Home Health Certification and Plan of Care

Order ID: 1163/961

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
95219274	03/27/2026	From: 03/27/2026 To: 05/25/2026	1327	497754

6. Patient's Name and Address
Chaudrey Kamal
13409 Classic Court,
WOODBRIDGE, VA 22192-
703-927-2850

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 03/01/1965 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z48.812	Encntr for surgical aftcr following surgery on the circ sys	03/27/26

13. ICD	Other Pertinent Diagnoses	Date
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	03/27/26
E11.9	Type 2 diabetes mellitus without complications	03/27/26
I10.	Essential (primary) hypertension	03/27/26
E78.5	Hyperlipidemia unspecified	03/27/26
F41.9	Anxiety disorder unspecified	03/27/26
Z79.82	Long term (current) use of aspirin	03/27/26
Z95.1	Presence of aortocoronary bypass graft	03/27/26

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

8-HOUR BAYER 325 mg EC tablet 1 tablet by mouth once a day CABG
Tylenol - Acetaminophen 500 mg 2tablet by mouth every 6 hours Mild pain as needed
Atorvastatin - Atorvastatin Calcium 80 mg 1 tab by mouth at bedtime HLD
BENZONATATE 100 mg 1 Tablet by mouth three times a day needed for cough
Metformin - Metformin Hydrochloride 500mg 1 tab by mouth once a day DM
Nulytely - Polyethylene Glycol 3350: Potassium Chloride: Sodium Bicarbonate: Sodium Chloride 17 gram 1 Packet by mouth once a day Constipation as needed
BIOTIN 25 mcg (1,000 unit) capsule by mouth once a day Supplement
Metoprolol Tartrate - Metoprolol Tartrate 25 mg 1 Tablet by mouth twice a day HTN
Furosemide - Furosemide 20 mg 1 Tablet by mouth once a day HTN

14. DME and Supplies:
None of the above

15. Safety Measures:
diabetic precautions, ambulates with assistance

16. Nutrition:
diabetic

17. Allergies:
pork

18.A. Functional Limitations
Ambulation, Endurance

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

Homebound status: After undergoing CABG x3 with lima and vein grafts, 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 61-year-old Indian male with a past medical history significant for <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-12 CE-FMS-hypertension">hypertension</mh>, <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-16 CE-FMS-hyperlipidemia">hyperlipidemia</mh>, type 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-18 CE-FMS-diabetes">diabetes</mh> mellitus, anxiety, and recently diagnosed severe multivessel coronary artery disease. Cardiac catheterization revealed significant stenosis involving the right coronary artery, distal left main/ostial left anterior descending artery, mid left anterior descending artery, and obtuse marginal branch, with corresponding ischemia on stress testing. The patient subsequently underwent coronary artery bypass grafting (CABG) 3 utilizing left internal mammary artery and vein grafts. His postoperative course was notable for transient hypotension, medication adjustments, and a mild pericardial effusion, after which he was stabilized and discharged home. The patient resides in a single-family home with his family, with his son serving as the primary caregiver and his wife assisting with instrumental activities of daily living. At the time of assessment, the patient is alert and oriented to person, place, time, and situation, with intact neurological status including symmetrical facial movement and equal bilateral hand grasps. He denies visual or hearing impairment. Respiratory assessment reveals clear lung sounds without use of accessory muscles. Cardiovascular assessment shows no lower extremity edema. The abdomen is soft, mildly distended, non-tender, with active bowel sounds in all four quadrants. The patient is continent of bowel and bladder. The patient reports mild chest soreness associated with coughing, consistent with recent sternotomy. Education was provided regarding pain management, including taking prescribed analgesics as directed and utilizing splinting techniques such as hugging a pillow during coughing to reduce discomfort and protect the surgical site. He is ambulating independently without an assistive device but demonstrates decreased cardiovascular endurance and activity tolerance; he was instructed to incorporate rest periods and gradually increase activity as tolerated. Surgical site assessment reveals small, well-approximated incisions, including groin bruising and abdominal incision sites measuring approximately 0.2 cm 1 cm, all of which are intact without signs or symptoms of infection. The patient is able to perform activities of daily living and functional transfers with modified independence and is able to feed himself with setup assistance. Occupational therapy evaluation indicates that the patient demonstrates adequate bilateral upper extremity strength and functional capacity to perform daily activities safely. He has demonstrated and verbalized understanding of sternal precautions. Given his current level of function, no further skilled occupational therapy services are indicated, and he has been discharged from OT care following evaluation. The plan of care includes continued monitoring of postoperative recovery, reinforcement of sternal precautions, pain management, and gradual progression of activity. The patient is advised to maintain close follow-up with cardiology and primary care providers, with anticipated transition to a structured cardiac rehabilitation program once medically cleared. With strong family support and adherence to recommendations, the patient is expected to continue progressing toward full recovery.
 Date of Order 03/27/2026 Orders Physician Face-to-Face Date: 03/18/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN, PT, OT due to CABG x3 with lima and vein grafts 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 OT Eval Notes: PT Eval Notes:
 Physician Abisuga, Olakunle

SN Careplans

SN Goals

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 03/27/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Olakunle Abisuga
14139 Potomac Mills Road
Woodbridge, VA 22192
PHONE: 7034908400 FAX: 17034907635 NPI: 1841358835

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 : 03/18/2026

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 WK1: 1 (03/27/26-03/28/26) ,WK2: 1 (03/29/26-04/04/26) ,WK3: 1 (04/05/26-04/11/26) ,WK4: 1 (04/12/26-04/18/26)

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: 2. Unintentional weight loss of a total of 10 pounds or more in the past 12 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, 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:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: meal preparation, M2020 - Oral Med Management, M1033 - Exhaustion, M1400 - Dyspnea, M1033 - Unintentional Weight Loss, muscle weakness, limited strength, limited range of motion, limited endurance, muscle spasms, poor muscle tone, balance deficit, Pain Interference with ADLs, Pain Interference with Therapy activities, Pain Effect on Sleep, bruising/discoloration, #1 - Other - Other - Mid chest incision - , #2 - Other - Other - Left calf incision -

PROCEDURES: physician-ordered wound care: #1 - Other - Other - Mid chest incision -: Monitor for signs and symptoms of infection, physician-ordered wound care: #2 - Other - Other - Left calf incision -: Monitor for signs and symptoms of infection, cough/deep breathing exercises: Demonstrated understanding, glucose testing via monitor: Wife monitor, coordinate/arrange preparation of missing meals: Wife managed

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 achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, * strategies to increase caloric intake, 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, meal preparation is available to patient for all meals

PATIENT-STATED GOAL: I want to gain my strength again and eat a lot of protein

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
* 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
* strategies to increase caloric intake
* 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

meal preparation is available to patient for all meals

PT Careplans

PT WK1: 1 (03/27/26-03/28/26) ,WK2: 1 (03/29/26-04/04/26) ,WK3: 1 (04/05/26-04/11/26) ,WK4: 1 (04/12/26-04/18/26) ,WK5: 1 (04/19/26-04/25/26) ,WK6: 1 (04/26/26-05/02/26)

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: cough/deep breathing exercises, gait training on uneven surfaces, gait training/stair training, transfers training

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 Surface - 06. Independent, 1 - Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent

PT Goals

PATIENT-STATED GOAL: Patient desire to ambulate around the neighborhood with RPE scale of 5/10

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

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

12 Steps - 06. Independent

Signature of Physician:

Date

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

Date
03/27/2026

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Picking Up Object - 06. Independent

OT Careplans

OT WK2: 1 (03/29/26-04/04/26)

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: cough/deep breathing exercises, incentive spirometer, equipment training, work simplification/energy conservation, gait training on uneven surfaces, gait training/stair training, transfers training

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, Chair to Bed to Chair - 06. Independent, Sit to Stand - 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 Surface - 06. Independent, 1 - Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 06. Independent, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: OT evaluation only

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

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

12 Steps - 06. Independent

Picking Up Object - 06. Independent

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	03/27/2026