
Coder Summary:

DRG: 057 Degenerative nervous system disorders w/o MCC

Admitting Diagnosis:

I69.351 Hemiplegia following cerebral infrc aff right dominant side

Principal Diagnosis:

I69.351 Hemiplegia following cerebral infrc aff right dominant side

POA: Yes, present at the time of inpatient admission

Secondary Diagnoses:

G40.409 generalized epilepsy, not intractable, w/o stat epi

I25.10 Athscl heart disease of native coronary artery w/o ang pctrs

I25.2 Old myocardial infarction

Z86.718 Personal history of other venous thrombosis and embolism

M13.0 Polyarthritis, unspecified

N31.9 Neuromuscular dysfunction of bladder, unspecified

J44.9 Chronic obstructive pulmonary disease, unspecified

R13.10 Dysphagia, unspecified

M71.551 Other bursitis, not elsewhere classified, right hip

Z74.09 Other reduced mobility

M54.01 Panniculitis aff regions of neck/bk, occipt-atlan-ax region

R53.81 Other malaise

K28.9 Gastrojejunal ulcer, unsp as acute or chr, w/o hemor or perf

Z68.27 Body mass index (BMI) 27.0-27.9, adult

K13.70 Unspecified lesions of oral mucosa

R62.7 Adult failure to thrive

R63.0 Anorexia

I10 Essential (primary) hypertension

Pre-Admission Screening:

IGC: 17.9 Other Medically complex conditions

Etiology: A. Ulcer of the GE junction, B. lower lobe atelectasis, C. seizures

Date of screening: 5/25/22

87 y/o male has been going to the VA for services. He presented to the ED with right hip pain which was going on for one day. Pain was consistent and sharp in nature. He has also had retrosternal chest pain, nonspecific. Characterized as if he has heaviness and tightness in the chest and the degree was moderate. Patient was constantly complaining of pain in the

right knee, admitted to acute rehab prior but on day one vomited brown residue. Patient diagnosed with ileus and transferred back to medical floor before returning here. Ileus now appears to be resolved but now presents with atelectasis.

Patient has a history of CVA with left hemiplegia, epilepsy, lumbar and cervical spine surgery,

TURP of prostate, insertion of coronary stents, coronary angioplasty, HTN, CAD and was admitted for cardiac workup.

Venous doppler exam shows evidence of venous thromboses and obstruction of distal segment of the right jugular vein.

ADMISSION GG SCORE: 29

History and Physical 5/26/22

DATE OF BIRTH: 04/11/1936

HISTORY OF PRESENT ILLNESS: This is an 86-year-old male who has a history of smoking and who recently was admitted with hip pain, chest pain and has been worked up. Patient also developed some partial abdominal discomfort with nausea, but which cleared up. Patient has a known history of atrial fibrillation, cerebrovascular accident, epilepsy, hypertensive disorder, coronary artery disease and MI. Patient also had a back surgery of the cervical and lumbar spine and a TURP for prostate and coronary stent and hemorrhoidectomy.

He is mainly admitted here for rehab for his PT, occupational for strengthening.

ALLERGIES: No known allergy.

PAST MEDICAL HISTORY: History of atrial fibrillation, CVA, epilepsy, hypertension, myocardial infarction.

PAST SURGICAL HISTORY: The patient has a past surgical history of back and neck surgery, history of TURP, history of coronary artery catheterization with stent placement and history of hemorrhoidectomy.

SOCIAL HISTORY: The patient has a 60-year remote history of smoking, now stopped. Patient has a former ETOH use, but now stopped.

HOME MEDICATIONS: See the MR in detail for the medications he has been for multiple problems. As mentioned, patient is taking: 10 mg, vitamin D3, clonidine, Colace, Cardura, Lovenox, Proscar, gabapentin, levofloxacin, lisinopril, metoprolol and a few p.r.n. medicine.

PHYSICAL EXAMINATION:

GENERAL: This is a well-developed, well-nourished male.

VITAL SIGNS: Temperature is 100, heart rate is 88, respirations 18, blood pressure 144 systolic, diastolic 82, O2 sat 96%.

CONSTITUTIONAL: No weight loss. No fever, chills, abdominal issues are now resolved.

ENT: No hearing loss. No blurred vision, no double vision.

Sclerae are clear, not yellow. Not hard of hearing.

SKIN: No rash, no itching.

HEART: No chest pain. No chest pressure, no complaint. 81, 82 normal. No 83, no gallop.

ABDOMEN: Soft, bowel sounds present. No nausea, no vomiting or diarrhea. No muscle guarding. No phlegmon.

CHEST: Bilaterally symmetrical.

LUNGS: Congested with COPD, long history of smoking, but no shortness of breath, no diaphoresis.

GENITOURINARY: The patient has no hematuria, dysuria and now is clearing up, history of TURP.

NEUROLOGICAL: No headache, no dizziness, no syncope.

MUSCULOSKELETAL: Generalized weakness in the legs for which PT/OT has been requested and his Hematology: No anemia.

LYMPHATIC: No enlarged lymph nodes.

PSYCHIATRIC: No history of depression, looks fine.

Patient admitted to rehab. PT/OT evaluation and treatment by Dr. A- and he is participating in that.

Currently, the patient remains hemodynamically stable, I plan to keep him here until he gets well.

DIAGNOSTIC IMPRESSION: Generalized weakness, difficulty in ambulation, recent history of atrial fibrillation, atelectasis, cerebrovascular accident, epilepsy, hypertensive disorder, coronary artery disease, MI and venous thrombosis, ileus, some anorexia. Patient is tolerating food well but does not complete meals. PT/OT, has continued. Currently, the patient is stable and Dr. A- will continue the course of rehabilitation and is participating in the exercise program.

Signature Dr. B, Hospitalists

Physical Medicine and Rehabilitation Consult

Date of Admission: 5/26/22

Reason for Consult: Comprehensive rehabilitation for clinical evidence of CVA with R hemiparesis, and neurogenic bladder

Chief Complaint: new right hemiparesis

HISTORY OF PRESENT ILLNESS:

87 you. WM admitted to ABC Hospital on 5/19/22 for atypical chest pain. Cardiology ordered stress test which was normal. His hospital course further complicated by seizure d/o with subtherapeutic AED level, right extremities pain associated with weakness (HCT w/o acute pathology), urinary retention (on Tamsulosin & Foley), and pseudogout involving the right knee (non-operative).

Currently he is having persistent deficits with: Right hemiparesis, neurogenic bladder, debility, impaired ADLs, and impaired mobility. He reports having generalized right extremity pain/soreness (non-specific), worst with movements, better with Norco and rest, and associated with weakness, swelling and RUE hyperesthesia.

Prior to patient's hospitalization, pt was independent with all ADLs and intermittently using RW

for house mobility. He has wheelchair for community as needed. Patient now with functional deficits and was thought to be a good candidate for comprehensive inpatient rehabilitation at REHAB Center.

PAST MEDICAL HISTORY:

HTN

Epilepsy

Urinary retention CAD

CVA HLD

Afib MI

Current Medications:

aspirin (aspirin chewable) 81 mg= 1 tab, Chewed, Daily

atorvastatin 10 mg= 1 tab, Oral, Q Bedtime

cholecalciferol (Vitamin O3 (cholecalciferol)) 800 int_units = 2 tab, Oral, Daily

doxazosin (Cardura) 4 mg = 1 tab, Oral, Q Evening enoxaparin (Lovenox) 40 mg = 0.4 mL,
Subcut, Daily finasteride (Proscar) 5 mg = 1 tab, Oral, Q Bedtime folic acid 1 mg = 1 tab,
Oral, Daily

lactulose 20 g = 30 mL, Oral, Daily

lamotrigine (LaMictal) 100 mg= 1 tab, Oral, BID

lisinopril 10 mg = 1 tab, Oral, Daily

metoprolol 12.5 mg= 0.5 tab, Oral, Q12hr

mirtazapine (Remeron) 30 mg = 2 tab, Oral, Q Bedtime pantoprazole (Protonix) 40 mg = 1-tab,
Oral, Daily Phenobarbital (Luminal) 32.4 mg = 1 tab, Oral, QAM PHENobarbital (Luminal)

64. 8 mg = 2 tabs, Oral, Q Bedtime

phenytoin (Dilantin extended release) 100 mg= 1 cap, Oral, BID

potassium chloride (KCl) 10 mEq = 1 tab, Oral, BID

mg = 1 cap, Oral, Q Bedtime

PRN: (6)

acetaminophen (Tylenol) 650 mg = 2 tab, Oral, Q4hr

acetaminophen-Hydrocodone (Norco 325 mg-10 mg oral tablet) 1 tab, Oral, Q4hr

polyethylene glycol 3350 (MiraLAX) 17 g = 1packet(s), Oral, Daily

simethicone (Millicom) 80 mg= 1 tab, Chewed, As Directed

Studies done at acute hospitalization:

IMAGING:

5/20/22: Lexiscan with Myoview myocardial perfusion imaging study.

CONCLUSION: Normal. There were no reported symptoms or diagnostic EKG changes during
Lexiscan infusion. There is normal LV systolic function with no inducible ischemia

Head CT 5/19/22:

IMPRESSION:

No acute intracranial abnormality.

Findings suggestive of small vessel ischemic disease, although nonspecific

CT Knee W/O Contrast Right (05/25/22)

IMPRESSION:

No acute fractures detected. Moderate-sized joint effusion. Osteoarthritic changes and

findings suggestive of calcium pyrophosphate deposition disease

Orthopedic Consultation

DATE OF CONSULTATION: 06/02/2022.

CONSULTING PHYSICIAN: Dr. S-

REASON FOR CONSULTATION: Right hip pain.

HISTORY OF PRESENT ILLNESS: Patient is an 86-year-old male with multiple medical problems who has been admitted for hip and chest pain, managed inpatient and eventually was transferred to inpatient rehab. However, he had difficulty with ambulating this morning due to his hip pain. Pain is noted to be lateral and posterior along the hip. Patient is unable to weight bear or lift himself. When the symptoms continued to persist, orthopedic was consulted for evaluation.

PAST MEDICAL HISTORY: Notable for atrial fibrillation, CVA, epilepsy, hypertension, previous MI.

PAST SURGICAL HISTORY: Notable for spine surgery along the cervical and lumbar spine, history of transurethral resection of the prostate, stent placement and hemorrhoidectomy.

MEDICATIONS: Please refer to Medical Record.

ALLERGIES TO MEDICATIONS: INCLUDE AMOXICILLIN AND CLARITHROMYCIN.

REVIEW OF SYSTEMS:

PHYSICAL EXAMINATION:

GENERAL: Reveals a well-appearing male. He is alert and oriented x 3.

HEENT: Per internal medicine note.

CHEST: Per internal medicine note.

ABDOMEN: Per internal medicine note.

EXTREMITIES: Examination is most notable for pain along the right lateral hip with tenderness to palpation and patient with difficulty with flexion of the hip joint and flexion of the knee while supine. Patient has good dorsalis pedis pulse and has limited motor function along his ankle.

X-rays of the hip were taken, reviewed and notable for minimal osteoarthritis, but no significant fractures or deformities.

ASSESSMENT: Patient is an 86-year-old male with right hip greater trochanteric bursitis, but also possible right sciatic nerve symptoms. I have discussed with the attending physician. He does have a history of GI ulceration and was recommended that he avoid any oral anti-inflammatories or oral steroids. Thus, I have discussed with the patient a corticosteroid injection along his right greater trochanter bursa. The details of procedure and risk and benefits discussed with patient, and he wished to proceed with the procedure.

PROCEDURE NOTE: Under sterile condition, the right greater trochanter was injected with combination of 8 mL of 1% Xylocaine and 1 mL of Solu-Medrol. Patient tolerated the procedure well.

DIAGNOSES:

CVA, acute, ischemic by physical exam.

Case "A"

Ileus
Pseudogout
Right hemiparesis
Right extremity pain
Seizure disorder, followed by Dr. B.
Neurogenic bladder, on Foley.

PLAN: Patient will continue with weightbearing as tolerated once he improves. Thank you for this consultation.

Discharge Summary: 6/8/22

Pain in right hip joint keeps increasing despite strong pain medication dosage. Currently with protein calorie malnutrition and diagnosis of failure to thrive, as he refuses to eat. Patient has decided to go home.

Impression: Generalized weakness and deconditioning, right hip pain with difficulty in

ambulation. Patient was on PT with improvement but slowly dwindled down due to poor appetite, history of aFIB, hx of CVA, hx of epilepsy.

Discharge to home with family. Follow up with outpatient PT in 1 week.

IGC:

ETIOLOGIC:

TIER:

60% QUALIFIER:

COMMENTS:

AQ-IQ IRF PRO LAB

Case "B"

Coder Summary

Patient Four

DRG: 065 Intracranial hemorrhage or cerebral infarction w CC or tPA in 24 hrs

Admitting Diagnosis:

I62.01 Nontraumatic acute subdural hemorrhage

Principal Diagnosis:

I62.01 Nontraumatic acute subdural hemorrhage (DRG)

Secondary Diagnoses:

G20 Parkinson's disease

F03.90 Unspecified dementia without behavioral disturbance

I10 Essential (primary) hypertension

E11.65 Type 2 diabetes with hyperglycemia

I69.251 Hemiplegia fol oth ntrm intrn hemor aff right dominant side (Ce)

N40.0 Enlarged prostate without lower urinary tract symptoms

R56.9 Unspecified convulsions

K59.00 Constipation, unspecified

D62 Acute posthemorrhagic anemia (Ce) (DRG)

I69.81 Cognitive deficits following other cerebrovascular disease

G89.18 Other acute postprocedural pain

R49.0 Dysphonia

R51 Headache

Pre-Admission Screening:

IGC: 2.1

Etiology: Subdural hematoma

Date of screening: 8/11/19

Patient is a 79 year old right handed male with a history of Parkinson's disease, who has had progressive right-sided weakness, gait abnormalities for the past month or 2. The patient underwent CT of the head which revealed a complicated acute on chronic left nontraumatic subdural hematoma with 6 mm left to right midline shift. The patient was evaluated by Dr. K- and underwent craniotomy with hematoma evacuation on August 1st. Hospital course was complicated by severe headache, vomiting and elevated blood pressures. He returned for second craniotomy on August 8th. He remains with a drain in place.

Complications include: right hemiparesis, dysarthria, possible dysphagia, impaired mobility and ADLs, gait abnormality, Parkinson's disease, postoperative pain, constipation, dementia, hypertension, type 2 diabetes and benign prostatic hypertrophy.

ADMISSION GG SCORE: 30

Case "B"

Post-Admission Note

DATE OF ADMISSION: 08/11/2019.

REASON FOR ADMISSION: Acute on chronic nontraumatic left subdural hematoma status post craniotomy and evacuation times 2, impaired mobility, ADLs, gait abnormality and Parkinson's disease.

HISTORY OF PRESENT ILLNESS: The patient is a 78-year-old right-handed Polish speaking male with a history of Parkinson's disease, who has had progressive right-sided weakness, difficulties with speech and gait abnormalities. The patient had a CT of the head revealing a complicated acute on chronic left nontraumatic subdural hematoma with 6 mm of right midline shift. He underwent craniotomy with hematoma evacuation on 08/01/2019 with Dr. R_. During the hospital course, the patient had severe headaches and vomiting with elevated blood pressures. He returned for a second craniotomy and evacuation on 08/08/2019 with Dr. R_. There was concern for a postoperative seizure for which neurology was consulted and the patient was placed on Vimpat. He was also noted to have difficulty to control blood pressures and blood sugars. He was able to participate with therapies and found to be below his functional baseline and thus admitted to acute inpatient rehabilitation.

PAST MEDICAL HISTORY AND MEDICAL COMORBIDITIES: Parkinson's disease, dementia, hypertension, type 2 diabetes, BPH, left subdural hematoma and possible seizures.

FAMILY HISTORY: Reviewed and noncontributory to this admission.

CURRENT MEDICATIONS: Flomax 0.4 mg at bedtime, lisinopril 5 mg daily, Tylenol No.3 as needed, amlodipine 10 mg daily, Senokot two tablets daily, Tylenol as needed, Sinemet 25/100 mg t.i.d., Colace 100 mg b.i.d., Vimpat 50 mg b.i.d., metoprolol 25 mg q. 12 hours, Advair q. 12 hours, Dulcolax suppository as needed, nortriptyline 25 mg at bedtime, MiraLax one packet daily, glipizide 10 mg daily, metformin 1000 mg b.i.d., and Humalog insulin sliding scale.

ALLERGIES: No known drug allergies.

SOCIAL HISTORY: The patient lives with his wife in a second story apartment but does have a stair lift. He denies any tobacco or alcohol use.

PRIOR LEVEL OF FUNCTION: The patient was ambulating within the home without an assistive device and was independent for basic ADLs. His wife occasionally assists with dressing and also assists with IADLs.

CURRENT LEVEL OF FUNCTION: Transfers min assist, toileting dependent, upper body dressing max assist, lower body dressing dependent, bathing max assist.

REVIEW OF SYSTEMS: Positive for mild headache, difficulty sleeping and constipation. The patient denies any fevers, chills, chest pain, shortness of breath, abdominal pain, nausea, vomiting, bladder issues, extremity numbness, tingling or focal weakness. Complete 12-point review of systems otherwise unremarkable.

PHYSICAL EXAMINATION: Vital signs, temperature 97.6, pulse 76, blood pressure 117/60, respirations 18, and oxygen saturation 94% on room air. In general, he is a well-developed and well-nourished male in no acute distress. He is alert and oriented to person, place, and situation.

Case "B"

HEENT: He has a large left craniotomy incision with staples in place. There is mild swelling and tenderness to palpation. Extraocular muscles are intact.

Cardiovascular: S1, S2

Lungs: clear to auscultation bilaterally.

Abdomen is soft, nontender, nondistended with present bowel sounds.

Extremities are without edema.

Neurologic exam: strength is grossly 5/5 throughout all extremities. Fine motor coordination is impaired in the right hand. Sensation is intact and symmetric to light touch. Babinskis are negative. Cranial nerves II-XII are grossly intact.

He does not appear to have any resting tremor or cogwheeling of the wrists.

Skin: his craniotomy incision is clean, dry and intact with staples in place. Otherwise, skin appears intact.

LABORATORY: Sodium 135, potassium 3.9, chloride 101, bicarb 22, BUN 7, creatinine 0.71, glucose 197, white blood cells 8.6, hemoglobin 11.2, hematocrit 33.2, and platelets 469.

ASSESSMENT: This is a 79-year-old male with left acute on chronic nontraumatic subdural hematoma, status post evacuation on 08/01/2019 followed by repeat evacuation on 08/08/2019 with Dr. R_; Parkinson's disease; impaired mobility; activities of daily living; cognition; gait abnormality; postoperative pain and headache; possible seizure, constipation; active type 2 diabetes; hypertension; and anemia secondary to blood loss.

PLAN:

1. The patient will be admitted to acute inpatient rehabilitation for comprehensive therapies including PT, OT, speech therapy and 24-hour rehab nursing. Physical therapy will address lower extremity strengthening, endurance, bed mobility, gait, balance, transfer, and stair training. Occupational therapy for upper extremity strengthening, ADLs, FMC, and use of adaptive equipment. Speech therapy for assessment of cognition. A 24-hour rehab nursing for monitoring his pain and incision, skin, establishment of bowel and bladder program as well as education on medical issues and assistance with carryover of therapies. Dr. E_ will continue to follow to assist with medical needs. Risks and barriers include risk for reaccumulation of the hematoma, seizures, intractable headache, uncontrolled diabetes and hypertension and risk for falls due to gait abnormality.
1. Neurology issues. Continue Sinemet dosing for Parkinson's disease.
Continue Vimpat for seizure prophylaxis per the neurology team. We will need to clarify the duration of treatment.
2. Pain. Continue Tylenol and Tylenol No. 3 as needed. He is also receiving nortriptyline for headaches.
3. Bowel and bladder. Continue Colace, Senokot, MiraLax, and suppository as needed for constipation. Continue Flomax for BPH. Nursing to establish bowel and bladder program.
4. Diet. Diabetic diet.
5. Skin. Nursing to monitor incision site and for signs of skin breakdown.
6. DVT prophylaxis. Continue SCDs and ambulation. We will not begin any chemoprophylaxis due to the subdural hematoma.
7. Active type 2 diabetes. Continue metformin and glipizide with insulin sliding scale as needed. Dr. E_ will continue to follow to assist with management.
8. Hypertension. Blood pressures appear controlled with lisinopril, amlodipine, and metoprolol.

Continue to monitor for elevations in blood pressures that could also indicate acute underlying

Case "B"

neurologic abnormality.

9. Anemia secondary to blood loss. We will repeat a CBC in the morning to monitor trends.

Preadmission screening was reviewed and the patient is an appropriate candidate for acute inpatient rehabilitation and requires comprehensive medical management in addition to inpatient PT, OT, ST and 24-hour rehab nursing.

There have been no significant changes in functional status, medical condition or discharge plan. The patient is motivated and able to tolerate 180 minutes of therapy a day at least 5 days a week with goal of discharging home with his wife at a modified level of independence for gait and basic ADLs. Rehab potential is good. The estimated length of stay is 2 weeks.

Progress Note

Date: 8/15/2019 S: Pt report, he is doing ok today. He denies any HA currently, but wife notes he had one yesterday while family was visiting. Pt notes voice hoarseness- wife reports pt typically takes baclofen when this happens & attributes it to PD. Denies any dysphagia

PE:

T 98 P 79 R 18 BP 124/62 O2 97% on RA

Gen: NAD, Alert

HEENT: NC/at crani site with staples

CV: S1, S2

Lungs: CTAB

Abd: soft, nr/nd, BS+

Ext: no edema.

Therapy Progress: Amb CGA w/SC, stairs minA, transfers minA Goals modi.

Medication list reviewed & updated. Labs:

A/P:

1. Rehabilitation: Left acute on chronic nontraumatic subdural hematoma s/p evacuation 8/1 and 8/8, with Dr. A_. Parkinson's disease. Continue comprehensive PT, OT, ST & 24-hour nursing care. Cont sinemet for PD.
2. Cont Vimpat for seizure ppx per Neurology. Will repeat CT head monday to f/u SDH. Dr. A_ following.
3. Pain: Tylenol & Tylenol #3 pm, nortrip1ylinc for 1-f.t\.
4. Bladder & Bowels: Colace, senokor, mirilax, suppository pm for constipation; will change senna to pm per wife request. Flomax for BPH.
6. Nursing for bowel/bladder program.
7. Diet: diabetic diet.
8. Skin: nursing to continue monitor. DVT ppx: SCDs,
9. ambulation.
10. DM2: cont metformin, glipizide, ISS. Will add lantus at bedtime as blood sugars remain elevated.

