

10/21/2025 12:35:08 PM
Printed By: HUGHES, TERESA L

Patient Information Report

Patient:	BARNETT, THOMAS	Insured ID:	101242561400	Primary Payor:	CARELON MYNEXUS FOR AETNA MCR ADV PDGM
MR No:	04200076640801				
Legacy MR No:					

Assigned Branch	VISITING NURSES ASSOCIATION HEALTH AT HOME LEXINGTON	Assigned Team	TEAM A	Location	
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Patient Nickname		Patient ID	766408	SSN	
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Referral Info

Referral Date	05/05/2025	Referral Type	RECERTIFICATION	Referral Taken By	ELIZABETH ARMIJO
Referral Source	PHYSICIAN	Referring Physician	BASHAM, SHELBI	Referring Physician Contact	SHELBI BASHAM

Care Type and Effective Dates (P=Primary)

HOME HEALTH 09/04/2025 - (P)
CARELINK - SKIN AND WOUND 09/04/2025 -
RSP1 09/04/2025 -

Demographics

Patient Info

Gender	MALE	DOB	05/09/1955	Race	
Preferred Language					
Primary Phone	5023828245	Alt Phone		Email	

Primary Address

Street		City		State	Zip	County
122 LEONARDWOOD DR APT 222		FRANKFORT		KY	40601-	FRANKLIN
Phone	MSA #	CBSA		Floor		Room
(502)382-8245		99918				
Travel Directions						

Current Service Location: CLIENT'S HOME/RESIDENCE

Street		City		State	Zip	County
122 LEONARDWOOD DR APT 222		FRANKFORT		KY	40601-	FRANKLIN
Phone	MSA #	CBSA		Floor		Room
(502) 382-8245		99918				
Travel Directions						

Patient Contacts

Contact Name	Relationship	Contact Type	Contact Relationship Type
JOHNNY JONES POA	UNKNOWN	EMERGENCY CONTACT	PRIMARY CAREGIVER
Home Phone	Primary Phone	Alternate Phone	Address
	(502) 320-9742		

Payor Source Info

Payor Source Type	Payor Type	Payor Source	Is patient in an HMO (HHCAHPS)?
PRIMARY	MANAGED MEDICARE PPS / PDGM	CARELON MYNEXUS FOR AETNA MCR ADV PDGM	
Medicare No.	Medicare A Effective	Medicare B Effective	Admission Source
			1 - PHYSICIAN REFERRAL
Medicaid No.	Medicaid Effective	Physician Medicaid No.	Physician Name
			SMITH, BRIAN

Private Payor Type Info

Claim No.	Policy No.	Insured ID
	101242561400	
Insured Name	Insured Relation	Insured Address

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	Insured City	Insured State	Insured Zip
	Insured Phone		
Employer Name	Employer ID	Employer Address	
	Employer City	Employer State	Employer Zip
	Employer Phone		

<u>Program Name</u>	<u>Obtained Date</u>	<u>Obtained By/ Authorized By</u>	<u>Authorization No./ Active</u>	<u>Start Date/ End Date</u>
PPS PROGRAM	8/28/2025 10:59:47 AM	HCHB RECERTIFICATION	Y	09/04/2025 11/02/2025

	Unit Type	Budget Type	Billing Code	Qty Per Period	Qty Per Day	Qty Per Week	Qty Per Month	Qty Per Year	Active
	VISITS	DISCIPLINES							Y

PPS PROGRAM	9/4/2025 12:19:41 PM	STACEY BROWN, ot	00DNU Y	09/04/2025 11/02/2025
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	Unit Type	Budget Type	Billing Code	Qty Per Period	Qty Per Day	Qty Per Week	Qty Per Month	Qty Per Year	Active
	VISITS	DISCIPLINES							Y

PPS PROGRAM	9/4/2025 12:19:49 PM	STACEY BROWN, pt	00DNU Y	09/04/2025 11/02/2025
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	Unit Type	Budget Type	Billing Code	Qty Per Period	Qty Per Day	Qty Per Week	Qty Per Month	Qty Per Year	Active
	VISITS	DISCIPLINES							Y

PPS PROGRAM	9/11/2025 1:05:47 PM	STACEY BROWN, sn	121125050870333 Y	09/04/2025 10/03/2025
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	Unit Type	Budget Type	Billing Code	Qty Per Period	Qty Per Day	Qty Per Week	Qty Per Month	Qty Per Year	Active
	VISITS	DISCIPLINES	SN	5					Y

PPS PROGRAM	10/16/2025 10:46:32 AM	STACEY BROWN, SN	121125050870333 Y	10/04/2025 11/02/2025
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	Unit Type	Budget Type	Billing Code	Qty Per Period	Qty Per Day	Qty Per Week	Qty Per Month	Qty Per Year	Active
	VISITS	DISCIPLINES	SN	4					Y

Physician Info

Primary Physician	NPI #	Date Last Seen
SMITH, BRIAN	1992749873	
Address	City	State
460 WILSON AVE	VERSAILLES	KY
Phone	Fax	Zip
	Pager	40383-

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(859)879-0111 (859)879-0363

Secondary Physician

BASHAM, SHELBI

Requested Date of Evaluation

09/04/2025

Requested Date of Add-On Evaluation

Admitting Discipline

SN

Add-On Discipline

Perform Add-On Evaluation Prior to Approval
of the Plan of Care associated with the
Completed SOC Visit?

N

Clinical Info

Case Manager

MANDI MCBRIDE, RN

Team Member(s)

CHERYL COOK, LPN

JERRI CRAGER, OT

MEGAN KIFER, PTA

WALTER LUTTRELL, PT

Weight

Height

Pregnant

N

Paperwork Received By Patient

Y

Medical Release Code

YES, PROVIDER HAS A SIGNED STATEMENT PERMITTING RELEASE OF MEDICAL BILLING DATA RELATED TO A CLAIM

Acuity Status

3 - WITHIN WEEK

Disaster Status

AMBULATORY W/ ASSIST

Evacuation Location

UNKNOWN

Type	Location	Contents	Contact Name	Contact Phone	Was Adv Dir Info Left With Caregiver?
DUR. PWR. OF ATTY	HOME OF POA		JOHNNY JONES	502-320-9742	N

Home Health Care Survey

Is care related to surgical discharge?	Does patient have end-stage renal disease?	Number of ADLs for which patient is not independent?
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Has patient requested "No Publicity" status?	Is maternity care the primary reason for home health care?	Primary Spoken Language
N	N	

ICD-10 Diagnoses/Procedures

Order	Code	Description	Onset / Exac.	O/E Date	Type	Sym. Ctrl. Rtg.	OASIS Item
1	L98.491	NON-PRS CHRONIC ULCER SKIN/ SITES LIMITED TO BRKDOWN SKIN	E	05/07/2025	D	2 - Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring.	M1021
2	I89.0	LYMPHEDEMA, NOT ELSEWHERE CLASSIFIED	E	05/07/2025	D	1 - Symptoms well controlled with current therapy.	M1023
3	E11.9	TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS	E	05/07/2025	D	1 - Symptoms well controlled with current therapy.	M1023
4	I50.9	HEART FAILURE, UNSPECIFIED	E	05/07/2025	D	1 - Symptoms well controlled with current therapy.	M1023
5	Z79.4	LONG TERM (CURRENT) USE OF INSULIN	E	05/07/2025	D		M1023
6	E78.5	HYPERLIPIDEMIA, UNSPECIFIED	E	05/07/2025	D	1 - Symptoms well controlled with current therapy.	M1023
7	Z79.82	LONG TERM (CURRENT) USE OF ASPIRIN	E	05/07/2025	D		M1023
8	Z79.84	LONG TERM (CURRENT) USE OF ORAL HYPOGLYCEMIC DRUGS	E	05/07/2025	D		M1023
9	Z79.85	LNG TRM (CRNT) USE INJECTABLE NON-INSULIN ANTIDIABETIC DRUGS	E	05/07/2025	D		M1023
10	Z55.6	Problems related to health literacy	E	05/07/2025	D		M1023
11	Z91.81	HISTORY OF FALLING	E	05/07/2025	D		M1023

