Order Number:
12369922

HOME HEALTH CERTIFICATION AND PLAN OF CARE

Patient's Medicare No.	SOC Date	Certification Period	Medical Record No.	Provider No.
9DJ9EU0UU11	4/12/2025	4/12/2025 to 6/10/2025	PLF00079504601	227537

Patient's Name and Address:
BARBARA ARCHER
157 SOUTH ST #103
PLYMOUTH, MA 02360-7605

Provider's Name, Address and Telephone Number:
BAYADA HOME HEALTH CARE INC 227537
20 NORTH PARK AVENUE SUITE 2200A
PLYMOUTH, MA 02360-
F: (774) 283-7007
P: (508) 830-6990

Physician's Name & Address: P: (774)202-3090 F: (774)202-1733

EFRAIN A. TORRES, MD
651 ORCHARD ST
NEW BEDFORD, MA 02744-

Patient's Date of Birth: 6/27/1953
Patient's Gender: FEMALE
Order Date: 4/12/2025 12:26 PM
Verbal Order: N

Nurse's Signature and Date of Verbal SOC Where Applicable: (deemed as electronic signature)
JAMIE BALONIS, RN / SARAH DAY CLINICAL ASSOCIATE, RN 4/12/2025

Date HHA Received Signed POC

Patient's Expressed Goals:
PT CONFUSED

ICD-10 Diagnoses:

Order	Code	Description	Onset or Exacerbation	O/E Date
1	F03.94	UNSPECIFIED DEMENTIA, UNSPECIFIED SEVERITY, WITH ANXIETY	EXACERBATION	04/12/2025
2	F03.918	UNSP DEMENTIA, UNSP SEVERITY, WITH OTHER BEHAVIORAL DISTURB	EXACERBATION	04/12/2025
3	F03.911	UNSPECIFIED DEMENTIA, UNSPECIFIED SEVERITY, WITH AGITATION	EXACERBATION	04/12/2025
4	L89.620	PRESSURE ULCER OF LEFT HEEL, UNSTAGEABLE	ONSET	01/01/2025
5	I10	ESSENTIAL (PRIMARY) HYPERTENSION	ONSET	01/01/2025
6	I89.0	LYMPHEDEMA, NOT ELSEWHERE CLASSIFIED	ONSET	01/01/2025
7	I77.819	AORTIC ECTASIA, UNSPECIFIED SITE	ONSET	01/01/2025
8	M17.11	UNILATERAL PRIMARY OSTEOARTHRITIS, RIGHT KNEE	ONSET	01/01/2025
9	M25.461	EFFUSION, RIGHT KNEE	ONSET	01/01/2025
10	D64.9	ANEMIA, UNSPECIFIED	ONSET	01/01/2025
11	Z87.440	PERSONAL HISTORY OF URINARY (TRACT) INFECTIONS	ONSET	01/01/2025
12	Z91.81	HISTORY OF FALLING	ONSET	01/01/2025

Frequency/Duration of Visits:
SN 1WK2,2WK1,1WK2
PT Effective 04/13/2025 1WK1
OT Effective 04/13/2025 1WK4

Orders of Discipline and Treatments:
PHYSICAL THERAPIST TO EVALUATE TO DETERMINE CONDITION, PHYSICAL THERAPY PLANS AND REHABILITATION POTENTIAL; EVALUATE HOME ENVIRONMENT TO ELIMINATE STRUCTURAL BARRIERS AND IMPROVE SAFETY TO INCREASE FUNCTIONAL INDEPENDENCE (RAMPS, ADAPTIVE WHEELCHAIR, BATHROOM AIDES) AND DEVELOP PHYSICAL THERAPY PLAN OF CARE TO BE SIGNED BY THE PHYSICIAN.

OCCUPATIONAL THERAPIST TO EVALUATE FOR OT SERVICES AND DEVELOP PLAN OF CARE IN CONJUNCTION WITH THE PHYSICIAN TO INCLUDE PHYSICAL AND PSYCHOSOCIAL TEST RESULTS, ESTABLISHMENT OF A PLAN OF TREATMENT, REHABILITATION GOALS, AND EVALUATING THE HOME ENVIRONMENT FOR ACCESSIBILITY AND SAFETY AND RECOMMENDING MODIFICATION.

