Overview

Dunn et al v. Dunn et al

Executive Summary

Laube et al v. Campbell *Plata v. Davis*

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- *Plata v. Davis*
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- *Duval et al v. Hogan*
- *Dunn et al v Thomas*
- *Lewis v. Cain*
- *Hall v. County of Fresno*

Organizational Structure and Facility Leadership

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Poor Oversight by OHS

Inadequate Peer Review Process

Opinions:

13.

Findings:

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-

Sick Call

Methodology:

Opinions:

Location of Sick Call Boxes and Health Request Slips

Examples of Inadequate Sick Call Process Identified in Chart Reviews

Pharmacy/Medication Administration

Methodology:

Failure to Document Medication Administration and Errors in Medication Administration

Findings:

Lack of OHS policy on Specialty Care

Failure to Refer Patients for Necessary Specialty Care

147

Infirmary Care

Methodology:

Opinions:

Findings:

-
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- [redacted]
- [redacted]
- [redacted]

[redacted]

Mortality Review

Methodology:

Opinions:

Discontinuation of Mortality Review Meetings and Lack of Effective Mortality Review

Sentinel Review Process

Examples of the Poor Mortality Review and Failure to Recognize Deficiencies and Preventable Deaths[191]

[redacted]

Failure to Designate an Individual Responsible for Infection Control

Tuberculosis Outbreaks at Donaldson and St. Clair

Hepatitis C

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-
-
- **Incarceration**
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-
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Appendix A

APPENDIX A[235]

Facility	Designed Capacity	Month End Populations	Occupancy Rate	Date of Opening/Construction[236]

Kilby

APPENDIX C

CHART REVIEWS

Patient 1

Date	Summary	Comment
1/28/1999	PPD 20 mm positive. A TB record documented that the patient received INH 3/5/99	
1/5/2012	A physician assistant saw the patient for chronic illness clinic for his hyperlipidemia.	

11/1/2012 The patient receive

11/7/2013	The patient received medication 11/7/13 5 days late. But it appears that the patient did receive single doses of medication for 4 of the 5 missing days. After November,

4/15/2014 A physician documented discussing with the patient the abnormal CT scan results which indicated a 3.4 cm mass. The

11/26/2014	DOC nurses did symptom screening for TB but identified no loss of appetite, cough or weight loss.	This demonstrates poor quality of evaluation by ADOC staff which likely promotes tuberculosis disease being detected.
11/26/2014	A FU CT of the chest was requested on 11/26/14 for 4 weeks	
11/26/2014	A nurse documented that the patient returned from his last chemotherapy session	
11/26/2014	The oncologist recommended a FU CT scan in 4 weeks with a follow-up clinic visit the same day as the CT scan	
12/2/2014	A doctor wrote a very brief note documenting that the patient was doing well and needed a CT scan in 4 weeks. There was no history or physical examination.	The doctor did not document the progress of the patient. An appropriate history was not taken.
12/2/2014	A physician ordered a FU CT of the chest and an oncology follow-up for the same	

2/11/2015	The patient received an x-ray for tuberculosis but the report stated "Port catheter is followed to SVC. The cardiac silhouette, mediastinum, lungs, and pleural spaces show no gross acute abnormalities. If there are unexplained symptoms, follow-up radiography is suggested. Conclusion: No active tuberculosis". The radiologist apparently missed the lung cancer unless it had completely regressed. Also, the facility left the portacath in place after chemotherapy without consideration for how long it would be needed.	This demonstrates poor follow-up. Indwelling catheters place the patient at risk of harm because of potential for infections and clots. The physicians following this patient should know when the catheter should be removed.

1/23/2012	Patient complained to a nurse about burning when he urinates and pain in his testicle which was documented on a GU/GYN NET tool form. The nurse referred him to a provider because the urinalysis was abnormal but the nurse didn't document what the abnormality was. The nurse also gave the patient ibuprofen.	
1/23/2012	A provider saw the patient and only addressed the hip pain but not the testicular pain and abnormal urine. The provider was not certain about the hip pain diagnosis and thought it might be sciatica. The provider prescribed toradol.	The provider didn't address the testicular pain, abnormal urine, or urinary catheter. The patient had obvious symptoms of urinary tract infection but these were not evaluated.
1/23/2012	At 8:30 PM the patient complained to a nurse urTJ 0 -1.s7.5(0.48 re f 132.c8ad)-12.p paiooa2(w)-2.9(a8)]TJn T <<>>B.5(he pr)-6.3(ov)4(i)-8.2ed tpaii1urT	

2/1/2012	LS spine x-ray normal	
2/1/2012	A provider saw the patient for chronic illness visit listing diabetes and hypertension as problems. The provider history mentioned that the patient was still using crutches but did not describe why the patient needed crutches. The provider did not mention that the patient had a suprapubic catheter and did not note why the patient had a catheter and did not take any history with respect to this. The provider didn't take any history with respect to medication and did not note that the patient had gaps in medication. The provider took no history with respect to diabetes except that the patient had no hypoglycemia. The LDL cholesterol was 130 which is elevated for a diabetic but the provider did not address it. The patient was not on anti-lipid medication. The provider noted that the blood sugar was 363 and A1c was 7.1(this test was collected 1/17/12) and noted that the diabetes control was good. .	The provider failed to address why the patient had a suprapubic catheter and did not address the indication of the catheter. The provider failed to address medications and failed to treat an abnormal LDL cholesterol. Persons with diabetes should have their LDL controlled at least < 100.
2/5/2012	A provider renewed isosorbide, Lisinopril, Zante, Maxide and atenolol all for 90 days but failed to renew diabetic medication.	
2/6/2012	The suprapubic catheter was changed	
2/7/2012	Patient complains of back pain to nurse. The nurse referred to a provider.	
2/17/2012	Patient received 30 days of multiple KOP medications including atenolol, isosorbide, Lisinopril, macrodantin, ranitidine, and Maxide.	
2/19/2012	Patient saw a provider for back pain. The provider noted that the back pain had completely resolved.	
2/22/2012	The patient asked to see a provider about his catheter.	
3/7/2012	A nurse changed the patient's catheter; the nurse noted that there was blood in the urine.	
3/17/2012	A nurse changed the suprapubic catheter.	
3/28/2012	The patient received macrodantin and atenolol but none of his other KOP medications. The medication was delivered 11 days late.	The patient failed to receive ordered medication.
4/1/2012	A nurse changed the suprapubic catheter.	

4/5/2012	Patient complained to a nurse about testicular and penile pain with polyuria. The nurse contacted a provider. The urinalysis showed blood, white cells and was nitrite positive indicating a possible infection. The patient was referred to a provider for the abnormal urine test.	A provider failed to see the patient after a referral by a nurse.
4/10/2012	A provider renewed isosorbide, Lisinopril, Zante, Maxide and atenolol all for 90 days but failed to renew diabetic medication.	
4/12/2012	The patient complained to a nurse about penile and testicular pain. The nurse noted that the patient had previously been seen by a nurse and given Motrin. A physician had not seen the patient in follow-up. The blood	

5/3/2012 A provider saw the patient. The patient weighed 217 pounds and based on a provider note from 1/23/12 when the patient weighed 235 pounds, the patient had lost 18 pounds over approximately 4 months. This was possibly from untreated diabetes. The provider examined the patient and found no penile swelling, no lesions and normal testicles. The doctor diagnosed "stable" "genital discomfort" and poorly controlled diabetes. The doctor felt that patient's symptoms were due to diabetes. The doctor started insulin for 14 days along with another antibiotic - Bactrim. The doctor did not order a culture of the urine or assess for infection or order a white count but did order a hemoglobin A1c and a chemistry panel. The doctor alsn1(on3(el)3.18)2ore f-8(he)-2.3(el)38(he)k0.1(y)2-1.1(he)-1b9(y)1oo12.3(po)8(ul)-ga6.4( )-12.1(a

[redacted]

5/22/2012 The patient did not show up for a medical

12/18/2012	The patient complained of boils on his body. The nurse saw the patient on 12/19/12 and noted a boil on the patient's neck and referred the patient to a provider but a provider did not see the patient.	Again a nurse referral to a provider failed to occur. This placed the patient at risk of harm.
12/19/2012	A nurse saw the patient in evaluating the health request of the day before and noted a boil on the neck, a healed lesion on the chest and a small scab on the thigh. A provider wrote on the nursing NET tool note and wrote a prescription for 2 Bactrim BID.	
12/21/2012	A nurse gave the patient a 30-day supply of metformin KOP.	
1/5/2013	A nurse documented giving KOP meds simvastatin, glipizide, Isordil, Zestril, atenolol. These were 3 days late. The January MAR did not document delivery of metformin. The last delivery of metformin was 12/21/12.	The patient failed to receive ordered medication.
1/6/2013	A nurse changed the suprapubic catheter.	
1/16/2013	A nurse saw the patient for 3 separate boils on his neck, buttock, and chest. The nurse apparently prescribed Bactrim DS 2 tabs BID. It is not clear that a physician ordered this medication.	

1/16/2013

1/26/2013	A urine culture collected 1/23/13 and reported 1/26/13 showing e coli resistant to Bactrim but sensitive to nitrofurantoin (macrodantin). This was not reviewed until 1/30/13. The reviewer documented wanting to add macrodantin and discontinue Bactrim but it appears that the Bactrim was not stopped until the 4th of February.	The provider failed to timely change antibiotics as the patient was resistant to the antibiotic he prescribed for urinary tract infection. In general, long-term indwelling catheters become colonized.
2/4/2013	A provider saw the patient and noted that the patient complained of only receiving 4 days of his Bactrim. The MAR documents that the patient receive Bactrim for 9 days. The provider noted that the urine was growing e coli sensitive to macrodantin so the provider discontinued the Bactrim which was to stop on 2/4/13 anyway. The provider prescribe 30 days of macrodantin.	The provider should have determined when the catheter was last changed and considered changing it. It isn't clear whether the patient needed treatment as long-term indwelling catheters become colonized and are often only treated when symptomatic.
2/8/2013	Labs: creatinine 1.25, LDL was 150 but the patient was receiving only a low dose (5 mg of simvastatin) of medication; A1c 5.9; urine turbid with protein, ketones, blood, nitrites and large leukocyte esterase with many white cells and many bacteria which grew e coli.	The patient should have been on a higher dose of simvastatin.
2/13/2013	The patient received KOP medication ten days late.	The patient failed to receive ordered medication.
2/15/2013	A provider visit to follow up on a urinary tract infection was rescheduled.	
2/18/2013	A provider saw the patient and wrote a very brief note without any examination of the patient. The provider wrote to check a urine culture and treat accordingly.	
2/23/2013	The urine was again turbid and had protein, blood, nitrites, leukocyte esterase, bacteria and white cells. The urine grew pseudomonas.	The patient had a urinary tract infection. The reason for the suprapubic catheter was still not identified.
2/26/2013	A provider prescribed macrodantin for 180 days. This was a prophylactic antibiotic.	
2/28/2013	A provider wrote that he saw the patient and discussed urinalysis results and the need for antibiotic treatment. The patient agreed. The patient noted drainage from the left thigh but the provider did not find drainage on examination. The same provider dated a prescription 2/27/13 for gentamycin IM for 5 days with a metabolic panel in a week. There was no follow-up of the patient.	The provider should have determined when the catheter was last changed and considered changing it. The indication for gentamycin was not clear. It did not appear that the patient needed this medication.
3/4/2013	Lab: creatinine 1.35	This elevation of creatinine is a likely side effect of use of gentamycin.
3/5/2013	A provider renewed isosorbide for 180 days.	

3/11/2013	A urine sample was collected for culture which was reported 3/16/13 and positive for pseudomonas resistant to gentamycin which was the antibiotic used to treat his recent infection.	The provider should have determined when the catheter was last changed and considered changing it.
3/13/2013	A provider saw the patient for chronic illness clinic for diabetes and hypertension. The provider did not address the prior urinary tract infections. The provider did not ask the patient about his medications or ensure that the patient was receiving the correct medication. The patient's blood pressure was 130/80. The provider documented that the patient was in good control and did not change therapy. Although the LDL was 150 the provider did not address it, assess whether the patient was receiving medication or whether medication should be adjusted. The patient had recently been treated with intramuscular antibiotics for a urinary tract infection but the provider did not address it or follow-up with a urine culture.	The provider failed to address all of the patient's problems in this chronic care visit. The LDL cholesterol was high and the patient should have had an increased dose of lipid drug.
3/16/2013	The patient received KOP verapamil and also received Zocor which was last given as a 30-day supply on 1/5/13 so this was over a month overdue.	The patient failed to receive ordered medication.
3/30/2013	Metformin given as KOP and last given 2/5/13 so it was over 3 weeks late.	The patient failed to receive ordered medication.
4/12/2013	A provider renewed Zocor, Glucophage, verapamil and HCTZ for 120 days.	
4/14/2013	The patient received KOP atenolol, HCTZ, and Lisinopril but had last received a 30-	

4/18/2013	Labs reported 4/18/13 showed: sodium 134, white count 12, urine turbid, with protein, blood, leukocyte esterase and 2+ bacteria. This result was not reviewed until 4/25/13. The urine culture from this specimen was positive for pseudomonas	The provider should have determined when the catheter was last changed and considered changing it.
4/18/2013	A provider ordered a referral to an urologist because of the infected urine. The referral documented that the appointment would be 4/23/13 but there is no evidence that it occurred.	It appeared that this referral was delayed.
4/19/2013	A nurse saw the patient for urinary discomfort. The temperature was 96.3. The patient had abdominal tenderness and contacted a physician who gave a phone order to change the suprapubic catheter and to give pain medication. The nurse changed the urinary catheter.	The lack of on-site physician coverage was resulting in management by phone.
4/21/2013	A nurse documented calling the patient to the prison ER by orders of Dr. Crocker. The nurse then called Dr. Crocker who wanted to be called but the nurse didn't get a return call. The patient waited apparently in the prison ER for an hour and a half. The patient wasn't evaluated.	The patient didn't have access to a physician as there was no onsite physician. Remote management did not appear to be working.
4/20/2013	Lab reported 4/20/13: white count 9.6	
4/28/2013	A nurse filled out a non-adherence medication f1( )-1[re W n BT -0>.481 re f(28/)-13.12.3(nd)-12.2(a h)-12.3(al)3.2(f)-13. 24.4(14.079 115.079	

8/29/2013	A provider saw the patient for chronic illness visit. The provider took no history in follow-up of the recent urinary tract infection and did not mention whether the ordered referral to an urologist from 4/18/13 had occurred. The history was meager. Although the LDL was 134 the provider did not identify high blood lipids as a problem and did not evaluate the treatment including whether the patient was actually receiving medication.	The provider failed to address all of the patient's problems in this chronic care visit. The LDL cholesterol was high and the patient should have had an increased dose of lipid drug. The urinary catheter and ongoing infections were not addressed at all.
9/10/2013	There was a prescription in the chart starting Bactrim on 9/10/13 for 10 days with a notation "F/U this Thursday skin infection". However there was no note associated with this prescription.	It appears that medical record documents are missing.
9/17/2013	A nurse practitioner saw the patient for a follow-	

10/9/2013 The Regional Medical Director saw the

12/17/2013	The patient received a catheter change.	
5/22/2014	The patient received a catheter change.	
6/18/2014	The patient received a catheter change.	
12/13/2013	Patient received KOP Zocor 3 days late. No evidence in the MAR that the patient received atenolol, glipizide, Imdur, o96 352.8-1.1(h)-5ddur	

1/23/2014	The provider who apparently was an NP saw the patient with a physician. The NP documented that the doctor said the patient had a fistula and would be sent back to the urologist.	The patient was being referred to an urologist several years after incarceration. This referral was indicated years earlier and it was harmful to the patient (repeated infection) to not do this.
1/23/2014	The patient received HCTZ, metformin, and verapamil 2 days early. But the Zocor was 6 days late. There was no evidence that the patient received atenolol, glipizide Imdur, or Zestril.	The patient failed to receive ordered medication.
1/29/2014	An NP noted that the patient was non-compliant with medication. It was not clear on what basis this determination was made as it appears that the patient was not consistently receiving timely medication.	
1/29/2014	A physician referred the patient to an urologist for a fistula.	
2/4/2014	normal chest x-ray	

3/10/2014 3/13/2014	A provider saw the patient for chronic care follow-up. The potential fistula was not discussed. The provider listed the medications but made no attempt to document whether the patient was actually receiving medication or whether the patient was not taking medication. The provider listed the LDL as 117 which was still not at goal but there was no attempt to modify treatment. The patient's weight increased at least 20 pounds to 240 but the provider made no attempt to discuss. The lipids were not in control but were not assessed as not in control.	The provider did not address all of the patient's problems. The lipids needed better management. The weight increase should have been discussed.

6/27/2014	An NP who saw the patient for chronic illness clinic saw the patient based on an urgent nurse referral for penile pain and noted that the patient had abdominal pain and was unable to void via his suprapubic catheter. The NP ordered a change of the catheter and get a urine analysis. Later that day the NP stated that there was sediment in the urine specimen with blood, nitrite, and leukocytes.

10/8/2014	An NP documented starting Diflucan for the yeast growing in the urine.

12/17/2014 A provider saw the patient for chronic care follow-up. The provider did not address the recent surgery for urethroplasty. The blood sugar was 371 but the recent A1c of 7.5 was not mentioned. The provider did not discuss whether the patient was taking his medication or receiving medication. There was no evidence in the record that the patient was

Patient 3

Date	Summary	Comment

2/20/2012	The patient had a cardiac catheterization showing LMCA normal; LAD proximal 95% stenosis, L circumflex normal; R coronary 30-40% stenosis with anterior apical hypokinesis with LVEF 35%. A proximal LAD bare metal stent was placed without complications. The discharge recommendations were for daily aspirin 325 and Plavix 75 mg daily.	When bare metal stents are placed, it is imperative that Plavix or a similar drug be used to reduce clotting of the stent. Failure to do this can result in clotting, failure of the stent and possible myocardial infarction.
2/21/2012	The patient was discharged from the hospital	
2/21/2012	Hospital discharge summary with cardiac catheterization results and stent placement results were signed as reviewed 2/27/12. Recommendations included Plavix and sublingual nitroglycerin. The Plavix was ordered by a nurse but the nitroglycerin was not.	
2/22/2012	An NP reviewed the nurse return sheet for the cardiac catheterization and documented that the results of the cardiac catheterization were pending and to schedule with a physician when they were available. The hospital discharge summary which included the cardiac catheterization results were signed as reviewed on 2/21/12.	Providers failed to obtain information from the hospital that was vital for the patient. The NP failed to continue the Plavix.
2/23/2012	75 mg Plavix was ordered but the MAR for February does not document administration of this medication. A for absent was documented from 2/23/12 to 2/29/12.	A vital medication was ordered 2 days late. There was no evidence that the patient received this vital medication.

3/1/2012	The patient had a persantine stress test prior to bypass surgery. There was no evidence of ischemia but fixed anterior, septal, and anterolateral infarction and severe septal and apical hypokinesis and an ejection fraction of 29%.	
3/2/2012	The patient had 3 vessel coronary artery bypass surgery CABG.	
3/6/2012	The patient was discharged from the hospital after CABG with recommendations to start Percocet (a pain reliever). Plavix was no longer recommended.	
3/6/2012	The patient was admitted to the infirmary post CABG. The physician admission note documented holding Plavix but it had been discontinued. Coreg was recommended instead of atenolol	

3/28/2012 A PA saw the patient for chronic illness clinic. The PA noted the recent CABG and the abnormal hemoglobin. The blood

5/1/2012 The May MAR documented that the patient received Maxide, Mylanta, ibuprofen, aspirin, Coreg, Cozaar on 5/23/12 and Zocor and Protonix on 5/24/12 about a week after prescription. There was no evidence that the patient had received Coreg

11/12/2012	A PA saw the patient for chronic illness. The BP was 124/74, weight was 228, LDL was 57 and the patient had no complaints. The echocardiogram ordered 9/10/12 had not been done. The PA ordered FU in 90 days but made no comment about the echocardiogram.	
12/1/2012	The December MAR did not document delivery of any medication.	The patient did not apparently receive medication timely.
12/6/2012	The echocardiogram showed an ejection fraction of 20% with depressed systolic function. These results were signed as reviewed on 12/10/12.	

