Home Health Certification and Plan of Care

Order ID: 179/12283

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
1EG4TE5MK73	09/01/2025	From: 09/01/2025 To: 10/30/2025	7361	242353

6. Patient's Name and Address
Orion Pearson
(410) 296-2785 3 Ruxview Ct,
GWYNN OAK, MD 21207
667-352-9484

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** Male

10. Medications: Dose/Frequency/Route (N)ew (C)hanged
There are no Medications for this Plan of Care

11. ICD	Principal Diagnosis	Date
I10.	Essential (primary) hypertension	09/01/25

13. ICD	Other Pertinent Diagnoses	Date
E08.3499	Diabetes with severe nonp rtnop without macular edema unsp	09/01/25
L89.303	Pressure ulcer of unspecified buttock stage 3	09/01/25

14. DME and Supplies:
None of the above

15. Safety Measures:
None of the above

16. Nutrition:
1800cal ADA

17. Allergies:
no known allergies

18.A. Functional Limitations
None of the above

18.B. Activities Permitted
None of the above

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: 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: medical condition could get worse if patient leaves home

Clinical Condition Requiring Homecare: Dementia

SN Careplans

SN WK1: 6 (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: A1250 - Lack of Necessary Transportation, M2020 - Oral Med Management, Financial, Home Safety, meal preparation, M1400 - Dyspnea, cramping calves/thighs/hips, abnormal sputum production, heartburn/indigestion, M1600 - UTI, painful urination, limited endurance, weak hand grips, B1000 - Vision Deficit, tooth pain/decay/sensitivity, #1 - 3 - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles not exposed. - Posterior Left Buttock -

PROCEDURES: cough/deep breathing exercises, incentive spirometer, physician-ordered wound care: added wound care., physician-ordered wound care, wound vacuum, glucose testing via monitor, coordinate/arrange preparation of missing meals, coordinate/arrange repair of inadequate heating, 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, * diabetic medication management blood sugar testing diabetic foot care exercise diabetic diet, 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 has adequate heating, patient has access to medicine/medical supplies considering inability to pay, meal preparation is available to patient for all meals

SN Goals

PATIENT-STATED GOAL: Move Independently

GOALS
patient/caregiver recalls
* how to take the patient's blood pressure
* record the reading
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* diabetic medication management
* blood sugar testing
* diabetic foot care
* exercise
* diabetic diet
* 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
* 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 has adequate heating

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Aquino, EmyAnne SN PT on 09/01/2025

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 : 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.

Home Health Certification and Plan of Care

Order ID: 179/12283

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
1EG4TE5MK73	09/01/2025	From: 09/01/2025 To: 10/30/2025	7361	242353

6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number
Orion Pearson (410) 296-2785 3 Ruxview Ct, GWYNN OAK, MD 21207 667-352-9484	Home Health Cares 579# EAST MARKET@STREETS HARRISONBURG, VA 22801-1234 540-433-7146 1234567891

patient has adequate heating

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

meal preparation is available to patient for all meals

Signature of Physician:	Date
	PAGE 2 of 2
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Aquino, EmyAnne SN PT	09/01/2025