

Home Health Certification and Plan of Care				Order ID: 1150/15751				
1. Patient s HI claim No. 3EJ9CN7FG21		2. Start Of Care Date 01/21/2026		3. Certification Period From: 01/21/2026 To: 03/21/2026				
		4. Medical Record No. 21566		5. Provider No. 217058				
6. Patient's Name and Address Haiddie Edmundson 2540 Terra Firma Rd, Baltimore, MD 21225- 410-491-6882			7. Provider's Name, Address and Telephone Number HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239					
8. DOB 09/29/1951 9.Sex Male			10. Medications: Dose/Frequency/Route (N)ew (C)hanged					
11. ICD L89.153	Principal Diagnosis Pressure ulcer of sacral region stage 3	Date 01/21/26	Alfuzosin Hydrochloride - Alfuzosin Hydrochloride 10 mg 1 Tablet by mouth once a day for bph Aspirin-Dipyridamole ER Oral Capsule Extended Release 12 Hour 25-200 MG (Aspirin-Dipyridamole) 1 capsule by mouth twice a day for prophylaxis Cosopt - Dorzolamide Hydrochloride: Timolol Maleate eq 2 perc base;eq 0.5 perc base 1 drop both eyes twice a day for glaucoma Brimonidine Tartrate - Brimonidine Tartrate 0.2 perc 1 Drop both eyes three times a day for glaucoma Ferrous Sulfate - Ferrous Sulfate: Folic Acid 325 (65 Fe) mg / 1 Tablet by mouth once a day Give 1 tablet by mouth one time a day every other day for supplement Insulin Lispro (1 Unit Dial) Solution pen injector 100 UNIT/ML subcutaneous before meal Inject as per sliding scale: if 0 - 200 = 0 UNITS; 201 - 250 = 2 UNITS; 251 - 300 = 4 UNITS; 301 - 350 = 6 UN ITS; 351 - 400 = 8 UNITS CALL PHYSICIAN IF BLOOD SUGAR IS LESS THAN 60 OR GREATER THAN 400, subcutaneously before meals and at bedtime for DIABETES SUBCUTANEOUSLY BEFORE MEALS FOR DIABETES and at bedtime Latanoprost - Latanoprost 0.005 perc 1 Drop both eyes once a day for glaucoma Levothyroxine Sodium - Levothyroxine Sodium 0.050 mg 1 Tablet by mouth once a day for hypothyroidism Melatonin - Melatonin 3 mg / 1 Tablet by mouth once a day for insomnia Rosuvastatin Calcium - Rosuvastatin Calcium 40 mg 1 Tablet by mouth once a day for hypercholesterolemia Tylenol - Acetaminophen 325 mg / 1 Tablet by mouth every 8 hours as needed for Pain. Vit C - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpantenol: Folic Acid: Niacinamide: Pyridox 500 mg / 1 Tablet by mouth once a day for wound healing/ supplement Insulin Glargine Subcutaneous Solution Pen-injector 100 UNIT/ML 20 units subcutaneous once a day Inject 20 units every morning for Diabetes. Ozempic (1 MG/DOSE) Subcutaneous Solution Pen injector 4 MG/3ML (Semaglutide) Inject 0.25 ml every Sunday subcutaneous once a week Inject 0.25 ml subcutaneously one time a day every Sun for weight loss Extra Strength Tylenol - Acetaminophen Pain control Crestor - Rosuvastatin Calcium p.o. Armour Thyroid - Levothyroxine Sodium 50 mcg once daily					
13. ICD E11.9 I10. G47.33 E78.5 N40.0	Other Pertinent Diagnoses Type 2 diabetes mellitus without complications Essential (primary) hypertension Obstructive sleep apnea (adult) (pediatric) Hyperlipidemia unspecified Benign prostatic hyperplasia without lower urinry tract symp	Date 01/21/26 01/21/26 01/21/26 01/21/26 01/21/26						
E03.9 E66.9 Z68.34 Z86.19 Z79.4 Z79.85 Z79.82 Z86.73 Z87.440	Hypothyroidism unspecified Obesity unspecified Body mass index [BMI] 34.0-34.9 adult Personal history of other infectious and parasitic diseases Long term (current) use of insulin Lng trm (crnt) use injectable non-insulin antidiabetic drugs Long term (current) use of aspirin Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits Personal history of urinary (tract) infections	Date 01/21/26 01/21/26 01/21/26 01/21/26 01/21/26 01/21/26 01/21/26 01/21/26 01/21/26						
14. DME and Supplies: rolling walker, wheelchair, hand held shower, diabetic supplies, walker, grab bars, commode, wound care supplies, hospital bed, 4 wheeled walker								
15. Safety Measures: walker precautions, smoke detectors , emergency phone # clearly displayed, bedrails up while in bed, bathroom safety, anticoagulant precautions, ambulates with device, ambulates with assistance, electrical safety measures, hand rails, medication safety, sharps precautions, supervision at all times, transfer with assist, wheelchair precautions, standard precautions, fall precautions, diabetic precautions, bleeding precautions, activity supervision								
16. Nutrition: diabetic								
17. Allergies: no known allergies								
18.A. Functional Limitations Bowel/Bladder Incontinence, Endurance, Ambulation								
18.B. Activities Permitted Wheelchair, Complete Bedrest, Exercises Prescribed, Up As Tolerated								
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: 1. Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required!2. Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions, 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 family/caregiver will be responsible for managing treatment						
23. Signature and Date of Verbal SOC Where Applicable: Electronically Signed by Messick, Charles RN on 01/21/2026						25. Date HHA Received Signed POT		
24. Physician's Name and Address Soon Kim 5808 Main St Elkridge, MD 21075 PHONE: 4107967730 FAX: 14103791537 NPI: 1023095643						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 : 01/14/2026		
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. PAGE 1 of 4		