5/1/2013	The May MAR documented receipt of KOP meds on 5/1/13 and 5/29/13 including Protonix, Zocor, Tylenol, aspirin, Coreg, HCTZ, Cozaar	
5/13/2013	A PA saw the patient and restarted the Coreg because of decreased ejection fraction and ordered another echocardiogram.	
6/1/2013	The June MAR documented no medications given.	The patient did not receive medication timely.
6/5/2013	TG were 93 and LDL 89.	
7/1/2013	The July MAR documented receipt of KOP Zocor, Tylenol, aspirin, Coreg, HCTZ, Cozaar, and Protonix on 7/3/13 about 4-5 days late. Meds were also given on 7/31/13 which would have been on time.	The patient did not receive medication timely.
7/10/2013	The echocardiogram showed an ejection fraction of 50%	
7/23/2013	TG 231	This is a high level for triglycerides but was not noted.

8/1/2013 There was no August MAR in the record but the Zh8(t)-1.1(M)-oe51g045.8 Tm(b2(v)4(e)904 208208.8 38.28 r7.28 D4 20820Tj ET Q qp38.289a33ET E

3/11/2014 The patient went to cardiology and was diagnosed with recurrent angina. The cardiologist recommended increasing the Cozaar to 50 and starting Imdur an antianginal drug and return in 2-3 months. The cardiologist documented that the patient had episodes of angina. The cardiologist also recommended NTG which the patient had not been on. The cardiologist also recommended a SPECT at the next avai.1(he p2.7(i2.3(l)3.2(s)-8.1(o)]TJ 0 -1.145 TD [()-1 -12.3(l)pp(t)-1.1oended a(2)]TJ 0n)3.2(s)-8.18(o r).1

4/30/2014	A PA saw the patient for FU of the stress test almost 3 weeks after the test. The PA noted that the stress test results weren't yet available. The PA took a history that the patient had no chest pain. The PA ordered FU in 3 months. He listed the CAD as in good control which was not consistent with the stress test result.	This visit was almost 3 weeks after the stress test and the result should have been available. The follow-up was poor. 3 months was too long a follow-up with a pending a stress test result.
5/2/2014	The stress test result was signed as reviewed but the report appeared to have been dictated 4/10/14. Someone wrote on this report that the cardiologist wanted a cardiac catheterization which was ordered by Guthrie on 5/1/14 and approved 5/5/14.	

6/16/2014

7/1/2014	Because MARs are not present it wasn't clear how to verify receipt of medication. Another type of medication form is in the record but it isn't clear how to interpret its meaning.		
7/10/2014	A pr52.2 57.48 T /TT1 1 Tf -0.0028(ei)-4		

2/10/2015	The BP was documented as 94/60 and a nurse was instructed to hold HCTZ and Cozaar for 2 days. The patient should have been on an infirmary unit.	This one time therapy would be inadequate. The dosage of medication should have been lowered.
2/11/2015	The BP was 116/80	
2/20/2015 2/21/2015	Glucose was 134 and BUN was 21.	

7/19/2012	A nurse completing intake Form 3 indicated that the patient was to have had follow-up with orthopedics but failed to go to that appointment. This apparently was not communicated to the provider who did not order follow-up with an orthopedic physician who specializes in Charcot foot. The nurse noted that the patient was to be non-weight bearing.	This nurse history appears disconnected from

1/3/2013 Chronic illness clinic. Doctor noted that the patient was on 34 units of 70/30 in am and 50 units of Levemir in pm with sliding scale. He documented that the patient was getting an additional snack and had only 1 hypoglycemic episode. The patient weighed 204 pounds which was a 38 pound weight loss since intake. This was unnoticed by the doctor. (At the chronic clinic of 9/12/12 the patient weighed 219; at intake [form 2] sd2ieunno

3/12/2013

5/20/2013	Patient passed out from hypoglycemia. BS 36 treated with glucagon and glucose and given a food tray.	The patient should have had insulin adjusted
5/29/2013	Patient found unresponsive from hypoglycemia. BS 37.	The patient should have had insulin adjusted
6/2/2013	A1c 7.7	This is an improvement but the repeated hypoglycemia suggests that the insulin regimen should have been adjusted to try to avoid the hypoglycemia.
6/10/2013	Chronic clinic visit; there was little history. The doctor noted a few episodes of hypoglycemia, but failed to note the 52 pound weight loss. The A1c was documented as 7.7 and the doctor listed the patient in fair control yet decreased the am 70/30 insulin to 28 units.	The A1c was not at goal. To decrease the insulin would worsen diabetes control. The patient needed adjustment of the insulin regimen not necessarily a decrease in dose. The doctor failed to notice significant weight loss and failed to address one of the significant complications of his diabetes- the Charcot foot. The patient needed to see his orthopedic surgeon and orthotist.
6/12/2013	Lemevir decreased to 40 units pm from 50	
6/12/2013	The patient was foun	

8/29/2013	The patient was due for an annual TB check but a PPD was not planted due to a tuberculin shortage. Quantiferon was not used.	If tuberculin was not available, quantiferon should have been used.

9/17/2013 A provider who did not sign their note wrote that the patient had a lesion on the R toe secondary to an injury sustained about a month previous. The toe had a large abrasion and drainage. There was no further documentation of an assessment or plan although on the same day there was an order for antibiotic. This was a diabetic foot which should have prompted infirmary admission, off-loading the foot and laboratory work to rule out infection and x-ray to consider oste9(ng9P <<>>BDdo. -0.0022 w)9.2(a)i3.1(o)-12.3(n.1(T)-17.5(he t)-1.1(o)-12.3(l)-1.1(i)]TJ T* v)-8.1(eoc

10/3/2013	An NP saw the patient in FU of the toe lesion. The toe was noted to be rubbing against his shoe. The NP said that the toe was healing and did not appear infected and assessed that the wound was slowly healing. No change in therapy was recommended.	The NP should have housed the patient on the infirmary so that the patient would not bear weight on the foot. Also, an x-ray, blood count and sedimentation rate were indicated. Also the wound should have been probed to assess how deep the wound was.
10/16/2013	The patient's BS was 502; 2 hours later the blood sugar was 192.	This is a very high blood sugar. The ketones should have been checked. The insulin should have been eva 0.001 Tw 9.96 0 0 9.96 10.5982 13.1(i)3/2013

12/5/2013	An NP saw the patient in FU of the buttock infection and documented that the infection had resolved.

2/26/2014 A doctor saw the patient for chronic illness visit. The doctor noted 1 episode of

6/24/2014	A mid-level provider saw the patient for open wounds to his finger and toe. The patient's weight was 205. The patient was now gaining weight and had lost 37 pounds since his intake evaluation. The provider documented a healing abrasion to his leg with a chronic ulcer of his toe and a small paronychia of his finger. The diagnosis was a chronic ulcer of the toe. The only therapy was to continue current wound management which was inadequate.	The management of the chronic foot ulcer was below an acceptable standard of care.
6/24/2014	Patient experienced hypoglycemia with BS 30.	
7/2/2014	Patient experienced hypoglycemia with BS 39.	
8/9/2014	Emergently seen for BS 45.	
8/20/2014	A1c 7.8	
8/21/2014	Chronic illness visit by doctor. No history taken re hypoglycemia, medication management, other symptoms. No history taken with respect to chronic ulcer. A1c not documented. Weight now 209 but not addressed. The toe was not evaluated. The tibia wound was described as indurated. The wounds or neuropathy not listed as problems. The diabetes was listed in good control despite high A1c and hypoglycemia.	This was a poor evaluation. An A1c of 7.8 with multiple episodes of hypoglycemia is not good control. Multiple problems of the patient were not addressed.
8/25/2014	CXR no evidence of tuberculosis	
8/29/2014	Patient experienced hypoglycemia with BS 40. An LPN scheduled the patient for a nurse encounter which the patient refused. The nurse charged the patient $4	This is improper. A case could be made that the hypoglycemia resulted from poor physician insulin management yet the result of this was to charge the patient. Also, an LPN assessed the patient but the LPN is not traietrs ned.7333.24 360 0.48 0.48 r

10/12/2014	The patient placed a health request stating he had a sore in his armpit.	
10/13/2014	An LPN saw the patient and noted several raised areas in the left axilla. The nurse referred to a provider.	RNs should perform assessments. This assessment was not signed as reviewed by an P 54.3(196 0 4

Patient 5

Date	Summary	Comment
12/8/2009	This chart did not contain the initial intake evaluation which by OHS policy is supposed to be in the current record.	
12/8/2008	The patient saw a cardiologist. The cardiologist noted that the patient had 2 prior stents and had another coronary artery occluded which was not stented. Because of angina symptoms, the cardiologist recommended another nuclear stress test with a follow-up after the stress test to determine if catheterization needed to be done. This test was ordered on 12/8/08 but not done. The cardiologist recommended follow-up in a year.	A recommended test was not done.
10/1/2009	Blood test showing uric acid of 7.6 (normal 2.4-7). No follow-up was noted.	

3/12/2010 March MAR shows delivery of KOP

1/4/2012	The January MAR documents delivery of metoprolol on 1/4/12 apparently on time.	
1/5/2012	Lab tests show a bilirubin of 1.4, LD of 244, and CO2 of 17 all of which are abnormal. There was no evidence a provider discussed whether any action needed to be done.	These lab tests were not reviewed
1/27/2012	The January MAR documents delivery of KOP medication on 1/27/12 apparently on time. A second MAR documents that the patient was absent and did not receive any doses of aspirin, isosorbide or Lisinopril. Another MAR documents the patient received this medication via KOP.	Documentation on the MAR was poor
2/26/2012	The February MAR documents delivery of KOP medication on 2/26/12 approximately on time.	
3/27/2012	The March MAR documents delivery of KOP medication approximately on time.	
4/27/2012	The March MAR documents delivery of KOP medication approximately on time.	
5/28/2012	The May MAR documents delivery of KOP medication approximately on time.	

10/17/2012	A nurse responded to the grievance of 10/14/12 stating that the nitroglycerin was available, that the omega 3 was discontinued and that if the truss didn't fit, the patient should sign up for sick call. There was no evidence that a physician had evaluated the patient for his multiple conditions for over a couple years.	The patient failed to receive ordered medication.
10/25/2012	The October MAR documents delivery of KOP medication approximately on time.	
11/29/2012	The November MAR documents delivery of most KOP medication approximately 4 days late. The November MAR documented that nitroglycerin was delivered 10/25/12 but this appears to be a postdated entry.	The patient failed to receive ordered medication.
12/13/2012	An LPN documented that the patient received a hernia truss. There was no provider evaluation associated with provision of this item.	It appears that the nurse was managing the patient's medical condition (presumed hernia) which is beyond the scope of her license.
12/26/2012	The December MAR documents administration of KOP medication including aspirin, metoprolol, simvastatin, and ranitidine on 12/26/12 approximately on time. Nitroglycerin, Lisinopril, niacin, Imdur were not apparently delivered to the patient.	The patient failed to receive ordered medication.

11/25/2014	A nurse practitioner saw the patient for chronic care follow-up. The NP only addressed hypertension and high lipids and failed to address the patient's coronary artery disease or the abnormal chest x-ray of 9/15/14 which appears not to have been addressed. Recent abnormal lab test (MCV 105) was not addressed. Medication was not addressed. Aside from checked formatted history questions, no history was taken.	The NP did not evaluate all of the patient's problems. The patient had potential heart failure and should probably have had an echocardiogram. The failure to evaluate all of the patient's problems placed the patient at risk of harm.
2/13/2015	The patient filed a grievance stating he did not have an order for his niacin which had been prescribed previously for him to address his high blood lipids. The nurse responded that he did not have a current order for niacin and must place a sick call request. The niacin was not addressed by the NP at the latest chronic care visit in November including whether to continue or discontinue the medication. Notably, over the past year, MAR documents no longer verified receipt of medication. There are no documents in the medical record verifying receipt of medication. Only medication orders are present in the medical record.	The patient again needed to use the grievance process to obtain what he perceived as needed care.
2/19/2015	An NP saw the patient for chronic care but only documented hypertension and high blood lipids as problems. The most recent laboratory tests for lipids were not mentioned. The recent elevated MCV was not addressed. The patient complained of chest pain but his angina was not listed as a problem. The NP did not address the patient's grievance that he was no longer receiving niacin. A 90-day follow-upang. as .1 oneashe -6.((w(t)-1.1)]T3/ [(he 4/ [(he 1)-8(.)-5 2.2(i)3)2(1(pr)21.3nt)tt)-1.1nogripri e2 80952 01 Tw 9.96	

7/30/2013	Supplemental chart not provided until June 2016 right before report due. A provider saw the patient for chronic care. Only hypertension and lipid disorder were addressed. The history consisted of filling in the check box format of the chronic disease form. Medication problems were not addressed even though the patient had placed recent health requests stating that he was having problems with medication. Coronary artery disease was not listed as a problem.	The NP did not evaluate all of the patient's problems.

Patient 6

Date	Summary	Comments
4/2/2007	CT scan of the chest showed emphysema, but no evidence of the suspicious pulmonary nodule.	All patients suspicious for COPD should have spirometry and in this case full pulmonary function testing with blood gas testing, blood counts to assess for anemia, BNP with respect to assessment for heart failure, calcium and phosphorous and alpha-1 antitrypsin testing. Regular pulse oximetry should be done. ABGs should be done with low FEV1 (<50% predicted) which this patient had repeatedly, low oxygen saturation by pulse oximetry (<92 %), depressed consciousness, acute exacerbation of COPD, and assessment after initiation of oxygen in high risk patients. Chest x-ray and CT scan of chest are usually performed when cause of dyspnea is unclear and during acute exacerbations. This patient did not have recommended testing for his condition.
8/25/2009	AST 51 (<37) and ALT 70 (<40)	Providers did not appropriately assess or act on these abnormal laboratory results.
1/7/2010	T4 =15.4 (normal 4.5-12) free T4 1.81 (normal 0.93-1.7)	Providers did not appropriately assess or act on these abnormal laboratory results.
8/6/2010	An unknown writer documented that the	

11/30/2010 On an annual nurse evaluation the patient had a weight of 110 and measured 5 foot 9

5/12/2011	The patient was apparently asking to return to camp and was seen by an unidentified staff who noted that the patient was thin with COPD on Dulera and Atrovent and Albuterol 3 inhalers and intermittent Albuterol nebulization along with Theophylline an oral medication for severe COPD. This staff person documented that the patient could return to camp despite his COPD which had yet to be adequately classified.	The provider did not obtain pulmonary function tests/ blood gas to adequately assess the patient. The NP could have referred to a pulmonologist if he didn't know how to manage the patient.
5/20/2011	The patient was seen urgently for diarrhea(-1 tno ndeea ThiePstOP w]TJ 0.013 Tw 0T*at1	

9/23/2012	A provider documented that the patient had an exacerbation of COPD but took no other history except that the patient was better on steroids. The provider documented review of an x-ray that showed hyperinflation. However, there was no x-ray in the medical record.	The patient had symptoms of infection. There was no evidence of an x-ray in the medical record. But the patient certainly needed an x-ray.
9/23/2012	Another nurse note documented that the patient had a respiratory rate of 32 with a productive cough with a "bucket bottom full of fluid brownish sputum". The patient had chest pain but was afebrile. The patient should have been hospitalized.	Nurses were managing this patient who should have been hospitalized. There were no physician examinations. He should have been sent to a hospital.
9/24/2012	The patient was admitted to the infirmary. The admission note by a nurse practitioner documented diarrhea and said that the patient complained that it was hard to breathe. The NP ordered a stool specimen but did not start antibiotics, get a blood culture, blood count or blood gas. The examination did not include an oxygen saturation. The NP did not order a chest x-ray or laboratory tests indicated for his prior symptoms. The NPs history was poor and did not include information identified by nurses over the last few days.	The NP failed to take an adequate history, failed to complete an adequate examination, failed to order appropriate diagnostic tests and had a treatment plan that was not consistent with the patient's complaints for this episode of care and for his complaints over the last several days. The patient should have been sent to a hospital.
9/24/2012	An infirmary admission record recorded a pulse of 125 but a temperature of 98.7.	
9/24/2012	At 4 am a nurse documented that the patient complained of still being nauseated.	
9/24/2012	At 9:45 am a nurse recorded that the patient felt like he was going to faint. The pulse was 111 and oxygen saturation was 86% on room airas 1OF.1(ha)-12.3(t)-1.1(t)-1ha. .44 re W n .1(.4661.44 226.2(t)-1i)3.1(t) .1(.448 0c)-8(u(.	

9/24/2012	At noon an RN saw the patient. The pulse was 125 and respiratory rate 26. The patient had productive cough and was using accessory muscles to breathe.	
9/25/2012	At 1:04 pm a nurse documented an oxygen saturation of 86% on room air with shortness of breath and abdominal cramping. The patient was speaking in a "pressured and scared tone". Based on the description of the patient, he should have been sent to a hospital.	The patient needed a higher level of management that was not occurring at the facility.
9/25/2012	The patient was sent to a hospital at 1:20 pm for COPD exacerbation and abdominal pain based on a nurse consultation with a physician.	The patient was on an observation unit for 3 days intermittently and inadequately evaluated by nurses and nurse practitioners without appropriate diagnostic testing. This placed the patient at significant risk of harm.
9/25/2012	At the hospital the patient had a WBC of 11.8, a pO2 of 76 with a pCO2 of 43 with a dense consolidation of the left upper lobe on chest x-ray. The sodium was 132. The patient was diagnosed with high risk respiratory failure and was admitted to the ICU. The patient was found to have a lung mass. This was consistent with pneumonia or cancer. The patient was noted to have malnutrition as well.	This patient was placed at significant risk of harm by this untimely admission to a hospital. The patient had malnutrition showing lack of attention. The patient had very infrequent provider evaluations at the prison and was not seen on two occasions for months despite having advanced COPD.
10/1/2012	The patient was discharged back to prison on antibiotics and oral steroids.	
10/1/2012	Upon return to the prison the patient was admitted to the infirmary by an RN at about 4:30 pm. The pulse was 120 and the weight 104. The patient received no nutritional supplementation.	
10/2/2012	A doctor wrote an infirmary admission note. The doctor noted that the patient was on oxygen but could come off the oxygen later. The doctor did not address the need for pulmonary function testing or blood gas testing when the patient was stable. The doctor did not address nutrition even though the patient was malnourished. COPD and post-sepsis with respiratory failure and pneumonia were the only diagnoses. The doctor wrote an order for tapering the oxygen and ultimately discontinuing after 2 days without any assessment of long-term need.	The doctor did not address all of the patient's complaints and the plan did not appropriately stage the patient's COPD disease including whether the patient needed long-term oxygen therapy. This placed the patient at risk of harm.

10/23/2012	An NP saw the patient for follow-up on his respiratory status. Except to note that the patient was recently hospitalized, no history was taken except to note that the patient was weak and it was hard to get around. The NP assessed COPD but did not stage the patient's disease nor make note of the patient's progress. The NP did not note the x-ray results or note that a follow-up CT scan was recommended. The chronic clinic for this patient never occurred.	The evaluation was inadequate. Minimal history was taken. The NP did not order the follow-up x-ray, recommended CT scan, or order pulmonary function tests to stage the patient's COPD. This was a deviation from the standard of care.
11/5/2012	An NP saw the patient but except for noting that the patient's breathing was better took no history. The NP failed to check the 9(ent)-1.1(')-3.c508 4llow4.4(onnd t)-1-17.5(he N1(w)9.1(ahTAu f)-.145 Td T)-17.5(1(.)-13.-1.1(e)- COe n TP. T not prwprd ofed.	

