Lower Keys Medical Center

5900 College Road
Key West, FL 33040
305-294-5531

FACILITY NUMBER: 0246
ADVANCE DIRECTIVE: N MRSA ISOLATION:

PATIENT	ACCT#: 5882539 ADM DATE: 05/26/24 TIME: 18:58 ROOM #: ER0071 MED. REC. #: 010108506 DCH DATE: 05/26/24 TIME: 23:43 SVRC. CODE: EOP NAME: RUSSEILL BEIRRY O PT. TYPE: E FC: N EMERGENCY NAME: NONE PHONE #: (777)777-7777 RELATION:G8 DCH STATUS: 01 Preferred Language E Ethnicity : NOT HISPANIC OR LAT PREV. SERVICE DATE: 07/11/24 ADM. TYPE: 1 ADM. SOURCE: 1 ACC. DATE: TIME: 00 ACC. SITE: ADMITTING DIAGNOSIS: M25551 PAIN IN RIGHT HIP
PATIENT DEMOGRAPHIC	STREET: PO BOX 4683 CITY / ST: KEY WEST FL ZIP: 33040 COUNTY: MONROE PHONE: (239)445-7170 RELIGION: NO PREFER SS #: ***-**-0571 BIRTHDATE: 08/01/1949 AGE: 74 RACE: B SEX: M MARITAL STATUS: D SPOUSE'S NAME: FATHER'S NAME:
PATIENT EMPLOYER	EMPLOYER: STREET: CITY / ST: ZIP: EMP. ID #: 0 EMP. OCCUPATION: RETIRED
GUARANTOR	NAME: RUSSEILL BEIRRY O RELATIONSHIP: SELF STREET: PO BOX 4683 CITY / ST: KEY WEST FL ZIP: 33040 SS #: ***-**-0571 DOB: 08/01/1949
GUARANTOR EMPLOYER	EMPLOYER: STREET: CITY / ST: ZIP: EMP. OCCUPATION: RETIRED
INSURANCE # 1	PAYOR: UHC MEDICARE 903 20 INS. PH #: (877)842-3210 PO BOX 30995 SALT LAKE CITY UT 841300995 POLICY #: 114077051 GROUP: 1GY4J15VM87 FLDSNP AUTH. #: HOLDER: RUSSEILL BEIRRY O REL.: SELF DOB: 08/01/1949
INSURANCE # 2	PAYOR: MEDICAID FLORIDA 208 2 INS. PH #: (800)289-7799 PO BOX 7062 TALLAHASSEE FL 323147062 POLICY #: 8898478518 GROUP: AUTH. #: HOLDER: RUSSEILL BEIRRY O REL.: SELF DOB: 08/01/1949
PHYSICIAN	ER / ADMIT PHYS: GANDIA ANTONIO SURGEON: ATTENDING PHYS: GANDIA ANTONIO REFERRING PHYS: FAMILY PHYS: NO PCP ADMITTED BY: BOT

COMMENTS:

Exhibit

>>>> 5882539 EOP 05/26/24 18:58

** 02465882539 FACE246 ADMISSIONS 05/26/24 010108506 RUSSEILL BEIRRY O

Nurse's Notes

Lower Keys Medical Center
Emergency Department

Name: Russeill, Beirry O
Age: 74 yrs **Sex:** Male **DOB:** 08/01/1949
Arrival Date: 05/26/2024 **Time:** 18:58
Bed 11

MRN: 10108506
Account#: 5882539
Private MD: PCP, No Local

Presentation:

05/26 19:05 Presenting Complaint: Patient states: c/o left hip pain. sts struck by vehicle 3 months ago come to ER and follow up with multiple MDs and had CT that pt reports was negative. sts pain continues also c/o leg swelling and back pain. PT ambulatory at triage no acute distress. Transition of care: patient was not received from another setting of care. Care prior to arrival: None. mm11

05/26 19:05 Acuity: ESI Level 3. mm11

05/26 19:05 Method Of Arrival: Walk-in. mm11

Triage Assessment:

05/26 19:23 **General:** Appears in no apparent distress, comfortable, Behavior is cooperative. **Pain:** Complains of pain in back, left hip, right leg and left leg. **Neuro:** Level of Consciousness is awake, alert, obeys commands, Oriented to person, place, time, Moves all extremities. Gait is steady, Speech is normal. **Cardiovascular:** No gross abnormalities. **Respiratory:** Airway is patent Respiratory effort is even, unlabored, Respiratory pattern is regular, symmetrical. **GI:** No gross abnormalities. **Derm:** Skin is intact, is healthy with good turgor, Skin is pink, warm & dry. normal. **Musculoskeletal:** Reports pain in back, left hip, right leg and left leg. mm11

05/26 19:23 Acuity: ESI Level 3. mm11

Historical:

- **Allergies:** Aspirin; Not Specified; Penicillins; Not Specified;
- **PMHx:** Acute non-ST segment elevation myocardial infarction; Anxiety; Cataract of right eye; Essential hypertension; Glaucoma; Normocytic normochromic anemia; Osteoarthritis of knee; Spastic neurogenic bladder
- **PSHx:** Coronary artery bypass graft; Coronary artery bypass graft; Exploratory laparotomy; Gunshot wound to abdomen (1982); Exploratory laparotomy (2019); Exploratory laparotomy (2019); Hemorrhoidectomy; Hemorrhoidectomy; Procedure on eye
- **Social history: :** Smoking Status: Unknown No barriers to communication noted..
- **History obtained from:** patient..
- **Immunization history:** Last tetanus immunization: unknown.
- **Code Status::** Full code.
- **Family history:** Not pertinent,.

