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\*\*\* TX REPORT \*\*\*  
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JOB NO. 1582  
ST. TIME 08/06 10:44  
PGS. 12  
SEND DOCUMENT NAME

TX INCOMPLETE -----  
TRANSACTION OK 12292091306  
ERROR -----

August 06, 2015

Attention  
To #: 1(229) 209-1306  
Joe - Anne Burgin Nursing Home  
321 Randolph Street  
Cuthbert, Georgia 39840

From: Lee Nola Hall West  
P.O. Box 441 407 Winding Way  
Georgetown, Georgia 39854  
Phone Numbers 1(229) [REDACTED] Home  
Cell # 1(229) 296-0379

In compliance with HIPPA 45 CFR 164.524  
Privacy rule and Centers for Medicare  
and Medicaid Services, HHS 483.10.  
Permitting Power of Attorney Representative  
and Patient to have legal access to obtain  
medical records of the individual related

# HIPAA 45 CFR 164.524 Medical Records Release

FROM : Lee Nola Hall West P.O. Box 441 407 Winding Way Georgetown , Georgia 39854 Phone Numbers 1 { 229 } ~~334-4599~~ Home , Cell 1 { 229 } ~~336-4021~~.

TO : Joe - Anne Burgin Nursing Home 321 Randolph Street Cuthbert , Georgia 39840.

I Lee Nola Hall West has Durable Power of Attorney for my Mother Annie Doris Hall. In compliance to the HIPPA Privacy Rule at 45 CFR 164. 524.,that permits a representative . To have access to all the medical records of the individual related to such representation . Medical Records that are being requested are :

Here is four pages of HIPAA privacy rule at 45 CFR 164.524. That is being sent with this medical release form, for requested information pertaining to my mother Annie Doris Hall.

PATIENT / RESIDENT NAME : Annie Doris Hall

DATE OF BIRTH : June 03, 2015

SOCIAL SECURITY NUMBER : 257 - 15 - 7641

DATE OF MEDICAL RECORDS REQUESTED : March 01, 2015 - August 05 , 2015

MEDICAL RECORDS BEING REQUESTED : All Laboratories Tests such as Blood Works , Urinalysis , Mouth Swab , Any and all Cultures performed around Gastric Peg Feeding Tube Site of Entrance , Mental Status , Medications , MRI , EKG , Emergency Room Visits , Hospitalizations, AIDS or HIV tests , and any and all Medical information pertaining to my Mother Annie Doris Hall's Health and Welfare , etc . I will pay a fee for the cost of my Mother Annie Doris Hall's Medical Records , upon receiving all of records being requested .

NAME OF REPRREPRESENTATIVE : Lee Nola Hall West

SIGNATURE OF REPRESENTATIVE : Lee Nola Hall West

PRINTED SIGNATURE OF REPRESENTATIVE : Lee Nola Hall West

DATE : August 05, 2015

WITNESS SIGNATURE : ~~Shirley A. Johnson~~

DATE : 8/5/15

Here is also six pages of Centers for Medicare and Medicaid Services, AAS 483.10, pages 45, 46, 47, 48, 49 and 50. that is being sent along with this medical release form. Lee Nola Hall West.





July 20, 2015

Lee Nola West  
P.O. Box 441  
Georgetown, GA 39854

Complaint #: GA00150931

Dear Lee Nola West:

We have completed our investigation into your allegation(s) regarding the services at Joe-Anne Burgin Nursing Home. Our professional surveyor(s) investigated your allegation(s) on 06/12/2015 and were unable to obtain sufficient evidence to support a regulatory violation. An unsubstantiated allegation is an allegation where either the evidence cannot be found to support that a regulatory violation occurred, or the evidence is inconclusive. The visit was unannounced and the investigator utilized methods designed to keep the identity of all persons involved confidential. The care and services were reviewed for the residents identified in your complaint as well as other residents with similar problems.

Each concern of your complaint was reviewed and/or investigated. This investigation may have included an on-site visit by this office, record reviews, and interviews with a variety of individuals, including facility staff and patients/residents and their families, as appropriate.

Please note that as of April 14, 2003, the Health Insurance Portability and Accountability Act (HIPAA) went into effect. This Act protects personal health information of individuals from being disclosed to the public except on the individual's request, or on the request of the individual's legally appointed guardian or to the durable power of attorney for health care. Therefore, in order to comply with HIPAA our report of findings must be limited and specific health related information cannot be disclosed.

Thank you for sharing your concerns with us. I hope this letter is responsive to your concerns. Please be assured that we will continue to hold this facility accountable for providing safe care. If you have additional concerns or questions, you may contact me at 404-657-5850.

Sincerely,

Julie Fisher, R.N.  
Complaint and Investigations Manager  
Healthcare Facility Regulation Division

cc: Facility File



## Case of MRSA found at nursing home; complaint filed

Posted: May 14, 2015 7:53 PM CST  
Updated: May 21, 2015 7:53 PM CST

By Teresa Whitaker **CONNECT**

Knowing that a loved one living in a nursing home is getting the care they need and deserve is a concern for millions of Americans.

A Georgetown, Georgia woman, Lee Nola West, filed a complaint with the Georgia Department of Community Health when her mother, Annie Hall caught an infection that, in some cases, can be deadly. MRSA, or Methacillin Resistant Staphylococcus Aureus is a bacteria that is highly resistant to antibiotics. Hall's medical records confirmed MRSA.

The State investigated the Joe-Anne Burgin Nursing Home in Cuthbert, Georgia. Julie Fisher, The Complaint and Investigative Manager at the Department of Community Health, later responded writing: "...the evidence obtained during the investigation was able to support one or more of your allegations."

We contacted Phoebe Putney Health System which runs Joe-Anne Burgin about the Hall case. They declined an on-camera interview but issued this statement to News 3:

"Infection prevention in our facility, and all nursing homes, is a multidisciplinary function involving every member of the care team. We follow professional best practices and comply with state and federal regulations to ensure the safest environment possible for our residents. "

Mary Scruggs with Georgia Department of Community Health says there are more than 350 nursing homes in Georgia. The responsibility of monitoring those Georgia facilities falls on a group of less than 40 inspectors spread out across the state to conduct regular, unannounced surveys.

If you have a complaint about a nursing home you can call Georgia's Adult Protective Services Hotline at 1-800-878-6442.

If you have concerns about a Nursing Home, you can visit <http://dch.georgia.gov/> or <http://www.medicare.gov/NursingHomeCompare/search.html>. There you can find inspection reports and an overall rating. Below are other helpful websites.

<http://nursinghomereportcards.com/>

<http://nursinghomereportcards.com/state/ga/>

<http://nursinghomereportcards.com/state/al/>





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Nathan Deal, Governor

Clyde L. Reese III, Esq., Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | [www.dch.georgia.gov](http://www.dch.georgia.gov)

December 8, 2014

Lee Nola West  
P.O. Box 441  
Georgetown, GA 39854

Joe-Anne Burgin Nursing Home  
321 Randolph Street  
Cuthbert, GA 39840-3129

RE: ANNIE HALL/ROSA HALL  
Complaint #: GA00146318

Dear Lee Nola West:

This is to acknowledge receipt of your complaint. The complaint has been referred to the Long Term Care Section of the Healthcare Facility Regulation Division (HFRD) for review. First, we must determine if your complaint raises issues that are within our regulatory authority to oversee as outlined in state and/or federal regulations. If so, a member of our staff will investigate the complaint. If we do not investigate your complaint for some reason, we will write you and let you know why. If we determine that your complaint would be more appropriately addressed by another entity, we will provide contact information.

If a determination is made that an on-site investigation is required, the visit will be unannounced and your identity will remain confidential, unless you have granted permission to us to divulge your identity. Investigations are conducted by professional surveyors who are qualified to interpret the rules and regulations that apply to the facility. The surveyors will, as appropriate, review records, conduct interviews, and observe activities related to your concerns. If the surveyor/s are able to find evidence to support your concerns or evidence that similar situations have occurred with others receiving similar services, state and/or federal violations may be cited. When HFR cites a facility for failing to meet state and/or federal rules and regulations, the facility submits a plan of correction, and depending upon the severity of the violation, follow-up surveys may be conducted and enforcement actions considered.

After the investigation is completed, you will be notified in writing of the outcome of the investigation. However, because of federal confidentiality laws, personal health information will not be provided.

The surveyor may attempt to contact you during the course of the investigation. In the meantime, if you have any additional information or questions regarding this complaint, please call the Long Term Care Section at 404-657-5850 or send written reports to:

Long Term Care Section, Complaint Unit  
Healthcare Facility Regulation Division  
Two Peachtree Street, N.W. Suite 31-447  
Atlanta, Georgia 30303-3167  
Fax Number (404) 657-8935

Thank you for notifying us about your concerns. Be assured that our office is committed to monitoring facilities to ensure that individuals are receiving care in accordance with applicable regulations.

Sincerely,  
Complaint Intake and Referral Unit  
Healthcare Facility Regulation Division





**GEORGIA DEPARTMENT  
OF COMMUNITY HEALTH**

**Clyde Reese, Commissioner**

**Nathan Deal, Governor**

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2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | [www.dch.georgia.gov](http://www.dch.georgia.gov)

March 12, 2015

Lee Nola West  
P. Box 441  
Georgetown, Ga. 39854

RE: GA00146318/ Joe-Anne Burgin Nursing Home

Dear Ms. West,

The Georgia Department of Community Health (DCH) acknowledges receipt of your Open Records Act Request, 33703, dated March 9, 2015. You have requested a report of the findings on complaint # GA00146318. You have requested certain federal records that we are not authorized to release, pursuant to O.C.G.A. Sec. 50-18-72(a)(1) and Section 1864 of the Social Security Act and the CMS state operations manual. Specifically, we are not authorized to release complaint face sheets, because we investigated these complaints on behalf of CMS for federal certification and survey activity, you must file a freedom of information act (FOIA) request with CMS to obtain them. Here is the link to the web site where you can obtain contact information for region IV; <http://www.cms.gov/center/freedom-of-information-act/regional-comtacts.html>. You may access additional information concerning FOIA issues by visiting [www.cms.gov/FOIA](http://www.cms.gov/FOIA). Click on region IV. If you have questions regarding the FOIA process, you may contact Bobby Cobb at 404-562-7445. This concludes fulfillment of your Open Records Act Request 33703. Please contact us at [HFRDOpenRecords@dch.ga.gov](mailto:HFRDOpenRecords@dch.ga.gov) if you have any questions about this request.

Thank you,

Rochelle Stembridge  
Healthcare Facility Regulation Division

HP Officejet 6310  
Personal Printer/Fax/Copier/Scanner

Log for

Oct 13 2014 4:51PM

GFI  
HA  
01/

**Last Transaction**

Date	Time	Type	Station ID	Duration	Pages	Result
Oct 13	4:49PM	Fax Sent	12297326528	1:15	3	OK



JF0000660261  
HALL, ROSA B  
01/04/1917 97



GX00021978

F 10/08/14

**SOUTHWEST GEORGIA**  
**REGIONAL MEDICAL CENTER**  
361 Randolph Street  
Cuthbert, Georgia 39840

**PATIENT RELEASE AND CONSENT FORM**

**AUTHORIZATION FOR MEDICAL TREATMENT:** I consent for admission to the hospital and I voluntarily consent to the rendering of such care including diagnostic procedures and the medical treatment, by authorized employees of the hospital, and by its medical staff or their diagnoses. I also certify that no guarantee or assurance has been made as to the results that me be obtained.

**PATIENT INFORMATION RELEASE:** I hereby authorize the release of information concerning my illness or injury and hospital treatment for news publication while a patient in Southwest Georgia Regional Medical Center and hereby agree to hold the hospital, its physicians and staff free and harmless from any and all liabilities or ill effects which might arise from the publication of such information.

