Home Health Certification and Plan of Care

Order ID: 1163/517

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
01221770	11/19/2025	From: 11/19/2025 To: 01/17/2026	310	497754

6. Patient's Name and Address

Johnnie Moore
2145 S Pollard St,
ARLINGTON, VA 22204-
202-597-2605

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 02/14/1940 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
M17.0	Bilateral primary osteoarthritis of knee	11/19/25

13. ICD	Other Pertinent Diagnoses	Date
I10.	Essential (primary) hypertension	11/19/25
E78.5	Hyperlipidemia unspecified	11/19/25
E03.9	Hypothyroidism unspecified	11/19/25
Z79.82	Long term (current) use of aspirin	11/19/25
Z79.51	Long term (current) use of inhaled steroids	11/19/25
Z91.81	History of falling	11/19/25

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

Lipitor - Atorvastatin Calcium 20 mg, Take 1 tablet by mouth once a day Take 1 tablet by mouth daily for cholesterol and heart protection
Cozaar - Losartan Potassium 50 mg, Take 1 tablet by mouth twice a day
Norvasc - Amlodipine Besylate 10 mg, Take 1 tablet by mouth once a day
Tenoretic 100 - Atenolol: Chlorthalidone 100-25 mg, Take 1 tablet by mouth in the morning Take 1 tablet by mouth every morning
Levothyroxine (LEVOTHROID/SYNTHROID) 150 mcg Oral Tab 150 mcg, Take 1 tablet by mouth in the morning Take 1 tablet by mouth every morning 30 minutes before a meal
Fluticasone (FLONASE ALLERGY RELIEF) 50 mcg/actuation Nasl SpSn 50 mcg/actuation, Use 2 Sprays Nasal once a day Use 2 Sprays in each nostril daily
Tylenol - Acetaminophen 500 mg, Take 1 tablet by mouth every 6 hours Take 1 tablet by mouth every 6 hours as needed for pain

14. DME and Supplies:

grab bars, bath bench, walker, cane

15. Safety Measures:

walker precautions, ambulates with device, , bathroom safety

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

aspirin

18.A. Functional Limitations

Endurance, Ambulation

18.B. Activities Permitted

Cane, Walker, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 1. Rarely, 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
family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Bilateral Primary Osteoarthritis Of Knee, 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 11/19/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address

Donna Lee
201 North Washington Street
Falls Church, VA 22046
PHONE: 7032374000 FAX: 17035361400 NPI: 1750468344

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 : 10/14/2025

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.

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Clinical Condition Requiring Homecare:

The patient is an 85-year-old African American female residing alone in a multilevel townhouse, with her sister and niece serving as rotating caregivers who provide intermittent supervision and assistance. Upon <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>, the patient was alert and oriented to person, place, time, and situation, and she demonstrated no apparent visual or auditory deficits. The admission packet was reviewed in detail with the patient and caregivers, and paper consent was signed. The patient does not have a durable power of attorney or advance directives and is designated as Full Code. Her medical history is significant for generalized muscle weakness and atrophy, hypertension, hyperlipidemia, hypothyroidism, osteoarthritis, dysphagia, cognitive deficit, and a recent hospitalization related to hypertension, hyperlipidemia, diarrhea, and generalized weakness. During that hospitalization, she received intravenous fluids and medication adjustments. Currently, vital signs are stable. Respiratory <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh> reveals clear bilateral breath sounds on auscultation. Cardiovascular and peripheral <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>s show warm, dry skin with pink mucous membranes; the lower extremities demonstrate chronic discoloration and firmness without edema. The abdomen is soft and non-tender with active bowel sounds in all quadrants. Medication reconciliation was completed with the patient and caregivers, and she was counseled to take medications as scheduled and to avoid delaying doses. Functionally, the patient ambulates indoors and outdoors with either a rolling walker or rollator and uses a stair lift to navigate between floors. She requires intermittent physical assistance for basic activities of daily living, including grooming, dressing, bathing, toileting, and assistance with oral medication management and meal preparation. Although she lives alone, her niece <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-1 CE-FMS-visits">visits</mh> frequently; however, the patient remains in need of formal home health aide support to ensure consistent assistance with daily tasks. The home environment was noted to be cluttered, and the patient and her niece were educated on removing wall and floor obstructions to improve safety and maintain a clear walking path; both verbalized understanding. Recommendations included obtaining a walker tray to facilitate safe transport of items and considering a life alert system for emergency needs. A physical therapy evaluation was completed, and skilled PT services were recommended to improve lower-extremity strength, endurance, standing tolerance, ambulation, and overall functional mobility. The patient participated in the initiation of a home exercise program, demonstrating adequate comprehension and agreement with the plan. Training was provided on safe mobility, transfers, and use of assistive devices. Given her current level of weakness, fall history, and need for support with activities of daily living, initiation of home health aide services once weekly for assistance with instrumental ADLs was recommended.
 Date of Order 11/19/2025 Orders Physician Face-to-Face Date: 10/14/2025 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Bilateral Primary Osteoarthritis Of Knee 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 Lee, Donna

