Salkinder Orthopaedic Services, Inc

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ORTHOPAEDIC SURGERY

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November 9, 2021

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Anaheim, CA 92808

Floyd Skeren Manukian Langevin, LLP
3835R E. Thousand Oaks Blvd., PMB 630
Westlake Village, CA 91362

PATIENT:	CHANEY, ANISA
EMPLOYER:	Bold Quail Holdings, LLC
SOCIAL SECURITY NO.:	XXX-XX-6450
DATE OF BIRTH:	September 6, 1973
DATE OF INJURY:	CT January 6, 2020 to June 30, 2020 CT July 6, 2019 to October 19, 2021
CLAIM NO.:	2080381794
WCAB NO.:	ADJ3521045(AHM)
DATE OF EVALUATION:	October 19, 2021

PANEL QUALIFIED MEDICAL EVALUATION AND REPORT

Dear Sir/Madame:

IDENTIFYING INFORMATION:

Ms. Anisa Chaney was orthopaedically evaluated by me on October 19, 2021, at my office located at 2930 West Imperial Hwy., Ste. 508, Inglewood, CA 90303. The patient currently resides in Gardena, CA.

JOB DESCRIPTION:

The patient stated that she began working for Bold Quail Holdings, LLC, dba Playa Del Rey Center in April 2010. She was terminated on 7/6/2020. The patient worked as a registered nurse. She worked 10+ hours per day, 40 to 60 hours per week.

Her job responsibilities included clinical operations, including direct patient care four to five hours per day. The rest of the time, she was delegating staff assignments. She was performing staff management and staff education. During her work shift, she spent two to three hours using computer keyboard and mouse. When the patient performed direct patient care, she was assisting patients with washing, dressing, and assisting with transfers. She was feeding the patients and changing diapers as needed.

Her normal activities during a workday included occasional sitting, frequent walking, frequent standing, frequent bending at the neck and waist level, occasional squatting, occasional kneeling and frequent twisting at the neck and waist level.

With regard to the upper extremities, she was constantly using her right and left hands for simple grasping, occasionally for power grasping with the right and left hands, occasionally for fine manipulation with the left hand, occasionally for pushing and pulling with the left hand and occasionally for reaching above and below the shoulder level.

With regard to the lifting requirements, she was frequently lifting objects weighing up to 10 pounds. She would occasionally lift objects weighing up to 20 pounds. The patient was occasionally carrying objects weighing up to 20 pounds for a distance of several feet. The patient also stated that she was pushing heavy

medication cart. She was also pushing wheelchairs and pushing and pulling patients in bed while repositioning them.

Her normal activities during workday did not include any driving of cars. She worked with the medical equipment. She was not required to walk on uneven ground. She was not exposed to excessive noise, extremes in temperature, humidity or wetness. She was not exposed to dust, gas, fumes and chemicals. She was not required to work at heights. She was not operating any foot controls and was not performing any repetitive movements. She was sometimes using safety glasses. She was exposed to biohazards.

HISTORY OF CONCURENT EMPLOYMENTS:

The patient stated that from January 2009 until April 1, 2020, she was working for My Life Foundation as a nurse consultant. She worked two to four hours per day, two to three times per week. Her job responsibilities included assessing and consulting with the staff and clients in their homes. She also administered medications and performed wound care as needed.

Her normal activities during workday included occasional sitting, occasional walking, occasional standing, occasional bending at the neck and waist level, occasional squatting, occasional climbing and occasional twisting at the neck and waist level. With regard to the upper extremities, she was frequently using her right and left hands for simple grasping and occasionally reaching below the shoulder level. There were minimal lifting and carrying requirements associated with her position.

As part of her normal job duties, she was required to drive a car. She did not work with any equipment. She was not required to walk on uneven ground. She was not exposed to excessive noise, extremes in temperature, humidity or wetness. She was not exposed to dust, gas, fumes or chemicals. She was not required to work at heights. She was not operating any foot controls and not performing repetitive foot movements. She was not using any visual or protective equipment. She was not exposed to biohazards.

She also stated that in her spare time, she has been doing **cosmetology**, which involved hairdressing and makeup. In the last five years, she had about two clients per week, and she would spend one to three hours with each client depending on what needed to be done. She mostly did hair and makeup. She

used the brush and a blow dryer and was holding a blow dryer in her right hand and the brush in her left hand.

HISTORY OF WORK-RELATED INJURY AND TREATMENT:

The patient stated that her problems started approximately in 2017, with the injury to the left shoulder. At that time, as she was helping a patient with transferring from bed to a chair, the patient suddenly collapsed on her. As she tried to hold the patient in order for the patient not to fall on the floor, she felt a pulling sensation in her left shoulder and arm, followed by pain. She reported the injury to the Director of Nursing, Ms. Rosa Manuel, however, was never referred for treatment. She self-medicated with over-the-counter medication and went for evaluation to her primary care physician, Dr. Hernandez. (No records of the visit was found in the submitted medical records from Dr. Hernandez). According to the patient, she was referred for x-rays or MRI, the results of which were not available for my review. The patient was informed by Dr. Hernandez that the studies were negative. Left shoulder pain got better within a year; however, it did not disappear. She continued to have pain with rotation, overhead use and lifting more than 20 pounds with the left arm. She also developed pain in the neck at that time, which continued after the left shoulder got better. She experienced more pain in her neck while performing direct patient care.

Approximately late 2018-early 2019, the patient had to jump over a fence in order to get the patient, who escaped from the facility where she worked. She landed on her feet and felt pain in both of her knees, right greater than left. She reported the injury to the supervisor, however, was never referred for evaluation and treatment. She purchased a brace, and self-medicated with over-the-counter medications. She never saw Dr. Hernandez for her bilateral knees. (There are records of multiple visits to Dr. Hernandez with complaints of pain in multiple joints including both knees. She was diagnosed by Dr. Hernandez with having osteoarthritis). The patient stated that with time, her knees improved but not 100%. She continued to have pain as she continued working performing her regular job duties.

With regard to the lumbar spine, the patient developed the gradual onset of pain in her low back in 2019 from pushing and pulling patients in bed. She reported her symptoms to the supervisor, however, was never referred for medical evaluation. She has not seen any medical providers for that.

She stopped working at My Life Foundation on 4/1/2020, due to COVID exposure at Playa Del Rey Center. She continued working performing her regular job duties at Playa Del Rey Center until 7/6/2020, when she was terminated.

The patient retained an attorney, and on 10/5/2020, she was referred for an evaluation and treatment to Dr. Eric Gofnung, who became her primary treating physician. While under the care of Dr. Gofnung, she was referred for multiple MRIs. She received 24 physical therapy treatments, 24 chiropractic treatments and 24 acupuncture treatments with some benefit. Injections were offered to the patient but she refused. She also indicated that she was not interested in any kind of surgical procedure. She continued to be followed by Dr. Gofnung on a regular basis until she was discharged as Permanent and Stationary on 4/30/2021.

Ms. Chaney stated that she developed increased pain in her right knee approximately in June 2021. She contacted her attorney, and on 7/15/2021, she was referred for an evaluation and treatment to Dr. Edwin Haronian, who became her new primary treating physician. Dr. Haronian recommended additional physical therapy; however, the therapy was not authorized by the insurance carrier. No other treatment was provided to date.

The patient presented to this office today for a Panel Qualified Medical Evaluation.

RELEVANT MEDICAL HISTORY:

Past Medical History: The patient has history of osteoarthritis diagnosed in 2012.

History of Prior Injuries:

Work: The patient denies any prior or subsequent work-related injuries.

Car Accidents: In 2003, the patient was involved in a car accident and sustained whiplash injury to the neck and back. She was treated for about two months with physical therapy and chiropractic treatments and recovered fully.

Slip and Fall Accidents: The patient denies any slip and fall accidents.

Sport Injuries: The patient denies any sports-related injuries.

Past Surgical History: Negative.

Current Medications: Naproxen 500 mg six to eight tablets per week, Pepcid 20 mg one tablet when the patient takes Naproxen and compound cream once daily.

Allergies: None.

Social History: The patient is separated. She has two children. She denied smoking cigarettes. She used to smoke and quit about 8 to 10 years ago. Recently, she reported occasionally smoking cigarettes. She stated that she drinks alcohol rarely. She denied using drugs. She denied ever being treated for drug or alcohol abuse.

Family History: The patient's mother is deceased. She had aneurysm. Her father died of liver cirrhosis at age 59. She has one brother and one sister, both in good general health.

CHIEF COMPLAINTS ON EXAMINATION:

Neck: The patient complained of neck pain present most of the time. She reported intermittent radiation of pain to the upper back and top portion of both shoulders. She reported occasional radiation of pain into the left upper extremity down to the left hand. On a scale from 1 to 10, (1 being no pain at all, 10 being the most severe pain), the patient graded the pain in her neck as being 3-4/10 with activities of daily living, increased to 4-6/10 with repetitive bending, twisting, and prolonged positioning. Rest and medications decreased her symptoms.

Left Shoulder: The patient reported occasional mild discomfort in the left shoulder with prolonged overhead use of the left upper extremity.

Lower Back: The patient reported intermittent lower back pain with occasional radiation to the right buttock and right thigh. With activities of daily living, she graded the pain as being 2/10. The pain increased to 4-5/10 with repetitive bending, twisting, sitting for more than one hour, standing and walking for more than 30 minutes, and with lifting more than 30 to 40 pounds. Rest and medications decreased her symptoms.

Right Knee: The patient reported no pain at rest. With activities of daily living, she graded the pain as being 3/10. The pain increased to 4-5/10 with standing for more than 1 hour, walking for more than 15 to 20 minutes, going up and down the stairs, and with kneeling, twisting and pivoting. She reported occasional buckling and giving way of her right knee. Rest and medications released her symptoms.

Left Knee: The patient reported occasional mild discomfort in the left knee with prolonged standing and walking, with kneeling, and going up and down the stairs.

ACTIVITIES OF DAILY LIVING:

The patient was specifically questioned regarding her activities of daily living, and the effect of her injuries on her normal activities of daily living, and she has provided the following responses:

1. Regarding the ability to perform personal self-care activities including washing, dressing, using the bathroom, the patient indicated that she can look after herself normally but has extra discomfort.

2. Regarding the ability to lift and carry objects, the patient indicated that she can lift and carry light to medium objects if they are conveniently positioned.

3. Regarding the ability to walk, the patient indicated that her injury and discomfort prevent her from walking more than 1/4 mile.

4. Regarding the most strenuous level of activity that she could do for at least two minutes, the patient indicated that she can do moderate activity.

5. Regarding the ability to climb one flight of stairs, the patient indicated that she has some difficulty (but she can still perform the activity well enough).

6. Regarding the ability to sit for 30 minutes to an hour, the patient indicated that she does not experience any difficulty (and she can easily perform the activity).

7. Regarding the ability to sit for two hours, the patient indicated that she has some difficulty (but she can still perform the activity well enough).

8. Regarding the ability to stand or walk for 30 minutes to an hour, the patient indicated that she has some difficulty (but she can still perform the activity well enough).

9. Regarding the ability to stand or walk for two hours, the patient indicated that she has a lot of difficulty (but she can still do the activity).

10. Regarding the ability to reach and grasp something off a shelf at eye level, the patient indicated that she does not experience any difficulty (and she can easily perform the activity).

11. Regarding the ability to reach or grasp something off a shelf overhead, the patient indicated that she has some difficulty (but she can still perform the activity well enough).

12. Regarding any difficulty with pushing and pulling activities, the patient indicated that she has some difficulty (but she can still perform the activity well enough).

13. Regarding any difficulty with gripping, grasping, and holding and manipulating objects with the hands, the patient indicated that she does not experience any difficulty (and she can easily perform the activity).

14. Regarding any difficulty with repetitive motions such as typing on a computer, the patient indicated that she does not experience any difficulty (and she can easily perform the activity).

15. Regarding any difficulty with forceful activities with her arms and hands, the patient indicated that she has some difficulty (but she can still perform the activity well enough).

16. Regarding any difficulty with kneeling, bending or squatting, the patient indicated that she has a lot of difficulty (but she can still do the activity).

17. Regarding any difficulty with sleeping, the patient indicated that her sleep is mildy disturbed (1 to 2 hours sleeplessness) since her injury.

18. Regarding sexual activity since and because her injury, the patient indicated that it is a little less frequent because of her injury.

19. Regarding her pain at the moment, the patient indicated that it is mild.

20. Regarding her pain most of the time, the patient indicated that it is mild.

21. Regarding how much the injury and/or pain interfered with the patient's ability to travel, she indicated that it interferes some or a little of the time.

22. Regarding how much the injury and/or pain interfered with the patient's ability to engage in recreational activities, she indicated that it interferes most of the time.

23. Regarding how much the injury and/or pain interfered with the patient's ability to engage in social activities, she indicated that it interferes some or a little of the time.

24. Regarding how much the injury and/or pain interfered with the patient's concentrating and thinking, she indicated that it interferes some or a little of the time.

25. Regarding how much the injury and/or pain caused emotional distress with depression or anxiety, the patient indicated some or a little of the time (mild depression or anxiety from the injury or discomfort).

PHYSICAL EXAMINATION:

The patient was a well-developed, well-nourished, 48-year-old, left-hand dominant female in good apparent general health, weighing 140 pounds, height of 5 feet and 2 inches. She walked with a mild antalgic gait favoring the right lower extremity. She was carrying a cane in her right hand but was not really using it for walking.

Neck and Cervical Spine: On examination of the neck and cervical spine, there was tenderness to palpation over the paracervical muscle bilaterally. The patient had an asymmetric loss of range of motion.

RANGE OF MOTION:	RIGHT		LEFT	NORMAL
FORWARD FLEXION:		50		50
EXTENSION:		60		60

LATERAL ROTATION:	**68**		**74**	80
LATERAL BENDING:	**40**		**43**	45

ORTHOPAEDIC SIGNS & TESTS:	RIGHT		LEFT
Cervical Compression	Negative		**Positive**
Cervical Distraction	Negative		Negative
Soto Hall		**Positive**	
Spurling Maneuver	**Positive**		**Positive**
Wright's Test	Negative		Negative

Thoracic Spine: On examination of the thoracic spine, there was no tenderness to palpation over the thoracic spinous processes. There was no tenderness or spasm to palpation over the parathoracic muscles bilaterally. The range of motion of the thoracic spine was within normal limits.

RANGE OF MOTION:	RIGHT		LEFT	NORMAL
FORWARD FLEXION:		50		50
ROTATION:	30		30	30

Lumbar Spine: On examination of the lumbar spine, there was tenderness to palpation over the paralumbar muscles bilaterally and over the gluteal muscles and sciatic notch on the right. Straight leg raise test was positive on the right side at 75 degrees of leg elevation. The patient had an asymmetric loss of range of motion.

(Measurements were taken using Dual Inclinometer technique after an appropriate period of warm-up.)

RANGE OF MOTION:	RIGHT		LEFT	NORMAL
FORWARD FLEXION:		60		60
EXTENSION:		**15**		25
LATERAL BENDING:	**22**		**24**	25

ORTHOPAEDIC SIGNS & TESTS:	RIGHT	LEFT
Sitting Root Test	**Positive**	Negative
Patrick Fabere Test	Negative	Negative
Kemp's Test	**Positive**	**Positive**
Bragard Test	**Positive**	Negative

Upper Extremities: Examination of the upper extremities was significant for the *left shoulder.* There was tenderness to palpation over the acromioclavicular joint on the left. The rest of the examination of the upper extremities was within normal limits.