Case "B"

Appreciate Dr. E_ assistance.

HTN: cont lisinopril, amlodipine, metoprolol.

Anemia: 2* to blood loss. Cont to monitor

CBC. Dysphonia: will order baclofen pm

per wife's request. Dispo: anticipated

d/c 8/25.

Case "B"

Progress Note

Date:

8/16/19

S: Pt is doing ok, reports minimal occasional HA Per wife, pr has had worsening of coordination of R hand over the past few days. Per nursing, pt's BP has been running low.

PE:

T 98 P 97 R 16 BP 100/60 02 97% on RA

Gen: **NAD, Alert**

HEENT: nc/at, crani site c/d/1 with staples

CV: S1,S2

Lungs: CTAB

Abd: soft, nt/nd, BS+ Ext: no

edema.

Neuro: strength 5/5 R hand grip, elbow flexion, extension, 4/5 R hip flexion, 5/5 knee extension, ankle DF/PF> Reduced FMC & motor planning of R hand

Therapy Progress: 8 stairs CGA standing tasks w/SC CGA. Goals mod

Medication list reviewed & updated.

Labs:

CT head: decreased thickness L frontal fluid, increased L parietal-

occipital fluid A/P:

1. Rehabilitation: Left acute on chronic non traumatic subdural hematoma s/p evacuation 8/1 and 8/8 with Dr. A_ Parkinson's disease. Continue comprehensive PT, OT, ST & 24-hour nursing care. Cont Sinemet for PD. Cont Vimpat for seizure ppx per Neurology. Will notify Dr. A_ of CT head results & await recommendations.
2. Pain: Tylenol & Tylenol # 3 prn, nortriptyline for HA.
3. Bladder & Bowels: Colace, senokot, miralax, suppository pm for constipation. Flomax for BPH. Nursing for bowel/bladder program.
4. Diet: diabetic diet
5. Skin: nursing to continue to monitor.
6. DVT ppx: SCDs, ambulation.
7. Dr.i-2: cont. metformin, glipizide, lantus, ISS. Blood sugars improving with addition of lantus. Appreciate Dr. E_ assistance.
8. HTN: cont lisinopril, amlodipine, metoprolol. BPs running low- will d/ c amlodipine & reduce lisinopril dose. Monitor BP response.
9. Anemia: 2* to blood loss. Cont to monitor CBC.
10. Dysphonia: cont baclofen prn for spasms.
11. Dispo: anticipated d/c 8/25.

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Case "B"

Progress Note

Date
:
8/17/2019

S: Pt seen and examined in room with Dr. W_, Pt states he is feeling better today compared to yesterday. He has improved coordination of the R hand. He has mild headache which is improved overall. He slept well overnight. Per therapists, weakness tends to be worse in the evening when he is more fatigued.

PE:

T 98 P 74 R 18 BP 124/74 02 97%onRA

Gen: NAD, Alert

HEENT: nc/at, crani site

c/d/1 with staples

CV: S1,S2

Lungs: CTAB

Abd: soft,

nt/nd, BS+ Ext:

no edema.

Therapy Progress: 50' x2 w/SC CGA,
grooming/hygiene- min A. Goals modl Medication list
reviewed & updated.

Labs:

CT head: decreased thickness; L frontal fluid, increased L parietal-occipital fluid A/P:

1. Rehabilitation: Left acute on chronic nontraumatic subdural hematoma s/p evacuation 8/1 and 8/8 with Dr. A_, Parkinson's disease. Continue comprehensive PT, OT, ST & 24-hour nursing care. Cont sinemet for PD. Cont Vimpat for seizure ppx per
2. Neurology. Will discuss pt's weakness with Dr. A_ and :any need for repeat imaging.
3. Pain: Tylenol & Tylenol #3 pm, nortriptyline for HA.
4. Bladder & Bowels: Colace, senokot, MiraLAX, suppository pm for constipation. Flomax for BPH Nursing for bowel/bladder program.
5. Diet: diabetic diet.
6. Skin: nursing to continue to monitor.
DVT ppx:
7. SCDs, :ambulation.
8. DM-2: cont. metformin, glipizide, lantus, ISS. Blood sugars improving with addition of lantus. Appreciate Dr. E_ assistance.
9. HTN: cont lisinopril, metoprolol. BP improved with d/c of amlodipine & decreased Lisinopril.
10. Anemia: 2'* to blood loss. Cont to monitor CBC. Dysphonia: cont baclofen pm for
11. throat spasms. Dispo: anticipated d /c 8/25.

Case "B"

Attending ,Addendum:

Pt seen & examined with NP; agree with above. Pt reports sleep is improving and denies any HA. His R hand function was improved yesterday with therapy, but tends to be worse when he is fatigued. Speak with Dr. A_ re: need for repeat CT head to f/u on posterior parietal collection. Pt now ambulating 50' w/SC CGA, goal modl. BPs improved with changes to meds yesterday.

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Case "B"

Progress Note

Date

:
8/18/2019

S: Pt cont to note issues with R hand dexterity/coordination but appears to be worse upon awakening & when fatigued. He notes only minimal HA.
Discussed CT results with pt & wife

PE:

T 98.5 P 98 R 18 BP 116/67 O2 97% on RA

Gen: NAD, Alert

HEENT: nc/at, crani site c/d/l with staples

CV: S1,S2

Lungs: CTAB

Abd: soft, nt/nd,

BS+ Ext: no

edema.

Neuro: reduced FMC in R hand, strength 4+ /5 for hand grip & finger abduction, mild apraxia noted

Therapy Progress: 8 stairs with bilat HR SBA UE dressing SBA. Goals modl.

Medication list reviewed &

updated. Labs:

CT head stable to a few millimeters decrease in size of L subdural hematoma

A/P:

- 1 Rehabilitation: Left acute on chronic nontraumatic subdural hematoma s/p evacuation 8/1 and 8/8 with Dr. A Parkinson's disease. Continue comprehensive PT, OT, ST & 24-hour nursing care. Cont sinemet for PD. Cont Vimpat for seizure ppx per Neurology. Repeat CT as above; per Dr. A, will cont to monitor for clinical changes.
- 2 Pain: Tylenol & Tylenol #3 prn, nortriptyline for HA
- 3 Bladder & Bowels: Colace, senokot, miralax suppository pm for constipation. Flomax for BPH. Nursing for bowel/bladder program.
- 4 Diet: diabetic diet.
- 5 Skin: nursing to continue to monitor.
- 6 DVT ppx: SCDs, ambulation.
- 7 DM-2: cont. metformin, glipizide, lantus, ISS. Blood sugars improving with addition of lantus. Appreciate Dr. E_ assistance.
- 8 HTN: cont lisinopril, metoprolol. BP improved with d/c of amlodipine & decreased Lisinopril.
- 9 Anemia: 2* to blood loss. Cont to monitor CBC.
- 10 Dysphonia: cont. baclofen pm for throat spasms.
- 11 Disposition: anticipated d /c 8/25.

Case "B"

Progress Note

Date
8/24/2019

S: Pt seen and examined in room with Dr. H_ Pt states he has a sore throat this morning he attributes to the weather. His wife is having the same symptoms. He denies any headache, fever, cough, chest congestion, sinus pain or pressure or rhinorrhea. He states he slept well overnight. He asks what time his staples can come out.

PE:

T 98.0 P 77 R 18 BP 122/68 O2 92% on RA

Gen: N, \D, AOx3

HEENT: nc/at, crani site c/d/l with staples. Oropharynx with no signs of erythema, edema or exudate. CV: S1, S2

Lungs: CTAB

Abd: soft, nt/nd,

BS+ Ext: no

edema.

Therapy Progress: toileting SBA, up and down 8 stairs with BL HR
CGA/SBA Goals modl Medication list reviewed & updated.

Labs:

A/P:

1. Rehabilitation: Left acute on chronic nontraumatic subdural hematoma s/p evacuation 8/1 and 8/8, with Dr. A_ Parkinson's disease. Continue comprehensive PT, OT, ST & 24-hour nursing care. Cont sinemet for PD. Cont Vimpat for seizure ppx per
2. Neurology. Dr. A_ available pm. Pain: Tylenol & Tylenol #3 pm, nortriptyline for HA
3. Bladder & Bowels: Colace, senokot, miralax, suppository pm for constipation. Flomax for BPH. Nursing for bowel/bladder program.
4. Diet: diabetic diet.
5. Skin: nursing to continue to monitor. Per Dr. A_ will remove staples today. DVT ppx: SCDs, ambulation.
6. DM-2: cont metformin, glipizide, lantus, ISS. Blood sugars improving with the addition of lantus.
7. Appreciate Dr. E_ assistance.
8. HTN: cont lisinopril, metoprolol.
9. Anemia: 2 * to blood loss. Hgb improving; monitor CBC.
10. Dysphonia: cont baclofen pm for throat spasms. Will add cepacol throat lozenges for pain.

Case "B"

Discharge Summary: 8/25/19

Discharge diagnoses: left acute on chronic nontraumatic subdural hematoma status post evacuation x2, Parkinson's disease, right hand weakness and impaired fine motor coordination, impaired cognition, possible seizures, headaches, BPH, DM II, HTN, and anemia secondary to blood loss.

Discharge to home and will attend outpatient PT, OT and speech therapy.

IGC:

ETIOLOGIC:

TIER:

60% QUALIFIER:

COMMENTS:

AQ-IQ IRF PRO LAB

Case Study "C"

DRG: 541 Osteomyelitis w/o CC/MCC

Admitting Diagnosis:

M46.26 Osteomyelitis of vertebra, lumbar region

Principal Diagnosis:

M46.26 Osteomyelitis of vertebra, lumbar region (DRG)

Secondary Diagnoses:

D64.9 Anemia, unspecified

I10 Essential (primary) hypertension

M75.102 Unsp rotator-cuff tear/rupture of left shoulder, not trauma

M54.5 Low back pain

R20.9 Unspecified disturbances of skin sensation

R25.2 Cramp and spasm

R53.1 Weakness

K21.9 Gastro-esophageal reflux disease without esophagitis

Z96.653 Presence of artificial knee joint, bilateral

Z92.3 Personal history of irradiation

Z98.89 Other specified postprocedural states

M62.838 Other muscle spasm

M19.90 Unspecified osteoarthritis, unspecified site

E78.5 Hyperlipidemia, unspecified

Z96.611 Presence of right artificial shoulder joint

M25.552 Pain in left hip

Z88.8 Allergy status to oth drug/meds/biol subst status

K59.09 Other constipation

T40.2X5A Adverse effect of other opioids, initial encounter

Pre-Admission Screening

IGC: 4.13

Etiology: Exploration of L4-L5 with foraminotomies bilateral sides L4-5 with removal of scar tissue and bony overgrowth due to osteomyelitis

Date of screening: 4/04/20

71-year-old male admitted for exploration of L4-L5 and foraminotomies bilateral sides with removal of scar tissue and bone overgrowth. Patient has been having increased pain and heaviness bilateral lower extremities after biopsy on 2/16 showed osteomyelitis. Running low grade fevers. Patient now having bilateral lower extremity muscle spasms, post op day 4. Patient had multiple cultures sent and wound cultures were pending, empirically started on IV vancomycin for his longstanding history of osteomyelitis at a two-week course.

PMH: long history of lumbar pain, non-insulin dependent diabetes, hypertension, hyperlipidemia, GERD, osteomyelitis in spine, left knee arthroplasty, right knee arthroplasty, ongoing chronic suppressive oral antibiotics, staphylococcus aeruginosa, prostate cancer with radiation, osteoarthritis, angina, lumbar aspiration

ADMISSION GG SCORE: 37

Case Study "C"

History and Physical

DATE OF SERVICE:

04/05/2020.

CHIEF COMPLAINT: Inability to care for self.

ETIOLOGIC DIAGNOSIS: Exploration of L4-L5 with foraminotomies bilaterally with removal of scar tissue and bony overgrowth due to osteomyelitis.

HISTORY OF PRESENT ILLNESS: Patient is a 71-year-old right-hand dominant male well known to me from a previous admission. He was admitted to our inpatient rehabilitation facility on 04/04/2020 for comprehensive orthopedic rehabilitation. Per chart review/ patient presented to [Hospital Name] on 03/19/2020 for exploration of L4-L5 and bilateral foraminotomies with removal of scar tissue and bony overgrowth by Dr. B_. Patient with postoperative diagnosis of foraminal narrowing of the lumbar spine with increasing low back pain and bilateral lower extremity weakness. Patient tolerated the procedure well with an estimated blood loss of 50 mL. Postoperative course significant for anemia/ immobility and acute-on-chronic back pain. Patient had multiple cultures sent and wound cultures were currently pending upon discharge. He was empirically started on IV vancomycin for his longstanding history of osteomyelitis with recommendations for short 2-week course and then continuation on all doxycycline and Levaquin therapy per infectious disease.

Patient reports during his inpatient stay at [Hospital Name] during physical therapy session bilateral knees had buckled. He had fallen to the ground with an intense left hip pain that was located in his inner groin. No further workup was done. He currently reports that his pain is not well controlled on current narcotic regimen. Denies any fevers/ chills or sweats. He was medically stabilized and deemed an appropriate candidate for comprehensive rehabilitation to address his recent gait dysfunction/ impairments in self-care/ balance/ transfers/ safety and limited endurance.

PAST MEDICAL HISTORY:

1. Longstanding history of lumbar back pain.
2. Acute-on-chronic back pain.
3. Non-insulin-dependent diabetes mellitus.
4. Hypertension.
5. Hyperlipidemia.
6. Gastroesophageal reflux disease.
7. Osteomyelitis of the lumbar spine.
8. Prostate cancer with radiation.
9. Osteoarthritis.
10. Angina.

PAST SURGICAL HISTORY:

1. Bilateral total knee arthroplasties.
2. Multiple lumbar surgeries for chronic low back pain.

ALLERGIES: BACLOFEN.

CURRENT MEDICATIONS: IV vancomycin, doxycycline, insulin lispro, metformin, metoprolol, gabapentin, amlodipine, fenofibrate, hydrochlorothiazide, Lactobacillus, lidocaine topical, lisinopril, fentanyl patch, Lisinopril/hydrochlorothiazide.

FAMILY HISTORY: Noncontributory to this stay.

SOCIAL HISTORY: Patient is married, lives with his wife in a one-level home with small step to enter. Denies any alcohol, tobacco, or illicit drugs.

PRIOR LEVEL OF FUNCTION: Patient was non-ambulatory prior to most recent hospitalization/surgical procedures secondary to severe low back pain and bilateral lower extremity weakness. He was requiring

Case Study "C"

assistance with ADLs.

CURRENT LEVEL OF FUNCTION: Mod assist with bed mobility and supine to sit. Maximal assistance x 2 with sit to stand and bed to chair. Patient ambulated 5 feet with the use of rolling walker at a moderate assistance level x 2. Patient requires extra time to complete tasks. Patient also reports bilateral lower extremities spasms. Independent with self-feeding and grooming. Minimal assistance with upper body bathing. Maximal assistance for lower body bathing and toileting.

SPEECH AND SWALLOW: Within functional limits.

COGNITIVE STATUS: Awake, alert, oriented x 3.

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

REVIEW OF SYSTEMS: Lumbar back pain, bilateral lower extremity weakness, left hip/groin pain. Paresthesias to right lower extremity and left shoulder pain, which is chronic in nature. Otherwise, a 10-point review of systems is negative.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature 97.6, heart rate 79, respirations 17, blood pressure 134/67, pulse ox 96 on room air.

GENERAL: Awake, alert, sitting upright in his wheelchair, in no acute distress. PICC line to right upper extremity.

HEENT: Normocephalic, atraumatic. Extraocular muscles are intact.

HEART: Regular rate and rhythm.

LUNGS: Clear to auscultation bilaterally. No wheezes, rales or rhonchi appreciated.

ABDOMEN: Obese, soft, nontender, audible bowel sounds.

EXTREMITIES: With no clubbing, cyanosis or edema noted.

NEUROLOGIC: Diminished sensation to light touch in right lower extremity compared to left. Sensation is intact to light touch in bilateral upper extremities. Patient with depressed reflexes in bilateral lower extremities. **NEUROVASCULAR:** Bilateral lower extremities pulses are intact.

SKIN: Lumbar incision clean, dry and intact with sutures in place with minimal serosanguineous drainage.

MUSCULOSKELETAL: Limited range of motion to left shoulder joint secondary to history of rotator cuff tear. Grossly 2 out of 5 strength in bilateral lower extremities proximally and distally. Grossly 3 out of 5 strength in bilateral upper extremities proximally and distally, limited left shoulder abduction and shoulder flexion, extension secondary to chronic pain from rotator cuff tear.

EMOTIONAL AND BEHAVIORAL: Pleasant, no overt signs of anxiety and/or depression.

LABORATORY DATA: WBC is 8.06, H&H 12.0 and 38.2, platelet count 263. Sodium 138, potassium 4.1, BUN and creatinine 18 and 0.73, glucose level 121, prealbumin 27.0.

DIAGNOSTIC STUDIES: Chest x-ray completed on 04/03/2016 with no acute process. PICC line in place to right upper extremity.

IMPRESSION:

1. Chronic low back pain with osteomyelitis of the lumbar spine, status post exploration of L4-L5 with foraminotomies bilateral sides with removal of scar tissue and bony overgrowth.
2. Foraminal narrowing of the lumbar spine.
3. Non-insulin-dependent diabetes mellitus.
4. Hypertension.
5. Hyperlipidemia.
6. Gastroesophageal reflux disease.
7. Chronic left shoulder pain secondary to rotator cuff tear.
8. Right lower extremity paresthesias.
9. Bilateral lower extremity weakness.
10. Gait dysfunction.
11. Impairments in self-care.
12. Impairments in balance, transfers and safety.

13. Deconditioned state.

PLAN:

1. Admit patient for comprehensive rehabilitation with physical, occupational therapies, case management, dietitian, rehabilitation nursing and daily physiatry oversight.
2. Physical therapy consult placed for gait balance, transfer training and evaluation for assistive device.
3. Occupational therapy consult placed for activities of daily living and evaluation for adaptive equipment.
4. Dietary consult 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.

Patient's goal is to return home with his wife and additional home health therapies and nursing care. Durable medical equipment to be determined pending patient's overall functional recovery.

PROGNOSIS: Good. The patient will require 3 hours of daily therapy over a 5 period.

ESTIMATED LENGTH OF STAY: 2 weeks.

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. The patient is at risk for skin breakdown secondary to lower extremity weakness and immobility. 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.
4. The patient is at risk for constipation secondary to opioid-induced narcotic medication. We will place patient on daily bowel regimen.
5. Patient at risk for worsening infection secondary to history of osteomyelitis of the lumbar spine. We will continue patient on IV antibiotics with close monitoring by pharmacy.

POST-ADMISSION PHYSICIAN'S EVALUATION: There is no change in status compared to preadmission screen done within the last 24 hours. Considering all the information above, it is my best judgment that the patient can participate and benefit from a comprehensive course of 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.

FACILITY-Consultation Report

DATE OF CONSULTATION:

04/06/2020 REQUESTING

PHYSICIAN: [Dr H-] CONSULTING

PHYSICIAN: [Dr K-]

REASON FOR CONSULTATION: Left shoulder and left anterior hip pain.

HISTORY OF PRESENT ILLNESS: This is a 71-year-old white male who is currently an inpatient at [Facility Name] for a lumbar laminectomy approximately 1 week ago. Patient was operated on by a neurosurgeon at another facility and while in acute rehab, patient suffered a fall landing on to his backside that initiated pain to his left anterior hip and he has been complaining of it since the fall shortly after his surgery. This discomfort is down in the hip and is limiting his ability to

Case Study "C"

participate fully with the rehab at [Facility Name]. Patient has also a complaint of left shoulder pain, has a history of a left rotator cuff injury, treated with occasional steroid injection in his shoulder. Last steroid injection was approximately a year and a half ago and lasted until recently.

Patient's left hip pain is described as muscular and described it over the anterior part of the hip. Most of the discomfort is felt when the patient tries to put weight on the hip or try to perform a straight leg raise. He states that pain does radiate down to the lateral aspect of the hip, but there is no specific connection with the lumbar spine. Patient has an extensive history of lumbar spine surgeries including C-spine fusions in the 1960s with subsequent hardware removal, upper lumbar fusion approximately 1 year ago. He then unfortunately became infected and has the hardware removed and treated with IV antibiotics for approximately 7 months. Patient does complain of on and off numbness and tingling in his lower extremities but denies any weakness or any changes with bowel and bladder. Patient has not had any surgical procedures to his left hip.

He describes his left shoulder pain as worse at approximately 90 degrees of flexion and then trying to reach and perform activities above his shoulders. Denies any symptoms in his upper extremities.

PAST MEDICAL HISTORY: As per intake sheet.

ALLERGIES: BACLOFEN.

PAST SURGICAL HISTORY: Right total shoulder arthroplasty by [Dr U-] 1-1/2 years ago; left total knee replacement by a physician approximately 5 years ago; T-spine fracture with fusion in 1962; lumbar fusion in 2/2016 with subsequent hardware removal a few months later compromised with diagnosis of osteomyelitis and IV vancomycin for approximately 7 months; lumbar decompression, L4-L5 approximately 1 week ago.

SOCIAL HISTORY: Patient lives locally here in the area. Denies use of tobacco or alcohol. Patient is currently retired. Denies any allergies to any metals and patient's right total shoulder and right total knee functions well.

