Home Health Certification and Plan of Care

Order ID: 1150/14000

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
35949476	11/13/2025	From: 11/13/2025 To: 01/11/2026	19356	217058

6. Patient's Name and Address
Melvenia Cooper
1711 Waverly Way Apt A,
BALTIMORE, MD 21239-
443-435-3374

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 03/09/1966 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
M31.19	Other thrombotic microangiopathy	11/13/25

13. ICD	Other Pertinent Diagnoses	Date
E11.65	Type 2 diabetes mellitus with hyperglycemia	11/13/25
I10.	Essential (primary) hypertension	11/13/25
E11.40	Type 2 diabetes mellitus with diabetic neuropathy unsp	11/13/25
J44.9	Chronic obstructive pulmonary disease unspecified	11/13/25
M79.651	Pain in right thigh	11/13/25
M79.652	Pain in left thigh	11/13/25
F41.9	Anxiety disorder unspecified	11/13/25
F32.1	Major depressive disorder single episode moderate	11/13/25
F41.0	Panic disorder [episodic paroxysmal anxiety]	11/13/25
R10.11	Right upper quadrant pain	11/13/25
R60.0	Localized edema	11/13/25
Z79.82	Long term (current) use of aspirin	11/13/25
Z79.51	Long term (current) use of inhaled steroids	11/13/25
Z87.891	Personal history of nicotine dependence	11/13/25
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	11/13/25

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

Humalog - Insulin Lispro Recombinant 100 units/ml 5units subcutaneous three times a day DM
Lantus Solostar - Insulin Glargine Recombinant 20 UNITS subcutaneous once a day DM
Melatonin - Melatonin 5 MG Tablet 1 tablet by mouth at bedtime at bedtime as needed Orally Once a day
SLEEP AIDE
Amlodipine - Amlodipine Besylate 5 MG Tablet 2 tabletS by mouth once a day BLOOD PRESSURE
cioBAZam 10 MG Tablet 1tablet by mouth twice a day SEIZURE
Levetiracetam - Levetiracetam 750 mg 750 MG Tablet 2 tablet by mouth every 12 hours SEIZURE
Clonidine - Clonidine 0.2 MG Tablet by mouth three times a day tablet Oral 3 times a day
BLOOD PRESSURE
Aspirin 81Mg - Aspirin 81 MG , 1 tablet by mouth once a day PROPHYLACTIC
Pantoprazole - Pantoprazole Sodium 40 mg 40 MG Tablet by mouth once a day STOMACH
Eliquis - Apixaban 5MG; 1TAB by mouth twice a day BLOOD THINNER
CVA
Potassium Cl - Potassium Chloride 99MG; 1 TAB by mouth once a day SUPPLEMENT
Atorvastatin Calcium - Atorvastatin Calcium 80 MG Tablet 1 tablet by mouth once a day CHOLESTEROL
Nicotine Patch - Nicotine Patch 14MG; 1 TACH subcutaneous once a day SMOKING CESSATION
Lorazepam - Lorazepam 1 mg 1 MG Tablet by mouth at bedtime AS NEEDED FOR ANXIETY
Ipratropium - Ipratropium Bromide .5-2.5 (3) MG/3ML, Solution 1 Nebule inhalant four times a day 1 Nebule Four Times A Day PRN Inhalation
Advair - Fluticasone Propionate: Salmeterol Xinafoate 115 mcg-21 mcg/inh inhalation aerosol 1 puff inhalant twice a day at bedtime (Advair HFA 115 mcg-21 mcg/inh inhalation aerosol 1 puff bid, Notes to Pharmacist: "Reorder from Medispan for eRx and Interaction Alerts
)
COPD
Albuterol - Albuterol 108 (90 Base) MCG/ACT , 1 puff inhalant four times a day Albuterol Sulfate HFA 108 (90 Base) MCG/ACT Aerosol Solution 1 puff as needed Inhalation 4 times a day AS NEEDED FOR SOB
COPD

14. DME and Supplies:
diabetic supplies, bath bench, walker

15. Safety Measures:
standard precautions, seizure precautions, fall precautions, diabetic precautions, bleeding precautions, ambulates with device, walker precautions, medication safety, sharps precautions, anticoagulant precautions, activity supervision

16. Nutrition:
diabetic, cardiac diet,

17. Allergies:
penicilin doxycycline

18.A. Functional Limitations
Ambulation, Endurance

18.B. Activities Permitted
Walker, Exercises Prescribed

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: 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 Other thrombotic microangiopathy, 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.

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 11/13/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address
Pankaj Kheterpal
223 Eastern Ave
Essex, MD 21221
PHONE: 410-687-8818 FAX: 14106823989 NPI: 1801813746

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 : 11/04/2025

27. Attending Physician's Signature and Date Signed **11/20/2025**: 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.

