Patient Information

Name:

Date

Brief Summary

is a 73-year-old female who was admitted to Temple University Hospital on 10/8/22 with no pressure injuries. She was discharged to Caring Heart Rehabilitation on 10/14/22 and was noted to have bilateral deep tissue injuries to her heels upon arrival. Liability for Temple cannot fully be evaluated at this time, as the facility failed to produce several key documents. Ms. heel DTIs deteriorated, and she developed a sacral pressure injury while at Caring Heart. Liability against Caring Heart exists due to the failure to create a resident-centered care plan and the failure to ensure that Ms. was turned and repositioned at least every two hours. Ms. was subsequently admitted to Immaculate Mary Rehabilitation, where she developed two medical device-related pressure injuries and experienced continued deterioration of her bilateral heel wounds and sacral pressure ulcer. Liability vs. Immaculate Mary exists due to missed wound care, failure to ensure that Ms. was turned and repositioned per standard of care, and failure to timely notify a physician upon a change in Ms. medical status. Peripheral artery disease may have played a role in poor wound healing, but it is my professional opinion that ***all wounds are pressure related in etiology****. Damages include a sacral debridement, pain and suffering, and bilateral above-the-knee amputations.*

Liability/Causation/Damages

<u>Temple University Hospital-Jeanes Campus (TJ)</u>: **Development of bilateral heel Deep tissue pressure injuries.**

- It appears that TJ is responsible for the development of Ms. right and left foot (heel) deep tissue injuries. Documentation from the emergency department at TJ indicates that Ms. did NOT have any skin lesions upon admission. Subsequent documentation from Caring Heart Rehabilitation indicated that Ms. had a deep tissue injury (DTI) to both heels upon admission. Sarah Hood, ADON at Caring Heart, documented that Ms. reported that the injuries started while she was at TJ. However, TJ failed to provide the proper medical records to examine this claim fully. Please see the "recommend requesting" section. Upon reviewing further records, I am confident *I will uncover liability and causation.*

<u>Caring Heart Rehabilitation:</u> **Failure to promote healing of bilateral heel deep tissue injuries, development of a full thickness sacral pressure injury.**

- **Failure to Develop and Implement Resident-Centered Plan of Care [42 CFR § 483.21(b)]**
  - A baseline care plan was completed on 10/14/22. The document was not fully completed, specifically, section H4 which addresses skin concerns [002667].
    - Completion of this section would've likely resulted in skin care interventions being implemented (frequent assessments, Q2 hr turns etc.). Because skin care interventions were not included in the care plan, Ms. developed a full-thickness sacral wound, and her BL heel DTIs continued deteriorating.
    - Standard of care is that a care plan meets individual needs of the patient and addresses specific concerns with measurable goals.

- **Failure of the facility to ensure that Ms. received care consistent with professional standards of practice to prevent pressure ulcers. [42 CFR §483.25(b)(1)]**

- Admission documentation noted that Ms. ██████ had redness to her sacrum upon admission. The facility failed to ensure appropriate orders were in place to prevent further deterioration.
  - Dr. Larry Spector placed BL heel wound care orders on 10/14/22. He failed to place preventative orders for the sacrum (padded foam dressing, barrier cream). By 11/1/2022, the redness had deteriorated into a full thickness pressure injury measuring 1.0 x 0.4 x 0.1 cm. [002675]

This is an example of a common, preventative coccyx/sacrum wound care dressing.[1]

  - Standard of care is that preventative measures are put in place to prevent skin breakdown. This wound does not meet the definition of a preventable pressure ulcer.

- MDS Section G: functional status, was completed on 10/21/2022. [002820] The assessment concluded that Ms. ██████ needed "extensive assistance" during bed mobility. This means that Ms. ██████ could not independently change positions in bed to offload pressure from vulnerable body parts.
  - Despite this finding, Dr. Spector failed to order Q2 hour turns.
  - MDS section M focuses on skin conditions and appropriate treatments. [002841] Deena Johnson, RN, failed to select the option to place Ms.

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6647510/

on a **turn/reposition program** (which was vital, considering she needed extensive assistance). This program is meant to organize frequent turns, including direction and timing. Caring Heart failed to provide evidence that Ms. was turned every 2 hours.

- Standard of care is that nurses have the correct competencies and knowledge to protect patients from harm. By not placing Ms. on a T&R program, this nurse did not demonstrate appropriate knowledge of pressure ulcer prevention.

- **Failure to follow physician orders. [42 CFR § 483.21(b)(3)]**
  - Wound care orders for Ms. bilateral deep tissue heel injuries were as follows: Cleanse with normal saline, apply skin prep BID (twice a day), and leave open to air.
    - The nursing staff did not complete wound care on 10/27, 10/28, or 11/31. [002790, 002789]
    - The standard of care is that wound care treatments are provided as ordered by the facility physician. Missed treatments place the patient at risk for further wound deterioration.

