Home Health Certification and Plan of Care

Order ID: 1163/984

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
3GW3EP6GY75	04/01/2026	From: 04/01/2026 To: 05/30/2026	1350	497754

6. Patient's Name and Address
Ramona Sheftel
3344 Conquistador Court,
Annandale, VA 22003-
703-349-9983

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 04/06/1942 | 9.Sex Female

11. ICD	Principal Diagnosis	Date
E11.65	Type 2 diabetes mellitus with hyperglycemia	04/01/26

13. ICD	Other Pertinent Diagnoses	Date
D64.89	Other specified anemias	04/01/26
I10.	Essential (primary) hypertension	04/01/26
J43.9	Emphysema unspecified	04/01/26
R91.8	Other nonspecific abnormal finding of lung field	04/01/26
F03.90	Unsp dementia unsp severity without beh/psych/mood/anx	04/01/26
K59.00	Constipation unspecified	04/01/26
H35.30	Unspecified macular degeneration	04/01/26
H91.93	Unspecified hearing loss bilateral	04/01/26
F17.210	Nicotine dependence cigarettes uncomplicated	04/01/26
Z79.4	Long term (current) use of insulin	04/01/26
Z87.891	Personal history of nicotine dependence	04/01/26
Z91.81	History of falling	04/01/26

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

Lantus - Insulin Glargine Recombinant 100 UNIT/ML injection / Inject 8 units subcutaneous once every morning DM
Pericolace - Docusate Sodium 8.6-50 mg/tablet / Take 2 tablet mouth two times daily Constipation
Cozaar - Losartan Potassium 25 mg / 1 Tablet by mouth once a day HTN
Norvasc - Amlodipine Besylate 5 mg / 1 Tablet mouth once daily HTN
Miralax - Polyethylene Glycol 3350 17gm/scoopful 1 packet by mouth as necessary as needed for constipation

14. DME and Supplies:
reacher, cane, , hand held shower

15. Safety Measures:
standard precautions, medication safety, fall precautions, ambulates with assistance, activity supervision

16. Nutrition:
soft

17. Allergies:
no known allergies

18.A. Functional Limitations
Ambulation, Endurance

18.B. Activities Permitted
Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 4. Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium., ANXIETY: NA Patient nonresponsive, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 1. Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required!2. Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions, HISTORY OF DEPRESSION: No

20. Prognosis: good

22. A Rehabilitation Potential:
SELF-CARE: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities., 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
family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Type 2 diabetes mellitus with hyperglycemia, 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 83-year-old White female with a past medical history significant for chronic obstructive pulmonary disease (COPD), dementia, type 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-12 CE-FMS-diabetes">diabetes</mh> mellitus, and <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-6 CE-FMS-hypertension">hypertension</mh>. The patient was recently hospitalized following a fall in her home without reported injuries and was subsequently transferred to a rehabilitation facility before returning home. During the hospitalization, she was treated for acute metabolic encephalopathy, hyperglycemia, and hypercalcemia, which have since resolved. The patient currently resides alone in a multi-level townhouse and receives daily assistance from a private aide as well as support from her daughter, who assists with medication management, meal preparation, and general supervision. Private caregiver support is provided on Monday, Tuesday, Thursday, and Friday, while the patient's daughter assists on Wednesday and Sunday. Upon assessment, the patient was alert, awake, and oriented to person, though she demonstrated confusion consistent with her dementia diagnosis. She was noted to be easily redirected and remained pleasant and cooperative throughout the evaluation. The patient has significant sensory impairments including macular degeneration, deafness in the left ear, and poor hearing in the right ear, and she does not currently use hearing aids. The right eyelid was observed to be closed at rest but the patient was able to open it on command. Cognitive deficits include decreased command following, impaired safety awareness, and difficulty initiating tasks, requiring verbal cues for completion of activities. Respiratory assessment revealed posterior lung lobes clear to auscultation. Cardiovascular assessment showed no lower extremity edema. Abdominal examination revealed a soft, non-tender abdomen with active bowel sounds present in all four quadrants. The patient remains continent of both bowel and bladder. She reports hip pain, which is currently managed with satisfactory relief. Behavior during the visit was calm, cooperative, and appropriate. Functionally, the patient demonstrates significant decline from her prior baseline. Previously she was able to ambulate limited household distances using an assistive device; however, she has recently demonstrated reluctance to consistently use her assistive device and now presents with impaired balance, generalized weakness, and increased fall risk. The patient currently uses a cane for ambulation but requires frequent verbal cueing to ensure safe use. According to her daughter, the patient occasionally "furniture walks" throughout the home rather than using the cane. The patient remains independent with self-feeding when provided with setup assistance and demonstrates no fine motor deficits. However, she requires assistance with bathing and instrumental activities of daily living (IADLs). The patient also requires verbal cueing to initiate tasks and complete certain daily activities due to cognitive impairment. Occupational therapy evaluation identified decreased bilateral upper extremity strength and endurance, which further limits the patient's ability to safely perform daily activities. The patient currently has a shower chair and handheld shower hose installed in the bathroom. Additional safety recommendations were made, including the installation of grab bars to assist with shower transfers and reduce fall risk. Environmental safety concerns were also noted. The patient reportedly smokes cigarettes in the basement of the townhouse, and there are currently no smoke detectors or fire extinguishers present in the home. The patient's daughter reported plans to obtain and install these safety devices within the week while assisting the patient. The patient is considered homebound due to impaired cognition, significant fall risk, decreased strength and balance, need for assistance with mobility, and inability to safely ambulate community distances without considerable effort and supervision. Skilled physical therapy is indicated to address gait instability, transfer deficits, lower extremity weakness, impaired balance, and decreased safety awareness in order to reduce fall risk and improve functional mobility within the home environment. Occupational therapy will focus on therapeutic exercises to improve upper extremity strength and endurance, as well as training to maximize safety and independence with activities of daily living and functional transfers. Education was provided to the patient and caregiver regarding fall prevention strategies, proper use of assistive devices, home safety modifications, and the importance of supervision during mobility and activities of daily living. The patient's prognosis is

