

Signature HealthCare of South Louisville

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FAX

TO:		FROM: Signature South	
ADDRESS:		PAGES: 29	
FAX: 859-399-6697		PHONE:	
DATE: 11-7-25		TIME:	
RE: Dang		CC:	
<input type="checkbox"/> URGENT	<input checked="" type="checkbox"/> FOR REVIEW	<input type="checkbox"/> PLEASE COMMENT	<input type="checkbox"/> PLEASE REPLY
<input type="checkbox"/> PLEASE RECYCLE			

COMMENTS:

waived notes.

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South Louisville

Physician Order Report: 11/07/2025 - 11/07/2025**Dang, Chin T (Full Code)**

MR#:	392500-04	DOB:	04/18/1947	Age:	78	Sex:	F
Room/Bed:	126/A	Unit:	East Wing	Admit Date:	08/21/2025 15:16		
Alerts:				Allergies:	No known allergies		
Diagnoses:	S98.011B Complete traumatic amputation of right foot at ankle level, subsequent encounter(Primary), Z47.81 Encounter for orthopedic aftercare following surgical amputation(Admission), I73.9 Peripheral vascular disease, unspecified, E46 Unspecified protein-calorie malnutrition-at risk for malnutrition/MNS, I70.261 Atherosclerosis of native arteries of extremities with gangrene, right leg, M16.11 Unilateral primary osteoarthritis, right hip, N17.9 Acute kidney failure, unspecified, I21.4 Non-ST elevation (NSTEMI) myocardial infarction, M86.171 Other acute osteomyelitis, right ankle and foot, E11.52 Type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene, D72.829 Elevated white blood cell count, unspecified, I25.10 Atherosclerotic heart disease of native coronary artery without angina pectoris, I50.9 Heart failure, unspecified, E11.528 Type 2 diabetes mellitus with other skin complications, E78.5 Hyperlipidemia, unspecified, I10 Essential (primary) hyper						

Order Type	Start Date	End Date	Description	Ordered By
General	09/27/2025	Open Ended	Healing Partners to provide wound management assessment and treatment by provider as needed	Dr. Muhammad Babar MD

Order Type	Start Date	End Date	Description	Ordered By
Prescription	09/28/2025	Open Ended	Betadine (povidone-iodine) [OTC] solution; 10 %; amt: 1 application; topical Special Instructions: Cleanse right foot with wound cleanser, pat dry. Apply betadine moistened gauze to open areas and cover with ABD pad. Secure with kerlix. Change once daily and PRN sollage/dislodgement. Twice A Day - PRN; PRN 1, PRN 2	Dr. Muhammad Babar MD
Prescription	09/28/2025	Open Ended	Betadine (povidone-iodine) [OTC] solution; 10 %; amt: 1 application; topical Special Instructions: Cleanse right foot with wound cleanser, pat dry. Apply betadine moistened gauze to open areas and cover with ABD pad. Secure with kerlix. Change once daily and PRN sollage/dislodgement. Twice A Day; 07:00 - 11:00, 19:00 - 23:00	Dr. Muhammad Babar MD

Order Type	Start Date	End Date	Description	Ordered By
General	09/27/2025	Open Ended	NWB to RLE	Dr. Muhammad Babar MD
Prescription	11/07/2025	Open Ended	Betadine (povidone-iodine) [OTC] solution; 10 %; amt: 1 application; topical Special Instructions: Cleanse right shin surgical wound with normal saline, pat dry. Apply betadine moistened gauze to wound bed and cover with ABD pad. Secure with kerlix. Change BID and PRN sollage/dislodgement. Twice A Day; 07:00 - 11:00, 19:00 - 23:00	Dr. Muhammad Babar MD

Signatures

Phys. Sig.	Date:	Above Orders Noted by:	Date:
R.N. Review	Date:	Pharm Review	Date:

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Wound Management Detail Report

Patient: Chln T

MR# 392500 U/R/B: East Wing/126/A

Status: In House Attending: Dr. Muhammad Babar MD

Surgical incision

Wound Type	Wound Location	Date/Time Identified
Surgical incision	Left knee left BKA	09/26/2025 20:16
Present on Admission/Re-entry?	Created By	Created Date/Time
Yes	Yarberry RN, Kathryn	10/03/2025 08:43

Closed/Discontinued Information

Comment: resolved

Closed/Discontinued Date/Time: 10/15/2025 12:25

Observation

Date/Time Observed Surgical Incision: 09/27/2025 14:16

Length - head to toe direction (centimeters): 2

Width - hip to hip direction (centimeters): 10

Observation of surgical incision completed?: Yes

Appearance of surgical incision: Incision with open area

Skin surrounding incision: Normal color

Incision drainage: None

Surgical drains: None

Wound healing status: Stable

Comments: NO s/s infection noted, Improvement seen since last assessment

Created By: Yarberry RN, Kathryn

Created Date/Time: 10/03/2025 08:43

South Louisville

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Wound Management Detail Report

Wound, Chlnt

MR# 392500 U/R/B: East Wing/126/A

Status: In House Attending: Dr. Muhammad Babar MD

Surgical incision

Wound Type	Wound Location	Date/Time Identified
Surgical incision	Right shin right anterior leg	09/26/2025 20:16
Present on Admission/Re-entry?	Created By	Created Date/Time
Yes	Yarberry RN, Kathryn	10/03/2025 08:45

Healed/Discontinued Information

This wound has not been healed/discontinued.

