Patient Name **DOB: MM/DD/YYYY**

Narrative Summary

XXXX is an 83-year-old female with past medical history significant for Dementia, Depression, Subdural Hematoma (SDH), Hyperlipidemia, Transient Ischemic Attack (TIA), Urethral stent and Mild hydronephrosis of left kidney. On August 15, 2017, she was initially admitted to ABC for long term care. It was noted that she was admitted from ABCD Hospital (GSH) with a qualifying diagnosis of Urinary Tract Infection (UTI). Ms. XXXX was initially presented from Sunrise Assisted Living with Altered Mental Status (AMS) and vomiting and was found to have a recurrence of UTI. She was 100% dependent of all ADLs and required 1 person assist for mobility and also required wheelchair. Her comorbid condition documented included Decreased functional ability, Impaired mobility, Neurologic disease/injury, Terminal diagnosis, Cognitive impairment, Psychosis, Urinary incontinence and Osteoporosis. She was currently taking prescription for Ampicillin 250 mg 4 times a day for 9 days for UTI, Miralax for constipation, Remeron for dementia/depression and Xanax for anxiety. Fall prevention questionnaire revealed a score of 75 indicating high risk. She was placed on 1/4 side rail in bed for protection. On August 15, 2017, occupational therapy evaluation was performed by Brooke O'Reilly, O.T. and assessed with impairment with Cognition, orientation, ADL selfcare. On the same day, physical therapy evaluation was performed by Cathy Mailman, P.T. and assessed with impairment in mobility, muscle weakness and difficulty in walking. She underwent physical and occupational therapy until September 21, 2017 and was discharged in stable condition to home/Assisted living with family.

On July 31, 2018, Ms. XXXX presented to ABCD Hospital ER via EMS with complaints of vaginal bleeding. She was evaluated by XXX, D.O. and Wojciech Bober, D.O. Rectal examination revealed guaiac positive stool (bright red blood) and no vaginal discharge or bleeding was found. She was admitted by Joseph Adiyody, M.D. for further evaluation. Physical therapy evaluation was performed by Kelly Lind, P.T. and was assessed with Decreased transfers, decreased ambulation, decreased bed mobility and Decreased strength. She was recommended skilled restorative physical therapy. On August 03, 2017, she was transferred to OLOC Rehab for subacute rehabilitation.

On August 03, 2018, Ms. XXXX was admitted to ABC Nursing and Rehabilitation with admitting diagnosis of UTI, MRSA in urine. She required 1 person assist for dressing, Feed self, set up only, continual help/supervision for eating, 1 person assist for transfer, toileting, mobility, personal hygiene. Fall precautions included 1/4 side rail placement for positioning and turning, eliminating all clutter in room and keeping bed in lowest position when in bed. Fall prevention questionnaire (Morse score) revealed a score of 65 indicating a higher risk.

On August 03, 2018, occupational therapy evaluation was performed by XXX, OT and XXX, OT. She presented with decreased functional independence, ADL, balance, bed mob, endurance, strength, ROM, transfers. She required Therapeutic exercise, Neuromuscular re-education, Therapeutic activities, Self care/home management and wheel chair management training to address the functional deficits.

On August 04, 2018, physical therapy evaluation was performed by XXX, P.T. She presented with decreased muscle strength, increased assistance with bed mobility and transfers, difficulty in walking and decline in function. She required Therapeutic exercise, Neuromuscular re-education, Therapeutic activities, and Gait training to address the functional deficits.

On the same day, admission report was documented by Dr. XXX. Her admission diagnosis included GI bleed requiring no further workup per family, stable dementia and depression, MRSA UTI on PO Zyvox and hypercalcemia. Her list of psychoactive medications included Donepezil 10 mg for dementia, Namenda 10 mg, Paxil 20 mg and Remeron 15 mg for Major Depressive Disorder (MDD).

On August 06, 2018, Psychological Diagnostic Interview was performed by XXX, PsyD. Psychological evaluation was requested for depression and to consider need for psychotherapy given history of depression. Ms. XXXX was unaware of treatment of depression with Paxil and Remeron and denied feelings of depression. Her ability to report on recent events or even on how she was feeling, however, was very limited. Cognitive impairments including severe memory loss and confusion were present and reflected dementia process. She had been cooperative in accepting treatment and rehabilitation in a passive manner and psychotherapy was not indicated.

On August 21, 2018, Ms. XXXX completed Zyvox for MRSA urine and recommended to follow up as needed. On 08/22/2019, assisted living evaluation was performed by XXX, LMSW. Primary diagnoses included Dementia and major depressive disorder. Secondary diagnoses included Vitamin deficiency, hyperlipidemia, hypertension, long term use of antibiotics, pain. She required continuous assist for ambulation, transfer and could not manage medical equipment. On August 24, 2018, physical and occupational therapy were discontinued and she was transferred to previous assisted living facility. Her discharge assessment revealed she required supervision with bed mobility, distant supervision for transfers, distant supervision for ambulation with RW over 200 feet. She was able to ambulate with hand hold assist or without a device requiring CG/Close supervision. Ms. XXXX was able to negotiate 16 steps using 1 rail with Close Supervision. She had a RW at prior assisted living facility as per social work.

On February 15, YYYY, Ms. XXXX presented to ABCD Hospital Medical Center ER via EMS at 1837 hours following an unwitnessed fall at Sunrise at Dix Hills. She was evaluated by XXX and XXX, D.O. in ER. She complained of hip pain and headache. On examination, there was bilateral hip tenderness to palpation and pain with ROM. She was reported questionable loss of consciousness following the fall. Imaging studies were recommended to rule out fracture.

On the same day at 1956 hours, X-ray of chest was performed by XXX, M.D. and it revealed no acute disease process. X-ray of right hip with pelvis was performed by Brendan Miner, M.D. and it revealed joint space narrowing and hypertrophic changes noted which were consistent with moderate-to-severe degenerative change. There was a fracture of the right superior pubic ramus at the acetabular margin level. There appeared to be fracture deformities along the more medial superior pubic, inferior pubic ramus on the right. X-ray of left hip with pelvis revealed no acute changes. At 2138 hours, CT of head without contrast was performed by Eugene Kim, M.D. and it revealed no acute intracranial abnormality. CT of cervical spine was performed by Eugene Kim, M.D. and it revealed no acute fractures. At 2146 hours, CT of abdomen and pelvis was performed by Brendan Miner, M.D. and it revealed a displaced right inferior pubic ramus fracture with a minimally displaced right superior pubic ramus fracture. There was a minimally displaced anterior right sacral fracture.

On the same day at 2203 hours, Trauma consultation was obtained from XXX, M.D. Per history provided by daughter, her mother usually ambulates very well and is fairly independent at the facility but was unable to get up without assistance at the nursing home. CT imaging showed fractures of the right superior and inferior pubic ramus. GCS was 14. Examination revealed she was alert and oriented x1 with temporal wasting. There was tenderness to palpation in the left paraspinal area. It was recommended to

get MRI in the morning. She was also diagnosed with UTI and recommended Azactam and to follow up urine culture.

On the same day at 2204 hours, Dr. XXX of Ortho was contacted, and he requested admission for UTI/pubic rami fracture, unable to bear weight and need for further workup/rehab. She was admitted by Justin Szpillka, P.A. Labs revealed increased WBC 13.48, chloride 108 and calcium 10.5. She was diagnosed to have right displaced superior/inferior pubic rami fracture, right minimally displaced sacral fracture and a left non-displaced superior pubic ramus fracture and UTI. She was recommended physical therapy, pain medication as needed and to restart home medications. Neurosurgery/Ortho/Medicine consults were requested.

On February 16, YYYY, Neurosurgery consult was obtained from Lisa Persico, P.A. GCS score was 15 and she was noted with dementia. Her neuro examination was stable and was recommended pain control. At this time, no acute neurological intervention indicated.

On the same day at 1103 hours, Ortho follow up was made by XXX, M.D. She had not been able to ambulate since the unwitnessed fall. Labs revealed WBC 8.06, RBC 3.86, hemoglobin 11.6, hematocrit 36.0, platelet 159. On examination, she was unable to straight leg raise but no pain noted with log roll or heel strike. It was planned for MRI right hip without contrast to rule out right hip fracture. She remained on non-weightbearing (NWB) on right lower extremity (RLE) and out of bed activity were not restricted. It was also suggested for chemical DVT prophylaxis and pain control. She was advised to remain nil per oral until after MRI was completed and hip fracture was ruled out.

