1 PATIENT INFORMATION

NAME
Marguerite A. Delacroix-Finn

DATE OF SERVICE
November 12, 2026

DOB
03/08/1945 (81 yrs)

PROVIDER
Idris Farrokhzad, MD

AGE / SEX
81 / Female

CREDENTIALS
MD, Geriatric Psychiatry

MRN / PATIENT ID
GER-208844

VISIT TYPE
Geriatric Psychiatry Consultation — facility-requested, urgent

CARE SETTING
Assisted Living — on-site consultation

REFERRAL SOURCE
Willow Grove Assisted Living nursing director, requesting “something for agitation”

PRIMARY CARE PROVIDER, IF APPLICABLE
Dr. Bernard Osei, Geriatrics

CAREGIVER / FAMILY MEMBER PRESENT
Daughter (Colette Finn), healthcare proxy, present

INFORMANT / COLLATERAL SOURCE
Daughter; facility nursing notes and 14-day behavior log; night aide interviewed

RESIDENCE / LIVING SITUATION
Private studio in assisted living for 3 years; staff assist with medications and bathing

CC CHIEF COMPLAINT

Facility reports: “She’s agitated in the evenings, seeing people who aren’t there, and resisting care — we need a medication.” Daughter reports: “She’s not herself. She was fine in August and now she’s falling and confused.”

S SUBJECTIVE

3a REASON FOR GERIATRIC PSYCHIATRY EVALUATION

Urgent facility-requested consultation for evening agitation, visual hallucinations, and resistance to personal care, with an explicit request to initiate an antipsychotic. The clinical task is to determine what is actually driving the change over approximately 10 weeks before any medication is added — particularly because, as detailed below, the emerging diagnostic picture makes antipsychotics potentially dangerous rather than merely unhelpful.

3b MOOD SYMPTOMS

Daughter reports withdrawal from the dining room and from the weekly music group she previously enjoyed, beginning around September. Apathy is prominent — she sits without initiating activity, which staff have interpreted as depression. On direct interview Marguerite denies feeling sad, denies hopelessness or guilt, and says "I'm just tired, and I don't like not knowing what's happening." No tearfulness observed or reported. Some irritability, occurring almost exclusively during bathing and dressing. No anhedonia in the classic sense — she engaged warmly and with evident pleasure when her daughter mentioned her grandchildren.

3c ANXIETY SYMPTOMS

Situational anxiety, reported by staff as worse in the late afternoon and evening. Notable fear of falling since two falls in October, and she now grips furniture when walking. Some health-related worry. No panic attacks. No separation anxiety. The anxiety appears secondary to genuine perceptual and postural instability rather than primary.

3d COGNITIVE SYMPTOMS

Daughter dates cognitive change to roughly 18 months, with marked acceleration in the last 10 weeks. **Fluctuation is the striking feature** — she describes days when her mother "is completely herself, sharp, does the crossword" alternating with days of confusion and staring. Facility notes corroborate this, with nursing describing her as "variable, sometimes oriented and sometimes not, within the same 24 hours." Memory complaints are present but comparatively mild; she recalls remote events well. More prominent are attentional lapses, visuospatial difficulty (misjudging chair position, difficulty with the television remote), and executive difficulty managing her pillbox. Word-finding is mildly affected. No repetitive questioning of the kind typical in Alzheimer disease.

3e BEHAVIORAL AND PSYCHOLOGICAL SYMPTOMS OF DEMENTIA, IF APPLICABLE

Visual hallucinations — well-formed, recurrent, and non-threatening. She describes seeing "children playing in the corner" and "a small dog" in her room, typically in the late afternoon and evening, several times weekly for at least 8 weeks. Critically, she has partial insight: "I know they're not really there, but I see them plainly." She is not distressed by them. Some misidentification — twice called a night aide by her late sister's name. Mild paranoia limited to believing staff "move her things." Resistance to care occurs specifically during bathing, is not random aggression, and staff acknowledge it happens when two aides approach her quickly from behind. No wandering. No hoarding. Sleep-wake disruption prominent, as below. **Caregiver distress is high** and the facility is explicitly considering discharge to memory care.

3f PSYCHOTIC SYMPTOMS

Recurrent well-formed visual hallucinations as described, with retained partial insight. No auditory hallucinations. Delusional content limited and non-systematized — the belief that items are moved. Misidentification present. No disorganized thinking. Reality testing partially preserved, which is itself diagnostically informative.

