Home Health Certification and Plan of Care

Order ID: 1163/1081

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
47123967	06/08/2026	From: 06/08/2026 To: 08/06/2026	1624	497754

6. Patient's Name and Address

Richard Anckner
2140 N Pollard Street,
ARLINGTON, VA 22207-
540-229-8398

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 09/20/1959 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
E11.621	Type 2 diabetes mellitus with foot ulcer	06/08/26

13. ICD	Other Pertinent Diagnoses	Date
L97.511	Non-prs chronic ulcer oth prt r foot limited to brkdwn skin	06/08/26
E11.43	Type 2 diabetes w diabetic autonomic (poly)neuropathy	06/08/26
I10.	Essential (primary) hypertension	06/08/26
F33.9	Major depressive disorder recurrent unspecified	06/08/26
E11.69	Type 2 diabetes mellitus with other specified complication	06/08/26
E78.49	Other hyperlipidemia	06/08/26
L85.3	Xerosis cutis	06/08/26
Z79.4	Long term (current) use of insulin	06/08/26
Z91.81	History of falling	06/08/26

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

Kirsty 100 unit/ML 6 units subcutaneous three times a day DM
Insulin Glargine-yfgn 10 Units subcutaneous at bedtime DM
GABAPENTIN 300 mg 3 tabs Oral 3-TIMES-A-DAY Moderate pain
LOSARTAN POTASSIUM 25 mg 1 Tablet Oral DAILY HTN
ESCITALOPRAM 5 mg 1 Tablet Oral DAILY Depression
ATORVASTATIN 20 mg 1 tab Oral DAILY For cholesterol and heart protection

14. DME and Supplies:

walker, grab bars, hand held shower, diabetic supplies, bath bench

15. Safety Measures:

walker precautions, standard precautions, medication safety, hand rails, fall precautions, diabetic precautions, bathroom safety, ambulates with device, ambulates with assistance

16. Nutrition:

regular, diabetic

17. Allergies:

no known allergies

18.A. Functional Limitations

Ambulation, Endurance

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: Yes

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: Due to diagnosis of Type 2 diabetes mellitus with foot ulcer, 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 66-year-old White male referred to home health services for wound care management following a recent wound clinic visit. He resides in a single-family home with family members, and his sister and mother serve as his primary caregivers. Upon assessment, the patient was alert, awake, and oriented to person, place, and time. Neurological assessment revealed positive facial symmetry, equal bilateral hand grasps, and pupils that were equal, round, and reactive to light. The patient wears corrective eyeglasses for vision support. Respiratory assessment demonstrated clear posterior lung sounds bilaterally without the use of accessory muscles or signs of respiratory distress. Cardiovascular assessment revealed bilateral lower extremity edema with faint pedal pulses. The patient was educated on the importance of lower extremity elevation to assist with edema management and promote circulation. Abdominal assessment revealed a soft, non-tender abdomen with active bowel sounds present in all four quadrants. The patient is continent of both bowel and bladder. The patient ambulates with the assistance of a walker and reported left foot pain during the visit. Pain medication had been administered as prescribed, with the patient reporting satisfactory pain relief. Skin assessment revealed dry, flaky skin, and the patient was encouraged to shower as tolerated and maintain adequate skin hygiene and moisturization to preserve skin integrity. Wound care was performed during the visit in accordance with current treatment orders. The patient has physician orders for Coban compression wraps; however, Ace wraps were present on both lower extremities at the time of assessment. The patient reported that Ace wraps have routinely been applied during wound clinic visits. Assessment of the right plantar foot revealed a dry, dark scab measuring approximately 0.5 cm x 0.5 cm with no measurable depth, drainage, or signs of infection. Assessment of the left heel revealed a wound measuring 3.0 cm x 4.0 cm x 0.2 cm with a large amount of serous drainage present and no odor noted. The wound was cleansed and dressed per physician orders, and the patient tolerated the procedure well. Education was provided regarding wound care, infection prevention, edema management through leg elevation, skin care, fall prevention, safe use of the walker, and the importance of adhering to prescribed wound treatment recommendations. The patient and caregivers verbalized understanding of the instructions provided. The plan of care includes continued skilled nursing visits for wound assessment and management, monitoring for signs and symptoms of infection, evaluation of wound healing progress, reinforcement of education, pain assessment, and ongoing support to promote optimal wound healing and prevent complications.
 Date of Order 06/08/2026 Orders Physician Face-to-Face Date: 05/06/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management due to Type 2 diabetes mellitus with foot ulcer 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
 Physician Donald, Robin

SN Careplans

SN WK1: 1 (06/08/26-06/13/26) ,WK2: 1 (06/14/26-06/20/26) ,WK3: 1 (06/21/26-06/27/26) ,WK4: 1 (06/28/26-07/04/26) ,WK5: 1 (07/05/26-07/11/26) ,WK6: 1 (07/12/26-07/18/26) ,WK7: 1 (07/19/26-07/25/26) ,WK8: 1 (07/26/26-08/01/26)

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

SN Goals

PATIENT-STATED GOAL: I need help with my wound

GOALS
patient/caregiver recalls
* depression-prevention strategies including avoidance of isolation
* healthy eating
* sleeping habits
* identification of activities that bring pleasure
* preventive care
* recalls related medication(s) purpose, schedule

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 06/08/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Robin Donald
6551 Loisdale
Springfield, VA 22150
PHONE: 5716222000 FAX: NPI: 1083742621

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 : 05/06/2026

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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HOSPITALIZATION RISKS: 1. History of falls (2 or more falls - or any fall with an injury - 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, 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: D0160 - Depression, A1250 - Lack of Necessary Transportation, M2020 - Oral Med Management, meal preparation, M2102f - Patient Supervision, M1400 - Dyspnea, limited endurance, limited range of motion, limited strength, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs

PROCEDURES: cough/deep breathing exercises: Demonstrated understanding, physician-ordered wound care: Cleanse left heel wound with normal saline, apply beading, cover with abdominal pad, roll wrap and coban 2 times weekly, glucose testing via monitor: Self monitoring, coordinate/arrange for adequate patient supervision: Lives with family, coordinate/arrange preparation of missing meals: Family assist, coordinate/arrange transportation services: Family 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 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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient's transportation needs are met, patient is adequately supervised, meal preparation is available to patient for all meals

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

patient's transportation needs are met

patient is adequately supervised

meal preparation is available to patient for all meals

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/08/2026