PHYSICAL EXAMINATION:

LUMBAR SPINE: Patient does have a 4-cm incision with nylon sutures in place. He does have a thick, grayish, slightly purulent drainage on the 4 x 4. There is no erythema. There is no acute sign of infection on the skin and not able to express any fluid from the lumbar incision. Physical exam of the left hip, I can passively flex his left hip to approximately 110 degrees, pain with internal and external rotation, also pain with internal rotation of approximately 20 degrees, external rotation of approximately 35 degrees. Patient is tender to palpation over the proximal anterior quadriceps and mildly tender over the left greater trochanter. Patient's compartments and bilateral lower extremities are soft and nontender. Bilateral lower extremity strength is grossly graded at 5-/5. Patient does have some discomfort with axial compression of the left hip. Pelvis is stable. Patient has full active range of motion of the right knee and right hip. Has a well-healed midline knee incision on the right, approximately 7 cm. Physical exam of the right upper extremity, there is an anterior shoulder well-healed incision. Deltopectoral incision approximately 5 cm is also well healed. Active range of motion of his shoulder. Flexion is approximately 120 degrees with abduction 110 degrees. Nontender over the right shoulder. Physical exam of the left shoulder, he is tender on palpation of the left AC joint and subacromial bursa. Active range of motion is approximately 120 degrees with discomfort from 90 degrees all the way up to 120 degrees. External rotation is approximately 30 degrees. He does have positive impingement signs of Hawkins and Neer and also has weakness of the supraspinatus at 4-/5. Patient does not have a drop arm test. Patient is grossly neurovascularly intact.

DIAGNOSTIC DATA: X-rays reviewed of the left hip show no fracture or dislocation. MRI without contrast of the left hip showed no obvious labral tears, no acute fractures or bony abnormalities, no abscesses, essentially a negative MRI. X-ray of the shoulder was pending.

ASSESSMENT: A 71-year-old right-hand dominant white male with left rotator cuff syndrome and left muscular hip pain.

Case Study "C"

PLAN OF TREATMENT: X-ray of the left shoulder was ordered. We have asked to continue rehab, weightbearing as tolerated on the left lower extremity.

Patient is currently being treated with vancomycin through a peripherally inserted central catheter line, so a steroid injection does not appear appropriate at this time. Patient will be followed closely with rehab specific pain modalities for these 2 painful areas. Patient may need advanced imaging including MRI with contrast or treatment with p.o. steroids from the rehab services.

Back care is to continue with a patient's prior spine surgeon and rehab with [Dr H-]

FACILITY-Physician Progress Notes

DATE OF SERVICE: 04/06/2020

SUBJECTIVE: Patient was seen and evaluated today. He reported severe lumbar left gluteal region and anterior thigh pain. He was evaluated by his primary spine surgeon, Dr. B_ from [Hospital Name]. Dr. B_ would like to order MRI of lumbar spine with and without contrast for further evaluation. Initial recommendations then include injection to left trochanteric bursa. The patient is not a candidate for this. He is currently being treated for osteomyelitis. He denies any chest pain or shortness of breath.

Patient missed physical therapy today secondary to scheduled doctor's appointment.

OBJECTIVE:

VITAL SIGNS: Temperature 97.5, heart rate pressure 129/62.

GENERAL: Awake, alert, in no acute distress. **HEART:** Regular rate.

LUNGS: Unlabored breathing. **ABDOMEN:** Obese, soft, nontender. **EXTREMITIES:** No palpable edema.

IMPRESSION AND PLAN: ,

1. Low back pain with radicular pain to left anterior thigh. Patient is status post reexploration of L4-L5 with foraminotomies, removal of scar tissue and bony overgrowth due to osteomyelitis. He is to continue on IV vancomycin at this time. Repeat MRI of the lumbar spine with and without contrast will be ordered for further evaluation of patient's pain.
2. Acute on chronic pain syndrome. Patient to continue fentanyl patch with breakthrough oxycodone.
3. Constipation. The patient to continue on daily bowel regimen, stool softener and laxative.
4. Deep venous thrombosis prophylaxis. Continue daily Lovenox.
4. Neuropathic pain. Patient to continue daily gabapentin 700 mg t.i.d.

FUNCTIONAL ASSESSMENT: Modified independent with grooming, supervision with upper body dressing, total assist to lower body dressing, moderate assistance with bed to chair to wheelchair transfers and shower transfers.

FACILITY-Physician Progress Notes

DATE OF SERVICE: 04/13/2020

SUBJECTIVE: Patient was seen and evaluated today in therapy gym. He reported poor pain control at this time. We will increase patient's oxycodone to q. 4 hours as needed for pain. Patient was agreeable for trialing this. He will go for MRI of the left hip as his x-ray was unrevealing.

OBJECTIVE:

VITAL SIGNS: Temperature 98.5, heart rate 91, respirations 18, blood pressure 121/

HEART: Regular rate.

LUNGS: Unlabored breathing. **ABDOMEN:** Soft, nontender.

EXTREMITIES: With no palpable edema.

Case Study "C"

DIAGNOSTIC STUDIES: Hip x-rays 2 views completed on 4/5/2022 no acute bony

IMPRESSION AND PLAN:

1. Patient is a 71-year-old male, well-known to me from previous admission. He is status post exploration of L4-L5 with foraminotomies bilaterally with removal of scar tissue and bony overgrowth due to osteomyelitis. He is to continue comprehensive orthopedic rehabilitation with physical and occupational therapies. We will continue to authorize patient's narcotic pain management at this time. We will await MRI results of the left hip. Further recommendations as per orthopedic surgery_____.

FUNCTIONAL ASSESSMENT: Modified independent with grooming and upper body dressing, minimal assistance for lower body dressing, supervision with bed to chair to wheelchair transfers.

Discharge Summary: 4/15/2020

Date of admission: 4/05/20

Discharge diagnoses:

- Chronic low back pain with osteomyelitis of the lumbar spine
- Foraminal narrowing of the lumbar spine
- Non-insulin-dependent diabetes mellitus
- Hypertension
- Hyperlipidemia
- Chronic left shoulder pain secondary to rotator cuff tear
- Right lower extremity paresthesias
- Bilateral lower extremity weakness
- Chronic pain syndrome

Discharge to skilled nursing facility until he can participate fully in therapies.

IGC:

ETIOLOGIC:

TIER:

60% QUALIFIER:

COMMENTS:

Coder Summary:

Principal Diagnosis:

S32.059B Unsp fracture of fifth lumbar vertebra, init for opn fx

Secondary Diagnoses:

S31.811D Laceration w/o foreign body of right buttock, subs encntr

R26.2 Difficulty in walking, not elsewhere classified

R29.898 Oth symptoms and signs involving the musculoskeletal system

R53.1 Weakness

S32.049D Unsp fx fourth lum vertebra, subs for fx w routine healing

D72.829 Elevated white blood cell count, unspecified

Pre-Admission Screening

Etiology: L4-L5 spinal fractures due to gunshot wound of the spine, intradural bullet, paraparesis, subdural hematoma

Date of screening: 3/09/22

A 34 year old male who presented to the ED with a gunshot wound to the back, overlying the buttock. At a party when it occurred but had no alcohol found in his system. Impression: gait disturbance, right leg weakness, s/p laminectomy L4-L5, L5-S1 due to gunshot wound, previous craniotomy. No obvious spinal cord or bladder issues.

ADMISSION MOTOR SCORE: 28

History and Physical

*** Final Report ***

Patient: [PATIENT]

Age: **34 years** Sex: **Male** DOB: [removed]

Associated Diagnoses: **Right leg weakness; Abnormal gait; Gunshot wound of right side of back with complication**

Date of Service: 03/11/2022.

Chief Complaint

Reason for Rehab

right leg weakness with difficulty walking

History of Present Illness

34-year-old gentleman who presented to [Hospital] after a gunshot wound to the right buttock/low back. He states that he was at a party where he was shot in the right buttock and lower back. He describes pain in his lower back with 7/10 in intensity without radiation, but had some numbness and paresthesias in the right foot. No bowel or bladder symptoms were reported. He was taken to the operating room by [Dr H-] on March for L4-5 spinal fractures, intradural bullet and paraparesis. He had L4-5, L5-S1 laminectomy with excision of the bullet from the intradural space and removal of subdural hematoma, repair of dural laceration was also done. Postoperatively, he has done well. He has some weakness residual in the right leg. No bowel or bladder problems. PT/OT has assessed the patient and he is still needing assist with ADLs and ambulation. Patient is transferred to IPR unit today to regain independence.

Social & Psychosocial Habits

Alcohol Use: Current
Type: Liquor

Substance Abuse
Use: Current
Type: Marijuana

SOCIAL HISTORY: Lives with his girlfriend in an apartment where there are 3 steps to enter the building and one flight of stairs to his apartment. He was totally independent without assistive device prior to admission.

Physical Examination
VS/Measurements

Vital Signs

03/11/2022
14:29

Heart Rate (bpm)
Pulse Oximetry
Oxygen Therapy
Respiratory Rate
Systolic Blood
Pressure
Diastolic Blood
Pressure

91 bpm
96
Room air
20 BrPM
124 mmHg
67 mmHg

03/11/2022
14:29
03/11/2022
14:27

General: Alert and oriented, No acute distress.

Eye: Pupils are equal, round and reactive to light.

HENMT: Normocephalic.

Neck: Supple.

Respiratory: Lungs are clear to auscultation, Respirations are non-labored, Breath sounds are equal.

Cardiovascular: Normal rate, Regular rhythm, No murmur, No gallop.

Gastrointestinal: Soft, Non-tender, Non-distended, Normal bowel sounds.

Integumentary: right low back incision is healing without any drainage, right upper medial buttock GSW entrance wound.

Mental status/ Cognition

Alert.

Oriented x 4.

Speech and language intact.

Cognition intact.

Psychiatric: Cooperative, Appropriate mood & affect.

Cranial Nerves: Cranial nerves II - XII grossly intact.

Sensorimotor/ Reflexes

Motor examination, upper extremity strength is good. Left lower extremity strength is good. Right lower extremity strength is limited in hip flexion due to pain, but also limited in right gluteus medius strength, hamstrings and dorsiflexors. Dorsiflexors are over 5, hamstrings are 2/5, gluteus medius is also 1-2/5. Remainder of the exam is 4/5 or better in the right leg.

Dysesthesias are noted with numbness in the right foot, more so on the dorsum of the foot. Cerebellar exam is intact in the upper extremities.

Sodium	139 mMol/L
Potassium	3.5 mMol/L
Chloride	100 mMol/L
Carbon Dioxide	30 mMol/L
Anion Gap	9 mMol/L
Glucose	135 mg/dL HI
Urea Nitrogen (BUN)	14 mg/dL
Creatinine	0.96 mg/dL
Calcium	9.0 mg/dL
GFR for African Amer	112 mL/min/1.73 m2
GFR for Other Races	93 mL/min/1.73 m2
WBC	12.9 K/CUMM HI
RBC	3.80 M/CUMM LOW
Hemoglobin	11.1 gm/dL LOW
Hematocrit	34.5 LOW
MCV	90.8 FL
MCH	29.2 pg
MCHC	32.2 LOW

Impression and Plan

Diagnosis

Right leg weakness (ICD-10-CM R29.898, Admitting, Medical).

Abnormal gait (ICD-10-CM R26.9, Admitting, Medical).

Gunshot wound of right side of back with complication (ICD-10-CM S21.201A, Admitting, Medical).

Impairments: Monoparesis.

Disabilities/Handicaps: Decreased: Mobility, Ability to self-care.

Limiting factors: Pain.

Safety/Precautions: Weight bearing: As tolerated.

Nursing goals:

Medication monitor for treatment: Effects, Adverse reactions.

Bladder: Continent.

Bowel: Continent.

Skin: Wound healing.

Pain/Sleep: Decrease pain level.

Occupational therapy goals: Modified independent, Equipment/ DME assessment.

Preliminary Plan of Care: OT therapy 5-6x/week for 0.5 - 2.5 hours, 7 days of therapy.

Physical therapy goals: Equipment/DME assessment.

Preliminary Plan of Care: PT therapy 5-6x/week for 0.5 - 2.5 hours, 7 days of therapy.

Pt/Family Goals: Return to premorbid status.

Rehab Prognosis: Excellent.

Code Status: Full code.

Stable for IPR: Yes.

Medical Plan

DVT prophylaxis

: low molecular weight heparin.

Pain: neuropathic, postoperative, controlled.

Estimated length of stay: 7 days.

Disposition: home with caregiver.

Medical Necessity: 24 hour rehabilitation nursing due to: skin/ wounds and pain management.
24 hour physician services due to: Pain.

Post Admission Physician Evaluation:

Documentation Reviewed: I have reviewed the Preadmission Screen.
Functional status documented at preadmission: I agree with the patient's current functional status as documented in the preadmission screening.
Risk for complications: I agree with the risk for clinical complications documented in the preadmission screening.
Medical conditions: The patient's medical conditions can be managed in the rehab hospital.
Patient participation in therapy: The patient can participate in, and will benefit from an intense therapy program at least 3 hours per day / 5 days per week. Therapies/services include:, Physical therapy, Occupational therapy, Rehabilitation Nursing, Psychology.

IMPRESSION/PLAN:

- Gait disturbance.
- Right leg weakness.
- Status post laminectomy L4-L5, LS-S1 due to gunshot wound.
 - continue with comprehensive IP rehabilitation program 3 hours/day including PT/OT/Rehab RN to work on gait, transfers, self care, wound care, bowel/bladder care
 - wound care
 - monitor bowel and bladder function
 - pain management
- Leukocytosis
 - no evidence of infection, trending down
- DVT ppx
 - Lovenox

Patient: [PATIENT]
Age: **34 years** Sex: **Male** DOB:
Associated Diagnoses: **None**

Date of Service: 03/14/2022

Basic Information

Pt is S/P GSW to R. buttock and low back which required surgical intervention for spinal fractures and the removal of a bullet in the intradural space. Pt. has R. leg weakness.

He is alert and fully oriented and able to give a coherent history. He said he lost consciousness at some point in the shooting incident but he did not sustain a head trauma and he does not notice any cognitive or memory changes now. He denied any signs of depression and he denied anxiety. He was hesitant at first to talk about the incident itself but did eventually give his account of what happened. He said he had pain but did not specify the level. He felt he was doing well in therapy so far. He voiced his intention to avoid the circumstances that surrounded his injury. He seemed to have goals for the future but may need reassurance as he progresses in treatment. I will monitor his emotional adjustment during his rehabilitation stay.

OX. Rule out Adjustment Reaction with anxiety.
F43.22

Progress Note

Patient: [PATIENT] Age: **34 years** Sex: **Male**
Date of Service: 03/15/2022
Associated Diagnoses: **None**

Subjective

CC: weakness

Subjective: Patient reports drainage from lumbar wound. No fevers, chills. No new complaints of chest pain, shortness of breath, no difficulty eating, no swelling and no headaches.

Impression and Plan

- Gait disturbance/Difficulty walking
- Right leg weakness due to right sciatic nerve injury.
- Status post laminectomy L4-L5, L5-S1 due to gunshot wound.
 - continue with comprehensive IP rehabilitation program 3 hours/day including PT/OT/Rehab RN to work on gait, transfers, self care, wound care, bowel/bladder care. PT and OT evals reviewed/discussed. -wound care
- monitor bowel and bladder function
- 3/13:Transfers and sit to stand are Min assist at this time
- 3/14: current status noted, continue IPR
- 3/15: patient observed walking to sink for ADLs, excellent progress., continue progress, monitor wound, no evidence of infection

- borderline low K+
3/13 Reck lytes at 2100: Discussed with RN
3/14: K-4.0

- pain management: Continue norco 10/325 which was started 3/12 due to pain increased.
3/13 discussed with RN: last norco 10 dose given today 5am
3/14: better pain control with inc in pain meds

- Leukocytosis
 - no evidence of infection, trending down
- 3/13 repeat cbc
- 3/14: WBC 11.9; trending down, VSS, afebrile

- DVT ppx
 - cont Lovenox

- Prognosis:
Good
ELOS 1-2 weeks

Discharge Summary: 3/16/22

Date of admission: 3/11/22

Discharge diagnoses:

- Right leg weakness
- Abnormal gait
- Gunshot wound of right side of back with complication
- Diabetes

Patient discharged to home with family.

IGC:

ETIOLOGIC:

TIER:

60% QUALIFIER:

COMMENTS:

Coder Summary:

Admitting Diagnosis:

G90.523 Complex regional pain syndrome I of lower limb, bilateral

Principal Diagnosis:

G90.523 Complex regional pain syndrome I of lower limb, bilateral (DRG)

Secondary Diagnoses:

G62.9 Polyneuropathy, unspecified

G82.22 Paraplegia, incomplete (CC excluded)

E66.9 Obesity, unspecified

N80.9 Endometriosis, unspecified

B27.00 Gamma herpes viral mononucleosis without complication

F44.6 Conversion disorder with sensory symptom or deficit

G89.4 Chronic pain syndrome

R26.2 Difficulty in walking, not elsewhere classified

R60.0 Localized edema

F43.21 Adjustment disorder with depressed mood

M47.816 Spondylosis w/o myelopathy or radiculopathy, lumbar region

Z87.442 Personal history of urinary calculi

M62.838 Other muscle spasm

G47.9 Sleep disorder, unspecified

R30.0 Dysuria

R11.0 Nausea

R39.15 Urgency of urination

Z79.891 Long term (current) use of opiate analgesic

Pre-Admission Screening:

Etiology: G62.9 chronic pain syndrome, polyneuropathy, G89.4

Date of screening: 3/14/22

A 35-year-old female who was well until approximately 3 months prior when she developed a complication from UTI associated with kidney stones. Since then, patient has had an exacerbation of her previously diagnosed regional pain syndrome, which she had as a child with associated neuropathy, increased difficulty with walking and increased severity of pain to the lower extremities. She woke up early yesterday morning and was unable to move her legs. At that point, EMS was activated and patient eventually was transferred to our facility.

Impression and comorbidities: Lower extremity graft paralysis, possibly psychogenic pending lumbar MRI, complex pain syndrome, generalized anxiety disorder, chronic neuropathy, chronic EBV infection, endometriosis

ADMISSION MOTORSCORE: 25

History and Physical

DATE OF SERVICE:

03/16/2022

CHIEF COMPLAINT:

Leg weakness.

HISTORY OF PRESENT ILLNESS:

This is a 34-year-old female with complex pain issues, who states she has chronic regional pain syndrome, but currently she had a stent placed because of ureteral stone, which flared up her lower extremity weakness.

She said the last time she walked was 2 days ago _____ move her legs all and usually when she has one leg and not as bad. She states she is unable to walk, so she came in to the hospital where routine investigations were done including MRIs, but this did not show anything acute or anything causing her leg paralysis. Her arms are also little weak and little tingly. She is still complaining of significant back pain and she goes to a pain management doctor and she was also diagnosed with chronic regional pain syndrome. The patient is now admitted for further evaluation and treatment.

PAST MEDICAL HISTORY:

Significant for chronic pain, endometriosis, chronic neuropathy, chronic EBV infection, polyneuropathy, obesity, lumbar spondylosis, sleep disorder

PAST SURGICAL HISTORY:

Significant for exploratory laparotomy, cholecystectomy, appendectomy, L5-S1 laminectomy, ureteral stent placement and over 30 epidural steroid injections.

FAMILY HISTORY:

Reviewed, significant for coronary artery disease, CVA, diabetes and lung cancer.

REVIEW OF SYSTEMS:

A 14-point review of systems is negative except for the significant back pain and lower extremity paralysis as described in the HPI. She denies any fecal or urinary incontinence.

SOCIAL HISTORY:

She does not smoke. Occasionally drinks. Does not use any illicit drugs.

ALLERGIES:

BACLOFEN.

PHYSICAL EXAMINATION:

Vitals: Temp is 97, pulse 93, regular, respirations 18, blood pressure 113/73, O2 sat 97. On examination, she is currently lying comfortably on the bed in no acute distress. HEENT: Atraumatic, normocephalic. Mucous membranes are moist. Neck: Supple. Heart sounds normal and regular. Lungs sounds are clear. Abdomen: Soft, nontender. Extremities: No acute deformity, edema or cyanosis noted. Skin: Warm and dry. Neuropsych: She is euthymic, alert, awake, oriented x 3. Cranial nerves II through XII grossly intact. Power is 4/5 in the upper extremities, 0/5 in the lower extremities with normal reflexes and sensations.

LABORATORY DATA:

White count 7.9~ hemoglobin 13, platelets 199. Prealbumin 29, BUN and creatinine of 20 and 0.9. Sodium 142, potassium 4.1. MRI of the C-spine does not show anything acute. MRI of the brain was negative. MRI of T-spine was negative. The lumbar spine does not show an acute, but it shows DJD and disk disease at the lumbar levels.

ASSESSMENT:

1. Chronic regional pain syndrome.
2. Lower extremity paralysis secondary to the above.
3. Chronic pain.
4. Neuropathy .
5. Chronic EBV infection.
6. Obesity.
7. Endometriosis.

PLAN:

The patient is currently admitted to IRF. She will continue with the transfer medications. In the meantime, PT, OT will come and evaluate the patient's to see how she does. Plan has been discussed with the patient.

Progress Note 3/15/22

Subjective: Patient says she's had no changes. Pain management doctor says no changes to the current treatment are necessary.

Objective: Temperature 97.9, Pulse 93, BP 113/73, Respiratory Rate 18 and saturations 97%.

Impression:

- 1) Bilateral lower extremity paralysis-intact sensation-working diagnosis is conversion disorder
- 2) Chronic EBV
- 3) Pain

Psychology Consult: 3/16/22

Subjective: Working diagnosis is conversion disorder as her physical presentation is not consistent with a medical diagnosis. She does have some risk factors for a psychogenic condition, but it is too soon to be definitive from my perspective. The differential diagnosis would be factitious disorder.

Discharge Summary: 3/30/22

Date of Admission: 3/15/22

Discharge diagnoses:

- Chronic regional pain syndrome, severe
- Paraplegia secondary to the above with intense psychological overlay
- Chronic pain syndrome
- Chronic EBV infection
- Peripheral neuropathy
- Obesity
- Endometriosis
- Gravity dependent, lower extremity edema.

Discharge to SNF.

IGC:

ETIOLOGIC:

TIER:

60% QUALIFIER:

COMMENTS:

Coder Summary:

Admitting Diagnosis:

M48.56XA Collapsed vertebra, NEC, lumbar region, init (DRG)

Principal Diagnosis:

M48.56XA Collapsed vertebra, NEC, lumbar region, init (DRG)

Secondary Diagnoses:

N390 Urinary tract infection, site not specified (CC) (DRG)

M54.5 Low back pain

G62.9 Polyneuropathy, unspecified

R53.1 Weakness

M62.830 Muscle spasm of back

I10 Essential (primary) hypertension

E78.5 Hyperlipidemia, unspecified

Z79.01 Long term (current) use of anticoagulants

E87.6 Hypokalemia

B96.20 Unsp Escherichia coli as the cause of diseases classd elswhr

Pre-Admission Screening

Etiology: Recent total hip arthroplasty with a readmission for encephalopathy and disorientation and a greater weakness.