3g SLEEP AND APPETITE

The night aide provided the single most valuable piece of history in this consultation: Marguerite shouts, thrashes, and "acts out" during sleep, on one occasion striking the bedrail and once falling out of bed. This has been occurring for at least two years, predating all other symptoms, and had never been documented or reported to a physician — it was recorded in the aide's shift notes as "restless." This is dream-enactment behavior. Otherwise: sleep-wake reversal with daytime napping and nocturnal wakefulness. Appetite reduced with 3.6 kg weight loss over 4 months. Hydration marginal; staff note she often does not finish drinks.

3h FUNCTIONAL STATUS

Decline over 10 weeks. ADLs: needs standby assistance for bathing and dressing (previously independent with setup), continent but with new urgency, independent with feeding, and now requires contact-guard assistance for transfers after her falls. IADLs: no longer manages her own medications (facility took over 6 weeks ago after a double-dosing incident), does not manage finances (daughter has power of attorney), does not cook or shop, uses the phone with difficulty. No longer drives — stopped 4 years ago voluntarily.

3i MEDICAL AND NEUROLOGIC CONTEXT

Parkinsonism is present and has not been formally recognized. Daughter reports her mother has become "slower and stiffer" over the past year with a shuffling gait, reduced arm swing, and softer voice; this was attributed by others to "just aging." Two falls in October, one resulting in a **T12 compression fracture** confirmed on imaging, for which she receives only scheduled paracetamol. Other history: hypertension, osteoporosis, overactive bladder, remote hysterectomy, osteoarthritis. **Moderate bilateral sensorineural hearing loss** — she owns hearing aids but the batteries have been dead for approximately two months and no one noticed. Cataracts, moderate, with surgery deferred. No stroke, seizure, or diabetes. **A urine culture from three days ago grew E. coli** and no antibiotic has been started — the result had not been acted upon.

3j MEDICATION HISTORY AND TREATMENT RESPONSE

The medication list is a substantial part of the problem. Current: oxybutynin 10 mg daily for overactive bladder (strongly anticholinergic); diphenhydramine 50 mg at bedtime, started by the facility 10 weeks ago for sleep (strongly anticholinergic, and the timing correlates precisely with symptom acceleration); lorazepam 0.5 mg as needed, given on 9 of the last 14 nights per the MAR; amlodipine; alendronate; paracetamol 650 mg three times daily scheduled; and a multivitamin. Anticholinergic burden is high, with two potent agents in a patient with parkinsonism and visual hallucinations. No cholinesterase inhibitor has ever been trialed. Adherence is facility-managed and reliable.

3k SUBSTANCE USE

No alcohol for over 20 years. Never smoked. No cannabis or illicit substances. No prescription misuse — medications are facility-administered. The relevant substance-related risk is iatrogenic: benzodiazepine and anticholinergic exposure, both contributing to falls, sedation, and cognitive impairment.

3l SAFETY CONCERNS

Denies suicidal ideation, and there is no passive death wish on direct questioning. No homicidal ideation. Resistance to care is defensive rather than aggressive. **Fall risk is high** — two falls with a resulting vertebral fracture, parkinsonian gait, benzodiazepine and anticholinergic exposure, and dream-enactment behavior with a prior fall from bed. No wandering or elopement. Not driving. Medication errors occurred before facility supervision. No stove access. No financial exploitation — daughter holds power of attorney and the family is trustworthy. No abuse or neglect, though the failure to act on the urine culture and the dead hearing-aid batteries represent significant lapses in care quality that warrant direct feedback. Facility is considering transfer to memory care.

3m CAREGIVER / FACILITY INPUT

Nursing director requests an antipsychotic for evening agitation. Fourteen-day behavior log reviewed in detail: agitation episodes cluster between 4 and 8 pm and, importantly, **every documented resistance episode occurred during bathing or dressing** — not spontaneously. Night aide interviewed directly and provided the dream-enactment history. Staff report she is "easier" with one particular aide who speaks slowly and approaches from the front. Daughter is distressed, feels her mother is being "written off," and is resistant to antipsychotics because she read they are dangerous in dementia — a concern that is, in this case, entirely correct.

3n PERTINENT NEGATIVES

Denies suicidal or homicidal ideation, auditory hallucinations, and systematized delusions. No wandering or elopement. No medication misuse. No abuse or exploitation identified. No fever, dysuria, or frank delirium at the time of examination, though attention fluctuates. No chest pain, dyspnea, or focal neurologic deficit. No history of neuroleptic exposure — which is fortunate, given the diagnostic considerations below.

