

# EpicEdge Tips & Tricks

## Quality Review: Review and Send a Home Health Plan of Care

The home health Plan of Care activity has a new look and new features. This tip sheet walks you through the process of reviewing, updating, and sending out a patient's Plan of Care.

The tip sheet assumes that there's a patient who's had a Start of Care assessment, and that assessment has been synced in the Remote Client.

1. From the Workqueues activity, select the Deficiency tab and open the HH POC Review Needed Workqueue.
2. Select a patient and then click the **POC** button in the toolbar. The plan opens in the Plan of Care activity.

The screenshot displays the Epic Edge 'Plan of Care' interface for a Home Health Plan of Care as of 01/31/22. The interface is organized into several sections:

- Patient Information:**

(M0040) Name January, Bethany	(M0040-M0060) Address 15 Star Road MADISON, WI 53717	(M0060) Date of Birth 1/31/1949	(M0069) Sex Female	(M0065) HI Claim No. —
(M0030) Start of Care Date 1/31/2022	Referral Date —	Certification Period 1/31/2022 - 3/31/2022	MRN 895430	
- Agency Information:**

(M0010) CMS Certification Number 16-5387	Name WI HOME HEALTH	Address 1979 Milky Way Verona, Wisconsin 53593	Telephone Number Ph: 715-555-5555
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- Medications:**

Prescriptions and Patient-Reported

  - Acidinium Bromide 400 MCG/ACT AEROSOL POWDER, BREATH ACTIVATED - (C)**  
Sig: Inhale 1 puff into the lungs twice a day. Route: Inhalation Indications: Chronic Obstructive Lung Disease
  - Carbocysteine 750 MG Chew Tab - (N)**  
Sig: Chew 1 tablet by the mouth daily for 30 days. Route: Oral
  - metformin (GLUCOPHAGE) 500 MG tablet - (C)**  
Sig: Take 1 tablet by mouth in the morning and 1 tablet in the evening. Take with meals. Route: Oral Indications: Type 2 Diabetes
  - Roflumilast 250 MCG Tablet - (C)**  
Sig: Take 1 tablet by mouth twice a day. Route: Oral Indications: Chronic Obstructive Lung Disease
- Diagnoses:**

(M1021) Principal Diagnosis ICD J44.1	Description Chronic obstructive pulmonary disease with (acute) exacerbation	Date 1/31/2022	Flag Onset
(M1023) Other Pertinent Diagnoses ICD	Description	Date	Flag

Additional interface elements include a 'Dates' section with a Certification Period of 1/31/2022 - 3/31/2022, an 'Attachments (0)' section, and a 'Participants' section listing Tim Hollan, MD as the M0018 Provider and Reviewer. The bottom of the screen features a 'Delete' button and 'Print' and 'Finalize' buttons.

- You review the plan to make sure that the information looks correct. You notice that a medication shouldn't appear on the plan because the patient isn't taking it anymore (1). Click the pencil icon next to the title of the Medications section (2).

**Agency Information**  
 as of 2/1/2022

(M0010) CMS Certification Number 16-5387	Name WI HOME HEALTH	Address 1979 Milky Way Verona, Wisconsin 53593	Telephone Number Ph: 715-555-5555
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**Medications** ✎ 2  
 as of 2/1/2022

**Prescriptions and Patient-Reported**  
 Name - (N)ew/(C)hanged  
**Acclidinium Bromide 400 MCG/ACT AEROSOL POWDER, BREATH ACTIVATED - (C)**  
 Sig: Inhale 1 puff into the lungs twice a day. Route: Inhalation Indications: Chronic Obstructive Lung Disease  
**Carbocysteine 750 MG Chew Tab - (N)** 1  
 Sig: Chew 1 tablet by the mouth daily for 30 days. Route: Oral  
**metformin (GLUCOPHAGE) 500 MG tablet - (C)**  
 Sig: Take 1 tablet by mouth in the morning and 1 tablet in the evening. Take with meals. Route: Oral Indications: Type 2 Diabetes  
**Roflumilast 250 MCG Tablet - (C)**  
 Sig: Take 1 tablet by mouth twice a day. Route: Oral Indications: Chronic Obstructive Lung Disease

**Diagnoses**  
 as of 2/1/2022

**(M1021) Principal Diagnosis**  

ICD	Description	Date	Flag
J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation	1/31/2022	Onset

- The Plan of Care Edit activity opens in a window. Uncheck the medication that the patient isn't taking anymore (1). If you need to remove items from the patient's care plan or visit sets, you can expand those sections of the activity to do so (2). Click **Care Plan** to expand that section.

