Home Health Certification and Plan of Care

Order ID: 1150/15373

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
861298147	11/01/2025	From: 12/30/2025 To: 02/27/2026	18444	217058

6. Patient's Name and Address
Debra Middleton-Lane
7408 Marston Rd,
GWYNN OAK, MD 21207-
443-924-9448

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 09/07/1956 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
I13.0	Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny	11/01/25

13. ICD	Other Pertinent Diagnoses	Date
I50.42	Chronic combined systolic and diastolic hrt fail	11/01/25
N18.30	Chronic kidney disease stage 3 unspecified	11/01/25
J43.9	Emphysema unspecified	11/01/25
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	11/01/25
I48.0	Paroxysmal atrial fibrillation	11/01/25
F43.21	Adjustment disorder with depressed mood	11/01/25
F51.01	Primary insomnia	11/01/25
M06.9	Rheumatoid arthritis unspecified	11/01/25
J96.10	Chronic respiratory failure unsp w hypoxia or hypercapnia	11/01/25
G47.33	Obstructive sleep apnea (adult) (pediatric)	11/01/25
M79.7	Fibromyalgia	11/01/25
M10.9	Gout unspecified	11/01/25
K44.9	Diaphragmatic hernia without obstruction or gangrene	11/01/25
M81.0	Age-related osteoporosis w/o current pathological fracture	11/01/25
F32.9	Major depressive disorder single episode unspecified	11/01/25
I35.1	Nonrheumatic aortic (valve) insufficiency	11/01/25
E66.01	Morbid (severe) obesity due to excess calories	11/01/25
Z68.43	Body mass index [BMI] 50.0-59.9 adult	11/01/25
Z99.81	Dependence on supplemental oxygen	11/01/25

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

Metoprolol Succinate - Metoprolol Succinate eq 50 mg tartrate 50 mg ,Take 50 mg tablet by mouth once a day BLOOD PRESSURE/A-FIB
Methocarbamol - Methocarbamol 500 mg 500 MG tablet,Take 1 tablet by mouth twice a day for pain and stiffness, taken as 1 tablet every 8 hours as needed.
Tramadol Hcl - Tramadol Hydrochloride 50 mg,Take 1 tablet by mouth once a day 50 mg oral tablet, taken every 24 hours as needed for pain.
Pregabalin - Pregabalin 200 MG capsule,Take 1 capsule by mouth in the morning 200 MG capsule, 1 tablet every morning and at bedtime for neuropathic pain.
Oxygen - Oxygen 2 litres per minute nasal cannula continuous o2 @ dl/m. may titrate to keep sats at 92 percent or greater each shift
Albuterol Sulfate - Albuterol Sulfate 10-(90 Base),1 inhalation inhalant every 4 hours 1 inhalation orally every 4 hours as needed for COPD.
Amjevita - Adalimumab-Atto 40mg/0.4 ml autoinjector. Inject 0.4 ml intramuscular every other week Rheumatoid arthritis
Diclofenac Sodium - Diclofenac Sodium 0.1 perc 1 application topical as necessary On joints for pain
Spiriva - Tiotropium Bromide Monohydrate 2.5 mg 2 puffs inhalant in the morning
Allopurinal - Allopurinol 300mg by mouth once a day For gout
Sinus And Allergy Relief PE 1 tablet - 4mg/10mg by mouth every 4 hours As needed for nasal congestion
Furosemide - Furosemide 40 mg 40 MG,Take 2 tablet by mouth once a day 2 tablet by mouth every morning for CHF.
Wegovy (semaglutide) 0.25mg/0.5mL subcutaneous once a week

14. DME and Supplies:
rolling walker, reacher, oxygen supplies, ,

15. Safety Measures:
walker precautions, , , , , , bathroom safety, ambulates with device, activity supervision, ambulates with assistance

16. Nutrition:
low sodium, fluid restriction

17. Allergies:
codeine losartan lactose

18.A. Functional Limitations
Endurance, Ambulation

18.B. Activities Permitted
Walker, Exercises Prescribed, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 0. Able to get to and from the toilet and transfer independently with or without a device., ANXIETY: 0. Never, SOCIAL ISOLATION: , BEHAVIORAL ISSUES: , HISTORY OF DEPRESSION:

20. Prognosis: fair

22. A Rehabilitation Potential:
SELF-CARE: , MOBILITY:

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

Homebound status: Due to diagnosis of Hypertensive Heart And Chronic Kidney Disease With Heart Failure And Stage 1 Through Stage 4 Chronic Kidney Disease, Or Unspecified Chronic Kidney Disease, 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 69-year-old female recently discharged from an inpatient stay following an exacerbation of congestive heart failure (CHF) and complications associated with multiple chronic comorbidities. Her past medical history is significant for CHF with an ejection fraction of 65%, chronic obstructive pulmonary disease (COPD) on 2 L continuous oxygen, chronic atrial fibrillation, hypertension, coronary artery disease (CAD), obstructive sleep apnea (OSA), rheumatoid arthritis (RA), fibromyalgia, obesity, and bilateral lower extremity lymphedema. The patient also reported a recent history of two falls within one week-one incident occurred when she tripped over a carpet sweeper while ambulating to the bathroom and another when she turned to retrieve her phone. She has since had difficulty weight-bearing on her right ankle, which was not evaluated during her hospital stay. On <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>, the patient was alert and oriented 3 and reported bilateral foot and right shoulder pain rated at 8/10, managed with Lyrica. She denied chest pain but reported shortness of breath with exertion. Lung sounds were diminished throughout all fields. She remains on continuous 2 L nasal cannula oxygen. The patient has a good appetite and reported her last bowel movement as occurring yesterday. Bilateral lower extremities are grossly edematous with lymphedema; no open wounds or drainage were observed. She is not currently using compression wraps. The patient ambulates short distances within the home using a rolling walker for safety but demonstrates fatigue and limited endurance. She is unable to weigh herself daily due to mobility restrictions, though a scale is available in the home. Medication reconciliation was completed, and all medications, including Lyrica, Furosemide, and Eliquis, were reviewed for dosage, frequency, indication, and side effects. The patient was educated on medication adherence, monitoring for signs and symptoms of bleeding related to anticoagulant therapy, and the importance of maintaining skin integrity, particularly in the lower extremities. Education was also provided on fall prevention strategies, including keeping walkways clear, using appropriate footwear, and pacing activities to avoid overexertion. The patient verbalized understanding of all instructions. The physical therapy evaluation revealed decreased bilateral lower extremity strength with manual muscle testing at approximately 2-/5. The patient currently requires minimal assistance for transfers and can ambulate only short distances, limited by weakness and pain. Skilled physical therapy is recommended to address deficits in strength, balance, endurance, and safety to promote a return to her prior level of function. The occupational therapy evaluation noted a decline in independence with activities of daily living (ADLs) since the recent falls. The patient is currently using adult incontinence briefs due to inability to reach the bathroom safely when on diuretics. Installation of a bedside commode was recommended to enhance safety and accessibility. The patient will benefit from skilled occupational therapy services at a frequency of 1w1, 2w2, 1w1 to focus on ADL retraining, adaptive equipment education, therapeutic exercises, home exercise program instruction, functional mobility, and safety training. The plan of care includes skilled nursing <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-1 CE-FMS-visits">visits</mh> (1w1, 2w2, 1w2) to monitor cardiopulmonary status, pain control, medication compliance, and lower extremity edema management, in addition to continued PT and OT interventions. The interdisciplinary goal is

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 12/29/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address
Naeha Quasba
7141 Security Blvd
Baltimore, MD 21244
PHONE: 410-230-7827 FAX: 1-410-230-7827 NPI: 1609119049

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 : 09/25/2025

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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to improve the patient's functional mobility, endurance, and self-care ability while reducing fall risk and preventing further hospital readmission.
 Date of Order 12/29/2025 Orders Physician Face-to-Face Date: 09/25/2025 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Hypertensive Heart And Chronic Kidney Disease With Heart Failure And Stage 1 Through Stage 4 Chronic Kidney Disease, Or Unspecified Chronic Kidney Disease Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home
 4 - Recertification Notes: Patient is being recertified due to struggling with pain in her shoulders elbows thighs due to rheumatoid arthritis.
 Physician Quasba, Naeha

SN Careplans

SN WK3: 1 (01/11/26-01/17/26) ,WK4: 1 (01/18/26-01/24/26)

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

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

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:POLST (Physician Orders for Life-Sustaining Treatment)

PROBLEMS IDENTIFIED ON ASSESSMENT: M2102d - Caregiver Performs Treatment, frequent urination, lethargy, tooth pain/decay/sensitivity

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , Edema Management : Apply ace wraps to BLE from base of toes to gatch of knee. Apply each morning and remove at bedtime., Edema Management : Apply ace wraps to BLE from base of toes to gatch of knee. Apply each morning and remove at bedtime., cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments, monitor intake & output, monitor dialysis schedule

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, * 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 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, * 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 gout flare-ups including non-medical pain relief dietary modifications, 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 journal of food and fluid intake healthy meal plan tips exercise program nutritional knowledge, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, caregiver performs medical/rehabilitation treatments with adequate competence

SN Goals

PATIENT-STATED GOAL: I WANT TO GET BETTER BECAUSE I HAVE BEEN IN HOSPITAL SO MUCH IN THE LAST YEAR

GOALS
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

caregiver performs medical/rehabilitation treatments with adequate competence

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 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
* how to keep journal of food and fluid intake
* healthy meal plan tips
* exercise program
* nutritional knowledge
* recalls related medication(s) purpose, schedule

patient self-administers medications as prescribed
* 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
* how to manage gout flare-ups including non-medical pain relief
* dietary modifications
* 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
* 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
* how to manage inflammatory process
* optimize mobility with active and passive range of motion exercises

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	12/29/2025

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* 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

Signature of Physician:	Date
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