CLIENT HAS A VALID MOLST, SEE ATTACHMENT IN MEDICAL RECORD

SKILLED NURSE WILL ASSESS AND INSTRUCT ON ANY CHANGES IN CO-EXISTING AND/OR RECURRING CONDITIONS SUCH AS DEMENTIA AND DEVELOP A PLAN IN CONSULTATION WITH THE PROVIDER THAT INCLUDES INFECTION PREVENTION/CONTROL, DEPRESSION, ENVIRONMENTAL SAFETY AND FALL PREVENTION, HEALTH PROMOTION, NUTRITIONAL NEEDS, AND CONTINUOUS REVIEW OF MEDICATION REGIMEN TO FACILITATE TIMELY DISCHARGE. MAY RESUME CARE IF PATIENT IS TRANSFERRED TO AN INPATIENT FACILITY AND SUBSEQUENTLY DISCHARGED DURING THE EPISODE OF CARE. MAY D/C FROM AGENCY/SKILLED DISCIPLINE FOR GOALS MET, NO FURTHER SKILLS, NO LONGER HOMEBOUND, PER CT/PCG/MD REQUEST, UNSAFE HOME ENVIRONMENT, MOVED OUT OF SERVICE AREA OR DISCHARGED TO HOSPICE SERVICE.

I CERTIFY 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 SERVICES ON THIS PLAN OF CARE AND WILL PERIODICALLY REVIEW THE PLAN. THE PATIENT HAD A FACE-TO-FACE ENCOUNTER RELATED TO THE PRIMARY REASON FOR HOME HEALTH CARE WITH AN ALLOWED PROVIDER TYPE ON 3/25/25

I certify 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

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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Patient's Name	Provider's Name
BARBARA ARCHER	BAYADA HOME HEALTH CARE INC 227537

Orders of Discipline and Treatments:

SKILLED NURSE WILL ASSESS AND INSTRUCT ON PAIN MANAGEMENT, REPORT CHANGES TO PHYSICIAN AS NEEDED AND PROVIDE INSTRUCTION REGARDING PAIN CONTROL, INCLUDING PHARMACOLOGICAL AND NON-PHARMACOLOGICAL METHODS

SKILLED NURSE WILL ASSESS AND INSTRUCT CLIENT/CAREGIVER IN GENERAL MODIFIABLE RISKS AND SAFETY ROUTINES FOR FALLS PREVENTION.

SKILLED NURSE WILL ASSESS AND INSTRUCT CLIENT/CAREGIVER ON DEMENTIA MANAGEMENT TO INCLUDE HOME ENVIRONMENT, SAFETY, SCHEDULE ROUTINES, AND IDENTIFYING CLIENT'S TRIGGERS FOR BEHAVIORAL DISTURBANCES.

SKILLED NURSE WILL ASSESS AND INSTRUCT CLIENT/CAREGIVER ON MANAGEMENT OF SKIN INTEGRITY AND PREVENTION OF PRESSURE ULCER WITH/WITHOUT MOIST SKIN BARRIER, POSITIONING, INSPECTION, AND OFFLOADING TECHNIQUES. SKILLED NURSE WILL ASSESS NEED FOR SUPPORT SURFACES (CUSHION, MATTRESS ETC).

LEFT HEEL UNSTAGEABLE PRESSURE INJURY COVERED WITH ESCHAR. APPLY SKIN PREP AT EACH VISIT AND LOTA. ASSESS FOR S/SX. PT TO WEAR HEEL PROTECTORS WHILE IN BED.

PT EVALUATION PERFORMED. NO ADDITIONAL VISITS REQUIRED.