[redacted]

2/7/2013	A nurse evaluated the patient. The patient had temperature of 99.3 with respirations of 20. PEFRs were 200/180/220. The patient had productive cough. The nurse documented that the patient was worse and referred the patient to a provider.	
2/8/2013	An NP saw the patient. The NP took virtually no history and performed minimal examination. The NP arranged for a nebulization treatment but did not otherwise change therapy or do any other testing (e.g. chest x-ray, spirometry, blood counts, etc.)	The NP failed to take a proper history; failed to

3/14/2013	An NP documented admitting the patient apparently to an infirmary bed until seen by a physician. However, there were no physician notes in the record. Later that same day the NP documented speaking with the Regional Medical Director about the patient and said that there were further orders. Later still the same day the NP evaluated the patient and documented that the patient was breathing "OK". No history was taken and minimal physical examination was done. The plan was unclear. The initial provider orders for this date include a Duoneb treatment now with repeat PEFR testing. Later orders included changing Duoneb treatments to every 6 hours and starting Solumedrol along with Ciprofloxacin and oral prednisone on a tapering dosage. Later Theophylline was added along with 1 liter of oxygen. A chest x-ray was ordered stat.	Documentation was poor. It was not possible to determine what the providers were treating. It

4/30/2013 5/17/2013	A provider documented a note stating that the patient was still on tapering steroids. The note documented sending the patient to general population; it isn't clear that the patient was in higher level housing as there was no provider evaluation for over a month. The provider ordered hepatitis testing, blood count, chemistry panel, ferritin and ANA.	Provider visits were not consistent. Based on the provider notes, it was not clear where the patient was being housed.

9/5/2013	The Regional Medical Director discharged the patient from the infirmary with a diagnosis of end-stage COPD. There was no physical examination. The doctor documented poor prognosis. If the patient had COPD, the stage of his COPD had not been documented by a pulmonary function test.	To document poor prognosis without ever staging the patient's COPD was inappropriate care. The patient should have seen a pulmonologist and been questioned with respect to exertional capacity. Given the lack of physician coverage at this facility, the patient should have been referred to a pulmonologist.
9/30/2013	The Regional Medical Director documented that the patient was discharged from the medical observation unit because "we do not have space for him in the MOU." There was no clinical note for this patient.	The Regional Medical Director had stated previously that the patient had a poor prognosis. If there was no room on the MOU at Staton, then he should have found room at another facility. This placed the patient at risk of harm since he would have to walk more than he was probably capable of doing.
12/28/2013	A nurse saw the patient for shortness of breath. The weight was 125. The pulse oximeter was 97%. The nurse seeing the patient was an LPN who is not trained to assess the patient. A-12.2(pa-1(ne)-12.2(a)-12.2(i)3.1(ne)-12.2.2(i)3.1(t)-1.1(hat)-13.2(t) pl)-8.9.9(at)-	

	very high.		
2/5/2014	A physician saw the patient who		

2/18/2014	A physician saw the patient who had a pulse of 103 with an oxygen saturation of 97 on room air. The doctor wrote a very brief note stating that there was no significant change. Yet the patient was apparently not in distress and had a normal oxygen saturation on room air. This was inconsistent with severe COPD. The medications were not addressed. Pain was not addressed. The doctor did not address the patient's therapeutic plan.	The patient had a 97% oxygen saturation on room air, was on steroid medication without indication, was on narcotic medication without indication, did not have abnormal test results (ANA) reviewed, did not have a definitive status of his lung disease, and was placed in hospice when he apparently was not terminal. This is neglectful care.
2/25/2014	A nurse documented a hospice note and documented that the patient was only using oxygen at night. The patient never had an evaluation to determine if continuous oxygen was indicated. The patient did not appear to have an indication for continuous oxygen. The diagnosis may not have been correct.	
2/26/2014	A doctor saw the patient in hospice. The pulse was 82, PEFRs were better that they had been in a long time at 250/300/250 with an oxygen saturation of 93%. The patient said he felt better. The doctor took almost no history; did not address the ANA or improvement and continued DNR status.	The doctor still did not have a definitive status determined for his lung disease and did not adequately monitor the presumed COPD, long-term steroid use, narcotic use, abnormal test result (ANA). The patient should have been referred to someone who could manage the patient appropriately.
3/11/2014	A doctor again saw the patient who had normal vitals with a 98% saturation and felt "fine". Almost no history was taken with minimal physical examination. The doctor wrote that the patient was DNR even though the patient was clearly not terminal.	The doctor still did not have a definitive diagnosis of the patient's condition and did not adequately monitor the presumed COPD, long-term steroid use, narcotic use, abnormal test result (ANA). The patient should have been referred to someone who could manage the patient appropriately.
3/19/2014	A physician saw the patient in hospice the	

3/26/2014	The doctor noted weight up to 130, saturation of 98% with PEFR of 300. The doctor noted that the patient had a positive ANA and ordered a DS DNA test but instead the patient should have been referred to a rheumatologist and possibly a pulmonologist. A pulmonary function test was indicated to determine if the patient had pulmonary fibrosis.	The doctor still did not have a definitive status of the patient's lung condition and did not adequately monitor the presumed COPD, long-term steroa def uate1 Tw 9.9dbM uum.663 0 Tdab ( )T-12o st winss1.8(m)l13.1(i)3. T* [24.9((-12.3()-1.1(A)2.3(t)-1.1()-12.3(i inadeq st.he adeqtieion . C-1.1( )-12.2(lat)-1.1()-24.4(onar)-18.4(y)16.1(f)-1

7/24/2014 A provider saw the patient for chronic care clinic. This was the 1st chronic care visit in the record. The doctor noted hepatitis C, positive ANA and COPD as problems the weight was now 130; oxygen saturation 98%, triglycerides 217. The doctor noted that COPD was diagnosed in 1995 but PFT results were not documented. It is not clear that this was an accurate diagnosis. The doctor documented that the patient knew nothing about the positive ANA. The doctor ordered an A1c but had no therapeutic plan for the +ANA. The hepatitis C was also never evaluated. The doctor did not address medications yet the patient was continuously on oral steroids for almost a year which appeared to be raising the blood sugar. The doctor did not consider discontinuation of steroids. The indication for steroids was not clh( )-12.1(w)9.1(as)-8( )-12.2(.9-.2(.9-.23d(er)( )-12.1(w)2.3(i)3.1(d i)3n(or)-6

9/25/2014

11/23/2014	A provider was to perform a chronic clinic follow-up but the provider was unavailable and the visit was not conducted.	
12/29/2014	A doctor conducted a chronic clinic follow-up. A history with respect to COPD was not performed. The PEFRs were 160/160/150 oxygen saturation was 95%. COPD was listed as in good control and hepatitis C was in good control but the APRI indicated possible borderline fibrosis and not work up was done. The ANA	

1/29/2015	A physician saw the patient for chronic care follow-up. The doctor didn't document an adequate history for COPD. The saturation was 96%. COPD and ANA were listed as in fair control without a basis for giving this assessment. The physician failed again to conduct a diagnostic evaluation of the positive ANA. The hepatitis C was documented as in good control but there was no evidence that the patient was being monitored for this. The doctor noted an abscess but documented that the patient refused an incision and drainage. The doctor failed to monitor the indication for long term steroid use.	The doctor again failed to address all of the patient's problems and failed to address long term steroid use that was likely to harm the patient.
2/2/2015	A nurse noted that a physician gave orders for stat lab tests and blood cultures but stated being unable to obtain these without stating why. Solumedrol was given IM and the patient refused Duoneb. The orders were given by the Regional Medical Director because there was no physician available at the facility.	The patient should have been sent to an ER for evaluation if there were not physicians available on site. Remote control management by phone is inadequate care.
2/3/2015	A nurse documented that the patient had severe shortness of breath and was using the inhaler without improvement. The patient was on oxygen by nasal cannula. Vancomycin and Solumedrol were ordered but the physician note documenting this was not in the record.	The physician ordered medication by phone wi**t**sà(^Ú 3 S OÕd ªŽ1 #ï|ã Jâ>÷®#ït *Y ^ º>

3/27/2012	The patient was discharged from the hospital. The patient had such a significant abscess that the penis was completely buried. The urethral meatus was not visible and the patient had developed urethral stricture making him unable to urinate. This resulted in renal failure and outlet obstruction. The patient had massive necrosis requiring orchiectomy and extensive debridement of necrotic tissue. The white count was over 19 thousand. The hospital physician instructed the prison to do daily dressing and debridement. The physician was worried about potential for infection and said re-admission might be necessary.	The failure to promptly hospitalize the patient for an emergency for 3 days resulted in loss of the patient's testicle.
3/27/2012	After discharge from the hospital, there were no infirmary, nursing or provider notes in the medical record. It was not possible to verify whether the patient was evaluated.	The patient was not evaluated appropriately at the facility. There appeared to be no medical director at this site and there appeared to be inadequate nurses on the infirmary. This placed the patient at risk of harm.
3/30/2012	An urologist saw the patient in FU. The wound was healing and the Foley was still in place. The patient had some swelling.	

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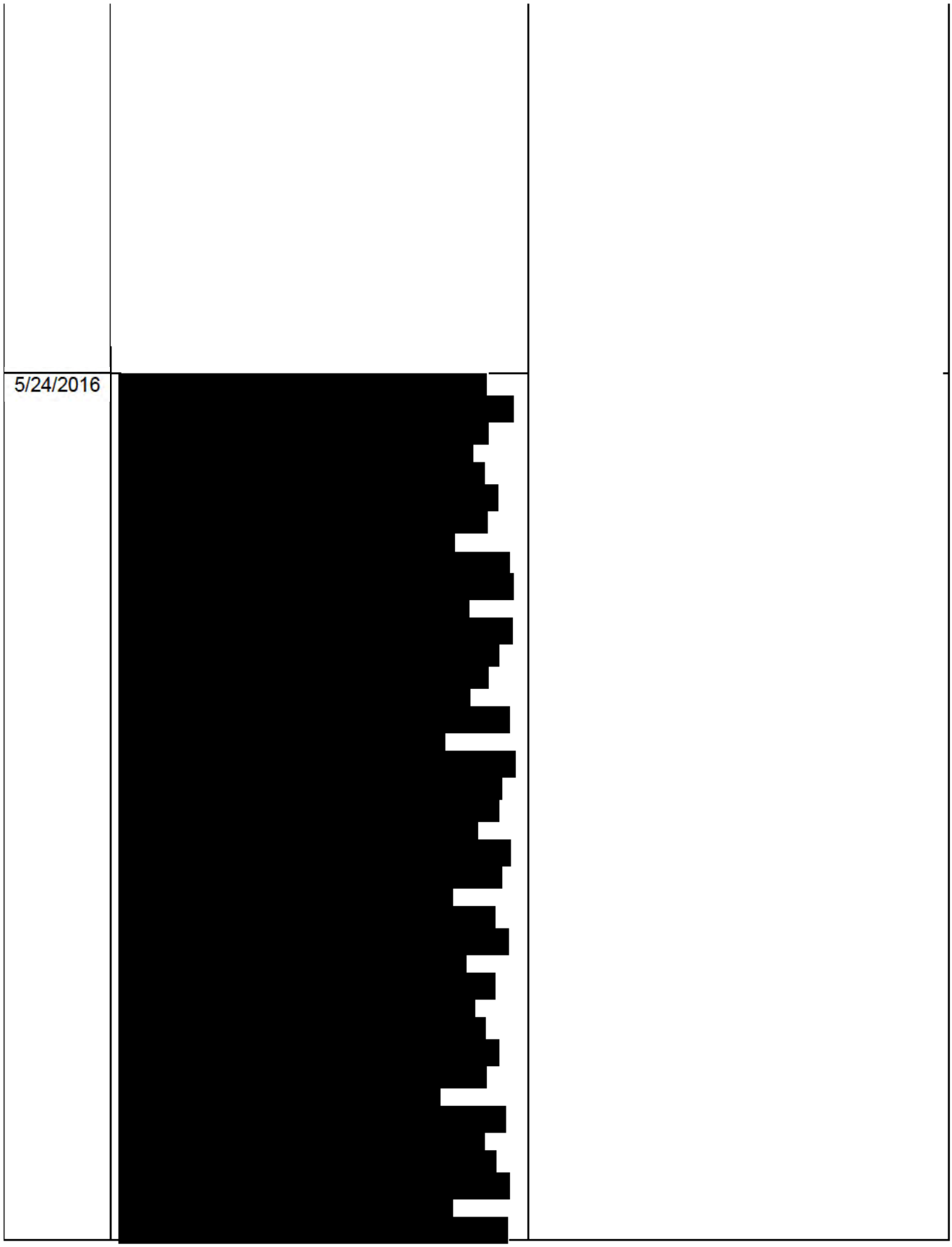
4/15/2012	The patient was admitted to the hospital for cellulitis of the surgical site. The surgeon's admission note documented that they "will try to control his diabetes". This had not been listed as a problem at the facility. A consultant during this hospitalization mentioned that during the prior admission in March the patient was treated for septic shock. The description of events then by the consultant included that the patient had pus from the abscess and "massive necrosis in the left scrotum extending to the phallus and up into the groin (there was no hernia)". The consultant mentioned that the patient had a hemoglobin of 7.3 with a hemoglobin A1c of 6.3. Apparently the patient was transfused. The 2nd surgery included debridement of necrotic tissue in the inguinal area. The infection during the 2nd hospitalization was with MRSA. The patient was discharged on HCTZ, vancomycin, Crestor, Naproxen, iron, Prilosec, and 81 mg of aspirin.	Because of lack of care of the patient, the patient developed an extensive, necrotic abscess that was life threatening. There was no documented nursing notes on the infirmary and no evidence that a provider

5/30/2013	The patient filed a pro se malpractice suit in circuit court of Limestone County against Corizon, et al. The claim was that on March 16, 2012 the patient noticed swelling in his groin and scrotum. The patient stated that on Saturday 3/16/13 the patient sought medical care by notifying the officer that he wanted to be seen in health care. The patient couldn't walk so he was placed on a wheelchair and taken to the health care unit. A nurse saw him. The patient alleges that there was no practitioner on duty and that the nurse accused him of waiting until the weekend so that he could expose himself to the nurse. The patient alleges that the nurse did not call a provider; instead gave him Tylenol and instructed him to ice the scrotum and that he would see a physician the following Monday. The patient alleges that the following Monday the doctor was not available in the morning. Later that day the doctor saw the patient who apparently had swelling in the groin area and scrotum. The patient said he wasn't able to urinate. The doctor placed the patient in the health care unit and ordered drinking water and ice on the scrotum. The patient then alleged that on Tuesday the doctor attempted at catheterize the bladder but was unsuccessful. The doctor then arranged to have the patient transferred to a hospital. The patient was told that he had gangrene of his scrotum which required surgery including removal of the left testicle. The patient alleges that follow-up care after hospitalization was poor resulting in an infection to his surgical site necessitating re-hospitalization and a second surgery. The patient alleged that failure to adequately change dressings resulted in the infection. After return to the prison, follow-up with the surgeon was allegedly prohibited. The patient apparently lost blood during the surgery but claims that no action was taken. Months later the patient claims that prison staff left packing inside his wound which he physically removed in June 2012.	This is the patient's version of events.
6/26/2013		

6/20/2014	A nurse evaluated the patient for abdominal pain. The nurse documented pain when trying to reduce the 4 by 5 cm hernia. The nurse referred the patient to a provider.	This hernia was not documented as a problem and not documented as a physical finding on the prior chronic illness evaluation. The abdominal examination was documented as normal.
6/24/2014	A nurse practitioner saw the patient on 6/24/14 for chronic care follow-up. The provider documented high blood lipids and resolved anemia as problems. The provider took no history. The BMI was 37.7 and the LDL cholesterol was 116 with an HDL of 41 and triglycerides of 230. On physical examination the provider	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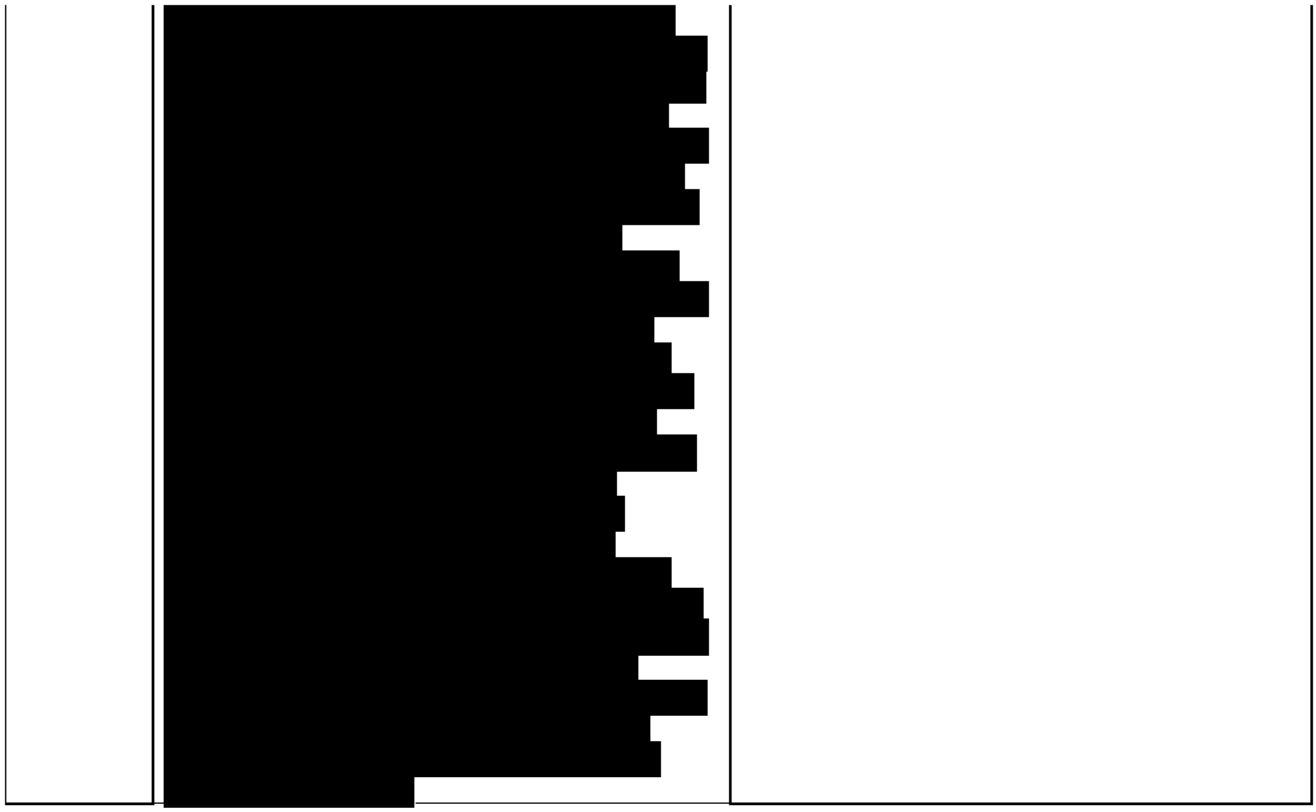