Observation

Date/Time Observed Surgical Incision: 11/05/2025 10:02

Length - head to toe direction (centimeters): 7

Width - hip to hip direction (centimeters): 2

Observation of surgical incision completed? Yes

Appearance of surgical incision: Incision with open area

Skin surrounding incision: Normal color

Incision drainage: None

Surgical drain: None

Wound healing status: Stable

Comments: Fixator removed on 10/31. No visible/s. Infection, no c/o pain or discomfort.

Created By: Yarberry RN, Kathryn

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Wound Management Detail Report

Patient: Chin T

MR# 392500 U/R/B: East Wing/126/A

Status: In House Attending: Dr. Muhammad Babar MD

Created Date/Time: 11/07/2025 10:02

Observation Edit History

Edited			
Date/Time Edited	Edited by	Reason	Reason Note
	Yarberry RN, Kathryne	Incorrect Date	
Date/Time Observed Surgical Incision:			
Length - head to toe direction (centimeters)	7		
Width - hip to hip direction (centimeters)	2		
Observation of surgical incision completed?	Yes		
Appearance of surgical incision	Incision with open area		
Skin surrounding incision	Normal color		
Incision drainage	None		
Surgical drains	None		
Wound healing status	Stable		
Comments	Fixator removed on 10/31. No visible s/s infection, no		
Created By:	Yarberry RN, Kathryne		
Created Date/Time:			

Observation

Date/Time Observed Surgical Incision: 10/29/2025 15:00

Length - head to toe direction (centimeters): 8.8

Width - hip to hip direction (centimeters): 2

Observation of surgical incision completed?: Yes

Appearance of surgical incision: Edges well approximated

Skin surrounding incision: Normal color

Incision drainage: None

South Louisville

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Wound Management Detail Report

ing, Chin T

MR# 392500 U/R/B: East Wing/126/A

Status: In House Attending: Dr. Muhammad Babar MD

Surgical drains:	None
Wound healing status:	Stable
Treated By:	Yarberry RN, Kathryn
Treated Date/Time:	10/29/2025 16:00

Observation

Date/Time Observed Surgical Incision:	10/22/2025 12:21
Length - head to toe direction (centimeters):	8.8
Width - hip to hip direction (centimeters):	2
Observation of surgical incision completed?:	Yes
Appearance of surgical incision:	Edges well approximated; Sutures present
Skin surrounding incision:	Normal color
Incision drainage:	None
Surgical drains:	None
Wound healing status:	Improving
Comments:	No visible s/s infection, pain controlled. Fixator present. Will continue with current treatment per surgeon order.
Treated By:	Yarberry RN, Kathryn
Treated Date/Time:	10/22/2025 12:22

Observation

Date/Time Observed Surgical Incision:	10/15/2025 14:23
Length - head to toe direction (centimeters):	8.8

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Wound Management Detail Report

Wound, Chin T

MR# 392500 U/R/B: East Wing/126/A

Status: In House Attending: Dr. Muhammad Babar MD

Width - hip to hip direction (centimeters): 2

Observation of surgical incision completed?: Yes

Appearance of surgical incision: Incision with open area

Skin surrounding incision: Normal color

Incision drainage: None

Surgical drains: None

Wound healing status: Stable

Treated By: Yarberry RN, Kathryn

Treated Date/Time: 10/15/2025 14:24

Observation

Date/Time Observed Surgical Incision: 09/27/2025 14:16

Length - head to toe direction (centimeters): 8.8

Width - hip to hip direction (centimeters): 2

Observation of surgical incision completed?: Yes

Appearance of surgical incision: Sutures present

Skin surrounding incision: Normal color

Incision drainage: None

Surgical drains: None

Wound healing status: Stable

Comments: external fixator in place. No visible s/s infection noted. treatment orders per surgeon.

