

# PRACTICE EXAM 4: LNCC CERTIFICATION SIMULATION (200 QUESTIONS)

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1. An LNC is reviewing a medical malpractice case involving a 52-year-old woman who presented to her primary care physician with persistent hoarseness lasting eight weeks. The physician prescribed a course of antibiotics and a proton pump inhibitor for presumed laryngopharyngeal reflux. No laryngoscopy was performed and no ENT referral was made. The hoarseness persisted for an additional four months before the patient independently sought an ENT consultation. Direct laryngoscopy revealed a glottic squamous cell carcinoma. Published clinical guidelines recommend laryngoscopy for any patient with hoarseness persisting beyond four weeks to rule out laryngeal pathology. What is the critical diagnostic failure?

A. The proton pump inhibitor trial was an inappropriate first-line treatment for persistent hoarseness in this age group

B. The physician should have ordered a CT scan of the neck rather than making a referral for laryngoscopic evaluation

C. Hoarseness persisting beyond four weeks requires laryngoscopy to evaluate for laryngeal pathology including malignancy — treating persistent hoarseness empirically without direct visualization of the larynx deviated from clinical guidelines and resulted in a four-month diagnostic delay during which the cancer potentially progressed

D. The antibiotic prescription was unnecessary because hoarseness is rarely caused by bacterial infection in adult patients

2. An LNC is evaluating a long-term care case in which a nursing home resident with advanced Parkinson's disease and documented dysphagia was found unresponsive after choking on solid food during a meal. The resident had a speech-language pathologist evaluation three months prior recommending a pureed diet with nectar-thick liquids. The meal tray delivered to the resident contained regular-texture food including a dinner roll, sliced chicken, and raw carrot sticks. The nursing aide who served the tray was a newly hired employee who stated she had "not been told about any special diets." The facility's meal ticket system and the nursing aide's orientation records both lack any documentation of dietary restriction training. What is the most comprehensive analysis of this event?

A. The speech-language pathologist should have scheduled a follow-up evaluation within 30 days to reassess the dysphagia

B. The attending physician should have entered the diet order in a more prominent location within the medical record

C. The newly hired dietary aide bears sole responsibility because aides are expected to check each resident's diet order before serving

D. Multiple systems failures converged: the facility's training program did not include dietary modification awareness for newly hired staff, the meal ticket system did not communicate the diet restriction to the point of meal service, and the shift report did not include critical dietary information — the choking event resulted from institutional communication failures, not a single individual's error

3. An LNC is analyzing a personal injury case involving a 44-year-old professional chef who sustained a severe thermal burn to her dominant right hand when she slipped on an unmarked wet floor at a catering venue and grabbed a heated surface to break her fall. The burn involved the palmar surface of the hand, affecting the digital nerves and flexor tendons. Despite surgical treatment and extensive hand therapy, the plaintiff has permanent loss of fine touch sensation in the index and middle fingers, a 30% reduction in grip strength, and an inability to tolerate sustained heat exposure. These residual impairments prevent her from performing the essential functions of professional cooking — knife work requiring fine tactile feedback, handling hot cookware, and sustained manual food preparation. The defense argues the plaintiff can work in food industry management. What is the most important damages consideration?

A. The permanent loss of the specific sensory and motor functions required for professional cooking — fine touch sensation, grip strength, and heat tolerance — constitutes both an economic loss (earning capacity at the professional chef level) and a non-economic loss (the inability to practice a skilled craft that defined the plaintiff's professional identity and creative expression), and neither loss is adequately addressed by suggesting management work, which requires fundamentally different skills and offers different compensation

B. The plaintiff should undergo a functional capacity evaluation to objectively verify the claimed sensory and motor deficits

C. The plaintiff's pre-injury income as a chef should be compared to management salaries to calculate the precise economic differential

D. The venue's liability should be limited to the burn treatment costs because the hand impairments are a consequence of treatment

4. An LNC is reviewing a medical malpractice case involving a 68-year-old patient who underwent a total knee replacement and developed a postoperative deep vein thrombosis despite being prescribed enoxaparin for VTE prophylaxis. The medication administration record shows that 4 of the first 7 postoperative enoxaparin doses were not administered — two entries state "patient refused," one states "held per pharmacy," and one has no documentation at all. The attending surgeon was never notified

about the missed doses. The patient developed an extensive iliofemoral DVT on postoperative day six. What should the LNC evaluate?

- A. The enoxaparin prescription demonstrates the surgeon fulfilled all VTE prophylaxis obligations regardless of actual administration
- B. The gap between ordered and administered prophylaxis is the critical issue — the LNC should evaluate whether the nursing staff adequately educated the patient about VTE risk (potentially preventing the refusals), what "held per pharmacy" means and whether it was clinically justified, why one dose has no documentation at all, and why the surgeon was not notified about four missed doses so that alternative prophylaxis could be considered
- C. The patient's refusal of two doses constitutes contributory negligence that should reduce the defendant's liability significantly
- D. The pharmacy bears sole responsibility for the "held per pharmacy" notation and should be the primary defendant in the case

5. An LNC is evaluating a workers' compensation case involving a 39-year-old dental hygienist who developed bilateral carpal tunnel syndrome and bilateral de Quervain's tenosynovitis after nine years of performing dental scaling, root planing, and polishing procedures. The hygienist's job analysis documents that the position requires sustained pinch grip on dental instruments with repetitive wrist flexion-extension and ulnar-radial deviation for 6–7 hours per day, five days per week. The employer's IME physician concluded the conditions are "constitutional" because bilateral involvement suggests a systemic predisposition rather than occupational causation. What is the fundamental flaw in the IME physician's reasoning?

- A. The IME physician should have ordered nerve conduction studies before reaching any conclusion about the conditions' etiology
- B. The hygienist's recreational activities should be investigated as the primary cause of the bilateral upper extremity conditions
- C. The hygienist should undergo a functional capacity evaluation before any determination about occupational causation is made
- D. Bilateral involvement does not disprove occupational causation when the occupational exposure is itself bilateral — a dental hygienist uses both hands symmetrically during scaling and instrumentation, so bilateral CTS and bilateral de Quervain's are the expected pattern of occupational injury for symmetrically demanding hand-intensive work

6. An LNC is analyzing a medical malpractice case involving a patient who presented to the emergency department with acute onset of right-sided facial droop, right arm weakness, and expressive aphasia at 10:00 AM. The patient arrived at the hospital at 10:35 AM. A head CT was completed at 10:55 AM (negative for hemorrhage). The neurologist was paged at 11:00 AM but did not respond until 11:45 AM. During this 45-minute period, no tPA was ordered because the emergency physician stated the hospital's stroke protocol required neurologist authorization before tPA administration. The tPA was finally administered at 12:15 PM — 2 hours and 15 minutes after symptom onset. Published evidence demonstrates that every 15-minute delay in tPA administration reduces the probability of a good neurological outcome. What is the primary systems failure?

- A. The hospital's stroke protocol requiring neurologist authorization before tPA administration — without a contingency for delayed neurologist response — created a systems-level barrier to time-critical treatment, and the 45-minute delay waiting for neurologist response deprived the patient of the time-dependent benefit of earlier thrombolysis
- B. The emergency physician should have administered tPA without neurologist authorization under the emergency doctrine
- C. The neurologist should be individually liable for the 45-minute response delay without any institutional responsibility
- D. The CT technologist should have expedited the scan to allow more time for the neurologist to respond before tPA was needed

7. An LNC is reviewing a product liability case involving a patient who received a defective vascular access port (Port-a-Cath) for chemotherapy administration. The port's catheter fractured and embolized — a fragment of the catheter broke free and traveled through the venous system to the right ventricle. The patient required emergent interventional radiology retrieval of the catheter fragment from the heart. The manufacturer's post-market surveillance data shows a catheter fracture rate of 4.8% at two years for this specific port model — significantly higher than the industry benchmark of less than 0.5%. The manufacturer was aware of the elevated fracture rate for 14 months before the plaintiff's catheter fractured but had not issued a product advisory or recall. What is the most significant liability issue?

- A. The interventional radiologist who retrieved the fragment should have used a different technique to minimize the procedure's risks
- B. The surgeon who implanted the port should have selected a different manufacturer's device based on clinical experience
- C. The manufacturer's knowledge of the elevated catheter fracture rate (4.8% vs. <0.5% benchmark) for 14 months without issuing a product advisory constitutes a failure to warn — the delay deprived

oncologists and patients of information needed to make informed decisions about device selection and monitoring frequency

D. The patient should have reported symptoms of catheter migration (chest pain, palpitations) earlier to allow prompt intervention

8. An LNC is analyzing a risk management case involving a hospital that has experienced a significant increase in surgical site infections (SSIs) over a six-month period. The SSI rate has risen from 1.2% to 3.8% — well above the national benchmark of 1.5%. The infection control team's investigation reveals that the hospital recently switched to a new surgical skin preparation product that requires a different application technique and drying time than the previous product. The surgical staff were not formally trained on the new product's application requirements, and observational audits show inconsistent application technique and inadequate drying time before incision across multiple surgical specialties. What risk management conclusion should the LNC draw?

A. The new skin preparation product manufacturer should be solely liable for the increased SSI rate because the product is inferior

B. The increased SSI rate temporally correlated with the product change suggests that the transition was implemented without adequate staff training on the new product's specific application requirements — the inconsistent technique and inadequate drying time across multiple specialties indicate a systems-level training failure during the product transition, not individual performance failures

C. The individual surgeons should be retrained on skin preparation technique before any systems-level changes are considered

D. The hospital should immediately revert to the previous skin preparation product without investigating the root cause further

9. An LNC is reviewing a medical malpractice case involving a 45-year-old patient who presented to the emergency department with acute onset of right upper quadrant pain, fever, and jaundice — Charcot's triad, which is the classic presentation of acute cholangitis (infection of the bile duct). The emergency physician diagnosed "biliary colic" and discharged the patient with pain medication and instructions to follow up with a surgeon. The patient returned 36 hours later in septic shock from ascending cholangitis requiring emergent biliary decompression and ICU admission. What clinical finding should have prompted a different management approach?

A. Charcot's triad — right upper quadrant pain, fever, and jaundice — represents the classic presentation of acute cholangitis, a potentially life-threatening biliary infection requiring hospital admission, IV antibiotics, and likely urgent biliary decompression, not outpatient management with pain medication

- B. The physician should have ordered an ultrasound before making any disposition decision about the patient's biliary complaint
- C. The surgeon who was to receive the follow-up referral should have been consulted before the patient was discharged home
- D. The patient should have been prescribed prophylactic antibiotics before discharge to prevent cholangitis from developing

10. An LNC is evaluating a toxic tort case involving former workers at a lead smelting facility who were occupationally exposed to lead for 10–25 years. Blood lead levels during employment ranged from 40 to 75  $\mu\text{g}/\text{dL}$ . Several workers have developed peripheral neuropathy. The defense argues the workers' neuropathy is caused by their diabetes (three of five workers are diabetic) and alcohol use (two workers report moderate alcohol consumption). The LNC reviews the published literature on lead neuropathy and finds that chronic lead exposure at the documented levels is consistently associated with peripheral neuropathy, with a predominantly motor pattern that may differ from the predominantly sensory pattern of diabetic neuropathy. What is the most appropriate causation analysis approach?

- A. The workers' diabetes and alcohol use eliminate lead as a possible contributing cause of their neuropathy conditions
- B. The elevated blood lead levels confirm causation without any need for individual clinical analysis of each worker
- C. The workers should undergo nerve biopsy to definitively distinguish between lead, diabetic, and alcoholic neuropathy
- D. The LNC should evaluate each worker individually, assessing the documented lead levels relative to the dose-response curve for lead neuropathy, the temporal relationship between exposure and symptom onset, whether the neuropathy pattern (motor vs. sensory predominance) is more consistent with lead neuropathy or diabetic/alcoholic neuropathy, and whether multiple etiologies may have contributed independently or synergistically

11. An LNC is analyzing a personal injury case involving a 58-year-old woman who was injured when the chair she was sitting in at a restaurant collapsed. The plaintiff sustained a compression fracture of the L1 vertebra and bilateral sacral insufficiency fractures. She has documented severe osteoporosis (T-score of -3.5). The defense argues the fractures were caused by the osteoporosis, not the fall. The plaintiff's pre-injury medical records show no prior vertebral or sacral fractures despite the longstanding osteoporosis. What legal doctrine governs this analysis?

A. Comparative negligence applies because the plaintiff's failure to treat her osteoporosis contributed to the injury severity

B. Under the eggshell plaintiff doctrine, the defendant takes the plaintiff as found — the osteoporosis made the plaintiff more vulnerable to fracture, but the chair collapse was the triggering event that produced the fractures in bones that had not previously fractured despite the longstanding osteoporosis, and the defendant is liable for the full extent of the resulting injuries

C. The plaintiff must demonstrate she would have sustained fractures even without the osteoporotic bone condition to establish causation

D. The restaurant should have screened all patrons for osteoporosis before allowing them to sit in standard restaurant seating

12. An LNC is reviewing a medical malpractice case involving a 40-year-old woman who underwent a bilateral breast augmentation. The patient developed capsular contracture in the left breast, progressing to Baker Grade IV over six months. The surgeon recommended observation and massage. After 14 additional months of failed conservative management, the patient sought a second opinion. The second surgeon performed a capsulectomy with implant exchange and documented extensive chronic inflammation, scar tissue calcification, and thinned breast tissue that complicated the revision. The defense argues capsular contracture is a recognized complication. How should the LNC evaluate the defense argument?

A. Capsular contracture is a recognized complication and therefore cannot constitute the basis of a malpractice claim

B. The LNC should evaluate whether the plaintiff's choice of implant type contributed to the capsular contracture development

C. The defense argument addresses the occurrence of contracture but not the management — Baker Grade IV contracture that fails conservative management for six months requires escalation (capsulectomy, implant exchange), and the additional 14-month delay in definitive treatment allowed chronic inflammation and tissue damage that complicated the eventual revision surgery

D. The second surgeon's opinion constitutes the definitive standard of care analysis and no further evaluation is needed

13. An LNC is evaluating a healthcare fraud case involving a physician-owned clinical laboratory. A Medicare audit reveals that the laboratory routinely performs comprehensive metabolic panels and complete blood counts on every specimen received, regardless of the tests actually ordered by the referring physician. The referring physicians' orders consistently request only specific individual tests (e.g., hemoglobin A1c, lipid panel), but the laboratory bills Medicare for the comprehensive panel in addition to the ordered tests. The laboratory's medical director has signed a standing order authorizing

the comprehensive testing on all specimens "for quality assurance purposes." What regulatory violation does this pattern represent?

- A. The standing order for comprehensive testing on all specimens regardless of clinical indication — combined with billing Medicare for tests not ordered by the treating physician — constitutes billing for medically unnecessary services, implicating the False Claims Act
- B. The comprehensive panels are appropriate because they provide additional clinical information that benefits patient care
- C. The referring physicians bear responsibility because they should have specified that only the ordered tests should be performed
- D. The medical director's standing order provides legal authorization for the additional testing and Medicare billing

14. An LNC is reviewing a medical malpractice case involving a patient who underwent spinal surgery and developed a postoperative epidural hematoma. The patient was taking clopidogrel (Plavix) for a coronary stent placed eight months earlier. Current surgical guidelines recommend discontinuing clopidogrel 5–7 days before elective spinal surgery due to the increased bleeding risk. The surgeon did not discontinue clopidogrel before the procedure. The patient developed progressive bilateral lower extremity weakness 12 hours after surgery, and an emergent MRI confirmed a cervical epidural hematoma. Emergency surgical evacuation was performed, but the patient has residual incomplete quadriparesis. What additional step should the LNC evaluate beyond the failure to discontinue clopidogrel?

- A. The anesthesiologist should have refused to proceed with the case when learning the patient was still on clopidogrel therapy
- B. The patient should have independently discontinued the clopidogrel before presenting for the elective spinal procedure
- C. The pharmacy should have flagged clopidogrel as a contraindicated medication for patients scheduled for spinal surgery
- D. Whether the surgeon consulted with the patient's cardiologist before discontinuing clopidogrel — because the drug was prescribed to prevent stent thrombosis, and premature discontinuation could cause a catastrophic coronary event — the standard of care requires a coordinated multidisciplinary decision about the timing and safety of antiplatelet cessation before elective surgery in patients with coronary stents

15. An LNC is analyzing a long-term care case in which a nursing home resident was prescribed warfarin for atrial fibrillation. The facility's pharmacy consultant review identified an INR of 5.2 (supratherapeutic and dangerously elevated) and recommended immediate dose adjustment and physician notification. The pharmacy report was filed in the resident's chart but was not communicated to the attending physician or the nursing staff for action. Three days later, the resident developed a spontaneous intracranial hemorrhage and died. The LNC reviews the facility's process for handling pharmacy consultant recommendations and finds no documented system for ensuring physician review of and response to pharmacy reports. What systems failure does this case illustrate?

A. The pharmacy consultant fulfilled all professional obligations by documenting the recommendation in the chart

B. The absence of a system for ensuring that pharmacy consultant recommendations — particularly urgent safety findings like a dangerously supratherapeutic INR — are communicated to and acted upon by the responsible physician represents a critical gap between identification and action, and the three-day delay between the recommendation and the fatal hemorrhage was a foreseeable consequence of this gap

C. The attending physician should have reviewed the chart daily and would have discovered the pharmacy recommendation

D. The nursing staff should have independently adjusted the warfarin dose without waiting for a physician order or notification

16. An LNC is reviewing a medical malpractice case involving a 35-year-old woman who presented to the emergency department with acute-onset severe abdominal pain, tachycardia, and hypotension. A positive pregnancy test was obtained. The emergency physician ordered a pelvic ultrasound, which showed no intrauterine pregnancy and free fluid in the pelvis. The physician diagnosed a ruptured ectopic pregnancy and called for an emergency surgical consultation. However, the surgeon was engaged in another procedure and did not arrive for 90 minutes. During this delay, the patient's blood pressure dropped to 70/40 mmHg and she required massive transfusion. Emergency salpingectomy was eventually performed, and the patient survived but lost her only remaining fallopian tube — resulting in permanent infertility. Beyond the surgical delay, what additional element of damages should the LNC evaluate?

A. The cost of future oral contraception should be included because the patient no longer needs contraception after sterilization

B. The emergency physician should have performed the emergency surgery without waiting for the surgical consultant to arrive

C. The permanent loss of fertility — the inability to conceive naturally after loss of the only remaining fallopian tube — constitutes a distinct and significant non-economic damage element encompassing the emotional distress of lost reproductive capacity, the potential cost of in vitro fertilization with a gestational carrier, and the profound personal impact on the patient's life plans

D. The surgeon who was engaged in another procedure should bear sole liability for the delay in treating the ruptured ectopic

17. An LNC is evaluating a workers' compensation case involving a 47-year-old registered nurse who developed chronic low back pain after a specific lifting injury — the nurse felt an acute onset of severe back pain while lifting a 280-pound patient without assistance or a mechanical lift. The employer accepted the initial injury but disputes the need for lumbar fusion surgery, arguing that the nurse's pre-existing degenerative disc disease at L4-L5 and L5-S1 is the primary cause of the symptoms and the surgery is not related to the work injury. The LNC reviews the nurse's pre-injury medical records and finds documentation of intermittent mild back pain treated with occasional over-the-counter medications, no prior imaging of the lumbar spine, and no prior functional limitations. Post-injury MRI shows disc herniations at L4-L5 and L5-S1 superimposed on degenerative changes. What should the LNC evaluate?

A. The pre-existing degenerative changes prove the back condition is entirely unrelated to the lifting injury at work

B. The nurse should undergo a functional capacity evaluation before the surgical necessity can be evaluated by the LNC

C. The nurse's recreational activities should be investigated as an alternative cause of the disc herniations identified on MRI

D. Whether the acute lifting injury aggravated the pre-existing degenerative condition — transforming an intermittent mild condition manageable with OTC medications into a disabling condition requiring surgical intervention — and whether the documented clinical trajectory (acute onset during a specific lifting event, progression to radiculopathy, failure of conservative treatment) supports the work injury as the precipitating cause of the surgical condition

18. An LNC is analyzing a medical malpractice case involving a patient who underwent elective laparoscopic cholecystectomy. Intraoperatively, the surgeon clipped and transected the common bile duct, mistaking it for the cystic duct — the most commonly litigated complication of laparoscopic cholecystectomy. The injury was not recognized during the procedure. The patient developed jaundice, abdominal pain, and fever on postoperative day four. An ERCP confirmed a complete common bile duct transection. The patient required a hepaticojejunostomy, experienced recurrent episodes of cholangitis, and has a lifelong risk of biliary stricture and secondary biliary cirrhosis. Current surgical guidelines

emphasize the "critical view of safety" technique — a specific dissection method designed to identify the cystic duct and cystic artery definitively before clipping and cutting. What should the LNC evaluate?

- A. Whether the surgeon achieved the "critical view of safety" before clipping — the operative report should document clear identification of the cystic duct and cystic artery with the hepatocystic triangle dissected free, and failure to achieve or document this view before transection may constitute a deviation from the surgical standard of care designed specifically to prevent common bile duct injuries
- B. Common bile duct injury during laparoscopic cholecystectomy is a recognized complication and cannot constitute malpractice
- C. The patient should have elected open cholecystectomy rather than the laparoscopic approach to reduce the bile duct injury risk
- D. The radiologist who read the preoperative imaging should have warned the surgeon about difficult biliary anatomy before surgery

19. An LNC is reviewing a Medicare Set-Aside case involving a 71-year-old Medicare beneficiary settling a workers' compensation claim for a workplace injury that resulted in a below-knee amputation. The claimant's current prosthesis is a basic prosthetic leg with a solid ankle cushioned heel (SACH) foot. The treating prosthetist recommends upgrading to a dynamic-response carbon fiber foot prosthesis that would improve the claimant's mobility, reduce energy expenditure during ambulation, and decrease compensatory gait abnormalities that are contributing to secondary knee and hip pain. The defense argues the MSA should include only the current basic prosthesis type at replacement intervals. What should the LNC evaluate?

- A. The defense argument should be accepted because the current prosthesis is functional and the upgrade is cosmetic in nature
- B. The MSA should exclude all prosthetic costs because Medicare does not cover prosthetic devices under any circumstances
- C. Whether the prosthetist's clinical recommendation for the upgraded prosthesis is medically justified — if the dynamic-response foot addresses documented functional limitations and prevents secondary musculoskeletal complications, the MSA should reflect the cost of the clinically recommended prosthesis rather than a basic model that does not meet the claimant's documented functional and medical needs
- D. The MSA should include the basic prosthesis costs and add a separate line item for the upgrade differential as an optional expense

20. An LNC is evaluating a risk management case involving a hospital that uses patient-controlled analgesia (PCA) pumps for postoperative pain management. A near-miss event occurred when a nurse programmed a hydromorphone PCA pump with a concentration of 1 mg/mL instead of the correct 0.2 mg/mL — a fivefold concentration error. The error was caught by a second nurse during a routine PCA verification check before the patient received any doses. Investigation reveals the hospital's PCA programming protocol requires independent double-check verification of all PCA pump settings, but this double-check is performed in only 65% of cases. What does this near-miss event reveal?

- A. The nurse who made the programming error should be disciplined because PCA concentration errors are never acceptable
- B. The near-miss event demonstrates both the value of the independent double-check (which caught this potentially fatal error) and the vulnerability created by the 35% non-compliance rate — in 35% of cases, a similar error would not have been detected before reaching the patient, and the risk management response should address why the double-check is not being performed consistently
- C. The PCA pump manufacturer should redesign the pump interface to prevent concentration entry errors during programming
- D. The event does not require a risk management response because no patient was actually harmed by the programming error

21. An LNC is analyzing a medical malpractice case involving a 60-year-old patient who underwent a total hip arthroplasty. The surgeon used a posterior surgical approach. On postoperative day one, the patient's hip dislocated during a physical therapy session when the therapist flexed the hip beyond 90 degrees while the patient was simultaneously internally rotating. The posterior approach to hip arthroplasty has specific postoperative hip precautions — including avoiding hip flexion beyond 90 degrees, internal rotation, and adduction past midline — that must be communicated to all members of the care team. The physical therapist stated she was "not informed about posterior precautions." What communication failure should the LNC identify?

- A. The surgeon's failure to communicate the approach-specific hip precautions to the physical therapy team — or the absence of a system to ensure this communication — created a gap between the surgical plan and the rehabilitation plan that resulted in a foreseeable dislocation
- B. The physical therapist should have independently known the hip precautions for all surgical approaches without surgeon communication
- C. The patient should have stopped the therapist when the hip was being flexed beyond a comfortable range during the session
- D. The nursing staff should have been present during all physical therapy sessions to monitor for hip precaution compliance

22. An LNC is reviewing a long-term care case in which a nursing home resident with documented wandering behavior and moderate dementia was found in the facility's kitchen after hours, with burns on both hands from contact with a hot stove that had been left on by the evening cooking staff. The facility's elopement prevention system included a wander guard bracelet, but the kitchen door was not equipped with an alarm or lock to prevent resident access. The resident's care plan documented wandering as a significant risk but did not address access to hazardous areas of the facility. What institutional failures should the LNC identify?

- A. The dietary staff who left the stove on should be held solely responsible for the resident's burns and the resulting injuries
- B. The resident's family should have been required to provide a private sitter during nighttime hours to prevent wandering
- C. The resident's physician should have prescribed sedating medication to control the nighttime wandering behavior pattern
- D. The facility failed to secure the kitchen — a hazardous area with hot surfaces and sharp implements — from access by wandering cognitively impaired residents, and the care plan's failure to address access to hazardous areas despite documenting wandering as a risk demonstrates a care planning deficiency that created a foreseeable and preventable injury

23. An LNC is evaluating a personal injury case involving a 50-year-old man who sustained a rotator cuff tear when a ceiling-mounted light fixture fell and struck his shoulder at a retail store. Despite arthroscopic rotator cuff repair, the plaintiff has residual shoulder weakness, limited overhead reach, and chronic pain. His pre-injury occupation was commercial painter, which requires repetitive overhead reaching, sustained shoulder elevation, and heavy lifting of equipment. The defense argues the plaintiff can transition to painting supervision or estimating. What should the LNC evaluate?

- A. The plaintiff's workers' compensation status should be verified before the personal injury damages analysis is initiated
- B. The clinical documentation of residual shoulder impairments — particularly the limited overhead reach and sustained elevation capacity — and their specific impact on the physical demands of commercial painting should determine whether the plaintiff can perform his pre-injury occupation, and whether the defense's proposed alternative roles are actually compatible with the plaintiff's documented functional limitations
- C. The plaintiff should undergo a second surgical repair before claiming permanent inability to perform commercial painting
- D. The plaintiff's age of 50 indicates he was approaching retirement from physical labor and damages should be limited accordingly

24. An LNC is analyzing a medical malpractice case involving a patient who underwent a diagnostic cardiac catheterization via the right radial artery approach. During the procedure, the patient developed a radial artery occlusion. The standard of care requires performing a pre-procedure Allen's test to verify adequate collateral circulation through the ulnar artery before using the radial artery for catheterization. If the Allen's test demonstrates inadequate collateral flow, the radial approach should not be used. The physician did not document performing an Allen's test. The patient developed hand ischemia and ultimately lost the tip of the right index finger to dry gangrene. What should the LNC evaluate?

- A. The radial approach should never be used for cardiac catheterization due to the inherent risk of hand ischemia in all patients
- B. The catheterization laboratory nurse should have independently verified that the Allen's test was performed before the procedure
- C. The patient should have been informed about the risk of hand ischemia and given the option to choose the femoral approach
- D. Whether the physician performed and documented the Allen's test before using the radial approach — the absence of documentation creates an inference that the test was not performed, and the failure to assess collateral circulation before radial artery access deviates from the procedural standard of care

25. An LNC is reviewing a life care plan for a 40-year-old man who sustained a complete T6 spinal cord injury. The plan includes annual physiatric evaluation, annual urological evaluation, annual pulmonary function testing, annual dermatological evaluation, annual psychological assessment, and ongoing physical and occupational therapy. The defense argues these specialty evaluations are excessive and should be replaced by primary care visits. What is the most appropriate response to the defense argument?

- A. Published SCI clinical practice guidelines specifically recommend these annual specialty evaluations as part of the preventive care regimen for thoracic-level SCI — T6 complete injury creates lifelong risk for urological complications (neurogenic bladder, UTIs, renal stones), respiratory compromise, pressure ulcers, musculoskeletal deterioration, and psychological sequelae that require specialist-level monitoring exceeding the scope of routine primary care
- B. The specialty evaluations should be reduced to biennial frequency as a compromise between the two expert positions
- C. The plaintiff should choose the three most important specialties rather than seeing all five specialists annually
- D. The defense argument should be accepted because primary care physicians can adequately manage all SCI-related complications

26. An LNC is analyzing a pharmaceutical product liability case involving a patient who developed Stevens-Johnson syndrome (SJS) after taking an anticonvulsant medication. The FDA-approved labeling for the drug recommends genetic testing for the HLA-B1502 allele before prescribing to patients of Southeast Asian descent because carriers of this allele have a significantly increased risk of SJS. The patient was of Filipino descent. The prescribing physician did not order the genetic test before prescribing the medication. The patient developed severe SJS with extensive skin and mucous membrane involvement requiring burn unit admission, and sustained permanent visual impairment from corneal scarring. What liability theory applies to the prescribing physician?

A. The manufacturer is solely liable because the drug caused the adverse reaction regardless of genetic testing availability

B. The pharmacist should have verified the patient's ethnic background before dispensing the anticonvulsant medication

C. The patient is responsible for not disclosing ethnic heritage information to the prescribing physician before the prescription

D. The prescribing physician's failure to order the recommended genetic test before prescribing the medication to a patient of Southeast Asian descent — when the FDA labeling specifically recommends testing in this population to prevent SJS — constitutes prescribing negligence, as the test would have identified the patient's elevated risk and prompted selection of an alternative medication

27. An LNC is evaluating a workers' compensation case involving a 35-year-old firefighter who developed cardiac arrhythmias (atrial fibrillation and ventricular tachycardia) after acute exposure to hydrogen cyanide and carbon monoxide during a residential structure fire. The firefighter was not wearing a self-contained breathing apparatus (SCBA) at the time of the exposure because the SCBA malfunctioned. Pre-employment cardiac screening was normal. The employer's IME physician concluded the arrhythmias are caused by "idiopathic cardiac disease" unrelated to the fire exposure. The LNC reviews the toxicology literature and finds that both hydrogen cyanide and carbon monoxide are documented cardiac toxicants that can cause arrhythmias, myocardial injury, and conduction abnormalities through disruption of cellular respiration and oxygen delivery. What should the LNC evaluate?

A. The IME physician's cardiac evaluation was sufficient and the arrhythmias should be classified as idiopathic as concluded

B. The firefighter's recreational caffeine and alcohol consumption should be investigated as the primary arrhythmia triggers

C. Whether the documented exposure to known cardiac toxicants (HCN and CO) during the fire — combined with the temporal onset of arrhythmias following the exposure and the normal pre-

employment cardiac screening — establishes a causal relationship between the toxic exposure and the cardiac arrhythmias, and whether the SCBA malfunction that prevented respiratory protection constitutes an employer safety violation that contributed to the injury

D. The SCBA manufacturer should be the sole defendant because the equipment malfunction caused the unprotected exposure

28. An LNC is reviewing a medical malpractice case involving a patient who underwent an outpatient surgical procedure under general anesthesia and was discharged with an Aldrete score of 8 when the facility's discharge threshold requires a minimum score of 9. The patient experienced respiratory depression during the car ride home and was brought to the emergency department by the companion, where the patient required intubation and ICU admission. The patient sustained a hypoxic brain injury. Beyond the premature discharge, what additional standard of care issue should the LNC evaluate?

A. The companion should have been trained in basic airway management techniques before taking the patient home after surgery

B. Whether the discharging nurse adequately assessed the patient's companion — the discharge criteria require that the patient be released into the care of a responsible adult, and the nurse should have verified that the companion understood the signs of respiratory depression, had transportation that allowed close monitoring, and had access to emergency services

C. The anesthesiologist should have used a regional anesthetic technique rather than general anesthesia for the outpatient procedure

D. The patient should have been kept overnight for observation regardless of the Aldrete score achieved after the procedure

29. An LNC is analyzing a long-term care case in which a nursing home resident with documented bilateral below-knee amputations and wheelchair dependence developed bilateral ischial pressure ulcers. The resident's wheelchair cushion was a standard foam cushion that had not been replaced in 14 months. The manufacturer's recommended replacement schedule for the foam cushion is every 6–12 months because the foam degrades and loses its pressure-redistributing properties over time. The facility did not have a wheelchair cushion replacement schedule. The LNC notes that the resident's weight exceeded the cushion's rated weight capacity by 30 pounds, and the cushion was visibly compressed and deformed. What should the LNC evaluate?

A. The pressure ulcers were caused by the resident's underlying vascular disease rather than the wheelchair cushion condition

B. The degraded wheelchair cushion — used beyond its recommended replacement interval, loaded beyond its rated weight capacity, and visibly deformed — was no longer providing adequate pressure redistribution, and the facility's failure to maintain a cushion replacement schedule and to match the cushion to the resident's weight demonstrates a failure in equipment maintenance that directly contributed to the bilateral ischial pressure ulcer development

C. The wheelchair cushion manufacturer should bear sole liability for not designing a more durable cushion for heavy-use applications

D. The physical therapy department should have independently assessed the wheelchair cushion adequacy at every therapy session

30. An LNC is evaluating a medical malpractice case involving a patient who developed postpartum hemorrhage following a vaginal delivery. The patient delivered at 4:15 PM. The nursing documentation shows the uterine fundus was checked at 4:30 PM (firm) and again at 6:45 PM (boggy, with heavy vaginal bleeding). Between these two assessments — a gap of 2 hours and 15 minutes — no fundal checks or vital signs were documented. The standard of care for postpartum monitoring requires fundal assessment and vital signs every 15 minutes for the first hour, then every 30 minutes for the second hour. By the time the boggy fundus was identified at 6:45 PM, the patient had lost an estimated 1,800 mL of blood and required emergency transfusion, uterine balloon tamponade, and ICU admission. What should the LNC identify?

A. The physician should have remained at the bedside for continuous postpartum monitoring during the first two hours after delivery

B. The patient should have alerted the nursing staff about the increasing bleeding rather than waiting for the scheduled assessment

C. The initial fundal assessment at 4:30 PM confirmed a firm fundus and no further monitoring was needed until symptoms developed

D. The 2-hour-and-15-minute gap between postpartum assessments — when the standard of care requires assessments every 15–30 minutes during the first two hours — represents a critical monitoring failure that allowed postpartum hemorrhage to progress undetected from a treatable uterine atony to a life-threatening hemorrhage requiring emergency intervention

31. An LNC is reviewing a product liability case involving a patient who received a recalled knee prosthesis. The tibial baseplate of the prosthesis fractured at 22 months postoperatively, causing sudden knee instability and a fall that resulted in a contralateral hip fracture. The manufacturer recalled the tibial baseplate due to a metallurgical defect in a specific manufacturing lot that reduced fatigue strength. The manufacturer's recall notice acknowledged the lot-specific defect. What type of product defect does this scenario represent?

- A. Design defect, because all knee prostheses of this model share the same design vulnerability that causes tibial baseplate fracture
- B. Failure to warn, because the manufacturer should have warned surgeons about the risk of baseplate fracture before implantation
- C. Manufacturing defect — the metallurgical defect was specific to a particular manufacturing lot, making the affected baseplates different from the product as designed, and the manufacturer's recall acknowledging the lot-specific defect confirms a production-level problem rather than an inherent design flaw
- D. Breach of implied warranty, because the prosthesis failed to serve its intended purpose of providing stable knee joint function

32. An LNC is evaluating a medical malpractice case involving a 55-year-old patient who underwent a colonoscopy. During the procedure, the gastroenterologist removed several polyps, including a large sessile polyp in the ascending colon. The pathology report on the large polyp showed "adenocarcinoma with positive margins and lymphovascular invasion." The gastroenterologist informed the patient that "all the polyps were benign" and did not recommend surgical consultation. The patient was not evaluated further until a different physician reviewed the pathology results nine months later and immediately referred the patient for surgical consultation. By that time, the cancer had progressed to regional lymph node involvement. What is the most critical failure?

- A. The pathologist who interpreted the specimen should have personally contacted the gastroenterologist about the malignant findings
- B. The gastroenterologist either failed to review the pathology results or misrepresented them to the patient — a pathology report showing adenocarcinoma with positive margins and lymphovascular invasion demands immediate surgical referral, and the nine-month delay during which the patient was told the results were benign allowed the cancer to progress from what may have been a resectable local lesion to regional disease
- C. The patient should have independently requested a copy of the pathology report rather than relying on the physician's interpretation
- D. The facility's pathology results notification system should have automatically alerted the gastroenterologist about malignant findings

33. An LNC is analyzing a case involving the scope of an LNC's practice. An attorney asks the LNC to review a medical malpractice case and provide an opinion on whether the surgeon's intraoperative decisions constituted a deviation from the surgical standard of care. The LNC is a registered nurse with 15 years of operating room nursing experience and LNCC certification but does not have advanced practice credentials or surgical training. What is the most appropriate response?

