Encounter Summary (October 29, 2025, 2:33:43PM -0400)

Patient	Legal: Jennifer Jennifer PATEL **Date of Birth:** February 11, 1964 **Gender:** Male **Patient-ID:** SPR8N9D13RMDRC4 (1.2.840.114350.1.13.445.2.7.3.688884.100)
Encounter	**ID:** 100102522631 (1.2.840.114350.1.13.445.2.7.3.698084.8), 150042611714 (1.2.840.114350.1.13.445.2.7.3.698084.2500), **Type:** Inpatient Encounter - Hospital Encounter translation: Hospital Encounter translation: 1 (1.2.840.114350.1.72.1.30.1) , **Date/Time:** from March 16, 2025, 2:07PM -0400 to March 20, 2025, 2:13PM -0400 **Location:** Medical Ward - Vascular Surgery translation: Vascular Surgery
Documentation Of	Care provision, **Date/Time:** from March 16, 2025, 2:07PM -0400 to March 20, 2025, 2:13PM -0400, **Performer:** Legal: Alison RENNER DO
Author	Epic - Version 11.3, **Organization:** Melbourne Regional Healthcare, **Authored On:** October 29, 2025, 2:33:43PM -0400

Reason for Referral

- **Home Health (Routine) - Authorized**

Specialty	Diagnoses / Procedures	Referred By Contact	Referred To Contact
Home Health Services	Diagnoses Dysarthria Intracerebral hemorrhage (HCC)	Botts, James Glenn, MD 101 East Wood Street Spartanburg, SC 29303 Phone: tel:+1-864-560-6654 fax:+1-864-560-7353	HHLTH Regional Home Health 120 Heywood Ave Spartanburg, SC 29302-1210 Phone: tel:+1-864-560-3900 fax:+1-864-560-3910

Referral ID	Status	Reason	Start Date	Expiration Date	Visits Requested	Visits Authorized
5914209	Authorized	Specialty Services Required	3/20/2025	3/20/2026	1	1

Electronically signed by Botts, James Glenn, MD at 03/20/2025 10:07 AM EDT

Reason for Visit

- **Auth/Cert (Routine)**

Specialty	Diagnoses / Procedures	Referred By Contact	Referred To Contact
	Diagnoses ICH (intracerebral hemorrhage) (HCC) code stroke/ HTN Procedures na		

Referral ID	Status	Reason	Start Date	Expiration Date	Visits Requested	Visits Authorized
5901586					1	1

Encounter Details

Date	Type	Department	Care Team (Latest Contact Info)	Description
03/16/2025 2:07 PM EDT - 03/20/2025 2:13 PM EDT	Hospital Encounter	SMC 5 Main 101 E Wood St Spartanburg, SC 29303-3040 864-560-6506	**Lapointe, Ryan, MD** 101 EAST WOOD STREET SPARTANBURG, SC 29303 864-560-6654 (Work) 864-560-7353 (Fax) **Wan, Sau-Yin, MD** 101 E WOOD ST Spartanburg, SC 29303 864-560-6654 (Work) 864-560-7353 (Fax) **Gudger, Jeffrey N, MD** 101 East Wood Street Spartanburg, SC 29303 864-560-6654 (Work) 864-560-7353 (Fax) **Botts, James Glenn, MD** 101 East Wood Street Spartanburg, SC 29303 864-560-6654 (Work) 864-560-7353 (Fax)	Dysarthria (Primary Dx); Cognitive communication deficit; Impaired mobility; Impaired mobility and activities of daily living; Nontraumatic cortical hemorrhage of left cerebral hemisphere (HCC) Discharge Disposition: Home Health Care Svc

Social History

Tobacco Use	Types	Packs/Day	Years Used	Date
Smoking Tobacco: Former	Cigarettes			
Smokeless Tobacco: Never				

Alcohol Use	Standard Drinks/Week	Comments
Not Currently	0 (1 standard drink = 0.6 oz pure alcohol)	occasional

AHC Utilities	Answer	Date Recorded
In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?	No	03/17/2025

Humiliation, Afraid, Rape, and Kick questionnaire	Answer	Date Recorded
Within the last year, have you been afraid of your partner or ex-partner?	No	03/17/2025
Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?	No	03/17/2025
Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner?	No	03/17/2025
Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-	No	03/17/2025

Humiliation, Afraid, Rape, and Kick questionnaire	Answer	Date Recorded
partner?		

Social Connection and Isolation Panel	Answer	Date Recorded
In a typical week, how many times do you talk on the phone with family, friends, or neighbors?	More than three times a week	03/17/2025
How often do you get together with friends or relatives?	Twice a week	03/17/2025
How often do you attend church or religious services?	More than 4 times per year	03/17/2025
Do you belong to any clubs or organizations such as church groups, unions, fraternal or athletic groups, or school groups?	No	03/17/2025
How often do you attend meetings of the clubs or organizations you belong to?	More than 4 times per year	03/17/2025
Are you married, widowed, divorced, separated, never married, or living with a partner?	Divorced	03/17/2025

AUDIT-C	Answer	Date Recorded
Q1: How often do you have a drink containing alcohol?	Monthly or less	03/16/2025
Q2: How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	03/16/2025
Q3: How often do you have six or more drinks on one occasion?	Never	03/16/2025

Overall Financial Resource Strain (CARDIA)	Answer	Date Recorded
How hard is it for you to pay for the very basics like food, housing, medical care, and heating?	Not hard at all	03/17/2025

PHQ-2	Answer	Date Recorded
PHQ-2 Total Score	0	02/17/2025

Finnish Institute of Occupational Health - Occupational Stress Questionnaire	Answer	Date Recorded
Do you feel stress - tense, restless, nervous, or anxious, or unable to sleep at night because your mind is troubled all the time - these days?	Not at all	03/17/2025

Exercise Vital Sign	Answer	Date Recorded
On average, how many days per week do you engage in moderate to strenuous exercise (like a brisk walk)?	0 days	03/17/2025
On average, how many minutes do you engage in exercise at this level?	0 min	03/17/2025

Hunger Vital Sign	Answer	Date Recorded
Within the past 12 months, you worried that your food would run out before you got the money to buy more.	Never true	03/17/2025
Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.	Never true	03/17/2025

PRAPARE - Transportation	Answer	Date Recorded
In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications?	No	03/17/2025
In the past 12 months, has lack of transportation kept you from meetings, work, or from getting things needed for daily living?	No	03/17/2025

Housing Stability Vital Sign	Answer	Date Recorded
In the last 12 months, was there a time when you were not able to pay the mortgage or rent on time?	No	03/08/2024
In the last 12 months, how many places have you lived?	1	03/08/2024
In the last 12 months, was there a time when you did not have a steady place to sleep or slept in a shelter (including now)?	No	03/08/2024

Housing Stability Vital Sign	Answer	Date Recorded
In the last 12 months, was there a time when you were not able to pay the mortgage or rent on time?	No	03/17/2025

Housing Stability Vital Sign	Answer	Date Recorded
In the past 12 months, how many times have you moved where you were living?	0	03/17/2025
At any time in the past 12 months, were you homeless or living in a shelter (including now)?	No	03/17/2025

Sex and Gender Information	Value	Date Recorded
Sex Assigned at Birth	Not on file	
Legal Sex	Male	05/02/2016 5:15 PM EDT
Gender Identity	Not on file	
Sexual Orientation	Not on file	

[1]. documented as of this encounter

Last Filed Vital Signs

Vital Sign	Reading	Time Taken	Comments
Blood Pressure	132/77	03/20/2025 11:09 AM EDT	
Pulse	67	03/20/2025 11:09 AM EDT	
Temperature	36.3 °C (97.3 °F)	03/20/2025 11:09 AM EDT	
Respiratory Rate	17	03/20/2025 11:09 AM EDT	
Oxygen Saturation	100%	03/20/2025 11:09 AM EDT	
Inhaled Oxygen Concentration	-	-	
Weight	69.4 kg (153 lb)	03/20/2025 3:30 AM EDT	
Height	162.6 cm (5' 4")	03/17/2025 4:25 PM EDT	
Body Mass Index	26.26	03/17/2025 4:25 PM EDT	

[2]. documented in this encounter

Functional Status

- **AUDIT-C Score**

Answer	Date of Assessment	Author
1	03/16/2025 2:50 PM EDT	Huey, Enreicika, RN

-

Question	Answer	Date of Assessment	Author
Q1: How often do you have a drink containing alcohol?	Monthly or less	03/16/2025 2:50 PM EDT	Huey, Enreicika, RN
Q2: How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	03/16/2025 2:50 PM EDT	Huey, Enreicika, RN
Q3: How often do you have six or more drinks on one occasion?	Never	03/16/2025 2:50 PM EDT	Huey, Enreicika, RN

- **Are you deaf or do you have serious difficulty hearing?**

Answer	Date of Assessment	Author
No	03/20/2025 10:09 AM EDT	Dill, Katie B, RN

- **Are you blind or do you have serious difficulty seeing, even when wearing glasses?**

Answer	Date of Assessment	Author
No	03/20/2025 10:09 AM EDT	Dill, Katie B, RN

- **Do you have serious difficulty walking or climbing stairs?**

Answer	Date of Assessment	Author
No	03/20/2025 10:09 AM EDT	Dill, Katie B, RN

- **Do you have serious difficulty dressing or bathing?**

Answer	Date of Assessment	Author
No	03/20/2025 10:09 AM EDT	Dill, Katie B, RN

- **Because of a physical, mental, or emotional condition, do you have serious difficulty doing errands alone such as visiting the doctor?**

Answer	Date of Assessment	Author
No	03/20/2025 10:09 AM EDT	Dill, Katie B, RN

[3]. documented as of this encounter

Mental Status

- **Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? (5 years old or older)**

Answer	Entry Date	Author
No	03/20/2025 10:09 AM EDT	Dill, Katie B, RN

[4]. documented in this encounter

Discharge Summaries

- **James Glenn Botts, MD - 03/20/2025 10:07 AM EDT**

Formatting of this note is different from the original.
DISCHARGE SUMMARY

Date of Admission: 3/16/2025
Date of Discharge: 3/20/2025

Primary Care Physician: Alison Renner, DO
Consultants:

Primary Discharge Diagnosis:
Principal Problem:
ICH (intracerebral hemorrhage) (HCC)
Active Problems:
Nontraumatic cortical hemorrhage of left cerebral hemisphere (HCC)
Hypertensive emergency

Secondary/Chronic Diagnoses:
Past Medical History:
Diagnosis Date
Abnormal nuclear stress test 09/22/2021
Added automatically from request for surgery 504201
Acute gastric ulcer without hemorrhage or perforation 03/16/2024
Chronic kidney disease
Coronary artery disease
PT STATES DOES NOT HAVE CARDIO- PCP MANAGES
Diabetes mellitus (HCC)
NIDDM
Hypertension
Mini stroke
Stab wound

Hypokalemia (resolved)
Acute Kidney Injury, KDIGO Stage 1
Chronic Kidney Disease Stage: 3

Discharge Medications:

Discharge Medications

New Medications

Sig Disp Refill Start End
atorvastatin 40 mg tablet

Commonly known as: use for LIPITOR
40 mg, Oral, Nightly
30 tablet
0

hydrALAZINE 100 mg tablet
Commonly known as: use for APRESOLINE
100 mg, Oral, Every 8 hours
90 tablet
2

Medications To Continue

Sig Disp Refill Start End
amLODIPine 10 mg tablet
Commonly known as: use for NORVASC
10 mg, Oral, Daily
30 tablet
2

blood-glucose meter
Use blood glucose meter to test blood sugar 4 times per day
1 each
0

carvediloL 3.125 mg tablet
Commonly known as: use for COREG
3.125 mg, Oral, 2 times daily with meals
60 tablet
1

dapagliflozin propanediol 5 mg tablet tablet
Commonly known as: FARXIGA
5 mg, Oral, Daily
30 tablet
6

FeroSuL 325 mg (65 mg iron) tablet
Generic drug: ferrous sulfate 325 mg tablet (65 mg as elemental)
TAKE 1 TABLET BY MOUTH IN THE MORNING AND 1 AT NOON AND 1 IN THE EVENING WITH MEALS
0

FLUoxetine 10 mg capsule
Commonly known as: use for PROzac
10 mg, Oral, Daily
30 capsule
3

glucose blood test strip
Generic drug: blood glucose test strips
Use test strips to test blood sugar 4 times per day
100 strip
0

indapamide 2.5 mg tablet
Commonly known as: use for LOZOL
2.5 mg, Oral, Every morning
30 tablet
1

lancets
Use lancets to test blood sugar 4 times per day
100 each
0

losartan 50 mg tablet
Commonly known as: use for COZAAR
50 mg, Oral, 2 times daily
60 tablet
3

pantoprazole 40 mg EC tablet
Commonly known as: use for PROTONIX
40 mg, Oral, 2 times daily before meals
60 tablet
3

sucralfate 1 gram tablet
Commonly known as: use for CARAFATE
1 g, Oral, 4 times daily
120 tablet
0

Brief Summary of Hospital Course:
1. ICH: no blood thinners. Doing well with PT no longer candidate for rehab. Will send with home health.

2. Hypertensive emergency: more aggressive BP control. Increased hydralazine. BP better.

3. HTN; increased BP meds. Better control.

4. H/o polysubstance abuse: educated.

5. Debility: due to #1. PT and OT .

Exam on Day of Discharge

Vitals:
03/19/25 1946 03/19/25 2342 03/20/25 0330 03/20/25 0714
BP: (!) 152/82 (!) 140/79 (!) 137/71 (!) 165/93
BP Cuff Site Location: Right arm Right arm Right arm Right arm
Patient Position: Lying Lying Lying Lying
BP Cuff Size : Regular Regular Regular
Pulse: 63 77 69 71
Resp: 18 18 18 17
Temp: 98.3 °F (36.8 °C) 98.6 °F (37 °C) 98.1 °F (36.7 °C) 97.7 °F (36.5 °C)
TempSrc: Temporal Temporal Temporal Temporal
SpO2: 99% 98% 97% 98%
Weight: 69.4 kg (153 lb)
Height:

Constitutional: Oriented to person, place, and time. Appears well-developed and well-nourished.
HENT: Normocephalic and atraumatic. Pupils are equal, round, and reactive to light.
Neck: Normal range of motion. Neck supple. No thyromegaly present.
Cardiovascular: Regular rate and rhythm; no murmurs, rubs, gallops heard.
Pulmonary/Chest: No increased work of breathing. No respiratory distress. No wheezes, rales.
Abdominal: Soft, non distended, non tender. Bowel sounds are normal.
Musculoskeletal: Normal range of motion, no edema.
Neurological: Alert and oriented to person, place, and time.
Skin: Skin is warm, dry, well perfused.
Psychiatric: Appropriate mood and affect. Thought content normal.

Discharge/Follow Up Instructions:
Pcp in 2 weeks

Procedures:
None.

Diet:

Dietary Orders
(From admission, onward)

Start Ordered
03/16/25 1510 Adult Diet: Regular Diet effective now
References: Fluid Restriction

Question: Diet Type Answer: Regular
03/16/25 1510
03/16/25 1410 Activate oral nutrition ordering protocol as indicated in the care of this patient Until discontinued
03/16/25 1410

Activity: As Tolerated
Restrictions:

I spent a total of 38 minutes coordinating patient's discharge.

James Glenn Botts, MD,03/20/25, 10:07 AM

Electronically signed by James Glenn Botts, MD at 03/20/2025 10:11 AM EDT

[5]. documented in this encounter

Discharge Instructions

- **Attachments**

  The following attachments cannot be sent through Care Everywhere.

  - Atorvastatin (English)
  - Hydralazine (English)
  - High Blood Pressure (Hypertension)? Discharge Instructions (English)
  - Stroke? What is Hemorrhagic (English)
  - Stroke (Completed) (English)
  - Stroke? Discharge Instructions for (English)

[6]. documented in this encounter

Medications at Time of Discharge

Medication	Sig	Dispense Quantity	Refills	Last Filled	Start Date	End Date
blood glucose test strips (glucose blood) Indications: DM	Use test strips to test blood sugar 4 times per day	100 strip			03/17/2024	
blood-glucose meter Indications: DM	Use blood glucose meter to test blood sugar 4 times per day	1 each			03/17/2024	
lancets Indications: DM	Use lancets to test blood sugar 4 times per day	100 each			03/17/2024	
sucralfate (use for CARAFATE) 1 gram tablet	Take 1 tablet (1 g total) by mouth in the morning and 1 tablet (1 g total) at noon and 1 tablet (1 g total) in the evening and 1 tablet (1 g total) before bedtime.	120 tablet			11/30/2024	11/30/2025
amLODIPine (use for NORVASC) 10 mg tablet Indications: hypertension	Take 1 tablet (10 mg total) by mouth in the morning.	30 tablet	2		01/13/2025	07/28/2025
atorvastatin (use for LIPITOR) 40 mg tablet Indications: hypercholesterolemia	Take 1 tablet (40 mg total) by mouth nightly	30 tablet			03/20/2025	07/28/2025

Medication	Sig	Dispense Quantity	Refills	Last Filled	Start Date	End Date
carvediloL (use for COREG) 3.125 mg tablet Indications: hypertension	Take 1 tablet (3.125 mg total) by mouth in the morning and 1 tablet (3.125 mg total) in the evening. Take with meals.	60 tablet	1		02/17/2025	07/28/2025
dapagliflozin propanediol (FARXIGA) 5 mg tablet tablet Indications: type 2 diabetes mellitus	Take 1 tablet (5 mg total) by mouth in the morning.	30 tablet	6		08/16/2023	09/16/2025
FeroSuL 325 mg (65 mg iron) tablet Indications: iron deficiency anemia	TAKE 1 TABLET BY MOUTH IN THE MORNING AND 1 AT NOON AND 1 IN THE EVENING WITH MEALS					09/16/2025
FLUoxetine (use for PROzac) 10 mg capsule Indications: major depressive disorder	Take 1 capsule (10 mg total) by mouth in the morning.	30 capsule	3		01/30/2025	09/16/2025
hydrALAZINE (use for APRESOLINE) 100 mg tablet Indications: hypertension	Take 1 tablet (100 mg total) by mouth every 8 (eight) hours	90 tablet	2		03/20/2025	07/28/2025
indapamide (use for LOZOL) 2.5 mg tablet Indications: Primary hypertension	Take 1 tablet (2.5 mg total) by mouth every morning	30 tablet	1		02/17/2025	07/28/2025
losartan (use for COZAAR) 50 mg tablet Indications: hypertension	Take 1 tablet (50 mg total) by mouth in the morning and 1 tablet (50 mg total) in the evening.	60 tablet	3		01/30/2025	07/28/2025
pantoprazole (use for PROTONIX) 40 mg EC tablet Indications: PUD (peptic ulcer disease)	Take 1 tablet (40 mg total) by mouth in the morning and 1 tablet (40 mg total) in the evening. Take before meals.	60 tablet	3		01/30/2025	07/28/2025

[7]. documented as of this encounter

Progress Notes

- **Patricia A Freeman, RN - 03/20/2025 10:35 AM EDT**
  Formatting of this note is different from the original.

  03/20/25 1035
  Case Management Discharge Plan
  Discharge Plan Comments RW delivered bedside.
  Discharge Needs Noted Yes

  Electronically signed by Patricia A Freeman, RN at 03/20/2025 10:35 AM EDT
- **Patricia A Freeman, RN - 03/20/2025 9:47 AM EDT**
  Formatting of this note is different from the original.

  03/20/25 0945
  Case Management Discharge Plan
  DC Plan discussed with Patient;Physician;Facility;Care Rounds
  Discharge Plan Comments CM spoke with pt bedside, he no longer wishes to go to rehab. He would like to go home with SRHH. CM sent email to SRHH.
  Discharge Needs Noted Yes
  Patient/Representative participated in the development of the discharge planning Yes

Patient/Representative gave CM their choice of DME provider, agency or facility? Yes
Expected Discharge Disposition HH Services
Patient/representative agrees with DC plan? Yes

Electronically signed by Patricia A Freeman, RN at 03/20/2025 9:47 AM EDT

- **James Glenn Botts, MD - 03/19/2025 3:50 PM EDT**

Formatting of this note is different from the original.
Hospital Day: 3 days

ASSESSMENT AND PLAN:

Principal Problem:
ICH (intracerebral hemorrhage) (HCC)
Active Problems:
Nontraumatic cortical hemorrhage of left cerebral hemisphere (HCC)
Hypertensive emergency

SUBJECTIVE:
Patient feels well no complaints.