SHOULDER RANGE OF MOTION:	RIGHT	LEFT	NORMAL
FLEXION:	180	180	180
EXTENSION:	50	50	50
ABDUCTION	180	180	180
ADDUCTION	50	50	50
EXTERNAL ROTATION	90	90	90
INTERNAL ROTATION	90	90	90

Orthopaedic Tests (shoulders):	Right	Left
Neer Impingement Sign	Negative	**Mildly Positive**
Hawkins Test	Negative	**Mildly Positive**
Jobe Test	Negative	**Mildly Positive**
Cross Chest Adduction Test	Negative	Negative
Drop Arm Test	Negative	Negative
Sulcus Sign	Negative	Negative
Active Comprehension Test	Negative	Negative
Speed Test	Negative	Negative
Yergason Test	Negative	Negative

ELBOW RANGE OF MOTION:	RIGHT	LEFT	NORMAL
FLEXION:	150	150	150
EXTENSION:	0	0	0

ORTHOPAEDIC SIGNS & TESTS:	RIGHT	LEFT
Cozen Test	Negative	Negative
Mill's Test	Negative	Negative

FOREARM RANGE OF MOTION:	RIGHT	LEFT	NORMAL
SUPINATION:	80	80	80
PRONATION:	80	80	80

ORTHOPAEDIC SIGNS & TESTS:	RIGHT	LEFT
Tinel's Sign	Negative	Negative
Phalen's Test	Negative	Negative

Finkelstein's Test	Negative	Negative
Median Nerve Compression Test	Negative	Negative

WRIST RANGE OF MOTION:	RIGHT	LEFT	NORMAL
EXTENSION:	60	60	60
FLEXION:	60	60	60
ULNAR DEVIATION:	30	30	30
RADIAL DEVIATION:	20	20	20

RIGHT HAND/FINGERS

	MP			PIP		DIP	
Finger	Action	Normal	Actual	Normal	Actual	Normal	Actual
Thumb	(Ext)	+40°	+40°	****		+30°	+30°
	(Flx)	60°	60°	****		80°	80°
Index	(Ext)	0°	0°	0°	0°	0°	0°
	(Flx)	90°	90°	100°	100°	70°	70°
Middle	(Ext)	0°	0°	0°	0°	0°	0°
	(Flx)	90°	90°	100°	100°	70°	70°
Ring	(Ext)	0°	0°	0°	0°	0°	0°
	(Flx)	90°	90°	100°	100°	70°	70°
Little	(Ext)	0°	0°	0°	0°	0°	0°
	(Flx)	90°	90°	100°	100°	70°	70°

Thumb Radial Abduction __50__ (0-50°) (hand flat, abduct thumb)

Thumb Adduction ___1___cm (from flexion crease of IP joint to distal palmar crease over the level of the MP joint of the little finger) (0-1 cm of abduction normal range).

Thumb Opposition ___8___ cm (Normal 8 cm) (distance between the flexion crease of the thumb PI joint to the distal palmar crease directly over 3rd MP joint).

LEFT HAND/FINGERS

	MP			PIP		DIP	
Finger	Action	Normal	Actual	Normal	Actual	Normal	Actual
Thumb	(Ext)	+40°	+40°	****		+30°	+30°
	(Flx)	60°	60°	****		80°	80°
Index	(Ext)	0°	0°	0°	0°	0°	0°
	(Flx)	90°	90°	100°	100°	70°	70°
Middle	(Ext)	0°	0°	0°	0°	0°	0°
	(Flx)	90°	90°	100°	100°	70°	70°
Ring	(Ext)	0°	0°	0°	0°	0°	0°
	(Flx)	90°	90°	100°	100°	70°	70°
Little	(Ext)	0°	0°	0°	0°	0°	0°
	(Flx)	90°	90°	100°	100°	70°	70°

Thumb Radial Abduction __50__ (0-50°) (hand flat, abduct thumb)

Thumb Adduction ____1____cm (from flexion crease of IP joint to distal palmar crease over the level of the MP joint of the little finger) (0-1 cm of abduction normal range).

Thumb Opposition ____8____ cm (Normal 8 cm) (distance between the flexion crease of the thumb PI joint to the distal palmar crease directly over 3rd MP joint).

NEUROLOGIC EVALUATION: (UPPER EXTREMITIES)

SENSORY EXAMINATION: There was normal sensation in all dermatomes bilaterally to light touch and Wartenberg wheel testing.

Muscle Strength:	Right	Left	Normal
Deltoids (C5)	5/5	5/5	5/5
Biceps (C5)	5/5	5/5	5/5
Triceps (C7	5/5	5/5	5/5

Wrist Extension (C6)	5/5	5/5	5/5
Wrist Flexion (C7)	5/5	5/5	5/5
Finger Extension (C7)	5/5	5/5	5/5
Interossei (T1)	5/5	5/5	5/5

Reflexes:	Right	Left	Normal
Biceps	2+	2+	2+
Triceps	2+	2+	2+
Brachioradialis	2+	2+	2+

Lower Extremities: Examination of the lower extremities was significant for the *right knee.* There was crepitus in the right knee with range of motion. There was tenderness to palpation over the right patellofemoral joint. The patient was able to squat 1/3 way. The rest of the examination of the lower extremities was within normal limits.

HIP RANGE OF MOTION:	RIGHT	LEFT	NORMAL
FLEXION:	100	100	100
EXTENSION:	30	30	30
INTERNAL ROTATION:	40	40	40
EXTERNAL ROTATION:	50	50	50
ABDUCTION:	40	40	40
ADDUCTION:	20	20	20

KNEE RANGE OF MOTION:	RIGHT	LEFT	NORMAL
FLEXION:	150	150	150
EXTENSION:	0	0	0

ORTHOPEDIC SIGNS & TESTS:	RIGHT	LEFT	NORMAL
Apley's Compression Test:	Negative	Negative	Negative
McMurray's Test:	Negative	Negative	Negative
Patella Grind Test:	**Positive**	Negative	Negative
Quadriceps Inhibition Test:	**Positive**	Negative	Negative
Lachman Test:	Negative	Negative	Negative
Pivot Shift Test:	Negative	Negative	Negative
Anterior Drawer Test:	Negative	Negative	Negative
Posterior Drawer Test:	Negative	Negative	Negative
Varus Stress Test:	Negative	Negative	Negative
Valgus Stress Test:	Negative	Negative	Negative

ANKLE RANGE OF MOTION:	RIGHT	LEFT	NORMAL
EXTENSION:	20	20	20
PLANTAR FLEXION:	40	40	40
EVERSION:	20	20	20
INVERSION:	30	30	30

ORTHOPEDIC SIGNS & TESTS:	RIGHT	LEFT	NORMAL
Anterior Drawer Sign:	Negative	Negative	Negative
Posterior Drawer Sign:	Negative	Negative	Negative

NEUROLOGIC EVALUATION: (LOWER EXTREMITIES)

SENSORY EXAMINATION: There was normal sensation in all dermatomes bilaterally to light touch and Wartenberg wheel testing.

MUSCLE STRENGTH:	RIGHT	LEFT	NORMAL
Hip Flexion (L1, L2, L3, L4):	5/5	5/5	5/5
Knee Extension (L2, L3, L4):	5/5	5/5	5/5
Knee Flexion (L5, S1, S2):	5/5	5/5	5/5
Foot Dorsiflexion (L4, L5):	5/5	5/5	5/5
Foot Inversion (L4, L5):	5/5	5/5	5/5
Foot Eversion (L5, S1):	5/5	5/5	5/5
Great Toe Extension (L5, S1):	5/5	5/5	5/5

REFLEXES:	RIGHT	LEFT	NORMAL
Patellar:	2+	2+	2+
Achilles:	2+	2+	2+

DISTAL PULSES:	RIGHT	LEFT	NORMAL
Popliteal:	2+	2+	2+
Dorsalis Pedis:	2+	2+	2+
Posterior Tibial:	2+	2+	2+

GRIP STRENGTH (Kilogram Force):	RIGHT	LEFT
JAMAR (1st Attempt)	32	36
JAMAR (2nd Attempt)	34	38
JAMAR (3rdt Attempt)	34	38

MEASUREMENTS (cm):	RIGHT	LEFT
Biceps (3" Above elbow):	49.5	39

Forearms (3" Below elbow):	35	35

MEASUREMENTS (cm):	RIGHT	LEFT
6" Above the patella:	26.5	27
3" Below the patella:	24	24

DIAGNOSTIC STUDIES:

6/11/21 – MRI of Cervical Spine, Pacific MRI, Nicholas Dzebolo, M.D.

Impression:

1) Small degenerative anterior osteophytes at C3 through T1.
2) Disc desiccation involving the entire cervical spine.
3) C4-C5. A disc bulge is identified. A disc osteophyte complex is identified. Also noted is bilateral facet joint arthrosis. Disc material and facet joint hypertrophy cause mild bilateral neural foraminal narrowing. Associated contact on bilateral exiting nerve root is seen. Disc measures 2.0 mm.
4) C5-C6: A disc bulge is identified. A disc osteophyte complex is identified. Also noted is bilateral facet joint arthrosis. Disc material and facet joint hypertrophy cause mild bilateral neural foraminal narrowing. Associated contact on bilateral exiting nerve root is seen. Disc measures 1.9 mm.

6/11/21 – MRI of Lumbar, Pacific MRI, Nicholas Dzebolo, M.D.

Impression:

1) Mild disc desiccation at L4-L5.
2) Discal deformity L4-L5. A disc bulge is identified. Transiting and exiting nerve roots are normal. Disc deformity measures 1.6 mm.
3) Discal deformity L5-S1. A disc bulge is identified. Transiting and exiting nerve roots are normal. Disc deformity measures 1.8 mm.

6/11/21 – MRI of Right Knee without Contrast, Pacific MRI, Amjad Safvi, M.D.

Impression:

1) Moderate joint effusion.
2) Intrameniscal hyperintensity within the posterior horn of the medial meniscus, not extending to superior and inferior articular margins suggestive of Grade II meniscal signal changes.
3) Mild laxity of lateral collateral ligament with intrasubstance hyperintensity suggestive of partial tear/contusion.
4) Intrasubstance hyperintensity in anterior cruciate ligament suggestive of myxoid degeneration.
5) Degenerative narrowing with thinning of articular cartilages and patello-femoral and tibio-femoral joints.

This concludes the review of the diagnostic studies.

REVIEW OF RECORDS:

The following medical records were reviewed:

1/27/12 - Laboratory Report, Quest Diagnostics. Total cholesterol was low. Basic metabolic panel revealed high glucose. Hepatic function panel revealed low globulin and high albumin/ globulin ratio. Complete urinalysis revealed traces of squamous epithelial cells. Thyroid panel and CBC were within normal limits.

1/27/12 - Pathology Report, Quest Diagnostics. Source: Cervical. Interpretation: Negative for intraepithelial lesion or malignancy.

1/27/12 to 5/24/13 -- History and Physical Reports, Valentin Hernandez, MD. On 1/27/12, the patient was complaining of cough, phlegm, sore throat and hoarseness getting worse and worsening fungus with redness of the skin and desquamation. She had been having a sore throat with cough and phlegm and green mucous with fevers which were not getting better even though she was drinking a lot of fluids. She noted a fungus over the extremities as well as the groin which was quite pruritic and felt like it was on fire.

Impressions:

1) Pharyngitis.
2) Tinea corporis.

Laboratory studies and pap smear were ordered. Patient education was given.

On 2/2/12, the patient was complaining of being exhausted with even the most elementary work and tired and a persistent cough not getting better in spite of medications and keeping her awake and redness and thickness of the skin with pruritus. She felt weak and tired and felt no matter how much sleep still tired progressively getting worse over the past few weeks to the point that barely able to do most of the work such that even one block of exercise was enough to make her tired. She had not had any rest over the past two weeks as the cough had been getting worse and was associated with phlegm and feeling warm and sore throat and pleuritic chest pains associated with dyspnea. She was having worsening and pruritic burning pains all over the toes and feet as well as the groin which was quite red.

Impression:

1) Anemia, iron deficiency.
2) Bronchitis.
3) Tinea corporis.

B complex, ferrous sulfate, Tinactin cream and Lamisil were prescribed.

On 12/18/12, she was complaining of pains in most of the large joints especially over the knees and sore throat with phlegm and cough with a thick phlegm and redness and thickness of the skin with pruritus. The joint pains were getting worse even with the medicines especially in the mornings even though she had tried applying warm packs and towels to the joints. She was having a purulent cough over the past few days not getting any better and noted difficulties with hoarseness even though she had been doing gargling. She was worsening and pruritic burning pains all over the toes and feet as well as the groin which was quite red.

Impression:

1) Osteoarthritis.
2) Pharyngitis.
3) Tinea corporis.

B complex, ferrous sulfate, Tinactin cream and Tylenol were prescribed. CBC was ordered.

On 12/21/12, she was complaining of redness and thickness of the skin with pruritus and sore throat with phlegm and cough with a thick phlegm. She had noticed hot and pruritic redness and a worsening rash over the feet and groin which was not responding to the over the counter creams. She noted an increase in the cough, phlegm, sore throat and headaches over the past week even though she had been taking some over the counter medications. Nizoral was prescribed.

On 5/24/13, she had infection and redness of the skin which is getting worse and a vaginal discharge with white-yellow consistency and chest pains and shortness of breath with a persistent cough of thick and difficult to expectorate phlegm and fevers. She was having redness over the skin and warmth which had not responded to the antibiotics. At this time, she came in for change of medication. She had developed a white vaginal discharge over the past week which was getting worse on taking the medications. She had difficulties because of the intense pruritus. She had not any rest over the past two weeks as the cough had been getting worse and was associated with phlegm and feeling warm and sore throat and pleuritic chest pains associated with dyspnea.

Impression:

1) Cellulitis.
2) Vaginitis.
3) Bronchitis.

Tylenol and laboratory studies and serum pregnancy test were ordered. Ultrasound of the right pelvis for pains was requested.

5/24/13 - Laboratory Report, Quest Diagnostics. Cholesterol, total was low. BUN was low. Urinalysis showed hazy appearance, with high leukocyte, WBC, squamous epithelial cells with moderate traces of bacteria. CBC was within normal range.

5/25/13 - Pelvic Transvaginal Ultrasound, United Medical Imaging, Alan Todd Turner, MD.

Impression:

1) Uterus didelphys.

2) Right ovarian cyst.

5/29/13 to 10/2/15 -- History and Physical Reports, Valentin Hernandez, MD. On 5/29/13, the patient presented for fevers, dysuria, and pains in the flanks going down into the groin and a purulent greenish cough, with sore throat and headaches. She had been having dysuria and burning on urination for the past week associated with fevers and not getting better with fluids and medications. At this time, she had and flank pains. She noted an increase in the cough, phlegm, sore throat and headaches over the past week even though she had been taking some over the counter medications.

<u>Impression:</u>

1) Urinary tract infection.
2) Pharyngitis.

Doxycycline, Diflucan, Nizoral, B complex and ferrous sulfate were prescribed.

