4/18/13 DELRAY MEDICAL CENTER ADMISSION
10:20:10 5352 LINTON BLVD. DELRAY BEACH FL 33484 RECORD-F01

PATIENT NO: 012314973 ADMIT DT/TIME: 9/12/12 13:12 M/R NO: 000491496
NS/RM/BED/ACM: CC 2 K 22 RESISTANT ORG:
DISCH DT/TIME: 9/13/12 06:41 BY: AUTO
PATIENT NAME: BERNSTEIN, SIMON L TITLE:
MAILING ADDR: 7020 LIONS HEAD LN SOCIAL SECURITY: 371325211
CITY/STATE: BOCA RATON FL 33496 5931 PHONE: (561) 477-9096
PHYSICAL ADR: NPP: 2.0 DATE: 12/08/03
CITY/STATE: 00000 0000 PHONE: ( )
OCCUPATION: SELF EMPLOYED LANGUAGE: EN FC: 40
POB: ADMT PHYS: 1250- OKO NNACHI HSV: 41
DOB: 12/02/1935 ADMT PHYS PHONE: (561) 276-1722 RLG: JE PAR:
AGE: 77 Y RACE: WHI ATTEND PHYS: 1250- OKO NNACHI MS: F
SEX: M REF PHY: 1250-OKO NNACHI PHN: 561 276-1722 SMK: N
PCP PHY: - PHN: VAL: PT: 1
ETHNICTY:NON FLAG: FATHER'S DOB: MOTHER'S DOB:

EMER CONTACT: ELLIOTT BERNSTEIN REL: NATURAL CHILD
ADDRESS: 7020 LIONS HEAD LN PHONE: (561) 886-7628
CITY/STATE: BOCA RATON FL 33496 5931
NEAREST RELT: MARITZA PUCCIO REL: FRIEND
ADDRESS: PHONE: (561) 305-2999
CITY/STATE: 00000 0000 RESEARCH ID:

GUARANTOR: BERNSTEIN, SIMON L REL: SELF
ADDRESS 1: 7020 LIONS HEAD LN PHONE: (561) 477-9096
ADDRESS 2: SOCIAL SECURITY: 371325211
CTY/STE/ZIP: BOCA RATON FL 33496 5931 OCC:SELF EMPLOYED AF:
PAYOR NAME 1: MEDICARE INS. PLAN ID: 53544 SRV/TYPE: ALLIP
PLAN NAME: MEDICARE IPA:
BILL C/O NAME: MEDICARE AUTH #:
BILL ADDRESS: PO BOX 1602 CERT-SSN-HIC-ID#: 371325211A
CTY/STE/CNTRY: OMAHA NE 68101 1602 BILL PHONE: (402) 342-7600
BILLING NAME: GP #:
INSURED: BERNSTEIN, SIMON L SEX/REL: M SELF
EMPLOYER: SELF EMPLOYED MSP: TRACKING#:
ADDRESS: 950 PENINSULA CT EMP PHONE: (561) 988-8984
CITY/STATE: BOCA RATON FL 33462 0000 ESC: 4
PAYOR NAME 2: AMERICAN PIONEER INS. PLAN ID: 32201
PLAN NAME: AMERICAN PIONEER INDEM
BILL C/O NAME: AMERICAN PIONEER CERT-SSN-HIC-ID#: AP011032666
BILL ADDRESS: PO BOX 130 AUTH #:
CTY/STE/CNTRY: PENSACOLA FL 32591 0130 BILL PHONE: (800) 999-2224
BILLING NAME: GP #:
INSURED: BERNSTEIN, SIMON L SEX/REL: M SELF
EMPLOYER: SELF EMPLOYED TRACKING#:
ADDRESS: 950 PENINSULA CT EMP PHONE: (561) 988-8984
CITY/STATE: BOCA RATON FL 33462 0000 ESC: 4

SPAN CODE: PRIOR VISIT: 8/20/12
FROM/TO DATE: PRIOR HOSPITAL:

CONDITION CD	CONDITION CD	OCCURRENCE CD/DATE	OCCURRENCE CD/DATE
P7			
09		11 9/12/12	
		18 12/01/00	

CHIEF COMPLAINT DESCRIPTION: ADMIT DIAGNOSIS CODE: 458.9
CHF PLUS TROPONIN PNEUMONIA CAD BY HX
COMMENTS: MEDICARE ADMIT TO ON-CALL

DATE 01/13/2015

PRINTED BY: MariaNoriega

DELRAY MEDICAL CENTER
5352 Linton Boulevard
Delray Beach, FL 33484

Name: BERNSTEIN, SIMON L
MRN: 000491496
ACCT: 012314973

Nnachi Oko, MD
ADM: 09/12/2012
DIS: 09/13/2012

Death Summary

ADMITTING DIAGNOSES:
1. Hypotension.
2. Possible congestive heart failure
3. Possible pneumonia.
4. Positive cardiac enzymes.
5. Fibromyalgia.
6. Hepatitis.
7. Previous cardiac stent.

DISCHARGE DIAGNOSES:
1. Possible pneumonia.
2. Positive cardiac enzymes.
3. Coronary artery disease by history.
4. Fibromyalgia.
5. Possible myocardial infarction.
6. Chronic renal insufficiency.
7. Anemia.
8. Cardiopulmonary arrest leading to his demise.

CONSULTATIONS:
1. Cardiology.
2. Nephrology.
3. Hematology.
4. Infectious disease.

HOSPITAL COURSE: This patient is a 76-year-old white male admitted through the Emergency Room. The patient was admitted to the intensive care unit and given bed rest. Cardiology consult was obtained with Dr. Silver. However, the family decided on Dr. Zelcer. Later on, the patient elected for Dr. Anesta to be patient's cardiologist. The patient was started on IV antibiotics and IV fluids. He was continued on his medication from home. Due to his low hemoglobin, anticoagulation was not started. Stool for occult blood was obtained. Hematology consult was obtained. While in the hospital, I had the opportunity to talk to the patient's granddaughter at the bedside by name Rachel. Earlier this morning, I received a call that the patient had coded and coded so many times and that the family had some issues making a decision. After the patient was coded so many times, the family finally decided to stop the code and the patient expired. I had the opportunity to talk to the family members, who were able to tell me a lot of things that was going on with this patient before he even came to the hospital. I spoke with the son by name, Ted who tells me that in 2010 their mother passed away and before their mother passed away, they had a housekeeper that the mother late go. When their mother passed away, the father went on brought back the

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DATE 01/13/2015

PRINTED BY: MariaNoriega

Name: BERNSTEIN, SIMON L
MRN: 000491496
ACCT: 012314973

Nnachi Oko, MD
ADM: 09/12/2012
DIS: 09/13/2012

Death Summary

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housekeeper and apparently they developed a relationship. Ted and her sisters are concerned and suspicious as to what was going on with their father at home. They indicated that their father just got back from Bahamas with the housekeeper who is now living with their father as a significant other. They indicated that when the patient came back from Bahamas that he was apparently not feeling very well and the woman that he is living with now made no attempt whatsoever to bring him to the hospital for medical attention until yesterday when they intervened. The family was very concerned and suspicious of the activities of this lady that was a significant other to their father who was previously a housekeeper for them. They tend to think and suspect that she may be doing something and they do not know what exactly it is, but they are very suspicious. Based on the narrative they give to me and their concern about the probable cause of death and the suspicion surrounding the home environment, I suggested that they get an autopsy done. The medical examiner's office was contacted, but they indicated that the patient's case is not a medical examiner case and that the family can have autopsy done at their own expense in any facility that they choose. The institution that conduct autopsy was made available to the family for their pursue. In conclusion, the cause of death will eventually be determined by autopsy if the family decides to pursue that end. If the autopsy did not proceed at the family _____, then the possible cause of death may be due to patient's underlying medical problems and its sequelae.

