Home Health Certification and Plan of Care

Order ID: 1163/197

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
117010875	08/20/2025	From: 08/20/2025 To: 10/18/2025	319	497754

6. Patient's Name and Address

Marcia Suskin
4615 28th Road S Apt A,
ARLINGTON, VA 22206-
336-509-0058

7. Provider's Name, Address and Telephone Number

Grace Home Healthcare, LLC
9735 Main Street Suite 200 Fairfax,
Fairfax, VA 22031-3736
703-865-7370
1073904009

8. DOB 02/04/1960 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
G93.41	Metabolic encephalopathy	08/20/25

13. ICD	Other Pertinent Diagnoses	Date
F31.9	Bipolar disorder unspecified	08/20/25
G47.33	Obstructive sleep apnea (adult) (pediatric)	08/20/25
M15.9	Polyosteoarthritis unspecified	08/20/25
K76.0	Fatty (change of) liver not elsewhere classified	08/20/25
K21.9	Gastro-esophageal reflux disease without esophagitis	08/20/25
E03.9	Hypothyroidism unspecified	08/20/25
G47.00	Insomnia unspecified	08/20/25
I10.	Essential (primary) hypertension	08/20/25
D50.9	Iron deficiency anemia unspecified	08/20/25
G40.909	Epilepsy unsp not intractable without status epilepticus	08/20/25
F50.00	Anorexia nervosa unspecified	08/20/25
K58.9	Irritable bowel syndrome without diarrhea	08/20/25
M81.0	Age-related osteoporosis w/o current pathological fracture	08/20/25
K57.90	Dvrtclos of intest part unsp w/o perf or abscess w/o bleed	08/20/25
G43.909	Migraine unsp not intractable without status migrainosus	08/20/25
E55.9	Vitamin D deficiency unspecified	08/20/25
R21.	Rash and other nonspecific skin eruption	08/20/25
E66.01	Morbid (severe) obesity due to excess calories	08/20/25
Z68.41	Body mass index [BMI] 40.0-44.9 adult	08/20/25
Z86.718	Personal history of other venous thrombosis and embolism	08/20/25
Z87.891	Personal history of nicotine dependence	08/20/25
Z87.440	Personal history of urinary (tract) infections	08/20/25
Z86.19	Personal history of other infectious and parasitic diseases	08/20/25
Z91.81	History of falling	08/20/25

10. Medications: Dose/Frequency/Route (N)ew (C)hanged

Tums - Simethicone (TUMS) 200 mg calcium (500 mg) , Chew 1 tablet (200 mg), by mouth every 4 hours Chew 1 tablet (200 mg total) every 4 (four) hours if needed for indigestion or heartburn
Depakote - Divalproex Sodium 500 mg , Take 1 tablet 500 mg by mouth at bedtime Take 1 tablet (500 mg total) by mouth every night
Lunesta - Eszopiclone 2 mg , Take 1 tablet (2 mg) by mouth at bedtime Take 1 tablet (2 mg total) by mouth every night
Vistaril - Hydroxyzine Hydrochloride 50 mg , Take 1 capsule (50 mg) by mouth three times a day Take 1 capsule (50 mg total) by mouth 3 (three) times a day if needed for anxiety, allergies or itching For 14 days
iron-vitamin C (Vitron-C) 65 mg iron- 125 mg 65 mg iron- 125 mg , Take 1 tablet by mouth once a day Take 1 tablet by mouth 1 (one) time each day
Synthroid - Levothyroxine Sodium 112 mcg , Take 1 tablet (112 mcg) by mouth once a day Take 1 tablet (112 mcg total) by mouth 1 (one) time each day
Cozaar - Losartan Potassium 25 mg , Take 1 tablet (25 mg) by mouth once a day Take 1 tablet (25 mg total) by mouth 1 (one) time each day
Melatonin - Melatonin 3 mg , Take 1 tablet (3 mg) by mouth at bedtime Take 1 tablet (3 mg total) by mouth at night if needed for sleep
Multivitamin - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox Take 1 capsule by mouth once a day Take 1 capsule by mouth 1 (one) time each day
Senokot - Senna 8.6 mg , Take 1 tablet (8.6 mg) by mouth at bedtime Take 1 tablet (8.6 mg total) by mouth every night
Desyrel - Trazodone Hydrochloride 100 mg , Take 1 tablet (100 mg) by mouth at bedtime Take 1 tablet (100 mg total) by mouth every night
Pepcid - Famotidine 20 mg , Take 1 tablet (20 mg) by mouth twice a day Take 1 tablet (20 mg 60 tablet total) by mouth in the morning and 1 tablet (20 mg total) before bedtime
lidocaine 4 % adhesive patch,medicated 4 % adhesive patch, Apply 1 patch topical once a day Apply 1 patch topically 1 (one) time each day Apply to back. Remove & discard patch within 12 hours or as directed by MD

