Home Health Certification and Plan of Care

Order ID: 1150/13950

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
83143192	11/12/2025	From: 11/12/2025 To: 01/10/2026	19241	217058

6. Patient's Name and Address
Mary McClain
2640 Pennsylvania Ave Apt 127,
BALTIMORE, MD 21217-
443-452-0368

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 09/07/1948 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
M62.82	Rhabdomyolysis	11/12/25

13. ICD	Other Pertinent Diagnoses	Date
R82.81	Pyuria	11/12/25
B95.2	Enterococcus as the cause of diseases classified elsewhere	11/12/25
T14.8XXD	Other injury of unspecified body region subs	11/12/25
E11.9	Type 2 diabetes mellitus without complications	11/12/25
I10.	Essential (primary) hypertension	11/12/25
M50.30	Other cervical disc degeneration unsp cervical region	11/12/25
E78.5	Hyperlipidemia unspecified	11/12/25
Z91.81	History of falling	11/12/25

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

Tylenol #3 - Acetaminophen: Codeine Phosphate 300-30 mg, Take 1 tablet by mouth every 6 hours Take 1 tablet by mouth every 6 hours as needed for pain This is for short term use.
Acetaminophen - Acetaminophen 650 mg, Take 2 tablets by mouth every 8 hours Take 2 tablets by mouth every 8 hours, as needed, for pain
Lidocaine - Lidocaine 4 % Top, Apply 1 patch topical twice a day

14. DME and Supplies:
walker

15. Safety Measures:
ambulates with device, , , bedrails up while in bed, , ambulates with assistance, activity supervision, bathroom safety, transfer with assist, walker precautions, supervision at all times,

16. Nutrition:
diabetic, low cholesterol, low sodium,

17. Allergies:
lasix percocet

18.A. Functional Limitations
Bowel/Bladder Incontinence, Endurance, Ambulation

18.B. Activities Permitted
Walker

19. Mental & Pyschosocial Status: COGNITION: 1. Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 1. Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required!2. Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions, HISTORY OF DEPRESSION: No

20. Prognosis: fair

22. A Rehabilitation Potential:
SELF-CARE: 1. Dependent - A helper completed all the activities for the patient., MOBILITY: 1. Dependent - A helper completed all the activities for the patient.

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

Homebound status: Due to diagnosis of Rhabdomyolysis, 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 77-year-old female with a significant medical history of rhabdomyolysis, type 2 diabetes mellitus, hypertension, hyperlipidemia, pyuria, degenerative disc disease, a history of enterococcus infection, and recurrent falls, including three falls within the past six months, the most recent occurring on 10/31/25. She has experienced a notable functional decline since that event and is currently staying with her sister Beatrice and nephew in the city for supervision and assistance, as she requires continuous support for ambulation, transfers, and safety, making it a taxing effort for her to leave the home. The patient is alert and oriented 3 but speaks slowly and exhibits intermittent confusion and forgetfulness. She is currently non-ambulatory per caregivers and requires moderate to maximal assistance for mobility tasks, including rolling, supine-to-sit transitions, and brief standing. She tolerated sitting at the edge of the bed for 2 minutes with close supervision and required moderate assistance for standing for approximately 20 seconds 2 trials; ambulation was not assessed. The patient has a painful sacral/buttock wound with minimal serosanguineous drainage, currently treated with barrier cream containing zinc and covered with a foam border dressing; additional incontinence care and pressure-relief education were provided. The caregiver is managing wound photography for progression and declined additional photos due to patient comfort. The patient also has a healed right lower leg wound that resolved with prior wound care. She reports pain in the sacral area rated 5/10, and available medications include Tylenol #3, lidocaine patches, and tramadol 50 mg. Medications were reviewed with the caregiver; no somatic medications are present in the home. The patient was seen by her primary care provider the previous day, and per the caregiver, imaging of the brain has been ordered due to concerns for a possible neurological event. The patient uses a hospital bed and walker; however, no bathroom assistive devices are in place due to her inability to walk. Caregivers report a good appetite, supplemented with nutritional drinks as needed. Last bowel movement was today, and no abnormal bleeding or lung abnormalities were noted. Education was provided regarding pressure relief, safe mobility, and avoiding over-assistance; it was recommended that the sister reposition the bed to allow space for a chair at bedside and to facilitate sitting at the edge of the bed several times daily. The patient completed five repetitions each of hip flexion, bridging, hooklying rotation, straight leg raises, and hip abduction with active-assisted range of motion to both lower extremities. She remains homebound due to significant effort and assistance required to leave the residence. Skilled nursing is ordered at 2w2 and 1w4, and physical therapy, occupational therapy, and home health aide services have also been initiated to address strength, mobility, safety, and wound care needs.
 Date of Order 11/12/2025 Orders Physician Face-to-Face Date: 11/03/2025 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Rhabdomyolysis 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: eval OT Eval Notes: eval
 Physician Dicocco, Eva

SN Careplans | **SN Goals**

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 11/12/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address
Eva Dicocco
7141 Security Blvd
Woodlawn, MD 21244
PHONE: 443-663-6000 FAX: 14436636215 NPI: 1598990624