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Allergies	
Description	Date Entered
NKA	5/7/2025 2:28:29 PM
* denotes Non-Visit QI Reporting Collection	

Order Number: **6293433**

Printed: 10/21/2025 12:35 PM
Eastern Time Zone

VISITING NURSES ASSOCIATION HEALTH AT HOME LEXINGT
2464 FORTUNE DRIVE SUITE 110
LEXINGTON, KY 40509-4254
Phone: (859) 277-5111
Fax: (859) 317-2507

PHYSICIAN:

BRIAN SMITH, MD
460 WILSON AVE
VERSAILLES, KY 40383-

Phone: (859)879-0111

Fax: (859)879-0363

2nd Physician:

Send to Physician: Y

Verbal Order: Y

Verbal Date: 10/21/2025 Time: 12:30 PM

CLIENT:

BARNETT, THOMAS
122 LEONARDWOOD DR APT 222
FRANKFORT, KY 40601-

SSN:

DOB: 5/9/1955 MR#: 04200076640801

CERT: 9/4/2025 to 11/2/2025

Order Read Back to Physician/Agent of Physician?: Y

ABN Delivered to Patient?: NA

Order Date: 10/21/2025 12:30 PM

Order Type: PHYSICIAN ORDER

Order Description:

VERBAL ORDER OBTAINED FROM SARAH TO REFER TO MCGRATH WOUND CARE FOR NONHEALING ABD WOUND.

ENTERED / TAKEN BY (ELECTRONICALLY SIGNED):

CHERYL COOK, LPN

DATE: 10/21/2025

APPROVED / PROCESSED BY (ELECTRONICALLY SIGNED):

DATE:

PHYSICIAN SIGNATURE:

DATE:

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Legacy MR No:
Primary Payor: CARELON MYNEXUS FOR AETNA MCR ADV PDGM
Visit Date: 10/14/2025 **Visit Number:** 6 **Visit Type:** SN11 - SN SUBSEQUENT VISIT

General: BARNETT, THOMAS 04200076640801

Visit Date: 10/14/2025 **Visit Number:** 6 **Visit Type:** SN11 - SN SUBSEQUENT VISIT **Branch Code:** 042 **Billable:** ☒
Agent ID: 211549 **Agent Name:** CHERYL COOK LPN **Mileage Payment Method:** AM **Trip Fees:** 0.00 **Mileage Start:** 0 **Mileage End:** 0 **Mileage:** 0

Time:
 TRAVEL TIME DRIVE START TIME 10/14/2025 02:18 PM DRIVE END TIME 10/14/2025 03:00 PM
 IN-HOME TIME BEGAN 10/14/2025 03:00 PM COMPLETED 10/14/2025 03:34 PM
 Total In-Home Time: 0.57 Hours
 Total Drive Time: 0.71 Hours
 Total Time: 0.57 Hours

Vital Signs

Vital Signs	Reading	Time Recorded	Details	Instrument Problems
Temperature	97	10/14/2025 03:30 PM	TEMPORAL	N
Pulse	84	10/14/2025 03:30 PM	RADIAL	N
Pulse Characteristics:			WNL	
Respirations	16	10/14/2025 03:30 PM		N
Respiration Characteristics:			WNL	
Blood Pressure	128 / 68	10/14/2025 03:30 PM	LYING ARM - RT	N

Assessment

PATIENT ELIGIBILITY

INDICATE TWO PATIENT IDENTIFIERS USED TO IDENTIFY THE PATIENT:

PATIENT NAME

DATE OF BIRTH

VISUAL RECOGNITION

PATIENT ADDRESS

HAS PATIENT'S INSURANCE CHANGED SINCE LAST VISIT?

NO

THE PATIENT IS CONSIDERED HOMEBOUND/CONFINED TO HOME BECAUSE:

BECAUSE OF ILLNESS OR INJURY, PATIENT NEEDS AID OF SUPPORTIVE DEVICES - WHEELCHAIR - LEVEL 1

BECAUSE OF ILLNESS OR INJURY, PATIENT NEEDS AID OF SUPPORTIVE DEVICES - WALKER - LEVEL 1

ASSISTANCE OF ANOTHER PERSON IN ORDER TO LEAVE PLACE OF RESIDENCE - LEVEL 1

THE PATIENT HAS NORMAL INABILITY TO LEAVE THE HOME AND LEAVING THE HOME TAKES CONSIDERABLE AND TAXING EFFORT BECAUSE:

FALL RISK

EYES/EARS/NOSE/THROAT

INDICATE EYES/EARS/NOSE/THROAT FINDINGS:

HARD OF HEARING

INDICATE HEAD AND NECK ASSESSMENT FINDINGS:

WNL

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SN11 - SN SUBSEQUENT VISIT

Assessment

PAIN

IS PATIENT UNCOMFORTABLE BECAUSE OF PAIN?

NO

ARE THERE ANY ADDITIONAL DETAILS THAT NEED TO BE PROVIDED TO DESCRIBE THE CLIENT'S PAIN?

NO

INTEGUMENTARY

INDICATE INTEGUMENTARY ASSESSMENT FINDINGS: (MARK ALL THAT APPLY)

NO PROBLEMS IDENTIFIED

CARDIOVASCULAR

CARDIOVASCULAR ASSESSMENT FINDINGS: (MARK ALL THAT APPLY)

HEART SOUNDS WITH NORMAL RATE AND RHYTHM

ARE COMPRESSION STOCKINGS ORDERED?

NO

RESPIRATORY

INDICATE RESPIRATORY ASSESSMENT FINDINGS: (MARK ALL THAT APPLY)

LUNGS CLEAR IN ALL LOBES

WAS O2 SATURATION LEVEL TESTED?

NO

WAS PERCEIVED FUNCTIONAL DYSPNEA SCALE PERFORMED?

NO

GENITOURINARY

INDICATE GENITOURINARY ASSESSMENT: (MARK ALL THAT APPLY)

WNL

GASTROINTESTINAL

INDICATE GASTROINTESTINAL ASSESSMENT FINDINGS: (MARK ALL THAT APPLY)

WNL

INDICATE DATE OF LAST BOWEL MOVEMENT:

10/14/2025

NUTRITIONAL STATUS:

GOOD APPETITE

COGNITIVE/BEHAVIORAL

INDICATE CLIENT'S MENTAL STATUS: (MARK ALL THAT APPLY)

ALERT

ORIENTED TO PERSON

ORIENTED TO PLACE

ORIENTED TO TIME

FORGETFUL

INDICATE ABNORMAL NEUROLOGIC FINDINGS: (MARK ALL THAT APPLY)

WNL

PSYCHIATRIC

DOES THE PATIENT TAKE A PSYCHOTROPIC MEDICATION?

