


**PT Re-Evaluation** : 06/09/2025 (1288269992)DOliveira, Jeanne ( Hcbr-MC893 ) 

Date of Birth: 09/11/1952

✓ Patient identity confirmed

**Visiting Rehab and Nursing**

125 High Street , STE 204

Mansfield , MA 02048

Phone: (877) 242-8771

Fax: (774) 244-4404

Time In: 15:30

Time Out: 16:08

Visit Date: 06/09/2025

**Diagnosis / History****Medical Diagnosis:** M17.11 Unilateral primary osteoarthritis right knee

Exacerbation 05/21/2025

**PT Diagnosis:** R26.89 Abnormality of gait and mobility

Exacerbation 05/21/2025

**Relevant Medical History:**

Patient is a 72 year old female with PMH including right knee OA, Lewy Body dementia, anemia, arthropathy, frank hematuria, hyperlipidemia, intellectual disability, urinary incontinence, HTN, osteoporosis, anxiety, bipolar disorder, eczema, presbyopia, bilateral cataracts, blepharitis, COVID-19, left TKR, and chronic kidney (Continued)

**Prior Level of Functioning:**

At PLOF, patient was mod I for bed mobility, mod I for transfers, and independent for ambulation without AD unlimited distances on even and uneven surfaces. At CLOF, patient requires SBA for rolling side to side in bed, min assist for supine <-> sit with bed rail, CGA to SBA (Continued)

**Patient's Goals:**

walk better and longer distances

**Precautions:** fall risk, safety, full code**Homebound?**☐ No

✓ Yes

*For a patient to be eligible to receive covered home health services under both Part A and Part B, the law requires that a physician certify in all cases that the patient is confined to his/her home. For purposes of the statute, an individual shall be considered "confined to the home" (homebound) if the following two criteria are met:*

**Criteria One:**

✓ Patient is confined because of illness, needs the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence.

**AND/OR**☐ Patient has a condition such that leaving his or her home is medically contraindicated.**Specify:**

Pt requires supervision 24/7 for optimal safety. Pt does not drive and relies on caregivers for all transportation. Pt requires SBA for functional mobility in home. CGA outdoors. Decreased strength, (Continued)

*If the patient meets one of the criterion one conditions, then the patient must ALSO meet two additional requirements defined in criterion two below.*

**Criteria Two:**

✓ Patient has a normal inability to leave home.


**AND**

✓ Leaving home requires a considerable and taxing effort for the patient.

**Specify:**

Pt does not drive and relies 24/7 supervision for all aspects of functional mobility . Pt requires SBA ambulating in home, CGA outdoors. Pt demonstrates poor cognition, decreased coordination and stability.

**PT Re-evaluation w/Supervisory Visit** : 06/09/2025

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**Social Supports / Safety Hazards**

**Patient Living Situation and Availability of Assistance**

Patient lives: In congregate situation, e.g., assisted living

Assistance is available: Around the clock

**Current Types of Assistance Received**

Patient has assistance from group home staff for transportation, med management, meal prep, and ADLs.

**Safety / Sanitation Hazards**

☒ No hazards identified

☐ Steps / Stairs:

☐ Narrow or obstructed walkway

☐ Cluttered / soiled living area

Other:

☐ No running water, plumbing

☐ Lack of fire safety devices

☐ Inadequate lighting, heating and/or cooling

☐ Insect / rodent infestation

☐ No gas / electric appliance

☐ Pets

☐ Unsecured floor coverings

**Evaluation of Living Situation, Supports, and Hazards**

Patient resides in a group home in Dartmouth, MA. The home is neat and tidy. There are no entry steps and ramps on all entry doors. There are no throw rugs and the floors are hardwood or (Continued)

**Vital Signs**

**Temperature:**

96.2 Taken: Temporal

BP:			Position	Side	Heart Rate:		Respirations:		O2 Sat:		Room Air / Rate	Route
Prior	128	/77	Sitting	Right	Prior	68	Prior	18	Prior	98	Room Air	via
Post		/			Post		Post		Post			via

**Comments:**

Patient has not had any recent falls, doctor's appointments, or medication changes.


**Subjective Information**

Patient seen at home with caregivers present. Patient agreeable to evaluation.

