suspension/Protection device
- [ ] 8. Incontinence management
- [x] 9. Mattress with Pump
- [ ] 10. Mobility aid(s) provided
- [ ] 11. Moisture barrier
- [ ] 12. Moisture Control
- [x] 13. Nutrition/Dietary supplementation
- [ ] 14. Padded rails/chair
- [ ] 15. Positioning Wedge
- [ ] 16. Repositioning device(s)
- [x] 17. Turning/repositioning program
- [ ] 18. Other
- [ ] 19. None

I. Progress

1. Progress:

- ( ) 1. New
- (•) 2. Improving
- ( ) 3. Stable
- ( ) 4. Stalled
- ( ) 5. Deteriorating
- ( ) 6. Monitoring
- ( ) 7. Resolved

2. Infection

( ) 1. MD/Provider diagnosed infection ( ) 2. Suspected infection ( ) 3. None

3. Notes:

n/a

4. Education:

n/a

Notifications:

Skin & Wound Evaluation V7.0

Resident: Bates, Eddie (10012)

5. ☑ Practitioner Notified

5a. Enter name of practitioner notified:

Dr. Doodnauth

6. ☑ Resident/Responsible Party Notified:

6a. Enter name of resident/responsible party notified:

Self

7. ☑ Dietician Notified

7a. Enter the name of dietician notified:

Haven Kitchens

8. ☑ Therapy (PT, OT, ST) Notified

Signed By	Signed Date
Andreala Clark, LPN, Unit Coordinator [e-SIGNED]	08/14/2025

Patient: Bates, Eddie - 68yrs / Male
DOB: 01/13/1957
Location: Homestead Post Acute, DNR
Facility MRN: 10012
Admit/Discharge Date: 06/24/2025
Supervising Provider: Davanand Doodnauth
Rendering Provider: Davanand Doodnauth, MD

CC/HPI THIS VISIT

Chief Complaint/Reason for this Visit
Acute/F/u ER Visit

HPI Relating to this Visit
Discussed his recent ER visit, explaining that he had called 911 the previous day due to concerns about a bowel impaction. He reported that at the ER, large amounts of stool were noted in his colon, and he was advised to start Miralax; however, the order had not yet been placed at the facility. During the conversation, he expressed ongoing lower abdominal discomfort and pressure, as well as anxiety, stating he felt "on edge with his nerves" and requested reinstatement of his Xanax, which had previously been prescribed daily PRN but had fallen off his medication list after 14 days. He also reported difficulty with urination despite having a Foley catheter, noting only ~50 mL output in the bag at the time of assessment, and asked, "Why don't they just scan me with that thing?" Additionally, he complained of itching on his back. He denied fevers, chills, nausea, vomiting, or other systemic symptoms. Discussed the ER visit and his recent symptoms in detail, explaining the need for bowel regimen support, anxiety management, and skin treatment. The plan of care includes starting Miralax 17 GM PO QD, to be held if loose stools develop; restarting Xanax 0.5 mg PO QD PRN for anxiety for 14 days; and applying Nystatin cream to the back BID for cutaneous candidiasis until healed, with monitoring for effectiveness and notification of the provider if no improvement or worsening occurs.

ADMISSION INFORMATION RELATING TO THIS STAY

Admit History - Reason for Admission for this Stay
Assumption of Care visit for 68 yo WM resident of Homestead Post Acute following admission in 6/24/2025 from CRMC (6/22-6/24/25) after checking himself out of LTC facility had a fall at home resulting in right hip fracture . Non-operative management per Orthopedics. Evaluated by Urology for split urethra/chronic foley cath for BPH. Hopes to have suprapubic catheter placed in near future. Was DC home and unable to care for himself and returned to hospital and readmitted for placement to SNF.

PAST MEDICAL HISTORY

Active Medical Problems
- Benign prostatic hypertrophy with outflow obstruction
- Cerebral infarction
- Chronic Foley catheter
- Chronic obstructive lung disease
- Deep venous thrombosis
- Diabetes mellitus
- Dysfunction of urinary bladder
- Hypertensive disorder
- Hypokalemia
- Peripheral vascular disease
- Stage IV coccyx wound

Procedures:
- Appendectomy
- LBKA
- Percutaneous transluminal angioplasty of vein
- RAKA
- Stent in left leg

SOCIAL HISTORY

Alcohol Use
Never

Smoking Status (current)
Never smoker

Drug Use
Never

FAMILY HISTORY

Additional Text
Mother - DM2 (Non-contributory)
Deceased
Father - DM2, COPD, CAD (Non-contributory)
Deceased

