Home Health Certification and Plan of Care

Order ID: 1150/18386

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
30773960570	04/25/2026	From: 04/25/2026 To: 06/23/2026	25242	217058

6. Patient's Name and Address

Jacqueline Jacobs
5920 Franklin Avenue Apt 2B,
Gwynn Oak, MD 21207-
443-570-3720

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 06/19/1957 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
C32.0	Malignant neoplasm of glottis	04/25/26

13. ICD	Other Pertinent Diagnoses	Date
G89.3	Neoplasm related pain (acute) (chronic)	04/25/26
J44.9	Chronic obstructive pulmonary disease unspecified	04/25/26
L89.153	Pressure ulcer of sacral region stage 3	04/25/26
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	04/25/26
N18.31	Chronic kidney disease stage 3a	04/25/26
D63.1	Anemia in chronic kidney disease	04/25/26
E78.5	Hyperlipidemia unspecified	04/25/26
E87.3	Alkalosis	04/25/26
G89.29	Other chronic pain	04/25/26
E43.	Unspecified severe protein-calorie malnutrition	04/25/26
D72.829	Elevated white blood cell count unspecified	04/25/26
N28.1	Cyst of kidney acquired	04/25/26
E55.9	Vitamin D deficiency unspecified	04/25/26
R74.01	Elevation of levels of liver transaminase levels	04/25/26
F11.20	Opioid dependence uncomplicated	04/25/26
Z95.828	Presence of other vascular implants and grafts	04/25/26
Z86.711	Personal history of pulmonary embolism	04/25/26
Z86.718	Personal history of other venous thrombosis and embolism	04/25/26
Z99.81	Dependence on supplemental oxygen	04/25/26

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

Benzonatate - Benzonatate 100 mg / 1 Capsule by mouth every 8 hours as needed for sore throat
Cepacol Sore Throat Mouth/Throat Lozenge 1 Tablet by mouth every 3 hours as needed for sore throat
FUROSEMIDE 40 mg tablet by mouth one time a day for edema
Atorvastatin - Atorvastatin Calcium 10mg by mouth once a day
Multivitamin - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1 tablet by mouth once a day Supplement
Albuterol Sulfate: Ipratropium Bromide - Albuterol Sulfate: Ipratropium Bromide 0.5-2.5 (3) mg/3ml / 1 vial inhale orally inhalant every 6 hours as needed for SOB/ Wheezing/COPD
Oxygen - Oxygen 2L/min nasal cannula as necessary Breathing

14. DME and Supplies:

wound care supplies, oxygen supplies, walker

15. Safety Measures:

walker precautions, standard precautions, remove environmental barriers, medication safety, infectious material management, fall precautions, bathroom safety, aspiration precautions, ambulates with device, ambulates with assistance

