

1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME

Walter J. Prosky

DOB

04/12/1952

AGE / SEX

74 yrs / Male

MRN / PATIENT ID

5561290

DATE OF SERVICE

08/05/2026

PROVIDER

Grace Nwosu, DNP

CREDENTIALS

DNP, APRN, CWOCN

REFERRAL SOURCE

Cedar Hollow Skilled Nursing — facility wound consult request

VISIT TYPE

Wound Care Follow-Up — bedside consult, SNF day 61

CARE SETTING

Skilled Nursing Facility — bedside

PRIMARY CARE PROVIDER

Ellis Tran, MD (facility medical director)

SPECIALIST / SURGEON

Bethany Oyelaran, MD — plastic surgery, consulted 07/2026

CC CHIEF COMPLAINT

2 PRIMARY WOUND-RELATED CONCERN

Patient is aphasic following a left MCA infarct and cannot give a verbal history. His daughter, present at the bedside and healthcare proxy, states: "The sore on his tailbone has gotten deeper again and it smells now. The nurses said they can see something white at the bottom. He grimaces every time they turn him."

S SUBJECTIVE

3 WOUND HISTORY, SYMPTOMS & TREATMENT RESPONSE — COLLATERAL FROM DAUGHTER AND FACILITY NURSING

3a INDICATION, ONSET & WOUND COURSE

Reason for Wound Care Evaluation

Interval wound clinic follow-up at day 61 of skilled nursing placement for a deteriorating stage 4 sacral pressure injury with

new malodour, new visible bone at the wound base, and expanding undermining, together with a second right heel deep tissue pressure injury that has evolved to unstageable since the last assessment. Visit purpose: bedside reassessment and measurement of both wounds, sharp debridement, deep tissue culture, evaluation for osteomyelitis, review of the surface and repositioning programme, nutrition escalation, and coordination of the plastic surgery flap discussion.

Wound Onset and Course

The sacral wound first appeared as a non-blanchable erythematous area on hospital day 6 (03/2026) during the acute stroke admission, when he was largely immobile and intermittently hypotensive. It progressed to a full-thickness defect by discharge on 04/04/2026 and was staged 3 on SNF admission 06/05/2026. It has been documented as stage 4 since 07/09/2026. The trajectory has been one of steady deterioration rather than plateau: surface area has increased 34% over the last four weeks and depth has increased from 2.1 cm to 3.4 cm. The right heel injury was first documented on 07/12/2026 as a deep tissue pressure injury with an intact purple bulla, which ruptured on 07/28 and has since formed dry eschar.

Wound Location and Laterality

Wound 1: sacrococcygeal midline, directly over the sacral prominence, with the greatest depth to the left of midline. Wound 2: right posterior calcaneus at the point of bed contact. Both sites correspond precisely to unrelieved bony pressure points. His right hemiplegia means he consistently rolls back onto the sacrum from the left-lateral position without assistance, and the right heel is the dependent heel in his habitual posture.

3b WOUND SYMPTOMS, DRAINAGE & INFECTION

Wound Symptoms

He is expressively aphasic and cannot self-report pain. Facility nursing and his daughter both describe consistent grimacing, guarding, and vocalisation during repositioning and dressing changes, with a PAINAD score of 6 of 10 during care and 2 of 10 at rest. New foul odour reported by nursing since 08/01. Drainage volume has increased. Periwound redness has extended over the last week. No itching reported. No new numbness assessable given the neurologic baseline.

Drainage / Exudate History

Moderate to heavy serosanguinous exudate that has turned opaque and tan-green over the last five days. Foul odour, described by two separate nurses as distinct from the baseline. Dressings are now saturating within 12 hours, whereas they previously held for 24 hours — nursing has been changing twice daily since 08/02 as a result.

Infection Symptoms

Low-grade temperature of 37.9 °C recorded twice in the last 72 hours. No rigors. Nursing reports increased somnolence and reduced participation in therapy over the last week. Expanding periwound erythema, warmth, new odour, purulent-appearing exudate, and probe-to-bone on examination. White cell count has risen from 8.9 to 13.4. No prior cellulitis or osteomyelitis at this site; he had a urinary tract infection with *Proteus mirabilis* treated in 06/2026.

