Home Health Certification and Plan of Care

Order ID: 1163/1038

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
74333657	04/17/2026	From: 04/17/2026 To: 06/15/2026	674	497754

6. Patient's Name and Address

Leslie Pinckney
2199 Mountain View Road Apt 314,
STAFFORD, VA 22556-
571-230-4109

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 11/14/1962 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
I12.0	Hyp chr kidney disease w stage 5 chr kidney disease or ESRD	04/17/26

13. ICD	Other Pertinent Diagnoses	Date
N18.6	End stage renal disease	04/17/26
D63.1	Anemia in chronic kidney disease	04/17/26
Z99.2	Dependence on renal dialysis	04/17/26
F20.9	Schizophrenia unspecified	04/17/26
M79.671	Pain in right foot	04/17/26
E78.5	Hyperlipidemia unspecified	04/17/26
M10.9	Gout unspecified	04/17/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	04/17/26

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

Vitamin B Complex - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1 Tablet by mouth once a day Supplement
Abilify - Aripiprazole 10 mg 1 tablet by mouth once a day
Nifedipine - Nifedipine 60 mg Take 1 tablet by mouth twice a day
Coreg - Carvedilol 25 mg 1 tablet by mouth twice a day for blood pressure control
Hydralazine - Hydralazine Hydrochloride 100 mg 1 tab by mouth twice a day HTN
Atorvastatin - Atorvastatin Calcium 40 mg 1 tab by mouth at bedtime Stroke
Benztropine - Benztropine Mesylate 1mg take 1 tablet by mouth once a day Parkinson
Zyloprim - Allopurinol 100 mg 1 Tablet by mouth once a day Gout Tuesday, Thursday and Saturday after dialysis
Trazadone - Trazodone Hydrochloride 50 mg takee 0.5 tablet by mouth at bedtime Insomnia
Cozaar - Losartan Potassium 50 mg , Take 1 tablet by mouth once a day
Prednisone - Prednisone 20 mg 2 tablets by mouth
Tylenol Es 500 Mg - Acetaminophen 2 tablets by mouth every 6 hours as needed for mild pain
Aspirin - Aspirin 81 mg 1 tab by mouth once a day Prophylactic
Senna Plus - Senna 50 mg 1 tab by mouth once a day Constipation

14. DME and Supplies:

hand held shower

15. Safety Measures:

standard precautions, medication safety, , , fall precautions, bathroom safety, emergency phone # clearly displayed, ambulates with assistance

16. Nutrition:

low sodium, cardiac diet

17. Allergies:

povidone iodine shellfish

18.A. Functional Limitations

Ambulation, Endurance

18.B. Activities Permitted

Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 2. Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility, ANXIETY: 3. During the day and evening, but not constantly, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 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

