Home Health Certification and Plan of Care

Order ID: 1150/12003

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
AA00014731	08/25/2025	From: 08/25/2025 To: 10/23/2025	16702	217058

6. Patient's Name and Address
Bettie McKnight
1032 Vine Street,
BALTIMORE, MD 21223-
410-258-0382

7. Provider's Name, Address and Telephone Number
HomeCentris Healthcare LLC
10 Crossroads Drive, Suite 102
Owings Mills, MD 21117-8284
410-321-8448
1487113239

8. DOB 09/30/1944 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
I11.0	Hypertensive heart disease with heart failure	08/25/25

13. ICD	Other Pertinent Diagnoses	Date
I50.20	Unspecified systolic (congestive) heart failure	08/25/25
E11.9	Type 2 diabetes mellitus without complications	08/25/25
I25.5	Ischemic cardiomyopathy	08/25/25
F43.23	Adjustment disorder with mixed anxiety and depressed mood	08/25/25
D64.9	Anemia unspecified	08/25/25
I26.99	Other pulmonary embolism without acute cor pulmonale	08/25/25
I82.401	Acute embolism and thombos unsp deep veins of r low extrem	08/25/25
K74.60	Unspecified cirrhosis of liver	08/25/25
R13.10	Dysphagia unspecified	08/25/25
Z79.01	Long term (current) use of anticoagulants	08/25/25
Z79.84	Long term (current) use of oral hypoglycemic drugs	08/25/25
Z95.810	Presence of automatic (implantable) cardiac defibrillator	08/25/25

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

Acetaminophen - Acetaminophen 325 MG, Give 3 tablet by mouth every 6 hours Give 3 tablet by mouth every 6 hours as needed for Pain Total Dose 975 mg *DO NOT EXCEED 3 GRAMS per 24 HOURS*
Atorvastatin Calcium - Atorvastatin Calcium 80 MG , Give 1 tablet by mouth at bedtime Give 1 tablet by mouth at bedtime for cholesterol management
Greer Goo Nystatin plus Zinc Oxide plus Hydrocortisone Cream Apply to Sacrum topical twice a day Cream Apply to Sacrum topically two times a day for MASD Until heal
Losartan Potassium - Losartan Potassium 100 MG, Give 1 tablet by mouth once a day Give 1 tablet by mouth one time a day for HTN Hold for SBP less than 110 or pulse less than 60
Magnesium Oxide - Simethicone 400 MG , Give 1 tablet by mouth twice a day Give 1 tablet by mouth two times a day for low magnesium levels
Metformin Hcl - Metformin Hydrochloride 500 MG , Give 1 tablet by mouth twice a day Give 1 tablet by mouth two times a day for DM management
Eliquis - Apixaban 2.5 MG , Give 1 tablet by mouth twice a day Give 1/2 tablet by mouth two times a day for DVT prophylaxis
Furosemide - Furosemide 20 MG , Give 1 tablet by mouth twice a day Give 1 tablet by mouth two times a day for HTN
Carvedilol - Carvedilol 3.125 MG , Give 1 tablet by mouth twice a day Give 1/2 tablet by mouth two times a day for HTN Hold for SBP less than 110 or pulse less than 60

14. DME and Supplies:
cane, walker

15. Safety Measures:
walker precautions, , fall precautions, medication safety, supervision at all times, standard precautions, bathroom safety, anticoagulant precautions, activity supervision, ambulates with assistance, ambulates with device

16. Nutrition:
low sodium, low cholesterol, cardiac diet, diabetic

17. Allergies:
no known allergies

18.A. Functional Limitations
Ambulation, Endurance

18.B. Activities Permitted
Cane, Walker, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No

20. Prognosis: good

22. A Rehabilitation Potential:
SELF-CARE: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities., MOBILITY: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities.

22.B.Discharge Plans
patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Hypertensive heart disease with heart failure, the patient is experiencing decreased endurance and mobility, increasing the likelihood of falls. To safely leave their home, the patient needs assistance from another person and an assistive mobility device.

