I would like to sincerely thank you in advance for taking the time to read the enclosed information. My goal is to bring public and government awareness about the serious abuse and neglect that has and is occurring at the Jacksonville Sherriff's Office, Duval County Jail (JSO), Jacksonville, Florida, to the extent that death is the result. I also want to get justice for my loving father, William Merrifield, who died much too young at the age of 63, on July 5, 2009 as a result of gross negligence and medical incompetence at the JSO.

Enclosed are the following items:

- A brief background of my father
- Brief notes from close family members
- Pictures
- Summary of events leading to my father's death
- An Excel spreadsheet summarizing all of Mr. Merrifield's medical care
- A list of points indicating where JSO made errors and where they have questionable discrepancies in their records and reports
- Back up information for each point listed above
- Copy of the hospital admission report listing the severe medical conditions he was admitted with along with descriptions of each

My father, William M. Merrifield, was a 63-year old man who could only walk with a cane in addition to human help for support. William suffered from Diabetes, Chron's disease, Shingles and mild brain atrophy among other health conditions. He was arrested and detained for a two-week period before his death, because of a traffic violation; driving with a suspended license. He was not allowed to see the judge at his arraignment because he had shingles; which according to the doctor who saw him earlier that day said was no longer contagious. He should have been taken to the hospital and released on his own recognizance or detained in the hospital; instead they isolated him in a jail cell and deprived him of his legal right to one phone call. The JSO neglected his medical needs to the point where he suffered a slow and painful death. My father is not the only one who has suffered and died because of the negligent medical attention received at the JSO. Please help me bring about the necessary investigations

and changes needed to assure that no one needlessly loses a loved one while in the care of JSO or any other jail or prison facility.

I know that the jails are overcrowded and there is a shortage of funds, but this in no way excuses the neglect of adequate and life saving medical care. We live in the United States of America where every person should be treated humanely and with respect. Police officers take an oath to Serve and Protect, not to Abuse and Neglect. My father was neither served nor protected, he was neglected to such an extreme extent that he lost his precious life. The United States spends billions of dollars fighting wars in other countries because the people are abused and killed by government and law officials, but what about the citizens of the United States who are abused and neglected by law officials, shouldn't we protect and guarantee the safety of our own citizens? How can we justify defending other countries citizens' rights and safety when we cannot even protect our own citizens. We must make our citizens and our country a priority; otherwise what are we fighting to defend? There need to be major changes and reform in the overcrowded penal system. We need to take care of our country and the problems within it before we can effectively help other countries.

Once again, I truly appreciate you taking the time to read the enclosed material. I have been working with Scott Burleigh, Esquire in Jacksonville, Florida in filing a wrongful death suit. Please do not hesitate to contact me if you have any questions. There are many more details and records than what is included here. If there is anything you can do to help me in bringing justice for my father or to help in bringing changes and launching an investigation into the enclosed issues discussed at JSO, I implore you to please take this opportunity to make a difference in the world and in the lives of many people in the future because we never know whose life could be saved, it could be the life of a dear friend or loved one; now is the time to take action and save lives and make the difference that we all aspire to make in our lifetimes.

Kind regards,
Kerrie Merrifield
Kerrie Merrifield

My father, William, was a wonderful, loving and giving man. He was passionate about cooking, traveling and his dog, Gizmo. Ever since I was little, my father had a zest for cooking and creating recipes. He even made a few cooking videos, his goal was to have his own cooking show. He suffered terribly for decades with Chron's disease. He would be in excruciating pain, but would still go to work as a salesman to support his family; often having to lay down in the backseat of the car to rest, but he always provided for us. My father always made sure I was taken care of. When I had my first child, he came to visit us and bought all the baby furniture. His generosity and love knew no limits.

My father was a true survivor and was a very strong man who overcame every obstacle that he encountered with vigor. As a result of experiencing much pain and painful medical conditions, William had become addicted to pain pills several times. Each time, he realized his addiction and sought help and he would recover. William was a fighter and in one of the Doctor's notes, William said his strongest point was, "I am a fighter."

My father loved his children, grandchildren and mother with all his heart and soul. My father called his mother nightly at 9:00 p.m. to say goodnight. My father had done this ever since my grandfather passed away several years ago because his mother was lonely; my father was an only child. I spoke with my father several times a week. My father didn't have much money, but he didn't let it get him down, he had his family that loved him dearly, and that was more valuable. For some reason, last year I sent my father his Father's Day present at the end of May. He was so happy with the sentimental card and the $25 cash that I sent; it meant the world to me to hear him happy. Something that will always haunt me is the day I found out that my father was in the hospital and dying. That very same morning I had decided that I wanted to give my Dad a huge surprise; I was so excited. He had been living with no living room furniture and tv, so I wanted to buy him a nice living room set and tv and have it delivered without him knowing. I am eternally deprived of bringing that joy to my father, my children are deprived of the only grandfather they knew and I no longer have a father. His mother has had her only child ripped from her heart; her pain and overwhelming grief will stay with her forever. Our lives have been uselessly and permanently scarred.

Kerrie Merrifield (Loving daughter)

I'm the Mother of Billy (William M. Merrifield). I am an 86-year old widow. My only son, Billy, did not have to die the way he did; it was very cruel and inhumane. As a mother I cannot explain how I feel because it is so devastating and heart-wrenching. Every night Billy would call me and see how I was and we would talk for awhile. I can still hear his voice in my head and see his face in front of my eyes. I cannot sleep; I leave the light on. Sometimes, for awhile, I think that he will call me at 9:00 pm; I could hear him say, "Mother, how are you doing?", but the phone never rings and I end up crying myself to sleep knowing that I will never hear his voice or see his face ever again. My heart has a pain and emptiness that that transcends any human words; I feel as though I have died but must suffer my death day after day. He was my only child and it doesn't matter how old one's child is, the pain is unbearable. Sometimes I feel numb, I know it is the grief. My only son's death was completely unnecessary and his last two weeks were spent suffering alone; what is wrong with the Jacksonville Sheriff's Office, how could they neglect him the way they did?

Jennie Merrifield (Mother)

I really feel that this tragic incident with my dad could and should have been prevented. Because of this, I will never again be able to see or talk to him again. He loved life, and I know he loved his children and grandchildren. My kids will never have the chance again to spend time with him, or talk to him. They will only have the memories that I hope they never forget. I will never forget the memories of how hard he tried to give my sister and I the happiness that life offered. He always would take us on vacation every summer, and he just wanted us to be happy and enjoy life. I just hope and pray that he is looking down on us, and sees how happy he has made us, and how much he is missed and loved.

We love you, Michael (son)

As far back as I can remember, Bill Merrifield was always my "Grandpa Bill." Although he was my step Grandfather, I never looked at it that way. Growing up, he always had me laughing; he would joke with me about anything and play pranks on each other. He always told me stories about how he was the best salesman in the world, and I believed it, he always spoiled me. I was not close with my parents so Grandpa Bill and Nonny Donna were like a second parent to me.

They often took me to restaurants and when they traveled. They took me and my siblings to Disney World twice, Jamaica and quite frequently to Canada; my Aunt Kerrie lived there. I will never forget the time I brought one of my first boyfriends home. As soon as I introduced him to Grandpa Bill, he asked my boyfriend what his favorite food was. My boyfriend said he was a vegetarian. Later that evening my Grandpa Bill told me that vegetarians are bad news and three weeks later was my first heartbreak.

I often talk to family and friends about Grandpa Bill and what a joy he was to have around. I still to this day, have not dealt with his death. He was so happy and full of life the last time I saw him, which was just a couple of months before his death. He was not supposed to die yet, if he was taken care of, he would still be alive. I feel sick to my stomach over the whole thing. My Grandfather who always made me laugh, my Grandfather who should have seen me graduate, my Grandfather who should have seen me get married, my Grandfather who loved everybody, my Grandfather died because of neglect. He is still supposed to be here, there has to be somebody held accountable.

Sincerely,

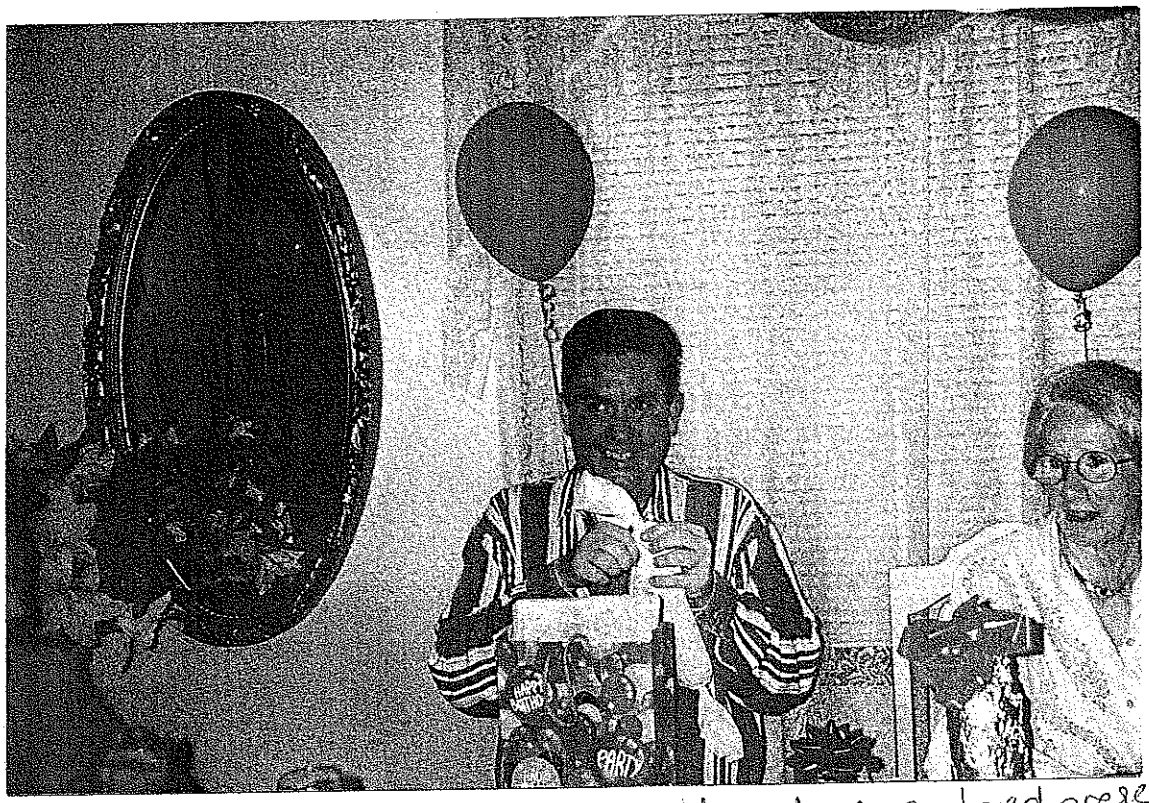
Ashley M. Pelosi

My meeting Bill turned out to be my life until his untimely death last year. We chose to live together for two years before getting married; we were married for 18 years. We did everything together; he showed me a life I had never known. He wined and dined me and we traveled frequently. He was my best friend and companion. His best buddy, our dog, Gizmo, still looks for him. When Bill's name is mentioned, Gizmo's ears perk up and he looks around for him. It is such a sad thing to see. They had a very special bond only a pet owner could understand. I am a nurse and I know that he was too ill to be in jail; he needed to be in a hospital or very closely monitored.

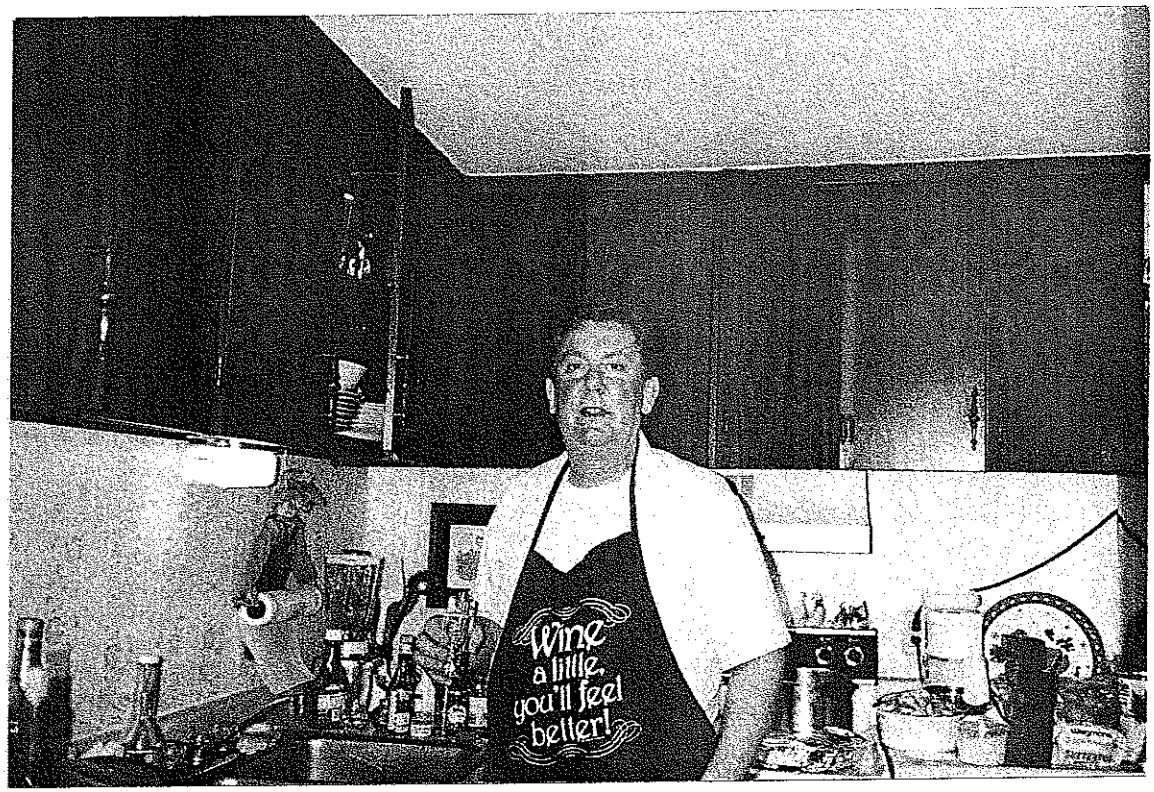
Sincerely,

Donna Merrifield and Gizmo

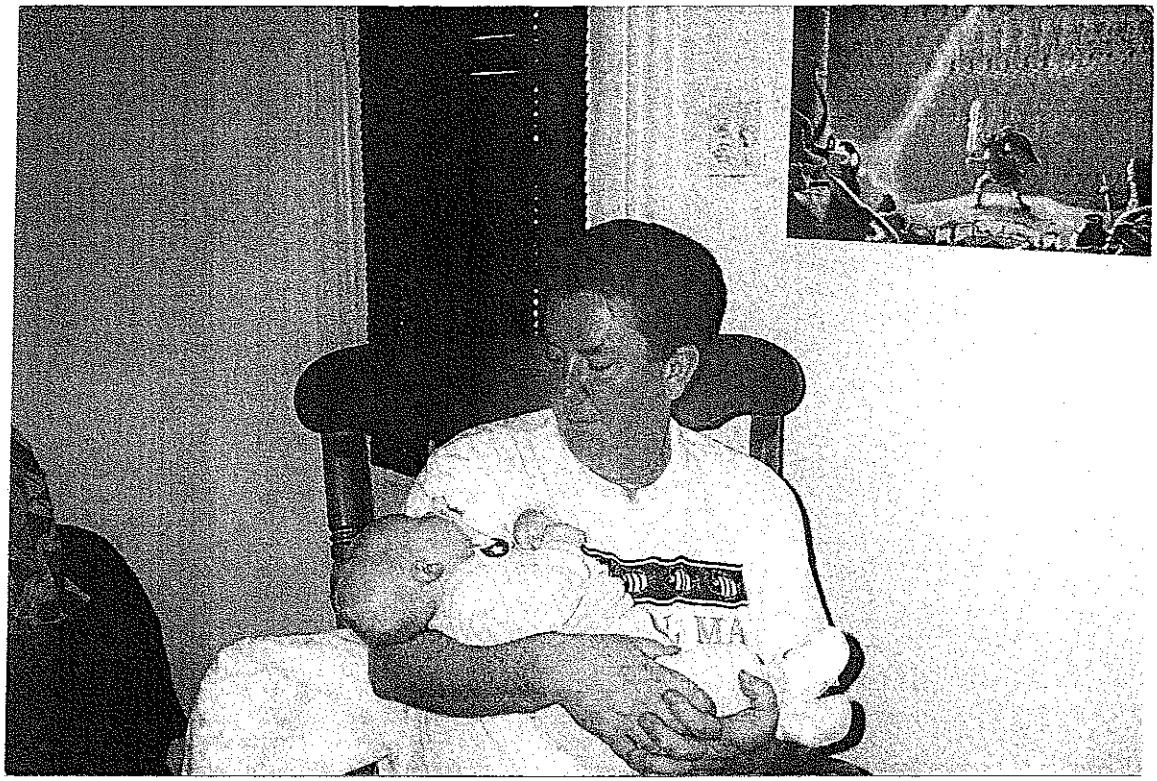
William Merrifield and his mother, Jennie Merrifield, at a birthday celebration.



William's birthday celebration. He always loved presents; he was like a little kid.

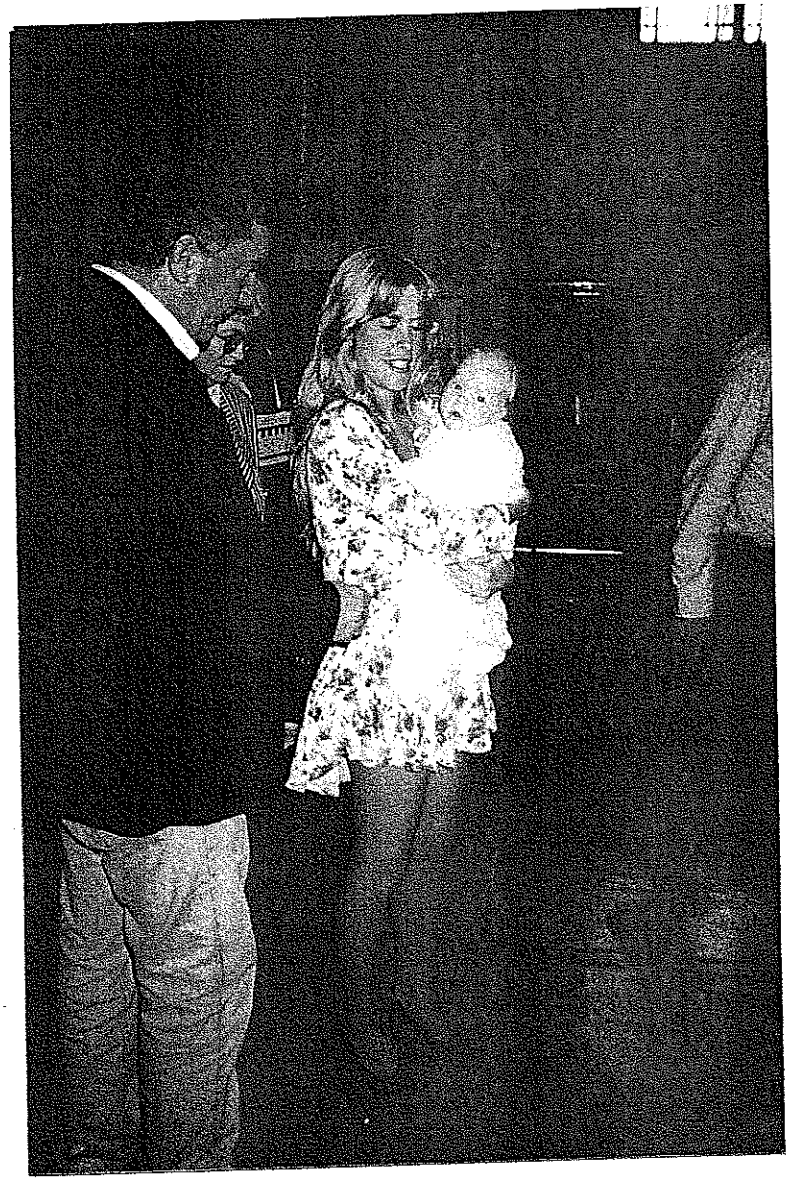


William's favorite place was the kitchen.
His love and passion for cooking was something extraordinary -

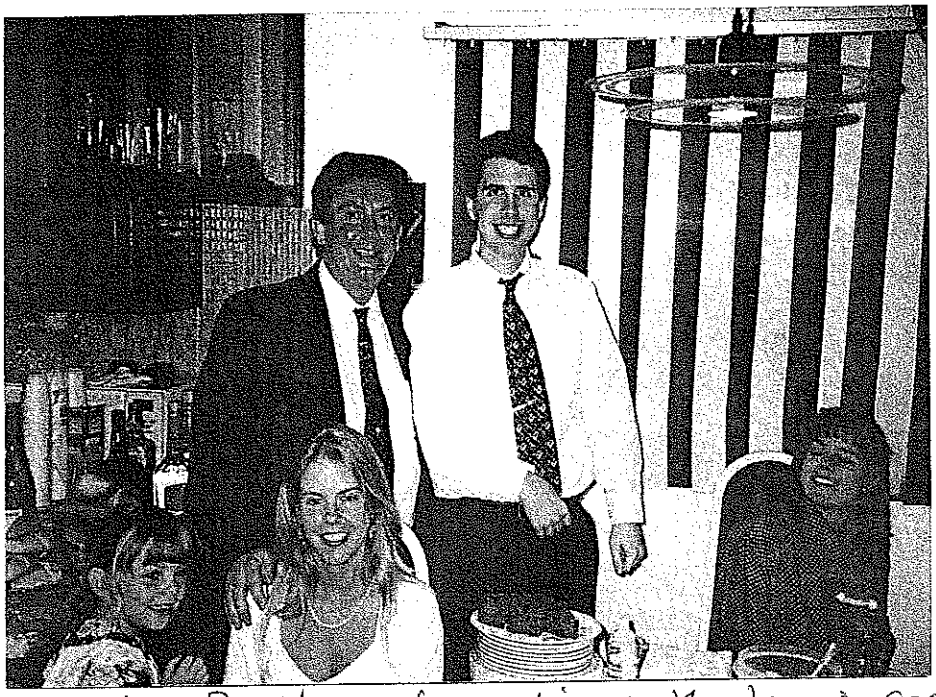


William holding his 1st grandson, Alexander.

