Home Health Certification and Plan of Care

Order ID: 1150/12513

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
65318699	09/16/2025	From: 09/16/2025 To: 11/14/2025	17458	217058

6. Patient's Name and Address
Janie Johnson
1004 WOODSON ROAD Apt D #00911,
BALTIMORE, MD 21212-
410-323-5690

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 12/11/1944 | **9.Sex** Female

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

Nifedipine - Nifedipine take 60 mg tablet by mouth once a day
Augmentin '125' - Amoxicillin: Clavulanate Potassium 875mg/125mg by mouth twice a day ABX therapy
Tylenol Extra Strength - Acetaminophen 650mg by mouth every 8 hours and as needed for pain
HCTZ/ Lorsartan 50mg/12.5mg by mouth once a day HTN

11. ICD	Principal Diagnosis	Date
N30.01	Acute cystitis with hematuria	09/16/25

13. ICD	Other Pertinent Diagnoses	Date
I89.0	Lymphedema not elsewhere classified	09/16/25
I10.	Essential (primary) hypertension	09/16/25
G47.33	Obstructive sleep apnea (adult) (pediatric)	09/16/25
E78.5	Hyperlipidemia unspecified	09/16/25
E55.9	Vitamin D deficiency unspecified	09/16/25
E66.9	Obesity unspecified	09/16/25

14. DME and Supplies:
wound care supplies, hospital bed, commode, grab bars, reacher, walker, wheelchair

15. Safety Measures:
infectious material management, , , transfer with assist, smoke detectors , supervision at all times, wheelchair precautions, , bathroom safety, activity supervision, ambulates with assistance, ambulates with device

16. Nutrition:
low cholesterol, low sodium

17. Allergies:
penicillamine

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

18.B. Activities Permitted
Wheelchair

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: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No

20. Prognosis: fair

22. A Rehabilitation Potential:
SELF-CARE: 1. Dependent - A helper completed all the activities for the patient., MOBILITY: 1. Dependent - A helper completed all the activities for the patient.

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

Homebound status:
Due to diagnosis of Acute Cystitis With Hematuria , 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 79-year-old female with a past medical history significant for hypertension, lymphedema, obesity, recurrent urinary tract infections including acute cystitis with hematuria, obstructive sleep apnea, hyperlipidemia, vitamin D deficiency, chronic bilateral knee pain with severe limitation in range of motion (right knee 80 flexion, left knee 55), and flexed thoracic spine posture of approximately 45 degrees. She was recently hospitalized for urinary tract infection and discharged home on Augmentin for five days. Current medications include Augmentin, calcium carbonate, acetaminophen extra strength, hydrochlorothiazide/losartan, nifedipine, and vitamin D 50,000 units weekly. Medications were reviewed and confirmed with the patient's PCP, Dr. Nettles, and caregiver. On assessment, the patient is alert and oriented 4, reports no nausea or vomiting, maintains a good appetite, and sleeps well. She reports shortness of breath only with exertion and denies chest pain or palpitations. Physical exam reveals significant lower extremity edema with a wound on the left lower leg measuring 15 6.3 cm with several smaller injury sites, attributed to scratching. Wound care was completed per provider order: cleanse with normal saline, pat dry, apply Xeroform, cover with ABD pad or gauze wrap, and secure with tape. A photograph was obtained for documentation. Additional excoriations were noted due to scratching, exacerbated by dry skin and long nails. Patient and caregiver were instructed on regular moisturizing to reduce skin breakdown and scratching. Hygiene care was provided with assistance from a family friend, Wanda, after patient was found soiled with a large, hardened stool (approximately 8 8 cm). Additional wound care orders were given verbally by Dr. Nettles to apply antibiotic ointment followed by barrier/moisturizing cream to support healing. Functionally, the patient demonstrates profound debility. She was able to transition sit-to-supine and supine-to-sit with supervision. Sit-to-stand transfer required bed height elevation, use of a walker, and moderate assistance. She tolerated standing for 20 seconds with moderate assistance but was unable to ambulate. She is fully dependent for toileting and requires maximal assistance for bathing. She is standby assistance for upper body dressing and dependent for lower body dressing. Bilateral upper extremity weakness and limited left upper extremity range of motion were noted. Tinetti score is 1/28, confirming very high fall risk and homebound status due to taxing effort to leave the home. The patient resides with her blind and immobile husband in a first-floor apartment, where she receives intermittent support from family, neighbors, and a family friend. She reports inability to hire outside help due to financial limitations. Caregiver Wanda reported she will begin a new job next week, raising concern about caregiver coverage for wound care. Education was provided to the patient and caregiver regarding the need for a trained individual to perform wound care, the importance of maintaining dry skin to prevent pressure injuries, and strategies for safe care. The therapist recommended consideration of assisted living due to significant care needs, though the patient declined, stating she does not wish to enter a nursing home. Patient and caregiver were educated on the importance of regular pain medication use to facilitate participation in therapy and improve knee range of motion for transfers. Education was also provided on infection prevention, signs and symptoms of wound infection (fever, chills, redness, swelling, pain, bleeding, drainage, unrelieved pain, nausea, or vomiting), fall prevention strategies, safe transfers, and edema management (lower extremity elevation above the heart during rest, compression garment use if prescribed). Plan includes continuation of skilled nursing for wound care and medication management, initiation of skilled physical and occupational therapy to improve strength, range of motion, functional mobility, and ADL participation, as well as home health aide support for personal care. The patient is homebound due to significant weakness, impaired mobility, high fall risk, and taxing effort required to leave the home. Skilled services remain medically necessary to prevent further decline, promote wound healing, improve safety, and optimize functional independence within the home environment.
 Date of Order 09/16/2025 Orders Physician Face-to-Face Date: 09/12/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN-disease management PT-eval & treat OT-eval & treat hha-adl's due to Acute Cystitis With Hematuria Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home
 1 - SOC - SN Notes: soc PT Eval Notes: <span style="font-size:

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles SN RN on 09/16/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address
Tamischer Nettles
3400 Box Hill Corporate Center Dr
Abingdon, MD 21009
PHONE: 410-515-5440 FAX: 14105155581 NPI: 1285778225

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 : 09/12/2025

27. Attending Physician's Signature and Date Signed **09/29/2025** 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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14px;">OT Eval Notes: Physician Nettles, Tamischer

SN Careplans

SN WK1: 1 (09/16/25-09/20/25) ,WK2: 2 (09/21/25-09/27/25) ,WK3: 2 (09/28/25-10/04/25) ,WK4: 1 (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)

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: 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: Home Safety, Home Safety, M2102d - Caregiver Performs Treatment, M2020 - Oral Med Management, M2102f - Patient Supervision, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, dependent edema, abnormal blood pressure, abn cholesterol > 200 mg/dL, frequent urination, M1600 - UTI, limited range of motion, limited endurance, limited strength, swelling of affected area, muscle weakness, weak hand grips, balance deficit, pain radiating to arms/legs, Pain Interference with ADLs, Pain Interference with Therapy activities, Pain Effect on Sleep, obesity, open sores/lesions, #1 - Open Wound - Posterior Right Thigh - multiple scratched areas, #2 - Open Wound - Anterior Left Below Knee - wound care ordered

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments, physician-ordered wound care: To left lower leg with wound care confirmed by provider. Cleanse with NSS, pat dry, apply Xeroform, apply ABD pad or gauze wrap with gauze wrap secure with tape. Change twice a week and as needed if soiled. To posterior right thigh- Order for cleanse pat dry apply antibiotic ointment then barrier/moisturizing cream for healing per Dr. Nettles. Daily., monitor intake & output, coordinate/arrange for adequate patient supervision, coordinate/arrange preparation of missing meals, coordinate/arrange for maintenance of clean/uncluttered living area

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, * 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, * how to incorporate lifestyle modifications to optimize renal condition including renal-specific diet exercise monitoring of blood pressure blood sugar home, related medication(s) purpose, schedule remedies, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, * prevention including increase fluid intake increase Vitamin C intake to promote acidic bladder environment (cranberry juice) perineal hygiene, related medication(s) purpose, schedule, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, * how to keep journal of food and fluid intake healthy meal plan tips exercise program nutritional knowledge, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient's living environment is clean/uncluttered, insects/rodents not present in the patient's living environment, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver performs medical/rehabilitation treatments with adequate competence

SN Goals

PATIENT-STATED GOAL: to get better

GOALS
patient/caregiver recalls
* how to incorporate lifestyle modifications to optimize renal condition including renal-specific diet
* exercise
* monitoring of blood pressure
* blood sugar
* home
* recalls related medication(s) purpose, schedule remedies

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/caregiver recalls
* prevention including increase fluid intake
* increase Vitamin C intake to promote acidic bladder environment (cranberry juice)
* perineal hygiene
* recalls related medication(s) purpose, schedule

