Occupational Therapy OT Evaluation & Plan of Treatment Form

Occupational Therapy OT Evaluation & Plan of Treatment

Provider: Delaware Valley Veterans Ho Dates of Service: 2/1/2011 - 5/1/2011

Occupational Therapy

Identific	ation Inform	ation				
Patier	•	DOB : 09/07/1958	Start of Ca	re:	2/1/2011	
Payer MRN:	: VA Onl	у	HICN:			
			111014.			
Diagnos					1.	
Туре	Code	Description			Onset	
Med	348.1	CONDITION OF BRAIN; ANOXIC BRAIN DAMAGE			2/1/2011	
Med	718.44	CONTRACTURE OF JOINT; HAND			2/1/2011	
Med,Tx	718.49	CONTRACTURE OF JOINT; MULTIPLE SITES			2/1/2011	
Plan of	Treatment					
Short-T	erm Goals		Treatment App	roaches May Include		
#1	Tolerate b/l u	oper exteremity range of motion (Target: 2/14/2011)	I OT evaluation	on (97003)		
#2 Tolerate bilateral hand splints x 2 hrs, off for ADLs and skin checks (Target: 3/7/2011)			I Therapeutic	I Therapeutic exercises (97110)		
Long-Te	erm Goals		I Neuromuscu	ılar reeducation (97112)		
#1 Establish RNP to maintain gains (Target: 5/2/2011)				,		
#2 Tolerate bilateral hand splints x 6 hrs off for ADLs, and skin checks		i inerapeutic	activities (97530)			
	(Target: 5/2/2011)		I Self care management training (97535)			
			l Wheelchair r	management training (975	542)	
Caregive		goals are to decrease the risk of skin break down and	Frequency:	5 Times/Wk		
Potentia	I for Achievin	g Goals: Good for established goals	Duration:	90 Days		
Participa	ation = Patien	t/Caregiver participated in establishing POT	Intensity:	Daily		
			Cert. Period:	2/1/2011 - 5/1/2011		
Signat	ure of thera	pist establishing plan:		Date:		
			Bullock, Misty S.		·	
	fy the need 011 through	for these medically necessary services furnished unde 5/1/2011.	r this plan of trea	atment while under my	care from	
o P	nysician Sig	nature Not Required				
Physi	cian Signatı	ure:		Date:		

Lynch, Gregory

Occupational Therapy OT Evaluation & Plan of Treatment

Provider: Delaware Valley Veterans Ho Dates of Service: 2/1/2011 - 5/1/2011

Occupational Therapy

Identification Information

Patient: DOB: 09/07/1958 Start of Care: 2/1/2011

Payer: VA Only

MRN: HICN:

Initial Assessment / Current Level of Function & Underlying Impairments

Factors Supporting Medical Necessity

Current Referral Reason for Referral: Readmitted from the hospital, muliple contractures and increased risk for contracture and skin

break down

Hx/Complexities Current/PMHx: Anoxic brain damage, persit vegatative state, old myocardial infart, coronary

Complexities/Co-Morbidities Impacting Tx: Complicated medical hx, Interaction of conditions, Medically complicated

hospitalization and Multiple diagnoses.

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: 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

Grimices 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 Sensory Processing = Impaired

Visual Spatial Visual Spatial Perceptual Skills = Impaired

Perceptual Skills

al Chille

Cognition

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

Functional Skills Assessment - Activities of Daily Living & Instrumental ADLs

Self Feeding Self Feeding = N/A - Not Applicable at this time

Hygiene &

Hygiene / Grooming = Total Dependence w/o attempts to initiate

Grooming Bathing

Bathing = Total Dependence w/o attempts to initiate

Toileting Toileting = Total Dependence w/o attempts to initiate

UB Dressing UB Dressing = Total Dependence w/o attempts to initiate

LB Dressing = Total Dependence w/o attempts to initiate

Community Community ADLs = N/A - Not Applicable at this time

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

Delaware Valley Veterans Ho Dates of Service: 2/1/2011 - 5/1/2011 Provider:

Occupational Therapy

Identification Information

Patient: **DOB**: 09/07/1958 Start of Care: 2/1/2011

Payer: VA Only

MRN: HICN:

Initial Assessment / Current Level of Function & Underlying Impairments

Assessment Summary

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

secondary to increase spasms

Skilled Reason for Skilled Services: Ot services are recommeded to decrease the risk of skin break down and decrease

Justification additional contractures.