Physical Assessment

	Level	Functional Impact
Orientation:	Impairment present.	Lewy body dementia, intellectual disability
Speech:	Within normal limits.	
Vision:	Impairment present.	glasses, bilateral cataracts
Hearing:	Impairment present.	HOH
Skin:	Within normal limits.	
Muscle Tone:	Impairment present but not impacting functional ability.	
Coordination:	Impairment present.	impaired BLE coordination resulting in an increased risk for falls
Sensation:	Impairment present but not impacting functional ability.	
Endurance:	Impairment present.	increased fatigue with minimal exertion
Posture:	Impairment present.	flexed standing posture
Edema		
<input type="checkbox"/> Absent <input type="checkbox"/> Dependent		
<input checked="" type="checkbox"/> Present <input type="checkbox"/> Pitting      +1		
Location: fluctuating edema BLEs		
Circumferential Measurements:		
Pain Assessment		
<input checked="" type="checkbox"/> No Pain Reported		
Primary Site:	Location	Intensity (0-10)
Increased by:		
Relieved by:		
Interferes with:		

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**Physical Assessment**

**ROM / Strength**


Part	Action	ROM		Strength		Part	Action	ROM		Strength	
		Right	Left	Right	Left			Right	Left	Right	Left
Shoulder	Flexion	wfl	wfl	3/5	3/5	Hip	Flexion	wfl	wfl	3+/5	3+/5
	Extension	wfl	wfl	3/5	3/5		Extension	wfl	wfl	3+/5	3+/5
	Abduction	wfl	wfl	3/5	3/5		Abduction	wfl	wfl	3+/5	3+/5
	Adduction	wfl	wfl	3/5	3/5		Adduction	wfl	wfl	3+/5	3+/5
	Int Rot	wfl	wfl	3/5	3/5		Int Rot	wfl	wfl	3+/5	3+/5
	Ext Rot	wfl	wfl	3/5	3/5		Ext Rot	wfl	wfl	3+/5	3+/5
Elbow	Flexion	wfl	wfl	3+/5	3+/5	Knee	Flexion	wfl	wfl	3+/5	3+/5
	Extension	wfl	wfl	3+/5	3+/5		Extension	-38	-20	3+/5	3+/5
Forearm	Pronation	wfl	wfl	3+/5	3+/5	Ankle	Plantar Flexion	wfl	wfl	3+/5	3+/5
	Supination	wfl	wfl	3+/5	3+/5		Dorsiflexion	wfl	wfl	3+/5	3+/5
Finger	Flexion	wfl	wfl	3+/5	3+/5	Neck	Inversion	wfl	wfl	3+/5	3+/5
	Extension	wfl	wfl	3+/5	3+/5		Eversion	wfl	wfl	3+/5	3+/5
Wrist	Flexion	wfl	wfl	3+/5	3+/5		Flexion	wfl	wfl	3+/5	3+/5
	Extension	wfl	wfl	3+/5	3+/5		Extension	wfl	wfl	3+/5	3+/5
Trunk	Extension	wfl	wfl	3/5	3/5		Lat Flexion	wfl	wfl	3+/5	3+/5
	Rotation	wfl	wfl	3/5	3/5		Rotation	wfl	wfl	3+/5	3+/5
	Flexion	wfl	wfl	3/5	3/5						

**Description of Functional Impact:**

muscle weakness and impaired ROM impacting independence with functional mobility

**Functional Assessment**

Independence Scale Key		Dep	Max Assist	Mod Assist	Min Assist	CGA	SBA	Supervision	Ind with Equip	Indep
Bed Mobility					Gait					
	Assist Level					Assist Level		Distance/ Amount (Ft)		Assistive Device
Rolling	SBA		✓ L ✓ R							
			Assistive Device		Level	SBA		X 150		none
Supine - Sit	min assist		bed rail		Unlevel	CGA		X 40		gait belt
Sit - Supine	min assist		bed rail		Steps / Stairs	na		X		
Factors Contributing to Functional Impairment: muscle weakness, impaired balance, impaired coordination, decreased endurance, cognitive deficits					Factors Contributing to Functional Impairment: muscle weakness, impaired balance, impaired coordination, decreased endurance, cognitive deficits					

