Order Number:
2625547

HOME HEALTH CERTIFICATION AND PLAN OF CARE

Patient's Medicare No.	SOC Date	Certification Period	Medical Record No.	Provider No.
3X62KX7PR70	12/12/2025	12/12/2025 to 2/9/2026	ADA00023171801	377196

Patient's Name and Address:
JAMES B JENKINS (580) 272-8911
710 W. MAIN
FRANCIS, OK 74844-

Provider's Name, Address and Telephone Number:
ENHABIT HOME HEALTH OF CENTRAL OKLAHOMA (NOR) F: (580) 436-6773
1172 NORTH HILLS CENTRE
ADA, OK 74820- P: (580) 436-0551

Physician's Name & Address: P: (580)436-5111 F: (580)279-1994

MIKA STRONG, PA
905 COLONY DRIVE
ADA, OK 74820

Patient's Date of Birth: 9/29/1953
Patient's Gender: MALE
Order Date: 12/12/2025 1:19 PM
Verbal Order: N

Nurse's Signature and Date of Verbal SOC Where Applicable: (deemed as electronic signature)
KRISTEN NICKELL, RN / JAMIE LYSINGER RN/BRANCH DIRECTOR 12/12/2025

Date HHA Received Signed POC

Patient's Expressed Goals:
FOR WOUND TO HEAL

ICD-10
Diagnoses:

Order	Code	Description	Onset or Exacerbation	O/E Date
1	T81.49XA	INFECTION FOLLOWING A PROCEDURE, OTHER SURGICAL SITE, INIT	EXACERBATION	12/12/2025
2	T81.44XA	SEPSIS FOLLOWING A PROCEDURE, INITIAL ENCOUNTER	ONSET	12/12/2025
3	A41.9	SEPSIS, UNSPECIFIED ORGANISM	ONSET	12/12/2025
4	L03.115	CELLULITIS OF RIGHT LOWER LIMB	ONSET	12/12/2025
5	I10	ESSENTIAL (PRIMARY) HYPERTENSION	ONSET	12/12/2025
6	E11.9	TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS	ONSET	12/12/2025
7	I25.10	ATHSCL HEART DISEASE OF NATIVE CORONARY ARTERY W/O ANG PCTRS	ONSET	12/12/2025
8	M10.9	GOUT, UNSPECIFIED	ONSET	12/12/2025
9	E87.1	HYPO-OSMOLALITY AND HYPONATREMIA	ONSET	12/12/2025
10	F99	MENTAL DISORDER, NOT OTHERWISE SPECIFIED	ONSET	12/12/2025
11	D75.1	SECONDARY POLYCYTHEMIA	ONSET	12/12/2025
12	D72.829	ELEVATED WHITE BLOOD CELL COUNT, UNSPECIFIED	ONSET	12/12/2025
13	Z79.2	LONG TERM (CURRENT) USE OF ANTIBIOTICS	ONSET	12/12/2025
14	Z79.1	LONG TERM (CURRENT) USE OF NON-STEROIDAL NON-INFLAM (NSAID)	ONSET	12/12/2025
15	Z87.891	PERSONAL HISTORY OF NICOTINE DEPENDENCE	ONSET	12/12/2025
16	Z96.642	PRESENCE OF LEFT ARTIFICIAL HIP JOINT	ONSET	12/12/2025

Frequency/Duration of Visits:
SN 1WK1,2WK2,1WK5,2WK1,1WK1
PT EFFECTIVE 12/14/2025 1WK1

Orders of Discipline and Treatments:
SKILLED NURSE TO PERFORM A COMPREHENSIVE ASSESSMENT AND EVALUATE NEED FOR HOME HEALTH SERVICES. PLAN OF CARE DEVELOPED IN COORDINATION BETWEEN AGENCY STAFF, PHYSICIAN, AND PATIENT. SKILLED NURSE TO ASSESS/EVALUATE CO-MORBID CONDITIONS INCLUDING HTN, DEPRESSION. SN WILL PROVIDE INTERVENTIONS TO HELP REDUCE PATIENT RISK OF HAVING AN ACUTE CARE HOSPITALIZATION. MAY PERFORM O2 SATURATION LEVEL AT EVALUATION VISIT AND PRN FOR SIGNS AND/OR SYMPTOMS OF POSSIBLE RESPIRATORY COMPLICATIONS. MAY PERFORM UP TO 10 TELEHEALTH VISITS PRN TO PERFORM INTERVENTIONS INCLUDED ON PHYSICIAN APPROVED POC TO MITIGATE PATIENTS RISK FOR HOSPITALIZATION AND EMERGENT CARE. WILL MONITOR FOR CHANGES IN THE 4M'S OF AGE-FRIENDLY CARE AND UPDATE THE PLAN OF CARE AS NEEDED RELATED TO WHAT MATTERS, MEDICATIONS, MOBILITY, AND MENTATION. MAY RESUME CARE IF PATIENT IS TRANSFERRED TO AN INPATIENT FACILITY AND SUBSEQUENTLY DISCHARGED DURING THE EPISODE OF CARE. DISCHARGE SUMMARY WILL BE SENT TO THE PRIMARY CARE PHYSICIAN OR OTHER HEALTH PROFESSIONAL WHO WILL BE RESPONSIBLE FOR PROVIDING CARE AND SERVICES TO THE PATIENT AFTER DISCHARGE WITHIN FIVE BUSINESS DAYS OF THE DATE OF THE ORDER FOR DISCHARGE FROM THE RESPONSIBLE PHYSICIAN. MAY DISCHARGE PATIENT IF ALL GOALS ARE MET PRIOR TO ESTABLISHED FREQUENCY BEING COMPLETED.

