Appendix I – Rehab Optima Therapy Forms

Occupational Therapy

OT Evaluation & Plan of Treatment Form
Identification Information

Payer: VA Only HICN: [Redacted]
MRN: [Redacted]

Diagnoses

<table>
<thead>
<tr>
<th>Type</th>
<th>Code</th>
<th>Description</th>
<th>Onset</th>
</tr>
</thead>
<tbody>
<tr>
<td>Med</td>
<td>348.1</td>
<td>CONDITION OF BRAIN; ANOXIC BRAIN DAMAGE</td>
<td>2/1/2011</td>
</tr>
<tr>
<td>Med</td>
<td>718.44</td>
<td>CONTRACTURE OF JOINT; HAND</td>
<td>2/1/2011</td>
</tr>
<tr>
<td>Med,Tx</td>
<td>718.49</td>
<td>CONTRACTURE OF JOINT; MULTIPLE SITES</td>
<td>2/1/2011</td>
</tr>
</tbody>
</table>

Plan of Treatment

Short-Term Goals

#1 Tolerate b/l upper extremity range of motion (Target: 2/14/2011)
#2 Tolerate bilateral hand splints x 2 hrs, off for ADLs and skin checks (Target: 3/7/2011)

Long-Term Goals

#1 Establish RNP to maintain gains (Target: 5/2/2011)
#2 Tolerate bilateral hand splints x 6 hrs off for ADLs, and skin checks (Target: 5/2/2011)

Caregiver Goals: LTC goals are to decrease the risk of skin break down and contracture
Potential for Achieving Goals: Good for established goals
Participation = Patient/Caregiver participated in establishing POT

Signature of therapist establishing plan: ______________________________ Date: __________________
Bullock, Misty S.

I certify the need for these medically necessary services furnished under this plan of treatment while under my care from 2/1/2011 through 5/1/2011.

Physician Signature Not Required

Physician Signature: ______________________________ Date: __________________
Lynch, Gregory
### Identification Information

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Payer: VA Only</td>
<td>MRN:</td>
<td>HICN:</td>
</tr>
</tbody>
</table>

### Initial Assessment / Current Level of Function & Underlying Impairments

#### Factors Supporting Medical Necessity

- **Current Referral**: Reason for Referral: Readmitted from the hospital, multiple contractures and increased risk for contracture and skin breakdown.
- **Hx/Complexities**: Current/PMHx: Anoxic brain damage, persistent vegetative state, old myocardial infarct, coronary.
- **Residence**: Prior Living Environment = Patient is a resident of this facility.
- **Prior Level(s)**: PLOF: Problem Solving = N/A - Not Applicable at this time; Self Feeding = N/A - Not Applicable at this time (NPO); Hygiene / Grooming = Total Dependence w/o attempts to initiate; Bathing = Total Dependence w/o attempts to initiate; Toileting = Total Dependence w/o attempts to initiate; UB Dressing = Total Dependence w/o attempts to initiate; LB Dressing = Total Dependence w/o attempts to initiate; Community ADLs = N/A - Not Applicable at this time; Functional Mobility During ADLs = N/A - Not Applicable at this time.

#### Background Assessment

- **Medical**: Precautions: Aspiration, Diabetic restrictions, Fall risk, Skin integrity, O2 dependent and NPO.
- **Directives / Code Status**: Info currently unavailable in medical chart.
- **Respiratory Status**: Patient presents with tracheostomy (metal trach placement)

#### Balance

- **Sitting Balance**: Sitting During ADLs = Poor+ (maintains balance w/mod(A) and UE support)
- **Standing Balance**: Standing During ADLs = Unable (total dependence)

#### Additional Abilities/Underlying Impairments

- **Pain at Rest**: Intensity = 0/10 (Resident non verbal Grimaces at rest and with range of motion)
- **Pain Assessment**: Pain Assessment Method = Patient communicated pain using “faces” pain rating scale
- **Tone and Posture**: Posture = Asymmetrical; UE Muscle Tone = Spastic,Rigid,Hypertonic
- **Skin and Edema**: Skin Integrity = Reddened areas; Edema = None Present
- **Coordination**: Fine Motor Coordination = Impaired; Gross Motor Coordination = Impaired
- **Sensation**: Sensation / Sensory Processing = Impaired
- **Visual Spatial Perceptual Skills**: Visual Spatial Perceptual Skills = Impaired

#### Cognition

- **Problem Solving**: Problem Solving = N/A - Not Applicable at this time

#### Functional Skills Assessment - Activities of Daily Living & Instrumental ADLs

<table>
<thead>
<tr>
<th>Self Feeding</th>
<th>Hygiene &amp; Grooming</th>
<th>Bathing</th>
<th>Toileting</th>
<th>UB Dressing</th>
<th>LB Dressing</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Feeding = N/A - Not Applicable at this time</td>
<td>Hygiene / Grooming = Total Dependence w/o attempts to initiate</td>
<td>Bathing = Total Dependence w/o attempts to initiate</td>
<td>Toileting = Total Dependence w/o attempts to initiate</td>
<td>UB Dressing = Total Dependence w/o attempts to initiate</td>
<td>LB Dressing = Total Dependence w/o attempts to initiate</td>
<td>Community ADLs = N/A - Not Applicable at this time</td>
</tr>
</tbody>
</table>