14. DME and Supplies:

bath bench, grab bars,

15. Safety Measures:

medication safety, fall precautions, ambulates with device, ambulates with assistance, standard precautions, seizure precautions, knee precautions, bathroom safety

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 08/20/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address

Julie Passarelli
500 W Annandale Rd
Falls Church, VA 22046
PHONE: 7035216662 FAX: 17035215991 NPI: 1205368156

26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.

F2F date : 08/13/2025

27. Attending Physician's Signature and Date Signed : Date of physician last face-to-face

28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

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16. Nutrition:
low sodium, low cholesterol

17. Allergies:
codeine diphenhydramine diprophylline morphine

18.A. Functional Limitations
Endurance, Ambulation, Hearing

18.B. Activities Permitted
Independent at Home, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 2. Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility, ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 1. Rarely, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes

20. Prognosis: fair

22. A Rehabilitation Potential:
SELF-CARE: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities., MOBILITY: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities.

22.B.Discharge Plans
patient will be responsible for managing treatment

Homebound status:
Due to diagnosis of Metabolic Encephalopathy , the patient is experiencing decreased endurance and mobility, increasing the likelihood of falls. To safely leave their home, the patient needs assistance from another person and an assistive mobility device.

Clinical Condition Requiring Homecare:
The patient is a 65-year-old Caucasian female who resides alone in a condominium. She is alert and oriented to person, place, and time. She was recently hospitalized for a urinary tract infection (UTI) that progressed to sepsis, requiring intravenous antibiotic therapy. Following stabilization, she was transferred to Carlin Springs Rehabilitation and subsequently discharged home on 8/14/2025 with skilled aftercare. A primary care follow-up is scheduled for 8/27/2025. Past medical history is extensive and includes hypothyroidism, hypertension, osteoarthritis, osteoporosis, diverticulitis, gastroesophageal reflux disease (GERD), epilepsy, depression, bipolar disorder, anxiety, obstructive sleep apnea, insomnia, anemia, hepatic steatosis, transaminitis, metabolic encephalopathy, irritable bowel syndrome, muscle weakness, cognitive communication deficit, anorexia, and history of recurrent falls. She also has a history of bilateral knee replacements and currently wears bilateral hearing aids. Allergies include codeine, diphenhydramine, diprophylline, and morphine. On examination, vital signs were stable: T 97.9F, P 76 bpm, R 16, BP 132/74 mmHg, and oxygen saturation 96% on room air. Skin is warm and dry; mucous membranes are pink. Lungs are clear to auscultation bilaterally. The abdomen is soft, non-tender, with active bowel sounds in all quadrants. No peripheral edema noted. She reports chronic low back pain, rated 2/10, for which she uses a lidocaine patch (8 hours daily) and celecoxib. Functionally, the patient demonstrates decreased strength, endurance, balance, steadiness of gait, and overall mobility tolerance following hospitalization. She ambulates independently indoors but requires a single-arm cane (SAC) for outdoor mobility and longer distances. Gait is steady but not well-balanced, placing her at moderate fall risk as evidenced by a Timed Up and Go (TUG) score of 13 seconds. She ambulates without an assistive device at times but continues to rely on furniture for support. She is independent with transfers and basic ADLs, including bathing (with use of a shower chair), grooming, dressing, toileting, and oral medication management, provided medications are pre-filled in a pill case. She is currently utilizing a meal service while transitioning back to her normal routine. The patient expressed difficulty organizing medications and requested skilled nursing assistance for pillbox setup due to feeling temporarily disorganized post-hospitalization. She verbalized strong motivation to regain independence, stating her goals include returning to fishing, cooking, shopping, and managing her personal grooming. During this visit, the admission booklet was reviewed, and medication reconciliation was completed. Education was provided on medication adherence, safe mobility with a SAC, fall prevention strategies, home environment safety, and hydration/nutrition to optimize recovery. The patient was instructed on her home exercise program, including seated and standing lower extremity therapeutic exercises, which she demonstrated with understanding and compliance. Gait training and adjustment of her SAC were also performed. The plan of care includes skilled nursing one time weekly for eight weeks for medication management, education reinforcement, and continued monitoring; physical therapy twice weekly for eight weeks to improve strength, endurance, balance, gait safety, and functional mobility; and occupational therapy once weekly for eight weeks to support ADLs and home safety strategies. Collaboration with the patient's caregiver and coordination with Grace Home Healthcare regarding potential personal care services were discussed, though financial and insurance barriers remain. Ongoing multidisciplinary support is recommended to reduce fall risk, optimize recovery, and restore the patient to her prior level of function.
 Date of Order 08/20/2025 Orders Physician Face-to-Face Date: 08/13/2025 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Metabolic Encephalopathy Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home
 1 - SOC - SN Notes: PT Eval Notes: OT Eval Notes: Physician Passarelli, Julie