REVIEW OF SYSTEMS

Additional Text
JUNE 2025
BIMS 14
PHQ9 12

PHYSICAL EXAM

Metrics

Date	Height	Weight	BMI
07/22/2025 07:23	59 in	159.8 lbs	32.3

Vitals

Date	Blood Pressure	Heart Rate	Resp Rate	Sp O_2	Blood Glucose	Temperature
08/05/2025 07:23	147/87	91	18	93%		97.9 °F

Additional Text: 7/25/2025 13:09 145.0 mg/dL

Additional Text
Late mild-aged WM, in bed on left side, in no distress; pleasant, cooperative, good historian: grey hair, mental status was appropriate aside from noted anxiety
nc/at, eomi, PEERL, pink conjunctiva, DMM, no thyromegaly or cervical lymphadenopathy, puffy sub orbits
=expansion b/l without wheezes rales or rhonchi
non-displaced PMI, reg s1, s2
ABD is distended and tender, consistent with bladder fullness, which was further supported by a report from staff that 800 mL of urine had been drained after a recent foley catheter change, norm bowel sounds
skin warm, dry, back with light erythematous rash consistent with cutaneous candidiasis
ext: without edema to bil stumps, BLE amputee, right AKA, left BKA
Neuro: cn 2-12 intact, gross motor weakness without sensory deficits
Psych: normal affect, good mood

MEDICATIONS/ALLERGIES

Environmental Allergies
- No known environmental allergies

Medication Allergies
Benadryl (Onset: Unknown)
cyclobenzaprine (Onset: Unknown)
Tramadol (Onset: Unknown)

Medications Additional Text
ACETAMINOPHEN ORAL TABLET 325 MG 2 TABLETS EVERY 4 HOURS AS NEEDED
ADVAIR DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 250-50 MCG/ACT 1 INHALATION TWO TIMES A DAY
ANTIBIOTIC EXTERNAL OINTMENT 500 UNIT/GM APPLY EVERY SHIFT
ASCORBIC ACID ORAL TABLET 500 MG ONE TIME A DAY
ATORVASTATIN CALCIUM ORAL TABLET 40 MG AT BEDTIME
BUMETANIDE ORAL TABLET 1 MG ONE TIME A DAY
BUPROPION HCL ER (XL) ORAL TABLET EXTENDED RELEASE 24 HOUR 300 MG ONE TIME A DAY
CALCIUM CARBONATE ORAL TABLET 500 MG THREE TIMES A DAY
CARVEDILOL ORAL TABLET 3.125 MG TWO TIMES A DAY
CLONIDINE HCL ORAL TABLET 0.1 MG ONE TIME A DAY
ENALAPRIL MALEATE ORAL TABLET 2.5 MG ONE TIME A DAY
FEROSUL ORAL TABLET 325 (65 FE) MG ONE TIME A DAY
GABAPENTIN ORAL TABLET 100 MG 2 TABLETS THREE TIMES A DAY
HYDROCODONE-ACETAMINOPHEN ORAL TABLET 5-325 MG EVERY 6 HOURS AS NEEDED
VENELEX EXTERNAL OINTMENT APPLY EVERY SHIFT
VITAMIN D-3 ORAL TABLET 2000 UNIT ONE TIME A DAY
ZINC ORAL TABLET 50 MG ONE TIME A DAY

DATA

Laboratory

Date: 06/13/2025
CBC
WBC: 10.23
HB/Hgb: 10.8
HCT: 34.5
MCV: 84.4
Platelet count: 426

CMP
NA: 137
K: 4.0
Glu: 82
BUN: 43
Creat: 1.3
Cl: 103
Cal: 9.0
TP 7.4
ALB 3.4
AST 32 ALT 32
ALP 171
CK 355

BT 0.6

Date: 07/01/2025

CMP
NA: 143
K: 4.3
Glu: 86
BUN: 29
Creat: 1.18
Cl: 104
Cal: 8.6
TP: 5.7
AST: 48
TBIL: <0.2
ALP: 182
Alb: 2.6
ALT: 75

Lipid panel
Cholesterol 100
HDL 33.6
LDL 45.2
Triglycerides 106

TSH 2.72

CBC cancelled
HgA1c cancelled

Date: 07/02/2025

CBC
WBC: 7.58
HB/Hgb: 9.7
HCT: 32.6
MCV: 87.9
Platelet count: 324

HgA1c 5.6

CXR . No acute focal consolidation or effusion. 2. The prior opacities are not redemonstrated.

ASSESSMENT AND PLAN

1. acute on chronic constipation: He called 911 the previous day due to concerns about a bowel impaction. He reported that at the ER, large amounts of stool were noted in his colon, and he was advised to start Miralax; however, the order had not yet been placed at the facility.

