Home Health Certification and Plan of Care

Order ID: 1150/13784

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
36563048	11/06/2025	From: 11/06/2025 To: 01/04/2026	19094	217058

6. Patient's Name and Address

Mitzi Ingrao
1234 Patapsco Street APT 18,
Baltimore, MD 21230-
410-350-6938

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 11/05/1947 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
I44.2	Atrioventricular block complete	11/06/25

13. ICD	Other Pertinent Diagnoses	Date
I13.0	Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny	11/06/25
I50.22	Chronic systolic (congestive) heart failure	11/06/25
N18.9	Chronic kidney disease u	11/06/25
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	11/06/25
J44.9	Chronic obstructive pulmonary disease unspecified	11/06/25
I35.0	Nonrheumatic aortic (valve) stenosis	11/06/25
D33.3	Benign neoplasm of cranial nerves	11/06/25
I44.7	Left bundle-branch block unspecified	11/06/25
E78.5	Hyperlipidemia unspecified	11/06/25
F32.9	Major depressive disorder single episode unspecified	11/06/25
F41.9	Anxiety disorder unspecified	11/06/25
M54.9	Dorsalgia unspecified	11/06/25
G89.29	Other chronic pain	11/06/25
G47.00	Insomnia unspecified	11/06/25
E66.9	Obesity unspecified	11/06/25
Z68.36	Body mass index [BMI] 36.0-36.9 adult	11/06/25
Z95.0	Presence of cardiac pacemaker	11/06/25
Z85.3	Personal history of malignant neoplasm of breast	11/06/25
Z90.13	Acquired absence of bilateral breasts and nipples	11/06/25
Z79.82	Long term (current) use of aspirin	11/06/25
Z87.891	Personal history of nicotine dependence	11/06/25

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

Albuterol - Albuterol 2.5 mg/3 mL (0.083%) inhalation solution inhalant every 6 hours PRN for wheezing
Aspirin - Aspirin 81 mg oral tablet by mouth once a day
Cyclobenzaprine - Cyclobenzaprine Hydrochloride 5 mg oral tablet, 1 tablet by mouth three times a day PRN muscle spasm
fluticasone-vilanterol 100 mcg-25 mcg inhalation powder), take 1 puff inhalant once a day
Nifedipine Er - Nifedipine 30 mg tablet, Take 1 tablet by mouth once a day
Omeprazole - Omeprazole 40 mg oral capsule, Take 1 capsule by mouth once a day
Polyethylene Glycol 3350 - Polyethylene Glycol 3350 17 gm oral powder by mouth once a day for reconstitution
rosuvastatin 20 mg oral tablet, Take 1 tablet by mouth once a day
Entresto - Sacubitril: Valsartan 24 mg-26 mg Tab, Take 1 tablet by mouth twice a day for 90 Day(s)
Sertraline - Sertraline Hydrochloride 100 mg oral tablet,Take 1 tablet by mouth once a day
Torsemide - Torsemide 20 mg oral tablet, Take 1 tablet by mouth once a day
Zolpidem - Zolpidem Tartrate 10 mg oral tablet, Take 1 tablet by mouth at bedtime PRN as needed for sleep
empagliflozin 10 mg oral tablet, take 1 tablet by mouth as necessary qAM for 90 Day(s)
Metoprolol - Hydrochlorothiazide: Metoprolol Succinate 25 mg oral tablet, take 1 tablet by mouth once a day
Oxycodone Hydrochloride - Oxycodone Hydrochloride 10 mg 1 tab by mouth four times a day

14. DME and Supplies:

rolling walker, , 4 wheeled walker

15. Safety Measures:

ambulates with assistance, ambulates with device, bathroom safety, emergency phone # clearly displayed, , , medical alert/lifeline, no bp left arm, restricted ROM

16. Nutrition:

low sodium, fluid restriction, cardiac diet

17. Allergies:

avelox codeine morphine sulfa drugs

18.A. Functional Limitations

Ambulation, Dyspnea With Minimal Exertion

18.B. Activities Permitted

Walker

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: 2. Sometimes, 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: 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 Atrioventricular Block Complete, 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 78-year-old female, status post pacemaker replacement, with a complex medical history significant for congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), stent placement, chronic kidney disease (CKD), myocardial infarction (MI), hyperlipidemia, bilateral mastectomy for breast cancer, benign neoplasm of cranial nerves, aortic valve stenosis, left-sided sciatic nerve pain, chronic back and neck pain, depression, and anxiety. She was discharged home on October 29, 2025, following pacemaker revision and currently presents for post-acute home health evaluation. The patient is alert and oriented 4 and resides alone in an elevator-accessible apartment. She is homebound due to the significant effort required to leave her residence, as evidenced by a Tinetti balance score of 16/28, indicating an elevated fall risk. The patient ambulates 30 feet on level indoor surfaces without an assistive device but requires supervision for safety. Transfers to bed, chair, and toilet, as well as bed mobility, are performed with supervision. Outdoor mobility, stair negotiation, and car transfers were not assessed at this time. She demonstrates decreased strength and endurance, contributing to limited functional mobility and reduced independence in daily activities. On <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>, lung sounds were clear, bowel sounds were present, and no peripheral edema was noted. The right upper chest incision from the pacemaker change was covered with Steri-Strips and appeared intact without signs of infection. A stent was observed in the right groin area. The patient was instructed to avoid all procedures on the left arm, including blood pressure measurement and blood draws, to prevent complications associated with her pacemaker placement. She is hard of hearing and uses hearing aids. The patient performed therapeutic exercises including 10 repetitions each of supine hip flexion, bridging, hooklying trunk rotation, straight leg raises, hip abduction, and standing exercises-knee flexion, hip abduction, hip extension, plantar flexion, and squats. Written instructions were provided, and she was advised to perform the home exercise program daily to promote strength, endurance, and functional mobility. The patient performs basic self-care activities independently but requires increased time and demonstrates reduced safety awareness. Occupational therapy evaluation determined that she would benefit from continued skilled OT services once weekly for four weeks (1w4) focused on activities of daily living (ADL) retraining, energy conservation strategies,