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

Focus of POT Skilled Intervention Focus = Adaptation

Physical Therapy Treatment Encounter Note(s) Form

Provider: Delaware Valley Veterans Home Identification Information Patient: MRN: DOB: 06/01/1918 Date of Service: 4/22/2011 Summary of Skill 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 ~>15 minutes. 97150: Patient participated in functional activities group, functional mobility group, coordination group, UE ROM group, **Group Tx** 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 Pre Tx = Intact Skin Condition Post Tx = Intact Subjective/Objective: Res. C/O still Right Knee pain with limiting all WB/gait activities. Rx. tol'd well with decrease Comments pain. Signature: Zachariah, Joseph Date Date of Service: 4/22/2011 Summary of Skill 97116 97116: Gait Trg: gait training to normalize gait pattern, directional changes and facilitation of symmetrical stance. Signature: Wexler, Holly Date 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.

Provider: Delaware Valley Veterans Home

Summary of Skill

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 ~>15 minutes.

97150: Patient participated in functional activities group, functional mobility group, coordination group, UE ROM group, **Group Tx**

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.

G0283: safety awareness techniques, balance/motor control techniques, facilitation of ROM, strength, functional Modalities

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

Date

Date of Service: 4/20/2011

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 Cq. 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 ~>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/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 .

Skin Condition Pre Tx = Intact 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

	Treatment Encounter Note(s)	
Provider:	Delaware Valley Veterans Home	
Signature:		
Oignature.	Zachariah, Joseph D.	ate
D		
	vice: 4/19/2011	
Summary of S		
97116	97116: Gait Trg: gait training to normalize gait pattern, training in increasing base of support (BOS), training in cor sequencing of gait with AD to increase safety and gait training w/emphasis on stride length. Amb. approx. 75 ft.x1 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 mobility.	
97112	97112: Neuro Re-Ed: and gross motor coordination techniques, fine motor coordination techniques and proprioces 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 exercises increased from 3 to 5 pound weights, Nustep, weights and LE therapend resistive exercises f/b UBE~>10 minutes Bike ~>20 minutes.	
Group Tx	97150: Patient participated in functional activities group, functional mobility group, coordination group, UE ROM gr LE ROM group, environmental safety awareness group and therapeutic exercise group with 3 patients with empha 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.	asis
	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, environmenta modification and strengthening exercises.	ıl
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 .	
Comments	Subjective/Objective: Res. C/O increased Right Knee pain with limiting all WB/gait activities. Rx. tol'd well with decrease pain.	
Signature:	Zenhariah Jasanh	ate
	Zachariah, Joseph D.	ale
Date of Ser	vice: 4/18/2011	
Summary of S	Skill	
97116	97116: Gait Trg: directional changes.	
97110	97110: Ther Ex: therapeutic resistance exercises, open chain kinetic exercises, closed chain kinetic exercises and Nustep.	i
Modalities	G0283: E-Stim applied to right knee in order to reduce pain and decrease muscle spasm with intensity level, durat and settings at IFC.	ions
	Skin Condition Pre Tx = Intact	
	Skin Condition Post Tx = Intact	
Comments	Subjective/Objective: MH to knee x 15 minutes	

Wexler, Holly

Date

Signature:

Provider: Delaware Valley Veterans Home

Date of Service	: 4/15/2011
Summary of Skill	
97116	97116: Gait Trg: gait training to normalize gait pattern and directional changes. ambulate with rw 75ft close supervision vc 80%
97530	97530: Therapeutic Activities: training in safe sit to stand/stand to sit mobility.
97110	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.
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.
	Skilled Interventions Used to Facilitate Function: strength and strengthening exercises.
Comments	Subjective/Objective: MH
Signature:	
-	Wexler, Holly Date
Date of Service	: 4/14/2011
Summary of Skill	
97001	97001: Physician's order received, chart reviewed, hx noted, evaluation completed and POT developed on this date.
97110	97110: Ther Ex: Nustep.
Signature:	
oignature.	Wexler, Holly Date
	wexiei, noily Date