On 6/14/13, the patient had pains in the flanks with heat over the bladder on urinating and chills and fevers over the past four days which was getting worse even on fluids although she did not relate any previous infections of this type. She felt weak and tired and felt no matter how much sleep still tired progressively getting worse over the past few weeks to the point that barely able to do most of the work such that even one block of exercise was enough to make her tired.

<u>Impression</u>:

1) Urinary tract infection.
2) Anemia, iron deficiency.

Patient education was discussed.

On 12/30/13, she had noticed hot and pruritic redness and a worsening rash over the feet and groin which is not responding to the over the counter creams. She noted an increase in the cough, phlegm, sore throat and headaches over the past week even though she had been taking some over the counter medications.

<u>Impression</u>:

1) Tinea corporis.

2) Pharyngitis.

Prescription was given for Lamisil cream and Tylenol.

On 10/2/15, she complained of greenish mucous from a very productive cough, which was not altered by cough medicines and cough, phlegm, sore throat and hoarseness getting worse and a vaginal discharge with white-yellow consistency and had been having pains over the joints and some of them have become swollen. The cough had been keeping the patient from getting any sleep and every time she coughs the chest hurts and felt like a burning inside, inspite of trying lozenges and over the counter cough medicines. She had been having a purulent cough over the past few days not getting any better and noted difficulties with hoarseness even though she had been doing gargling. She had developed a white vaginal discharge over the past week, which was getting worse on taking the medications. She had difficulties because of the intense pruritus. She was having difficulties moving the wrists, closing the hands, and walking because of pains of the ankles and knees and hips hurting at different times but getting worse over the past two weeks.

Impression:

1) Bronchitis.
2) Pharyngitis.
3) Vaginitis.
4) Osteoarthritis.

She was prescribed Clotrimazole cream, Doxycicline and Diflucan. Laboratory tests, HIV test and Mammogram were recommended.

10/2/15 - Laboratory Report, Quest Diagnostics. Cholesterol, total was low. Hepatic function panel showed high bilirubin, total and bilirubin, direct. Urinalysis showed traces of leukocytes. HIV AG/AB, 4th generation was non-reactive. Thyroid panel and CBC were within range.

10/12/15 - Pelvic Transvaginal Ultrasound, ICM Medical, Arash Tehranzadeh, MD. Impression: Anterior myometrial uterine body fibroid measuring 1.1 x 0.9 x 1.6 cm.

10/15/15 - History and Physical Report, Valentin Hernandez, MD. The patient had been having progressively and worsening weakness over the past month

and runs out of breath with almost any work not being able to complete most things able to be done in the past. She noted an increase in the cough, phlegm, sore throat and headaches over the past week even though she had been taking some over the counter medications.

Impression:

1) Anemia, iron deficiency.
2) Pharyngitis.

She was given prescription for B complex, ferrous sulfate and Lamisil. Papanicolau smear was requested.

10/15/15- Laboratory Report, Quest Diagnostics. Negative for intraepithelial lesion or malignancy. HPV mRNA E6/E7 was not detected.

4/13/16 - History and Physical Report, Valentin Hernandez, MD. The patient was complaining of being exhausted with even the most elementary work and tired and sore throat with phlegm and cough with a thick phlegm. She felt weak and tired and felt no matter how much sleep still tired progressively getting worse over the past few weeks to the point that barely able to do most of the work such that even one block of exercise was enough to make her tired. She noted an increase in the cough, phlegm, sore throat and headaches over the past week even taking some over the counter medication.

Impression:

1) Anemia, iron deficiency.
2) Pharyngitis.

It was requested to undergo laboratory studies.

4/13/16 - Laboratory Report, Quest Diagnostics. Cholesterol, total was decreased. CBC showed low hemoglobin and hematocrit. HCG, total was positive. BUN, hepatic function panel and thyroid panel within normal limits.

4/20/16 - History and Physical Report, Valentin Hernandez, MD. The patient had missed the period and was worried of the consequences since it was scheduled to occur two weeks ago and had noticed some cramps and tenderness. She had been having progressively and worsening weakness over

the past month and runs out of breath with almost any work not being able to complete most things able to be done in the past.

Impression:

1) Amenorrhea.
2) Anemia, iron deficiency.

Patient education was discussed.

5/15/18 - Progress Note, Kaiser Permanente, Peter Sungpop Chong, MD. The patient was doing okay. She would like to have pap smear. Also, would like to have laboratory works including STDs.

Assessment:

1) Smoking cessation counseling.
2) Screening for cervical cancer.
3) Screening for HPV.
4) Vaccination for diphtheria, tetanus and acellular pertussis.
5) Screening for std.
6) Screening.
7) Tobacco smoker

Pap smear was obtained. She had an appointment with GYN regarding cyst in vaginal area which she had for several years. Tdap was given. Screening laboratory works were ordered per request. It was strongly recommended to stop smoking.

5/15/18 - Gyn Cytology, Kaiser Permanente. Interpretation: Cervix, liquid based pap test: Negative for intraepithelial lesion or malignancy.

5/15/18 - Laboratory Report, Kaiser Permanente. HPV cotest screening was negative. Glucose was low. Lipid panel and hemoglobin A1C were within normal range.

6/13/18 - Gynecological Visit, Kaiser Permanente, Zoila Argentina, Paz, NP. The patient complained of vaginal lump to right side of vaginal near opening for years. She noted no pain or change to lump since she initially felt lump.

Impression:

1) Smoking cessation counseling.
2) Vulvar cyst.

She was advised to return for WWE to reassess vulvar cyst annually or when she noted change in size of cyst.

4/13/20 and 6/23/20 -- History and Physical Reports, Valentin Hernandez, MD.

Impression:

1) Bronchitis.
2) Pharyngitis.
3) Osteoarthritis

On 4/13/20, the patient was complaining of a persistent cough not getting better in spite of medications and kept her awake and cough, phlegm, sore throat and hoarseness getting worse and had been having pains over the joints and some of them had become swollen. Patient education was given.

On 6/23/20, she noted pains in most of the large joints especially over the knees and a purulent greenish cough, with sore throat and headaches and upset over the way life was taking a turn and was quite nervous. Prescription was given for Buspar. Laboratory studies were ordered.

7/6/20 - Laboratory Report, LabCorp. Comprehensive metabolic panel showed low glucose. Urinalysis showed cloudy in appearance and traces of WBC esterase and WBC. CBC, hepatic function panel, T4 and T3 uptake were normal.

7/22/20 - History and Physical Report, Valentin Hernandez, MD. The patient complained of dysuria getting worse with burning and a red-tinge and flank pains and worsening fungus with redness of the skin and desquamation.

Impression:

1) Urinary tract infection.
2) Tinea corporis.

She was prescribed Bactrim DS and Lamisil.

7/31/20 - Laboratory Report, LabCorp. SARS - CoV- 2 Antibody, IgG was negative.

8/20/20 - Worker's Compensation Claim Form. The applicant claimed that she sustained cumulative trauma from 1/6/20 to 6/30/20. She allegedly suffered from stress due to hostile work environment with difficulties breathing, chest pain, irritable bowel syndrome, headache and high blood pressure.

9/9/20 - History and Physical Report, Valentin Hernandez, MD. The patient was complaining of a purulent greenish cough, with sore throat and headaches and noted pains and difficulties moving the joints as they were quite stiff. She had an unrelenting cough of green and yellow phlegm, which was associated with a painful sore throat and hoarseness over the past week. She had been having an increase in the joint pains and it was more difficult to move in the morning than in the afternoons although the medications had not been helping to any significant degree. There was an effusion of the knee with tenderness and warmth.

Impression:

1) Pharyngitis.
2) Osteoarthritis.

Discussed the above diagnoses, medications and their indications and needed for resolution of the above problems.

10/5/20 - Primary Treating Physician's Initial Evaluation Report and Request for Authorization, Eric Gofnung, DC. DOI: CT-7/6/19 - 7/5/20. The patient was employed by Sunbridge Hallmark Health Serv. DBA: Playa Del Rey Center as a registered nurse at the time of the injury. She was asymptomatic and without any disability or impairment prior to the continuous trauma injury from 7/5/19 to 7/5/20 as related to the neck, bilateral shoulder, greater in the left shoulder, left arm, wrist/hand and finger, low back, left hip, bilateral knees, ankles and bilateral feet. At this time, her pain was moderate and the symptoms occur frequently. There was pain and limited range of motion or twisting and turning the head and neck. The pain was aggravated with flexing or extending the head and neck, turning her head from side to side, prolonged positioning of the head

and neck, forward bending, pushing, pulling, lifting and carrying greater than 5-10 pounds, and working or reaching at or above shoulder level. There was radiating pain from the neck into his/her shoulders, and down the left arm to the finger tips. She had been experiencing frequent headaches. She was experiencing numbness and tingling. She had difficulty falling asleep and was often awakened during the night by the neck pain. There was stiffness and restricted range of motion in the head and neck. Her pain level varied throughout the day. Pain medication, analgesic balms, heating pads, gave her temporary relief, she remained symptomatic.

She reported bilateral shoulders, which was moderate and the symptoms occur frequently, greater on the left. The pain radiated to her left elbow, arm and wrist/hand and fingers. She had instability in the left shoulder. She experienced weakness and a restricted range of motion for the shoulder as well as in the left side, there was numbness and tingling in the shoulder, arm, hand and fingers. The numbness and tingling in the hands and fingers awaken him at night. She complained of stiffness and experienced increased pain with repetitive motion of the arms/shoulders. The pain was aggravated with backward, lateral, and overhead reaching, pushing, pulling, lifting and carrying greater than 3-5 pounds, and repetitive use of the bilateral upper extremities. Her pain level varies throughout the day, depending on activities. She had occasionally, however when lying her shoulder, they became numb. She had difficulty falling asleep and awakens throughout the night due to the pain and discomfort.

She was complaining of bilateral hands/wrist pain. It was described as moderate, and the symptoms occurred frequently in bilateral hand/wrists/finger, greater in the left. The pain was aggravated with gripping, grasping, torquing motions, flexion, and extension of the wrist/hand, pinching, fine finger manipulation, driving, repetitive use of the left upper extremity pushing, pulling, and lifting and carrying greater than 2-3 pounds. She had cramping, weakness, and loss of grip strength in hand and wrist and had dropped objects, as a result. There was tingling in the hands and fingers. She had difficulty sleeping and awakens with numbness, tingling and pain, and discomfort. Her pain level varied throughout the day, depending on activities.

The lower back pain was moderate and the symptoms occur frequently, which increased becoming aching cramping and depending how she move, becoming sharp. The pain radiated to her bilateral hip, greater in the left hip, down her left buttocks and back of her thighs. She did have numbness and tingling in her left leg, to the foot. She stated coughing and sneezing aggravate the back pain.

The pain increased with activities of standing or walking as well as sitting over 15 minutes as well as activities of kneeling, stooping, squatting, forward bending, ascending and descending stairs, forceful pushing and pulling, lifting and carrying greater than 5-10 pounds, going from a seated position to a standing position and twisting and turning at the torso. She complained of muscle spasms and difficulty with intimate relations/sexual activity due to increased pain to her lower back. She denied experiencing bowel problems. She did awaken from sleep as a result of the low back pain. She had self-restricted by limiting her activities. She occasionally drags or leans her left side due to his low back symptoms. Pain medication, analgesic balms, had temporary relief, but she remained symptomatic.

She also had bilateral knees pain, and was moderate and occurred frequently, which was greater on the left side. The pain increased with flexing, extending, prolonged standing and walking, going up and downstairs, bending, stooping, squatting, and walking on uneven surfaces or slanted surfaces. There was popping and grinding in both knees and experiences buckling episodes. She had lost his balance as a result of the buckling. The knees were slightly swollen, and the pain radiated down to the calves. She had episodes of swelling in the knees, and felt she had fluid. She was unable to kneel and squat. She had difficulty ascending and descending stairs and occasional limping. In addition, bilateral ankles pain was noted. The pain was moderate, frequently, greater in the left in the bilateral ankles and heels. There was slight swelling and cracking of the ankles. She complained of the instability of the ankles and cramping of the feet, worse on the left ankle. The pain was aggravated with standing and walking over 15 minutes, flexing, extending, squatting, stooping, and standing on the tiptoes. She cannot hop, jump, or run due to the pain. There was radiating pain from the ankles into the toes. There was numbness and tingling in her toes. She occasionally limps while walking and ambulating. There was slight swelling and cracking of the ankles. She had feet pain as moderate and frequent, greater in the left foot, became sharp, and numbness. Her pain traveled up to her leg, and down to her toes. She had cramping, swelling, numbness and tingling in bilateral feet, greater in the left foot. Her ankle/foot had given out, causing her to lose her balance. She had difficulty standing and walking for a prolonged period. Her pain worsened when she flexes/extends or rotates his/her foot/ankle. Her pain level varied throughout the day, depending on activities. She had difficulty sleeping and would awake with pain and discomfort. Pain medication, heating pads, and ice packs provided temporary relief. She had continued episodes of anxiety, stress, and depression due to chronic pain and disability status. She denied suicidal ideation. She had difficulty sleeping, often obtaining a few hours

of sleep at a time. She felt fatigued throughout the day and found herself lacking concentration and memory at times. She worried over her medical condition and the future. Her condition had worsened due to lack of medical treatment, and activities of daily living. In 2003, she was the driver, she sustained a whiplash type injury to her neck and back and received chiropractic treatment, her symptoms resolved. She was taking Ativan, Prozac and Tylenol or Motrin over the counter. Review of systems were remarkable for trouble sleeping, muscle and joint pain, stiffness, anxiety, depressed mood, social withdrawal, emotional problems, and stress.

Examination of the cervical spine revealed tenderness to palpation with muscle guarding of bilateral paracervical and left upper trapezius musculature. There was tenderness and hypomobility at C3 through C7 vertebral regions. Shoulder depression test was positive on the left. Ranges of motion for the cervical spine were decreased and painful. Examination of the shoulders and upper arms revealed antalgic position of the left shoulder. There was tenderness to palpation with myospasm of left supraspinatus, infraspinatus, and periscapular musculature. Hawkins test was positive at the left shoulder. Ranges of motion for the left shoulders was decreased and painful. Examination of the elbows and forearms revealed tenderness to palpation at left elbow medial epicondyle and left forearm extensor muscle group. Valgus Stress Test was positive at the left elbow. Ranges of motion for the elbows were within normal limits with pain at the left elbow. Examination of the wrists and hands revealed tenderness to palpation at left carpals, distal ulna, distal radius, TFCC. There was tenderness at left thenar region. Tinel's sign was positive at the left. Finkelstein's and Phalen's test were positive at the left. Ranges of motion for both wrists were within normal limits with pain at the left. Examination of the fingers revealed digital painful ranges of motion of digits one and five on the left hand. Tenderness at the left thumb was noted during palpation. Ranges of motion for the fingers were within normal limits with pain at the left first and fifth digits. Jamar grip strength on the left was 18/32/32 and on the left was 34/34/34. She complained of increased pain at the left hand during the testing. Motor testing of the cervical spine and upper extremities with the exception of deltoid left graded 4/5; wrist extensor in the left was 4/5; finger flexor, finger abduction and wrist flexor were 4/5 on the left; triceps in the left was 4/5. Sensory testing was intact bilaterally as tested with a Whartenberg's pinwheel with the exception of dysesthesia at left C6-C7 dermatomal levels, dysesthesia in left hand medial nerve distribution. Examination of the thoracic spine revealed tenderness to palpation with myospasm of left parathoracic and left trapezius musculature. Tenderness and hypomobility were noted at Tl through T5 vertebral regions. Kemp's test was

positive on the left. Ranges of motion for thoracic spine were decreased and painful. Examination of the lumbosacral; spine revealed tenderness to palpation with muscle guarding of bilateral paralumbar musculature. Tenderness at left sacroiliac joint and hypomobility at L3 through L5 vertebral regions were noted. Milgram's test was positive. Sacroiliac joint compression test was positive on the left. Straight leg raising test (supine) elicited increased low back pain with increased radiculopathy to left lower extremity: Ranges of motion for the lumbar spine were decreased and painful. Examination of the knees and lower legs revealed tenderness to palpation at left knee medial joint line. Tenderness to palpation was noted at left lower leg musculature, including gastrocnemius and peroneal musculature. McMurray's test was positive at the left knee. Pain and weakness at the left knee during the squat were present. Range of motion for the knees decreased with pain on the left. Examination of the ankles and feet revealed tenderness to palpation at left talus, calcaneus, talonavicular joint, anterior talofibular ligament, Achilles tendon and tibialis posterior tendons. Anterior drawer test was positive on the left. Ranges of motion for the ankles on the left was decreased and painful. Squatting was positive for back pain and left knee pain. Heel and toe walking were positive for back pain and left knee and left ankle pain. Antalgic gait favoring left lower extremity. Deep tendon reflex testing of the lumbar spine and lower extremities were intact with the exception of dysesthesia at left L5 dermatomal level.