ROS GERIATRIC PSYCHIATRIC REVIEW OF SYSTEMS

DEPRESSION / APATHY
Positive for apathy and social withdrawal; denies sadness, hopelessness, guilt, or loneliness

ANXIETY
Positive — evening anxiety and marked fear of falling since October; denies panic

COGNITION
Positive — fluctuating attention and confusion, visuospatial and executive difficulty; memory relatively less affected

PERCEPTUAL
Positive — recurrent well-formed visual hallucinations with partial insight; misidentification; mild non-systematized paranoia

BEHAVIORAL
Positive — evening agitation and resistance during bathing; denies wandering, hoarding, or unprovoked aggression

SLEEP
Positive — dream-enactment behavior for ~2 years (newly elicited), sleep-wake reversal, daytime napping

NUTRITION
Positive — reduced appetite, 3.6 kg weight loss over 4 months, marginal hydration

NEUROLOGIC / FALLS
Positive — two falls, T12 compression fracture, shuffling gait, rigidity, bradykinesia, hypophonia

MEDICATION EFFECTS
Positive — high anticholinergic burden (oxybutynin, diphenhydramine), PRN benzodiazepine given 9 of 14 nights

SAFETY
Denies SI, HI, self-harm; no abuse, neglect, or exploitation identified; high fall risk

O OBJECTIVE / MENTAL STATUS EXAMINATION

5a VITALS, IF OBTAINED

TEMPERATURE
36.5 °C — afebrile

OXYGEN SATURATION
96% on room air

BLOOD PRESSURE
Seated 138/78; standing 108/64 — symptomatic orthostatic drop

WEIGHT / BMI IF RELEVANT
52.1 kg; BMI 20.3 — down 3.6 kg over 4 months

HEART RATE
76 seated, 88 standing

ORTHOSTATIC VITALS, IF OBTAINED
Positive — 30 mmHg systolic drop with reported lightheadedness

RESPIRATORY RATE
16 / min

5b MENTAL STATUS EXAMINATION

GENERAL APPEARANCE
Frail, thin elderly woman, neatly dressed with hair done; mildly cachectic; alert on arrival but with observable waxing and waning of engagement across the 70-minute visit — fully conversant at the outset and notably vaguer 30 minutes in, then re-engaging

BEHAVIOR

Cooperative and courteous throughout. Eye contact good when engaged. **Reduced spontaneous movement, masked facies, and hypophonia.** Mild resting tremor of the right hand. No agitation during this examination — notably, she was approached slowly, from the front, with her hearing aids fitted with fresh batteries obtained during the visit. Interaction with her daughter is warm.

SPEECH

Soft and hypophonic, reduced volume, mildly reduced rate; fluent with occasional word-finding pauses; coherent; no pressured speech; increased latency when fatigued later in the visit

MOOD

"Tired. A bit muddled" (patient-reported). Daughter reports "flat, not sad"

AFFECT

Restricted range with masked facies confounding assessment; congruent; reactive — smiled genuinely and at length when grandchildren were mentioned

THOUGHT PROCESS

Largely linear and goal-directed when attention is sustained; became tangential and vague during the observed period of reduced engagement, then returned to coherence — this within-visit fluctuation is itself a key finding

THOUGHT CONTENT

No suicidal or homicidal ideation. Non-systematized belief that items are moved. No guilt or hopelessness. Some concern about being "a bother." No somatic preoccupation.

PERCEPTION

Reports recurrent well-formed visual hallucinations of children and a small dog, typically late afternoon and evening, non-threatening, with retained partial insight ("I know they aren't real"). No auditory hallucinations. Misidentification of staff reported.

COGNITION

MoCA 18/30 administered with hearing aids functioning. Orientation to person and place intact; date incorrect by 4 days. **Attention markedly impaired** — serial sevens 2/5, digit span reduced. **Visuospatial function disproportionately impaired** — clock drawing significantly distorted with poor spatial planning, cube copy failed. Delayed recall 2/5, improving to 4/5 with cueing, indicating a retrieval rather than storage deficit. Verbal fluency reduced. Language largely preserved. This profile — attention and visuospatial out of proportion to memory, with cueing benefit — is not the pattern of Alzheimer disease.

INSIGHT

Partial — aware that she is confused at times and that the hallucinations are not real, but underestimates her fall risk and functional decline

JUDGMENT

Impaired for complex decisions such as medication management and finances; adequate for expressing care preferences and daily choices; retains capacity to express values regarding care

IMPULSE CONTROL

Intact — no disinhibition or impulsive behavior observed or reported

SAFETY

No acute psychiatric safety concern requiring hospitalization. High fall risk. Requires supervision. Managed in place with the plan below rather than transfer.

