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IN THE DISTRICT COURT OF THE FOURTH JUDICIAL DISTRICT OF THE STATE OF IDAHO, IN AND FOR THE COUNTY OF ADA

ST. LUKE'S HEALTH SYSTEM, LTD; ST. LUKE'S REGIONAL MEDICAL CENTER, LTD; CHRIS ROTH, an individual; NATASHA D. ERICKSON, MD, an individual; and TRACY W. JUNGMAN, NP, an individual, Plaintiffs, vs. AMMON BUNDY, an individual; AMMON BUNDY FOR GOVERNOR, a political organization; DIEGO RODRIGUEZ, an individual; FREEDOM MAN PRESS LLC, a limited liability company; FREEDOM MAN PAC, a registered political action committee; and PEOPLE'S RIGHTS NETWORK, a political organization, Defendants.	Case No. CV01-22-06789 **DECLARATION OF TRACY W. JUNGMAN, NP IN SUPPORT OF MOTIONS FOR LEAVE TO AMEND COMPLAINT TO ALLEGE PUNITIVE DAMAGES** **FILED UNDER SEAL**

I, Tracy W. Jungman, NP, declare and state as follows:

1. I make this declaration based on my personal knowledge.

2. I am a nurse practitioner specializing in pediatrics at St. Luke's CARES in Boise, Idaho ("CARES"). My job is to evaluate and treat children that may be victims of abuse,

neglect, or other forms of child maltreatment. I have worked at CARES for about five years. During that time, I have provided assistance to more than 1,700 patients. I am an employee of St. Luke's Regional Medical Center, Ltd. ("St. Luke's") and am not an agent or employee of the Idaho Department of Health and Welfare ("DHW") or any other governmental entity.

3. I have been a registered nurse since 2002 and obtained my Master of Science in Nursing, becoming a certified nurse practitioner in 2017. From 2002 to the present my practice has been in pediatrics. I have obtained ongoing additional education in pediatric medicine, focusing on survivors of child abuse. In the course of my regular job duties, I am often called upon to testify in court in child abuse cases because of my expertise in recognizing and treating victims of child abuse and neglect.

4. On March 11, 2022, I was contacted by a DHW safety assessor. The safety assessor informed me that DHW received a Priority I referral regarding a ten-month-old infant (the "Infant") and asked that I consult on the referral. DHW contacted me for consultation; I did not initiate contact with DHW.

5. I reviewed all available medical records and information. This included medical records from the Infant's admission to St. Luke's from March 1, 2022, to March 4, 2022, the Priority I referral, and additional information provided to me by the DHW safety assessor.

6. Based on the medical records that were provided to me and the additional information regarding the Infant's loss of weight, the parents' failure to attend the previously scheduled medical appointment, and the parents' refusal to answer or return phone calls, I was very concerned for the health of the Infant. I informed DHW that I would stay in the office until 4:00 p.m. that afternoon in order to accommodate an evaluation (typically patients are not scheduled after 3:00 p.m.), but the parents and the Infant did not show up. I then advised DHW

and the Meridian Police that the Infant should be medically evaluated as soon as the Infant could be located. I did not diagnose the Infant, I did not play any role in DHW's decision to contact the Meridian Police, I did not play any role in the manner or method by which the Infant was taken into custody, and I did not make any decisions regarding the Infant's custody or care at any time.

7. On the morning of March 12, 2022, I was informed that the Infant had been located and brought to St. Luke's Boise. I offered to complete the requested CARES consult because I was already familiar with the Infant's medical records and information. I examined the Infant, who appeared listless, lethargic, dehydrated, and thin. His weight was at the .02 percentile for age, meaning he weighed less than 99.98 percent of similarly aged children, which is consistent with moderate to severe malnutrition. I was particularly concerned because the Infant was minimally responsive during repeated attempts to place an IV catheter to provide fluids, likely due to severe dehydration. Furthermore, the lab work completed at that time demonstrated alterations in the Infant's kidney function consistent with significant dehydration. I was concerned because the level of dehydration and malnutrition the Infant was experiencing could have potentially devastating effects on a child's health and development. Various body organs, including the brain, require adequate nutrition in order to function properly and develop. It was imperative that the Infant be provided sufficient hydration and nutrition.

8. I continued to assist with the medical care and treatment of the Infant for the next several days. On March 13, 2022, the Infant was given an NG feeding tube to provide sufficient nourishment for healthy growth.

9. The St. Luke's team caring for the Infant updated the Infant's parents regularly. I participated in one such call with the parents on March 12, 2022 and another call on March 13,

2022. During these calls, the parents refused to provide basic medical history about the Infant (for instance, information about whether the Infant had had routine newborn screening (PKU) completed and results of prior allergy testing), even though that information would aid in the Infant's care and treatment. During the phone call on March 12, when I declined to provide my name, the Infant's mother Marissa stated "nothing will happen to you unless you do something to my baby" and "I won't tell anyone your name unless something happens to my baby."

10. During the days the Infant was at St. Luke's, there were crowds of protesters outside the hospital, shouting profanity and holding firearms and signs. I could see and hear them while I was at the hospital to care for the Infant. Each day, I had to take an alternate entrance into the building to avoid the protesters' harassment and intimidation. I understood from online video postings that the protesters had been called to St. Luke's by Ammon Bundy.

11. On March 15, 2022, the crowd of armed protesters swelled in number and became louder and more threatening. Due to the security risk, St. Luke's hospital went into lockdown. I was at my office that day, which is located approximately one mile from the hospital. CARES administration was informed that morning that there was likely to be protests at our clinic within 48 hours. The CARES office also received a phone call that day from an unknown caller inquiring whether or not the Infant was in our clinic. Worried for the safety of the staff there and the threat of the protesters committing acts of violence against them because of the lies Ammon Bundy was telling his followers about the Infant being kidnapped and about St. Luke's employees being "wicked," the decision was made to cancel the afternoon appointments and close the clinic. Additionally, the appointments for March 16 were cancelled and staff remained home in an abundance of caution.

12. Every step of the way, I provided competent and caring medical treatment to the Infant. Even when my own safety and well-being were threatened, I continued to do my job because that was required of me, and the Infant needed medical intervention. Attached hereto as **Exhibit A** is a true and correct copy of the Infant's medical records with St. Luke's.

13. I understand that the website www.freedomman.org accused me of kidnapping the Infant. This is false. I know that the police had lawful authority to bring the Infant to St. Luke's.

14. I understand that the website www.freedomman.org accused me of medical malpractice for diagnosing the Infant. This is false. I did not diagnose the Infant until evaluating him independently, which occurred on March 12.

15. I understand that the website www.freedomman.org implied that I inappropriately look at and ask "innocent little children that have just been ripped from their families" about their privates. This is false. As part of my job, I evaluate and treat children that may be victims of abuse. Although this may include examining a child's genitals, it is always done with the explicit consent of the child (if old enough) and guardian and is completed for medical purposes. Guardians are typically present during this examination and any conversations regarding genital health.

16. I understand that the website www.freedomman.org states that I forced the Infant's feeding tube "through his nose into his gut" after he "accidentally pulled [it] out" without sanitizing it, washing my hands, or using gloves. This misrepresents the facts. On March 18, 2022, I was contacted by DHW after they were notified by the Infant's parents that the feeding tube had inadvertently come out. I then offered to arrange for home health to start providing services in the home, including the management and replacement of the feeding tube. I also recommended that the parents could proceed to the emergency room of their choosing to

have the tube replaced. The parents then requested that I replace the feeding tube that evening as opposed to pursuing the other options. I agreed to do so in order to help the family and Infant, and to ensure ongoing nutritional support, even though this was not necessarily my responsibility. As security continued to be a concern, arrangements were made to meet at a neutral (non-medical) location. Upon arriving, I used hand sanitizer and re-inserted the tube per standard guidelines. As this is not a sterile procedure, there is no reason to sanitize the tube prior to re-insertion. Parents are often taught to re-insert feeding tubes in the home, assuming they are comfortable doing so, using the same procedure.

17. The false public accusations of kidnapping and trafficking of children by Ammon Bundy and on the www.freedomman.org website caused and continue to cause me interpersonal harm. These defamatory actions, coupled with the incitements to harass me and my family and implied threats of violence from Defendants' followers, have had a traumatic effect.

18. Defendants' complete and utter disregard for others, their irrational behavior, their extremism, their intentional and repeated interruption at a medical institution, and their willingness to harass and defame others to push their agendas is what I fear most.

19. I have experienced flashbacks accompanied by physical symptoms, reoccurring memories and nightmares, difficulty sleeping, distressing thoughts, and physical signs of distress such as racing heart, tightness of chest, and difficulty breathing.

20. Ever since the Boise Police Department informed me that I had been doxed by Defendants, I have had ongoing feelings of anxiety. The doxing has disrupted my work.

21. In September, I watched a video online of Ammon Bundy talking about this lawsuit and in particular the St. Luke's protest/lockdown in which he stated that he "was holding a tremendous amount of patriots back from coming from all over the country that were basically

wanting to come clean house." The idea that he had, and continues to have, the ability to so easily and swiftly incite violence against myself and others is truly horrifying. I furthermore have significant concerns regarding the overall effect that this case will have on child safety in the state of Idaho.

22. I have experienced avoidance symptoms such as staying away from places and activities owing to concern for my safety, the safety of my coworkers, and the safety of my family and friends. These symptoms have caused me to make changes in my routines and activities. For example, for a time I avoided going to the grocery store or having my minor children spend the night in my home. I avoid posting on social media, I avoid wearing my St. Luke's badge outside of the CARES clinic, and I avoid telling people my last name or my place of work.

23. I have experienced arousal and reactivity symptoms, including being more easily startled, feeling tense, and difficulty sleeping. I feel obsessed with the safety of those in my home. These symptoms have occurred in ordinary circumstances, like when I come home from work and see my garage door open, or when I sign my name on a bill at a restaurant. In fact, I am constantly worried that my doors are unlocked, that my garage is open, or that my windows are unsecured. This has led me to invest in a home security system—something I never considered buying before. Attached hereto as **Exhibit B** is the receipt for the home security cameras, which cost $296.78 plus a recurring monthly fee of $9.99.

24. I have experienced cognition and mood symptoms owing to the trauma such as negative thoughts about my circumstances. I feel guilty for exposing my family and friends to scrutiny and possibly harm. I constantly worry that children needing care will not be brought in for necessary medical care because of the untrue and heinous accusations made by the

Defendants. Because of the lies and threats from the Defendants, I have suffered from anxiety and take an antidepressant medication regularly to ameliorate it.

25. This mental distress has disrupted my daily life and made it more difficult for me to do my job as a nurse practitioner. I have also suffered harm to my reputation.

26. Moreover, the impact is repeated each time Defendants make another defamatory statement about me and grows each day that Defendants persist in keeping the defamatory postings up on the websites they control.

I declare under penalty of perjury of the laws of the State of Idaho that the foregoing is true and correct.

Executed this 8th day of November, 2022.

/s/ Tracy W. Jungman
Tracy W. Jungman, NP

CERTIFICATE OF SERVICE

I hereby certify that on this 5th day of December, 2022, I caused to be filed and served, via iCourt, a true and correct copy of the foregoing by the method indicated below, and addressed to the following:

Ammon Bundy for Governor P.O. Box 370 Emmett, ID 83617	☑ U.S. Mail ☐ Hand Delivered ☐ Overnight Mail ☐ Email/iCourt/eServe:
Ammon Bundy for Governor c/o Ammon Bundy 4615 Harvest Ln. Emmett, ID 83617-3601	☐ U.S. Mail ☐ Hand Delivered ☑ Overnight Mail ☐ Email/iCourt/eServe:
Ammon Bundy 4615 Harvest Ln. Emmett, ID 83617-3601	☐ U.S. Mail ☐ Hand Delivered ☑ Overnight Mail ☐ Email/iCourt/eServe:
People's Rights Network c/o Ammon Bundy 4615 Harvest Ln. Emmett, ID 83617-3601	☐ U.S. Mail ☐ Hand Delivered ☑ Overnight Mail ☐ Email/iCourt/eServe:
People's Rights Network c/o Ammon Bundy P.O. Box 370 Emmett, ID 83617	☑ U.S. Mail ☐ Hand Delivered ☐ Overnight Mail ☐ Email/iCourt/eServe:
Freedom Man Press LLC c/o Diego Rodriguez 1317 Edgewater Dr. #5077 Orlando, FL 32804	☑ U.S. Mail ☐ Hand Delivered ☐ Overnight Mail ☐ Email/iCourt/eServe:
Freedom Man Press LLC c/o Diego Rodriguez 9169 W. State St., Ste. 3177 Boise, ID 83714	☑ U.S. Mail ☐ Hand Delivered ☐ Overnight Mail ☐ Email/iCourt/eServe:
Freedom Man PAC c/o Diego Rodriguez 1317 Edgewater Dr., #5077 Orlando, FL 32804	☑ U.S. Mail ☐ Hand Delivered ☐ Overnight Mail ☐ Email/iCourt/eServe:

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☐ U.S. Mail
☐ Hand Delivered
☐ Overnight Mail
☑ Email/iCourt/eServe:
freedommanpress@protonmail.com

/s/ *Erik F. Stidham*
Erik F. Stidham
OF HOLLAND & HART LLP

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JUNGMAN DECLARATION

EXHIBIT A

03/12/2022 - ED to Hosp-Admission (Current) in Boise Pediatrics

All Encounter Notes

H&P by at 3/12/2022 0304

PEDIATRIC HOSPITALIST ADMISSION NOTE

ADMITTING ATTENDING

ADMISSION DIAGNOSES
Active Problems:
Malnutrition (HCC)
Failure to thrive (child)

CHIEF COMPLAINT
Weight loss

HISTORY OF PRESENT ILLNESS
Cyrus is a 10 m.o. male discharged from the hospital on 3/4, who presents with weight loss in the setting of failure to thrive. Patient was admitted from 3/1-3/4 after being referred for admission due to severe malnutrition. Initially the patient required NG feeds, but at discharge, he was taking bottle feeds without issue. He was discharged home with an NG in place and family was provided syringe feeding supplies in case the patient's po intake dropped off. Family did not go home with a feeding pump as they declined this, citing cost (they are self-pay). He was scheduled to see his PCP on 3/6, but did not show for the appointment. Home health was also not able to get in touch with the family. Case was discussed on 3/11 with with CARES who reported the child had not been seen and despite multiple attempts to contact the family, the patient had not returned for a weight check. Ultimately, health and welfare and law enforcement became involved. It is my understanding a warrant was issued and the child was removed from the home and declared immediately. He was brought to the Meridian ED for evaluation. Health and welfare identified a foster family but due to protesters surrounding the hospital regarding this case, it was felt that discharge with the foster family from the ED was unsafe for all involved. For this reason, the patient was transferred to Boise for further care.

ED COURSE
CBC and BMP was obtained in the ED. Patient reportedly took 2 ounces of formula eagerly in the ED.

