Home Health Certification and Plan of Care

Order ID: 1163/222

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
3WU9HG0QW11	08/29/2025	From: 08/29/2025 To: 10/27/2025	349	497754

6. Patient's Name and Address
Christine Andrea
4292 Galesbury Lane,
CHANTILLY, VA 20151-
7033768348

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 02/07/1948 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z48.812	Encntr for surgical aftcr following surgery on the circ sys	08/29/25

13. ICD	Other Pertinent Diagnoses	Date
I25.810	Atherosclerosis of CABG w/o angina pectoris	08/29/25
I48.0	Paroxysmal atrial fibrillation	08/29/25
I10.	Essential (primary) hypertension	08/29/25
E78.5	Hyperlipidemia unspecified	08/29/25
J45.909	Unspecified asthma uncomplicated	08/29/25
F41.9	Anxiety disorder unspecified	08/29/25
Z95.2	Presence of prosthetic heart valve	08/29/25
Z95.1	Presence of aortocoronary bypass graft	08/29/25
Z79.82	Long term (current) use of aspirin	08/29/25
Z79.02	Long term (current) use of antithrombotics/antiplatelets	08/29/25

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

Aspirin 81Mg - Aspirin 81 mg , take 81 mg tablet by mouth once a day
Lipitor - Atorvastatin Calcium 40 mg , take 40 mg tablet by mouth once a day
Dulcolax - Bisacodyl 10 mg, take 10 mg suppository rectal once a day
Pradaxa - Dabigatran Etexilate Mesylate 150 mg , take 150 mg capsule by mouth twice a day
Pepcid - Famotidine 20 mg , take 20 mg tablet by mouth twice a day
Lopressor - Metoprolol Tartrate 25 mg , take 25 mg tablet by mouth twice a day
Tikosyn - Dofetilide 500 mcg , take 500 mcg capsule by mouth twice a day
ondansetron ODT (ZOFRAN-ODT) 4 mg , take 4 mg tablet by mouth every 8 hours As Needed
Ultram - Tramadol Hydrochloride 50 mg , take 50 mg tablet by mouth every 6 hours As Needed For Pain
Tylenol - Acetaminophen 1,000 mg , give 1,000 mg tablet by mouth every 8 hours As Needed for Pain
Alendronate Sodium - Alendronate Sodium eq 70 mg base 1 by mouth once a week
A-Hydrocort - Hydrocortisone Sodium Succinate Ointment topical every 6 hours For Hemorrhoids

14. DME and Supplies:
small base cane, rolling walker, bath bench, grab bars

15. Safety Measures:
non-slip surface in tub, medication safety, fall precautions, ambulates with device, walker precautions, standard precautions, electrical safety measures, cardiac precautions, bathroom safety, anticoagulant precautions, activity supervision

16. Nutrition:
cardiac diet

17. Allergies:
propoxyphene n-acetaminophen lisinopril

18.A. Functional Limitations
Endurance, Ambulation

18.B. Activities Permitted
Walker, Cane, 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: 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
patient will be responsible for managing treatment
family/caregiver will be responsible for managing treatment

Homebound status:
After undergoing Coronary Artery Bypass Grafting With Bioprosthetic Valve Replacement And Left Atrial Appendage Ligation, 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 77-year-old female who is status post hospitalization and discharge following coronary artery bypass grafting (CABG x3) with bioprosthetic valve replacement and left atrial appendage ligation performed on 08/14/2025. Her past medical history is significant for atherosclerosis of coronary artery bypass graft without angina pectoris, paroxysmal atrial fibrillation, hypertension, asthma, prosthetic heart valve, presence of aortocoronary bypass graft, and long-term use of antithrombotic/antiplatelet therapy. She previously worked as a special education educator and is currently on medical leave until a projected return date of November 2025 per surgical recommendations. During this visit, the patient was alert, oriented 4, and observed resting in bed while watching television. She continues to report right shoulder pain rated 5/10. Examination revealed a moderate amount of purulent serosanguinous drainage on the dressing. The skin surrounding the wound was noted to be covered with a white ointment and baby powder, reportedly applied after the dressing came off overnight and was replaced by her home health aide (HHA). The sacral wound areas appeared swollen and erythematous. The wounds were cleansed with Dakin's solution, saline-soaked foam dressings were applied, and wound measurements remained unchanged. The skilled nurse reiterated that HHAs are not permitted to perform wound care or dressing changes, and education was provided to both the patient and caregiver regarding proper wound care procedures. Despite repeated teaching, the patient and caregiver continue to decline skilled nursing wound care education and prefer to have the aide perform dressing changes. A nurse from a non-skilled facility also confirmed that HHAs are not authorized to complete wound care. The patient was advised that the wound appears to be worsening and was strongly counseled to follow the plan of care for skilled nursing oversight. The patient's vital signs were stable, and her appetite was reported as good. Medication reconciliation was performed with no changes identified. Pain management includes the use of prescribed medications as well as non-pharmacologic strategies. The patient is on post-operative restrictions, including no lifting greater than five pounds, no pulling or pushing off with the upper extremities when rising from a seated position, and avoidance of overhead or backward arm movements to reduce strain on the surgical site. She reports shortness of breath with minimal exertion, particularly with ambulation greater than 20 feet and when negotiating a full flight of stairs in her home. Functional assessment revealed decreased strength, endurance, and mobility tolerance. While she ambulates independently indoors, she occasionally requires physical assistance with basic grooming, dressing, reaching overhead items, and oral medication management. She does not drive and relies on her husband for assistance with community activities. Education was provided on safe home setup, use of adaptive equipment, and energy conservation strategies. Recommendations included installation of grab bars and use of a shower chair with a back to promote safety during bathing transfers, which both the patient and her husband acknowledged and understood. A home exercise program (HEP) was initiated, including seated and standing therapeutic exercises for the bilateral lower extremities, respiratory capacity training, and instruction in incentive spirometer use. The patient's spirometer is set at 1,500 mL, though she has only been able to achieve 1,000 mL during attempts. She was encouraged to continue daily use until she can consistently meet and exceed her target volume and no longer