OCCUPATIONAL THERAPIST WILL ASSESS AND INSTRUCT ON INTERVENTIONS FOR IMPROVED FUNCTIONAL MOBILITY AS RELATED TO ADL'S AND/OR IADL'S, AND HOME PROGRAM INCLUDING THERAPEUTIC EXERCISES AS NEEDED. OCCUPATIONAL THERAPY WILL ASSESS AND INSTRUCT CLIENT/CAREGIVER ON MANAGEMENT OF SKIN INTEGRITY AND PREVENTION OF PRESSURE ULCERS WITH/WITHOUT MOIST SKIN BARRIER, POSITIONING, INSPECTION, AND OFFLOADING TECHNIQUES. THERAPIST WILL ASSESS THE NEED FOR SUPPORT SURFACES (CUSHION, MATTRESS ETC).OCCUPATIONAL THERAPIST WILL ASSESS AND INSTRUCT ON ANY CHANGES IN CO-EXISTING AND/OR RECURRING CONDITIONS SUCH AS DEMENTIA FACTORS THAT IMPACT ACTIVITY AND PARTICIPATION, DEVELOP OCCUPATIONAL THERAPY PLAN OF CARE IN CONSULTATION WITH THE PHYSICIAN THAT INCLUDES INFECTION PREVENTION/CONTROL, DEPRESSION, HEALTH PROMOTION, HOME SAFETY, NUTRITIONAL NEEDS, IDENTIFICATION OF NEW OR CHANGED MEDICATIONS AND HOME INSTRUCTIONS TO FACILITATE TIMELY DISCHARGE. MAY RESUME CARE IF PATIENT IS TRANSFERRED TO AN INPATIENT FACILITY AND SUBSEQUENTLY DISCHARGED DURING THE EPISODE OF CARE. MAY D/C FROM AGENCY/SKILLED DISCIPLINE FOR GOALS MET, NO FURTHER SKILLS, NO LONGER HOMEBOUND, PER CT/PCG/MD REQUEST, UNSAFE HOME ENVIRONMENT, MOVED OUT OF SERVICE AREA OR DISCHARGED TO HOSPICE SERVICE.

THE LICENSED PROFESSIONAL WHOSE SIGNATURE APPEARS IN BLOCK 23 ATTESTS THAT THE PHYSICIAN'S VERBAL ORDERS FOR SOC WERE RECEIVED ON 4/12/2025.

Goals/Rehabilitation Potential/Discharge Plans:

A PHYSICAL THERAPY EVALUATION WILL BE COMPLETED AND A PLAN OF CARE WILL BE ESTABLISHED FOR THE PHYSICIAN'S SIGNATURE FOR THE ENHANCEMENT OF THE PATIENT'S REHABILITATION POTENTIAL , ELIMINATION OF STRUCTURAL BARRIERS AND IMPROVE SAFETY TO INCREASE FUNCTIONAL INDEPENDENCE.
AN OCCUPATIONAL THERAPY EVALUATION WILL BE COMPLETED AND A PLAN OF CARE WILL BE DEVELOPED IN CONJUNCTION WITH THE PHYSICIAN FOR THE ENHANCEMENT OF THE PATIENT'S REHABILITATION POTENTIAL, AND ELIMINATION OF SAFETY HAZARDS TO INCREASE FUNCTIONAL INDEPENDENCE.

SKILLED NURSE GOAL
CLIENT/CAREGIVER WILL VERBALIZE/DEMONSTRATE UNDERSTANDING OF CHANGES IN CO-EXISTING AND/OR RECURRING CONDITIONS THAT MAY IMPACT PLAN OF CARE, INFECTION PREVENTION/CONTROL, DEPRESSION, ENVIRONMENTAL SAFETY AND FALL PREVENTION, HEALTH PROMOTION, NUTRITIONAL NEEDS, AND CONTINUOUS REVIEW OF MEDICATION AS EVIDENCED BY 100% TEACHBACK/DEMONSTRATION OF STRATEGIES IN ORDER TO REDUCE POTENTIALLY AVOIDABLE HOSPITALIZATION WITHIN 6 WEEKS.
SKILLED NURSE GOAL
FACE-TO-FACE TO BE COMPLETED TIMELY
SKILLED NURSE GOAL
CLIENT/CAREGIVER WILL VERBALIZE/DEMONSTRATE ABILITY TO SELF ASSESS AND MANAGE PAIN ADEQUATELY AS MEASURED BY PAIN AD SCALE WITH THE USE OF APPROPRIATE THERMAL MODALITIES AS ORDERED, OTHER NON-PHARMOCOLOGICAL TECHNIQUES. STAFF WILL TEACHBACK 2 S/SX OF PAIN EXACERBATION AND TWO INTERVENTIONS AS EVIDENCE BY PAIN NOT INTERFERING W ADLS WITHIN 2 WKS.
SKILLED NURSING GOAL

