

Home Health Certification and Plan of Care										Order ID: 1150/17540							
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							7. Provider's Name, Address and Telephone Number										
Mary Porter 7029 Starwort Way #B, HANOVER, MD 21076- 443-545-9760							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		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								
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										
14. DME and Supplies:							15. Safety Measures:										
cane, walker, diabetic supplies							walker precautions, medication safety, fall precautions, diabetic precautions, ambulates with device, supervision at all times, sharps precautions, standard precautions, activity supervision										
16. Nutrition:							17. Allergies:										
low sodium, diabetic,							metformin										
18.A. Functional Limitations							18.B. Activities Permitted										
Endurance							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:							22.B.Discharge Plans										
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.							family/caregiver will be responsible for managing treatment add discharge plan										
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:		<div>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.</div><div> </div><div>Date of Order</div><div>03/19/2026</div><div>Orders</div><div>Physician Face-to-Face Date: 03/13/2026</div><div>Clinical Condition Requiring Home Care per Certifying Physician: FOLLOW UP CARE due to Type 2 Diabetes Mellitus With Diabetic Chronic															
23. Signature and Date of Verbal SOC Where Applicable:									25. Date HHA Received Signed POT								
Electronically Signed by Messick, Charles RN on 03/19/2026																	
24. Physician's Name and Address							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.										
Madhavi Ambati 7070 Samuel Morse Dr Columbia, MD 21046 PHONE: 800-777-7904 FAX: 18554141694 NPI: 1396056297							F2F date : 03/13/2026										
27. Attending Physician's Signature and Date Signed							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.										
Date of physician last face-to-face							PAGE 1 of 2										

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Kidney Disease</div><div>Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home</div><div>
</div><div>1 - SOC - SN Notes: soc</div><div>
</div><div>Physician</div><div>Madhavi, Ambati</div>

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