**Plan of Care**

**Patient Information**  
 as of 2/1/2022  
 (M0040) Name  
 January, Bethany  
  
 (M0030) Start of Care Date  
 1/31/2022

**Agency Information**  
 as of 2/1/2022  
 (M0010) CMS Certification Number  
 16-5387

**Medications** ✎  
 as of 2/1/2022

**Prescriptions and Patient-Reported**  
 Name - (N)ew/(C)hanged  
**Acclidinium Bromide 400 MCG/ACT AEROSOL POWDER, BREATH ACTIVATED - (C)**  
 Sig: Inhale 1 puff into the lungs twice a day. Route: Inhalation Indications: Chronic Obstructive Lung Disease  
**Carbocysteine 750 MG Chew Tab - (N)**  
 Sig: Chew 1 tablet by the mouth daily for 30 days. Route: Oral  
**metformin (GLUCOPHAGE) 500 MG tablet - (C)**  
 Sig: Take 1 tablet by mouth in the morning and 1 tablet in the evening. Take with meals. Route: Oral Indications: Type 2 Diabetes  
**Roflumilast 250 MCG Tablet - (C)**  
 Sig: Take 1 tablet by mouth twice a day. Route: Oral Indications: Chronic Obstructive Lung Disease

**Diagnoses**  
 as of 2/1/2022

**(M1021) Principal Diagnosis**  
 ICD  
 J44.1

**Plan of Care Edit**

**Medications**

**Prescriptions and Patient-Reported**  
 **Acclidinium Bromide 400 MCG/ACT AEROSOL POWDER, BREATH ACTIVATED - (C)**  
 Dates: 1/31/2022 to 1/31/2023  
 Sig: Inhale 1 puff into the lungs twice a day.  
 Authorizing Provider: Hollan, Tim, MD  
 **Carbocysteine 750 MG Chew Tab - (N)** 1  
 Dates: 1/31/2022 to 3/2/2022  
 Sig: Chew 1 tablet by the mouth daily for 30 days.  
 Authorizing Provider: Hollan, Tim, MD  
 **metformin (GLUCOPHAGE) 500 MG tablet - (C)**  
 Dates: 1/31/2022 to —  
 Sig: Take 1 tablet by mouth in the morning and 1 tablet in the evening. Take with meals.  
 Authorizing Provider: Hollan, Tim, MD  
 **Roflumilast 250 MCG Tablet - (C)**  
 Dates: 1/31/2022 to 1/31/2023  
 Sig: Take 1 tablet by mouth twice a day.  
 Authorizing Provider: Hollan, Tim, MD

**Care Plan** ▼ 2

**Visit Sets** ▼

- You review the Care Plan section and decide not to make any changes. Click **Review and Accept** to confirm the change you made to the medication list. This locks the sections, meaning that changes Remote Client users make to medications, the care plan, and visit sets won't be reflected in the plan after that point.

The screenshot shows the 'Plan of Care Edit' window. On the left, there are sections for Patient Information, Agency Information, Medications, and Diagnoses. The main area is divided into 'Medications' and 'Care Plan'. In the 'Medications' section, four items are listed with checkboxes: Acclidinium Bromide 400 MCG/ACT AEROSOL POWDER, BREATH ACTIVATED - (C) (checked), Carbocysteine 750 MG Chew Tab - (N) (unchecked), metformin (GLUCOPHAGE) 500 MG tablet - (C) (checked), and Roflumilast 250 MCG Tablet - (C) (checked). In the 'Care Plan' section, three items are listed with checkboxes: Problem: Patient Care and Rehospitalization Risk (checked), Intervention: Next Visit Planning (checked), and Intervention: Assess Rehospitalization Risk (checked). At the bottom right, there are two buttons: 'Review and Accept' (checked) and 'Cancel' (unchecked). A red box highlights the 'Review and Accept' button.

- Notice that the medication you unchecked is no longer listed in the plan.

The screenshot shows the 'Medications' section of the plan. It lists three medications: Acclidinium Bromide 400 MCG/ACT AEROSOL POWDER, BREATH ACTIVATED - (C), metformin (GLUCOPHAGE) 500 MG tablet - (C), and Roflumilast 250 MCG Tablet - (C). The Carbocysteine 750 MG Chew Tab - (N) medication is no longer listed.

- Scroll down through the rest of the plan. If there were an issue that needed fixing such as, for example, an incorrect medication dose, you'd need to send a case communication message to the clinician, who would then make the change in the Remote Client.