Immaculate Mary Center For Rehabilitation & Healthcare: Development of two medical device-related pressure injuries (left and right dorsal foot), deterioration of Right heel pressure injury, deterioration of sacral pressure injury, deterioration of left heel pressure injury, need for sacral wound debridement.

- **Failure to ensure Ms. did not develop new pressure sores. [42 CFR §483.25]**
  - On 11/23/2022, Lisa Schoen RN noted that Ms. had two new deep tissue pressure injuries caused by an ACE bandage. [001194] Lisa documented, “ACE wrap pressure and friction caused DTI x 2.”
    - Nurses are expected to have the knowledge and competencies to ensure patient safety. [42 CFR § 483.35] By failing to apply an ACE bandage

correctly, thus causing deep tissue injuries, nurses at this facility failed to protect Ms. from harm.

- **Failure to ensure that Mr. was provided the necessary treatment and services to promote the healing of current pressure ulcers. [42 CFR §483.25]**
    - MDS Section G: functional status was completed on 11/19/2022. [000606] The assessment concluded that Ms. needed "extensive assistance" during bed mobility.
        - The facility failed to place Ms. on a turn/reposition program. This program is meant to organize frequent turns, including direction and timing. Immaculate Mary Rehabilitation failed to provide evidence that Ms. was turned every 2 hours. [000624]
        - MDS Section M was completed again on 12/16/2022. [000767] Again, Ms. was not placed on a turning and repositioning program.
        - The standard of care is that patients should be turned at least every two hours.
    - Wound documentation on 11/16/2022 states that Ms. wounds measured as follows: Right heel (5.6x 5.0 cm), Left heel (2.5x4.0 cm), Sacrum (1x0.9x0.2 cm). [001221]
        - By 1/18/2022, wound measurements increased to: Right heel (6.5x 5.8 cm), Left heel (5x6.5 cm), Sacrum (2x1.9x0.1 cm). [001511]
        - My professional opinion is that Ms. wounds deteriorated due to her not being turned and repositioned at least Q2 hours, which is the current standard of care.
- **Failure to follow physician orders. [42 CFR § 483.21(b)(3)]**
    - Wound care for Ms. left heel pressure injury in November, December, and January.
        - The nursing staff did not complete wound care on 11/19, 11/20, or 11/28. [000174]

- The nursing staff did not complete wound care on 12/7, 12/16, or 12/30. [000223, 000224]
- The nursing staff did not complete wound care on 1/10 or 1/19. [000260]

- Wound care for Ms. right heel pressure injury in November, December, and January.
  - The nursing staff did not complete wound care on 11/19, 11/20, 11/28, or 11/29. [000174]
  - The nursing staff did not complete wound care on 12/7, 12/16, or 12/30. [000226, 000227]
  - The nursing staff did not complete wound care on 1/10 or 1/16. [000261]
- Wound care for Ms. sacral pressure injury in November, December, and January.
  - The nursing staff did not complete wound care on 11/19, 11/20, 11/28, or 11/29. [000175]
  - The nursing staff did not complete wound care on 12/7, 12/16, or 12/30. [000228]
  - The nursing staff did not complete wound care on 1/10 or 1/16. [000261]

- **Failure to appropriately notify the resident's physician of changes in condition. [42 CFR § 483.10(g)] (14)]**
  - On 1/18/2022, Mari, Steven, DO, relayed to nurse supervisor Lisa Schoen, RN, that Ms. Left heel had purulent drainage and was malodorous. He recommended that Ms. be started on the Doxycycline antibiotic as long as Dr. Spector approved it. [001511]
    - Lisa Schoen, RN, did not relay this information until 11/20/22, two days later. This is not a timely physician notification.
    - The standard of care would be that Schoen immediately contacted Dr. Spector due to the change in the patient's condition.

Possible Defense Argument

The defense will likely contend that Mrs. heel pressure injuries were arterial and not pressure related. This, however, is not the case. Ms. did not have pressure injuries on her heels/feet when she presented to TJ on 10/8/2022. Also, on 10/8/22, her legs were described as "warm and well perfused." Someone with significant PAD will not have lower extremities that meet this description. Legs afflicted with PAD will be cool to the touch, have no/weak pulse, crampy and painful, shiny skin, and hair loss.[2] None of these symptoms were noted when Ms. developed her heel pressure injuries. Although PAD likely played a role in the poor healing of her pressure injuries, it is not what initially caused them.

