Home Health Certification and Plan of Care

Order ID: 1150/17435

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
8NH6GH5VN55	03/24/2026	From: 03/24/2026 To: 05/22/2026	23903	217058

6. Patient's Name and Address
Elizabeth Breeden
3000 Towanda Avenue Apt 310,
BALTIMORE, MD 21215-
410-245-7876

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 03/05/1937 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
L89.310	Pressure ulcer of right buttock unstageable	03/24/26

13. ICD	Other Pertinent Diagnoses	Date
I13.0	Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny	03/24/26
I50.32	Chronic diastolic (congestive) heart failure	03/24/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	03/24/26
N18.30	Chronic kidney disease stage 3 unspecified	03/24/26
I35.0	Nonrheumatic aortic (valve) stenosis	03/24/26
H54.40	Blindness one eye unspecified eye	03/24/26
H40.9	Unspecified glaucoma	03/24/26
E78.5	Hyperlipidemia unspecified	03/24/26
I73.9	Peripheral vascular disease unspecified	03/24/26
H54.10	Blindness one eye low vision other eye unspecified eyes	03/24/26
I65.29	Occlusion and stenosis of unspecified carotid artery	03/24/26
H26.9	Unspecified cataract	03/24/26
B02.29	Other postherpetic nervous system involvement	03/24/26
N83.209	Unspecified ovarian cyst unspecified side	03/24/26
E55.9	Vitamin D deficiency unspecified	03/24/26
R32.	Unspecified urinary incontinence	03/24/26
Z85.6	Personal history of leukemia	03/24/26
Z96.642	Presence of left artificial hip joint	03/24/26

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

Aspirin Delayed Release Tablet 0 81 mg by mouth once a day Heart health
Cholecalciferol 0 25 MCG (1000 UT) / 1 Capsule by mouth once a day Supplement
Furosemide - Furosemide 40 mg 1/2 tablet by mouth once a day Edema
Glucotrol Xl - Glipizide 5 mg 5 mg / 1 Tablet by mouth once a day with food
Iron 0 325 (65 Fe) mg / 1 Tablet by mouth once a day Supplement
Metoprolol Succinate ER 0 100 mg by mouth once a day Supplement
Potassium Chloride - Potassium Chloride 20meq 1 tablet by mouth once a day Supplement
Albuterol Inhaler - Albuterol 1 puff inhalant every 6 hours As needed for breathing
Oxygen - Oxygen 1.5 L/min inhalant continuous Via nasal cannula for breathing
Guaifenesin - Guaifenesin 0 100 MG/5ML syrup / 10 mL by mouth every 4 hours as needed for cough
Tylenol Arthritis - Acetaminophen 1 tablet by mouth every 8 hours As needed for pain

14. DME and Supplies:
wound care supplies, wheelchair, bath bench, oxygen supplies, commode, 4 wheeled walker

15. Safety Measures:
emergency phone number prominently displayed, , diabetic precautions, bathroom safety, avoid temperature extremes, activity supervision

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
PENICILLINS: rash - Allergy - Onset Date 01/16/2020. Allergies Verified.

18.A. Functional Limitations
Endurance, Ambulation,

18.B. Activities Permitted
Exercises Prescribed, 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: 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 Pressure Ulcer Of Right Buttock Unstageable, 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:

Start of care (SOC) was completed for an 89-year-old female with a significant past medical history including anemia, aortic valve stenosis, coronary artery disease (CAD), heart failure with preserved ejection fraction (HFpEF), hypertension (HTN), osteoarthritis (OA), glaucoma, diabetes mellitus (DM), and prior pneumonia, who was referred for home health services due to functional decline. The patient reports a hospitalization in December for fluid accumulation in the lungs, after which she has experienced a marked decline in mobility and has been unable to stand or ambulate independently. On <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>, the patient demonstrates significant bilateral lower extremity weakness, with manual muscle testing (MMT) graded at 2-/5, and requires moderate assistance for transfers using a rollator. She is currently non-ambulatory. The patient also has a sacral wound, with dressing intact, and ongoing wound care is being appropriately managed by skilled nursing services through Amedisys Home Health. The patient resides alone in a senior apartment, with strong family support from her daughter, who lives in the same building and assists frequently, and her son, who was present during the occupational therapy evaluation. The patient is blind in the right eye and currently sleeps in a lounge chair, as she declined the use of a hospital bed; although a bed rail was obtained for her standard bed, she has been unable to utilize it effectively. Family members assist the patient with transfers to a bedside commode (BSC) as needed, and her daughter occasionally assists with transfers into a walk-in shower. Functional limitations significantly impact her ability to perform activities of daily living (ADLs), requiring a high level of caregiver support. The patient would benefit from skilled physical therapy services to address deficits in strength, balance, and functional mobility, with the goal of improving safety and progressing toward her prior level of function. Occupational therapy services are also indicated at a frequency of once weekly for eight weeks (1w8) to focus on ADL training, functional mobility, therapeutic exercise, development and implementation of a home exercise program (HEP), safety training, and caregiver education. The plan of care emphasizes fall prevention, strengthening, and maximizing independence while supporting the patient's current living situation and preferences.
 Date of Order 03/24/2026 Orders Physician Face-to-Face Date: 03/17/2026 Clinical Condition Requiring Home Care per Certifying Physician: Sacral wound x 4 weeks, unable to walk, would care and PT, incontinent d/t gait abnormality due to Pressure Ulcer Of Right Buttock Unstageable 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 - PT Notes: soc OT Eval Notes:
 Physician Choi, Jane

SN Careplans | SN Goals

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 03/24/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Jane choi
1501 Division St
Baltimore, MD 21217
PHONE: 4103838300 FAX: 14103833160 NPI: 1225879083

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 : 03/17/2026

27. Attending Physician's Signature and Date Signed **03/31/2026**: 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.