On the same day at 1141 hours, Trauma follow up was made by XXX, PA. She was seen and examined, resting comfortably in bed without complaint. She denied chest pain, SOB, nausea, vomiting, diarrhea, visual disturbances, numbness or tingling of extremities. Examination revealed RLE movement restricted secondary to pain. It was recommended to continue with pain control, incentive spirometry and to remain NPO pending right hip MRI and LR at 75 ml/hr.

On the same day at 1208 hours, Hospitalist consultation was obtained from XXX, M.D. She was diagnosed with bilateral fracture of pubic rami, Depression, Hyperlipidemia, Mental status alteration, fall at nursing home and closed sacral fracture. Home medication were reviewed and advised to continue with Acetaminophen tablet 650 mg, Amlodipine tablet 5 mg, Ascorbic acid tablet 250 mg, Atorvastatin tablet 40 mg, Aztreonam 1 g in dextrose in water 5 % 50 ml IVPB, Bisacodyl EC tablet 5 mg, Calcium Citrate-Vitamin D 315-250 mg, Docusate sodium capsule 100 mg, Donepezil tablet 10 mg, Famotidine tablet 20 mg, Lactated ringers infusion, Memantine tablet 10 mg, Mirtazapine tablet 15 mg, Multivitamin with minerals tablet 1 tablet, Ondansetron injection 4 mg, Oxycodone immediate release tablet 5 mg, Paroxetine tablet 20 mg and Vitamin D tablet 400 units.

On the same day at 1410 hours, Ortho follow up was made by XXX, M.D. Lower extremities examination revealed that she was able to move her foot and ankle without difficulty. It was suggested to proceed with MRI just to ensure that she did not have a proximal femur fracture on the right hip region. She had displaced superior and inferior pubic rami fracture and a non-displaced left superior rami fracture and displaced sacral fractures. It was recommended to follow the geriatric fracture protocol and to obtain a vitamin D3 level. If her hip was not compromised, she would be a candidate for ambulation and then plan to follow her hemoglobin on an every 12 basis for her fractures. Once her hemoglobin was stable, she would be considered a candidate for anticoagulation.

On the same day at 1445 hours, Infectious Disease consultation was obtained from XXX, D.O. for UTI. It was recommended to continue Azactum, follow up cultures, ortho follow up and monitor labs.

On February 17, YYYY at 0648 hours, Ortho follow up was made by XXX, M.D. MRI of hip was still pending at this time. On examination, she was unable to straight leg raise but no pain noted with log roll or heel strike. She remained on non-weightbearing (NWB) on right lower extremity (RLE) and out of bed activity were not restricted. It was recommended to complete MRI as early as possible in order to allow ambulation if negative or to proceed with OR if positive.

On the same day at 0831 hours, Hospitalist follow up made by XXX, M.D. She was alert and oriented x3 and not in acute distress. She was recommended to continue Azactum day 2 out of 7 for UTI. Physical evaluation was requested for rehabilitation needs.

On the same day at 0918 hours, Trauma follow up made by XXX, PA and Kazim Doganay, M.D. She was resting in bed without complaints. Examination revealed positive tenderness noted to the hip/groin area with decreased ROM secondary to pain. She was recommended to continue home medications, NPO until MRI. Lovenox was held until MRI was completed. Physical therapy evaluation was planned after completion of MRI. Trauma was planned to sign off to Medicine on this day if she was a non-operative candidate.

On the same day at 1120 hours, Infectious Disease follow up made by XXX, D.O. for UTI. It was recommended to continue Azactum day 2 out of 7, follow up cultures and monitor labs.

On the same day at 1123 hours, MRI of right hip was performed by XXX, M.D. to rule out hip fracture. It revealed advanced arthritic changes seen at the right hip joint. There was no evidence of right femoral head or neck fracture. There was a non-displaced fracture seen involving the right sacral ala as well as the parasymphyseal region of the right to be bone and right inferior pubic ramus. A small joint effusion was seen at the right hip joint. There was a nonspecific increased T2 signal within the right hip adductor musculature representing muscle strain.

On the same day at 1231 hours, nutritional consultation was obtained from XXX, R.D. Ms. XXXX's son reported that he did not feel she had lost any significant amount of weight PTA, she recently gained some weight but unsure of UBW. He did not think she takes any supplements PTA. She was diagnosed with inadequate energy intake related to lack of access to nutrition as evidenced by NPO status. It was recommended to restart regular diet, SLP evaluation to determine appropriate consistency, provide Ensure Enlive thrice daily and monitor per oral intake/tolerance, labs, weight trends, skin reassessment and nutrition related changes.

On February 18, YYYY at 0651 hours, Ortho follow up was made by XXX, PA-C and XXX, M.D. No new complaints were noted. It was recommended to continue current care and also suggested that she was a candidate for SARS.

On the same day at 1411 hours, Hospitalist follow up made by XXX, M.D. She was alert and oriented x3 and not in acute distress. Labs revealed elevated calcium 10.6, chloride 108, BUN/Creatinine 25. She was recommended to continue Azactum for UTI. Physical evaluation was requested for

rehabilitation needs. Physical therapy consult was held by XXX, P.T. due to her being extremely lethargic, only opening eyes briefly to verbal/tactile stimuli.

On February 19, YYYY at 0730 hours, Ortho follow up was made by XXX, PA and XXX, M.D. No new complaints were noted. It was recommended to continue current care and weightbearing to right lower extremity.

On the same day at 0950 hours, Infectious Disease follow up made by XXX, D.O. for UTI. Urine culture on 2/17 revealed positive for enterococcus and was started on Vancomycin on this day. She was also continued on Azactum day 4 out of 7.

On the same day, physical therapy evaluation was performed by XXX, P.T. She was assessed with Decreased transfers, decreased ambulation, decreased bed mobility, decreased endurance, decreased strength, Decreased ROM. She was recommended Strengthening/ROM, Bed mobility, Transfer training, Gait training, Balance training, Endurance training, Patient/caregiver education for 5-7 per week.

On the same day, physical medicine and rehabilitation consult was obtained from XXX, D.O. It was noted that in PT, she required max assist x2 for transfer, ambulated 3 steps RW max assist x2. Ms. XXXX was very confused and did not participate in neuro exam. She was spontaneously moving extremities. She was recommended physical and occupational therapy for bed mobility, transfers, strengthening, therapeutic exercise, range of motion, progressive ambulation, and activities of daily living. She was on weightbearing as tolerated (WBAT) status. It was recommended to transfer her to subacute rehab for further management.

On the same day, Infectious Disease follow up made by XXX, D.O. It was recommended to continue Azactum for 3 more days. Vancomycin was discontinued and recommended to start with Zyvox 600 per oral every 12 hours x 3 more days.

On the same day, she was discharged to OLOC by XXX. Discharge medications included Amlodipine tablet 5 mg, Ascorbic acid tablet 250 mg, Bisacodyl EC tablet 5 mg, Calcium Citrate-Vitamin D 315-250 mg, Cranberry capsule 500 mg, Crestor 10 mg, Dextrose in water 5% son 50 ml with Aztreonam 1g Solr 1g, Docusate sodium capsule 100 mg, Donepezil tablet 10 mg, Enoxaparin sodium 30 mg/0.3 ml soln injection, Famotidine tablet 20 mg, Memantine tablet 10 mg, Mirtazapine tablet 15 mg, Multivitamin with minerals tablet 1 tablet, Paroxetine tablet 20 mg and Vitamin D tablet 400 units.

On February 19, YYYY at 1958 hours, Ms. XXXX was admitted to ABC Nursing and Rehabilitation. She was administered 1g of IV Azactam in 50mL (Dextrose in water 5%) at 2000 hours by Felipe Lima, R.N. Admission evaluation was performed by Patricia Lotridge, N.P. at 2013 hours. On assessment, she was alert and oriented to person, clear speech, adequate hearing and using glasses for reading. She was noted with bilateral lower extremity weakness but no limitation in ROM was noted. She was status post bilateral pubic rami fractures. Ecchymosis was noted in superior left hand, measuring 5 cm x 2 cm. She was currently being treated for UTI with Azactum with 3 more three more days of antibiotic remaining. She was able to use call bell. She was noted with incontinent of bowel/bladder and was also noted with increased risk of fall. Mobility was limited secondary to fracture.

