Home Health Certification and Plan of Care

Order ID: 1150/18268

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
78283121	04/16/2026	From: 04/16/2026 To: 06/14/2026	16062	217058

6. Patient's Name and Address

Gwendolyn Wiggins
6804 PARSONS AVE,
GWYNN OAK, MD 21207-
443-608-6986

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 03/18/1956 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
E87.5	Hyperkalemia	04/16/26

13. ICD	Other Pertinent Diagnoses	Date
I13.2	Hyp hrt & chr kdny dis w hrt fail and w stg 5 chr kdny/ESRD	04/16/26
I50.32	Chronic diastolic (congestive) heart failure	04/16/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	04/16/26
N18.6	End stage renal disease	04/16/26
D63.1	Anemia in chronic kidney disease	04/16/26
Z47.81	Encounter for orthopedic aftercare following surgical amp	04/16/26
E11.51	Type 2 diabetes w diabetic peripheral angiopath w/o gangrene	04/16/26
I27.20	Pulmonary hypertension unspecified	04/16/26
I45.10	Unspecified right bundle-branch block	04/16/26
D86.9	Sarcoidosis unspecified	04/16/26
Z99.2	Dependence on renal dialysis	04/16/26
Z89.431	Acquired absence of right foot	04/16/26
Z79.4	Long term (current) use of insulin	04/16/26
Z79.82	Long term (current) use of aspirin	04/16/26

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

Alphagan - Brimonidine Tartrate 0.2 perc both eyes three times a day
Coreg - Carvedilol 3.125 mg Take 1 tablet by mouth twice a day Take 1 tablet by mouth 2 times daily with meals for 30 days
Apresoline - Hydralazine Hydrochloride 100 mg tablet by mouth three times a day 50 MG tablet Take 100 mg by mouth 3 times daily.
Cozaar - Losartan Potassium 50 MG tablet Take 1 tablet by mouth once a day 50 MG tablet Take 1 tablet by mouth daily for 30 days.
Lipitor - Atorvastatin Calcium 40 MG, Take 40 mg tablet by mouth once a day 40 MG tablet Take 40 mg by mouth daily
Rena-Vite Rx 1 MG Tabs 1 MG, 60mg, 300mcg take 1 tablet by mouth once a day Take 1 tablet by mouth daily before dinner for 30 days
Lasix - Furosemide 40 mg by mouth once a day
Catapres - Clonidine Hydrochloride 0.1 mg by mouth twice a day
Norvasc - Amlodipine Besylate eq 10 mg base by mouth once a day
Asa 325Mg - Aspirin 325mg by mouth once a day
Cardura - Doxazosin Mesylate eq 2 mg base by mouth once a day
Imdur - Isosorbide Mononitrate 60 mg by mouth in the morning
Mycophenolate Mofetil - Mycophenolate Mofetil 360mg by mouth twice a day
Protonix - Pantoprazole Sodium eq 40 mg base by mouth twice a day
Renvela - Sevelamer Carbonate 800 mg by mouth three times a day
Acetaminophen - Acetaminophen 500 mg by mouth every 6 hours
Ventolin Hfa - Albuterol Sulfate 108 (90 BASE) mcg/act aerosol solution Take 1-2 puffs inhalant every 4 hours 108 (90 BASE) mcg/act aerosol solution Take 1-2 puffs by inhalation every 4 hours as needed.
Lantus - Insulin Glargine Recombinant 10 units subcutaneous once a day
Humalog - Insulin Lispro Recombinant 3 units subcutaneous three times a day
Heparin - Heparin Sodium 5,000 Units subcutaneous three times a day

14. DME and Supplies:

large base quad cane, wheelchair, , bath bench

15. Safety Measures:

wheelchair precautions, standard precautions, medication safety, fall precautions, diabetic precautions, bleeding precautions, bathroom safety, anticoagulant precautions

16. Nutrition:

diabetic

17. Allergies:

no known allergies

18.A. Functional Limitations

Ambulation, Amputation

18.B. Activities Permitted

Wheelchair, Up As Tolerated

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: 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