**FINANCIAL AGREEMENT:** In consideration of the admission and care of the said patient the undersigned hereby agrees to pay Southwest Georgia Regional Medical Center and/or treating physicians at Cuthbert, Georgia for the services to be rendered to the patient, he hereby obligates himself to pay the account. Should the account be referred to an attorney for collection, the undersigned pay reasonable attorney's fees and collection expenses.

**ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize payment directly to Southwest Georgia Regional Medical Center of medical insurance benefits, automobile Med pay if available and any other third party payments otherwise payable to me but not to exceed the balance due of the hospital's regular charges for this period of service rendered. I understand I am financially responsible to the hospital for charges not covered by this authorization.

**RELEASE OF INFORMATION:** The undersigned authorizes Southwest Georgia Regional Medical Center to automatically furnish my family physician any medical data or information related to this visit. The undersigned authorizes release of medical information regarding treatment and care received at Southwest Georgia Regional Medical Center, to other healthcare providers who will provide treatment.

The undersigned authorizes Southwest Georgia Regional Medical Center to release to any insurance company and/or physicians agency that might be liable for payment of benefits for all or part of charges for services rendered, the dates of service, chief complaint, diagnosis and operative, diagnostic or therapeutic procedures performed, as may be necessary for the processing and payment of claims by said insurance companies or agencies. (A photocopy of this from is valid)

**TISSUE DISPOSAL:** I consent to the disposal by the hospital of any tissue parts which may be removed in the course of any procedure performed upon me.

**PERSONAL VAULABLES:** The undersigned understands that this healthcare facility maintain a safe for money and valuables of small size and agrees that the facility shall not be liable for loss or damage to any other article of personal property, unless deposited with the healthcare facility for safekeeping.

Patient's Certification, Authorization to Release Information and Payment Release. I certify that the information given by me in applying under Title XVIII of social Security Administration any information needed for this or a Medicare related claim. I request that payment of authorized benefits be made on my behalf.

SIGNATURE *Rosa B Hall* DATE 10/8/14 TIME \_\_\_\_\_

(PATIENT OR AUTHORIZED REPRESENTATIVE)(SIGNATURE BY MARK MUST BE WITNESSED)

Rosa B Hall  
PRINT PATIENT NAME


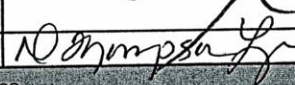
Mandaughter  
RELATIONSHIP TO PATIENT

WITNESS *April Walker*  
DATE 10/8/14 TIME \_\_\_\_\_

# Physicians Order Sheet

For Date: 6/27/2014 12:00:00AM

Order Date	Start Date	Finish Date	Category	Order Details
1/7/2014	1/8/2014		Medications	HYDROCHLOROTHIAZIDE (Carozide / Esidrix), tablet, 25 mg: Administer 25 mgs Enteral Tube 1 time per day at 16:00, For ESSENTIAL HYPERTENSION, MALIGNANT, Special Instructions: HCTC 25mg QD via Peg Tube., From OZIMBA, EMMANUAL, MD, Medical Doctor, Order entered by Thompson, Deambra, LPN, Licensed Practical Nurse
4/1/2014	4/1/2014		Medications	FERROUS SULFATE (Feosol / FeroSul), Tablet, 325 mg (65 mg iron): Administer 325 Tablets Enteral Tube 1 time per day at 16:00, For UNSPECIFIED IRON DEFICIENCY ANEMIA, Special Instructions: Give 1 tablet 325mg tablet qd by Enteral Tube, From OZIMBA, EMMANUAL, MD, Medical Doctor, Order entered by Thompson, Deambra, LPN, Licensed Practical Nurse
11/27/2013	11/27/2013		Medications	ACETAMINOPHEN, Solution, 160 mg/5 mL (5 mL): Administer 20 mLs Enteral Tube As needed every six hours, For HEMIPL/HEMIPARESIS-CEREBRVASC DZ, From Sanders, Jennifer, PA, Physician Assistant, Order entered by Patterson, Carla, LPN, Licensed Practical Nurse
11/27/2013	11/27/2013		Medications	ALPRAZOLAM (Niravam), tablet, disintegrating, 0.5 mg: Give 1 Tablet Enteral Tube As needed 4 times per day, For ALTERED MENTAL STATUS, Special Instructions: GIVE PER TUBE, From OZIMBA, EMMANUAL, MD, Medical Doctor, Order entered by Patterson, Carla, LPN, Licensed Practical Nurse
2/18/2014	2/18/2014		Medications	ALBUTEROL SULFATE, Solution for Nebulization, 2.5 mg/0.5 mL: Administer 2.5 mgs Inhaled As needed every four hours, For Shortness of Breath, From OZIMBA, EMMANUAL, MD, Medical Doctor, Order entered by PONDER, ANDREA, LPN, Licensed Practical Nurse
4/14/2014	4/14/2014		Medications	IBUPROFEN (Dolgesic / IB Pro), tablet, 400 mg: Administer 400 mgs Enteral Tube As needed every eight hours, For HEMIPL/HEMIPARESIS-CEREBRVASC DZ, Special Instructions: Ibuprofen 400 mg per enteral tube q 8 hours as needed for pain, From OZIMBA, EMMANUAL, MD, Medical Doctor, Order entered by Thompson, Deambra, LPN, Licensed Practical Nurse
5/9/2014	5/13/2014		Medications	LORATADINE (ALAVERT / ALLERGY RELIEF), tablet, disintegrating, 10 mg: Give 10 mgs By Mouth As needed 1 time per day, For allergy symptoms, Special Instructions: loratadine 10mg 1 po qd prn per John Chitoh, NP, From OZIMBA, EMMANUAL, MD, Medical Doctor, Order entered by Thompson, Deambra, LPN, Licensed Practical Nurse

Physician	Phone	Signature	Date
GHIATHI, A S			7/2/14
<b>Nurse Review</b>			6-30-14

Diagnosis	Allergies
ESSENTIAL HYPERTENSION, MALIGNANT; OTHER&UNSPECIFIED HYPERLIPIDEMIA; UNSPECIFIED IRON DEFICIENCY ANEMIA; OTH INTRARETINAL MICVASC ABNORM; SEE CHART FOR MORE CONDITIONS	NKA - No Known Allergies;

Resident Name	Medical Record #	Gender	Age	Date of Birth	Unit & Room
HALL, ANNIE	3099	F	64	6/3/1950	DOGWOOD LANE, 0125 - 1



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\*\*\* TX REPORT \*\*\*  
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August 06, 2015

Attention  
To #: 1(229) 209-1306  
Joe - Anne Burgin Nursing Home  
321 Randolph Street  
Cuthbert, Georgia 39840

From: Lee Nola Hall West  
P.O. Box 441 407 Winding Way  
Georgetown, Georgia 39854  
Phone Numbers 1(229) [REDACTED] Home  
Cell: # [REDACTED]

In compliance with HIPPA 45 CFR 164.524  
Privacy rule and Centers for Medicare  
and Medicaid Services, HHS 483.10.  
Permitting Power of Attorney Representative  
and Patient to have legal access to obtain  
medical records of this individual. Related

# HIPAA 45 CFR 164.524 Medical Records Release

FROM : Lee Nola Hall West P.O. Box 441 407 Winding Way Georgetown , Georgia 39854 Phone Numbers 1 { 229 } ~~334-4599~~ Home , Cell 1 { 229 } ~~336-6211~~ .

TO : Joe - Anne Burgin Nursing Home 321 Randolph Street Cuthbert , Georgia 39840.

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PATIENT / RESIDENT NAME : Annie Doris Hall

DATE OF BIRTH : June 03, 2015

SOCIAL SECURITY NUMBER : 257 - 15 - 7641

DATE OF MEDICAL RECORDS REQUESTED : March 01, 2015 - August 05 , 2015

MEDICAL RECORDS BEING REQUESTED : All Laboratories Tests such as Blood Works , Urinalysis , Mouth Swab , Any and all Cultures performed around Gastric Peg Feeding Tube Site of Entrance , Mental Status , Medications , MRI , EKG , Emergency Room Visits , Hospitalizations, AIDS or HIV tests , and any and all Medical information pertaining to my Mother Annie Doris Hall's Health and Welfare , etc . I will pay a fee for the cost of my Mother Annie Doris Hall's Medical Records , upon receiving all of records being requested .

NAME OF REPRREPRESENTATIVE : Lee Nola Hall West

SIGNATURE OF REPRESENTATIVE : Lee Nola Hall West

PRINTED SIGNATURE OF REPRESENTATIVE : Lee Nola Hall West

DATE : August 05, 2015

WITNESS SIGNATURE : ~~Shirley A. Johnson~~

DATE : 8/5/15

Here is also six pages of Centers for Medicare and Medicaid Services, AAS 483.10, pages 45, 46, 47, 48, 49 and 50. that is being sent along with this medical release form. Lee Nola Hall West.





July 20, 2015

Lee Nola West  
P.O. Box 441  
Georgetown, GA 39854

Complaint #: GA00150931

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Each concern of your complaint was reviewed and/or investigated. This investigation may have included an on-site visit by this office, record reviews, and interviews with a variety of individuals, including facility staff and patients/residents and their families, as appropriate.

Please note that as of April 14, 2003, the Health Insurance Portability and Accountability Act (HIPAA) went into effect. This Act protects personal health information of individuals from being disclosed to the public except on the individual's request, or on the request of the individual's legally appointed guardian or to the durable power of attorney for health care. Therefore, in order to comply with HIPAA our report of findings must be limited and specific health related information cannot be disclosed.

Thank you for sharing your concerns with us. I hope this letter is responsive to your concerns. Please be assured that we will continue to hold this facility accountable for providing safe care. If you have additional concerns or questions, you may contact me at 404-657-5850.

Sincerely,

Julie Fisher, R.N.  
Complaint and Investigations Manager  
Healthcare Facility Regulation Division

cc: Facility File



## Case of MRSA found at nursing home; complaint filed

Posted: May 14, 2015 7:53 PM CST

Updated: May 21, 2015 7:53 PM CST

By Teresa Whitaker **CONNECT**

Knowing that a loved one living in a nursing home is getting the care they need and deserve is a concern for millions of Americans.

A Georgetown, Georgia woman, Lee Nola West, filed a complaint with the Georgia Department of Community Health when her mother, Annie Hall caught an infection that, in some cases, can be deadly. MRSA, or Methacillin Resistant Staphylococcus Aureus is a bacteria that is highly resistant to antibiotics. Hall's medical records confirmed MRSA.

The State investigated the Joe-Anne Burgin Nursing Home in Cuthbert, Georgia. Julie Fisher, The Complaint and Investigative Manager at the Department of Community Health, later responded writing: "...the evidence obtained during the investigation was able to support one or more of your allegations."

We contacted Phoebe Putney Health System which runs Joe-Anne Burgin about the Hall case. They declined an on-camera interview but issued this statement to News 3:

"Infection prevention in our facility, and all nursing homes, is a multidisciplinary function involving every member of the care team. We follow professional best practices and comply with state and federal regulations to ensure the safest environment possible for our residents. "

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<http://nursinghomereportcards.com/>

<http://nursinghomereportcards.com/state/ga/>

<http://nursinghomereportcards.com/state/al/>





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 Fax: 706.327.6655  
 Email: [news@wrbl.com](mailto:news@wrbl.com)

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Nathan Deal, Governor

Clyde L. Reese III, Esq., Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

December 8, 2014

Lee Nola West  
P.O. Box 441  
Georgetown, GA 39854

Joe-Anne Burgin Nursing Home  
321 Randolph Street  
Cuthbert, GA 39840-3129

RE: ANNIE HALL/ROSA HALL  
Complaint #: GA00146318

Dear Lee Nola West:

This is to acknowledge receipt of your complaint. The complaint has been referred to the Long Term Care Section of the Healthcare Facility Regulation Division (HFRD) for review. First, we must determine if your complaint raises issues that are within our regulatory authority to oversee as outlined in state and/or federal regulations. If so, a member of our staff will investigate the complaint. If we do not investigate your complaint for some reason, we will write you and let you know why. If we determine that your complaint would be more appropriately addressed by another entity, we will provide contact information.

