# Home Health Certification and Plan of Care

**Order ID: 1150/15009**

| 1. Patient s HI claim No. | 2. Start Of Care Date | 3. Certification Period | 4. Medical Record No. | 5. Provider No. |
|---|---|---|---|---|
| 351089380 | 10/22/2025 | From: 12/21/2025 To: 02/18/2026 | 18720 | 217058 |

**6. Patient's Name and Address**
Loretta Lucas
2820 Oswego Avenue,
Baltimore, MD 21215-
410-371-5773

**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** 09/05/1938 | **9.Sex** Female

| 11. ICD | Principal Diagnosis | Date |
|---|---|---|
| I48.91 | Unspecified atrial fibrillation | 10/22/25 |

| 13. ICD | Other Pertinent Diagnoses | Date |
|---|---|---|
| I13.0 | Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny | 10/22/25 |
| I50.20 | Unspecified systolic (congestive) heart failure | 10/22/25 |
| E11.22 | Type 2 diabetes mellitus w diabetic chronic kidney disease | 10/22/25 |
| N18.9 | Chronic kidney disease u | 10/22/25 |
| D63.1 | Anemia in chronic kidney disease | 10/22/25 |
| I26.99 | Other pulmonary embolism without acute cor pulmonale | 10/22/25 |
| I25.10 | Athscl heart disease of native coronary artery w/o ang pctrs | 10/22/25 |
| I71.40 | Abdominal aortic aneurysm without rupture unspecified | 10/22/25 |
| L89.153 | Pressure ulcer of sacral region stage 3 | 10/22/25 |
| E78.5 | Hyperlipidemia unspecified | 10/22/25 |
| K21.9 | Gastro-esophageal reflux disease without esophagitis | 10/22/25 |
| J44.9 | Chronic obstructive pulmonary disease unspecified | 10/22/25 |
| M10.9 | Gout unspecified | 10/22/25 |
| M48.061 | Spinal stenosis lumbar region without neurogenic claud | 10/22/25 |
| E03.9 | Hypothyroidism unspecified | 10/22/25 |
| Z95.1 | Presence of aortocoronary bypass graft | 10/22/25 |
| Z98.61 | Coronary angioplasty status | 10/22/25 |
| Z79.84 | Long term (current) use of oral hypoglycemic drugs | 10/22/25 |
| Z79.01 | Long term (current) use of anticoagulants | 10/22/25 |
| Z86.718 | Personal history of other venous thrombosis and embolism | 10/22/25 |
| Z87.891 | Personal history of nicotine dependence | 10/22/25 |

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

Crestor - Rosuvastatin Calcium 40 MG 1 tab by mouth once a day Caregiver is aware of meds, dosage, frequency.
Toprol-Xl - Metoprolol Succinate 25mg- Take 0.5 tab by mouth once a day CG confirmed with Kaiser pharmacist meds to be taken. Meds to be picked up today- 10/22/25.
Protonix - Pantoprazole Sodium Take 40 mg by mouth once a day CG aware of med dose, frequency, purpose.
Tylenol #3 - Acetaminophen: Codeine Phosphate 300-30 MG , Take 1 tablet by mouth every 4 hours CG aware of dosage, frequency, purpose. Pt stated she hasn't needed recently.
Pradaxa - Dabigatran Etexilate Mesylate 75 MG, Take 1 capsule by mouth twice a day CG aware of bleeding precautions ; dosage, frequency, purpose.
Ventolin Hfa - Albuterol Sulfate 108 (90 BASE) mcg/act ,Take 2 puffs inhalant every 6 hours Take 2 puffs by inhalation every 6 hours as needed. Pt/ CG understands when to use med.
Trazodone - Trazodone Hydrochloride 50 MG, Take 1 tab by mouth at bedtime Pt understands dosage, frequency, purpose.
Nitroglycerine - Nitroglycerin 0.4 mg sublingual as necessary Patient reports she has the medicine for prn use.
Methimazole - Methimazole 5 mg 2 tablets by mouth in the morning Caregivers aware of medication purpose.
Robitussin - Chlorpheniramine Polistirex: Hydrocodone Polistirex Take 200 mg by mouth every 6 hours Pt denies cough and is not taking med.
Lasix - Furosemide 40 mg 1 tab by mouth once a day 11/4/25 dosage increased from 20 mg to 40 mg. Family aware. Medicines pill boxes updated to current dosage.
Kcl - Potassium Chloride 20 mEq, ER Take 1 tablet by mouth once a day for 3 days. Patient and daughter instructed in medicine.

