

-Auth  
Tri-

SLM Salem Campus  
81 Highland Ave  
Salem MA 01970-2714  
4Next Referral Report

PIRL: 2113 SCL: F  
Acct #: 2113  
ADM: 3/31/2024; D/C: -

## Patient Demographics

Name	Patient ID	SSN	Gender Identity	Birth Date
	0	xxx-xx-4535	Female	(yrs)
Address	Phone	Email		
County	Race			
ESSEX	White			
Reg Status	PCP			
Verified	Lee, Rebecca Symmes, MD 978-646-2100			
Marital Status	Religion	Language		
widowed	Roman Catholic	English		
Emergency Contact 1		Emergency Contact 2		
Steve (on)	12	Pat (on)	12	Pat (on)
PE				
(M)				

## Insurance Information

TUFTS HEALTH PLAN/TUFTS MEDICARE PREFERRED IMO REPLACEMENT		Phone: 800-279-9022
Subscriber:	E	Subscriber#:
Group#:	3000	Precert#:

Admission Information			
unit/bed:	SLM PHIPPEN 7/34 A	Service:	Medicine
Admitting provider:	Devineni, Praveen, MD	Phone:	978-354-2551
Attending provider:	Sood, Megha, MD	Phone:	978-354-4727
PCP:	Lee, Rebecca Symmes, MD	Phone:	978-646-2100
Admission dx:		Patient class:	Inpatient
Admission type:	ER		

Travel Screening	
Flowsheet Row	Most Recent Value
Have you had a fever or felt feverish in the past 24 hours?	No Filed at 03/31/2024 1747
(Retired) Have you had contact with a known or suspected case of COVID-19?	
Do you have trouble breathing or a new cough?	No Filed at 03/31/2024 1747
Are you having nausea, vomiting, or diarrhea?	No Filed at 03/31/2024 1747
Do you have a new rash?	No Filed at 03/31/2024 1747

Admit Orders (From admission, onward)	
Start	Ordered
03/31/24 2012 Admit to Inpatient Once	03/31/24 2012

Specialty Equipment	
Flowsheet Row	Most Recent Value
Specialty Mattress/Support Surface	Low Air Loss Therapy
Assistive Device	None (P)

Patient Infection Status	
None to display	

Patient Isolation Status	
None to display	

Precaution Orders (From admission, onward)	
Start	Ordered
03/31/24 2143 Aspiration precautions until discontinued	03/31/24 2142
Comments: Per unit policy	

## Non-Violent or Non-Self Destructive Restraints Application Information

None

## Non-Violent or Non-Self Destructive Restraints Episode Patient Monitoring Information

None

Allergies as of 4/4/2024

Reviewed by Page Saint-Vil, Marie Olga, RN at 7:58 AM

Codeine	06/11/2009	Allergy/hypersensitivity	Other (See Comments)
Mental status change			
Diazepam	10/26/2005	Allergy/hypersensitivity	Unknown
Sertraline	10/17/2023		Sweating
Venlafaxine	10/17/2023		Other (See Comments), Sweating

Dreams

## Expected Discharge Date and Time

Expected Discharge Date

Apr 5, 2024

## Flowsheet Rows

Flowsheet Row	Most Recent Value
Discharge Plan	Skilled nursing facility
Anticipated discharge disposition	Skilled nursing facility
Non-Medical Barriers to Discharge	Await acceptance

## Services and Referrals

Flowsheet Row	Most Recent Value
Services	Skilled home health services
Active PTA	No
Referrals	

Program:

iCNP/IMP Status:

iCNP Plus Status:

## Legal Information

Flowsheet Row	Most Recent Value
Legal Information	

Does patient have a Health Care Proxy Form completed? Electronic copy of HCP available filed at 04/01/2024 0928

## Hospital Problems as of 4/4/2024

	ICD-10-CM	Noted - Resolved	Last Modified
Closed left hip fracture	S72.002A	3/31/2024 - Present	3/31/2024 by Devineni, Praveen, MD

Entered by Devineni, Praveen, MD

## Problem List as of 4/4/2024

	ICD-10-CM	Noted - Resolved	Last Modified
dyslipidemia	E78.5	2/22/2008 - Present	2/17/2015 by Lee, Rebecca S, MD
Glaucoma	H40.9	2/22/2008 - Present	2/17/2015 by Lee, Rebecca S, MD
H/O small bowel obstruction	287.19	2/17/2012 - Present	5/27/2021 by Salerno, Kathleen A, CNP
Macrocytosis	D75.89	5/24/2012 - Present	2/17/2015 by Lee, Rebecca S, MD
Anxiety	F41.9	3/29/2013 - Present	5/25/2022 by Salerno, Kathleen A, CNP
Verruca plantaris	B07.0	8/8/2013 - Present	2/17/2015 by Marcus, Daniel R, DPM
Deep venous thrombosis of lower extremity	I82.409	7/24/2014 - Present	5/25/2022 by Salerno, Kathleen A, CNP

Tobacco dependence syndrome	F17.200	Entered by Salerno, Kathleen A, CNP 7/24/2014 - 2/17/2015 by Present Salerno, Kathleen A, CNP
Disorder of bone and articular cartilage	M89.9, M94.9	Entered by Salerno, Kathleen A, CNP 7/24/2014 - 2/17/2015 by Present Salerno, Kathleen A, CNP
Chronic obstructive pulmonary disease	I44.9	Entered by Salerno, Kathleen A, CNP 6/29/2015 - 9/27/2022 by Present Salerno, Kathleen A, CNP
Atherosclerosis of aorta	I70.0	Entered by Gillis, Aileen Mary, CNP 5/29/2017 - 5/29/2017 by Lee, Present Rebecca S, MD
Chronic coronary artery disease	I25.10	Entered by Lee, Rebecca S, MD 5/29/2017 - 5/29/2017 by Lee, Present Rebecca S, MD
Recurrent major depressive disorder, in full remission	F33.42	Entered by Lee, Rebecca S, MD 5/29/2017 - 4/3/2018 by Lee, Present Rebecca S, MD
Hyperlipidemia	E78.5	Entered by Lee, Rebecca S, MD 5/29/2017 - 5/29/2017 by Lee, Present Rebecca S, MD
Riedel's thyroiditis	E06.5	Entered by Lee, Rebecca S, MD 5/29/2017 - 5/29/2017 by Lee, Present Rebecca S, MD
Morton's neuroma of right foot	G57.61	Entered by Lee, Rebecca S, MD 5/29/2017 - 5/29/2017 by Lee, Present Rebecca S, MD
Raynaud disease	I73.00	Entered by Lee, Rebecca S, MD 5/29/2017 - 5/29/2017 by Lee, Present Rebecca S, MD
Unintended weight loss	R63.4	Entered by Lee, Rebecca S, MD 5/30/2017 - 5/30/2017 by Lee, Present Rebecca S, MD
chronic idiopathic constipation	K59.04	Entered by Lee, Rebecca S, MD 7/9/2017 - Present 7/9/2017 by Gillis, Aileen Mary, CNP
Annual physical exam	200.00	Entered by Gillis, Aileen Mary, CNP 7/11/2018 - 7/11/2018 by Lee, Present Rebecca S, MD
Macular degeneration	H35.30	Entered by Lee, Rebecca S, MD 1/11/2019 - 10/5/2021 by Present Salerno, Kathleen A, CNP
Alcoholism in remission	F10.21	Entered by Salerno, Kathleen A, CNP 4/17/2019 - 12/15/2020 by Lee, Present Rebecca Symmes, MD
cerebral atrophy	G31.9	Entered by Lee, Rebecca Symmes, MD 4/17/2019 - 12/15/2020 by Lee, Present Rebecca Symmes, MD
Multiple lung nodules on CT	R91.8	Entered by Lee, Rebecca Symmes, MD 9/7/2019 - Present 10/3/2022 by Mertens, Avalon Corinne, DO
slow transit constipation	K59.01	Entered by Lee, Rebecca S, MD 1/23/2020 - 12/15/2020 by Lee, Present Rebecca Symmes, MD
Mild protein-calorie malnutrition	E44.1	Entered by Lee, Rebecca Symmes, MD 10/2/2020 - 10/2/2020 by Lee, Present Rebecca Symmes, MD
Stage 3a chronic kidney disease	N18.31	Entered by Lee, Rebecca Symmes, MD 12/22/2020 - 12/22/2020 by Lee, Present Rebecca Symmes, MD
Acute pain of left knee	M25.562	Entered by Lee, Rebecca Symmes, MD 5/6/2021 - Present 5/6/2021 by Salerno, Kathleen A, CNP
Nocturnal leg cramps	G47.62	Entered by Salerno, Kathleen A, CNP 5/25/2021 - 5/25/2021 by Present Salerno, Kathleen A, CNP
Osteoarthritis of left knee	M17.12	Entered by Salerno, Kathleen A, CNP 6/16/2021 - 6/16/2021 by Present Corrente, James, PT
		Entered by Corrente, James, PT

Allergic rhinitis	J30.9	10/4/2022 - Present	10/4/2022 by Mertens, Avalon Corinne, DO
Age-related osteoporosis without current pathological fracture	M81.0	10/11/2022 - Present	10/11/2022 by Salerno, Kathleen A, CNP
Night sweats	R61	1/26/2023 - Present	1/26/2023 by Salerno, Kathleen A, CNP

## Current Code Status

Date Active	Code Status	Order ID	Comments	User	Context
3/31/2024 9:42 PM	Full Code	1360615904		Devineni, Praveen, MD	Inpatient
Question				Answer	
Code Status Confirmed With				Patient	

## PT Current Functional Status

Flowsheet	Most Recent Value
Row	
<u>Bed Mobility</u>	
<u>Bed</u>	Supine to sit
<u>Mobility</u>	
<u>Supine to</u>	
<u>Sit</u>	
Supine to	Minimum assist
Sit Level of Assistance	
Additional Verbal, Minimum	
Cueing	
Supine to	Head of bed elevated, Bed rail
Sit Device Used	
Number of 1	
Staff	
Assisting with Supine to Sit	
Clinical Observation	assist for LLE
Sit to supine	
Sit to	Minimum assist, Moderate
Supine Level assist of Assistance	
Additional Moderate, Verbal, Tactile	
Cueing	
Sit to Bed rail	
Supine	
Device Used	
Number of 2	
Staff	
Assisting with Sit to Supine	
Clinical Observation	Increased effort and pain, cued for HP and to lay supine in bed, poor control
Transfer	
Mobility	
Transfer	First surface to surface
Mobility	
Task	
<u>Sit to stand</u>	
<u>Sit to</u>	Moderate assist
<u>Stand Level of Assistance</u>	
Additional Moderate, Verbal, Tactile	
Cueing	
Sit to	walker - rolling, Chair
Stand Device with arms	
Used	
Number of 2	
Staff	

## OT Current Functional Status

Flowsheet	Most Recent Value
Row	
<u>ADL</u>	
<u>ADL Task</u>	Bed mobility, dressing lower body, Functional ambulation, Functional transfers, Toileting hygiene, Toilet transfer
<u>Functional</u>	Unable to assess
<u>Ambulation</u>	
<u>Level of Assistance</u>	
Functional	Limited 2/2 orthostatic
Ambulation	hypotension
Context and Activity	
Demands	
Bed	Moderate assistance
Mobility	
Level of Assistance	
Number of 2	
Staff	
Assisting with Bed	
Bed	Minimum, Tactile, Verbal
Mobility	
Level of Cue	
Bed	sup <-> sit EOB with use of bed rails and HOB raised,
Mobility	Context and assist at trunk and LLE, Activity min cues for safe hand placement
Demands	
Dressing	placement Maximum assistance
Lower Body	
Level of Assistance	
Dressing	assist to donn/doff b socks
Lower Body	
Context and Activity	
Demands	
Functional	Moderate assistance
Transfers	
Level of Assistance	
Number of 2	
Staff	
Assisting with	
Functional	
Transfer	
Functional	Moderate, Tactile, Verbal
Transfers	
Level of cue	
Functional	min-mod A x 2 stand step
Transfers	transfer with mod cues for
Context and	safe hand placement and
Activity	walker management, pt
Demands	orthostatic during session