Review of Systems:
Constitutional: Negative for fevers, negative for chills
Respiratory: Negative for cough, Negative for shortness of breath, Negative for wheezing
Cardiovascular- Negative for chest pain, Negative for palpitations
Gastrointestinal- Negative for abdominal pain, Negative for constipation, Negative for diarrhea, Negative for vomiting
Psychiatric/Behavioral- Negative for hallucinations, Negative for anxiety

OBJECTIVE:

Vitals:
03/19/25 0336 03/19/25 0732 03/19/25 1114 03/19/25 1527
BP: (!) 146/85 (!) 159/96 (!) 140/84 (!) 135/81
BP Cuff Site Location: Right arm Right arm Right arm Right arm
Patient Position: Lying Lying Lying
Pulse: 72 60 68 70
Resp: 18 19 18 17
Temp: 97.6 °F (36.4 °C) 97.9 °F (36.6 °C) 97.8 °F (36.6 °C) 97.7 °F (36.5 °C)
TempSrc: Temporal Temporal Temporal Temporal
SpO2: 98% 98% 98% 98%
Weight: 70.5 kg (155 lb 8 oz)
Height:

Constitutional: Oriented to person, place, and time. Appears well-developed and well-nourished.
HENT: Normocephalic and atraumatic. Pupils are equal, round, and reactive to light.
Neck: Normal range of motion. Neck supple. No thyromegaly present.
Cardiovascular: Regular rate and rhythm; no murmurs, rubs, gallops heard.
Pulmonary/Chest: No increased work of breathing. No respiratory distress. No wheezes, rales.
Abdominal: Soft, non distended, non tender. Bowel sounds are normal.
Musculoskeletal: Normal range of motion, no edema.
Neurological: Alert and oriented to person, place, and time.
Skin: Skin is warm, dry, well perfused. .
Psychiatric: Appropriate mood and affect. Thought content normal.

DATA:

Labs: No results found for this or any previous visit (from the past 24 hours).

Chest X-ray:
MRI BRAIN WITH AND WITHOUT CONTRAST
Final Result by Stephan O Haas, MD (03/17 0924)
Impression:

1. Stable left thalamic intraparenchymal hematoma with otherwise age-related senescent changes and chronic microangiopathy.
2. Bilateral mastoiditis and mild sphenoid sinusitis.

CPT Code: 70551

Note to Patient: If you have questions regarding this report, please contact your primary heath care provider.

CT HEAD WITHOUT CONTRAST
Final Result by Luther Person, MD (03/16 1711)
IMPRESSION:
1. Stable known left thalamic parenchymal hemorrhage..
2. Atherosclerosis

EKG/Telemetry: regular on exam.

Inpatient Medicines:
amLODIPine, 10 mg, Daily
atorvastatin, 40 mg, Nightly
carvediloL, 25 mg, BID with meals
hydrALAZINE, 100 mg, Q8H
losartan, 50 mg, Q12H
pantoprazole, 40 mg, Daily

1. ICH: no blood thinners.

2. Hypertensive emergency: more aggressive BP control. Increased hydralazine. BP better.

3. HTN; increased BP meds.

4. H/o polysubstance abuse: educated.

5. Debility: due to #1. PT and OT and rehab.

James Glenn Botts, MD,03/19/25, 3:51 PM

Electronically signed by James Glenn Botts, MD at 03/19/2025 3:54 PM EDT

- **Patricia A Freeman, RN - 03/19/2025 10:16 AM EDT**

Formatting of this note is different from the original.

03/19/25 1014
Case Management Discharge Plan
DC Plan discussed with Patient;Facility;Care Rounds
Discharge Plan Comments CM notified by SRI, they are unable to offer a bed. CM spoke with pt regarding Encompass IRF bed offer. He is in agreement for STR with Encompass..
Discharge Needs Noted Yes
Patient/Representative participated in the development of the discharge planning Yes
Expected Discharge Disposition IRF
Disposition Status Not clinically stable;Pre-cert pending
Patient/representative agrees with DC plan? Yes
Post acute provider list with quality measures provided to patient/representative? Yes

Electronically signed by Patricia A Freeman, RN at 03/19/2025 10:16 AM EDT

- **James Glenn Botts, MD - 03/18/2025 3:05 PM EDT**

Formatting of this note is different from the original.
Hospital Day: 2 days

ASSESSMENT AND PLAN:

Principal Problem:
ICH (intracerebral hemorrhage) (HCC)
Active Problems:
Nontraumatic cortical hemorrhage of left cerebral hemisphere (HCC)
Hypertensive emergency

SUBJECTIVE:
Patient feels well. Says he will do rehab now. Says he took his BP meds day before he woke up with CVA from ICH.

Review of Systems:

Constitutional: Negative for fevers, negative for chills
Respiratory: Negative for cough, Negative for shortness of breath, Negative for wheezing
Cardiovascular- Negative for chest pain, Negative for palpitations
Gastrointestinal- Negative for abdominal pain, Negative for constipation, Negative for diarrhea, Negative for vomiting
Psychiatric/Behavioral- Negative for hallucinations, Negative for anxiety

OBJECTIVE:

Vitals:
03/18/25 0000 03/18/25 0359 03/18/25 0746 03/18/25 1137
BP: (!) 150/84 (!) 158/86 (!) 160/89 (!) 164/80
BP Cuff Site Location: Right arm Right arm Right arm Right arm
Patient Position: Lying Lying Lying Lying
BP Cuff Size : Regular Regular Regular
Pulse: 67 68 62 55
Resp: 18 16 16
Temp: 98.3 °F (36.8 °C) 98 °F (36.7 °C) 98 °F (36.7 °C)
TempSrc: Temporal Temporal Temporal
SpO2: 99% 99% 98% 100%
Weight: 68.4 kg (150 lb 14.4 oz)
Height:

Constitutional: Oriented to person, place, and time. Appears well-developed and well-nourished.
HENT: Normocephalic and atraumatic. Pupils are equal, round, and reactive to light.
Neck: Normal range of motion. Neck supple. No thyromegaly present.
Cardiovascular: Regular rate and rhythm; no murmurs, rubs, gallops heard.
Pulmonary/Chest: No increased work of breathing. No respiratory distress. No wheezes, rales.
Abdominal: Soft, non distended, non tender. Bowel sounds are normal.
Musculoskeletal: Normal range of motion, no edema.
Neurological: Alert and oriented to person, place, and time.
Skin: Skin is warm, dry, well perfused. .
Psychiatric: Appropriate mood and affect. Thought content normal.

DATA:

Labs:
Recent Results (from the past 24 hours)
Basic metabolic panel
Result Value Ref Range
Sodium 142 135 - 145 mmol/L
Potassium 3.7 3.5 - 5.2 mmol/L
Chloride 110 (H) 96 - 106 mmol/L
Carbon Dioxide 25.0 22.0 - 29.0 mmol/L
Anion Gap 7 6 - 13 mmol/L
Urea Nitrogen 20 7 - 23 mg/dL
Creatinine 1.91 (H) 0.70 - 1.30 mg/dL
BUN/Creat Ratio 10.47 8.00 - 20.00 NULL
eGFR 39.4 (L) >60.0 mL/min/1.73m*2
Glucose 185 (H) 70 - 99 mg/dL
Calcium 8.7 8.5 - 10.2 mg/dL
Modified Cockcroft-Gault CrCl
Osmolality Calculation 301.42 271.00 - 318.00 mOsm/kg
Magnesium
Result Value Ref Range
MAGNESIUM 1.9 1.6 - 2.3 mg/dL
Phosphorus
Result Value Ref Range
PHOSPHOROUS 2.9 2.8 - 4.5 mg/dL
CBC
Result Value Ref Range
WBC 7.9 4.0 - 11.0 10*3/uL
RBC 3.91 (L) 4.50 - 5.90 10*6/uL
HGB 10.5 (L) 13.0 - 16.5 g/dL
HCT 31.6 (L) 39.0 - 50.0 %
MCV 80.8 80.0 - 100.0 fL
MCH 26.8 25.0 - 35.0 pg
MCHC 33.1 32.0 - 36.0 g/dL
RDW 17.7 (H) 0.0 - 15.0 %
Platelets 277 135 - 400 10*3/uL

Chest X-ray:
MRI BRAIN WITH AND WITHOUT CONTRAST

Final Result by Stephan O Haas, MD (03/17 0924)
Impression:

1. Stable left thalamic intraparenchymal hematoma with otherwise age-related senescent changes and chronic microangiopathy.
2. Bilateral mastoiditis and mild sphenoid sinusitis.

CPT Code: 70551

Note to Patient: If you have questions regarding this report, please contact your primary heath care provider.

CT HEAD WITHOUT CONTRAST
Final Result by Luther Person, MD (03/16 1711)
IMPRESSION:
1. Stable known left thalamic parenchymal hemorrhage..
2. Atherosclerosis

EKG/Telemetry: regular on exam.

Inpatient Medicines:
amLODIPine, 10 mg, Daily
atorvastatin, 40 mg, Nightly
carvediloL, 25 mg, BID with meals
hydrALAZINE, 25 mg, Q8H
losartan, 50 mg, Q12H
pantoprazole, 40 mg, Daily

1. ICH: no blood thinners.

2. Hypertensive emergency: more aggressive BP control. Increase hydralazine.

3. HTN; increase BP meds.

4. H/o polysubstance abuse: educated.

5. Debility: due to #1. PT and OT and rehab.

James Glenn Botts, MD,03/18/25, 3:06 PM

Electronically signed by James Glenn Botts, MD at 03/18/2025 3:11 PM EDT

- **Patricia A Freeman, RN - 03/18/2025 12:44 PM EDT**

Formatting of this note is different from the original.

03/18/25 1243
Case Management Discharge Plan
DC Plan discussed with Patient;Facility;Physician
Discharge Plan Comments SRI offerd a bed. The pt accepted. They will start authorization with Absolute Total Care.
Discharge Needs Noted Yes
Patient/Representative participated in the development of the discharge planning Yes
Expected Discharge Disposition IRF
Disposition Status Not clinically stable;Bed offers to patient/family;Pre-cert pending
Patient/representative agrees with DC plan? Yes
Post acute provider list with quality measures provided to patient/representative? Yes

Electronically signed by Patricia A Freeman, RN at 03/18/2025 12:44 PM EDT

- **Patricia A Freeman, RN - 03/18/2025 11:22 AM EDT**

Formatting of this note is different from the original.

03/18/25 1118
Case Management Discharge Plan
DC Plan discussed with Patient

Discharge Plan Comments The pt is open to STR if one can be obtained with his Absolute total care. CM sent out for bed offers.
Discharge Needs Noted Yes
Patient/Representative participated in the development of the discharge planning Yes
Patient/Representative gave CM their choice of DME provider, agency or facility? Yes
Expected Discharge Disposition HH Services
(VS STR)
Disposition Status Not clinically stable
Patient/representative agrees with DC plan? Yes
Post acute provider list with quality measures provided to patient/representative? Yes

Electronically signed by Patricia A Freeman, RN at 03/18/2025 11:22 AM EDT

- **Patricia A Freeman, RN - 03/18/2025 11:07 AM EDT**

Formatting of this note is different from the original.

03/18/25 1103
Referral Data
ASSESSMENT TYPE Reassessment
Referral Comments CM agrees with previous assessment. The pt transferred from Pavilion 4. The pt has no DME at home. He lives at home with his brother, he admitted with ICH. The pt declines STR. He would like to return to home brother and SRHH, order pended.
County Information
County patient resides Union
Patient Information
Patient-stated Goal Go to Home with Home Health
Admitted From Home
Home Address Verified Yes

Electronically signed by Patricia A Freeman, RN at 03/18/2025 11:07 AM EDT

- **Jeffrey N Gudger, MD - 03/17/2025 3:03 PM EDT**

Formatting of this note might be different from the original.
Courtesy note-patient seen by MD already today-hemodynamically stable-no new neurological events
Electronically signed by Jeffrey N Gudger, MD at 03/17/2025 3:04 PM EDT

- **Gina N Powell, RN - 03/17/2025 11:24 AM EDT**

Formatting of this note is different from the original.

03/17/25 1123
Case Management Discharge Plan
DC Plan discussed with Patient
Return to previous provider? Yes
Discharge Plan Comments CM spoke with pt and he is from home with brother. Pt was independent of adl's prior to admission. CM to await therapy rec for pt needs.
Discharge Needs Noted No
Patient/Representative participated in the development of the discharge planning Yes
Expected Discharge Disposition Home
Disposition Status Not clinically stable
Patient/representative agrees with DC plan? Yes
Does the patient need discharge transport arranged? No
Case Management Discharge Referrals
DME required at discharge? No

Electronically signed by Gina N Powell, RN at 03/17/2025 11:24 AM EDT

- **Gina N Powell, RN - 03/17/2025 11:23 AM EDT**

Formatting of this note is different from the original.

03/17/25 1121
Referral Data
ASSESSMENT TYPE Initial
Referral Source CM assessed needs
Case Management Referral Reason Discharge Planning
County Information
County patient resides Union
Patient Information
Patient-stated Goal Go to home
Admitted From Home
Home Address Verified Yes
Name of PCP, OB/GYN or Prenatal Care Provider Alison Renner
How recent was your last visit with this provider? 02/17/25
Outpatient Medical Services Emergency Department
Activities of Daily Living

Pre Hospital Level of Function Independent
Independent All ADL's
Living Arrangement Home
Home Sibling
Financial
Income Source Social Security
Financial Resources - Preadmission Medicare;Social Security/Disability
How hard is it for you to pay for the very basics like food, housing, medical care, and heating? Not hard
Utilities
In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home? No
Food Insecurity
Within the past 12 months, you worried that your food would run out before you got the money to buy more. Never true
Within the past 12 months, the food you bought just didn't last and you didn't have money to get more. Never true
Housing Stability
In the last 12 months, was there a time when you were not able to pay the mortgage or rent on time? N
In the past 12 months, how many times have you moved where you were living? 0
At any time in the past 12 months, were you homeless or living in a shelter (including now)? N
Intimate Partner Violence
Within the last year, have you been afraid of your partner or ex-partner? No
Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner? No
Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner? No
Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner? No
Transportation Needs
In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications? no
In the past 12 months, has lack of transportation kept you from meetings, work, or from getting things needed for daily living? No
Social Connections
In a typical week, how many times do you talk on the phone with family, friends, or neighbors? More than 3
How often do you get together with friends or relatives? Twice
How often do you attend church or religious services? More than 4
Do you belong to any clubs or organizations such as church groups, unions, fraternal or athletic groups, or school groups? No
How often do you attend meetings of the clubs or organizations you belong to? More than 4
Are you married, widowed, divorced, separated, never married, or living with a partner? Divorced
Stress
Do you feel stress - tense, restless, nervous, or anxious, or unable to sleep at night because your mind is troubled all the time - these days? Not at all
Physical Activity
On average, how many days per week do you engage in moderate to strenuous exercise (like a brisk walk)? 0 days
On average, how many minutes do you engage in exercise at this level? 0 min

Electronically signed by Gina N Powell, RN at 03/17/2025 11:23 AM EDT

- **Stacy L Mahaffey, OT - 03/17/2025 9:00 AM EDT**

Formatting of this note might be different from the original.
Treatment Type: Attempted visit
Reason for attempted visit: Other
Will defer OT eval 24 hours post admission per order.

STACY L MAHAFFEY, OT

Electronically signed by Stacy L Mahaffey, OT at 03/17/2025 1:12 PM EDT

- **Hannah Nussman Shue, NP - 03/17/2025 8:29 AM EDT**

Formatting of this note is different from the original.
Images from the original note were not included.

Spartanburg Medical Center
Critical Care Medicine
Progress Note

Hospital Admission Date: 3/16/2025 Code Status: Full Code
Hospital LOS: LOS: 1 day Allergies: Lisinopril and Tramadol

ICU LOS: 0
Room: P411/P411-A

Primary Emergency Contact: Green,Trina

Hospital Course / Summary:
61 yo M w/ PMH of HTN, HLD, CAD, CKD 3a, DMII admitted on 3/16 for Left Thalamic ICH, presenting with Rt arm and leg heaviness.numbness that started upon awakening this AM. He was found to be hypertensive w/ systolic BP of 240mmHg. He was given nitroglycerin. In the ED CT head confirmed Left Thalamic ICH. He was started on a cardene gtt to get his BP down and admitted to P4 ICU at SMC Church Street.

ICH Score: 0

Images of ICH below:

Subjective / 24 Hour Events:
Awake, alert, moving all extremities, eating breakfast, off cardene at the time of MDR

Assessment & Plan:
Neuro: Left Thalamic ICH, hx polysubstance abuse
ICH Score 0 on admission
Neurochecks per protocol
UDS positive for cocaine, cannabis
Systolic BP goal less than 160mmHg
Repeat CT head stable
MRI showing stable thalamic hematoma
No keppra at this time as no witnessed seizures
No role for neurosurgery at this time given no surgical intervention needed
If CT head stable, OK to resume DVT ppx 72 hrs stability scan

Pulm: No active issues
On Room Air

CVS: Hypertensive Emergency, likely etiology of ICH
SBP goal <160
Amlodipine 10 mg daily
Carvedilol 25 mg BID
Losartan 50 mg q12h
Add hydralazine 25 mg q8h
Off cardene gtt
Troponin transiently elevated, now down-trending

GI/GU: No active issues // Nutrition // GERD
Diet as tolerated
Cont home PPI

Renal: hypokalemia
Monitor Cr and Lytes with AM labs
Replace potassium via PO route

Endo: Diabetes Mellitus Type II
Insulin Lispro SS AC&HS

Heme/Onc: Normocytic Anemia
Monitor Hgb/Plts with AM labs

MSK/Skin: No Active Issues
Monitor Skin for breakdown

ID: No active issues
Afebrile
Monitor off Abx

SOCIAL/GOC: Full Code

DISPO: transfer out of ICU

Objective
ICU Prophylaxis:
GI: Indicated as the pt has either a coagulopathy, shock, or chronic liver disease:
Hospital Medications as of 3/17/2025

Dose Frequency Start End
pantoprazole (use for PROTONIX) EC tablet 40 mg 40 mg Daily 3/17/2025 --
Admin Instructions: Do not crush.
Route: Oral

DVT: Holding given active bleed/bleeding

VAP: Per Unit Protocol for mouth care

Objective:
Vitals:
Temp: [97.8 °F (36.6 °C)-98.5 °F (36.9 °C)] 98.5 °F (36.9 °C)
Pulse: [58-90] 68
Resp: [0-65] 29
BP: (115-205)/(60-124) 137/81
BMI: Body mass index is 26.09 kg/m².

Physical Exam:
GEN: Awake, Alert, NAD, comfortable lying in bed
HEENT: Neck supple, PEARL, EOMI, moist oral mucosa
PULM: Clear to auscultation bilaterally
CVS: RRR, no appreciable murmurs
GI: Soft, non-tender, non-distended, active bowel sounds
SKIN/MSK/EXT: No LE pitting edema noted
Neuro: Alert, oriented x3/3, no focal motor deficits, moves all extremities equally on command, R sided numbness resolving

Billing Statements:
Patient able to speak and/or participate in assessment: Yes

Care Level: Telemetry Level 1

The patient was seen independently by myself. Dr. Sau-Yin Wan was immediately available for consultation as needed.

HANNAH N SHUE, NP

Cosigned by Sau-Yin Wan, MD at 03/17/2025 3:21 PM EDT
Electronically signed by Hannah Nussman Shue, NP at 03/17/2025 1:06 PM EDT
Electronically signed by Hannah Nussman Shue, NP at 03/17/2025 1:06 PM EDT
Electronically signed by Hannah Nussman Shue, NP at 03/17/2025 1:07 PM EDT
Electronically signed by Hannah Nussman Shue, NP at 03/17/2025 1:07 PM EDT
Electronically signed by Sau-Yin Wan, MD at 03/17/2025 3:21 PM EDT

Associated attestation - Wan, Sau-Yin, MD - 03/17/2025 3:21 PM EDT
Formatting of this note might be different from the original.
Images from the original note were not included.
I was the supervising physician in the delivery of the service. I have seen and examined the patient. I participated on MDR with CCNP, RRT and RN. I have reviewed the chart, CCNP's note, labs and imaging studies. I agree with plan as outlined in the note.

61 y.o male admitted to ICU for

Left thalamic ICH d/t HTN emergency
H/o polysubstance abuse
Type 2 DM

Plan:
- carvedilol increased this morning and cardene drip weaned off
- add hydralazine 25mg q8h
- dc PRN labetalol d/t bradycardia
- continue amlodipine and losartan

Stable for floor transfer

SAU-YIN WAN, MD

- **Ryan Lapointe, MD - 03/16/2025 5:53 PM EDT**

  Formatting of this note might be different from the original.
  Critical Care Medicine Attending Note:

  Repeat CT head with unchanged ICH size. Patient was hypertensive with systolics over 160, and Cardene drip was restarted. MRI pending.

  Critical Care Time: 5 minutes.

  Ryan Lapointe, MD
  Critical Care Medicine Attending
  Electronically signed by Ryan Lapointe, MD at 03/16/2025 5:53 PM EDT

[8]. documented in this encounter

H&P Notes

- **Ryan Lapointe, MD - 03/16/2025 12:28 PM EDT**

  Formatting of this note is different from the original.
  Images from the original note were not included.

