Home Health Certification and Plan of Care

Order ID: 1150/18006

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
97157239	04/16/2026	From: 04/16/2026 To: 06/14/2026	23718	217058

6. Patient's Name and Address

Tanya Smith
8439 Allenswood Rd,
RANDALLSTOWN, MD 21133-
443-810-3848

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 04/20/1966 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
L89.153	Pressure ulcer of sacral region stage 3	04/16/26

13. ICD	Other Pertinent Diagnoses	Date
C79.51	Secondary malignant neoplasm of bone	04/16/26
D63.0	Anemia in neoplastic disease	04/16/26
G89.3	Neoplasm related pain (acute) (chronic)	04/16/26
N12.	Tubulo-interstitial nephritis not spcf as acute or chronic	04/16/26
B96.20	Unsp Escherichia coli as the cause of diseases classd elswhr	04/16/26
B96.89	Oth bacterial agents as the cause of diseases classd elswhr	04/16/26
E43.	Unspecified severe protein-calorie malnutrition	04/16/26
I10.	Essential (primary) hypertension	04/16/26
E87.1	Hypo-osmolality and hyponatremia	04/16/26
R33.9	Retention of urine unspecified	04/16/26
Z85.3	Personal history of malignant neoplasm of breast	04/16/26
Z79.891	Long term (current) use of opiate analgesic	04/16/26
Z86.19	Personal history of other infectious and parasitic diseases	04/16/26
Z96.0	Presence of urogenital implants	04/16/26

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

Dilaudid - Hydromorphone Hydrochloride 0.5 mg inj subcutaneous as necessary Inj Syg .5 mg Q4H
Oxycontin - Oxycodone Hydrochloride 15 mg by mouth every 12 hours Take 1 tablet by mouth every 12 hours for 3 days
Levofloxacin - Levofloxacin: Sodium Chloride 750 mg 750mg; 1 tab by mouth once a day sacral wound for 3 days
Lidocaine - Lidocaine 4% 2patch transdermal as necessary
clorpactin 1 application topical twice a day apply 1 application to the skin 2 times a day. Apply to sacral wound 2-3 times a day with dressing changes. Recommend clorpactin moistened gauze and foam dressing twice a day.
Tamsulosin Hydrochloride - Tamsulosin Hydrochloride 0.4 mg 0.4mg; 1 tab by mouth in the evening urinary retention
Extra Strength Tylenol - Acetaminophen 325mg; 2 tabs by mouth every 6 hours as needed for pain
Lactulose - Lactulose 10gm/15ml 30mls by mouth every 12 hours for constipation
Roxicodone - Oxycodone Hydrochloride 10 mg 10mg; 1 tab by mouth every 6 hours for pain
Senna - Senna 8.6 mg ; 2 tabs by mouth at bedtime as needed (Constipation)
Narcan - Naloxone Hydrochloride 4 mg Nasal as necessary Spray in 1 nostril if not breathing/responding. Call 911. If still not breathing/responding, use new spray in 2 to 3 minutes in other nostril. For suspected opioid overdose use only

14. DME and Supplies:

hospital bed, urinary/catheter supplies, wheelchair, wound care supplies

15. Safety Measures:

wheelchair precautions, standard precautions, fall precautions, medication safety, transfer with assist, activity supervision

16. Nutrition:

regular

17. Allergies:

zithromax

18.A. Functional Limitations

Endurance, Bowel/Bladder Incontinence, Ambulation

18.B. Activities Permitted

Transfer bed/Chair, Exercises Prescribed, Wheelchair,

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: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No

20. Prognosis: poor

22. A Rehabilitation Potential:

SELF-CARE: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities., MOBILITY: 1. Dependent - A helper completed all the activities for the patient.