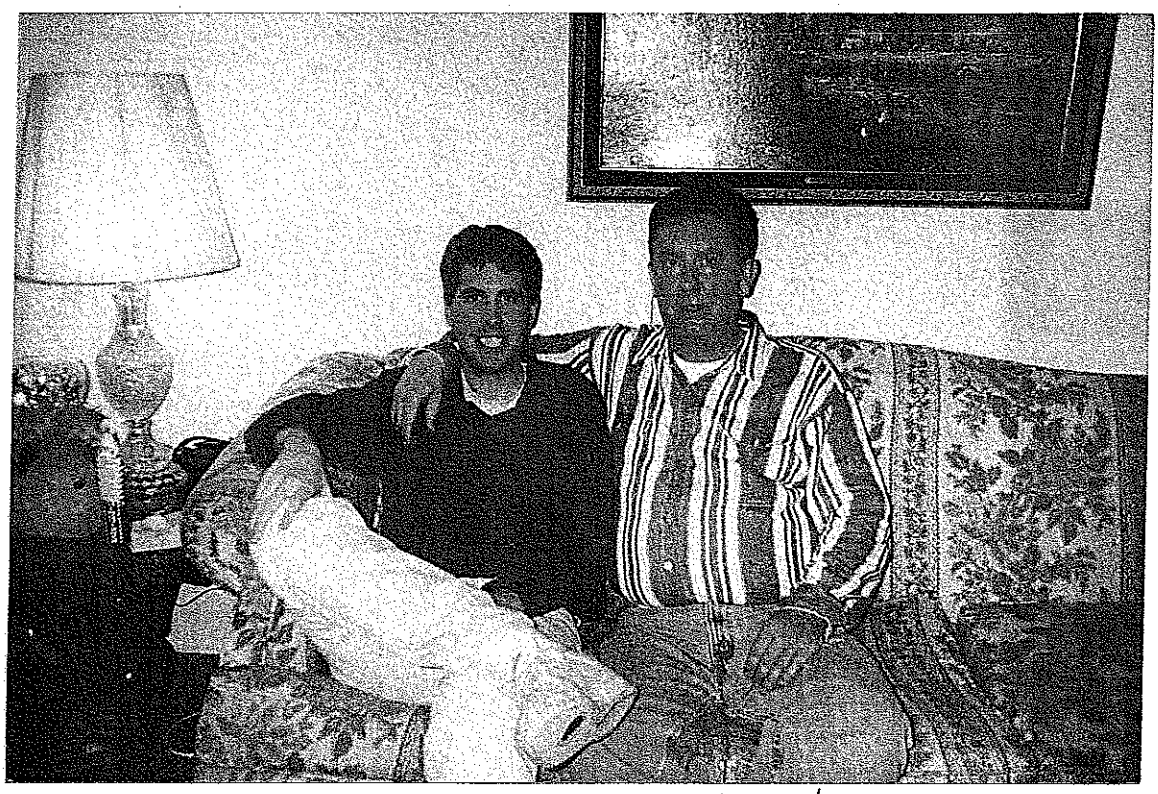
William loved spending time with Alexander. They had a very special bond.



William was always present for special events. This was Alexander's baptism.



A family celebration with Kenya (daughter) and Michael. (son)



William and his son Michael.

On June 7, 2009, William Merrifield left his home in South Carolina to pick up Donna Merrifield (Mr. Merrifield's wife). William was suffering from a severe case of shingles, his diabetes and a recent broken wrist and ankle which made it impossible for him to be self-sufficient and assistance with daily activities was now required. William decided that his only option was to have his estranged wife, Donna come to take care of him in his apartment. Donna had been staying with her daughter in Florida.

While Mr. Merrifield was driving through Hindsville, Georgia, Officer Walter (?last name) stopped William for erratic driving. William was found to be driving with a suspended driver's license. After speaking with William, the officer saw that William was not physically well and William was transported to Liberty Memorial Hospital where he was immediately admitted. William's blood sugar had dropped critically low. William's attending physician, Dr. Binute suspected that William may have been suffering some brain problems and ordered an MRI of his brain/head. It was found that William suffered from mild brain atrophy. Dr. Binute was running more tests on William and was extremely concerned about the future of William's health. On June 10, 2009, Mr. Merrifield checked himself out of the hospital AMA (against medical advice) because he missed his dog and he wanted to be in his home. Dr. Binute claims that he asked William questions to test his state of mind such as the day, who the president was, etc... and that William correctly answered the questions.

On June 10, 2009, William, dressed in a green hospital scrubs, took a taxi to Simmon's Towing where his car was located. The attendant at Simmon's Towing, Bobby, helped William from the taxi and assisted him in going through the process of retrieving his car, including accepting the $341 fee from William. Bobby explained to me that it is absolutely required to produce a valid driver's license and valid insurance in order to pick up a car. William did not have either of these documents but was allowed to leave with his car.

According to the arrest report on June 10,2009, William was involved in an accident around 11p.m. and was arrested by Trooper Ezell. Trooper Ezell told me that she thought William had Alzheimer's because he seemed very confused and unaware of what was happening; he did not remember the accident or any personal information. Trooper Ezell told me that she identified William from his release papers from Liberty Memorial Hospital on the front seat of his car. He was dressed in hospital scrubs so his wallet was not on his person, it was in the car. The police never had his wallet in their possession; it was not on the inventory or personal effects form. To be strongly noted is that on the release papers it states that the risks of leaving are worsening condition, inconclusive diagnosis and possible death. At this moment, the JSO was put on notice that William had critical and serious current health conditions that could result in death if not in the hospital. Their failure to follow up on this was and take the appropriate actions that would have avoided his death is deliberate indifference, gross negligence and by some could be considered manslaughter. To my knowledge, William was not seen by a physician while in the custody of the Jacksonville Police Department. Why didn't any one of the trained police officers notice that a frail, elderly man, who could hardly walk,

dressed in green hospital scrubs (not normal clothing) with AMA release papers dated earlier that same day, needed medical attention or at least warranted further investigation.

William made no phone call to anyone after his arrest which is not to be considered normal. William was in contact almost daily with his Mother before the incident. William had been arrested and spent three weeks in jail in 2008 for a bad check written several years before immediately after his father passed away. William had expressed to me that he would never spend another day in jail, his one time ever in jail was the worst experience in his life because he was not well taken care of. William knew he would have to spend a few weeks in jail to await trial if he was unable to pay the $1500 bail set by the judge. William would have called every person he knew to help so he would not have to spend one minute more than needed in the jail. William spoke with a chaplain at the Jacksonville jail and told him that his mother had died; this was not true. This shows that William was in a confused state and was in need of medical attention. The chaplain located the funeral home who then located his mother and that is when the family became aware of his whereabouts. Donna had been waiting on June 11th for William to pick her up in Florida. There was a Missing Person's report that had been filed.

William did not see the judge at his arraignment; an officer was sent in his place and pled guilty.

While speaking with Officer J.E. Smith, Officer Smith informed me that there was a diabetic clinic on site in the jail and that William was free to go as often as needed. Officer Smith indicated to me that William went to the clinic at least two times daily. Officer Smith also informed me that there is a satellite clinic on site at the jail that monitors blood pressure and other small health issues. William also suffered from high blood pressure. Officer Smith informed me that inmates are required to check both in and out when going to the clinics. Officer Smith informed me that diabetic inmates are offered a special diet. William was erroneously prescribed a heart failure diet and not a diabetic diet.

Officer Smith had first told me that William was released on June 25th on his own recognizance. I asked Officer Smith several times if he was absolutely sure that William had left on his own and Officer Smith insisted that William had left the jail on his own recognizance. Officer Smith changed his story only after I informed him that I had spoken with Shands Memorial Hospital and that William had been transported by ambulance to Shands Memorial Hospital after being found unconscious and not breathing. Officer Smith told me that on June 24th, William was found unconscious and not breathing in his cell and was transported to the hospital and placed on life support. Upon receiving the EMS report, I discovered that William was not found in his cell but in the hallway of the courthouse in a wheelchair. The JSO took responsibility for William's $102,000 medical bill; I called Shands and they informed me that his bill was completely paid.

During the period from June 24th to July 5th, 2009, when William passed away, he spent a couple of days on life support and was then put on a respirator. I believe on June 28th they took William off the respirator and he was able to breath unassisted. William's left lung was collapsed and he was also suffering from pneumonia and placed on antibiotics. William was able to open his eyes but was unable to move or speak. William was unable to follow commands such as squeezing a hand when asked to do so. William was seen by two doctors that I have noted, Dr. Alexandraki, a pneumonologist, and Dr. Poledo. The doctor informed me that William's condition was irreversible because his blood sugar was so low for such a long time it had caused cardiac arrest and permanent brain damage; He was already brain dead upon arriving at the hospital. When William was admitted to the hospital, his body temperature was so low and his blood sugar was so low the doctors were surprised that no one had noticed Williams' deterioration many hours sooner. The doctor stated that William would have exhibited serious and very noticeable symptoms of being very confused, aggressive and would not have been coherent; he would have seemed like he was very drunk and aggressive. William had to have experienced many hours of serious and noticeable deterioration before suffering cardiac arrest. The Jacksonville Police were aware of his condition since he was frequenting the diabetic clinic. His condition was not monitored and he slowly deteriorated over a two-week period until his body could not continue.

William was required to take insulin daily and Lantus every evening. William also suffered from Chron's disease and Shingles. His diabetes was in an advanced stage. The diabetes was not under control at the JSO and had become very dangerous and unpredictable as evidenced from the previous week's event. William had difficulty to walk without a cane and had difficulty getting up from a laying down position unassisted, climbing or descending stairs was nearly impossible. The severity of William's fragile health was easily visible. Why was William kept in jail in his physically and mentally deteriorating condition instead of being placed in a hospital or with a family member is a question that needs to be answered.

I was unsuccessful in obtaining the video footage from the courthouse on morning of the incident. There are JSO clinic records that state that William was in the clinic at 11:50 and at 12:30, but the EMS report states he was at the courthouse at the time of being called and that he had been there all morning. There are also two conflicting reports by officers regarding the events and the timeline of the events at the courthouse on June 24, 2009.

Officer Sanders states the event occurred on June 26, 2009 and dates his signature on June 25, 2009; the event occurred on June 24, 2009. Officer Sanders states that he observed William sitting in a wheelchair at 12:30 and said he asked him questions and William did not respond in a coherent manner so instead of calling for an ambulance, as would have been the responsible course of action given William's serious health problems to date and being a diabetic, he called sally port to have the wheelchair van come and pick him up. Officer Sanders states that Officer Norton arrived 10 minutes later, at 12:40, and upon loading William into the van noticed he

was unresponsive. He then states that Rescue was notified. Officer Sanders did not monitor William during the wait or he would have noticed a change in his status.

Officer Norton has a different timeline of events. Officer Norton states that Officer Tuten, not Officer Sanders called sally port for the wheelchair transport van to pick up the inmates at 11:45, not 12:30. Officer Norton states that he arrived at the courthouse at the very specific time of 12:23, not 12:40. Officer Norton states that William was slumped over and had drool coming from his mouth and was unresponsive and then Rescue was called.

JAX Fire and Rescue records the call coming in at 12:31, arriving at the courthouse at 12:40 and leaving for the hospital at 12:50.

A third conflicting report, by Jhasmine Perez states that on June 24, 2009 at 11:50 a.m., William came to the clinic complaining of low blood sugar, had a glucose reading of 56 and was given 4 glucose tab "per Luna". Obviously William could not have been in two places at the same time; the courthouse and the clinic; at least one of these reports are falsified.

I believe that there are two parties who contributed to William's death. First, Simmon's Towing would be responsible for allowing William, dressed in a hospital gown and without a valid driver's license and without valid insurance to be able to pay the $341 fee and drive away. Second, the Jacksonville Police Department carries the most responsibility for William's death due to negligence in caring for his severe health issues while he was under their care and supervision from June 11th to June 25th. It seems irresponsible and completely reckless to incarcerate a person suffering from serious health problems for over two weeks on a traffic violation. By being aware of William's serious health issues and accepting to take on the responsibility of caring for William and assuring that his health would not be in jeopardy, the Jacksonville Police Department willingly accepted to medically care for and monitor William's diabetes and other health issues. The Jacksonville Police Department was grossly negligent in their duty to assure that William would receive any and all medical attention needed to remain in good health. According to doctors at Shands Memorial Hospital, William had most definitely not received the care he needed to live, let alone to be healthy. Had William's diabetes been closely monitored as it needed to be, he would have never deteriorated over many hours and days to the point where his blood sugar was so low that it caused his body to go into cardiac arrest causing irreversible brain damage and ultimately death.

I noted that a doctor had told me it would haven taken weeks for him to get into the state of health that preceded his cardiac arrest. This can be verified by the autopsy and by a medical expert.

William was admitted to the hospital on June 24, 2009 with critically low blood sugar a body temperature of 93 degrees, suffering from prolonged hypoglycemia, hypotension

with the principal diagnosis as septicemia. William was brain dead upon arriving at the hospital. The secondary admitting diagnosis were:

-Acute respiratory failure
-Subendo infarct, initial
-Metabolic encephalopathy
-Pneumonia, organism nos
-Pulmonary collapse
-Melena
-Regional enteritis
-Hyperosmality
-Alkalosis
-Protein-Cal malnutrition nos
-Coagulat defect nec/nos
-Diastolic heart failure
-Septic shock
-FB Trace/bronch/lung NE
-Severe sepsis
-DMII ote nt st uncntrld
-Abn serum enzyme level ne
-Hypercalcemia
-Dis phosphorus metabol
-Hy kid nos cr kid I-I
-Chronic kidney disease nos
-Anemia nos
-CHF nos
-Sed, hyp, anxiolytc ab-no
-Fb entering other orifice

As you can see, most of the above items are life threatening, but they could have been prevented. Many of the above problems would have exhibited severe symptoms many hours before being admitted to the hospital. Had Mr. Merrifield's seriously low blood sugar reading of 67 at 4:00 a.m. been followed up on and retested and had he not been sent to the courthouse with absolutely no follow up care to be sure that his blood sugar levels were in a normal range and that he was not in any physical danger, he would still be alive today.

Dr. Karmand at Shands Memorial Hospital in Jacksonville, Florida who attended to my father before passing away informed me that he was immuno-compromised and that his condition was severe. He had been acutely immuno-compromised before being admitted to the hospital. He had pneumonia and most likely had it in the jail. He did not respond to the antibiotics administered in the hospital.

liam Michael Merrifield)B October 30, 1945	x Provider (4:58 a.m.)	x Screening (5:59 a.m.) Provider (7:58 a.m.)	x Nursing ?? (4:48 p.m.) IST(2:57 p.m.)	x HST (10:30 a.m.)	x Nursing (4:57 p.m.)	x HST (10:25 p.m.)	x Provider (2:57 a.m.)	x Nursing (4:08 a.m.)	x HST	x HST (8:48 p.m.)	x HST (12:24 a.m.)	x Nursing (4:21 a.m.)
	Medical 11-Jun-09 5:37AM	Medical 11-Jun-09 6:04 AM	Diabetes Mellitus FS 11-Jun-09 BD 2:57 PM	Diabetes Mellitus FS 12-Jun-09 BB 10:30 AM	Diabetes Mellitus FS 12-Jun-09 BD 4:30 PM	Diagnostics Laboratory In House 12-Jun-09 10:24 PM	Medical notes Provider 13-Jun-09 3:04 AM	Diabetes Mellitus FS 13-Jun-09 BB 4:00 AM	Diagnostics Laboratory In House 3:48 PM	Diabetes Mellitus FS 13-Jun-09 BD 8:47 PM	Diagnostics Laboratory In House 13-Jun-09 11:00 PM	Diabetes Mellitus FS 14-Jun-09 BB 4:00 a.m.
1I		21.62					Used 6/11 VS 21.62					
;A		1.89					1.89					
;ight		71 inches					71 inches					
eight		155 lbs					155 lbs					
ood Pressure	132/76	132/82	138/98	130/80		176/99	132/82		167/110		160/120	
espiration	16		19	19		18			18		16	
emperature		95.9				97.5	95.9		97.6			
eart Rate	68	109	87	64		114	109		97		69	
2 Saturation		99	99	99		99	99		100		97	
'hole Blood Finger Stick House Glucose Fingerstick		173mg/dl	284mg/dl	216mg/dl	222mg/dl 279mg/dl R2		[redacted]	237 mg/dl		333		140 mg/dl
nsulin given			R3	R-2	R3			R-2		20N-R5U(Lynn?)		0
ignature on Diabetes Mellitus low Sheet			J	H	J			??		CP		?S
ignatures (Author)	M. Leach (5:37 a.m.)	A. Richards (6:04am) M. Leach (8:43am)	M. Leach BS at 4:30 Results:4:47	M. Leach order provider **BS collected 6/12** **BS results 6/15**	M. Leach order provider	m2 Notified M. Leach order provider	C. Garner	M. Leach order provider	M. Leach order provider	M. Leach order provider Collected 8:47p.m. Resulted 8:46 p.m.	M. Leach order provider VS at 11:00pm Results at 12:23 a.m.	M. Leach order provider

\ssessment/Plan

/11/09 6:04am- Visit for: Multiphasic Screening exam V82.6

/13/09 3:04 am -Herpes-Shingles acute pain/Naproxin500 BIDX1-0days
Tylenol 2 tabs for now for pain, cont gabapentin per order neuropahies

)6/14/09 4:14 a.m. - Hypertension/Plendil 10mg and Lisinopril 40 mg po now and QD Clonidine .1mg poQD

)6/15/09 10:01 a.m. - Risk for deficient fluid volume/put on withdrawl protocol, given 25mg IM and librium 50mg po X1 now
Patient to clinic in wheelchair, states he is too sick to walk, BP elevated, actively vomiting, hand tremors

)6/18/09 9:00 a.m. - NANDA diagnosis-Risk for unstable blood glucose

)6/18/09 3:50 p.m. - Pt c/o being very cold in his cell all day-pt with dm. will order sweatshirt thru nurse

)6/20/09 4:41 p.m. - patient here for DM check and he complains of having a Chron's attack and he needs pain meds and to be taken to the ER
Patient did not report history of Chron's in screening/ abdominal soft and tender to touch in all areas
P decrease dose of lisinopril monitor VS; will have chronic care request medical records to verify chron's history. Patient is hostile and demanding he go to ER

)6/11/09 - Stated a no-show at 8:00 p.m.