  Spartanburg Medical Center
  Critical Care Medicine
  History & Physical Note

  Hospital Admission Date: 3/16/2025 Code Status: Full Code
  Hospital LOS: LOS: 0 days Allergies: Lisinopril and Tramadol
  ICU LOS: 0
  Room: P411/P411-A

  Primary Emergency Contact: Green,Trina

  HPI / Admission Summary:
  61 yo M w/ PMH of HTN, HLD, CAD, CKD 3a, DMII admitted on 3/16 for Left Thalamic ICH, presenting with Rt arm and leg heaviness.numbness that started upon awakening this AM. He was found to be hypertensive w/ systolic BP of 240mmHg. He was given nitroglycerin. In the ED CT head confirmed Left Thalamic ICH. He was started on a cardene gtt to get his BP down and admitted to P4 ICU at SMC Church Street.

  ICH Score: 0

  Images of ICH below:

  Assessment & Plan:

  Neuro: Left Thalamic ICH
  ICH Score 0 on admission
  Neurochecks Q2hrs
  Systolic BP goal less than 160mmHg
  Cardene gtt titrateable to augment BP target
  Resume home Norvasc 10mg PO Daily
  Resume home Coreg 12.5mg PO Q12hrs
  Resume home Losartan 50mg PO Q12hrs
  Stop home clonidine (pt was suppose to stop taking per his PCP)
  Repeat CT head in 6-12 hours to ensure stability
  MRI to ensure no structural etiologies for bleed
  No keppra at this time as no witnessed seizures
  No role for neurosurgery at this time given no surgical intervention needed
  If CT head stable, OK to resume DVT ppx 72 hrs stability scan

  Pulm: No active issues
  On Room Air

  CVS: Hypertensive Emergency, likely etiology of ICH
  BP management as under Neuro

  GI/GU: No active issues // Nutrition // GERD
  Diet as tolerated after he passes his Dyshagia screen
  Cont home PPI

Renal: No active issues
Monitor Cr and Lytes with AM labs

Endo: Diabetes Mellitus Type II
Insulin Lispro SS AC&HS

Heme/Onc: Normocytic Anemia
Monitor Hgb/Plts with AM labs

MSK/Skin: No Active Issues
Monitor Skin for breakdown

ID: No active issues
Afebrile
Monitor off Abx

SOCIAL/GOC: Full Code

DISPO: ICU for neurochecks and strict BP control

Objective
ICU Prophylaxis:
GI: Home medication
Hospital Medications as of 3/16/2025

Dose Frequency Start End
pantoprazole (use for PROTONIX) EC tablet 40 mg 40 mg Daily 3/17/2025 --
Admin Instructions: Do not crush.
Route: Oral

DVT: Holding given active bleed/bleeding

VAP: Per Unit Protocol for mouth care

Objective:
Vitals:
Temp: [97.8 °F (36.6 °C)-98 °F (36.7 °C)] 97.8 °F (36.6 °C)
Pulse: [63-81] 75
Resp: [12-16] 14
BP: (115-205)/(60-124) 138/81
BMI: There is no height or weight on file to calculate BMI.

Physical Exam:
GEN: Awake, Alert, NAD, comfortable sitting upright in bed
HEENT: Neck supple, PEARL, EOMI, moist oral mucosa, missing most of his teeth
PULM: Deferred
CVS: Deferred
GI: Soft, non-tender, non-distended, active bowel sounds
SKIN/MSK/EXT: No LE pitting edema noted
Neuro: Alert, oriented x3/3, no focal motor deficits 5/5 power to BL UE and LE, moves all extremities on command. Tongue deviates to right.

Medication Review:
Scheduled Meds:
amLODIPine, 10 mg, Oral, Daily
atorvastatin, 40 mg, Oral, Nightly
carvediloL, 12.5 mg, Oral, BID with meals
losartan, 50 mg, Oral, Q12H
[START ON 3/17/2025] pantoprazole, 40 mg, Oral, Daily

Infusions:
niCARdipine, 0-15 mg/hr

PRNs:
ondansetron

Past Medical History:

Past Medical History:
Diagnosis Date
Abnormal nuclear stress test 09/22/2021
Added automatically from request for surgery 504201
Acute gastric ulcer without hemorrhage or perforation 03/16/2024
Chronic kidney disease
Coronary artery disease
PT STATES DOES NOT HAVE CARDIO- PCP MANAGES
Diabetes mellitus (HCC)
NIDDM
Hypertension
Mini stroke
Stab wound

Past Surgical History:
Past Surgical History:
Procedure Laterality Date
CARDIAC CATHETERIZATION Right 10/13/2021
Procedure: Left heart cath Right Radial; Surgeon: Yoganand J Hiremath, MD; Location: Cath Lab Spartanburg; Service: Cardiovascular; Laterality: Right; 1030for12
CHOLECYSTECTOMY
COLONOSCOPY 08/03/2023
Dr.Kobes / Pedunculated polyp found in ascending colon, mild diverticulosis in sigmoid/descending colon
ESOPHAGOGASTRODUODENOSCOPY 08/03/2023
Dr.Kobes / No abnormalities
ESOPHAGOGASTRODUODENOSCOPY 03/08/2024
Douglass
ESOPHAGOGASTRODUODENOSCOPY 01/17/2025
Malcolm - SRMC
WRIST SURGERY

Billing Statements:
Patient able to speak and/or participate in assessment: Yes

Care Level: Critical Care (ICU Level 3)
Critical Care Time:47 Min. Service Type: Critical Care, exclusive of Procedures or CPR
Signover(s), MDR's performed, systematic review of the patient has occurred & available labs and imaging reviewed.

The patient has acute impairment of one or more vital organ systems. Therapies have been undertaken to mitigate the chance of acute life-threatening deterioration.

Case was discussed with: Bedside RN

RYAN LAPOINTE, MD
Medical Intensivist
Electronically signed by Ryan Lapointe, MD at 03/16/2025 2:35 PM EDT

[9]. documented in this encounter

Nursing Notes

- **Katie B Dill, RN - 03/20/2025 10:41 AM EDT**
  Formatting of this note might be different from the original.
  RN reviewed dc instructions with pt including but not limited to medication details, next dose due, follow-up appointments, and education. Pt verbalized understanding of dc instructions and denies questions/concerns at this time. CM delivered RW to bedside prior to dc. Pt states his daughter will transport him home today.
  Electronically signed by Katie B Dill, RN at 03/20/2025 10:42 AM EDT

[10]. documented in this encounter

Miscellaneous Notes

- **POC & Treatment Note - Abby Green, RN - 03/20/2025 10:18 AM EDT**
  Formatting of this note might be different from the original.

  Problem: Activity:
  Goal: Ability to perform activities at highest level will be supported
  Outcome: Adequate for Discharge

Problem: Bowel/Gastric:
Goal: Will not experience complications related to bowel motility
Outcome: Adequate for Discharge

Problem: Cardiac:
Goal: Will achieve and/or maintain adequate cardiac output
Outcome: Adequate for Discharge

Problem: Cognitive:
Goal: Knowledge of disease or condition and prescribed therapeutic regimen will improve
Outcome: Adequate for Discharge

Problem: Coping:
Goal: Level of anxiety will be controlled/managed
Outcome: Adequate for Discharge

Problem: Fluid Volume:
Goal: Will achieve and/or maintain a balanced intake and output
Outcome: Adequate for Discharge

Problem: Health Behavior - Tobacco Use:
Goal: Complications related to the disease process, condition or treatment will be avoided or minimized
Outcome: Adequate for Discharge

Problem: Medication:
Goal: Will comply/adhere with prescribed medication regimen
Outcome: Adequate for Discharge

Problem: Metabolic - Influenza Immunization:
Goal: Complications related to the disease process, condition or treatment will be avoided or minimized
Outcome: Adequate for Discharge

Problem: Nutritional:
Goal: Nutritional status will be supported
Outcome: Adequate for Discharge

Problem: Physical Regulation:
Goal: Complications related to the disease process, condition or treatment will be avoided or minimized
Outcome: Adequate for Discharge
Goal: Will remain free from infection
Outcome: Adequate for Discharge

Problem: Respiratory:
Goal: Will maintain a patent airway
Outcome: Adequate for Discharge

Problem: Safety:
Goal: Will remain free from injury
Outcome: Adequate for Discharge

Problem: Self-Care:
Goal: Will perform or participate in self-care at the highest level possible as condition permits
Outcome: Adequate for Discharge

Problem: Sensory:
Goal: General experience of comfort will improve and/or be controlled
Outcome: Adequate for Discharge

Problem: Skin Integrity:
Goal: Skin integrity will be maintained
Outcome: Adequate for Discharge

Problem: Tissue Perfusion - VTE Prevention:
Goal: Will show no signs or symptoms of venous thromboembolism
Outcome: Adequate for Discharge

Problem: Cognitive:
Goal: Knowledge of risk factors and measures for prevention of condition will improve
Outcome: Adequate for Discharge

Problem: Safety:
Goal: Will remain free from falls
Outcome: Adequate for Discharge

Problem: Activity - Level 1:
Goal: Bed mobility will improve
Outcome: Adequate for Discharge

Problem: Activity - Level 2:
Goal: Bed mobility will improve
Outcome: Adequate for Discharge

Problem: Activity - Level 3:
Goal: Will sit unassisted with legs in dependent position
Outcome: Adequate for Discharge

Problem: Activity - Level 4:
Goal: Dynamic and static standing balance will improve
Outcome: Adequate for Discharge

Problem: Activity - Level 5:
Goal: Ability to ambulate will improve
Outcome: Adequate for Discharge

Problem: Activity - Level 5 plus:
Goal: Ability to ambulate will improve
Outcome: Adequate for Discharge

Problem: Cognitive:
Goal: Will demonstrate different strategies to decrease or manage pain
Outcome: Adequate for Discharge

Problem: Sensory:
Goal: Pain level will decrease
Outcome: Adequate for Discharge

Problem: Cognitive:
Goal: Knowledge of risk factors and measures for prevention of condition will improve
Outcome: Adequate for Discharge

Problem: Fluid Volume:
Goal: Will show no signs and symptoms of excessive bleeding
Description: Ie, Blood pressure within normal limits for pt., stable/normalized hemoglobin and hematocrits, coagulation profiles within designated parameters
Outcome: Adequate for Discharge

Problem: Cognitive:
Goal: Understanding of ways to prevent future skin breakdown will improve
Outcome: Adequate for Discharge

Problem: Nutritional:
Goal: Maintenance of adequate nutrition will be supported
Outcome: Adequate for Discharge

Problem: Skin Integrity:
Goal: Skin integrity will be maintained
Outcome: Adequate for Discharge

Problem: Activity:
Goal: Functional abilities will be maintained or improve
Outcome: Adequate for Discharge

Problem: Cognitive - Stroke Education:
Goal: Understanding of discharge needs will improve
Outcome: Adequate for Discharge
Goal: Ability to verbalize understanding of risk factors for stroke will improve
Outcome: Adequate for Discharge

Problem: Coping:
Goal: Level of anxiety will decrease
Outcome: Adequate for Discharge

Problem: Nutritional:
Goal: Will achieve and/or maintain adequate nutritional intake
Outcome: Adequate for Discharge

Problem: Respiratory:
Goal: Will maintain a patent airway
Outcome: Adequate for Discharge

Problem: Role Relationship:
Goal: Will communicate needs effectively
Outcome: Adequate for Discharge

Problem: Safety:
Goal: Will remain free from injury
Outcome: Adequate for Discharge

Problem: Self-Care:
Goal: Ability to participate in self-care as condition permits will improve
Outcome: Adequate for Discharge

Problem: Sensory:
Goal: General experience of comfort will improve and/or be controlled
Outcome: Adequate for Discharge

Problem: Skin Integrity:
Goal: Skin integrity will be maintained
Outcome: Adequate for Discharge

Problem: Tissue Perfusion:
Goal: Signs of adequate cerebral perfusion will increase
Description: AHA/ASA recommends measures to control blood pressure should begin immediately after onset of ICH.
Outcome: Adequate for Discharge
Goal: Complications related to the disease process, condition or treatment will be avoided or minimized
Outcome: Adequate for Discharge

Problem: Urinary Elimination - Catheter Associated Urinary Tract Infection Prevention:
Goal: Complications related to the disease process, condition or treatment will be avoided or minimized
Outcome: Adequate for Discharge

Problem: Cognitive:
Goal: Knowledge of the prescribed therapeutic regimen will improve
Outcome: Adequate for Discharge

Problem: Health Behavior:
Goal: Will eval/address economic, enviro, & social factors that may affect ability to manage condition
Outcome: Adequate for Discharge

Problem: Metabolic:
Goal: Will maintain appropriate blood glucose levels by discharge
Outcome: Adequate for Discharge

Problem: Physical Regulation:
Goal: Complications related to the disease process, condition or treatment will be avoided or minimized
Outcome: Adequate for Discharge

Problem: Skin Integrity:
Goal: Skin integrity will be maintained or improve
Outcome: Adequate for Discharge

Problem: Activity:
Goal: Patient will tolerate increased activity
Outcome: Adequate for Discharge

Problem: Cardiac:
Goal: Will attain and/or maintain blood pressure within individually acceptable range as per MD order
Outcome: Adequate for Discharge

Problem: Cognitive:
Goal: Knowledge of the prescribed therapeutic regimen will improve
Outcome: Adequate for Discharge

Problem: Nutritional:
Goal: Ability to identify appropriate dietary choices will improve
Outcome: Adequate for Discharge

Electronically signed by Abby Green, RN at 03/20/2025 10:19 AM EDT

- **POC & Treatment Note - Ashley H Peevy, PT - 03/20/2025 10:12 AM EDT**

Formatting of this note is different from the original.
PT Treatment

Room/Bed: 580/580-A
PR PT Visit #: 3

Weight Bearing and Activity Orders
Nursing Activity Orders

Start Ordered
03/16/25 1410 OT eval and treat Once
Comments: Start 24 hours following admission.
Document pre-morbid modified rankin score and daily current modified rankin score.
Question: Reason for OT? Answer: Stroke team consult
03/16/25 1410
03/16/25 1410 PT eval and treat Once
Comments: Start 24 hours following admission.
Document pre-morbid modified rankin score and daily current modified rankin score.
Question: Reason for PT? Answer: Stroke team consult
03/16/25 1410

Precautions
Precautions
Other Precautions: fall, R sided weakness, SBP < 160

Treatment Type: Individual treatment
Family/Caregiver Present: No

Subjective: RN cleared pt for PT; pt agreeable to PT; pt states "I'm going home today"

Objective Comments: Pt received and returned sitting on edge of bed; all needs within reach

Intervention/Activity Sets/Reps/Wt/Time Skill Provided/Performance Accuracy Purpose Bill as
Education X 1 min Progression of PT POC and goals; importance of edge of bed/OOB mobility; safety with transfers and ambulation with assist; pt verbalized understanding to all education provided Functional Activity/Mobility Therapeutic Activity-97530
Sit to stand X 1 Supervision; use of rolling walker; good motor planning and coordination Transfer Training Therapeutic Activity-97530
Gait training X 250' Supervision; use of rolling walker; good step length; reciprocal stepping pattern; no loss of balance observed; pt with 2 brief standing rest breaks Gait Training Gait Training-97116
Stand to sit X 1 Supervision; good eccentric control Transfer Training Therapeutic Activity-97530

-

-

Pain:
Pt does not report pain

Assessment: Pt with good effort and participation in skilled PT services this date and with progress towards goals as anticipated. Pt continues to demonstrate decreased strength, impaired mobility, decreased endurance and increased need for assist and will benefit from ongoing skilled PT services to address his deficit areas. Once medically stable and ready for discharge, pt will be able to return home with HHPT to maximize safety and independence with functional mobility and to reduce fall risk. Pt will benefit from rolling walker at discharge for safety with mobility and improved balance in the home and community setting.

Plan for next visit: B lower extremity strengthening; transfers; gait training

ASHLEY H PEEVY, PT

Patient Time

Start Time: 1000
End Time: 1012
Total Therapy Minutes: 12

PT Timed Code (minutes)
$ Gait Training: 8
$ Therapeutic Activity: 4
Total Time in Timed Codes (PT): 12 min

Electronically signed by Ashley H Peevy, PT at 03/20/2025 10:20 AM EDT

- **POC & Treatment Note - Garrin Walker, COTA - 03/20/2025 9:41 AM EDT**

Formatting of this note is different from the original.
OT Treatment

Room/Bed: 580/580-A
PR OT Visit #: 3

Weight Bearing and Activity Orders
Nursing Activity Orders

Start Ordered
03/16/25 1410 OT eval and treat Once
Comments: Start 24 hours following admission.
Document pre-morbid modified rankin score and daily current modified rankin score.
Question: Reason for OT? Answer: Stroke team consult
03/16/25 1410
03/16/25 1410 PT eval and treat Once
Comments: Start 24 hours following admission.
Document pre-morbid modified rankin score and daily current modified rankin score.
Question: Reason for PT? Answer: Stroke team consult
03/16/25 1410

Precautions
Precautions
Other Precautions: falls

Treatment Type: Individual treatment
Family/Caregiver Present: No

Subjective: pt agreeable to OT. "Get me out of here".

Objective Comments: Pt semi supine in bed on entry and sitting up at exit w/ needs in reach.

Intervention/Activity Sets/Reps/Wt/Time Skill Provided/Performance Accuracy
Education x1 Role of OT, safety, activity pacing, adaptive ways to complete ADLs if issues arise, problem solving home setting.
Bed mobility x1 Independent.
Sink level ADLs 3 tasks Oral care, facial hygiene, and shaving completed at sink w/ pt gathering items and completing ADLs w/ supervision.
Functional mobility x1 Pt completed mobility around room w/o assistive device and Stand by assist.
Upper body dressing x1 Pt doffed and donned gown w/ set up. COTA assist for tying up gown in back.
Shower transfer 1x Pt completed w/ contact guard assist. Pt did not need to use grab bars and instead using wall as needed 2* pt not having grab bars in home shower/tub.
Bathing in shower ~10 minutes Pt completed bathing in shower in standing w/ distant supervision.
Drying off inside the shower completed w/ supervision. Pt able to reach knees in standing but sat down to

complete drying of feet in figure 4.
Lower body dressing x1 Pt completed doffing and donning of socks sitting at edge of bed w/ in figure 4.

-

Modified Rankin Score: 1 - No significant disability. Able to carry out all usual activities, despite some symptoms.

Pain:
Pt did not rate.

Assessment: pt progressing w/ overall in room ADL skills and mobility. Pt able to complete short distance mobility w/o assistive device but would benefit from rolling walker in longer distance mobility. Pt completed shower and sink level ADLs w/ Stand by assist and supervision. Pt notes he has a daughter who will come and help him if needed at home.
Pt would benefit from HHOT at dc w/ caregiver assist.

Plan for next visit: Cont POC w/ progressive ADL completion.

GARRIN WALKER, COTA

Patient Time
Start Time: 0858
End Time: 0940
Total OT Patient Minutes: 42 minutes

OT Timed Code (minutes)
$ Self Care/Home Mgmt Training: 42
Total Time in Timed Codes (OT): 42 min

Electronically signed by Garrin Walker, COTA at 03/20/2025 11:41 AM EDT

- **POC & Treatment Note - Jasmeen Kaur, RN - 03/20/2025 3:41 AM EDT**

Formatting of this note might be different from the original.

