Home Health Certification and Plan of Care

Order ID: 1163/498

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
311070719	11/07/2025	From: 11/07/2025 To: 01/05/2026	645	497754

6. Patient's Name and Address
Fetnat Masri-Imadi
6844 Corder lane,
LORTON, VA 22079-
202-294-4183

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 01/06/1956 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
C50.311	Malig neoplm of lower-inner quadrant of right female breast	11/07/25

13. ICD	Other Pertinent Diagnoses	Date
R41.82	Altered mental status unspecified	11/07/25
I10.	Essential (primary) hypertension	11/07/25
E11.69	Type 2 diabetes mellitus with other specified complication	11/07/25
E78.00	Pure hypercholesterolemia unspecified	11/07/25
E55.9	Vitamin D deficiency unspecified	11/07/25
G43.909	Migraine unsp not intractable without status migrainosus	11/07/25
Z79.84	Long term (current) use of oral hypoglycemic drugs	11/07/25
Z91.81	History of falling	11/07/25

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

Clonazepam - Clonazepam 0.5 mg, Tablet by mouth at bedtime
Lipitor - Atorvastatin Calcium 40 mg , Tablet by mouth once a day
Glucotrol - Glipizide 10 mg , Tablet by mouth as necessary
Glucophage - Metformin Hydrochloride 1,000 mg, Tablet by mouth twice a day 1,000 mg, oral, 2 times daily
Lopressor - Metoprolol Tartrate 40 mg , Tablet by mouth twice a day 40 mg, oral 2 times daily
Inderal - Propranolol Hydrochloride 40 mg , Tablet by mouth twice a day 40 mg, 2 times daily
Desyrel - Trazodone Hydrochloride 50 mg , Tablet by mouth at bedtime 50 mg. Nightly PRN

14. DME and Supplies:
rolling walker, bath bench, cane, diabetic supplies, grab bars, walker

15. Safety Measures:
diabetic precautions, fall precautions, medication safety, walker precautions, supervision at all times, sharps precautions, no bp right arm, ambulates with assistance, ambulates with device, standard precautions, bathroom safety

16. Nutrition:
2gm sodium, diabetic

17. Allergies:
no known allergies

18.A. Functional Limitations
Endurance, Ambulation

18.B. Activities Permitted
Walker, Cane, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 1. Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions., ANXIETY: 3. During the day and evening, but not constantly, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No

20. Prognosis: fair

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
patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Malignant neoplasm of lower-inner quadrant of right female breast, 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 69-year-old Arabic female residing with her husband in a single-family, multi-level home. She is a retired family physician, alert and oriented to time, place, and person, though presenting with altered memory and occasional confusion. Her past medical history includes Type 2 diabetes mellitus (with a blood sugar of 364 mg/dL post-lunch), hypertension, hyperlipidemia, dementia, migraines, depression, and a history of right breast carcinoma treated with lumpectomy, axillary node dissection, and radiation therapy. The patient's skin is warm and dry with pink mucous membranes; lungs are clear, and her abdomen is soft and non-tender with active bowel sounds. No lower extremity edema is noted. She has a small posterior scalp bump from a recent fall, for which the caregiver was instructed to monitor for changes in size or mental status. The patient's appetite is poor, she reports intermittent right hip and knee pain, as well as daily morning headaches relieved with Tylenol. Medications were reviewed and reconciled. She is a full code, has advance directives and a DPOA, and denies any known drug allergies. The patient presents with decreased strength, endurance, balance, and mobility associated with dementia and a history of frequent falls. She ambulates independently indoors but is strongly advised to use a rolling walker at all times for safety. She performs basic ADLs with supervision or standby assistance due to cognitive deficits and requires assistance with medication and meal management, including supervision during meals to prevent aspiration. Adaptive equipment such as a toilet frame, suction grab bars, and a shower chair were recommended to enhance bathroom safety. Education was provided to the patient and her husband regarding fall prevention, home safety, safe mobility, and energy conservation. They were advised to keep snacks and water by the bedside to reduce nighttime wandering and falls. The Tinetti score of 19 indicates a moderate fall risk. A home exercise program was initiated, focusing on strengthening, balance, transfers, and gait training. The patient and her caregiver demonstrated understanding and agreed with the care plan. Skilled nursing and physical therapy services will continue to address safety, functional mobility, and management of chronic conditions to prevent further decline.<o:p></o:p> <o:p> </o:p> Date of Order<o:p></o:p> 11/07/2025
 Order<o:p></o:p> Physician Face-to-Face Date: 11/03/2025
 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat dx: Malignant neoplasm of lower-inner quadrant of right female breast
 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:
 PT Eval Notes:
 OT Eval Notes:<o:p></o:p> Physician: Sindhu, Rahul