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Long Term Care Section, Complaint Unit  
Healthcare Facility Regulation Division  
Two Peachtree Street, N.W. Suite 31-447  
Atlanta, Georgia 30303-3167  
Fax Number (404) 657-8935

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Sincerely,  
Complaint Intake and Referral Unit  
Healthcare Facility Regulation Division





**GEORGIA DEPARTMENT  
OF COMMUNITY HEALTH**

**Clyde Reese, Commissioner**

**Nathan Deal, Governor**

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March 12, 2015

Lee Nola West  
P. Box 441  
Georgetown, Ga. 39854

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Thank you,

Rochelle Stenbridge  
Healthcare Facility Regulation Division

JF0000660261  
HALL, ROSA B  
01/04/1917 97



GX00021978

F 10/08/14

**SOUTHWEST GEORGIA**  
**REGIONAL MEDICAL CENTER**  
361 Randolph Street  
Cuthbert, Georgia 39840

**PATIENT RELEASE AND CONSENT FORM**

**AUTHORIZATION FOR MEDICAL TREATMENT:** I consent for admission to the hospital and I voluntarily consent to the rendering of such care including diagnostic procedures and the medical treatment, by authorized employees of the hospital, and by its medical staff or their diagnoses. I also certify that no guarantee or assurance has been made as to the results that me be obtained.

**PATIENT INFORMATION RELEASE:** I hereby authorize the release of information concerning my illness or injury and hospital treatment for news publication while a patient in Southwest Georgia Regional Medical Center and hereby agree to hold the hospital, its physicians and staff free and harmless from any and all liabilities or ill effects which might arise from the publication of such information.

**FINANCIAL AGREEMENT:** In consideration of the admission and care of the said patient the undersigned hereby agrees to pay Southwest Georgia Regional Medical Center and/or treating physicians at Cuthbert, Georgia for the services to be rendered to the patient, he hereby obligates himself to pay the account. Should the account be referred to an attorney for collection, the undersigned pay reasonable attorney's fees and collection expenses.

**ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize payment directly to Southwest Georgia Regional Medical Center of medical insurance benefits, automobile Med pay if available and any other third party payments otherwise payable to me but not to exceed the balance due of the hospital's regular charges for this period of service rendered. I understand I am financially responsible to the hospital for charges not covered by this authorization.

**RELEASE OF INFORMATION:** The undersigned authorizes Southwest Georgia Regional Medical Center to automatically furnish my family physician any medical data or information related to this visit. The undersigned authorizes release of medical information regarding treatment and care received at Southwest Georgia Regional Medical Center, to other healthcare providers who will provide treatment.

The undersigned authorizes Southwest Georgia Regional Medical Center to release to any insurance company and/or physicians agency that might be liable for payment of benefits for all or part of charges for services rendered, the dates of service, chief complaint, diagnosis and operative, diagnostic or therapeutic procedures performed, as may be necessary for the processing and payment of claims by said insurance companies or agencies. (A photocopy of this from is valid)

**TISSUE DISPOSAL:** I consent to the disposal by the hospital of any tissue parts which may be removed in the course of any procedure performed upon me.

**PERSONAL VAULABLES:** The undersigned understands that this healthcare facility maintain a safe for money and valuables of small size and agrees that the facility shall not be liable for loss or damage to any other article of personal property, unless deposited with the healthcare facility for safekeeping.

Patient's Certification, Authorization to Release Information and Payment Release. I certify that the information given by me in applying under Title XVIII of social Security Administration any information needed for this or a Medicare related claim. I request that payment of authorized benefits be made on my behalf.

SIGNATURE *Rosa B Hall* DATE 10/8/14 TIME \_\_\_\_\_

(PATIENT OR AUTHORIZED REPRESENTATIVE)(SIGNATURE BY MARK MUST BE WITNESSED)

Rosa B Hall  
PRINT PATIENT NAME

Granddaughter  
RELATIONSHIP TO PATIENT


WITNESS *April Walker*  
DATE 10/8/14 TIME \_\_\_\_\_

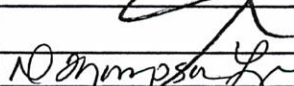


# Physicians Order Sheet

For Date: 6/27/2014 12:00:00AM

Order Date	Start Date	Finish Date	Category	Order Details
1/7/2014	1/8/2014		Medications	HYDROCHLOROTHIAZIDE (Carozide / Esidrix), tablet, 25 mg: Administer 25 mgs Enteral Tube 1 time per day at 16:00, For ESSENTIAL HYPERTENSION, MALIGNANT, Special Instructions: HCTC 25mg QD via Peg Tude., From OZIMBA, EMMANUAL, MD, Medical Doctor, Order entered by Thompson, Deambra, LPN, Licensed Practical Nurse
4/1/2014	4/1/2014		Medications	FERROUS SULFATE (Feosol / FeroSul), Tablet, 325 mg (65 mg iron): Administer 325 Tablets Enteral Tube 1 time per day at 16:00, For UNSPECIFIED IRON DEFICIENCY ANEMIA, Special Instructions: Give 1 tablet 325mg tablet qd by Enteral Tube, From OZIMBA, EMMANUAL, MD, Medical Doctor, Order entered by Thompson, Deambra, LPN, Licensed Practical Nurse
11/27/2013	11/27/2013		Medications	ACETAMINOPHEN, Solution, 160 mg/5 mL (5 mL): Administer 20 mLs Enteral Tube As needed every six hours, For HEMIPL/HEMIPARETIC-CEREBRASC DZ, From Sanders, Jennifer, PA, Physician Assistant, Order entered by Patterson, Carla, LPN, Licensed Practical Nurse
11/27/2013	11/27/2013		Medications	ALPRAZOLAM (Niravam), tablet, disintegrating, 0.5 mg: Give 1 Tablet Enteral Tube As needed 4 times per day, For ALTERED MENTAL STATUS, Special Instructions: GIVE PER TUBE, From OZIMBA, EMMANUAL, MD, Medical Doctor, Order entered by Patterson, Carla, LPN, Licensed Practical Nurse
2/18/2014	2/18/2014		Medications	ALBUTEROL SULFATE, Solution for Nebulization, 2.5 mg/0.5 mL: Administer 2.5 mgs Inhaled As needed every four hours, For Shortness of Breath, From OZIMBA, EMMANUAL, MD, Medical Doctor, Order entered by PONDER, ANDREA, LPN, Licensed Practical Nurse
4/14/2014	4/14/2014		Medications	IBUPROFEN (Dolgesic / IB Pro), tablet, 400 mg: Administer 400 mgs Enteral Tube As needed every eight hours, For HEMIPL/HEMIPARETIC-CEREBRASC DZ, Special Instructions: Ibuprofen 400 mg per enteral tube q 8 hours as needed for pain, From OZIMBA, EMMANUAL, MD, Medical Doctor, Order entered by Thompson, Deambra, LPN, Licensed Practical Nurse
5/9/2014	5/13/2014		Medications	LORATADINE (ALAVERT / ALLERGY RELIEF), tablet, disintegrating, 10 mg: Give 10 mgs By Mouth As needed 1 time per day, For allergy symptoms, Special Instructions: loratadine 10mg 1 po qd prn per John Chitoh, NP, From OZIMBA, EMMANUAL, MD, Medical Doctor, Order entered by Thompson, Deambra, LPN, Licensed Practical Nurse

Physician	Phone	Signature	Date
GHIATHI, A S			7/2/14

Nurse Review	Signature	Date
		6-30-14

Diagnosis	Allergies
ESSENTIAL HYPERTENSION, MALIGNANT; OTHER&UNSPECIFIED HYPERLIPIDEMIA; UNSPECIFIED IRON DEFICIENCY ANEMIA; OTH INTRARETINAL MICVASC ABNORM; SEE CHART FOR MORE CONDITIONS	NKA - No Known Allergies;

Resident Name	Medical Record #	Gender	Age	Date of Birth	Unit & Room
HALL, ANNIE	3099	F	64	6/3/1950	DOGWOOD LANE, 0125 - 1



GF0000660261 GX00021978  
HALL, ROSA B  
01/04/1917 97 F 10/08/14

**S AFFILIATED COVERED ENTITY  
ACKNOWLEDGEMENT FORM NOTICE OF PRIVACY PRACTICES**

By signing this form, you acknowledge that you have received the Notice of Privacy Practices for PPHS Affiliated Covered Entity (PPHS), which describes PPHS' use and disclosure of your individually identifiable health information and your rights with respect to this information.

If you refuse to sign this form, but receive health care services from PPHS, you have implicitly consented to PPHS' use and disclosure of your individually identifiable health information as described in our Notice of Privacy Practices.

If someone calls or visits and asks about you, can we acknowledge that you are here?

Yes  No

Other than yourself, who can we communicate with if we need to reach you for information we may need in order to get paid for providing services to you?

1) \_\_\_\_\_ 2) \_\_\_\_\_

PPHS has a Financial Assistance Program; would you like to receive information on how to apply?

Yes \_\_\_\_\_ No \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Patient Name (Printed): \_\_\_\_\_

Date: 10-8-14

If patient is unable/unwilling to acknowledge receipt or is a minor, complete the following:

Patient is: \_\_\_\_\_ A Minor

\_\_\_\_\_ Unable to acknowledge receipt

\_\_\_\_\_ Unwilling to acknowledge receipt

Signature of Personal Representative (if applicable): Lee Nota West

Personal Representative's Name (Print): Lee Nota West

Relationship to patient: \_\_\_\_\_

Reason patient is unable to sign: Nursing Home Patient

By initialing, you have indicated that you want to receive a paper copy of this form.

\_\_\_\_\_  
(Initials)

\_\_\_\_\_  
(Date)

JF0000660261  
HALL, ROSA B  
01/04/1917 97

GX00021978  
F 10/08/14

### ADVANCED DIRECTIVE ACKNOWLEDGEMENT

Please read the following four (3) statements and initial each one.

1. I have been given written material on my rights to accept or refuse medical and surgical treatment and my rights to formulate advance directives.

RKH (initials)

2. I understand that I am not required to have an advanced directive in order to receive medical treatment at Southwest Georgia Regional Medical Center.

RKH (initials)

3. I understand that the terms of any advanced directive that I execute will be followed by Southwest Georgia Regional Medical Center to the extent permitted by the law and in accordance with the facility's or service policies and procedures.

RKH (initials)

Please check one of the following statements:

I have executed an advance directive and will provide a copy to the facility or services. I understand that the staff and physicians of Southwest Georgia Regional Medical Center will not be able to follow the terms of my advanced directive until I provide them with a copy.

I have not executed an advanced directive and NO NOT wish to discuss advanced directives any further at this time.

I have not executed an advanced directive but would like to obtain additional information on advanced directives.