#### Functional Skills Assessment - Mobility During ADLs

- **Other Mobility**: Functional Mobility During ADLs = N/A - Not Applicable at this time
**Occupational Therapy**  
**OT Evaluation & Plan of Treatment**  

**Identification Information**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Payer: VA Only</td>
<td>MRN:</td>
<td>HICN:</td>
</tr>
</tbody>
</table>

**Initial Assessment / Current Level of Function & Underlying Impairments**

**Assessment Summary**

**Impressions**
Clinical Impressions: Long Term Care resident of DVVH  
Risk for contracture and skin break down secondary to increase spasms

**Skilled Justification**
Reason for Skilled Services: Ot services are recommended to decrease the risk of skin break down and decrease additional contractures.

**Risk Factors**
Risk Factors: Aspiration, spasms, and, impaired skin integrity

**Focus of POT**
Skilled Intervention Focus = Adaptation
Appendix I – Rehab Optima Therapy Forms

Physical Therapy

Treatment Encounter Note(s) Form
## Physical Therapy
### Treatment Encounter Note(s)

**Provider:** Delaware Valley Veterans Home

---

### Identification Information

**Patient:**

**MRN:**

**DOB:** 06/01/1918

---

### Date of Service: 4/22/2011

#### Summary of Skill

97112: Neuro Re-Ed: and gross motor coordination techniques, fine motor coordination techniques and proprioceptive techniques to improve safety and decrease fall risk and static standing balance training and techniques to facilitate functional balance skills and facilitation of proper body alignment, facilitation of normal movement, techniques to improve functional skill performance and techniques to promote safety.

97110: Ther Ex: therapeutic resistance exercises, contract/relaxation therapeutic exercises, LE therapeutic exercise increased from 3 to 5 pound weights, Nustep, weights and LE theraband resistive exercises f/b UBE->10 minutes and Bike ~>15 minutes.

Group Tx: Patient participated in functional activities group, functional mobility group, coordination group, UE ROM group, LE ROM group, environmental safety awareness group and therapeutic exercise group with 3 patients with emphasis on the following goals/objectives: increase balance/positioning/postural alignment skills, increase ROM of affected extremities through exercise and functional activities, increase strength, activity tolerance and body awareness to perform ADLs and improve ROM and strength to increase functional task performance.

Skilled Interventions Used to Facilitate Function: safety awareness techniques, balance/motor control techniques, facilitation of ROM, strength, functional mobility, static/dynamic balance, transfer skills, gait training, environmental modification and strengthening exercises.

Modalities:

- G0283: E-Stim applied to right knee in order to reduce pain, increase ROM, decrease muscle tone and enhance muscle strength, power and functional activity tolerance with intensity level, durations and settings at .
- 97035: Ultrasound 1.4 W/cm2 applied to right knee for 10 minutes for purpose of decrease muscle spasm, decrease pain and enhance functional mobility with intensity level/settings at .

**Skin Condition Post Tx = Intact**

**Comments**

Subjective/Objective: Res. C/O still Right Knee pain with limiting all WB/gait activities. Rx. tol'd well with decrease pain.

---

### Date of Service: 4/22/2011

#### Summary of Skill

97116: Gait Trg: gait training to normalize gait pattern, directional changes and facilitation of symmetrical stance.

---

### Date of Service: 4/21/2011

#### Summary of Skill

97116: Gait Trg: gait training to normalize gait pattern, training in increasing base of support (BOS), training in correct sequencing of gait with AD to increase safety and gait training w/emphasis on stride length. Amb. approx. 75 ft.x1 with RW with Clo.S to Cg. ofx1 with VC

97530: Therapeutic Activities: gross motor coordination, fine motor coordination training, weight shifting to improve safety with unsupported sit/stand and dynamic balance activities while standing training in safe sit to stand/stand to sit mobility.

---

**Signature:**

Zachariah, Joseph

**Date:**

---

**Signature:**

Wexler, Holly

**Date:**

---

**Identification Information**

**Patient:**

**MRN:**

**DOB:**

---

**Date of Service:**

4/21/2011

**Date of Service:**

4/22/2011

**Date of Service:**

4/22/2011
Provider: Delaware Valley Veterans Home

<table>
<thead>
<tr>
<th>Date of Service: 4/20/2011</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Summary of Skill</strong></td>
</tr>
</tbody>
</table>

97116: Gait Trg: gait training to normalize gait pattern, training in increasing base of support (BOS), training in correct sequencing of gait with AD to increase safety and gait training w/emphasis on stride length. Amb. approx. 75 ft.x1 with RW with Cls.S to Cg. ofx1 with VC

97530: Therapeutic Activities: gross motor coordination, fine motor coordination training, weight shifting to improve safety with unsupported sit/stand and dynamic balance activities while standing training in safe sit to stand/sit to sit mobility.

