Home Health Certification and Plan of Care

Order ID: 1150/16563

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
6GD2PV2KJ88	02/25/2026	From: 02/25/2026 To: 04/25/2026	22216	217058

6. Patient's Name and Address
Darla Plaugher
5404 Belair Road,
Baltimore, MD 21206-
410-236-7199

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 02/28/1957 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy	02/25/26

13. ICD	Other Pertinent Diagnoses	Date
I10.	Essential (primary) hypertension	02/25/26
E03.9	Hypothyroidism unspecified	02/25/26
G40.909	Epilepsy unsp not intractable without status epilepticus	02/25/26
G47.00	Insomnia unspecified	02/25/26
F31.9	Bipolar disorder unspecified	02/25/26
K57.30	Dvrtclos of lg int w/o perforation or abscess w/o bleeding	02/25/26
M54.9	Dorsalgia unspecified	02/25/26
G89.29	Other chronic pain	02/25/26
F41.9	Anxiety disorder unspecified	02/25/26
F17.210	Nicotine dependence cigarettes uncomplicated	02/25/26
F10.11	Alcohol abuse in remission	02/25/26
F11.11	Opioid abuse in remission	02/25/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	02/25/26
Z79.4	Long term (current) use of insulin	02/25/26
Z90.710	Acquired absence of both cervix and uterus	02/25/26

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

Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 0 25 mcg (1,000 units) 1 capsule by mouth once a day for supplement
Tresiba - Insulin Degludec 0 100 unit/ml (3ml) 56 units subcutaneous once a day for diabetes
Extra Strength Tylenol - Acetaminophen 0 500 mg tablet by mouth every 8 hours 2 tablets Q8H for pain
Levothroxine - Levothyroxine Sodium 200 mcg 1 tablet by mouth in the morning for hypothyroidism
Melatonin - Melatonin 3mg 1 tablet by mouth at bedtime for insomnia
Famotidine - Famotidine 0 20 mg 1 tablet by mouth twice a day for GERD
Metformin - Metformin Hydrochloride 0 1000 mg 1 tablet by mouth every 12 hours for diabetes
Oxcarbazepine - Oxcarbazepine 150 mg 0 150 mg tablet by mouth three times a day 3 tablets TID for seizures
Gabapentin - Gabapentin 0 300 mg 1 capsule by mouth every 8 hours for neuropathy
Lisinipril - Hydrochlorothiazide: Lisinopril 2.5 mg 1tab by mouth once a day for HTN (Hold for SBP <110)
Ascorbic Acid - Ascorbic Acid: Biotin: Cyanocobalamin: Dexpanthenol: Ergocalciferol: Folic Acid: Niacinamide: Pyridoxine Hydrochloride: Riboflav 0 500 mg 1 tablet by mouth once a day for supplement
Centrum Multivitamin - Ascorbic Acid: Biotin: Cyanocobalamin: Ergocalciferol: Folic Acid: Niacinamide: Pantothenic Acid: Phytonadione: Pyridoxine: Ribo 0 1 tablet by mouth once a day for supplement
Ondansetron - Ondansetron 0 4 mg 1 tablet by mouth as necessary Q4H for nausea and vomiting
Ativan - Lorazepam 0.5 mg 0 0.5 mg 1 tablet by mouth every 12 hours for anxiety

14. DME and Supplies:
None of the above

15. Safety Measures:
diabetic precautions

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
amitriptyline augmentin codeine penicillin sulfa zosyn

18.A. Functional Limitations
Ambulation

18.B. Activities Permitted
Up As Tolerated, No Restrictions

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 1. Rarely, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes

20. Prognosis: fair

22. A Rehabilitation Potential:
SELF-CARE: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper., 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 Polyneuropathy, 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 68-year-old female with a past medical history significant for hypertension, hypothyroidism, type 2 diabetes mellitus with neuropathy, seizure disorder, gastroesophageal reflux disease, bipolar disorder, depression, and anxiety. She has been admitted to home health services for skilled nursing, physical therapy, and occupational therapy evaluations and ongoing care and education. She resides in an assisted living facility and is an active smoker, though she reports decreased tobacco use since returning to the facility. On assessment, the patient was alert and oriented to person, place, time, and situation. She reported severe pain rated 8/10 localized to the left labial region, and during the visit also exhibited significant right hip pain, becoming tearful and demonstrating difficulty with ambulation. Gait was observed to be impaired, with discontinuous steps and dragging of her feet, indicating increased fall risk. The severity of her right hip pain was communicated to her primary care provider, Dr. Rollins, for further evaluation and management recommendations. The patient also reported intermittent nausea with episodes of dry heaves and an occasional dry cough. She denied increased smoking but acknowledged ongoing tobacco use. Respiratory assessment revealed lungs clear to auscultation bilaterally. Bowel sounds were present and active in all quadrants, with the patient reporting loose stools over the past several days; her last bowel movement occurred this morning. Skin was warm and dry without noted bruising or discoloration. Peripheral pulses were palpable throughout, and no edema was observed. Vital signs were obtained and were within normal limits at the time of assessment. Given her complex medical and psychiatric history, including diabetes, neuropathy, seizure disorder, and mood disorders, as well as her current reports of severe pain and altered gait, the patient remains at elevated risk for falls and further complications. Skilled nursing will continue to monitor pain status, gastrointestinal symptoms, respiratory status, medication adherence, and overall safety. Physical and occupational therapy services are indicated to address mobility deficits, pain-related functional decline, balance impairment, and activities of daily living. Education was initiated regarding pain management strategies,

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 02/25/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Lawanda Rollins Mrs.
8831 Satyr Hill Rd Ste 100
Parkville, MD 21234
PHONE: 443-946-1896 FAX: 14434952902 NPI: 1003384165

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 : 01/31/2026

27. Attending Physician's Signature and Date Signed **03/26/2026**: 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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fall prevention, smoking reduction, and the importance of medication compliance. The plan of care focuses on stabilizing pain, improving mobility and safety, managing chronic conditions, and preventing rehospitalization.
 Date of Order 02/25/2026 Orders Physician Face-to-Face Date: 01/31/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN medication management, PT eval and treat, OT eval and treat SW community resources due to Type 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-12 CE-FMS-Diabetes">Diabetes</mh> Mellitus With Diabetic Polyneuropathy 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:
 Physician Rollins Mrs., Lawanda

SN Careplans

SN WK1: 2 (02/25/26-02/28/26) ,WK2: 1 (03/01/26-03/07/26) ,WK3: 1 (03/08/26-03/14/26) ,WK4: 1 (03/15/26-03/21/26)

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

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, D0160 - Depression, M2020 - Oral Med Management, M1400 - Dyspnea, cramping calves/thighs/hips, abnormal blood pressure, abnormal BS < 70/140 > mg/dL, heartburn/indigestion, diarrhea, nausea/vomiting, muscle weakness, limited endurance, Pain Effect on Sleep, balance deficit, involuntary movement of extremity, Pain Interference with ADLs, pallor, #1 - Abrasion - Other - Left labia - Patient has reddened area where an open wound once was. She is encouraged to use A&D or Aquafor ointment.

PROCEDURES: physician-ordered wound care: #1 - Abrasion - Other - Left labia - Patient has reddened area where an open wound once was. She is encouraged to use A&D or Aquafor ointment., cough/deep breathing exercises, glucose testing via monitor

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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits

SN Goals

PATIENT-STATED GOAL: I want this pain to go away.

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
* 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
* 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 self-administers medications as prescribed
* 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 achieve wound healing including cleaning and dressing wound
* position changes
* skin care
* diet modification
* record wound measurements
* recalls related medication(s) purpose, schedule

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	02/25/2026

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identification of activities that bring pleasure preventive care, related medication(s) purpose, schedule, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule

PT Careplans

PT WK1: 1 (02/25/26-02/28/26) ,WK2: 1 (03/01/26-03/07/26) ,WK3: 1 (03/08/26-03/14/26) ,WK4: 1 (03/15/26-03/21/26) ,WK5: 1 (03/22/26-03/28/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, Pain Interference with ADLs, Pain Effect on Sleep, GG0170I1 - Walk 10 Feet, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170L1 - Walk 10 ft on Uneven Surface, GG0170K1 - Walk 150 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0130B1 - Oral Hygiene, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170D1 - Sit to Stand, GG0130C1 - Toileting Hygiene, GG0170F1 - Toilet Transfer, GG0130E1 - Shower/Bathe Self, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing

PROCEDURES: cough/deep breathing exercises, incentive spirometer, equipment training, 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, * 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 - 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, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 06. Independent, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Upper Body Dressing - 06. Independent

PT Goals

PATIENT-STATED GOAL: To walk better with out pain

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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 - 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

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 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	02/25/2026