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	Assist Level	Assistive Device
Sit - Stand	SBA	none
Stand - Sit	SBA	none
Bed - Wheelchair	na	
Wheelchair - Bed	na	
Toilet or BSC	CGA	grab bar
Tub or Shower	CGA	grab bar, shower chair
Car / Van	min assist	grab bar

**Factors Contributing to Functional Impairment:**

muscle weakness, impaired balance, impaired coordination, decreased endurance, cognitive deficits

**Wheelchair Mobility**

Assist Level	Assist Level	Assist Level
Level na	Unlevel na	Maneuver na
Factors Contributing to Functional Impairment:		

**Weight Bearing Status**

FWB BLE

**Balance**

- ✓ Able to assume midline orientation
- ✓ Able to maintain midline orientation

Sitting: Movement into/out of position

Standing: Movement/mobility within position

**DME****Available**

✓ Wheelchair ☐ Walker ☐ Hospital Bed ☐ Bedside Commode ☐ Raised Toilet Seat ☐ Tub / Shower Bench

Other:

**Needs**

none


**Clinical Statement of Assessment Findings and Recommendations**

Patient is a 72 year old female with PMH including right knee OA, Lewy Body dementia, anemia, arthropathy, frank hematuria, hyperlipidemia, intellectual disability, urinary incontinence, HTN, osteoporosis, anxiety, bipolar disorder, eczema, presbyopia, bilateral cataracts, blepharitis, COVID-19, left TKR, and chronic kidney disease stage 3. Patient recently moved to new group home setting and caregivers report difficulty with van transfers and unsteady gait. At PLOF, patient was mod I for bed (Continued)

**Treatment Goals**

	Time Frame
1: Patient will safely perform supine <-> sit with SBA and bed rail to increase participation in out of bed activities and decrease risk for falls.	2 weeks
2: Patient will safely perform all functional transfers with supervision to decrease risk for falls.	2 weeks
3: Patient will safely ambulate 100 feet with SBA on uneven surfaces to access transportation to appointments.	3 weeks
4: Patient will safely perform van transfers with CGA to enter/exit transportation to/from day program.	3 weeks
5: Patient will complete LE HEP with caregiver assistance and written program for strengthening, ROM, and balance.	3 weeks
6: Caregivers will safely assist patient during all functional mobility decreasing risk for falls/injury.	3 weeks
7: Patient will demonstrate improvement in TUG score to <= 20 seconds indicating a decrease in risk for falls.	3 weeks
8:	
9:	
10:	

☐ **No Change to Plan of Care:** physician signature is not required if no change to Plan of Care for therapy reassessment visit

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- |  |   |   |
|--|---|---|
| <input checked="" type="checkbox"/> Thera Ex                 | <input checked="" type="checkbox"/> Balance Training      | <input type="checkbox"/> Home Safety Training         |
| <input type="checkbox"/> Hip Precaution Training             | <input type="checkbox"/> Muscle Re-education              | <input type="checkbox"/> Assistive Device Training:   |
| <input checked="" type="checkbox"/> Establish or Upgrade HEP | <input checked="" type="checkbox"/> Bed Mobility Training | <input type="checkbox"/> Modalities for Pain Control: |
| <input type="checkbox"/> Knee Precaution Training            | <input type="checkbox"/> Ultrasound                       | <input type="checkbox"/> CPM:                         |
| <input checked="" type="checkbox"/> Transfer Training        | <input type="checkbox"/> Prosthetic Training              |   |
| <input type="checkbox"/> Pulmonary Physical Therapy          | <input type="checkbox"/> Electrotherapy                   |   |
| <input checked="" type="checkbox"/> Gait Training            | <input type="checkbox"/> Stairs / Steps Training          |   |
| <input checked="" type="checkbox"/> Range of Motion          | <input checked="" type="checkbox"/> O2 Sat Monitoring PRN |   |

Other:

Comments:

**Care Coordination**

Conference with:

☐ PT ☒ PTA ☐ OT ☐ COTA ☐ ST ☐ SN ☐ Aide ☐ Supervisor Other:

Name(s): Dawn Cetrone, PTA

Regarding: POC, CLOF, scheduling

☒ Physician Notified Re: Plan of Care, Goals, Frequency, Duration and DirectionOther Discipline Recommendations: ☐ OT ☐ ST ☐ MSW ☐ Aide Other:

Reason:

**Statement of Rehab Potential**

This patient has the potential to benefit from interventions provided by physical therapy

☒ Yes ☐ No**Treatment / Skilled Intervention This Visit**

- ☒ Completion of the evaluation and development of the plan of care
- ☒ Other

Gait training with emphasis on upright posture and pacing. Transfer training with emphasis on safe surface approach and controlled descent to surface.