I would like to obtain a hard copy of Patient Rights and Responsibilities:  Yes  No

Joseph Robert / Rosa B Hall  
Patient's Signature

10/8/14  
Date/Time

Doni Ballek  
Witness

10/8/14  
Date/Time

For Facility use only

Registration gave information regarding Advanced Directive: GIVEN / NOT GIVEN  
Nursing staff follow-up required: REQUIRED / NOT REQUIRED



**Last Transaction**

<u>Date</u>	<u>Time</u>	<u>Type</u>	<u>Station ID</u>	<u>Duration</u>	<u>Pages</u>	<u>Result</u>
Oct 13	4:49PM	Fax Sent	12297326528	1:15	3	OK

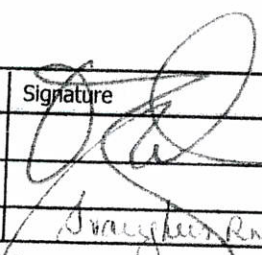
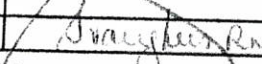
Last Transaction

Date	Time	Type	Station ID	Duration	Pages	Result
May 2	3:46PM	Fax Sent	12297326528	3:04	8	OK

# Physicians Order Sheet

For Date: 1/21/2014 12:00:00AM

Order Date	Start Date	Finish Date	Category	Order Details
11/27/2013	11/27/2013		Medications	ASPIRIN (ASPIRIN / BAYER CHEWABLE), tablet, chewable, 81 mg: Administer 1 Tablet By Mouth 1 time per day at 16:00, For OTH INTRARETINAL MICVASC ABNORM, From Sanders, Jennifer, PA, Physician Assistant, Order entered by Patterson, Carla, LPN, Licensed Practical Nurse
11/27/2013	11/28/2013		Medications	CARVEDILOL (COREG), tablet, 25 mg: Give 25 mgs Enteral Tube 1 time per day at 04:00, For HEMIPL/HEMIPAREISIS-CEREBRVASC DZ, Special Instructions: GIVE PER PEG, From OZIMBA, EMMANUAL, MD, Medical Doctor, Order entered by Patterson, Carla, LPN, Licensed Practical Nurse
11/27/2013	11/28/2013		Medications	LORATADINE (ALLERCLEAR / ALLERGY), tablet, 10 mg: Give 1 Tablet Enteral Tube 1 time per day at 04:00, For OTHER&UNSPECIFIED HYPERLIPIDEMIA, Special Instructions: GIVE PER PEG TUBE, From OZIMBA, EMMANUAL, MD, Medical Doctor, Order entered by Patterson, Carla, LPN, Licensed Practical Nurse
11/27/2013	11/28/2013		Medications	RANITIDINE HCL (ZANTAC), Solution, 25 mg/mL: Give 6 mLs Enteral Tube 1 time per day at 04:00, For OTHER&UNSPECIFIED HYPERLIPIDEMIA, Special Instructions: GIVE PER PEG, From OZIMBA, EMMANUAL, MD, Medical Doctor, Order entered by Patterson, Carla, LPN, Licensed Practical Nurse
11/27/2013	11/28/2013		Medications	SERTRALINE HCL (ZOLOFT), tablet, 50 mg: Give 1 Tablet Enteral Tube 1 time per day at 04:00, For ALTERED MENTAL STATUS, Special Instructions: GIVE PER PEG TUBE, From OZIMBA, EMMANUAL, MD, Medical Doctor, Order entered by Patterson, Carla, LPN, Licensed Practical Nurse
12/1/2013	12/2/2013		Medications	GLYBURIDE (Diabeta), Tablet: Give 1 mg Enteral Tube 2 times per day at 04:00, 16:00, For DB W/KETOACIDOS TYPE II/UNS UNCNTL, Special Instructions: GIVE PER TUBE, From OZIMBA, EMMANUAL, MD, Medical Doctor, Order entered by Dunwoody, Cathy, LPN, Licensed Practical Nurse
12/9/2013	12/9/2013		Medications	LANTUS (Insulin Glargine), Solution, 100 unit/mL: Give 10 Units Subcutaneous 1 time per day at bedtime at 20:00, For DB W/KETOACIDOS TYPE II/UNS UNCNTL, Doctors Instructions: Order received from John Chitoh, Np, From OZIMBA, EMMANUAL, MD, Medical Doctor, Order entered by Smith, Kemekia, LPN, Licensed Practical Nurse

Physician	Phone	Signature	Date
OZIMBA, EMMANUAL			1/23/14
Nurse Review			1/23/14

Diagnosis	Allergies
ESSENTIAL HYPERTENSION, MALIGNANT; OTHER&UNSPECIFIED HYPERLIPIDEMIA; UNSPECIFIED IRON DEFICIENCY ANEMIA; OTH INTRARETINAL MICVASC ABNORM; SEE CHART FOR MORE CONDITIONS	NKA - No Known Allergies;

Resident Name	Medical Record #	Gender	Age	Date of Birth	Unit & Room
HALL, ANNIE	3099	F	63	6/3/1950	DOGWOOD LANE, 0125 - 1



# Physicians Order Sheet

For Date: 3/23/2015 12:00:00AM

Order Date	Start Date	Finish Date	Category	Order Details
11/27/2013	11/20/2014		Medications	RANITIDINE HCL (ZANTAC), Solution, 25 mg/mL: Give 6 mLs Enteral Tube 1 time per day at 04:00, For GERD; , Special Instructions: GIVE PER PEG, From OZIMBA, EMMANUEL, MD, Medical Doctor, Order entered by Mills, Ola, LPN, Licensed Practical Nurse
1/7/2014	1/7/2014		Medications	LISINAPRIL (PRINIVIL / ZESTRIL), tablet, 10 mg: Administer 10 mgs Enteral Tube 1 time per day at 16:00, For ESSENTIAL HYPERTENSION, MALIGNANT; , Special Instructions: Give Lisinopril 10mg QD via Peg Tube, From OZIMBA, EMMANUEL, MD, Medical Doctor, Order entered by Thompson, Deambra, LPN, Licensed Practical Nurse
1/7/2014	1/8/2014		Medications	HYDROCHLOROTHIAZIDE (Carozide / Esidrix), tablet, 25 mg: Administer 25 mgs Enteral Tube 1 time per day at 16:00, For ESSENTIAL HYPERTENSION, MALIGNANT; , Special Instructions: HCTC 25mg QD via Peg Tude., From OZIMBA, EMMANUEL, MD, Medical Doctor, Order entered by Thompson, Deambra, LPN, Licensed Practical Nurse
9/29/2014	12/31/2014		Medications	ASPIRIN (ASPIRIN / BAYER CHEWABLE), tablet, chewable, 81 mg: Administer 1 Tablet Enteral Tube 1 time per day at 16:00, For OTH INTRARETINAL MICVASC ABNORM; , From OZIMBA, EMMANUEL, MD, Medical Doctor, Order entered by Brookins, Stephanie, RN, Registered Nurse
1/13/2015	1/14/2015		Medications	CARVEDILOL (COREG), tablet, 25 mg: Give 25 mgs Enteral Tube 1 time per day at 04:00, For HTN/ heart rate; , Special Instructions: GIVE PER PEG, From OZIMBA, EMMANUEL, MD, Medical Doctor, Order entered by Bentley, Lindsey, RN, Registered Nurse
3/11/2015	3/11/2015		Medications	LANTUS (Insulin Glargine), Solution, 100 unit/mL: Administer 15 Units Subcutaneous 1 time per day at bedtime at 20:00, For DB W/KETOACIDOS TYPE II/UNS UNCNTL; , From GHIATHI, A S, MD, Medical Doctor, Order entered by Brookins, Stephanie, RN, Registered Nurse
11/27/2013	11/27/2013		Medications	ALPRAZOLAM (Niravam), tablet, disintegrating, 0.5 mg: Give 1 Tablet Enteral Tube As needed 4 times per day, For ALTERED MENTAL STATUS; , Special Instructions: GIVE PER TUBE, From OZIMBA, EMMANUEL, MD, Medical Doctor, Order entered by Patterson, Carla, LPN, Licensed Practical Nurse

Physician	Phone	Signature	Date
GHIATHI, A S	229-732-3721		

Nurse Review	Allergies
	NKA - No Known Allergies;

Resident Name	Medical Record #	Gender	Age	Date of Birth	Unit & Room
HALL, ANNIE	3099	F	64	6/3/1950	CAMELLIA LANE, 0123 - 1

# Physicians Order Sheet

For Date: 3/23/2015 12:00:00AM

Order Date	Start Date	Finish Date	Category	Order Details
10/1/2014	12/31/2014		Medications	LORATADINE (ALAVERT / ALLERGY RELIEF), tablet, disintegrating, 10 mg: Give 10 mgs Enteral Tube As needed 1 time per day, For allergy symptoms; , Special Instructions: loratadine 10mg 1 po qd prn per John Chitoh, NP, From OZIMBA, EMMANUEL, MD, Medical Doctor, Order entered by Brookins, Stephanie, RN, Registered Nurse
3/11/2015	3/11/2015		Medications	IBUPROFEN (Child Ibuprofen / Children's Advil), Suspension, 100 mg/5 mL: Administer 400 mgs Enteral Tube As needed every eight hours, For pain; , Special Instructions: Ibuprofen 400 mg liquid per enteral tube q 8 hours as needed for pain, From OZIMBA, EMMANUEL, MD, Medical Doctor, Order entered by Brookins, Stephanie, RN, Registered Nurse

Physician	Phone	Signature	Date
GHIATHI, A S	229-732-3721		
<b>Nurse Review</b>			

Diagnosis	Allergies
ESSENTIAL HYPERTENSION, MALIGNANT; OTHER&UNSPECIFIED HYPERLIPIDEMIA; UNSPECIFIED IRON DEFICIENCY ANEMIA; OTH INTRARETINAL MICVASC ABNORM; SEE CHART FOR MORE CONDITIONS	NKA - No Known Allergies;

Resident Name	Medical Record #	Gender	Age	Date of Birth	Unit & Room
HALL, ANNIE	3099	F	64	6/3/1950	CAMELLIA LANE, 0123 - 1



\*\*\*\*\*  
\*\*\* TX REPORT \*\*\*  
\*\*\*\*\*

JOB NO. 1200  
ST. TIME 12/11 12:19  
PGS. 4  
SEND DOCUMENT NAME

TX INCOMPLETE -----  
TRANSACTION OK 12297326528  
ERROR -----

December 11, 2014

To: Dr Shiatki  
Fax #: (229) 732-6528

From:  
Lee Nola West  
P.O. Box 441  
Georgetown, GA 39854

Home (229) 334-4599  
Cell (229) 296-0219



HALL, ANNIE

4/01/14 NH

Assessments were done in the presence of Dr. Ghiathi and Destinee Johnson, LPN.

The resident is currently in bed and gives me the hand that she is doing fine. However, the nurse has concerns about drainage to the PEG tube site.

VITAL SIGNS: Temperature is 98.4, heart rate is 76, respirations 16, blood pressure 152/88.

CV: Regular rate and rhythm, no murmurs or gallops.

LUNGS: Clear to auscultation bilaterally.

ABDOMEN: Soft, nontender. No organomegaly or masses palpated. The patient has a central line and a PEG tube at the midline with some drainage around the tube.

EXTREMITIES: No cyanosis, clubbing or edema. Patient had lower extremity weakness, more to the left side.

HEENT: Essentially unremarkable.

NECK: Supple.

NEURO: Patient is aphasic and has left sided weakness secondary to CVA.

ASSESSMENT:

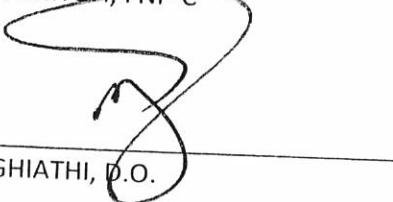
1. HYPERTENSION.
2. HYPERLIPIDEMIA.
3. ANEMIA.
4. LEFT SIDED WEAKNESS SECONDARY TO CVA.
5. HISTORY OF ALTERED MENTAL STATUS.
6. DEHYDRATION.
7. HYPOGLYCEMIA.
8. A MASS AT THE PEG TUBE SITE.

PLAN:

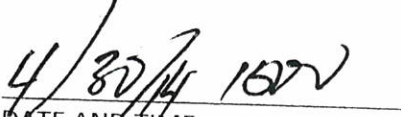
We will implement recommendations made by pharmacist. Nurses are advised to put Bactroban on the PEG tube site at every dressing. We will continue to monitor resident's weight for reevaluation next month.

JC/ASG/mbw

  
JOHN CHITOH, FNP-C

  
A.S. GHIATHI, D.O.

