Home Health Certification and Plan of Care

Order ID: 1150/16812

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
6VH5H60TV51	02/28/2026	From: 02/28/2026 To: 04/28/2026	23069	217058

6. Patient's Name and Address

Lalita Jett
2706 W. Fairmount Ave,
BALTIMORE, MD 21223-
443-848-2986

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 10/01/1947 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
M17.0	Bilateral primary osteoarthritis of knee	02/28/26

13. ICD	Other Pertinent Diagnoses	Date
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	02/28/26
N18.30	Chronic kidney disease stage 3 unspecified	02/28/26
M10.9	Gout unspecified	02/28/26
E02.	Subclinical iodine-deficiency hypothyroidism	02/28/26
G89.29	Other chronic pain	02/28/26
M54.9	Dorsalgia unspecified	02/28/26
K21.00	Gastro-esophageal reflux dis with esophagitis without bleed	02/28/26
E78.5	Hyperlipidemia unspecified	02/28/26
I87.2	Venous insufficiency (chronic) (peripheral)	02/28/26
G43.909	Migraine unsp not intractable without status migrainosus	02/28/26
G50.0	Trigeminal neuralgia	02/28/26
I73.9	Peripheral vascular disease unspecified	02/28/26
E66.9	Obesity unspecified	02/28/26
Z79.01	Long term (current) use of anticoagulants	02/28/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	02/28/26
Z85.528	Personal history of other malignant neoplasm of kidney	02/28/26
Z90.5	Acquired absence of kidney	02/28/26
Z86.718	Personal history of other venous thrombosis and embolism	02/28/26
Z74.01	Bed confinement status	02/28/26

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

AMLODIPINE BESYLATE AND ATORVASTATIN CALCIUM 1 tablet mouth at bedtime for HYPERLIPIDEMIA
CETIRIZINE HYDROCHLORIDE 1 tablet mouth one time a day for Allergic Rhinitis
AMRIX 1 tablet mouth every 6 hours for muscle pain
ARTHROTEC Apply Apply topically three times a day to Bilateral Knees/Shoulders for Pain
BISCODYL 1 suppository rectally every 24 hours as needed for Constipation if no effective in 8 hrs Notify MD/NP
ELIQUIS 1 tablet mouth two times a day for DVT Prophylaxis
ASCORBIC ACID one one PO every Wed for 12 Weeks for Vitamin D deficiency for 12 Weeks
APRESAZIDE 1 tablet mouth as indicated Hold for systolic blood pressure less than 120. Recheck and administer medication as indicated.
ARMOUR THYROID 1 tablet mouth in the morning for Hypothyroidism
COZAAR 1 tablet mouth one time a day for HTN Hold for SBP less than 100, HR less than 60
LYRICA 1 capsule mouth every 12 hours for Chronic pain
DUTOPROL 1 tablet mouth one time a day for HTN Hold if SBP is less than 110 or HR less than 60
ALUMINUM HYDROXIDE AND MAGNESIUM TRISILICATE 30 ml mouth as needed for Constipation daily if NO BM FOR 3 DAYS
PANTOPRAZOLE one tablet mouth in the morning for GERD
SENOKOT-S 2 tablet mouth Two times a day for Bowel Regimen Hold for loose stool.
Zofran - Ondansetron Hydrochloride eq 4 mg base 1 by mouth every 8 hours As needed for nausea
Metoprolol - Hydrochlorothiazide: Metoprolol Succinate 1 by mouth once a day
Hydralazine And Hydrochlorthiazide - Hydralazine Hydrochloride: Hydrochlorothiazide 1 by mouth twice a day For hypertension
Cyclobenzaprine - Cyclobenzaprine Hydrochloride 1 by mouth every 6 hours For muscle spasm

14. DME and Supplies:

wheelchair, walker, reacher, hoyer lift, hospital bed

15. Safety Measures:

wheelchair precautions, walker precautions, transfer with assist, , remove environmental barriers, , knee precautions, , emergency phone # clearly displayed

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

aspirin benazepril fluticasone oxycodone gadavist iodinated contrast media

18.A. Functional Limitations

Ambulation, Endurance, Bowel/Bladder Incontinence

18.B. Activities Permitted

Walker, Wheelchair, Up As Tolerated

19. Mental & Psychosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 0. Never, SOCIAL ISOLATION: 2. Sometimes, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes

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 Bilateral Primary Osteoarthritis Of Knee, 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 78-year-old female who is alert and oriented and currently resides in a multi-level townhouse with a first-floor setup, receiving daily assistance from rotating family members. She was referred to home health services following a recent hospitalization and rehabilitation stay related to complications from severe osteoarthritis of the bilateral knees. Her past medical history is significant for bilateral knee osteoarthritis, chronic kidney disease, gout, chronic pain, trigeminal neuralgia, peripheral vascular disease, transient ischemic attack, history of kidney cancer, deep vein thrombosis, and bilateral knee extension contractures. Prior to hospitalization in November, the patient was living with her son, ambulating with a cane, and receiving assistance with activities of daily living. She has since returned to her own home where family members assist with care. At the time of <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>, the patient is bedbound due to severe bilateral knee pain and significant functional limitations. She reports persistent bilateral knee pain and demonstrates very limited tolerance to touch or manipulation of the knees. The patient is incontinent; however, skin remains intact at this time. Bed mobility from supine to sitting and sitting to supine is performed with supervision. Attempts to facilitate standing were unsuccessful due to inadequate knee flexion secondary to bilateral extension contractures. Wheelchair transfer training could not be attempted because the current wheelchair in the home is too narrow (18 inches), and a transfer board is not available. The patient requires a larger wheelchair (22-24 inches) to accommodate safe mobility, and the family reports that arrangements are being made to exchange the current wheelchair. Durable medical equipment present in the home includes a hospital bed, Hoyer lift, walker, reacher, and wheelchair; however, the Hoyer lift is currently not usable due to limited space within the home environment, and the family plans to return it. The patient reported that during her rehabilitation stay she transferred by removing the wheelchair armrest and scooting between the bed and wheelchair. Functional <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 02/28/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Tara Hebert
1000 E Eager St
Baltimore, MD 21202
PHONE: 4105229800 FAX: 14103672174 NPI: 1225089337

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 : 01/12/2026

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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CE-FMS-assessment">assessment</mh> indicates severe mobility impairment with a Tinetti score of 1/28, confirming a very high fall risk and significant mobility limitations. The patient tolerated therapeutic exercise including 10 repetitions of straight leg raises and hip abduction exercises. Attempts to perform passive stretching into knee flexion were not tolerated due to pain. The therapist instructed the patient to sit at the edge of the bed at least three times daily to allow passive knee flexion and promote joint mobility. The home environment includes stairs at the exit and is noted to have significant clutter and limited space, which poses additional safety concerns. Education was provided to the family recommending removal of excess clutter to improve safety and accessibility for the patient. During the occupational therapy evaluation, the patient continued to report severe knee pain and could not tolerate tactile contact to the knees. The patient indicated that topical treatment in the hospital consisting of an ointment followed by a lidocaine patch provided relief; however, she was unable to identify the specific ointment used. She reported previous benefit from lidocaine-prilocaine cream for pain management and stated that she prefers to avoid narcotic or opioid medications. The occupational therapist recommended continued occupational therapy services at a frequency of 1 visit per week for 9 weeks to address activities of daily living training, adaptive equipment training, functional mobility training, therapeutic exercises, home exercise program development, safety training, and caregiver education. The patient remains homebound due to the significant physical effort required to leave the home and would require ambulance transport because of her bedbound status and severe mobility limitations. Skilled nursing services are recommended at a frequency of 1 visit for 1 week, followed by 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-1 CE-FMS-visits">visits</mh> for 1 week, and then 1 visit weekly for 2 additional weeks for ongoing <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>, care coordination, pain management monitoring, and patient and caregiver education. The next skilled nursing visit is scheduled for Tuesday. Physical therapy and occupational therapy evaluations have been ordered to address mobility deficits, strengthening, and functional independence within the home environment.
 Date of Order 02/28/2026 Orders Physician Face-to-Face Date: 01/12/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN disease management, PT eval and treat, OT eval and treat, HHA daily adl's due to Bilateral Primary Osteoarthritis Of Knee 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 Hebert, Tara

SN Careplans

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

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: 3. Multiple hospitalizations (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 ; 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.

