## II. Case Summary:

Dr. Wilson saw Mr. Daniel Fussell, age 43, on 7/14/08 at the Wilson Care Medical Center. Dr. Wilson's initial history stated that he was there to "establish as primary care" and that he was "on seizure and psychiatric medication, well controlled." (MR 0110) This note lists his medications and pill sizes, but does not indicate the dosing. The past history is listed as "lipemia/bipolar/MR." Family history is listed as "NP" which from his interview, Dr. Wilson indicates this means "nothing particular." Drug allergy is "N" which Dr. Wilson indicates means "none." The review of systems is positive for shortness of breath, headache, diarrhea, constipation and painful urine. Lab is listed as "UA;RBCs." The physical exam has the vital signs "BP 120/78 RR 24/M PR 80/M WT 257," HENT and Ortho exams are "NP," and abdomen exam is "N," which Dr. Wilson stated in his interview meant normal in this instance. His abdominal exam is listed twice. Mental exam is "Out Touch." The diagnosis is "Bipolar, ASCVD/MR, Lipidemia" and the treatment plan is "Keep same until reviewed next." Of note, the patient intake form filled out by the patient's caregiver, Rebecca Madison, from the same date, indicates that the patient also has "swelling of both legs, incontinence, obesity and medications not filled" as well as a medication list that differs from Dr. Wilson's in that it states he is taking simvastatin 10 mg. (MR 0012) In the diagnosis and treatment plan, there is no assessment of the positive review of systems items (shortness of breath, diarrhea, constipation, headache, painful urination), the history of leg edema, or the red blood cells seen on urinalysis.

The second visit to Dr. Wilson was on 11/20/2008, when his medical assistant indicated he came in for "check up, blood was coming out of his left ear, flu shot" and that his vitals were "BP 128/78 P74 R Wt 205." (MR 0109) The note from Dr. Wilson does have a history about the ear drainage and bleeding, congestion and sore throat. The diagnosis and treatment plan were changed to reflect this history, but the remainder of the note, including the physical examination, lab results, and review of systems, is identical to Dr. Wilson's note from 7/14/08. (MR 0107) In particular, the vital signs were unchanged (BP 120/78 RR 24/M PR 80M WT 257") and are different from his medical assistant's notes. The HENT exam states "NP" again. Again, the positive review of systems items and blood in the urinalysis were not addressed.

The third visit to Dr. Wilson was on 12/17/08 again for ear problems. (MR 0104) Dr. Wilson's note did change some on this visit, in that the history section reflected "ear pain and drainage other conditions stationary." The review of systems was changed to "ditto." The HENT exam was changed to "red and drain ext ears," but the remainder of the physical exam is identical to the initial visit, including the vital signs ("BP 120/78 RR 24/M PR 80/M WT 257"), which again is different from the medical assistant's vital signs for that date. (MR 0105-0106)

The fourth visit was on 12/24/08 for follow-up on the ear infection. (MR 0103) The review of systems again says "ditto" and the vital signs remain unchanged from the initial July 2008 visit as does the rest of the physical examination except for the HENT exam which again states "NP."

There was a visit with Dr. Wilson on 2/25/09, as there is a medical assistant note with vital signs (MR 0101), a stamp on a page that lists each visit (MR 0177), and labs were ordered on that date (MR 0184), but there was no physician note for that date.

The fifth visit was on 3/25/09, where the history is "all time somnolence general condition stable." (MR 0098) The remainder of the exam is once again identical to the 7/14/08 note, including the vital signs and the annotation "ditto" for review of systems. The diagnosis is "resolving ear infection" which is copied from the previous 12/24/08 note and the treatment plan is "sleep study." His medical assistant indicates the medication "allopurinol 100 mg" but there is no indication of this on Dr. Wilson's note. (MR 0099)

The sixth visit was on 4/27/09 for check on bilateral ear infection per the medical assistant, who noted "see list" for medications. (MR 0097) The medication list section of the chart, however, lists no medications (MR 0177- 0178). Dr. Wilson's note indicates a history of "ears infection all time somnolence, general condition stable." The remainder of the note is identical to the initial note from 7/14/08, including the vital signs ("BP 120/78 RR 24/M PR 80/M WT 257"). HENT exam is listed as "NP" and the diagnosis is again "resolving ear infection."

The seventh and final visit to Dr. Wilson was on 6/1/09. The medical assistant note indicates a chief complaint of "fell and right side hurts" and documents vital signs of "BP 132/76 Wt 235 P82 R20 T100.3." (MR 0095) Dr. Wilson's note indicates a history of "fell and bruise his left leg otherwise status quo general condition stable." The remainder of the note is unchanged except for the diagnosis and treatment plan sections. Again, the entire physical exam is unchanged from his initial note, including the vital signs and orthopedic exam, which is indicated as "NP." There are no pertinent positives and negatives for the abdominal or chest exam, only "CHEST/COR/ABDOMEN; 2/6 murmur" which was the same exam documented at every visit. The diagnosis is of "contusion of skin; falling episode" and the copied "Bipolar, ASCVD/MR, Lipidemia" from prior notes. The treatment plan is "observation neuro. Rx; maintain same for now." (MR 0094) He does not indicate that he recognized the low-grade fever of 100.3.

On 6/6/09, Mr. Fussell was found unresponsive on the bathroom floor at his care home. He was pronounced dead by emergency personnel. The Sacramento Coroner performed a complete autopsy and determined the cause of death to be right hemothorax due to blunt force thoracic injuries. Thus, he died of bleeding into his right chest after trauma to the right chest. The coroner's autopsy report reports multiple contusions over the body. Notably, he found "large healing contusions of the right hip and flank" and "contusions of extremities, healing and recent." The right hip contusion measured 17 by 11 cm and the right flank contusion measured 6 by 23.5 cm. There were also fractures of multiple right ribs.

The investigation report indicates that Mr. Fussell had a fall on the steps at his facility on 5/31/09, which led to the visit with Dr. Wilson on 6/1/09 for evaluation. The care home where Mr. Fussell resided was found to have multiple violations in regards to their care of Mr. Fussell.

Investigator Stefani interviewed Mr. Fussell's parents and their lawyer. They told her that Mr. Fussell had an IQ of 62, but he had finished high school and some college. He could communicate readily at a 5th or 6th grade level.

Other areas of chart review indicate that Mr. Fussell was on omeprazole, hydrochlorothiazide, aspirin, phonation, and allopurinol, which Dr. Wilson prescribed (MR 0185, 0186, 0190, 0191, 0192, 0193 0194). These are never listed in Dr. Wilson's medication Lists. There are no diagnoses to support omeprazole, hydrochlorothiazide, or allopurinol use in any of his notes.