22.B.Discharge Plans

family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Pressure ulcer of sacral region stage 3, 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 60-year-old female admitted to home health services following a recent hospitalization for sepsis secondary to a Stage IV sacral decubitus ulcer complicated by E. coli bacteremia, urinary tract infection/pyelonephritis, and significant deconditioning in the context of metastatic breast cancer with diffuse osseous involvement. Additional past medical history includes hypertension, chronic hyponatremia, iron deficiency anemia status post blood transfusion, chronic lower back pain with prior spinal fracture, urinary retention status post Foley catheter insertion on 04/09/2026, and prolonged immunosuppression related to chemotherapy and radiation therapy. The patient is scheduled to follow up with urology for ongoing Foley catheter management. She resides with family in a multi-level home and remains on the basement level, requiring total assistance from family members for all activities of daily living (ADLs) and instrumental activities of daily living (IADLs). On assessment, the patient is alert and oriented to person, place, and time. She reports chronic back pain but denies shortness of breath and endorses a good appetite. She is incontinent of bowel, with last bowel movement reported as occurring the previous day. A 16 French, 10 cc indwelling urinary catheter is in place, draining clear yellow urine without noted complications. The sacral pressure injury measures 2.5 cm x 2.5 cm x 2.0 cm with 2.0 cm circumferential undermining, consistent with a Stage IV ulcer requiring ongoing skilled wound care management. Skilled nursing services have been initiated at a frequency of once weekly for 12 weeks, followed by three additional visits, with interventions including medication reconciliation, wound care management using Clorpactin-moistened gauze and foam dressing, and education on indwelling Foley catheter care. Both the patient and her daughter demonstrated understanding and were receptive to all instructions provided. Functionally, the patient presents with significant generalized weakness, decreased activity tolerance, and impaired mobility. She is chairfast and requires maximal assistance for bed mobility, including supine-to-sit transitions, as well as for transfers from bed to wheelchair. She is unable to stand functionally, even with assistive devices such as a walker. Sitting tolerance is limited to approximately one hour in a wheelchair due to fatigue, although she is able to sit at the edge of the bed for meals with support. She requires maximal assistance for all self-care tasks, including upper and lower body dressing and bathing, which is performed in bed. Manual muscle testing reveals bilateral upper extremity strength at approximately 4-/5, and static sitting balance is assessed as fair. Given the patient's complex medical condition, profound deconditioning, and high level of functional dependence, skilled physical therapy evaluation has been completed and services are indicated to address deficits in strength, endurance, balance, bed mobility, and transfer training, with progression toward safe sitting and eventual standing as tolerated. The overall goal is to improve functional independence, reduce caregiver burden, prevent further complications such as falls or worsening pressure injuries, and enhance quality of life. Without skilled intervention, the patient remains at high risk for further functional decline, complications related to immobility, and decreased overall health status.
 Date of Order 04/16/2026 Orders Physician Face-to-Face Date: 04/14/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Pressure ulcer of sacral region stage 3 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: OT Eval Notes: Physician Lee, Shirley

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 04/16/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Shirley Lee
7141 Security Blvd
Baltimore, MD 21244
PHONE: (443) 663-6000 FAX: 14436636295 NPI: 1730398819

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 : 04/14/2026

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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7. Provider's Name, Address and Telephone Number
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SN Careplans

SN WK1: 1 (04/06/26-04/11/26) ,WK2: 1 (04/12/26-04/18/26) ,WK3: 2 (04/19/26-04/25/26) ,WK4: 2 (04/26/26-05/02/26)

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, 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: M1720 - Anxiety, meal preparation, M2020 - Oral Med Management, M1033 - Exhaustion, M1400 - Dyspnea, M1620 - Bowel Incontinence, M1600 - UTI, M1610 - Urinary Catheter, urine retention, limited endurance, muscle weakness, limited range of motion, limited strength, pain radiating to arms/legs, weak hand grips, Pain Interference with ADLs, Pain Effect on Sleep, #1 - 3 - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles not exposed. - Other - sacrum - 2.0 cm undermining the entire circumference of wound

PROCEDURES: physician-ordered wound care: #1 - 4 - Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present. - Other - sacrum - 2.0 cm undermining the entire circumference of wound: SN/CG TO PERFORM WOUND CARE TO STAGE 3 SACRAL DECUBITUS, CLEANSE WITH NSS, LOOSELY PACK WITH CLORPACTIN GAUZE AND COVER WITH FOAM DRESSING TWICE A DAY,, cough/deep breathing exercises, catheter change, care & irrigation: MD MANAGING THE INDWELLING CATHETER. NO HH ORDERS. PER DC INSTRUCTIONS IN THE HOME, PT TO FOLLOW UP WITH UROLOGIST, coordinate/arrange preparation of missing meals

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 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 catheter management including how to flush catheter change and wash drainage bags prevent infection including proper handwashing positioning of catheter, related medication(s) purpose, schedule, * prevention including increase fluid intake increase Vitamin C intake to promote acidic bladder environment (cranberry juice) perineal hygiene, related medication(s) purpose,