REVIEW OF SYSTEMS
Review of Systems:
Unable to perform ROS: Age

Pertinent positives and negatives mentioned in HPI and ROS, All others negative.

PAST MEDICAL HISTORY

Past Medical History:

Diagnosis	Date
• Severe malnutrition (HCC)	

On last admission, no newborn screen or growth curves were able to be obtained

BIRTH HISTORY

All Encounter Notes (continued)

Per chart review, patient born at term at a birthing center. Went home with mother 3 hours later.

PAST SURGICAL HISTORY

Past Surgical History:

Procedure	Laterality	Date
• FRENULECTOMY, LINGUAL		

PCP

IMMUNIZATIONS

Unimmunized

MEDICATIONS

Prior to Admission medications

Medication	Sig	Start Date	End Date	Taking?	Authorizing Provider
ENTERAL FEEDING PUMP SUPPLIES	**NG feeding supplies: 1) Feeding pump 2) Feeding pump bags - use 1 daily Disp: 30 per month with 1 refill 3) IV pole 4) backpack for portability 5) 60cc syringes 6) NG securement devices.**	**3/3/22**			
ENTERAL FEEDING PUMP	**Pump for bolus NGT feeds. 128 ml 8 times daily. Run pump over 60 minutes. Use as directed.**	**3/3/22**			
miscellaneous medical supply	**Nutramigen mixed to 20kcal/oz. EBM + Nutramigen for total volume of 1024 ml per day via NG tube.**	**3/3/22**			

ALLERGIES

03/12/2022 - ED to Hosp-Admission (Current) in Boise Pediatrics (continued)

All Encounter Notes (continued)

Allergies

Allergen	Reactions
• Lactose	Nausea And Vomiting

DIET

Discharged home on breastmilk and nutramigen. Uncertain what patient has been eating since discharge.

DEVELOPMENT

Per last admission, family reported development was normal for age

FAMILY HISTORY

Per last admission H&P:
"Mother with food sensitivities. No true allergies. No other health concerns.
Father is healthy"

SOCIAL HISTORY

Unable to confirm on admission. Patient has been declared and is currently a ward of the state. Shelter care hearing planned for Tuesday per hospital documentation.

OBJECTIVE DATA

Vitals: [Range] current
Temp: [36.6 °C (97.9 °F)-37 °C (98.6 °F)] 37 °C (98.6 °F)
Heart Rate: [127-140] 127
Resp: [16-30] 16
BP: (99-111)/(56-84) 99/56
MAP (mmHg): [71] 71
SpO2: [98 %-99 %] 99 %

Wt Readings from Last 1 Encounters:

03/12/22	6.28 kg (13 lb 13.5 oz) (<1 %, Z= -3.50)*

* Growth percentiles are based on WHO (Boys, 0-2 years) data.

Ht Readings from Last 1 Encounters:

03/12/22	71.5 cm (28.15") (17 %, Z= -0.96)*

* Growth percentiles are based on WHO (Boys, 0-2 years) data.

Body mass index is 12.28 kg/m².
<1 %ile (Z= -4.29) based on WHO (Boys, 0-2 years) BMI-for-age based on BMI available as of 3/12/2022.
<1 %ile (Z= -3.50) based on WHO (Boys, 0-2 years) weight-for-age data using vitals from 3/12/2022.
17 %ile (Z= -0.96) based on WHO (Boys, 0-2 years) Length-for-age data based on Length recorded on 3/12/2022.
Blood pressure percentiles are not available for patients under the age of 1.

PHYSICAL EXAMINATION

Physical Exam

Constitutional:
General: He is not in acute distress.
Appearance: He is not toxic-appearing.
Comments: **Small, wasted, appears dehydrated**

HENT:
Head: Normocephalic and atraumatic. Anterior fontanelle is sunken.
Right Ear: External ear normal.
Left Ear: External ear normal.
Nose: Congestion **(mild)** present.
Comments: **NG is not in place**
Mouth/Throat:
Mouth: Mucous membranes are moist.
Comments: **Lips dry and cracked**

Eyes:
General:
Right eye: No discharge.
Left eye: No discharge.
Conjunctiva/sclera: Conjunctivae normal.
Pupils: Pupils are equal, round, and reactive to light.

Cardiovascular:
Rate and Rhythm: Normal rate and regular rhythm.
Pulses: Normal pulses.
Heart sounds: Normal heart sounds. No murmur heard.

Pulmonary:
Effort: Pulmonary effort is normal. No respiratory distress or retractions.
Breath sounds: Normal breath sounds. No decreased air movement. No wheezing or rales.

Abdominal:
General: Abdomen is flat. Bowel sounds are normal. There is no distension.
Palpations: Abdomen is soft. There is no mass.
Tenderness: There is no abdominal tenderness.

Genitourinary:
Penis: Circumcised.

Musculoskeletal:
General: No swelling, tenderness, deformity or signs of injury. Normal range of motion.
Cervical back: Normal range of motion.
Comments: **Extremities are thin. Minimal subcutaneous fat**

Skin:
General: Skin is warm and dry.
Capillary Refill: Capillary refill takes less than 2 seconds.
Findings: No rash.

Neurological:
Mental Status: He is alert.
Comments: **Mild head lag; sits without support, bears weight on legs**

All Encounter Notes (continued)

ASSESSMENT & PLAN

10 month old male being readmitted for malnutrition and failure to thrive. He gained weight well in the hospital last admission. Discharge weight was 6.545kg. Today's weight is down to 6.28kg. He appears dehydrated with a sunken fontanelle and dry lips. His labs support dehydration with an elevated BUN. He also had a mildly low blood glucose of 59. Notably, the patient does not have an NG in place, though he was discharged with one. He is a ward of the state and awaiting shelter care hearing. Due to safety concerns, he is to have no visitors.

1. FEN/GI: Feed nutramigen 130mL q3 hours. This was what he was supposed to be getting at home and demonstrated good weight gain on this feeding plan last admission. If able, may be able to space out feeds and provide higher volume, but unclear if the patient will tolerate higher volumes. Would advance gradually. Daily weights. Monitor I/O.
-Recheck POC BG as patient's was mildly low in the ED.
-Check LFTs, Lipase, UA, UDS.

2. CV/RESP: Routine vitals

3. NEURO: tylenol PRN

4. DISPO: SW consult. Discuss with cares in the AM. Discharge per health and welfare and law enforcement.

Time: 70+ minutes spent in evaluating the patient, reviewing the chart, reviewing labs/studies, and discussing with subspecialists and/or other team members about result and clinical course, and updating parents on patient's condition, lab results, response to therapy, and criteria for discharge, with >50% on counseling and coordinating of care with staff.

ELECTRONICALLY SIGNED:

3/12/2022
3:41 AM

Electronically signed at 3/14/2022 6:25 PM

Progress Notes by at 3/13/2022 0844

PEDS HOSPITALIST PROGRESS NOTE

DATE OF SERVICE

3/13/2022

REASON FOR HOSPITAL ADMISSION

Cyrus is a 10 m.o. male admitted on 3/12/2022 12:59 AM for:

Active Hospital Problems

Diagnosis	Date Noted

03/12/2022 - ED to Hosp-Admission (Current) in Boise Pediatrics (continued)

All Encounter Notes (continued)

Active Hospital Problems

Diagnosis	Date Noted
• Failure to thrive (child)	03/12/2022
• Malnutrition (HCC)	03/01/2022

Resolved Hospital Problems

No resolved problems to display.

INTERVAL HISTORY

Overnight and through the day yesterday, nursing notes that patient continues to be somnolent overall. Decreasing po intake since admission. Patient disinterested in the bottle and gagging on the nipple. Clarified during discussion with parents yesterday that they have been using a bottle, which is what we are using here.
Mom was able to provide breast milk, so have been using this and per parents, he was taking 6-8 oz by mouth every 3 hours at home.
He has had spitting up with feeds, which seems more associated with gagging on the bottle than spontaneous vomiting. He has seemed wean with early fatigue at the bottle when he does eat.
Due to poor intake here and low urine output, he had an IV placed and was provided 2 normal saline boluses followed by maintenance IVF overnight. Urine output improved following the second fluid bolus.
This morning, initially refusing the bottle this morning. Discussed NG with the family via phone updated and gave consent for the NG "under duress".
Patient then decided to perk up and take a full feed this morning. Will see how the next feed goes prior to placing the NG.

CURRENT MEDICATIONS

Scheduled Meds:

• sodium chloride 0.9 % (flush)	1 mL	IntraVENOUS	3 times per day

Continuous Infusions:

• dextrose 5 % and sodium chloride 0.9 % with KCl 20 mEq/L infusion	25 mL/hr at 03/12/22 1218

PRN Meds:.acetaminophen, ondansetron HCL, sodium chloride 0.9 % (flush)

OBJECTIVE DATA

Vital signs, last 24h ranges, current
Temp: [36 °C (96.8 °F)-36.7 °C (98.1 °F)] 36.4 °C (97.5 °F)
Heart Rate: [99-114] 107
Resp: [24-28] 28
BP: (99-114)/(66-81) 99/66
MAP (mmHg): [78-93] 78
SpO2: [98 %-100 %] 100 %
Blood pressure percentiles are not available for patients under the age of 1.

I/O Report

03/12/2022 - ED to Hosp-Admission (Current) in Boise Pediatrics (continued)

All Encounter Notes (continued)

	03/11 0701 03/12 0700	03/12 0701 03/13 0700	03/13 0701 03/14 0700
P.O.	235	255	140
I.V. (mL/kg)		390.4 (58.9)	
Total Intake(mL/kg)	**235 (37.4)**	**645.4 (97.3)**	**140 (21.1)**
Urine (mL/kg/hr)		431 (2.7)	137 (3.5)
Emesis/NG output		0	
Stool		0	
Total Output		**431**	**137**
Net	**+235**	**+214.4**	**+3**

Emesis (Unmeasured)	5 x
Urine (Unmeasured)	0 x
Stool (Unmeasured)	0 x

Weight Change (last 7 days)

Date/Time	Weight	+/- Last Wt (g)	% Weight Change Since Admission
03/13/22 0453	6.63 kg (14 lb 9.9 oz)	350 g	5.07
03/12/22 0225	6.28 kg (13 lb 13.5 oz)	-30 g	-0.48
03/12/22 0102	6.31 kg (13 lb 14.6 oz)	0 g	0

PHYSICAL EXAMINATION

Physical Exam

Vitals and nursing note reviewed.

Constitutional:
General: He is not in acute distress.
Appearance: He is not toxic-appearing.
Comments: **Sleeping this morning. Hydration appears improved. Cachectic on exam with poor muscle tone and bulk. Once awake and reassessed, appears interactive and happily playing with toys with staff.**

HENT:
Head: Normocephalic. Anterior fontanelle is flat.
Nose: Nose normal.
Mouth/Throat:
Mouth: Mucous membranes are moist.

Cardiovascular:
Rate and Rhythm: Normal rate and regular rhythm.
Pulses: Normal pulses.
Heart sounds: Normal heart sounds. No murmur heard.

Pulmonary:
Effort: Pulmonary effort is normal. No respiratory distress.
Breath sounds: Normal breath sounds.

Abdominal:
General: Abdomen is flat. There is no distension.

Palpations: Abdomen is soft.

Musculoskeletal:
General: No swelling, tenderness or signs of injury.
Comments: **Low muscle bulk and tone for age**

Skin:
General: Skin is warm.
Capillary Refill: Capillary refill takes less than 2 seconds.
Turgor: Normal.

LABORATORY

Reviewed in EMR, with significant result highlighted below

TOTAL BILIRUBIN	0.7	0.2 - 1.3 mg/dL
ALK PHOS	129	101 - 394 U/L
AST(SGOT)	44	16 - 52 U/L
ALT(SGPT)	13	<=50 U/L

Magnesium

Collection Time: 03/13/22 6:57 AM

Result	Value	Ref Range
MAGNESIUM	2.1	1.5 - 2.4 mg/dL

Phosphorus

Collection Time: 03/13/22 6:57 AM

Result	Value	Ref Range
PHOSPHORUS	4.4	4.0 - 7.0 mg/dL

MICROBIOLOGY

Reviewed in EMR, with significant result highlighted below

Microbiology Results for orders placed or performed during the Hospital Encounter of 03/12/22

COVID-19 Pre-Procedure Screening Priority 2: Result will change management in the next 1-3 days

Collection Time: 03/12/22 6:04 AM

Specimen: Mid-Turbinate; Upper Respiratory

Result	Value	Ref Range
SARS-COV-2 BY TMA / NAAT	Not Detected	Not Detected

DIAGNOSTIC IMAGING

ATTESTATION: I have personally reviewed the images and agreed with reported findings

No results found.

ASSESSMENT & PLAN

ENDOCRINE/METABOLIC/NUTRITION

Malnutrition (HCC)

Assessment & Plan

10 month old male being readmitted for malnutrition and failure to thrive. He gained weight well in the hospital last admission. Discharge weight was 6.545kg. Admission weight is down to 6.28kg. He appeared dehydrated with a sunken fontanelle and dry lips on admission. His labs support dehydration with an elevated BUN. He also had a mildly low blood glucose of 59. Labs and glucose improved with fluids. Weight up to 6.63 this am, but this is an artificial increase secondary to fluid resuscitation.

1. FEN/GI: Feed elemental formula or MBM 130mL q3 hours. This was what he was discharged on for home and

demonstrated good weight gain on this feeding plan last admission. If able, may be able to space out feeds and provide higher volume, but unclear if the patient will tolerate higher volumes. Would advance gradually. Daily weights. Monitor I/O.
Based on mom's report of 6-8 oz of breast milk every 3 hours at home, he would have been getting 150 kcal/kg/day at the minimum. Parents report that NG came out the day after discharge and it was left out because he was eating so well.
Here he has had varied degrees of po intake. He did not meet po goals overnight and intermittently will refuse the bottle. Intermittent gagging and spitting up as well. This am took the full feed without difficulty.
On testing, patient does have a low vitamin D level, this is common in this country and particularly common in breast fed babies. Will supplement Vitamin D as recommended by the AAP.
To ensure that the underlying cause of his weight loss is clearly determined, it's important that complete a full work up. Parents report prior food sensitivity testing, but have not been willing to provide that documentation. They report sensitivities to wheat and dairy and mom has been on an elimination diet.
Discussed the case with pediatric gastroenterology to assess the patient and provide further recommendations regarding any additional work up that would be recommended.
In addition there are metabolic and genetic syndromes that could cause poor weight gain in children. The testing for these are often not accurate when patients are malnourished. Will discuss the case further with the genetics/metabolics team to ensure appropriate testing is done.
Parents updated (see care conference note for full details), Mom reports that patient does not eat from a bottle and is exclusively breast fed. Per the documentation from prior admission, patient was tolerating oral intake from the bottle while in the hospital. In addition, on discussion 3/12/22 with parents, they stated that the patient was taking 6-8 oz by mouth every 3 hours while at home. It is unclear how this was being measured accurately if mom was exclusively feeding at the breast.
Mom feels that his oral intake is decreased because she is not here to nurse him (parents have not been allowed at the bedside as patient has been declared in imminent danger by the state and due multiple factors, it has been deemed unsafe to have them in this facility).
- Given improved intake at the bottle this morning, will assess over the next feeding to determine if NG is needed at this time
- GI consult
- Goal feeds 130 mL of MBM or elemental formula every 3 hours

2. CV/RESP: Routine vitals

3. NEURO: tylenol PRN

4. DISPO: Social work and CARES team consulted, appreciate assistance in navigating the current social situation. There is a shelter care hearing on 3/15/22. Patient has been declared, but parents retain medical decision making for any major procedure or intervention. Parents have given verbal consent witnessed by myself and of the CARES team that we may continue standard medical care, but they would like to discuss any additional interventions. The consented to NG as needed "under duress" stating that they are uncomfortable because they do not have the ordering provider's name. Please see care conference note for further details. Discharge date and time to be determined. Would like to see weight gain prior to discharge and ensure that he is tolerating feeds.