[redacted] Item not recorded on Diabetes Mellitus Flow Sheet

[redacted] Timing discrepancies

[redacted] Strange entry (time collected/resulted, also not on flow sheet)

[redacted] No back up detail sheet. Item written on Diabetes FS but **no** signature.

ovider :03 a.m.)	x HST (12:45 p.m.)	x HST (5:16 p.m.)	x HST (10:03 p.m)		x Nursing (5:21 a.m.)	x Provider (1:04 p.m.)	x HST (2:40p.m.)	x Nursing (5:10 p.m.)	x HST (9:34 p.m.)	HST (5:39 a.m.)	x HST (5:10 p.m.) Nursing (4:55 p.m.?)	x HST
dical notes Provider 4-Jun-09 4:14 AM	Diagnostics Laboratory In House 14-Jun-09 12:45 p.m.	Diabetes Mellitus FS 14-Jun-09 BD 5:15 PM	Diagnostics Laboratory In House 14-Jun-09 10:02 PM		Diabetes Mellitus FS 15-Jun-09 BB 4:00 AM	Walk-in 15-Jun-09 10:01 AM	Diagnostics Laboratory In House 15-Jun-09 2:40 p.m.	Diabetes Mellitus FS 15-Jun-09 BD 4:30 PM	Diagnostics Laboratory In House 15-Jun-09 9:33 PM	Diabetes Mellitus FS 16-Jun-09 BB	Diabetes Mellitus FS 16-Jun-09 BD 4:30 PM	Diagnostics Laboratory In House 16-Jun-09 11:14 PM
202/124	168/103		182/110			172/99	140/100		120/70			110/60
22	22		20			18	19		18			18
	97.6					98						97.5
106	90		99			109	90					97
	98											100
		312mg/dl		216mg/dl	94mg/dl			118mg/dl		129mg/dl	95mg/dl	
		20N-R5U			L-20			0		L-20	0	
		CP			??			J		U	J	
C. Garner	M. Leach order provider		M. Leach order provider		M. Leach order provider Collected-4a.m. Results-5:20a.m.	B. Smith-RN (10:08) W. Ortiz MD (reviewed 1:06p.m.)	M. Leach order provider	M. Leach order provider BS collected-4:30PM results-5:10p.m.	M. Leach order provider		M. Leach order provider Collected-4:30p.m. Resulted 4:54 p.m.	Patricia Wood- bury provider

sing	x Nursing (11:22 p.m.)	x HST (10:08 p.m.)	x Nursing (5:25 a.m.)	x Nursing	HST 4:07 p.m.	x Provider (3:49 p.m.)	x HST	x Nursing (4:36 a.m.)	x Chronic Care	x	x HST	x Nursing (5:20 a.m.)	x Provider (4:37 p.m.)
Diabetes Mellitus FS 7-Jun-09 BB 4:57 AM	Diabetes Mellitus FS 17-Jun-09 BD 4:30 PM	Diagnostics Laboratory In House 17-Jun-09 10:07 PM	Diabetes Mellitus FS 18-Jun-09 BB 5:24 AM	Walk-in 18-Jun-09 9:00 AM	Diabetes Mellitus FS 18-Jun-09 BD	Medical Notes Provider 18-Jun-09 3:50 PM	Diagnostics Laboratory In House 18-Jun-09 10:26 PM	Diabetes Mellitus FS 19-Jun-09 BB 4:35 AM	Diabetes Mellitus FS 19-Jun-09 BL 1:30 PM	Diabetes Mellitus FS 19-Jun-09 BD 4:30 AM	Diagnostics Laboratory In House 19-Jun-09 10:50 PM	Diabetes Mellitus FS 20-Jun-09 BB 5:19 AM	Medical Notes Provider 20-Jun-09 4:41 PM
						Used 6/18 VS							used partial 6/18
													21.62
													1.89
													71 inches
													155 lbs
		120/60		155/83		155/83	117/65				139/81		100/72
		18		18		18	18				18		18
		96.9		94.4		94.4	96.9				97.4		96.8
		66		68		68	84				89		116
		98		98		98	98				97		98
tates refusal to come in	158mg/dl		215mg/dl	[redacted]	[redacted]	[redacted]		60mg/dl	163mg/dl	160mg/dl		160mg/dl	[redacted]
	0		L20 R2		nothing written			held L20-call back		0		L20	
??	J?		Ur?		no signature			Ur?	P	A?		DS	
	M. Leach order provider	Patricia Wood- bury provider	M. Leach order provider	E. Logan, LPN (9:53,9:55, 9:56 a.m.)		N. Aguilar,PA-C (3:50p.m.)	Patricia Wood- bury provider	M. Leach order provider	Jhasmine Perez order provider Collected-1:30 p.m. Results-1:48 p.m.	M. Leach order provider	Patricia Wood- bury provider	M. Leach order provider	B. Luna, NP (4:41p.m.)
	Collected-4:30 p.m. Results-11:21 p.m.									Collected 4:30 a.m. Reults-9:46 p.m.			
					No back up detail sheet								

ST :13 p.m.)	x Nursing (7:31 a.m.)	x HST (6:58 p.m.)	x HST	x Nursing (4:53 a.m.)	x Nursing (4:57 p.m.)	x Nursing (4:47 a.m.)	x Chronic Care (1:56 p.m.)	x HST (6:45 p.m.)	x Nursing (7:00 a.m.)	x	x
Diabetes Mellitus FS 20-Jun-09 BD 5:12 PM	Diabetes Mellitus FS 21-Jun-09 BB 7:29 AM	Diabetes Mellitus FS 21-Jun-09 BD 4:00 PM	Diagnostics Laboratory In House 21-Jun-09 4:42 PM	Diabetes Mellitus FS 22-Jun-09 BB 4:00 AM	Diabetes Mellitus FS 22-Jun-09 BD 4:00 PM	Diabetes Mellitus FS 23-Jun-09 BB 4:46 AM	Diabetes Mellitus FS 23-Jun-09 BL 12:15 PM	Diabetes Mellitus FS 23-Jun-09 BD 4:30 PM	Diabetes Mellitus FS 24-Jun-09 BB 4:00 AM	NOT ON FLOW SHEET Diagnostics Other 24-Jun-09 11:50 AM	NOT ON FLOW SHEET Diagnostics Other 23-Jun-09 1:10 PM
			110/80								
114mg/dl	128mg/dl	190mg/dl		163mg/dl	76mg/dl	80mg/dl	56mg/dl 4 glucose tabs	176mg/dl	67	[redacted]	75
othing written	L20	0		L20,R-1	0	L-20	62 @13h00 75 @ 13h15 2 glucose tabs	0	Insulin held	4 glucose tabs	sent back to the floor
CP	B?	CP		A?	BD	??	P?	??	??		
M. Leach rder provider	M. Leach order provider	M. Leach order provider	Patricia Wood- bury provider	M. Leach order provider	M. Leach order provider	M. Leach order provider	Yvonne Waler order provider	M. Leach order provider	M. Leach order provider	Jhasmine Perez order provider	Jhasmine Perez order provider
		Collected 4:00p.m. Results-6:53 p.m.		Collected 4:00a.m. Results 4:54 a.m.	Collected 4:00p.m. Results-10:00 p.m.		Collected-12:15 p.m. Results - 1:57 p.m.		Collected-4:00 a.m. Resulted-6:58 a.m.		**Collected 1:10p.m. Resulted 9:38 a.m.**
										Collected-11:50a.m. Resulted-9:37 a.m. 6/26/2009	**6/26/2009**

Questions, discrepancies and points to explore:

1. Mr. Merrifield had in his possession, and the police took possession of the paper reinstating Mr. Merrifield's license. Mr. Merrifield was in the process of obtaining his birth and marriage certificates required to reinstate his license in South Carolina.

2. There is no paperwork stating that Mr. Merrifield agreed to enter a guilty plea. Mr. Merrifield was denied appearing in court because the JSO said his shingles was contagious; although the reports from Liberty Memorial from a day prior state that his shingles was not contagious; it was in the healing phase.

3. Was Mr. Merrifield ever physically examined by an MD during his incarceration period?

4. On 06/11/09 at 12:55 p.m. Dr. Ortiz ordered Mr. Merrifield into isolation. Did Dr. Ortiz ever personally examine him? If so, where are his notes and reports? According to Liberty Memorial Hospital records, the same day he arrived at the JSO, William was no longer contagious, his shingles was in the healing stage. He had every legal and civil right to appear in court and plead himself; the judge could have seen his extremely fragile state and order that he be hospitalized or find a family member to take him to the hospital. JSO did not want to be bothered with the task of finding a family member.

5. Were Mr. Merrifield's regular medications; the ones he had in his possession, continued while he was in jail?

6. Where are the copies of the sick call request slips, they are required according to regulations?

7. On the diagnostics sheets, why do only a few sheets have an indication under Flag Reference Range when the results are not normal and most don't?

8. Mr. Merrifield was on the second floor; where was the cafeteria and the clinic in relation to his cell. Were his meals brought to his cell?

9. On the BSHC - Worksheet for Order form, a heart failure diet was ordered, not a diabetic diet, why? This seems rather inappropriate and unsafe given the severity of his frail medical state.

10. On the DCHD Screening form, the only vitals taken in order to have Mr. Merrifield medically cleared at 5:37 a.m. on June 11, 2009 were blood pressure (132/76), pulse (68) and respirations (16). The vitals were taken by Mary Leach, NP at 5:37 a.m..

11. On the BSHC - Worksheet for Orders Form, the accucheck section states that his blood sugar should be tested before breakfast and dinner. Mr. Merrifield was supposed to check his blood sugar before breakfast, before lunch, before dinner and before bed. He was also required to take Lantus, 35 units every evening to stabilize his blood sugar, as prescribed by his regular doctor; he had the same dosage for many years; this did not happen.

12. Why are VS (vital signs) and BB (before breakfast) glucose readings always taken at 4:00 a.m.? Shouldn't he be sleeping at that time? Nightly readings seem to be taken at 11:00 p.m. This leaves only five hours or less to sleep.

13. On the BSHC – Worksheet for Orders form, Mr. Merrifield's vital signs were to be monitored five times per day in the protocols section and two times a day in the vital signs section; this was not done every day.

14. Lantus is a medication that is vitally important to be given on a daily basis to help regulate blood sugar, in addition to any other insulin given. Mr. Merrifield did not receive his 35 units of nightly Lantus. Mr. Merrifield received almost half his prescribed daily dosage on eight out of 14 days. Not only did Mr. Merrifield receive only half the prescribed dosage but Mr. Merrifield did not receive this medication on a daily basis as

was prescribed, and as he told the officers when he was booked. Mr. Merrifield told the officers the name of the medication, the amount, and that he took the medication daily. Mr. Merrifield was very careful about taking this daily because he was very fearful of his blood sugar getting too high or too low. These two crucial aspects concerning this medication were neglected by the JSO. In order for this medication to be effective, it MUST be taken daily at the same time each day. It is the same analogy as for an antibiotic to be effective; it must be taken at the same time daily; if you take the antibiotic only every couple of days, it will be ineffective; the same holds true for Lantus.

15. Is there a drug disbursement record/file or sheet indicating dates, times and amounts given to Mr. Merrifield of **each** for his medications?

16. I was informed that inmates must sign out in a log in the jail when they go to the clinic and sign back in when they return. I was also informed that the inmate must also sign both in and out of the clinic. I was unable to obtain a copy of the actual log, is it electronic?

17. How far was the clinic from Mr. Merrifield's cell? Was it on the same floor as his cell? On each of Mr. Merrifield's clinic visits did he go alone, was he assisted, or did a nurse go to his cell to check his sugar and vital signs? He was in an isolation cell so I am not sure if the procedure of going to the clinic is the same or different in this situation.

18. On the intake form, Mr. Merrifield told the officers during the interview that his wife had leukemia and that he and his wife were coming to Jacksonville from Gainsville, GA for treatments. The officers also stated that Mr. Merrifield said he took the luggage from the trunk and brought it into their temporary housing, independently. The report states that Mr. Merrifield said that he was ambulatory with his cane. This was not true, he needed help into the police car and into the police station. The arrest report, in the info needed to know section, it is stated that Mr. Merrifield could hardly walk.First, the story of his wife and the luggage is untrue. Mr. Merrifield's wife was not ill and they were not living in Gainsville (the officers knew this because of his license information). It would

have been physically impossible for a man that can only walk short distances with a cane or with human support to carry in suitcases. Mr. Merrifield neither had the strength (he had recently broke his wrist and ankle), nor did he have the balance necessary to simultaneously carry a suitcase and use a cane. This fact should have been visually obvious, regardless of what was said. William's physical capabilities were noted in the Liberty Memorial records.

19. After the screening interview, were any attempts made to locate his "sick" wife or any other family member? According to the report, Mr. Merrifield's wife was seriously ill from Leukemia, receiving treatments and depended on Mr. Merrifield for transportation and care. Since Mr. Merrifield "carried in the luggage independently," his wife must have been too ill and weak. Were the police not worried about some seriously ill woman being left alone in an apartment, maybe dying with no one to care for her?

20. On June 25, 2009, Shands Memorial Hospital made a note to contact a social worker to locate William's family. The police department had this responsibility. Why wasn't this done in the two-week period he was in JSO's care? Donna Merrifield had contacted JSO earlier that week of June 24, 2009, to go get William and to speak to him. They refused to let her come and get him and also refused to let her talk to him. He never received his one phone call, this violates his legal rights. JSO continued their negligence and disregard for humane treatment by telling Shands Memorial Hospital that they did not have any family contact information, when in fact they had spoken with his wife earlier that week.

21. In the Mental Health screening on June 11, 2009 at 6:05 a.m., the report states that Mr. Merrifield was coherent. What was this assumption based on? Was Mr. Merrifield asked questions such his home address, phone number, wife's name, wife's phone number, where she currently was, other family members' names and phone numbers, day of the week, etc…? Was any of the information that Mr. Merrifield gave, ever verified as to its accuracy? I could be arrested and say I was the granddaughter of the Queen of England; would the JSO just take everything that is told them at face value even if the

physical facts speak otherwise? At the scene of the accident, Trooper Ezell stated that she thought Mr. Merrifield suffered from Alzheimer's since he did not even remember being in the accident or any personal information. Mr. Merrifield was obviously not coherent based on the story about his wife's leukemia, the luggage, and the fact that he was unable to provide any phone number or other important personal information. Mr. Merrifield's mental status was impaired, not normal.

22. On the Screening form, it is stated that Mr. Merrifield said he was self-reliant in usual daily activities, but this was untrue because his inability to be self-sufficient was the reason that he was going to Florida to get his wife to help take care of him, as stated in the Liberty Memorial Hospital records. It was also obvious his clothing, the green hospital scrubs and the AMA papers on his front seat that were used for his identification.

23. Did any officer contact Liberty Mutual Hospital in Gainsville (the report states that Mr. Merrifield told the officers he had just been released from there)? Liberty Mutual Hospital had Mr. Merrifield's wife's contact information. Donna would have immediately picked him up and his death would not have occurred. If they had taken the time to contact Liberty Memorial Hospital, they would have been aware of the serious of his medical and mental condition; they obviously did not care.

24. The officers did not allow Mr. Merrifield a wheelchair, although a wheelchair was needed for any distance more than a few rooms length long, and was needed upon arrival at the jail.

25. Was Mr. Merrifield kept isolated from all human contact for his entire stay?
Was Mr. Merrifield given outside privileges; did he go outside at all during his stay?
There were no notes of any outside activity or human contact.

26. Where are **all** the segregation rounds reports? There was only one included on 06/18/09 at 4:05 p.m.. There should be several for every day. I was informed that the procedure was to do hourly checks on inmates in isolation.

27. On the BSHC - Worksheet for Order form, it was ordered that Mr. Merrifield receive chronic care and wound care for his shingles. I saw no notes on clinic visits that his "contagious" shingles was ever evaluated or followed up on.

28. On the BSHC – Worksheet for Orders form, an ECG was ordered, and the form of refusal. Given his apparent health condition, this test should have been obligatory. Since a heart failure diet and not a diabetic diet was prescribed, the JSO must have felt that William had a serious heart condition. William's signature on the refusal form is not the same as his other signatures and the date was not written by him, it was also changed.

29. It is a case of falsifying medical records in reporting that Mr. Merrifield's weight remained a constant 155 during his two- week stay as noted in his JSO clinic chart. His actual recorded weight on June 10, 2009, according to the Liberty Memorial Hospital records was 173 pounds and his actual recorded weight on June 24, 2010 at Shands Memorial Hospital was 143 pounds. William **lost 30 pounds** in his 2-week stay at the JSO. This explains why part of his admitting diagnosis into Shands was anemia and malnutrition.

30. On 6/13/09 at 3:04 a.m. when Mr. Merrifield went to the clinic the NP did not take his vitals, she entered in vitals form 6/11/09. This also occurred on 06/14/09 at 4:14 a.m..Why?

31. Lab-Radiology-ECG report from samples collected on 6/15/09 at 4:00 a.m. and 2:10 a.m. and results dated on 6/16/09 at 2:00 a.m. indicate that Mr. Merrifield was suffering from SEVERE kidney problems and his kidneys were most likely failing to some extent (these results should be evaluated by a specialist to determine exactly what state his kidneys were in with these results). Mr. Merrifield's Hemoglobin A1C was almost twice the normal limit as well and his estimated average glucose was 235. (normal range is 70-99)

32. With the results listed in the Lab-Radiology-ECG report, what actions if any did JSO take to further investigate or treat Mr. Merrifield's serious kidney problems? They noted at the time of booking that he had urinated in his pants some. The extremely high results indicate severe kidney disease and possible kidney failure. This should have been immediately followed up on. Lantus is NOT recommended during periods of rapidly declining renal function because of the risk for prolonged hypoglycemia. The primary cause of death was prolonged hypoglycemia, coincidence? The doctor in charge should have known about the dangers of giving Lantus with his severe kidney problem.

33. In the nursing notes dated 06/18/09 at 9:00a.m., Eva Logan L.P.N. states that Mr. Merrifield was alert and was given four glucose tablet. This was also listed as a walk-in visit. It would be physically impossible for a person with blood sugar of 52 and a temperature of 94.4 to be alert and to go to the clinic even with assistance, unless he was in a wheelchair or stretcher. He would have been semi-conscious and incoherent; a blood sugar reading this low requires an effective treatment via IM or IV at a hospital.

34. What treatment was given to Mr. Merrifield for his hypothermia on June 18, 2009, and the several other times his body temperature was very low? I only saw that a sweatshirt was ordered on June 18, 2009 by N. Aguilar. Did he receive extra blankets? How many blankets did he have? Is a sweatshirt the new "approved medical treatment" for hypothermia? I was told the jail was kept a cold 70 degrees. This was unsafe and unhealthy for Mr. Merrifield; nothing was done to correct the situation even after he complained several times and had a body temperature of 94.4. It is extremely dangerous for a diabetic to be that cold.