Assisting with sit to stand Clinical Increased trunk flexion Observation with increased effort, cued for HP and to grab RW, min-mod Ax2 throughout entire sequence

Stand to sit

Stand to Moderate assist Sit Level of Assistance Additional Moderate, Verbal, Tactile Cuing Stand to Chair with arms, walker - Sit Device rolling Used Number of 2 Staff Assisting with stand to sit Clinical Increased anxiety, cued to Observation grab for chair to sit, poor eccentric control with increased pain

requiring mod A x2 squat pivot transfer chair > bed

Toileting Unable to assess

Hygiene Level of Assistance Toileting anticipate mod A for Hygiene posterior hygiene Context and Activity Demands Toilet Moderate assistance

Transfer Level of Assistance Number of 2 Staff Assisting with Toilet Transfer Toilet anticipate min- mod A x 2 Transfer stand step transfer bed <> Context and commode Activity Demands

First

Surface to Surface Transfer

Starting Bed Surface Ending Commode/toilet Surface Number of 1 Staff Assisting with First Transfer Activity Stand - step First Min assist to left

Surface to Surface Level of Assistance Additional Verbal, Tactile, Moderate Cuing First walker - rolling, chair Surface to with arms Surface Device Used Clinical cues for sequencing, Observation initial forward flexed trunk, antalgic

Balance

Balance Standing Balance Fair with RW Clinical Observation

MedicationsScheduled

Medication	Ordered Dose/Rate, Route, Frequency	Last Action
acetaminophen (TYLENOL) tablet 975 mg	975 mg, Oral, Q8H	Given, 975 mg at 04/04 0530
aspirin EC tablet 81 mg	81 mg, Oral, BID	Given, 81 mg at 04/04 0922
atorvastatin (LIPITOR) tablet 80 mg	80 mg, Oral, Nightly	Given, 80 mg at 04/03 2008
cyanocobalamin (vitamin B-12) tablet 1,000 mcg	1,000 Mcg, Oral, 4x weekly	Given, 1,000 mcg at 04/04 0921
donepezil (ARICEPT) tablet 5 mg	5 mg, Oral, QAM	Given, 5 mg at 04/04 0922
fluticasone propionate (FLONASE) 50 mcg/actuation nasal spray 11 spray, Each Nare, BID spray	11 spray, Each Nare, BID	Given, 1 spray at 04/04 0923
folic acid (FOLVITE) tablet 1,000 mcg	1,000 mcg, Oral, QAM	Given, 1,000 mcg at 04/04 0921
levothyroxine (SYNTHROID, LEVOTHROID) tablet 37.5 mcg	37.5 mcg, Oral, 2x weekly	Ordered
levothyroxine (SYNTHROID, LEVOTHROID) tablet 75 mcg	75 mcg, Oral, 5x Weekly	Given, 75 mcg at 04/04 0530

lidocaine 4 % 1 patch	1 patch, TD, Q24H SCH	Patch Applied, 1 patch at 04/04 0922
melatonin tablet 5 mg	5 mg, Oral, Nightly	Given, 5 mg at 04/03 2008
mirtazapine (REMERON) tablet 15 mg	15 mg, Oral, daily	Given, 15 mg at 04/03 2008
nicotine (NICODERM CQ) 21 mg/24 hr 1 patch	1 patch, TD, daily	Patch Applied, 1 patch at 04/03 1904
polyethylene glycol packet	17 g, Oral, BID	Given, 17 g at 04/03 0939
senna (SENOKOT) tablet 2 tablet (Or Linked Group #1)	2 tablet, Oral, Nightly	Given, 2 tablet at 04/02 2019
senosides 8.8 mg/5 mL syrup 17.6 mg (Or Linked Group #1)	17.6 mg, Oral, Nightly	See Alternative, 04/03 2008

## PRN

Medication	ordered dose/rate, route, frequency	Last Action
albuterol 90 mcg/actuation inhaler 2 puff	2 puff, Inhl, Q6H PRN	Given, 2 puff at 04/03 2009
aluminum-magnesium hydroxide-simethicone (MAALOX) 200-200-20 mg/5 mL oral suspension 30 mL	30 mL, Oral, Daily PRN	Ordered
bisacodyl (BULCOLAX) suppository 10 mg	10 mg, Rect, Daily PRN	Ordered
[Held by provider] HYDROmorphine (PF) (DILAUDID) injection syringe 0.2-0.4 mg	0.2-0.4 mg, IV, Q4H PRN	Ordered
ipratropium-albuterol (DUONEB) 0.5-3 mg (2.5 mg base)/3 mL nebulizer solution 3 mL	3 mL, Nebu, Q6H PRN	Ordered
oxycodone tablet 2.5-5 mg	2.5-5 mg, Oral, Q4H PRN	Given, 5 mg at 04/04 0250
trazodone (DESYREL) tablet 25 mg	25 mg, Oral, Nightly PRN	Given, 25 mg at 04/03 2248

## IMMUNIZATION

Flowsheet Row	Most Recent Value			
Pneumococcal Vaccine Screen - Year Round				
Have you ever had a pneumonia vaccination?	-			
Previous Pneumovax Date	-			
I give my consent to receive pneumococcal vaccine	-			
Pneumovax Contraindications/Refused	-			
Benefits & Risks Fact Sheets on Pneumococcal Vaccine Given	-			
Influenza Vaccine Screen - October through May				
Have you had an influenza vaccine this season?	-			
Influenza Vaccine Date	-			
I give my consent to receive an annual flu vaccine	-			
Influenza Vaccine	Previously immunized this flu season			
Contraindications/Refused				
Benefits & Risks Fact Sheets on Influenza Vaccine Given	-			
Tuberculosis Screen				
Signs and Symptoms	-			
Tuberculosis Risk Factors	-			
Do You Experience Any of the Above	-			
S/SX				
Notified MD/NP/PA	-			
Immunizations				
Name	Date	Dose	Route	Site
COVID-19 (2023-2024) Moderna Spikevax Vaccine 12+	10/09/23	0.5 mL	Intramuscular	Left deltoid
Given By:				
COVID-19 (Pre-10/23) Pfizer Vaccine, Bivalent 12+	12/06/22	0.3 mL	Intramuscular	Right deltoid
Given By:				
COVID-19 (Pre-10/23) Pfizer Vaccine, mRNA, PF	11/03/21	0.3 mL	Intramuscular	Left deltoid
Given By:				
COVID-19 (Pre-10/23) Pfizer Vaccine, mRNA, PF	04/19/21	0.3 mL	Intramuscular	Left arm
Given By:				
COVID-19 (Pre-10/23) Pfizer Vaccine, mRNA, PF	03/28/21	0.3 mL	Intramuscular	Left arm
Given By:				

Influenza High-Dose Quadrivalent Preservative Free IM	10/11/22	0.7 mL	Intramuscular	Left deltoid
Given By: Lacasse, Carol, MA				
Influenza High-Dose Quadrivalent Preservative Free IM	10/05/21	0.7 mL	Intramuscular	Right deltoid
Given By: Lacasse, Carol, MA				
Influenza High-Dose Quadrivalent Preservative Free IM	10/02/20	0.7 mL	Intramuscular	Left deltoid
Given By: Puska, Angela F				
Influenza Quadrivalent Adjuvanted Preservative Free IM	10/07/23	0.5 mL	Intramuscular	Left deltoid
Given By:				
Influenza, Unspecified Formulation	defer-02/12/12		Deferral: other	
Given By:				
Pneumococcal conjugate PCV13	07/07/15	0.5 mL	Intramuscular	Left arm
Given By:				
Pneumococcal polysaccharide PPSV23	06/07/10			
Given By:				
Pneumococcal, Unspecified Formulation	06/07/10			
Given By:				
RSV Vaccine (monovalent, adjuvanted)	09/22/23	0.5 mL	Intramuscular	Left deltoid
Given By:				
Td, unspecified formulation	11/14/05			
Given By:				
Tdap	10/05/21	0.5 mL	Intramuscular	Left deltoid
Given By: Lacasse, Carol, MA				
Zoster Live	10/20/13	0.65 mL	Subcutaneous	Left arm
Given By:				
Zoster Live	10/05/07		Subcutaneous	
Given By:				

## Lab Results (Last 48 hours) (Up to last 2 results from the past 48 hours)

	04/03/2024	04/03/1959	04/04/2023
WBC	—	6.65	5.69
Hgb	—	7.5	7.8
HCT	—	21.8	22.4
PLT	—	107	119
Sodium	137	—	137
Potassium	3.9	—	4.1
Chloride	102	—	104
Carbon Dioxide	26	—	26
Anion Gap	9	—	7
BUN	8	—	12
Creatinine	0.77	—	0.63
eGFR (Creatinine)	78	—	90
Glucose	100	—	99
Calcium	8.3	—	8.1
Magnesium	1.9	—	2.0
Phosphorus	2.6	—	2.7

## Micro Results (Last 10 results in the past 30 days)

	04/04/24	04/03/24	04/03/24	04/03/24	04/02/24	04/02/24	04/02/24	04/01/24
25 (OH)Vitamin D	0533	1559	0601	0524	1241	0830	0533	0721
Total							69	
ABO/Rh								A Positive
Albumin								
Alk Phos								
ALT (SGPT) (U/L)								
Anion Gap	7			9			8	
Antibody screen								Negative
Atrial Rate			86					
AST (SGOT)								
Baso#	0.03	0.03						
Basos (auto)	0.5	0.5						
Bilirubin (Total)								
Expiration Date of Sample								04/04/2024, 2359
BUN	12		8				10	

Calcium	8.1		8.3		8.1	
Carbon dioxide	26		26		26	
Chloride	104		102		101	
Creatinine	0.63		0.77		0.97	
D-Dimer (ng/mL)			1,569			
Diastolic Blood Pressure						
Diff Method	Auto	Auto				
Eos	2.5	2.1				
Eos#	0.14	0.14				
eGFR (Creatinine)	90		78		59	
Globulin						
Glucose	99		100		94	
Glucose (POC)				128		
Granulocytes, immature	0.03	0.05				
Granulocytes, immature (%)	0.5	0.8				
HCT	22.4	21.8	20.7	21.7	21.9	
Hgb	7.8	7.5	7.1	7.7	7.6	
Lymph#	1.59	1.21				
Lymphs	27.9	18.2				
Magnesium	2.0		1.9		1.8	
MCH	32.1	32.5	34.0		33.9	
MCHC	34.8	34.4	34.3		34.7	
MCV	92.2	94.4	99.0		97.8	
Mono#	0.63	0.75				
Monos	11.3	11.3				
MPV	10.5	10.9	10.9		10.9	
Neutrophil #	3.27	4.47				
Neutrophils	57.5	67.1				
NRBC#, auto	0.02	0.02	0.00		0.00	
NRBCs (auto)	0.40	0.30	0.00		0.00	
P Axis		79				
Phosphorus	2.7		2.6		3.1	
PLT	119	107	112		106	
Potassium	4.1		3.9		3.8	
PR Interval		158				
Product Code					E0179V00	
Component Type					RBC IR LR	
Product Status					ISSUED	
Unit Division					00	
PTH, intact (pg/ml)				63		
QRS Duration		84				
QTc Interval		552				
QT Interval		462				
RBC	2.43	2.31	2.09		2.24	
RDW	15.9	14.9	13.4		13.3	
Resulting Agency					[P] NS	
R Wave Axis		19				
Systolic Blood Pressure						
Sodium	137		137		135	
Total Protein						
Troponin T-hs Gen5			13			
T Wave Axis		81				
Unit Number						
Ventricular Rate		86				
EKG/MIN						
WBC	5.69	6.65	6.18		5.38	

