Home Health Certification and Plan of Care

Order ID: 1150/17873

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
951015772	04/08/2026	From: 04/08/2026 To: 06/06/2026	24395	217058

6. Patient's Name and Address

Jennifer Seiders
9689 GWYNN PARK DR,
ELLICOTT CITY, MD 21042-
410-313-8057

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 08/01/1953 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
I50.20	Unspecified systolic (congestive) heart failure	04/08/26

13. ICD	Other Pertinent Diagnoses	Date
G45.A	Multiple sclerosis unspecified	04/08/26
J45.20	Mild intermittent asthma uncomplicated	04/08/26
M81.0	Age-related osteoporosis w/o current pathological fracture	04/08/26
E78.00	Pure hypercholesterolemia unspecified	04/08/26
G50.0	Trigeminal neuralgia	04/08/26
G47.00	Insomnia unspecified	04/08/26
G89.4	Chronic pain syndrome	04/08/26
E43.	Unspecified severe protein-calorie malnutrition	04/08/26
K21.9	Gastro-esophageal reflux disease without esophagitis	04/08/26
Z87.891	Personal history of nicotine dependence	04/08/26

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

ALBUTEROL 108 (90 BASE) mcg/act aerosol solution inhalation by inhalation every 4 hours as needed Commonly known as: VENTOLIN HFA
ALVESCO 80 MCG/ACT Aers inhalation by inhalation Generic drug: Ciclesonide
AMITRIPTYLINE 25 MG tablet mouth nightly Commonly known as: ELAVIL
BACLOFEN 10 MG tablet mouth 2 times daily as needed for Pain
CARBAMAZEPINE 200 MG Tablet mouth 4 times daily Commonly known as: TEGretol
OXYCONTIN 10 MG extended-release tablet mouth 2 times daily Generic drug: oxyCODONE
PANTOPRAZOLE 20 mg tablet mouth daily Commonly known as: PROTONIX
PREGABALIN 150 MG capsule mouth daily Commonly known as: LYRICA
ZOLPIDEM 10 MG tablet mouth nightly Commonly known as: AMBIEN
GLYXAMBI 10 MG Tabs tablet mouth daily Commonly known as: JARDIANCE Start taking on: March 31, 2026
FUROSEMIDE 20 MG tablet mouth every morning Commonly known as: LASIX
POLYETHYLENE GLYCOL 17 g packet mouth 1 packet daily for 7 days Commonly known as: MIRALAX Start taking on: March 31, 2026
SPIRONOLACTONE 25 MG tablet mouth daily Commonly known as: ALDACTONE Start taking on: March 31, 2026

14. DME and Supplies:

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

15. Safety Measures:

wheelchair precautions, walker precautions, transfer with assist, supervision at all times, standard precautions, smoke detectors , medication safety, fall precautions, cardiac precautions, bathroom safety, aspiration precautions, ambulates with device, ambulates with assistance, activity supervision

