CONFIDENTIAL REPORT
PREPARED FOR:
James Doe, Esq.

COMPREHENSIVE

FORENSIC MEDICAL CONSULTING

EVALUATE | ANALYZE | IDENTIFY

Personal Injury Fact Sheet and Summary

Patient Information

Name: Doe, Jane
Date of Birth: 12.03.1940
Date of Injury: 03.04.2019
Date of Death: N/A
Primary Care Physician:
Treating Physicians:

- **Dr. John Doe –** Primary Care Physician
- **Dr. John Doe –** Dentist [03.27.2019 to ongoing]
- **Dr. John Doe** – Community Orthopedic Medical Clinic [03.14.2019 – ongoing]
- **John Doe, PT –** Physical Therapist [03.19.2019 – 03.18.2020]
- **John Doe, OT –** Occupational Therapist [03.19.2019 – 03.18.2020]

Records Reviewed

File Name/Designation	Relevant Pages	Total Pages
Medical Records_Redacted	3	3
2019_03_21Family & Urgent Care MR_Redacted	2	2
Neck Back Medical Center medical records_Redacted	150	165
2019_3_21 Ortho Medical Group MR_Redacted	1	3
2019 04 24 Ortho Med Grp Medical Records_Redacted	22	24
(Imaging) Medical Records_Redacted	8	8
2019_03_21 Orthopedic Medical Group PT	4	7
2019.0425 Med Grp Med Records_Redacted	4	4
2019.0830_Dentist MR_Redacted	10	13
2020 03 30 Ortho Medical Records_Redacted	64	72
2020_02_27_Imaging MR_Redacted	4	4
MRI Order 11-10-2020_Redacted	1	1
Physical Therapy Medical Records_Redacted	63	63
TOTAL	**336**	**369**

Prior Medical Conditions

The Following are Prior Medical Conditions based on the review of the above records:
Barrett's Esophagus
Mumps

Chicken Pox
Lung Disease – Bronchitis – pneumonia in past
Idopathic Pulmonary Fibrosis Dx May 2018 (Neck Back Medical Center medical records pg13)
Neck pain
Back pain
Lower back pain
Headaches
Night sweats in the past
Joint pain/stiffness
Arthritis
Sinusitis
Anemia in the past
Osteoarthritis of both knees
Right forefoot fracture 20 years prior (mentioned in note 03.14.2019)
Impaired cognition
History of prior falls
Sprained left ankle (mentioned in note 03.14.2019)
Subluxation of the TMJ - Medical Records_Redacted pg 1-3/3
Shin splints (mentioned in note 03.14.2019)

Injuries Sustained from Accident

The Plaintiff is Claiming the Following Injuries as a result of the Accident: (According to the medical records and discovery responses)
Right knee pain
Left knee pain
Fractured front teeth

Additional Medical Diagnoses

Other Medical Diagnoses found in the Medical Records AFTER the Date of the Incident that are Pertinent to this Claim:
Bilateral knee chondrocalcinosis
Bilateral knee contusion
Contusion of face
Abrasions
Closed head injury without concussion
Chondrocalcinosis
Mildly Antalgic gait

Patellofemoral Syndrome
Mild Chondromalacia patella, right knee
Mild Chondromalacia patella, left knee
Meniscal tear
Retrolisthesis
Degenerative root tear at the posterior root attachment of the medial meniscus with subluxation of meniscal tissue
Oblique tear at the anterior horn and body junction of the lateral meniscus extending to the superior articular surface
Tiny Popliteal cyst
Moderate to severe degenerative disc changes at L1-L2
Anterolisthesis of L5 on S1
Straightening of the cervical lordosis
Moderate to severe degenerative disc changes at C4 through C7
Possible internal derangement
Ples Planus
Increased Thoracic Kyphosis
Anterior Pelvic Tilt
spondylolisthesis

Narrative Summary of the Case

The Facts

Synopsis Provided by Legal Counsel: Date of Injury reported as 03.04.2019. "Client fell in the store parking lot. She suffered severe facial injuries. Required 40k in dental work. Went to ortho that Rx PT for injuries to back, neck and knees. After 8 weeks, client's knees were not getting better. She sought treatment at Generic Neck and Back. They did MRIs and found out meniscus tears in the both knees non-surgical, treated with lasers and client notes significant progress during my last conversation with her."

