Home Health Certification and Plan of Care

Order ID: 1163/424

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
93270187	10/09/2025	From: 10/09/2025 To: 12/07/2025	527	497754

6. Patient's Name and Address
Larbi Tazka
5614 Bloomfield Dr Apt 102,
ALEXANDRIA, VA 22312-
703-598-0877

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 06/07/1962 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
S06.36AD	Traum hemor cereb with LOC status unknown subs	10/09/25

13. ICD	Other Pertinent Diagnoses	Date
I10.	Essential (primary) hypertension	10/09/25
E11.69	Type 2 diabetes mellitus with other specified complication	10/09/25
E78.5	Hyperlipidemia unspecified	10/09/25
E11.65	Type 2 diabetes mellitus with hyperglycemia	10/09/25
K21.9	Gastro-esophageal reflux disease without esophagitis	10/09/25
E11.29	Type 2 diabetes mellitus w oth diabetic kidney complication	10/09/25
J32.0	Chronic maxillary sinusitis	10/09/25
Z79.84	Long term (current) use of oral hypoglycemic drugs	10/09/25

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

Atorvastatin - Atorvastatin Calcium take 80 mg, tablet by mouth once a day
Acetaminophen - Acetaminophen take tablet by mouth as necessary dose, route, and frequency, where note mentioned
Glucophage Xr - Metformin Hydrochloride 750 mg take 750 mg, tablet by mouth twice a day 750 mg in the morning, 750 mg in the evening
Lantus Insulin - Insulin Glargine Recombinant 10 units subcutaneous once a day

14. DME and Supplies:
None of the above

15. Safety Measures:
infectious material management, , , bathroom safety, sharps precautions, , diabetic precautions

16. Nutrition:
diabetic

17. Allergies:
no known allergies

18.A. Functional Limitations
Endurance

18.B. Activities Permitted
Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 0. Never, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No

20. Prognosis: good

22. A Rehabilitation Potential:
SELF-CARE: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper., MOBILITY: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper.

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

Homebound status: Due to diagnosis of Traumatic Hemorrhage Of Cerebrum, Unspecified, With Loss Of Consciousness Status Unknown, Subsequent Encounter, 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 63-year-old Arabic male who resides with his wife in an apartment complex with a split flight of stairs leading to their first-level unit. He was admitted with a diagnosis of intraparenchymal hemorrhage in the basal ganglia following a head trauma sustained when he was struck on the head by a dumpster lid while at work. His past medical history includes type 2 diabetes mellitus, latent tuberculosis, and hyperlipidemia, with ongoing use of oral hypoglycemic medications. The patient is alert and oriented to person, place, time, and situation, with no reported or observed visual or hearing impairments. Sensation is intact. Upon <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>, the patient demonstrated an unsteady gait but was able to ambulate independently without the use of an assistive device such as a cane or walker. He performed transfers, stair navigation, and activities of daily living (ADLs) with independence and required only supervision for safety. The patient denied shortness of breath and exhibited no signs of respiratory distress during or after physical activity. Bilateral breath sounds were clear on auscultation. The skin was warm and dry, and mucous membranes were pink. The abdomen was soft and non-tender, with active bowel sounds in all quadrants, and no swelling was noted in the lower extremities. The patient denied pain during the <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>. Blood sugar this morning was 90 mg/dL. The admission booklet was reviewed in detail with the patient and his wife, and consent forms were signed. The patient does not have a durable power of attorney (DPOA) or advance directives on file and is designated as Full Code. Medication reconciliation was completed and reviewed with the patient and his wife, who verbalized understanding of the prescribed regimen. The patient's wife assists in preparing meals and organizing medications, though the patient self-administers and feeds independently. Vital signs were stable throughout the visit. A physical therapy evaluation was completed, during which the patient and his wife declined ongoing skilled PT services, stating they felt confident managing his current level of function. Both verbalized understanding and agreement with the plan for an evaluation-only visit. The plan of care includes continued monitoring of neurological status, maintenance of safety during ambulation due to unsteady gait, reinforcement of medication adherence, diabetic management, and education on recognizing signs of neurological change or imbalance that may warrant immediate medical attention.
 Date of Order 10/09/2025 Orders Physician Face-to-Face Date: 10/06/2025 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Traumatic Hemorrhage Of Cerebrum, Unspecified, With Loss Of Consciousness Status Unknown, Subsequent Encounter 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: soc PT Eval Notes: OT Eval Notes:
 Physician Seshadri, Jayashree

SN Careplans	SN Goals

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 10/09/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address
Jayashree Seshadri
6501 Loisdale Ct Ste 1100
Springfield, VA 22150
PHONE: 5716222000 FAX: NPI: 1659699718

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 : 10/06/2025

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: 1 (10/09/25-10/11/25) ,WK4: 1 (10/26/25-11/01/25) ,WK5: 1 (11/02/25-11/08/25) ,WK6: 1 (11/09/25-11/15/25) ,WK7: 1 (11/16/25-11/22/25) ,WK8: 1 (11/23/25-11/29/25) ,WK9: 1 (11/30/25-12/06/25)

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, blood sugar < 60 > 300

CAREGIVER: 1. Non-agency caregiver(s) currently provide assistance

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

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, M1033 - Exhaustion, M1400 - Dyspnea, muscle weakness, limited endurance, daytime fatigue, loss of appetite

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , cough/deep breathing exercises, incentive spirometer, glucose testing via monitor

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, * low cholesterol dietary guidelines, 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, * prescribed dietary modifications monitoring intake and output monitoring weight loss or weight gain monitor changes in neurological status, related medication(s) purpose, schedule, * diabetic medication management blood sugar testing diabetic foot care exercise diabetic diet, 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

PATIENT-STATED GOAL: I would like to feel better so I can go back to work

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
* diabetic medication management
* blood sugar testing
* diabetic foot care
* exercise
* diabetic diet
* 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
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* recalls related medication(s) purpose, schedule

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

patient/caregiver recalls
* low cholesterol dietary guidelines
* 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

PT Careplans

PT WK2: 1 (10/12/25-10/18/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: 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

PT Goals

PATIENT-STATED GOAL: No pt stated goal necessary as pt is indep in all ADLs and funct activities; NA, NOT ADMITTING Pt

OT Careplans

OT WK2: 1 (10/12/25-10/18/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: 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: cough/deep breathing exercises, incentive spirometer, 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, 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: OT evaluation only

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

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

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

Date
10/09/2025