Impressions:

1) Cervical spine myofasciitis.
2) Cervical facet-induced versus discogenic pain.
3) Cervical radiculitis left, rule out.
4) Thoracic spine myofasciitis
5) Thoracic facet-induced versus discogenic pain.
6) Lumbar spine myofasciitis.
7) Left sacroiliac joint dysfunction, sprain/strain.
8) Lumbar facet-induced versus discogenic pain.
9) Lumbar radiculitis left, rule out.
10) Left shoulder tenosynovitis/bursitis.
11) Left shoulder impingement syndrome, rule out.
12) Left elbow medial epicondylitis.
13) Left brachioradialis tendinitis.
14) Left wrist tenosynovitis.
15) Left carpal tunnel syndrome, rule out.
16) Triangular fibrocartilage complex tear, left, rule out.

17) Knee internal derangement, left, rule out.
18) Tenosynovitis of left lower leg.
19) Tenosynovitis of left ankle and foot.
20) Left Achilles tendinitis.
21) Anxiety and depression, sleeping difficulty.

It was recommended comprehensive treatment course consisting of chiropractic manipulations and adjunctive multimodality physiotherapy at two times per week for four weeks for cervical, thoracic and lumbar spine. left shoulder, left elbow. left wrist and hand, left knee and lower leg, left ankle and foot. She required x-rays for cervical, thoracic and lumbar spine, left shoulder. left elbow, left wrist, left knee and left ankle. With regard to causation, her condition was considered industrially related. Her condition was not pem1anent and stationary. With respect to work status, no lifting in excess of 15 pounds. No repeated work with left arm above shoulder height No repeated bending or twisting. No repeated or forceful grasping, torqueing, pulling, and pushing with left hands. No repeated squatting, kneeling, or climbing. If modified duty as indicated was not provided, then she was considered temporarily totally disabled until reevaluation in four weeks.

11/9/20 - Primary Treating Physician's Initial Evaluation Report, Del Carmen Medical Center, Marvin Pietruszka, MD and Koruon Daldalyan, MD. DOI: CT-1/6/20 to 6/30/20; CT 7/6/19 to 7/5/20. The patient was specifically referred for evaluation and treatment of various musculoskeletal and other injuries that she sustained during the course of her employment with Sunbridge Hallmark Health Services as a skilled nursing. She filed two continuous trauma claims between the dates of 7/6/19 and 7/5/20 and between 1/6/20 and 6/30/20, for injuries that she sustained during the course of her employment. She stated that the company had a license facilitating up to 99 patients. She worked as the supervisor and would provide supervising duties for the entire staff including the CNA's, LVN's and other registered nurses. She also performed administrative duties. Throughout the course of her work there was a very low amount of staff. She began to notice that she was performing various job duties besides her administrative duties as the registered nurse supervisor. She would perform duties for CNA's, LVN's and other RN's. She stated that overtime she began to have increased stress levels. When she reported her stress to her supervisors, she was advised that additional personnel would be hired for assisting her. The company never hired additional personnel causing her stress levels to continue. She eventually presented to an urgent care center as she had the onset of a panic attack. She was provided various medications and she was referred to a

psychiatrist for which she continued in treatment with. She was prescribed various medications including Prozac and Buspar. She did have some relief with both of these medications. However, at this time, she was on Tylenol and at times she was taking Ativan. Her significant stress continued at the workplace. She also had other symptoms including abdominal pain, nausea, vomiting, and diarrhea and weight loss. She had difficulty with concentration and sleep. She also complained of headaches and dizziness. She also complained of musculoskeletal pain that has progressed since leaving her workplace. She had pain in the cervical spine, left shoulder, left elbow and left hand. She had numbness of the left hand, as well as dropping items with the left hand, bilateral knee, left ankle and left foot pain. With regard to occupational exposure, she was exposed to chemicals, dust and vapors during the course of her work. She was exposed to excessive noise during the course of her work, excessive heat and cold. Review of systems were significant of headaches, dizziness, lightheadedness, chest pain, palpitations, and shortness of breath. She complained of abdominal pain, nausea, vomiting, diarrhea, and weight loss. She had musculoskeletal complaints involved cervical spine pain 8/10, lumbar spine pain 7/10, left shoulder pain 8/10, left elbow pain 7/10, left wrist pain 7/10, bilateral hand pain 5/10, left hip pain 6-8/10, right knee pain 6/10, left knee pain 7/10, left ankle pain 6/10 and left foot pain 6/10. There was peripheral edema and swelling of the ankles. She had psychosocial complaints included anxiety, depression, difficulty concentrating, sleeping, and making decisions. There was a complaint of diaphoresis. She complained of difficulty sleeping due to her musculoskeletal pain. She would wake up several times a night because of the pain. She also had problems with activities of daily living. She was taking Tylenol, Ativan, Prozac and Buspar.

Musculoskeletal examination revealed tenderness of the left side of the cervical spine, lumbar paraspinal musculature, left shoulder, left elbow and left wrist. Tinel's was positive at the left wrist. There was tenderness of the left hand and left knee. Ranges of motion of the cervical spine, thoracic spine, lumbosacral spine, left shoulder and hips were limited.

<u>Diagnoses:</u>

1) Musculoskeletal injuries involving cervical spine, lumbar spine, left shoulder, left elbow, left wrist, bilateral hands, left hip, bilateral knees, left ankle and left foot.
2) Cervical spine sprain/strain.
3) Lumbar spine sprain/strain.

4) Internal derangement, left shoulder.
5) Epicondylitis left elbow.
6) Carpal tunnel syndrome left wrist.
7) Internal derangement left knee.
8) Internal derangement bilateral ankles.
9) Elevated blood pressure, rule out hypertension.
10) Cephalgia.
11) Vertigo.
12) Chest pain.
13) Palpitations.
14) Dyspnea.
15) Gastritis secondary to NSAID medications.
16) Nausea/vomiting.
17) Irritable bowel syndrome manifested by diarrhea.
18) Weight loss.
19) Peripheral edema/swelling of ankles.
20) Anxiety disorder.
21) Depressive disorder.
22) Sleep disorder.
23) Diaphoresis.

It was believed that the diagnoses listed thus far were AOE/COE. She was to continue on temporary and total disability for a period of one month. She was to continue with her current medications. She was prescribed Ativan, Flurbiprofen topical cream to apply and Gabapentin topical cream. She was referred for an EMG nerve conduction study of the upper extremities.

11/13/20 - Deposition of Anisa Michelle Chaney. Pages 9-15: The deponent had not taken any medication, alcohol, or chemical substance. She stated her name as Anisa Michelle Chaney. She was born on 9/6/73. She was married with last name of Chaney-Stakely. In the last 24 hours, she took over-the-counter Tylenol for neck, lower back, left arm, left leg, ankle, knee, foot and hip pain. She was taking Tylenol for almost everyday for the past 6-7 months. In the last 7 days, she took Ativan for anxiety, prescribed by a psychiatrist.

Pages 16-20: The Ativan was prescribed in 5/2020 by Dr. Michael N. at Long Beach Urgent Care. She only treated once with the psychiatrist in 7/2020 due to lost insurance. She had a pending appointment due to insurance. She held a California driver's license. She denied presenting any other social security number.

Pages 20-21: At present, she was living at 13200 Doty Avenue, Apartment 101, Hawthorne, California 90250. Her P.O Box address was 1274, Gardena, California 90249. She lived in her current address for 3.5 years with her children and sometimes her brother. She has 2 children Taylor, 27 and a 14-year-old son. They paid their rent amounting to $1,685 monthly.

Pages 23-25: Prior, she lived at 14404 Budlong Gardena, California 90249 for about a year and a half with her husband and children. Tyrone Stakely was her husband and was working as a youth counselor. Before that, she lived at 3311 West 139th Street, Apartment No. A, Hawthorne 90250 for 18 years. At this time, she was separated from her husband but not divorced yet. She had been married for 20 years. Her husband has 4 other children. She stated that she had a good relationship with her stepchildren.

Pages 25-28: On 7/31/20, she had her health insurance for the last time. She was with Aetna through her employer at Playa del Rey Center. She denied having other health insurance. She had been separated for 3 years instigated by irreconcilable differences.

Pages 29-30: Her health insurance was an PPO. Dr. Valentine Hernandez in Hawthorne, her primary doctor treated her through Aetna insurance. She had been seeing Dr. Hernandez for 20 years. Last year, she changed her insurance to Kaiser. At some point in 2018, she was at Kaiser, Gardena for a year. Then, switched back to Aetna.

Pages 32-33: She was evaluated by her primary care physician and she believed pain medication was prescribed for work injuries. She was also treated by another unrecalled psychiatrist for stress. She also visited Dusk to Dawn Urgent Care in Long Beach or Cerritos in 6/2020. Going back to the psychiatrist in Long Beach Boulevard, she believed being treated in 5/2020. She was seen by seen Dr. Gofnung in Los Angeles, and Dr. Daldalyan in Reseda, Vanowen. She had seen Dr. Gofnung in late 9/2020.

Pages 33-34: In 6/2020, she visited Dusk to Dawn, she complained of having chest pain, shortness of breath and headaches. She just saw Dr. Daldalyan just this week in 5/9 for stress, stomach or gastrointestinal [problems], headaches, anxiety and some orthopedic problems.

Pages 35-39: She changed insurance through her employer. Since her termination, she was receiving benefits from unemployment or EDD, amounting to $3000 monthly. She was terminated on 7/9/20. Since then, she was trying to apply, but had not found any. She was hired with Playa in 4/2020 as a nurse supervisor. At the time of her termination, her hourly earnings were $39. Mae Young was her supervisor. Her duties entailed as supervising the staff, the LVN's, CNA's, maintaining the building integrity, patient care, medication pass and did housekeeping. She had physical requirements with lifting, pushing a medication cart, assisting patients with mobility, and transfers. She worked 5 days per week. At the time of her termination, she was working full duty. Concurrently, she worked for My Life Foundation at least 10 years since 2009. She was a nurse consultant, performing duties as assessing and consulting with the staff and clients with the foundation in their homes, in-home care visits. Primarily, patient care and no physical patient care involved. In the meantime, she stopped working at My Life Foundation as she was exposed to COVID at Playa del Rey.

Pages 40-44: She got paid per diem or per assignment at My Life. She regularly monitoring the houses. Last year, she worked for Genesis HealthCare and was transitioned to New Gen. The owners had changed. Her duties were assigned by Playa del Rey Center. At My Life Foundation in La Tijera, Los Angeles, she was working full duty or no restrictions. She last worked for My Life Foundation on 4/1/20. Before working at Playa del Rey Center, she was self-employed, and worked for IHSS as a licensed cosmetologist. She had been doing cosmetology for 30 years. She last doing cosmetology in early 2019. She was doing at client's home. She was working as a nurse supervisor 5 days a week and would work at My Life Foundation at about 2-4 hours at 2-3 times a week. Then doing cosmetology at her spare time in the last 5 years. She was also doing hair and make up like 2 clients a week.

Pages 44-48: Concerning IHSS, she believed being employed in 1990 to 2010. She believed ended up in IHSS, Hawthorne office. She was seeing 2 patients only in the last 5 years. She assisted some patient's personal care and needs. Billy Fletcher was her last patient. The patient had his limitations like walking with brace. She denied sustaining any injuries while working for My Life Foundation or at IHSS and never filed a claim. She was working concurrently, so she was experiencing some discomfort. She drove like 20-30 minutes to her patient's homes. In doing hair and makeup, she only carried small bag that weighed 10 or 15 pounds.

Pages 48-51: She was receiving unemployment benefits every 2 weeks. She was seeking out job with less physical positions. She applied at Department of Veteran Affairs as a coding nurse. She received her nurse license in 2009. She had her first nurse position with My Life Foundation.

Pages 51-55: At this time, she confirmed complaints of low back, left arm pain, headaches, bilateral knees, ankles, feet, hip and left side. Her neck pain was more on the left side radiated to jaw down to her shoulder, arm and fingers and was 4-5/10. She had entire left arm pain as sharp with numbness and tingling sensation in her fingers, aching especially when sleeping and moving. She felt left arm numbness and heaviness rated 3-4/10, and that she would awake at times when sleeping. She had tension headaches like a couple times a week. She had left knee pain when walking and bending and arising from seated position. At times, she got locked up and rated 6-7/10. The pain was aggravated with prolonged standing, walking and relieved by rest or sitting. Her right knee pain was 3-4/10 and pain with driving. She had not undergone MRI of the knees.

Pages 56-63: Regarding left hip pain, the pain started when walking too much and by positioning, it would also occur daily and when sleeping. She had 7/10 left foot pain with excessive walking to more than 15 minutes. At My Life Foundation, she had to sit and stand. She did a little bending when doing physical examinations for patients. At this time, back pain was 3-4/10. If escalated it went up about 8/10. She also having 7-8/10 pain in the shoulders, greater than the left side. At this point, she had stiffness in the shoulder and rated 3/10. All the time, she felt neck and shoulder pain at 7/10. The pain was aggravated with wrong positioning, lifting or reaching. Her sleep was broken because of the pain and discomfort. She was having difficulty lifting up to10 pounds. She started feeling the neck pain around a year ago. She reported the injury to Mae Young, the director. She was only advised to take Tylenol and had a rest.

Pages 66-71: She sought medical treatment on her own with Dr. Hernandez for the neck and left arm pain. She did missed days off work because of neck pain. Back in 2019, the left arm pain was noticed. She reported the left arm injury to Mae Young. She clarified complaining of pain and discomfort with no specific treatment with Dr. Hernandez. She believed pain medications were prescribed. In 2019, she asked for work adjustment to lift and pull since the problem continued. She informed to her employer that she had overall pain.

