

Home Health Certification and Plan of Care				Order ID: 1163/247										
1. Patient's HI claim No. 01254115		2. Start Of Care Date 08/29/2025		3. Certification Period From: 08/29/2025 To: 10/27/2025		4. Medical Record No. 373		5. Provider No. 497754						
6. Patient's Name and Address Winifred Peterson 15951 Loves Mill Ln Apt 3203, GAINESVILLE, VA 20155- 571-636-1076					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 09/05/1949					9. Sex Female					10. Medications: Dose/Frequency/Route (N)ew (C)hanged There are no Medications for this Plan of Care				
11. ICD S82.61XD		Principal Diagnosis Disp fx of lateral malleolus of r fibula 7thD				Date 08/29/25		10. Medications: Dose/Frequency/Route (N)ew (C)hanged There are no Medications for this Plan of Care						
13. ICD I13.0		Other Pertinent Diagnoses Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny				Date 08/29/25								
I50.32		Chronic diastolic (congestive) heart failure				08/29/25								
E11.22		Type 2 diabetes mellitus w diabetic chronic kidney disease				08/29/25								
N18.32		Chronic kidney disease stage 3b				08/29/25								
D63.1		Anemia in chronic kidney disease				08/29/25								
E78.5		Hyperlipidemia unspecified				08/29/25								
J44.9		Chronic obstructive pulmonary disease unspecified				08/29/25								
J96.11		Chronic respiratory failure with hypoxia				08/29/25								
E11.3219		Type 2 diab with mild nonp rtnop with macular edema unsp				08/29/25								
G47.33		Obstructive sleep apnea (adult) (pediatric)				08/29/25								
E03.9		Hypothyroidism unspecified				08/29/25								
F41.1		Generalized anxiety disorder				08/29/25								
H35.3131		Nexdtve age-related mclr degn bilateral early dry stage				08/29/25								
F33.9		Major depressive disorder recurrent unspecified				08/29/25								
G47.00		Insomnia unspecified				08/29/25								
E66.01		Morbid (severe) obesity due to excess calories				08/29/25								
Z68.37		Body mass index [BMI] 37.0-37.9 adult				08/29/25								
Z79.84		Long term (current) use of oral hypoglycemic drugs				08/29/25								
Z86.0100		Personal history of colonic polyps				08/29/25								
Z91.81		History of falling				08/29/25								
14. DME and Supplies: cane, 4 wheeled walker, walker, grab bars, commode, wheelchair, rolling walker, diabetic supplies					15. Safety Measures: fall precautions, medical alert/lifeline, wheelchair precautions, standard precautions, no stair use, hand rails, cardiac precautions, bathroom safety, activity supervision									
16. Nutrition: low sodium, diabetic,					17. Allergies: pcn									
18.A. Functional Limitations Endurance, Dyspnea With Minimal Exertion, Ambulation					18.B. Activities Permitted Exercises Prescribed, Wheelchair									
19. Mental & Psychosocial Status: COGNITION: 2. Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility, ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 2. Sometimes, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes														
20. Prognosis: fair														
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 another facility/provider will be responsible for managing treatment family/caregiver will be responsible for managing treatment									
Homebound status:					Due to diagnosis of Displaced Fracture Of Lateral Malleolus Of Right Fibula, Subsequent Encounter For Closed Fracture With Routine Healing, 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 08/29/2025					25. Date HHA Received Signed POT									
24. Physician's Name and Address Farah Abdulsalam 1890 Metro Center Dr Reston, VA 20190 PHONE: 7037091500 FAX: NPI: 1417952367					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 : 09/04/2025									
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. PAGE 1 of 4									

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01254115	08/29/2025	From: 08/29/2025 To: 10/27/2025	373	497754
6. Patient's Name and Address Winifred Peterson 15951 Loves Mill Ln Apt 3203, GAINESVILLE, VA 20155- 571-636-1076			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	

