

## LTC – H&P #1

Chief Complaint: “fall” x yesterday night

### HPI

75-year-old female with PMHx of HTN, HLD, atrial fibrillation on apixaban, type 2 diabetes mellitus, and depression who presents today after a witnessed fall last night. Per RN report, the patient was seated in a wheelchair when she attempted to stand, the wheelchair was not locked at the time, causing her to lose balance and fall directly onto her buttocks. She denies injury to her head, neck, shoulders, upper extremities, or lower extremities aside from the hip/buttock region. Patient denies any loss of consciousness or headaches afterwards. Pt reports right buttock/hip discomfort without radiation that began after the fall that has improved with PRN acetaminophen. She is able to bear weight and ambulates at baseline with a walker without difficulty. She denies any worsening pain since the fall, bruising, swelling, or visible skin changes. She also denies any acute back pain. Patient also reports bilateral lower extremity swelling that has been present for approximately 2 weeks and has been gradually worsening.

Denies fever, chills, dizziness, shortness of breath, chest pain, palpitations, nausea/vomiting.

### PMHx

- HTN, controlled on medications
- HLD, controlled on medications
- AFib, controlled on medications (including anticoagulation)
- CKD Stage 3B (GFR 34), on Dapagliflozin
- DM 2, controlled on medications
- Depression, on medication
- Received 3 doses of COVID-19 vaccinations. Refused Influenza, Shingrix, and Pneumococcal Vaccines

### PSHx

- No known past surgeries

### Medications

- Atorvastatin 40mg PO QD for HLD
- Diltiazem HCl 180mg PO QD for HTN
- Metoprolol Succinate ER Tablet 25mg PO QD for HTN
- Linagliptin 5mg PO QD for DM 2
- Pioglitazone HCl 30mg PO QD for DM 2
- Apixaban 2.5mg PO QD for AFib
- Dapagliflozin 5mg PO BID for DM 2
- Insulin Lispro per sliding scale for DM 2
- Insulin Glargine 5U SQ for DM 2
- Venlafaxine HCl ER PO 37.5mg PO QD for Depression
- Compliant with her daily medications per RN

### Allergies

- No known drug, food, or environmental allergies.

### FHx:

- Mother → HTN, Liver Disease
- Father → HTN, DM 2

### SHx

- Y.C. is a friendly 75y/o F in the LTC unit who is well and is interacting with other residents.
- Habits → past alcohol consumption. No past tobacco smoking and illicit drug use.
- Diet → eats a consistent carbohydrate diet with soft & bite-sized level 6 texture, thin consistency
- Exercise → main physical activity is during recreational periods per RN

### ROS

**General** – Denies fever, chills, and night sweats.

**Skin** – Denies any new lesions, new itchiness, or wounds.

**HEENT** – Denies headaches, vision changes, epistaxis, or sore throat.

**Neck** – Denies any neck pain or stiffness.

**Chest/Cardiovascular** – Denies any chest pain or palpitations.

**Pulmonary** – Denies shortness of breath, cough, wheezing, or hemoptysis.

**Gastrointestinal** – Denies abdominal pain, nausea/vomiting/diarrhea, or constipation.

**Neurologic** – Denies numbness or tingling of the upper and lower extremities, headaches, or dizziness

**Musculoskeletal** – Admits to new R buttock & hip pain after yesterday's fall. Admits to chronic lower back pain. Denies claudication, joint pain, calf pain, or decreased ROM.

**Peripheral Vascular** – Admits to swelling of the BLE.

### Vital Signs (04/20/2026 8:50 AM)

**BP:** Seated 111/73 mmHg

**P:** 67 bpm

**RR:** 18 breaths/min, unlabored breathing with no accessory muscle use

**T (oral):** 97.7 °F

**O2 Sat:** 100% on room air

**Height:** 58 in | **Weight:** 139.4 lbs | **BMI:** 29.1

### Physical Exam

**General:** Well-appearing female in NAD laying in bed. Appears well-nourished. Appears stated age of 75 years old.

**Skin:** No signs of diaphoresis, cyanosis, or pallor. Warm and dry to palpation throughout

**HEENT:** PERRLA bilaterally, sclera is white, conjunctiva is pink, mucous membranes are pink and moist without lesions or exudates seen. Crowns & dark discoloration of some teeth seen. No gingivitis, mucosal ulcers, or erythema/exudates seen in the oropharynx.

**Cardiac:** Rate is irregularly irregular consistent with atrial fibrillation. S1 and S2 audible. No S3 or S4 gallops. No murmurs, rubs, or extra heart sounds noted.