Problem: Activity:
Goal: Ability to perform activities at highest level will be supported
Outcome: Progressing

Problem: Bowel/Gastric:
Goal: Will not experience complications related to bowel motility
Outcome: Progressing

Problem: Cardiac:
Goal: Will achieve and/or maintain adequate cardiac output
Outcome: Progressing

Problem: Cognitive:
Goal: Knowledge of disease or condition and prescribed therapeutic regimen will improve
Outcome: Progressing

Problem: Coping:
Goal: Level of anxiety will be controlled/managed
Outcome: Progressing

Problem: Fluid Volume:
Goal: Will achieve and/or maintain a balanced intake and output
Outcome: Progressing

Problem: Health Behavior - Tobacco Use:
Goal: Complications related to the disease process, condition or treatment will be avoided or minimized
Outcome: Progressing

Problem: Medication:
Goal: Will comply/adhere with prescribed medication regimen
Outcome: Progressing

Problem: Metabolic - Influenza Immunization:
Goal: Complications related to the disease process, condition or treatment will be avoided or minimized
Outcome: Progressing

Problem: Nutritional:
Goal: Nutritional status will be supported
Outcome: Progressing

Problem: Physical Regulation:
Goal: Complications related to the disease process, condition or treatment will be avoided or minimized
Outcome: Progressing
Goal: Will remain free from infection
Outcome: Progressing

Problem: Respiratory:
Goal: Will maintain a patent airway
Outcome: Progressing

Problem: Safety:
Goal: Will remain free from injury
Outcome: Progressing

Problem: Self-Care:
Goal: Will perform or participate in self-care at the highest level possible as condition permits
Outcome: Progressing

Problem: Sensory:
Goal: General experience of comfort will improve and/or be controlled
Outcome: Progressing

Problem: Skin Integrity:
Goal: Skin integrity will be maintained
Outcome: Progressing

Problem: Tissue Perfusion - VTE Prevention:
Goal: Will show no signs or symptoms of venous thromboembolism
Outcome: Progressing

Problem: Cognitive:
Goal: Knowledge of risk factors and measures for prevention of condition will improve
Outcome: Progressing

Problem: Safety:
Goal: Will remain free from falls
Outcome: Progressing

Problem: Activity - Level 5 plus:
Goal: Ability to ambulate will improve
Outcome: Progressing

Problem: Cognitive:
Goal: Will demonstrate different strategies to decrease or manage pain
Outcome: Progressing

Problem: Sensory:
Goal: Pain level will decrease
Outcome: Progressing

Problem: Cognitive:
Goal: Knowledge of risk factors and measures for prevention of condition will improve
Outcome: Progressing

Problem: Fluid Volume:
Goal: Will show no signs and symptoms of excessive bleeding
Description: Ie, Blood pressure within normal limits for pt., stable/normalized hemoglobin and hematocrits, coagulation profiles within designated parameters
Outcome: Progressing

Problem: Cognitive:
Goal: Understanding of ways to prevent future skin breakdown will improve
Outcome: Progressing

Problem: Nutritional:

Goal: Maintenance of adequate nutrition will be supported
Outcome: Progressing

Problem: Skin Integrity:
Goal: Skin integrity will be maintained
Outcome: Progressing

Problem: Activity:
Goal: Functional abilities will be maintained or improve
Outcome: Progressing

Problem: Cognitive - Stroke Education:
Goal: Understanding of discharge needs will improve
Outcome: Progressing
Goal: Ability to verbalize understanding of risk factors for stroke will improve
Outcome: Progressing

Problem: Coping:
Goal: Level of anxiety will decrease
Outcome: Progressing

Problem: Nutritional:
Goal: Will achieve and/or maintain adequate nutritional intake
Outcome: Progressing

Problem: Respiratory:
Goal: Will maintain a patent airway
Outcome: Progressing

Electronically signed by Jasmeen Kaur, RN at 03/20/2025 3:41 AM EDT

- **POC & Treatment Note - Kayla B Sylvester, RN - 03/19/2025 2:23 PM EDT**

Formatting of this note might be different from the original.

Problem: Activity:
Goal: Ability to perform activities at highest level will be supported
Outcome: Progressing

Problem: Bowel/Gastric:
Goal: Will not experience complications related to bowel motility
Outcome: Progressing

Problem: Cardiac:
Goal: Will achieve and/or maintain adequate cardiac output
Outcome: Progressing

Problem: Cognitive:
Goal: Knowledge of disease or condition and prescribed therapeutic regimen will improve
Outcome: Progressing

Problem: Coping:
Goal: Level of anxiety will be controlled/managed
Outcome: Progressing

Problem: Fluid Volume:
Goal: Will achieve and/or maintain a balanced intake and output
Outcome: Progressing

Problem: Health Behavior - Tobacco Use:
Goal: Complications related to the disease process, condition or treatment will be avoided or minimized
Outcome: Progressing

Problem: Medication:
Goal: Will comply/adhere with prescribed medication regimen
Outcome: Progressing

Problem: Metabolic - Influenza Immunization:
Goal: Complications related to the disease process, condition or treatment will be avoided or minimized
Outcome: Progressing

Problem: Nutritional:
Goal: Nutritional status will be supported
Outcome: Progressing

Problem: Physical Regulation:
Goal: Complications related to the disease process, condition or treatment will be avoided or minimized
Outcome: Progressing
Goal: Will remain free from infection
Outcome: Progressing

Problem: Respiratory:
Goal: Will maintain a patent airway
Outcome: Progressing

Problem: Safety:
Goal: Will remain free from injury
Outcome: Progressing

Problem: Self-Care:
Goal: Will perform or participate in self-care at the highest level possible as condition permits
Outcome: Progressing

Problem: Sensory:
Goal: General experience of comfort will improve and/or be controlled
Outcome: Progressing

Problem: Skin Integrity:
Goal: Skin integrity will be maintained
Outcome: Progressing

Problem: Tissue Perfusion - VTE Prevention:
Goal: Will show no signs or symptoms of venous thromboembolism
Outcome: Progressing

Problem: Cognitive:
Goal: Knowledge of risk factors and measures for prevention of condition will improve
Outcome: Progressing

Problem: Safety:
Goal: Will remain free from falls
Outcome: Progressing

Problem: Activity - Level 1:
Goal: Bed mobility will improve
Outcome: Progressing

Problem: Activity - Level 2:
Goal: Bed mobility will improve
Outcome: Progressing

Problem: Activity - Level 3:
Goal: Will sit unassisted with legs in dependent position
Outcome: Progressing

Problem: Activity - Level 4:
Goal: Dynamic and static standing balance will improve
Outcome: Progressing

Problem: Activity - Level 5:
Goal: Ability to ambulate will improve
Outcome: Progressing

Problem: Activity - Level 5 plus:
Goal: Ability to ambulate will improve
Outcome: Progressing

Problem: Cognitive:
Goal: Will demonstrate different strategies to decrease or manage pain
Outcome: Progressing

Problem: Sensory:
Goal: Pain level will decrease
Outcome: Progressing

Problem: Cognitive:
Goal: Knowledge of risk factors and measures for prevention of condition will improve
Outcome: Progressing

Problem: Fluid Volume:
Goal: Will show no signs and symptoms of excessive bleeding
Description: Ie, Blood pressure within normal limits for pt., stable/normalized hemoglobin and hematocrits, coagulation profiles within designated parameters
Outcome: Progressing

Problem: Cognitive:
Goal: Understanding of ways to prevent future skin breakdown will improve
Outcome: Progressing

Problem: Nutritional:
Goal: Maintenance of adequate nutrition will be supported
Outcome: Progressing

Problem: Skin Integrity:
Goal: Skin integrity will be maintained
Outcome: Progressing

Problem: Activity:
Goal: Functional abilities will be maintained or improve
Outcome: Progressing

Problem: Cognitive - Stroke Education:
Goal: Understanding of discharge needs will improve
Outcome: Progressing
Goal: Ability to verbalize understanding of risk factors for stroke will improve
Outcome: Progressing

Problem: Coping:
Goal: Level of anxiety will decrease
Outcome: Progressing

Problem: Nutritional:
Goal: Will achieve and/or maintain adequate nutritional intake
Outcome: Progressing

Problem: Respiratory:
Goal: Will maintain a patent airway
Outcome: Progressing

Electronically signed by Kayla B Sylvester, RN at 03/19/2025 2:23 PM EDT

- **POC & Treatment Note - Katelyn Sierra, CCC-SLP - 03/19/2025 1:54 PM EDT**

Formatting of this note is different from the original.
SLP Treatment

Room/Bed: 580/580-A

Treatment Type: Individual treatment
Family/Caregiver Present: No

Subjective
Pt reported no difficulty with speech/cognition at this time. Pt reported he feels his speech is back to baseline, and has no concerns with cognition/memory.

Objective
Objective Comments: Completed diagnostic speech/cognitive therapy this date. Refer to grid/assessment for details. Discussed patient's status with RN. Patient left with needs met/in-reach.

Intervention/Activity Sets/Reps/Wt/Time Skill Provided/Performance Accuracy Purpose Bill as
Education 3 minutes SLP role, rationale, POC
Plan to discharge SLP services at this time, given pt with no speech/cognitive concerns and 100% intelligible at the conversation level and oriented to all questions presented
Pt and RN verbalized understanding Cognition Speech Treatment/Individual-92507
Orientation Task 8 items Able to correctly and independently state his name, the type of place, name of the hospital, current year, month, date, day of the week, time, and situation
Provided feedback of pt's improvement in cognition as compared to previous session Cognition Speech Treatment/Individual-92507
Attention Throughout session Able to sustain attention throughout session without verbal cues, participating in conversation without becoming distracted

Quick responses to all questions in conversation
Pt slightly drowsy, resting eyes at times, however, pt reported not getting much sleep last night due to arm tingling/not able to get comfortable to sleep Cognition Speech Treatment/Individual-92507
Speech Intelligibility 3 minutes 100% intelligible at the conversation/sentence level
Pt reported feeling as though his speech is back to baseline at this time
Provided education of clear speech strategies and encouraged pt to implement these if someone has a difficult time understanding his speech, pt verbalized understanding Communication Speech Treatment/Individual-92507

Pain:
Pt did not report pain.

Assessment:
Pt meeting cognitive and speech goals this date. Pt able to answer all orientation questions correctly and independently, as well as recall recent events and living situation. Pt able to sustain attention to conversation throughout session. Although pt slightly drowsy, pt able to rouse to voicing and continue conversation. Pt reported not sleeping well last night due to arm tingling. Pt with 100% speech intelligibility at the sentence/conversation level this date, and pt reported feeling his speech and cognition are now at baseline. RN reported no concerns at this time. Given pt meeting speech and cognitive goals, plan to discharge pt from acute SLP services at this time. Please re-consult if new concern arises.

Katelyn Sierra, CF-SLP

Patient Time
Start Time: 1103
End Time: 1111
Total Therapy Minutes: 8

SLP Procedure
$ Speech Treatment/Individual: Procedure

Electronically signed by Katelyn Sierra, CCC-SLP at 03/19/2025 2:13 PM EDT

- **POC & Treatment Note - Katherine M Hobbs, COTA - 03/19/2025 1:42 PM EDT**

Formatting of this note is different from the original.
OT Treatment

Room/Bed: 580/580-A
PR OT Visit #: 2

Weight Bearing and Activity Orders
Nursing Activity Orders

Start Ordered
03/16/25 1410 OT eval and treat Once
Comments: Start 24 hours following admission.
Document pre-morbid modified rankin score and daily current modified rankin score.
Question: Reason for OT? Answer: Stroke team consult
03/16/25 1410
03/16/25 1410 PT eval and treat Once
Comments: Start 24 hours following admission.
Document pre-morbid modified rankin score and daily current modified rankin score.
Question: Reason for PT? Answer: Stroke team consult
03/16/25 1410

Precautions
Precautions
Other Precautions: falls

Treatment Type: Individual treatment
Family/Caregiver Present: No

Subjective: "independent hope to go home." - when discussing discharge plan

Objective Comments: Pt on edge of bed with no bed alarm on arrival and exit.

Intervention/Activity Sets/Reps/Wt/Time Skill Provided/Performance Accuracy Purpose Bill as
Education X ~ 15 minutes Role of OT, importance of mobility, goals of care, safety awareness, and transfer techniques.
Education Therapeutic Activity-97530
Sit to stand with no assistive device X 2 Supervision when standing from edge of bed. Functional Activity/Mobility Therapeutic Activity-97530
Functional mobility into and out of bathroom X ~ 15 ft each way Stand by assist; pt furniture surfs at times. Functional Activity/Mobility Therapeutic Activity-97530
Toilet transfers X 1 each way Mod independent using grab bars ADL/IADL Self Care/Home Management Training-97535
Grooming standing at sink X 1 Supervision ADL/IADL Self Care/Home Management Training-97535
Stand to sit at edge of bed X 1 Supervision Functional Activity/Mobility Therapeutic Activity-97530
Lower body dressing X 1 Pt doffs and dons both socks independently at edge of bed. ADL/IADL Self Care/Home Management Training-97535

-

Modified Rankin Score: 3 - Moderate disability. Requires some help, but able to walk unassisted.

Pain:
None

Patient is progressing with activities of daily living, balance, cognition, endurance, fine motor control, functional mobility, and safe judgment during activities of daily living.
Requires less assistance for ADLs and ADL related mobility .
Remains limited by decreased balance, decreased fine motor control, decreased instrumental activities of daily living, and decreased upper extremity strength.
Will benefit from skilled Occupational Therapy services to address stated deficits and maximize independence with activities of daily living and functional mobility to facilitate safe discharge.
Recommend home with caregiver assist as needed at discharge.

Plan for next visit: full body ADLs

KATHERINE M HOBBS, COTA

Patient Time
Start Time: 1230
End Time: 1245
Total OT Patient Minutes: 15 minutes

OT Timed Code (minutes)
$ Self Care/Home Mgmt Training: 15
Total Time in Timed Codes (OT): 15 min

Electronically signed by Katherine M Hobbs, COTA at 03/19/2025 1:47 PM EDT

- **POC & Treatment Note - Addie Ledbetter, RN - 03/18/2025 11:45 PM EDT**

Formatting of this note might be different from the original.
Bps controlled with po meds. Still c/o RUE/RLE numbness.

Problem: Activity:
Goal: Ability to perform activities at highest level will be supported
Outcome: Progressing

Problem: Bowel/Gastric:
Goal: Will not experience complications related to bowel motility
Outcome: Progressing

Problem: Cardiac:
Goal: Will achieve and/or maintain adequate cardiac output
Outcome: Progressing

Problem: Cognitive:
Goal: Knowledge of disease or condition and prescribed therapeutic regimen will improve
Outcome: Progressing

Problem: Coping:
Goal: Level of anxiety will be controlled/managed
Outcome: Progressing

Problem: Fluid Volume:
Goal: Will achieve and/or maintain a balanced intake and output
Outcome: Progressing

Problem: Health Behavior - Tobacco Use:
Goal: Complications related to the disease process, condition or treatment will be avoided or minimized
Outcome: Progressing

Problem: Medication:
Goal: Will comply/adhere with prescribed medication regimen
Outcome: Progressing

Problem: Metabolic - Influenza Immunization:
Goal: Complications related to the disease process, condition or treatment will be avoided or minimized
Outcome: Progressing

Problem: Nutritional:
Goal: Nutritional status will be supported
Outcome: Progressing

Problem: Physical Regulation:
Goal: Complications related to the disease process, condition or treatment will be avoided or minimized
Outcome: Progressing
Goal: Will remain free from infection
Outcome: Progressing

Problem: Respiratory:
Goal: Will maintain a patent airway
Outcome: Progressing

Problem: Safety:
Goal: Will remain free from injury
Outcome: Progressing

Problem: Self-Care:
Goal: Will perform or participate in self-care at the highest level possible as condition permits
Outcome: Progressing

Problem: Sensory:
Goal: General experience of comfort will improve and/or be controlled
Outcome: Progressing

Problem: Skin Integrity:
Goal: Skin integrity will be maintained
Outcome: Progressing

Problem: Tissue Perfusion - VTE Prevention:
Goal: Will show no signs or symptoms of venous thromboembolism
Outcome: Progressing

Problem: Cognitive:
Goal: Knowledge of risk factors and measures for prevention of condition will improve
Outcome: Progressing

Problem: Safety:
Goal: Will remain free from falls
Outcome: Progressing

Problem: Activity - Level 1:
Goal: Bed mobility will improve
Outcome: Progressing

Problem: Activity - Level 2:
Goal: Bed mobility will improve
Outcome: Progressing

Problem: Activity - Level 3:
Goal: Will sit unassisted with legs in dependent position
Outcome: Progressing

Problem: Activity - Level 4:
Goal: Dynamic and static standing balance will improve
Outcome: Progressing

Problem: Activity - Level 5:
Goal: Ability to ambulate will improve
Outcome: Progressing

Problem: Activity - Level 5 plus:
Goal: Ability to ambulate will improve
Outcome: Progressing

Problem: Cognitive:
Goal: Will demonstrate different strategies to decrease or manage pain
Outcome: Progressing

Problem: Sensory:
Goal: Pain level will decrease
Outcome: Progressing

Problem: Cognitive:
Goal: Knowledge of risk factors and measures for prevention of condition will improve
Outcome: Progressing

Problem: Fluid Volume:
Goal: Will show no signs and symptoms of excessive bleeding
Description: Ie, Blood pressure within normal limits for pt., stable/normalized hemoglobin and hematocrits, coagulation profiles within designated parameters
Outcome: Progressing

Problem: Cognitive:
Goal: Understanding of ways to prevent future skin breakdown will improve
Outcome: Progressing

Problem: Nutritional:
Goal: Maintenance of adequate nutrition will be supported
Outcome: Progressing

Problem: Skin Integrity:
Goal: Skin integrity will be maintained
Outcome: Progressing

Problem: Activity:
Goal: Functional abilities will be maintained or improve
Outcome: Progressing

Problem: Cognitive - Stroke Education:
Goal: Understanding of discharge needs will improve
Outcome: Progressing
Goal: Ability to verbalize understanding of risk factors for stroke will improve
Outcome: Progressing

Problem: Coping:
Goal: Level of anxiety will decrease
Outcome: Progressing

Problem: Nutritional:
Goal: Will achieve and/or maintain adequate nutritional intake
Outcome: Progressing

Problem: Respiratory:
Goal: Will maintain a patent airway
Outcome: Progressing

Problem: Role Relationship:
Goal: Will communicate needs effectively
Outcome: Progressing

Problem: Safety:
Goal: Will remain free from injury
Outcome: Progressing

Problem: Self-Care:
Goal: Ability to participate in self-care as condition permits will improve
Outcome: Progressing

Problem: Sensory:
Goal: General experience of comfort will improve and/or be controlled
Outcome: Progressing

Problem: Skin Integrity:
Goal: Skin integrity will be maintained
Outcome: Progressing

Problem: Tissue Perfusion:
Goal: Signs of adequate cerebral perfusion will increase
Description: AHA/ASA recommends measures to control blood pressure should begin immediately after onset of ICH.
Outcome: Progressing
Goal: Complications related to the disease process, condition or treatment will be avoided or minimized
Outcome: Progressing

Problem: Urinary Elimination - Catheter Associated Urinary Tract Infection Prevention:
Goal: Complications related to the disease process, condition or treatment will be avoided or minimized
Outcome: Progressing

Problem: Cognitive:
Goal: Knowledge of the prescribed therapeutic regimen will improve
Outcome: Progressing

Problem: Health Behavior:
Goal: Will eval/address economic, enviro, & social factors that may affect ability to manage condition
Outcome: Progressing

Problem: Metabolic:
Goal: Will maintain appropriate blood glucose levels by discharge
Outcome: Progressing

Problem: Physical Regulation:
Goal: Complications related to the disease process, condition or treatment will be avoided or minimized
Outcome: Progressing

Problem: Skin Integrity:
Goal: Skin integrity will be maintained or improve
Outcome: Progressing

Problem: Activity:
Goal: Patient will tolerate increased activity
Outcome: Progressing

Problem: Cardiac:
Goal: Will attain and/or maintain blood pressure within individually acceptable range as per MD order
Outcome: Progressing

Problem: Cognitive:
Goal: Knowledge of the prescribed therapeutic regimen will improve
Outcome: Progressing

Problem: Nutritional:
Goal: Ability to identify appropriate dietary choices will improve
Outcome: Progressing

Electronically signed by Addie Ledbetter, RN at 03/18/2025 11:46 PM EDT

- **Nutrition - Nina Golding Diaz, RD - 03/18/2025 9:23 PM EDT**

Formatting of this note is different from the original.
Nutrition Note Consult

REASON FOR INITIAL ASSESSMENT: nutrition assessment 24 hours post admission

Problem: no acute nutrition diagnosis
Etiology: related to oral intake

Signs and Symptoms: pt meeting nutrition needs with meals provided

Interventions
Continue current plan of care - diet as ordered
Brought snacks from floor stock; cereal and milk

Monitoring (Goal)
Adequate PO intake
Intake goal: 50-75% to meet protein and energy needs (at goal)

Evaluation
F/U in 15 days

Nutrition Discharge Planning
Discharge plan to rehab, diet per facility
Recommend renal diet with carb controlled portions, low sodium and low fat selections from all food groups
Maintain A1c <7

Patient Information:
Prior diet: Diabetic (per Jan/25 RD note)
Prior diet comment: DASH diet ed (2021)
PO difficulties: No difficulties identified (SLP - functional swallow)
PO intake: 75% or more
GI status: Within normal limits
Evaluation of intake: Adequate calories, Adequate protein
Assessment of weight: (BMI 25.9)

[] Social Determinants of Health Identified:

[] Un housed
[] Food Insecurity
[] Lack of family/caregiver support
[] Language barriers
[] Unable to read
[] Cognitive barriers
[] Transportation barriers

[x] None identified

Subjective:
Pt reports no barriers to intake, still hungry after eating supper, RD brought snacks
No food allergies to note
Intakes since admit meet energy needs, exceed protein goals

Objective:
Intakes 100% x4 meals recorded after dinner today
A1c 6.5 (1/30)
Fasting glucose (range) 152 - 185
BP 149 / 83
Lipids WNL
Troponin HS 734
Cre 1.91
eGFR 39.4

Estimated Needs:

Weight Used for Equation Calculations (kg): (68 kg CBW)
Total Calories- Range used: (25)
Calories Calculation - 1: 1700
Total Protein- Range used: (0.8)
Protein Calculation - 1: 54
Equation Chosen to Use by RD: KCal/KG

Anthropometric Measurements:
Height: 5' 4" (162.6 cm)
Weight: 68.4 kg (150 lb 14.4 oz)
Weight Method: Bed scale
BMI: 25.9
IBW (Calculated) : 130 lbs
IBW/kg (Calculated): 58.97 kg
Weight Used for Equation Calculations (kg): (68 kg CBW)
Temp: 98.7 °F (37.1 °C)

Weight Change History:

Dietary Orders
(From admission, onward)

Start Ordered
03/16/25 1510 Adult Diet: Regular Diet effective now
References: Fluid Restriction
Question: Diet Type Answer: Regular
03/16/25 1510
03/16/25 1410 Activate oral nutrition ordering protocol as indicated in the care of this patient Until discontinued
03/16/25 1410

03/18/25

Electronically signed by Nina Golding Diaz, RD at 03/18/2025 9:31 PM EDT
Electronically signed by Nina Golding Diaz, RD at 03/18/2025 9:34 PM EDT

- **POC & Treatment Note - Nicole Voltenburg, PT - 03/18/2025 12:46 PM EDT**

Formatting of this note is different from the original.
PT Treatment

Room/Bed: 580/580-A
PR PT Visit #: 2

Weight Bearing and Activity Orders
Nursing Activity Orders

Start Ordered
03/16/25 1410 OT eval and treat Once
Comments: Start 24 hours following admission.
Document pre-morbid modified rankin score and daily current modified rankin score.
Question: Reason for OT? Answer: Stroke team consult
03/16/25 1410
03/16/25 1410 PT eval and treat Once
Comments: Start 24 hours following admission.
Document pre-morbid modified rankin score and daily current modified rankin score.
Question: Reason for PT? Answer: Stroke team consult
03/16/25 1410

Precautions
Precautions
Other Precautions: fall, R sided weakness, SBP < 160

Treatment Type: Individual treatment
Family/Caregiver Present: No

Subjective: Patient agreeable to physical therapy treatment.

