Home Health Certification and Plan of Care

Order ID: 1163/704

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
356012120019	01/15/2026	From: 01/15/2026 To: 03/15/2026	980	497754

6. Patient's Name and Address
Ledell Webster
305 Oak spring Drive, Apt 210,
WARRENTON, VA 20186-
703-856-5549

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 01/12/1955 | 9.Sex Male

11. ICD	Principal Diagnosis	Date
I87.2	Venous insufficiency (chronic) (peripheral)	01/15/26

13. ICD	Other Pertinent Diagnoses	Date
L97.412	Non-prs chr ulcer of right heel and midft w fat layer expos	01/15/26
L97.812	Non-prs chronic ulcer oth prt r low leg w fat layer exposed	01/15/26
L97.822	Non-prs chronic ulcer oth prt l low leg w fat layer exposed	01/15/26
I10.	Essential (primary) hypertension	01/15/26
E11.40	Type 2 diabetes mellitus with diabetic neuropathy unsp	01/15/26
E78.5	Hyperlipidemia unspecified	01/15/26
E03.9	Hypothyroidism unspecified	01/15/26
F32.9	Major depressive disorder single episode unspecified	01/15/26
E55.9	Vitamin D deficiency unspecified	01/15/26
Z86.19	Personal history of other infectious and parasitic diseases	01/15/26
Z86.718	Personal history of other venous thrombosis and embolism	01/15/26
Z87.01	Personal history of pneumonia (recurrent)	01/15/26

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

(Calcium Carbonate-Cholecalciferol) Calcium 600/Vitamin D Oral Tablet 600 -10 MG-MCG / 1 Tablet by mouth once a day for Vitamin D- deficiency
Simvastatin - Simvastatin 10 mg 10 mg1 Tablet by mouth at bedtime for Hyperlipidemia

14. DME and Supplies:
wheelchair, walker, hand held shower

15. Safety Measures:
walker precautions, wheelchair precautions, supervision at all times, , hand rails, , bathroom safety, ambulates with assistance

16. Nutrition:
cardiac diet, regular

17. Allergies:
no known allergies

18.A. Functional Limitations
Bowel/Bladder Incontinence, Ambulation, Endurance

18.B. Activities Permitted
Walker, Wheelchair, 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: 1. Rarely, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes

20. Prognosis: good

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
family/caregiver will be responsible for managing treatment

Homebound status:
Due to diagnosis of Venous insufficiency (chronic) (peripheral), 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 71-year-old African American male with a history of hospitalization following a fall with fracture, followed by an extended rehabilitation stay (approximately one year). He currently resides alone in a secured-access apartment with assistance from his daughter. Upon arrival, the nurse met the daughter downstairs; the daughter requested that the nurse clean the patient following a bowel movement earlier today. The nurse offered education and hands-on training regarding incontinence care; however, the daughter declined, stating she was unable to perform this care. The patient was found in bed with a strong foul odor and reported he had been lying in feces and urine for approximately two days because he was unable to get to the toilet. The daughter reported a wound on the patient's buttock. The nurse provided thorough incontinence care and performed a skin assessment of the buttocks/sacral area; no skin breakdown was observed at the time of this visit. The nurse assisted with application of a clean brief/diaper and reinforced hygiene needs to reduce risk of skin breakdown and infection. On assessment, the patient was alert, awake, and oriented (reported as oriented to person, place, and time; also documented as alert and oriented x4), with no reported vision or hearing impairment. Neurological screening was within expected limits for this visit, with facial symmetry present, equal bilateral grips, and pupils equal and reactive to light. Respiratory assessment revealed posterior lung fields clear to auscultation without use of accessory muscles. The abdomen was distended but soft and non-tender, with active bowel sounds in all four quadrants. The patient is incontinent of both bowel and bladder. Bilateral lower extremities demonstrated edema with discoloration and multiple small open blisters; the patient also reported left calf pain with partial relief from medication (pain medication not specified). Vital signs were notable for elevated blood pressure of 189/100 mmHg; the patient was without acute distress and denied dizziness, lightheadedness, or headache. The patient reported he had not taken his blood pressure medication since Monday; the daughter contacted the pharmacy during the visit and stated she would pick up the medication today. The nurse notified the provider by calling and leaving a message with the service for a return call. The patient has a Life Alert system in place. He is currently receiving caregiver assistance through Right at Home through Sunday. The patient utilizes bilateral knee flexion orthoses. Plan of care includes resumption of prescribed antihypertensive therapy as soon as obtained, monitoring of blood pressure and symptoms, continued incontinence care and frequent hygiene/brief changes to prevent skin breakdown, ongoing assessment and protection of lower-extremity skin integrity (open blisters/edema), and follow-up with the provider regarding uncontrolled blood pressure and reported left calf pain. Education was offered to the daughter regarding safe, routine incontinence care and skin protection measures; the daughter declined training at this time. The patient and daughter were advised to seek urgent medical evaluation for worsening calf pain, increased swelling/redness/warmth, shortness of breath, chest pain, new neurologic symptoms, or symptoms associated with severe hypertension.
 Date of Order 01/15/2026 Orders Physician Face-to-Face Date: 01/05/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Venous insufficiency (chronic) (peripheral) Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 01/15/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Aras Kay
805 Constellation Dr
Great Falls, VA 22066
PHONE: 7033435073 FAX: NPI: 1104182559