97112: Neuro Re-Ed: and gross motor coordination techniques, fine motor coordination techniques and proprioceptive techniques to improve safety and decrease fall risk and static standing balance training and techniques to facilitate functional balance skills and facilitation of proper body alignment, facilitation of normal movement, techniques to improve functional skill performance and techniques to promote safety.

97110: Ther Ex: therapeutic resistance exercises, contract/relaxation therapeutic exercises, LE therapeutic exercise increased from 3 to 5 pound weights, Nustep, weights and LE theraband resistive exercises f/b UBE~>10 minutes and Bike ~>15 minutes.

Group Tx

97150: Patient participated in functional activities group, functional mobility group, coordination group, UE ROM group, LE ROM group, environmental safety awareness group and therapeutic exercise group with 3 patients with emphasis on the following goals/objectives: increase balance/postural alignment skills, increase ROM of affected extremities through exercise and functional activities, increase strength, activity tolerance and body awareness to perform ADLs and improve ROM and strength to increase functional task performance.

Skilled Interventions Used to Facilitate Function: safety awareness techniques, balance/motor control techniques, facilitation of ROM, strength, functional mobility, static/dynamic balance, transfer skills, gait training, environmental modification and strengthening exercises.

Modalities

G0283: safety awareness techniques, balance/motor control techniques, facilitation of ROM, strength, functional mobility, static/dynamic balance, transfer skills, gait training, environmental modification and strengthening exercises.

Skin Condition Pre Tx = Intact
Skin Condition Post Tx = Intact

Comments

Subjective/Objective: Res. stated feels okay. Rx. tol'd well with decrease pain.

Signature: Zachariah, Joseph
Skin Condition Pre Tx = Intact

Modalities
G0283: E-Stim applied to right knee in order to reduce pain and decrease muscle spasm with intensity level, durations and settings at IFC.

Comments
Subjective/Objective: MH to knee x 15 minutes

Summary of Skill

Signature:

Date of Service: 4/18/2011

Provider: Delaware Valley Veterans Home

Date of Service: 4/19/2011

Summary of Skill

97116 97116: Gait Trg: gait training to normalize gait pattern, training in increasing base of support (BOS), training in correct sequencing of gait with AD to increase safety and gait training w/emphasis on stride length. Amb. approx. 75 ft.x1 with RW with Clo.S to Cg. ofx1 with VC

97530 97530: Therapeutic Activities: gross motor coordination, fine motor coordination training, weight shifting to improve safety with unsupported sit/stand and dynamic balance activities while standing training in safe sit to stand/stand to sit mobility.

97112 97112: Neuro Re-Ed: and gross motor coordination techniques, fine motor coordination techniques and proprioceptive techniques to improve safety and decrease fall risk and static standing balance training and techniques to facilitate functional balance skills and facilitation of proper body alignment, facilitation of normal movement, techniques to improve functional skill performance and techniques to promote safety.

97110 97110: Ther Ex: therapeutic resistance exercises, contract/relaxation therapeutic exercises, LE therapeutic exercise increased from 3 to 5 pound weights, Nustep, weights and LE theraband resistive exercises f/b UBE~>10 minutes and Bike ~>20 minutes.

Group Tx
97150: Patient participated in functional activities group, functional mobility group, coordination group, UE ROM group, LE ROM group, environmental safety awareness group and therapeutic exercise group with 3 patients with emphasis on the following goals/objectives: increase balance/positioning/postural alignment skills, increase ROM of affected extremities through exercise and functional activities, increase strength, activity tolerance and body awareness to perform ADLs and improve ROM and strength to increase functional task performance.

Skilled Interventions Used to Facilitate Function: safety awareness techniques, balance/motor control techniques, facilitation of ROM, strength, functional mobility, static/dynamic balance, transfer skills, gait training, environmental modification and strengthening exercises.

Modalities
G0283: E-Stim applied to right knee in order to reduce pain, increase ROM, decrease muscle tone and enhance muscle strength, power and functional activity tolerance with intensity level, durations and settings at IFC.

Comments
Subjective/Objective: Res. C/O increased Right Knee pain with limiting all WB/gait activities. Rx. tol'd well with decrease pain.

Signature:

Date of Service: 4/19/2011

Provider: Delaware Valley Veterans Home

Date of Service: 4/18/2011

Summary of Skill

97116 97116: Gait Trg: directional changes.

97110 97110: Ther Ex: therapeutic resistance exercises, open chain kinetic exercises, closed chain kinetic exercises and Nustep.

Modalities
G0283: E-Stim applied to right knee in order to reduce pain and decrease muscle spasm with intensity level, durations and settings at IFC.

