Recent Medical History

Mrs. S is a 78-year-old female who was admitted to an acute care hospital on November 3 with respiratory distress and right hip pain following a fall. For the 2 weeks prior to admission, she had noted difficulty breathing and weakness, resulting in a fall at home. Upon admission to the hospital, she was noted to have acute respiratory distress, and a fracture of the neck of her right femur. Her past medical history includes hypertension, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and depression.

On November 4, Mrs. S underwent total hip arthroplasty surgery to repair her right femoral neck fracture. Mrs. S also had a peripherally inserted central catheter (PICC) for intravenous (IV) access and an indwelling urinary catheter.

During her acute care hospitalization, Mrs. S developed a Stage 4 pressure ulcer on her coccyx, measuring 4 cm by 3 cm by 2.5 cm.

After 4 weeks of acute care hospitalization, her clinical status improved, and her PICC line was removed. Due to continued shortness of breath, she was placed on oxygen at 2 liters per minute via nasal cannula. In the third week, Mrs. S was able to maintain adequate oxygen saturation on room air, and her supplemental oxygen was discontinued. Mrs. S was also voiding without difficulty, therefore the indwelling urinary catheter was also discontinued.

Given her need for occupational therapy (OT) and physical therapy (PT), as well as for continued need for pressure ulcer care, turning and repositioning, she was transferred to a skilled nursing facility (SNF) on December 1 for aftercare following her right hip replacement surgery. Upon discharge from the acute care hospital, Mrs. S was weight-bearing as tolerated on her right lower extremity.

Prior Level of Function and Device Use

Mrs. S lives with her son in a two-level home. Prior to her acute care hospitalization, Mrs. S was independent with self-care activities, but she required assistance with some mobility activities and instrumental activities of daily living. She walked on indoor surfaces with a rollator walker, but required her son to provide standby assistance when climbing stairs. For longer distances of 60 feet or greater, Mrs. S required a manual wheelchair due to endurance limitations. She reports being able to propel the wheelchair independently for short distances, like going to her mailbox (approximately 70 feet). For distances greater than 70 feet, such as visits to her next-door neighbor, a helper propelled her in her wheelchair. She also needed some assistance from her son with medication management, paying her bills and grocery shopping prior to admission.

Excerpt from the Nursing Admission Note

Upon admission to the SNF**,** Mrs. S is showing no signs or symptoms of respiratory difficulty, with no need for supplemental oxygen. The right lower extremity has intact peripheral pulses, normal sensation to light touch, and normal movement of the toes.

The nurse also conducts a skin assessment and notes the following findings:

- Coccyx pressure ulcer presents with full thickness tissue loss. It is clean with granulation tissue evident in the wound bed. The ulcer measures 3.5 cm by 3 cm by 1.5 cm.
- Right femoral surgical site is clean, dry, and well-approximated with surgical staples closing the 10-cm incision line.

A review of the acute care transfer notes provides the nurse with information regarding the documented stage of the coccyx pressure ulcer while Mrs. S was still in the acute care hospital. According to the transfer notes, the pressure ulcer was a Stage 4. The nurse records this in the nursing notes, and on the MDS in Section M, item. M0300D1 as a Stage 4 pressure ulcer present on admission.

An ICD-10 CM code of S72.001D, Fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing was noted in the medical record as reflecting Mrs. S' primary medical condition category.

Mrs. S is immediately started on a turning and repositioning program, and pressure ulcer care for management of the wound is initiated by the wound care nurse. This is documented in the nursing notes and also on the MDS. Items M1200C (Turning/repositioning) and M1200E (Pressure ulcer/injury care) are checked to reflect these skin management interventions.

The nurse also conducted both the Brief Interview for Mental Status (BIMS) to screen Mrs. S's cognition, as well as the PHQ-9© to screen for signs and symptoms of depression. The BIMS Summary Score (C0500) is recorded at 14, and the Total Severity Score (D0300) from the PHQ-9© is recorded as 2.