Objective Comments: Patient found semi reclined in bed and left sitting edge of bed per his request with all needs within reach.

Intervention/Activity Sets/Reps/Wt/Time Skill Provided/Performance Accuracy Purpose Bill as
Supine to sit x1 Independent Bed Mobility Therapeutic Activity-97530
Sit to stand from edge of bed x2 Stand by assist with hands on walker, cued to push up from bed but he refused, stating he wanted to do it the hard way Transfer Training Therapeutic Activity-97530
Gait with rolling walker 190 feet with 3 turns
130 feet with 3 turns Contact guard assist-stand by assist with cues to improve walker proximity and posture

Right knee partially buckled multiple times but patient able to self correct

Moderate upper extremity force leaning on walker Gait Training Gait Training-97116
Seated long arc quad 2x15 bilateral Cues to perform through full range of motion Strengthening Therapeutic Exercise-97110
Seated:
Ankle pumps with knee extended
Hip flexion X15 each bilateral Difficulty with hip flexion Strengthening Therapeutic Exercise-97110
Standing balance while talking on the phone with 1 upper extremity support on walker X3 minutes Stand by assist, mild sway Functional Activity/Mobility Therapeutic Activity-97530

PT Functional Tests

Row Name 03/18/25 1245

AM-PAC Basic Mobility- Does the patient need help?
AM-PAC Basic Mobility yes
Turning from your back to your side while in a flat bed without using bedrails? 4
Moving from lying on your back to sitting on the side of a flat bed without using bedrails? 4
Moving to and from a bed to a chair (including a wheelchair)? 3
Standing up from a chair using your arms (e.g. wheelchair, or bedside chair)? 3
Walking in hospital room? 3
Climbing 3-5 steps with a railing?+ 3
Raw Score 20
% of impairment 35.83%

Row Name 03/18/25 1245

Modified Rankin (mRS)
Modified Rankin Score Yes

Premorbid Modified Rankin Score: 0 - The patient had no residual symptoms.

Modified Rankin Score: 3 - Moderate disability. Requires some help, but able to walk unassisted.

Pain:
No complaints of pain

Assessment: Patient is making good progress towards physical therapy goals. He was able to ambulate further today and with less assistance using a rolling walker. He demonstrated right lower extremity weakness with multiple episodes of knee instability. He continues to demonstrated decreased endurance and strength. Recommend continued acute care physical therapy to further improve independence and safety with mobility and facilitate discharge. Recommend discharge to home with family support and home with home health services .

Plan for next visit: Gait and transfer training, lower extremity strengthening

Nicole Voltenburg, PT

Patient Time
Start Time: 0951
End Time: 1018
Total Therapy Minutes: 27

PT Timed Code (minutes)
$ Therapeutic Exercise: 9
$ Gait Training: 13
$ Therapeutic Activity: 5

Total Time in Timed Codes (PT): 27 min

Electronically signed by Nicole Voltenburg, PT at 03/18/2025 12:54 PM EDT

- **Therapy POC (Eval/Re-eval) - Thuy Nguyen, OT - 03/18/2025 9:36 AM EDT**

Formatting of this note is different from the original.
OT Plan of Care
Date: 3/18/2025

Treatment Type: Evaluation
Patient Name: Jennifer Patel
Medical Record Number: 00069679
Date of Birth: 2/11/1964
Sex: Male
Room/Bed: 580/580-A

Therapy Diagnosis:
1. Dysarthria
2. Cognitive communication deficit
3. Impaired mobility
4. Impaired mobility and activities of daily living

Assessment
Jennifer Patel is a 61 y.o. male admitted right hemi, numbness, found to have left thalamic ICH.
Prior to admission, patient lived with family (his brother lives with him) and was independent.
Patient presents with decreased activities of daily living status, decreased functional mobility, and decreased sensation.
Patient will benefit from skilled Occupational Therapy services to address stated deficits and maximize independence with activities of daily living and functional mobility to facilitate safe discharge.
Recommend home health services at discharge.
Prognosis: Good

Plan
Plan for next visit: progress with activities of daily living, functional mobility
Problem List: Decreased ADL status, Decreased balance, Decreased endurance, Decreased functional mobility, Decreased sensation
Treatment Interventions: ADL retraining, Neuromuscular reeducation, Functional transfer training, Patient/family training, Ther Exercise, Ther Activity, Equipment evaluation/education, Gross motor coordination activities, UE strengthening/ROM
OT Frequency: 3-5x/week
Expected Treatment Duration: 2 weeks
Date next assessment due: 04/01/25

Equipment Recommended: Shower chair
Discharge Recommendations: Post-acute rehab referral

Treatment Goals:
Multi-Disciplinary Problems (from Occupational Therapy)

Active Problems

Problem: Impaired Activities of Daily Living Start Date: 03/18/25

Goal Start Date Expected End Date End Date
LTG - Misc 1 - To be met by discharge (Therapy Use Only) 03/18/25 -- --
Goal Details: 1.Patient modified independent for functional transfer
2.Patient modified independent for upper body, lower body ADLs
3.Patient modified independent for functional standing for ADLs
4.Patient will ambulate from bed to bathroom and back with rolling walker to perform ADLs safely with no loss of balance and modified independent assistance
5.Patient will ambulate with multiple starts, stops, and changes of direction with no loss of balance to simulate retrieving items with modified independent
6. Patient modified independent for shower transfer

Thuy Nguyen, OT
03/18/25

Your co-signature indicates that you agree with the Plan of Care documented by the Occupational Therapist.

Overview
History of current condition: Admitted with right hemi, numbness, found hypertensive with systolic BP 240. CT showed left thalmaic ICH. Pt was admitted to P4 for cardene gtt to get his BP down

Family/Caregiver Present: No
Subjective: Agreeable to occupational therapy, asks to return to bed to sleep

Past Medical History:
Diagnosis Date
Abnormal nuclear stress test 09/22/2021
Added automatically from request for surgery 504201
Acute gastric ulcer without hemorrhage or perforation 03/16/2024
Chronic kidney disease
Coronary artery disease
PT STATES DOES NOT HAVE CARDIO- PCP MANAGES
Diabetes mellitus (HCC)
NIDDM
Hypertension
Mini stroke
Stab wound

Past Surgical History:
Procedure Laterality Date
CARDIAC CATHETERIZATION Right 10/13/2021
Procedure: Left heart cath Right Radial; Surgeon: Yoganand J Hiremath, MD; Location: Cath Lab Spartanburg; Service: Cardiovascular; Laterality: Right; 1030for12
CHOLECYSTECTOMY
COLONOSCOPY 08/03/2023
Dr.Kobes / Pedunculated polyp found in ascending colon, mild diverticulosis in sigmoid/descending colon
ESOPHAGOGASTRODUODENOSCOPY 08/03/2023
Dr.Kobes / No abnormalities
ESOPHAGOGASTRODUODENOSCOPY 03/08/2024
Douglass
ESOPHAGOGASTRODUODENOSCOPY 01/17/2025
Malcolm - SRMC
WRIST SURGERY

Evaluation Objective
Objective Comments: At exit in no distress needs in reach
Education: role of occupational therapy , call for assist for out of bed

Hygiene
Oral care assistance: Independent
Oral Care: Teeth/gums brushed

Weight Bearing and Activity Orders
Nursing Activity Orders

Start Ordered
03/16/25 1410 OT eval and treat Once
Comments: Start 24 hours following admission.
Document pre-morbid modified rankin score and daily current modified rankin score.
Question: Reason for OT? Answer: Stroke team consult
03/16/25 1410
03/16/25 1410 PT eval and treat Once
Comments: Start 24 hours following admission.
Document pre-morbid modified rankin score and daily current modified rankin score.
Question: Reason for PT? Answer: Stroke team consult
03/16/25 1410

Precautions
Precautions
Other Precautions: falls

03/18/25 1155
Home Living
Type of Home Mobile home
Lives With Family
(brother lives with patient)
Adaptive Equipment/Assistive Devices None
Prior Function
Level of Independence Independent with all activities
Mobility Method No Device
ADL Assistance Independent
Meal Prep Independent
Driving Independent
Static Sitting Balance
Static Sitting - Level of Assistance Independent
Static Standing Balance
Static Standing - Level of Assistance Close supervision/Stand by assistance
Static Standing - Devices Walker
ADL
Feeding Assistance Modified independent
Oral Hygiene Assistance Close supervision/Stand by assistance
Grooming Assistance Close supervision/Stand by assistance
UE Bathing Level of Assistance Close supervision/Stand by assistance
LE Bathing Level of Assistance Contact guard
UE Dressing Assistance Close supervision/Stand by assistance
LE Dressing Assistance Contact guard
Toileting Assistance Contact guard
Vision - Basic Assessment
Current Vision No visual deficits
Cognition
Arousal/Alertness Appropriate responses to stimuli
Attention Span Appears intact
Orientation Level Oriented x 4
Following Commands Follows all commands and directions without difficulty
Deficits Fully aware of deficits
Sensation
Light Touch RUE impaired;LUE intact
Sensation Comments reporrts tingling right arm.
Coordination
Gross Grasp Functional;Right;Left
Gross Motor intact
Finger to Nose WFL
RUE Assessment
RUE Assessment WFL
RUE Assessment Comment 4+/5
LUE Assessment
LUE Assessment WFL
LUE Assessment Comment 4+/5
Bed Mobility 1
Bed Mobility From 1 Supine
Bed Mobility to 1 Other
(sit)
Level of Assistance 1 Close supervision/Stand by assistance
Transfers 1
Transfer from 1 Sit
Transfer to 1 Stand
Transfer Level of Assistance 1 Close supervision/Stand by assistance
Transfers 2
Transfer from 2 Bed
Transfer to 2 Chair with arms
Transfer Device 2 Walker-rolling
Transfer Level of Assistance 2 Close supervision/Stand by assistance
Transfers 3
Transfer from 3 Sit
Transfer to 3 Supine
Transfer Level of Assistance 3 Close supervision/Stand by assistance

Treatment

Intervention/Activity Sets/Reps/Wt/Time Skill Provided/
Performance Accuracy Purpose Bill as
Education 1 x Call for assist for out of bed due to fall risk, verbalizes understanding ADL/IADL Self Care/Home Management Training-97535
Lower body dressing 1 x Stand by assist with increased time to thread LLE into pants.
Stand by assist to stand to pull over hip ADL/IADL Self Care/Home Management Training-97535
Footwear 1 x Donns socks with bilateral upper extremity sitting at edge of bed with stand by assist.
Left lean when donning right sock and increased time to cross right leg to contralateral knee with stand by assist ADL/IADL Self Care/Home Management Training-97535
Grooming at sink 1 x Stand by assist for grooming at sink.
Brushes teeth with right hand ADL/IADL Self Care/Home Management Training-97535
Functional mobility to/from sink 20 feet Stand by assist with rolling walker ADL/IADL Self Care/Home Management Training-97535

Pain:
Reports no pain

OT Functional Tests

Row Name 03/18/25 1157

Modified Rankin (mRS)
Modified Rankin Score Yes

-

Modified Rankin Score: 4 - Moderately severe disability. Unable to attend to own bodily needs without assistance or unable to walk unassisted.

Patient Time
Start Time: 0917
End Time: 0936
Total OT Patient Minutes: 19 minutes

OT Evaluation
$OT Evaluation: Low Complexity Eval

OT Timed Code (minutes)
$ Self Care/Home Mgmt Training: 9
Total Time in Timed Codes (OT): 9 min

Cosigned by James Glenn Botts, MD at 03/21/2025 8:12 AM EDT
Electronically signed by Thuy Nguyen, OT at 03/18/2025 12:08 PM EDT
Electronically signed by James Glenn Botts, MD at 03/21/2025 8:12 AM EDT

- **POC & Treatment Note - Victoria A Dimov, RN - 03/18/2025 7:47 AM EDT**

Formatting of this note might be different from the original.

Problem: Activity:
Goal: Ability to perform activities at highest level will be supported
Outcome: Progressing

Problem: Bowel/Gastric:
Goal: Will not experience complications related to bowel motility
Outcome: Progressing

Problem: Cardiac:
Goal: Will achieve and/or maintain adequate cardiac output
Outcome: Progressing

Problem: Cognitive:
Goal: Knowledge of disease or condition and prescribed therapeutic regimen will improve
Outcome: Progressing

Problem: Coping:
Goal: Level of anxiety will be controlled/managed
Outcome: Progressing

Problem: Fluid Volume:
Goal: Will achieve and/or maintain a balanced intake and output
Outcome: Progressing

Problem: Health Behavior - Tobacco Use:
Goal: Complications related to the disease process, condition or treatment will be avoided or minimized
Outcome: Progressing

Problem: Medication:
Goal: Will comply/adhere with prescribed medication regimen
Outcome: Progressing

Problem: Metabolic - Influenza Immunization:
Goal: Complications related to the disease process, condition or treatment will be avoided or minimized
Outcome: Progressing

Problem: Nutritional:
Goal: Nutritional status will be supported
Outcome: Progressing

Problem: Physical Regulation:
Goal: Complications related to the disease process, condition or treatment will be avoided or minimized
Outcome: Progressing
Goal: Will remain free from infection
Outcome: Progressing

Problem: Respiratory:
Goal: Will maintain a patent airway
Outcome: Progressing

Problem: Safety:
Goal: Will remain free from injury
Outcome: Progressing

Problem: Self-Care:
Goal: Will perform or participate in self-care at the highest level possible as condition permits
Outcome: Progressing

Problem: Sensory:
Goal: General experience of comfort will improve and/or be controlled
Outcome: Progressing

Problem: Skin Integrity:
Goal: Skin integrity will be maintained
Outcome: Progressing

Problem: Tissue Perfusion - VTE Prevention:
Goal: Will show no signs or symptoms of venous thromboembolism
Outcome: Progressing

Problem: Cognitive:
Goal: Knowledge of risk factors and measures for prevention of condition will improve
Outcome: Progressing

Problem: Safety:
Goal: Will remain free from falls
Outcome: Progressing

Problem: Activity - Level 1:
Goal: Bed mobility will improve
Outcome: Progressing

Problem: Activity - Level 2:
Goal: Bed mobility will improve
Outcome: Progressing

Problem: Activity - Level 3:
Goal: Will sit unassisted with legs in dependent position
Outcome: Progressing

Problem: Activity - Level 4:
Goal: Dynamic and static standing balance will improve
Outcome: Progressing

Problem: Activity - Level 5:
Goal: Ability to ambulate will improve
Outcome: Progressing

Problem: Activity - Level 5 plus:
Goal: Ability to ambulate will improve
Outcome: Progressing

Problem: Cognitive:
Goal: Will demonstrate different strategies to decrease or manage pain
Outcome: Progressing

Problem: Sensory:
Goal: Pain level will decrease
Outcome: Progressing

Problem: Cognitive:
Goal: Knowledge of risk factors and measures for prevention of condition will improve
Outcome: Progressing

Problem: Fluid Volume:
Goal: Will show no signs and symptoms of excessive bleeding
Description: Ie, Blood pressure within normal limits for pt., stable/normalized hemoglobin and hematocrits, coagulation profiles within designated parameters
Outcome: Progressing

Problem: Cognitive:
Goal: Understanding of ways to prevent future skin breakdown will improve
Outcome: Progressing

Problem: Nutritional:
Goal: Maintenance of adequate nutrition will be supported
Outcome: Progressing

Problem: Skin Integrity:
Goal: Skin integrity will be maintained
Outcome: Progressing

Problem: Activity:
Goal: Functional abilities will be maintained or improve
Outcome: Progressing

Problem: Cognitive - Stroke Education:
Goal: Understanding of discharge needs will improve
Outcome: Progressing
Goal: Ability to verbalize understanding of risk factors for stroke will improve
Outcome: Progressing

Problem: Coping:
Goal: Level of anxiety will decrease
Outcome: Progressing

Problem: Nutritional:
Goal: Will achieve and/or maintain adequate nutritional intake
Outcome: Progressing

Problem: Respiratory:
Goal: Will maintain a patent airway
Outcome: Progressing

Electronically signed by Victoria A Dimov, RN at 03/18/2025 7:47 AM EDT

- **POC & Treatment Note - Zenamie Bugahod, RN - 03/17/2025 10:14 PM EDT**

Formatting of this note might be different from the original.

Problem: Activity:
Goal: Ability to perform activities at highest level will be supported
Outcome: Progressing

Problem: Cardiac:
Goal: Will achieve and/or maintain adequate cardiac output
Outcome: Progressing

Problem: Medication:
Goal: Will comply/adhere with prescribed medication regimen
Outcome: Progressing

Problem: Metabolic - Influenza Immunization:
Goal: Complications related to the disease process, condition or treatment will be avoided or minimized
Outcome: Progressing

Problem: Nutritional:
Goal: Nutritional status will be supported
Outcome: Progressing

Problem: Safety:
Goal: Will remain free from injury
Outcome: Progressing

Problem: Sensory:
Goal: General experience of comfort will improve and/or be controlled
Outcome: Progressing

Problem: Skin Integrity:
Goal: Skin integrity will be maintained
Outcome: Progressing

Problem: Tissue Perfusion - VTE Prevention:
Goal: Will show no signs or symptoms of venous thromboembolism
Outcome: Progressing

Problem: Safety:
Goal: Will remain free from falls
Outcome: Progressing

Problem: Sensory:
Goal: Pain level will decrease
Outcome: Progressing

Electronically signed by Zenamie Bugahod, RN at 03/17/2025 10:14 PM EDT

- **POC & Treatment Note - Victoria A Dimov, RN - 03/17/2025 4:52 PM EDT**

Formatting of this note might be different from the original.