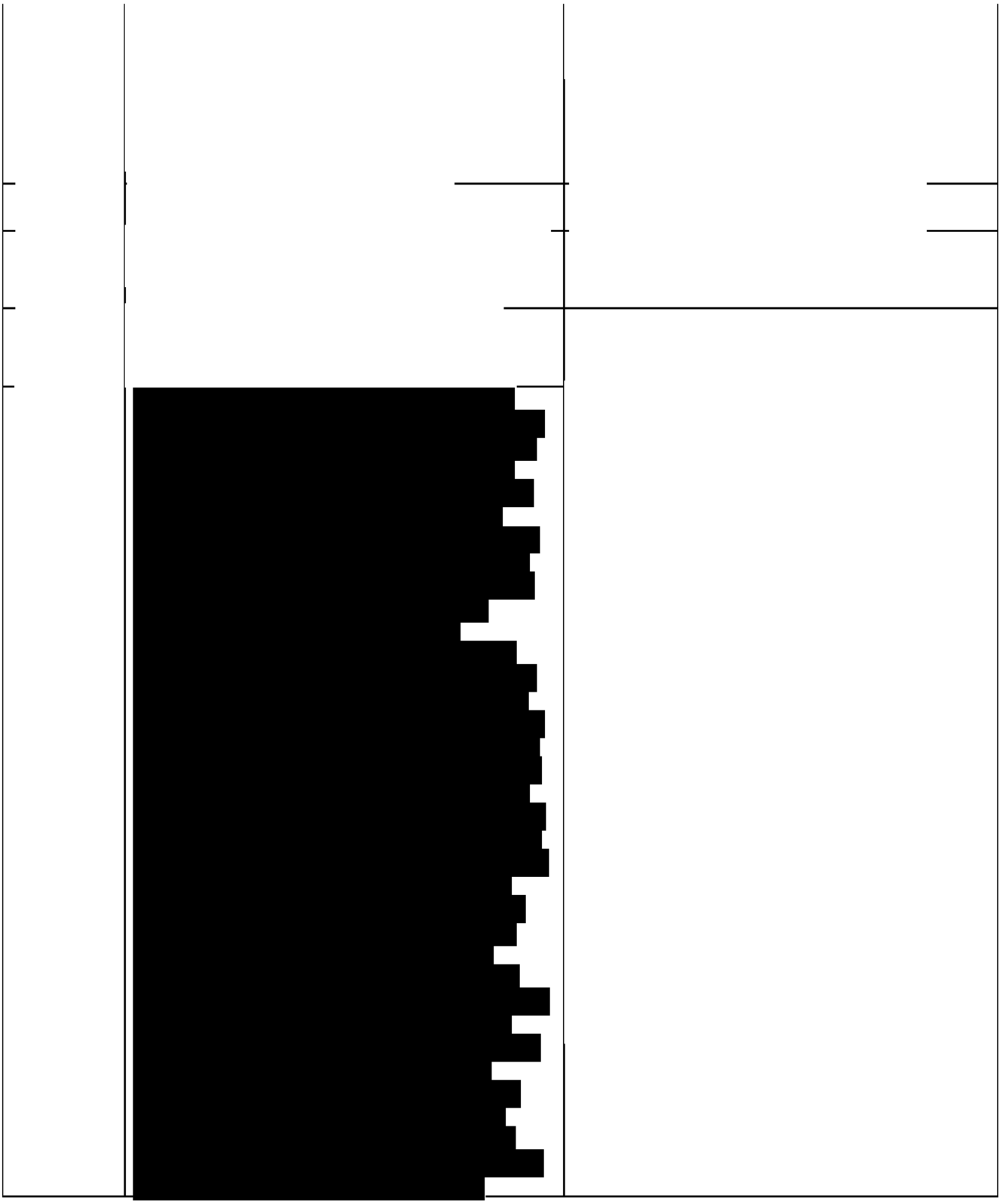
	Comments
12/19/2012	

6/6/2013	The admission note to the Kilby infirmary was on 6/6/13. The admission diagnoses were cellulitis, hypertension, renal insufficiency, rule out hepatitis, and liver cirrhosis.	
6/7/2013	A doctor at Kilby documented that the patient had end-stage liver disease with cirrhosis and started lactulose. The doctor ordered no other interventions for ESLD including vaccination for hepatitis A or B; EGD, ultrasound to screen for hepatocellular cancer, beta blocker but did start lactulose.	The doctor identified cirrhosis but failed to initiate other treatment called for by OHS policy. Also, the provider did not discuss treatment options for his hepatitis C. The patient was now identified as cirrhosis but had not yet been offered treatment.
6/7/2013	BNP 325 (normal 0-100)	This test is used to identify heart failure. However, it only suggests heart failure. This person did not otherwise have enough evidence to suggest heart failure.
6/12/2013	The cellulitis was improving but there was significant swelling and erythema so the doctor continued the antibiotic for 5 more days. The plan was to transfer the patient back to Ventress.	
6/14/2013	The doctor documented that the cellulitis was resolving. The doctor also newly diagnosed heart failure on the basis only of the BNP. The patient probably didn't have heart failure as there were no other signs. To verify this the doctor should have ordered an echocardiogram. The doctor continued the antibiotic.	There is a reluctance to order diagnostic tests for diagnoses. Doctors presume patients have disease instead of performing diagnostic tests. This is below the standard of care.
6/24/2013	The patient was discharged from the infirmary.	
6/25/2013	The patient returned to Ventress. On the day of arrival at Ventress, the nurse at Ventress documented on the intra-system transfer form that the groin wound was still draining.	The wound was not healed and the patient should still have been on antibiotics.
7/1/2013	A doctor at Ventress evaluated the patient. The doctor noted that the wound was healing. There was still a "superficial wound". The doctor discharged the patient from the Ventress infirmary and sent the patient to his housing unit.	The wound had not completely healed. The antibiotics should have been continued and it appeared that the patient needed further diagnostic work up.

5/20/2014	The doctor saw the patient for chronic care. He took a history that the patient took lactulose on weekends and advised the patient not to use alcohol, drugs or have tattoos. The exam noted no edema. The doctor assessed hepatitis C with cirrhosis and decreased platelets. The doctor initiated no interventions for the cirrhosis.	The doctor continued to fail to properly treat the patient's hepatitis C.
6/16/2014	The doctor's only history was to note that the patient didn't smoke and "c/o joint pain". There was no other documented history. A few of the irrelevant check boxes were checked. The doctor noted pitting edema of the lower extremities. The only assessment was hepatitis C with increased liver function tests. The doctor initiated no interventions for the cirrhosis.	The doctor continued to fail to properly treat the patient's hepatitis C. The joint pain complaint was inadequately evaluated.
6/17/2014	AST 146; platelets 95K; bilirubin 1.6	The patient continued to have likely cirrhosis.
7/15/2014	A doctor saw the patient for chronic care. Except for checking irrelevant boxes on the	

10/29/2014	A doctor performed an admission note to the infirmary at Kilby. The doctor documented that the patient had necrotizing cellulitis from Coumadin. The history was not thorough. The physical examination was the acronym WNL with an arrow through the entire examination section with the one comment "necrotizing cellulitis RLE". The doctor documented that the antibiotics would continue and he would watch for progression of fasciitis a serious deterioration of cellulitis. The doctor noted that if the patient didn't improve he would refer to surgery. The patient was on vancomycin and Cefepime along with prednisone, Vasotec, Lasix and spironolactone.	This was a dangerous situation. Kilby's infirmary is not equivalent to a hospital and it was dangerous to move the patient there. This appears to be an effort to save money at the expense of the patient's safety.
10/31/2014		

11/24/2014	A doctor evaluated the patient and noted that he couldn't stand up. The nurses reported drainage. The doctor noted that his right leg was swollen and draining from ulcerated blisters. The ulcerated areas had necrotic tissue or eschars. The plan of the doctor was to consult with a wound care nurse.	The patient needed to be hospitalized immediately. This was a significant departure from standard of care.
11/25/2014	A doctor saw the patient again. The patient had 1-2 cm blister with cellulitis with ulceration and blisters.	This indicated deteriorating infection. The patient needed immediate hospitalization.
11/25/2014	BUN 42; creatinine 1.7; sodium 126; albumin 1.5; WBC 6.5; hemoglobin 8.8	These indicate significant anemia, early renal failure with hyponatremia. They were treating him with fairly large doses of Lasix and aldactone which could have caused the hyponatremia and dehydration. The albumin was very low and needed investigation as to whether it was related to liver or kidney disease or due to malnutre t12.3(w)9.28 47ld haveuB Tw 9



Patient 10

Date	Summary	Comments
2/3/2008	This is the first progress note of the medical record. It is a psychiatric progress note. There was no evidence of tuberculosis screening.	The medical record has no verification of tuberculosis screening on an annual basis.
1/7/2010	The patient placed a health request for hip and shoulder pain.	
1/8/2010	A nurse evaluated the patient and documented that the patient just wanted to get an egg crate mattress and referred the patient to a provider.	
1/14/2010	A provider evaluated the patient for hip pain. The patient weighed 244 pounds. A minimal examination was performed only of inspection and elicitation of range of motion of the hips. The patient had folliculitis. The provider ordered hip x-rays. There was no evidence of a hip x-ray or follow-up of the ordered x-ray in the medical record. The shoulder was not evaluated.	The provider did not adequately evaluate the patient's stated complaints from 1/7/10 of hip and shoulder pain. Ordered diagnostic testing was not apparently done.
1/28/2010	The patient placed a health request for abdominal discomfort and hip pain.	
2/1/2010	A nurse evaluated the patient and noted hip and abdominal pain and referred to a physician.	This evaluation was 3 days after the request.
2/3/2010	A provider [title not signed] saw the patient for abdominal and left leg cramping. The provider performed minimal history and examination and diagnosed gastroenteritis "recovering phase". Aside from recommending fluids, no other treatment plan was initiated. The hip x-rays ordered 1/14/10 were not checked and there is no evidence that they were done.	Ordered hip x-rays do not appear to have been completed. Inadequate evaluation occurred.
2/19/2010	HCTZ was discontinued	The patient's medication were apparently changed without discussion with the patient.
[redacted]2/20/2010	The patient placed a health request asking to see a physician about his blood pressure and	

6/25/2010 An NP signed off on an annual health evaluation. The TB skin test was recorded as

10/22/2010 10/22/2010	A nurse evaluated the 10/20/10 health request and documented referral to a physician the same day.	

1/5/2011 A provider ordered a tapering dose of steroids starting at 40 mg prednisone tapering over a 12

2/21/2011	An NP saw the patient for headaches. The only history taken was that the patient had headaches not relieved by multiple medications. Aside from examining the eyes, the only documented examination was to state "neurologically intact" which is meaningless documentation. The assessment was headaches and GERD. The NP started Topamax a medication used to treat migraines. The NP also prescribed Motrin at 600 mg BID and Prilosec.	The NP failed to take adequate history or perform adequate examination for a person with long-standing headache. Long-term headache should have been evaluated with a CT scan or MRI of the brain.
3/10/2011	A provider saw the patient for abdominal and rib pain which had been present for about 6 months. The pain increased with breathing and palpation. The doctor diagnosed muscle strain. This group of symptoms suggests pleural disease or rib disease, yet the provider ordered x-rays of the abdomen which did not appear to be involved.	The choice of diagnostic test could have been better.
3/21/2011	A PA saw the patient for follow-up of headaches. The BP was 142/90 which is abnormal. The pulse was 110 which is abnormal. These were not addressed. The patient said that the headaches were different after starting Topamax but the difference wasn't elucidated. The PA diagnosed chronic headache and sinusitis but had not examined the sinuses and did not take any history of sinus related problems. The PA ordered Zyrtec and Topamax. The Topamax is for migraine headache and the Zyrtec is an antihistamine	

4/6/2011	The patient placed a health request for unspecified skin problems. Notably, the skin biopsy previously recommended as alternative treatment never occurred.	
4/7/2011	A nurse referred the patient to a provider for an ongoing skin rash.	
4/8/2011	A PA saw the patient for chronic illness clinic and documented high blood lipids, hepatitis B and non-insulin dependent diabetes as problems. The hypertension was no longer listed as a problem even though the patient was being treated with an antihypertensive drug (Lisinopril). The PA documented that the patient complained of headache yet took no history except that the patient was getting better on Topamax except for the last few days when the headaches were getting worse. The BP was 134/82 which is abnormal for a person with diabetes. The LDL cholesterol was 123 which is abnormal for a person with diabetes. The PA did not make an assessment of the status of the high blood pressure and	

5/18/2011

7/18/2011	An eye clinic referral was denied; the Regional Medical Director said that the alternate plan was to manage the patient on site but what the management was to be was not specified. Apparently the patient was evaluated by optometry in 2010 when astigmatism was diagnosed. A new prescription didn't help the patient.	It is not clear what the alternative treatment plan should be. The referring provider was reasonably trying to eliminate eye conditions as a cause of the patient's headache.
7/28/2011	A PA saw the patient for chronic illness clinic. The only problems listed were high blood lipids, hepatitis B, and diabetes (diet controlled). The blood pressure was 130/80. The LDL-C was 129 and A1c was 5.9. The high blood lipids were documented as in good control which they were not. The patient's high blood pressure was no longer being documented as a problem even though apparently the patient was still on medication. Medications however were not listed.	This was a poor chronic clinic visit as the provider did not acknowledge all of the patient's problems and did not address all problems. The elevated lipids were not treated adequately.
7/29/2011	A nurse evaluated the patient for L ear pain. The nurse documented contacting a provider. An NP signed an order for Cortisporin otic drops without seeing the patient	It appears that Cortisporin otic was ordered but without provider evaluation. This isn't appropriate practice.
8/5/2011	An NP saw the patient for follow-up of ear pain. The NP continued Cortisporin eardrops which are for otitis externa; the NP documented that the patient had otitis media. The NP diagnosed and treated tinea cruris but did not document examination of the patient for this condition.	The NP was treating otitis media with a drug used for otitis externa. The NP treated a person for a condition without evaluation of the patient.
8/9/2011	The patient requested a blood test for hepatitis B. Apparently, even though the patient already had a diagnosis of hepatitis B, staff had either not diagnosed the condition or had not explained their diagnosis with the patient because on 8/15/11 another hepatitis A, B, and C test were ordered.	Communication with the patient was ineffective with respect to his prior positive hepatitis B test. Retesting the patient for hepatitis B a second time was unnecessary.
8/15/2011	A hepatitis A, B and C panel was ordered. Hydrochlorothiazide was started	
8/15/2011	A provider documented that the patient was being evaluated for lab results but the results were not in the medical record. The provider documented a history of hepatitis C even though the chronic illness visits documented history of hepatitis B. The blood pressure was 150/92 and the provider documented hypertension again which apparently had fallen off the problem list on recent chronic care visits. The provider did not document what medications the patient was on and started hydrochlorothiazide another blood pressure medication.	The system had lost track of the patient's medical conditions and failed to know what type of hepatitis the patient had or even whether he had hepatitis. There was no evidence that the hepatitis tests were done.

8/16/2011	A provider saw the patient for complaint of headache, foot pain and changes in bowel movements. The provider did not take a thorough history. Nevertheless the provider diagnosed irritable bowel syndrome, chronic tension headache and chronic foot pain and treated the patient with a nonsteroidal medication and fiber.	A neurology referral should have been undertaken as the patient had headache for over 2 years without improvement despite attempts at treatment.
9/25/2011	The patient placed a health request stating that he had severe headaches every day and thought that the headache might be from the Lisinopril.	
9/26/2011	A provider saw the patient for headache. The blood pressure was 142/92 which is high. The doctor diagnosed tension headache or intolerance to Lisinopril. The provider stopped the Lisinopril and started Norvasc	

2/12/2012 An NP saw the patient for chronic care for high blood lipids and diabetes. The NP documented that the patient was on Lopressor but there was no medical condition associated with this

9/5/2013	A provider saw the patient and documented MRSA lesion and continued Clindamycin but did not culture the lesion. The provider stopped Norvasc and started hydralazine 25 BID and ordered an A1c in 4 weeks.

9/11/2014	The patient complained of dizziness with palpitations for 4-5 months. Orthostatic BP was normal. He had a normal EKG. The patient appeared anxious. The ultrasound results were discussed with the patient.	
9/24/2014	An EKG showed sinus tachycardia	
9/30/2014	A nurse evaluated the patient for a complaint of	

11/20/2014	A PA saw the patient for chronic illness follow-up. Hyperlipidemia, hypertension, hepatitis B, and diabetes were listed as problems. The PA documented that the patient had no further chest pain while on Coreg. If this were true then there would be a high suspicion of angina which should have prompted a work up given the risk factors of the patient. The blood pressure was 122/82 and pulse was 94. The patient's weight was back up to 246 and the LDL was documented as 116. All of his conditions were listed as in good control. The PA without explanation increased the Carvedilol dose from 3.125 to 6.25.	The PA did not document a rationale for increasing the Coreg.
11/26/2014	A provider noted a tender nodule on the left breast and requested a mammogram along with pelvic and LS spine x-rays for back pain.	
12/1/2014	A hip x-ray showed narrowing of the articular space of the hips with spurring of the acetabulum consistent with degenerative arthritis of the hips. The LS spine also showed degenerative arthritis.	
12/2/2014	The request for mammogram was denied. The Regional Medical Director recommended surgical removal of the nodule for diagnosis.	
12/19/2014	A PA saw the patient for chronic illness follow-up. Hyperlipidemia, hypertension, hepatitis B, and diabetes were listed as problems. BP and pulse were normal. Although the A1c was documented as 6.5 no therapy was initiated. The LDL cholesterol was 116. The diabetes and hyperlipidemia were documented as in good control.	Medications were not listed. It was not possible to determine what medication the patient was on as no MAR records were in the medical file.
12/22/2014	Hydralazine 50 mg BID was started. The patient was additionally on Cozaar, aspirin and apparently Carvedilol and apresoline.	It wasn't clear why a new blood pressure medication was started.
1/7/2015	LDL cholesterol 126; glucose 128 and A1c 6.4	
8/1/2015	No records were found for August, Sept, or November of 2015	
1/13/2015	There were orders on the same day and time to both start and stop spironolactone. It wasn't clear whether the patient was still on this medication.	

7/19/2012	The patient refused chronic care visits for hepatitis C and hypertension. The patient was not on medication for hypertension and blood pressure values on nursing notes during 2012 were normal.	The basis for hypertension was not clear.
9/12/2012	ALT 58 (normal <41); AST 33 (normal < 40); creatinine 0.74 (normal 0.9-1.30)	A liver function test was still abnormal
11/6/2012	Patient placed a health request stating that he had severe left hip pain	
11/7/2012	Patient placed another health request for severe back pain and requested to see a doctor.	
11/8/2012	A nurse saw the patient for pain. The nurse recorded no examination on the nursing protocol; the nurse assessed alteration in comfort and gave 5 days of ibuprofen by protocol.	