3c TREATMENT HISTORY, FUNCTION & HEALING BARRIERS

Prior Wound Treatment

Hydrocolloid at the acute hospital, transitioned to alginate with a foam cover on SNF admission, then to silver alginate on 07/09 when depth increased. Two prior bedside selective debridements on 07/09 and 07/23. No systemic antibiotics for the wound to date. No compression (not indicated). No negative pressure wound therapy — it was ordered on 07/23 but never initiated because the facility could not obtain a canister supply. No grafts, hyperbaric oxygen, or surgery. Plastic surgery reviewed on 07/16 and recommended reassessment for flap coverage once infection and nutrition are controlled.

Dressing and Home Care Adherence

Dressing changes are facility-performed and documented reliably, now twice daily. The material gap is not dressing adherence but pressure redistribution: the turn log shows documented repositioning at a median interval of 3 hours 40 minutes against a 2-hour order, with the longest recorded gap being 6 hours 15 minutes on the night shift. He remains on a standard foam mattress; the low-air-loss surface requested on 06/28 has not been delivered. Heel offloading boots were issued but are documented as in place on only 4 of the last 14 night checks.

Functional Impact

Fully dependent for all mobility, transfers, and hygiene. Bed-to-chair with a mechanical lift, tolerating 45 minutes in a chair twice daily on a gel cushion. Right hemiplegia with flaccid arm and 1/5 leg strength. Expressive aphasia with preserved comprehension — he follows one-step commands and communicates yes and no reliably by hand squeeze. Sleep disrupted by turning. Participation in physiotherapy has declined over the past week, coinciding with the wound deterioration.

Risk Factors for Poor Healing

Dense right hemiplegia with complete immobility, urinary and faecal incontinence with intermittent moisture-associated skin damage, protein-calorie malnutrition with albumin 2.4 and prealbumin 11, type 2 diabetes with an A1c of 8.1%, CKD stage 3b, a 40 pack-year smoking history quit only at the time of his stroke, prior chronic prednisone for polymyalgia rheumatica now tapered to 5 mg daily, and anemia with a hemoglobin of 9.6. He is PEG-fed following a failed swallow study, and the tube feed regimen has been interrupted repeatedly for procedures and residual checks.

Vascular / Neuropathy Symptoms

Cannot report claudication or rest pain due to aphasia. No dependent rubor or pallor on elevation. Pedal pulses palpable bilaterally. No prior vascular testing. Diabetic peripheral neuropathy documented before the stroke with reduced monofilament sensation bilaterally, which is directly relevant to the heel injury.

Nutrition and Metabolic Factors

PEG feeds delivering an estimated 1,450 kcal and 62 g of protein daily against a calculated requirement of approximately 1,900 kcal and 105 g of protein — a substantial and sustained deficit. Weight has fallen 7.2 kg since the stroke. Albumin 2.4 g/dL, prealbumin 11 mg/dL. Glucose control is erratic with readings of 180–260 on the current sliding scale. Hydration adequate. No oral intake.

Pertinent Negatives

No rigors, no hypotension, no tachypnea, no mental status change beyond the reported somnolence, no rapidly advancing erythema or crepitus, no bullae or dusky skin change beyond the heel eschar to suggest necrotizing infection, and no new limb pallor or coolness. Daughter denies any missed antibiotic or feed since 08/01.

