Home Health Certification and Plan of Care

Order ID: 1163/1245

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
5R94AX7HN68	07/23/2026	From: 07/23/2026 To: 09/20/2026	1786	497754

6. Patient's Name and Address
Lucia Seyranyan
6109 Dominican Dr,
Springfield, VA 22152-
703-609-0473

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 04/12/1955 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
E11.51	Type 2 diabetes w diabetic peripheral angiopath w/o gangrene	07/23/26

13. ICD	Other Pertinent Diagnoses	Date
I70.213	Athscl native arteries of extrm w intrmt claud bi legs	07/23/26
E46.	Unspecified protein-calorie malnutrition	07/23/26
E78.5	Hyperlipidemia unspecified	07/23/26
F03.911	Unspecified dementia unspecified severity with agitation	07/23/26
F03.93	Unsp dementia unspecified severity with mood disturb	07/23/26
F33.1	Major depressive disorder recurrent moderate	07/23/26
I10.	Essential (primary) hypertension	07/23/26
L89.101	Pressure ulcer of unspecified part of back stage 1	07/23/26
L89.211	Pressure ulcer of right hip stage 1	07/23/26
M17.11	Unilateral primary osteoarthritis right knee	07/23/26
J45.909	Unspecified asthma uncomplicated	07/23/26
M62.81	Muscle weakness (generalized)	07/23/26
Z79.899	Other long term (current) drug therapy	07/23/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	07/23/26
Z79.891	Long term (current) use of opiate analgesic	07/23/26
Z74.01	Bed confinement status	07/23/26

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

Doxycycline Hyclate - Doxycycline Hyclate 100 MG TAB by mouth once a day
Lidocaine Patch - Lidocaine 5 % topical once a day
Metformin Er - Metformin Hydrochloride 500 MG GP TAB by mouth once a day
Tramadol Hcl - Tramadol Hydrochloride 50 MG TAB by mouth as necessary
DONEPEZIL HYDROCHLORIDE 10 mg 10 MG TAB by mouth once a day
ESCITALOPRAM 10 MG TAB by mouth once a day
FUROSEMIDE 20 mg 20 MG TAB inhalant once a day
IBUPROFEN 600 mg 600 MG TAB inhalant as necessary
LISINOPRIL 20 mg 20 MG TAB by mouth once a day
LOSARTAN POTASSIUM 50 MG / 1 Tablet by mouth twice a day for HTN
MEMANTINE HYDROCHLORIDE 10 MG TAB by mouth once a day
NYSTATIN 100,000 units/g topical cream Apply to rash area twice a day for fungal and diaper rash
QUETIAPINE FUMARATE 25 MG / 1 Tablet by mouth at bedtime for insomnia
DICLOFENAC 1 % Gel topical as necessary
TRAZODONE 50 MG TAB by mouth at bedtime
PREGABALIN 25 GM CAP by mouth once a day
Baza-Protect topical cream Use topically twice a day for skin rash
WIXELA INHUB 250/50 INH 250/50 inhalant twice a day

14. DME and Supplies:
None of the above

15. Safety Measures:
fall precautions, diabetic precautions, supervision at all times, emergency phone # clearly displayed, bedrails up while in bed, aspiration precautions, standard precautions

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
None

18.A. Functional Limitations
Ambulation, Contracture, Bowel/Bladder Incontinence, Paralysis

18.B. Activities Permitted
No Restrictions

19. Mental & Pyschosocial Status: COGNITION: 4. Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium., ANXIETY: 4. Constantly, SOCIAL ISOLATION: 8. Patient unable to respond, 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: Yes

20. Prognosis: poor

22. A Rehabilitation Potential:
SELF-CARE: 1. Dependent - A helper completed all the activities for the patient., MOBILITY: 1. Dependent - A helper completed all the activities for the patient.