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Homebound status: Due to diagnosis of Pressure ulcer of sacral region stage 3, the patient is experiencing decreased endurance and mobility, increasing the likelihood of falls. To safely leave their home, the patient needs assistance from another person and an assistive mobility device.

Clinical Condition Requiring Homecare: <p class="MsoNoSpacing">The patient is a 74-year-old male who was hospitalized for lower back pain, weakness, and altered mental status and was found to have acute cholecystitis status post cholecystostomy tube placement, osteomyelitis, acute kidney injury, metabolic encephalopathy, and a previously documented stage III sacral ulcer, now healed. He was discharged to Autumn Lake Rehabilitation and has since returned home. The patient resides in a multi-level townhouse with his spouse, who serves as his primary caregiver 24/7. A hospital bed is set up on the main level, and the home is equipped with stair lifts to the second floor and basement. He primarily uses a wheelchair due to significant weakness and deconditioning, though he has a rolling walker and is able to stand and pivot with two-person assistance. Past medical history is significant for severe sepsis, UTI with E. coli bacteremia, discitis, CVA, diabetes, hypertension, chronic anemia, BPH, hypothyroidism, hyperlipidemia, obstructive sleep apnea on CPAP, and new-onset dialysis. The patient reports a history of multiple falls over the past year and is homebound due to weakness, unsteady gait, and decreased functional mobility, requiring human assistance and assistive devices to leave the home safely. A cholecystostomy drain remains in place and is ordered to be flushed twice daily with 10 mL of normal saline; the drain was found clogged at the start of care, causing mild discomfort, which resolved after flushing. Nursing provided drain care supplies, education, and contacted the provider to obtain orders for caregiver training. The patient requires minimal to moderate assistance with ADLs, has decreased balance, strength, and endurance, and demonstrates poor safety awareness, placing him at high risk for falls. He will benefit from skilled home health services, including nursing for drain management and safety education, physical therapy to address strength, balance, gait, transfers, and mobility, and occupational therapy for ADL training and upper extremity strengthening to prevent further functional decline and promote independence.</o:p></o:p></p> <p class="MsoNoSpacing"><o:p> </o:p></p> <p class="MsoNoSpacing"><o:p> </o:p></p> <p class="MsoNoSpacing">Date of Order<o:p></o:p></p> <p class="MsoNoSpacing">01/21/2026
 Order<o:p></o:p></p> <p class="MsoNoSpacing">Physician Face-to-Face Date: 01/14/2026
 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat dx: Pressure ulcer of sacral region stage 3
 Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home<o:p></o:p></p> <p class="MsoNoSpacing">
 1 - SOC - SN Notes:
 PT Eval Notes:
 OT Eval Notes:<o:p></o:p></p> <p class="MsoNoSpacing">Physician: Kim, Soon</p>

SN Careplans

SN WK1: 1 (01/21/26-01/24/26) ,WK2: 1 (01/25/26-01/31/26) ,WK3: 1 (02/01/26-02/07/26) ,WK4: 1 (02/08/26-02/14/26) ,WK5: 1 (02/15/26-02/21/26) ,WK6: 1 (02/22/26-02/28/26) ,WK7: 1 (03/01/26-03/07/26) ,WK8: 1 (03/08/26-03/14/26) ,WK9: 1 (03/15/26-03/18/26)

PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature < 95 > 100.5, heart rate < 50 > 110, respiratory rate < 8 > 22, blood pressure systolic < 90 > 169, blood pressure diastolic < 60 > 90, O2 saturation < 88 > 100, pain < 0 > 5

