# Home Health Certification and Plan of Care

**Order ID: 179/12062**

| 1. Patient s HI claim No. | 2. Start Of Care Date | 3. Certification Period | 4. Medical Record No. | 5. Provider No. |
|---|---|---|---|---|
| G123BE5A | 08/05/2025 | From: 08/05/2025 To: 10/03/2025 | 7121 | 242353 |

**6. Patient's Name and Address**
Kristina Test
611 Newman,
HIGHMORE, SD 57345
999-999-9999

**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** 01/01/1980 | **9.Sex** Male

**10. Medications: Dose/Frequency/Route (N)ew (C)hanged**
Synthroid - Levothyroxine Sodium 0.075 mg **see current annual edition, 1.8 description of special situations, levothyroxine sodium transdermal every 4 hours a

| 11. ICD | Principal Diagnosis | Date |
|---|---|---|
| I50.9 | Heart failure unspecified | 08/05/25 |

| 13. ICD | Other Pertinent Diagnoses | Date |
|---|---|---|
| E11.9 | Type 2 diabetes mellitus without complications | 08/05/25 |

**14. DME and Supplies:**
grab bars

**15. Safety Measures:**
knee precautions

**16. Nutrition:**
1400cal ADA

**17. Allergies:**
antibiotics

**18.A. Functional Limitations**
Legally Blind

**18.B. Activities Permitted**
Complete Bedrest,

**19. Mental & Pyschosocial Status:** COGNITION: 1. Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions., 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:** good

**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:** medical condition could get worse if patient leaves home

**Clinical Condition Requiring Homecare:**

## SN Careplans

SN

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

HOSPITALIZATION RISKS: 4. Multiple emergency department visits (2 or more) in the past 6 months

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: M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2020 - Oral Med Management, M2102c - Med Admin, A1250 - Lack of Necessary Transportation, M1400 - Dyspnea, cramping calves/thighs/hips, abnormal thyroid 0.40 - 4.50 mIU/mL, heartburn/indigestion, genital irritation, M1610 - Urinary Catheter, M1600 - UTI, muscle spasms, B1000 - Vision Deficit, withdrawal from conversations, tooth pain/decay/sensitivity, bruising/discoloration

PROCEDURES: cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, catheter change, care & irrigation, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange resources for vision-impaired, coordinate/arrange transportation services

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, * 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, * prevention including increase fluid intake increase Vitamin C intake to promote acidic bladder environment (cranberry juice) perineal hygiene, 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, patient's transportation needs are met, patient is adequately supervised, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

## SN Goals

PATIENT-STATED GOAL: add patient-stated goalaa

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
* 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

patient/caregiver recalls
* prevention including increase fluid intake
* increase Vitamin C intake to promote acidic bladder environment (cranberry juice)
* perineal hygiene
* 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

patient's transportation needs are met

patient is adequately supervised

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

**23. Signature and Date of Verbal SOC Where Applicable:**
Electronically Signed by Casias, Kathy SN on 08/05/2025

**25. Date HHA Received Signed POT**

**24. Physician's Name and Address**
Jane Doe
310, NATARAJAPURAM 4TH EAST STREET
KVP, HI 628502
PHONE: 999-999-9999 FAX: 12077802774 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** **09/17/2025**: 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.



Signature of Physician:

Date

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Optional Name/Signature of Nurse/Therapist:
Electronically Signed by Casias, Kathy SN on 08/05/2025

Date
09/17/2025