SN Careplans

SN WK1: 1 (11/07/25-11/08/25) ,WK2: 1 (11/09/25-11/15/25) ,WK3: 1 (11/16/25-11/22/25) ,WK4: 1 (11/23/25-11/29/25) ,WK5: 1 (11/30/25-12/06/25) ,WK6: 1 (12/07/25-12/13/25) ,WK7: 1 (12/14/25-12/20/25) ,WK8: 1 (12/21/25-12/27/25)

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, blood sugar < 60 > 300

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

HOSPITALIZATION RISKS: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 5. Decline in mental, emotional, or behavioral status in the past 3 months, 6. Reported or

SN Goals

PATIENT-STATED GOAL: Patient would like to walk without falling

GOALS
patient/caregiver recalls
* diabetic medication management
* blood sugar testing
* diabetic foot care
* exercise
* diabetic diet
* recalls related medication(s) purpose, schedule

patient/caregiver recalls

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 11/07/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address
Rahul Sindhu
6551 Loisdale Ct
Springfield, VA 22150
PHONE: 7579355310 FAX: NPI: 1841635646

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 : 11/03/2025

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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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, 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:Durable power of attorney for health care/Medical power of attorney

PROBLEMS IDENTIFIED ON ASSESSMENT: M1720 - Anxiety, M2102c - Med Admin, M2102f - Patient Supervision, M2102d - Caregiver Performs Treatment, M2020 - Oral Med Management, M1400 - Dyspnea, abnormal BS < 70/140 > mg/dL, increased urine output, muscle weakness, limited endurance, Pain Effect on Sleep, Pain Interference with ADLs, headache, balance deficit, loss of appetite

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, glucose testing via monitor, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision

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, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, related medication(s) purpose, schedule, * diabetic medication management blood sugar testing diabetic foot care exercise diabetic diet, related medication(s) purpose, schedule, * migraine/headache prevention including lifestyle changes home remedies dietary modifications to reduce or eliminate triggers alternative medicines such as acupuncture and biofeedback, 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

* migraine/headache prevention including lifestyle changes
* home remedies
* dietary modifications to reduce or eliminate triggers
* alternative medicines such as acupuncture and biofeedback
* 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/caregiver recalls
* prevention exacerbation of anxiety condition including coping patterns
* improved concentration
* strategies to reduce anxiety
* identification of anxiety precipitants, conflicts, and threats
* 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

PT Careplans

PT WK2: 1 (11/09/25-11/15/25) ,WK3: 2 (11/16/25-11/22/25) ,WK4: 2 (11/23/25-11/29/25) ,WK5: 2 (11/30/25-12/06/25) ,WK6: 1 (12/07/25-12/13/25)

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

PROCEDURES: Medication Review: Medications reviewed with patient/caregiver. , home exercise program: Seated therex BLE, 2x10, 1-2x/daily, with red theraband (tb) where applicable: sit to stands with RW and chair with B arms for push off to stand, marches, LAQ, clams, hip add with pillow squeezes x 2-3 sec holds; HR/TR, standing tolerance exercises, gait training/stair training, transfers training, therapeutic exercises

TEACH PATIENT/CAREGIVER: Sit to Stand - 04. Supervision or touching assistance, Chair to Bed to Chair - 04. Supervision or touching assistance, Car Transfer - 04. Supervision or touching assistance, Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Walk 150 Feet - 04. Supervision or touching assistance, 1 - Step (curb) - 04. Supervision or touching assistance, 4 Steps - 04. Supervision or touching assistance, 12 Steps - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance

PT Goals

PATIENT-STATED GOAL: To feel stronger in BLE to walk around different rooms of home with use of RW with better strength, balance and steadiness and also not fall

GOALS
Sit to Stand - 04. Supervision or touching assistance

Chair to Bed to Chair - 04. Supervision or touching assistance

Car Transfer - 04. Supervision or touching assistance

Walk 10 Feet - 04. Supervision or touching assistance

Walk 50 ft with 2 Turns - 04. Supervision or touching assistance

Walk 150 Feet - 04. Supervision or touching assistance

1 - Step (curb) - 04. Supervision or touching assistance

4 Steps - 04. Supervision or touching assistance

12 Steps - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

OT Careplans

OT WK2: 1 (11/09/25-11/15/25) ,WK3: 1 (11/16/25-11/22/25) ,WK5: 1 (11/30/25-12/06/25) ,WK6: 1 (12/07/25-12/13/25) ,WK7: 1 (12/14/25-12/20/25) ,WK8: 1 (12/21/25-12/27/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, 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: 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, * how to maintain a diary to monitor effective and non-effective pain relief including documenting

OT Goals

PATIENT-STATED GOAL: I want to get stronger and get back to feeling like myself

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
* 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

Signature of Physician:

Date

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

Date
11/07/2025

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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, Oral Hygiene - 05. Setup or clean-up assistance, Upper Body Dressing - 05. Setup or clean-up 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	* recalls related medication(s) purpose, schedule Oral Hygiene - 05. Setup or clean-up assistance Upper Body Dressing - 05. Setup or clean-up 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

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	11/07/2025