On the same day, Braden scale assessment was performed by XXX, LPN. Total score was 16 which was determined as at risk category. Fall prevention observation was also performed by XXX, LPN

and it was documented that Ms. XXXX was able to use a call bell, able to communicate their needs, act impulsively. She had recent diagnosis of dementia, Parkinson's, CVA, Hypotension, Seizures, recent fractures and was on prescribed opiates, anticonvulsants, antihypertensives, diuretics, sedatives, hypnotics or laxatives. She was not anxious or restless at this time. Fall prevention questionnaire revealed that pain had decreased her ability to move and she requires help with bathing, dressing, using toilet. Admission Morse scale for fall risk indicated a total score of 95 which was determined as high risk category.

On the same day, admission side rail assessment was performed by XXX, N.P. It was documented that Ms. XXXX was mobile, with voluntary movements to get in and out of bed and could egress the bed with 1/4 rail up. She also needed 1/4 rail to enhance independence in mobility and/or turning and positioning. It was suggested that use of 1/4 rail was appropriate for movement within the bed, assist her getting in and out of bed and to provide her with independent access to bed controls. Admission antipsychotic review revealed that she was on Remeron 15 mg for depression and she was also taking Aricept, Namenda.

On February 20, YYYY at 0453 hours, nursing notes by XXX, LPN revealed Ms. XXXX slept without incident or complaints of pain. Azactam via left hand forearm PIV continued for UTI with no adverse reactions noted at this time. Fluid was encouraged and safety maintained, with call bell within her reach. On the same day, wandering/elopement risk was assessed by Alyssa Van Yahres, SW and total score was 5 which was determined as low risk category.

On the same day, nutritional assessment was performed by XXX. Her supplements included Multivitamin (MVI), Vitamin C, Acidophilus, Cal-D3, CranCap, Mg, D3. She was currently on NAS, Low Fat and Low Cholesterol diet. It was recommended to discontinue Low Fat, Low Cholesterol to promote optimal per oral intake. She was alert, able to make preferences known, and feed self with tray prep. Ms. XXXX reported no difficulty chewing or swallowing. She was recommended Pro-Stat SF 30ml 2/day for additional 30 gm pro daily and Ensure Enlive 4 oz 2x/day for additional 350cal, 20gm protein daily. Lab report revealed increased BUN/Creatinine ratio 28, chloride 108, calcium 10.3 and decreased Potassium 3.4.

On the same day, physical therapy initial evaluation was performed by XXX, P.T. She was referred for skilled PT services, as she grossly required max assist x2 for supine to sit, max assist x2 for STS, total assist for SPT, and was non-ambulatory at this time. She was limited by complaints of pain to bilateral lower extremities. Cognitively she was oriented to person, safety awareness was 60-79% improved, following one step direction. She was placed at weightbearing as tolerated to bilateral lower extremities. It was suggested that immobility associated with recent hospitalization, along with prior medical complications, had contributed to an overall decline in her functional abilities. It was recommended that she would benefit from skilled PT intervention to establish POC to address functional deficits associated with her medical diagnosis to restore function to maximize safety/independence in all ADLs, transfers and functional mobility maneuvers to promote safe return to PLOF. It was planned to proceed with skilled therapy consisted of Hot/cold packs, Therapeutic exercise, Gait training, Manual therapy, Group therapeutic procedure and Therapeutic activities.

On the same day, occupation therapy evaluation was performed by XXX, O.T. It was noted that she presented with decline in functional mobility (bed mobility, transfers, balance, functional mobility, ADLs, strength and endurance level). She was referred to skilled OT from the hospital for further evaluation and potential interventions in order to increase safety, performance in ADLs and transfers in

order to increase ease transition to the next step of care. She required Supervision or Touching Assistance for eating, upper body dressing, upper body wash. She was dependent for lower body dressing, footwear management, shower/bathe self, toileting hygiene, indoor mobility, stairs. She required total assist for toileting, clothing management, supine/sit, sit/stand, shower/tub, wheelchair/bed. Her fall risk was estimated as high at this time. Ms. XXXX required total assist for bed mobility, Hoyer lift for transfers, unable to come to full upright stand despite max assist x2.

On the same day at 2158 hours, physician admission note was documented by XXX, M.D. Her current complaints included recent fall with pubic rami fracture, Enterococcus UTI, Alzheimer's and depression. Her assistive device included walker. She was recommended to continue with calcium and daily restorative PT for bilateral pubic rami fracture, completed Zyvox on 02/21/2019. She was advised to continue with Remeron and Paroxetine for depression, Norvasc for hypertension and Memantine and Donepezil for Alzheimer's.

On February 21, YYYY, nursing notes was documented by XXX, RN at 1050 hours. Ms. XXXX was alert denied pain ADLs, left forearm PIV in place site clean dry intact, receiving Azactam in progress. No adverse reactions were noted secondary to UTI.

On February 23, YYYY, nursing notes was documented by XXX, R.N. at 1433 hours. It was noted that Azactum was completed for UTI and peripheral IV was removed. No excessive bleeding was noted. Per oral fluids was encouraged, safety maintained. No complaints of pain or discomfort were reported.

On February 25, YYYY, psychiatric evaluation was performed for dementia and depression. Primary psychiatric diagnoses were dementia, fall, major depressive disorder. It was recommended to continue with labs and medication and recommended to use one antidepressant instead of two because of Lovenox and risk and bleeding were thought to be high. On the same day, nursing notes by Dawn Kollen, R.N. revealed she required max assist of 2, transfers with Hoyer. Fall precautions were in place and safety maintained.

On February 26, YYYY, Psychosocial Diagnostic Interview was performed by XXX, PsyD. Current psychiatric medications were Paxil, Remeron. She was diagnosed with dementia without behavioral disturbance. Ms. XXXX had significant difficulty in reporting on recent events which included inability to recall most recent living situation at an assisted living facility or to recall that she was hospitalized following a fall which resulted in a fracture of pubic rami. It was suggested that psychotherapy was not indicated or possible given severity of cognitive deficits.

On the same day, physical therapy progress note was documented by XXX, P.T. It was noted that she now exhibited ability to complete sit to stand from wheelchair with max A, able to sustain stance with mod A when agreeable. Ms. XXXX exhibited difficulty weight bearing through RLE in stance.

On the same day, occupational therapy progress note was documented by XXX, O.T. Ms. XXXX was attending with all therapeutic interventions and was making progress toward all goals that were being addressed in therapy. During this reporting period, she had demonstrated improvements with dynamic standing balance, functional transfers. Her CLOF were dynamic standing balance, bed mobility dependent, clothing management total A, functional transfers max A, UB dressing max A. Ms. XXXX was recommended to continue with skilled OT to maximize independence with ADLs.

On the same day, physician follow up was made by XXX, M.D. No issues were reported. She was status post Zyvox, stable on Namenda and Donepezil. She was recommended to continue with restorative PT.

On February 28, YYYY, physician follow up was made by XXX, M.D. She was doing well without complaints. Hypertension was well controlled and depression was stable with stable mood. She was recommended to continue with restorative PT.

Medication administration sheet from February 19, YYYY to February 28, YYYY revealed medication documented for Acidophillus capsule, Multivitamin with Folic acid, Amlodipine 5 mg, Aricept 10 mg, Ascorbic acid 250 mg, Azactam 1 g in dextrose (Last administered on 02/22), Bisacodyl 5 mg, Calcium citrate + D 315-200 mg, Colace 100 mg, Cranberry extract 425 mg, Crestor 10 mg, Ensure Enlive 0.08 g-1.5 kcal/ml, Famotidine 20 mg, Lovenox 30 mg/0.3 mg, Magnesium oxide 400 mg, Namenda 10 mg, Paxil 20 mg, Prostat AWC 17-100 g-kcal/30 ml, Remeron 15 mg, Vitamin D3, Utilize pain scale to determine her level of pain, Weekly weight for 4 weeks.