_____
Nnachi Oko, MD

TR:NO/HN
DD:09/13/2012 05:09 EDT
DT:09/13/2012 10:33 EDT
Dictation ID: 7348717/Confirmation #: 3116133
R:

Authenticated by NNACHI OKO, MD On 10/02/2012 04:47:49 PM

DATE 01/13/2015
PRINTED BY: MariaNoriega

Name: BERNSTEIN, SIMON L
MRN: 000491496
ACCT: 012314973

ERNESTO R MONTESINO VARGAS
ADM: 09/12/2012

Consultation

DATE OF SERVICE: 9/12/2012

REQUESTING PHYSICIAN: Nnachi Oko, MD

Thank you for the consultation.

REASON FOR CONSULTATION: Pneumonia.

HISTORY OF PRESENT ILLNESS: Mr. Simon Bernstein is a 76-year-old male with past medical history significant for fibromyalgia, coronary artery disease, status post CABG and PCI, history of hepatitis, history of previous myocardial infarction and hypertension. The patient was brought by his family secondary to significant weakness and cough for the last 3-4 days. He claims that he has been put on steroids for history of fibromyalgia and has not been feeling well, has been pretty much going downhill. There is not that much information that I can obtain from the patient. The patient became very frustrated when I mentioned that I was from infectious disease and was pretty adamant that he did not have any infectious disease. I obtained some information from himself and also from some family members who actually reported to me the patient having some cough, which he claims is a dry cough, but they said he sounded a little bit wet and with some sputum production during the last few days. No fevers have been reported. No significant shortness of breath or chest pain has been reported as well. Significant lower extremity edema. No headache, no visual problems. No sinus tenderness was reported during my assessment and no problems swallowing. He mentioned a couple of episodes of vomiting during the last few days. Denied any diarrhea or constipation. No dysuria, hematuria or frequency. No numbness, no tingling. We are asked to evaluate in this particular setting. When we evaluated the patient, the patient at that point had a white blood cell count that was just marginally elevated of 11.2, but he was noted to have an increased troponin at that point and a BNP of 393. On my initial assessment while the patient was in the Emergency Department, he was also found to be febrile and in no significant respiratory distress despite the fact that his chest x-ray showed evidence of patchy right lung consolidation suspicious for pneumonia. We are asked to evaluate in this particular setting.

PAST MEDICAL HISTORY: Basically as I mentioned above.

PAST SURGICAL HISTORY: Includes CABG and percutaneous coronary interventions with stent.

ALLERGIES: He is allergic to PENICILLIN offered at the moment of my assessment. The patient, as per nursing report, has received a dose of

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meropenem ordered by the emergency physician, which he tolerated very well. At the point of my assessment, he is already receiving azithromycin as well.

MEDICATIONS: His outpatient medications include Cartia XT, Lyrica, Plavix, aspirin, folic acid, Tylenol, Imdur, prednisone, Protonix, and Ranexa.

FAMILY HISTORY: Noncontributory to this illness.

SOCIAL HISTORY: There is no history of tobacco, alcohol or drugs. He lives with his aide. His wife died last year.

REVIEW OF SYSTEMS: Pretty much as outlined in the history of present illness. All other systems were reviewed and were negative.

PHYSICAL EXAMINATION:
VITAL SIGNS: The most recent vital signs, his temperature is 97.8, pulse 78, respiratory rate 18, blood pressure 95/52, and saturating 96% on 2 L nasal cannula.
HEENT: Normocephalic, atraumatic. Pupils equal, round, reactive to light and accommodation. Extraocular movement intact. Pale conjunctivae. No conjunctival lesions. No sinus tenderness. Oral mucosa is dry. Oropharynx is negative for any plaques or erythema on limited examination.
NECK: Supple, no JVD. No masses, no lymphadenopathy.
CHEST: Clear to auscultation anteriorly with decreased breath sounds in both bases.
ABDOMEN: Bowel sounds positive, soft, nontender. No masses, no hepatosplenomegaly.
EXTREMITIES: Significant edema. No cyanosis or clubbing.
SKIN: No rash.
NEUROLOGIC: Awake, alert, oriented x 3. No focal deficits.

LABORATORY WORKUP: Reveals a white blood cell count of 11.2, hemoglobin of 8.5, platelets of 123 with 82% neutrophils. His urinalysis was negative. His BUN is 101 and creatinine is 2.7. Liver function tests are within normal limits. His troponin, the first set is 3.85. In terms of radiologic studies, is basically as I mentioned in the chest x-ray above.

IMPRESSION:
1. Pneumonia, right middle and right lower lobe.
2. History of fibromyalgia in the setting of intensive steroid therapy at this point.
3. Mild leukocytosis.
4. Coronary artery disease, status post myocardial infarction with positive

troponins at this point.
5. Acute kidney injury.

RECOMMENDATIONS:
1. Blood cultures x 2, sputum cultures if possible. His urine looks clean at this point.
2. Close followup of respiratory status.
3. The patient has received a dose of meropenem and azithromycin since he is coming from home and also because of the fact that he mentioned a couple of episodes of vomiting in the setting of his questionable penicillin allergy. We are going to start the patient on coverage for community-acquired pneumonia and also for the possibility of aspiration as well. We are going to start the patient on Levaquin adjusted to his renal function and also Flagyl.
4. Based on respiratory status may decide the need for further imaging studies. I had the chance to discuss this case at length with both the patient and the family. We will follow this patient along with you.

Thank you for the consult.

_____
ERNESTO MONTESINO, MD

TR:EM/HN
DD:09/13/2012 08:54 EDT
DT:09/13/2012 18:53 EDT
Dictation ID: 7349389/Confirmation #: 3116411
R: 09/13/2012 20:16 EDT

Authenticated by ERNESTO R MONTESINO VARGAS MD [02136] on 09/26/2012 at 11:34:34

DELRAY MEDICAL CENTER
5352 Linton Boulevard
Delray Beach, FL 33484

Name: BERNSTEIN, SIMON L
MRN: 000491496
ACCT: 012314973

Joseph Krause, MD
ADM: 09/12/2012

Consultation

DATE OF SERVICE: 09/12/2012

Patient is being seen at the request of Dr. Nnachi Oko.

HISTORY OF PRESENT ILLNESS: The patient is a 76-year-old white male who has a known history of atherosclerotic heart disease, hypertension, polymyalgia rheumatica, on tapering steroids, who is admitted for generalized weakness and collapse and is being currently seen for an elevated BUN and creatinine of 101 and 2.7 mg/dL.

The patient's female companion/significant other notes the above history, but denies having had the patient see a urologist or a nephrologist in the past. There is no prior history for kidney problems. The patient is admitted for pneumonia.

The patient is examined, the chart is reviewed.

The patient is totally disoriented, although alert and awake. He appears to not understand any instructions or questions and does not respond appropriately. Patient's girlfriend notes that this has been a new situation since last evening. In the Emergency Room, the bladder scan ordered was notable in that it showed 460 mL of urine. A Foley catheter was placed and he is draining clear urine.