The defense will likely also contend that Ms. pressure injuries were **unavoidable** because of her numerous risk factors: Diabetes Mellitus 2, decreased strength, decreased nutritional status, advanced age, incontinence, and chronic kidney disease. The *Wound, Ostomy, and Continence Nurses Society* describe that a pressure injury is only unavoidable if appropriate interventions are implemented that are consistent with the patient's needs and consistent with recognized standards of practice. (see attached PDF) This is not the case. Several deviations in the standard of care have been identified at Caring Heart and Immaculate Mary (TJ pending additional medical records). Physicians and staff at these facilities should've appreciated that Ms. was at high risk for developing pressure ulcers and acted accordingly.

Medical Records to Request

10/8/22-10/14/22 Temple Jeanes admission-Records included are discharge summary, laboratory result, imaging results, and initial history and physical. Additional records are needed to identify negligence and link causation to Ms. developing bilateral heel deep tissue injuries.

- All physician orders for this hospitalization.

[2] https://www.cdc.gov/heartdisease/PAD.htm

- Hospital care plan.
- All nursing physical assessment records.
- All physician notes for this hospitalization.

Records Legend

Prefix	File Name/Designation	Total Pages
	Caring Heart	395
	Temple-Jeanes	608
	Immaculate Mary	1530
TOTAL		**2.533**

Chronology

Date	Event	Record Reference	Comments
TEMPLE UNIVERSITY HOSPITAL-JEANES CAMPUS			
10/8/2022	**History of Present Illness** The patient presents with 4 days of bright red blood noticed in the toilet bowl. Clots noted. Decreased energy, fatigue, and cold feeling associated. ED course: hemodynamically stable. Creatinine 3.21 (high), Hemoglobin 5.9 (low), WBC 15.7 (high). The patient started on 2 units PRBC and is being admitted for management of GI bleed. ED physical examination: Awake, alert, regular cardiac rhythm, lungs clear bilaterally to auscultation,	001722 001746	Patient has hx of kidney disease (CKD), which explains high creatinine. ** Ms. [redacted] came into the hospital with no pressure injuries.

Date	Event	Record Reference	Comments
	extremities warm and well perfused, **skin warm/dry/intact, no rashes or lesions**.		Physical exam states her extremities are "warm and well perfused" this indicates that wounds that develop are not due to peripheral artery disease (PAD)**
10/14/2022	**Hospital Course** 73-year-old admitted for acute blood loss. Bleeding found to be vaginal. Total of 3 units of blood given, with improvement in hemoglobin. CAT scan and physical examination by gynecology revealed vagina/vulvar irregularities. Patient to follow up with gynecology oncology after discharge. Patient fell prior to arrival at hospital. Found to have right knee displaced avulsion fracture of the right tibial tuberosity, with moderate knee effusion. Knee immobilizer placed.	001723	*More records needed to prove liability. See recommendations above.*
CARING HEART REHABILITATION			
10/14/2022	**Admission Note** Resident is a 73-year-old female admitted for blood loss. PMH: vulva cancer, diabetes mellitus 2, hypertension, NSTEMI (heart attack), chronic kidney disease, anemia, hyperlipidemia. **On assessment redness to sacral area and large blisters to both heels/DTI noted.**	002985	Gale Wilson, RN

Date	Event	Record Reference	Comments
10/14/2022	**Admission Screener** Admitting Dx: acute on chronic blood loss. Wound #1: Left heel DTI. Wound #2: Left heel DTI. Wound #4: Sacral/peri-area redness.	002635 002638 002639 002640	DTI-Deep tissue injury
10/14/2022	**Braden Scale** 17-mild risk of developing pressure injuries.	002670	
10/14/2022	**Baseline Care Plan** H. Safety Risks Current or history of skin integrity issues? Not completed. Care plan summary	002667 002669	Completion of this section could have triggered the need for Q2 hour turns due to current skin integrity issues. Summary does not address need for turn/reposition schedule due to DTI's.
10/14/2022	**Order Summary Report** Left heel deep tissue injuries-apply skin prep every day and evening for wound care. Offload heels-every shift. Podiatry consult. Pressure reducing mattress.	002959 002960 002961	An order for sacral wound care should've been placed-to include a padded dressing to prevent further deterioration.