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Clinical data printed from 4NEXT - Confidential

ALT (SGPT) (U/L)	19	
Anion Gap	9	8
Antibody screen		
Atrial Rate		
AST (SGOT)	28	
Baso#	0.03	0.06
Basos (auto)	0.5	1.1
Bilirubin (Total)	0.6	
Expiration Date of Sample		
BUN	8	9
Calcium	8.9	8.9
Carbon Dioxide	27	28
chloride	101	102
Creatinine	0.74	0.93
D-Dimer (ng/mL)		
Diastolic Blood Pressure		
Diff Method	Auto	Auto
Eos	0.4	3.4
Eos#	0.02	0.18
eGFR (Creatinine)	82	62
Globulin	2.5	
Glucose	116	102
Glucose (POC)		
Granulocytes, immature	0.02	0.01
Granulocytes, immature (%)	0.4	0.2
HCT	29.5	33.3
Hgb	10.4	12.0
Lymph#	0.91	1.78
Lymphs	16.0	34.0
Magnesium	1.8	
MCH	33.3	33.6
MCHC	35.3	36.0
MCV	94.6	93.3
Monof#	0.54	0.59
Monos	9.5	11.3
MPV	10.6	10.5
Neutrophil #	4.15	2.62
Neutrophils	73.2	50.0
NRBC#, auto	0.00	0.00
NRBCs (auto)	0.00	0.00
P Axis		
Phosphorus	3.4	
Plt	158	187
Potassium	3.9	4.4
PR Interval		
Product Code		
Component Type		
Product Status		
Unit Division		
PTH, Intact (pg/mL)		
QRS Duration		
QTc Interval		
QT Interval		
RBC	3.12	3.57
RDW	13.4	13.2
Resulting Agency		
R Wave Axis		
Systolic Blood Pressure		
Sodium	137	138
Total Protein	6.2	
Troponin T-hs Gens		
T Wave Axis		
Unit Number		

Ventricular Rate		
EKG/MIN		
WBC	5.67	5.24

[P] - Preliminary Result - Comment

## Bowel &amp; Bladder

Flowsheet Row	Most Recent Value
Urine Assessment	
Urine (mL)	1200 mL [Purwik canester]
Urine Occurrence (Unmeasured)	1 (P)
Urine Amount (qualitative)	-
Due to Void	- [dtv 1300]
Bladder Continenence	Continent (P)
Bladder Incontinence Containment	-
Urine Color	-
Urine Appearance	-
Urine Odor	-
Bladder Scan Volume	-
Intermittent/Straight Cath (mL)	-
Post Void Residual Bladder Scan	199 mL

## Volume

Post Void Cath Residual (mL)	-
Urine LDAs	-

## Stool Assessment

Stool (mL)	-
Stool occurrence (Unmeasured)	1 (P)
Stool Amount (qualitative)	Medium (P)
Bowel Continenence	Continent (P)
Bowel Incontinence Containment	-
Stool Color	Brown (P)
Stool Appearance	Loose, soft (P)
Stool LDAs	-

## Diet Orders (From admission, onward)

Start	Ordered
04/03/24 2119	04/03/24 2119
Diet Regular	Diet effective now
Comments: Progress from clear as tolerated.	
04/01/24 1303	04/01/24 1302
Adult/Pediatric nutrition supplements Supplement: Gelatine Plus; Number of servings: One; Frequency: Breakfast until discontinued	
04/01/24 1303	04/01/24 1302
Adult/Pediatric nutrition supplements Supplement: Magic cup (chocolate); Number of servings: One; Frequency: Dinner until discontinued	
04/01/24 1209	04/01/24 1208
Advance diet as tolerated until discontinued	

## Respiratory

## Labs (Last 48 hours)

None

## O2/Mechanical Ventilation (Last 48 hours)

02 Device	04/03 1521	04/03 1948	04/04 0528
	None (R...)	None (R...)	None (R...)

## Respiratory

Flowsheet Row	Most Recent Value
Respiratory	-
Respiratory System Assessment	No change
Respiratory Exceptions/Add'l Assessments	-
Bilateral Breath Sounds	-
Resp Pattern	-
Respiratory Effort/Chest Assessment	-

## Patient Lines/Drains/Airways Status

## Active Lines, Drains, Airways, Wounds

## Peripheral IV Anterior:Left Forearm

Placement date	04/01/24	Site	Forearm
Placement time	0721	Days	3

## Assessments

Row Name	04/04/24 0600	04/04/24 0850	04/03/24 2315	04/03/24 2009	04/03/24 1600
Site Assessment	-	-	-	Clean, dry, intact	-

Infiltration Scale	-	-	-	-	0	-
Phlebitis Scale	-	-	-	-	0	-
Line Status	-	-	-	-	Saline Locked	-
Line Care	-	-	-	-	Flushed;Cap(s), alcohol changed;Connections checked and tightened	-

Dressing Type	-	-	-	-	TSM	-
Dressing Status	-	-	-	-	Clean,Dry,Intact	-
Dressing Change Due	-	-	-	-	04/07/24	-

Row Name 04/03/24 1130

Site Assessment	-	-	-	-	-	-
Infiltration Scale	-	-	-	-	-	-
Phlebitis Scale	-	-	-	-	-	-
Line Status	-	-	-	-	-	-
Line Care	-	-	-	-	-	-
Dressing Type	-	-	-	-	-	-
Dressing Status	-	-	-	-	-	-
Dressing Change Due	-	-	-	-	-	-

External Urinary Suction Device	-	-	-	-	-	-
Placement Date	04/01/24					
Placement Time	1035					

Days 2

Assessments	-	-	-	-	-	-
Row Name	04/04/24 0600	04/04/24 0350	04/03/24 2315	04/03/24 2009	04/03/24 1600	
Site Assessment	-	-	-	-	-	-
Date Changed:	-	-	-	-	-	-
Time Changed:	-	-	-	-	-	-
Output (mL)	300 mL	-	-	-	-	-
Row Name	04/03/24 1130					
Site Assessment	-	-	-	-	-	-
Date Changed:	-	-	-	-	-	-
Time Changed:	-	-	-	-	-	-
Output (mL)	-	-	-	-	-	-

Wound Incision Left;Lateral Hip	-	-	-	-	-	-
Date First Assessed	04/01/24					
Time First Assessed	0814					

Days 3

Assessments	-	-	-	-	-	-
Row Name	04/04/24 0600	04/04/24 0350	04/03/24 2315	04/03/24 2009	04/03/24 1600	
Dressing Status	-	-	-	-	Clean,dry,intact	
Drainage Amount	-	None	None	None	None	
Wound Bed/Site Assessment	-	Clean, dry, intact;Black	Approximated;Clean, Approximated;clean, dry, intact	-	-	-
Peri-Wound Assessment	-	Clean, dry, intact	Clean, dry, intact	Clean, dry, intact	-	-
Closure	-	Steri strips	-	Steri strips	-	-
Dressing	-	Open to air	Open to air	Open to air	ABD	
Color/Movement/Sensation Distal to Site	-	Capillary refill < 2 sec;Color appropriate	2 sec;Color appropriate	Capillary refill < 2 sec;Color appropriate	Capillary refill < 2 sec;Color appropriate	

Row Name	04/03/24 1130					
Dressing Status	Clean,dry,intact					
Drainage Amount	None					
Wound Bed/Site Assessment	-					
Peri-Wound Assessment	-					
Closure	-					
Dressing	ABD					
Color/movement/sensation Distal to Site	-					

Wound Incision Left;Lateral;Medial Leg	-	-	-	-	-	-
Date First Assessed	04/01/24					
Time First Assessed	0814					

Days 3

Assessments	-	-	-	-	-	-
Row Name	04/04/24 0600	04/04/24 0350	04/03/24 2315	04/03/24 2009	04/03/24 1600	
Dressing Status	-	-	-	-	Clean,dry,intact	
Drainage Amount	-	None	None	None	None	

Wound Bed/Site Assessment - Clean, dry, intact;Approximated intact;Approximated intact;Approximated due to order: do not remove

Closure	-	Steri strips	Steri strips	Steri strips	dressing
Dressing	-	Open to air	Open to air	Open to air	ABD
Color/Movement/Sensation Distal to Site	-	Capillary refill < 2 sec; color appropriate			
Row Name	04/03/24 1130				

Dressing Status	Clean, dry, intact
Drainage Amount	None
Wound Bed/Site Assessment	
Closure	-
Dressing	ABD
Color/Movement/Sensation Distal to Site	Capillary refill < 2 sec; color appropriate

MIS Incisions Other (comment) OPEN REDUCTION INTERNAL FIXATION FRACTURE PERTROCHANTERIC INTERTROCHANTERIC OR SUBTROCHANTERIC FEMUR WITH INTRAMEDULLARY ROD - Left (1) Left;Lateral;Upper Knee

Surgical Date	04/01/24	Site	Knee
Surgical Time	0814	Days	3

Assessments	
Row Name	04/04/24 0600
Multiple Sites Dressing Status	-
Multiple Sites Dressing Type	-
Multiple Sites Assessment	-
Row Name	04/03/24 1130
Multiple Sites Dressing Status	-
Multiple Sites Dressing Type	-
Multiple Sites Assessment	-

#### Skin at Risk Pressure Left;Right Heel

Date First Assessed	03/31/24	Days	3
Time First Assessed	2227		

Assessments	
Row Name	04/04/24 04/04/24 0350
	0600
Site Assessment	-
Interventions/Treatments	Patient repositioned; Pressure offloading device; Preventative dressing applied/changed; Preventative dressing in place
Preventative Dressing	Bordered silicone foam
Row Name	04/03/24 1130
Site Assessment	Blanchable erythema
Interventions/Treatments	Patient repositioned; Pressure offloading device; Preventative dressing in place
Preventative Dressing	Bordered silicone foam

#### PICC Line Details

Active PICC Line	
None	

#### Vital Signs

Most recent update: 4/4/2024 7:56 AM				
SP (P) 117/55	Pulse (P) 82	Temp (P) 36.7 °C (98.1 °F) (Temporal)	Resp (P) 18	Ht 157.5 cm (5' 2")
Wt 53.5 kg (118 lb)	LMP (LMP Unknown)	SpO2 (P) 93%	BMI 21.58 kg/m²	

#### Case Management Assessment

Case Management Assess Flowsheet	Prior Toileting clothing Independent Management Level of Assistance
HIGH RISK SCREEN	Bowel control Continent Prior Bed Mobility Level of Independent Assistance

Discharge services needed at this time		Yes	First Surface to Surface	Independent	
PATIENT INFORMATION			Level of Assistance		
Home Caregiver	Self		Bathroom Equipment	Shower chair with back	
Support Systems		Children;Family members	Dressing Lower Body	Level of Maximum assistance	
PSYCHOSOCIAL			Toileting Hygiene	Level of Unable to assess	
Lives With	Self/alone	Assistance	Bed Mobility	Level of Moderate assistance	
Transportation	Family;Friends gave up her license		Assistance		
Last year					
Type of Residence	Independent housing	CURRENT FUNCTIONAL STATUS			
Prior or Current Services	skilled home health services	IADL Assistance	Driving;Shopping Family takes her grocery shopping		
Type of Skilled HH Nursing	PT comes every 3 week				
Services active on admission		No	FINANCIAL INFORMATION		
Needs PCP at discharge	NO Dr Rebecca Symes		Insurance verified	Yes	
PTA FUNCTIONAL STATUS			Coverage for next level of care	Yes	
Stairs to Enter Home	6		Prescription benefits	Yes CVS Lowell St, Peabody, MA	
Stairs Inside Home	0		Afford co-pays	Yes	
Home Equipment	Bathroom equipment	LEGAL INFORMATION			
Prior Dressing Lower Body Level of Assistance	Independent	Does patient have a Health Care Proxy form completed?	Electronic copy of HCP available		
Prior Grooming Level of Assistance	Independent	Patient/Family/Caregiver discharge preference/goals	skilled nursing facility		
Prior Self Feeding Level of Assistance	Independent	Anticipated discharge disposition	skilled nursing facility		
Prior Bathing/Showering Assistance	Independent	Non-Medical Barriers to Discharge	Await acceptance		
Prior Toileting Hygiene Level of Assistance	Independent	NEXT ACTIONS			
		Assessment/High Risk Screening	Complete		

## Case Management Notes

Progress Notes by Fisher, Dianna M, RN at 4/3/2024 10:44 AM  
 Author: Fisher, Dianna M, RN Author Type: Case Manager Filed: 4/3/2024  
 10:45 AM  
 Note Status: signed Cosign: Cosign Not Required Date of Service: 4/3/2024  
 10:44 AM  
 Editor: Fisher, Dianna M, RN (Case Manager)

## Case Management - Progress Note

04/03/24 1042  
 Discharge Plan  
 To be discharged to Skilled Nursing Facility - short-term <30 days  
 Disposition Comments STR-ref. pending  
 Non-Medical Barriers to Discharge Await acceptance  
 Medical Barriers to Discharge Medically not ready; Awaiting imaging  
 (POD #2-> H/H 7.1/20.7, TX 1U PRBC, pain management, c/o pain in knee)  
 Mode of DC Transportation Ambulance  
 Discharge address same as facesheet No  
 Patient/Family declines facility rehab No

Expected Discharge Date: 4/5/24

Communication summary with patient, family, team about the discharge plan: met with the patient, plan for the day and d/c plan reviewed. STR needed on d/c, she is agreeable. Ref. Pending.

