Home Health Certification and Plan of Care

Order ID: 1150/17149

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
5GD6YR4PC62	03/14/2026	From: 03/14/2026 To: 05/12/2026	23015	217058

6. Patient's Name and Address

Betty Otto
916 Greenfawn Ct,
ABINGDON, MD 21009-
443-417-4613

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 10/18/1945 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
M47.26	Other spondylosis with radiculopathy lumbar region	03/14/26

13. ICD	Other Pertinent Diagnoses	Date
I50.32	Chronic diastolic (congestive) heart failure	03/14/26
J43.9	Emphysema unspecified	03/14/26
I48.91	Unspecified atrial fibrillation	03/14/26
M47.816	Spondylosis w/o myelopathy or radiculopathy lumbar region	03/14/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	03/14/26
G62.9	Polyneuropathy unspecified	03/14/26
K21.9	Gastro-esophageal reflux disease without esophagitis	03/14/26
K74.60	Unspecified cirrhosis of liver	03/14/26
M10.9	Gout unspecified	03/14/26
M85.80	Oth disrd of bone density and structure unspecified site	03/14/26
L24.A2	Irritant cntct derm d/t fecal urinry or dual incontinence	03/14/26
E87.3	Alkalosis	03/14/26
M81.0	Age-related osteoporosis w/o current pathological fracture	03/14/26
D64.9	Anemia unspecified	03/14/26
F41.9	Anxiety disorder unspecified	03/14/26
F32.A	Depression unspecified	03/14/26
Z79.82	Long term (current) use of aspirin	03/14/26
J96.11	Chronic respiratory failure with hypoxia	03/14/26
Z96.653	Presence of artificial knee joint bilateral	03/14/26
Z90.710	Acquired absence of both cervix and uterus	03/14/26
Z99.81	Dependence on supplemental oxygen	03/14/26
Z87.891	Personal history of nicotine dependence	03/14/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	03/14/26

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

Stiolto Respimat - Olodaterol Hydrochloride: Tiotropium Bromide Inhalation Aerosol Solution 2.5-2.5 MCG/ACT / 1 puff inhalant once a day inhale orally for COPD rinse and spit after use
PANTOPRAZOLE 40 mg / 1 Tablet by mouth twice a day for GERD
MELATONIN 3 mg / 1 Tablet by mouth at bedtime Give 2 tablet for sleep aid
FLUOXETINE 60 mg / 1 Tablet by mouth once a day Give 30 mg for Depression
ATENOLOL 50 mg / 1 Tablet by mouth once a day for heart failure
Acetaminophen - Acetaminophen Extra Strength 500 mg / 1 Tablet by mouth every 6 hours as needed for Mild Pain (1-4) Do not exceed more than 2 grams per day from all sources
Albuterol Sulfate - Albuterol Sulfate Nebulizer Solution 0.63 MG/3ML / 3mL inhalant every 6 hours inhale orally via nebulizer as needed for SOB/Wheezing
Aspirin Ec - Aspirin 81 mg / 1 Tablet by mouth once a day for CAD
Buspirone Hcl - Buspirone Hydrochloride 5 mg / 1 Tablet by mouth every 8 hours for anxiety
Greer Go Nystatin + Zinc Oxide + Hydrocortisone - topical Apply to sacrum every shift for IAD prevention
Acetaminophen And Hydrocodone Bitartrate - Acetaminophen: Hydrocodone Bitartrate 10-325 mg / 1 Tablet by mouth every 4 hours as needed for Pain
Lidocaine Patch - Lidocaine 4% topical once a day Apply to bilateral knees for pain remove per schedule
Multivitamins - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1 Tablet by mouth once a day for supplement
Nifedipine Er - Nifedipine 30 mg / 1 Tablet by mouth once a day for HTN Hold for systolic less than 110 and HR less than 50
probiotics 1 Capsule by mouth every 12 hours for supplement
Oxygen - Oxygen 2 Liters nasal cannula as necessary Use as needed for shortness of breath

14. DME and Supplies:

wheelchair, rolling walker, commode, nebulizer, walker, oxygen supplies, cane, 4 wheeled walker

15. Safety Measures:

walker precautions, , , , ambulates with device, ambulates with assistance, supervision at all times, transfer with assist, wheelchair precautions, , hand rails, bathroom safety, , activity supervision