Treated By: Yarberry RN, Kathryn

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Wound Management Detail Report

Wound, Chin T

MR# 392500 U/R/B: East Wing/126/A

Status: In House Attending: Dr. Muhammad Babar MD

Created Date/Time: 10/03/2025 08:48

Observation Edit History

Edited			
Date/Time Edited	Edited by	Reason	Reason Note
	Yarberry RN, Kathyryne	More Data Available	
Date/Time Observed Surgical Incision:			
Length - head to toe direction (centimeters)	8.8		
Width - hip to hip direction (centimeters)	2.1		
Observation of surgical incision completed?	Yes		
Appearance of surgical incision	Sutures present		
Skin surrounding incision	Normal color		
Incision drainage	None		
Surgical drains	None		
Wound healing status	Stable		
Created By:	Yarberry RN, Kathyryne		
Created Date/Time:			

Surgical incision

Wound Type	Wound Location	Date/Time Identified
Surgical incision	Right top of foot right foot	09/26/2025 20:18
Present on Admission/Re-entry?	Created By	Created Date/Time
Yes	Yarberry RN, Kathyryne	10/03/2025 08:48

Healed/Discontinued Information

This wound has not been healed/discontinued.

Observation

IatrxCare Report

User: Kathyryne Yarberry RN

Date: 11/07/2025 10:07:25

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Wound Management Detail Report

ing, Chin T

MR# 392500 U/R/B: East Wing/128/A

Status: In House Attending: Dr. Muhammad Babar MD

Date/Time Observed Surgical Incision: 11/07/2025 10:03

Length - head to toe direction (centimeters): 4

Width - hip to hip direction (centimeters): 9

Observation of surgical incision completed?: Yes

Appearance of surgical incision: Incision with open area

Skin surrounding incision: Normal color

Incision drainage: None

Surgical drains: None

Wound healing status: Stable

Comments: No visible s/s infection noted, pain controlled with current pain regime. Treatment orders per surgeon.

Treated By: Yarberry RN, Kathryne

Treated Date/Time: 11/07/2025 10:04

Observation

Date/Time Observed Surgical Incision: 11/05/2025 15:38

Length - head to toe direction (centimeters): 4

Width - hip to hip direction (centimeters): 9.3

Observation of surgical incision completed?: Yes

Appearance of surgical incision: Incision with open area

Skin surrounding incision: Normal color

Incision drainage: None

Surgical drains: None

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Wound Management Detail Report

Wound, Chin T

MR# 392500 U/R/B: East Wing/126/A

Status: In House Attending: Dr. Muhammad Babar MD

Wound healing status:

Stable

Treated By:

Yarberry RN, Kathrynne

Treated Date/Time:

11/05/2025 15:36

Observation**Date/Time Observed Surgical Incision:**

10/29/2025 15:01

Length - head to toe direction (centimeters):

4

Width - hip to hip direction (centimeters):

9.3

Observation of surgical incision completed?:

Yes

Appearance of surgical incision:

Incision with open area

Skin surrounding incision:

Normal color

Incision drainage:

None

Surgical drains:

None

Wound healing status:

Improving

Treated By:

Yarberry RN, Kathrynne

Treated Date/Time:

10/29/2025 15:02

Observation**Date/Time Observed Surgical Incision:**

10/22/2025 12:17

Length - head to toe direction (centimeters):

4.1

Width - hip to hip direction (centimeters):

9.5

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Wound Management Detail Report

ing, Chin T

MR# 392500 U/R/B: East Wing/126/A

Status: In House Attending: Dr. Muhammad Babar MD

Observation of surgical incision completed?:	Yes
Appearance of surgical incision:	Incision with open area
Skin surrounding incision:	Normal color
Incision drainage:	None
Surgical drains:	None
Wound healing status:	Improving
Comments:	No visible s/s infection, pain controlled. Will continue with current treatment per surgeon order.
Treated By:	Yarberry RN, Kathryne
Treated Date/Time:	10/22/2025 12:19

Observation

Date/Time Observed Surgical Incision:	10/15/2025 14:21
Length - head to toe direction (centimeters):	9
Width - hip to hip direction (centimeters):	4.5
Observation of surgical incision completed?:	Yes
Appearance of surgical incision:	Incision with open area
Skin surrounding incision:	Normal color
Incision drainage:	None
Surgical drains:	None
Wound healing status:	Stable
Treated By:	Yarberry RN, Kathryne
Treated Date/Time:	10/15/2025 14:23

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Wound Management Detail Report

Wound, Chin T

MR# 392500 U/R/B: East Wing/126/A

Status: In House Attending: Dr. Muhammad Baber MD

Observation

Date/Time Observed Surgical Incision: 09/27/2025 14:18

Length - head to toe direction (centimeters): 9

Width - hip to hip direction (centimeters): 4

Observation of surgical incision completed?: Yes

Appearance of surgical incision: Incision with open area

Skin surrounding incision: Normal color

Incision drainage: None

Surgical drains: None

Wound healing status: Stable

Comments: Surgical site assessed by wound care nurse. treatment orders per surgeon. No visible s/s infection noted at this time. Currently on IV abt.