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 11/06/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address

Robert Dart Jr
1420 Key Highway
Baltimore, MD 21230
PHONE: 4102307800 FAX: 14102307801 NPI: 1790779700

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 : 10/24/2025

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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adaptive equipment use, therapeutic exercises, home exercise program instruction, functional mobility enhancement, and safety education. The plan of care includes ongoing nursing oversight to monitor incision healing, reinforce pacemaker precautions, and assess for cardiopulmonary stability. Continued physical and occupational therapy are recommended to improve strength, balance, endurance, and independence in ADLs, while minimizing fall risk and preventing hospital readmission. The patient verbalized understanding of all education provided and agreed with the established plan of care.
 Date of Order 11/06/2025 Orders Physician Face-to-Face Date: 10/24/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN disease management, PR eval and treat, OT eval and treat due to Atrioventricular Block Complete 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 Dart Jr, Robert

SN Careplans

SN WK1: 1 (11/06/2025 - 11/08/2025), WK2: 1 (11/09/2025 - 11/15/2025), WK3: 1 (11/16/2025 - 11/22/2025)

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: 0. No assistance needed - patient is independent or does not have needs in this area

HOSPITALIZATION RISKS: 3. Multiple hospitalizations (2 or more) in the past 6 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, 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:Living Will

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, D0700 - Social Isolation, M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2020 - Oral Med Management, A1250 - Lack of Necessary Transportation, M1400 - Dyspnea, M1033 - Exhaustion, M1610 - Urinary Incontinence, muscle weakness, limited endurance, limited range of motion, limited strength, Pain Interference with ADLs, Pain Effect on Sleep, difficulty sleeping, weak hand grips, lethargy, balance deficit, B0200 - Hearing Deficit

PROCEDURES: MEDICATION REVIEW: MEDICATIONS REVIEWED WITH PATIENT., cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments, monitor intake & output, coordinate/arrange for adequate patient supervision, coordinate/arrange home modifications for hearing impaired, i.e. alarms, coordinate/arrange transportation services

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 optimize mental status with cognition therapy home safety optimize mobility with active and passive range of motion therapeutic exercises diet and fluids to optimize peripheral circulation, 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 manage sleep disorder including changes to daytime habits and bedtime routine maintaining a journal to track sleep patterns, 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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpose, schedule, * urinary incontinence management including bladder training Kegel exercises skin care, 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 home safe for hearing-impaired including installing special fire-detector/CO2 alarms, 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's transportation needs are met, patient is adequately supervised, caregiver performs medical/rehabilitation treatments with adequate competence, MEDICATION REVIEW

SN Goals

PATIENT-STATED GOAL: I want to be able to stay out of the hospital.

GOALS
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 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
* how to optimize mental status with cognition therapy
* home safety
* optimize mobility with active and passive range of motion therapeutic exercises
* diet and fluids to optimize peripheral circulation
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* low cholesterol dietary guidelines
* 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
* 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
* 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 manage sleep disorder including changes to daytime habits and bedtime routine
* maintaining a journal to track sleep patterns
* recalls related medication(s) purpose, schedule

patient/caregiver recalls

Signature of Physician:	Date
	PAGE 2 of 4
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	11/06/2025

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patient/caregiver recalls
* urinary incontinence management including bladder training
* Kegel exercises
* skin care
* 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's transportation needs are met

patient is adequately supervised

caregiver performs medical/rehabilitation treatments with adequate competence

MEDICATION REVIEW

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 keep home safe for hearing-impaired including installing special fire-detector/CO2 alarms
* recalls related medication(s) purpose, schedule

PT Careplans

PT WK1: 1 (11/06/25-11/08/25)

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, Bed mobility training , Dynamic and static standing balance training, 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 - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, 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: Be able to get out by Uber and go where I want

GOALS
Chair to Bed to Chair - 06. Independent

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

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

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

Signature of Physician:

Date

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

Date
11/06/2025

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Picking Up Object - 04. Supervision or touching assistance

OT Careplans

OT WK1: 1 (11/06/25-11/08/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with ADLs, 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: cough/deep breathing exercises, incentive spirometer, equipment training, work simplification/energy conservation

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 - 06. Independent, Toileting Hygiene - 05. Setup or clean-up assistance, Don/Doff Footwear - 06. Independent, Eating - 06. Independent

OT Goals

PATIENT-STATED GOAL: "To not get SOB. "

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 - 06. Independent

Toileting Hygiene - 05. Setup or clean-up assistance

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

HHA Careplans

HHA WK1: 3 (11/06/25-11/08/25)

PROCEDURES: assist with bathing: Assist with shower in tub on seat, assist with transferring, assist with mobility: Supervision with or without device, assist with infection control, assist with fall prevention, assist with assistive devices prn: As neede, assist with assistive devices prn: As needed, assist with lower body dressing: As neede

HHA Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

11/06/2025