# Home Health Certification and Plan of Care

**Order ID: 179/13416**

| 1. Patient s HI claim No. | 2. Start Of Care Date | 3. Certification Period | 4. Medical Record No. | 5. Provider No. |
|---|---|---|---|---|
| 1EG4TE5MK72 | 06/23/2026 | From: 06/23/2026 To: 08/21/2026 | 8610 | 242353 |

**6. Patient's Name and Address**

Jed Smith
253 MC Bernardo,
SCHENECTADY, NY 12345
390-271-0000

**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** 03/03/1960 | **9.Sex** Male

**10. Medications: Dose/Frequency/Route (N)ew (C)hanged**

Eliquis - Apixaban 500mg by mouth every 2 hours
Paroxetine Hydrochloride - Paroxetine Hydrochloride eq 20 mg base
Simvastatin - Simvastatin 20 mg
Symadine - Amantadine Hydrochloride 100 mg
Lexapro - Escitalopram Oxalate eq 20 mg base
Fortamet - Metformin Hydrochloride 1gm
Anaprox - Naproxen Sodium eq 250 mg base
Advil Liqui-Gels - Ibuprofen eq 200 mg free acid and potassium salt

| 11. ICD | Principal Diagnosis | Date |
|---|---|---|
| I10. | Essential (primary) hypertension | 06/23/26 |

| 13. ICD | Other Pertinent Diagnoses | Date |
|---|---|---|
| E11.9 | Type 2 diabetes mellitus without complications | 06/23/26 |
| L89.312 | Pressure ulcer of right buttock stage 2 | 06/23/26 |
| G21.8 | Other secondary parkinsonism | 06/23/26 |

**14. DME and Supplies:**

hoyer lift, feeding tube supplies, eggcrate

**15. Safety Measures:**

knee precautions, hand rails

**16. Nutrition:**

cardiac diet, diabetic

**17. Allergies:**

aspirin

**18.A. Functional Limitations**

Hearing

**18.B. Activities Permitted**

Transfer bed/Chair, Walker jwhbecjhnwexkwbeck

**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:** 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

**Clinical Condition Requiring Homecare:** HTN and DM

## SN Careplans

SN WK1: 2 (06/23/26-06/27/26)

PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature < 95 > 100, heart rate < 50 > 110, respiratory rate < 8 > 22, blood pressure systolic < 90 > 169, blood pressure diastolic < 60 > 100, O2 saturation < 88 > 101, pain < 0 > 6

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), 2. Unintentional weight loss of a total of 10 pounds or more 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: M2020 - Oral Med Management, Financial, Home Safety, M1033 - Unintentional Weight Loss, M1400 - Dyspnea, coughing, chest pain, cramping calves/thighs/hips, abnormal sputum production, heartburn/indigestion, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, B1000 - Vision Deficit, skin breakdown r/t incontinence, #1 - 2 - Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed. - Posterior Right Buttock -

PROCEDURES: physician-ordered wound care: #1 - 2 - Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed. - Posterior Right Buttock -, cough/deep breathing exercises, incentive spirometer, physician-ordered wound care: cover wound with Kerlix wrap., wound vacuum, glucose testing via monitor, coordinate/arrange repair of inadequate lighting, coordinate/arrange access to medicine/medical supplies considering patient inability to pay, coordinate/arrange resources for vision-impaired

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, * strategies to increase caloric intake, 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, patient living environment has adequate lighting, patient has access to medicine/medical supplies considering inability to pay

## SN Goals

PATIENT-STATED GOAL: I want to breathe better without oxygen.

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
* strategies to increase caloric intake
* 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 living environment has adequate lighting

patient has access to medicine/medical supplies considering inability to pay

**23. Signature and Date of Verbal SOC Where Applicable:**
Electronically Signed by Calija, Mae SN on 06/23/2026

**25. Date HHA Received Signed POT**

**24. Physician's Name and Address**
Christian Oyibe
9750 CRESCENT PARK CIRCLE
ORLAND PARK, IL 60462-9999
PHONE: (708) 204-7612 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 : 06/20/2026

**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

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Optional Name/Signature of Nurse/Therapist:
Electronically Signed by Calija, Mae SN on 06/23/2026

Date