  
DATE AND TIME

  
DATE AND TIME

## Progress Notes By Resident

For Date Range: 11/27/2013 To 2/17/2014

Resident Name HALL, ANNIE	Medical Record # 3099	Unit & Room DOGWOOD LANE 0125 - 1
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11/27/2013 11:45 AM (Entered on: 11/27/2013 3:55 PM)

Progress Notes of Smith, Kemekia, LPN, Licensed Practical Nurse -- **Quick Notes** (actual entry date: 11/27/2013 3:55 PM)

**Comments:** General Quick Comments = 64 year old black female admitted to the nursing home from Pioneer Hospital in Blakely Ga. Arrived at the nursing home on stretcher with family members. Alert but non verbal. Fingertstick Bloodsugar upon arrival 232 mg /dl. Skin warm and dry to touch. Admitted to room 125A. Resident is the daughter in law of 125B. No signs or symptoms of distress or discomfort noted. Will continue to monitor..

11/27/2013 6:53 PM

Progress Notes of Thompson, Deambra, LPN, Licensed Practical Nurse -- **Enteral Nutrition**

**History:** Completely tube fed.

**Observation:** Clear lung sounds, Skin clear around tube site, HOB elevated 30 degrees, Active bowel sounds, good skin turgor, Mental status stable.

**Intake & Output:** Intake Enteral in ml = 202, Feeding tube present, Feeding tube amount in cc = 124, Feeding tube rate in cc/hr = 40, Feeding tube flush in cc = 78.

**Comments:** Nutrition Comments = Resident lying in bed with eyes open. Aroused by verbal stimuli, No verbals. Respirations are even and nonlabored. Skin Tugor is good, skin warm and dry to touch. Resident has a 16in Foley Catheter intake with patent urine flow. Resident tolerating Glucerna 1.2 cal at 40ml/hr. Resident depends on staff for all ADLs, and incontinent to bladder and bowel. No new orders at this time, will continue to monitor..

11/28/2013 4:59 AM

Progress Notes of Waymon, Annitra, LPN, Licensed Practical Nurse -- **Diabetes Mellitus**

**Blood Sugar:** Current blood sugar level in mg/dl = 297.

11/28/2013 5:55 AM

Progress Notes of Waymon, Annitra, LPN, Licensed Practical Nurse -- **Diabetes Mellitus**

**Blood Sugar:** Current blood sugar level in mg/dl = 269.

11/28/2013 7:45 PM

Progress Notes of Clark, Karen, LPN, Licensed Practical Nurse -- **Diabetes Mellitus**

**Blood Sugar:** Current blood sugar level in mg/dl = 262.

11/29/2013 5:33 AM

Progress Notes of Clark, Karen, LPN, Licensed Practical Nurse -- **Diabetes Mellitus**

**Blood Sugar:** Current blood sugar level in mg/dl = 333.

11/29/2013 2:03 PM

Progress Notes of Smith, Kemekia, LPN, Licensed Practical Nurse -- **Diabetes Mellitus**

**Blood Sugar:** Current blood sugar level in mg/dl = 269.

11/29/2013 6:02 PM

Progress Notes of Smith, Kemekia, LPN, Licensed Practical Nurse -- **Diabetes Mellitus**

**Blood Sugar:** Current blood sugar level in mg/dl = 256.

11/30/2013 2:35 AM

Progress Notes of Allen, Tron, LPN, Licensed Practical Nurse -- **Pain Control**

**Comments:** General Pain Comments = for temp of 100.6.



[Skip Navigation](#)

## U.S. Department of Health & Human Services

*Improving the health, safety, and well-being of America*

### Health Information Privacy

#### **If someone has health care power of attorney for an individual, can they obtain access to that individual's medical record?**

**Answer:**

Yes, an individual that has been given a health care power of attorney will have the right to access the medical records of the individual related to such representation to the extent permitted by the HIPAA Privacy Rule at [45 CFR 164.524](#).

However, when a physician or other covered entity reasonably believes that an individual, including an unemancipated minor, has been or may be subjected to domestic violence, abuse or neglect by the personal representative, or that treating a person as an individual's personal representative could endanger the individual, the covered entity may choose not to treat that person as the individual's personal representative, if in the exercise of professional judgment, doing so would not be in the best interests of the individual.

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Date Created: 12/19/2002

Last Updated: 03/14/2006

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U.S. Department of Health & Human Services • 200 Independence Avenue, S.W. • Washington, D.C. 20201

# Code of Federal Regulations

## Title 45 - Public Welfare

Volume: 1 Date: 2002-10-01 Original Date: 2002-10-01 Title: Section 164.524 - Access of individuals to protected health information. Context: Title 45 - Public Welfare. SUBCHAPTER C - ADMINISTRATIVE DATA STANDARDS AND RELATED REQUIREMENTS. PART 164 - SECURITY AND PRIVACY. Subpart E - Privacy of Individually Identifiable Health Information.

§ 164.524 Access of individuals to protected health information. (a) *Standard: Access to protected health information.* (1) *Right of access.* Except as otherwise provided in paragraph (a)(2) or (a)(3) of this section, an individual has a right of access to inspect and obtain a copy of protected health information about the individual in a designated record set, for as long as the protected health information is maintained in the designated record set, except for: (i) Psychotherapy notes; (ii) Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and (iii) Protected health information maintained by a covered entity that is: (A) Subject to the Clinical Laboratory Improvements Amendments of 1988, 42 U.S.C. 263a, to the extent the provision of access to the individual would be prohibited by law; or (B) Exempt from the Clinical Laboratory Improvements Amendments of 1988, pursuant to 42 CFR 493.3(a)(2). (2) *Unreviewable grounds for denial.* A covered entity may deny an individual access without providing the individual an opportunity for review, in the following circumstances: (i) The protected health information is excepted from the right of access by paragraph (a)(1) of this section. (ii) A covered entity that is a correctional institution or a covered health care provider acting under the direction of the correctional institution may deny, in whole or in part, an inmate's request to obtain a copy of protected health information, if obtaining such copy would jeopardize the health, safety, security, custody, or rehabilitation of the individual or of other inmates, or the safety of any officer, employee, or other person at the correctional institution or responsible for the transporting of the inmate. (iii) An individual's access to protected health information created or obtained by a covered health care provider in the course of research that includes treatment may be temporarily suspended for as long as the research is in progress, provided that the individual has agreed to the denial of access when consenting to participate in the research that includes treatment, and the covered health care provider has informed the individual that the right of access will be reinstated upon completion of the research. (iv) An individual's access to protected health information that is contained in records that are subject to the Privacy Act, 5 U.S.C. 552a, may be denied, if the denial of access under the Privacy Act would meet the requirements of that law. (v) An individual's access may be denied if the protected health information was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information. (3) *Reviewable grounds for denial.* A covered entity may deny an individual access, provided that the individual is given a right to have such denials reviewed, as required by paragraph (a)(4) of this section, in the following circumstances: (i) A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person; (ii) The protected health information makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or (iii) The request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to the individual or another person. (4) *Review of a denial of access.* If access is denied on a ground permitted under paragraph (a)(3) of this section, the individual has the right to have the denial reviewed by a licensed health care professional who is designated by the covered entity to act as a reviewing official and who did not participate in the original decision to deny. The covered entity must provide or deny access in accordance with the determination of the reviewing official under paragraph (d)(4) of this section. (b) *Implementation specifications: requests for access and timely action.* (1) *Individual's request for access.* The covered entity must permit an individual to request access to inspect or to obtain a copy of the protected health information about the individual that is maintained in a designated record set. The covered entity may



require individuals to make requests for access in writing, provided that it informs individuals of such a requirement. (2) *Timely action by the covered entity.* (i) Except as provided in paragraph (b)(2)(ii) of this section, the covered entity must act on a request for access no later than 30 days after receipt of the request as follows. (A) If the covered entity grants the request, in whole or in part, it must inform the individual of the acceptance of the request and provide the access requested, in accordance with paragraph (c) of this section. (B) If the covered entity denies the request, in whole or in part, it must provide the individual with a written denial, in accordance with paragraph (d) of this section. (ii) If the request for access is for protected health information that is not maintained or accessible to the covered entity on-site, the covered entity must take an action required by paragraph (b)(2)(i) of this section by no later than 60 days from the receipt of such a request. (iii) If the covered entity is unable to take an action required by paragraph (b)(2)(i)(A) or (B) of this section within the time required by paragraph (b)(2)(i) or (ii) of this section, as applicable, the covered entity may extend the time for such actions by no more than 30 days, provided that: (A) The covered entity, within the time limit set by paragraph (b)(2)(i) or (ii) of this section, as applicable, provides the individual with a written statement of the reasons for the delay and the date by which the covered entity will complete its action on the request; and (B) The covered entity may have only one such extension of time for action on a request for access. (c) *Implementation specifications: Provision of access.* If the covered entity provides an individual with access, in whole or in part, to protected health information, the covered entity must comply with the following requirements. (1) *Providing the access requested.* The covered entity must provide the access requested by individuals, including inspection or obtaining a copy, or both, of the protected health information about them in designated record sets. If the same protected health information that is the subject of a request for access is maintained in more than one designated record set or at more than one location, the covered entity need only produce the protected health information once in response to a request for access. (2) *Form of access requested.* (i) The covered entity must provide the individual with access to the protected health information in the form or format requested by the individual, if it is readily producible in such form or format; or, if not, in a readable hard copy form or such other form or format as agreed to by the covered entity and the individual. (ii) The covered entity may provide the individual with a summary of the protected health information requested, in lieu of providing access to the protected health information or may provide an explanation of the protected health information to which access has been provided, if: (A) The individual agrees in advance to such a summary or explanation; and (B) The individual agrees in advance to the fees imposed, if any, by the covered entity for such summary or explanation. (3) *Time and manner of access.* The covered entity must provide the access as requested by the individual in a timely manner as required by paragraph (b)(2) of this section, including arranging with the individual for a convenient time and place to inspect or obtain a copy of the protected health information, or mailing the copy of the protected health information at the individual's request. The covered entity may discuss the scope, format, and other aspects of the request for access with the individual as necessary to facilitate the timely provision of access. (4) *Fees.* If the individual requests a copy of the protected health information or agrees to a summary or explanation of such information, the covered entity may impose a reasonable, cost-based fee, provided that the fee includes only the cost of: (i) Copying, including the cost of supplies for and labor of copying, the protected health information requested by the individual; (ii) Postage, when the individual has requested the copy, or the summary or explanation, be mailed; and (iii) Preparing an explanation or summary of the protected health information, if agreed to by the individual as required by paragraph (c)(2)(ii) of this section. (d) *Implementation specifications: Denial of access.* If the covered entity denies access, in whole or in part, to protected health information, the covered entity must comply with the following requirements. (1) *Making other information accessible.* The covered entity must, to the extent possible, give the individual access to any other protected health information requested, after excluding the protected health information as to which the covered entity has a ground to deny access. (2) *Denial.* The covered entity must provide a timely, written denial to the individual, in accordance with paragraph (b)(2) of this section. The denial must be in plain language and contain: (i) The basis for the denial; (ii) If applicable, a statement of the individual's review rights under paragraph (a)(4) of this section, including a description of how the individual may exercise such review rights; and (iii) A description of how the individual may complain to the covered entity pursuant to the complaint procedures in § 164.530(d) or to the Secretary pursuant to the procedures in § 160.306. The description must include the name, or title, and telephone number of the contact person or office designated in § 164.530(a)(1)(ii). (3) *Other responsibility.* If the covered entity does not maintain the protected health information that is the subject of the individual's request for access, and the covered entity knows where

the requested information is maintained, the covered entity must inform the individual where to direct the request for access.(4) Review of denial requested. If the individual has requested a review of a denial under paragraph (a)(4) of this section, the covered entity must designate a licensed health care professional, who was not directly involved in the denial to review the decision to deny access. The covered entity must promptly refer a request for review to such designated reviewing official. The designated reviewing official must determine, within a reasonable period of time, whether or not to deny the access requested based on the standards in paragraph (a)(3) of this section. The covered entity must promptly provide written notice to the individual of the determination of the designated reviewing official and take other action as required by this section to carry out the designated reviewing official's determination.(e) *Implementation specification: Documentation.* A covered entity must document the following and retain the documentation as required by § 164.530(j):  
(1) The designated record sets that are subject to access by individuals; and(2) The titles of the persons or offices responsible for receiving and processing requests for access by individuals.