Mrs. Doe was walking in the Walmart parking on 03.04.2019, at an undisclosed time. She reported that she was walking and tripped, falling forward and landing on the front of both knees and then falling forward onto her face. She reported that she "didn't really hit her head hard". She then realized that she had caught her foot on the edge of some uneven ground. She had bruised and skinned up her knees. She scraped up her face, injured her upper teeth and her gums were bleeding.

Mrs. Doe was taken to the urgent care on 03.05.2019. During that examination she *denied* loss of consciousness and denied amnesia relating to the event. She denied changes in vision, hearing, speech or swallowing. She denied neck pain but acknowledged feeling stiff all over. She reported that her bite was off after the fall but felt better upon examination on 03.05.2019. She was able to chew with difficulty. She reported feeling "foggy". She reported that her right knee was sore and stiff. She reported that the location

of the pain was in the back side of the knee.

Physical examination, as documented by the physician, revealed abrasions to the front of her right knee, with questionable swelling. She had some bruising and shallow abrasions and mild tenderness over both knee caps. Her upper lip was swollen and slightly bruised. There was a small laceration inside her upper lip. Physician documented no tenderness to bones in her face, indicating no fractures. Her teeth appeared intact and solid. Physician strongly encouraged her to follow up with a dentist to have her teeth evaluated. Physician documented that "History suggests subluxation of the TMJ which appears to have spontaneously reduced. Bite is normal now and patient is able to chew." There were small and superficial abrasions just above her lip, on her upper lip and on her right cheek. No popping, clicking, locking or giving out of the knees were found on physical examination. Physician did document that Mrs. Doe had other minor abrasions but "no other big pain". There was no deformities of swelling noted to both knees. She had full range of motion in both knees. No laxity noted. Negative Lachman's test, which indicates no damage to the ACL. Negative McMurray's test, which indicates no torn meniscus. Negative anterior drawer, indicating no injury to the ACL. Negative posterior drawer test, indicating no injury to the PCL. She had no signs of a concussion.

Mrs. Does was instructed to follow up with a dentist, utilize ibuprofen or Aleve as needed for pain and inflammation, eat soft foods until cleared by dentist, watch for signs of infection (redness, heat, increasing pain, drainage or pus, fever), can use Neosporin on body and legs but not face, okay to use Aquaphor on scrapes, to return if symptoms worsen or develops headache, dizziness, nausea, changes in vision or hearing or confusion.

She followed up with a physician on 03.14.2019 to have her knees evaluated. She is now claiming that when she fell it "sent me across walkway falling on both knees very hard and flat on my face with contact to front teeth and right shoulder." A different description of events than previously given on 03.05.2019. Mrs. Doe also acknowledged at this visit that she had an attorney representing her for this problem. She informed physician that her knees were not evaluated or imaged at the urgent care visit. To the contrary, Mrs. Doe's knees were thoroughly assessed by the documenting physician. [See note on 03.05.2019 #2 & #3 under Physical Exam -- *Both knees no deform or edema. No effusion. + tx over the patella bilat and over the infra-patella area R side.. FROM without crepitation. No laxity, varus or valgus stress. Neg Lachman's. Neg McMurray's. Neg drawer signs*]. Due to negative findings on physical examination no imaging was warranted at that time. She had been treating the knee pain with rest, ice and Tylenol. She reported pain of 8/10 that was worse with walking up and down stairs or getting up from a seated position. She has not required the use of an assistive device. X-rays were performed. Her right knee without signs of acute fracture and was found to be in normal alignment. Some calcification of the medial and lateral meniscus was noted, which is a pre-existing problem. Her left knee was also found to be in normal alignment without sign of acute fractures. It also had some calcification of the medial and lateral meniscus. Orthopedic specialist educated Mrs. Doe that she had contusions, or bruising, to both knees and it would likely take several weeks for her symptoms to resolve. He also discussed with Mrs. Doe the potential benefit of using an assisted device including a walker or cane. It was documented in the records that Mrs. Doe does own a walker but chooses not to use it. He recommended conservative management including

