ADMISSION RECORD

Meadow Park Rehabilitation & Healthcare Center
1525 N. Rolling Road
Catonsville, Baltimore, MD 21228-1100
United States
TEL: (410) 402-1200

Jan 15, 2026 16:00:33 ET

RESIDENT INFORMATION

Resident Name	Preferred Name	Unit	Room / Bed	Admission Date	Init. Adm. Date	Orig.Adm.Date	Resident #
Rouse, Janet		1 South	118-1	01/14/2026	01/14/2026	01/14/2026	10569

Previous address	Previous Phone #	Legal Mailing address
327 ALENDALE ST, Baltimore, MD, 21229	4435097497	Same as Previous Address

Sex	Birthdate	Age	Marital Status	Religion	Race	Occupation(s)	Primary Lang.
F	08/17/1955	70	Separated	Orthodox	African American	Legal Secretaries and Administrative Assistants	English

Admitted From	Admission Location	Birth Place	Citizenship	Maiden Name
Acute care hospital	St Agnes Hospital		USA	

Medical Record #	Medicare (HIC) #	Medicare Beneficiary ID	Medicaid #
10569			

Social Security #	Insurance Name:	Insurance Policy #:	Medicaid Managed Care
***-**-5808	CignaHealthsprings	20004363	

MLTSS Insurance Co.	MLTSS Member #	Part D Policy #	Part D Insurance Name:

Secondary Ins Name	Secondary Ins. #	Tertiary Insurance	Tertiary Insurance #

Managed Care ID#	Managed Care Name	Drug Plan #	Drug Plan Name

Hospice Co. Tel. #	Hospice Company Name

PAYER INFORMATION

Primary Payer	Managed Care with Levels	Policy #	

OTHER INFORMATION

Most Recent Hospital Stay		Allergies
		No Known Allergies

Business mail to RP	Direct Deposit SSA/Govt Benefit	Gender Identity	Health Care Proxy

Medicare Coverage	Primary Care Physician (name / phone #)	Zero PR-1	
Managed Medicare			

CARE PROVIDERS

Provider	Phone	Address	UPIN	NPI
Attending Physician (Primary) Weldetsadik, Benorayehush	Office:(667) 300-8222	7250 Parkway Dr Hanover, MD 21076		1255579744
Nurse Practitioner Greene, Yolanda NP Temesgen	Office:(667) 300-8222	7957 Vernon Ave Nottingham, MD 21236		1073846382
Nurse Practitioner Kwende, Kennedy	Office:(443) 452-3112 Fax:(443) 205-1113	821 N Charles St Baltimore, MD 21201		1124719398
Nurse Practitioner Laniyi, Kehinde	Office:(443) 452-3112 Fax:(443) 205-1113	821 N Charles St Baltimore, MD 21201		1720553662
Nurse Practitioner Toller, Walter bdoc corp	Office:(443) 452-3112 Fax:(443) 205-1113	821 N Charles St Baltimore, MD 21201		1760060636

PHARMACY

Pharmacy	Phone/Fax	Address
Medwiz New Jersey LLC (Primary) Primary Contact: BBodenheim, SRedd, ASchrader,PBenson	Phone: (856) 403-3800 Fax: (856) 403-3805	2096 Springdale Rd Cherry Hill, NJ, 08003

EXTERNAL FACILITIES (No Data Found)

Facility Name	Phone	Facility Type

CONTACTS

Name	Contact Type	Relationship	Address	Phone/Email
Mcintyre, William	Emergency Contact # 1	Brother		Cell:4104991285

DIAGNOSIS INFORMATION

01/14/2026 - UNSPECIFIED PROTEIN-CALORIE MA... (E46)	01/14/2026 - PRIMARY HYPERPARATHYROIDISM (E21.0)
01/14/2026 - ALCOHOL ABUSE, UNCOMPLICATED (F10.10)	01/14/2026 - OTHER SEIZURES (G40.89)
01/14/2026 - ENCEPHALOPATHY, UNSPECIFIED (G93.40)	01/14/2026 - HYPERTENSIVE URGENCY (I16.0)

DIAGNOSIS INFORMATION

01/14/2026 - DYSPHAGIA, UNSPECIFIED (R13.10)	01/14/2026 - AGE-RELATED PHYSICAL DEBILITY (R54)

ADVANCE DIRECTIVE

SEE MOLST

MISCELLANEOUS INFORMATION

Date of Discharge	Time	Length of Stay	Discharged to (Mortician Name and Licence No.)
		1	

Signature	Date	Time

Personal Effects Sent With	Relationship	Date	Time

'esident: Rouse, Janet (10569) Active Orders As Of: 01/16/2026

'esident:	Rouse, Janet (10569)	**Location:**	118 1	**Admission:**	01/14/2026
'lient Id Number:	10569	**Gender:**	F	**Date of Birth:**	08/17/1955
'hysician:	Weldetsadik, Benorayehush	**Pharmacy:**	Medwiz New Jersey LLC		
llergies:	No Known Allergies				
)iagnoses:	OTHER SEIZURES(G40.89), ENCEPHALOPATHY, UNSPECIFIED(G93.40), HYPERTENSIVE URGENCY(I16.0), PRIMARY HYPERPARATHYROIDISM (E21.0), DYSPHAGIA, UNSPECIFIED(R13.10), AGE-RELATED PHYSICAL DEBILITY(R54), ALCOHOL ABUSE, UNCOMPLICATED(F10.10), UNSPECIFIED PROTEIN-CALORIE MALNUTRITION(E46)				

)ietary - Diet

)rder Summary	Communication Method	Order Status	Order Date	Start Date	End Date
leart Healthy diet Mechanical Soft texture, Thin :onsistency	Phone	Active	01/14/2026	01/14/2026	

