Home Health Certification and Plan of Care

Order ID: 1163/1010

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
98172748	04/23/2026	From: 04/23/2026 To: 06/21/2026	1304	497754

6. Patient's Name and Address
Rosa Flores
4425 Medford Drive,
ANNANDALE, VA 22003-
571-344-1076

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 12/29/1941 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
C67.9	Malignant neoplasm of bladder unspecified	04/23/26

13. ICD	Other Pertinent Diagnoses	Date
I10.	Essential (primary) hypertension	04/23/26
I70.0	Atherosclerosis of aorta	04/23/26
E78.00	Pure hypercholesterolemia unspecified	04/23/26
K21.9	Gastro-esophageal reflux disease without esophagitis	04/23/26
M47.817	Spondyls w/o myelopathy or radiculopathy lumbosacr region	04/23/26
M16.0	Bilateral primary osteoarthritis of hip	04/23/26
G47.00	Insomnia unspecified	04/23/26
M81.0	Age-related osteoporosis w/o current pathological fracture	04/23/26
H91.93	Unspecified hearing loss bilateral	04/23/26

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

Losartan Potassium - Losartan Potassium 100 mg by mouth in the morning HTN
Amilodipine - Amlodipine Besylate 5 mg 1 tab by mouth in the morning HTN
Docusate Sodium 100 mg by mouth twice a day Constipation as needed
Cetirizine Hydrochloride - Cetirizine Hydrochloride 10 mg by mouth in the morning Allergic
Atorvastatin - Atorvastatin Calcium 40 mg by mouth in the evening
Acetaminophen - Acetaminophen 500mg 1 tab by mouth every 6 hours Mild pain as needed
Trazadone - Trazodone Hydrochloride 50 mg 1 tab by mouth at bedtime Insomnia

14. DME and Supplies:
walker, hospital bed, hand held shower, bath bench

15. Safety Measures:
standard precautions, medication safety, fall precautions, bathroom safety, ambulates with device, ambulates with assistance

16. Nutrition:
cardiac diet,

17. Allergies:
no known allergies

18.A. Functional Limitations
Ambulation, Endurance, Hearing

18.B. Activities Permitted
Walker, 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

Homebound status: New ileal conduit, will need home health.

Clinical Condition Requiring Homecare: Invasive high-grade papillary urothelial carcinoma

SN Careplans

SN WK1: 1 (04/23/26-04/25/26)

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, 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, 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, M1033 -

SN Goals

PATIENT-STATED GOAL: I want to gain my strength back

GOALS
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
* 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

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 04/23/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Krista Frye
5999 Burke Commons Rd
Arlington, VA 22205
PHONE: 7032497700 FAX: NPI: 1336776228

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 : 04/17/2026

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.

Home Health Certification and Plan of Care

Order ID: 1163/1010

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
98172748	04/23/2026	From: 04/23/2026 To: 06/21/2026	1304	497754

6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number
Rosa Flores 4425 Medford Drive, ANNANDALE, VA 22003- 571-344-1076	Grace Home Healthcare, LLC 9735 Main Street Suite 200 Fairfax, Fairfax, VA 22031-3736 703-865-7370 1073904009

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, meal preparation, M1060 - Unintentional Weight Loss, M1400 - Dyspnea, balance deficit, B0200 - Hearing Deficit

PROCEDURES: cough/deep breathing exercises: Demonstrated understanding, coordinate/arrange preparation of missing meals: Family assist, coordinate/arrange home modifications for hearing impaired, i.e. alarms: Doesn't have hearing aids at time

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, * strategies to increase caloric intake, 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

Signature of Physician:	Date
	PAGE 2 of 2
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	04/23/2026