family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease, 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 63-year-old African American female referred to home health services following hospitalization for increased confusion and diagnosis of transient ischemic attack (TIA) with history of prior cerebrovascular accident (CVA). Past medical history is significant for chronic kidney disease stage 4 requiring hemodialysis on Tuesday, Thursday, and Saturday, hypertension, gastroesophageal reflux disease (GERD), schizophrenia, and cognitive impairment. The patient resides alone in a single-level apartment; however, her sister, Veronica, and other family members provide ongoing assistance with medication management, instrumental activities of daily living (IADLs), transportation to medical appointments, and overall supervision as needed. Upon assessment, the patient was alert, awake, and oriented to person and place, and at times oriented only to self and birthday, demonstrating intermittent confusion and impaired cognition. The patient was noted to be easily redirected during the visit but also displayed periods of suspicion regarding the nursing visit, questioning the purpose of services and requesting removal of signatures due to confusion about the visit. Skilled nursing staff explained that services were arranged by the patient's sister for disease management education, safety monitoring, and strengthening support. Neurological assessment revealed positive facial symmetry and equal bilateral hand grasps. Respiratory assessment demonstrated posterior lung fields clear to auscultation without use of accessory muscles or signs of respiratory distress. Abdomen was soft and non-tender with positive bowel sounds in all four quadrants. The patient remains continent of bowel and bladder. Dialysis access via right upper extremity arteriovenous shunt was assessed with positive bruit and thrill present and no bleeding or signs of complication noted at the access site. The patient reported right foot pain but refused nursing assessment of the foot during the visit. The patient ambulates independently and has a quad cane available for additional support with mobility. Environmental assessment revealed the presence of a shower chair and grab bars to improve safety during bathing activities. The patient is currently able to complete upper and lower body dressing tasks independently; however, deficits in cognition, judgment, safety awareness, and overall self-care management were noted. Poor personal grooming and hair maintenance were also observed, and encouragement was provided regarding personal hygiene and self-care routines. Due to cognitive impairment and limited insight, the patient would benefit from increased supervision and consideration of private caregiver assistance for meal preparation, household management, and overall safety within the home environment. Skilled occupational therapy evaluation was completed and determined the patient would benefit from continued OT services focused on improving safety and independence with activities of daily living, bathing tasks, transfers, and functional mobility. Planned interventions include therapeutic exercises, ADL retraining, safety education, and strategies to improve functional performance and reduce fall risk. Skilled nursing services remain medically necessary for ongoing assessment of cognitive status, disease process management, dialysis access monitoring, medication education, reinforcement of safety precautions, and caregiver education. Education was provided to the patient and family regarding safety awareness, medication management, use of assistive devices, importance of supervision, and when to notify the physician or agency of changes in condition. The patient and family verbalized understanding, though reinforcement will likely be required secondary to cognitive deficits.
 Date of Order 04/17/2026 Orders Physician

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 04/17/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Marissa Moultrie
125 Hospital Center Blvd Ste 110
Stafford, VA 22554
PHONE: 5406026500 FAX: NPI: 1235591769

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 : 04/10/2026

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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Face-to-Face Date: 04/10/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease 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:
 Physician Moultrie, Marissa

SN Careplans

SN WK1: 1 (04/17/26-04/18/26)

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: 3. Multiple hospitalizations (2 or more) in the past 6 months, 4. Multiple emergency department visits (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

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: M1700 - Cognition, M1745 - Behavioral Issues, A1250 - Lack of Necessary Transportation, M2020 - Oral Med Management, 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, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion: Sister involved, coordinate/arrange transportation services: Sister managed, monitor dialysis schedule: Tuesday Thursday and Saturday

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, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient's transportation needs are met

SN Goals

PATIENT-STATED GOAL: Help my sister to cook and clean

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 relaxation skills and diversional activities
* 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 keep home safe for patient with dementia
* coping strategies for the caregiver* 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 self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

patient's transportation needs are met

OT Careplans

OT WK2: 1 (04/19/26-04/25/26) ,WK3: 1 (04/26/26-05/02/26) ,WK4: 1 (05/03/26-05/09/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, GG0130H1 - Don/Doff Footwear, GG0130A1 - Eating, GG0170J1 - Walk 50 ft with 2 Turns, GG0170I1 - Walk 10 Feet, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170D1 - Sit to Stand, GG0130C1 - Toileting Hygiene, GG0170F1 - Toilet Transfer, GG0130E1 - Shower/Bathe Self, GG0170K1 - Walk 150 Feet, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing, GG0130B1 - Oral Hygiene, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170L1 - Walk 10 ft on Uneven Surface

PROCEDURES: home exercise program: Provide HEP handout for UB strengthening, 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 - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 05. Setup or clean-up assistance, 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 and be safe with bathing

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Shower/Bathe Self - 05. Setup or clean-up assistance

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 - 06. Independent

Toileting Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Eating - 06. Independent

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	04/17/2026

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Eating - 06. Independent

Upper Body Dressing - 06. Independent

Oral Hygiene - 06. Independent

Don/Doff Footwear - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
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