Clinical Condition Requiring Homecare:

The patient is an 80-year-old female with a complex medical history including congestive heart failure (CHF), hypertension, type 2 diabetes mellitus, cardiomyopathy, atrial fibrillation with a biventricular implantable cardioverter-defibrillator (ICD), cirrhosis, anemia, dysphagia, anxiety, depression, prior pulmonary embolism (PE) and deep vein thrombosis (DVT), pancreatitis, and adjustment disorder. She was recently hospitalized for altered mental status, weakness, tremors, and difficulty ambulating. Additional concerns include right-sided weakness, numbness in the fourth and fifth digits of the right hand, hypotension secondary to diarrheal illness, acute kidney injury, and hypomagnesemia. The patient denies urinary symptoms or buttock pain but reports right leg stiffness and infrequent bowel movements. A small left buttock pressure wound is present but healing with current barrier cream therapy. Vitals are stable, lungs are clear to auscultation, and no wounds or signs of bleeding were noted during the visit. Medications were reviewed and confirmed with the patient and caregiver, who demonstrated understanding of usage and dosages. The patient was educated on hydration and dietary changes to promote regular bowel movements. The patient resides in a multi-level townhouse with her son and granddaughters. The main living area has six steps to enter and 14 steps to access the bedroom and bathroom on the second floor. She ambulates short distances indoors using a cane or walker with close supervision, performs sit-to-stand transfers with supervision, and uses stairs with a rail and supervision. She declined assessment of the upper floor. Due to significant effort required to leave the home, supported by a Tinetti score of 14/28, the patient qualifies as homebound. Her goal is to return to her prior level of function, including walking short distances without assistive devices and achieving independence with basic activities of daily living (BADLs). She would benefit from skilled home therapy services to improve strength, balance, and functional mobility. A new primary care provider appointment is scheduled for 9/17/25, and coordination with the provider's office has been initiated.<o:p></o:p> <o:p> </o:p> Date of Order<o:p></o:p> 08/25/2025
 Order<o:p></o:p> Physician Face-to-Face Date: 08/07/2025
 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's dx: Hypertensive heart disease with heart failure
 Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home<o:p></o:p>
 1 - SOC - SN Notes:
 PT Eval Notes:
 OT Eval Notes:<o:p></o:p> Physician: Quainoo, Ebenezer

SN Careplans

SN Goals

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles SN RN on 08/25/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address
Ebenezer Quainoo
3350 Wilkens Ave
Baltimore, MD 21229
PHONE: 410-368-8317 FAX: 14103688319 NPI: 1326033952

26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.
F2F date : 08/07/2025

27. Attending Physician's Signature and Date Signed : Date of physician last face-to-face

28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

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6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number
Bettie McKnight 1032 Vine Street, BALTIMORE, MD 21223- 410-258-0382	HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239

SN WK1: 2 (08/25/25-08/30/25) ,WK2: 1 (08/31/25-09/06/25) ,WK3: 1 (09/07/25-09/13/25) ,WK4: 1 (09/14/25-09/20/25) ,WK5: 1 (09/21/25-09/27/25) ,WK6: 1 (09/28/25-09/30/25)

PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature < 95 > 100.5, heart rate < 50 > 110, respiratory rate < 8 > 22, blood pressure systolic < 90 > 169, blood pressure diastolic < 60 > 90, O2 saturation < 88 > 100, pain < 0 > 5

CAREGIVER: 1. Non-agency caregiver(s) currently provide assistance

HOSPITALIZATION RISKS: 5. Decline in mental, emotional, or behavioral status in the past 3 months, 7. Currently taking 5 or more medications, 8. Currently reports exhaustion