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 04/01/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Ngoc Ly
7306 Maple Pl
Annadale, VA 22003
PHONE: 7033335001 FAX: 17033335087 NPI: 1831345214

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 : 03/26/2026

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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considered fair given her cognitive impairment; however, she demonstrates potential for functional improvement with consistent skilled therapy interventions and caregiver support within the home setting.
 Date of Order 04/01/2026 Orders Physician Face-to-Face Date: 03/26/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN, PT, OT due to Type 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-12 CE-FMS-diabetes">diabetes</mh> mellitus with hyperglycemia 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 Ly, Ngoc

SN Careplans

SN WK1: 1 (04/01/26-04/04/26) ,WK2: 1 (04/05/26-04/11/26) ,WK3: 1 (04/12/26-04/18/26) ,WK4: 1 (04/19/26-04/25/26)

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, 5. Decline in mental, emotional, or behavioral status in the past 3 months, 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:Living Will

PROBLEMS IDENTIFIED ON ASSESSMENT: M1700 - Cognition, M1745 - Behavioral Issues, M2020 - Oral Med Management, meal preparation, M1033 - Unintentional Weight Loss, M1033 - Exhaustion, M1400 - Dyspnea, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, B0200 - Hearing Deficit

PROCEDURES: cough/deep breathing exercises: Demonstrated understanding, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion: Daughter involved, coordinate/arrange preparation of missing meals: Daughter managed, coordinate/arrange resources for vision-impaired: Daughter assist, coordinate/arrange home modifications for hearing impaired, i.e. alarms: Doesn't have hearing aid, has day time assistance

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, * how to keep home safe for patient with dementia coping strategies for the caregiver*, related medication(s) purpose, schedule, * management of mental health condition including joining a peer group maintaining regular contact with mental health professional avoiding known stressors controlling impulses, related medication(s) purpose, schedule, * strategies to increase caloric intake, related medication(s) purpose, schedule, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, * how to keep home safe for hearing-impaired including installing special fire-detector/CO2 alarms, 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

SN Goals

PATIENT-STATED GOAL: I don't want to go back to the rehabilitation

GOALS
patient/caregiver recalls
* how to keep home safe for patient with dementia
* coping strategies for the caregiver* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to keep home safe for hearing-impaired including installing special fire-detector/CO2 alarms
* 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/caregiver recalls
* management of mental health condition including joining a peer group
* maintaining regular contact with mental health professional
* avoiding known stressors
* controlling impulses
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* strategies to increase caloric intake
* 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

meal preparation is available to patient for all meals

PT Careplans

PT WK1: 1 (03/30/26-04/04/26)

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

PROCEDURES: gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven Surface - 06. Independent, 1 - Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent

PT Goals

PATIENT-STATED GOAL: Perform stair negotiation with reciprocal gait pattern with no incidents of falls

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	04/01/2026

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Walk 10 ft on Uneven Surface - 06. Independent

1 - Step (curb) - 06. Independent

4 Steps - 06. Independent

12 Steps - 06. Independent

Picking Up Object - 06. Independent

OT Careplans

OT WK1: 1 (03/30/26-04/04/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, GG0130A1 - Eating, GG0130B1 - Oral Hygiene, GG0130F1 - Upper Body Dressing, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene

PROCEDURES: equipment training, work simplification/energy conservation, transfers training

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, Sit to Stand - 05. Setup or clean-up assistance, Chair to Bed to Chair - 05. Setup or clean-up assistance, Toilet Transfer - 06. Independent, Oral Hygiene - 05. Setup or clean-up assistance, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 03. Partial/moderate assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: I want to get stronger and get back to feeling like myself and be safer with bathing

GOALS
Toilet Transfer - 06. Independent

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

Sit to Stand - 05. Setup or clean-up assistance

Chair to Bed to Chair - 05. Setup or clean-up assistance

Oral Hygiene - 05. Setup or clean-up assistance

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 03. Partial/moderate assistance

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
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