Home Health Certification and Plan of Care

Order ID: 1163/194

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
671283547	08/18/2025	From: 08/18/2025 To: 10/16/2025	329	497754

6. Patient's Name and Address
Bobbie Asbury
13329 Keystone Drive,
Woodbridge, VA 22193-
919-608-7278

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 04/06/1939 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
I48.91	Unspecified atrial fibrillation	08/18/25

13. ICD	Other Pertinent Diagnoses	Date
I21.4	Non-ST elevation (NSTEMI) myocardial infarction	08/18/25
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	08/18/25
N18.32	Chronic kidney disease stage 3b	08/18/25
I35.0	Nonrheumatic aortic (valve) stenosis	08/18/25
F03.90	Unsp dementia unsp severity without beh/psych/mood/anx	08/18/25
Z79.82	Long term (current) use of aspirin	08/18/25
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	08/18/25
Z87.440	Personal history of urinary (tract) infections	08/18/25

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

Aspirin 81Mg - Aspirin 81 mg, take (81mg) tablet by mouth once a day chewable tab
Famotidine - Famotidine 20mg, take (20mg) tablet by mouth at bedtime
Lopressor - Metoprolol Tartrate 12.5 mg , Take 12.5 mg tablet by mouth twice a day take .5 tabs (12.5 mg total) by mouth in the morning and .5 tabs (12.5 mg total) before bedtime
Lipitor - Atorvastatin Calcium 40 mg , Take 40 mg Tablet by mouth at bedtime Rx bottle reads correctly to take at bedtime, but d/c paperwork mistakenly reads in the morning per the med freq diagram listed; pt and son aware to take at bedtime
Cephalexin - Cephalexin eq 500 mg base 1 caps by mouth every 12 hours Take 1 capsule by mouth every 12 hours for 7 days
Ceftin - Cefuroxime Axetil eq 250 mg base 2 tabs by mouth twice a day Take 2 tabs (500mg total) by mouth in morning, and 2 tabs (500mg total) by mouth in evening; do all this for 3 days

14. DME and Supplies:
bath bench, wheelchair, rolling walker, ,

15. Safety Measures:
transfer with assist, ambulates with assistance, fall precautions, walker precautions, wheelchair precautions, , medication safety, standard precautions, supervision at all times, bathroom safety, activity supervision

16. Nutrition:
cardiac diet

17. Allergies:
no known allergies

18.A. Functional Limitations
Hearing, Ambulation

18.B. Activities Permitted
Up As Tolerated, Exercises Prescribed,

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: 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: No

20. Prognosis: fair

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 Unspecified Atrial Fibrillation, 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 an 86-year-old male recently discharged from the hospital on 8/15/2025 following admission for persistent hiccups, cough, and weakness that began on 8/9/2025. He was initially evaluated at urgent care on 8/11/2025 but was later transported by VHC on 8/12/2025, where he was diagnosed with aortic valve stenosis and initiated on dialysis. During hospitalization, he was further diagnosed with new-onset atrial fibrillation, urinary tract infection (treated with antibiotics), and experienced generalized weakness. His past medical history is significant for dementia, non-rheumatic aortic stenosis, atrial fibrillation, NSTEMI, acute renal insufficiency, hypertensive chronic kidney disease, possible congestive heart failure with elevated BNP, history of CVA, dialysis dependence, and recurrent UTIs. Prior to admission, the patient required some physical assistance for mobility outside the home, but since discharge, he demonstrates increased difficulty with transfers, standing tolerance, and ambulation. He presents with decreased strength, endurance, balance, steadiness of gait, and overall functional mobility. The patient is independent with feeding and medication administration only if meals and medications are prepared in advance. He requires complete caregiver assistance with bathing, grooming, dressing, toileting, and medication management. He wears adult diapers due to urinary incontinence associated with dementia, and incontinence pads are placed on seating surfaces. He utilizes a wheelchair outdoors and has access to a walker, although he does not use it appropriately. Currently, he ambulates with close supervision or contact guard assistance provided by his son, Jeffrey, and the therapist. During the evaluation, he demonstrated independence with transfers and ambulation but required supervision for safety. The patient's son reports decreased oral intake since discharge, with limited urine output of at least once daily. Notably, quetiapine fumarate was discontinued by the son in January 2023 due to vomiting without notifying the prescribing physician; he was advised to update the physician regarding this change and verbalized understanding. Medication reconciliation confirmed atorvastatin is to be taken at bedtime, correcting a discrepancy in discharge instructions. Education was provided on safe home setup, transfer techniques, and initiation of a home exercise program focusing on seated bilateral lower extremity strengthening. Skilled physical therapy is recommended to improve strength, endurance, standing tolerance, gait steadiness, balance, and overall safety in functional mobility. Additionally, occupational therapy evaluation revealed the patient requires minimal assistance and verbal cueing to complete total body dressing due to cognitive impairment. He is alert and oriented only to self, but cooperative and able to follow simple instructions. The patient has adaptive equipment in place, including a toilet riser with arms and a shower chair, and was recommended to add a tub clamp for safer transfers. The home environment is cluttered with narrow pathways limiting accessibility. He currently sleeps on an air mattress. Continued occupational therapy services are recommended to improve upper extremity strength, independence with dressing, and functional performance through therapeutic exercise, ADL retraining, endurance training, and caregiver education to maximize safety and independence with ADLs and transfers.
 Date of Order 08/18/2025 Orders Physician Face-to-Face Date: 08/12/2025 Clinical Condition Requiring Home Care per Certifying Physician: PT eval and treat, OT eval and treat due to Unspecified Atrial Fibrillation 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 - PT Notes: OT Eval Notes: Physician Policarpio, Cristinia

