Home Health Certification and Plan of Care

Order ID: 1150/17801

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
35789367	03/28/2026	From: 03/28/2026 To: 05/26/2026	24126	217058

6. Patient's Name and Address

Geraldine Cumberland
1 Rumford Dr Unit 204,
CATONSVILLE, MD 21228-
410-744-6596

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 02/04/1938 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
I11.9	Hypertensive heart disease without heart failure	03/28/26

13. ICD	Other Pertinent Diagnoses	Date
Z47.1	Aftercare following joint replacement surgery	03/28/26
Z96.651	Presence of right artificial knee joint	03/28/26
M16.11	Unilateral primary osteoarthritis right hip	03/28/26
M17.12	Unilateral primary osteoarthritis left knee	03/28/26
I34.0	Nonrheumatic mitral (valve) insufficiency	03/28/26
E78.2	Mixed hyperlipidemia	03/28/26
E03.9	Hypothyroidism unspecified	03/28/26
K59.00	Constipation unspecified	03/28/26
E04.1	Nontoxic single thyroid nodule	03/28/26
M48.061	Spinal stenosis lumbar region without neurogenic claud	03/28/26
M54.16	Radiculopathy lumbar region	03/28/26
K57.30	Dvrtclos of lg int w/o perforation or abscess w/o bleeding	03/28/26
M47.9	Spondylosis unspecified	03/28/26
G60.9	Hereditary and idiopathic neuropathy unspecified	03/28/26
Z85.118	Personal history of malignant neoplasm of bronchus and lung	03/28/26
Z79.82	Long term (current) use of aspirin	03/28/26
Z86.0100	Personal history of colonic polyps	03/28/26
Z87.891	Personal history of nicotine dependence	03/28/26

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

TUMERIC 500MG by mouth twice a day SUPPLEMENT
Centrum Silver - Ascorbic Acid: Biotin: Cyanocobalamin: Ergocalciferol: Folic Acid: Niacinamide: Pantothenic Acid: Phytonadione: Pyridoxine: Ribo 1 TAB by mouth once a day SUPPLEMENT
probiotics 1 TAB by mouth once a day GUT HEALTH
Glucosamine Chondroitin - Glucosamine 1 TAB by mouth once a day SUPPLEMENT
Coq10 - Coenzyme Q10 200MG; 1 TAB by mouth once a day SUPPLEMENT
Potassium - Potassium Chloride 99MG; 1 TAB by mouth once a day SUPPLEMENT
L-Arginine 500MG; 1 TAB by mouth once a day SUPPLEMENT
Niacin - Niacin 500 mg 500MG; 1 TAB by mouth once a day SUPPLEMENT
Lysine L-Lysine 500MG; 1 TAB by mouth once a day SUPPLEMENT
Endari - L-Glutamine 500MG; 1 TAB by mouth once a day SUPPLEMENT
B12 - Ascorbic Acid: Biotin: Cyanocobalamin: Dexpanthenol: Ergocalciferol: Folic Acid: Niacinamide: Pyridoxine Hydrochloride: Riboflav 500MCG; 1 TAB by mouth once a day SUPPLEMENT
ALPHALIPSIC ACID 200MG; 1 TAB by mouth three times a day SUPPLEMENT
L-CARNITINE 500MG; 1 TAB by mouth once a day SUPPLEMENT
Calcium With Vitamin D - Calcium Acetate 1000MG/400MG/15MG/15MCG; 1 TAB by mouth three times a day SUPPLEMENT
Omeprazole - Omeprazole 20 mg 20MG; 1 CAP by mouth once a day AS NEEDED FOR HEART BURN
Amlodipine Besylate - Amlodipine Besylate 5 mg/tablet / Give 2 Tablet by mouth once a day For HTN
Levothroxine - Levothyroxine Sodium 100 mcg / 1 Tablet by mouth in the morning for Hypothyroidism
Losartan Potassium - Losartan Potassium 100 mg 100 mg / 1 Tablet by mouth once a day for HTN able to tolerate losartan alone
Tylenol - Acetaminophen 325MG/ 3 tablet by mouth every 8 hours for Pain

14. DME and Supplies:

walker

15. Safety Measures:

standard precautions, fall precautions, ambulates with device, walker precautions

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

lisinopril losartan potassium/hctz

18.A. Functional Limitations

Endurance, Ambulation

18.B. Activities Permitted

Up As Tolerated, Walker, Exercises Prescribed

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: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper., MOBILITY: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper.