STANDING ORDERS: infection control: hygiene, proper hand washing; advance directive: plan if patient is unable to make healthcare decisions ; fall precautions: wear sensible shoes, remove home hazards, living space adequately lit, assistive devices prn; emergency preparedness: plan for prn evacuation, resumption of home health visits; Assess the patient's incision on post op day 7 and the nurse or physical therapist will remove aquacel dressing leaving OTA; if incision is draining educate pt/pcg on cleaning with normal saline and covering with dry gauze daily and as needed.
Assess the pt's incision and on post op day 12-14 the nurse or physical therapist will remove the patient's staples and leave OTA., Assess/Instruct Pt/Pcg: Ice to ____ x 20 minutes each hour while awake. If cold machine ordered apply 20 minutes on and 20 minutes off for 3-4 times a day.
Assess/Instruct all body systems/vital signs/complications, Blood Pressure; systolic is greater than 169 mm Hg or less than 90 mm Hg; diastolic is greater than 100 mm Hg or less than 55 mm Hg, Clinician to assess comorbidities and report changes in condition to the patient's physician, Pain Rating is greater than 6 on 0-10 scale, Pulse is greater than 110 or less than 50, Respirations are greater than 22 or less than 8, SPO2: is less than 90 % at rest /with exertion, Temperature is greater than 100.5 F or less than 95.0 F, Pain Rating is greater than 6 on 0-10 scale
Implement Fall Prevention Program, Instruct and educate the patient/PCG on wearing compression stockings for the next 4 weeks per discharge instructions.
Instruct the pt/PCG on using the incentive spirometer 10 times every 2 hour while awake.
Provide education content at patient's level of health literacy.
Assess/Instruct Pt/Pcg: Safety measures to prevent injury.
Assess: Musculoskeletal status.
Teach Pt/Pcg to maintain appropriate wt bearing status as ordered by MD, total joint replacement precautions as applicable, Safe stair climbing skills, Safe, effective use of adaptive/assist device
Assess/Instruct Pt/Pcg: Pain management measures; assess pain level, pain medication, rest, body alignment, ROM, meditation, massage.
Pt/Pcg educated in pain management techniques including positioning and relaxation techniques
Instruct Pt/Pcg: Medication actions, uses, frequency, dose, side effects, interactions of all new/change meds, Provide medication education,.
Assess/Instruct Pt/Pcg: Safety measures to prevent injury, Therapeutic Exercise, Transfer Training
Monitor surgical wound for s/s of infection, educate on s/s of concern and infection prevention to promote wound healing.

; Skin Preservation: Measures to prevent skin breakdown; pressure relief, incontinence care, nutrition, hydration ; Pain: Pain management measures; pain medication, rest, body alignment, ROM, meditation, massage ; Medications: Medication actions, uses, frequency, dose, interactions of all new/change meds
Advance Directive:Durable power of attorney for health care/Medical power of attorney

PROBLEMS IDENTIFIED ON ASSESSMENT: M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2020 - Oral Med Management, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, swelling in the arms/legs, abnormal blood pressure, abn cholesterol > 200 mg/dL, abnormal BS < 70/140 > mg/dL, constipation, muscle weakness, swelling of affected area, limited strength, limited endurance, Pain Effect on Sleep, balance deficit, Pain Interference with ADLs, Pain Interference with Therapy activities, discolored patches of skin, #1 - 1 - Intact skin with non-blanchable redness of a localized area usually over a bony prominence. - Posterior Left Buttock - healing with barrier application

PROCEDURES: cough/deep breathing exercises, incentive spirometer, apply anti-embolitic stockings, train caregiver(s) to perform medical/rehabilitation treatments, coordinate/arrange for adequate patient supervision, coordinate/arrange preparation of missing meals

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage cardiac condition including symptom management diet changes regular exercise getting enough sleep, related medication(s) purpose, schedule, * how to take the patient's blood pressure record the reading, related medication(s) purpose, schedule, * lifestyle modifications to manage respiratory condition including diet changes and regular exercise strategies to control shortness of breath home remedies to keep lungs healthy, related medication(s) purpose, schedule, * lifestyle modifications to manage peripheral vascular condition including how to apply compression stockings physical exercise plan diet, related medication(s) purpose, schedule, * how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain teach relaxation skills and diversional activities, related medication(s) purpose, schedule, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, * diabetic medication management blood sugar testing diabetic foot care exercise diabetic diet, related medication(s) purpose, schedule, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient is adequately supervised, meal preparation is available to patient for all meals, meal preparation is available to patient for all meals, caregiver performs medical/rehabilitation treatments with adequate competence