- A. The LNC should evaluate the nursing aspects of the case (preoperative preparation, intraoperative nursing duties, postoperative monitoring) but should advise the attorney that opinions on the surgeon's intraoperative surgical decisions — a physician scope of practice issue — require a surgeon expert, as the LNC's OR nursing experience does not qualify her to opine on surgical technique or intraoperative decision-making
- B. The LNC's 15 years of OR experience qualifies her to opine on all aspects of the surgical procedure including surgical technique
- C. The LNC should decline the entire case because any case involving surgical care is outside the nursing scope of practice
- D. The LNC should provide the surgical standard of care opinion because LNCC certification qualifies LNCs to opine on all clinical matters

34. An LNC is reviewing a Medicare Set-Aside case involving a 68-year-old Medicare beneficiary settling a workers' compensation claim for a lumbar spine injury. The MSA includes projected costs for ongoing epidural steroid injections every four months. The defense argues the injections should be limited to three per year based on a general insurance utilization management guideline. The treating pain specialist has documented the clinical rationale for injections every four months based on the patient's documented pain response pattern — significant pain relief lasting approximately three months after each injection, with predictable pain recurrence at four months. What should the LNC evaluate?

- A. The defense argument should be accepted because insurance utilization guidelines represent the maximum frequency for epidural injections
- B. The LNC should recommend a compromise of injections every five months to split the difference between the opposing positions
- C. The injections should be excluded entirely from the MSA because they are interventional procedures rather than medical necessities
- D. The MSA should project the injection frequency based on the treating physician's documented clinical rationale and the patient's demonstrated response pattern — the injection frequency should be determined by clinical need rather than arbitrary utilization guidelines, and the physician's documentation of a predictable three-month pain relief duration with four-month recurrence provides the clinical basis for the projected interval

35. An LNC is analyzing a medical malpractice case involving a patient who was admitted to the hospital for pneumonia treatment and developed *Clostridium difficile* colitis during the hospitalization. The patient was prescribed a broad-spectrum fluoroquinolone antibiotic for the pneumonia. The patient had two significant risk factors for *C. difficile* infection: age over 65 and concurrent proton pump inhibitor use. Current antimicrobial stewardship guidelines recommend narrowing antibiotic therapy to

the most targeted agent effective against the identified organism, and fluoroquinolones are specifically identified as a high-risk antibiotic class for *C. difficile*. The sputum culture obtained on admission grew *Streptococcus pneumoniae* — an organism susceptible to narrow-spectrum agents (amoxicillin, narrow-spectrum cephalosporins). What should the LNC evaluate?

- A. Fluoroquinolones are the standard of care for community-acquired pneumonia and cannot be questioned as an antibiotic choice
- B. The patient's concurrent PPI use is the sole cause of the *C. difficile* infection and the antibiotic choice is irrelevant to the analysis
- C. Whether the continued use of a broad-spectrum fluoroquinolone — identified as high-risk for *C. difficile* — was clinically justified when the sputum culture identified an organism susceptible to narrower-spectrum agents, and whether antibiotic stewardship principles required de-escalation to a narrow-spectrum agent once culture results were available
- D. The hospital's infection control practices should be the primary focus rather than the antibiotic prescribing decision for pneumonia

36. An LNC is evaluating a personal injury case involving a 62-year-old retired professor who was struck by a vehicle while crossing the street. The plaintiff sustained a traumatic brain injury with bilateral frontal contusions. Following acute care and rehabilitation, the plaintiff has documented executive function deficits, impaired short-term memory, and reduced processing speed. The plaintiff was not employed at the time of the accident but was actively volunteering as a literacy tutor, writing a book, and serving on two nonprofit boards. The defense argues that because the plaintiff was retired, there are no economic damages. What should the LNC evaluate?

- A. The plaintiff's productive activities — volunteering, writing, and board service — represent real-world functional capabilities that have been impaired by the TBI, and the damages analysis should evaluate the non-economic impact of losing these activities (purpose, social engagement, intellectual stimulation, community contribution) as well as any economic component (book income, board stipends) and the cost of assistance needed for tasks the plaintiff previously performed independently
- B. The defense argument should be accepted because retired individuals cannot claim economic damages under any circumstances
- C. The plaintiff should attempt to resume all pre-injury activities before claiming permanent functional limitations from the TBI
- D. Only the plaintiff's book project has economic value and all other activities are non-compensable volunteer work

37. An LNC is reviewing a medical malpractice case involving a patient who underwent a thyroidectomy and developed a postoperative neck hematoma that rapidly expanded, causing airway compromise. The patient was on the surgical ward when the nurse noticed neck swelling and difficulty breathing. The surgeon was contacted but was not in the hospital and arrived 45 minutes later. During this time, the patient's airway was managed with jaw thrust and supplemental oxygen by the ward nurse, but no emergency airway intervention (intubation or cricothyrotomy) was performed. By the time the surgeon arrived, the patient was severely hypoxic and required emergency tracheostomy. The patient sustained a hypoxic brain injury. What systems failure should the LNC identify?

- A. The ward nurse should have performed an emergency cricothyrotomy without waiting for the surgeon to arrive at the hospital
- B. The hospital's post-thyroidectomy protocol should include immediate availability of a physician capable of performing emergency airway intervention — rapid neck hematoma with airway compromise is a recognized life-threatening complication of thyroidectomy that requires emergent airway management within minutes, and the 45-minute delay waiting for an off-site surgeon to arrive represents a failure to ensure appropriate emergency coverage for this foreseeable postoperative emergency
- C. The anesthesiologist on call should have been contacted to perform an emergency intubation before the surgeon arrived
- D. The patient should have been monitored in the ICU rather than the surgical ward after thyroidectomy to ensure closer observation

38. An LNC is analyzing a long-term care case in which a nursing home resident with documented osteoporosis, a history of three prior falls, and a high fall risk assessment score fell from her wheelchair while reaching for an item on a table. The wheelchair's wheel locks were not engaged at the time of the fall. The care plan specified "wheel locks engaged at all times when the wheelchair is stationary." The resident sustained a hip fracture requiring surgical repair. The CNA who positioned the resident stated she "forgot to lock the wheels because I was in a hurry." What should the LNC evaluate?

- A. The resident should have locked the wheels independently rather than relying on staff to secure the wheelchair before reaching
- B. The physician should have ordered a wheelchair with automatic locking mechanisms to eliminate the human factor in wheel locking
- C. The wheelchair manufacturer should be investigated for a design defect in the wheel lock mechanism making it difficult to engage
- D. Both the individual care failure (the CNA's failure to engage the wheel locks as specified in the care plan) and the institutional context (the CNA's statement about being "in a hurry" suggests staffing or

workload pressure that contributed to the shortcut) should be evaluated — the analysis should address both the direct cause and the systemic factors that enabled it

39. An LNC is evaluating a medical malpractice case involving a 42-year-old patient who was prescribed isotretinoin for severe cystic acne. The patient was a woman of childbearing age. The prescribing dermatologist did not enroll the patient in the iPLEDGE program, did not obtain a pregnancy test before starting the medication, did not document contraception counseling, and did not obtain monthly pregnancy tests during treatment as required by the FDA risk management program. The patient became pregnant during isotretinoin therapy. The pregnancy resulted in a live birth with craniofacial anomalies and cardiac defects consistent with isotretinoin embryopathy. What standard of care violations should the LNC identify?

- A. The pharmacist should have refused to dispense isotretinoin without documentation of iPLEDGE enrollment and pregnancy testing
- B. The patient should have independently researched isotretinoin's teratogenic risks before agreeing to take the medication
- C. The dermatologist violated multiple mandatory prescribing safeguards — no iPLEDGE enrollment, no baseline or monthly pregnancy testing, and no documented contraception counseling — all of which are FDA-mandated requirements designed specifically to prevent fetal exposure to a known teratogen, and these cumulative violations constitute clear deviations from the prescribing standard of care
- D. The baby's cardiac defects may be coincidental and unrelated to the isotretinoin exposure during the pregnancy period

40. An LNC is reviewing a risk management case involving a hospital where a patient experienced an adverse drug event from a look-alike, sound-alike (LASA) medication error. The nurse administered hydrALAZINE (an antihypertensive) instead of hydrOXYzine (an antihistamine/anxiolytic). The patient, who was prescribed hydroxyzine for preoperative anxiety, experienced a significant hypotensive episode from the hydralazine, requiring IV fluid resuscitation and vasopressor support. The hospital's medication management system does not use tall-man lettering to differentiate LASA medications, does not physically separate LASA pairs in the automated dispensing cabinet, and does not require independent double-check verification for LASA medications. What risk management analysis should the LNC apply?

- A. The hospital should implement a multi-layered LASA safety strategy — including tall-man lettering on labels and electronic screens, physical separation of LASA pairs in dispensing cabinets, independent double-check verification for high-risk LASA medications, and clinical decision support alerts —

because single interventions are insufficient to prevent LASA errors, and a layered approach addresses the risk at multiple points in the medication use process

B. The nurse who selected the wrong medication bears sole responsibility and no systems changes are warranted or necessary

C. The pharmaceutical manufacturer should be required to change the drug name to prevent future LASA confusion errors

D. The automated dispensing cabinet vendor should be solely liable for not incorporating LASA safeguards into the system design

41. An LNC is evaluating a medical malpractice case involving a 50-year-old patient who underwent a screening colonoscopy. A 3 cm sessile polyp was found in the cecum. The gastroenterologist attempted endoscopic removal using a hot snare polypectomy technique. During the removal, the patient developed a perforation at the polypectomy site. The perforation was recognized intraoperatively by the gastroenterologist, who attempted endoscopic closure with clips. The clip closure failed, and the patient required emergent surgical repair. The LNC reviews the medical literature and finds that the 3 cm size and sessile morphology of this polyp placed it in a higher-risk category for endoscopic removal, and current guidelines recommend that these complex polyps be referred to endoscopists with advanced polypectomy training or considered for surgical resection. What should the LNC evaluate?

A. The perforation is a recognized complication of polypectomy and the gastroenterologist cannot be held liable for its occurrence

B. Whether the gastroenterologist's decision to attempt endoscopic removal of a complex polyp (3 cm, sessile, cecal location) — rather than referring to an advanced endoscopist or recommending surgical resection — was within the standard of care given the polyp's risk characteristics and the physician's training and experience level

C. The endoscopic clip closure was the standard of care for managing perforations and the failure of the clips was unforeseeable

D. The patient should have been informed about the specific perforation risk for this polyp type before consenting to the removal

42. An LNC is reviewing a regulatory compliance case involving a hospital that performed elective surgical procedures on patients who tested positive for MRSA colonization on preoperative screening. The hospital's surgical site infection prevention protocol requires that MRSA-colonized patients undergo a five-day preoperative decolonization regimen (intranasal mupirocin and chlorhexidine body washes) before elective surgery. A compliance audit reveals that the decolonization protocol was completed in only 40% of MRSA-positive patients before their scheduled procedures — the remaining 60% underwent surgery without completing the decolonization regimen. The hospital's SSI rate among

MRSA-colonized patients is four times higher than among non-colonized patients. What should the LNC conclude?

- A. The 40% compliance rate with the decolonization protocol is within the acceptable range for infection prevention programs
- B. MRSA colonization does not increase surgical site infection risk and the decolonization protocol is unnecessary in all cases
- C. The individual surgeons who operated on non-decolonized patients bear sole responsibility for the elevated infection rate
- D. The 60% non-compliance rate with the hospital's own decolonization protocol represents a systems-level failure in preoperative infection prevention — the protocol was established because MRSA colonization increases SSI risk (confirmed by the fourfold rate differential), and the failure to ensure compliance allowed preventable infections to occur in patients who were identified as high-risk but not treated accordingly

43. An LNC is analyzing a medical malpractice case involving a patient who presented to the emergency department with a fish bone lodged in the throat. The emergency physician performed a visual examination of the oropharynx, did not visualize a foreign body, and discharged the patient with reassurance that the sensation was likely from a mucosal scratch. The physician did not perform lateral neck X-ray or CT scan. The patient returned four days later with neck swelling, fever, and dysphagia. A CT scan revealed a retropharyngeal abscess caused by the embedded fish bone that had perforated the esophagus. The patient required emergency surgical drainage and IV antibiotics. What should the LNC evaluate?

- A. Whether the emergency physician's evaluation was adequate — fish bones are radiolucent on plain X-ray, and when a foreign body is suspected but not visualized on direct examination, CT scan is the recommended imaging modality for detection, and the failure to obtain appropriate imaging when the patient reported a lodged fish bone may represent a deviation from the diagnostic standard of care
- B. The patient should have returned sooner when the throat discomfort did not resolve within 24 hours of the initial visit
- C. The otolaryngologist on call should have been consulted to perform a fiberoptic laryngoscopy during the initial visit
- D. Fish bone ingestion rarely causes serious complications and the emergency physician's discharge decision was appropriate

44. An LNC is evaluating a workers' compensation case involving a 48-year-old hospital pharmacist who developed chronic migraine headaches and photophobia after prolonged daily exposure to fluorescent lighting in the pharmacy compounding area. The pharmacist works in a windowless room under continuous fluorescent lighting for 10-hour shifts. The employee's pre-employment records show no history of migraines. An occupational medicine physician has documented the temporal relationship between the fluorescent light exposure and the migraine onset, noting that symptoms improve on days off and worsen on work days. The employer argues that migraines are a common medical condition unrelated to workplace conditions. What should the LNC evaluate?

- A. The IME physician's conclusion should be accepted because migraines are a common condition in the general population
- B. The pharmacist's caffeine consumption and sleep habits should be investigated as the primary migraine triggers instead
- C. Whether the documented temporal pattern (symptom improvement on days off, worsening on work days) combined with the pre-employment absence of migraine history and the occupational medicine physician's clinical assessment support an occupational contribution to the migraine condition — fluorescent lighting is a recognized migraine trigger, and the work-relatedness pattern provides clinical evidence of occupational causation
- D. The pharmacist should be required to try anti-migraine medication before the claim can be considered for compensability

45. An LNC is reviewing a medical malpractice case involving a 70-year-old patient who underwent an elective inguinal hernia repair under spinal anesthesia. During the spinal needle insertion, the patient reported a sharp, electric shock-like pain shooting down the right leg. The anesthesiologist continued the injection despite this symptom. Postoperatively, the patient developed persistent right leg weakness and numbness in the L4 dermatome. An EMG/NCV performed six weeks later confirmed an L4 nerve root injury. The standard of care requires that when a patient reports paresthesias or radicular symptoms during spinal needle placement, the needle must be withdrawn and repositioned before injection. What is the standard of care violation?

- A. Spinal anesthesia should not be used for patients over age 65 due to the increased risk of neurological complications
- B. The anesthesiologist's decision to continue the injection despite the patient's report of radicular symptoms — which indicate nerve root contact — deviated from the standard of care requiring needle withdrawal and repositioning before injection when paresthesias occur
- C. The EMG/NCV testing was performed too late to accurately document the nerve injury and earlier testing should have been ordered

D. The surgeon should have elected general anesthesia rather than spinal anesthesia for an inguinal hernia repair in this patient

46. An LNC is analyzing a toxic tort case involving workers at a chromium electroplating facility who were exposed to hexavalent chromium (Cr(VI)) through inhalation during plating operations over periods ranging from 5 to 20 years. Several workers have been diagnosed with nasal septum perforation and one worker has developed sinonasal carcinoma. Hexavalent chromium is classified by IARC as a Group 1 carcinogen with established carcinogenicity for respiratory tract cancers. The workers' exposure monitoring data shows Cr(VI) levels consistently exceeding the OSHA permissible exposure limit during their employment. The defense argues the worker with sinonasal carcinoma was a former smoker and the cancer should be attributed to tobacco use. What should the LNC evaluate?

A. The worker's smoking history eliminates hexavalent chromium as a contributing cause of the sinonasal carcinoma entirely

B. The IARC Group 1 classification automatically establishes specific causation for the individual worker with sinonasal cancer

C. The worker should undergo nasal biopsy to distinguish between chromium-related and smoking-related sinonasal carcinoma

D. Both hexavalent chromium and tobacco are established respiratory carcinogens — smoking is primarily associated with lung cancer rather than sinonasal cancer, while hexavalent chromium has a specific and well-documented association with sinonasal carcinomas, and the documented chronic Cr(VI) exposure above the PEL combined with the specific tumor location (sinonasal rather than pulmonary) supports occupational rather than smoking-related etiology

47. An LNC is reviewing a medical malpractice case involving a patient who developed a catheter-related bloodstream infection (CRBSI) from a peripherally inserted central catheter (PICC line). The PICC line was placed for home IV antibiotic therapy. The home health nurse responsible for PICC line maintenance performed weekly dressing changes but did not document assessment of the insertion site for signs of infection, did not document measurement of the external catheter length at each visit (to detect catheter migration), and did not document flushing the line with heparin or saline per the maintenance protocol. The patient developed CRBSI requiring hospitalization, line removal, and treatment for MRSA bacteremia. What nursing standard of care violations should the LNC identify?

A. The home health nurse's failure to document site assessment for infection signs, catheter length measurement to detect migration, and line flushing per protocol constitutes multiple deviations from the PICC line maintenance standard of care — each omission represents a separate monitoring failure, and

the cumulative effect of absent monitoring is that the developing infection was not detected early when less invasive intervention would have sufficed

B. The physician who ordered home IV therapy should have ordered oral antibiotics instead to avoid central line complications

C. The patient should have independently inspected the PICC site daily and reported any signs of redness or drainage to the nurse

D. The home health agency bears sole liability because the individual nurse was following the agency's standard procedures

48. An LNC is analyzing a Medicare Set-Aside case involving a 73-year-old Medicare beneficiary settling a workers' compensation claim for bilateral shoulder injuries. The claimant has undergone bilateral total shoulder replacements. The treating orthopedist has documented that each prosthesis will likely require revision in 12–15 years based on published prosthetic longevity data. The claimant's rated life expectancy is 11 years. Should revision shoulder replacement surgeries be included in the MSA?

A. Both revision surgeries should be included at full cost because the orthopedist documented the clinical need for future revisions

B. Both revisions should be included but at a discounted rate reflecting the probability that only one revision may be needed

C. The revision surgeries should be excluded from the MSA because the projected timeline for revision (12–15 years) exceeds the claimant's rated life expectancy (11 years) — the MSA should include only expenses reasonably expected to occur within the claimant's projected remaining lifetime

D. Only one revision should be included because the claimant may die before the second shoulder requires revision surgery

49. An LNC is evaluating a personal injury case involving a 37-year-old woman who sustained a brachial plexus injury during a motor vehicle accident. The injury affected the C8-T1 nerve roots (lower trunk), resulting in weakness of hand intrinsic muscles, loss of fine motor dexterity, and sensory loss in the ulnar nerve distribution. The plaintiff was a surgeon who performed minimally invasive procedures requiring precise hand movements under magnification. Despite nerve repair surgery and two years of rehabilitation, the plaintiff has residual hand weakness and absent fine touch sensation that prevent her from operating. The defense argues the plaintiff can practice medicine in a non-surgical capacity. What is the most important damages consideration?

A. The plaintiff's surgical malpractice insurance premiums should be credited against the damages calculation as a cost savings

B. The permanent loss of the specific fine motor and sensory functions required for surgical practice constitutes a unique vocational loss — transitioning to a non-surgical medical role involves significant income reduction, loss of surgical subspecialty identity, and loss of the specific professional skills that represent years of specialized training

C. The plaintiff should attempt to operate using adaptive instruments before claiming permanent inability to perform surgery

D. The plaintiff's surgical subspecialty income should be compared to primary care income to calculate the precise earnings differential

50. An LNC is reviewing a medical malpractice case involving a patient who underwent a robotic-assisted laparoscopic hysterectomy. During the procedure, the surgeon lacerated the left ureter. The injury was not recognized intraoperatively. The patient presented three days later with left flank pain, fever, and rising creatinine. A CT scan revealed a left urinoma from the ureteral injury. The patient required ureteral stent placement and eventually ureteral reimplantation surgery. The standard of care for laparoscopic and robotic hysterectomy includes maintaining awareness of ureteral anatomy, using retroperitoneal dissection techniques that protect the ureter, and verifying ureteral integrity before completing the procedure (through direct visualization, indigo carmine dye, or cystoscopy). What two standard of care issues should the LNC evaluate?

A. Only the ureteral laceration itself constitutes the malpractice claim because all consequences flow from that single technical error

B. The patient should have elected an open hysterectomy approach rather than the robotic-assisted laparoscopic technique

C. The ureteral injury is a recognized complication of hysterectomy and the surgeon cannot be held liable for a known surgical risk

D. First, whether the surgical technique used to protect the ureter met the standard of care (did the surgeon identify and protect the ureter during dissection), and second, whether the failure to verify ureteral integrity before completing the procedure (using visualization, dye, or cystoscopy) represents a separate standard of care failure — each issue is independently analyzable

51. An LNC is analyzing a case involving the professional obligations of an LNC who has been asked to provide a case screening opinion. The attorney provides medical records and asks the LNC whether the case has merit. After thorough review, the LNC concludes that the medical care met the standard of care and there is no deviation. The attorney is disappointed and asks the LNC to "look again more carefully" and "find something the doctors did wrong." What is the LNC's professional obligation?

- A. The LNC must maintain the original opinion — the ethical obligation to objectivity requires honest assessment regardless of the retaining party's preference, and the LNC should explain that the analysis was thorough and that the findings cannot be changed to accommodate the attorney's desired outcome
- B. The LNC should review the records again to satisfy the attorney's request, as a second look may reveal previously missed issues
- C. The LNC should modify the analysis to identify a potential deviation to maintain the professional relationship with the attorney
- D. The LNC should withdraw from the engagement without providing any opinion to avoid conflict with the retaining attorney

52. An LNC is reviewing a long-term care case involving a 78-year-old nursing home resident with type 2 diabetes who developed a diabetic foot ulcer on the right great toe. The wound care documentation shows the wound was identified on Day 1 as a "superficial blister" measuring 0.5 cm. On Day 8, the wound was documented as "1.5 cm open area with necrotic base." On Day 15, the wound was documented as "2.5 cm ulcer with exposed tendon." On Day 22, the wound culture grew MRSA and the resident was diagnosed with osteomyelitis. The attending physician was not notified about the wound until Day 15. What cascade of failures does this timeline reveal?

- A. The resident's diabetes made the wound progression inevitable regardless of any nursing interventions provided
- B. The attending physician should have ordered prophylactic antibiotics at the time of the resident's admission to prevent infection
- C. The wound progression from superficial blister to osteomyelitis over 22 days demonstrates sequential failures — delayed physician notification (15 days before the physician was informed of the wound), apparent absence of wound treatment escalation as the wound deteriorated, and no wound care specialist or podiatrist referral despite a clearly worsening trajectory in a high-risk diabetic patient
- D. The wound care nurse should have independently ordered debridement without waiting for a physician order or assessment

53. An LNC is analyzing a medical malpractice case involving a 38-year-old man who presented to the emergency department with acute onset of severe testicular pain, nausea, and vomiting. The emergency physician documented a "high-riding right testicle with absent cremasteric reflex" on physical examination. Despite these classic findings of testicular torsion, the physician ordered a testicular ultrasound rather than immediately consulting urology for emergent surgical exploration. The ultrasound was not performed for three hours due to the sonographer's unavailability. The ultrasound ultimately showed absent blood flow to the right testicle. By the time the patient was taken to the operating room

— six hours after symptom onset — the testicle was non-viable and required orchiectomy. What should the LNC identify?

A. The ultrasound was the appropriate diagnostic test and the delay was caused by radiology staffing rather than physician decision-making

B. When clinical findings are classic for testicular torsion (high-riding testicle, absent cremasteric reflex), the standard of care requires immediate urological consultation for emergent surgical exploration — ordering ultrasound confirmation when the diagnosis is clinically evident introduces a diagnostic delay that wastes the narrow salvage window, and the three-hour ultrasound delay contributed to the loss of the testicle

C. The sonographer's unavailability is the sole cause of the delay and the emergency physician's decision to order ultrasound was correct

D. The patient should have presented to the emergency department sooner to allow more time for diagnostic workup before surgery

54. An LNC is evaluating a healthcare fraud case involving a home health agency that provides physical therapy services to Medicare beneficiaries. A Medicare audit reveals that 50% of the patients receiving physical therapy do not have documented functional goals in their treatment plans, therapy progress notes use identical template language for patients with vastly different conditions, and the agency bills for 60-minute therapy sessions but the therapists' daily schedules show they are scheduled for 20 patients per 8-hour shift — allowing only 24 minutes per patient including travel and documentation time. What should the LNC conclude?

A. The absence of individualized functional goals is a minor documentation deficiency that does not indicate fraudulent billing

B. The template-based documentation may reflect efficient charting practices and does not indicate inadequate clinical care

C. The therapists may be working extended hours to accommodate all 20 patients within their daily schedules as assigned

D. The scheduling data demonstrating that 60-minute sessions could not have been consistently provided, combined with the absent functional goals and template documentation, suggests a pattern of billing for therapy services that were either shorter than billed or not individualized as required — this implicates the False Claims Act for submission of claims that misrepresent the services actually provided

55. An LNC is reviewing a medical malpractice case involving a patient who underwent a cervical laminectomy and developed a postoperative wound infection. The patient had a hemoglobin A1c of 10.1% (poorly controlled diabetes) documented in the preoperative records. The surgeon did not delay the elective procedure to optimize glycemic control and did not implement any diabetes-specific perioperative management. Published spine surgery guidelines recommend achieving an A1c below 8% before elective spinal procedures to reduce infection risk. What should the LNC evaluate?

- A. Whether the surgeon's decision to proceed with elective cervical spine surgery without optimizing glycemic control — when published guidelines recommend delaying elective procedures until A1c is below 8% — deviated from the preoperative standard of care, and whether glycemic optimization would have reduced the foreseeable surgical site infection risk in this patient with documented poorly controlled diabetes
- B. The patient bears sole responsibility for the surgical site infection because the patient failed to control the diabetes independently
- C. The endocrinologist who manages the patient's diabetes should be named as a co-defendant for failing to achieve A1c control
- D. The surgical site infection was caused by intraoperative contamination rather than the patient's elevated glucose levels

56. An LNC is analyzing a personal injury case involving a 55-year-old woman who sustained a closed head injury in a slip-and-fall at a grocery store. The plaintiff has documented executive function deficits, impaired short-term memory, and reduced processing speed on neuropsychological testing. The defense retained a neuropsychologist who administered performance validity testing and reported that the plaintiff demonstrated "suboptimal effort" on several validity measures. The defense argues this proves the plaintiff is malingering. What should the LNC evaluate regarding the validity testing results?

- A. The suboptimal effort findings automatically prove the plaintiff is fabricating all cognitive complaints and the claims should be dismissed
- B. The defense neuropsychologist's report should be automatically accepted because independent examiners are more objective
- C. Suboptimal effort on validity testing means the cognitive test scores cannot be reliably interpreted as reflecting actual functioning, but does not automatically prove malingering — suboptimal effort can result from pain, fatigue, medication effects, depression, anxiety, or genuine cognitive impairment affecting test engagement, and the LNC should evaluate whether alternative explanations for the suboptimal effort were considered before the malingering conclusion was reached
- D. Performance validity testing is unreliable and should never be used to evaluate the credibility of neuropsychological testing results

57. An LNC is evaluating a risk management case involving a hospital that has experienced four patient elopement events in the past six months — all involving patients with documented psychiatric disorders who left the facility against medical advice before being evaluated for safety. In two of the four cases, the patients were subsequently harmed (one was struck by a vehicle, one attempted suicide). The hospital's current policy for psychiatric patients states "monitor closely" but does not define monitoring frequency, does not specify elopement precautions, and does not include an elopement risk assessment tool. What risk management analysis should the LNC perform?

- A. The individual nurses who were monitoring the patients at the time of elopement should be disciplined for inadequate monitoring
- B. The patients who left against medical advice assumed the risk of their subsequent harm by choosing to leave the facility
- C. The psychiatric diagnoses do not create a special duty of care and the hospital cannot prevent patients from leaving voluntarily
- D. The hospital's psychiatric patient management policy is inadequate — "monitor closely" without defined monitoring frequency, elopement precautions, or a standardized elopement risk assessment tool provides insufficient guidance for staff to prevent elopements in a population at known risk, and the four events in six months indicate a systemic policy deficiency rather than isolated individual failures

58. An LNC is reviewing a medical malpractice case involving a 65-year-old patient who underwent a total knee replacement and developed a periprosthetic joint infection (PJI) with methicillin-resistant *Staphylococcus aureus*. The patient had a documented preoperative MRSA nasal colonization that was identified on preoperative screening. The hospital's surgical site infection prevention protocol requires MRSA decolonization (intranasal mupirocin and chlorhexidine washes for five days) before elective joint replacement surgery. The patient underwent surgery without completing the decolonization protocol. What standard of care deviation should the LNC identify?

- A. MRSA nasal colonization is a normal finding and does not require any preoperative intervention before joint replacement surgery
- B. The hospital's failure to implement its own preoperative MRSA decolonization protocol — for a patient identified as MRSA-colonized through the hospital's own screening program — represents a failure to follow its established infection prevention standard, and the resulting MRSA PJI is a foreseeable consequence of operating on a colonized patient without decolonization
- C. The patient should have independently completed the decolonization regimen without relying on the hospital to initiate the protocol
- D. The orthopedic surgeon bears sole responsibility for ensuring that all preoperative protocols are completed before the procedure

59. An LNC is analyzing a life care plan for a 28-year-old man who sustained a complete C5 spinal cord injury in a diving accident. The plaintiff is ventilator-independent but has upper extremity weakness with preserved wrist extension but absent hand intrinsic (finger flexion/extension). The defense argues the plaintiff has "significant upper extremity function" and should require minimal attendant care. What clinical reality should the LNC evaluate?

A. While C5 SCI preserves some upper extremity function (shoulder, elbow), the absence of hand intrinsic function means the plaintiff cannot independently perform tasks requiring fine motor dexterity, pinch grip, or grasp release — including most self-care activities, food preparation, medication management, and household tasks — and published guidelines for C5 complete SCI recommend 10–16 hours of attendant care daily depending on the individual's functional abilities and living situation

B. The defense argument should be accepted because C5 patients retain significant arm function sufficient for most daily activities

C. The plaintiff should be placed in a residential care facility rather than receiving attendant care at home for cost reduction

D. Only the physical therapy assessment of the plaintiff's current function should determine the attendant care projection

60. An LNC is reviewing a medical malpractice case involving a patient who developed a spinal cord infarction following an aortic aneurysm repair. The surgery involved clamping the aorta for repair, which temporarily interrupted blood flow to the spinal cord through the artery of Adamkiewicz. The standard of care for aortic surgery with anticipated prolonged aortic cross-clamping includes consideration of spinal cord perfusion protection strategies — cerebrospinal fluid drainage, motor evoked potential monitoring, and staged repair techniques. The operative record does not document that any spinal cord protection strategy was employed. The patient developed paraplegia. What should the LNC evaluate?

A. Spinal cord infarction is an inevitable complication of aortic surgery that cannot be prevented through any protective strategy

B. The patient should have been informed about the specific risk of paraplegia and given the option to decline the aortic repair

C. Whether the surgeon employed any of the available spinal cord protection strategies during the aortic surgery — the failure to document the use of CSF drainage, neuromonitoring, or staged repair in a procedure with anticipated prolonged aortic clamping may represent a deviation from the current standard of care for spinal cord perfusion protection during aortic surgery

D. The anesthesiologist is solely responsible for implementing spinal cord protection strategies during aortic surgical procedures

61. An LNC is evaluating a long-term care case in which a nursing home resident with documented severe dysphagia on a pureed diet with honey-thick liquids choked on a regular-texture meal and died. The investigation reveals the resident's diet order was correctly entered in the electronic health record. However, the dietary department uses a separate, non-integrated meal preparation system, and the correct diet order was never transmitted to the kitchen. The resident had been receiving the wrong diet for three weeks before the fatal choking event. Multiple nursing aides served the incorrect diet during this period without questioning the consistency. What systems failures should the LNC identify?

- A. The individual nursing aides who served the incorrect diet bear sole responsibility for not checking the diet orders before meals
- B. The attending physician should have entered the diet order in both the clinical and dietary systems simultaneously to prevent gaps
- C. The speech-language pathologist should have personally monitored all meals for residents with documented dysphagia orders
- D. The non-integrated clinical and dietary systems created a communication gap that allowed a three-week diet order discrepancy to persist, and the absence of a reconciliation process between the two systems, combined with the nursing aides' failure to verify diet consistency against the care plan, demonstrate multiple systems-level failures that collectively produced the fatal choking event

62. An LNC is reviewing a personal injury case involving a 48-year-old man who sustained bilateral calcaneal fractures after falling from a second-story balcony that collapsed at a vacation rental property. Despite surgical fixation of both heels, the plaintiff has residual bilateral chronic heel pain, limited ankle dorsiflexion, and an altered gait pattern. He was a letter carrier for the U.S. Postal Service, walking an average of 12 miles per day on his mail route. The defense argues the plaintiff can perform a desk-based postal service role. What should the LNC evaluate?

- A. The plaintiff's postal service seniority should determine whether a desk assignment is available within the organization
- B. The clinical documentation of residual bilateral heel impairments — chronic pain with weight-bearing, limited dorsiflexion affecting gait mechanics, and reduced tolerance for prolonged standing and walking — and their specific impact on the physical demands of letter carrier work (12 miles of daily walking, stair climbing, standing at mail boxes) should determine whether the plaintiff can perform his pre-injury occupation, and whether the proposed desk role is actually compatible with his functional limitations and available within the organization
- C. The plaintiff should undergo bilateral ankle fusion to improve his walking tolerance before claiming permanent disability

D. The plaintiff's age of 48 indicates he could retrain for a new career with sufficient time to reach comparable earning potential

63. An LNC is analyzing a medical malpractice case involving a patient who was prescribed lithium for bipolar disorder. The physician ordered baseline renal function testing before initiating lithium therapy but did not order follow-up renal function monitoring during the next 18 months of lithium treatment. The patient's baseline creatinine was 0.9 mg/dL (normal). At 18 months, the patient presented to the emergency department with tremor, confusion, and ataxia — symptoms of lithium toxicity. The serum lithium level was 2.8 mEq/L (toxic; therapeutic range 0.6–1.2 mEq/L). The creatinine had risen to 3.2 mg/dL, indicating significant renal impairment that reduced lithium clearance and caused drug accumulation. Published lithium prescribing guidelines require monitoring of renal function at least every six months. What should the LNC identify?

A. The failure to monitor renal function during 18 months of lithium therapy — when guidelines require monitoring at least every six months — allowed progressive renal impairment to develop undetected, resulting in reduced lithium clearance and toxic drug accumulation that was entirely preventable through routine monitoring

B. The patient should have independently requested renal function testing during the 18-month treatment period with lithium

C. The emergency department physician who treated the toxicity should have identified the underlying renal impairment sooner

D. The lithium manufacturer should have included a more prominent warning about the need for renal monitoring on the drug label

64. An LNC is evaluating a healthcare fraud case involving a chain of walk-in clinics. An audit reveals that every patient visit — regardless of the presenting complaint — includes the same battery of tests: a comprehensive metabolic panel, complete blood count, urinalysis, and a rapid influenza test. The medical records contain no individualized clinical rationale for the testing; instead, all records contain a template statement reading "comprehensive screening panel performed per clinic protocol." Patients presenting with complaints such as ankle sprains, insect bites, and medication refills all received the identical testing panel. What should the LNC conclude?

A. The comprehensive testing panel demonstrates a thorough approach to patient care that exceeds the minimum standard

B. The rapid influenza test is the only questionable component because it should only be performed during influenza season

C. The uniform ordering of the same testing panel for all patients regardless of clinical indication — without documented medical necessity — is consistent with a pattern of ordering medically unnecessary services driven by revenue generation rather than individualized patient care, implicating the False Claims Act

D. The clinic protocol authorizing the comprehensive panel provides legal justification for the testing regardless of indication

65. An LNC is reviewing a medical malpractice case involving a patient who underwent a coronary artery bypass grafting (CABG) procedure. The patient's preoperative records documented a known left internal mammary artery (LIMA) stenosis from a prior subclavian artery stent. Despite this documented finding, the surgeon used the LIMA as a bypass conduit. Postoperatively, the patient developed myocardial ischemia in the LIMA-grafted territory due to inadequate flow through the stenotic artery. The patient required emergency re-operation with a different conduit. The standard of care requires evaluation of LIMA inflow before using it as a bypass conduit, and a known proximal stenosis is a relative contraindication to LIMA use. What should the LNC evaluate?

A. The LIMA is always the preferred conduit for CABG and should be used regardless of any proximal arterial stenosis

B. The patient should have informed the surgeon about the prior subclavian stent before consenting to the CABG procedure

C. The bypass graft failure was caused by the subclavian stent rather than the surgeon's conduit selection decision

D. Whether the surgeon's decision to use the LIMA as a bypass conduit despite the documented proximal subclavian stenosis — which is a known relative contraindication to LIMA use — deviated from the standard of care, and whether preoperative evaluation of LIMA inflow (angiography, duplex ultrasound) would have identified the inadequate flow before the conduit was used

66. An LNC is evaluating a workers' compensation case involving a 43-year-old registered nurse who developed occupational asthma from repeated exposure to aerosolized glutaraldehyde during high-level disinfection of endoscopic equipment. The nurse's pre-employment pulmonary function tests were normal. Serial PFTs over the two-year exposure period show progressive decline in FEV1. A specific inhalation challenge test with glutaraldehyde was positive. The nurse has been removed from exposure but continues to have persistent asthma symptoms requiring daily inhaler use and periodic oral corticosteroid bursts. The insurer argues the nurse should have fully recovered after removal from exposure. What should the LNC evaluate?

