Case Study 6 Class 7 AQ-IQ IRF-PRO LAB

Coder Summary:

Principal Diagnosis:

S32.591A Oth fracture of right pubis, init encntr for closed fracture

Secondary Diagnoses:

I42.0 Dilated cardiomyopathy (CC)
F03.90 Unspecified dementia without behavioral disturbance
D64.9 Anemia, unspecified
E11.9 Type 2 diabetes mellitus without complications
I12.9 Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny
N18.9 Chronic kidney disease, unspecified
S32.059A Unsp fracture of fifth lumbar vertebra, init for clos fx (HAC)
R26.9 Unspecified abnormalities of gait and mobility
I25.10 Athscl heart disease of native coronary artery *wlo* ang pctrs
I50.9 Heart failure, unspecified
E87.5 Hyperkalemia
I48.91 Unspecified atrial fibrillation
E03.9 Hypothyroidism, unspecified
Z86.73 Prsnl hx ofTIA (TIA), and cereb infrc *wlo* resid deficits
Z90.49 Acquired absence of other specified parts of digestive tract

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Pre-Admission Screening

Etiology: 1) right pubic fracture, 2) L5 compression fracture, 3) CHF

Date of screening: 2/6/22

Patient is a 93-year-old female with history of CHF, aFib admitted with a mechanical fall while transferring from wheelchair to bed, resulting in right pelvic pain. X-rays of bilateral hips on 2/06/21 showed acute nondisplaced fracture of right superior and inferior pubic rami. EKG showed aFib with RVR. Patient is to have nonsurgical involvement with pain controlled on tramadol as needed.

Comorbidities: Hypertension, DM II, CAD, CHF, aFib, Hypothyroidism

ADMISSION MOTOR SCORE: 27

History and Physical Exam

REHABILITATION MEDICINE HISTORY AND PHYSICAL

DATE OF ADMISSION: 02/6/2022.

Post-admission evaluation – Compared to the preadmission screening, there have been no significant changes in the functional status, medical status, or discharge plan. The patient is expected to participate in and benefit from the center for rehabilitation program at [REHAB] with 3 hours of therapy, minimum 5 days a week with a goal of modified independence and anticipate discharge home with daughter.

CHIEF COMPLAINT: Fall, right pelvic pain.

HISTORY OF PRESENT ILLNESS: The patient is a 93-year-old female with past medical history of CAD, CHF,

hypertension, diabetes type 2, stroke, atrial fibrillation, hypothyroidism, admitted with mechanical fall while transferring from wheelchair to bed, resulting in right pelvic pain and right hip pain. In the emergency room, x-ray of the bilateral hips on 02/06/2022 showed acute nondisplaced fracture of right superior inferior pubic rami. EKG showed atrial fibrillation with RVR. Patient with dilated cardiomyopathy. The patient to be managed with nonsurgical management and pain is controlled with tramadol
as needed. The patient is on DVT prophylaxis with heparin. The patient also found to have acute L5 compression fracture with x-ray of lumbar spine on 02/12/2022. The patient was to have a TLSO brace by ortho, but the patient is improving in her transfers and mobility and is just to have an abdominal binder when out of bed. The patient has had a function decline and is admitted for comprehensive acute inpatient rehabilitation program.

PAST MEDICAL HISTORY: Hypertension, diabetes type 2, CAD, CHF, atrial fibrillation, stroke, hypothyroidism.

PAST SURGICAL HISTORY: Cholecystectomy.

PRIOR FUNCTIONAL LEVEL: The patient was standby assist to supervision for ADL, mobility, and self-care skills.

CURRENT FUNCTIONAL HISTORY; The patient is ambulating with min assist 20 feet with a rolling walker, min assist for transfers, modified independent for bed mobility. The patient is set up for grooming, min assist for upper extremity dressing, dependent for toileting.

SOCIAL HISTORY: The patient was a resident of a nursing home, but the patient's daughter states she will be taking her mother home upon discharge from acute rehab. The patient denies any tobacco, alcohol, illicit drug abuse.

MEDICATIONS: Diltiazem, Lasix, aspirin, Colace, Senokot, Dulcolax, Vasotec, Ambien, Norco, morphine, Synthroid, heparin subq, Lipitor, ferrous sulfate. ALLERGIES: TO SEA SALT.

REVIEW OF SYSTEMS: Twelve-point review of systems negative except the patient complaining of right pelvic pain, especially with movement. Denies any chest pain, shortness of breath, dizziness, palpitation, abdominal pain, nausea, vomiting, constipation, or diarrhea. The patient's Foley catheter has been removed today and is on toileting program. Continent of bowel. Denies any paresthesias. Does have generalized weakness. Otherwise, 12-point review of systems negative.

PHYSICAL EXAMINATION: General, the patient is an elderly female, in no acute distress, sitting up in chair. Vitals, temperature 98, pulse 77, respirations 18, blood pressure 114/68, saturating 95 on room air.
Heart -- regular rate and rhythm, SI, S2. Lungs -- clear to auscultation bilaterally, no wheezes , no crackles. Abdomen -- plus bowel sounds, soft, nontender, nondistended. Extremities -- negative Homans' sign bilaterally. Peripheral pulses palpable bilaterally. Neuro -- cranial nerves II-XII intact, sensation intact to pinprick, fine touch, proprioception in all dermatomes. Motor strength is 4-/5 bilateral shoulder abductors, otherwise, 4/5 bilateral upper extremity myotomes. Left Lower extremity is 4/5 in all myotomes. Right hip flexor 2/5, limited by pain. Right knee extensor 3/5, limited by pain. Right knee flexor 2/5, limited by pain. Dorsiflexor 4/5, plantar flexor 4/5 bilaterally. DTRs -- +2 bilateral biceps, triceps, brachialis, patellar, Achilles. Tone - normal in all extremities. Psych -- mood and affect are stable.

LABS; hemoglobin 10.8, hematocrit 23.8, platelets 232. Sodium 134, potassium 5.8, BUN 46, creatinine 1.83, glucose 102.

ASSESSMENT AND PLAN:

1. A 93-year-old female with a past medical history of hypertension, diabetes type 2, coronary artery disease, congestive heart failure, atrial fibrillation, hypothyroidism, and stroke, who was admitted with mechanical fall resulting in right nondisplaced superior and inferior pubic rami fracture, acute L5 compression fracture, now with gait disorder, activities of daily living and mobility deficits -- the patient will benefit from acute inpatient rehabilitation program with inpatient

physical therapy, speech therapy, occupational therapy, 24-hour rehabilitation nursing with goals of modified independence to supervision for activities of daily living, mobility, and self-care skills with estimated length of stay of 3 weeks and discharge home with her daughter.

