Home Health Certification and Plan of Care

Order ID: 1163/1188

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
25213824	07/27/2026	From: 07/27/2026 To: 09/24/2026	1767	497754

6. Patient's Name and Address
Ainagul Jumabaeva
10216 SCOUT DR,
FAIRFAX, VA 22030-
202-243-9202

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 05/27/1976 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
C20.	Malignant neoplasm of rectum	07/27/26

13. ICD	Other Pertinent Diagnoses	Date
C77.2	Secondary and unsp malignant neoplasm of intra-abd nodes	07/27/26
I05.1	Rheumatic mitral insufficiency	07/27/26
F33.9	Major depressive disorder recurrent unspecified	07/27/26
Z43.2	Encounter for attention to ileostomy	07/27/26
Z87.891	Personal history of nicotine dependence	07/27/26

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

Vitamin B Complex - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox Take 1 capsule by mouth daily Patient not taking: Reported on 7/2/2026

Zofran Odt - Ondansetron Disintegrating 8 MG / Dissolve 1 tablet on the tongue by mouth twice a day as needed for nausea or vomiting. Patient not taking: Reported on 7/2/2026

14. DME and Supplies:
ostomy supplies

15. Safety Measures:
medication safety, smoke detectors , emergency phone # clearly displayed, standard precautions, fall precautions, bleeding precautions, activity supervision

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
no known allergies

18.A. Functional Limitations
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: Yes

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
family/caregiver will be responsible for managing treatment

Homebound status:
Due to diagnosis of Malignant neoplasm of rectum, 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:

Patient was found lying in bed upon the skilled nursing (SN) visit, alert and oriented 4, with vital signs within her baseline and no acute distress observed. The patient reported mild postoperative wound pain, which was controlled with prescribed medication. A comprehensive nursing assessment was completed, including medication reconciliation, cardiopulmonary and gastrointestinal assessment, and evaluation of the temporary loop ileostomy. The stoma was pink, moist, viable, and draining appropriate liquid stool, with intact peristomal skin and no evidence of infection or skin breakdown. The ostomy appliance was changed using clean technique, and the patient tolerated the procedure without complaints. Surgical incision(s) were healing appropriately without signs of infection. Education was reinforced regarding ostomy care, including emptying the pouch when one-third full, changing the appliance every 3-5 days or as needed for leakage, recognizing signs and symptoms of dehydration, infection, and bowel obstruction, maintaining adequate hydration and nutrition, medication adherence, incision care, fall prevention, and the importance of follow-up appointments. The patient verbalized understanding of the teaching provided. The plan is to continue skilled nursing services for ongoing assessment, ostomy and incision management, pain and hydration monitoring, medication management, and reinforcement of disease process and self-care education, while coordinating care with the surgeon and oncology team. The patient continues to require skilled physical therapy to address generalized weakness, impaired balance, reduced lower-extremity strength, decreased endurance, and functional deconditioning following rectal cancer treatment and abdominal surgery to improve mobility, safety, and independence with activities of daily living.<o:p></o:p>   Date of Order<o:p></o:p> 07/27/2026<o:p></o:p> Physician Face-to-Face Date: 07/16/2026<o:p></o:p> Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management dx: Malignant neoplasm of rectum<o:p></o:p> Homebound Status per

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 07/27/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Yodit Benalfew
12255 Fair Lakes Parkway
Fairfax, VA 22033
PHONE: 7039345905 FAX: 17039345778 NPI: 1699847186

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 : 07/16/2026

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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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:<o:p></o:p> PT Eval Notes:<o:p></o:p> Physician: Benalfew, Yodit

SN Careplans

SN WK1: 2 (07/27/26-08/01/26) ,WK2: 2 (08/02/26-08/08/26) ,WK3: 1 (08/09/26-08/15/26) ,WK4: 1 (08/16/26-08/22/26) ,WK5: 1 (08/23/26-08/29/26) ,WK6: 1 (08/30/26-09/05/26) ,WK7: 1 (09/06/26-09/12/26)

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

HOSPITALIZATION RISKS: 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:Jacob

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2020 - Oral Med Management, M2102c - Med Admin, M1400 - Dyspnea, nausea/vomiting (GI), diarrhea (GI), M1610 - Urinary Catheter, Pain Interference with Therapy activities, Pain Interference with ADLs, bruising/discoloration, #1 - GI Ostomy - Other - RUQ - Stoma size 30mm Pink, moist edematous red rubber cath output is brown liquid

PROCEDURES: physician-ordered wound care: #1 - GI Ostomy - Other - RUQ - Stoma size 30mm Pink, moist edematous red rubber cath output is brown liquid, cough/deep breathing exercises, incentive spirometer, apply collection/fistula pouch, ostomy care & irrigation: SN Orders - Loop Ileostomy Assess loop ileostomy at each visit for stoma color, size, edema, viability, output, and peristomal skin integrity. Empty ostomy pouch when 1/3 full to prevent leakage and excess weight on the pouching system. Change ostomy pouching system every 3-5 days and as needed for leakage, loss of seal, or skin irritation. Remove existing pouch gently using adhesive remover wipes. Cleanse peristomal skin with water only using disposable washcloths; avoid soaps or cleansers that may interfere with pouch adhesion. Pat skin completely dry. Measure stoma as needed and cut skin barrier opening to fit the stoma, allowing no more than 1/8 inch of exposed peristomal skin. For moldable barriers, roll back barrier to fit snugly around the stoma. If peristomal skin is denuded or irritated, apply stoma powder to affected skin, brush away excess, then apply no-sting barrier film. Allow to dry for 20-30 seconds before applying the skin barrier. If skin is intact, omit this step. Apply skin barrier securely to clean, dry skin and attach ostomy pouch per manufacturer instructions. Connect ostomy pouch to bedside gravity drainage while patient is in bed, if indicated, using the appropriate adapter. Monitor stool output, hydration status, signs of dehydration, electrolyte imbalance, leakage, skin breakdown, bleeding, prolapse, retraction, or obstruction. Notify the provider of significant changes. Reinforce patient/caregiver education on ostomy care, pouch emptying and changing, skin care, hydration, diet, and when to report complications. Encourage patient independence with ostomy care as tolerated., catheter change, care & irrigation, teach/coordinate/arrange medication packaging and/or administration

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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpose, schedule, * ostomy management including how to clean stoma change ostomy pouch, related medication(s) purpose, schedule, * urinary catheter management including how to flush catheter change and wash drainage bags prevent infection including proper handwashing positioning of catheter, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, caregiver administers and/or packages medications appropriately

SN Goals

PATIENT-STATED GOAL: Patient wants to learn how to be independent with her loop ileostomy

GOALS
patient/caregiver recalls
* depression-prevention strategies including avoidance of isolation
* healthy eating
* sleeping habits
* identification of activities that bring pleasure
* preventive care
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* ostomy management including how to clean stoma
* change ostomy pouch
* 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
* urinary catheter management including how to flush catheter
* change and wash drainage bags
* prevent infection including proper handwashing
* positioning of catheter
* recalls related medication(s) purpose, schedule

caregiver administers and/or packages medications appropriately

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

PT Careplans

PT Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

07/27/2026

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PT WK1: 1 (07/27/26-08/01/26) ,WK2: 1 (08/02/26-08/08/26) ,WK3: 1 (08/09/26-08/15/26) ,WK4: 1 (08/16/26-08/22/26) ,WK5: 1 (08/23/26-08/29/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170G1 - Car Transfer, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170L1 - Walk 10 ft on Uneven Surface, GG0170K1 - Walk 150 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170I1 - Walk 10 Feet, GG0130B1 - Oral Hygiene, GG0170E1 - Chair to Bed to Chair, GG0170D1 - Sit to Stand, GG0130C1 - Toileting Hygiene, GG0170F1 - Toilet Transfer, GG0130E1 - Shower/Bathe Self, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing

PROCEDURES: home exercise program: diaphragmatic breathing, ankle pumps, seated heel/toe raises, seated marches, LAQ, seated hip abduction, sit-to-stands, standing weight shifts, standing marches, heel raises, standing hip abduction, standing hip extension, mini squats, side stepping, tandem stance, and progressive walking program., gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 05. Setup or clean-up assistance, Chair to Bed to Chair - 05. Setup or clean-up assistance, Toilet Transfer - 05. Setup or clean-up 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, Car Transfer - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 05. Setup or clean-up assistance, Shower/Bathe Self - 05. Setup or clean-up assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Upper Body Dressing - 06. Independent

PATIENT-STATED GOAL: Increase sitting/tolerance for 1 hour with modified RPE < 4/10

GOALS

Shower/Bathe Self - 05. Setup or clean-up assistance

Sit to Stand - 05. Setup or clean-up assistance

Chair to Bed to Chair - 05. Setup or clean-up assistance

Toilet Transfer - 05. Setup or clean-up 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

Car Transfer - 05. Setup or clean-up assistance

Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

Oral Hygiene - 06. Independent

Toileting Hygiene - 05. Setup or clean-up assistance

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 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	07/27/2026