Home Health Certification and Plan of Care

Order ID: 1163/783

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
29124887	02/02/2026	From: 02/02/2026 To: 04/02/2026	1041	497754

6. Patient's Name and Address

Sophia Halpern
8209 Bell Ln,
VIENNA, VA 22182-
703-517-2137

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 08/21/1954 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
S22.41XD	Multiple fx of ribs right side subs for fx w routn heal	02/02/26

13. ICD	Other Pertinent Diagnoses	Date
S22.088A	Oth fracture of T11-T12 vertebra init for clos fx	02/02/26
I10.	Essential (primary) hypertension	02/02/26
E11.9	Type 2 diabetes mellitus without complications	02/02/26
I26.99	Other pulmonary embolism without acute cor pulmonale	02/02/26
E78.5	Hyperlipidemia unspecified	02/02/26
K21.9	Gastro-esophageal reflux disease without esophagitis	02/02/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	02/02/26
Z85.850	Personal history of malignant neoplasm of thyroid	02/02/26
Z79.01	Long term (current) use of anticoagulants	02/02/26
Z79.4	Long term (current) use of insulin	02/02/26
Z79.85	Lng trm (crnt) use injectable non-insulin antidiabetic drugs	02/02/26

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

Amlodipine Besylate And Atorvastatin Calcium - Amlodipine Besylate: Atorvastatin Calcium 10mg 1 tab by mouth once a day
Ascorbic Acid - Ascorbic Acid: Biotin: Cyanocobalamin: Dexpanthenol: Ergocalciferol: Folic Acid: Niacinamide: Pyridoxine Hydrochloride: Riboflav 1000 mg 1 tab by mouth at bedtime Supplement
Atorvastatin - Atorvastatin Calcium 10 mg 1 table by mouth at bedtime HLD
Rocaltrol - Calcitriol 0.5mcg 1 tab by mouth at bedtime Supplement
Caltrate Plus D - Calcium Acetate 500 mg I tab by mouth at bedtime Supplement
Vit D - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 2000 units by mouth at bedtime Supplement
Ferrous Sulfate - Ferrous Sulfate: Folic Acid 65 mg 1 tab by mouth once a day Anemia
Fluoxetine - Fluoxetine Hydrochloride 60 mg 1 tab by mouth in the morning Depression
Gabapentin - Gabapentin 200 mg 1 tab by mouth every 8 hours Moderate pain
Basaglar - Insulin Glargine 10 units subcutaneous at bedtime DM
Synthroid - Levothyroxine Sodium 0.112 mg **see current annual edition, 1.8 description of special situations, levothyroxine sodium 1 tab by mouth in the morning Hypothyroidism
Lidocaine - Lidocaine 5% 3 patches topical once a day Moderate pain
Robaxin - Methocarbamol 500 mg by mouth every 6 hours Muscles spams
Magnesium Oxide - Simethicone 400 mg 1 table by mouth at bedtime Supplement
Trazadone - Trazodone Hydrochloride 50 mg 1 tab by mouth at bedtime Insomnia
Effexor - Venlafaxine Hydrochloride eq 37.5 mg base 1 tab by mouth twice a day Depression
Coumadin - Warfarin Sodium 7.5 mg 1 tab by mouth at bedtime Afib alternate with 5 mg daily
Coumadin - Warfarin Sodium 5 mg 1 Tablet by mouth at bedtime Afib alternate with 7.5 mg daily

14. DME and Supplies:
grab bars, hand held shower

15. Safety Measures:
transfer with assist, supervision at all times, , , , bathroom safety, activity supervision

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
cephalosporins sulfa cefdinir levofloxacin sulfamethoxazole amoxicillin trimetho