Looking through the notes, it appears that Dr. Anesta was able to obtain some additional information presumably from Dr. Seth Baum, cardiologist, noting that the patient's prior serum creatinine was 1.8 mg/dL.

ALLERGIES: PENICILLIN.

MEDICATIONS AT HOME: Include homocysteine, over-the-counter Cartia XT 180 b.i.d., Serevent 1 puff b.i.d., vitamin D3, Qvar, Plavix 75 daily, Benicar 20 mg daily, Bayer aspirin 81 mg daily, acetaminophen as needed, Lyrica 50 mg daily, isosorbide mononitrate 30 mg a day, prednisone 5 mg daily, patient had been on tapered doses as per Dr. Pardo after diagnosis of PMR and temporal artery biopsy that was confirmed, Protonix 40 mg daily, Ranexa 500 b.i.d.

PAST MEDICAL HISTORY: Notable for hypertension, myocardial infarction, coronary artery disease, CABG. Patient again with polymyalgia rheumatica, hepatitis.

SOCIAL HISTORY: The patient lives with his significant other. Nondrinker, nonsmoker. Further history is not currently available under the

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DATE 01/13/2015
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circumstances.

FAMILY HISTORY: Parents deceased.

REVIEW OF SYSTEMS: Would refer to the data from the patient's primary physician.

PHYSICAL EXAMINATION:
GENERAL: Well-developed, well-nourished, very confused and disoriented white male in no respiratory distress, but very agitated and appears totally uncomfortable. He is not able to transmit what is bothering him. He just complained overall and again very uncomfortable.
VITAL SIGNS: Blood pressure 110/70, pulse 70, respirations unlabored 16, is afebrile.
HEENT: Normocephalic, atraumatic. Conjunctivae pink. Sclerae are anicteric. ENT is normal.
NECK: Supple without lymphadenopathy, thyroid enlargement, or bruits.
CARDIAC: Regular rate and rhythm. S1, S2 is normal.
LUNGS: Clear to percussion and auscultation with scattered rales noted.
ABDOMEN: Distended, soft and nontender without organomegaly.
RECTAL: Deferred.
EXTREMITIES: Without cyanosis, clubbing or edema.
NEUROLOGICAL: The patient is alert, but not oriented, very confused.

IMPRESSION:
1. Acute renal failure superimposed on chronic kidney disease secondary to hypovolemia, dehydration, pulmonary sepsis as well as urinary retention.
2. Pneumonia.
3. Atherosclerotic heart disease status post coronary artery bypass grafting, status post stents.
4. Polymyalgia rheumatica, on steroids.
5. History of hepatitis.
6. History of hypertension.
7. Encephalopathy obviously secondary to toxic metabolic and septic syndrome.
8. Gastroesophageal reflux disease.
9. Anemia.

PLAN: At this particular time, would try to obtain any additional medications and labs from Dr. Seth Baum, Dr. Ira Pardo et al. Since the patient appears in some distress, would raise the patient's _____ level Solu-Medrol 30 mg b.i.d. to stabilize the glucocorticoids system. Additional laboratory data including CMP, phosphorus, magnesium, T4, TSH will be obtained.

Name: BERNSTEIN, SIMON L
MRN: 000491496
ACCT: 012314973

Joseph Krause, MD
ADM: 09/12/2012

Consultation

Further workups including renal ultrasounds will be done once the patient stabilizes. In the meantime, a Foley catheter is placed, strict intake and output records will be encouraged. Infectious disease involved in the case already antibiotics had been given.

Thank you once again for allowing me to participate in the care of this patient. We will follow along with you and assist you in whatever way I can.

_____
Joseph Krause, MD

cc: Indira Marmolejos MD
Ira Pardo MD
Michael Anesta MD
Nnachi Oko MD

TR:JK/IN
DD:09/13/2012 22:16 EDT
DT:09/14/2012 04:11 EDT
Dictation ID: 7357058/Confirmation #: 2806226
R:

DELRAY
Medical Center

DEL2017

TO DR. (CONSULTING PHYSICIAN) KAPLAN	SERVICE	DATE	TIME

REASON FOR REFERRAL: Code blue

REFERRING PHYSICIAN REQUESTS:
- ☐ EVALUATION AND RECOMMENDATIONS
- ☐ CONSULTANT FOLLOW PT. WITH ATTENDING PHYSICIAN
- ☐ CONSULTANT ASSUME MANAGEMENT OF THIS CONDITION
- ☐ CONSULTANT ASSUME PRIMARY CARE AND RECEIVE IN TRANSFER

FROM DR. (REFERRING PHYSICIAN)

CONSULTANT PLEASE COMPLETE > DATE 9/13/12 TIME 1245 AM

Called to see patient for code blue. CPR in progress Bradycardia c PEA on monitor. Pt orally intubated c #8.0 ETT c difficulty. Equal BS when bagged. ACLS protocol followed c II amps Nc Bicarb. Pt now c palpable pulse @ 50's c spontaneous respirations.

☐ DELRAY MEDICAL CENTER
☐ PINECREST HOSPITAL

CONSULTATION RECORD

F/C:40

ACCT:012314973 MR:000491496 09/12/2012
BERNSTEIN, SIMON L
OKO NNACHI DOB:12/02/1935 M 76

DATE 01/13/2015
PRINTED BY: MariaNoriega

DELRAY MEDICAL CENTER
5352 Linton Boulevard
Delray Beach, FL 33484

Name: BERNSTEIN, SIMON L
MRN: 000491496
ACCT: 012260253

JONATHAN WIDEROFF, MD
ADM: 08/20/2012

Operative Report

DATE OF PROCEDURE: 8/20/12

PREOPERATIVE DIAGNOSIS: Left temporal headaches.

POSTOPERATIVE DIAGNOSIS: Left temporal headaches.

OPERATION PERFORMED: Left temporal artery biopsy.

SURGEON: Jonathan Wideroff, MD

ANESTHESIA: Local with sedation.

JUSTIFICATION: The patient has increasing left temporal headaches and some vague visual complaints with a history of polymyalgia rheumatica, on relatively low doses of prednisone. It appears that he may be developing temporal arteritis requiring increasing prednisone, so a left temporal artery biopsy was requested by his rheumatologist. All of his symptoms were on the left side, so only the left side is being done. He had some left temporal tenderness over a very prominent pulse.

DESCRIPTION OF THE OPERATION: The patient was placed on the operating table in the supine position and sedated. Minimal shaving was done over the left temporal pulse. The left side of the scalp was prepped with DuraPrep and sterilely draped. Xylocaine 1% with epinephrine was instilled into the skin extending up from the hairline in the shaved area. A skin incision was made sharply in line with the front of the ear extending up into the temporal region from the hairline for several centimeters. This was carried through to subcutaneous tissue with cautery cauterizing the skin edges. The patient oozed a bit, but it was not profound considering he was on Plavix and it all came under control very quickly. The superficial fascia was incised. A serpiginous temporal artery was identified, dissected out for several centimeters. It was suture ligated at either end with 3-0 Vicryl. A piece measuring 3.5 cm when it was laid out flat was removed and sent to the lab. It looked grossly normal, but of course this was indeterminate. The wound was completely hemostatic at this point. The subcutaneous tissue was closed with interrupted 3-0 Vicryl. The skin was closed with running 4-0 Monocryl subcuticular suture with Dermabond on the surface. The patient tolerated the procedure well with no blood loss and was discharged to the recovery room in stable condition.

