Home Health Certification and Plan of Care

Order ID: 1163/887

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
999412278	03/11/2026	From: 03/11/2026 To: 05/09/2026	454	497754

6. Patient's Name and Address
Louise Fairley
5525 Sideburn Rd,
FAIRFAX, VA 22032-
703-503-3347

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 02/22/1955 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
I69.254	Hemiplga fol oth ntrm intcrn hemor aff left nondom side	03/11/26

13. ICD	Other Pertinent Diagnoses	Date
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy	03/11/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	03/11/26
I48.0	Paroxysmal atrial fibrillation	03/11/26
R32.	Unspecified urinary incontinence	03/11/26
M19.90	Unspecified osteoarthritis unspecified site	03/11/26
Z79.01	Long term (current) use of anticoagulants	03/11/26

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

Budesonide-Formoterol (BREYNA) 160-4.5 mcg/actuation Inhl HFAA 160-4.5 mcg/actuation , Inhale 2 puffs inhalant twice a day Inhale 2 puffs by mouth 2 times a day
Vit D - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 0 1000 unit 1 tab by mouth once a day Supplement
Claritin - Loratadine 10 mg 1 table by mouth once a day Congestion
Oxybutynin - Oxybutynin 10 mg 1 tab by mouth once a day Overactive bladder XL
Spiriva Respimat - Tiotropium Bromide 2.5 mcg 1 puff by mouth once a day Respiratory distress
Acetaminophen - Acetaminophen 500 mg 2 tabs by mouth every 6 hours Mild pain as needed
Proventil - Albuterol eq 0.083 perc base eq 0.083 perc base 0 2.5 mg /3 mL (0.083 %) , Use 3 mL via nebulize Nasal every 4 hours COPD 3 ml as needed
Albuterol - Albuterol 0.09 mg/inh 2 puff by mouth every 4 hours COPD as needed
Atenolol - Atenolol 50 mg 1 tablet by mouth once a day HTN
Lipitor - Atorvastatin Calcium 0 40 mg , Take 1 tablet by mouth once a day cholesterol
Restasis - Cyclosporine 0.05% 1 drop both eyes twice a day Dry eyes
Eliquis - Apixaban 5 mg 1 tab by mouth twice a day CVA
Pepcid - Famotidine 20 mg 0 20 mg , Take 1 tablet by mouth twice a day Gerd
Lasix - Furosemide 40 mg 0 40 mg , Take 1 tablet by mouth once a day HTN
Basaglar - Insulin Glargine 100 units/solution 3 units subcutaneous at bedtime DM
Jardiance - Empagliflozin 0 10 mg 1 tablet by mouth once a day DM II controlled
LIDOCAINE PAIN RELIEF 4 % Top PTMD Patch 0 4 % , Apply 1 Patch to skin topical once a day Moderate pain
Lyrica - Pregabalin 300 mg 100 mg 0 300 mg , Take 1 capsule by mouth twice a day Moderate pain

14. DME and Supplies:
wheelchair, hoyer lift, hospital bed, 4 wheeled walker

15. Safety Measures:
wheelchair precautions, , , , diabetic precautions, bedrails up while in bed,

16. Nutrition:
diabetic,

17. Allergies:
amitriptyline ampicillin aspirin gabapentin ibuprofen iodine lisinopril orlistat pen gatorade

18.A. Functional Limitations
Bowel/Bladder Incontinence, Endurance

18.B. Activities Permitted
Wheelchair, 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: 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 Hemiplegia And Hemiparesis Following Other Nontraumatic Intracranial Hemorrhage Affecting Left Non-Dominant Side, 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 71-year-old African American female who was recently evaluated via telehealth by her physician for complaints of headaches. She denies any recent hospitalizations and resides at home with her husband in a single-family residence, with assistance from a daytime private aide. On <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>, the patient was alert, awake, and oriented to person, place, and time. Neurologically, she presents with left-sided weakness accompanied by facial asymmetry and contractures, with limited ability to move the left upper and lower extremities. Strength is intact on the right side. A prosthetic right eye is in place following recent fitting, and the left pupil is reactive to light. Although she previously reported headaches, she denies headache symptoms during this visit. Respiratory <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh> revealed wheezing in the posterior lobes with associated congestion and a non-productive cough. The patient also exhibits bilateral lower extremity edema as well as edema in the left upper extremity; elevation was encouraged to assist with fluid management. She requires maximum assistance for transfers and utilizes a Hoyer lift with two-person assistance. The patient is incontinent of both bowel and bladder. Her husband manages medication administration, and the patient is able to feed herself with setup assistance. During the visit, the patient displayed intermittent agitation toward her husband, including an observed verbal outburst. Nursing staff provided assistance with activities of daily living due to the absence of the private aide on the day of the visit. The patient reports left shoulder pain, which is partially relieved with medication. Education was provided regarding proper positioning, edema management, and safety with transfers. The plan of care includes continued monitoring of neurological status, respiratory symptoms, edema, pain management, and reinforcement of caregiver support and safe transfer techniques.
 Date of Order 03/11/2026 Orders Physician Face-to-Face Date: 03/06/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN Med management due to Hemiplegia And Hemiparesis Following Other Nontraumatic Intracranial Hemorrhage Affecting Left Non-Dominant

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 03/11/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Jeffrey Wright
5999 Burke Commons Rd
Arlington, VA 22205
PHONE: 8007777904 FAX: NPI: 1396366803

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 : 03/06/2026

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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Side 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 Wright, Jeffrey

SN Careplans

SN WK1: 1 (03/11/26-03/14/26) ,WK2: 1 (03/15/26-03/21/26) ,WK3: 1 (03/22/26-03/28/26) ,WK4: 1 (03/29/26-04/04/26)

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: 3. Multiple hospitalizations (2 or more) in the past 6 months, 4. Multiple emergency department visits (2 or more) in the past 6 months, 5. Decline in mental, emotional, or behavioral status in the past 3 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: meal preparation, M2020 - Oral Med Management, M1400 - Dyspnea, swelling in the arms/legs, frequent urination, M1610 - Urinary Incontinence, muscle weakness, limited strength, limited range of motion, limited endurance, swelling of affected area, balance deficit, Pain Interference with ADLs, Pain Interference with Therapy activities, B1000 - Vision Deficit, Pain Effect on Sleep, obesity

PROCEDURES: cough/deep breathing exercises: Demonstrated understanding, glucose testing via monitor: Husband managed, coordinate/arrange preparation of missing meals: Husband managed, coordinate/arrange resources for vision-impaired: Right prosthetic eye

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, * urinary incontinence management including bladder training Kegel exercises skin care, related medication(s) purpose, schedule, * how to keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, patient self-administers medications as prescribed, related medication(s) purpose, schedule, meal preparation is available to patient for all meals

SN Goals

PATIENT-STATED GOAL: Louise needs to help self getting up in the bed

GOALS
patient/caregiver recalls
* urinary incontinence management including bladder training
* Kegel exercises
* skin care
* 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
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

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

meal preparation is available to patient for all meals

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	03/11/2026