HCP Confirmed:  
 Does patient have a Health Care Proxy Form completed?: Electronic copy of HCP available

ACO/TMP? Yes

ACO Actions:  
 PT eval ordered Yes  
 PT recommendation: STR  
 If PT recommends STR, I have discussed this recommendation and patient's current medical and functional status with the ACO Transition's Coordinator (pager 74675, ext 4781) to explore possible alternative

discharge options. Yes

MGB and Salem Hospital have established relationships with non-acute providers that meet Partners Healthcare performance criteria. These relationships were discussed with the patient/surrogate decision maker before a VNA referral was made. Choice was provided before making a referral.

Dianna M Fisher, RN

Showing 1 note, more notes may be available.

Infectious Disease Note  
No notes found.

#### History and Physical Notes

Interval H&P Note by O'Brien, Todd M, MD at 4/1/2024 7:44 AM  
Author: O'Brien, Todd M, MD Service: Orthopedics Author Type: Physician  
Filed: 4/1/2024 7:44 AM Date of Service: 4/1/2024 7:44 AM Status:  
Signed  
Editor: O'Brien, Todd M, MD (Physician)

H&P reviewed. The patient was examined and there are no changes to the H&P.

Signed by O'Brien, Todd M, MD on 4/1/2024 7:44 AM  
Source Note  
Author: Devineni, Praveen, MD Service: Hospital Medicine Author Type:  
Physician  
Filed: 3/31/2024 9:43 PM Date of Service: 3/31/2024 9:10 PM Status:  
Signed  
Editor: Devineni, Praveen, MD (Physician)

#### Hospitalist Admission History and Physical Exam

3/31/2024  
9:10 PM

Patient: [REDACTED]  
DOB: 1  
MRN:  
PCP: Lee, Rebecca Symmes, MD

CHIEF COMPLAINT:  
Chief Complaint

Complaint Comment  
Fall [160198]

Primary language: English

#### HISTORY OF PRESENT ILLNESS:

is a 80 y.o. female with a history of hypertension, hyperlipidemia, tobacco dependence, COPD, history of DVT/PE, protein calorie malnutrition, CKD, osteoarthritis, glaucoma, Raynaud's disease, CAD, anxiety, depression, pulmonary nodules, history of small bowel obstruction; presented to the hospital today with a chief complaint of fall.

Patient mentions she was walking down the stairs; she missed the hold on the last rail; and tripped and fell on her left hip; hit her head on the grass; denies any loss of consciousness. Denies any neck pain or back pain. Reports after the fall she developed severe pain in her hip and unable to get up; subsequently came to the ER for further evaluation.

Patient denies any chest pain palpitations lightheadedness or dizziness.

Denies any shortness of breath or dyspnea on exertion.

Patient reports she smokes cigarettes regularly.

Denies any fevers chills cough or sputum production.

Denies any GI/GU symptoms.

Review of all other systems is negative except mentioned above

ER course:

Per ER team, patient noted to have left hip tenderness; CT head and CT C-spine showed no acute findings; hip x-ray showed fracture; orthopedics team was notified consulted n.p.o. after midnight for possible surgery. LLE was neurovascularly intact. EKG nonischemic.

ED Course:

VS in ED

Temperature: [35.8 °C (96.4 °F)] 35.8 °C (96.4 °F)

Heart Rate: [70-94] 72

Respiratory Rate: [9-29] 19

BP: (119-178)/(58-98) 132/62

Abnormal Labs Reviewed

CBC AND DIFFERENTIAL - Abnormal; Notable for the following components:

Result	Value
--------	-------

RBC 3.57 (\*)

HCT 33.3 (\*)

MCH 33.6 (\*)

NEUTS 50.0 (\*)

LYMPHS 34.0 (\*)

EOS 3.4 (\*)

BASOS 1.1 (\*)

All other components within normal limits

BASIC METABOLIC PANEL - Abnormal; Notable for the following components:

GLUCOSE 102 (\*)

All other components within normal limits

Clinical Impressions as of 03/31/24 2110

Closed left hip fracture

Medication administered in ED:

Medications

nicotine (NICODERM CQ) 21 mg/24 hr 1 patch (1 patch Transdermal Patch

Applied 3/31/24 1956)

morphine injection syringe 2 mg (2 mg Intravenous Given 3/31/24 1810)

morphine injection syringe 2 mg (2 mg Intravenous Given 3/31/24 1922)

Allergy

Allergies

Allergen Reactions

Codeine Other (See Comments)

Mental status change

Diazepam Unknown

Valium (Diazepam)

Sertraline Sweating

Venlafaxine Other (See Comments) and Sweating

Dreams

MEDICAL & SURGICAL HX:

Past Medical History:

Diagnosis Date

Anxiety

Anxiety state 7/24/2014

Anxiety state

Depression

High cholesterol

History of hysterectomy

age 37

Pulmonary embolism 5/29/2017

Past Surgical History:

Procedure L laterality Date

APPENDECTOMY

Appendectomy

BREAST NEEDLE BIOPSY

Breast biopsy; Had to remove the nipple

CHOLECYSTECTOMY  
Cholecystectomy  
HERNIA REPAIR  
Hernia repair  
HYSTERECTOMY  
Hysterectomy; Has one ovary left  
UNCODED SURGICAL HISTORY  
Tonsillectomy  
UNCODED SURGICAL HISTORY  
Eye surgery; Laser for glaucoma, membrane on retina  
UNCODED SURGICAL HISTORY  
ysis of adhesions; Procedure date: 07/04/2008; lysis of adhesions, open, for high grade ileal obstruction.

## FAMILY HX:

Family History  
Problem Relation Age of Onset  
Alzheimer's disease Mother  
Alzheimers disease  
Stroke Father  
Cerebrovascular Accident  
Vertigo Sister  
Skin cancer Sister  
Coronary artery disease Brother  
coronary artery disease  
Uncoded Family History Maternal Grandmother  
heart attack  
Type 2 Diabetes Maternal Grandfather  
Diabetes Mellitus type 2

## SOCIAL HX:

## Social History

Socioeconomic History  
Marital status: Widowed  
Spouse name: Not on file  
Number of children: Not on file  
Years of education: Not on file  
Highest education level: Not on file  
Occupational History  
Not on file  
Tobacco Use  
Smoking status: Every Day  
Packs/day: 0.50  
Years: 60.00  
Additional pack years: 0.00  
Total pack years: 30.00  
Types: Cigarettes  
Start date: 1958  
Last attempt to quit: 9/1/2018  
Years since quitting: 5.5  
Smokeless tobacco: Never  
Tobacco comments:  
started smoking again in 2019- 1/2 pack daily  
Vaping Use  
Vaping Use: never used  
Substance and Sexual Activity  
Alcohol use: No  
Comment: Sober for 37 years  
Drug use: No  
Sexual activity: Not Currently  
Other Topics Concern  
Not on file  
Social History Narrative  
Married; widower, lives alone with dog  
Stays with son in Maine most summers and holidays  
Has a 48 year old son who is helpful., no grandchildren.  
Sexually active: Not currently  
Employment: Worked for the state as a supervisor for mentally retarded individuals  
Smoke: started smoking again in 2019 - 1/2 pack daily-1 ppd for 30+years, has cut back a bit, using ecig too.  
ETOH: Previously heavy, sober for 37 years.  
Illicit drug use: Never  
Exercise: dog walking and walking in woods, ATV rides, jet skis and tubing, fishing

## Social Determinants of Health

Residential stability: Not on file

PRIOR TO ADMISSION MEDICATIONS:

Medication reconciliation:

List source: The patient/family is confident with the accuracy of the medication list.

Prior to Admission medications

Medication Sig

albuterol 90 mcg/actuation inhaler 2 puffs, Inhalation, Every 6 hours PRN

aspirin 81 MG EC tablet 81 mg, Oral, Daily

atorvastatin (LIPITOR) 80 MG tablet 80 mg, Oral, Every morning

azelastine (ASTELIN) 137 mcg (0.1 %) nasal spray 1 spray, Nasal, 2 times

daily, Use in each nostril as directed

calcium carbonate-vitamin D3 1500 mg (600 mg elemental)-400 units per

tablet Dose: 1 TAB; Form: Not available; Route: PO; Frequency: BID;

Directions: Not available; Details: Not available; Date: 07/24/2014

cyanocobalamin, vitamin B-12, 1000 MCG tablet 1,000 mcg, Oral, See admin

instructions, Every 3-4 days

donepezil (ARICEPT) 5 MG tablet 1 tablet, Oral, Every morning

fluticasone propionate (FLONASE) 50 mcg/actuation nasal spray 1 spray,

Nasal, Daily

levothyroxine (SYNTHROID, LEVOTHROID) 75 MCG tablet Take one daily for 5 days and for 2 days per week take 1/2 tablet (total 450 mcg per week)

mirtazapine (REMERON) 7.5 MG tablet 45 mg, oral, Daily, Takes 3 tablets daily for total of 45 mg

omega-3 fatty acids-fish oil 300-1,000 mg Cap 2 g, Oral, Daily

trazodone (DESYREL) 100 MG tablet 50 mg, Oral, Nightly PRN

folic acid (FOLVITE) 1 MG tablet 1 tablet, Oral, Every morning

olodaterol 2.5 mcg/actuation Mist 2 puffs, Inhalation, Daily

polyethylene glycol (MIRALAX) 17 gram/dose powder 17 g, oral, daily

polyvinyl alcohol (AKWA TEARS) 1.4 % ophthalmic solution 1 drop, Daily as

needed

vitamin B complex 3-FA-C-biotin (NEPHRO-VITE RX) 1-60-300 mg-mg-mcg Tab 1 tablet, Oral

PDMP was reviewed

PHYSICAL EXAMINATION:

Temperature: [35.8 °C (96.4 °F)] 35.8 °C (96.4 °F)

Heart Rate: [70-94] 72

Respiratory Rate: [9-29] 19

BP: (119-178)/(58-98) 132/62

[92 % 97 %] 96 % (03/31 2100)

Gen: NAD, Appear stated age, talk in full sentences, no use of accessory muscles.

Head: AT/NC

Eyes: PERRL, EOMI, not pale, anicteric

Cardio.: RRR, S1S2, no M/R/G, No JVD, BP/PT +2

Resp.: Equal chest expansion, CTAB, no wheezing or rales

Gastro.: NT/ND, soft, + BS, no CVA tenderness.