Skin Condition Pre Tx = Intact

Skin Condition Post Tx = Intact

Comments
Subjective/Objective: MH to knee x 15 minutes

Signature:
### Date of Service: 4/15/2011

#### Summary of Skill

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>97116</td>
<td>97116: Gait Trg: gait training to normalize gait pattern and directional changes. ambulate with rw 75ft close supervision vc 80%</td>
</tr>
<tr>
<td>97530</td>
<td>97530: Therapeutic Activities: training in safe sit to stand/stand to sit mobility.</td>
</tr>
<tr>
<td>97110</td>
<td>97110: Ther Ex: therapeutic resistance exercises, therapeutic graded exercises, progressed to open chain kinetic exercises, progressed to closed chain kinetic exercises, Nustep and therapeutic exercises for LE to facilitate independence in mobility tasks.</td>
</tr>
</tbody>
</table>

**Group Tx**

97150: Patient participated in therapeutic exercise group and LE ROM group with 2 patients with emphasis on the following goals/objectives: increase ROM of affected extremities through exercise and functional activities.

#### Comments

Subjective/Objective: MH

---

**Signature:**

Wexler, Holly

Date

### Date of Service: 4/14/2011

#### Summary of Skill

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>97001</td>
<td>97001: Physician's order received, chart reviewed, hx noted, evaluation completed and POT developed on this date.</td>
</tr>
<tr>
<td>97110</td>
<td>97110: Ther Ex: Nustep.</td>
</tr>
</tbody>
</table>

**Signature:**

Wexler, Holly

Date
Appendix I – Rehab Optima Therapy Forms

Physical Therapy

PT Evaluation & Plan of Treatment Form
P.T. Evaluation & Plan of Treatment

Provider: Delaware Valley Veterans Ho

Dates of Service: 4/14/2011 - 7/12/2011

Identification Information

Patient: [redacted]
DOB: 06/01/1918
Start of Care: 4/14/2011
Payer: Medicare Part B
MRN: [redacted]

Diagnoses

<table>
<thead>
<tr>
<th>Type</th>
<th>Code</th>
<th>Description</th>
<th>Onset</th>
</tr>
</thead>
<tbody>
<tr>
<td>Med</td>
<td>719.7</td>
<td>DIFFICULTY IN WALKING</td>
<td>4/14/2011</td>
</tr>
<tr>
<td>Tx</td>
<td>728.87</td>
<td>MUSCLE WEAKNESS (GENERALIZED)</td>
<td>4/14/2011</td>
</tr>
<tr>
<td>Tx</td>
<td>781.2</td>
<td>ABNORMALITY OF GAIT</td>
<td>4/14/2011</td>
</tr>
</tbody>
</table>

Plan of Treatment

Short-Term Goals

#1 Patient will increase RLE Strength to 3+/5 to allow for a normal gait pattern, to facilitate safety during ambulation, to facilitate improved functional mobility, to decrease risk for falls and to facilitate balance during functional mobility. (Target: 5/4/2011)

#2 Patient will increase LLE Strength to 3+/5 to facilitate improved functional mobility, to decrease risk for falls, to facilitate balance during functional mobility and to facilitate safety during ambulation. (Target: 5/4/2011)

#3 Patient will exhibit a decrease in pain with movement to 2/10 in the left knee and in the right knee to increase patient's ability to perform gait on level surfaces with Independence. (Target: 6/22/2011)

#4 Patient will safely ambulate on level surfaces 125 feet using RW with CGA and 90% Verbal Cues for safety awareness, for correct use of AE and for proper sequencing w/o LOB in order to increase independence within facility. (Target: 5/4/2011)

Long-Term Goals

#1 Patient will exhibit a decrease in pain with movement to 2/10 in the left knee and in the right knee to increase patient’s ability to perform gait on level surfaces with Independence. (Target: 6/22/2011)

#2 Patient will safely ambulate on level surfaces 300 feet using RW with Independence and occasional Verbal Cues for safety awareness, for correct use of AE and for proper sequencing w/o LOB in order to increase independence within facility. (Target: 6/22/2011)

Patient Goals: decrease pain

Potential for Achieving Goals: Patient demonstrates excellent rehab potential as evidenced by strong family support and supportive caregivers/staff.

Participation = Patient/Caregiver participated in establishing POT

Signature of therapist establishing plan: ____________________________ Date: ______________

Wexler, Holly

I certify the need for these medically necessary services furnished under this plan of treatment while under my care from 4/14/2011 through 7/12/2011.

Physician Signature: ____________________________ Date: ______________

Lynch, Gregory
Physical Therapy Evaluation & Plan of Treatment

Provider: Delaware Valley Veterans Home
Dates of Service: 4/14/2011 - 7/12/2011

Identification Information

| Patient: | DOB: 06/01/1918 | Start of Care: 4/14/2011 |
| Payer: | Medicare Part B |
| MRN: | |

Patient: Daulerio, Nicholas

Initial Assessment / Current Level of Function & Underlying Impairments

Factors Supporting Medical Necessity

Current Referral
Reason for Referral: Patient referred to PT due to to admission to personal care unit from skilled therapy. Patient referred to PT due to new onset of decrease in strength, decrease in functional mobility, decrease in transfers and reduced ability to safely ambulate indicating the need for PT to improve dynamic balance, increase LE ROM and strength, minimize falls and facilitate (I) with all functional mobility.

