Home Health Certification and Plan of Care

Order ID: 1163/813

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
02218011	02/10/2026	From: 02/10/2026 To: 04/10/2026	1133	497754

6. Patient's Name and Address

Permvir Singh
3900 VICTORIA OAKS TRL,
ANNANDALE, VA 22003-
703-606-8183

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 08/14/1951 | **9.Sex** Male

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

Lipitor - Atorvastatin Calcium eq 40 mg base eq 40 mg base by mouth once a day cholesterol
Folic Acid - Folic Acid 1 mg 1 mg by mouth once a day Supplement
Hydrochlorothiazide - Hydrochlorothiazide 25 mg 1 Tablet by mouth once a day HTN
Hyzaar - Hydrochlorothiazide: Losartan Potassium 12.5 mg;50 mg 1 Tablet by mouth once a day HTN
Methotrexate - Methotrexate Sodium 2.5 mg 4 tablet by mouth once a week Autoimmune

11. ICD	Principal Diagnosis	Date
G91.2	(Idiopathic) normal pressure hydrocephalus	02/10/26

13. ICD	Other Pertinent Diagnoses	Date
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy	02/10/26
I10.	Essential (primary) hypertension	02/10/26
E78.00	Pure hypercholesterolemia unspecified	02/10/26
K57.30	Dvrtclos of lg int w/o perforation or abscess w/o bleeding	02/10/26
M19.90	Unspecified osteoarthritis unspecified site	02/10/26
H52.203	Unspecified astigmatism bilateral	02/10/26
Z79.82	Long term (current) use of aspirin	02/10/26
Z86.0100	Personal history of colonic polyps	02/10/26

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

15. Safety Measures:
hand rails, , diabetic precautions, ambulates with assistance

16. Nutrition:
diabetic

17. Allergies:
sulfa shellfish

18.A. Functional Limitations
Ambulation, Endurance

18.B. Activities Permitted
Cane, 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 Normal Pressure Hydrocephalus, 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 74-year-old Asian male who was admitted to the hospital for a planned surgical procedure and observation and is now status post right ventriculoperitoneal (VP) shunt placement performed on 02/06 for idiopathic normal pressure hydrocephalus. His past medical history is significant for hypertension, hyperlipidemia, hypercholesterolemia, type II diabetes mellitus, diverticulosis, and unspecified osteoarthritis. He was discharged home to his wife, who is a physician and serves as his primary caregiver. The patient resides with his wife and family in a multilevel single-family home. 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. He wears glasses and denies hearing impairment. Neurological examination revealed intact facial symmetry, equal and strong bilateral hand grasps, and pupils equal, round, and reactive to light. He denies headaches, visual changes beyond baseline, or new neurological deficits. Respiratory <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh> demonstrated 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> revealed no bilateral lower extremity edema. The abdomen was soft, non-tender, with bowel sounds present in all four quadrants. The patient is continent of bowel and bladder. Surgical incisions were assessed and include a lower abdominal incision measuring approximately 7 cm x 0.2 cm, a right neck incision measuring 0.2 cm x 4 cm, and a right cranial C-shaped incision measuring approximately 0.2 cm x 6 cm. All incisions were observed to be clean, dry, and intact, without signs or symptoms of infection such as erythema, warmth, drainage, or dehiscence. Continued monitoring for proper healing and signs of shunt-related complications is indicated. The patient reports pain at a level of 4/10, which is adequately managed with acetaminophen taken twice daily, providing satisfactory relief. Immunizations are up to date, including influenza vaccination in November 2025 and current pneumococcal vaccination. Functionally, the patient presents with fair to fair-plus bilateral lower extremity strength and mobility. He ambulates with an unsteady gait and uses a cane outdoors; gait training with a rolling walker and quad cane was provided during the visit to improve safety. He is independent with feeding once meals are set up but requires assistance from his wife with medication management and meal preparation. He performs grooming, dressing, bathing, and toileting largely independently, requiring occasional physical assistance. He is independent with transfers but requires pushing off from chair arms or nearby surfaces for sit-to-stand transitions. A physical therapy evaluation was completed, and a home exercise program consisting of seated and standing bilateral lower extremity therapeutic exercises was initiated to address strength, balance, and endurance deficits. Education was provided regarding safe home setup, fall prevention strategies, and appropriate use of assistive devices for ambulation. The patient demonstrated understanding through verbalization and return demonstration and agreed with the plan of care. Skilled physical therapy services are medically necessary to improve strength, standing and ambulation tolerance, gait stability, and overall functional mobility in order to facilitate return to prior level of function, maximize safety within the multilevel home environment, and reduce the risk of falls or rehospitalization.
 Date of Order 02/10/2026 Orders Physician Face-to-Face Date: 02/06/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-disease management PT-eval & treat OT-eval & treat due to Normal Pressure Hydrocephalus 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 Al-Shaar, Abdel

