Home Health Certification and Plan of Care

Order ID: 1150/12454

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
231282836	09/20/2025	From: 09/20/2025 To: 11/18/2025	16603	217058

6. Patient's Name and Address
Patricia Kearney
936 Wampler Rd,
MIDDLE RIVER, MD 21220-
410-967-0642

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 02/15/1957 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
L02.212	Cutaneous abscess of back [any part except buttock]	09/20/25

13. ICD	Other Pertinent Diagnoses	Date
G93.41	Metabolic encephalopathy	09/20/25
I10.	Essential (primary) hypertension	09/20/25
F03.93	Unsp dementia unspecified severity with mood disturb	09/20/25
F33.1	Major depressive disorder recurrent moderate	09/20/25
D64.9	Anemia unspecified	09/20/25
F43.20	Adjustment disorder unspecified	09/20/25
E78.5	Hyperlipidemia unspecified	09/20/25
E43.	Unspecified severe protein-calorie malnutrition	09/20/25
E53.8	Deficiency of other specified B group vitamins	09/20/25
E55.9	Vitamin D deficiency unspecified	09/20/25
K57.30	Dvrtclos of lg int w/o perforation or abscess w/o bleeding	09/20/25
R32.	Unspecified urinary incontinence	09/20/25
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	09/20/25
Z87.891	Personal history of nicotine dependence	09/20/25
Z87.440	Personal history of urinary (tract) infections	09/20/25

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

Acetaminophen - Acetaminophen 500 mG, Give 1 tablet by mouth every 12 hours
Atorvastatin Calcium - Atorvastatin Calcium 40 Mg, Give 1 tablet by mouth in the evening
Ferrous Sulfate - Ferrous Sulfate: Folic Acid 325(65 Fe) Mg, Give 325 mg tablet by mouth every 12 hours
Gabapentin - Gabapentin 100 Mg, Give 1 capsule by mouth twice a day
Sertraline Hcl - Sertraline Hydrochloride 25 Mg, Give 1 tablet by mouth once a day Give with 50 mg tab to equal 75 mg
Sertraline Hcl - Sertraline Hydrochloride 50 MG, Give 1 tablet by mouth once a day

14. DME and Supplies:
cane, walker, wheelchair

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

16. Nutrition:
low sodium, low cholesterol

17. Allergies:
pcn sulfa antibiotics

18.A. Functional Limitations
Ambulation, Endurance, Bowel/Bladder Incontinence

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

19. Mental & Pyschosocial Status: COGNITION: 1. Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 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, HISTORY OF DEPRESSION: Yes

20. Prognosis: fair

22. A Rehabilitation Potential:
SELF-CARE: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities., MOBILITY: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper.

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

Homebound status: Due to diagnosis of Cutaneous abscess of back [any part except buttock], 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 a 68-year-old female with a complex medical history including dementia, metabolic encephalopathy, hypertension, hyperlipidemia, depression/anxiety, anemia, adjustment disorder, protein-calorie malnutrition, vitamin B and D deficiencies, abnormal gait, diverticulosis without bleeding, history of transient ischemic attack (TIA), urinary tract infections, and urinary incontinence. She presents with immobility and lower extremity weakness requiring one-person assistance for safe ambulation and transfers to prevent falls. The patient is alert but oriented to person and place only and is notably confused. She has an unobserved cutaneous abscess on her mid-back, currently managed with daily wound care, showing mostly granulation tissue. Appetite is poor, and she reports restless thoughts interfering with sleep. Medication administration is overseen by her husband, who notes the patient's noncompliance when independent. The patient was recently discharged from a skilled nursing facility following a week of rehabilitation and expresses a desire to regain her previous mobility. Currently, the patient requires significant assistance with activities of daily living, including incontinence care, and experiences emotional distress, expressing feelings of being a burden. Hydration and infection prevention have been emphasized to both the patient and caregiver. Despite occasional irritability toward visitors, the patient's husband remains supportive, and the family resides locally. No recent falls or abnormal bleeding have been reported. Plans include initiating physical therapy, occupational therapy, and home health aide services to support the patient's rehabilitation and care needs.<o:p></o:p> <o:p> </o:p> Date of Order<o:p></o:p> 09/20/2025
 Order<o:p></o:p> Physician Face-to-Face Date: 09/17/2025
 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's dx: Cutaneous abscess of back [any part except buttock]
 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:<o:p></o:p> Physician: Hans, Jasmin

