Home Health Certification and Plan of Care

Order ID: 1150/17314

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
94263903	03/19/2026	From: 03/19/2026 To: 05/17/2026	23710	217058

6. Patient's Name and Address

Mary Porter
7029 Starwort Way #B,
HANOVER, MD 21076-
443-545-9760

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 03/26/1954 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	03/19/26

13. ICD	Other Pertinent Diagnoses	Date
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	03/19/26
N18.9	Chronic kidney disease u	03/19/26
D63.1	Anemia in chronic kidney disease	03/19/26
E78.5	Hyperlipidemia unspecified	03/19/26
E11.40	Type 2 diabetes mellitus with diabetic neuropathy unsp	03/19/26
E11.3293	Type 2 diab with mild nonp rtnop without macular edema bi	03/19/26
K55.20	Angiodysplasia of colon without hemorrhage	03/19/26
F39.	Unspecified mood [affective] disorder	03/19/26
K57.30	Dvrtclos of lg int w/o perforation or abscess w/o bleeding	03/19/26
R41.3	Other amnesia	03/19/26
F41.9	Anxiety disorder unspecified	03/19/26
F32.A	Depression unspecified	03/19/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	03/19/26
G47.00	Insomnia unspecified	03/19/26
E11.36	Type 2 diabetes mellitus with diabetic cataract	03/19/26
E21.3	Hyperparathyroidism unspecified	03/19/26
E04.9	Nontoxic goiter unspecified	03/19/26
Z79.899	Other long term (current) drug therapy	03/19/26
Z79.4	Long term (current) use of insulin	03/19/26
Z90.710	Acquired absence of both cervix and uterus	03/19/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	03/19/26

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

Humulin 70/30 - Insulin Recombinant Human: Insulin Susp Isophane Recombinant Human 45 UNITS subcutaneous twice a day Inject 45 Units subcutaneously 2 times a day 30 minutes before meals
Glipizide - Glipizide 10 mg 10MG; 1 TAB by mouth twice a day DM
Gabapentin - Gabapentin 300 mg 300 mg by mouth three times a day Take 1 capsule by mouth 3 times a day
NEUROPATHY
Simvastatin - Simvastatin 20 mg 20 mg by mouth in the evening Take 1 tablet by mouth every evening
CHOLESTEROL
Hyzaar - Hydrochlorothiazide: Losartan Potassium 25 mg;100 mg 100MG/25MG; 1 TAB by mouth once a day BLOOD PRESSURE
Metoprolol Succinate - Metoprolol Succinate eq 25 mg tartrate 0 25mg by mouth once a day Take 2 tablets by mouth daily
HTN
Levothyroxine - Levothyroxine Sodium 50mcg; 1 TAB by mouth in the morning Take 1 tablet by mouth daily before breakfast.
SYNTHYROID
Asa 81 Mg - Aspirin 81MG; 1 TAB by mouth once a day PROPHYLACTIC
BUSPIRONE 10mg 1 1/2 TAB by mouth twice a day Take 1.5 tablets by mouth 2 times a day
ANXIETY
QUETIAPINE 100mg; 3 TABS by mouth once a day Take 3 tablets by mouth daily at bedtime
MOOD DISORDER

14. DME and Supplies:

cane, walker, diabetic supplies

15. Safety Measures:

walker precautions, , , diabetic precautions, ambulates with device, supervision at all times, sharps precautions, , activity supervision

16. Nutrition:

low sodium, diabetic,

17. Allergies:

metformin

18.A. Functional Limitations

Endurance

18.B. Activities Permitted

Cane, Walker

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, 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: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper.

22.B.Discharge Plans

family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Type 2 Diabetes Mellitus With Diabetic Chronic Kidney Disease, 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 was referred to home health services for disease process management and medication management following recent medication changes, with instructions to follow up with the primary care provider and neurologist. The patient's past medical history is significant for hypertension, type 2 diabetes mellitus, mood disorder, anemia, depression, anxiety, and obesity. On <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>, the patient is alert and oriented to person, place, and time, though exhibits some forgetfulness. The patient denies pain and shortness of breath, with lung sounds clear to auscultation throughout. The patient reports a good appetite, with last bowel movement occurring today. Blood glucose at the time of visit was 195 mg/dL. The patient demonstrates decreased endurance and ambulates with the use of a walker for safety. Skilled nursing reviewed all prescribed medications with the patient and caregiver, including dosages, frequency, and potential side effects, with emphasis on monitoring medication effectiveness due to recent changes. The patient's daughter is currently managing medication administration; however, despite the use of a pillbox, the patient has been noted to occasionally forget to take medications. Education was provided on strategies to improve medication adherence, including routine scheduling, reminders, and caregiver supervision. Both the patient and daughter were receptive to teaching. Continued skilled nursing services are indicated to monitor disease progression, assess medication compliance and effectiveness, reinforce education, and ensure overall patient safety and stability.
 Date of Order 03/19/2026 Orders Physician Face-to-Face Date: 03/13/2026 Clinical Condition Requiring Home Care per Certifying Physician: FOLLOW UP CARE due to Type 2 Diabetes Mellitus With Diabetic Chronic Kidney Disease 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
 Physician Higgins, Maria

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 03/19/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Maria Higgins
821 N Eutaw St
Baltimore, MD 21201
PHONE: 4435522900 FAX: NPI: 1750917399

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 : 03/13/2026

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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SN Careplans

SN WK1: 1 (03/19/26-03/21/26) ,WK2: 1 (03/22/26-03/28/26) ,WK3: 1 (03/29/26-04/04/26) ,WK4: 1 (04/05/26-04/11/26) ,WK5: 1 (04/12/26-04/18/26) ,WK6: 1 (04/19/26-04/25/26) ,WK7: 1 (04/26/26-05/02/26)

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, 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; 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: M1745 - Behavioral Issues, D0160 - Depression, M2020 - Oral Med Management, meal preparation, M1400 - Dyspnea, limited endurance, Pain Interference with ADLs, obesity

PROCEDURES: coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, glucose testing via monitor: PT TO OBTAIN BLOOD GLUCOSE LEVEL TWICE A DAY

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, * 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

SN Goals

PATIENT-STATED GOAL: I WANT TO GET BETTER AND NOT BE A BURDEN ON MY DAUGHTER

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
* 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
* 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
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	03/19/2026