ROS

WOUND CARE REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES — COLLATERAL

Wound pain, tenderness, drainage, bleeding, odor, or itching	Positive — PAINAD 6/10 during care, heavy drainage, new foul odour since 08/01.
Redness, warmth, swelling, maceration, necrosis, or skin breakdown	Positive — expanding periwound erythema and warmth, sacral necrotic slough, right heel eschar, moisture-associated damage in the gluteal cleft.
Fever, chills, fatigue, or systemic infection symptoms	Positive — 37.9 °C twice in 72 hours, increased somnolence, WBC risen to 13.4. No rigors.
Numbness, tingling, neuropathy symptoms, or decreased sensation	Positive — pre-existing diabetic neuropathy with reduced monofilament sensation; sensory reporting limited by aphasia.
Claudication, rest pain, cold extremity, edema, or vascular symptoms	Not reportable due to aphasia. Pedal pulses palpable, limbs warm, no dependent rubor.
Difficulty walking, transferring, wearing footwear, or performing ADLs	Positive — fully dependent, mechanical lift transfers, right hemiplegia.
Hyperglycemia, poor appetite, weight change, or nutrition concerns	Positive — glucose 180–260, 7.2 kg loss, albumin 2.4, feeds delivering 59% of protein requirement.
Dressing adherence, supply issues, or home care barriers	Positive — NPWT never initiated for want of supply, low-

air-loss surface undelivered since 06/28, turn intervals exceeding order.

O OBJECTIVE

5 OBSERVED FINDINGS

V VITALS

TEMPERATURE

37.8 °C

BLOOD PRESSURE

118/68 mmHg

HEART RATE

98 bpm

RESPIRATORY RATE

18 /min

OXYGEN SATURATION

96% on room air

WEIGHT

61.4 kg

BMI

20.1 kg/m²

PAIN SCORE

PAINAD 6/10 during care; 2/10 at rest

5a GENERAL, VASCULAR & PULMONARY

General Appearance

Cachectic elderly man, supine in a left-lateral 30-degree position on arrival, drowsy but rousable to voice and following one-step commands. Temporal and interosseous wasting. Poor hygiene of the gluteal cleft with faecal soiling present at the start of the examination, cleaned before assessment. Unable to participate in his own wound care.

Cardiovascular / Vascular

Regular rate and rhythm, mildly tachycardic at 98. Dorsalis pedis and posterior tibial pulses 2+ and palpable bilaterally. Capillary refill under 3 seconds in all digits. Both limbs warm. Trace dependent edema in the right leg. No varicosities, hemosiderin staining, or lipodermatosclerosis. No dependent rubor, no pallor on elevation. No findings of arterial insufficiency.

Pulmonary

Clear anteriorly and at the accessible posterior bases. No crackles or wheeze. No increased work of breathing. Room air. Adequate for consideration of hyperbaric therapy should it later be indicated.

5b EXTREMITIES, NEUROLOGIC & SKIN

Extremities

Right upper limb flaccid with a developing elbow flexion contracture. Right lower limb 1/5 with early ankle plantarflexion contracture — this holds the heel in a fixed position of contact and is a direct mechanical contributor to the heel wound. Left side 4/5. No amputation, no Charcot change. Heel offloading boots present at the bedside but not on the patient at the time of the visit. Standard foam mattress in place, not a low-air-loss surface.

Neurologic

Awake, drowsy, follows one-step commands, communicates yes and no by hand squeeze. Expressive aphasia. Right hemiplegia as described. Protective sensation reduced at both feet on 10 g monofilament testing at 6 of 10 sites. Proprioception impaired on the right. Motor function otherwise as documented.

Skin

Moisture-associated skin damage across the gluteal cleft and perianal skin with erythema and superficial denudation, distinct from the pressure injury itself. Periwound skin at the sacrum is erythematous, indurated, and warm, extending 4

cm beyond the wound margin. Maceration at the inferior wound edge. No hemosiderin staining or lipodermatosclerosis. Candidal intertrigo in the inguinal folds. No other pressure injuries identified on a full skin survey of the occiput, scapulae, elbows, ischia, trochanters, malleoli, and left heel.