4/16/2013 A doctor saw the patient for chronic illness clinic for hepatitis C and hypertension. The patient did not appear to have hypertension. Except for asking about nausea, vomiting, abdominal pain or diarrhea, no history was taken. ALT of 58 was noted but no comment was made. The hepatitis C was noted to be in good control. The viral load for hepatitis C was not ordered. FU was ordered for 6 months. The doctor did not address the patient's complaint of headache, fever and difficulty breathing for which the patient had submitted a health request on the same day. The doctor ordered minocycline for 14 days but gave no indication in his note why he ordered this medication. The doctor documented that the hypert13.21oo.1()-12. .2(t)-1.1.1(s)-8( )]gg33.8(s)-8cont0.3(e)12.2(w)-2.9(h)-12.2(y)16

11/15/2013	The patient was apparently sent to a local emergency room for a CT scan as recorded on a "Return from Offsite" form. An NP reviewed the patient post return on 11/19/13 and documented that the patient had a kidney stone. FU was recommended if the patient was unable to pass the stone but the patient had not been on an infirmary and the urine was not screened. The consultant recommended increased fluid, Macrobid, Flomax and Percocet but this was noted 4 days after the consultant evaluation. The NP consulted a physician who asked to have the dictated emergency room report along with the CT scan results and lab results.	The medication were apparently started on 11/16/13 when the patient returned from the hospital.
11/16/2013	A nurse noted that the patient had vomited 3 times and had chest pain. The nurse noted that an NP saw the patient for the same complaint on 11/12/13 and that cardiac enzymes were normal. The patient was sent to a hospital.	
11/16/2013	Vicodin,	

11/25/2013 An NP saw the patient for "pain" management. There was no evidence that the patient had been examined since the ER visit on 11/16/13. The NP said that the patient remained in pain. The patient complained of a hard time urinated. The NP stated that the patient was on naproxen but on examination had marked tenderness. The

4/19/2014	The patient placed a health request stating that he was in severe pain and couldn't urinate.	
4/21/2014	A PA saw the patient for chronic care follow-up for hepatitis C. The PA noted that the patient had low back pain (related to his sick call request on 4/19/). The PA did not ask about hematuria and didn't order urinalysis. The PA documented that the kidney stone "has passed" but the fact was that it was lysed via surgical laser therapy. The PA documented that the APRI was now 0.19 and that hepatitis C was in good control.	A repeat liver function test was indicated.
4/23/2014	Urinalysis negative for blood but positive for protein.	
4/23/2014	A nurse saw the patient for "urinary symptoms" without being more specific. The nurse referred the patient to a physician.	
4/25/2014	An NP saw the patient for FU of urinary symptoms and noted that the urinalysis was negative and chlamydia test was negative. The urine culture was pending. Notably, the patient's heart rate was 122 but was not addressed.	
4/29/2014	A nurse saw the patient urgently documenting on a "body chart" that the patient had multiple sores "all over body". The patient's pulse was 126. The weight was 169. The nurse didn't refer the patient.	The patient had an abnormal vital sign with a rash and should have been referred to a physician.
5/15/2014	The patient placed a health request complaining of back pain.	
5/16/2014	A urinalysis was positive for protein	
5/16/2014	A nurse evaluated the patient for back pain. The patient complained of occasional blood in his urine and painful urination.	The second page of the nurse occasional blood

5/27/2014 An NP saw the patient for passing out. The pulse was 86. The supine blood pressure

10/10/2013	The patient was received at Limestone but the intra-system transfer form was not used; instead a nurse wrote a single line that the inmate was transferred. The nurse noted giving the inmate information on MRSA, HIV, Hepatitis, tattoos, sick call etc. but documented nothing else.	The transfer screening did not occur according to ADOC policy.
10/10/2013	A nurse wrote on an inmate checklist that verbal explanation was given regarding access to health services including sick call and the grievance procedure. The problem was that the patient couldn't hear. The nurse did not acknowledge this.	It is not clear if effective communication occurred.
10/10/2013	The inmate transferred from DWR to Limestone. The intra-system transfer form indicated that the inmate was hearing impaired but the nurse stated that the inmate could read lips but that he preferred written communication. No medical problems were identified even though the patient had prior abnormal lab tests.	Effective communication appeared difficult.
12/2/2013	The inmate placed a health request stating in writing that "I am deaf and I need a hearing aid. The ADA (Alabama Disability Advocate) has told my family I am entitled to a hearing aid and I need one."	
12/4/2013	A nurse saw the patient for the hearing aid issue. The nurse did not identify why the inmate was deaf but that he was deaf since childhood. The nurse referred to a provider.	
12/12/2013	An NP saw the patient for a hearing aid and documented she had to communicate with the inmate through writing. The NP documented that the patient was "totally	

4/14/2014	The NP documented trying Target, HH Gregg, Walmart, and Best Buy but could not find an amplifying device that the patient could use. The NP documented finding a chargeable device at CVS and gave the information to an administrator to purchase.	The vendor wanted to give the appearance of obtaining a hearing aid when the device they were attempting to provide would be useless for the patient.
4/15/2014	A nurse evaluated the patient for headache and right eye pain and referred the patient to an optometrist.	
4/17/2014	An optometrist saw the patient and diagnosed a macular scar on the patient's right eye and a cataract on the left eye and said that these would need to be monitored.	
5/1/2014	The patient placed another health request asking about his hearing aid.	
5/5/2014	A nurse saw the patient who had questions about his care. The patient wanted to know what was the percentage hearing loss on his audiology test and what was wrong with his eyes based on the recent optometry visit. The nurse wrote that she "interpreted notes" for the inmate. It is clear that the patient did not understand the outcomes of his evaluations and was having trouble communicating.	Effective communication had not been achieved with the patient who did not understand what was wrong with him and the results of recent testing.
5/15/2014	The NP stated that the amplifying device required a charge and that the inmate was not able to keep a charged device on his person and that the device could not always have the device accessible from the health unit. The administrator was going to attempt again to get a device from the contract company.	
6/5/2014	The NP documented reminding the administrator about the hearing device.	
7/10/2014	The NP documented that she would re-submit a UM request for the device for the inmate.	This was appropriate.
7/10/2014	The NP re-submitted a request for the hearing aids stating "have exhausted efforts with local hearing contractor for alternate devices. Any other device other than above will not provide inmate with ability to balance".	This was correct.
7/10/2014	The doctor approved only one hearing aid despite prior information that the patient needed two devices for balance.	The Regional Medical Director did not appear to understand the reason for the request.
8/22/2014	AST and ALT were normal	
9/4/2014	The NP documented speaking again with the administrator about the hearing aides	Additional delays.

1/1/13	An LPN evaluated the patient for complaints of a fever and a cough based on the health request. The temperature was documented as 100.8 and the pulse was 100. Weight was documented as 137 pounds. The LPN did not ask about weight loss even though this is a prompted question on the NET tool. The only history was to check boxes with formatted questions and the nurse checked as positive questions about productive cough and fever. The LPN referred to a provider. The date of referral wasn't included.	LPNs should perform independent assessments as they are not trained to do so. A RN did not review this evaluation. The patient had urgent issues (cough and fever) that should have prompted an immediate provider evaluation. But the patient was referred as a routine and the appointment didn't occur.
1/8/13	Allegedly the inmate refused to see a physician but a staff person signed the form with a notation that the inmate refused to sign. An officer witnessed the signature.	Given the nature of the symptom the patient should have been called back at another time.
1/16/13	The inmate placed a health request complaining of chest pain and productive cough. A nurse wrote a brief response on the health request documenting that she gave Coricidin and Motrin to the patient and referred to a mid-level provider.	
1/16/13	An LPN completed a NET tool for "respiratory" but failed to ask formatted questions about night sweats or weight loss. The weight was documented as "20" and it appeared that the nurse documented the respiratory rate in the wrong box and failed to take a weight.	

1/29/13	An NP saw the patient for "F/U Pneumonia". The history was documented in the objective findings section and documented that the patient still had cough and was now on Azithromycin but did not get the nebulizer. Except for listening to the lungs no other physical examination was done. The NP did not order a white count or electrolytes. The NP ordered a follow-up in a week.	The history and physical examination were inadequate for a person with two lobe pneumonia. Even though the patient was 36 years old at this time, a more thorough evaluation should be done for someone with infiltrates in two lobes. The follow-up never occurred. The patient wasn't seen for a year.
1/7/14	A RN evaluated the patient for a complaint of "trouble breathing" for 2-3 weeks. The nurse used an upper respiratory NET tool which had a line for last documented TB test date. On this line the nurse documented the she couldn't find the chart. The patient complained of weight loss and cough although the weight was not taken. The pulse was 131 and blood pressure 98/80, vital signs consistent with sepsis. The nurse also documented that the patient had abdominal pain but did not assess this complaint. The nurse contacted a physician who ordered a single dose of parenteral Rocephin (an antibiotic), followed by oral Levaquin for 10 days along with Albuterol nebulization.	It is a significant departure from standard of care for a provider to order antibiotics by phone for a patient with unstable vital signs and difficulty breathing. The patient should have been sent to a hospital for evaluation. The doctor did not order a

1/10/14

1/15/14	A repeat chest x-ray showed prominent interstitial markings with airspace consolidation present in the left lung. There was a large cavity in the left upper lung. The conclusion was pulmonary edema vs atypical pneumonia. The report also documented, "There appears to be a large cavitary lesion in the left upper lung. Consider TB and neoplasm. I recommend CT to further evaluate." A physician reviewed the report and wrote "Agree CT ordered". However there was not a date for the day of his review. However the CT scan was not ordered until 1/27/14 over a week later.	A physician did not review a critical x-ray for over

2/4/14	The CT scan result was not in the ADOC medical record but was on the Department of Public Health record, parts of which were present in the ADOC medical record. The DPH record documents that the CT scan showed a cavitation with fluid in the right upper lobe along with lower lobe consolidation with miliary nodularity of the right lung. There was adenopathy in the left hilum. The conclusion was "extensive pulmonary and mediastinal abnormalities represent tuberculosis until proven otherwise".	All medical record documents should be present in the medical record.
2/4/14	A DPH note present in the ADOC medical record documents that the patient was a past positive but non-compliant with therapy "per documentation". He completed 47 twice weekly doses.	
2/4/14	ADPH TB clinical record/correctional contact investigation form was in the record. It indicated that the patient had weight loss from 150 pounds to 116 pounds. The report documented "massive loculated cavitary infiltrate LUL w/ miliary dissemination LLL and throughout R lung".	

2/6/14 A provider (apparently-note does not have title documented) admitted the patient to the infirmary. The note documents that the patient "has been ill for over a year". Virtually no other history was taken with respect to the patient's current condition. A brief physical examination was documented. The admitting diagnosis was cavitary tuberculosis. The abnormal laboratory

		been sent to a hospital for his safety.
2/12/14	A nurse documented a blood pressure of 80/51. The nurse documented that the patient drank about 350 ml of water without difficulty. The nurse discussed with the patient the need to drink fluid. But the patient was in a negative pressure cell. The nurse notified Dr. Hood of the blood pressure and he ordered intravenous fluid by phone order. Apparently the intravenous fluid was given in the isolation cell at 5:40 pm. A nurse checked the patient at 11 pm and the fluid was still infusing. By 2:30 am the patient was asking to have the intravenous line removed but a nurse noted that the fluid was still infusing.	This blood pressure is extremely low. A physician should have immediately evaluated the patient. Instead, a nurse called the Regional Medical Director for a phone consultation. This placed the patient at risk of harm. If there were insufficient physician staff, the patient should have been sent

2/18/14 Nurses obtained verbal orders for a change

2/24/14

2/25/14	At 9:10 pm dexamethasone IV push was given. An ACTH and random cortisol was collected at 9:38.	This test appeared to be affected by administration of parenteral steroids. It did not appe

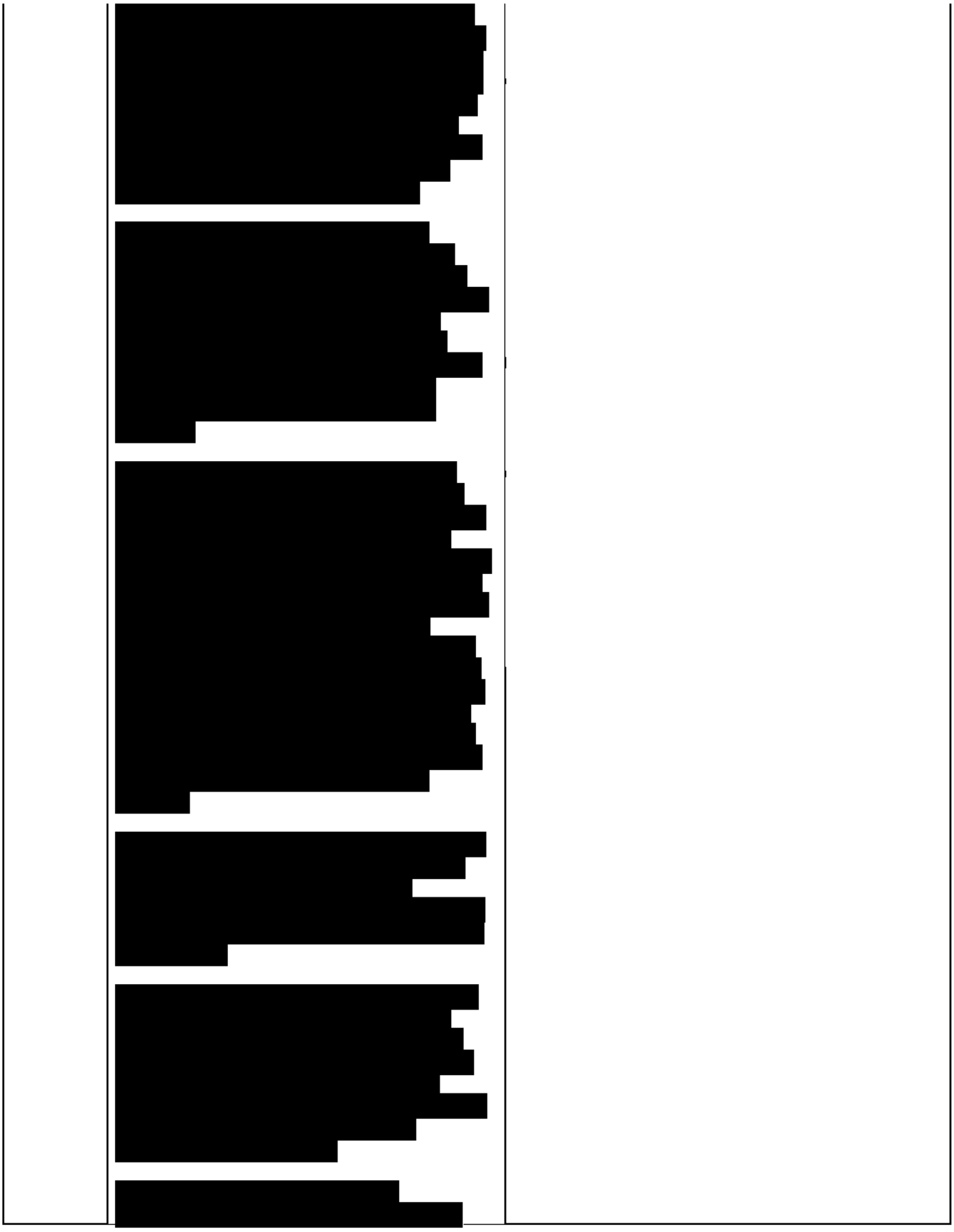
2/26/14	A second test was done to measure both ACTH and cortisol. This test is called an ACTH stimulation test. The test calls for administration of Cortrosyn IV and then at 30 and 60 minutes draw blood levels of ACTH and cortisol. However, Cortrosyn was requested on 2/25/14 and approved but the date of approval was not documented. There is no evidence in the MAR or medical record I reviewed that demonstrated that the patient received the Cortrosyn. Also only a 30 minute sample was done based on medical records I reviewed. The laboratory documented that the ACTH and cortisol levels were collected at 9:38 am only. A 60 minute test was not done. The cortisol was very low and the ACTH was minimally low. These are difficult to interpret because it is does not appear that the patient received Cortrosyn. The cortisol was low which suggests adrenal insufficiency but the ACTH was also low which does not suggest adrenal insufficiency.	The facility staff seldom if ever perform these tests and when adrenal insufficiency was suspected the patient should have immediately been hospitalized. The patient needed to be evaluated by an endocrinologist or have the test conducted in a facility with staff experienced in performing this test. It did not appear that the staff performed this test accurately.
2/26/14	The lab report showed a random cortisol of 4 (normal 2.5 to 25) and a low normal ACTH of 12 (normal 10-50). A low morning serum cortisol such as this patient has is strongly suggestive of adrenal insufficiency. This test was done about 9 hours after the patient was given dexamethasone	Cortisol is normally higher in the early morning. This test was done at 9:30 am and should be expected to be higher. A level this low suggested adrenal insufficiency. These tests are difficult to interpret and the facility should have consulted an endocrinologist.
2/25/14	Intravenous dexamethasone was given at 9:10 pm.	

2/27/14	A physician documented that the Cortrosyn stimulation test was completed yesterday. He documented that a dose of prednisone was given yesterday. He stated, "cortisol values determine further management".	The tests did not appear to be accurately performed.
3/1/14	A MAR documents for a nurse to use a tuning fork to check hearing on first of each month. This was done because the patient was on streptomycin. The recommendation to monito02 Tc 0.p.f24.4(oni)3.dtCuo4(on[t <<-6.3(s)-8.1(t)-1.1(of)-13.2(eac)-8(h)]TJ 0 Tc 0 Tw d<<-6.3(s)-8(	

3/3/14 3/4/14	The next morning a physician evaluated the patient. He noted that the Cortrosyn stimulation test was normal when it may have been done incorrectly. He failed to note that the patient had received corticosteroids on two occasions prior to the test. He documented that the patient had blood tinged sputum and said that the concern was breach of the pulmonary artery which was a serious concern. He failed to note multiple episodes of hypotension, tachycardia and fever present of the graphic record over the past two weeks. The only assessment was new onset hemoptysis. He ordered IV fluid and a stat hematocrit and wrote that if the hematocrit dropped significantly he would admit to a hospital. He did not note that the Regional Medical Director had recently ordered parenteral Rocephin for a fever of 104.6. This was gross lack of coordination of team management of the patient. He did not document the need to follow up on the blood cultures.	Coordination of care was a significant departure from standard of care. The patient should have been hospitalized.

6/17/14	A DPH representative wrote an email to the Regional Medical Director stating that based on negative culture results, [name redacted] could be released from isolation.	
7/2/14	The patient placed a health request stating that his feet were swelling.	
7/4/14	An LPN saw the patient for his 7/2/14 complaint. The LPN used a skin/nail problem NET form for the evaluation. The	

	effusion.	
8/16/14	HGB 12.5 (normal 12.3-17); platelets 547 K; iron low at 37	
8/22/14	An NP saw the patient for chronic care. The NP did not evaluate the MRI results and only assessed TB. The iron deficiency anemia or ankle issue were not addressed.	The NP evaluating the patient in chronic care did not address all of the patient's problems.
9/16/14	T3 was 216 (normal 72-180); HCT 37 (normal 39.3-52.5); platelets 516 K	
9/22/14	An NP evaluated the patient for chronic care. The NP took virtually no history and did not note recent abnormal lab tests including iron -8.9(e)-12.3(nt)-1.1	



1/31/2012

3/27/2012

3/13/2013	LDL 106; BUN 26; alk pho 175 (normal 40-156); AST 48 (<40); ALT 99 (normal <41); TG 189	The patient may have had fatty liver and should have had an ultrasound and probably needed treatment for his high triglycerides. An A1c test was indicated. This placed the patient at risk of harm.
3/21/2013	Hepatitis A, B, and C were all negative.	
4/10/2013	An NP again started seeing the patient in chronic care. An ultrasound of the liver was ordered and approved. The BP was 150/95. The NP noted the high glucose from about 6 months previous. The patient had polyuria but was on Lasix twice a day. The weight was 216. The patient was communicating with sign language but it didn't appear that the NP could understand sign language. The NP increase Cozaar to 75 mg. and ordered a diagnostic A1c.	The patient had not had an evaluation of his hearing device for almost a year and couldn't hear making it difficult or impossible for the provider to understand. The patient should have had an evaluation for secondary hypertension.
5/1/2013	The date wasn't clear but appeared to be May. This was the high acuity clinic. The doctor wrote that the patient had shortness of breath with exertion. The doctor wrote that the patient hadn't been receiving Losartan for two weeks. The BP was 154/102 the doctor didn't check the A1c that had presumably been ordered. The weight was 207.	This is the third time that the patient was missing his medication with adverse effect. He failed to check on the A1c, but it appears that it was not done as it was not

8/22/2013	Chronic clinic visit. The NP discussed the lab results. The BP 140/98 which is high. The NP wrote "impaired fasting BS" but the patient had diabetes. The NP started Glucophage at 750 extended release. And ordered another A1c and a urine micro albumin and an EKG. The NP did not adjust the BP meds even though the BP was elevated	The blood pressure medication should have been adjusted as the patient's blood pressure remained high, particularly since the patient had diabetes. The blood pressure goal should now be 130/80. Jab r
11/13/2013		

8/12/2014	Chronic care follow-up. The BP was 180/100 and rechecked at 140/90. The LDL of 119 was noted but not treated. The NP increased the Carvedilol to 25 and Minoxidil to 10	The LDL cholesterol elevation should have been treated. The patient had uncontrolled blood pressure for at least 2 years and should have been referred to a physician who could better manage this disease as the uncontrolled blood pressure was harming the patient.
8/29/2014	The patient had a medication sheet for Minoxidil which showed that the patient missed 21 doses of Minoxi	inoxJ ET Q BT 9.96 0 0 9.96 138.n ()-12.2(nd)]TJ(bet

Patient 15

11/18/2011	A provider filled out a chronic disease clinic initial baseline medical data base and identified only hypertension, cardiovascular

1/12/2012	An NP saw the patient who complained of food getting stuck in his throat. He told the doctor that he had a history of esophageal stricture with a prior balloon procedure. The NP ordered old records and sent the patient to the doctor to evaluate.	
1/26/2012	The patient ate an apple and wasn't able to swallow it and it hurt. The patient had vomited. The LPN doing the evaluation contacted a provider who ordered sick call if the pain didn't improve.	
1/26/2012	An NP saw the patient and ordered a soft diet until the patient saw a gastroenterologist.	