DATE 01/13/2015

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DELRAY MEDICAL CENTER
5352 Linton Boulevard
Delray Beach, FL 33484

Name: BERNSTEIN, SIMON L
MRN: 000491496
ACCT: 012260253

JONATHAN WIDEROFF, MD
ADM: 08/20/2012

Operative Report

_____
Jonathan Wideroff, MD

TR:JW/HN
DD:08/20/2012 10:25 EDT
DT:08/20/2012 10:51 EDT
Dictation ID: 7156459/Confirmation #: 3044407
R: 08/20/2012 11:06 EDT

Authenticated by JONATHAN WIDEROFF MD [00766] on 08/21/2012 at 18:54:52

Delray Medical Center
5352 Linton Blvd.
Delray Beach, FL 33484
Clinical Laboratory
Phone (561) 495-3209
Medical Director:
Albert Cohen, M.D.

Patient Name: BERNSTEIN, SIMON L
MRN: 491496
Acct#: 12260253
DOB:12/02/1935 Age:76 years Sex:Male
Location:DEL-OS One-day Surgery,-
Patient Type: 2 - Outpatient
Admitted: 08/20/2012
Discharged: 08/20/2012

A n a t o m i c P a t h o l o g y

Collected:	Accession Number	Verified:	Pathologist:
08/20/2012 09:25:00 EDT	006- D-12-003396	08/22/2012 15:02:45 EDT	MENES, MANUEL

DIAGNOSIS:
TEMPORAL ARTERY, LEFT, BIOPSY:

COMPLETE CROSS SECTION THROUGH UNREMARKABLE TEMPORAL ARTERY WITH NO EVIDENCE OF ACUTE OR CHRONIC INFLAMMATION AND NO EVIDENCE OF GIANT CELLS, AND THUS NO EVIDENCE OF TEMPORAL ARTERITIS

MANUEL MENES
Electronically signed by
Verified: 08/22/2012
MM /TK

SPECIMEN SOURCE:
A left temporal artery biopsy

CLINICAL INFORMATION:
Diagnosis/Clinical Information: headaches
Post-Op Diagnosis:
Procedure/Source: left temporal artery biopsy

GROSS EXAMINATION:
The specimen is received on telfa pad in formalin labeled left temporal artery biopsy and consists of one temporal artery measuring 3.0 cm. The specimen is serially sectioned and entirely submitted in Cassettes A1 and A2 for multiple levels.

This gross dictation was reviewed by Dr. Menes.

Legend: * = Abnormal, H = High, L = Low, C = Critical, f = footnote, r = reference, c = corrected, i = interpretation

Admitting Physician: WIDEROFF MD, JONATHAN
Ordering Physician: WIDEROFF MD, JONATHAN
Consulting Physician: BUSCH MD, ERIC M

Delray Medical Center
Clinical Laboratory
Location:DEL-OS One-day Surgery,-

Patient Name: BERNSTEIN, SIMON L
MRN: 491496
Acct #: 12260253

Anatomic Pathology

Collected:	Accession Number	Verified:	Pathologist:
08/20/2012 09:25:00 EDT	006- D-12-003396	08/22/2012 15:02:45 EDT	MENES, MANUEL

CPT 88305

SK /JP

Legend: * = Abnormal, H = High, L = Low, C = Critical, f = footnote, r = reference c = corrected, i = interpretation

Admitting Physician: WIDEROFF MD, JONATHAN
Ordering Physician: WIDEROFF MD, JONATHAN
Consulting Physician: BUSCH MD, ERIC M

DATE 01/13/2015
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PRINTED BY: MariaNoriega DATE: 01/13/2015

BERNSTEIN, SIMON ID:000491496 12-SEP-2012 10:32:38 Delray Medical Center-DEFLT ROUTINE RECORD

02-DEC-1935 (76 yr)
Male Caucasian

Room:0002

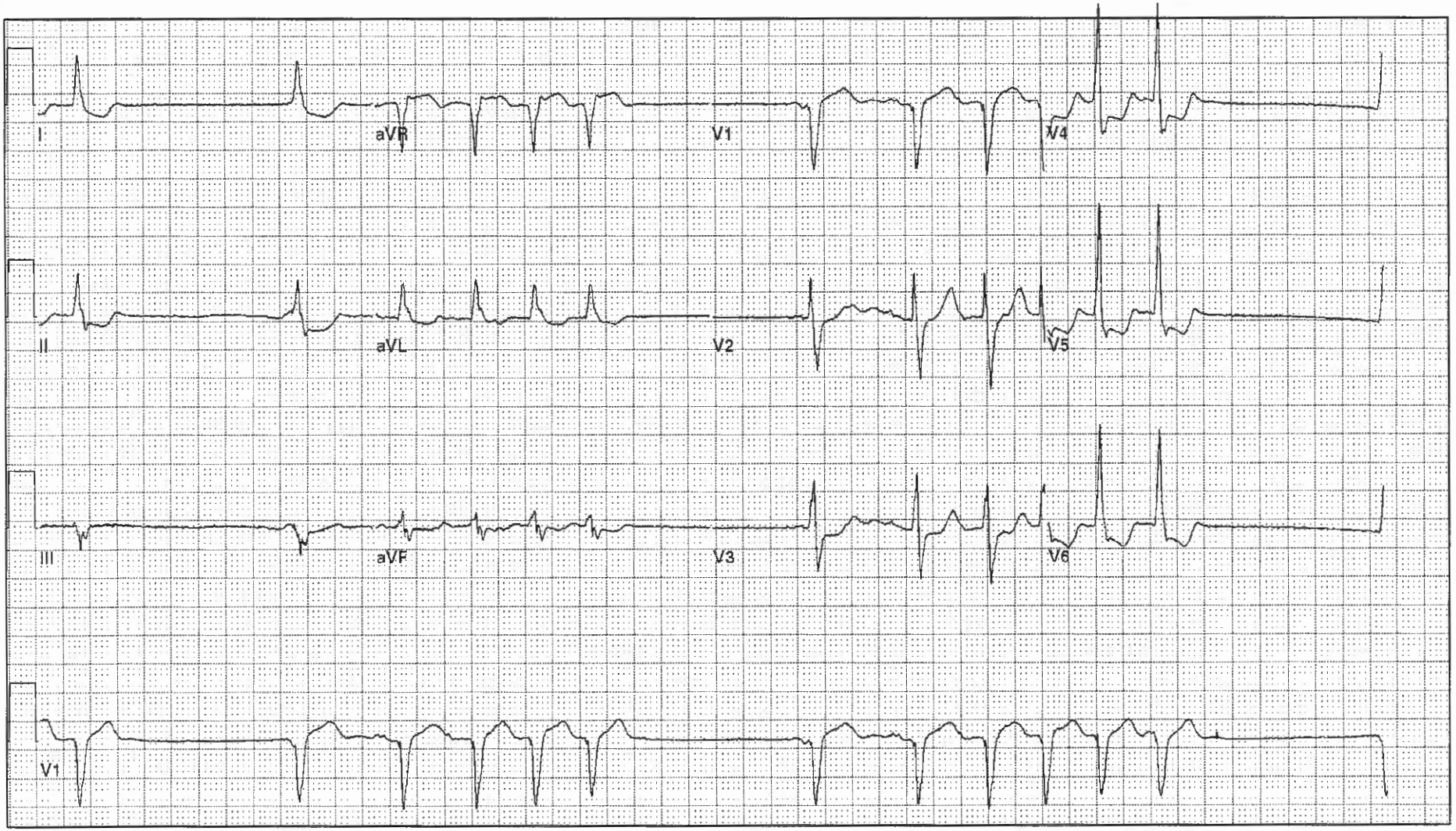
Vent. rate	82	BPM
PR interval	*	ms
QRS duration	120	ms
QT/QTc	382/446	ms
P-R-T axes	* 2	205