WA

WOUND ASSESSMENT

6

WOUND 1 — SACROCCOCCYGEAL PRESSURE INJURY

WOUND NUMBER

1 of 2

LOCATION AND LATERALITY

Sacroccocygeal midline, deepest aspect left of midline

WOUND TYPE OR SUSPECTED ETIOLOGY

Pressure injury — unrelieved interface pressure over the sacral prominence

DATE FIRST ASSESSED

03/2026 (acute hospital); by this service 06/07/2026

LENGTH × WIDTH × DEPTH

7.8 cm × 6.2 cm × 3.4 cm (from 6.4 × 4.9 × 2.1 cm on 07/08)

STAGE OR GRADE

Stage 4 pressure injury

EXUDATE AMOUNT, COLOR, CONSISTENCY, ODOR

Heavy; tan-green, opaque, purulent-appearing; foul odour present

WOUND PHOTOGRAPHS OBTAINED

Yes — 3 images with a disposable measuring guide, filed to the chart

Undermining and tunneling

Undermining from 2 o'clock to 7 o'clock, maximal at 4 o'clock measuring 3.1 cm (from 1.8 cm on 07/23). A tunnel is present at 5 o'clock extending 4.6 cm toward the left ischium, blind-ending, with purulent return on gentle irrigation.

Wound bed tissue type

Approximately 40% adherent yellow-grey slough, 25% granulation of poor quality (dusky, friable, non-proliferative), 30% exposed sacral periosteum and cortical bone at the wound base measuring 2.2 × 1.4 cm, and 5% epithelialization at the superior margin only. **Probe-to-bone positive** with the bone feeling gritty and soft rather than hard and smooth.

Wound edges

Rolled and epibolic at the inferior and lateral margins. Macerated inferiorly. Non-advancing throughout apart from the superior margin. No callus.

Periwound condition

Erythematous, indurated, and warm to 4 cm beyond the margin. Blanching only partially. Moisture-associated damage inferiorly. No fluctuance and no crepitus.

Bleeding, friability, signs of infection

Granulation tissue is friable and bleeds readily on light contact. Signs of infection are present and multiple: purulent exudate, foul odour, expanding periwound erythema and warmth, increased exudate volume, wound deterioration despite appropriate topical care, probe-to-bone, low-grade fever, and a rising white cell count.

Pain with wound care or palpation

PAINAD 6/10 during debridement and repositioning; 2/10 at rest. Premedication was given before the procedure as detailed below.

Comparison to prior measurements

Deterioration on every axis. Surface area up 34% and depth up 62% since 07/08. Undermining has increased from 1.8 cm to 3.1 cm, a tunnel is newly identified, and bone is newly exposed and probe-positive. This wound is not responding to the

current plan.

6b WOUND 2 — RIGHT HEEL PRESSURE INJURY

WOUND NUMBER	LOCATION AND LATERALITY
2 of 2	Right posterior calcaneus
WOUND TYPE OR SUSPECTED ETIOLOGY	DATE FIRST ASSESSED
Pressure injury — heel contact pressure compounded by a plantarflexion contracture and neuropathy	07/12/2026
LENGTH × WIDTH × DEPTH	STAGE OR GRADE
4.2 cm × 3.8 cm; depth not assessable beneath intact eschar	Unstageable — evolved from a deep tissue pressure injury
EXUDATE AMOUNT, COLOR, CONSISTENCY, ODOR	WOUND PHOTOGRAPHS OBTAINED
None — eschar dry and intact	Yes — 2 images filed to the chart

Wound bed, edges, and periwound

Dry, stable, adherent black eschar covering the full wound surface. Edges attached and dry. Periwound skin intact with no erythema, warmth, fluctuance, drainage, or odour. Pedal pulses palpable and the limb is warm and well perfused.

Comparison to prior assessment

Unchanged in dimension since 07/28 when the bulla ruptured. The eschar is dry, stable, and non-infected — this is a heel eschar that should be left intact and offloaded, not debrided.