SN Goals

PATIENT-STATED GOAL: I WANT THE WOUND TO GET BETTER

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

patient/caregiver recalls
* urinary catheter management including how to flush catheter
* change and wash drainage bags
* prevent infection including proper handwashing
* positioning of catheter
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* prevention including increase fluid intake
* increase Vitamin C intake to promote acidic bladder environment (cranberry juice)
* perineal hygiene
* 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

meal preparation is available to patient for all meals

Signature of Physician:

Date

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

Date
04/16/2026

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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, meal preparation is available to patient for all meals

PT Careplans

PT WK1: 1 (04/16/26-04/18/26) ,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) ,WK7: 1 (05/24/26-05/30/26) ,WK8: 1 (05/31/26-06/06/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, Pain Interference with Therapy activities, Pain Effect on Sleep, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170R1 - Wheel 50 ft w 2 Turns, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170S1 - Wheel 150 feet, 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, GG0170F1 - Toilet Transfer

PROCEDURES: HEP: Patient instructed on proper technique, pacing, use of ice after exercises, and safe frequency throughout the day. Patient verbalized understanding and demonstrated good carryover., 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, Pregait Training: 1, Pregait Training: 1, wheelchair training, home exercise program, transfers training

TEACH PATIENT/CAREGIVER: * 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 - 04. Supervision or touching assistance, Toilet Transfer - 03. Partial/moderate assistance, Car Transfer - 06. Independent, Wheel 50 ft w 2 Turns - 06. Independent, Wheel 150 feet - 06. Independent, 1 - Step (curb) - 02. Substantial/maximal assistance, 12 Steps - 02. Substantial/maximal assistance, 4 Steps - 02. Substantial/maximal assistance, Picking Up Object - 02. Substantial/maximal assistance, Walk 10 Feet - 02. Substantial/maximal assistance, Walk 10 ft on Uneven Surface - 02. Substantial/maximal assistance, Walk 150 Feet - 02. Substantial/maximal assistance, Walk 50 ft with 2 Turns - 02. Substantial/maximal assistance

PT Goals

PATIENT-STATED GOAL: not to go back to hospital

GOALS
Chair to Bed to Chair - 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

Sit to Stand - 04. Supervision or touching assistance

Toilet Transfer - 03. Partial/moderate assistance

Car Transfer - 06. Independent

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

12 Steps - 02. Substantial/maximal assistance

4 Steps - 02. Substantial/maximal assistance

Picking Up Object - 02. Substantial/maximal assistance

Walk 10 Feet - 02. Substantial/maximal assistance

Walk 10 ft on Uneven Surface - 02. Substantial/maximal assistance

Walk 150 Feet - 02. Substantial/maximal assistance

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

Wheel 50 ft w 2 Turns - 06. Independent

Wheel 150 feet - 06. Independent

OT Careplans

OT 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) ,WK7: 1 (05/24/26-05/30/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: 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: Sitting balance/tolerance : Therapy, Patient/caregiver recalls related purpose and schedule of medications: Medication review, therapeutic exercises: Therapy, work simplification/energy conservation, transfers training: Therapy

TEACH PATIENT/CAREGIVER: Oral Hygiene - 05. Setup or clean-up assistance, Toileting Hygiene - 03. Partial/moderate assistance, Shower/Bathe Self - 02. Substantial/maximal assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 03. Partial/moderate assistance, Don/Doff Footwear - 03. Partial/moderate assistance, Eating - 06. Independent, Patient will demonstrate improved bilateral upper extremity muscle strength from 4-/5 mmt to 5/5 mmt to improve ADLs and transfers within 6 wks

OT Goals

PATIENT-STATED GOAL: Patient wants to be able to stand

GOALS
Oral Hygiene - 05. Setup or clean-up assistance

Toileting Hygiene - 03. Partial/moderate assistance

Shower/Bathe Self - 02. Substantial/maximal assistance

Upper Body Dressing - 05. Setup or clean-up assistance

Lower Body Dressing - 03. Partial/moderate assistance

Don/Doff Footwear - 03. Partial/moderate assistance

Eating - 06. Independent

Patient will demonstrate improved bilateral upper extremity muscle strength from 4-/5 mmt to 5/5 mmt to improve ADLs and transfers within 6 wks

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	04/16/2026