rest, ice and activity. Physician documented that Mrs. Doe "has a history of 1-2 personal factors and/or comorbidities that impact the plan of care". No specifics were given. Documentation states that Mrs. Doe is not compliant with weight bearing restrictions. Standing posture documented as: (1) Rounded shoulders, (2) Increased Thoracic Kyphosis (3) Decreased Lumbar Lordosis (4) Anterior Pelvic Tilt (5) Pes Planus (6) Level Pelvis (7) Decreased weight bearing on left.

Mrs. Doe was referred to physical therapy and began therapy on 03.19.2019. Upon initial PT evaluation Mr. Doe reports that she fell landing on the front of her knees and on her face, slightly turned right. She is also reporting that she blacked out for about 30 seconds. This is the first time that Mrs. Doe is documented as reporting that she blacked out for 30 seconds. She denied loss of consciousness at urgent care on 03.05.2019.

At the time of this examination she reported swelling in her right knee and the inability to stand long enough to cook dinner before it starts to ache in her right calf. She states that her left knee hurts in certain positions like getting into bed and weight bearing on it. She reported pain 6-10/10. She stated that she was primarily homebound since the fall and had to rely on her husband to assist with her ADLs and iADLs. Mrs. Doe reported that prior to the fall she could walk and move around without pain or needing to use an assisted device. Just because Mrs. Doe states that she could get around without needing an assisted device doesn't mean that it hadn't been recommended to her by her physician in the past. The fact that she owned one at the time of the fall indicates that she was likely, at some point, told that she should be using one for her own personal safety.

She could stand without pain or difficulty. At time of the exam she reported that she was unable to lift her right leg to put socks on, unable to get into and out of step in tub without assistance, unable to drive, unable to do household chores, unable to stand at the sink and cook dinner without severe ache, limited in walking distances and limited stair negotiation. Pain is aggravated by standing, walking, going up and down stairs, going from sitting to standing, and bending. She has a walker but is not using it. It was documented that there are *no known* complicating factors affecting the plan of care. In the next sentence it's documented that "The patient *has a history of present problem with a history of 1-2 personal factors and/or comorbidities"* which is a contradicting statement. It is this writer's recommendation that this be looked into further. Mrs. Doe could have quite a few medical conditions that could have contributed, in some part, to her fall.

Physical Therapist documents that Mrs. Doe exhibited "very slow and apprehensive sit to stand and waiting area. Unsteady--needed assistance in initial steps by holding therapist hand. No assistive device." Her standing posture was described as: "Rounding shoulders, increased thoracic kyphosis, decreased lumbar lordosis, anterior pelvic tilt, Pes Planus," which is where the arch of the foot has fallen or flattened and the forefoot may align slightly outward. Her gait was described as: "Antalgic, lacks proper heel strike/toe off, apprehensive with weightbearing, shortened stride length; CGA [contact guard assist – able to do work with PT only providing a light touch] on walk back to room". Mrs. Doe admits to previous, undocumented, falls. She has a walker but isn't using it. She continued physical therapy through 03.18.2020 at which time she rated the pain in her right knee at 2/10, pain in her left knee at 1/10 and swelling in right knee at 2/10.