CL PRESSURE INJURY / ULCER CLASSIFICATION

7 WOUND CLASSIFICATION

PRESSURE INJURY STAGE	DIABETIC FOOT ULCER GRADE
Wound 1: Stage 4. Wound 2: Unstageable (stable dry eschar)	Not applicable — neither wound is a diabetic foot ulcer
VENOUS LEG ULCER FEATURES	ARTERIAL ULCER FEATURES
Absent — no hemosiderin staining, lipodermatosclerosis, or venous distribution	Absent — pulses palpable, no dependent rubor, no pallor on elevation
NEUROPATHIC ULCER FEATURES	SURGICAL WOUND STATUS
Contributory — reduced protective sensation at 6 of 10 monofilament sites bilaterally	Not applicable
TRAUMATIC WOUND FEATURES	BURN DEPTH
Not applicable	Not applicable

Exposed bone, tendon, muscle, joint capsule, hardware, or graft material

Wound 1: exposed sacral periosteum and cortical bone measuring 2.2 × 1.4 cm at the wound base, probe-to-bone positive. No tendon, joint capsule, hardware, or graft material. Wound 2: no exposed structure visible beneath intact eschar.

Concern for osteomyelitis, ischemia, abscess, necrosis, or deep infection

High clinical suspicion of sacral osteomyelitis in wound 1 — probe-to-bone positive with soft, gritty bone, a 4.6 cm purulent tunnel, foul odour, deterioration despite topical care, fever, and a rising white cell count. Deep-space infection or abscess along the tunnel cannot be excluded on examination and requires imaging. No ischemia in either wound. Necrotic

slough present in wound 1; stable eschar in wound 2 without infection.

PR

PROCEDURES PERFORMED

8

WOUND PROCEDURES THIS VISIT

PROCEDURE NAME

Excisional debridement, sacrococcygeal wound, with deep tissue culture

WOUND LOCATION AND LATERALITY

Sacrococcygeal midline, deepest aspect left of midline

ANESTHESIA, IF USED

Topical lidocaine 4% applied 20 minutes prior; oral oxycodone 5 mg 30 minutes prior

TISSUE REMOVED

Devitalized dermis, subcutaneous tissue, and adherent slough — approximately 18 cm² of surface area to a depth of subcutaneous tissue

POST-PROCEDURE WOUND MEASUREMENTS

8.1 cm × 6.4 cm × 3.5 cm after removal of devitalized tissue

INDICATION

Devitalized tissue, purulent tunnel, suspected underlying osteomyelitis

CONSENT OBTAINED

Verbal consent from daughter and healthcare proxy, witnessed and documented

INSTRUMENTS USED

Sterile scalpel #15, Adson forceps, curette, sterile scissors

BLEEDING / HEMOSTASIS

Minimal punctate bleeding at the viable margin; hemostasis achieved with 4 minutes of direct pressure and calcium alginate

DRESSING APPLIED

Sodium hypochlorite-moistened gauze loosely packed into the wound base and tunnel, foam cover, changed twice daily

Technique

Sharp excisional debridement performed at the bedside after cleansing with normal saline. Devitalized dermis and subcutaneous tissue excised sharply to a bleeding viable margin. The 5 o'clock tunnel was gently irrigated with 60 mL of normal saline with purulent return; the tract was not laid open at the bedside given its depth and its trajectory toward the left ischium. Deep tissue culture obtained by the Levine technique from the debrided wound base after cleansing, and a separate specimen taken from within the tunnel. Bone was visualised and probed but bone biopsy was deferred to interventional radiology or the operating room rather than being attempted at the bedside. Epibolic edges at the inferior margin were sharply released. Wound 2 was **not** debrided — the heel eschar is dry, stable, and non-infected and was deliberately left intact.

Patient tolerance and complications

Tolerated the procedure adequately with premedication. PAINAD peaked at 6/10 during debridement and returned to 2/10 within 10 minutes of completion. No excessive bleeding, no vasovagal response, no complications. Repositioned to the right-lateral 30-degree position at the end of the visit with the wound offloaded.

L

LABORATORY AND DIAGNOSTIC RESULTS

9

RESULTS REVIEWED OR ORDERED

Laboratory Studies — 08/04/2026

White cells 13.4 K/ μ L with 82% neutrophils (from 8.9 on 07/21). Hemoglobin 9.6 g/dL, MCV 88, consistent with anemia of chronic disease. Platelets 402. ESR 88 mm/hr. CRP 96 mg/L (from 41 on 07/21). Albumin 2.4 g/dL, prealbumin 11 mg/dL.

