Home Health Certification and Plan of Care

Order ID: 1150/18311

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
43501896500	02/25/2026	From: 04/26/2026 To: 06/24/2026	22750	217058

6. Patient's Name and Address
Bernadine Pinkney
2860 West Baltimore St Unit B,
Baltimore, MD 21223-
443-991-2082

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 12/15/1950 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	02/25/26

13. ICD	Other Pertinent Diagnoses	Date
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	02/25/26
N18.9	Chronic kidney disease u	02/25/26
D63.1	Anemia in chronic kidney disease	02/25/26
E78.5	Hyperlipidemia unspecified	02/25/26
S31.809D	Unspecified open wound of unspecified buttock subs encntr	02/25/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	02/25/26
Z91.81	History of falling	02/25/26

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

GLIPIZIDE 10 mg / 1 Tablet by mouth once a day for diabetes
Atorvastatin Calcium - Atorvastatin Calcium 40 mg / 1 Tablet by mouth once a day for
hyperlipidemia
Docusate Sodium - Docusate Sodium 100 mg / 1 Tablet by mouth once a day for bowel regimen
Lisinopril - Lisinopril 40 mg / 1 Tablet by mouth once a day for hypertension
Metoprolol Succinate - Metoprolol Succinate Extended Release 24 Hour 25 MG / 1 Tablet by mouth once a day for hypertension
Hctz - Hydralazine Hydrochloride: Hydrochlorothiazide 25mg by mouth once a day

14. DME and Supplies:
hospital bed, rolling walker, wheelchair

15. Safety Measures:
standard precautions, remove environmental barriers, fall precautions, diabetic precautions, bleeding precautions, bathroom safety, anticoagulant precautions, ambulates with device, ambulates with assistance, activity supervision

16. Nutrition:
diabetic

17. Allergies:
no known allergies

18.A. Functional Limitations
Ambulation, Endurance, Balance

18.B. Activities Permitted
Up As Tolerated, Wheelchair, Walker, Exercises Prescribed, Transfer bed/Chair

19. Mental & Pyschosocial Status: COGNITION: 4. Is totally dependent in toileting., ANXIETY: , SOCIAL ISOLATION: , BEHAVIORAL ISSUES: WNL , HISTORY OF DEPRESSION:

