Home Health Certification and Plan of Care

Order ID: 1150/15253

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
36647736	12/31/2025	From: 12/31/2025 To: 02/28/2026	20891	217058

6. Patient's Name and Address

Donette Johnson
10 WALDEN POPLAR CT,
GWYNN OAK, MD 21207-
443-977-1811

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 01/17/1957 | **9.Sex** Male

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

Norvasc - Amlodipine Besylate 10 MG tablet,Take 1 tablet by mouth once a day Take 1 tablet by mouth daily
Lomotil - Atropine Sulfate: Diphenoxylate Hydrochloride 2.5-0.025 mg tablet,Take 1 tablet by mouth twice a day Take 1 tablet by mouth 2 times daily. TAKE 1 TABLET BY
MOUTH 2 TIMES DAILY - BREAKFAST AND LUNCH
FOR 30 DAYS
Pravachol - Pravastatin Sodium 40 MG tablet,Take 1 tablet by mouth once a day Take 1 tablet by mouth daily.

11. ICD	Principal Diagnosis	Date
Z48.815	Encntr for surgical aftcr following surgery on the dgstv sys	12/31/25

13. ICD	Other Pertinent Diagnoses	Date
I10.	Essential (primary) hypertension	12/31/25
J96.01	Acute respiratory failure with hypoxia	12/31/25
E78.2	Mixed hyperlipidemia	12/31/25
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	12/31/25
F32.A	Depression unspecified	12/31/25
F17.210	Nicotine dependence cigarettes uncomplicated	12/31/25
Z90.49	Acquired absence of other specified parts of digestive tract	12/31/25

14. DME and Supplies:

4 wheeled walker, wound care supplies

15. Safety Measures:

infectious material management, ambulates with device, bathroom safety, emergency phone # clearly displayed, electrical safety measures, smoke detectors , walker precautions, transfer with assist, supervision at all times, , hand rails, ambulates with assistance, , no straining, , activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

strawberries

18.A. Functional Limitations

Endurance, Ambulation

18.B. Activities Permitted

Walker, No lifting more than 10lbs for 8 weeks

19. Mental & Pyschosocial Status: COGNITION: 2. Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility, ANXIETY: 3. During the day and evening, but not constantly, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes

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: After undergoing Colostomy Reversal, 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 68-year-old female who underwent a colostomy reversal on 12/17 and has since been discharged home to recover. She resides with her sister in a three-level row home and was found resting in bed upon the registered nurse's arrival. The patient was accompanied during the visit by another sister, as her primary household caregiver was at work. Past medical history is significant for diverticulitis secondary to large bowel obstruction status post Hartmann's procedure in December 2024, hyperlipidemia, hypertension, cerebrovascular accident with residual memory loss, and a right lower lobe mucus plug noted on 12/20. The patient is a smoker, and education was provided regarding the negative impact of smoking on wound healing. On assessment, the patient has a large midline abdominal incision measuring approximately 20 inches in length, closed with staples, which were intact at the time of the visit. She also has an open wound at the former stoma site requiring daily wound care. Wound care is currently being performed by the patient's sisters using a wet-to-dry dressing with Vashe solution. The family reported that they had run out of bordered foam gauze to cover the wound; arrangements will be made for supply ordering through Daisy, and a nurse will bring the supplies at the next visit. In the interim, the family plans to purchase bordered foam gauze independently. The patient's sister successfully return-demonstrated wound care using aseptic technique. The patient has no pets in the home. She is designated as full code and has a documented allergy to strawberries. The family has requested home health aide services to assist with bathing and dressing. A physical therapy evaluation was completed. According to the physical therapy assessment, the patient has a past medical history of hypertension, hyperlipidemia, and diverticulitis status post Hartmann's procedure in 2024, with recent hospitalization for ostomy reversal. Prior to hospitalization, the patient ambulated independently without an assistive device and was working full time. At the time of evaluation, she demonstrated bilateral lower extremity strength of approximately 4/5 on manual muscle testing, was independent with transfers, and ambulating slowly without an assistive device under distant supervision. The patient reported that her cautious gait speed was due to concern about her abdominal staples and fear of disrupting the surgical site. She was observed to negotiate stairs safely within the home and appeared to be recovering well from surgery. The patient declined further physical therapy services, stating that she is not experiencing difficulties with functional mobility at this time. The plan of care includes continued skilled nursing for wound assessment, monitoring for signs and symptoms of infection, coordination of wound care supplies, reinforcement of smoking cessation education, and caregiver education. A referral for home health aide services will be initiated per family request to assist with personal care needs during the recovery period.
 Date of Order 12/31/2025 Orders Physician Face-to-Face Date: 12/26/2025 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat due to Colostomy Reversal 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 Saluja, Darshan

SN Careplans | SN Goals

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 12/31/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address

Darshan Saluja
6821 Reisterstown Rd
Baltimore, MD 21215
PHONE: 4103586450 FAX: 18777511761 NPI: 1164498523

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 : 12/26/2025

27. Attending Physician's Signature and Date Signed **02/06/2026**: 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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SN WK1: 1 (12/31/2025 - 01/03/2026), WK2: 1 (01/04/2026 - 01/10/2026), WK3: 2 (01/11/2026 - 01/17/2026), WK4: 1 (01/18/2026 - 01/24/2026), WK5: 1 (01/25/2026 - 01/27/2026)