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

patient's living environment is clean/uncluttered

insects/rodents not present in the patient's living environment

patient is adequately supervised

meal preparation is available to patient for all meals

caregiver performs medical/rehabilitation treatments with adequate competence

patient/caregiver recalls
* low cholesterol dietary guidelines
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to keep journal of food and fluid intake
* healthy meal plan tips
* exercise program
* nutritional knowledge
* 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 cardiac condition including symptom management
* diet changes
* regular exercise
* getting enough sleep
* 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 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

Signature of Physician:	Date
	PAGE 2 of 4
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles SN RN	09/16/2025

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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

PT Careplans

PT WK1: 1 (09/16/25-09/20/25) ,WK2: 2 (09/21/25-09/27/25) ,WK3: 2 (09/28/25-10/04/25) ,WK4: 1 (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)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with ADLs, 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 : Sitting knee extension, ankle pumps. Supine hip flexion, bridging, hooklying rotation, straight leg raise, hip abduction., Stretching to bilateral knees , Standing tolerance at walker, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: * 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, Sit to Stand - 04. Supervision or touching assistance, Chair to Bed to Chair - 04. Supervision or touching assistance, Toilet Transfer - 05. Setup or clean-up assistance, Car Transfer - 04. Supervision or touching assistance, Walk 10 Feet - 03. Partial/moderate assistance, Walk 50 ft with 2 Turns - 03. Partial/moderate assistance, Walk 150 Feet - 03. Partial/moderate assistance, 1 - Step (curb) - 03. Partial/moderate assistance, 4 Steps - 03. Partial/moderate assistance, 12 Steps - 03. Partial/moderate assistance, Picking Up Object - 03. Partial/moderate assistance, Bilateral knees 0-90. Initially left 55. Right 80

PT Goals

PATIENT-STATED GOAL: To be able to walk around the house like I used to

GOALS
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

Sit to Stand - 04. Supervision or touching assistance

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

Toilet Transfer - 05. Setup or clean-up assistance

Car Transfer - 04. Supervision or touching assistance

Walk 10 Feet - 03. Partial/moderate assistance

Walk 50 ft with 2 Turns - 03. Partial/moderate assistance

Walk 150 Feet - 03. Partial/moderate assistance

1 - Step (curb) - 03. Partial/moderate assistance

4 Steps - 03. Partial/moderate assistance

12 Steps - 03. Partial/moderate assistance

Picking Up Object - 03. Partial/moderate assistance

Bilateral knees 0-90. Initially left 55. Right 80

OT Careplans

OT WK2: 1 (09/21/25-09/27/25) ,WK3: 1 (09/28/25-10/04/25) ,WK4: 1 (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)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, M1400, 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: ADLs , Bed mobility , Patient/caregiver recalls related purpose and schedule of medications: Medication Review , cough/deep breathing exercises, therapeutic exercises

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, * 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, Oral Hygiene - 05. Setup or clean-up assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Shower/Bathe Self - 03. Partial/moderate assistance, Toileting Hygiene - 03. Partial/moderate assistance, Eating - 06. Independent

OT Goals

PATIENT-STATED GOAL: Patient wants to get stronger

GOALS
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/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

Oral Hygiene - 05. Setup or clean-up assistance

Upper Body Dressing - 05. Setup or clean-up assistance

Shower/Bathe Self - 03. Partial/moderate assistance

Toileting Hygiene - 03. Partial/moderate assistance

Eating - 06. Independent

HHA Careplans

HHA 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: 2 (10/12/25-10/18/25) ,WK6: 2 (10/19/25-10/25/25) ,WK7: 1

HHA Goals

Signature of Physician:

Date

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

Date
09/16/2025

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(10/05/25-10/11/25) ,WK5: 2 (10/12/25-10/18/25) ,WK6: 2 (10/19/25-10/25/25) ,WK7: 1 (10/26/25-11/01/25)

PROCEDURES: assist with bathing: Aide to assist with bed bath on each visit, assist with toileting hygiene: Aide to assist with toileting hygiene on each visit. Patient is bedbound make sure to ask patient if she needs anything before you leave, assist with fall prevention: Assist with teaching on fall precautions, on each visit, assist with lower body dressing: Aide to put on lower body and upper body dressing on each visit after bathing, assist with light housekeeping: Aide to clean area used to work, make bed if clean linens are available

Signature of Physician:	Date
	PAGE 4 of 4
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