Home Health Certification and Plan of Care

Order ID: 1163/773

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
021007972	01/29/2026	From: 01/29/2026 To: 03/29/2026	1044	497754

6. Patient's Name and Address
Judith Towers
44324 PANTHER RIDGE DR,
ASHBURN, VA 20147-
703-729-7602

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 03/27/1943 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.89	Encounter for other orthopedic aftercare	01/29/26

13. ICD	Other Pertinent Diagnoses	Date
M84.351D	Stress fracture right femur subs for fx w routn heal	01/29/26
Z79.82	Long term (current) use of aspirin	01/29/26
Z79.891	Long term (current) use of opiate analgesic	01/29/26

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

calcium-vitamin D3-vitamin K 650 mg-12.5 mcg-40 mcg tablet,chewable Chew in the morning and before bedtime
Acetaminophen - Acetaminophen 500 mg / 1 Tablet by mouth every 6 hours if needed for mild pain Commonly known as: Tylenol Extra Strength
Aspirin - Aspirin 81 mg / 1 Tablet by mouth in the morning and 1 tablet (81 mg total) before bedtime. Do all this for 21 days.
Atorvastatin - Atorvastatin Calcium 10 mg / 1 Tablet by mouth once a day Commonly known as: LIPITOR
Levothyroxine - Levothyroxine Sodium 25 mcg / 1 Tablet by mouth once a day before breakfast Commonly known as: SYNTHROID, LEVOTHROID
multivitamin tablet 1 Tablet by mouth once a day Commonly known as: THERAGRAN
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 05 mg / 1 Tablet by mouth every 4 hours Commonly known as: ROXICODONE;

In home, Pt does not take
Erythromycin - Erythromycin 5 mg/gm ophthalmic ointment (.5%) both eyes four times a day Apply 0.5 inches to affected eye(s) Commonly known as: ROMYCIN

14. DME and Supplies:
4 wheeled walker, bath bench, grab bars, cane, BUE axillary crutches

15. Safety Measures:
bathroom safety, walker precautions, , , , ambulates with device, , , WBAT

16. Nutrition:
regular

17. Allergies:
no known allergies

18.A. Functional Limitations
Ambulation, Endurance

18.B. Activities Permitted
Walker, Crutches, Exercises Prescribed, 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

Homebound status: Due to diagnosis of Encounter For Other Orthopedic Aftercare, 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: Start of care and physical therapy evaluation were completed for this 82-year-old female status post open reduction with right femur intramedullary rodding performed on 01/23/2026. Surgery was required secondary to a rare adverse reaction to bisphosphonate therapy prescribed for osteoporosis, which resulted in a right femoral stress fracture necessitating surgical stabilization. Her past medical history is significant for osteoporosis and unspecified stress fracture of the right femur. The patient is weight bearing as tolerated (WBAT) per surgeon orders, with no additional movement restrictions at this time. She has a scheduled postoperative follow-up appointment with her surgeon on 02/11/2026. The patient resides with her husband in a multilevel home. She is alert and oriented to person, place, time, and situation, with no reported vision or hearing deficits. Upper extremity strength is good bilaterally, allowing her to independently perform most activities of daily living and transfers. She is independent with basic grooming, toileting, and bathing tasks and utilizes a built-in bench in her walk-in shower to enhance safety during bathing. She requires minimal physical assistance to don pants, socks, and underwear; however, she reports being able to independently don a specific pair of loose-fitting pants when seated on the toilet. She is independent in managing oral medications and participates in meal preparation with her husband, stating she is capable of completing these tasks independently if needed. Functionally, the patient is independent with all transfers and ambulates independently indoors and outdoors using either a rollator or bilateral upper extremity axillary crutches. She reports preferring axillary crutches for outdoor mobility. Although independent with assistive devices, she would benefit from supervision or standby assistance during outdoor ambulation at this time due to her recent postoperative status and potential fall risk. Strength, endurance, and dynamic balance remain below her prior level of function but are progressing appropriately for her postoperative stage. Education was provided regarding safe home setup, fall prevention strategies, and appropriate use of assistive devices, including gait training with both the rollator and bilateral axillary crutches to promote safe and efficient ambulation. A home exercise program was initiated during this session, consisting of seated and standing bilateral lower extremity therapeutic exercises aimed at improving strength, stability, and tolerance for functional mobility. The patient and her husband verbalized understanding and demonstrated proper technique and agreement with the plan of care. Skilled physical therapy services are medically necessary to address residual lower extremity weakness, improve endurance and gait steadiness, enhance safety with functional mobility, and facilitate return to prior level of function. Continued therapy will focus on progressive strengthening, balance training, stair negotiation within the multilevel home, and advancement of ambulation to maximize independence and reduce fall risk.
 Date of Order 01/29/2026 Orders Physician Face-to-Face Date: 01/24/2026 Clinical Condition Requiring home Care per Certifying Physician: PT-eval & treat OT-eval & treat due to Encounter For Other Orthopedic Aftercare 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-PT Notes: SOC OT Eval Notes:
 Physician Nguyen, Hoang An

SN Careplans

SN Goals

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 01/29/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Hoang An Nguyen
43480 Yukon Dr Ste 100
Ashburn, VA 20147
PHONE: 5712526000 FAX: 15712526011 NPI: 1114095528

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 : 01/24/2026

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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PT Careplans

PT WK1: 1 (01/29/26-01/31/26) ,WK2: 1 (02/01/26-02/07/26) ,WK3: 1 (02/08/26-02/14/26) ,WK4: 1 (02/15/26-02/21/26) ,WK6: 1 (03/01/26-03/07/26) ,WK7: 1 (03/08/26-03/14/26)

PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature < 95 > 100, heart rate < 60 > 100, respiratory rate < 10 > 24, blood pressure systolic < 100 > 150, blood pressure diastolic < 60 > 90, O2 saturation < 90 > 100, pain < 0 > 7

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

HOSPITALIZATION RISKS: 7. Currently taking 5 or more medications, 9. Other risk(s) not listed in 1- 8

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:POLST (Physician Orders for Life-Sustaining Treatment)

PROBLEMS IDENTIFIED ON ASSESSMENT: , GG0170D1 - Sit to Stand, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170L1 - Walk 10 ft on Uneven Surface, GG0170K1 - Walk 150 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170I1 - Walk 10 Feet, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170F1 - Toilet Transfer, M2020 - Oral Med Management, M1400 - Dyspnea, limited range of motion, swelling of affected area, limited strength, Pain Effect on Sleep, Pain Interference with ADLs, #1 - Non-Observable Surgical Wound - Other - post op R Open Reduction (OR) with Femur intramedullary rodding -

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Other - post op R Open Reduction (OR) with Femur intramedullary rodding -: None provided; non observable wounds due to steri bandages (3) that she has no orders for managing presently. f/u with surgeon 2.11, where she may be given more information/details., home exercise program: seated SLR hip flex, standing SLR hip abd, seated and/or standing marches, LAQs, seated HR/TR, seated clams and hip add pillow squeezes, strengthening exercises, gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: patient self-administers medications as prescribed, related medication(s) purpose, schedule, 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, 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

PT Goals

PATIENT-STATED GOAL: To return to her pain free PLOF during ADLs, funct activities and ambul

GOALS
Car Transfer - 06. Independent

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

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

Sit to Stand - 06. Independent

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

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

OT Careplans

OT WK1: 1 (01/29/26-01/31/26)

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 medicatio, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 06. Independent, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 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 medicatio

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:

Date

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

Date
01/29/2026