Home Health Certification and Plan of Care

Order ID: 1150/15726

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
6UH4Y67JE50	01/15/2026	From: 01/15/2026 To: 03/15/2026	21254	217058

6. Patient's Name and Address
Jacqueline Feaster
1610 Melby Court,
Parkville, MD 21234-
410-900-0171

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 09/18/1945 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
G30.8	Other Alzheimer's disease	01/15/26

13. ICD	Other Pertinent Diagnoses	Date
F02.80	Dem in oth dis classd elswhrunsp sevw/o beh/psych/mood/anx	01/15/26
I10.	Essential (primary) hypertension	01/15/26
K50.00	Crohn's disease of small intestine without complications	01/15/26
E44.1	Mild protein-calorie malnutrition	01/15/26
Z79.01	Long term (current) use of anticoagulants	01/15/26
Z79.4	Long term (current) use of insulin	01/15/26

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

Aquaphilic External Ointment (Emollient) 0- topical twice a day Apply to BLE topically every day and evening shift for Chronic dry skin
Tylenol - Acetaminophen 0325 mg by mouth every 6 hours Give 2 tablet by mouth every 6 hours as needed for For pain level 1-5
Melatonin - Melatonin 3 mg / 1 Tablet by mouth once a day Give 1 tablet by mouth every 24 hours as needed for Insomnia
Nifedipine Er - Nifedipine 90mg tablet by mouth once a day Blood pressure
Spironolactone - Spironolactone 25 mg by mouth once a day
Biotin - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 50mcg by mouth once a day

14. DME and Supplies:
wound care supplies, wheelchair, walker, cane, commode, bath bench

15. Safety Measures:
infectious material management, walker precautions, wheelchair precautions, , , bathroom safety, , activity supervision

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
penicillin, Lactose

18.A. Functional Limitations
Ambulation, Bowel/Bladder Incontinence

18.B. Activities Permitted
Cane, Wheelchair, Walker, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 3. Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time., ANXIETY: 3. During the day and evening, but not constantly, SOCIAL ISOLATION: 8. Patient unable to respond, BEHAVIORAL ISSUES: 1. Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required!2. Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions, HISTORY OF DEPRESSION: No

20. Prognosis: fair

22. A Rehabilitation Potential:
SELF-CARE: 8. Unknown, MOBILITY: 8. Unknown

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

Homebound status:
Due to diagnosis of Other Alzheimer'S 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 80-year-old female with a past medical history significant for Crohn's disease, hypertension, and Alzheimer's disease. She was admitted to home health services for skilled nursing, physical therapy, and occupational therapy related to impaired mobility and management of a full-thickness sacral pressure ulcer. Upon arrival, the patient was found in bed, alert but oriented to self only. She appeared confused and verbally combative, demonstrating poor cooperation with assessment and care activities. The patient complained of generalized pain but was unable or unwilling to localize or further describe the pain. Attempts to obtain vital signs and perform a full physical assessment were unsuccessful due to patient refusal and physical aggression, including swinging her arms toward staff during care attempts. The patient's niece was present in the home during the visit, and the patient's spouse participated via telephone. Both assisted with completion of the admission interview and provided relevant history. During attempts to reposition the patient for wound assessment, the patient became physically combative. With significant calming assistance from the niece, the patient was briefly repositioned during incontinence care, allowing for photographic documentation of the sacral ulcer. Measurement of the wound was not possible due to continued patient agitation and safety concerns. Functionally, per family report, the patient was previously independent with basic self-care, functional transfers, functional ambulation, and household instrumental activities of daily living prior to her recent decline. Currently, the patient presents with decreased standing balance, reduced standing tolerance, diminished bilateral upper extremity strength, impaired mobility, and significant cognitive deficits, all of which substantially limit her ability to safely perform self-care, transfers, and ambulation. During the physical therapy visit, the patient remained confused and verbally combative, though the caregiver was able to assist in redirecting her to follow simple directions intermittently. A home exercise program was initiated, and education was provided to the caregiver regarding safe performance of exercises. The caregiver demonstrated understanding and will assist the patient with the home exercise program daily. The primary goal expressed by the patient's spouse is for the patient to regain strength and ambulate again with supervision. Physical therapy will follow up weekly to address strength, balance, mobility, and safety. Skilled occupational therapy services are recommended to address deficits in self-care performance, functional transfers, and adaptive strategies, with the goal of maximizing safety and supporting return toward the patient's prior level of function as tolerated. Skilled nursing services will continue to monitor and manage the full-thickness sacral ulcer, assess pain, and provide ongoing education to caregivers as the patient's condition allows. The interdisciplinary plan of care emphasizes safety, wound management, caregiver education, and functional improvement within the home setting, while accounting for cognitive limitations and behavioral challenges.
 Date of Order 01/15/2026 Orders Physician Face-to-Face Date: 12/26/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN Disease management, PT eval and treat, OT eval and treat HHA due to Other Alzheimer'S Disease Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home
 1 - SOC - SN Notes: soc PT Eval Notes: OT Eval Notes:
 Physician Rollins Mrs., Lawanda