- If you need to make an adjustment to the certification period dates associated with the plan, click the **Certification Period** link in the Dates section on the right.

The screenshot shows the 'Home Health Plan of Care' interface. The main content area on the left contains clinical details such as 'Problem: Pain/Comfort Deficit', 'Goal: Patient reports that pain has been reduced or controlled through verbal or nonverbal means...', and 'Intervention: Pain Management'. On the right side, the 'Dates' section is highlighted with a red box, showing a 'Certification Period (1/31/2022 - 3/31/2022)' link. Below this, there are sections for 'Attachments (0)', 'Participants' (listing Tim Hollan, MD), and 'Face to Face Details'.

- Adjust the **Cert Start** date to be one day later (1). Note that the Cert End date adjusts automatically. Click **Accept** (2).

The screenshot shows the 'Cert Period Management' dialog box. It features a table with the following data:

#	Encounter Date	Cert Start	Cert End
1	01/31/2022	01/31/2022	03/31/2022

Below the table, the 'Cert Start' field is highlighted with a red circle and the number '1', and the 'Cert End' field is highlighted with a red circle and the number '2'. The 'Cert Period Length' is set to 60 days. There is a 'Use Default Length' button and a 'Restore' button. At the bottom, there are 'Accept' and 'Cancel' buttons.

10. Notice that the certification period shows the change you made (1). Click Finalize (2) to finalize the plan and send it to the participant or participants listed as required signers in the Participants section (3), typically the M0018 provider, for signature. Required signers have the pen-and-squiggle icon next to their names.

**Dates**  
Certification Period (2/1/2022 - 4/1/2022) 1

**Attachments (0)**

**Participants** + Add Me + Add

Tim Hollan, MD M0018 Provider Reviewer 3

11. A window prompts you to review the date and time of the Plan of Care order. Click **Finalize** to send the plan for signing.

1979 Milky Way Ph: 715-555-5555

**Finalize Plan of Care** X

Order Date: 2/1/2022 Order Time: 12:36 PM

Order Comments: [Text Area]

[Finalize] [Cancel]

meals. Route: Oral Indications: Type 2 Diabetes

ive Lung Disease

	Date	Flag
ase with (acute) exacerbation	1/31/2022	Onset
mplications	1/31/2022	Onset

[Print] [Finalize]

12. The finalized form of the plan appears. This is how it looks to other users when they open the plan, including the provider.

**Plan of Care**  
All Plans Home Health Plan of Care 02/01/22

**Home Health Plan of Care 02/01/22** Plan ID: 10253  
Effective from: 2/1/2022 Effective to: 4/1/2022

**Participants as of 2/1/2022**

Name	Type	Comments	Contact Info
Tim Hollan, MD Health Nolan	M0018 Provider Skilled Nursing		608-555-4121 973-229-9173

**Patient Information as of 2/1/2022**

(M0040) Name	(M0049-M0050) Address	(M0066) Date of Birth	(M0069) Sex	(M0065) HI Claim No.
January, Bethany	15 Star Road MADISON, WI 53717	1/31/1949	Female	—

**Agency Information as of 2/1/2022**

(M0010) CMS Certification Number	Name	Address	Telephone Number
16-5387	WI HOME HEALTH	1579 Milky Way Verona, Wisconsin 53593	Ph: 715-555-5555

**Medications as of 2/1/2022**

**Prescriptions and Patient-Reported**

Name - (New/Changed)
Acidinium Bromide 400 MCG/ACT AEROSOL POWDER, BREATH ACTIVATED - (C) Sig: Inhale 1 puff into the lungs twice a day. Route: Inhalation. Indications: Chronic Obstructive Lung Disease
metformin (GLUCOPHAGE) 500 MG tablet - (C) Sig: Take 1 tablet by mouth in the morning and 1 tablet in the evening. Take with meals. Route: Oral. Indications: Type 2 Diabetes
Roflumilast 250 MCG Tablet - (C) Sig: Take 1 tablet by mouth twice a day. Route: Oral. Indications: Chronic Obstructive Lung Disease

**Diagnoses as of 2/1/2022**

(M1021) Principal Diagnosis	(M1023) Other Pertinent Diagnoses
ICD: J44.1 Description: Chronic obstructive pulmonary disease with (acute) exacerbation Date: 1/31/2022 Flag: Onset	ICD: E10.9 Description: Type 1 diabetes mellitus without complications Date: 1/31/2022 Flag: Onset

**Procedures as of 2/1/2022**

Buttons: X Delete, Create Revision, Print

## Edit Providers and Signers on the Plan of Care

### Change the M0018 Provider

If you need to change the OASIS M0018 provider on the Plan of Care, click the **Change** link. Making that change creates an addendum to the Plan of Care.