35. On the diagnostics form dated 6/18/09 at 5:24 a.m. it states that Mr. Merrifield's blood sugar was both collected and resulted at 5:24 a.m. and the results were 215. The report states that Mr. Merrifield was given L20 R2. Either this is false or Mr. Merrifield was given too much medication for his blood sugar to drop to 52 in 3 ½ hours.

36. In the Nursing Notes section, subsection Isolation-General, on 06/11/09, the Nursing Assessment is dated 6/11/09 at 1:55 p.m. states that Mr. Merrifield was seen lying in bed, no complaints voiced but the signature by nurse Pamela Broomfield, L.P.N. was dated 6/18/09 at 4:05 p.m.. What is the correct date? On that same form is the segregation rounds saying that Mr. Merrifield appeared alert, well hydrated, followed verbal directions, eating as expected, physically active, not expressing health concerns and not requesting a sick call slip. I am unclear as to the date and time of this portion of the page.

37. Continuing with the same report above, P. Bloomfield, L.P.N. is the author under the signature section on June 18, 2009 under the nursing assessment although at this time, 3:50 p.m., Mr. Merrifield was in the clinic. This page needs date and time clarifications and names of the segregation rounds officer and the nurse who made the assessment.

38. There is an entry for a nursing encounter on 6/17/09 at 4:57 a.m., but the detailed back up indicated that Mr. Merrifield refused to come in. Why is this entry listed as a nursing encounter if none occurred?

39. On Medical notes Provider on 6/20/09 at 4:41 p.m. Mr. Merrifield complained of a painful Chron's attack and requested to go to the ER, he was hostile, in pain, and his abdomen was tender to the touch. He was not treated for his Chron's attack nor taken to the ER. There is no follow up on his treatment and no follow up on the VS noted. Were the records requested? Where did they request the records from? There was no plan of treatment indicated nor any follow up; incomplete notes. Mr. Merrifield's attacks lasted for several days and needed to be treated with prednisone. Where was Mr. Merrifield kept or taken after he complained of his Chron's attack? Why was there no follow up?

40. The Resident Transaction Receipt form states that William was unable to sign, why? If he could not sign his name, he should have been in a hospital.

41. There are several BD (before dinner) glucose testings that show high blood sugar levels, for example 160, and no insulin was given, why?

42. On 6/11/09 at 8:00 p.m. it was stated that Mr. Merrifield was a no show for his VS. Did anyone follow up as to why he did not show?

43. Did Mr. Merrifield have to go to the clinic for VS monitoring or did they go to his cell? Same question for BS testing.

44. On 6/12/09, the BS reading of 216mg/dl on the Diabetes Mellitus Flow Sheet does not have a back up diagnostics detail sheet only BP, pulse, respiration and O2 saturation were taken. Was this a false entry? The flow sheet states there was a BB reading but on the 10:30 a.m. in-house VS detail, no BS was taken.

45. On 06/12/09, the flow sheet indicates a before dinner BS reading of 279 with a treatment of R3 while the detail diagnostics sheet dated 6/12/09 with a collect time of 4:30p.m. and a result time of 4:56 p.m. indicates a BS reading of 222 and treatment of R2. This is another discrepancy. I am not sure which is more reliable, if either.

46. On the Diagnostics sheet dated 06/13/09, the time that the information was collected was 8:47 p.m. and the time of results was 8:46 p.m.. This is physically impossible. **The clinic's recordkeeping is consistently inaccurate which would make it unreliable. If the recordkeeping is so inaccurate, how accurate is the dispensing of the medication and the dosages given?**

47. On 6/15/09, Mr. Merrifield was taken to the clinic at 10:01 a.m. for vomiting and was too ill to walk, and was returned to his cell. At 2:40 p.m., he had his vitals taken and at 4:30 p.m. had his blood sugar tested. Was his blood sugar taken? The symptoms he was experiencing are consistent with hypoglycemia. They stated that it was very cold. If it was withdrawals, he would have exhibited symptoms before 4 days.

48. On the Diabetes Flow Sheet it indicates Mr. Merrifield had his blood sugar reading but there is no diagnostics detail sheet for 6/16/09 for the BB reading; was it actually taken?

49. On the Laboratory In House report dated 06/16/09 at 11:14 p.m., the collect time was 11:14 p.m. and the result time was 11:10 p.m., this is impossible, once again.

50. On 06/17/09 it is stated that Mr. Merrifield refused to come in for his BB reading. This reading was most likely at 4:00 a.m.. Mr. Merrifield was in the clinic at 11:14 p.m. the night before, maybe he needed to sleep more than 5 hours? This is a daily occurrence of nightly readings at 11 p.m. and morning readings at 4:00 a.m.. It is very important for a diabetic and ill person to get adequate sleep, which was not happening. **This would contribute to his declining health.**

51. On 06/19/09 the Flow sheet indicates that Mr. Merrifield's blood sugar was 60 and insulin was withheld and that Mr. Merrifield was to be called back. No action was taken to raise his blood sugar level that was noted and no further reading was taken until 1:30 p.m.. Why? This was completely irresponsible.

52. On 06/19/09 the Diabetes Flow Sheet indicates that Mr. Merrifield had a BD reading of 160. The Diagnostics-Other reports that the reading of 160 taken on 06/19/09, was taken at 4:30 a.m. and the results were at 9:46 p.m.. The reading at 4:35 a.m. on this date had a reading result of 60. These results and times are conflicting, again. These inconsistencies should be investigated further.

53. Mr. Merrifield's VS were not taken since his blood pressure was taken on 06/21/09 at 4:42 p.m.. Mr. Merrifield was supposed to have his vitals taken two times per day and his VS should have been monitored even more closely with his severe blood sugar problems in the days after 06/20/09.

54. On 06/23/09 at 12:15 Mr. Merrifield's blood sugar was 56 and at 1:10 p.m. it was 75 (resulted 06/26/09 at 9:38) and at 4:30 p.m. Mr. Merrifield's blood sugar was 176. The Diabetes Mellitus Flowsheet, the 1:10 results of 56 are recorded as 62; which was it? This is another inconsistency. Too much insulin was given, most likely. What did he eat in between those times? Mr. Merrifield's blood sugar was not retested after 4:30 p.m. on 6/23/09 until 06/24/09 at 4:00 a.m. when it was 67.

55. The Diagnostics-Other form dated 06/23/09 at 1:10 p.m., indicates that Mr. Merrifield had a blood sugar reading of 75 and was sent back to the floor but on the Diabetes Mellitus Flowsheet it is recorded as 62. This was not indicated on the Diabetes Mellutis Flow Sheet. The resulted time was indicated as 06/26/09 at 9:38 a.m.. Once again this is physically impossible since Mr. Merrifield was transported to the hospital on 06/24/09.

56. On 06/24/09 Mr. Merrifield's blood sugar was 67 at 4:00 a.m.. Was any action taken, any follow up?

57. The Diagnostics-Other form dated 06/24/09, by Jhasmine Perez, states that Mr. Merrifield came in to the clinic at 11:50 a.m. and had a blood sugar reading of 56 and was given four glucose tabs "per Luna." The resulted time is indicated as two days later on 06/26/09 at 9:37 a.m.. This blood sugar reading was not indicated on the Diabetes Mellitus Flow Sheet at all. It is not plausible that he was resulted on 06/26/09, Mr. Merrifield had been in the hospital for two days. Mr. Merrifield could not have been both in the clinic and in the courthouse drooling and incoherent. **This medical record has obviously been falsified. If this record is false, how many more records provided by the JSO and the clinic have been falsified?**

58. Officer Sanders states the event occurred on June 26, 2009 and dates his signature on June 25, 2009. The event occurred on June 24, 2009. Officer Sanders states that he observed William sitting in a wheelchair at 12:30 and said he asked him questions and William did not respond in a coherent manner so, instead of calling for an ambulance as would have been the responsible course of action given William's serious health

problems to date and being a diabetic, he called sally port to have the wheelchair van come and pick him up. Officer Sanders states that Officer Norton arrived 10 minutes later, at 12:40, and upon loading William into the van noticed he was unresponsive. He then states that Rescue was notified. Officer Sanders did not monitor William during the wait or he would have noticed a change in his status. This delay cost William his life.

59. Officer Norton states that Officer Tuten, not Officer Sanders called sally port for the wheelchair transport van to pick up the inmates at 11:45, not 12:30. Officer Norton states that he arrived at the courthouse at the very specific time of 12:23, not 12:40. Officer Norton states that William was slumped over and had drool coming from his mouth and was unresponsive and then Rescue was called. This delay cost William his life. JAX Fire and Rescue records the call coming in at 12:31, arriving at the courthouse at 12:40 and leaving for the hospital at 12:50. Either Officer Sanders or Officer Norton has falsified his report. The month, in the date section, was whited out and hand written in. Verification of the phone records from the service provider can easily prove whose report is accurate, if either. Interviewing defendants and workers who were present that morning would be of great help as would being able to view any videotapes at the courthouse from that day.

60. In the PTDF Patient Snapshot there are image encounters for 6/29/09(12:00 a.m.), 6/29/09(12:00 a.m.), 6/26/09(12:00 a.m.) and a nursing encounter on 6/27/09(01:26 a.m.). Mr. Merrifield was no longer being detained by the JSO, he was ROR on 6/25 /09 or 6/26/09 after he was taken to the hospital. Why are there image encounter and a nursing encounter after the ROR date?

61. On the Diabetes Mellitus Flow Sheet there are two entries that do not have a back up detail page, 06/16, BB and 06/18, BB. Interestingly, the provider's signature is the same person. This person's signature appears three times on this flow sheet; two times where there is no back up detail and a third time on 6/19, BB when the insulin was held and Mr. Merrifield was supposed to be called back but the next reading was at 1:30 p.m. Was he returned to his cell in between? Were these real entries by a real person, I find it is

questionable and should be further investigated as to who this person is. The entry on 06/18, BD, has no signature, needs to be investigated as well.

62. On the patient Snapshot form, the following entries have no backup (data collected, results, no detail back up sheet):

- 6/11 (10:04 a.m.)
- 06/11 (12:55 p.m.)
- 06/11 (5:34 p.m.)
- 06/11 (10:03 p.m.)
- 06/12 (2:38 a.m.)
- 06/12 (7:52 a.m.)
- 06/12 (8:03 a.m.)
- 06/14 (2:55 p.m.)
- 06/14 (9:04 p.m.)
- 06/14 (9:34 p.m.)
- 06/15 (2:38 a.m.)
- 06/15 (10:01 a.m.)
- 06/15 (11:04 a.m.)
- 06/16 (3:00 p.m.)
- 06/19 (9:46 p.m.)
- 06/21 (6:23 a.m.)
- 6/23 (9:36 a.m.)
- 06/26 (12:00 a.m.)
- 06/27 (1:46 a.m.)
- 06/29 (12:00 a.m.)
- 06/29 (12:00 a.m.)

63. Mr. Merrifield's blood sugar was at an abnormally high rate for weeks. It would be vital to get a professional opinion of the mental status and mental clarity of a person in that condition and constant state of high blood sugar for that extended period of time.

64. On the Diabete Mellutis Flow Sheet, William's Lantus was mis-prescribed to be on a sliding scale. Lantus cannot be prescribed on a sliding scale. This is a clear case of medical malpractice. Under prescribing a medication can be just as fatal as overprescribing a medication. If a doctor prescribed 500mg of a medication instead of 5mg and the patient died; this would be considered medical malpractice. This holds true for a medication that is under prescribed and death is the result, as is the case here.

65. Any law enforcement official who intentionally or negligently harms another person or who causes or contributes to their death needs to be held accountable as would any other citizen.

66. We place our trust, confidence and respect in law enforcement officials. Any law enforcement official who falsifies a record or report or who lies about events and their actions, needs to be made an example of and prosecuted to the fullest extent of the law. If we cannot trust in our law enforcement officials, we have lost something that we consider very important in the United States of America. Years ago, the Los Angeles Police Department underwent a complete "overhaul" and I strongly feel that the same actions are needed at the JSO.

67. Regarding the Examination Report by Jesse C. Giles, MD, dated July 17, 2009, in the section titled, Circumstances of Death, he states that "withdrawal" protocol were given Mr. Merrifield on 06/15/09, 4 days after being admitted. If his nausea and vomiting were caused by withdrawals, he would have exhibited symptoms before 4 days had passed.

68. In the same report as above, Dr.Giles implies in several areas that this was most likely due to a Benzodiazepines overdose. Mr. Merrifield had been in the custody of the JSO for 2 weeks prior to his collapse; an overdose was an impossibility and should have been obvious to Dr. Giles. Dr. Giles' comments throughout this report referring to a drug overdose seem to be a deliberate attempt to portray Mr. Merrifield as a drug addicted man who committed suicide and deflect any responsibility off of the JSO. Mr. Merrifield never received any Bezodiazapines during his two-week stay at the JSO and he tested

negative at Shands for any drugs, so any kind of overdose was an impossibility and should have clearly evident from the records.

69. In the same report as above, Dr. Giles states that Mr. Merrifield had been released from police custody well before his death and did not require an autopsy. This is not true; the collapse occurred while Mr. Merrifield was still in police custody. The fact that the JSO decided to ROR William the day after he was admitted to the hospital was a blatant attempt to try and avoid any autopsy and try to avoid any responsibility for his death. The fact remains that Mr. Merrifield was brain dead when he arrived at the hospital on 06/24/09, while still in police custody. An autopsy should have been done. Dr. Giles' excuses of why an autopsy was not performed are weak and unprofessional. The first excuse Dr. Giles uses is that the records Dr. Giles requested were not received from the JSO "in a timely-enough fashion to allow for a review and a non-jurisdiction decision." I did not know there was a time limit that he had before making a decision in a questionable case, and if the records were not received in a timely fashion, Dr. Giles should have followed up in a professional manner to assure he received the records he needed. The second excuse he uses is that he "didn't want to keep the family and funeral home waiting overly-long for the cremation authorization." I believe doing a thorough and professional job is more important than waiting a week or two longer. This whole report looks like it is tainted against Mr. Merrifield and the autopsy not performed for reasons other than the untimely receiving of reports.

70. The Medical Examination Report states that Mr. Merrifield was admitted to the examination room with the clothing in a bag, along with a walking cane.
The JSO Screening Form states that Mr. Merrifield was advised that he may continue to use HIS cane and JSO wheelchair will be returned.
I have a photo from the insurance company that is date stamped July 30, 2009 (weeks after Mr. Merrifield's death) clearly showing Mr. Merrifield's one and only cane in the front seat of his car.
Clearly Mr. Merrifield did NOT have his cane as stated in the screening report and the Medical Examination Report.

If the JSO would like to now say that they lent him a cane, where is the requisition form, and why was it never mentioned in any single report or record? I spoke with a nurse in the clinic and she said that sometimes they have an extra cane they can lend to an inmate but it is always, always taken back since they are so limited, no exceptions.

71.Mr. Merrifield's blood sugar was never retested after his dangerously low reading of 67 on 06/24/09 at 4:00 a.m.. Mr. Merrifield was transferred to the courthouse with no follow up to see if his blood sugar was out of a dangerous range. Mr. Merrifield was ordered, by Dr. Solano, to have his blood sugar tested before breakfast, before lunch and before dinner. On 06/24/09, Mr. Merrifield's blood sugar was not tested before lunch as ordered by Dr. Solano. Had Mr. Merrifield's blood sugar been tested at 10:00 or 11:00 as it had been every other morning, his life would have been saved. By not following up after a seriously low blood sugar reading of 67 and by not following Dr. Solano's orders, and testing his sugar before lunch, Mr. Merrifield's dangerously low blood sugar persisted during the entire morning, while he slipped into a diabetic coma, suffered severe hypothermia and encephalopathy and ultimately death, while there were trained officers and staff in the immediate vicinity who should have known and recognized the symptoms of a diabetic crisis. Had anyone followed up on the low blood sugar reading, or tested his sugar later that morning, as prescribed, my father would be alive today.

72. An Internal Affairs Complaint was filed October 22, 2010 regarding the issues with medical records and police report discrepancies and conflicts. (Copy is attached) Attached is the response from Dr. Solano regarding the many discrepancies and errors in the medical records from his clinic. Dr. Solano states that the MAR (Medication Administration Record) is the MFS (Mellitus Flow Sheet). Dr. Solano states that orders and clinical decisions are based on this information. In his own report, Dr. Solano admits to at least three (3) omissions on the MAR, including one entry on the MAR that was not even signed by the nurse, as required by law. Out of the 27 entries, there are 3 errors, which is an error rate of 11%. These are only the errors that I could locate with the given information, there are sure to be others. If the MAR, the report relied upon to prescribe medication is inaccurate, how accurate is the dispensing of the medication and how

reliable is this report. The nurses in charge of this report do not even follow the legal law of signing the report. If such little care is given to accurate and important medical record keeping, how much care is given to the patient and their physical well-being? When I spoke with Dr. Solano, and I asked him about the 11% rate of errors that I spotted just on this one report, regardless of the dozens of other errors reported on his other records, which he said are not important, his exact response to me was, " Every clinic makes errors and 11% is not bad, it is the same everywhere." The rate is actually higher if we take into account all the records. Dr. Solano told me that this was only 1 patient, not every patient has errors, I beg to differ. Dr. Solano's report states that strives for 100% accuracy, but that was not even close to what he said to me on the phone. He was very condescending and nonchalant regarding the entire matter. With the lack of internal controls and quality controls, I am sure that the incidence of errors is quite high. I would like to officially request a complete and thorough audit/investigation of Dr. Solano's clinic medical records. Dr. Solano's attitude regarding the acceptability of the high incidence of errors is unacceptable of a person in Dr. Solano's position of authority and responsibility. Given the unacceptable lack of internal controls and quality, it is clear that Dr. Solano is not qualified to hold the position of Chief Medical Examiner. I am requesting that any and all appropriate actions be taken to ensure that proper and adequate medical care is given at the clinic.

As of January 1, 2011, I have not had any response to the Internal Affairs Complaint form filed in regards to the falsification of officers' reports. I called and spoke with Assistant Chief Redmond and he told me that he will not give me any information. I told him that if anyone in the investigation had any questions, to please call me. His response was, "If anyone had any questions for you, they would have already called you." That was the end of the cold conversation.

STATE OF
SOUTH CAROLINA

NOTICE OF WITHDRAWAL OF SUSPENSION

A SUSPENSION IMPOSED FOR THIS VIOLATION MAY BE WITHDRAWN

PAYMENT HAS BEEN MADE IN THE AMOUNT OF 9762697
$ 60.00 COVERING THE FINE AND COST FOR THE VIOLATION DESCRIBED HEREIN.
AUTH. SIGNATURE O G Chase DATE 05/07/09

FOR ADMINISTRATIVE USE

To have this suspension withdrawn, you must take this form to the local DMV office. For mailing instructions, please see below.

#3 HOME JURISDICTION (SUSPENSION WITHDRAWAL)

CITATION NO.	DATE OF VIOLATION	LOCATION OF VIOLATION	SECTION VIOLATED
D059283	3/4/2008	Beaufort	2100

DESCRIPTION OF VIOLATION	FINE AND COSTS	TRIAL DATE
Speeding, 10 mph or less over the speed limit	$60.00	3/27/2008

DOCKET NO. D059283 COURT NO. 07104

DRIVER'S LICENSE NO.	STATE	DATE OF BIRTH
622490106	NY	10/30/1945

NAME LAST	FIRST	MIDDLE	SEX
Merrifield	William	M	M

STREET ADDRESS: 4352 Heritage Drive

CITY	STATE	ZIP CODE
Liverpool	NY	13090

REGIS.(TAG) NO.	STATE	YEAR	MAKE	MODEL
EBB3964	NY	2004	HYUN	

COURT INFO

NAME OF COURT: Beaufort Magistrate
MAILING ADDRESS: 104 Ribaut Road

CITY	STATE	ZIP CODE
Beaufort	SC	29901

TELEPHONE: AREA CODE (843) NUMBER 470-5202
AUTHORIZED BY: O G Chase 5/7/2009

FORM DL-53 (REVISED 08/06)

TRIAL OFFICER'S INSTRUCTIONS: Upon the defendant complying with the citation, the top portion of Form DL-53 (blue & pink) copies are completed and the blue copy is forwarded to the defendant.