YES

WAS MOTOR ACTIVITY ASSESSED?

NO

DOES THE PATIENT LIVE IN THE STATE OF ARIZONA?

NO

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Assessment

WERE BEHAVIORAL SCALES ASSESSMENTS COMPLETED?

NO

ENDOCRINE/HEMATOPOIETIC

INDICATE ENDOCRINE/HEMATOPOIETIC ASSESSMENT: (MARK ALL THAT APPLY)

DIABETES

THYROID PROBLEMS

IS THE CLIENT TAKING INSULIN?

YES

HOW FREQUENT ARE BLOOD SUGARS CHECKED?

DAILY

WHAT ARE THE CLIENT'S USUAL BLOOD SUGAR READINGS?

100S TO 200S

CAN THE PATIENT DRAW UP INJECTABLE MEDICATION (I.E., INSULIN, B12, CALCIMAR) ?

YES

CAN THE PATIENT SELF INJECT INJECTABLE MEDICATION (I.E., INSULIN, B12, CALCIMAR) ?

YES

IS THE CLIENT TAKING AN ANTICOAGULANT?

YES

FUNCTIONAL

INDICATE MUSCULOSKELETAL ASSESSMENT: (MARK ALL THAT APPLY)

WNL

HAS THE PATIENT HAD ANY UNREPORTED FALLS SINCE LAST VISIT?

NO

CARE COORDINATION

INDICATE IF YOU COMMUNICATED WITH OTHER DISCIPLINES INVOLVED IN THIS CASE:

NA-NOT APPLICABLE

INDICATE WHO YOU REVIEWED WRITTEN PLAN OF CARE INSTRUCTIONS WITH (MARK ALL THAT APPLY)

PATIENT

CAREGIVER

WRITTEN PATIENT INSTRUCTIONS ARE KEPT IN THE FOLLOWING LOCATION IN THE HOME:

APARTMENT

SUPERVISORY FUNCTIONS

WERE SUPERVISORY FUNCTIONS PERFORMED?

NOT APPLICABLE

Wound Assessment

Historical wounds are retained as inactive and wound numbers continuously increment for subsequent episodes and admissions.

Anatomical Figures

Anatomical View

Wound # / Location / Type / Source

Question

Answer

MALE ANTERIOR

#1 - UP ABDOMINAL, MIDLINE, CHRONIC NON PRESSURE ULCERS
MULTIPLE SCATTERED - HCHB

Onset Date: 03/03/2025

CHANGE IN STATUS

NONE

WOUND ASSESSED

YES

TOTAL WAT SCORE

N/A

MEASUREMENTS TAKEN

NO

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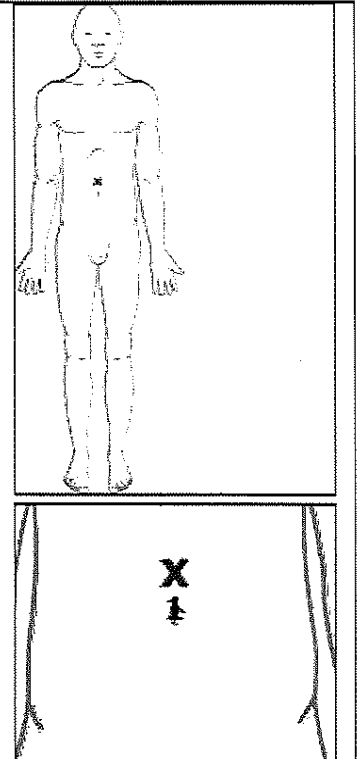
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SN11 - SN SUBSEQUENT VISIT

REASON MEASUREMENTS NOT TAKEN	UNABLE
DEPTH DESCRIPTION	NECROTIC
IS THIS A CLOSED SURGICAL WOUND OR SUSPECTED DEEP TISSUE INJURY?	NO
GRANULATION TISSUE	75-100%
EDGES	INDIST
SHAPE	IRREG
EXUDATE TYPE	SEROUS
EXUDATE AMOUNT	SCANT
ODOR	NONE
EPITHELIALIZATION	75-<100%
NECROTIC TISSUE TYPE	NONE
NECROTIC TISSUE AMOUNT	NONE
TOTAL NECROTIC TISSUE SLOUGH	0-25%
TOTAL NECROTIC TISSUE ESCHAR	0-25%
EDGE / SURROUNDING TISSUE - MACERATION	ABSENT
UNDERMINING	NONE
TUNNELING	NO
SKIN COLOR SURROUNDING WOUND	NORM
PERIPHERAL TISSUE EDEMA	NONE
PERIPHERAL TISSUE INDURATION	NONE
DOES PATIENT HAVE PAIN ASSOCIATED WITH THIS WOUND?	NO
STATE	CHRONIC
SIGNS AND SYMPTOMS OF INFECTION	NO
DEBRIDEMENT THIS VISIT	NO
DRAIN PRESENT	NO
WOUND CARE PROVIDED	<p>SKILLED NURSE FOR INSTRUCTIONS / REINFORCEMENT OF / MANAGEMENT OF DIABETES TO INCLUDE DIET, SKIN CARE, MEDICATION MANAGEMENT, BLOOD GLUCOSE TESTING AND DIABETIC FOOT CARE. FACILITY STAFF CHECK GLU QID AND ADMINISTER MEDICATIONS</p> <p>SKILLED NURSE TO PROVIDE SKILLED TEACHING TO PATIENT/CAREGIVER OF HYPERTENSION TO INCLUDE MEDICATION MANAGEMENT, SELF-ASSESSMENT, LOW SODIUM DIET, AND TRACKING OF BLOOD PRESSURE RESULTS.</p> <p>SKILLED NURSE TO OBSERVE AND ASSESS PATIENT WITH GENERALIZED DEPRESSION. ASSESS NEED FOR MEDICATION, MEDICATION CHANGES AND POTENTIAL NEED FOR REFERRAL TO PROVIDE COUNSELING AND ASSISTANCE WITH MANAGING DEPRESSION.</p> <p>SKILLED NURSE TO FOCUS ON IDENTIFIED NEED FOR HIGH RISK MEDICATION INTERVENTION.</p> <p>SKILLED NURSE TO OBSERVE AND ASSESS INTEGUMENTARY STATUS TO IDENTIFY CHANGES AND</p>