Clinical Condition <div>The patient is a 75-year-old Caucasian female residing in an assisted living facility, where she is currently chairfast. She
Requiring Homecare:sustained a right ankle injury after falling out of bed, resulting in a closed displaced fracture of the lateral malleolus of the fibula. A closed reduction was performed,
and a cast was applied. Following a three-week stay in acute rehabilitation, she was discharged and has since returned to a temporary residential unit within the
assisted living wing of her senior living facility. Her past medical history is significant for hypertension, chronic kidney disease, congestive heart failure, type
2 diabetes mellitus with mild non-proliferative diabetic retinopathy and macular edema, anemia secondary to CKD, chronic respiratory failure with hypoxia, chronic
obstructive pulmonary disease, obstructive sleep apnea, insomnia, anxiety, and major depressive disorder. She also carries a history of hypoxemia requiring oxygen
support. At present, she uses supplemental oxygen at 2 L/min via nasal cannula, primarily at night, and reports not using it continuously during the day. On
assessment, the patient was alert and oriented 4. Vital signs were stable. She remained on oxygen support at 2 L/min with even, unlabored respirations and no
acute respiratory distress noted. Her right ankle cast was intact with no signs of drainage, skin breakdown, or compromise to circulation. No edema was observed in
the exposed areas, and pedal pulses were palpable. She continues to be chairfast and requires assistance with transfers and activities of daily living. On
Medication reconciliation was completed, and treatments were reviewed with the patient, who verbalized understanding. Education was provided regarding safe
oxygen use, cast care, skin integrity monitoring, and fall prevention strategies. The plan of care includes continued monitoring of her cardiopulmonary status,
diabetes management, cast site integrity, and oxygen use, as well as reinforcement of safety and fall prevention measures within her assisted living environment.
Ongoing interdisciplinary coordination with nursing, rehabilitation services, and facility caregivers will support the patient's recovery, optimize function, and prevent
complications.</div><div>Date of Order</div><div>Physician Face-to-Face Date:
09/04/2025</div><div>Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval
& treat ot-eval & treat due to Displaced Fracture Of Lateral Malleolus Of Right Fibula, Subsequent Encounter For Closed Fracture With Routine
Healing</div><div>Homebound Status per Certifying Physician: patient requires another person or medical equipment
such as crutches, a walker, or a wheelchair to leave home</div><div>white-space: pre; font-size: 14px; white-space: normal;">
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</div><div>1 - SOC - SN Notes:</div><div>OT Eval Notes:</div><div>PT Eval Notes:</div><div>Physician</div><div>Abdulsalam, Farah</div>

SN Careplans

SN WK1: 1 (08/29/25-08/30/25) ,WK2: 2 (08/31/25-09/06/25) ,WK3: 2 (09/07/25-09/13/25) ,WK4: 1 (09/14/25-09/20/25)

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 sugar < 60 > 300

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), 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:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M1700 - Cognition, D0160 - Depression, D0700 - Social Isolation, M2020 - Oral Med Management, M1400 - Dyspnea, weak pulses in feet, swelling in legs/around eyes, dependent edema, abnormal blood pressure, swelling in the arms/legs, abnormal BS < 70/140 > mg/dL, constipation, diarrhea, muscle weakness, swelling of affected area, limited strength, limited endurance, Pain Effect on Sleep, Pain Interference with ADLs, weak hand grips, daytime fatigue, Pain Interference with Therapy activities, obesity

PROCEDURES: cough/deep breathing exercises, incentive spirometer, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, glucose testing via monitor, monitor intake & output, home exercise program: na, coordinate/arrange long-term socialization activities

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage cardiac condition including symptom management diet changes regular exercise getting enough sleep, related medication(s) purpose, schedule, * how to take the patient's blood pressure record the reading, related medication(s) purpose, schedule, * 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 modification to manage blood condition including dietary changes bleeding precautions, 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, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, related medication(s) purpose, schedule, * how to manage sleep disorder including changes to daytime habits and bedtime routine maintaining a journal to track sleep patterns, related medication(s) purpose, schedule, * how to keep home safe for patient with dementia coping strategies for the caregiver, related medication(s) purpose, schedule, * how to incorporate lifestyle modifications to optimize renal condition including renal-specific diet exercise monitoring of blood pressure blood sugar home, related medication(s) purpose, schedule remedies, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpose, schedule, * diabetic medication management blood sugar testing diabetic foot care exercise diabetic diet, related medication(s) purpose, schedule, * pain control therapeutic exercises to optimize range of motion of affected area diet and fluids to promote healing, related medication(s) purpose, schedule, * how to keep journal of food and fluid intake healthy meal plan

