# Home Health Certification and Plan of Care

**Order ID: 1150/16446**

| 1. Patient s HI claim No. | 2. Start Of Care Date | 3. Certification Period | 4. Medical Record No. | 5. Provider No. |
|---|---|---|---|---|
| 35931316 | 12/26/2025 | From: 02/24/2026 To: 04/24/2026 | 10210 | 217058 |

**6. Patient's Name and Address**

Doretha Burch
6916 Brompton Rd,
GWYNN OAK, MD 21207-
410-298-0418

**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 08/15/1936 | 9.Sex Female

| 11. ICD | Principal Diagnosis | Date |
|---|---|---|
| S31.000A | Unsp opn wnd low back and pelv w/o penet retroperiton init | 12/26/25 |

| 13. ICD | Other Pertinent Diagnoses | Date |
|---|---|---|
| N39.0 | Urinary tract infection site not specified | 12/26/25 |
| G20.A1 | Parkinson's dis w/o dyskinesia w/o mention of fluctuations | 12/26/25 |
| R31.9 | Hematuria unspecified | 12/26/25 |
| M84.552D | Path fx in neopltc dis l femur subs for fx w routn heal | 12/26/25 |
| I11.9 | Hypertensive heart disease without heart failure | 12/26/25 |
| M80.08XD | Age-rel osteopor w crnt path fx verteb 7thD | 12/26/25 |
| J43.9 | Emphysema unspecified | 12/26/25 |
| I11.0 | Hypertensive heart disease with heart failure | 12/26/25 |
| K44.9 | Diaphragmatic hernia without obstruction or gangrene | 12/26/25 |
| I50.33 | Acute on chronic diastolic (congestive) heart failure | 12/26/25 |
| K75.4 | Autoimmune hepatitis | 12/26/25 |
| G47.00 | Insomnia unspecified | 12/26/25 |
| I48.91 | Unspecified atrial fibrillation | 12/26/25 |
| K22.70 | Barrett's esophagus without dysplasia | 12/26/25 |
| E78.2 | Mixed hyperlipidemia | 12/26/25 |
| I25.10 | Athscl heart disease of native coronary artery w/o ang pctrs | 12/26/25 |
| D50.9 | Iron deficiency anemia unspecified | 12/26/25 |
| E55.9 | Vitamin D deficiency unspecified | 12/26/25 |
| M19.90 | Unspecified osteoarthritis unspecified site | 12/26/25 |
| G89.29 | Other chronic pain | 12/26/25 |
| R60.9 | Edema unspecified | 12/26/25 |
| H40.1133 | Primary open-angle glaucoma bilateral severe stage | 12/26/25 |
| Z79.82 | Long term (current) use of aspirin | 12/26/25 |
| K80.20 | Calculus of gallbladder w/o cholecystitis w/o obstruction | 12/26/25 |
| Z91.81 | History of falling | 12/26/25 |
| K76.0 | Fatty (change of) liver not elsewhere classified | 12/26/25 |
| K74.3 | Primary biliary cirrhosis | 12/26/25 |
| I27.20 | Pulmonary hypertension unspecified | 12/26/25 |
| M35.1 | Other overlap syndromes | 12/26/25 |
| R91.8 | Other nonspecific abnormal finding of lung field | 12/26/25 |
| R59.0 | Localized enlarged lymph nodes | 12/26/25 |
| Z86.19 | Personal history of other infectious and parasitic diseases | 12/26/25 |
| Z87.891 | Personal history of nicotine dependence | 12/26/25 |
| Z87.01 | Personal history of pneumonia (recurrent) | 12/26/25 |
| Z99.81 | Dependence on supplemental oxygen | 12/26/25 |
| Z79.52 | Long term (current) use of systemic steroids | 12/26/25 |
| Z79.01 | Long term (current) use of anticoagulants | 12/26/25 |
| I13.0 | Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny | 12/26/25 |
| N18.32 | Chronic kidney disease stage 3b | 12/26/25 |
| I48.0 | Paroxysmal atrial fibrillation | 12/26/25 |
| I25.2 | Old myocardial infarction | 12/26/25 |
| Z87.440 | Personal history of urinary (tract) infections | 12/26/25 |
| N18.2 | Chronic kidney disease stage 2 (mild) | 12/26/25 |
| D63.1 | Anemia in chronic kidney disease | 12/26/25 |
| M81.0 | Age-related osteoporosis w/o current pathological fracture | 12/26/25 |
| E78.5 | Hyperlipidemia unspecified | 12/26/25 |

