Home Health Certification and Plan of Care

Order ID: 1150/12851

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
22316255	09/25/2025	From: 09/25/2025 To: 11/22/2025	148	217058

6. Patient's Name and Address

Virginia Laumann
2943 Keswick Rd,
BALTIMORE, MD 21211-
443-854-6231

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 01/03/1957 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
J44.9	Chronic obstructive pulmonary disease unspecified	09/25/25

13. ICD	Other Pertinent Diagnoses	Date
I11.0	Hypertensive heart disease with heart failure	09/25/25
I50.9	Heart failure unspecified	09/25/25
E78.2	Mixed hyperlipidemia	09/25/25
G47.33	Obstructive sleep apnea (adult) (pediatric)	09/25/25
I48.91	Unspecified atrial fibrillation	09/25/25
K21.9	Gastro-esophageal reflux disease without esophagitis	09/25/25
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	09/25/25
F32.A	Depression unspecified	09/25/25
M16.12	Unilateral primary osteoarthritis left hip	09/25/25
E04.1	Nontoxic single thyroid nodule	09/25/25
E55.9	Vitamin D deficiency unspecified	09/25/25
N83.209	Unspecified ovarian cyst unspecified side	09/25/25
R91.1	Solitary pulmonary nodule	09/25/25
E66.9	Obesity unspecified	09/25/25
Z79.01	Long term (current) use of anticoagulants	09/25/25
Z99.81	Dependence on supplemental oxygen	09/25/25
Z87.891	Personal history of nicotine dependence	09/25/25
Z96.1	Presence of intraocular lens	09/25/25

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

Lipitor - Atorvastatin Calcium eq 20 mg base 1 tablet by mouth once a day
Dabigatran Etexilate - Dabigatran Etexilate 150mg; 1 tab by mouth every 12 hours anticoagulant
WIXELA INHUB 250-50 mcg 1 puff inhalant twice a day COPD
Cozaar - Losartan Potassium 100 mg 100MG; 1 TAB by mouth once a day BLOOD PRESSURE
Pantoprazole - Pantoprazole Sodium 20 mg 20MG; 1 TAB by mouth once a day GERD
Spiriva Respimat - Tiotropium Bromide 2.5 mcg, 2 puffs inhalant once a day COPD
Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1 TAB; 5000iu by mouth once a day VITAMIN DEFICIENCY
Albuterol Inhaler - Albuterol 90 MCG; 1-2 PUFFS inhalant every 4 hours AS NEEDED FOR SOB COPD
Lasix - Furosemide 40 mg 40MG; 1 TAB by mouth every other day FLUID PILL