Treatment sheet from February 19, YYYY to February 28, YYYY revealed treatment documented for Physical Therapy (Therapeutic exercise, Therapeutic Activities, Gait training, Modalities/pain, Positioning and pressure management, Wheelchair mobility), Baza Protect to peri-area after cleanse with soap and water and Float Heels with pillow when in bed. *(Details related to documentation about fall prevention protocol are not available for this month.)*

On March 05, YYYY, physical therapy progress note was documented by XXX, P.T. It was noted that she now exhibited improved participation which had led to improved transfer sit to stand with moderate A, amb with RW up to 50' and min A, cadence was slow with limited safety awareness.

On the same day, occupational therapy progress note was documented by XXX, O.T. It was noted that she required Min/mod for transfers, min A for bed mob, Upper Body Dressing (UBD) with min/mod, Lower Body Dressing (LBD) with max A, clothing management max/dep.

On the same day, Braden scale for predicting pressure ulcer was performed by XXX, R.N. Total score was calculated as 16 which was determined as at risk category.

On March 06, YYYY, physician follow up was made by XXX, M.D. She admitted to improving pain and doing better on physical therapy, no specific complaints reported on this day. Hypertension was well controlled and depression was stable. She was recommended to continue with restorative PT.

On March 08, YYYY, physician follow up was made by XXX, M.D. No new issues were reported on this day. ROM at bilateral hips had improved with no pain at present. Hypertension was well controlled and depression was stable. She was recommended to continue with restorative PT.

On the same day, nutrition follow up was made by XXX. Weight on 02/19/2019 was 126, February 26, YYYY was 125, March 05, YYYY was 116.8 with 9.2# loss x 15 days (-7.3%). Her per oral intake was noted to be good generally more than 75%. It was recommended to increase Ensure Enlive to 3x/day 4 oz. for additional 525cal, 30gm protein daily.

On March 10, YYYY, nursing note was documented by XXX, LPN. It was noted that she was currently under observation for lethargy. She offers no complaints, no signs/symptoms of pain or discomfort. Comfort and safety were maintained and call bell within reach.

On March 12, YYYY, physical therapy progress note was documented by XXX, PTA and XXX, P.T. It was noted that bed mobility was done with max/mod A, sit to stand with mod A, ambulation with RW x70 feet with mod A x1. Elder mobility scale had increased from a 0/20 to a 6/20.

On the same day, occupational therapy progress note was documented by XXX, O.T. It was noted that she required min/mod A for transfers, min A for bed mob, UBD with min/mod A, LBD with max A, clothing management max/dep.

On the same day, physician follow up was made by XXX, M.D. She was doing well with no pain. ROM at bilateral hips had improved with no pain at present. Hypertension was well controlled and depression was stable. She was recommended to continue with restorative PT.

On March 14, YYYY, nutrition follow up was made by XXX. Weekly weight 03/12/2019 was 117#, weight stable x 1 week, desirable weight range was 114-146#. It was recommended to add Ensure Clear 8 oz. 2x/day for addl. 480cal, 16gm protein daily, and to increase Ensure Enlive to 4x/day 4 oz. for 700cal, 40gm protein.

On the same day, physician follow up was made by XXX, M.D. She was doing well with no new complaints on this day. Hypertension was well controlled and depression was stable. She was recommended to continue with daily restorative PT.

On March 18, YYYY, nutrition follow up was made by XXX. Weight on March 14, YYYY was 112.3# with 4.7# loss x 2 days (-4%). It was suggested that appetite fluctuates and recommended 3 day calorie count to assess per oral intake and continue weekly weights to monitor.

On the same day, physician follow up was made by XXX, M.D. She was doing well with no new complaints on this day. Hip was noted with adequate range of motion. Hypertension was well controlled and depression was stable. She was recommended to continue with daily restorative PT.

On March 19, YYYY, physical therapy progress note was documented by XXX, P.T. She now exhibited ability to complete sit to stand with min A, amb with RW up to 100'+ with CG due to decreased cadence and limited safety awareness. Level of achievement was noted to be fluctuating based on variable cognitive status.

On the same day, occupational therapy progress note was documented by XXX, O.T. It was noted that she required min A for transfers, min A for bed mob, UBD with min A, LBD with max A, clothing management max/dep.

On March 20, YYYY, Ms. XXXX presented for orthopedic follow up with XXX, M.D. She reported with no significant complaints. On examination, she was ambulating with a wheeled walker with assistance. Her hip range of motion was non-painful. Right hip flexion was 120°, internal rotation 10°, external rotation 30°. Rotation of the right hip was painful. Forward flexion of left hip was 120°, internal rotation 20°, external rotation 40° with no pain on rotation of her left hip. She was neurologically intact in

the lower extremity. She was diagnosed with pubic rami fracture osteoporosis and closed fracture of pubic ramus with routine healing. She was recommended to continue therapy modalities for ambulation, weightbearing as tolerated to her lower extremities. She was advised to continue with vitamin D 2000 international units daily, vitamin C 250 mg daily and calcium citrate 600 mg twice a day. She was advised to return to office in 6 weeks for repeat X-rays of her pelvis.

On March 23, YYYY, nursing documentation by XXX, LPN revealed that she was currently under observation for calorie count (day 3 of 3). She offered no complaints and no signs/symptoms of pain or discomfort was noted. Comfort and safety maintained and call bell within reach.

On March 25, YYYY, physician follow up was made by XXX, M.D. She reported no new complaints on this day. No hip tenderness was noted. Hypertension was well controlled and depression was stable. She was recommended to continue with daily restorative PT.

On March 26, YYYY, physical therapy progress note was documented by XXX, PTA and Donna Adams, P.T. She now exhibited ability to ambulate RW 100 feet CG and limited carryover. She would sit to stand and Static and dynamic standing balance with Contact Guard assist (CG).

On the same day, occupational therapy progress note was documented by XXX, O.T. It was noted that she required CGA for transfers, CG/SUP for bed mob, UBD with min A, LBD with max A, clothing management mod A. It was noted that she was making progress towards her goals as evidence from increasing performance in transfers, bed mob, and clothing management.

On March 27, YYYY, nutrition follow up was made by XXX. 3 day calorie count suggested intake of fluids/beverages better than foods, Day 1- 735cal, 36gm pro; Day 2- 810cal, 41gm pro; Day 3- 721cal, 32gm pro; average daily intake 755cal, 36gm pro, inadequate to meet estimated needs for calories and protein, however intake of nutritional beverages were good >75% generally. It was recommended to increase Ensure Enlive 8 oz. to 4x/day for additional 1400cal, 80gm pro and Ensure Clear 8 oz. to 4x/day for additional 960cal, 32gm pro.

On March 29, YYYY, at 0530 hours, nursing note documented by XXX, R.N. It was noted that Ms. XXXX was found on the floor with hematoma to left side of head, bloody nose and increased confusion following a fall which was unwitnessed. Vital signs were temp 97.5, BP 166/83, heart rate 100, resp. rate 20, SpO2 95% on room air. Location of fall was documented as resident bathroom. Pain scale was documented as 5/10. Location of injury was noted as forehead, and possible mouth injury. There was no restriction with the range on motion in all extremities. Hematoma to left side of head was measured as 6 cm x 4cm x 4cm. MD was notified about the fall and ordered to transfer to GSH for management.

Treatment sheet from March 01, YYYY to March 29, YYYY revealed treatment documented for Physical Therapy (Therapeutic exercise, Therapeutic Activities, Gait training, Modalities/pain, Positioning and pressure management, Wheelchair mobility), Baza Protect to peri-area after cleanse with soap and water and Float Heels with pillow when in bed. Documentation about fall prevention program was documented only on March 29, YYYY by Nerlande Guillaume, R.N.

On March 29, YYYY at 0639 hours, ER triage was performed by XXX, R.N. Examination revealed hematoma above left eye. Pupils were reactive to light, respirations were even and unlabored. Bed was placed in the lowest position and safety maintained. At 0745 hours, ER physician evaluation was

performed by Arman Sobhani, M.D. and Wojciach Bober, D.O. It was noted that Ms. XXXX was on Lovenox daily and physical examination revealed hematoma above left eye. There was left preorbital ecchymosis and erythematous nose with blood in bilateral nare and significant nasal tenderness. There was no tenderness on cervical spine, or no stepoffs. She was able to move all extremities with no evidence of trauma. There was not spinal tenderness or step offs. It was planned for diagnostic imaging studies.