.aboratory

)rder Summary	Communication Method	Order Status	Order Date	Start Date	End Date
:BC W/Diff / CMP one time only until 01/22/2026 23: 59	Phone	Active	01/15/2026	01/22/2026	01/22/2026

)ther

)rder Summary	Communication Method	Order Status	Order Date	Start Date	End Date
Admit to SNF under Skilled Services	Phone	Active	01/14/2026		
Appraise and observe patient every shift for changes n physical / mental condition every shift for Patient)bservation	Phone	Active	01/14/2026	01/14/2026	
Bath/Shower and Skin Check 7-3 Shift Twice Weekly. INITIALS of LN indicates completion of Bath/Shower and Skin Check every day shift every Tue, Fri	Phone	Active	01/15/2026	01/16/2026	

Resident: Rouse, Janet (10569) Active Orders As Of: 01/16/2026

Resident: Rouse, Janet (10569) **Location:** 118 1 **Admission:** 01/14/2026

Order Summary	Communication Method	Order Status	Order Date	Start Date	End Date
Endocrine consult Re: Hyperparathyroidism	Phone	Active	01/14/2026		
Eval and treat - OT	Phone	Active	01/14/2026		
Eval and treat - PT	Phone	Active	01/14/2026		
Eval and treat - SLP	Phone	Active	01/14/2026		
Give 2nd step PPD one time only until 01/23/2026 23:59	Phone	Active	01/14/2026	01/23/2026	01/23/2026
House Barrier Cream with each incontinence episode. GNA may apply. every shift	Phone	Active	01/14/2026	01/14/2026	
May use OTC meds from house stock per facility policy	Phone	Active	01/14/2026		
Obtain Vital Signs and monitor Resident every day shift for symptoms indicative of Covid: Respiratory: Cough, sore throat, shortness of breath, difficulty breathing, chest pain or pressure GI: Nausea, vomiting, or diarrhea Other Symptoms: malaise, confusion, fever/chills, fatigue, muscle or body aches, headache, new loss of taste or smell every shift Document any noted symptoms in the progress notes.	Phone	Active	01/14/2026	01/14/2026	
OT clarification order: Skilled OT services for evaluation and treatment 5x/week for 30 days from 01/15/26 to 02/13/26. May include Self-care/ADLs retraining, therapeutic exercise, therapeutic activities, neuromuscular re-education, group therapy, manual therapy, w/c training if needed, PAM's (SWD, ultrasound, E-stim) as needed &indicated and pt. &care giver education and training and discharge planning. one time only until 02/13/2026 23:59	Phone	Active	01/15/2026	01/15/2026	02/13/2026

Resident: Rouse, Janet (10569) **Active Orders As Of: 01/16/2026**

Resident: Rouse, Janet (10569) **Location:** 118 1 **Admission:** 01/14/2026

Order Summary	Communication Method	Order Status	Order Date	Start Date	End Date
Overall plan of care approved	Phone	Active	01/14/2026		
Pain Evaluation every shift for Monitoring of patient's pain level	Phone	Active	01/14/2026	01/14/2026	
Read Results of Tuberculin Skin Test-2 Step one time only for Tuberculin Skin Test - Step 1 until 01/25/2026 23:00 Read within 48-72 hours after administration	Phone	Active	01/14/2026	01/25/2026	01/25/2026
SEE MOLST	Phone	Active	01/14/2026		
Skin Checks weekly on Tuesdsay 7-3 every day shift every Tue	Phone	Active	01/15/2026	01/20/2026	
Turned and positioned q 2 hours and prn every shift for Patient observation	Phone	Active	01/14/2026	01/14/2026	
Weights Weekly	Phone	Active	01/14/2026		

Pharmacy

Order Summary	Communication Method	Order Status	Order Date	Start Date	End Date
Acetaminophen Extra Strength Oral Tablet 500 MG (Acetaminophen) Give 2 tablet by mouth every 8 hours as needed for pain	Phone	Active	01/14/2026	01/14/2026	
amLODIPine Besylate Oral Tablet 10 MG (Amlodipine Besylate) Give 1 tablet by mouth one time a day for HTN Hold for sbp less than 110	Phone	Active	01/14/2026	01/15/2026	
Folic Acid Oral Tablet 1 MG (Folic Acid) Give 1 tablet by mouth one time a day for Supplement	Phone	Active	01/14/2026	01/15/2026	
GuaiFENesin Liquid 100 MG/5ML Give 10 ml by mouth every 6 hours as needed for Cough	Phone	Active	01/14/2026	01/14/2026	

Resident: Rouse, Janet (10569) Active Orders As Of: 01/16/2026

Resident: Rouse, Janet (10569) **Location:** 118 1 **Admission:** 01/14/2026

Order Summary	Communication Method	Order Status	Order Date	Start Date	End Date
Keppra Oral Tablet 1000 MG (Levetiracetam) Give 1 tablet by mouth two times a day for Seizure	Phone	Active	01/14/2026	01/15/2026	
Multiple Vitamin Tablet Give 1 tablet by mouth one time a day for supplementation	Phone	Active	01/14/2026	01/15/2026	
Nystatin External Cream 100000 UNIT/GM (Nystatin (Topical)) Apply to vaginal area topically two times a day for Itching for 14 Days	Phone	Active	01/14/2026	01/15/2026	01/29/2026
Thiamine HCl Oral Tablet 100 MG (Thiamine HCl) Give 1 tablet by mouth one time a day for Supplement	Phone	Active	01/14/2026	01/15/2026	

I have approved these orders for Rouse, Janet (10569). Total pages 4.

