Home Health Certification and Plan of Care

Order ID: 1150/17899

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
03238861000	02/12/2026	From: 04/13/2026 To: 06/11/2026	22295	217058

6. Patient's Name and Address

Martha Smith
718 E 43rd ST,
BALTIMORE, MD 21212-
443-642-0826

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 05/01/1951 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
I11.0	Hypertensive heart disease with heart failure	02/12/26

13. ICD	Other Pertinent Diagnoses	Date
I50.32	Chronic diastolic (congestive) heart failure	02/12/26
E11.40	Type 2 diabetes mellitus with diabetic neuropathy unsp	02/12/26
I87.2	Venous insufficiency (chronic) (peripheral)	02/12/26
L97.811	Non-prs chr ulcer oth prt r low leg limited to brkdwn skin	02/12/26
I26.93	Single subsegmental pulmon emblsm w/o acute cor pulmonale	02/12/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	02/12/26
M17.0	Bilateral primary osteoarthritis of knee	02/12/26
E66.813	Other obesity	02/12/26
Z68.43	Body mass index [BMI] 50.0-59.9 adult	02/12/26
Z85.42	Personal history of malignant neoplasm of oth prt uterus	02/12/26
Z90.710	Acquired absence of both cervix and uterus	02/12/26
Z79.01	Long term (current) use of anticoagulants	02/12/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	02/12/26
Z79.82	Long term (current) use of aspirin	02/12/26
Z79.891	Long term (current) use of opiate analgesic	02/12/26

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

Zinc Sulfate - Zinc Sulfate 50 mg Capsule by mouth once a day Take 1 capsule (50 mg of elemental zinc total) by mouth daily.
Gabapentin - Gabapentin 100 mg 100 MG by mouth every 8 hours Commonly known as: NEURONTIN
FOR NEUROPATHY PAIN
Farxiga - Dapagliflozin Propanediol 5MG; 1 TAB by mouth once a day DM
Ondansetron - Ondansetron 4 mg 0 4 MG by mouth every 6 hours Take 1 tablet (4 mg total) by mouth every six hours as needed for nausea or vomitting.
Eliquis - Apixaban 5 mg Tab by mouth 2 (two) times daily Commonly known as: ELIQUIS
BLOOD THINNER
Lopressor - Metoprolol Tartrate 25 mg; 1 TAB by mouth twice a day Take 1 tablet (25 mg total) by mouth for 2 times daily.
BLOOD PRESSURE
Constulose - Lactulose 10 gram/15 mL; 30ML by mouth every 12 hours AS NEEDED FOR CONSTIPATION
Fluticasone Propionate - Fluticasone Propionate 0.05 mg/spray 1 SPRAY nasal every 12 hours EACH NOSTRIL FOR ALLERGIES
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 10 mg Tablet by mouth every 12 hours as needed for pain
Cyclobenzaprine - Cyclobenzaprine Hydrochloride 5MG; 1 TAB by mouth every 8 hours AS NEEDED FOR MUSCLE SPASMS
Antivert - Meclizine Hydrochloride 25 mg 25 mg by mouth every 12 hours Take 1 tablet (25 mg total) by mouth 2 times daily as needed for Dizziness
Oxygen - Oxygen 2L nasal cannula continuous SUPPLEMENT

14. DME and Supplies:

wound care supplies, oxygen supplies, wheelchair, hospital bed

15. Safety Measures:

bedrails up while in bed, standard precautions, supervision at all times, fall precautions, activity supervision, ambulates with assistance, ambulates with device

16. Nutrition:

low sodium

17. Allergies:

banana strawberry

18.A. Functional Limitations

Dyspnea With Minimal Exertion, Ambulation, Endurance

18.B. Activities Permitted

Wheelchair

19. Mental & Pyschosocial Status: COGNITION: 3. Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently, ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: , BEHAVIORAL ISSUES: , HISTORY OF DEPRESSION:

20. Prognosis: fair

22. A Rehabilitation Potential:

SELF-CARE: , MOBILITY:

22.B.Discharge Plans

patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Hypertensive heart disease with heart failure, 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 74-year-old female recently discharged home following hospitalization and subsequent subacute rehabilitation related to multiple falls. Her past medical history is significant for congestive heart failure (CHF), hypertension, bilateral knee osteoarthritis, type 2 diabetes mellitus, peripheral neuropathy, obesity, obstructive sleep apnea (CPAP not currently available in the home), prior pulmonary embolism managed with Eliquis, chronic right lower extremity (RLE) venous stasis ulcer, and history of uterine cancer. She resides in a two-story home with her two sons; however, her bedroom and bathroom have been relocated to the first floor due to inability to safely negotiate stairs. There are seven steps with a railing at the entrance of the home. Her sons provide assistance with all activities of daily living (ADLs) and instrumental activities of daily living (IADLs), including transportation to medical appointments. At the time of skilled nursing assessment, the patient was alert and oriented to person, place, and time. She denied shortness of breath and was receiving supplemental oxygen at 2 L/min continuously, with oxygen saturation measured at 95% on oxygen. She reported a good appetite and stated her last bowel movement occurred on the day of assessment. She reported intermittent left leg cramping but denied acute pain. The patient was noted to be incontinent of urine and wearing a diaper, with urine odor present in the room, indicating the need for ongoing skin integrity monitoring and hygiene support. Physical assessment revealed bilateral lower extremity hyperpigmentation consistent with chronic venous insufficiency and a venous stasis ulcer located on the lateral aspect of the right lower extremity. Additionally, the patient has a right subclavian Port-a-Cath in place, which she reports is flushed and managed by her physician every three months. Skilled nursing services were initiated with a frequency of 1 visit per week for 12 weeks, followed by 2 visits per week for 1 week, then 1 visit per week for 6 weeks (1W12, 2W1, 1W6). A substantial amount of time was spent reconciling and organizing medications in the home with the patient's son. A comprehensive medication profile was completed, and missing medications were identified; the son was instructed to obtain refills promptly to ensure compliance. The use of a pillbox was recommended to improve medication adherence and reduce risk of dosing errors. Skilled nursing will continue medication reconciliation and compliance monitoring at the next visit, along with cardiopulmonary assessment, diabetic monitoring, wound assessment and care, anticoagulation monitoring related to Eliquis, and reinforcement of disease management education. From a functional standpoint, the patient is currently spending the majority of the day in bed. Bed mobility from supine to sit is performed with supervision using a bed rail. She is able to roll side to side with supervision and use of the rail. Sit-to-supine transfer requires use of the bed rail and moderate assistance at the left lower extremity. She is able to scoot up in bed with the bed flat using rails with supervision. Sit-to-stand transfers to a walker require moderate assistance of two persons, and she is able to maintain standing for approximately 20 seconds. Due to her current functional limitations, gait, car transfers, and outdoor mobility were not assessed. Her Tinetti balance assessment score is 1/28, indicating extremely high fall risk. She is considered homebound due to the significant physical effort required to leave the home and her severely impaired mobility. Therapeutic exercises performed during evaluation included 10 repetitions each of hip flexion, bridging, hooklying rotation, straight leg raises, hip abduction, knee extension, and ankle pumps, which were tolerated without acute distress. Her sons were present during training and were educated on safe assistance techniques and instructed to avoid over-assisting in order to promote the patient's independence and strength recovery. Occupational therapy evaluation indicates that prior to hospitalization, the patient was independent with basic self-care, functional transfers, and functional ambulation tasks, with assistance from her sons primarily for IADLs. Currently, she demonstrates decreased standing balance,

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 04/08/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Sharareh Badri
8617 Loch Raven Blvd
Baltimore, MD 21239
PHONE: 443-444-6100 FAX: 14434446110 NPI: 1003278250

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 : 02/01/2026

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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reduced standing tolerance, diminished bilateral upper extremity strength, and limited activity tolerance, all contributing to decreased independence with self-care, functional transfers, and mobility. She utilizes 2 L of oxygen as needed for shortness of breath. The interdisciplinary plan of care includes skilled nursing for cardiopulmonary monitoring, diabetes management, wound care, medication management, and patient/caregiver education; physical therapy to address lower extremity strength, balance, transfer training, fall prevention, and progressive mobility; and occupational therapy to improve upper extremity strength, activity tolerance, self-care performance, and safety with functional tasks. The overall goals are to improve strength and endurance, enhance safety and independence with ADLs and transfers, promote wound healing, ensure medication compliance, reduce fall risk, and prevent rehospitalization.
 Date of Order 04/08/2026 Orders Physician Face-to-Face Date: 02/01/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Hypertensive Heart Disease With Heart Failure Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home
 4 - Recertification Notes:Recertified due to Heart failure with OSA and bedridden obesity requiring supplemental oxygen with static ulcer to lower right leg requiring wound care makes it a taxing effort to leave the home. Physician Badri, Sharareh