Excerpt from Occupational Therapy Admission Evaluation

Upon initial evaluation, Mrs. S was found to have the following levels of function.

- **Eating:** When Mrs. S entered the facility, she was receiving a no salt, regular consistency diet. She requires some assistance with tasks such as opening containers and cutting up meat and vegetables. For this reason, Mrs. S immediately requested that her diet be

downgraded to a mechanical soft diet. The discharge goal of Mrs. S is to eat and drink without any type of assistance or mechanically altered diet.

- **Oral hygiene:** Mrs. S brushes her teeth after a helper sets up her oral hygiene items on her bedside table. When she finishes brushing her teeth, the helper puts away these items. It is anticipated Mrs. S will not require any type of assistance with this activity by discharge.
- **Toilet transfer:** Mrs. S requires the assistance of one helper. The helper provides some assistance to slowly lower her, with trunk support (less than half of the effort) onto the bedside commode and provides contact guard assistance as Mrs. S gets off the bedside commode. It is expected that Mrs. S will perform toilet transfers using a standard toilet with raised toilet seat without any type of assistance by discharge.
- **Toileting hygiene:** Once she is standing before the bedside commode, Mrs. S requires steadying assistance from one helper while she adjusts her underwear and slacks. After she finishes voiding, Mrs. S wipes herself and adjusts her underwear and slacks with contact guard assistance from a helper. It is expected that Mrs. S will perform her perineal hygiene, underwear, and slacks without any type of assistance by discharge.
- **Shower/bathe self:** Mrs. S requires the assistance of one helper. The helper provides assistance by wheeling her to the shower and transferring her onto a shower chair. She provides contact guard assist as Mrs. S washes her upper body and anterior thighs. The helper completes more than half of the activity by bathing all other parts of her body. It is expected by discharge that Mrs. S will be able to bathe herself without any assistance, although may need a shower chair and other adaptive equipment for safety.
- **Upper body dressing:** Mrs. S requires set-up assistance to retrieve her bra and blouse. Once Mrs. S has her bra and blouse in hand, she is able to put on her bra and fasten the front closure, and is able to put both arms though the sleeves of her blouse and fasten the buttons without further assistance. It is expected that Mrs. S will be able to dress her upper body independently without any type of assistance by discharge.
- **Lower body dressing:** Mrs. S requires some helper assistance to complete this activity. The helper retrieves Mrs. S's underwear and slacks. Once the helper threads Mrs. S's feet through her underwear and pants and pulls them up to about mid-calf level, Mrs. S then pulls both her underwear and slacks up her legs and over her hips. When removing her underwear and slacks, the helper slides Mrs. S's underwear and slacks down over her hips. Mrs. S then slides her pants down the rest of the way, and lets them drop to the floor. The helper then removes Mrs. S's underwear and slacks from around her feet. Throughout this activity, the helper provided less than half the effort required to complete lower body

dressing. It is expected that Mrs. S will be able to dress her lower body without any type of assistance by discharge.

- **Putting on/taking off footwear:** Mrs. S requires the assistance of one helper to put on her socks and shoes for her. By discharge, it is expected that Mrs. S will be able to put on and remove her own socks and shoes independently without the use of adaptive equipment.

Excerpt from Physical Therapy Admission Evaluation

Upon initial evaluation, Mrs. S was found to have the following levels of function related to mobility:

- **Roll left and right:** Mrs. S required the therapist to position a pillow between her legs to prevent adduction of the affected extremity and then to assist her to roll side to side in bed. The therapist provided more than half the effort. The physical therapy goal states that by discharge, it is expected that Mrs. S will be independent with bed mobility including being able to roll left and right.
- **Sit to lying:** Mrs. S required assistance of the therapist to bring both legs back into bed as well as support her trunk. Mrs. S did contribute a small amount of effort as she used her right arm to lower herself to a supine position. The physical therapy goal states that the resident will be independent with bed mobility, including moving from a sitting to lying position and lying to sitting on the edge of the bed by discharge.
- **Lying to sitting on side of bed:** Mrs. S was able to bring her left leg off the bed and assist with pushing up with her right arm. She required assistance to bring her right leg off the side of the bed and needed to be fully supported by the therapist to come to a sitting position. The helper provided more than half the effort. The physical therapy goal states that the resident will be independent with bed mobility, including moving from a sitting to lying position and lying to sitting on the edge of the bed by discharge.
- **Sit to Stand:** Mrs. S was able to come to a standing position with maximal assistance of the therapist. Once standing, the therapist used a gait belt to support Mrs. S while she steadied herself on her walker. The physical therapy goal states that the resident will move from a sitting to standing position independently with the use of her rollator walker.

