

Home Health Certification and Plan of Care				Order ID: 1192/1	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
5A97T15GD69		04/01/2026		From: 04/01/2026 To: 05/30/2026	
				4. Medical Record No.	
				7639	
				5. Provider No.	
				45-3145	
6. Patient's Name and Address				7. Provider's Name, Address and Telephone Number	
Test Fax				Sienna Home Health, Inc.	
12 Main St.,				14011 PARK DRIVE SUITE 218	
BALTIMORE, MD 21213				TOMBALL, TX 77377-6288	
999-999-9999				281-760-7341	
				1467489377	
8. DOB				9.Sex	
04/13/1960				Male	
10. Medications: Dose/Frequency/Route (N)ew (C)hanged					
There are no Medications for this Plan of Care					
11. ICD		Principal Diagnosis		Date	
110.		Essential (primary) hypertension		04/01/26	
13. ICD		Other Pertinent Diagnoses		Date	
E11.9		Type 2 diabetes mellitus without complications		04/01/26	
14. DME and Supplies:				15. Safety Measures:	
walker				walker precautions	
16. Nutrition:				17. Allergies:	
diabetic				no known allergies	
18.A. Functional Limitations				18.B. Activities Permitted	
None of the above				Walker	
19. Mental & Psychosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 0. Never, SOCIAL ISOLATION: 2. Sometimes, 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, HISTORY OF DEPRESSION: No					
20. Prognosis: fair					
22. A Rehabilitation Potential:				22.B.Discharge Plans	
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.				family/caregiver 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, other					
Clinical Condition Requiring Homecare: Diabetes, Hypertension					
SN Careplans				SN Goals	
SN WK1: 1 (04/01/26-04/04/26) ,WK2: 1 (04/05/26-04/11/26) ,WK3: 1 (04/12/26-04/18/26) ,WK4: 1 (04/19/26-04/25/26) ,WK5: 1 (04/26/26-05/02/26)				PATIENT-STATED GOAL: I want to walk without a walker	
PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature < 96 > 100.5, heart rate < 60 > 100, respiratory rate < 12 > 24, blood pressure systolic < 100 > 170, blood pressure diastolic < 60 > 100, O2 saturation < 90 > 100, pain < 0 > 5				GOALS	
CAREGIVER: 1. Non-agency caregiver(s) currently provide assistance				patient/caregiver recalls	
HOSPITALIZATION RISKS: 10. None of the above				* lifestyle modifications to manage respiratory condition including	
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				* diet changes and regular exercise	
Advance Directive:No Advance Directive				* strategies to control shortness of breath	
PROBLEMS IDENTIFIED ON ASSESSMENT: M1745 - Behavioral Issues, D0700 - Social Isolation, M2020 - Oral Med Management, M1400 - Dyspnea, lightheadedness, chest pain, abnormal BS < 70/140 > mg/dL, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, B1000 - Vision Deficit				* home remedies to keep lungs healthy	
PROCEDURES: cough/deep breathing exercises, incentive spirometer, glucose testing via monitor, coordinate/arrange resources for vision-impaired, coordinate/arrange long-term socialization activities				* recalls related medication(s) purpose, schedule	
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, * 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 relaxation skills and diversional activities, related medication(s) purpose, schedule, * management of mental health condition including joining a peer group maintaining regular contact with mental health professional avoiding known stressors controlling impulses, 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, * strategies to increase socialization, related medication(s) purpose, schedule				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 relaxation skills and diversional activities	
				* recalls related medication(s) purpose, schedule	
				patient/caregiver recalls	
				* management of mental health condition including joining a peer group	
				* maintaining regular contact with mental health professional	
				* avoiding known stressors	
				* controlling impulses	
				* recalls related medication(s) purpose, schedule	
				patient self-administers medications as prescribed	
				* recalls related medication(s) purpose, schedule	
				patient/caregiver recalls	
				* strategies to increase socialization	
				* recalls related medication(s) purpose, schedule	
23. Signature and Date of Verbal SOC Where Applicable: Electronically Signed by Bietz, Doug on 04/01/2026				25. Date HHA Received Signed POT	
24. Physician's Name and Address				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.	
Test Physician				F2F date : 03/30/2026	
310. NATARAJAPURAM 4TH EAST STREET					
KVP, HI 628502					
PHONE: 999-999-9999 FAX: 12072219995 NPI: 1801093968					
27. Attending Physician's Signature and Date Signed 04/13/2026: 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 Bietz, Doug on 04/01/2026				Date	
				04/13/2026	