**Participants** + Add Me + Add

**DENLINGER, BOSS** [Change](#)  
M0018 Provider  
Reviewer

**Carla Cohen, MD**   
Provider  
Reviewer  
608-453-1212  
Contributor **Reviewer** Owner

## Change the Required Signer

The pen-and-squiggle icon indicates which participant is the required signer (1). If your organization allows you to change the M0018 provider on a Plan of Care, you can do that by checking or unchecking the **Must Sign** box (2) for participants. You can add participants using the **Add** button (3). Note that, to finalize the plan, you need at least one required signer.

The screenshot shows a 'Participants' window with the following elements:

- Participants** header with two '+ Add' buttons. The right '+ Add' button is circled with a red '3'.
- DENLINGER, BOSS**: M0018 Provider, Reviewer. Includes a 'Change' button.
- Carla Cohen, MD**: Provider, Reviewer. Includes a pen-and-squiggle icon circled with a red '1', a phone number (608-453-1212), and role buttons: Contributor, Reviewer (selected), Owner. A 'Must Sign' checkbox is checked and circled with a red '2'. Below it is a 'Comment' text box and 'Accept'/'Cancel' buttons.
- Betty Gregson**: Skilled Nursing, Contributor.

## Where to Find Fields in the New Plan of Care

The following shows you where specific fields appeared in the old Plan of Care based on the CMS-485 form and where they appear in the new Plan of Care.

- A. The patient's HI claim number, start of care date, certification period, medical record number, name and address, date of birth, and sex appear in the Patient Information section.
- B. The provider number and the provider's name, address, and telephone number appear in the Agency Information section.

HOME HEALTH CERTIFICATION AND PLAN OF CARE				
1. Patient's HI Claim No. 4A44A44A44	2. Start of Care Date 3/7/2022	3. Certification Period From: 3/7/2022 To: 5/5/2022	4. Medical Record No. 116064	5. Provider No. 12-3456
6. Patient's Name and Address January, Bethany 42 Grace Lane Madison, WI 53717 608-432-4545		7. Provider's Name, Address and telephone Number WI HOME HEALTH 1979 Milky Way Verona, WI 53593 Ph: 608-271-9000		
8. Date of Birth 03/07/1947	9. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	10. Medications: Dose/Frequency/Route (N)ew (C)hanged furosemide (LASIX) 20 MG tablet Take 20 mg by mouth in the morning (C) (N)		

  

**Plan of Care**

← All Plans Home Health Plan of Care 02/28/22

**Patient Information** A

as of 3/8/2022

(M0040) Name	(M0040-M0060) Address	(M0066) Date of Birth	(M0069) Sex	(M0065) HI Claim No.
January, Bethany	42 Grace Lane MADISON, WI 53717 608-432-4545	2/22/1947	Female	—

  

(M0030) Start of Care Date	Referral Date	Certification Period	MRN
2/22/2022	—	2/28/2022 - 4/28/2022	113611

**Agency Information** B

as of 3/8/2022

(M0010) CMS Certification Number	Name	Address	Telephone Number
27-0011	WI HH EAST	555 Lincoln St Verona, Wisconsin 53593	Ph: 608-271-9000

- C. Medications appear in the Medications section.

D. Diagnoses and surgical procedures appear in the Diagnoses and Procedures sections.

8. Date of Birth 03/07/1947		9. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		10. Medications: Dose/Frequency/Route (N)ew (C)hanged furosemide (LASIX) 20 MG tablet Take 20 mg by mouth in the morning. - Oral (N) metformin (GLUCOPHAGE) 500 MG tablet Take 500 mg by mouth in the morning and 500 mg in the evening. Take with meals. - Oral (N) pioglitazone (ACTOS) 15 MG tablet Take 15 mg by mouth nightly. - Oral (N) rosuvastatin (CRESTOR) 10 MG tablet Take 10 mg by mouth in the morning. - Oral (N)	
11. Code E11.59	Principal Diagnosis Type 2 diabetes mellitus with other circulatory complications	Date 03/07/2022	D		
12. Code N/A	Surgical Procedure	Date			
13. Code I25.10	Other Pertinent Diagnoses Atherosclerotic heart disease of native coronary artery without angina pectoris	Date 03/07/2022			

  