SN Careplans

SN Goals

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 01/15/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Lawanda Rollins Mrs.
8831 Satyr Hill Rd Ste 100
Parkville, MD 21234
PHONE: 443-946-1896 FAX: 14434952902 NPI: 1003384165

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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SN WK1: 1 (01/15/26-01/17/26) ,WK2: 1 (01/18/26-01/24/26) ,WK3: 1 (01/25/26-01/31/26) ,WK4: 1 (02/01/26-02/07/26) ,WK5: 1 (02/08/26-02/14/26) ,WK6: 1 (02/15/26-02/21/26) ,WK7: 1 (02/22/26-02/28/26) ,WK8: 1 (03/01/26-03/07/26) ,WK9: 1 (03/08/26-03/14/26)

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: 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:Durable power of attorney for health care/Medical power of attorney

PROBLEMS IDENTIFIED ON ASSESSMENT: M1720 - Anxiety, M1745 - Behavioral Issues, M1700 - Cognition, M2020 - Oral Med Management, M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2102c - Med Admin, M1400 - Dyspnea, M1620 - Bowel Incontinence, M1610 - Urinary Incontinence, limited range of motion, muscle weakness, limited strength, withdrawal from conversations, loss of appetite, open sores/lesions, #1 - Open Wound - Posterior Sacrum - unable to measure due to patient combative.

PROCEDURES: physician-ordered wound care: #1 - Open Wound - Posterior Sacrum - unable to measure due to patient combative., Medication Review- : Medications reviewed with patient/caregiver. , cough/deep breathing exercises, incentive spirometer, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, physician-ordered wound care, bladder training, teach/coordinate/arrange medication packaging and/or administration, venipuncture: Skilled nurse to obtain CBC w/Diff, CMP w/GFR, TSH w/Reflex, HgA1C, Lipid Panel, Vitamin D. Fax results to Dr. Rollins 443-495-2902. MD NPI#: 1003384165. ICD 10 codes are- E44.1, K50.00, E55.9, E11.9.

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, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, related m, * how to keep home safe for patient with dementia coping strategies for the caregiver, related medication(s) purpose, schedule, * management of mental health condition including joining a peer group maintaining regular contact with mental health professional avoiding known stressors controlling impulses, related medication(s, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, * bowel incontinence management including dietary changes bowel training skin care, related medication(s) purpose, schedule, * urinary incontinence management including bladder training Kegel exercises skin care, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient is adequately supervised, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

PATIENT-STATED GOAL: Family's goal- get patient more mobile and cooperative with care.