Home Health Certification and Plan of Care

Order ID: 1150/17435

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
8NH6GH5VN55	03/24/2026	From: 03/24/2026 To: 05/22/2026	23903	217058

6. Patient's Name and Address
Elizabeth Breeden
3000 Towanda Avenue Apt 310,
BALTIMORE, MD 21215-
410-245-7876

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

PT Careplans

PT WK1: 1 (03/24/26-03/28/26) ,WK2: 1 (03/29/26-04/04/26) ,WK3: 1 (04/05/26-04/11/26) ,WK4: 1 (04/12/26-04/18/26) ,WK5: 1 (04/19/26-04/25/26) ,WK6: 1 (04/26/26-05/02/26) ,WK7: 1 (05/03/26-05/09/26) ,WK8: 1 (05/10/26-05/16/26)

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: 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:POLST (Physician Orders for Life-Sustaining Treatment)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170J1 - Walk 50 ft with 2 Turns, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170D1 - Sit to Stand, GG0170F1 - Toilet Transfer, GG0170S1 - Wheel 150 feet, GG0170R1 - Wheel 50 ft w 2 Turns, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170L1 - Walk 10 ft on Uneven Surface, GG0170K1 - Walk 150 Feet, GG0170I1 - Walk 10 Feet, GG0170P1 - Picking Up Object, M2102c - Med Admin, M2102d - Caregiver Performs Treatment, M2020 - Oral Med Management, M1400 - Dyspnea, M1033 - Exhaustion, M1610 - Urinary Incontinence, limited endurance, limited strength, Pain Interference with Therapy activities, Pain Interference with ADLs, Pain Effect on Sleep, balance deficit

PT Goals

PATIENT-STATED GOAL: To be able to walk again

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

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

caregiver administers and/or packages medications appropriately

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

caregiver performs medical/rehabilitation treatments with adequate competence

Sit to Stand - 04. Supervision or touching assistance

Toilet Transfer - 03. Partial/moderate assistance

Car Transfer - 04. Supervision or touching assistance

Walk 10 Feet - 02. Substantial/maximal assistance

Signature of Physician:

Date

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

Date
03/24/2026

Home Health Certification and Plan of Care

Order ID: 1150/17435

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
8NH6GH5VN55	03/24/2026	From: 03/24/2026 To: 05/22/2026	23903	217058

6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number
Elizabeth Breeden 3000 Towanda Avenue Apt 310, BALTIMORE, MD 21215- 410-245-7876	HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239

PROCEDURES: cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments, physician-ordered wound care: Wound care to be performed by nursing services through Amedysis, therapeutic exercises, gait training/stair training, transfers training, teach/coordinate/arrange medication packaging and/or 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, Chair to Bed to Chair - 02. Substantial/maximal assistance, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence, Sit to Stand - 04. Supervision or touching assistance, Toilet Transfer - 03. Partial/moderate assistance, Car Transfer - 04. Supervision or touching assistance, Walk 10 Feet - 02. Substantial/maximal assistance

OT Careplans

OT WK1: 1 (03/24/26-03/28/26) ,WK4: 1 (04/12/26-04/18/26) ,WK5: 1 (04/19/26-04/25/26) ,WK6: 1 (04/26/26-05/02/26) ,WK7: 1 (05/03/26-05/09/26) ,WK8: 1 (05/10/26-05/16/26) ,WK9: 1 (05/17/26-05/22/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, 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, 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, * 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, Oral Hygiene - 03. Partial/moderate assistance, Toileting Hygiene - 03. Partial/moderate assistance, Shower/Bathe Self - 03. Partial/moderate assistance, Upper Body Dressing - 03. Partial/moderate assistance, Lower Body Dressing - 03. Partial/moderate assistance, Don/Doff Footwear - 03. Partial/moderate assistance, Eating - 05. Setup or clean-up assistance

OT Goals

PATIENT-STATED GOAL: to be able to move around

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

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

Oral Hygiene - 03. Partial/moderate assistance

Toileting Hygiene - 03. Partial/moderate assistance

Shower/Bathe Self - 03. Partial/moderate assistance

Upper Body Dressing - 03. Partial/moderate assistance

Lower Body Dressing - 03. Partial/moderate assistance

Don/Doff Footwear - 03. Partial/moderate assistance

Eating - 05. Setup or clean-up assistance

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	03/24/2026