

Home Health Certification and Plan of Care				Order ID: 1150/15816	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
5HE4X37TT86		01/24/2026		From: 01/24/2026 To: 03/24/2026	
				4. Medical Record No.	
				21742	
				5. Provider No.	
				217058	
6. Patient's Name and Address			7. Provider's Name, Address and Telephone Number		
Shirley Sciortino			HomeCentris Healthcare LLC		
919 Rustling Oaks Drive,			10 Crossroads Drive, Suite 102		
MILLERSVILLE, MD 21108-			Owings Mills, MD 21117-8284		
443-421-1332			410-321-8448		
			1487113239		
8. DOB			9. Sex		
01/12/1947			Female		
11. ICD			Date		
N17.9			01/24/26		
Principal Diagnosis			Acute kidney failure unspecified		
13. ICD			Date		
I12.9			01/24/26		
Other Pertinent Diagnoses			Hypertensive chronic kidney disease w stg 1-4/unspld chr kdny		
N18.30			01/24/26		
Chronic kidney disease stage 3 unspecified					
D63.1			01/24/26		
Anemia in chronic kidney disease					
E87.1			01/24/26		
Hypo-osmolality and hyponatremia					
E87.5			01/24/26		
Hyperkalemia					
M31.7			01/24/26		
Microscopic polyangiitis					
I48.91			01/24/26		
Unspecified atrial fibrillation					
I77.82			01/24/26		
Antineutrophilic cytoplasmic antibody [ANCA] vasculitis					
J84.9			01/24/26		
Interstitial pulmonary disease unspecified					
G58.7			01/24/26		
Mononeuritis multiplex					
G62.89			01/24/26		
Other specified polyneuropathies					
H49.20			01/24/26		
Sixth [abducent] nerve palsy unspecified eye					
F41.9			01/24/26		
Anxiety disorder unspecified					
K21.9			01/24/26		
Gastro-esophageal reflux disease without esophagitis					
R05.3			01/24/26		
Chronic cough					
Z79.01			01/24/26		
Long term (current) use of anticoagulants					
Z90.49			01/24/26		
Acquired absence of other specified parts of digestive tract					
Z90.710			01/24/26		
Acquired absence of both cervix and uterus					
Z86.73			01/24/26		
Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits					
14. DME and Supplies:			15. Safety Measures:		
walker, bath bench, hospital bed, grab bars, cane			ambulates with device, walker precautions, , emergency phone # clearly displayed, ambulates with assistance, supervision at all times, , activity supervision		
16. Nutrition:			17. Allergies:		
regular, renal diet			codeine morphine		
18.A. Functional Limitations			18.B. Activities Permitted		
Endurance, Ambulation			Up As Tolerated, 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:			22.B.Discharge Plans		
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.			patient will be responsible for managing treatment		
Homebound status:			Due to diagnosis of Acute Kidney Failure 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			<div>The patient is a 79-year-old female recently discharged following a prolonged 31-day inpatient hospitalization for nausea, diarrhea, and confusion, during which she was diagnosed with acute renal failure requiring urgent initiation of hemodialysis, complicated by severe hyperkalemia and metabolic acidosis. Since discharge, the patient remains dialysis-dependent and receives hemodialysis three times weekly via a right subclavian dialysis catheter, which is intact without noted complications. She reports oliguria. Past medical history is significant for vasculitis with a recent flare managed with prednisone, cerebrovascular accident two years ago, chronic bronchial disease, interstitial lung disease, hypertension, peripheral neuropathy, gastroesophageal reflux disease, pseudoaneurysm status post surgical repair, three prior cerebral aneurysms, and multiple surgical procedures including cholecystectomy, hysterectomy, left total knee replacement, tonsillectomy, and aneurysm repairs. On assessment, the patient is awake, alert, and oriented to person, place, and time. She denies pain but reports shortness of breath with minimal to moderate exertion. Lung auscultation reveals diminished breath sounds bilaterally with crackles at the lung bases. Trace bilateral lower extremity edema is noted. Appetite is fair, with the patient consuming approximately three meals daily, and her last bowel movement was reported as occurring the day prior to assessment. Vital signs revealed elevated blood pressure earlier in the day (144/100 mmHg) due to missed medications; following medication administration, blood pressure improved to 140/70 mmHg by the afternoon. The patient reports chronic lower extremity weakness and neuropathy, altered taste sensation (difficulty tasting salt), and decreased endurance. She utilizes a wheelchair at the dialysis center and has assistive devices		
23. Signature and Date of Verbal SOC Where Applicable:			25. Date HHA Received Signed POT		
Electronically Signed by Messick, Charles RN on 01/24/2026					
24. Physician's Name and Address			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.		
Elliott Gorbaty			F2F date : 12/20/2025		
1411 Madison Park Dr					
Glen Bernie, MD 21061					
PHONE: 4105539571 FAX: 14105539573 NPI: 1528043049					
27. Attending Physician's Signature and Date Signed			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.		
02/19/2026 Date of physician last face-to-face					
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available in the home but is not currently using them for ambulation. No falls were reported in the past year. Due to limited endurance related to cardiovascular and respiratory disease, the patient has significant difficulty safely leaving the home and requires prolonged recovery time after outings. The patient resides in a multi-level home and currently sleeps in a hospital bed located in the den, as she has been unable to access her second-floor bedroom for over a month. Environmental barriers include two steps through the garage to enter and exit the home and three steps to access the kitchen. The patient's spouse, Joseph, provides assistance with all activities of daily living (ADLs) and instrumental activities of daily living (IADLs), although the patient is able to complete select IADLs such as writing checks, light meal preparation (e.g., cutting vegetables), and computer use. Skilled nursing reviewed all medications with the patient and spouse, including anticoagulation therapy with Eliquis taken twice daily, and provided education regarding signs and symptoms of bleeding; both the patient and spouse verbalized understanding. Given the patient's decreased strength in bilateral upper and lower extremities, impaired balance, unsteady gait, difficulty with transfers and stair negotiation, reduced activity tolerance, and poor safety awareness, she is at high risk for falls and further functional decline. Physical therapy and occupational therapy evaluations have been ordered to address deficits in strength, functional mobility, transfers, ambulation safety, balance, stair management, and ADL performance. The plan of care includes skilled nursing