Inpatient physical therapy to upgrade range of motion, strengthening, balance, gait, transfers, endurance, stair negotiation skills to a supervision level.

Prognosis -- fair. Barriers - pain, cardiovascular status. Risk - deep venous thrombosis, falls, decubitus ulcers.
2.Pain -- controlled with Norco p.r.n., morphine IR p.r.n.
3.Anemia - on ferrous sulfate.
4.Cardiac -- hypertension, coronary artery disease, congestive heart failure, atrial fibrillation - stable --- on Lipitor, Vasotec, Lasix, Cardizem.
5. Hypothyroidism -- on Synthroid.
Deep venous thrombosis prophylaxis -- heparin subq.
6.Bowel/bladder -- Foley catheter removed today, PVRs *x3,* straight cath if more than 250 mL. Continent of bowel, continue bowel program.
8. Hyperkalemia -- Kayexalate 15 grams given today. We will check BMP in the morning.

DISCHARGE PLAN -- anticipated discharge home with daughter with goals of modified independence to supervision for ADL, mobility, self-care skills with 3 weeks and will need home therapies after discharge.

REHABILITATION MEDICINE CONSULTATION

DATE OF ADMISSION: 02/06/2022

DATE OF CONSULTATION: 02/09/2022

REFERRING PHYSICIAN: [Dr S-].

CHIEF COMPLAINT: Fall, right pelvic pain.

HISTORY OF PRESENT ILLNESS: The patient is a 93-year-old female with past medical history of CAD, CHF, hypertension, diabetes type 2, stroke, atrial fibrillation, hypothyroidism who was admitted with a mechanical fall while transferring from wheelchair to bed, resulting in right pelvic pain. In the emergency room, x-rays of bilateral hips on 02/06/2022 showed acute nondisplaced fracture of right superior and inferior pubic rami. EKG showed an atrial fibrillation with RVR. The patient to have nonsurgical management and pain is currently controlled with tramadol as needed. The patient is on heparin for DVT prophylaxis. The patient has had a functional decline and we are asked to assess her rehabilitation needs.

PAST MEDICAL HISTORY: Hypertension, diabetes type 2, CAD, CHF, atrial fibrillation, stroke, hypothyroidism.

PAST SURGICAL HISTORY: Cholecystectomy.

PRIOR FUNCTIONAL LEVEL: The patient was standby assist to supervision for mobility and minimal assistance for ADLs.

CURRENT FUNCTIONAL LEVEL: The patient is min assist to contact guard assist for transfers, ambulated 6 steps with min assist with a rolling walker, min assist for bed mobility, moderate assistance for bed to

chair transfer, min assist for upper extremity dressing, dependent for Lower extremity dressing.

SOCIAL HISTORY: The patient is currently a resident at [Name] Nursing Home. The patient's family would like her to be placed in a different nursing home after hospital discharge. The patient denies any tobacco, alcohol or illicit drug abuse.

MEDICATIONS: Tramadol, heparin subcutaneous, Ambien, Synthroid, aspirin, Vasotec, Lasix, Lipitor.

ALLERGIES: TO SEA SALT.

REVIEW OF SYSTEMS: Twelve point review of systems negative except the patient complaining of right pelvic pain with movement. Denies any chest pain, shortness of breath, dizziness, palpitation, abdominal pain, nausea, vomiting, constipation, diarrhea. The patient has a Foley catheter. Denies any paresthesias. Otherwise, 12-point review of systems is negative.

PHYSICAL EXAMINATION: General, the patient is an elderly female sitting up in chair in no acute distress. Vitals, temperature 98, pulse 98, respirations 20, blood pressure *122/68,* saturating 96. Heart-- regular rate and rhythm, SI, 52. Lungs – clear to auscultation bilaterally, no wheezing, no crackles. Abdomen -- plus bowel sounds, soft, nontender, nondistended. Extremities -- negative Homans' sign bilaterally. Peripheral pulses bilaterally. Right pelvic pain with movement. Neuro – cranial nerves II-XII intact. Sensation -- intact to pinprick, fine touch, proprioception in all dermatomes. Motor strength is *4-/5,* bilateral shoulder abductors, otherwise 4/5 bilateral upper extremity myotomes. Left Lowe r extremity is *4/5* all myotomes. Right hip flexor is *2/5,* limited by pain. Right knee extensor is 3/5, limited by pain, right knee flexor is 3/5, limited by pain, dorsiflexor 4/5, plantar flexor *4/5.* DTRs -- +2 bilateral biceps, triceps, brachioradialis, patellar, Achilles. Tone -- normal in all extremities. Psych – mood and affect are stable.

LABORATORY DATA: Sodium 137, potassium 4.9, BUN 49, creatinine 2.3, glucose 56. WBC 5.9, hemoglobin 8.1, hematocrit 25.2, platelets 105.

IMPRESSION: The patient is a 93-year-old female with a past medical history of hypertension, diabetes type 2, coronary artery disease, congestive heart failure, atrial fibrillation, stroke, hypothyroidism, admitted with mechanical fall resulting in right nondisplaced superior and inferior pubic rami fracture, now with gait disorder, activities of daily living and mobility deficits.

RECOMMENDATIONS: The patient will benefit from acute inpatient rehabilitation program as the patient is below her baseline functional status. Her estimated length of stay would be 3 weeks with goals of standby assist for mobility and minimal assistance for ADLs. The patient will be discharged to a SNF for long-term placement and family is requesting a different facility than [Name].

The patient will benefit from inpatient physical therapy, occupational therapy, speech therapy, 24-hour rehabilitation nursing and physiatry.

Inpatient physical therapy to upgrade range of motion, strengthening, balance, gait, transfers, endurance to standby assist level.

occupational therapy to upgrade range of motion, strengthening, transfers, dressing skills, bathing skills, toilet transfers, and tub shower transfer skills to minimal assistance to modified independent level.

Speech therapy to upgrade cognitive status and swallow status to modified independent level.

Prognosis -- fair.

Barriers -- pain, cardiovascular status.

Risks DVT, falls, pneumonia, decubiti.
Thank you for allowing us to participate in the care of this patient.

PROGRESS NOTE

PHYSICAL MEDICINE NOTE.

DATE OF EXAMINATION: 02/19/2022.