SKILLED NURSE TO PROVIDE INSTRUCTION REGARDING PAIN CONTROL INCLUDING PHARMACOLOGICAL AND NON-PHARMACOLOGICAL METHODS.

SN TO EDUCATE ON BEST PRACTICES TO MITIGATE RISK DEPRESSION

SN TO EDUCATE ON BEST PRACTICES TO MITIGATE FALL RISK

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. I further certify that this patient had a Face-to-Face Encounter performed by a physician or allowed non-physician practitioner that was related to the primary reason the patient requires Home Health services on 12/09/2025.

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.

Electronically signed by STRONG, MIKA PA-C on 12/22/2025

Patient's Medicare No.	SOC Date	Certification Period	Medical Record No.	Provider No.
3X62KX7PR70	12/12/2025	12/12/2025 to 2/9/2026	ADA00023171801	377196

Patient's Name	Provider's Name
JAMES B JENKINS	ENHABIT HOME HEALTH OF CENTRAL OKLAHOMA (NOR)

Orders of Discipline and Treatments:

SKILLED NURSE TO PERFORM WOUND CARE TORIGHT LOWER EXT CLEANSE WITH VASHE APPLY THERAHONEY GEL, COVER WITH GAUZE, COBPVER WITH ABSORBENT DRESSING AND WRAP WITH ROLLED GAUZE, MAY SECURE WITH LOOSE ACE WRAP. USING CLEAN/ASEPTIC TECHNIQUE. FREQUENCY OF DRESSING CHANGE: DAILY. SN MAY TEACH WOUND CARE TO PATIENT/CAREGIVER. Z

HOME HEALTH AGENCY MAY ACCEPT ORDERS FROM THE FOLLOWING PHYSICIANS: ADDITIONAL PHYSICIANS

SKILLED NURSE TO O/A PATIENT FOR SIGNS AND SYMPTOMS OF INFECTION.

THE LP WHOSE SIGNATURE APPEARS ON THE POC VERIFIES THAT PHYSICIAN ORDERS WERE CONFIRMED ON DATE ENTERED BELOW. ADDITIONAL CONFIRMATION WILL BE OBTAINED BY THE LP FOR ONGOING DISCIPLINE SPECIFIC POC NOT ORIGINALLY SPECIFIED. 12/12/2025.

LICENSED PROFESSIONAL TO REPORT VITAL SIGNS FALLING OUTSIDE THE FOLLOWING ESTABLISHED PARAMETERS. TEMP<95>100 PULSE<50>100 RESP<12>24 SYSTOLICBP<85>160 DIASTOLICBP<50>95 PAIN>6 O2SAT<90

Goals/Rehabilitation Potential/Discharge Plans:

A PATIENT-CENTERED PLAN OF CARE WILL BE ESTABLISHED AND UPDATED AS NECESSARY TO ADDRESS MEDICALLY NECESSARY SKILLED NURSING SERVICES.
PATIENT AND/OR CAREGIVER WILL DEMONSTRATE UNDERSTANDING OF EFFECTIVE PHARMACOLOGICAL AND NON-PHARMACOLOGICAL PAIN CONTROL METHODS
PATIENT AND/OR CAREGIVER WILL BE ABLE TO TEACH BACK DEPRESSION MITIGATION TECHNIQUES BY DC
PATIENT AND/OR CAREGIVER WILL BE ABLE TO TEACH BACK FALL RISK MITIGATION TECHNIQUES BY DC
WOUND STATUS WILL IMPROVE AS EVIDENCED BY WOUND CLOSURE, TO BE ACHIEVED WITHIN 4 WEEKS. PATIENT WILL VERBALIZE/DEMONSTRATE ABILITY TO PERFORM WOUND CARE.
ADDITIONAL ORDERS WILL BE RECEIVED FROM ALTERNATE PHYSICIAN IN A TIMELY MANNER.
PT/CG WILL BE ABLE TO IDENTIFY AND TEACHBACK 2 SIGNS AND SYMPTOMS OF INFECTION AND S/SX WILL BE IDENTIFIED AND PHYSICIAN NOTIFIED FOR PROMPT INTERVENTION TO MINIMIZE ASSOCIATED RISKS WITHIN 8 WEEKS .

