Home Health Certification and Plan of Care

Order ID: 1150/12564

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
95323500	09/25/2025	From: 09/25/2025 To: 11/23/2025	14289	217058

6. Patient's Name and Address

Madeline Joyave
4015 Wilkens Ave,
BALTIMORE, MD 21229-
443-251-8543

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 10/25/1954 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
L89.152	Pressure ulcer of sacral region stage 2	09/25/25

13. ICD	Other Pertinent Diagnoses	Date
M54.16	Radiculopathy lumbar region	09/25/25
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	09/25/25
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	09/25/25
N18.32	Chronic kidney disease stage 3b	09/25/25
E11.69	Type 2 diabetes mellitus with other specified complication	09/25/25
E78.49	Other hyperlipidemia	09/25/25
G47.33	Obstructive sleep apnea (adult) (pediatric)	09/25/25
M1A.9XX0	Chronic gout unspecified without tophus (tophi)	09/25/25
F19.90	Other psychoactive substance use unspecified uncomplicated	09/25/25
E66.9	Obesity unspecified	09/25/25
Z68.33	Body mass index [BMI] 33.0-33.9 adult	09/25/25
Z91.81	History of falling	09/25/25
Z85.3	Personal history of malignant neoplasm of breast	09/25/25
Z79.4	Long term (current) use of insulin	09/25/25

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

Tylenol - Acetaminophen 500 mg, Take 2 tablets by mouth every 8 hours Take 2 tablets by mouth every 8 hours as needed for pain
Flonase - Fluticasone Propionate 0.05% inhalant twice a day for allergy
Desitin - Desitin Thin layer topical once a day Apply to left thigh wound.
Acetaminophen And Codeine Phosphate - Acetaminophen: Codeine Phosphate 300 mg;30 mg 1 tab by mouth every 6 hours Prn pain
Singulair - Montelukast Sodium eq 4 mg base 10 mg, Take 1 tablet by mouth once a day "To keep mysinouses draining"
Lipitor - Atorvastatin Calcium eq 10 mg base 10 mg, Take 1 tablet by mouth every other day Take 1 tablet by mouth every other to manage cholesterol
LisinoprilhydroCHLOROthiazide (PRINZIDE/ZESTORETIC) 20-12.5 mg Oral Tab 20-12.5 mg, Take 2 tablets by mouth once a day Take 2 tablets by mouth daily For high blood pressure
Amoxicillin - Amoxicillin 500 mg 500 mg by mouth as necessary " Because I've had 2 knee replacements.I take four capsules before each appointment for my dental cleaning procedures"
Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 125 mcg (1,000 unit), Take 1 tablet by mouth once a day Supplements
Multivit-Minerals-FALycopene-Lutei (CENTRUM SILVER) 0.4 mg-300 mcg- 250 mcg Oral Tab 0.4 mg-300 mcg- 250 mcg, Take 1 tablet by mouth once a day Supplement
Asprin - Aspirin 81mg by mouth once a day Last taken, 2 months ago was instructed by Doctor to discontinue.
Lidoderm - Lidocaine 5 % Top PTMD Patch, Apply 1 patch to skin topical once a day Apply 1 patch to skin daily . May keep patch in place for up to 12 hours in a 24-hour period for back pain

14. DME and Supplies:

wound care supplies, Boardered gauze, medihoney, Normal saline

15. Safety Measures:

bathroom safety, infectious material management, , restricted ROM, , diabetic precautions, ambulates with device, ambulates with assistance, remove environmental barriers, , hand rails, knee precautions, no stair use, cardiac precautions, , activity supervision

16. Nutrition:

17. Allergies:

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles SN RN on 09/25/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address

Abigail Hamilton
1701 Twin Springs Rd
Halthorpe, MD 21227
PHONE: 410-737-5000 FAX: 14107375401 NPI: 1821592817

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 : 09/19/2025

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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cardiac diet, diabetic	no known allergies
18.A. Functional Limitations	18.B. Activities Permitted
Dyspnea With Minimal Exertion, Endurance, Ambulation	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: 2. Sometimes, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No