22.B.Discharge Plans

patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Hypertensive heart disease without 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 an 88-year-old female recently discharged from subacute rehabilitation following hospitalization for persistent hypertension and end-stage osteoarthritis of the left hip, status post left total hip arthroplasty performed on 02/13/2026. Her past medical history is significant for lumbar stenosis with radiculopathy, chronic venous insufficiency, primary adenocarcinoma of the lung status post radiation therapy, hypertension, hypothyroidism, hyperlipidemia, and diverticulosis. The patient resides alone in a second-floor apartment, with her sister identified as the primary caregiver and additional support from neighbors as needed. Skilled nursing services have been initiated with a planned frequency, and physical and occupational therapy evaluations were ordered upon admission. On assessment, the patient is alert and oriented to person, place, and time. She reports left hip pain at a level of 2/10 and denies shortness of breath at rest, though she notes occasional shortness of breath associated with gastrointestinal upset. Appetite is poor, and last bowel movement was reported today. Physical examination reveals +1 bilateral lower extremity edema. The patient ambulates with a rolling walker for safety; however, she reports left knee buckling with ambulation. Functional assessment indicates bilateral lower extremity weakness, ataxic gait, impaired balance, and decreased endurance, requiring minimal assistance for bed mobility and transfers and limiting ambulation to approximately 75-100 feet within the household. Medication reconciliation was initiated during the visit, with review of medications and prescriptions present in the home. The patient has been instructed to consult with her primary care provider regarding her prescriptions, and skilled nursing will complete full medication reconciliation at the next follow-up visit. From a therapy perspective, skilled physical therapy is medically necessary to address strength deficits, gait instability, balance impairment, and decreased endurance, with interventions including progressive strengthening, gait training, balance re-education, reinforcement of hip precautions, and fall prevention strategies to promote safe functional mobility. Occupational therapy assessment indicates the patient is currently independent with upper and lower body dressing using compensatory techniques and assistive devices, independent with toileting and hygiene, and performs bathing at sink level due to fear of falling in the tub. She is also independent with upper extremity home exercise programs using theraband and pulley systems despite limited range of motion. At this time, no further skilled occupational therapy services are indicated.
 Date of Order 03/28/2026 Orders Physician Face-to-Face Date: 03/12/2026 Clinical Condition Requiring Home Care per Certifying Physician: PT/OT eval and treat. Nursing for med management due to Hypertensive heart disease without heart failure Homebound Status per

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 03/28/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Rodolfo Fernandez
724 Maiden Choice Ln
Catonsville, MD 21228
PHONE: 410-747-6080 FAX: 14435756553 NPI: 1487661237

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 : 03/12/2026

27. Attending Physician's Signature and Date Signed **04/13/2026**: 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.

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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 Fernandez, Rodolfo

SN Careplans

SN WK1: 1 (03/28/26-03/28/26) ,WK3: 1 (04/05/26-04/11/26) ,WK4: 1 (04/12/26-04/18/26) ,WK5: 1 (04/19/26-04/25/26)

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: 3. Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance

HOSPITALIZATION RISKS: 7. Currently taking 5 or more medications

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: M2020 - Oral Med Management, meal preparation, M2102c - Med Admin, M2102f - Patient Supervision, M2102d - Caregiver Performs Treatment, M1033 - Exhaustion, M1400 - Dyspnea, dependent edema, nausea/vomiting, limited strength, limited range of motion, limited endurance, Pain Interference with Therapy activities, Pain Interference with ADLs, balance deficit

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, * 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, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

SN Goals

PATIENT-STATED GOAL: I WANT TO BE SAFE AND WALK BETTER

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
* 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 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 self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

patient is adequately supervised

meal preparation is available to patient for all meals

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT 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)

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

PT Goals

PATIENT-STATED GOAL: not to go back to hospital

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	03/28/2026

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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: q, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 05. Setup or clean-up assistance, Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance, Walk 150 Feet - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance, 1 - Step (curb) - 05. Setup or clean-up assistance, 4 Steps - 05. Setup or clean-up assistance, 12 Steps - 05. Setup or clean-up assistance, Picking Up Object - 05. Setup or clean-up assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 06. Independent, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Upper Body Dressing - 06. Independent

1 - Step (curb) - 05. Setup or clean-up assistance

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 05. Setup or clean-up assistance

Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance

Walk 150 Feet - 05. Setup or clean-up assistance

4 Steps - 05. Setup or clean-up assistance

12 Steps - 05. Setup or clean-up assistance

Picking Up Object - 05. Setup or clean-up assistance

Toileting Hygiene - 06. Independent

Oral Hygiene - 06. Independent

Shower/Bathe Self - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Upper Body Dressing - 06. Independent

OT Careplans

OT WK1: 6 (03/28/26-03/28/26)

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

OT Goals

PATIENT-STATED GOAL: OT 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

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 - 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

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

Date
03/28/2026