**Medications** C

as of 3/8/2022

**Prescriptions and Patient-Reported**

Name - (N)ew/(C)hanged	Dispense	Refills	Start Date	End Date
<b>furosemide (LASIX) 20 MG tablet - (N)</b> Sig: Take 20 mg by mouth daily. Route: Oral Indications: High Blood Pressure Disorder Authorizing Provider: Martinez, Rick, MD	—	—	—	—
<b>metformin (GLUCOPHAGE) 500 MG tablet - (C) (Removed: 2/25/2022)</b> Sig: Take 500 mg by mouth in the morning and 500 mg in the evening. Route: Oral Indications: Type 2 Diabetes Authorizing Provider: Martinez, Rick, MD	—	—	—	—
<b>pioglitazone (ACTOS) 15 MG tablet - (C)</b> Sig: Take 15 mg by mouth in the morning. Route: Oral Indications: Type 2 Diabetes Authorizing Provider: Martinez, Rick, MD	—	—	—	—
<b>rosuvastatin (CRESTOR) 10 MG tablet - (C)</b> Sig: Take 10 mg by mouth in the morning. Route: Oral Indications: Disease involving Lipid Deposits in the Arteries, Disease of the Heart and Blood Vessels Authorizing Provider: Martinez, Rick, MD	—	—	—	—

  

**Diagnoses** D

as of 3/8/2022

**(M1021) Principal Diagnosis**

ICD	Description	Date
E11.59	Type 2 diabetes mellitus with other circulatory complications	2/22/2022

**(M1023) Other Pertinent Diagnoses**

ICD	Description	Date
I25.10	Atherosclerotic heart disease of native coronary artery without angina pectoris	2/22/2022

  

**Procedures**

as of 3/8/2022

No procedures on file.

E. DME and supplies appear in the Durable Medical Equipment section.

F. Safety measures and nutritional requirements appear in the Safety & Nutrition section.

G. Allergies appear in the Allergies section.

H. Functional limitations and activities permitted appear in the Functional Assessment section.

<b>14. DME and Supplies</b> <b>E</b> Front wheeled walker		<b>15. Safety Measures:</b> Adequate emergency plan, Smoke detectors, Ambulate only with assistance, Bathtub safety bars, Bleeding precautions, Correct use of support devices, Needle precautions, No stairs, Phone access, Proper medication use, Ramps/hand railings													
<b>16. Nutritional Req.</b> Diabetic diet <b>F</b>		<b>17. Allergies:</b> Sulfa Antibiotics <b>G</b>													
<b>18.A. Functional Limitations</b>		<b>18.B. Activities Permitted</b>													
1 <input type="checkbox"/> Amputation 2 <input type="checkbox"/> Bowel/Bladder (Incontinence) 3 <input type="checkbox"/> Contracture 4 <input type="checkbox"/> Hearing	5 <input type="checkbox"/> Paralysis 6 <input checked="" type="checkbox"/> Endurance 7 <input checked="" type="checkbox"/> Ambulation 8 <input type="checkbox"/> Speech	9 <input type="checkbox"/> Legally Blind A <input type="checkbox"/> Dyspnea with Minimal Exertion B <input type="checkbox"/> Other (Specify)	1 <input type="checkbox"/> Complete Bedrest 2 <input type="checkbox"/> Bedrest BRP 3 <input checked="" type="checkbox"/> Up As Tolerated 4 <input checked="" type="checkbox"/> Transfer Bed/Chair 5 <input checked="" type="checkbox"/> Exercises Prescribed 6 <input type="checkbox"/> Partial Weight Bearing 7 <input type="checkbox"/> Independent at Home 8 <input type="checkbox"/> Crutches 9 <input type="checkbox"/> Cane A <input type="checkbox"/> Wheelchair B <input type="checkbox"/> Walker C <input type="checkbox"/> No Restrictions D <input type="checkbox"/> Other (Specify)												
<b>Durable Medical Equipment</b> <b>E</b> as of 3/9/2022															
<table border="1"> <thead> <tr> <th>Name</th> <th>Start Date</th> <th>End Date</th> <th>Comments</th> </tr> </thead> <tbody> <tr> <td>Front wheeled walker</td> <td>—</td> <td>—</td> <td>—</td> </tr> </tbody> </table>				Name	Start Date	End Date	Comments	Front wheeled walker	—	—	—				
Name	Start Date	End Date	Comments												
Front wheeled walker	—	—	—												
<b>Safety &amp; Nutrition</b> <b>F</b> as of 2/22/2022 OASIS assessment															
Safety Measures Adequate emergency plan, Smoke detectors, Ambulate only with assistance, Bathtub safety bars, Bleeding precautions, Correct use of support devices, Needle precautions, No stairs, Phone access, Proper medication use, Ramps/hand railings		Nutritional Requirements Diabetic diet													
<b>Allergies</b> <b>G</b> as of 3/9/2022															
<table border="1"> <thead> <tr> <th>Allergen</th> <th>Reactions</th> <th>Severity</th> <th>Type</th> <th>Noted</th> <th>Comments</th> </tr> </thead> <tbody> <tr> <td>Sulfa Antibiotics</td> <td>Rash</td> <td>Medium</td> <td>Allergy</td> <td>2/22/2022</td> <td>—</td> </tr> </tbody> </table>				Allergen	Reactions	Severity	Type	Noted	Comments	Sulfa Antibiotics	Rash	Medium	Allergy	2/22/2022	—
Allergen	Reactions	Severity	Type	Noted	Comments										
Sulfa Antibiotics	Rash	Medium	Allergy	2/22/2022	—										
<b>Functional Assessment</b> <b>H</b> as of 2/22/2022 OASIS assessment															
Functional Limitations Endurance, Ambulation		Activities Permitted Up as Tolerated, Transfer Bed/Chair, Exercises Prescribed													
Prognosis Guarded <b>?</b>															