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 08/29/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address
Mahvash Mujahid
12255 Fair Oaks Pkwy
Fairfax , VA 22033
PHONE: 7039345700 FAX: NPI: 1902192479

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 : 08/20/2025

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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experiences shortness of breath during ADLs or functional mobility. The patient would benefit from continued skilled nursing services for wound assessment, dressing changes, pain management, and patient/caregiver education. In addition, ongoing skilled physical therapy is recommended to address deficits in strength, endurance, functional mobility, and respiratory function, with the goal of improving safety, reducing fall risk, and progressing toward her prior level of function in preparation for a safe return to work.
 Date of Order 08/29/2025 Orders Physician Face-to-Face Date: 08/20/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN disease management, PR eval and treat, OT eval and treat due to Coronary Artery Bypass Grafting With Bioprosthetic Valve Replacement And Left Atrial Appendage Ligation 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: PT Eval Notes: OT Eval Notes: Physician Mujahid , Mahvash

SN Careplans

SN WK1: 1 (08/29/25-08/30/25) ,WK2: 2 (08/31/25-09/06/25) ,WK3: 2 (09/07/25-09/13/25) ,WK4: 2 (09/14/25-09/20/25) ,WK5: 1 (09/21/25-09/27/25)

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), 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: M2020 - Oral Med Management, M2102d - Caregiver Performs Treatment, M1400 - Dyspnea, abnormal blood pressure, constipation, diarrhea, muscle weakness, limited strength, limited endurance, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, loss of appetite

PROCEDURES: cough/deep breathing exercises, incentive spirometer, apply anti-embolitic stockings, train caregiver(s) to perform medical/rehabilitation treatments, apply compression bandage, physician-ordered wound care

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage cardiac condition including symptom management diet changes regular exercise getting enough sleep, related medication(s) purpose, schedule, * how to take the patient's blood pressure record the reading, related medication(s) purpose, schedule, * 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, * lifestyle modifications to manage peripheral vascular condition including how to apply compression stockings physical exercise plan diet, 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, patient self-administers medications as prescribed, related medication(s) purpose, schedule, caregiver performs medical/rehabilitation treatments with adequate competence

SN Goals

PATIENT-STATED GOAL: To Feel Better

GOALS
patient/caregiver recalls
* lifestyle modifications to manage cardiac condition including symptom management
* diet changes
* regular exercise
* getting enough sleep
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to take the patient's blood pressure
* record the reading
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* lifestyle modifications to manage peripheral vascular condition including how to apply compression stockings
* physical exercise plan
* diet
* 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
* 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

caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT WK2: 1 (08/31/25-09/06/25) ,WK3: 1 (09/07/25-09/13/25) ,WK4: 1 (09/14/25-09/20/25) ,WK5: 1 (09/21/25-09/27/25) ,WK6: 1 (09/28/25-10/04/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 Dyspnea, GG0170F1 - Toilet Transfer, 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

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: LAQs, HR/TR, clams, hip add pillow squeezes Standing therex, BLE 2x10, 3-4x/week: SLR hip abd/ext BLE, dynamic standing balance exercises, gait training on uneven surfaces, gait training/stair training, transfers training, therapeutic exercises

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, Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven

PT Goals

PATIENT-STATED GOAL: To be able to walk around home, neg stairs and walk outside with without feeling SOB. To also return to being able to return to working, drive herself to grocery store, doctor's appointments and other errands.

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 06. Independent

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
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Surface - 06. Independent, 1 _ Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent, Medication Review

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Walk 10 ft on Uneven Surface - 06. Independent

1 _ Step (curb) - 06. Independent

4 Steps - 06. Independent

Medication Review

12 Steps - 06. Independent

Picking Up Object - 06. Independent

OT Careplans

OT WK2: 1 (08/31/25-09/06/25) ,WK3: 1 (09/07/25-09/13/25) ,WK4: 1 (09/14/25-09/20/25) ,WK5: 1 (09/21/25-09/27/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, 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: cough/deep breathing exercises, incentive spirometer, 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 - 06. Independent, Lower Body Dressing - 06. Independent, Shower/Bathe Self - 06. Independent, Toileting Hygiene - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent

OT Goals

PATIENT-STATED GOAL: I want to be able to make myself something to eat

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 - 06. Independent

Lower Body Dressing - 06. Independent

Shower/Bathe Self - 06. Independent

Toileting Hygiene - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
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