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

Anusol Hc - Hydrocortisone 2.5 % rectal cream, Insert into the rectum rectal twice a day Insert into the rectum 2 (two) times a day.
Digox 125 mcg (0.125 mg) tablet 125 mcg (0.125 mg), Take 1 tablet (125 mcg total) by mouth once a day
Actigall - Ursodiol 300 mg 2 capsules in the morning and 1 at bedtime by mouth twice a day
Dulcolax - Bisacodyl 5 mg tablet by mouth at bedtime As needed for constipation
Lipitor - Atorvastatin Calcium eq 80 mg base 1 tablet by mouth once a day Cholesterol
Xarelto - Rivaroxaban 15mg, Take tablet by mouth at bedtime
Tramadol - Tramadol Hydrochloride 1 tablet 50 mg by mouth every 6 hours As needed for pain
Albuterol Nebulizer - Albuterol 1 application inhalant three times a day As needed for breathing
Tylenol - Acetaminophen 0500 mg, Take 1 or 2 tablet (500 mg total) by mouth as necessary Every 8 hours for Pain to back
Imuran - Azathioprine 100 MG Tablet 1 tablet by mouth once a day Liver
Cosopt - Dorzolamide Hydrochloride: Timolol Maleate 22.3-6.8 mg/ML both eyes once a day
Ergocalciferol - Ergocalciferol 50,000 International Units 1 capsule by mouth once a week Supplement
Lasix - Furosemide 40 mg 1 tablet by mouth every other day Edema
Xalatan - Latanoprost 00.005 % ophthalmic solution drops once a day In both eyes
Cozaar - Losartan Potassium 0100mg, take 1/2 tablet (50 mg) by mouth once a day
Menthol-zinc oxide 0.44-20.6% ointment topical as necessary On rash on buttocks
Metoprolol - Hydrochlorothiazide: Metoprolol Succinate 25 mg , take 1 tablet by mouth once a day Blood pressure
Spironolactone - Spironolactone 50 mg 1 tablet by mouth once a day Blood pressure
Oxygen - Oxygen 2 L/min nasal cannula continuous For breathing
Azathioprine - Azathioprine Sodium 100 mg by mouth once a day Patient reported it's for her liver

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 02/20/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Nnemdi Baird Cross
10085 Red Run Blvd
Owings Mills, MD 21117
PHONE: 4105817804 FAX: 14103566507 NPI: 1669616520

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 : 12/01/2025

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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| 6. Patient's Name and Address | 7. Provider's Name, Address and Telephone Number |
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| | | |
|---|---|---|
| M48.50XD | Collapsed vertebra NEC site unsp subs for fx w routn heal | 12/26/25 |

| 14. DME and Supplies: | 15. Safety Measures: |
|---|---|
| reacher, nebulizer, oxygen supplies, hospital bed, commode, rolling walker, 4 wheeled walker | standard precautions, O2 precautions, fall precautions |
| **16. Nutrition:** | **17. Allergies:** |
| regular | Oxycodone |
| **18.A. Functional Limitations** | **18.B. Activities Permitted** |
| Endurance | Other, Spinal precautions |

**19. Mental & Pyschosocial Status:** COGNITION: 1. When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer, ANXIETY: , SOCIAL ISOLATION: 2 independent, BEHAVIORAL ISSUES: 2 independent, HISTORY OF DEPRESSION:

**20. Prognosis:** fair

| 22. A Rehabilitation Potential: | 22.B.Discharge Plans |
|---|---|
| SELF-CARE: N/A, MOBILITY: N/A | patient will be responsible for managing treatment<br>family/caregiver will be responsible for managing treatment |