I. Mental status appears in the Mental Status section.

J. Prognosis appears in the Functional Assessment section.

<b>19. Mental Status</b> <b>I</b>							
1 <input checked="" type="checkbox"/> Oriented	3 <input type="checkbox"/> Forgetful	5 <input type="checkbox"/> Disoriented	7 <input type="checkbox"/> Agitated	2 <input type="checkbox"/> Comatose	4 <input type="checkbox"/> Depressed	6 <input type="checkbox"/> Lethargic	8 <input type="checkbox"/> Other
<b>Other mental, psychosocial, and cognitive status observations</b> 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. When Confused (Reported or Observed Within the Last 14 Days): 1 - In new or complex situations only When Anxious (Reported or Observed Within the Last 14 Days): 1 - Less often than daily Over the last two weeks, how often has the patient been bothered by any of the following problems: Little interest or pleasure in doing things: Not at all (0 to 1 day)/Feeling down, depressed, or hopeless: Not at all (0 to 1 day)/Has the patient been screened for depression, using a standardized, validated depression screening tool?: 1 - Yes, patient was screened using the PHQ-2 scale. Cognitive, behavioral, and psychiatric symptoms that are demonstrated at least once a week (Reported or Observed): 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 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc. Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety: 1 - Less than once a month							
<b>20. Prognosis</b> <b>J</b>							
1 <input type="checkbox"/> Poor	2 <input checked="" type="checkbox"/> Guarded	3 <input type="checkbox"/> Fair	4 <input type="checkbox"/> Good	5 <input type="checkbox"/> Excellent			

<h3>✦ Functional Assessment</h3> <p>as of 2/22/2022 OASIS assessment</p> <p>Functional Limitations Endurance, Ambulation</p>		<p>Activities Permitted Up as Tolerated, Transfer Bed/Chair, Exercises Prescribed</p>	<div style="border: 1px solid red; padding: 5px;"> <p>Prognosis <b>J</b> Guarded <b>?</b></p> </div>
<h3>🔍 Mental Status</h3> <p>as of 4/17/2023 assessment <b>I</b></p> <p>Should Brief Interview for Mental Status (C0200-C0500) be Conducted? 1. Yes</p> <p>Repetition of Three Words Ask patient: "I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue and bed. Now tell me the three words." Number of words repeated after first attempt 3. Three</p> <p>Temporal Orientation to Year 3. Correct</p> <p>Temporal Orientation to Month 2. Accurate within 5 days</p> <p>Temporal Orientation to Day 1. Correct</p> <p>Recall "Sock" 2. Yes, no cue required</p> <p>Recall "Blue" 2. Yes, no cue required</p> <p>Recall "Bed" 2. Yes, no cue required</p> <p>BIMS Summary Score 15 (Cognitively intact)</p> <p>Acute Onset of Mental Status Change 0. No</p> <p>Inattention 0. Behavior not present</p> <p>Disorganized Thinking 0. Behavior not present</p>			

- K. Orders for a discipline and treatments that specify visits appear in the Visit Sets section.
- L. Orders for a discipline and treatments that specify a patient's problems and interventions to address those problems appear in the Care Plan section. Goals also appear in the Care Plan section.