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

HOSPITALIZATION RISKS: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 3. Multiple hospitalizations (2 or more) in the past 6 months, 7. Currently taking 5 or more medications, 8. Currently reports exhaustion, 9. Other risk(s) not listed in 1- 8

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; Assess the patient's incision on post op day 7 and the nurse or physical therapist will remove aquacel dressing leaving OTA; if incision is draining educate pt/pcg on cleaning with normal saline and covering with dry gauze daily and as needed. Assess/Instruct Pt/Pcg: Ice to ____ x 20 minutes each hour while awake. If cold machine ordered apply 20 minutes on and 20 minutes off for 3-4 times a day. Assess/Instruct all body systems/vital signs/complications, Blood Pressure; systolic is greater than 169 mm Hg or less than 90 mm Hg; diastolic is greater than 100 mm Hg or less than 55 mm Hg, Clinician to assess comorbidities and report changes in condition to the patient's physician, Pain Rating is greater than 6 on 0-10 scale, Pulse is greater than 110 or less than 50, Respirations are greater than 22 or less than 8, SPO2: is less than 90 % at rest /with exertion, Temperature is greater than 100.5 F or less than 95.0 F, Pain Rating is greater than 6 on 0-10 scale Implement Fall Prevention Program, Instruct and educate the patient/PCG on wearing compression stockings for the next 4 weeks per discharge instructions. Instruct the pt/PCG on using the incentive spirometer 10 times every 2 hour while awake. Provide education content at patient's level of health literacy. Assess/Instruct Pt/Pcg: Safety measures to prevent injury. Assess: Musculoskeletal status. Teach Pt/Pcg to maintain appropriate wt bearing status as ordered by MD, total joint replacement precautions as applicable, Safe stair climbing skills, Safe, effective use of adaptive/assist device Assess/Instruct Pt/Pcg: Pain management measures; assess pain level, pain medication, rest, body alignment, ROM, meditation, massage. Pt/Pcg educated in pain management techniques including positioning and relaxation techniques Instruct Pt/Pcg: Medication actions, uses, frequency, dose, side effects, interactions of all new/change meds, Provide medication education,. Assess/Instruct Pt/Pcg: Safety measures to prevent injury, Therapeutic Exercise, Transfer Training Monitor surgical wound for s/s of infection, educate on s/s of concern and infection prevention to promote wound healing.

; Skin Preservation: Measures to prevent skin breakdown; pressure relief, incontinence care, nutrition, hydration ; Pain: Pain management measures; pain medication, rest, body alignment, ROM, meditation, massage ; Medications: Medication actions, uses, frequency, dose, interactions of all new/change meds Advance Directive:Living Will

PROBLEMS IDENTIFIED ON ASSESSMENT: M1745 - Behavioral Issues, M2102d - Caregiver Performs Treatment, M2020 - Oral Med Management, M2102f - Patient Supervision, M2102c - Med Admin,

SN Goals

PATIENT-STATED GOAL: Patient states he wants to be able to walk again so he can do more things for himself

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

patient/caregiver recalls

- * bowel incontinence management including dietary changes
- * bowel training
- * skin care
- * 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

- * strategies to minimize fatigue and exhaustion including work simplification
- * energy conservation
- * lifestyle changes
- * diet
- * recalls related medication(s) purpose, schedule

