Home Health Certification and Plan of Care

Order ID: 1163/786

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
781147976	02/02/2026	From: 02/02/2026 To: 04/02/2026	1100	497754

6. Patient's Name and Address

Ingrid Oneal
18609 Kerill Rd,
TRIANGLE, VA 22172
703-221-7577

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 11/18/1957 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
G89.11	Acute pain due to trauma	02/02/26

13. ICD	Other Pertinent Diagnoses	Date
M25.561	Pain in right knee	02/02/26
M19.011	Primary osteoarthritis right shoulder	02/02/26
I69.354	Hemiplga following cerebral infrc affecting left nondom side	02/02/26
I10.	Essential (primary) hypertension	02/02/26
E11.9	Type 2 diabetes mellitus without complications	02/02/26
E78.00	Pure hypercholesterolemia unspecified	02/02/26
M47.816	Spondylosis w/o myelopathy or radiculopathy lumbar region	02/02/26
Q76.49	Oth congenital malform of spine not associated w scoliosis	02/02/26
N39.3	Stress incontinence (female) (male)	02/02/26
F33.42	Major depressive disorder recurrent in full remission	02/02/26
L72.0	Epidermal cyst	02/02/26
Z79.02	Long term (current) use of antithrombotics/antiplatelets	02/02/26
Z91.81	History of falling	02/02/26

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

Lidocaine (LIDODERM) 5 % Top PTMD Patch 1 patch topical once a day Moderate pain
Multivitamin Minerals Oral Tab 1 Tablet by mouth once a day Supplement
Lipitor - Atorvastatin Calcium eq 80 mg base 1 table by mouth once a day Cholesterol
Vit B-12 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 01,000 mcg 1 Tablet by mouth once a day Supplement
Plavix - Clopidogrel Bisulfate eq 75 mg base 1 Tablet by mouth once a day Prophylactic
Depakote - Divalproex Sodium eq 250 mg valproic acid eq 250 mg valproic acid1 Tablet by mouth at bedtime Seizure
Flonase Allergy Relief - Fluticasone Propionate 050 mcg/actuation Nasl SpSn 1 spray Nasal twice a day Allergy
Mucinex - Guaifenesin 600 mg 600 mg 1 tab by mouth every 12 hours Cough
Cymbalta - Duloxetine Hydrochloride 60 mg 1 Capsule by mouth twice a day Depression
Drisdol - Ergocalciferol 50,000 unit 1 Capsule by mouth once a week Supplement
Restasis - Cyclosporine 00.05 % Opht Dropperette 1 drop both eyes twice a day Dry eyes
Prinivil - Lisinopril 20 mg 1 Tablet by mouth once a day HTN
Pantoprazole - Pantoprazole Sodium 40 mg 1 Tablet by mouth in the morning Gerd
Protonix - Pantoprazole Sodium eq 40 mg base eq 40 mg base 1 Tablet by mouth in the morning Gerd

14. DME and Supplies:

rolling walker, hand held shower, grab bars

15. Safety Measures:

walker precautions, supervision at all times, , hand rails, , ambulates with device, ambulates with assistance, activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