At 0916 hours, CT brain without contrast was performed by XXX, M.D. There was suspicion of a thin subdural collection in the right frontal region laterally. Scalp hematoma was noted with left periorbital/forehead. There appeared to be slightly displaced fractures involving the medial and lateral walls of the right and left maxillary sinuses as well as the medial and lateral pterygoid plates bilaterally. Air was seen within the soft tissues adjacent to the maxillary sinuses. There was slightly displaced left nasal bone fracture. CT of facial bone was performed by XXX, M.D. It revealed multiple facial bone fractures with pattern of involvement including the bilateral pterygoid plates suggested as Le Fort type fracture. Fluid levels were seen within both maxillary sinuses which might be related to posttraumatic hemorrhage and/ or inflammatory change. There was increased density seen within the nasal cavity which might be represented post traumatic and or inflammatory change. There was left forehead and periorbital soft tissue swelling/hematoma.

On the same day, CT of cervical spine without contrast was performed by XXX, M.D. There was no cervical spine fracture noted. There were degenerative changes and varying degrees of bony spinal stenosis and neural from narrowing seen at several levels. Minimal grade 1 retrolisthesis was seen at the C2-C3 and C5-C6 levels. CT of lumbar spine was performed by James McHale, M.D. It revealed narrowing of the lumbar discs from L2 through the S1 vertebral bodies with posterior disc ridge complexes of the adjoining endplates of the L4 through the S1 vertebral bodies. CT of abdomen and pelvis was performed by James McHale, M.D. and it revealed calcified cholelithiasis and right hydronephrosis extending to a 1.7 cm calculus within the right ureteropelvic junction. CT of chest revealed no acute changes. CT of thoracic spine revealed no acute changes.

On the same day at 1037 hours, neurosurgery consultation was obtained from XXX, PA. GCS was 14. Examination revealed left periorbital ecchymosis. Labs revealed increased WBC 16.09, chloride 120, BUN 41, glucose 126, calcium 10.9, alkaline phosphatase 132, BUN/creatinine 46 and decreased Albumin 3.1, PTT 18.5. She was assessed with questionable right subdural hemorrhage (SDH). At this time, no neurosurgical intervention was recommended. It was also suggested to repeat CT the next morning and planned to restart Lovenox after follow up CT.

On the same day at 1048 hours, admission note was documented by XXX, D.O. At this time, Ms. XXXX was not denying any pain but was not cooperative with the physical exam. Her home medications included Acetaminophen 325 mg, Acidophilus capsule, Amlodipine 5 mg, Ascorbic acid 250 mg, Bisacodyl 5 mg, Calcium Citrate-Vitamin D 315-250 mg, Cranberry 500 mg, Docusate sodium 100 mg, Donepezil 10 mg, Lovenox 30/0.3 ml, Famotidine 20 mg, Magnesium oxide 250 mg, Memantine 10 mg, Mirtazepine 15 mg, Oxycodone 5 mg, Paroxetine 20 mg, Crestor 10 mg and Vitamin D. Physical examination revealed left supraorbital swelling, left peri-orbital swelling and ecchymosis, dried blood in nares. There was no battle signs. She was assessed with thin right frontal subdural hematoma, multiple facial bone fractures involvement including the bilateral pterygoid plates suggested as LeFort type fracture with left forehead and periorbital soft tissue swelling/hematoma. She was admitted to monitored floor bed. It was recommended to perform neuro checks every 4 hours, antibiotics for facial fractures. Plastics consult requested for facial fractures. Fall precautions and One to one monitoring were in place. It

was also advised neb treatment as needed for wheezing and encouraged to use Incentive Spirometry (IS) while awake. Hypertension was under control and placed on cardiac monitor. IV fluids were started and planned to monitor renal output. Physical therapy evaluation was requested and advised to offload pressure points.

On the same day, plastic surgery consult was obtained from XXX, M.D. Physical examination revealed left supraorbital swelling, left peri-orbital swelling and ecchymosis, dried blood in nares. She was diagnosed with thin right frontal subdural hematoma, multiple facial bone fractures involving the bilateral pterygoid plates suggested as Le Fort type fracture and nasal fracture bilateral with Le Fort type II and left forehead and periorbital soft tissue swelling/hematoma. It was recommended to continue with IV antibiotics, no nose blowing, continue with puree soft diet and oral hygiene with Peridex oral rinse swish and spit twice daily.

On the same day, speech therapy evaluation was performed by XXX, MA, CCC-SLP. It was noted that she was on a regular consistency with thin liquids prior to arrival. Diet recommendations included Puree diet, thin liquids and to be placed upright as possible for all oral intake, remain upright for 20-30 minutes after meals, one to one assist with meals, small bites/sips, Eat/feed slowly. No speech therapy interventions were recommended at this time.

On March 30, YYYY, CT of brain without contrast was performed by XXX, M.D. It revealed stable thin subdural hematoma in the right frontal region, stable left forehead scalp laceration and swelling of the left eye. There were nasal bone fractures, fractures of the medial and lateral walls of the right and left maxillary sinuses as well as the medial and lateral pterygoid plates. There was air-fluid level seen in the maxillary sinuses bilaterally and ethmoid sinuses. There was mucoperiosteal thickening in the sphenoid and frontal sinuses.

On the same day, Trauma follow up was made by Tracey John, PA and XXX, D.O. No complaints were reported at this time. Labs revealed elevated WBC 13.49, sodium 157, chloride 124, glucose 123, and calcium 11.0. It was noted that repeat CT head was stable and advised to continue with oral care. Preliminary urine culture resulted >100,000 gram negative rods. IVF was changed to 0.45% NS at 75 ml/hr and Macrobid started for UTI (awaiting UC). Unasyn continued for facial fracture. She was continued on Incentive spirometry, Pain control and Puree Diet with assistance. Physical therapy evaluation was requested.

On the same day, neurosurgery follow up was made by XXX, NP. Ms. XXXX reported no complaints. CT head was reviewed and noted as stable. Neurosurgery decided to sign off and advised to follow up as outpatient in 2 weeks with repeat head CT.

On the same day, plastic surgery follow up was made by XXX, M.D. It was recommended to continue with IV antibiotics, no nose blowing, puree soft diet and oral hygiene with Peridex oral rinse swish and spit twice daily.

On March 31, YYYY, Trauma follow up was made by XXX, D.O. She was resting comfortably in bed without complaint, more co-operative and less combative with physical exam. Pain was well controlled. Labs revealed elevated Chloride 123, calcium 10.3, BUN 20, sodium 157. Physical examination revealed decreased swelling and ecchymosis left eye and resolving left periorbital edema. She was continued on neuro check every 4 hours, Incentive spirometry, and pain control.

On the same day, nutrition consult was obtained from XXX, R.D. It was recommended to continue with Ensure Enlive thrice daily, encourage/assist PO intake. If there was no improvement in per oral, palliative care consult was planned to be requested to establish nutrition goals of care with family.

On the same day, plastic surgery follow up was made by XXX, M.D. It was recommended to continue with IV antibiotics, no nose blowing, puree soft diet for now as well as post discharge and oral hygiene with Peridex oral rinse swish and spit twice daily. It was suggested that she would require per oral antibiotics upon discharge for 2 weeks.

On the same day, physical therapy evaluation was performed by XXX, P.T. It was noted that cognitive status was impaired. She was following one step commands with increased time. She was assessed with Decreased transfers, decreased ambulation, decreased bed mobility, Decreased strength. She was recommended restorative therapy interventions such as Bed mobility, Transfer training, Gait training, Therapeutic exercise, Patient/caregiver education, Strengthening/ROM for 5 times per week.

On April 01, YYYY, Trauma follow up was made by XXX, M.D. and XXX, D.O. Ms. XXXX was lying in bed, not oriented to time or place. She was eating 25% of her food and required considerable encouragement to do that. She also had periods of agitation while in bed. Physical examination revealed left periorbital ecchymosis. She was started on Keppra 500 mg twice daily and continued on neuro checks every 4 hours. Macrobid was discontinued and Azactum was added for E. coli UTI. Augmentin was continued for nasal bone fracture.

On the same day, Palliative Medicine consult was obtained from XXX, M.D. Physical examination revealed left eye and orbit with ecchymosis and lethargic note and not arousable. It was planned to continue to follow for any signs of pain or dyspnea.

On the same day, ultrasound of bilateral lower extremity was performed by James McHale, M.D. for evaluation of pain and swelling of bilateral lower extremities. It revealed no abnormal findings.

