Home Health Certification and Plan of Care

Order ID: 1150/15385

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
9XY0UG4DC20	01/10/2026	From: 01/10/2026 To: 03/10/2026	21075	217058

6. Patient's Name and Address
Eliza Banks
4127 Callaway Ave,
Baltimore, MD 21215-
443-722-5414

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 11/21/1941 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
I12.0	Hyp chr kidney disease w stage 5 chr kidney disease or ESRD	01/10/26

13. ICD	Other Pertinent Diagnoses	Date
N18.6	End stage renal disease	01/10/26
D63.1	Anemia in chronic kidney disease	01/10/26
N25.81	Secondary hyperparathyroidism of renal origin	01/10/26
S72.011D	Unsp intracap fx right femur subs for clos fx w routn heal	01/10/26
I48.0	Paroxysmal atrial fibrillation	01/10/26
I48.92	Unspecified atrial flutter	01/10/26
I27.20	Pulmonary hypertension unspecified	01/10/26
I95.9	Hypotension unspecified	01/10/26
K59.00	Constipation unspecified	01/10/26
Z79.82	Long term (current) use of aspirin	01/10/26
Z79.01	Long term (current) use of anticoagulants	01/10/26
Z96.641	Presence of right artificial hip joint	01/10/26

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

Coreg - Carvedilol 25 mg 25mg; 1 tab by mouth twice a day blood pressure
Amilodipine - Amlodipine Besylate 10mg; 1 tab by mouth once a day blood pressure
Cinacalcet Hydrochloride - Cinacalcet Hydrochloride 30 mg 30mg; 1 tab by mouth once a day calciminetic agent
Sevelamer Carbonate - Sevelamer Carbonate 00800 MG, Give 2 tablet by mouth as necessary Give 2 tablet by mouth with meals for supplement
Eliquis - Apixaban 2.5 MG, Give 2.5 mg tablet by mouth twice a day Give 2.5 mg Phone by mouth two times a day for DVT Prophylaxis
Furosemide - Furosemide 80 mg 80mg; 1 tab by mouth once a day fluid pill
Hydralazine - Hydralazine Hydrochloride 25mg; 1 tab by mouth once a day blood pressure
Losartan Potassium - Losartan Potassium 100 mg 100mg; 1 tab by mouth in the morning

14. DME and Supplies:
bath bench, walker, cane

15. Safety Measures:
ambulates with device, walker precautions, ,

16. Nutrition:
renal diet, , cardiac diet,

17. Allergies:
no known allergies

18.A. Functional Limitations
Ambulation, Endurance

18.B. Activities Permitted
Cane, Walker, Exercises Prescribed

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 0. Never, SOCIAL ISOLATION: 0. Never, 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 Hypertensive Chronic Kidney Disease With Stage 5 Chronic Kidney Disease Or End-Stage Renal 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 an 84-year-old female admitted to home health services for skilled nursing, physical therapy, and occupational therapy evaluations, with occupational therapy to further assess the need for a home health aide once the bathroom setup is completed. Skilled nursing services are ordered at a frequency of 1 visit per week for 12 weeks, then 1 visit per week for 1 week, followed by 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-1 CE-FMS-visits">visits</mh> in the final week. The patient's past medical history is significant for type 2 diabetes mellitus, anemia, end-stage renal disease on hemodialysis three times weekly (Monday, Wednesday, Friday), history of frequent falls, essential hypertension, atrial fibrillation on Eliquis, hypotension, and a history of type A aortic dissection status post repair. Family members provide assistance with all activities of daily living and instrumental activities of daily living. At the skilled nursing visit, the patient was alert and oriented to person, place, and time. She denied pain at the time of <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh> but reported a history of right knee and right arm pain. She had not taken any medications prior to the visit. The patient denied shortness of breath; lung sounds were clear to auscultation bilaterally. Appetite was reported as good, with the last bowel movement occurring the previous night. The patient is anuric due to ESRD. Examination of the right arm revealed a functioning arteriovenous fistula with palpable thrill and audible bruit. Trace to +1 bilateral lower extremity edema was noted. The patient ambulates using a rolling walker for safety. Skilled nursing reviewed all current medications with the patient and granddaughter, including dosage, frequency, and pertinent side effects; both the patient and granddaughter were receptive to medication education. Physical therapy evaluation revealed that the patient was recently hospitalized following a fall that resulted in a right hip fracture, for which she underwent right hip arthroplasty. Prior to hospitalization, she ambulated independently without an assistive device indoors and used a single-point cane outdoors. Currently, she presents with decreased lower extremity strength, measured at 2-/5 manual muscle testing in the right lower extremity and 3+/5 in the left lower extremity. She requires contact guard assistance for transfers and short-distance ambulation with a rolling walker, demonstrating short step length and gait limitations due to right-sided pain. Physical therapy instructed the patient in safe stair negotiation techniques and practiced ascending one step using the rolling walker for support, which the patient completed with contact guard assistance. Education was also provided on increasing step length during ambulation to promote a more normalized gait pattern. The patient would benefit from continued skilled physical therapy services to improve strength, balance, safety, and independence with functional mobility in order to return to her prior level of function. Occupational therapy evaluation noted that the patient is status post right hip fracture secondary to a fall caused by dizziness while ambulating out of the bathroom; she also sustained a right shoulder injury during the fall. The patient is currently residing on the first floor of the home. Although a stair glide is present, she must still negotiate one step to the landing, which she is not yet able to do safely. Due to the absence of a bathroom on the first floor, the patient is currently wearing diapers and declined the use of a bedside commode, stating she anticipates returning upstairs soon. Family has purchased suction grab bars, a raised toilet seat, and a tub seat in preparation for safe bathroom use. A home health aide will be added once the bathroom setup is completed. The patient would benefit from skilled occupational therapy services at a frequency of 1 visit per week for 5 weeks to address activities of daily living training, adaptive equipment education, therapeutic exercises, home exercise program instruction, functional mobility training, and safety education. An initial home exercise program was initiated, including backward shoulder rolls and supine cane-assisted shoulder flexion exercises.
 Date of Order 01/10/2026 Orders Physician Face-to-Face Date: 12/26/2025 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Hypertensive Chronic Kidney Disease With Stage 5 Chronic Kidney Disease Or End-Stage Renal Disease Homebound Status per Certifying Physician: patient requires another person or medical equipment such as