GOALS
patient/caregiver recalls
* how to keep home safe for patient with dementia
* coping strategies for the caregiver
* 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 m

patient/caregiver recalls
* management of mental health condition including joining a peer group
* maintaining regular contact with mental health professional
* avoiding known stressors
* controlling impulses
* recalls related medication(s

patient/caregiver recalls
* bowel incontinence management including dietary changes
* bowel training
* skin care
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* urinary incontinence management including bladder training
* Kegel exercises
* skin care
* recalls related medication(s) purpose, schedule

patient is adequately supervised

caregiver administers and/or packages medications appropriately

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 achieve wound healing including cleaning and dressing wound
* position changes
* skin care
* diet modification
* record wound measurements
* recalls related medication(s) purpose, schedule

patient self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

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

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 Dyspnea, GG0170R1 - Wheel 50 ft w 2 Turns, GG0170S1 - Wheel 150 feet, 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 caregiver, cough/deep breathing exercises, incentive spirometer, wheelchair training, equipment training, 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, Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 05. Setup or clean-up assistance, Car Transfer - 06. Independent, 1 - Step (curb) - 06. Independent, Wheel 50 ft w 2 Turns - 06. Independent, Wheel 150 feet - 06. Independent, 12 Steps - 02.

PT Goals

PATIENT-STATED GOAL: To walk and transfer from bed with CGA

GOALS
Chair to Bed to Chair - 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

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

Toilet Transfer - 01. Dependent

Car Transfer - 04. Supervision or touching assistance

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

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:
Electronically Signed by Messick, Charles RN

Date
01/15/2026

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Substantial/maximal assistance, 4 Steps - 02. Substantial/maximal assistance, Picking Up Object - 02. Substantial/maximal assistance, Walk 10 Feet - 02. Substantial/maximal assistance, Walk 10 ft on Uneven Surface - 02. Substantial/maximal assistance, Walk 150 Feet - 02. Substantial/maximal assistance, Walk 50 ft with 2 Turns - 02. Substantial/maximal assistance, Oral Hygiene - 03. Partial/moderate assistance, Toileting Hygiene - 05. Setup or clean-up assistance, Shower/Bathe Self - 03. Partial/moderate assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 03. Partial/moderate assistance, Don/Doff Footwear - 03. Partial/moderate assistance

Wheel 50 ft w 2 Turns - 06. Independent

Wheel 150 feet - 06. Independent

12 Steps - 04. Supervision or touching assistance

4 Steps - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

Walk 10 Feet - 04. Supervision or touching assistance

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

Walk 150 Feet - 04. Supervision or touching assistance

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

Oral Hygiene - 03. Partial/moderate assistance

Toileting Hygiene - 05. Setup or clean-up assistance

Shower/Bathe Self - 03. Partial/moderate assistance

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

Lower Body Dressing - 03. Partial/moderate assistance

Don/Doff Footwear - 03. Partial/moderate assistance

OT Careplans

OT WK2: 1 (01/18/26-01/24/26) ,WK3: 1 (01/25/26-01/31/26) ,WK4: 1 (02/01/26-02/07/26) ,WK5: 1 (02/08/26-02/14/26) ,WK6: 1 (02/15/26-02/21/26) ,WK7: 1 (02/22/26-02/28/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, 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: Medication Review : Medication reviewed with caregiver with all medications in the home,, incentive spirometer, equipment training, work simplification/energy conservation, transfers training, assist with bathing, assist with lower body dressing, assist with upper body dressing

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 - 03. Partial/moderate assistance, Toileting Hygiene - 01. Dependent, Shower/Bathe Self - 04. Supervision or touching assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 03. Partial/moderate assistance, Don/Doff Footwear - 03. Partial/moderate assistance, Eating - 05. Setup or clean-up assistance

OT Goals

PATIENT-STATED GOAL: Walk 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 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 - 03. Partial/moderate assistance

Toileting Hygiene - 01. Dependent

Shower/Bathe Self - 04. Supervision or touching assistance

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

Lower Body Dressing - 03. Partial/moderate assistance

Don/Doff Footwear - 03. Partial/moderate assistance

Eating - 05. Setup or clean-up assistance

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	01/15/2026