Treated By: Yarberry RN, Kathryn

Treated Date/Time: 10/03/2025 08:49

Arterial Ulcer

Wound Type	Wound Location	Date/Time Identified
Arterial Ulcer	Right heel	09/26/2025 20:16
Present on Admission/Re-entry?	Created By	Created Date/Time
Yes	Yarberry RN, Kathryn	10/03/2025 08:50

Discontinued Information

MatrixCare Report

User: Kathryn Yarberry RN

Date: 11/07/2025 10:07:25

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Wound Management Detail Report

Patient, Chln T

MR# 392500 U/R/B: East Wing/126/A

Status: In House Attending: Dr. Muhammad Babar MD

This wound has not been healed/discontinued.

Observation

Date/Time Observed Arterial Ulcer: 11/05/2025 15:36

Length - head to toe direction (centimeters): 3

Width - side to side direction (centimeters): 3

Can depth be measured?: Yes

Exudate Amount: None

Wound odor present?: No

Depth of tissue injury: Full thickness: Through dermis & down to subq tissue, muscle

Undermining present?: No

Sinus tract/tunneling present: No

Issue Type: Necrotic Tissue

Percent of wound covered by eschar tissue: 100

Wound edges/margins: Edge attached to base; Well defined wound edges

Skin surrounding wound: Assess within
cm of wound edge: Pink/Normal

Is a wound vac present?: No

Wound healing status: Stable

Treated By: Yarberry RN, Kathrynne

Treated Date/Time: 11/05/2025 15:37

Observation

outh Louisville

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Wound Management Detail Report

ing, Chin T

MR# 392500 U/R/B: East Wing/126/A

Status: In House Attending: Dr. Muhammad Babar MD

Date/Time Observed Arterial Ulcer: 10/29/2025 15:01

Length - head to toe direction (centimeters): 3

Width - side to side direction (centimeters): 3

Can depth be measured?: No

Exudate Amount: None

Foul odor present?: No

Depth of tissue injury: Full thickness: Through dermis & down to subq tissue, muscle

Undermining present?: No

Sinus tract/tunneling present: No

Issue Type: Necrotic Tissue

Wound edges/margins: Well defined wound edges

Is a wound vac present?: No

Wound healing status: Stable

Treated By: Yarberry RN, Kathryn

Treated Date/Time: 10/29/2025 15:01

Observation

Date/Time Observed Arterial Ulcer: 10/22/2025 12:19

Length - head to toe direction (centimeters): 3

Width - side to side direction (centimeters): 3

Exudate Amount: None

Foul odor present?: No

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Wound Management Detail Report

ing, Chin T

MR# 392500 U/R/B: East Wing/126/A

Status: In House Attending: Dr. Muhammed Baber MD

Depth of tissue injury: Full thickness: Through dermis & down to subq tissue, muscle

Undermining present?: No

sinus tract/tunnelling present: No

Issue Type: Necrotic Tissue

Percent of wound covered by eschar tissue: 100

Wound edges/margins: Edge attached to base; Well defined wound edges

Skin surrounding wound: Assess within 1 cm of wound edge: Dry & thin

Is a wound vac present?: No

Wound healing status: Improving

Comments: No visible s/s infection, pain controlled. Will continue with current treatment per surgeon order.

Treated By: Yarberry RN, Kathrynne

Treated Date/Time: 10/22/2025 12:21

Observation

Date/Time Observed Arterial Ulcer: 10/15/2025 14:24

Length - head to toe direction (centimeters): 4

Width - side to side direction (centimeters): 3

Can depth be measured?: Yes

Depth - measure deepest part of visible wound (centimeters): 0.1

Exudate Amount: None

Wound odor present?: No

Depth of tissue injury: Full thickness: Through dermis & down to subq tissue, muscle

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Wound Management Detail Report

Wound, Chin T

MR# 392500 U/R/B: East Wing/126/A

Status: In House Attending: Dr. Muhammad Babar MD

Undermining present?:	No
Inus tract/tunneling present:	No
Issue Type:	Necrotic Tissue
Percent of wound covered by eschar tissue:	100
Wound edges/margins:	Edge attached to base; Well defined wound edges
Skin surrounding wound: Assess within cm of wound edge:	Pink/Normal
Is a wound vac present?:	No
Wound healing status:	Stable
Treated By:	Yarberry RN, Kathrynne
Treated Date/Time:	10/15/2025 14:24

Observation

Date/Time Observed Arterial Ulcer:	09/26/2025 20:16
Length - head to toe direction (centimeters):	3.6
Width - side to side direction (centimeters):	3.5
Can depth be measured?:	No
Exudate Amount:	Light
Exudate color and consistency:	Serous (clear, amber, thin and watery)
Wound odor present?:	No
Undermining present?:	No
Inus tract/tunneling present:	No
Issue Type:	Necrotic Tissue

South Louisville

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Wound Management Detail Report

Patient, Chin T

MR# 392500 U/R/B: East Wing/126/A

Status: In House Attending: Dr. Muhammad Babar MD

Wound edges/margins: Edge attached to base; Well defined wound edges

Skin surrounding wound: Assess within
cm of wound edge: Pink/Normal

Is a wound VAD present?: No

Wound healing status: Stable

Comments: New wound present on admission. Treatment orders per surgeon.
No visible s/s infection

Treated By: Yarberry RN, Kathryn

Treated Date/Time: 10/03/2025 08:51

NOTE:

Healing Partners
Skin and Wound Note
Wendi Whitworth, N.P.