8/5/25: Start Miralax 17GM PO QD . Hold for loose stool
2. anxiety: During the conversation, he expressed anxiety, stating he felt "on edge with his nerves" and requested reinstatement of his Xanax, which had previously been prescribed daily PRN but had fallen off his medication list after 14 days.

8/5/25: Restart Xanax 0.5mg PO QD PRN for anxiety for 14 days
3. candidiasis: He complained of itching on his back. Examination of his back revealed a light erythematous rash consistent with cutaneous candidiasis.

8/5/25: Start Nystatin cream to back BID for Candidiasis of skin on back until healed. Monitor everyday for effectiveness

of treatment and notify provider if no improvement or worsens
4. urinary retention: Reinforce order for bladder scan if minimal F/C output is noted.

Catheter change or adjustment if mechanical obstruction suspected.

Provider to assess for possible suprapubic catheter if chronic urinary retention persists and related to known prostate issues.

Additional text
8/5/25
Orders
1. Miralax 17GM PO QD . Hold for loose stool
2. Restart Xanax 0.5mg PO QD PRN for anxiety for 14 days
3. Nystatin cream to back BID for Candidiasis of skin on back until healed. Monitor everyday for effectiveness of treatment and notify provider if no improvement or worsens

GENERAL

Summary of episode note
8/5/25
PLAN OF CARE / ORDERS TO BE IMPLEMENTED
Miralax 17g PO QD for constipation; hold if patient develops loose stools.

Restart Xanax 0.5mg PO QD PRN for anxiety for 14 days. Medication previously discontinued after 14-day period; now reinstated per patient request and behavioral need.

Nystatin cream BID to affected areas of back for cutaneous candidiasis until resolution. Monitor rash daily; notify provider if no improvement or if condition worsens.

Evaluate urinary retention:

Reinforce order for bladder scan if minimal F/C output is noted.

Consider catheter change or adjustment if mechanical obstruction suspected.

Provider to assess for possible suprapubic catheter if chronic urinary retention persists and related to known prostate issues.

Continue addressing abdominal discomfort:

Encourage stool softeners and laxatives as tolerated.

Monitor bowel movements closely and document response to Miralax.

Communicate clearly with nursing staff and management:

Ensure all orders are implemented timely.

Emphasize need for prompt action when patient reports urinary or bowel concerns.

Direct conversation occurred with nursing manager regarding care delays.

Follow-up monitoring:

Daily assessment of urine output, abdominal girth/pain.

Continue Foley care; reassess catheter function as needed.

Monitor anxiety and sleep; assess need for continuation of Xanax at 14-day mark

Signed by:
- Alicia Lewis LPN on Aug 5, 2025 at 7:32AM CDT
- Julia Martinez Limon on Aug 13, 2025 at 11:07AM CDT
- Davanand Doodnauth MD on Aug 17, 2025 at 10:12AM CDT

Patient Name: EDDIE BATES Patient DOB: 01/03/1957 Encounter: 4240336

Department:
Report Type: **/dms/physd**
Interpreter:
Order Number: **378575_PHYSICIAN_DOCUMENTATION**

Start Date: **06/13/2025**
End Date:

*Admission History and Physical

Clark Regional Medical Center

Date of Service Jun-13-2025

Admitted Jun-13-2025

Discharged -

Name Bates, Eddie DOBJan-03-1957 (M) 2106
Attending ZOHARY HOSSAM MD Encounter4240336
Primary VANBUSSUM RITCH MRN 53261

Chief Complaint

= Fell at home

HPI / Subjective

Mr. Eddie Bates is a 68-year-old male with a past medical history of right above-knee amputation and left below-knee amputation who was brought by EMS to Clark Regional Medical Center Emergency Department on 06/13/2025 after a fall at home occurred on 06/13/2025. The patient is with bilateral amputation lower extremity wheelchair-bound presents with the ED with a fall during transfer. Patient apparently has been MayFair Manor Nursing home but left against medical advice on 06/12/2025 he went home. While at home has been transferred and he fell. Your like to go back to the nursing home because he cannot take care of himself at home since he cannot walk. Pain Management: The patient declined offer of pain medication. No head trauma. No loss of consciousness. No bleeding. No open wounds

Past Medical History

Dysfunction of urinary bladder
Unstageable pressure injury
Peripheral vascular disease
Cerebral infarction
Hypokalemia
Deep venous thrombosis

Patient Name: EDDIE BATES Patient DOB: 01/03/1957 Encounter: 4240336

Benign prostatic hypertrophy with outflow obstruction
Chronic obstructive lung disease
Diabetes mellitus
Hypertensive disorder

Past Surgical History

Stent in left leg
Percutaneous transluminal angioplasty of vein
Amputation of lower limb, Left and right
Appendectomy