Screening:

05/26 19:25 **Columbia Suicide Risk Assessment:** mm11

Highest Assessed Suicide Risk Level: Low suicide risk. No interventional action required at this time for assessed low suicide risk.

Recent Travel History:
No recent travel within the last 14 days.
Exposure/Syndromic
None identified.
Tuberculosis screening:

MDRO Surveillance;
Hx. Unknown Isolation.

Abuse assessment: No assessment findings of abuse, such as: unexplained injuries or bruising, suspicious burns, signs of withdrawal, depression, or fear of others. Assessment for neglect: No signs or indications of neglect noted, such as: exploitation, malnutrition, or poor hygiene.

Nurse's Notes Con't

05/26 19:25 Sepsis Screening Adult: Complete the sepsis screening, initiate protocol, and notify provider - Suspected Infection Factors=N/A- continue to SIRS Criteria(0 points),SIRS Criteria=Within Normal Limits(0 points),Sepsis Criteria Met=No,Physician Notified=No=Total Sepsis Score:0 points; mm11

05/26 19:25 UC Health Fall Risk: Assessment Type=Initial,History of Falls in Last 3 Months (Including since Admission) =No(0 points),Mobility Assist Deviced Used=Yes(5 points),Impaired Gait=No(0 points),Confusion or Disorientation=No(0 points),Intoxicated or Sedated=No(0 points),Altered Elimination=No(0 points),High Fall Risk (3+ Points)=Room Close to Nursing Station= Score:5 points; mm11

Assessment:

05/26 19:26 **Nursing diagnosis:** Alteration in comfort:. **Present on Arrival:** Central Line: NO. Foley Catheter: NO. Wound/Pressure Ulcer: NO. mm11

05/26 22:18 **General:** Appears in no apparent distress, slender, uncomfortable, Behavior is agitated, cooperative. **Recent Travel History:** No recent travel within the last 14 days. **Tuberculosis screening:** Never had TB. Exposure/Syndromic None identified. MDRO Surveillance; Hx VRE, Never had VRE. MDRO Interventions, Standard Precautions. **Pain:** Complains of pain in left leg and right leg and pelvis and back and left hip. **Neuro:** Level of Consciousness is awake, alert, Oriented to person, place, time. **EENT:** No gross abnormalities. **Cardiovascular:** No gross abnormalities. Capillary refill < 3 seconds. **GU:** No gross abnormalities. **Respiratory:** Respiratory effort is even, unlabored, Respiratory pattern is regular. **GI:** No gross abnormalities. **Derm:** No gross abnormalities. **Musculoskeletal:** Reports pain in left leg and right leg and pelvis and back and left hip. dh4

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	EtCO2	Weight	Pain	Staff
05/26 19:24	127 / 84	85	18	98.5	99%				mm11

Glasgow Coma Score:

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
05/26 19:23	spontaneous(4)	oriented(5)	obeys commands(6)		15	mm11
05/26 22:18	spontaneous(4)	oriented(5)	obeys commands(6)		15	dh4

ED Course:

05/26 18:59 Patient arrived in ED. md1

05/26 18:59 No Local PCP is Private Physician. md1

05/26 19:22 Triage completed. mm11

05/26 19:26 Arm band placed on. mm11

05/26 19:26 Patient has correct armband on for positive identification. Bed in low position. mm11

05/26 21:32 Maureen Hyland, RNP is PHCP. mh8

05/26 21:32 Matthew Partrick, MD is Attending Physician. mh8

05/26 21:34 Fernandez Cardenas, Emelia is Primary Nurse. ef

05/26 21:55 Primary Nurse role handed off by Fernandez Cardenas, Emelia. ef

05/26 21:55 House, Douglas, RN is Primary Nurse. ef

05/26 dh4

Nurse's Notes Con't

22:20 No procedures required assistance by the nurse.