Physical Therapy PT Evaluation & Plan of Treatment Form

Physical Therapy PT Evaluation & Plan of Treatment

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

Physical Therapy

Patie Payer		DOB: 06/01/1918 re Part B		Start of Car	e:	4/14/2011
MRN:						
Diagno	ses					
Туре	Code	Description				Onset
Med	719.7	DIFFICULTY IN WALKING				4/14/2011
Tx	728.87	MUSCLE WEAKNESS (GENERALIZED)				4/14/2011
Tx	781.2	ABNORMALITY OF GAIT				4/14/2011
Plan of	Treatment					
	erm Goals		Tre	eatment App	roaches May Include	
#1	Patient will inco	crease RLE Strength to 3+/5 to allow for a normal gait illitate safety during ambulation, to facilitate improved bility, to decrease risk for falls and to facilitate balance during	ı	Therapeutic	exercises (97110)	
	functional mol	bility. (Target: 5/4/2011) crease LLE Strength to 3+/5 to facilitate improved functional	l I		lar reeducation (97112) Deutic procedures (97150)	
		crease risk for falls, to facilitate balance during functional of facilitate safety during ambulation. (Target: 5/4/2011)	I	Therapeutic	activities (97530)	
	knee and in th	hibit a decrease in pain with movement to 4/10 in the left ne right knee to increase patient's ability to perform gait on	I	Electrical stir	nulation (97032)	
		with Supervised (A). (Target: 5/11/2011)	I Gait training therapy (97116)			
	and 90% Verb	fely ambulate on level surfaces 125 feet using RW with CGA bal Cues for safety awareness, for correct use of AE and for incing w/o LOB in order to increase independence within	I E-Stim Unattended (G0283)			
	facility. (Targe		I	PT evaluatio	n (97001)	
Long-T	erm Goals		I	Hot or cold p	acks therapy (97010)	
	knee and in th	hibit a decrease in pain with movement to 2/10 in the left ne right knee to increase patient's ability to perform gait on	Fr	equency:	5 Times/Wk	
		with Independence. (Target: 6/22/2011) fely ambulate on level surfaces 300 feet using RW with	Dι	ıration:	12 WEEKS	
	Independence	e and occasional Verbal Cues for safety awareness, for	Int	tensity:	Daily	
		AE and for proper sequencing w/o LOB in order to increase within facility. (Target: 6/22/2011)	Ce	ert. Period:	4/14/2011 - 7/12/2011	
Patient	Goals: decrea	se pain				
		g Goals: Patient demonstrates excellent rehab potential as amily support and supportive caregivers/staff.				
Participa	ation = Patien	t/Caregiver participated in establishing POT				
Signa	ture of thera	pist establishing plan:			Date:	
				Wexler, Holly		
		for these medically necessary services furnished under n 7/12/2011.	this	plan of trea	tment while under my o	care from
Phys	ician Signatu	ıre:			Date:	
	J		L	ynch, Gregory		

Physical Therapy PT Evaluation & Plan of Treatment

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

06/01/1918

Start of Care:

Physical Therapy

4/14/2011

Identification Information

Patient: Medicare Part B Paver:

MRN:

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

DOB:

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.

PLOF: Bed Mobility = DNT; Transfers = (I); Level Surfaces = (I); Distance Level Surfaces = 350 feet; Assistive Device Prior Level(s)

= 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

I F 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 Intensity = 7/10; Frequency/Duration = Intermittent; Location: left knee and right knee.; Pain Description/Type:

Movement 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 Visual Spatial Perceptual Skills = Intact

Perceptual Skills

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

Deviations: Patient exhibits ipsilateral pelvis drop which are associated with the underlying causes of muscle **Gait Analysis**

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

Patient: DOB: 06/01/1918 Start of Care: 4/14/2011

Payer: Medicare Part B MRN:

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 Reason for Skilled Services: Patient requires skilled PT services to increase LE ROM and strength, increase

Justification 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.

muscle atrophy and increased pain.