**Homebound status:** Due to diagnosis of Unspecified Open Wound Of Lower Back And Pelvis Without Penetration Into Retroperitoneum, Initial Encounter, 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 89-year-old female admitted to home health services for skilled nursing, physical therapy, and occupational therapy following recent hospitalization and rehabilitation for lumbar and thoracic spinal compression fractures. Her past medical history is significant for hypertension, atrial fibrillation, HFpEF/CHF, pulmonary hypertension, hyperlipidemia, autoimmune hepatitis with primary biliary cholangitis, osteoporosis, osteoarthritis, prior lumbar-sacral and thoracic compression fractures, and multiple additional comorbidities. Her recent hospitalization for lumbar compression fracture was complicated by a urinary tract infection with sepsis. The patient resides with her family in a single-level home. On initial skilled nursing assessment, the patient was observed sitting upright at the kitchen table wearing her prescribed back brace. She reported the brace to be uncomfortable but denied pain at rest. She was alert and oriented to person, place, time, and situation. The patient endorsed intermittent shortness of breath, which she attributed to her known diagnoses of CHF and pulmonary hypertension. Oxygen saturation levels remained in the mid to high 90s on room air throughout the visit. She was noted to demonstrate pursed-lip breathing but stated she felt comfortable. Lung auscultation revealed inspiratory and expiratory wheezes throughout. Bowel sounds were active in all quadrants, and the patient reported her last bowel movement occurred the previous day. The patient and her daughter reported current inflamed hemorrhoids, for which she is using hemorrhoidal cream. Trace bilateral lower extremity edema was noted, and the patient was instructed to elevate her legs when not ambulating. Skin was warm, intact, and without noted breakdown. The patient ambulates within the home using a rolling walker and follows strict spinal precautions, including no bending, twisting, or lifting. She wears her back brace whenever out of bed. Education was provided regarding proper positioning in bed, including the use of pillows between the knees and behind the back for comfort and spinal alignment. The patient and family were encouraged to continue daily therapeutic exercises as instructed during her prior rehabilitation stay, as tolerated. Vital signs were obtained, and the patient was admitted to home health services for ongoing monitoring, medication education, and management of recent medication changes. Physical therapy evaluation revealed the patient to have decreased bilateral lower extremity strength, measured at approximately 3/5 manual muscle testing. She currently requires contact guard assistance for transfers and short-distance ambulation with a rolling walker. She denies pain while sitting but reports pain with movement, particularly during transfers. The patient is required to wear her lumbar brace when out of bed. Compared to her prior level of function, during which she ambulated independently indoors without an assistive device and occasionally used a rollator for outdoor mobility, she demonstrates a significant decline in strength, balance, and functional mobility. Skilled physical therapy services are indicated to improve strength, balance, safety, and independence in order to facilitate return toward prior level of function. Occupational therapy assessment indicates the patient requires moderate assistance for bathing and maximal assistance to dependent levels for upper and lower body dressing tasks. She requires contact guard assistance for sit-to-stand and toilet transfers, with verbal cues for proper limb placement and adherence to spinal precautions. The patient continues to use her back brace during functional activities and remains compliant with no lifting, bending, or twisting restrictions. The plan of care includes continued skilled nursing for cardiopulmonary monitoring, medication education and management, edema monitoring, and reinforcement of disease management strategies; skilled physical therapy to address strength, balance, gait, and functional mobility deficits; and skilled occupational therapy to improve independence and safety with activities of daily living while maintaining spinal precautions. The patient and family demonstrated understanding of education provided and remain engaged in the plan of care. <br> Date of Order 02/20/2026 Orders Physician Face-to-Face Date: 12/01/2025 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Unspecified Open Wound Of Lower Back And Pelvis Without Penetration Into Retroperitoneum, Initial Encounter Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home <br> 4 - Recertification Notes: The patient is for recertification due to a recent compression fracture. The patient continues to demonstrate weakness of bilateral upper extremity muscle strength and has spinal precautions of no bending, twist and lifting. The patient can continue to benefit from continued OT services. <br> Physician Baird Cross, Nnemdi

| SN Careplans | SN Goals |
|---|---|
| | |

| Signature of Physician: | Date |
|---|---|
| | |



| Optional Name/Signature of Nurse/Therapist: | Date |
|---|---|
| Electronically Signed by Messick, Charles RN | 02/20/2026 |

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## OT Careplans

OT WK1: 7 (02/24/2026 - 02/28/2026)

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:

HOSPITALIZATION RISKS: 2. Unintentional weight loss of a total of 10 pounds or more in the past 12 months, 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 ; 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.
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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

## OT Goals

PATIENT-STATED GOAL: I want to dance again;Patient wants to get better and 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

Toileting Hygiene - 06. Independent

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

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

Don/Doff Footwear - 05. Setup or clean-up assistance

patient/caregiver recalls
* strategies to increase caloric intake
* recalls related medication(s) purpose, schedule

Toileting Hygiene - 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

Eating - 06. Independent

Oral Hygiene - 05. Setup or clean-up assistance

Shower/Bathe Self - 03. Partial/moderate assistance

Eating - 06. Independent

Signature of Physician:

Date



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

Date
02/20/2026

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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: M1033 - Unintentional Weight Loss

PROCEDURES: Medication Review : Medication reviewed with patient, Patient/caregiver recalls related purpose and schedule of medications: Medications review

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, * 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, * strategies to increase caloric intake, related medication(s) purpose, schedule, Oral Hygiene - 05. Setup or clean-up assistance, Toileting Hygiene - 05. Setup or clean-up assistance, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 03. Partial/moderate assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance, Eating - 06. Independent, Eating - 06. Independent

| Signature of Physician: | Date |
|---|---|
| | PAGE 4 of 4 |
| Optional Name/Signature of Nurse/Therapist: | Date |
| Electronically Signed by Messick, Charles RN | 02/20/2026 |