



Ohio Administrative Code

Rule 3701-83-28 Comprehensive inpatient rehabilitation evaluation, treatment plan, and discharge plan - inpatient rehabilitation facilities.

Effective: July 1, 2016

(A) Each inpatient rehabilitation facility shall perform a written comprehensive inpatient rehabilitation evaluation for each patient admitted to the facility. The comprehensive inpatient rehabilitation evaluation shall be developed by the interdisciplinary team and include the following:

- (1) Purpose and source of the patient's referral;
- (2) Summary of the patient's clinical condition;
- (3) Functional strengths and limitations of the patient; and
- (4) A determination of the patient's need for the following services:
 - (a) Medical;
 - (b) Nursing;
 - (c) Rehabilitation nursing;
 - (d) Dietary;
 - (e) Occupational therapy;
 - (f) Physical therapy;
 - (g) Prosthetics and orthotics;
 - (h) Psychological assessment and therapy;



- (i) Therapeutic recreation;
- (j) Rehabilitation medicine; and
- (k) Speech-language pathology.

(B) Each inpatient rehabilitation facility shall develop a written treatment plan for each patient admitted to the facility. The treatment plan shall be developed by the interdisciplinary team and shall include findings and services identified in the comprehensive inpatient evaluation completed in accordance with paragraph (A) of this rule, and information regarding the following:

- (1) Level of function prior to the disabling condition;
- (2) Current functional limitations;
- (3) Specific service needs;
- (4) A summary of the treatments to be provided;
- (5) Supports and adaptations to be provided;
- (6) Specific treatment goals and expected outcomes;
- (7) Disciplines to be utilized and their respective responsibilities for implementing the treatment plan; and
- (8) Anticipated time frames for achieving treatment goals and expected outcomes.

(C) The treatment plan shall be periodically reviewed by the interdisciplinary team as indicated, but not less than once every seven days. The periodic review of the treatment plan shall be documented in the patient's records and include documentation of, at a minimum, the following:

- (1) Progress toward achieving defined goals; and



(2) Any changes in the treatment plan.

(D) Each inpatient rehabilitation facility shall designate an individual from the patient's interdisciplinary team to be the case manager for each patient who shall be responsible for coordination of the patient's treatment plan.

(E) Each inpatient rehabilitation facility shall develop a written discharge plan for each patient admitted to the facility which is based on the treatment goals and expected outcomes defined in the treatment plan. The discharge plan shall:

(1) Identify the expected care setting for the patient after discharge;

(2) Be revised periodically based on the patient's progress in achieving the defined goals and any changes in treatment; and

(3) Document any referrals provided to the patient.

(F) Each inpatient rehabilitation facility shall complete and initiate implementation of a comprehensive inpatient evaluation, treatment plan, and discharge plan within seventy-two hours of admission.