MSK: No joint deformity, normal ROM.

Extremity: Warm and well perfused, left lower extremity exam limited secondary to the pain.

Psych: Normal affect

Hematology/Lymph nodes: No LAP, no bleeding

Skin: Warm, dry, no rash

Neuro:

Alert and awake, oriented x 3, grossly nonfocal

PERTINENT TESTS:

Recent Labs

03/31/24

1818

NA 138

K 4.4

CL 102

CO2 28

BUN 9

CRE 0.93

GLU 102\*

CA 8.9

No results for input(s): "TP", "ALB", "GLOB", "SGOT", "SGPT", "ALKP",

"TBIL", "DBILI" in the last 72 hours. Recent Labs  
03/31/24  
1818  
WBC 5.24  
HGB 12.0  
HCT 33.3\*  
PLT 187  
MCV 93.3  
RDW 13.2

No results for input(s): "PTT", "PT", "INR" in the last 72 hours.  
No results for input(s): "TROPT", "LACT" in the last 72 hours.

**COLOR**

Date Value Ref Range Status  
04/28/2017 YELLOW YELLOW Final

**CLARITY**

Date Value Ref Range Status  
04/28/2017 clear clear Final

**GLUCOSE**

Date Value Ref Range Status  
04/28/2017 Negative Negative Final

**BIL**

Date Value Ref Range Status  
04/28/2017 Negative Negative Final

**KETONES**

Date Value Ref Range Status  
04/28/2017 Negative Negative Final

**SPECIFIC GRAVITY**

Date Value Ref Range Status  
04/28/2017 1.003 1.003 - 1.030 Final

**BLOOD**

Date Value Ref Range Status  
04/28/2017 1+ (\*) Negative Final

**PH**

Date Value Ref Range Status  
04/28/2017 6.0 5.0 - 8.0 Final

**UROBILINOGEN**

Date Value Ref Range Status  
04/28/2017 Negative Negative Final

**NITRITE**

Date Value Ref Range Status  
04/28/2017 Negative Negative Final

**WBC**

Date Value Ref Range Status  
04/28/2017 0 (\*) 0 - 5 /hpf Final

**BACTERIA/HPF**

Date Value Ref Range Status  
05/29/2010 4+ Final

**SQUAMOUS CELLS**

Date Value Ref Range Status  
04/28/2017 7 (\*) None Final

Results for orders placed or performed in visit on 07/20/12

**Urine culture**

Collection Time: 07/20/12 6:16 PM

URINE, CLEAN CATCH

Result Value Ref Range

URINE CULTURE

Specimen: F64865

Collected 20-Jul-12 18:16

Received 20-Jul-12 21:57

Ordering Provider: GILLIS, ALICEN

Specimen Group: URINE

Specimen Type: URINE, CLEAN CATCH

Specimen Comment: NONE

URINE CULTURE - Final      Reported: 22-Jul-12 11:54

FEW CONTAMINANTS.

Results for orders placed or performed in visit on 05/29/10

Urine culture

Collection Time: 05/29/10 8:33 AM

URINE, CLEAN CATCH

Result Value Ref Range

URINE CULTURE

Specimen: S22130

Collected 29-May-10 08:33

Received 29-May-10 10:46

Ordering Provider: CHANG, EILEEN

Specimen Group: URINE

Specimen Type: URINE, CLEAN CATCH

Specimen Comment: NONE

URINE CULTURE - Final      Reported: 31-May-10 09:55

>100,000 COL/ML ESCHERICHIA COLI

MIC BREAKPOINT	
Antibiotic	Result
AMPICILLIN	R
AMPICILLIN/SULBACTAM	I
BACTRIM	S
CEFOXITIN	S
CEPHALOTHIN	I
CIPROFLOXACIN	R
GENTAMICIN	S
LEVOFLOXACIN	R
NITROFURANTOIN	S
PIPERACILLIN/TAZO	S
TETRACYCLINE	S

EKG: Normal sinus rhythm, nonischemic

XR Chest

Result Date: 3/31/2024  
No acute abnormality.

CT Cervical Spine

Result Date: 3/31/2024  
1. No acute intracranial findings. 2. No acute fracture or traumatic malalignment of the cervical spine.

CT Head

Result Date: 3/31/2024  
1. No acute intracranial findings. 2. No acute fracture or traumatic malalignment of the cervical spine.

Serum creatinine: 0.93 mg/dL 03/31/24 1818  
Estimated creatinine clearance: 40 mL/min  
Wt Readings from Last 3 Encounters:  
03/29/24 52.2 kg (115 lb)  
02/27/24 52.2 kg (115 lb)  
12/13/23 54.9 kg (121 lb)

IMPRESSION/PLAN:

80 y.o. female with a history of hypertension, hyperlipidemia, tobacco dependence, COPD, history of DVT/PE, protein calorie malnutrition, CKD, osteoarthritis, glaucoma, Raynaud's disease, CAD, anxiety, depression, pulmonary nodules, history of small bowel obstruction; presented to the

Hospital today with a chief complaint of fall. Sustained left hip fracture. Admitted to the hospital for further management.

Fall: Mechanical in nature.  
CT head and CT C-spine showed no acute findings  
Exam grossly nonfocal  
Fall precaution  
PT/OT when ready for discharge

Left hip intertrochanteric fracture:  
Neurovascularly intact  
Orthopedics team was notified-possible plan for surgery in a.m.  
N.p.o. after midnight  
Pain control

Preop evaluation:  
Patient is moderate risk for intermittent risk surgery.  
Routine pulmonary toileting recommended in the perioperative period.  
Hold home aspirin for now

Tobacco dependence: counseled on smoking cessation. Offer nicotine patch.

HTN/HLD/CAD: Blood pressure stable. Aspirin on hold. Continue statin.  
Hypothyroidism: Continue levothyroxine  
Anxiety/depression: Continue mirtazapine  
COPD: Not in exacerbation. DuoNeb as needed.

DVT Prophylaxis: SQ Heparin  
Delirium Prevention: Ambulation: As tolerated, Fall precautions, Sleep  
Hygiene: Calm Environment, Melatonin, Hydration: Oral Hydration, and  
Medications: Avoid benzodiazepines when possible

Diet: No diet orders on file  
Code Status: Full code, confirmed.  
Level of Care: Inpatient.

Decision-making capacity: Patient is capable to make own medical decision

Decision-making capacity: Surrogate Decision Maker activated. NO

I admitted the patient to inpatient status. I expect that the patient will require care that spans two midnights due to severe to the presentation and multiple comorbidities

Further management including, but not limited to consults, following up of test results, discharge planning, outpatient referrals will be determined and addressed by the hospitalist who will assume care of this patient.

Praveen Devineni, MD  
9:10 PM  
3/31/2024  
Pager: 71210

Please Note:  
Portions of this record may have been created with voice recognition software. Wrong word or 'sounded like' substitutions may have occurred due to the inherent limitations of the software. If words or phrases appear to be out of context and the meaning of a phrase or sentence is unclear, please contact the author for clarification.

Signed by Devineni, Praveen, MD on 3/31/2024 9:43 PM

**Nutrition Note**  
Consults by Berube, Juliane S, LDN at 4/1/2024 8:16 AM  
Author: Berube, Juliane S, LDN Author Type: Licensed  
Dietitian/Nutritionist Filed: 4/1/2024 1:27 PM  
Note Status: Signed Cosign: Cosign Not Required Date of Service: 4/1/2024  
8:16 AM  
Editor: Berube, Juliane S, LDN (Licensed Dietitian/Nutritionist)

**Consult Orders:**  
1. IP Consult to Nutrition Services [1360622835] ordered by Petti,

Alexander M, MD at 03/31/24 2154

#### Salem Hospital Clinical Nutrition

##### Assessment

History: N is a 80 y.o. female who was admitted on 3/31/2024 with chief complaint of Fall. Relevant medical history includes HTN, HLD, tobacco dependence, COPD, hx of DVT/PE, protein calorie malnutrition, CKD, Raynaud's disease, CAD, anxiety/depression, hx of SBO, who presented after a fall landing on L hip and hitting head on lawn, no LOC. Found with L hip intertrochanteric fx plan for OR today (4/1). Nutrition consulted given concern for malnutrition.

Assessment: Met with pt and son at bedside. Pt reported appetite has not been very good and has lost ~9 lbs over the past 4 months d/t some difficult circumstances. Pt noticed how thin and bony she looked in the mirror so contacted her PCP who advised pt to start eating more and avoid low fat and sugar free foods. Pt had just gotten Boost shakes at home but has not had a chance to taste them yet. Pt agreed to try gelatine plus and magic cup ice cream this admission, does not like ensure. Discussed with pt and son additional ways to add more calories to meals without increasing the portion sizes.

Pt noted that when she fell at home she must have hit her mouth on the ground resulting in damage to gums, thus pt is unable to wear dentures d/t pain; will place pt on easy to chew diet.

##### Malnutrition Identification

Malnutrition Screening Tool (MST) Score: 2

Malnutrition identified by dietitian: Yes

Patient meets criteria for: Moderate protein-calorie malnutrition in the context of chronic illness

##### Supporting Criteria (derived from AND/ASPEN 2012 Consensus Statement)

Exam: body fat: Orbital fat pad loss, mild, Triceps fat loss, mild

Exam: muscle mass: Clavicular protrusion, moderate, Temporal depression, mild

##### Hospital Day: 1

Diet Order: Advance diet as tolerated

Diet (Non Dysphagia) Mechanically altered; Easy to chew

Adult/Pediatric nutrition supplements Supplement: Gelatine Plus; Number of servings: One; Frequency: Breakfast

Adult/Pediatric nutrition supplements supplement: Magic Cup (chocolate); Number of servings: One; Frequency: Dinner

##### Allergies

##### Allergen Reactions

Codeine Other (See Comments)

Mental status change

Diazepam Unknown

Sertraline Sweating

Venlafaxine Other (See Comments) and Sweating

Dreams

##### Lab results

137 101 8 / 116\*

3.9 27 0.74 \

04/01 0556

##### Lab Results

Component Value Date

PHOS 3.4 04/01/2024

MG 1.8 04/01/2024

CA 8.9 04/01/2024

##### Lab Results

Component Value Date

VITDT 55 04/28/2017

VITDT 57 08/22/2013

VITDT 63 08/25/2011

No results found for: "HGBA1CPOC", "GHBA1C"

##### Medications

acetaminophen 975 mg Oral Q8H

atorvastatin 80 mg Oral QAM

ceFAZolin 2 g Intravenous Q8H

cyanocobalamin (vitamin B-12) 1,000 mcg oral See Admin Instructions

donepezil 5 mg Oral QAM  
folic acid 1,000 mcg Oral QAM  
heparin 5,000 Units Subcutaneous Q8H SCH  
levothyroxine 75 mcg Oral QAM  
melatonin 5 mg Oral Nightly  
mirtazapine 15 mg Oral Daily  
nicotine 1 patch Transdermal Once  
polyethylene glycol 17 g Oral BID  
senna 2 tablet Oral Nightly  
Or  
sennosides 17.6 mg Oral Nightly

Lactated Ringers 50 mL/hr (04/01/24 1215)

**Anthropometrics**

Height: 157.5 cm (5' 2") Weight: 53.5 kg (118 lb) BMI (Calculated): 21.58  
IBW: %IBW:  
UBW: %UBW:

**Wt Readings from Last 10 Encounters:**

04/01/24 53.5 kg (118 lb)  
03/29/24 52.2 kg (115 lb)  
02/27/24 52.2 kg (115 lb)  
12/13/23 54.9 kg (121 lb)  
10/17/23 54.4 kg (120 lb)  
07/11/23 55.8 kg (123 lb)  
01/26/23 57.6 kg (127 lb)  
01/17/23 57.2 kg (126 lb)  
10/11/22 56.2 kg (124 lb)  
10/04/22 59 kg (130 lb)

A multitude of studies in adults >65 years old indicate that a higher body weight is associated with improved clinical outcomes. BMI measurements below 23.0 kg/m<sup>2</sup> have been associated with increased risk of all-cause mortality in this population, while BMI 27.0-27.9 kg/m<sup>2</sup> is associated with lowest risk.