22.B.Discharge Plans
family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Type 2 diabetes with diabetic peripheral angiopath w/o gangrene, 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: Patient is a 70-year-old female admitted to home health services for skilled nursing evaluation and management of pressure injuries. Patient is homebound, bedbound, and alert and oriented to self only secondary to advanced dementia with agitation. She resides at home with her husband, who is present at the bedside and serves as her primary caregiver, providing total assistance with all activities of daily living, mobility, transfers, repositioning, and personal care. Past medical history is significant for asthma, advanced dementia with agitation, hypertension managed with antihypertensive medication, type 2 diabetes mellitus, peripheral vascular disease, major depressive disorder, osteoarthritis, and urinary and bowel incontinence. Comprehensive skilled nursing assessment was completed, and vital signs were obtained and documented. Patient remains completely dependent for bed mobility, transfers, repositioning, and all personal care. Bilateral lower extremities are flaccid with contractures, resulting in severely limited range of motion, inability to bear weight, and inability to ambulate. Skin assessment identified a Stage I pressure injury to the back and a Stage II pressure injury to the hip. Wounds were assessed and measured, cleansed, and treated according to physician orders. Patient tolerated wound care without signs of acute distress. Patient remains at high risk for delayed wound healing and further skin breakdown due to prolonged immobility, bedbound status, bilateral lower-extremity flaccidity and contractures, diabetes mellitus, peripheral vascular disease, urinary and bowel incontinence, and significant cognitive impairment. Continued skilled nursing services are medically necessary for ongoing wound assessment and management, dressing changes, monitoring for infection or deterioration, skin integrity surveillance, pain assessment, medication management, and evaluation of the patient's response to treatment. Education was provided to the husband/caregiver regarding pressure injury prevention and wound management, including repositioning the patient at least every two hours, use of pressure-relieving surfaces and devices, off-loading bony prominences, maintaining clean and dry skin, providing prompt incontinence care, monitoring for signs and symptoms of infection, promoting adequate nutrition and hydration to support wound healing, maintaining appropriate blood glucose control, adhering to prescribed medications and treatment orders, and notifying the physician or home health agency of any worsening wound condition or other significant change in status. Due to the patient's advanced dementia and limited ability to participate in teaching, education was directed primarily to the caregiver, who verbalized understanding but will require continued reinforcement. Plan is to continue skilled nursing visits for wound care, pressure injury prevention, medication and disease management, caregiver education, and ongoing assessment of the patient's overall condition and response to the plan of care.
 Date of Order 07/23/2026 Orders Physician Face-to-Face Date: 06/05/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease process due to Type 2 diabetes with diabetic peripheral angiopath w/o gangrene 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 Tracy, Lauren

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

25. Date HHA Received Signed POT

24. Physician's Name and Address
Lauren Tracy
2833 Cleave Dr
Falls Church, VA 22042
PHONE: 8009691104 FAX: 17033981519 NPI: 1790436749

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 : 06/05/2026

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 frequency WK1: 1 (07/23/26-07/25/26) ,WK2: 1 (07/26/26-08/01/26) ,WK3: 1 (08/02/26-08/08/26) ,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) ,WK9: 1 (09/13/26-09/19/26)

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: 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:PLACEHOLDER

09/03/2026 Problems : #1 - 2 - Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed. - Posterior Right Buttock - Wound bed appears pink and moist with partial-thickness skin loss. No slough or eschar noted. Drainage is scant serous without foul odor. Periwound skin intact with no signs of infection.
M1700 - Cognition
M1745 - Behavioral Issues
M1620 - Bowel Incontinence
M1033 - Exhaustion
Pain Effect on Sleep
Pain Interference with Therapy activities
Pain Interference with ADLs
M1400 - Dyspnea
M2020 - Oral Med Management
muscle weakness
limited range of motion
skin breakdown r/t incontinence
D0160 - Depression
M2102f - Patient Supervision
M2102d - Caregiver Performs Treatment

PROCEDURES: physician-ordered wound care: #1 - 2 - Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed. - Posterior Right Buttock - Wound bed appears pink and moist with partial-thickness skin loss. No slough or eschar noted. Drainage is scant serous without foul odor. Periwound skin intact with no signs of infection., cough/deep breathing exercises, incentive spirometer, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, physician-ordered wound care: Apply zinc oxide cream to stage 1 on back and right hip, turn patient every 2 hours, continue with padded mattress, physician-ordered wound care: Apply barrier cream to stage 1 on back and right hip, turn patient every 2 hours, physician-ordered wound care: Apply barrier cream to stage 1 on back and right hip, turn patient every 2 hours

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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, 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, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, * bowel incontinence management including dietary changes bowel training skin care, related medication(s) purpose, schedule, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule

SN Goals

PATIENT-STATED GOAL: Patient states she wants her wound to heal without infection

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
* 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

patient/caregiver recalls
* how to achieve wound healing including cleaning and dressing wound
* position changes
* skin care
* diet modification
* record wound measurements
* 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
* 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
* 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
* bowel incontinence management including dietary changes
* bowel training
* skin care
* 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

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:
Electronically Signed by Messick, Charles RN

Date
07/23/2026