Focus of POT Skilled Intervention Focus = Restoration

Physical Therapy Therapy Progress Report Form

Physical Therapy Therapy Progress Report

Provider: Delaware Valley Veterans Ho Dates of Service: 4/14/2011 - 4/22/2011

Physical Therapy

Identification Information

 Patient:
 DOB:
 06/01/1918
 Start of Care:
 4/14/2011

Payer: Medicare Part B MRN:

Diagnos	Diagnoses						
Туре	Code	Description	Onset				
Med	719.7	DIFFICULTY IN WALKING	4/14/2011				
Tx	728.87	MUSCLE WEAKNESS (GENERALIZED)	4/14/2011				
Tx	781.2	ABNORMALITY OF GAIT	4/14/2011				

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

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

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.

Baseline Prior Current (4/14/2011) (4/14/2011) (4/22/2011) 3+/5 (Part moves thru RLE Strength 3/5 (Part moves through full range 3/5 (Part moves through full range against gravity w/o added resistance; full range against against gravity w/o added resistance; muscle holds test position - no added muscle holds test position - no added gravity, takes min resist then breaks/relaxes pressure) pressure) suddenly; muscle holds test position against slight pressure)

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.

Physical Therapy Therapy Progress Report

Provider: Delaware Valley Veterans Ho Dates of Service: 4/14/2011 - 4/22/2011

Physical Therapy

Identification Information

Patient: Medi

DOB: 06/01/1918

Medicare Part B

Start of Care:

4/14/2011

slight pressure)

Objective Progress / Short-Term Goals

STG #2 - Upgrade

MRN:

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.

Baseline Prior Current (4/14/2011) (4/14/2011) (4/22/2011) 3/5 (Part moves through full range 3/5 (Part moves through full range 3+/5 (Part moves thru against gravity w/o added resistance; against gravity w/o added resistance; full range against muscle holds test position - no added muscle holds test position - no added gravity, takes min resist pressure) pressure) then breaks/relaxes suddenly; muscle holds test position against

Comments:

LLE Strength

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
I _			

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.

Physical Therapy Therapy Progress Report

Provider: Delaware Valley Veterans Ho Dates of Service: 4/14/2011 - 4/22/2011

Physical Therapy

Date

Identification Infor	mation				
Patient: Payer: Medic MRN:	care Part B	DOB:	06/01/1918	Start of Care:	4/14/2011
Assessment Sumi	mary				
Skill	exercises, Nustep and LE applied to right ankle in ord	theraband resistive der to increase RO	e exercises. N M, eliminate p	ercises, open chain kinetic exercis euro Re-Ed: and dynamic standin ain and reduce pain with intensity ern and directional changes.	ng balance training. E-Stim
	Pt and Caregiver Training:	n/a			
Patient Response	Progress & Response to T condition is improving as a			rogress towards reaching ST and s.	d LT goals and Patient's
Supervision	PT/Asst. Supervision: Skill	ed services provide	ed by therapis	t this reporting period, as well as	with assistant.
Justification for Si	killed Services				
Rehab Potential	Potential for Achieving Goa and supportive caregivers/		strates excelle	ent rehab potential as evidenced l	by strong family support
Continued Skill				cessary in order to facilitate (I) wi 's quality of life by improving abilit	
Signature:					
				Wexler, Holly	Date
Co-Signature:					

Speech Therapy SLP Evaluation & Plan of Treatment Form

Speech Therapy SLP Evaluation & Plan of Treatment

Delaware Valley Veterans Ho Dates of Service: 4/27/2011 - 7/25/2011 Provider:

Dysphagia Therapy

lentification Information

Patient: Payer: Medicare Part B **DOB**: 2/24/1929 Start of Care: 4/27/2011

MRN:

Diagnoses							
Туре	Code	Description	Onset				
Med	332.0	PARKINSON'S DISEASE; PARALYSIS AGITANS	4/27/2011				
Tx	787.22	DYSPHAGIA, OROPHARYNGEAL PHASE	4/27/2011				