7/9/2012	The patient told a psychiatric NP that he was having hypoglycemia and was not eating all his meals.	
7/25/2012	Glucose 158; uric acid 9.1; TG 237; A1c 6.4; HDL 23; HGB 12.1; BUN 22; phosphorus 2.5 (normal 2.7-4.5); HCT 36.5; LDL 74	
8/27/2012	Chronic illness clinic. BP 140/69. LDL 64 A1c 6.4.	
8/29/2012	The inmate refused rectal exam for colon cancer screening.	
10/8/2012	The inmate placed a sick call request stating that his sugar has been high.	This did not appear to be evaluated.
11/2/2012	The inmate transferred to Kilby. The BP was 120/60.	
11/7/2012	The inmate placed a sick call request stating that his sugar has been in the 200 range. A nurse triaging the slip recorded a blood pressure of 170/90 which is high. The LPN referred to an NP.	

T w 1 0 . 9 5 e f 1 3 2 . 8 4 1 6 . 7 2

8/21/2013	Chronic illness clinic. BP 120/56; A1c 6.6. The doctor did not address the urinary incontinence and did not assess the control of the patient's problems. The weight was 171. The doctor documented a 30 pound non-intentional weight loss. The doctor ordered FOBT, PSA and CEA test to evaluate the weight loss. The patient's weight at intake was 158 pounds so it is not clear how the physician obtained values of a 30 pound weight loss.	
8/22/2013	EKG showed sinus bradycardia with low voltage and questionable anterior infarct age indeterminate but the QRS looked wide with an RSR prime.	
8/22/2013	Hemoglobin 11.6 (normal 12.3-17) CEA normal	
10/24/2013	The patient placed a health request stating that he had burning and hurting with urination.	This is consistent with a urinary tract infection.
10/25/2013	An NP evaluated the patient for the health request. His penis hurt when he urinated. He was having a difficult time getting to the dining hall and to pill call given his disability. The NP documented that the dysuria might be due to inability to get medication daily but didn't document if he was missing medication. The NP documented he would benefit from assistance with activities of daily living. The NP documented she would talk to the doctor. The NP didn't order a urine test or culture. The NP gave the Ditropan KOP even though the patient had a cognitive disorder.	The patient should have been in a nursing home type environment. He had a disability and was unable to fend in a prison environment. The NP didn't order a urine test or culture even though the patient had symptoms of a urinary tract infection. Persons with cognitive disorders shouldn't be given keep on person medication. 2
11/3/2013 11/10/2013	A1c 6.4	

11/13/2013	The patient was admitted to the infirmary when discharged from the hospital.	
11/18/2013	The patient was discharged from the infirmary. When the patient was discharged he was provided with a urinal to keep by his bed.	
11/19/2013	creatinine 1.37; A1c 6.5;	
1/21/2014	Chronic care. BP 90/50. The patient told the doctor that he had to pay someone to help him get to pill call because it was hard for him to manage the wheelchair. He had trace edema of the legs. The doctor noticed that lipids had not recently been drawn.	Hypertension was not listed as a problem but the patient was still on HCTZ and Lisinopril for HTN. The Tamulosin would also be expected to lower the blood pressure. His pressure was too low and placed him at risk for a fall. He needed to have his medication lowered. The patient needed placement in a nursing home type environment.
1/23/2014	A1c 6.8; LDL 76	
3/7/2014	Normal chest x-ray	
3/24/2014	Chronic illness clinic. The BP was 162/70. Except for "paraplegia" all physical examinations were documented as "WNL". There was no history except that the patient	

8/28/2014	Chronic care clinic. The doctor took no history. The BP was elevated at 190/90 and the A1c had risen to 8.1. Under physical examination, the doctor wrote “WNL” and drew arrows through the physical examination section. This included the neurological examination. The doctor was documenting that the neurological examination was normal when the patient was in a wheelchair for paraplegia. The doctor made no modifications to therapy or diabetes care even though both had deteriorated since discontinuing medications.	The doctor performed a careless evaluation not even recognizing that the patient had paraplegia. The diabetes care had deteriorated since stopping insulin. The blood pressure control had significantly deteriorated. The polypharmacy issue was not as much of an issue since the patient was on the infirmary.
9/18/2014	A doctor met with the patient to discuss significant non-compliance issues. The doctor documented that the patient had a problem getting up at 3 am to receive his medication. Since the patient was on the infirmary, it should have been possible to make an accommodation. Instead, the doctor merely advised the patient of the risk of non-compliance.	To make a partially paralyzed man with significant cognitive disorder wake up at 3 am to go to a pill line is unnecessary and cruel.
10/7/2014	LDL cholesterol 134;	The patient's cholesterol level was also deteriorating.

12/3/2014	Chronic care clinic. The BP was 160/80 which was high; LDL 134 which was high; A1c 8.1 which was high. The doctor started Lisinopril, changed one lipid drug for another, and increased the Imdur an anti-angina drug.	The doctor might have considered reverting to the medication dosage that had been used when the patient was in control.
1/25/2015	Chronic illness clinic. BP was 210/94; LDL 70; A1c 8.1. The cholesterol level was improved but the blood pressure had deteriorated. The doctor increased the Lisinopril for the blood pressure and increased Metformin for diabetes.	The doctor might have considered reverting to the medication dosage that had been used when the patient was in control.
2/5/2015	A1c 8.5	
2/26/2015	A physician at Easterling discussed an advanced directive and living will. The patient did not want to complete an advanced directive. This was documented by a nurse not the doctor.	The patient was not expected to die soon. It was not clear why this needed to be discussed at this time.

Patient 16

Date	Summary	Comments
2/27/2015	His problems on the problem list were given as DM/insulin; hypertension; and coronary artery disease (CAD).	
6/28/2014	He was admitted to a hospital. The patient was 71 years old. The hospital note documented CKD, type 2 DM, HTN, and HBL. He had slurred speech. CT scan did not show acute bleed but showed a suggestion of a	

2/26/2015	Presumably an intake nurse performed a monofilament testing form and noted that there was no loss of protective sensation and that everything was normal. The patient had a prior diagnosis of neuropathy.	It does not appear that diabetic neuropathy testing by nurses is appropriately performed.
2/26/2015	Presumably a nurse practitioner (title not signed and name illegible) performed the intake physical examination. The provider took no history. Everything was documented as normal. The provider noted that enrollment in diabetes, hypertension and CAD chronic clinics. The neuropathy was not noted. The NP did not note the patient's mediche	

2/26/2015	An LPN completed a special needs communication form indicating that the patient needed no special housing work restrictions, or any special accommodation for medical reasons. The LPN apparently ordered blood sugar checks 2 times daily at 3 am and 3 pm for 180 days.	An LPN should not be filling this type of form out and making a decision with respect to medical housing.
2/26/2015	An LPN also ordered the therapeutic diet for the patient. This was a wellness diet of 2400 calories with an evening snack even though the patient was described on physical examination by the NP as obese with a weight of 240 pounds at a height of 5 foot 9 inches for a BMI of 35.4 which constitutes obesity.	This is the same LPN who completed all of the LPN intake records and presumably this is the intake nurse. This nurse should not order a therapeutic diet.

2/27/2015	An eye examination not signed by an optometrist documents 20/50 vision OU. This test was documented on an optometry form.	It isn't clear who performed this test. It appears that a nurse performs this Snellen test.
2/27/2015	As part of the intake evaluation, someone (staff did not sign sheet, title, name or date- presumably this is a nurse) filled out a "Diabetic Checklist" presumably an annual checklist. The list documented that the patient was a new intake and for 2015-16 was enrolled in chronic care, had a monofilament, had foot disorder treated, was given an dd f-157 Td tar8.28 at,iorreat,1.1(,)-1.1(.5(abl)-209(v)4(en)-i r)-6nilhrabei r-157 Td 4(d)-12.2(er4-6.4(t-12-13	

2/27/2015

3/5/2015 An LPN saw the patient at 7 am in follow-up of the health request and used an upper

Patient 17 0r6 18 Tme n.1(w)9.1(as)-8(1)-1

Date	Summary	Comments
1/11/2005 11/11/2010	The BP on ALAT was 160/100	

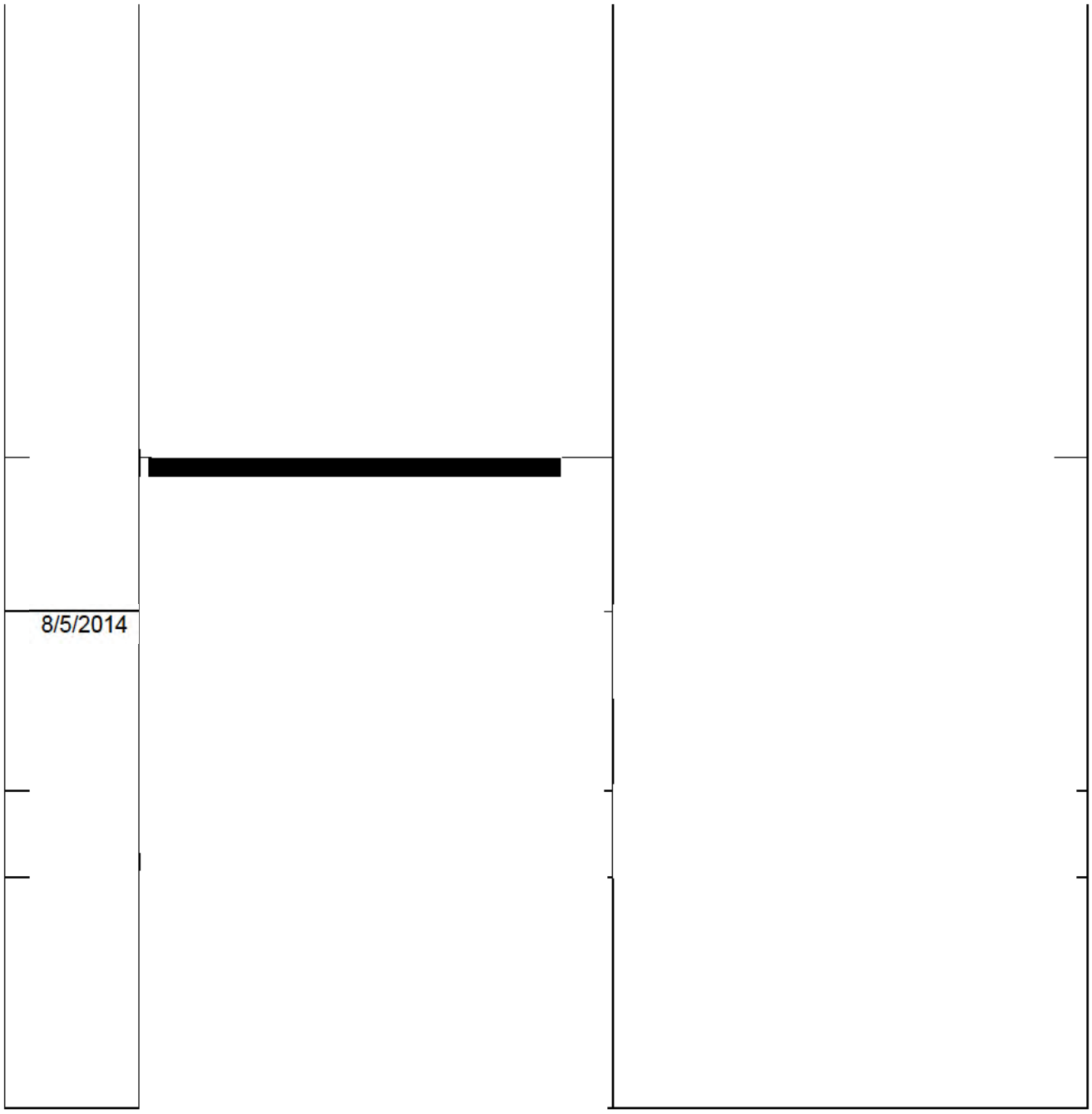
5/1/2013	Seen in FU. BP 150/94. The provider discontinued Lopressor and hydralazine and started Coreg and a low dose of Minoxidil. The order was for DC Cozaar and hydralazine and start Coreg 25 mg BID and Minoxidil 2.5 mg daily. The Lopressor was not discontinued. The provider also noted he would need renal Doppler studies and to rule out pheo (meaning pheochromocytoma).	The provider hadn't determined that the patient was actually taking his medication. Since he was perhaps legally blind perhaps he couldn't see the labels, he might have trouble seeing the labels.
5/1/2013	May MAR shows Clonidine given 5/15; 5/16; and 5/17 am and 5/18 through 5/22 BID so he missed about 3 doses of medication. Lasix was given one dose on 5/22 and then again on 5/24 and 5/31. The patient was listed as absent for Lasix on 5/25 through 5/30. KCL was also listed as given 5/24 and 5/31 but absent for 5/25 through 5/30. There were no other medications documented as given in May so apparently the missed Minoxidil, Coreg, and HCTZ.	It appeared that the patient was not provided medication.
5/16/2013	A provider ordered Clonidine increased from 0.2 Bid to 0.3 BID for 7 days and a 24 hour urine for VMA, metanepherines, catecholamine, a CBC, metabolic panel, and TSH	These tests include tests for secondary causes of hypertension.

5/23/2013	Seen by provider BP 148/88. On a nurse exam for the same day the weight was 244 pounds. The provider wrote that the inmate had bilateral ankle swelling. Heart and lung exams were normal. The provider diagnosed new onset of edema and increased blood pressure. But the provider did not list all of the patient's problems. The provider ordered an echocardiogram and Lasix with potassium for 180 days and ordered stool for occult blood and B12, folate, iron, ferritin, and TIBC. The HGB reported on 5/22/13 was normal at 13.4. It did not appear that the patient had anemia.	The echocardiogram was an appropriate test as the patient had signs of he /P <<>>3.2(g)b6 Tm [tTc -0.-

6/5/2013

3/31/2014	Patient discharge instructions from the hospital were in the medical record but a discharge summary was not in the record. It is not clear what happened at the hospital. On the same day there was a form for release of records so that the hospital record could be obtained. This should be administratively handled so that medical record can be timely obtained.	Medical record documents are missing.
4/1/2014	The April MAR shows that the patient received Minoxidil, Mobic, potassium, Carvedilol, and Lasix on 4/15/14. The Minoxidil was about 2 weeks late, the Lasix and Mobic were a few days late and the Carvedilol and potassium were about on time. After this MAR the new eMAR system was put in place but no paper copy was placed in the medical record.	The patient failed to receive necessary medication.
4/2/2014	The doctor admitted the patient to P ward as acuity level red and reordered Carvedilol, Lasix, Mobic, Minoxidil and potassium. The Minoxidil was at 2.5 mg.	The patient had apparently recently been hospitalized and was sent to Kilby in follow-up. However the Kilby provider did not document why the patient was hospitalized.
4/3/2014	An order sending the patient back to population ECC (presumably Easterling Correctional Center) and a provider referral for 4/7/14	A provider never evaluated the patient at Kilby.
4/3/2014	BUN 23, creatinine 1.31 (normal .9-1.3) CO2 30 (normal 22-29). These tests were ordered from Kilby.	The renal function is now abnormal.
4/8/2014	The patient was seen at Elmore in follow-up after return from Kilby after a syncopal	

7/31/2014	A note by an NP at 6:30 am describing that the patient was brought in from Elmore unresponsive. The writer noted that a physician was present. A Foley was inserted and the patient was sent to Staton for observation per a doctor. No vital signs or examination was documented.	To transfer unresponsive patients between facilities is dangerous. It did not appear the unresponsive patient was transferred by ambulance. The patient should have been immediately hospitalized.
7/31/2014	Narcan was given and the patient was sent to an ER. No vitals were recorded. The patient was able to open eyes and a slight movement was noted. This note was timed by an RN at 12:20 pm.	
7/31/2014	At 1:45 pm a doctor wrote an infirmary admission note describing that the patient was being admitted for a "somewhat catatonic state". The doctor wrote "Was found to be unresponsive by ADOC around 4:35 am. Was felt to be not breathing and chest compressions were done. Then transferred to HCU". This indicates that CPR was initiated. The patient was being evaluated by the doctor almost 9 hours later. The patient was felt to not be breathing and chest compressions were done and he was then transferred to HCU where he was observed for the past 8 hours. Oxygen and fluids were given in the health care unit. On examination the patient was alert but not verbally responsive. The CBG was 125, pulse 76, and BP 140/98. The neck was supple, the eye exam as documented was illegible. The lungs were clear and heart was regular. The doctor diagnosed a catatonic episode, hypertension and something else that was illegible. The doctor wrote discussing the case with the Regional Medical Director and would continue to closely observe the patient. On the same note the doctor documented that the patient was hospitalized on 3/31/14 for a syncopal episode. The EKG was documented as NSR but the remainder of the EKG reading was illegible. The WBC was 10.6 and Potassium was 3.24 with glucose of 114 and Creatinine of 1.46.	This is a significant departure from the standard of care. The patient experience cardiac arrest yet after resuscitation was not sent to a hospital. The patient had experienced a massive stroke yedarm


8/5/2014

8/6/2014 A doctor wrote an admission note to the

9/26/2014

11/19/2014	The patient said that he was "feeling pretty good today". The nurse did an ALAT. P was 110.	
11/20/2014	ALAT BP 142/98	
11/21/2014	ALAT 150/94	
11/24/2014	ALAT done	
11/25/2014	ALAT BP 120/90 P 104	
11/26/2014	ALAT P 100	
11/27/2014	ALAT P 100; BP 140/76	
11/28/2014	ALAT P 102	
11/29/2014	ALAT BP 140/90	
11/30/2014	ALAT BP 112/76	
12/3/2014	The wound nurse saw the patient and described a 14 by 12 by 5 cm wound with 4.5 undermining the coccyx wound. Trochanter wounds were 1.5 by 2.5 cm	This was a very large ulcer and reflects on nursing care.
12/10/2014	The patient pulled out the PEG tube. A nurse placed a Foley catheter in the PEG insertion site and taped in in place and notified the doctor.	
12/16/2014	The doctor documented that the patient pulled the PEG tube out. The BP was 144/98. He made no change to hypertension medication and noted that they were awaiting mesalt dressing change material for debridement.	
12/19/2014	Creatinine 0.58 (normal 0.7-1.3) suggesting that the patient was developing protein calorie malnutrition.	The provider failed to attend to the nutritional needs of the patient.
12/19/2014 12/20/2014	BP on ALAT 156/100	

12/29/2014	The doctor drained a pubic and penile abscess and placed a dressing.	The level of development of decubiti appeared to reflect neglect with respect to nursing care.
1/3/2015	ALAT A nurse noted that the patient was spoon fed with P 59 and BP 156/90	
1/3/2015	The medical record stops at 1/3/15 but the patient died on 3/14/15 from sepsis.	
1/20/2015	WBC was 16.18 with HGB of 7.1 and C difficile toxin A & B positive and C Difficile	

8/3/2014	The patient placed another health request stating that he never saw the doctor and was still having knee pain.	Although documentation was that the inmate didn't show up for an appointment on 7/14/14, he appears to not have known he had a sick call appointment.
8/27/2014 12/9/2013	The inmate showed up for a provider evaluation for his knee pain.	

