Home Health Certification and Plan of Care

Order ID: 1163/1238

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
56355899	06/26/2026	From: 08/25/2026 To: 10/23/2026	1676	497754

6. Patient's Name and Address
Patricia Olson
14055 Central Loop Apt 418,
WOODBRIDGE, VA 22193-
908-309-4680

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 10/15/1951 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
G89.29	Other chronic pain	06/26/26

13. ICD	Other Pertinent Diagnoses	Date
M54.2	Cervicalgia (M54.2)	06/26/26
M25.511	Pain in right shoulder	06/26/26
M25.512	Pain in left shoulder	06/26/26
M54.42	Lumbago with sciatica left side	06/26/26
G62.9	Polyneuropathy unspecified	06/26/26
R13.10	Dysphagia unspecified	06/26/26
I10.	Essential (primary) hypertension	06/26/26
E03.9	Hypothyroidism unspecified	06/26/26
J44.89	Other specified chronic obstructive pulmonary disease	06/26/26
F41.9	Anxiety disorder unspecified	06/26/26
F32.A	Depression unspecified	06/26/26
H54.8	Legal blindness as defined in USA	06/26/26
H35.30	Unspecified macular degeneration	06/26/26
K21.9	Gastro-esophageal reflux disease without esophagitis	06/26/26
K76.0	Fatty (change of) liver not elsewhere classified	06/26/26
G56.00	Carpal tunnel syndrome unspecified upper limb	06/26/26
M19.90	Unspecified osteoarthritis unspecified site	06/26/26
M48.00	Spinal stenosis site unspecified	06/26/26
M47.9	Spondylosis unspecified	06/26/26
G25.81	Restless legs syndrome	06/26/26
M10.9	Gout unspecified	06/26/26
K43.2	Incisional hernia without obstruction or gangrene	06/26/26
K57.90	Dvrtclos of intest part unsp w/o perf or abscess w/o bleed	06/26/26
R21.	Rash and other nonspecific skin eruption	06/26/26
R32.	Unspecified urinary incontinence	06/26/26
E66.9	Obesity unspecified	06/26/26
Z68.42	Body mass index [BMI] 45.0-49.9 adult	06/26/26
Z79.890	Hormone replacement therapy	06/26/26
Z79.891	Long term (current) use of opiate analgesic	06/26/26

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

ACYCLOVIR 400 mg 1 tablet by mouth every 6 hours Rash as needed
ALLOPURINOL 100 mg 1 tablet by mouth once a day Gout
Simvastatin - Simvastatin 20 mg 1 tablet by mouth at bedtime HLD
Bupropion Hydrochloride - Bupropion Hydrochloride 300 mg 1 tablet by mouth once a day Depression
Duloxetine Hydrochloride - Duloxetine Hydrochloride 20 mg 2 tablets by mouth twice a day Depression
Lisinopril - Lisinopril 20 mg 1 tablet by mouth once a day HTN
Montelukast Sodium - Montelukast Sodium 10 mg 1 tablet by mouth once a day Allergic
ONDANSETRON 4 mg 1 Tablet Oral twice a day Nausea or Vomiting
Pantoprazole - Pantoprazole Sodium 20 mg 1 tablet by mouth once a day Gerd
LEVOTHYROXINE 112 MIcrograms by mouth in the morning Hypothyroidism
Oxybutynin - Oxybutynin 10 miligram by mouth once a day Overactive bladder

14. DME and Supplies:
reacher, commode, 4 wheeled walker, , walker, hand held shower, grab bars, cane, bath bench

15. Safety Measures:
standard precautions, fall precautions

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
oxycodone

18.A. Functional Limitations
Legally Blind

18.B. Activities Permitted
No Restrictions

19. Mental & Pyschosocial Status: COGNITION: 0. Able to get to and from the toilet and transfer independently with or without a device., ANXIETY: , SOCIAL ISOLATION: 1 Requires assistance, BEHAVIORAL ISSUES: 2 independent, HISTORY OF DEPRESSION:

20. Prognosis: good

22. A Rehabilitation Potential:
SELF-CARE: Intact , MOBILITY: NA

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

Homebound status:
Due to diagnosis of Other chronic pain, 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

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 08/21/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Stuart Hopkins
14139 Potomac Mills Road
Woodbridge, VA 22192
PHONE: 7034908400 FAX: 17034907635 NPI: 1962569996

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 : 06/18/2026

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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Clinical Condition Requiring Homecare:

Patient demonstrates slow but steady progress with improved left upper-extremity (LUE) active range of motion (AROM), currently achieving 0-110 degrees of shoulder flexion. Patient is modified independent with activities of daily living (ADLs), functional tasks, and transfers and lives alone. Patient's daughter, Kelly, provides assistance with instrumental activities of daily living (IADLs), medical appointments, grocery shopping, and other needs. Continued skilled occupational therapy services are recommended to further improve LUE AROM and overall strength to facilitate greater ease and safety with daily ADL tasks. Patient demonstrates good rehabilitation potential and motivation to continue with skilled OT services. <o:p></o:p>   Date of Order<o:p></o:p> 08/21/2026
Order<o:p></o:p> Physician Face-to-Face Date: 06/18/2026<o:p></o:p> Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's dx: Other chronic pain<o:p></o:p> Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home<o:p></o:p>
4 - Recertification OT Notes: to to further improve LUE AROM and overall strength to facilitate greater ease and safety with daily ADL tasks<o:p></o:p> Physician: Hopkins, Stuart

SN Careplans

SN Goals

OT Careplans

OT WK2: 1 (08/30/26-09/05/26) ,WK3: 1 (09/06/26-09/12/26) ,WK4: 1 (09/13/26-09/19/26)

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:

HOSPITALIZATION RISKS: 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

OT Goals

PATIENT-STATED GOAL: I want to continue to improve my balance and UB strength and AROM

GOALS
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

08/21/2026

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alignment, ROM, meditation, massage, Medications: Medication actions, uses, frequency, dose, interactions of all new/change meds
Advance Directive:No Advance Directive

08/21/2026 Problems : balance deficit
limited endurance
limited strength
limited range of motion

PROCEDURES: equipment training, work simplification/energy conservation

TEACH PATIENT/CAREGIVER: 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
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	08/21/2026