Physician: _____ **Signature:** _____ **Date:** _____

Signed
To: Patient: ROUSE,JANET
SA0040133142 ADM IN

ASCENSION SAINT AGNES HOSPITAL
TRANSFER SUMMARY REPORT

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Patient: ROUSE,JANET
MR #: SA01480359
Room Number: S5519-1
Date of Admission: 01/05/26

==========

TRANSFER SUMMARY

Patient Name:ROUSE, JANET
Patient ID:SA01480359Date of Birth:08/17/1955
Clinician:LYNN TAO, MDLocation:Ascension Saint Agnes Hospital

TRANSFER DIAGNOSES:
1. Seizure.
2. Acute encephalopathy.
3. Hypertensive urgency.
4. Hyperparathyroidism
5. Dysphagia.
6. Debility

HOSPITAL COURSE:
The patient is a 70-year-old woman brought in to the hospital due to mental status change. She was admitted on 01/05 to ICU. For detail, please refer to ICU notes and Dr. Joshi's notes. I involved her care on 01/14.

Per ICU, the patient has significant past medical history of alcohol abuse. She was brought from her home for evaluation of altered mental status and seizure-like activity. The patient's roommate noted the patient has altered mental status on day of admission. In the evening, the patient was found "unresponsive." So 911 was called. The patient had generalized tonic-clonic activity when EMS arrived. The patient received IV Ativan and brought to the emergency room. Additionally, the patient's blood pressure was 222/95. ICU consulted. The patient was intubated for airway protection.

Her CT scan did not show acute abnormality. EEG was negative. The patient was loaded with phenobarbital for seizure and nicardipine for hypertensive urgency.

Neurology consulted and placed on continuous EEG monitor. She was subsequently started on Keppra. The patient had LP done, which is negative for any signs of CNS infection. The patient initially placed on empirical antibiotics and subsequently discontinued. The patient's mental status gradually improved and she is now alert and oriented x3.

After her blood pressure improved, she is placed on amlodipine. Her echocardiogram showed normal left ventricular function with EF of 60%.

The patient has a history of alcohol use. Her initial alcohol level was less than 10. Her tox screen is positive for cannabinoids.

The patient is noted to have hypercalcemia. PTH is elevated. The patient needs to follow with endocrinology /general surgery for treatment of hyperparathyroidism.

Copy To: Patient Name: ROUSE,JANET

Signed
To: Patient: ROUSE,JANET
SA0040133142 ADM IN

ASCENSION SAINT AGNES HOSPITAL
TRANSFER SUMMARY REPORT

Patient has generalized weakness and poor appetite. Patient needs to follow-up with physician regularly, needs age-appropriate routine screening in addition to her current workup.

MOST RECENT LABORATORY DATA:
WBC 8.4, hemoglobin 13.2, platelets 257. Sodium 142, potassium 3.3, (she received supplement), BUN 7, creatinine 0.6, glucose 91, calcium 11.2, phosphorus 2.6.

TRANSFER MEDICATIONS:
1. Amlodipine 10 mg daily.
2. Multivitamin once a day.
3. Thiamine 100 mg daily.
4. Folic acid 1 mg daily.
5. Keppra 1000 mg b.i.d.

TRANSFER INSTRUCTIONS:
Low-salt mechanical soft diet. Activity as tolerated. PT/OT. Wean oxygen as tolerated. Schedule parathroid scan, and endocrinology/general surgery for further treatment of hyperparathyroidism.

Total time on discharge: 38 minutes
<<Signature on File>> TAO, LYNN MD

Dictated: 01/14/26 1046 TAOLYN
Transcribed:01/14/26 1114 ESCRIPT
Signed: 01/14/26 1344 TAO, LYNN MD

cc:
TAO,LYNN MD

Copy To: Patient Name: ROUSE,JANET

Resident: Rouse, Janet (10569)

Order Details

Order Date: 1/16/2026 08 57 *

Order Category: Other *

Communication Method: Phone Verbal Prescriber written Prescriber entered *

Ordered By: Greene, Yolanda * (Current Primary Physician: Benor

Description: Discharge Orders: May be Discharged to Home with Home Thera Services SN for medication management, PT/OT eval and treat for gait, mobility, strengthening, and IADLS training high fall risk related to G40.89 OTHER SEIZURES, G93.40 ENCEPHALOPATHY, UNSPECIFIED

Order Type: Standard Other - [] *

Scheduling Details

Audit Details

Created By: Yolanda Greene, NP
Created Date: 1/16/2026 08:58
Confirmed By: Harinder Kaur, RN/LPN
Confirmed Date: 1/16/2026 10:52
Revised By: Yolanda Greene, NP
Revision Date: 1/16/2026 08:58
Signed By: Yolanda Greene, NP
Signed Date: 1/16/2026 08:59
Signed Method: Password; Web Application

Order Summary:

Discharge Orders: May be Discharged to Home with Home Therapy Services SN for medication management, PT/OT eval and treat for gait, mobility, strengthening, and IADLS training high fall risk related to G40.89 OTHER SEIZURES, G93.40 ENCEPHALOPATHY, UNSPECIFIED

Formularies Contains

No Formulary Found

No Formulary Found

No Formulary Found

No Formulary Found

Additional Information

Close

Physical Therapy
PT Evaluation & Plan of Treatment

Provider: Meadow Park Rehabilitation and Healthcare Center
NPI: 1912404377

Certification Period: 1/15/2026 - 3/15/2026
Physical Therapy

Identification Information

Patient: Rouse, Janet **DOB:** 8/17/1955 **Start of Care:** 1/15/2026
Payer: Managed Care Daily Level (MGA)
MRN: 10569

