Home Health Certification and Plan of Care

Order ID: 1163/643

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
74249974	12/18/2025	From: 12/18/2025 To: 02/15/2026	861	497754

6. Patient's Name and Address
Mosammat Begum
5925 Quantrell Avenue Apt 104,
ALEXANDRIA, VA 22312-
571-598-7821

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 11/12/1972 | **9.Sex** Female

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

Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 2,000 Units, Tablet by mouth once a day
Glucotrol - Glipizide 10 Mg, Tablet by mouth twice a day before meal.
Glucophage - Metformin Hydrochloride 1000 Mg , Tablet by mouth twice a day
Protonix - Pantoprazole Sodium 40 mg, Tablet by mouth twice a day Do not crush ,chew or split.
Lantus - Insulin Glargine Recombinant 100 units/ml 10 units subcutaneous as necessary For blood sugar control over 200

11. ICD	Principal Diagnosis	Date
I95.1	Orthostatic hypotension	12/18/25

13. ICD	Other Pertinent Diagnoses	Date
E11.65	Type 2 diabetes mellitus with hyperglycemia	12/18/25
E11.39	Type 2 diabetes w oth diabetic ophthalmic complication	12/18/25
D25.9	Leiomyoma of uterus unspecified	12/18/25
E11.43	Type 2 diabetes w diabetic autonomic (poly)neuropathy	12/18/25
K31.84	Gastroparesis	12/18/25
E78.5	Hyperlipidemia unspecified	12/18/25
Z79.84	Long term (current) use of oral hypoglycemic drugs	12/18/25

14. DME and Supplies:
walker, diabetic supplies

15. Safety Measures:
walker precautions, , diabetic precautions, supervision at all times, sharps precautions, , ambulates with assistance

16. Nutrition:
fluids for hydration, diabetic

17. Allergies:
no known allergies

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

18.B. Activities Permitted
Walker, 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: fair

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 Orthostatic Hypotension, 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 53-year-old female admitted to home health services for skilled nursing and physical therapy following recent hospitalization for uncontrolled type 2 diabetes mellitus, significant weight loss, and severe dehydration, resulting in profound deconditioning and weakness. She resides in a condominium with her husband and son, who provide assistance with care needs. The home environment includes multiple stairs (approximately 10 steps to enter the building and an additional 7-8 steps to access the condo unit). The family reports plans to sell the condo and relocate to a single-family home within the next three months to better accommodate the patient's mobility needs. The patient is alert and oriented to person, place, time, and situation (A&O x4), with no noted hearing or vision impairments. A comprehensive nursing start-of-care assessment revealed skin that is clean, dry, and intact. The patient appears markedly weak and frail. She has a history of traveling out of the country for four months and returning in July in a significantly ill state. Family reports that her hemoglobin A1c was greater than 15 for a prolonged period prior to seeking medical care. Past medical history is significant for type 2 diabetes mellitus with hyperglycemia, diabetic autonomic (poly)neuropathy, diabetic ophthalmic complications, long-term use of oral hypoglycemic medications, severe dehydration, orthostatic hypotension, gastroparesis, hyperlipidemia, leiomyoma of the uterus, failure to thrive, nausea and vomiting, and significant unintentional weight loss. Orthostatic vital signs obtained by nursing demonstrated marked hypotension with positional changes, with blood pressure measuring 139/87 mmHg supine, 87/62 mmHg sitting, and 68/42 mmHg standing, consistent with severe orthostatic hypotension. Physical therapy evaluation identified pronounced bilateral lower extremity weakness and deconditioning due to prolonged sedentary status and muscle atrophy. According to the patient and family, she had been largely bedbound for much of the past year due to severe gastrointestinal and abdominal pain attributed to diabetic nerve damage. While her diabetes is now reportedly better controlled, she continues to experience intermittent pain rated at 1-3/10, which improves when lying prone. She expresses fear of eating, drinking, and moving due to prior symptoms, contributing to dehydration and frequent emergency department <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-9 CE-FMS-visits">visits</mh> earlier in the year. The family reports ongoing drops in blood pressure with transitions from lying to standing, though less so with sitting. Functionally, the patient requires physical assistance for all activities of daily living and functional mobility. Previously, approximately two months ago, she was able to bathe independently using a shower chair with minimal assistance from her husband toward the end of bathing. Currently, she performs sponge bathing at the sink. She requires hands-on assistance from her husband or son for transfers and ambulation, often holding onto their arm for support. She refuses to use a walker consistently, expressing reluctance related to age perception, though documentation notes she has access to and intermittently uses a front-wheeled walker and requires moderate assistance of two persons for mobility when attempted. Toileting requires significant effort, though she is able to access the bathroom adjacent to her bedroom with assistance. She is unable to transition from supine or side-lying to sitting at the edge of the bed without physical assistance and experiences severe orthostatic symptoms, including dizziness and body sway, with attempts at upright positioning. The physical therapy visit conducted was evaluation only, as the patient declined participation in mobility or exercise activities due to fear of symptom exacerbation. Education was provided to the patient and family regarding the role of therapy, safety concerns related to orthostatic hypotension, and the importance of medical management to improve tolerance for upright positioning. The family expressed a desire to first achieve improved management of the patient's orthostatic hypotension, with the longer-term goal of enabling the patient to tolerate prolonged sitting for international travel to return to her home country and eventually reside with her sisters. The patient and family verbalized understanding of and agreement with the evaluation-only visit. Continued skilled nursing services are indicated to closely monitor vital signs, orthostatic hypotension, hydration status, and diabetes management, as well as to reinforce education and coordinate care with the medical provider. Skilled physical therapy services may be beneficial once medically appropriate and once the patient is able to tolerate activity, to address severe deconditioning, improve strength and functional mobility, reduce fall risk, and support safe transitions and caregiver training as part of the overall plan of care.
 Date of Order 12/18/2025 <span