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SN11 - SN SUBSEQUENT VISIT

INTERVENE TO MINIMIZE COMPLICATIONS. CLINICIAN TO PROVIDE SKILLED TEACHING RELATED TO ALTERED SKIN INTEGRITY INCLUDING PATHOPHYSIOLOGY, NUTRITION, MEDICATION REGIMEN, AND MEASURES TO PROMOTE OPTIMAL SKIN INTEGRITY. SKILLED NURSE TO PERFORM/TEACH WOUND CARE TO NON PRESSURE ULCERS TO ABDOMEN. CLEANSE WITH NS OR WOUND CLEANSER, APPLY CALMOSEPTINE TO WOUND BED AND COVER WITH BORDER FOAM DRESSING. WOUND CARE TO BE PERFORMED EVERY 2 X WEEKLY AND PRN FOR LOOSE OR SOILED DRESSING. PATIENT OR CAREGIVER TO PERFORM WHEN SN UNAVAILABLE. SKILLED NURSE PRN VISIT ORDER: 1 REMOTE AND 2 PRN VISITS MAY BE PERFORMED DURING THIS CERTIFICATION PERIOD FOR THE FOLLOWING REASON(S): WOUND CARE, MEDICATION ISSUES, FALLS, LABS SKILLED NURSE TO EVALUATE AND DEVELOP PLAN OF CARE TO BE SIGNED BY THE PHYSICIAN. SKILLED NURSE TO ASSESS/EVALUATE ANY CONDITIONS THAT PRESENT THEMSELVES AND THAT WILL IMPACT THE PLAN OF CARE DURING THE COURSE OF THE EPISODE TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS. TEACH AND MONITOR PATIENT/CAREGIVER ABILITY TO SAFELY ADMINISTER MEDICATIONS. PHONE TOUCHPOINTS CAN BE PERFORMED AS NEEDED TO SUPPLEMENT THE PLAN OF CARE SKILLED NURSE TO OBSERVE AND ASSESS CARDIOVASCULAR SYSTEM TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS AND PROMOTE SELF CARE MANAGEMENT. SKILLED NURSE TO PROVIDE SKILLED TEACHING RELATED TO PATHOPHYSIOLOGY, DISEASE MANAGEMENT, SAFE MEDICATION ADMINISTRATION, WEIGHT/EDEMA MANAGEMENT, PERMITTED ACTIVITIES, S/SX OF EXACERBATION, AND S/SX TO NOTIFY AGENCY, PHYSICIAN OR 911 RELATED TO THE DIAGNOSIS OF CHF

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PATIENT/CAREGIVER WILL BE KNOWLEDGEABLE OF DISCHARGE PLANS AND WILL DEMONSTRATE/PROVIDE EDUCATION AND RESOURCES NEEDED TO MAINTAIN HEALTH. AGENCY WILL DISCHARGE PATIENT TO KATHRYN OVERBERG APRN PHYSICIAN/HEALTH CARE PROVIDER AND MAY ACCEPT ORDERS FROM THE FOLLOWING PHYSICIANS: KATHRYN OVERBERG APRN
 SN REMOTE VIDEO VISIT(S) TO ASSESS/EVALUATE AND PROVIDE EDUCATION/TRAINING ON INTERVENTIONS/PROCEDURES PER THE POC, SAFE MEDICATION ADMINISTRATION, DISEASE MANAGEMENT, SIGNS/SYMPTOMS OF EXACERBATION, METHODS TO PREVENT EXACERBATION, AND SIGNS/SYMPTOMS TO REPORT AGENCY, PHYSICIAN OR 911. CLINICIAN TO EDUCATE PATIENT / CAREGIVER IN FALL PREVENTION AND PROVIDE INTERVENTIONS TO REDUCE FALL RISK AND ENHANCE HOME SAFETY
 PSYCHOSOCIAL / COGNITIVE ASSESSMENT INDICATES NO NEED FOR SOCIAL, FINANCIAL, OR TRANSPORTATION SUPPORT OR FOR ADDITIONAL CARE PROVIDERS/DISCIPLINES OR REFERRALS TO OUTSIDE ENTITIES. TOLERATED WELL

Wound Images
 N/A

Narrative

NURSING SUBSEQUENT VISIT NARRATIVE
 SITUATION / BACKGROUND

REASON FOR SKILLED VISIT SUPPORTING MEDICAL NECESSITY: WOUND CARE TO ABDOMEN, ASSESSMENT AND EDUCATION OF COMORBIDITIES AND MEDICATIONS.

ASSESSMENT

IN BED ASLEEP AND WEARING CPAP. EASILY AWAKENED BUT DID CONTINUE TO FALL ASLEEP THROUGHOUT VISIT. NO ACUTE DISTRESS. DENIES PAIN. ABD REMAINS WITH MULTIPLE SCATTERED OPEN AREAS WITH SLIGHT IMPROVEMENT NOTED SINCE THIS CLINICIAN LAST ASSESSED. WOUND CARE PROVIDED.

PATIENT/CAREGIVER RESPONSE TO SKILLED SERVICES / EDUCATION:
 INSTRUCTED ON KEEPING SITE CLEAN AND COVERED AT ALL TIMES AND NEED TO INCREASE PROTEIN INTAKE.

PATIENT VERBALIZED UNDERSTANDING VIA TEACH BACK METHOD.

RECOMMENDATION
 CHANGES IN PLAN OF CARE IF INDICATED: NA
 SCHEDULED OFFICE / CLINIC APPOINTMENTS:
 PLAN FOR NEXT VISIT: CONTINUE WITH WOUND CARE.

Patient Goals

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Patient Goal

"SORES TO HEAL"

Interventions Provided

1. COLLABORATE WITH PATIENT/CAREGIVER AND APPROPRIATE PHYSICIAN(S) IN POC DEVELOPMENT. CHANGES IN POC ARE AGREED UPON AND COMMUNICATED WITH THE PATIENT/CAREGIVER, PHYSICIANS WRITING ORDERS ON THE POC AND/OR THE RECEIVING PHYSICIAN/HEALTH CARE PROVIDER.

DETAILS/COMMENTS: COLLABORATED WITH PATIENT/CAREGIVER IN THE DEVELOPMENT OF THE POC.

2. ASSESS AND EVALUATE CO-MORBID CONDITIONS

DETAILS/COMMENTS: REVIEWED AND INSTRUCTED ON RECENT EXACERBATION OF CO-MORBID CONDITIONS

WHEN TO REPORT TO NURSE/PHYSICIAN

REVIEWED DIETARY NEEDS AND RESTRICTIONS

MEDICATION REGIMEN, SIDE EFFECTS/DESIRED EFFECTS, POTENTIAL INTERACTIONS AND REFILL PROCESS

BALANCING ACTIVITIES AND NEED FOR FREQUENT REST PERIODS

3. PROVIDE/INSTRUCT ON WOUND CARE. (ALL INTERVENTION DETAILS MUST BE INSTRUCTED ON PRIOR TO MARKING THE INTERVENTION GOAL AS ACHIEVED)

DETAILS/COMMENTS: INSTRUCTED ON ORDERED WOUND CARE. DEMONSTRATE PROPER WOUND CARE TECHNIQUE

INSTRUCTED ON PRINCIPLES OF STANDARD PRECAUTIONS: PROPER HANDLING/DISPOSAL OF ITEMS COMING IN CONTACT WITH BODY FLUIDS.

INSTRUCTED ON SIGNS / SYMPTOMS OF INFECTION TO WOUND (REDNESS, DRAINAGE, ODOR)

4. INSTRUCT ON THE USE OF MEDICATION THERAPY ASSOCIATED WITH SKIN INTEGRITY

DETAILS/COMMENTS: MANAGEMENT OF MEDICATION REGIMEN INCLUDING CORRECT MEDICATION DOSAGE, FREQUENCY, ROUTE

SPECIFIC MEDICATION EDUCATION INCLUDING PURPOSE, DOSE, SCHEDULE, SIDE EFFECTS, INEFFECTIVE DRUG THERAPY, DUPLICATE DRUG THERAPY, SPECIAL CONSIDERATIONS, AND POTENTIAL INTERACTIONS

Goals Met

1. POC, CHANGES IN POC, AND CHANGES IMPACTING DISCHARGE PLAN WILL BE AGREED UPON AND COMMUNICATED WITH THE PATIENT/CAREGIVER, PHYSICIANS WRITING ORDERS ON THE POC AND/OR THE RECEIVING PHYSICIAN/HEALTH CARE PROVIDER THROUGHOUT THE EPISODE OF CARE.