SN Careplans

SN Goals

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles SN RN on 09/20/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address
Jasmin Hans
1701 Twin Springs Rd
Halethorpe, MD 21227
PHONE: 410-933-79616 FAX: 14109337666 NPI: 1497805147

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 : 09/17/2025

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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SN WK1: 1 (09/20/25-09/20/25) ,WK2: 1 (09/21/25-09/27/25) ,WK3: 2 (09/28/25-10/04/25) ,WK4: 2 (10/05/25-10/11/25) ,WK5: 1 (10/12/25-10/18/25) ,WK6: 1 (10/19/25-10/25/25) ,WK7: 1 (10/26/25-11/01/25) ,WK8: 1 (11/02/25-11/08/25) ,WK9: 1 (11/09/25-11/15/25) ,WK10: 1 (11/16/25-11/18/25)

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, blood pressure systolic ortho-1 < 80 > 80, blood pressure diastolic ortho-1 < 30 > 30

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

HOSPITALIZATION RISKS: 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

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; 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:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M1745 - Behavioral Issues, M1720 - Anxiety, D0160 - Depression, M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, meal preparation, M2020 - Oral Med Management, abnormal blood pressure, abn cholesterol > 200 mg/dL, M1400 - Dyspnea, M1033 - Exhaustion, frequent urination, limited strength, limited endurance, poor muscle tone, muscle weakness, lethargy, withdrawal from conversations, difficulty sleeping, weak hand grips, pain radiating to arms/legs, Pain Interference with ADLs, Pain Interference with Therapy activities, Pain Effect on Sleep, tooth pain/decay/sensitivity, loss of appetite, open sores/lesions, #1 - Other - Posterior Left Shoulder/Upper Back -

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , cough/deep breathing exercises, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, physician-ordered wound care: Wound care, clean right upper back wound with NNS, pat dry, pack with iodoform and cover with form border gauze QD and PRN. Sized at 1x1.3x0.5cm with 90% granulation and 10% slough., monitor intake & output, coordinate/arrange for adequate patient supervision, coordinate/arrange preparation of missing meals

TEACH PATIENT/CAREGIVER: * 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 modification to manage blood condition including dietary changes bleeding precautions, related medication(s) purpose, schedule, * low cholesterol dietary guidelines, 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, * management of mental health condition including joining a peer group maintaining regular contact with mental health professional avoiding known stressors controlling impulses, related medication(s) purpose, schedule, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, related medication(s) purpose, schedule, * how to keep home safe for patient with dementia coping strategies for the caregiver, related medication(s) purpose, schedule, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, 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, * dietary guidelines for managing nutritional deficit, 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 get around like before and walk

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
* how to keep home safe for patient with dementia
* coping strategies for the caregiver
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* depression-prevention strategies including avoidance of isolation
* healthy eating
* sleeping habits
* identification of activities that bring pleasure
* preventive care
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* lifestyle modification to manage blood condition including dietary changes
* bleeding precautions
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* management of mental health condition including joining a peer group
* maintaining regular contact with mental health professional
* avoiding known stressors
* controlling impulses
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* dietary guidelines for managing nutritional deficit
* recalls related medication(s) purpose, schedule

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
* prevention exacerbation of anxiety condition including coping patterns
* improved concentration
* strategies to reduce anxiety
* identification of anxiety precipitants, conflicts, and threats
* 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 self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

caregiver performs medical/rehabilitation treatments with adequate competence

patient/caregiver recalls
* low cholesterol dietary guidelines
* 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

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:
Electronically Signed by Messick, Charles SN RN

Date
09/20/2025

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patient is adequately supervised

meal preparation is available to patient for all meals

meal preparation is available to patient for all meals

Signature of Physician:	Date
	PAGE 3 of 3
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