SUBJECTIVE: The patient is seen and examined. still with the pelvic area pain, but much more managed. She denies chest pain, shortness of breath, nausea, vomiting. Still is generally weak.

OBJECTIVE: Her vital signs show a temperature of 98, BP is 123/77, respirations are 16. The patient is alert, she is oriented. Her heart is regular rhythm. Her lungs are clear to auscultation bilaterally.
Abdomen is soft, nontender, bowel sounds are present. Extremities showed no clubbing, cyanosis, or edema.

IMPRESSION:

1. Abnormality of gait.
2. Congestive heart failure.
3. Lumbar fracture, LS.
4. Hypertension.
5. Coronary artery disease.
6. Atrial fibrillation.

PLAN: Continue PT, OT as ordered. Functionally, the patient is doing well. We will have a team conference next week to further discuss discharge planning. She is currently ambulating about 70 feet with contact guard assist. Goals are to be for modified independent. She continues to have need for 24-hour skilled nursing and is making good functional gains.

PROGRESS NOTE

DATE OF ADMISSION: 02/16/2022.

DATE OF SERVICE: 02/20/2022.

SUBJECTIVE: The patient reports that she is not feeling well today. She *did* not sleep well overnight and reports having several loose bowel movements for the past 2 days. She, however, continues to participate with therapies within her room. Per nursing report, the patient has not been eating well. Prealbumin level is pending today.

PHYSICAL EXAMINATION: Vital signs, temperature 98.4, pulse 97, blood pressure 131/85, respirations 18, oxygen saturation 97 on room air. In general, she is a well-developed, well-nourished female in no acute distress. She is alert and oriented *x3.* HEENT is normocephalic, atraumatic. Cardiovascular, 51, S2. Lungs are clear to auscultation bilaterally. Abdomen is soft, nontender, nondistended with hyperactive bowel sounds. Extremities are without edema. The patient is observed performing lower extremity therapeutic exercises such as hip adduction.

THERAPY PROGRESS: Transfers, standby assist; ambulation 76 feet, standby assist with rolling walker, 4 stairs, min assist with bilateral handrails, upper body dressing, min assist.
MEDICATION LIST: Has been reviewed and updated.

ASSESSMENT AND PLAN: This is a 93-year-old female status post fall with right superior and inferior pubic rami fractures, L5 compression fracture, pain, deconditioning, impaired mobility, activities of daily

living, gait disturbance, congestive heart failure, coronary artery disease, atrial fibrillation, hypertension, loose stools, insomnia and poor oral intake.

PLAN: Continue physical and occupational therapy as tolerated. The patient has been making progress with therapies, but has been limited today due to loose stools and not sleeping last night. She reports that the Ambien 10 mg does not appear to be having any effect on her. We will initiate Remeron 7.5 mg at bedtime which can aid in sleep as well as improve her appetite. Prealbumin level is pending. The patient has been drinking Ensure supplements. We will change her bowel medications to p.r.n. and continue to have rehab nursing monitor for loose stools and provide bowel program for the patient. Continue current pain regimen. Heparin for DVT prophylaxis.

PROGRESS NOTE

DATE OF EXAMINATION: 02/25/2022

SUBJECTIVE: The patient is seen and examined. There are no new complaints. Pain is well controlled. Denies chest pain, shortness of breath, nausea, vomiting. Functionally doing well.

OBJECTIVE: Vital signs show a temperature of 98, BP 100/60/ respirations 16. General, the patient is alert, she is oriented. Her heart is regular rhythm. Her lungs are clear to auscultation bilaterally. Abdomen is soft, nontender, bowel sounds are present. Extremities show no clubbing, cyanosis, or edema.

IMPRESSION:

1. Abnormality of gait.
2. Pelvic fracture.
3. Dementia.
4. L5 compression fracture.
5. Congestive heart failure.

PLAN: PT, OT as ordered. Functionally, the patient is contact guard assist. Goals are for modified independent. Discharge is 03/01/2016. Continue current p.o. pain control with Norco. This is adequate at this time. Further recommendations to follow. The patient continues to have need for 24-hour skilled nursing.

Discharge Summary: 2/28/22

Date of admission: 2/6/22

Discharge diagnoses:

- ADL mobility deficits secondary to L5 compression fracture, right superior and inferior pubic rami fracture, hyperkalemia

Patient was due to be discharged to a skilled nursing facility when she developed hyperkalemia of 6.5, she was discharged to telemetry.

IGC:

ETIOLOGIC:

Case Study 6 Class 7 AQ-IQ IRF-PRO LAB
TIER:

60% QUALIFIER:

COMMENTS

Coder Summary:

DRG: 563 Fx, sprn, strn & disl except femur, hip, pelvis & thigh *wlo* MCC

Admitting Diagnosis:

S52.571A- Oth intartic fracture of lower end of right radius, init

Principal Diagnosis:

S52.571A- Oth intartic fracture of lower end of right radius, init

Secondary Diagnoses:

S18.11XA Laceration *wlo* foreign body of right forearm, init encntr
D62 Acute posthemorrhagic anemia (CC)
L89.319 Pressure ulcer of right buttock, unspecified stage
D69.6 Thrombocytopenia, unspecified
Z95.1 Presence of aortocoronary bypass graft
D70.9 Neutropenia, unspecified
E11.9 Type 2 diabetes mellitus without complications
E55.9 Vitamin D deficiency, unspecified
V43.62XD Car passenger injured in collision w car in traf, subs
H91.90 Unspecified hearing loss, unspecified ear
D50.9 Iron deficiency anemia, unspecified
K59.00 Constipation, unspecified
M10.9 Gout, unspecified
F51.04 Psychophysiologic insomnia
110 Essential (primary) hypertension
I25.10 Athscl heart disease of native coronary artery *wlo* ang pctrs
Z96.651 Presence of right artificial knee joint
Z79.82 Long term (current) use of aspirin
Z79.02 Long term (current) use of antithrombotics/antiplatelets

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Pre-Admission Screening

Etiology: Multiple trauma with fractures, hemi arthrosis and mild traumatic brain injury after motor vehicle accident with impaired mobility, ambulation, self-cares, transfers, cognition.

Date of screening: 3/04/22

85 year old lady who was a restrained passenger in a motor vehicle. Her friend was driving and was pulling out of the driveway when they were struck on the driver's side; however, the patient sustained multiple injuries. There was a positive airbag deployment, and this hit her in the face. She presented to the hospital with a large skin tear over the right forearm, right distal clavicle fracture large right knee hemi arthrosis to the point that she dropped her hemoglobin and required transfusion of 2 units of packed red blood cells. She also began complaining of pain in her right wrist and a CT scan and orthopedic reevaluation were completed with findings of right distal radial and ulnar fractures.