HbA1c 8.1%. Glucose 214 mg/dL. Creatinine 1.68 with an eGFR of 39. Sodium 138, potassium 4.1. Zinc and vitamin C pending.

Microbiology

Deep tissue culture and tunnel culture obtained today, both pending. A superficial swab from 07/23 grew mixed skin flora and was not clinically actionable. Blood cultures × 2 drawn today given the fever and rising inflammatory markers. Prior urinary *Proteus mirabilis* from 06/2026 was pan-sensitive. No history of MRSA, VRE, or other resistant organism colonisation on facility screening.

Imaging

Sacral MRI with and without contrast ordered today — the study of choice to confirm osteomyelitis, define its extent, and identify any deep abscess along the tunnel. Plain sacral radiograph 07/16 showed no definite osseous destruction, which does not exclude early osteomyelitis and should not be relied upon. Right heel radiograph 07/14 was normal with no calcaneal abnormality.

Vascular Studies

Not previously performed. ABI and toe pressures ordered for the right lower limb to document perfusion before any future decision about heel eschar management, although pulses are palpable and clinical perfusion appears adequate.

Pathology

No biopsy performed to date. Bone biopsy for histopathology and culture recommended and requested — this is the definitive test for both the diagnosis of osteomyelitis and the organism-directed antibiotic choice. Malignant transformation is not suspected given the short wound duration.

Prior Records Reviewed

Acute hospital discharge summary 04/04/2026, stroke unit notes, swallow study and PEG placement records, SNF admission assessment 06/05, all facility wound assessments and photographs from 06/07 to 07/28, the repositioning turn log for the last 21 days, the dietitian assessment of 07/02, plastic surgery consultation of 07/16, the medication administration record, and the equipment order history confirming the undelivered low-air-loss surface. Approximately 24 minutes of independent record review.

A

ASSESSMENT

10 WOUND CARE CLINICAL INTERPRETATION

- **Stage 4 sacrococcygeal pressure injury with probable underlying sacral osteomyelitis and a deep purulent tunnel — clinically deteriorating.** Probe-to-bone positive with soft gritty bone, a 4.6 cm tunnel with purulent return, foul odour, expanding periwound cellulitis, fever, ESR 88, CRP 96, and a white cell count of 13.4. This is now an infected deep wound, not a chronic stable ulcer.
- **The wound is deteriorating on every objective measure** — surface area up 34%, depth up 62%, undermining up from 1.8 to 3.1 cm, a new tunnel, and newly exposed bone since 07/08. The current plan has failed and requires escalation rather than continuation.
- **The dominant, correctable healing barrier is pressure, not the dressing.** The turn log shows a median repositioning interval of 3 hours 40 minutes against a 2-hour order with a longest gap of 6 hours 15 minutes, and the low-air-loss surface ordered on 06/28 has never been delivered. No topical therapy will overcome sustained interface pressure at a sacral prominence in a hemiplegic patient.
- **Severe protein-calorie malnutrition is the second dominant barrier.** Feeds are delivering 62 g of protein against a requirement of approximately 105 g — 59% of need — with albumin 2.4, prealbumin 11, and a 7.2 kg loss. A stage 4 wound of this surface area cannot granulate on a sustained nitrogen deficit.
- **Additional contributory barriers:** HbA1c 8.1% with glucose 180–260, chronic prednisone 5 mg daily, anemia at 9.6, CKD stage 3b, incontinence-associated moisture damage, and diabetic neuropathy.

- **Right heel unstageable pressure injury with dry, stable, non-infected eschar — appropriately left intact.** Perfusion is clinically adequate with palpable pulses. The correct management is strict offloading and daily surveillance, not debridement. The fixed plantarflexion contracture is the mechanical driver and needs a therapy intervention, not a wound intervention.
- **No evidence of necrotizing soft tissue infection or systemic sepsis** — no crepitus, no dusky skin beyond the heel eschar, no hypotension, no tachypnea, and no mental status change beyond a reported increase in somnolence. He does not require emergency transfer today, but he is on a trajectory that will lead there if the plan is not escalated now.
- **Flap coverage is not currently feasible.** Plastic surgery is correct that reconstruction cannot proceed over infected bone in a malnourished, incontinent, immobile patient. Infection control, nutritional repletion, and a demonstrated pressure-relief programme are the prerequisites, and they should be pursued as an explicit sequence rather than left open-ended.
- **Communication and consent are proxy-dependent** given expressive aphasia with preserved comprehension. His daughter is the healthcare proxy and is engaged. A goals-of-care conversation is appropriate alongside the escalation, not instead of it.