Date	Event	Record Reference	Comments
	Right heel deep tissue injuries-apply skin prep every day and evening for wound care. Turn and reposition frequently throughout shift. Consult wound care.	002962	This order is not consistent with standard of care. Order should state "turn and reposition at least every two hours".
10/17/2022	**Pressure Ulcer Evaluation** Right heel: 4.0 x 5.0 cm. Date first observed: 10/14/2022. Stage: DTI. No exudate, no odor. *Patient reports area started while in the hospital*.	002966 002967	Sarah Hood, ADON
10/17/2022	**Pressure Ulcer Evaluation** Right heel: 3.8 x 4.3 cm. Date first observed: 10/14/2022. Stage: DTI. No exudate, no odor. *Patient reports area started while in the hospital.*	002968	Sarah Hood, ADON
10/18/2022	**Wound Specialist Evaluation** Patient is seen for evaluation and management for bilateral heel DTI's and right 3rd toe wound present on admission. Left heel DTI: 3.5 x 4.5 cm. Purple/maroon localized area of discolored intact skin with blood-filled blister roof. Peri wound intact.	002672	Wound Healing Solutions PA & DE Donna Burgmayer, CRNP, CWOCN

Date	Event	Record Reference	Comments
	Left heel DTI: 5 x 5 cm. Purple/maroon localized area of discolored intact skin with blood-filled blister roof. Peri wound intact. Plan: cleanse with normal saline, apply skin prep BID. Pressure offload, reposition, no shoes.	 002672	
10/2022	**October Turn and Reposition Task Documentation Record**	002795	This doesn't give us any information about how often per shift she was turned. They could've turned her once and checked the box. However, documentation for 10/27 &10/28-day shift, and 11/31-evening shift is blank, indicating she wasn't turned frequently those days.
10/2022	**October Heel Wound Care** Right heel- Left heel-	 002790 002789	documentation for 10/27 &10/28-day shift, and 11/31-evening shift is blank, indicating wound care wasn't provided.
10/21/2022	**MDS Section G: Functional Status** Bed Mobility-**Extensive assistance** needed, one-person physical assistance.	002820	This indicates that she cannot independently offload pressure while in bed.
10/21/2022	**MDS Section M: Skin Conditions** Skin and ulcer/injury treatments (check all that apply): pressure reducing devise for bed, skin care.	00284	**Turning/repositioning program** NOT selected. This program involves coordinating and

Date	Event	Record Reference	Comments
			documentation turns (duration and position)
10/25/2022	**Wound Specialist Evaluation** Left heel DTI: 4 x 6 cm. Purple/maroon localized area of discolored intact skin with blood-filled blister roof. Peri wound intact. Left heel DTI: 6 x 6.5 cm. Purple/maroon localized area of discolored intact skin with blood-filled blister roof. Peri wound intact.	002673	Left heel deterioration noted. Right heel deterioration noted.
11/1/2022	**Wound Specialist Evaluation** **New this day:** Full thickness ulceration of the sacrum -1.0 x 0.4 x 0.1 cm. 100% slough, scant drainage, no odor. Left heel DTI: 4 x 4.5 cm. Purple/maroon localized area of discolored intact skin with blood-filled blister roof. Peri wound intact. Left heel DTI: 5 x 5 cm. Purple/maroon localized area of discolored intact skin with blood-filled blister roof. Peri wound intact.	002675	Sacrum was documented as being reddened upon admission. The facility failed to stop the deterioration into a pressure injury.
11/1/2022	**Order Summary Report** Sacrum: cleanse with normal saline. Apply medihoney. Cover with gauze and bordered dressing-every evening shift.	002962	This order should've been placed upon admission when the sacral redness was discovered.
11/1/2022	**Nurses Note** Pt was sent out per Dr. Spector because of abnormal creatinine level. Sent to Jeanes Hospital for a kidney biopsy.	002971	

Date	Event	Record Reference	Comments
TEMPLE UNIVERSITY HOSPITAL-JEANES CAMPUS			
11/1/2022	**History of Present Illness** Pt comes from caring heart rehab for evaluation of abnormal blood work. ER physician spoke to patients nephrologist who recommended her to come to the ER for renal evaluation and IV fluids.	001814	
11/2/2022	**Radiology Report** Study: x-ray 3 view-bilateral feet. Impression: Left- posterior heel soft tissue defect with vascular calcifications noted. No definite cortical erosion or fragmentation to suggest acute osteomyelitis. Right-Posterior soft tissues and posterior calcaneus are limited in evaluation due to overlying external material. Suggest repeat calcaneal study.	001920	
11/15/2022	**Hospital Course** Patient had permacath placed and was started on hemodialysis. Orthopedic consulted and recommended weight bearing as tolerated, use unlocked brace, and to allow 40-degree flexion. PT recommended subacute rehab at a facility with hemodialysis capacity. Pt discharged to Immaculate Mary in stable condition.	001815	
IMMACULATE MARY CENTER FOR REHABILITATION &HEALTHCARE			
11/15/2022	**Nursing Progress Note**	001223	