2. CHANGES TO CO-MORBID CONDITIONS WILL BE IDENTIFIED AND REPORTED TO THE PHYSICIAN.

3. PATIENT VERBALIZES TOLERANCE TO WOUND CARE. PATIENT / CAREGIVER VERBALIZES / RETURNS DEMONSTRATION OF WOUND CARE. (DO NOT MARK GOAL AS MET UNLESS ALL INTERVENTION DETAILS ARE UNDERSTOOD BY PATIENT / CAREGIVER)

4. PATIENT/CAREGIVER VERBALIZES UNDERSTANDING OF THE USE OF MEDICATIONS TO TREAT DISEASE PROCESS/SYMPTOMS (DO NOT MARK GOAL AS MET UNLESS ALL INTERVENTION DETAILS ARE UNDERSTOOD BY PATIENT/CAREGIVER)

Visit Note Report

Client: BARNETT, THOMAS
Client DOB: 5/9/1955
Insured ID: 101242561400

MR No: 04200076640801

Legacy MR No:

Primary Payor:

CARELON MYNEXUS FOR AETNA MCR ADV PDGM

Visit Date: 10/14/2025

Visit Number: 6

Visit Type:

SN11 - SN SUBSEQUENT VISIT

Goals Not Met

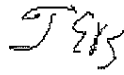
1. PATIENT/CAREGIVER WILL VERBALIZE UNDERSTANDING OF LAB TESTS TO HELP INDICATE LEVEL OF HEALING.
 EXCEPTION CODE: NOT APPLICABLE TO CURRENT VISIT
2. PATIENT/CAREGIVER VERBALIZES AGREEMENT WITH DISCHARGE PLANS.
 EXCEPTION CODE: ADDITIONAL TIME REQUIRED TO MEET INTERVENTION/GOAL

Supplies Delivered

6 - OPTIFOAM GENTLE EX SACRUM 7CM X 7CM - EACH

Agent Signature:

Client Signature:

CHERYL COOK LPN 10/14/2025 03:34 PM
 (Electronically Signed)

Last Modification Date:

Last Modified By:

10/14/2025 3:46 PM

SQL-SVC-JAMS-PRD-RWX

ADDENDUM

SUPPLIES DELIVERED/USED EDITED BY SQL-SVC-JAMS-PRD-RWX ON Oct 14 2025 3:46PM

Order Number:

6196020

HOME HEALTH CERTIFICATION AND PLAN OF CARE

Patient's Medicare No.	SOC Date 5/7/2025	Certification Period 9/4/2025 to 11/2/2025	Medical Record No. 04200076640801	Provider No. 187113
Patient's Name and Address: THOMAS BARNETT (502) 382-8245 122 LEONARDWOOD DR APT 222 FRANKFORT, KY 40601-		Provider's Name, Address and Telephone Number: VISITING NURSES ASSOCIATION HEALTH AT HOME LEXINGT F: (859) 317-2507 2464 FORTUNE DRIVE SUITE 110 LEXINGTON, KY 40509- P: (859) 277-5111		
Physician's Name & Address: BRIAN A. SMITH, MD 460 WILSON AVE VERSAILLES, KY 40383-		Patient's Date of Birth: 5/9/1955 Patient's Gender: MALE Order Date: 9/3/2025 12:14 PM Verbal Order: Y Verbal Date: 9/3/2025 Verbal Time: 3:20 PM		
Nurse's Signature and Date of Verbal SOC Where Applicable: (deemed as electronic signature) MANDI MCBRIDE, RN 9/3/2025				Date HHA Received Signed POC 9/10/2025

Patient's Expressed Goals:
"SORES TO HEAL"

ICD-10

Diagnoses:

Order	Code	Description	Onset or Exacerbation	O/E Date
1	L98.491	NON-PRS CHRONIC ULCER SKIN/ SITES LIMITED TO BRKDOWN SKIN	EXACERBATION	05/07/2025
2	I89.0	LYMPHEDEMA, NOT ELSEWHERE CLASSIFIED	EXACERBATION	05/07/2025
3	E11.9	TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS	EXACERBATION	05/07/2025
4	I50.9	HEART FAILURE, UNSPECIFIED	EXACERBATION	05/07/2025
5	Z79.4	LONG TERM (CURRENT) USE OF INSULIN	EXACERBATION	05/07/2025
6	E78.5	HYPERLIPIDEMIA, UNSPECIFIED	EXACERBATION	05/07/2025
7	Z79.82	LONG TERM (CURRENT) USE OF ASPIRIN	EXACERBATION	05/07/2025
8	Z79.84	LONG TERM (CURRENT) USE OF ORAL HYPOGLYCEMIC DRUGS	EXACERBATION	05/07/2025
9	Z79.85	LNG TRM (CRNT) USE INJECTABLE NON-INSULIN ANTIDIABETIC DRUGS	EXACERBATION	05/07/2025
10	Z55.6	Problems related to health literacy	EXACERBATION	05/07/2025
11	Z91.81	HISTORY OF FALLING	EXACERBATION	05/07/2025

Frequency/Duration of Visits:

SN EFFECTIVE 09/07/2025 1WK8, 2 PRN, 1 PRN REMOTE

Orders of Discipline and Treatments:

SKILLED NURSE FOR INSTRUCTIONS / REINFORCEMENT OF / MANAGEMENT OF DIABETES TO INCLUDE DIET, SKIN CARE, MEDICATION MANAGEMENT, BLOOD GLUCOSE TESTING AND DIABETIC FOOT CARE. FACILITY STAFF CHECK GLU QID AND ADMINISTER MEDICATIONS

SKILLED NURSE TO PROVIDE SKILLED TEACHING TO PATIENT/CAREGIVER OF HYPERTENSION TO INCLUDE MEDICATION MANAGEMENT, SELF-ASSESSMENT, LOW SODIUM DIET, AND TRACKING OF BLOOD PRESSURE RESULTS.

SKILLED NURSE TO OBSERVE AND ASSESS PATIENT WITH GENERALIZED DEPRESSION. ASSESS NEED FOR MEDICATION, MEDICATION CHANGES AND POTENTIAL NEED FOR REFERRAL TO PROVIDE COUNSELING AND ASSISTANCE WITH MANAGING DEPRESSION.

SKILLED NURSE TO FOCUS ON IDENTIFIED NEED FOR HIGH RISK MEDICATION INTERVENTION.

SKILLED NURSE TO OBSERVE AND ASSESS INTEGUMENTARY STATUS TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS. CLINICIAN TO PROVIDE SKILLED TEACHING RELATED TO ALTERED SKIN INTEGRITY INCLUDING PATHOPHYSIOLOGY, NUTRITION, MEDICATION REGIMEN, AND MEASURES TO PROMOTE OPTIMAL SKIN INTEGRITY.

SKILLED NURSE TO PERFORM/TEACH WOUND CARE TO NON PRESSURE ULCERS TO ABDOMEN. CLEANSE WITH NS OR WOUND CLEANSER, APPLY CALMOSEPTINE TO WOUND BED AND COVER WITH BORDER FOAM DRESSING. WOUND CARE TO BE PERFORMED EVERY 2 X WEEKLY AND PRN FOR LOOSE OR SOILED DRESSING. PATIENT OR CAREGIVER TO PERFORM WHEN SN UNAVAILABLE.