PATIENT NAME: Dang, Chin
DATE OF SERVICE: 10/01/2025
DOB: 04/18/1947
FACILITY: SOUTH LOUISVILLE

HPI:

Information necessary for today's visit was obtained from the staff, the patient's medical records. Reason for visit: readmission to the facility, skin/wound assessment.

Chin T Dang is a female who is a resident at SOUTH LOUISVILLE on 08/21/2025. Ms. Dang is being seen today due to recent hospital stay from September 16 and discharged back to skilled nursing facility September 26, 2025. Patient with history of diabetic foot ulcer that has been difficult to treat. Patient originally presented to orthopedic for follow up and was noted to have worsening of her wound. Patient admitted to the hospital for further treatment. Patient was taken to the OR on September 17 and again on September 19 was noted to have gangrene and underwent ID amputation of transmetatarsal. She went back for revision on September 19. Patient's cultures group Proteus Mirabilis patient has been receiving IV ceftriaxone and was discharged on this as well. Patient was discharged back to skilled nursing facility for continued PT/OT. Labs reviewed CBC, CMP and albumin. Also reviewed CT of the foot without contrast dated 9/16. Also reviewed patient's history and physical. Patient seemed today for comprehensive skin assessment following re-admission into skilled nursing facility. Patient has a history of right foot gangrene and vasculopathy. She has a history of left BKA. Patient underwent right leg proximal tibia osteotomy, and right leg application of multiplanar external fixator. Pt with Vascular f/u 9/29 wounds not viewed today. Pt with clear and intact skin with exception of wounds to rt anterior leg, RLE surgical site, and left BKA site.

PMH: CAD, T2DM, HLD, and PVD

REVIEW OF SYSTEMS (ROS):

Obtained from nursing staff r/t pt non english speaking.

CONSTITUTIONAL: Patient unable to participate in full ROS related to altered mental status, no recent fever or chills, no reported weight-loss

NEURO: gait instability

CV: No chest pain

RESP: no cough, no orthopnea, no recent respiratory illness

GI: fecal incontinence

GU: urinary incontinence

MSK: weakness

SKIN: no rashes, no history of chronic wounds, no history of pressure ulcers, dry skin

SOCIAL HX: unknown

PAST MEDICAL HISTORY:

Complete Traumatic Amputation Of Right Foot At Ankle Level, Subsequent Encounter

Peripheral Vascular Disease, Unspecified

Unspecified Protein-calorie Malnutrition

Unilateral Primary Osteoarthritis, Right Hip

Atherosclerosis Of Native Arteries Of Extremities With Gangrene, Right Leg

Acute Kidney Failure, Unspecified

Non-ST Elevation (NSTEMI) Myocardial Infarction

Dang Chin DOB: 04/18/1947 MRN: 1762363993796

Encounter For Orthopedic Aftercare Following Surgical Amputation
Type 2 Diabetes Mellitus With Diabetic Peripheral Angiopathy With Gangrene
Elevated White Blood Cell Count, Unspecified
Acute Metabolic Acidosis
Acquired Absence Of Left Leg Below Knee
Type 2 Diabetes Mellitus With Other Skin Complications
Local Infection Of The Skin And Subcutaneous Tissue, Unspecified
Hyperlipidemia, Unspecified
Constipation, Unspecified
Heart Failure, Unspecified
Atherosclerotic Heart Disease Of Native Coronary Artery Without Angina Pectoris
Type 2 Diabetes Mellitus Without Complications
Essential (Primary) Hypertension
Chronic Kidney Disease, Unspecified
Bradycardia, Unspecified
Need For Assistance With Personal Care
Muscle Weakness (Generalized)
Unspecified Lack Of Coordination
Difficulty In Walking, Not Elsewhere Classified
Other Lack Of Coordination
Dysphagia, Unspecified

PAST SURGICAL HISTORY:

Hx of amputations, Hx of vascular surgery

MEDICATIONS:

Reviewed per Matrix.

ALLERGIES: No known allergies

PHYSICAL EXAMINATION:

CONSTITUTIONAL: comfortable, no acute distress, poor historian, thin
AMBULATION: Has limited ambulation, Out of bed mobility with a wheelchair
NEURO: Awake and alert
CV: No obvious chest abnormalities, no LE edema noted
RESP: No acute respiratory distress
GI: non-distended, fecal incontinence
GU: urinary incontinence
MSK: Generalized weakness, decreased ROM left lower extremity
SKIN: wound/skin condition noted. See wound assessment below.