Hx/Complexities
Current/PMHx: THR, bowel obstruction diff walking
Complexities/Co-Morbidities Impacting Tx: Age and Multiple medications.

Residence
Prior Living Environment = Patient resided in an ALF.
Anticipated D/C Plan = Patient to return to ALF.

Prior Level(s)
PLOF: Bed Mobility = DNT; Transfers = (I); Level Surfaces = (I); Distance Level Surfaces = 350 feet; Assistive Device = Rolling walker; W/C Mobility = (I); STairs = N/A - Not Applicable at this time; Community Mobility = N/A - Not Applicable at this time

Background Assessment

Medical
Precautions: Fall risk and Total hip.
Directives / Code Status = Full Code
Respiratory Status = WFL

Range of Motion (ROM)/Goniometric Measurements

LE ROM
RLE ROM = WFL; LLE ROM = WFL

Strength / Manual Muscle Testing

Lower Extremity
RLE Strength = 3/5 (Part moves through full range against gravity w/o added resistance; muscle holds test position - no added pressure) LLE Strength = 3/5 (Part moves through full range against gravity w/o added resistance; muscle holds test position - no added pressure)

Balance

Sitting Balance
Static Sitting = G-/F+ (maintains balance w/o support against min resistance); Dynamic Sitting = G-/F+ (maintains balance w/o support against min resistance)

Standing Balance
Static Standing = G-/F+ (maintains standing balances w/o support against min resistance); Dynamic Standing = Fair (maintains standing balance 1 - 2 mins w/o UE support w/o LOB)

Additional Abilities/Underlying Impairments

Pain at Rest
Intensity = 3/10; Frequency/Duration = Intermittent; Location: right knee and left foot.

Pain With Movement
Intensity = 7/10; Frequency/Duration = Intermittent; Location: left knee and right knee.; Pain Description/Type: Discomforting and Chronic.

Pain Assessment
Pain Assessment Method = Patient verbalized pain level.; Does pain limit patient's functional activities? = No; IDT Pain Interventions = Patient receives meds PRN

Tone and Posture
Posture = Symmetrical posture throughout; LE Muscle Tone = Normal

Skin and Edema
Skin Integrity = Intact; Edema = None Present

Coordination
Gross Motor Coordination = Intact

Sensation
Sensation / Sensory Processing = Impaired; Touch / Pressure = Impaired

Visual Spatial Perceptual Skills
Visual Spatial Perceptual Skills = Intact

Functional Assessment

Bed Mobility
Bed Mobility = DNT

Transfers
Transfers = MI

Gait
Level Surfaces = Min (A); Distance Level Surfaces = 75 feet; Assistive Device = Rolling walker; Uneven Surfaces = N/A - Not Applicable at this time

Gait Analysis
Deviations: Patient exhibits ipsilateral pelvis drop which are associated with the underlying causes of muscle instability, limited ROM and leg length discrepancy.
Physical Therapy
PT Evaluation & Plan of Treatment

Provider: Delaware Valley Veterans Ho Dates of Service: 4/14/2011 - 7/12/2011

Physical Therapy

Identification Information

<table>
<thead>
<tr>
<th>Patient:</th>
<th>DOB: 06/01/1918</th>
<th>Start of Care: 4/14/2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payer:</td>
<td>Medicare Part B</td>
<td></td>
</tr>
<tr>
<td>MRN:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Initial Assessment / Current Level of Function & Underlying Impairments

Functional Assessment

- **Gait Analysis**: Gait Pattern: The patient exhibits the following characteristics during gait: leg length discrepancy.
- **Fall Predictors**: Reduced quad strength and Weak trunk and hip extensors.
- **W/C Mobility**: W/C Mobility = (I)
- **Other Areas**: Stairs = N/A - Not Applicable at this time
  - Community Mobility = N/A - Not Applicable at this time

Assessment Summary

- **Impressions**: Clinical Impressions: decrease general strength, pain limiting functional mobility
- **Skilled Justification**: Reason for Skilled Services: Patient requires skilled PT services to increase LE ROM and strength, increase functional activity tolerance, minimize falls, decrease complaints of pain and facilitate (I) with all functional mobility in order to enhance patient's quality of life by improving ability to.
- **Risk Factors**: Risk Factors: Due to the documented physical impairments and associated functional deficits, the patient is at risk for: muscle atrophy and increased pain.
- **Focus of POT**: Skilled Intervention Focus = Restoration
Appendix I – Rehab Optima Therapy Forms

Physical Therapy
Therapy Progress Report Form
Physical Therapy Progress Report

Identification Information

Patient: [Redacted] DOB: 06/01/1918 Start of Care: 4/14/2011
Payer: Medicare Part B
MRN: [Redacted]

Diagnoses

<table>
<thead>
<tr>
<th>Type</th>
<th>Code</th>
<th>Description</th>
<th>Onset</th>
</tr>
</thead>
<tbody>
<tr>
<td>Med</td>
<td>719.7</td>
<td>DIFFICULTY IN WALKING</td>
<td>4/14/2011</td>
</tr>
<tr>
<td>Tx</td>
<td>728.87</td>
<td>MUSCLE WEAKNESS (GENERALIZED)</td>
<td>4/14/2011</td>
</tr>
<tr>
<td>Tx</td>
<td>781.2</td>
<td>ABNORMALITY OF GAIT</td>
<td>4/14/2011</td>
</tr>
</tbody>
</table>

Patient was seen for 7 day(s) during the 4/14/2011 - 4/22/2011 progress period.