SN Careplans

SN Goals

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 08/18/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address
Cristinia Policarpio
13285 Minnieville Rd
Woodbridge, VA 22192
PHONE: 7039862400 FAX: NPI: 1316948086

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 : 08/12/2025

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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PT Careplans

PT WK1: 1 (08/18/25-08/23/25)

PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature < 95 > 100, heart rate < 60 > 100, respiratory rate < 10 > 24, blood pressure systolic < 100 > 150, blood pressure diastolic < 60 > 90, O2 saturation < 90 > 100, pain < 0 > 6

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, 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: GG0170D1 - Sit to Stand, GG0170E1 - Chair to Bed to Chair, GG0170G1 - Car Transfer, GG0170I1 - Walk 10 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170K1 - Walk 150 Feet, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object, GG0170F1 - Toilet Transfer, M1700 - Cognition, M1745 - Behavioral Issues, M2020 - Oral Med Management, Home Safety, Home Safety, M1033 - Exhaustion, M1400 - Dyspnea, M1600 - UTI, decreased urine output, muscle weakness, limited strength, limited endurance, B0200 - Hearing Deficit

PROCEDURES: Medication Review: Medications reviewed with patient/caregiver. , cough/deep breathing exercises, incentive spirometer, seated strengthening exercises, home exercise program: Seated therex BLE 2x10, 3-4x/week: clams, hip add pillow squeezes, marches, LAQ, HR/TR, standing tolerance exercises, dynamic standing balance exercises, gait training on uneven surfaces, gait training/stair training, transfers training, therapeutic exercises

TEACH PATIENT/CAREGIVER: * how to keep home safe for patient with dementia coping strategies for the caregiver, related medication(s) purpose, schedule, * how to incorporate lifestyle modifications to optimize renal condition including renal-specific diet exercise monitoring of blood pressure blood sugar home, related medication(s) purpose, schedule remedies, * prevention including increase fluid intake increase Vitamin C intake to promote acidic bladder environment (cranberry juice) perineal hygiene, 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's living environment is clean/uncluttered, insects/rodents not present in the patient's living environment, Sit to Stand - 04. Supervision or touching assistance, Toilet Transfer - 05. Setup or clean-up assistance, Car Transfer - 04. Supervision or touching assistance, Walk 10 Feet - 03. Partial/moderate assistance, Walk 50 ft with 2 Turns - 03. Partial/moderate assistance, Walk 150 Feet - 03. Partial/moderate assistance, 1 - Step (curb) - 03. Partial/moderate assistance, 4 Steps - 03. Partial/moderate assistance, Picking Up Object - 03. Partial/moderate assistance, Medication Review

PT Goals

PATIENT-STATED GOAL: to be able to walk around home between rooms and outside of home with steady balance and feel safe and balanced when getting into/out of tub shower and walking outside with use of his RW or without AD, but CGA from caregiver son due to dementia dx

GOALS
patient/caregiver recalls
* how to incorporate lifestyle modifications to optimize renal condition including renal-specific diet
* exercise
* monitoring of blood pressure
* blood sugar
* home
* recalls related medication(s) purpose, schedule remedies

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
* prevention including increase fluid intake
* increase Vitamin C intake to promote acidic bladder environment (cranberry juice)
* perineal hygiene
* 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's living environment is clean/uncluttered

insects/rodents not present in the patient's living environment

Sit to Stand - 04. Supervision or touching assistance

Toilet Transfer - 05. Setup or clean-up assistance

Car Transfer - 04. Supervision or touching assistance

Walk 10 Feet - 03. Partial/moderate assistance

Walk 50 ft with 2 Turns - 03. Partial/moderate assistance

Walk 150 Feet - 03. Partial/moderate assistance

1 - Step (curb) - 03. Partial/moderate assistance

4 Steps - 03. Partial/moderate assistance

Picking Up Object - 03. Partial/moderate assistance

Medication Review

OT Careplans

OT WK1: 1 (08/18/25-08/23/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400, GG0130B1 - Oral Hygiene, GG0130F1 - Upper Body Dressing, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130A1 - Eating

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver., equipment training, work simplification/energy conservation

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, Oral Hygiene - 05. Setup or clean-up assistance, Upper Body Dressing - 05. Setup or clean-up

OT Goals

PATIENT-STATED GOAL: Improve Ind with UB and LB dressing

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

Oral Hygiene - 05. Setup or clean-up assistance

Upper Body Dressing - 05. Setup or clean-up assistance

Signature of Physician:

Date

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

Date
08/18/2025

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assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Shower/Bathe Self - 04. Supervision or touching assistance, Toileting Hygiene - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance, Eating - 05. Setup or clean-up assistance, Medication Review-	Lower Body Dressing - 05. Setup or clean-up assistance Shower/Bathe Self - 04. Supervision or touching assistance Toileting Hygiene - 05. Setup or clean-up assistance Don/Doff Footwear - 05. Setup or clean-up assistance Eating - 05. Setup or clean-up assistance Medication Review-

Signature of Physician:	Date
	PAGE 3 of 3
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