Home Medications

Advair Diskus 250-50 mcg/dose Blister, With Device
Dose: 1 INH INHALED TWICE A DAY
alprazolam 0.5 mg Tablet, Extended Release 24 hr
Dose: 1 TAB BY MOUTH TWICE A DAY
atorvastatin 40 mg tablet
Dose: 1 TAB BY MOUTH ONCE DAILY
bumetanide 1 mg tablet
Dose: 1 TAB BY MOUTH ONCE DAILY
bupropion HCl 300 mg Tablet, Extended Release 24 hr
Dose: 1 TAB BY MOUTH ONCE DAILY
carvedilol 3.125 mg tablet
Dose: 1 TAB BY MOUTH TWICE A DAY
clonidine HCl 0.1 mg tablet
Dose: 1 TAB BY MOUTH ONCE DAILY
gabapentin 100 mg capsule
Dose: 2 CAP BY MOUTH THREE TIMES A DAY
Insulin Syringe 1 mL 29 gauge x 1/2" Syringe
Dose: FOUR TIMES A DAY
Lipitor 40 mg tablet
Dose: 1 TAB BY MOUTH AT BEDTIME
Zyrtec 10 mg tablet
Dose: 1 TAB BY MOUTH ONCE DAILY

Patient Name: EDDIE BATES Patient DOB: 01/03/1957 Encounter: 4240336

Name Bates, Eddie Date of Service Jun-13-2025
2106 DOBJan-03-1957 (M)
Attending ZOHARY HOSSAM MD Admitted Jun-13-
2025 Encounter4240336
Discharged -
Primary VANBUSSUM RITCH
MRN 53261

Allergies

Benadryl - Not Specified
TRAMADOL - Not Specified
CYCLOBENZAPRINE - hallucinateS

Family History

Parents
Father Deceased
Diabetes mellitus; Chronic obstructive lung disease; Coronary arteriosclerosis
Mother Deceased
Diabetes mellitus

Social History

Denies: Tobacco abuse, Alcohol Use, Drug abuse

Review of Systems

Narrative
Constitutional: No Weight Change, No Fever, No Chills, No Night Sweats, No Fatigue, No Malaise

HEENT: NC/AT, No blurred vision, No double vision, No Nasal Congestion, No Sinus Pain, No Hoarseness, No sore throat, No Rhinorrhea, No Dysphagia

Neck: No neck pain, No Lymphadenopathy

Cardiovascular: No Chest Pain, No Palpitations, No tachycardia, No bradycardia, NO DOE, No Orthopnea, No Edema

Respiratory: No Cough, No Sputum, No Hemoptysis, No Wheezing, No Dyspnea

Gastrointestinal: No Abdominal Pain, No Nausea, No Vomiting, No Diarrhea, No Constipation, No Heartburn, No Anorexia, No Dysphagia, No Hematochezia, No Melena,

Genitourinary: No painful urination, No Hematuria, No Incontinence

Musculoskeletal: No Arthralgias, No Myalgias, No Joint Swelling, No Joint Stiffness, No Back Pain, No Neck Pain, No Injury History

Patient Name: EDDIE BATES Patient DOB: 01/03/1957 Encounter: 4240336

Skin: No Skin Lesions, No Pruritis

Neuro: No Weakness, No Numbness, No Paresthesias, No Loss of Consciousness, No Syncope, No Dizziness, No Headache,

Psych: No Anxiety/Panic, No Depression, No Hallucinations

Heme/Lymph: No Bruising, No Bleeding, No Lymphadenopathy

Endocrine: No Polyuria, No Polydipsia, No Temperature Intolerance

Physical Exam

Vital Signs

Jun-13-2025 2106
T 97.7 HR 78 RR 18 BP 140 / 65 O2Sat 98

Jun-13-2025 1603
T 98.9 HR 83 RR 16 BP 175 / 75 O2Sat 98 WTKG 68

Narrative

*Admission History and Physical

Clark Regional Medical Center

Name Bates, Eddie
DOBJan-03-1957 (M)
Date of Service Jun-13-2025
2106
Attending ZOHARY HOSSAM MD
Admitted Jun-13-
2025
Encounter4240336
Discharged
-
Primary VANBUSSUM RITCH
MRN 53261

General: NAD, sitting comfortably in bed

HEENT: NC/AT, PERRL, EOMI, No pharyngeal erythema, No tonsillar exudate

Neck: No tenderness, No lymphadenopathy

Cardiovascular: RRR no m/r/g, no JVD, no carotid bruits

Patient Name: EDDIE BATES Patient DOB: 01/03/1957 Encounter: 4240336

Lungs: CTA bilaterally, No w/r/r

Abdomen: Nontender, Nondistended, BS+ X4, No guarding,

Extremities: No edema, cyanosis or clubbing

Skin: no signs of skin infection

Musculoskeletal: -limitation of motion of right hip

Neurological: Alert and oriented x 3, CN 2-12 grossly intact. No loss of sensation

