

Home Health Certification and Plan of Care				Order ID: 1163/986	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
3GW3EP6GY75		04/01/2026		From: 04/01/2026 To: 05/30/2026	
4. Medical Record No.				5. Provider No.	
1350				497754	
6. Patient's Name and Address				7. Provider's Name, Address and Telephone Number	
Ramona Sheffel 3344 Conquistador Court, Annandale, VA 22003- 703-349-9983				Grace Home Healthcare, LLC 9735 Main Street Suite 200 Fairfax, Fairfax, VA 22031-3736 703-865-7370 1073904009	
8. DOB 04/06/1942 9.Sex Female				10. Medications: Dose/Frequency/Route (N)ew (C)hanged	
11. ICD E11.65		Principal Diagnosis Type 2 diabetes mellitus with hyperglycemia		Date 04/01/26	
13. ICD D64.89 I10. J43.9 R91.8 F03.90 K59.00 H35.30 H91.93 F17.210 Z79.4 Z87.891 Z91.81		Other Pertinent Diagnoses Other specified anemias Essential (primary) hypertension Emphysema unspecified Other nonspecific abnormal finding of lung field Unsp dementia unsp severity without beh/psych/mood/anx Constipation unspecified Unspecified macular degeneration Unspecified hearing loss bilateral Nicotine dependence cigarettes uncomplicated Long term (current) use of insulin Personal history of nicotine dependence History of falling		Date 04/01/26 04/01/26 04/01/26 04/01/26 04/01/26 04/01/26 04/01/26 04/01/26 04/01/26 04/01/26 04/01/26 04/01/26	
14. DME and Supplies: reacher, cane, , hand held shower				15. Safety Measures: standard precautions, medication safety, fall precautions, ambulates with assistance, activity supervision	
16. Nutrition: soft				17. Allergies: no known allergies	
18.A. Functional Limitations Ambulation, Endurance				18.B. Activities Permitted Up As Tolerated	
19. Mental & Pyschosocial Status: COGNITION: 4. Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium., ANXIETY: NA Patient nonresponsive, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 1. Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required!2. Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions, HISTORY OF DEPRESSION: No					
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 patient will be responsible for managing treatment family/caregiver will be responsible for managing treatment patient will be responsible for managing treatment	
Homebound status: Due to diagnosis of Type 2 diabetes mellitus with hyperglycemia, 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:		<div>The patient is an 83-year-old White female with a past medical history significant for chronic obstructive pulmonary disease (COPD), dementia, type 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-12 CE-FMS-diabetes">diabetes</mh> <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-6 CE-FMS-hypertension">hypertension</mh>. The patient was recently hospitalized following a fall in her home without reported injuries and was subsequently transferred to a rehabilitation facility before returning home. During the hospitalization, she was treated for acute metabolic encephalopathy, hyperglycemia, and hypercalcemia, which have since resolved. The patient currently resides alone in a multi-level townhouse and receives daily assistance from a private aide as well as support from her daughter, who assists with medication management, meal preparation, and general supervision. Private caregiver support is provided on Monday, Tuesday, Thursday, and Friday, while the patient's daughter assists on Wednesday and Sunday. Upon assessment, the patient was alert, awake, and oriented to person, though she demonstrated confusion consistent with her dementia diagnosis. She was noted to be easily redirected and remained pleasant and cooperative throughout the evaluation. The patient has significant sensory impairments including macular degeneration, deafness in the left ear, and poor hearing in the right ear, and she does not currently use hearing aids. The right eyelid was observed to be closed at rest but the patient was able to open it on command. Cognitive deficits include decreased command following, impaired safety awareness, and difficulty initiating tasks, requiring verbal cues for completion of activities. Respiratory assessment revealed posterior lung lobes clear to auscultation. Cardiovascular assessment showed no lower extremity edema. Abdominal examination revealed a soft, non-tender abdomen with active bowel sounds present in all four quadrants. The patient remains continent of both bowel and bladder. She reports hip pain, which is currently managed with satisfactory relief. Behavior during the visit was calm, cooperative, and appropriate. Functionally, the patient demonstrates significant decline from her prior baseline. Previously she was able to ambulate limited household distances using an assistive device; however, she has recently demonstrated reluctance to consistently use her assistive device and now presents with impaired balance, generalized weakness, and increased fall risk. The patient currently uses a cane for ambulation but requires frequent verbal cueing to ensure safe use. According to her daughter, the patient occasionally "furniture walks" throughout the home rather than using the cane. The patient remains independent with self-feeding when provided with setup assistance and demonstrates no fine motor deficits. However, she requires assistance with bathing and instrumental activities of daily living (IADLs). The patient also requires verbal cueing to initiate tasks and complete certain daily activities due to cognitive impairment. Occupational therapy evaluation identified decreased bilateral upper extremity strength and endurance, which further limits the patient's ability to safely perform daily activities. The patient currently has a shower chair and handheld shower hose installed in the bathroom. Additional safety recommendations were made, including the installation of grab bars to assist with shower transfers and reduce fall risk. Environmental safety concerns were also noted. The patient reportedly smokes cigarettes in the basement of the townhouse, and there are currently no smoke detectors or fire extinguishers present in the home. The patient's daughter reported plans to obtain and install these safety devices within the week while assisting the patient. The patient is considered homebound due to impaired cognition, significant fall risk, decreased strength and balance, need for assistance with mobility, and inability to safely ambulate community distances without considerable effort and supervision. Skilled physical therapy is indicated to address gait instability, transfer deficits, lower extremity weakness, impaired balance, and decreased safety awareness in order to reduce fall risk and improve functional mobility within the home environment. Occupational therapy will focus on therapeutic exercises to improve upper extremity strength and endurance, as well as training to maximize safety and independence with activities of daily living and functional transfers. Education was provided to the patient and caregiver regarding fall prevention strategies, proper use of assistive			
23. Signature and Date of Verbal SOC Where Applicable: Electronically Signed by Messick, Charles RN on 04/01/2026				25. Date HHA Received Signed POT	
24. Physician's Name and Address Myoung Kwak 12600 Fair Lakes Cir Suite 100 Fairfax, VA 22033-4904 PHONE: 703-994-4511 FAX: 17039944787 NPI: 1891350013				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 : 03/26/2026	
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. PAGE 1 of 3	