5/9/2015		
5/24/2016	[redacted]	[redacted]

	Comments

5/22/2013

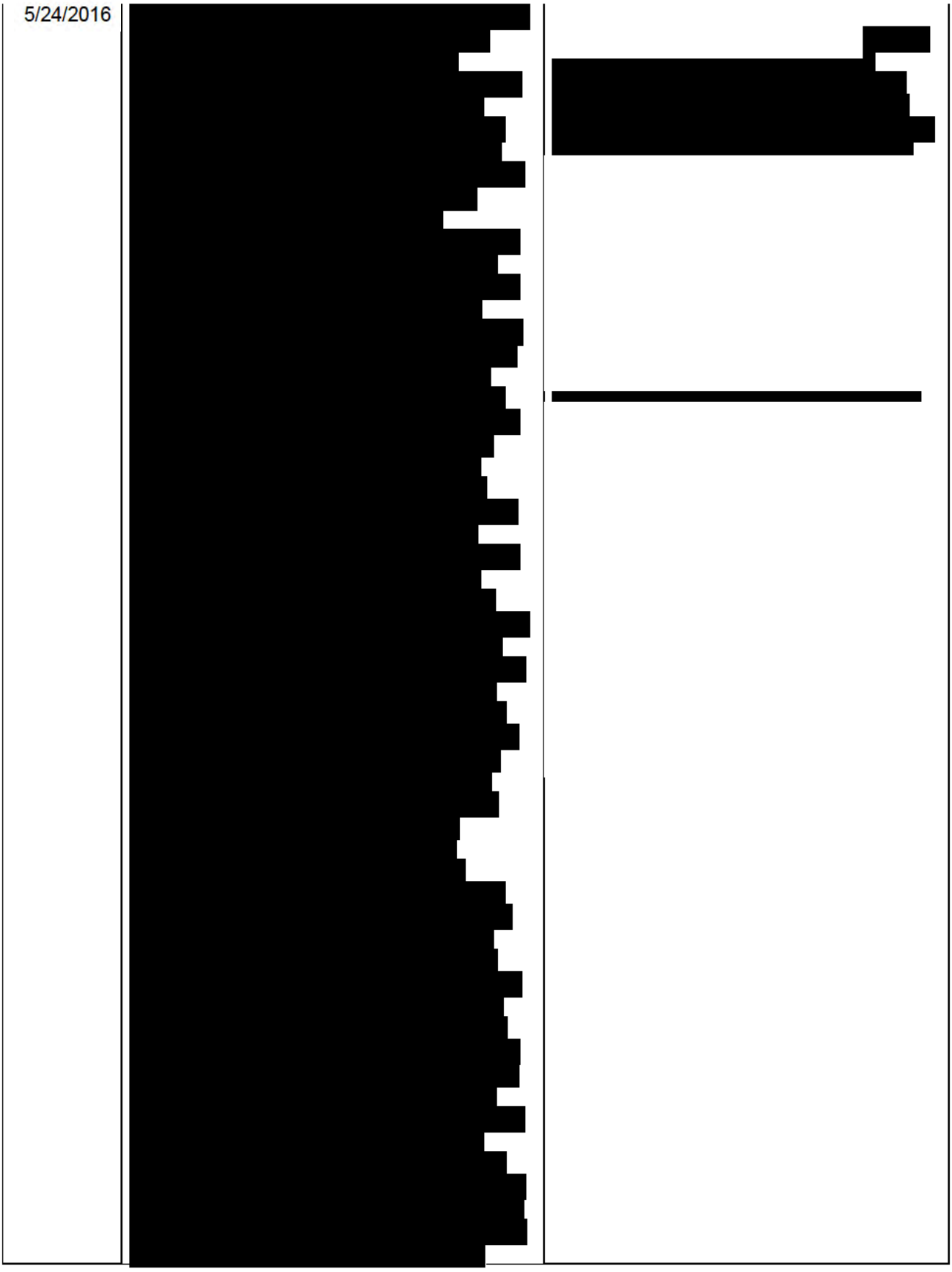
5/23/2013	Metabolic panel, FLP, A1c, EKG, CXR, eye clinic referral and bottom bunk profile were ordered along with chronic care appointment for hypertension only.	
5/23/2013	An NP and RN filled out a special needs communication form (the 2nd one) for a bottom bunk for the duration of stay because the inmate was over 65 years old.	
5/23/2013	A nurse filled out a ADOC Intake Current Medication List including HCTZ, metoprolol, aspirin, and Zocor	
5/23/2013	An RN filled out Intake Screening Form 4	

5/23/2013	Labs reported 5/24/13 included a glucose of 147 which is high and indicative of possible diabetes. Potassium of 3.1. This was not included in the intake evaluation. This lab result was signed as reviewed on 5/28/13.	Providers do not appear to review abnormal intake laboratory results. For abnormal test results the provider should document a brief note giving comments about therapeutic plan changes.
5/23/2013	An RN (apparently) filled out a New Arrival Intake Screening Form 3 that listed blood pressure as 138/60. This appears to be a checklist format of what tests need to be done in intake.	
5/24/2013	HIV, RPR and urine tests were negative as part of intake screening.	Is RPR necessary in a 72 year old

9/1/2013	The September MAR showed that the patient received aspirin, HCTZ, metoprolol and Zocor through the entire month. The patient was on DOT medication.	
10/1/2013	The October MAR showed that the patient received aspirin, HCTZ, metoprolol and Zocor through the entire month except for missing 2 days of aspirin, HCTZ, and metoprolol and 1 day of Zocor. The patient was on DOT medication.	The patient missed a few days of medication.
11/1/2013	The November MAR showed that the patient received 6 days of all of his medication.	The patient appears to have missed medication for most of the month of November.
12/9/2013	The patient went to his first	

4/19/2014 An LPN evaluated the patient at about 6:30

5/24/2016



5/30/2013	The patient placed a health request to get his hand creams renewed.	
5/31/2013	Eucerin hand cream prescribed with hydrocortisone cream and A & D ointment.	
6/3/2013	IVIG from 6/3/13; 6/4/13; 6/5/13; 6/6/13; 6/7/13 (the patient said he was not seen because his appointment was at 11:45 he didn't arrive until 1 pm and it was too late); 6/10/13	
6/20/2013	Seen by a physician for chronic care. The patient complained about dysphagia but noted no weight loss. The doctor did examine the skin. The doctor noted that an EGD was pending with dilation. He ordered CBC, CMP, thyroid profile and CRP and ESR with a FU in 30 days C 96 0.96 -3<<>507.48 0.481 12.8398 04948 Td (up3<<>C 96 0.96 /P <<>1 Tw 9.96 0	
6/28/2013	The patient received EGD	

11/15/2013 The patient went back to his oncology appointment and told a nurse upon return that the oncologist straightened out appointments for treatment. The oncologist wrote on an offsite specialty report form that the patient requires IVIG every 28 days. He underlined every 28 days twice. He added,

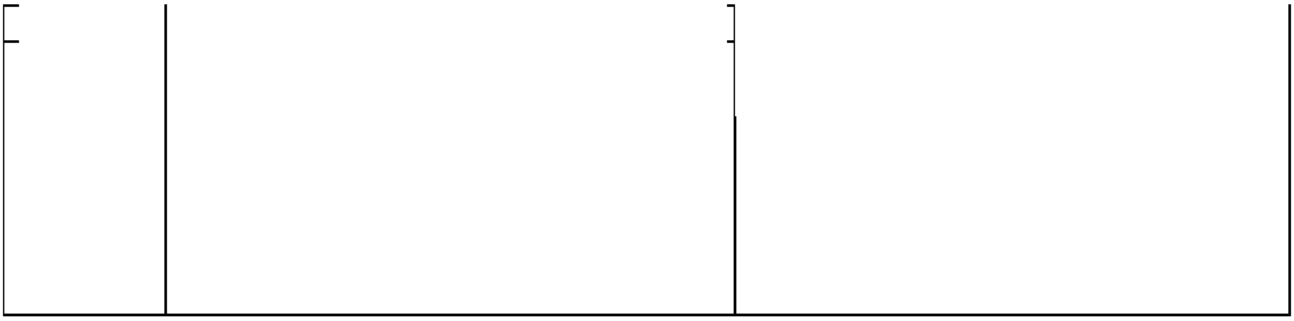
5/26/2014	A doctor saw the patient for chronic care clinic. No history was taken but the patient was examined including the skin. The provider, like all providers, failed to review the oncology notes.	Providers did not document review of the oncology notes so that they could be informed of the progress of the patient.
6/9/2014	The patient had IVIG from 6/9/14 to 6/13/14	
6/10/2014	An NP in the oncology office evaluated the patient. The patient was doing well on IVIG. His skin was becoming more flexible and his swallowing was improved. The recommendation was to continue IVIG and to give the patient an extra sandwich.	The patient was improving after return to the specialist.
7/7/2014	The patient had IVIG 7/7 to 7/11/14	
8/4/2014	The patient had IVIG from 8/4/14 to 8/8/14	
9/8/2014	the patient had IVIG from 9/8 to 9/12/14	
9/13/2014	The patient had chronic clinic with a PA. The PA mentioned that the patient was doing well on IVIG and had no new muscle aches since diagnosis. The PA did not evaluate the skin. No assessment was made of the patient's condition. A thyroid panel was ordered.	
10/6/2014	The patient had IVIG from 10/6 to 10/11/14	
10/6/2014	The patient saw an oncologist. The patient lost 6 pounds and weighed 170 pounds. Labs were done and were normal. The creatinine was 0.87	
11/3/2014	The patient had IVIG from 11/3 to 11/7/14	
12/1/2014	The patient had IVIG from 12/1/14 to 12/5/14	
12/17/2014	A doctor saw the patient in chronic care clinic. He documented that the skin was improved on IVIG. The examinations were documented as "WNL" for all boxes however the patient had significant skin abnormalities. This examination was not accurate. In the assessment, the doctor wrote, "will see about giving IVIG on site".	It was not an appropriate strategy to give IVIG on site. No one provider demonstrated knowledge or willingness to take a history and examine the patient required for this condition. Also, the staffing is not appropriate for administration of intravenous infusions that require intensive monitoring. ADOC nurses do not typically give infusion therapy and there would likely be a skills deficit. This placed the patient at risk of harm. Also, it was unclear if the providers at the facility had knowledge in the use of this medication that had serious potential side effects. The patient was given the infusions in the evening hours when a provider was unavailable on site. Nursing assessments were not consistently documented prior to starting the infusion.

1/12/2015

2/16/2015 An LPN

2/18/2015 At 10 am the doctor admitted the patient to the infirmary. The admitting diagnosis was dehydration secondary to viral illness. His history was that the patient had been feeling

Patient 21



7/13/2010	Received a health code of 1 which states that the patient is generally healthy and can be assigned to any facility. This is despite one of the problems on one of the 6 problem lists states that in 2008 the patient had 2 heart attacks in 2008 and then developed heart failure with an ejection fraction of 25% with a poor prognosis. The coding was filled out by a nurse practitioner.	This health coding places the patient at risk of harm by misclassifying the acuity of his illness.
7/7/2011	An LPN performed an inmate periodic health assessment Form E-4. The patient was listed as having no medical problems or symptoms (question 10) even though he had end-staged heart failure.	This was not accurately completed by an LPN who could not perform an adequate assessment.
7/12/2011	A provider signed a coding assessment but did not document what the code of the patient was.	
1/10/2012	Labs were reported includi Tw 9.96 0 0 9.j3i54(	

4/12/2012 An NP saw the patient for chronic care. Hepatitis B and C, HTN, MI, and allergies were listed as medical problems. Heart failure [illegible]

2/20/2014 The patient was hospitalized on 2/20/14 until 2/24/14. The hospital face sheet indicates that the patient was hospitalized from the Elmore correctional facility. Echocardiogram results from an admission 2/20/14 show moderate dilated LV; severely dilated atrium; mild septal hypertrophy; ejection fraction 25% moderate mitral regurgitation, aortic insufficiency and tricuspid regurgitation. A m r0041(e m)-24 oeptal h

3/4/2014	A transfer summary form documented that the patient was transferred from Kilby by order of the ADOC. Apparently he moved back to Elmore. His PPD was listed a 0 mm on 10/31/13 although a problem list documented that on 5/17/07 the patient had a 20 mm PPD. The problem list from 2003 documented that the patient completed INH prophylactic treatment. TST from 2013 and 2015 were both recorded as 0. The medication summary on the transfer form noted "see MAR". But there is no evidence from the MAR that the patient received medication at the new facility.	Some TST tests appear to be inaccurate and appear to result from either being falsely recorded, not being done and recorded as negative or being incompetently performed. This kind of TST testing demonstrates why there are tuberculosis outbreaks. The transfer process is inadequate given that patients miss necessary medication. This placed the inmate at risk of harm.
3/4/2014	A provider note from Elmore documented that the patient was recently hospitalized and was being returned to Elmore.	
3/8/2014	At 10:05 am the patient was transferred to the hospital from Elmore for severe SOB and weakness. The blood pressure was 84/62 indicating severe hypotension.	The patient was transferred from Kilby to Elmore. There was no evidence of the patient receiving medication and the patient deteriorated and required hospitalization. This demonstrates extremely poor transfer procedures and very poor coordination between facilities.
3/10/2014	Medication orders for S	

6/8/2014	An LPN documented ad emergency transfer form indicating that the patient had chest pain and fainting outside of chow hall and was sent to the hospital. The LPN listed his current medications as Simvastatin, Carvedilol and furosemide.	The patient's medications had changed since his last provider visit on 3/18/14 and it wasn't clear how this happened.
7/11/2014	A provider saw the patient whose weight was 193. The provider wrote "Pt has no complaints today. Was seen in ED-8th; no c/o CP or SOB He continues to smoke - needs to quit No DOE". That was the entire note. There was little pertinent history and no physical examination. The patient's problems including advancing cirrhosis and CAD were not addressed.	This was extremely inadequate note. The patient had not been adequately evaluated for almost 4 months and had recently been in the hospital. He should have had a thorough evaluation. The history needs to be probing with respect to the patient's conditions. That a patient has no complaints is insufficient as a history. The history needs to include questions pertinent with respect to the patient's conditionsent ent(hs)-1

12/31/2014	an RN did a new arrival screening (form 4) identifying that the patient denied hepatitis C but identifying history of stroke, heart condition, high blood pressure, asthma and alcoholism. The nurse document PEFRs of 250/250/200. The RN did a better history than the NP on 12/23/14 even though it was partly inaccurate. There was no evidence for asthma or stroke. On a form 3 the same nurse on the same day documented that the

1/6/2015	Furosemide was added.	
1/15/2015	Potassium was ordered and furosemide was increased to twice a day from once a day.	
1/15/2015	This is the first evaluation from the doctor since he admitted the patient to P ward 10 days previous. He noted that the weight was increasing but didn't document what the weight was. The BP was 160/100; the patient had 2-3+ edema of the extremities. The problems were listed as heart failure with coronary atherosclerotic disease, high blood lipids and dementia. The hepatitis C and hypertension were not noted. The doctor increased the Lasix. This is the first diagnosis of dementia on a doctor's note but there was no history or physical examination that documents the reasoning for the diagnosis. The doctor stated what the patient's diagnoses were without documenting an accompanying history or physical examination.	This is poor care. The doctor makes a diagnosis without taking a history or performing a physical examination required in order to make that diagnosis. The doctor also didn't determine why the patient was gaining weight. Notably, the doctor appears to fail to acknowledge the patient's hepatitis C and probable cirrhosis which could have caused the weight gain. The doctor should have ordered tests to evaluate why the patient had edema.
1/16/2015	Labs glucose 124; CO2 21	
1/20/2015	Daily weights were ordered.	
1/21/2015	WBC 4.92	
1/22/2015	The doctor evaluated the patient and documented no new complaints. The weight decreased from 226 to 220. The examination was documented only as not changed except for a decrease in edema with the phrase "not weeping anymore". Notably the doctor had never documented that the patient had weeping from his extremity edema. The electrolytes were noted. There was no change to the plan. Weeping edema would be significant edema that warranted investigation. It wasn't clear why the patient had edema. The doctor noted the abnormal glucose of 124 but did nothing.	This is another example of findings appearing that were not identified before but with documentation indicating that the finding had been present for a while. This is poor care. The doctor may have assumed that the heart failure was due to the patient's heart failure but he didn't say so. Since the edema could have been due to cirrhosis, additional evaluation was indicated (CXR, abdominal ultrasound to assess for cirrhosis). The doctor did not follow up on an abnormal glucose level.
1/22/2015	The doctor discontinued the patient from chronic clinic follow-up and stated in the order that he would follow up on the patient on P ward. However, the doctor was not following all of his conditions.	Apparently, the patient was assigned permanent P ward housing.
1/23/2015	The doctor ordered oxygen to maintain an oxygen saturation of 90%	It was not clear in the doctor's notes what the indication for the oxygen was. This was very poor documentation.
1/24/2015	A nurse documented on a weight flow sheet that the patient couldn't be weighed because he couldn't stand. On 1/20/15 the weight was 226 pounds.	This is a significant finding. From physical examinations, it isn't clear why the patient couldn't stand.
1/24/2015	Glucose 101; CO2 21; creatinine 1.45	The abnormal labs were not addressed.

2/3/2015	The doctor ordered to clean the wound with an antiseptic and then to put silvadene cream on it with a dry dressing and to elevate the feet.	
2/3/2015	Glucose 145; creatinine 1.18	

2/10/2015 The doctor documented no new complaints. The leg was still weeping. The doctor documented that weights were not being done. He made no change to the assessment or plan. He did not take note of the elevated glucose of 145. He didn't take a pul Q q 346.44yg(as)-8(s)-hr 2.2(of)oo3.2(eet)-1.1(n BT 0 Tc7BT -0.001 Tc 0 Tw 9.9528.9(t) /P <<>>BDC

3/3/2015 A licensed counselor evaluated the patient as a mental health referral due to a statement by the inmate that he didn't want to live. The counselor documented that the inmate denied making that statement. He told the counselor that he was distressed from continue(i)3.2(s8s)-8(tn76 Tm s)-

4/3/2015 A hospital admission note documents that the patient was a poor historian and was sent to the hospital for gangrene. The doctor noted that the prior history was CVA with dementia based on the records from the correctional facility. The doctor apparently was told that the patient had a wound that started about a week prior to hospitalization when in fact it started about 3-4 months before hospitalization. The patient complained of increasing pain in the foot, pus draining and blackish discoloration of the toes and foot which "started two days ago" He had multiple

4/10/2015	The patient was returned to prison and admitted to P ward on Coumadin, Coreg, aspirin, Lovenox, Tylenol #3, Prilosec, Motrin, Lasix, Lipitor, and Lisinopril. INR was ordered every Tuesday and Thursday. There was no discharge summary in the medical record. The initial admission orders were not signed until 4/18/15 about 8 days after admission.	The doctor did not review and sign his phone orders admitting the patient for 8 days.
4/10/2015	The patient was returned to prison and admitted to P ward on Coumadin, Coreg, aspirin, Lovenox, Tylenol #3, Prilosec, Motrin, Lasix, Lipitor, and Lisinopril. INR was ordered every Tuesday and Thursday. The doctor performed the intake history and physical. The history noted severe PVD, CHF with atherosclerotic heart disease and psychosis. The reason for diagnosing psychosis was unclear as was the diagnosis of dementia. The doctor did not assess cirrhosis or liver disease even though there were indications that the patient might have this disease. The patient was diagnosed with pre-diabetes at the hospital and this was noted. The history included that the patient had a below knee amputation. The doctor noted that the patient was uncooperative with removing his pressure drestattalemov02 N(es.1(v)-8a N(es.1(v)-7-0.002)]TJ 0 -106.3)-1.1( )]TJ Thvene drvi notd thate1.1(i)3.(02 N(es5 T12(Ww 16(No3.2(.L.9(ast)-1.1(al-12.2(a-6.32(da)-12.2(12.2(as)-8(e e(a)-12.3l-1	