Date	Event	Record Reference	Comments
	Resident received on a stretcher from Temple Hospital. Resident alert and oriented x 3. Bilateral unstageable heel wounds with ecchymosis on the top of feet noted. Sacrum wound noted, with ecchymosis on the vulva and buttocks.		
11/15/2022	**Diagnosis Report**	000126	Peripheral vascular/arterial vascular disease not listed.
11/15/2022	**Physician Order** Left heel cleanse with normal saline, apply betadine, cover with 4x4 and cover with Kling and **ACE wrap** daily. Right heel cleanse with normal saline, apply betadine, cover with 4x4 and cover with Kling and ACE wrap.	000281 000286	
11/15/2022	**Facility Care Plan** Actual skin breakdown related to bilateral heel open blisters, open area on sacrum, rt chest wall permacath. Interventions: Prevalon boots to BL feet, administer treatment per physician order, anti-pressure mattress, provide diet and supplements per physician orders. [redacted] has a potential for alteration in skin integrity. Interventions: assist or provide turn and reposition Q2 hrs for pressure relief.	001232 001279	Consistent with standard of care, however, no order for

Date	Event	Record Reference	Comments
			Q2 hour turns was placed.
11/16/2022	**Physician Order** Prevalon boots to BL feet at all times when in bed.	000284	
11/16/2022	**Weekly Wound Note** 1. Right heel- 5.6 x 5.0 cm. 100% dry eschar. Paint betadine and leave open to air. Prevalon heel boot on for offloading. 2. Left heel-2.5 x 4 cm. 100% dry eschar. Paint betadine and leave open to air. Prevalon heel boot on for offloading. 3. Sacrum-1 x 0.9 x 0.2 cm. 20% granulated, 80% slough, small serous drainage. Periwound erythema and excoriation. Plan: Santyl, gauze and border dressing daily. Dermafungal for diffuse peri fungal rash. Interventions: APM (low pressure loss mattress), cushion wheelchair, dietician eval, wound consult, assist frequent turning and repositioning, skin check every shift, incontinent care, diabetic management.	001221	
11/18/2022	**PA Progress Note** Pt is participating in PT and OT. She reports pain in RLE as well as BL feet due to ulcers.	001213 001214	Matthew Abad, PA-C

Date	Event	Record Reference	Comments
	BL foot ulcers-stable. Continue wound care. Continue Prevalon boots.		
11/18/2022	**Dietary Progress Note** Recommend protein supplement 30 ml BID (+30 gm of protein) for additional protein to aid in wound healing. Will provide additional caloric/protein dense snacks.	001208	Catherine Nguyen
11/19/2022	**MDS Section G: Functional Status** Bed mobility- **extensive assistance** required, two + persons physical assistance.	000606	This indicates that Ms. [redacted] cannot independently pressure offload while in bed.
11/19/2022	**MDS Section M: Skin Conditions** Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar: 3-present on admission. Skin treatments: wound care, nutrition intervention, pressure reducing device for bed.	000624	**Turning/Repositioning program** is NOT selected. This is vital to implement when a patient cannot offload pressure independently.
11/23/2022	**Weekly Wound Note** -Bilateral heel unstageable wounds improved. Continue betadine and open to air. -Right dorsal foot DTI **new** (7 x 7.9 cm) 100% purple defined skin, paint betadine and leave open to air. -Left dorsal foot DTI **new** (5 x 3.5 cm). 100% defined purple blister, and Periwound erythema. Plan same as above.	001194	2 new pressure injuries identified. The dorsal foot (top/flat surface) CAN develop pressure injuries, although less common than heel. What is described here is a medical device-related pressure ulcer.[3] Lisa Schoen, RN

[3] https://www.myamericannurse.com/medical-device-pressure-injury-prevent/#:~:text=The%20National%20Pressure%20Ulcer%20Advisory,a%20medical%20or%20other%20device.

Date	Event	Record Reference	Comments
	ACE wrap pressure and friction caused DTI x 2. DC ace wrap and kerlix. -Sacral wound unstageable. Not improved due to moderate serous drainage and Periwound rash. Add calcium alginate and dressing daily. Dermafungal Periwound.		
11/23/2022	**Wound Specialist Note** #1) Right heel unstageable pressure injury. Obscured full-thickness wound. (3 x 4 cm), area of 12 sq cm. 100% eschar. Paint with betadine, open to air, change once a day. #2) Sacral wound chronic unstageable, obscured full-thickness pressure ulcer. (3 x 4cm), with an area of 1.44 sq cm. 80% slough, 20% granulation. Wound is deteriorating. Santyl, calcium alginate pads, bordered dressing. Change once a day. #3) Left heel unstageable pressure injury. obscured full-thickness wound. (2.1 x 2.3 cm), area of 4.83 sq cm. 100% dry eschar. Paint with betadine, open to air. #4) Right dorsal foot deep tissue pressure injury. Persistent non-blanchable deep red, maroon or purple discoloration. 7 x 7.9 cm, with no measurable depth. Area of 55.3sq cm. Paint with betadine, open to air.	001517	Eyiah-Mensah, Godfred