Problem: Role Relationship:
Goal: Will communicate needs effectively
Outcome: Progressing

Problem: Safety:
Goal: Will remain free from injury
Outcome: Progressing

Problem: Self-Care:
Goal: Ability to participate in self-care as condition permits will improve
Outcome: Progressing

Problem: Sensory:
Goal: General experience of comfort will improve and/or be controlled
Outcome: Progressing

Problem: Skin Integrity:
Goal: Skin integrity will be maintained
Outcome: Progressing

Problem: Tissue Perfusion:
Goal: Signs of adequate cerebral perfusion will increase
Description: AHA/ASA recommends measures to control blood pressure should begin immediately after onset of ICH.
Outcome: Progressing
Goal: Complications related to the disease process, condition or treatment will be avoided or minimized
Outcome: Progressing

Problem: Urinary Elimination - Catheter Associated Urinary Tract Infection Prevention:

Goal: Complications related to the disease process, condition or treatment will be avoided or minimized
Outcome: Progressing

Problem: Cognitive:
Goal: Knowledge of the prescribed therapeutic regimen will improve
Outcome: Progressing

Problem: Health Behavior:
Goal: Will eval/address economic, enviro, & social factors that may affect ability to manage condition
Outcome: Progressing

Problem: Metabolic:
Goal: Will maintain appropriate blood glucose levels by discharge
Outcome: Progressing

Problem: Physical Regulation:
Goal: Complications related to the disease process, condition or treatment will be avoided or minimized
Outcome: Progressing

Problem: Skin Integrity:
Goal: Skin integrity will be maintained or improve
Outcome: Progressing

Electronically signed by Victoria A Dimov, RN at 03/17/2025 4:52 PM EDT

- **Therapy POC (Eval/Re-eval) - Wilson Campbell, PT - 03/17/2025 2:30 PM EDT**

Formatting of this note is different from the original.
PT Plan of Care
Date: 3/17/2025

Treatment Type: Evaluation
Patient Name: Jennifer Patel
Medical Record Number: 00069679
Date of Birth: 2/11/1964
Sex: Male
Room/Bed: P411/P411-A

Therapy Diagnosis:
1. Dysarthria
2. Cognitive communication deficit
3. Impaired mobility

Assessment
Assessment: Jennifer Patel is a 61 y.o. male who presented to ED 3/16/25 with Rightt arm and leg heaviness.numbness that started upon awakening. Patient found to have L 3/16 for Left Thalamic ICH. Prior to admission, pt was independent with functional mobility tasks. At time of PT evaluation, pt required moderate assist for mobility tasks and demonstrated impaired functional strength, balance, and endurance. Patient will benefit from skilled PT services to address these deficits and safely progress mobility as able. Recommend post acute rehab at discharge when medically stable.

Prognosis: Good
Impairments: Impaired balance, Impaired coordination, Impaired endurance, Impaired mobility, Impaired strength
Barriers to safe and independent mobility: Decreased safety awareness, Fall risk

Plan
Plan for next visit: Bed mobility, transfer training, bilateral lower extremity strengthening, gait training.

Treatment/Interventions: Equipment education, Patient/family education, Gait training, Ther Activities, Ther Ex, Neuromuscular Re-education
PT Frequency: 3-5x/wk
Expected Treatment Duration: 2 weeks
Date next assessment due: 04/04/25

Discharge recommendations: Post-acute rehab referral

Treatment Goals:
Multi-Disciplinary Problems (from Physical Therapy)

Active Problems

Problem: Impaired mobility Start Date: 03/17/25

Goal Start Date Expected End Date End Date

LTG - Misc 1 - To be met by discharge (Therapy Use Only) 03/17/25 -- --
Goal Details: 1. Patient will transfer supine to/from sit with supervision.

2. Patient will perform stand pivot transfer bed to/from chair with least restrictive assistive device and supervision.

3. Patient will ambulate 150 ft with least restrictive assistive device and supervision.

4. Patient will ambulate up/down 3 steps with handrails per home environment with supervision.

5. Patient will complete HEP consisting of but not limited to ankle pumps, quad sets, supine heel slides, supine hip abduction, straight leg raise, long arc quads, seated marching x 30/2 reps on B LE SBA for strengthening and endurance.

Wilson Campbell, PT
03/17/25

Your co-signature indicates that you agree with the Plan of Care documented by the Physical Therapist.

Overview

Family/Caregiver Present: No
Subjective: Patient in agreement with PT session.

Past Medical History:
Diagnosis Date
Abnormal nuclear stress test 09/22/2021
Added automatically from request for surgery 504201
Acute gastric ulcer without hemorrhage or perforation 03/16/2024
Chronic kidney disease
Coronary artery disease
PT STATES DOES NOT HAVE CARDIO- PCP MANAGES
Diabetes mellitus (HCC)
NIDDM
Hypertension
Mini stroke
Stab wound

Past Surgical History:
Procedure Laterality Date
CARDIAC CATHETERIZATION Right 10/13/2021
Procedure: Left heart cath Right Radial; Surgeon: Yoganand J Hiremath, MD; Location: Cath Lab Spartanburg; Service: Cardiovascular; Laterality: Right; 1030for12
CHOLECYSTECTOMY
COLONOSCOPY 08/03/2023
Dr.Kobes / Pedunculated polyp found in ascending colon, mild diverticulosis in sigmoid/descending colon
ESOPHAGOGASTRODUODENOSCOPY 08/03/2023
Dr.Kobes / No abnormalities
ESOPHAGOGASTRODUODENOSCOPY 03/08/2024
Douglass
ESOPHAGOGASTRODUODENOSCOPY 01/17/2025
Malcolm - SRMC
WRIST SURGERY

Evaluation Objective
PR PT Visit #: 1
History: Moderate - 1-2 personal factors or comorbidities
Examination: Moderate - 3 or more elements
Presentation: Moderate - Evolving/Changing Characteristics
Clinical Decision Making: Moderate complexity

Eval Complexity: Moderate - 4 moderate categories or up to 3 high categories
Objective Comments: Patient supine in bed with head of bed elevated at PT entry and at PT exit. All lines intact throughout PT encounter. Patient status discussed with RN. Alarm in place.

Education: PT POC, role of PT, safety with mobility.

Weight Bearing and Activity Orders
Nursing Activity Orders

Start Ordered
03/16/25 1410 OT eval and treat Once
Comments: Start 24 hours following admission.
Document pre-morbid modified rankin score and daily current modified rankin score.
Question: Reason for OT? Answer: Stroke team consult
03/16/25 1410
03/16/25 1410 PT eval and treat Once
Comments: Start 24 hours following admission.
Document pre-morbid modified rankin score and daily current modified rankin score.
Question: Reason for PT? Answer: Stroke team consult
03/16/25 1410

Precautions
Precautions
Other Precautions: fall, R sided weakness, SBP < 160

03/17/25 1440
Home Living
Type of Home Mobile home
Lives With
(brother)
Home Layout One level
Home Access
(3 steps)
Adaptive Equipment/Assistive Devices None
Prior Function
Level of Independence Independent with all activities
Mobility Method No Device
Gait Independent
Functional Transfers Independent
Activity Tolerance
Endurance Tolerates less than 20 min activity with rest breaks
Static Sitting Balance
Static Sitting - Balance Support Feet supported
Static Sitting - Level of Assistance Close supervision/Stand by assistance
Static Standing Balance
Static Standing - Balance Support Left upper extremity support
Static Standing - Level of Assistance Minimum assistance
Static Standing - Devices Hand held assist
Cognition
Arousal/Alertness Delayed responses to stimuli
Orientation Level Oriented x 4
Sensation
Light Touch RLE impaired;LLE intact
RLE Assessment
RLE Overall Strength
(strength 4/5)
LLE Assessment
LLE Overall Strength
(strength 4+/5)
Transfers 1
Transfer from 1 Supine
Transfer to 1 Sit
Transfer Level of Assistance 1 Minimum assistance
Transfers 2
Transfer from 2 Sit
Transfer to 2 Stand
Transfer Level of Assistance 2 Minimum assistance
Transfers 3

Transfer from 3 Stand
Transfer to 3 Sit
Transfer Level of Assistance 3 Minimum assistance
Transfers 4
Transfer from 4 Sit
Transfer to 4 Supine
Transfer Level of Assistance 4 Contact guard
Gait 1
Distance (ft) 1 15
Device 1
(hand held assist)
Gait Assistance 1 Moderate assistance
Deviations 1 Decreased step length - right;Decreased step length - left;Narrow base of support

Pain:
No pain indicated.

PT Functional Tests

Row Name 03/17/25 1442

AM-PAC Basic Mobility- Does the patient need help?
AM-PAC Basic Mobility yes
Turning from your back to your side while in a flat bed without using bedrails? 4
Moving from lying on your back to sitting on the side of a flat bed without using bedrails? 3
Moving to and from a bed to a chair (including a wheelchair)? 3
Standing up from a chair using your arms (e.g. wheelchair, or bedside chair)? 3
Walking in hospital room? 2
Climbing 3-5 steps with a railing?+ 2
Raw Score 17
% of impairment 50.57%

Row Name 03/17/25 1442

Modified Rankin (mRS)
Modified Rankin Score Yes

Premorbid Modified Rankin Score: 0 - The patient had no residual symptoms.

Modified Rankin Score: 4 - Moderately severe disability. Unable to attend to own bodily needs without assistance or unable to walk unassisted.

Patient Time
Start Time: 1412
End Time: 1430
Total Therapy Minutes: 18

PT Evaluation
$ Initial PT Evaluation: Moderate Complexity Eval

Cosigned by Jeffrey N Gudger, MD at 03/17/2025 3:03 PM EDT
Electronically signed by Wilson Campbell, PT at 03/17/2025 2:46 PM EDT
Electronically signed by Jeffrey N Gudger, MD at 03/17/2025 3:03 PM EDT

- **Therapy POC (Eval/Re-eval) - Madilyn Locey, CCC-SLP - 03/17/2025 10:44 AM EDT**

Formatting of this note is different from the original.
SLP Stroke Team Consult
Date: 3/17/2025

Treatment Type: Evaluation
Patient Name: Jennifer Patel
Medical Record Number: 00069679
Date of Birth: 2/11/1964

Sex: Male
Room/Bed: P411/P411-A

Therapy Diagnosis:
1. Dysarthria
2. Cognitive communication deficit

Assessment:
Presented with seemingly functional oropharyngeal swallow. Tolerated all PO trials with no overt clinical s/s of aspiration or reported difficulty. Based on today's PO trials and assessment, recommend continuance of regular solids with thin liquids given adherence to aspiration precautions listed below.

Presented with mild-moderate dysarthria in sentences and conversation and demonstrated mild-moderate cognitive communication impairments likely in the setting of acute L thalamic ICH. Benefited from implementation of clear speech strategies for dysarthria and intermittent cues to maintain attention/alertness. Motor speech and cognitive communication prognoses are fair.

Pt would continue to benefit from ongoing speech therapy services while in house and at the next level of care following discharge to continue addressing speech and cognitive communication deficits.

Recommendations
Diet recommendations: Regular, Thin liquids
Swallow Recommendations: Position patient upright for all meals, Single sips/bites, Slow rate
Medication Recommendations: Whole, With water

Recommendations for this setting: Short-term skilled SLP
Discharge Recommendations: Discharge recommendations pending (SLP services next level of care)
Further recommendations: Oral care 2x/day

Plan
Plan for next visit: motor speech tx, cognitive communication tx, and pt/caregiver education
Follow up treatments: Cognitive Therapy, Patient/family education, Speech Therapy
Frequency of Services: 1-3x/week
Treatment Duration: 1 week

Treatment Goals:
Multi-Disciplinary Problems (from Speech Language Pathology)

Active Problems

Problem: Motor Speech Start Date: 03/17/25

Goal Start Date Expected End Date End Date
LTG-To be met by discharge-Patient will be >90% comprehendible at 6ft distance in conversation with familiar and unfamiliar communication partners. 03/17/25 -- --

Goal Start Date Expected End Date End Date
STG-Patient will state and demonstrate dysarthria strategies on 80% of trials in order to facilitate clear speech. 03/17/25 -- --
Goal Details: Dysarthria strategies: Over-articulation, Pacing techniques, and Shorter phrasing

Problem: Attention Start Date: 03/17/25

Goal Start Date Expected End Date End Date
LTG-To be met by discharge-Patient will demonstrate attention sufficient to support functional language tasks. 03/17/25 -- --

Goal Start Date Expected End Date End Date
STG-Patient will demonstrate sustained attention to task for 3 minutes to support recovery of cognitive-linguistic skills. 03/17/25 -- --
Goal Details:

Problem: Memory Start Date: 03/17/25

Goal Start Date Expected End Date End Date
LTG-To be met by discharge-Patient will demonstrate memory skills sufficient to support functional language tasks or complete activities of daily living as evidenced by standardized testing or patient and/or caregiver report. 03/17/25 -- --

Goal Start Date Expected End Date End Date
STG-Patient will recall 3 target pieces of information with 66% accuracy. 03/17/25 -- --
Goal Details: After 3 minute filled delay

Madilyn Locey, CCC-SLP
03/17/25

Your signature indicates that you agree with the Plan of Care documented by the Speech Language Pathologist.

Overview
History of current condition: 61 yo M admitted on 3/16 for Left Thalamic ICH, presenting with Rt arm and leg heaviness.numbness.

Family/Caregiver Present: No

Subjective
Agreeable to SLP services. Required moderate verbal prompting throughout session to maintain alertness.

Past Medical History:
Diagnosis Date
Abnormal nuclear stress test 09/22/2021
Added automatically from request for surgery 504201
Acute gastric ulcer without hemorrhage or perforation 03/16/2024
Chronic kidney disease
Coronary artery disease
PT STATES DOES NOT HAVE CARDIO- PCP MANAGES
Diabetes mellitus (HCC)
NIDDM
Hypertension
Mini stroke
Stab wound

Past Surgical History:
Procedure Laterality Date
CARDIAC CATHETERIZATION Right 10/13/2021
Procedure: Left heart cath Right Radial; Surgeon: Yoganand J Hiremath, MD; Location: Cath Lab Spartanburg; Service: Cardiovascular; Laterality: Right; 1030for12
CHOLECYSTECTOMY
COLONOSCOPY 08/03/2023
Dr.Kobes / Pedunculated polyp found in ascending colon, mild diverticulosis in sigmoid/descending colon
ESOPHAGOGASTRODUODENOSCOPY 08/03/2023
Dr.Kobes / No abnormalities
ESOPHAGOGASTRODUODENOSCOPY 03/08/2024
Douglass
ESOPHAGOGASTRODUODENOSCOPY 01/17/2025
Malcolm - SRMC
WRIST SURGERY

Evaluation Objective
Objective Comments: RN agreeable to SLP services; reported no concerns w/ swallowing, language, and speech. Pt seen asleep and partially reclined in bed upon arrival. Roused to voice. HOB raised for PO trials. On room air. Clinical bedside swallow evaluation, Informal speech and language evaluation, and Informal cognitive communication evaluation completed. Please see grid/assessment for details. Pt left alert and partially reclined in bed with needs met/in reach. Recommendations discussed w/ RN.

Education: SLP role, SLP POC, diet recommendation/rationale, overt clinical s/s of aspiration, aspiration precautions, oral care relationship to pulmonary health, and clear speech strategies for dysarthria ; Pt demonstrated some understanding

03/17/25 1410
Oral Motor
Labial ROM Reduced right
Labial Symmetry Abnormal symmetry right
Lingual ROM Reduced right
Lingual Symmetry Deviates to right
Vocal Quality WFL
Vocal Intensity No impairment
Cognitive Linguistic Function
Attention X
Arousal/Alertness Delayed responses to stimuli
Memory X
Short-term Memory Moderate
Abstract Reasoning X
Convergent Thinking Minimal
Divergent Thinking Moderate
Safety/Judgement X
Task Initiation Delayed initiation
Cognition
Orientation Level Oriented x 4
Motor Speech
Speech intelligiblity - Conversation Impaired
(mild)
Auditory Comprehension
Yes/No Questions WFL
Commands WFL
Object Identification WFL
Conversation WFL
Verbal Expression
Primary Mode of Expression Verbal
Primary Language English
Rote language WNL
Confrontation Naming WFL
Responsive Naming WFL
Repetition WFL
Sentence Completion WFL
Open Ended Questions WFL
Conversation WFL
Bedside Assessment
Respiratory Status Room air
Behavior/Cognition Lethargic;Distractible;Requires cueing
Vision Functional for self-feeding
Baseline Vocal Quality Normal
Volitional Cough Strong
Volitional Swallow WFL
Dentition
(essentially edentulous)
Consistencies Assessed
Consistencies Assessed - Liquids Thin by straw
Results with liquid Ongoing assessment revealed:
Trials: self administered
Oral acceptance: Adequate
Labial seal: Adequate
Oral clearance: Adequate
No overt clinical s/s of aspiration appreciated across trials
Consistencies Assessed - Solids Regular
Results with solids Ongoing assessment revealed:
Trials: self administered
Oral acceptance: Adequate
Labial seal: Adequate
Bolus manipulation/mastication: Timely, Functional
Oral clearance: Adequate
No overt clinical s/s of aspiration appreciated across trials

Functional Tests

Row Name 03/17/25 1408

Dysphagia Outcome and Severity Scale (DOSS)
Dysphagia Outcome and Severity Scale (DOSS) 7-CH

Row Name 03/17/25 1408

Other Functional Tests
Other functional tests performed yes
Additional functional test #1 informal speech, language, cognitive evaluation

Patient Time
Start Time: 1029
End Time: 1047
Total Therapy Minutes: 18

SLP Evaluation
$ Swallowing Assessment: Procedure
$ Sound Production w/Eval of Language Comp/Exp: Procedure

Cosigned by Jeffrey N Gudger, MD at 03/17/2025 3:03 PM EDT
Electronically signed by Madilyn Locey, CCC-SLP at 03/17/2025 2:25 PM EDT
Electronically signed by Jeffrey N Gudger, MD at 03/17/2025 3:03 PM EDT

- **POC & Treatment Note - Tyler T Rembowski, RN - 03/17/2025 6:09 AM EDT**

Formatting of this note might be different from the original.
Patient remains a Riker 4 on no sedation, ANO x4, follows commands, reflexes intact, afebrile, and PERRL. Adequate oxygenation and saturation on RA. NSR with 1st HB with BP supported by Cardene and SBP </=160 and DBP </=100. No BM on shift with nutrition being supported. Adequate UOP on shift. Skin integrity remains unchanged. Continue with monitoring and current plan.

Tyler T Rembowski, RN

Problem: Activity:
Goal: Ability to perform activities at highest level will be supported
Outcome: Progressing

Problem: Bowel/Gastric:
Goal: Will not experience complications related to bowel motility
Outcome: Progressing

Problem: Cardiac:
Goal: Will achieve and/or maintain adequate cardiac output
Outcome: Progressing

Problem: Fluid Volume:
Goal: Will achieve and/or maintain a balanced intake and output
Outcome: Progressing

Problem: Medication:
Goal: Will comply/adhere with prescribed medication regimen
Outcome: Progressing

Problem: Nutritional:
Goal: Nutritional status will be supported
Outcome: Progressing

Problem: Respiratory:
Goal: Will maintain a patent airway
Outcome: Progressing

Problem: Safety:

Goal: Will remain free from injury
Outcome: Progressing

Problem: Skin Integrity:
Goal: Skin integrity will be maintained
Outcome: Progressing

Problem: Safety:
Goal: Will remain free from falls
Outcome: Progressing

Problem: Activity - Level 4:
Goal: Dynamic and static standing balance will improve
Outcome: Progressing

Electronically signed by Tyler T Rembowski, RN at 03/17/2025 6:11 AM EDT

- **POC & Treatment Note - Enreicika Huey, RN - 03/16/2025 6:37 PM EDT**

Formatting of this note might be different from the original.

