

Home Health Certification and Plan of Care				Order ID: 1150/13222					
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period		4. Medical Record No.		5. Provider No.	
30440192530		10/16/2025		From: 10/16/2025 To: 12/13/2025		1062		217058	
6. Patient's Name and Address					7. Provider's Name, Address and Telephone Number				
Rena Ross 1715 E. Eager Street Apt 201, BALTIMORE, MD 21205- 443-869-5685					HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239				
8. DOB 06/20/1953 9.Sex Female					10. Medications: Dose/Frequency/Route (N)ew (C)hanged				
11. ICD J44.1	Principal Diagnosis Chronic obstructive pulmonary disease w (acute) exacerbation			Date 10/16/25	Meclizine - Meclizine Hydrochloride 25mg, 1 tablet by mouth every 12 hours as needed aerochamber plus flo-vu large inhale inhalant as necessary miscellaneous use as directed with inhalers Vitamin C - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpantenol: Folic Acid: Niacinamide: Pyridox 500mg, 2 capsule by mouth once a day Colace - Docusate Sodium 100mg, 1 capsule by mouth once a day trelegy ellipta 100-62.5-25 by mouth once a day Senna - Senna 8.6mg, 2 tablet by mouth at bedtime as needed orally once a day Losartan Potassium - Losartan Potassium 50mg, 1 tablet by mouth once a day Sertraline Hcl - Sertraline Hydrochloride 50mg, 1 tablet by mouth once a day Atorvastatin - Atorvastatin Calcium 40mg,1 tablet by mouth once a day cholecalciferol 50mcg(2000 units),1 capsule by mouth once a day gemtesa 75mg, 1 tablet by mouth once a day Albuterol Sulfate - Albuterol Sulfate 108(90base)mcg, 1 puff inhalant every 4 hours flonase sensimist 2 spray Nasal once a day suspension 2 sprays (1 spray in each nostril) nasally once a day, notes to pharamacist pt has dexterity issue, we would like to switch to this semsimit from her previous nasal spray Aspirin 81Mg - Aspirin 81mg by mouth once a day chewable chew and swallow one tablet daily Oxygen - Oxygen 2-3 l inhalant continuous Amlodipine - Amlodipine Besylate 5 mg by mouth once a day Astelin - Azelastine Hydrochloride 0.1% inhalant in the morning 2 sprays in each nostril 2x daily Lopressor - Metoprolol Tartrate 25mg by mouth twice a day For BP Montelukast Sodium - Montelukast Sodium 10mg, 2tablet by mouth at bedtime Extra Strength Tylenol - Acetaminophen 500 mg by mouth as necessary				
13. ICD J96.22 J96.21 I10. I25.10 I69.351 N32.81 M81.0 D64.9 M19.90 J30.9 K59.00 Z79.51 Z79.82 Z99.81 Z87.891	Other Pertinent Diagnoses Acute and chronic respiratory failure with hypercapnia Acute and chronic respiratory failure with hypoxia Essential (primary) hypertension AthscI heart disease of native coronary artery w/o ang pctrs Hemiplga following cerebral infrc aff right dominant side Overactive bladder Age-related osteoporosis w/o current pathological fracture Anemia unspecified Unspecified osteoarthritis unspecified site Allergic rhinitis unspecified Constipation unspecified Long term (current) use of inhaled steroids Long term (current) use of aspirin Dependence on supplemental oxygen Personal history of nicotine dependence			Date 10/16/25 10/16/25 10/16/25 10/16/25 10/16/25 10/16/25 10/16/25 10/16/25 10/16/25 10/16/25 10/16/25 10/16/25 10/16/25 10/16/25 10/16/25 10/16/25 10/16/25 10/16/25					
14. DME and Supplies: oxygen supplies, wheelchair, rolling walker					15. Safety Measures: walker precautions, restricted ROM, , ambulates with device, ambulates with assistance, wheelchair precautions, , activity supervision, bathroom safety, hand rails				
16. Nutrition: Z. NO PHYSICIAN-ORDERED DIET					17. Allergies: no known allergies				
18.A. Functional Limitations Endurance, Bowel/Bladder Incontinence, Ambulation					18.B. Activities Permitted Exercises Prescribed, Up As Tolerated				
19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 2. Sometimes, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No									
20. Prognosis: fair									
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 Chronic Obstructive Pulmonary Disease With Exacerbation , 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: <div>The patient is a 72-year-old female, alert and oriented 3, who presents as pleasant and cooperative. She resides alone in an apartment and receives daily assistance from a home health aide in the mornings for bathing and activities of daily living (ADLs). Her significant medical history includes aortic dissection, asthma, arthritis, chronic obstructive pulmonary disease (COPD), hypertension, left cerebrovascular accident (CVA) with right hemiparesis, anemia, and osteoarthritis. She was recently hospitalized for COPD with acute and chronic respiratory failure. During the visit, the patient reported nasal congestion, predominantly in the left nostril, causing breathing difficulty. It was noted that she had not been consistently using her prescribed nasal sprays; education was provided on proper and regular use, and she verbalized understanding. She also complained of right wrist pain with limited ability to maintain wrist extension, reporting increased discomfort during movement. The patient requested a wrist brace for stabilization and pain relief. Additionally, she described a sore area on her mid-lower back, attributed to pressure from a hospital bed during her recent admission. The area was noted to be mildly reddened without open lesions or drainage; a skin barrier cream and padding were applied by the caregiver for protection and comfort. On observation, the patient was seated comfortably, in no acute distress, and communicating clearly. She was on continuous oxygen at 2-3 L/min via nasal cannula. Lung sounds were clear with occasional mild expiratory wheeze; no shortness of breath was observed during conversation. Vital signs were stable except for mildly elevated blood pressure (refer to chart for details). The right wrist demonstrated limited range of motion due to pain but no visible deformity. Functionally, the patient ambulated approximately 3 feet with a rollator under supervision, demonstrating right foot drop and utilizing her left foot to propel herself while seated on the rollator to reach the living room. She uses a seated walker indoors and a wheelchair for community mobility. Bed mobility was independent, and she performed sit-to-stand transfers from bed with supervision. The therapist did not assess outdoor mobility, steps, or car transfers. The patient remains homebound due to significant effort required to leave the home, as supported by a Tinetti score of 9/28, indicating high fall risk. During therapy, the patient completed five repetitions each of hip flexion, bridging, hooklying rotation, straight									
23. Signature and Date of Verbal SOC Where Applicable: Electronically Signed by Messick, Charles RN on 10/16/2025							25. Date HHA Received Signed POT		
24. Physician's Name and Address Amal Awadalla 1000 E Eager St Baltimore, MD 21202 PHONE: 4105229800 FAX: 14103672174 NPI: 1366530651					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 : 10/13/2025				
27. Attending Physician's Signature and Date Signed 10/24/2025 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. PAGE 1 of 3				