05/26 23:43 Dr. David Perry, MD is Referral Physician. mm11

Administered Medications:

Time	Drug & Dose *Dispensable & Quantity*	Volume	Route	Rate	Infused Over	Site	Delivery	Staff
05/26 22:18	oxyCODONE-acetaminophen PO (5 mg-325 mg) 1 tabs		PO					dh4

Outcome:

05/26 23:43 Discharge ordered by MD. mm11

Signatures:

Diaz, Monica		md1	Markillie, Matt, RN	RN	mm11
Maureen Hyland, RNP	RNP	mh8	House, Douglas, RN	RN	dh4
Fernandez Cardenas, Emelia, RN	RN	ef			

Corrections:

05/26 ~~05/26~~ ~~Patient left the ED.~~
23:48 ~~23:43~~ ~~mm11~~ mm11

Name: Russeill, Beirry O
Age: 74 yrs **Sex:** Male **DOB:** 08/01/1949
Arrival Date: 05/26/2024 **Time:** 18:58
Bed 11
ED Physician Partrick, Matthew

MRN: 10108506
Account#: 5882539
Private MD: PCP, No Local

Disposition:

05/26 21:32 Attestation: I have reviewed the history, exam, and assessment and agree with the plan of care documented by Maureen Hyland RNP. Electronically signed by: Matthew Partrick, MD. Chart complete. mp1

05/26 22:06 Electronically signed by: Maureen Hyland, RNP. mh8

Disposition Summary:
05/26/24 23:43
Discharge Ordered

- Location: Home/Self Care. MSE Completed — mm11
- Problem: new — mm11
- Symptoms: have improved — mm11
- Condition: Stable — mm11
- Diagnosis:
  - Pain in hip — mm11
- Follow-up: — mp1
  - With:
  - When:
  - Reason: Continuity of care
- Discharge Instructions:
  - Discharge Summary Sheet — mp1
  - Hip Pain — mp1
- Forms:
  - Medication Reconciliation Form — mp1
- Prescriptions:
  - oxycodone-acetaminophen 5-325 mg Oral Tablet — mp1
    - take 1 tablet by ORAL route every 4 hours As needed; 18 tablet; Refills: 0; Product Selection Permitted

HPI:

05/26 21:32 This 74 yrs old Black Male presents to ED via Walk-in with complaints of **Hip Pain**. mp1

05/26 22:04 The patient or guardian reports pain. 74-year-old male complaining of bilateral hip pain no new trauma or injury states he got hit by a car while riding his bike 3 months ago he has had multiple CT scans and x-rays and no doctor can help him he has fired 3 physicians because no one is able to we relieve his pain. He denies any leg weakness no urinary or bowel incontinence no back pain. mh8

Historical:

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- **History obtained from:** patient..
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- **Code Status::** Full code.
- **Family history:** Not pertinent,.

Physician Documentation Con't.

ROS:

05/26 22:04 All other systems are reviewed and negative, **MS/extremity:** Positive for pain, of the left hip. — mh8

Exam:

05/26 22:04 — mh8

Head/Face: Normocephalic, atraumatic.
Eyes: Pupils equal round and reactive to light, extra-ocular motions intact. Lids and lashes normal. Conjunctiva and sclera are non-icteric and not injected. Cornea within normal limits. Periorbital areas with no swelling, redness, or edema.
ENT: Nares patent. No nasal discharge, no septal abnormalities noted. Tympanic membranes are normal and external auditory canals are clear. Oropharynx with no redness, swelling, or masses, exudates, or evidence of obstruction, uvula midline. Mucous membranes moist.
Neck: Trachea midline, no thyromegaly or masses palpated, and no cervical lymphadenopathy. Supple, full range of motion without nuchal rigidity, or vertebral point tenderness. No Meningismus.
Cardiovascular: Regular rate and rhythm with a normal S1 and S2. No gallops, murmurs, or rubs. Normal PMI, no JVD. No pulse deficits.
Respiratory: Lungs have equal breath sounds bilaterally, clear to auscultation and percussion. No rales, rhonchi or wheezes noted. No increased work of breathing, no retractions or nasal flaring.
Abdomen/GI: Soft, non-tender, with normal bowel sounds. No distension or tympany. No guarding or rebound. No evidence of tenderness throughout.
Back: No spinal tenderness. No costovertebral tenderness. Full range of motion.
Skin: Warm, dry with normal turgor. Normal color with no rashes, no lesions, and no evidence of cellulitis.
Neuro: Awake and alert, GCS 15, oriented to person, place, time, and situation. Cranial nerves II-XII grossly intact. Motor strength 5/5 in all extremities. Sensory grossly intact. Cerebellar exam normal. Normal gait.
Constitutional: The patient appears in no acute distress, alert, awake, agitated.
Musculoskeletal/extremity: Patient is reporting bilateral hip pain however no palpable pain patient is ambulating with a cane full range of motion pulses are intact no leg edema.

Vital Signs:

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MDM:

05/26 21:32 Patient medically screened. — mp1

05/26 22:05 — mh8

Differential diagnosis: hip fracture, bursitis, arthritis, strain.
Data reviewed: I reviewed the presenting history and prior records with the patient. I reviewed the prior records available within this EMR and reviewed the "Outside Records" vital signs, nurses notes.
Transition of care: After a detail discussion of the patient's case, care is transferred to Matthew Partrick