Home Health Certification and Plan of Care

Order ID: 1163/688

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
05107654500	01/07/2026	From: 01/07/2026 To: 03/07/2026	828	497754

6. Patient's Name and Address

Lawrence Perkins
8804 Newington Commons Rd,
LORTON, VA 22079-
571-835-0244

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 07/09/1976 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
S76.112D	Strain of left quadriceps muscle fascia and tendon subs	01/07/26

13. ICD	Other Pertinent Diagnoses	Date
S86.811D	Strain of musc/tend at lower leg level right leg subs	01/07/26
M66.261	Spontaneous rupture of extensor tendons right lower leg	01/07/26
I10.	Essential (primary) hypertension	01/07/26
D64.9	Anemia unspecified	01/07/26
G47.00	Insomnia unspecified	01/07/26
R73.03	Prediabetes	01/07/26
R34.	Anuria and oliguria	01/07/26
Z79.82	Long term (current) use of aspirin	01/07/26

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

Cyclobenzaprine - Cyclobenzaprine Hydrochloride 10 mg 1 table by mouth at bedtime Muscle spasms
Lopressor - Metoprolol Tartrate 50 mg 1 tab by mouth twice a day HTN
Acetaminophen - Acetaminophen 325 mg 2 tables by mouth every 6 hours Mild pain PRN
Aspirin - Aspirin 325 mg 1 tab by mouth once a day Prophylactic

14. DME and Supplies:

rolling walker, long leg brace

15. Safety Measures:

walker precautions, , non-slip surface in tub, , knee precautions, , bathroom safety, activity supervision, ambulates with device

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

no known allergies

18.A. Functional Limitations

Ambulation, Endurance

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: 0. Never, 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 Strain Of Left Quadriceps Muscle, Fascia And Tendon, 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 a 49-year-old African American male admitted to home health services following a hospitalization and subsequent rehabilitation after sustaining injuries from a fall while ice skating in November 2025. His injuries include left quadriceps tendon rupture and right patellar tendon rupture, status post surgical repair on 11/15/25. His past medical history is significant for anemia, diabetes mellitus/pre-diabetes, hypertension, insomnia, and long-term use of aspirin. He resides in a townhouse with his wife and family. Prior to this incident, the patient was independent with all activities of daily living and functional mobility. On <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>, the patient was alert, awake, and fully oriented to person, place, time, and situation. Neurological <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh> was unremarkable, with positive facial symmetry, equal and strong bilateral hand grasps, and pupils equal and reactive to light. The patient wears glasses and denies hearing impairment. He reports a tingling sensation in both feet since the bilateral knee surgeries. Respiratory <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh> revealed clear posterior lung fields to auscultation without use of accessory muscles. Cardiovascular <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh> noted bilateral lower extremity edema with faint peripheral pulses; the patient was encouraged to elevate his legs. Blood pressure was noted to be elevated at 156/92 mmHg; the patient denied headache, dizziness, or lightheadedness and was instructed to monitor blood pressure and report elevated readings to the nurse or physician. The patient is continent of bowel and bladder. He reports knee pain rated at 2-3/10, with some relief obtained through the use of acetaminophen. Both lower extremities are supported with hinged knee braces, currently set at 70 degrees of flexion per the surgeon's protocol. The patient ambulates using a front-wheeled walker. He reports concern regarding a left lower extremity incision; <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh> revealed a small healing scab measuring approximately 0.2 cm x 0.2 cm with no depth, drainage, or odor, indicating appropriate healing. Influenza vaccination was offered and refused. Pneumococcal vaccination is not indicated due to the patient's age. A physical therapy evaluation was completed, noting that the patient is currently eight weeks post-operative as of 1/10/26. Per surgical protocol, brace flexion is increased by 10 degrees every other week through weeks 8-12 post-operatively, with a follow-up appointment with the surgeon scheduled for 1/28/26. The patient demonstrates decreased functional strength, mobility, gait, and balance. He is able to perform straight leg raises in supine and seated positions and reports no current postoperative pain. He primarily sleeps in a supine position but is able to alternate to side-lying. Although he can lie in bed without braces, he reapplies them for sleep and typically sets them at neutral (0 degrees) to reduce stress on the quadriceps tendons and patellae. Stair negotiation is performed using a step-to pattern, ascending with left upper extremity rail support and descending backward with rail support; his son provides guarding during stair descent for safety. At this time, the patient is moderately independent with activities of daily living but requires intermittent assistance from his wife or son. Education was provided regarding safe home setup, mobility strategies, and use of adaptive durable medical equipment, including a tub clamp and shower chair to enhance safety during bathing and bathroom activities. A home exercise program was initiated within surgical protocol parameters, including active and active-assisted range of motion for knee flexion and extension, bilateral lower extremity therapeutic exercises, and the use of icing and compression for swelling and inflammation management. The patient demonstrated and verbalized understanding of the education and exercises provided. The plan of care includes continued skilled physical therapy to improve strength, mobility, gait, balance, and overall safety, with the goal of returning the patient to his prior level of function.
 Date of Order 01/07/2026 Orders Physician Face-to-Face Date: 12/01/2025 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Strain Of Left Quadriceps Muscle, Fascia And Tendon, 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 OT Eval Notes: PT Eval Notes:
 Physician Brooks, Bonnie

