Home Health Certification and Plan of Care

Order ID: 1150/16562

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
17176946	02/25/2026	From: 02/25/2026 To: 04/25/2026	22593	217058

6. Patient's Name and Address

Vondirea Holley
1400 E Madison St Apt 1120,
BALTIMORE, MD 21205-
410-591-2503

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 04/23/1961 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
J20.9	Acute bronchitis unspecified	02/25/26

13. ICD	Other Pertinent Diagnoses	Date
J44.0	Chr obstructive pulmon disease with (acute) lower resp infct	02/25/26
I13.0	Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny	02/25/26
I50.30	Unspecified diastolic (congestive) heart failure	02/25/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	02/25/26
N18.32	Chronic kidney disease stage 3b	02/25/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	02/25/26
I26.99	Other pulmonary embolism without acute cor pulmonale	02/25/26
E78.5	Hyperlipidemia unspecified	02/25/26
F32.A	Depression unspecified	02/25/26
E55.9	Vitamin D deficiency unspecified	02/25/26
E11.40	Type 2 diabetes mellitus with diabetic neuropathy unsp	02/25/26
E05.00	Thyrotoxicosis w diffuse goiter w/o thyrotoxic crisis	02/25/26
E03.9	Hypothyroidism unspecified	02/25/26
G89.4	Chronic pain syndrome	02/25/26
M79.7	Fibromyalgia	02/25/26
E66.01	Morbid (severe) obesity due to excess calories	02/25/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	02/25/26
Z79.01	Long term (current) use of anticoagulants	02/25/26
Z79.4	Long term (current) use of insulin	02/25/26
Z87.891	Personal history of nicotine dependence	02/25/26

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

Albuterol - Albuterol 108 (90 BASE) mcg/act aerosol solution / 2 puffs inhalant as necessary every 6 hours as needed Commonly known as: VENTOLIN HFA
Duoneb - Albuterol Sulfate: Ipratropium Bromide 0 0.5-2.5 3 mg / 3mL nebulizer solution inhalant four times a day give 3 ml
Allopurinol - Allopurinol 100 mg / 1 tablet by mouth in the morning Commonly known as: ZYLOPRIM
ELIQUIS 5 mg / 1 tablet by mouth twice a day
Atorvastatin - Atorvastatin Calcium 40 mg / 1 tablet by mouth in the evening Commonly known as: LIPITOR
Bupropion Hydrochloride - Bupropion Hydrochloride 300 mg / 1 tablet by mouth in the morning Commonly known as: WELLBUTRIN XL
Jardiance - Empagliflozin 25 mg / 1 tablet by mouth in the morning Generic drug: Empagliflozin
ESCITALOPRAM 20 mg / 1 tablet by mouth in the morning Commonly known as: LEXAPRO
Famotidine - Famotidine 40 mg / 1 tablet by mouth in the morning Commonly known as: PEPCID
FLUOCINONIDE 0.05 % ointment topical 1 Application, every other day Apply to scalp.
Fluticasone Propionate - Fluticasone Propionate 0 50 MCG/ACT nasal spray Nasal once a day give 2 sprays, commonly known as: FLONASE
Advair - Fluticasone Propionate: Salmeterol Xinafoate 250-50 mcg/actuation inhaler inhalant every 12 hours give 1 puff
GABAPENTIN 300 mg / 1 tablet by mouth three times a day Commonly known as: NEURONTIN
Humulin R Kwikpen - Insulin Human 0 500 UNIT/ML solution pen-injector subcutaneous twice a day Inject 60 Units into the skin 2 times daily before meals. Generic drug: insulin regular concentrated
Levothyroxine - Levothyroxine Sodium 200 mcg / 1 tablet by mouth once a day Take 200 mcg by mouth daily before breakfast.
Commonly known as: SYNTHROID
Lidocaine Patch - Lidocaine 0 5 % patch / 1 patch topical once a day Onto the skin every 24 hours.Commonly known as: LIDODERM
Montelukast Sodium - Montelukast Sodium 10 mg / 1 tablet by mouth in the morning Commonly known as: SINGULAIR
Nystatin - Nystatin 100,000 units/gm 100,000 units/gm 1 application topical twice a day Commonly known as: MYCOSTATIN
Olopatadine Hydrochloride - Olopatadine Hydrochloride 0.1 percent right eye as necessary Give 1 drop twice a day as needed for Allergies.
For: Inflammation of Eyelid Lining due to
Allergy
Commonly known as: PATANOL
Spironolactone - Spironolactone 25 mg / 1 tablet by mouth in the morning Commonly known as: ALDACTONE
Spiriva Respimat - Tiotropium Bromide 0 2.5 MCG/ACT Aers inhaler inhalant once a day give 2 puffs daily, Generic drug: tiotropium
Tramadol - Tramadol Hydrochloride 50 mg / 1 tablet by mouth as necessary every 12 hours as needed.
Commonly known as: ULTRAM
Trazadone - Trazodone Hydrochloride 50 mg / 1 tablet by mouth in the evening
Torsemide - Torsemide 20 mg / 1 tablet by mouth once a day Commonly known as: DEMADEX
Prednisone - Prednisone 20 mg / 1 tablet by mouth once a day give 40 mg by mouth daily x3 days then 20 mg by mouth daily x3 days then 10 mg by mouth daily x3 days. Do not start before February 11, 2026. Start taking on February 11, 2026
Azelastine Hydrochloride - Azelastine Hydrochloride 0 0.1 % nasal solution Nasal twice a day 2 sprays by each nare. Commonly known as: ASTELIN