Problem: Activity:
Goal: Ability to perform activities at highest level will be supported
Outcome: Progressing

Problem: Bowel/Gastric:
Goal: Will not experience complications related to bowel motility
Outcome: Progressing

Problem: Cardiac:
Goal: Will achieve and/or maintain adequate cardiac output
Outcome: Progressing

Problem: Cognitive:
Goal: Knowledge of disease or condition and prescribed therapeutic regimen will improve
Outcome: Progressing

Problem: Coping:
Goal: Level of anxiety will be controlled/managed
Outcome: Progressing

Problem: Fluid Volume:
Goal: Will achieve and/or maintain a balanced intake and output
Outcome: Progressing

Problem: Medication:
Goal: Will comply/adhere with prescribed medication regimen
Outcome: Progressing

Problem: Nutritional:
Goal: Nutritional status will be supported
Outcome: Progressing

Problem: Activity - Level 2:
Goal: Bed mobility will improve
Outcome: Progressing

Problem: Cognitive - Stroke Education:
Goal: Understanding of discharge needs will improve
Outcome: Progressing

Electronically signed by Enreicika Huey, RN at 03/16/2025 6:37 PM EDT

[11]. documented in this encounter

Plan of Treatment

Upcoming Encounters

Date	Type	Department	Care Team (Latest Contact Info)	Description
11/13/2025 1:30 PM EST	Office Visit	SMC Neurology Spartanburg 1650 Skylyn Dr. Suite 200	**Jhunjhunwala, Ketan R, MD** 2755 Hwy 14	

Date	Type	Department	Care Team (Latest Contact Info)	Description
		SPARTANBURG, SC 29307-3077 864-560-4500	Suite 1450 GREER, SC 29650 864-849-9350 (Work)	
11/17/2025 9:30 AM EST	Office Visit	MGC Family Medicine Boiling Springs 3981 Hwy 9 Boiling Springs, SC 29316-7415 864-560-3650	**Renner, Alison, DO** 3981 Highway 9 BOILING SPRINGS, SC 29316-7415 864-560-3650 (Work) 864-560-3675 (Fax)	

Scheduled Referrals

Name	Type	Priority	Associated Diagnoses	Order Schedule
Ambulatory referral to Home Health	Outpatient Referral	Routine	Dysarthria	Expected: 03/20/2025, Expires: 09/18/2025

[12]. documented as of this encounter

Procedures

Procedure Name	Priority	Date/Time	Associated Diagnosis	Comments
CBC	Routine	03/18/2025 4:06 AM EDT		**Results for this procedure are in the results section.**
PHOSPHORUS	Routine	03/18/2025 4:06 AM EDT		**Results for this procedure are in the results section.**
MAGNESIUM	Routine	03/18/2025 4:06 AM EDT		**Results for this procedure are in the results section.**
BASIC METABOLIC PANEL	Routine	03/18/2025 4:06 AM EDT		**Results for this procedure are in the results section.**
TROPONIN HS SINGLE	Routine	03/17/2025 9:07 AM EDT		**Results for this procedure are in the results section.**
CBC	ASAP	03/17/2025 9:07 AM EDT		**Results for this procedure are in the results section.**
PHOSPHORUS	ASAP	03/17/2025 9:07 AM EDT		**Results for this procedure are in the results section.**
MAGNESIUM	ASAP	03/17/2025 9:07 AM EDT		**Results for this procedure are in the results section.**
BASIC METABOLIC PANEL	ASAP	03/17/2025 9:07 AM EDT		**Results for this procedure are in the results section.**

Procedure Name	Priority	Date/Time	Associated Diagnosis	Comments
MRI BRAIN WITH AND WITHOUT CONTRAST	Routine	03/17/2025 3:13 AM EDT		**Results for this procedure are in the results section.**
CT HEAD WITHOUT CONTRAST	Routine	03/16/2025 5:00 PM EDT		**Results for this procedure are in the results section.**
POC BLOOD GLUCOSE	Routine	03/16/2025 2:35 PM EDT		**Results for this procedure are in the results section.**

[13]. documented in this encounter

Results

- (ABNORMAL) CBC (03/18/2025 4:06 AM EDT)

Component	Value	Ref Range	Test Method	Analysis Time	Performed At	Pathologist Signature
WBC	7.9	4.0 - 11.0 10*3/uL		03/18/2025 4:47 AM EDT	SPARTANBURG MEDICAL CENTER	
RBC	3.91 (L)	4.50 - 5.90 10*6/uL		03/18/2025 4:47 AM EDT	SPARTANBURG MEDICAL CENTER	
HGB	10.5 (L)	13.0 - 16.5 g/dL		03/18/2025 4:47 AM EDT	SPARTANBURG MEDICAL CENTER	
HCT	31.6 (L)	39.0 - 50.0 %		03/18/2025 4:47 AM EDT	SPARTANBURG MEDICAL CENTER	
MCV	80.8	80.0 - 100.0 fL		03/18/2025 4:47 AM EDT	SPARTANBURG MEDICAL CENTER	
MCH	26.8	25.0 - 35.0 pg		03/18/2025 4:47 AM EDT	SPARTANBURG MEDICAL CENTER	
MCHC	33.1	32.0 - 36.0 g/dL		03/18/2025 4:47 AM EDT	SPARTANBURG MEDICAL CENTER	
RDW	17.7 (H)	0.0 - 15.0 %		03/18/2025 4:47 AM EDT	SPARTANBURG MEDICAL CENTER	
Platelets	277	135 - 400 10*3/uL		03/18/2025 4:47 AM EDT	SPARTANBURG MEDICAL CENTER	

Specimen (Source)	Anatomical Location / Laterality	Collection Method / Volume	Collection Time	Received Time
Blood	Blood specimen / Unknown	Venipuncture / Unknown	03/18/2025 4:06 AM EDT	03/18/2025 4:34 AM EDT

Narrative

Authorizing Provider	Result Type	Result Status
Hannah Nussman Shue NP	LAB BLOOD ORDERABLES	Final Result

Performing Organization	Address	City/State/ZIP Code	Phone Number
SPARTANBURG MEDICAL CENTER	101 East Wood St	Spartanburg, SC 29303, US	864-560-6212

- **Phosphorus (03/18/2025 4:06 AM EDT)**

Component	Value	Ref Range	Test Method	Analysis Time	Performed At	Pathologist Signature
PHOSPHOROUS	2.9	2.8 - 4.5 mg/dL		03/18/2025 5:01 AM EDT	SPARTANBURG MEDICAL CENTER	

Specimen (Source)	Anatomical Location / Laterality	Collection Method / Volume	Collection Time	Received Time
Blood	Blood specimen / Unknown	Venipuncture / Unknown	03/18/2025 4:06 AM EDT	03/18/2025 4:34 AM EDT

Narrative

Authorizing Provider	Result Type	Result Status
Hannah Nussman Shue NP	LAB BLOOD ORDERABLES	Final Result

Performing Organization	Address	City/State/ZIP Code	Phone Number
SPARTANBURG MEDICAL CENTER	101 East Wood St	Spartanburg, SC 29303, US	864-560-6212

- **Magnesium (03/18/2025 4:06 AM EDT)**

Component	Value	Ref Range	Test Method	Analysis Time	Performed At	Pathologist Signature
MAGNESIUM	1.9	1.6 - 2.3 mg/dL		03/18/2025 5:01 AM EDT	SPARTANBURG MEDICAL CENTER	

Specimen (Source)	Anatomical Location / Laterality	Collection Method / Volume	Collection Time	Received Time
Blood	Blood specimen / Unknown	Venipuncture / Unknown	03/18/2025 4:06 AM EDT	03/18/2025 4:34 AM EDT

Narrative

Authorizing Provider	Result Type	Result Status
Hannah Nussman Shue NP	LAB BLOOD ORDERABLES	Final Result

Performing Organization	Address	City/State/ZIP Code	Phone Number
SPARTANBURG MEDICAL CENTER	101 East Wood St	Spartanburg, SC 29303, US	864-560-6212

- (ABNORMAL) Basic metabolic panel (03/18/2025 4:06 AM EDT)

Component	Value	Ref Range	Test Method	Analysis Time	Performed At	Pathologist Signature
Sodium	142	135 - 145 mmol/L		03/18/2025 5:01 AM EDT	SPARTANBURG MEDICAL CENTER	
Potassium	3.7	3.5 - 5.2 mmol/L		03/18/2025 5:01 AM EDT	SPARTANBURG MEDICAL CENTER	
Chloride	110 (H)	96 - 106 mmol/L		03/18/2025 5:01 AM EDT	SPARTANBURG MEDICAL CENTER	
Carbon Dioxide	25.0	22.0 - 29.0 mmol/L		03/18/2025 5:01 AM EDT	SPARTANBURG MEDICAL CENTER	
Anion Gap	7	6 - 13 mmol/L		03/18/2025 5:01 AM EDT	SPARTANBURG MEDICAL CENTER	
Urea Nitrogen	20	7 - 23 mg/dL		03/18/2025 5:01 AM EDT	SPARTANBURG MEDICAL CENTER	

Component	Value	Ref Range	Test Method	Analysis Time	Performed At	Pathologist Signature
Creatinine	1.91 (H)	0.70 - 1.30 mg/dL		03/18/2025 5:01 AM EDT	SPARTANBURG MEDICAL CENTER	
BUN/Creat Ratio	10.47	8.00 - 20.00 NULL		03/18/2025 5:01 AM EDT	SPARTANBURG MEDICAL CENTER	
eGFR	39.4 (L)	>60.0 mL/min/1.73m*2		03/18/2025 5:01 AM EDT	SPARTANBURG MEDICAL CENTER	
Comment: eGFR calculation is based on the NKF/ASN CKD-EPI 2021 equation						
Glucose	185 (H)	70 - 99 mg/dL		03/18/2025 5:01 AM EDT	SPARTANBURG MEDICAL CENTER	
Calcium	8.7	8.5 - 10.2 mg/dL		03/18/2025 5:01 AM EDT	SPARTANBURG MEDICAL CENTER	
Modified Cockcroft-Gault CrCl				03/18/2025 5:01 AM EDT	SPARTANBURG MEDICAL CENTER	
Osmolality Calculation	301.42	271.00 - 318.00 mOsm/kg		03/18/2025 5:01 AM EDT	SPARTANBURG MEDICAL CENTER	

Specimen (Source)	Anatomical Location / Laterality	Collection Method / Volume	Collection Time	Received Time
Blood	Blood specimen / Unknown	Venipuncture / Unknown	03/18/2025 4:06 AM EDT	03/18/2025 4:34 AM EDT

Narrative

Authorizing Provider	Result Type	Result Status
Hannah Nussman Shue NP	LAB BLOOD ORDERABLES	Final Result

Performing Organization	Address	City/State/ZIP Code	Phone Number
SPARTANBURG MEDICAL CENTER	101 East Wood St	Spartanburg, SC 29303, US	864-560-6212

- (ABNORMAL) CBC (03/17/2025 9:07 AM EDT)

Component	Value	Ref Range	Test Method	Analysis Time	Performed At	Pathologist Signature
WBC	9.4	4.0 - 11.0 10*3/uL		03/17/2025 9:55 AM EDT	SPARTANBURG MEDICAL CENTER	
RBC	4.14 (L)	4.50 - 5.90 10*6/uL		03/17/2025 9:55 AM EDT	SPARTANBURG MEDICAL CENTER	
HGB	10.6 (L)	13.0 - 16.5 g/dL		03/17/2025 9:55 AM EDT	SPARTANBURG MEDICAL CENTER	
HCT	33.2 (L)	39.0 - 50.0 %		03/17/2025 9:55 AM EDT	SPARTANBURG MEDICAL CENTER	
MCV	80.2	80.0 - 100.0 fL		03/17/2025 9:55 AM EDT	SPARTANBURG MEDICAL CENTER	
MCH	25.5	25.0 - 35.0 pg		03/17/2025 9:55 AM EDT	SPARTANBURG MEDICAL CENTER	
MCHC	31.9 (L)	32.0 - 36.0 g/dL		03/17/2025 9:55 AM EDT	SPARTANBURG MEDICAL CENTER	

Component	Value	Ref Range	Test Method	Analysis Time	Performed At	Pathologist Signature
RDW	18.0 (H)	0.0 - 15.0 %		03/17/2025 9:55 AM EDT	SPARTANBURG MEDICAL CENTER	
Platelets	301	135 - 400 10*3/uL		03/17/2025 9:55 AM EDT	SPARTANBURG MEDICAL CENTER	

Specimen (Source)	Anatomical Location / Laterality	Collection Method / Volume	Collection Time	Received Time
Blood	Blood specimen / Unknown	Venipuncture / Unknown	03/17/2025 9:07 AM EDT	03/17/2025 9:48 AM EDT

Narrative

Authorizing Provider	Result Type	Result Status
Hannah Nussman Shue NP	LAB BLOOD ORDERABLES	Final Result

Performing Organization	Address	City/State/ZIP Code	Phone Number
SPARTANBURG MEDICAL CENTER	101 East Wood St	Spartanburg, SC 29303, US	864-560-6212

- **Magnesium (03/17/2025 9:07 AM EDT)**

Component	Value	Ref Range	Test Method	Analysis Time	Performed At	Pathologist Signature
MAGNESIUM	1.8	1.6 - 2.3 mg/dL		03/17/2025 10:13 AM EDT	SPARTANBURG MEDICAL CENTER	

Specimen (Source)	Anatomical Location / Laterality	Collection Method / Volume	Collection Time	Received Time
Blood	Blood specimen / Unknown	Venipuncture / Unknown	03/17/2025 9:07 AM EDT	03/17/2025 9:48 AM EDT

Narrative

Authorizing Provider	Result Type	Result Status
Hannah Nussman Shue NP	LAB BLOOD ORDERABLES	Final Result

Performing Organization	Address	City/State/ZIP Code	Phone Number
SPARTANBURG MEDICAL CENTER	101 East Wood St	Spartanburg, SC 29303, US	864-560-6212

- **Phosphorus (03/17/2025 9:07 AM EDT)**

Component	Value	Ref Range	Test Method	Analysis Time	Performed At	Pathologist Signature
PHOSPHOROUS	2.8	2.8 - 4.5 mg/dL		03/17/2025 10:13 AM EDT	SPARTANBURG MEDICAL CENTER	

Specimen (Source)	Anatomical Location / Laterality	Collection Method / Volume	Collection Time	Received Time
Blood	Blood specimen / Unknown	Venipuncture / Unknown	03/17/2025 9:07 AM EDT	03/17/2025 9:48 AM EDT

Narrative

Authorizing Provider	Result Type	Result Status
Hannah Nussman Shue NP	LAB BLOOD ORDERABLES	Final Result

Performing Organization	Address	City/State/ZIP Code	Phone Number
SPARTANBURG MEDICAL CENTER	101 East Wood St	Spartanburg, SC 29303, US	864-560-6212

- (ABNORMAL) Basic metabolic panel (03/17/2025 9:07 AM EDT)

Component	Value	Ref Range	Test Method	Analysis Time	Performed At	Pathologist Signature
Sodium	141	135 - 145 mmol/L		03/17/2025 10:13 AM EDT	SPARTANBURG MEDICAL CENTER	
Potassium	3.4 (L)	3.5 - 5.2 mmol/L		03/17/2025 10:13 AM EDT	SPARTANBURG MEDICAL CENTER	
Chloride	106	96 - 106 mmol/L		03/17/2025 10:13 AM EDT	SPARTANBURG MEDICAL CENTER	
Carbon Dioxide	26.2	22.0 - 29.0 mmol/L		03/17/2025 10:13 AM EDT	SPARTANBURG MEDICAL CENTER	
Anion Gap	9	6 - 13 mmol/L		03/17/2025 10:13 AM EDT	SPARTANBURG MEDICAL CENTER	
Urea Nitrogen	19	7 - 23 mg/dL		03/17/2025 10:13 AM EDT	SPARTANBURG MEDICAL CENTER	
Creatinine	1.58 (H)	0.70 - 1.30 mg/dL		03/17/2025 10:13 AM EDT	SPARTANBURG MEDICAL CENTER	
BUN/Creat Ratio	12.03	8.00 - 20.00 NULL		03/17/2025 10:13 AM EDT	SPARTANBURG MEDICAL CENTER	
eGFR	49.5 (L)	>60.0 mL/min/1.73m*2		03/17/2025 10:13 AM EDT	SPARTANBURG MEDICAL CENTER	
Glucose	184 (H)	70 - 99 mg/dL		03/17/2025 10:13 AM EDT	SPARTANBURG MEDICAL CENTER	
Calcium	8.8	8.5 - 10.2 mg/dL		03/17/2025 10:13 AM EDT	SPARTANBURG MEDICAL CENTER	
Modified Cockcroft-Gault CrCl				03/17/2025 10:13 AM EDT	SPARTANBURG MEDICAL CENTER	
Osmolality Calculation	299.01	271.00 - 318.00 mOsm/kg		03/17/2025 10:13 AM EDT	SPARTANBURG MEDICAL CENTER	

Specimen (Source)	Anatomical Location / Laterality	Collection Method / Volume	Collection Time	Received Time
Blood	Blood specimen / Unknown	Venipuncture / Unknown	03/17/2025 9:07 AM EDT	03/17/2025 9:48 AM EDT

Narrative

Authorizing Provider	Result Type	Result Status
Hannah Nussman Shue NP	LAB BLOOD ORDERABLES	Final Result

Performing Organization	Address	City/State/ZIP Code	Phone Number
SPARTANBURG MEDICAL CENTER	101 East Wood St	Spartanburg, SC 29303, US	864-560-6212

- (ABNORMAL) Troponin HS Single (03/17/2025 9:07 AM EDT)

Component	Value	Ref Range	Test Method	Analysis Time	Performed At	Pathologist Signature
Troponin High Sensitivity	734 (HH)	See Comment pg/mL		03/17/2025 10:23 AM EDT	SPARTANBURG MEDICAL CENTER	

Comment:
A single value of HS-TnI <18 pg/ml has a 99% predictive value for healthy adults.
A single HS-TnI value >/=50 pg/ml has a high positive predictive value for Acute Coronary Syndrome and is a critical value.
A rise in HS-TnI value from time 0 to 1 hour or time 0 to 3 hours of >/=15 pg/ml has a high positive predictive value for ACS and is a critical value.

Specimen (Source)	Anatomical Location / Laterality	Collection Method / Volume	Collection Time	Received Time
Blood	Blood specimen / Unknown	Venipuncture / Unknown	03/17/2025 9:07 AM EDT	03/17/2025 9:48 AM EDT

Narrative

Authorizing Provider	Result Type	Result Status
Hannah Nussman Shue NP	LAB BLOOD ORDERABLES	Final Result

Performing Organization	Address	City/State/ZIP Code	Phone Number
SPARTANBURG MEDICAL CENTER	101 East Wood St	Spartanburg, SC 29303, US	864-560-6212

- **MRI BRAIN WITH AND WITHOUT CONTRAST (03/17/2025 3:13 AM EDT)**

Anatomical Region	Laterality	Modality
Head and Neck		Magnetic Resonance

Specimen (Source)	Anatomical Location / Laterality	Collection Method / Volume	Collection Time	Received Time

Impressions

03/17/2025 9:24 AM EDT

Impression:

1. Stable left thalamic intraparenchymal hematoma with otherwise age-related senescent changes and chronic microangiopathy.
2. Bilateral mastoiditis and mild sphenoid sinusitis.

CPT Code: 70551

Note to Patient: If you have questions regarding this report, please contact your primary heath care provider.

Narrative

03/17/2025 9:24 AM EDT

Exam: MRI BRAIN WITH AND WITHOUT CONTRAST on 3/17/2025 3:13 AM EDT.

Clinical History: The Male patient is 61 years old presenting for right arm heaviness and right leg heaviness.

Technique: Multiplanar and multisequence pre contrast as well as post contrast T1 weighted imaging of the brain was performed.

Total contrast dose:

Narrative

1. GADOBUTROL 1 MMOL/ML (604.72 MG/ML) INTRAVENOUS SOLUTION 6 mL

Comparison: Head CT 3/16/2025

Findings:

Stable known left thalamic hematoma. Otherwise age-related senescent changes and chronic periventricular white matter disease with scattered lacunae throughout the basal ganglia, thalami, as well as corona radiata and centrum semiovale. There are
additional few foci of chronic hemosiderin deposition from remote microhemorrhage most notably within the right thalamic nucleus and along the posterior left frontal parietal convexity. No evidence of restricted diffusion is seen to suggest acute
ischemia.

There are no areas of abnormal enhancement. There are no abnormal extra-axial fluid collections. No evidence of mass or mass effect is seen. Expected flow voids are maintained in the major intracranial vessels.

There are mild cerebellar involutional changes with chronic lacunae. Mild to moderate microvascular disease throughout the pons. There is no evidence of Chiari malformation.

The ventricular system and CSF containing spaces are unremarkable in appearance.

Visualized extracranial soft tissues are unremarkable.

There is fluid signal throughout the mastoid air cells and layering in the sphenoid sinus.

Procedure Note

Haas, Stephan O, MD - 03/17/2025

Formatting of this note might be different from the original.

Exam: MRI BRAIN WITH AND WITHOUT CONTRAST on 3/17/2025 3:13 AM EDT.

Clinical History: The Male patient is 61 years old presenting for right arm heaviness and right leg heaviness.

Technique: Multiplanar and multisequence pre contrast as well as post contrast T1 weighted imaging of the brain was performed.

Total contrast dose:
1. GADOBUTROL 1 MMOL/ML (604.72 MG/ML) INTRAVENOUS SOLUTION 6 mL

Comparison: Head CT 3/16/2025

Findings:

Stable known left thalamic hematoma. Otherwise age-related senescent changes and chronic periventricular white matter disease with scattered lacunae throughout the basal ganglia, thalami, as well as corona radiata and centrum semiovale. There are
additional few foci of chronic hemosiderin deposition from remote microhemorrhage most notably within the right thalamic nucleus and along the posterior left frontal parietal convexity. No evidence of restricted diffusion is seen to suggest acute
ischemia.

There are no areas of abnormal enhancement. There are no abnormal extra-axial fluid collections. No evidence of mass or mass effect is seen. Expected flow voids are maintained in the major intracranial vessels.

There are mild cerebellar involutional changes with chronic lacunae. Mild to moderate microvascular disease throughout the pons. There is no evidence of Chiari malformation.

The ventricular system and CSF containing spaces are unremarkable in appearance.

Visualized extracranial soft tissues are unremarkable.

There is fluid signal throughout the mastoid air cells and layering in the sphenoid sinus.

IMPRESSION
Impression:

1. Stable left thalamic intraparenchymal hematoma with otherwise age-related senescent changes and chronic microangiopathy.
2. Bilateral mastoiditis and mild sphenoid sinusitis.

Procedure Note

CPT Code: 70551

Note to Patient: If you have questions regarding this report, please contact your primary heath care provider.