**Lungs:** Able to speak in full sentences without accessory muscle use. Lung sounds are vesicular bilaterally without rales or wheezing.

**Neurologic:** AxO4 (self, place, time, situation). CN II-XII grossly intact. Motor strength 5/5 in upper and lower extremities. No pronator drift. No focal neurological deficits noted.

**MSK:** Full active range of motion in all extremities. Right hip/buttock region with minimal tenderness to palpation. No deformity, swelling, ecchymosis, or skin discoloration noted. No calf tenderness or palpable cords bilaterally. No spinal or paraspinal tenderness or step offs.

**Peripheral Vascular:** capillary refill <2 seconds in upper & lower extremity nailbeds. BLE pitting edema 4+ extending from shin to forefoot. No erythema, warmth, or skin breakdown noted. No cyanosis or clubbing. Dorsalis pedis and posterior tibial pulses not palpable bilaterally, likely limited by significant edema.

#### Labs/Imaging

None done at this time.

#### Assessment

Ms. Y.C. is a 75-year-old female with PMHx of HTN, HLD, atrial fibrillation on anticoagulation, type 2 diabetes, and depression who presents after a witnessed mechanical fall from an unlocked wheelchair with mild right hip/buttock pain. She denies head strike or loss of consciousness and remains able to bear weight, with exam showing only minimal tenderness, making acute fracture less likely though occult injury cannot be excluded. She also reports 2 weeks of bilateral lower extremity edema without cardiopulmonary symptoms, likely due to medication effect, venous insufficiency, or early volume overload.

#### **Primary Diagnosis:** Mechanical Fall

- Rationale: Witnessed fall by RN due to an unlocked wheelchair. No head strike, LOC, or neurological deficits. Mild localized right hip/buttock tenderness without bruising or deformities

#### D/Dx

1. Occult Hip Fx
  - a. Rationale: Elderly pt with osteoporosis risk presenting with right hip/buttock pain after a fall. With occult fx's, pts may still ambulate with walkers comfortably.
2. Acute HF/Volume Overload
  - a. Rationale: Can be considered due to BLE 4+ pitting edema with RFs like HTN and DM2. Pt does not present with any cardiopulmonary complaints at this time.
3. Medication-Induced Edema

- a. **Rationale:** Can be considered as pt is on pioglitazone and diltiazem, which both cause peripheral edema and fluid retention
4. Chronic Venous Insufficiency
  - a. **Rationale:** Common in elderly patients who present with bilateral pitting edema. However, this patient does not have erythema, warmth, ulcers, or a dusky-brown appearance above the medial malleolus.

#### Problem Lists & Plan

##### **#Fall & Hip Pain [Primary Plan]**

- **Order R hip/pelvic XR to r/o occult fractures**
- PT/OT evaluation
- Orthostatic BP check
- Monitor patient & her symptoms for any delayed bruising and/or worsening pain
- Start Lidocaine Patch, applied daily to the right buttock/hip area
- Continue Acetaminophen 650mg q8h PRN
- Encourage continued ambulation with a walker as tolerated
- Fall Precautions (wheelchair locking, assistance with transfers)

##### **#Bilateral Lower Extremity Edema**

- Taper Diltiazem from 180mg to 120mg, consider D/C and start on an ACE-I/ARB
- Consider D/C Pioglitazone
- Daily weights
- Start compression stockings and elevate lower extremities

##### **#A-Fib**

- Hold Apixaban for the next 48hrs
- Monitor for delayed bleeding (HA, AMS, bruising, hematuria)
- Fall Precautions (wheelchair locking, assistance with transfers)

##### **#HTN**

- Taper Diltiazem from 180mg to 120mg
- Continue Metoprolol Succinate ER Tablet 25mg QD

##### **#HLD**

- Continue Atorvastatin 40mg QD

##### **#DM 2**

- Continue Linagliptin 5mg PO QD, Pioglitazone HCl 30mg PO QD, Dapagliflozin 5mg PO BID, Insulin Lispro per sliding scale, Insulin Glargine 5U SQ
- Consider D/C Pioglitazone

##### **#Depression**

- Continue Venlafaxine HCl ER PO 37.5mg PO QD
- Psychiatry/Psychology Consult if needed

##### **#Patient Education**

- Education on fall prevention (wheelchair locking, asking for assistance)
- Signs of bleeding (especially on apixaban)
- When to report worsening pain/swelling
- Importance of leg elevation/compression adherence