Home Health Certification and Plan of Care

Order ID: 1150/13605

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
52606698800	11/01/2025	From: 11/01/2025 To: 12/29/2025	19036	217058

6. Patient's Name and Address
Tanisha Clendenin
3625 Coolidge Ave,
Baltimore, MD 21229-
516-405-9952

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 06/14/1980 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
K70.31	Alcoholic cirrhosis of liver with ascites	11/01/25

13. ICD	Other Pertinent Diagnoses	Date
B18.1	Chronic viral hepatitis B without delta-agent	11/01/25
J45.998	Other asthma	11/01/25
G43.909	Migraine unsp not intractable without status migrainosus	11/01/25
D69.49	Other primary thrombocytopenia	11/01/25
K76.82	Hepatic encephalopathy	11/01/25
D69.6	Thrombocytopenia unspecified	11/01/25
D64.89	Other specified anemias	11/01/25
E44.1	Mild protein-calorie malnutrition	11/01/25
F10.10	Alcohol abuse uncomplicated	11/01/25
R60.1	Generalized edema	11/01/25
E66.9	Obesity unspecified	11/01/25
Z68.35	Body mass index [BMI] 35.0-35.9 adult	11/01/25
Z87.01	Personal history of pneumonia (recurrent)	11/01/25

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

Metoprolol Tartrate - Metoprolol Tartrate 25 mg 25 MG Oral Tablet,Take 0.5 tablet by mouth twice a day for HTN Holf for SBP <100
Protonix - Pantoprazole Sodium eq 40 mg base 40 MG Oral Tablet,Take 1 tablet by mouth every 12 hours for Gerd
Tramadol Hcl - Tramadol Hydrochloride 50 MG Oral Table,Take 25 mg by mouth every 6 hours as needed for pain
Lactulose - Lactulose 20mg/ml; 60ml by mouth once a day laxative
Gabapentin - Gabapentin 100 mg 100 MG Oral Tablet,Take 1 tablet by mouth once a day for neuropathic pain
Folic Acid - Folic Acid 1 mg 1 MG Oral Tablet,Take 1 tablet by mouth once a day for Supplement/anemia
Aldactone - Spironolactone 50 mg 50 MG Oral Tablet,Take 1 tablet by mouth once a day for fluid retention
Furosemide - Furosemide 40 mg 40 MG Oral Tablet, Take 1 tablet by mouth once a day for Cirrhosis of Liver with Ascites.

14. DME and Supplies:
commode, grab bars, bath bench, walker

15. Safety Measures:
ambulates with device, walker precautions, , ambulates with assistance, transfer with assist, supervision at all times, activity supervision

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
penicillin coconut

18.A. Functional Limitations
Ambulation, Endurance

18.B. Activities Permitted
Up As Tolerated, Walker, 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: No

20. Prognosis: poor

22. A Rehabilitation Potential:
SELF-CARE: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities., MOBILITY: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities.

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

Homebound status:
Due to diagnosis of Alcoholic Cirrhosis Of Liver With Ascites, 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 45-year-old individual recently discharged from inpatient care following management of fluid overload and anasarca secondary to decompensated cirrhosis with significant third spacing. The patient was also treated for pneumonia during hospitalization. Past medical history is significant for alcoholic versus hepatitis B-related cirrhosis, chronic anemia, thrombocytopenia, migraines, and obesity. Notably, there is a history of medication noncompliance since May 2025. The patient resides at home with their spouse, who assists with all activities of daily living (ADLs) and instrumental activities of daily living (IADLs). On assessment, the patient was alert and oriented 3, reporting bilateral foot pain attributed to lower extremity edema and neuropathic pain in the hands. The patient also reported shortness of breath associated with abdominal distention and ascites, which is relieved when sitting upright. Lung sounds were diminished bilaterally. Physical examination revealed left upper extremity swelling and +3 pitting edema in both lower extremities. The patient ambulates short distances using a walker for support and demonstrates limited endurance due to fluid overload and deconditioning. Medication reconciliation was completed, and all medications were reviewed for correct dosage, frequency, and potential side effects. The skilled nurse provided education regarding the importance of medication adherence, fluid and sodium restriction, daily weight monitoring, and early recognition of complications associated with liver disease, including worsening ascites, confusion, jaundice, and bleeding tendencies. The patient and spouse verbalized understanding of the teaching provided and demonstrated receptiveness to ongoing education. The current plan of care includes skilled nursing <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-9 CE-FMS-visits">visits</mh> at a frequency of 1w1, 2w2, 1w3 to monitor cardiopulmonary status, medication compliance, fluid retention, and overall disease management. Physical and occupational therapy evaluations were ordered to address mobility limitations, strengthen endurance, and improve safety with ADLs. Skilled nursing will continue to reinforce teaching regarding liver disease management, monitor for signs of hepatic decompensation, and coordinate with the interdisciplinary team to optimize the patient's overall functional status and prevent rehospitalization.
 Date of Order 11/01/2025 Orders Physician Face-to-Face Date: 10/14/2025 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Alcoholic Cirrhosis Of Liver With Ascites 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
 Physician Modjo Kenmogne, Leopoldine

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 11/01/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address
Leopoldine Modjo Kenmogne
3001 Hospital Dr
Cheverly, MD 20785
PHONE: 410-737-5000 FAX: 14107375401 NPI: 1114312444

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 : 10/14/2025

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 Careplans

SN WK1: 1 (11/01/25-11/01/25) ,WK3: 2 (11/09/25-11/15/25) ,WK4: 1 (11/16/25-11/22/25) ,WK5: 1 (11/23/25-11/29/25) ,WK6: 1 (11/30/25-12/06/25)

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: 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, 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:POLST (Physician Orders for Life-Sustaining Treatment)

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, Home Safety, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, dependent edema, lung sounds not clear, swelling in the arms/legs, muscle weakness, swelling of affected area, limited strength, limited endurance, Pain Effect on Sleep, Pain Interference with ADLs, balance deficit, weak hand grips

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , cough/deep breathing exercises, monitor intake & output, 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, * 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, * 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, * dietary guidelines for managing nutritional deficit, related medication(s) purpose, schedule, * dietary modifications for liver disorder, related medication(s) purpose, schedule, * how to help resolve infection including hygiene proper hand washing food-safety techniques travel precautions vaccinations animal-control cough etiquette, 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's living environment is clean/uncluttered, meal preparation is available to patient for all meals

SN Goals

PATIENT-STATED GOAL: TO BE ABLE TO GET AROUND BETTER

GOALS
patient/caregiver recalls
* dietary modifications for liver disorder
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to help resolve infection including hygiene
* proper hand washing
* food-safety techniques
* travel precautions
* vaccinations
* animal-control
* cough etiquette
* 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
* dietary guidelines for managing nutritional deficit
* 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
* 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

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's living environment is clean/uncluttered

meal preparation is available to patient for all meals

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	11/01/2025