A. The insurer's argument should be accepted because removal from the sensitizing agent should result in complete resolution

B. Whether the published literature supports persistent asthma symptoms after glutaraldehyde sensitization — occupational asthma from sensitizing agents frequently persists after exposure cessation, often for years or permanently, because the immunological sensitization does not necessarily resolve when the exposure stops, and the ongoing treatment is medically necessary for a condition that may not fully remit

C. The nurse should return to the same position with a respirator rather than claiming ongoing pulmonary disability

D. The nurse's recreational exercise habits should be evaluated as an alternative cause of the persistent asthma symptoms

67. An LNC is analyzing a medical malpractice case involving a 55-year-old patient who developed acute limb ischemia following a cardiac catheterization performed via the left femoral artery. Immediately after the procedure, the patient complained of left foot numbness, coolness, and progressive pain. The nurse documented these findings and notified the cardiologist. The cardiologist attributed the symptoms to "post-procedure vasospasm" and ordered "warm blankets and observation." Over the next four hours, the patient's left foot became pale, pulseless, and painful. An emergent vascular surgery consultation was obtained, and an iliofemoral thrombectomy was performed. Despite successful revascularization, the patient sustained permanent foot weakness from ischemic nerve injury. What clinical principle should the LNC apply?

A. The cardiologist's assessment must be evaluated against the "six P's" of acute limb ischemia — pain, pallor, pulselessness, paresthesias, paralysis, and poikilothermia — which the patient's symptoms progressively demonstrated, and the four-hour delay in obtaining vascular consultation while attributing ischemic symptoms to "vasospasm" represents a diagnostic failure that allowed reversible ischemia to progress to permanent nerve injury

B. Post-procedure vasospasm is a common cause of extremity symptoms after femoral catheterization and observation is appropriate

C. The nurse should have independently consulted the vascular surgeon without waiting for the cardiologist's authorization

D. The patient should have demanded immediate vascular evaluation rather than accepting the cardiologist's vasospasm diagnosis

68. An LNC is reviewing a risk management case involving a hospital where a patient received an MRI examination despite having an MRI-incompatible cardiac pacemaker. The patient developed device malfunction and cardiac arrhythmia during the scan, requiring emergency cardioversion and pacemaker

replacement. The hospital's MRI safety protocol requires screening all patients for implanted devices before entering the MRI suite. Investigation reveals the MRI technologist asked the patient about implants, but the patient (who had cognitive impairment from dementia) incorrectly denied having any implants. The patient's medical record — which was available in the electronic health record — clearly documented the pacemaker. The MRI technologist did not review the patient's medical record before the scan. What should the LNC evaluate?

- A. The patient is responsible for the complication because the patient denied having any implanted devices when directly asked
- B. The patient's cognitive impairment makes verbal screening unreliable and should not have been relied upon as the sole method
- C. Relying solely on a cognitively impaired patient's verbal denial of implants — without independently verifying the implant history through the medical record that was available in the EHR — represents a failure in the MRI safety screening process, and the hospital's protocol should include mandatory medical record review in addition to patient screening for all patients, particularly those with known cognitive impairment
- D. The MRI machine manufacturer should have designed the scanner to automatically detect metallic implants before starting

69. An LNC is analyzing a Medicare Set-Aside case involving a 67-year-old Medicare beneficiary settling a workers' compensation claim for a cervical spine injury. The MSA includes projected costs for cervical epidural steroid injections every four months. The claimant's treating pain specialist has documented that the injections provide approximately three months of pain relief with predictable recurrence at four months. The defense argues the injections should be limited to three per year based on a general utilization guideline. What is the most appropriate analysis?

- A. The defense argument should be accepted because three injections per year is the standard insurance utilization limit
- B. The MSA should project the injection frequency at three per year to match the general utilization guideline cited by the defense
- C. The injections should be excluded from the MSA entirely because they are interventional procedures not covered by Medicare
- D. The MSA should project the injection frequency based on the treating physician's documented clinical rationale — a predictable three-month relief duration with four-month recurrence provides the clinical basis for injections every four months, and the MSA should use this clinically documented frequency rather than an arbitrary utilization guideline

70. An LNC is reviewing a medical malpractice case involving a patient who underwent a laparoscopic appendectomy. The operative report documents that the surgeon used monopolar electrocautery near the base of the appendix and "noted a thermal injury to the cecal wall." The surgeon repaired the thermal injury with sutures intraoperatively. On postoperative day three, the patient developed signs of peritonitis, and a CT scan revealed a cecal perforation at the repair site. The patient required emergency exploratory laparotomy with right hemicolectomy and temporary ileostomy. What should the LNC evaluate?

A. Thermal bowel injury during laparoscopic surgery is a recognized complication that cannot constitute the basis of a malpractice claim

B. Whether the intraoperative thermal injury to the cecal wall resulted from a deviation in electrocautery technique (inappropriate instrument settings, excessive tissue contact duration, or inadequate distance from non-target structures), and whether the intraoperative repair was adequate — the subsequent perforation at the repair site suggests the repair may have been insufficient to address the full extent of the thermal damage

C. The monopolar electrocautery device manufacturer should be held liable for producing a device capable of causing thermal injury

D. The patient should have elected open appendectomy rather than the laparoscopic approach to reduce the thermal injury risk

71. An LNC is evaluating a personal injury case involving a 60-year-old retired teacher who was struck by a car while crossing the street. The plaintiff sustained a traumatic brain injury with a right frontotemporal contusion. Following acute care and rehabilitation, the plaintiff has documented impairments in word-finding, verbal fluency, and reading comprehension. The plaintiff was an active member of a book club, volunteered at a library literacy program, and was writing memoirs. The defense argues the cognitive deficits are mild and do not significantly impact the plaintiff's quality of life because she is retired. What should the LNC evaluate?

A. The documented language-based cognitive deficits — impaired word-finding, reduced verbal fluency, and diminished reading comprehension — directly impact the specific activities that defined the plaintiff's post-retirement quality of life (book club participation, literacy tutoring, memoir writing), and these losses constitute significant non-economic damages regardless of the plaintiff's employment status because they affect the intellectual and social activities central to the plaintiff's daily functioning and personal fulfillment

B. The defense argument should be accepted because retired individuals' cognitive deficits have minimal practical impact

C. The plaintiff should undergo additional speech therapy before claiming permanent language deficits from the traumatic brain injury

D. Only the memoir-writing loss has compensable value because it represents a potential income-generating activity for the plaintiff

72. An LNC is analyzing a medical malpractice case involving a patient who underwent a total thyroidectomy. Postoperatively, the patient developed signs of hypocalcemia — perioral tingling, Chvostek's sign (facial twitching with cheek tapping), and carpopedal spasm. These symptoms appeared at 8:00 PM. The nurse documented the findings but did not obtain a serum calcium level or notify the physician until 6:00 AM the following morning — a 10-hour delay. By that time, the patient's serum calcium was critically low at 5.8 mg/dL (normal 8.5–10.5 mg/dL), and the patient had developed a seizure from severe hypocalcemia. What nursing standard of care failure should the LNC identify?

A. The surgeon should have ordered prophylactic calcium supplementation before the symptoms developed in the patient

B. The patient should have reported the tingling symptoms more urgently to the nursing staff rather than waiting for the assessment

C. Perioral tingling, Chvostek's sign, and carpopedal spasm in a post-thyroidectomy patient are classic signs of hypocalcemia — the nurse's failure to obtain a stat serum calcium level and notify the physician immediately upon recognizing these findings represents a critical assessment and communication failure that allowed a treatable electrolyte emergency to progress to a seizure over a 10-hour unmonitored period

D. The endocrinology service should have been automatically consulted for all post-thyroidectomy patients to manage calcium levels

73. An LNC is reviewing a product liability case involving a defective hip prosthesis with a ceramic-on-ceramic bearing surface. The plaintiff's ceramic femoral head component fractured in vivo, producing ceramic fragments that caused severe third-body wear damage to the acetabular component and surrounding soft tissues. The manufacturer's post-market surveillance data shows a ceramic head fracture rate of 0.8% at five years for this specific product — higher than the industry benchmark of less than 0.02%. The plaintiff required a complex revision surgery to remove the fractured ceramic and all embedded fragments, replace both components, and repair the damaged soft tissues. What product liability issue is most significant?

A. Ceramic fracture is a recognized risk of ceramic-on-ceramic bearings and cannot form the basis of a product liability claim

B. The surgeon who selected the ceramic bearing should have chosen a metal-on-polyethylene bearing surface instead

C. The patient should have been more careful to avoid activities that could stress the ceramic component of the hip prosthesis

D. The significantly elevated ceramic head fracture rate (0.8% vs. <0.02% benchmark) across the product line suggests a design or manufacturing defect in this specific ceramic component — the 40-fold higher fracture rate compared to industry standard indicates a systematic product quality problem rather than an inherent and accepted risk of ceramic bearings

74. An LNC is evaluating a medical malpractice case involving a 40-year-old patient who underwent an elective inguinal hernia repair. The surgeon prescribed a 30-day supply of oxycodone at discharge. The patient had a documented history of opioid use disorder (in remission for four years) in the preoperative assessment. Current prescribing guidelines recommend screening for substance use disorder risk factors before prescribing opioids and using opioid-sparing multimodal analgesic strategies for patients with SUD history. The patient relapsed during the 30-day opioid prescription and required inpatient substance abuse treatment. What standard of care issue should the LNC identify?

A. The patient's substance use history is protected health information that cannot be considered in prescribing decisions

B. The surgeon's failure to acknowledge the documented SUD history, implement opioid-sparing analgesic strategies, and limit the opioid prescription duration deviated from current prescribing guidelines for patients with substance use disorder history — a 30-day opioid supply for a patient with known OUD history represents an excessive prescription that created a foreseeable relapse risk

C. The pharmacy should have refused to fill the 30-day opioid prescription given the patient's documented addiction history

D. The patient bears sole responsibility for the relapse because addiction is a behavioral choice, not a medical condition

75. An LNC is analyzing a long-term care case in which a nursing home resident with documented Parkinson's disease and dysphagia was prescribed medications to be administered with water. The resident's dietary order specified nectar-thick liquids only. The medication nurse administered the medications with thin water rather than thickened water because "I didn't know the resident needed thickened liquids." The resident aspirated the thin water and developed aspiration pneumonia requiring hospitalization. The facility's medication administration record did not include any notation about the thickened liquid requirement, and no alert system existed to notify medication administration staff about dietary texture modifications. What systems failure does this illustrate?

- A. The facility lacked a system to communicate dietary texture modifications to medication administration staff — the absence of a thickened liquid alert in the medication administration record and the absence of any mechanism to notify medication staff about residents' fluid consistency requirements created a predictable gap between the dietary order and medication administration practice
- B. The attending physician should have ordered all medications in a crushable or liquid form to avoid the need for water
- C. The resident should have refused the thin water and reminded the nurse about the thickened liquid dietary restriction
- D. The medication nurse bears sole responsibility because nurses are expected to review all patient orders before medication passes

76. An LNC is reviewing a medical malpractice case involving a 50-year-old patient who underwent a screening mammogram. The mammogram was interpreted as BI-RADS 1 (negative). The radiologist's report noted "extremely dense breast tissue bilaterally" but did not recommend supplemental screening. The patient was not informed about the dense breast tissue finding or the limitations of mammography in detecting cancers in dense breast tissue. Twenty months later, the patient was diagnosed with Stage IIIA breast cancer that was not visible on the prior mammogram due to the masking effect of the dense tissue. The patient's state has enacted a breast density notification law requiring patient notification and discussion of supplemental screening options. What should the LNC evaluate?

- A. The mammographic interpretation as BI-RADS 1 was appropriate and the radiologist fulfilled all professional obligations
- B. The patient should have independently requested supplemental screening based on her own knowledge of breast density
- C. Whether the radiologist had an obligation — under the applicable state breast density notification law and/or the evolving standard of care — to inform the patient about the dense breast tissue and its impact on mammographic sensitivity, and whether supplemental screening (ultrasound, MRI) should have been recommended to improve cancer detection in the setting of extremely dense breast tissue
- D. Breast density is a normal anatomical variant that does not require any special notification or additional screening recommendations

77. An LNC is evaluating a risk management case involving a hospital that has experienced a cluster of retained surgical instruments over a six-month period — two retained sponges and one retained needle. Root cause analysis of all three events reveals common contributing factors: surgical count discrepancies at the end of the procedure were resolved by recounting rather than obtaining an intraoperative X-ray, the surgical team reported feeling pressured to close quickly to maintain operative

schedule efficiency, and the "sign-out" phase of the surgical safety checklist was not completed in any of the three cases. What risk management action should the LNC recommend?

- A. The individual surgeons should be counseled about the importance of complete surgical counts during all procedures
- B. The circulating nurses bear sole responsibility for the retained items because surgical counting is exclusively a nursing duty
- C. The hospital should implement routine postoperative X-ray for all surgical cases to detect retained items before patient discharge
- D. The risk management program should address all identified systemic factors: revise the protocol to mandate intraoperative X-ray for any unresolved count discrepancy, address the production pressure that discourages thorough count reconciliation through leadership reinforcement of the count process, and enforce completion of the sign-out phase of the surgical safety checklist

78. An LNC is analyzing a medical malpractice case involving a 60-year-old patient who developed necrotizing fasciitis following a minor outpatient procedure. The patient presented to the emergency department 36 hours after the procedure with severe wound pain disproportionate to the wound's appearance, erythema extending beyond the wound margins, crepitus, and fever. The emergency physician diagnosed wound cellulitis and prescribed oral antibiotics with outpatient follow-up. The patient returned 24 hours later with extensive tissue necrosis and sepsis requiring ICU admission, multiple debridement surgeries, and a prolonged hospitalization. What clinical finding should have prompted a different diagnosis?

- A. The erythema extending beyond wound margins is a normal finding in postoperative wound infection and supports cellulitis
- B. Crepitus — subcutaneous gas formation palpable on physical examination — is a hallmark finding of necrotizing fasciitis that distinguishes it from cellulitis, and its presence combined with pain out of proportion and rapidly spreading erythema should have prompted immediate surgical consultation for emergent debridement rather than outpatient antibiotic management
- C. The fever confirms the diagnosis of cellulitis and oral antibiotics are the appropriate first-line treatment for this condition
- D. The 36-hour post-procedure timing makes necrotizing fasciitis unlikely because NF typically develops more than 72 hours after surgery

79. An LNC is reviewing a life care plan for a 35-year-old man who sustained bilateral above-knee amputations in a workplace explosion. The plan projects bilateral prosthetic limbs with replacement

every 3–5 years, prosthetic socks and liners with regular replacement, annual prosthetic evaluations, ongoing physical therapy, wheelchair and adaptive equipment, home modifications, and a modified vehicle. The defense argues that the prosthetic replacement interval should be every seven years rather than every 3–5 years. What should the LNC evaluate to resolve this dispute?

- A. The LNC should evaluate the published literature on prosthetic replacement intervals for bilateral above-knee amputees, the manufacturer's recommended replacement schedule, and the treating prosthetist's clinical rationale for the 3–5 year cycle based on this specific patient's bilateral amputation level (which increases prosthetic component stress), activity level, and documented prosthetic wear patterns — bilateral AK amputees typically require more frequent replacement than unilateral amputees due to the increased demands on the prosthetic components
- B. The defense argument should be accepted because seven years is the standard replacement interval for all prosthetic limbs
- C. The LNC should recommend a compromise replacement interval of five years to split the difference between the positions
- D. The prosthetic manufacturer's warranty period should determine the replacement interval for the life care plan projection

80. An LNC is evaluating a medical malpractice case involving a patient who underwent a routine cataract surgery and developed endophthalmitis — a severe intraocular infection — postoperatively. The patient presented on postoperative day two with eye pain, reduced vision, and purulent discharge. The ophthalmologist examined the patient and documented "mild postoperative inflammation" without performing a vitreous tap for culture or initiating empiric intravitreal antibiotics. The patient returned the following day with severe endophthalmitis, and despite aggressive treatment with intravitreal antibiotics, the patient lost all useful vision in the affected eye. Current guidelines for suspected postoperative endophthalmitis recommend emergent vitreous tap and intravitreal antibiotic injection when the clinical presentation is suggestive. What should the LNC evaluate?

- A. Endophthalmitis is a recognized complication of cataract surgery and the ophthalmologist cannot be held liable for its occurrence
- B. The patient should have returned to the surgeon's office sooner when the eye pain and vision changes developed postoperatively
- C. Whether the ophthalmologist's assessment of "mild postoperative inflammation" — when the clinical findings (eye pain, reduced vision, purulent discharge) were more consistent with endophthalmitis — represented a diagnostic failure, and whether the delay in performing vitreous tap and initiating intravitreal antibiotics allowed the infection to progress beyond the point of visual salvage

D. The surgical facility's operating room sterilization procedures should be the primary focus of the investigation instead

81. An LNC is analyzing a regulatory compliance case involving a hospital that routinely performs urinary catheter placement without documented clinical indication. A quality improvement audit reveals that 45% of hospitalized patients with urinary catheters have no documented indication for catheterization in the medical record. CMS Conditions of Participation require that urinary catheters be placed only for appropriate clinical indications and that the clinical justification be documented. The hospital's catheter-associated urinary tract infection (CAUTI) rate is 3.5 times the national benchmark. What should the LNC conclude?

A. Urinary catheterization is a routine nursing procedure that does not require specific clinical indication or physician documentation

B. The 45% rate of catheter placement without documented indication represents a systemic overuse of urinary catheters in violation of CMS requirements

C. The absence of documented clinical indication for 45% of urinary catheterizations represents systemic noncompliance with CMS Conditions of Participation and evidence-based catheter management standards — the elevated CAUTI rate (3.5 times benchmark) is a foreseeable consequence of catheter overuse, and the institution should implement a catheter appropriateness protocol, mandatory indication documentation, and daily catheter necessity assessments

D. The individual nurses who placed the catheters bear sole responsibility for obtaining physician orders with documented indications

82. An LNC is reviewing a personal injury case involving a 45-year-old woman who was injured in a motor vehicle accident and developed fibromyalgia nine months after the accident. The defense argues fibromyalgia is not a legitimate medical diagnosis and the plaintiff is fabricating her symptoms. The plaintiff's rheumatologist has documented findings meeting the American College of Rheumatology diagnostic criteria, including widespread pain index and symptom severity scores that exceed the diagnostic thresholds. Pre-accident medical records show no prior pain complaints or fibromyalgia diagnosis. What should the LNC evaluate?

A. The defense argument should be accepted because fibromyalgia lacks objective diagnostic tests like imaging or laboratory markers

B. Fibromyalgia is a recognized medical diagnosis with established ACR diagnostic criteria — the plaintiff's documented findings meeting these criteria, combined with the absence of pre-accident pain complaints and the temporal relationship between the accident and symptom onset, support the diagnosis

and its relationship to the traumatic event, and published literature documents trauma-onset fibromyalgia as a recognized clinical entity

C. The plaintiff should undergo additional diagnostic testing to rule out all other possible causes before the fibromyalgia diagnosis

D. The neuropsychological testing results are more important than the rheumatological findings for establishing the fibromyalgia

83. An LNC is analyzing a medical malpractice case involving a patient who underwent a lumbar microdiscectomy. The surgeon operated at the L3-L4 level instead of the L4-L5 level identified on the preoperative MRI and surgical consent. The error was discovered on postoperative imaging. The patient required a second surgery at the correct level, experiencing additional pain, tissue damage, and recovery time. The operative report documents that the surgeon "confirmed the surgical level using anatomical landmarks." No intraoperative fluoroscopy or X-ray was used for level verification. Current guidelines recommend intraoperative imaging for level confirmation. What standard of care issue should the LNC identify?

A. The surgeon's reliance on anatomical landmarks alone — without intraoperative imaging for level confirmation as recommended by current guidelines — deviated from the standard of care for lumbar spine surgery, and the wrong-level error objectively demonstrates that the landmark-based verification was inadequate for this patient

B. The preoperative MRI should have been available in the operating room for the surgeon to reference during the procedure

C. The radiologist who read the preoperative MRI should have more clearly marked the correct surgical level on the images

D. The patient should have confirmed the correct surgical level with the surgeon immediately before anesthesia induction

84. An LNC is evaluating a Medicare Set-Aside case involving a 70-year-old Medicare beneficiary settling a workers' compensation claim for a lumbar spine injury. The claimant requires ongoing pain management including prescription medications and interventional procedures. The claimant also takes medications for pre-existing hypertension and type 2 diabetes that were present before the work injury. The defense argues all of the claimant's medications should be included in the MSA. What is the correct MSA treatment?

A. All medications should be included because the claimant takes them daily and they are all medically necessary for overall health

- B. The defense argument should be accepted to ensure Medicare's interests are fully protected by including all medication costs
- C. The medications should be split proportionally between the MSA and the claimant's personal responsibility based on relative cost
- D. Only medications related to the compensable lumbar spine injury should be included in the MSA — the hypertension and diabetes medications are for pre-existing conditions unrelated to the work injury and remain the claimant's personal responsibility under Medicare

85. An LNC is reviewing a medical malpractice case involving a patient who was admitted to the hospital with a hip fracture and developed a hospital-acquired pressure ulcer on the sacrum during the hospitalization. The patient's Braden Scale score on admission was 12 (high risk). The nursing documentation shows: the Braden Scale assessment was completed on admission but not repeated during the 10-day hospitalization; the care plan specified "reposition every 2 hours"; the repositioning documentation shows gaps of 6–8 hours on multiple occasions; no specialty mattress was ordered; and no nutrition consultation was obtained despite an albumin of 2.0 g/dL. What should the LNC identify?

- A. The hip fracture made the patient immobile and the pressure ulcer was an unavoidable consequence of the immobility
- B. The attending physician bears sole responsibility for the pressure ulcer because the physician should have ordered a specialty mattress
- C. The multiple failures in pressure injury prevention — absent repeat risk assessments, inadequate repositioning (6–8 hour gaps versus the 2-hour care plan specification), no specialty mattress for a high-risk patient, and no nutritional intervention despite low albumin — collectively demonstrate a systemic failure to implement the comprehensive prevention strategy that the patient's documented high risk demanded
- D. The patient should have requested more frequent repositioning from the nursing staff to prevent sacral pressure development

86. An LNC is analyzing a workers' compensation case involving a 52-year-old factory worker who developed bilateral hearing loss after 20 years of occupational noise exposure. The worker's noise exposure levels were documented at 92–98 dB (above the OSHA PEL of 90 dB for an 8-hour TWA). The worker's audiogram shows bilateral symmetric sensorineural hearing loss with the characteristic 4000 Hz notch — the hallmark pattern of noise-induced hearing loss. The employer argues the hearing loss is age-related (presbycusis). What clinical evidence most strongly supports occupational causation?

- A. The worker's subjective report that hearing loss began during the period of noise exposure is the strongest evidence
- B. The bilateral symmetric hearing loss with the characteristic 4000 Hz audiometric notch — which distinguishes noise-induced hearing loss from presbycusis (which shows gradual sloping high-frequency loss without a discrete notch) — combined with 20 years of documented exposure above the OSHA PEL, provides strong clinical and objective evidence of occupational noise-induced hearing loss
- C. The employer's failure to provide hearing protection programs proves the hearing loss is occupational in origin
- D. An MRI should be obtained to rule out acoustic neuroma before any causation determination can be made

87. An LNC is reviewing a medical malpractice case involving a patient who underwent bariatric surgery (Roux-en-Y gastric bypass) and developed a vitamin B12 deficiency that went undiagnosed for three years. The patient developed peripheral neuropathy and subacute combined degeneration of the spinal cord from the prolonged B12 deficiency. The surgeon's postoperative follow-up records show no B12 levels were ever monitored. The standard of care after Roux-en-Y gastric bypass requires lifelong monitoring of nutritional parameters including B12. What is the straightforward standard of care issue?

- A. The failure to monitor B12 levels during three years of post-bariatric surgery follow-up — when guidelines require lifelong nutritional monitoring — allowed a predictable and preventable deficiency to progress to irreversible neurological damage, and the standard of care deviation is clear and unambiguous
- B. The patient should have independently supplemented with B12 after reading about nutritional risks of gastric bypass surgery
- C. The primary care physician should have assumed responsibility for B12 monitoring from the bariatric surgeon postoperatively
- D. The gastroenterologist who referred the patient for bariatric surgery should have warned about nutritional deficiency risks

88. An LNC is evaluating a toxic tort case involving residents near a former industrial facility where trichloroethylene (TCE) contaminated the groundwater. Several plaintiffs have developed kidney cancer. TCE is classified by IARC as a Group 1 carcinogen with sufficient evidence for kidney cancer in humans. The defense argues that two of the plaintiffs are obese and obesity is a risk factor for kidney cancer. What should the LNC evaluate?

- A. The defense argument should be accepted because obesity is a stronger risk factor for kidney cancer than chemical exposure
- B. The plaintiffs' obesity should be investigated as the sole cause of their kidney cancers before evaluating TCE exposure
- C. Both TCE exposure and obesity are established risk factors for kidney cancer — they may have contributed independently
- D. Both TCE exposure and obesity are established independent risk factors for kidney cancer — the presence of one does not eliminate the contribution of the other, and the LNC should evaluate each plaintiff individually, considering documented TCE exposure levels and duration, the known dose-response relationship for TCE and kidney cancer, the BMI and duration of obesity, and whether the two factors may have acted independently or synergistically to increase the overall cancer risk

89. An LNC is analyzing a personal injury case involving a 38-year-old woman who sustained a Lisfranc fracture-dislocation of her right foot in a fall at a commercial property. Despite surgical fixation, the plaintiff developed post-traumatic midfoot arthritis requiring midfoot fusion (arthrodesis). The plaintiff was a professional ballet dancer. The midfoot fusion eliminates the midfoot motion essential for ballet pointe work. The defense argues the plaintiff can teach ballet. What is the most important damages consideration?

- A. The plaintiff's ballet career earnings history should be discounted because dancer income is inherently variable and unpredictable
- B. The plaintiff should attempt to dance with modified choreography before claiming permanent inability to perform professionally
- C. The permanent elimination of midfoot motion from the arthrodesis prevents the biomechanical function essential for ballet pointe work — a specialized physical skill that cannot be replaced by teaching, which requires fundamentally different skills, provides fundamentally different compensation, and does not substitute for the loss of artistic performance, professional identity, and the unique creative expression that defined the plaintiff's career
- D. The plaintiff's age of 38 indicates she was approaching retirement from professional dance and damages should be limited

90. An LNC is reviewing a medical malpractice case involving a patient who was prescribed warfarin for atrial fibrillation. The physician ordered INR monitoring every four weeks. The patient's INR was consistently within the therapeutic range (2.0–3.0) for the first six months. At the seventh-month visit, the INR was 6.8 (dangerously elevated). The physician was notified of the result but did not contact the patient or adjust the warfarin dose. Four days later, the patient presented to the emergency department

with a massive gastrointestinal hemorrhage requiring ICU admission and blood transfusion. What should the LNC identify?

- A. The INR monitoring frequency of every four weeks was adequate and met the standard of care for warfarin management
- B. The physician's failure to respond to the critically elevated INR of 6.8 — by contacting the patient, holding or reducing the warfarin dose, and arranging repeat INR testing — represents a failure to act on a critical laboratory result, and the four-day delay between the elevated result and the hemorrhagic event allowed a treatable anticoagulation excess to progress to a life-threatening bleeding complication
- C. The laboratory should have called the physician directly with the critical INR value rather than reporting it through routine channels
- D. The patient should have independently reduced or held the warfarin dose when feeling any unusual symptoms during the interval

91. An LNC is evaluating a long-term care case in which a nursing home resident who was prescribed a pureed diet with honey-thick liquids was served a regular-texture meal by a dietary aide. The resident aspirated and developed aspiration pneumonia requiring hospitalization. Investigation reveals the diet order was correctly entered in the electronic health record. However, the dietary department uses a separate meal preparation system that was not updated with the correct diet order. The resident had been receiving the incorrect diet for two weeks before the aspiration event. What systems failure does this case illustrate?

- A. The dietary aide bears sole responsibility because aides should check diet orders before serving every meal to every resident
- B. The attending physician should have confirmed the diet order was transmitted to the dietary department before the order took effect
- C. The speech-language pathologist should have monitored all meals for residents with documented dysphagia and dietary restrictions
- D. The use of two separate, non-integrated systems — one for clinical orders and one for meal production — without a reconciliation process created a communication gap where the diet modification documented in the clinical record was never transmitted to the kitchen, resulting in two weeks of incorrect diet delivery and a foreseeable aspiration event

92. An LNC is analyzing a medical malpractice case involving a 45-year-old patient who underwent a routine upper endoscopy (EGD) for dyspepsia. During the procedure, the patient's oxygen saturation dropped to 80% and the patient became bradycardic. The endoscopy nurse documented the desaturation

and bradycardia but did not interrupt the procedure, did not administer supplemental oxygen, and did not alert the endoscopist. The oxygen saturation remained below 85% for approximately five minutes before the endoscopist independently noticed the monitor. The patient was resuscitated but sustained a brief hypoxic event resulting in short-term cognitive deficits. What is the primary nursing standard of care violation?

- A. The nurse's failure to respond to the oxygen desaturation and bradycardia — by immediately administering supplemental oxygen, alerting the endoscopist, and initiating rescue interventions — represents a critical failure to act on an acute change in the patient's condition during procedural sedation
- B. The endoscopist should have been independently monitoring the patient's vital signs throughout the entire procedure
- C. The patient should have been intubated before the endoscopy to prevent desaturation during the sedation procedure
- D. The sedation protocol should prohibit the use of moderate sedation for routine endoscopy in patients over age 40

93. An LNC is reviewing a healthcare fraud case involving a pain management clinic that prescribes compounded topical pain creams. The clinic's billing records show that every patient receives the same five-ingredient compounded cream regardless of diagnosis, the cream is billed at \$4,200 per month, commercially available products with similar active ingredients cost \$60–\$100 per month, the prescribing physician has a financial ownership interest in the compounding pharmacy, and the clinical records contain no documentation explaining why a compounded preparation is medically necessary when commercial alternatives exist. What regulatory concerns does this pattern raise?

- A. Compounded medications are always superior to commercial products and justify the higher cost in every clinical situation
- B. The physician's ownership interest in the pharmacy is permissible because physicians may own pharmacies in most jurisdictions
- C. The uniform prescribing pattern without individualized clinical justification, the significant cost differential without documented medical necessity, and the physician's financial interest in the compounding pharmacy raise concerns about prescribing driven by financial incentive rather than clinical need — potentially implicating the Anti-Kickback Statute, the False Claims Act, and the Stark Law
- D. The patients should have independently researched whether compounded or commercial formulations were more appropriate

94. An LNC is evaluating a medical malpractice case involving a patient who developed a postoperative wound infection after a cesarean section. The anesthesia record documents that the prophylactic antibiotic (cefazolin) was administered 15 minutes after the skin incision. The standard of care requires antibiotic administration within 60 minutes before the incision to achieve adequate tissue levels at the time of surgical exposure. Investigation reveals the antibiotic was ordered at the correct time but was delayed because the automated dispensing cabinet in the operating room malfunctioned. What should the LNC evaluate?

- A. The 15-minute post-incision administration is clinically equivalent to pre-incision administration and does not affect infection risk
- B. The dispensing cabinet malfunction that delayed antibiotic delivery represents a systems failure — the hospital's processes should ensure prophylactic antibiotics are available and administered before incision for every surgical case, and the failure of the dispensing system created a gap in the infection prevention protocol that may have contributed to the wound infection
- C. The pharmacy bears sole responsibility for the delayed antibiotic delivery due to the cabinet malfunction problem
- D. The surgical team should have delayed the incision until the antibiotic was available and administered to the patient

95. An LNC is reviewing a case involving the LNC's obligations when testifying as an expert witness. During cross-examination, the opposing counsel asks the LNC whether she was paid for her testimony. What is the most appropriate response?

- A. The LNC should decline to answer the question because compensation information is privileged and confidential
- B. The LNC should explain that she was paid for her time and the preparation of her opinions but not for the substance of her testimony
- C. The LNC should state that she was not paid for her work on the case to avoid the appearance of bias in her testimony
- D. The LNC should answer the question honestly — LNCs are compensated for their time and expertise, not for specific opinions, and the appropriate response is to confirm compensation for time while clarifying that the compensation is for time and expert analysis, not for the content or direction of the testimony

96. An LNC is analyzing a medical malpractice case involving a patient who underwent a total knee replacement and developed a periprosthetic fracture of the femur during physical therapy on

postoperative day three. The physical therapist documented that the patient was performing a weight-bearing exercise when the fracture occurred. The patient had documented severe osteoporosis (T-score of -3.8) and was on chronic corticosteroid therapy for rheumatoid arthritis — both significant risk factors for periprosthetic fracture. The surgeon's postoperative orders did not include weight-bearing precautions or modified physical therapy protocols despite the documented bone quality concerns. What should the LNC evaluate?

- A. Whether the surgeon's failure to implement modified weight-bearing protocols and communicate the bone quality concerns to the physical therapy team — in a patient with severe osteoporosis and chronic steroid use, both of which significantly increase periprosthetic fracture risk — deviated from the standard of care for managing post-arthroplasty rehabilitation in patients with compromised bone quality
- B. The physical therapist should have independently assessed the patient's bone quality before initiating weight-bearing exercises
- C. The patient's rheumatoid arthritis makes periprosthetic fracture an inevitable complication regardless of rehabilitation protocols
- D. The orthopedic implant manufacturer should be investigated for a device design that is incompatible with osteoporotic bone

97. An LNC is evaluating a risk management case involving a hospital that has identified a pattern of patient misidentification errors in the laboratory department. Over a six-month period, five specimens were mislabeled — two blood bank specimens, two chemistry specimens, and one pathology specimen. Investigation reveals the laboratory uses a manual label-and-apply process for specimen labeling and does not have a barcode-based positive patient identification system. What risk management analysis should the LNC perform?

- A. The individual phlebotomists who mislabeled specimens should be retrained on proper specimen labeling technique
- B. The laboratory should reduce its specimen volume to allow more time for accurate labeling of each individual specimen
- C. The convergence of five mislabeling events across multiple specimen types over six months — in the absence of a barcode-based positive identification system — indicates a systemic vulnerability in the manual labeling process rather than isolated individual errors, and the risk management response should include implementation of barcode-based specimen identification technology
- D. The blood bank specimens are the most critical because blood type errors can be fatal and should be the sole focus

98. An LNC is reviewing a personal injury case involving a 55-year-old man who sustained a traumatic brain injury in a construction accident. The plaintiff has documented executive function deficits, impaired memory, and behavioral dysregulation (impulsivity, irritability). The plaintiff was a construction project manager earning \$130,000 annually. He has been unable to return to project management due to the cognitive and behavioral deficits. The defense retained a vocational expert who opines the plaintiff can perform "simple supervisory tasks" in the construction industry. What should the LNC evaluate?

- A. The vocational expert's opinion should be accepted because vocational experts are qualified to make employment capacity determinations
- B. The LNC should evaluate whether the documented cognitive deficits (executive dysfunction, memory impairment) and behavioral changes (impulsivity, irritability) are compatible with any supervisory role — construction supervision requires planning, sequencing, multi-tasking, conflict resolution, and consistent interpersonal interactions, all of which may be impaired by the documented deficits
- C. The plaintiff should attempt a graded return-to-work trial in a supervisory role before claiming total vocational disability
- D. The plaintiff's pre-injury income should be the sole basis for calculating lost earning capacity regardless of current functional status

99. An LNC is analyzing a medical malpractice case involving a newborn who developed kernicterus from severe untreated neonatal jaundice. The infant was discharged from the hospital at 30 hours of life with a total serum bilirubin of 13.8 mg/dL. When plotted on the Bhutani hour-specific nomogram, this level fell in the high-risk zone. The AAP guidelines recommend specific follow-up and monitoring for infants in the high-risk zone. The discharge instructions specified "follow up with pediatrician in one week." The infant was not seen again until six days later, when the parents brought the infant to the emergency department with extreme jaundice, lethargy, and high-pitched crying. The total bilirubin was 32.4 mg/dL. The infant was diagnosed with acute bilirubin encephalopathy and developed permanent kernicterus. What is the primary standard of care failure?