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 01/10/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
YURY MALACHEVSKY
2700 Quarry Lake Dr Ste 280
BALTIMORE, MD 21215
PHONE: 4104695544 FAX: 14105852867 NPI: 1326443086

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 : 12/26/2025

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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crutches, a walker, or a wheelchair to leave home
 1 - SOC - SN Notes: soc PT Eval Notes: OT Eval Notes:
 Physician Malachevsky, Yury

SN Careplans

SN WK1: 1 (01/10/26-01/10/26) ,WK2: 1 (01/11/26-01/17/26) ,WK3: 1 (01/18/26-01/24/26) ,WK4: 1 (01/25/26-01/31/26) ,WK5: 1 (02/01/26-02/07/26)

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: 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), 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; 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: M2020 - Oral Med Management, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, dependent edema, limited range of motion, limited strength, limited endurance, weak hand grips, balance deficit

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , cough/deep breathing exercises, 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 medicatio, * lifestyle modification to manage blood condition including dietary changes bleeding precautions, 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, sch, * 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, meal preparation is available to patient for all meals

SN Goals

PATIENT-STATED GOAL: PATIENT WANTS TO GET BETTER AND STRONGER

GOALS
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, sch

patient/caregiver recalls
* lifestyle modification to manage blood condition including dietary changes
* bleeding precautions
* 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
* 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 respiratory condition including
* diet changes and regular exercise
* strategies to control shortness of breath
* home remedies to keep lungs healthy
* recalls related medicatio

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

meal preparation is available to patient for all meals

PT Careplans

PT WK2: 1 (01/11/26-01/17/26) ,WK3: 1 (01/18/26-01/24/26) ,WK4: 1 (01/25/26-01/31/26) ,WK5: 1 (02/01/26-02/07/26) ,WK6: 1 (02/08/26-02/14/26) ,WK7: 1 (02/15/26-02/21/26) ,WK8: 1 (02/22/26-02/28/26) ,WK9: 1 (03/01/26-03/07/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, 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: - medications reviewed with patient/caregiver, 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 medicatio, * 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 relaxatio, Sit to Stand - 05. Setup or clean-up assistance, Chair to Bed to Chair - 05. Setup or clean-up assistance, Toilet Transfer - 05. Setup or clean-up assistance, Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Walk 150 Feet - 04. Supervision or touching assistance, 1 - Step (curb) - 04. Supervision or touching assistance, 4 Steps - 04. Supervision or touching assistance, 12 Steps - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance, Car Transfer - 06. Independent, Walk 10 ft on Uneven Surface - 02. Substantial/maximal assistance, Medication Review

PT Goals

PATIENT-STATED GOAL: To be able to walk without pain

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 medicatio

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 relaxatio

Sit to Stand - 05. Setup or clean-up assistance

Chair to Bed to Chair - 05. Setup or clean-up assistance

Toilet Transfer - 05. Setup or clean-up assistance

Walk 10 Feet - 04. Supervision or touching assistance

Walk 50 ft with 2 Turns - 04. Supervision or touching assistance

Walk 150 Feet - 04. Supervision or touching assistance

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	01/10/2026

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1 - Step (curb) - 04. Supervision or touching assistance

4 Steps - 04. Supervision or touching assistance

12 Steps - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

Car Transfer - 06. Independent

Walk 10 ft on Uneven Surface - 02. Substantial/maximal assistance

Medication Review

OT Careplans

OT WK2: 1 (01/11/26-01/17/26) ,WK3: 1 (01/18/26-01/24/26) ,WK4: 1 (01/25/26-01/31/26) ,WK5: 1 (02/01/26-02/07/26) ,WK6: 1 (02/08/26-02/14/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with ADLs, M1400 - Dyspnea, GG0130B1 - Oral Hygiene, GG0130F1 - Upper Body Dressing, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130A1 - Eating

PROCEDURES: heat application, therapeutic exercises, equipment training, work simplification/energy conservation

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 medicatio, * 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 relaxatio, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 05. Setup or clean-up assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: To do what I usually do

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

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 medicatio

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 relaxatio

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	01/10/2026