**14. DME and Supplies:**
sling, rolling walker, reacher, bath bench, commode, cane

**15. Safety Measures:**
sharps precautions, , , diabetic precautions

**16. Nutrition:**
regular

**17. Allergies:**
no known allergies

**18.A. Functional Limitations**
Ambulation

**18.B. Activities Permitted**
No Restrictions

**19. Mental & Pyschosocial Status:** COGNITION: 1. When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer, ANXIETY: , SOCIAL ISOLATION: 1 Requires assistance, BEHAVIORAL ISSUES: 2 independent, HISTORY OF DEPRESSION:

**20. Prognosis:** good

**22. A Rehabilitation Potential:**
SELF-CARE: 2+ pitted edema in both legs , MOBILITY: N/A

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

**Homebound status:**
Due to diagnosis of Unspecified Atrial Fibrillation, 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 an alert and oriented 87-year-old African American female, recently hospitalized after a fall resulting in a right humerus fracture and found to have bilateral pulmonary embolisms. Her past medical history includes coronary artery disease status post CABG, hypertension, congestive heart failure, abdominal aortic aneurysm, diabetes mellitus, and a non-ruptured cerebral aneurysm. At home, she is totally dependent on family for all activities of daily living (ADLs) and instrumental activities of daily living (IADLs). During the visit, she was observed sitting on the edge of her bed with feet dangling in a small cluttered bedroom. Vital signs were within normal limits. Notable findings included rales in the right lung lobe, swelling and limited mobility of the right arm and hand, an absorbing hematoma on the left antecubital area, and significant bilateral lower extremity edema with dry, flaking skin. Occlusive dressings were noted on the hips and sacral area, placed by hospital staff; they were not removed due to lack of orders and supplies. Medications were not present at home; the family coordinated with the pharmacy to have prescriptions transferred to a closer location. Patient and family were educated on fall and <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-11 CE-FMS-bleeding%20precautions">bleeding precautions</mh>, daily weights, and wound care. Physical therapy evaluation revealed decreased strength with 3-/5 MMT in bilateral lower extremities and limited right upper extremity mobility, requiring moderate assistance for transfers and short-distance ambulation with a rolling walker. The patient is unable to negotiate stairs in her multilevel home and would benefit from a home safety assessment for adaptive equipment, including a stair lift and bath rails. She currently requires maximal assistance with bathing and dressing, minimal-to-moderate assistance with sit-to-stand and commode transfers, and no weight bearing on the right upper extremity. Skilled physical therapy services are recommended to improve strength, balance, and safety, with the goal of increasing functional independence and facilitating return to prior level of function. The skilled nursing visit schedule includes wound care, medication teaching, weight monitoring, and management of fluid retention. <br> Date of Order 12/16/2025 Orders Physician Face-to-Face Date: 10/22/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN disease management, PR eval and treat, OT eval and treat due to Unspecified Atrial Fibrillation Homebound Status per Certifying Physician:

**23. Signature and Date of Verbal SOC Where Applicable:**
Electronically Signed by Messick, Charles RN on 12/16/2025

**25. Date HHA Received Signed POT**

**24. Physician's Name and Address**
Eddye Bullock
7141 Security Blvd
Baltimore, MD 21244
PHONE: 443-663-6220 FAX: 14436636475 NPI: 1366510703

**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 : 10/22/2025

**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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patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home <br> 4 - Recertification Notes: The patient has edema for both Lower extremities and was instructed to use her compression socks and take fluid medications as prescribed. The patient can continue to benefit from continued OT services to address ADLs, transfers and right shoulder rom and function of the right shoulder. Physician Bullock, Eddye

## SN Careplans

## SN Goals

## OT Careplans

OT WK1: 1 (12/21/25-12/27/25) ,WK2: 1 (12/28/25-01/03/26) ,WK3: 1 (01/04/26-01/10/26) ,WK4: 1 (01/11/26-01/17/26)

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, blood sugar < 60 > 300

CAREGIVER:

HOSPITALIZATION RISKS: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 4. Multiple emergency department visits (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

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:Living Will

PROBLEMS IDENTIFIED ON ASSESSMENT: dizziness/syncope

## OT Goals

PATIENT-STATED GOAL: Patient wants to get better

GOALS
Shower/Bathe Self - 05. Setup or clean-up assistance

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

Upper Body Dressing - 05. Setup or clean-up assistance

Lower Body Dressing - 05. Setup or clean-up assistance

Toileting Hygiene - 05. Setup or clean-up assistance

Don/Doff Footwear - 05. Setup or clean-up assistance

Patient will demonstrate improved Rsh flexion prom from 70 degs to 100 degs to improve function of the right shoulder

Patient will demostrated improved right shoulder flexion prom from 105 degs to 120 degs to improve ADLs

Eating - 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

Oral Hygiene - 05. Setup or clean-up assistance

Signature of Physician:

Date



Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

12/16/2025

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PROCEDURES: ADLs , Patient/caregiver recalls related purpose and schedule of medications: Medication review , transfers training, therapeutic exercises

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 - 05. Setup or clean-up assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Shower/Bathe Self - 05. Setup or clean-up assistance, Toileting Hygiene - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance, Eating - 06. Independent, Patient will demonstrate improved Rsh flexion prom from 70 degs to 100 degs to improve function of the right shoulder , Patient will demostrated improved right shoulder flexion prom from 105 degs to 120 degs to improve ADLs

| Signature of Physician: | Date |
|---|---|
| | PAGE 3 of 3 |
| Optional Name/Signature of Nurse/Therapist: | Date |
| Electronically Signed by Messick, Charles RN | 12/16/2025 |