Lower Extremity Exam:

Edema no edema
Texture: intact, dry
Perfusion: palpable pedal pulses- RLE
Sensation: RLE intact to light touch
Associated Findings: generalized dryness, scarring

WOUND ASSESSMENT:

Wounds not assessed today due to f/u with vascular

ICD-10s:

Non-pressure chronic ulcer of right heel and midfoot limited to breakdown of skin (L97.411)

Peripheral vascular disease, unspecified (I73.9)
Type 2 diabetes mellitus with foot ulcer (E11.621)
Unspecified lack of coordination (R27.9)
Muscle weakness (generalized) (M62.81)
Heart failure, unspecified (I50.9)
Essential (primary) hypertension (I10)
Other chronic osteomyelitis, left ankle and foot (M86.672)
Unspecified protein-calorie malnutrition (E46)
Acquired absence of left leg below knee (Z89.512)
Atherosclerotic heart disease of native coronary artery without angina pectoris (I25.10)
Type 2 diabetes mellitus without complications (E11.9)
Chronic kidney disease, unspecified (N18.9)
Hyperlipidemia, unspecified (E78.5)

RISK FACTORS:

Due to the above comorbidities listed in the ICD-10 section, the patient is at an increased risk of skin breakdown. Recommend good hygiene and skin care to prevent skin breakdown. Recommend continuing with moderate assistance with ADLs as needed. Recommend application of emollients daily. Please keep the patient's skin clean and dry, apply barrier cream as necessary to prevent skin breakdown, and avoid pressure on any bony prominence by adhering to turning protocols and floating heels as applicable.

The resident is incontinent of bowel and bladder. Use appropriate moisture barrier creams per formulary to provide thorough skin care with each incontinent episode. Use formulary briefs when indicated to manage moisture and assess often.

Float heel while in bed with use of pillows.

The patient is at risk for skin breakdown related to decreased mobility, advanced age, multiple comorbidities, decreased sensation. Continue to monitor prominent areas and report any nonblanchable redness or open areas. Continue current preventative measures to decrease risk of skin breakdown.

The patient has hx of an arterial ulcer. Please monitor for ischemic changes and notify the provider for changes in skin color/temperature and/or ulcer presentation. Discussed signs and symptoms of limb ischemia with staff at time of visit. Avoid application of compression therapy or tight bandages.

WOUND TREATMENT:

See wound management in EMR for wound treatment recommendations.

ASSESSMENT/PLAN:

10/1 Wound: RLE medial foot, Left BKA: The following wound treatment is recommended to continue as ordered, per surgeon based on the wound assessment completed today. Reference associated wound care treatment under orders in the facility EMR. Education was provided to the staff regarding the patient's wound, dressing care, and general treatment recommendations.

10/1 The patient has a surgical wound. There is no evidence of infection noted today upon assessment. If complications arise, staff understands to contact operating surgeon.

Pt to f/u with ortho and vascular PRN.

The risk of complications and/or morbidity/mortality of the patient's management is low.

Wendi Whitworth, N.P.

This note was electronically signed by Wendi Whitworth, N.P. on 10/01/2025.

Parts of this note were dictated using voice recognition software. As such, it may contain typographic or grammatical errors that may have been missed using correction.

NOTE:

Healing Partners
Skin and Wound Note
Wendi Whitworth, N.P.

PATIENT NAME: Dang, Chin
DATE OF SERVICE: 10/08/2025
DOB: 04/18/1947
FACILITY: SOUTH LOUISVILLE

Patient was unable to be evaluated by the skin and wound team today; patient was away at an appointment. .

NOTE:

Healing Partners
Skin and Wound Note
Wendi Whitworth, N.P.

PATIENT NAME: Dang, Chin
DATE OF SERVICE: 10/15/2025
DOB: 04/18/1947
FACILITY: SOUTH LOUISVILLE

HPI:

Information necessary for today's visit was obtained from the staff, the patient's medical records. Reason for visit: readmission to the facility, skin/wound assessment.

Chin T Dang is a female who is a resident at SOUTH LOUISVILLE on 08/21/2025. Ms. Dang is being seen today due wounds present upon admission. Pt with hospital stay from September 16 and discharged back to skilled nursing facility September 26, 2025. Patient with history of diabetic foot ulcer that has been difficult to treat. Patient originally presented to orthopedic for follow up and was noted to have worsening of her wound. Patient admitted to the hospital for further treatment. Patient was taken to the OR on September 17 and again on September 19 was noted to have gangrene and underwent ID amputation of transmetatarsal. She went back for revision on September 19. Patient's cultures grew *Proteus Mirabilis* patient has been receiving IV ceftriaxone and was discharged on this as well. Patient was discharged back to skilled nursing facility for continued PT/OT. Patient has a history of right foot gangrene and vasculopathy. She has a history of left BKA. Patient underwent right leg proximal tibia osteotomy, and right leg application of multiplanar external fixator.