IMPORTANT DRIVER INSTRUCTIONS

SOUTH CAROLINA DRIVERS: **DMV MUST RECEIVE THIS FORM** You may take this blue form to a DMV office or mail it to the address below. If this form is not received, your driving privilege will remain suspended. If the fine is paid on or after the beginning date of the suspension, a **$100.00 reinstatement fee** must be paid before the suspension is withdrawn.

MAILING INSTRUCTIONS: This form and reinstatement fee, if required, may be mailed to:

2306 Southside Blvd
Beaufort, SC 29902

South Carolina Department of Motor Vehicles
Driver Records
Post Office Box 1498
Blythewood, South Carolina 29016-0028

OUT-OF-STATE DRIVERS: YOU must present or mail this blue copy of Form DL-53 along with any applicable reinstatement fees to the state in which you are a licensed driver. Any questions you may have concerning reinstatement fees or driver license suspension must be directed to your home state.

#1

PTDF Pre-Trial Detention Facility

500 East Adams Street
Jacksonville,FL 32202
(904) 630-7409

Patient: MERRIFIELD, WILLIAM M
2306 SOUTHSIDE
BEAUFORT, SC 29902-0000

Age/DOB 63 yrs 30-Oct-1945
EMRN: 713772
OMRN: 713772
Home:
Work:

Results

Lab Accession # 0001
Ordering Provider: Leach,Mary
Performing Location: PTDF

Collected: 6/11/2009 12:55:00PM
Resulted: 6/11/2009 12:55:00PM
Verified By: <Verification Not Required>
Auto Verify: N

Isolation-Contact

Stage: **Final**

d/c isolation per dr. ortiz

Test	Result	Units	Flag	Reference Range
Isolation	d/c			

#2
#4

IN THE COUNTY COURT OF THE
FOURTH JUDICIAL CIRCUIT, IN
AND FOR DUVAL COUNTY, FLORIDA.

CASE NO: 2009-CT-013621

DIVISION: I

STATE OF FLORIDA

-vs-

WILLIAM MERRIFIELD,

Defendant.

STATE OF FLORIDA)

COUNTY OF DUVAL)

Proceedings before the Honorable Pauline Drake, Judge of the County Court, Division I, as cause in this matter came to be heard on the 11th of June, 2009, before Catherine M. Morrow, Florida Professional Reporter and a Notary Public in and for the State of Florida at Large.

OFFICIAL REPORTERS, INC.
201 EAST ADAMS STREET
JACKSONVILLE, FL 32202
(904) 358-2090

#2

APPEARANCES:

Richard Komando, Esquire,

Assistant State Attorney,

220 East Bay Street
Jacksonville, Florida 32202

Appearing on behalf of the State of Florida.

Melanie Thompson, Attorney at Law,

Assistant State Attorney,
25 North Market Street, Suite 200

Jacksonville, Florida 32202

Appearing on behalf of the Defendant.

P R O C E E D I N G S

(Constitutional Rights Video played.)

(The Group was duly sworn.)

* * * * *

THE COURT: Okay. Let's do William Merrifield. Driving while license suspended. No local record.

THE BAILIFF: Your Honor. He's upstairs with a communicable disease. And he's out of state.

THE COURT: State of South Carolina and State of New York. Okay. Give him a pass date of 6/24 at 2 o'clock in courtroom 23 and leave the bond where it is at 1503.

* * * * *

(Whereupon the proceedings were concluded at 4:01 p.m.)

C E R T I F I C A T E

STATE OF FLORIDA)

COUNTY OF DUVAL)

I, Catherine M. Morrow, Florida Professional Reporter, certify that I was authorized to and did stenographically report the foregoing proceedings and that the transcript is a true and complete record of my stenographic notes.

DATED this 21st day of October, 2009.

CATHERINE M. MORROW
Florida Professional Reporter

INITIAL INTERVIEW

MODERATE NUTRITIONAL RISK FACTORS: 06/07/09 17:37 (G.LEWIS, RN)
Insulin dependent diabetic, Non-compliance to therapeutic diet.

NUTRITIONAL SCREENING: 06/07/09 17:37 (G.LEWIS, RN)
Moderate nutritional risk.

HIGH RISK FUNCTIONAL FACTORS: 06/07/09 17:37 (G.LEWIS, RN)
PT ADMITED WITH AMS PT WAS ALSO INVOLVED IN AVA 2 DAYS AGO USES CANE WITH AMBULATION 06/07/09 17:37 (G.LEWIS, RN)

FUNCTIONAL SCREENING: 06/07/09 17:37 (G.LEWIS, RN)
Abnormal gait/history of frequent falls.

ISOLATION PRECAUTIONS NEEDED?: 06/07/09 17:37 (G.LEWIS, RN)
No isolation precautions needed.

LOW RISK FOR FALLS WITH NON-AGGRESSIVE PREVENTION: 06/07/09 17:37 (G.LEWIS, RN)
Patient has impaired ability affecting A, Patient is exhibiting CONFUSION AND DISORIENTATION 06/07/09 17:37 (G.LEWIS, RN)

HIGH RISK FOR FALLS WITH AGGRESSIVE PREVENTION: 06/07/09 17:37 (G.LEWIS, RN)
Low risk for falls, Patient has a history of falls in the la, Patient has a history of drug/alcohol ab. 06/07/09 17:37 (G.LEWIS, RN)

HIGH RISK FOR SKIN BREAKDOWN: 06/07/09 17:37 (G.LEWIS, RN)
See Physical Assessment-Metabolic/Integu.

PRE-OPERATIVE TEACHING: 06/07/09 17:37 (G.LEWIS, RN)
N/A.

PLAN OF CARE/ADMISSION PROCESS DISCUSSED WITH PATIENT/FAMILY: 06/07/09 17:37 (G.LEWIS, RN)
Verbalized understanding and agrees.

PATIENT SAFETY BROCHURE DISCUSSED W/ PT/FAMILY: 06/07/09 17:37 (G.LEWIS, RN)
Yes, safety brochure given and discussed.

MEDICATION RECONCILIATION PRINTED: 06/07/09 17:37 (G.LEWIS, RN)
Yes and placed on chart.

DISCHARGE PLANNER

SOCIOECONOMIC STATUS: 06/08/09 15:00 (G.LEWIS, RN)
Unemployed.

MENTAL STATUS: 06/08/09 15:00 (G.LEWIS, RN)
Disoriented, Confused.

CARE STATUS: 06/08/09 15:00 (G.LEWIS, RN)
Requires assistance, Ambulation assistance, Bathing assistance.

LIVING ARRANGEMENTS: 06/08/09 15:00 (G.LEWIS, RN)
Lives Alone.

ANTICIPATED NEEDS AT TIME OF DISCHARGE: 06/08/09 15:00 (G.LEWIS, RN)
PT HAS NO TRANSPORTATION, CAR WAS INPOUNDED PRIOR TO ADMISSION AND PT LIVES IN NORTH CAROLINA BUT IS HEADED TO FLORIDA TO PICK UP FAMILY FOR ASSISTANCCE AT HOME. 06/08/09 15:00 (G.LEWIS, RN) 06/08/09 15:00 (G.LEWIS, RN)

Does patient need pneumococcal vaccine? 06/08/09 15:00 (G.LEWIS, RN)
Yes, pt is diabetic, BUT PT COULD NOT PROVIDE INFO NEEDED TO DETERMINE HX OF VACCINATIONS 06/08/09 15:00 (G.LEWIS, RN)

IS PATIENT CURRENTLY BEING VISITED BY HOME HEALTH?: 06/08/09 15:00 (G.LEWIS, RN)
No.

DOES PATIENT RECEIVE OXYGEN AT HOME?: 06/08/09 15:00 (G.LEWIS, RN)
No.

DOES PATIENT HAVE A HOME NEBULIZER?: 06/08/09 15:00 (G.LEWIS, RN)
No.

IF CVA (OLD/NEW),PATIENT, DOES PATIENT NEED REHAB EVALUATION?: 06/08/09 15:00 (G.LEWIS, RN)
NA

#2 #4

Nurse's signature: G Lewis RN

PHYSICAL ASSESSMENT

Oxygen: None.
Pulse Oximeter: _100__% saturation ON ROOM AIR

07:30 P/A (G.LEWIS, RN)

NEUROLOGICAL ASSESSMENT:
Level of Consciousness: Alert, Oriented X_3___.
Best Motor Response: Responsive to Voice/obeys commands.
Articulation: Clear.
Eyes: Consensual, Reddened.
Pupils: PERRLA.
Pupil Size: Left, Right, 3.
Vision: No difficulty noted.
Corneal Reflex: Both eyes blink.
Cough Reflex: Normal.
Gag Reflex: Normal
Hearing: No difficulty noted.
Planter Extension: Moderate.
Planter Flexion: Moderate.
Deep tendon reflexes: Active.

07:30 P/A (G.LEWIS, RN)

GENITOURINARY ASSESSMENT:
Incontinent: Occasional.
Urine: Yellow in color.
Assistive Devices: NA.
Was catheter inserted or reinserted after admission? NA.
Who inserted the catheter? NA.
Date and time of insertion of catheter: NA.
Why did patient need a catheter? NA.
Date and time catheter was removed: NA.
Dialysis patient: No.
Kidney stones: No.

07:30 P/A (G.LEWIS, RN)

INTRAVENOUS ASSESSMENT:
IV site: Left, Forearm.
Type of IV fluids: NS.
Rate: _200__ml/hr.
Site: BLOOD AT SITE FROM INITIAL START, OTHER WISE SITE IS W/O COMPLICATIONS
Central Venous Line: NA.
Port-a-cath: NA.
PICC: NA.
Other: NA.

07:30 P/A (G.LEWIS, RN)

PAIN ASSESSMENT:
Pain Scale (0-10) 0
Frequency of pain: NA.
Description of pain: NA.
Any changes in activity r/t pain No.

07:30 P/A (G.LEWIS, RN)

WOUND ASSESSMENT:
Type of wound: WOUND TO RT HEEL IS HEALING NO DRAINAGE NOTED PT DENIES PAIN
Location: See Unisex man documentation.

18:23 P/A (G.LEWIS, RN)

NEUROLOGICAL ASSESSMENT:
Level of Consciousness:
Confused, Oriented X_1ONLY REORIENTED TO PLACE SITUATION AND TIME PT IS AWAKEN AND REPONDS TO VERBAL STIMULI BUT SEEMS TO BE VERY CONFUSED.

PROBLEMS/GOALS & EDUCATION

#2
#4

INITIAL PHYSICAL ASSESSMENT

Dressing:

06/07/09 18:27 {GRL RN} NA.

Decubitus:

06/07/09 18:27 {GRL RN} Stage 2-superficial breakdown/blisters.

Decubitus drainage:

06/07/09 18:27 {GRL RN} None.

Undermining:

06/07/09 18:27 {GRL RN} Absent.

Necrotic tissue:

06/07/09 18:27 {GRL RN} Absent.

PAIN ASSESSMENT

Pain Scale (0-10)

06/07/09 18:25 {GRL RN} 0

Pt complains of:

06/07/09 18:25 {GRL RN} No pain at this time.

Frequency of pain:

06/07/09 18:25 {GRL RN} NA.

Description of pain:

06/07/09 18:25 {GRL RN} NA.

Any changes in activity r/t pain

06/07/09 18:25 {GRL RN} No.

Pain scale:

06/07/09 18:25 {GRL RN} 0.

Pain face scale:

06/07/09 18:25 {GRL RN} Face 0-happy, no pain.

Evidence of pain:

06/07/09 18:25 {GRL RN} NONE NOTED

Non-medicinal comfort measures utilized to relieve pain:

06/07/09 18:25 {GRL RN} Back rub, Deep breathing techniques, Distraction techniques.

Response to oral pain medication:

06/07/09 18:25 {GRL RN} NA.

Response to IM pain medication:

06/07/09 18:25 {GRL RN} NA.

Response to IV pain medication:

06/07/09 18:25 {GRL RN} NA.

PSYCHOSOCIAL ASSESSMENT

Behavior Pattern:

06/07/09 18:03 {GRL RN} Confused, Disoriented.

Interaction within environment:

06/07/09 18:03 {GRL RN} Answers questions inappropriately,PT IS VERY DROWSY AND CONFUSED

Major concerns regarding hospitalization that may impact nursing care:

06/07/09 18:03 {GRL RN} None voiced.

Major life change in past year:

06/07/09 18:03 {GRL RN} None.

Support System:

06/07/09 18:03 {GRL RN} None.

Family concerns regarding hospitalization that may impact nursing care:

06/07/09 18:03 {GRL RN} None voiced.

Sleep habits:

06/07/09 18:03 {GRL RN} _6-_ hrs/night.

Recent changes in sleep pattern:

06/07/09 18:03 {GRL RN} No.

Signs/symptoms of abuse:

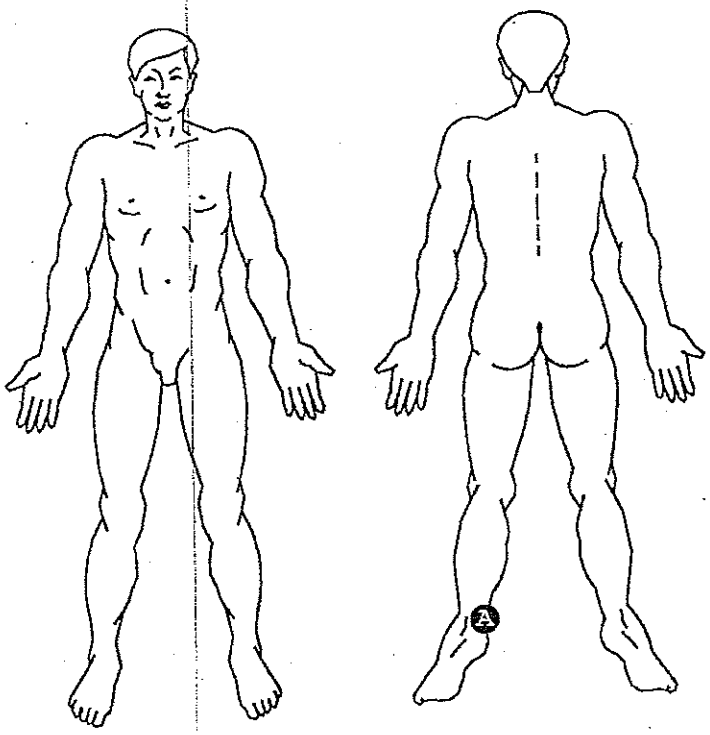
#2
#4

Nurse's signature: _____ Validated by: _____

562 MERRIFIELD WILLIAM
Location:

06/08/09 07:30 (GRL RN)

SITE A: Location:
Date First Observed:
Notes:



STAGE I : REDNESS WITHOUT A BREAK IN SKIN
DOES NOT DISAPPEAR WHEN PRESSURE IS RELIEVED

STAGE II : PARTIAL THICKNESS LOSS OF SKIN LAYERS
PRESENTING AS AN ABRASION, BLISTER OR SHALLOW CRATER

STAGE III : FULL THICKNESS OF SKIN IS LOST
EXPOSING SUBCUTANEOUS TISSUE
PRESENTS AS A DEEP CRATER
UNDERMINING TO ADJACENT TISSUE MAY OR MAY NOT BE PRESENT

STAGE IV : FULL THICKNESS OF SKIN AND SUBCUTANEOUS TISSUE IS LOST
EXPOSING MUSCLE OR BONE

#2
#4

LIBERTY REGIONAL [illegible] CENTER

INITIAL INTERVIEW

Printed: 06/07/09 18:02

MERRIFIE[illegible]VILLIAM AGE: 63 SEX: M
BANNOUT FIRAS MD ROOM: 223-A
ALLERGIES: NO KNOWN ALL M/R#: 142775

Patient Name	MERRIFIELD WILLIAM
Birth date	10/30/1945 63
Sex	M
Marital Status	S
Occupation	
Religion	NO PREFERENCE
Admit. Diag.	ALTERED MENTAL STATUS

IN AN EMERGENCY	
Name	LIBERTY CO JAIL
Relation	GUARDIAN
Address	180 PAUL SIKES RD
Phone	912/876-6411
Admitting Physician	BANNOUT FIRAS MD
Second Physician	BANNOUT FIRAS MD

PERTINENT HISTORY

WEIGHT & HEIGHT:
174 LBS 0 OZ 78.93 KG 78925.1 GM 0 INCHES (scale type unknown)

DOES PATIENT SMOKE?:
Y

ALLERGIES - DRUG:
No Known Allergies

CURRENT MEDICATIONS:

LANTUS Last Dose: 060609	Dose: 37 UNITS Compliant: N	Freq: Q HS Need Education: N	Route: SQ 06/07/09 17:37	{G.LEWIS, RN}
CARVEDILOL Last Dose:	Dose: 12.5MG Compliant: N	Freq: BID Need Education:	Route: PO 06/07/09 17:37	{G.LEWIS, RN}
XANAX Last Dose:	Dose: 1MG Compliant: N	Freq: BID Need Education: N	Route: PO 06/07/09 17:37	{G.LEWIS, RN}
CYCLOBENZAPRINE Last Dose:	Dose: 10MG Compliant: N	Freq: TID Need Education: N	Route: PO 06/07/09 17:37	{G.LEWIS, RN}
PREDISONE Last Dose:	Dose: 10MG Compliant: N	Freq: DAILY Need Education: N	Route: PO 06/07/09 17:37	{G.LEWIS, RN}
GABAPENTIN Last Dose:	Dose: 800MG Compliant: N	Freq: TID Need Education: N	Route: PO 06/07/09 17:37	{G.LEWIS, RN}

HERBAL REMENDIES/SUPPLIMENTS:
N/A. 06/07/09 17:37 {G.LEWIS, RN}

DISPOSITION OF MEDICATIONS:
Remains with patient. 06/07/09 17:37 {G.LEWIS, RN}

TIME OF ARRIVAL ON FLOOR/ADMITTING DIAGNOSES:
_1658_____. 06/07/09 17:37 {G.LEWIS, RN}

REASON FOR ADMISSION {patient's own words}:
PT STATES"HAD A LITTLE ACCIDENT" 06/07/09 17:37 {G.LEWIS, RN}

ADMITTED FROM:
Other _JAIL_____. 06/07/09 17:37 {G.LEWIS, RN}

MODE OF ARRIVAL/ACCOMPANIED BY:
Other _POLICE_CAR___ACCOMPANIED BY OFFICER 06/07/09 17:37 {G.LEWIS, RN}

PATIENT AND/OR FAMILY TEACHING RELATED TO:
Nurse call system, Siderails, ID band, Daily nursing activities, Smoking policy, Telephone/Television, Bed controls, Valuables policy. 06/07/09 17:37 {G.LEWIS, RN}

Nurse's signature: Georgia Lewis RN

#5

Liberty Regional Medical Center

MEDICATION RECONCILIATION REPORT FOR THE EMERGENCY DEPARTMENT AND FAST TRACK

Date	Time	Medication	Dose	Route	Frequency	Taken Last
		Neurontin	800mg			
		Flexeril	10mg			
		Zantac Zanax	1mg			
		Prevazone	10mg			
		Lantus	25 units			
		Coreg	12.5mg			

Attachment 1
"Medication Reconciliation"
12/1/2008

Reviewed By:

562410 RM- 142775 P/T-ER
MERRIFIELD WILLIAM M 63
LIBERTY CO JAIL HINESVILLE , GA
SIMMONS CH SIMMONS CH
06/07/09 B/D 10/30/45

#5

PTDF Pre-Trial Detention Facility

500 East Adams Street
Jacksonville,FL 32202
(904) 630-7409

Patient: MERRIFIELD, WILLIAM M
2306 SOUTHSIDE
BEAUFORT, SC 29902-0000

Age/DOB 63 yrs 30-Oct-1945
EMRN: 713772
OMRN: 713772
Home:
Work:

Results

Lab Accession # 0001
Ordering Provider: Leach,Mary
Performing Location: PTDF

Collected: 6/11/2009 4:30:00PM
Resulted: 6/11/2009 4:47:00PM
Verified By: <Verification Not Required>
Auto Verify: N

Accucheck-PTDF BD

Stage: Final

Test	Result	Units	Flag	Reference Range
In House Blood Glucose Fingerstick	284	mg/dl		
Instructions	R3			

COMPLETED
OCT 2 - 2009
TRUE COPY OF ORIGINAL MEDICAL RECORD
BY

Printed by: Espinosa, Maria P. | 9/30/2009 2:21:00PM

#7

PTDF Pre-Trial Detention Facility

500 East Adams Street
Jacksonville,FL 32202
(904) 630-7409

Patient: MERRIFIELD, WILLIAM M
2306 SOUTHSIDE
BEAUFORT, SC 29902-0000

Age/DOB 63 yrs 30-Oct-1945
EMRN: 713772
OMRN: 713772
Home:
Work:

Results

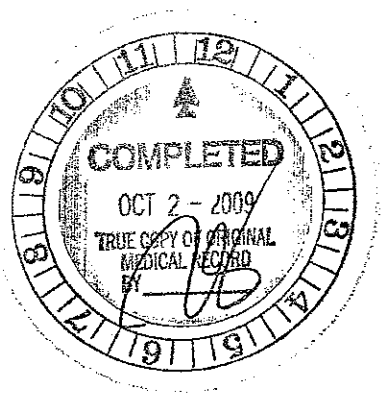
Lab Accession # 0001
Ordering Provider: Leach,Mary
Performing Location: PTDF

Collected: 6/11/2009 4:30:00PM
Resulted: 6/11/2009 4:47:00PM
Verified By: <Verification Not Required>
Auto Verify: N

Accucheck-PTDF BD

Stage: **Final**

Test	Result	Units	Flag	Reference Range
In House Blood Glucose Fingerstick	284	mg/dl		
Instructions	R3			



#7

PTDF Pre-Trial Detention Facility

500 East Adams Street
Jacksonville,FL 32202
(904) 630-7409

Patient: MERRIFIELD, WILLIAM M
2306 SOUTHSIDE
BEAUFORT, SC 29902-0000

Age/DOB 63 yrs 30-Oct-1945
EMRN: 713772
OMRN: 713772
Home:
Work:

Results

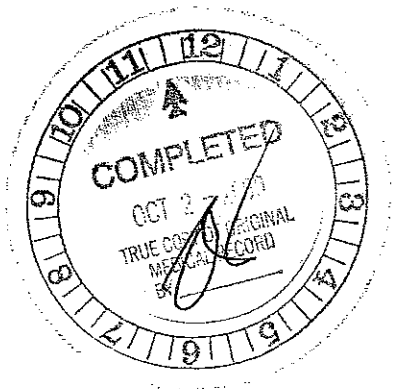
Lab Accession # 0001
Ordering Provider: Leach,Mary
Performing Location: PTDF

Collected: 6/14/2009 12:45:00PM
Resulted: 6/14/2009 12:44:00PM
Verified By: <Verification Not Required>
Auto Verify: N

PTDF In-house vital signs 1:00 PM

Stage: **Final**

Test	Result	Units	Flag	Reference Range
Blood Pressure	168/103		A	
Pulse Rate	90			
Respiration	22			
Temperature	97.6	F		
O2 Saturation	98			



PTDF Pre-Trial Detention Facility

500 East Adams Street
Jacksonville,FL 32202
(904) 630-7409

Patient: MERRIFIELD, WILLIAM M
2306 SOUTHSIDE
BEAUFORT, SC 29902-0000

Age/DOB 63 yrs 30-Oct-1945
EMRN: 713772
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Results

Lab Accession # 0001
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Auto Verify: N

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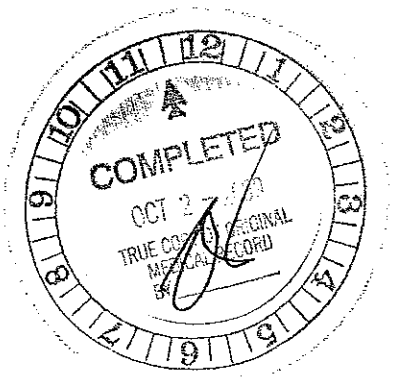
Stage: Final

Test	Result	Units	Flag	Reference Range
Blood Pressure	168/103		A	
Pulse Rate	90			
Respiration	22			
Temperature	97.6	F		
O2 Saturation	98			



#7

PTDF Pre-Trial Detention Facility

500 East Adams Street
Jacksonville,FL 32202
(904) 630-7409

Patient: MERRIFIELD, WILLIAM M
2306 SOUTHSIDE
BEAUFORT, SC 29902-0000

Age/DOB 63 yrs 30-Oct-1945
EMRN: 713772
OMRN: 713772
Home:
Work:

Results

Lab Accession # 0001
Ordering Provider: Leach,Mary
Performing Location: PTDF

Collected: 6/12/2009 4:30:00PM
Resulted: 6/12/2009 4:56:00PM
Verified By: <Verification Not Required>
Auto Verify: N

Accucheck-PTDF BD

Stage: **Final**

Test	Result	Units	Flag	Reference Range
In House Blood Glucose Fingerstick	222	mg/dl		
Instructions	R2			

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y: Espinosa, Maria P. | 9/30/2009 2:21:00PM

#7

BSHC – Worksheet for Orders
(NO MEDICATIONS ORDERS)

Schedule for:

☐ Dr. _____ Reason:

Clinical Procedures

☒ ECG – Multiple comorbids in pt - ? ACS ANLT - results?

☐ Nebulizer – Albuterol 2.5 mg every 8 hours/PRN if asthma/COPD exacerbation present
☐ Nebulizer– Ipratropium 500mg every 8 hours/PRN if asthma/COPD exacerbation present
☐ Nebulizer – Other

☐ Foot Soak daily for 5 days
☐ Staple removal in _____ days
☐ PPD (TST) implant
☐ Ice bag 3 times a day for 3 days
☐ Suture removal in _____ days
Other:

Shands Referrals

☐ CXR ☐ CT scan of _____ ☐ with contrast ☐ without contrast ☐ MRI of _____
☐ X ray of _____ ☐ Other procedure:
Reason:

Specialty Service: (indicate which one)
Reason: (Be very specific use SBAR mnemonic)

S: Situation B: Background A: Assessment R: Recommendations

Diets: ; Why not 4 diabetic diet??

☐ Regular
☐ ~~Diabetic 2800 calories~~
☒ Heart Failure Diet
☐ ~~Renal diet 60 g~~
☐ Clear Liquid Diet
☐ Diabetic diet (hs snack)
☐ Prenatal Diet
☐ Renal diet 90 g
☐ Coumadin Diet
☐ Full liquid diet
☐ Renal diet 60 g
☐ Wired jaw full liquid
☐ Diabetic 2200 calories
☐ High Calorie Diet
☐ Renal diet 70 g
Comments:

Recommendations to JSO

☐ Lower Tier Lower Bunk ☐ Indefinitively ☐ for _____ days
☐ Shaving Pass
☐ Eyeglasses
☐ Other orthoses/prostheis (Describe)
☐ Lice recommendations(isolation, new clothes/linen)
☐ Work limitations: ☐ Permanent ☐ Temporary for _____days
Describe work limitations:

☐ Unclear to transfer: ☐ Permanent ☐ Temporary for _____days

☐ Lay in for _____days
☐ C-PAP
☐ Wheelchair
☐ Scabies recommendations (isolation, new clothes/linen)

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Provider Signature: CAPD

POSMay-09v1

#9

Bay Street Health Center
Site: PTDF Pre-Trial Detention Facility
500 East Adams Street
JacksonvilleFL 32202
(904)630-7409

MERRIFIELD, WILLIAM M.
MRN: 713772 DOB: 10/30/1945 Docket # 2009024776

Screening

ITR Call:
Call to back door for: Other reason: Arrived w/ cane and urinary incont. w/ poor hygiene In summary: 63 yo Caus. male whom appears 83 y/o seen while sitting in JSO wheelchair, refusing to walk. Demanding "percocet" as "I fell about a week ago and my back is sore but I have peripheral neuropathy and I take a lot of pin pills for it." Additionally, states was recently hospitalized "at Liberty Hospital in Gainesville, FL for my nerves and my sugar." States has been using ETOH intermittently, in addition to "xanax for my nerves two times a day because my doctor said the stress of my wife having leukemia and coming here for treatments made me too nervous so I could have xanax." States is IDDM and on Lantus 35 U Q HS. Also has Hx remote AMI and new dx CHF w/ Coreg 12.5 mg rx'ed to take 1 po BID, Noted R flank lesions of varying stages of healing, but obviously resolving, in dermatone pattern, on erythematous base, w/ cluster of some resolving blisters posterior R flank ~ 4x5 cm. However, the entire region of erythema is ~ 7 X 25 cm R ant/post. flank. No current d/c noted. Pt. states he has been using prednisone 10 mg po QD for same and has 14 days tx'ment remaining. He is also using neurontin 300mg po tid for pain management but, is requesting narcotics. However, there is no facial grimmace, no other physiological s/sx's of pain @ present. Pt. now refuses to ambulate, "unless I get my percocet.' Discussed pt's previous and current functional abilities and he eventually states he was able to ambulate w/cane @ home, drive both he and his spouse here from Gainesville, and then remove their luggage from his car and take it in their temporary housing independently. Pt. advised he may cont. use of his cane and wheel chair will be returned to JSO as he can actually do harm to hmelf by self-restricting mobility/create additional health problems r/t immobility. Pt. cont. to demand "percocet and xanax." Pt. arrives w/the following med bottles (all sent to property): Prednisone 10 mg 1 po QD, Carvediol 12.5 mg 1 po BID, and Xanax 1 mg take 1 po BID, Rx'ed by Dr. Assoegi, Salvatore and # 50 filled on 6/2/09 at Publix Pharm (843-986-9658) # 20 remain in bottle, and partially full vial of Lantus insulin w/8 insulin syringes. Noticiably absent, is pt's "percocet" and he states, "they wouldn't give me a refill and I ran out." Pt. states he usually does not have urinary incont. but has taken his xanax and "I don't always clean myself after I go." Clothing soiled/dirty in appearance and appears w/poor hygiene. Placed in contact isolation, may cont. use cane, no wheelchair. Pt. inst. in sick call process and verbalized understanding of same. Speech clear, A&O X3, PERL (senile cataracts noted), EOMI. See orders and referrals.
Disposition: Patient Accepted - medically cleared

Home Medications
See summary above

Vitals
132/76, 68, 16

Signatures
Mary Leach, NP; Jun 11 2009 5:37AM (Author)

#10

Bay Street Health Center
Site: PTDF Pre-Trial Detention Facility
500 East Adams Street
JacksonvilleFL 32202
(904)630-7409

MERRIFIELD, WILLIAM M.
MRN: 713772 DOB: 10/30/1945 Docket # 2009024776

Screening

Intake - Medical:
Patient relates history of
Denies medical problems requiring immediate attention
Denies history of seizures
Denies history of asthma
Denies history of COPD
POSITIVE for history of hypertension
POSITIVE for the following heart problems:
POSITIVE for history of diabetes mellitus.
Denies history of hepatitis
Denies history of veneral diseases
Denies history of HIV
OTHER medical conditions stated by the patient include: see ITR, Patient educated about access to health care during incarceration including the Sick Call process - did he sign a paper that he understood?
Medications: SEE ITR
Substance abuse
POSITIVE for history of alcohol use.
POSITIVE for history of drug use to include
Tuberculosis history Patient denies history of treatment for Active Tuberculosis, Patient denies prior PDD (TST), States not exposure to a person diagnosed with Active tuberculosis In the last 3 weeks or more Patient denies constant cough, Patient denies history of hemoptysis, Patient denies history of chest pain wth cough Patient experiencing the following systemic symptoms patient denies history of fever, Patient denies history of night sweats, Patient denies history of feeling tired, Patient denies history of loss of appetite, Patient denies history of unwanted weigtht loss, Patient denies history of chills
Oral health screening shows denies dental pain, No current treatment for dental problems, no recent major dental procedures, No lower dentures present, No upper dentures present, not wearing dentures, not severe dental caries observed
General visual inspection of exposed areas show No skin lesions noted, no needle tracks, no pediculosis and no scabies
not currently wearing eyeglassesnot currently wearing contact lenses
Activities of Daily Living difficulty walking unassisted, Patient describe the following work limitations, but self-reliant in usual daily activities, no prosthetic devices, no splint, no crutches, no cast, no brace(s), no deafness/mute, cognitive functioning normal. Not legally blind
General behavior of patient during interview: was cooperative, was not hostile, was not elated, was not depressed, was not tearful
Health Insurance(s) No insurance
Disposition Referred to: Chronic Care, Infection Control Nurse, WITHDRAWALS
Placement Contact Isolation, Lower Tier Lower Bunk - what floor? how close to clinic?

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Vitals
Vital Signs [Filter Applied : Last 5 Entries]
11Jun2009 06:00AM
Height Weight BMI BSA
BMI Calculated: 21.62
Height Weight BMI BSA

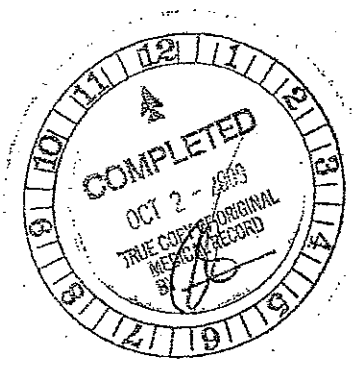
10

BSA Calculated: 1.89
Height Weight BMI BSA
Height: 71in
Height Weight BMI BSA
Weight: 155lb ---- Check Liberty Medical records - Why is the weight 155 in all his records?
Blood Pressure
Blood Pressure: 132/82
Temperature
Temperature: 95.9F
Pulse
Heart Rate: 109
O2 Saturation
O2 Saturation: 99
Whole Blood Finger Stick
In House Blood Glucose Fingerstick: 173mg/dl

Allergies
Medication
No Known Drug Allergies

Assessment
Assessed
Visit For: Multiphasic Screening Exam V82.6

Signatures
Amanda Richards, ; Jun 11 2009 6:04AM (Author)
Mary Leach, NP; Jun 11 2009 8:43AM (Author)



BSHC – Worksheet for Orders
(NO MEDICATIONS ORDERS)

Patient: Merrifield, William **Docket Number** 2009024776

Provider: (type name) Leach, ARNP **Date:** 6/10/09 0615

Instructions: Provide a diagnosis for every order. For laboratory indicate the provider receiving the report.
ENTER MEDICATIONS DIRECTLY IN THE ELECTRONIC HEALTH RECORDS.

Laboratory In-House: ---------- Diagnosis:

☐ Urinalysis ☐ Pregnancy test ☐ Strep test ☐ FOB x3 ☐ INR/PT

To be Done: ☐ Today ☐ _____

Report to:

Laboratory Shands: ---------- Diagnosis:

☒ Diabetes baseline (HgA1c) ☐ HIV baseline (CD4, VL, CBC) ☐ Prenatal profile ☐ Dilantin level baseline

☐ Mental Health metabolic panel (Gluc,FLP,TSH) ☒ Diabetes Profile (TSH, Alb/Cr urine, BMP, FLP) ☐ Diabetes Annual (Alb/Cr urine)

☐ Other: (Indicate priority, When to be done, Report to)

☐ Biopsy. Site: Clinical Data/Diagnosis:

☐ PAP smear: Prior date: ☐ Abnormal ☐ Normal ☐ Unknown ☐ LMP

Protocols (EXCLUDE MEDICATIONS)

☐ Benzo-withdrawal Protocol (If benzo taper was ordered) (Vital Signs daily for 5 days, Chart Alert: Unclear to transfer while on benzo tx)

☐ Diabetes Protocol (If patient started on insulin) (HbA1c baseline, and accucheck BID for 90 days)

☐ ETHO Withdrawal Protocol (If Librium or Klonopin started) (Lower tier, lower bunk, VS daily x 5 d, Chart Alert: Unclear to transfer while on tx)

☐ HIV Protocol (TST implant, CXR if not done within last 3 months, Referral to ID, CD4, Viral Load and CBC)

☐ LTBI-TB Protocol (Referral to ICN, TST implant, CXR if not done within last 6 months)

☒ Opiod Protocol (If patient started on meds) (Lower Tier, Lower Bunk, VS daily x 5d, Chart Alert: Unclear to transfer while on tx)

☐ Prenatal protocol (Referral to Shands, Prenatal profile, prenatal diet. If more than 7 months chart alert not to transfer, and lower tier/bunk)

Vital Signs: ----- Diagnosis: CHF, HTN, Polysubs. Abuse, Physical Deconditioning

☐ Once a day for 3 days ☐ Once a day for 5 days (Recommended for potential withdrawal)

☒ Twice a day for 5 days (Recommended for severe withdrawals)

☐ In 3 days and weekly times two (Recommended for mild to moderate elevated BP readings on asymptomatic patients)

☐ Once a week for two weeks (Recommended for h/o of HTN no meds and normal BP readings)

☐ For 3 days and reevaluate (Recommended for initiation of tx and/or change of medication on patients with significant HTN)

☐ Other (Justify)

☐ Report if SBP>160 or <90 BDP >120 or <60 HR>110 or <50 RR>25 or <15 Temp >100.3 SpO2 <95%

Accuchecks (Whole Blood Finger-stick blood sugar)

☐ Fasting in 48 hours and in 7 days (Recommended for h/o of DM no meds and BS level WNL)

☐ Daily fasting for 90 days (Recommended for patients only on long acting insulin – i.e. Lantus or patients on oral hypoglycemics)

☐ Three times fasting a week for 90 days (Recommended for patients only on oral hypoglycemics, BS readings acceptable)

☒ Before breakfast and dinner for 90 days (Recommended for patients on Insulin combinations)

☐ Two times a week fasting for 90 days (Recommended for patients on oral hypoglycemics well controlled)

☐ Once a week fasting for 90 (Recommended for patients on oral hypoglycemics very well controlled)

☐ Other (Justify)

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Wound Care ---- Diagnosis/Site:

☐ Wound Care Once a day for 7 days

☐ Wound Care twice a day for 7 days

☒ Evaluate by Wound Care Nurse

☒ Wound care Other (Justify) qd till healed. Pt. c/o HSV (Shingles)

☐ Refer if signs/symptoms of infection

Instructions:

Internal Referrals

☒ Chronic Care ☐ Critical Care ☐ Infectious Disease ☒ Infection Control Nurse - Shingles

☒ Wound Care - Shingles ☐ TEAS symptomatic ☐ TEAS by patient request ☐ Transition Team

☐ Mental Health ☐ Dental

Reason:
CHF, HTN, IDDM, Peripheral Neuropathy, Shingles, Polysubs Abuse

Provider Signature: _____

POSMay-09

#11

William Merrifield

Vital Signs

Vital Signs Taken

Date	Time	Blood Pressure	Respiration	Temperature	Pulse	O2 Saturation
11-Jun	5:37 a.m.	X	X		X	
	6:04 a.m.	X		X	X	X
	2:57 p.m.	X	X		X	X
12-Jun	10:30 a.m.	X	X		X	X
	10:24 p.m.	X	X	X	X	X
13-Jun	3:48 p.m.	X	X	X	X	X
	11:00 p.m.	X	X		X	X
14-Jun	4:14 a.m.	X	X		X	
	12:45 p.m.	X	X	X	X	X
	10:02 p.m.	X	X		X	
15-Jun	10:01 a.m	X	X	X	X	
	4:30 p.m.	X	X		X	
	9:33 p.m.	X	X			
16-Jun	11:14 p.m.	X	X	X	X	X
17-Jun	10:07 p.m.	X	X	X	X	X
18-Jun	9:00 a.m.	X	X	X	X	X
	10:26 p.m.	X	X	X	X	X
19-Jun	10:50 p.m.	X	X	X	X	X
20-Jun	4:41 p.m.	X	X	X	X	X
21-Jun	4:42 p.m.	X				

O VITAL SIGNS TAKEN AFTER 6/21/09

###
= 20

William Merrifield

Blood Sugar

Date	Time	Blood Sugar mg/dl	Lantus
6/11/2009	6:04 a.m.	173	
	2:57 p.m.	284	
6/12/2009	10:30 a.m.	216	
	4:30 p.m.	222/279	
6/13/2009	3:04 a.m.	173	
	4:00 a.m.	227	
	8:47 p.m.	333	
6/14/2009	4:00 a.m	140	
	5:15 p.m.	312	
6/15/2009	4:00 a.m	94	L-20
	4:30 p.m.	118	
6/16/2009	No detail	129	L-20
	4:30 p.m.	95	
6/17/2009	did not show		
	4:30 p.m.	158	
6/18/2009	5:24 a.m.	215	L-20
	9:00 a.m.	52	
	no detail	221	
	3:50 p.m.	Used morning VS	
6/19/2009	4:35 a.m.	60	
	1:30 p.m.	163	
	4:30 p.m.	160	
6/20/2009	5:19 a.m.	160	L-20
	4:41 p.m.	Used 6/18/09 results of 52	
	5:12 p.m.	114	
6/21/2009	7:29 a.m.	128	L-20
	4:00 p.m.	190	
6/22/2009	4:00 a.m.	163	L-20
	4:00 p.m.	76	
6/23/2009	4:46 a.m.	80	L-20
	12:15 p.m.	56	
	1:00 p.m.	62	
	1:15 p.m.	75	
	4:30 p.m.	176	
6/24/2009	4:00 a.m.	67	
	11:50 a.m.	56	

#14
#11
#12

Bay Street Health Center
Site: PTDF Pre-Trial Detention Facility
500 East Adams Street
JacksonvilleFL 32202
(904)630-7409

-was he given all medications he came in with?