Diagnoses

Type	Code	Description	Onset
Med	E46	Unspecified protein-calorie malnutrition	1/15/2026
Med	G40.89	Other seizures	1/15/2026
Med	G93.40	Encephalopathy, unspecified	1/15/2026
Med	I16.0	Hypertensive urgency	1/15/2026
Med	E21.0	Primary hyperparathyroidism	1/15/2026
Med	R13.10	Dysphagia, unspecified	1/15/2026
Med	R54	Age-related physical debility	1/15/2026
Med	F10.10	Alcohol abuse, uncomplicated	1/15/2026
Tx	M62.81	Muscle weakness (generalized)	1/15/2026
Tx	R26.9	Unspecified abnormalities of gait and mobility	1/15/2026

Plan of Treatment

Treatment Approaches May Include

- Therapeutic exercises (97110)
- Neuromuscular reeducation (97112)
- Gait training therapy (97116)
- Group therapeutic procedure (97150)
- Physical therapy evaluation: moderate complexity (97162)
- Therapeutic activities (97530)
- Wheelchair management training (97542)

Frequency: 5 time(s)/week
Duration: 60 day(s)
Cert. Period: 1/15/2026 - 3/15/2026

Objective Progress / Short-Term Goals

STG #1.0 - New Goal

Pt will be able to complete STS and functional transfer between bed/WC/toilet seat and simulated car transfer using AD with MI . (Target: 2/11/2026)

PLOF (prior to onset)	Baseline (1/15/2026)
	SBA/SUP

STG #2.0 - New Goal

Pt will be able to self-propel in WC>150 feet with MI . (Target: 2/11/2026)

PLOF (prior to onset)	Baseline (1/15/2026)
	To be initiated

Physical Therapy
PT Evaluation & Plan of Treatment

Provider: Meadow Park Rehabilitation and Healthcare Center
NPI: 1912404377

Certification Period: 1/15/2026 - 3/15/2026
Physical Therapy

Identification Information

Patient: Rouse, Janet **DOB:** 8/17/1955 **Start of Care:** 1/15/2026
Payer: Managed Care Daily Level (MGA)
MRN: 10569

Objective Progress / Short-Term Goals

STG #3.0 - New Goal

Pt will be able to complete obj retrieve from floor level with/without AD MI . (Target: 2/11/2026)

	PLOF (prior to onset)	Baseline (1/15/2026)
		SBA/CGA

Objective Progress / Long-Term Goals

LTG #1.0 - New Goal

Patient will decrease risk for falls as evidenced by a decrease (improved) score on the TUG to 20 seconds. (Target: 3/15/2026)

	PLOF (prior to onset)	Baseline (1/15/2026)
Timed Up and Go		43 seconds

LTG #2.0 - New Goal

Patient will demonstrate improved functional capacity as evidenced by an improved score to 10 on the 30-Second Chair Rise Test. (Target: 3/15/2026)

	PLOF (prior to onset)	Baseline (1/15/2026)
30 Second Chair Rise Test		7

LTG #3.0 - New Goal

Pt will be able to ambulate >250 feet on even surfaces and >10 feet on uneven surface with S/U (Target: 3/15/2026)

	PLOF (prior to onset)	Baseline (1/15/2026)
		x175feet using 2WW with SBA

LTG #4.0 - New Goal

Pt will be able to ascend/descend >12 steps with S/U (Target: 3/15/2026)

	PLOF (prior to onset)	Baseline (1/15/2026)
		SBA

Patient Goals: strengthen my legs

Potential for Achieving Rehab Goals: Patient demonstrates excellent rehab potential as evidenced by ability to follow multi-step directions, recent onset and motivated to return to prior level of living.

Focus of Plan of Treatment = Restoration,Compensation

Participation = Patient/Caregiver participated in establishing POT

Original Signature: Electronically signed by Nisrin Abdel Rahman, PT MD 26457 1/15/2026 08:38:37 PM EST
Date

Physical Therapy
PT Evaluation & Plan of Treatment

Provider: Meadow Park Rehabilitation and Healthcare Center
NPI: 1912404377

Certification Period: 1/15/2026 - 3/15/2026
Physical Therapy

Identification Information

Patient: Rouse, Janet **DOB:** 8/17/1955 **Start of Care:** 1/15/2026
Payer: Managed Care Daily Level (MGA)
MRN: 10569

I certify the need for these medically necessary services furnished under this plan of treatment while under my care from 1/15/2026 through 3/15/2026.

☐ Physician Signature Not Required

Physician Signature: _____

Benorayehush Weldetsadik NPI: 1255579744 Date:

Initial Assessment / Current Level of Function & Underlying Impairments

Patient Referral and History

Current Referral	Reason for Referral / Current Illness: The patient is a 70-year-old female with PMHX of seizures, hypertension, dysphagia, hyperthyroidism, significant alcohol abuse disorder brought in to the hospital due to mental status change and seizure-like activity . The patient's roommate noted the patient has altered mental and in the evening was unresponsive so called 911 when EMS arrived. The patient received IV Ativan and brought to the emergency room. Additionally, the patient's blood pressure was 222/95. ICU consulted. The patient was intubated for airway protection. Her CT scan did not show acute abnormality. EEG was negative. The patient was loaded with phenobarbital for seizure and nicardipine for hypertensive urgency. Neurology consulted and placed on continuous EEG monitor. She was subsequently started on Keppra. The patient had LP done, which is negative for any signs of CNS infection. The patient has a history of alcohol use. Her initial alcohol level was less than 10. Her tox screen is positive for cannabinoids. The patient is noted to have hypercalcemia. PTH is elevated. The patient needs to follow with endocrinology /general surgery for treatment of hyperparathyroidism.
Hx/Complexities	PMHx: seizures, hypertension, dysphagia, hyperthyroidism
Medical	Precautions / Contraindications: on anti seizure medication, Falls
	Directives / Code Status = Full Code
	Respiratory Status = WFL
Medications	Medications Impacting Condition/Treatment: fall risk On Keppra for seizures
Vision	Vision = Vision appears WFL.
Hearing	Hearing = WFL
Hand Dominance	Hand Dominance = Patient is right-handed.
Prior Therapy	Did Patient Receive Therapy Previously? = Yes
	Location = Hospital
	Date(s) of Service: during hospitalization
	Prior Tx Outcome: refer to SAR
Prior Living	Prior Living Environment = Patient resided in private residence.
	Prior Cognitive Assistance = No supervision required
	Prior Living Description: Lives alone in a MLH (2 floor + basement) 3 STE, no HR, 2nd floor setup, 12 steps to 2nd floor, R HR going up. Bath tub , takes a bath sitting in tub.no HR regular commode, no HR, uses sink as support if needed.
Prior Equipment	Equipment Prior to Onset: No AD.
Transition/DC	Transition/Discharge Plan = Patient to live at home w/support/(A) from others.
	Assistance / Support to be Provided = Community Assistance
Prior Level(s) of Function	PLOF: Transfers = (I); Level Surfaces = (I); Distance Level Surfaces = Community Distances; Assistive Device = No AD; Stairs = (I); Number of Stairs = 12 steps; Negotiates Stairs = Using handrails bilaterally; Community Mobility = N/A - Not Applicable at this time; Pt. was I in ADL and IADL prior to admission with exception of yard work(brother assists)

Provider: Meadow Park Rehabilitation and Healthcare Center
NPI: 1912404377

Certification Period: 1/15/2026 - 3/15/2026
Physical Therapy

Identification Information

Patient: Rouse, Janet **DOB:** 8/17/1955 **Start of Care:** 1/15/2026
Payer: Managed Care Daily Level (MGA)
MRN: 10569

Initial Assessment / Current Level of Function & Underlying Impairments

Patient Referral and History

Prior Level(s) of Function	PLOF Source(s) = Patient,Medical Record

Patient Factors

Behaviors	Patient Behaviors: Attentive, Requires consistent instruction, Requires consistent supervision and Able to make needs known.

Fall Risk Assessment

History of Falls	Has Patient fallen in past year? = No
Steadiness	Does Patient feel unsteady when standing? = Yes; Does Patient feel unsteady when walking? = Yes
Fear of Falling	Does Patient worry about falling? = Yes
Tests and Measures	Timed Up and Go = 43 seconds
	30 Second Chair Rise Test = 7

Musculoskeletal System Assessment

LE ROM	RLE ROM = WFL; LLE ROM = WFL
RLE Strength	RLE Strength = Impaired
LLE Strength	LLE Strength = Impaired
RLE Strength	General RLE Strength = 4-/5; Hip = Impaired; Knee = Impaired; Ankle = Impaired
LLE Strength	General LLE Strength = 4-/5; Hip = Impaired; Knee = Impaired; Ankle = Impaired
Contracture	Functional Limitations Present d/t Contracture = No

Other System/Condition Assessment

Cardiovascular	CardioPulmonary System = Functional for age and condition
Integumentary	Integumentary System = Functional for age and condition
Pain	Pain = Patient unable to communicate pain; lack of pain determined based upon patient behavior (patient presents with no signs/symptoms of pain)

Neuromuscular Assessment

Sitting Balance	Static Sitting = Good; Dynamic Sitting = Good -
Standing Balance	Static Standing = Fair; Dynamic Standing = Fair-
LE Tone	LE Muscle Tone = Normal

Cognitive-Communicative Assessment

Instructions	Follows Directions = Multi-step w/o (A)
Cognition	Oriented To = Person, place, time, purpose and caregivers; Safety Awareness = Impaired

Functional Mobility Assessment

Bed Mobility	Bed Mobility = Independent
Transfers	Transfers = Supervised (A)
Gait	Level Surfaces = SBA; Distance Level Surfaces = 175 feet; Assistive Device = Two-wheeled walker; Uneven Surfaces = DNT
Stairs	Stairs = SBA; Number of Stairs = 12 steps; Negotiates Stairs = Using handrails bilaterally
Other Ambulation	Community Mobility = N/A - Not Applicable at this time

Additional Abilities/Impairments/Needs

Coordination	Gross Motor Coordination = Intact
Sensation	Sensation / Sensory Processing = Intact

Physical Therapy
PT Evaluation & Plan of Treatment

Provider: Meadow Park Rehabilitation and Healthcare Center
NPI: 1912404377

Certification Period: 1/15/2026 - 3/15/2026
Physical Therapy

Identification Information

Patient:	Rouse, Janet	**DOB:**	8/17/1955	**Start of Care:**	1/15/2026
Payer:	Managed Care Daily Level (MGA)				
MRN:	10569				

Initial Assessment / Current Level of Function & Underlying Impairments

Assessment Summary

Clinical Impressions	Clinical Impressions: pt present with recent onset of decreased tolerance to physical activities and decline in functional mobility with increased muscle weakness and need of assistance from others , increased pain and physical exertion with ADLs she believe to benefit from skilled physical therapy to address her limitation and improve quality of life .