SN: patient will be responsible for managing treatment
PT: family/caregiver will be responsible for managing treatment
OT: patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Hyperkalemia, 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 70-year-old female with a significant past medical history including hypertension (HTN), end-stage renal disease (ESRD) on hemodialysis, type 2 diabetes mellitus (T2DM), heart failure, peripheral vascular disease (PVD), sarcoidosis, chronic respiratory failure, and other comorbidities. She was recently hospitalized for diabetic ketoacidosis (DKA), osteomyelitis, and a right foot infection resulting in partial amputation of four toes with subsequent debridement and washout. She is currently admitted to home health services for ongoing wound management and rehabilitation. The patient presents with an open wound to the right forefoot and is weight-bearing on the right heel only. She reported that her wound dressing had not been changed since the previous nursing visit, and she was educated on the importance of daily wound care and adherence to nursing instructions. A skilled nursing visit is scheduled for wound care management. Physical therapy evaluation reveals decreased lower extremity strength, graded at 3+/5 bilaterally, and the patient requires contact guard assistance for transfers. She is currently non-ambulatory and relies on a wheelchair for mobility, pending receipt of a rollator previously requested from her primary care provider. Prior to hospitalization, the patient was independently ambulatory without an assistive device. She was instructed in an initial home exercise program consisting of seated therapeutic exercises, with plans to progress as tolerated. The patient would benefit from continued skilled physical therapy services to improve strength, balance, safety, and functional mobility with the goal of returning to her prior level of function. Follow-up appointments are scheduled for 04/28 at 1:00 PM and 05/05 at 10:45 AM. Occupational therapy assessment indicates that the patient resides with family in a multi-level home and is currently functioning independently at the

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

Nkechinyerem Eseonu Ewoh
7070 Samuel Morse Dr
Columbia, MD 21246
PHONE: FAX: NPI: 1114247541

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 : 04/11/2026

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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wheelchair level for activities of daily living (ADLs). She is independent with upper and lower body dressing and performs sink-side bathing independently, as she is unable to access the shower due to the presence of a dialysis port. The patient is able to complete transfers from the wheelchair to the couch and toilet with setup assistance only and without the need for cues. Bilateral upper extremity strength is within normal limits at 5/5. At this time, no further skilled occupational therapy services are indicated. The plan of care includes continued skilled nursing for wound care and education, ongoing physical therapy to address strength and mobility deficits, reinforcement of safety precautions, and coordination of care to support the patient's return to her prior level of independence.
 Date of Order 04/16/2026 Orders Physician Face-to-Face Date: 04/11/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-disease management , PT-eval & treat, OT-eval & treat due to Hyperkalemia 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 Eseonu Ewoh, Nkechinyerem

SN Careplans

SN WK1: 1 (04/16/26-04/18/26) ,WK2: 2 (04/19/26-04/25/26) ,WK3: 2 (04/26/26-05/02/26) ,WK4: 2 (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 > 5

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

HOSPITALIZATION RISKS: 3. Multiple hospitalizations (2 or more) in the past 6 months, 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:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M1720 - Anxiety, M2102d - Caregiver Performs Treatment, M2102c - Med Admin, M2102f - Patient Supervision, M2020 - Oral Med Management, dependent edema, M1400 - Dyspnea, M1033 - Exhaustion, weak pulses in feet, swelling of affected area, limited endurance, limited strength, Pain Effect on Sleep, B1000 - Vision Deficit, Pain Interference with ADLs, balance deficit, open sores/lesions, #1 - Open Wound - Anterior Right Foot - Amputation of 4 toes on right foot. Recently debridment and washed out.

PROCEDURES: physician-ordered wound care: #1 - Open Wound - Anterior Right Foot - Amputation of 4 toes on right foot. Recently debridment and washed out.: Every other day (3 times weekly) Procedure: Perform hand hygiene Remove existing dressing carefully Perform hand hygiene again Cleanse wound with soap and water, rinse thoroughly, and pat dry Apply acetic acid-soaked gauze to wound bed as ordered Cover with appropriate secondary dressing and secure in place Perform hand hygiene after completion (Patient's sister lives with the patient and performs the wound care in the absence of the nurse) Additional Orders: Continue use of prescribed offloading device (e.g., surgical shoe, cast boot, or cast) during standing and ambulation Reposition regularly to relieve pressure on affected area Monitoring / Notify Provider If: Increased redness, swelling, or warmth around wound Increased drainage or purulent discharge Foul odor from wound Fever, chills Nausea or vomiting Any worsening of wound condition or new skin breakdown, physician-ordered wound care: #1 - Open Wound - Anterior Right Foot - Amputation of 4 toes on right foot. Recently debridment and washed out.: Every other day (3 times weekly) Procedure: Perform hand hygiene Remove existing dressing carefully Perform hand hygiene again Cleanse wound with soap and water, rinse thoroughly, and pat

SN Goals

PATIENT-STATED GOAL: I want my foot wound to heal.