ADMISSION MOTOR SCORE: 27

PHYSICAL MEDICINE REHABILITATION ADMISSION HISTORY AND PHYSICAL

POST ADMISSION PHYSICIAN EVALUATION

CHIEF COMPLAINT: Multiple trauma with fractures, hemarthrosis and mild traumatic brain injury after motor vehicle accident with impaired mobility, ambulation, self-cares, transfers, cognition.

HISTORY: This is a pleasant 85-year-old lady who was a restrained passenger in a motor vehicle. Her friend was driving and was pulling out when they were struck on the driver's side; however, the patient sustained multiple injuries. There was positive airbag deployment, and this did hit her in the face. She was presented to the hospital and noted to have a large skin tear over the right forearm, right distal clavicle fracture, large right knee hemarthrosis to the point that she dropped her hemoglobin and required transfusion of 2 units of packed red blood cells. She also began complaining of pain in her right wrist and a CT scan and orthopedic reevaluation were completed with findings of a right distal radial and ulnar fractures deemed stable.

Recommendations for treatment with a splint and non-weightbearing. She was evaluated by therapy, noted to have significant functional deficits, felt to be appropriate for acute inpatient rehabilitation.

PRIOR FUNCTIONAL STATUS: Prior to admission, she reportedly was modified independent with use of a cane. Currently, she is min assist to max assist with bed mobility and transfers, mod assist ambulating a few steps with a front-wheeled walker, dependent with activities of daily living.

PAST MEDICAL HISTORY: Includes coronary artery disease, hyperuricemia with history of gout, chronic insomnia, hypertension, history of perforated gastric ulcer, renal lithiasis, breast cancer, colorectal cancer, chronic anemia, history of prior CVA, intermittent dizziness, chronic hearing loss, diabetes.

PAST SURGICAL HISTORY: Includes coronary artery bypass grafting, right total knee arthroplasty with subsequent hardware removal and spacer placement due to infection and subsequent revision total knee arthroplasty, surgical repair of perforated gastric ulcer, hysterectomy, partial colon resection.

SOCIAL HISTORY: She typically lives alone in a single level residence with 5-7 steps to enter with bilateral handrails but no internal architectural barriers. Denies tobacco, alcohol or recreational drug use.

ALLERGIES: STATIN.

ADMISSION MEDICATIONS: Colace 100 mg p.o. b.i.d., Senokot 8.6 mg p.o. b.l.d., allopurinol 100 mg p.o. daily, Norvasc 5 mg p.o. daily, aspirin 81 mg p.o. daily, Coreg 25 mg p.o. twice daily, Plavix 75 mg p.o. daily, Lasix 40 mg p.o. daily, isosorbide mononitrate 60 mg p.o. every morning, Lidoderm 1 patch topically once daily, magnesium oxide 400 mg p.o. daily, multivitamin 1 p.o. daily, metformin 500 mg p.o. twice daily with meals, valsartan 320 mg p.o. daily. P.r.n. medications for pain, nausea, bowels, sleep, blood sugar and muscle spasm.

REVIEW OF SYSTEMS: The patient denies current nausea, although did have nausea this morning. Denies vomiting, chest pain, shortness of breath. Admits to occasional coughing. Denies current dizziness or double vision.

PHYSICAL EXAM:
GENERAL: Well-developed, well-nourished, well-hydrated, elderly lady seen lying in bed, alert,

pleasant, generally cooperative with the exam, mitd apparent distress.
VITAL SIGNS: Temperature 98.1, pulse 62, respirations 18, blood pressure *100/62,* pulse ox 97 on room air.
HEENT: Head is normocephallc, atraumatic other than some resolving bruising around both orbits.
EXTREMITIES: She has extensive bruising and edema around the right knee. It is fluctuant. No warmth to touch. There is visible bruising. She has Steri-Strip laceration on the left lower leg as well as some scab on the medial aspect of the left lower leg, right upper extremity she has a wrist splint in place. Dressing in place on the right forearm and a sling in place.
NEUROLOGIC: Mental status: The patient is alert, generally oriented to person, place, situation, answers questions appropriately, follows simple commands. Speech is fluent with no evidence of acute dysarthria or aphasia. Cranial nerves 2-12 grossly intact to confrontation. She has recall of the events preceding the accident and intermittently after the accident really does not recall the accident itself. She does have some mildly decreased speed of processing. Sensation is intact to light touch bilateral upper and lower extremities, although she does note some decreased light touch sensation in the right upper extremity and hand. Reflexes: Biceps, triceps, brachioradialis 1 + on the left, not tested on the right. Patellar 1 + on the left, not tested on the right. Babinski equivocal bilaterally. Hoffman's and palmomental are negative bilaterally. Strength: Upper extremity strength is 5/5 on the left. Right upper extremity strength, she has active, although pain limited elbow flexion, shoulder abduction and finger flexion and extension. Left lower extremity strength 5- 5/5, right lower extremity strength 5-/5 for ankle and great toe dorsiflexion. She does have active knee flexion, extension and hip flexion, but range of motion is limited. Balance not tested. Gait not tested.

IMPRESSION: An 85-year-old lady status post motor vehicle accident with right clavicle fracture, right distal radius and ulnar fractures, large right knee hemarthrosis mild traumatic brain injury with overall impairments in mobility, ambulation, self-cares, transfers, communication and mild cognitive impairment.
PLAN: At this time, she is admitted to acute inpatient rehabilitation here at [Rehab] .
She will be seen by physical, occupational, and speech therapy for evaluation and treatment as it relates to strength, balance, transfers, mobility, ambulation, self cares, cognitive perceptual tests, cognition and speech. She will be seen by social work for discharge planning. She will be followed by rehabilitative nursing for skin and wound care management, medication knowledge teaching, and nutrition. She will be followed by rehabilitative psychology for cognitive testing and adjustment issues. We will ask the IPC hospitalist group to follow her for medical management given significant hemarthrosis with acute anemia. We will utilize SCDs and TED hose for venous thromboembolism prophylaxis. She also will continue on aspirin and Plavix. Continue other cardiac regimen. Continue diabetic regimen, diabetic diet and monitoring of blood sugars. Continue current pain regimen with adjustment as needed for comfort and to allow full participation with therapy. The patient reports that as long as she gets her pain medication on time, it does a fairly good job of controlling the pain. Anticipate need for physical and occupational therapy 1-1.5 hours per day and speech therapy 0.5 hours per day.