Pages 72-76: She was not referred to see a doctor. She did not know that she needed to seek treatment, until she complained to Dr. Hernandez, pain medications were prescribed. She denied having the right to report any work-related injuries. However, she had knowledge to report when people injured on the job. Back in around 1/2019, she started feeling headaches. She reported to Mae Young about the headaches was caused by work. She could not remember either requesting to get medical treatment.

Pages 81-85: In 6/2019 or 7/2019, she started noticing left knee pain. She informed Mae Young that she was having physical pain because of the work. She was only advised to relax. She would have some medical staff to assist her to lighten her load. Recently, she started receiving treatment, but not when she first reported it. She used knee braces, Tylenol and topical gels. She had intense pain back in June or July. She complained overall pain several times constantly. She mentioned the left knee pain to Dr. Hernandez. In 2020, she first complained the left knee pain with Dr. Hernandez. She was not provided any treatment for her knee.

Pages 86-90: In 2020. She started treating for the left knee with Dr. Gofnung. Regarding her left hip/leg and back pain, it started to notice in 2019 and the same thing. she reported it to Mae Young. Yet again, only getting some help and taking medicine. She could not remember requesting medical treatment for her injuries. She thought the discomfort and the pain would pass. She self-medicated and continued working. The medications would help get through her shifts. But it did not go away completely. She complained to her doctor, no treatment either was recommended. She believed at Kaiser, she was directed to make more appointments as she had too many things going on. However, she did not return back to Kaiser.

Pages 91-94: Her condition got worse and she raise that concern to her employer. None of the times that she complained to Mae about the work injuries was sent for medical treatment. She denied filling out a report about these injuries. She worked as a supervisor, at some point, there was a folder given that if there was an injury, to fill out a form and report it to the director. For her complaint, she denied that should have been done.

Pages 95- 99: She reported at least twice a month about her work-related injuries to Mae in the past year. Again, she reiterated complaining all those pain to her primary doctor with no treatment was done. In early 1/2020 or 2/20220, Dr. Hernandez offered her pain medications and she declined. She was

prescribed but not for pain. She supposed a prescription for Celebrex, anti-inflammatory for anxiety and depression was given, but she never got those medications. She avoided to take those medications, but she was taking Tylenol and Ativan in the past. She refused to take the anti-inflammatory because she was very particular of the side effects.

Pages 100-103: She stated having like work-related injuries aside from those mentioned, stress, anxiety, chest pain, shortness of breath and abdominal discomfort almost daily. Earlier this year, she started having increased anxiety and heart rate/palpitations, and sweaty palms. In the last 15 years, she denied going to any other urgent care aside from in Long Beach and Dusk to Dawn Urgent Care. She denied ongoing medical problems aside from the work-related. However, she had episodes of elevated blood pressure around 1/2020. She denied having been involved in any motor vehicle accident. She shorn of filing any other workers' compensation injuries in the past.

This is a 105-page condensed deposition transcript. The proceedings lasted 2 hours and 52 minutes.

11/16/20 - Primary Treating Physician's Follow-Up Evaluation Report, Eric Gofnung, DC and Mayya Kravchenko, DC. The patient was feeling some improvement with treatment she was undergoing while under our care. She denied any new accidents or injuries. however, she remained symptomatic. At this point, she complained of neck pain best described as intermittent and slight to moderate, occasionally becoming moderate with prolonged posturing. She had bilateral shoulder pain, frequent and slight to moderate, worse on the left. On the right occasional and slight, on the left was frequent and moderate. She noted bilateral wrist and hand pain, which was worse on the left. On the right intermittent and slight and on the left was frequent and moderate, associated with numbness and tingling in both hands. Lower back pain was also noted as frequent and moderate, worse with prolonged weight bearing, forward bending, lifting, pushing or pulling. She reported left knee pain was intermittent to frequent and moderate, associated with occasional swelling and giving way. She noted bilateral ankle and foot pain as intermittent and slight to moderate. Cervical spine examination revealed tenderness to palpation with muscle guarding of bilateral paracervical and left upper trapezius musculature. Tenderness and hypomobility were noted at C3 through C7 vertebral regions. Shoulder depression test was positive on the left. Ranges of motion for the cervical spine were decreased and painful. Examination of the shoulders and upper arms revealed antalgic position of the left shoulder. Tenderness to palpation with

myospasm of left supraspinatus, infraspinatus, and periscapular musculature was noted. Hawkins test was positive at the left shoulder. Ranges of motion for the shoulders on the left was decreased and painful. Examination of the elbows and forearms revealed tenderness to palpation at left elbow medial epicondyle and left forearm extensor muscle group. Valgus stress test was positive at the left elbow. Ranges of motion for the elbows were within normal limits with pain at the left elbow. Examination of the wrists and hands revealed tenderness to palpation at left carpals, distal ulna, distal radius, TFCC. There was tenderness at left thenar region. Tinel's sign was positive at the left. Finkelstein's and Phalen's test were positive at the left. Ranges of motion for both wrists were within normal limits with pain at the left. Examination of the fingers revealed digital painful ranges of motion of digits one and five on the left hand. Tenderness at the left thumb was noted during palpation. Ranges of motion for the fingers were within normal limits with pain at the left first and fifth digits. Jamar Dynamometer grip strength testing showed 12/12/12 on the left and on the right was 30/28/28 kg. Motor testing of the deltoid on the left, left wrist extensor, finger flexor, finger abduction and wrist flexor on the left and left triceps were graded 4/5. There was dysesthesia at left C6-C7 dermatomal levels, dysesthesia in left hand medial nerve distribution. Examination of the thoracic spine revealed tenderness to palpation with myospasm of left parathoracic and left trapezius musculature. Tenderness and hypomobility were noted at Tl through T5 vertebral regions. Kemp's test was positive on the left. Ranges of motion for thoracic spine were decreased and painful. Examination of the lumbosacral spine revealed tenderness to palpation with muscle guarding of bilateral paralumbar musculature. There was tenderness at left sacroiliac joint and hypomobility at L3 through L5 vertebral regions. Milgram 's test was positive. Sacroiliac joint compression test was positive on the left. Straight leg raising test (supine) elicited increase low back pain with increased radiculopathy to left lower extremity. Ranges of motion for the lumbar spine were decreased and painful. Examination of the knees and lower legs revealed tenderness to palpation at left knee medial joint line. Tenderness to palpation was noted at left lower leg musculature, including gastrocnemius and peroneal musculature. McMurray's test was positive at the left knee. There was pain and weakness at the left knee during the squat. Range of motion for the knees decreased with pain on the left. Examination of the ankles and feet revealed tenderness to palpation at left talus, calcaneus, talonavicular joint, anterior talofibular ligament, Achilles tendon and tibialis posterior tendons.
Anterior drawer· test was positive on the left. Ranges of motion for the ankles on the left was decreased and painful.

Impression:

1) Cervical spine myofasciitis.
2) Cervical facet-induced versus discogenic pain.
3) Cervical radiculitis left, rule out.
4) Thoracic spine myofasciitis.
5) Thoracic facet-induced versus discogenic pain.
6) Lumbar spine myofasciitis.
7) Left sacroiliac joint dysfunction, sprain/strain.
8) Lumbar facet-induced versus discogenic pain.
9) Lumbar radiculitis left, rule out.
10) Left shoulder tenosynovitis/bursitis.
11) Left shoulder impingement syndrome, rule out.
12) Left elbow medial epicondylitis.
13) Left brachioradialis tendinitis.
14) Len wrist tenosynovitis.
15) Left carpal tunnel syndrome, rule out.
16) Triangular fibrocartilage complex tear, left, rule out.
17) Knee internal derangement, left, rule out.
18) Tenosynovitis of left lower leg.
19) Tenosynovitis of left ankle and foot.
20) Left Achilles tendinitis.
21) Anxiety and depression, sleeping difficulty.

The patient was recommended to continue with comprehensive treatment course consisting of chiropractic manipulations and adjunctive multimodality physiotherapy to included myofascial release, hydrocollator, infrared, cryotherapy, electrical stimulation, ultrasound, strengthening, range of motion (active I passive) joint mobilization, home program instruction, therapeutic exercise, intersegmental spine traction and all other appropriate physiotherapeutic modalities for cervical, thoracic and lumbar spine, left shoulder, left elbow, left wrist and hand, left knee and lower leg, left ankle and foot at once per week. It was recommended to proceed with x-rays for cervical, thoracic and lumbar spine, left shoulder, left elbow, left wrist, left knee and left ankle.
Her condition was not permanent and stationary. With regard to work status, she was instructed of no lifting in excess of 15 pounds. No repeated work with left arm above shoulder height. No repeated bending or twisting. No repeated or forceful grasping, torqueing, pulling, and pushing with left hands. No repeated

squatting. kneeling, or climbing. If modil1ed duty as indicated was not provided, then she was considered temporarily totally disabled until reevaluation.

12/4/20 - Deposition by Zoom of Anisa Chaney. Page 110- The deponent name is Anisa Chaney.

Page 112-116: In the last 24 hours, she had not taken any medication or any alcohol. She recalled the lists of injured orthopedic body parts as a result of her employment such as neck, shoulders, whole left arm, back, left leg/hip down to leg, knee, foot and ankle. In addition, she had some discomfort in her right hand and fingers. She clarified from the last deposition, She initially felt hurt in the left arm, left shoulder in 2017 with the same employer caused by handling a patient. She felt intense pain where she went to the doctor. She reported the injury to Rosa Mansel, the director of nursing. At this time, Rosa Mansel, was no longer employed at that company. She went to Dr. Hernandez for continued pain. She did not file a workers' compensation claim as a result of that incident. She believed she called off a couple of days from work. She believed undergoing x-ray or an MRI at that time.

Pages 117-120: She believed Dr. Hernandez reviewed her scans and showed negative. She denied writing any incident report about this 2017 accident involving left arm and the left shoulder. She felt those issues as to the left arm and left shoulder went away within a year. She elaborated still having discomfort but it was not intense at times. From that 2017 incident, she did not have impairment as to that left arm or left shoulder. She last work on 7/6/20. She did not recall the exact incident date in 2017. She confirmed not always working the usual and customary work from 2017 incident up to her last day of work. She never had a chance to work on modified or on restrictions to any body part.

Pages 121-126: In 2017, she started having neck, shoulder/arm pain. In 2019, around fall her back pain started, left leg, left hip, left foot pain was noticed in early 2019. However, she could not remember when the pain started in the right knee, right shoulder and right hand. She recalled reporting the pain and discomfort to Mae several times, but not specific to body parts. She did have to let Rose Mansel know about her arm at that time as well. As of 2019, Mae had been the director, that she had been having to communicate with. She stated that she sustained these injuries at work by a lot of physical work. She alleged suffering stress, some discomfort, some intestinal discomfort as a result of her employment too. For these problems, she was seeing Dr. Daldalyan as she mentioned the last time. She was having a little headache, episodes of chest

pain and shortness of breath. These was involved with the COVID and wearing masks with no circulation. She stated that they were doing CPR constantly. Meaning, having 40 patients' deaths in a few months. It was just lot of work and under stressful conditions. She had elevated blood pressure, which she initially went to Dusk to Dawn urgent care with Dr. Allan.

Pages 127-130: In about 1/2020, she noticed intestinal discomfort. She believed through stress caused her intestinal discomfort. At this time, she felt better and experienced occasionally but not frequent. She was not taking any medications for the intestinal discomfort. She clarified describing intestinal discomfort as abdominal pain with diarrhea. She affirmed mentioning this to a doctor at the Stars Behavioral Health Group in Long Beach, and Dusk to Dawn. Both, related it to stress. Also, mentioned it to Mae. In early 1/2019, her headache started and she opined through stress. Her stress/headache assumed to cause by her responsibilities, work conditions and environment. Initially, in 2019 she spoke to Rose, then to Mae. At this point, headache was better, less frequent and less intense. She still getting friction, but it was not as bad.

Pages 130-133: In 1/2020 or 2/2020, chest pain and shortness of breath were noticed. She was hesitant what caused those problems. She had chest pain by having heart palpitation and anxiety. For these problems, she went to the same place at Dusk to Dawn and the Behavioral. She alleged wearing mask contributed to these problems. At this time, she denied suffering chest pain, anxiety and shortness of breath. She started wearing the N95 mask in late 1/2020 because of COVID exposure. She was having stress for several years; however, it became unbearable in early 2019.

Pages 133-135: She agreed regarding her attorney's filing a claim, an application for injuries starting 1/6/20 to 6/30/20. Her attorney on her behalf alleged stress and strain due to hostile work environment. The applicant was forced to wear N95 mask that was causing difficulties of breathing, chest pain, irritable bowel syndrome, headache and high blood pressure. Per this pleading, she believed the environment with the COVID and the restrictions that added or compounded on top of everything else. She thought wearing N95 mask contributed these symptoms.

Pages 136-137: Between 1/6/20 and 6/30/20, she explained and experienced a hostile environment because her boss not happy with her constant complaining of pain, anxiety and was getting backlash, staff not cooperating, issues with staff performance, not following the precautions with the virus and putting in

dangerous situations with all that. Outside workplace, she was complying with various recommended restrictions for COVID.

Pages 138-143: In addition, she had stress between 1/6/20 and 6/30/20, for a different situation like having to go to work due to understaffing and not going home on time. She denied attending psychiatric counseling. In 2014 or 2015, she had counseling due to a family situation, regarding her 22-year-old daughter for having a mental health crisis. They had a few sessions over a couple of months and those issues were resolved. Her daughter was diagnosed with bipolar schizophrenia. Her daughter was on medication and continued until she came off of it. At this time, she was absolutely well with no more medications. She has 14-year-old son, no physical or mental disabilities. She described him as an excellent student with no history of any disciplinary actions.

Pages 144-147: Back in 2013/2014, she was uncertain if her daughter had ever been a victim of a violent of crime specifically rape or assault that could trigger her psychiatric issues. She reiterated that her daughter was doing better. It had not been an issue to her. Her daughter has a mentor if she did not comfortable talking to her about anything, she could express it to someone else. At this time, her daughter was working in logistics and transportation. She went to school and finished during her psychiatric episode. She denied together with her daughter had ever been arrested, abuse drugs or alcohol. Similarly, her son had not ever been assaulted or been a victim of a violent crime. She had once domestic violence issue with her estranged husband before they got separated. She had physical altercation and her husband was arrested for that incident.

Pages 148-150: After this incident, they had marriage counseling with their church about 8 or 9 months. She did not have any reason why the divorced had not progress. Physically, she last saw her husband in August. Her husband had not had abuse alcohol or drugs during their marriage. Her husband lived in Los Angeles.

Pages 150-152: At this time that she was not working, she was a student at Capella University. She was working on her bachelor's degree for psychology, precounseling. She started a month ago and enrolled in one through online. Regarding hostile work environment, she expressed that she experienced and felt discrimination, because she was black. As a black registered nurse, she was forced to do duties that the other nurses in her position of other races did not have to do. She felt like that contributed to even complained of pain and addressing certain issues, until she got fired. She got terminated after ten years.

She felt retaliation and the discrimination was very obvious. And mentioning it, she also received threats, harassment from staff. She had documented all of that.