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 12/18/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address
Uzma Hasan
6551 Loisdale Ct
Springfield, VA 22150
PHONE: 5716222000 FAX: NPI: 1770527814

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 : 12/16/2025

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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style="color: rgb(51, 51, 51); font-size: 14px;">Orders Physician Face-to-Face Date: 12/16/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN disease management, PR eval and treat, OT eval and treat due to Orthostatic Hypotension 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 Hasan, Uzma

SN Careplans

SN WK1: 1 (12/18/25-12/20/25) ,WK2: 1 (12/21/25-12/27/25) ,WK3: 2 (12/28/25-01/03/26) ,WK4: 2 (01/04/26-01/10/26) ,WK5: 2 (01/11/26-01/17/26)

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 pressure systolic ortho-1 < 90 > 169, blood pressure diastolic ortho-1 < 60 > 90

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

HOSPITALIZATION RISKS: 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: M2102d - Caregiver Performs Treatment, M2020 - Oral Med Management, M2102f - Patient Supervision, M2102c - Med Admin, meal preparation, M1400 - Dyspnea, M1033 - Exhaustion, weak pulses in feet, abnormal blood pressure, lightheadedness, abnormal BS < 70/140 > mg/dL, abnormal electrolyte panel, heartburn/indigestion, nausea/vomiting, decreased urine output, dark-colored urine, limited endurance, limited strength, poor muscle tone, limited range of motion, muscle weakness, balance deficit, weak hand grips, daytime fatigue, itchy skin

PROCEDURES: cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision

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, * lifestyle changes to manage hypotension including diet changes proper posture body position changes wearing of compression stockings, 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, * dietary guidelines lifestyle modifications to manage gastric condition, 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 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

SN Goals

PATIENT-STATED GOAL: "I want to not fall again"

GOALS
patient/caregiver recalls
* lifestyle changes to manage hypotension including diet changes
* proper posture
* body position changes
* wearing of compression stockings
* 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
* 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
* dietary guidelines
* lifestyle modifications to manage gastric condition
* 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 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 (12/18/25-12/20/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 Dyspnea, 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

TEACH PATIENT/CAREGIVER: 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, 4 Steps - 05.

PT Goals

PATIENT-STATED GOAL: NA, NOT ADMITTING Pt

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

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

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	12/18/2025

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Setup or clean-up assistance, 12 Steps - 05. Setup or clean-up assistance, Picking Up Object - 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

OT Careplans

OT WK1: 1 (12/18/25-12/20/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, 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, cough/deep breathing exercises, incentive spirometer

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 - 05. Setup or clean-up assistance, Toileting Hygiene - 05. Setup or clean-up assistance, Shower/Bathe Self - 04. Supervision or touching assistance, Upper Body Dressing - 03. Partial/moderate assistance, Lower Body Dressing - 03. Partial/moderate assistance, Don/Doff Footwear - 03. Partial/moderate assistance, 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 - 05. Setup or clean-up assistance

Toileting Hygiene - 05. Setup or clean-up assistance

Shower/Bathe Self - 04. Supervision or touching assistance

Upper Body Dressing - 03. Partial/moderate assistance

Lower Body Dressing - 03. Partial/moderate assistance

Don/Doff Footwear - 03. Partial/moderate assistance

Eating - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
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