

Home Health Certification and Plan of Care				Order ID: 1163/329	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
126386138		09/17/2025		From: 09/17/2025 To: 11/14/2025	
				4. Medical Record No.	
				344	
				5. Provider No.	
				497754	
6. Patient's Name and Address			7. Provider's Name, Address and Telephone Number		
Janis Altizer			Grace Home Healthcare, LLC		
20440 Broad Run Dr,			9735 Main Street Suite 200 Fairfax,		
STERLING, VA 20165-			Fairfax, VA 22031-3736		
703-430-3759			703-865-7370		
			1073904009		
8. DOB			9. Sex		
04/17/1945			Female		
11. ICD			10. Medications: Dose/Frequency/Route (N)ew (C)hanged		
G20.A1			Carbidopa And Levodopa - Carbidopa: Levodopa 25-100 MG, Give 2 tablet by mouth three times a day) Give 2 tablet by mouth three times a day for Parkinson's Disease		
13. ICD			Brimonidine Tartrate - Brimonidine Tartrate 0.2-0.5 %, Instill 1 drop both eyes three times a day		
E11.42			Dorzolamide Hydrochloride - Dorzolamide Hydrochloride 2 %, Instill 1 drop right eye three times a day		
I10.			Duloxetine Hydrochloride - Duloxetine Hydrochloride 20 MG Give 1 capsule by mouth once a day		
I48.91			Glimepiride - Glimepiride 2 MG Give 1 tablet by mouth once a day		
K21.9			Latanoprost - Latanoprost 0.005 %, Instill 1 drop by mouth at bedtime		
F43.23			Methocarbamol - Methocarbamol 500 MG , Give 1 tablet by mouth four times a day		
F32.A			Metoprolol Succinate - Metoprolol Succinate 50 MG, Give 1 tablet by mouth once a day		
F41.9			Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5 MG, Give 1 tablet by mouth every 4 hours Give 1 tablet by mouth every 4 hours as needed for Moderate-Severe Pain		
H40.9			Pantoprazole - Pantoprazole Sodium 40 MG, Give 1 tablet by mouth twice a day		
R13.12			Potassium Chloride - Potassium Chloride 10 MEQ Give 1 tablet by mouth once a day		
Z79.01			probiotics Give 1 capsule by mouth once a day		
Z79.84			Sucralfate - Sucralfate 1 GM , Give 1 tablet by mouth three times a day		
Z85.51			Acetaminophen - Acetaminophen 325 MG , Give 2 tablet by mouth every 6 hours		
Z96.642					
14. DME and Supplies:			15. Safety Measures:		
small base cane, rolling walker, bath bench, walker, grab bars, cane			walker precautions, medication safety, fall precautions, diabetic precautions, ambulates with device, medical alert/lifeline, ambulates with assistance, standard precautions, cardiac precautions, bathroom safety, anticoagulant precautions		
16. Nutrition:			17. Allergies:		
regular			cipro gabapentin metoclopramide pcn phenobarbital pregabalin		
18.A. Functional Limitations			18.B. Activities Permitted		
Dyspnea With Minimal Exertion, Ambulation			Cane, Up As Tolerated, Walker		
19. Mental & Psychosocial Status:			20. Prognosis:		
COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 2. Sometimes, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes			fair		
22. A Rehabilitation Potential:			22.B.Discharge Plans		
SELF-CARE: 1. Dependent - A helper completed all the activities for the patient., MOBILITY: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities.			patient will be responsible for managing treatment		
Homebound status:					
Due to diagnosis of Parkinson's disease without dyskinesia without mention of fluctuations, 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:		
<p class="MsoNoSpacing">The patient is an 80-year-old female recently discharged home following hospitalization and inpatient rehabilitation for gastric ulcer surgery, specifically an exploratory laparotomy with gastric intervention. She is alert and oriented to person, place, time, and situation. The patient received and signed the admission booklet and consent forms, and advance directives, including DPOA and Living Will, were reviewed-she expressed a desire to remain Full Code. Her abdominal incision is well approximated with no drainage or signs of infection; a photo was taken and measured at 10 cm. Lung sounds are clear bilaterally, the abdomen is soft but tender to palpation (5/10 pain), and bowel sounds are present in all quadrants. Mucous membranes are pink, skin is warm and dry, and no edema is observed in the lower extremities. Vital signs are stable. She has a significant medical history, including hypertension, Type 2 diabetes with polyneuropathy, atrial fibrillation, Parkinson's disease, glaucoma, GERD, dysphagia, depression, anxiety, muscle weakness, arthritis, and a history of bladder cancer (surgically excised in 2023), for which she continues treatment. The patient