Mr. F is a 66 year-old man who lives independently with his wife in a two-story, single-family home. While visiting friends out of town, Mr. F injured his back and was transported emergently to the local acute care hospital. During his hospitalization in the acute care facility, he demonstrated confusion and, when questioned, indicated he was suffering ill effects from the pain medication administered to him. Mr. F became acutely agitated, and providers suspected alcohol withdrawal. He was intubated for airway protection. Mr. F remained intubated for 7 days and was noted to have loss of movement in his lower extremities. When his respiratory status improved, he was extubated. The patient's blood cultures returned positive for MSSA bacteremia, and his sputum cultures were positive for *E. coli*. He was treated with cefazolin and levofloxacin. A follow-up MRI revealed a fluid collection in Mr. F's spinal canal, which was suspicious for hematoma and the possible source of the bacteremia. This was the likely cause of his initial back pain. The patient suffered acute kidney injury and elevated liver function tests (LFTs) from alcoholic hepatitis. Mr. F was admitted to the LTCH on June 3, 2016, for management of the epidural abscess, MSSA bacteremia, hepatic encephalopathy, alcohol withdrawal, diabetes, hypertension, lower extremity weakness, and neuropathy.

Prior Level of Function

Prior to Mr. F's acute care admission, he was independent for all activities of daily living (ADLs). Mr. F did not use any assistive devices or aids.

Excerpt From the LTCH Admission Nursing Assessment

Mr. F's admission nursing assessment was completed on June 3, 2016. He was alert and oriented. His speech was clear, but he had difficulty finishing thoughts and finding words periodically throughout the assessment. Mr. F uses glasses for reading but frequently refuses to wear them. His wife, who was present at the time of his admission assessment, brought his eyeglasses to the hospital for him. The patient has a pain scale score of 6 out of 10, most intense in the lower back area, which increases to a pain score of 8 with movement and turning. The two-nurse skin assessment noted two healing scabs on the left nose and left knee, along with scattered bruising on the left flank. It is also noted that the patient has a 2 cm wide by 1 cm long reddened area over his coccyx, with a 0.5 cm serum-filled blister in the center of the reddened area. This is determined to be a Stage 2 pressure ulcer. The patient also has a skin rash in the groin area. Mr. F reported that he has full control of his bowels and urination, but over the last 2 days has had frequent loose stool and has not made it to the commode a few times. A stool sample has been collected and sent to the lab. The patient reports that he is weak and unsure if he can ambulate and has needed some help with his ADLs. He will be evaluated by Physical Therapy and Occupational Therapy on June 4, 2016. Mr. F is on a diabetic diet. The patient has a PICC line in place, and the dressing was changed on admission without issue. The patient has a temperature of 101º and will be seen by the physician later today.

Excerpt From the Physical Therapy Admission Evaluation

- Walk 10 Feet: Mr. F is able to walk with the use of a rolling walker for a distance of 10 feet without assistance from a helper.
- Walk 50 Feet With 2 Turns: Mr. F is able to walk 50 feet with the use of a rolling walker and two helpers providing verbal cues to walk slowly with one foot in front of the other. He required touching assistance to perform two turns.
- Walk 150 Feet: Mr. F was unable to walk 150 feet due to his leg weakness. This was not attempted at this time.
- Rolling Left: Mr. F is able to roll to the left without assistance of any helpers.
- Rolling Right: Mr. F is able to roll to the right without assistance of any helpers.
- Sit to Supine: Because of Mr. F's back pain, lowering into the bed from the sitting position is difficult. He requires two helpers to hold onto his arms and lower him into the bed. He is able to bring his legs halfway onto the bed but requires assistance to bring them all the way into the supine position.
- Supine to Sit: Mr. F is able to use the side rails of his bed to pull himself from a supine position to a sitting position. A helper assists him to lift his legs all the way to sitting on the side of the bed.
- Sit to Stand: Mr. F is able to get himself from the sitting position to standing with support on either side from two helpers.
- Chair-to-Bed Transfer: Mr. F is able to get himself from his chair to the bed with the use of a transfer board.
- Stairs: Mr. F is unable to climb up and down stairs. This was not attempted at this time.
- Floor Transfer: This activity was not attempted at this time.
- Car Transfer: Mr. F requires steadying assistance to transfer to the car.
- Does the patient use a wheelchair? No.
- Does the patient use a scooter? No.