Diagnostic tests plan
Today: No labs indicated
Tomorrow: No labs indicated

0900-1000: Meeting with St. Luke's administration, health and welfare, security services, and medical team regarding safety issues surrounding a potential visit with parents.

1100-1300: Time at bedside, discussion with care team regarding plan, phone update with parents, and documentation.

Time: 180 minutes spent in evaluating the patient, reviewing the chart, reviewing labs/studies, and discussing with subspecialists about result and clinical course, and updating parents on patient's condition, lab results, response to therapy, and criteria for discharge, with >50% on counseling and coordinating of care with staff.
Additional time for Prolonged Services: 180.

Family called by medical team to provide update to them regarding overnight events and plans for the day.
Both parents: Marissa and Levi were on the phone for the update
Present during the call includes and of incident command.

Confirmed parents name and they provided patient's date of birth.
Parents updated that patient was overall doing well.
Discussed that he has not been meeting his oral intake goals and that the medical team feels he will need his NG replaced.
Parents asked questions regarding if he has been gagging or spitting up. They were informed that he has been intermittently spitting up and intermittently has gagged, primarily on the bottle. In addition he has been pushing the bottle away and becoming fatigued at the bottle after 1-2 oz when he is interested in eating. Mom states that she believes that the patient would feed better at the breast as he is exclusively breast fed. Referred them back to health and welfare case worker as visitation is not a decision that the medical team makes.
Updated them regarding improvement in lab results as well as hydration status and the medical team's goal to discontinued IVF once his nutrition is up to full.
Discussed with them that the team would like to ensure that we look for any additional medical cause for his failure to thrive. In light of that the team will be discussing the case with additional sub-specialists to get together a list of possible diagnosis that should be worked up and what labs, imaging studies, or additional interventions would be recommended.
Parents requested a list of these which we will provide once additional data can be gathered. Told them we would try to have that put together by tomorrow if possible as well as a plan for next steps. Some of the studies that would be recommended may need to wait until patient has a better nutritional status.
Family requested my name. I did provide information regarding my professional degrees, number of years experience and board certification, but told them that I had been advised not to share my name by St. Luke's legal

department and security due to the current protests surrounding the case.
(unsure if this is the correct spelling) reported herself to be the the family advocate requested by the family to speak on their behalf spoke up to once again request this providers name. Reiterated that for my safety I had been advised not to provide that information. The advocate reported that the families lawyer would come to the hospital to obtain that information.
I encouraged them to contact the St. Luke's legal department.
Parents returned to the call. They request an update following NG placement on how he is tolerating the feeds. The prior plan had been to update them at 1600 today. Will plan to update them with medical information at that time.

Following the family discussion, case once again discussed with the St. Luke's Legal team who again recommended not providing my name at this time.

PEDS HOSPITALIST PROGRESS NOTE

DATE OF SERVICE
3/14/2022

REASON FOR HOSPITAL ADMISSION
Cyrus is a 10 m.o. male admitted on 3/12/2022 12:59 AM for:

Active Hospital Problems

Diagnosis	Date Noted
• Failure to thrive (child)	03/12/2022
• Malnutrition (HCC)	03/01/2022

Resolved Hospital Problems
No resolved problems to display.

INTERVAL HISTORY
Patient had visitation with parents for 2 hours last night off the pediatric floor with health and welfare present. As patient was due for a feed prior to the visit, 1/2 the feed was given via NG tube. He reportedly breast fed at the meeting and then developed vomiting afterward. His NG was also dislodged during the visit.
On arrival to the pediatric floor he had no interest in taking the bottle or putting anything in his mouth. The NG was replaced.
He had 1 more emesis overnight and has tolerated his morning feed without further vomiting.
He did not have any vomiting yesterday prior to the visit with parents.
Overnight, parents requested an update about feeds. This was done by an RN as the provider was not

available and there was no significant update.
Parents requested that patient be given an enema for stooling, they reiterated their desire that patient not receive vaccines during his stay and requested we attempt oral feeds prior to replacing the NG tube.
The night physician observed the oral attempt and it was clear that Cyrus would not take oral feeds overnight, so NG was replaced. We continue to offer oral feeds prior to tube feeds.
We have already addressed with the family that vaccines will not be given during this hospital stay.
Per their request an enema has been ordered.

CURRENT MEDICATIONS

Scheduled Meds:

• cholecalciferol	1,000 Units	Oral	BID

Continuous Infusions:
PRN Meds:.acetaminophen, ondansetron HCL

OBJECTIVE DATA

Vital signs, last 24h ranges, current
Temp: [36.2 °C (97.1 °F)-37.2 °C (99 °F)] 37.2 °C (99 °F)
Heart Rate: [103-128] 115
Resp: [24-28] 28
BP: (88-111)/(62-80) 98/62
MAP (mmHg): [71-99] 75
SpO2: [97 %-99 %] 98 %
Blood pressure percentiles are not available for patients under the age of 1.

I/O Report

	03/12 0701 03/13 0700	03/13 0701 03/14 0700	03/14 0701 03/15 0700
P.O.	255	160	75
I.V. (mL/kg)	390.4 (58.9)	171 (26.5)	
NG/GT		565	55
Total Intake(mL/kg)	**645.4 (97.3)**	**896 (138.7)**	**130 (20.1)**
Urine (mL/kg/hr)	431 (2.7)	665 (4.3)	42 (1.3)
Emesis/NG output	0	0	
Stool	0		24
Diaper		0	
Total Output	**431**	**665**	**66**
Net	**+214.4**	**+231**	**+64**
Breastfeeding Count		1 x	
Emesis (Unmeasured)	5 x	7 x	
Urine (Unmeasured)	0 x		
Stool (Unmeasured)	0 x		

Weight Change (last 7 days)

Date/Time	Weight	+/- Last Wt (g)	% Weight Change Since Admission
03/14/22 0257	6.46 kg (14 lb 3.9 oz)	-170 g	2.38
03/13/22 0453	6.63 kg (14 lb 9.9 oz)	350 g	5.07
03/12/22 0225	6.28 kg (13 lb 13.5 oz)	-30 g	-0.48
03/12/22 0102	6.31 kg (13 lb 14.6 oz)	0 g	0

PHYSICAL EXAMINATION

Physical Exam

Vitals and nursing note reviewed.

Constitutional:
General: He is active. He is not in acute distress.
Appearance: He is not toxic-appearing.
Comments: **Continues to appear small for age and cachectic, but temporal wasting has resolved and hydration is normal. Patient is awake and smiling with staff this morning. He appears stronger with better head control**

HENT:
Head: Normocephalic. Anterior fontanelle is flat.
Nose: Nose normal.
Mouth/Throat:
Mouth: Mucous membranes are moist.

Eyes:
Conjunctiva/sclera: Conjunctivae normal.

Cardiovascular:
Rate and Rhythm: Normal rate and regular rhythm.
Pulses: Normal pulses.
Heart sounds: Normal heart sounds. No murmur heard.

Pulmonary:
Effort: Pulmonary effort is normal. No respiratory distress.
Breath sounds: Normal breath sounds.

Abdominal:
General: Abdomen is flat. Bowel sounds are normal. There is no distension.
Palpations: Abdomen is soft.
Tenderness: There is no abdominal tenderness.

Musculoskeletal:
General: Normal range of motion.
Cervical back: Neck supple.
Comments: **Low muscle bulk for age**

Skin:
General: Skin is warm.
Capillary Refill: Capillary refill takes less than 2 seconds.
Turgor: Normal.
Coloration: Skin is not mottled or pale.
Findings: No rash.

Neurological:

General: No focal deficit present.
Mental Status: He is alert.
Comments: **Sitting with staff comfortably. Tone appears normal. Makes good eye contact and tracks appropriately. During the visit, he reached for toys offered on the same side.**

LABORATORY

Reviewed in EMR, with significant result highlighted below
No new labs

MICROBIOLOGY

Reviewed in EMR, with significant result highlighted below
NO NEW MICROBIOLOGY RESULTS

DIAGNOSTIC IMAGING

XR Abdomen 1 Vw

Result Date: 3/13/2022
Enteric tube tip terminates in the region of the gastric body.

ASSESSMENT & PLAN

ENDOCRINE/METABOLIC/NUTRITION

Malnutrition (HCC)

Assessment & Plan

10 month old male being readmitted for malnutrition and failure to thrive. He gained weight well in the hospital last admission. Discharge weight was 6.545kg. Admission weight is down to 6.28kg. He appeared dehydrated with a sunken fontanelle and dry lips on admission. His labs support dehydration with an elevated BUN. He also had a mildly low blood glucose of 59. Labs and glucose improved with fluids.
Weight down 170 grams from yesterday, but up 150 g since admission (this is not surprising due to the need for aggressive fluid resuscitation on first day of admission, he is now diuresing some of that fluid off - It will take several days to have truly accurate weights for this baby).

1. FEN/GI: Feed elemental formula or MBM 130mL q3 hours, offer the bottle for 15 minutes and gavage whatever volume he doesn't take orally. This was what he was discharged on for home and demonstrated good weight gain on this feeding plan last admission. If able, may be able to space out feeds and provide higher volume, but unclear if the patient will tolerate higher volumes. Would advance gradually. Daily weights. Monitor I/O.

Parents concerned overnight for lack of stool. He did receive a glycerin suppository 3/13/22 without stool output. During clinical update, the team did ask parents their typical interventions for constipation and mom reported that they increase fluids and it usually corrects. He tolerated his morning feed without interventions, but given parental request, glycerin enema was given. He did have a small soft stool, but to be clear, he was not vomiting with the morning feed prior to this intervention.
Had not intervened further regarding stooling as patient was admitted emaciated and dehydrated and he was given a solid attempt at taking his oral feeds prior to the NG, thus he did not have much in the GI tract and stooling was not expected to pick up until more nutrition had been given.

During last night's visit, parents reported that they would give enemas for him at home. This is not unreasonable, but had not been shared with the team.

Based on mom's report of 6-8 oz of breast milk every 3 hours at home, he would have been getting 150 kcal/kg/day at the minimum at home. Parents report that NG came out the day after discharge and it was left out because he was eating so well. In other conversations, mom has reported that he is exclusively breast fed, which would make it difficult to assess the volume he was getting at each feed.

Based on parental report as well as the medical record, he has had intermittent vomiting, gagging, and spitting up since around 6 months of life. This has been thought to be due to food sensitivities, but the testing for this has been unclear.
On testing here, patient does have a low vitamin D level, this is common in this country and particularly common in breast fed babies. Will supplement Vitamin D as recommended by the AAP.
To ensure that the underlying cause of his weight loss is clearly determined, it's important that the team assess a full differential diagnosis and tiered testing occur. Parents report prior food sensitivity testing, but have not been willing to provide that documentation. They report sensitivities to wheat and dairy and mom has been on an elimination diet.
Discussed the case with pediatric gastroenterology to assess the patient and provide further recommendations regarding any additional work up that would be recommended. GI would like to monitor in the hospital while he is here to see what his vomiting pattern is. In addition, will discuss with outpatient allergy/immunolgy to get ideas for further testing that could be considered.
There are metabolic and genetic syndromes that could cause poor weight gain in children. The testing for these are often not accurate when patients are malnourished. Will discuss the case further with the genetics/metabolics team to ensure appropriate testing is done. Genetics, will see the patient and assist with getting together a tiered work up plan and differential diagnosis.
Mom feels that his oral intake is decreased because she is not here to nurse him (parents have not been allowed at the bedside as patient has been declared in imminent danger by the state and due multiple factors, it has been deemed unsafe to have them in this facility).
- Po + gavage feeds via NG with goal 130 mL MBM or Nutramigen if we run out of MBM
- GI consult
- There are no allergy/immunology specialists here at St. Lukes - have reached out to
for recommendations
- Goal feeds 130 mL of MBM or elemental formula every 3 hours
- Patient discussed with genetics/metabolics who will review the case and provide recommendations for additional work up and testing with timing.

2. CV/RESP: Routine vitals

3. NEURO: tylenol PRN

4. DISPO: Social work and CARES team consulted, appreciate assistance in navigating the current social situation. There is a shelter care hearing on 3/15/22. Patient has been declared, but parents retain medical decision making for any major procedure or intervention. Parents have given verbal consent witnessed by myself and of the CARES team that we may continue standard medical care, but they would like to discuss any additional interventions. The consented to NG as needed "under duress" stating that they are uncomfortable because they do not have the ordering provider's name. Please see care conference note for further details. Discharge date and time to be determined. Would like to see weight gain prior to discharge and ensure that he is tolerating feeds.