P PLAN

11 WOUND CARE MANAGEMENT BY PROBLEM

- **Pressure redistribution — the highest-priority intervention:** low-air-loss mattress escalated to an urgent facility order today, with the wound service to verify delivery by telephone within 48 hours and to escalate to the medical director if not in place. Repositioning every 2 hours reinforced with the charge nurse on both shifts, with the turn log to be reviewed by this service at every visit. Chair time capped at 45 minutes twice daily on the existing gel cushion. Right heel to be floated free of the bed at all times with offloading boots, with boot placement added to the hourly night-round checklist.
- **Infection management:** empiric intravenous ampicillin-sulbactam 3 g every 6 hours started today pending culture, chosen for anaerobic and enteric Gram-negative coverage appropriate to a sacral wound with faecal contamination, and renally dose-adjusted for an eGFR of 39. Deep tissue and tunnel cultures and two sets of blood cultures sent. Infectious disease consultation requested today for antibiotic duration and for the osteomyelitis pathway. Antibiotics to be narrowed on culture results — a definitive course should not be committed to before bone biopsy where feasible.
- **Osteomyelitis workup:** sacral MRI with and without contrast ordered urgently to confirm osteomyelitis, define its extent, and exclude a deep abscess along the 5 o'clock tunnel. Bone biopsy for histopathology and culture requested through interventional radiology, or at the time of operative debridement should surgery proceed. The plain film of 07/16 is explicitly not being relied upon.
- **Surgical consultation:** plastic surgery re-consulted today with the updated findings. If MRI confirms osteomyelitis or an abscess, request operative debridement with sacral bone resection and biopsy as the next step, with flap reconstruction deferred as a separate later decision.
- **Wound 1 local care:** sodium hypochlorite-moistened gauze loosely packed into the wound base and tunnel with a foam cover, changed twice daily, for antimicrobial and desloughing effect while awaiting imaging. Serial sharp debridement at each wound visit. Negative pressure wound therapy is **deferred** until osteomyelitis and abscess are excluded or addressed operatively, and until a reliable canister supply is confirmed — the failed 07/23 order is documented as a supply-chain failure, not a clinical decision.
- **Wound 2 local care:** leave the heel eschar intact. Paint with povidone-iodine daily and allow it to dry. Daily inspection for fluctuance, drainage, erythema, or odour, with immediate notification of this service if any appears. Do not debride. ABI and toe pressures ordered to document perfusion.