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devices, home safety modifications, and the importance of supervision during mobility and activities of daily living. The patient's prognosis is considered fair given her cognitive impairment; however, she demonstrates potential for functional improvement with consistent skilled therapy interventions and caregiver support within the home setting.

Date of Order: 04/01/2026

Orders: Physician Face-to-Face Date: 03/26/2026

Clinical Condition Requiring Home Care per Certifying Physician: SN, PT, OT due to Type 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-12 CE-FMS-diabetes">diabetes</mh> mellitus with hyperglycemia

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:

SN Careplans

SN WK1: 1 (04/01/26-04/04/26) ,WK3: 1 (04/12/26-04/18/26) ,WK4: 1 (04/19/26-04/25/26)

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), 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, 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, 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:Living Will

PROBLEMS IDENTIFIED ON ASSESSMENT: M1700 - Cognition, M1745 - Behavioral Issues, M2020 - Oral Med Management, meal preparation, M1033 - Unintentional Weight Loss, M1033 - Exhaustion, M1400 - Dyspnea, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, B0200 - Hearing Deficit

PROCEDURES: cough/deep breathing exercises: Demonstrated understanding, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion: Daughter involved, coordinate/arrange preparation of missing meals: Daughter managed, coordinate/arrange resources for vision-impaired: Daughter assist, coordinate/arrange home modifications for hearing impaired, i.e. alarms: Doesn't have hearing aid, has day time assistance

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 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 relaxation skills and diversional activities, related medication(s) purpose, schedule, * how to keep home safe for patient with dementia coping strategies for the caregiver*, related medication(s) purpose, schedule, * management of mental health condition including joining a peer group maintaining regular contact with mental health professional avoiding known stressors controlling impulses, related medication(s) purpose, schedule, * strategies to increase caloric intake, related medication(s) purpose, schedule, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, * how to keep home safe for hearing-impaired including installing special fire-detector/CO2 alarms, 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 don't want to go back to the rehabilitation

- GOALS
- patient/caregiver recalls
- * how to keep home safe for patient with dementia
 - * coping strategies for the caregiver* recalls related medication(s) purpose, schedule
- patient/caregiver recalls
- * how to keep home safe for hearing-impaired including installing special fire-detector/CO2 alarms
 - * recalls related medication(s) purpose, schedule
- 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 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 relaxation skills and diversional activities
 - * recalls related medication(s) purpose, schedule
- patient/caregiver recalls
- * management of mental health condition including joining a peer group
 - * maintaining regular contact with mental health professional
 - * avoiding known stressors
 - * controlling impulses
 - * recalls related medication(s) purpose, schedule
- patient/caregiver recalls
- * strategies to increase caloric intake
 - * 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

PT Careplans

PT WK2: 1 (04/05/26-04/11/26) ,WK3: 1 (04/12/26-04/18/26) ,WK4: 1 (04/19/26-04/25/26) ,WK5: 1 (04/26/26-05/02/26) ,WK6: 1 (05/03/26-05/09/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: 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: gait training on uneven surfaces, gait training/stair training, transfers training

PT Goals

- PATIENT-STATED GOAL: Perform stair negotiation with reciprocal gait pattern with no incidents of falls
- GOALS

OT Careplans

OT Goals

Signature of Physician:

Date

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Optional Name/Signature of Nurse/Therapist:

Date

Electronically Signed by Messick, Charles RN

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OT WK2: 1 (04/05/26-04/11/26) ,WK3: 1 (04/12/26-04/18/26) ,WK4: 1 (04/19/26-04/25/26) ,WK5: 1 (04/26/26-05/02/26) PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, GG0130A1 - Eating, GG0130B1 - Oral Hygiene, GG0130F1 - Upper Body Dressing, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene PROCEDURES: 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 medication(s) purpose, schedule, Sit to Stand - 05. Setup or clean-up assistance, Chair to Bed to Chair - 05. Setup or clean-up assistance, Toilet Transfer - 06. Independent, Oral Hygiene - 05. Setup or clean-up assistance, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 03. Partial/moderate assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent		PATIENT-STATED GOAL: I want to get stronger and get back to feeling like myself and be safer with bathing GOALS Toilet Transfer - 06. Independent 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 medication(s) purpose, schedule Sit to Stand - 05. Setup or clean-up assistance Chair to Bed to Chair - 05. Setup or clean-up assistance Oral Hygiene - 05. Setup or clean-up assistance Toileting Hygiene - 06. Independent Shower/Bathe Self - 03. Partial/moderate assistance Lower Body Dressing - 06. Independent Don/Doff Footwear - 06. Independent Eating - 06. Independent Upper Body Dressing - 06. Independent		

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	04/01/2026