

Home Health Certification and Plan of Care					Order ID: 179/12610				
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		7484		242353	
6. Patient's Name and Address Mat Pearson 6910 Marsue Drive Apt 1A, TOWSON, MD 21204 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 Metformin - Metformin Hydrochloride 1 tablet by mouth after meal				
11. ICD 10.		Principal Diagnosis Essential (primary) hypertension			Date 09/01/25				
13. ICD E09.8		Other Pertinent Diagnoses Drug/chem diabetes mellitus w unsp complications			Date 09/01/25				
14. DME and Supplies: None of the above					15. Safety Measures: None of the above				
16. Nutrition: 1800cal ADA					17. Allergies: antibiotics				
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: 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: 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: hypertension									
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: 1. History of falls (2 or more falls – or any fall with an injury – in the past 12 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: A1250 - Lack of Necessary Transportation, M2020 - Oral Med Management, meal preparation, M1400 - Dyspnea, abnormal sputum production, limited endurance, muscle spasms, weak hand grips PROCEDURES: cough/deep breathing exercises, incentive spirometer, glucose testing via monitor, coordinate/arrange preparation of missing meals, 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, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient's transportation needs are met, 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 self-administers medications as prescribed * recalls related medication(s) purpose, schedule patient's transportation needs are met meal preparation is available to patient for all meals				
23. Signature and Date of Verbal SOC Where Applicable: Electronically Signed by Apigo R.N., Marion SN on 09/01/2025						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 : 09/01/2025				
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.				
Signature of Physician:					Date PAGE 1 of 1				
Optional Name/Signature of Nurse/Therapist: Electronically Signed by Apigo R.N., Marion SN on 09/01/2025					Date				