Pages 153-157: Her attorney was aware about the threats. During her employment with Genesis, she believed having one disciplinary action when Rose was the director. She was definite rebutting or contesting the write-ups. She thought it was about lying for something that needed to cover up. She added, one incident, she got blamed on taking the lady off the oxygen, but actually on. That she could not contact the doctor, something like that. She admitted having some issues with Rose. Before they were friends, having out to her home and so forth. Initially, when Mae came in, she found it friendly with good intentions; however, after she was complaining consistently, she started to get a little different. Mae started to get rude and disrespectful towards her. She also had issues with LVN's, CNA's and housekeeping staff. For instance, they were complaining about her required standards that they refused to follow.

Pages 157-158: They had corporate meetings and these issues were raised. But with the director, the administrator, and so forth, finding herself initiating the complaints and then they came back with something. She wrote them up then the staff complained about several things, as such being belittled and stated "I'm doing too much." Their behavior was acknowledged by the supervisors also, and she was asked to deal with it.

Pages 159-160: In the last 30 days, she had seen Dr. Daldalyan and Dr. Gofnung. With Dr. Gofnung, she was doing therapy sessions, which helped. Along with some cream from Dr. Daldalyan for neck, shoulders and back pain. She refused medications, but did get Ativan that either had not use it. She was not taking Tylenol too often either. She denied taking any medications for her other concerns that were discussed.

Page 161: She stated having an online study at Capella University in Minnesota. They had their marriage counselling at Central Baptist Church in Inglewood.

Pages 163-167: She still attending church at Central Baptist Church, but she stopped due to COVID. She clarified her daughter has a different father with her son. They had good relationship with the fathers of her children. She worked concurrently with Genesis and My Life Foundation. After being exposed to COVID, she had not been back to work. She clarified that in her last deposition, she stopped working for My Life Foundation in 4/2020 due to exposure to COVID

at Playa Del Rey. In January to March, she still was working for My Life Foundation but it was not clear to her until it came to her knowledge that they were exposed to COVID, so they stopped going to other job.

Pages 168-171: Earlier she stated wearing the mask contributed to her anxiety and feeling shortness of breath. She was having anxiety a long time at her job. Outside of it, she did not have any problems. The chest pain and palpitation started to get worse in January. She explained wearing a mask was stressful, uncomfortable, her stress elevated and all those excessive works. A lot of things were contributing to her anxiety at that point. She added that wearing the mask definitely was making her feel claustrophobic. She needed to go outside and took it off and breathe. She recalled being diagnosed with generalized anxiety during the time that she mentioned with her daughter. In 2014, she went for counselling with Dr. Ronald Milestone at Gelbart & Associates in Torrance. At this time, she believed Dr. Milestone had retired.

Pages 172-176: Back in the topic of wearing a mask, she narrated that initially started a COVID unit, where patients were to be isolated to one portion of the building, but it was not happened. They ended up with COVID all around the whole building. It became mandatory to use the masks even not in direct contact with the COVID. She recalled having the first person passing away suspiciously and assumed it was COVID. They made the COVID unit around February or March. The staff did not wear mask in that COVID, but she had to wear one as had been reported to the State on several occasions. However, she was not assigned to the COVID unit though. Her employer as well as the State mandated everybody to wear N95 masks in all units at one point. She was the supervisor, she did the whole building. But she refrained from the COVID unit as much as possible. At a certain point it was N95 was necessary with the face shield, goggles and whole PPE. Initially, she stated that they started with the surgical masks, before the outbreak just went out or out of control. She reported having problems breathing with the N95.

Pages 176-178: They were given a different N95. She described as it suffocated her. The whole was different until Mae came. Mae came with different staff from other facility. Since then, she claimed having a lot of differences made between them and her and other staff. There was a big difference made, discrimination differences, favoritism and the accommodations. Briefly, by unit, like a different unit had different N95. She made a request of mask for more comfortable one. She asked Mae, Brenda Renemar and Kyle Colt about it.

Pages 179-183: From her first deposition, she denied asking supervisors or superiors to be sent to the doctor in regard to her pain. She clarified as supervisor, she performed duties different from supervising position. She was doing more physical work than a normal supervisor's duty equated to other supervisors. Other supervisors were other nationalities and other races. She brought that to their attention, making a difference with her. She testified connecting her pain outside of her job description. She should not have to do those physical hard duties. As a supervisor, if people complaining about their physical pain at work, she would evaluate the severity and what pain was and if there was a reason to leave and excuse to go home. She admitted that she had no authority sending staff to clinic for complained pain. In her case, she did not have any knowledge of what she did. She was not aware of her rights to be sent to industrial clinic with complained about pain.

Pages 184-189: She admitted filing for bankruptcy about two years ago in 2017 or 2018. She had not been involved in any lawsuits other than this specific claim. In 2018, she had less income because of the separation with her husband. The reason she filed for bankruptcy. She was still married in the state of California in 2018. Personally, she did not ask any assistance from her husband, but they did have a joint responsibility. In 2018, there was an income changed with her husband as they were separated and had two separate households. She denied struggling paying off her credit cards. In 2019-2020, she had some family members who passed away. Her uncle died in December 2019 with cancer at age 70. It was obviously different after losing her dad and mom as to her uncle. Her mother passed away in 1992, and her dad in 1996. She did good after that. Her cousin died suddenly in 2019. She usually worked but they were in touch. She felt sad and did not know how it affected her.

Pages 189-190: She denied having been under similar stress or anxiety outside her employment. In passing of her parents, she was not dysfunctional even if feeling sad, hurt with stress and anxiety, heartache or pain. She stated that she was pregnant at that time her mom died. She raised her children and little sister. Then few years later, her father died and helped her brother. She even took care of both of her grandparents after her parents passed away for many years. She went to nursing school, became a registered nurse, got married and raised her children. It affected her but she was able to function.

Pages 191-193: She was dysfunctional at a period of time about stress and anxiety at work. At this time, she claimed that she was relieved even unemployed. She had not been to work but she was functioning.

Page 194-195: She testified going through the psychology study. She felt grief as a response to the death.

This is a 91-page deposition transcript. The proceedings lasted 2 hours and 26 minutes.

1/27/21 - Primary Treating Physician's Follow-Up Evaluation Report, Eric Gofnung, DC. T116 he patient reported was not working. She denied any new accidents or injuries. She was not aware of any AME or QME examination scheduled. She had been receiving chiropractic and physiotherapeutic treatment while under my care and was feeling better. She had seen an internist Dr. Koruon Daldalyan twice, where she underwent some x-rays as well as was given prescription medication for her stomach pain and anxiety as well as received analgesic cream. She had not undergone x-rays at SoCal as recommended by the undersigned until present. At this time, she complained neck pain with radiation to left shoulder and moderate. She had left shoulder and left elbow pain as slight to moderate. She reported slight bilateral wrist and hand pain. She had low back pain with radiation to left posterior hip and was moderate. Also, she noted slight pain with occasional episode of locking of the left knee. Left ankle and foot pain were also slight. She had sleeping problems, anxiety, stress, headaches, and abdominal pain. Cervical spine examination revealed tenderness to palpation with muscle guarding of bilateral paracervical and left upper trapezius musculature. Tenderness and hypomobility were noted at C3 through C7 vertebral regions. Shoulder depression test was positive on the left. Ranges of motion for the cervical spine were decreased and painful. Examination of the left shoulder revealed tenderness to left supraspinatus. Hawkins test was positive at the left shoulder. Ranges of motion for the left shoulder was decreased and painful. Examination of the left elbow revealed tenderness over the left lateral epicondyle and left forearm extensor muscle group. Left Cozen's test was positive at this time. Ranges of motion for the elbows were within normal limits with pain at the left elbow. Examination of the wrists and hands revealed tenderness, was present over the left thumb over the first carpometacarpal joint and metacarpophalangeal joint.
Tinel's test was unremarkable. Finkelstein's test and Phalen's test on the left wrist were positive.

Ranges of motion of the left-hand digits were within normal limits with tenderness at the left thumb at extremes. Motor testing of the left deltoid was graded 4/5. Examination of the thoracic spine revealed tenderness to palpation with myospasm of left parathoracic and left trapezius musculature. Tenderness and hypomobility were noted at TI through T8 vertebral regions. Kemp's test was positive on the left. Ranges of ·motion for thoracic spine were decreased and panful. Examination of the lumbosacral spine revealed tenderness to palpation with muscle guarding of bilateral paralumbar musculature. There was tenderness at left sacroiliac joint and hypomobility at L3 through L5 vertebral regions. Milgram's test and sacroiliac joint compression test were positive on the left. Ranges of motion for the lumbar spine were decreased and painful. Examination of the left knee revealed tenderness to palpation at medial joint line. Tenderness to palpation was noted at left lower leg musculature, including gastrocnemius and peroneal musculature. McMurray's test was positive at the left knee. There was pain and weakness at the left knee during the squat. Range of motion for the knee was decreased with pain on the left. Extermination of the ankles and feet revealed tenderness to palpation at left talus, calcaneus, talonavicular joint, anterior talofibular ligament, Achille's tendon and tibialis posterior tendons. Anterior drawer test was positive on the left. Ranges of motion for the ankles with within normal limits with pain at the extremes.

<u>Impression</u>:

1) Cervical spine myofasciitis.
2) Cervical facet-induced versus discogenic pain.
3) Cervical radiculitis left, rule out.
4) Thoracic spine myofasciitis.
5) Thoracic facet-induced versus discogenic pain.
6) Lumbar spine myofasciitis.
7) Left sacroiliac joint dysfunction, sprain/strain.
8) Lumbar facet-induced versus discogenic pain.
9) Lumbar radiculitis left, rule out.
10 Left shoulder tenosynovitis/bursitis.
11 Left shoulder impingement syndrome, rule out.
12 Left elbow medial epicondylitis.
13 Left brachioradialis tendinitis.
14 Len wrist tenosynovitis.
15 Left carpal tunnel syndrome, rule out.
16 Triangular fibrocartilage complex tear, left, rule out.
17 Knee internal derangement, left, rule out.

18 Tenosynovitis of left lower leg.
19 Tenosynovitis of left ankle and foot.
20 Left Achilles tendinitis.
21 Anxiety and depression, sleeping difficulty.
22 Abdominal pain.
23 Flare-up secondary to no treatment for the last month as well as performance of activities of daily living as evidenced by physical examination.

She was to continue with comprehensive treatment course consisting of chiropractic manipulations and adjunctive multimodality physiotherapy. Acupuncture evaluation and treatment was recommended. It was also recommended to proceed with x-rays for cervica1, thoracic and lumbar spine. left shoulder, left elbow, left wrist, left knee and left ankle. MRI of the cervical spine, lumbar spine and left knee were ordered. Home exercises to include range of motion and stretching, McKenzie exercises, wall squats core strengthening, utilizing a gym ball as well as resistance band training to improve function and strength was suggested. Her condition was not permanent and stationary. She was instructed of no lifting in excess of 15 pounds. She was to avoid repeated work with left arm above shoulder height. No repeated bending or twisting, forceful grasping, torqueing, pulling; and pushing with left hand. No repeated squatting, kneeling; or climbing. If modified duty was not provided then she was considered temporarily totally disabled.

4/30/21 - Primary Treating Physician's Comprehensive Permanent and Stationary Evaluation Report, Eric Gofnung, DC. The patient was stated that while working at her usual and customary occupation as a registered nurse for Sunbridge Hallmark Health Services DBA: Playa Del Rey Center, she sustained a work-related injury to her neck, bilateral shoulder, greater in the left shoulder, left arm, wrist/hand and fingers, low back, left hip, bilateral knees, ankles and bilateral feet, which she developed in the course of her employment due to continued trauma dated from 7/6/19 to 7/5/20. She attributed the injuries due to the repetitive movements while pushing the medicart, and assisting patient with lifting or mobility and transfers. She explained that she began having symptoms in her neck and bilateral shoulders, greater in the left in 2019. She had difficulty performing her work duties; the pain was causing interruption of sleep. She self-treated her symptom with massages and over-the-counter medications. She reported the injuries to her supervisor, and did advise her that the physical therapy was available, and they offered to reduce her work duties, but it never happened. She continued working with pain and discomfort. She stated

progressively with the same workload, she began experiencing pain in her left arm, wrist/hand and finger, low back, left side hip, bilateral knees and bilateral feet. She reported these injuries, to her supervisor and all they would say they were working on it, and she never received medical attention. She continued to self-treat. Around 2019, she visited her primary care physician Dr. Valentin Hernandez about some discomfort in her neck and back, she was given medication. She was advised to try and reduce her work load. She occasionally had follow-up visits and was complaining of anxiety, stress and depression, due to her work environment. She was prescribed pain medication, anti-inflammatory, and anti-depressants. She was referred to a psychiatrist. In 5/2020, she was seen by a psychiatrist, he prescribed medication anti-anxiety and antidepressant, she continued under his treatment every month, one on one basis. He might implement a psychologist and group therapy, which was pending. She was not working. She denied any new accidents or injuries. She was last seen on 3/12/21. She had attended her scheduled acupuncture evaluation; however, the doctor would not see her as she was late and she did not wish right at this time to get rescheduled. She had been feeling better overall with the exercise she had been doing at home as instructed of range of motion and stretching. She was scheduled to undergo MRI and x-rays next month. At this moment, she complained of neck pain, intermittent and slight to moderate, worse with prolonged posturing and turning the head from side-to-side. She had left shoulder pain, it was intermittent and slight, occasionally increasing to moderate with overhead reach. Left elbow pain was occasional and minimal. Her left wrist, hand and thumb pain was noted occasional and slight. While low back pain was intermittent and slight to moderate. She noted left knee pain, was occasional and minimal. In addition, right knee pain was noted as frequent and slight, associated with occasional spasming. Her left ankle and foot pain were resolved. She was suffering from sleeping problem, anxiety and stress. At this time, she did not have abdominal pain. She was taking Ativan, Prozac and Tylenol or Motrin. Review of systems were remarkable for trouble sleeping, muscle and joint pain, stiffness; anxiety, depressed mood, social withdrawal, emotional problems, and stress. She had difficulty performing her activities of daily living.

Examination of the cervical spine revealed tenderness to palpation of bilateral paracervical and left upper trapezius musculature. Tenderness and hypomobility were noted at C3 through C7 vertebral regions. Shoulder depression test was positive on the left. Ranges of motion for the cervical spine were restricted and painful. Examination of the left shoulder revealed tenderness over the left supraspinatus near insertion as well as over the subacromial and subdeltoid

bursa. Hawkins test was positive at the left shoulder. Left shoulder ranges of motion were normal with pain at extremes, particularly with flexion and abduction. Examination of the left wrist and hand revealed tenderness over the left thumb over the first carpometacarpal joint and metacarpophalangeal joint. Finkelstein's test was positive. Ranges of motion of the left-hand digits with tenderness at the left thumb at extremes. Examination of the thoracic spine revealed tenderness to palpation of left parathoracic and left trapezius musculature. Tenderness and hypomobility were noted at T4 through T6 vertebral regions. Kemp's test was positive on the left. Ranges of motion for thoracic spine were decreased and painful. Examination of the lumbosacral spine revealed tenderness to palpation of bilateral paralumbar musculature. Tenderness at left sacroiliac joint and hypomobility at L3 through L5 vertebral regions. Milgram's test and sacroiliac joint compression test were positive on the left. Straight leg raising test (supine) was performed and was positive for increased back discomfort. Lumbar spine ranges of motion were decreased and painful. Examination of the right knee revealed tenderness to palpation was noted at the medial joint line with pain and difficulty rising from squatting position. Right knee McMurray's test elicited increased pain at the right knee.