Undetermined rhythm
Incomplete left bundle branch block
Marked ST abnormality, possible inferior subendocardial injury
Marked ST abnormality, possible anterolateral subendocardial injury
Abnormal ECG
No previous ECGs available
Confirmed by Verma, Anil (156) on 9/12/2012 9:39:40 PM

Technician: SP
Test ind:

Referred by: NNACHI OKO

Electronically Signed By: Anil Verma



25mm/s 10mm/mV 150Hz 7.1.1 12SL 237 CID: 76

SID: 69186 EID:156 EDT: 21:39 12-SEP-2012 ORDER: 336694204 ACCOUNT: 012314973

PRINTED BY: MariaNoriega

DATE 12/13/2015

BERNSTEIN, SIMON ID:000491496 12-SEP-2012 15:58:38 Delray Medical Center-CCU ROUTINE RECORD

02-DEC-1935 (76 yr)
Male Caucasian

Room:0002
Loc:18

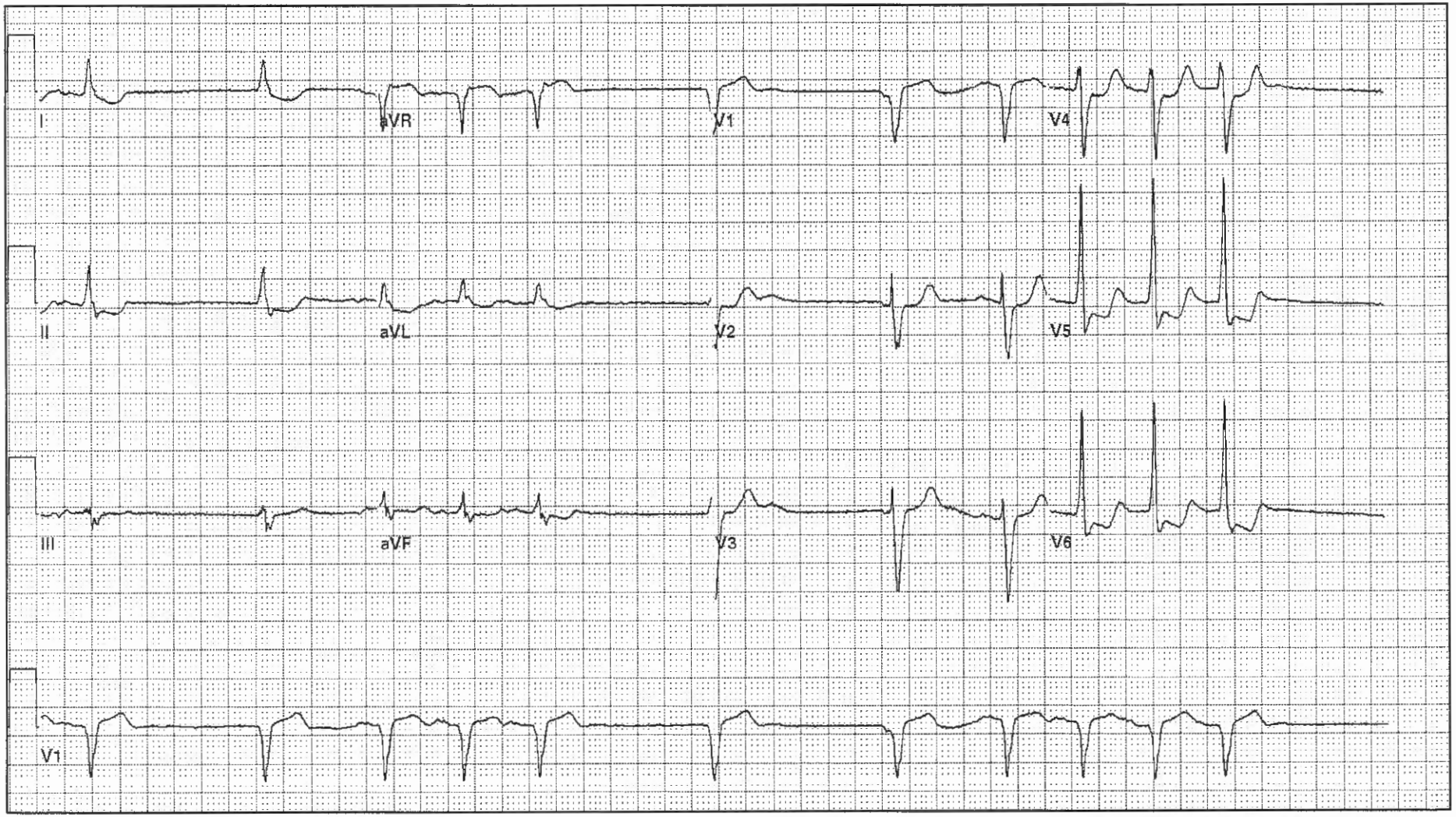
Vent. rate	71	BPM
PR interval	*	ms
QRS duration	120	ms
QT/QTc	400/434	ms
P-R-T axes	* 10	190

Atrial fibrillation
Incomplete left bundle branch block
Marked ST abnormality, possible inferolateral subendocardial injury
Abnormal ECG
When compared with ECG of 12-SEP-2012 10:32,
No significant change was found
Confirmed by Verma, Anil (156) on 9/12/2012 9:45:08 PM

Technician: ST
Test ind:

Referred by: NNACHI OKO

Electronically Signed By: Anil Verma



25mm/s 10mm/mV 150Hz 7.1.1 12SL 239 CID: 12

SID: 69186 EID:156 EDT: 21:45 12-SEP-2012 ORDER: 337222628 ACCOUNT: 012314973

PRINTED BY: MariaNoriega

DATE: 9/13/2015

BERNSTEIN, SIMON ID:000491496 13-SEP-2012 00:54:52 Delray Medical Center-DEFLT ROUTINE RECORD