She presented to the dental office on 03.27.2019 with a chief complaint of "broken teeth". She reported on 03.27.2019 that she was experiencing pain when she chews. Upon examination by this dentist Mrs. Doe was told that she had fractures on teeth #07, #08 and #09. Teeth #07, #08 and #09 were tender to percussion and tooth #08 was also found to be sensitive to temperature. Imaging at that time also revealed widening of the periodontal ligament and apical radiolucency on tooth #08. Her dentist documented that he believed that her current symptoms and radiographic findings were consistent with the nature of her accident. A comprehensive treatment plan was set up to restore teeth #07, 08 and 09 on 03.27.2019 to which Mrs. Doe agreed to. Treatment was started on 04.03.2019 by performing a root canal on tooth #08 and preparing build up and crowns on teeth #07, 08 and 09. Mrs. Doe returned on 04.17.2019 at which time the crowns on #07, 08 and 09 were cemented. The patient was advised that as a result of trauma she may require, at a minimum, additional root canal therapy on teeth #07 and 09, the extent of which they weren't able to predict at that time. Mrs. Doe subsequently received a bill for the dental work. It totaled $39,899.00.

Discussion of Claims and Injuries

Right knee pain
Left knee pain
Fractured front teeth
Impaired functional ability

1. **RIGHT KNEE PAIN/ LEFT KNEE PAIN/IMPAIRED FUNCTIONAL ABILITY:** Mrs. Doe was walking in the Walmart parking on 03.04.2019, at an undisclosed time. She reported that she was walking and tripped, falling forward and landing on the front of both knees and then falling forward onto her face. Her right knee is less painful than her left knee. Prior to the fall Mrs. Doe was able to stand without difficulty. She had no pain or difficulty moving around. Following the fall she had difficulty lifting her right leg to put her sock on. She also had difficulty stepping into and out of the bath tub without assistance. She had difficulty doing household chores. She had decreased endurance standing at the sink. She was also having difficulty stepping into the car and getting in to bed. She is unable to sit for long periods of time in a car or plane. She could not stand long enough to cook dinner without having a severe ache. She was not able to walk long distances. She reported experiencing pain with the following activities: putting on pants, putting on shoes, taking a bath, sleeping, caring for grandchildren or great grandchildren, sitting in a movie theatre, exercise, stooping, squatting down, kneeling, climbing stairs, housework such as laundry, vacuuming, washing car, mowing lawn, taking out trash. She had to rely on others living with her to do her share of the work.

2. **FRACTURED/CHIPPED FRONT TEETH:** Mrs. Doe sought out the help of a dentist when she began having pain that was interrupting her everyday life. She presented to the dental office on 03.27.2019 with a chief complaint of "broken teeth". She reported on 03.27.2019 that she was experiencing pain when she chews. Upon examination by this dentist Mrs. Doe was told that she had fractures on teeth #07, #08 and #09. Teeth #07, #08 and #09 were tender to percussion and tooth #08 was also found to be sensitive to temperature as well. Imaging at that time also revealed widening of the periodontal ligament and apical radiolucency on tooth #08. Her dentist documented that he believed that

her current symptoms and radiographic findings were consistent with the nature of her accident. A comprehensive treatment plan was set up to restore teeth #07, 08 and 09 on 03.27.2019 to which Mrs. Doe agreed to. Treatment was started on 04.03.2019 by performing a root canal on tooth #08 and preparing build up and crowns on teeth #07, 08 and 09. Mrs. Doe returned on 04.17.2019 at which time the Crowns on #07, 08 and 09 were cemented. The patient was advised that as a result of trauma she may require, at a minimum, additional root canal therapy on teeth #07 and 09, the extent of which they weren't able to predict at that time. Mrs. Doe subsequently received a bill for the dental work. The total cost of her dental work was $39,899.00.

Discussion of New Diagnoses:

1. **Bilateral knee chondrocalcinosis:** painful type of arthritis where calcium crystals form in the joint tissues
2. **Bilateral knee contusion:** bruising on both knees
3. **Contusion of face:** bruising on the face
4. **Abrasions**: minor, superficial scrape of skin
5. **Closed head injury without concussion**: Receiving a hard blow to the head from striking an object, but the object did not penetrate the skull.
6. **Mildly Antalgic gait**: abnormal pattern of walking secondary to pain that ultimately causes a limp
7. **Patellofemoral Syndrome**: A condition in which the cartilage under the kneecap is damaged due to injury or overuse. The most common symptom is knee pain that increases with stair climbing or squatting movements. The primary treatment is rest.
8. **Mild Chondromalacia patella, right/left knee:** the breakdown of cartilage on the underside of the kneecap (patella). When the kneecap rubs against the thigh bone, it hurts and swells. It is common among runners and other athletes and has been given the nickname "runner's knee."
9. **Meniscal tear:** the menisci sit between the tibia (lower leg bone) and the femur (thigh bone) and protect the lower part of the leg from the shock created by out body weight. The medial meniscus sits on the inside of the knee and the lateral meniscus sits on the outside of the knee. Meniscus tears usually take place when an athlete twists or turns their upper leg while their foot is planted and their knee is bent.
10. **Retrolisthesis:** a condition in which one vertebra in the spine slips backward in relation to the vertebra below it
11. Degenerative root tear at the posterior root attachment of the medial meniscus with subluxation of meniscal tissue
    a. **Degenerative Root Tear:** meniscal root tears are devastating tears of the meniscal cartilage in the knee at the point where it connects to bone
    b. **Subluxation:** partial location
12. Oblique tear at the anterior horn and body junction of the lateral meniscus extending to the superior articular surface
    a. **An anterior horn meniscus tear** is a specific type of meniscal tear that occurs in the front part of the meniscus, where it attaches to the front of the knee joint. An anterior horn meniscus tear

can occur as a result of an injury to the knee, such as a sudden twisting or hyperextension of the joint, or from wear and tear over time.

13. **Tiny Popliteal cyst:** (Baker's Cyst) one of the most common disorders in the knee. These fluid-filled cysts form a lump at the back of the knee that often cause stiffness and discomfort.
14. **Moderate to severe degenerative disc changes at L1-L2:** condition in which natural, are-related wear and tear on a disc causes pain, instability and other symptoms
15. **Anterolisthesis of L5 on S1:** a type of spondylolisthesis, which occurs when one of the spine's vertebrae slips out of position. Anterolisthesis refers to anterior (forward) slippage of the vertebra.
16. **Straightening of the cervical lordosis**: Lordosis is the forward curved spine in your neck or lower back. Straightening of the cervical lordosis, also known as loss of cervical lordosis, is a condition where the natural inward curve of the neck, upper back, and lower back is reduced or straightened. A normal cervical lordosis curve is between 20-40 degrees.
17. **Moderate to severe degenerative disc changes at C4 through C7**: conditions in which natural, age-related wear and tear on a disc causes pain, instability and other symptoms
18. **Possible internal derangement:** A fragment of soft tissue or bone that suddenly becomes interposed between the articular surfaces is the classic cause of internal derangement.
19. **Ples Planus:** arch of the foot has fallen or flattened and the forefoot may align slightly outward
20. **Increased Thoracic Kyphosis:** an exaggerated, forward rounding of the upper back.
21. **Anterior Pelvic Tilt:** common condition where pelvis is rotated or tilted forward. Affects approximately 75% of women and 85% of men. This inappropriate posture can cause various health problems.
22. **Crepitus**: sound of popping, crackling, crunching, or grinding that occurs when moving the joint.
23. **Spondylolisthesis**: Spondylolisthesis is a condition that occurs when one vertebral body slips with respect to the adjacent vertebral body causing radicular or mechanical symptoms or pain. It is graded based on the degree of slippage of one vertebral body on the adjacent vertebral body

Legal Nurse Discussion and Opinion Based on the Medical Records Provided

Based on the review of the medical records made available to this writer, it is my opinion that Mrs. Doe's current complaints and problems are related to the injuries she sustained as a result of the ground level fall she experienced on 03.04.2019. That being said, it is also this provider's opinion that this fall could have prevented should Mrs. Doe have been using walker as has been recommended. Even after the fall it is documented that Mrs. Doe does not use a walker despite documented evidence that it was recommended to her by more than one provider.

Legal Nurse "Next Step" Recommendations

Please schedule a call with our LNC after you review to discuss this case.