Evaluation Summary

Components	History/Personal Factors/Comorbidities = A history of present problem w/3 or more personal factors and/or comorbidities that impact the plan of care
	# of Body Structures/Functions/Limitations = An examination of 3 or more body structures and functions, activity limitations and/or participation restrictions using standardized tests
	Clinical Presentation = Stable and/or uncomplicated characteristics
	Clinical Decision Making = Moderate Complexity (using standardized patient assessment instrument and/or measurable assessment of functional outcome)

Occupational Therapy
OT Evaluation & Plan of Treatment

Provider: Meadow Park Rehabilitation and Healthcare Center
NPI: 1912404377

Certification Period: 1/15/2026 - 2/13/2026
Occupational Therapy

Identification Information

Patient: Rouse, Janet **DOB:** 8/17/1955 **Start of Care:** 1/15/2026
Payer: Managed Care Daily Level (MGA)
MRN: 10569

Diagnoses

Type	Code	Description	Onset
Med	G40.89	Other seizures	1/5/2026
Med	G93.40	Encephalopathy, unspecified	1/5/2026
Med	I16.0	Hypertensive urgency	1/5/2026
Med	E21.0	Primary hyperparathyroidism	1/5/2026
Med	R54	Age-related physical debility	1/5/2026
Med	F10.10	Alcohol abuse, uncomplicated	1/5/2026
Tx	R29.898	Other symptoms and signs involving the musculoskeletal system	1/15/2026
Tx	M54.50	Low back pain, unspecified	1/5/2026

Plan of Treatment

Treatment Approaches May Include

- Therapeutic exercises (97110)
- Neuromuscular reeducation (97112)
- Manual therapy techniques (97140)
- Group therapeutic procedure (97150)
- Occupational therapy evaluation: low complexity (97165)
- Therapeutic activities (97530)
- Self care management training (97535)
- Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community; face to face; initial 30 min (97550)
- Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community; face to face; each additional 15 min (97551)
- Modality application, Diathermy, supervised (97024)

Frequency: 5 time(s)/week

Duration: 30 day(s)

Cert. Period: 1/15/2026 - 2/13/2026

Objective Progress / Short-Term Goals

STG #1.0 - New Goal

Patient will increase ability to stand unsupported for 10 mins w/o loss of balance and w/o dizziness in order to increase participation with ADL tasks. (Target: 1/28/2026)

	PLOF (prior to onset)	Baseline (1/15/2026)
Standing Support	Unsupported	Unsupported
Standing Duration	30 mins	> 3 - 5 mins

STG #2.0 - New Goal

Patient will increase bilateral UE's Strength by ½ grade in order restore maximum functional use of the effected extremities. (Target: 1/21/2026)

PLOF (prior to onset)	Baseline (1/15/2026)
DNT	4/5

Occupational Therapy
OT Evaluation & Plan of Treatment

Provider: Meadow Park Rehabilitation and Healthcare Center
NPI: 1912404377

Certification Period: 1/15/2026 - 2/13/2026
Occupational Therapy

Identification Information

Patient: Rouse, Janet **DOB:** 8/17/1955 **Start of Care:** 1/15/2026
Payer: Managed Care Daily Level (MGA)
MRN: 10569

Objective Progress / Short-Term Goals

STG #3.0 - New Goal

Patient will complete functional transfers from various surfaces at Mod I level with LRD while maintaining precautions to facilitate safe return to PLOF and decrease fall risk. (Target: 1/28/2026)

	PLOF (prior to onset)	Baseline (1/15/2026)
	I	Sup(A)

Objective Progress / Long-Term Goals

LTG #1.0 - New Goal

Patient will complete all ADL/self care tasks with Modified Independence without signs/symptoms of physical exertion using AE as needed/trained. (Target: 2/13/2026)

	PLOF (prior to onset)	Baseline (1/15/2026)
LOA	I	SBA

Patient Goals: I want to go home and my niece is trying to take me home.

Potential for Achieving Rehab Goals: Patient demonstrates excellent rehab potential as evidenced by active participation in skilled treatment, active participation with plan of treatment, high prior level of function, high cognitive functioning, motivated to return to prior level of living and strong family support.

Focus of Plan of Treatment = Restoration,Compensation

Participation = Patient/Caregiver participated in establishing POT

Original Signature: Electronically signed by Jahen Zeb Alam, OT MD 08625 1/15/2026 11:46:17 PM EST
Date

I certify the need for these medically necessary services furnished under this plan of treatment while under my care from 1/15/2026 through 2/13/2026.

☐ Physician Signature Not Required

Physician Signature:

Benorayehush Weldetsadik NPI: 1255579744 Date:

Initial Assessment / Current Level of Function & Underlying Impairments

Patient Referral and History

Current Referral Reason for Referral / Current Illness: Pt. is a 70 y/o female , new admit from St Agnes hospital into this SNF to continue SAR prior to returning to community living.Pt.mbrought in to the hospital due to AMS and seizure-like activity, had generalized tonic-clonic activity when EMS arrived. The patient received IV Ativan and brought to the emergency room. BP 22/95. ICU consulted, ntubated for airway protection.

Hx/Complexities PMHx: history of seizures, hypertension, dysphagia, hyperthyroidism, h/o alocohol use.