MERRIFIELD, WILLIAM M.
MRN: 713772 DOB: 10/30/1945 Docket # 2009024776

Screening

ITR Call:
Call to back door for: Other reason: Arrived w/ cane and urinary incont. w/ poor hygiene In summary: 63 yo Caus. male whom appears 83 y/o seen while sitting in JSO wheelchair, refusing to walk. Demanding "percocet" as "I fell about a week ago and my back is sore but I have peripheral neuropathy and I take a lot of pin pills for it." Additionally, states was recently hospitalized "at Liberty Hospital in Gainesville, FL for my nerves and my sugar." States has been using ETOH intermittently, in addition to "xanax for my nerves two times a day because my doctor said the stress of my wife having leukemia and coming here for treatments made me too nervous so I could have xanax." States is IDDM and on Lantus 35 U Q HS. Also has Hx remote AMI and new dx CHF w/ Coreg 12.5 mg rx'ed to take 1 po BID, Noted R flank lesions of varying stages of healing, but obviously resolving, in dermatone pattern, on erythematous base, w/ cluster of some resolving blisters posterior R flank ~ 4x5 cm. However, the entire region of erythema is ~ 7 X 25 cm R ant/post. flank. No current d/c noted. Pt. states he has been using prednisone 10 mg po QD for same and has 14 days tx'ment remaining. He is also using neurontin 300mg po tid for pain management but, is requesting narcotics. However, there is no facial grimmace, no other physiological s/sx's of pain @ present. Pt. now refuses to ambulate, "unless I get my percocet.' Discussed pt's previous and current functional abilities and he eventually states he was able to ambulate w/cane @ home, drive both he and his spouse here from Gainesville, and then remove their luggage from his car and take it in their temporary housing independently. Pt. advised he may cont. use of his cane and wheel chair will be returned to JSO as he can actually do harm to hmelf by self-restricting mobility/create additional health problems r/t immobility. Pt. cont. to demand "percocet and xanax." Pt. arrives w/the following med bottles (all sent to property): Prednisone 10 mg 1 po QD, Carvediol 12.5 mg 1 po BID, and Xanax 1 mg take 1 po BID, Rx'ed by Dr. Assoegi, Salvatore and # 50 filled on 6/2/09 at Publix Pharm (843-986-9658) # 20 remain in bottle, and partially full vial of Lantus insulin w/8 insulin syringes. Noticiably absent, is pt's "percocet" and he states, "they wouldn't give me a refill and I ran out." Pt. states he usually does not have urinary incont. but has taken his xanax and "I don't always clean myself after I go." Clothing soiled/dirty in appearance and appears w/poor hygiene. Placed in contact isolation, may cont. use cane, no wheelchair. Pt. inst. in sick call process and verbalized understanding of same. Speech clear, A&O X3, PERL (senile cataracts noted) EOMI. See orders and referrals.
Disposition: Patient Accepted - medically cleared

Needed wheelchair for anything further than a room or two distance

Home Medications
See summary above

Vitals
132/76, 68, 16

Signatures
Mary Leach, NP; Jun 11 2009 5:37AM (Author)

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BY

- did they make any attempt to locate and contact his wife?
- did they contact Liberty Hospital for his records? Library had his wife's contact info.

#14

For U.S. Residents Only

LANTUS
insulin glargine [rDNA origin] injection

Important Safety Information for Lantus®

Do not take Lantus® if you are allergic to insulin or any of the inactive ingredients in Lantus®.

You must test your blood sugar levels while using insulin, such as Lantus®. Do not make any changes to your dose or type of insulin without talking to your healthcare provider. Any change of insulin should be made cautiously and only under medical supervision.

Do NOT dilute or mix Lantus® with any other insulin or solution. It will not work as intended and you may lose blood sugar control, which could be serious. Lantus® must only be used if the solution is clear and colorless with no particles visible. **Do not share needles, insulin pens or syringes with others.**

The most common side effect of insulin, including Lantus®, is low blood sugar (hypoglycemia), which may be serious. Some people may experience symptoms such as shaking, sweating, fast heartbeat, and blurred vision. Severe hypoglycemia can be dangerous and can cause harm to your heart or brain. It may cause unconsciousness, seizures, or death. Other possible side effects may include injection site reactions, including changes in fat tissue at the injection site, and allergic reactions, including itching and rash. In rare cases, some allergic reactions may be life threatening.

Tell your doctor about other medicines and supplements you are taking because they can change the way insulin works. Before starting Lantus®, tell your doctor about all your medical conditions including if you have liver or kidney problems, are pregnant or planning to become pregnant, or are breast-feeding or planning to breast-feed.

Indications and Usage

Prescription Lantus® is a long-acting insulin used to treat adults with type 2 diabetes and adults and children (6 years and older) with type 1 diabetes for the control of high blood sugar. It should be taken once a day at the same time each day to lower blood glucose.

Do not use Lantus® to treat diabetic ketoacidosis.

Lantus® SoloSTAR® is a disposable prefilled insulin pen.

Click here for additional important information for Lantus®.

Click here for information on Sharps Medical Waste Disposal.

Click here for information on drug anti-counterfeiting.

The health information contained herein is provided for general educational purposes only. Your healthcare professional is the single best source of information regarding your health. Please consult your healthcare professional if you have any questions about your health or treatment.

#14

LANTUS®

Prescribing Information

(insulin glargine [rDNA origin] injection)

Rx only

HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use LANTUS safely and effectively. See full prescribing information for LANTUS.

LANTUS (insulin glargine [rDNA origin] injection) solution for subcutaneous injection
Initial U.S. Approval: 2000

INDICATIONS AND USAGE

LANTUS is a long- acting human insulin analog indicated to improve glycemic control in adults and children with type 1 diabetes mellitus and in adults with type 2 diabetes mellitus. (1)
Important Limitations of Use:

- Not recommended for treating diabetic ketoacidosis. Use intravenous, short-acting insulin instead.

DOSAGE AND ADMINISTRATION

- The starting dose should be individualized based on the type of diabetes and whether the patient is insulin-naïve (2.1, 2.2, 2.3)
- Administer subcutaneously once daily at any time of day, but at the same time every day. (2.1)
- Rotate injection sites within an injection area (abdomen, thigh, or deltoid) to reduce the risk of lipodystrophy. (2.1)
- Converting from other insulin therapies may require adjustment of timing and dose of LANTUS. Closely monitor glucoses especially upon converting to LANTUS and during the initial weeks thereafter. (2.3)

DOSAGE FORMS AND STRENGTHS

Solution for injection 100 units/mL (U-100) in

- 10 mL vials
- 3 mL cartridge system for use in OptiClik (Insulin Delivery Device)
- 3 mL SoloStar disposable insulin device (3)

CONTRAINDICATIONS

#14

*Sections or subsections omitted from the full prescribing information are not listed

BACK TO TOP

FULL PRESCRIBING INFORMATION

1. INDICATIONS AND USAGE

LANTUS is indicated to improve glycemic control in adults and children with type 1 diabetes mellitus and in adults with type 2 diabetes mellitus.

Important Limitations of Use:

- LANTUS is not recommended for the treatment of diabetic ketoacidosis. Intravenous short-acting insulin is the preferred treatment for this condition.

BACK TO TOP

2. DOSAGE AND ADMINISTRATION

2.1 Dosing

LANTUS is a recombinant human insulin analog for once daily subcutaneous administration with potency that is approximately the same as the potency of human insulin. LANTUS exhibits a relatively constant glucose-lowering profile over 24 hours that permits once-daily dosing.

LANTUS may be administered at any time during the day. LANTUS should be administered subcutaneously once a day at the same time every day. The dose of LANTUS must be individualized based on clinical response. Blood glucose monitoring is essential in all patients receiving insulin therapy.

Patients adjusting the amount or timing of dosing with LANTUS, should only do so under medical supervision with appropriate glucose monitoring *[see Warnings and Precautions (5.1)*.]

In patients with type 1 diabetes, LANTUS must be used in regimens with short-acting insulin.

The intended duration of activity of LANTUS is dependent on injection into

#14

Bay Street Health Center
Site: PTDF Pre-Trial Detention Facility
500 East Adams Street
JacksonvilleFL 32202
(904)630-7409

-was he continued to be given all medications he came in with?

MERRIFIELD, WILLIAM M.
MRN: 713772 DOB: 10/30/1945 Docket # 2009024776

Screening

ITR Call:
Call to back door for: Other reason: Arrived w/ cane and urinary incont. w/ poor hygiene In summary: 63 yo Caus. male whom appears 83 y/o seen while sitting in JSO wheelchair, refusing to walk. Demanding "percocet" as "I fell about a week ago and my back is sore but I have peripheral neuropathy and I take a lot of pin pills for it." Additionally, states was recently hospitalized "at Liberty Hospital in Gainesville, FL for my nerves and my sugar." States has been using ETOH intermittently, in addition to "xanax for my nerves two times a day because my doctor said the stress of my wife having leukemia and coming here for treatments made me too nervous so I could have xanax." States is IDDM and on Lantus 35 U Q HS. Also has Hx remote AMI and new dx CHF w/ Coreg 12.5 mg rx'ed to take 1 po BID, Noted R flank lesions of varying stages of healing, but obviously resolving, in dermatone pattern, on erythematous base, w/ cluster of some resolving blisters posterior R flank ~ 4x5 cm. However, the entire region of erythema is ~ 7 X 25 cm R ant/post. flank. No current d/c noted. Pt. states he has been using prednisone 10 mg po QD for same and has 14 days tx'ment remaining. He is also using neurontin 300mg po tid for pain management but, is requesting narcotics. However, there is no facial grimmace, no other physiological s/sx's of pain @ present. Pt. now refuses to ambulate, "unless I get my percocet.' Discussed pt's previous and current functional abilities and he eventually states he was able to ambulate w/cane @ home, drive both he and his spouse here from Gainesville, and then remove their luggage from his car and take it in their temporary housing independently. Pt. advised he may cont. use of his cane and wheel chair will be returned to JSO as he can actually do harm to hmelf by self-restricting mobility/create additional health problems r/t immobility. Pt. cont. to demand "percocet and xanax." Pt. arrives w/the following med bottles (all sent to property): Prednisone 10 mg 1 po QD, Carvediol 12.5 mg 1 po BID, and Xanax 1 mg take 1 po BID, Rx'ed by Dr. Assoegi, Salvatore and # 50 filled on 6/2/09 at Publix Pharm (843-986-9658) # 20 remain in bottle, and partially full vial of Lantus insulin w/8 insulin syringes. Noticiably absent, is pt's "percocet" and he states, "they wouldn't give me a refill and I ran out." Pt. states he usually does not have urinary incont. but has taken his xanax and "I don't always clean myself after I go." Clothing soiled/dirty in appearance and appears w/poor hygiene. Placed in contact isolation, may cont. use cane, no wheelchair. Pt. inst. in sick call process and verbalized understanding of same. Speech clear, A&O X3, PERL (senile cataracts noted), EOMI. See orders and referrals.
Disposition: Patient Accepted - medically cleared

Needed wheelchair for anything further than a room or two distance

Home Medications
See summary above

Vitals
132/76, 68, 16

Signatures
Mary Leach, NP; Jun 11 2009 5:37AM (Author)

COMPLETED
OCT 2 2009
TRUE COPY OF ORIGINAL MEDICAL RECORD
BY

- did they make any attempt to locate and contact his wife?
- did they contact Liberty Hospital for his records & Liberty had his wife's contact info.

#18

PHYSICAL ASSESSMENT

06/08/09

20:13 P/A (D.GOODRUM, RN)

NORMAL STATEMENT:
I received report from GEORGIA_____ utilizing the patient's MED and 24 Hour Summary. I had the opportunity to ask questions via face-to-face. I agree with the initial assessment with the exception of: Injury risk. Cardiovascular. Pulmonary. Neurological. Gastrointestinal. Genitourinary. Intravenous. Pain.

20:13 P/A (D.GOODRUM, RN)

INJURY RISK ASSESSMENT:
ADLs: Needs assistance, Ambulating assistance, Dressing/Grooming assistance. Toileting assistance.
Ambulatory status: Unsteady, Staff assists, Uses assistive device.
Assistive Devices: Cane.
Side rails up for bed mobility: Left, Right, Top, Up.
Call bell within reach: Yes.
Bed in low position: Yes.
Non-skid shoes on patient's feet? No.
Is lighting dimmed for ambulation? No.
Is safety equipment in place? Increased bed checks.
Arm band is on patients wrist and labeled properly: Yes.

20:13 P/A (D.GOODRUM, RN)

CARDIOVASCULAR ASSESSMENT:
Chest pain: NO SIGNS OF
Peripheral Pulses: Full, strong, and symmetrical, Right, Left, Radial, Dorsalis pedis.
Jugular Vein: Flat at a 45 degree angle.
Homan's Sign: Negative.
Ascultation: S1, S2, Regular.
Rate: _89___beats per minute.
Bruit: Absent.
Atrial Rhythms(see strip): NSR.
Junctional or Ventricular Rhythms: PVC'S less than 6/min.

20:13 P/A (D.GOODRUM, RN)

PULMONARY ASSESSMENT:
Was patient admitted with pneumonia? No.
Quality of Respirations: Regular, Unlabored.
Rate: _20_____ breaths per minute.
Right Upper Lobes: Clear.
Left Upper Lobes: Clear.
Right Lower Lobes: Clear.
Left Lower Lobes: Clear.
Cough: None.
Nail: Pale.
Capillary Refill: Less than 3 seconds.
Airway: Patent.
Oxygen: Nasal cannula.
Flow Rate: 2 liters
Pulse Oximeter: _98___% saturation.

20:13 P/A (D.GOODRUM, RN)

NEUROLOGICAL ASSESSMENT:
Level of Consciousness: Oriented X_2___, Drowsy, RESPONDS TO NAME AND TOUCH

#18

First Appearance:	Continued:	Continued:	Continued: 6/24	Continued: (2) 23 Arr.
Continued:	Continued:	Continued:	Continued:	Continued:

Arrest And Booking Report
Jacksonville Sheriff's Office
Jacksonville Florida

ADULT

Yr: 2009 Incident # FHPG09020122 Amend #
Jail # 2009024776 6/11/2009 02:06 File Direct: YES
Court: County
JSO ID #
SSN OBTS #
Day/Date/Time Arrested: Thursday 6/11/2009 00:12

Arresting Agency: FHP
Name: MERRIFIELD, WILLIAM M I
Aliases:
Nickname(s):
Subject's Home Address: 2306 SOUTHSIDE Apt./Lot #: 6F
City: BEAUFORT State: SOUTH CAROLINA Zip: 29902
Race: WHITE Sex: Male DOB: 10/30/1945 Age: 63 Eye Color: GRAY
Hair Color: GRAY/SALT & PEPPER Complexion: PALE Height: 5' 8" Weight: 180 Build: Thin
Drivers License # 011355217 State: SOUTH CAROLINA Subject's Resident Type: OUT OF STATE
Hm Phone # Bus. Phone # Phone Ext.
Subject's Residence Status: NON-RESIDENT Armed With:
Distinguishing Marks:
Employer: UNKNOWN Place of Birth: UNKNOWN UNKNOWN UNKNOWN
School Last Attended: UNKNOWN

Sub-Sector of Arrest: 6/11/09 PM
Sub-Sector of Residence: OJ
OC deployed prior to/during Arrest: NO
How long in Jax:
Arrest Made On: OV
US Citizen: YES

19 JSF CDK

Domestic Violence Involved: NO Children under 18 Present: If No is it Domestic Related: NO
Day/Date/Time of Incident-From: Wednesday 6/10/2009 22:49 Day/Date/Time of Incident-To: Wednesday 6/10/2009 22:49
Incident Address: I 95 S Apt./Lot #:
Offense Location Type: Interviewed by:
Where Arrested: I 95 S Apt./Lot #:
Involved in Traffic Accident: YES Injuries from Accident: Is Incident Gang Related: NO Is Arrestee a Gang member? NO

Statute or Ordinance Number(s): 6/11/2009-02:02
#1 Statute No: 322.34(1) Degree: MV UCR Code: 540A Attempt Code: Commit
DRIVING WHILE DL SUSP, CANL, OR REV. (UNKNOWINGLY)
Warrant Type: Not Applicable
Citation # SA# 09GT64078
Capias/Warrant # Case # CT. Location/Div.: No. of Counts:
Jurisdiction: Judge:
Bond Amount: $. Date of Issue: Date of Return: Disposition Date:
Disposition:

Blanket Bond:

ADDITIONAL INFORMATION 1 Reporting Officer: FHP 8600
MR MERRIFIELD WAS INVOLVED IN ACCIDENT ON SR 9 (I-95). DRIVER'S LICENSE IN THE STATE OF SOUTH CAROLINA AND THE STATE OF NEW YORK REVEALS THAT DL IS SUSPENDED. MR MERRIFIELD WAS ARREST AND TAKEN TO THE COUNTY JAIL

ENTERED 6/12

Transported By: FHP #8600
Arresting Officer(s) #1: FHP #8600
Div/Zone or Unit:

Approving Supervisor: FHP #8600
#2: #0
# of Cases Cleared:

State of Florida, County of Duval

Arresting / Transporting Officer's Signature: _____

Sworn to (or affirmed) and subscribed before me this_____day of _____, 20 ___, by

Personally Known ____ or Produced Identification ____ Type of Identification produced: _____

Print,Type, or Stamp, Commissioned name of Notary Public

Signature of Notary - State of Florida Certified Law Enforcement Officer or Corrections Officer:

Drug Activity: NOT APPLICABLE
Alcohol Related: NO ONE USING

Drug Type: NOT APPLICABLE
Drug Related: NO ONE USING

Jail Information (Back Door)

Jail # 2009024776

Date and Time Admited: 6/11/2009 02:06
Juvenile/Court Clerk #

Triage Questions:

Involved in Traffic Accident: YES Injuries from Accident:
OC deployed prior to/during Arrest: NO Was a hobble restraint used on the arrestee? NO
Does the arrestee exhibit any signs of suicidal behavior or attempts? NO Does the arrested have any observable medical/mental health problems? NO
Has the arrestee shown any escape potential or violence propensity behaviors? NO
Is there any other information about the arrestee that jail personnel need to know? YES
If yes, what? CAN HARDLY WALK AND TAKES MEDS