CE-FMS-visits">visits</mh> at the prescribed frequency for ongoing monitoring, medication management, and education, as well as home-based PT and OT services to promote safety, prevent rehospitalization, and support the patient's goal of maximizing independence within the home environment.

Date of Order

Physician Face-to-Face Date: 12/20/2025

Clinical Condition Requiring Home Care per Certifying Physician: SN for disease management: PT eval and treat OT eval and treat due to Acute Kidney Failure 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

OT Eval Notes:

PT Eval Notes:

Physician

Gorbaty, Elliott

SN Careplans

SN WK1: 1 (01/24/26-01/24/26) ,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: 1 (02/15/26-02/21/26) ,WK6: 1 (02/22/26-02/28/26) ,WK7: 1 (03/01/26-03/07/26) ,WK8: 1 (03/08/26-03/14/26) ,WK9: 1 (03/15/26-03/21/26) ,WK10: 1 (03/22/26-03/24/26)

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: 7. Currently taking 5 or more medications, 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; 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:Living Will

PROBLEMS IDENTIFIED ON ASSESSMENT: , M2020 - Oral Med Management, meal preparation, M1400 - Dyspnea, dependent edema, lung sounds not clear, nausea/vomiting, decreased urine output, limited strength, limited endurance, balance deficit

PROCEDURES: cough/deep breathing exercises, home exercise program, monitor dialysis schedule

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage respiratory condition including diet

SN Goals

PATIENT-STATED GOAL: TO GET STRONGER

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 self-administers medications as prescribed

- * recalls related medication(s) purpose, schedule

meal preparation is available to patient for all meals

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	01/24/2026