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

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
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

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

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
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dry Apply acetic acid-soaked gauze to wound bed as ordered Cover with appropriate secondary dressing and secure in place Perform hand hygiene after completion Additional Orders: Continue use of prescribed offloading device (e.g., surgical shoe, cast boot, or cast) during standing and ambulation Reposition regularly to relieve pressure on affected area Monitoring / Notify Provider If: Increased redness, swelling, or warmth around wound Increased drainage or purulent discharge Foul odor from wound Fever, chills Nausea or vomiting Any worsening of wound condition or new skin breakdown, physician-ordered wound care: #1 - Open Wound - Anterior Right Foot - Amputation of 4 toes on right foot. Recently debridment and washed out.: Every other day (3 times weekly) Procedure: Perform hand hygiene Remove existing dressing carefully Perform hand hygiene again Cleanse wound with soap and water, rinse thoroughly, and pat dry Apply acetic acid-soaked gauze to wound bed as ordered Cover with appropriate secondary dressing and secure in place Perform hand hygiene after completion Additional Orders: Continue use of prescribed offloading device (e.g., surgical shoe, cast boot, or cast) during standing and ambulation Reposition regularly to relieve pressure on affected area Monitoring / Notify Provider If: Increased redness, swelling, or warmth around wound Increased drainage or purulent discharge Foul odor from wound Fever, chills Nausea or vomiting Any worsening of wound condition or new skin breakdown, cough/deep breathing exercises, monitor dialysis schedule

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, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, * how to keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, 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

PT Careplans

PT 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)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, M1400 - Dyspnea, Pain Interference with Therapy activities, GG0170J1 - Walk 50 ft with 2 Turns, GG0170K1 - Walk 150 Feet, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170I1 - Walk 10 Feet, GG0170P1 - Picking Up Object, GG0170E1 - Chair to Bed to Chair, GG0170G1 - Car Transfer, GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170M1 - 1 - Step (curb), GG0170S1 - Wheel 150 feet, GG0170R1 - Wheel 50 ft w 2 Turns, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand

PROCEDURES: Medication Review: - medications reviewed with patient/caregiver, cough/deep breathing exercises, home exercise program: Review HEP: seated knee ext, hip flex, hip abd, quad sets, gluteal squeezes, ankle pumps at least 1x10. Once tolerated, upgrade to standing heel/ toe raises, knee flex, hip flex, hip abd at least 1x10 with UE support as needed, gait training/stair training: Ambulation with walker and heel weight bearing on RLE, 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 - 05. Setup or clean-up assistance, Sit to Stand - 05. Setup or clean-up assistance, Toilet Transfer - 05. Setup or clean-up assistance, 1 - Step (curb) - 02. Substantial/maximal assistance, Car Transfer - 05. Setup or clean-up assistance, Picking Up Object - 02. Substantial/maximal assistance, Walk 10 Feet - 02. Substantial/maximal assistance, Walk 50 ft with 2 Turns - 02. Substantial/maximal assistance

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

Sit to Stand - 05. Setup or clean-up assistance

Chair to Bed to Chair - 05. Setup or clean-up assistance

Toilet Transfer - 05. Setup or clean-up assistance

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

Car Transfer - 05. Setup or clean-up assistance

Picking Up Object - 02. Substantial/maximal assistance

Walk 10 Feet - 02. Substantial/maximal assistance

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

OT Careplans

OT WK1: 1 (04/16/26-04/18/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400, GG0130B1 - Oral Hygiene, GG0130C1 - Toileting Hygiene, GG0130E1 - Shower/Bathe Self, GG0130F1 - Upper Body Dressing, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130A1 - Eating

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, Sit to Stand - 05. Setup or clean-up assistance, Chair to Bed to Chair - 05. Setup or clean-up assistance, Toilet Transfer - 05. Setup or clean-up assistance, Car Transfer - 05. Setup or

OT Goals

PATIENT-STATED GOAL: Eval only

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

Sit to Stand - 05. Setup or clean-up assistance

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

04/16/2026

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clean-up assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 02. Substantial/maximal assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

Chair to Bed to Chair - 05. Setup or clean-up assistance

Toilet Transfer - 05. Setup or clean-up assistance

Car Transfer - 05. Setup or clean-up assistance

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 02. Substantial/maximal assistance

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:	Date
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