Home Health Certification and Plan of Care

Order ID: 1150/16520

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
15310252	02/22/2026	From: 02/22/2026 To: 04/22/2026	22844	217058

6. Patient's Name and Address
Marjorie Hall
3736 Columbus Drive,
BALTIMORE, MD 21215-
443-847-7791

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 05/28/1953 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
C34.12	Malignant neoplasm of upper lobe left bronchus or lung	02/22/26

13. ICD	Other Pertinent Diagnoses	Date
J91.0	Malignant pleural effusion	02/22/26
G89.3	Neoplasm related pain (acute) (chronic)	02/22/26
I10.	Essential (primary) hypertension	02/22/26
F03.90	Unsp dementia unsp severity without beh/psych/mood/anx	02/22/26
E78.5	Hyperlipidemia unspecified	02/22/26
Z87.891	Personal history of nicotine dependence	02/22/26

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

ARICEPT 5 mg / 1 Tablet by mouth once a day at bedtime
Lipitor - Atorvastatin Calcium eq 40 mg base / 1 Tablet by mouth once a day For
cholesterol
and heart
protection
Maxzide-25 - Hydrochlorothiazide: Triamterene 25 mg;37.5 mg / 1 Tablet by mouth once a day
Oxycodone Hydrochloride - Oxycodone Hydrochloride 5 mg 5mg by mouth as necessary For pain
Lactulose - Lactulose 10gm/15ml 10gr/10ml by mouth as necessary Constipation
Senekot - Senna 8.6- 50 mg, Take 2 tablets by mouth at bedtime 2 tables for stool softners
Melatonin - Melatonin 5mg by mouth at bedtime Sleep aid
Seroquel - Quetiapine Fumarate eq 25 mg base 25mg by mouth at bedtime
Multiple Vitamin - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1 tab by mouth once a day Supplement

14. DME and Supplies:
Pleura vacuum

15. Safety Measures:
supervision at all times, activity supervision, ambulates with assistance, ambulates with device, Drain precautions

16. Nutrition:
low cholesterol, low sodium,

17. Allergies:
no known allergies

18.A. Functional Limitations
Endurance, , ,

18.B. Activities Permitted
None of the above

19. Mental & Pyschosocial Status: COGNITION: 1. Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 1. Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required!2. Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions, HISTORY OF DEPRESSION: No

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 Malignant Neoplasm Of Upper Lobe Left Bronchus Or Lung, 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 72-year-old female who lives alone in a two-story home and was admitted to home health services following recent hospitalization for pleural effusion secondary to a lung mass. Her past medical history is significant for recurrent pleural effusion requiring management with a PleurX catheter drainage system, lung mass, generalized weakness, neoplasm-related pain, dementia, hypertension, hyperlipidemia, and a history of nicotine use. The pleural effusion contributes to shortness of breath, making it a taxing effort for the patient to leave the home and supporting homebound status. Informed consent for services was explained and signed by the patient at the start of care. Upon <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>, the patient was alert but demonstrated cognitive impairment consistent with dementia, requiring cues and reminders for comprehension and retention of instructions. She resides alone; however, her son, Eugene, and daughter-in-law, Damita, are actively involved in her care and were present during the visit. The patient requires weekly drainage of her left posterior mid-back PleurX catheter due to pleural effusion. The catheter tubing was observed to be patent, and the drainage site was intact. Approximately 3-5 mL of fluid was drained during the visit without complication. The patient requires assistance with catheter drainage due to cognitive deficits. Extensive education was provided to the patient and caregivers regarding sterile technique and proper drainage procedures. Instructions included thorough hand hygiene with soap and warm water for at least 20 seconds (or use of hand sanitizer if unavailable); careful removal of the dressing; preparation of the vacuum-sealed drainage container; ensuring the drainage line is fully clamped prior to breaking the vacuum seal; maintaining sterility of the access tip; proper connection of the access tip to the catheter valve with audible click confirmation; activating the vacuum by inserting the T-plunger; opening the clamp to allow drainage; keeping the drainage container below chest level; and limiting drainage to the prescribed amount, not exceeding 1,000 mL. Education was provided to stop drainage and notify the healthcare provider if severe pain or foamy drainage occurs. Post-drainage care instructions included cleansing the catheter tip with alcohol, applying a new sterile cap, cleaning the surrounding skin, allowing it to air dry, properly securing the catheter on a pad without placing it directly against the skin, applying a new sterile dressing, discarding the drainage container per provider instructions without reuse, and performing hand hygiene after completion. The caregiver verbalized prior instruction on catheter management from the hospital and demonstrated understanding. Complete written instructions were uploaded to the patient's chart for reference. Skilled nursing <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-1 CE-FMS-visits">visits</mh> were scheduled at a frequency of twice weekly for one week, followed by once weekly for seven weeks (2w1, 1w7) to monitor respiratory status, catheter function, drainage volume, signs of infection, pain control, medication management, and ongoing caregiver education. A physical therapy evaluation was completed. Prior to hospitalization, the patient was independent with mobility and did not require an assistive device. At evaluation, bilateral lower extremity strength was intact (5/5 manual muscle testing), and the patient was able to ambulate and negotiate stairs independently without an assistive device. She denied pain and shortness of breath during <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>. Functional testing revealed 18 repetitions on the 30-second chair rise test, indicating above-average lower extremity strength and functional capacity. No further skilled physical therapy services were deemed necessary at this time. An occupational therapy evaluation was also completed. The patient remains independent with basic self-care tasks, mobility, and reheating meals. Family members assist with meal preparation and visit daily to monitor safety. Due to cognitive impairment and forgetfulness, the patient requires supervision for safety and medication management. The family prepares a pill organizer and provides reminder calls to ensure adherence. A recommendation was made to utilize a visible whiteboard in the home to reinforce instructions and daily reminders. All occupational therapy goals were addressed during the evaluation visit, and no further skilled

