Home Health Certification and Plan of Care

Order ID: 1163/1185

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
61115339	07/24/2026	From: 07/24/2026 To: 09/21/2026	1774	497754

6. Patient's Name and Address
Thomas Kennedy
2208 Russell Rd,
ALEXANDRIA, VA 22301-
703-517-1095

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 11/25/1962 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z48.816	Encounter for surgical aftcr following surgery on the GU sys	07/24/26

13. ICD	Other Pertinent Diagnoses	Date
Z90.6	Acquired absence of other parts of urinary tract	07/24/26
Z43.6	Encounter for attn to oth artif openings of urinary tract	07/24/26

10. Medications: Dose/Frequency/Route (N)ew (C)hanged
FLOMAX 0.4 MG / 1 Capsule by mouth daily
NORVASC 10 MG / 1 Tablet by mouth once a day
Zestril - Lisinopril 5 MG / 1 Tablet by mouth daily
Zofran Odt - Ondansetron Disintegrating 8 MG / Dissolve 1 tablet on the tongue by mouth three times a day after meals as needed for nausea or vomiting

14. DME and Supplies:
ostomy supplies

15. Safety Measures:
hand rails, fall precautions, standard precautions, smoke detectors , medication safety, emergency phone # clearly displayed, ambulates with assistance, transfer with assist, bathroom safety, activity supervision

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
no known allergies

18.A. Functional Limitations
Endurance

18.B. Activities Permitted
Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 1. In new or complex situations only, 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:
Due to diagnosis of Encounter for surgical aftercare following surgery on the genitourinary system, 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 was seen today for ongoing colostomy care, evaluation, and treatment. He was alert and oriented 4, with clear lung sounds, normal heart sounds, active bowel sounds in all four quadrants, and regular bowel movements. The patient was observed sitting at the dining table accompanied by his two private caregivers. He was pleasant, cooperative, and highly motivated to participate in physical therapy to improve his strength and functional mobility. The patient reported receiving comprehensive colostomy care education prior to hospital discharge and demonstrated independence and confidence in managing and changing his colostomy appliance. Overall, he remains clinically stable with no acute concerns noted during today's visit.
<o:p></o:p> Date of Order<o:p></o:p> 07/24/2026<o:p></o:p> Physician Face-to-Face Date: 07/19/2026<o:p></o:p> Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management dx: Encounter for surgical aftercare following surgery on the genitourinary system<o:p></o:p> Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home<o:p></o:p>   1 - SOC - SN Notes: Physician: Chaudri, Faisal

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 07/24/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Faisal Chaudri
6501 Loisdale Ct Ste 1100
Springfield, VA 22150
PHONE: 5716222000 FAX: NPI: 1750430682

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 : 07/19/2026

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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SN Careplans

SN WK1: 1 (07/24/26-07/25/26) ,WK2: 2 (07/26/26-08/01/26) ,WK3: 2 (08/02/26-08/08/26) ,WK4: 1 (08/09/26-08/15/26) ,WK5: 1 (08/16/26-08/22/26) ,WK6: 1 (08/23/26-08/29/26) ,WK7: 1 (08/30/26-09/05/26) ,WK8: 1 (09/06/26-09/12/26)

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: 2. Non-agency caregiver(s) need training/supportive services to provide assistance

HOSPITALIZATION RISKS: 10. None of the above

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:POLST (Physician Orders for Life-Sustaining Treatment)

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, M2102c - Med Admin, M2102f - Patient Supervision, M2102d - Caregiver Performs Treatment, M1400 - Dyspnea, swelling of affected area, limited endurance, M1630 - GI Ostomy, #1 - GI Ostomy - Other - RUQ - Ileal Conduit

PROCEDURES: physician-ordered wound care: #1 - GI Ostomy - Other - RUQ - Ileal Conduit: SN Orders - Loop Ileostomy SN to assess loop ileostomy at each visit for stoma appearance (color, size, edema, viability), peristomal skin integrity, pouch seal, and amount/consistency of output. Remove pouching system gently using adhesive remover wipes. Cleanse peristomal skin with water only using disposable washcloths. Do not use Theraworx or other products that may interfere with pouch adhesion. Pat skin completely dry. Measure stoma as needed and cut skin barrier opening to fit the stoma, allowing no more than 1/8 inch of exposed peristomal skin. For moldable barriers, mold barrier to fit snugly around the stoma. If peristomal skin is broken or irritated, apply stoma powder, brush away excess, then apply no-sting barrier film and allow to dry for 20-30 seconds before applying the barrier. If skin is intact, omit this step. Apply skin barrier securely to dry skin and attach pouch per manufacturer's instructions. Empty pouch when 1/3 full. Change pouching system every 3-5 days and as needed for leakage or loss of seal. Connect urostomy/high-output pouch to bedside gravity drainage while patient is in bed using the prescribed adapter, if ordered. Monitor for signs of dehydration, electrolyte imbalance, decreased or excessive output, leakage, peristomal skin breakdown, bleeding, stoma ischemia, prolapse, retraction, or obstruction. Notify the provider of significant findings. Instruct and reinforce patient/caregiver on ostomy care, hydration, diet, pouch management, skin care, and symptoms requiring medical attention. Encourage independence with ostomy care as tolerated., physician-ordered wound care: #1 - GI Ostomy - Other - RUQ - Ileal Conduit: SN Orders - Ileal Conduit SN to assess Ileal Conduit at each visit for stoma appearance (color, size, edema, viability), peristomal skin integrity, pouch seal, and amount/consistency of output. Remove pouching system gently using adhesive remover wipes. Cleanse peristomal skin with water only using disposable washcloths. Do not use Theraworx or other products that may interfere with pouch adhesion. Pat skin completely dry. Measure stoma as needed and cut skin barrier opening to fit the stoma, allowing no more than 1/8 inch of exposed peristomal skin. For moldable barriers, mold barrier to fit snugly around the stoma. If peristomal skin is broken or irritated, apply stoma powder, brush away excess, then apply no-sting barrier film and allow to dry for 20-30 seconds before applying the barrier. If skin is intact, omit this step. Apply skin barrier securely to dry skin and attach pouch per manufacturer's instructions. Empty pouch when 1/3 full. Change pouching system every 3-5 days and as needed for leakage or loss of seal. Connect urostomy/high-output pouch to bedside gravity drainage while patient is in bed using the prescribed adapter, if ordered. Monitor for signs of dehydration, electrolyte imbalance, decreased or excessive output, leakage, peristomal skin breakdown, bleeding, stoma ischemia, prolapse, retraction, or obstruction. Notify the provider of significant findings. Instruct and reinforce patient/caregiver on ostomy care, hydration, diet, pouch management, skin care, and symptoms requiring medical attention. Encourage independence with ostomy care as tolerated., cough/deep breathing exercises, incentive spirometer

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, * ostomy management including how to clean stoma change ostomy pouch, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient is adequately supervised, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

SN Goals

PATIENT-STATED GOAL: Patient wants to become independent with her ileal conduit

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 medication(s) purpose, schedule

patient/caregiver recalls
* ostomy management including how to clean stoma
* change ostomy pouch
* recalls related medication(s) purpose, schedule

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

patient is adequately supervised

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

Signature of Physician:	Date
	PAGE 2 of 2
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/24/2026