AS COGNITIVE / FUNCTIONAL ASSESSMENT TOOLS

MOCA

MMSE

18/30 — administered today with hearing aids functioning; attention 2/6, visuospatial/executive 2/5, delayed recall 2/5 improving to 4/5 with cueing

Not administered — MoCA preferred for its sensitivity to executive and visuospatial domains

SLUMS

Not administered

MINI-COG

Not administered — full MoCA performed instead

PHQ-9 / GDS

GDS-15 score 4 — below the depression threshold, arguing against major depression despite the apathy

GAD-7

8 — mild-to-moderate anxiety, situational

C-SSRS

Negative on all items — no suicidal ideation, no lifetime attempt

NEUROPSYCHIATRIC INVENTORY

NPI-Q administered with daughter and nursing: hallucinations, sleep/nighttime behavior, apathy, anxiety, and irritability endorsed; total severity 14, caregiver distress 16 — high

AD8

6/8 — informant-rated, consistent with cognitive impairment

FUNCTIONAL ACTIVITIES QUESTIONNAIRE

21/30 — significant IADL dependence

AIMS

0 — no abnormal involuntary movements; baseline documented (note: no antipsychotic exposure to date)

FALLS RISK ASSESSMENT

High risk — two falls in 6 months, orthostatic hypotension, parkinsonian gait, sedating medications, impaired vision

SLEEP, BEHAVIOR, OR CAREGIVER BURDEN SCALES

Facility 14-day behavior log analysed; Zarit Burden Interview with daughter score 31 — moderate-to-severe caregiver burden

Interpretation and limitations:

The most important interpretive point is that **the prior MoCA of 21 recorded in June was administered without functioning hearing aids**, as was much of the facility's informal assessment — meaning her cognitive scores have been systematically confounded by uncorrected moderate hearing loss for months, and some of what has been recorded as confusion or non-cooperation is very likely non-comprehension. Today's testing was done with hearing corrected. Additional limitations: cataracts affect visuospatial task performance, and fatigue plus fluctuating attention mean scores obtained late in a session underestimate her true baseline. A GDS-15 of 4 meaningfully argues against major depression, supporting apathy as a neurodegenerative rather than depressive feature.

RA RISK ASSESSMENT

Suicidal ideation, plan, intent, means, prior attempts, and protective factors:

None. C-SSRS negative across all items. No passive death wish on direct and careful questioning. No lifetime attempt and no family history. Protective factors: close relationship with her daughter, engagement with grandchildren, no hopelessness, and religious belief she describes as sustaining.

Self-harm thoughts, passive death wish, hopelessness, or access to lethal means:

None. No hopelessness elicited. Medications are facility-controlled and not accessible to her.

Homicidal ideation, aggression, threats, target, means, and protective factors:

No homicidal ideation. The resistance during bathing is defensive and provoked, not aggression with intent — an important distinction, as the framing determines whether the response is a medication or a change in care approach.

Psychosis-related safety concerns:

Low. Visual hallucinations are non-threatening, non-command, and she retains partial insight. They do not drive behavior. She is not frightened by them and has not acted on them.

Dementia-related wandering, agitation, aggression, medication refusal, or unsafe behavior:

No wandering or elopement. Agitation is time-limited, evening-predominant, and consistently task-triggered by bathing and dressing. No medication refusal. The main unsafe behavior is dream enactment during sleep with a prior fall from bed.

Fall risk, driving risk, medication mismanagement, stove/fire risk, financial exploitation, or self-neglect:

Fall risk is high and is the most immediate physical danger. Contributors: two falls with a resulting T12 fracture, symptomatic orthostatic hypotension with a 30 mmHg drop, parkinsonian gait with reduced arm swing, nightly diphenhydramine, benzodiazepine on 9 of 14 nights, untreated pain limiting mobility, cataracts, and dream-enactment behavior with a fall from bed. Not driving. Medications now facility-managed following a double-dosing incident. No stove access. No financial exploitation — daughter holds power of attorney appropriately. No self-neglect in the supervised setting.

Abuse, neglect, exploitation, or domestic violence concerns:

No abuse or exploitation. However, two significant care-quality lapses are documented: **a positive urine culture from three days ago on which no action was taken**, and hearing aids non-functional for approximately two months without staff noticing. These do not meet the threshold for a neglect report given the absence of intent or pattern, but they require direct, documented feedback to facility leadership and follow-up verification, which is planned.