16. Nutrition:

cardiac diet

17. Allergies:

no known allergies

18.A. Functional Limitations

Ambulation, Bowel/Bladder Incontinence, Endurance

18.B. Activities Permitted

Up As Tolerated, Exercises Prescribed, Walker

19. Mental & Pyschosocial Status: COGNITION: 2. Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility, 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!2. Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions, 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

Homebound status: Due to diagnosis of Other Spondylosis With Radiculopathy Lumbar Region, 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 80-year-old female with a complex medical history significant for chronic obstructive pulmonary disease (COPD), heart failure with preserved ejection fraction (HFpEF), atrial fibrillation, and cirrhosis. She resides with her son, who serves as her primary caregiver, in a first-floor living arrangement. The patient is designated as DNR/DNI, and all prescribed medications are available in the home. At the time of start of care, the patient is clinically stable with no signs of acute cardiopulmonary distress. <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-14 CE-FMS-Oxygen">Oxygen</mh>ation is adequate on room air, with supplemental oxygen available for use as needed. A comprehensive head-to-toe assessment was completed, including cardiopulmonary and integumentary evaluation. Skin impairment was noted but is currently improving, with no evidence of active infection. The patient tolerated the assessment well and demonstrated understanding of education provided. Given her chronic conditions, the patient remains at ongoing risk for exacerbation of COPD and heart failure, as well as for further skin breakdown. Skilled nursing services are required for continued cardiopulmonary monitoring, early identification of exacerbation symptoms, management of oxygen therapy, skin assessment and treatment oversight, medication reconciliation, and patient and caregiver education. Interventions during the visit included medication review and reinforcement of education on disease management, including recognition of worsening respiratory or cardiac symptoms, proper use of oxygen therapy, safety precautions, and skin care strategies, including incontinence management and use of barrier creams. The plan of care includes skilled nursing <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-9 CE-FMS-visits">visits</mh> at a frequency of approximately twice weekly for four weeks, followed by reassessment.

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 03/14/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Wilbur Roese
7106 Ridge Rd
Baltimore, MD 21237
PHONE: 4106872300 FAX: 18443045355 NPI: 1588764278

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 : 02/03/2026

27. Attending Physician's Signature and Date Signed **03/23/2026**: 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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Ongoing monitoring of respiratory and cardiac status, adherence to prescribed therapies, and laboratory evaluation as ordered will be conducted. Education will be reinforced at each visit to support disease self-management and reduce risk of hospitalization. Goals of care include maintaining stable respiratory function with oxygen saturation greater than 92%, preventing exacerbations of COPD and heart failure, promoting healing and preservation of skin integrity without infection, and ensuring that the patient and caregiver demonstrate understanding of disease processes and management strategies.
 Date of Order 03/14/2026 Orders Physician Face-to-Face Date: 02/03/2026 Clinical Condition Requiring Home Care per Certifying Physician: Discharge home 02/27/2026 with home health services to include RN for medication management, PT/OT for evaluation and treatment, aid for ADL care. due to Other Spondylosis With Radiculopathy Lumbar Region 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 Roese, Wilbur

SN Careplans

SN WK1: 1 (03/14/2026 - 03/14/2026), WK3: 1 (03/22/2026 - 03/28/2026)

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), 2. Unintentional weight loss of a total of 10 pounds or more 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: M1720 - Anxiety, M1745 - Behavioral Issues, M1700 - Cognition, D0160 - Depression, M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2102c - Med Admin, M2020 - Oral Med Management, M1400 - Dyspnea, dependent edema, M1033 - Exhaustion, M1033 - Unintentional Weight Loss, limited strength, muscle weakness, limited endurance, daytime fatigue, balance deficit, Pain Interference with ADLs, Pain Effect on Sleep

PROCEDURES: incentive spirometer, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, teach/coordinate/arrange medication packaging and/or administration

SN Goals

PATIENT-STATED GOAL: Patient states she wants to be able to take a shower in the shower and not have to wash up at the sink.

GOALS
patient/caregiver recalls
* prevention exacerbation of anxiety condition including coping patterns
* improved concentration
* strategies to reduce anxiety
* identification of anxiety precipitants, conflicts, and threats
* 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
* 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
* how to keep home safe for patient with dementia
* coping strategies for the caregiver* 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/caregiver recalls
* strategies to increase caloric intake
* 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
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	03/14/2026

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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, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, related medication(s) purpose, schedule, * how to keep home safe for patient with dementia coping strategies for the caregiver*, 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, * strategies to increase caloric intake, 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

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	03/14/2026