SKILLED NURSE PRN VISIT ORDER: 1 REMOTE AND 2 PRN VISITS MAY BE PERFORMED DURING THIS CERTIFICATION PERIOD FOR THE FOLLOWING REASON(S): WOUND CARE, MEDICATION ISSUES, FALLS, LABS SKILLED NURSE TO EVALUATE AND DEVELOP PLAN OF CARE TO BE SIGNED BY THE PHYSICIAN. SKILLED NURSE TO ASSESS/EVALUATE ANY CONDITIONS THAT PRESENT THEMSELVES AND THAT WILL IMPACT THE PLAN OF CARE DURING THE COURSE OF THE EPISODE TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS. TEACH AND MONITOR PATIENT/CAREGIVER ABILITY TO SAFELY ADMINISTER MEDICATIONS. PHONE TOUCHPOINTS CAN BE PERFORMED AS NEEDED TO SUPPLEMENT THE PLAN OF CARE.

I 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. This patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.

Attending Physician's Signature and Date Signed

BRIAN SMITH, MD 09/10/2025
(Electronically Signed)

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.

Patient's Medicare No.	SOC Date 5/7/2025	Certification Period 9/4/2025 to 11/2/2025	Medical Record No. 04200076640801	Provider No. 187113
Patient's Name THOMAS BARNETT		Provider's Name VISITING NURSES ASSOCIATION HEALTH AT HOME LEXINGT		

Orders of Discipline and Treatments:

SKILLED NURSE TO OBSERVE AND ASSESS CARDIOVASCULAR SYSTEM TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS AND PROMOTE SELF CARE MANAGEMENT. SKILLED NURSE TO PROVIDE SKILLED TEACHING RELATED TO PATHOPHYSIOLOGY, DISEASE MANAGEMENT, SAFE MEDICATION ADMINISTRATION, WEIGHT/EDEMA MANAGEMENT, PERMITTED ACTIVITIES, S/SX OF EXACERBATION, AND S/SX TO NOTIFY AGENCY, PHYSICIAN OR 911 RELATED TO THE DIAGNOSIS OF CHF

PATIENT/CAREGIVER WILL BE KNOWLEDGEABLE OF DISCHARGE PLANS AND WILL DEMONSTRATE/PROVIDE EDUCATION AND RESOURCES NEEDED TO MAINTAIN HEALTH.

AGENCY WILL DISCHARGE PATIENT TO KATHRYN OVERBERG APRN PHYSICIAN/HEALTH CARE PROVIDER AND MAY ACCEPT ORDERS FROM THE FOLLOWING PHYSICIANS: KATHRYN OVERBERG APRN

SN REMOTE VIDEO VISIT(S) TO ASSESS/EVALUATE AND PROVIDE EDUCATION/TRAINING ON INTERVENTIONS/PROCEDURES PER THE POC, SAFE MEDICATION ADMINISTRATION, DISEASE MANAGEMENT, SIGNS/SYMPTOMS OF EXACERBATION, METHODS TO PREVENT EXACERBATION, AND SIGNS/SYMPTOMS TO REPORT AGENCY, PHYSICIAN OR 911.

CLINICIAN TO EDUCATE PATIENT / CAREGIVER IN FALL PREVENTION AND PROVIDE INTERVENTIONS TO REDUCE FALL RISK AND ENHANCE HOME SAFETY

PSYCHOSOCIAL / COGNITIVE ASSESSMENT INDICATES NO NEED FOR SOCIAL, FINANCIAL, OR TRANSPORTATION SUPPORT OR FOR ADDITIONAL CARE PROVIDERS/DISCIPLINES OR REFERRALS TO OUTSIDE ENTITIES.

THE LICENSED PROFESSIONAL WHOSE SIGNATURE APPEARS ON THIS PLAN OF CARE ATTESTS THAT THE COMPREHENSIVE ASSESSMENT FINDINGS WERE DISCUSSED AND ORDERS WERE RECEIVED AS INDICATED BY THE VERBAL ORDER DATE AND TIME 9/3/2025.

LICENSED PROFESSIONAL TO REPORT VITAL SIGNS FALLING OUTSIDE THE FOLLOWING ESTABLISHED PARAMETERS. TEMP<95>101.1 PULSE<50>100 RESP<12>25 SYSTOLICBP<90>160 DIASTOLICBP<50>100 FBS<60>140 PAIN>9 O2SAT<88

Goals/Rehabilitation Potential/Discharge Plans:

PATIENT / CAREGIVER WILL VERBALIZE / DEMONSTRATE ADEQUATE KNOWLEDGE OF ENDOCRINE STATUS. GOAL TO BE MET BY 10.5.25

PATIENT/CAREGIVER WILL VERBALIZE/DEMONSTRATE ABILITY TO CARE FOR HYPERTENSION. GOAL TO BE MET BY 9.15.25

PATIENT/CAREGIVER WILL VERBALIZE MEASURES TO COPE WITH DEPRESSION AND STATE SIGNS AND SYMPTOMS TO REPORT TO PHYSICIAN BY 9.25.25

PATIENT/CAREGIVER DEMONSTRATES ABILITY TO ADHERE TO MEDICATION REGIMEN. FACILITY STAFF KNOWLEDGEABLE CHANGES IN SKIN INTEGRITY STATUS WILL BE IDENTIFIED AND REPORTED TO THE PHYSICIAN FOR PROMPT INTERVENTION. PATIENT / CAREGIVER WILL VERBALIZE/DEMONSTRATE ADEQUATE KNOWLEDGE OF INTEGUMENTARY STATUS AND APPROPRIATE MEASURES TO PROMOTE SKIN INTEGRITY AND PREVENT INJURY. GOAL TO BE MET BY 10.25.25

PATIENT / CAREGIVER WILL VERBALIZE/DEMONSTRATE ABILITY TO PERFORM WOUND CARE. WOUND STATUS WILL IMPROVE AS EVIDENCED BY A DECREASE IN SIZE, DRAINAGE, ABSENCE OF INFECTION, AND DECREASED PAIN. GOAL TO BE MET BY 9.20.25

A PLAN OF CARE WILL BE ESTABLISHED THAT MEETS ALL PATIENT'S NURSING NEEDS AND COUNTERSIGNED BY PHYSICIAN.

CARDIOVASCULAR EXACERBATIONS WILL BE IDENTIFIED PROMPTLY AND INTERVENTIONS INITIATED TO MINIMIZE ASSOCIATED RISK.

PATIENT/CAREGIVER WILL VERBALIZE/DEMONSTRATE ABILITY TO CARE FOR ALTERED CARDIOVASCULAR STATUS. GOALS TO BE MET BY 10.5.25

PATIENT AND/OR CAREGIVER WILL BE IN AGREEMENT WITH DISCHARGE PLANS AND WILL VERBALIZE HAVING RESOURCES AND KNOWLEDGE TO MAINTAIN HEALTH.

PATIENT WILL REMAIN SAFE AND NEEDS WILL BE MET BY COLLABORATING ON POC AND COMMUNICATING CHANGES IN POC AND CHANGES AFFECTING DISCHARGE PLAN WITH PATIENT, CAREGIVER, RECEIVING PHYSICIAN/HEALTH CARE PROVIDER, AND OTHER PHYSICIANS WRITING ORDERS ON THE POC THROUGHOUT CERTIFICATION PERIOD.

