

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		4. Medical Record No.		5. Provider No.	
5A97T15GD69		04/01/2026		From: 04/01/2026 To: 05/30/2026		7639		45-3145	
6. Patient's Name and Address Test Fax 12 Main St., BALTIMORE, MD 21213 999-999-9999					7. Provider's Name, Address and Telephone Number Sienna Home Health, Inc. 14011 PARK DRIVE SUITE 218 TOMBALL, TX 77377-6288 281-760-7341 1467489377				
8. DOB 04/13/1960 9.Sex Male					10. Medications: Dose/Frequency/Route (N)ew (C)hanged There are no Medications for this Plan of Care				
11. ICD I10.		Principal Diagnosis Essential (primary) hypertension			Date 04/01/26				
13. ICD E11.9		Other Pertinent Diagnoses Type 2 diabetes mellitus without complications			Date 04/01/26				
14. DME and Supplies: walker					15. Safety Measures: walker precautions				
16. Nutrition: diabetic					17. Allergies: no known allergies				
18.A. Functional Limitations None of the above					18.B. Activities Permitted 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: 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				
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 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				
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					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				
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					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				
PROCEDURES: cough/deep breathing exercises, incentive spirometer, glucose testing via monitor, coordinate/arrange resources for vision-impaired, coordinate/arrange long-term socialization activities									
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 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 Test Physician 310. NATARAJAPURAM 4TH EAST STREET KVP, HI 628502 PHONE: 999-999-9999 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 : 03/30/2026				
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.				
Signature of Physician:					Date PAGE 1 of 1				
Optional Name/Signature of Nurse/Therapist: Electronically Signed by Bietz, Doug on 04/01/2026					Date				