Part II of Arrest And Booking Report:

Arrestee Personal Information:

Special Needs:

SOCIAL SECURITY #	OBTS #
Corrected Name of Suspect:	Corrected DOB:
Place of Birth:	Religion:
Height: / Weight: / Build:	Defense Attorney:
Marital Status:	Length of Present Employment: Yrs. Months
Education (# of years)	Occupation:
Employer:	How long in Jax. / Local Prior Arrests:
Employer Address:	Relationship:
Next of Kin, Name:	
Next of Kin Address & Ph # :	

Admission Officer ID #: K.N.GAINES #5599	Searching Officer ID #:
Property Officer ID #:	Fingerprinting Officer ID #:
Booking Officer ID #:	Date &Time Booked:
Arraignment:	Trial:

DATE & TIME	DATE, TIME AND SIGN ALL ENTRIES
	NPO ex
6/25/09 1250	Spoke w/ TSO. They are working on getting in touch with family. They would call us soon they get the info. Kate 6651
25 Jun 09 0115	PCXR Order #50 put down for ex
6/25/09 0225	PCXR done #75 AI RT(R)
6-25-09 0600	PCXR in AM #47 REG vent OM RTC
6.25.09 1245 PM	2D echo done SOT
6.25.09 4:20 pm	2D echo w contrast done. SOT

Shands Jacksonville

Form # 120015
Page 1 of 2
Approved: 07/00
Revised: 06/06

MERRIFIELD, WILLIAM M
Unit # 13895767 IM MCU
Acct # 0917500942 ADM:06/24/09
DOB: 10/30/45 63Y M

#20

DATE & TIME	DATE, TIME AND SIGN ALL ENTRIES
6/25/09	MICU PM note
1430	S: UOP ↓ 0800-1000 (10/hr). ↑ Dobut + IVF bolus c good response. 1 melanotic BM. 0 since.
	O: BP 90-120 / 50-100 P90-100 R 20 T99.5 5L+ 100%
	PE unchanged from AM x pt opens eyes to painful stimuli
	8.9→8.8→7.5 / 150/225/178 Cortisol 35.9 LA 2.3↓3.3
	(Alb 1.7) 142/117/54 / 4.3/16/2.05/17 Ca 8.3 Phos 3.2 Urine Ag ⊖
	LFT: AP 73, Alt 21, AST 37 Lipase 5
	A/P: 63 y/o WM, unk PMH, Presented c AMS s/p intubation
	① Neuro - ↓ sedation + still mm responsive. Monitor
	② CV - Dobutamine @ 7.5 - Cards says not cardiogenic shock or NSTEMI. SBP stable 100-110s Echo ⊖
	③ Pulm - on vent. PS: 15/5/50% Cont to monitor
	④ GI - Pt c 2 large melanotic stools, will monitor. NG lavage ⊖ x 2.
	⑤ Heme - Hgb 7.5 (from 11→8→7.5). Monitor + consider transfusion if Sx or further bleeding
	⑥ Social - Beverly trying to find family. Still full code by default
	6849 (SMOLE)

Physicians Progress Notes

Shands Jacksonville

Form # 120015
Page 1 of 2
Approved: 07/06
Revised: 06/06

MERRIFIELD, WILLIAM M
Unit # 13895767 IM MCU
Acct # 0917500942 ADM: 06/24/09
DOB: 10/30/45 63Y M

#20

ALLSCRIPTS
Inform. Connect. Transform.

Chart Print Separator Page

Patient: **MERRIFIELD, WILLIAM M**

MRN: **713772**

Organization: **Bay Street HealthCenter**

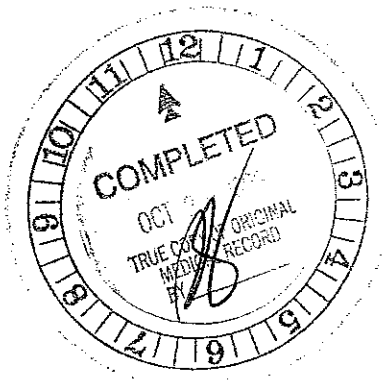
View: **All by Section by Sub-Section**

Group: **SECTIONNAME**

Screening

Sub Group: **SUBSECTIONNAME**

Mental Health



Printed: 9/30/2009 2:20:00PM

By: Espinosa, Maria P.

#21

Bay Street Health Center
Site: PTDF Pre-Trial Detention Facility
500 East Adams Street
JacksonvilleFL 32202
(904)630-7409

MERRIFIELD, WILLIAM M.
MRN: 713772 DOB: 10/30/1945 Docket # 2009024776

Screening
Mental Health Screening:
Patient denies major depression, denies bipolar disorder, denies schizophrenia, denies hospitalization due to psychiatric problems, denies using psychotropics, denies coming from a State Hospital, denies coming from prison with psychotropics, denies association with the ACT or FACT team and denies current hallucinations
The patient seems not hallucinating, not restless, not agitated, not loud, cooperative, not hostile, not aggressive, speaking normal tone and speed and coherent
Self harm screening shows patient denies recent overdose with any medication, patient denies recent experience of loss of job or significant family member or friend, patient denies history of prior attempted suicide and patient denies thinking about suicide
In addition denies history of sex offenses, denies history of violent behavior and denies history of victimization

Assessment
Assessed
Visit For: Multiphasic Screening Exam V82.6

Signatures
Amanda Richards, ; Jun 11 2009 6:05AM (Author)
Karen Mccarthy, R.N.; Jun 11 2009 6:42AM (Author)

P21

INITIAL INTERVIEW

VALUABLES/ASSISTIVE DEVICES/DURABLE EQUIPMENT: 06/07/09 17:37 {G.LEWIS, RN}
CELL PHONE AND CHARGER 1 PAIR OF SNEAKERS.

SOURCE OF PATIENT DATA: 06/07/09 17:37 {G.LEWIS, RN}
Patient.

CONTACT IN CASE OF EMERGENCY: 06/07/09 17:37 {G.LEWIS, RN}
PT WAS UNABLE TO RECALL CONTACT INFO

ADVANCED DIRECTIVE: 06/07/09 17:37 {G.LEWIS, RN}
No, Unknown.

MEDICAL HISTORY: 06/07/09 17:37 {G.LEWIS, RN}
Diabetes Mellitus.

MEDICAL HISTORY {continued}: 06/07/09 17:37 {G.LEWIS, RN}
Arthritis, Mental Disorders.

HAVE YOU RECEIVED THE INFLUENZA OR PNEUMOCOCCAL VACCINES? 06/07/09 17:37 {G.LEWIS, RN}
PT STATES YES HOWEVER PT IS SLIGHTLY CONFUSED AND DISORIENTED

SIGNIFICANT FAMILY HISTORY: 06/07/09 17:37 {G.LEWIS, RN}
PT DID NOT ANSWER FAMILY QUESTIONS APPROPRIATLY D/T CONFUSION

HAVE YOU RECENTLY BEEN EXPOSED TO ANY COMMUNICABLE DISEASES?: 06/07/09 17:37 {G.LEWIS, RN}
No.

LAST HOSPITALIZATION: 06/07/09 17:37 {G.LEWIS, RN}
2008 R/T FALL AT HOME IN SOUTH CAROLINA

PAST SURGICAL HISTORY {year}: 06/07/09 17:37 {G.LEWIS, RN}
None.

ALCOHOL USE: 06/07/09 17:37 {G.LEWIS, RN}
PT STATES HAS DRANK BOTH BEER AND ALCOHOL ALL HIS LIFE WHENEVER HE LIKES NO SPECIFICS GIVEN 06/07/09 17:37 {G.LEWIS, RN}

RECREATIONAL DRUG USE: 06/07/09 17:37 {G.LEWIS, RN}
No.

TOBACCO USE: 06/07/09 17:37 {G.LEWIS, RN}
Yes 1/2 PACK DAILY

SMOKING CESSATION EDUCATION/INFORMATION: 06/07/09 17:37 {G.LEWIS, RN}
Smoking cessation education given..

POTENTIAL BARRIERS TO CARE: 06/07/09 17:37 {G.LEWIS, RN}
Impaired mobility.

SPIRITUAL BELIEFS THAT MAY IMPACT CARE: 06/07/09 17:37 {G.LEWIS, RN}
No.

CULTURAL OR ETHICAL BELIEFS THAT MAY IMPACT CARE: 06/07/09 17:37 {G.LEWIS, RN}
No.

FINANCIAL ISSUES THAT MAY IMPACT CARE: 06/07/09 17:37 {G.LEWIS, RN}
No.

LEARNING ASSESSMENT: 06/07/09 17:37 {G.LEWIS, RN}
Of patient, Exhibits ability to grasp concepts, Responds to questions. 06/07/09 17:37 {G.LEWIS, RN}
Understands admitting diagnosis.

READINESS TO LEARN AND STRESS LEVEL ASSESSMENT: 06/07/09 17:37 {G.LEWIS, RN}
Uninterested.

TEACHING METHOD CODES: 06/07/09 17:37 {G.LEWIS, RN}
Explanation.

RESPONSE TO TEACHING: 06/07/09 17:37 {G.LEWIS, RN}
Needs reinforcement.

CURRENT DIET: 06/07/09 17:37 {G.LEWIS, RN}
Other_DIABETIC_DIET_____.

HIGH NUTRITIONAL RISK FACTORS: 06/07/09 17:37 {G.LEWIS, RN}
Glucose level >300 or IDDM <75.

Nurse's signature: G Lewis RN

#21

INITIAL INTERVIEW

Printed: 06/08/09 15:13

MODERATE NUTRITIONAL RISK FACTORS: 06/07/09 17:37 {G.LEWIS, RN}
Insulin dependent diabetic, Non-compliance to therapeutic diet.

NUTRITIONAL SCREENING: 06/07/09 17:37 {G.LEWIS, RN}
Moderate nutritional risk.

HIGH RISK FUNCTIONAL FACTORS: 06/07/09 17:37 {G.LEWIS, RN}
PT ADMITED WITH AMS PT WAS ALSO INVOLVED IN AVA 2 DAYS AGO USES CANE WITH AMBULATION 06/07/09 17:37 {G.LEWIS, RN}

FUNCTIONAL SCREENING: 06/07/09 17:37 {G.LEWIS, RN}
Abnormal gait/history of frequent falls.

ISOLATION PRECAUTIONS NEEDED?: 06/07/09 17:37 {G.LEWIS, RN}
No isolation precautions needed.

LOW RISK FOR FALLS WITH NON-AGGRESSIVE PREVENTION: 06/07/09 17:37 {G.LEWIS, RN}
Patient has impaired ability affecting A, Patient is exhibiting CONFUSION AND DISORIENTATION 06/07/09 17:37 {G.LEWIS, RN}

HIGH RISK FOR FALLS WITH AGGRESSIVE PREVENTION: 06/07/09 17:37 {G.LEWIS, RN}
Low risk for falls, Patient has a history of falls in the la, Patient has a history of drug/alcohol ab. 06/07/09 17:37 {G.LEWIS, RN}

HIGH RISK FOR SKIN BREAKDOWN: 06/07/09 17:37 {G.LEWIS, RN}
See Physical Assessment-Metabolic/Integu.

PRE-OPERATIVE TEACHING: 06/07/09 17:37 {G.LEWIS, RN}
N/A.

PLAN OF CARE/ADMISSION PROCESS DISCUSSED WITH PATIENT/FAMILY: 06/07/09 17:37 {G.LEWIS, RN}
Verbalized understanding and agrees.

PATIENT SAFETY BROCHURE DISCUSSED W/ PT/FAMILY: 06/07/09 17:37 {G.LEWIS, RN}
Yes, safety brochure given and discussed.

MEDICATION RECONCILIATION PRINTED: 06/07/09 17:37 {G.LEWIS, RN}
Yes and placed on chart.

DISCHARGE PLANNER

SOCIOECONOMIC STATUS: 06/08/09 15:00 {G.LEWIS, RN}
Unemployed.

MENTAL STATUS: 06/08/09 15:00 {G.LEWIS, RN}
Disoriented, Confused.

CARE STATUS: 06/08/09 15:00 {G.LEWIS, RN}
Requires assistance, Ambulation assistance, Bathing assistance.

LIVING ARRANGEMENTS: 06/08/09 15:00 {G.LEWIS, RN}
Lives Alone.

ANTICIPATED NEEDS AT TIME OF DISCHARGE: 06/08/09 15:00 {G.LEWIS, RN}
PT HAS NO TRANSPORTATION, CAR WAS INPOUNDED PRIOR TO ADMISSION AND PT LIVES IN NORTH CAROLINA BUT IS HEADED TO FLORIDA TO PICK UP FAMILY FOR ASSISTANCCE AT HOME. 06/08/09 15:00 {G.LEWIS, RN} 06/08/09 15:00 {G.LEWIS, RN}

Does patient need pneumococcal vaccine? 06/08/09 15:00 {G.LEWIS, RN}
Yes, pt is diabetic, BUT PT COULD NOT PROVIDE INFO NEEDED TO DETERMINE HX OF VACCINATIONS 06/08/09 15:00 {G.LEWIS, RN}

IS PATIENT CURRENTLY BEING VISITED BY HOME HEALTH?: 06/08/09 15:00 {G.LEWIS, RN}
No.

DOES PATIENT RECEIVE OXYGEN AT HOME?: 06/08/09 15:00 {G.LEWIS, RN}
No.

DOES PATIENT HAVE A HOME NEBULIZER?: 06/08/09 15:00 {G.LEWIS, RN}
No.

IF CVA {OLD/NEW},PATIENT, DOES PATIENT NEED REHAB EVALUATION?: 06/08/09 15:00 {G.LEWIS, RN}
NA

Nurse's signature: G Lewis RN #22

INITIAL INTERVIEW

Printed: 06/08/09 15:13

WAS PATIENT ADMITTED WITH PNEUMONIA? 06/08/09 15:00 {G.LEWIS, RN}
No.

HAVE YOU COME IN CONTACT WITH SOMEONE WITH TB? 06/08/09 15:00 {G.LEWIS, RN}
No.

HAVE YOU COME IN CLOSE CONTACT WITH SOMEONE WITH PNEUMONIA? 06/08/09 15:00 {G.LEWIS, RN}
No.

HAVE YOU BEEN IN CLOSE CONTACT WITH SOMEONE WITH THE SARS OR THE FLU? 06/08/09 15:00 {G.LEWIS, RN}
No, No.

HAVE YOU TRAVELED OUTSIDE THE COUNTRY IN THE LAST 10 DAYS? 06/08/09 15:00 {G.LEWIS, RN}
No.

HAVE YOU BEEN IN HOSPITAL/CLINIC THAT TREATS SARS? 06/08/09 15:00 {G.LEWIS, RN}
No.

DOES PATIENT CARE FOR SOMEONE AT HOME?: 06/08/09 15:00 {G.LEWIS, RN}
No,BUT HAS A PET THAT IS VERY IMPORTANT TO PT

SOURCE OF PAYMENT: 06/08/09 15:00 {G.LEWIS, RN}
PT STATES HAS MEDICARE BUT NO PROOF HAS BEEN REPORTED PT STAES ALL INFO IS POV 06/08/09 15:00 {G.LEWIS, RN}

IS PATIENT ABLE TO PAY FOR POST DISCHARGE NEEDS?: 06/08/09 15:00 {G.LEWIS, RN}
N/A.

SOCIAL SUPPORT: 06/08/09 15:00 {G.LEWIS, RN}
Limited family support.

PATIENT GOALS FROM HOSPITALIZATION: 06/08/09 15:00 {G.LEWIS, RN}
Resume ADLs, Resume appropriate level of wellness.

EMOTIONAL CONCERNS EXPRESSED BY PATIENT: 06/08/09 15:00 {G.LEWIS, RN}
PT HAS CONCERNS REGARDING PET THAT WAS SENT TO THE ANIMAL SHELTER AT TIME OF ACCIDENT AND ARREST. 06/08/09 15:00 {G.LEWIS, RN}

NAME OF PRIMARY CAREGIVER: 06/08/09 15:00 {G.LEWIS, RN}
N/A.

CONCERNS EXPRESSED BY CAREGIVER: 06/08/09 15:00 {G.LEWIS, RN}
N/A.

INTENDED DESTINATION POST DISCHARGE: 06/08/09 15:00 {G.LEWIS, RN}
Home.

HIGH RISK CRITIERIA FOR EVALUATION BY CASE MANAGER: 06/08/09 15:00 {G.LEWIS, RN}
Difficulty/inability to purchase medicat.

OTHER REFERRALS DETERMINED AT ADMISSION FOR DISCHARGE: 06/08/09 15:00 {G.LEWIS, RN}
None, Utilization Management.

Mode of contact after discharge: 06/08/09 15:00 {G.LEWIS, RN}
Telephone: _____.

Nurse's signature: [signature] RN #22

Bay Street Health Center
Site: PTDF Pre-Trial Detention Facility
500 East Adams Street
JacksonvilleFL 32202
(904)630-7409

MERRIFIELD, WILLIAM M.
MRN: 713772 DOB: 10/30/1945 Docket # 2009024776

Screening

ITR Call:
Call to back door for: Other reason: Arrived w/ cane and urinary incont. w/ poor hygiene In summary: 63 yo Caus. male whom appears 83 y/o seen while sitting in JSO wheelchair, refusing to walk. Demanding "percocet" as "I fell about a week ago and my back is sore but I have peripheral neuropathy and I take a lot of pin pills for it." Additionally, states was recently hospitalized "at Liberty Hospital in Gainesville, FL for my nerves and my sugar." States has been using ETOH intermittently, in addition to "xanax for my nerves two times a day because my doctor said the stress of my wife having leukemia and coming here for treatments made me too nervous so I could have xanax." States is IDDM and on Lantus 35 U Q HS. Also has Hx remote AMI and new dx CHF w/ Coreg 12.5 mg rx'ed to take 1 po BID, Noted R flank lesions of varying stages of healing, but obviously resolving, in dermatone pattern, on erythematous base, w/ cluster of some resolving blisters posterior R flank ~ 4x5 cm. However, the entire region of erythema is ~ 7 X 25 cm R ant/post. flank. No current d/c noted. Pt. states he has been using prednisone 10 mg po QD for same and has 14 days tx'ment remaining. He is also using neurontin 300mg po tid for pain management but, is requesting narcotics. However, there is no facial grimmace, no other physiological s/sx's of pain @ present. Pt. now refuses to ambulate, "unless I get my percocet." Discussed pt's previous and current functional abilities and he eventually states he was able to ambulate w/cane @ home, drive both he and his spouse here from Gainesville, and then remove their luggage from his car and take it in their temporary housing independently. Pt. advised he may cont. use of his cane and wheel chair will be returned to JSO as he can actually do harm to hmelf by self-restricting mobility/create additional health problems r/t immobility. Pt. cont. to demand "percocet and xanax." Pt. arrives w/the following med bottles (all sent to property): Prednisone 10 mg 1 po QD, Carvediol 12.5 mg 1 po BID, and Xanax 1 mg take 1 po BID, Rx'ed by Dr. Assoegi, Salvatore and # 50 filled on 6/2/09 at Publix Pharm (843-986-9658) # 20 remain in bottle, and partially full vial of Lantus insulin w/8 insulin syringes. Noticiably absent, is pt's "percocet" and he states, "they wouldn't give me a refill and I ran out." Pt. states he usually does not have urinary incont. but has taken his xanax and "I don't always clean myself after I go." Clothing soiled/dirty in appearance and appears w/poor hygiene. Placed in contact isolation, may cont. use cane, no wheelchair. Pt. inst. in sick call process and verbalized understanding of same. Speech clear, A&O X3, PERL (senile cataracts noted), EOMI. See orders and referrals.
Disposition: Patient Accepted - medically cleared

Home Medications
See summary above

Vitals
132/76, 68, 16

Signatures
Mary Leach, NP; Jun 11 2009 5:37AM (Author)

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