- A. The hospital laboratory should have reported the bilirubin result as critical and flagged it for immediate physician review
- B. The parents should have recognized the worsening jaundice and brought the infant to the physician sooner than six days
- C. The pediatrician's office should have contacted the parents proactively to schedule an earlier follow-up appointment
- D. The bilirubin level in the high-risk zone required follow-up within 24 hours per AAP guidelines — the one-week follow-up instruction deviated from this standard, creating a six-day gap during which the

rising bilirubin went unmonitored and untreated, ultimately reaching neurotoxic levels that caused permanent brain damage

100. An LNC is evaluating a medical malpractice case involving a patient who underwent an elective laparoscopic cholecystectomy and developed a bile duct injury. The injury was not recognized intraoperatively. The patient presented five days later with jaundice, abdominal pain, and fever. An ERCP confirmed a complete transection of the common bile duct. The patient required a hepaticojejunostomy and has a lifelong elevated risk of biliary stricture and secondary biliary cirrhosis. The surgeon's operative report does not document achievement of the "critical view of safety" — the standard dissection technique specifically designed to prevent bile duct injuries during laparoscopic cholecystectomy. What should the LNC evaluate?

A. Whether the surgeon achieved and documented the critical view of safety — the absence of documentation suggests this standard safety technique may not have been performed, and the failure to achieve this view before clipping and transecting structures is the most commonly identified technical factor in bile duct injuries during laparoscopic cholecystectomy

B. Bile duct injury is a recognized complication and cannot form the basis of a malpractice claim regardless of surgical technique

C. The patient should have elected open cholecystectomy rather than the laparoscopic approach to eliminate bile duct injury risk

D. The radiologist should have identified difficult biliary anatomy on preoperative imaging to warn the surgeon before the procedure

101. An LNC is reviewing a medical malpractice case involving a 47-year-old man who presented to the emergency department with acute onset of left-sided weakness and speech difficulty. The patient arrived 50 minutes after symptom onset. A head CT was obtained within 20 minutes (negative for hemorrhage). The emergency physician activated the stroke protocol and ordered tPA. However, the tPA was not administered for an additional 75 minutes because the pharmacy could not locate the alteplase in the emergency department's medication storage and had to retrieve it from the central pharmacy. The tPA was eventually administered at 2 hours and 25 minutes after symptom onset. While still within the 4.5-hour treatment window, published evidence demonstrates that every 15 minutes of delay reduces the probability of a good neurological outcome. What systems failure contributed to the delayed treatment?

A. The emergency physician should have ordered the tPA sooner during the diagnostic evaluation to account for potential delays

- B. The hospital's failure to ensure immediate tPA availability in the emergency department — requiring pharmacy retrieval from a remote location — represents a stroke readiness systems failure that delayed time-critical thrombolytic therapy and reduced the patient's probability of a good neurological outcome
- C. The CT technologist should have performed the head CT faster to allow more time for the pharmacy to locate the tPA medication
- D. The neurologist should have been consulted before the tPA was ordered to authorize its administration for this stroke patient

102. An LNC is evaluating a long-term care case in which a 84-year-old nursing home resident with documented severe osteoporosis and a Braden Scale score of 11 (very high risk for pressure injury) developed a deep tissue injury (DTI) on both heels within the first two weeks of admission. The admission assessment identified heel pressure injury risk. The care plan specified "heel offloading devices." The LNC reviews the nursing documentation and finds no evidence that heel offloading devices were ever applied, no heel skin assessments documented after the admission assessment, and no evidence that the heel-specific care plan intervention was implemented at any point during the two-week period. What is the most significant analytical finding?

- A. The resident's osteoporosis and extremely high risk score made heel DTIs unavoidable regardless of any preventive interventions
- B. The attending physician should have ordered specific heel offloading devices by brand name rather than using a generic care plan order
- C. The facility should have assigned a dedicated wound care nurse to perform daily heel assessments for all high-risk residents admitted
- D. The facility identified the heel pressure injury risk at admission and developed a care plan to address it, but completely failed to implement the planned intervention — the total absence of documentation that offloading was ever applied, combined with absent heel skin assessments, demonstrates a complete disconnect between the documented plan and the actual care delivered

103. An LNC is analyzing a product liability case involving a defective cardiac implantable cardioverter-defibrillator (ICD). The device's lead fractured, causing failure to detect and treat a lethal ventricular arrhythmia. The patient died of sudden cardiac death. The manufacturer's post-market surveillance data shows a lead fracture rate of 7.2% at four years — significantly higher than the industry benchmark of less than 1%. The manufacturer was aware of the elevated fracture rate for 16 months before the patient's death but had not issued a product advisory, recall, or safety communication. What is the most critical liability issue?

- A. The implanting electrophysiologist should have monitored the device more frequently to detect lead fracture before clinical failure
- B. The patient should have reported symptoms of lead malfunction (palpitations, inappropriate shocks) sooner to the physician
- C. The manufacturer's knowledge of the elevated lead fracture rate (7.2% vs. <1% benchmark) for 16 months without issuing a safety communication constitutes a failure to warn — the delay deprived physicians and patients of information needed to make informed decisions about device management, including the option of prophylactic lead replacement or enhanced monitoring
- D. The ICD manufacturer should have designed a lead with a redundant conductor wire to prevent fracture-related failure

104. An LNC is reviewing a medical malpractice case involving a 55-year-old patient who underwent a screening colonoscopy. During the procedure, the gastroenterologist removed a 2.5 cm sessile polyp from the ascending colon. The pathology report returned showing "tubular adenoma with high-grade dysplasia — margins cannot be assessed due to piecemeal removal." The gastroenterologist informed the patient that "the polyp was completely removed and no follow-up is needed for three years." Current guidelines recommend that when a polyp with high-grade dysplasia is removed in a piecemeal fashion (making margin assessment impossible), a follow-up colonoscopy should be performed in 3–6 months to evaluate the polypectomy site for residual adenomatous tissue. The patient was not seen again for 2.5 years, at which point a colon cancer was found at the prior polypectomy site. What is the critical standard of care failure?

- A. The gastroenterologist failed to follow current surveillance guidelines for piecemeal-removed polyps with high-grade dysplasia — when margins cannot be assessed, a short-interval follow-up colonoscopy (3–6 months) is required to evaluate for residual tissue, and the recommendation for a three-year interval was clinically inappropriate for this pathology finding
- B. The pathologist should have insisted on receiving an intact specimen to assess margins rather than accepting piecemeal fragments
- C. The patient should have independently researched the pathology report and requested an earlier follow-up colonoscopy appointment
- D. The gastroenterologist should have referred the patient to a surgical oncologist immediately after the piecemeal polyp removal

105. An LNC is evaluating a workers' compensation case involving a 44-year-old industrial electrician who developed bilateral hand tremors and difficulty with fine motor tasks after chronic occupational exposure to mercury vapor during fluorescent lamp recycling operations over eight years. The worker's urine mercury levels during employment ranged from 40 to 85  $\mu\text{g/L}$  (the ACGIH biological exposure

index is 35 µg/L). Pre-employment neurological examination was normal. Post-exposure neuropsychological testing shows impairments in motor speed, manual dexterity, and visuospatial processing — a pattern consistent with mercury neurotoxicity. The employer's IME physician attributed the tremors to "essential tremor" unrelated to mercury exposure. What should the LNC evaluate?

- A. The IME physician's conclusion should be accepted because essential tremor is a common neurological condition unrelated to toxicant exposure
- B. Whether the documented mercury exposure levels (consistently above the biological exposure index), the temporal onset of tremors during the exposure period, the normal pre-employment neurological examination, and the neuropsychological deficit pattern (motor speed, manual dexterity, visuospatial processing impairment consistent with mercury neurotoxicity) collectively support an occupational etiology rather than the IME's attribution to essential tremor
- C. The worker should undergo a brain MRI to differentiate between mercury-induced tremor and essential tremor before causation analysis
- D. The worker's caffeine consumption and medication use should be investigated as alternative causes of the bilateral hand tremors

106. An LNC is reviewing a medical malpractice case involving a patient who underwent a cesarean section. Prophylactic antibiotics (cefazolin) were ordered to be administered within 60 minutes before the skin incision, as required by the standard of care for surgical infection prevention. The anesthesia record documents that the cefazolin was administered 20 minutes after the skin incision rather than before. Investigation reveals the antibiotic was not available in the operating room's automated dispensing cabinet because the cabinet had not been restocked after the previous case. The nursing staff contacted the pharmacy, but the antibiotic was not delivered until after the incision had been made. What should the LNC evaluate?

- A. The 20-minute post-incision timing is clinically equivalent to pre-incision administration and does not affect the infection risk
- B. The surgeon should have delayed the incision until the antibiotic was available and had been administered to the patient
- C. The pharmacy bears sole responsibility for the restocking failure and should be the primary defendant in this malpractice case
- D. The automated dispensing cabinet restocking failure represents a systems-level breakdown in the perioperative infection prevention process — the hospital's systems should ensure prophylactic antibiotics are available in the OR for every surgical case, and the failure of the restocking process created a gap in the infection prevention protocol

107. An LNC is analyzing a personal injury case involving a 63-year-old man who sustained a complete tear of the right Achilles tendon when he stepped into a pothole on a commercial property. Despite surgical repair and 12 months of rehabilitation, the plaintiff has residual plantar flexion weakness, chronic pain at the repair site, and an altered gait pattern with compensatory knee and hip biomechanical changes. The plaintiff was a semi-retired golf instructor who taught 20 hours per week. The Achilles impairment prevents the weight transfer and push-off mechanics essential for the golf swing and for walking the course. The defense argues the plaintiff was only semi-retired and earning limited income. What is the most important damages consideration?

- A. The plaintiff's golf instructor income should be the sole basis for calculating economic damages in the personal injury case
- B. The plaintiff should undergo a functional capacity evaluation before any determination about vocational capacity is made
- C. The documented residual Achilles impairments specifically disable the biomechanical functions essential to the plaintiff's profession — golf instruction requires demonstration of proper swing mechanics (dependent on push-off strength) and walking the course (affected by the altered gait), and the damages must account for both the economic loss (teaching income) and the significant non-economic loss (inability to perform and teach the sport that defined the plaintiff's post-retirement professional identity and lifestyle)
- D. The defense argument should be accepted because semi-retired individuals' economic damages are inherently limited by their choice to reduce work hours

108. An LNC is evaluating a risk management case involving a hospital where a patient with a documented severe allergy to latex (documented anaphylaxis) experienced an anaphylactic reaction during a surgical procedure. The patient's allergy was documented in the electronic health record, on the allergy wristband, and on the preoperative nursing assessment. Despite these three separate documentations, the surgical team used latex-containing surgical gloves because the operating room was not set up as a latex-free environment. The hospital's latex allergy protocol requires identifying latex-allergic patients 24 hours before surgery and preparing a latex-free OR suite. What risk management conclusion should the LNC draw?

- A. The allergy was documented in three separate locations but the hospital's latex allergy protocol was never activated — illustrating the critical gap between identifying a hazard (documenting the allergy) and implementing the safety intervention designed to address it (preparing a latex-free OR), and demonstrating that documentation alone does not prevent harm without reliable systems to trigger the required safety response
- B. The circulating nurse bears sole responsibility for verifying the OR is latex-free for all patients with documented latex allergy

C. The surgeon should have independently inspected all supplies in the operating room for latex content before beginning surgery

D. The patient should have reminded the surgical team about the latex allergy immediately before the induction of general anesthesia

109. An LNC is reviewing a long-term care case involving a 80-year-old nursing home resident with documented type 2 diabetes and peripheral vascular disease who developed gangrene of the right foot requiring a below-knee amputation. The LNC's review of the nursing documentation reveals that daily foot inspections were care-planned but documented only sporadically — approximately twice per week rather than daily. A wound on the right great toe was first noted in a nursing progress note but was not reported to the attending physician for nine days, during which the wound progressed from a superficial ulcer to a deep infected wound with surrounding cellulitis. By the time the physician was notified and treatment initiated, the infection had progressed to osteomyelitis and wet gangrene. What cascade of failures does this case demonstrate?

A. The resident's diabetes and peripheral vascular disease made gangrene inevitable regardless of any nursing monitoring provided

B. The sporadically performed foot inspections (twice weekly versus the care-planned daily frequency) allowed the wound to develop without timely detection, and the nine-day delay in physician notification allowed a treatable superficial ulcer to progress to a limb-threatening infection — this cascade of monitoring failure followed by communication failure demonstrates how sequential nursing care lapses produce catastrophic outcomes in high-risk diabetic patients

C. The podiatrist should have been performing weekly foot assessments rather than relying on the nursing staff for daily inspections

D. The attending physician should have prescribed prophylactic antibiotics for the diabetic foot to prevent wound infection

110. An LNC is analyzing a medical malpractice case involving a 38-year-old woman who presented to the emergency department at 36 weeks gestation with sudden-onset severe headache, visual disturbances (scotomata), and right upper quadrant pain. Her blood pressure was 178/112 mmHg and she had 4+ proteinuria on dipstick urinalysis. The emergency physician documented "pregnancy-related headache" and contacted the patient's obstetrician. The obstetrician, who was at home, instructed the ED physician to give the patient acetaminophen and discharge her with instructions to follow up at the office the next morning. Eight hours later, the patient presented by ambulance with eclamptic seizures and HELLP syndrome (hemolysis, elevated liver enzymes, low platelets). Emergency cesarean delivery was performed, but the infant had sustained in utero distress and the mother required ICU admission for DIC and hepatic hemorrhage. What constellation of findings should have prompted immediate intervention?

- A. The headache alone should have warranted hospital admission because headaches in the third trimester are always pathological
- B. The blood pressure elevation required antihypertensive medication but outpatient management was otherwise appropriate here
- C. The obstetrician should have consulted a maternal-fetal medicine specialist before making any management decisions by telephone
- D. Severe headache, visual disturbances, right upper quadrant pain, blood pressure of 178/112, and 4+ proteinuria at 36 weeks gestation constitute a classic and unmistakable presentation of severe preeclampsia with warning signs of impending eclampsia and HELLP syndrome — this presentation demands immediate hospital admission, IV magnesium for seizure prophylaxis, antihypertensive therapy, laboratory evaluation, and likely emergent delivery

111. An LNC is evaluating a case involving the professional boundaries of the LNC role. An attorney retaining an LNC for case screening asks the LNC to contact the defendant physician's office, pose as a prospective patient, and inquire about the physician's typical treatment approach for the condition at issue in the malpractice case. The attorney explains this would help assess the standard of care. What is the LNC's appropriate response?

- A. The LNC should decline — the request to pose as a prospective patient to gather information about the defendant physician constitutes deception and potentially violates ethical standards for LNC practice, rules of professional conduct, and may constitute improper ex parte contact with a represented party
- B. The LNC should comply because the attorney directs all aspects of the engagement and the LNC works under the attorney's authority
- C. The LNC should contact the physician's office but identify herself as an LNC rather than posing as a prospective patient
- D. The LNC should delegate the call to an office assistant who is not bound by the LNC's professional ethical obligations

112. An LNC is reviewing a medical malpractice case involving a patient who underwent a total hip replacement and developed a deep prosthetic joint infection (PJI) with *Staphylococcus aureus*. The patient's preoperative records document a hemoglobin A1c of 9.8% (poorly controlled diabetes) and active tobacco use. Published orthopedic guidelines recommend glycemic optimization (A1c below 8%) and smoking cessation before elective joint replacement to reduce infection risk. The surgeon did not delay the elective procedure to address either modifiable risk factor and did not document a risk-benefit analysis. What should the LNC evaluate?

- A. The patient's diabetes and smoking make PJI an unavoidable complication regardless of any preoperative risk factor optimization
- B. The patient should have independently optimized glycemic control and quit smoking before presenting for elective surgery
- C. Whether the surgeon's decision to proceed with elective joint replacement without addressing two documented modifiable infection risk factors — poorly controlled diabetes and active smoking — deviated from published guidelines that recommend risk factor optimization before elective joint surgery, and whether a documented risk-benefit analysis was required
- D. The infectious disease physician should have been consulted preoperatively to assess the patient's infection risk profile

113. An LNC is analyzing a toxic tort case involving former workers at a polyvinyl chloride (PVC) manufacturing facility who were exposed to vinyl chloride monomer (VCM) during polymerization operations for periods of 10–20 years. One worker has been diagnosed with hepatic angiosarcoma — a rare and aggressive liver cancer. Vinyl chloride is classified by IARC as a Group 1 carcinogen with hepatic angiosarcoma specifically identified as having sufficient evidence of carcinogenicity in humans. The defense argues the worker's moderate alcohol consumption (2–3 drinks per week) caused the liver cancer. What should the LNC evaluate?

- A. The worker's alcohol consumption eliminates VCM as a possible cause because alcohol is a more common cause of liver disease
- B. Hepatic angiosarcoma is an extremely rare tumor with a very specific association with vinyl chloride exposure — it is almost never caused by alcohol consumption, which is associated with hepatocellular carcinoma rather than angiosarcoma, and the specific tumor histology (angiosarcoma vs. hepatocellular carcinoma) effectively distinguishes between the competing causation arguments
- C. The worker should undergo liver biopsy to distinguish between vinyl chloride-induced and alcohol-induced liver cancer
- D. The IARC Group 1 classification automatically establishes specific causation for this individual worker without further analysis

114. An LNC is evaluating a Medicare Set-Aside case involving a 74-year-old Medicare beneficiary settling a workers' compensation claim for bilateral knee injuries. The claimant has undergone bilateral total knee replacements. The MSA projects ongoing bilateral knee pain management including prescription medications, periodic joint injections, and annual orthopedic evaluations. The claimant also takes daily medications for pre-existing hypertension, type 2 diabetes, and hypothyroidism. The defense argues all of the claimant's medications should be included in the MSA. What is the correct MSA treatment of the pre-existing condition medications?

- A. All medications should be included in the MSA because the claimant takes them all daily and they are all medically necessary
- B. The medications should be divided proportionally between the MSA and the claimant's personal responsibility based on cost
- C. The pre-existing condition medications (hypertension, diabetes, hypothyroidism) were not caused by the work injury and should be excluded
- D. Only medications related to the compensable bilateral knee injuries should be included in the MSA — the hypertension, diabetes, and hypothyroidism medications are for pre-existing conditions unrelated to the work injury and remain the claimant's personal responsibility under regular Medicare coverage

115. An LNC is reviewing a medical malpractice case involving a 42-year-old patient who underwent an elective laparoscopic cholecystectomy and developed a bile duct injury. The injury was not recognized intraoperatively. The patient presented four days later with jaundice, abdominal pain, and elevated liver enzymes. An MRCP confirmed a partial transection of the common hepatic duct. The surgeon's operative report does not document achievement of the "critical view of safety" — the standard dissection technique designed to prevent bile duct injuries by definitively identifying the cystic duct and cystic artery before clipping. What should the LNC evaluate?

- A. Whether the surgeon achieved and documented the critical view of safety before clipping any structures — the absence of documentation suggests this standard safety technique may not have been performed, and failure to achieve the critical view is the most commonly identified technical factor in bile duct injuries during laparoscopic cholecystectomy
- B. Bile duct injury is a recognized complication of laparoscopic cholecystectomy that cannot constitute malpractice in any context
- C. The patient should have elected open cholecystectomy rather than the laparoscopic approach to eliminate the bile duct injury risk
- D. The preoperative imaging should have identified difficult biliary anatomy and alerted the surgeon to increased injury risk

116. An LNC is analyzing a long-term care case in which a nursing home resident with documented recurrent urinary tract infections and an indwelling urinary catheter developed urosepsis and died. The catheter had been in place for 13 months. The original indication for catheter placement was post-surgical urinary retention from a procedure performed 15 months prior. The surgical recovery period was approximately six weeks. After the recovery period, no documented reassessment of catheter necessity was performed, and the catheter remained in place for an additional 12 months without documented clinical justification. What standard of care violation should the LNC identify?

- A. The urologist should have been consulted to evaluate the continued need for the indwelling catheter after the recovery period
- B. The attending physician should have prescribed prophylactic antibiotics to prevent catheter-associated urinary tract infections
- C. The indwelling catheter remained 12 months beyond the original clinical indication without documented reassessment of necessity — evidence-based catheter management standards require daily reassessment and prompt removal when the indication no longer exists, and the prolonged unnecessary catheterization directly increased the risk of the catheter-associated infection that progressed to fatal urosepsis
- D. The nursing staff should have independently removed the catheter when the surgical recovery period was clearly completed

117. An LNC is reviewing a medical malpractice case involving a patient who received an overdose of a chemotherapy drug. The oncologist intended to prescribe cyclophosphamide at a dose of 750 mg/m<sup>2</sup> but accidentally wrote the order as 750 mg/kg — a dosing error that resulted in approximately a threefold overdose based on the patient's weight and body surface area. The pharmacist verified the order without recognizing the unit error (mg/kg instead of mg/m<sup>2</sup>). The nurse administered the medication as dispensed. The patient developed severe pancytopenia, sepsis, and multi-organ failure requiring ICU admission. What multi-provider error analysis should the LNC perform?

- A. The oncologist committed the prescribing error, but the pharmacist — who has specific expertise in dose verification and should have recognized that the mg/kg dosing resulted in a dose far exceeding the standard mg/m<sup>2</sup> protocol — bears significant responsibility for the failure to catch the error
- B. The oncologist committed the prescribing error by writing the wrong unit — mg/kg instead of mg/m<sup>2</sup> — and both the pharmacist (who should have recognized the non-standard dosing unit for this drug) and the nurse (who should have questioned the unusually large dose) failed to catch the error before administration, creating a three-layer safety barrier failure
- C. The nurse bears sole responsibility because nurses are the last safety check before medication reaches the patient
- D. The pharmacy computer system should have automatically flagged the dosing unit error and prevented the order from processing

118. An LNC is evaluating a personal injury case involving a 52-year-old commercial truck driver who sustained a right shoulder rotator cuff tear and a mild traumatic brain injury when his vehicle was struck by a car that ran a red light. Despite successful surgical repair of the rotator cuff and resolution of most TBI symptoms, the plaintiff has residual right shoulder overhead reach limitation, chronic shoulder pain with weather changes, and persistent mild cognitive symptoms (slowed processing speed, concentration

difficulty). The plaintiff held a Class A commercial driver's license and drove long-haul routes. The defense argues the plaintiff can return to local delivery driving. What should the LNC evaluate?

- A. The plaintiff's pre-injury driving record should be the sole factor in determining his ability to return to commercial driving
- B. The plaintiff's BMI should be evaluated as a factor that contributed to the severity of the shoulder injury in the accident
- C. The plaintiff should attempt local delivery driving before claiming permanent disability from commercial trucking employment
- D. Whether the combination of residual shoulder impairment (limiting overhead loading and unloading) and persistent cognitive symptoms (slowed processing speed, concentration difficulty) are compatible with any commercial driving — long-haul and local delivery driving both require sustained concentration, defensive driving judgment, and physical loading/unloading tasks that the plaintiff's documented deficits may preclude

119. An LNC is analyzing a medical malpractice case involving a 33-year-old woman who presented to the emergency department with acute onset of unilateral leg swelling, calf pain, and warmth. The patient was six weeks postpartum and had delivered via cesarean section. The emergency physician obtained a D-dimer test, which was elevated at 3,200 ng/mL (normal <500 ng/mL). Despite the significantly elevated D-dimer and the high-risk clinical presentation, the physician did not order a lower extremity duplex ultrasound or CT venography. The physician diagnosed "postpartum edema" and discharged the patient. Four days later, the patient presented in respiratory arrest from a massive pulmonary embolism and died. What clinical factors should have prevented the misdiagnosis?

- A. The combination of unilateral leg swelling and calf pain in a patient six weeks postpartum from a cesarean section — with three VTE risk factors (postpartum state, recent surgery, and immobility) plus a significantly elevated D-dimer — demanded definitive imaging for DVT, and diagnosing "postpartum edema" without duplex ultrasound in this clinical context constitutes a critical diagnostic failure
- B. The D-dimer level was only mildly elevated and should not have prompted additional diagnostic evaluation for DVT
- C. The emergency physician should have consulted a vascular surgeon before ordering any diagnostic imaging for the leg swelling
- D. The patient's obstetrician should have prescribed VTE prophylaxis at discharge and the failure to do so is the sole cause of death

120. An LNC is reviewing a risk management case involving a hospital that has experienced a series of medication administration errors related to insulin. Over a four-month period, six insulin-related errors occurred: two involved administration of rapid-acting insulin instead of the prescribed long-acting formulation, two involved tenfold dosing errors, one involved insulin administered to a non-diabetic patient, and one involved failure to hold insulin when the patient's blood glucose was 48 mg/dL. The hospital has not implemented a standardized insulin management protocol, does not use a dedicated insulin ordering template in the CPOE system, and does not require independent double-check verification for insulin doses. What risk management conclusion should the LNC draw?

- A. Insulin errors are expected in any hospital setting and six events over four months does not indicate a systemic problem
- B. The endocrinology department should manage all insulin orders throughout the hospital to prevent nursing medication errors
- C. The six insulin-related errors across multiple error types (wrong formulation, wrong dose, wrong patient, failure to hold) indicate a systemic deficit in the hospital's insulin safety practices — the absence of a standardized protocol, dedicated ordering template, and independent double-check verification creates a risk environment in which insulin errors are predictable, and comprehensive insulin safety measures addressing ordering, dispensing, and administration are required
- D. The individual nurses who committed the errors should complete insulin competency assessments before returning to clinical duty

121. An LNC is analyzing a medical malpractice case involving a delayed diagnosis of appendicitis in a 7-year-old child. The child was brought to the emergency department with periumbilical pain, nausea, and one episode of vomiting. The emergency physician documented "viral gastroenteritis" and discharged the child with antiemetics and clear liquid diet instructions. The physician did not obtain any laboratory studies or imaging. Thirty-six hours later, the child returned with a rigid abdomen, rebound tenderness, and a temperature of 103.2°F. A CT scan revealed a perforated appendix with peritonitis. The child required emergency appendectomy, peritoneal lavage, and a 10-day hospitalization for IV antibiotics. Published guidelines recommend that abdominal pain in children be evaluated with a high index of suspicion for surgical conditions, and appendicitis should remain on the differential in any child with acute abdominal pain until definitively excluded. What should the LNC evaluate?

- A. The emergency physician's diagnosis of viral gastroenteritis was appropriate because it is the most common cause of pediatric abdominal pain
- B. The physician should have consulted a pediatric surgeon before performing any diagnostic evaluation on the child

C. The child's parents should have returned to the ED sooner when the child's symptoms did not improve within 12 hours of discharge

D. Whether the emergency physician's failure to consider appendicitis in the differential diagnosis for a child with acute abdominal pain — and the failure to obtain basic laboratory studies (white blood cell count) or imaging that would have supported or excluded appendicitis — deviated from the diagnostic standard of care for pediatric abdominal pain evaluation

122. An LNC is evaluating a workers' compensation case involving a 46-year-old registered nurse who developed thoracic outlet syndrome (TOS) after five years of repetitive overhead reaching to access medication supplies stored on high shelves, operating overhead IV pump controls, and performing chest compressions during cardiac arrests. The employer's IME physician concluded the TOS is caused by the nurse's "anatomical predisposition — a cervical rib identified on imaging" and is unrelated to work. The LNC reviews the nurse's pre-employment physical, which documented no upper extremity symptoms despite the cervical rib being present (but undiagnosed) at that time. What should the LNC evaluate?

A. The cervical rib finding proves the TOS is entirely anatomical and cannot have been caused by occupational activities

B. Whether the occupational activities (repetitive overhead reaching, overhead arm positioning for IV pumps, forceful chest compressions) created the biomechanical stress that converted the asymptomatic anatomical predisposition (cervical rib) into symptomatic TOS — the cervical rib was present and asymptomatic during the pre-employment physical, and the development of symptoms during the period of occupational exposure suggests the work activities provoked the condition

C. The nurse should undergo surgical resection of the cervical rib before the causation analysis can be completed

D. The nurse's recreational activities should be investigated as the primary trigger for the symptomatic thoracic outlet syndrome

123. An LNC is reviewing a medical malpractice case involving a 70-year-old patient who underwent a right total knee replacement. The preoperative plan specified the right knee. The surgeon marked the right knee with initials preoperatively. However, during the time-out procedure in the operating room, the team did not verify the marked site against the operative consent and the surgical schedule. The surgeon then draped, prepared, and operated on the left knee. The error was discovered in the post-anesthesia care unit when the patient noticed the incision was on the wrong side. A second surgery on the correct (right) knee was performed five days later. What is the primary failure in the universal protocol?

- A. The time-out failed to include verification of the surgical site marking against the consent form and operative schedule — conducting a time-out without meaningful site verification defeats the safety purpose of the protocol, and the wrong-site surgery demonstrates that performing the time-out as a procedural formality without actual verification provides false reassurance rather than genuine safety protection
- B. The preoperative nurse should have verified the surgical site independently before the patient entered the operating room
- C. The patient should have confirmed the correct surgical site verbally before the induction of anesthesia in the operating room
- D. The surgeon fulfilled all preoperative obligations by marking the correct knee and the time-out team is solely responsible

124. An LNC is evaluating a pharmaceutical product liability case involving a patient who developed drug-induced lupus erythematosus (DILE) after long-term treatment with procainamide, an antiarrhythmic medication. Drug-induced lupus is a well-documented adverse effect of procainamide, occurring in approximately 20% of patients on long-term therapy. The prescribing physician did not monitor for anti-nuclear antibody (ANA) development during the treatment period despite published guidelines recommending periodic ANA testing. The patient developed joint pain, serositis, and renal involvement. The diagnosis was delayed because the prescribing cardiologist attributed the joint pain and malaise to "aging" rather than considering drug-induced lupus. What should the LNC evaluate?

- A. The manufacturer's labeling adequately warned about the lupus risk and the manufacturer has no liability in this case
- B. The pharmacist should have independently monitored ANA levels without physician orders during the procainamide therapy
- C. The prescribing physician committed two independent failures: failure to monitor for a known dose-related adverse effect (ANA development during long-term procainamide therapy as recommended by prescribing guidelines), and failure to recognize the symptoms when they appeared (attributing lupus symptoms to "aging") — both are physician-level breaches independent of product labeling adequacy
- D. The patient should have independently researched procainamide's adverse effects and requested periodic ANA blood testing

125. An LNC is analyzing a long-term care case in which a nursing home resident with documented bilateral lower extremity contractures and complete bed dependence developed bilateral trochanteric pressure ulcers. The resident's Braden Scale score was 10 (very high risk). The care plan specified repositioning every two hours and a specialty pressure-redistributing mattress. The LNC reviews the documentation and finds: repositioning was documented only every 4–6 hours (not every 2 hours as

care-planned), the specialty mattress was not ordered until three weeks after admission despite the care plan specification, and no nutritional supplementation was initiated despite a serum albumin of 1.8 g/dL. What does this evidence demonstrate?

- A. The resident's bilateral contractures and immobility made pressure ulcers unavoidable regardless of any preventive interventions
- B. The attending physician bears sole responsibility for the pressure ulcers because the physician should have ordered the mattress sooner
- C. The nursing staff fulfilled their obligations by documenting repositioning, even if at reduced frequency compared to the care plan
- D. The facility identified the very high pressure ulcer risk (Braden 10), developed a care plan with appropriate interventions, but failed to implement them — repositioning at 4–6 hours instead of the care-planned 2 hours, a three-week delay in providing the ordered specialty mattress, and no nutritional intervention despite critically low albumin collectively demonstrate a pattern of planning without execution

126. An LNC is reviewing a medical malpractice case involving a patient who underwent a cervical laminectomy and developed a postoperative spinal epidural hematoma causing progressive quadriplegia. The patient was taking aspirin 81 mg daily for cardiovascular prophylaxis. The surgeon's preoperative orders did not include aspirin discontinuation. Current surgical guidelines recommend discontinuing aspirin 7–10 days before elective cervical spine surgery to reduce postoperative bleeding risk. The patient developed progressive bilateral upper and lower extremity weakness six hours after surgery. An emergent MRI confirmed a cervical epidural hematoma compressing the spinal cord. Emergency decompression was performed, but the patient has residual bilateral hand weakness and spasticity. What should the LNC evaluate?

- A. Aspirin 81 mg daily is a low dose that does not significantly affect bleeding risk during or after spinal surgery procedures
- B. The surgeon's failure to discontinue aspirin before elective cervical spine surgery — when guidelines recommend cessation 7–10 days preoperatively to reduce postoperative bleeding — deviates from the standard of care, and the continued aspirin use is a modifiable risk factor that likely contributed to the postoperative epidural hematoma
- C. The anesthesiologist should have independently verified the patient's medication list and held the aspirin before surgery
- D. The patient should have stopped taking the aspirin independently before presenting for elective cervical spine surgery

127. An LNC is evaluating a healthcare fraud case involving a physician-owned outpatient surgery center. A Medicare audit reveals that the center performs a high volume of spinal epidural steroid injections, with each patient receiving bilateral injections at three levels at every visit. Independent medical review of 75 patient charts found that the multi-level, bilateral injection pattern was clinically justified in only 15% of cases — the remaining 85% of patients had single-level pathology that did not warrant bilateral multi-level injections. The physicians who own the center receive facility fees from the center in addition to their professional fees. What regulatory concerns does this pattern raise?

- A. The performance of multi-level bilateral injections when clinical documentation supports only single-level pathology in 85% of cases — combined with the physicians' financial interest in the facility — raises concerns about medically unnecessary procedures driven by revenue generation, potentially implicating the False Claims Act, the Stark Law (self-referral to an owned facility), and the Anti-Kickback Statute
- B. The multi-level bilateral injection approach represents a conservative treatment philosophy and does not indicate overutilization
- C. The physicians' ownership interest in the surgery center is permissible and has no bearing on the appropriateness of treatment
- D. The independent medical review methodology was flawed and the 85% non-justification rate does not reflect clinical reality

128. An LNC is analyzing a medical malpractice case involving a patient who underwent an outpatient arthroscopic knee surgery under general anesthesia. The patient was discharged from the surgery center with an Aldrete score of 8 (the facility's minimum discharge threshold is 9). The patient's companion drove the patient home. Approximately 45 minutes after arriving home, the patient became unresponsive and was found in respiratory arrest. The patient was resuscitated by emergency medical services but sustained a severe hypoxic brain injury. What should the LNC evaluate?

- A. The companion who drove the patient home should have been trained in basic airway management techniques before discharge
- B. The anesthesiologist should have used a regional anesthetic technique rather than general anesthesia for the outpatient procedure
- C. The patient was discharged with an Aldrete score below the facility's own discharge threshold — an objective, documented deviation from discharge criteria indicating the patient had not adequately recovered from anesthesia, and the respiratory arrest was a foreseeable consequence of premature discharge before sufficient recovery
- D. The surgery center should have a policy requiring all patients to remain for a minimum of three hours after general anesthesia

129. An LNC is reviewing a personal injury case involving a 40-year-old woman who sustained a traumatic brain injury in a motor vehicle accident. The plaintiff has documented executive function deficits, impaired short-term memory, and behavioral dysregulation (impulsivity, irritability, emotional lability). The plaintiff has two school-age children. A neuropsychologist has documented that the cognitive and behavioral deficits impair the plaintiff's capacity for child supervision, consistent discipline, meal planning, homework assistance, and emergency decision-making. The defense argues parenting deficits are not compensable in a personal injury action. What should the LNC evaluate?

- A. The parenting deficit claim should be evaluated solely through a family court parenting evaluation rather than neuropsychological testing
- B. The children's academic performance should be the only measure of whether the plaintiff's parenting has been actually impaired
- C. Only the cost of tutoring for the children should be included in the damages analysis to address the homework assistance deficit
- D. The documented impairment of the plaintiff's parenting capacity constitutes both a non-economic damage (loss of the ability to fulfill a fundamental life role) and an economic damage (cost of supplemental childcare and supervisory assistance), and the neuropsychological documentation provides the clinical basis for quantifying both dimensions

130. An LNC is evaluating a medical malpractice case involving a patient who developed a wound dehiscence after a midline laparotomy. The patient had four documented risk factors for wound complications: morbid obesity (BMI 46), poorly controlled diabetes (A1c 10.4%), chronic corticosteroid use for COPD, and severe malnutrition (albumin 1.9 g/dL). The surgeon performed a standard layered closure without prophylactic retention sutures, without subcutaneous drainage, and without preoperative nutritional optimization. Published guidelines recommend enhanced closure techniques (retention sutures, subcutaneous drainage) and preoperative risk factor modification for patients with multiple wound healing risk factors. What should the LNC evaluate?

- A. Wound dehiscence is a recognized complication of midline laparotomy and the surgeon cannot be held liable for a known risk
- B. Whether the surgeon's failure to implement prophylactic measures — retention sutures, subcutaneous drainage, and nutritional optimization — in a patient with four significant wound healing risk factors deviated from published guidelines recommending enhanced closure and preoperative risk factor modification for high-risk patients
- C. The patient bears sole responsibility for the dehiscence because the patient failed to optimize nutrition and diabetes before surgery

D. The primary care physician who manages the diabetes and COPD should be named as a co-defendant for the poor disease control

131. An LNC is analyzing a risk management case involving a hospital that uses temporary (agency) nursing staff to supplement its permanent workforce. Adverse event data over a six-month period shows agency nurses were involved in 12 medication errors compared to 3 for permanent staff on the same units during the same period — a fourfold higher error rate. Investigation reveals the hospital's agency nurse orientation consists of a 20-minute facility tour and a signed acknowledgment form. No unit-specific orientation, medication system training, or competency verification is performed before agency nurses begin providing patient care. What should the LNC conclude?