Substance-related risk, intoxication, withdrawal, or sedative-related fall/cognitive risk:

No alcohol or illicit substance use. The substantive risk is iatrogenic: high anticholinergic burden from oxybutynin and diphenhydramine, plus frequent PRN lorazepam, all contributing to sedation, cognitive impairment, orthostasis, and falls. Abrupt benzodiazepine cessation would risk withdrawal, so a taper is planned rather than a stop.

OVERALL RISK LEVEL

Moderate

CLINICAL RATIONALE FOR RISK LEVEL

Psychiatric risk is low — no suicidality, no dangerous psychosis, no true aggression. Moderate reflects physical risk: high fall risk with an existing vertebral fracture, an untreated urinary infection, weight loss, and orthostatic hypotension. Critically, the greatest single risk in this case would be the requested intervention itself — an antipsychotic in probable Lewy body dementia carries risk of severe sensitivity reactions.

Safety plan, caregiver supervision plan, lethal means restriction, crisis resources, adult protective services involvement, emergency instructions, or higher level of care:

Fall-prevention plan implemented with facility: bed in low position, floor mat on the exit side given dream-enactment behavior, night light, clear path to the bathroom, and removal of the bedside rail she previously struck. Bathing protocol rewritten as below. Orthostatic precautions with slow position changes. No lethal means restriction indicated. No adult protective services report warranted — lapses addressed directly with leadership and documented, with verification at follow-up. **Transfer to memory care deferred** — the behaviors are explicable and treatable, and relocation during an unresolved delirium and diagnostic workup would likely worsen confusion. Emergency instructions provided to staff and daughter.

L LABORATORY AND DIAGNOSTIC RESULTS

Medication Monitoring Labs:

CBC: WBC 11.4 (mildly elevated), haemoglobin 11.8, platelets normal. CMP: sodium 133 (mild hyponatremia), potassium 4.0, creatinine 0.9 with eGFR 62, glucose 96. LFTs normal. TSH 2.4 (normal). A1c 5.6. Albumin 3.3 — consistent with recent weight loss. No psychotropic levels applicable.

Cognitive / Reversible Cause Workup:

B12 288 pg/mL (low-normal — supplementation reasonable), folate normal, vitamin D 21 ng/mL (insufficient). TSH normal. **Urinalysis and culture from 11/09/2026: pyuria with E. coli greater than 100,000 CFU/mL, sensitive to nitrofurantoin — no antibiotic was started and the result had not been reviewed.** RPR non-reactive. HIV testing not indicated. This represents an actively contributing and entirely treatable delirium overlay.

Substance / Toxicology Testing:

Not indicated — no substance use history and all medications are facility-administered. MAR reviewed instead, which documented lorazepam administration on 9 of the last 14 nights, considerably more than staff verbally reported.

Cardiac Monitoring:

ECG obtained today given the orthostatic hypotension and to establish a baseline before any future psychotropic: normal sinus rhythm at 74, QTc 438 ms, no ischemic changes, no conduction abnormality.

Neurologic / Medical Workup:

Non-contrast CT head from October, following her fall: generalized atrophy appropriate for age, mild chronic small-vessel ischemic change, no acute infarct, hemorrhage, mass, or hydrocephalus. **Neurology referral placed today for formal evaluation of parkinsonism and consideration of DaTscan**, which would substantially clarify the diagnosis. Formal sleep study not immediately necessary — the dream-enactment history from a direct observer is strong — but polysomnography would confirm REM sleep behavior disorder if diagnostic certainty is later required. Thoracic spine imaging from October confirms the T12 compression fracture. Neuropsychological testing deferred until delirium and medication effects have resolved, as testing now would not reflect her true baseline.

Prior Records Reviewed:

Complete facility record including 14-day behavior log with timing analysis, medication administration records for 8 weeks, nursing notes from September to November, and incident reports for both falls. Primary care records from Dr. Osei including the 18-month cognitive history and the June MoCA of 21. October emergency department record and CT report. Thoracic spine imaging. The 11/09 urine culture. Pharmacy dispensing history confirming the diphenhydramine start date 10 weeks ago. Collateral interviews conducted with the daughter and, importantly, with the night aide directly.

A ASSESSMENT

The facility requested an antipsychotic for agitation. That would be the wrong intervention, and in this patient it could be a dangerous one. The presentation is not primary agitation requiring sedation; it is a convergence of four identifiable and largely reversible or modifiable problems layered on an unrecognized neurodegenerative disease.