N/A
Advance Directive:Living Will

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, D0700 - Social Isolation, M2020 - Oral Med Management, Home Safety, M1033 - Exhaustion, M1400 - Dyspnea, weak pulses in feet, M1620 - Bowel Incontinence, M1610 - Urinary Incontinence, muscle spasms, muscle weakness, swelling of affected area, limited endurance, limited range of motion, limited strength, poor muscle tone, obesity

PROCEDURES: bladder training, coordinate/arrange for maintenance of clean/uncluttered living area,

SN Goals

PATIENT-STATED GOAL: I need a new wheelchair. The one I have is too small.

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
* bowel incontinence management including dietary changes
* bowel training
* skin care
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* urinary incontinence management including bladder training
* Kegel exercises
* skin care
* 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
* 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/caregiver recalls
* strategies to increase socialization
* recalls related medication(s) purpose, schedule

patient's living environment is clean/uncluttered

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	02/28/2026

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coordinate/arrange long-term socialization activities

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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpose, schedule, * bowel incontinence management including dietary changes bowel training skin care, related medication(s) purpose, schedule, * urinary incontinence management including bladder training Kegel exercises skin 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, * strategies to increase socialization, related medication(s) purpose, schedule, patient's living environment is clean/uncluttered

PT Careplans

PT 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) ,WK9: 1 (04/19/26-04/25/26) ,WK10: 1 (04/26/26-04/28/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, Pain Effect on Sleep, Pain Interference with Therapy activities, GG0170S1 - Wheel 150 feet, GG0170I1 - Walk 10 Feet, GG0170R1 - Wheel 50 ft w 2 Turns, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170D1 - Sit to Stand, GG0170F1 - Toilet Transfer, 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

PROCEDURES: Home exercise program : Sitting knee extension, ankle pumps. Supine hip flexion, hip abduction, straight leg raise , wheelchair training, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: * 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, Sit to Stand - 02. Substantial/maximal assistance, Chair to Bed to Chair - 02. Substantial/maximal assistance, Car Transfer - 02. Substantial/maximal assistance, Toilet Transfer - 01. Dependent, Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, 1 - Step (curb) - 04. Supervision or touching assistance, 4 Steps - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance, Wheel 50 ft w 2 Turns - 01. Dependent, Wheel 150 feet - 01. Dependent, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

PT Goals

PATIENT-STATED GOAL: I want to be able to walk again

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

Sit to Stand - 02. Substantial/maximal assistance

Chair to Bed to Chair - 02. Substantial/maximal assistance

Car Transfer - 02. Substantial/maximal assistance

Toilet Transfer - 01. Dependent

Walk 10 Feet - 04. Supervision or touching assistance

Walk 50 ft with 2 Turns - 04. Supervision or touching assistance

1 - Step (curb) - 04. Supervision or touching assistance

4 Steps - 04. Supervision or touching assistance

Wheel 50 ft w 2 Turns - 01. Dependent

Picking Up Object - 04. Supervision or touching assistance

Wheel 150 feet - 01. Dependent

Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

OT Careplans

OT 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) ,WK9: 1 (04/19/26-04/25/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, 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, therapeutic exercises, equipment training, work simplification/energy conservation, transfers training

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, Oral Hygiene - 05. Setup or clean-up assistance, Toileting Hygiene - 03. Partial/moderate assistance, Shower/Bathe Self - 02. Substantial/maximal assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 03. Partial/moderate assistance, Don/Doff Footwear - 03. Partial/moderate assistance, Eating - 06. Independent

OT Goals

PATIENT-STATED GOAL: to not depend so much on other people

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

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

Oral Hygiene - 05. Setup or clean-up assistance

Toileting Hygiene - 03. Partial/moderate assistance

Shower/Bathe Self - 02. Substantial/maximal assistance

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

Lower Body Dressing - 03. Partial/moderate assistance

Don/Doff Footwear - 03. Partial/moderate assistance

Eating - 06. Independent

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	02/28/2026

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HHA Careplans

HHA WK1: 1 (02/28/26-02/28/26)

PROCEDURES: Change linens as needed, assist with bathing, assist with toilet transferring, assist with toileting hygiene, assist with transferring, assist with mobility, assist with feeding/eating, assist with infection control, assist with fall prevention, assist with assistive devices prn, assist with lower body dressing, assist with upper body dressing

HHA Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

02/28/2026