DATE OF CONSULTATION: *03/05/2022* **PRIMARY CARE PHYSICIAN:** [Dr T-] .
CHIEF COMPLAINT: Right arm pain.

REASON FOR MEDICAL CONSULTATION: Evaluation and treatment of patient with multiple traumatic fractures and acute blood loss anemia.

HISTORY OF PRESENT ILLNESS: This is a pleasant 85-year-old white female who unfortunately suffered a motor vehicle accident on *02/25/2022.* The patient was in a low-speed motor vehicle accident. She

was a restrained passenger with airbags deployed with a driver's side impact. The patient was complaining of right-sided shoulder and clavicle pain. The patient was diagnosed with right nondisplaced clavicular fracture and later diagnosed with distal radial/ulnar fracture and right knee hemarthrosis. The patient was admitted to the hospital, consultation was provided by [Dr E-] who recommended conservative management of the stable right clavicular fracture and also the right knee hematoma. The patient has been concerned about the right knee hemarthrosis secondary to a complex past medical history involving the right knee arthroplasty with subsequent hardware removal due to septic arthritis with spacer placement and subsequent revision of the total knee arthroplasty which further IV antibiotics for 6 weeks in *12/2021.* The patient was empirically started on ceftriaxone in the hospital. This was quickly discontinued when there was felt to be no evidence of infection. The patient did receive transfusion of packed red blood cells secondary to significant anemia associated with hemarthrosis. The patient's hemoglobin was 5.7 on 02/26/2022.

The patient had been on both Plavix and aspirin as an outpatient prior to admission. The patient also had some thrombocytopenia which likely contributed to her hemarthrosis with a low platelet count of 93,000. This also has improved up to 187,000. The patient mostly complains of right arm pain. She was diagnosed with right mildly dorsally displaced intra-articular fracture of the distal radius and nondisplaced ulnar styloid fracture on *02/29/2022* by CT of the upper extremity. The patient was placed in a splint and is non-weightbearing in the right upper extremity. The patient states she is mildly lightheaded and dizzy with therapy. She states she is getting adequate pain relief. The patient states she is having some constipation.

PAST MEDICAL HISTORY: Status post right total knee arthroplasty, complicated by septic arthritis with initial IV antibiotics for 6 weeks followed by explant of patient's right total knee arthroplasty hardware with a spacer placement and an additional 6 weeks of IV antibiotics. The patient finished with a new total knee arthroplasty on 12/2021. The patient has coronary artery disease, status post CABG with stenting by [Dr R-] in 10/2020. She is to remain on Plavix for her coronary artery disease, diabetes mellitus type 2, gout, chronic insomnia, hypertension, constipation, perforated gastric ulcer history requiring surgery. She is status post hysterectomy, history of breast cancer, colorectal cancer with partial colon resection, chronic anemia and anemia of acute blood loss, CVA, chronic hearing loss.

MEDICATIONS: The patient's medications at this time include:

1. Allopurinol 100 mg p.o. daily.
2. Amlodipine 5 mg p.o. daily.
3. Aspirin 81 mg p.o. daily.
4. Co reg 25 mg p.o. b.i.d.
5. Plavix 75 mg p.o. daily.
6. Colace 100 mg p.o. b.l.d,
7. Lasix 40 mg p.o. daily.
8. Humalog insulin sliding scale 3 times daily.
9. Imdur 60 mg p.o. q.a.m.
10. Lidoderm patch 5 topical daily.
11. Magnesium oxide 400 mg p.o. daily.
12. Metformin 500 mg p.o. b.l.d.
13. Multivitamin 1 tablet p.o. daily.
14. Senna 8.6 mg p.o. b.i.d,
15. Diovan 320 mg p.o. daily.

ALLERGIES: The patient has an allergy to STATINS.
SOCIAL HISTORY: She lives in [Local Area], part of the year and [Distant Area], the remainder of the year. She denies tobacco, alcohol or recreational drug use.

FAMILY HISTORY: Noncontributory to the current hospitalization.

REVIEW OF SYSTEMS: She denies headache. Denies cough, shortness of breath, chest pain. She has a left-sided central venous catheter secondary to poor IV access. She has pain in her right arm and some pain in her right knee and complains of some constipation. The patient does have some dizziness with standing up. She states she slept well and is eating okay. The patient's other 14-point review of systems are negative.

PHYSICAL EXAM: This is a pleasant, elderly female, sitting in a chair, in no acute distress. Her right arm is in a splint. She does have some mild right hand edema. There is no significant ecchymosis of the right hand. The patient's oropharynx is clear, without any thrush, no cervical or supraclavicular lymphadenopathy. No thyromegaly. VITAL SIGNS: Blood pressure 101/58, pulse of 58, 02 sat 98 on room air, temperature is 99.2. The patient's neck is supple. HEART: Regular rate and rhythm without murmurs, rubs or gallops. No S3. LUNGS: Clear to auscultation bilaterally without inspiratory crackles or expiratory wheezing. ABDOMEN: Soft, nontender, nondistended with normal bowel sounds. No appreciable hepatosplenomegaly. Right knee has significant hemarthrosis, this appears to be resolving. The patient does still have significant effusion present. There is no warmth or bright erythema. The patient has 1 + pretibial edema in the right leg. The patient is alert and oriented x3, pleasant, appropriate, in no acute distress. The patient's cranial nerves 2-12 grossly intact. The patient follows commands.

LABS AND STUDIES: CBC: White cell count 3.9, hemoglobin 8.2, hematocrit 25, platelet count 187,000,55 neutrophils. Basic metabolic panel: Sodium 135, potassium 5, chloride 99, C02 26, BUN of 35, creatinine 1.0. Glucose is 199. The patient's CT of the abdomen and pelvis without contrast *02/26/2022* showed no acute abnormality of the chest, abdomen or pelvis. It did show a 5-mm noncalcified left upper lobe pulmonary nodule, mild cardiomegaly, atherosclerosis of the thoracic aorta and native coronary arteries as well as the abdominal aorta without aneurysmal dilatation. CT scan of the cervical spine showed no acute fracture. She did have an enlarged thyroid. Please see other radiologic studies.

