Home Health Certification and Plan of Care

Order ID: 1150/15800

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
20004363	01/23/2026	From: 01/23/2026 To: 03/23/2026	21615	217058

6. Patient's Name and Address
Janet Rouse
327 Alendale St,
BALTIMORE, MD 21229-
410-294-1285

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 08/17/1955 | **9.Sex** Female

10. Medications: Dose/Frequency/Route (N)ew (C)hanged
Keppra - Levetiracetam 1000 MG mouth two times a day for Seizure
Amilodipine - Amlodipine Besylate 10 mg Oral daily
Acetaminophen - Acetaminophen 500mg (2) by mouth every 8 hours for pain

11. ICD	Principal Diagnosis	Date
G40.89	Other seizures	01/23/26

13. ICD	Other Pertinent Diagnoses	Date
E21.3	Hyperparathyroidism unspecified	01/23/26
R13.10	Dysphagia unspecified	01/23/26
E46.	Unspecified protein-calorie malnutrition	01/23/26
F10.10	Alcohol abuse uncomplicated	01/23/26

14. DME and Supplies:
None of the above

15. Safety Measures:
seizure precautions, , , supervision at all times, activity supervision

16. Nutrition:
low sodium

17. Allergies:
no known allergies

18.A. Functional Limitations
Endurance

18.B. Activities Permitted
Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 1. In new or complex situations only, 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: 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 Other Seizures, 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 70-year-old female with a recent hospitalization for seizure activity related to alcohol abuse, now requiring strict medication compliance to prevent recurrent seizures, which contributes to significant effort and difficulty leaving the home. The patient is alert and oriented 3-4 and demonstrates appropriate understanding of her condition and care. Past medical history is significant for seizure disorder, alcohol abuse, hypertension, hyperparathyroidism, history of encephalopathy, malnutrition, chronic back pain, and a prior fall associated with seizure activity. The patient reports no seizure activity since hospitalization and states her last alcohol intake was greater than one month ago. She reports chronic back pain rated 8/10. Physical assessment reveals scabbing to the right elbow with no open wounds noted. No abnormal bleeding, constipation, or dysuria reported; bowel movements are small and infrequent, attributed to decreased appetite. The patient reports eating approximately one meal per day. Medication reconciliation was completed, and the patient was able to accurately state all medications and their actions, demonstrating good understanding. She reports acetaminophen has limited effectiveness for pain management due to the requirement to eat with dosing, given her poor appetite, and states ibuprofen has been more effective for back pain in the past. The patient plans to follow up with her primary care provider regarding a prescription for ibuprofen and was educated on the importance of taking NSAIDs with food to protect the gastric lining. She verbalized understanding and reports she can tolerate dosing once in the morning and once at night. Consent for services was explained and signed. Functionally, the patient ambulates indoors up to 40 feet without an assistive device under supervision, ascends and descends 14 steps with a handrail and supervision, and performs transfers to chair, bed, and toilet with supervision; bed mobility is independent. Outdoor mobility and car transfers were not assessed. The patient lives alone with bedroom and bathroom located on the second floor and identifies her niece, Christina, as her emergency contact; she was seen at her niece's home during this visit. Balance assessment demonstrates a Tinetti score of 18/28, supporting homebound status due to high fall risk and the taxing effort required to leave the home. Therapeutic exercise tolerance included 10 repetitions of supine hip flexion, bridging, hook-lying trunk rotation, straight leg raises, and hip abduction, as well as side-stepping and tandem gait for 10 feet 2 with supervision and upper-extremity support during tandem gait. The patient would benefit from continued skilled home physical and occupational therapy to improve strength, balance, and functional mobility and to promote a safe return to maximal independence. Skilled nursing services are ordered at a frequency of 1/week for 1 week, 2/week for 1 week, and 2/week for 3 weeks, with OT and PT services also initiated as part of the plan of care.
 Date of Order 01/23/2026 Orders Physician Face-to-Face Date: 01/16/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Other Seizures 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:
 Physician Favero, Christopher

SN Careplans

SN WK1: 1 (01/23/26-01/24/26) ,WK2: 1 (01/25/26-01/31/26) ,WK3: 2 (02/01/26-02/07/26) ,WK4: 2 (02/08/26-02/14/26) ,WK5: 2 (02/15/26-02/21/26)

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: 8. Currently reports exhaustion

SN Goals

PATIENT-STATED GOAL: to be alright in her home and no seizures

GOALS
patient/caregiver recalls
* how to manage seizure triggers
* implement lifestyle changes including getting enough sleep
* avoiding alcohol
* recalls related medication(s) purpose, schedule

patient/caregiver recalls

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

25. Date HHA Received Signed POT

24. Physician's Name and Address
Christopher Favero
4660 Wilkens Ave
Baltimore, MD 21229
PHONE: 4102470782 FAX: 18662515693 NPI: 1881252617

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 : 01/16/2026

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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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 ; 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.

no wounds noted
Advance Directive:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, abnormal blood pressure, abnormal thyroid <> 0.40 - 4.50 mIU/mL, abnormal bowel sounds, muscle weakness, limited endurance, limited strength, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, seizures, loss of appetite

PROCEDURES: cough/deep breathing exercises, monitor intake & output, coordinate/arrange preparation of missing meals

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, * how to manage seizure triggers implement lifestyle changes including getting enough sleep avoiding alcohol, related medication(s) purpose, schedule, * dietary guidelines for managing nutritional deficit, 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

* dietary guidelines for managing nutritional deficit
* 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
* 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 (01/25/26-01/31/26) ,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, 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: Home exercise program : Sitting knee extension, ankle pumps. Standing knee flexion, hip abduction, hip extension, plantarflexion, squats. Supine hip flexion, bridging, hooklying rotation, straight leg raise, hip abduction , gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: * 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 - 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

PT Goals

PATIENT-STATED GOAL: Be able to drive again and get around

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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 - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

01/23/2026

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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

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	01/23/2026