CLIENT/CAREGIVER WILL VERBALIZE/DEMONSTRATE UNDERSTANDING OF ENVIRONMENTAL HAZARDS, COMMUNICATION DEVICES, STRATEGIES TO REDUCE INCONTINENCE/NOCTURIA INSTANCES, EDUCATION FOR HIGH-RISK MEDS, DISCUSS POLYPHARMACY WITH PHYSICIAN AND RISK FACTORS RELATED TO COGNITIVE AND BEHAVIORAL DEFICITS RESULTING IN FALLS AS EVIDENCED BY 100% TEACHBACK/DEMONSTRATION IN ORDER TO REDUCE FALLS WITH INJURY WITHIN 4 WEEKS.
SKILLED NURSE GOAL
CLIENT/CAREGIVER WILL VERBALIZE/DEMONSTRATE ABILITY TO MANAGE BEHAVIORS RELATED TO DEMENTIA, AS EVIDENCED BY 100% TEACHBACK/DEMONSTRATION OF TWO SAFETY PRECAUTIONS AND NO EXACERBATION OF BEHAVIOURS IN ORDER TO PROMOTE SAFETY WITHIN 5 WEEKS

Signature of Physician	Date
Optional Name/Signature Of JAMIE BALONIS, RN / SARAH DAY CLINICAL ASSOCIATE, RN	Date 4/12/2025

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Patient's Name	Provider's Name
BARBARA ARCHER	BAYADA HOME HEALTH CARE INC 227537

Goals/Rehabilitation Potential/Discharge Plans:

SKILLED NURSE GOAL
CLIENT/CAREGIVER WILL VERBALIZE/DEMONSTRATE ABILITY TO MANAGE SKIN INTEGRITY AND PREVENTION OF PRESSURE ULCERS AS EVIDENCED BY 100% TEACHBACK/DEMONSTRATION OF 2 STRATEGIES TO PREVENT PRESSURE ULCER IN ORDER TO MAINTAIN SKIN INTEGRITY WITHIN 3 WEEKS.
SKILLED NURSE GOAL
CLIENT/CAREGIVER WILL VERBALIZE/DEMONSTRATE ABILITY TO PERFORM/MANAGE WOUND CARE AND SHOW IMPROVEMENT AS EVIDENCED BY 100% TEACHBACK/DEMONSTRATION OF ABILITY TO PERFORM WOUND CARE, IMPROVED WOUND STATUS AND ABSENCE OF INFECTION SUCH AS DECREASE IN SIZE, DRAINAGE, REDNESS IN ORDER TO PROMOTE HEALING WITHIN 9 WEEKS.