demonstrates decreased strength, endurance, standing tolerance, and balance, requiring a Rollator for mobility and moderate assistance with transfers and ambulation due to unsteadiness. She lives alone and depends on four rotating caregivers for all ADLs except feeding and medication intake, which she can manage if meals and meds are prepped in advance. She wears an adult diaper at night for safety due to occasional incontinence and lack of overnight caregiver support. The patient uses a chairlift to exit her home and is able to transfer in and out of a vehicle with caregiver assistance. She reports poor appetite and does not follow a specific diet or monitor blood sugar regularly. Multiple drug allergies are noted, including to penicillin, gabapentin, ciprofloxacin, phenobarbital, pregabalin, and metoclopramide. Home exercise program (HEP) and transfer safety education were initiated, and both patient and caregiver demonstrated understanding. Skilled PT services are recommended to improve mobility, safety, and independence, and to prevent functional decline.</o:p></p><p class="MsoNoSpacing">&nbsp;</p><p class="MsoNoSpacing">Date of Order<o:p></o:p></p><p class="MsoNoSpacing">09/17/2025
 Order<o:p></o:p></p><p class="MsoNoSpacing">Physician Face-to-Face Date: 09/11/2025
 Clinical Condition Requiring Home Care per Certifying Physician: SN-disease management PT- eval & treat OT eval & treat DX: Parkinson's disease without dyskinesia without mention of fluctuations
 Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home<o:p></o:p></p><p class="MsoNoSpacing">
 1 - SOC - SN Notes:
 PT Eval Notes:
 OT Eval Notes:
&nbsp;</o:p></o:p></p><p class="MsoNoSpacing">Physician: Mujarwanda, Yvette</p>					
SN Careplans			SN Goals		
23. Signature and Date of Verbal SOC Where Applicable:			25. Date HHA Received Signed POT		
Electronically Signed by Messick, Charles RN on 09/17/2025					
24. Physician's Name and Address			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.		
Yvette Mujarwanda			F2F date : 09/11/2025		
2833 Cleave Dr					
Falls Church, VA 22042					
PHONE: 8009691105 FAX: 17033981516 NPI: 1083365985					
27. Attending Physician's Signature and Date Signed			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.		
10/10/2025 Date of physician last face-to-face			PAGE 1 of 3		

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SN WK1: 2 (09/17/25-09/20/25) ,WK2: 2 (09/21/25-09/27/25) ,WK3: 1 (09/28/25-10/04/25) ,WK4: 1 (10/05/25-10/11/25) ,WK5: 1 (10/12/25-10/18/25) ,WK6: 1 (10/19/25-10/25/25) ,WK7: 1 (10/26/25-11/01/25) ,WK8: 1 (11/02/25-11/08/25)			PATIENT-STATED GOAL: To get stronger		
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			GOALS		
CAREGIVER: 2. Non-agency caregiver(s) need training/supportive services to provide assistance			patient/caregiver recalls		
HOSPITALIZATION RISKS: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 7. Currently taking 5 or more medications, 8. Currently reports exhaustion			* how to optimize mental status with cognition therapy		
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: Medication actions, uses, frequency, dose, interactions of all new/change meds			* home safety		
Advance Directive:No Advance Directive			* optimize mobility with active and passive range of motion therapeutic exercises		
PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, D0700 - Social Isolation, M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2102c - Med Admin, M2020 - Oral Med Management, M1033 - Exhaustion, M1400 - Dyspnea, abnormal BS < 70/140 > mg/dL, abdominal pain, muscle weakness, poor muscle tone, limited strength, muscle spasms, limited endurance, daytime fatigue, difficulty sleeping, balance deficit, Pain Interference with ADLs, Pain Interference with Therapy activities, Pain Effect on Sleep, loss of appetite			* diet and fluids to optimize peripheral circulation		
PROCEDURES: cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, glucose testing via monitor, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange long-term socialization activities			* recalls related medication(s) purpose, schedule		
TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage cardiac condition including symptom management diet changes regular exercise getting enough sleep, 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, * 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, * 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, * diabetic medication management blood sugar testing diabetic foot care exercise diabetic diet, related medication(s) purpose, schedule, * how to minimize chemotherapy and radiation side-effects including management of nausea or vomiting diarrhea appetite loss hair loss fatigue insomnia, related medication(s) purpose, schedule, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, * strategies to increase socialization, related medication(s) purpose, schedule, patient is adequately supervised, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence			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 minimize chemotherapy and radiation side-effects including management of nausea or vomiting		
			* diarrhea		
			* appetite loss		
			* hair loss		
			* fatigue		
			* insomnia		
			* 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		
			* 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 self-administers medications as prescribed		
			* recalls related medication(s) purpose, schedule		
			patient/caregiver recalls		
			* strategies to increase socialization		
			* recalls related medication(s) purpose, schedule		
			patient is adequately supervised		
			caregiver administers and/or packages medications appropriately		
			caregiver performs medical/rehabilitation treatments with adequate competence		
			patient/caregiver recalls		
			* diabetic medication management		
			* blood sugar testing		
			* diabetic foot care		
			* exercise		
			* diabetic diet		
			* 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		
PT Careplans			PT Goals		
Signature of Physician:			Date		
			PAGE 2 of 3		
Optional Name/Signature of Nurse/Therapist:			Date		
Electronically Signed by Messick, Charles RN			09/17/2025		

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PT WK1: 1 (09/17/25-09/20/25) ,WK2: 1 (09/21/25-09/27/25) ,WK3: 1 (09/28/25-10/04/25) PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with Therapy activities, Pain Interference with ADLs, GG0170F1 - Toilet Transfer, 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., home exercise program: Seated therex, BUE/BLE, 2x10, 1-2x/daily: Scap retr with 2-3 sec holds, C/S retr with 2-3 sec holds, Bkwd shldr rolls, LAQ, alt marches, clams, hip add pillow squeezes with 3-5 sec holds, HR/TR, standing tolerance exercises, static standing balance exercises, gait training/stair training, transfers training, therapeutic exercises TEACH PATIENT/CAREGIVER: * 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, Sit to Stand - 04. Supervision or touching assistance, Chair to Bed to Chair - 04. Supervision or touching assistance, Toilet Transfer - 05. Setup or clean-up assistance, Car Transfer - 04. Supervision or touching assistance, Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, 4 Steps - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance			PATIENT-STATED GOAL: To feel stronger in BLE when walking around home/between rooms with Rollator, with improved strength, endurance and tolerance for standing and walking. GOALS Sit to Stand - 04. Supervision or touching assistance Chair to Bed to Chair - 04. Supervision or touching assistance Car Transfer - 04. Supervision or touching assistance Walk 10 Feet - 04. Supervision or touching assistance Walk 50 ft with 2 Turns - 04. Supervision or touching assistance 4 Steps - 04. Supervision or touching assistance Picking Up Object - 04. Supervision or touching assistance 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 Toilet Transfer - 05. Setup or clean-up assistance		
OT Careplans OT WK1: 1 (09/17/25-09/20/25) ,WK2: 1 (09/21/25-09/27/25) 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 - 05. Setup or clean-up assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Shower/Bathe Self - 04. Supervision or touching assistance, Toileting Hygiene - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance, Eating - 05. Setup or clean-up assistance			OT Goals PATIENT-STATED GOAL: I want to get stronger and get back to feeling like myself GOALS Lower Body Dressing - 05. Setup or clean-up assistance Don/Doff Footwear - 05. Setup or clean-up assistance 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 - 05. Setup or clean-up assistance Upper Body Dressing - 05. Setup or clean-up assistance Shower/Bathe Self - 04. Supervision or touching assistance Toileting Hygiene - 05. Setup or clean-up assistance Eating - 05. Setup or clean-up assistance		

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
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