SN Careplans

SN WK1: 2 (08/20/25-08/23/25) ,WK2: 1 (08/24/25-08/30/25) ,WK3: 1 (08/31/25-09/06/25) ,WK4: 1 (09/07/25-09/13/25) ,WK5: 1 (09/14/25-09/20/25) ,WK6: 1 (09/21/25-09/27/25) ,WK7: 1 (09/28/25-10/04/25) ,WK8: 1 (10/05/25-10/11/25)

PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature < 95 > 100.5, heart rate < 50 > 110, respiratory rate < 8 > 22, blood pressure systolic < 90 > 169, blood pressure diastolic < 60 > 90, O2 saturation < 88 > 100, pain < 0 > 5

CAREGIVER: 4. Assistance needed, but no non-agency caregiver(s) available

HOSPITALIZATION RISKS: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months, 7. Currently taking 5 or more medications, 8. Currently reports exhaustion

STANDING ORDERS: infection control: hygiene, proper hand washing; advance directive: plan if patient is unable to make healthcare decisions ; fall precautions: wear sensible shoes, remove home hazards, living space adequately lit, assistive devices prn; emergency preparedness: plan for prn evacuation, resumption of home health visits; Skin Preservation: Measures to prevent skin breakdown; pressure relief, incontinence care, nutrition, hydration; Pain: Pain management measures; pain medication, rest, body alignment, ROM, meditation, massage; Medications:

SN Goals

PATIENT-STATED GOAL: I would like to feel better

GOALS
patient/caregiver recalls
* how to optimize mental status with cognition therapy
* home safety
* optimize mobility with active and passive range of motion therapeutic exercises
* diet and fluids to optimize peripheral circulation
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* management of mental health condition including joining a peer group
* maintaining regular contact with mental health professional
* avoiding known stressors
* controlling impulses
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to manage sleep disorder including changes to daytime habits and bedtime routine

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:
Electronically Signed by Messick, Charles RN

Date
08/20/2025

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Medication actions, uses, frequency, dose, interactions of all new/change meds
Advance Directive:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M1720 - Anxiety, M1700 - Cognition, D0160 - Depression, M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2102c - Med Admin, meal preparation, M2020 - Oral Med Management, abnormal blood pressure, M1033 - Exhaustion, M1400 - Dyspnea, coughing, itchy/runny nose, abnormal thyroid <> 0.40 - 4.50 mIU/mL, constipation, heartburn/indigestion, diarrhea, limited strength, limited endurance, poor muscle tone, muscle weakness, daytime fatigue, seizures, B0200 - Hearing Deficit, balance deficit, Pain Interference with ADLs, Pain Interference with Therapy activities, Pain Effect on Sleep, difficulty sleeping, obesity

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver., cough/deep breathing exercises, incentive spirometer, apply anti-embolitic stockings, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, apply compression bandage, coordinate/arrange preparation of missing meals