<u>Impression</u>:

1) Cervical spine myofasciitis.
2) Cervical spine facet-induced versus discogenic pain. At C4-C5, 2 mm disc bulge and osteophyte complex with mild bilateral foraminal narrowing and contact on bilateral exiting nerve root. At C5-C6, 1.9 mm disc bulge with osteophyte complex with bilateral foraminal narrowing and contact on bilateral exiting nerve root. At C6-C7, 2.5 mm disc bulge with osteophyte complex with bilateral foraminal narrowing and contact on bilateral exiting nerve root.
3) Thoracic spine myofasciitis.
4) Thoracic facet-induced versus discogenic pain.
5) Lumbar spine myofasciitis.
6) Left sacroiliac joint dysfunction, sprain/strain.
7) Lumbar facet-induced versus discogenic pain.
8) Lumbar radiculitis left, rule out. At L4-L5, 1.6 mm disc bulge. At 1.5-SI, 1.8 mm disc bulge.
9) Left shoulder tenosynovitis bursitis.
10) Left shoulder impingement syndrome, rule out.
11) Left elbow medial epicondylitis, resolving.
12) Left brachioradialis tendinitis, resolving.

13) Left wrist tenosynovitis, resolving.
14) Left carpal tunnel syndrome, rule out.
15) Triangular fibrocartilage complex tear, left, rule out.
16) Left knee pain, resolving.
17) Right knee sprain, rule out internal derangement, moderate joint effusion. Intrameniscal hyperintensity in posterior horn of medial meniscus, grade II signal. Mild laxity of lateral collateral ligament suggestive of partial tear/contusion. Intrasubstance hyperintensity in anterior cruciate ligament. Degenerative narrowing with thinning of articular cartilages at patellofemoral and tibiofemoral joints.
18) Tenosynovitis of left lower leg, resolved.
19) Tenosynovitis of left ankle and foot, resolved.
20) Left Achilles tendinitis, resolved.
21) Anxiety and depression, sleeping difficulty.
22) Abdominal pain.

She was declared permanent and stationary. It was recommended to proceed with x-rays for cervical, thoracic and lumbar spine, left shoulder, left elbow, left wrist, right knee and left ankle.
MRI of the cervical spine, lumbar spine, left shoulder and right knee were also recommended.
Home exercises was recommended. She was encouraged to go to gym and perform strength training with light weight to tolerance to include free weights as well as machines as well as swimming and walking to tolerance to maintain her current level of condition in an effort to further improve. She underwent above MRI's, and was reviewed. Based on the review of the MRI reports and examination findings, she required orthopedic surgical consultation. With regard to causation, her condition was considered industrially related. With regards to work status, recommended prophylactic work restrictions would include of no Rifting in excess of over 20 pounds and furthermore restricted to occasional basis. She should be able to sit and stand as needed based on pain levels. If her abdominal pain returned, she should be seen by an internist for further work. Total calculated whole person impairment was 32% by combining 28% spinal impairment with 6% upper extremity whole person impairment. With respect to apportionment to causation; based on her past medical history, she had a prior injury to neck and back in a motor vehicle accident in 2003, for which she received treatment and her symptoms resolved. She denied my other prior injuries, any symptoms, disability or impairment with regards to cervical, thoracic or lumbar spine1 left upper extremity and bilateral lower extremities prior to above described continuous trauma. Review of the diagnostic studies revealed

traumatic disc herniations at cervical and lumbar spine. With regards to right knee, there were degenerative changes as well as traumatic changes noted on the MRI. However, the preexisting degenerative changes were dormant and asymptomatic and lit up as a result of the above described continuous trauma injuries. Based upon currently available information, it was apportioned causation with regards to cervical, thoracic and lumbar spine 95% to continuous trauma and 5% in preexisting degenerative changes. With regards to left shoulder and left wrist, 100% to continuous trauma and 0% to non-industrial causes. With regards to bilateral knees, 95% to continuous trauma and 5% to preexisting degenerative changes. Provisions should be made for further chiropractic, physiotherapy, acupuncture, orthopedic, interventional pain management internal medicine and repeat imaging studies of x-rays, MRI's to include diagnostic testing of NCV/EMG studies if needed.

7/15/21 - Initial Orthopedic Evaluation of a Secondary Physician, Nicholas Cascone, PAC and Edwin Haronian, MD. DOI: CT l/6/20 - 6/30/20. The patient had sustained cumulative trauma injuries to her neck, left shoulder lower back and right knee from 1/6/20 to 6/3/20 during the course of her employment as a registered nurse for Sunbridge Hallmark Health Services. She described about three years ago she had to jump over a fence in order to get a resident who escaped the facility where she worked. As she jumped and fell on the other side of the fence, she injured her right knee. She also developed psychological and internal injuries due to work-related stress. She reported the injuries to her supervisors; however, she was not sent to a company doctor. Around 2018, she self-procured treatment with her family physician who evaluated her and recommenced pain medications. She believed that she underwent MRI studies of her left shoulder; however, she did not undergo other treatment at the time. She indicated that that she worked through 710/20 at which point she was terminated. Around 8/2020, she commenced treatment with Dr. Eric Gofnung, who obtained MRI studies of her neck, lower back and right knee. She underwent a course of physical therapy; however, she did not feel improvement in her pain. She stated that she had not undergone other treatment for her orthopedic injuries.

At this time, she presented with complaints of intermittent pain in the neck. She had occasional headaches, which she associated with her neck pain. She had stiffness in the neck and her pain was aggravated when she tilted her head up and down or moved her head from side to side. Her pain increased with prolonged sitting, standing, walking, and with bending of her neck and turning of her head. She had difficulty sleeping and awakens with pain and discomfort.

Her pain level varied throughout the day depending on activities. Pain medication provided her pain improvement, but she remained symptomatic. She complained of intermittent pain in her left shoulder. She complained of stiffness to her shoulder. Her pain increased with reaching, pushing, pulling, and with any lifting. Lifting her upper extremity above shoulder level also increased her pain. Her pain level varied throughout the day depending on activities. She had difficulty sleeping and awakens with pain and discomfort. Rest and pain medication provided her pain improvement. She had constant lower back pain. Her pain increased with prolonged standing, walking, and sitting. She had difficulty bending, twisting, and turning. She complained of weakness and giving way of her legs. She exercises and used ice packs to relieve some of her pain. Lastly, she complained of frequent pain in her right knee associated with buckling and giving way. She had difficulty standing and walking for a prolonged period. She was unable to kneel and squat. She had difficulty ascending and descending stairs. Her pain level varied throughout the day depending on activities. She had difficulty sleeping and would awake with pain and discomfort. She stated that thirty years ago she injured her neck and back during a car accident. She underwent chiropractic treatment and fully recuperated. At present, she was taking Tramadol and Ativan. She also applied medicated ointments. Cervical spine examination revealed spasm and tenderness over the paravertebral musculature but not over the upper trapezium, interscapular area, cervical spinous processes or occiput. Range of motion was accomplished with discomfort and spasm. Sensory was decreased with pain at C6. Hoffman testing was positive on the left. Jamar Grip testing on the right was 51/58/60 and on the left was 73/68/72. Shoulder examination exhibited tenderness was noted over the left acromioclavicular joint. Impingement and Hawkins signs were positive on the left. Lumbar examination showed patient ambulated with a cane. There was tenderness and spasm in the paravertebral muscle. She could toe and heel walk and squats with pain. Supine straight leg raising on the right was 40 degrees and left was 90 degrees with right L5 pain. Deep tendon reflexes were reduced at the right knee. Sensory was decreased with pain at L5 lateral leg and mid foot. Knee examination revealed brace in place on the right. Patellar crepitus was noted on the right. Tenderness was noted with firm compression on the right. There was medial and lateral joint line tenderness noted on the right. McMurray's was positive on the right.

<u>Diagnoses</u>:

1) Cervical radiculopathy.
2) Lumbosacral radiculopathy.

3) Left shoulder impingement.
4) Right knee tendinitis/bursitis.

Given her instability in the right knee, it was opined that she was a candidate for intraarticular injection as well as arthroscopy. At this point, she wished to initiate conservative management. It was opined that the surgical intervention should be available as part of future care. She would be provided anti-inflammatory and anti-gastritis medications as well as limited supply of ibuprofen gel for a local relief. Correct usage of the knee brace and cane was discussed at length. Work restrictions and disability status would be deferred to the primary treating physician.

8/13/21 - Follow-Up Report of a Secondary Physician, Nicholas Cascone, PAC and Edwin Haronian, MD. The patient stated that she was increasing her activity level and had discontinued use of the rigid brace. She appeared to be walking well although she did continue to utilize a one-point cane for assistance. Physical examination showed spasm, tenderness and guarding in the paravertebral musculature of the cervical and lumbar spine. Right knee had patellar crepitus on flexion and extension with medial joint line tenderness.

Diagnoses:

1) Cervical radiculopathy.
2) Radiculopathy lumbosacral region.
3) Impingement syndrome shoulder.
4) Chronic instability of knee.
5) Unspecified osteoarthritis.

Her medications would be refilled as they provide pain relief and improved functional status. Work restrictions would be deferred to the primary treating physician.

549 pages of documents were reviewed. Out of the stack, 347 pages were reviewed and summarized, and 202 pages were reviewed but not summarized, as these were nonessential records such as subpoena duces tecum, custodian affidavit, history of medical and/or dental claim, request for protected health information, calibration certificate, demographics, face sheet, patient chart, prescription record, flowsheets, scanned copies, medical questionnaire and

physical form, consent form for HIV blood test, request for medical information and duplicate copies of reports.

This concludes the review of submitted records.

DIAGNOSTIC IMPRESSIONS:

1. Chronic neck pain.

2. Industrial aggravation of multilevel degenerative disc disease of cervical spine / degenerative arthritis of the cervical spine.

3. Cervical radiculitis.

4. Cervical facet syndrome.

5. Chronic lower back pain.

6. Small disc bulges at L4-L5 and L5-S1 levels without spinal canal stenosis or neuroforaminal stenosis, per MRI.

7. Lumbar radiculitis.

8. Patellofemoral arthralgia, right knee.

9. Left knee strain, improved.

10. History of osteoarthritis of both knees, **non-industrial**.

11. Left shoulder strain, improved.

12. Mild impingement syndrome of the left shoulder, improved.

SUMMARY/CAUSATION:

In the process of formulating my opinions regarding the issue of causation, I have taken into account various factors. These include the mechanism of injury, the type of temporal onset of symptoms, the history given by the injured worker, the response to various treatments, the physical examination findings, all the medical

records submitted for my review, the patient's deposition transcript, the radiographic findings and the results of other pertinent objective tests, the knowledge of the pathology and the pathophysiology of specific disease or injuries, the knowledge of the overall health of the individual, and other pertinent information including the examiner's experience, knowledge, and training.

After evaluating all the information presented to me, I have reached the conclusion that the patient had sustained **a cumulative trauma injury (CT July 6, 2019 – July 5, 2020) to her neck, lower back, both knees and left shoulder.** This can be stated within reasonable medical probability. It is my opinion that the patient had sustained these injuries as a result of the continuous repetitive nature of her job duties, as described in the job description section of this report.

It is also my opinion that except for the left shoulder injury, she has not sustained any injury to the upper extremities. Likewise, she did not sustain any injury to both hips or lower extremities, except for her both knees. At the time of the evaluation, the patient had only complaints with regard to the left shoulder and both knees. She had positive findings on physical examination with regard to the cervical spine lumbar spine, left shoulder and right knee.

Causation of the alleged injury on a non-orthopedic level, breathing, chest pain, irritable bowel syndrome, headache and high blood pressure is being deferred to the appropriate specialist in those fields.

DISABILITY STATUS:

The patient indicated that she was not interested in any injections or surgery. Absent any additional treatment, she can be considered to have reached Maximum Medical Improvement as of the time of this evaluation on 10/19/2021.

According to the AMA Guides, Maximum Medical Improvement is reached when a condition or state is well stabilized and is unlikely to change substantially in the next year with or without medical treatment. Although over time there may be some change, further deterioration or change is not anticipated.

As used in the Worker's Compensation Act [51-1-1 NMSA 1978], "date of Maximum Medical Improvement" means the date after which further recovery from or lasting improvement to an injury can no longer be reasonably anticipated

based upon reasonable medical probability, as determined by a healthcare provider.

Absent any additional treatment, the patient can be considered to have reached Maximum Medical Improvement on 10/19/2021. She is therefore ready to receive her Final Impairment Rating.

OBJECTIVE FACTORS OF DISABILITY:

1. Physical examination findings on 10/19/2021.

2. Results of the diagnostic studies as described in the body of this report.

IMPAIRMENT RATING:

Please the enclosed Basic Report of Impairment Rating for details of the Impairment Rating Calculations.

As was indicated in the Basic Report of Impairment Rating, the patient has a **10% Whole Person Impairment** due to the cervical spine, including a **2% Whole Person Impairment** add-on for her ongoing and chronic pain symptoms.

She also has a **6% Whole Person Impairment** due to the lumbar spine.

In addition, she has **7% Whole Person Impairment** due to the right knee.

She had no positive findings on physical examination with regard to the left shoulder. Therefore, she was given **0% Whole Person Impairment** for the left shoulder.

She had no positive findings with regard to the left knee. Therefore, she was given **0% Whole Person Impairment** for the left knee.

As was indicated in the Basic Report of Impairment Rating, it is my opinion that **21% Whole Person Impairment** accurately reflected the overall level of the patient's impairment at the time of the evaluation. Therefore, additional analysis was not indicated.

APPORTIONMENT:

Apportionment was addressed in accordance with Labor Code Sections 4663 and 4664. There is apportionment of causation to other factors as noted below.

Cervical Spine

Labor Code Section 4663[a] mandates that "*the apportionment of permanent disability shall be based on causation.*" The patient's current cervical spine disability is contributed to by causative factors separate and apart from his work activities. Those causative factors include multilevel degenerative arthritic changes/ degenerative disc changes present in the cervical spine. The presence of such degenerative changes is indicative of decreased integrity of cervical spine making it more vulnerable to injury.

Taking into account the patient's history, her complaints, physical examination findings, and the MRI findings, absent the industrial exposure, the patient would have had residual cervical spine disability at this time.

It is not exactly clear why some degenerated discs are painful and some are not. As with many common causes of neck, there is probably a variety of reasons that discs can become painful. Some theories about pain from degenerative disc disease are:

1. If a disc is injured or degenerated, it may become painful because of the resultant instability from the disc injury, which in turn can lead to an inflammatory reaction which results in neck pain.

2. Some people seem to have nerve endings that penetrate more deeply into the outer annulus than others, and this is thought to make the degenerated disc more susceptible to becoming a pain generator.

Disc degeneration follows a predictable pattern. First, the nucleus in the center of the disc begins to lose its ability to absorb water. The disc becomes dehydrated. Then the nucleus becomes thick and fibrous, so that it looks much the same as the annulus. As a result, the nucleus isn't able to absorb shock as well. Routine stress and strain begin to take a toll on the structures of the spine. Tears form around the annulus. The disc weakens. It starts to collapse, and the bones of the spine compress.