patient self-administers medications as prescribed

- * recalls related medication(s) purpose, schedule

caregiver administers and/or packages medications appropriately

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	01/21/2026

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M1033 - Exhaustion, M1400 - Dyspnea, M1620 - Bowel Incontinence, M1600 - UTI, M1610 - Urinary Incontinence, limited endurance, limited strength, muscle weakness, daytime fatigue, balance deficit, difficulty sleeping, lethargy PROCEDURES: Diabetic foot inspections: Inspect feet daily for cuts, redness, swelling, or blisters, wash feet daily and dry well, especially between toes. Moisturize dry skin (not between toes). Wear well-fitting shoes; avoid walking barefoot and report any non-healing wounds immediately.. Educate on carb controlled diet: Eat regular meals; avoid skipping meals. Balance meals using the plate method: vegetables lean protein whole grains or healthy carbohydrates Limit sugary foods, sweetened drinks, and refined carbohydrates. Choose high-fiber foods (vegetables, fruits, legumes, whole grains). Control portion sizes., incentive spirometer, apply anti-embolitic stockings, apply compression bandage, bladder training, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision 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 medicatio, * bowel incontinence management including dietary changes bowel training skin care, 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, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, caregiver administers and/or packages medications appropriately						
PT Careplans			PT Goals			
PT WK1: 1 (01/21/26-01/24/26) ,WK2: 2 (01/25/26-01/31/26) ,WK3: 2 (02/01/26-02/07/26) ,WK4: 2 (02/08/26-02/14/26) ,WK5: 1 (02/15/26-02/21/26) ,WK6: 1 (02/22/26-02/28/26) ,WK7: 1 (03/01/26-03/07/26) ,WK8: 1 (03/08/26-03/14/26) ,WK9: 1 (03/15/26-03/18/26) PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with Therapy activities, Pain Interference with ADLs, M1400 Dyspnea, Pain Effect on Sleep, GG0170S1 - Wheel 150 feet, GG0170R1 - Wheel 50 ft w 2 Turns, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170L1 - Walk 10 ft on Uneven Surface, GG0170K1 - Walk 150 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170I1 - Walk 10 Feet, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170D1 - Sit to Stand, GG0170F1 - Toilet Transfer PROCEDURES: wheelchair training, home exercise program: Supine- ankle pump, quad set, gluteal set, heel slide, SLR, bridging. Seated-LAQ hip flex, hip abd, pillow squeeze. Standing-Mini squat, heel/toe raise, hip flex, hip abd, hip ext, leg curls., dynamic standing balance exercises: Dynamic balance activity to be performed on firm surface with no hands on device, weight shifting L-R with wide BOS, and forward backward with separated stance., gait training/stair training, transfers training 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 medicatio, * 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 relaxatio, Sit to Stand - 05. Setup or clean-up assistance, Chair to Bed to Chair - 05. Setup or clean-up assistance, Toilet Transfer - 03. Partial/moderate assistance, Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, 1 - Step (curb) - 04. Supervision or touching assistance, 4 Steps - 04. Supervision or touching assistance, 12 Steps - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance, Wheel 50 ft w 2 Turns - 06. Independent, Wheel 150 feet - 06. Independent, Car Transfer - 04. Supervision or touching assistance, Walk 10 ft on Uneven Surface - 02. Substantial/maximal assistance			PATIENT-STATED GOAL: To be able to walk again 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 medicatio 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 relaxatio Sit to Stand - 05. Setup or clean-up assistance Chair to Bed to Chair - 05. Setup or clean-up assistance Toilet Transfer - 03. Partial/moderate assistance Walk 10 Feet - 04. Supervision or touching assistance Walk 50 ft with 2 Turns - 04. Supervision or touching assistance Walk 150 Feet - 04. Supervision or touching assistance 1 - Step (curb) - 04. Supervision or touching assistance 4 Steps - 04. Supervision or touching assistance 12 Steps - 04. Supervision or touching assistance Picking Up Object - 04. Supervision or touching assistance Wheel 50 ft w 2 Turns - 06. Independent Wheel 150 feet - 06. Independent Car Transfer - 04. Supervision or touching assistance Walk 10 ft on Uneven Surface - 02. Substantial/maximal assistance			
OT Careplans			OT Goals			
OT WK1: 1 (01/21/26-01/24/26) ,WK2: 1 (01/25/26-01/31/26) ,WK3: 1 (02/01/26-02/07/26) ,WK4: 1 (02/08/26-02/14/26) ,WK5: 1 (02/15/26-02/21/26) PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with ADLs, M1400 - Dyspnea, GG0130B1 - Oral Hygiene, GG0130F1 - Upper Body Dressing, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130A1 - Eating PROCEDURES: home health aid : verbal order from Dr Soon Kim for OT to eval home health aid , cough/deep breathing exercises, equipment training, work simplification/energy conservation			PATIENT-STATED GOAL: to return to PLOF 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 medicatio patient/caregiver recalls			
Signature of Physician:			Date			
			PAGE 3 of 4			
Optional Name/Signature of Nurse/Therapist:			Date			
Electronically Signed by Messick, Charles RN			01/21/2026			

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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 medicatio, * 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 relaxatio, Oral Hygiene - 06. Independent, Toileting Hygiene - 05. Setup or clean-up assistance, Shower/Bathe Self - 04. Supervision or touching assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance, Eating - 06. Independent, Upper Body Dressing - 06. Independent		* 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 relaxatio Oral Hygiene - 06. Independent Toileting Hygiene - 05. Setup or clean-up assistance Shower/Bathe Self - 04. Supervision or touching assistance Lower Body Dressing - 05. Setup or clean-up assistance Don/Doff Footwear - 05. Setup or clean-up assistance Eating - 06. Independent Upper Body Dressing - 06. Independent		

Signature of Physician:	Date
	PAGE 4 of 4
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