Home Health Certification and Plan of Care

Order ID: 1150/16116

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
2YJ8RC9QX34	02/07/2026	From: 02/07/2026 To: 04/07/2026	21855	217058

6. Patient's Name and Address

Lazelle Mullings
2507 Linden Ave,
BALTIMORE, MD 21217-
240-353-8899

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 12/21/1948 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
E11.621	Type 2 diabetes mellitus with foot ulcer	02/07/26

13. ICD	Other Pertinent Diagnoses	Date
L97.419	Non-prs chr ulcer of right heel and midfoot w unsp severt	02/07/26
E11.51	Type 2 diabetes w diabetic peripheral angiopath w/o gangrene	02/07/26
I13.0	Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny	02/07/26
I50.32	Chronic diastolic (congestive) heart failure	02/07/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	02/07/26
N18.30	Chronic kidney disease stage 3 unspecified	02/07/26
M62.552	Muscle wasting and atrophy NEC left thigh	02/07/26
I05.0	Rheumatic mitral stenosis	02/07/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	02/07/26
J44.9	Chronic obstructive pulmonary disease unspecified	02/07/26
Z85.118	Personal history of malignant neoplasm of bronchus and lung	02/07/26
Z91.81	History of falling	02/07/26

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

Multiple Vitamin Tablet 1 Tablet by mouth once a day for supplementation
Thiamine Hydrochloride - Thiamine Hydrochloride 100 mg / 1 Tablet by mouth once a day for supplement
Bupropion Hydrochloride - Bupropion Hydrochloride 150 mg 150 mg / 1 Tablet by mouth every 12 hours for Depression
Ferrous Sulfate - Ferrous Sulfate: Folic Acid 325 (65 Fe) mg / 1 Tablet by mouth once a day for supplementation
Aspirin 81Mg - Aspirin 81mg; 1 Tablet by mouth once a day for CAD/PAD
Amilodipine - Amlodipine Besylate 10 mg / 1 Tablet by mouth once a day for HTN
Senna - Senna 8.6 mg ; 1 Capsule by mouth once a day Give 2 tablet for Bowel regimen
Acetaminophen Extra Strength 500 mg ; 1 Tablet by mouth as necessary every 8 hours for Pain management
Anoro Ellipta Inhalation Aerosol Powder Breath Activated 62.5-25 MCG/ACT / 1 puff inhalant once a day inhale orally for COPD RINSE MOUTH AFTER USE
Hydralazine - Hydralazine Hydrochloride 0 50 mg / 1 Tablet by mouth every 8 hours for HTN
Carvedilol - Carvedilol 25 mg 25 mg 25 mg / 1 Tablet by mouth twice a day for HTN

14. DME and Supplies:

walker, wound care supplies, cane

15. Safety Measures:

diabetic precautions, ambulates with device, walker precautions, , infectious material management, supervision at all times, activity supervision

16. Nutrition:

cardiac diet

17. Allergies:

beans

18.A. Functional Limitations

Ambulation, Endurance

18.B. Activities Permitted

Cane, Walker, Exercises Prescribed

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 0. Never, SOCIAL ISOLATION: 0. Never, 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 Type 2 Diabetes Mellitus With Foot Ulcer, 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 77-year-old female recently hospitalized for right leg pain and weakness, during which she was diagnosed with peripheral vascular disease (PVD) and noted to have a right heel ulcer. Her past medical history is significant for chronic obstructive pulmonary disease (not requiring supplemental oxygen), type 2 diabetes mellitus, congestive heart failure, resistant hypertension, mitral stenosis, coronary artery disease, chronic kidney disease stage III, peripheral vascular disease, muscle wasting, history of falls, and lung adenocarcinoma status post radiation therapy in January 2024. A Medical Orders for Life-Sustaining Treatment (MOLST) form is on file indicating do not intubate (DNI) status. She resides in a two-story townhouse with her two sons and grandson. There are six steps to enter the home; she currently has a first-floor bedroom and bathroom setup, although the shower and her prior bedroom are located on the second floor. Her stated goal is to return to a second-floor living arrangement once functionally able. Prior to hospitalization, she was independent with activities of daily living (ADLs), homemaking, driving, and assisting with care of her 9-year-old grandson. On <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>, the patient was alert and oriented to person, place, and time. She reported minimal pain at the time of visit but endorsed shortness of breath with moderate exertion. Skilled nursing auscultation revealed decreased breath sounds in the right middle and lower lobes. She reports a fair appetite, with last bowel movement noted on Thursday. Trace edema was observed in the right lower extremity. She ambulates indoors up to approximately 30 feet with a cane under supervision and uses a rollator for safety as needed. She is able to negotiate four steps with use of a handrail and contact guard assistance. Bed mobility is independent, and she transfers to bed, chair, and toilet with supervision. Car transfers and outdoor ambulation were not assessed. Her Tinetti balance and gait <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh> score was 12/28, indicating high fall risk. She is considered homebound due to the significant effort required to leave the home with an assistive device and the need for supervision. The right heel wound is currently managed with calcium alginate silver dressing as ordered upon hospital discharge, with instructions for daily wound care. Although the patient reports independence with wound care, skilled nursing has recommended increasing dressing changes to at least every 2-3 days based on the amount of exudate and will continue to reassess the appropriateness of wound care frequency. Education was provided regarding proper wound care technique, signs and symptoms of infection, and the importance of re<mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh> as drainage levels change; the patient requires ongoing reinforcement. Trace right lower extremity edema and underlying PVD were discussed, and initial education was provided regarding PVD management, including circulation monitoring and risk factor control. Medication reconciliation was completed, and skilled nursing reviewed all medications with the patient, including dosage, frequency, and potential side effects, with emphasis on adherence given her complex comorbidities, including diabetes, heart failure, chronic kidney disease, coronary artery disease, and hypertension. The patient recently followed up with her pulmonologist and has a scheduled appointment with her primary care provider on February 11, 2026. Skilled nursing services are ordered at a frequency of once weekly for four weeks, then adjusted per care plan (1W12W41W4 as documented), with ongoing re<mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh> of cardiopulmonary status, wound healing, medication management, and disease process education. Physical therapy evaluation noted decreased lower extremity strength, impaired balance, and reduced functional activity tolerance. The patient tolerated five repetitions each of supine hip flexion, bridging, hooklying rotation, straight leg raises, hip

