Home Health Certification and Plan of Care

Order ID: 1163/945

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
441017094	03/23/2026	From: 03/23/2026 To: 05/21/2026	1291	497754

6. Patient's Name and Address
Tarasia Remhof
1775 Faversham Way,
WOODBRIDGE, VA 22192-
571-814-8877

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 11/09/1959 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
I82.403	Acute embolism and thombos unsp deep veins of low extrm bi	03/23/26

13. ICD	Other Pertinent Diagnoses	Date
I10.	Essential (primary) hypertension	03/23/26
E78.5	Hyperlipidemia unspecified	03/23/26
E05.00	Thyrotoxicosis w diffuse goiter w/o thyrotoxic crisis	03/23/26
M17.0	Bilateral primary osteoarthritis of knee	03/23/26
E66.9	Obesity unspecified	03/23/26
Z68.39	Body mass index [BMI] 39.0-39.9 adult	03/23/26
Z85.820	Personal history of malignant melanoma of skin	03/23/26
Z86.0101	Personal history of adeno	03/23/26

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

Amlodipine Besylate - Amlodipine Besylate eq 5 mg base eq 5 mg base / 1 Tablet by mouth once a day for HTN
Atorvastatin Calcium - Atorvastatin Calcium 40 mg 1 Tablet by mouth at bedtime for HLD
Cholecalciferol Oral Capsule 25 MCG 1 Capsule by mouth once a day for vitamin D deficiency
Magnesium Oxide - Simethicone 400mg / 2 Tablet by mouth twice a day hypomagnesemia
METHIMAZOLE 10 mg 0 10 mg / 1 Tablet by mouth once a day for hyperthyroidism
Thera-M Oral Tablet (Multiple Vitamins w/ Mineral) 1 Tablet by mouth once a day for supplement

14. DME and Supplies:
bath bench, wheelchair, hospital bed

15. Safety Measures:
wheelchair precautions, , , , emergency phone # clearly displayed, bathroom safety, ambulates with device, ambulates with assistance

16. Nutrition:
regular, cardiac diet

17. Allergies:
Corn, Adhesive Tape

18.A. Functional Limitations
Ambulation, Endurance, Bowel/Bladder Incontinence

18.B. Activities Permitted
Wheelchair, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 1. Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions., ANXIETY: 1. In new or complex situations only, 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: 1. Dependent - A helper completed all the activities for the patient., MOBILITY: 1. Dependent - A helper completed all the activities for the patient.

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

Homebound status: Due to diagnosis of Acute embolism and thrombosis of unspecified deep veins of lower extremity, bilateral, 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 66-year-old White female residing with her twin sister in a senior living community, with additional support from a daytime private aide. She was recently hospitalized following a syncopal episode, after which emergency services were activated by her sister. Her past medical history is significant for a recent large intraparenchymal hemorrhage resulting in right-sided hemiparesis, Graves' disease, obesity, and bilateral knee osteoarthritis, with associated deconditioning and functional decline. On assessment, the patient is alert and oriented to person, place, and time; however, she demonstrates mild cognitive impairment with forgetfulness and requires cueing to recall the current year and day of the week. She is easily redirected and cooperative with care. Neurologically, she presents with aphasia but is able to state her name and date of birth. Facial symmetry is intact, pupils are equal and reactive to light, and bilateral hand grasps are equal. Sensation is intact. Respiratory assessment reveals clear lung sounds without use of accessory muscles. The abdomen is distended but soft and non-tender with active bowel sounds in all four quadrants. The patient is incontinent of both bowel and bladder. Bilateral lower extremity swelling is noted to have decreased compared to prior assessments. Functionally, the patient is primarily wheelchair-dependent and requires assistance with all mobility tasks. She is able to perform limited ambulation up to approximately 30 feet using a front-wheeled walker with close supervision and frequent rest breaks due to decreased endurance and impaired motor control. Transfers, including sit-to-stand and bed-to-chair mobility, require partial to moderate assistance. She is able to feed herself with setup assistance but requires support for most other activities of daily living. The patient currently sleeps in a recliner lift chair. Durable medical equipment in place includes a wheelchair, hospital bed, and Hoyer lift; however, she would benefit from a front-wheeled walker to support mobility training. The patient reports bilateral knee pain with partial relief from prescribed medications. She demonstrates impaired strength, balance, coordination, and safety awareness, placing her at high risk for falls. Skilled physical therapy interventions have focused on therapeutic exercise, neuromuscular re-education, transfer training, gait training, and postural control to improve safety and functional independence. The patient actively participates in therapy; however, progress is limited by persistent weakness, reduced endurance, and motor control deficits. The plan of care includes continuation of skilled physical therapy to address deficits in strength, balance, and mobility, with the goal of maximizing functional recovery, improving safety, and reducing caregiver burden. Ongoing education is provided to the patient and caregivers regarding safe transfer techniques, fall prevention strategies, and proper use of assistive devices. Given her current functional limitations, need for assistance, and high fall risk, the patient is considered homebound and requires continued multidisciplinary support to maintain safety and optimize quality of life.
 Date of Order 03/23/2026 Orders Physician Face-to-Face Date: 03/10/2026 Clinical Condition Requiring Home Care per Certifying Physician: CVA with right hemiparesis, deconditioning due to Acute embolism and thrombosis of unspecified deep veins of lower extremity, bilateral 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 Khan, Sabuhi

SN Careplans

SN Goals

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 03/23/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Sabuhi Khan
4315 Chain Bridge Rd
Fairfax, VA 22030
PHONE: 7039345000 FAX: NPI: 1417019472

