Home Health Certification and Plan of Care

Order ID: 1150/12763

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
751004905	09/30/2025	From: 09/30/2025 To: 11/27/2025	17823	217058

6. Patient's Name and Address

Cheryl Solis
109 Reddish Hill Way,
BROOKLYN, MD 21225-
240-472-9614

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 06/03/1972 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z48.811	Encntr for surgical aftcr fol surgery on the nervous sys	09/30/25

13. ICD	Other Pertinent Diagnoses	Date
I10.	Essential (primary) hypertension	09/30/25
E78.5	Hyperlipidemia unspecified	09/30/25
K80.20	Calculus of gallbladder w/o cholecystitis w/o obstruction	09/30/25
K76.0	Fatty (change of) liver not elsewhere classified	09/30/25
Z86.011	Personal history of benign neoplasm of the brain	09/30/25

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

Keppra - Levetiracetam 500 mg ,Take 1 tablet by mouth twice a day Take 1 tablet (500 mg total) by mouth 2 (two) times daily.
Adalat Cc - Nifedipine 30 mg ,Take 1 tablet by mouth once a day Take 1 tablet (30 mg total) by mouth daily
Pravachol - Pravastatin Sodium 80 mg, Take 1 tablet by mouth at bedtime Take 1 tablet (80 mg total) by mouth nightly
Cozaar - Losartan Potassium 50 mg, Take 1 tablet by mouth once a day Take 1 tablet (50 mg total) by mouth daily.
Tylenol - Acetaminophen 500 mg, Take 2 tablets by mouth every 6 hours Take 2 tablets by mouth every 6 hours for 72 hours
Colace - Docusate Sodium 100 mg, Take 1 capsule by mouth twice a day Take 1 capsule by mouth 2 times a day .
Discontinue once bowel movements are soft and regular
Biscodyl - Bisacodyl: Polyethylene Glycol 3350: Potassium Chloride: Sodium Bicarbonate: Sodium Chloride 17 g by mouth once a day
Zoloft - Sertraline Hydrochloride 50 mg, Take 1 tablet by mouth once a day Take 1 tablet by mouth daily

14. DME and Supplies:
None of the above

15. Safety Measures:
bathroom safety

16. Nutrition:
regular

17. Allergies:
sulfacetamide sulfamethoxazole sulfasalazine

18.A. Functional Limitations
None of the above

18.B. Activities Permitted
No Restrictions, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 0. Never, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes

20. Prognosis: good

22. A Rehabilitation Potential:
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.

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

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles SN RN on 09/30/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address
Kenneth Villar
7670 Quarterfield Road
Glen Burnie, MD 21061
PHONE: FAX: NPI: 1235314436

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 : 09/22/2025

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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Homebound status: Due to diagnosis of Encounter For Surgical Aftercare Following Surgery On The Nervous System, 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 53-year-old female with a past medical history significant for hyperlipidemia and hypertension who was recently discharged home from Johns Hopkins Rehabilitation following a right frontal lobe craniotomy for tumor resection. The patient was initially found down in her home by a family member and subsequently transported to the emergency department, where imaging revealed a large right frontal lobe mass with vasogenic edema and an 11 mm midline shift. A CT of the chest, abdomen, and pelvis also revealed fatty liver and cholelithiasis without cholecystitis. On September 9, 2025, she underwent a right craniotomy with resection of the brain tumor and remained hospitalized for two weeks before being discharged home on September 26, 2025. The patient currently resides in a three-level townhome with her spouse and daughter. She is alone during the day except on Fridays, when her daughter is present for support. The home includes two steps to enter and sixteen steps per level. The patient reports independence with all activities of daily living and demonstrates excellent functional mobility. She ambulates without the use of an assistive device and ascends and descends stairs independently using a reciprocal gait pattern. No history of recent falls is reported. On examination, the patient is alert and oriented 4, denies chest pain, palpitations, dizziness, or shortness of breath. Lung sounds are clear but slightly diminished at the bases. Bowel sounds are normoactive, with a bowel movement reported this morning, and she voids without difficulty. There is no evidence of edema, and pedal pulses are palpable bilaterally. Muscle strength in both upper and lower extremities is 5/5 with no deformity, pronation, or weakness noted. The craniotomy site on the right side of the scalp is well-healed, closed with staples removed, dry, and open to air with no signs of infection or drainage. The patient was educated on incision site monitoring, infection prevention, and signs and symptoms that should prompt immediate medical attention, including fever, drainage, swelling, or neurological changes. She verbalized understanding of all instructions. The plan of care includes continued home health monitoring to ensure wound healing, maintain functional independence, and support a safe transition to full recovery.
 Date of Order 09/30/2025 Orders Physician Face-to-Face Date: 09/22/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN disease management, PR eval and treat, OT eval and treat due to Encounter For Surgical Aftercare Following Surgery On The Nervous System 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: Physician Villar, Kenneth

SN Careplans

SN WK1: 1 (09/30/25-10/04/25) ,WK2: 1 (10/05/25-10/11/25)

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: 3. Multiple hospitalizations (2 or more) in the past 6 months, 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

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:POLST (Physician Orders for Life-Sustaining Treatment)

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2020 - Oral Med Management, M2102f - Patient Supervision, M2102d - Caregiver Performs Treatment, M1400 - Dyspnea, abn cholesterol > 200 mg/dL, abnormal blood pressure, constipation, M1610 - Urinary Catheter, B1000 - Vision Deficit, stoma retraction, #1 - Observable Surgical Wound - Anterior Left Face -

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , cough/deep breathing exercises, incentive spirometer

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, * low cholesterol dietary guidelines, 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, * urinary catheter management including how to flush catheter change and wash drainage bags prevent infection including proper handwashing positioning of catheter, related medication(s) purpose, schedule, * how to keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient is adequately supervised, caregiver performs medical/rehabilitation treatments with adequate competence

SN Goals

PATIENT-STATED GOAL: I want to get back to normal

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

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

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
* 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
* urinary catheter management including how to flush catheter
* change and wash drainage bags
* prevent infection including proper handwashing
* positioning of catheter
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to keep home safe for patient with vision loss including eliminating hazards

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles SN RN	09/30/2025

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hazards
* enhancing lighting
* using mechanical aids

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

patient is adequately supervised

caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT WK1: 1 (09/30/25-10/04/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: 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

09/30/2025

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: gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent

PT Goals

PATIENT-STATED GOAL: No goal

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Walk 10 ft on Uneven Surface - 06. Independent

Signature of Physician:

Date

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

Date
09/30/2025