10/15 Pt was being seen daily for hyperbaric therapy for open areas, pt now with C-diff and is unable to attend daily hyperbaric therapy. Pt on PO abx until 11/10 and will be followed by HP until she can return. Per Nsg. pt will have surgery next week to remove external fixator to rt leg. Rt. heel arterial ulcer with stable eschar noted, Rt. anterior leg with external fixator is followed by ortho no s/s of infection noted today. Rt dorsal foot, also with stable eschar will follow WCC orders. Left BKA is resolved today.

PMH: CAD, T2DM, HLD, and PVD

REVIEW OF SYSTEMS (ROS):

Obtained from nursing staff r/t pt non english speaking.

CONSTITUTIONAL: Patient unable to participate in full ROS related to altered mental status, no recent fever or chills, no reported weight-loss

NEURO: gait instability

CV: No chest pain

RESP: no cough, no orthopnea, no recent respiratory illness

GI: fecal incontinence

GU: urinary incontinence

MSK: weakness

SKIN: no rashes, no history of chronic wounds, no history of pressure ulcers, dry skin

SOCIAL HX: unknown

PAST MEDICAL HISTORY:

Complete Traumatic Amputation Of Right Foot At Ankle Level, Subsequent Encounter

Peripheral Vascular Disease, Unspecified

Unspecified Protein-calorie Malnutrition

Unilateral Primary Osteoarthritis, Right Hip

Atherosclerosis Of Native Arteries Of Extremities With Gangrene, Right Leg
Acute Kidney Failure, Unspecified
Non-ST Elevation (NSTEMI) Myocardial Infarction
Encounter For Orthopedic Aftercare Following Surgical Amputation
Other Acute Osteomyelitis, Right Ankle And Foot
Type 2 Diabetes Mellitus With Diabetic Peripheral Angiopathy With Gangrene
Elevated White Blood Cell Count, Unspecified
Acute Metabolic Acidosis
Acquired Absence Of Left Leg Below Knee
Type 2 Diabetes Mellitus With Other Skin Complications
Local Infection Of The Skin And Subcutaneous Tissue, Unspecified
Hyperlipidemia, Unspecified
Constipation, Unspecified
Heart Failure, Unspecified
Atherosclerotic Heart Disease Of Native Coronary Artery Without Angina Pectoris
Essential (Primary) Hypertension
Chronic Kidney Disease, Unspecified
Bradycardia, Unspecified
Need For Assistance With Personal Care
Muscle Weakness (Generalized)
Unspecified Lack Of Coordination
Difficulty In Walking, Not Elsewhere Classified
Other Lack Of Coordination
Dysphagia, Unspecified

PAST SURGICAL HISTORY:

Hx of amputations, Hx of vascular surgery

MEDICATIONS:

Reviewed per Matrix.

ALLERGIES: No known allergies

PHYSICAL EXAMINATION:

CONSTITUTIONAL: comfortable, no acute distress, poor historian, thin
AMBULATION: Has limited ambulation, Out of bed mobility with a wheelchair
NEURO: Awake and alert
CV: No obvious chest abnormalities, no LE edema noted
RESP: No acute respiratory distress
GI: non-distended, fecal incontinence
GU: urinary incontinence
MSK: Generalized weakness, decreased ROM left lower extremity
SKIN: wound/skin condition noted. See wound assessment below.

Lower Extremity Exam:

Edema: no edema
Texture: intact, dry
Perfusion: palpable pedal pulses- RLE
Sensation: RLE intact to light touch
Associated Findings: generalized dryness, scarring

WOUND ASSESSMENT:

Wound: 2
Location: Left BKA
Primary Etiology: Surgical Dehiscence

Stage/Severity: Full Thickness

Wound: 4

Location: Rt anterior leg

Primary Etiology: Closed Surgical

Stage/Severity: Partial Thickness

Wound: 5

Location: Rt dorsal foot

Primary Etiology: Closed Surgical

Stage/Severity: Full Thickness

Wound: 6

Location: Rt heel

Primary Etiology: Arterial Ulcer

Stage/Severity: Full Thickness

ICD-10s:

Non-pressure chronic ulcer of right heel and midfoot limited to breakdown of skin (L97.411)

Peripheral vascular disease, unspecified (I73.9)

Type 2 diabetes mellitus with foot ulcer (E11.621)

Unspecified lack of coordination (R27.9)

Muscle weakness (generalized) (M62.81)

Heart failure, unspecified (I50.9)

Essential (primary) hypertension (I10)

Other chronic osteomyelitis, left ankle and foot (M86.672)