A. The agency nursing company bears sole liability for the errors because the company certifies its nurses as clinically competent

B. The individual agency nurses should be permanently barred from working at the facility due to their elevated error rate

C. The disproportionate error rate among agency nurses suggests the hospital's orientation process is inadequate — a 20-minute tour without unit-specific orientation, medication system training, or competency verification does not equip agency staff with the facility-specific knowledge needed for safe medication administration, and the hospital should implement a more rigorous orientation and competency verification process

D. The fourfold error rate differential is within the expected range for agency nursing staff and does not indicate a systemic issue

132. An LNC is reviewing a medical malpractice case involving a 58-year-old patient who underwent a total thyroidectomy for a multinodular goiter. Postoperatively, the patient developed signs of hypocalcemia — perioral numbness, tingling in the fingers, and muscle cramping — beginning at 6:00 PM. The nurse documented these findings but did not obtain a serum calcium level or notify the surgeon. At 2:00 AM (eight hours later), the patient developed laryngospasm and a seizure. The serum calcium obtained at that time was 5.2 mg/dL (critically low; normal 8.5–10.5 mg/dL). What is the nursing standard of care failure?

A. Perioral numbness, finger tingling, and muscle cramping after thyroidectomy are classic early signs of hypocalcemia — a recognized and potentially life-threatening post-thyroidectomy complication requiring immediate serum calcium measurement and physician notification, and the eight-hour delay in obtaining the lab and notifying the surgeon allowed a treatable electrolyte emergency to progress to laryngospasm and seizure

- B. The surgeon should have ordered routine prophylactic calcium supplementation for all patients after total thyroidectomy
- C. The patient should have reported the tingling and cramping more urgently to the nursing staff during the evening shift
- D. The endocrinology service should have been automatically consulted for calcium management in all thyroidectomy patients

133. An LNC is evaluating a toxic tort case involving workers at an asbestos brake manufacturing facility who were exposed to chrysotile asbestos fibers during brake pad production over periods of 15–30 years. Several workers have been diagnosed with malignant mesothelioma. Asbestos is classified by IARC as a Group 1 carcinogen with established carcinogenicity for mesothelioma. The defense argues that chrysotile asbestos is less potent than amphibole forms (crocidolite, amosite) and is insufficient to cause mesothelioma. What should the LNC evaluate?

- A. The defense argument should be accepted because chrysotile is the least potent form of asbestos for mesothelioma causation
- B. All forms of asbestos should be considered equally carcinogenic and no differentiation between fiber types is appropriate
- C. The workers should undergo lung biopsy with fiber type analysis before any causation determination can be made
- D. While chrysotile may be less potent than amphibole forms, the IARC Group 1 classification applies to all forms of asbestos including chrysotile — the scientific consensus recognizes that chrysotile can cause mesothelioma, particularly at the sustained high-level exposures documented in brake manufacturing, and the relative potency debate does not negate chrysotile's established carcinogenicity

134. An LNC is analyzing a life care plan for a 30-year-old man who sustained a complete C4 spinal cord injury requiring mechanical ventilation via tracheostomy. The plan projects 24-hour attendant care with trained respiratory caregivers, primary and backup ventilators, ventilator circuits and supplies, humidification equipment, suctioning equipment, pulse oximetry and capnography monitoring, tracheostomy supplies, respiratory therapy visits, and pulmonologist follow-up. The defense argues the attendant care cost can be reduced by using family members as primary caregivers. What is the most appropriate response?

- A. The life care plan should project family caregiving for the first five years and then transition to professional attendant care

B. The life care plan must project the full cost of professional attendant care regardless of family caregiving — the plan reflects the plaintiff's actual care needs independent of the family's current ability and willingness to provide care, because family members may become unable or unwilling to continue due to their own aging, health changes, burnout, or personal circumstances, and a ventilator-dependent patient's care requires trained respiratory caregivers, not family members without formal training

C. The family should be evaluated for their willingness and ability to provide care before the plan is finalized with professional costs

D. The defense argument should be accepted because family caregiving is a common and accepted alternative to professional care

135. An LNC is reviewing a medical malpractice case involving a patient who underwent a diagnostic cardiac catheterization and developed a retroperitoneal hematoma. Following the femoral artery access procedure, the patient complained of increasing groin and back pain over a three-hour period. The patient's heart rate increased from 72 to 128 bpm, and the hemoglobin dropped from 14.0 to 9.2 g/dL. The nurse documented these vital sign changes and the hemoglobin decline but attributed the pain to "expected post-procedure discomfort" and the tachycardia to "anxiety." The physician was not notified for three hours. By the time the physician was contacted, the patient was hypotensive (BP 78/42) and a CT scan confirmed a large retroperitoneal hematoma. What nursing assessment failure should the LNC identify?

A. The nurse should have applied additional manual compression to the femoral access site to prevent further bleeding at the site

B. The cardiologist who performed the catheterization should have remained at the bedside until all vital signs had stabilized

C. Progressive tachycardia (72 to 128), declining hemoglobin (14.0 to 9.2), and increasing pain after femoral artery catheterization constitute a clinical picture of active hemorrhage — attributing these trending changes to "post-procedure discomfort" and "anxiety" without recognizing them as warning signs and notifying the physician represents a critical assessment and communication failure

D. The femoral artery closure device manufacturer should be investigated for a device malfunction causing inadequate hemostasis

136. An LNC is evaluating a personal injury case involving a 48-year-old woman who sustained a complex distal radius fracture (intra-articular, comminuted) when she fell on an icy sidewalk at a commercial property. Despite surgical fixation with plate and screws, the plaintiff developed post-traumatic arthritis of the right wrist with chronic pain, limited range of motion, and a 40% reduction in grip strength. The plaintiff was a dental hygienist whose occupation requires sustained pinch grip for instrument manipulation, repetitive wrist flexion-extension during scaling procedures, and fine motor

dexterity for calculus removal. The defense argues the plaintiff can perform dental hygiene with ergonomic modifications. What should the LNC evaluate?

- A. The clinical documentation of residual wrist impairments — chronic pain, limited range of motion, and 40% grip strength reduction — and their specific impact on the physical demands of dental hygiene (sustained pinch grip, repetitive wrist motion, fine motor dexterity) should determine whether the plaintiff can perform her pre-injury occupation, rather than accepting the defense's assumption that ergonomic modifications can overcome a 40% grip strength deficit and chronic pain during sustained hand-intensive work
- B. The plaintiff should undergo a work hardening program before claiming inability to return to dental hygiene practice
- C. The plaintiff's dental hygiene license should be verified as current before calculating any lost earning capacity damages
- D. The defense argument should be accepted because modern ergonomic tools have eliminated most physical demands of dental hygiene

137. An LNC is analyzing a medical malpractice case involving a patient who developed a surgical site infection (SSI) following a spinal fusion procedure. The patient's preoperative hemoglobin A1c was 9.6% (poorly controlled diabetes). Published spine surgery guidelines recommend glycemic optimization (A1c below 8%) before elective spinal procedures. The surgeon did not delay the procedure or implement perioperative glucose management. The infection required surgical debridement, hardware removal, and six weeks of IV antibiotics. What should the LNC evaluate?

- A. The patient's diabetes makes SSI an inevitable complication regardless of any preoperative glycemic optimization efforts
- B. The surgeon should have referred the patient to an endocrinologist before scheduling any surgical procedure for the spine
- C. The patient bears sole responsibility because the patient should have independently optimized diabetes control before surgery
- D. Whether the surgeon's decision to proceed with elective spinal surgery without glycemic optimization — when guidelines recommend A1c below 8% before elective procedures — deviated from the preoperative standard of care, and whether optimization would have reduced the foreseeable SSI risk

138. An LNC is reviewing a workers' compensation case involving a 50-year-old highway maintenance worker who developed chronic low back pain after 18 years of operating heavy vibrating equipment (jackhammers, plate compactors, vibratory rollers). The worker's pre-employment physical at age 32

documented no back complaints. MRI shows multilevel degenerative disc disease with disc herniations at L4-L5 and L5-S1. The employer's IME physician concluded the findings are "age-related degeneration" unrelated to work. The LNC reviews the published literature on whole-body vibration (WBV) and lumbar spine disease. What should the LNC evaluate?

- A. The IME physician's conclusion should be accepted because degenerative disc disease is common in the general population at age 50
- B. Whether the worker's 18-year exposure to whole-body vibration from heavy equipment operation is consistent with the occupational risk factors for lumbar disc disease identified in the published WBV literature — whole-body vibration is a well-established occupational risk factor for lumbar disc degeneration and herniation, and the normal pre-employment physical at age 32 combined with the development of multilevel disease during the exposure period supports occupational contribution
- C. The worker's recreational activities should be investigated as the primary cause of the lumbar disc disease before work is considered
- D. The worker should undergo a functional capacity evaluation before any causation analysis can be performed by the LNC

139. An LNC is evaluating a medical malpractice case involving a patient who underwent a gastric sleeve procedure (vertical sleeve gastrectomy) and developed a staple line leak on postoperative day four. The patient presented with tachycardia (heart rate 130), left shoulder pain (Kehr's sign), and fever (101.6°F). The bariatric surgeon ordered an upper GI series with water-soluble contrast, which was reported as negative for leak. Despite the negative study, the patient's clinical signs persisted and worsened over the next 24 hours — progressive tachycardia, increasing white blood cell count, and new-onset tachypnea. The surgeon attributed the continued symptoms to "post-surgical stress response." A CT scan obtained 48 hours later confirmed a contained staple line leak with a peri-gastric fluid collection. What clinical principle should the LNC apply?

- A. The negative upper GI series conclusively excludes a staple line leak and the surgeon appropriately relied on the imaging result
- B. The surgeon should have immediately performed an exploratory laparotomy rather than ordering any imaging studies at all
- C. A negative contrast study does not definitively exclude a staple line leak — upper GI series sensitivity for bariatric staple line leaks is imperfect, and persistent concerning clinical signs (tachycardia, fever, rising WBC, Kehr's sign) after bariatric surgery require further investigation with CT even when the initial contrast study is negative
- D. The patient's obesity made the CT scan unreliable and an MRI should have been ordered instead of the CT for leak evaluation

140. An LNC is analyzing a case involving an LNC who is retained as a consulting expert by a defense attorney. After thorough medical record review, the LNC concludes that the defendant physician deviated from the standard of care in three specific areas and that the deviations likely contributed to the patient's injuries. The defense attorney is disappointed and instructs the LNC to "focus only on the positive aspects of the care" in the written report. What is the LNC's professional obligation?

- A. The LNC must communicate the findings honestly — the ethical obligation to objectivity requires reporting all clinically significant findings regardless of which side retained the LNC, and the LNC should explain that omitting unfavorable findings violates professional ethics and would ultimately disserve the attorney's ability to make informed case management decisions
- B. The LNC should comply with the attorney's instruction because the attorney is the client and directs the scope of the analysis
- C. The LNC should provide two separate reports — one with all findings and one with only the favorable findings for the attorney
- D. The LNC should withdraw from the engagement without providing any report to avoid the conflict with the attorney's request

141. An LNC is reviewing a medical malpractice case involving a 55-year-old patient who underwent a screening mammogram interpreted as BI-RADS 1 (negative). The radiologist's report noted "extremely dense breast tissue" but did not recommend supplemental screening or inform the patient about the breast density finding and its impact on mammographic sensitivity. The patient's state has enacted a breast density notification law requiring patient notification about dense tissue and discussion of supplemental screening options. Fourteen months later, the patient was diagnosed with Stage IIIA breast cancer that was not visible on the screening mammogram due to the masking effect of the dense tissue. What should the LNC evaluate?

- A. The mammographic interpretation as BI-RADS 1 was technically correct and the radiologist met all professional obligations
- B. Whether the radiologist's failure to notify the patient about the extremely dense breast tissue — in violation of the applicable state breast density notification law — and failure to recommend supplemental screening deprived the patient of the opportunity for earlier cancer detection through additional screening modalities (ultrasound, MRI) that have higher sensitivity in dense breast tissue
- C. The patient should have independently researched breast density and requested supplemental screening from a different provider
- D. Dense breast tissue is a normal anatomical variant that requires no special notification or additional screening recommendations

142. An LNC is evaluating a long-term care case in which a 90-year-old nursing home resident with end-stage Alzheimer's dementia and a documented advance directive specifying "comfort measures only" was transferred to the hospital when the nursing staff detected an irregular heart rhythm on a routine vital sign check. At the hospital, the resident was started on IV heparin, underwent cardiac catheterization, and had a coronary stent placed. The resident's advance directive was not sent with the transfer documentation and was not available to the hospital care team. The resident developed a groin hematoma from the catheterization site and died two weeks later from complications of the procedure. What is the most critical finding?

- A. The hospital should have verified advance directive status before performing invasive procedures on a 90-year-old patient
- B. The attending physician at the nursing home should have been present to prevent the inappropriate transfer decision
- C. The resident's family members should have been contacted before the transfer to verify the advance directive preferences
- D. The nursing home failed to transmit the advance directive with the transfer documentation — depriving the hospital of critical information about the resident's wishes and resulting in invasive procedures that violated the documented comfort-measures-only directive, and the facility's transfer process failed to ensure that advance directive documentation accompanied the resident

143. An LNC is analyzing a product liability case involving a patient who received a defective artificial disc implant in the lumbar spine. The device migrated posteriorly six months after implantation, compressing the spinal canal and producing cauda equina syndrome with bilateral lower extremity weakness and bowel/bladder dysfunction. The manufacturer's post-market surveillance data shows a posterior migration rate of 3.8% for this device — significantly higher than the <0.5% rate for comparable devices. The manufacturer had not updated its product labeling or issued a safety communication despite knowing about the elevated migration rate. What product liability theories apply?

- A. The surgeon who selected this particular device should have chosen a different manufacturer's implant based on clinical data
- B. The patient assumed the risk of device migration by consenting to the artificial disc replacement procedure in the first place
- C. Design defect (the elevated migration rate across the product line suggests an inherent problem with the device's fixation mechanism) and failure to warn (the manufacturer's knowledge of the elevated rate without updating labeling or issuing a safety communication deprived surgeons and patients of information material to their treatment decisions)

D. Manufacturing defect, because only the plaintiff's individual device migrated while all other devices functioned as designed

144. An LNC is reviewing a medical malpractice case involving a patient who underwent an elective hernia repair. The patient had a documented history of obstructive sleep apnea (OSA) treated with home CPAP at 14 cm H<sub>2</sub>O pressure. Postoperatively, the surgeon prescribed opioid analgesia (morphine PCA) but did not order CPAP continuation, continuous pulse oximetry, or enhanced respiratory monitoring despite the documented OSA. On the first postoperative night, the patient was found unresponsive with oxygen saturation of 52%. Resuscitation was successful but the patient sustained severe hypoxic brain injury. Current perioperative guidelines identify OSA patients receiving opioids as high-risk for respiratory depression requiring CPAP continuation, enhanced monitoring, and opioid-sparing strategies. What represents the most comprehensive standard of care violation?

A. The convergence of three standard of care failures — no CPAP continuation for a known OSA patient, no continuous pulse oximetry during opioid PCA administration, and no consideration of opioid-sparing analgesic strategies — created a foreseeable respiratory catastrophe, as guidelines specifically identify OSA patients receiving opioids as requiring all three safeguards

B. The anesthesiologist should have refused to provide anesthesia for any patient with documented obstructive sleep apnea

C. The nursing staff should have independently applied the home CPAP device without a physician order based on the medical history

D. The patient should have brought the home CPAP machine to the hospital and applied it independently during the postoperative period

145. An LNC is evaluating a workers' compensation case involving a 38-year-old physical therapist who developed bilateral lateral epicondylitis (tennis elbow) after six years of performing manual therapy techniques — including deep tissue mobilization, joint manipulation, and therapeutic exercise instruction — for eight hours per day, five days per week. The employer's IME physician concluded the epicondylitis is unrelated to work because "lateral epicondylitis is extremely common in the general population." The LNC reviews the occupational health literature and finds that healthcare workers performing repetitive forceful gripping and wrist extension have a significantly elevated risk of lateral epicondylitis. What is the fundamental flaw in the IME physician's reasoning?

A. The IME physician should have ordered EMG/NCV testing to confirm the epicondylitis diagnosis before opining on causation

B. The population prevalence of a condition does not determine its etiology in an individual — the fact that lateral epicondylitis is common in the general population does not prove this therapist's condition is

unrelated to six years of daily repetitive forceful gripping and wrist extension, particularly when the published literature identifies these exact occupational demands as risk factors

C. The physical therapist's recreational tennis playing should be investigated as the primary cause of the bilateral epicondylitis

D. The bilateral nature of the epicondylitis proves it is a constitutional condition rather than an occupational injury

146. An LNC is reviewing a medical malpractice case involving a patient who underwent bariatric surgery (Roux-en-Y gastric bypass) and developed iron deficiency anemia that went undiagnosed for two years postoperatively. The patient presented with progressive fatigue, exercise intolerance, and eventually pica (craving non-food items). Laboratory testing confirmed severe iron deficiency anemia with a hemoglobin of 6.8 g/dL. The standard of care after Roux-en-Y gastric bypass requires lifelong monitoring of nutritional parameters including iron levels because the bypass alters iron absorption. The surgeon's follow-up records show no iron studies were ever ordered during the two-year postoperative period. What should the LNC evaluate?

A. The patient should have independently supplemented with iron after learning about nutritional risks of gastric bypass surgery

B. The primary care physician should have assumed responsibility for nutritional monitoring from the bariatric surgeon postoperatively

C. Iron deficiency anemia following gastric bypass is a minor condition that does not require monitoring or early intervention

D. The failure to monitor iron levels during two years of post-bariatric surgery follow-up — when guidelines require lifelong nutritional monitoring — allowed a predictable and preventable deficiency to progress to severe symptomatic anemia that required emergency blood transfusion and could have been prevented with routine monitoring and prophylactic supplementation

147. An LNC is analyzing a personal injury case involving a 35-year-old woman who sustained bilateral wrist fractures when she fell through a collapsed floor section at a commercial building. Both wrists required surgical fixation. Despite successful surgery, the plaintiff has residual bilateral wrist stiffness, reduced grip strength, chronic pain, and limited fine motor dexterity. The plaintiff was a concert pianist who had been performing professionally for 15 years. The bilateral wrist impairments prevent her from performing at the concert level. The defense argues the plaintiff can transition to music teaching and composition. What is the most important damages consideration?

- A. The plaintiff's concert performance income should be discounted because pianist income is inherently unpredictable
- B. The plaintiff should attempt to perform with modified repertoire before claiming permanent inability to perform at the concert level
- C. The permanent bilateral wrist impairments eliminate the fine motor precision, sustained hand endurance, and dynamic range required for concert-level piano performance — a specialized skill developed over 15 years that cannot be replicated through teaching or composition, which require fundamentally different skills, provide fundamentally different compensation, and do not substitute for the loss of artistic performance and professional identity
- D. The plaintiff's age of 35 suggests she has many productive years remaining and should retrain for an alternative career

148. An LNC is evaluating a risk management case involving a hospital where a patient with a known drug allergy experienced an adverse drug reaction. The patient's allergy to penicillin (documented anaphylaxis) was recorded in the electronic health record and on the patient's allergy wristband. The physician ordered amoxicillin (a penicillin-class antibiotic) through the computerized provider order entry system. The CPOE system generated an allergy alert, which the physician overrode with a notation of "aware — clinically indicated." The pharmacist did not independently review the allergy override. The nurse did not verify the patient's allergy list before administering the amoxicillin. The patient experienced anaphylaxis requiring emergency treatment. How many independent safety barriers failed?

- A. At least three safety barriers failed: the physician overrode the allergy alert without valid clinical justification (amoxicillin has significant cross-reactivity with penicillin in patients with penicillin anaphylaxis), the pharmacist did not independently verify the override appropriateness, and the nurse did not check the allergy list before administration — each barrier was designed to independently prevent this exact event
- B. Only one barrier failed — the physician's allergy alert override was the sole cause of the adverse drug reaction
- C. Only two barriers failed — the physician's override and the nurse's failure to check allergies before medication administration
- D. No barriers failed because the physician documented "clinically indicated" when overriding the alert system

149. An LNC is reviewing a medical malpractice case involving a 45-year-old patient who presented to the emergency department with acute onset of severe flank pain, hematuria, nausea, and vomiting. A CT scan of the abdomen without contrast was performed and read by the radiologist as "8 mm left ureteral stone with mild left hydronephrosis — no other significant findings." The patient was treated for ureteral

colic and discharged. Seven months later, the patient was diagnosed with a 4.5 cm right renal mass — renal cell carcinoma — that was retrospectively visible on the original CT scan but had not been identified by the radiologist. The cancer had grown and metastasized during the seven-month delay. What should the LNC evaluate?

- A. The radiologist fulfilled all obligations by identifying the ureteral stone that was the reason for the CT scan being ordered
- B. Whether the radiologist's failure to identify the right renal mass on the original CT scan represents a diagnostic error — radiologists have a duty to evaluate all visualized structures on a CT scan, not just the area of clinical concern, and a 4.5 cm renal mass retrospectively visible on the study should have been identified, particularly when renal pathology is within the differential for a patient presenting with flank pain and hematuria
- C. The emergency physician who ordered the CT should have specifically requested that the radiologist evaluate both kidneys
- D. The patient should have requested a follow-up CT scan within three months of the initial study to verify the original reading

150. An LNC is analyzing a Medicare Set-Aside case involving a 69-year-old Medicare beneficiary settling a workers' compensation claim for a cervical spine injury. The claimant requires ongoing pain management. The treating pain specialist has documented a comprehensive pain management plan including prescription medications, cervical medial branch blocks every four months, and periodic radiofrequency ablation when blocks confirm facet-mediated pain. The defense argues the interventional procedures are "elective" and should be excluded from the MSA. What is the correct analysis?

- A. The defense argument should be accepted because interventional pain procedures are elective and not medically necessary
- B. The interventional procedures should be included at a reduced frequency of once per year as a compromise between the positions
- C. Only the prescription medications should be included in the MSA because they represent the minimum necessary treatment
- D. All components of the treating physician's documented pain management plan that are injury-related and Medicare-covered should be included — the physician's clinical recommendation with documented rationale establishes medical necessity for the interventional procedures, and characterizing medically recommended treatments as "elective" to exclude them from the MSA is inconsistent with the MSA's purpose of protecting Medicare's interests

151. An LNC is reviewing a medical malpractice case involving a patient who developed necrotizing fasciitis following a minor skin laceration repair in the emergency department. The patient returned 24 hours later with severe wound pain disproportionate to the wound's appearance, rapidly spreading erythema with dusky discoloration, crepitus on palpation, and systemic signs (fever 103°F, tachycardia to 130, hypotension). The emergency physician diagnosed severe cellulitis, prescribed IV antibiotics, and admitted the patient to the medical floor. A surgical consultation was not obtained for 12 hours, during which the tissue necrosis extended significantly. Emergency fasciotomy and debridement were eventually performed, but the patient required above-elbow amputation due to the extensive tissue destruction. What clinical finding should have prompted a different management approach?

- A. Crepitus — subcutaneous gas formation — combined with pain out of proportion, rapidly spreading erythema with dusky discoloration, and hemodynamic instability constitute a clinical picture that mandates immediate surgical consultation for emergent debridement, not medical floor admission for IV antibiotics alone — necrotizing fasciitis is a surgical emergency where every hour of delay increases tissue loss and mortality risk
- B. The IV antibiotic regimen prescribed was appropriate first-line therapy for necrotizing fasciitis before surgical consultation
- C. The admission to the medical floor was appropriate because the patient needed hemodynamic stabilization before surgical intervention
- D. Necrotizing fasciitis cannot be diagnosed without imaging confirmation and the physician correctly treated the presumed cellulitis

152. An LNC is evaluating a long-term care case involving a nursing home resident who was prescribed warfarin for atrial fibrillation. The INR monitoring schedule specified weekly monitoring during the first month, then every two weeks. The LNC reviews the monitoring records and finds the INR was checked weekly for the first three weeks, then no INR was checked for the next six weeks. During this unmonitored period, the resident developed a gastrointestinal hemorrhage and was found to have an INR of 7.2 (dangerously supratherapeutic). What standard of care issue should the LNC identify?

- A. The physician should have prescribed a direct oral anticoagulant instead of warfarin to eliminate the need for INR monitoring
- B. The pharmacy consultant should have independently flagged the extended monitoring interval as a medication safety concern
- C. The six-week gap in INR monitoring — when the care plan specified monitoring every two weeks after the first month — represents a deviation from the warfarin management standard of care, and the resulting supratherapeutic INR and hemorrhagic complication are foreseeable consequences of unmonitored anticoagulation therapy

D. The resident's family members should have been responsible for ensuring the INR was monitored according to the schedule

153. An LNC is analyzing a medical malpractice case involving a patient who underwent a total hip arthroplasty and developed a sciatic nerve palsy postoperatively. The patient woke from surgery with complete foot drop and numbness in the posterior leg and foot. The operative report documents that significant retraction was required during acetabular preparation and notes "tension on the sciatic nerve observed." The surgeon did not modify the surgical approach after noting nerve tension, did not reposition the extremity to reduce stretch, and did not use nerve monitoring. What should the LNC evaluate?

A. The surgeon should have performed a hip resurfacing procedure instead of a total hip replacement to avoid nerve injury risk

B. Whether the surgeon's failure to respond to observed nerve tension — by repositioning the limb, reducing retraction, or employing nerve monitoring — deviated from the standard of care for sciatic nerve protection during hip arthroplasty, and whether these modifications would have prevented the nerve injury documented by the immediate postoperative deficit

C. The patient should have been warned about sciatic nerve palsy and the signed consent form should resolve the liability claim

D. Sciatic nerve palsy is a recognized complication of total hip arthroplasty that occurs even with perfect surgical technique

154. An LNC is reviewing a healthcare fraud case involving a pain management clinic that performs urine drug screening on all patients at every visit. The clinic uses definitive quantitative testing (liquid chromatography-mass spectrometry) rather than qualitative point-of-care immunoassay screening for the initial test on every patient. Published guidelines recommend qualitative screening as the initial test, with definitive testing reserved for situations where the qualitative screen produces unexpected or clinically significant results requiring confirmation. The definitive testing generates \$600–\$900 per test compared to \$15–\$20 for qualitative screening. What should the LNC evaluate?

A. Definitive testing at every visit is appropriate because it provides more detailed information than qualitative screening methods

B. The clinic should switch to qualitative screening at every other visit rather than changing the initial testing methodology

C. The pharmacy laboratory that performs the testing should be investigated as the primary source of the excessive charges

D. The routine use of expensive definitive testing when qualitative screening would be clinically appropriate as the initial test — combined with the significant revenue differential — is consistent with ordering medically unnecessary testing driven by financial incentive rather than clinical need, potentially implicating the False Claims Act

155. An LNC is evaluating a medical malpractice case involving a 60-year-old patient who underwent an elective lumbar laminectomy. The patient was taking clopidogrel for a drug-eluting coronary stent placed 10 months earlier. The surgeon discontinued the clopidogrel five days before surgery without consulting the patient's cardiologist. Current guidelines recommend a multidisciplinary discussion between the surgeon and cardiologist when discontinuing dual antiplatelet therapy in patients with coronary stents — particularly drug-eluting stents, which have a higher risk of stent thrombosis with premature antiplatelet cessation. The patient experienced an acute myocardial infarction from stent thrombosis on postoperative day two and required emergency cardiac catheterization. What should the LNC evaluate?

A. Whether the surgeon's unilateral decision to discontinue clopidogrel without consulting the cardiologist — for a patient with a drug-eluting coronary stent — deviated from the standard of care requiring multidisciplinary coordination for antiplatelet cessation decisions in patients with coronary stents

B. The cardiologist who placed the stent should have proactively communicated with all of the patient's other physicians

C. The patient should have independently contacted the cardiologist when the surgeon discontinued the clopidogrel before surgery

D. The clopidogrel discontinuation was appropriate because the stent had been in place for 10 months, exceeding the minimum period

156. An LNC is reviewing a personal injury case involving a 42-year-old man who sustained a severe crush injury to his dominant right hand in a hydraulic press accident at a manufacturing plant. Despite multiple surgical procedures including tendon reconstruction, nerve repair, and bone fixation, the plaintiff has permanent loss of grip strength (measured at 12% of normal), absent protective sensation in the median and ulnar nerve distributions, and complex regional pain syndrome. The plaintiff was a master carpenter specializing in custom cabinetry. What should the LNC evaluate for the damages analysis?

A. The plaintiff should undergo a functional capacity evaluation to verify the claimed hand impairments before any damages analysis

B. The plaintiff should be retrained in computer-aided design (CAD) to remain in the woodworking industry at a comparable income

C. The permanent loss of the specific hand functions required for master carpentry — grip strength, protective sensation, and pain-free hand use — combined with the CRPS constitutes both an economic loss (earning capacity at the master craftsman level) and a profound non-economic loss (permanent inability to practice the specialized craft that defined the plaintiff's professional identity, creative expression, and life purpose)

D. The plaintiff's workers' compensation benefits should be credited against any personal injury damages to prevent double recovery

157. An LNC is analyzing a medical malpractice case involving a patient who developed a ventilator-associated pneumonia (VAP) in the ICU. The LNC reviews the nursing documentation and finds the head of the bed was maintained at less than 20 degrees for the majority of the ICU stay (the standard requires elevation to 30–45 degrees), oral care with chlorhexidine was performed once daily rather than the recommended twice daily, the ventilator circuit was routinely changed every 48 hours (current guidelines recommend changes only when visibly soiled or malfunctioning, as routine changes increase VAP risk), and sedation vacations were not performed daily as recommended. What should the LNC evaluate?

A. VAP is an inevitable complication of mechanical ventilation that cannot be prevented through any nursing interventions

B. The oral care frequency is the sole issue because oral hygiene is the most important VAP prevention measure available

C. The individual nurses who maintained the head of bed below 30 degrees should be retrained on ventilator bundle compliance

D. Multiple deviations from the evidence-based VAP prevention bundle — inadequate head-of-bed elevation, insufficient oral care frequency, inappropriate routine circuit changes (which paradoxically increase VAP risk), and absent sedation vacations — collectively increased the VAP risk, and the analysis should evaluate the comprehensive bundle compliance rather than any single element in isolation

158. An LNC is evaluating a risk management case involving a hospital that uses barcode medication administration (BCMA) technology. An internal review reveals that nurses override BCMA "no match" alerts in 22% of medication administrations. Investigation shows the high override rate is driven by BCMA scanner failures, medications arriving from pharmacy without scannable barcodes, and time pressure during peak medication administration periods. A medication error occurred when a nurse

overrode a legitimate "no match" alert — assuming it was another false alarm — and administered the wrong medication to a patient. What patient safety issue does this illustrate?

- A. The BCMA system should be removed because the high override rate proves the technology is ineffective for medication safety
- B. Alert fatigue from frequent false-positive alerts and equipment failures has conditioned nurses to override alerts reflexively — the 22% override rate driven by scanner failures, absent barcodes, and time pressure undermines the BCMA system's ability to prevent the genuine medication errors it was designed to catch
- C. The individual nurse who overrode the legitimate alert and administered the wrong medication bears sole individual liability
- D. The pharmaceutical manufacturer should be required to affix scannable barcodes to all medication packaging before distribution

159. An LNC is reviewing a medical malpractice case involving a 35-year-old woman who presented to her gynecologist with abnormal uterine bleeding and pelvic pain. The gynecologist performed a pelvic ultrasound that showed a 6 cm complex ovarian cyst on the left ovary. The gynecologist recommended "watchful waiting" with repeat ultrasound in three months. At the three-month follow-up, the cyst had grown to 9 cm. The gynecologist continued watchful waiting for an additional three months. At the six-month follow-up, the cyst was 12 cm. Surgical removal was finally performed, and pathology revealed ovarian cancer (Stage IC). Published guidelines recommend surgical evaluation for complex ovarian cysts larger than 6 cm that are persistent or enlarging. What should the LNC evaluate?

- A. Whether the gynecologist's decision to observe a complex ovarian cyst through six months of progressive enlargement (6 cm → 9 cm → 12 cm) — when published guidelines recommend surgical evaluation for complex cysts larger than 6 cm that are persistent or growing — deviated from the standard of care, and whether earlier surgical intervention would have identified the cancer at an earlier stage
- B. The gynecologist appropriately followed a conservative management strategy consistent with the standard of care for ovarian cysts
- C. The patient should have sought a second opinion after the first follow-up showed the cyst was increasing in size from 6 to 9 cm
- D. The pathologist who interpreted the surgical specimen should have recommended preoperative tumor marker testing

160. An LNC is analyzing a life care plan for a 28-year-old man who sustained a complete T10 spinal cord injury in a workplace accident. The plan includes annual physiatric evaluation, annual urological evaluation, annual dermatological evaluation, semi-annual pulmonary function testing, annual psychological assessment, ongoing physical and occupational therapy, and a comprehensive wheelchair and adaptive equipment program. The defense argues the specialty evaluations are excessive and should be replaced with primary care visits alone. What is the most appropriate analysis?

- A. The defense argument should be accepted because a comprehensive primary care physician can manage all SCI complications
- B. The specialty evaluations should be reduced to biennial (every two years) as a reasonable compromise between both positions
- C. Published SCI clinical practice guidelines specifically recommend the projected specialty evaluations as part of the preventive care regimen — T10 complete injury creates lifelong risk for neurogenic bladder complications, skin breakdown, musculoskeletal deterioration, respiratory changes, and psychological sequelae that each require specialist-level monitoring beyond the scope of routine primary care
- D. Only the urological and dermatological evaluations are justified; the other specialties can be managed by the primary care provider

161. An LNC is reviewing a medical malpractice case involving a patient who underwent a total knee replacement and developed a deep periprosthetic joint infection (PJI) with MRSA. The patient had a preoperative MRSA nasal screen that was positive. The hospital's surgical infection prevention protocol requires MRSA-positive patients to complete a five-day preoperative decolonization regimen (intranasal mupirocin and chlorhexidine body washes) before elective joint replacement. The patient underwent surgery without completing the decolonization protocol — the preoperative assessment form notes "decolonization not initiated." What should the LNC evaluate?

- A. The orthopedic surgeon bears sole personal responsibility for verifying that all preoperative protocols were completed before surgery
- B. MRSA nasal colonization does not increase surgical site infection risk and the decolonization protocol is clinically unnecessary
- C. The patient should have independently completed the decolonization regimen without relying on the hospital to initiate the protocol
- D. The hospital identified the patient as MRSA-colonized through its own screening program but failed to initiate its own decolonization protocol — this gap between risk identification (screening positive) and risk mitigation (decolonization not initiated) represents a systems failure in the preoperative infection prevention process

162. An LNC is evaluating a workers' compensation case involving a 47-year-old emergency department nurse who developed post-traumatic stress disorder after being physically assaulted by a patient during a psychiatric emergency. The nurse was punched in the face, thrown against a wall, and briefly lost consciousness. The nurse has been diagnosed with PTSD by a psychiatrist, with symptoms including flashbacks, hypervigilance, avoidance of the ED, nightmares, and emotional numbing. The employer accepted the physical injuries (facial fractures, concussion) but denied the PTSD claim, arguing PTSD is a pre-existing condition unrelated to the workplace assault. The nurse's pre-injury medical records show no prior psychiatric history. What evidence most strongly supports the PTSD causation?

- A. The nurse's subjective report that the PTSD symptoms began after the assault is the strongest evidence of occupational causation
- B. The documented absence of any pre-injury psychiatric history, the onset of PTSD symptoms temporally related to the assault, the psychiatric evaluation documenting specific PTSD diagnostic criteria met with the workplace assault as the identified traumatic event, and the nature of the event (violent physical assault with loss of consciousness) collectively establish the causal relationship between the workplace assault and the PTSD
- C. The nurse should undergo psychological testing to differentiate between PTSD and adjustment disorder before causation is evaluated
- D. The employer's acceptance of the physical injuries automatically establishes compensability for the psychological injuries

163. An LNC is analyzing a medical malpractice case involving a patient who underwent a diagnostic cardiac catheterization and developed a large retroperitoneal hematoma. The catheterization was performed via the right common femoral artery. Post-procedure, the patient developed progressive right groin pain, back pain, tachycardia (heart rate increasing from 80 to 135 over three hours), and a hemoglobin decline from 13.8 to 8.4 g/dL. The nurse documented these trending vital signs and laboratory values but did not notify the cardiologist for three hours. The nurse attributed the pain to "expected post-procedure discomfort" and the tachycardia to "patient anxiety." What nursing assessment failure should the LNC identify?

- A. The nurse's failure to recognize the progressive tachycardia, declining hemoglobin, and worsening pain as indicators of active hemorrhage — and failure to notify the physician for three hours — represents a critical assessment and communication failure that allowed the retroperitoneal hematoma to expand to a hemodynamically significant volume before intervention
- B. The cardiologist who performed the catheterization should have remained at the bedside for continuous monitoring after the procedure

- C. The patient should have reported the severity of the pain more emphatically to the nursing staff during the assessment period
- D. The femoral artery closure device manufacturer should be investigated for a device failure causing inadequate post-procedure hemostasis

164. An LNC is reviewing a long-term care case in which a nursing home resident with documented severe dysphagia and a physician order for pureed food with honey-thick liquids was found dead in bed with food material in the airway. The autopsy determined the cause of death as aspiration and asphyxiation. Investigation reveals the meal tray delivered to the resident at the time of death contained regular-texture food — a dinner roll, sliced meat, and raw vegetables. The dietary department's records show the correct diet order was in the electronic health record but had not been transmitted to the kitchen's meal preparation system because the two systems are not integrated. The incorrect diet had been served for 11 days before the fatal aspiration event. What systems failure does this case illustrate?