Psychiatry: No depression, No abnormal affect, Normal mood, Normal Cognition

Lab Results

Jun-13-2025 2020
Glucose Blood Strip/Poc
GLMETER 74

Jun-13-2025 1756
*****Reference Lab*****
IG# 0.07

Jun-13-2025 1756
*****Hematology*****
WBC 10.23 RBC 4.09 HGB 10.8 (L) HCT 34.5 (L) MCV 84.4 MCH 26.4 MCHC 31.3 (L)
RDW 14.6 (H) PLT 426 (H) MPV 8.8 NEUT% 83.2 (H) LYMPH % 9.8 (L) MONO% 5.6
EOS% 0.5 (L) BASO% 0.2 IG% 0.7 NRBC% 0.0 NEUT# 8.52 LYMPH # 1.00 MONO# 0.57
EOS# 0.05 BASO# 0.02 NRBC# 0.00 MAN DIFF No

Jun-13-2025 1755
*****Chemistry*****
SODIUM 137 K 4.0 CHLORIDE 103 CO2 23 AGAP 11 GLUCOSE 82 BUN 43 (H) CREA 1.3
BUN/CREA 33 (H) GFR 60 OSMO CAL 295 TP 7.4 ALB 3.4 (L) CALCIUM 9.0 BILI T 0.6
AST 32 ALT 32 ALP 171 (H) CK 355 (H)

Imaging Results

- CT PELVIS WO IV OR PO
CLINICAL HISTORY: 68 years Male, fall
COMPARISON: None.

TECHNIQUE:
Axial CT images of the pelvis were obtained without intravenous contrast. Coronal and sagittal reformats were obtained. Dose reduction techniques including dose modulation, automated exposure control and/or iterative reconstruction were utilized.
FINDINGS:
Images are slightly degraded due to motion artifact.
There is impacted subcapital fracture of the right femur. There is extensive sclerosis of the bilateral femoral heads, likely sequela of

severe degenerative changes versus osteonecrosis. Degenerative changes of the bilateral hip joints with the loss of joint space is noted.
There is extensive heterotopic ossification noted adjacent to the left hip joint with the soft tissue calcification.
There is soft tissue swelling adjacent to the right hip joint. Moderate to severe fecal retention of the rectosigmoid colon is noted. Foleys catheter is noted in the bladder. Atherosclerotic vascular calcification of the visualized abdominal aorta and its branches.
IMPRESSION:
Impacted subcapital fracture of the right femoral neck. Minor associated soft tissue swelling.

==========

- CT LUMBAR SPINE WITHOUT IV CONTRAST, 6/13/2025 5:25 PM CDT
EXAMINATION: CT LUMBAR SPINE WITHOUT CONTRAST
CLINICAL INDICATION: Male, 68 years old. fall
TECHNIQUE: Axial CT images were obtained through the lumbar spine in soft tissue and bone windows without intravenous contrast. Coronal and Sagittal reformatted images were created from the data set. One or more of the following dose reduction techniques were used: Automated exposure control, adjustment of the mA and/or kV according to patient size, and/or iterative reconstruction. Unless otherwise specified, incidental findings do not require dedicated imaging follow-up. RP0090.
COMPARISON: No existing relevant imaging and/or the patient did not have previous relevant imaging.

Patient Name: EDDIE BATES Patient DOB: 01/03/1957 Encounter: 4240336

FINDINGS:
Mild generalized osteopenia is noted. Multilevel degenerative changes of the lumbar spine with the mild loss of disc height. Facet joint arthropathy at multiple levels, worse in the lower lumbar levels noted. Anterior osteophyte formation at multiple levels. No acute fractures or traumatic subluxation is noted.
There is moderate to severe canal and foraminal narrowing noted at multiple levels, worse in the lower lumbar levels with moderate to severe bilateral foraminal narrowing at L4-5 and L5-S1. Degenerative changes of the bilateral sacroiliac joints are noted.
There is small bilateral pleural effusions, partially visualized.
Atherosclerotic vascular calcification of the visualized abdominal aorta..
IMPRESSION:
No acute fractures or traumatic subluxation. Degenerative changes of the lumbar spine.