4/14/2015	At about 1 am an RN noted that the patient was restless and making grunting noises and "bothering" his stump dressing. A doctor was notified but no orders were received. The nurse did not perform vital signs. The nurse noted instructions to refer the patient to mental health in the morning.	The nurse should have performed vital signs. This was a poor emergency nurse evaluation.
4/14/2015	At about 1:30 am the doctor was called because of continued restlessness. The doctor instructed the nursing staff to talk to the inmate. The inmate was moved to a different bed with guard rails but shortly after moving the patient, the patient fell. The	

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4/16/2015

4/18/2015 The doctor ordered a surgical follow-up.

	bullous lesions on the foot. The leg was very tender. He was on discharged on vancomycin, Cefapime and metronidazole.	
5/4/2015	At 6 pm the patient returned from the hospital. He was supposed to be on Cefepime, Lovenox, furosemide 40 BID, insulin sliding scale, Duoneb hand held inhaler, metoclopramide, lorazepam as needed, metronidazole IV, morphine as needed, Zofran as needed, vancomycin IV, Carvedilol, Lipitor, Lisinopril, Albuterol, potassium and Protonix. The Coumadin had been discontinued. The hospital recommended that the prison physician see the patient within 24 hours. The patient left the hospital with a Foley catheter and had a PICC line. The prison doctor did not start insulin or continue the Cefepime and Albuterol. He did not indicate why he did not start these recommended medications.	Not starting one of the antibiotics possibly placed the patient at risk of harm.
5/5/2015	The doctor started warfarin at 5 mg even though the hospital stopped this medication as the patient was on a different anticoagulant Lovenox.	
5/6/2015	The doctor didn't see the patient for 2 days after hospitalization. He took no history or note what happened at the hospital. He did say that the inmate disturbed other patients during the night by moaning all night. He didn't attempt to find out why the patient was moaning. He didn't examine the patient except noting vitals. He noted continuing vancomycin and Flagyl but didn't say why he stopped ed oted otg tbIty22e td opp20a3.w --29.084- Tw -10.482 (ex)-8(c)-8.1(ei)5 re (ex)-8(cu)11.8((ex)-8(c	

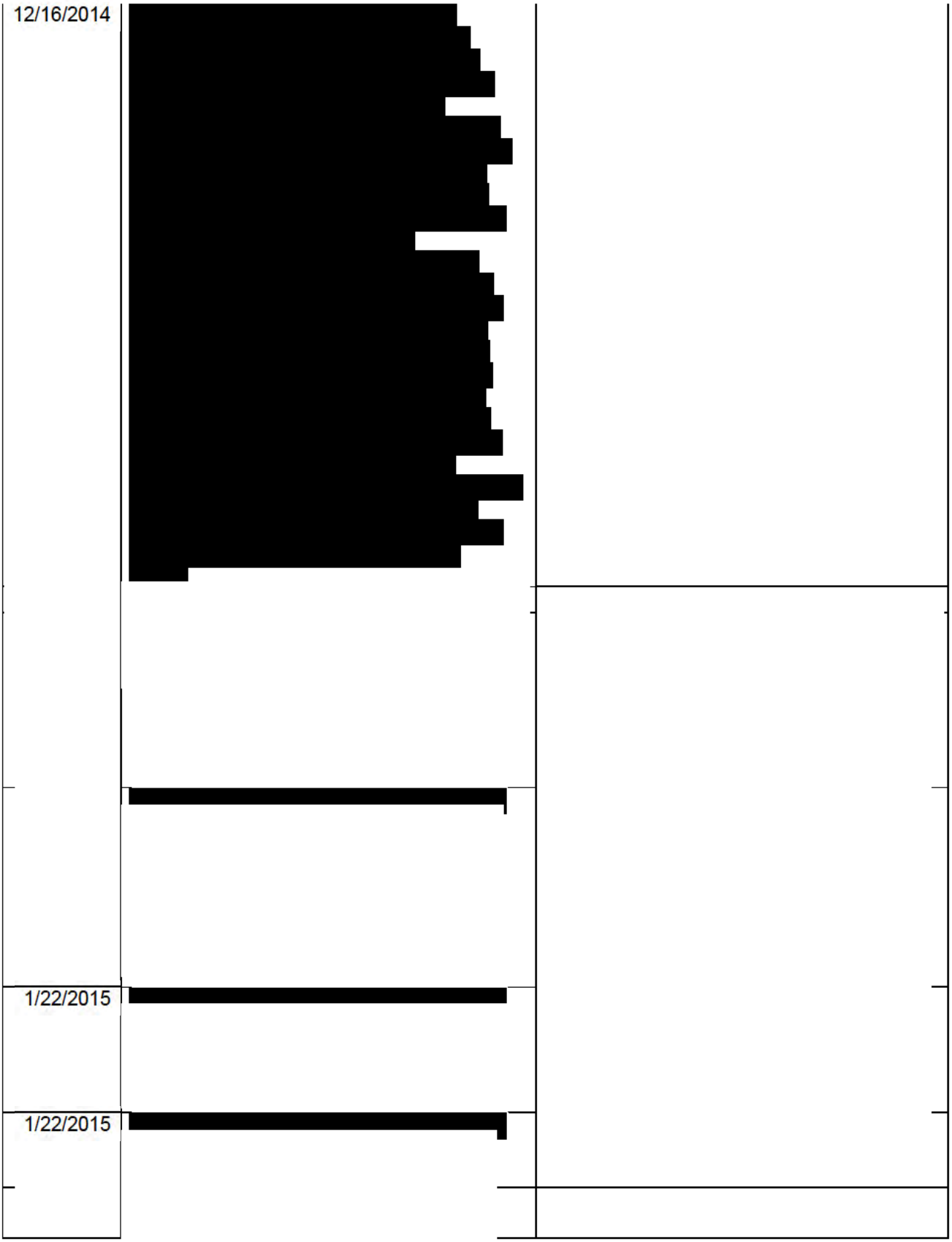
5/7/2015	Nurses on all shifts documented that the patient had 3+ edema over the entire body. At 1:30 pm a nurse notified a doctor that the patient still didn't have wound care orders 3 days after hospitalization. Nurses did not evaluate the Foley catheter except to say that it was patent and the urine was dark amber.	Not to have wound care orders for 3 days post hospitalization was not good care.
5/7/2015	The doctor increased Lasix to 80 mg BID	
5/8/2015	The doctor said that the patient was separated from other patients because he was making noise. But he made no attempt to find out why the patient was making noise. He said that there was no discharge from the stumps. He didn't evaluate the ulcer around the knee on the R found by the ID doctor at the hospital. The INR was 1.4 so he increased the Coumadin to 7.5. He ordered a BMP.	The doctor did not evaluate the Foley and appeared to not notice that the patient had a Foley

5/26/2015 The doctor saw the patient and documented that the patient had cardiogenic shock, MI with heart failure, urosepsis, and renal failure. He failed to appreciate again that the patient had end-stage liver disease. He spoke with the cardiologist who apparently agreed with a DNR status. The prison doctor documented blood pressure of 84 over palendpq

6/12/2015	A licensed counselor evaluated the inmate 2 weeks after hospitalization. The inmate was responsive and told the counselor that he eats his meals but was still losing weight. He said he was sleeping well and denied any mental health concerns. The mental health counselor asked him why he was looking down the hallway and he replied that he was just looking. The patient was using a wheelchair and had appropriate hygiene and was cooperative. His responses were described as coherent and rational.	The patient seemed to be improving but the doctor, except for continuing the patient's medication, stopped caring for the patient. He did not attempt to discuss advanced directives with the patient even though the patient was described as coherent by a counselor. This appears unethical. It is one thing to let a patient pass when they desire to die but in this case, the doctor had not discussed his decision to stop caring for the patient with the patient or the patient's family. The patient not the doctor should be making this type of decision. The patient at this point appeared to have adequate decision making capacity but was not allowed to make his own decision about living or dying. In particular, after the patient improved, a discussion about advanced directives should have occurred.
6/16/2015	The doctor evaluated the patient using a chronic disease form. He checked the boxes for the formatted questions but otherwise took no history and did not discuss with the patient his advanced directive decision made without informed consent of the patient. Remarkably, he checked the box asking about ankle edema "no" even though the patient had recent anasarca (which is edema throughout the body) and the patient had no ankles since he had bilateral amputations. He checked no under abdominal pain swelling even though the patient had ascites. The vital signs were normal with a blood pressure of 130/70. The doctor wrote WNL under head and neck, heart, lung and abdomen exams and 2+ edema of the lower extremities with BKA. He ordered no labs. His only diagnoses were heart failure and MI and dementia [which was not clear to what extent the patient had dementia]. He did not include any of the patient's other diagnoses. The only plan was to continue with the patient on P ward.	The doctor appeared to officially give up caring for the patient and failed to obtain an advance directive with informed consent. The doctor did not have the right to make this kind of decision particularly since the patient had been improving. The doctor should have discussed the DNR with the patient.
6/24/2015	Oral Lasix was discontinued and IV Lasix was started.	
6/25/2015	The patient fell out of bed and had a small raised area above the left eye. The nurse did not take vital signs.	
6/26/2015	The doctor stopped Duoderm and ordered cleaning the wound with Hibec	

5/22/2013	[redacted]	
	[redacted]	
5/24/2013	[redacted]	

6/17/2013 Nurses wrote mostly daily assisted living
assess gffnstti16.1( )-not1(17/2(s)-8(esinat1(17/2(hs)-8(i)3.1(pa6.3(o)-12.3(t)s)-8(ie6.1( )-n12.3(t).)-8(t) 16.1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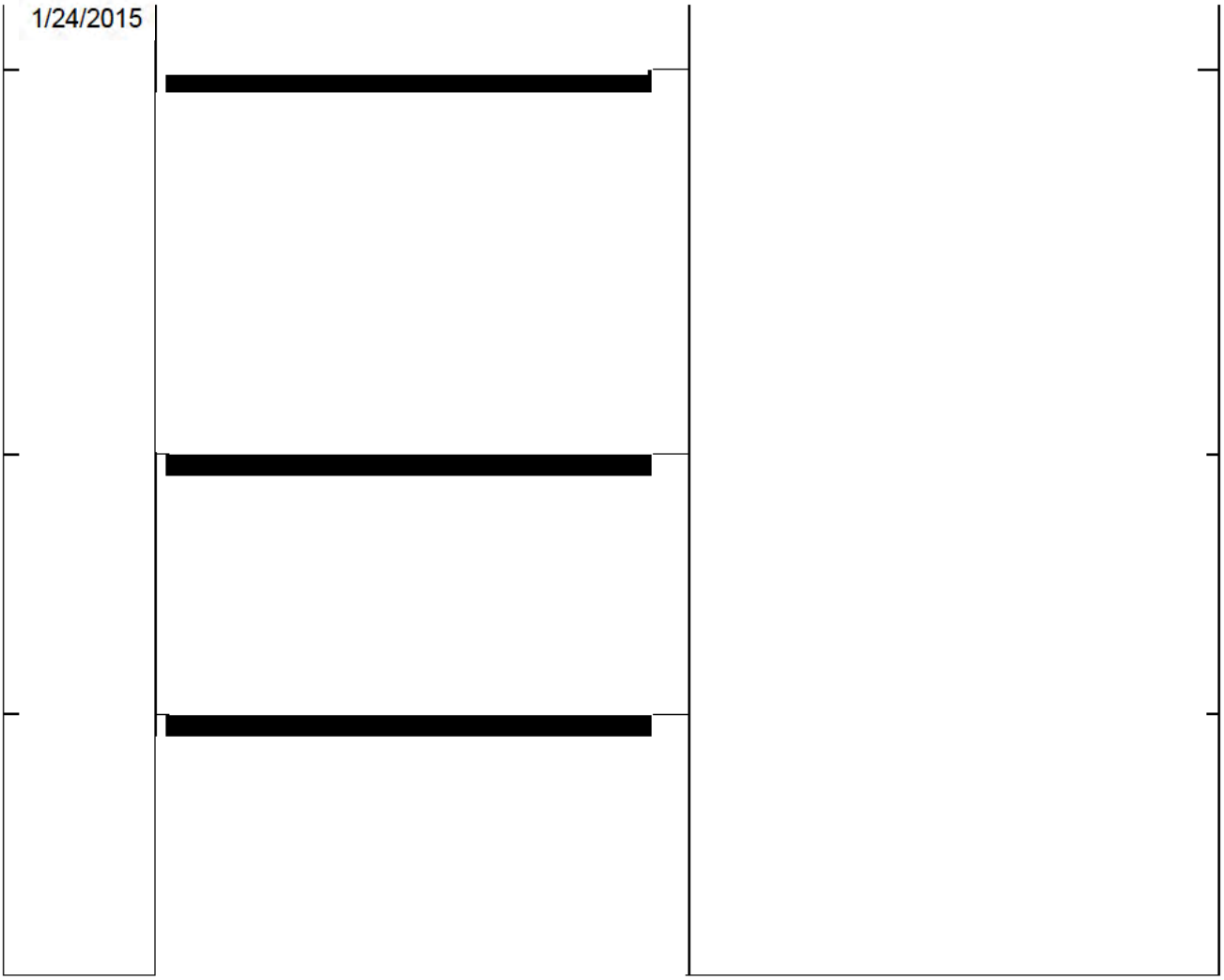
1/24/2015

5/24/2016	[redacted]	
		[redacted]

Patient 23

Date	Summary	Comments
5/10/2014	42 year old man placed a sick call request for upper abdominal pain and burning sensation with a bloated feeling for a week. The blood pressure was 140/92. He was evaluated by an LPN. The patient was given OTC by protocol and no referral. The nurse did not ask about chest pain.	An LPN is not licensed or trained to perform independent assessments. This LPN failed to identify elevated blood pressure. A better trained nurse might have asked the patient about chest pain. Upper abdominal pain can sometimes be cardiac in origin.
5/12/2014	An NP saw the patient for follow-up and noted that the patient complained of gas and bloating. The BP was 150/88. The NP started Prilosec and simethicone and advise to notify medical if pain worsened. The NP did not treat the elevated blood pressure.	The blood pressure was elevated and not noted. A better history might have included asking about chest pain.
8/30/2014	An LPN evaluated the patient emergently. The patient woke up sweating and felt nauseated with back pain. He vomited 3 times. The	

5/24/2016

Patient 24

This was a 69 year old man with a history of emphysema. He was housed at the Limestone facility from 12/18/00 until 1/18/11 when he transferred to Hamilton A & I where he was when he was hospitalized for chest pain. He had a prior positive tuberculin skin test in 1980 for which preventive therapy was completed. Department of Health records show that he had abnormal chest CT scans and x-rays beginning in February of 2010. These studies showed interstitial fibrotic changes but beginning in April of 2010 interstitial infiltrates began to appear.

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12/10/2014 The white count was 21.5 thousand showing continued possibility of significant systemic disease. The doctor ordered more blood cultures (prior cultures were negative) and urine culture but the patient had been on antibiotics which would have unlikely

3/29/2012	The patient places another health request complaining of numbness in his left foot. A nurse saw him the following day and referred to a provider. The nurse documented that the patient wanted his foot cut off.		
4/4//12	An NP evalua		

4/18/2012	The assistant Regional Medical Director wrote a very brief note. The history was extremely brief that the patient's pain was not responding to Neurontin. The doctor noted that the patient had no pulses on the left foot and diagnosed claudication and referred the patient for arterial Doppler studies.	This was an appropriate diagnostic test.
5/7/2012	An arterial Doppler study was done showing greater than 50% stenosis on the left leg.	This test result was never evaluated or addressed.
8/2/2012	The patient wasn't evaluated by a provider from 4/18/12 until 8/2/12. The NP saw the patient in chronic care and documented that she wanted the results of a Doppler done in May. The NP took no history of the progress of the patient's leg pain and made no diagnosis. Claudication was not listed as a problem.	The history was inadequate and the result of a diagnostic test was unavailable after almost 3 months. This follow-up was below standard of care.
8/16/2012	A doctor evaluated the patient who wanted to know about the Doppler study but the doctor didn't address it and apparent9.96 0 0 Td [(s)-8(t)-1.3.795 0 Td [(s)-8(t)-i tvald toumTJ 0 Tc 0 esults of a	

12/6/2012	Chest x-ray showed mild enlarged heart with interstitial prominence. This is consistent with heart failure and should have prompted an echocardiogram.	There was failure to follow up on this abnormal chest x-ray.
3/29/2013	A doctor saw the patient who had swelling of the left ankle. The doctor noted edema, decreased pulses and sensation and diagnosed dependentea002o0(12 -12m)-24	

12/6/2013	A doctor evaluated the patient for complaints including that his left foot was cold and the right stump prosthesis was causing an ulcer. The doctor noted that the left pedal pulses were decreased and that the left leg Doppler was "monophasic", that the left leg was cold and that there was a 2.5 by 1.5 right stump ulcer. The doctor did nothing except to note that the patient had an appointment with the orthotist and would be followed in chronic care.	An ulcer on the stump should have been evaluated for the risk of osteomyelitis and should have been treated as if it were a diabetic foot ulcer. Antibiotics were indicated. The doctor appeared to ignore the problem.
1/31/2014	A doctor saw the patient who was concerned about the prosthesis causing an ulcer. The doctor did not evaluate the ulceration and referred the patient for follow-up in chronic care where his problems were not being addressed.	The doctor ignored the problem.
2/14/2014	The patient was evaluated by a doctor for an ulcer on his stump for over 2 months. The doctor did not take a history and only noted the ulcer. He ordered no laboratory tests and did not order antibiotics. He said the orthotist appointment was pending and the patient would be followed in chronic care.	The doctor ignored the problem.
3/3/2014	The patient placed a health request stating he wanted to know if he was diabetic because he was told he lost his right leg due to complications of diabetes. He asked to see a leg specialist.	The patient's request was correct. He should have been referred to a vascular surgeon.
3/6/2014	A doctor evaluated the patient and documented that the patient was a diet controlled diabetic. The doctor took no history with respect to his claudication or request to see a leg specialist.	The patient's problems were ignored.

4/11/2014	The patient placed a health request complaining about a rash on the right stump and left foot problems. He was charged $4 for the evaluation which resulted in a provider visit the following day.	The patient was charged for a problem that was being mismanaged in chronic care.
6/15/2014	The patient placed a health request asking for help about his leg and neck.	
6/27/2014	A doctor saw the patient and noted that the patient lacked pulses in his left leg. He finally referred to a vascular surgeon.	The patient was referred finally for a problem that had existed for over 2 years.
7/7/2014	A different doctor saw the patient and documented that the patient had phantom limb pain in the right stump.	This physician did not competently assess the patient.
8/26/2014	This note was written 8/26 or 9/26/14. It was not clearly written. The physician documented that the patient had a stent placed in the left leg	

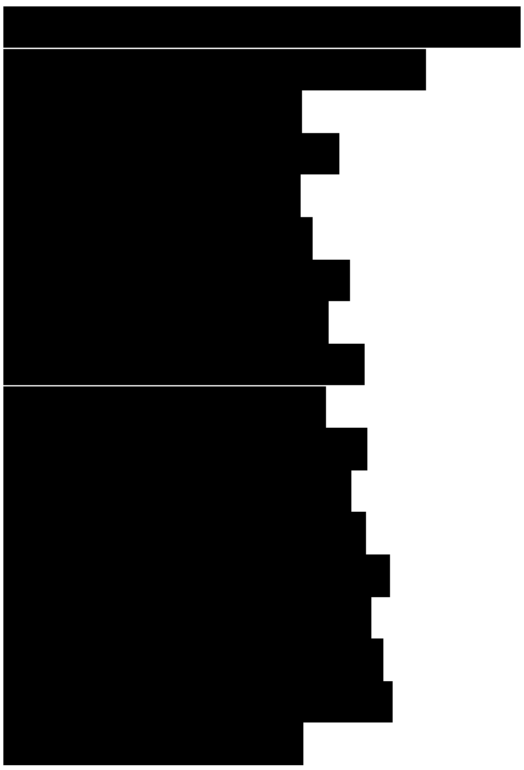
Consultant Work:

STD Screening, Treatment, and Early Intervention,

Diabetes Cases in Corrections

Contracting Out Medical Services

Additional charts reviewed:



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