20. Prognosis: fair

22. A Rehabilitation Potential:
SELF-CARE: , MOBILITY:

22.B.Discharge Plans
family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease, 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 75-year-old female admitted to home health services on 02/25/2026 following a recent hospitalization and subsequent rehabilitation stay for bilateral lower extremity edema, severe anemia, impaired ambulation, and gastrointestinal bleeding. The patient's past medical history is significant for diabetes mellitus, hypertension, chronic kidney disease, anemia, hyperlipidemia, peripheral neuropathy, and a previously treated left buttock wound which is now healed. During her recent hospitalization, the patient was treated for severe anemia with a hemoglobin level of 5.9, suspected gastrointestinal bleeding associated with a possible gastric gastrointestinal stromal tumor (GIST) and gastric polyp, persistent leukocytosis, acute kidney injury on chronic kidney disease, and progressive weakness resulting in difficulty standing and ambulating. At the time of home care admission, the patient is medically stable but requires continued skilled nursing and therapy services for rehabilitation, monitoring of medical conditions, wound and skin surveillance, and support with mobility and safety. On assessment, the patient demonstrates significant mobility limitations and high fall risk. She is able to stand with one-person moderate assistance for approximately 25 seconds and requires moderate assistance with stand-pivot transfers from bed to wheelchair. Bed mobility is performed with supervision using bed rails for support. The patient currently does not have a walker available and relies on a wheelchair for mobility. The home environment presents some accessibility challenges, as the patient's wheelchair cannot be easily maneuvered out of the bedroom due to limited spacing. The patient resides with her granddaughter and grandson in a home with eight steps to enter, three of which have a railing; however, a first-floor living setup is available. Due to the significant effort required to leave the home and the need for wheelchair mobility assistance, the patient is considered homebound. Functional mobility assessment revealed a Tinetti score of 1/28, indicating extremely high fall risk. The patient reports neuropathic symptoms including numbness and tingling extending from the hips to the calves. Skin assessment reveals that the previously documented left buttock wound has healed; however, ongoing monitoring for pressure injury or skin breakdown is required due to decreased mobility. Nutritional intake is supervised, and monitoring is recommended for potential anemia-related deficits. Vital signs and baseline measurements are obtained and will be monitored routinely. The patient is also being monitored for edema, urine output, renal status, and any signs of infection, bleeding, or recurrence of anemia. The patient has all prescribed medications available in the home. Medication management includes reinforcement of adherence to the prescribed regimen for diabetes, hypertension, hyperlipidemia, anemia, and chronic kidney disease. Education was provided to the patient and caregiver regarding medication purpose, administration, and potential side effects. The patient is a full code, has no known drug allergies, and a MOLST form is on file. Durable medical equipment currently available includes a hospital bed, wheelchair, and bedside commode; however, a rolling walker and improved access for mobility devices are recommended to enhance safety and independence. Skilled nursing interventions include ongoing monitoring of vital signs, weight, edema, renal function, and laboratory values including CBC, hemoglobin/hematocrit, and inflammatory markers as ordered. Nursing staff will also monitor for signs of gastrointestinal bleeding, infection, or worsening anemia. Patient and caregiver education focused on fall prevention strategies, safe transfer techniques, daily skin inspection, proper nutrition for anemia and chronic disease management, and early recognition of symptoms such as bleeding, infection, or worsening neuropathy. Rehabilitation services are indicated to improve strength, mobility, and functional independence. During the visit, the patient tolerated therapeutic exercises including supine hip flexion, bridging, hooklying trunk rotation, straight leg raises, hip abduction, knee extension, and ankle pumps, completing five repetitions of each exercise. Physical therapy will continue to reinforce strengthening exercises, mobility training, and safe transfer techniques to improve endurance and functional ability. Coordination of care will continue with the patient's primary care provider, gastroenterology, hematology, and the physical and occupational therapy teams. Follow-up appointments for gastrointestinal evaluation, including endoscopic ultrasound and colonoscopy, as well as laboratory monitoring, will be facilitated. The patient verbalized understanding of the home care plan and the education provided. The caregiver was present, engaged in the teaching process, and demonstrated the ability to assist with safe mobility, medication management, and skin inspection. The overall goals of care include maintaining stable hemoglobin and renal function, preventing falls, preserving skin integrity, improving mobility and strength through therapy, and promoting increased functional independence within the home environment.
 Date of Order 04/23/2026 Orders Physician Face-to-Face Date: 02/16/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Hypertensive chronic kidney disease with stage 1 through

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 04/23/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Suyi Park
700 WASHINGTON BLVD
BALTIMORE, MD 21230
PHONE: 410-539-1051 FAX: 14105392068 NPI: 1932177904

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 : 02/16/2026

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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stage 4 chronic kidney disease, or unspecified chronic kidney disease 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: The patient was recertified to continue to work on increasing leg strength and progress to independent transfers from bed to wheelchair and to continue to assess ambulation. Therapist would like to progress to the patient ambulating short distances.   Physician Park, Suyi

SN Careplans

SN Goals

PT Careplans

PT WK1: 1 (04/26/26-05/02/26) ,WK2: 1 (05/03/26-05/09/26) ,WK3: 1 (05/10/26-05/16/26)

PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature < 95 > 101, heart rate < 50 > 110, respiratory rate < 8 > 22, blood pressure systolic < 90 > 169, blood pressure diastolic < 60 > 90, O2 saturation < 88 > 100, pain < 0 > 8

CAREGIVER: WNL

HOSPITALIZATION RISKS: 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

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: dependent edema, limited strength, muscle weakness, balance deficit, difficulty sleeping, obesity

PROCEDURES: Home exercise program : Supine hip flexion, bridging, hooklying rotation, straight leg raise, hip abduction. Standing knee flexion, hip abduction, hip extension, plantarflexion, squats. Sitting knee extension, ankle pumps , Family training: Transfers, walking, therex, Review of current medications: Assess medications, wheelchair training, transfers training

PT Goals

PATIENT-STATED GOAL: Be able to walk to the bathroom with the walker

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

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

Walk 10 Feet - 04. Supervision or touching assistance

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

Wheel 50 ft w 2 Turns - 06. Independent

Car Transfer - 05. Setup or clean-up assistance

Toilet Transfer - 03. Partial/moderate assistance

Eating - 05. Setup or clean-up assistance

Shower/Bathe Self - 02. Substantial/maximal assistance

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	04/23/2026

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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 - 03. Partial/moderate assistance, Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Wheel 50 ft w 2 Turns - 06. Independent, Car Transfer - 05. Setup or clean-up assistance, Shower/Bathe Self - 02. Substantial/maximal 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	04/23/2026