Date of screening: 2/15/22

Patient is an 86 year old female who has a PMH significant for severe peripheral neuropathy with history of related multiple falls. Patient stated she was standing up tying her bath robe when she lost her balance and fell backward onto the floor on her back. Taken to emergency room immediately. CT of the spine revealed a superior endplate compression fracture of L1 which appears likely to be acute. Patient was admitted and underwent kyphoplasty.

Comorbidities: L1 vertebral closed compression fracture s/p kyphoplasty, severe peripheral neuropathy, chronic kidney disease, possible hypertensive nephropathy, HTN, CAD s/p lateral MI, no PCI, OA, HLD, back pain, constipation

ADMISSION MOTOR SCORE: 26

HISTORY AND PHYSICAL AND POST-ADMISSION PHYSICIAN EVALUATION

DATE OF ADMISSION: 2/16/22

CHIEF COMPLAINT: Back pain secondary to L1 compression fracture and weakness due to polyneuropathy.

HISTORY OF PRESENT ILLNESS: [Patient] is an 86-year-old white female with a history of severe peripheral neuropathy. Her husband reports that it is "idiopathic" and that there has been no history of diabetes and she has had this diagnosed for several years. She has progressively gotten weaker with regard to her legs and having more difficulty getting around and taking care of herself. She tends to walk with a walker or a cane prior to the events that brought her into the hospital this time. She was admitted to the hospital on 2/9/2022. She has a history of multiple falls. She was standing up, tying her bathrobe when she lost her balance and fell backwards, onto the

floor, onto her back. She called out her husband and had her brought to the Emergency Room. A CT of the spine revealed a superior endplate compression fracture of L1, likely to be acute. The patient was admitted, seen by an old family friend and [Dr N-]; also for L1 owed by [Dr R-], hospitalist; and [Dr V-], surgery. [Dr V-] ended up taking the patient for kyphoplasty of L1, which was done on 2/15th per [Dr V-]. The patient is now more stable postoperatively and needs comprehensive rehabilitation to help her regain her mobility, strength and independence.

PAST MEDICAL HISTORY: Notable for hypertension, severe peripheral neuropathy, osteoarthritis, hyperlipidemia, coronary artery disease, status post myocardial infarction, cholecystectomy, hysterectomy, bladder repair in the past, cataracts.

ALLERGIES: PENICILLIN AND SULFA.

She also has now had constipation. She was not eating very well during the first part of her stay. She is taking pain medicine and not being very active, so she reports constipation. Her husband reports that she is having some urinary incontinence. She apparently had a workup for urinary incontinence a few years ago and has been more stable with it recently but is now having some difficulty. She will call for help and by the time the help arrives to help her get to the toilet, she will stand up and then lose control of her bladder. It would probably be appropriate to put her on a bladder program right off and have her empty her bladder regularly every 2 hours preemptively.

DIET: Cardiac.

FAMILY HISTORY: Noncontributory.

SOCIAL HISTORY: The patient previously was independent prior to coming into the hospital. She uses a cane or a walker for ambulation and she does not drive. The patient does live as noted previously with her spouse in a 2-storey home. All of her needs are downstairs. There is only step at the entrance.

PRESENT FUNCTIONAL STATUS IN HER THERAPIES: She is moderate assistance with bed mobility, supine to sit, sit to stand and bed to chair transfers. She has ambulated as far as 5 feet with a rolling walker with minimal assistance with a rolling walker and short steps in a flexed posture. In occupational therapies, moderate assistance with upper body bathing and dressing, independent with lower body bathing and dressing. There are no speech therapy issues at this time.

Extensive workup includes the following : CT of the head was done on 2/9 showing no acute abnormality, chronic small -vessel ischemic or hypertensive changes and atrophy is noted. A CT of the lumbar spine indeed shows a superior endplate compression fracture of L1 likely to be acute. No other fractures noted. Pelvic x-ray on 2/9th shows no pelvic fracture identified. There is chronic narrowing of the left hip and to a lesser extent, the right hip. X-ray of the lumbar spine shows loss of height involving the superior endplate of L1 vertebral body, corresponding to compression fracture, no other interval change.

NOTABLE LABORATORY DATA: Include the following : CBC on the day of this dictation shows a white count of 7.50, hematocrit is 38.0 and these results were stable and consistent with the previous CBC results.

A comprehensive metabolic panel is notable for a potassium today of 3.2, BUN of 23, otherwise benign. Troponin was 0.012 on 2/9th.

REVIEW OF SYSTEMS: She notes that her appetite has been somewhat poor. She was not eating very well, maybe a little bit better now. No shortness of breath. No pain in her chest. She does have pain in her back, which as we were talking was a 10 on a scale of 0-10. She is noted to be constipated with no diarrhea. She also notes that she has incontinence of bladder. Other than that, her review of systems is essentially negative and benign.

MEDICATIONS ON ADMISSION: Include the following: Amitriptyline 50 mg p.o. at bedtime, Lipitor 20 mg p.o. daily, calcium with vitamin D 1 p.o. b.i.d. with meals, Plavix 75 mg p.o. daily, cyclobenzaprine 10 mg p.o. t.i.d. p.r.n. muscle spasms, folic acid 0.4 mg p.o. daily, Lasix 40 mg p.o. daily, heparin 5000 units subcutaneously q.12 hours,

Lidoderm patch, losartan 50 mg p.o. daily, Toprol-XL 25 mg p.o. b.i.d.; multivitamin 1 p.o. daily, 5-10 mg p.o. q.4 hours p.r.n. pain, Protonix 40 mg p.o. b.i.d., MiraLax p.r.n. for constipation. I have added potassium chloride 20 mEq p.o. daily and Carafate 1G p.o. q.i.d.

PHYSICAL EXAMINATION:

GENERAL: This is a well-developed, well-nourished, somewhat obese white female who is alert and oriented x 3. she is in acute discomfort, occasionally having muscle spasms in her back that affect her comfort in sitting still. She has no other specific issues except as noted above on request.

NEUROLOGIC~ Her cranial nerves are noted to be intact.

NECK~ Supple.

LUNGS: Clear.

HEART: Regular rate and rhythm.

ABDOMEN: Nontender, nondistended with normal bowel sounds.

EXTREMITIES: Both upper extremities show good strength and range of motion throughout. Both lower extremities have antigravity minus strength throughout. There is dorsiflexion present, but it is quite weak, Her grips are weak, but are fairly benign as well.

DIAGNOSES:

1. L1 compression fracture, status post kyphoplasty.
2. Known history of polyneuropathy, idiopathic type.
3. Muscle spasms secondary to L1 compression fracture.
4. Hypertension.
5. Polyneuropathy
6. Hyperlipidemia,
7. Heparin for venous thromboembolism prophylaxis.
8. Pantoprazole for gastroesophageal prophylaxis.
8. Hypokalemia. We will start supplemental potassium.

POST-ADMISSION PHYSICIAN EVALUATION: I saw [Patient] today in her room. I have admitted her for rehabilitation. I have reviewed her preadmission evaluation. I have reviewed her chart from [Hospital B], which is where she came from. I have also interviewed her and examined her. Based upon all of the above information, I attest to the fact that her post-admission physician evaluation is an accurate representation of her present clinical status. Also, I believe she can tolerate 3 hours of therapies a day for an average of 5 days a week or more.

She has multiple medical issues that will need close monitoring to be safe, especially issues that relate to further falls with her weakness due to her polyneuropathy.

We will need to monitor her potassium regularly. She is started on oral potassium and that will need to be monitored and checked periodically. I am going to start her on muscle spasm medication to try to help muscle spasms in her back. She is having a great deal of pain and a lot of it is muscular. She remains on heparin for venous thromboembolism prophylaxis and remains on pantoprazole for gastroesophageal prophylaxis. She remains on MiraLax for her constipation as well .

I believe she can tolerate 3 hours of therapies a day for an average of 5 days a week or more. We are going to need to be more concerned about her pain control. She has been on Lortab 10/325 one q.4 hours. I am going to change her oxycodone at a somewhat higher potential dose p.r.n. for pain, which should help her control her pain better. I have discussed this with the patient, who understands. Also, I am going to put her on a bladder program where she will be put on the toilet every 2 hours when awake and all owing her to void preemptively, so we can cut down on her incontinence and work on her being more mobile and independent.

Her program will include physical therapy will see her 5-6 days a week, 1-2 sessions a day, working on strength, endurance and mobility and occupational therapy will also see her 5-6 days a week, 1-2 sessions a day, working on activities of daily living, independence and self-care.

I believe she can tolerate therapies, though they may be slow to begin with in particular because of the pain, but I believe she has fair to good prognosis to be able to improve in PT and OT to go to the point where she can go home with her husband, which is what her plan is to do after discharge. I would estimate her length of stay to be approximately 2 weeks.

PHYSICAL MEDICINE AND REHABILITATION FACE-TO-FACE NOTE

SUBJECTIVE: I saw [Patient] today in her room. She reports that she did not sleep well last night, but she seems to have a little bit more energy today. I talked to both the son and the husband who thinks that she seems to be doing a little bit better today. She has no new complaints, specifically today.

OBJECTIVE:

GENERAL: She is alert, conversant and appropriate.

VITAL SIGNS: She is afebrile blood pressure 117/68, pulse 66 and respirations 18.

LABORATORY DATA: Today, the white count is 7.10. The hematocrit is 32.6. The last hematocrit was 37.1 on the 19th. I will recheck tomorrow and Check stools for occult blood. Urinalysis on 2/20 shows 182 white cells or more with 1 red cell and urine culture is presently growing out greater than 100,000 lactose fermenting gram-negative bacilli, culture and sensitivity pending. A basic metabolic panel today shows a BUN of 23, which is actually improved over previous levels.

FUNCTIONAL STATUS: She continues to participate in her therapies. She is ambulating 22 feet with a rolling walker with minimal assistance at this time.

ASSESSMENT/PLAN:

1. L1 compression fracture, status post kyphoplasty. Physical and occupational therapies continue. The first team conference is tomorrow. She is having a good deal of pain, but she seems to be doing somewhat better.
2. Drowsiness or lethargy. Note that she may have a urinary tract infection and she had some drop in her hematocrit. We will explore these issues further. Her pain medicines are now stable, and she seems to be more stable.
3. Known history of polyneuropathy idiopathic type. Physical and occupational therapies continue.
4. Muscle spasms secondary to L1 compression fracture, on cyclobenzaprine p.r.n.
5. Hypertension. Blood pressures are good.
6. Hyperlipidemia, stable.
7. Heparin for venous thromboembolism prophylaxis, stable.
8. Pantoprazole for gastroesophageal prophylaxis, stable.
9. Hypokalemia. improved and stable.
10. A 5 point drop in hematocrit in 3 days. We will recheck CBC tomorrow and we will check stools for occult blood.
11. possible urinary tract infection with leukocytosis in the urine and greater than 100,000 lactose fermenting gram-negative bacilli. Await culture and sensitivity.

PHYSICAL MEDICINE AND REHABILITATION FACE-TO-FACE NOTE

DATE OF SERVICE: 02/24/2022

SUBJECTIVE: I saw [Patient] today in the physical therapy gym accompanied by her husband. She has no new complaints. She does report continued arthritic pain, particularly in her left shoulder last night. She was on Daypro for that at home, apparently had some GI issues at one point, stopped having the GI issues and was started back on that by her primary doctor and she is requesting she be put back on it. I believe she can tolerate it and I believe that will help her.

OBJECTIVE:

GENERAL: She is alert, conversant and appropriate.

VITAL SIGNS: She is afebrile, blood pressure 128/57, pulse 65 and respirations 18.

LABORATORY DATA: stool was negative for occult blood on 2/23 and the white count was 35.1

FUNCTIONAL STATUS: [Patient] continues to participate in her therapies and seems to be having more energy today. She has ambulated 40 feet with a rolling walker with minimal assistance of 2.

ASSESSMENT/PLAN:

1. L1 compression fracture, status post kyphoplasty. Physical and occupational therapies continue. Discharge is targeted for 3/4 with outpatient physical and occupational therapies, rolling walker, bedside commode and wheelchair.
2. Drowsiness or lethargy, improved, probably secondary to urinary tract infection.
- ... 3. Known history of polyneuropathy, idiopathic type. Physical and occupational therapies continue.
4. Muscle spasms secondary to L1 compression fracture on cyclobenzaprine p.r.n., stable.
5. Hypertension. Blood pressures are good.
6. Hyperlipidemia, stable.
7. Heparin for venous thromboembolism prophylaxis, stable.
8. Pantoprazole for gastroesophageal prophylaxis, stable.
9. Hypokalemia, improved and stable.
10. Hematocrit improved today over recent levels, stable.
11. Urinary tract infection with Escherichia coli, on Levaquin for treatment

Discharge Summary: 3/04/22

Date of admission: 2/16/22

- L1 compression fracture, status post kyphoplasty
- Drowsiness or lethargy
- History of polyneuropathy, idiopathic type
- Muscle spasms secondary to L1 compression fracture
- Hypertension
- Hyperlipidemia
- Heparin for venous thromboembolism prophylaxis
- Pantoprazole
- Hypokalemia
- Hematocrit
- UTI, fully treated with Levaquin

Discharge to home with home health services.

IGC:

ETIOLOGIC:

TIER:

60% QUALIFIER:

COMMENTS:

AQ-IQ IRF PRO LAB Case "G"

Coder Summary:

Admitting Diagnosis:

G45.9 Transient cerebral ischemic attack, unspecified

Principal Diagnosis:

G45.9 Transient cerebral ischemic attack, unspecified

Secondary Diagnoses:

I10 Essential (primary) hypertension

I69.354 Hemiplegia following cerebral infarct affecting left nondominant side (CC)

R00.1 Bradycardia, unspecified

I82.532 Chronic embolism and thrombosis of left popliteal vein (CC)

Z79.899 Other long term (current) drug therapy

Z79.01 Long term (current) use of anticoagulants

E78.5 Hyperlipidemia, unspecified

K21.9 Gastro-esophageal reflux disease without esophagitis

H40.9 Unspecified glaucoma

I48.91 Unspecified atrial fibrillation

K57.90 Diverticulosis of intestine, part unspecified, without perforation or abscess without bleed

R26.9 Unspecified abnormalities of gait and mobility

R25.2 Cramp and spasm

I69.322 Dysarthria following cerebral infarction

Z91.81 History of falling

R29.6 Repeated falls

R26.0 Ataxic gait

R60.9 Edema, unspecified

R45.87 Impulsiveness

Pre-Admission Screening

Etiology: DVT of popliteal vein, uncontrolled blood pressure

Date of screening: 4/13/22

73 year old woman referred for evaluation of possible stroke. Patient has a history of stroke on December 31st which left her with residual left hemiparesis and dysarthria. She has been receiving outpatient rehab and yesterday at PT appointment when she seemed to be weaker than usual and had decreased coordination, patient's blood pressure was reportedly 216/80. Went home after blood pressure lowered, but then had difficulty later and family returned her to the ER. Blood pressure then noted to be 209/93. A CT scan of her brain was performed which showed encephalomalacia in the left basal ganglia as well as hypodensity in right corona radiata of uncertain age. No hemorrhage or edema noted. Ultrasound of her left lower extremity showed a deep vein thrombosis.

Comorbidities: Hypertension, hyperlipidemia, GERD, glaucoma; hx of aFib and diverticulosis

ADMISSION MOTOR SCORE: 31

HISTORY AND PHYSICAL EXAM**DATE:** 04/16/2022

Post-admission evaluation, preadmission screen has been reviewed.

compared to preadmission screen, there are no identifying relevant changes in functional status, discharge plan or living conditions that have occurred. The patient is expected to benefit and participate in center for rehab at this time and expected to benefit and participate in 3 hours of therapy a day 5-7 days a week.

HISTORY OF PRESENT ILLNESS: The patient is a very pleasant 72-year-old female who was primarily admitted to the acute rehabilitation unit after CVA with left hemiparesis. She was doing fairly well at home in outpatient rehabilitation when blood pressure began to elevate. She also felt like she had some increasing left-sided weakness. She was brought to the emergency room. Initial stroke was ruled out. However, she did need multiple medication adjustments. She was seen by cardiology, also found to have DVT of left lower extremity. She did also suffer a fairly significant decline in function as she is transferred here for further care at acute inpatient rehabilitation.

PAST MEDICAL HISTORY: Includes hypertension, hyperlipidemia, GERD, glaucoma, old CVA, left-sided weakness, atrial fibrillation, diverticulosis.

SOCIAL HISTORY: Lives with daughter single family home, 4 steps to enter. No tobacco, ETOH history.

PRIOR FUNCTIONAL HISTORY: The patient was mod I for ambulation, contact guard assist for ADLs, current min assist for transfers and bed mobility.

ALLERGIES: SHE HAS ALLERGIES TO CODEINE, IBUPROFEN, PENICILLIN, ASPIRIN.

MEDICATIONS: Include metoprolol, Xalatan, Lipitor, Protonix, Eliquis, amlodipine, Norvasc.

CURRENT LABORATORY DATA: Show a hemoglobin of 12.0, hematocrit 35.7.

PHYSICAL EXAMINATION: 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. Her deep tendon reflexes are intact. Her left upper extremity shows 1-2 strength throughout. Her left lower extremity 3-3+ strength throughout. Her right-sided upper and lower extremity shows normal strength. Skin is intact.

IMPRESSION:

1. Increased left-sided weakness secondary to hypertensive emergency, now with better control of blood pressure.

2. Abnormality of gait.
3. Spasticity.
4. Lower extremity deep venous thrombosis.
5. Glaucoma.
6. Hyperlipidemia.

PLAN: The patient has suffered a decline of function. She has multiple medical comorbidities that need to be managed. She is an excellent candidate for acute inpatient rehabilitation where she will get physical therapy for general strengthening, range of motion, gait training, occupational therapy for ADLs, transfers, upper extremity strengthening. Goals will be for modified independent. Estimated length of stay is 2 weeks. Prognosis is good. Eventually, we will transition her to a day rehabilitation. Barriers to discharge include lower extremity DVT, poor balance, history of multiple strokes. The risks include skin breakdown, pulmonary embolism and further cerebral event. The patient will have weekly team conference. We will ask primary care physician to follow as well.

PROGRESS NOTE 04/18/22

SUBJECTIVE: The patient had issues with her blood pressure over the weekend. Systolic pressure still bumping into the 190s and 170s this morning and is at 126 systolic. She denies any headaches or increase in her paresthesias. Norvasc was increased as per cardiology.

PHYSICAL EXAMINATION: On examination, she is alert and oriented x3. Temperature 98.3, blood pressure 126/62, pulse 60 with a respiratory rate 18. CVS is S1, S2, regular rate and rhythm with no ankle edema in bilateral extremities. Abdomen is soft, nontender, nondistended. Lungs are clear to auscultation. Functionally, she is at min assist for transfers, min assist for lower extremity dressing.

IMPRESSION: Activities of daily living gait dysfunction with exacerbation of left-sided weakness due to hypertensive emergency, gait ataxia, falls, spasticity, glaucoma, hypertension. Impulsivity.

PLAN: Continue with inpatient PT, OT, speech with 24-hour rehab nursing. Norvasc is being increased. We will continue to monitor blood pressures, especially with activities today. We will use modalities to help with tone management, range of motion exercises. We can consider Botox if these were unsuccessful.

Progress Note: 4/22/22

The patient's blood pressure was somewhat elevated overnight, going into the 160s; however, this morning it is in the 120s. She denies any headaches or paresthesias. She denies any nausea or vomiting. She is noted to have impaired balance with narrow space of standing requiring verbal cues, especially for ADLs. She denies any nausea, vomiting or headaches.

PHYSICAL EXAMINATION: Temperature 97.5, blood pressure 126/59, pulse 57 with respiratory rate 18. Cardiovascular system: S1 and S2. Again there was no ankle edema in bilateral extremities. Abdomen: Soft, nontender, and nondistended. Lungs are clear to auscultation.

IMPRESSION: Activities of daily living gait dysfunction secondary to left-sided hemiparesis, status post cerebrovascular accident; dysarthria; gait ataxia; hypertension.

PLAN: Continue with inpatient PT and OT, speech with 24-hour rehab nursing. Norvasc was increased as per cardiology and it seems to be working. We will continue to monitor. She needs to be using assistive device at all times. As per team conference today, they had still recommended that she have 24-hour supervision at home. Discharge planning is for 04/29/2022. Please see attached note in the chart.

Progress Note: 4/25/22

SUBJECTIVE: The patient's blood pressure has now been stabilizing. She denies any nausea, vomiting, or headaches. Denies any double vision. Tone is controlled in the right upper extremity without increasing pain. She can have full range of motion. She is contact guard assist for bed mobility, contact guard assist for transfers, still needing some cues for safety, but _____ verbalize proper sequencing.

PHYSICAL EXAMINATION: Vital Signs: Temperature 97.2, blood pressure 128/69, and pulse 76 with a respiratory rate of 19. Cardiovascular: S1, S2 regular rate and rhythm with no ankle edema in bilateral extremities. Abdomen: Soft, nontender, and nondistended. Lungs: Clear to auscultation.

IMPRESSION: Activities of daily living gait dysfunction secondary to right-sided hemiparesis due to recent history of cerebrovascular accident, hypertensive emergency, increased tone which is stabilizing, and falls.

PLAN: Continue with inpatient PT, OT, and speech. Blood pressure is being maintained with increased dose of metoprolol, we will continue amlodipine. Heart rate now in the 70s instead of in the 50s. We will continue with the decreased dose of Toprol.

Discharge Summary: 4/29/22

Date of admission: 4/15/22

Reason for admission: Hypertensive urgency, exacerbation of left-sided hemiparesis, spasticity, dysarthria, dysphagia, gait ataxia

Discharge to home with home health services.

IGC:

ETIOLOGIC:

TIER:

60% QUALIFIER:

COMMENTS:

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 w/o 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 w/o resid deficits

Z90.49 Acquired absence of other specified parts of digestive tract

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,

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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, S1, 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

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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

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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 Lower 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 psychiatry.

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

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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:**

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TIER:

60% QUALIFIER:

COMMENTS

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Coder Summary:

DRG: 563 Fx, sprn, strn & disl except femur, hip, pelvis & thigh w/o MCC
Admitting Diagnosis:

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

Principal Diagnosis:

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

Secondary Diagnoses:

S18.11XA Laceration w/o 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 w/o 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

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.i.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,

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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 normocephalic, 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

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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.i.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.i.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, O2 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, CO2 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 seeded 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.