14. DME and Supplies:

cane

15. Safety Measures:

diabetic precautions, supervision at all times, , cardiac precautions, bathroom safety, , activity supervision, ambulates with assistance, ambulates with device

16. Nutrition:

low cholesterol, low sodium, diabetic

17. Allergies:

erythromycin lisinopril vancomycin

18.A. Functional Limitations

18.B. Activities Permitted

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 02/25/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Laura Emmanuel-Allen
7141 Security Blvd
Woodlawn, MD 21044
PHONE: FAX: NPI: 1114312352

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 : 02/10/2026

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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Dyspnea With Minimal Exertion, Ambulation, Endurance | Up As Tolerated

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: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes

20. Prognosis: good

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

Homebound status: Due to diagnosis of Acute Bronchitis 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: The patient is an adult female recently hospitalized for respiratory distress and acute bronchitis, presenting with shortness of breath and requiring ongoing inhaler and nebulizer therapy. Her past medical history is significant for insulin-dependent diabetes mellitus, chronic obstructive pulmonary disease (COPD), congestive heart failure with prior fluid overload, chronic kidney disease, obstructive sleep apnea, hyperlipidemia, hypothyroidism, chronic pain, fibromyalgia, right Charcot foot, obesity, history of transient ischemic attack (TIA), pulmonary embolism (PE), long-term anticoagulant use, history of nicotine use, depression, and recurrent falls. She resides with her husband in an elevator-accessible apartment and is considered homebound due to the significant effort required to leave the home, as evidenced by impaired balance and a Tinetti score of 15/28, indicating high fall risk. On assessment, the patient was alert and oriented to person, place, and time. She denied abnormal bleeding, urinary discomfort, recent falls, or acute distress. She reported her last bowel movement occurred yesterday. Lung sounds were without abnormal findings on auscultation, although intermittent coughing was noted. The patient reports poor balance and acknowledges needing assistance with household tasks. She ambulates approximately 20 feet indoors without an assistive device but reaches for furniture for support and requires supervision. Transfers to the toilet, power wheelchair, and bed are completed with supervision, and bed mobility is also performed with supervision. No stairs are present in the home environment. Medication reconciliation revealed multiple duplicate medication bottles in the home, and levothyroxine was not located during the visit, though the patient reported she "just had it." The patient admitted to prior medication nonadherence, attributing this to depression and household clutter. She reports improved compliance currently and has a scheduled telehealth visit with her primary care provider for further medication reconciliation. Despite the duplication issues, she was able to verbalize the purpose and action of each medication. She remains on insulin and long-term anticoagulation therapy and denies any signs of abnormal bleeding. Skilled nursing provided extensive education on medication organization and adherence strategies, with plans to implement a structured medication management system to improve daily compliance. The patient has prescribed COPD maintenance and rescue inhalers as well as nebulizer treatments. Instruction was provided regarding inhaler technique, frequency of administration, and the importance of rinsing the mouth after corticosteroid inhaler use; the patient demonstrated correct inhaler technique and verbalized understanding. Education was reinforced regarding monitoring for signs and symptoms of CHF exacerbation, COPD worsening, hypoglycemia and hyperglycemia, and when to notify the provider. Physical therapy evaluation indicates decreased lower extremity strength and impaired balance contributing to fall risk. The patient tolerated 10 repetitions each of supine therapeutic exercises, including hip flexion, hip abduction, bridging, hooklying rotation, straight leg raises, knee extension, and ankle pumps. She would benefit from continued home therapy to improve strength, balance, and endurance in order to maximize independence and safety with functional mobility. Orders are in place for physical therapy, occupational therapy, and home health aide services. Skilled nursing frequency is planned as 1 visit for 1 week, followed by 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-9 CE-FMS-visits">visits</mh> for 1 week, then 1 visit weekly for 5 weeks to address cardiopulmonary status, medication compliance, chronic disease management, and safety. The overall plan of care focuses on improving respiratory stability, enhancing medication adherence, reducing fall risk, and promoting safe functional independence within the home.
 Date of Order 02/25/2026 Orders Physician Face-to-Face Date: 02/10/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Acute Bronchitis 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:
 Physician Emmanuel-Allen, Laura