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

HOSPITALIZATION RISKS: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 4. Multiple emergency department visits (2 or more) in the past 6 months, 5. Decline in mental, emotional, or behavioral status in the past 3 months, 6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 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; 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:Durable power of attorney for health care/Medical power of attorney

PROBLEMS IDENTIFIED ON ASSESSMENT: M1720 - Anxiety, D0160 - Depression, M1700 - Cognition, M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2020 - Oral Med Management, M2102c - Med Admin, M1033 - Exhaustion, M1400 - Dyspnea, abdominal pain, limited endurance, limited strength, muscle weakness, daytime fatigue, balance deficit, weak hand grips, Pain Interference with ADLs, Pain Effect on Sleep, obesity, #1 - Observable Surgical Wound - Other - Abdominal midline - 20 cm surgical wound closed with staples., #2 - Observable Surgical Wound - Other - Left mid abdominal - Surgical wound from stoma reversal. Wound bed in pink with scant drainage.

PROCEDURES: physician-ordered wound care: #2 - Observable Surgical Wound - Other - Left mid abdominal - Surgical wound from stoma reversal. Wound bed in pink with scant drainage.: Daily wet to dry dressing changes with vashe. Cover with boarder foam gauze. Monitor for s/s of infection such as foul odor, swelling at the site, increased redness or discharge, physician-ordered wound care: #1 - Observable Surgical Wound - Other - Abdominal midline - 20 cm surgical wound closed with staples.: Wound care performed by CG. No s/s of infection. Staples in place., Medication Review- : Medications reviewed with patient/caregiver. , cough/deep breathing exercises, incentive spirometer, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, physician-ordered wound care: To midline surgical site, open to air. NO ORDERS AT THIS TIME FOR SN TO REMOVE STAPLES. To left abdominal surgical wound site: Cleanse gently with soap and water or Vashe, apply silvasorb gel to wound base and pack with NSS wet to dry dressing. Cover with bordered gauze. Change daily. Monitor for s/s of infection such as foul odor, swelling at the site, increased redness or discharge, 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, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, related m, * how to keep home safe for patient with dementia coping strategies for the caregiver, related medication(s) purpose, schedule, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpos, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, 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

PATIENT-STATED GOAL: I want to be able to get out of the house again with my friends.

GOALS
patient/caregiver recalls
* how to achieve wound healing including cleaning and dressing wound
* position changes
* skin care
* diet modification
* record wound measurements
* 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
* 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/caregiver recalls
* how to keep home safe for patient with dementia
* coping strategies for the caregiver
* recalls related medication(s) purpose, schedule

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
* 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

patient is adequately supervised

caregiver administers and/or packages medications appropriately

PT Careplans

PT WK1: 1 (12/31/25-01/03/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 Dyspnea, GG0170F1 - Toilet Transfer - 06. Independent, GG0170D1 - Sit to Stand - 06. Independent, GG0170E1 - Chair to Bed to Chair - 06. Independent, GG0170G1 - Car Transfer - 06. Independent, GG0170I1 - Walk 10 Feet - 05. Setup or clean-up assistance, GG0170J1 - Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance, GG0170K1 - Walk 150 Feet - 05. Setup or clean-up assistance, GG0170L1 - Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance, GG0170M1 - 1 - Step (curb) - 05. Setup or clean-up assistance, GG0170N1 - 4 Steps - 05. Setup or clean-up assistance, GG0170O1 - 12 Steps - 05. Setup or clean-up assistance, GG0170P1 - Picking Up Object - 05. Setup or clean-up assistance

01/05/2026: GG0130B1 - Oral Hygiene - 06. Independent, GG0130F1 - Upper Body Dressing - 06.

PT Goals

PATIENT-STATED GOAL: To go back to work

GOALS
Toilet Transfer - 06. Independent

Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance

1 - Step (curb) - 05. Setup or clean-up assistance

Sit to Stand - 06. Independent

Sit to Stand - 05. Setup or clean-up assistance

Car Transfer - 06. Independent

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	12/31/2025

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Independent, GG0130G1 - Lower Body Dressing - 05. Setup or clean-up assistance, GG0130H1 - Don/Doff Footwear - 05. Setup or clean-up assistance, GG0130E1 - Shower/Bathe Self - 04. Supervision or touching assistance, GG0130C1 - Toileting Hygiene - 05. Setup or clean-up assistance, GG0130A1 - Eating - 06. Independent

PROCEDURES: Medication Review: - medications reviewed with patient/caregiver, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 06. Independent, Sit to Stand - 05. Setup or clean-up assistance, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 05. Setup or clean-up assistance, Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance, Walk 150 Feet - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance, 1 - Step (curb) - 05. Setup or clean-up assistance, 4 Steps - 05. Setup or clean-up assistance, 12 Steps - 05. Setup or clean-up assistance, Picking Up Object - 05. Setup or clean-up assistance

Walk 10 Feet - 05. Setup or clean-up assistance

Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance

Walk 150 Feet - 05. Setup or clean-up assistance

4 Steps - 05. Setup or clean-up assistance

12 Steps - 05. Setup or clean-up assistance

Picking Up Object - 05. Setup or clean-up assistance

Signature of Physician:

Date

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

Date
12/31/2025