03/01/2022 - ED to Hosp-Admission (Discharged) in Boise Pediatrics
Facesheet

ENCOUNTER

Patient Class:	**INPATIENT**	Unit:	**BMC PEDIATRICS**
Hospital Service:	**Pediatric**	Bed:	**4004-01**
Admitting	**Natasha D. Erickson, MD**	Admitting	**Dehydration [E86.0]**
Attending	**No att. providers found**	Referring	**No ref. provider found**
Appointment		Admit Date/Time	**3/1/2022 1145**
		Discharge Dt/Tm	**3/4/2022 1835**

ACCIDENT INFORMATION

Accident Type:		Accident	

PATIENT

Name:	**ANDERSON, CYRUS JAMES**	DOB:	**5/1/2021 (10 mos)**
Address:	**1876 E ADELAIDE DR**	Sex:	**male**
City/State/Zip:	**MERIDIAN, ID 83642-9219**	Marital Status:	**Single**
Care Plan:		Religion:	**Christian**
PCP:	**Nadezhda Kravchuk, NP**	Primary Phone:	**208-901-0889**
Occupation:	**Minor**	Mobile Phone:	**208-901-0889**
		Birth State:	**Idaho**

EMERGENCY CONTACT

Contact Name	Legal	Relation to	Home Phone	Work Phone	Mobile Phone
1. Anderson, Marissa		**Mother**	**208-901-0889**		**208-901-0889**
2. Anderson, Levi		**Father**	**208-901-1744**		**208-901-1744**

GUARANTOR

Guarantor:	**ANDERSON,MARISSA**	DOB:	**9/30/2000**
Address:	**1876 E ADELAIDE DR**	Sex:	**Female**
City/State/Zip:	**Meridian, ID 83642-9219**	Home Phone:	**208-901-0889**
Relation to	**Mother**	Work Phone:	
Guarantor ID:	**2160715**		
Guarantor		Employment	**NOT EMPLO***

COVERAGE

PRIMARY INSURANCE

Payor:		Plan:	
Group Number:		Insurance Type:	
Subscriber Name:		Subscriber DOB:	
Subscriber ID:		Member Rel to	

SECONDARY INSURANCE

Payor:		Plan:	
Group Number:		Insurance Type:	
Subscriber Name:		Subscriber DOB:	
Subscriber ID:		Member Rel to	

03/01/2022 - ED to Hosp-Admission (Discharged) in Boise Pediatrics
Facesheet (continued)

Reason for Visit

Chief complaint: Emesis
Visit diagnoses:
- **Malnutrition, unspecified type (HCC) (primary) [E46]**
- Dehydration [E86.0]
- Severe protein-calorie malnutrition (HCC) [E43]

Hospital problem: Malnutrition (HCC) [E46]

Visit Information

Admission Information

Arrival Date/Time:	03/01/2022 1134	Admit Date/Time:	03/01/2022 1145	IP Adm. Date/Time:	03/01/2022 1225
Admission Type:	Emergency	Point of Origin:	Self Referral	Admit Category:	
Means of Arrival:	Car	Primary Service:	Pediatric	Secondary Service:	N/A
Transfer Source:		Service Area:	SLHS SERVICE AREA	Unit:	Boise Pediatrics
Admit Provider:	Natasha D. Erickson, MD	Attending Provider:	D. Rick Hansen, MD	Referring Provider:	

ED Disposition

ED Disposition	Condition	User	Date/Time	Comment
Admit		D. Rick Hansen, MD	Tue Mar 1, 2022 12:25 PM	Facility Type: Acute Care Facility: SLHS BOISE MEDICAL CENTER [10100] Service: Pediatric [1002] Level of Care: Acute [1] Telemetry: No Telemetry Diagnosis: Malnutrition (HCC) [213351]

Discharge Information

Date/Time: 03/04/2022 1835	Disposition: Home Or Self Care	Destination: —
Provider: Natasha D. Erickson, MD	Unit: Boise Pediatrics	

Vitals (Encounter)

Date/Time	Temp	Pulse	Resp	BP	SpO2	Weight	Who
03/04/22 1744	—	—	—	—	—	6.545 kg (14 lb 6.9 oz)	CV
03/04/22 1500	36.2 °C (97.1 °F)	130	—	**111/46** !	94 %	—	KC
03/04/22 1113	36.2 °C (97.2 °F)	112	26	—	100 %	—	CB
03/04/22 0732	36.2 °C (97.2 °F)	124	26	95/69	99 %	—	CB
03/04/22 0512	—	110	—	—	100 %	6.45 kg (14 lb 3.5 oz)	TM
03/04/22 0319	36.2 °C (97.2 °F)	124	28	—	100 %	—	MM
03/03/22 2300	36.9 °C (98.5 °F)	120	26	101/79	99 %	—	MM
03/03/22 1917	37.2 °C (99 °F)	129	26	—	99 %	—	KC
03/03/22 1604	36.1 °C (97 °F)	121	28	103/79	100 %	—	ST
03/03/22 1119	36.8 °C (98.2 °F)	98	30	—	98 %	—	MS
03/03/22 0747	36.9 °C (98.4 °F)	106	26	105/73	96 %	—	ST

03/01/2022 - ED to Hosp-Admission (Discharged) in Boise Pediatrics (continued)

Vitals (Encounter) (continued)

Date/Time	Temp	Pulse	Resp	BP	SpO2	Weight	Who
03/03/22 0454	—	106	—	—	99 %	6.385 kg (14 lb 1.2 oz)	TM
03/03/22 0342	36.6 °C (97.9 °F)	109	26	103/85	97 %	—	MM
03/02/22 2323	36.8 °C (98.2 °F)	117	26	—	97 %	—	MM
03/02/22 2001	36.7 °C (98.1 °F)	110	26	—	99 %	—	MM
03/02/22 1951	—	—	—	100/68	—	—	MM
03/02/22 1653	36.6 °C (97.9 °F)	128	28	—	99 %	—	CR
03/02/22 1215	—	128	—	98/64	97 %	—	CG
03/02/22 1207	37 °C (98.6 °F)	116	**24** !	—	98 %	—	CR
03/02/22 0759	36.4 °C (97.6 °F)	112	35	**127/86** !	99 %	—	CG
03/02/22 0505	—	—	—	—	—	6.355 kg (14 lb 0.2 oz)	RB
03/02/22 0308	36.8 °C (98.3 °F)	107	26	—	98 %	—	RB
03/01/22 2352	37 °C (98.6 °F)	117	28	**118/83** !	96 %	—	RB
03/01/22 1931	36.8 °C (98.3 °F)	116	30	**122/77** !	100 %	—	MK
03/01/22 1737	37.1 °C (98.7 °F)	137	32	96/76	98 %	6.38 kg (14 lb 1.1 oz)	CW
03/01/22 1622	—	128	—	—	98 %	—	NM
03/01/22 1548	—	135	32	—	97 %	—	DE
03/01/22 1516	—	167	—	—	97 %	—	NM
03/01/22 1324	—	116	—	—	96 %	—	NM
03/01/22 1159	—	—	—	75/51	—	—	DE
03/01/22 1151	—	152	32	—	100 %	—	DE
03/01/22 1149	—	—	—	—	—	6.2 kg (13 lb 10.7 oz)	DE

Medication List

Medication List

This report is for documentation purposes only. The patient should not follow medication instructions within. For accurate instructions regarding medications, the patient should instead consult their physician or after visit summary.

Prior To Admission

None

Discharge Medication List

ENTERAL FEEDING PUMP

Instructions: Pump for bolus NGT feeds. 128 ml 8 times daily. Run pump over 60 minutes. Use as directed.
Authorized by: Natasha D. Erickson, MD
Ordered on: 3/3/2022
Start date: 3/3/2022
Quantity: 1 each
Refill: 1 refill by 6/1/2023

ENTERAL FEEDING PUMP SUPPLIES

Instructions: NG feeding supplies: 1) Feeding pump 2) Feeding pump bags - use 1 daily Disp: 30 per month with 1 refill 3) IV pole 4) backpack for portability 5) 60cc syringes 6) NG securement devices.
Authorized by: Natasha D. Erickson, MD
Ordered on: 3/3/2022
Start date: 3/3/2022
Quantity: 1 each

03/01/2022 - ED to Hosp-Admission (Discharged) in Boise Pediatrics (continued)

Medication List (continued)

Refill: 1 refill by 6/1/2023

miscellaneous medical supply

Instructions: Nutramigen mixed to 20kcal/oz. EBM + Nutramigen for total volume of 1024 ml per day via NG tube.
Authorized by: Natasha D. Erickson, MD
Ordered on: 3/3/2022
Start date: 3/3/2022
Quantity: 10 each
Refill: 1 refill by 6/1/2023

Stopped in Visit

None

All Encounter Notes

ED Triage Notes by David Eclaircy, RN at 3/1/2022 1147

Pt has been having emesis on and off for the past few weeks. Sent here from MD's office for loss of weight and possible malnutrition.

Electronically signed by David Eclaircy, RN at 3/1/2022 11:49 AM

ED Provider Notes by D. Rick Hansen, MD at 3/1/2022 1148

I was wearing a surgical mask during the patient's evaluation. Hand hygiene was performed before and after the patient encounter.

CHIEF COMPLAINT

Chief Complaint

Patient presents with

- Emesis

HPI

This is 10 month old male with no significant medical histoory who presents to the ED today with his parents for evaluation of emesis. The patient's mother reports patient has intermittently vomited over the last 3-4 weeks. She first suspected the patient had a "stomach bug" the first but when he continued to vomit, she had him evaluated for allergies. She reports patient is allergic to daily and gluten. When feeding with solid foods, she gives apple sauce, bananas, and avocados as tolerated. She notes patient is breast fed and vomited after his last feeding this morning. He was seen at his pediatrician this morning where they noted patient has lost ~4 lbs of weight since his 6 month wellness exam prompting their visit to the ED today. Associated symptoms include mild fevers of 99 F, constipation, and reduced urinary output. At-home therapies were not reported. any other acute concerns.

REVIEW OF SYSTEMS
Except as mentioned above, the following systems were reviewed and are negative: Constitutional, eyes, cardiovascular, respiratory, integument, gastrointestinal, immunologic, musculoskeletal, endocrine, and neurologic.

PAST MEDICAL HISTORY
History reviewed. No pertinent past medical history.

PAST SURGICAL HISTORY
History reviewed. No pertinent surgical history.

FAMILY HISTORY
family history is not on file.

SOCIAL HISTORY
is too young to have a social history on file.

CURRENT MEDICATIONS
There are no discharge medications for this patient.

ALLERGIES
Allergies

Allergen	Reactions
• Lactose	Nausea And Vomiting

PHYSICAL EXAM

ED Triage Vitals

Enc Vitals Group
- BP
- Pulse
- Resp
- Temp
- Temp src
- SpO2
- Weight
- Height
- Head Circumference
- Peak Flow
- Pain Score
- Pain Loc
- Pain Edu?
- Excl. in GC?

03/01/2022 - ED to Hosp-Admission (Discharged) in Boise Pediatrics (continued)

All Encounter Notes (continued)

ED Vitals

Date/Time	BP	Pulse	Resp	Temp	Temp src	SpO2	O2 Device	O2 Flow Rate	Who
03/01/22 1622	--	128	--	--	--	98 %	None (Room air)	--	NM
03/01/22 1548	--	135	32	--	--	97 %	None (Room air)	--	DE
03/01/22 1516	--	167	--	--	--	97 %	None (Room air)	--	NM
03/01/22 1324	--	116	--	--	--	96 %	None (Room air)	--	NM
03/01/22 1159	75/51	--	--	--	--	--	--	--	DE
03/01/22 1151	--	152	32	--	--	100 %	None (Room air)	--	DE

GENERAL: This 10 m.o. male patient is alert. He is rooting at his mother's breast frequently during history and exam.

HEAD: Normocephalic/atraumatic

EYES: Pupils are equal and round

OROPHARYNX: Dry, pink mucosa

SKIN: No pallor or diaphoresis. No rash.

PULMONARY: Lungs are clear to auscultation, bilaterally. He is not in respiratory distress.

CARDIOVASCULAR: Regular rate and rhythm without murmurs. No peripheral edema

GASTROINTESTINAL: Abdomen is soft and nontender. No guarding is noted.

MUSCULOSKELETAL: The patient has some muscle wasting evident and appears to be malnourished.

NEUROLOGIC: The infant is alert. He has good muscle tone. He has a vigorous cry.

ED DEPARTMENT COURSE:

Labs Reviewed

CBC WITH DIFFERENTIAL - Abnormal

03/01/2022 - ED to Hosp-Admission (Discharged) in Boise Pediatrics (continued)

All Encounter Notes (continued)

Result	Value
WBC COUNT	9.76
RBC COUNT	4.50
HEMOGLOBIN	12.5
HEMATOCRIT	38.8
MCV	86.2 (*)
MCH	27.8
MCHC	32.2
RDW-CV	14.3
PLATELET COUNT	584 (*)
MPV	9.3
NEUTROPHIL #	4.55
NRBC %	0
NRBC #	<0.01
NEUTROPHIL %	46.6 (*)
IMMATURE GRANULOCYTES %	0.2
LYMPHOCYTE %	45.4
MONOCYTE %	7.3
EOSINOPHIL %	0.1
BASOPHIL %	0.4
NEUTROPHIL #	4.55
IMMATURE GRANULOCYTES #	<0.03
LYMPHOCYTE #	4.43
MONOCYTE #	0.71
EOSINOPHIL #	<0.03
BASOPHIL #	0.04

URINALYSIS (MACROSCOPIC W/MICROSCOPIC IF INDICATED) - Abnormal

COLOR UA	Yellow
CLARITY UA	Clear
SPECIFIC GRAVITY UA	1.028
PH UA	6.0
PROTEIN UA	30 mg/dL (*)
GLUCOSE UA	50 mg/dL (*)
KETONES UA	80 mg/dL (*)
BILIRUBIN UA	Negative
OCCULT BLOOD UA	Negative
LEUKOCYTES UA	Negative
NITRITES UA	Negative
ASCORBICACID	40 mg/dL (*)

URINE MICROSCOPIC - Abnormal

03/01/2022 - ED to Hosp-Admission (Discharged) in Boise Pediatrics (continued)

All Encounter Notes (continued)

SQUAMOUS	0-5
EPITHELIAL CELL	
WBC UA	10 - 25 (*)
MUCUS UA	Present (*)

BLOOD CULTURE

COMPREHENSIVE METABOLIC

SODIUM	136
POTASSIUM	4.0
CHLORIDE	100
TOTAL CO2	22
ANION GAP	14
GLUCOSE	81
CALCIUM	10.0
BUN	16
CREATININE	0.20
GFR	
PROTEIN TOTAL	6.8
ALBUMIN	4.7
TOTAL BILIRUBIN	1.0
ALK PHOS	154
AST(SGOT)	43
ALT(SGPT)	21

EXTRA TUBES

Narrative:
The following orders were created for panel order Urine Array.

Procedure	*Abnormality*	*Status*
---	---	---
Urine Container[266229458]		*In process*

Please view results for these tests on the individual orders.

(EXTRA) URINE CONTAINER

POCT URINALYSIS AUTOMATED

ED Course as of 03/01/22 1740

Tue Mar 01, 2022

1240 Urinalysis showed a large amount of ketones consistent with dehydration. There was some glucose noted in the urinalysis, as well. Please note that this was not a catheterized specimen and not a check for infection. Urinalysis was based on a bagged sample and was only for the purposes of evaluating metabolic status.

Comprehensive metabolic panel shows a glucose of 81. BUN is 16 and creatinine is 0.20. [DH]

1241 Chest x-ray is normal.

RADIOLOGY INTERPRETATION: I have independently reviewed the patient's imaging studies and I have made decisions on the medical management of this patient based on this review. Additionally, I have reviewed the radiologist interpretation of these films.

I spoke to Dr. Erickson from the pediatric hospitalist service. We reviewed the patient's history and exam. We agreed on the following plan: The patient will be admitted to pediatrics. I discussed this plan with the patient's parents.

The patient was treated with an IV fluid bolus. [DH]

ED Course User Index
[DH] D. Rick Hansen, MD

PULSE OX
98% on room air
Interpretation: Normal

RADIOLOGY:

I have personally reviewed the radiologist interpretation of these studies.

XR Chest 2 Vw
Final Result
No acute abnormality.

MEDICAL RECORDS REVIEWED:

Wt Readings from Last 3 Encounters:
03/01/22 6.38 kg (14 lb 1.1 oz) (<1 %, Z= -3.27)*

* Growth percentiles are based on WHO (Boys, 0-2 years) data.