NONE

OCCUPATIONAL THERAPY GOAL
CLIENT/CAREGIVER WILL VERBALIZE/DEMONSTRATE IMPROVED ADL'S/IADL'S WITH LRAD AS EVIDENCED BY BARTGEL TEST FROM 9 TO 12 IN ORDER TO MAXIMIZE INDEPENDENCE AND SAFETY WITH SELF FEEDING WITHIN 4 WEEKS.
OCCUPATIONAL THERAPY GOAL
CLIENT/CAREGIVER WILL VERBALIZE/DEMONSTRATE ABILITY TO MANAGE SKIN INTEGRITY AND PREVENTION OF PRESSURE ULCERS AS EVIDENCED BY 100% TEACHBACK/DEMONSTRATION OF STRATEGIES TO PREVENT PRESSURE ULCER IN ORDER TO MAINTAIN SKIN INTEGRITY WITHIN 4 WEEKS.
OCCUPATIONAL THERAPY GOAL
CLIENT/CAREGIVER WILL VERBALIZE/DEMONSTRATE UNDERSTANDING OF CHANGES IN CO-EXISTING AND/OR RECURRING CONDITIONS THAT MAY IMPACT PLAN OF CARE, INFECTION PREVENTION/CONTROL, DEPRESSION, HEALTH PROMOTION, HOME SAFETY, NUTRITIONAL NEEDS, IDENTIFICATION OF NEW OR CHANGED MEDICATIONS AND HOME INSTRUCTIONS AS EVIDENCED BY 100% TEACHBACK/DEMONSTRATION IN ORDER TO REDUCE POTENTIALLY AVOIDABLE HOSPITALIZATION WITHIN 4 WEEKS.

Rehab Potential:

FAIR TO MEET GOALS BY END OF EPISODE

DC Plans:

DC TO SELF CARE WITH HELP OF CAREGIVER UNDER SUPERVISION OF MD WHEN GOALS ARE MET

DME and Supplies:

DME-LIFT; DME-WHEELCHAIR ; HEEL AND ELBOW PROTECTORS; SKIN PREP/BARRIER

Prognosis:

FAIR

Functional Limitations:

BOWEL/BLADDER (INCONTINENCE); ENDURANCE; AMBULATION

Safety Measures:

24 HOUR SUPERVISION, ADEQUATE LIGHTING, CLEAN TECHNIQUE, CLEAR PATHWAYS, EMERGENCY PLAN, FALL PRECAUTIONS, MED PRECAUTIONS, STANDARD PRECAUTIONS

Activities Permitted:

UP AS TOLERATED; EXERCISES PRESCRIBED; WHEELCHAIR

Nutritional Requirements:

NO ADDED SALT

Advance Directives:

MEDICAL ORDERS FOR LIFE SUSTAINING TREATMENT

Mental Statuses:

DISORIENTED

Supporting Documentation for Psychosocial Status:

INDICATE ISSUES WITH CLIENT RELATIONSHIPS AND LIVING ENVIRONMENT THAT IMPACT THE DELIVERY OF SERVICES AND CLIENT'S ABILITY TO PARTICIPATE IN HIS OR HER OWN CARE: (SELECT ALL THAT APPLY)

NO ISSUES IDENTIFIED

Signature of Physician	Date
Optional Name/Signature Of JAMIE BALONIS, RN / SARAH DAY CLINICAL ASSOCIATE, RN	Date 4/12/2025

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Supporting Documentation for Risk of Hospital Readmission:

NARRATIVE OF SKILLED SERVICES WITH SUPPORTING DETAILS: (INCLUDE HISTORY, REASON FOR REFERRAL, UNSTABLE CONDITIONS, LIMITATIONS AND/OR DEFICITS THAT WILL NOT IMPROVE WITHOUT SKILLED INTERVENTIONS AND ADDITIONAL RECOMMENDATIONS FOR CARE TEAM)

71YO ALERT AND CONFUSED FEMALE REFERRED BY ROYAL CC REHAB AFTER STAY FROM 2/10-4/10 FOR UTI. PMH SIGNIFICANT FOR HTN, DEMENTIA, RIGHT KNEE OA, ANXIETY, MILD ASCENDING AORTIC DILATION, ANEMIA. PT IS A NEW RESIDENT AT PLYMOUTH CROSSINGS ALF IN MCU. HCP IS BETHANY REBELLO AND HCP IS INVOKED. DETAILED VOICEMAIL LEFT FOR HCP TO OBTAIN VERBAL CONSENT FOR TREATMENT. MOLST FORM ON FILE DESIGNATING FULL CODE STATUS. PT IS DEPENDENT FOR ALL ACTIVITIES AND REQUIRES HOYER LIFT FOR TRANSFERS. USING WC FOR MOBILITY. P.T AND O.T EVALS ORDERED. FOCUS OF CARE WILL BE DEMENTIA. SKILLED NURSING SERVICES REQUIRED FOR DEMENTIA EDUCATION, ASSESS MOOD AND EFFECTIVENESS OF MEDICATIONS. MEDS RECONCILED AND PT NO LONGER USING BISACODYL, FLEET ENEMA, MOM. EDUCATION PROVIDED TO ALF WELLNESS NURSE REGARDING GOAL OF REDUCING RISK OF REHOSPITALIZATION AS WELL AS USE OF BAYADA ON CALL FOR QUESTIONS OR CONCERNS.