THROUGH REMOTE VIDEO VISIT(S) EDUCATION WILL BE RECEIVED TOWARDS POC ORDERS/GOALS. PATIENT/CAREGIVER WILL VERBALIZE/DEMONSTRATE THE FOLLOWING INTERVENTIONS/PROCEDURES

PATIENT TO DEMONSTRATE REDUCED FALL RISK AND IMPROVE HOME SAFETY BY 9.30.25

PATIENT/CAREGIVER VERBALIZES AND DEMONSTRATES ABILITY FOR THE PATIENT TO FUNCTION WITHIN THEIR COMMUNITY AND TO PARTICIPATE IN THE DEVELOPMENT AND IMPLEMENTATION OF THEIR CARE PLAN THROUGHOUT THE CERTIFICATION PERIOD.

Rehab Potential:

GOOD/MARKED IMPROVEMENT IN STATUS IS EXPECTED

DC Plans:

DISCHARGE TO SELF CARE UNDER SUPERVISION OF PHYSICIAN WHEN GOALS ARE MET

DME and Supplies:

DME-WALKER ; DME-WHEELCHAIR ; SOLUTION/SKIN PREP; WOUND CARE

Prognosis:

GOOD

Signature of Physician BRIAN SMITH, MD (Electronically Signed)	Date 9/10/2025
Optional Name/Signature Of MANDI MCBRIDE, RN	Date 9/3/2025

Patient's Medicare No.	SOC Date 5/7/2025	Certification Period 9/4/2025 to 11/2/2025	Medical Record No. 04200076640801	Provider No. 187113
Patient's Name THOMAS BARNETT		Provider's Name VISITING NURSES ASSOCIATION HEALTH AT HOME LEXINGT		

Functional Limitations:

ENDURANCE; AMBULATION; ASSIST TO LEAVE HOME; DYSPNEA WITH MODERATE EXERTION; WOUND; FALL RISK; WHEELCHAIR; WALKER; INSTABILITY; BLOOD PRESSURE; INJECTION; FALL; HYPERTENSION

Safety Measures:

DISPOSAL OF MEDICAL WASTE, EMERGENCY PLAN, FALL PREVENTION, FIRE RESPONSE PLAN, MED PRECAUTIONS, UNIVERSAL PRECAUTIONS

Activities Permitted:

UP AS TOLERATED; WHEELCHAIR; WALKER; 24 HR SUPERVISION; ASSIST MOBILITY; ELEVATE LOWER EXTREMITIES; NO DRIVING; STAND BY ASSISTANCE; FALL PRECAUTIONS; ASSIST WITH MEDICATION; UP AS TOLERATED WITH WALKER ONLY; UNSTEADY GAIT; ACTIVITY AS TOLERATED; WOUND; ASSIST WITH BATHING; ASSIST TO LEAVE HOME; CPAP

Nutritional Requirements:

CARDIAC DIET, CONSISTENT CARB

Advance Directives:

DUR. PWR. OF ATTY

Mental Statuses:

ORIENTED; DEPRESSED; ALERT; COOPERATIVE; ORIENTED TO PLACE; ORIENTED TO PERSON

Supporting Documentation for Risk of Hospital Readmission:

(PRA) (M1033) RISK FOR HOSPITALIZATION: WHICH OF THE FOLLOWING SIGNS OR SYMPTOMS CHARACTERIZE THIS PATIENT AS AT RISK FOR HOSPITALIZATION? (MARK ALL THAT APPLY.)

1 - HISTORY OF FALLS (2 OR MORE FALLS - OR ANY FALL WITH AN INJURY - IN THE PAST 12 MONTHS) || 5 - DECLINE IN MENTAL, EMOTIONAL, OR BEHAVIORAL STATUS IN THE PAST 3 MONTHS || 6 - REPORTED OR OBSERVED HISTORY OF DIFFICULTY COMPLYING WITH ANY MEDICAL INSTRUCTIONS (FOR EXAMPLE, MEDICATIONS, DIET, EXERCISE) IN THE PAST 3 MONTHS || 7 - CURRENTLY TAKING 5 OR MORE MEDICATIONS || 9 - OTHER RISK(S) NOT LISTED IN 1 - 8

Allergies:

NKA

Medications:

Medication/ Dose	Frequency	Route	Start Date/ End Date	DC Date	New/ Changed
ACETAMINOPHEN 325 MG TABLET 2 tablet	EVERY 6 HOURS/PRN	ORAL			
Reason: PAIN Instructions:					
ASPIRIN 81 MG TABLET, DELAYED RELEASE 1 tablet	DAILY	ORAL			
Reason: HEART Instructions:					
ATORVASTATIN 80 MG TABLET 1 tablet	DAILY	ORAL			
Reason: CHOLESTEROL Instructions:					
BRIMONIDINE 0.2 %-TIMOLOL 0.5 % EYE DROPS 1 drops	2 TIMES DAILY	OPHTHALMIC (EYE)			
Reason: GLACOMA Instructions:					
CALMOSEPTINE 0.44 %-20.6 % TOPICAL OINTMENT Per instructions	AS NEEDED/PRN	TOPICAL			
Reason: WOUND CARE Instructions: APPLY TO AFFECTED AREA					
CERTAVITE SENIOR 0.4 MG-300 MCG-250 MCG TABLET 1 tablet	DAILY	ORAL			
Reason: SUPPLEMENT Instructions:					
DIVALPROEX 125 MG TABLET, DELAYED RELEASE 1 tablet	2 TIMES DAILY	ORAL			
Reason: MOOD STABILIZER Instructions:					

Signature of Physician

BRIAN SMITH, MD (Electronically Signed)

Date

9/10/2025

Optional Name/Signature Of

MANDI MCBRIDE, RN

Date

9/3/2025

Patient's Medicare No.	SOC Date 5/7/2025	Certification Period 9/4/2025 to 11/2/2025	Medical Record No. 04200076640801	Provider No. 187113	
Patient's Name THOMAS BARNETT		Provider's Name VISITING NURSES ASSOCIATION HEALTH AT HOME LEXINGT			
Medication/ Dose	Frequency	Route	Start Date/ End Date	DC Date	New/ Changed
DOCUSATE SODIUM 100 MG TABLET 1 tablet	DAILY	ORAL			
Reason: CONSTIPATION					
Instructions:					
ESCITALOPRAM 20 MG TABLET 1 tablet	DAILY	ORAL			
Reason: DEPRESSION					
Instructions:					
FERROUS SULFATE 325 MG (65 MG IRON) TABLET 1 tablet	DAILY	ORAL			
Reason: IRON SUPPLEMENT					
Instructions:					
FUROSEMIDE 40 MG TABLET 1 tablet	DAILY	ORAL			
Reason: FLUID					
Instructions:					
GABAPENTIN 100 MG CAPSULE 1 capsule	3 TIMES DAILY	ORAL			
Reason: NERVE PAIN					
Instructions:					
GLIPIZIDE 10 MG TABLET 1 tablet	DAILY	ORAL			
Reason: DM2					
Instructions:					
HYDROXYZINE HCL 10 MG TABLET 1 tablet	3 TIMES DAILY	ORAL			
Reason: ALLERGIES					
Instructions:					
IBUPROFEN 400 MG TABLET 1 tablet	EVERY 6 HOURS/PRN	ORAL			
Reason: PAIN					
Instructions:					
JANUVIA 25 MG TABLET 1 tablet	DAILY	ORAL			
Reason: DIABETES					
Instructions:					
LACTULOSE 10 GRAM/15 ML (15 ML) ORAL SOLUTION 20 g	DAILY/PRN	ORAL			
Reason: CONSTIPATION					
Instructions:					
LANTUS U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SOLUTION 58 unit	DAILY	SUBCUTANEOUS			Changed
Reason: DM2					
Instructions:					
LANTUS U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SOLUTION 32 unit	EVERY PM	SUBCUTANEOUS			
Reason: DIABETES					
Instructions:					
LOPERAMIDE 2 MG CAPSULE 1 capsule	4 TIMES DAILY/PRN	ORAL			
Reason: DIARRHEA					
Instructions:					
MAGNESIUM OXIDE 400 MG (241.3 MG MAGNESIUM) TABLET 1 tablet	DAILY	ORAL			
Reason: SUPPLEMENT					
Instructions:					