- **Nutrition:** urgent dietitian re-referral today. Increase tube feed to deliver a minimum of 1,900 kcal and 105 g of protein daily, approximately 1.5–1.7 g/kg, and protect feed delivery time by consolidating residual checks and holding feeds only when clinically essential. Add arginine and glutamine-enriched wound supplementation twice daily, zinc sulfate 220 mg daily for 14 days, and vitamin C 500 mg twice daily. Recheck prealbumin in 2 weeks and again at 4 weeks as the objective marker of repletion.
- **Glycemic control:** sliding-scale insulin alone is inadequate at an HbA1c of 8.1% with readings of 180–260. Basal insulin recommended to the facility medical director with a target of 140–180 mg/dL, avoiding hypoglycemia. Endocrinology input requested if targets are not met within 2 weeks.
- **Continence and moisture:** structured toileting and prompt cleansing after every incontinent episode. Dimethicone-based barrier cream to intact perianal skin at every change. Faecal management system considered and discussed with nursing, to be deployed if liquid stool persists and continues to contaminate the wound. Treat the candidal intertrigo with topical nystatin twice daily for 14 days.
- **Contracture and mobility:** physiotherapy and occupational therapy re-referral for right ankle plantarflexion contracture management, resting ankle-foot orthosis at night, upper limb contracture prevention, and progressive out-of-bed tolerance as fever settles.
- **Pain:** premedicate with oxycodone 5 mg orally 30 minutes before every dressing change and before repositioning where tolerated. Topical lidocaine 4% before debridement. PAINAD to be scored and documented at every dressing change given his aphasia.
- **Anemia and comorbidity:** iron studies added to the next draw. Prednisone taper reviewed with rheumatology to determine whether 5 mg daily can be reduced further. Nephrology aware of CKD 3b for antibiotic dosing.
- **Family communication and goals of care:** 20 minutes spent with his daughter at the bedside reviewing the deterioration, the probable bone infection, the imaging and biopsy pathway, the realistic prospect and prerequisites for surgical closure, and the expected timeline. Palliative care co-consultation offered and accepted for goals-of-care clarification alongside active treatment, explicitly framed as concurrent and not as a withdrawal of care.
- **Coordination:** findings communicated directly to the facility charge nurse and to Dr. Tran today. Note routed to plastic surgery, infectious disease, dietetics, therapy services, and the facility director of nursing, with the equipment escalation documented in writing.

F

FOLLOW-UP

12 REASSESSMENT PLAN

Follow-up timeframe and purpose

Wound service bedside review in 3 days (08/08/2026) for culture results, antibiotic narrowing, MRI review, repeat debridement, and verification that the low-air-loss surface has been delivered, then twice weekly while the wound remains infected. Full remeasurement and photography weekly. Prealbumin at 2 and 4 weeks. Turn log audited at every visit. Immediate notification of this service for fever above 38.5 °C, hypotension, rapidly expanding erythema, crepitus, new drainage or fluctuance at the heel, or any acute change in alertness.

TB

TIME DOCUMENTATION & BILLING

TOTAL TIME SPENT

75 minutes

PROCEDURE TIME

22 minutes — excisional debridement with culture

COUNSELING / COORDINATION OF CARE TIME

20 minutes — family discussion and goals of care

RECORDS REVIEW TIME

24 minutes

HOME HEALTH / SUPPLY COORDINATION TIME

12 minutes — surface escalation, NPWT supply, dietitian and therapy referrals

BASIS FOR BILLING

Procedure-based plus Medical Decision Making (high complexity), separately identifiable E/M

E/M LEVEL

99215 with modifier 25 — separately identifiable evaluation and management service

DEBRIDEMENT CODE(S)

11043 — excisional debridement, muscle and/or fascia, first 20 sq cm

WOUND PROCEDURE CODE(S),

87070 — culture, bacterial, any source (deep tissue and tunnel specimens)

SKIN SUBSTITUTE / GRAFT CODE(S)

Not applicable this visit

NEGATIVE PRESSURE WOUND THERAPY CODE(S)

Not applicable — NPWT deferred pending imaging

COMPRESSION / CAST / DRESSING CODE(S)

Not applicable — compression not indicated

PRIMARY ICD-10 DIAGNOSIS CODE

L89.154 — Pressure ulcer of sacral region, stage 4

SECONDARY ICD-10 DIAGNOSIS CODE(S)

M86.68 — Other chronic osteomyelitis, other site (suspected, sacrum); L89.610 — Pressure ulcer of right heel, unstageable; I69.351 — Hemiplegia following cerebral infarction affecting right dominant side; R47.01 — Aphasia; E11.42 — Type 2 diabetes with diabetic polyneuropathy; E43 — Unspecified severe protein-calorie malnutrition; N18.32 — CKD stage 3b; D63.8 — Anemia in other chronic diseases; L24.A9 — Irritant contact dermatitis due to friction or contact with body fluids; Z93.1 — Gastrostomy status

SO

PROVIDER SIGN-OFF

PROVIDER NAME

Grace Nwosu, DNP

CREDENTIALS

DNP, APRN,
CWOCN

SPECIALTY

Wound Care — Wound,
Ostomy & Continence

DATE

08/05/2026

TIME

1:07 PM