- A. The individual dietary aide who served the tray bears sole responsibility for not checking the resident's diet orders before serving
- B. The attending physician should have confirmed the diet order was transmitted to the dietary department when it was written
- C. The non-integrated clinical and dietary information systems created a persistent communication gap where the correct diet order existed in the clinical record but was never reflected in the kitchen's meal production system — the 11-day persistence of the incorrect diet without detection or reconciliation demonstrates the absence of any process to verify consistency between the two systems
- D. The speech-language pathologist should have supervised all meals for residents with documented severe dysphagia orders

165. An LNC is evaluating a medical malpractice case involving a patient who underwent a laparoscopic appendectomy. The pathology report on the appendix revealed "appendiceal carcinoid tumor, 2.2 cm, with mesoappendiceal invasion." Current NCCN guidelines recommend right hemicolectomy for appendiceal carcinoid tumors larger than 2 cm with mesoappendix involvement because of the risk of lymph node metastasis. The surgeon informed the patient the appendiceal pathology was "benign" and did not recommend further surgical treatment. Two years later, the patient was diagnosed with metastatic carcinoid with liver involvement. What is the critical standard of care failure?

- A. The pathologist should have flagged the report for immediate surgeon attention due to the concerning carcinoid tumor findings

B. The patient should have independently researched the pathology results and sought additional medical opinions for the tumor

C. The surgeon should have consulted an oncologist before discussing the pathology results with the patient after the procedure

D. The surgeon either failed to review the pathology report or misunderstood the significance of the findings — a 2.2 cm appendiceal carcinoid with mesoappendix involvement requires right hemicolectomy per current guidelines, and the failure to recommend appropriate follow-up treatment allowed a potentially curable local tumor to metastasize

166. An LNC is analyzing a personal injury case involving a 55-year-old woman who sustained a traumatic brain injury in a motor vehicle accident. The plaintiff has documented executive function deficits, impaired memory, and behavioral changes (impulsivity, poor social judgment). The plaintiff was a real estate agent earning \$110,000 annually. She has been unable to return to work due to the cognitive and behavioral deficits. The defense argues the plaintiff can perform clerical work in a real estate office. What should the LNC evaluate?

A. The plaintiff's real estate license status should be the sole factor in determining whether she can return to the real estate industry

B. The LNC should evaluate whether the documented cognitive deficits (executive dysfunction, memory impairment) and behavioral changes (impulsivity, poor social judgment) are compatible with any real estate work — real estate requires negotiation, client relationship management, contract interpretation, financial calculation, and reliable social judgment, and even clerical real estate work may require organizational skills and client interaction that the plaintiff's documented impairments preclude

C. The plaintiff should attempt a graded return to work before claiming complete inability to perform any real estate function

D. The plaintiff's pre-injury income is the sole basis for calculating lost earning capacity regardless of current cognitive function

167. An LNC is reviewing a medical malpractice case involving a 40-year-old patient who underwent a routine upper endoscopy under moderate sedation. The patient received midazolam and fentanyl for sedation. During the procedure, the patient's respiratory rate decreased to 4 breaths per minute and the capnography waveform showed hypoventilation. The endoscopy nurse did not respond to the capnography findings because the sedation monitoring protocol at this facility does not require capnography — only pulse oximetry is used. The patient's oxygen saturation did not drop below 90% until approximately four minutes after the onset of hypoventilation (due to the oxygen reservoir effect from supplemental oxygen administration). By the time the pulse oximeter alarmed, the patient had been

significantly hypoventilating for four minutes. Emergency airway management was required. The patient sustained a brief hypoxic event with residual cognitive effects. What should the LNC evaluate?

- A. Whether the facility's sedation monitoring protocol — using only pulse oximetry without capnography — met the current standard of care for moderate sedation monitoring, given that current guidelines recommend capnography for all patients receiving moderate to deep sedation because capnography detects hypoventilation and apnea significantly earlier than pulse oximetry, which has a well-documented delayed detection due to the oxygen reservoir effect
- B. The pulse oximetry monitoring alone was adequate because it is the minimum standard required for moderate sedation procedures
- C. The endoscopist should have been independently monitoring the patient's respiratory rate throughout the entire procedure
- D. The patient should have been intubated before the endoscopy to prevent any possibility of respiratory compromise from sedation

168. An LNC is evaluating a risk management case involving a hospital where a medication error occurred because of a CPOE pick-list error. The physician intended to order hydrocortisone 100 mg IV but selected hydromorphone 100 mg IV from an alphabetical drop-down list. The pharmacy verified the order without questioning the extraordinarily high hydromorphone dose (a typical dose is 0.2–1 mg). The nurse administered the medication. The patient experienced respiratory arrest and required naloxone and intubation. The patient survived but sustained a hypoxic brain injury. What multi-layer safety analysis should the LNC perform?

- A. The pharmacy computer system vendor is solely liable because the system design allowed the physician to select the wrong drug
- B. The nurse bears sole responsibility because nurses are the final safety check before any medication reaches the patient
- C. The physician committed a CPOE pick-list error (a known risk of electronic ordering), the pharmacist failed to question a hydromorphone dose that was 100–500 times the standard range (a pharmacist should recognize a 100 mg dose as clearly erroneous), and the nurse failed to question an obviously excessive dose before administration — all three safety layers failed independently
- D. The hospital should return to paper-based ordering to eliminate the risk of electronic pick-list medication selection errors

169. An LNC is analyzing a Medicare Set-Aside case involving a 72-year-old Medicare beneficiary settling a workers' compensation claim for a shoulder injury. The claimant underwent a total shoulder

replacement. The treating orthopedist documents that the prosthesis will likely require revision in approximately 12–15 years. The claimant's rated life expectancy based on published mortality data specific to the claimant's comorbidities (diabetes, COPD, chronic kidney disease) is 8 years. The defense argues the revision should be included in the MSA. What is the correct analysis?

- A. The revision should be included because the orthopedist documented a clinical basis for the eventual need for the revision
- B. The revision should be projected at exactly 8 years to coincide with the end of the claimant's estimated life expectancy
- C. The revision costs should be split equally between the MSA and the claimant's personal Medicare responsibility in this case
- D. The revision should be excluded because the projected revision timeline (12–15 years) exceeds the claimant's rated life expectancy (8 years) — the MSA should include only expenses reasonably expected to occur within the claimant's projected remaining lifetime

170. An LNC is reviewing a medical malpractice case involving a patient who developed a postpartum hemorrhage after a vaginal delivery. The nursing documentation shows the uterine fundus was assessed at 15 minutes after delivery (firm, midline) and not reassessed for three hours. During this unmonitored interval, the patient developed uterine atony with heavy vaginal bleeding. By the time the boggy fundus was discovered, the patient had lost approximately 2,000 mL of blood and required emergency transfusion, uterine balloon tamponade, bilateral uterine artery embolization, and ICU admission. The standard of care for postpartum monitoring requires fundal assessment every 15 minutes for the first hour, then every 30 minutes for the second hour. What should the LNC identify?

- A. The physician should have remained at the bedside for continuous postpartum monitoring for the first two hours after delivery
- B. The three-hour gap between postpartum fundal assessments — when the standard of care requires assessments every 15–30 minutes — represents a critical monitoring failure that allowed postpartum hemorrhage from uterine atony to progress undetected from a treatable condition to a life-threatening hemorrhage requiring multiple emergency interventions
- C. The patient should have notified the nursing staff about increasing vaginal bleeding rather than waiting for the scheduled check
- D. The initial firm fundal assessment at 15 minutes confirmed adequate uterine tone and no additional monitoring was necessary

171. An LNC is evaluating a product liability case involving a defective surgical stapler used during a gastrointestinal procedure. The stapler misfired, leaving an incomplete staple line that resulted in a postoperative anastomotic leak. The leak caused peritonitis, sepsis, and a prolonged ICU stay. The surgeon documented the malfunction in the operative report: "stapler appeared to misfire — additional manual sutures placed to reinforce staple line." Despite the reinforcement, the anastomosis leaked at the site of the incomplete firing. The manufacturer had received 47 field reports of similar misfires in this stapler model over the preceding 18 months but had not issued a safety communication or recall. What is the most comprehensive liability analysis?

- A. The surgeon's intraoperative documentation of the malfunction constitutes the sole evidence needed for the product liability claim
- B. The surgeon should have abandoned the stapled anastomosis entirely and performed a hand-sewn anastomosis after the misfire
- C. Design defect (if the 47 field reports suggest a systematic design problem), failure to warn (the manufacturer's knowledge of repeated misfires without issuing a safety communication), and the surgeon's documentation of the intraoperative malfunction linked to the post-surgical leak at the misfire site collectively establish the causal chain from device defect to patient injury
- D. The patient assumed the risk of stapler malfunction by consenting to a procedure that uses surgical staplers for tissue connection

172. An LNC is analyzing a medical malpractice case involving a patient who developed contrast-induced nephropathy (CIN) after receiving IV contrast for a CT scan. The patient had chronic kidney disease with a baseline creatinine of 2.8 mg/dL (eGFR 22 mL/min). The radiologist's protocol requires renal function screening before IV contrast administration, but the contrast was administered without checking the patient's renal function. No renal protective protocol (IV hydration, N-acetylcysteine) was implemented. The patient's creatinine rose to 5.6 mg/dL post-contrast, requiring temporary hemodialysis. What should the LNC evaluate?

- A. Whether the contrast administration without checking renal function in a patient with known CKD (eGFR 22) — and without implementing the standard renal protection protocol — deviated from the radiological standard of care for contrast administration, and whether the CIN was a foreseeable and preventable consequence of these omissions
- B. The emergency physician who ordered the CT should be the sole defendant because the physician knew about the kidney disease
- C. The patient should have independently informed the CT technologist about the kidney disease before the scan was performed

D. Contrast-induced nephropathy is an unavoidable complication of CT scans that cannot be prevented through any renal protection

173. An LNC is reviewing a case involving the discoverability of an LNC's work product when the LNC's designation changes from consulting to testifying expert. The LNC was initially retained as a non-testifying consulting expert and prepared detailed internal memoranda analyzing the case — including several findings unfavorable to the retaining party. The attorney now wants to designate the LNC as a testifying expert. What should the LNC understand about this designation change?

A. All consulting work product is permanently protected from discovery regardless of the LNC's subsequent designation change

B. The LNC should destroy the unfavorable memoranda before the designation change to prevent their disclosure to opposing counsel

C. The designation change is routine and has no effect on the discoverability of any previously prepared work product materials

D. The transition from consulting to testifying expert may expose previously protected work product — including the unfavorable internal memoranda — to discovery, because the opposing party is entitled to discover the basis for the testifying expert's opinions and materials considered, and the LNC should discuss this implication with the attorney before agreeing to the designation change

174. An LNC is evaluating a medical malpractice case involving a patient who underwent a right hemicolectomy for colon cancer. The surgeon inadvertently transected the right ureter. The injury was not recognized intraoperatively. The patient developed right flank pain, fever, and elevated creatinine on postoperative day four. A CT scan revealed a right urinoma. The patient required ureteral stent placement and eventually ureteral reimplantation surgery. What should the LNC evaluate regarding the intraoperative identification of the ureter?

A. Ureteral injuries during hemicolectomy are so rare that the surgeon cannot be expected to protect the ureter during dissection

B. Whether the surgeon took appropriate measures to identify and protect the right ureter during the dissection — the standard of care requires awareness of the ureter's anatomical position and active measures to avoid injury, and the failure to recognize the transection intraoperatively suggests the ureter may not have been adequately visualized and protected

C. The radiologist should have identified the ureteral injury on the intraoperative imaging before the procedure was completed

D. The pathologist should have identified ureteral tissue in the surgical specimen and alerted the surgeon to the injury immediately

175. An LNC is analyzing a long-term care case in which a nursing home resident with documented recurrent falls and a high fall risk score fell from the bed at 0300 and sustained a traumatic brain injury. The care plan specified "bed in lowest position, side rails up on both sides, bed alarm activated." The investigation reveals the bed was in the highest position (raised during a 2100 dressing change and never lowered), one side rail was down, and the bed alarm battery was dead. The night shift nurse was caring for 12 patients simultaneously. What multi-level analysis should the LNC perform?

A. The resident's recurrent falls made this event inevitable regardless of any preventive measures that could have been implemented

B. The attending physician should have ordered a one-to-one sitter for a resident with documented recurrent falls and high risk score

C. The bed remaining elevated, the side rail down, and the dead bed alarm battery represent three simultaneous failures of care plan-specified safety measures — combined with the staffing context (1:12 nurse-to-patient ratio limiting the nurse's ability to monitor high-risk residents), the analysis should evaluate both the individual implementation failures and the institutional staffing adequacy that contributed to an environment where three safety measures simultaneously failed without detection

D. The bed alarm manufacturer should be investigated for producing a device with an inadequate battery life for clinical use

176. An LNC is reviewing a medical malpractice case involving a patient who developed a central line-associated bloodstream infection (CLABSI). The LNC reviews the central line insertion and maintenance documentation and identifies the following deviations from evidence-based central line bundle practices: no documentation that maximal sterile barrier precautions were used during insertion, no documentation of chlorhexidine skin preparation before insertion, the line dressing was changed only once in 12 days (rather than the recommended every 7 days or when soiled), and no daily assessment of continued line necessity was documented. What should the LNC conclude?

A. The multiple deviations from evidence-based central line bundle practices — absent maximal barriers, absent chlorhexidine documentation, inadequate dressing change frequency, and absent daily necessity assessments — collectively demonstrate systemic noncompliance with infection prevention standards that cumulatively increased the CLABSI risk far beyond what any single deviation would produce

B. The infection was caused by the patient's immunocompromised status rather than any deviation in central line management

C. The physician who inserted the central line bears sole responsibility and the ongoing maintenance deviations are irrelevant

D. The CLABSI was an unavoidable complication that would have occurred regardless of the line insertion and maintenance practices

177. An LNC is evaluating a personal injury case involving a 60-year-old retired firefighter who was struck by a vehicle while walking in a crosswalk. The plaintiff sustained a traumatic brain injury with bifrontal contusions, bilateral clavicle fractures, and a left hip fracture requiring total hip arthroplasty. Following acute care and rehabilitation, the plaintiff has residual cognitive deficits (executive dysfunction, impaired memory) and chronic left hip pain with limited mobility. The plaintiff was retired but was actively volunteering with the fire department's public education program, coaching youth baseball, and maintaining his home independently. The defense argues the plaintiff's retirement status eliminates economic damages. What should the LNC evaluate?

A. The defense argument should be accepted because retired individuals cannot claim any damages beyond medical expenses

B. The plaintiff should attempt to resume all pre-injury activities before claiming permanent impairment from the accident injuries

C. Only the volunteer fire department activities have potential economic value and all other activities are non-compensable in nature

D. The plaintiff's productive activities — fire department volunteering, youth baseball coaching, independent home maintenance — represent functional capacities impaired by the TBI and hip injury, and the damages should include the non-economic impact of losing these activities (purpose, community engagement, physical independence) and the cost of assistance for home maintenance tasks the plaintiff previously performed independently

178. An LNC is analyzing a medical malpractice case involving a patient who underwent a total knee replacement and developed acute compartment syndrome of the lower leg postoperatively. The patient reported progressive calf pain, paresthesias, and an inability to dorsiflex the foot beginning four hours after surgery. The orthopedic resident ordered elevation, ice, and morphine. Over the next six hours, the pain intensified despite maximum analgesic dosing. The attending surgeon was not notified until 10 hours after the onset of symptoms. By the time emergent fasciotomy was performed, the patient had sustained permanent foot drop and chronic pain. What clinical principle should the LNC apply?

A. The resident's initial management with elevation, ice, and morphine was appropriate for expected postoperative lower extremity swelling

B. Pain out of proportion to the expected postoperative course, progressive paresthesias, and loss of active dorsiflexion after total knee replacement are the hallmark progression of acute compartment syndrome — the resident's failure to consider compartment syndrome and the 10-hour delay in notifying the attending surgeon represent both a diagnostic failure and a communication failure that allowed a surgical emergency to progress to irreversible tissue damage

C. Compartment syndrome after total knee replacement is so rare that it is unreasonable to expect the resident to include it in the differential

D. The patient should have insisted on being evaluated by the attending surgeon rather than accepting the resident's management plan

179. An LNC is reviewing a regulatory compliance case involving a hospital that routinely performs moderate sedation for procedures by non-anesthesiologist physicians. A state survey found that physicians administering sedation do not maintain current ACLS certification, the hospital lacks a standardized pre-sedation patient assessment using ASA physical status classification, monitoring equipment at several procedure sites does not include capnography capability, and rescue equipment (bag-valve-mask, emergency airway devices) is not immediately available at all sedation sites. What should the LNC evaluate?

A. The sedation deficiencies are minor administrative issues that do not create actual patient safety risks requiring immediate action

B. The physicians should be retrained on sedation techniques but no equipment changes are needed at the procedure sites

C. The deficiencies represent noncompliance with CMS Conditions of Participation and professional sedation safety standards — absent ACLS certification, absent ASA assessment, inadequate monitoring equipment, and unavailable rescue equipment create systemic patient safety risks during every sedation procedure, and if a patient is harmed during sedation, these regulatory violations constitute strong evidence of institutional negligence

D. The state survey findings should be appealed because CMS does not specifically regulate moderate sedation practices in hospitals

180. An LNC is analyzing a medical malpractice case involving a patient who was prescribed methotrexate for rheumatoid arthritis. The prescription was correctly written as "methotrexate 15 mg weekly." However, the patient understood the instructions as "15 mg daily" and took the medication daily for three weeks. The patient developed severe pancytopenia, mucositis, and hepatotoxicity requiring hospitalization. Investigation reveals the physician did not provide written medication instructions emphasizing the weekly dosing schedule, the pharmacist did not counsel the patient about the critical importance of weekly (not daily) dosing, and the prescription label printed by the pharmacy

stated "take 15 mg by mouth" without specifying "weekly" or "once per week." What should the LNC evaluate?

A. Multiple communication failures contributed to this error: the physician did not provide clear written instructions emphasizing weekly dosing, the pharmacist did not counsel about the critical weekly schedule, and the pharmacy label omitted the "weekly" frequency — methotrexate's narrow therapeutic index and the well-documented danger of daily dosing errors make clear dosing communication a shared responsibility across all providers in the medication use process

B. The patient bears sole responsibility because patients are expected to follow prescription instructions exactly as written

C. The pharmacy computer system should have automatically flagged methotrexate prescriptions for mandatory weekly dosing counseling

D. The rheumatologist should have prescribed a different medication with less potential for catastrophic dosing misunderstanding

181. An LNC is evaluating a long-term care case in which a nursing home resident with documented bilateral below-knee amputations and wheelchair dependence developed bilateral ischial pressure ulcers. The resident's wheelchair cushion was a standard foam cushion that had not been replaced in 16 months — exceeding the manufacturer's recommended 6–12 month replacement schedule. The resident's weight exceeded the cushion's rated weight capacity by 25 pounds, and the cushion was visibly compressed with permanent deformation. The facility had no wheelchair cushion replacement schedule and no process for matching cushion weight capacity to individual residents. What should the LNC evaluate?

A. The pressure ulcers were caused by the resident's vascular disease and amputations rather than the wheelchair cushion condition

B. The physical therapy department should have assessed cushion adequacy at each therapy session without facility-level scheduling

C. The wheelchair cushion manufacturer should be investigated for not designing a more durable product for institutional use

D. The degraded cushion — used beyond its replacement interval, loaded beyond its weight capacity, and visibly deformed — was no longer providing adequate pressure redistribution, and the facility's failure to maintain a replacement schedule and match cushion specifications to resident weight represents an equipment maintenance failure that directly contributed to the bilateral pressure ulcer development

182. An LNC is reviewing a medical malpractice case involving a patient who underwent a thyroidectomy and developed permanent bilateral recurrent laryngeal nerve palsy resulting in bilateral vocal cord paralysis and permanent tracheostomy. The surgeon did not use intraoperative nerve monitoring (IONM) during the procedure. The pathology report documents "thyroid tissue with incidental parathyroid tissue in specimen." What two separate findings should the LNC evaluate?

- A. The surgeon should have referred the patient to a higher-volume thyroid surgeon rather than performing the procedure independently
- B. Two independent standard of care issues exist: (1) the failure to use or consider IONM — which could have detected nerve injury on the first side and prompted surgical modification to prevent the catastrophic bilateral injury, and (2) the pathology report documenting parathyroid tissue in the specimen, which is direct evidence that at least one parathyroid gland was removed rather than preserved as required by the standard of care
- C. The bilateral nerve palsy proves the surgeon was inadequately trained regardless of whether IONM was used during the procedure
- D. The pathology finding of parathyroid tissue is irrelevant because the primary injury is the bilateral recurrent laryngeal nerve palsy

183. An LNC is analyzing a toxic tort case involving residents near a coal-fired power plant who were exposed to elevated levels of mercury through consumption of fish from a contaminated lake downstream from the facility. Several children have been diagnosed with neurodevelopmental delays and cognitive impairment. Methylmercury — the organic form that bioaccumulates in fish — is a well-established developmental neurotoxicant. The defense argues the children's developmental delays are caused by genetic factors and socioeconomic disadvantage. What should the LNC evaluate?

- A. The mercury contamination automatically proves causation for all health effects in every exposed child in the community
- B. The defense argument should be accepted because genetic and socioeconomic factors are the primary causes of developmental delay
- C. The LNC should evaluate each child individually — assessing maternal fish consumption during pregnancy, documented mercury levels (cord blood, hair, or postnatal blood), the temporal relationship between exposure and developmental symptom onset, whether the pattern of cognitive deficits is consistent with mercury neurotoxicity (motor dysfunction, visuospatial deficits, attention impairment), and whether genetic or socioeconomic factors independently contribute to the documented delays
- D. All children living near the power plant should be presumed to have mercury-caused developmental delays without individual analysis

184. An LNC is reviewing a medical malpractice case involving a 50-year-old patient who presented to the emergency department with acute onset of right flank pain and hematuria. A CT scan was obtained and the radiologist's report identified "a 6 mm right ureteral stone with mild hydronephrosis." The patient was treated for ureteral colic and discharged. However, the CT scan also showed a 3 cm adrenal mass that the radiologist did not identify or report. Fourteen months later, the adrenal mass was incidentally discovered on imaging performed for an unrelated condition and was diagnosed as adrenal cortical carcinoma with distant metastases. What should the LNC evaluate?

- A. Whether the radiologist's failure to identify the 3 cm adrenal mass on the original CT scan represents a diagnostic error — radiologists have a duty to evaluate all visualized structures on cross-sectional imaging, not only the area of clinical concern, and a 3 cm adrenal mass should have been identified, reported, and recommended for further evaluation
- B. The emergency physician should have specifically requested evaluation of the adrenal glands when ordering the CT scan
- C. The patient should have requested a comprehensive review of the CT scan findings at a follow-up appointment with the PCP
- D. Adrenal masses are common incidental findings and do not require reporting or further evaluation in most clinical situations

185. An LNC is evaluating a personal injury case involving a 45-year-old woman who sustained a severe ankle fracture-dislocation in a fall at a commercial property. Despite surgical fixation, the plaintiff developed post-traumatic arthritis and complex regional pain syndrome (CRPS) in the affected ankle. The plaintiff's treating pain specialist has documented classic CRPS findings — edema, color changes, temperature asymmetry, allodynia, trophic changes — and a positive response to lumbar sympathetic block. The defense retained a neurologist who examined the plaintiff once and concluded CRPS is not present because a bone scan was normal. What should the LNC evaluate?

- A. The defense neurologist's bone scan reliance should be given decisive weight because imaging is more reliable than clinical assessment
- B. The plaintiff should undergo additional testing including thermography and quantitative sensory testing before CRPS can be confirmed
- C. The treating pain specialist's opinion should be automatically accepted without critical evaluation of the clinical findings documented
- D. The Budapest diagnostic criteria for CRPS are primarily clinical and do not require abnormal bone scan findings — the defense neurologist's reliance on a single normal bone scan to exclude CRPS contradicts the accepted diagnostic framework, particularly when multiple objective clinical signs and a positive sympathetic block are documented

186. An LNC is analyzing a medical malpractice case involving a patient who underwent a coronary artery bypass graft (CABG) procedure and developed a sternal wound infection. The patient's preoperative records documented a hemoglobin A1c of 10.2% (poorly controlled diabetes), a BMI of 43 (morbid obesity), and active smoking. All three are well-documented independent risk factors for sternal wound infection after cardiac surgery. The surgeon did not delay the elective procedure to address any of these modifiable risk factors and did not document a risk-benefit analysis. What should the LNC evaluate?

- A. The patient's multiple risk factors make sternal wound infection an inevitable outcome regardless of any preoperative optimization
- B. Whether the surgeon's decision to proceed with elective CABG without optimizing glycemic control, addressing smoking cessation, or documenting a risk-benefit analysis — when published guidelines recommend addressing modifiable risk factors before elective cardiac surgery — deviated from the preoperative standard of care
- C. The cardiologist who referred the patient for CABG should be named as a co-defendant for failing to optimize the risk factors
- D. The patient bears sole responsibility for the sternal wound infection because the patient chose not to optimize health before surgery

187. An LNC is reviewing a workers' compensation case involving a 52-year-old registered nurse who developed chronic hand dermatitis from repeated exposure to hand sanitizer and surgical scrub solutions over 15 years. The dermatitis progressed from irritant contact dermatitis to allergic contact dermatitis, and the nurse has now developed sensitization to multiple hand hygiene products. The employer's insurer accepted the initial irritant dermatitis but denied the allergic contact dermatitis, arguing it is a separate unrelated condition. What should the LNC evaluate?

- A. The insurer's denial should be accepted because irritant and allergic contact dermatitis are completely unrelated conditions
- B. The nurse should have used protective gloves under the surgical scrub to prevent chemical contact with the skin surface
- C. The clinical progression from irritant contact dermatitis to allergic contact dermatitis follows a well-documented immunological pathway — damaged skin from irritant dermatitis facilitates chemical absorption and sensitization, making the allergic dermatitis a compensable progression of the original occupational skin condition
- D. The nurse's personal skincare products should be investigated as the primary cause of the allergic contact dermatitis

188. An LNC is evaluating a medical malpractice case involving a patient who was admitted to the hospital for a hip fracture repair and developed a hospital-acquired sacral pressure ulcer during the hospitalization. The patient's Braden Scale score on admission was 11 (very high risk). The nursing documentation shows the Braden Scale was completed on admission but not reassessed during the eight-day hospitalization, the care plan specified repositioning every two hours but documentation shows gaps of 6–8 hours on multiple occasions, no specialty mattress was ordered despite the very high risk score, and no nutritional intervention was initiated despite an albumin of 2.1 g/dL. What should the LNC conclude?

- A. The multiple failures in pressure injury prevention — absent repeat risk assessments, inadequate repositioning frequency, no specialty mattress for a very high-risk patient, and no nutritional intervention despite low albumin — collectively demonstrate a systemic failure to implement the comprehensive prevention strategy the patient's documented risk demanded
- B. The hip fracture caused the immobility that led to the pressure ulcer and the surgeon bears sole responsibility for the outcome
- C. The patient should have requested more frequent repositioning from the nursing staff to prevent the pressure ulcer from developing
- D. The pressure ulcer was unavoidable because the hip fracture limited the patient's ability to reposition independently in the bed

189. An LNC is analyzing a risk management case involving a hospital that has experienced a series of wrong-patient medication errors in the pediatric unit. Over a three-month period, four wrong-patient errors occurred. Investigation reveals the unit uses a paper-based medication administration system without barcode scanning, several patients share similar first names, weight-based dosing calculations are performed manually by individual nurses without independent verification, and no independent double-check is required for high-alert medications. What risk management conclusion should the LNC draw?

- A. The individual nurses who committed the errors should be disciplined and no systems changes are needed at the institutional level
- B. The pharmacy should independently verify all weight-based dose calculations before dispensing any pediatric medications
- C. The hospital should prohibit parents from choosing similar names for their children to prevent future identification errors
- D. The convergence of multiple systems vulnerabilities — paper-based processes, absent barcode technology, manual calculations without double-checks, and no independent verification for high-alert

drugs — creates a risk environment in which wrong-patient errors are predictable rather than random, and the risk management response should address all identified vulnerabilities simultaneously

190. An LNC is reviewing a medical malpractice case involving a patient who underwent a routine arthroscopic knee surgery under spinal anesthesia. During the spinal needle insertion, the patient reported a sharp electric pain shooting down the left leg — indicating nerve root contact. The anesthesiologist continued advancing the needle and injected the spinal anesthetic despite this symptom. Postoperatively, the patient developed persistent left foot drop and numbness in the L5 dermatome. The standard of care requires withdrawal and repositioning of the needle when paresthesias occur during spinal needle placement. What should the LNC evaluate?

- A. Radicular symptoms during spinal anesthesia are normal and expected and do not require any modification to the technique
- B. The anesthesiologist's decision to continue advancing the needle and inject the anesthetic despite the patient's report of radicular symptoms — which indicate nerve root contact — deviated from the standard of care requiring needle withdrawal and repositioning before injection, and this deviation is causally linked to the resulting L5 nerve root injury
- C. The surgeon should have selected general anesthesia rather than spinal anesthesia to avoid any risk of neurological injury
- D. The patient should have tolerated the discomfort without reporting symptoms because spinal anesthesia placement is inherently painful

191. An LNC is evaluating a long-term care case in which a nursing home resident who was prescribed warfarin for atrial fibrillation developed a spontaneous subdural hematoma. The LNC reviews the INR monitoring records and finds the INR was monitored weekly for the first two weeks after initiation, then no INR was checked for the next eight weeks. During this unmonitored period, the INR rose to 6.4 (dangerously supratherapeutic). The facility's pharmacy consultant had identified the monitoring gap and submitted a written recommendation for immediate INR testing and dose adjustment five weeks before the hemorrhagic event. The recommendation was filed in the resident's chart but never communicated to the attending physician. What systems failure does this case illustrate?

- A. The pharmacy consultant identified the critical monitoring gap and recommended action five weeks before the hemorrhage, but the recommendation was filed in the chart without any system to ensure physician review and response — the absence of a process to communicate urgent pharmacy recommendations to the responsible physician represents a critical gap between identification and action
- B. The pharmacy consultant fulfilled all professional obligations by documenting the recommendation in the resident's chart

- C. The attending physician should have independently reviewed the chart and discovered the pharmacy consultant's recommendation
- D. The nursing staff should have adjusted the warfarin dose without waiting for a physician order when the INR was not monitored

192. An LNC is analyzing a medical malpractice case involving a patient who underwent a total hip replacement and developed a postoperative dislocation on postoperative day one during physical therapy. The surgeon used a posterior surgical approach. Posterior approach hip replacement has specific postoperative precautions — no hip flexion beyond 90 degrees, no internal rotation, no adduction past midline — that must be communicated to the physical therapy team. The physical therapist stated she was "not informed about any hip precautions" and flexed the patient's hip beyond 90 degrees during a transfer exercise. What communication failure should the LNC identify?

- A. The physical therapist should have independently known the precautions for all surgical approaches without any surgeon communication
- B. The patient should have stopped the therapist when the hip was being flexed beyond what felt comfortable during the exercise
- C. The surgeon's failure to communicate the posterior approach-specific hip precautions to the physical therapy team — or the absence of a system ensuring this communication — created a gap between the surgical plan and the rehabilitation plan that resulted in a foreseeable and preventable dislocation
- D. The nursing staff should have been present during all physical therapy sessions to monitor for hip precaution compliance

193. An LNC is reviewing a healthcare fraud case involving a mobile diagnostic imaging company that provides portable X-ray and ultrasound services to nursing homes. A Medicare audit reveals diagnostic imaging is performed on all residents regardless of clinical indication, orders are pre-signed by a physician who never examines the residents, imaging reports use template language with no individualized findings, and the facility receives a percentage of imaging revenue as a "site access fee." What federal statutes are implicated?

- A. Only HIPAA, because the imaging results were shared between the company and the facility without proper patient authorization
- B. Only the False Claims Act, because the company billed Medicare for medically unnecessary imaging studies on the residents
- C. Only state medical practice act violations, because the physician signed orders without examining the residents individually

D. The False Claims Act (billing for medically unnecessary imaging), the Anti-Kickback Statute (the "site access fee" to the facility constitutes remuneration for access to residents), the Stark Law (if the ordering physician has a financial relationship with the imaging company), and the physician's state medical practice act (signing orders without patient examination)

194. An LNC is evaluating a medical malpractice case involving a patient who was prescribed lithium for bipolar disorder. The patient's baseline renal function was normal (eGFR 92 mL/min). The prescribing psychiatrist monitored serum lithium levels every three months but did not monitor renal function at any point during three years of lithium therapy. When renal function was finally checked by the patient's primary care physician at a routine physical, the eGFR had declined to 25 mL/min (stage 4 CKD). Published lithium prescribing guidelines require renal function monitoring at least every six months. What should the LNC evaluate?

A. The psychiatrist monitored lithium levels appropriately and fulfilled all monitoring obligations for lithium therapy management

B. The psychiatrist monitored lithium levels but completely failed to monitor renal function — a separate and independent monitoring obligation — when lithium's well-documented nephrotoxicity specifically requires periodic creatinine and eGFR assessment to detect renal impairment before it progresses to advanced kidney disease

C. The primary care physician should have independently monitored renal function during the lithium therapy period

D. The patient should have requested renal function testing based on independent knowledge of lithium's nephrotoxic potential

195. An LNC is analyzing a personal injury case involving a 50-year-old woman who sustained a traumatic brain injury in a motor vehicle accident. The plaintiff has documented executive function deficits and behavioral dysregulation (impulsivity, poor social judgment, emotional lability). Her husband has filed a loss of consortium claim. The neuropsychological testing documents cognitive deficits that impair the plaintiff's interpersonal functioning, emotional regulation, and capacity for intimate relationships. What clinical documentation is most important for supporting the consortium claim?

A. The neuropsychological testing documenting the specific cognitive and behavioral deficits, combined with the treating clinicians' documentation of how these deficits affect the plaintiff's interpersonal functioning, emotional regulation, and capacity for marital relationships — this provides the clinical foundation establishing that the TBI has fundamentally altered the plaintiff's ability to fulfill her role as a marital partner

- B. The husband's testimony alone is sufficient to support the consortium claim without any clinical documentation
- C. Financial records documenting the decline in household income since the injury are the most relevant consortium evidence
- D. Only a formal marital assessment by a licensed marriage counselor can support a loss of consortium claim in litigation

196. An LNC is reviewing a medical malpractice case involving a patient who developed a surgical site infection after a spinal fusion. The patient's preoperative hemoglobin A1c was 10.0%. Published spine surgery guidelines recommend achieving glycemic optimization (A1c below 8%) before elective spinal procedures to reduce infection risk. The surgeon did not delay the elective procedure for glycemic optimization. What should the LNC evaluate?

- A. The SSI was caused by intraoperative contamination unrelated to the patient's glucose control status before the surgery
- B. The patient should have independently controlled the diabetes before presenting for elective spinal surgery without any guidance
- C. Whether the surgeon's decision to proceed with elective spinal surgery at A1c 10.0% — when published guidelines recommend A1c below 8% before elective procedures — deviated from the preoperative standard of care, and whether glycemic optimization would have reduced the foreseeable SSI risk
- D. The endocrinologist managing the patient's diabetes should be the sole defendant for failing to achieve adequate A1c control

197. An LNC is evaluating a risk management case involving a hospital where a patient experienced an anaphylactic reaction to a medication during a CT scan. The crash cart in the radiology department had not been checked per the hospital's policy requiring shift-based checks. When the crash cart was opened, the defibrillator battery was dead, the epinephrine was expired, and the bag-valve-mask was missing. The resuscitation was delayed by six minutes while emergency supplies were obtained from an adjacent unit. The patient sustained a hypoxic brain injury during the delay. What does this case illustrate?

- A. The radiology department should not be expected to maintain a functional crash cart because anaphylaxis during CT is extremely rare
- B. The physician who ordered the contrast CT should have personally verified the crash cart was functional before ordering the study

C. The CT technologist should have administered emergency medications from the nearest nursing unit without waiting for the crash cart

D. The failure to maintain a functional crash cart — by not performing the required shift-based checks — represents a systems failure in emergency preparedness that directly caused the resuscitation delay and the resulting hypoxic brain injury, and the crash cart maintenance policy existed specifically to prevent this exact scenario

198. An LNC is analyzing a medical malpractice case involving a patient who underwent an elective total knee replacement. The patient had documented obstructive sleep apnea (OSA) treated with home CPAP. Postoperatively, the patient received opioid PCA (hydromorphone) but CPAP was not ordered, continuous pulse oximetry was not implemented, and no opioid-sparing analgesic strategies were used. On postoperative night two, the patient was found unresponsive with an oxygen saturation of 48%. Resuscitation was successful but the patient sustained severe hypoxic brain injury. What standard of care failures should the LNC identify?