ASSESSMENT AND PLAN:

1. Right distal radial and ulnar fractures with conservative management, non-weightbearing in a splint. The patient's pain is controlled.
2. Distal right clavicle fracture. Again, pain is controlled at this time and conservative management was deemed appropriate by [Dr E-] .
3. Right knee hemarthrosis. The patient does not have any clinical evidence of infection at this time. I explained to the patient the reason that empiric antibiotic is not warranted at this time. Unfortunately, this is the knee where the patient has had significant complications with septic arthritis in the past associated with her total knee arthroplasty as noted above. Certainly, hemarthrosis can be seated by bacteria. We will need to clinically observe closely. The patient does not have any superficial abrasions or lacerations in this area that would warrant antibiotic treatment.
4. Acute blood loss anemia. The patient required 4 units of packed red blood cells during the hospital stay, her hemoglobin has remained stable at 8.2. She does have significant iron deficiency with an iron sat of 10. If the patient has not received Venofer, we will load her with Venofer as she does have IV access at this time.
5. Hypertension. The patient's blood pressure is actually on the low side, likely associated with her anemia. The patient is on amlodipine as well as Coreg, Lasix, Imdur and valsartan. We will set parameters on these medications to hold to try to prevent hypotension.
6. Diabetes mellitus type 2, somewhat labile. The patient normally takes metformin, but no

insulin. The patient will be continued on metformin. We will discontinue the sliding scale insulin protocol and check fingerstick blood sugars twice daily.

DATE OF CONSULTATION: *03/07/2022*

CONSULTANT: [Dr E-]

REASON FOR CONSULTATION: Injury to right upper extremity, right knee.

HISTORY: The patient is an 85-year-old female involved in a motor vehicle accident. About a month or so ago she was admitted with a fracture of distal clavicle, a scapholunate disruption of the right wrist and contusion to her knee. Historically, the patient relates to me that she had a septic total knee that was removed and treated with an antibiotic spacer. In December of this year underwent a revision arthroplasty after the infectious process was eradicated and her complaints today are some mild pain and stiffness and swelling in her wrist and shoulder. She complains of pain over the medial aspect of her knee with swelling.

PHYSICAL EXAMINATION: Her cervical spine is stable. Her right shoulder has some mild tenderness about the distal clavicle. Her distal clavicle is clinically stable. The glenohumeral joint is stable, and elbow is somewhat stiffening being mobilize, but is stable. Her wrist has some edema. Her wrist is stable. She does have some tenderness about scapholunate interval and diminished dorsiflexion and plantarflexion of her lumbar spine. Pelvis and hips are stable and intact. Her left lower extremity is normal. Her right hip is stable. Exam of her right knee shows a healed anterior incision. She does have swelling about the medial aspect of the knee with some fluctuance. Review of the radiographs of the patient's knee showed intact revision total knee arthroplasty. __ shoulder show nondisplaced fracture of the distal clavicle. Glenohumeral joint is intact. Radiographs of her forearm and wrist do not show a fracture of the distal radius, but rather show scapholunate disruption.

ASSESSMENT:

1. Hematoma medial aspect of right knee.
2. Nondisplaced fracture, right distal clavicle.
3. Scapholunate disruption.

DISCUSSION: At this point in time, she is __ . She needs no further mobilization. As far as her upper extremity is concerned, she is engaged in an aggressive range of motion exercises of her wrist and her fingers, her elbow and shoulder and weightbearing tolerance through the knee is permitted. One may consider an ultrasound of her knee to look at the fluid accumulation immediately as most likely hematoma but have been planned to leave it treated conservatively as it will absorb Again, no further mobilization involving her upper extremity is needed.

DATE OF CONSULTATION: *03/10/2022*
CONSULTANT: [Dr N-]
ATTENDING: [Dr O-]

TIME: 12:30 p.m.

PROBLEM:

1. Neutropenia.

a. Diagnosed in *05/2021.*
b. Transfusion-dependent anemia.

HISTORY OF PRESENT ILLNESS: This is a very nice 85-year-old female with a history of motor vehicle accident. She was admitted on 02/25/2022, with multiple injuries. She had a right knee hemarthrosis, right clavicle fracture and a large skin tear on the right forearm. She also had a right knee hematoma. She was transferred to rehabilitation and has been here. She has been found to have a low white count with neutropenia. I have been asked to see her regarding the neutropenia. She is anxious. She wants to go home. She is nauseated and has no energy. Otherwise, she is well.

LABORATORY DATA: Hemoglobin is 9.9, hematocrit 30, white count is 1.7, platelet count is 116,000, neutrophils 52, lymphocytes 21, monocytes 20. The absolute neutrophil count today is 884. Review of labs from May of last year show similar findings; hemoglobin is 9.9, hematocrit 30, white count 3,300, platelet count 124,000, neutrophils 42, lymphocytes 40, monocytes 14, absolute neutrophil count 1,400, the following day she was 0.8. Labs from today; glucose 124, BUN of 24, creatinine is 0.7, total protein 6.5, albumin 3, globulin 3.6. LDH is 143. B12 is 323. Hepatitis B and C were normal.

ASSESSMENT: Neutropenia: Asymptomatic, afebrile, no evidence of infection. We would hold off on growth factors. Support for fever or infections. Discussed the potential for a bone marrow biopsy, but she is not interested, though she understands that she could have early myelodysplastic syndrome. She has had these features from last year. She has a history of transfusion requirements, even has a Port-A-Cath ordered. Suspect, we will not be able to confirm cause. She might just recover. Labs ordered. Consider B12 addition. Could try something like danazol, would have to check for interactions with her medications. For now, labs are ordered. Discussed the potential for MDS. Nothing to add at this time. Supportive care as needed.

PLAN: As above.

Discharge Summary: 3/16/22

Date of admission: 3/04/22

Discharge diagnoses:

- Multiple trauma; was a restrained passenger in motor vehicle
- Right clavicular fracture
- Right distal radius and ulnar fractures
- Large right knee hemi arthrosis
- Mild traumatic brain injury
- Impaired mobility and self care
- Pain
- Higher level cognitive deficits
- Anemia
- Leukopenia and thrombocytopenia
- History of coronary artery disease, status post CABG procedure
- History of gout
- Remote breast and colon cancer, quiescent
- Diabetes mellitus with blood sugars well controlled

Patient discharged to home with family.