TEACH PATIENT/CAREGIVER: * how to take the patient's blood pressure record the reading, related medication(s) purpose, schedule, * lifestyle modifications to manage respiratory condition including diet changes and regular exercise strategies to control shortness of breath home remedies to keep lungs healthy, related medication(s) purpose, schedule, * lifestyle modifications to manage peripheral vascular condition including how to apply compression stockings physical exercise plan diet, related medication(s) purpose, schedule, * how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain teach relaxation skills and diversional activities, related medication(s) purpose, schedule, * how to optimize mental status with cognition therapy home safety optimize mobility with active and passive range of motion therapeutic exercises diet and fluids to optimize peripheral circulation, related medication(s) purpose, schedule, * how to manage seizure triggers implement lifestyle changes including getting enough sleep avoiding alcohol, related medication(s) purpose, schedule, * management of mental health condition including joining a peer group maintaining regular contact with mental health professional avoiding known stressors controlling impulses, related medication(s) purpose, schedule, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, related medication(s) purpose, schedule, * how to manage sleep disorder including changes to daytime habits and bedtime routine maintaining a journal to track sleep patterns, related medication(s) purpose, schedule, * how to keep home safe for patient with dementia coping strategies for the caregiver, related medication(s) purpose, schedule, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpose, schedule, * prescribed dietary modifications monitoring intake and output monitoring weight loss or weight gain monitor changes in neurological status, related medication(s) purpose, schedule, * how to manage symptoms of nicotine withdrawal and nicotine cravings, related medication(s) purpose, schedule, * low-fat diet lifestyle modifications to manage esophageal condition, related medication(s) purpose, schedule, * lifestyle modifications low-residue dietary guidelines alternative medicine options for ulcerative colitis, related medication(s) purpose, schedule, * dietary guidelines for managing nutritional deficit, related medication(s) purpose, schedule, * dietary modifications for liver disorder, related medication(s) purpose, schedule, * diet weight-bearing exercises to promote bone healing and strengthening fluids to prevent constipation home safety pain control, related medication(s) purpose, schedule, * how to manage inflammatory process optimize mobility with active and passive range of motion exercises fluid and diet intake to promote healing prevent constipation home safety, related medication(s) purpose, schedule, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, * how to keep home safe for hearing-impaired including installing special fire-detector/C O2 alarms, related medication(s) purpose, schedule, * how to keep journal of food and fluid intake healthy meal plan tips exercise program nutritional knowledge, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

* maintaining a journal to track sleep patterns
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to manage inflammatory process
* optimize mobility with active and passive range of motion exercises
* fluid and diet intake to promote healing
* prevent constipation
* home safety
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* dietary modifications for liver disorder
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* low-fat diet
* lifestyle modifications to manage esophageal condition
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* prescribed dietary modifications
* monitoring intake and output
* monitoring weight loss or weight gain
* monitor changes in neurological status
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to take the patient's blood pressure
* record the reading
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* dietary guidelines for managing nutritional deficit
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to manage seizure triggers
* implement lifestyle changes including getting enough sleep
* avoiding alcohol
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* lifestyle modifications
* low-residue dietary guidelines
* alternative medicine options for ulcerative colitis
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* diet
* weight-bearing exercises to promote bone healing and strengthening
* fluids to prevent constipation
* home safety
* pain control
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to keep journal of food and fluid intake
* healthy meal plan tips
* exercise program
* nutritional knowledge
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* lifestyle modifications to manage peripheral vascular condition including how to apply compression stockings
* physical exercise plan
* diet
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to manage symptoms of nicotine withdrawal and nicotine cravings
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* lifestyle modifications to manage respiratory condition including
* diet changes and regular exercise
* strategies to control shortness of breath
* home remedies to keep lungs healthy
* recalls related medication(s) purpose, schedule

patient/caregiver recalls

Signature of Physician:	Date
	PAGE 3 of 5
Optional Name/Signature of Nurse/Therapist:	Date
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* how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain
* teach relaxation skills and diversional activities
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* prevention exacerbation of anxiety condition including coping patterns
* improved concentration
* strategies to reduce anxiety
* identification of anxiety precipitants, conflicts, and threats
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to keep home safe for patient with dementia
* coping strategies for the caregiver
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* depression-prevention strategies including avoidance of isolation
* healthy eating
* sleeping habits
* identification of activities that bring pleasure
* preventive care
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to keep home safe for hearing-impaired including installing special fire-detector/CO2 alarms
* recalls related medication(s) purpose, schedule

