Home Health Certification and Plan of Care

Order ID: 1150/17083

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
7U44X80RU68	03/12/2026	From: 03/12/2026 To: 05/10/2026	23425	217058

6. Patient's Name and Address

Gwendolyn Hudson
107 Oak St,
Dundalk, MD 21222-
410-288-0075

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 12/26/1943 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
E87.0	Hyperosmolality and hypernatremia	03/12/26

13. ICD	Other Pertinent Diagnoses	Date
C50.911	Malignant neoplasm of unsp site of right female breast	03/12/26
E11.9	Type 2 diabetes mellitus without complications	03/12/26
I10.	Essential (primary) hypertension	03/12/26
I48.0	Paroxysmal atrial fibrillation	03/12/26
M06.9	Rheumatoid arthritis unspecified	03/12/26
M10.9	Gout unspecified	03/12/26
E78.5	Hyperlipidemia unspecified	03/12/26
I82.403	Acute embolism and thombos unsp deep veins of low extrm bi	03/12/26
F32.A	Depression unspecified	03/12/26
M11.29	Other chondrocalcinosis multiple sites	03/12/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	03/12/26
Z79.01	Long term (current) use of anticoagulants	03/12/26
Z87.01	Personal history of pneumonia (recurrent)	03/12/26
Z86.0100	Personal history of colonic polyps	03/12/26

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

Atorvastatin Calcium - Atorvastatin Calcium 80 mg / 1 Tablet by mouth at bedtime for high cholesterol
CARVEDILOL 3.125 mg / 1 Tablet by mouth every 12 hours for HTN hold for sbp<110 and HR less than 50
KINERET 100 MG/0.67ML / Inject 100 mg subcutaneously at bedtime for rheumatoid arthritis
Nifedipine Er - Nifedipine 90 mg / 1 Tablet by mouth every 12 hours for HTN HOLD FOR SBP<110 and HR less than 50
Onglyza - Saxagliptin Hydrochloride eq 2.5 mg base eq 2.5 mg base / 1 Tablet by mouth once a day for diabetes
XARELTO 10 mg / 1 Tablet by mouth in the evening for afib and recurrent DVTs
ANASTROZOLE 1 MG mouth one time a day for malignant neoplasm of right breast
ALLOPURINAL 100 mg mouth daily Take 0.5 tablets (of 300mg)
Losartan Potassium - Losartan Potassium 50 mg 1 tab=50mg by mouth once a day 1 tab daily for blood pressure control
Metoprolol Tartrate - Metoprolol Tartrate 50 mg 1 tab=50mg by mouth twice a day 1 tab twice daily for blood pressure control
Lasix - Furosemide 40 mg 1 tab=40mg by mouth once a day 1 tab daily for fluid retention

14. DME and Supplies:

grab bars, wheelchair, rolling walker, hand held shower, bath bench, diabetic supplies, commode, 4 wheeled walker, cane

15. Safety Measures:

wheelchair precautions, activity supervision, , , emergency phone # clearly displayed, sharps precautions, ambulates with assistance, transfer with assist, bathroom safety, walker precautions, smoke detectors , , , , diabetic precautions, ambulates with device