History of Falls = Yes (1 in last i year , no injuries)

Medical Precautions / Contraindications: on anti seizure medication, Falls,

Directives / Code Status = Full Code

Respiratory Status = WFL

Occupational Therapy
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Initial Assessment / Current Level of Function & Underlying Impairments

Patient Referral and History

Medications	Medications Impacting Condition/Treatment: On Keppra for seizures
Vision	Vision = Vision appears WFL.
Hearing	Hearing = WFL
Hand Dominance	Hand Dominance = Patient is right-handed.
Prior Living	Prior Living Environment = Patient resided in private residence.
	Prior Cognitive Assistance = No supervision required
	Prior Living Description: Lives alone in a MLH (2 floor + basement) 3 STE, no HR, 2nd floor setup, 12 steps to 2nd floor, R HR going up. Bath tub , takes a bath sitting in tub.no HR regular commode, no HR, uses sink as support if needed.
Prior Equipment	Equipment Prior to Onset: No AD.
Transition/DC	Transition/Discharge Plan = Patient to live at home w/support/(A) from others.
	Assistance / Support to be Provided = Community Assistance,AM Asst | LCA,PM Asst | LCA (Pt. may consider moving in with her sister for some time if needed.)
Prior Level(s) of Function	PLOF: Bathing = (I); Toileting = (I); UB Dressing = (I); LB Dressing = (I); Pt. was I in ADL and IADL prior to admission with exception of yard work(brother assists)
PLOF Source	PLOF Source(s) = Patient

Musculoskeletal System Assessment

UE ROM	RUE ROM = WFL; LUE ROM = WFL
RUE Strength	RUE Strength = Impaired
LUE Strength	LUE Strength = Impaired
RUE Strength	General RUE Strength = 4/5; Shoulder = Impaired; Elbow / Forearm = Impaired; Wrist = Impaired
LUE Strength	LUE Strength = 4-/5; Shoulder = Impaired; Elbow / Forearm = Impaired; Wrist = Impaired
Contracture	Functional Limitations Present d/t Contracture = No

Other System/Condition Assessment

Sensory	Sensory = Functional for age and condition, no further assessment indicated at this time
Pain	Pain = Present, assessment indicated

CardioPulmonary Assessment

At Rest	BP at Rest (Systolic/Diastolic): 131/71; Heart Rate at Rest = 81 beats/min
Activity	Patient's Rating of Perceived Exertion = 1/10 (s/p therapy)
Standing	Standing Duration = > 3 - 5 mins; Standing Support = Unsupported

Neuromuscular Assessment

Sitting Balance	Sitting During ADLs = Good
Standing Balance	Standing During ADLs = Fair +

Pain Assessment

Method	Pain Assessment Method = Patient verbalized pain level.
Pain at Rest	Pain at Rest = 4/10; Frequency = Constant; Location: Low back; Pain Description/Type: pressure
Pain With Movement	Pain with Movement = 5/10; Frequency = Constant; Location: low back; Pain Description/Type: pressure
Limitations	Pain limits the following functional activities:: limited ability to stand and sit.
Management	What relieves pain? = Prescribed Medications
Medications	Name/Dose of Pain Meds: Pl. refer to MAR
Causes	What exacerbates pain? = Inactivity,Other (when pain pill's effect fades away)

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Initial Assessment / Current Level of Function & Underlying Impairments

Functional Skills Assessment - Activities of Daily Living (ADLs) & Instrumental ADLs

Self Feeding	Self Feeding = Independent
Hygiene & Grooming	Hygiene and Grooming = Independent
Bathing	Bathing = Supervised (A); UB Bathing = Set-up (A); LB Bathing = Supervised (A); Bathing Location Assessed = During bathing
Toileting	Toileting = Supervised (A); Toilet Assessed = Standard Commode; Toilet / Commode Transfers = Supervised (A); Clothing Management = Supervised (A); Personal Hygiene = Set-up (A)
UB Dressing	UB Dressing = MI
LB Dressing	LB Dressing = Supervised (A)
Functional Assessment	Bed Mobility = Independent

Functional Skills Assessment - Mobility During ADLs

Transfers	Sit --> Stand = Supervised (A)

Additional Abilities/Impairments/Needs

UE Tone	UE Muscle Tone = Normal
Skin	Skin Integrity = Intact, no observable or reported issues
Fine Motor	Fine Motor Coordination = Intact
Gross Motor	Gross Motor Coordination = Intact
Edema	Edema = None Present

Assessment Summary

Clinical Impressions	Clinical Impressions: currently the pt demonstrates below baseline with ADLs, functional mobility, and IADLs within their daily routine. Based on functional skills demonstrated today the pt would benefit with skilled OT services maximize independence and safety before returning home

Evaluation Summary

Components	Occupational Profile / Medical and Therapy History = Includes a brief history including review of medical and/or therapy records relating to the presenting problem Assessment: # of Performance Deficits = Assessment identified 1-3 deficits in areas of physical, cognitive, psychosocial skills resulting in activity limitation or participation resrictions Physical/Cognitive/Pyschosocial Performance: Patient presents with impairments in balance, strength and mobility resulting in limitations and/or participation restrictions in the areas of mobility, self care, general tasks and demands and domestic life. Task Modifications / Assistance = Minimal to moderate modification of tasks or assistance (physical or verbal) w/assessment is necessary to enable completion of evaluation Clinical Decision Making = Low Complexity

Primary Physician: All Progress Note Type: All Effective Date Range: Effective Time Range: All Created Date Range: All Created Time Range: All Author: All Department: All

Resident Name :	Rouse, Janet (10569)	**Location :**	1 South 118 1	**Admission Date :**	01/14/2026
Medical Record # :	10569	**Gender :**	F	**Date of Birth :**	08/17/1955
Physician :	Weldetsadik, Benorayehush	**Pharmacy :**	Medwiz New Jersey LLC		
Allergies :	No Known Allergies				
Diagnoses :	No Medical Diagnosis Found				