Case Study "J" AQ-IQ IRF PRO LAB

- 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

Case Study "J" AQ-IQ IRF PRO LAB

Patient discharged to home with family.

IGC:

ETIOLOGIC:

TIER:

60% QUALIFIER:

COMMENTS:

Patient Case "K" 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

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

Patient Case "K" AQ-IQ IRF-PRO Lab

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.

Patient Case "K" AQ-IQ IRF-PRO Lab

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 I-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 to non-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 impediment 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:

Case Study "L" AQ-IQ IRF-PRO LAB

Coder Summary:

DRG: 280 Acute myocardial infarction, discharged alive w MCC

Admitting Diagnosis:

I25.10 Athscl heart disease of native coronary artery w/o ang pctrs

Principal Diagnosis:

I25.10 Athscl heart disease of native coronary artery w/o ang pctrs (DRG)

Secondary Diagnoses:

E78.4 . Other hyperlipidemia

I35.0 Nonrheumatic aortic (valve) stenosis

R53.81 Other malaise

F03.90 Unspecified dementia without behavioral disturbance

R06.02 Shortness of breath

R05 Cough

J69.0 Pneumonitis due to inhalation of food and vomit (DRG) (MCC)

N17.9 Acute kidney failure, unspecified (CC)

I21.19 STEMI involving oth coronary artery of inferior wall (DRG) (MCC)

Pre-Admission Screening:

IGC: 16-Debility

Etiology: Myocardial infarction

Date of screening: 6/11/22

90 y/o male came to the ED on 6/6/22. Patient reported for week prior to admission he was having intermittent chest pains, describing them as a dull precordial pain, not radiating, accompanied with shortness of breath. He had been taking sublingual nitroglycerin with relief of the pain. Patient has a history of CAD. On admission to ED patient continued with complaints of shortness of breath, chest pain and nausea. EKG findings of diffuse ST depressions with ST elevations in lead AVR. Dr. Robinson performed an emergency cardiac catheterization on 6/6/22.

Comorbidities: hypertension, hyperlipidemia, CAD, congestive heart failure, aspiration pneumonia, renal insufficiency, dyslipidemia, weakness, CABG

Motor Score 34

History & Physical/Post Admission Physician Evaluation

REASON FOR CONSULTATION: To coordinate a multidisciplinary cardiac rehabilitation program following an acute posterior wall MI, to improve activities of daily living, self-care, functional mobilities, and safety awareness.

HISTORY OF PRESENT ILLNESS: [Patient] is an 90-year-old retired oncologic surgeon with a past history of CAD, status post CABG in 2019, hypertension, hyperlipidemia, carotid stenosis, status post endarterectomy, and mild dementia, who was in his usual state of good health until 6/6/2022, during his 90th birthday party with family, he developed substernal chest pressure. He did not share with his family that he was suffering at that time from mild discomfort; however, over the subsequent 24 hours, his chest pressure increased and became accompanied by nausea and shortness of breath. He denies emesis, pain radiation to the jaw nor upper extremities, diaphoresis nor palpitations. He alerted his family of his worsening symptoms, at which time, EMS was called and the patient was transported to [Hospital] for immediate evaluation. The patient was taken to the catheterization lab for coronary artery catheterization by [Dr L-] where right posterior coronary artery stenosis was found and for which a drug-eluting stent was placed. During the procedure, the findings also included a left ventricular ejection fraction of 55, severe aortic stenosis, and moderate-to-severe mitral regurgitation. Notably, prior to and during the procedure, the patient became hypotensive, reason to be secondary to cardiogenic shock and he was treated aggressively with pressors and post-procedurally transferred to the ICU for further care. Over the subsequent days, the patient has gradually improved and not complained of any recurrence of chest discomfort nor shortness of breath. He has been treated conservatively for a suspected partial small bowel obstruction and associated small bowel ileus, also with continued radiographic and clinical evidence of resolution. The patient has had remobilization efforts initiated in the acute care setting, which have included OT and PT where deficits were noted and consequently, he has been referred, and admitted to, [REHAB] in an effort to improve his activities of daily living, self-care, mobility, and safety awareness.

MEDICATIONS: Include aspirin, Plavix, Coreg, DuoNeb, Pepcid, nitroglycerin and Flomax.

REVIEW OF SYSTEMS:

GENERAL: The patient denies recent fever, chills, night sweats, or unexplained weight loss.

HEENT: Denies vertigo, tinnitus, otalgia, odynophagia, dysphagia, dysphasia, odontalgia, or neck pain.

CARDIAC: As per HPI.

LUNGS: The patient reportedly suffered a suspected mild aspiration peri-procedurally with pulmonary infiltrate, treated with intravenous antibiotics. The patient does complain of a minimally frequent nonproductive cough in recent days. He notices the cough is worse during the night or then the day. He denies a history of sinusitis nor recurrent sinus discomfort nor postnasal drip.

GASTROINTESTINAL: Denies nausea, vomiting, diarrhea nor constipation. He has resumed a regular diet and has a very good appetite. He denies abdominal pain, melena nor hematochezia.

GENITOURINARY: Denies dysuria, frequency, urgency nor hematuria. He has minimal urinary hesitancy, reportedly due to benign prostatic hypertrophy.

MUSCULOSKELETAL: The patient denies myalgias, arthralgias nor any joint deformities.

NEUROLOGIC: The patient has a fairly remote history of a TIA. Otherwise, denies history of stroke, focal

Case Study "L" AQ-IQ IRF-PRO LAB

neurologic deficit, nor tremor.

INTEGUMENT: The patient denies rashes, bruising, nor any unusual lumps or bumps. Denies skin breakdown.

PSYCHOLOGIC: The patient denies a history of depression. He verbalizes an optimistic outlook toward the near future and in particular, with respect to participating in the acute inpatient rehabilitation program for which he is admitted.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature 97.7, heart rate 78, blood pressure 150/64, current weight is 65 kg.

GENERAL: The patient is a well-developed, well-nourished, Hispanic gentleman in no acute distress. He is very cooperative and pleasant throughout the entire encounter.

HEENT: Normocephalic, atraumatic. Pupils equally round and reactive to light. Extraocular motions intact. No nystagmus. Oropharynx with moist mucosa and intact dentition, without obvious visible dental caries. The patient has no tenderness to palpation over the facial sinuses.

NECK: Trachea midline.

HEART: Regular rate and rhythm. The patient has a II/VI systolic murmur over the apex and I/VI systolic ejection murmur at the apex without radiation to the left axilla.

LUNGS: Clear to auscultation. There are no rhonchi nor rales appreciated.

ABDOMEN: Normoactive bowel sounds, nontender, nondistended. No masses appreciated to palpation in all 4 quadrants.

MUSCULOSKELETAL: No joint effusions nor joint deformities appreciated.

NEUROLOGIC: Cranial nerves II through XII are intact. Motor function in both upper extremities and lower extremities bilaterally are 4+/5. Sensation is intact to simple light touch in all 4 extremities. Deep tendon reflexes are intact. Negative Babinski's.

INTEGUMENT: No rashes nor skin breakdown. The patient has no groin hematoma. No appreciable bruising from his angiogram performed on 6/6/2022.

PSYCHOLOGIC: Patient's affect is bright. There is no evidence of depression or agitation. He is a fair historian; of note, his daughter was present during the history and physical examination to confirm and correct some historical details.

LABORATORY DATA: As of 06/16/2021, WBC 7.9, hemoglobin 9.4, hematocrit 27 with 330,000 platelets. Serum sodium 134, potassium 3.8, creatinine 1.35, BUN 22 and glucose 122.

MOBILITIES: Patient is at a contact guard, supervision level for activities of daily living and ambulation. He required min assist to contact guard for sit to supine and edge of bed from straight leg sitting.

IMPRESSION:

1. Acute posterior wall myocardial infarction, 6/6/2022, status post right coronary artery stent placement with drug-eluting device.
2. Deconditioning and debilitation, secondary to disuse following:
#1 above.

Nonproductive cough.

Cardiogenic shock following:

Case Study "L" AQ-IQ IRF-PRO LAB

Without residual deficits.

Functional abilities, no activities of daily living.

5. Suspected acute kidney injury with reportedly improving creatinine level since admission to acute care, 6/6/2022.

6. Mild dementia.

PLAN:

1. Comprehensive evaluations by physical therapy and occupational therapy for functional mobilities and activities of daily living, respectively. We will initiate and appropriately gradual reconditioning and strengthening program, status post acute myocardial infarction as well.

We will order Robitussin syrup 5 mL q.4 hours, per family request. We will initiate Naprosyn 375 mg p.o. q.12 hours p.r.n. low back pain (per family request) .

4. Routine bowel and bladder, monitoring and treatment, as necessary, medical management per attending, [Dr P-].

GOALS:

1. The patient will be independent with functional mobilities including gait, transfers and bed mobility, by the time of discharge.
2. Patient will become independent with activities of daily living including bathing, dressing, toileting by the time of discharge.
3. I will request a speech therapy consultation to evaluate the patient's higher level cognitive functions in view of the history of mild dementia, particularly as it pertains to safety awareness and carryover of learned information from therapy.
4. The patient will demonstrate appropriate safety awareness throughout.

Estimated length of stay, I would anticipate a length of stay of 7 days for the patient to achieve a safe and appropriate discharge back to the care of his family.

[Dr P-], thank you very much for allowing me the pleasure and privilege of participating in your patient's care. I will follow closely along to manage all aspects of his rehabilitation course.

Progress Note

SUBJECTIVE:

awake and alert, ambulating in hallway with PT, no new issues.

OBJECTIVE:

VITAL SIGNS:

Vital Signs:

Last Charted:

24 Hr Minimum:

24 Hr Maximum:

Case Study 4 SESSION "L" AQ-IQ IRF PRO LAB

Temp C Converted	36.6	(06/21 08:39)	35.7 (L)	(06/21 00:00)	36.6	(06/21 04:00)
TempF	97.9 (L)	(06/21 08:39)	96.2 (L)	(06/21 00:00)	98.2	(06/20 20:53)
Heart Rate	60	(06/21 09:31)	60	(06/21 08:39)	71	(06/20 20:53)
Resp Rate	18	(06/21 08:39)	16	(06/20 20: 15)	20	(06/21 07:25)
SBP	135	(06/21 09:31)	113	(06/21 04:00)	146 (H)	(06/20 20:53)

IMPRESSION & PLAN:

- 1 Acute posterior wall myocardial infarction, 6/6/2022, status post right coronary artery stent placement with drug-eluting device. cont therapy
 - 2 Deconditioning and debilitation, secondary to disuse following:
 - #1 above. Cont therapy
 - 3 Nonproductive cough. Better
 - A Cardiogenic shock following: Without residual deficits.
 - B Functional abilities, no activities of daily living.
 - 4 Suspected acute kidney injury with reportedly improving creatinine level since admission to acute care, 6/6/2022
 - 5 Mild dementia. ST
 - 6 hyponatremia-mild
-

Discharge Summary: 6/25/22

Discharge diagnoses:

- Non-ST elevation MI, s/p percutaneous coronary intervention and stent placement.
- Hyperlipidemia
- AKI
- Debility
- Severe aortic stenosis

Discharge to home with family.

IGC:

ETIOLOGIC:

TIER:

60% QUALIFIER:

COMMENTS:

Coder Summary:

DRG: 307 Cardiac congenital & valvular disorders w/o MCC

Admitting Diagnosis:

I35.0 Nonrheumatic aortic (valve) stenosis

Principal Diagnosis:

I35.0 Nonrheumatic aortic (valve) stenosis (DRG)

Secondary Diagnoses:

I48.91 Unspecified atrial fibrillation

R41.0 Disorientation, unspecified

R09.02 Hypoxemia

N28.9 Disorder of kidney and ureter, unspecified

F32.9 Major depressive disorder, single episode, unspecified

F41.9 Anxiety disorder, unspecified

G47.00 Insomnia, unspecified

D64.9 Anemia, unspecified

R53.1 Weakness

G93.41 Metabolic Encephalopathy

Pre-Admission Screening

Etiology: Weakness; Severe aortic stenosis, aFIB, delirium

Date of screening: 3/10/22

Patient admitted to hospital on 3/1/22 with c/o intermittent chest pain overnight and through morning. EKG identified diffuse ST elevation. Cardiac catheterization done and showed false positive STEMI but critical aortic stenosis. Patient underwent aortic valve replacement on 3/3/22. S/p surgery, patient required ventilation and became confused, requiring restraints and a sitter. Patient also with course of aFib post op. Restraints have since been D/C'd, but patient continues to require a sitter. Patient started on diltiazem dip but continued to be in aFIB. Unsuccessful cardioversion 3/7/22. Patient has since had spontaneous conversion and is currently on anticoagulation therapy. Patient on 2 Floor and being treated for aFib and pain. At this time, patient medically cleared for transfer to rehab.

Comorbidities: s/p aortic valve replacement, confusion, hypoxemia, renal insufficiency, anemia, insomnia, anxiety, depression

ADMISSION MOTOR SCORE: 41

History and Physical

DATE OF ADMISSION: 3/11/2022

HISTORY LEADING TO ADMISSION: {Patient} is admitted to inpatient rehabilitation for continued daily medical and nursing interventions with comprehensive intensive integrated and interdisciplinary rehabilitation services to minimize functional deficits and facilitate a direct community discharge following encephalopathy secondary to an aortic valve replacement surgery.

CHANGES IN THE PATIENT'S CONDITION SINCE THE PREADMISSION SCREENING: None.

HISTORY LEADING TO ADMISSION: {Patient} is an 84-year-old Caucasian male, right-handed, who was admitted to [Hospital A] 3/1/2022 with complaints of shortness of breath and chest pain. The patient had diffuse ST elevation. Cardiac catheterization was performed demonstrating critical aortic stenosis. The patient underwent aortic valve replacement on 3/3/2022.

Following the surgery, the patient has required ventilation. He developed encephalopathy with confusion requiring restraints and a sitter. The patient also had complications of atrial fibrillation postoperatively. The patient had unsuccessful cardioversion attempts to IV diltiazem and through electrical cardioversion, he has since spontaneously converted and is currently anticoagulated with warfarin. Besides atrial fibrillation, the patient has also had sternal pain complaints, difficulties with sleep, need for supplemental oxygen and pain difficulties related to his sternal incision.

PAST MEDICAL HISTORY: Significant for insomnia, anxiety, depression and degenerative joint disease involving the bilateral knees, left hip and left ankle.

Other providers involved in patient's care have included [Dr I] and [Dr E-].

MEDICAL DECISION MAKING LEADING TO IN-HOSPITAL REHABILITATION:

The patient is able to tolerate the intensity of rehabilitation services.

2. He has a documented need for daily medical supervision.
3. There is a need for 24-hour nursing care.
4. There is a need for 2 or more skilled therapy disciplines_
5. The patient is medically stable to participate in therapies.
6. He is emotionally stable to participate in therapies.
7. He has a potential for improvement and can benefit from a rehabilitation program.
8. He has an appropriate disposition after discharge from acute rehabilitation.
9. Patient has agreed to participate in the rehabilitation program.

EXPECTED FREQUENCY AND DURATION OF TREATMENT: The patient will receive at least 3 hours of therapy per day consisting initially of physical therapy 60 minutes, occupational therapy 60 minutes and speech and language pathology services 60 minutes.

ANTICIPATED DISCHARGE LOCATION: For this patient is home with his wife.

ESTIMATED LENGTH OF STAY: 10-12 days.

PROGNOSIS: Good to excellent.

EXPECTED FUNCTIONAL RECOVERY: will be at least assisted level of supportive management. Ideally, a supervised level of care.

ANTICIPATED INTERVENTIONS FOLLOWING INPATIENT REHABILITATION :

Home health services followed by outpatient cardiac rehabilitation. durable medical equipment needs or assistive and adaptive equipment addressed during the patient's rehabilitation stay.

SIGNIFICANT LABORATORY: Values include a WBC of 12.9 and hemoglobin of 9.4 on 3/16/2022. His INR on the same date was 2.1.

SIGNIFICANT RADIOLOGIC STUDIES: The patient's last chest x-ray was performed on 3/14/22, demonstrating improved right base aeration as well as improved vascular and interstitial prominence.

ALLERGIES: None known to medications.

CURRENT MEDICATIONS: Include amiodarone, ascorbic acid, aspirin, cholecalciferol, furosemide, metoprolol, multivitamin, warfarin, omega-3 polyunsaturated fatty acids, oxazepam, potassium chloride, quetiapine. Saccharomyces boulardii lyo, simvastatin and spironolactone .

HOME MEDICATIONS: Similar but without the amiodarone and warfarin. The patient was taking different medications for sleep and anxiety.

CODE STATUS: Full code.

WEIGHTBEARING STATUS: Full weightbearing; however, the patient must follow sternal precautions.

FAMILY HISTORY: Reviewed and noncontributory to the chief complaint.

SOCIAL HISTORY: The patient lives with his wife in [local area]. They have a single-story home without steps. The patient's wife will be available to provide support for the patient if necessary and they can afford a higher support if necessary.

TOBACCO USE: Denied.

ALCOHOL USE: 1 ounce of wine per day.

DRUG USAGE: Denied.

PREHOSPITALIZATION LEVEL OF FUNCTION: Independent.

THE PATIENT'S CURRENT LEVEL OF FUNCTION: He has required a 24-hour sitter. He requires an overall minimal assist level of care.

REVIEW OF SYSTEMS: The patient wears reading glasses. He has bilateral hearing aids, but generally does not wear them. He does not have dentures. He denies any history of respiratory problems or gastrointestinal problems. He denies any difficulties with urination or defecation. He has had multiple joint pain complaints involving the bilateral knees, left hip and left ankle. He had a previous left ankle fracture. He wears orthotics in his shoes bilaterally. He denies any neurologic history. He has been treated in the past for anxiety as well as sleep difficulties and depression. He denies hematologic problems. He denies skin problems.

PHYSICAL EXAMINATION:

VITAL SIGNS: Oral temperature 36.6, heart rate 69, blood pressure 104/50, oxygen saturation 96 on 3 L of oxygen per minute.

GENERAL APPEARANCE: Elderly-appearing male, no acute distress.

HEENT: The patient has no specific abnormalities noted.

NECK: Without specific abnormalities.

RESPIRATORY: The patient is presently requiring 3 liters per minute of oxygen by nasal cannula. His lungs are clear to auscultation.

CARDIOVASCULAR: He is in regular rate and rhythm. He has strong pulses in all 4 extremities.

CASE STUDY "M" AQ-IQ IRF PRO LAB

GENITOURINARY: Without specific abnormalities.

ABDOMEN: The patient's abdomen is soft. He has positive bowel sounds. There is no pain to palpation of his abdomen nor rebound tenderness.

SKIN: Patient has a well-healing sternal incision that is closed, clean, dry and intact without sutures or staples.

LYMPHATIC: Without edema in the left or right lower extremities.

MUSCULOSKELETAL: The patient has normal joint stability and normal joint range of motion. Tone is normal. Strength is grossly 4/5 and slightly weaker involving his right side.

NEUROLOGIC: Cranial nerves II through XII are intact. Strength testing as above. Dysphagia: None. Mental status: Orientation and memory are generally good, although the patient does have a fairly rapid decay in his intermediate memory. He has good attention and concentration. Speech and language are grossly normal. Sensation is grossly intact. Spasticity: None.

Ataxia: None. He has good balance and coordination. Reflexes are 2+ and intact diffusely.

PSYCHIATRIC: Without specific abnormalities.

ASSESSMENT AND DIAGNOSES:

IMPAIRMENTS:

1. Status post aortic valve replacement on 3/3/2021. The patient's sternal incision is healing well. He must follow sternal and cardiac precautions. The patient will continue on oxygen 3 L per minute by nasal prongs with gradual weaning as able associated with activity progression. The patient will remain anticoagulated with warfarin and remain on medications to prevent recurrence of atrial fibrillation. The patient will need active pain management to facilitate activity progression. He has required a sitter because of confusion. As the patient becomes more oriented and has improved memory with lack of sundowning, then the sitter will be able to be discontinued. The patient did not have these cognitive difficulties prior to his surgery. The patient could benefit by comprehensive and intensive physical, occupational and speech therapies to minimize the patient's functional deficits.
2. Atrial fibrillation. Patient currently is in normal sinus rhythm. He will continue on his current medications. [Dr I] of cardiology has been involved. The patient will continue with anticoagulation as directed by the pharmacy.
3. Active pain management. Patient will need facilitation of activity with active pain management; however the patient's opioids will need to be gradually weaned and discontinued, as they can contribute to his cognitive impairment.
4. Bowel management. The patient will need to demonstrate regular bowel movements without incontinence.
5. Bladder management. Patient will need to demonstrate good bladder emptying with small post void residuals not demonstrating urinary retention. He will also need to be continent of urination.
6. Sleep management. The patient has had reversal of his day and night sleep patterns, medications are being utilized as directed by [Dr E-] to facilitate normalization of his day and night sleep cycles. This reversal is contributing to his cognitive impairment and overall fatigue.
7. Mood management. Patient has a history of anxiety and depression. He will need to be closely monitored as recurrence and worsening of these conditions will interfere with his cognition and physical recovery.
8. Venous thromboembolism prophylaxis. Patient will continue on warfarin, sequential compression devices and have rapid remobilization. He is at great risk for development of deep venous thrombosis, pulmonary embolism and premature death.
9. Degenerative joint disease. Patient has a history of multiple joint involvement including the bilateral knees, left hip and left ankle that will need to be considered during his remobilization. The patient through rehabilitation techniques may have overall improvement in his broader management of his

degenerative joint disease.

10. Nutrition. Prealbumin level will be obtained. A dietary involvement will occur. Adequate nutrition is necessary for full participation in the patient's remobilization program.

11. Acute blood loss anemia. The patient's hemoglobin on 3/16/2022 was 9.4. His hemoglobin will continued to be monitored, further declines in his hemoglobin could warrant bleeding complications, GI complications and an increased risk for development of atrial fibrillation or organ system damage.

ACTIVITY LIMITATIONS:

1. Difficulties with basic activities of daily living.
2. Difficulties with instrumental activities of daily living.
3. Difficulties with mobility.
4. Difficulties with transfers.
5. Difficulties with ambulation.
6. Difficulties with cognition.

