Home Health Certification and Plan of Care

Order ID: 1150/18241

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
41159685	02/23/2026	From: 04/24/2026 To: 06/22/2026	15657	217058

6. Patient's Name and Address

Janet Abey
19 Sidewell Ct,
ESSEX, MD 21221-
443-600-7323

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 12/31/1950 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
E11.9	Type 2 diabetes mellitus without complications	02/23/26

13. ICD	Other Pertinent Diagnoses	Date
E55.9	Vitamin D deficiency unspecified	02/23/26
I70.0	Atherosclerosis of aorta	02/23/26
E83.42	Hypomagnesemia	02/23/26
G89.29	Other chronic pain	02/23/26
M54.50	Low back pain unspecified	02/23/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	02/23/26
Z79.4	Long term (current) use of insulin	02/23/26
Z79.85	Lng trm (crnt) use injectable non-insulin antidiabetic drugs	02/23/26
Z79.82	Long term (current) use of aspirin	02/23/26

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

Metformin Hcl - Metformin Hydrochloride 500 MG,Give 1000 mg tablet by mouth once a day Give 1000 mg by mouth one time a day for DM
Atorvastatin Calcium - Atorvastatin Calcium 40 MG,Give 40 mg tablet by mouth at bedtime Give 40 mg by mouth at bedtime for HLD
Senna Plus Tablet 8.6-50 MG (Sennosides-Docusate Sodium) 8.6-50 MG, Give 2 tablet by mouth every 12 hours Give 2 tablet by mouth every 12 hours as needed for constipation
Bupropion Hydrochloride - Bupropion Hydrochloride 450mg, Give 1 tablet by mouth once a day DEPRESSION
Acetaminophen - Acetaminophen 325mg, take 2 tablets by mouth every 6 hours as needed for mild pain
Gabapentin - Gabapentin 300 mg take 2 capsules by mouth once a day neuropathy
Melatonin - Melatonin 3mg, take 1 tablet by mouth at bedtime Insomnia
Insulin glargine yfrn inject 40 units subcutaneous at bedtime DM
Amoxicillin - Amoxicillin 500 mg 1 by mouth every 8 hours Take until gone given by dentist

14. DME and Supplies:

urinary/catheter supplies, bath bench, diabetic supplies, commode, grab bars, rolling walker, wheelchair, 4 wheeled walker

15. Safety Measures:

wheelchair precautions, walker precautions, transfer with assist, standard precautions, fall precautions, diabetic precautions, bathroom safety, ambulates with assistance, ambulates with device

16. Nutrition:

diabetic

17. Allergies:

no known allergies

18.A. Functional Limitations

Dyspnea With Minimal Exertion, Ambulation, Endurance

18.B. Activities Permitted

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

19. Mental & Pyschosocial Status: COGNITION: 1. When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer, ANXIETY: , SOCIAL ISOLATION: , BEHAVIORAL ISSUES: Wfl , HISTORY OF DEPRESSION:

20. Prognosis: good

22. A Rehabilitation Potential:

SELF-CARE: , MOBILITY:

22.B.Discharge Plans

patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Type 2 diabetes mellitus without complications, 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:

Comprehensive assessment completed for this 75-year-old female referred to home health services following a recent hospital admission and subsequent subacute rehabilitation stay related to poorly controlled diabetes mellitus. The patient is alert and oriented to person, place, time, and situation (AOx4). She reports that prior to hospitalization she experienced worsening depression, discontinued her prescribed medications, and subsequently developed severe hyperglycemia with blood glucose levels reportedly reaching 600 mg/dL. During that period, she sustained a fall resulting in bruising to her left side. She was treated in the hospital and then transferred to a rehabilitation facility. At the time of this assessment, her skin is intact and prior bruising has resolved. Her past medical history is significant for diabetes mellitus, hypomagnesemia, vitamin D deficiency, depression, chronic pain, aortic stenosis status post aortic valve replacement, hypertension, hyperlipidemia, osteoarthritis, heart failure, chronic kidney disease, lymphoma, and chronic low back pain. She currently has an 18 French, 10 mL suprapubic catheter in place, which is managed by her urologist and changed monthly at Kaiser Clinic. Catheter site appears intact without reported complications. The patient reports recent evaluation by her primary care provider, who prescribed magnesium supplementation and benzonatate; however, she has not yet obtained these medications from the pharmacy. She continues to intermittently use an expired supply of benzonatate (expiration date 2025) for cough management. Despite education regarding the risks associated with expired medications and proper disposal recommendations, the patient declined to discard the medication and verbalized her belief that expired medications remain effective. Extensive education was provided regarding medication compliance, risks of using expired medications, the importance of glycemic control, diabetes self-management, safe insulin administration, and suprapubic catheter care. Medication reconciliation was completed. Regarding mental health management, she is currently prescribed bupropion 450 mg orally once daily for depression. The patient acknowledges prior noncompliance but verbalizes understanding of the importance of adhering to her medication regimen. Functionally, prior to hospitalization she primarily utilized a manual wheelchair for independent mobility, with assistance from her niece for instrumental and some basic activities of daily living. She resides alone in a single-story home without steps at the entrance; additional information indicates there are two tenants in the home. Currently, she demonstrates impaired balance and mobility. Objective testing reveals a Tinetti score of 12/28 and a Timed Up and Go (TUG) time of 38.7 seconds, indicating a high risk for falls. She presents with gait dysfunction, lower extremity weakness, transfer deficits, and difficulty with functional mobility, making leaving the home a considerable and taxing effort. Although she owns a walker, she reports rarely using it due to fear of falling and primarily mobilizes via manual wheelchair. The patient is considered homebound due to significant mobility limitations, high fall risk, and need for assistive devices. She demonstrates good rehabilitation potential and is an appropriate candidate for skilled home health services. The plan of care includes skilled nursing for ongoing assessment of medical status, medication management and compliance monitoring, diabetes education and glucose monitoring reinforcement, and catheter care oversight. Skilled physical therapy is recommended to address balance deficits, gait training, strengthening, and transfer training to reduce fall risk and improve functional independence. Ongoing interdisciplinary collaboration will focus on maximizing safety, promoting adherence to medical treatment, and preventing rehospitalization.
 Date of Order 04/22/2026 Orders Physician Face-to-Face Date: 02/18/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN disease management, PT eval and treat, OT eval and treat, SW community resources, HHA daily adl's due to Type 2 Diabetes Mellitus Without Complications 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: Patient is being recertified due to good potential to benefit from further skilled therapeutic Intervention to improve her lower extremities strength, dynamic balance, gait sequencing, transfers safety ambulation over even and uneven surfaces using rolling walker.
 Physician Ajide, Oluwakemi

SN Careplans

SN Goals

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 04/22/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Oluwakemi Ajide
4920 Campbell Blvd
Baltimore, MD 21236
PHONE: 410-933-7600 FAX: 410-933-7666 NPI: 1184919151

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 : 02/18/2026

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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PT Careplans

PT WK2: 1 (04/26/26-05/02/26) ,WK3: 1 (05/03/26-05/09/26) ,WK4: 1 (05/10/26-05/16/26) ,WK5: 1 (05/17/26-05/23/26) ,WK6: 1 (05/24/26-05/30/26) ,WK7: 1 (05/31/26-06/01/26)

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 > 6

CAREGIVER: Wfl

HOSPITALIZATION RISKS: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 5. Decline in mental, emotional, or behavioral status in the past 3 months, 6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months, 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:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M1033 - Exhaustion, abnormal BS < 70/140 > mg/dL, abdominal pain, muscle weakness, limited endurance, difficulty sleeping, balance deficit

PROCEDURES: home exercise program: Laq, heelraises toe raises, hip abduction, hip flexion, hamstring curls, dynamic standing balance exercises: Work on improvong wt shifting and reaching outside bos with single UE support, gait training on uneven surfaces: Improve safety and tech clearing feet while walking over even and uneven surfaces., transfers training: Improve safety and tech approaching to sit with rw reducing fall risk

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

PT Goals

PATIENT-STATED GOAL: To further improve walking and get out on my porch with the Walker and to the car by myself

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Car Transfer - 06. Independent

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

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

Walk 10 Feet - 04. Supervision or touching assistance

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Upper Body Dressing - 06. Independent

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

Picking Up Object - 04. Supervision or touching assistance

Sit to Stand - 06. Independent

Walk 50 ft with 2 Turns - 04. Supervision or touching assistance

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

04/22/2026

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06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 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	04/22/2026