<table>
<thead>
<tr>
<th>Skilled Service</th>
<th>04/14</th>
<th>04/15</th>
<th>04/18</th>
<th>04/19</th>
<th>04/20</th>
<th>04/21</th>
<th>04/22</th>
</tr>
</thead>
<tbody>
<tr>
<td>97001 - PT Eval</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>97110 - Ther Ex</td>
<td>20</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>97150 - Group</td>
<td>15</td>
<td></td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>97010 - Hot/Cold</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>97116 - Gait Tr</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>97530 - Ther Act</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G0283 - E-Stim</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>97112 - Neuro Reed</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>97035 - U/S Ther</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Eval Time</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tx Time</td>
<td>20</td>
<td>90</td>
<td>90</td>
<td>135</td>
<td>135</td>
<td>135</td>
<td>158</td>
</tr>
</tbody>
</table>

Objective Progress / Short-Term Goals

STG #1 - Upgrade

Patient will increase RLE Strength to 3+/5 to allow for a normal gait pattern, to facilitate safety during ambulation, to facilitate improved functional mobility, to decrease risk for falls and to facilitate balance during functional mobility.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3/5 (Part moves through full range against gravity w/o added resistance; muscle holds test position - no added pressure)</td>
<td>3/5 (Part moves through full range against gravity w/o added resistance; muscle holds test position - no added pressure)</td>
<td>3+/5 (Part moves thru full range against gravity, takes min resist then breaks/relaxes suddenly; muscle holds test position against slight pressure)</td>
</tr>
</tbody>
</table>

Comments:

STG #1.1 - New Goal

Patient will increase RLE Strength to 4/5 to allow for a normal gait pattern, to facilitate safety during ambulation, to facilitate improved functional mobility, to decrease risk for falls and to facilitate balance during functional mobility.
Patient: [redacted]
DOB: 06/01/1918
Start of Care: 4/14/2011

<table>
<thead>
<tr>
<th>Objective Progress / Short-Term Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STG #2 - Upgrade</strong></td>
</tr>
<tr>
<td>Patient will increase LLE Strength to 3+/5 to facilitate improved functional mobility, to decrease risk for falls, to facilitate balance during functional mobility and to facilitate safety during ambulation.</td>
</tr>
<tr>
<td><strong>Baseline</strong> (4/14/2011)</td>
</tr>
<tr>
<td>LLE Strength</td>
</tr>
<tr>
<td><strong>Comments:</strong></td>
</tr>
</tbody>
</table>

| **STG #2.1 - New Goal** |
| Patient will increase LLE Strength to 4-/5 to facilitate improved functional mobility, to decrease risk for falls, to facilitate balance during functional mobility and to facilitate safety during ambulation. |

| **STG #3 - Continue** |
| Patient will exhibit a decrease in pain with movement to 4/10 in the left knee and in the right knee to increase patient’s ability to perform gait on level surfaces with Supervised (A). |
| **Baseline** (4/14/2011) | **Prior** (4/14/2011) | **Current** (4/22/2011) |
| Intensity | 7/10 | 7/10 | 5/10 |
| Level Surfaces | Min (A) | Min (A) | SBA |
| **Comments:** | | | |

| **STG #4 - Upgrade** |
| Patient will safely ambulate on level surfaces 125 feet using RW with CGA and 90% Verbal Cues for safety awareness, for correct use of AE and for proper sequencing w/o LOB in order to increase independence within facility. |
| **Baseline** (4/14/2011) | **Prior** (4/14/2011) | **Current** (4/22/2011) |
| Level Surfaces | Min (A) | Min (A) | SBA |
| Verbal Cues | 100% | 100% | 20% |
| Distance Level Surfaces | 75 feet | 75 feet | 125 feet |
| **Comments:** | | | |

| **STG #4.1 - New Goal** |
| Patient will safely ambulate on level surfaces 125 feet using RW with Supervised (A) and 10% Verbal Cues for safety awareness, for correct use of AE and for proper sequencing w/o LOB in order to increase independence within facility. |

**Assessment Summary**

**Background**
Precautions: Fall risk and Total hip.

Anticipated D/C Plan = Patient to return to ALF.

Page 2 of 3
Therapy Progress Report

Provider: Delaware Valley Veterans Ho

Identification Information

<table>
<thead>
<tr>
<th>Patient:</th>
<th>DOB: 06/01/1918</th>
<th>Start of Care: 4/14/2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payer:</td>
<td>Medicare Part B</td>
<td></td>
</tr>
<tr>
<td>MRN:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Assessment Summary

**Skill**

Interventions Provided: Ther Ex: therapeutic resistance exercises, open chain kinetic exercises, closed chain kinetic exercises, Nustep and LE theraband resistive exercises. Neuro Re-Ed: and dynamic standing balance training. E-Stim applied to right ankle in order to increase ROM, eliminate pain and reduce pain with intensity level, durations and settings at IFC. Gait Trg: gait training to normalize gait pattern and directional changes.