Comprehensive physical, occupational and speech therapies will be provided to the patient to minimize his functional deficits, He is admitted in overall minimal physical assist level of care.

PROGRESS NOTES

DATE OF SERVICE: 3/22/2022

SUBJECTIVE: Rounds were made at the bedside on 3/22. The patient feels better. He wants his oxygen off.

OBJECTIVE :

VITAL SIGNS: Blood pressure 90/56, heart rate 57.

HEENT: Unremarkable.

NECK: Without thyromegaly.

LUNGS: Clear.

CARDIAC: Shows S1, S2, no S3. Well-healing sternotomy_

ABDOMEN: +2 bowel sounds.

EXTREMITIES: Without edema.

NEUROLOGIC: More and more alert and less confused everyday.

REVIEW OF SYSTEMS: Negative for nausea, vomiting, diarrhea, fever, chills, liver, kidney, thyroid, skin, stroke, seizure, hematuria, dysuria, blood in the stool, visual, auditory, lymph nodes,. psychiatric, tongue.

LABORATORY DATA: White count 8.5, hematocrit 29.5, platelet count 318. INR 2.4.

IMPRESSION:

1. An 84-year-old with severe aortic stenosis, status post aortic valve replacement.
2. Hypoxemia on oxygen.
3. Confusion, improving.
4. Paroxysmal atrial fibrillation, on Coumadin, remaining in sinus rhythm now clinically.
5. Weakness, getting rehabilitation.

PROGRESS NOTES

DATE OF SERVICE: 03/23/2022

CASE STUDY "M" AQ-IQ IRF PRO LAB

He is being readied for discharge.

OBJECTIVE:

VITAL SIGNS: Blood pressure 100/54, heart rate 67.

HEENT: Unremarkable.

NECK: Without thyromegaly.

LUNGS: Clear.

CARDIAC: Shows well-healing sternotomy, S1, S2, No S3.

ABDOMEN: +2 bowel sounds.

EXTREMITIES: Without edema.

NEUROLOGIC: Intact.

SKIN: Intact.

REVIEW OF SYSTEMS: Negative nausea, vomiting, diarrhea, fever, chills, liver, kidney, thyroid, skin, stroke, seizure, hematuria, dysuria, blood in the stool, visual, auditory, lymph nodes, psychiatric, tongue.

LABORATORY DATA: white count 8.5, hematocrit 29.5, platelet count 318. INR 2.4.

IMPRESSION: An 84-year-old with:

1. Status post aortic valve replacement for severe aortic stenosis.
2. Paroxysmal atrial fibrillation, remaining in sinus rhythm, on Coumadin.
3. Confusion, improved.
4. Weakness, improved.

DISPOSITION: For discharge today. Follow up in 1 week in the office for INR check.

PROGRESS NOTES

DATE OF SERVICE: 03/24/2022

SUBJECTIVE: Rounds were made at the bedside on 3/24. The patient denies chest pain or shortness of breath.

OBJECTIVE:

VITAL SIGNS: Blood pressure 124/64, heart rate 84, sinus rhythm.

HEENT: Unremarkable.

NECK: Without thyromegaly.

LUNGS: Clear.

CARDIAC: shows S1, S2, no S3.: well-healing sternotomy.

ABDOMEN: +2 bowel sounds.

EXTREMITIES: Without edema.

NEUROLOGIC: Intact.

SKIN: Intact

REVIEW OF SYSTEMS: Negative for nausea, vomiting, diarrhea, fever, chills, liver, kidney, thyroid, skin, stroke, seizure, hematuria, dysuria; blood in the stool, visual, auditory, lymph nodes, psychiatric, tongue.

LABORATORY DATA: White count 7.9, hematocrit 39.2, platelet count 189.

IMPRESSION:

1. Status post aortic valve replacement for aortic stenosis.
2. Paroxysmal atrial fibrillation, on Coumadin.
3. Confusion, improving.
4. Weakness, in rehabilitation.

PROGRESS NOTES

DATE OF SERVICE: 3/25/2022

SUBJECTIVE: Rounds were made at the bedside. The patient is participating in rehabilitation. He has incisional chest pain.

OBJECTIVE:

VITAL SIGNS: Blood pressure 98/48, heart rate 66.

HEENT: Unremarkable.

NECK: Without thyromegaly.

LUNGS: Clear.

CARDIAC: Shows S1, S2 regular. No S3, well-healing sternotomy.

ABDOMEN: +2 bowel sounds.

EXTREMITIES: Without edema.

NEUROLOGIC: Improved, is more alert.

SKIN: Otherwise intact.

REVIEW OF SYSTEMS: Negative for nausea, vomiting, diarrhea, fever, chills, liver, kidney, thyroid, skin, stroke, seizure, hematuria, dysuria, blood in the stool, visual, auditory, lymph nodes, psychiatric, tongue.

LABORATORY DATA: White count 8.5, hematocrit 29.7 and platelet count 247. INR 1.8 yesterday.

IMPRESSION: An 84-year-old with;

1. Status post aortic valve replacement for severe aortic stenosis, progressing well in rehabilitation. He has incisional chest pain. He has normal coronaries.
2. Paroxysmal atrial fibrillation, on Coumadin, goal INR 2-3
3. Confusion, improving.
4. Weakness, improving. Apparently, he says he is being discharged tomorrow.

Discharge Summary: 3/25/22

Date of admission: 3/16/22

Discharge diagnoses:

- Status post aortic valve replacement for severe aortic stenosis
- Paroxysmal atrial fibrillation, clinically remaining in sinus rhythm
- Active pain management
- Acute blood loss anemia/leukocytosis
- Weakness

Discharge to home with home health services.

IGC:

ETIOLOGIC:

TIER:

60% QUALIFIER:

COMMENTS:

Coder Summary:

DRG: 191 Chronic obstructive pulmonary disease w CC

Admitting Diagnosis:

J44.1 Chronic obstructive pulmonary disease w (acute) exacerbation

Principal Diagnosis:

J44.1 Chronic obstructive pulmonary disease w (acute) exacerbation (DRG)

Secondary Diagnoses:

J90 Pleural effusion, not elsewhere classified (CC) (DRG)

E46 Unspecified protein-calorie malnutrition (CC)

I27.2 Other secondary pulmonary hypertension

Z99.81 Dependence on supplemental oxygen

I27.81 Cor pulmonale (chronic)

E78.5 Hyperlipidemia, unspecified

E03.9 Hypothyroidism, unspecified

N40.0 Enlarged prostate without lower urinary tract symptoms

R32 Unspecified urinary incontinence

Z72.0 Tobacco use

Z96.653 Presence of artificial knee joint, bilateral

E66.9 Obesity, unspecified

Z68.37 Body mass index (BMI) 37.0-37.9, adult

E66.2 Morbid (severe) obesity with alveolar hypoventilation (CC)

J981.1 Atelectasis (CC)

M54.5 Low back pain

M25.512 Pain in left shoulder

Pre-Admission Screening:

Etiology: COPD with acute exacerbation

Date of screening: 2/29/22

95 y/o male admitted to acute hospital 1/31 with exacerbation of COPD, patient deteriorated and wound up on the ventilator. Patient transferred to Rehab on 2/8. Upon arrival he was wheezing, had shortness of breath with minimal exacerbation, cough with yellow sputum. Chest x-ray showed pulmonary vascular congestion with small bilateral pleural effusion. Diagnosed with aspiration pneumonia. By 2/25 he had no shortness of breath, diagnosed by cardiology with cor pulmonale and pulmonary hypertension. PO2 around 70. Patient back to acute and is evaluated to return to rehab,

Comorbidities: elevated BUN, steroid tapering, thrombocytopenia, obesity (BMI 37), dysphagia, BPH, hyperlipidemia, hypothyroidism, dermatitis, pressure ulcer stage 1 bridge of nose, urinary incontinence, hypoventilation, cor pulmonale.

Admission Motor Score =16

NO H&P

Progress Notes

DATE OF SERVICE:3/22/2022

SUBJECTIVE: Patient was seen and evaluated today. He denied any chest pain, reported baseline dyspnea on exertion and at rest. Denied any abdominal discomfort. Patient's wife was requesting to increase his Toviaz.

OBJECTIVE:

VITAL SIGNS: Temperature 97.5, heart rate 95, respirations 20, blood pressure 126/71.

GENERAL: Awake, alert, in no acute distress.

HEART: Regular rate and rhythm.

LUNGS: Clear to auscultation, but diminished in all lobes.

ABDOMEN: Soft, nontender.

EXTREMITIES: No edema.

IMPRESSION:

Debility.

1. Recent chronic obstructive pulmonary disease exacerbation secondary to aspiration-related pneumonia, status post treatment.
3. Obesity hypoventilation syndrome.

PLAN:

1. Continue comprehensive rehabilitation with physical, occupational, speech therapies.
2. We will increase patient's Toviaz to 6 mg at bedtime.
3. Continue use of BiPAP therapy as scheduled.
4. Continue Lovenox for DVT prophylaxis. Patient also to use sequential compression devices while in bed.

FUNCTIONAL ASSESSMENT: Minimal assistance with bed to chair to wheelchair transfers, minimal assistance with lower body dressing, minimal assistance with bathing, supervision with comprehension.

Progress Notes

DATE OF SERVICE: 03/23/2022

SUBJECTIVE: Patient seen and evaluated today. Denies any chest pain. Reports baseline shortness of breath. Does report left shoulder pain with therapeutic exercises.

CASE STUDY "N" AQ-IQ IRF PRO LAB

OBJECTIVE:

VITAL SIGNS: Temperature 97.9, heart rate 92, respirations 20, blood pressure 100/66.

GENERAL: Awake, alert, in no acute distress.

CARDIOVASCULAR: Regular rate and rhythm.

LUNGS: Clear to auscultation bilaterally, but diminished.

ABDOMEN: Soft, nontender.

EXTREMITIES: No edema.

IMPRESSION:

1. Debility secondary to recent chronic obstructive pulmonary disease exacerbation from aspiration-related pneumonia.

2. Left shoulder pain.

3. Dyspnea at rest and on exertion secondary to chronic obstructive pulmonary disease.

4. Deficits in gait, balance, transfers, safety, self-care, endurance.

PLAN: Continue comprehensive therapies and medical management. No new changes to current treatment plan. We will initiate low-dose Lidoderm patch on Monday morning on his therapies.

[Dr H-]

Consultation 3/23/22

Reason for the consult: Hypoventilation Syndrome associated to morbid obesity and chest bellows disease.

Patient is a 94-year-old male who is admitted to rehabilitation for aggressive PT/OT. He has been admitted previously to [HOSPITAL B-] for severe anasarca secondary to cor pulmonale.

He is obese, short and with large abdomen. He has been told that he snores. In fact, he was placed on CPAP at night and told to lose weight.

Today, he denies to me any significant discomfort. He is in good spirits.

His PMH is unremarkable. He quit smoking more than 30 years ago.

His ROS is significant for excessive sleepiness, orthopnea, PND, lower extremities edema, weight gain and decrease motility. He denies any GI, GU or CNS problems.

His physical examination shows an elderly male who looks much younger than stated age. His skin shows some chronic changes. His neck is short and fat. His ENT is Fujita grade IIIb. His lungs show poor air movement. His abdomen is large and impinge on his thoracic cage. His extremities show some edema. Neurologically, he is intact.

Vital Signs:	Last Charted:	24 Hr Minimum:	24 Hr Maximum:
Heart Rate	76 (03/04 18:48)	76 (03/04 18:48)	90 (03/04 13:42)
Resp Rate	20 (03/04 03:39)	20 (03/03 23:56)	20 (03/03 23:56)
SSP	115 (03/04 18:48)	112 (03/04 13:42)	115 (03/04 18:48)
DSP	71 (03/04 18:48)	64 (03/04 13:42)	71 (03/04 18:48)

His ancillary tests are significant for metabolic alkalosis as compensatory mechanism.

Diagnosis:

Severe hypoventilation syndrome
Severe pulmonary hypertension

Suggestions:

Patient must use CPAP every time he is on bed. In addition, it would be important to ensure that he has not history of chronic PTE by reviewing previous medical records. I will request US LE to rule out DVT.

Overall, patient is doing extremely well for his age and comorbidities. We will attempt to optimize his conditions as much as possible.

Discharge Summary: 3/23/22

Discharge diagnoses:

- Debility secondary to recent COPD exacerbation from aspiration-related pneumonia.
- Obesity, hypoventilation syndrome, on BiPAP therapy
- Deficits in gait, balance, transfers, safety, self-care and endurance.

Discharge to skilled nursing facility.

IGC:

ETIOLOGIC:

TIER:

60% QUALIFIER:

COMMENTS:

Case Study "O" AQ-IQ IRF-PRO LAB

Coder Summary:

DRG: 193 Simple pneumonia & pleurisy w MCC

Admitting Diagnosis:

J18.9 Pneumonia, unspecified organism

Principal Diagnosis:

J18.9 Pneumonia, unspecified organism (DRG)

Secondary Diagnoses:

J90 Pleural effusion, not elsewhere classified (Ce)
E43 Unspecified severe protein-calorie malnutrition (MCe)
G80.1 Spastic diplegic cerebral palsy
M48.02 Spinal stenosis, cervical region
N39.0 Urinary tract infection, site not specified (Ce)
N32.81 Overactive bladder
110 Essential (primary) hypertension
E78.5 Hyperlipidemia, unspecified
K21.9 Gastro-esophageal reflux disease without esophagitis
R33.9 Retention of urine, unspecified
M62.838 Other muscle spasm
R53.81 Other malaise
R09.02 Hypoxemia
R26.9 Unspecified abnormalities of gait and mobility
K59.00 Constipation, unspecified
R53.1 Weakness
R52 Pain, unspecified
A41.52 Sepsis due to Pseudomonas (DRG) (MCe)

Pre-Admission Screening

Etiology: J18.9 Bilateral Pneumonia

Date of screening: 5/16/22

Patient is a 68-year-old male who was admitted to ED with diagnosis of septic shock due to pseudomonas, UTI, rhabdomyolysis, and neutropenia/thrombocytopenia as a result of the acute kidney injury. He has a history of Cerebral Palsy, HTN, hyperlipidemia, GERD and cervical stenosis. He was treated for the UTI with IV antibiotics. Discharged and then readmitted with worsening respiratory status, and diagnosed with bilateral multilobar pneumonia, hypoxia with bronchospasm, bilateral pleural effusions, severe protein malnutrition, prerenal azotemia with severe dehydration, as well as an upper extremity thrombus from the PICC line, however not DVT.

Comorbidities: Cerebral palsy, HTN, hyperlipidemia, GERD, cervical stenosis, recent history of UTI and rhabdo, femur fx (2011), G80.8-other cerebral palsy

Case Study "O" AQ-IQ IRF-PRO LAB

ADMISSION MOTOR SCORE: 25

POST ADMISSION PHYSICIAN EVALUATION /History and Physical

DATE OF SERVICE:

05/17/2022

DATE OF ADMISSION:

05/16/2022

SERVICE:

Acute Rehab Unit.

CHIEF COMPLAINT:

Generalized weakness.

HISTORY OF PRESENT ILLNESS:

This patient is a very pleasant 68-year-old right-hand-dominant male with past medical history significant for spastic diplegia from cerebral palsy who had been originally admitted to [Hospital] on 05/04/2022 with a urinary tract infection and bacteremia and multilobar pneumonia who was treated with antibiotics and then subsequently discharged to [LTAC] and was noted to have worsening condition and readmitted to [Hospital], for which the diagnosis has not changed. patient was not started on any new antibiotics; however, the patient is having significant amount of weakness and deconditioning secondary to his prolonged hospital stay. He is at high risk for readmission. Patient was subsequently admitted to the Acute Rehab unit at [Hospital] for comprehensive inpatient therapy once medically stabilized.

PAST MEDICAL HISTORY:

overactive bladder, on Detrol; spastic diplegia; cerebral palsy; history of femur fracture; hypertension; hyperlipidemia; and GERD.

PAST SURGICAL HISTORY:

Denies any previous surgeries.

FAMILY HISTORY:

Negative for any neuromuscular disease and is currently noncontributory to present illness.

SOCIAL HISTORY:

Denies any tobacco, alcohol or illicit drug use. currently lives alone in a single-story home with a ramp to enter the garage and the back and has a walk-in shower, grab bars, tub transfer bench and a standard manual wheelchair and a platform walker at home.

PREVIOUS LEVEL OF FUNCTION:

Patient was previously modified independent for ADLs and mobility and ambulates with bilateral lofstrand crutches with a reciprocal gait pattern per patient.

CURRENT LEVEL OF FUNCTION:

The patient currently requires maximal assist for his transfers and is currently unable to ambulate at this time.

REVIEW OF SYSTEMS:

The patient denies any current fevers, chills, nausea or vomiting. The patient is concerned about restarting Detrol. States that this contributed to his urinary tract infection, denies any dysuria at this moment. Otherwise, remainder of 14-point review of systems is negative.

ALLERGIES:

No known medication allergies.

Case Study "O" AQ-IQ IRF-PRO LAB

MEDICATIONS:

please see medication reconciliation for complete listing of current medications, which is significant for Tylenol No.3, Lovenox, Lidoderm and pyridium.

PHYSICAL EXAMINATION:

Vital signs: Temperature 97.9, pulse 72, respirations 20, BP 135/84, O2 sats 94 on room air. General: Alert and oriented x 4, in no apparent distress. Head and neck: Normocephalic, atraumatic. PERRLA, EOMI. Mucous membranes are moist. Chest: Lungs are clear to auscultation bilaterally, no rhonchi, no wheezing. cardiovascular: s1 and s2 present. Regular rate and rhythm. NO murmurs, gallops or rubs. Abdomen: Protuberant, normal active bowel sounds throughout all 4 quadrants. Soft, nontender and nondistended, no hepatosplenomegaly. Extremities noted atrophic bilateral lower extremities with greatly diminished range of Motion at the hips, knees and ankles. only able to range the knees and ankles between 10 to 15 degrees passively. Skin: No rashes, no skin breakdown, no bruising. Neurologic: Cranial nerves II through XII are intact. sensation is intact to light touch in all dermatomes. Noted 5/5 strength to bilateral upper extremities, all muscle groups tested. Bilateral lower extremities demonstrate 2+ to 3/5, all muscle groups tested. Noted increased tone to bilateral lower extremities. Modified Ashworth scale 3 for hip flexors, hip extensors, knee flexors, knee extensors, ankle dorsiflexion and ankle plantar flexors. Reflexes are 1+ throughout. No clonus. Babinski equivocal. Hoffman's negative. coordination in bilateral upper extremities is intact. Noted equinovarus deformity on right lower extremity, more pronounced in the left lower extremity. Mood: Patient is in good spirits.

LABORATORY DATA:

Reviewed per the electronic medical records. Significant results include glucose of 98, creatinine of 0.73 and calcium of 8.4.

ASSESSMENT AND PLAN:

This patient is a very pleasant 68-year-old male with past medical history significant for spastic diplegia secondary to cerebral palsy who was admitted for multi lobar pneumonia and urinary tract infection and bacteremia, resulting in severe deconditioning and bilateral lower extremity weakness causing inability to ambulate and perform self-care tasks. The patient was subsequently admitted to the Acute Rehab Unit for comprehensive inpatient therapy aimed at restoring functional independence with goal of returning home to family. Patient has sisters who are very involved in his care.

1. The patient is appropriate for the Acute Rehab unit as the patient has demonstrated progress in therapies. He is able to tolerate 3 hours of daily therapy, and the patient will require close medical followup to prevent any complications. The patient is not safe to discharge home or to skilled nursing setting as the patient's multiple medical comorbidities require daily followup and medical management, and the patient is at risk for falls, complications and readmission. The physiatrist will see the patient daily for 5 to 7 days weekly for coordination of care with consulting physicians to ensure adequate pain control to allow participation in therapies, provide leadership for the multidisciplinary rehabilitation team and development of an individualized rehabilitation program.
2. The patient will continue on all transfer medications to include Tylenol NO.3 for pain control as well as Lidoderm patch. We will continue to adjust medications to allow participation in therapies. We will currently await therapy evaluations to address spastic diplegia and the need for titration of his baclofen, for which he has been on for several years. The current dose that he is on has allowed him to continue to ambulate with a reciprocal gait pattern using bilateral lofstrand crutches; however, given the amount of spasticity in his bilateral lower extremities, he may benefit from titration of this medication. Internal Medicine will continue to follow and manage the patient's chronic comorbid disorders.
3. PT was consulted to evaluate and treat the patient for goal of improving lower extremity strength, balance, transfers and ambulation. PT will see the patient daily for 90 to 120 minutes per day 5 to 6 days a week for duration of stay.
4. occupational Therapy is consulted to evaluate and treat the patient for goals of improving upper extremity strength, coordination, active assisted range of motion, ADLs, training with associated adaptive equipment and caregiver training. OT will see the patient daily for 90 to 120 minutes per day 5 to 6 days a week for duration of stay.
5. Rehabilitation nursing will be available to the patient 24 hours daily for medication education, maintaining skin integrity, restoration of autonomous control of bowel and bladder management and provide a caregiver training.
6. psychology is consulted to evaluate cognitive function screen for depression and supportive counseling for serious illness and loss of autonomy
7. Social work will evaluate the patient for review of resource eligibility for community-based assistance, DME procurement and

Case Study "O" AQ-IQ IRF-PRO LAB

discharge planning.

POTENTIAL REHABILITATION COMPLICATIONS:

1. Fall risk, for which bed alarm will be used as well as encouraging the patient to call for help prior to getting out of bed and transfers.
2. Patient is at risk for DVT, for Which she will continue on Lovenox and progressive mobility with therapies as well as TED hose.

REHABILITATION POTENTIAL:

Good for return home with family at supervision for ADLs and ambulation.

ESTIMATED LENGTH OF STAY: 13 days.

Progress Note

SEX: M

ADMISSION DATE: 05/16/2022

Progress Note

DATE OF SERVICE:

05/24/2022

CURRENT DIAGNOSES/PROBLEM LIST:

1. cerebral palsy.
2. Recent pseudomonas UTI with bacteremia.
3. Recent aspiration pneumonia.
4. Dysuria with urinary retention, resolved.
5. Hypertension.
6. cervical stenosis.
7. GERD.
8. Dyslipidemia.
9. spasticity .
10. Mild protein caloric malnutrition.
11. Debility following hospitalization.