1. **Medical Record Retrieval: video footage of accident; old records focused on his neck and back**

Please have your firm request the medical records listed below:

Record Type and Date	Facility	Date Requested	Date Received
Previous images to knees, preferably MRIs to assess whether she had any pre-existing problems with her knees	Generic hospital, PCP		
Any ER, urgent care visits in the past that may have documentation regarding any of her previous falls	Generic hospital, PCP		
Any previous cognitive tests; has it worsened?	Generic hospital, PCP		
MRI Brain ordered on 11-10-2020			
Previous dental visits and imaging to look for previously documented periodontal disease	Mrs. Doe's dentist		
Previous imaging of spine	Generic hospital, PCP		

2. **Expert Location and Screening:**
    - Recommend an expert on periodontal disease that might be able to clarify whether widening of the PDL was due to trauma or an pre-existing dental disease
    - Recommend an expert on the correlation between cognitive deficits and falls
    - Recommend an expert in foot deformities and falls risk
    - Recommend an expert in spinal deformities (kyphosis, lordosis, anterior pelvic tilt) and risk of falls
    - Recommend an expert in orthopedics to provide opinion on degree of degenerative disease that was existed prior to the fall and how much this current fall contributed to documented problems in her knees

    NNC can help find and facilitate experts for your case.

3. **Research and Summarization of Authoritative Literature: (**Some credibile sites are provided here should you choose to learn a little more about some of the conditions mentioned in this document. Feel free to reach out should you have any further questions.)
    - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5366266/

- *https://academic.oup.com/ageing/article/41/3/299/32006*
- *https://www.audiologist.org/_resources/documents/conference/2022-audacity/resources/Association-of-Cognitive-Impairment-and-Fall-Risk-in-Older-Adults.pdf*
- *https://jag.journalagent.com/ejm/pdfs/EJM_28_4_603_609.pdf*
- *https://www.ncbi.nlm.nih.gov/books/NBK430802/#:~:text=In%20adults%2C%20pes%20planus%20may,of%20an%20altered%20gait%20pattern.*
- *https://academic.oup.com/biomedgerontology/article/62/6/652/645607*
- *https://www.leagravetherapy.co.uk/the-tilted-pelvis-injury-prevention#:~:text=Pelvic%20tilt%20exercises%20can%20stretch,impaired%20balance%20and%20dynamic%20movements.*

Possible Defenses:

1. ***PRE-EXISTING MEDICAL CONDITIONS THAT PUT HER AT RISK FOR FALLS***:
   a. Mrs. Doe's standing posture was described as: "Rounding shoulders, increased thoracic kyphosis, decreased lumbar lordosis, anterior pelvic tilt, Pes Planus," which is where the arch of the foot has fallen or flattened and the forefoot may align slightly outward. None of these conditions were a result of the fall. On the contrary, they likely contributed to the fall. Mrs. Doe knew she had fallen multiple times in the past. She knew she should've been using an assistive device such as a walker or cane. (Walker would be more appropriate for her and she owns one). But she chose not to. Another fall was inevitable. She has cognitive impairment so it's likely that she doesn't remember to use her walker. That's why her family should be more assertive in intervening and encouraging her to use a walker. Documentation reports that Mrs. Doe's husband was with her at the time of the fall.
   b. Documentation dated 03.19.2019 reports that Mrs. Doe's cognitive function does not appear to be intact. Research shows there is a relationship between cognitive functioning and motor functions like balance and gait, and that cognitive impairment can increase the risk of mobility limitations which can often lead to falls. Because of her cognitive impairment it's likely that she doesn't remember to use her walker. Her family should always accompany her on outings. It was documented that her husband was with her at the time of her fall. Did he try to get her to use her walker? It's very common for people with cognitive impairment to refuse to use a walker. If her family knowingly let her walk around without a walker after knowing she's fallen multiple times in the past and knowing that her physician strongly encourages one then they need to accept some of the accountability in her fall.
   c. 03.19.2019 In the evaluation done by physical therapy it was documented that there are no known complicating factors affecting the plan of care. In the next sentence it's documented that "The patient has a history of present problem with a history of 1-2 personal factors and/or comorbidities" which is a contradicting statement. Mrs. Doe has several personal factors and comorbidities affecting her plan of care. She has multiple physical comorbid conditions that increase her risk of falling: kyphosis, fallen arch with outward turn of foot, improper gait. The cognitive impairment only makes this situation worse. Mrs. Doe has admitted to previous,

undocumented falls. It was not documented how many or whether she suffered injuries during this fall. This should be looked into further. If there were injuries then there should be documentation of them somewhere.