**Estimated Nutrition Requirements (using wt: 53.5 kg (118 lb))**

Calories: 1338 to 1606 kcals per day (25 to 30 kcals/kg)  
Protein: 54 to 75 grams per day (1 to 1.4 g/kg)

**Nutrition Diagnosis**

1. Inadequate protein energy intake related to age-related decreased appetite as evidenced by mild to moderate fat/muscle loss, pt report of weight loss.

Status: New

**Goals**

1. eating >2/3 of meals and supplements. (Goal's status: New)  
2. maintain current weight, no loss of lean body mass. (Goal's status: New)  
3. chem 7/Mag/Phos WNL. (Goal's status: New)

**Monitoring and Evaluation**

Food and nutrient intake, supplement acceptance, weight

**Nutrition Education**

Patient did not require education.

**Recommended Interventions**

1. Oral diet optimization

Diet order: regular, easy to chew

Supplements: chocolate magic cup ice cream and gelatin plus daily

Give pills with supplement rather than applesauce/water

Allot 45 minutes following meal delivery without labs/consults

Facilitate sitting in chair (rather than bed) for majority of meals

2. Micronutrient supplementation

Rec Multivitamin with minerals daily

Continue Folic acid 1 mg/day x 10 days

Continue Cyanocobalamin 1000 mcg orally daily

Rec Ferrous sulfate 65 mg every other day (less GI side effects, equal repletion)

3. Monitoring

Weigh patient weekly

Bowel protocol to ensure patient has a bowel movement every 1-2 days

Recurring labs: BMP with Phos and Mg daily, LFT's and Triglycerides weekly

Will continue to follow

Juliane S Berube, MS, RD, LDN p71321  
Date 4/1/2024 Time 1:25 PM

For non urgent concerns, reach out to the dietitian assigned to this unit on Voalte.  
For urgent or parenteral nutrition-related concerns, page on-call dietitian (70730).

Showing 1 note, more notes may be available.

#### PT/OT/SLP Evaluations/Consult notes

Consults by Marchena, Mia-Danielle, OT at 4/2/2024 1:05 PM  
Author: Marchena, Mia-Danielle, OT Service: Occupational Therapy Author  
Type: Occupational Therapist  
Filed: 4/2/2024 3:27 PM Date of Service: 4/2/2024 1:05 PM Status:  
Signed  
Editor: Marchena, Mia-Danielle, OT (Occupational Therapist)

#### Occupational Therapy Evaluation

Occupational Therapy Discharge Recommendations:  
OT Discharge Recommendation: Inpatient rehab  
OT Discharge Safety Recommendations: Should not be left alone, will need frequent physical assist  
OT Discharge Comment: unsafe to d/c home at this time

#### Impression:

[REDACTED] is a 80 y.o. female who presents to OT with post-op pain in the left hip & knee, generalized weakness, orthostatic hypotension, and fear of falling s/p ORIF of Left Hip (O'Brien). PTA, pt reports being independent with all ADLs/IADLs besides driving. Earlier this date, pt had a vasovagal episode on bedside commode with nursing. Pt is now anxious about syncope episode reoccurring and fear of falling. Pt was seen with PT co-treat to maximize safety. This date, pt required min-mod A x 2 for all bed mobility, sit > stands, and functionals transfers with the RW. Pt unable to complete LB dressing tasks while seated in bedside chair due to pain and fatigue - would benefit from LMAE. Pt initially slightly orthostatic with positional change with BP recovering in sitting for ~5 min with ankle pumps/arm exercises. Once BP stabilized, attempted to trial short distance mobility with pt. Pt orthostatic with s/s (see below). Pt then transferred (Mod A x2 squat pivot) back to bed with BP recovering in supine for ~3 min. Pt limited by orthostatic BP, pain, and weakness. Pt functioning below baseline and would benefit from inpt rehab stay to maximize safety and progress pt back to PLOF.

#### Vital Signs:

Patient Position supine sitting in bedside chair Post seated marching/ankle pumps Post standing with s/s Supine ~3 min  
BP 115/53 97/51 107/70 87/68 109/56  
Vital Signs Sx Comments: pt noted to have s/s of orthostatic hypotension with positional changes. Worse with sit > stand vs supine > sit.

OT History of Present Illness/Hospital Course: 80 y.o. female patient presents 3/31/2024 with a history of hypertension, hyperlipidemia, tobacco dependence, COPD, history of DVT/PE, protein calorie malnutrition, CKD, osteoarthritis, glaucoma, Raynaud's disease, CAD, anxiety, depression, pulmonary nodules, history of small bowel obstruction; presented to the hospital today with a chief complaint of fall. Sustained left hip fracture. Admitted to the hospital for further management. Pt is s/p L hip ORIF 4/01/24. OT eval completed on 04/02/24.

#### Precautions/Safety:

Weight Bearing: WBAT on L LE  
Activity and Positioning: Ax 2 to squat pivot or stand pivot <> commode  
Safety: Monitor BP

#### Occupational Profile:

Social Context:  
Lives With: Self/alone  
Receives Help From: No one  
Who will be available at discharge to receive the patient?: Extended Family (Niece)  
Home Caregiver: Self

Social Context Comment : pt lives alone and receives assist from son and niece for IADLs who are local

Environment Context:

Type of Home: Condo

Home Layout: One level

Stairs to Enter Home: 6

Railing to Enter Home: On both sides

Stairs Inside Home: 0

Bathroom Shower/Tub: Walk-in shower

Prior Level of Function:

Hearing: Within functional limits

Level of Independence: Independent with ADL, Independent with Mobility,

Needs Assistance with IADL

IADL Assistance: Driving, Shopping (Family takes her grocery shopping)

Activity Level: Independent with no AD

Equipment:

Home Equipment: Bathroom equipment

Bathroom Equipment: Shower chair with back

Pain:

Pain Assessment: Simple Descriptive

Simple Descriptive Pain Score: Moderate pain

Pain Orientation: Left

Pain Location: Hip, Knee

Pain Descriptors: Aching, Sore

Exacerbating Factors: Activity, Positional

Pain Intervention(s): Cold applied, Reposition

Response to Interventions: +effect

Cognitive Function:

Cognitive Function: Intact

Arousal: Intact

Ability to Follow Commands: Structured/familiar tasks

Follow Commands With: Tactile cues, Verbal cues

Range of Motion and Muscle Performance:

Strength/PROM/AROM

Overall Strength RUE : Able to perform ADL tasks

Overall Strength LUE: Able to perform ADL tasks

Overall Strength RLE: Able to perform ADL tasks

Overall Strength LLE: Deficits due to pain, Partial active/spontaneous movements against gravity, Partial active/spontaneous movements in gravity minimized

Current Occupational Performance Status:

Activity Assistance Cues Context

Functional Bed Mobility Moderate assistance X 2 Minimum, Tactile, Verbal sup < sit EOB with use of bed rails and HOB raised, assist at trunk and LLE, min cues for safe hand placement

Functional Transfers Moderate assistance X 2 Moderate, Tactile, Verbal min-mod A x 2 stand step transfer with mod cues for safe hand placement and walker management; pt orthostatic during session requiring mod A x2 squat pivot transfer chair > bed

Functional Ambulation Unable to assess Limited 2/2 orthostatic hypotension

Toileting Unable to assess anticipate mod A for posterior hygiene

Toilet Transfer Moderate assistance anticipate min- mod A x 2 stand step transfer bed < commode

Dressing: LB Maximum assistance assist to donn/doff B socks

\*This note may not reflect all data entered in the flow sheets. Please refer to the column associated with the time of this note for any additional information.

Occupational Therapy Plan of Care:

Patient Goals: "To get back to how I was"

Frequency: 3-5x/wk

Duration: pending medical

Interventions:

Therapeutic exercise, Therapeutic activities, Activities of daily living,

Activity tolerance, Discharge planning, Home management, Positioning

Goals:

Within 14-17 days patient will achieve the following goals:

Toileting Independent

Lower body dressing Modified independent with LHAE as appropriate.

Transfer to/from toilet Modified independent with LRAD.

Signature:  
Mia-Danielle Marchena, OT  
License #: 015096

\*The patient's progress will be assessed at each session. The frequency may be increased or tapered as treatment progresses based on the therapist's judgment of factors including but not limited to; co morbidities, tissue healing, patient/caregiver independent self management, ability to participate in/receive therapy due to medical stability and/or competing care priorities.

Signed by Marchena, Mia-Danielle, OT on 4/2/2024 3:27 PM

**PT/OT/SLP Progress Notes (48 Hours)**

Progress Notes by Ambrose, Taryn Elizabeth, PT at 4/3/2024 9:00 AM  
Author: Ambrose, Taryn Elizabeth, PT Service: Physical Therapy Author  
Type: Physical Therapist  
Filed: 4/3/2024 10:32 AM Date of Service: 4/3/2024 9:00 AM Status:  
Signed  
Editor: Ambrose, Taryn Elizabeth, PT (Physical Therapist)

**Physical Therapy  
Daily Treatment Note**

**Physical Therapy Discharge Recommendations:**  
PT Discharge Recommendation: Inpatient rehab

---

**Impression:**  
Pt progressing with PT today with improvement in activity tolerance, balance and overall strength from yesterday. Pt's BP stable throughout session with position changes. Pt required min A x 1 for supine to sit and tolerated sitting edge of bed at mod I level. Pt performed stand step transfer with min A x 1 and RW to bedside chair. Pt agreeable to staying up in chair at this time. Continue to recommend d/c to STR when medically cleared.

**Pain:**  
Pain Assessment: 0-10  
Pain Score: 8  
Exacerbating Factors: Activity, Positional  
Pain Location: Hip, Knee  
Pain Orientation: Left  
Pain Descriptors: Sore

John's Hopkins Highest Level of Mobility Scale  
Score: Active transfer to chair  
Barriers to Mobilization Goal: Deconditioned/Weakness, Pain  
Target Mobility Level: Walk 25+ feet

**Current Functional Status:**

Activity Assistance Required and Device Used Cues Comments  
Supine to Sit Minimum assist x 1  
Head of bed elevated, Bed rail Verbal, Minimum assist for LLE

Transfer Stand - step Bed to Commode/toilet  
Min assist to left x 1  
Walker - rolling, Chair with arms Verbal, Tactile, Moderate cues for sequencing, initial forward flexed trunk, antalgic

**Plan for Next Treatment:**  
Continue to follow per plan.

\*The patient's progress will be assessed at each session. The frequency may be increased or tapered as treatment progresses based on the therapist's judgment of factors including but not limited to; co

morbidities, tissue healing, patient/caregiver independent self management, ability to participate in/receive therapy due to medical stability and/or competing care priorities.

Signature:  
Taryn Elizabeth Ambrose, PT  
License #: 018373

Signed by Ambrose, Taryn Elizabeth, PT on 4/3/2024 10:32 AM

Wound Consult/Progress Note  
No notes found.

Ostomy Consult/Progress Note  
No notes found.