SUBJECTIVE:

The patient is a 68-year-old male admitted for the past week in Acute Rehabilitation unit. The patient is making good progress. Today, the patient reports some mild cough, but denies use of any inhaled medications other than p.r.n. albuterol at home. States he was not on long-acting steroids or beta2-agonists previously. The patient's urinary retention and dysuria has completely resolved. The patient's weakness versus spasticity appears improved with use of p.r.n., baclofen rather than scheduled. He denies headaches, fevers, chills, sweats, nausea, vomiting, constipation, diarrhea. There is no chest pain, shortness breath or abdominal discomfort.

OBJECTIVE:

Vital signs: Temperature 97.5, blood pressure 110/71, heart rate 82, respiratory rate 18, O2 sat 94 on room air. General: He is alert and oriented male in no apparent distress. HEENT: Benign. Mucous membranes moist. Lungs: Clear to auscultation without wheezes or crackles. Heart: Regular rate and rhythm without appreciable murmur or extra sounds. Abdomen: soft, nontender, nondistended, bowel sounds active. Extremities: Without edema or calf tenderness.

LABORATORY DATA:

None.

Case Study "O" AQ-IQ IRF-PRO LAB

ASSESSMENT AND PLAN:

1. Dysuria, urinary retention: This seems resolved with pyridium and VESicare. care was discussed with patient's urologist, [Dr T-], earlier in the week. He is to follow up with [Dr T-] after discharge.
2. GERD: The patient being treated with PPI. No complaints today.

Case Study "O" AQ-IQ IRF-PRO LAB

3. spasticity: The patient was concerned the use of round-the-clock baclofen was making him weak in PT. This has been changed to p.r.n. The patient reports good PT performance.
 4. Mild protein caloric malnutrition: The patient with albumin of 2.6, but normal prealbumin. continue to encourage p.o.
 5. Recent aspiration pneumonia: The patient will need to get a chest x-ray next month for followup.
 6. Follow care: The patient's PCM ([Dr U-]) recently deceased. Case manager is helping patient locate a new primary care manager.
 7. Debility: The patient doing well in rehabilitation with plans for probable discharge on Saturday.
-

Discharge Summary: 5/28/22

Date of admission: 5/16/22

Discharge diagnoses:

- Aspiration pneumonia, treated
- Debility with chronic weakness, cerebral palsy
- Urine retention
- Treated for a UTI sepsis
- Bilateral pleural effusions

Discharge to home with home health services.

IGC:

ETIOLOGIC:

TIER:

60% QUALIFIER:

COMMENTS:

Coder Summary:

DRG: 091 Other disorders of nervous system w MCC

Admitting Diagnosis:

G93.41 Metabolic encephalopathy

Principal Diagnosis:

G93.41 Metabolic encephalopathy

Secondary Diagnoses:

N17.9 Acute kidney failure, unspecified (CC)
M19.90 Unspecified osteoarthritis, unspecified site
E66.01 Morbid (severe) obesity due to excess calories
S52.501A Unsp fracture of the lower end of right radius, init (HAC)
E46 Unspecified protein-calorie malnutrition (CC)
N39.0 Urinary tract infection, site not specified (CC)
Z68.41 Body mass index (BMI) 40.0-44.9, adult (CC)
E86.0 Dehydration
110 Essential (primary) hypertension
M25.531 Pain in right wrist
F41.9 Anxiety disorder, unspecified
F43.21 Adjustment disorder with depressed mood
M85.80 Oth disrd of bone density and structure, unspecified site
E89.0 Postprocedural hypothyroidism
G89.11 Acute pain due to trauma
E78.5 Hyperlipidemia, unspecified
F09 Unsp mental disorder due to known physiological condition
R53.1 Weakness
T40.605A Adverse effect of unspecified narcotics, initial encounter
Z96.653 Presence of artificial knee joint, bilateral
Z88.2 Allergy status to sulfonamides status

Pre-Admission Screening

Etiology: G93.41-metabolic encephalopathy

Date of screening: 7/01/23

75-year-old female, with history of a fall two weeks ago resulting in a fractured wrist, has been treated conservatively. Over the past 10 days she has been taking pain medication and the family has noted increasing confusion and increased difficulty ambulating, more dependence on others for ADLs. Patient diagnosed with multifactorial encephalopathy, acute renal failure, severe dehydration, hypokalemia, UTI, and mild bradycardia. Pt treated with fluids, potassium, antibiotics and change from narcotic pain meds to non-narcotic. Beta blocker was restarted at a lower dose, and Lisinopril and hydrochlorothiazide were held pending improvement in renal function. Acute rehab was recommended in order to facilitate

improvement in functional mobility and self care skills in an effort to decrease the likelihood of further falls and readmission to the hospital and for safe transition back to her home and prior level of function.

Comorbidities: HTN, dyslipidemia, anxiety, osteoarthritis, osteopenia, acute pain due to trauma, history of migraines, hysterectomy, bladder suspension, bilateral total knee replacements, ORIF of left arm, morbid obesity (BMI of 41), UTI, unspec. Protein-calorie malnutrition

ADMISSION MOTOR SCORE: 35

History and Physical

7/6/23

HISTORY OF PRESENT ILLNESS:

I was told by the nurse at the Rehab Unit that we were asked to see the patient when she was at the Rehab. Apparently, the patient was discharged by [Dr V-] from [Hospital C] to [Rehab] on 07/01/2023. We were not notified that the patient was going to [Rehab] and hence nobody saw the patient since then until today when I was notified by the nurse that there is an order from [Dr L-] on 07/06/2023 to change the attending name to [Dr V-]. The patient was admitted to [Hospital C] and was discharged on 07/01/2023 with a discharge diagnosis at the time being of metabolic encephalopathy, likely secondary to narcotic pain medication/dehydration/UTI. she was admitted to rehab on 07/01/2023 and as per the charting and the nurses, the patient has been doing well at the rehab, except that she was complaining of some fatigue.

When I saw the patient, she mentioned that she has gained some weight in the last couple of weeks. She has a history of hyperthyroidism from what she was explaining and had radioactive iodine treatment done many years ago. Since then, she has had iatrogenic hypothyroidism and has been on Synthroid. Her last TSH check was in January this year as per her and it was normal. Normally, her TSH levels run fine as per her. During the last admission to [Hospital C], she forgot to tell us about the Synthroid and she has not taken Synthroid in about 2 weeks and today, the TSH level is more than 50. She has been complaining of some cold intolerance also last few days.

PAST MEDICAL HISTORY:

Hypertension. hyperlipidemia. hypothyroidism. anxiety, osteoarthritis, osteopenia, migraine headaches.

PAST SURGICAL HISTORY:

Hysterectomy, bladder suspension surgery, right total knee replacement, left total knee replacement, left arm open reduction and internal fixation for injury, tonsillectomy.

ALLERGIES:

SULFA.

SOCIAL HISTORY:

Denies smoking, alcohol or recreational drug use. She is a retired elementary teacher. She walks with a walker at baseline.

FAMILY HISTORY:

Denies any significant medical problems in her parents. They both lived into their 80s.

REVIEW OF SYSTEMS:

positive for just fatigue, cold intolerance, pain in the arm is controlled. All other systems reviewed and are negative except as mentioned.

OUTPATIENT MEDICATIONS:

Reviewed, please see the attached med rec.

PHYSICAL EXAMINATION:

Vitals: Temperature 97.3 Fahrenheit, pulse 61, respiratory rate 18, oxygen saturation 95, blood pressure 146/63. General appearance: No apparent distress. Head and neck: Pupils equally reacting to light and accommodation. Extraocular movements intact. Neck is supple, no jugular venous distention. Chest: Clear to auscultation and percussion, no rales or rhonchi. Abdomen: Soft, nontender, nondistended. positive bowel sounds. Extremities: No cyanosis, clubbing. Right arm in a cast. No joint effusions. Skin: Warm and moist.

LABORATORY DATA AND INVESTIGATIONS:

Potassium 3.7. TSH 17.9, magnesium 1.9.

ASSESSMENT AND PLAN:

1. Status post right distal radius fracture, managed nonoperatively in a short arm cast, for which the patient is admitted to Rehab for rehabilitation purposes. Continue physical therapy and occupational therapy. The patient is being seen by Rehab doctor. Pain is well controlled.
2. History of hypothyroidism. The patient has not taken Synthroid in 2 weeks. TSH level is very high. We will check a free T4 level. Restart her home dose of Synthroid and make adjustments to her steroids as needed.
3. Hypertension. Continue with outpatient medications.
4. Hyperlipidemia. Continue with outpatient medications.
5. History of anxiety disorder.

We will continue to see the patient while she stays at the rehab.

Consultation Report – Physical Medicine and Rehab

ADMISSION DATE: 07/01/2023

CHIEF COMPLAINT:

Generalized weakness and pain in her right wrist.

HISTORY OF PRESENT ILLNESS:

This patient is a very pleasant 75-year-old female with past medical history significant for hypertension, dyslipidemia, anxiety, osteoarthritis, osteopenia, history of migraine headaches, who had a fall 2 weeks prior to her original admission to [Hospital C], which is currently 06/28/2023, had a right wrist fracture and is managed nonoperatively and conservatively with a short arm cast. The patient had been given Norco for her pain control. The family recently found her to be very confused and not behaving like herself and was admitted for further evaluation and workup, which demonstrated hypovolemia, dehydration and narcotics-induced altered mental status. The patient was determined to have metabolic encephalopathy secondary to the above.

This has resulted in nontraumatic brain dysfunction. The patient was subsequently admitted to the Acute

CASE "P" AQ-IQ IRF PRO LAB

Rehab unit for comprehensive inpatient therapy as the patient is having difficulty ambulating and performing self-care tasks.

PAST MEDICAL HISTORY:

Hypertension, dyslipidemia, anxiety, osteoarthritis, osteopenia and history of migraine headaches.

PAST SURGICAL HISTORY:

Hysterectomy, bladder suspension, right TKA, left TKA, left arm ORIF, tonsillectomy.

FAMILY HISTORY:

Reviewed and noncontributory to present illness.

SOCIAL HISTORY:

Denies any tobacco, alcohol or illicit drug use, was previously an elementary school teacher, is now retired. Currently, lives alone, has friends who assist her at times during the day, and she is living in a single-story home, no steps to enter and has a narrow standup shower. The patient has a front-wheeled walker, straight cane and wheelchair at home.

PREVIOUS LEVEL OF FUNCTION:

The patient was previously independent for all ADLs and mobility.

CURRENT LEVEL OF FUNCTION:

The patient currently requires moderate assistance for transfers and is only able to ambulate 40 feet with constant cues using a rolling walker, total assistance.

REVIEW OF SYSTEMS:

The patient denies any fevers, chills, nausea, vomiting. Otherwise, 14-point review of systems is negative.

ALLERGIES:

SULFA.

MEDICATIONS:

Please see medication reconciliation for complete listing of admission medications, which are significant for gabapentin, duloxetine, Lidoderm patch, tramadol, albuterol.

PHYSICAL EXAMINATION:

Vital signs: Temperature 96.3, pulse 64, respirations 17, BP 141/66, O2 sats 99 on room air. General: Alert and oriented x 3, in no apparent distress. Head and neck: Normocephalic, atraumatic. PERRLA, EOMI. Mucous membranes moist. Chest: Lungs are clear to auscultation bilaterally, no rhonchi, no wheezing. Cardiovascular: S1, S2 present. Regular rate and rhythm, no murmurs, gallops, rubs. Abdomen: Protuberant, normal active bowel sounds throughout all 4 quadrants. Soft, nontender, nondistended, no hepatosplenomegaly. Extremities: Right upper extremity noted to be in a short arm cast. Mild tenderness to palpation to her digits; however, no sensation is lost. Brisk capillary refill to the right upper extremity. Remainder of extremities demonstrate full passive range of motion without any significant pain.

Skin: No rashes, no skin breakdown, no bruising. Neurologic: Cranial nerves intact. Coordination is diminished bilaterally. Sensation intact to light touch in all dermatomes. Strength is 5/5 strength for left upper extremity. Right upper extremity has 4/5 strength throughout all muscle groups tested and

CASE "P" AQ-IQ IRF PRO LAB

bilateral lower extremities demonstrate 4/5 hip strength, 4/5 quads and hamstrings, 5/5 gastrocnemius complex and EHL. pathologic reflexes are negative. DTRs are 1+.

LABORATORY DATA:

Albumin of 2.9, BUN of 8, magnesium of 1.4, prealbumin of 15, H&H of 12.9 and 37.1. Normal white blood cell and platelet count.

IMAGING:

X-rays of the hip on 06/28/2023 did not demonstrate any acute fracture or dislocation and demonstrated mild degenerative changes in the hips. Imaging was reviewed by me independently and I agree with the radiologist's interpretation.

ASSESSMENT AND PLAN:

This patient is a very pleasant 75-year-old female with nontraumatic brain dysfunction secondary to metabolic encephalopathy as a result of a significant amount of dehydration and narcotics-induced altered mental status, which was being used for right wrist pain status post mechanical fall resulting in a distal radius fracture, currently managed with a short arm cast. The patient was previously independent for all ADLs and mobility; however, now is having difficulty ambulating and performing self-care tasks and is therefore admitted to the Acute Rehab Unit for comprehensive inpatient therapy aimed at restoring functional independence to this patient with a goal of returning home to family.

1. The patient is appropriate for the Acute Rehab Unit as the patient has demonstrated progress in therapies, is able to tolerate 3 hours of daily therapy, and the patient will require close medical followup to prevent any complications. The patient is not safe to discharge home or to skilled nursing setting as the patient's multiple medical comorbidities require daily followup and medical management, and the patient is at risk for falls, complications and readmission. physiatrist will see the patient daily 5 to 7 days weekly for coordination of care with consulting physicians to ensure adequate pain control to allow participation in therapies and provide leadership for the multidisciplinary rehabilitation team as well as development of an individualized rehabilitation program.
2. The patient will continue on all transfer medications to include Tylenol and Lidoderm patch for pain control as well as Neurontin. The patient will be on heparin for DVT prophylaxis. Internal medicine will continue to follow and manage the patient's chronic comorbid disorders
3. PT was consulted to evaluate and treat the patient for goal of improving lower extremity strength, balance, transfers and ambulation. PT will see the patient daily for 60 to 90 minutes per day, 5 to 6 days a week for duration of stay.
4. Occupational Therapy was to evaluate and treat the patient for goals of improving upper extremity strength, coordination, active assisted range of motion, ADLs, training associated adaptive equipment and caregiver training. OT will see the patient daily for 60 to 90 minutes per day, 5 to 6 days a week for duration of stay.
5. Speech therapy is consulted to evaluate and treat the patient for goals of improved cognition. Speech Therapy will see the patient daily for 60 minutes per day, 5 to 6 days a week for duration of stay.
6. Rehabilitation nursing will be available to the patient 24 hours daily for medication education, maintaining skin integrity, restoration of autonomous control of bowel and bladder management, provide caregiver training and neuro rehabilitative assistance.
7. Psychology is consulted to evaluate cognitive function, screen for depression and supportive counseling for serious illness and loss of autonomy.
8. Nutrition is consulted to provide recommendations for total calorie and fluid needs as well as

CASE "P" AQ-IQ IRF PRO LAB

supplementation for protein malnutrition.

9. Social work will evaluate the patient for review of resource eligibility for community based assistance, DME procurement and discharge planning.

POTENTIAL REHABILITATION COMPLICATIONS:

1. Fall risk for which bed alarm will be used as well as encouraging the patient to call for help prior to getting out of bed and transfers.
2. The patient is at risk for *DVT*, for which she will continue on heparin as well as progressive mobility with therapies.

REHABILITATION POTENTIAL:

Good for return home with family at supervision for ADLs and ambulation.

ESTIMATED LENGTH OF STAY:

13 days.

Team Conference Notes:

No speech ordered at this time.

Psychology consult 7/2/23: Today, patient is alert and oriented x4. Fair historian. Denies history of depression, but has experienced panic attacks about once a month. She was using a walker prior this admission but she reported that for the past several months she has been falling out of bed and had placed her mattress on the floor to protect herself.

Progress Note: 7/5/23

Subjective: Patient has loose stools. No skin issues.

Lab data: No new labs since H&P.

Impression and Plan:

- 1) NTBI-metabolic encephalopathy
 - 2) s/p R wrist fx—non-operative-6/28/23
 - 3) HTN-lisinopril
 - 4) Anxiety-cymbalta
 - 5) UTI-cipro
 - 6) DVT prophylaxis-ASA, progressive mobility, TEDS
-

Discharge Summary: 7/13/23

Date of admission: 7/01/23

Discharge diagnoses:

- Debility needing skilled rehab services
- Pain control with ongoing debility with right wrist fracture
- Uncontrolled hypothyroidism with elevated TSH in 70s
- History of hypertension and resolved metabolic encephalopathy, dyslipidemia

Discharge to skilled nursing facility.

CASE "P" AQ-IQ IRF PRO LAB

IGC:

ETIOLOGIC:

TIER:

60% QUALIFIER: PRINCIPAL:

BEST PRACTICES

OPPORTUNITIES

QUERY POTENTIAL?

IF SO PROVIDE A QUERY

Coder Summary:

DRG: 552 Medical back problems w/o MCC

Admitting Diagnosis:

M48.06 Spinal stenosis, lumbar region

Principal Diagnosis:

M48.06 Spinal stenosis, lumbar region (DRG)

Secondary Diagnoses:

K31.84 Gastroparesis

K86.1 Other chronic pancreatitis (CC)

E11.40 Type 2 diabetes mellitus with diabetic neuropathy, unsp

I10 Essential (primary) hypertension

M54.89 Other dorsalgia

D57.3 Sickle-cell trait

Pre-Admission Screening

Etiology: Spinal stenosis. Left lumbar hemilaminectomy and posterolateral fusion of L2 through S1.

Date of screening: 5/10/23

Patient is a 47-year-old patient with history of lumbar stenosis, L3-L4 and L4-L5 hemilaminectomy and posterolateral fusion of L2 through S1. Patient had left lower extremity weakness after her surgery and was put on Decadron treatment. During subacute stay, patient was trying to get out of the bed, had difficulty moving her LLE and fell on the floor sustaining trauma to the head. She denied loss of consciousness. Patient admitted to IRF due to impaired ambulation and ADL's secondary to lumbar stenosis L3-L3 and L4-L5 with radiculopathy. The patient subsequently developed post op fluid collection with worsening in her lower left extremity function.

PMHx: HTN, DM, HLD, anxiety, fibromyalgia, seronegative RA, questionable Crohn's disease, alpha thalassemia, morbid obesity (BMI of 42), chronic lower back spinal stenosis, gastroparesis syndrome, diabetic peripheral neuropathy, chronic pancreatitis, chronic ischemic colitis, bilateral CTs, right shoulder rotator cuff injury.

ADMISSION MOTOR SCORE: 41

History and Physical

Chief Complaint

LES weakness

History of Present Illness

[Patient] is a 47-year-old patient with h/o of lumbar stenosis, L3-L4 and L4-L5, and radiculopathy. This patient underwent left L3-L4 and L4-L5 hemilaminectomy and posterolateral fusion of L2 through S1 by [Dr M-Jon 4/4/23]. The patient had left lower extremity weakness after her surgery and was put on Decadron treatment by neurosurgery. She had a follow up CT scan of the lumbar spine on 4/5/23 that showed no significant changes. The patient was discharged to a subacute facility to continue her comprehensive rehabilitation. Per the EMR, the patient reported that on 4/13/23 she was trying to get out of the bed, had difficulty moving her LLE and fell on the floor sustaining trauma to the head. She denied loss of consciousness. According to the facility, the patient was taking Valium and Percocet and was drowsy when she was trying to get out of bed. The patient had a CAT scan of the head in the Emergency Room on 4/13/23 that showed no intracranial bleeding, and the CAT scan of the lumbar spine showed post-surgical changes; no acute event.

The patient was admitted to [FACILITY] for IPR on 4/15/23 due to impaired ambulation and ADL's secondary to lumbar stenosis L3-L4 and L4-L5 with radiculopathy. The patient subsequently developed post operative fluid collection w/ worsening in her LLE function. Per the EMR, the patient underwent MRI lumbar spine which revealed large fluid collection. ID was following for possible infection. Pt went for aspiration of fluid collection by IR on 4/25/23. Cx after IR drainage negative to date. The patient requested a second neurosurgical opinion, per the EMR, and [Dr L-] was consulted. A myelogram was recommended by [Dr L-].

Per the neurosurgery note, the myelogram showed persistent compression and stenosis at L3-L4 and L4-L5, but no blockage of the dye. The MRI cervical spine showed cervical spondylosis and a C1-C2 arthropathy with mild signal changes in the cord on the right side.

The patient was transferred to [Hospital B] on 5/2/23 for further workup and management. LE Doppler on 5/3/23 was negative for DVT.

On 5/4/23, the patient underwent wound exploration and debridement with drainage of the fluid collection and sampling for microbiology and bilateral midline laminectomy L3-L5 with decompression of the thecal sac, bilateral foraminotomies and decompression of the nerve roots with [Dr L-].

PMR was consulted on 5/5/23 for IPR needs.

Currently, pt is reporting constipation. No BM x 5 days. Vol void without difficulty. Reports no change in lower ext sensation, feels cont to be diminished. Denies spasticity. Decrease sharp/shooting pain to back and bilateral lower ext.

Active PRN Medications:

oxyCODONE (oxyCODONE immediate release) 15mg = 1 Tab By Mouth Q4

Histories

Past Medical History:

Active

Hypertensive disorder
Sickle-cell thalassemia without crisis
Gastroparesis syndrome
Backache
herniated disk
Diabetic peripheral neuropathy
Sickle cell trait
Chronic pancreatitis
Chronic ischemic colitis

Resolved

DIABETES MELLITUS : Resolved.

Fibromyalgia : Resolved.

Family History: OM and HTN

Procedure history:

Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive on 04/3/2023. Fusion of 2 or more Lumbar Vertebral Joints with Interbody Fusion Device, Posterior Approach, Posterior Column, Open Approach on 04/04/2023.

Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach on 05/04/2023. Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach on 05/04/2023.

Social History

This patient is single and will be living with brother upon discharge from [FACILITY] in an apartment. Pt reports unsure if there are steps and brother recently found this apartment. Pt denies h/o smoking cigarettes, etoh. Positive h/o of marijuana.