NSAIDs cox-2 inhibitors imitrex keppra

18.A. Functional Limitations

Ambulation, Endurance

18.B. Activities Permitted

Walker, Cane, Up As Tolerated

19. Mental & Psychosocial 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: Yes

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

family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Acute Pain Due To Trauma, 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 68-year-old African American female who was recently hospitalized following a fall. She has a significant past medical history of cerebrovascular accident (CVA) approximately 10 years ago with residual left-sided hemiplegia affecting her non-dominant side, hypertension, type 2 diabetes mellitus, hypercholesterolemia, right shoulder osteoarthritis, chronic right knee pain, lumbar spondylosis without myelopathy or radiculopathy, congenital spinal malformation not associated with scoliosis, stress incontinence, depression, epidermal cyst, history of falls, and long-term use of antithrombotic/antiplatelet therapy. The recent fall occurred while she was seated awaiting an appointment; upon standing when her name was called, she became aware that she was on the floor and required assistance to return to standing. She currently resides in a multi-level home with her husband and daughter, both of whom assist with her care. She requires moderate assistance with activities of daily living. On <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. Neurological examination revealed intact facial symmetry, equal and strong bilateral hand grasps, and pupils equal, round, and reactive to light. Respiratory examination demonstrated clear breath sounds in the posterior lobes bilaterally without use of accessory muscles. The abdomen was distended but soft and non-tender, with active bowel sounds in all four quadrants. She is continent of bowel and bladder. Musculoskeletal <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh> revealed right knee swelling and pain rated at 7/10. She wears a knee brace on a schedule of 12 hours on and 12 hours off and was encouraged to elevate the right lower extremity and take prescribed pain medication around the clock as directed for improved pain control. She also reports right-sided low back pain following the fall. No acute skin breakdown was noted. Functionally, the patient requires moderate physical assistance for grooming, dressing, bathing, toileting, oral medication management, and meal preparation; her husband prepares meals, and she is able to feed herself with setup assistance. She is independent with transfers but requires close supervision for safety. She ambulates indoors with a small-base quad cane and outdoors with a rollator and is able to negotiate stairs with supervision. Her gait is unsteady, and she remains at increased fall risk given her prior CVA with residual hemiplegia and recent fall. Physical therapy evaluation has been completed, and education was provided regarding safe home setup, fall prevention strategies, proper use of the small-base quad cane, and stair negotiation techniques with and without the assistive device. A home exercise program was initiated, including seated and standing bilateral lower extremity therapeutic exercises, with demonstration and return demonstration by the patient and her husband, who verbalized understanding and agreement with the plan. Recommendations were also made for installation of a bedrail to assist with bed mobility and transfers, as well as use of therapy putty to improve bilateral hand grip strength and fine motor coordination. The patient would benefit from continued skilled physical therapy services to address decreased strength, impaired balance, pain management, and reduced endurance in order to improve safety, increase independence with functional mobility, and facilitate return to prior

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 02/02/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Florence Tchouaffi-Nana
14139 Potomac Mills Rd
Woodbridge , MD 22192
PHONE: 7034908400 FAX: 17034907650 NPI: 1780889337

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 : 01/29/2026

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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level of function. The plan of care includes strengthening exercises, gait and stair training, fall prevention education, pain management strategies, and caregiver education to support safe mobility and reduce risk of future falls.
 Date of Order 02/02/2026 Orders Physician Face-to-Face Date: 01/29/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hhadl's due to Acute Pain Due To Trauma 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 Tchouaffi-Nana, Florence

SN Careplans

SN WK1: 1 (02/02/26-02/07/26) ,WK2: 1 (02/08/26-02/14/26) ,WK3: 1 (02/15/26-02/21/26) ,WK4: 1 (02/22/26-02/28/26)

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, M2020 - Oral Med Management, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, muscle weakness, limited endurance, limited range of motion, limited strength, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs

PROCEDURES: cough/deep breathing exercises: Demonstrated understanding, glucose testing via monitor: Doesn't monitor the blood sugar, coordinate/arrange preparation of missing meals: Husband managed

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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpos, * 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 the pain to my knee to stop

GOALS
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
* 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
* 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

PT Careplans

PT WK1: 1 (02/02/26-02/07/26) ,WK3: 1 (02/15/26-02/21/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, 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: home exercise program: sit to stands, seated and/or standing marches, LAQs, seated HR/TR, seated clams and hip add pillow squeezes, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: * 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, Sit to Stand - 05. Setup or clean-up 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, 4 Steps - 04. Supervision or touching assistance, 12 Steps - 04. Supervision or touching assistance, Car Transfer - 05. Setup or clean-up assistance

PT Goals

PATIENT-STATED GOAL: To return to her pain free pre-fall PLOF during ADLs, funct activities and ambul

GOALS
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

Sit to Stand - 05. Setup or clean-up 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

4 Steps - 04. Supervision or touching assistance

12 Steps - 04. Supervision or touching assistance

Car Transfer - 05. Setup or clean-up assistance

OT Careplans

OT Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

02/02/2026

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OT WK1: 1 (02/02/26-02/07/26) ,WK2: 1 (02/08/26-02/14/26) ,WK3: 1 (02/15/26-02/21/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, 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 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 - 05. Setup or clean-up assistance, Toileting Hygiene - 05. Setup or clean-up assistance, Shower/Bathe Self - 04. Supervision or touching assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent

PATIENT-STATED GOAL: I want to be able to get in/out of bed safer and easier and improve my hand strength

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

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Oral Hygiene - 05. Setup or clean-up assistance

Toileting Hygiene - 05. Setup or clean-up assistance

Shower/Bathe Self - 04. Supervision or touching assistance

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

Eating - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	02/02/2026