Diagnoses								
Туре	Code	Description						
Med	332.0 PARKINSON'S DISEASE; PARALYSIS AGITANS			4/27/2011				
Tx	787.22 DYSPHAGIA, OROPHARYNGEAL PHASE			4/27/2011				
Plan o	f Treatment							
Short-	Term Goals		Treatment Approaches May Include					
#1		tolerate 75% meal given max assistance on 50% occasions aspiration (Target: 5/24/2011)	I Oral function therapy (92526)					
Long-Term Goals			Frequency:	5 Times/Wk				
#1	Resident will tolerate least restrictive p.o. diet w/o pulmonary or nutritional compromise. (Target: 5/24/2011)		Duration:	12 WEEKS				
			Intensity:	Daily				
Patient Goals: n/a			Cert. Period:	4/27/2011 - 7/25/2011				
Potenti	al for Achievin	g Goals: Fair						
		egiver did not take part in establishing POT (Resident unable fusion. Family not present during evaluation.)						
Signs	ature of there	nist establishing plan:		Date:				

Signature of therapist esta	blishing plan:		Date:			
		Rayca, Kathy				
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:			Date:			
		Lynch, Gregory				

Speech Therapy SLP Evaluation & Plan of Treatment

Provider: Delaware Valley Veterans Ho Dates of Service: 4/27/2011 - 7/25/2011

Dysphagia Therapy

Identification Information

Patient: DOB: 2/24/1929 Start of Care: 4/27/2011

Payer: Medicare Part B

MRN:

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 Impacting Tx: Concomittant 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 Follows Directions = Total Dependence

Processes

Mandibular

Oral Peripheral Exam

General, Facial and 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 Lingual Sensation = Unable; Lingual Elevation = Unable; Lingual Lateralization = Unable; Lingual Grooving = Unable;

on Lingual Base Retraction = Unable; Lingual Strength / Tone = Unable; Lingual Coordination = Unable

& Function Lingual Base Retraction = Unable; Lingual Strength / To

Pre-Swallow Assessment

Laryngeal / Reflexive Throat Clear = Breathy; Reflexive Cough = Breathy

Pharyngeal Func.

Clinical Bedside Assessment of Swallowing: Neuromuscular/Anatomic Disorders

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

Oral Prep Phase Severe

Task Recognition = Impaired; Food Removal From Utensil / Cup = Impaired

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 = 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

Speech Therapy SLP Evaluation & Plan of Treatment

Delaware Valley Veterans Ho Dates of Service: 4/27/2011 - 7/25/2011 Provider:

Dysphagia Therapy

Identification Information

Patient: Start of Care: 4/27/2011 DOB: 2/24/1929

Medicare Part B Payer:

MRN:

Initial Assessment / Current Level of Function & Underlying Impairments

Clinical Bedside Assessment of Swallowing: Diet Texture Analysis

Puree Puree = 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.

Meds/Pills Pills/Meds = Profound: Clinical S/S Dysphagia: difficulty and/or inability to open oral cavity, difficulty initiating oral

stage, anterior spillage, pocketing bilaterally, incomplete bolus formation

Nectar Thick Liquids

Nectar Liquids = Profound; Clinical S/S Dysphagia: anterior spillage and suspected premature spillage into pharynx

coughing after the swallow.

Honey Thick Honey Thick Liquids = Moderate; Clinical S/S Dysphagia: anterior spillage.

Liquids

Objective Tests/Measures & Additional Analysis

Analysis Behaviors Impacting Safety: Absent swallow reflex and Reduced attention to task.

Swallow Tests Prior MBS / FEES / GI / ENT = No

Other Position During Eval = WFL for safety and communication

Recommendations

Intake Diet Recs - Solids = Puree Consistencies

Diet Recs - Liquids = Honey thick liquids

Supervision Supervision for Oral Intake = Close supervision

Swallow Strategies/Positions: To facilitate safety and efficiency, it is recommended the patient use the following **Strategies**

strategies and/or maneuvers during oral intake: alternation of liquid/solids, bolus size modifications and general

swallow techniques/precautions.

MBS/FEES/ENT/GI Indicated = No; Further exam/consult not indicated d/t: = Patient is unable to cooperate at this **Further Testing**

time., Results would not change clinical management of the patient.

Assessment Summary

Skilled Reason for Skilled Services: Skilled SLP services for dysphagia are warranted to minimize aspiration/risk of in order to

Justification enhance patient's quality of life by improving ability to safely consume least restrictive diet.

Risk Factors Risk Factors: Aspiration pneumonia, nutrition/hydration compromise

Focus of POT Skilled Intervention Focus = Compensation