- **Chair/Bed-to-chair transfer:** Mrs. S required maximal assistance from the therapist to pivot transfer to a wheelchair. In addition to providing physical assistance with the transfer, Mrs. S needed the therapist to position the walker prior to and during the transfer and provide verbal cues. Using a gait belt, the therapist supported the resident during the transfer. The therapist provided more than half the effort. The physical therapy goal states that the resident will complete chair/bed to chair transfers independently with the use of her rollator walker.
- **Car transfer:** Not attempted due to medical condition and safety concerns, due to Mrs. S's fatigue and decreased endurance. It is anticipated that by discharge, Mrs. S will be able to complete car transfers with contact guard assist and the use of her rollator walker.
- **Walk 10 feet:** Mrs. S walks 10 feet with a walker and assistance of one helper. She requires steadying as she begins to walk and then progressively requires some of her weight to be supported for the last 3 feet of the 10-foot walk. By discharge, it is expected that Mrs. S will be able to walk 10 feet using her rollator walker with supervision due to balance limitations.
- **Walk 50 feet with two turns:** This activity was not attempted due to her fatigue and decreased endurance. Currently, Mrs. S requires a manual wheelchair for distances beyond 15 feet. Based on her prior mobility status, comorbidities, current functional performance, and motivation to improve, it is anticipated that Mrs. S will require contact guard assistance when walking 50 feet and making two turns by discharge using a rollator walker.
- **Walk 150 feet:** This activity was not attempted, as Mrs. S was not walking more than 60 feet prior to her current injury. The discharge goal is not applicable for walk 150 feet.
- **Walking 10 feet on uneven surfaces:** This activity was not attempted due to her fatigue and decreased balance and endurance. By discharge, it is expected that Mrs. S will require standby assistance from one helper while walking 10 feet on uneven surfaces using a rollator walker.
- **1 Step (curb), 4 Steps, 12 Steps:** This activity was not attempted due to medical condition and safety concerns. Prior to admission, Mrs. S did require the assistance of her son to provide standby assist when walking up steps. The physical therapist will evaluate this activity during the stay when safe for the resident, and provide recommendations as needed.
- **Picking up object:** This activity was not attempted due to medical condition and safety concerns. By discharge, it is expected that Mrs. S will be able to pick up an object from a bending or stooping position, after setup of adaptive equipment.

- **Wheel 50 feet with two turns:** Once seated in her manual wheelchair, Mrs. S propels herself about 20 feet and completes two turns with some assistance to straighten herself after a turn. The helper propels her wheelchair for the last 30 feet due to her poor endurance. It is anticipated that by discharge Mrs. S will increase her endurance and complete this activity without any type of assistance.
- **Wheel 150 feet:** After propelling herself 20 feet, Mrs. S becomes fatigued, and the therapist must complete the remaining 130 feet distance. By discharge, it is anticipated that Mrs. S will return to her prior level of ability, independently self-propelling her wheelchair approximately 70 feet, and require a helper to complete further distances, such as 150 feet.

Excerpt from the Interdisciplinary and Physician Progress Notes

Mrs. S continues to demonstrate a stable respiratory status on room air, with no need for supplemental oxygen.

On Day 14, the pressure ulcer on the coccyx has begun to show improvement. It now measures 3 cm by 2 cm by 1 cm, and it is clean with granulation tissue.