Assessments

Closed fracture of neck of right femur

Plan

= Acute subcapital Right Hip fracture [Impacted subcapital fracture of the right femoral neck]
CT scan of the pelvis on the right hip has been performed in the ED
ED medical provider spoke with Dr. Price, orthopedic surgeon who agreed to get the patient admitted to Clark Regional
Medical Center
I placed a consult to case management for discharge planning

= Mechanical fall at home on 6/13/2025
No head trauma, no loss of consciousness
CT scan of the lumbar spine without acute fracture

Patient Name: EDDIE BATES Patient DOB: 01/03/1957 Encounter: 4240336

Clark Regional Medical Center

Name Bates, Eddie Date of Service Jun-13-2025
2106 DOBJan-03-1957 (M)
Attending ZOHARY HOSSAM MD Admitted Jun-13-
2025 Encounter4240336
Discharged
Primary VANBUSSUM RITCH -
MRN 53261

= history of Right Above-knee amputation

= History of Left Below-knee amputation

= essential hypertension

We will verify his home medication and resume home antihypertensives accordingly

- Mayfair Manor nursing home in Lexington Kentucky
The patient was in the nursing home and he left AMA on 06/12/2025
Placed a consult to case management

= GI prophylaxis. I placed the patient on Protonix

= DVT prophylaxis. I placed the patient on subcutaneous Lovenox and sequential compression device

Inpatient - 2 Midnight Stay

Positive for The patient is being admitted with expected length of stay of at least 2 midnights.

Discharge Plan

Upon discharge I anticipate the patient will need SNF/rehab placement or going back to Nursing Home

Time spent with Patient

41 minutes

Electronically signed by ZOHARY HOSSAM MD on Jun-14-2025 0622

Clark Regional

Facsimile Transmission

To:	Name:	LoriHomestead
	Fax Number:	18592865906
	Voice Phone:	18008071301
	Company:	Homestead
	Time:	Tuesday, June 24, 2025 8:20:40 AM (Eastern Time Zone)
From:	Name:	Jennifer Ashcraft
	Phone:	(859)745-3500
	Fax Number	(859)737-6602
	Pages:	09

Message:

Clark Regional Medical Center (NPI: 1811213994)
175 Hospital Dr
Winchester, KY 40391

Patient Name: EDDIE BATES Patient DOB: 01/03/1957 Encounter: 4242907

Clark Regional Medical Center (NPI: 1811213994)

Encounter No: **4242907** **BATES, EDDIE** **01/03/1957** **Male**

Insurance Plan: **MEDICAID KY**
Insurance Type: **Medicaid**
Group/Policy/Seq: **/0031966741/1**

Admission Date: **06/22/2025 9:14 PM** Admitting MD: **3202**
Discharge Date: Attending MD: **3202**
Effective Date: Pre-Approved Days/Cert #: **/ PENDING/**

Contact Date/Time: **06/23/2025 08:12 AM**
Company: **MEDICAID KY**
Reviewer: **Jennifer Ashcraft**
Agency: **Homestead**
Contact Type:
Contact: **Lori/Homestead**
Phone: **(800)807-1301** Fax: **(859)286-5906** Master Fax:

PC Status: **Completed (C)**
PC Outcome:
Reason:

Days Requested: **0** Req From: Req Thru:
Days Approved: **0** App From: App Thru:

Ref #: Cert#: **PENDING/**

Note:
06/24/25 DC Summary. Thanks Jennifer
06/23/25 DC Summary. Thanks Jennifer
06/23/25 H&P. Thanks jennfier

Return Call: Next Contact:

Patient Name: EDDIE BATES Patient DOB: 01/03/1957 Encounter: 4242907

Department:
Report Type: **/dms/physd**
Interpreter:
Order Number: **379538_PHYSICIAN_DOCUMENTATION_4189241**

Start Date: **06/23/2025**
End Date:

Discharge Summary

Clark Regional Medical Center

Name Bates, Eddie
DOBJan-03-1957 (M)
Date of Service Jun-23-2025
1020
Attending RAINES SELENA GM DO
Admitted Jun-22-2025
Encounter4242907
Discharged
Primary VANBUSSUM RITCH
MRN 53261

Addendum

Patient discharged to Homestead nursing home yesterday. He remained in the hospital overnight secondary to transportation issues. Stable for transport this morning.

Electronically signed by MILLER KEVIN D APRN on Jun-24-2025 0746

Addendum

45 minutes
Discharge plan again discussed with the case management team and with patient in person.

