Home Health Certification and Plan of Care

Order ID: 1163/677

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
611018653	12/26/2025	From: 12/26/2025 To: 02/23/2026	772	497754

6. Patient's Name and Address

John Sullivan
1382 Northgate Square,
Reston, VA 20190-
703-437-1568

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 08/16/1939 | 9.Sex Male

11. ICD	Principal Diagnosis	Date
S01.81XD	Laceration w/o foreign body of oth part of head subs encntr	12/26/25

13. ICD	Other Pertinent Diagnoses	Date
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	12/26/25
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	12/26/25
N18.4	Chronic kidney disease stage 4 (severe)	12/26/25
D63.1	Anemia in chronic kidney disease	12/26/25
N25.81	Secondary hyperparathyroidism of renal origin	12/26/25
B02.9	Zoster without complications	12/26/25
M17.0	Bilateral primary osteoarthritis of knee	12/26/25
M10.9	Gout unspecified	12/26/25
M62.59	Muscle wasting and atrophy NEC multiple sites	12/26/25
E78.5	Hyperlipidemia unspecified	12/26/25
R63.0	Anorexia	12/26/25
Z79.84	Long term (current) use of oral hypoglycemic drugs	12/26/25
Z85.828	Personal history of other malignant neoplasm of skin	12/26/25
Z86.718	Personal history of other venous thrombosis and embolism	12/26/25
Z91.81	History of falling	12/26/25

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

Norvasc - Amlodipine Besylate 5 mg, Take 1 tablet by mouth once a day
Mevacor - Lovastatin 20 mg , Take 1 tablet by mouth in the evening Take 1 tablet by mouth every evening with food
Glucotrol - Glipizide 5 mg 5 mg, Take 1 tablet by mouth twice a day Take 1 tablet by mouth 2 times a day 30 minutes before meals
Baros - Sodium Bicarbonate: Tartaric Acid 650 mg , Take 1 tablet by mouth twice a day Take 1 tablet by mouth 2 times a day
Zyloprim - Allopurinol 100 mg, Take half tablet by mouth every other day Take half tablet by mouth every other day
Diclofenac Sodium - Diclofenac Sodium 1 % Top Gel, Apply 2 g to affected area(s) topical twice a day Apply 2 g to affected area(s) 2 times a day (Patient not taking: Reported on 8/26/2025)
Ferrous Sulfate - Ferrous Sulfate: Folic Acid 325 mg (65 mg iron) , Take as directed by mouth as necessary Take as directed for anemia.
Biotin - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 50 mcg (2,000 unit), Take 2,000 Units by mouth twice a day Take 2,000 Units by mouth 2 times a day
Colace - Docusate Sodium 100 mg, 1 tablet by mouth as necessary daily as needed for constipation
Garlique 1 tablet by mouth once a day supplement for blood pressure control
PreserVision Areds 2 2 soft gels by mouth once a day with food for eye health
Humulin N - Insulin Susp Isophane Recombinant Human 100 units/ml 5 units subcutaneous once a day for blood sugar control
Tylenol W/ Codeine No. 3 - Acetaminophen: Codeine Phosphate 300 mg;30 mg 1 tablet by mouth as necessary every 6 hours as needed for pain
Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1 tablet by mouth once a day as a supplement

14. DME and Supplies:

walker, diabetic supplies

15. Safety Measures:

walker precautions, medication safety, fall precautions, diabetic precautions, bleeding precautions, ambulates with device, sharps precautions, standard precautions, cardiac precautions, anticoagulant precautions

16. Nutrition:

diabetic, renal diet

17. Allergies:

no known allergies

18.A. Functional Limitations

Endurance, Dyspnea With Minimal Exertion, Ambulation

18.B. Activities Permitted

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: 0. Never, 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

patient will be responsible for managing treatment
patient will be responsible for managing treatment
patient will be responsible for managing treatment

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 12/26/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address

Jonathan Menezes
1890 Metro Center Dr
Reston, VA 20190
PHONE: 7037091500 FAX: NPI: 1023329802

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 : 12/21/2025

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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John Sullivan 1382 Northgate Square, Reston, VA 20190- 703-437-1568	Grace Home Healthcare, LLC 9735 Main Street Suite 200 Fairfax, Fairfax, VA 22031-3736 703-865-7370 1073904009