On the same day, infectious disease consult was obtained from XXX, D.O. for UTI. It was documented that she was noted with mild leukocytosis, pyuria and UTI. Physical examination revealed left facial ecchymosis. Urine culture revealed >100,000 CFU/ml Escherichia coli and urinalysis revealed urine WBC 63, urine RBC 43, slightly-cloudy appearance and Large urine leukocyte. It was recommended to continue Azactum for 7-day course. It was also suggested per oral option was not available due to allergies.

On the same day, plastic surgery follow up was made by XXX, M.D. It was recommended to continue with IV antibiotics, no nose blowing, puree soft diet for now as well as post discharge and oral hygiene with Peridex oral rinse swish and spit twice daily.

On April 02, YYYY, X-ray of chest was performed by XXX, M.D. for follow up exam. It revealed no abnormal findings.

On the same day, plastic surgery follow up was made by XXX, M.D. It was recommended to continue with IV antibiotics per ID, no nose blowing, puree soft diet for now as well as post discharge

and oral hygiene with Peridex oral rinse swish and spit twice daily. It was suggested to continue soft diet as outpatient until fractures have been given opportunity to heal for a total of six weeks.

On the same day, Trauma follow up was made by XXX, M.D. and Justin Szpilka, PA. Ms. XXXX had an eventful night in which she was found to be lethargic but able to protect her airway. Opiates were discontinued due to lethargy. She was found to be lethargic this morning but was able to obey simple commands. She started gargling on her secretions after eating, then she was lifted with her head up and suctioned out some thick secretions. Therefore made NPO with continued maintenance fluids. Labs revealed sodium decreased to 153 and WBC decreased to 11. Physical examination revealed scattered rhonchi with adequate excursion, resolving left periorbital ecchymosis. Stat CT was suggested due to decreased mental status to rule out increased intra-cranial hemorrhage. Head of bed was suggested to be kept elevated 45 degrees at all times. She was continued on Azactum for UTI and Augmentin for nasal bone fracture.

On the same day, Infectious Disease follow up was made by XXX, D.O. for UTI. Leukocytosis was noted to be resolving and recommended to continue Azactum for 7 day course and monitor labs.

On the same day, CT of brain was performed by XXX, M.D. It revealed thin subdural collection along the right anterolateral frontal convexity, similar to questionably slightly decreased as compared with prior studies. Multiple facial bone fractures again identified, similar to prior. Paranasal sinus disease, with evidence for fluid levels within bilateral maxillary sinuses. Retained fluid were suggested to be related to posttraumatic change.

On the same day, speech therapy evaluation was performed by XXX, MS, CCC-SLP. On evaluation, no overt signs/symptoms of airway penetration/aspiration were observed. Diet recommendations included Puree diet, thin liquids and to be placed upright for all oral intake, remain upright for 30 minutes after meals, one to one assist with meals, small bites/sips, Eat/feed slowly.

On April 03, YYYY, plastic surgery follow up was made by XXX, M.D. It was recommended to continue with IV antibiotics per ID, no nose blowing, puree soft diet for now as well as post discharge and oral hygiene with Peridex oral rinse swish and spit twice daily. It was suggested to continue soft diet as outpatient until fractures have been given opportunity to heal for a total of six weeks.

On the same day, speech therapy follow up was made by XXX, MS, CCC-SLP. Ms. XXXX was tolerating puree diet with thin liquids per report; observed NA feeding her with no signs/symptoms of aspiration. Speech therapy signed off at this time.

On the same day, Trauma follow up was made by XXX, M.D. There was no distress noted or complaint raised. Labs revealed sodium decreased to 153 and WBC decreased to 11. Physical examination revealed that she continued to protect her airway and following commands. She was continued on Azactum for UTI and Augmentin for nasal bone fracture. It was suggested to plan for discharge.

On the same day, Infectious Disease follow up was made by XXX, D.O. for UTI. Leukocytosis was noted to be resolving and recommended to discontinue Azactum and start Vantin 100 per oral every 12 hours for 7 days.

On the same day, she was discharged from ABCD Hospital Medical Center by XXX, PA. At the time of discharge, Ms. XXXX was hemodynamically stable, voiding spontaneously, tolerating per oral diet, ambulating minimally with PT, and pain controlled. She was told to follow-up with PCP and Plastics. Per neurosurgery, she did not require outpatient follow-up. Her discharge medications included Cefpodoxime tablet 100 mg, Chlorhexidine 0.12% solution, Bisacodyl 10 mg solution, Calcium citrate-vitamin D tablet 315-325 mg, Cranberry 500 mg, Acetaminophen tablet 325 mg, Acidophilus caps, Amlodipine 5 mg, Ascorbic acid tablet 250 mg, Crestor tablet 10 mg, Dimethicone-zinc oxide cream, Docusate sodium capsule 100 mg, Donepezil tablet 10 mg, Enoxaparin sodium 30 mg/0.3ml solution injection, Famotidine 20 mg tablet, Fleet enema, Magnesium oxide 250 mg tablet, Memantine 10 mg tablet, Mirtazapine 15 mg tablet, Multivitamin with minerals 1 tablet, Oxycodone immediate release 5 mg immediate release tablet, Paroxetine 20mg tablet and Vitamin D 400 units tablet. She was discharged to OLOC in stable condition.

On April 03, YYYY at 2255 hours, Ms. XXXX was admitted to ABC Nursing and Rehabilitation. Admission assessment was performed by XXX, R.N. Braden scale revealed a total score of 13 which was determined as moderate risk. At the time of admission, Ms. XXXX did not have any complaints of pain. She was alert and confused. There was redness noted in bilateral hands with bruising. Fall prevention observation was also performed by XXX, R.N. and it was documented that she was able to use a call bell, able to communicate their needs, act impulsively. She had recent diagnosis of dementia, Parkinson's, CVA, Hypotension, Seizures, recent fractures and was on prescribed opiates, anticonvulsants, antihypertensives, diuretics, sedatives, hypnotics or laxatives. She was anxious or restless at this time. Fall prevention questionnaire revealed that pain had not decreased her ability to move and she requires help with bathing, dressing, using toilet. Admission Morse scale for fall risk indicated a total score of 55 which was determined as high risk category. Admission side rail assessment was performed by XXX, R.N. It was documented that she was mobile, with voluntary movements to get in and out of bed and could egress the bed with 1/4 rail up. She also needed 1/4 rail to enhance independence in mobility and/or turning and positioning. It was suggested that use of 1/4 rail was appropriate for movement within the bed, assists her getting in and out of bed and to provide her with independent access to bed controls.

On April 04, YYYY, physical therapy evaluation was performed by XXX, P.T. Ms. XXXX currently presented with decreased functional mobility requiring max A x2 for bed mobility, max A x2 for transfers and ambulatory with RW and max A x2 up to 5'. Her current devices included manual wheelchair and walker. She was suggested to receive skilled PT for therex to increase strength and endurance to increase transfers and ambulatory, neuromuscular re-education, bed mobility, transfer training, gait training, balance exercise to increase balance to improve transfers and ambulatory and decrease fall risk. It was suggested that without skilled PT, she would not maximize functional level to return to home environment with decreased burden of care. Therapy was recommended 5-6 times a week for 10 weeks.

On the same day, occupational therapy evaluation was performed by XXX, O.T. It was noted that Ms. XXXX now require total care for bathing, UB/LB dressing, hygiene/grooming, toileting, and eating and was now dependent upon a wheelchair for mobility due weakness and reduced ability to perform ADL's on her own and therefore unable to resume prior lifestyle in home environment. It was suggested that she would benefit from skilled OT intervention to improve safety and autonomy during ADL tasks, address decline in strength and endurance, related to decreased muscle strength from hospital stay, environmental modification to reduce the risk of falls, and energy conservation techniques to reduce

fatigue during light ADL tasks. Interventions was suggested to facilitate improved dynamic/static sitting and standing balance through increased trunk stability during self-care tasks, toilet and tub/shower transfers to reduce the risk of falls and promote safety. Therapy was recommended 5-6 times a week for 10 weeks.