I reviewed outpatient labs that were drawn yesterday. CBC showed a white blood cell count of 7.1 and hemoglobin was 11.7, yesterday.

CLINICAL INDICATION FOR INTRAVENOUS HYDRATION:

Clinical evidence of dehydration.

DIFFERENTIAL DIAGNOSIS:

I considered severe metabolic derangements, dehydration, pulmonary disorders, malignant causes of his symptoms, and other possibilities in the differential diagnosis.

MEDICAL DECISION MAKING:

There was no evidence of a malignant cause of his symptoms. The patient was dehydrated. He was treated with an IV fluid bolus. The patient was admitted to the hospital for inpatient management of his obvious malnutrition and dehydration.

A blood culture is pending. The patient was admitted in guarded condition.

Clinical impression/diagnosis:
Final diagnoses:
[E46] Malnutrition, unspecified type (HCC)
[E86.0] Dehydration

Medication List

You have not been prescribed any medications.

Results, treatment and diagnosis were discussed with patient and/or family. They expressed understanding of the

All Encounter Notes (continued)

Attempted to give report. RN not available. Family notified.

David Eclaircy, RN
03/01/22 1548

Electronically signed by David Eclaircy, RN at 3/1/2022 3:48 PM

H&P by Natasha D. Erickson, MD at 3/1/2022 1800

PEDIATRIC HOSPITALIST ADMISSION NOTE

ADMITTING ATTENDING
Natasha D. Erickson, MD

ADMISSION DIAGNOSES
Active Problems:
Malnutrition (HCC)

CHIEF COMPLAINT
Poor weight gain, intermittent vomiting

HISTORY OF PRESENT ILLNESS
Cyrus is a 10 m.o. male born at 38 weeks with "food sensitivities" diagnosed by a naturopath, who presents with weight loss and intermittent vomiting. Parents report the patient did well until about 7 months or so. Around that time, solid foods were introduced and since then the patient has had intermittent episodes of vomiting. Some days the patient will gag and retch all day with vomiting and appears to tolerate very little breastmilk or solid foods. He usually can keep down pedialyte. This vomiting course can last for several days. The vomit looks like breastmilk or food, sometimes, yellow, orange, or brown. The patient will then return to normal and is able to tolerate his regular diet without issue. Initially family thought the patient had a stomach bug, but due to the recurrence, they had the patient allergy tested by a naturopath. Family reports it wasn't formal allergy testing, but was muscle testing for food sensitivity. He is sensitive to milk, soy, and grains.
Patient has continued to have intermittent vomiting over the last several months. He has reportedly lost 4 lbs in about 3-4 months. There has been no diarrhea. No fever. The patient seems to have less energy. Overall, his development seems to have slowed a bit, but still meeting milestones. He continues to make a good number of wet diapers when he is able to eat, though family notices a decrease when he is vomiting. Stools are regular and soft without blood.

Patient was seen by his PCP, an NP at Functional Medicine of Idaho, who recommended the patient come to the ED due to concerns for the weight loss.

ED COURSE
CBC, CMP, CXR, bag UA obtained and admission requested.

REVIEW OF SYSTEMS
Review of Systems:

MUCUS UA	Present (A)	None /hpf

MICROBIOLOGY

Reviewed in EMR, with significant result highlighted below
No results found for this or any previous visit.

DIAGNOSTIC IMAGING

ATTESTATION: I have personally reviewed the images and agreed with reported findings
XR Chest 2 Vw

Result Date: 3/1/2022
No acute abnormality.

ASSESSMENT & PLAN

Malnutrition (HCC)
10 month old male admitted with failure to thrive and recurrent episodes of vomiting. Weight loss appears to have started around the time that solid foods were initiated and family is concerned about possible food sensitivities, though they recognize that perhaps that is not the explanation for the patient's severe malnutrition and recurrent vomiting. Patient's exam is reassuring other than revealing a clearly small and malnourished infant. His labs are also reassuring. Based on the provided history, it appears that mother's milk supply ought to be sufficient for growth, though perhaps her supply is over-estimated. I suspect the patient's likely cause is related to his recurrent severe vomiting. Patient had vomiting shortly after admission and it was noted to be a a bright yellow-green. I am concerned for possible anatomical abnormality such as malrotation. Metabolic disorder, possibly thyroid disorder is considered, but seems less likely as the patient's symptoms developed after several months of reportedly normal growth. I have seen a video of the patient from several months ago and he appears well-nourished in the video.

-I have ordered a stat UGI to evaluate for malrotation. Family is aware that if this is found, the patient will need to see pediatric surgery for surgical correction.
-If UGI is negative, plan to feed the infant every 3 hours. OK to breastfeed, but offer supplement of 3 ounces of Alimentum after each feed. Monitor daily weights closely. Dietitian consult in the AM. Also consider lactation consult in the AM. I have discussed the possibility of tube feeds to achieve adequate nutrition. I am concerned the patient does not have sufficient stamina due to his degree of malnutrition to successfully PO feed and take in enough calories for catch up growth.
-Saline lock PIV for now. Zofran PRN.
-Will call Functional medicine of Idaho tomorrow to see if newborn screen was sent. Consider thyroid studies.
-CR monitoring tonight.
-Plan of care reviewed with the family. All questions answered. They understand the infant will require several days of hospitalization at a minimum in order to establish a viable and sustainable feeding plan. Would like to see at least 2 days of good weight gain prior to considering discharge home, regardless of etiology of the patient's failure to thrive.

Time: 75 minutes spent in evaluating the patient, reviewing the chart, reviewing labs/studies, and discussing with subspecialists and/or other team members about result and clinical course, and updating parents on patient's condition, lab results, response to therapy, and criteria for discharge, with >50% on counseling and coordinating of care with staff.

All Encounter Notes (continued)

ELECTRONICALLY SIGNED:
Natasha D. Erickson, MD
3/1/2022
6:52 PM

Electronically signed by Natasha D. Erickson, MD at 3/1/2022 6:53 PM

Assessment & Plan Note by Natasha D. Erickson, MD at 3/1/2022 1839

10 month old male admitted with failure to thrive and recurrent episodes of vomiting. He is severely malnourished. Initially mother's milk supply was reported to be good, but it is dwindling. I suspect that perhaps milk supply has been more diminished than mother has perceived given the severity of the patient's malnutrition. With the changing history of where the patient has reportedly received care, I am concerned that the patient's history is also unclear and he may have been struggling with weight issues for longer than formerly appreciated. I am unable to obtain any growth curves and it appears the patient never had a newborn screen.
He continues to have some vomiting, but it is intermittent. His weight is up today, but this may reflect fluids that were initially given, particularly since the patient has not been on full calorie feeds. Refeeding labs are reassuring today.

It is quite clear the patient is going to need NG feeds for an extended period of time, in addition to close PCP follow up, outpatient home nursing, feeding therapy, etc. I have discussed the patient with his PCP, Nadia Kravchuk, NP, who also expressed a high level of concern for the severity of malnutrition. She stated that she is not comfortable managing outpatient NG feeding for an infant. However, she has referred to her practice partner who has much more experience with such issues, including placing NG feeds on infants. The patient is scheduled to see Aaron Dykstra on Monday.

The patient's thyroid studies are suppressed. I have discussed this with peds endocrinology. It is possible that he is euthyroid sick due to his severe malnutrition. However, suppressed TSH and free T4 could also suggest central hypothyroidism.

Given the patient has not had any significant monitoring for development, it is possible that there is an underlying medical disorder resulting in the patient's failure to thrive. However, prior to pursuing what could be a very extensive (and possibly unfruitful, let alone expensive) evaluation, would like to continue to advance tube feeds and monitor weight gain, particularly since the majority of cases of failure to thrive is due to insufficient caloric intake.

I have had several conversations with the family today that the patient should remain hospitalized while we continue to work on feeds and monitor for weight gain. I would not recommend discharge today and leaving AMA would result in a CPS referral. Family states they are willing to stay as long as needed. Appreciate social work seeing the family.

FEN/GI: Continue NG feeds. Will advance to goal calories today. May do breastmilk or nutramigen. Will not fortify feeds at this time, but this may be needed, particularly if the patient appears to be volume sensitive. Will begin to arrange home tube feeding supplies, appreciate PCC assistance. Recheck CMP, Phos tomorrow to monitor for refeeding syndrome.

03/01/2022 - ED to Hosp-Admission (Discharged) in Boise Pediatrics (continued)

All Encounter Notes (continued)

Continue to work with SLP.
Could consider additional evaluation for metabolic disorder if patient is not able to demonstrate good weight gain with current feeding plan.
Continue to weigh the patient daily. Goal weight gain per dietitian is 8-15g/day.

ENDO: Repeat TFTs in a few days. If normal, then euthyroid sick seems most likely. If continues to be abnormal, will likely need brain and pituitary MRI per Dr. Baez's recommendations and start levothyroxine.

Electronically signed by Natasha D. Erickson, MD at 3/3/2022 6:24 PM

Provider Communication by Ramiza Bilajac, RN at 3/2/2022 0024

PROVIDER COMMUNICATION

Reason for Communication: **Review Case/Status Update**
Time Communicated to Provider: **3/1/2022 11:00 PM**
Provider notified: **Jessica R. Maddox, MD**
Action taken: **Notified in person**
Notified provider that pt. Has not POed since start of shift. MOC attempted to breastfeed pt and bottle feed, but both times he was not interested and gagging. MD told RN to see if pt. Will take Pedialyte. Will update provider on whether or not pt. Takes pedialyte

Electronically signed by Ramiza Bilajac, RN at 3/2/2022 12:26 AM

Provider Communication by Ramiza Bilajac, RN at 3/2/2022 0026

PROVIDER COMMUNICATION

Reason for Communication: **Review Case/Status Update**
Time Communicated to Provider: **3/2/2022 12:00 AM**
Provider notified: **Jessica R. Maddox, MD**
Action taken: **Notified via secure text messaging application**
Notified provider that MOC attempted to give pt. Pedialyte, but he did not take any of it. MD to re-start IVF.

Electronically signed by Ramiza Bilajac, RN at 3/2/2022 12:26 AM

03/01/2022 - ED to Hosp-Admission (Discharged) in Boise Pediatrics (continued)

All Encounter Notes (continued)

Progress Notes by Ramiza Bilajac, RN at 3/2/2022 0446

End of shift note:

Poor PO intake throughout shift (total PO intake for shift 15mL). Pt. Gagging when mom attempted to feed him, w/ 1 small emesis during shift. MD aware and IVF started. PRN zofran given x1. UOP for shift 0.85mL/kg/hr. Mom and dad at bedside and attentive to cares.

Electronically signed by Ramiza Bilajac, RN at 3/2/2022 6:07 AM

Progress Notes by Kristin G. Booton, Speech and Language Pathologist at 3/2/2022 0930

SPEECH LANGUAGE PATHOLOGY EVALUATION

Pertinent information for providers: Pt is a 10mo who was admitted with FTT. Pt's mother and father were very informative and provided detailed history. Pt was born full term without complications. Pt was breastfed exclusively until purees introduced around 6mos of age. Family noted that shortly after purees introduced, pt started having episodes of vomiting. Pt gained weight well until about 7mos of age when vomiting started. Parents reported that pt has cycles of eating well for 5-7 days and then having 3-7 days of vomiting. Mother noted that pt did have frenulectomy as infant. He also was evaluated by Functional Medicine Provider who reported "food sensitivities" to soy, dairy, and grains. Mother noted that pt will typically breastfeed on demand every few hours. When he's having "bad days" of emesis, she will keep up her supply by pumping. She reported that she would get between 3-4 oz each breast when pumping. When pt is starting to recover, they only offer breastfeeding or EBM via Dr. Brown's bottle with "slow flow" nipple. When pt is feeling well, they offer a combination of avocado, applesauce, and 1/2 banana (so about 4oz each), and he gets about 4oz 3x/day. Pt has lost significant weight over the last 2-3 months. Feeding evaluation ordered to determine safe feeding plan.

Feeding Observation:
Pt was very lethargic and sleeping initially. When he woke, he was very fussy. SLP spent this session obtaining history with plans to come back for another feeding later. MD was in the room at this time, and we both agreed that pt needs NG tube to meet nutritional needs. Pt has been gagging and vomiting for the last several days. SLP then attempted to come back after NG tube placed, at 1600, but mother and pt were sleeping. Father stated that pt tolerated the first bolus feed well that ran over 60min. No gagging or emesis noted. Father stated that pt has been sleeping since. SLP discussed that pt will need time to "catch up" energy wise to get back to PO skills. SLP did not feel that waking infant would provide good results for his already stressful feeding situation. Also, SLP discussed that if family were to offer any PO it would be in the form of breastfeeding. However, SLP voiced caution to keep all PO trials positive, so if pt gags, then to stop and just use the tube tonight. SLP will follow up with family tomorrow morning to coordinate another feeding observation.

Recommendations:
Primary nutrition via NG tube tonight
Mother may offer breastfeeding if pt showing interest, but to stop with any gagging or stress cues
Reflux precautions
Manage stooling to decrease risks of constipation

Discharge Recommendations: feeding therapy; if going home with NG tube, recommended homecare feeding therapy with SLP

03/01/2022 - ED to Hosp-Admission (Discharged) in Boise Pediatrics (continued)

All Encounter Notes (continued)

$Dysphagia Therapy Charge Units	1
SLP Time Calculation	
Total Therapy Time Calculation (min)	40 min

Kristin Booton, MS CCC SLP
Speech Language Pathologist, Level 2

Inpatient Pediatric Therapist
VOALTE: 208-381-1100 x7912400
bootonk@slhs.org

Electronically signed by Kristin G. Booton, Speech and Language Pathologist at 3/2/2022 5:19 PM

Consults by Gracie M. McDermott, RD at 3/2/2022 0959

Consult Orders
1. IP consult to Pediatric Clinical Nutrition [266289239] ordered by Natasha D. Erickson, MD at 03/01/22 1848

CHILDREN'S CLINICAL NUTRITION CONSULT NOTE

NUTRITION PLAN:

1. Per discussion with Dr. Erickson, place NG tube and intitiate enteral nutrition support.

2. Given reported wt loss, there is some concern for refeeding syndrome. Will begin with feeds to meet 100% estimated fluid needs today (**100 mL/kg and 67 kcal/kg**). If labs are within normal limits tomorrow, will advance to goal to meet 100% of estimated energy needs for catch up growth (goal = 107 kcal/kg).

3. RDN ordered the following NG-tube feeding regimen for today 3/2/2022:
   a. Product: EBM, Secondary: Nutramigen
   b. Caloric density: 20 kcal/oz
   c. Daily goal volume: 640 mL/day
   d. Bolus volume and frequency: 80 mL x 8 feeds per day
   e. Run via pump over 60 minutes (@ 80 mL/hr), condense as tolerated
   f. This will provide 427 kcal/day (67 kcal/kg), 12 g protein/day (1.8 g/kg), and 640 mL fluid (101 mL/kg) daily based on 6.355 kg.
   g. This will meet 63% of estimated energy needs for catch up growth and 100% of estimated protein needs. Assessing free water only, this meets 100% of estimated fluid needs.

