

3/22/2020 12:58 PM (CDT)

Assessment Id: 63933622

Patient: Lowum, Bernadette C. (Admission PPE-77870SN)

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Amper
*3/22/2020***Progress Note****Assessment Date:**

02/23/2020

Client Demographics**Name:**

Lowum, Bernadette C.

Date of Birth:

01/05/1932

Age:

88

Gender:

F

Physician:

Elezi, Dr. Arlinda

Client ID:

156853

Admit Date:

01/29/20

Room #:

213

Admission ID:

PPE-77870SN

Reason For Visit:

f/u L hip wound

History Present Illness**Onset:****Quantity:****Location:****Timing:****Improved With:****Worsened With:****Symptoms**

88yo female admitted to EMH on 1/24/20 after falling. Found to have CHF exacerbation so started on IV Lasix and cardiology consulted who started on sotalol. Had a L hip wound that was draining white discharge, so wound care consulted. Ortho consulted for L hip wound and started on clindamycin, was not cleared for surgery to removal hip hardware. ID consulted for infection, wound cultures NGTD, and changed antibiotics to keflex. Pulm consulted for COPD and O2 dependence. Participated in therapy.

Pt admitted to Park Place on 1/29/20 for SAR.

Pt seen today for f/u L hip wound. Pt in bed, alert, NAD. Denies CP, HA, SOB, dizziness, n/v/c/d, fever, chills, pain. Participating in therapy. Appetite is fair.

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PMH: A-fib, COPD on home O2, emphysema, pulm nodules, diastolic dysfunction, HTN, anemia, anxiety, osteoporosis, L hip osteomyelitis
 PSH: L hip pinning, pacemaker, tonsillectomy

Past Medical / Surgical History

Current Diagnoses:

Reviewed

Anticoagulation

Is resident receiving anticoagulation medication?

Yes

Reason for Anticoagulation:
 thromboembolism prevention

Medication:

ASA

Bleeding:

No

Review Of System:

Bleeding

No

Epistaxis

No

Oral Bleeding

No

Hemoptysis

No

Melena

No

Hematuria

No

Bruising

No

Incision

No

Wound

Yes

Physical Exam

General:

NAD Thin / Frail Nontoxic

Skin:

HEENT:

NC Non-icteric MMM

CV:

Reg S1S2

Pulm:

Clear B

GI:

Soft ND NT BS NL

GU:

No Bladder Distension

Review Of Systems

Const:

Fever

No

Mental Status

No

Function

Shirley
3/26/2020

Yes		
Weight		
No		
Pain		
No		
Resp:		
SOB		
No		
Cough		
No		
Wheezing		
No		
Phlegm		
No		
Hx Smoking		
Yes		
GU:		
Dysuria		
No		
Hematuria		
No		
Frequency		
Yes		
Urgency		
No		
Nocturia		
No		
Foley		
No		
MS:		
Joint Pain		
No		
Swelling		
No		
Myalgia		
No		
Arthralgia		
No		
ROM		
Yes		
Fall last 30 days		
No		
Hx of falls		
No		
Gait D/O		
Yes		
HEENT:		
Eye discharge		
No		
Visual		
No		
HOH		
No		
Epistaxis		
No		
Rhinitis		
No		
Tinnitus		
No		
Sore Throat		
No		

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GI:		
Nausea		
No		
Vomiting		
No		
Obesity		
No		
Abd Pain		
No		
Diarrhea		
No		
Constipation		
No		
Melena		
No		
Heme-occult		
Dysphagia		
No		
Dyspepsia		
No		
Appetite		
No		
Stools		
No		
G tube		
No		
Neuro:		
Syncope		
No		
Aphasia		
No		
HA		
No		
Vertigo		
No		
Focal Weakness		
No		
Paraesthesia		
No		
Seizures		
No		
Confused		
No		
PSYCH:		
Anxiety		
No		
Depression		
No		
Sleep Disturbance		
No		
Agitation		
No		
Combative		
No		
Hallucinations		
No		
Psychosis		
No		
NL Mood		
Yes		
CV/PV:		