Pt and Caregiver Training: n/a

**Patient Response**

Progress & Response to Tx: Patient is making consistent progress towards reaching ST and LT goals and Patient's condition is improving as a result of skilled therapy services.

**Supervision**

PT/Asst. Supervision: Skilled services provided by therapist this reporting period, as well as with assistant.

Justification for Skilled Services

**Rehab Potential**

Potential for Achieving Goals: Patient demonstrates excellent rehab potential as evidenced by strong family support and supportive caregivers/staff.

**Continued Skill**

Reason for Skilled Services: Continued PT services are necessary in order to facilitate (I) with all functional mobility and promote safety awareness in order to enhance patient's quality of life by improving ability to safely return to ALF.

---

Signature: ____________________________  Wexler, Holly  Date

Co-Signature: ____________________________  Date
Appendix I – Rehab Optima Therapy Forms

Speech Therapy

SLP Evaluation & Plan of Treatment Form
Speech Therapy
SLP Evaluation & Plan of Treatment

Provider: Delaware Valley Veterans Ho


Dysphagia Therapy

Identification Information

<table>
<thead>
<tr>
<th>Patient:</th>
<th>DOB: 2/24/1929</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payer: Medicare Part B</td>
<td></td>
</tr>
<tr>
<td>MRN:</td>
<td></td>
</tr>
</tbody>
</table>

Start of Care: 4/27/2011

Patient: Iwaskiw, Gregory

MRN: 498

Payer: Medicare Part B


DOB: 2/24/1929

Diagnoses

<table>
<thead>
<tr>
<th>Type</th>
<th>Code</th>
<th>Description</th>
<th>Onset</th>
</tr>
</thead>
<tbody>
<tr>
<td>Med</td>
<td>332.0</td>
<td>PARKINSON'S DISEASE; PARALYSIS AGITANS</td>
<td>4/27/2011</td>
</tr>
<tr>
<td>Tx</td>
<td>787.22</td>
<td>DYSPHAGIA, OROPHARYNGEAL PHASE</td>
<td>4/27/2011</td>
</tr>
</tbody>
</table>

Plan of Treatment

Short-Term Goals

#1 Resident will tolerate 75% meal given max assistance on 50% occasions w/o overt s/s aspiration (Target: 5/24/2011)

Long-Term Goals

#1 Resident will tolerate least restrictive p.o. diet w/o pulmonary or nutritional compromise. (Target: 5/24/2011)

Patient Goals: n/a

Potential for Achieving Goals: Fair

Participation = Pt/Caregiver did not take part in establishing POT (Resident unable to participate 2/2 confusion. Family not present during evaluation.)

Treatment Approaches May Include

- Oral function therapy (92526)

Frequency: 5 Times/Wk

Duration: 12 WEEKS

Intensity: Daily


Signature of therapist establishing plan: Rayca, Kathy

Date: ____________________________

I certify the need for these medically necessary services furnished under this plan of treatment while under my care from 4/27/2011 through 7/25/2011.

Physician Signature: Lynch, Gregory

Date: ____________________________
Speech Therapy
SLP Evaluation & Plan of Treatment

Provider: Delaware Valley Veterans Ho
Dysphagia Therapy

Identification Information
Payer: Medicare Part B
MRN: [redacted]

Initial Assessment / Current Level of Function & Underlying Impairments

Factors Supporting Medical Necessity
Current Referral: Reason for Referral: Asked by nursing to evaluate resident 2/2 increased difficulty w/p.o. intake.

Hx/Complexities: Current/PMHx: Parkinson's Disease, HTN, old MI, peripheral neuropathy, rosacea, syncope and dysphagia
Complexities/Co-Morbidities: Concomitant cognition deficits, Exacerbation of impairments, Interaction of conditions and Severity level.

Residence: Prior Living Environment = Patient is a resident of this facility.
Anticipated D/C Plan = Patient to reside in this LTC facility.

Prior Level(s): PLOF: Intake/Diet Level = Puree consistencies, Nectar thick liquids; Weight = N/A; Swallowing Abilities = Severe

Background Assessment

Medical: Precautions: Aspiration, Fall
Directives / Code Status = DNR
Respiratory Status = WFL

Other: Dentition = Partial; Oral Hygiene = WFL

Intake: Medication Intake Method = Crushed, In applesauce / pudding; Intake Method = All oral; Intake/Diet Level = Puree consistencies, Honey thick liquids; Weight = N/A

Behaviors: Patient Behaviors: Increased frequency of episodes of decreased LOA

Cognition

General Processes: Alertness = Impaired; Responsive to Stimulation = < 25%; Responsive to Strategies = 0%