1. Probable dementia with Lewy bodies — previously undiagnosed. Marguerite meets multiple core criteria: recurrent well-formed visual hallucinations with retained partial insight; pronounced cognitive fluctuation, observed within this single visit and corroborated by both daughter and nursing; spontaneous parkinsonism with bradykinesia, rigidity, masked facies, hypophonia and shuffling gait, dismissed by others as “just aging”; and

REM sleep behavior disorder, elicited today for the first time from the night aide and predating all other symptoms by two years. The neuropsychological profile supports it — attention and visuospatial function impaired out of proportion to memory, with delayed recall improving markedly on cueing, which is a retrieval pattern quite unlike Alzheimer disease. **This diagnosis changes everything about management.** Patients with DLB have up to 50% risk of severe neuroleptic sensitivity reactions, which can be irreversible or fatal; the requested antipsychotic is therefore relatively contraindicated, and cholinesterase inhibitors — which are often strikingly effective for the hallucinations in DLB — become the rational treatment instead.

2. Superimposed delirium from an untreated urinary tract infection. A culture from three days ago grew E. coli and no antibiotic was started. This is very likely driving the acute-on-chronic worsening and is immediately treatable.

3. Iatrogenic contribution — substantial and correctable. Two potent anticholinergics: oxybutynin, and diphenhydramine started 10 weeks ago, a timeline that maps precisely onto the symptom acceleration. Anticholinergics worsen cognition, precipitate hallucinations, and are particularly harmful in DLB, where cholinergic deficit is already profound. Add lorazepam given on 9 of 14 nights, contributing to sedation, confusion, and falls. Much of the presentation was arguably prescribed.

4. Unaddressed sensory and pain contributions. Hearing aids non-functional for two months in a woman with moderate hearing loss — some of what is recorded as confusion is plausibly non-comprehension, and her June MoCA was administered under the same handicap. Untreated pain from a T12 compression fracture, managed only with scheduled paracetamol; unrecognized pain is one of the most common drivers of resistance to care during bathing and dressing in older adults, which is precisely when her agitation occurs.

The agitation is explicable, not random. Every documented episode in the 14-day log occurred during bathing or dressing, and staff themselves observe she is easier with the aide who approaches slowly from the front and speaks clearly — that is, the aide who inadvertently accommodates her hearing loss, visuospatial impairment, and pain.

Apathy rather than depression — GDS-15 of 4, no sadness, guilt, or hopelessness, with preserved reactivity; apathy is a recognized feature of DLB and would not respond well to an antidepressant. **Additional issues:** symptomatic orthostatic hypotension (itself common in DLB as autonomic dysfunction), weight loss of 3.6 kg with hypoalbuminemia, mild hyponatremia, high fall risk, vitamin D insufficiency, and moderate-to-severe caregiver burden with a Zarit score of 31. **Care-quality lapses** — the unactioned culture and the dead hearing-aid batteries — require direct feedback.

P PLAN

Medication plan:

Do not initiate an antipsychotic. This was discussed at length with facility leadership and the daughter, with the rationale documented prominently in the chart and communicated in writing: in probable DLB, neuroleptic sensitivity carries risk of severe parkinsonism, autonomic instability, and death. An allergy-style alert for typical and high-potency atypical antipsychotics was entered in the record. If an agent ever becomes unavoidable, quetiapine or pimavanserin at minimal dose would be the only reasonable options. **Deprescribe the anticholinergics:** stop diphenhydramine outright — it was started 10 weeks ago and correlates directly with the deterioration; discontinue oxybutynin and, if overactive bladder symptoms return, substitute mirabegron, which is not anticholinergic. **Taper lorazepam** — remove the PRN order and taper the effective nightly exposure over 3–4 weeks rather than stopping abruptly, given administration on 9 of 14 nights. **Treat the infection:** nitrofurantoin per sensitivities, starting today. **Initiate rivastigmine** — a cholinesterase inhibitor is the evidence-based treatment for DLB and frequently produces marked improvement in hallucinations, fluctuation, and attention; start low at 1.5 mg twice daily with food and titrate slowly, monitoring for GI effects and bradycardia. **Address pain:** add scheduled low-dose analgesia appropriate to a vertebral fracture beyond paracetamol alone, and give it before bathing — pre-emptive analgesia timed to care is a specific intervention, not general advice. Start vitamin D and B12 supplementation.

Behavioral and non-pharmacologic plan:

This is the primary treatment for the agitation, and it is specific rather than generic. Bathing protocol rewritten with facility: one aide rather than two, approach from the front within her visual field, make eye contact and confirm she has heard before touching, announce each step, offer a choice of timing, use a warm room and warmed towels, and give analgesia 45 minutes beforehand. Staff to verify hearing aids are fitted and functioning at the start of every shift — added to the shift checklist. Consistent aide assignment where rostering permits, particularly the aide with whom she does well. Evening routine: increase daytime light exposure and activity, discourage naps after 2 pm, and reduce evening stimulation. Reassurance rather than confrontation regarding hallucinations — staff explicitly instructed not to argue that they are not real, since she has insight and correction humiliates her. Environmental modification for visuospatial impairment: contrasting colours on chair edges and the toilet seat, removal of patterned rugs that she misperceives, and improved lighting to reduce shadow-driven misperception.