Date	Event	Record Reference	Comments
	#5) Left dorsal foot is a deep tissue pressure injury. 5 x 3.5 cm, no measurable depth. Area of 17.5 sq c. Paint with betadine, open to air. Physical exam: **pedal pulses are diminished**.		
11/30/2022	**Wound Specialist Note** #1) Right heel unstageable pressure injury. Obscured full-thickness wound. (2.5 x 3 x 0.1 cm), area of 7.5 sq cm. 100% eschar. #2) Sacral wound chronic unstageable, obscured full-thickness pressure ulcer. (1.3 x 2 x 0.2cm), with an area of 2.5 sq cm. 30% slough, 70% granulation. #3) Left heel unstageable pressure injury. obscured full-thickness wound. (2.2 x 2.6 x 0.1 cm), area of 5.72 sq cm. 20% epithelialization, 80% eschar. #4) Right dorsal foot deep tissue pressure injury. Persistent non-blanchable deep red, maroon or purple discoloration. 6 x 6.9 x 0.1 cm, with no measurable depth. Area of 41.4 sq cm. #5) Left dorsal foot is a deep tissue pressure injury. 3.9 x 3 cm, no measurable depth. Area of 11.7 sq cm. Physical exam: **pedal pulses are diminished**.	001522	

Date	Event	Record Reference	Comments
11/2022	**November Left Heel Wound Care**	000174	Missed days: 11/19, 11/20, 11/28
11/2022	**November Right Heel Wound Care**	000174	Missed days: 11/19, 11/20, 11/28, 11/29
11/2022	**November Sacrum Wound Care**	000175	Missed days: 11/19, 11/20, 11/28, 11/29
12/8/2022	**Nursing Note** Hemoglobin 6.2. Nephrology aware and recommends transfusion. Resident left facility via stretcher, en route to Temple.	001179	
TEMPLE UNIVERSITY HOSPITAL-JEANES CAMPUS 12/8/22-12/12/2022			
	Records not available for review at this time.		
IMMACULATE MARY CENTER FOR REHABILITATION &HEALTHCARE			
12/12/2022	**Nursing Note** Resident received from Temple Hospital around 2100. Alert and oriented x 3. Bilateral heels with unstageable wounds and ecchymosis on the top of both feet. Sacrum, vulva, and buttocks redness. Pedal and radial pulses palpable.	001178	
12/13/2022	**Weekly Wound Note** - Right heel unstageable ulcer (5x 5 cm), 100% dry eschar, Periwound intact. Paint with betadine and leave open to air. - Left heel unstageable ulcer (3 x 4 cm), 100% dry eschar, Periwound intact. Paint with betadine and leave open to air. -Sacral wound unstageable (2.5 x 1.5 x 0.1 cm) 20% slough, 80% skin, small	001173	

Date	Event	Record Reference	Comments
	serous drainage, Periwound erythema and excoriation. Plan- Santyl, gauze and bordered dressing daily. -Right dorsal foot unstageable (6 x 5 cm) 100% dry eschar, paint betadine and leave open to air. -Left dorsal foot unstageable (4 x 3.5 cm) 100% dry eschar, paint betadine and leave open to air.		
12/16/2022	**Dietary Note** Resident with increased energy expenditure due to multiple unstageable wounds. Resident reported to have poor PO intake for greater than five days. Additional sandwiches provided with meals. Recommend Nepro 8oz QD (+420kcal, 19 gm protein) to aid in wound healing.	001162	
12/16/2022	**MDS Section M: Skin Conditions** Skin treatments: wound care, nutrition intervention, pressure reducing device for bed.	000767	Turning and repositioning program still not initiated.
12/21/2022	**Wound Specialist Note** #1) Right heel **chronic arterial ulcer** (4.5 x 6 cm), area of 27 sq cm. 100% eschar. Paint with betadine, open to air, change once a day. #2) Sacral wound chronic unstageable, obscured full-thickness pressure ulcer. (1.3 x 2 x 0.2 cm), with an area of 2.6 sq cm and a volume of 0.52 cubic cm. 20% slough, 40% epithelization, 40% granulation.	001527	Eyiah-Mensah, Godfred This is the first time the heel ulcers are restaged as “chronic arterial ulcers”. Her heel pressure ulcers are not consistent with an arterial ulcer. Arterial ulcers are characteristically deep. Ms. [redacted] have no