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it is a distinct part, as evidenced by the sharing of income and expenses with that institution, and the reporting of its costs on that institution's cost report.

(v) A single institution can have a maximum of only one distinct part SNF and one distinct part NF.

(vi) (A) An institution cannot designate a distinct part SNF or NF, but instead must submit a written request with documentation that demonstrates it meets the criteria set forth above to CMS to determine if it may be considered a distinct part.

(B) The effective date of approval of a distinct part is the date that CMS determines all requirements (including enrollment with the fiscal intermediary (FI)) are met for approval, and cannot be made retroactive.

(C) The institution must request approval from CMS for all proposed changes in the number of beds in the approved distinct part.

(c) *Composite distinct part*—(1) *Definition*. A composite distinct part is a distinct part consisting of two or more noncontiguous components that are not located within the same campus, as defined in § 413.65(a)(2) of this chapter.

(2) *Requirements*. In addition to meeting the requirements of paragraph (b) of this section, a composite distinct part must meet all of the following requirements:

(i) A SNF or NF that is a composite of more than one location will be treated as a single distinct part of the institution of which it is a distinct part. As such, the composite distinct part will have only one provider agreement and only one provider number.

(ii) If two or more institutions (each with a distinct part SNF or NF) undergo a change of ownership, CMS must approve the existing SNFs or NFs as meeting the requirements before they are considered a composite distinct part of a single institution. In making such a determination, CMS considers whether its approval or disapproval of a composite distinct part promotes the effective and efficient use of public monies without sacrificing the quality of care.

(iii) If there is a change of ownership of a composite distinct part SNF or NF, the assignment of the provider

agreement to the new owner will apply to all of the approved locations that comprise the composite distinct part SNF or NF.

(iv) To ensure quality of care and quality of life for all residents, the various components of a composite distinct part must meet all of the requirements for participation independently in each location.

(d) *Common area*. Common areas are dining rooms, activity rooms, meeting rooms where residents are located on a regular basis, and other areas in the facility where residents may gather together with other residents, visitors, and staff.

(e) *Fully sprinklered*. A fully sprinklered long term care facility is one that has all areas sprinklered in accordance with National Fire Protection Association 13 "Standard for the Installation of Sprinkler Systems" without the use of waivers or the Fire Safety Evaluation System.

[68 FR 46071, Aug. 4, 2003, as amended at 71 FR 39229, July 12, 2006; 71 FR 55340, Sept. 22, 2006]

§ 483.10 Resident rights.

The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident, including each of the following rights:

(a) *Exercise of rights*. (1) The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.

(3) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf.

(4) In the case of a resident who has not been adjudged incompetent by the State court, any legal-surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law.



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(b) *Notice of rights and services.* (1) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under section 1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing;

(2) The resident or his or her legal representative has the right—

(i) Upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and

(ii) After receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility.

(3) The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition;

(4) The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section; and

(5) The facility must—

(i) Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of—

(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;

(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and

(ii) Inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

(6) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

(7) The facility must furnish a written description of legal rights which includes—

(i) A description of the manner of protecting personal funds, under paragraph (c) of this section;

(ii) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels;

(iii) A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and

(iv) A statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

(8) The facility must comply with the requirements specified in subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. Facilities are permitted to contract with other entities

to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. If an adult individual is incapacitated at the time of admission and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated individual or to a surrogate or other concerned persons in accordance with State law. The facility is not relieved of its obligation to provide this information to the individual once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

(9) The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

(10) The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

(11) *Notification of changes.* (i) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is—

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(B) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or

(D) A decision to transfer or discharge the resident from the facility as specified in § 483.12(a).

(ii) The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is—

(A) A change in room or roommate assignment as specified in § 483.15(e)(2); or

(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

(iii) The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

(12) *Admission to a composite distinct part.* A facility that is a composite distinct part (as defined in § 483.5(c) of this subpart) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under § 483.12(a)(8).

(c) *Protection of resident funds.* (1) The resident has the right to manage his or her financial affairs, and the facility may not require residents to deposit their personal funds with the facility.

(2) *Management of personal funds.* Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)–(8) of this section.

(3) *Deposit of funds.* (i) *Funds in excess of \$50.* The facility must deposit any residents' personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)

(ii) *Funds less than \$50.* The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.

(4) *Accounting and records.* The facility must establish and maintain a system that assures a full and complete



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and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

(i) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

(ii) The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

(5) *Notice of certain balances.* The facility must notify each resident that receives Medicaid benefits—

(i) When the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and

(ii) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

(6) *Conveyance upon death.* Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.

(7) *Assurance of financial security.* The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.

(8) *Limitation on charges to personal funds.* The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with § 489.32 of this chapter. (This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See § 447.15, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or copayment

required by the plan to be paid by the individual.)

(i) *Services included in Medicare or Medicaid payment.* During the course of a covered Medicare or Medicaid stay, facilities may not charge a resident for the following categories of items and services:

(A) Nursing services as required at § 483.30 of this subpart.

(B) Dietary services as required at § 483.35 of this subpart.

(C) An activities program as required at § 483.15(f) of this subpart.

(D) Room/bed maintenance services.

(E) Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing, and basic personal laundry.

(F) Medically-related social services as required at § 483.15(g) of this subpart.

(ii) *Items and services that may be charged to residents' funds.* Listed below are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid:

(A) Telephone.

(B) Television/radio for personal use.

(C) Personal comfort items, including smoking materials, notions and novelties, and confections.

(D) Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare.

(E) Personal clothing.

(F) Personal reading matter.

(G) Gifts purchased on behalf of a resident.

(H) Flowers and plants.



- (I) Social events and entertainment offered outside the scope of the activities program, provided under § 483.15(f) of this subpart.
- (J) Noncovered special care services such as privately hired nurses or aides.
- (K) Private room, except when therapeutically required (for example, isolation for infection control).
- (L) Specially prepared or alternative food requested instead of the food generally prepared by the facility, as required by § 483.35 of this subpart.
- (iii) *Requests for items and services.* (A) The facility must not charge a resident (or his or her representative) for any item or service not requested by the resident.
- (B) The facility must not require a resident (or his or her representative) to request any item or service as a condition of admission or continued stay.
- (C) The facility must inform the resident (or his or her representative) requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be.
- (d) *Free choice.* The resident has the right to—
- (1) Choose a personal attending physician;
  - (2) Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being; and
  - (3) Unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment.
- (e) *Privacy and confidentiality.* The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.
- (1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident;
  - (2) Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility;
  - (3) The resident's right to refuse release of personal and clinical records does not apply when—
    - (i) The resident is transferred to another health care institution; or
    - (ii) Record release is required by law.
- (f) *Grievances.* A resident has the right to—
- (1) Voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished; and
  - (2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.
- (g) *Examination of survey results.* A resident has the right to—
- (1) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination in a place readily accessible to residents, and must post a notice of their availability; and
  - (2) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.
- (h) *Work.* The resident has the right to—
- (1) Refuse to perform services for the facility;
  - (2) Perform services for the facility, if he or she chooses, when—
    - (i) The facility has documented the need or desire for work in the plan of care;
    - (ii) The plan specifies the nature of the services performed and whether the services are voluntary or paid;
    - (iii) Compensation for paid services is at or above prevailing rates; and
    - (iv) The resident agrees to the work arrangement described in the plan of care.
- (i) *Mail.* The resident has the right to privacy in written communications, including the right to—
- (1) Send and promptly receive mail that is unopened; and
  - (2) Have access to stationery, postage, and writing implements at the resident's own expense.

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(j) *Access and visitation rights.* (1) The resident has the right and the facility must provide immediate access to any resident by the following:

(i) Any representative of the Secretary;

(ii) Any representative of the State;

(iii) The resident's individual physician;

(iv) The State long term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965);

(v) The agency responsible for the protection and advocacy system for developmentally disabled individuals (established under part C of the Developmental Disabilities Assistance and Bill of Rights Act);

(vi) The agency responsible for the protection and advocacy system for mentally ill individuals (established under the Protection and Advocacy for Mentally Ill Individuals Act);

(vii) Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and

(viii) Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident.

(2) The facility must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

(3) The facility must allow representatives of the State Ombudsman, described in paragraph (j)(1)(iv) of this section, to examine a resident's clinical records with the permission of the resident or the resident's legal representative, and consistent with State law.

(k) *Telephone.* The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.

(l) *Personal property.* The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

(m) *Married couples.* The resident has the right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.

(n) *Self-Administration of Drugs.* An individual resident may self-administer drugs if the interdisciplinary team, as defined by § 483.20(d)(2)(ii), has determined that this practice is safe.

(o) *Refusal of certain transfers.* (1) An individual has the right to refuse a transfer to another room within the institution, if the purpose of the transfer is to relocate—

(i) A resident of a SNF from the distinct part of the institution that is a SNF to a part of the institution that is not a SNF, or

(ii) A resident of a NF from the distinct part of the institution that is a NF to a distinct part of the institution that is a SNF.

(2) A resident's exercise of the right to refuse transfer under paragraph (o)(1) of this section does not affect the individual's eligibility or entitlement to Medicare or Medicaid benefits.

[56 FR 48867, Sept. 26, 1991, as amended at 57 FR 8202, Mar. 6, 1992; 57 FR 43924, Sept. 23, 1992; 57 FR 53587, Nov. 12, 1992; 60 FR 33293, June 27, 1995; 68 FR 46072, Aug. 4, 2003]

§ 483.12 Admission, transfer and discharge rights.

(a) Transfer and discharge—

(1) *Definition:* Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

(2) *Transfer and discharge requirements.* The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—

(i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

(ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;



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# Physician's Order

SOUTHWEST GEROGIA  
REGIONAL MEDICAL CENTER

HALL, ANNIE DORIS DR OZIMBA

Alle DOB: 06/03/1950 B-F

Use Ball Point Pen Only

Patient Status:  Observation  In-Patient  Extended Recovery (Post Surgical / Post Procedure)

11/30/13 6:35am Sliding Scale: give <sup>Novolin R 100 units</sup> if blood sugar is between  
 201-250 = 2 units, 251-300 = 4 units, 301-350 = 6 units,  
 351-400 = 8 units. Notify MD IF FBS is  
 greater than 400 or less than 60. V.O. Dr. Ozimba / Alle  
 noted ~~Alle~~ in 11/30/13

11/30/13 Ent  
 0830 obtain U/A per Dr. Ozimba  
 T/O Dr. Ozimba / K Smith  
 noted J. M. De PV

12/9/13 Chest Xray U/A. Start Lantus 10  
 Units at 8's hs. T/O John Chitch / K Smith  
 RBT V by J. M. De PV

12/9/13 Cipro 500mg <sup>740</sup> i per marks tablet per peg  
 bid x 10 days. Give first dose now.  
 T/O John Chitch, NP / K Smith noted RBT V by J. M. De PV

DO NOT USE	USE	Potential Problem
, u	"Units"	Mistaken for "0" (zero), the number "4" (four) or "cc"
J	"International Units"	Mistaken for IV (intravenous) or the number 10 (ten)
.D., QD, q.d., qd,	Write "daily",	Mistaken for each other
.O.D., QOD, q.o.d., qod	Write, "every other day"	Period after Q mistaken for "I" and "O" mistaken for "I"
railing "0" (X.0 mg)	Write X mg	
ack of leading zero (.Xmg)	Write 0.X mg	Decimal point is missed
S, MSO <sub>4</sub> , MgSO <sub>4</sub>	Write "morphine sulfate" or "magnesium sulfate"	Can mean morphine sulfate or magnesium sulfate: Confused for one another



NURSE'S NOTES

Date and Time: \_\_\_\_\_ Nurse's Name: \_\_\_\_\_

11-30-13 9:25am - U/A results called to Dr. Ozimba in ER. No new orders received. *K. M. O'Leary*

11-30-13 1300 - BP 129/74. Pulse 94 Resp 18. Hematocrits of back elevated 30-45°. Skin warm and dry to the touch. Continues on Cilia 40cc/hr. Foley Catheter intact with amber colored urine. All needs met per staff. Will continue to monitor. *K. M. O'Leary*

11-30-13 1915 Resting quietly in bed at this time. No S/S distress or discomfort noted. Will continue to monitor. *K. M. O'Leary*

11-30-13 Enteral Feeding intake 477 Flush 30ml Irrigation 20ml. *K. M. O'Leary*

11-30-13 7p-7A Resident is alert unable to make needs known. Skin warm and dry to touch. Resp. even and nonlabored. F/C intact and patent. Turning of his Peg tube is intact and patent. Peg tube site is dry and clear. No vitals signs 194/RS, 94, 94/RA and Temp: 100.5. 14ml Sal administered @ 1.0am, rechecked @ 2.15am with results 989. Enteral Feedings Intake 366, H<sub>2</sub>O 226. No distress noted will continue to monitor. *K. M. O'Leary*

FSBS 262 and 8pm, administered 4 units Nov R and 253 administered 4 units Nov L.