Electronically signed by KUVLIEV ENIO E MD on Jun-23-2025 1223

Admit Date

Admit Date: Jun-22-2025

Discharge Date

Discharge Date: 6/23/2025

Patient Care Team

Admitting Provider: RAINES SELENA GM DO
Attending Provider: RAINES SELENA GM DO

Patient Name: EDDIE BATES Patient DOB: 01/03/1957 Encounter: 4242907

Consulting Provider:

Discharge Diagnosis

Social factor

Fracture of bone of hip region

chronic
Hyperlipidemia

Retention of urine

Essential hypertension

Diabetes mellitus

History of Present Illness

Patient is a 68-year-old Caucasian male just recently admitted after he checked himself out of a long-term care facility. Patient had went home and sustained a fall right hip fracture was evaluated by Orthopedics who did not recommend any surgery. Patient also with history of BPH and chronic Foley with split urethra was evaluated by Urology in hopes of having suprapubic catheter placed. Patient was evaluated by Urology his previous admission and he tells me the plan is for the suprapubic catheter placement in the near future. Additional past medical history significant for diabetes mellitus, COPD, hypertension. Patient was evaluated by AP who felt that the patient could be discharged home however when the patient did arrived home he was unable to care for himself and came right back to the hospital. He does have chronic unstageable pressure injury and osteomyelitis. Patient was admitted to the hospitalist service.

Hospital Course

Hospital day 2: 06/23/2025: Day of discharge. Patient re-evaluated in the medical-surgical unit. He is working physical therapy. He is getting a bath this morning. He feels well. He

Patient Name: EDDIE BATES Patient DOB: 01/03/1957 Encounter: 4242907

Name Bates, Eddie Date of Service Jun-23-2025
1020 DOBJan-03-1957 (M)
Attending RAINES SELENA GM DO Admitted Jun-22-
2025 Encounter4242907
Discharged
Primary VANBUSSUM RITCH -
MRN 53261

is on room air oxygen. Denies any pain. No nausea or vomiting. Denies any constipation. Patient was accepted by
Homestead skilled nursing facility in his stable for transfer today.

Vital Signs

Jun-23-2025 0719
T 97.7 HR 77 RR 18 BP 167 / 72 O2Sat 97

Intake and Output

	previous day	current day	encounter cumulative
Intake	-	-	-
Output	302	-	302
Balance	(-302)	-	(-302)

Physical Exam

Narrative

General: Patient is a 68-year-old Caucasian male who is alert and oriented x3 and in no acute distress, appears
chronically ill.
HEENT: Head atraumatic, normocephalic, pupils equal round react light, ear nose throat unremarkable.
Neck: Supple, trachea midline, no JVD.
Respiratory: Lungs clear to auscultation bilaterally.
Cardiovasculer: Regular rate and rhythm no murmur gallop or rub.
Abdomen: Soft, nontender, bowel sounds present x4 quadrants.
GU: Chronic Foley catheter his urethra split to the base of his penis.
Musculoskeletal/extremities: No edema, no pulse deficits. Right AKA left BKA noted. No bruising at hips.
Neurological: Cranial nerves grossly intact, no focal deficits.
Psychiatric: Affect is appropriate.
Skin: He does have a chronic sacral decubitus with a foam dressing does not appear to be infected also has ulcer
to the left. Also dressed does not appear to be infected.

Procedures and Surgeries

None

Patient Name: EDDIE BATES Patient DOB: 01/03/1957 Encounter: 4242907

Condition at Discharge

Stable

Discharge Medications

ACETAMINOPHEN 650 MG BY MOUTH EVERY FOUR HOURS AS NEEDED for FEVER (TEMP]101F), MILD PAIN: 1-3 PAIN SCALE, MODERATE PAIN: 4-6 PAIN SCALE

Advair Diskus 250-50 mcg/dose Blister, With Device 1 INH INHALED TWICE A DAY

alprazolam 0.5 mg Tablet, Extended Release 24 hr 1 TAB BY MOUTH TWICE A DAY AS NEEDED for ANXIETY (Printed by MILLER KEVIN D APRN on Jun-23-2025 1013)

ascorbic acid (VITAMIN C) 500 MG BY MOUTH ONCE DAILY

bumetanide 1 mg tablet 1 TAB BY MOUTH ONCE DAILY

bupropion HCl 300 mg Tablet, Extended Release 24 hr 1 TAB BY MOUTH ONCE DAILY

carvedilol 3.125 mg tablet 1 TAB BY MOUTH TWICE A DAY

clonidine HCl 0.1 mg tablet 1 TAB BY MOUTH ONCE DAILY

dextrose 50% SYRINGE (25 GM) 25 ML IV PUSH AS NEEDED for HYPOGLYCEMIA

FEROSUL 325 MG BY MOUTH ONCE DAILY

Patient Name: EDDIE BATES Patient DOB: 01/03/1957 Encounter: 4242907

gabapentin 100 mg capsule 2 CAP BY MOUTH THREE TIMES A DAY (Printed by KUVLIEV ENIO E MD on Jun-23-2025 1017)

HYDROcodone/acetaminophen 5/325 MG 1 TAB BY MOUTH EVERY SIX HOURS AS NEEDED for SEVERE PAIN: 7-10 PAIN SCALE (Printed by MILLER KEVIN D APRN on Jun-23-2025 1013)

insulin lispro (HumaLOG) 100 UNIT/ML Sliding Scale SUBCUTANEOUS SLIDING SCALE AS NEEDED for HYPERGLYCEMIA

Lipitor 40 mg tablet 1 TAB BY MOUTH AT BEDTIME

multivitamin (ONE-A-DAY) 1 TAB BY MOUTH ONCE DAILY

Discharge Instructions

Diabetic diet
Daily wound care stage IV to the coccyx as follow cleanse daily with soap water, apply silver alginate to the wound bed daily and covered with foam dressing. Turn q.2h. Offloading mattress.