4. Advance to the following GOAL feeds as able, likely tomorrow 03/03/22:
   a. Product: EBM, Secondary: Nutramigen

b. Caloric density: 20 kcal/oz
c. Daily goal volume: 1024 mL/day
d. Bolus volume and frequency: 128 mL x 8 feeds per day
e. Run via pump over 60 minutes (@ 128 mL/hr), condense as tolerated
f. This will provide 683 kcal/day (107 kcal/kg), 18.5 g protein/day (2.9 g/kg), and 1024 mL fluid (161 mL/kg) daily based on 6.355 kg.
g. This will meet 100% of estimated energy needs for catch up growth and 100% of estimated protein needs. Assessing free water only, this meets 100% of estimated fluid needs.

5. Monitor for refeeding syndrome. Daily CMP and Phos labs ordered.

6. Appreciate daily weights. RDN ordered.

7. Weekly lengths to be completed by RDN throughout admission.

8. Growth velocity goals:
   a. Weight- Catch up growth goals are: 8-15 g/day (norm is 6-11 g/day for 8-12mo)
   b. Length: 0.28-0.37cm/wk for 8-12 mo
   c. OFC: 0.08-0.11cm/wk for 8-12 mo

NUTRITION SCREEN:

Nutrition Risk Score: 13
Nutrition Risk Level: Severe

ASSESSMENT:

Nutrition therapy consult received for 10 m.o. male admitted with failure to thrive and recurrent episodes of vomiting. Cyrus presented with reported wt loss and newly diagnosed "food sensitivities" per naturopath at Functional Medicine of Idaho.

Pt is on RA. Pt is not on IV fluids. NG in place; EN will be initiated this PM. Pt is afebrile. Patient's mother and father were present during time of RD visit today; reviewed baseline feeding and GI hx.

ADMISSION DIAGNOSIS:

Dehydration [E86.0]
Malnutrition (HCC) [E46]
Malnutrition, unspecified type (HCC) [E46]

PMH:

Patient Active Problem List

Diagnosis

- Malnutrition (HCC)

HOME DIET:

03/01/2022 - ED to Hosp-Admission (Discharged) in Boise Pediatrics (continued)

Other Orders (group 2 of 2) (continued)

Ordering user: Natasha D. Erickson, MD 03/04/22 1819
Authorized by: Natasha D. Erickson, MD
Frequency: Routine 03/04/22 -
Quantity: 1
Diagnoses
Severe protein-calorie malnutrition (HCC) [E43]
Ordering provider: Natasha D. Erickson, MD
Ordering mode: Standard
Class: Clinic Performed
Released by: Natasha D. Erickson, MD 03/04/22 1819
Order comments: If tube is accidentally removed, notify your home health team or your PCP. If the tube is dislodged and your child is unable to take his feeds by mouth, he will need to urgently have the tube replaced in the emergency department or by your PCP.

Indications

Severe protein-calorie malnutrition (HCC) [E43 (ICD-10-CM)]

Tube Replacement (Order 266514024)

Nursing

Date: **3/4/2022**
Department: **Boise Pediatrics**
Ordering/Authorizing: **Natasha D. Erickson, MD**

Patient Demographics

Patient Name	Legal Sex	DOB	SSN	Address	Phone
Anderson, Cyrus James	Male	5/1/2021	xxx-xx-0000	1876 E Adelaide Dr Meridian ID 83642-9219	208-901-0889 (Home) 208-901-0889 (Mobile) *Preferred*

Visit Information

Date & Time	Department	Encounter #
3/1/2022 11:45 AM	Boise Pediatrics	658572369

Primary Coverage

Payer	Plan	Sponsor Code	Group Number	Group Name
No coverage found				

Order Details

Frequency	Duration	Priority	Order Class
None	None	Routine	Clinic Performed

Associated Diagnoses

Severe protein-calorie malnutrition (HCC) [E43]

Comments

```
If tube is accidentally removed, notify your home health team or your PCP.

If the tube is dislodged and your child is unable to take his feeds by mouth, he will need
to urgently have the tube replaced in the emergency department or by your PCP.
```

Order Questions

Reason for Exam

Dx: Severe protein-calorie malnutrition (HCC) [E43 (ICD-10-CM)]

Order Providers

03/01/2022 - ED to Hosp-Admission (Discharged) in Boise Pediatrics (continued)

Media (Encounter and Order) (continued)

Immunizations Administered for This Admission
None

Activity instructions
Activity
Your activity upon discharge: activity as tolerated

Diet instructions
Diet
Follow this diet upon discharge: Continue to offer a bottle of breastmilk or formula every 3 hours. Goal of 128mL every 3 hours. If your child cannot complete the feed by mouth, then syringe feed via NG to achieve their goal.

Other instructions
Follow-Ups
Follow up with primary care provider, Aaron Dykstra, within 3 days as previously scheduled for hospital follow-up. No follow up labs or tests are recommended at this time.

Physician Instructions
You may offer 1-2 ounces more if the patient seems to still be hungry after 15-20 minutes, but keep feeding time limited to 30-45 minutes.

Goal feeds are 1024mL in 24 hours for now. Would enourage mom to pump every 3 hours for now and bottle feed so that we can precisely know how much Cyrus is eating. Hopefully he will be able to return to breastfeeding very soon!

If your child becomes constipated, you can try over the counter miralax (or generic equivalent). Would suggest 4.25 to 8.5g once daily as needed as a starting dose. This can be titrated up or down to achieve soft, regular stools.

Tube Replacement
If tube is accidentally removed, notify your home health team or your PCP.

If the tube is dislodged and your child is unable to take his feeds by mouth, he will need to urgently have the tube replaced in the emergency department or by your PCP.

03/01/2022 - ED to Hosp-Admission (Discharged) in Boise Pediatrics (continued)

Media (Encounter and Order) (continued)

What's Next

Follow up with St. Luke's Treasure Valley Home Health
Referral Source: SLHS BOISE MEDICAL CENTER
BOISE PEDIATRICS
190 E BANNOCK ST
BOISE ID 83712-6241
208-381-2222
Primary Care Providers:
Nadezhda Kravchuk, NP (General)
Required - Community Physician Following Home Health: Dr Aaron Dykstra, Functional Medicine of Idaho with appointment on Monday morning.
Anticipated Date of Discharge for This Hospital Admission: 3/4/2022 possible evening.

3330 E LOUISE DR STE 400
MERIDIAN ID 83642-5123
208-381-2138

I or a Non-Physician Practitioner working with me, had a face-to-face encounter that meets the physician face-to-face encounter requirements on (date): 3/4/2022.

Based on the clinical findings of this encounter, the patient has a need for skilled services because: 10 month old male admitted with failure to thrive. He is severely malnourished. NG placed. Tolerating po/Ng tube feeding of EBM and formula. Coram to provide NG supplies.
(To be completed in narrative form. Diagnosis alone not acceptable.)

This patient meets the definition of HOMEBOUND STATUS because they meet both of the following TWO criteria required by CMS:

Criteria-One: Describe what assistive devices the patient is dependent on (if any) & specifically why the patient's condition warrants special transportation or the assistance of another person OR describe the condition that makes leaving home medically contraindicated: patient is a minor.

AND

Criteria-Two: Describe why the patient has a normal inability to leave home and why leaving home must require a considerable and taxing effort: patient is a minor.

Home Health to include education on the following:
Medication management/compliance/tolerance/instruction
Pressure ulcer prevention and treatment education
NG nutrition support
Fall risk prevention
Pharm and non-pharm pain management

Physician will be notified for the following:
Peds : any question or concern related to care of patient.

Based on the above findings, this patient is confined to the home and needs intermittent skilled nursing care, and/or physical therapy and/or speech therapy or continues to need occupational therapy. This patient will be followed by a physician who will periodically review the plan of care.

03/01/2022 - ED to Hosp-Admission (Discharged) in Boise Pediatrics (continued)

Media (Encounter and Order) (continued)

What's Next (continued)

Discharge Referral To Pediatric Feeding Therapy
Hospital discharge likely home on ng feeding for dehydration and malnutrition. Tolerates po bottle.
Region patient should be seen in: Treasure Valley
New or established patient?: New patient
Treatment: Eval and Treat

Below is a summary of your medications that you need to START, CONTINUE, or STOP. The Medication List includes a complete list of your current medications. Share this list with your Primary Care Provider and update the list when any changes occur. Carry your medication information with you at all times in case of an emergency.

Refer to Pharmacy labeling in instances where substitutions may be required.

03/01/2022 - ED to Hosp-Admission (Discharged) in Boise Pediatrics (continued)

Media (Encounter and Order) (continued)

Medication List

	Morning	Afternoon	Evening	Bedtime	As Needed
START **ENTERAL FEEDING PUMP** Pump for bolus NGT feeds. 128 ml 8 times daily. Run pump over 60 minutes. Use as directed.					✓
START **ENTERAL FEEDING PUMP SUPPLIES** NG feeding supplies: 1) Feeding pump 2) Feeding pump bags - use 1 daily Disp: 30 per month with 1 refill 3) IV pole 4) backpack for portability 5) 60cc syringes 6) NG securement devices.					✓
START **miscellaneous medical supply** Nutramigen mixed to 20kcal/oz. EBM + Nutramigen for total volume of 1024 ml per day via NG tube.					✓

Where to pick up your medications

Pick these up from any pharmacy with your printed prescription

ENTERAL FEEDING PUMP • ENTERAL FEEDING PUMP SUPPLIES • miscellaneous medical supply

Patient-Level E-Signatures:

No documentation.

Encounter-Level E-Signatures:

No documentation.

Patient Signature: _____ Date: _____

03/12/2022 - ED to Hosp-Admission (Current) in Boise Pediatrics: records until 3/14/2022 (continued)

All Encounter Notes (group 1 of 2)

ED Triage Notes by at 3/12/2022 0101

Pt BIBA with PD for failure to thrive.

Electronically signed by at 3/12/2022 1:01 AM

ED Notes by at 3/12/2022 0117

Pt arrives by ambulance for malnourishment. Pt has an existing CARES case. PD present on arrival as well. Per PD, Pt was admitted to hospital 11 days ago for malnutrition. Pt was discharged with positive weight gain. Pt reported to have lost weight after leaving hospital at well child check. PD took custody of child and requested ambulance transport.

Pt is alert and interactive with environment, breathing is even and unlabored, skin is pink and warm. Pt eyes are sunken, slight depression in anterior fontanel.

03/12/22 0124

Electronically signed by at 3/12/2022 1:24 AM

ED Notes by at 3/12/2022 0119

60mL of formula mixed from bag presented with Pt.

03/12/22 0213

Electronically signed by at 3/12/2022 2:13 AM

ED Notes by at 3/12/2022 0140

Additional 60mL of formula mixed. Pt did not consume; Pt fell asleep in staff members arms.

03/12/22 0214

Electronically signed by at 3/12/2022 2:14 AM

ED Notes by at 3/12/2022 0148

03/12/2022 - ED to Hosp-Admission (Current) in Boise Pediatrics: records until 3/14/2022 (continued)

All Encounter Notes (group 1 of 2) (continued)

☐ **Education Needs**
*Comment: Will monitor for any specialty discharge education needs.

☐ **Nutrition**
*Comment: Coram provides NG supplies/pump/nutrition. Will monitor for any changes to the plan during admission and update Coram as needed.

☐ **Home Health**
*Comment: St Luke's home health for skilled nursing - **resumption of care order needed at discharge.**

☒ **Transportation needs**
*Comment: no transport needs.

☐ **Insurance**
*Comment: No insurance. Family has worked with PFA during last admission. **Will contact PFA on Monday to check on status**.

☒ **Medical Supplies Currently in the home**
*Comment: NG pump, supplies and nutrition - **need to determine location of these supplies should child not be discharged with parents.**

☐ **Medical Supplies NEW this admission**
*Comment:

☐ **Miscellaneous**
*Comment:

Electronically signed by at 3/12/2022 2:04 PM

Consults by at 3/12/2022 1113

Attestation signed by at 3/14/2022 2:55 PM

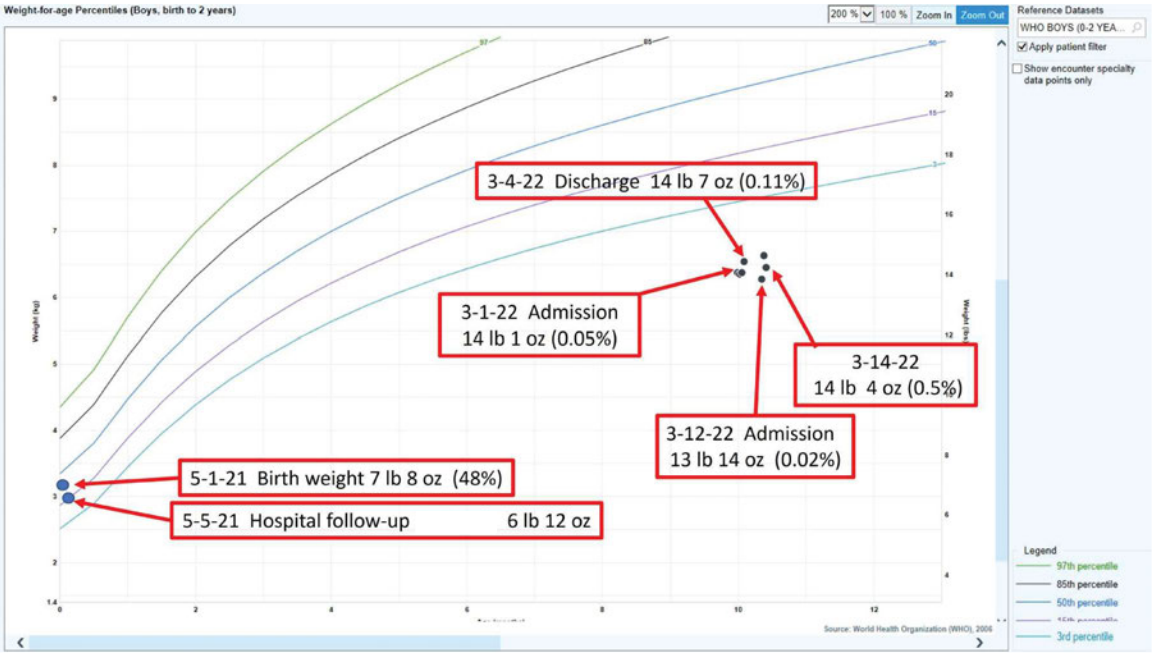
CARES Attending Attestation

I have reviewed the history and physical examination as documented by CARES NP. I agree with the documentation and assessment.