Nursing Progress Notes  
Plan of Care by Shea, Allyson Mariah Baricuatro, RN at 4/4/2024 12:35 AM  
Author: Shea, Allyson Mariah Baricuatro, RN Author Type: Registered Nurse  
Filed: 4/4/2024 12:36 AM  
Note Status: Signed Cosign: Cosign Not Required Date of Service: 4/4/2024  
12:35 AM  
Editor: Shea, Allyson Mariah Baricuatro, RN (Registered Nurse)

Problem: Pain - Adult/Pediatric  
Goal: Demonstrates or reports acceptable level of pain during hospitalization  
Outcome: Progressing

Problem: Fall Risk - Adult  
Goal: Absence of falls during hospitalization  
Outcome: Progressing  
Goal: Minimize injury from falls during hospitalization  
Outcome: Progressing

Problem: Mobility, Impaired - Adult/Pediatric  
Goal: Demonstrates ability to achieve maximum mobility level by discharge  
Outcome: Progressing

Problem: Venous Thromboembolism (VTE), Risk or Actual - Adult/Pediatric  
Goal: Absence or resolution of venous thromboembolism (VTE) during hospitalization  
Outcome: Progressing

Problem: Discharge Planning / Transitions in Care - Adult/Pediatric  
Goal: Discharge to level of care that meets patient needs.  
Outcome: Progressing

Problem: Pressure Injury, Risk or Actual - Adult/Pediatric  
Goal: Absence of a new pressure injury during hospitalization  
Outcome: Progressing  
Goal: Pressure injury healing during hospitalization for active pressure injuries  
Outcome: Progressing

Progress Notes by Kolodziej, Brian Joseph, RN at 4/2/2024 10:56 AM  
Author: Kolodziej, Brian Joseph, RN Author Type: Registered Nurse Filed:  
4/2/2024 10:58 AM  
Note Status: Signed Cosign: Cosign Not Required Date of Service: 4/2/2024  
10:56 AM  
Editor: Kolodziej, Brian Joseph, RN (Registered Nurse)

Anesthesia Post Operative Note

Anesthesia Type: general

Patient evaluated in: inpatient unit

Consciousness: awake

Nausea/ Vomiting:

nausea and vomiting control satisfactory

Hydration status: adequate

Analgesia/ Pain:

Pain control is: adequate

Functional pain assessment: 2 - Tolerable (interferes with some activities)

Other:

Patient experienced no anesthesia complications.

Patient does not report unexpected awareness during procedure.

Patient's questions answered.

Patient satisfied with anesthesia care.

Entered by: Brian Joseph Kolodziej, RN

No notable events documented.

Vital Signs:

Vitals Value Taken Time

Pulse 84 04/02/24 0721

BP 109/55 04/02/24 0828

Spo2 93 % 04/02/24 0721

Resp 18 04/02/24 0721

Temp 37.3 °C (99.2 °F) 04/02/24 0721

No vitals data found for the desired time range.

Showing 2 notes, more notes may be available.

#### Provider notes

Progress Notes by Sood, Megha, MD at 4/3/2024 6:22 AM

Author: Sood, Megha, MD Service: Medicine Author Type: Physician

Filed: 4/3/2024 2:07 PM Date of Service: 4/3/2024 6:22 AM Status:

Signed

Editor: Sood, Megha, MD (Physician)

?

Salem Hospital Medicine Progress Note

4/3/2024

6:22 AM

Patient: [REDACTED]

PCP: Lee, Rebecca Symmes, MD

Hospital Day: Hospital Day: 4

Language: English

Interpreter used: No - Patient's preferred language is English

#### SUBJECTIVE INTERVAL HISTORY:

S/p Left TFN for IT femur fx with ortho on 4/1. Hb slowly downtrending to 7.1 today. Continues to have mild pain with ROM, but pain relatively well controlled at rest with current regimen. Able to sit up in chair for 1 hour earlier this morning.

Will pre-emptively transfuse with 1U PRBC given low H&H. Consent obtained.

#### CURRENT MEDICATIONS:

Scheduled Medications:

acetaminophen 975 mg Oral Q8H

atorvastatin 80 mg Oral Nightly  
 cyanocobalamin (vitamin B-12) 1,000 mcg Oral Once per day on Mon Tue Wed  
 Thu  
 donepezil 5 mg Oral QAM  
 fluticasone propionate 1 spray Each Nare BID  
 folic acid 1,000 mcg Oral QAM  
 [Held by provider] heparin 5,000 Units Subcutaneous Q8H SCH  
 [START ON 4/6/2024] levothyroxine 37.5 mcg Oral Once per day on Sun Sat  
 levothyroxine 75 mcg Oral Once per day on Mon Tue Wed Thu Fri  
 melatonin 5 mg Oral Nightly  
 mirtazapine 15 mg Oral Daily  
 nicotine 1 patch Transdermal Daily  
 polyethylene glycol 17 g Oral BID  
 senna 2 tablet Oral Nightly  
 Or  
 sennosides 17.6 mg Oral Nightly  
 Infusion Medications and IV Fluids:  
 lactated Ringers 75 mL/hr (04/02/24 2038)

## As Needed Medications:

albuterol, 2 puff, Q6H PRN  
 aluminum-magnesium hydroxide-simethicone, 30 mL, Daily PRN  
 bisacodyl, 10 mg, Daily PRN  
 [Held by provider] HYDROMORPHONE, 0.2-0.4 mg, Q4H PRN  
 ipratropium-albuterol, 3 mL, Q6H PRN  
 oxycodone, 2.5-5 mg, Q4H PRN  
 trazodone, 25 mg, Nightly PRN

## VITAL SIGNS &amp; PHYSICAL EXAMINATION:

Current Vital Signs with 24 Hour Ranges:  
 Temperature: [36.9 °C (98.5 °F)-37.3 °C (99.2 °F)] 37 °C (98.6 °F)  
 Heart Rate: [56-91] 90  
 Respiratory Rate: [18] 18  
 BP: (87-115)/(49-83) 111/55  
 SpO2 SpO2: [92 %-94 %] 93 % | O2 Device: None (Room air) (04/03 0523)

## Physical Exam

General: alert, laying in bed, thin, non-toxic  
 HEENT: NC/AT; EOMI  
 Heart: RRR, +S1, S2  
 Lungs: CTA b/l with no rales/rhonchi/wheezes  
 Abdomen: Soft, NT/ND  
 Extremities: L hip and lateral thigh incision sites appear clean, dry, and intact; 2+ L dp and femoral pulses; NVI distally  
 Neuro: Alert, speech clear and coherent  
 Skin: Warm, dressing c/d/i  
 Psych: cooperative

## DATA REVIEW:

Labs reviewed  
 Recent Labs  
 03/31/24  
 1818 04/01/24  
 0556 04/02/24  
 0533  
 NA 138 137 135\*  
 K 4.4 3.9 3.8  
 CL 102 101 101  
 CO2 28 27 26  
 BUN 9 8 10  
 CRE 0.93 0.74 0.97  
 GLU 102\* 116\* 94  
 CA 8.9 8.9 8.1\*  
 MG -- 1.8 1.8  
 PHOS -- 3.4 3.1

Recent Labs  
 04/01/24  
 0556  
 TP 6.2  
 ALB 3.7  
 GLOB 2.5  
 SGOT 28  
 SGPT 19  
 ALKP 73  
 TBIL 0.6

Recent Labs  
03/31/24  
1818 04/01/24  
0556 04/02/24  
0533 04/02/24  
1241  
WBC 5.24 5.67 5.38 --  
HGB 12.0 10.4\* 7.6\* 7.7\*  
HCT 33.3\* 29.5\* 21.9\* 21.7\*  
PLT 187 158 106\* --  
MCV 93.3 94.6 97.8 --  
RDW 13.2 13.4 13.3 --

No results for input(s): "PTT", "PT", "INR" in the last 72 hours.  
No results for input(s): "TROPT", "LACT" in the last 72 hours.

#### Imaging:

##### XR Pelvis

Result Date: 4/1/2024

FINDINGS/IMPRESSION: There are interval sequela of intramedullary nail fixation of a left proximal femur intertrochanteric fracture, partially visualized, extending beyond the field of view inferiorly. There is expected overlying postoperative soft tissue air. The hip joint space is grossly preserved. Evaluation of the sacrum is limited by overlying bowel gas.

##### XR Hip (Left)

Result Date: 3/31/2024

Mildly displaced intertrochanteric fracture with greatest displacement at the lesser trochanter.

##### XR Chest

Result Date: 3/31/2024

No acute abnormality.

##### CT Cervical Spine

Result Date: 3/31/2024

1. No acute intracranial findings. 2. No acute fracture or traumatic malalignment of the cervical spine.

##### CT Head

Result Date: 3/31/2024

1. No acute intracranial findings. 2. No acute fracture or traumatic malalignment of the cervical spine.

#### ASSESSMENT & PLAN:

80 y.o. female with a history of hypertension, hyperlipidemia, tobacco dependence, COPD, history of DVT/PE, protein calorie malnutrition, CKD, osteoarthritis, glaucoma, Raynaud's disease, CAD, anxiety, depression, pulmonary nodules, history of small bowel obstruction; presented to the hospital today with a chief complaint of fall. Sustained left hip fracture. Admitted to the hospital for further management.

#Mechanical fall on stairs  
#Left intertrochanteric hip fractures s/p ORIF 4/1/24  
- s/p OR 4/1  
- multimodal pain control  
- per orthopedics: WBAT, dry dressing change on POD #2, and steri strip removal on POD#14, ancef 2g Q8hours for 2 doses, f/u with Dr. O'Brien in 2 weeks  
- patient with acute blood loss anemia so SQ heparin on hold, will discuss with orthopedics if they want to reinstate SQ heparin once H/H stable or if they want to start ASA twice a day and monitor H/H trend on this given this will be her discharge med.  
- Plan for Aspirin 81mg BID x 6 weeks beginning at discharge once Hb stable  
- PT eval completed, recommending STR

- early mobilization as possible
- not a true fragility fracture, but could benefit from outpatient DEXA
- Incentive spirometer use
- aggressive bowel regimen
- anti-delirium measures as well melatonin nightly

#Syncope

#Orthostasis

#Volume depletion

#Acute blood loss anemia

- Slow Hgb down trend post-operatively from 10.4-->7.1 this morning. Likely from intraoperative blood losses. No active signs of bleeding at this time. No melena, hematochezia noted.
- Also developed brief 30 sec LOC noted on 4/2 with resolution once in reverse trendelenburg on bed and following LR bolus and mIVF
- Hb 7.1 this morning; plan to transfuse 1U PRBC and f/u post-transfusion CBC this afternoon
- holding DVT Chemoppx for now. Discussed with Ortho who agrees with resuming ASA 81mg BID inpatient once Hb levels stabilize and monitoring
- H&H
- transfusion parameters for Hgb <7

#Chronic conditions:

COPD

tobacco dependence

- nicotine patch

- cessation counselling

- SpO2 goal 88-92%

- incentive spirometer use

- albuterol inhaler and duoneb as needed

HTN/HLD/CAD: Blood pressure stable. Aspirin on hold. Continue statin.

Resume ASA tomorrow if H/H stable following PRBC transfusion

Hypothyroidism: Continue levothyroxine

Alzheimer's/Anxiety/depression: Continue mirtazapine, donepezil, trazodone

PRN

Anticipated date of discharge: 4/4-4/5

I have billed 99232 based on time greater than 35 minutes to complete. I personally spent a total of 38 minutes on the date of the encounter including face to face time and non face to face time. This includes time spent on work such as documentation, chart review, care coordination, and discussion with patient, family, and other members of the care team.

UNIT BUNDLE:

Diet/Nutrition: Advance diet as tolerated

Diet (Non Dysphagia) Mechanically altered; Easy to chew

Adult/Pediatric nutrition supplements Supplement: Gelatin Plus; Number of

servings: One; Frequency: Breakfast

Adult/Pediatric nutrition supplements Supplement: Magic Cup (chocolate);

Number of servings: One; Frequency: Dinner

DVT Prophylaxis: SCDS

Code Status: Full Code

Megha Sood, MD

Pager#71540

Signed by Sood, Megha, MD on 4/3/2024 2:07 PM

# Eligibility & Benefits

Use the Benefits & Eligibility tool to find plan information for your patient such as plan type, effective dates, member-specific benefit coverage information, and copayment and coinsurance amounts.