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leg raises, and hip abduction exercises, with active-assisted range of motion (AAROM) performed on the right side. She exhibited resistance to getting out of bed but tolerated exercises fairly well. Education was provided on the importance of continued participation in therapy to improve mobility, strength, and overall functional independence.

Order Date: 10/13/2025
Physician Face-to-Face Date: 10/13/2025
Clinical Condition Requiring Home Care per Certifying Physician: SN disease management, PT eval and treat, OT eval and treat due to Chronic Obstructive Pulmonary Disease With Exacerbation
Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home
SOC - SN Notes: soc
PT Eval Notes:
OT Eval Notes:

SN Careplans

SN WK1: 1 (10/16/2025 - 10/18/2025), WK2: 2 (10/19/2025 - 10/25/2025), WK3: 2 (10/26/2025 - 11/01/2025), WK4: 1 (11/02/2025 - 11/05/2025)

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: 2. Non-agency caregiver(s) need training/supportive services to provide assistance

HOSPITALIZATION RISKS: 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: D0700 - Social Isolation, meal preparation, M2102c - Med Admin, M2102f - Patient Supervision, M2102d - Caregiver Performs Treatment, M2020 - Oral Med Management, M1033 - Exhaustion, M1400 - Dyspnea, poor muscle tone, muscle weakness, limited range of motion, limited strength, limited endurance, balance deficit, B1000 - Vision Deficit, red/tender pressure points

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange resources for vision-impaired

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 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, * diet weight-bearing exercises to promote bone healing and strengthening fluids to prevent constipation home safety pain control, 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, * 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, * strategies to increase socialization, related medication(s) purpose, schedule, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

SN Goals

PATIENT-STATED GOAL: "I want to get better"

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

- * diet
- * weight-bearing exercises to promote bone healing and strengthening
- * fluids to prevent constipation
- * home safety
- * pain control
- * 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

- * 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

- * strategies to minimize fatigue and exhaustion including work simplification
- * energy conservation
- * lifestyle changes
- * diet
- * recalls related medication(s) purpose, schedule

patient/caregiver recalls

- * how to keep home safe for patient with vision loss including eliminating hazards
- * enhancing lighting
- * using mechanical aids

patient/caregiver recalls

- * strategies to increase socialization
- * 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 self-administers medications as prescribed

- * recalls related medication(s) purpose, schedule

patient is adequately supervised

meal preparation is available to patient for all meals

caregiver administers and/or packages medications appropriately

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	10/16/2025

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		caregiver performs medical/rehabilitation treatments with adequate competence
PT Careplans PT WK1: 9 (10/16/25-10/18/25) 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. Sitting knee extension, ankle pumps. Standing hip abduction, knee flexion, squats, cough/deep breathing exercises, 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 - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 05. Setup or clean-up assistance, Car Transfer - 06. Independent, Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching, 1 - Step (curb) - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance		PT Goals PATIENT-STATED GOAL: To be able to walk to the kitchen GOALS Chair to Bed to Chair - 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 - 06. Independent Toilet Transfer - 05. Setup or clean-up assistance Car Transfer - 06. Independent Walk 10 Feet - 04. Supervision or touching assistance Walk 50 ft with 2 Turns - 04. Supervision or touching assistance Walk 10 ft on Uneven Surface - 04. Supervision or touching 1 - Step (curb) - 04. Supervision or touching assistance Picking Up Object - 04. Supervision or touching assistance

Signature of Physician:	Date PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist: Electronically Signed by Messick, Charles RN	Date 10/16/2025