18.A. Functional Limitations
Ambulation, Endurance

18.B. Activities Permitted
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
family/caregiver will be responsible for managing treatment
patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Multiple Fractures Of Ribs, Right Side, Subsequent Encounter For Fracture With Routine Healing, 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 Asian female recently hospitalized following a motor vehicle accident resulting in nondisplaced fractures of the right third through fifth ribs. She was discharged home and currently resides alone in a single-family residence. Upon arrival for the skilled nursing visit, the patient expressed suspicion and dissatisfaction regarding the visit, questioning the referral source, insurance coverage, and why a Maryland phone number appeared on her caller ID instead of a Virginia number. The nurse contacted the agency office, and the patient spoke directly with staff for clarification, after which she verbalized understanding. She has requested that future <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-1 CE-FMS-visits">visits</mh> be scheduled with notification several days in advance and expressed interest in obtaining a daily private aide; this request will be communicated to the office for follow-up. 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. She denies visual or hearing impairments. Respiratory examination demonstrated clear breath sounds in the posterior lobes bilaterally without use of accessory muscles. Cardiovascular <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh> revealed no bilateral lower extremity edema. The abdomen was soft and non-tender with active bowel sounds in all four quadrants. She is continent of bowel and bladder. The patient reports right shoulder pain associated with the recent motor vehicle accident, with partial relief

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
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 : 01/24/2026

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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obtained from acetaminophen (Tylenol) and use of a lidocaine patch. She denies additional fractures or skin breakdown. The patient ambulates independently indoors and outdoors without an assistive device; however, her gait is noted to be unsteady. Due to pain and impaired stability related to her recent rib fractures, she is considered unable to safely leave the home independently without physical assistance. Use of a cane for outdoor ambulation was recommended to improve safety and reduce fall risk. The patient remains on warfarin (Coumadin) therapy but declined to review her medication list during this visit, stating that the medication list on file is accurate. She also declined to discuss INR/PT monitoring. No signs or symptoms of active bleeding, such as bruising, petechiae, hematuria, or melena, were observed during the visit. Medication reconciliation and anticoagulation monitoring will require follow-up at the next encounter to ensure safe management. Education was provided regarding fall prevention strategies, safe ambulation, proper use of assistive devices, pain management, and the importance of routine INR monitoring and medication adherence while on anticoagulation therapy. The plan of care includes continued skilled nursing <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh> focusing on safety, pain control, cardiopulmonary status, medication reconciliation, and monitoring for potential complications related to rib fractures and anticoagulation therapy. Coordination with the agency office will be completed to address her request for private aide services and advance scheduling notification.
 Date of Order 02/02/2026 Orders Physician Face-to-Face Date: 01/24/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-disease management due to Multiple Fractures Of Ribs, Right Side, Subsequent Encounter For Fracture With Routine Healing 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 Lee, Donna

SN Careplans

SN WK1: 1 (02/02/26-02/07/26) ,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: 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, 9. Other risk(s) not listed in 1- 8

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, 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: cough/deep breathing exercises: Demonstrated understanding, glucose testing via monitor: Monitor Blood sugar, coordinate/arrange preparation of missing meals: Friends assist

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

meal preparation is available to patient for all meals

PT Careplans

PT WK2: 1 (02/08/26-02/14/26) ,WK3: 1 (02/15/26-02/21/26) ,WK5: 1 (03/01/26-03/07/26) ,WK6: 1 (03/08/26-03/14/26) ,WK7: 1 (03/15/26-03/21/26)

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: Seated therex 10-20 reps: marches, hip add pillow squeezes, clams, sit to stands, LAQ Standing therex 10-20 reps: sit to stands, 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 - 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

PT Goals

PATIENT-STATED GOAL: To be pain free in ribs, return to her pain free PLOF during ADLs, funct activities and ambul and hopefully obtain HHA services for assistance around her home

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 - 06. Independent

Walk 10 Feet - 06. Independent

Car Transfer - 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

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	02/02/2026

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OT Careplans

OT WK2: 6 (02/08/26-02/14/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: 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: cough/deep breathing exercises, 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

OT Goals

PATIENT-STATED GOAL: I want to get stronger and get back to feeling like myself

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
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