A. The anesthesiologist should have refused to provide anesthesia for any patient with obstructive sleep apnea diagnosis

B. Three standard of care failures converged: no CPAP continuation for a documented OSA patient, no continuous pulse oximetry during opioid PCA, and no opioid-sparing strategies — current perioperative guidelines specifically identify OSA patients on opioids as high-risk and recommend all three safeguards, and the absence of all three created a foreseeable respiratory catastrophe

C. The nursing staff should have independently initiated CPAP therapy without a physician order based on the admission assessment

D. The patient should have brought the home CPAP machine and administered it independently during the postoperative stay

199. An LNC is reviewing a case involving the scope of an LNC's expert testimony. The LNC is a registered nurse with 20 years of medical-surgical nursing experience and LNCC certification. The attorney wants the LNC to testify about whether the surgeon's intraoperative technique during a complex spinal fusion procedure met the surgical standard of care. What should the LNC advise the attorney?

A. The LNC should advise that opinions on the surgeon's intraoperative surgical technique require a surgeon expert — the LNC's medical-surgical nursing experience provides knowledge of perioperative nursing standards but does not qualify her to opine on surgical technique, and the attorney should retain a spine surgeon to address the intraoperative surgical standard of care questions

- B. The LNCC certification qualifies the LNC to testify on all aspects of medical care including surgical technique standards
- C. The LNC's 20 years of medical-surgical experience provides adequate qualification to testify about spinal fusion technique
- D. The LNC should provide the surgical standard of care testimony because no other expert is available for the case

200. An LNC is evaluating a medical malpractice case involving a patient who underwent a diagnostic colonoscopy. The gastroenterologist removed a large sessile polyp from the sigmoid colon. The pathology report showed "invasive adenocarcinoma with lymphovascular invasion — margins positive." The gastroenterologist informed the patient that "the polyp was completely removed and you need a repeat colonoscopy in three years." The patient was not referred for surgical consultation or oncological evaluation. Twenty-two months later, the patient was diagnosed with Stage III sigmoid colon cancer at the prior polypectomy site with regional lymph node metastases. What is the critical standard of care failure?

- A. The pathologist should have personally called the gastroenterologist to communicate the malignant findings before the report was filed
- B. The patient should have requested a copy of the pathology report and independently sought a surgical oncology consultation
- C. The gastroenterologist either failed to review or misrepresented the pathology results — invasive adenocarcinoma with positive margins and lymphovascular invasion requires immediate surgical referral for segmental colonic resection with lymph node evaluation, and informing the patient the polyp was "completely removed" with three-year follow-up was clinically inappropriate and allowed a potentially curable cancer to progress to Stage III regional disease
- D. The primary care physician should have independently reviewed the pathology results and referred the patient for surgical consultation

## Practice Exam 4: Answer Key and Explanations

1. C — Hoarseness persisting beyond four weeks requires laryngoscopy to evaluate for laryngeal pathology including malignancy. Published guidelines set the four-week threshold specifically because persistent hoarseness may indicate laryngeal cancer, vocal cord paralysis, or other significant pathology. Treating empirically without direct visualization deviates from these guidelines, and the four-month diagnostic delay allowed the cancer to potentially progress to a more advanced stage.

2. D — Multiple systems failures converged to produce this event: the training program did not include dietary modification awareness for new staff, the meal ticket system did not communicate the restriction to the point of service, and the shift report omitted critical dietary information. No single individual's error caused the choking — the institutional communication infrastructure failed at multiple points, each independently capable of preventing the event if functioning properly.

3. A — The permanent loss of fine touch sensation, grip strength, and heat tolerance constitutes both an economic loss (earning capacity at the professional chef level) and a non-economic loss (inability to practice a skilled craft defining the plaintiff's identity). Management work requires fundamentally different skills and provides different compensation — it does not replace the loss of a specialized craft requiring sensory and motor precision developed over a career.

4. B — The critical issue is the gap between ordered and administered prophylaxis. Four missed doses out of seven (57% non-administration rate) left the patient without adequate VTE protection. The LNC should evaluate whether the patient was educated about VTE risk (preventing refusals), the clinical justification for the pharmacy hold, the undocumented missed dose, and why the surgeon was never notified about four missed doses — which would have allowed consideration of alternative prophylaxis.

5. D — Bilateral involvement does not disprove occupational causation when the occupational exposure is itself bilateral. A dental hygienist uses both hands symmetrically during scaling and instrumentation for 6–7 hours daily. Bilateral CTS and bilateral de Quervain's are the expected injury pattern for symmetrically demanding hand-intensive work. The IME physician's reasoning contains a fundamental logical error that ignores the bilateral nature of the occupational exposure.

6. A — The hospital's stroke protocol requiring neurologist authorization before tPA — without a contingency for delayed neurologist response — created a systems-level barrier to time-critical treatment. The 45-minute wait for neurologist response deprived the patient of time-dependent treatment benefit. For time-critical interventions, protocols must include backup authorization pathways to prevent delayed physician response from delaying treatment.

7. C — The manufacturer's knowledge of the elevated catheter fracture rate (4.8% vs. <0.5% benchmark) for 14 months without issuing a product advisory constitutes a failure to warn. This delay deprived oncologists and patients of information needed for informed decisions about device selection and monitoring frequency. The 14-month gap between the manufacturer's awareness of the elevated rate and any safety communication is the critical liability issue.

8. B — The increased SSI rate temporally correlating with the skin preparation product change — combined with documented inconsistent application technique and inadequate drying time across

multiple specialties — indicates a systems-level training failure during the product transition. The staff were not formally educated on the new product's specific application requirements. The universal nature of the problem (multiple specialties) confirms a systemic rather than individual issue.

9. A — Charcot's triad — right upper quadrant pain, fever, and jaundice — is the classic presentation of acute cholangitis, a potentially life-threatening biliary infection. This presentation requires hospital admission, IV antibiotics, and likely urgent biliary decompression. Diagnosing "biliary colic" and discharging with pain medication ignores the fever and jaundice components that elevate this from a simple biliary complaint to a surgical emergency.

10. D — Each worker must be evaluated individually, assessing documented lead levels against the dose-response curve, temporal relationships, and whether the neuropathy pattern supports lead etiology (predominantly motor) versus diabetic or alcoholic neuropathy (predominantly sensory). Multiple etiologies may contribute independently or synergistically. The clinical pattern of the neuropathy may itself help distinguish between competing causes.

11. B — Under the eggshell plaintiff doctrine, the defendant takes the plaintiff as found. The osteoporosis made the plaintiff more vulnerable to fracture, but the chair collapse was the triggering event — and the absence of prior fractures despite longstanding osteoporosis demonstrates that the bones had withstood normal activities without fracturing. The defendant is liable for the full extent of injuries including the severity attributable to the pre-existing bone condition.

12. C — The defense addresses the occurrence of capsular contracture but not the management. Baker Grade IV contracture failing conservative treatment for six months requires escalation (capsulectomy, implant exchange). The additional 14 months of observation while conservative measures demonstrably failed allowed chronic inflammation and tissue damage that significantly complicated the eventual revision surgery — transforming what could have been a straightforward revision into a complex reconstruction.

13. A — The standing order authorizing comprehensive testing on all specimens — regardless of clinical indication — combined with billing Medicare for tests not ordered by the treating physician constitutes billing for medically unnecessary services. A physician's standing order does not create clinical indication for testing in individual patients. The False Claims Act is implicated because Medicare is being billed for tests that lack individualized medical necessity.

14. D — Beyond the failure to discontinue clopidogrel, the LNC should evaluate whether the surgeon consulted the patient's cardiologist before making the antiplatelet cessation decision. Clopidogrel was prescribed to prevent coronary stent thrombosis — premature discontinuation can cause a fatal coronary event. The standard of care requires coordinated multidisciplinary decision-making about the timing and safety of antiplatelet cessation in patients with coronary stents.

15. B — The pharmacy consultant identified a dangerously supratherapeutic INR and recommended action, but no system existed to ensure the recommendation reached the attending physician. The report was filed in the chart but never communicated. This gap between identifying a critical safety finding and ensuring it is acted upon — a three-day delay during which a fatal hemorrhage occurred — represents a foreseeable consequence of having no process for urgent pharmacy recommendation communication.

16. C — The permanent loss of fertility — the inability to conceive naturally after loss of the only remaining fallopian tube — is a distinct and significant non-economic damage element. It encompasses emotional distress from lost reproductive capacity, the potential cost of IVF with a gestational carrier, and the profound personal impact on life plans. Loss of fertility is recognized as a unique damage category separate from pain, suffering, and medical expenses.

17. D — The LNC should evaluate whether the acute lifting injury aggravated the pre-existing degenerative condition, transforming an intermittent mild condition manageable with OTC medications into a disabling condition requiring surgery. The clinical trajectory — acute onset during a specific event, progression to radiculopathy, and failure of conservative treatment — supports the work injury as the precipitating cause. Pre-existing degeneration does not preclude occupational aggravation.

18. A — The critical view of safety is a specific dissection technique designed to prevent bile duct injuries. The operative report should document clear identification of the cystic duct and cystic artery with the hepatocystic triangle dissected free before any structure is clipped or transected. Failure to achieve or document this view before transection is the most commonly identified technical factor in bile duct injuries during laparoscopic cholecystectomy.

19. C — The LNC should evaluate whether the prosthetist's recommendation for the upgraded prosthesis is clinically justified. If the dynamic-response foot addresses documented functional limitations (energy expenditure, compensatory gait abnormalities causing secondary joint pain), the MSA should reflect the cost of the clinically recommended prosthesis. The MSA should project the medically necessary device — not the cheapest available option that does not meet the claimant's documented needs.

20. B — The near-miss demonstrates both the value of the independent double-check (which caught the potentially fatal fivefold concentration error) and the vulnerability created by 35% non-compliance. In more than one-third of PCA setups, this same error would not be caught before reaching the patient. The risk management response must address why the double-check is not being performed consistently — because the near-miss reveals the system is functional but underutilized.

21. A — The surgeon's failure to communicate the posterior approach-specific hip precautions to the physical therapy team — or the absence of a system to ensure this communication — created a gap between the surgical plan and the rehabilitation plan. The posterior approach has specific precautions (no flexion beyond 90°, no internal rotation, no adduction past midline) that differ from other approaches, and the therapist's ignorance of these precautions directly caused the foreseeable dislocation.

22. D — The facility failed to secure the kitchen from access by wandering cognitively impaired residents. A kitchen with hot surfaces and sharp implements is a hazardous area that should be inaccessible to residents with documented wandering behavior and moderate dementia. The care plan's failure to address access to hazardous areas — despite documenting wandering as a risk — demonstrates a care planning deficiency that created a foreseeable and preventable injury.

23. B — The clinical documentation of residual shoulder impairments — limited overhead reach and sustained elevation capacity — must be evaluated against the specific physical demands of commercial painting. The LNC should determine whether the documented limitations are compatible with the essential functions of the pre-injury occupation and whether the proposed alternative roles (supervision, estimating) are actually compatible with the plaintiff's functional restrictions.

24. D — The absence of Allen's test documentation creates an inference that the test was not performed. The standard of care requires assessing collateral circulation through the ulnar artery before using the radial artery for catheterization. If the Allen's test demonstrates inadequate collateral flow, the radial approach should not be used. The failure to verify collateral circulation before radial access deviates from the procedural standard of care and directly exposed the patient to the ischemic complication.

25. A — Published SCI clinical practice guidelines specifically recommend these annual specialty evaluations. T6 complete injury creates lifelong risk for urological complications (neurogenic bladder, UTIs, renal stones), respiratory compromise, pressure ulcers, musculoskeletal deterioration, and psychological sequelae. Each complication category requires specialist-level monitoring that exceeds the scope of routine primary care. The defense argument ignores the complexity and specialty-specific nature of SCI management.

26. D — The prescribing physician's failure to order the HLA-B1502 genetic test before prescribing the anticonvulsant to a patient of Filipino (Southeast Asian) descent — when the FDA labeling specifically recommends testing in this population — constitutes prescribing negligence. The test would have identified the patient's elevated SJS risk and prompted selection of an alternative medication. The genetic test exists precisely to prevent the catastrophic outcome that occurred.

27. C — The LNC should evaluate whether the documented exposure to known cardiac toxicants (HCN and CO) during the fire, combined with the temporal onset of arrhythmias following the exposure and the normal pre-employment cardiac screening, establishes a causal relationship. The IME physician's "idiopathic" conclusion ignores the well-documented cardiac toxicity of both substances. The SCBA malfunction that prevented respiratory protection may constitute an additional employer safety violation.

28. B — Beyond the premature discharge (Aldrete score 8 vs. threshold 9), the LNC should evaluate whether the discharging nurse adequately assessed the companion's capacity. The discharge criteria require release to a responsible adult — the nurse should have verified the companion understood respiratory depression signs, had appropriate transportation, and had emergency service access. The companion assessment is a separate and independent standard of care obligation.

29. B — The wheelchair cushion — used 14 months beyond the manufacturer's recommended replacement interval, loaded 30 pounds beyond its rated capacity, and visibly compressed and deformed — was no longer providing adequate pressure redistribution. The facility's absence of a cushion replacement schedule and failure to match the cushion to the resident's weight demonstrates an equipment maintenance failure. The bilateral ischial pressure ulcers were a foreseeable consequence of sitting on a degraded, inadequate cushion surface.

30. D — The 2-hour-and-15-minute gap between postpartum assessments deviates from the standard requiring assessments every 15–30 minutes during the first two hours after delivery. This monitoring failure allowed uterine atony to develop and progress undetected. The 1,800 mL blood loss requiring emergency transfusion, uterine balloon tamponade, and ICU admission was a preventable consequence of the prolonged unmonitored interval.

31. C — The metallurgical defect was specific to a particular manufacturing lot, making the affected baseplates different from the product as designed. This is a manufacturing defect — the screws were intended to have a specific fatigue strength, but the lot-specific defect reduced that strength. The manufacturer's recall notice acknowledging the lot-specific metallurgical problem confirms a production-level defect rather than an inherent design flaw.

32. B — A pathology report showing adenocarcinoma with positive margins and lymphovascular invasion demands immediate surgical referral. The gastroenterologist either failed to review the results or misrepresented them by telling the patient all polyps were "benign." The nine-month delay — during which the patient believed the results were normal — allowed the cancer to progress from what may have been a resectable lesion to regional disease with lymph node involvement.

33. A — The LNC should evaluate the nursing aspects of the case (preoperative preparation, intraoperative nursing duties, postoperative monitoring) but should advise the attorney that opinions on surgical technique and intraoperative surgical decision-making require a surgeon expert. Operating room nursing experience provides knowledge of the perioperative environment but does not qualify the LNC to opine on physician-scope surgical decisions.

34. D — The MSA should project injection frequency based on the treating physician's documented clinical rationale. The documented pain response pattern — three months of relief with predictable four-month recurrence — provides the clinical basis for the projected interval. Injection frequency should be determined by individualized clinical response rather than arbitrary utilization guidelines that do not account for the specific patient's documented treatment needs.

35. C — Once sputum culture identified *Streptococcus pneumoniae* — an organism susceptible to narrow-spectrum agents — antibiotic stewardship principles required de-escalation from the broad-spectrum fluoroquinolone. Fluoroquinolones are specifically identified as high-risk for *C. difficile*, and the patient had two additional *C. difficile* risk factors (age >65, concurrent PPI). Continuing a high-risk broad-spectrum antibiotic when a narrow-spectrum alternative was available deviates from stewardship standards.

36. A — Retirement does not eliminate non-economic damages. The plaintiff's productive activities — volunteering, writing, and board service — represent real-world functional capabilities impaired by the TBI. The damages analysis should evaluate the non-economic impact (loss of purpose, social engagement, intellectual stimulation), any economic components (book income, stipends), and the cost of assistance for tasks the plaintiff previously performed independently. These damages exist regardless of employment status.

37. B — The hospital's post-thyroidectomy protocol should include immediate availability of a physician capable of emergency airway intervention. Rapid neck hematoma with airway compromise is a recognized life-threatening complication requiring emergent airway management within minutes. The 45-minute delay waiting for an off-site surgeon represents a failure to ensure appropriate emergency coverage for this foreseeable postoperative emergency.

38. D — Both the individual care failure (the CNA not engaging wheel locks as specified in the care plan) and the institutional context (the CNA's statement about being "in a hurry" suggesting staffing or workload pressure) should be evaluated. The care plan specified wheel locks engaged at all times when stationary. The direct cause was the unlocked wheels, but the systemic context that enabled the shortcut is equally important for the comprehensive analysis.

39. C — The dermatologist violated multiple mandatory FDA prescribing safeguards for isotretinoin: no iPLEDGE enrollment, no baseline or monthly pregnancy testing, and no documented contraception counseling. Each requirement exists specifically to prevent fetal exposure to a known teratogen. The cumulative violation of all safeguards — not just one — constitutes clear deviations from the prescribing standard of care that directly caused the foreseeable congenital malformations.

40. A — A multi-layered LASA safety strategy is needed because single interventions cannot reliably prevent all LASA errors. Tall-man lettering visually differentiates similar names, physical separation in cabinets reduces selection proximity, independent double-checks add a verification layer, and clinical decision support provides electronic alerts. Each layer addresses the risk at a different point in the medication use process, and the layered approach is the evidence-based standard.

41. B — The LNC should evaluate whether the gastroenterologist's decision to attempt endoscopic removal of a 3 cm sessile cecal polyp — a complex lesion with higher perforation risk — was within the standard of care given the polyp's characteristics and the physician's training level. Current guidelines recommend that complex polyps be referred to advanced endoscopists or considered for surgical resection. The decision to attempt removal, not just the perforation itself, is the central standard of care question.

42. D — The 60% non-compliance rate with the hospital's own MRSA decolonization protocol represents a systems-level failure. The protocol was established because MRSA colonization increases SSI risk — confirmed by the fourfold rate differential. Identifying colonized patients through screening and then failing to decolonize 60% of them before surgery defeats the purpose of the screening program and allows preventable infections in patients already identified as high-risk.

43. A — Fish bones are often radiolucent on plain X-ray, making CT the recommended imaging modality when a foreign body is suspected but not visualized on direct examination. The failure to obtain CT imaging when the patient reported a lodged fish bone may represent a diagnostic standard of care deviation. The four-day delay allowed the embedded bone to perforate the esophagus and cause a retropharyngeal abscess — a life-threatening complication that imaging would have prevented.

44. C — The documented temporal pattern — symptom improvement on days off and worsening on work days — combined with the absence of pre-employment migraine history and the occupational medicine physician's clinical assessment, supports an occupational contribution. Fluorescent lighting is a recognized migraine trigger in the medical literature. The work-relatedness pattern provides clinical evidence that the occupational environment is contributing to the migraine condition.

45. B — The anesthesiologist's decision to continue the injection despite the patient's report of radicular symptoms (sharp, electric shock-like pain shooting down the leg) deviated from the standard of care. Radicular symptoms during spinal needle placement indicate nerve root contact. The standard of care requires immediate needle withdrawal and repositioning before injection. Continuing to inject at the site of nerve contact created the foreseeable nerve root injury.

46. D — Both hexavalent chromium and tobacco are respiratory carcinogens, but they have different target organ specificity. Smoking is primarily associated with lung cancer rather than sinonasal cancer, while hexavalent chromium has a specific, well-documented association with sinonasal carcinomas. The specific tumor location (sinonasal rather than pulmonary) combined with chronic Cr(VI) exposure above the OSHA PEL supports an occupational rather than smoking-related etiology for the sinonasal carcinoma.

47. A — The home health nurse's failure to document site assessment for infection signs, catheter length measurement to detect migration, and line flushing per protocol constitutes multiple deviations from PICC line maintenance standards. Each omission is a separate monitoring failure, and their cumulative effect is that the developing infection was not detected when less invasive intervention would have sufficed. The MRSA bacteremia resulted from a complete absence of maintenance monitoring.

48. C — The projected revision timeline (12–15 years) exceeds the claimant's rated life expectancy (11 years). The MSA should include only expenses reasonably expected to occur within the projected remaining lifetime. Including revision surgeries projected beyond the life expectancy would overstate the MSA allocation. The orthopedist's documentation provides clinical basis for the eventual need, but the timing falls outside the relevant projection window.

49. B — The permanent loss of fine motor dexterity and fine touch sensation required for minimally invasive surgery constitutes a unique vocational loss. Transitioning to a non-surgical medical role involves significant income reduction, loss of surgical subspecialty identity, and loss of the specific professional skills developed over years of specialized training. The damages analysis must capture both the economic differential and the non-economic loss of surgical professional capacity.

50. D — Two separate standard of care issues exist: first, whether the surgical technique protected the ureter during dissection (did the surgeon identify and avoid the ureter); and second, whether ureteral integrity was verified before completing the procedure (using direct visualization, indigo carmine dye, or cystoscopy). Each issue is independently analyzable — the injury may have resulted from a dissection technique failure, a verification omission, or both.

51. A — The LNC's ethical obligation to objectivity requires maintaining the original honest assessment. The finding that the care met the standard of care is a valid and important conclusion that helps the attorney evaluate the case accurately. The LNC cannot change clinical findings to accommodate the attorney's desired outcome. Honest assessment — even when unfavorable — is one of the most valuable services the LNC provides.

52. C — The wound progression from blister to osteomyelitis over 22 days reveals sequential failures: the physician was not notified for 15 days (delayed communication), no treatment escalation occurred as the wound deteriorated (absent clinical response), and no wound care specialist or podiatrist was consulted despite a worsening trajectory in a high-risk diabetic patient (absent specialty referral). Each failure compounded the previous one, allowing a treatable wound to become limb-threatening.

53. B — When clinical findings are classic for testicular torsion (high-riding testicle, absent cremasteric reflex), the standard of care requires immediate urological consultation for emergent surgical exploration. Ordering ultrasound confirmation when the diagnosis is clinically evident introduces a diagnostic delay — the three-hour ultrasound wait consumed the narrow salvage window. Testicular salvage rates exceed 90% within six hours but drop below 10% after 24 hours.

54. D — The scheduling data demonstrating that 60-minute sessions could not have been consistently provided (only 24 minutes per patient including travel and documentation), combined with absent functional goals and template-based documentation, suggests billing for services that were either shorter than billed or not individualized. This pattern misrepresents the services actually provided and implicates the False Claims Act for submission of claims that overstate service duration and content.

55. A — Published spine surgery guidelines recommend achieving an A1c below 8% before elective procedures to reduce infection risk. Proceeding with elective cervical surgery at an A1c of 10.1% without glycemic optimization deviates from these guidelines. The poorly controlled diabetes was a modifiable preoperative risk factor that the surgeon had the opportunity and obligation to address before the elective procedure. The surgical site infection was a foreseeable consequence of operating on an unoptimized diabetic patient.

56. C — Suboptimal effort on performance validity testing indicates the cognitive test scores cannot be reliably interpreted as reflecting actual functioning, but does not automatically prove malingering. Suboptimal effort can result from pain, fatigue, medication effects, depression, anxiety, or genuine cognitive impairment affecting test engagement. The LNC should evaluate whether the defense neuropsychologist considered and ruled out alternative explanations before concluding the plaintiff was fabricating symptoms.

57. D — The hospital's psychiatric patient management policy is inadequate. "Monitor closely" without defined monitoring frequency, elopement precautions, or a standardized elopement risk assessment tool provides insufficient guidance for staff. Four elopement events in six months — with two resulting in patient harm — indicate a systemic policy deficiency rather than isolated individual failures. The policy must define specific, actionable interventions for patients at elopement risk.

58. B — The hospital identified the patient as MRSA-colonized through its own screening program but failed to implement its own decolonization protocol before surgery. This failure to follow the established infection prevention standard — for a patient identified as high-risk by the hospital's own screening — represents a gap between risk identification and risk mitigation. The MRSA periprosthetic joint infection was a foreseeable consequence of operating on a colonized, non-decolonized patient.

59. A — While C5 SCI preserves some upper extremity function (shoulder, elbow, wrist extension), the absence of hand intrinsic function means the plaintiff cannot perform tasks requiring fine motor dexterity, pinch grip, or grasp release — including most self-care activities, food preparation, medication management, and household tasks. Published guidelines for C5 complete SCI recommend 10–16 hours of daily attendant care. The defense argument conflates preserved proximal function with overall independence.

60. C — Whether the surgeon employed spinal cord protection strategies during the aortic surgery — CSF drainage, motor evoked potential monitoring, or staged repair — should be evaluated against the current standard of care. These strategies are specifically recommended for aortic procedures with anticipated prolonged cross-clamping to reduce spinal cord ischemia risk. The operative record's silence on protection strategies raises the question of whether standard precautions were taken.

61. D — The non-integrated clinical and dietary systems created a communication gap that persisted for three weeks. The correct diet order existed in the EHR but was never transmitted to the kitchen's meal preparation system. The absence of a reconciliation process between the two systems, combined with nursing aides' failure to verify diet consistency, demonstrates multiple systems-level failures that collectively produced the fatal choking event.

62. B — The clinical documentation of bilateral heel impairments — chronic pain, limited dorsiflexion, and reduced walking tolerance — must be evaluated against the specific demands of letter carrier work (12 miles daily walking, stair climbing, prolonged standing). The LNC should determine whether these documented limitations are compatible with the essential functions of the pre-injury occupation and whether the proposed desk role is actually available and compatible with the plaintiff's functional restrictions.

63. A — The failure to monitor renal function during 18 months of lithium therapy — when guidelines require monitoring at least every six months — allowed progressive renal impairment to develop undetected. The declining renal function reduced lithium clearance, causing drug accumulation to toxic levels. Routine creatinine monitoring would have detected the rising creatinine before it caused clinically significant lithium accumulation, allowing dose adjustment or drug substitution.

64. C — Ordering the same comprehensive testing panel for all patients regardless of clinical indication — ankle sprains, insect bites, medication refills — without documented medical necessity is consistent with ordering medically unnecessary services driven by revenue rather than individualized care. The template statement "per clinic protocol" does not constitute individualized clinical justification. The False Claims Act is implicated by submission of claims for tests lacking patient-specific medical necessity.

65. D — The surgeon used the LIMA as a bypass conduit despite the documented proximal subclavian stenosis — a known relative contraindication to LIMA use. The standard of care requires evaluation of LIMA inflow before use, and a documented proximal stenosis should have prompted either preoperative flow assessment or selection of an alternative conduit. The postoperative ischemia in the LIMA-grafted territory was a foreseeable consequence of using a conduit with compromised inflow.

66. B — Published evidence demonstrates that occupational asthma from sensitizing agents frequently persists after exposure cessation — often for years or permanently. The immunological sensitization that produces airway hyperresponsiveness does not necessarily resolve when the exposure stops. The insurer's assumption that removal from exposure guarantees complete recovery is not supported by the medical literature, and the ongoing pulmonary treatment is medically necessary for a condition that may not fully remit.

67. A — The patient's progressive symptoms — numbness, coolness, pain, pallor, pulselessness — demonstrate the "six P's" of acute limb ischemia. Attributing these classic ischemic findings to "vasospasm" and ordering warm blankets represents a diagnostic failure. The four-hour delay in obtaining vascular consultation allowed reversible ischemia to progress to permanent ischemic nerve injury. Acute post-catheterization limb ischemia is a vascular emergency requiring immediate intervention.

68. C — Relying solely on a cognitively impaired patient's verbal denial of implants — without independently verifying through the available medical record — represents a failure in the MRI safety screening process. The pacemaker was clearly documented in the EHR. The MRI safety protocol should include mandatory medical record review in addition to patient screening, particularly for patients with known cognitive impairment whose verbal responses may be unreliable.

69. D — The MSA should project injection frequency based on the treating physician's documented clinical rationale. The documented three-month relief duration with predictable four-month recurrence provides the clinical basis for injections every four months. Clinical need — not arbitrary utilization guidelines — should determine the injection frequency. The physician's documentation of the patient's specific response pattern supports the projected interval.

70. B — The LNC should evaluate two issues: whether the thermal injury resulted from a deviation in electrocautery technique (inappropriate settings, excessive contact duration, or inadequate distance from non-target tissue), and whether the intraoperative repair was adequate. The subsequent perforation at the repair site suggests the repair may not have addressed the full extent of the thermal damage — thermal injuries can extend beyond the visible injury zone.

71. A — The documented language-based cognitive deficits directly impact the specific activities that defined the plaintiff's post-retirement quality of life. Impaired word-finding, reduced verbal fluency, and diminished reading comprehension affect book club participation, literacy tutoring, and memoir writing — the intellectual and social activities central to the plaintiff's daily functioning. These losses constitute significant non-economic damages regardless of employment status.

72. C — Perioral tingling, Chvostek's sign, and carpopedal spasm in a post-thyroidectomy patient are classic signs of hypocalcemia — a recognized and potentially life-threatening complication. The nurse's failure to obtain a stat serum calcium and notify the physician immediately upon recognizing these findings allowed a treatable electrolyte emergency to progress to a seizure over 10 unmonitored hours. Critical findings require immediate communication regardless of time of day.

73. D — The ceramic head fracture rate of 0.8% — forty times higher than the industry benchmark of less than 0.02% — indicates a systematic product quality problem. This dramatically elevated rate across the product line cannot be attributed to the inherent and accepted risks of ceramic bearings. The magnitude of the rate differential suggests a design or manufacturing defect specific to this ceramic component that distinguishes it from the general class of ceramic bearing products.

74. B — The surgeon failed to acknowledge the documented SUD history, implement opioid-sparing strategies, and limit the prescription duration. A 30-day opioid supply for a patient with known opioid

use disorder history (in remission for four years) is excessive by current prescribing guidelines, which recommend short courses with multimodal adjuncts for SUD-history patients. The prescription created a foreseeable relapse risk that the guidelines are specifically designed to prevent.

75. A — The facility lacked a system to communicate dietary texture modifications to medication administration staff. No thickened liquid alert existed in the medication administration record, and no mechanism notified medication staff about fluid consistency requirements. The nurse administered thin water because the information needed to prevent the error was not accessible at the point of medication administration — a predictable systems gap between dietary orders and medication delivery.

76. C — The LNC should evaluate whether the radiologist had an obligation — under state breast density notification law and/or the evolving standard of care — to inform the patient about dense tissue and its impact on mammographic sensitivity. Extremely dense breast tissue reduces mammographic cancer detection sensitivity, and the patient was not informed of this limitation or the potential benefit of supplemental screening. The 20-month delay allowed the cancer to reach Stage IIIA.

77. D — The risk management program should address all three identified systemic factors: mandate intraoperative X-ray for unresolved count discrepancies (eliminating recount-only resolution), address production pressure through leadership reinforcement of the count process, and enforce sign-out checklist completion. These three interventions target the specific contributing factors common to all three retained item events, addressing the systemic vulnerability rather than individual performance.

78. B — Crepitus — subcutaneous gas formation palpable on examination — is a hallmark finding of necrotizing fasciitis that distinguishes it from simple cellulitis. Its presence, combined with pain out of proportion to the wound's appearance and rapidly spreading erythema, should have prompted immediate surgical consultation for emergent debridement. Diagnosing cellulitis and prescribing oral antibiotics when crepitus is present is a critical diagnostic failure with life-or-limb consequences.

79. A — The LNC should evaluate published literature on prosthetic replacement intervals for bilateral above-knee amputees, manufacturer recommendations, and the treating prosthetist's clinical rationale. Bilateral AK amputees place greater stress on prosthetic components than unilateral amputees, typically requiring more frequent replacement. The prosthetist's rationale based on the patient's bilateral amputation level, activity, and documented wear patterns provides the clinical basis for the 3–5 year cycle.

80. C — The ophthalmologist's assessment of "mild postoperative inflammation" was inconsistent with the clinical presentation (eye pain, reduced vision, purulent discharge), which was more suggestive of

endophthalmitis. Current guidelines for suspected postoperative endophthalmitis recommend emergent vitreous tap and intravitreal antibiotics. The delay in recognizing the infection and initiating appropriate treatment allowed it to progress beyond the point of visual salvage.

81. C — The 45% rate of catheterization without documented indication represents systemic noncompliance with CMS requirements and catheter management standards. The elevated CAUTI rate (3.5 times benchmark) is a foreseeable consequence of catheter overuse. The institution should implement a catheter appropriateness protocol, mandatory indication documentation, and daily necessity assessments to reduce both unnecessary catheterization and the resulting preventable infections.

82. B — Fibromyalgia is a recognized medical diagnosis with established ACR diagnostic criteria. The plaintiff's documented findings meeting these criteria, the absence of pre-accident pain complaints, and the temporal relationship between the accident and symptom onset collectively support both the diagnosis and its relationship to the traumatic event. Published medical literature documents trauma-onset fibromyalgia as a recognized clinical entity, directly contradicting the defense's characterization.

83. A — The surgeon relied on anatomical landmarks alone without intraoperative imaging as recommended by current guidelines. The wrong-level error is objective proof that the landmark-based verification was inadequate. Current guidelines recommend intraoperative radiographic confirmation specifically because anatomical landmarks can be unreliable — the wrong-level error demonstrates exactly why the imaging standard exists and was needed.

84. D — Only medications related to the compensable lumbar spine injury should be included in the MSA. Hypertension and diabetes medications are for pre-existing conditions unrelated to the work injury and remain the claimant's personal responsibility under Medicare. The MSA's purpose is to protect Medicare's interests for injury-related future medical expenses — not to fund treatment for pre-existing, unrelated conditions.

85. C — Multiple pressure injury prevention failures converged: no repeat risk assessments during a 10-day stay, repositioning gaps of 6–8 hours (versus the 2-hour care plan), no specialty mattress for a high-risk patient, and no nutritional intervention despite low albumin. These failures collectively demonstrate a systemic breakdown in implementing the comprehensive prevention strategy demanded by the patient's documented high risk. No single failure alone explains the outcome.

86. B — The bilateral symmetric hearing loss with the characteristic 4000 Hz audiometric notch is the hallmark pattern of noise-induced hearing loss. This pattern distinguishes NIHL from presbycusis, which produces gradual sloping high-frequency loss without a discrete notch. Combined with 20 years

of documented exposure above the OSHA PEL, the audiometric pattern provides strong objective evidence supporting occupational noise-induced hearing loss rather than age-related degeneration.

87. A — The failure to monitor B12 levels during three years of post-bariatric surgery follow-up is a clear, unambiguous standard of care deviation. B12 deficiency is a predictable and preventable consequence of Roux-en-Y gastric bypass due to altered absorption. Guidelines require lifelong nutritional monitoring. The three-year gap allowed a treatable deficiency to progress to irreversible neurological damage (subacute combined degeneration of the spinal cord).

88. D — Both TCE exposure and obesity are established independent risk factors for kidney cancer. The presence of one does not eliminate the contribution of the other. The LNC should evaluate each plaintiff individually, considering TCE exposure levels and duration, the dose-response relationship, BMI and obesity duration, and whether the factors may have acted independently or synergistically. The analysis must assess each risk factor's relative contribution rather than attributing causation to either one exclusively.

89. C — The midfoot fusion eliminates the midfoot motion essential for ballet pointe work — a fundamental biomechanical requirement that cannot be compensated for or worked around. Teaching ballet requires different skills, provides different compensation, and does not substitute for the loss of artistic performance, professional identity, and creative expression. The damages analysis must capture both the economic loss and the irreplaceable non-economic loss of performance capacity.

90. B — The physician's failure to respond to the critically elevated INR of 6.8 — by contacting the patient, adjusting the warfarin dose, and arranging repeat testing — represents a failure to act on a critical laboratory result. The four-day delay between the elevated result and the hemorrhagic event allowed a treatable anticoagulation excess to progress to a life-threatening gastrointestinal hemorrhage. Critical laboratory values mandate immediate clinical response.

91. D — The non-integrated clinical and dietary systems created a communication gap where the diet order documented in the EHR was never transmitted to the kitchen's meal production system. The two-week persistence of the incorrect diet — without detection or reconciliation — demonstrates the absence of any process to verify that clinical diet orders are accurately reflected in the meal preparation system. The aspiration event was a foreseeable consequence of this systems gap.

92. A — The nurse's failure to respond to oxygen desaturation (80%) and bradycardia — by administering supplemental oxygen, alerting the endoscopist, and initiating rescue interventions — represents a critical failure to act on acute deterioration during procedural sedation. Continuous

monitoring during sedation requires immediate response to vital sign changes. The five-minute period of sustained hypoxemia below 85% caused the preventable cognitive deficits.

93. C — The uniform prescribing of the same compounded cream for all patients, the \$4,200 monthly cost versus \$60–\$100 for commercial alternatives, the physician's ownership interest in the pharmacy, and the absent medical necessity documentation collectively raise concerns about financially motivated prescribing. The Anti-Kickback Statute (physician-pharmacy ownership), the False Claims Act (billing without medical necessity), and the Stark Law (self-referral) are all potentially implicated.

94. B — The dispensing cabinet malfunction that delayed antibiotic delivery represents a systems failure. The hospital's processes should ensure prophylactic antibiotics are available and administered before incision for every case. The failure of the dispensing system created a gap in the infection prevention protocol. The antibiotic was ordered correctly and on time — the delay was entirely attributable to equipment failure, which is an institutional responsibility.