SPECIFIC INTERVENTION DETAILS FOR EDUCATION OR ACTIVITY PROVIDED. (SPECIFY CHANGES TO PROGRAM INCLUDING VERBAL/AUDITORY AND MANUAL/TACTILE CUES USED, SAFETY EDUCATION TO CAREGIVER/CLIENT, BODY MECHANICS EDUCATION, EXERCISES OR ACTIVITIES ADDED/MODIFIED/REMOVED, POSITIONING INSTRUCTION, EQUIPMENT TRAINING, MOBILITY TRAINING)

PT ALERT AND CONFUSED. VS UNREMARKABLE. COVID SCREENING NEGATIVE. 2/10 PAIN TO LEFT HEEL USING PAIN AD SCALE. LEFT HEEL NOTED TO HAVE AREA OF ESCHAR. AREA DRY AND CLOSED. HEEL BOOTS ORDERED FOR PT TO USE WHEN IN BED TO REDUCE PRESSURE TO HEELS AS PT WAS FOUND LYING IN BED FLAT ON BACK WITH HEELS ON BED UPON RN ARRIVAL TODAY. APPETITE FAIR AND FLUID INTAKE ADEQUATE. LSCTA. PT IN NO APPARENT RESPIRATORY DISTRESS. INCONT OF BOWEL AND BLADDER. STAFF DENIES NOTING CONSTIPATION, DIARRHEA OR S/SX UTI. EDUCATION PROVIDED TO WELLNESS NURSE REGARDING PRESSURE REDUCTION TECHNIQUES AND KEEPING HEELS OFF BED, PROPER PROTEIN INTAKE, CALL BAYADA IF LEFT HEEL OPENS OR BECOMES RED.

OUTCOME OF INTERVENTIONS/EDUCATION TODAY (INDICATE LEVEL OF KNOWLEDGE/SKILL BY CLIENT AND SPECIFY ANY ABILITIES OR LIMITATIONS TO LEARN OR DEMONSTRATE ACTIVITY - SPECIFY IF ADDITIONAL TEACHING/TRAINING IS REQUIRED OR IF SOME KNOWLEDGE/SKILL WAS OBTAINED BUT FURTHER TEACHING OR TRAINING NEEDED FOR ACCURACY AND CARRYOVER)

WELLNESS NURSE ABLE TO TEACH BACK ALL EDUCATION PROVIDED

NEXT STEPS IN PLAN (INCLUDE NEW AND NEXT PROGRESSIVE STEPS IN TEACHING/ACTIVITY OR COMPONENT OF NEW ACTIVITY, ANY NEW OR MODIFIED STRATEGIES OR ABANDONED GOALS

GU ASSESSMENT, DEMENTIA EDUCATION, ASSESS MOOD, ASSESS LEFT HEEL AND CONFIRM PT IS COMPLIANT WITH USE OF HEEL BOOTS IN BED

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

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 || 8 - CURRENTLY REPORTS EXHAUSTION || 9 - OTHER RISK(S) NOT LISTED IN 1 - 8

ARE THERE ANY FACTORS THAT PUT THIS CLIENT AT ADDITIONAL RISK FOR EMERGENCY DEPARTMENT VISITS, BEYOND THOSE CAPTURED WITHIN RISK FOR HOSPITALIZATION?