On the same day, physician evaluated was performed by XXX, N.P. She was lethargic minimally verbal confused and did not follow commands. There was periorbital/maxillary ecchymosis on examination. She was recommended to continue Remeron/Paxil for depression, Pepcid for GERD, Aricept, Namenda for dementia, Vantin until 4/10 for UTI, Norvasc for hypertension, Crestor for hyperlipidemia, Lovenox for DVT prophylaxis, Colace for constipation, supplements like Oscal, Prostat, Ensure, MVI, D3, Calcium, Mag ox, Cranberry.

On the same day, nutrition assessment was performed by XXX. It was documented that she had lost significant amounts of weight over the past month and x8 months since initial admit at OLOC. It was suggested to add Ensure Clear 8 ozs at meals and Ensure Enlive 8 ozs per oral thrice daily. Her cognitive deficits, depression and intermittent agitation, suboptimal per oral intake history and weight loss with current BMI of 17.7, were suggested to increase the potential for fluid and electrolyte imbalance and weight loss and place her at high nutritional and hydration risk. It was recommended to continue with supplements, Ensure Clear 8 ozs po at meals, Ensure Enlive 8 ozs po thrice daily and to monitor Weights as Per Policy.

On April 05, YYYY, nursing documentation performed by XXX, R.N. revealed that Ms. XXXX was alert oriented x 1 with confusion, and able to make some needs known. Per oral Vantin 100 mg twice daily x 7 days for UTI was in progress. There was no Adverse Reactions (A/R) noted. Physical examination revealed bruising to left of face from status post fall. She was on low bed, PT/OT attended, need a x 1 with transfer and ADL. Safety was maintained.

On the same day, Psychological Diagnostic Interview was performed by XXX, PsyD. Ms. XXXX had significant difficulty reporting on recent events although she was able to acknowledge being hospitalized due to a fall. Psychotherapy was not indicated at this time. It was also suggested that her cooperative manner might allow for acceptance of treatment and limited involvement with rehabilitation.

On April 08, YYYY, physician follow up was made by XXX, N.P. Ms. XXXX remain confused, eating well, participating in therapy, sleeps well at night. Vital signs stable, labs stable, and no weight changes documented. There was periorbital ecchymosis and muscle weakness on examination. She was recommended to continue her routine medications.

On April 10, YYYY, nursing documentation performed by XXX, LPN revealed that Ms. XXXX was alert with confusion. She eats with staff assistance at meal times. She was incontinent of bowel and bladder. Her last dose of Vantin was given with no adverse reactions noted. Per oral fluid were encouraged. She requires assist x2 for transfers and toileting. She was attending PT/OT as scheduled. No signs of pain were reported. Safety was maintained.

On April 10, YYYY, physician follow up was made by XXX, N.P. Ms. XXXX was seen for follow up episode of emesis the previous night. No episodes of emesis noted on this morning. Family was concerned for UTI as this was her presentation last time. She was afebrile and in no distress. It was

recommended to obtain urinalysis and urine culture to rule out UTI. She was recommended to continue her routine medications.

On April 11, YYYY, nutritional assessment was performed by XXX. She was currently on Ensure Clear 8 ozs TID at meals taken variably which provided an average of 480 kc/16 g protein per day. Ensure Enlive 8 ozs per oral TID taken variably which provided an average of 582 kc/33 g protein per day. She was also on Prostat SF 30 mls per oral BID taken at 100% which provided 200 kc/ 30 g protein per day. It was documented that she was to be transferred to Aquinas Harbor community (Long term unit) on this day and would be monitored. She remained at elevated nutritional and hydration risk related to her cognitive deficits, weight loss and suboptimal per oral intake at meals with supplements taken relatively well.

On the same day, Physician note by XXX, M.D. revealed that Lovenox was discontinued as she had a history of falling and a Subdural hematoma. Risk vs benefits of a DVT were reviewed and felt Lovenox should be discontinued. On this day, she was transferred to Aquinas 104w at 4:30 pm. Nursing assessment at 2337 hours by XXX, LPN revealed Ms. XXXX alert with confusion. She was assessed with fall risk. She was provided with bed, wheelchair alarm and floor mats. Skin check revealed left eye area ecchymotic, facial bone fracture. There were other ecchymotic areas on both arms. She was currently on blended diet and appetite was poor for dinner. She required one assist for transfer.

On April 12, YYYY, physician follow up was made by XXX, D.O. She was noted with abnormal urinalysis with no other complaints. She was stated on Macrobid empirically and planned to follow up culture and sensitivity. Bed alarm and wheelchair alarm were in place and functional.

On April 13, YYYY, physician monthly follow up was made by XXX, M.D. Ms. XXXX was resting comfortably, abnormal UA noted, and no new issues reported at this time. No recent falls reported and she was currently in skilled PT/OT. It was recommended to continue Macrobid 100 mg thrice daily until April 19, YYYY. She was advised to continue with skilled therapy and nursing care.

On April 14, YYYY, nursing note by XXX, LPN, urine culture was reported positive for Vancomycin Resistant Enterococcus faecium. It was planned to move her to Deporres unit.

On April 15, YYYY, nursing note by April Sensale, R.N. at 0221 hours revealed Ms. XXXX was on Macrobid for VRE urine. She was awake, alert, with periods of confusion, resolving left sided facial ecchymosis. Floor mats were in room, and safety maintained. She was placed on contact precautions for VRE urine.

On April 17, YYYY, physical therapy progress note was updated by XXX, P.T. It was noted that she had completed 2nd week of skilled PT program and had progressed in functional status. She now performs sit>stand and SPt transfers with min A x1, having improved from requiring min/mod A x 1. Ms. XXXX progressed to amb up to 100' with RW and min/CG x 1 with wheelchair follow, having improved from amb 75' with RW and min Ax 1 with wheelchair follow. Gait was unsteady with variable cadence, poor RW management, impaired cognition and safety awareness requiring increased frequency of cues for safety and technique in turn/obstacle negating and attention to task in open environments.

On the same day, occupational therapy progress note was updated by XXX, O.T. It was noted that she continued to require Max A for UB/LB dressing, total assist for toileting, Mod A for bed mobility and Min A for transfers.

On April 20, YYYY, nursing note by Natasha Roszko, R.N. at 1149 hours revealed that Ms. XXXX was status post antibiotics (last dose on 04/19/2019), with no delayed reactions noted. She was alert with periods of confusion and required assist of one for ADL's and transfers. She was able to feed self with tray setup, and appetite remain poor. Contact precautions were still maintained for VRE UTI.

On April 24, YYYY, physical therapy progress note was updated by XXX, P.T. It was noted that she had completed 3rd week of skilled PT program and had progressed in functional status. She now performs sit to stand and SPt transfers with min A x1. She progressed to amb up to 100' with RW and min A/CG x 1 with wheelchair follow, although participation in gait/transfer activities was limited and fluctuated secondary to impaired cognition, variable cooperation. Gait was unsteady with variable cadence, poor RW management, impaired cognition and safety awareness requiring increased frequency of cues for safety and technique in turn/obstacle negating and attention to task in open environments.

On the same day, occupational therapy progress note was updated by XXX, O.T. It was noted that she continued to be dependent for LB dressing, Mod A for UB dressing, total assist for toileting, Mod/max A for bed mobility and Min/mod A x 1-2 for transfers.

On April 26, YYYY, nursing note by XXX, R.N. at 1934 hours revealed that Ms. XXXX was alert with periods of confusion. There was no signs/symptoms of distress or discomfort. Contact precautions were maintained. Safety was maintained and call bell was within reach.

On April 29, YYYY, nursing note by XXX, R.N. at 1838 hours revealed that Ms. XXXX was alert with periods of confusion. She was noted with poor appetite but drinks Ensure shakes. Contact precautions were maintained. Safety was maintained and call bell was within reach.

Treatment sheet from April 03, YYYY to April 30, YYYY revealed treatment documented for Baza Protect and Float Heels with pillow when in bed. *(Details related to documentation about fall prevention protocol are not available for this month.)*

On May 01, YYYY, nursing note by XXX, R.N. at 1835 hours revealed that Ms. XXXX was alert with periods of confusion. Contact precautions were maintained. Safety was maintained and call bell was within reach.

On May 01, YYYY, physical therapy progress note was updated by XXX, P.T. It was noted that she now performs sit to stand and SPt transfers with min A x1. She progressed to amb up to 100' with RW and min A/CG x 1 with wheelchair follow, although participation in gait/transfer activities was limited and fluctuated secondary to impaired cognition, variable cooperation. Gait was unsteady with variable cadence, poor RW management, impaired cognition and safety awareness requiring increased frequency of cues for safety and technique in turn/obstacle negating and attention to task in open environments.