16. Nutrition:

cardiac diet

17. Allergies:

penicillin sulfa antibiotics sulfanilamide

18.A. Functional Limitations

Ambulation, Endurance

18.B. Activities Permitted

Walker, Wheelchair, Transfer bed/Chair, Up As Tolerated

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: No

20. Prognosis: fair

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

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

Homebound status: Due to diagnosis of Unspecified systolic (congestive) 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 72-year-old female with a complex medical history significant for relapsing-remitting multiple sclerosis (diagnosed at age 34), trigeminal neuralgia, asthma, chronic pain disorder, osteoporosis, insomnia, and newly diagnosed congestive heart failure (CHF). She was recently hospitalized for four days following an acute episode of shortness of breath and was subsequently diagnosed with CHF. Since discharge, she remains under close monitoring and is scheduled for a cardiology follow-up on April 15. The patient is currently prescribed furosemide (Lasix) and adheres to a fluid restriction regimen for volume management. She reports chronic lower extremity swelling, now presenting with significant edema graded as +3 in the left leg and +4 in the right leg. During the nursing visit, the patient was found resting in bed with legs elevated. She is homebound due to mobility limitations requiring a walker, increased fall risk, and dependence on caregiver assistance. Functionally, the patient demonstrates a marked decline in mobility and endurance following her recent hospitalization. Physical therapy evaluation reveals bilateral lower extremity weakness with strength approximately 3-/5 to 3/5 on manual muscle testing, impaired dynamic standing balance (ranging from poor to fair-), decreased cardiopulmonary endurance, and altered gait mechanics. The patient requires minimal to moderate assistance for bed mobility and transfers and is only able to ambulate less than 50 feet with an assistive device and frequent rest breaks due to fatigue and dyspnea. Gait assessment is notable for abnormal mechanics consistent with multiple sclerosis, including reliance on a rolling walker for upper extremity support, limited weight-bearing through the lower extremities, and compensatory swing-through advancement of the legs rather than a typical step-through pattern, contributing to poor stability and increased fall risk. The patient utilizes multiple adaptive devices within the home, including a chair lift (in use for approximately 1.5 years), grab bars, bath bench, toilet hygiene aids, and bed rails. She has a history of a right humerus fracture following a fall in 2019, after which she transitioned from cane use to a rolling walker for ambulation. She reports additional symptoms including stiffness, sensitivity to extreme temperatures, and nausea associated with recent medication changes. She denies difficulty swallowing. Skilled nursing services are indicated for ongoing assessment and management of CHF, including monitoring of fluid status, edema, medication adherence, and symptom progression, as well as patient education regarding disease process, fluid restriction, and when to report worsening symptoms such as increased shortness of breath or swelling. Skilled physical therapy is medically necessary to address lower extremity weakness, impaired balance, decreased endurance, gait abnormalities, and transfer deficits. Interventions will focus on strengthening, balance training, gait and transfer training, cardiopulmonary reconditioning, and energy conservation techniques to improve functional mobility, enhance safety, and reduce fall risk. The patient has been educated on fall prevention strategies, safe use of assistive devices, and activity pacing. Missed visit attempts were documented, with no response at the residence despite multiple drive-by attempts and door tag notification. The plan of care will continue with close interdisciplinary coordination to optimize functional outcomes and prevent rehospitalization.
 Date of Order 04/08/2026 Orders Physician Face-to-Face Date: 03/30/2026 Clinical Condition Requiring Home Care per Certifying Physician: new diagnosis of heart failure with acute exacerbation, asthma, chronic pain from left trigeminal neuralgia and progressive relapsing multiple sclerosis, weakness, deconditioning, ambulatory dysfunction due to Unspecified systolic (congestive) 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 <span style="font-size:

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

Tracy Gutierrez
7070 Samuel Morse Dr
Columbia, MD 21046
PHONE: FAX: NPI: 1336113091

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 : 03/30/2026

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;">
 1 - SOC - SN Notes: soc PT Eval Notes: OT Eval Notes: Physician Gutierrez, Tracy

SN Careplans

SN WK1: 1 (04/08/26-04/11/26) ,WK2: 1 (04/12/26-04/18/26) ,WK3: 1 (04/19/26-04/25/26) ,WK4: 1 (04/26/26-05/02/26) ,WK5: 1 (05/03/26-05/09/26)

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 > 10

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

HOSPITALIZATION RISKS: 7. Currently taking 5 or more medications, 8. Currently reports exhaustion, 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:REFUSED

PROBLEMS IDENTIFIED ON ASSESSMENT: M1720 - Anxiety, M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2102c - Med Admin, M2020 - Oral Med Management, M1033 - Exhaustion, abnormal blood pressure, abn cholesterol > 200 mg/dL, chest pain, coughing, swelling in legs/around eyes, swelling in the arms/legs, weak pulses in feet, M1400 - Dyspnea, dependent edema, nausea/vomiting, heartburn/indigestion, limited endurance, limited strength, limited range of motion, muscle weakness, poor muscle tone, balance deficit, lethargy, daytime fatigue, Pain Interference with ADLs, Pain Effect on Sleep, bruising/discoloration

PROCEDURES: cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, home exercise program, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision

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, * 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, patient is adequately supervised, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

SN Goals

PATIENT-STATED GOAL: To be able to get up and walk around like a normal person

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

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
* 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
* 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

patient is adequately supervised

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

04/08/2026

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PT WK2: 1 (04/12/26-04/18/26) ,WK3: 2 (04/19/26-04/25/26) ,WK4: 2 (04/26/26-05/02/26) ,WK5: 1 (05/03/26-05/09/26) ,WK6: 1 (05/10/26-05/16/26) ,WK7: 1 (05/17/26-05/23/26) ,WK8: 1 (05/24/26-05/30/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: 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-: Patient verbalized understanding of current prescriptions, dosages, and schedule. No reported issues with adherence, side effects, or confusion at this time., B LE strengthening: 1, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 04. Supervision or touching assistance, Chair to Bed to Chair - 04. Supervision or touching 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 - 04. Supervision or touching assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

PATIENT-STATED GOAL: Not to go back to hospital

GOALS
Sit to Stand - 04. Supervision or touching assistance

Chair to Bed to Chair - 04. Supervision or touching 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 - 04. Supervision or touching assistance

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

OT Careplans

OT WK2: 1 (04/12/26-04/18/26) ,WK3: 1 (04/19/26-04/25/26) ,WK4: 1 (04/26/26-05/02/26) ,WK5: 1 (05/03/26-05/09/26) ,WK6: 1 (05/10/26-05/16/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: 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, incentive spirometer, equipment training, work simplification/energy conservation

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, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 06. Independent, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: pt wants to walk cane

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

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 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	04/08/2026