16. Nutrition:

diabetic

17. Allergies:

cephalexin codeine lisinopril metformin

18.A. Functional Limitations

Endurance, Ambulation, Bowel/Bladder Incontinence

18.B. Activities Permitted

Transfer bed/Chair, Exercises Prescribed, Walker, Cane, Up As Tolerated

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

family/caregiver will be responsible for managing treatment
patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Hyperosmolality And Hypernatremia, 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 82-year-old female recently discharged from a skilled nursing facility on 03/03/2026 and referred to home health services for continued care. Her past medical history is significant for hyperlipidemia, hypertension, type 2 diabetes mellitus, gout, deep vein thrombosis (currently on rivaroxaban/Xarelto), rheumatoid arthritis, and breast cancer for which she is receiving oral chemotherapy. She was previously hospitalized for diffuse bilateral lower extremity joint pain, edema, skin sensitivity, and decreased grip strength, and was treated for pseudogout and rheumatoid arthritis exacerbation. During that admission, she was restarted on anakinra (Kineret), initiated on a prednisone taper, and resumed allopurinol therapy. At the time of assessment, the patient denies pain but reports generalized fatigue and weakness. She demonstrates an unsteady, discontinuous gait and remains at increased risk for falls. The patient ambulates with a walker outside the home but relies on furniture for support when ambulating the home. She resides in a single-family home with her grandson; however, portions of the home environment, including the living room and hallway to the bedroom and bathroom, were noted to be cluttered, and education was provided regarding decluttering to improve safety and reduce fall risk. The home is equipped with assistive devices including a walker, canes, bedside commode, shower chair, and bathroom rails. Functionally, the patient is currently independent with basic self-care activities, functional transfers, and ambulation, consistent with her prior level of function. Occupational therapy evaluation was completed, and no ongoing skilled OT services are recommended at this time. The patient is a full code, and all prescribed medications are available in the home. She has documented allergies to cephalexin (Keflex), codeine, lisinopril, and metformin. Skilled nursing services are indicated to provide medication education, disease process management, and reinforcement of safety strategies within the home. Physical therapy services have been ordered to address gait instability, strength deficits, and fall prevention. The plan of care focuses on improving endurance, mobility, and overall safety while supporting the patient's ability to remain independent in the home setting and prevent rehospitalization.
 Date of Order 03/12/2026 Orders Physician Face-to-Face Date: 03/05/2026 Clinical Condition Requiring Home Care per Certifying Physician: Discharge home 03/06/2026 with home health services to include RN for medication management, PT/OT for evaluation and treatment, and for ADL care due to Hyperosmolality And Hypernatremia 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 Harrell, Anthony

SN Careplans

SN Goals

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 03/12/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Anthony Harrell
2112 Dundalk Ave
Baltimore, MD 21222
PHONE: 4102884800 FAX: 14103672211 NPI: 1497859763

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 : 03/05/2026

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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Gwendolyn Hudson 107 Oak St, Dundalk, MD 21222- 410-288-0075	HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239

SN WK1: 1 (03/12/26-03/14/26)

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

HOSPITALIZATION RISKS: 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; 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.

; 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, A1250 - Lack of Necessary Transportation, M2020 - Oral Med Management, M2102c - Med Admin, M2102f - Patient Supervision, M2102d - Caregiver Performs Treatment, M1033 - Exhaustion, M1400 - Dyspnea, dependent edema, M1610 - Urinary Incontinence, limited endurance, limited strength, Pain Effect on Sleep, Pain Interference with ADLs, balance deficit, obesity

PROCEDURES: incentive spirometer, bladder training, 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 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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive 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, caregiver administers and/or packages medications appropriately

PATIENT-STATED GOAL: Patient states she wants to be able to feel comfortable leaving the house 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 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
* 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
* urinary incontinence management including bladder training
* Kegel exercises
* skin care
* 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

caregiver administers and/or packages medications appropriately

PT Careplans

PT WK1: 1 (03/12/26-03/14/26) ,WK2: 2 (03/15/26-03/21/26) ,WK3: 1 (03/22/26-03/28/26) ,WK4: 1 (03/29/26-04/04/26) ,WK5: 1 (04/05/26-04/11/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, 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

PT Goals

PATIENT-STATED GOAL: To get stronger and walk better

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

patient/caregiver recalls
* lifestyle modifications to manage respiratory condition including

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	03/12/2026

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PROCEDURES: cough/deep breathing exercises, incentive spirometer, gait training on uneven surfaces, gait training/stair training, 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, Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven Surface - 06. Independent, 1 - Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent

* diet changes and regular exercise
* strategies to control shortness of breath
* home remedies to keep lungs healthy
* recalls related medication(s) purpose, schedule

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Walk 10 ft on Uneven Surface - 06. Independent

1 - Step (curb) - 06. Independent

4 Steps - 06. Independent

12 Steps - 06. Independent

Picking Up Object - 06. Independent

OT Careplans

OT WK2: 1 (03/15/26-03/21/26)

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

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 - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 05. Setup or clean-up assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: Evaluation only

GOALS
Shower/Bathe Self - 05. Setup or clean-up assistance

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 - 06. Independent

Toileting Hygiene - 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	03/12/2026