IGC:

ETIOLOGIC:

TIER:

60% QUALIFIER:

COMMENTS:

Patient Case 8 Class 7 AQ-IQ IRF-PRO Lab

Coder Summary:
DRG: 605 Trauma to the skin, subcut tiss & breast w/o MCC

Principal Diagnosis:
T07 Unspecified multiple injuries

Secondary Diagnoses:
S32.591D Oth fracture of right pubis, subs for fx w routn heal
S22.41XD Multiple fx of ribs, right side, subs for fx w routn heal
S32.591D Oth fracture of right pubis, subs for fx w routn heal
S42.301D Unsp fx shaft of humer, right arm, subs for fx w routn heal
E66.01 Morbid (severe) obesity due to excess calories
Z68.42 Body mass index (BMI) 45.0-49.9, adult (CC)
I10 Essential (primary) hypertension
I48.91 Unspecified atrial fibrillation
V89.2XXD Person injured in unsp motor-vehicle accident, traffic, subs

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Pre-Admission Screening
Etiology: Major multiple trauma due to motor vehicle accident with multiple rib fractures, right acetabulum pubic rami, humeral fractures
Date of screening: 3/2/22
52 year old male who presented to ZZMC after being hit while riding his scooter on 2/10/22. No loss of consciousness. Glasgow of 15. Complaining of chest pain. Morbidly obese. Chest x-ray revealed multiple right sided rib fractures, small pneumothorax with subcutaneous emphysema. Pelvic x-ray right acetabular, rami fractures. CT chest ribs 1-9 fractures. Chest tube placed. CT abdomen right acetabulum and rami fractures with 4cm hematoma. Per ortho closed displaced T type fracture right acetabulum. Hospital course included aFib with rapid ventricular rate, new onset, blunt chest requiring mechanical ventilation and tracheostomy (2/25/22) , insertion of right distal femoral skeletal traction pin with attempted ORIF but aborted due to intraoperative bleeding from superior gluteal artery (2/24/22), removal of lap sponges from pelvis and irrigation and debridement right pelvic incision and layered wound closure (2/26/22), pneumonia, on and off ventilator, CT removed on 2/26/22. 2/18/22 per ortho NWB right upper and lower for 3 more weeks. 2/29/22 trach decannulated by trauma. per cardiology telemetry showing sinus rhythm to sinus tachycardia. no further runs of atrial fibrillation 2/27/22 per trauma following commands tolerating diet. stable for transfer to stepdown. 3/1/22 patient stable for discharge to rehab.

Comorbidities: HTN, aFib, morbidly obese, BMI of 47. PSH: tracheostomy (none documented prior to most recent hospitalization).

ADMISSION MOTOR SCORE: 25

History and Physical

DATE OF ADMISSION:

03/03/2022.

DATE OF SERVICE: 03/04/2022

CHIEF COMPLAINT: Inability to care for self.

ETIOLOGIC DIAGNOSES: Major multiple trauma including a right complex acetabular fracture, multiple right rib fractures, right pneumothorax, right inferior pubic rami fracture.

HISTORY OF PRESENT ILLNESS: Patient is a 51-year-old morbidly obese male, who was admitted here on 03/03/2022 for comprehensive rehabilitation. Patient presented to [FACILITY] on 02/10/2022 as a trauma alert after being hit while riding his scooter. There was no loss of consciousness noted. Patient was a GCS score of 15 upon arrival.

Injuries sustained include multiple right-sided rib fractures, 1 through 9, small right-sided pneumothorax with subcutaneous emphysema, right acetabular and pubic rami fractures with a 4-cm hematoma.

Patient was evaluated by orthopedic surgeon for his multiple fractures. He was placed in traction therapy and placed on non-weightbearing status to right lower extremity. Secondary to high risk of thromboembolism, he did receive an IVC filter. He was noted to be in respiratory failure secondary to his morbid obesity, requiring a tracheostomy tube, which has since been removed and stoma site has healed well. Hospital course significant for atrial fibrillation with rapid ventricular rate, which is new in onset, blunt chest trauma, requiring mechanical ventilation and tracheostomy on 02/25/2022, insertion of a right distal femoral skeletal traction pin was attempted ORIF, but aborted due to intraoperative bleeding from the superior gluteal artery on 02/24/2022, removal of laparoscopic sponges from the pelvis and irrigation and debridement of right pelvic incision and layered wound closure on 02/26/2022, ventilator-associated pneumonia. The patient's right-sided chest tube for pneumothorax was removed on 02/26/22.

Patient will require non-weightbearing status to both right upper and lower extremities for a total of 3 more weeks from 02/18/2022.

Patient was evaluated by cardiology. Rhythm strips were reviewed on telemetry. Patient noted to be in sinus rhythm and occasionally in sinus tachycardia with no further runs of atrial fibrillation. He was placed on rate and rhythm control medications. The patient was medically stabilized and deemed an appropriate candidate for comprehensive rehabilitation to address his recent gait dysfunction, impairment in self-care, balance, transfers, safety and limited endurance. Patient was given a total of 3 days via the Health Care District trauma service. He will be discharged home with support of his friends and brother.

PAST MEDICAL HISTORY:
1. Hypertension.
2. Morbid obesity with a body mass index of 47.

PAST SURGICAL HISTORY: None documented, prior to most recent hospitalization.

ALLERGIES: No known drug allergies.

CURRENT MEDICATIONS: Diltiazem, heparin, alprazolam, amiodarone, carvedilol, docusate, famotidine, quetiapine, aspirin, digoxin and MiraLax.

FAMILY HISTORY: Noncontributory to this stay.

SOCIAL HISTORY: Patient is single, reports being homeless, but will be staying with his friend upon discharge. Patient's friend's home is l-level home with a small step to enter. He reports working full-time at his friend's business doing asphalt. Patient reports positive tobacco abuse and negative for alcohol or drug abuse.

PRIOR LEVEL OF FUNCTION: Patient was independent with all activities of daily living, independent with ambulation, not requiring assistive device.

CURRENT LEVEL OF FUNCTION: Moderate assistance with bed mobility and supine to sit, maximal assistance with sit to stand and bed to chair. Patient was doing slide board transfers from bed to wheelchair propelling with left upper and lower extremities with assistance needed for steering and maneuvering.
Patient with poor insight into deficits. Minimal assistance with self-feeding and grooming. Maximal assistance with upper body bathing and lower body bathing. Total assistance with toileting.

SPEECH AND SWALLOW:

Patient with cough x strong cough reflex. mechanical soft diet Bedside swallow evaluation completed on 02/26/2022. 1 on multiple sips of thins via straw. Patient with No overt signs of aspiration. Patient placed on a diet with thin liquids.