95. D — The LNC should answer honestly. Expert witnesses are compensated for their time and expertise, not for specific opinions. The appropriate response confirms compensation while clarifying that payment is for time and expert analysis, not for the content or direction of the testimony. This distinction is professionally important — it demonstrates that the LNC's opinions are based on clinical evidence, not financial incentive.

96. A — The surgeon's failure to implement modified weight-bearing protocols and communicate bone quality concerns in a patient with severe osteoporosis (T-score -3.8) and chronic steroid use deviates from the standard of care. Both conditions significantly increase periprosthetic fracture risk during rehabilitation. The standard of care requires tailoring the postoperative rehabilitation plan to the patient's bone quality and communicating any restrictions to the therapy team.

97. C — Five specimen mislabeling events across multiple specimen types in six months — in the absence of barcode-based positive patient identification — indicates a systemic vulnerability in the manual labeling process. The consistent error pattern across different specimen types (blood bank, chemistry, pathology) demonstrates that the manual process is inherently error-prone and requires technology-based intervention (barcode specimen identification) rather than individual retraining.

98. B — The LNC should evaluate whether the documented executive dysfunction, memory impairment, impulsivity, and irritability are compatible with any supervisory role. Construction supervision requires planning, sequencing, multi-tasking, conflict resolution, and consistent interpersonal interactions — cognitive and behavioral functions specifically impaired by the

documented TBI deficits. The vocational expert's "simple supervisory tasks" recommendation must be tested against the full spectrum of documented impairments.

99. D — The bilirubin level in the high-risk zone on the Bhutani nomogram required follow-up within 24 hours per AAP guidelines. The one-week follow-up instruction deviated from this standard, creating a six-day gap during which the rising bilirubin went unmonitored. Timely follow-up would have identified the escalating bilirubin before it reached neurotoxic levels, allowing phototherapy or exchange transfusion to prevent the permanent brain damage of kernicterus.

100. A — The critical view of safety is the standard dissection technique specifically designed to prevent bile duct injuries during laparoscopic cholecystectomy. The operative report's failure to document achievement of this view suggests it may not have been performed before clipping and transecting structures. Failure to achieve the critical view is the most commonly identified technical factor in bile duct injuries, and its absence from the operative documentation is the most significant finding.

101. B — The hospital's failure to ensure immediate tPA availability in the emergency department represents a stroke readiness systems failure. The 75-minute pharmacy retrieval delay consumed time-dependent treatment benefit — published evidence shows every 15-minute delay reduces the probability of a good neurological outcome. For time-critical interventions like tPA, the medication must be immediately accessible at the point of care to prevent avoidable delays.

102. D — The facility identified heel pressure injury risk at admission and developed a care plan specifying offloading devices, but completely failed to implement the intervention. The total absence of documentation that offloading was ever applied, combined with absent heel skin assessments after admission, demonstrates a complete disconnect between the documented plan and actual care. Planning without execution does not constitute adequate care.

103. C — The manufacturer's knowledge of the elevated lead fracture rate (7.2% vs. <1% benchmark) for 16 months without issuing any safety communication constitutes a failure to warn. This delay deprived electrophysiologists and patients of information needed for informed device management decisions — including enhanced monitoring or prophylactic lead replacement. The 16-month gap between awareness and any communication is the critical liability issue.

104. A — When a polyp with high-grade dysplasia is removed piecemeal (making margin assessment impossible), current guidelines require a short-interval follow-up colonoscopy in 3–6 months to evaluate for residual tissue. The gastroenterologist's recommendation for a three-year interval was clinically

inappropriate for this pathology finding. The 2.5-year gap allowed residual adenomatous tissue to progress to invasive carcinoma at the polypectomy site.

105. B — The documented mercury exposure levels consistently above the biological exposure index, the temporal onset of tremors during the exposure period, the normal pre-employment neurological examination, and the neuropsychological deficit pattern (motor speed, manual dexterity, visuospatial processing) collectively support an occupational etiology. The deficit pattern is specifically consistent with mercury neurotoxicity as described in the published toxicology literature, undermining the IME's attribution to essential tremor.

106. D — The automated dispensing cabinet restocking failure represents a systems-level breakdown. The hospital's processes should ensure prophylactic antibiotics are available in the OR for every surgical case. The failure of the restocking process created a gap in the infection prevention protocol — the antibiotic was ordered correctly and on time, but the dispensing system failure prevented timely administration. Equipment reliability is an institutional responsibility.

107. C — The residual Achilles impairments specifically disable the biomechanical functions essential to golf instruction — push-off strength for swing demonstration and walking tolerance for course instruction. The damages must account for both the economic loss (teaching income) and the significant non-economic loss (inability to perform and teach the sport that defined the plaintiff's post-retirement identity). Semi-retired status does not eliminate the significance of these losses.

108. A — The latex allergy was documented in three separate locations but the hospital's latex allergy protocol was never activated. This illustrates the critical gap between identifying a hazard and implementing the safety intervention. Documentation alone does not prevent harm — the protocol designed to translate the allergy documentation into a latex-free operative environment must be reliably triggered. Three documentations without action equals zero protection.

109. B — Sequential nursing care failures produced a catastrophic outcome: sporadically performed foot inspections (twice weekly versus daily) delayed wound detection, and the nine-day delay in physician notification allowed a treatable ulcer to progress to osteomyelitis and gangrene. Each failure compounded the previous one — the monitoring failure prevented early detection, and the communication failure prevented early treatment, transforming a manageable wound into a limb-threatening emergency.

110. D — Severe headache, visual disturbances, right upper quadrant pain, blood pressure 178/112, and 4+ proteinuria at 36 weeks constitute a classic and unmistakable presentation of severe preeclampsia with impending eclampsia. This presentation demands immediate hospital admission, IV magnesium for seizure prophylaxis, antihypertensive therapy, and likely emergent delivery. The obstetrician's telephone instruction to discharge the patient with acetaminophen and next-day follow-up was a dangerous mismanagement of a life-threatening emergency.

111. A — The request to pose as a prospective patient to gather information about the defendant physician constitutes deception and potentially violates LNC ethical standards, rules of professional conduct, and may constitute improper ex parte contact with a represented party. The LNC must decline regardless of the attorney's rationale. Professional ethical obligations cannot be overridden by an attorney's litigation strategy.

112. C — The surgeon proceeded with elective joint replacement without addressing two documented modifiable infection risk factors — poorly controlled diabetes (A1c 9.8%) and active smoking — both of which published guidelines recommend optimizing before elective surgery. The absence of a documented risk-benefit analysis further compounds the deviation. The standard of care requires at minimum acknowledging and addressing modifiable risks before elective procedures.

113. B — Hepatic angiosarcoma is an extremely rare tumor with a very specific and well-documented association with vinyl chloride exposure. Alcohol consumption causes hepatocellular carcinoma — a fundamentally different tumor type — not angiosarcoma. The specific tumor histology effectively distinguishes between the competing causation arguments. The defense's attempt to attribute angiosarcoma to moderate alcohol use contradicts basic oncological principles about tumor-specific etiology.

114. D — Only medications related to the compensable bilateral knee injuries should be included in the MSA. The hypertension, diabetes, and hypothyroidism medications are for pre-existing conditions unrelated to the work injury and remain the claimant's personal responsibility under regular Medicare coverage. The MSA's purpose is to protect Medicare's interests for injury-related future medical expenses, not to fund treatment for unrelated pre-existing conditions.

115. A — The critical view of safety is the standard technique designed to prevent bile duct injuries by definitively identifying the cystic duct and cystic artery before clipping. The operative report's failure to document achievement of this view suggests it may not have been performed. Failure to achieve the critical view is the most commonly identified technical factor in bile duct injuries during laparoscopic cholecystectomy.

116. C — The indwelling catheter remained 12 months beyond the original clinical indication without documented reassessment. Evidence-based catheter management standards require daily necessity assessment and prompt removal when the indication no longer exists. Each additional day of catheterization increases the CAUTI rate by 3–7%. The prolonged unnecessary catheterization directly increased the risk of the infection that progressed to fatal urosepsis.

117. B — Three independent safety layers failed: the oncologist wrote the wrong dosing unit (mg/kg instead of mg/m<sup>2</sup>), the pharmacist failed to recognize that the resulting dose was 100–500 times the standard range, and the nurse failed to question the obviously excessive dose before administration. Each provider had an independent opportunity to catch the error. The convergence of all three failures allowed a threefold overdose to reach the patient.

118. D — The combination of residual shoulder impairment (limiting overhead loading/unloading) and persistent cognitive symptoms (slowed processing speed, concentration difficulty) must be evaluated against the demands of all commercial driving — not just long-haul. Both long-haul and local delivery driving require sustained concentration, defensive driving judgment, and physical loading tasks. The documented deficits may preclude both driving categories, not just long-haul routes.

119. A — Unilateral leg swelling with calf pain in a patient six weeks postpartum from cesarean section — with three VTE risk factors and a significantly elevated D-dimer — demanded definitive DVT imaging. Diagnosing "postpartum edema" without duplex ultrasound in this clinical context is a critical diagnostic failure. The fatal PE was a foreseeable and preventable consequence of the missed DVT diagnosis.

120. C — Six insulin errors across multiple types (wrong formulation, wrong dose, wrong patient, failure to hold) in four months indicate a systemic deficit. The absence of a standardized protocol, dedicated ordering template, and independent double-check verification creates an environment where insulin errors are predictable. Comprehensive safety measures addressing ordering, dispensing, and administration are needed to address the institutional vulnerability.

121. D — The emergency physician failed to consider appendicitis in the differential for a child with acute abdominal pain and failed to obtain basic diagnostic studies (WBC count, imaging) that would have supported or excluded the diagnosis. Appendicitis must remain on the differential in any child with acute abdominal pain until definitively excluded. The 36-hour delay allowed the appendix to perforate, converting a straightforward appendectomy into a complicated peritonitis case.

122. B — The cervical rib was present and asymptomatic during the pre-employment physical — the development of TOS symptoms during the period of occupational exposure (repetitive overhead reaching, IV pump operation, chest compressions) suggests the work activities converted the asymptomatic predisposition into symptomatic disease. Under the aggravation doctrine, the occupational activities provoked a condition that was dormant despite the pre-existing anatomical variant.

123. A — The time-out failed to include meaningful verification of the marked site against the consent form and operative schedule. The surgeon marked the correct knee, but during the time-out, no one confirmed the draped surgical field matched the marking. A time-out conducted without actual site verification is a procedural formality providing false reassurance rather than genuine safety protection. The wrong-site surgery proves the verification was not performed.

124. C — The prescribing physician committed two independent failures: failure to monitor ANA levels during long-term procainamide therapy (a known monitoring requirement for a drug with a 20% lupus incidence rate), and failure to recognize DILE symptoms when they appeared (attributing joint pain and malaise to "aging"). Both are physician-level breaches independent of whether the manufacturer's labeling was adequate.

125. D — The facility identified the very high risk (Braden 10), developed a care plan with appropriate interventions, but failed to implement them. Repositioning at 4–6 hours instead of the care-planned 2 hours, a three-week specialty mattress delay, and no nutritional intervention despite albumin of 1.8 g/dL demonstrate planning without execution. Each failure independently increased pressure ulcer risk; together they represent a systemic breakdown in implementing the care plan.

126. B — The surgeon's failure to discontinue aspirin before elective cervical spine surgery — when guidelines recommend cessation 7–10 days preoperatively — deviates from the standard of care. Aspirin's antiplatelet effect increases postoperative bleeding risk, and the epidural hematoma is the exact complication the guideline-recommended cessation is designed to prevent. The continued aspirin was a modifiable risk factor the surgeon had the opportunity and obligation to address.

127. A — Multi-level bilateral injections clinically justified in only 15% of cases — with 85% having single-level pathology — combined with the physicians' financial interest in the facility raises concerns about medically unnecessary procedures driven by revenue. The False Claims Act (billing for unjustified procedures), the Stark Law (self-referral), and the Anti-Kickback Statute are all potentially implicated by this pattern.

128. C — The patient was discharged with an Aldrete score of 8 when the facility's minimum threshold is 9 — an objective, documented deviation from discharge criteria. The Aldrete score quantifies post-anesthesia recovery, and a score below threshold indicates inadequate recovery. The respiratory arrest 45 minutes after arriving home was a foreseeable consequence of premature discharge before sufficient anesthesia recovery.

129. D — The documented impairment of parenting capacity constitutes both a non-economic damage (loss of the ability to fulfill a fundamental life role) and an economic damage (cost of supplemental childcare and supervisory assistance). The neuropsychological documentation of deficits in supervision, discipline, meal planning, homework assistance, and emergency decision-making provides the clinical basis for quantifying both dimensions of this compensable damage.

130. B — The surgeon failed to implement prophylactic measures in a patient with four significant wound healing risk factors. Published guidelines recommend enhanced closure techniques and preoperative risk factor modification for high-risk patients. Standard layered closure without retention sutures, subcutaneous drainage, or nutritional optimization in a patient with this risk profile represents a failure to match the surgical approach to the patient's documented clinical needs.

131. C — The fourfold error rate among agency nurses suggests the hospital's orientation process is inadequate. A 20-minute tour without unit-specific orientation, medication system training, or competency verification cannot equip agency staff with facility-specific knowledge for safe care. The disproportionate error rate is a measurable indicator that the orientation process fails to prepare temporary staff for the facility's specific protocols, systems, and patient population.

132. A — Perioral numbness, finger tingling, and muscle cramping after thyroidectomy are classic early signs of hypocalcemia — a recognized, potentially life-threatening complication. These findings require immediate serum calcium measurement and physician notification. The eight-hour delay allowed a treatable electrolyte emergency to progress to laryngospasm and seizure. Critical post-thyroidectomy findings demand immediate assessment and communication regardless of time of day.

133. D — While chrysotile may be less potent than amphibole forms, the IARC Group 1 classification applies to all asbestos forms including chrysotile. The scientific consensus recognizes that chrysotile can cause mesothelioma, particularly at sustained high-level exposures documented in brake manufacturing. The relative potency debate affects the magnitude of risk at different exposure levels but does not negate chrysotile's established carcinogenicity.

134. B — The life care plan must project full professional attendant care costs regardless of family caregiving. The plan reflects the plaintiff's actual care needs independent of the family's current willingness and ability — family members may become unable to continue due to aging, health changes, burnout, or personal circumstances. For a ventilator-dependent patient, care requires trained respiratory caregivers, not family members without formal training.

135. C — Progressive tachycardia (72 to 128), declining hemoglobin (14.0 to 9.2), and increasing pain after femoral artery catheterization constitute a clinical picture of active hemorrhage. Attributing these trending changes to "post-procedure discomfort" and "anxiety" without recognizing them as warning signs and notifying the physician represents a critical assessment and communication failure. The three-hour notification delay allowed the hematoma to expand to hemodynamically significant volume.

136. A — The clinical documentation of residual wrist impairments and their impact on dental hygiene demands should determine the vocational outcome. A 40% grip strength reduction, chronic pain, and limited range of motion must be evaluated against the specific requirements of dental hygiene — sustained pinch grip, repetitive wrist motion, and fine motor dexterity. The defense's assumption that ergonomic modifications can overcome these deficits should be tested against the clinical evidence.

137. D — Published guidelines recommend A1c below 8% before elective spinal procedures. Proceeding at A1c 9.6% without glycemic optimization deviates from the preoperative standard of care. The A1c was a modifiable risk factor the surgeon had the opportunity and obligation to address before the elective procedure. The SSI requiring hardware removal and prolonged IV antibiotics was a foreseeable consequence of operating on an unoptimized diabetic patient.

138. B — Whole-body vibration from heavy equipment operation is a well-established occupational risk factor for lumbar disc degeneration and herniation. The normal pre-employment physical at age 32 combined with 18 years of documented WBV exposure and the development of multilevel disease during this period supports occupational contribution. The IME physician's categorical attribution to "age-related degeneration" ignores the extensive published literature linking WBV to lumbar disc disease.

139. C — A negative upper GI series does not definitively exclude a staple line leak — the sensitivity is imperfect for bariatric leaks. When clinical signs persist and worsen (tachycardia, fever, rising WBC, Kehr's sign) despite a negative contrast study, CT scanning is required. Attributing persistent concerning signs to "post-surgical stress response" without further workup ignores the clinical reality that contrast studies can miss contained leaks.

140. A — The LNC's ethical obligation to objectivity requires reporting all clinically significant findings honestly. Omitting unfavorable findings at the attorney's instruction violates professional ethics and would ultimately disserve the attorney by preventing informed case management decisions. The LNC should explain that honest assessment — even when unfavorable — is one of the most valuable services provided, enabling the attorney to make realistic settlement and strategy decisions.

141. B — The radiologist's failure to notify the patient about extremely dense breast tissue — in violation of the applicable state law — and failure to recommend supplemental screening deprived the patient of the opportunity for earlier cancer detection. Dense breast tissue significantly reduces mammographic sensitivity, and supplemental screening (ultrasound, MRI) has demonstrated improved cancer detection in dense breasts. The 14-month delay allowed progression to Stage IIIA disease.

142. D — The nursing home failed to transmit the advance directive with the transfer documentation, depriving the hospital of critical information about the resident's comfort-measures-only wishes. The resulting invasive procedures (heparin, catheterization, stent placement) directly violated the documented directive. The facility's transfer process failed at its most fundamental obligation — ensuring that the resident's wishes regarding the scope of medical care accompanied the resident to the receiving facility.

143. C — Design defect (the elevated posterior migration rate of 3.8% vs. <0.5% across the product line suggests an inherent fixation mechanism problem) and failure to warn (the manufacturer's knowledge of the elevated rate without updating labeling deprived surgeons and patients of material information) are both applicable. The combination of a systematic product defect with concealed knowledge of elevated failure rates creates dual liability theories.

144. A — Three simultaneous standard of care failures converged: no CPAP continuation for a documented OSA patient, no continuous pulse oximetry during opioid PCA, and no opioid-sparing strategies. Current guidelines specifically identify OSA patients receiving opioids as high-risk and recommend all three safeguards. Each absent safeguard independently would have reduced the risk — the absence of all three left the patient completely unprotected.

145. B — The population prevalence of a condition does not determine its etiology in an individual case. Lateral epicondylitis being common in the general population does not prove this therapist's condition is unrelated to six years of daily repetitive forceful gripping and wrist extension. The published occupational health literature identifies these exact demands as risk factors. The IME physician's reasoning contains a fundamental logical error.

146. D — The failure to monitor iron levels during two years of post-bariatric surgery follow-up allowed a predictable deficiency to progress to severe symptomatic anemia (hemoglobin 6.8 g/dL). Iron deficiency after Roux-en-Y is predictable due to altered absorption. Guidelines require lifelong monitoring. Routine iron studies would have detected the declining levels before they reached the critical threshold requiring emergency transfusion.

147. C — The permanent bilateral wrist impairments eliminate the fine motor precision, sustained endurance, and dynamic range required for concert-level piano performance. Teaching and composition require fundamentally different skills, provide different compensation, and do not substitute for the loss of artistic performance and professional identity developed over 15 years. The damages analysis must capture both the economic and the irreplaceable non-economic losses.

148. A — Three independent safety barriers failed: the physician overrode the allergy alert without valid justification (amoxicillin has significant cross-reactivity with penicillin in anaphylaxis patients), the pharmacist did not verify the override, and the nurse did not check allergies before administration. Each barrier was designed to independently prevent this event. The cascade of three simultaneous failures allowed the documented severe allergy to cause a preventable anaphylactic reaction.

149. B — Radiologists have a duty to evaluate all visualized structures on cross-sectional imaging, not only the area of clinical concern. A 4.5 cm renal mass retrospectively visible on the study should have been identified, particularly when renal pathology is within the differential for flank pain and hematuria. The seven-month delay allowed the cancer to grow and metastasize, significantly changing the treatment options and prognosis.

150. D — All components of the treating physician's documented pain management plan that are injury-related and Medicare-covered should be included. The physician's clinical recommendation with documented rationale establishes medical necessity for the interventional procedures. Characterizing medically recommended treatments as "elective" to exclude them is inconsistent with the MSA's purpose of protecting Medicare's interests in covering future injury-related expenses.

151. A — Crepitus combined with pain out of proportion, rapidly spreading erythema with dusky discoloration, and hemodynamic instability mandates immediate surgical consultation for emergent debridement. Necrotizing fasciitis is a surgical emergency where every hour of delay increases tissue loss and mortality. The 12-hour delay before surgical consultation allowed extensive tissue destruction that ultimately required above-elbow amputation.

152. C — The six-week gap in INR monitoring — when the schedule specified every two weeks — represents a warfarin management standard of care deviation. The supratherapeutic INR of 7.2 and resulting hemorrhage are foreseeable consequences of unmonitored anticoagulation. Regular INR monitoring exists specifically to detect supratherapeutic levels before they cause bleeding complications.

153. B — The surgeon's failure to respond to observed sciatic nerve tension — by repositioning the limb, reducing retraction, or employing nerve monitoring — should be evaluated against the standard of care for nerve protection during hip arthroplasty. The operative report's documentation of tension creates direct evidence that the surgeon was aware of the nerve stress and did not modify the approach. The immediate postoperative foot drop confirms the nerve was injured during the procedure.

154. D — The routine use of expensive definitive testing (\$600–\$900) when qualitative screening (\$15–\$20) would be clinically appropriate as the initial test — combined with the significant revenue differential — is consistent with ordering medically unnecessary testing driven by financial incentive. Published guidelines recommend qualitative screening first, with definitive testing reserved for unexpected or clinically significant results requiring confirmation.

155. A — The surgeon's unilateral decision to discontinue clopidogrel without consulting the cardiologist — for a patient with a drug-eluting coronary stent — deviated from the standard of care requiring multidisciplinary coordination. Drug-eluting stents have higher stent thrombosis risk with premature antiplatelet cessation. The acute MI from stent thrombosis was a foreseeable consequence of the uncoordinated antiplatelet cessation decision.

156. C — The permanent loss of grip strength (12% of normal), absent protective sensation, and CRPS constitute both an economic loss (master craftsman earning capacity) and a profound non-economic loss (permanent inability to practice a specialized craft defining the plaintiff's identity, creative expression, and life purpose). CAD work is a fundamentally different occupation that cannot compensate for the irreplaceable loss of hands-on craftsmanship.

157. D — Multiple VAP bundle deviations — inadequate head-of-bed elevation, insufficient oral care frequency, inappropriate routine circuit changes (which paradoxically increase VAP risk), and absent sedation vacations — collectively increased the VAP risk. The VAP prevention bundle is designed as a comprehensive package where each element provides independent benefit. The analysis should evaluate the cumulative impact of all bundle deviations rather than any single element.

158. B — Alert fatigue from scanner failures, absent barcodes, and time pressure has conditioned nurses to override BCMA alerts reflexively. The 22% override rate driven by system reliability problems undermines the technology's ability to prevent genuine medication errors. The nurse who overrode the legitimate alert assumed it was another false alarm — a rational response conditioned by the system's own unreliability. The root cause is the system reliability, not the individual nurse's judgment.

159. A — Published guidelines recommend surgical evaluation for complex ovarian cysts larger than 6 cm that are persistent or enlarging. Observing a progressively enlarging complex cyst through six months of growth (6→9→12 cm) without surgical intervention deviated from these guidelines. Earlier surgical intervention would have identified the cancer at an earlier stage with potentially better treatment options and prognosis.

160. C — Published SCI clinical practice guidelines specifically recommend the projected specialty evaluations as preventive care for thoracic-level SCI. T10 complete injury creates lifelong risk for neurogenic bladder complications, skin breakdown, musculoskeletal deterioration, respiratory changes, and psychological sequelae — each requiring specialist-level monitoring beyond primary care scope. The defense argument ignores the published evidence supporting the necessity of specialty-level SCI management.

161. D — The hospital identified the patient as MRSA-colonized through its own screening program but failed to initiate its own decolonization protocol. This gap between risk identification (positive screen) and risk mitigation (decolonization not initiated) represents a systems failure. The hospital screened for the risk, found the risk, and then failed to act on the finding — defeating the purpose of the screening program entirely.

162. B — The documented absence of pre-injury psychiatric history, the temporal onset of PTSD related to the assault, the psychiatric evaluation documenting specific DSM-5 criteria with the assault as the traumatic event, and the severity of the event (violent assault with LOC) collectively establish the causal relationship. The employer's acceptance of the physical injuries does not automatically establish psychiatric compensability, but the clinical evidence independently supports occupational causation.

163. A — Progressive tachycardia (80 to 135), declining hemoglobin (13.8 to 8.4), and worsening pain after femoral catheterization are indicators of active hemorrhage. The nurse's failure to recognize these trending changes and the three-hour notification delay represent critical assessment and communication failures. Attributing these findings to "discomfort" and "anxiety" demonstrates failure to synthesize clinical data indicating a surgical emergency.

164. C — The non-integrated clinical and dietary systems created a persistent communication gap. The correct diet order existed in the EHR but was never reflected in the kitchen's meal production system for 11 days. The absence of any reconciliation process between the two systems allowed the discrepancy to persist undetected until the fatal aspiration event — demonstrating a foreseeable and preventable consequence of non-integrated information systems.

165. D — A 2.2 cm appendiceal carcinoid with mesoappendix involvement requires right hemicolectomy per NCCN guidelines because of the risk of lymph node metastasis. The surgeon either failed to review the pathology or misunderstood its significance by characterizing a malignant tumor as "benign." The two-year delay allowed a potentially curable local tumor to metastasize, fundamentally changing the treatment options and prognosis.

166. B — The documented cognitive deficits (executive dysfunction, memory impairment) and behavioral changes (impulsivity, poor social judgment) must be evaluated against all real estate functions — including the clerical role proposed by the defense. Real estate work requires negotiation, client management, contract interpretation, financial calculation, and reliable judgment. Even clerical roles may require organizational skills and client interaction that the plaintiff's documented impairments preclude.

167. A — Current sedation monitoring guidelines recommend capnography for all patients receiving moderate to deep sedation because capnography detects hypoventilation and apnea significantly earlier than pulse oximetry. The well-documented oxygen reservoir effect delays pulse oximetry desaturation detection by 3–4 minutes after the onset of hypoventilation. The facility's reliance on pulse oximetry alone — without capnography — should be evaluated against the current standard of care.

168. C — Three independent safety layers failed: the physician committed a CPOE pick-list error, the pharmacist failed to recognize that 100 mg of hydromorphone is 100–500 times the standard dose range, and the nurse failed to question an obviously excessive dose before administration. Each provider had an independent opportunity to catch an error of this magnitude. The convergence of all three failures allowed a catastrophic overdose to reach the patient.

169. D — The projected revision timeline (12–15 years) exceeds the claimant's rated life expectancy (8 years). The MSA should include only expenses reasonably expected to occur within the projected remaining lifetime. Including a revision projected beyond the life expectancy would overstate the allocation. The orthopedist's documentation provides clinical basis for eventual need, but the timing falls outside the relevant projection window.

170. B — The three-hour gap between postpartum assessments — when the standard of care requires every 15–30 minutes — is a critical monitoring failure. The unmonitored interval allowed uterine atony to develop and progress to a 2,000 mL hemorrhage requiring multiple emergency interventions. Timely fundal assessment would have detected the boggy uterus early, when fundal massage and uterotonics could have prevented the hemorrhagic cascade.

171. C — Design defect (47 field reports suggesting a systematic problem), failure to warn (manufacturer's knowledge of misfires without safety communication), and the surgeon's operative documentation of the malfunction linked to the leak at the misfire site collectively establish the causal chain. The manufacturer knew about repeated misfires in this model for 18 months but did not warn — depriving surgeons of information needed to consider alternative stapling devices.

172. A — Administering IV contrast without checking renal function in a patient with known CKD (eGFR 22) and without implementing renal protection (hydration, N-acetylcysteine) deviated from the radiological standard of care for contrast administration. The contrast-induced nephropathy requiring temporary dialysis was a foreseeable and preventable consequence of administering nephrotoxic contrast to a patient with severely impaired renal function without protective measures.

173. D — The transition from consulting to testifying expert may expose previously protected work product to discovery. The opposing party is entitled to discover the basis for the testifying expert's opinions and materials considered. Internal memoranda — including unfavorable findings — prepared during the consulting phase may become discoverable. The LNC must understand this implication and discuss it with the attorney before agreeing to the designation change.

174. B — The standard of care for right hemicolectomy requires awareness of the right ureter's anatomical position and active measures to identify and protect it during dissection. The failure to recognize the transection intraoperatively suggests the ureter was not adequately visualized and protected. The defense's "recognized complication" argument does not address whether the surgeon followed the standard of care to prevent the injury.

175. C — Three simultaneous failures of care plan-specified safety measures — elevated bed, side rail down, dead alarm battery — combined with a 1:12 nurse-to-patient ratio limiting the nurse's ability to monitor high-risk residents. The analysis should evaluate both the individual implementation failures (each safety measure that was not maintained) and the institutional staffing that created an environment where three safety measures simultaneously failed without anyone detecting the gaps.

176. A — Multiple central line bundle deviations — absent maximal barriers, absent chlorhexidine documentation, inadequate dressing changes, and absent daily necessity assessments — collectively demonstrate systemic noncompliance with infection prevention standards. Each bundle element independently reduces CLABSI risk, and the cumulative effect of multiple absent elements increases the risk far beyond what any single deviation would produce.

177. D — The plaintiff's productive activities — volunteer fire education, youth coaching, independent home maintenance — represent functional capacities impaired by the TBI and hip injury. Retirement does not eliminate non-economic damages. The analysis should include the impact of losing purposeful activities and the cost of assistance for tasks previously performed independently. These damages exist regardless of employment status.

178. B — Pain out of proportion to the expected course, progressive paresthesias, and loss of dorsiflexion are the hallmark progression of acute compartment syndrome. The resident's failure to consider compartment syndrome and the 10-hour delay in notifying the attending represent both a diagnostic failure and a communication failure. Compartment syndrome is a surgical emergency where every hour of delay increases the risk of permanent tissue damage.

179. C — The deficiencies — absent ACLS certification, absent ASA assessment, inadequate monitoring equipment, and unavailable rescue equipment — represent noncompliance with CMS Conditions of Participation and professional sedation standards. These deficiencies create patient safety risks during every sedation procedure. If a patient is harmed during sedation, the regulatory violations would constitute strong evidence of institutional negligence.

180. A — Multiple communication failures contributed: the physician did not provide clear written instructions emphasizing weekly dosing, the pharmacist did not counsel about the critical weekly schedule, and the pharmacy label omitted the "weekly" frequency. Methotrexate's narrow therapeutic index and the well-documented danger of daily dosing errors make clear dosing communication a shared responsibility across all providers.

181. D — The degraded cushion — used beyond replacement interval, overloaded beyond weight capacity, and visibly deformed — was no longer providing adequate pressure redistribution. The facility's absence of a replacement schedule and failure to match cushion specifications to resident weight represents an equipment maintenance failure. Proper cushion management is a fundamental aspect of pressure ulcer prevention for wheelchair-dependent residents.

182. B — Two independent standard of care issues exist: the failure to use IONM (which could have detected nerve injury on the first side, potentially preventing bilateral injury) and the pathology report documenting parathyroid tissue in the specimen (direct evidence that glands were removed rather than preserved). Each finding represents a separate standard of care deviation that should be evaluated independently.

183. C — Each child requires individual evaluation assessing maternal fish consumption, documented mercury levels, temporal relationships, whether the cognitive deficit pattern is consistent with mercury neurotoxicity (motor dysfunction, visuospatial deficits, attention impairment), and whether genetic or socioeconomic factors independently contribute. Neither the exposure alone nor the defense's alternative explanations can be evaluated without individual-level clinical analysis.

184. A — Radiologists have a duty to evaluate all visualized structures on cross-sectional imaging. A 3 cm adrenal mass should have been identified, reported, and recommended for further evaluation. The 14-month delay allowed the adrenal cortical carcinoma to metastasize, fundamentally changing the treatment options from potentially curative surgery to palliative management.

185. D — The Budapest diagnostic criteria for CRPS are primarily clinical and do not require abnormal bone scan findings. The defense neurologist's reliance on a single normal bone scan contradicts the accepted diagnostic framework. The documented objective clinical signs (edema, temperature asymmetry, trophic changes) and the positive sympathetic block provide strong clinical evidence supporting the diagnosis regardless of the bone scan result.

186. B — The surgeon proceeded with elective CABG without optimizing three documented modifiable risk factors (A1c 10.2%, BMI 43, active smoking) and without documenting a risk-benefit analysis. Published guidelines recommend addressing modifiable risks before elective cardiac surgery. The failure to optimize any of the three factors or document the rationale for proceeding despite them deviates from preoperative standards.

187. C — The clinical progression from irritant contact dermatitis to allergic contact dermatitis follows a documented immunological pathway — damaged skin from irritant dermatitis facilitates chemical absorption and sensitization. The allergic dermatitis is a compensable progression of the original occupational skin condition, not a separate unrelated condition. The entire sensitization cascade was initiated and maintained by the occupational chemical exposure.

188. A — Multiple pressure injury prevention failures converged: absent repeat risk assessments, repositioning gaps of 6–8 hours (versus the 2-hour care plan), no specialty mattress despite very high risk, and no nutritional intervention despite low albumin. These failures collectively demonstrate a systemic breakdown in implementing the prevention strategy demanded by the patient's documented very high risk score.

189. D — Multiple systems vulnerabilities — paper-based processes, absent barcode technology, manual calculations without double-checks, and no independent verification for high-alert drugs — create a risk environment where wrong-patient errors are predictable. Four errors in three months in a single unit confirms a systemic vulnerability rather than random individual failures. The risk management response must address all vulnerabilities simultaneously.

190. B — The anesthesiologist continued advancing and injecting despite the patient's report of radicular symptoms — clear indication of nerve root contact. The standard of care requires immediate needle withdrawal and repositioning when paresthesias occur. Continuing injection at the site of nerve contact created the foreseeable L5 nerve root injury. The deviation and the resulting injury are directly linked.

191. A — The pharmacy consultant identified the monitoring gap and recommended action five weeks before the hemorrhage, but the recommendation was filed without any system ensuring physician review. This gap between identification and action — urgent safety finding documented but never communicated to the responsible physician — represents the same systems failure pattern as critical laboratory value notification failures.

192. C — The surgeon's failure to communicate posterior approach hip precautions to the physical therapy team created a gap between the surgical plan and rehabilitation plan. The posterior approach has specific precautions that differ from other approaches, and the therapist's ignorance of these precautions directly caused the foreseeable dislocation. The communication failure — not the therapist's technique per se — was the root cause.

193. D — Multiple federal statutes are implicated: the False Claims Act (billing for medically unnecessary imaging), the Anti-Kickback Statute (site access fees constituting remuneration), the Stark Law (if the ordering physician has a financial relationship), and state medical practice act violations (signing orders without examination). The scheme involves blanket testing, pre-signed orders, template reports, and financial incentives.

194. B — The psychiatrist monitored lithium levels but completely failed to monitor renal function — a separate, independent monitoring obligation. Lithium's nephrotoxicity requires periodic creatinine and eGFR assessment at least every six months. The three-year monitoring gap allowed eGFR to decline from 92 to 25 (stage 4 CKD) undetected. Routine monitoring would have detected the decline and prompted dose adjustment or drug substitution.

195. A — The neuropsychological testing documenting specific cognitive and behavioral deficits, combined with treating clinicians' documentation of how these deficits affect interpersonal functioning, emotional regulation, and capacity for marital relationships, provides the clinical foundation. This establishes that the TBI fundamentally altered the plaintiff's ability to fulfill her role as a marital partner — transforming subjective relationship complaints into clinically documented impairments.

196. C — Published guidelines recommend A1c below 8% before elective spinal procedures. Proceeding at A1c 10.0% without optimization deviates from the preoperative standard of care. Glycemic control is a modifiable risk factor that the surgeon had the opportunity and obligation to address before elective surgery. The SSI was a foreseeable consequence of operating on a patient with documented poorly controlled diabetes.

197. D — The failure to maintain a functional crash cart — dead battery, expired epinephrine, missing BVM — represents a systems failure in emergency preparedness. The shift-based crash cart check policy existed specifically to prevent this scenario. The six-minute resuscitation delay caused by nonfunctional equipment directly caused the hypoxic brain injury. The policy existed but was not implemented.

198. B — Three standard of care failures converged: no CPAP for documented OSA, no continuous pulse oximetry during opioid PCA, and no opioid-sparing strategies. Current guidelines specifically identify OSA patients receiving opioids as high-risk requiring all three safeguards. Any single safeguard might have prevented the event — the absence of all three created a foreseeable respiratory catastrophe.

199. A — Opinions on surgical technique during complex spinal fusion require a spine surgeon expert. The LNC's medical-surgical nursing experience provides knowledge of perioperative nursing standards but does not qualify testimony on intraoperative surgical technique. Staying within the nursing scope during testimony is both an ethical obligation and essential for maintaining credibility. The attorney should retain a spine surgeon for the surgical standard of care questions.

200. C — Invasive adenocarcinoma with positive margins and lymphovascular invasion demands immediate surgical referral for segmental resection with lymph node evaluation. The gastroenterologist either failed to review the pathology or misrepresented the findings by telling the patient the polyp was "completely removed." The 22-month delay allowed a potentially curable cancer to progress to Stage III regional disease with lymph node metastases.