## Frequently Asked Questions

**How Do I Find If My Patient Has Active Coverage?**

**How can I find patient cost share?**

**How do I find my patient's primary care physician?**

\*Required field \*\*

Provider Name/ID \*

ALLIANCE HEALTHCARE CTR @ BRAI (1700873072)

Member ID\*

[REDACTED]

Suffix

01

Date Of Service

04/04/2024



ADVANCED SEARCH

Viewing:

Benefit Year: ?

ELIGIBILITY

BENEFITS

DEDUCTIBLE

OUT OF POCKET MAXIMUM

Please be advised all coverage is contingent upon eligibility on the date of service and that some changes to eligibility are retroactive. Confirmation of eligibility does not guarantee payment of service.

**Critical Member Alerts**

- Member information displayed on this page is accurate for the current year only.

**Eligibility: Member Information**

Member Name:

Member ID#:

Date of Birth:

Eligibility Status:

Active Coverage for 04/04/2024

Term Date:

Active for 04/04/2024

Date of Service:

04/04/2024

Gender:

Female

Plan Type:

Tufts Health Plan Medicare Preferred - HMO

Enrollment:

Employer Group Plan

**PCP Information**

PCP ID/Name:

1497723415 - REBECCA S. LEE, MD

Provider Unit ID/Name:

011 - HARBOR MEDICAL

## Behavioral Health/Substance Abuse Inpatient Designated Facility Information

### Inpatient Facility

Member is assigned to Partners HealthCare System, phone number 877-445-6607 (North Shore Medical Center), 617-983-7060 (Brigham and Women's Faulkner Hospital), 888-345-4009 (MGH/McLean Hospital), or 617-243-6319 (Newton Wellesley Hospital).

# Eligibility & Benefits

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\*Required field \*\*

**Provider Name/ID \***

ALLIANCE HEALTHCARE CTR @ BRAI (1700873072)

**Member ID\***

**Suffix**

01

**Date Of Service**

04/04/2024



**SEARCH**

**ADVANCED SEARCH**

**Viewing:**

**Benefit Year:** ?

01/01/2024 - 12/31/2024

**ELIGIBILITY**

**BENEFITS**

**DEDUCTIBLE**

**OUT OF POCKET MAXIMUM**

**Benefits Categories**

Acupuncture

Chiropractic Services

Diabetes Services

Durable Medical Equipment

Emergency Services

Hearing

Imaging Services - Outpatient

**Inpatient Hospital Care**

Mental Health and Substance Abuse

Nutritional Counseling

Outpatient Services

PCP Services

Prescription Drugs

Preventative Services

Rehabilitative Services - Outpatient

Routine Medical Services

Specialist Services

Transport Services

Urgent Care Center Services

Vision and Eye Wear

Wellness Allowance

**Inpatient Hospital Care**

Inpatient Hospital Care and Surgery generally includes acute, rehabilitation, and other types of inpatient hospital services like meals, nursing services and room costs.

Please see below for a complete description of your plan's Inpatient Hospital Care and Surgery coverage.

**Attention:** Covered services must be provided or approved by the member's primary care provider (PCP) or approved by Tufts Health Plan Medicare Preferred, if applicable. See the member's benefit document for full details, including when a referral is not required.

[Specific Benefits](#) | [View All](#)

Hospital Services	Rehab Hosp or Long Term Care Facility
-------------------	---------------------------------------

**Skilled Nursing in a Skilled Nursing Facility**

**Skilled Nursing in a Skilled Nursing Facility**

\$0 per day. Days 1-20

\$0 per day. Days 21-44

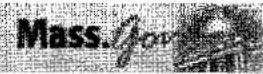
\$0 per day. Days 45-100. Maximum \$0 per benefit period

\*Coverage for up to 100 days per benefit period. The benefit period starts when a member is admitted to the hospital and ends when the member is out of the hospital/SNF for more than 60 days. Then a new benefit period begins.

# Health and Human Services

April 4, 2024

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Mass.Gov Home > State Agencies > State Online Services



Verify Member Eligibility

The following messages are generated:

④ No Records Found

Check Member Eligibility

Please select your Provider

Provider \*

To identify the member, please enter the Member's ID, or Social Security Number, or the Member's name, date of birth and gender

Member ID  found on the Mass Health card

OR

SSN

OR

Other  
Agency ID

OR

Member  
Last Name

Member  
First Name

Date of Birth

Gender

Submit

Please enter "From Date of Service" or date of service range within a 31 calendar day span:

From Date of Service \*

To Date of Service

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Provider: 225769 ALLIANCE OF SE MASS

as of 04/04/2024

Eligibility Period: 04/04/23 - 07/30/24

Patient Name: BF  
Per Medicare: B  
Address: 30-15-2

Beneficiary ID: 3\*

Birth Date: 01/

Gender: F

Previous Inquiry Date: N/A - new inquiry\*

**Benefit Information**

Effective	Terminated	Lifetime Psychiatric Days: 190	ESRD Dialysis Date:
Part A: 01/01/2009 -		Lifetime Reserve Days: 60	ESRD Transplant Eff. Date:
Part B: 01/01/2009 -			ESRD Coverage Period Date:
Date of Death	-	Smoking Cessation Days: 8	Initial Cessation Session Date:
QMB:	-		Beneficiary ID Crosswalk: Data not Available

**Part A/B**

Type	Part A					Part B					Blood Pints Part A/B
	First Bill	Last Bill	Hospital Days	SNF Days	Inpatient	Deductible	Physical	Occupational	Therapy	Therapy	
		Full Coins.	Base	Deductible	Remaining						
BASE	01/01/2024	12/31/2024	60	30	\$ 408.00	20	80	\$ 204.00	\$ 1,632.00	\$ 0.00	\$ 0.00
BASE	01/01/2023	12/31/2023	60	30	\$ 400.00	20	80	\$ 200.00	\$ 1,600.00	\$ 0.00	\$ 0.00

**Medicare Advantage**

Effective	Terminated	Plan Code	Payer Name/Address	Plan Name/Type/Website	Phone
07/01/2019 -		H2256-808	TUFTS ASSOCIATED HEALTH MAINTENANCE ORGANIZATION C 705 Mount Auburn Street Watertown MA 02472	Tufts Medicare Preferred HMO No Rx Health Maintenance Organization (HMO) - Medicare Risk tuftsmedicarepreferred.org	(781) 612-1000

**Part D**

Effective	Terminated	Plan Code	Payer Name/Address	Plan Name/Website	Phone
07/01/2018 -		S5601-805	SILVERSCRIPT INSURANCE COMPANY 445 Great Circle Road Nashville TN 37228	SilverScript Group SF www.aetnamedicare.com	(866) 235-5660

**Rehabilitation Sessions**

Pulmonary Remaining (G0424)	Cardiac Applied (93797, 93798)	Intensive Cardiac Applied (G0422, G0423)
Tech: 72	Prof: 72	Tech: 0 Prof: 0

**Behavioral Services**

HCPCS	Description	Tech Date	Prof Date	Deductible	Deductible	Coinsurance Percent
				Base	Remaining	
G0444	Adult Depression Screening	10/14/2011	10/14/2011	- waived -	- waived -	- waived -
G0442	Alcohol Misuse Screening		10/14/2011	- waived -	- waived -	- waived -
G0446	Cardiovascular Disease Counseling	11/08/2011	11/08/2011	- waived -	- waived -	- waived -
G0447	Obesity Counseling	11/29/2011	11/29/2011	- waived -	- waived -	- waived -
G0473	Obesity Counseling	01/01/2015	01/01/2015	- waived -	- waived -	- waived -
G0445	STIs Screening/Counseling	11/08/2011	11/08/2011	- waived -	- waived -	- waived -

**Preventive Services**

HCPCS	Description	Tech Date	Prof Date	Deductible	Deductible	Coinsurance Percent
				Base	Remaining	
G0472	Adults (HCV) Screening	06/02/2014	06/02/2014	- waived -	- waived -	- waived -
G0438	Annual Wellness Visit		01/01/2011	- waived -	- waived -	- waived -
G0439	Annual Wellness Visit		01/01/2011	- waived -	- waived -	- waived -
80061	Cardiovascular Disease Screening	01/01/2009	01/01/2009	- waived -	- waived -	- waived -
82465	Cardiovascular Disease Screening	01/01/2009	01/01/2009	- waived -	- waived -	- waived -
83718	Cardiovascular Disease Screening	01/01/2009	01/01/2009	- waived -	- waived -	- waived -

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Provider: 225769 ALLIANCE OF SE MASS

as of 04/04/2024

Eligibility Period: 04/04/23 - 07/30/24

Patient Name	Beneficiary ID:3YR1XH8QC13	Gender: F				
<b>Preventive Services</b>						
HCPCS	Description	Tech Date	Prof Date	Deductible Base	Deductible Remaining	Coinsurance Percent
84478	Cardiovascular Disease Screening	01/01/2009	01/01/2009	- waived -	- waived -	- waived -
81528	Colorectal Cancer Screening	10/09/2014		- waived -	- waived -	- waived -
G0104	Colorectal Cancer Screening	01/01/2009	01/01/2009	- waived -	- waived -	- waived -
G0105	Colorectal Cancer Screening	01/01/2009	01/01/2009	- waived -	- waived -	- waived -
G0106	Colorectal Cancer Screening	01/01/2009	01/01/2009	- waived -		20%
G0120	Colorectal Cancer Screening	01/01/2009	01/01/2009	- waived -		20%
G0121	Colorectal Cancer Screening	01/01/2009	01/01/2009	- waived -		- waived -
77078	CT Bone Density, Axial	01/01/2009	01/01/2009	- waived -		- waived -
82947	Diabetes Screening	01/01/2009	01/01/2009	- waived -		- waived -
82950	Diabetes Screening	01/01/2009	01/01/2009	- waived -		- waived -
82951	Diabetes Screening	01/01/2009	01/01/2009	- waived -		- waived -
77080	DXA Bone Density, Axial	01/01/2009	01/01/2009	- waived -		- waived -
77081	DXA Bone Density/Peripheral	01/01/2009	01/01/2009	- waived -		- waived -
82270	Fecal Occult Blood Test	01/01/2009	01/01/2009	- waived -		- waived -
G0328	Fecal Occult Blood Test	01/01/2009	01/01/2009	- waived -		- waived -
G0117	Glaucoma Screening	01/01/2009	01/01/2009	\$ 240.00		20%
G0118	Glaucoma Screening	01/01/2009	01/01/2009	\$ 240.00		20%
G0499	Infection (Hepatitis B) Screening	09/28/2016	09/28/2016	- waived -		- waived -
G0475	Infection (HIV) Screening	04/13/2015		- waived -		- waived -
77067	Mammography Screening	01/01/2009	01/01/2009	- waived -		- waived -
G0123	Pap Screening	01/01/2009	01/01/2009	- waived -		- waived -
G0143	Pap Screening	01/01/2009	01/01/2009	- waived -		- waived -
G0144	Pap Screening	01/01/2009	01/01/2009	- waived -		- waived -
G0145	Pap Screening	01/01/2009	01/01/2009	- waived -		- waived -
G0147	Pap Screening	01/01/2009	01/01/2009	- waived -		- waived -
G0148	Pap Screening	01/01/2009	01/01/2009	- waived -		- waived -
P3000	Pap Screening	01/01/2009	01/01/2009	- waived -		- waived -
Q0091	Pap Screening	01/01/2009	01/01/2009	- waived -		- waived -
G0101	Pelvic Exam Screening	01/01/2009	01/01/2009	- waived -		- waived -
76977	US Bone Density Measure	01/01/2009	01/01/2009	- waived -		- waived -

**Immunizations**

Part B Status:

Part B Date:

Part B Deductible

Part B Coinsurance

HCPCS	Description	Vaccination Date	Rendering NPI	Rendering Name
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The following sections had no data available: Hospice, PPS Episodes, MSP, Home Health Certification

\* Previous requests must be within 90 days to be used for change comparison. Requests after 90 days are considered "new."

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