Physical Therapy Discharge Goals on Admission

1. Mr. F will be independent with bed mobility, including moving from a sitting to supine position and vice versa.
2. Mr. F will complete bed-to-chair transfers independently.
3. Mr. F will complete car transfers independently.

4. Mr. F will walk 150 feet independently with the use of a rolling walker.
5. Mr. F will walk 50 feet independently with the use of a rolling walker and complete two turns with touching assistance.

Excerpt From the Occupational Therapy Evaluation on Admission

- Eating: Mr. F is able to feed himself without the assistance of a helper.
- Oral Care: Mr. F is able to brush his teeth without the assistance of a helper.
- Toilet Transfer: Mr. F is able to stand-pivot with rolling walker to the toilet and tub bench with contact-guard assistance.
- Toileting Hygiene: Mr. F is able to perform his own perineal hygiene after supplies were set up for him. He requires the assistance of one staff member to pull his pants and underwear up and down.
- Shower/Bathe Self: Mr. F is able to bathe upper body, including washing, rinsing, and drying the face, hands, and chest without the assistance of helpers after setup. Mr. F requires verbal cues for lower body bathing. He is able to wash the lower body without physical assistance with the use of a washcloth but requires verbal cues for rinsing and drying.
- Upper Body Dressing: Mr. F is able to thread both arms through his shirt and pull the shirt down over his body without the assistance of any helpers.
- Lower Body Dressing: Mr. F requires the therapist's assistance to don his pants and underpants. Once his pants were mid-calf level, Mr. F could reach down far enough to move the pants up his legs. The staff member put Mr. F's socks and shoes on for him.

Occupational Therapy Discharge Goals on Admission

1. Mr. F will independently set up and eat meals and snacks.
2. Mr. F will independently complete his oral care.
3. Mr. F will complete toilet transfers independently.
4. Mr. F will complete toilet hygiene independently.
5. Mr. F will complete bathing seated on a shower chair independently.
6. Mr. F will independently dress.

Additional Notes

The wound care nurse was scheduled to see Mr. F on June 4, 2016, but was delayed and did not see him until June 5, 2016. Hospital policy indicates that initial assessment must be completed within the first 24 hours following admission. The wound care nurse sees Mr. F and evaluates his coccyx wound. The wound is now open with some slough noted and assessed to be a Stage 3 pressure ulcer.

On June 6, 2016, Mr. F's patency of PICC line is questioned, and he is sent to Interventional Radiology located in the host hospital for evaluation. While at the hospital, Mr. F felt weak during a transfer from the wheelchair to the stretcher and was assisted to the floor. The patient hit his left hand on the rail of the stretcher and had a small skin tear. The patient was assessed with no major injuries. He had his PICC line replaced and returned to the LTCH the same day.

On June 10, 2016, Mr. F has an order for a follow-up MRI at the local acute care facility. He is transported via ambulance at 8:30 a.m. During his MRI, Mr. F becomes confused and agitated. He is monitored in the Emergency Department and returns to the LTCH at 1:30 a.m. on June 11, 2016.

On June 14, 2016, during physical therapy, Mr. F is attempting to ambulate 150 feet and is lowered to the ground by the physical therapist when his legs buckle beneath him.

Discharge

Mr. F progressed nicely toward his goals, and he was discharged to home on June 29, 2016. At that time, the pressure ulcer over his coccyx remained open. Home care was arranged for his pressure ulcer treatment. Mr. F's MRI showed a resolving spinal abscess, but he continues to have some lower back pain and lower extremity weakness.

Therapy discharge summaries stated his functional status was as follows:

- Eating: Independent.
- Oral Care: Independent.
- Toilet Hygiene: Independent.
- Shower: Independently showers while seated.
- Dressing: Setup or clean-up assistance
- Roll left and right: Independent.
- Supine to Sitting on side of bed: Independent.
- Sit to Supine: Independent.
- Sit to Stand: Independent with the use of a cane.
- Bed-to-Chair Transfer: Independent with the use of a cane.
- Toilet Transfer: Independent with the use of a cane or grab bar in the bathroom.

- Car Transfer: Able to get in and out of a car using a cane with contact-guard assistance for steadying.
- Ambulation: Walks 10 feet, 50 feet with two turns, and 150 feet independently with the use of a rolling walker.