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 : 11/03/2025

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 WK1: 1 (11/12/25-11/15/25) ,WK2: 2 (11/16/25-11/22/25) ,WK3: 2 (11/23/25-11/29/25) ,WK4: 1 (11/30/25-12/06/25) ,WK5: 1 (12/07/25-12/13/25) ,WK6: 1 (12/14/25-12/20/25)

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: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 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, 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: M1745 - Behavioral Issues, M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, meal preparation, M2020 - Oral Med Management, M1033 - Exhaustion, M1400 - Dyspnea, abnormal blood pressure, abn cholesterol > 200 mg/dL, abnormal BS < 70/140 > mg/dL, M1610 - Urinary Incontinence, muscle weakness, poor muscle tone, limited endurance, limited strength, weak hand grips, balance deficit, daytime fatigue, impaired speech, Pain Interference with ADLs, Pain Interference with Therapy activities, Pain Effect on Sleep, loss of appetite, bruising/discoloration, red/tender pressure points, open sores/lesions, #1 - 1 - Intact skin with non-blanchable redness of a localized area usually over a bony prominence. - Other - sacral - cleanse, pat dry, apply barrier cream with zinc and cover with foam border gauze

PROCEDURES: cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, physician-ordered wound care: sacral wound cleanse pat dry apply barrier cream/ ointment cover with foam border gauze, daily and as needed., glucose testing via monitor, bladder training, coordinate/arrange for adequate patient supervision

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, * 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, * management of mental health condition including joining a peer group maintaining regular contact with mental health professional avoiding known stressors controlling impulses, 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, * diabetic medication management blood sugar testing diabetic foot care exercise diabetic diet, related medication(s) purpose, schedule, * how to promote optimized mobility with strength balance dexterity range-of-motion therapeutic exercises promotion of peripheral circulation fluid and diet intake to promote healing prevent constipation, related medication(s) purpose, schedule, * urinary incontinence management including bladder training Kegel exercises skin care, 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, * pain control therapeutic exercises for muscle strengthening and flexibility diet and fluids to optimize and prevent constipation, related medication(s) purpose, schedule, * pain control therapeutic exercises to optimize range of motion of affected area diet and fluids to promote healing, 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 is adequately supervised, meal preparation is available to patient for all meals, caregiver performs medical/rehabilitation treatments with adequate competence

PATIENT-STATED GOAL: caregiver states she would like patient to return to baseline, "being active"

GOALS
patient/caregiver recalls
* pain control
* therapeutic exercises for muscle strengthening and flexibility
* diet and fluids to optimize and prevent constipation
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* pain control
* therapeutic exercises to optimize range of motion of affected area
* diet and fluids to promote healing
* recalls related medication(s) purpose, schedule

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 promote optimized mobility with strength
* balance
* dexterity
* range-of-motion therapeutic exercises
* promotion of peripheral circulation
* fluid and diet intake to promote healing
* prevent constipation
* 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
* 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 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 incontinence management including bladder training
* Kegel exercises
* skin care
* recalls related medication(s) purpose, schedule

caregiver performs medical/rehabilitation treatments with adequate competence

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
* diabetic medication management
* blood sugar testing
* diabetic foot care
* exercise
* diabetic diet

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	11/12/2025

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* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* management of mental health condition including joining a peer group
* maintaining regular contact with mental health professional
* avoiding known stressors
* controlling impulses
* 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 is adequately supervised

meal preparation is available to patient for all meals

PT Careplans

PT WK1: 1 (11/12/25-11/15/25) ,WK3: 1 (11/23/25-11/29/25) ,WK4: 2 (11/30/25-12/06/25) ,WK5: 2 (12/07/25-12/13/25) ,WK6: 1 (12/14/25-12/20/25) ,WK7: 1 (12/21/25-12/27/25) ,WK8: 1 (12/28/25-01/03/26) ,WK9: 1 (01/04/26-01/10/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with ADLs, 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,. Sitting knee extension, ankle pumps, Bed mobility training , Standing tolerance at walker, gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: * 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 - 03. Partial/moderate assistance, Chair to Bed to Chair - 03. Partial/moderate assistance, Toilet Transfer - 04. Supervision or touching assistance, Car Transfer - 03. Partial/moderate assistance, Walk 10 Feet - 03. Partial/moderate assistance, Walk 50 ft with 2 Turns - 03. Partial/moderate assistance, Walk 150 Feet - 03. Partial/moderate assistance, 1 - Step (curb) - 03. Partial/moderate assistance, 4 Steps - 03. Partial/moderate assistance, 12 Steps - 03. Partial/moderate assistance, Picking Up Object - 03. Partial/moderate assistance

PT Goals

PATIENT-STATED GOAL: I would like to be able to get out of bed

GOALS
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 - 03. Partial/moderate assistance

Chair to Bed to Chair - 03. Partial/moderate assistance

Toilet Transfer - 04. Supervision or touching assistance

Car Transfer - 03. Partial/moderate assistance

Walk 10 Feet - 03. Partial/moderate assistance

Walk 50 ft with 2 Turns - 03. Partial/moderate assistance

Walk 150 Feet - 03. Partial/moderate assistance

1 - Step (curb) - 03. Partial/moderate assistance

4 Steps - 03. Partial/moderate assistance

12 Steps - 03. Partial/moderate assistance

Picking Up Object - 03. Partial/moderate assistance

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	11/12/2025