20. Prognosis: fair

22. A Rehabilitation Potential:	22.B.Discharge Plans
SELF-CARE: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper., MOBILITY: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper.	patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Pressure Ulcer Of Sacral Region Stage 2 , 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 71-year-old female with a significant medical history of type 2 diabetes mellitus, hypertension, hyperlipidemia, chronic kidney disease, radiculopathy, obesity, obstructive sleep apnea, gout, and a history of breast cancer. She also has a history of multiple falls, bilateral total knee replacements, and a recent hospitalization with subsequent subacute rehabilitation secondary to repeated falls and a right hip wound. She currently resides alone in a three-story townhome but has adapted her living space to remain primarily on the first floor, where she spends most of her time on the couch due to her inability to safely climb stairs. She utilizes a bedside commode for toileting needs and reports that she has not showered in over a week because of her fear of falling. On evaluation, the patient is alert, oriented 4, and demonstrates intact cognition without memory deficits. She reports chronic pain, rating it as 4/10 in the right knee and 7/10 in the lower back, with the latter being most bothersome. Pain is managed with acetaminophen as needed. She experienced a recent fall in her home during which she remained on the floor for five days before accessing help, resulting in incontinence and subsequent pressure ulcers on the buttocks. She is unable to manage wound care independently and verbalizes understanding of the need for 24-hour assistance with activities of daily living, expressing willingness to pay privately for support. Friends occasionally check in, but she does not wish to burden them. She demonstrates strong medication knowledge, including the names, purposes, and schedules of her prescribed therapies, and reports good adherence. However, a full bottle of hydroxyzine, not prescribed to her, was found in her home. She admitted it was given by a friend for sleep. She was counseled on the dangers of taking non-prescribed medications and advised to dispose of the hydroxyzine along with any expired or unapproved medications. She reports regular daily bowel movements. Physical examination revealed lungs clear to auscultation, active bowel sounds, and visualization of pressure wounds, with photos uploaded into her chart. Muscle strength testing revealed 4/5 in bilateral upper extremities. Functionally, she ambulates with a rolling walker and requires standby assistance with sit-to-stand and commode transfers, needing verbal cues for limb placement. She requires supervision for upper and lower body dressing and setup assistance for toileting and clothing management. The patient was educated on pain management, fall prevention, wound care needs, and safe medication practices. She was informed that skilled nursing services will continue for wound care, monitoring, and support. Physical therapy will remain involved to address mobility limitations, strength, and safety with functional transfers. The overall plan of care focuses on wound management, pain control, safety in the home, and maximizing independence while ensuring appropriate 24-hour support is in place.
 Date of Order 09/25/2025 Orders Physician Face-to-Face Date: 09/19/2025 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adls due to Pressure Ulcer Of Sacral Region Stage 2 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: OT Eval Notes: Physician Hamilton, Abigail

SN Careplans

SN WK1: 1 (09/25/25-09/27/25) ,WK2: 2 (09/28/25-10/04/25) ,WK3: 2 (10/05/25-10/11/25) ,WK4: 2 (10/12/25-10/18/25) ,WK5: 2 (10/19/25-10/25/25) ,WK6: 1 (10/26/25-11/01/25) ,WK7: 1 (11/02/25-11/08/25) ,WK8: 1 (11/09/25-11/15/25) ,WK9: 1 (11/16/25-11/22/25)

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: 2. Non-agency caregiver(s) need training/supportive services to provide assistance

HOSPITALIZATION RISKS: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 3. Multiple hospitalizations (2 or more) in the past 6 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: M1720 - Anxiety, D0700 - Social Isolation, Home Safety, M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2102c - Med Admin, meal

SN Goals

PATIENT-STATED GOAL: "I want to be able to go upstairs again to be room. I want to be able to get back in the shower.";"I want to be able to go upstairs again to my room. I want to be able to get back in the shower."