PATIENT-STATED GOAL: To have bowel movement -greater than 3 days

GOALS
patient/caregiver recalls
* how to achieve wound healing including cleaning and dressing wound
* position changes
* skin care
* diet modification
* record wound measurements
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to take the patient's blood pressure
* record the reading
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* lifestyle modifications to manage cardiac condition including symptom management
* diet changes
* regular exercise
* getting enough sleep
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* diabetic medication management
* blood sugar testing
* diabetic foot care
* exercise
* diabetic diet
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* lifestyle modifications to manage respiratory condition including
* diet changes and regular exercise
* strategies to control shortness of breath
* home remedies to keep lungs healthy
* recalls related medication(s) purpose, schedule

patient self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

patient is adequately supervised

meal preparation is available to patient for all meals

meal preparation is available to patient for all meals

caregiver performs medical/rehabilitation treatments with adequate competence

patient/caregiver recalls
* how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain
* teach relaxation skills and diversional activities
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* lifestyle modifications to manage peripheral vascular condition including how to apply compression stockings
* physical exercise plan
* diet
* recalls related medication(s) purpose, schedule

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles SN RN	08/25/2025

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PT Careplans

PT WK1: 1 (08/25/25-08/30/25) ,WK2: 1 (08/31/25-09/06/25) ,WK3: 2 (09/07/25-09/13/25) ,WK4: 2 (09/14/25-09/20/25) ,WK5: 1 (09/21/25-09/27/25) ,WK6: 1 (09/28/25-09/30/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 Dyspnea, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand, GG0170E1 - Chair to Bed to Chair, GG0170G1 - Car Transfer, GG0170I1 - Walk 10 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170K1 - Walk 150 Feet, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object

PROCEDURES: Home exercise program : Supine hip flexion, bridging, hooklying rotation, straight leg raise, hip abduction. Standing knee flexion, hip extension, plantarflexion, squats,hip abduction. Sitting knee extension, ankle pumps , Bed mobility training , cough/deep breathing exercises, gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage respiratory condition including diet changes and regular exercise strategies to control shortness of breath home remedies to keep lungs healthy, related medication(s) purpose, schedule, Sit to Stand - 04. Supervision or touching assistance, Chair to Bed to Chair - 04. Supervision or touching assistance, Toilet Transfer - 06. Independent, Car Transfer - 04. Supervision or touching assistance, Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Walk 150 Feet - 04. Supervision or touching assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching, 1 - Step (curb) - 04. Supervision or touching assistance, 4 Steps - 04. Supervision or touching assistance, 12 Steps - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance

PT Goals

PATIENT-STATED GOAL: Ambulate independently with cane on indoor surface and be independent on the stepssurfaces

GOALS
Toilet Transfer - 06. Independent

patient/caregiver recalls
* lifestyle modifications to manage respiratory condition including
* diet changes and regular exercise
* strategies to control shortness of breath
* home remedies to keep lungs healthy
* recalls related medication(s) purpose, schedule

Car Transfer - 04. Supervision or touching assistance

Walk 150 Feet - 04. Supervision or touching assistance

Walk 10 ft on Uneven Surface - 04. Supervision or touching

1 - Step (curb) - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

Sit to Stand - 04. Supervision or touching assistance

Chair to Bed to Chair - 04. Supervision or touching assistance

Walk 50 ft with 2 Turns - 04. Supervision or touching assistance

Walk 10 Feet - 04. Supervision or touching assistance

4 Steps - 04. Supervision or touching assistance

12 Steps - 04. Supervision or touching assistance

OT Careplans

OT WK1: 1 (08/25/25-08/30/25) ,WK5: 2 (09/21/25-09/27/25) ,WK6: 1 (09/28/25-09/30/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, GG0130B1 - Oral Hygiene, GG0130F1 - Upper Body Dressing, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130A1 - Eating

PROCEDURES: Medication review : Medications reviewed with patient/caregiver. , cough/deep breathing exercises, equipment training, work simplification/energy conservation

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage respiratory condition including diet changes and regular exercise strategies to control shortness of breath home remedies to keep lungs healthy, related medication(s) purpose, schedule, Oral Hygiene - 06. Independent, Lower Body Dressing - 06. Independent, Shower/Bathe Self - 05. Setup or clean-up assistance, Toileting Hygiene - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Medication review

OT Goals

PATIENT-STATED GOAL: Patient wants to get better

GOALS
Shower/Bathe Self - 05. Setup or clean-up assistance

patient/caregiver recalls
* lifestyle modifications to manage respiratory condition including
* diet changes and regular exercise
* strategies to control shortness of breath
* home remedies to keep lungs healthy
* recalls related medication(s) purpose, schedule

Oral Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Toileting Hygiene - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Medication review

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles SN RN	08/25/2025