On the same day, occupational therapy progress note was updated by XXX, O.T. It was noted that she continued to require mod A for UB dressing, Dependent for toileting and LB dressing, max A for

supine to sit and min A for sit to supine during bed mobility, mod A with wheelchair mob, min A for transfers.

On May 08, YYYY, physical therapy progress note was updated by XXX, P.T. It was documented that she was demonstrating progress towards short term goals and currently requiring CG x 1 for transfers sit to stand, and ambulating up to 100' with RW and CG A x1 with assist to maneuver RW especially with turns and to avoid obstacles.

On the same day, occupational therapy progress note was updated by XXX, COTA and XXX, O.T. It was noted that she required Min/Mod A for bed mobility, Sit to Supine, Min/Mod A for LB dressing, dependent for Toileting Hygiene, Min A for Transfers, Sit to Stand, Min A for transfers toilet, Mod A for UB Dressing.

On May 09, YYYY, nursing note by XXX, LPN at 1151 hours revealed that Ms. XXXX was alert. Safety was maintained, wheelchair and bed alarms were functioning and low bed in place.

On May 10, YYYY, nursing note by Herry Johnson, LPN at 0326 hours revealed that Ms. XXXX was alert and responsive, resting comfortably. Safety precautions were maintained, bed alarms was in place and functioning well. Call bell and remote in progress.

On May 15, YYYY, physical therapy progress note was updated by XXX, P.T. It was documented that she continued to participate with skilled PT and currently CG x 1 for transfers sit to stand, and amb up to 150' with RW and CG A x1 with assist to maneuver RW especially with turns and to avoid obstacles. She required 1:1 cuing to attend to activity.

On the same day, occupational therapy progress note was updated by XXX, O.T. It was noted that she required Min A for bed mobility, min A for LB dressing, max A for Toileting Hygiene, min A for transfers, min/mod A for UB Dressing.

On May 16, YYYY, nursing note by XXX, R.N. revealed that Ms. XXXX was reaching maximum benefit from therapy. Her last day of therapy was documented as May 20, YYYY (Last day of Medicare coverage).

On May 19, YYYY, nursing note by XXX, LPN at 2326 hours revealed that Ms. XXXX had her supplements and appetite remains poor at this time. No complaints of pain were documented. Safety was maintained and call bell was within her reach.

On May 20, YYYY, Ms. XXXX was discharged from physical therapy by XXX, P.T. At this time, she required CG x 1 for transfers sit to stand, and amb up to 150' with RW and CG A x1 with assist to maneuver RW especially with turns and to avoid obstacles. She required 1:1 cuing to attend to activity. She required CG at all times for mobility for safety and had attained max functional level at this time. She was recommended to ambulate daily on nursing unit with RW to maintain functional level. On the same day, she was discharged from occupational therapy by Mia Flanders, COTA and Danielle Judge, O.T. She was discharged to Aquinas Community (Long term care) with recommendations including nursing encourage her to participate in basic ADLs.

On May 22, YYYY, nursing note by XXX, LPN at 2322 hours revealed that Ms. XXXX was alert with confusion. She was noted to be playing in her feces and had to be washed and changed. Appetite remains poor, and she drank supplements. She refused to take her night medications.

On May 24, YYYY, nursing note by XXX, LPN at 1402 hours revealed that Ms. XXXX was alert, verbal and appetite remains poor despite encouraging. She became agitated and attempting to punch staff. Supplements were taking well.

Treatment sheet from May 01, YYYY to May 31, YYYY revealed treatment documented for Baza Protect cream and weekly weights. *(Details related to documentation about fall prevention protocol are not available for this month.)*

On June 10, YYYY, speech therapy was consulted for evaluation and diet upgrade. As per ST screen, Ms. XXXX was recommended to be upgraded to chopped solids. No further ST was recommended. She was noted with higher resistance to per oral intake and associated with behavior component.

Treatment sheet from June 01, YYYY to June 30, YYYY revealed treatment documented for Baza Protect cream. *(Details related to documentation about fall prevention protocol are not available for this month.)*

On July 08/2019, Psychiatric Evaluation was performed by XXX, NP. She was noted with poor appetite and poor safety awareness. Current psychiatric medications included Aricept 10 mg, Namenda 10 mg, Paxil 20 mg and Remeron 15 mg. It was recommended to continue current medications as prescribed. She was stable at current dose and needed more time to see beneficial effects. It was suggested that dose reduction attempts and/or reduction will cause decompensation of her condition.

On July 20/2019, nursing note by XXX, R.N. at 0826 hours revealed that at approximately 8 AM, Ms. XXXX was on toilet and fell to the floor. CNA stated that Ms. XXXX jumped forward and she was not able to catch her. It was documented that staff was beside her. She fell on her front/left side. No injury was noted and she was able to perform AROM to all 4 extremities. Ms. XXXX was educated on safety and message left for her daughter and son. MD was notified. Supervisor was called and evaluated her, put her back in bed due to weakness. No new orders received. Pain scale was 0/10. Morse fall risk score was calculated as 80 which was determined as high risk category.

On July 21, YYYY, nursing note by XXX, LPN at 1413 hours revealed that she was noted with increased fatigue, but responsive to stimuli. Temp 101.8, BP 110/73, pulse 100. She was assessed with poor appetite. MD aware and new orders received to obtain urinalysis, culture and sensitivity, chest X-ray rule out pneumonia, CBC, BMP labs. Tylenol sup 650 mg was ordered every 4 hours as needed. Fluids encouraged, approx. 300cc fluids given throughout the shift via teaspoon. Urine culture revealed more than 100,000 CFU/ml of Escherichia coli and Staphylococcus schleiferi. Labs revealed increased Glucose 308, BUN 78, creatinine 2.2, BUN/creatinine 35, sodium 159, chloride 122, AGAP 16, calcium 11.3, WBC 15.82, hemoglobin 15.9, hematocrit 50.3 and decreased Potassium 3.4. Urinalysis revealed cloudy appearance, moderate leukoesterase, WBC >182, WBC clumps many, RBC 77, many bacteria, moderate squamous cells, few mucous, hyaline cast 16. X-ray was performed by Justin Weiss, M.D. and it revealed a minimal amount of acute inflammatory change in both perihilar areas extending into both the upper and lower lobes with the peripheral chest clear. She was started on Levaquin IV for 7 days.

Treatment sheet from July 01, YYYY to July 31, YYYY revealed treatment documented for Baza Protect cream, Initiate Fall Prevention Program - Every shift *(start dated July 20, YYYY)* and Fall - Monitor status for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to fall – Every shift *(Start date July 20, YYYY- End date July 23, YYYY)*, Intake and output – record intake and output every shift *(Start date: July 24/2019 – End date July 30, YYYY)*, and Oxygen 2-3 L via nasal canula *(Start date July 22, YYYY)*

On August 02, YYYY, Morse Fall Scale assessment was performed by XXX, R.N. Total was calculated as 55 which was determined as high risk for fall. She was noted to be with poor appetite throughout this month.

Treatment sheet from August 01, YYYY to August 31, YYYY revealed treatment documented for Baza Protect cream, Initiate Fall Prevention Program - Every shift *(start dated July 20, YYYY).*

Plan of care for fall prevention was updated on September 09, YYYY (per medical record). It was noted that she had fell next to bed on March 29, YYYY, fell from toilet to the floor on July 20, YYYY and no injury was reported, Rolled out of bed on December 04, YYYY. Protocol included are CNA to check on Ms. XXXX every 1-2 Hours, Keep call bell and personal items within reach, Encourage use of call light, Instruct on safety measures, Review footwear for proper fit and non-skid soles, Low bed, Bed alarm and floor mats, she was educated on safe practices while on toilet and observation x 3 days and PT referral as needed.

On December 04, YYYY, nursing note by XXX, LPN revealed that Ms. XXXX had a fall where she rolled out of bed to floor mat in her room. The fall was unwitnessed and pain scale was 0/10. No injury was noted as a result of fall.

Nursing home records are available until January 13, 2020. Note was available on February 12, 2020, where it was recommended to discontinue KAFO and to change to 2 person assist for 1-3 minutes as tolerated.

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