SN Goals

PATIENT-STATED GOAL: I would like to be able to walk

GOALS
patient/caregiver recalls
* pain control
* therapeutic exercises to optimize range of motion of affected area
* diet and fluids to promote healing
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to take the patient's blood pressure
* record the reading
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* lifestyle modifications to manage cardiac condition including symptom management
* diet changes
* regular exercise
* getting enough sleep
* 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 incorporate lifestyle modifications to optimize renal condition including renal-specific diet
* exercise
* monitoring of blood pressure
* blood sugar
* home
* recalls related medication(s) purpose, schedule remedies

patient/caregiver recalls
* lifestyle modification to manage blood condition including dietary changes
* bleeding precautions
* 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 manage sleep disorder including changes to daytime habits and bedtime routine
* maintaining a journal to track sleep patterns
* recalls related medication(s) purpose, schedule

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	08/29/2025

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tips exercise program nutritional knowledge, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, * strategies to increase socialization, related medication(s) purpose, schedule	patient/caregiver recalls * prevention exacerbation of anxiety condition including coping patterns * improved concentration * strategies to reduce anxiety * identification of anxiety precipitants, conflicts, and threats * recalls related medication(s) purpose, schedule patient/caregiver recalls * depression-prevention strategies including avoidance of isolation * healthy eating * sleeping habits * identification of activities that bring pleasure * preventive care * recalls related medication(s) purpose, schedule patient/caregiver recalls * how to keep journal of food and fluid intake * healthy meal plan tips * exercise program * nutritional knowledge * 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 * how to keep home safe for patient with dementia * coping strategies for the caregiver * recalls related medication(s) purpose, schedule patient self-administers medications as prescribed * recalls related medication(s) purpose, schedule patient/caregiver recalls * strategies to increase socialization * recalls related medication(s) purpose, schedule
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PT Careplans PT WK3: 1 (09/07/25-09/13/25) ,WK4: 2 (09/14/25-09/20/25) ,WK5: 2 (09/21/25-09/27/25) ,WK6: 2 (09/28/25-10/04/25) 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 PROCEDURES: Medication Review: Medications reviewed with patient/caregiver. , cough/deep breathing exercises, home exercise program: seated, 2-3x/10 1-2x/day (unless otherwise notated): ankle IV/EV and HR/TR (in and outside of boot), ankle pumps 3x10, ankle ABC 1 set, LAQ, clams, hip add pillow squeezes, marches, SLR hip flex, standing tolerance exercises, gait training/stair training, transfers training, therapeutic exercises 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 - 04. Supervision or touching assistance, Chair to Bed to Chair - 04. Supervision or touching assistance, Toilet Transfer - 05. Setup or clean-up assistance, Car Transfer - 04. Supervision or touching assistance, Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Walk 150 Feet - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance, Medication Review	PT Goals PATIENT-STATED GOAL: To feel stronger in L foot/ankle/LE to be able to tol walk around home/between rooms with RW and boot with improved strength, endurance and tolerance for standing and walking. As well as be so to return to her indep wing of her senior community residence home.;To feel stronger in R foot/ankle/LE to be able to tol walk around home/between rooms with Rollator and boot with improved strength, endurance and tolerance for standing and walking. As well as be so to return to her indep wing of her senior community residence home. GOALS Sit to Stand - 04. Supervision or touching assistance 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 Chair to Bed to Chair - 04. Supervision or touching assistance Toilet Transfer - 05. Setup or clean-up assistance Car Transfer - 04. Supervision or touching assistance Walk 10 Feet - 04. Supervision or touching assistance Walk 50 ft with 2 Turns - 04. Supervision or touching assistance Walk 150 Feet - 04. Supervision or touching assistance Picking Up Object - 04. Supervision or touching assistance Medication Review
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OT Careplans	OT Goals
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Signature of Physician:	Date PAGE 3 of 4
Optional Name/Signature of Nurse/Therapist: Electronically Signed by Messick, Charles RN	Date 08/29/2025

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