Homebound status: Due to diagnosis of Laceration Without Foreign Body Of Other Part Of Head, Subsequent Encounter, 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 86-year-old male admitted to home health services for skilled nursing and physical therapy following discharge from an inpatient rehabilitation stay after hospitalization related to a fall with resulting impaired mobility. The patient is alert and oriented 4, hard of hearing, and wears prescription glasses. He lives alone in an attached multi-level home and is currently unable to drive, limiting his ability to attend medical appointments and complete errands independently. Since this hospitalization, the patient has obtained additional assistance from friends, neighbors, and his girlfriend, Chi Hao, who provides intermittent support, including help with grocery shopping and transportation to medical appointments. At the time of admission, the patient reported no acute complaints; however, during the therapy evaluation he endorsed right hip pain rated at 6/10 related to the recent fall. A comprehensive head-to-toe nursing assessment revealed skin that was clean, dry, and intact. Vital observations were stable, and no immediate nursing concerns were identified. The admission booklet was reviewed with the patient, and medication reconciliation was completed without discrepancies or issues. The patient is independent with management of oral medications and meal preparation. Past medical history is significant for chronic kidney disease stage 4, hypertension, type II diabetes mellitus with chronic kidney disease and long-term use of oral hypoglycemic agents, hyperparathyroidism, anemia, hyperlipidemia, osteoarthritis (notably bilateral knees), gout, anorexia, muscle weakness, and a history of falls. The physical therapy evaluation was completed and identified deficits in strength, endurance, balance, tolerance for standing and ambulation, and overall functional mobility following the fall. Despite these impairments, the patient remains independent with basic activities of daily living, including grooming, dressing, bathing, toileting, and self-care tasks. He ambulates independently indoors without an assistive device and ambulates outdoors with the use of a cane or rolling walker. Current durable medical equipment in the home includes a front-wheeled walker, quad cane, and single-point cane. Education was provided regarding safe home setup, fall prevention strategies, and safe mobility within the home, with specific instruction on bathroom safety. Recommendations were made for the use of a shower chair and tub clamp to reduce fall risk during bathing. Gait training with the cane was initiated, and a home exercise program was started during this session, focusing on seated and standing therapeutic exercises for bilateral lower extremities. The patient was able to demonstrate the exercises and verbalized understanding and agreement with the plan. The patient would benefit from continued skilled physical therapy services to address decreased strength, endurance, balance, and functional mobility, improve tolerance for standing and ambulation, enhance safety, and increase independence with mobility tasks in order to return to his prior level of function. Skilled nursing will continue to monitor the patient's medical status, medications, and safety in the home, reinforce education, and coordinate care as needed.
 Date of Order 12/26/2025 Orders Physician Face-to-Face Date: 12/21/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN disease management, PTeval and treat, OT eval and treat due to Laceration Without Foreign Body Of Other Part Of Head, Subsequent Encounter 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 Menezes, Jonathan

SN Careplans

SN WK1: 1 (12/26/25-12/27/25) ,WK3: 1 (01/04/26-01/10/26) ,WK4: 1 (01/11/26-01/17/26)

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: 4. Assistance needed, but no non-agency caregiver(s) available

HOSPITALIZATION RISKS: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 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:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, D0700 - Social Isolation, M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2102c - Med Admin, meal preparation, A1250 - Lack of Necessary Transportation, M2020 - Oral Med Management, swelling in the arms/legs, M1033 - Exhaustion, M1400 - Dyspnea, abn cholesterol > 200 mg/dL, abnormal blood pressure, abnormal BS < 70/140 > mg/dL, nausea/vomiting, heartburn/indigestion, poor muscle tone, limited strength, limited endurance, limited range of motion, muscle weakness, weak hand grips, balance deficit, bruising/discoloration

PROCEDURES: cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, glucose testing via monitor, home exercise program, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange long-term socialization activities, coordinate/arrange transportation services

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 medicatio, * lifestyle modifications to manage peripheral vascular condition including how to apply compression stockings physical exercise plan diet, related medication(s) purpose, schedule, * lifestyle modification to manage blood condition including dietary changes bleeding precautions, related medication(s) purpose, schedule, * low cholesterol dietary guidelines, 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, sch, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpos, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, * diabetic medication management blood sugar testing diabetic foot care

SN Goals

PATIENT-STATED GOAL: "I want to be able to go to church"

GOALS
patient/caregiver recalls
* how to achieve wound healing including cleaning and dressing wound
* position changes
* skin care
* diet modification
* record wound measurements
* 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
* 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, sch

patient/caregiver recalls
* lifestyle modification to manage blood condition including dietary changes
* bleeding precautions
* recalls related medication(s) purpose, schedule

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 medic

patient/caregiver recalls
* pain control
* therapeutic exercises for muscle strengthening and flexibility
* diet and fluids to optimize and prevent constipation