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 02/22/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Eva Dicocco
7141 Security Blvd
Woodlawn, MD 21244
PHONE: 443-663-6000 FAX: 14436636215 NPI: 1598990624

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 : 02/16/2026

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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occupational therapy services were indicated. The plan of care includes continued skilled nursing oversight for pleural effusion management, catheter care, respiratory monitoring, medication oversight, and caregiver education to ensure safe management in the home environment. The patient remains homebound due to shortness of breath with exertion related to pleural effusion and underlying lung mass, as well as cognitive impairment requiring supervision.
 Date of Order 02/22/2026 Orders Physician Face-to-Face Date: 02/16/2026 Clinical Condition Requiring home Care per Certifying Physician: SN disease management, PT eval and treat, OT eval and treat due to Malignant Neoplasm Of Upper Lobe Left Bronchus Or Lung 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 Dicocco, Eva

SN Careplans

SN WK1: 2 (02/22/26-02/28/26) ,WK2: 1 (03/01/26-03/07/26) ,WK3: 1 (03/08/26-03/14/26) ,WK4: 1 (03/15/26-03/21/26) ,WK5: 1 (03/22/26-03/28/26) ,WK6: 1 (03/29/26-04/04/26) ,WK7: 1 (04/05/26-04/11/26) ,WK8: 1 (04/12/26-04/18/26)

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: 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, 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; 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 open wounds noted
Advance Directive:Durable power of attorney for health care/Medical power of attorney

PROBLEMS IDENTIFIED ON ASSESSMENT: M1745 - Behavioral Issues, M1720 - Anxiety, meal preparation, M2020 - Oral Med Management, M1400 - Dyspnea, lung sounds not clear, abn cholesterol > 200 mg/dL, abnormal blood pressure, constipation, muscle weakness, limited strength, limited endurance, Pain Interference with ADLs, Pain Interference with Therapy activities, balance deficit, withdrawal from conversations, Pain Effect on Sleep, bruising/discoloration

PROCEDURES: cough/deep breathing exercises, incentive spirometer, postural drainage/chest percussion: plerux drainage system weekly. Drain site to posterior left mid back. Drain tube patent. Instructions for catheter change wash hands with soap and warm water for at least 20 seconds if soap and water are not available use hand sanitizer. Carefully remove dressing from around the catheter. Do Not discard unless performing dressing change. Wash hands again. Prepare the vacuum seal drainage container and drainage line. Close the drainage line of the vacuum seal drainage container by squeezing the pinch clamp or rolling the wheel of the roller clamp towards the container. The vacuum in the container will be lost if the line is not closed completely. Remove the access tip cover from the drainage line. Do not touch the end. Set it on a sterile surface. Remove the catheter valve cap and throw it away. Insert the access tip into the catheter valve. Make sure the valve and access tip are securely connected. Listen for a click to confirm that they are connected. Insert the T plunger to break the vacuum seal on the drainage container. Open the clamp on the drainage line. Allow the catheter to drain. Keep the catheter in the drainage container below the

SN Goals

PATIENT-STATED GOAL: To go to church and have tube drained as ordered

GOALS
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 relaxation skills and diversional activities
* 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 medication(s) purpose, schedule

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 medication(s) purpose, schedule

patient/caregiver recalls
* management of mental health condition including joining a peer group
* maintaining regular contact with mental health professional
* avoiding known stressors
* controlling impulses
* 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

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	02/22/2026

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level of your chest. There may be one way valve on the end of the tubing that will allow liquid in air to flow out of the catheter without letting air inside. Drain the amount of fluid is told by your health care provider. It usually takes 5 to 15 minutes. Do not drain more than 1,000 mL of fluid. You may feel a little discomfort while you are draining. If the pain is severe, stop draining and contact your health care provider. After you finish draining the catheter remove the drainage container tubing from the catheter. Use a clean alcohol swab to wipe the catheter tip. Please a clean cap on the end of the catheter use an alcohol pad to clean the skin around the catheter. Allow skin to air dry. Put the catheter pad on your skin. Catheter into a leap in place it on the pad do not place the catheter on your skin replace the dressing over the catheter. Discard the drainage container as instructed by your health care provider. Do not reuse the drainage container. Wash your hands with soap and warm water for at least 20 seconds. If soap and water are not available use hand sanitizer. Complete instructions uploaded to patient chart., coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, 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 medication(s) purpose, schedule, * 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 relaxation skills and diversional activities, related medication(s) purpose, schedule, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, related medication(s) purpose, schedule, * management of mental health condition including joining a peer group maintaining regular contact with mental health professional avoiding known stressors controlling impulses, 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

PT Careplans

PT WK1: 1 (02/22/26-02/28/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: 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: gait training on uneven surfaces, gait training/stair training

PT Goals

PATIENT-STATED GOAL: Pt states she is back to her baseline

OT Careplans

OT WK1: 1 (02/22/26-02/28/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: , 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: cough/deep breathing exercises, incentive spirometer, equipment training, work simplification/energy conservation

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 medication(s) purpose, schedule, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 06. Independent, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: Patient is at baseline

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 medication(s) purpose, schedule

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	02/22/2026