02-DEC-1935 (76 yr)
Male Caucasian

Room:0002

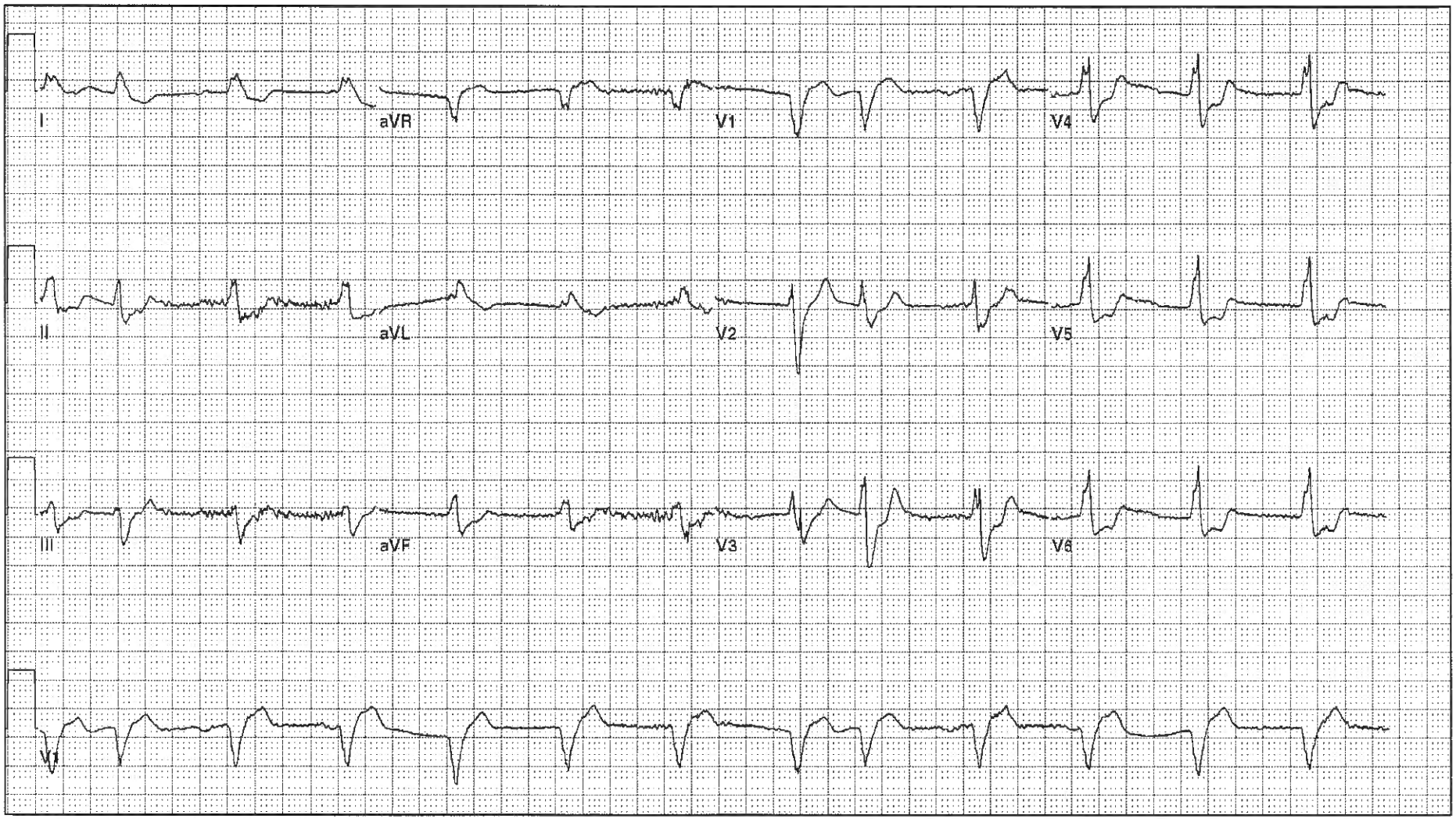
Vent. rate	77	BPM
PR interval	*	ms
QRS duration	150	ms
QT/QTc	376/425	ms
P-R-T axes	* -9	153

Wide QRS rhythm with occasional , and consecutive premature ventricular complexes and fusion complexes
Left bundle branch block
Abnormal ECG
When compared with ECG of 12-SEP-2012 15:58,
Wide QRS rhythm has replaced Atrial fibrillation
ST CHANGES OF ISCHEMIA
Confirmed by Verma, Anil (156) on 9/13/2012 4:55:54 PM

Technician: DJH
Test ind:

Referred by: NNACHI OKO

Electronically Signed By: Anil Verma



25mm/s 10mm/mV 150Hz 7.1.1 12SL 237 CID: 1

SID: 69186 EID:156 EDT: 16:55 13-SEP-2012 ORDER: 337840064 ACCOUNT: 012314973

Delray Medical Center
5352 Linton Blvd.
Delray Beach, FL 33484
Clinical Laboratory
Phone (561) 495-3209
Medical Director:
Albert Cohen, M.D.

Patient Name: BERNSTEIN, SIMON L
MRN: 491496
Acct#: 12314973
DOB:12/02/1935 Age:76 years Sex:Male
Location:DEL-CC CC,0002-K
Patient Type: 1 - Inpatient
Admitted: 09/12/2012
Discharged: 09/13/2012

M i c r o b i o l o g y

PROCEDURE: Culture Blood
SOURCE: Peripheral Draw
COLLECTED: 09/12/2012 13:48 EDT

STARTED: 09/12/2012 14:28 EDT

ACCESSION: 006-MB-12-036661

*** FINAL REPORT ***

Final Report
Verified:09/17/2012 13:00 MDT
No growth at 5 days. at 120 Hours

*** PRELIMINARY REPORT ***

Preliminary Report
Verified:09/16/2012 13:01 MDT
No growth at 4 days.

Preliminary Report
Verified:09/15/2012 13:00 MDT
No growth at 3 days.

Preliminary Report
Verified:09/14/2012 13:01 MDT
No growth at 48 hours.

Preliminary Report
Verified:09/13/2012 13:01 MDT
No growth at 24 hours.

Preliminary Report
Verified:09/13/2012 07:01 MDT
No growth after 8 hours

Legend: * = Abnormal, H = High, L = Low, C = Critical, f = footnote, r = reference, c = corrected, i = interpretation

Admitting Physician: OKO MD, NNACHI
Ordering Physician: MONTESINO VARGAS MD, ERNESTO R

DATE 01/13/2015

PRINTED BY: MariaNoriega

Consulting Physician: MARMOLEJOS MD, INDIRA M; SILVER MD, MITCHELL; ZELCER MD, ALAN; KRAUSE MD, JOSEPH Z; LOUTFI MD, CHADI/PUD H; ANESTA MD, MICHAEL; MONTESINO VARGAS MD, ERNESTO R

Delray Medical Center
Clinical Laboratory
Location:DEL-CC CC,0002-K

Patient Name: BERNSTEIN, SIMON L
MRN: 491496
Acct #: 12314973

M i c r o b i o l o g y

PROCEDURE: Culture Blood
SOURCE: Peripheral Draw
COLLECTED: 09/12/2012 13:48 EDT

STARTED: 09/12/2012 14:28 EDT

ACCESSION: 006-MB-12-036661

Legend: * = Abnormal, H = High, L = Low, C = Critical, f = footnote, r = reference c = corrected, i = interpretation

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Ordering Physician: MONTESINO VARGAS MD, ERNESTO R
Consulting Physician: MARMOLEJOS MD, INDIRA M; SILVER MD, MITCHELL; ZELCER MD, ALAN; KRAUSE MD, JOSEPH Z; LOUTFI MD, CHADI/PUD H; ANESTA MD, MICHAEL; MONTESINO VARGAS MD, ERNESTO R

DATE 01/13/2015

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Clinical Laboratory
Phone (561) 495-3209
Medical Director:
Albert Cohen, M.D.