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 01/07/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Bonnie Brooks
9500 Richmond Highway
Lortan, VA 22079
PHONE: 5718008915 FAX: 18339545512 NPI: 1104892876

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 : 12/01/2025

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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SN Careplans

SN WK1: 1 (01/07/26-01/10/26) ,WK2: 1 (01/11/26-01/17/26) ,WK3: 1 (01/18/26-01/24/26) ,WK4: 1 (01/25/26-01/31/26)

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, meal preparation, M1400 - Dyspnea, swelling of affected area, muscle weakness, limited endurance, limited range of motion, limited strength, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, balance deficit

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , cough/deep breathing exercises, incentive spirometer, coordinate/arrange preparation of missing meals

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, * 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 relaxatio, * how to optimize joint mobility with active and passive range of motion exercises fluid and diet intake to promote healing prevent constipation home safety pain control, related medication(s) , * pain control therapeutic exercises to optimize range of motion of affected area diet and fluids to promote healing, 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 want to be able to walk independently

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

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 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 relaxatio

patient/caregiver recalls
* how to optimize joint mobility with active and passive range of motion exercises
* fluid and diet intake to promote healing
* prevent constipation
* home safety
* pain control
* recalls related medication(s)

patient self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

meal preparation is available to patient for all meals

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

PT Careplans

PT WK1: 1 (01/07/26-01/10/26) ,WK2: 1 (01/11/26-01/17/26) ,WK4: 1 (01/25/26-01/31/26) ,WK5: 2 (02/01/26-02/07/26) ,WK6: 2 (02/08/26-02/14/26) ,WK7: 2 (02/15/26-02/21/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with Therapy activities, Pain Interference with ADLs, Pain Effect on Sleep, GG0170J1 - Walk 50 ft with 2 Turns, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170L1 - Walk 10 ft on Uneven Surface, GG0170K1 - Walk 150 Feet, GG0170I1 - Walk 10 Feet, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170D1 - Sit to Stand, GG0170F1 - Toilet Transfer, #1 - Observable Surgical Wound - Anterior Right Knee - , #2 - Observable Surgical Wound - Anterior Left Knee -

PROCEDURES: physician-ordered wound care: #2 - Observable Surgical Wound - Anterior Left Knee -: No formal order by sx; will f/u 1/28/26 and obtain further details. currently donning hinged knee braces BLE, physician-ordered wound care: #1 - Observable Surgical Wound - Anterior Right Knee -: No formal order by sx; will f/u 1/28/26 and obtain further details. currently donning hinged knee braces BLE, home exercise program: BLE 2-3x10, 1-2x/day: Standing SLR hip abd/ext/flex, seated and/or supine SLR hip flex, seated and/or standing HR, ankle pumps, ankle ABC, strengthening exercises, gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Chair to Bed to Chair - 06. Independent, Sit to Stand - 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: To be able to walk around between rooms, toilet and bathe in tub shower indep, walk up/down stairs without sup, and ambul outside with RW to/into car to get to/from appointments

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Walk 10 ft on Uneven Surface - 06. Independent

1 - Step (curb) - 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

4 Steps - 06. Independent

12 Steps - 06. Independent

Picking Up Object - 06. Independent

OT Careplans

OT Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

01/07/2026

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OT WK1: 1 (01/07/26-01/10/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, M1400, 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: 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, * 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 relaxatio, 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

PATIENT-STATED GOAL: OT evaluation only

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

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 relaxatio

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	01/07/2026