Home Health Certification and Plan of Care

Order ID: 1150/15807

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
67180393	01/22/2026	From: 01/22/2026 To: 03/22/2026	21627	217058

6. Patient's Name and Address

Stefanie Minor
7903 Orlon Cir Unit B203,
LAUREL, MD 20724-
667-321-9611

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 04/20/1967 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
M10.9	Gout unspecified	01/22/26

13. ICD	Other Pertinent Diagnoses	Date
I11.0	Hypertensive heart disease with heart failure	01/22/26
I10.	Essential (primary) hypertension	01/22/26
I50.9	Heart failure unspecified	01/22/26
D50.9	Iron deficiency anemia unspecified	01/22/26
R53.81	Other malaise	01/22/26
E43.	Unspecified severe protein-calorie malnutrition	01/22/26
E83.42	Hypomagnesemia	01/22/26
K86.2	Cyst of pancreas	01/22/26
F10.10	Alcohol abuse uncomplicated	01/22/26
K86.89	Other specified diseases of pancreas	01/22/26

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

Allopurinal - Allopurinol 100 MG by mouth one time a day for Gout
Amilodipine - Amlodipine Besylate 10 MG by mouth one time a day for HTN
Gabapentin - Gabapentin 300 MG by mouth two times a day for Neuropathic Pain
Folic Acid - Folic Acid 1 mg Take 1 tablet by mouth once a day
Lisinopril And Hydrochlorothiazide - Hydrochlorothiazide: Lisinopril 12.5 mg;10 mg Take 1 tablet by mouth once a day
Naltrexone Hydrochloride - Naltrexone Hydrochloride 50 mg Take 1 tablet by mouth once a day
Colchicine - Colchicine 1 Tablet (0.6mg) by mouth once a day
Predisone - Prednisone 2 Tablets (20mg each = 40mg) by mouth once a day
Magnesium Oxide - Simethicone 1 Tablet (400mg) by mouth twice a day For Hypomagnesima
Thiamine Hydrochloride - Thiamine Hydrochloride 100 mg/ml 1 Tablet by mouth once a day

14. DME and Supplies:

walker, , , grab bars, , cane

15. Safety Measures:

emergency phone # clearly displayed, bathroom safety, supervision at all times, , , , activity supervision

16. Nutrition:

regular

17. Allergies:

no known allergies

18.A. Functional Limitations

Endurance, Bowel/Bladder Incontinence

18.B. Activities Permitted

Cane, Walker, , Up As Tolerated

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: good

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

family/caregiver will be responsible for managing treatment
patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Gout Unspecified, 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 58-year-old female referred for home health services following hospitalization for a gout flare complicated by acute kidney injury (AKI), hypomagnesemia, severe protein-calorie malnutrition, dehydration, anemia, and alcohol use disorder. During her hospital stay, she was treated for gouty arthritis involving the knee joint and was transfused with two units of packed red blood cells for anemia. She was subsequently discharged to a skilled nursing facility for rehabilitation due to significant deconditioning and functional decline, and later discharged home with skilled nursing and home health physical therapy orders for continued education, medication management, and mobility rehabilitation. The patient's past medical history is significant for hypertension, alcohol use disorder, tobacco use disorder, iron-deficiency anemia, gouty arthritis, AKI on chronic kidney disease, hypomagnesemia, severe protein-calorie malnutrition, ambulatory dysfunction, poor tolerance for ambulation, history of gastroenteritis, and a dilated pancreatic duct. She resides in a single-level home with her husband, who serves as her primary caregiver. The home has zero steps to enter. The patient does not currently drive, having stopped in 2020, and relies on her husband or rideshare services for transportation. At the time of evaluation, the patient ambulated without an assistive device but required supervision for activities of daily living (ADLs) and ambulation, as well as minimal assistance for instrumental activities of daily living (IADLs), including opening medication bottles, buttoning clothing, and fine motor tasks. She reports intermittent unsteadiness with ambulation and ongoing balance concerns. The patient complains of joint pain, difficulty getting in and out of the bathtub, difficulty ascending and descending stairs, and challenges with transfers from low surfaces such as toilets. She reports generalized lower extremity weakness, decreased hand strength, difficulty making a fist with the right hand, difficulty holding a pencil, tingling in the hands and feet, and a prior history of burning sensations in the feet. Although she reports that gout-related pain has significantly improved, she continues to express fear and hesitation with prolonged ambulation due to perceived instability. A skilled home health physical therapy evaluation revealed bilateral lower extremity weakness with manual muscle testing scores of 3+/5 in the right lower extremity and 3-/5 in the left lower extremity. The patient demonstrated impaired balance, with dynamic standing balance assessed as fair plus, and altered gait mechanics characterized by decreased hip and knee control. She required contact guard to standby assistance for bed mobility and transfers, and contact guard to minimal assistance for household ambulation distances of approximately 30-70 feet without an assistive device. These impairments place her at increased risk for falls and further functional decline. Skilled home health physical therapy is medically necessary to address deficits in strength, balance, gait, transfers, and endurance through therapeutic exercise, neuromuscular re-education, gait and transfer training, and patient education. Skilled nursing services are also indicated to provide disease process education, medication management, and reinforcement of safety strategies related to her complex medical conditions, including gout management, nutritional status, renal function, and alcohol use disorder. The overall plan of care is focused on improving functional mobility, reducing fall risk, increasing independence with daily activities, and preventing rehospitalization. The patient and caregiver were educated on the plan of care and verbalized understanding and agreement.
 Date of Order 01/22/2026 Orders Physician Face-to-Face Date: 01/12/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Gout Unspecified 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 <span style="font-size:

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 01/22/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Shanita Chase
3319 W Belvedere Ave
Baltimore, MD 21215
PHONE: 410-737-5000 FAX: 14107375401 NPI: 1487650891

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 : 01/12/2026

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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14px;">PT Eval Notes: OT Eval Notes:
 Physician Chase , Shanita

SN Careplans

SN WK1: 1 (01/22/26-01/24/26) ,WK2: 1 (01/25/26-01/31/26) ,WK3: 1 (02/01/26-02/07/26) ,WK4: 1 (02/08/26-02/14/26)

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: 3. Multiple hospitalizations (2 or more) in the past 6 months, 4. Multiple emergency department visits (2 or more) in the past 6 months, 7. Currently taking 5 or more medications, 8. Currently reports exhaustion

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: M2020 - Oral Med Management, M2102c - Med Admin, M2102f - Patient Supervision, M2102d - Caregiver Performs Treatment, M1033 - Exhaustion, M1400 - Dyspnea, M1610 - Urinary Incontinence, limited endurance, limited strength, Pain Effect on Sleep, Pain Interference with ADLs, balance deficit, loss of appetite

PROCEDURES: cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments, bladder training, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision

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, * urinary incontinence management including bladder training Kegel exercises skin care, 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 is adequately supervised, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

SN Goals

PATIENT-STATED GOAL: Pt states "I want to get my strength back and be able to work."

GOALS
patient/caregiver recalls
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* 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 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

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

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

patient is adequately supervised

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT Goals

Signature of Physician:

Date

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

Date
01/22/2026

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PT WK1: 1 (01/22/26-01/24/26) ,WK2: 1 (01/25/26-01/31/26) ,WK3: 1 (02/01/26-02/07/26) ,WK4: 1 (02/08/26-02/14/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: 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: HEP: Ankle pumps, quad sets, glute sets, heel slides, partial squats, and seated/standing knee flexion and extension within tolerance. 10-15 reps ea. 1-2 set per day., Medication Review-: Patient verbalized understanding of current prescriptions, dosages, and schedule. No reported issues with adherence, side effects, or confusion at this time. , gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: 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, Walk 10 ft on Uneven Surface - 06. Independent, 1 - Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent

PATIENT-STATED GOAL: Not to go back to hospital

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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

Walk 10 ft on Uneven Surface - 06. Independent

1 - Step (curb) - 06. Independent

4 Steps - 06. Independent

12 Steps - 06. Independent

Picking Up Object - 06. Independent

OT Careplans

OT WK1: 1 (01/22/26-01/24/26) ,WK2: 1 (01/25/26-01/31/26) ,WK3: 1 (02/01/26-02/07/26) ,WK4: 1 (02/08/26-02/14/26) ,WK5: 1 (02/15/26-02/21/26)

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: Home exercise program , Balance training , Medication review , Improve hand function to aid in IADLs , Improve ROM , Joint protection techniques & safety precautions , cough/deep breathing 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 - 06. Independent, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: to improve functionally

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 - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 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	01/22/2026