Am APRN
3/26/2020

Chest Pain
 No

Palpitations
 No

Dizzy
 No

DOE
 Yes

Edema
 No

DERM:

Rash
 No

Pruritus
 No

Bruising
 No

Physical Exam

General:

NAD Thin/Frail Nontoxic
 Comments:
 in bed

Skin

Wound
 Comments:
 L hip DSG is CDI, PICC DSG is CDI

HEENT

NC Non-Icteric MMM
 Comments:

Neck

Supple
 Comments:
 no JVD

CV

Reg S1S2
 Comments:

Pulm

Clear B
 Comments:
 on 3L O2 satting 95%

Breast

Comments:
 deferred

GI

Soft ND NT BS NL
 Comments:

GU

No Bladder Distension Continent
 Comments:

M/S

Joint swelling/erythema
 Comments:
 ambulates with rolling walker

Neuro

Alert OX3
 Comments:

M. APPEN
3/24/2020

Psych

NL Mood Cooperative
 Comments:

Ext.

No edema
 Comments:

Other**Labs:**

2/21/20: L hip wound culture 1+ growth enterococcus faecalis sens to ampicillin, daptomycin, vancomycin, tigecycline

2/20/20: HgB 8.8, HCT 27.8

2/18/20: WBC 7.0, HgB 8.6, HCT 27.5

2/14/20: HgB 8.0, HCT 26.0

2/9/20: HgB 8.3, HCT 25.7

2/6/20: HgB 7.7, HCT 24.9, Na 142, K 4.5, BUN 34, Cr 1.34

2/2/20: Na 139, K 4.5, BUN 45, Cr 1.34, HgB 8.1, HgB 25.7

1/30/20: WBC 8.9, HgB 7.9, HCT 25.0, Na 133, K 4.9, BUN 54, Cr 1.63

hospital labs: 1/27/20 Na 135, K 5.2, BUN 51, Cr 1.80

12/29/19: Na 139, K 4.2, BUN 24, Cr 1.21

12/27/19: C-diff neg

12/24/19: WBC 5.1, HgB 8.2, HCT 25.4, Na 139, K 4.5, BUN 25, Cr 1.34

hospital labs: 12/17/19 WBC 6.9, HgB 9.1, HCT 29.2, Na 141, K 4.6, BUN 36, Cr 1.78

Assessment & Plan:

L hip osteomyelitis/L hip pain (M86.652/M25.552)

improving

on IV vanco via PICC

on PRN ultram and Tylenol for pain

wound care and ID following

has allergist appt tomorrow to assess if PCN allergy is a true one, ID would like to put on PO abx for lifelong use

afebrile, WBC stable

cont to monitor

acute on chronic diastolic CHF/A-fib/HTN (I50.33/I48.2/I10)

improving

on Lasix, sotalol, ASA, and Cardizem

daily weights

cardio following

cont to monitor

Anemia (D63.1)

improving

on PO iron

cont to monitor

CKD stage 3 (N18.3)

improving

on Lasix

cont to monitor

Fall/Weakness (R29.6/M62.81)

stable

cont PT/OT

fall precautions

dietitian and ST following

cont to monitor

COPD w/ O2 dependence (J44.9/Z99.81)

stable

on Anoro and nebs with PRN nebs and albuterol inhaler

*K. Hill APRN
3/23/2020*

Pulm and RT following
cont to monitor

Kathryn Hill MS APRN-BC

Signature:

Electronically Signed By Hill, Kathryn 02/23/2020 10:02 AM (CST)

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3/22/2020
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3/22/2020 12:58 PM (CDT)

Patient: Lowum, Bernadette C. (Admission PPE-77870SN)