SN Careplans

SN Goals

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 02/10/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Abdel Al-Shaar
1740401710
Springfield, VA 22150
PHONE: 5716222000 FAX: NPI: 1740401710

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 : 02/06/2026

27. Attending Physician's Signature and Date Signed **02/25/2026**: 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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6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number
Permvir Singh 3900 VICTORIA OAKS TRL, ANNANDALE, VA 22003- 703-606-8183	Grace Home Healthcare, LLC 9735 Main Street Suite 200 Fairfax, Fairfax, VA 22031-3736 703-865-7370 1073904009

SN WK1: 1 (02/10/26-02/14/26) ,WK2: 1 (02/15/26-02/21/26) ,WK3: 1 (02/22/26-02/28/26) ,WK4: 1 (03/01/26-03/07/26) ,WK5: 1 (03/08/26-03/14/26)

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: 2. Unintentional weight loss of a total of 10 pounds or more in the past 12 months, 3. Multiple hospitalizations (2 or more) in the past 6 months, 5. Decline in mental, emotional, or behavioral status in the past 3 months, 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:Do not resuscitate (DNR) orders

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, meal preparation, M1033 - Unintentional Weight Loss, 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: Doesn't monitor the blood sugar, coordinate/arrange preparation of missing meals: Wife who is a doctor managed, coordinate/arrange resources for vision-impaired: Wife follow up

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, * strategies to increase caloric intake, 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

PATIENT-STATED GOAL: I want to get back to my routine

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/caregiver recalls
* strategies to increase caloric intake
* 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 (02/10/26-02/14/26) ,WK2: 1 (02/15/26-02/21/26) ,WK4: 1 (03/01/26-03/07/26) ,WK5: 1 (03/08/26-03/14/26) ,WK6: 1 (03/15/26-03/21/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, Pain Interference with ADLs, Pain Interference with Therapy activities, Pain Effect on Sleep, GG0170D1 - Sit to Stand, 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, GG0170J1 - Walk 50 ft with 2 Turns, GG0170I1 - Walk 10 Feet, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170F1 - Toilet Transfer, #1 - Observable Surgical Wound - Other - superior right head - , #2 - Observable Surgical Wound - Other - lateral right neck - , #3 - Observable Surgical Wound - Other - anterior lower abdomen -

PROCEDURES: physician-ordered wound care: #1 - Observable Surgical Wound - Other - superior right head -: None specified at this time. Being managed by MD., physician-ordered wound care: #2 - Observable Surgical Wound - Other - lateral right neck -: None specified at this time. Being managed by MD., physician-ordered wound care: #3 - Observable Surgical Wound - Other - anterior lower abdomen -: None specified at this time. Being managed by MD., 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, strengthening exercises, 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, 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, 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

PT Goals

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

GOALS
Toilet Transfer - 06. Independent

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

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

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

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

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

OT Careplans

OT WK1: 1 (02/10/26-02/14/26) ,WK2: 1 (02/15/26-02/21/26) ,WK3: 1 (02/22/26-02/28/26) ,WK4: 1 (03/01/26-03/07/26)

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: equipment training, work simplification/energy conservation

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

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	02/10/2026

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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/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

Shower/Bathe Self - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Upper Body Dressing - 06. Independent

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Eating - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
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