Follow-Up

With PCP in 3-4 weeks.
With Orthopedics as scheduled.
With urology as scheduled.

Time spent with Patient

45 minutes spent evaluating the patient with Dr. Kuvliev, reviewing the chart formulating discharge plan, discharging the patient from the hospital.

Electronically signed by MILLER KEVIN D APRN on Jun-23-2025 1120

I hereby attest the note that was written on this patient accurately reflects the notations made when patient was examined.
Electronically signed by KUVLIEV ENIO E MD on Jun-23-2025 1223

Patient Name: EDDIE BATES Patient DOB: 01/03/1957 Encounter: 4242907

Patient Name: EDDIE BATES Patient DOB: 01/03/1957 Encounter: 4242907

MRSA: Y
VRE:

CLARK REGIONAL MEDICAL CENTER

175 Hospital Drive • Winchester, Kentucky 40391 • (859) 745-3500

Advance Directive: N

REGISTRATION ADMISSION

PATIENT ACCOUNT NO:	MEDICAL RECORD NO:
4242907	000053261

PATIENT (Name, Address, Phone)

BATES EDDIE
254 RIDGEWAY DR
WINCHESTER KY 40391
COUNTY: CLARK
PHONE: (859)213-1966

BIRTH DATE	AGE	SEX	RACE	SOCIAL SECURITY NO	PRIMARY LANGUAGE
01/03/1957	68	M	W	307-58-1125	E

MAR STATUS	RELIGION	FC	ADMITTED BY	HIPAA NM	HIPAA RM	HIPAA REL	HIPAA COND
D	N	12	OPT	Y	Y	Y	Y

ADMISSION DATE & TIME	DISCHARGE DATE & TIME	SERVICE	ROOM / BED NO
06/22/25 21:14		MIP	102 / 1

PATIENT EMAIL ADDRESSES

HOME: fbates8509@gmail.com
WORK:
OTHER:

PATIENT EMPLOYER (Name, Address, Phone, Occ)

DISABLED
WINCHESTER KY 40391
PHONE:
OCC:

EMERGENCY CONTACT 1 (Name, Address, Phone, Rel)

BATES FLORENCE
PHONE: (859)882-9059
REL: OTHER/POA/CONSERVATO

EMERGENCY CONTACT 2 (Name, Address, Phone, Rel)

DECLINED
PHONE:
REL:

GUARANTOR (Name, Address, Phone, Rel)

BATES EDDIE
254 RIDGEWAY DR
WINCHESTER KY 40391
PHONE: (859)213-1966
REL: SELF

GUARANTOR EMPLOYER (Name, Address, Phone)

DISABLED
WINCHESTER KY 40391
PHONE:

ATTENDING PHYSICIAN (Name, Number)

RAINES SELENA GM DO 3202

ADMITTING PHYSICIAN (Name, Number)

RAINES SELENA GM DO 3202

REFERRING PHYSICIAN (Name, Number)

RAINES SELENA GM DO 3202

PRIMARY CARE PHYSICIAN (Name, Number)

VANBUSSUM RITCH 3729

PRIMARY INSURANCE

MMC AETNA MCARE PPO
PO BOX 981106
EL PASO TX 79998
PHONE: (800)624-0756
POLICY# 102155039900
GROUP #: 0
GRP NAME:
AUTH#: PENDING/
BATES EDDIE
SEX: M RELATION: 18

SECONDARY INSURANCE

MEDICAID KY
PO BOX 2106
FRANKFORT KY 406022106
PHONE: (800)807-1301
POLICY# 0031966741
GROUP #:
GRP NAME:
AUTH#: PENDING/
BATES EDDIE
SEX: M RELATION: 18

TERTIARY INSURANCE

PHONE:
POLICY#
GROUP #:
GRP NAME:
AUTH#:
SEX: RELATION:

CHIEF COMPLAINT / ADMITTING DIAGNOSIS

HIP FRACTURE

COMMENTS

OCCURRENCE CODES

11

CR1000/040325

06/23/25 08:23

FACESHET

** 00724242907 CR1000A ADMISSIONS 06/22/25 000053261 BATES EDDIE