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 : 03/10/2026

27. Attending Physician's Signature and Date Signed **04/06/2026**: 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 (03/23/26-03/28/26) ,WK2: 1 (03/29/26-04/04/26) ,WK3: 1 (04/05/26-04/11/26) ,WK4: 1 (04/12/26-04/18/26)

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

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

HOSPITALIZATION RISKS: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 2. Unintentional weight loss of a total of 10 pounds or more in the past 12 months, 3. Multiple hospitalizations (2 or more) in the past 6 months, 4. Multiple emergency department visits (2 or more) in the past 6 months, 5. Decline in mental, emotional, or behavioral status in the past 3 months, 7. Currently taking 5 or more medications

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:Living Will

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, meal preparation, M1033 - Unintentional Weight Loss, M1400 - Dyspnea, M1620 - Bowel Incontinence, frequent urination, increased urine output, swelling of affected area, muscle weakness, limited endurance, limited range of motion, limited strength, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, balance deficit

PROCEDURES: cough/deep breathing exercises: Demonstrated understanding, home exercise program: Eval and treat by therapy, coordinate/arrange preparation of missing meals: Sister prepared

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, * strategies to increase caloric intake, related medication(s) purpose, schedule, * bowel incontinence management including dietary changes bowel training skin care, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, meal preparation is available to patient for all meals

PATIENT-STATED GOAL: I want to sleep in my bed

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

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/caregiver recalls
* strategies to increase caloric intake
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* bowel incontinence management including dietary changes
* bowel training
* skin care
* recalls related medication(s) purpose, schedule

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

meal preparation is available to patient for all meals

PT Careplans

PT WK2: 1 (03/29/26-04/04/26) ,WK3: 1 (04/05/26-04/11/26) ,WK4: 1 (04/12/26-04/18/26) ,WK5: 1 (04/19/26-04/25/26) ,WK6: 1 (04/26/26-05/02/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, Pain Interference with Therapy activities, Pain Effect on Sleep, GG0170G1 - Car Transfer, GG0170S1 - Wheel 150 feet, GG0170C1 - Lying to sitting/bed, GG0170B1 - Sit to Lying, GG0170A1 - Roll left & Right, GG0170F1 - Toilet Transfer, GG0170R1 - Wheel 50 ft w 2 Turns, GG0170I1 - Walk 10 Feet, GG0170E1 - Chair to Bed to Chair, 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

PROCEDURES: wheelchair training, transfers training

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, Roll left & Right - 06. Independent, Sit to Lying - 06. Independent, Lying to sitting/bed - 06. Independent, Chair to Bed to Chair - 04. Supervision or touching assistance, Sit to Stand - 04. Supervision or touching assistance, Toilet Transfer - 01. Dependent, Wheel 50 ft w 2 Turns - 06. Independent, Wheel 150 feet - 06. Independent, 1 - Step (curb) - 02. Substantial/maximal assistance, 12 Steps - 02. Substantial/maximal assistance, 4 Steps - 02. Substantial/maximal assistance, Car Transfer - 04. Supervision or touching assistance, Picking Up Object - 02. Substantial/maximal assistance, Walk 10 Feet - 02. Substantial/maximal assistance, Walk 10 ft on Uneven Surface - 02. Substantial/maximal assistance, Walk 150 Feet - 02. Substantial/maximal assistance, Walk 50 ft with 2 Turns - 02. Substantial/maximal assistance

PT Goals

PATIENT-STATED GOAL: Patient desire to perform STS independently

GOALS
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

Roll left & Right - 06. Independent

Sit to Lying - 06. Independent

Lying to sitting/bed - 06. Independent

Chair to Bed to Chair - 04. Supervision or touching assistance

Sit to Stand - 04. Supervision or touching assistance

Toilet Transfer - 01. Dependent

Wheel 50 ft w 2 Turns - 06. Independent

Wheel 150 feet - 06. Independent

1 - Step (curb) - 02. Substantial/maximal assistance

12 Steps - 02. Substantial/maximal assistance

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	03/23/2026

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12 Steps - 02. Substantial/maximal assistance

4 Steps - 02. Substantial/maximal assistance

Car Transfer - 04. Supervision or touching assistance

Picking Up Object - 02. Substantial/maximal assistance

Walk 10 Feet - 02. Substantial/maximal assistance

Walk 10 ft on Uneven Surface - 02. Substantial/maximal assistance

Walk 150 Feet - 02. Substantial/maximal assistance

Walk 50 ft with 2 Turns - 02. Substantial/maximal assistance

OT Careplans

OT WK1: 1 (03/23/26-03/28/26) ,WK2: 1 (03/29/26-04/04/26) ,WK3: 1 (04/05/26-04/11/26) ,WK4: 1 (04/12/26-04/18/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, Pain Interference with Therapy activities, Pain Interference with ADLs, GG0130B1 - Oral Hygiene, GG0130F1 - Upper 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, Toileting Hygiene - 03. Partial/moderate assistance, Shower/Bathe Self - 03. Partial/moderate assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Don/Doff Footwear - 01. Dependent, Eating - 05. Setup or clean-up assistance

OT Goals

PATIENT-STATED GOAL: I want to get stronger and and be able to dress myself;I want to get stronger and and be able to stand again

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

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

Shower/Bathe Self - 03. Partial/moderate assistance

Oral Hygiene - 05. Setup or clean-up assistance

Toileting Hygiene - 03. Partial/moderate assistance

Upper Body Dressing - 05. Setup or clean-up assistance

Don/Doff Footwear - 01. Dependent

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	03/23/2026