Other Cognitive Processes: Follows Directions = Total Dependence

Oral Peripheral Exam

General, Facial and Mandibular: Oral Motor Function = Moderate; Facial Symmetry = Impaired; Side of Impairment = Left; Facial Sensation = Impaired; Mandibular ROM = Severe; Mandibular Strength / Tone = Severe; Mandibular Coordination = Severe; Saliva Management = Impaired

Labial Structure & Function: Labial Sensation = Unable; Labial Closure = Unable; Labial Strength / Tone = Unable; Labial Coordination = Unable

Lingual Structure & Function: Lingual Sensation = Unable; Lingual Elevation = Unable; Lingual Lateralization = Unable; Lingual Grooving = Unable; Lingual Base Retraction = Unable; Lingual Strength / Tone = Unable; Lingual Coordination = Unable

Pre-Swallow Assessment

Laryngeal / Pharyngeal Func.: Reflexive Throat Clear = Breathy; Reflexive Cough = Breathy

Clinical Bedside Assessment of Swallowing: Neuromuscular/Anatomic Disorders

Overall Abilities: Swallowing Abilities = Marked - Patient attempts to initiate/participate

Oral Prep Phase: Oral Prep Phase = Severe
Task Recognition = Impaired; Food Removal From Utensil / Cup = Impaired

Oral Phase: Oral Phase = Profound
Oral Phase Initiation = Profound; Labial Closure - Liquids = Profound; Labial Closure - Solids = Profound; Mastication = Profound; Bolus Formation = Profound
A/P Movement = Profound; Oral Clearance = Profound

Pharyngeal Phase: Pharyngeal Phase = Severe
Swallow Onset Time = 5 seconds; Respiratory / Swallow Coordination = Impaired; Laryngeal Elev/Excur = Decreased; Airway Protection = Moderate

Esophageal Phase: The patient and/or medical record indicates: No s/s of esophageal dysphagia present.

Clinical Bedside Assessment of Swallowing: Neuromuscular/Anatomic Disorders

Oral Phase: Bolus Control = Profound
### Initial Assessment / Current Level of Function & Underlying Impairments

#### Clinical Bedside Assessment of Swallowing: Diet Texture Analysis

<table>
<thead>
<tr>
<th>Consistency</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Puree</td>
<td>Profound; Clinical S/S Dysphagia: drooling, difficulty and/or inability to open oral cavity, difficulty initiating oral stage, anterior spillage, pocketing bilaterally, incomplete bolus formation and suspected premature spillage into pharynx reflexive throat clearing after intake.</td>
</tr>
<tr>
<td>Meds/Pills</td>
<td>Profound; Clinical S/S Dysphagia: difficulty and/or inability to open oral cavity, difficulty initiating oral stage, anterior spillage, pocketing bilaterally, incomplete bolus formation</td>
</tr>
<tr>
<td>Nectar Thick Liquids</td>
<td>Profound; Clinical S/S Dysphagia: anterior spillage and suspected premature spillage into pharynx coughing after the swallow.</td>
</tr>
<tr>
<td>Honey Thick Liquids</td>
<td>Moderate; Clinical S/S Dysphagia: anterior spillage.</td>
</tr>
</tbody>
</table>

#### Objective Tests/Measures & Additional Analysis

<table>
<thead>
<tr>
<th>Analysis</th>
<th>Behaviors Impacting Safety: Absent swallow reflex and Reduced attention to task.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Swallow Tests</td>
<td>Prior MBS / FEES / GI / ENT = No</td>
</tr>
<tr>
<td>Other</td>
<td>Position During Eval = WFL for safety and communication</td>
</tr>
</tbody>
</table>

#### Recommendations

<table>
<thead>
<tr>
<th>Intake</th>
<th>Diet Recs - Solids = Puree Consistencies</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Diet Recs - Liquids = Honey thick liquids</td>
</tr>
<tr>
<td>Supervision</td>
<td>Supervision for Oral Intake = Close supervision</td>
</tr>
<tr>
<td>Strategies</td>
<td>Swallow Strategies/Positions: To facilitate safety and efficiency, it is recommended the patient use the following strategies and/or maneuvers during oral intake: alternation of liquid/solids, bolus size modifications and general swallow techniques/precautions.</td>
</tr>
<tr>
<td>Further Testing</td>
<td>MBS/FEES/ENT/GI Indicated = No; Further exam/consult not indicated d/t: = Patient is unable to cooperate at this time., Results would not change clinical management of the patient.</td>
</tr>
</tbody>
</table>

#### Assessment Summary

<table>
<thead>
<tr>
<th>Skilled Justification</th>
<th>Reason for Skilled Services: Skilled SLP services for dysphagia are warranted to minimize aspiration/risk of in order to enhance patient's quality of life by improving ability to safely consume least restrictive diet.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Factors</td>
<td>Risk Factors: Aspiration pneumonia, nutrition/hydration compromise</td>
</tr>
<tr>
<td>Focus of POT</td>
<td>Skilled Intervention Focus = Compensation</td>
</tr>
</tbody>
</table>