Home Health Certification and Plan of Care

Order ID: 1150/16177

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
16228119630	02/09/2026	From: 02/09/2026 To: 04/09/2026	22296	217058

6. Patient's Name and Address

Sherri Noll
2903 E Northern Pkwy,
Baltimore, MD 21214-
443-400-3373

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 02/11/1963 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
J44.9	Chronic obstructive pulmonary disease unspecified	02/09/26

13. ICD	Other Pertinent Diagnoses	Date
I10.	Essential (primary) hypertension	02/09/26
E11.69	Type 2 diabetes mellitus with other specified complication	02/09/26
D64.9	Anemia unspecified	02/09/26
E03.9	Hypothyroidism unspecified	02/09/26
F31.5	Bipolar disord crnt epsd depress severe w psych features	02/09/26
M54.9	Dorsalgia unspecified	02/09/26
G89.29	Other chronic pain	02/09/26
E87.5	Hyperkalemia	02/09/26
F29.	Unsp psychosis not due to a substance or known physiol cond	02/09/26
F11.20	Opioid dependence uncomplicated	02/09/26
R13.10	Dysphagia unspecified	02/09/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	02/09/26
Z79.899	Other long term (current) drug therapy	02/09/26
Z98.1	Arthrodesis status	02/09/26
Z87.440	Personal history of urinary (tract) infections	02/09/26
Z86.0100	Personal history of colonic polyps	02/09/26

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

Amilodipine - Amlodipine Besylate 5 MG mouth one time a day for Hypertension
Cymbalta - Duloxetine Hydrochloride 30 MG mouth one a day in the morning for pain
Gabapentin - Gabapentin 100 MG mouth two times a day for Neuropathy
Lamictal - Lamotrigine 200 MG mouth one time a day for Bipolar disorder
Desyrel - Trazodone Hydrochloride 50 MG mouth at bedtime for Insomnia
Voltaren - Diclofenac Sodium 1 % Apply to Back one time a day for pain 1 gram dose
Vit D - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 50000u by mouth once a week on Friday for Vit D def
Risperdal - Risperidone 1 mg 1mg by mouth at bedtime bipolar
Buspirone Hcl - Buspirone Hydrochloride 5 mg 5mg by mouth three times a day anxiety

14. DME and Supplies:

reacher, wheelchair, hospital bed

15. Safety Measures:

walker precautions, supervision at all times, transfer with assist, wheelchair precautions, , bathroom safety, bedrails up while in bed, ambulates with device, ambulates with assistance, activity supervision

16. Nutrition:

low cholesterol

17. Allergies:

ibuprofen penicillin lisinopril

18.A. Functional Limitations

Bowel/Bladder Incontinence, Endurance, Ambulation

18.B. Activities Permitted

Wheelchair, 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: Yes

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
family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Chronic Obstructive Pulmonary Disease 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:

Start of care <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh> completed for a female patient with a significant past medical history of bipolar disorder, depression, chronic pain, hypothyroidism, hyperlipidemia, vitamin D deficiency, chronic obstructive pulmonary disease (COPD), and documented history of poor medical compliance. The patient was recently hospitalized for back pain requiring surgery at Johns Hopkins Hospital, followed by readmission and subsequent stay at a skilled nursing facility for rehabilitation. She has since returned home and currently resides with a friend, Renee, who serves as her informal caregiver. The patient also has a service coordinator, Sincere (443-761-0284). Primary care provider is Dr. Buresh (410-550-2999), psychiatric provider contact number 410-498-2603, with additional contact listed as Jen Krause (877-936-8028). Pharmacy services are through Specialty Rx Pennsylvania. Upon <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>, the patient was found bedbound in a hospital bed, positioned supine with bilateral knee flexion contractures and significant hamstring tightness. Both lower and upper extremities appear atrophied, and the patient demonstrates generalized weakness. She is fully dependent for bed mobility and transfers. The patient reports severe left hip pain rated 10/10 and states she is unable to "straighten out her legs." Caregiver reports that the bilateral lower extremity contractures developed following her recent surgery. The patient expresses a strong desire to regain independence, stating her goal is "to walk by myself" and "to do for herself." She has not been out of bed since returning home from rehabilitation. Sitting balance, sitting tolerance, standing tolerance, standing balance, bilateral upper extremity strength, and overall activity tolerance are significantly decreased, resulting in substantial impairment in self-care tasks, transfers, and functional ambulation. The patient was noted to have poor hygiene, smelling strongly of urine at the time of visit, raising concerns for inadequate personal care and limited caregiver support. Although a friend is present, there appears to be no structured or reliable caregiving system in place, and the caregiver verbalized difficulty providing maximal assistance. The home environment was assessed for safety. The hospital bed was initially set up with rails positioned at the foot of the bed; the caregiver was instructed to reposition the rails to the head of the bed to reduce fall risk. The caregiver verbalized understanding. No wounds were observed during <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>. The patient is considered homebound due to profound weakness, bedbound status, severe contractures, pain, ambulatory dysfunction, and the taxing effort required to leave the home. Medication reconciliation revealed the patient has punch-card medications available including risperidone (Risperdal), vitamin D 50,000 IU, trazodone, amlodipine, buspirone, duloxetine (Cymbalta), gabapentin, lamotrigine, and diclofenac 1% topical gel. Additional prescriptions were found in a skilled nursing facility discharge folder and were provided to the caregiver with instructions to have them filled promptly. The caregiver was educated on the importance of scheduling a follow-up appointment with the primary care provider to ensure proper medication reconciliation, as medication changes commonly occur during