14. DME and Supplies:

bath bench, oxygen supplies

15. Safety Measures:

, , , , ,

16. Nutrition:

fluid restriction, 2gm sodium, 1800CC FLUID RESTRICTION

17. Allergies:

lexapro zoloft

18.A. Functional Limitations

Endurance

18.B. Activities Permitted

Exercises Prescribed

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: fair

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

Homebound status: Due to diagnosis of Chronic Obstructive Pulmonary Disease Unspecified, 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 individual recently hospitalized for an exacerbation of congestive heart failure (CHF). Past medical history is significant for chronic obstructive pulmonary disease (COPD), hypertension, hyperlipidemia, obstructive sleep apnea, atrial fibrillation managed with Pradaxa, gastroesophageal reflux disease (GERD), obesity, vitamin D deficiency, and a history of left total hip replacement. The patient is currently on continuous home oxygen at 3 liters per minute and has been prescribed a fluid restriction of 1800 cc per day. The patient resides in a townhouse with their son, with bedroom and bathroom located on the second floor, and receives assistance from family members with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) as needed. On <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>, the patient was alert and oriented 3, denying pain but reporting shortness of breath with moderate exertion, which resolved with rest. Oxygen saturation was 97% on 3 L of oxygen. The patient demonstrated decreased endurance but was able to ambulate 30 feet indoors twice under supervision without the use of an assistive device. Bed mobility and sit-to-stand transfers from both a sofa and chair were performed with supervision. The patient was also able to negotiate two steps with the use of a railing under supervision. Outdoor mobility and car transfers were not assessed at this visit. The home environment includes two large dogs, which may pose safety considerations during ambulation. Skilled nursing initiated comprehensive CHF education, including instruction on disease management, recognition of early warning signs, adherence to a cardiac diet, and strict fluid restriction compliance. The patient was receptive to all teaching. Physical therapy evaluation identified significant functional limitations, evidenced by a Tinetti score of 16/28, indicating increased fall risk and decreased balance and mobility. The plan of care includes skilled nursing for continued cardiopulmonary <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>, monitoring of oxygen use and fluid balance, and reinforcement of dietary and medication adherence. Physical and occupational therapy are recommended to improve strength, endurance, and functional mobility, enhance safety within the home, and reduce the risk of rehospitalization.
 Date of Order 9/25/2025 Orders Physician Face-to-Face Date: 09/21/2025 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Chronic Obstructive Pulmonary Disease Unspecified 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 Varghese, Sherin

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

Sherin Varghese
2931 Greenspring Drive
Timonium, MD 21093
PHONE: FAX: NPI: 1952471153

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 : 09/21/2025

27. Attending Physician's Signature and Date Signed **10/09/2025**: 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.

Home Health Certification and Plan of Care

Order ID: 1150/12851

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
22316255	09/25/2025	From: 09/25/2025 To: 11/22/2025	148	217058

6. Patient's Name and Address
Virginia Laumann
2943 Keswick Rd,
BALTIMORE, MD 21211-
443-854-6231

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

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: 1 (10/12/25-10/18/25) ,WK5: 1 (10/19/25-10/25/25)

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, 9. Other risk(s) not listed in 1- 8

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: D0160 - Depression, M2020 - Oral Med Management, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, lung sounds not clear, swelling in the arms/legs, limited endurance, bruising/discoloration

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

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage cardiac condition including symptom management diet changes regular exercise getting enough sleep, 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, * strict compliance with physician orders for anticoagulant administration avoiding activities that create unnecessary risk for injury monitoring for prolonged bleeding from cuts, blood in urine or stool, or unusual bruising for warfarin, limiting foods high in Vitamin K, such as leafy green vegetables, * 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 manage inflammatory process optimize mobility with active and passive range of motion exercises fluid and diet intake to promote healing prevent constipation home safety, 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, meal preparation is available to patient for all meals

SN Goals

PATIENT-STATED GOAL: To breathe better and not have swelling

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
* 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
* 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 manage inflammatory process
* optimize mobility with active and passive range of motion exercises
* fluid and diet intake to promote healing
* prevent constipation
* home safety
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* strict compliance with physician orders for anticoagulant administration
* avoiding activities that create unnecessary risk for injury
* monitoring for prolonged bleeding from cuts, blood in urine or stool, or unusual bruising
* for warfarin, limiting foods high in Vitamin K, such as leafy green vegetables

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

meal preparation is available to patient for all meals

PT Careplans

PT 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: 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, 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 - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven Surface - 06. Independent, 1 _ Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent

PT Goals

PATIENT-STATED GOAL: To be able to walk further and not get short of breath

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

Sit to Stand - 04. Supervision or touching assistance

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

Car Transfer - 04. Supervision or touching assistance

Walk 10 Feet - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Signature of Physician:

Date

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

Date
09/25/2025

Home Health Certification and Plan of Care

Order ID: 1150/12851

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
22316255	09/25/2025	From: 09/25/2025 To: 11/22/2025	148	217058

6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number
Virginia Laumann 2943 Keswick Rd, BALTIMORE, MD 21211- 443-854-6231	HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239

Walk 10 ft on Uneven Surface - 06. Independent

1 _ Step (curb) - 06. Independent

4 Steps - 06. Independent

12 Steps - 06. Independent

Picking Up Object - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles SN RN	09/25/2025