Vital Signs		
B/P: 121 / 54		
Pulse: 72.00 [Pulse Oximeter]		
Pulse Ox: 94.00 [Nasal Cannula 2-3 L]		
Respirations: 20.00		
Temp: 97.80 [Oral]		
Weight: 86.80		
Blood Sugar:		

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Medications

furosemide 20 mg tablet (1 TAB) TABLET One Time Daily Oral ICD-10: UNSPECIFIED DIASTOLIC (CONGESTIVE) HEART FAILURE Anoro Ellipta 62.5 mcg-25 mcg/actuation powder for inhalation (1 PUFF) BLISTER, WITH INHALATION DEVICE One Time Daily Inhalation ICD-10: CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED levothyroxine 75 mcg tablet (1 TAB) TABLET One Time Daily Oral ICD-10: HYPOTHYROIDISM, UNSPECIFIED albuterol sulfate HFA 90 mcg/actuation aerosol inhaler (2 PUFFS) HFA AEROSOL WITH ADAPTER (GRAM) As Needed Every Four Hours Inhalation ICD-10: CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED cyanocobalamin (vit B-12) 1,000 mcg tablet (1 TAB) TABLET One Time Daily Oral ICD-10: VITAMIN DEFICIENCY, UNSPECIFIED aspirin 81 mg tablet, delayed release (1 TAB) TABLET, DELAYED RELEASE (ENTERIC COATED) One Time Daily Oral ICD-10: ATHEROSCLEROTIC HEART DISEASE OF NATIVE CORONARY ARTERY WITHOUT ANGINA PECTORIS diltiazem 30 mg tablet (1 TAB) TABLET Two Times Daily Oral ICD-10: ESSENTIAL (PRIMARY) HYPERTENSION docusate sodium 100 mg capsule (1 CAP) CAPSULE As Needed Two Times Daily Oral ICD-10: CONSTIPATION, UNSPECIFIED ipratropium 0.5 mg-albuterol 3 mg (2.5 mg base)/3 mL nebulization soln (3ML) AMPUL FOR NEBULIZATION (ML) As Needed Every Four Hours Inhalation ICD-10: CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED loperamide 2 mg capsule (1 CAP) CAPSULE As Needed Every Eight Hours Oral ICD-10: DIARRHEA, UNSPECIFIED polyethylene glycol 3350 17 gram oral powder packet (17 GRAMS) POWDER IN PACKET (EA) One Time Daily Oral ICD-10: CONSTIPATION, UNSPECIFIED sotalolol 80 mg tablet (0.5 TAB) TABLET One Time Daily Oral ICD-10: ESSENTIAL (PRIMARY) HYPERTENSION tramadol 50 mg tablet (1 TAB) TABLET As Needed Every Twelve Hours Oral ICD-10: PAIN, UNSPECIFIED Tylenol 325 mg tablet (650mg) TABLET As Needed Every Six Hours Oral ICD-10: PAIN, UNSPECIFIED Colace 100 mg capsule (100mg) CAPSULE As Needed Two Times Daily Oral ICD-10: CONSTIPATION, UNSPECIFIED polyethylene glycol 3350 17 gram oral powder packet (17 gram) POWDER IN PACKET (EA) As Needed One Time Daily Oral ICD-10: CONSTIPATION, UNSPECIFIED Ensure Plus 0.06 gram-1.5 kcal/mL oral liquid (8oz BID) LIQUID (ML) Two Times Daily Oral ICD-10: UNSPECIFIED SEVERE PROTEIN-CALORIE MALNUTRITION ferrous sulfate 325 mg (65 mg iron) tablet, delayed release (1 TAB) TABLET, DELAYED RELEASE (ENTERIC COATED) Two Times Daily Oral ICD-10: ANEMIA, UNSPECIFIED acetaminophen 325 mg tablet (2 TABS) TABLET As Needed Every Six Hours Oral ICD-10: PAIN, UNSPECIFIED dextromethorphan-guaifenesin 10 mg-100 mg/5 mL oral syrup (10mL) SYRUP As Needed Every Six Hours Oral ICD-10: COUGH sodium chloride 0.9 % (flush) injection syringe (Flush with 10cc) SYRINGE (ML) Two Times Daily Intravenous ICD-10: FRACTURE OF UNSPECIFIED PART OF NECK OF UNSPECIFIED FEMUR, SUBSEQUENT ENCOUNTER FOR CLOSED FRACTURE WITH ROUTINE HEALING Saline Nasal 0.65 % spray aerosol (1) AEROSOL, SPRAY (ML) As Needed Every Eight Hours Intranasal - Both Nostrils ICD-10: CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED vancomycin 500 mg/100 mL in 0.9% sodium chloride intravenous piggyback (500mg) IV SOLUTION, PIGGYBACK PREMIX FROZEN (ML) Every One Day for Sixteen Days Intravenous ICD-10: CHRONIC OSTEOMYELITIS WITH DRAINING SINUS, LEFT FEMUR budesonide 0.5 mg/2 mL suspension for nebulization (1 VIAL) AMPUL FOR NEBULIZATION (ML) Two Times Daily Nebulization ICD-10: CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED vancomycin 500 mg intravenous solution (500 mg) VIAL (EA) One Time Daily for Four Days Intravenous ICD-10: FRACTURE OF UNSPECIFIED PART OF NECK OF UNSPECIFIED FEMUR, SUBSEQUENT ENCOUNTER FOR CLOSED FRACTURE WITH ROUTINE HEALING vancomycin 500 mg intravenous solution (500 MG) VIAL (EA) One Time Daily for Three Days Intravenous ICD-10: CONTUSION OF LEFT HIP, SUBSEQUENT ENCOUNTER FOR CLOSED FRACTURE WITH ROUTINE HEALING vancomycin 500 mg intravenous solution (500 MG) VIAL (EA) One Time Daily for Three Days Intravenous ICD-10: CONTUSION OF LEFT HIP, SUBSEQUENT ENCOUNTER FOR CLOSED FRACTURE WITH ROUTINE HEALING vancomycin 500 mg intravenous solution (500 mg) VIAL (EA) Every Two Days Intravenous ICD-10: FRACTURE OF UNSPECIFIED PART OF NECK OF UNSPECIFIED FEMUR, SUBSEQUENT ENCOUNTER FOR CLOSED FRACTURE WITH ROUTINE HEALING sodium chloride 0.9 % (flush) injection syringe (Flush with 10cc) SYRINGE (ML) Every Two Days Intravenous ICD-10: FRACTURE OF UNSPECIFIED PART OF NECK OF UNSPECIFIED FEMUR, SUBSEQUENT ENCOUNTER FOR CLOSED FRACTURE WITH ROUTINE HEALING vancomycin 500 mg intravenous solution (500 mg) VIAL (EA) Every One Day Intravenous ICD-10: FRACTURE OF UNSPECIFIED PART OF NECK OF UNSPECIFIED FEMUR, SUBSEQUENT ENCOUNTER FOR CLOSED FRACTURE WITH ROUTINE HEALING vancomycin 500 mg intravenous solution (600 mg) VIAL (EA) One Time Daily for Four Days Intravenous ICD-10: FRACTURE OF UNSPECIFIED PART OF NECK OF UNSPECIFIED FEMUR, SUBSEQUENT ENCOUNTER FOR CLOSED FRACTURE WITH ROUTINE HEALING vancomycin 500 mg/100 mL in 0.9% sodium chloride intravenous piggyback (500mg) IV SOLUTION, PIGGYBACK PREMIX FROZEN (ML) Every One Day for Seventeen Days Intravenous ICD-10: CHRONIC OSTEOMYELITIS WITH DRAINING SINUS, LEFT FEMUR

Signature:

Electronically Signed By Hill, Kathryn 02/23/2020 10:02 AM (CST)