SN Careplans

SN WK1: 1 (02/25/26-02/28/26) ,WK2: 2 (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)

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, blood sugar < 60 > 300

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

HOSPITALIZATION RISKS: 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 ; 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

SN Goals

PATIENT-STATED GOAL: to get stronger and take medications as I should

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) purpose, schedule

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

Signature of Physician: | Date

Optional Name/Signature of Nurse/Therapist: Electronically Signed by Messick, Charles RN | Date 02/25/2026

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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 wounds noted
Advance Directive:Living Will

PROBLEMS IDENTIFIED ON ASSESSMENT: M1720 - Anxiety, D0160 - Depression, M2102c - Med Admin, meal preparation, M2020 - Oral Med Management, M1033 - Exhaustion, abnormal blood pressure, abn cholesterol > 200 mg/dL, coughing, lightheadedness, M1400 - Dyspnea, dizziness/syncope, abnormal BS < 70/140 > mg/dL, abnormal bowel sounds, increased urine output, limited endurance, limited strength, muscle weakness, balance deficit, difficulty sleeping, pain radiating to arms/legs, Pain Interference with ADLs, Pain Interference with Therapy activities, Pain Effect on Sleep, obesity, loss of appetite

PROCEDURES: cough/deep breathing exercises, glucose testing via monitor, monitor intake & output, teach/coordinate/arrange medication packaging and/or administration, 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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, 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, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately

* improved concentration
* strategies to reduce anxiety
* identification of anxiety precipitants, conflicts, and threats
* recalls related medication(s) purpose, schedule

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

meal preparation is available to patient for all meals

caregiver administers and/or packages medications appropriately

PT Careplans

PT WK1: 1 (02/25/26-02/28/26) ,WK2: 2 (03/01/26-03/07/26) ,WK3: 2 (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)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, Pain Interference with ADLs, Pain Effect on Sleep, GG0170I1 - Walk 10 Feet, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170L1 - Walk 10 ft on Uneven Surface, GG0170K1 - Walk 150 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0130B1 - Oral Hygiene, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170D1 - Sit to Stand, GG0130C1 - Toileting Hygiene, GG0170F1 - Toilet Transfer, GG0130E1 - Shower/Bathe Self, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing

PROCEDURES: Home exercise program : Supine hip flexion, bridging, hooklying rotation, straight leg raise, hip abduction. Standing knee flexion, hip abduction, hip extension, plantarflexion, squats. Sitting knee extension, ankle pumps.

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

PT Goals

PATIENT-STATED GOAL: Be able to walk outside with my rollator and get on transportation.

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

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

02/25/2026