*K. M. O'Leary*

# Southwest GA Regional Medical Center

## CT Patient History Worksheet

GF0000671575      GX00051806  
 HALL, ANNIE D  
 06/03/1950 65      F 07/24/15  
 Pa. GHIATHI, A S DO      M/F      Date: 7/24/15

**History of Present Illness:**

Chief Complaint (What patient is here for today): pt has  
larynx & neck swelling

How long has patient had problem: X 7/11/15

Scan is to evaluate patient for: abnormalities

Previous CT scan: Y N When / Where: \_\_\_\_\_

Previous related imaging studies (MRI, XRay, U/S, NM, PET) with report / films:

When / Where: \_\_\_\_\_ obtainable: Y / N

Patient History:	Y	N
Asthma		<input checked="" type="checkbox"/>
Heart Disease	<input checked="" type="checkbox"/>	
High Blood Pressure	<input checked="" type="checkbox"/>	
Diabetes	<input checked="" type="checkbox"/>	
Kidney Disease	<input checked="" type="checkbox"/>	
Patient Pregnant	<input checked="" type="checkbox"/>	
Last menstrual cycle	<input checked="" type="checkbox"/>	

Cancer Information:	Y	N
Cancer Diagnosis		<input checked="" type="checkbox"/>
When Diagnosed		<input checked="" type="checkbox"/>
Mets? Where		<input checked="" type="checkbox"/>
Chemotherapy		<input checked="" type="checkbox"/>
Radiation Therapy		<input checked="" type="checkbox"/>

Smoking History:	Yes	No
How many packs a day? _____		<input checked="" type="checkbox"/>
For how many years? _____		<input checked="" type="checkbox"/>

Previous Surgery and dates of Procedures: hypertension  
tubal

History completed by: Mississippi



**Southwest GA Regional Medical Center**  
Radiology Department Consent Form

GF0000671575    GX00051806  
HALL, ANNIE D  
06/03/1950 65    F 07/24/15  
GHIATHI, A S DO

1. I hereby authorize the CT Department, and whoever they designate as assistants to perform upon Annie Hall, the following diagnostic procedure CT SOFT TISSUE NECK, and if any unforeseen conditions arises in the course of the procedure to utilize his/her judgment in performing additional procedures/treatments to treat such circumstances.
2. I understand this procedure involves the injection of a contrast material used to visualize and inspect for blockage, blood clots, etc. Contrast material is considered safe; however, any introduction into the body of a previously unknown substance carries with risk of harm including, but not limited to, injury to the vein, infection and reaction to the material being injected. Occasionally, persons will have mild reactions to the contrast, such as nausea, vomiting, sneezing and development of hives. Uncommonly a more serious reaction occurs, the Radiology Department staff is trained to treat these reactions. Very rarely, death has occurred related to contrast administration.
3. I have been fully informed to the risks and possible consequences involved and that unforeseen results may occur. I acknowledge that no guarantee or assurance has been made as to the results obtained.
4. The nature and purpose of the procedure and possible alternative methods of treatment have been fully explained to me.

I certify that I have read and fully understand the above consent, that the explanations therein were made, and that all blanks or statements requiring insertion or completion were filled in, and inapplicable paragraphs, if any, were stricken before I signed.

Annie Hall  
Signature of Patient

July 24 2015 4:20 PM  
Date / Time

When a patient is a minor or incompetent to give consent:

Dr. [Signature]  
Signature of Person Authorized to Consent for Patient

July 24 2015 4:20 PM  
Date / Time

Daughter  
Relationship

Miss [Signature]  
Witness

7/24/15  
Date/Time



Southwest Ga Regional Medical Center  
Radiology Department

GF0000671575  
HALL, ANNIE D  
06/03/1950 65  
GHIATHI, A S DO

GX00051806  
F 07/24/15

Patient's Name

DOB

Date

7/24/15

List of medications patient is taking: (Prescriptions, Vitamins, Herbals, Over the Counter, etc.)

Albuterol Sulfate

Glyburide

Duoneb

Hctz

Xanax

Lantus

Ecotrin

lisinopril

Coreg

Zoloft

Ferrous Sulfate

Any allergies to food, medications, or anything?

Yes

No

If Yes, please list below

List of medications reviewed by pharmacist:

Pharmacist Signature

Date

List of medications reviewed by physician:

Physician Signature

Date

I do not take any medications.

Patient Signature

Date

# Southwest GA Regional Medical Center

## IV Contrast Media Patient History

GF0000671575      GX00051806

Name: HALL, ANNIE D  
 06/03/1950 65      F 07/24/15

Date: 7/24/15

DOB: GHIATHI, A S DO

Physician: \_\_\_\_\_

Risk Factors	Yes	No	Risk Factors	Yes	No
<b>If Yes - then BUN/Creatinine</b>			<b>If Yes - Get Radiologist/Ordering Dr approval before proceeding</b>		
• Diabetes Mellitus	<input checked="" type="checkbox"/>		• Thyroid Cancer		<input checked="" type="checkbox"/>
• Congestive Heart Failure		<input checked="" type="checkbox"/>	• Prior Contrast Media Reaction		<input checked="" type="checkbox"/>
• AIDS/HIV		<input checked="" type="checkbox"/>	• Multiple Myeloma		<input checked="" type="checkbox"/>
• Advanced Malignancy		<input checked="" type="checkbox"/>	• Waldrenstrom's syndrome		<input checked="" type="checkbox"/>
• Solitary Kidney-nephrectomy/ congenial absence		<input checked="" type="checkbox"/>	• Pheochromocytoma		<input checked="" type="checkbox"/>
• Lupus		<input checked="" type="checkbox"/>	• Sickle Cell		<input checked="" type="checkbox"/>
• Vasculitis		<input checked="" type="checkbox"/>	• Acute trauma		<input checked="" type="checkbox"/>
• Scleroderma		<input checked="" type="checkbox"/>			
• Renal Failure		<input checked="" type="checkbox"/>	Pt had IV Dye? Y or N?		
• Renal Transplant		<input checked="" type="checkbox"/>	Any history of allergic reaction to IV dye? Y or N		
• Immediate Family w/ renal failure		<input checked="" type="checkbox"/>	Type of reaction: _____		
• Cirrhosis		<input checked="" type="checkbox"/>			
• Hepatitis		<input checked="" type="checkbox"/>	Lab Date & Date: <u>7/24/15</u>		
• Drug - Metformin containing Medications		<input checked="" type="checkbox"/>	BUN <u>17</u> Creatinine <u>0.7</u>		
• Over the age of 35	<input checked="" type="checkbox"/>				
• Anemia	<input checked="" type="checkbox"/>				
• Pulmonary Edema	<input checked="" type="checkbox"/>				

Any known allergies to food, medicines, or anything?      Yes or No

I agree with the above assessment: Xwendia Hall West      July 24, 2015  
 Patient / Guardian      Date

If there is a marked YES in the Right column then:  
 Contacted Ordering physician/ Radiologist: \_\_\_\_\_  
 Instructions from Ordering Physician: \_\_\_\_\_  
 Technologist's signature (Time/Date): \_\_\_\_\_

IV Size 20G      IV Site \_\_\_\_\_      Site Appearance after injection C1000

Injected By: C Swift

Contrast Type	Amount	Lot#	Expires
IV - <u>Omnipaque 350</u>	<u>130</u>		
Oral -			

IV Removed?      YES NO      Reactions?      YES NO      If YES, explain reaction \_\_\_\_\_

Completed by: Amssygerfe      7/24/15      4:20  
 Technologist      Date      Time



**Robert Kikel, D.D.S.**

505 N. Cuthbert St.  
Colquitt, Georgia 39837  
Phone (229) 758-2127

BNDDAK1204003

STATE NO. 94

Name

*Annie Hall*

Age

Address

Date

*9-18-14*

Rx

*Amox 500mg*

*one tab QID X 7D*

May use generic equivalent

D.D.S.

Dispense as written

D.D.S.

PRN (1) 2 3 4 5 NR





Nathan Deal, Governor

Clyde L. Reese III, Esq., Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | [www.dch.georgia.gov](http://www.dch.georgia.gov)

February 20, 2015

Lee Nola West  
P.O. Box 441  
Georgetown, GA 39854

Complaint #: GA00146318

Dear Lee Nola West:

We have completed our investigation into your allegation(s) regarding the services at Joe-Anne Burgin Nursing Home. Our professional surveyor(s) investigated your allegation(s) on 02/12/2015 and the evidence obtained during the investigation was able to support one or more of your allegation(s). A substantiated allegation is an allegation that did occur and is verified by evidence. This may result in federal and/or state deficiency(ies). The visit was unannounced and the investigator utilized methods designed to keep the identity of all persons involved confidential. The care and services were reviewed for the residents identified in your complaint as well as other residents with similar problems.

Each concern of your complaint was reviewed and/or investigated. This investigation may have included an on-site visit by this office, record reviews, and interviews with a variety of individuals, including facility staff and patients/residents and their families, as appropriate.

Please note that as of April 14, 2003, the Health Insurance Portability and Accountability Act (HIPAA) went into effect. This Act protects personal health information of individuals from being disclosed to the public except on the individual's request, or on the request of the individual's legally appointed guardian or to the durable power of attorney for health care. Therefore, in order to comply with HIPAA our report of findings must be limited and specific health related information cannot be disclosed.

Thank you for sharing your concerns with us. I hope this letter is responsive to your concerns. Please be assured that we will continue to hold this facility accountable for providing safecare. If you have additional concerns or questions, you may contact me at 404-657-5850.

Sincerely,

Julie Fisher, R.N.  
Complaint and Investigations Manager  
Healthcare Facility Regulation Division

cc: Facility File



HALL, ANNIE

4/14/14 NH EPISODIC NOTE

I was called to the nursing home to come and check the PEG tube placement.

VITAL SIGNS: Temperature 98.4, heart rate 77, respirations 20, blood pressure 141/83.

CV: Regular rate and rhythm, no murmurs or gallops.

LUNGS: Clear to auscultation bilaterally.

ABDOMEN: PEG tube site midline. However, in place of PEG tube was a Foley that was inserted.

Attempts to pull it out were futile after aspiration of the liquid from the bulb.

EXTREMITIES: No cyanosis, clubbing or edema.


ASSESSMENT:


1. HYPERTENSION.
2. HYPERLIPIDEMIA.
3. ANEMIA.
4. LEFT SIDED HEMIPARESIS SECONDARY TO CVA.
5. ANEMIA.
6. HISTORY OF ALTERED MENTAL STATUS.
7. DEHYDRATION.
8. HYPOGLYCEMIA.
9. PEG TUBE.