Education- College with Liberal Arts degree

Employment- Not working. Previously worked as a stationary engineer for that city of {CITY}

Premorbid Functional Status:

Eating: Independent.
Grooming: Independent.
Bathing Upper: Independent.
Bathing Lower: Independent.
Dressing Upper: Independent.
Dressing Lower: Independent.
Toileting: Independent.
Bed Mobility: Independent.
Transfers Bed to and from Chair: Independent.

Transfers: Toilet: Independent.

Transfers: Tub/Shower: Independent.

Ambulation (Home): Independent.

Pt able to lift both arms above 90 without difficulty.

Neg babinski/Neg clonus/neq hoffman bilaterally

Proprioception Intact bilateral thumbs/Absent
bilateral Toes

DTR's upper ext bilateral 2's throughout and lower ext
diminished throughout

Upper and lower ext easy to range

Light Touch and Pin Prick Sensation- Intact sensation except has impaired sensation
bilateral lower exts. Still has numbness in perineal areas and buttocks

MMT

Right- C5 -5/5, C6-5/5, C7-5/5, C8-5/5, TI-5/5, L2- 3-/5, L3- 3/5, L4- 3/5,
L5-1/5, 51- 3/5

Left- C5- 5/5, C6-5/5, C7-5/5, C8-5/5, TI-5/5, L2- 1/5, L3-1/5, L4-0/5, LS-
0/5, 51-0/5

Quality and Safety

Quality and Safety: Core Measures Indwelling Urethral Catheter Indication (Patient does not
have an indwelling urethral catheter), and Central Venous Catheter Indication (Patient does
not have a central venous catheter).

Review / Management
Results review: Lab
results
05/10/2023 06:40
EDT

Sodium
Potassium
Chloride
Carbon Dioxide
Anion Gap
Glucose
Urea Nitrogen (BUN)
Creatinine
Calcium
GFR for African Amer
GFR for Other Races
WBC
RBC
Hemoglobin
Hematocrit
MCV
MCH
MCHC
Red Cell Distribution Width
(RDW)
Platelets
Mean Platelet Volume (MPV)
Nucleated RBCs
D Dimer
139 mMol/L
4.4 mMol/L
106 mMol/L
28 mMol/L
5 mMol/L
85 mg/dL
10 mg/dL
0.60 mg/dL
9.0 mg/dL
>120 mL/min/1.73 m²
108 mL/min/1.73 m²
9.2 K/CUMM
3.49 M/CUMM LOW
8.7 gm/dL LOW
27.4 IOW
78.5 FI LOW
24.9 pg LOW
31.8 LOW
16.6 HI

323 K/CUMM
10.8 FL
0.00 K/CUMM
2.26 mg/L FEU HI History and Physical

Impression and Plan

[Patient] readmitted to [Hospital] after recent left L3-L4/ L4-L5 hemilaminectomy on April 4, 2023. Patient was discharged to [Facility]. During her stay at the facility, she experienced a fall. She complained of lower extremity weakness. She was admitted to [Hospital] for closer monitoring, pain control and further diagnostic testing. No findings noted. Pt admitted to to [FACILITY] on 4/15/23 for IPR. During course c/o of severe low back/left leg pain with continued weakness. Pt seen and evaluated by [Dr L-] from [Practice]. Imaging revealed continued severe lumbar stenosis L3 -LS. Pt OX with Post- Laminectomy Syndrome. - Pt is now s/p L3-S laminectomy and b/l medial facetectomy for decompression on 5/4/23 by [Dr L-] [Patient] still remains below baseline and requires IPR rehab prior to returning home.

*Impaired ambulation and ADL's secondary to Lumbar stenosis with radiculopathy. Lumbar stenosis, L3-L4 and L4-L5.

Pt is s/p left L3-L4/L4-L5 hemilaminectomy on April 4, 2023. performed by [Dr O-],

*New Post-laminectomy syndrome due Severe L3-L5 lumbar stenosis- s/p L3-5 laminectomy and b/l medial facetectomy for decompression on 5/4/23 by [Dr L-]

left LE still very weak

-FT: patient to be seen by PT S-6x/week for 1.5-2.5 hours per day.

-OT: patient to be seen by OT 5-6x/week for 1.5-2.5 hours per day.

- Rehabilitation Nursing, Recreational Therapy, Neuro-Psych for adjustment to disability, Social Work, PMR

physician supv

No back brace, Pain is better controlled now so expect to have better participation in therapies.

*Bladder Mang- pt reports voiding. Will order bladder scan's. If pvr's greater than 150 or no void greater than 6 hours, pt will require sterile IC cath,

*Bowel Mang/constipation- No x 5 day will place pt on bowel program- colace 100mg 1 tab po bid, senna

8.6mg 2 tab po qhs, and dulcolax supp 10mg PR

Will order abdominal X-ray on 5/11 to assess severity of fecal stasis.

*DM with gastroparesis- Pt is not on OM meds, Controlled by Diet. Monitor CBG's, and low dose Insulin

SSI. Will consult [Dr W-] from IM,

4/16: hgb A1C 6.1

* Leukocytosis

Most probably from steroid. Monitor. Afebrile

WBC 9.2 on 5/10.

*HTN-BP in the low 100's. Not on BP meds. [Dr W-] 1M consulted

*HLP- Cont with Zocor 10 mg daily. check Lipid profile on 4/16

4/16: lipid profile WNL except low HDL (34) and elevated triglyceride (225)

IM consult

*Sickle Cell trait/ Borderline Anemic-

Labs on 4/16- Iron -72/TIBC-264/Iron St- 28/Ferritin- 305

Not consistent with Iron def. Will Monitor Hb/HCT

*H/O Anxiety- Mood is currently stable. Will consult Neuropsychology to teach relaxation tech.

CASE "Q" AQ-IQ IRF PRO LAB

*IBS/Crohn's dz - Pt is not on Medication. Will monitor
Currently, no abdominal pain, no diarrhea and no hematochezia. The patient to follow with the gastroenterology clinic as outpatient.

*?Rt shoulder rotator cuff injury- Pt has limited ROM but improved since previous admission
US of bilateral shoulder to assess for rotator cuff injury- Outpatient

•Smoking Cessation- Pt is non-smoker

*Bilateral lower ext swelling- Doppler neg for DVT in bilateral LEs on 4/15 and 5/10

*GI/DVT prophylaxis- Protonix 40mg daily/ Heparin 5000U every 8 hours

*Pain Control/Diabetic peripheral neuropathy- Lyrica 300mg po BID/Cymbalta 60mg qhs/
oxycodone 15mg immediate release 1 tab po every 4 hours prn pain
tylenol 1,000 mg q8 hours Pt was seen by Pain service at [Hospital]. If needed, will reconsult pain service. Currently pain is better controlled

*Immunization- Pt has received both the Influenza vaccine/Pneumovaccine Fall of 2015

"Asses nutritional status - BMI- 29 (Not morbid obese) Nutrition Consult, 4/16: Albumin 3.1
and prealb 19.9. Will recheck Pre-alb, and albumin

Consults

[Dr W-] from IM

[Dr T-] from NP

Expected function at the time of discharge- Mod I with ADL's and Mod 1 with w/c propulsion

Prognosis- Good for rehab goals

Disposition- Home with brother

ELOS-2 weeks

Stable for IPR: Yes.

Medical Plan

DVT prophylaxis: Heparin 5,000U every 8 hours.

Estimated length of stay: 3 to 4 weeks.

Disposition: home with family.

Documentation Reviewed: I have reviewed the Preadmission Screen.

Functional status documented at preadmission: I agree with the patient's current functional status as documented in the preadmission screening.

Risk for complications: I agree with the risk for clinical complications documented in the preadmission screening.

Medical conditions: The plan of treatment is documented above in the history and physical.

Patient participation in therapy: The patient can participate in, and will benefit from an intense therapy program at least 3 hours per day / 5 days per week. Therapies/services include:, Physical therapy, Occupational therapy, Orthotics, Rehabilitation Nursing, Psychology, Case Management, Therapeutic Recreation, Dietician.

Created by Attestation

Teaching Attestation

Teaching Attestation

Attestation/ Supervisor Note: Attestation to History and physical, Participation (management reviewed and discussed, seen and exam with PA. report was edited. Still no functional active movement in the left LE but there is active movement in right hip flexor and quads and Os in AD, Posterior PF and big toe extensor. heart-regular; lungs- no rales, no wheeze. Abdomen - soft, good bowel sounds. See detailed MMT and sensory testing above., Spent 2 hrs, reviewing medical records, discussing with consult team, evaluating patient and coordinating care.), I agree with findings & plan,
Age: 46 years Sex: Female
Associated Diagnoses: None
Author: [DR O-]

Internal Medicine Consult H&P

Chief Complaint

The patient is a 46 years old Female weighing 79.6 kg 215 lb.

CC: medical co-management

Date of Service:
05/11/2023.

History of Present Illness

46 yof w/ pmh significant for sickle cell thalassemia, HTN, OM and lumbar stenosis, L3-L4 and L4-L5 w/ radiculopathy admitted 4/4/2023 for a left L3-L4 and L4-L5 hemilaminectomy and posterolateral fusion of L2 through S1. Post op course complicated by left lower extremity weakness and was put on Decadron treatment by neurosurgery. She had a follow up CT scan of the lumbar spine on 4/5/23 that showed no Significant changes. The patient was discharged to a subacute facility to continue her comprehensive rehabilitation. On 4/13/23 she was trying to get out of the bed, had difficulty moving her LLE and fell on the floor sustaining trauma to the head. She denied loss of consciousness. Head CT in ED on 4/13/23 showed no intracranial bleeding, and the CAT scan of the lumbar spine showed post-surgical changes; no acute event.

She was admitted to [FACILITY] for IPR on 4/15/23 due to impaired ambulation. pt developed post operative fluid collection w/ worsening in her LLE function. MRI lumbar spine showed revealed large fluid collection. ID was following for possible infection. Pt went for aspiration of fluid collection by IR on 4/25/23. Neurosurgery requested myelogram which showed persistent compression and stenosis at L3-L4 and L4-L5. pt transferred to {Hospital} 5/2 and underwent wound exploration and debridement with drainage of the fluid collection and sampling for microbiology and bilateral midline laminectomy L3-L5 with decompression of the thecal sac on 5/4. Currently denies cp/sob, no nausea/vomiting. Tol po diet. Consulted for medical co-management.

IGC:

ETIOLOGIC:

TIER:

60% QUALIFIER:

PRINCIPAL:

BEST PRACTICES

OPPORTUNITIES

QUERY POTENTIAL?

IF SO PROVIDE A QUERY

CASE "R" AQ-IQ IRF PRO LAB

REHAB Etiologic DX: Postictal State with Left non dominant hemiparesis

Date of Admission: 02/07/2022

Coding Abstract

ICD10		ICD9																
Admit DX: 0		G81.94		HEMIPL UNS AFFECT LT NONDOM SIDE														
	Ok	P	E	DX	POA	CC	S	M	#		HAC	HCC	RA	Description	R	I	N	C
1	☒			R26.9	Y		S	M	0	☒				UNS ABNORMALITIES GAIT & MOI	☒			
2	☒			I48.20	Y	cc	S2	M1	0	☒		HCC	RA	CHRONIC ATRIAL FIBRILLATION U	☒	☒		
3	☒			G93.40	Y	cc	S3	M3	0	☒			RA	ENCEPHALOPATHY UNSPECIFIED	☒			
4	☒			I49.5	Y		S2	M2	0	☒		HCC	RA	SICK SINUS SYNDROME	☒	☒		
5	☒		▲	E11.22	Y		1	M2	0	☒		HCC	RA	TYPE 2 DM W/DIABETIC CKD	☒	☒		
6	☒			E11.42	Y		1	M2	0	☒		HCC	RA	TYPE 2 DM W/DIABETIC POLYNEU	☒	☒		
7	☒			E11.51	Y		1	M2	0	☒		HCC	RA	TYPE 2 DM DIAB P ANGIOPATHY NC	☒	☒		
8	☒			G31.84	Y		1	M1	0	☒			RA	MILD COGNITIVE IMPAIRMENT SC	☒	☒		
9	☒			G40.909	Y		1	1	0	☒		HCC	RA	EPILEPSY UNS NOT INTRACT W/C	☒			
10	☒		▲	N18.30	Y		1	1	0	☒		HCC		CHRN KIDNEY DISEASE STG 3 UN	☒	☒		
11	☒			E78.5	Y		1	1	0	☒			RA	HYPERLIPIDEMIA UNSPECIFIED	☒	☒		
12	☒		▲	H53.40	Y		1	1	0	☒			RA	UNSPECIFIED VISUAL FIELD DEF	☒			
13	☒		▲	I12.9	Y		1	1	0	☒			RA	HTN CKD W/STAGE 1-4 CKD/UNS	☒	☒		
14	☒			H35.30	Y		1	1	0	☒			RA	UNSPECIFIED MACULAR DEGENE	☒			
15	☒			R68.89	Y		1	1	0	☒				OTHER GENERAL SYMPTOMS AN	☒			
16	☒			Z86.73	1		1	1	0	☒				PERS HX TIA & CI NO RESID DEF	☒	☒		
17	☒			Z79.01	1		1	1	0	☒				LONG TERM CURRNT USE ANTIC	☒	☒		N
18	☒			Z95.0	1		1	1	0	☒				PRESENCE OF CARDIAC PACEM/	☒	☒		

ADMISSION MOTOR SCORE - 29

HISTORY AND PHYSICAL

Assessment

Problem list

Post-ictal state. (02.1)
 S/P seizures on 01/27/2022.
 Multiple prior strokes.
 Hx of prior seizure disorder.
 S/P right craniotomy for intracerebral hematoma evacuation. (2017)
 Left hemiparesis.
 Balance impairment.

CASE "R" AQ-IQ IRF PRO LAB

Cognitive impairment.
Right visual field deficit.
Chronic AF.
Hx of sinus node dysfunction.
Cardiac pacemaker in place.
PAD.
HTN.
HLD.
DM.
Diabetic PN.
CKD III.
Macular degeneration.

70-year-old right-handed man presented to the ED at Medical Center on 01/27/2022 after awakening with left-sided weakness, sensory loss, and visual deficit, and falling out of bed. There was no LOC; unknown whether he hit his head. EMS witnessed 2 seizures en route to the hospital. BP was 203/103. He was admitted to the hospital. He was seen for neurology by Dr. Smith. Assessment was simple partial status epilepticus and chronic bilateral occipitoparietal stroke with petechial hemorrhages. He noted that focal seizures stopped after 4 mg of Ativan were given. He was treated with Keppra and Vimpat. He was continued on Coumadin, ASA, and statin. He was agitated and combative. He was treated with Seroquel and Haldol. He subsequently became cooperative. He was found to have right posterior tibial artery occlusion. He was seen for vascular surgery by Dr. Who on 01/28, and diagnosed peripheral arterial occlusive disease. SLP on 01/28 noted the patient passed a 3-oz water challenge. They suspected bolus efficiency deficit due to edentia. Recommended minced/moist diet consistency with thin liquids. They noted left neglect and field cut, and motor planning deficits, and deficits across higher order cognitive domains. There are no subsequent SLP notes. I discussed the case with Dr. Smith, who reports that his diagnosis is postictal state plus hospital delirium, but no new stroke. He was transferred here to the rehab unit this afternoon.

CURRENT FUNCTION PER PREADMISSION SCREEN:

Eating min A, grooming/hygiene min A, upper body dressing max A, lower body dressing min A, bed mobility CGA, sit-stand min A, transfer min A, ambulation 160 feet with FWW min-mod A, memory mod A, expression independent. Sitting balance was 4 and standing balance 1+.

Review of Systems

He says he feels "great". He admits to a little chronic numbness in his feet. Balance is off. Loss of vision to the right, chronic, but denies any recent change in vision. Admits to short-term memory impairment. His wife notes other cognitive impairment as well. He denies weakness, dizziness, nausea, dysphagia, cough, dyspnea, chest pain, abdominal pain, dyspepsia, symptoms or difficulty with urination or BMs, headache, musculoskeletal pain, or depression.

PLOF:

He could walk by himself up to about 300 yards at a time using a single-point cane. He needed assistance at times for ADLs. He was not driving. His wife manages his medications and finances.

Histories

Past Medical History

Multiple CVAs, including ICH.
Chronic atrial fibrillation.
On Coumadin at home.
Sinus node dysfunction.
HTN.
HLD.
DM.
Diabetic PN.
Diabetic retinopathy.
CKD III.
Hepatitis D in 1983.
Orthostatic dizziness.
Previous seizures.
MRSA.
Macular degeneration.
Valley fever.

Ophthalmologist:

Dr. Kumimoto.

Cardiologist:

Patient and wife do not recall the name of his current cardiologist.

Procedure history

Right craniotomy/intracerebral hematoma evacuation.
TKR.
Left carpal tunnel surgery.
Cardiac pacemaker placement in 2018.

Family History

Cardiac arrest
Mother
Diabetes mellitus type 2
Mother
Father
Acute myocardial infarction
Mother
Hypertension
Mother
Alzheimer's disease
Brother

CASE "R" AQ-IQ IRF PRO LAB

Social History

Retired pipeline worker and then airbag assembly worker.

High school graduate + 2 years of college.

Lives with wife and son.

Wife is able-bodied and available full-time.

Son works.

Habits:

He smoked about ½ pack of cigarettes a day from around age 18 to 36.

He denies EtOH or illicit drugs.

He does about 10 minutes of exercise at a counter, e.g. squats and running in place, about 3 times a week.

Objective

Tape

vancomycin

Medications: Medications

ACTIVE MEDS

aspirin (aspirin 81 mg oral tablet, chewable) 81 mg 1 tab PO DAILY

gabapentin 600 mg 2 cap PO TID

insulin glargine (insulin glargine-yfgn) 15 units 0.15 mL SubCutaneous Q24h-interval

lacosamide 100 mg 2 tab Oral BID

levETIRAcetam (Keppra) 500 mg 1 tab PO BID

lisinopril 5 mg 1 tab PO QHS

pravastatin 40 mg 1 tab PO QHS

warfarin (Coumadin) 2 mg 1 tab Oral Daily

QUetiapine (SEROquel) 50 mg 2 tab Oral BID PRN: Agitation

docusate-senna 1 tab Oral BID PRN: Constipation

glucagon 1 mg 1 mL IntraMuscular On Call PRN: Blood Glucose

glucose (Dextrose 50%) 25 Gm 50 mL IV Push On Call PRN: Blood Glucose

glucose 15 Gm Oral On Call PRN: Blood Glucose

glucose 30 Gm Oral On Call PRN: Blood Glucose

insulin lispro (Correction Dose HumaLOG) Bedtime correction scale SubCutaneous QBedtime PRN: Blood Glucose

insulin lispro (Correction Dose HumaLOG) Low resistance correction scale SubCutaneous TID before meals PRN: Blood Glucose

Vital Signs: Last vitals

VITALS

Height/Weight : HEIGHT/WEIGHT

02/07/2022 19:06 MST

BMI (Pt Care)

29.26

02/07/2022 18:20 MST

Height

188 cm

Weight

103.4 kg

5 Physical Examination

General: NAD. Alert. Pleasant. Cooperative.

HEENT: PERL, cloudy. Pharynx appears normal. Edentulous, with full upper and lower dentures in place, 1 missing front tooth on the upper denture.

Neck: Functional ROM, pain-free, without dizziness.

Chest: Lungs are clear to auscultation.

Heart: Regular rate and rhythm currently. No murmur is heard.

Abdomen: Bowel sounds present. Soft, nontender. No masses or organomegaly are palpated.

Extremities: No peripheral edema. No calf tenderness. Negative Homans bilaterally. Hands are warm, left foot fairly warm, right foot a little cooler; without cyanosis or pallor. Capillary refill is about 3 seconds in great toes bilaterally. Unable to definitely palpate DP or PT pulses.

Neuro: Speech is intact. Follows directions accurately. Oriented to year and month, off by 1 day on the date; oriented to city, Medical Center, and with a slight hint able to state rehab unit. Repeats 3 words immediately and recalls all of them after 3 minutes. Names the current and 2 past presidents, but not the prior one. Number of nickels in \$1.50 is correct. Subtracts 5 of 5 serial 7s correctly. Proverb interpretation is inadequate. EOMI. Complete right VFD. Face is approximately symmetric. Opens/closes both eyes adequately. Tongue is midline. Sensation to light touch is present and localizable in bilateral hands and legs, but absent in the toes bilaterally. Position sense is correct in bilateral thumbs but absent in bilateral toes. Manual muscle testing in RUE is 5; LUE is 4+ to 5; proximal BLEs are 5; ankle DF and PF are 4- bilaterally. Finger tapping is intact on the right and slightly slow on the left. Toe tapping is limited and slow bilaterally. Finger-to-nose is a little slow with right hand, and slower/mildly clumsy with the left hand. Heel-to-shin is somewhat clumsy with the right foot, but worse with the left foot.

Assessment

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HTN.
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CKD III.
Macular degeneration.

Plan:

CASE "R" AQ-IQ IRF PRO LAB

Admitted for acute inpt rehab due to postictal state.

No significant discrepancy between current medical/functional status and that noted in PAS.

DC destination: Home with full-time family assistance.

DC goal: Mod I to CGA range of fct for ADLs and household mobility.

ELOS: 1 wk - subject to change pending therapy evals.

Appropriate for AIRF as opposed to lower level of care in view of postictal state with significant functional impairment and comorbidities listed above.

Needs multidisciplinary rehab: PT, OT, and ST each 1 h/d 5 d/wk with shorter weekend sessions, and rehab nsg.

Rehab will include gait and tfr training, WC mobility, ADL training, cognitive remediation, and ther ex for strength, coordination, balance, ROM and endurance.

Expected to fully participate in intensive rehab, make significant progress, and be able to DC home as planned.

DME: TBD.

Caregiver training for family prior to DC.

Risk of falls - fall precautions.

Rehab nsg to monitor B&B fct; check PVR bladder volume; intervention if indicated.

Rehab nsg to monitor skin integrity; intervention as indicated.

Medical mgmt per IM.

Risk of recurrent seizure -continue seizure precautions; continue antiepileptic medications.

Risk of embolic stroke - continue ASA and Coumadin.

Risk of VTE - continue Coumadin.

Coumadin dosing per pharmacist.

Monitoring/mgmt of HTN and DM to ensure good control.

He is to follow up with Dr. Toe for neurology in 1 to 2 months.

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