patient self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

patient is adequately supervised

meal preparation is available to patient for all meals

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT WK1: 1 (08/20/25-08/23/25) ,WK2: 1 (08/24/25-08/30/25) ,WK3: 1 (08/31/25-09/06/25) ,WK4: 1 (09/07/25-09/13/25) ,WK5: 1 (09/14/25-09/20/25) ,WK6: 1 (09/21/25-09/27/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170D1 - Sit to Stand, GG0170E1 - Chair to Bed to Chair, GG0170G1 - Car Transfer, GG0170I1 - Walk 10 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170K1 - Walk 150 Feet, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object

PROCEDURES: Medication Review: Medications reviewed with patient/caregiver. , seated strengthening exercises, home exercise program: Seated therex BLE 2x10, 3-4x/week: clams, hip add pillow squeezes, marches, LAQ, HR/TR Sanding therex BLE 2x10, 3-4x/week: SLR hip abd/ext and HR/TR at counter height for balance/support, dynamic standing balance exercises, gait training on uneven surfaces, gait training/stair training, transfers training, therapeutic exercises

TEACH PATIENT/CAREGIVER: Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 05. Setup or clean-up assistance, Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance, Walk 150 Feet - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance, 1 - Step (curb) - 05. Setup or clean-up assistance, 4 Steps - 05. Setup or clean-up assistance, 12 Steps - 05. Setup or clean-up assistance, Picking Up Object - 05. Setup or clean-up assistance, Medication Review

PT Goals

PATIENT-STATED GOAL: to be able to walk around home, outdoors in her neighborhood and up/down the stairs outside her apartment door/in the neighborhood steady and balanced, and to feel safe and balanced when walking outside with use of her SAC, as well as perform ADLs and funct activities indep and safely with use of SAC and/or reacher assist;;to be able to walk around home, outdoors in her neighborhood and up/down the stairs outside her apartment door/in the neighborhood steady and balanced, and to feel safe and balanced when walking outside with use of her SAC, as well as perform ADLs and funct activities indep and safely with use of SAC and/or grabber tool assist

GOALS
Chair to Bed to Chair - 06. Independent

Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance

1 - Step (curb) - 05. Setup or clean-up assistance

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 05. Setup or clean-up assistance

Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
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Walk 150 Feet - 05. Setup or clean-up assistance

4 Steps - 05. Setup or clean-up assistance

12 Steps - 05. Setup or clean-up assistance

Picking Up Object - 05. Setup or clean-up assistance

Medication Review

OT Careplans

OT WK1: 1 (08/20/25-08/23/25) ,WK2: 1 (08/24/25-08/30/25) ,WK3: 1 (08/31/25-09/06/25) ,WK4: 1 (09/07/25-09/13/25) ,WK5: 1 (09/14/25-09/20/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with Therapy activities, Pain Interference with ADLs, M1400, GG0130B1 - Oral Hygiene, GG0130F1 - Upper Body Dressing, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130A1 - Eating

PROCEDURES: equipment training, work simplification/energy conservation

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage respiratory condition including diet changes and regular exercise strategies to control shortness of breath home remedies to keep lungs healthy, related medication(s) purpose, schedule, * how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain teach relaxation skills and diversional activities, related medication(s) purpose, schedule, Oral Hygiene - 06. Independent, Lower Body Dressing - 06. Independent, Shower/Bathe Self - 06. Independent, Toileting Hygiene - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent

OT Goals

PATIENT-STATED GOAL: I want to improve the my strength and get back to doing things for myself.

GOALS
patient/caregiver recalls
* lifestyle modifications to manage respiratory condition including
* diet changes and regular exercise
* strategies to control shortness of breath
* home remedies to keep lungs healthy
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain
* teach relaxation skills and diversional activities
* recalls related medication(s) purpose, schedule

Oral Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Shower/Bathe Self - 06. Independent

Toileting Hygiene - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Signature of Physician:	Date
	PAGE 5 of 5
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