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	4. Medical Record No.	5. Provider No.
126386138	09/17/2025	From: 09/17/2025 To: 11/14/2025	344	497754

6. Patient's Name and Address
Janis Altizer
20440 Broad Run Dr,
STERLING, VA 20165-
703-430-3759

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 04/17/1945 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
G20.A1	Parkinson's dis w/o dyskinesia w/o mention of fluctuations	09/17/25

13. ICD	Other Pertinent Diagnoses	Date
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy	09/17/25
I10.	Essential (primary) hypertension	09/17/25
I48.91	Unspecified atrial fibrillation	09/17/25
K21.9	Gastro-esophageal reflux disease without esophagitis	09/17/25
F43.23	Adjustment disorder with mixed anxiety and depressed mood	09/17/25
F32.A	Depression unspecified	09/17/25
F41.9	Anxiety disorder unspecified	09/17/25
H40.9	Unspecified glaucoma	09/17/25
R13.12	Dysphagia oropharyngeal phase	09/17/25
Z79.01	Long term (current) use of anticoagulants	09/17/25
Z79.84	Long term (current) use of oral hypoglycemic drugs	09/17/25
Z85.51	Personal history of malignant neoplasm of bladder	09/17/25
Z96.642	Presence of left artificial hip joint	09/17/25

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

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
Brimonidine Tartrate - Brimonidine Tartrate 0.2-0.5 %, Instill 1 drop both eyes three times a day
Dorzolamide Hydrochloride - Dorzolamide Hydrochloride 2 %, Instill 1 drop right eye three times a day
Duloxetine Hydrochloride - Duloxetine Hydrochloride 20 MG Give 1 capsule by mouth once a day
Glimepiride - Glimepiride 2 MG Give 1 tablet by mouth once a day
Latanoprost - Latanoprost 0.005 %, Instill 1 drop by mouth at bedtime
Methocarbamol - Methocarbamol 500 MG , Give 1 tablet by mouth four times a day
Metoprolol Succinate - Metoprolol Succinate 50 MG, Give 1 tablet by mouth once a day
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
Pantoprazole - Pantoprazole Sodium 40 MG, Give 1 tablet by mouth twice a day
Potassium Chloride - Potassium Chloride 10 MEQ Give 1 tablet by mouth once a day
probiotics Give 1 capsule by mouth once a day
Sucralfate - Sucralfate 1 GM , Give 1 tablet by mouth three times a day
Acetaminophen - Acetaminophen 325 MG , Give 2 tablet by mouth every 6 hours

14. DME and Supplies:
small base cane, rolling walker, bath bench, walker, grab bars, cane

15. Safety Measures:
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:
regular

17. Allergies:
cipro gabapentin metoclopramide pcn phenobarbital pregabalin

18.A. Functional Limitations
Dyspnea With Minimal Exertion, Ambulation

18.B. Activities Permitted
Cane, Up As Tolerated, Walker

19. Mental & Pyschosocial Status: 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

20. Prognosis: fair

22. A Rehabilitation Potential:
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.

22.B.Discharge Plans
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: 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></o:p>   Date of Order<o:p></o:p> 09/17/2025
 Order<o:p></o:p> 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>
 1 - SOC - SN Notes:
 PT Eval Notes:
 OT Eval Notes: <o:p></o:p> Physician: Mujarwanda, Yvette

SN Careplans

SN Goals

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 09/17/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address
Yvette Mujarwanda
2833 Cleave Dr
Falls Church, VA 22042
PHONE: 8009691105 FAX: 17033981516 NPI: 1083365985

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 : 09/11/2025

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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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)

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: 2. Non-agency caregiver(s) need training/supportive services to provide assistance

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

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
Advance Directive:No Advance Directive

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

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

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-STATED GOAL: To get stronger

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
* lifestyle modifications to manage cardiac condition including symptom management
* diet changes
* regular exercise
* getting enough sleep
* 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 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

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

Date
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
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	09/17/2025