NO, THE RISK FOR EMERGENCY DEPARTMENT VISITS IS INCLUSIVE OF THE RISK FOR HOSPITALIZATION

Allergies:

AMOXICILLIN; BEE VENOM; SULFA

Signature of Physician	Date
Optional Name/Signature Of JAMIE BALONIS, RN / SARAH DAY CLINICAL ASSOCIATE, RN	Date 4/12/2025

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Medications:

Medication/ Dose	Frequency	Route	Start Date/ End Date	DC Date	New/ Changed
ACETAMINOPHEN 325 MG TABLET		ORAL	04/11/2025		
2 tablet	*EVERY 4 HOURS/PRN*				
Instructions: PAIN					
BUSPIRONE 7.5 MG TABLET		ORAL	04/11/2025		
1 tablet	*2 TIMES DAILY*				
Instructions:					
CARBIDOPA 25 MG-LEVODOPA 100 MG TABLET		ORAL	04/11/2025		
1 tablet	*3 TIMES DAILY*				
Instructions:					
DEPAKOTE SPRINKLES 125 MG CAPSULE,DELAYED RELEASE		ORAL	04/11/2025		
2 capsule	*EVERY AM*				
Instructions:					
DEPAKOTE SPRINKLES 125 MG CAPSULE,DELAYED RELEASE		ORAL	04/11/2025		
4 capsule	*EVERY PM*				
Instructions:					
DONEPEZIL 5 MG TABLET		ORAL	04/11/2025		
1 tablet	*BEDTIME*				
Instructions:					
MELATONIN 5 MG TABLET		ORAL	04/11/2025		
1 tablet	*BEDTIME*				
Instructions:					
TRAZODONE 50 MG TABLET		ORAL	04/11/2025		
1 tablet	*2 TIMES DAILY*				
Instructions:					
TRAZODONE 50 MG TABLET		ORAL	04/11/2025		
1 tablet	*DAILY/PRN*				
Instructions: ANXIETY, AGITATION					

Supporting Documentation for Home Health Eligibility:

CRITERIA 1 - DESCRIBE AMOUNT AND TYPE OF SUPERVISION NEEDED, ASSISTIVE DEVICE OR SPECIAL TRANSPORTATION NEEDED TO LEAVE THE HOME OR CURRENT CONDITION MAKES LEAVING HOME MEDICALLY CONTRAINDICATED AND INCLUDE ENVIRONMENTAL CONDITIONS THAT IMPACT HOMEBOUND STATUS

A1 AND WC REQUIRED FOR SAFE MOBILITY TO REACH VEHICLE AND WC VAN REQUIRED TO LEAVE HOME

CRITERIA 2 - DESCRIBE EXACTLY WHAT SYMPTOMS OR IMPAIRMENTS ARE CAUSING THE INABILITY TO LEAVE THE HOME AND CONSIDERABLE AND TAXING EFFORT WHEN LEAVING THE HOME THAT WERE NOT PRESENT PRIOR TO THE ACUTE ILLNESS OR INJURY

BLE WEAKNESS, POOR ENDURANCE, BALANCE IMPAIRMENT, MEMORY IMPAIRMENT

SKILLED SERVICES ARE NEEDED DUE TO SELF-CARE DEFICIT FROM PRIOR LEVEL OF FUNCTION THAT RESULTS IN DIFFICULTY IN ABILITY TO ACCESS TUB/SHOWER, BATHING SAFETY, BED MOBILITY, DRESSING, GROOMING, MANAGING BEHAVIORAL SYMPTOMS OF DEPRESSION/ANXIETY, MANAGING HYGIENE, MANAGING LAUNDRY, MANAGING MEAL PREP, MANAGING MEDICATIONS, MANAGING PAIN, MANAGING TOILETING, NAVIGATING STAIRS/STEPS, ORGANIZING OR SEQUENCING FOR SAFE ADL/IADL, SAFETY AWARENESS IN ALL ENVIRONMENTS, SELF-MANAGEMENT OF CONDITIONS/ILLNESS, TRANSFERRING FROM VARIABLE SEATING SURFACES, WALKING ROOM TO ROOM

Signature of Physician	Date
Optional Name/Signature Of JAMIE BALONIS, RN / SARAH DAY CLINICAL ASSOCIATE, RN	Date 4/12/2025