Unspecified protein-calorie malnutrition (E46)

Acquired absence of left leg below knee (Z89.512)

Atherosclerotic heart disease of native coronary artery without angina pectoris (I25.10)

Type 2 diabetes mellitus without complications (E11.9)

Chronic kidney disease, unspecified (N18.9)

Hyperlipidemia, unspecified (E78.5)

RISK FACTORS:

Due to the above comorbidities listed in the ICD-10 section, the patient is at an increased risk of skin breakdown. Recommend good hygiene and skin care to prevent skin breakdown. Recommend continuing with moderate assistance with ADLs as needed. Recommend application of emollients daily. Please keep the patient's skin clean and dry, apply barrier cream as necessary to prevent skin breakdown, and avoid pressure on any bony prominence by adhering to turning protocols and floating heels as applicable.

The resident is incontinent of bowel and bladder. Use appropriate moisture barrier creams per formulary to provide thorough skin care with each incontinent episode. Use formulary briefs when indicated to manage moisture and assess often.

Float heel while in bed with use of pillows.

The patient is at risk for skin breakdown related to decreased mobility, advanced age, multiple comorbidities, decreased sensation. Continue to monitor prominent areas and report any nonblanchable redness or open areas. Continue current preventative measures to decrease risk of skin breakdown.

The patient has hx of an arterial ulcer. Please monitor for ischemic changes and notify the provider for changes in skin color/temperature and/or ulcer presentation. Discussed signs and symptoms of limb ischemia with staff at time of visit. Avoid application of compression therapy or tight bandages.

WOUND TREATMENT:

See wound management in EMR for wound treatment recommendations.

ASSESSMENT/PLAN:

10/15 Rt dorsal foot, rt heel: The following wound treatment is recommended to continue as ordered, per WCC based on the wound assessment completed today. Reference associated wound care treatment under orders in the facility EMR. Education was provided to the staff regarding the patient's wound, dressing care, and general treatment recommendations.

10/15 The patient has a surgical wound. There is no evidence of infection noted today upon assessment. If complications arise, staff understands to contact operating surgeon.

Pt to f/u with ortho and vascular PRN.

The risk of complications and/or morbidity/mortality of the patient's management is low.

Wendi Whitworth, N.P.

This note was electronically signed by Wendi Whitworth, N.P. on 10/15/2025.

Parts of this note were dictated using voice recognition software. As such, it may contain typographic or grammatical errors that may have been missed using correction.

NOTE:

Healing Partners
Skin and Wound Note
Wendi Whitworth, N.P.

PATIENT NAME: Dang, Chin
DATE OF SERVICE: 10/22/2025
DOB: 04/18/1947
FACILITY: SOUTH LOUISVILLE

HPI:

Information necessary for today's visit was obtained from the staff, the patient's medical records. Reason for visit: readmission to the facility, skin/wound assessment.

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10/22 Pt unable to attend hyperbaric therapy due to C diff, Pt on PQ abx until 11/10 and will be followed by HP until she can return. Per Nsg, pt will have surgery 10/27 to remove external fixator to rt leg. Rt. heel arterial ulcer with stable eschar noted, Rt. anterior leg with external fixator is followed by ortho no s/s of infection noted today. Rt dorsal foot, also with stable eschar will follow WCC orders.

PMH: CAD, T2DM, HLD, and PVD

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Need For Assistance With Personal Care
Muscle Weakness (Generalized)
Unspecified Lack Of Coordination
Difficulty In Walking, Not Elsewhere Classified
Other Lack Of Coordination
Dysphagia, Unspecified

PAST SURGICAL HISTORY:

Hx of amputations, Hx of vascular surgery

MEDICATIONS:

Reviewed per Matrix.

ALLERGIES: No known allergies

PHYSICAL EXAMINATION:

CONSTITUTIONAL: comfortable, no acute distress, poor historian, thin
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SKIN: wound/skin condition noted. See wound assessment below.

Lower Extremity Exam:

Edema no edema
Texture: intact, dry
Perfusion: palpable pedal pulses- RLE
Sensation: RLE intact to light touch
Associated Findings: generalized dryness, scarring

WOUND ASSESSMENT:

Wound: 4
Location: Rt anterior leg
Primary Etiology: Closed Surgical
Stage/Severity: Partial Thickness

Wound: 5
Location: Rt dorsal foot
Primary Etiology: Closed Surgical
Stage/Severity: Full Thickness

Wound: 6
Location: Rt heel
Primary Etiology: Arterial Ulcer
Stage/Severity: Full Thickness

PROCEDURES:

A sharp debridement was not performed today due to arterial insufficiency. The surgical wound is currently being managed by the surgeon.

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Peripheral vascular disease, unspecified (I73.9)
Type 2 diabetes mellitus with foot ulcer (E11.621)
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Wendi Whitworth, N.P.

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