Therapy plan:

Supportive contact rather than formal psychotherapy, given cognitive impairment. **Caregiver-directed intervention for the daughter is the higher-yield therapy here** — Zarit score of 31 indicates moderate-to-severe burden. Referral to a caregiver support programme and to the Lewy Body Dementia Association, whose material is specifically relevant and which will help her understand what she is seeing. Brief supportive counselling provided today, including validation that her instinct to resist antipsychotics was clinically correct — which she was visibly relieved to hear. Grief and anticipatory loss acknowledged and normalised.

Cognitive and dementia care plan:

Neurology referral placed for formal parkinsonism assessment and consideration of DaTscan to support the DLB diagnosis. Rivastigmine initiated as above with response reassessment at 6 weeks. Repeat MoCA in 6–8 weeks, after the infection is treated, the anticholinergics are withdrawn, and hearing is corrected — the current score of 18 almost certainly underestimates her true capacity. Neuropsychological testing deferred until then for the same reason. Polysomnography considered if REM sleep behavior disorder requires formal confirmation. **Advance care planning initiated** with the daughter as healthcare proxy — discussed illness trajectory, and specifically documented the antipsychotic sensitivity so that any future emergency department or hospital clinician is warned. Daughter given a written card to carry stating the DLB diagnosis and neuroleptic caution.

Safety plan:

Fall prevention as detailed in the Risk Assessment: low bed, floor mat on the exit side given dream-enactment behavior, removal of the bedrail she struck, night lighting, clear bathroom path, and physiotherapy referral for gait and transfer training adapted to parkinsonism. Orthostatic precautions — slow position changes, adequate hydration, and review of amlodipine with primary care given the 30 mmHg drop. Medication supervision continues at facility level. No driving — already ceased. No wandering precautions required. Financial safety adequate under the existing power of attorney. Escalation criteria provided to staff in writing.

Sleep and lifestyle plan:

Diphenhydramine stopped — it was worsening precisely what it was prescribed to treat. Sleep hygiene: consistent wake time, morning light exposure, daytime activity, no naps after 2 pm, and reduced evening stimulation. If pharmacological support for sleep proves necessary once the anticholinergics are cleared, melatonin is the appropriate first choice and is additionally the preferred agent for REM sleep behavior disorder. Nutrition: dietitian referral for 3.6 kg weight loss and albumin of 3.3, with fortified foods and supervised hydration given marginal intake and mild hyponatremia. Hearing aids maintained and verified daily. Ophthalmology referral to reconsider cataract surgery, as improving vision would reduce both misperception and fall risk. Social engagement encouraged with a return to the music group, which she previously enjoyed.

Laboratory or monitoring plan:

Repeat urinalysis and culture after completing antibiotics to confirm clearance. Repeat CBC and CMP in 2 weeks, watching sodium and renal function. Heart rate monitoring during rivastigmine titration given bradycardia risk, with the ECG obtained today as baseline. Weight weekly. Orthostatic vitals weekly until stable. Repeat vitamin D and B12 in 3 months. Repeat MoCA at 6–8 weeks. AIMS not required unless an antipsychotic is ever introduced. Behavior log continued with the same timing analysis so that response to the non-pharmacological plan can be measured objectively rather than impressionistically.

Caregiver and facility coordination plan:

On-site case conference held today with the nursing director, the day and evening charge nurses, and the daughter — the rewritten bathing protocol and the rationale for withholding antipsychotics were explained directly to the people who will implement them, which matters more than a written order. Written summary and standing orders left in the chart. **Two care-quality issues raised directly and documented:** the urine culture that went unactioned for three days, and the hearing aids non-functional for two months; both were acknowledged by leadership, and a process check will be verified at follow-up. Primary care Dr. Osei updated regarding the probable DLB diagnosis, deprescribing, antibiotic, and the amlodipine review. Neurology, physiotherapy, dietitian, and ophthalmology referrals placed. Daughter given direct clinic contact.