Rehab Potential:

GOOD TO MEET STATED GOALS BY THE END OF THE CURRENT HEALTHCARE EPISODE.

DC Plans:

DISCHARGE TO CARE OF SELF UNDER SUPERVISION OF PHYSICIAN WHEN GOALS ARE MET OR SKILLED SERVICES ARE NO LONGER NEEDED

DME and Supplies:

NURSING SUPPLIES; WOUND CARE ----- DRESSINGS/SUPPLIES; WOUND CARE ----- HONEY; WOUND CARE ----- SUPERABSORBER / HYDROCONDUCTIVE; WOUND CARE ----- TAPE; WOUND CARE ----- WOUND CLEANSER

Prognosis:

GOOD

Functional Limitations:

ENDURANCE; AMBULATION

Safety Measures:

EMERGENCY PLAN, FALL PRECAUTIONS, HOME SAFETY, MEDICATION SAFETY AND STORAGE, UNIVERSAL/STANDARD PRECAUTIONS, HIGH RISK MEDICATIONS, WOUND PRECAUTIONS

Activities Permitted:

UP AS TOLERATED

Nutritional Requirements:

CARDIAC DIET

Advance Directives:

NONE

Mental Statuses:

ORIENTED

Supporting Documentation for Cognitive Status:

INDICATE LEVEL OF COGNITIVE IMPAIRMENT BASED ON BRIEF INTERVIEW FOR MENTAL STATUS (BIMS):
PATIENT UNABLE TO COMPLETE INTERVIEW
(C1) (QM) (PRA) (M1700) COGNITIVE FUNCTIONING: PATIENT'S CURRENT (DAY OF ASSESSMENT) LEVEL OF ALERTNESS, ORIENTATION, COMPREHENSION, CONCENTRATION, AND IMMEDIATE MEMORY FOR SIMPLE COMMANDS.
0 - ALERT/ORIENTED, ABLE TO FOCUS AND SHIFT ATTENTION, COMPREHENDS AND RECALLS TASK DIRECTIONS INDEPENDENTLY.
(QM) (M1710) WHEN CONFUSED (REPORTED OR OBSERVED) WITHIN THE LAST 14 DAYS:
1 - IN NEW OR COMPLEX SITUATIONS ONLY

Signature of Physician	Date

Optional Name/Signature Of	Date
KRISTEN NICKELL, RN / JAMIE LYSINGER RN/BRANCH DIRECTOR	12/12/2025

Electronically signed by STRONG, MIKA PA-C on 12/22/2025

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Supporting Documentation for Psychosocial Status:

(A1250) TRANSPORTATION (NAHC (C)): HAS LACK OF TRANSPORTATION KEPT YOU FROM MEDICAL APPOINTMENTS, MEETINGS, WORK, OR FROM GETTING THINGS NEEDED FOR DAILY LIVING?

C. NO

(B1300) HEALTH LITERACY (FROM CREATIVE COMMONS (C)): HOW OFTEN DO YOU NEED TO HAVE SOMEONE HELP YOU WHEN YOU READ INSTRUCTIONS, PAMPHLETS, OR OTHER WRITTEN MATERIAL FROM YOUR DOCTOR OR PHARMACY?

0. NEVER

(D0700) SOCIAL ISOLATION: HOW OFTEN DO YOU FEEL LONELY OR ISOLATED FROM THOSE AROUND YOU?

0. NEVER

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.)

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

Allergies:

ALEVE

Medications:

Medication/ Dose	Frequency	Route	Start Date/ End Date	DC Date	New/ Changed
ALLOPURINOL 300 MG TABLET		ORAL			
1 tablet	*DAILY*				
Reason: GOUT Instructions:					
AMOXICILLIN 875 MG TABLET		ORAL			
1 tablet	*2 TIMES DAILY*		12/21/2025		
Reason: ANTIBIOTIC Instructions:					
ASCORBIC ACID 90 MG-ZINC OXIDE 50 MG CAPSULE		ORAL			
1 capsule	*DAILY*				
Reason: SUPPLEMENT Instructions:					
CELEBREX 200 MG CAPSULE		ORAL			
1 capsule	*DAILY*				
Reason: ARTHRITIS Instructions:					
CRESTOR 5 MG TABLET		ORAL			
1 tablet	*DAILY*				
Reason: CHOLESTEROL Instructions:					
DOXEPIN 25 MG CAPSULE		ORAL			
1 capsule	*BEDTIME*				
Reason: SLEEP Instructions:					
GABAPENTIN 300 MG CAPSULE		ORAL			
1 capsule	*3 TIMES DAILY*				
Reason: BACK PAIN Instructions:					
HYDROCODONE 5 MG-ACETAMINOPHEN 325 MG TABLET		ORAL			
1 tablet	*EVERY 6 HOURS/PRN*				
Reason: PAIN Instructions:					
HYDROXYZINE HCL 25 MG TABLET		ORAL			
2 tablet	*DAILY*				
Reason: ITCHING Instructions:					

Signature of Physician	Date
Optional Name/Signature Of KRISTEN NICKELL, RN / JAMIE LYSINGER RN/BRANCH DIRECTOR	Date 12/12/2025

Electronically signed by STRONG, MIKA PA-C on 12/22/2025

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Medication/ Dose	Frequency	Route	Start Date/ End Date	DC Date	New/ Changed
LEXAPRO 20 MG TABLET		ORAL			
1 tablet	*DAILY*				
Reason: DEPRESSION Instructions:					
MEDIHONEY (HONEY) 80 % TOPICAL GEL		TOPICAL			
Per instructions	*DAILY*				
Reason: WOUNDCARE Instructions: APPLY DURING WOUND CARE DAILY					
PAMELOR 25 MG CAPSULE		ORAL			
1 capsule	*BEDTIME*				
Reason: DEPRESSION Instructions:					
TELMISARTAN 40 MG TABLET		ORAL			
1 tablet	*EVERY PM*				
Reason: HYPERTENSION Instructions:					
VITAMIN B COMPLEX TABLET		ORAL			
1 tablet	*DAILY*				
Reason: SUPPLEMENT Instructions:					
VITAMIN D3 50 MCG (2,000 UNIT) TABLET		ORAL			
1 tablet	*DAILY*				
Reason: SUPPLEMENT Instructions:					

Supporting Documentation for Home Health Eligibility:

SELECT THE BODY STRUCTURE IMPAIRMENTS THAT SUPPORT THE FOCUS OF CARE AND HOMEBOUND STATUS:
CARDIAC SYSTEM (HEART), INTEGUMENTARY SYSTEM (SKIN), LOWER EXTREMITY (LEG OR FOOT), MUSCULOSKELETAL SYSTEM (BONE, LIGAMENT, TENDON, OR MUSCLE), VASCULAR SYSTEM (VESSELS)

SELECT THE BODY FUNCTION IMPAIRMENTS THAT SUPPORT THE FOCUS OF CARE AND HOMEBOUND STATUS:
CARDIAC FUNCTIONS (HEART FUNCTIONS), FUNCTIONS OF THE SKIN (REPAIR AND HEALING), MOVEMENT RELATED FUNCTION-MUSCLE ENDURANCE / ACTIVITY TOLERANCE, MOVEMENT RELATED FUNCTION-MUSCLE POWER (STRENGTH), PAIN RELATED FUNCTIONS, RESPIRATORY FUNCTIONS (BREATHING OR RESPIRATION), VASCULAR FUNCTIONS (BLOOD PRESSURE OR CIRCULATION)

SELECT THE ACTIVITY LIMITATIONS AND PARTICIPATION RESTRICTIONS THAT SUPPORT THE FOCUS OF CARE AND HOMEBOUND STATUS:

MOBILITY AND MOVEMENT, OBTAINING NECESSARY GOODS AND SUPPLIES, SELF CARE (ADLS), SELF MANAGEMENT OF HEALTH CONDITIONS

DUE TO ILLNESS OR INJURY, THE PATIENT IS RESTRICTED FROM LEAVING HOME EXCEPT WITH:
THE ASSISTANCE OF ANOTHER PERSON

DOES THE PATIENT HAVE A NORMAL INABILITY TO LEAVE HOME SUCH THAT LEAVING HOME REQUIRES CONSIDERABLE AND TAXING EFFORT?
YES, DUE TO BODY STRUCTURE/FUNCTION IMPAIRMENTS AND ACTIVITY LIMITATIONS LISTED ABOVE

Signature of Physician	Date
Optional Name/Signature Of KRISTEN NICKELL, RN / JAMIE LYSINGER RN/BRANCH DIRECTOR	Date 12/12/2025

Electronically signed by STRONG, MIKA PA-C on 12/22/2025