M. Advance care plan information appears in the Advance Care Planning section.

<p>21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)</p> <p>SN: 3/7/2022 to 4/2/2022: 1 to 4 visits every week for 4 weeks. <span style="border: 1px solid black; border-radius: 50%; padding: 2px;">K</span></p>
<p>SN, PT, OT, LPN: History of Falls/Fall Risk [- Recent falls without injury related to difficult walking. - Lacks safety awareness.] Falls/Fall Risk [SN, PT, OT, LPN] [PRN, Start: 3/7/2022] [- Perform home safety assessment and give recommendations. - Instruct in home safety and fall prevention strategies. - Monitor adherence to and mindfulness of fall prevention strategies. - Assess appropriate use of assistive devices. - Interdisciplinary involvement with focused therapy to evaluate balance, gait, transfers, and assistive devices.] <span style="border: 1px solid black; border-radius: 50%; padding: 2px;">L</span></p> <p>Pain/Comfort Deficit [Pain/comfort deficit related to foot (site) and ulcer (cause).] Pain Management [SN, PT, OT, LPN] [PRN, Start: 3/7/2022] [Instruct in pharmacologic and nonpharmacologic pain management techniques.] Skilled Assessment Pain [SN, PT, OT, LPN] [PRN, Start: 3/7/2022] [Assess pain (with standardized pain assessment tool).]</p> <p>Risk for Skin Breakdown [Risk for skin breakdown related to type two diabetes.] Infection Prevention [SN, PT, OT, LPN] [PRN, Start: 3/7/2022] [- Instruct in strategies to prevent infection. - Instruct in how to recognize signs and symptoms of infection and when to notify home care agency and/or physician.] Instruct Diabetic Foot Care [SN, PT, OT, LPN] [PRN, Start: 3/7/2022] [Instruct in care of feet including: Checking feet for cracks, sores, cuts]</p>
<p>Advance Care Plan <span style="border: 1px solid black; border-radius: 50%; padding: 2px;">M</span> Code Status: Not on file</p>
<p>22. Goals/Rehabilitation Potential/Discharge Plans</p> <p>GOALS</p> <p>SN, PT, OT, LPN: History of Falls/Fall Risk Patient reduces fall injury risk and frequency [SN, PT, OT, LPN] [- Patient/Caregiver will implement strategies to reduce fall risk within the home. - Decrease fall frequency and reduction in injury risk.]</p> <p>Pain/Comfort Deficit Patient reports that pain has been reduced or controlled through verbal or nonverbal means and that measures to promote comfort are effective [SN, PT, OT, LPN] [Patient will report that pain has been reduced or controlled through verbal or nonverbal means and that measures to promote comfort are effective before discharge.]</p> <p>Risk for Skin Breakdown Patient verbalizes understanding of infection prevention strategies and methods to prevent development or worsening of pressure injuries [SN, PT, OT, LPN] [Patient/Caregiver will verbalize understanding of infection prevention strategies and methods to prevent development or worsening of pressure injuries.]</p> <p>ED/HOSPITAL READMISSION RISKS Skilled Nursing (3/7/2022) 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 3 - Multiple hospitalizations (2 or more) in the past 6 months 4 - Multiple emergency department visits (2 or more) in the past 6 months</p> <p>REHABILITATION POTENTIAL Skilled Nursing (3/7/2022) Fair.</p> <p>DISCHARGE PLANS ***</p>

**Visit Sets** Expand All Collapse All

as of 3/9/2022

**Skilled Nursing**

Visits	Dates
4 visits every week for 4 weeks	2/22/2022 to 3/19/2022

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**Care Plan** Expand All Collapse All

as of 3/9/2022

**Licensed Practical Nurse**

**Problem: History of Falls/Fall Risk**  
 Starting: 2/22/2022  
 - Recent falls without injury related to difficulty walking.  
 - Lacks safety awareness.

**Goal: Patient reduces fall injury risk and frequency**  
 Starting: 2/22/2022  
 - Patient/Caregiver will implement strategies to reduce fall risk within the home.  
 - Decrease fall frequency and reduction in injury risk.

**Intervention: Falls/Fall Risk**  
 Starting: 2/22/2022      Frequency: PRN  
 - Perform home safety assessment and give recommendations.  
 - Instruct in home safety and fall prevention strategies.  
 - Monitor adherence to and mindfulness of fall prevention strategies.  
 - Assess appropriate use of assistive devices.  
 - Interdisciplinary involvement with focused therapy to evaluate balance, gait, transfers, and assistive devices.