Signature of Physician BRIAN SMITH, MD (Electronically Signed)	Date 9/10/2025
Optional Name/Signature Of MANDI MCBRIDE, RN	Date 9/3/2025

Patient's Medicare No.	SOC Date 5/7/2025	Certification Period 9/4/2025 to 11/2/2025	Medical Record No. 04200076640801	Provider No. 187113
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Medication/ Dose	Frequency	Route	Start Date/ End Date	DC Date	New/ Changed
MELATONIN 5 MG CAPSULE 1 capsule	BEDTIME/PRN	ORAL			
Reason: SLEEP					
Instructions:					
NOVOLIN 70-30 FLEXPEN U-100 INSULIN 100 UNIT/ML (70-30) SUBCUTANEOUS	4 TIMES DAILY/PRN	SUBCUTANEOUS			
Reason: DIABETES					
Instructions: BEFORE MEALS AND AT BEDTIME					
BS 150-200 6U					
BS 201-250 8U					
BS 251-300 10U					
BS 301-350 12U					
BS 351-400 14U					
CALL MD OF BS BELOW <70 OR >400					
OMEPRAZOLE 20 MG CAPSULE, DELAYED RELEASE 1 capsule	DAILY	ORAL			
Reason: GERD					
Instructions:					
ONDANSETRON 4 MG DISINTEGRATING TABLET 1 tablet	3 TIMES DAILY/PRN	ORAL			
Reason: NAUSEA					
Instructions:					
OZEMPIC 2 MG/DOSE (8 MG/3 ML) SUBCUTANEOUS PEN INJECTOR 2 mg	WEEKLY	SUBCUTANEOUS			Changed
Reason: DM2					
Instructions:					
SALINE WOUND WASH 0.9 % TOPICAL SPRAY Per instructions	AS NEEDED/PRN	TOPICAL			
Reason: WOUND CARE					
Instructions: CLEANSE WOUND					
SIROLIMUS 2 MG TABLET 1 tablet	DAILY	ORAL			
Reason: IMMUNOSUPPRESSANT					
Instructions:					
SPIRONOLACTONE 25 MG TABLET 1 tablet	DAILY	ORAL			Changed
Reason: EDEMA					
Instructions:					
SPIRONOLACTONE 50 MG TABLET 1 tablet	DAILY	ORAL			
Reason: FLUID					
Instructions:					
TAMSULOSIN 0.4 MG CAPSULE 1 capsule	DAILY	ORAL			
Reason: PROSTATE					
Instructions:					
VITAMIN C 500 MG TABLET 1 tablet	DAILY	ORAL			
Reason: SUPPLEMENT					
Instructions:					
VITAMIN D3 50 MCG (2,000 UNIT) TABLET 1 tablet	DAILY	ORAL			
Reason: SUPPLEMENT					
Instructions:					

Signature of Physician BRIAN SMITH, MD (Electronically Signed)	Date 9/10/2025
Optional Name/Signature Of MANDI MCBRIDE, RN	Date 9/3/2025

Patient's Medicare No.	SOC Date 5/7/2025	Certification Period 9/4/2025 to 11/2/2025	Medical Record No. 04200076640801	Provider No. 187113
Patient's Name THOMAS BARNETT		Provider's Name VISITING NURSES ASSOCIATION HEALTH AT HOME LEXINGT		
Medication/ Dose	Frequency	Route	Start Date/ End Date	DC Date
VITAMIN E (DL, ACETATE) 450 MG (1,000 UNIT) CAPSULE 1 capsule	DAILY	ORAL		
Reason: SUPPLEMENT				
Instructions:				
WOUND CLEANSER IRRIGATION SPRAY		IRRIGATION		
Per instructions	AS NEEDED/PRN			
Reason: WOUND CARE				
Instructions: CLEANSE WOUND				
ZINC SULFATE 50 MG ZINC (220 MG) CAPSULE 1 capsule	DAILY	ORAL		
Reason: SUPPLEMENT				
Instructions:				

Supporting Documentation for Home Health Eligibility:

ACTIVITY LIMITATIONS: SKILLED SERVICES, LISTED IN FIELD 21 OF PLAN OF CARE ORDER, ARE NEEDED IN THE FOLLOWING MANNER:
COMMUNICATION/LEARNING, SELF-CARE OF HEALTH CONDITIONS/MEDICATION MANAGEMENT

STRUCTURAL AND FUNCTIONAL LIMITATIONS: IMPAIRED BODY FUNCTIONS THAT EITHER REQUIRE HOME HEALTH INTERVENTION OR WILL
IMPACT THE PLAN OF CARE:

FUNCTIONS OF THE CARDIOVASCULAR SYSTEM (F), FUNCTIONS OF THE METABOLIC AND ENDOCRINE SYSTEMS (F), FUNCTIONS OF THE
SKIN AND RELATED STRUCTURES (F), SKIN AND RELATED STRUCTURES (S), STRUCTURES OF THE CARDIOVASCULAR SYSTEM (S),
STRUCTURES RELATED TO THE METABOLIC AND ENDOCRINE SYSTEMS (S)

THE PATIENT IS CONSIDERED HOMEBOUND/CONFINED TO HOME BECAUSE: (MARK ALL THAT APPLY)

ASSISTANCE OF ANOTHER PERSON IN ORDER TO LEAVE PLACE OF RESIDENCE, BECAUSE OF ILLNESS OR INJURY, PATIENT NEEDS AID OF
SUPPORTIVE DEVICES - WALKER, BECAUSE OF ILLNESS OR INJURY, PATIENT NEEDS AID OF SUPPORTIVE DEVICES - WHEELCHAIR,
PATIENT HAS A CONDITION SUCH THAT LEAVING HOME IS MEDICALLY CONTRAINDICATED

THE FOLLOWING DISCIPLINES ARE REASONABLE AND NECESSARY AT THIS TIME:

SKILLED NURSING

THE PATIENT HAS NORMAL INABILITY TO LEAVE THE HOME AND LEAVING THE HOME TAKES CONSIDERABLE AND TAXING EFFORT BECAUSE:

FALL RISK, LIMITED AMBULATION

Signature of Physician BRIAN SMITH, MD (Electronically Signed)	Date 9/10/2025
Optional Name/Signature Of MANDI MCBRIDE, RN	Date 9/3/2025