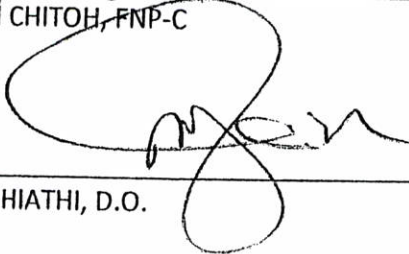
PLAN:

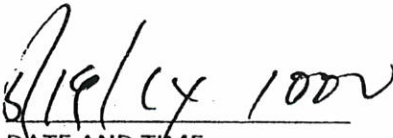
We will perform an x-ray of the abdomen to ascertain placement of the tube. We will have to consult Dr. Joyner tomorrow morning to replace the tube.

JC/ASG/mbw

  
\_\_\_\_\_  
JOHN CHITOH, FNP-C

  
\_\_\_\_\_  
DATE AND TIME

  
\_\_\_\_\_  
A.S. GHIATHI, D.O.

  
\_\_\_\_\_  
DATE AND TIME

*6/4/14  
IAS*

**PHOEBE PUTNEY  
MEMORIAL HOSPITAL**

417 Third Avenue | PO Box 1828  
Albany, GA 31702-1828  
Lab 229-312-6168, Fax 229-312-6151

M. Lisa Pinkston, Lab Director Charles E. Hawkins, M.D., Medical Director

Pt Name: HALL, ANNIE D  
Acc/ MR: 1415000450/2301414  
DOB: 06/03/1950/F

RMC Southwest GA Regional Medical Center  
Loc: Southwest GA Regional Medical Center  
Physician: GHIATHI, ABDOLLATIF S, MD

**Microbiology**

Culture/Sens Wound (Final) Accession #: M053014037  
Specimen: Wound  
Collected: 05/30/2014 09:51  
Inoculated: 05/30/2014 17:20  
Last updated: 06/03/2014 13:00  
Ordering Physician: GHIATHI, ABDOLLATIF S, MD/5/30 NH

Gram Stain (Final)  
*Rare PMN WBC's (Moderate Epithelial Cells)*  
*Rare Gram Positive Cocci in pairs*  
*Rare Gram negative rods*  
*Rare Yeast*

Culture Result (Final)  
*Anaerobic testing NOT performed.*  
*Aerobic culture=*  
*Abundant colonies Mixed bacterial flora (>3 organisms) Including Diphtheroids with*

Isolate #1 (Final)  
*Abundant colonies*  
*Group B Beta Strep*  
Group B is normally susceptible to penicillin and ampicillin and further testing is not needed unless the patient is penicillin allergic or pregnant. Please advise if additional workup is indicated.

Isolate #2 (Final)  
*Abundant colonies*  
*\*\*\*Methicillin Resistant Staphylococcus aureus\*\*\**  
This isolate is presumed to be clindamycin resistant based on detection of inducible clindamycin resistance (D-Test). Clindamycin may still be effective in some patients. Rifampin may be additive or synergistic in combination with another antibiotic but should not be used as solo therapy.  
*Infection Control Notified*

Isolate #3 (Final)  
*Abundant colonies*  
*Yeast*  
*Please advise lab within 7 days if additional Yeast workup is desired.*

Isolate #2  
*\*\*\*Methicillin Resistant Staphylococcus aureus\*\*\**  
MIC    Interpret

**Antibiotics Tested**

Amox /K Clavate	<=4/2	R
Amp / Sulb	<=8/4	R
Ampicillin	>8	R
Cefazolin	<=4	R
Cefox Screen	>4	POS
Clindamycin		R

Pt Name: HALL, ANNIE D

Pg: 1/2 Admit Date: 05/30/2014

Print Date: 06/03/2014 17:35

*A. Collins*



# PHOEBE PUTNEY MEMORIAL HOSPITAL

427 Third Avenue \ PO Box 1828  
Albany, GA 31702-1828  
Lab 229-312-6165, Fax 229-312-6191

M. Lea Pinkston, Lab Director Charles E. Hawkins, M.D., Medical Director

Pt Name: HALL, ANNIE D  
Acc/MR: 1415000450/2301414  
DOB: 06/03/1950/F

RMC Southwest GA Regional Medical Center  
Loc: Southwest GA Regional Medical Center  
Physician: GHIATHI, ABDOLLATIF S, MD

Isolate #2

\*\*\*Methicillin Resistant Staphylococcus aureus\*\*\*

	MIC	Interp
Erythromycin	>4	R
Gentamicin	<=4	S
Induc Clinda	>4/0.5	POS
Levofloxacin	4	I
Oxacillin	>2	R
Penicillin	>8	R
Rifampin	<=1	S
Tetracycline	8	I
Trimeth/Sulfa	<=0.5/	S
Vancomycin	9.5	S
	1	S

Interpretation Table:

Code	Description
R	Resistant
POS	Positive
S	Susceptible
I	Intermediate

Result before changed by BPH on 06/03/2014 13:00:

Culture Result (Prelim)

~~Anaerobic testing NOT performed.~~

~~Aerobic culture~~

Abundant colonies mixed bacterial flora being isolated including diphtheroids and yeast with

# PHOEBE PUTNEY MEMORIAL HOSPITAL

417 Third Avenue / PO Box 1828  
 Albany, GA 31702-1828  
 Lab 229-312-6165, Fax 229-312-6151

M. Lisa Pinkston, Lab Director Charles E. Hawkins, M.D., Medical Director

Pt Name: HALL, ANNIE D  
 Acct/MR: 1402800458/2301414  
 DOB: 06/03/1950/F

Fax Report for Southwest GA Regional Med. Ctr  
 Loc: Contract (Southwest GA Regional Med. Ctr)  
 Physician: GHIATHI, ABDOLLATIF S, MD

## Microbiology

Culture/Sens Wound (Final) Accession #: M012814044  
 Specimen: Wound  
 Collected: 01/27/2014 17:00  
 Inoculated: 01/28/2014 17:40  
 Last updated: 02/01/2014 15:55  
 Ordering Physician: GHIATHI, ABDOLLATIF S, MD GHIATHI/NH/DOC:1/27/14  
 SOURCE: PEG TUBE

Gram Stain (Final)  
**SOURCE = PEG TUBE**  
 Many PMN WBC's  
 Many Gram positive rods  
 Many Gram negative rods

Culture Result (Final)  
 Anaerobic testing NOT performed.  
 Aerobic cultures  
 Abundant colonies Mixed bacterial flora (>3 organisms) including Gram negative rods - Possible Proteus species ( Presumptive Identification ) . Providencia stuartii, and diphtheroids, with

Isolate #1 (Final)  
 Abundant colonies  
 \*\*\*Methicillin Resistant Staphylococcus aureus\*\*\*  
 This isolate is presumed to be clindamycin resistant based on detection of inducible clindamycin resistance (D-Test). Clindamycin may still be effective in some patients.  
 Rifampin may be additive or synergistic in combination with another antibiotic but should not be used as solo therapy.  
 Infection Control Notified

Isolate #1  
 \*\*\*Methicillin Resistant Staphylococcus aureus\*\*\*  
 MIC Interp

### Antibiotics Tested

Amox /K Clavate	>4/2	R
Amp / Sulb	<=8/4	R
Ampicillin	>8	R
Cefazolin	8	R
Cefox Screen	>4	POS
Clindamycin		R
Erythromycin	>4	R
Gentamicin	<=4	S
Induc Clinda	>4/0.5	POS
Levofloxacin	4	I
Oxacillin	>2	R
Penicillin	>8	R
Rifampin	<=1	S
Tetracycline	<=4	S
Trimeth/Sulfa	<=0.5/	S
	9.5	S

Pt Name: HALL, ANNIE D

Pg: 1/2 Admit Date: 01/27/2014

Print Date: 02/01/2014 15:56



# PHOEBE PUTNEY MEMORIAL HOSPITAL

417 Third Avenue \ PO Box 1838  
Albany, GA 31702-1828  
Lab 229-312-6163, Fax 229-312-6151

M. Lisa Pinkston, Lab Director Charles E. Hawkins, M.D., Medical Director

Pt Name: **HALL, ANNIE D**  
Acct/MR: 1402800458/2301414  
DOB: 06/03/1950/F

Fax Report for Southwest GA Regional Med.Ctr  
Loc:Contract (Southwest GA Regional Med.Ctr)  
Physician:GHIATHI, ABDOLLATIF S, MD

Isolate #1

\*\*\*Methicillin Resistant Staphylococcus  
aureus\*\*\*

MIC	Interp
1	S

Vancomycin

### Interpretation Table:

Code	Description
R	Resistant
POS	Positive
S	Susceptible
I	Intermediate

Result before changed by CPS on 02/01/2014 13:34:

### Culture Result (Prelim)

**Anaerobic testing NOT performed.**

**Aerobic culture=**

**Abundant colonies Mixed organisms >3 organisms, including Gram negative rods - Possible Proteus species ( Presumptive Identification ),**

.and

Result before changed by SLJ on 01/31/2014 10:28:

### Isolate #1 (Prelim)

**Abundant colonies**

**Possible Staphylococcus aureus**

.being isolated for further workup

Result before changed by SLJ on 01/30/2014 17:40:

### Culture Result (Prelim)

**Anaerobic testing NOT performed.**

**Aerobic culture=**

**Abundant colonies Mixed organisms being isolated including Gram negative rods - Possible Proteus species ,**

.Further report to follow

# PHOEBE PUTNEY MEMORIAL HOSPITAL

417 Third Avenue | PO Box 1828  
 Albany, GA 31702-1828  
 Lab 229-312-6165, Fax 229-312-8151

*Joyce to NH*  
*4-26-14*  
*M*

Pt Name: HALL, ANNIE D  
 Accl/MR: 1411400578/2301414  
 DOB: 06/03/1950/F

M. Lisa Pinkston, Lab Director Charles E. Hawkins, M.D., Medical Director

RMC Southwest GA Regional Medical Center  
 Loc: Southwest GA Regional Med. Ctr  
 Physician: OZIMBA, EMMANUEL, MD

## Microbiology

Culture/Sens Wound (Preliminary) Accession #: M042414032  
 Specimen: Wound  
 Collected: 04/24/2014 09:58  
 Inoculated: 04/24/2014 18:50  
 Last updated: 04/26/2014 15:58  
 Ordering Physician: OZIMBA, EMMANUEL, MD 4/24 NH SOURCE: G-TUBE AREA

Gram Stain (Prelim)  
 Rare PMN WBC's  
 Rare Gram Positive Cocci

Culture Result (Prelim)  
 Anaerobic testing NOT performed.  
 Aerobic culture=

Isolate #1 (Prelim)  
 Abundant colonies  
 \*\*\*Methicillin Resistant Staphylococcus aureus\*\*\*  
 Infection Control Notified

This isolate is presumed to be clindamycin resistant based on detection of inducible clindamycin resistance (D-Test). Clindamycin may still be effective in some patients. Rifampin may be additive or synergistic in combination with another antibiotic but should not be used as solo therapy.

Isolate #1  
 \*\*\*Methicillin Resistant Staphylococcus aureus\*\*\*  
 MIC Interpret

Antibiotics Tested	MIC	Interp
Amax /K Clav'ate	>4/2	R
Amp / Sulb	<=8/4	R
Ampicillin	>8	R
Cefazolin	<=4	R
Cefox Screen	>4	POS
Clindamycin		R
Erythromycin	>4	R
Gentamicin	<=4	S
Induc Clinda	>4/0.5	POS
Levofloxacin	4	I
Oxacillin	>2	R
Penicillin	>8	R
Rifampin	<=1	S
Tetracycline	<=4	S
Trimeth/Sulfa	<=0.5/	S
Vancomycin	9.5	S
	2	S

*Back to*  
*DS And*  
*1/10/14*  
*noted 4-26-14*  
*K. Cameron 04:30*

Pt Name: HALL, ANNIE D

Pg: 1/2 Admit Date: 04/24/2014

Print Date: 04/26/2014 17:35