Patient Name: BERNSTEIN, SIMON L
MRN: 491496
Acct#: 12314973
DOB:12/02/1935 Age:76 years Sex:Male
Location:DEL-CC CC,0002-K
Patient Type: 1 - Inpatient
Admitted: 09/12/2012
Discharged: 09/13/2012

M i c r o b i o l o g y

PROCEDURE: Culture MRSA Screen
SOURCE: Nasal
COLLECTED: 09/12/2012 15:59 EDT

STARTED: 09/12/2012 18:17 EDT

ACCESSION: 006-MB-12-036684

*** FINAL REPORT ***

Final Report
Verified:09/14/2012 07:30 EDT
No Methicillin Resistant Staphylococcus aureus isolated

Legend: * = Abnormal, H = High, L = Low, C = Critical, f = footnote, r = reference, c = corrected, i = interpretation

Admitting Physician: OKO MD, NNACHI
Ordering Physician: OKO MD, NNACHI
Consulting Physician: MARMOLEJOS MD, INDIRA M; SILVER MD, MITCHELL; ZELCER MD, ALAN; KRAUSE MD, JOSEPH Z; LOUTFI MD, CHADI/PUD H; ANESTA MD, MICHAEL; MONTESINO VARGAS MD, ERNESTO R

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Patient Name: BERNSTEIN, SIMON L
MRN: 491496
Acct#: 12314973
DOB:12/02/1935 Age:76 years Sex:Male
Location:DEL-CC CC,0002-K
Patient Type: 1 - Inpatient
Admitted: 09/12/2012
Discharged: 09/13/2012

M i c r o b i o l o g y

PROCEDURE: Culture Urine
SOURCE: Urine
COLLECTED: 09/12/2012 17:56 EDT

STARTED: 09/12/2012 21:16 EDT

ACCESSION: 006-MB-12-036630

*** FINAL REPORT ***

Final Report
Verified:09/14/2012 10:40 EDT
No growth at 48 hours.

*** PRELIMINARY REPORT ***

Preliminary Report
Verified:09/13/2012 11:47 EDT
No growth to date

Legend: * = Abnormal, H = High, L = Low, C = Critical, f = footnote, r = reference, c = corrected, i = interpretation

Admitting Physician: OKO MD, NNACHI
Ordering Physician: WILLIAMS MD, ALEXANDER J
Consulting Physician: MARMOLEJOS MD, INDIRA M; SILVER MD, MITCHELL; ZELCER MD, ALAN; KRAUSE MD, JOSEPH Z; LOUTFI MD, CHADI/PUD H; ANESTA MD, MICHAEL; MONTESINO VARGAS MD, ERNESTO R

DATE 01/13/2015

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Medical Director:
Albert Cohen, M.D.

Patient Name:BERNSTEIN, SIMON L
MRN:491496
Acct:12314973
DOB:12/02/1935 Age:76 years Sex:Male
Location:DEL-CC CC,0002-K
Patient Type:1 - Inpatient
Chart Type:Addendum
Admitted:09/12/2012,13:12:00 EDT
Discharged:09/13/2012,06:41:00 EDT

M i c r o b i o l o g y

PROCEDURE: Culture Urine
SOURCE: Urine
COLLECTED: 09/12/2012 17:56 EDT

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Patient Type:1 - Inpatient
Chart Type:Addendum
Admitted:09/12/2012,13:12:00 EDT
Discharged:09/13/2012,06:41:00 EDT

M i c r o b i o l o g y

PROCEDURE: Culture Blood
SOURCE: Peripheral Draw
COLLECTED: 09/12/2012 13:48 EDT

STARTED: 09/12/2012 14:28 EDT

ACCESSION: 006-MB-12-036661

*** PRELIMINARY REPORT ***

Preliminary Report
Verified:09/14/2012 13:01 MDT
No growth at 48 hours.

Preliminary Report
Verified:09/13/2012 13:01 MDT
No growth at 24 hours.

Preliminary Report
Verified:09/13/2012 07:01 MDT
No growth after 8 hours

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Admitted:09/12/2012,13:12:00 EDT
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Microbiology

PROCEDURE: Culture MRSA Screen
SOURCE: Nasal
COLLECTED: 09/12/2012 15:59 EDT

STARTED: 09/12/2012 18:17 EDT

ACCESSION: 006-MB-12-036684

*** FINAL REPORT ***

Final Report
Verified:09/14/2012 07:30 EDT
No Methicillin Resistant Staphylococcus aureus isolated

Pending Tests

Drawn Date	Drawn Time	Order Name	Mnemonic	Order Status	Department Status	Ordering provider
09/12/2012	13:48:00 EDT	Culture Blood	C Blood	InProcess	Preliminary	MONTESINO VARGAS MD, ERNESTO R

Legend: * = Abnormal, H = High, L = Low, C = Critical, f = footnote, r reference, c = corrected, i = interpretation

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Medical Director:
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MRN:491496
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Chart Type:Addendum
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M i c r o b i o l o g y

PROCEDURE: Culture Blood
SOURCE: Peripheral Draw
COLLECTED: 09/12/2012 13:48 EDT

STARTED: 09/12/2012 14:28 EDT

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Acct:12314973
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Chart Type:Addendum
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Discharged:09/13/2012,06:41:00 EDT

P e n d i n g T e s t s

Drawn Date	Drawn Time	Order Name	Mnemonic	Order Status	Department Status	Ordering provider

P e n d i n g T e s t s

Drawn Date	Drawn Time	Order Name	Mnemonic	Order Status	Department Status	Ordering provider
09/12/2012	13:48:00 EDT	Culture Blood	C Blood	InProcess	Preliminary	MONTESINO VARGAS MD, ERNESTO R

Legend: * = Abnormal, H = High, L = Low, C = Critical, f = fo
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Attending Physician: OKO MD, NNACHI
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DATE 01/13/2015

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Phone (561) 495-3209

Medical Director:
Albert Cohen, M.D.

Patient Name:BERNSTEIN, SIMON L
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Acct:12314973
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M i c r o b i o l o g y

PROCEDURE: Culture Blood
SOURCE: Peripheral Draw
COLLECTED: 09/12/2012 13:48 EDT

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Preliminary Report
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No growth at 4 days.

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Attending Physician: OKO MD, NNACHI
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DATE 01/13/2015

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Medical Director:
Albert Cohen, M.D.

Patient Name:BERNSTEIN, SIMON L
MRN:491496
Acct:12314973
DOB:12/02/1935 Age:76 years Sex:Male
Location:DEL-CC CC,0002-K
Patient Type:1 - Inpatient
Chart Type:Addendum
Admitted:09/12/2012,13:12:00 EDT
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Pending Tests

Drawn Date	Drawn Time	Order Name	Mnemonic	Order Status	Department Status	Ordering provider
09/12/2012	13:48:00 EDT	Culture Blood	C Blood	InProcess	Preliminary	MONTESINO VARGAS MD, ERNESTO R

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DATE 01/13/2015

PRINTED BY: MariaNoriega

RADIOLOGY REPORT

DELRAY MEDICAL CENTER | 5352 LINTON BOULEVARD | DELRAY BEACH, FL

AREA CODE (561) 495-3170

PT NAME: BERNSTEIN, SIMON L | DOB: 12/02/1935

LOCATION: CC 0002-K | ACCT. # 012314973

DR. KRAUSE, JOSEPH | MR # 000491496

ORDER # 337294517
09/12/2012
US RETROPERITONEAL COMPLE
Abbrv: USRPCM

The right kidney measures 10.5 x 5.9 x 4.7 cm, the left kidney 10.4 x 6.8 x 5.4 cm

There is increase in echogenicity of the central renal sinus bilaterally suggesting fatty changes.