SN Careplans

SN WK1: 1 (11/19/25-11/22/25) ,WK3: 1 (11/30/25-12/06/25) ,WK4: 1 (12/07/25-12/13/25) ,WK5: 1 (12/14/25-12/20/25) ,WK6: 1 (12/21/25-12/27/25) ,WK7: 1 (12/28/25-01/03/26) ,WK8: 1 (01/04/26-01/10/26)

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: 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: M2020 - Oral Med Management, Home Safety, M1400 - Dyspnea, abnormal blood pressure, abnormal thyroid <> 0.40 - 4.50 mIU/mL, limited endurance, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, bruising/discoloration

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , cough/deep breathing exercises, incentive spirometer, coordinate/arrange for maintenance of clean/uncluttered living area

TEACH PATIENT/CAREGIVER: * 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, * 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, * prescribed dietary modifications monitoring intake and output monitoring weight loss or weight gain monitor changes in neurological status, related medication(s) purpose, schedule, * how to manage inflammatory process optimize mobility with active and passive range of motion exercises fluid and diet intake to promote healing prevent constipation home safety, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient's living environment is clean/uncluttered

SN Goals

PATIENT-STATED GOAL: To be able to walk without falling

GOALS
patient/caregiver recalls
* how to manage inflammatory process
* optimize mobility with active and passive range of motion exercises
* fluid and diet intake to promote healing
* prevent constipation
* home safety
* 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
* prescribed dietary modifications
* monitoring intake and output
* monitoring weight loss or weight gain
* monitor changes in neurological status
* 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 self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

patient's living environment is clean/uncluttered

PT Careplans

PT Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

11/19/2025

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PT WK1: 1 (11/19/25-11/22/25) ,WK2: 1 (11/23/25-11/29/25) ,WK3: 2 (11/30/25-12/06/25) ,WK4: 2 (12/07/25-12/13/25) ,WK5: 1 (12/14/25-12/20/25) ,WK6: 2 (12/21/25-12/27/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, 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. , home exercise program: Seated therex BLE, 1-2x10, 1-2x/daily: sit to stands, marches, LAQ, clams, hip add with pillow squeezes x3-5 sec holds, HR/TR, 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, * 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, 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

PATIENT-STATED GOAL: To feel stronger and better balanced in BLE to be able to sit/stand with ease and to tol walk around home/between rooms with improved strength, endurance and tolerance for standing and walking.

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

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

OT Careplans

OT WK1: 1 (11/19/25-11/22/25) ,WK3: 2 (11/30/25-12/06/25) ,WK4: 2 (12/07/25-12/13/25) ,WK5: 2 (12/14/25-12/20/25) ,WK6: 1 (12/21/25-12/27/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, M1400 - Dyspnea, 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: 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 - 06. Independent, Lower Body Dressing - 06. Independent, Shower/Bathe Self - 05. Setup or clean-up assistance, Toileting Hygiene - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 05. Setup or clean-up assistance

OT Goals

PATIENT-STATED GOAL: I want to get better with getting in/out of bed and the tub

GOALS
Shower/Bathe Self - 05. Setup or clean-up 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

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

Oral Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Toileting Hygiene - 06. Independent

Don/Doff Footwear - 06. Independent

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	11/19/2025