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	12/26/2025

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exercise diabetic diet, related medication(s) purpose, schedule, * how to minimize chemotherapy and radiation side-effects including management of nausea or vomiting diarrhea appetite loss hair loss fatigue insomnia, related medication(s) purpose, sched, * dietary guidelines for managing nutritional deficit, 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 medic, * pain control therapeutic exercises for muscle strengthening and flexibility diet and fluids to optimize and prevent constipation, related medication(s) purpose, schedule, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, 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's transportation needs are met, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* low cholesterol dietary guidelines
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* dietary guidelines for managing nutritional deficit
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to minimize chemotherapy and radiation side-effects including management of nausea or vomiting
* diarrhea
* appetite loss
* hair loss
* fatigue
* insomnia
* recalls related medication(s) purpose, sched

patient/caregiver recalls
* lifestyle modifications to manage peripheral vascular condition including how to apply compression stockings
* physical exercise plan
* diet
* 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 medicatio

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) purpos

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

patient/caregiver recalls
* strategies to increase socialization
* recalls related medication(s) purpose, schedule

patient's transportation needs are met

patient is adequately supervised

meal preparation is available to patient for all meals

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT WK2: 1 (12/28/25-01/03/26) ,WK3: 1 (01/04/26-01/10/26) ,WK4: 2 (01/11/26-01/17/26) ,WK5: 2 (01/18/26-01/24/26) ,WK6: 2 (01/25/26-01/31/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 Dyspnea, GG0170F1 - Toilet Transfer - 06. Independent, GG0170D1 - Sit to Stand - 06. Independent, GG0170E1 - Chair to Bed to Chair - 06. Independent, GG0170G1 - Car Transfer - 06. Independent, GG0170I1 - Walk 10 Feet - 05. Setup or clean-up assistance, GG0170J1 - Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance, GG0170K1 - Walk 150 Feet - 05. Setup or clean-up assistance, GG0170L1 - Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance, GG0170M1 - 1 - Step (curb) - 05. Setup or clean-up assistance, GG0170N1 - 4 Steps - 05. Setup or clean-up assistance, GG0170O1 - 12 Steps - 05. Setup or clean-up assistance, GG0170P1 - Picking Up Object - 05. Setup or clean-up assistance

PROCEDURES: Medication Review: Medications reviewed with patient/caregiver., home

PT Goals

PATIENT-STATED GOAL: To feel stronger in BLE to tol walk around home/between rooms and with improved strength, endurance, tolerance for and pain-free during standing and walking.

GOALS
Toilet Transfer - 06. Independent

1 - Step (curb) - 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

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
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exercise program: Seated/Standing therex BLE, 1-2x10, 1-2x/daily with tb where applicable: sit to stands, marches, LAQ, clams, hip add with pillow squeezes x3-5 sec holds, HR/TR, strengthening exercises, static standing balance exercises, gait training/stair training, 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 medicatio, Sit to Stand - 06. Independent, Sit to Stand - 05. Setup or clean-up assistance, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 05. Setup or clean-up assistance, Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance, Walk 150 Feet - 05. Setup or clean-up assistance, 1 - Step (curb) - 05. Setup or clean-up assistance, 4 Steps - 05. Setup or clean-up assistance, 12 Steps - 05. Setup or clean-up assistance, Picking Up Object - 05. Setup or clean-up assistance

* recalls related medicatio

Sit to Stand - 06. Independent

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

Car Transfer - 06. Independent

Walk 10 Feet - 05. Setup or clean-up assistance

Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance

Walk 150 Feet - 05. Setup or clean-up assistance

4 Steps - 05. Setup or clean-up assistance

12 Steps - 05. Setup or clean-up assistance

Picking Up Object - 05. Setup or clean-up assistance

OT Careplans

OT WK2: 1 (12/28/25-01/03/26) ,WK3: 1 (01/04/26-01/10/26) ,WK4: 1 (01/11/26-01/17/26) ,WK5: 1 (01/18/26-01/24/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, GG0130B1 - Oral Hygiene - 06. Independent, GG0130F1 - Upper Body Dressing - 06. Independent, GG0130G1 - Lower Body Dressing - 06. Independent, GG0130H1 - Don/Doff Footwear - 06. Independent, GG0130E1 - Shower/Bathe Self - 06. Independent, GG0130C1 - Toileting Hygiene - 06. Independent, GG0130A1 - Eating - 06. Independent

PROCEDURES: cough/deep breathing exercises, incentive spirometer, 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 medicatio, 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

OT Goals

PATIENT-STATED GOAL: I want to be safer with stepping in/out of the tub

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 medicatio

Shower/Bathe Self - 06. Independent

Oral Hygiene - 06. Independent

Toileting Hygiene - 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 4 of 4
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