There is a calcification within the a lower pole of the right kidney which measures 6 mm probably related to a calculus

No hydronephrosis, no perirenal collections, the bladder was not demonstrated

IMPRESSION: Atrophic changes within the central renal sinus bilaterally

Calcification/calculus within the lower pole of the right kidney

*** Final ***
Dictated By: MATA, MARIA B (09/12/2012 18:42)
Signed By: MATA, MARIA B (09/12/2012 18:43)

DATE 01/13/2015

PRINTED BY: MariaNoriega

RADIOLOGY REPORT

DELRAY MEDICAL CENTER 5352 LINTON BOULEVARD DELRAY BEACH, FL
AREA CODE (561) 495-3170

PT NAME: BERNSTEIN, SIMON L DOB: 12/02/1935

LOCATION: ER - ACCT. # 012314973

DR. WILLIAMS, ALEXANDER MR # 000491496

ORDER # 336677495
09/12/2012
XR CHEST 1 VIEW
Abbrv: XRCH1

Portable chest:

INDICATION: Difficulty breathing.

FINDINGS:

The trachea is midline. The mediastinum is not widened. Patchy airspace consolidations are present in the right mid and lower lung fields. The left lung is clear. No pneumothorax or pleural effusion identified. The visualized osseous structures appear unremarkable.

IMPRESSION:

Patchy right lung consolidations, suspicious for pneumonia.

*** Final ***
Dictated By: LEIGHTON, STEPHEN J (09/12/2012 11:13)
Signed By: LEIGHTON, STEPHEN J (09/12/2012 11:15)

DATE 01/13/2015

PRINTED BY: MariaNoriega

RADIOLOGY REPORT

DELRAY MEDICAL CENTER
5352 LINTON BOULEVARD
AREA CODE (561) 495-3170
DELRAY BEACH, FL

PT NAME: BERNSTEIN, SIMON L
DOB: 12/02/1935

LOCATION: CC 0002-K
ACCT. # 012314973

DR. OKO, NNACHI
MR # 000491496

ORDER # 337838416
09/13/2012
XR CHEST 1 VIEW
Abbrv: XRCH1

IMPRESSION: Interval placement of an endotracheal tube measuring 4.2 cm from the level of the carina. The heart is enlarged. Persistent right patchy consolidation. New consolidation has also developed on the left. No obvious pneumothorax.

*** Final ***
Dictated By: BOO, HEATHER (09/13/2012 01:15)
Signed By: BOO, HEATHER (09/13/2012 01:15)

DATE 01/13/2015

PRINTED BY: MariaNoriega

STATE OF FLORIDA

THIS DOCUMENT HAS A LIGHT BACKGROUND ON TRUE WATERMARKED PAPER. HOLD AT ANGLE TO VERIFY FLORIDA WATERMARK.

OFFICE of VITAL STATISTICS

50 2012 CP 04391 XXXX SB
I2

CERTIFICATION OF DEATH

STATE FILE NUMBER: 2012256765 **DATE ISSUED:** September 18, 2012

STATE FILE DATE: September 17, 2012

DECEDENT INFORMATION

NAME: **SIMON LEON BERNSTEIN**

DATE OF DEATH: **September 13, 2012** SEX: **MALE** AGE: **076 YEARS**
DATE OF BIRTH: **December 2, 1935** SSN: [redacted]
BIRTHPLACE: **FLINT, MICHIGAN**
PLACE WHERE DEATH OCCURRED: **INPATIENT**
FACILITY NAME OR STREET ADDRESS: **DELRAY MEDICAL CENTER**
LOCATION OF DEATH: **DELRAY BEACH, PALM BEACH COUNTY**

SURVIVING SPOUSE, DECEDENT'S RESIDENCE AND HISTORY INFORMATION

MARITAL STATUS: **WIDOWED**
SPOUSE: **NONE**
RESIDENCE: **7020 LIONS HEAD LANE, BOCA RATON, FLORIDA 33496**
COUNTY: **PALM BEACH**
OCCUPATION, INDUSTRY: **SALES, LIFE INSURANCE**
RACE: X White ___Black or African American ___Asian Indian ___Chinese ___Filipino ___Native Hawaiian
___American Indian or Alaskan Native--Tribe: ___Japanese ___Korean ___Vietnamese
___Guamian or Chamorro ___Samoan ___Other Pacific Isl:
___Other Asian: ___Other: ___Unknown
HISPANIC OR HAITIAN ORIGIN? **NO, NOT OF HISPANIC/HAITIAN ORIGIN**
EDUCATION: **HIGH SCHOOL GRADUATE OR GED** EVER IN U.S. ARMED FORCES? **NO**

PARENTS AND INFORMANT INFORMATION

FATHER: **THEODORE BERNSTEIN**
MOTHER: **NORA UNKNOWN**
INFORMANT: **TED STUART BERNSTEIN**
RELATIONSHIP TO DECEDENT: **SON**
INFORMANT'S ADDRESS: **880 Berkley Street, BOCA RATON, FLORIDA 33487**

SHARON R. BOCK, CLERK
PALM BEACH COUNTY, FL
SOUTH CTY BRANCH-FILED
2012 OCT -2 AM 9:32

PLACE OF DISPOSITION AND FUNERAL FACILITY INFORMATION

PLACE OF DISPOSITION: **THE GARDENS MEMORIAL PARK**
BOCA RATON, FLORIDA
METHOD OF DISPOSITION: **ENTOMBMENT**
FUNERAL DIRECTOR/LICENSE NUMBER: **GARRETT JACOBS, F019844**
FUNERAL FACILITY: **BOCA RATON FUNERAL HOME F040152**
19785 HAMPTON DRIVE, BOCA RATON, FLORIDA 33434

CERTIFIER INFORMATION

TYPE OF CERTIFIER: **MEDICAL EXAMINER** MEDICAL EXAMINER CASE NUMBER: **121500913**
TIME OF DEATH (24 hr): **0227**
CERTIFIER'S NAME: **MICHAEL D BELL**
CERTIFIER'S LICENSE NUMBER: **ME54359**
NAME OF ATTENDING PHYSICIAN (If other than Certifier): **NOT ENTERED**

THE ABOVE SIGNATURE CERTIFIES THAT THIS IS A TRUE AND CORRECT COPY OF THE OFFICIAL RECORD ON FILE IN THIS OFFICE. State Registrar

REQ: **2013124648**

WARNING: THIS DOCUMENT IS PRINTED OR PHOTOCOPIED ON SECURITY PAPER WITH WATERMARKS OF THE GREAT SEAL OF THE STATE OF FLORIDA. DO NOT ACCEPT WITHOUT VERIFYING THE PRESENCE OF THE WATERMARKS. THE DOCUMENT FACE CONTAINS A MULTICOLORED BACKGROUND, GOLD EMBOSSED SEAL, AND THERMOCHROMIC FL. THE BACK CONTAINS SPECIAL LINES WITH TEXT.

* 2 8 3 6 6 0 6 0 *

DH FORM 1946 (04-10)

CERTIFICATION OF VITAL RECORD

FLORIDA DEPARTMENT OF HEALTH

VOID IF ALTERED OR ERASED

VOID IF ALTERED OR ERASED