Home Health Certification and Plan of Care

Order ID: 179/11968

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
1EG4TE5MK73	07/01/2025	From: 07/01/2025 To: 08/29/2025	7071	242353

6. Patient's Name and Address
Reynolds Pearson
(410) 296-2785 3 Ruxview Ct,
TOWSON, MD 21204-
410-952-3140

7. Provider's Name, Address and Telephone Number
Home Health Cares
579# EAST MARKET@STREETS
HARRISONBURG, VA 22801-1234
540-433-7146
1234567891

8. DOB 06/14/1967 | **9.Sex** Female

10. Medications: Dose/Frequency/Route (N)ew (C)hanged
Avandamet - Metformin Hydrochloride: Rosiglitazone Maleate 1gm;eq 2 mg base by mouth once a day

11. ICD	Principal Diagnosis	Date
E11.69	Type 2 diabetes mellitus with other specified complication	07/01/25

13. ICD	Other Pertinent Diagnoses	Date
I10.	Essential (primary) hypertension	07/01/25

14. DME and Supplies:
cane

15. Safety Measures:
walker precautions

16. Nutrition:
2gm sodium, cardiac diet, 1400cal ADA

17. Allergies:
antibiotics

18.A. Functional Limitations
Amputation, Hearing,

18.B. Activities Permitted
None of the above

19. Mental & Pyschosocial Status: COGNITION: 2. Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility, ANXIETY: 1. In new or complex situations only, 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: 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

Homebound status: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home, medical condition could get worse if patient leaves home

Clinical Condition Requiring Homecare: Parkinsons

SN Careplans

SN WK1: 1 (09/01/25-09/06/25)

PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature < 98 > 99, heart rate < 50 > 80, respiratory rate < 8 > 15, blood pressure systolic < 100 > 150, blood pressure diastolic < 50 > 100, O2 saturation < 98 > 101, pain < 0 > 0

CAREGIVER: 1. Non-agency caregiver(s) currently provide assistance

HOSPITALIZATION RISKS: 10. None of the above

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
Advance Directive:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M1700 - Cognition, Home Safety, A1250 - Lack of Necessary Transportation, Home Safety, Financial, M2020 - Oral Med Management, M1400 - Dyspnea, abnormal sputum production, cramping calves/thighs/hips, abnormal thyroid 0.40 - 4.50 mIU/mL, odor of breath/sweat/saliva, heartburn/indigestion, abnormal bowel sounds, tarry/bloody stools, M1610 - Urinary Incontinence, painful urination, increased urine output, cloudy urine, limited endurance, muscle spasms, weak hand grips, seizures, B1000 - Vision Deficit, Pain Effect on Sleep, Pain Interference with ADLs, not interested in feeding, bad breath, tooth pain/decay/sensitivity, bruising/discoloration, skin breakdown r/t incontinence

PROCEDURES: cough/deep breathing exercises, incentive spirometer, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, glucose testing via monitor, bladder training, coordinate/arrange repair of inadequate heating, coordinate/arrange repair of inadequate lighting, coordinate/arrange access to medicine/medical supplies considering patient inability to pay, coordinate/arrange resources for vision-impaired, coordinate/arrange transportation services

TEACH PATIENT/CAREGIVER: * 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, * 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 keep home safe for patient with dementia coping strategies for the caregiver, related medication(s) purpose, schedule, * diabetic medication management blood sugar testing diabetic foot care exercise diabetic diet, 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,

SN Goals

PATIENT-STATED GOAL: Move Independently

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

patient/caregiver recalls
* urinary incontinence management including bladder training
* Kegel exercises
* skin care
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to keep home safe for patient with vision loss including eliminating hazards

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Aquino, EmyAnne SN PT on 07/01/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address
Joy De Castro

maine, ME
PHONE: 2077499791 FAX: 12072219995 NPI: 1801093968

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 :

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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patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient's transportation needs are met, patient has adequate heating, patient living environment has adequate lighting, patient has access to medicine/medical supplies considering inability to pay

* enhancing lighting
* using mechanical aids

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

patient's transportation needs are met

patient has adequate heating

patient living environment has adequate lighting

patient has access to medicine/medical supplies considering inability to pay

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Aquino, EmyAnne SN PT	07/01/2025