Authorizing Provider	Result Type	Result Status
Ryan Lapointe MD	IMG MRI PROCEDURES	Final Result

- **CT HEAD WITHOUT CONTRAST (03/16/2025 5:00 PM EDT)**

Anatomical Region	Laterality	Modality
Head		Computed Tomography

Specimen (Source)	Anatomical Location / Laterality	Collection Method / Volume	Collection Time	Received Time

Impressions

03/16/2025 5:11 PM EDT

IMPRESSION:
1. Stable known left thalamic parenchymal hemorrhage..
2. Atherosclerosis

Narrative

03/16/2025 5:11 PM EDT

EXAMINATION: CT HEAD WITHOUT CONTRAST 3/16/2025 4:58 PM EDT

ACCESSION NUMBER: E7340076

COMPARISON: 3/16/2025

INDICATION: 1. Nontraumatic intracerebral hemorrhage in hemisphere, cortical
2. Hypertensive emergency
3. Nontraumatic intracerebral hemorrhage, unspecified

TECHNIQUE: Multiple-row detector helical CT examination of the head without intravenous contrast.

Radiation dose reduction techniques were used for this study. Our CT scanners use one or all of the following: Automated exposure control, adjustment of the mA and/or kV according to patient size, iterative reconstruction.

FINDINGS:
Brain: Again seen is a hypodense focus in the left thalamus. This is unchanged measuring 1.5 x 1.2 cm. There is no new hemorrhage. There is no distinct mass. There is no extra-axial fluid collection.

Ventricles: Normal

Vasculature: Calcifications are seen in the intracranial internal carotid arteries.

Bones: Normal

Surrounding soft tissues: Normal

Procedure Note

Person, Luther, MD - 03/16/2025

Formatting of this note might be different from the original.

Procedure Note
EXAMINATION: CT HEAD WITHOUT CONTRAST 3/16/2025 4:58 PM EDT ACCESSION NUMBER: E7340076 COMPARISON: 3/16/2025 INDICATION: 1. Nontraumatic intracerebral hemorrhage in hemisphere, cortical 2. Hypertensive emergency 3. Nontraumatic intracerebral hemorrhage, unspecified TECHNIQUE: Multiple-row detector helical CT examination of the head without intravenous contrast. Radiation dose reduction techniques were used for this study. Our CT scanners use one or all of the following: Automated exposure control, adjustment of the mA and/or kV according to patient size, iterative reconstruction. FINDINGS: Brain: Again seen is a hypodense focus in the left thalamus. This is unchanged measuring 1.5 x 1.2 cm. There is no new hemorrhage. There is no distinct mass. There is no extra-axial fluid collection. Ventricles: Normal Vasculature: Calcifications are seen in the intracranial internal carotid arteries. Bones: Normal Surrounding soft tissues: Normal IMPRESSION IMPRESSION: 1. Stable known left thalamic parenchymal hemorrhage.. 2. Atherosclerosis

Authorizing Provider	Result Type	Result Status
Ryan Lapointe MD	IMG CT PROCEDURES	Final Result

- (ABNORMAL) POC Blood Glucose (03/16/2025 2:35 PM EDT)

Component	Value	Ref Range	Test Method	Analysis Time	Performed At	Pathologist Signature
Whole Blood Glucose	172 (H)	70 - 100 mg/dL		03/16/2025 2:36 PM EDT	SPARTANBURG MEDICAL CENTER	
Collector ID	105147			03/16/2025 2:36 PM EDT	SPARTANBURG MEDICAL CENTER	

Specimen (Source)	Anatomical Location / Laterality	Collection Method / Volume	Collection Time	Received Time
Blood	Capillary blood / Unknown		03/16/2025 2:35 PM EDT	03/16/2025 2:36 PM EDT

Narrative

Authorizing Provider	Result Type	Result Status
Ryan Lapointe MD	LAB POCT ORDERABLES - DEVICE	Final Result

Performing Organization	Address	City/State/ZIP Code	Phone Number
SPARTANBURG MEDICAL CENTER	101 East Wood St	Spartanburg, SC 29303, US	864-560-6212

[14]. documented in this encounter

Visit Diagnoses

Diagnosis
ICH (intracerebral hemorrhage) (HCC) - Primary

Diagnosis
Intracerebral hemorrhage
Dysarthria
Cognitive communication deficit
Impaired mobility Other ill-defined conditions
Impaired mobility and activities of daily living
Nontraumatic cortical hemorrhage of left cerebral hemisphere (HCC)
Nontraumatic cortical hemorrhage of left cerebral hemisphere (HCC) Hypertensive emergency

[15]. documented in this encounter

Admitting Diagnoses

Diagnosis
ICH (intracerebral hemorrhage) (HCC) Intracerebral hemorrhage

[16]. documented in this encounter

Administered Medications

Inactive Administered Medications - up to 3 most recent administrations

Medication Order	MAR Action	Action Date	Dose	Rate	Site
amLODIPine (use for NORVASC) tablet 10 mg 10 mg, Oral, Daily, First dose on Sun 3/16/25 at 1600	Given	03/20/2025 8:00 AM EDT	10 mg		
	Given	03/19/2025 8:13 AM EDT	10 mg		
	Given	03/18/2025 8:47 AM EDT	10 mg		
atorvastatin (use for LIPITOR) tablet 40 mg 40 mg, Oral, Nightly, First dose on Sun 3/16/25 at 2100	Given	03/19/2025 8:36 PM EDT	40 mg		
	Given	03/18/2025 8:56 PM EDT	40 mg		
	Given	03/17/2025 8:51 PM EDT	40 mg		
carvediloL (use for COREG) tablet 12.5 mg 12.5 mg, Oral, 2 times daily with meals, First dose on Sun 3/16/25 at 1700	Given	03/16/2025 4:50 PM EDT	12.5 mg		
carvediloL (use for COREG) tablet 25 mg	Given	03/20/2025 8:00 AM EDT	25 mg		

Medication Order	MAR Action	Action Date	Dose	Rate	Site
25 mg, Oral, 2 times daily with meals, First dose (after last modification) on Mon 3/17/25 at 0900	Given	03/19/2025 4:18 PM EDT	25 mg		
	Given	03/19/2025 8:13 AM EDT	25 mg		
gadobutroL (Gadavist) injection 6 mL 6 mL, Intravenous, Once in imaging, contrast, Starting on Mon 3/17/25 at 0300	Given	03/17/2025 3:00 AM EDT	6 mL		
hydrALAZINE (use for APRESOLINE) injection 20 mg 20 mg, Intravenous, Every 6 hours PRN, high blood pressure, Starting on Mon 3/17/25 at 1134	Given	03/17/2025 2:11 PM EDT	20 mg		
hydrALAZINE (use for APRESOLINE) tablet 100 mg 100 mg, Oral, Every 8 hours, First dose (after last modification) on Wed 3/19/25 at 1600	Given	03/20/2025 8:00 AM EDT	100 mg		
	Given	03/20/2025 12:03 AM EDT	100 mg		
	Given	03/19/2025 4:18 PM EDT	100 mg		
hydrALAZINE (use for APRESOLINE) tablet 25 mg 25 mg, Oral, Every 8 hours, First dose on Mon 3/17/25 at 1300	Given	03/18/2025 8:46 AM EDT	25 mg		
	Given	03/18/2025 12:43 AM EDT	25 mg		
	Given	03/17/2025 3:54 PM EDT	25 mg		
hydrALAZINE (use for APRESOLINE) tablet 50 mg 50 mg, Oral, Every 8 hours, First dose (after last modification) on Tue 3/18/25 at 1700	Given	03/19/2025 8:13 AM EDT	50 mg		
	Given	03/18/2025 11:24 PM EDT	50 mg		
	Given	03/18/2025 4:57 PM EDT	50 mg		
labetaloL (use for TRANDATE) injection 20 mg 20 mg, Intravenous, Every 6 hours PRN, high blood pressure, Systolic BP over 160 or Diastolic BP over 100, Starting on Sun 3/16/25 at 1510, Lowers heart rate. May hold if less than 40. Monitor blood pressure--IVP: before dose and 5 and 10 minutes after each injection. Drip: every 5 minutes during. Bolus dose may be administered IV push at a max rate of 10 mg/minute.	Given	03/16/2025 8:29 PM EDT	20 mg		
	Given	03/16/2025 3:55 PM EDT	20 mg		
labetaloL (use for TRANDATE) injection 20 mg 20 mg, Intravenous, Every 4 hours PRN, high blood pressure, Systolic BP over 160	Given	03/17/2025 2:07 AM EDT	20 mg		

Medication Order	MAR Action	Action Date	Dose	Rate	Site
or Diastolic BP over 100, Starting on Sun 3/16/25 at 2102, Lowers heart rate. May hold if less than 40. Monitor blood pressure--IVP: before dose and 5 and 10 minutes after each injection. Drip: every 5 minutes during. Bolus dose may be administered IV push at a max rate of 10 mg/minute.					
losartan (use for COZAAR) tablet 50 mg 50 mg, Oral, Every 12 hours, First dose on Sun 3/16/25 at 2100	Given	03/20/2025 8:01 AM EDT	50 mg		
	Given	03/19/2025 8:36 PM EDT	50 mg		
	Given	03/19/2025 8:13 AM EDT	50 mg		
niCARdipine in sodium chloride 0.9% (use for CARDENE) 20 mg/200 mL (0.1 mg/mL) IVPB premix 0-15 mg/hr (0-150 mL/hr), Intravenous, Continuous, Starting on Sun 3/16/25 at 1600, Initiation: Initiate at 5 mg/hr. Titration: Titrate by 2.5 mg/hr every 15 minutes. Titration Goal: SBP < 160 Maximum: Do not exceed maximum rate on the order. Notify Physician: SBP < 90 mmHg Peripheral infusion sites should be changed every 12 hours to minimize venous irritation. TITRATABLE INFUSION: For use only in critical care units: SMC-CS Pavilion 4, Pavilion 5, CCU, CVRU, ICU Overflow; PMC ICU; SMC-MB ICU; CMC ICU; SHRC ICU NON-TITRATABLE INFUSION: use is ONLY approved in the Following units: SMC-CS 4 Heart, 5 Heart, 5 Main, RTU, and Pavilion 6 OR in these critical care units: SMC-CS Pavilion 4, Pavilion 5, CCU, CVRU, ICU Overflow; PMC ICU; SMC-MB ICU; CMC ICU; SHRC ICU	New Bag	03/17/2025 5:10 AM EDT	2.5 mg/hr	25 mL/hr	
	Restarted	03/17/2025 3:34 AM EDT	2.5 mg/hr	25 mL/hr	
	Rate/Dose Change	03/16/2025 11:05 PM EDT	2.5 mg/hr	25 mL/hr	
ondansetron (PF) (use for ZOFRAN) injection 4 mg 4 mg, Intravenous, Every 6 hours PRN, nausea, vomiting, Starting on Sun 3/16/25 at 1409, If IV PUSH- give over 2-5 minutes. Caution: may prolong QT interval.					
pantoprazole (use for PROTONIX) EC tablet 40 mg 40 mg, Oral, Daily, First dose on Mon 3/17/25 at 0900, Do not crush.	Given	03/20/2025 8:01 AM EDT	40 mg		
	Given	03/19/2025 8:13 AM EDT	40 mg		
	Given	03/18/2025 8:47 AM EDT	40 mg		

[17]. documented in this encounter

Active and Recently Administered Medications

Times are shown in EDT.

	Scheduled		
Medication Order	03/18/2025	03/19/2025	03/20/2025

Medication Order	03/18/2025	03/19/2025	03/20/2025
amLODIPine (use for NORVASC) tablet 10 mg 10 mg, Oral, Daily, First dose on Sun 3/16/25 at 1600	• 0847 (Given - Provider: Victoria A Dimov, RN)	• 0813 (Given - Provider: Kayla B Sylvester, RN)	• 0800 (Given - Provider: Abby Green, RN)
atorvastatin (use for LIPITOR) tablet 40 mg 40 mg, Oral, Nightly, First dose on Sun 3/16/25 at 2100	• 2056 (Given - Provider: Addie Ledbetter, RN)	• 2036 (Given - Provider: Jasmeen Kaur, RN)	
carvediloL (use for COREG) tablet 25 mg 25 mg, Oral, 2 times daily with meals, First dose (after last modification) on Mon 3/17/25 at 0900	• 0846 (Given - Provider: Victoria A Dimov, RN) • 1657 (Given - Provider: Victoria A Dimov, RN)	• 0813 (Given - Provider: Kayla B Sylvester, RN) • 1618 (Given - Provider: Kayla B Sylvester, RN)	• 0800 (Given - Provider: Abby Green, RN)
hydrALAZINE (use for APRESOLINE) tablet 100 mg 100 mg, Oral, Every 8 hours, First dose (after last modification) on Wed 3/19/25 at 1600		• 1618 (Given - Provider: Kayla B Sylvester, RN)	• 0003 (Given - Provider: Jasmeen Kaur, RN) • 0800 (Given - Provider: Abby Green, RN)
hydrALAZINE (use for APRESOLINE) tablet 25 mg (CANCELED) 25 mg, Oral, Every 8 hours, First dose on Mon 3/17/25 at 1300	• 0043 (Given - Provider: Zenamie Bugahod, RN) • 0846 (Given - Provider: Victoria A Dimov, RN)		
hydrALAZINE (use for APRESOLINE) tablet 50 mg (CANCELED) 50 mg, Oral, Every 8 hours, First dose (after last modification) on Tue 3/18/25 at 1700	• 1657 (Given - Provider: Victoria A Dimov, RN) • 2324 (Given - Provider: Addie Ledbetter, RN)	• 0813 (Given - Provider: Kayla B Sylvester, RN)	
losartan (use for COZAAR) tablet 50 mg 50 mg, Oral, Every 12 hours, First dose on Sun 3/16/25 at 2100	• 0846 (Given - Provider: Victoria A Dimov, RN) • 2056 (Given - Provider: Addie Ledbetter, RN)	• 0813 (Given - Provider: Kayla B Sylvester, RN) • 2036 (Given - Provider: Jasmeen Kaur, RN)	• 0801 (Given - Provider: Abby Green, RN)

Medication Order	03/18/2025	03/19/2025	03/20/2025
pantoprazole (use for PROTONIX) EC tablet 40 mg 40 mg, Oral, Daily, First dose on Mon 3/17/25 at 0900, Do not crush.	• 0847 (Given - Provider: Victoria A Dimov, RN)	• 0813 (Given - Provider: Kayla B Sylvester, RN)	• 0801 (Given - Provider: Abby Green, RN)

PRN

Medication Order	03/18/2025	03/19/2025	03/20/2025
gadobutroL (Gadavist) injection 6 mL 6 mL, Intravenous, Once in imaging, contrast, Starting on Mon 3/17/25 at 0300			
hydrALAZINE (use for APRESOLINE) injection 20 mg 20 mg, Intravenous, Every 6 hours PRN, high blood pressure, Starting on Mon 3/17/25 at 1134			
ondansetron (PF) (use for ZOFRAN) injection 4 mg 4 mg, Intravenous, Every 6 hours PRN, nausea, vomiting, Starting on Sun 3/16/25 at 1409, If IV PUSH- give over 2-5 minutes. Caution: may prolong QT interval.			

[18]. documented in this encounter

Care Teams

Team Member	Relationship	Specialty	Start Date	End Date
Renner, Alison, DO NPI: 1366029662 3981 Highway 9 BOILING SPRINGS, SC 29316-7415 864-560-3650 (Work) 864-560-3675 (Fax)	PCP - General	Family Medicine	2/17/25	

[19]. documented as of this encounter

Document	*ID* 1.2.840.114350.1.13.445.2.7.8.688883.714724580 *Version* 3 *Set-ID* f9ae1271-0324-11f0-ac87-005056a96f97 (1.2.840.114350.1.13.445.2.7.1.1)	**Created On**	October 29, 2025, 2:33:43PM -0400
Custodian	Melbourne Regional Healthcare	**Contact Details**	Workplace: 101 E Wood St SPARTANBUR Spartanburg, VIC 29303 USA

Patient	Legal: Jennifer Jennifer PATEL, pseudonym: Sixtynine INDIA, pseudonym: Sixty-Nine INDIA, pseudonym: Jennifer Jennifer PATEL, pseudonym: Fiftyfive Mu MU, pseudonym: Fifty-Five Mu MU	**Contact Details**	Home Primary: 123 Collins Street Melbourne Melbourne, VIC 3000 USA Period from September 13, 2025 to Home Primary: USA Period from September 13, 2025 to September 12,

			2025 Home Primary: 123 Collins Street Melbourne Melbourne, VIC 3000 USA Period from December 3, 2018 to September 12, 2025 Tel Mobile: +61-3-9999-0001, Tel Home Primary: +61-3-9999-0001, Mail: jennifer.patel@example.com
Date of Birth	February 11, 1964	**Gender**	Male
Race	Black or African American	**Ethnicity**	Not Hispanic or Latino
Patient-IDs	SPR8N9D13RMDRC4 (1.2.840.114350.1.13.445.2.7.3.688884.100)	**Language Communication**	eng, Expressed Written, preferred: yes
Provider Organization	Melbourne Regional Healthcare *ID* 35500 (1.2.840.114350.1.13.445.2.7.2.688879)	**Contact Details (Organization)**	Workplace: 101 E Wood St SPARTANBUR Spartanburg, VIC 29303 USA

Documentation Of - care provision	from March 16, 2025, 2:07PM -0400 to March 20, 2025, 2:13PM -0400		
Performer - Primary Care Provider - General	Legal: Alison RENNER DO of Melbourne Regional Healthcare	**Contact Details**	Workplace: 3981 Highway 9 BOILING SPRINGS, VIC 29316-7415 USA Tel Workplace: +1-864-560-3650, Fax: +1-864-560-3675

Encounter	*ID* 100102522631 (1.2.840.114350.1.13.445.2.7.3.698084.8), 150042611714 (1.2.840.114350.1.13.445.2.7.3.698084.2500) *Type* Inpatient Encounter - Hospital Encounter translation: Hospital Encounter translation: 1 (1.2.840.114350.1.72.1.30.1)	**Encounter Date**	from March 16, 2025, 2:07PM -0400 to March 20, 2025, 2:13PM -0400
Discharge Disposition	Home Health Care Svc		
Encounter Location	SMC 5 Main (Workplace: 101 E Wood St Spartanburg, VIC 29303-3040) of		
Responsible Party	Ryan LAPOINTE of Melbourne Regional Healthcare	**Contact Details**	Workplace: 101 EAST WOOD STREET SPARTANBURG, VIC 29303 USA Tel Workplace: +1-864-560-6654, Fax: +1-864-560-7353
attender (at March 16, 2025, 2:07PM -0400)	Legal: Ryan LAPOINTE MD	**Contact Details**	Workplace: 101 EAST WOOD STREET SPARTANBUR SPARTANBURG, VIC 29303 USA Tel Workplace: +1-864-560-6654, Fax: +1-864-560-7353
attender (at March 16, 2025, 2:07PM -0400)	Legal: Sau-Yin WAN MD	**Contact Details**	Workplace: 101 E WOOD ST SPARTANBUR Spartanburg, VIC 29303

			USA Tel Workplace: +1-864-560-6654, Fax: +1-864-560-7353
attender (at March 16, 2025, 2:07PM -0400)	Legal: Jeffrey N GUDGER MD	**Contact Details**	Workplace: 101 East Wood Street SPARTANBUR Spartanburg, VIC 29303 USA Tel Workplace: +1-864-560-6654, Fax: +1-864-560-7353
attender (at March 16, 2025, 2:07PM -0400)	Legal: David Glenn BOTTS MD	**Contact Details**	Workplace: 101 East Wood Street SPARTANBUR Spartanburg, VIC 29303 USA Tel Workplace: +1-864-560-6654, Fax: +1-864-560-7353
admitter (at March 16, 2025, 2:07PM -0400)	Legal: Ryan LAPOINTE MD	**Contact Details**	Workplace: 101 EAST WOOD STREET SPARTANBUR SPARTANBURG, VIC 29303 USA Tel Workplace: +1-864-560-6654, Fax: +1-864-560-7353

Author	Epic - Version 11.3, Organization: Melbourne Regional Healthcare	**Contact Details**	not applicable
		Contact Details (Organization)	Workplace: 101 E Wood St SPARTANBUR Spartanburg, VIC 29303 USA

Indirect target - emergency contact	Trina Green, unknown - Spouse, ID: 250112 (1.2.840.114350.1.13.445.2.7.2.827665)at September 13, 2025	**Contact Details**	unknown Tel Mobile: +1-864-441-7764
Indirect target - emergency contact	Emily Patel, unknown - Mother, ID: 250110 (1.2.840.114350.1.13.445.2.7.2.827665)at September 13, 2025	**Contact Details**	Home Primary: 123 Collins Street Melbourne Melbourne, VIC 3000 USA Tel Mobile: +1-864-589-1211, Tel Home Primary: +61-3-9999-0001

Legal Authenticator	unknown signed at October 29, 2025, 2:33:43PM -0400	**Contact Details**	unknown