COGNITIVE STATUS: Patient is awake, alert, oriented x 1 to 2. Confused and agitated at times.

COMMUNICATION STATUS: Patient displays functional expressive and receptive communication skills.

REVIEW OF SYSTEMS: Patient reports opioid-induced constipation and reports right pelvis pain and right ribcage pain, otherwise the 10-point review of systems is negative.

PHYSICAL EXAMINATION:
VITAL SIGNS: Temperature 98.1, heart rate 96, respirations 20, blood pressure 156/92, pulse ox 98 on room air.
GENERAL: Awake, alert, resting in bed, in no acute distress. HEENT: Normocephalic, atraumatic. Extraocular muscles are intact. HEART: Regular rate and rhythm.
LUNGS: Clear to auscultation anteriorly. No wheezes, rales or rhonchi appreciated.
ABDOMEN: Obese, soft, nontender, audible bowel sounds.
EXTREMITIES: No clubbing, cyanosis or edema noted. No palpable calf tenderness.
NEUROLOGIC: Cranial nerves II-XII grossly intact. Sensation is intact to light touch in all 4 extremities.
EMOTIONAL AND BEHAVIORAL: Patient is pleasant, no overt signs of anxiety and/or depression.

LABORATORY DATA: WBC is 7.14, H&H 11.4 and 36.6, platelets 475. Sodium 140, potassium 4.6, BUN and creatinine 8 and 0.64. Alkaline phosphatase 328, ALT and AST 14 and 15. Glucose level 126.

DIAGNOSTIC STUDIES:

1. Ultrasound bilateral lower extremities completed on 03/03/2022 with no evidence of DVT.
2. Chest x-ray completed on 02/26/2022 with no evidence of acute cardiopulmonary disease.
3. Right humerus x-ray completed on 02/22/2022 shows a partially healed fracture of the humerus. There is angulation.

IMPRESSION:

1. Major multiple trauma.
2. Multiple right-sided rib fractures 1 through 9.
3. Right acetabular fracture.
4. Pubic rami fracture on the right with a 4-cm hematoma.
5. Blunt chest trauma.
6. Respiratory failure requiring mechanical ventilation, status post tracheostomy and decannulation.
7. Status post right distal femoral skeletal traction pin.
8. Intraoperative bleeding from superior gluteal artery.
9. Small right-sided pneumothorax, status post chest tube placement and removal.
10. Hypertension.
11. New onset atrial fibrillation, currently on rate and rhythm control medications.
12. Morbid obesity with a body mass index of 47.
13. Gait dysfunction.
14. Impairments in self-care.
15. Impairments in balance, transfers and safety with limited endurance.

PLAN:

1. Admit patient for comprehensive rehabilitation with physical, occupational therapies, case management, dietitian, rehabilitation nursing and daily physiatry oversight.
2. Physical therapy consultation for gait balance, transfer training and evaluation for assistive device.
3. Occupational therapy consultation placed for activities of daily living, evaluation for adaptive equipment.
4. Dietary consultation placed to assist with all nutritional needs.
5. Rehabilitation nursing to provide 24 hours a day, 7 days a week of nursing care and supervision to monitor patient's bowel, bladder and skin needs.
6. Case management to assist with all discharge planning and durable medical equipment. Patient with a total of 3 days given by [Known Entity]
trauma. He will return home to his friend's home, which is 1 level with one small step to enter.

PROGNOSIS: Good. The patient will require 3 hours of daily therapy over a 4-day period that he is with us.

ESTIMATED LENGTH OF STAY: 4 days.

SPECIAL RISKS FOR COMPLICATIONS AND COMORBIDITIES (MEDICAL AND FUNCTIONAL) :

1. The patient is at risk for falls. We will place patient on bed and chair alarms and close supervision daily by all staff.
2. Patient is at risk for skin breakdown secondary to immobility and post-fracture pain. We will continue to encourage q.2 hour turns while in bed and frequent weight shifts while in a wheelchair.
3. Patient at risk for hypoxemia and decreased exercise tolerance. We will continue to encourage use of incentive spirometry q. 2 hours while awake and encourage deep breathing, early mobilization.
4. The patient is at high risk for thromboembolism. We will continue patient on heparin subcutaneous injections.

There is no change in status compared to preadmission screening done within last 24 hours. Considering all the information above, it is my best judgment that patient can participate and benefit significantly from intensive inpatient rehabilitation under the direction of a rehabilitation physician. Care at a less intensive setting would not adequately meet this patient's medical or rehabilitative needs.

Physician Progress Notes
DATE OF SERVICE: 03/06/2022

SUBJECTIVE: Patient was seen and evaluated this morning in the presence of a friend. Patient was scheduled for discharge today 03/06/2022, however, patient reports that he cannot get in contact with the friend he is supposed to be staying with. Additionally, patient reports uncertainty with discharge plan. Patient was counseled on the importance of adhering tonon-weightbearing restrictions to right upper and lower extremities. Patient is noted to be using his right upper extremity to reach for items, hold up his plate while he is eating.

OBJECTIVE:
VITAL SIGNS: Temperature 98.3, heart rate 103, respiratory rate 18, blood pressure 142/92.
GENERAL: Awake, alert and in no acute distress.
HEART: Tachycardic.
LUNGS: No labored breathing noted. ABDOMEN: Soft, nontender, obese.
EXTREMITIES: Without edema.
NEUROLOGIC: Emotional and behavioral, patient is tearful throughout.

PLAN:
1. On-call case manager was notified of patient's current impede meant to discharge, message was left call back with recommendations pending.

Discharge Summary: 3/7/22

Date of admission: 3/03/22

Discharge Diagnoses:

- Major multiple trauma.
- Multiple right-sided rib fractures 1 through 9.
- Right acetabulum fracture.
- Pubic rami fracture on the right, with a 4-cm hematoma.
- Blunt chest trauma.
- Respiratory failure requiring mechanical ventilation, status post
- tracheostomy and decannulation.
- Status post right distal femoral skeletal traction pin.
- Intraoperative bleeding from the superior gluteal artery.
- Small right-sided pneumothorax, status post chest tube placement and
- removal.
- New-onset atrial fibrillation, on rate and rhythm control medications.
- Hypertension.
- Morbid obesity with a body mass index of 47.
- Gait dysfunction.
- Impairments in self-care.
- Impairments in balance, transfers and safety with limited endurance.

Discharge to home with friend.

IGC:

ETIOLOGIC:

TIER:

60% QUALIFIER:

COMMENTS: