

Home Health Certification and Plan of Care				Order ID: 179/12433	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
1EG4TE5MK73		11/01/2025		From: 11/01/2025 To: 12/30/2025	
				4. Medical Record No.	
				7503	
				5. Provider No.	
				242353	
6. Patient's Name and Address				7. Provider's Name, Address and Telephone Number	
Gel Pearson				Home Health Cares	
6910 Marsue Drive Apt 1A,				579# EAST MARKET@STREETS	
BALTIMORE, MD 21205				HARRISONBURG, VA 22801-1234	
667-352-9484				540-433-7146	
				1234567891	
8. DOB				9. Sex	
12/16/1979				Male	
11. ICD		Principal Diagnosis		Date	
E13.29		Oth diabetes mellitus with oth diabetic kidney complication		11/01/25	
13. ICD		Other Pertinent Diagnoses		Date	
14. DME and Supplies:				15. Safety Measures:	
None of the above				None of the above	
16. Nutrition:				17. Allergies:	
1800cal ADA				no known allergies	
18.A. Functional Limitations				18.B. Activities Permitted	
None of the above				None of the above	
19. Mental & COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 0. Never, SOCIAL ISOLATION: 0. Pyschosocial Status: Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No					
20. Prognosis: good					
22. A Rehabilitation Potential:				22.B.Discharge Plans	
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.				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: Stroke Patient					
SN Careplans				SN Goals	
SN WK1: 1 (11/01/25-11/01/25)				PATIENT-STATED GOAL: Move independently	
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				GOALS	
CAREGIVER: 0. No assistance needed - patient is independent or does not have needs in this area				patient/caregiver recalls	
HOSPITALIZATION RISKS: 10. None of the above				* diabetic medication management	
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				* blood sugar testing	
Advance Directive:No Advance Directive				* diabetic foot care	
PROBLEMS IDENTIFIED ON ASSESSMENT: A1250 - Lack of Necessary Transportation, M2020 - Oral Med Management, M1400 - Dyspnea, abnormal thyroid 0.40 - 4.50 mIU/mL, M1600 - UTI, painful urination, tooth pain/decay/sensitivity, skin breakdown r/t incontinence				* exercise	
PROCEDURES: cough/deep breathing exercises, incentive spirometer, glucose testing via monitor, coordinate/arrange transportation services				* diabetic diet	
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, * 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, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient's transportation needs are met				* 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 self-administers medications as prescribed	
				* recalls related medication(s) purpose, schedule	
				patient's transportation needs are met	

23. Signature and Date of Verbal SOC Where Applicable: Electronically Signed by Antoine, Cherry (SN) SN on 11/01/2025		25. Date HHA Received Signed POT	
24. Physician's Name and Address Joy De Castro		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.	
maine, ME PHONE: 2077499791 FAX: 12072219995 NPI: 1801093968		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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Signature of Physician:		Date	
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Optional Name/Signature of Nurse/Therapist: Electronically Signed by Antoine, Cherry (SN) SN on 11/01/2025		Date	