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 : 01/05/2026

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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home
 1 - SOC - SN Notes: soc OT Eval Notes:
 Physician Kay, Aras

SN Careplans

SN WK1: 1 (01/15/26-01/17/26) ,WK2: 1 (01/18/26-01/24/26) ,WK3: 1 (01/25/26-01/31/26) ,WK4: 1 (02/01/26-02/07/26)

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: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 3. Multiple hospitalizations (2 or more) in the past 6 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, meal preparation, M2020 - Oral Med Management, M1033 - Exhaustion, M1400 - Dyspnea, dependent edema, M1620 - Bowel Incontinence, frequent urination, foul-smelling urine, M1610 - Urinary Incontinence, muscle weakness, limited strength, limited range of motion, limited endurance, muscle spasms, pain radiating to arms/legs, Pain Interference with ADLs, Pain Interference with Therapy activities, Pain Effect on Sleep, discolored patches of skin, open sores/lesions, swell/redness surround. skin, #1 - Blister - Other - Left lower leg - , #2 - Blister - Other - Right lower leg - , #3 - 6 - Unstageable due to coverage of wound bed by slough and/or eschar. - Other - Right heel -

PROCEDURES: physician-ordered wound care: #2 - Blister - Other - Right lower leg -, physician-ordered wound care: #1 - Blister - Other - Left lower leg -, cough/deep breathing exercises, physician-ordered wound care, glucose testing via monitor, bladder 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, * lifestyle modifications to manage peripheral vascular condition including how to apply compression stockings physical exercise plan diet, 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, * 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 exercise diabetic diet, related medication(s) purpose, schedule, * bowel incontinence management including dietary changes bowel training skin care, related medication(s) purpose, schedule, * urinary incontinence management including bladder training Kegel exercises skin care, 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, meal preparation is available to patient for all meals

SN Goals

PATIENT-STATED GOAL: I want to help myself more

GOALS
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
* 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
* diabetic medication management
* blood sugar testing
* diabetic foot care
* exercise
* diabetic diet
* 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) purpos

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

patient/caregiver recalls
* bowel incontinence management including dietary changes
* bowel training
* skin care
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* urinary incontinence management including bladder training
* Kegel exercises
* skin care
* recalls related medication(s) purpose, schedule

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

meal preparation is available to patient for all meals

OT Careplans

OT Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

01/15/2026

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PROBLEMS IDENTIFIED ON ASSESSMENT: M1400, GG0130B1 - Oral Hygiene, GG0130F1 - Upper Body Dressing, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130E1 - Shower/Bathe Self, GG0170F1 - Toilet Transfer, GG0130C1 - Toileting Hygiene, GG0170D1 - Sit to Stand, GG0170E1 - Chair to Bed to Chair, GG0170G1 - Car Transfer, GG0170R1 - Wheel 50 ft w 2 Turns, GG0170S1 - Wheel 150 feet, GG0130A1 - Eating

PROCEDURES: wheelchair training, equipment training, work simplification/energy conservation, 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, Chair to Bed to Chair - 03. Partial/moderate assistance, Sit to Stand - 03. Partial/moderate assistance, Toilet Transfer - 01. Dependent, Oral Hygiene - 05. Setup or clean-up assistance, Toileting Hygiene - 01. Dependent, Shower/Bathe Self - 03. Partial/moderate assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 01. Dependent, Don/Doff Footwear - 01. Dependent, Eating - 05. Setup or clean-up assistance

PATIENT-STATED GOAL: Improve the strength in my arms and hands to help with transfers

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

Sit to Stand - 03. Partial/moderate assistance

Shower/Bathe Self - 03. Partial/moderate assistance

Chair to Bed to Chair - 03. Partial/moderate assistance

Toilet Transfer - 01. Dependent

Oral Hygiene - 05. Setup or clean-up assistance

Toileting Hygiene - 01. Dependent

Upper Body Dressing - 05. Setup or clean-up assistance

Lower Body Dressing - 01. Dependent

Don/Doff Footwear - 01. Dependent

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	01/15/2026