Excerpt from Occupational Therapy Discharge Assessment Note

Upon evaluation at discharge, Mrs. S was found to have the following levels of function.

- **Eating:** Mrs. S opens containers, cuts meat and vegetables, and uses utensils appropriately. She also uses a cup/glass to drink liquids without assistance.
- **Oral hygiene:** Mrs. S performs all oral hygiene tasks included in the oral hygiene activity without any type of assistance.
- **Toilet transfer and toileting hygiene:** Mrs. S performs toilet transfers and perineal hygiene without any type of assistance from a helper.
- **Shower/Bathe Self:** Mrs. S is able to wash her body independently while seated on a shower chair and using other adaptive equipment for safety.
- **Upper Body Dressing:** Mrs. S completes upper body dressing independently.
- **Lower Body Dressing and Footwear:** Mrs. S completes lower body dressing and puts on her socks and shoes independently without any adaptive equipment or assistance.

While in the facility, Mrs. S had 16 occupational therapy treatment sessions during her stay (5 times a week), totaling 908 minutes of occupational therapy.

Her OT therapy was broken down as follows:
Individual Therapy: 732 minutes
Co-treatment- 47 minutes
Group Therapy- 106 minutes
Concurrent Therapy- 70 minutes

Excerpt from Physical Therapy Discharge Assessment Note

Upon evaluation at discharge, Mrs. S was found to have the following levels of function related to mobility:

- **Rolling Left and Right:** Mrs. S rolled side to side and on to her back without any type of assistance.
- **Sit to Lying:** Mrs. S moved from a sitting to supine position without any type of assistance.
- **Lying to Sitting on Side of Bed:** Mrs. S moved from a supine to sitting position without any type of assistance.
- **Sit to Stand:** Mrs. S stands from a sitting position using her rollator walker without any assistance.
- **Chair/Bed-to-Chair Transfer:** Mrs. S completed chair/bed-to-chair transfer using her rollator walker without any assistance.
- **Car transfer:** Mrs. S performed car transfers with contact guard assist using her rollator walker.
- **Walk 10 feet:** Mrs. S walks 10 feet using a rollator walker with supervision from a helper due to her balance limitations.
- **Walk 50 feet with two turns:** Mrs. S walks 50 feet, making two turns using a rollator walker and contact guard assistance from a helper due to her balance limitations.
- **Walk 150 feet:** Mrs. S cannot walk the entire distance required for this activity. This activity was not attempted, as Mrs. S was not walking 150 feet prior to her current injury.
- **Walking 10 feet on uneven surfaces:** Mrs. S walks 10 feet on uneven surfaces with contact guard assist using her rollator walker.
- **1 Step, 4 Steps, 12 Steps:** Mrs. S went up 1 step, 4 steps, and 1 flight of stairs (12 steps) with contact guard assistance of one helper.

- **Picking Up Object:** Mrs. S retrieved an object from a bending position independently after setup of adaptive equipment.

- **Wheel 50 feet with two turns:** Mrs. S wheels herself approximately 60 feet and completes two turns without any type of assistance.

- **Wheel 150 feet:** Mrs. S wheels herself 60 feet, which is nearly as far as her prior level of function. A helper is needed to propel her wheelchair the remaining distance of 90 feet.

While in the facility, Mrs. S had 15 physical therapy treatment sessions during her stay (5 times a week), totaling 825 minutes of physical therapy.

Her PT therapy modes were broken down as follows:
Individual Therapy – 635 minutes
Co-treatment- 63 minutes
Group therapy- 100 minutes
Concurrent Therapy 90 minutes

Excerpt from the Nursing Discharge Note

Mrs. S continues to improve, and her respiratory status remains stable. Mrs. S's nutritional status has remained stable, here mechanically soft diet discontinued, and she remains on a no salt added diet.

The pressure ulcer on her coccyx has closed with epithelial tissue.

On December 22, day 22 of her stay, Mrs. S is discharged to home with a referral to a home health agency for nursing to include medication assessment, nutrition and therapy for home safety evaluation and mobility.