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Clinical Condition Requiring Homecare:

The patient is a recently hospitalized individual with a diagnosis of CVA and frailty. Her past medical history includes abdominal swelling, anxiety, asymptomatic diabetic neuropathy, COPD, type 2 diabetes on insulin, hand and shoulder pain, hypertension, major depressive disorder, panic disorder, and peripheral edema. She is alert and oriented 3 but occasionally forgetful and anxious. The patient reports intermittent shortness of breath, denies pain, has a good appetite, and had a bowel movement today. On assessment, left-hand swelling and an unsteady gait were noted. She uses a rollator at home for safe ambulation. Skilled nursing visits have focused on medication review, including dose, frequency, indications, and side effects, with emphasis on recognizing signs of bleeding due to concurrent use of Eliquis and aspirin. Both the patient and her daughter verbalized understanding of disease process management and medication instructions, with the daughter assisting with all ADLs and IADLs as needed. Physical therapy evaluation revealed general weakness, limited endurance, and unsteady gait. The patient was educated on and performed home exercises, including long arcs, mini squats, sidekicks, and heel raise (10 2 reps). She received instruction on fall prevention, safe use of the rolling walker, and strategies to improve mobility and balance. Skilled therapy services are indicated to enhance strength, functional mobility, transfer safety, and independence in the home environment, with continued caregiver support.<o:p></o:p> <o:p> </o:p> Date of Order<o:p></o:p> 11/13/2025<o:p></o:p> Order<o:p></o:p> Physician Face-to-Face Date: 11/04/2025
 Clinical Condition Requiring Home Care per Certifying Physician: RN-disease management PT eval and treat OT eval and treat DX: Other thrombotic microangiopathy
 Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home<o:p></o:p>
 1 - SOC - SN Notes: <o:p></o:p> PT Eval Notes:<o:p></o:p> Physician: Kheterpal, Pankaj

SN Careplans

SN WK1: 1 (11/13/25-11/15/25) ,WK2: 2 (11/16/25-11/22/25) ,WK3: 2 (11/23/25-11/29/25) ,WK4: 1 (11/30/25-12/06/25)

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; Assess the patient's incision on post op day 7 and the nurse or physical therapist will remove aquacel dressing leaving OTA; if incision is draining educate pt/pcg on cleaning with normal saline and covering with dry gauze daily and as needed.
Assess/Instruct Pt/Pcg: Ice to ____ x 20 minutes each hour while awake. If cold machine ordered apply 20 minutes on and 20 minutes off for 3-4 times a day.
Assess/Instruct all body systems/vital signs/complications, Blood Pressure; systolic is greater than 169 mm Hg or less than 90 mm Hg; diastolic is greater than 100 mm Hg or less than 55 mm Hg, Clinician to assess comorbidities and report changes in condition to the patient's physician, Pain Rating is greater than 6 on 0-10 scale, Pulse is greater than 110 or less than 50, Respirations are greater than 22 or less than 8, SPO2: is less than 90 % at rest /with exertion, Temperature is greater than 100.5 F or less than 95.0 F, Pain Rating is greater than 6 on 0-10 scale
Implement Fall Prevention Program, Instruct and educate the patient/PCG on wearing compression stockings for the next 4 weeks per discharge instructions.
Instruct the pt/PCG on using the incentive spirometer 10 times every 2 hour while awake.
Provide education content at patient's level of health literacy.
Assess/Instruct Pt/Pcg: Safety measures to prevent injury.
Assess: Musculoskeletal status.
Teach Pt/Pcg to maintain appropriate wt bearing status as ordered by MD, total joint replacement precautions as applicable, Safe stair climbing skills, Safe, effective use of adaptive/assist device
Assess/Instruct Pt/Pcg: Pain management measures; assess pain level, pain medication, rest, body alignment, ROM, meditation, massage.
Pt/Pcg educated in pain management techniques including positioning and relaxation techniques
Instruct Pt/Pcg: Medication actions, uses, frequency, dose, side effects, interactions of all new/change meds, Provide medication education,.
Assess/Instruct Pt/Pcg: Safety measures to prevent injury, Therapeutic Exercise, Transfer Training
Monitor surgical wound for s/s of infection, educate on s/s of concern and infection prevention to promote wound healing.

; 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: M1720 - Anxiety, D0160 - Depression, A1250 - Lack of Necessary Transportation, M2020 - Oral Med Management, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, lung sounds not clear, swelling in the arms/legs, abnormal BS < 70/140 > mg/dL, limited endurance, limited strength, balance deficit

PROCEDURES: cough/deep breathing exercises, glucose testing via monitor

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 modifications to manage peripheral vascular condition including how to apply compression stockings physical exercise plan diet, related medication(s) purpose, schedule, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts,

SN Goals

PATIENT-STATED GOAL: TO GO HOME

GOALS
patient/caregiver recalls
* how to optimize range of motion with active and passive therapeutic exercises
* manage pain/discomfort
* fluid and diet intake to promote healing
* prevent constipation
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* diabetic medication management
* blood sugar testing
* diabetic foot care
* exercise
* diabetic diet
* 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
* 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
* 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
* 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 peripheral vascular condition including how to apply compression stockings
* physical exercise plan
* diet
* 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

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	11/13/2025

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and threats, related medication(s) purpose, schedule, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpose, schedule, * diabetic medication management blood sugar testing diabetic foot care exercise diabetic diet, related medication(s) purpose, schedule, * how to optimize range of motion with active and passive therapeutic exercises manage pain/discomfort fluid and diet intake to promote healing prevent constipation, 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 transportation needs are met, meal preparation is available to patient for all meals

* recalls related medication(s) purpose, schedule

patient's transportation needs are met

meal preparation is available to patient for all meals

PT Careplans

PT WK1: 1 (11/13/25-11/15/25) ,WK2: 1 (11/16/25-11/22/25) ,WK3: 1 (11/23/25-11/29/25) ,WK4: 1 (11/30/25-12/06/25)

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: Medication Review: The medication was reviewed with the patient, Home exercises: Long arc, marching, mini squats and heel raises --10x2 reps , cough/deep breathing exercises, incentive spirometer, 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 - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent

PT Goals

PATIENT-STATED GOAL: To get stronger and walk better

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

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	11/13/2025