Home Health Certification and Plan of Care

Order ID: 1150/17517

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
36640856	03/23/2026	From: 03/23/2026 To: 05/21/2026	23572	217058

6. Patient's Name and Address

April Oneal
3406 Dolfield Ave Apt 110,
BALTIMORE, MD 21215-
410-908-9045

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 03/31/1964 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
M00.88	Arthritis due to other bacteria vertebrae	03/23/26

13. ICD	Other Pertinent Diagnoses	Date
I69.351	Hemiplga following cerebral infrc aff right dominant side	03/23/26
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	03/23/26
N18.4	Chronic kidney disease stage 4 (severe)	03/23/26
D63.1	Anemia in chronic kidney disease	03/23/26
E78.5	Hyperlipidemia unspecified	03/23/26
M62.521	Muscle wasting and atrophy NEC right upper arm	03/23/26
E46.	Unspecified protein-calorie malnutrition	03/23/26
G62.9	Polyneuropathy unspecified	03/23/26
K21.9	Gastro-esophageal reflux disease without esophagitis	03/23/26
E55.9	Vitamin D deficiency unspecified	03/23/26
Z45.2	Encounter for adjustment and management of VAD	03/23/26
Z79.2	Long term (current) use of antibiotics	03/23/26
Z96.649	Presence of unspecified artificial hip joint	03/23/26

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

Hydralazine - Hydralazine Hydrochloride 1 tablet 100 mg by mouth twice a day Blood pressure
GABAPENTIN 100 mg one capsule by mouth twice a day Give for Neuropathy pain
DITROPAN 5 mg 1 tablet by mouth twice a day Give for Overactive bladder
TIZANIDINE HYDROCHLORIDE eq 2 mg base 1 tablet by mouth every 8 hours Give as needed for Muscle spasm
Hydrochlorthiazide - Hydralazine Hydrochloride: Hydrochlorothiazide 1 tablet 125 mg by mouth once a day Blood pressure
Metoprolol Succinate - Metoprolol Succinate eq 100 mg tartrate 1 tablet by mouth once a day Blood pressure
AMILODIPINE 1 Tablet, 5 mg by mouth one time a day for HTN. Hold for sbp less than 110
Extra Strength Tylenol - Acetaminophen 500 mg, 2 tablets by mouth every 6 hours As needed for pain
Nifedipine Er - Nifedipine 60mg=1 tab by mouth once a day 1 tab daily for blood pressure control
Extra Strength Tylenol - Acetaminophen 500mg tabs by mouth every 6 hours 2 tabs every 6 hours as needed for pain

14. DME and Supplies:

wheelchair, rolling walker, hand held shower, bath bench, commode, , walker, cane, 4 wheeled walker

15. Safety Measures:

walker precautions, smoke detectors , , , , ambulates with device, ambulates with assistance, emergency phone # clearly displayed, supervision at all times, transfer with assist, wheelchair precautions, , hand rails, cardiac precautions, bathroom safety, , activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

no known allergies

18.A. Functional Limitations

Ambulation, Bowel/Bladder Incontinence, Speech, Contracture, Endurance

18.B. Activities Permitted

Exercises Prescribed, Up As Tolerated, Wheelchair, Walker

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: 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

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

Homebound status: Due to diagnosis of Arthritis due to other bacteria vertebrae, 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 61-year-old female with a complex medical history significant for prior cerebrovascular accidents with residual right-sided weakness and hemiplegia, chronic kidney disease stage IV, <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-12 CE-FMS-hypertension">hypertension</mh>, <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-16 CE-FMS-hyperlipidemia">hyperlipidemia</mh>, gastroesophageal reflux disease, neuropathy, depression, and osteoarthritis status post left hip replacement. She was recently hospitalized after presenting via EMS with severe lower back pain and generalized weakness resulting in inability to ambulate. Diagnostic evaluation revealed leukocytosis (WBC 16.7), and MRI of the lumbar spine demonstrated edema and enhancement of the left facet joints at L2-L3 and L3-L4 with associated paraspinal soft tissue changes, concerning for an infectious or inflammatory process, including suspected septic arthritis. Neurosurgery and infectious disease consultations were obtained, and the patient was initiated on intravenous antibiotic therapy. Interventional radiology was unable to obtain a fluid sample due to insufficient collection. A central venous line was placed for long-term antibiotic administration, and the patient was discharged to a skilled nursing facility before transitioning to home health services for continued care. The patient is currently receiving IV daptomycin and ceftriaxone via central line, with a planned six-week course and orders for weekly laboratory monitoring. She resides in a ground-level apartment with her fianc and son, who assist with bathing, meals, and transportation. Prior to hospitalization, the patient ambulated short distances with a rolling walker and relied on furniture for support indoors, while using a power wheelchair or scooter for longer distances. At present, she demonstrates significant functional decline, with marked weakness, impaired balance, and limited endurance. Manual muscle testing reveals strength of approximately 1-2-/5 in the right lower extremity and 3/5 in the left lower extremity. She requires minimal assistance for transfers and short-distance ambulation with a rollator, with mobility limited by pain and instability. She reports poor activity tolerance and completes activities of daily living at a slower pace. While she remains independent with dressing and grooming, she requires assistance for other ADLs and keeps a bedside commode nearby due to limited mobility. The patient also has minimal functional use of the right upper extremity, using it primarily as a stabilizer, and utilizes a resting hand splint, which she is able to independently don and doff. Skilled nursing care focuses on management of intravenous antibiotic therapy, central line maintenance, and monitoring for complications, including signs of infection, adverse medication effects, and renal function given her underlying CKD. Weekly laboratory draws, including CBC and CMP, are performed as ordered. Pain management remains a priority due to ongoing severe lower back pain, which continues to limit functional mobility. Physical therapy evaluation identifies deficits in strength, balance, coordination, and functional mobility, contributing to high fall risk. Skilled PT interventions are indicated to improve strength, gait, transfers, and overall safety, with the goal of returning the patient to her prior level of function. Occupational therapy evaluation further supports the need for skilled services, focusing on ADL retraining, adaptive equipment use, upper extremity function, and safety training. A structured plan includes therapeutic exercise, functional mobility training, and a home exercise program. Patient and caregiver education has been provided regarding medication adherence, central line care, fall prevention, and safe mobility techniques. The patient and family are in agreement with the plan of care. Given her significant mobility limitations, pain, and need for ongoing skilled interventions, the patient is considered homebound, requiring assistance and assistive devices to safely leave the home. Prognosis is guarded due to the severity of her current condition and multiple comorbidities; however, she remains clinically stable with ongoing treatment and multidisciplinary support. <span style="font-size:

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 03/23/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Valeria Fomitcheva
821 N. Eutaw St
Baltimore, MD 21201
PHONE: 4105231404 FAX: 18777511761 NPI: 1972165405

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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14px;">
 Date of Order 03/23/2026 Orders Physician Face-to-Face Date: 03/05/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN, PT, OT due to Arthritis due to other bacteria vertebrae 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 Fomitcheva, Valeria

SN Careplans

SN WK1: 1 (03/23/26-03/28/26) ,WK2: 1 (03/29/26-04/04/26) ,WK3: 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

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

HOSPITALIZATION RISKS: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 3. Multiple hospitalizations (2 or more) in the past 6 months, 4. Multiple emergency department visits (2 or more) in the past 6 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, M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2020 - Oral Med Management, M2102c - Med Admin, M1400 - Dyspnea, dependent edema, M1033 - Exhaustion, muscle weakness, limited range of motion, limited endurance, muscle spasms, limited strength, balance deficit, daytime fatigue, difficulty sleeping, impaired speech, weak hand grips, Pain Interference with ADLs, Pain Effect on Sleep

PROCEDURES: incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, monitor intake & output, 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 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, * 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

SN Goals

PATIENT-STATED GOAL: Patient wants to be able to regain her strength back so she can start planning her wedding.

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
* 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

Signature of Physician:	Date
	PAGE 2 of 4
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	03/23/2026

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PT Careplans

PT WK1: 1 (03/23/26-03/28/26) ,WK2: 1 (03/29/26-04/04/26) ,WK3: 1 (04/05/26-04/11/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, 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

PROCEDURES: Medication Review: - medications reviewed with patient/caregiver, cough/deep breathing exercises, 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 - 05. Setup or clean-up assistance, Chair to Bed to Chair - 05. Setup or clean-up assistance, Toilet Transfer - 05. Setup or clean-up assistance, Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Walk 150 Feet - 04. Supervision or touching assistance, 1 - Step (curb) - 04. Supervision or touching assistance, Car Transfer - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

PT Goals

PATIENT-STATED GOAL: To be able to walk without pain

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 - 05. Setup or clean-up assistance

Chair to Bed to Chair - 05. Setup or clean-up assistance

Toilet Transfer - 05. Setup or clean-up assistance

Walk 10 Feet - 04. Supervision or touching assistance

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

Walk 150 Feet - 04. Supervision or touching assistance

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

Car Transfer - 05. Setup or clean-up assistance

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

OT Careplans

OT WK1: 1 (03/23/26-03/28/26) ,WK4: 1 (04/12/26-04/13/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, 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, Chair to Bed to Chair - 05. Setup or clean-up assistance, Sit to Stand - 05. Setup or clean-up assistance, Toilet Transfer - 05. Setup or clean-up assistance, Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Walk 150 Feet - 04. Supervision or touching assistance, 1 - Step (curb) - 04. Supervision or touching assistance, 4 Steps - 04. Supervision or touching assistance, 12 Steps - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance, Car Transfer - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 04. Supervision or touching assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: To get stronger

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

Sit to Stand - 05. Setup or clean-up assistance

Chair to Bed to Chair - 05. Setup or clean-up assistance

Toilet Transfer - 05. Setup or clean-up assistance

Walk 10 Feet - 04. Supervision or touching assistance

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

Walk 150 Feet - 04. Supervision or touching assistance

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

4 Steps - 04. Supervision or touching assistance

12 Steps - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

Car Transfer - 05. Setup or clean-up assistance

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

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 04. Supervision or touching assistance

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:
Electronically Signed by Messick, Charles RN

Date
03/23/2026

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Eating - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:	Date
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