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 02/07/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Gail Berkenblit
601 N. Caroline Street
Baltimore, MD 21287
PHONE: 4109552834 FAX: 14109551545 NPI: 1841256781

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 : 01/22/2026

27. Attending Physician's Signature and Date Signed **03/13/2026**: 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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abduction, seated knee extension, and ankle pumps during the session. She would benefit from continued home physical therapy to improve strength, balance, and endurance with the goal of returning to her prior level of independence and resuming use of the second-floor living space. Occupational therapy evaluation identified deficits in instrumental activities of daily living (IADLs), functional mobility, activity tolerance, and safety awareness. Occupational therapy is recommended at a frequency of once weekly for four weeks to address ADL retraining, therapeutic exercise, home exercise program development, homemaking skills, functional mobility training, and safety education. In summary, the patient presents with complex cardiopulmonary and vascular comorbidities, an active right heel ulcer related to PVD, decreased endurance, and high fall risk following recent hospitalization. She requires skilled nursing for wound management, cardiopulmonary <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>, and medication education, as well as physical and occupational therapy to restore strength, safety, and functional independence. The overall plan of care focuses on wound healing, optimization of chronic disease management, fall prevention, and gradual return to prior level of function within the home environment.
 Date of Order 02/07/2026 Orders Physician Face-to-Face Date: 01/22/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Type 2 Diabetes Mellitus With Foot Ulcer 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 Berkenblit, Gail

SN Careplans

SN WK1: 1 (02/07/26-02/07/26) ,WK2: 1 (02/08/26-02/14/26) ,WK3: 2 (02/15/26-02/21/26) ,WK4: 2 (02/22/26-02/28/26) ,WK5: 2 (03/01/26-03/07/26) ,WK6: 1 (03/08/26-03/14/26) ,WK7: 1 (03/15/26-03/21/26) ,WK8: 1 (03/22/26-03/28/26) ,WK9: 1 (03/29/26-04/04/26)

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: 7. Currently taking 5 or more medications, 8. Currently reports exhaustion, 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
Advance Directive:POLST (Physician Orders for Life-Sustaining Treatment)

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2020 - Oral Med Management, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, weak pulses in feet, dependent edema, swelling of affected area, limited strength, limited endurance, Pain Interference with ADLs, balance deficit, discolored patches of skin, #1 - Open Wound - Posterior Right Heel - BEEFY RED WOUND BED

PROCEDURES: physician-ordered wound care: #1 - Open Wound - Posterior Right Heel - BEEFY RED WOUND BED: SN/PT TO CLEANSE WITH WOUND CLEANSER OR NSS; PAT DRY, APPY CALCIUM ALGINATE AG , COVER WITH 4X4 GAUZE, SECURE WITH KERLIX AND TAPE EVERY 2-3 DAYS OR AS NEEDED FOR INCREASED DRAINAGE.PATIENT IS INDEPENDENT WITH WOUND CARE., cough/deep breathing exercises

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, * 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, meal preparation is available to patient for all meals

SN Goals

PATIENT-STATED GOAL: I WANT THE WOUND ON MY FOOT TO HEAL

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

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
* 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
* 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
* 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

PT Careplans

PT WK2: 1 (02/08/26-02/14/26) ,WK3: 1 (02/15/26-02/21/26) ,WK4: 1 (02/22/26-02/28/26) ,WK5: 1 (03/01/26-03/07/26) ,WK6: 1 (03/08/26-03/14/26) ,WK7: 1 (03/15/26-03/21/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, M1400 - Dyspnea

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 , cough/deep breathing exercises, incentive spirometer

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

PT Goals

PATIENT-STATED GOAL: Be able to walk straight and not fall again.

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

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

OT Careplans

OT Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

02/07/2026

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OT WK1: 1 (02/07/26-02/07/26)

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, equipment training, work simplification/energy conservation, teach/coordinate/arrange medication packaging and/or administration

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, 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

PATIENT-STATED GOAL: To be able to take care of my grandson

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

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	02/07/2026