2. ***IMPAIRED COGNITION:*** Documentation dated 03.19.2019 reports that Mrs. Doe's cognitive function does not appear to be intact. Research shows there is a relationship between cognitive functioning and motor functions like balance and gait, and that cognitive impairment can increase the risk of mobility limitations which can often lead to falls. Throughout the documentation Mrs. Doe has been documented giving conflicting statements.
   a. When Mrs. Doe saw her physician on 03.14.2019 she described the injury as "stumped toe on edge of walkway & sent me across walking falling on both knees very hard & flat on my face with contact to front teeth & right shoulder." This is vastly different than her recall of events the day after the injury when she went to the urgent care on 03.05.2019. At that time she reported that she "fell on some uneven ground. Fell forward onto her face. Didn't really hit her head hard but skidded on the ground and damaged the skin. No loss of consciousness." There was no mention of injuring the right shoulder.
   b. Mrs. Doe was referred to physical therapy and began on 03.19.2019. At that time she describes the injury stating that she "fell in Walmart parking lot landing on the front of her knees and her face, slightly turned right" but on her initial exam on 03.05.2019, she had abrasions on her right cheek which would indicate her head was turned to the left. She also reported that she "blacked out for 30 seconds." This is contrary to her statement on her initial exam 03.05.2019, one day after the fall, when she denied loss of consciousness. Is her poor recall due to intentional deceit or possibly due to impaired cognition?
   c. It was documented in her records that Mrs. Doe didn't show much improvement with physical therapy. It is very common for individuals with impaired cognition/Dementia to do poorly at physical therapy. Because of their impaired cognition they don't always understand what is being asked of them or understand why they're doing it. They can mimic the therapist well during therapy but as soon as the therapist is gone they have no idea what they just did. They rarely follow through on doing home exercises. They don't even remember that they need to do the exercises. If family is very involved they can help remind them but because their cognition is impaired they can't remember what was taught or how to do it properly. There is no one there for them to mimic and copy so they usually refuse to do the home exercises. This will cause them to become frustrated and they'll fight the family. Family will usually give in and not force the issue. They don't progress very far if they can't do the exercises outside of the scheduled therapy time.

3. ***HISTORY OF PREVIOUS FALLS:*** 03.19.2019 Mrs. Doe admits to previous, undocumented, falls. She reported having a walker but not using it. She reported that she wasn't using home health. Most patients that have a history of falls are usually working with home health for physical and occupational therapy or attending outpatient physical and occupational therapy intermittently on a

continual basis. It's likely that Mrs. Doe wasn't on home health because her medical provider(s) are unaware that she was falling. For some reason she had chosen not to disclose this to her medical providers. More often than not a patient will not disclose falls when they are having more falls than they are wanting to admit to their medical provider. There is a deep fear that admitting to falls will deem them unsafe to remain at home and they'll be taken to a "care center". It's difficult to say how many undocumented falls Mrs. Doe had prior to the fall on 03.04.2019. If Mrs. Doe is a frequent faller and she refuses to use a walker or cane then her risk of falling is even greater. Mrs. Doe's standing posture was described as: "Rounding shoulders, increased thoracic kyphosis, decreased lumbar lordosis, anterior pelvic tilt, Pes Planus," which is where the arch of the foot has fallen or flattened and the forefoot may align slightly outward. None of these conditions were a result of the fall. On the contrary, they likely contributed to the fall. This is another reason that Mrs. Doe's family should be encouraging her to use her walker.

Mrs. Doe had 20 PT visits between 03.19.2019 to 06.13.2019
Mrs. Doe had 20 PT visits between 12.27.2019 to 03.18.2020