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 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
* how to incorporate lifestyle modifications to optimize renal condition including renal-specific diet
* exercise
* monitoring of blood pressure

Signature of Physician:	Date
	PAGE 2 of 4
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles SN RN	09/25/2025

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preparation, M2020 - Oral Med Management, Home Safety, weak pulses in feet, M1400 - Dyspnea, M1033 - Exhaustion, muscle weakness, limited range of motion, limited strength, limited endurance, poor muscle tone, Pain Interference with ADLs, Pain Effect on Sleep, #1 - 2 - Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed. - Other - Right upper buttock - Wound care: Cleanse with normal saline, apply medlhoney and bordered gauze. One time a day., #2 - 3 - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles not exposed. - Other - Right lower buttock - Wound care: Cleanse with normal saline, apply medlhoney and bordered gauze. One time a day., bruising/discoloration, skin breakdown r/t incontinence, red/tender pressure points, open sores/lesions

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, physician-ordered wound care: To right buttock pressure ulcer wounds- Cleanse with normal saline, apply medihoney and bordered gauze. Change daily., monitor intake & output, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange for adequate fire safety devices, coordinate/arrange for maintenance of clean/uncluttered living area, coordinate/arrange long-term socialization activities

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, * 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 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, * how to manage gout flare-ups including non-medical pain relief dietary modifications, 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, * strategies to increase socialization, related medication(s) purpose, schedule, patient home enviroment has adequate fire safety devices, patient's living environment is clean/uncluttered, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

* blood sugar
* home
* recalls related medication(s) purpose, schedule remedies

patient/caregiver recalls
* how to manage gout flare-ups including non-medical pain relief
* dietary modifications
* 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/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

patient/caregiver recalls
* strategies to increase socialization
* recalls related medication(s) purpose, schedule

patient home enviroment has adequate fire safety devices

patient's living environment is clean/uncluttered

patient is adequately supervised

meal preparation is available to patient for all meals

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT WK1: 1 (09/25/25-09/27/25) ,WK2: 1 (09/28/25-10/04/25) ,WK3: 1 (10/05/25-10/11/25) ,WK4: 1 (10/12/25-10/18/25) ,WK5: 1 (10/19/25-10/25/25) ,WK6: 1 (10/26/25-11/01/25) ,WK7: 1 (11/02/25-11/08/25) ,WK8: 1 (11/09/25-11/15/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with ADLs, 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 abduction, hip extension, plantarflexion, squats. Sitting knee extension, ankle pumps , 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, * 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 - 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: To be able to get upstairs to take a shower

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

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

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

12 Steps - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles SN RN

Date

09/25/2025

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Sit to Stand - 04. Supervision or touching assistance

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

Walk 10 Feet - 04. Supervision or touching assistance

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

4 Steps - 04. Supervision or touching assistance

OT Careplans

OT WK2: 1 (09/28/25-10/04/25) ,WK3: 1 (10/05/25-10/11/25) ,WK4: 1 (10/12/25-10/18/25) ,WK5: 1 (10/19/25-10/25/25) ,WK6: 1 (10/26/25-11/01/25) ,WK7: 1 (11/02/25-11/08/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, 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: ADLS , Patient/caregiver recalls related purpose and schedule of medications: Medications Review , cough/deep breathing exercises, transfers training, 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 - 06. Independent, Lower Body Dressing - 06. Independent, Shower/Bathe Self - 03. Partial/moderate assistance, Toileting Hygiene - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Patient will demonstrate improved bilateral upper extremity muscle strength from 4/5 mmt to 5/5 mmt to improve ADLs and transfers within 6 wks

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 - 06. Independent

Lower Body Dressing - 06. Independent

Shower/Bathe Self - 03. Partial/moderate assistance

Toileting Hygiene - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Patient will demonstrate improved bilateral upper extremity muscle strength from 4/5 mmt to 5/5 mmt to improve ADLs and transfers within 6 wks

Signature of Physician:	Date
	PAGE 4 of 4
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles SN RN	09/25/2025