**Problem: Pain/Comfort Deficit**  
 Starting: 2/22/2022

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**Advance Care Planning**

as of 3/9/2022

Code Status	Code Status Comments	Capacity to Make Own Care
Full Code	Full Code. Please complete progress note to document conversation with patient as appropriate.	Decisions Full capacity

N. Readmission risks, rehabilitation potential, and discharge plans appear in the Readmission Risks/Rehab Potential/Discharge Plans section.

**22. Goals/Rehabilitation Potential/Discharge Plans**  
GOALS

SN, PT, OT, LPN:  
History of Falls/Fall Risk  
Patient reduces fall injury risk and frequency [SN, PT, OT, LPN] [- Patient/Caregiver will implement strategies to reduce fall risk within the home. - Decrease fall frequency and reduction in injury risk.]

Pain/Comfort Deficit  
Patient reports that pain has been reduced or controlled through verbal or nonverbal means and that measures to promote comfort are effective [SN, PT, OT, LPN] [Patient will report that pain has been reduced or controlled through verbal or nonverbal means and that measures to promote comfort are effective before discharge.]

Risk for Skin Breakdown  
Patient verbalizes understanding of infection prevention strategies and methods to prevent development or worsening of pressure injuries [SN, PT, OT, LPN] [Patient/Caregiver will verbalize understanding of infection prevention strategies and methods to prevent development or worsening of pressure injuries.]

**ED/HOSPITAL READMISSION RISKS**  
Skilled Nursing (3/7/2022) N

- 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
- 3 - Multiple hospitalizations (2 or more) in the past 6 months
- 4 - Multiple emergency department visits (2 or more) in the past 6 months

**REHABILITATION POTENTIAL**  
Skilled Nursing (3/7/2022)  
Fair.

**DISCHARGE PLANS**

**Readmission Risks/Rehab Potential/Discharge Plans**  
as of 3/9/2022 N

**(M1033) ED/Hospital Readmission Risks**  
Skilled Nursing (2/22/2022)  
2 - Unintentional weight loss of a total of 10 pounds or more in the past 12 months  
3 - Multiple hospitalizations (2 or more) in the past 6 months  
7 - Currently taking 5 or more medications

**Rehabilitation Potential**  
Skilled Nursing (2/22/2022)  
Fair.

**Discharge Plans**  
Skilled Nursing (2/22/2022)  
Work with patient to get blood sugar under control.

- O. The date the HHA received the signed POT does not appear.
- P. The physician's name and contact number appear on the plan after you finalize it. The physician's address does not, nor does the statement in field 26.

<b>23. Nurse's Signature and Date of Verbal SOC Where Applicable</b> Electronically signed by Tim Hollan, Health Nurse Hollan - 3/7/2022 <span style="border: 1px solid red; border-radius: 50%; padding: 2px;">O</span>	<b>25. Date HHA Received Signed POT</b> <span style="border: 1px solid red; border-radius: 50%; padding: 2px;">P</span>
<b>24. Physician's Name and Address</b> Tim Hollan, MD 30 Northwards Road MADISON Wisconsin 53719 Phone: 608-555-4121 <span style="border: 1px solid red; border-radius: 50%; padding: 2px;">Q</span>	<b>26. I certify/recertify that the above stated patient is homebound and that upon completion of this FTF encounter, has a need/continued need for intermittent skilled nursing, physical therapy and/or speech or occupational therapy services in their home for their current diagnosis as outlined in their initial plan of care. These services will continue to be monitored by myself or another physician who will periodically review and update the plan of care as required.</b>

**Patient Information**  
as of 3/8/2022

(M0040) Name January, Bethany <span style="border: 1px solid red; border-radius: 50%; padding: 2px;">O</span>	(M0040-M0060) Address 42 Grace Lane MADISON, WI 53717 608-432-4545	(M0066) Date of Birth 2/22/1947	(M0069) Sex Female	(M0065) HI Claim No. —
(M0030) Start of Care Date 2/22/2022	Referral Date —	Certification Period 2/28/2022 - 4/28/2022	MRN 113611	

**Participants** as of 3/8/2022

Name	Type	Comments	Contact Info
Carla Cohen, MD	M0018 Provider		608-453-1212 <span style="border: 1px solid red; border-radius: 50%; padding: 2px;">Q</span>
Betty Gregson	Skilled Nursing		

**Patient Information** as of 3/8/2022

(M0040) Name	(M0040-M0060) Address	(M0066) Date of Birth	(M0069) Sex	(M0065) HI Claim
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- Q. The attending physician's signature and date signed appear on plan after you've finalized it and they've signed it. The statement in field 28 does not.