Cyrus was admitted initial March 1-4 for FTT concerns. He was 14 lb 1 oz at admission on March 1 and on discharge March 4 was 14 lb 7 oz (6 oz weight gain in 3 days). Family requested early discharge on 3/4 and he was discharged with NGT in place to use with poor po intake. He had follow-up at PCP office on March 7 and had demonstrated weight loss. Family missed the planned weight check at PCP on March 11. Child welfare and law enforcement involved on Friday, March 11 and child ultimately declared and brought to St Luke's for assessment. On admission noted to have weight loss of 9 oz between March 4 and early morning of March 12 when admitted. He appeared dehydrated, was listless and had lab findings of increased BUN (kidney dysfunction of dehydration). CARES NP involved over the weekend and has been

working to gather additional information. It is not known if patient had weight checks between May 5th (documented visit with Meridian Family Medicine -) and February 28 - initial visit at Functional Medicine of Idaho. At his initial visit on May 5 with he had lost weight (12 oz) which is normal for a newborn to lose up to 10% of birthweight in first few days of life. Usually by 2 weeks of age they should be at or above birth weight. In first few months a gain of 1 oz per day is average - usually by 4 months of age the infant has doubled their birth weight and by 1 year of age they have tripled birth weight.
Known weights for Cyrus

Birth weight May 1 7 lb 8oz per family (48%)
Dr Butuk May 5 6 lb 12 oz
March 1, 2022 Admission to hospital 14 lb 1oz (0.05%)
March 4, 2022 Discharge from hospital 14 lb 7oz (0.11%)
March 12, 2022 Admission to hospital 13 lb 14 oz (0.02%)
March 14, 2022 Hospital day #2 14 lb 4 oz (0.5%)



On exam on March 14, Cyrus was sitting in lap of staff. He was quiet during exam but interactive. He is thin and small appearing for his age (length is at 16% so he is long and lean). Limited muscle mass Neurologically - weak for age. Good head control. Sits with some support.

A: Cyrus is a 10 month old infant with failure to thrive. His weight at admission is 68% of the average weight of a 10 month old boy which categorizes him as moderate to severe malnutrition. Lab evaluation at admission noted low blood glucose of 59 (should be >70), elevated blood urea nitrogen (BUN) at 18 (normal <17) - was 7 at discharge on March 4. Given his very poor weight gain and recent weight loss Cyrus needs to be admitted to the hospital to evaluate underlying causes of his failure to thrive and manage the complications of his malnutrition. Once rehydrated he has shown improved neurologic examination and repeat lab studies on March 13 showed improved kidney function after rehydration. Cyrus is needing a feeding tube to ensure adequate caloric intake as he was unable to take adequate volume by mouth when initially admitted. He will continue to receive subspecialty medical evaluation to ensure all potential causes

for his failure to thrive/malnutrition are evaluated.

Child welfare and law enforcement are involved - they are aware of CARES assessment as per our NP and are working with family.

CARES Physician

CARES Team
Inpatient Consults

Patient Information:
Patient Name: Cyrus James Anderson
Patient Date of Birth: 5/1/2021
MRN: 4289116

BACKGROUND INFORMATION:
Brought by: Health and Welfare and Law enforcement
History provided by: Health and Welfare and review of electronic medical records, and attending team
Language: English

Reason for Evaluation/Chief Complaint: Failure to thrive

Location of Exam: Inpatient unit room 4002

Consult Requested by:

DATE of EVALUATION: March 12, 2022

History of Present Illness:
Cyrus is a 10 month-old male with a history of failure to thrive and reported intermittent vomiting over the last several months. Per parents, he was born at 38 weeks, and gained weight appropriately for the first several months of life while being exclusively breastfed. Around 6 or 7 months of age solids were introduced, and parents report that since that time, there have been intermittent episodes of vomiting and retching. The patient would go through periods of days up to one week without vomiting, and then would vomit intermittently for several days in a row. During this time period, food allergy testing was completed, and family was told that Cyrus was allergic to grains and dairy. Parents have declined to provide documentation of this testing, and have furthermore declined to provide where the testing was completed per the advice of their attorney. They eliminated dairy and grain items from Cyrus' diet, and eventually from his mother's diet. Parents reported that they continued to offer specific solid foods approximately three times daily, particularly avocados, applesauce, and sweet potatoes. In addition, he was breastfed on demand.

Cyrus was evaluated by a provider at Functional Medicine of Idaho on February 28, at which time the failure to thrive was noted (reportedly had a 4 pound weight loss over approximately four months), and further evaluation at the ED was recommended. He was then taken to St. Luke's ED in Boise on March 1st, where he was noted by the ED provider to appear malnourished. Was admitted to the Pediatric floor from March 1 to March 4 under the care of the Pediatric Hospitalist Service. He had one episode of what was described as bilious vomiting on the evening of admission, and an upper GI was completed and was normal. There were 2-3 other episodes of small to moderate volume emesis documented throughout the hospitalization and several incidences of gagging/retching. He was initially quite listless and uninterested in oral feeds, so was briefly placed on intravenous fluids. An NG tube was placed in order to help facilitate enteral feeds.

Parents reported that Cyrus is uninsured, and the attending physician documented multiple conversations with the parents during which they requested premature discharge due to financial concerns. Cyrus had excellent weight gain during the hospitalization (gained 165 grams), and at the time of discharge was taking the majority of his feeds orally. He was, however, discharged with the NG tube in place, and family was instructed to offer breastmilk or formula every 3 hours (goal of four ounces) orally, and then to use the NG tube if Cyrus was unable to take the amount recommended. Family was instructed on how to use the feeding tube, and home health nursing was set up to assist with the management of the feeding tube and do frequent in home weight checks.

St. Luke's Home Health attempted to visit the home (as was recommended at discharge) on both March 5 and March 6, but family did not return any of their calls.

Hospital follow-up was arranged at the Functional Medicine Clinic, where Cyrus was reportedly seen on March 7. Weight was noted at that time to be down 35 grams from discharge on the 4th. NG tube was no longer present, and parents reported that it "fell out" the day following discharge. Parents reported that Cyrus had been eating well--taking between 6 and 8 ounces of breastmilk every 3 hours (including overnight) along with solid foods per his home routine. There had been no vomiting, and no spitting up. Because of the weight loss, provider recommended weight check in 24-48 hours. This was reportedly scheduled on March 11, but was cancelled by the family as it was reported that Cyrus' mother Marissa was not feeling well. The provider reported that he and his office staff had repeatedly tried to reach the family, and were unsuccessful. A health and welfare referral was initiated at that time.

I was contacted by Health and Welfare regarding the referral on the afternoon of March 11. I reviewed the medical records, and reported that I had significant concerns for Cyrus' health and welfare because of the weight loss and ongoing non-compliance regarding medical recommendations. I also contacted Meridian PD (who was already aware of the patient), and shared my concerns with them. CARES appointment was then scheduled for that afternoon, but family did not show for appointment. There was reportedly significant difficulty in locating Cyrus and his parents, but once he was located last night, he was declared in imminent danger and placed in the custody of health and welfare. He was then transported to St. Luke's ED in Meridian for medical evaluation. In the ED, patient was noted to be cachectic. Initial labs included a glucose of 59, BUN of 18, and AST of 60. Patient appeared somewhat listless. Transfer to St. Luke's Children's Hospital in Boise was arranged for continued evaluation and care. CARES consult requested.

Upon admission, Cyrus' physical examination and labs were consistent with dehydration. Overnight and this morning, he has taken several bottles of formula without vomiting, although remains somewhat listless, and has less interest in eating this afternoon. Has had poor urinary output, and intravenous fluids were administered.

Past Medical History:

Primary Healthcare Provider: Was seen by reportedly when younger according to parents, but his office reported to hospital staff during previous hospitalization that he was only seen on one occasion. He was then seen by a provider at the Functional Medicine Clinic of Idaho on February 28, and then by a different provider at the same clinic on March 7. Parents have declined to provide information regarding other providers who have provided care (including well-child checks) previously, citing the advice of their attorney.

Past Medical History:
Birth: reported SVD at 38 weeks in birthing center. Family has declined to provide the name of the birthing center. They also have refused to provide information regarding whether or not routine newborn screening (PKU) was completed (again on the advice of their attorney).
Birth Weight: 7.5 pounds
Length of Newborn Stay: unclear
Hospitalizations: St. Luke's Children's hospital March 1-4, 2022
Surgery: reported lingual frenulum
Other Medical History: unknown
Medications: unknown
Immunizations: Unimmunized per parental preference
Allergies: No medication allergies and Multiple "food sensitivities" per family, although they have refused to provide documention or additional information regarding the testing performed

Family History:
History of childhood illnesses? Unknown
History of bleeding problems? unknown
History of fractures in family members? unknown
History of hearing loss: unknown
History of dental problems: unknown
Maternal family history: mom with food allergies, otherwise reportedly healthy
Paternal family history: none reported

Review of Systems:

Constitutional	no fever and normal activity level per parents, although appeared quite somnolent and listless at time of admission
HEENT	no vision changes, no nasal congestion and no sore throat
Respiratory	denies cough, denies dyspnea and denies wheezing
Cardiovascular	no color change, no chest pain and no chest wall deformity
Gastrointestinal	no abdominal pain, no constipation, no diarrhea and no vomiting since discharge, had normal stool on day of admission per parents
Hematologic	no bruising problems and no lymphadenopathy
Genitourinary	no genital bleeding
Musculoskeletal	no joint pain and No muscular pain
Neurologic	no involuntary movements, tremors or abnormal muscle tone and no seizures
Endocrine	No concerns

Skin/ Hair	No skin concerns and No chronic skin conditions
Psych/ Behavior	N/A

Dietary History:
Per HPI

Developmental History:
Appears somewhat delayed, although no formal developmental testing. Has difficulty sitting without assistance.

Social History:
Lives with: parents Marissa and Levi
Past history of CPS: Yes (currently, no prior reports)
Family violence: unknown
Psychiatric history: unknown
Primary caregiver at home: mother
Drug/Alcohol use: unknown
Day care: no
Maternal employment: no
Paternal employment: unknown

Social worker present for evaluation: No, discussed in detail with .

Physical Examination:
BP 99/56 (BP Location: Right leg, Patient Position: Lying) | Pulse 100 | Temp 36.9 °C (98.5 °F) (Axillary) | Resp 28 | Ht 71.5 cm (28.15") | Wt 6.28 kg (13 lb 13.5 oz) | HC 45 cm (17.72") | SpO2 99% | BMI 12.28 kg/m²

GENERAL: **Somnolent, falls asleep when left undisturbed, arouses without difficulty, cachectic, thin appearing**
HEENT: Ears: well-positioned, well-formed pinnae. pearly TM, Mouth: Normal tongue, palate intact, Neck: normal structure, Nose and sinus: Nose: small amount of dried, yellow secretions in right nare discharge
NECK: Normal, supple
LUNGS: Normal respiratory effort. Lungs clear to auscultation
HEART: Normal PMI, regular rate & rhythm, normal S1,S2, no murmurs, rubs, or gallops
ABDOMEN: Soft, Nontender, No organomegaly
MUSCULOSKELETAL: **Poor muscle bulk**
NEUROLOGIC: **Intermittently listless, poor tone, significant head lag**
GENITOURINARY: Normal Tanner 1 male genitalia, urine bag in place
SKIN: **Decreased skin turgor, ribs and spine visibly protruding, area of discoloration (slight hyperpigmentation) on right lateral/posterior lower ribcage**

03/12/2022 - ED to Hosp-Admission (Current) in Boise Pediatrics: records until 3/14/2022 (continued)

All Encounter Notes (group 1 of 2) (continued)

ALT(SGPT)	15	<=50 U/L

Lipase

Collection Time: 03/12/22 1:24 AM

Result	Value	Ref Range
LIPASE	34	23 - 300 U/L
	37	

POCT blood glucose

Collection Time: 03/12/22 6:37 AM

Result	Value	Ref Range
BEDSIDE GLUCOSE	78	60 - 100 mg/dL

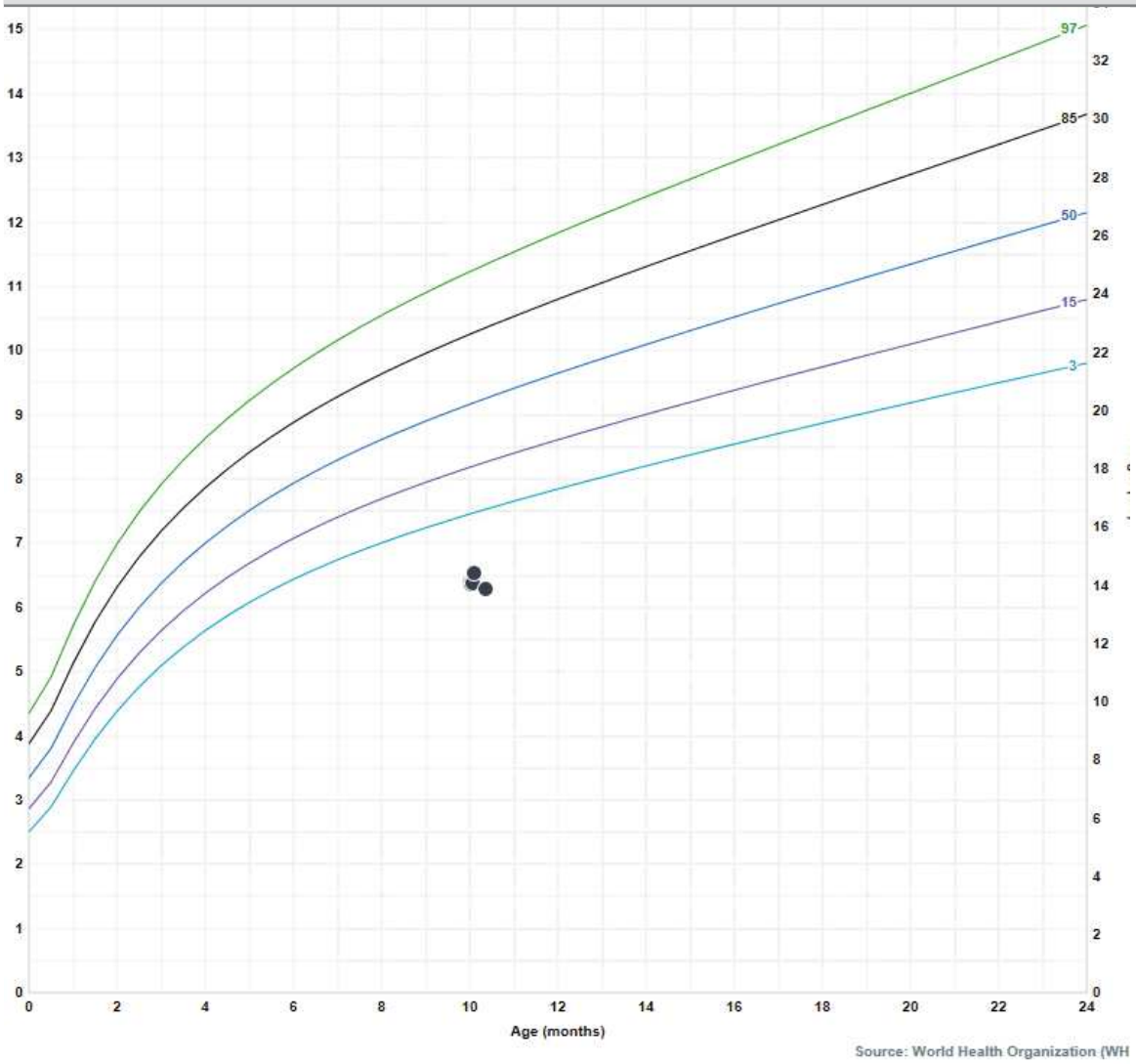
Radiology Studies:
None

Photo Documentation:
Yes see above

Medical Assessment:
Cyrus is a 10 m.o. male with failure to thrive and cyclical vomiting admitted with recent weight loss after gaining weight appropriately during recent hospitalization. Was declared in imminent danger prior to admission due to concerns for nutritional neglect and parental non-compliance with medical recommendations.