Date	Event	Record Reference	Comments
	Wound is deteriorating. Zinc barrier cream, Santyl, calcium alginate pads, bordered dressing. Change once a day. #3) Left heel **chronic arterial ulcer** (4.5 x 5.9 x 0.1 cm), area of 26.55 sq cm and a volume of 2.655 cubic cm. 80% dry eschar, 20% granulation. Paint with betadine, open to air. #4) Right dorsal foot is an eschar covered arterial ulcer. (4.5 x 5.5 cm), with no measurable depth. Area of 24.75 sq cm. Paint with betadine, open to air. #5) Left dorsal foot is an eschar covered arterial ulcer. 0.9x 1.5 cm, no measurable depth. Area of 1.35 sq c. Paint with betadine, open to air. **#6) New**: left, lateral foot is an eschar covered arterial ulcer. 3x1.5 cm with no measurable depth. Area of 4.5 sq cm. Paint with betadine, open to air, change once a day. Physical exam: **pedal pulses are diminished**. Mild/moderate edema.		measurable depth/are very shallow. Integumentary (skin/hair) section is not completed to include evidence to support that wounds are arterial. Leg with arterial wound will often be cool, thin/shiny shin, decreased/absent hair, slow capillary refill, dusky colored skin. None of these findings are documented. No diagnostic tests were completed to confirm that the ulcers were vascular in nature.
12/2022	**December Left Heel/Dorsal Ft Wound Care**	000223 000224	Missed Days: 12/7, 12/16, 12/30
12/2022	**December Right Heel/Dorsal Ft Wound Care**	000226 000227	Missed Days: 12/7, 12/16, 12/30
12/2022	**December Sacrum Wound Care**	000228	Missed Days: 12/7, 12/16, 12/30
1/11/2022	**Wound Specialist Note**	001506	Mari, Steven, DO

Date	Event	Record Reference	Comments
	#1) Right heel chronic arterial ulcer (7.5 x 5.3 cm), area of 39.75 sq cm. 100% eschar. Paint with betadine, open to air, change once a day. #2) Sacral wound chronic unstageable, obscured full-thickness pressure ulcer. (3 x 3 x 0.1 cm), with an area of 9 sq cm and a volume of 0.9 cubic cm. 50% slough, 50% epithelization. Wound is deteriorating. Antifungal cream, Zinc barrier cream, Santyl, calcium alginate pads, bordered dressing. Change once a day. #3) Left heel chronic arterial ulcer (4.5 x 5.5 cm), area of 24.75 sq cm. 100% dry eschar. Paint with betadine, open to air. #4) Right dorsal foot is an eschar covered arterial ulcer. (5.5 x 6.5 cm), with no measurable depth. Area of 35.75 sq cm. Paint with betadine, open to air. #5) Left dorsal foot is an eschar covered arterial ulcer. 3.5x 1.5 cm, no measurable depth. Area of 5.25 sq c. Paint with betadine, open to air. #6) Left, lateral foot is an eschar covered arterial ulcer. (0.1 x 1.8 cm) with no measurable depth. Area of 0.18 sq cm. Paint with betadine, open to air, change once a day. Physical exam: **pedal pulses are diminished**. Mild/moderate edema		Increasing in size. Increasing in size. Slight improvement in size. Increasing in size. Increasing in size. Decreasing in size.

Date	Event	Record Reference	Comments
	Procedures: Sacral pressure injury underwent excisional/surgical debridement, with a total area debrided of 9 sq cm. Post debridement measurement: (3 x 3 x 0.2 cm), with total area of 9 sq cm and volume of 1.8 cubic cm.		Mari, Steven, DO
1/18/2022	**Wound Specialist Note** #1) Right heel chronic arterial ulcer (6.5 x 5.8 cm), area of 37.7 sq cm. 100% eschar. Paint with betadine, open to air, change once a day. #2) Sacral wound chronic unstageable, obscured full-thickness pressure ulcer. (2 x 1.9 x 0.1 cm), with an area of 3.8 sq cm and a volume of 0.38 cubic cm. 35% slough, 30% epithelization, 35% granulation. Wound is deteriorating. Antifungal cream, Zinc barrier cream, Santyl, calcium alginate pads, bordered dressing. Change once a day. #3) Left heel chronic arterial ulcer (5 x 6.5cm), area of 32.5 sq cm. 100% dry eschar. Paint with betadine, secure with foam dressing. #4) Right dorsal foot is an eschar covered arterial ulcer. (5.8 x 6.5 cm), with no measurable depth. Area of 37.7 sq cm. Paint with betadine, open to air. #5) Left dorsal foot is an eschar covered arterial ulcer. (3.8 x 1.5 cm), no measurable depth. Area of 5.7 sq c. Paint with betadine, open to air.	001511	Mari, Steven, DO Decease in size. Decrease in size. Increase in size. Increase in size. Increase in size.