Ms. Chaney's MRI of the cervical spine has revealed the evidence of **facet joint arthropathy at C4-C5, C5-C6, and C6-C7 levels**. Although the existence of a "facet syndrome" had long been questioned, it is now generally accepted as a clinical entity. Depending on the diagnostic criteria, the zygapophysial joints account for between 5% and 15% of cases of chronic, axial neck back pain. Most commonly, facetogenic pain is the result inflammation and stretching of the joint capsule. The most frequent complaint is axial neck pain is referred pain perceived in the shoulders and upper back.

Accordingly and taking all factors into consideration, it is my opinion that 80% of the patient's residual disability with regard to the cervical spine is apportioned to the cumulative trauma injury she had sustained while working for Playa Del Rey Center, and 20% is apportioned to the above-referenced progressive non-industrial causative factors (degenerative arthritic changes in the cervical spine/degenerative disc changes in the cervical spine), which are considered, in all medical probability to continue to be causative/contributory. This can be stated within reasonable medical probability.

It is also my opinion that there is no contribution to the patient's presenting symptomatology and findings from her employment at My Life Foundation. The patient's job duties were not physical, and she worked only very limited number of hours during each week. There was likewise no apportionment due to her occupation as a hairdresser/makeup artist. This can be stated within reasonable medical probability.

Lumbar Spine

With regard to the lumbar spine, there appears to be no indication for apportionment of permanent disability in this case. The patient had no prior history of problems with her lower back, except for a car accident in 2003, from which she had apparently recovered. She had minimal degenerative changes in the lumbar spine on MRI study. Therefore, 100% of the patient's residual disability with regard to the lumbar spine is apportioned to the cumulative trauma injury she had sustained while working for Playa Del Rey Center. This can be stated within reasonable medical probability.

Right Knee

With regard to the patient's right knee, she had multiple evaluations by her primary treating physician, Dr. Hernandez for swelling and pain of multiple joints, including both knees. She was diagnosed with having osteoarthritis. Accordingly and taking all factors into consideration, it is my opinion that 70% of the patient's residual disability with regard to knees is apportioned to the cumulative trauma injury she had sustained while working for Playa Del Rey Center, 20% to the pre-existing arthritis, and 10% to her concurrent employment for My Life Foundation, which required her to stand and walk and also drive prolonged distances. This can be stated within reasonable medical probability.

APPROPRIATENESS OF TREATMENT PROVIDED:

During the course of the management of the patient's industrial condition, she underwent several diagnostic studies, such as x-rays and MRI scans to better evaluate her injuries. Medications were provided to relieve her pain. She was treated with physical therapy, chiropractic treatments and acupuncture treatments. These diagnostic and treatment modalities are considered to be reasonable and necessary in the management of the patient's medical conditions caused by the industrial injury as referenced above.

FUTURE MEDICAL CARE:

The patient will require future medical care. As such, I would recommend that future orthopedic evaluations be provided to her, especially during episodes of exacerbations and/or worsening of her symptoms. Short courses of physical therapy, chiropractic treatments and acupuncture treatments, not to exceed 12-15 treatments per year in each modality, may be provided to her in conjunction with the oral and topical medications that would be prescribed. She should also have an access to a pain management specialist for possible cervical epidural steroid injections and/or facet nerve block/facet joint injections. Based on the current MRI findings and the patient's clinical findings, she is not a candidate for any surgical procedure on the cervical or lumbar spine.

With regard to the patient's left shoulder, she may require corticosteroid injection(s) in the shoulder, if her symptoms worsen. She may also require a corticosteroid injection(s) in the right knee, if her symptoms worsen.

PERIODS OF DISABILITY:

The patient remained temporarily totally disabled from 7/7/2020 until 10/19/2021.

WORK RESTRICTIONS:

The patient is precluded from repetitive bending and twisting at the neck or waist. In addition, she is precluded from lifting more than 40 pounds.

She is also prophylactically precluded from prolonged overhead use of the left upper extremity.

With regard to the right knee, she is precluded from repetitive going up and down the stairs. She is precluded from kneeling, twisting and pivoting or other activities involving comparable physical effort.

VOCATIONAL REHABILITATION:

If work with the above restrictions is not available, the patient should be eligible to receive a Supplemental Job Displacement Voucher.

The patient indicated that she started an online school in October 2020. She is studying towards the BS/Master's Degree in Psychology. She studies 30 hours per week. She types two to three hours per week. She sits most of the time. Sometimes, she has live classes but most of the time, she has access on demand. She is expected to receive Bachelor of Science degree in 2022 and the Master's degree in 2024.

RATIONALE FOR CONCLUSIONS:

1) Review of all submitted records.
2. Physical examination findings on 10/19/2021.
3) Correlation of the patient's oral history compared to records.
4) My clinical experience in treating patients with similar injuries over the past 28 years.

I reserve the right to alter my opinion in the light of any additional submitted medical information that may be presented subsequent to this evaluation and report.

If I may be of further assistance to you, please do not hesitate to contact me. This examiner appreciates the confidence of all parties involved in this case in allowing me to examine this patient in the capacity of a Panel Qualified Medical Examiner.

DISCLOSURE:

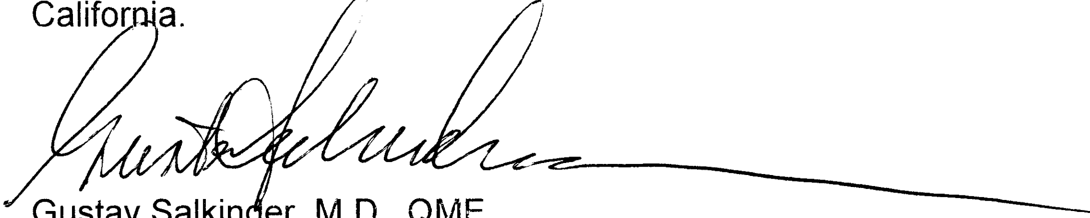
The orthopaedic examination of Anisa Chaney was conducted in its entirety by Gustav Salkinder, M.D. The patient was interviewed by Gustav Salkinder, M.D., personally. Vital signs and measurements were obtained by Gustav Salkinder, M.D., personally. Editorial and clerical assistance was provided by Donna Bailey. The final draft of the report was reviewed and signed by Gustav Salkinder, M.D.

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to the information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

I declare under penalty of perjury that there has been no violation of Labor Code Section 139.3, and that the contents of the report are true and correct to the best of my knowledge, and any statements concerning any bill for services are true and correct to the best of my knowledge.

Date of report: November 9, 2021

Signed this 9th day of November, 2021 at Los Angeles County, California.



Gustav Salkinder, M.D., QME
Diplomate American Board of Orthopaedic Surgery
Qualified Medical Examiner #: 907884
California License #: G073167

BASIC REPORT OF IMPAIRMENT RATING

Date: 11/9/2021

Examinee Name: **Anisa Chaney**
Social Security #: ___-__-____
Date of Birth: **9/6/1973**

INTRODUCTION

This report includes the impairment ratings that were calculated for each of the organ systems for which data was entered into the AMA Guides Impairment Calculator, 5th Edition.

The opinions expressed in this report are those of the examiner. The examinee was informed that a written report would be sent to. The examinee was informed that this examination was for evaluative purposes only, intended to address specific questions and conditions, and is not intended to be a general medical examination.

The examinee was asked at the time of the examination not to engage in any maneuver beyond what she could tolerate or which would cause harm or injury.

ORGAN SYSTEM RATINGS

CERVICAL SPINE (Chapter-15, Table 15-5/P.392):

DRE method was selected.
Chapter 15 of AMA Guides to the *Evaluation of Permanent Impairment, Fifth Edition* discusses whole person impairment referable to the spine. Box 15-1 on page 382, lists clinical findings used to place individual in a DRE Category. I chose the DRE Category Method for the following reasons:

1. There was a distinct injury.

2. This is the preferred method for rating.

The DRE method has five diagnosis-related categories for each of the three spinal regions. There are two approaches used to place individual in the appropriate DRE Category. The first is based on signs, symptoms and appropriate diagnostic tests; the second is the presence of fractures and/or dislocations.

Cervical Spine DRE is classified as Category II that calculates **8 %Whole Person Impairment**. The DRE cervical category II was selected using the following criteria: there was an asymmetric loss of range of motion and non-verifiable radicular complaints. The highest value in the range (5%-8%) was selected due to the impact of the cervical spine disability on the patient's activities of daily living.

LUMBAR SPINE (Chapter-15, Table 15-3/P.384):

DRE method was selected.
Chapter 15 of AMA Guides to the *Evaluation of Permanent Impairment, Fifth Edition* discusses whole person impairment referable to the spine. Box 15-1 on page 382, lists clinical findings used to place individual in a DRE Category. I chose the DRE Category Method for the following reasons:

1. There was a distinct injury
2. This is the preferred method for rating.

The DRE method has five diagnosis-related categories for each of the three spinal regions. There are two approaches used to place individual in the appropriate DRE Category. The first is based on signs, symptoms and appropriate diagnostic tests; the second is the presence of fractures and/or dislocations.

Lumbar Spine DRE is classified as Category II,that calculates **6 % Whole Person Impairment**. The DRE Lumbar Category II was selected using the following criteria: there was an asymmetric loss of range of motion and non-verifiable radicular complaints. The lower value in the range (5%-8%) was selected due to the impact of the lumbar spine disability on the patient's activities of daily living.

CHRONIC PAIN

As a result of the persistent pain following the industrial injury as described above, the patient has a well-established pain syndrome that is normally not associated with measurable organ dysfunction, *but that does impact the patient's activities of daily living* (ADL). It has been decided by this examiner that the pain-related impairment makes the patient's burden of illness **slightly** greater than the conventional rating indicates. As a result, per the AMA *Guides to the Evaluation of Permanent Impairment, Fifth Edition*, I have assigned a Discretionary PRI allowance of **2% Impairment of the Whole Person,** resulting from the patient's chronic pain following this industrial injury, with **2% WPI** added to the impairment due to the cervical spine.

GAIT DERANGEMENT

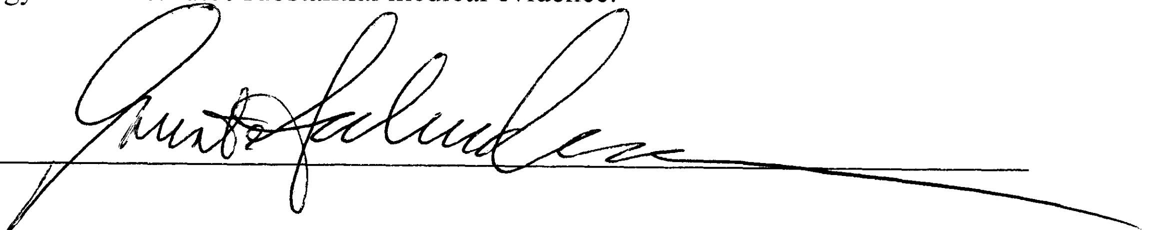
The patient walks with abnormal mildly antalgic gait favoring right lower extremity. It is my opinion, based on my training, skill and expertise, that Impairment rating based on Gait Derangement most accurately reflects the patient's impairment with regard to the right lower extremity. Using Table 17-5, p. 529, the patient's Gait Derangement is classified as **Mild**, which corresponds to **7% Whole Person Impairment.**

IMPAIRMENT SYSTEM AND RATIONALE Organ System and whole person impairment
All calculations are based on the Guides to the Evaluation of Permanent Impairment, Fifth Edition. Combined values chart (Page 604) has been used throughout the application to combine impairments wherever necessary, Table 16-1 (digits to hand), Table 16-3 (hand to upper extremity. If both limbs are involved, calculate the whole person impairment for each on a separate chart and combine the percents (Combined values chart)

Body Part or System	Chapter No	Impairment %
Lower Extremity	17	7
Spine	15	14
Pain	18	2

CALCULATED TOTAL WHOLE PERSON IMPAIRMENT: 21 %.

Recent case law, Almaraz-Guzman II, charged the rating physician with providing a Whole Person Impairment rating utilizing any chapter, table or methods in the AMA *Guides* Fifth Edition that most accurately reflects the injured claimant's impairment. The AMA *Guides* state, "*Impairment percentages or ratings developed by medical specialist are consensus derived, estimated to reflect the severity of the medical condition and the degree to which the impairment decreases an individual's abilities to perform common Activities of Daily Living, excluding work*". In the course of this evaluation, I have critically analyzed the injured worker's activities of daily living and applied Almaraz-Guzman II. The issues surrounding activities of daily living may be problematic, as these activities are subjective in nature and not something that I can actually measure. However, my job is to compare what the claimant reports in the loss of activities of daily living with what was expected from the objective findings and pathology. I opine that the **21% Whole Person Impairment** rating given in this report accurately addresses the legitimate objective medical factors in pathology and constitutes substantial medical evidence.



Examinee Name: Anisa Chaney
Date of Report: 11/9/2021

PATIENT: CHANEY, ANISA
CLAIM NO.: 2080381794
WCAB NO.: ADJ3521045(AHM)

PHYSICIAN DECLARATION OF RECORDS REVIEW

I declare under penalty of perjury that, pursuant to Labor Code section 4628 and Title 8, California Code of Regulations section 9793(n), I have personally reviewed a total of 549 (number of pages) of 81/2 by 11 single-sided document, chart or paper, whether in physical or electronic form of records in connection with my examination of this patient.

Printed Name: Gustav Salkinder, M.D.

Signature

November 9, 2021

Date

PROOF OF SERVICES BY MAIL

STATE OF CALIFORNIA - COUNTY OF LOS ANGELES
I, the undersigned, am employed in the County of Los angeles and the State of California. I am over eighteen years of age and not a party to the within action. My business address is:

SALKINDER ORTHOPAEDIC SVC INC.
16250 VENTURA BLVD. #255
ENCINO, CA 91436

On 11/09/2021, I served a Medical / Legal Lien and report on CHANEY, ANISA
Account # A02906 , by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully prepaid, in the United States mail at Sherman Oaks, CA, Addressed as

1) Insurance Carrier: ZURICH
P.O. BOX 968005
SCHAUMBURG IL 60196

2) WCAB:

3) Applicant Attorney: WORKERS DEFENDERS LAW GROUP
751 S WEIR CANYON RD#157 455
ANAHEIM CA 92808

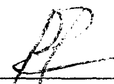
4) Defense Attorney: FLOYD SKEREN MANUKIAN
3835 R E THOUSAND OAKS 630
WESTLAKE WILLAGE CA 91362

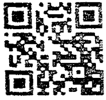
"I Declare, under penalty of perjury under the laws of the State of California that the foregoing is true and correct."

DATE OF REPORT:

Dated this: 11/09/2021

at Encino, California.

SIGNED 



ZURICH
P.O. BOX 968005
SCHAUMBURG, IL 60196

CLAIM P08394

X 561396450

CHANEY, ANISA 09 06 1973 X CHANEY, ANISA

P.O. BOX 1274 X SAME

GARDENA CA

90249 310 413-5025

2080381794

X 09 06 1973 X

X BOLD QUIL HOLDINGS LLC

X ZURICH

ADJ3521045(AHM) X

SIGNATURE ON FILE 10 19 21 SIGNATURE ON FILE

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310 275-3835

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