03/12/2022 - ED to Hosp-Admission (Current) in Boise Pediatrics: records until 3/14/2022 (continued)

All Encounter Notes (group 1 of 2) (continued)



The following weights have been documented on Cyrus:

- March 1 (initial hospital admission) 6.38 kg
- March 2 6.355 kg (+ 25 g)
- March 3 6.385 kg (+ 30 g)
- March 4 (day of discharge) 6.545 kg (+ 160 g)
- March 7 (hospital f/u at PCP clinic) 6.51 kg (- 35 g)
- March 12 (readmission) 6.28 kg (- 230 g)

Weights of children this age are typically (at least in the medical field) documented in kilograms instead of pounds. The conversion is 2.2 pounds per kilgram. Weight gain is often measured in grams (there are 1000 grams per kilogram).

Cyrus' weight is currently at the 0.02 percentile. His failure to thrive has been consistent and significant over the last several months. The most common etiology of failure to thrive is inadequate oral intake, although there are certainly other less common etiologies including various metabolic disorders. The fact that he gained weight well during the

previous hospitalization supports the notion that if provided with adequately calories, he can grow appropriately, although the hospitalization itself was quite short.

Labwork upon admission was notable for kidney and liver dysfunction in addition to low blood glucose level, all consistent with acute dehydration.

Treatment Plan/Recommendations:
Case discussed in detail with (hospitalist attending) and CARES attending .

and I had a detailed telephone discussion with Cyrus' parents Levi and Marissa this afternoon, during which they were provided an update on his condition and plan of care. They were hesitant to provide certain information (birth records, newborn screening, previous medical records with other providers) upon the advisement of their attorney. and I did not provide our names, only roles. They repeatedly asked for name, and were told that it would not be provided at this time due to safety concerns (family and friends organized and participated a large protest outside of the hospital throughout the afternoon). Marissa stated "nothing will happen to you unless you do something to my baby" and "I won't tell anyone your name unless something happens to my baby".

Parents were provided with a direct phone number for security, should they wish to discuss Cyrus with his medical providers going forward (security will triage call appropriately to and/or myself). We scheduled a phone update for the afternoon of the 13th with parents. Also requested they bring some breastmilk to the hospital (arranged to be dropped off at the ED) so that can be used instead of formula for feedings.

Chronic failure to thrive can have potentially devastating effects on a child's health and development. Various body organs, including the brain, require adequate nutrition in order to function properly. It is imperative that Cyrus be able to maintain appropriate growth (minimum goal of 8-15 gram weight gain daily for catch up growth). It will be important to objectively document all feeds throughout the hospitalization, along with any episodes of emesis. Recommend a minimum of three days of consistent and appropriate weight gain prior to discharge with close f/u with PCP and CARES.

Will attempt to obtain previous medical records on Monday.

Consider formal food allergy testing.
Recommend pre-Albumin

I spent a total of 670 minutes on the date of service in the care of this patient including chart review, discussions with various hospital staff and administration, discussion with family, and chart completion (including orders and coordinating care).

DHW report status: DHW already involved and worker assigned
Was law enforcement contacted: Yes Case discussed with assigned detective MPD
Needs PR

Signatures:

Electronically signed by at 3/14/2022 2:23 PM
Electronically signed by at 3/14/2022 2:55 PM

Progress Notes by at 3/12/2022 1203

Children's Rehab Inpatient PT MISSED VISIT NOTE

Pt was not seen for PT eval today secondary to pt too lethargic and listless today to participate in PT eval for motor skill assessment. Discussed with RN and MD. Will follow for PT eval tomorrow as appropriate. Thank you.

	03/12/22 1200
Missed Visit	
Missed Visit	Other (Comment) *(pt too lethargic to participate in PT eval and assessment, will assess for readiness tomorrow.)*

3/12/2022
12:03 PM

Electronically signed by at 3/13/2022 1:36 PM

Progress Notes by at 3/12/2022 1218

PEDS HOSPITALIST PROGRESS NOTE

DATE OF SERVICE
3/12/2022

REASON FOR HOSPITAL ADMISSION
Cyrus is a 10 m.o. male admitted on 3/12/2022 12:59 AM for:

Active Hospital Problems

Diagnosis	Date Noted
• Failure to thrive (child)	03/12/2022
• Malnutrition (HCC)	03/01/2022

Resolved Hospital Problems
No resolved problems to display.

INTERVAL HISTORY
Patient admitted urgently overnight from the Meridian ER following removal from parents and declaration by health

and welfare.
Patient had labs and clinical exam consistent with dehydration on arrival to the pediatric floor by report.
The ER note documents that he vigorously took 6 oz without difficulty. On arrival to the floor he took 60 mL at 0126, 45 mL at 0314, and 130 mL at 0630. He tolerated all of these well, but has still not had urine output indicating quite profound dehydration as demonstrated by his hypoglycemia and admission electrolyte panel.
Unfortunately this morning, he is less interested in eating and appears be gagging and retching. Nursing notes that he appears hungry, but after only a little intake will refuse the bottle.
Following discussion with parents today, suspect he does not like the taste of the formula as he has been getting only breast milk at home.
Parents report over the phone that he has been taking 6-8 oz of breast milk every 3 hours, including through the night and he has not been spitting up at all.
In addition they have done limited solids including avecado, sweet potatoes and apple sauce.

CURRENT MEDICATIONS

Scheduled Meds:

• sodium chloride 0.9 % (flush)	1 mL	IntraVENOUS	3 times per day

Continuous Infusions:

• dextrose 5 % and sodium chloride 0.9 % with KCl 20 mEq/L infusion	25 mL/hr at 03/12/22 1218

PRN Meds:.acetaminophen, ondansetron HCL, sodium chloride 0.9 % (flush)

OBJECTIVE DATA

Vital signs, last 24h ranges, current
Temp: [36.4 °C (97.5 °F)-37 °C (98.6 °F)] 36.4 °C (97.5 °F)
Heart Rate: [99-140] 99
Resp: [16-30] 28
BP: (99-111)/(56-84) 106/72
MAP (mmHg): [71] 71
SpO2: [95 %-99 %] 98 %
Blood pressure percentiles are not available for patients under the age of 1.

I/O Report

	03/10 0701 03/11 0700	03/11 0701 03/12 0700	03/12 0701 03/13 0700
P.O.		235	80
Total Intake(mL/kg)		**235 (37.4)**	**80 (12.7)**
Urine (mL/kg/hr)			50 (0.8)
Emesis/NG output			0
Stool			0
Total Output			**50**
Net		**+235**	**+30**
Emesis (Unmeasured)			1 x
Urine (Unmeasured)			0 x
Stool (Unmeasured)			0 x

Wt Readings from Last 3 Encounters:

03/12/22	6.28 kg (13 lb 13.5 oz) (<1 %, Z= -3.50)*
03/04/22	6.545 kg (14 lb 6.9 oz) (<1 %, Z= -3.07)*

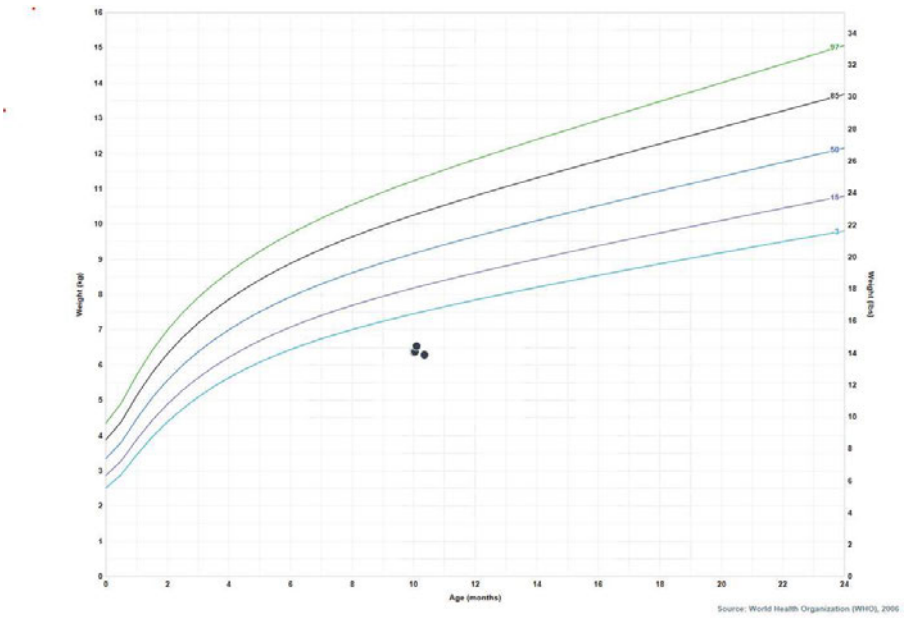
* Growth percentiles are based on WHO (Boys, 0-2 years) data.

Ht Readings from Last 3 Encounters:

03/12/22	71.5 cm (28.15") (17 %, Z= -0.96)*
03/01/22	70 cm (27.56") (8 %, Z= -1.43)*

* Growth percentiles are based on WHO (Boys, 0-2 years) data.

Body mass index is 12.28 kg/m².
<1 %ile (Z= -4.29) based on WHO (Boys, 0-2 years) BMI-for-age based on BMI available as of 3/12/2022.
<1 %ile (Z= -3.50) based on WHO (Boys, 0-2 years) weight-for-age data using vitals from 3/12/2022.



PHYSICAL EXAMINATION

Physical Exam

Vitals and nursing note reviewed.

Constitutional:

General: He is sleeping. He is not in acute distress.
Appearance: He is not toxic-appearing.
Comments: **Cachectic male, appears small for age**

Sleepy, but interactive when awakened.

03/12/2022 - ED to Hosp-Admission (Current) in Boise Pediatrics: records until 3/14/2022 (continued)

All Encounter Notes (group 2 of 2) (continued)

5. Parents request that they be notified if we run out of breast milk.
- Will discuss with the team the best way to notify to ensure they are aware before we run out. We appreciate parents hard work as pumping is not an easy task particularly under the circumstances. Will endeavor to let them know prior to running out.

Will provide this information to medical liason that is updating parents throughout the day.
Patient evaluated on return to the floor and he appears well. Not currently giving feeding cues, but discussed again watching for this to move feeds up as needed.

No additional changes to the plan for now. Subspecialists are still coming up with a plan for additional workup. GI without additional recommendations for now.
Once again, no vaccines will be given and none have been given.
Patient overall appears much stronger today and more engaged and interactive.
Should have a list of testing recommendations tomorrow at the earliest as the medical team is working on ensure only necessary testing is performed.

03/14/22
5:19 PM

Electronically signed by at 3/14/2022 5:20 PM

Progress Notes by at 3/14/2022 1836

Patient has improved throughout the day. This morning, patient was passing lots of gas and had a bowel movement. Good UOP. With each feed, patient has taken in more PO. For the 1500 feed, patient was with mother and breastfed for that feed. For the 1800 feed, patient took the entire feed PO. No emesis or retching noted. Patient has been more alert today and interacting with staff more than yesterday and the day prior.

Electronically signed by at 3/14/2022 6:40 PM

Labs

CBC [266514029] (Final result)

Electronically signed by: **on 03/12/22 0113** Status: **Completed**
Ordering user: 03/12/22 0113 Ordering provider:
Authorized by: Ordering mode: Standard
Frequency: STAT STAT 03/12/22 0114 - 1 occurrence Class: Unit Collect
Quantity: 1 Lab status: Final result
Instance released by: (auto-released) 3/12/2022 1:13 AM

Questionnaire

Question	Answer
Order Class Override	System Default

Specimen Information

ID	Type	Source	Collected By

EXHIBIT B

amazon.com

Final Details for Order #111-7448823-1456214

Print this page for your records.

Order Placed: May 12, 2022
Amazon.com order number: 111-7448823-1456214
Order Total: $105.99

Shipped on May 13, 2022

Items Ordered	Price
1 of: *Arlo Essential Spotlight Camera - 1 Pack - Wireless Security, 1080p Video, Color Night Vision, 2 Way Audio, Wire-Free, Direct to WiFi No Hub Needed, Works with Alexa, White - VMC2030* Sold by: Amazon.com Services LLC Condition: New	$99.99

Shipping Address:
Tracy Jungman
4930 N MORNINGGALE WAY
BOISE, ID 83713-1446
United States

Shipping Speed:
FREE Prime Delivery

Payment information

Payment Method:
Visa | Last digits: 2602

Billing address
Tracy Jungman
4930 N MORNINGGALE WAY
BOISE, ID 83713-1446
United States

Item(s) Subtotal:	$99.99
Shipping & Handling:	$0.00
Total before tax:	$99.99
Estimated tax to be collected:	$6.00
Grand Total:	**$105.99**

Credit Card transactions

Visa ending in 2602: May 13, 2022: $105.99

To view the status of your order, return to Order Summary.

amazon.com

Final Details for Order #114-0103668-1374633

Print this page for your records.

Order Placed: March 18, 2022
Amazon.com order number: 114-0103668-1374633
Order Total: $190.79

Shipped on March 19, 2022

Items Ordered	Price
1 of: *Arlo Pro 4 Spotlight Camera - 1 Pack - Wireless Security, 2K Video & HDR, Color Night Vision, 2 Way Audio, Wire-Free, Direct to WiFi No Hub Needed, White - VMC4050P* Sold by: Amazon.com Services LLC Condition: New	$179.99

Shipping Address:
Tracy Jungman
4930 N MORNINGGALE WAY
BOISE, ID 83713-1446
United States

Shipping Speed:
FREE Prime Delivery

Payment information

Payment Method:
Visa | Last digits: 2602

Billing address
Tracy Jungman
4930 N MORNINGGALE WAY
BOISE, ID 83713-1446
United States

Item(s) Subtotal:	$179.99
Shipping & Handling:	$0.00
Total before tax:	$179.99
Estimated tax to be collected:	$10.80
Grand Total:	**$190.79**

Credit Card transactions

Visa ending in 2602: March 19, 2022: $190.79

To view the status of your order, return to Order Summary.