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 02/09/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Megan Buresh
5200 Eastern Ave
Baltimore, MD 21224
PHONE: 4105502999 FAX: 14103672442 NPI: 1710257290

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 : 01/29/2026

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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hospitalization and SNF stays. Education was also provided regarding adherence to prescribed psychiatric and medical regimens to prevent exacerbations and rehospitalization. The caregiver verbalized understanding and agreed to contact the primary care provider for follow-up. Skilled nursing services are indicated for medication management, compliance monitoring, pain <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh> and management, safety education, and coordination of care. Physical therapy initiated a home exercise program with caregiver instruction, including passive knee stretching, assisted straight leg raises, and lower extremity abduction/adduction exercises to address contractures and prevent further decline. Occupational therapy evaluation indicates the patient was previously independent with basic self-care, functional transfers, and ambulation, and attended adult day care five days per week prior to hospitalization. Skilled OT services are recommended to address deficits in strength, balance, activity tolerance, contracture management, ADL retraining, positioning, and caregiver education, with the goal of maximizing functional recovery and facilitating return toward prior level of function. The overall plan of care focuses on aggressive rehabilitation within tolerance, prevention of further deconditioning and skin breakdown, pain control, medication compliance, caregiver support and training, and close coordination with medical and psychiatric providers to stabilize the patient's complex medical and psychosocial needs.
 Date of Order 02/09/2026 Orders Physician Face-to-Face Date: 01/29/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Chronic Obstructive Pulmonary Disease 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 PT Eval Notes: OT Eval Notes:
 Physician Buresh, Megan

SN Careplans

SN WK1: 1 (02/09/26-02/14/26) ,WK2: 1 (02/15/26-02/21/26) ,WK3: 1 (02/22/26-02/28/26) ,WK4: 1 (03/01/26-03/07/26) ,WK5: 1 (03/08/26-03/14/26) ,WK6: 1 (03/15/26-03/21/26)

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

HOSPITALIZATION RISKS: 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: D0160 - Depression, M1720 - Anxiety, M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2020 - Oral Med Management, Home Safety, M2102c - Med Admin, meal preparation, M1400 - Dyspnea, abn cholesterol > 200 mg/dL, abnormal thyroid <> 0.40 - 4.50 mIU/mL, muscle weakness, limited endurance, muscle spasms, limited strength, balance deficit, pain radiating to arms/legs, Pain Interference with ADLs, Pain Interference with Therapy activities, Pain Effect on Sleep

PROCEDURES: cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange preparation of missing meals, coordinate/arrange repair of inadequate heating

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, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, related m, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpos, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient has adequate heating, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

SN Goals

PATIENT-STATED GOAL: TO WALK AND AND DO FOR MYSELF

GOALS
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) purpos

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

patient has adequate heating

patient is adequately supervised

meal preparation is available to patient for all meals

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT WK1: 1 (02/08/26-02/14/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with ADLs, M1400 - Dyspnea, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand, GG0170E1 - Chair to Bed to Chair, GG0170G1 - Car Transfer, GG0170R1 - Wheel 50 ft w 2 Turns, GG0170S1 - Wheel 150 feet

PROCEDURES: cough/deep breathing exercises, incentive spirometer, wheelchair training, home exercise program: Passive stretching of both knees, slr, keep the knees from the stretching., 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, Chair to Bed to Chair - 05. Setup or clean-up assistance, Sit to Stand - 05. Setup or clean-up assistance, Toilet Transfer - 05. Setup or clean-up assistance, Wheel 50 ft w 2

PT Goals

PATIENT-STATED GOAL: To transfer in and out of bed by my self

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

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	02/09/2026

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Turns - 06. Independent, Wheel 150 feet - 06. Independent, Car Transfer - 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

Wheel 50 ft w 2 Turns - 06. Independent

Wheel 150 feet - 06. Independent

Car Transfer - 05. Setup or clean-up assistance

OT Careplans

OT WK1: 1 (02/09/26-02/14/26) ,WK2: 1 (02/15/26-02/21/26) ,WK3: 1 (02/22/26-02/28/26) ,WK4: 1 (03/01/26-03/07/26) ,WK5: 1 (03/08/26-03/14/26) ,WK6: 1 (03/15/26-03/21/26)

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: therapeutic exercises, work simplification/energy conservation, transfers training, assist with bathing, assist with toileting hygiene, assist with transferring, 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 - 06. Independent, Toileting Hygiene - 05. Setup or clean-up assistance, Shower/Bathe Self - 02. Substantial/maximal assistance, Lower Body Dressing - 03. Partial/moderate assistance, Don/Doff Footwear - 03. Partial/moderate assistance, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: I want to walk

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 - 05. Setup or clean-up assistance

Shower/Bathe Self - 02. Substantial/maximal assistance

Lower Body Dressing - 03. Partial/moderate assistance

Don/Doff Footwear - 03. Partial/moderate assistance

Eating - 06. Independent

Upper Body Dressing - 06. Independent

HHA Careplans

HHA WK2: 2 (02/15/26-02/21/26) ,WK3: 2 (02/22/26-02/28/26) ,WK4: 2 (03/01/26-03/07/26) ,WK5: 2 (03/08/26-03/14/26) ,WK6: 2 (03/15/26-03/21/26)

PROCEDURES: assist with bathing: Max A, assist with toilet transferring: Total assistance, assist with toileting hygiene: Max A, assist with transferring: Total assistance, assist with mobility, assist with fall prevention, assist with assistive devices prn, assist with lower body dressing: Max A, assist with lower body dressing: Total assistance, assist with upper body dressing: Max A

HHA Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

02/09/2026