Effective Date: 01/16/2026 10:11 Type: Physician Progress Note

Note Text : History and Physical
History
Room:
118
Floor:
1 South
Chief Complaint / Nature of Presenting Problem:
S/p Hospitalization for AMS sec to seizure disorder- started on Keppra.
History Of Present Illness:
The patient is a 70-year-old woman brought in to the hospital due to mental status change. She was admitted on 01/05 to ICU. For detail, please refer to ICU notes and Dr. Joshi's notes. I involved her care on 01/14. Per ICU, the patient has significant past medical history of alcohol abuse. She wasbrought from her home for evaluation of altered mental status and seizure-like activity. The patient's roommate noted the patient has altered mental status on day of admission. In the evening, the patient was found "unresponsive." So 911 was called. The patient had generalized tonic-clonic activity when EMS arrived. The patient received IV Ativan and brought to the emergency room. Additionally, the patient's blood pressure was 222/95. ICU consulted. The patient was intubated for airway protection. Her CTscan did not show acute abnormality. EEG was negative. The patient was loaded with phenobarbital for seizure and nicardipine for hypertensive urgency. Neurology consulted and placed on continuous EEG monitor. She was subsequently started on Keppra. The patient had LP done, which is negative for any signs of CNS infection. The patient initially placed on empirical antibiotics and subsequently discontinued. The patient's mental status gradually improved and she is now alert and oriented x3. After her bloodpressure improved, she is placed on amlodipine. Her echocardiogram showed normal left ventricular function with EF of 60%. The patient has a history of alcohol use. Her initial alcohol level was less than 10. Her tox screen is positive for cannabinoids. The patient is noted to have hypercalcemia. PTH is elevated. The patient needs to follow with endocrinology /general surgery for treatment of hyperparathyroidism.
01/16/26 Patient seen and examined in her room in no form of distress. no cough or SOB.
Medication List:
See Medication Administration Record (MAR).
Allergy List:
No known medication allergies.
Past Medical History:
AS IN HPI
Past Surgical History:
AS IN HPI
Social History:
ETOH abuse
Review Of Systems
General:
All systems reviewednegative except stated in HPI
Vital Signs/Constitutional
Weight: 106.6 pounds; 1/15/2026 11:08:56 AM; Height: 66 inches; 1/14/2026 9:36:00 PM; Pulse: 75 BPM; 1/16/2026 1:11:06 AM; Blood Pressure: 126/75; 1/16/2026 1:11:06 AM; O2 Saturation: 97 Room Air; 1/15/2026 11:19:00 AM; Temperature: 97.6 Fahrenheit (Warnings: Low of 97.8 exceeded, False); 1/16/2026 1:11:06 AM; Respiratory Rate: 18 Breaths per minute; 1/15/2026 9:02:16 PM; BMI: 17.2; Pain Level: 0; 1/16/2026 8:12:53 AM;
Physical Exam
General:

Primary Physician: All Progress Note Type: All Effective Date Range: Effective Time Range: All Created Date Range: All Created Time Range: All Author: All Department: All

Resident Name :	Rouse, Janet (10569)	**Location :**	1 South 118 1	**Admission Date :**	01/14/2026
Medical Record # :	10569	**Gender :**	F	**Date of Birth :**	08/17/1955
Physician :	Weldetsadik, Benorayehush	**Pharmacy :**	Medwiz New Jersey LLC		
Allergies :	No Known Allergies				
Diagnoses :	No Medical Diagnosis Found				

Gen: Awake, alert, not in any form of distress.

Eyes: normal exam.

ENT: Hearing grossly intact

Neck: Supple, trachea midline. No swollen lymph nodes

Resp: Lungs CTA, no wheezing, rales or crackles. Respirations are even and unlabored. No use of accessory muscles

CVS: Heart rate and rhythm regular. No gallops, murmurs, or rubs. S1 and S2 are present.

Arterial: Pedal Pulses +2

Edema/Ext:no edema

GI: Abdomen round, soft .Active bowel sounds in all four quadrants.

MK: Generalized Muscle weakness

Neuro: Awake, alert, oriented x3 ,non-focal, moves all ext .

Psych: Calm and cooperative.
Diagnosis and Assessment
Assessment:
CPT Codes:
99306 (1 unit), 99497 (1 unit)
ICD Codes:
F10.10: Alcohol abuse, uncomplicated
G93.40: Encephalopathy, unspecified
I16.0: Hypertensive urgency
G40.89: Other seizures
E21.0: Primary hyperparathyroidism
E46: Unspecified protein-calorie malnutrition
Plan:
1. Seizure. continue on Keppra . seizure precaution.
2. Acute encephalopathy- resolved. patient alert and oriented x3
3. Hypertensive urgency s/p Nicardipine drip - resolved. Currently patient on Norvasc
4. Hyperparathyroidism - fu with endo out pat.
5. Dysphagia. on mechanical soft diet, SLP fu.
6. Debility- PT/OT treatment.
7.ETOH abuse- on Thiamine and folate. counselled on cessation.
DVT PPX- Encourage ambulation.
Code status- see MOLST.
Advance Care Plan; Goal of care including prognosis discussed in detail with patient ,MOLST form reviewed copy of MOLST form placed in the chart ,patient has medical decision capacity, all questions answered ,took me more than 30min discussing GOC and completing MOLST form.

Primary Physician: All Progress Note Type: All Effective Date Range: Effective Time Range: All Created Date Range: All Created Time Range: All Author: All Department: All

Resident Name :	Rouse, Janet (10569)	**Location :**	1 South 118 1	**Admission Date :**	01/14/2026
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Allergies :	No Known Allergies				
Diagnoses :	No Medical Diagnosis Found				

***** Document e-signed by Dr Benorayehush Weldetsadik MD on Jan 16 2026 10:06AM EST *****
Graceway Healthcare

Author:Yolanda Greene Practitioners - NP [e-SIGNED]