Date	Event	Record Reference	Comments
	#6) Left, lateral foot is an eschar covered arterial ulcer. (0.1 x 1.8 cm) with no measurable depth. Area of 0.18 sq cm. Paint with betadine, open to air, change once a day. Physical exam: **pedal pulses are diminished**. Mild/moderate edema		No change.
1/18/2022	**Weekly Wound Note** Left heel draining moderate purulence, malodorous, with severe pain. Per Dr, etiology is wound infection, recommends starting Doxycycline if approved by Dr. Spector.	001105	Lisa Schoen, RN supervisor
1/20/2022	**Weekly Wound Note** Called Dr. Spector regarding left heel and need for antibiotic per wound consultant.	001102	Lisa Schoen, RN supervisor Two-day delay in contacting Dr. Spector.
1/20/2022	**Physician Progress Note** Pt seen for vascular ulcers and drainage from left heel wound and several other wounds on lower extremities. Concern for vascular compromise. Discussed with staff and will send to Jeanes.	001101	Dr. Larry Spector
1/2023	**January Left Heel/Dorsal Ft Wound Care**	000260	Missed Days: 1/10, 1/19
1/2023	**January Right Heel/Dorsal Ft Wound Care**	000261	Missed Days: 1/10
1/2023	**January Sacrum Wound Care**	000261	Missed Days: 1/10, 1/16
TEMPLE UNIVERSITY HOSPITAL-JEANES CAMPUS			
1/20/2023	**History of Present Illness**	001930	

Date	Event	Record Reference	Comments
	73-year-old female presented from Immaculate Mary NH due to infected wounds of bilateral feet. Patient with chronic bilateral foot diabetic ulcers was sent to ED when physician was unable to palpate pedal pulses. Pt reports that she has noticed drainage from both feet and increased pain. Her ulcers were noted to have dry drainage around the wound, in addition to having an odorous smell with necrotic tissue. She also endorses numbness and tingling in BL feet.		
1/20/2023	**ED Course** Patient was noted to have a mildly elevated WBC of 14.3. BL pedal doppler signals detected. Odorous purulent drainage noted from BL heels. Pt started on Ceftriaxone and Vancomycin. Xray of bl feet showed osteomyelitis is NOT excluded.	001931	
1/23/2022	**MRI Bilateral Feet** Impression: 1.Abnormal signal and enhancement in the right second metatarsal head and neck without cortical erosions, concerning for acute osteomyelitis. No other findings of acute osteomyelitis. 2.No drainable fluid collections bilaterally. 3.Diffuse bilateral cellulitis and myositis. 4.Bilateral flexor tenosynovitis, likely reactive. 5.The calcaneus is excluded from the field-of-view, precluding evaluation.	002126	Acute osteomyelitis identified.

Date	Event	Record Reference	Comments
1/24/2022	**Peripheral Arterial Testing** Reason for test: suspected peripheral artery disease. Right leg: Abnormal results suggestive of significant peripheral arterial disease at rest in the right leg. Moderate peripheral arterial disease indicated at rest in the right leg. The right ankle/brachial index is 0.79. Left leg: Abnormal results suggestive of significant peripheral arterial disease at rest in the left leg. Moderate peripheral arterial disease indicated at rest in the left leg. The left ankle/brachial index is 0.73.	002133	Ankle brachial index is a screening tool for PAD. Normal range is 0.9-1.4[4]
1/30/2022	**Operative Report** Procedure: right above the knee amputation. Indications for surgery: **Bilateral pressure necrosis** of her heels, she also developed calcaneal osteomyelitis bilaterally. Given this, her limbs were both deemed non salvageable. The risks, benefits and alternatives to amputation were explained to Ms. [redacted] and she agreed to proceed in a staged fashion.	001950	Andrea Lubitz, MD Calcaneus-heel bone. **This documentation is significant to the case. The vascular surgeon described the heels as having pressure related necrosis**
2/1/2022	**Operative Report**	001953	Andrea Lubitz, MD

[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4306002/#:~:text=Normal%20cut%2Doff%20values%20for,independent%20marker%20of%20cardiovascular%20risk.

Date	Event	Record Reference	Comments
	Procedure: Left above the knee amputation.		
2/15/2022	**Discharged** Disposition: good. Follow up care: vascular surgery. Discharge to: SNF.	001939	