**Frequency and Duration**

	<b>Start Date</b>	<b>End Date</b>	<b>Effective Date</b>	<b>Frequency</b>
Current Episode:	05/21/2025	07/19/2025	06/15/2025	1 time per week for 3 weeks
Next Episode:				

**Discharge Plan**

- ☐ To self care when goals met ☐ To self care when max potential achieved ☐ To outpatient therapy with MD approval
- ☒ Other: To reside in group home with 24 hour assistance from staff as needed

**Therapist Signature ( Palmer , Brian ) & Date of Verbal Order for Start of PT Treatment** **Date**  
Digitally Signed by: Brian Palmer , PTL23178 06/09/2025


**Physician Name**  
Karmina Bautista MD

**Physician Phone:** (508) 996-3991  
**Physician FAX:** (508) 961-2982

**Physician Signature** *Physician Signature*

**Date**

**PT Re-Evaluation Addendum Page : 06/09/2025**

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**Relevant Medical History**

disease stage 3.

**Prior Level of Functioning**

for transfers without AD, SBA for ambulation without AD x 20 feet on even surfaces, and CGA for ambulation with gait belt x 40 feet on uneven surfaces.

**Specify:**


coordination, stability and balance

**Evaluation of Living Situation, Supports, and Hazards**

tile. The doorways are wide and unobstructed. The hallways are free of clutter. The bathroom is handicap accessible with a roll in shower and grab bars.

**Clinical Statement of Assessment Findings and Recommendations**

mobility, mod I for transfers, and independent for ambulation without AD unlimited distances on even and uneven surfaces. She demonstrates improved LE strength and ambulation tolerance/safety since previous assessment. At CLOF, patient requires SBA for rolling side to side in bed, min assist for supine <-> sit with bed rail, SBA for transfers without AD, SBA for ambulation with occasional CGA and sometimes HHA x 150 feet on even surfaces, and CGA for ambulation with gait belt x 40 feet on uneven surfaces. Patient requires occasional standing rest breaks. Patient reported no pain during visit today, but staff reports that patient often has increased right knee pain at night. Patient demonstrating TUG score of 29 seconds indicating an increased risk for falls. She requires cueing throughout the test. Patient requires skilled PT services to address and improve activity tolerance, dynamic standing balance, BLE strength, and coordination to increase independence with functional mobility and decrease risk for falls. Without skilled physical therapy services, she is at risk for falls and related injuries, immobility causing skin breakdown, muscle tightness and development of contractures leading to further decline in functional mobility and decrease ability to return to her PLOF requiring increased need for assistance from caregivers that necessitate transfer to a higher level of care and poor quality of life.

**Supervisory Visit** : 06/09/2025 (1288269992)  
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125 High Street , STE 204  
Mansfield , MA 02048  
Phone: (877) 242-8771  
Fax: (774) 244-4404

**Visit Assessment**

Supervision Date: 06/09/2025 **Start:** 15:30 **End:** 16:08

Supervisor Name: Brian Palmer, PTL23178

Clinician Name: Cetrone, Dawn

*Name of person being supervised*

Clinician Present at Time of Visit: ☐ Yes ☒ No

Notifies client/caregiver of schedule: Excellent

Reports for duty as assigned: Excellent

Cooperative with client and others: Excellent

Courteous toward client and others: Excellent

Maintains an open communication with client and others: Excellent

Follows client plan of care as instructed: Excellent

Demonstrates competency with assigned tasks: Excellent

Documents appropriately: Excellent

Timely notification to supervisor of client's needs or changes in condition: Excellent

Adheres to organizational policies and procedures: Excellent

Complies with infection prevention and control policies and procedures: Excellent

Honors patient rights: Excellent

**Changes and/or Instructions**

**Comments**

**Therapist Signature ( Palmer , Brian ) & Date of Verbal Order for Start of PT Treatment** **Date**  
Digitally Signed by: Brian Palmer , PTL23178 06/09/2025