Home Health Certification and Plan of Care

Order ID: 1192/5

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
5A97T15GD69	04/30/2026	From: 04/30/2026 To: 06/28/2026	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	Principal Diagnosis	Date
I10.	Essential (primary) hypertension	04/30/26

13. ICD	Other Pertinent Diagnoses	Date
E11.9	Type 2 diabetes mellitus without complications	04/30/26

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 & Pyschosocial 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 WK1: 1 (04/30/26-05/02/26) ,WK2: 1 (05/03/26-05/09/26) ,WK3: 1 (05/10/26-05/16/26) ,WK4: 1 (05/17/26-05/23/26) ,WK5: 1 (05/24/26-05/30/26)

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, blood sugar < 70 > 350

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

PROBLEMS IDENTIFIED ON ASSESSMENT: M1745 - Behavioral Issues, D0700 - Social Isolation, M2020 - Oral Med Management, M1400 - Dyspnea, chest pain, lightheadedness, abnormal BS < 70/140 > mg/dL, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, B1000 - Vision Deficit

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

SN Goals

PATIENT-STATED GOAL: I want to walk without a walker

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

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/caregiver recalls
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

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 04/30/2026

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 : 04/28/2026

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 04/30/2026

Date