Disposition or level-of-care plan:

Remain in current assisted living — transfer to memory care deferred. The behaviors are explicable and treatable rather than intrinsic escalation, and relocating a patient with fluctuating cognition and an active delirium would predictably worsen confusion and could precipitate further decline. This was discussed with facility leadership, who agreed to defer the discharge consideration pending an 8-week reassessment. If the behaviors persist after the infection is treated, the anticholinergics are withdrawn, rivastigmine is titrated, pain is controlled, and the bathing protocol is embedded, then memory care can be reconsidered on a sound basis. No indication for inpatient psychiatric or medical admission.

Patient and caregiver education:

Explained probable Lewy body dementia to the daughter in plain terms — what it is, why the hallucinations occur, why the fluctuation is characteristic rather than inconsistency or exaggeration, and above all why antipsychotics are hazardous. Her existing concern was validated as correct. Explained that several contributors are reversible and that her mother may improve meaningfully over the coming weeks, while being careful not to overpromise. Educated staff on DLB, on distinguishing fluctuation from non-cooperation, and on the risks of the medication they had requested. Spoke with Marguerite directly and at her level, with hearing aids working, explaining the medication changes and the reason for the new bathing approach; she said “That would be better — they come at me so fast.” Written materials provided to daughter and facility. Warning signs documented: fever, worsening confusion, new falls, and any GI intolerance to rivastigmine.

F FOLLOW-UP

On-site review in 2 weeks to assess the response to antibiotic treatment and the initial deprescribing, verify that

diphenhydramine and oxybutynin have stopped and the lorazepam taper is proceeding, confirm the bathing protocol is in use, and check hearing-aid maintenance. Repeat behavior log analysis at that visit to measure change objectively. Rivastigmine titration review at 4 weeks with heart rate monitoring. Comprehensive reassessment at 8 weeks including repeat MoCA, which should now reflect her genuine baseline once infection, anticholinergics, and hearing loss are addressed. Neurology within 4–6 weeks. Physiotherapy, dietitian, and ophthalmology as scheduled. Facility to contact the clinic immediately for fever, worsening confusion, a further fall, or any new symptom; explicit instruction given that **no antipsychotic is to be started by any clinician without discussion with this service**, and this is flagged in the chart. Daughter to be called after the 2-week review.

TD TIME DOCUMENTATION, IF APPLICABLE

TOTAL TIME SPENT

120 minutes (on-site facility consultation)

CARE COORDINATION TIME

20 minutes (primary care, neurology, physiotherapy, dietitian, ophthalmology referrals)

MEDICATION MANAGEMENT TIME

25 minutes (deprescribing plan, rivastigmine initiation, antibiotic)

SAFETY PLANNING TIME

15 minutes

PSYCHOTHERAPY / COUNSELING TIME

Not separately billed — supportive counselling included in caregiver time

RECORDS REVIEW TIME, IF APPLICABLE

25 minutes (behavior log, MAR, CT, cultures, primary care history)

CAREGIVER COUNSELING TIME

30 minutes with daughter

FACILITY / COLLATERAL COMMUNICATION TIME, IF APPLICABLE

25 minutes (case conference with nursing leadership; night aide interview)

TB BILLING CONSIDERATIONS

E/M LEVEL

99345 — Domiciliary/assisted living new patient, high complexity (or 99205 equivalent by setting)

PSYCHOTHERAPY CODE(S), IF APPLICABLE

Not applicable this visit

FAMILY PSYCHOTHERAPY CODE(S), IF APPLICABLE

90846 — Family psychotherapy without patient present, considered for the caregiver session

PSYCHIATRIC DIAGNOSTIC EVALUATION CODE, IF APPLICABLE

90792 — Psychiatric diagnostic evaluation with medical services

BASIS FOR BILLING

Medical Decision Making (high); total time 120 minutes documented, with prolonged service code as applicable

PRIMARY GERIATRIC PSYCHIATRIC DIAGNOSIS CODE + DESCRIPTION

G31.83 — Dementia with Lewy bodies (probable), with F02.83 behavioral disturbance

SECONDARY NEUROCOGNITIVE / MEDICAL DIAGNOSIS CODE(S)

F05 (delirium due to known physiological condition); N39.0 (urinary tract infection); G25.81 (REM sleep behavior disorder); S22.080A (T12 compression fracture); I95.1 (orthostatic hypotension); H90.3 (bilateral sensorineural hearing loss); R63.4 (abnormal weight loss); E55.9 (vitamin D deficiency); T50.905A (adverse effect of drug — anticholinergic burden)

SO SIGNATURE

PROVIDER NAME	CREDENTIALS	SPECIALTY	DATE	TIME
Idris Farrokhzad, MD	MD, AGSF	Geriatric Psychiatry	11/12/2026	14:50