SN Careplans

SN WK1: 1 (04/13/26-04/18/26) ,WK2: 1 (04/19/26-04/25/26) ,WK3: 1 (04/26/26-05/02/26) ,WK4: 1 (05/03/26-05/09/26) ,WK5: 1 (05/10/26-05/16/26) ,WK6: 1 (05/17/26-05/23/26)

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, 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: abnormal BS < 70/140 > mg/dL

PROCEDURES: physician-ordered wound care: #1 - Observable Stasis Ulcer - Other - RLE LATERAL ASPECT - UNABLE TO MEASURE SCATTERED OPEN AREA: SN/CG TO CLEANSE RLE STASIS ULCER WITH WOUND CLEANSER, APPLY MEDIHONEY, CALCIUM ALGINATE, 4X4 GAUZE AND WRAP WITH KERLIX, SECURE WITH TAPE DAILY. SON CAPABLE TO PERFORM WOUND CARE ON DAYS SN NOT AVAILABLE., cough/deep breathing exercises, glucose testing via monitor, home exercise program, coordinate/arrange for maintenance of clean/uncluttered living area

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 medicatio, * 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 relaxatio, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpos, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, * bowel incontinence management including dietary changes bowel training skin care, related medication(s) purpose, schedule, * urinary incontinence management including bladder training Kegel exercises skin care, related medication(s) purpose, schedule, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet,

SN Goals

PATIENT-STATED GOAL: I WANT TO GET STRONGER

GOALS
patient living environment has safe floor coverings

patient's living environment is clean/uncluttered

patient/caregiver recalls
* bowel incontinence management including dietary changes
* bowel training
* skin care
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* urinary incontinence management including bladder training
* Kegel exercises
* skin 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

meal preparation is available to patient for all meals

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 relaxatio

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) purpos

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

patient self-administers medications as prescribed
* 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 medicatio

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	04/08/2026

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related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient living environment has safe floor coverings, patient's living environment is clean/uncluttered, meal preparation is available to patient for all meals

PT Careplans

PT WK1: 1 (04/13/26-04/18/26) ,WK2: 1 (04/19/26-04/25/26) ,WK4: 1 (05/03/26-05/09/26) ,WK6: 1 (05/17/26-05/23/26) ,WK8: 1 (05/31/26-06/06/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, Pain Interference with ADLs, Pain Interference with Therapy activities, GG0170O1 - 12 Steps, GG0170M1 - 1 - Step (curb), GG0170M1 - 1 - Step (curb), GG0170S1 - Wheel 150 feet, GG0170R1 - Wheel 50 ft w 2 Turns, GG0170M1 - 1 - Step (curb), GG0170P1 - Picking Up Object, GG0170F1 - Toilet Transfer, 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, GG0170I1 - Walk 10 Feet, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170D1 - Sit to Stand

PROCEDURES: Home exercise program : Supine hip flexion, bridging, hooklying rotation, straight leg raise, hip abduction. Sitting knee extension, ankle pumps , cough/deep breathing exercises, wheelchair training, 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 medicatio, * 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 - 02. Substantial/maximal assistance, Sit to Stand - 02. Substantial/maximal assistance, Toilet Transfer - 05. Setup or clean-up 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, Wheel 50 ft w 2 Turns - 06. Independent, Wheel 150 feet - 06. Independent, 1 - Step (curb) - 02. Substantial/maximal assistance, Car Transfer - 05. Setup or clean-up assistance, Walk 10 Feet - 02. Substantial/maximal assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 02. Substantial/maximal assistance

PT Goals

PATIENT-STATED GOAL: To be able to walk in the house with my walker and be able to get out of the house

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

1 - Step (curb) - 02. Substantial/maximal assistance

Wheel 150 feet - 06. Independent

Wheel 50 ft w 2 Turns - 06. Independent

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
* 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 medicatio

Toilet Transfer - 05. Setup or clean-up 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

Chair to Bed to Chair - 02. Substantial/maximal assistance

Sit to Stand - 02. Substantial/maximal assistance

Walk 10 Feet - 02. Substantial/maximal assistance

Walk 50 ft with 2 Turns - 02. Substantial/maximal assistance

Signature of Physician:

Date

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

Date
04/08/2026