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

no known allergies

18.A. Functional Limitations

Dyspnea With Minimal Exertion, Ambulation, Endurance, Bowel/Bladder Incontinence

18.B. Activities Permitted

Walker, Up As Tolerated

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

Homebound status: Due to diagnosis of Malignant neoplasm of glottis, 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 68-year-old female who is alert and oriented, with vital signs stable, currently receiving home health services following recent hospitalization and rehabilitation related to throat cancer status post surgical intervention in September 2025, with subsequent radiation and chemotherapy. Her past medical history is significant for hypertension, chronic obstructive pulmonary disease (COPD), pulmonary embolism, hyperlipidemia, bacteriuria with chronic Foley catheter use, leukocytosis, and anemia. She resides in an apartment and is currently receiving daily assistance from her estranged husband during her recovery period. The patient requires continuous oxygen therapy at 2-3.5 L/min via nasal cannula and experiences shortness of breath, which limits her functional activity tolerance. On assessment, the patient is incontinent and presents with a stage 3 pressure injury to the sacral area. Wound care orders include cleansing with wound cleanser, light packing with silver alginate, and covering with a bordered foam dressing three times weekly and as needed for soiling or dislodgement. Required wound care supplies include 4x4 gauze, silver alginate, wound cleanser, bordered foam dressing, and cotton-tipped applicators. Skilled nursing visits are planned at a frequency of 1 visit for 1 week, 2 visits per week for 2 weeks, followed by 1 visit per week for 4 weeks, with the next visit scheduled for Tuesday. Functionally, the patient demonstrates a decline from her prior level of independence. Prior to hospitalization, she was independently ambulatory without assistive devices; currently, she requires contact guard assistance for transfers and short-distance ambulation using a rollator. Physical therapy evaluation reveals decreased lower extremity strength at 3/5 manual muscle testing (MMT), while upper extremity strength is noted at 4/5 MMT. She requires standby assistance for upper body dressing and minimal assistance for lower body dressing, as well as minimal assistance for sink-side bathing. The patient also requires standby assistance with verbal cueing for sit-to-stand and toilet transfers due to impaired strength and coordination. A home exercise program was initiated, consisting of seated therapeutic exercises for bilateral lower extremities, including ankle pumps, marches, lateral leg movements, hip abduction, and knee extension, performed at 2 sets of 15 repetitions. The patient would benefit from continued skilled physical and occupational therapy services to improve strength, balance, safety, and independence in functional mobility, with the goal of returning to her prior level of function. A previously scheduled physical therapy visit was missed due to a communication issue with the patient's husband but has since been rescheduled. Overall, the plan of care focuses on wound management, functional rehabilitation, safety, and prevention of further complications.
 Date of Order 04/25/2026 Orders Physician Face-to-Face Date:

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 04/25/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Christopher J Favero
4660 Wilkens Ave
Baltimore, MD 21229
PHONE: 4102470782 FAX: 18662515693 NPI: 1881252617

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 : 04/20/2026

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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04/20/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management, pt-eval & treat, ot-eval & treat, hha-adl's, msw due to Malignant neoplasm of glottis 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 Favero, Christopher J

SN Careplans

SN WK1: 1 (04/25/26-04/25/26) ,WK2: 2 (04/26/26-05/02/26) ,WK3: 2 (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 (05/31/26-06/06/26)

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

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; 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 ; 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.

NA
Advance Directive:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, Home Safety, dependent edema, coughing, M1400 - Dyspnea, M1610 - Urinary Incontinence, poor muscle tone, limited strength, weak hand grips, skin breakdown r/t incontinence, #1 - 3 - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles not exposed. - Other - Sacrum - Cleanse with wound cleanser lightly pack with silver alginate cover with bordered foam dressing

PROCEDURES: physician-ordered wound care: #1 - 3 - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles not exposed. - Other - Sacrum - Cleanse with wound cleanser lightly pack with silver alginate cover with bordered foam dressing: SN/family/caregiver to cleanse sacrum wound with wound cleanser or normal saline, pack lightly with silver alginate and cover with bordered foam dressing every other day or as needed if soiled., cough/deep breathing exercises, bladder training, coordinate/arrange for maintenance of clean/uncluttered living area

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, * urinary incontinence management including bladder training Kegel exercises skin care, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient's living environment is clean/uncluttered

SN Goals

PATIENT-STATED GOAL: I want my 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
* urinary incontinence management including bladder training
* Kegel exercises
* skin care
* recalls related medication(s) purpose, schedule

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

patient's living environment is clean/uncluttered

PT Careplans

PT Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

04/25/2026

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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 (05/31/26-06/06/26) ,WK8: 1 (06/07/26-06/13/26)

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

PROCEDURES: 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. Upgrade as tolerated, gait training/stair training, 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, Sit to Stand - 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, Walk 150 Feet - 04. Supervision or touching assistance, 1 - Step (curb) - 04. Supervision or touching assistance, 4 Steps - 04. Supervision or touching assistance, 12 Steps - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

PATIENT-STATED GOAL: To be able to walk without help

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

1 - Step (curb) - 04. Supervision or touching assistance

4 Steps - 04. Supervision or touching assistance

12 Steps - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

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

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

Walk 10 Feet - 04. Supervision or touching assistance

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

Walk 150 Feet - 04. Supervision or touching assistance

OT Careplans

OT 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)

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

PROCEDURES: Patient/caregiver recalls related purpose and schedule of medications: Medication review, cough/deep breathing exercises, home exercise program: Home exercise program to constant of using water bottles, dumbbells or theraband for upper extremity., therapeutic exercises: clinician will describe procedure at time of visits, transfers training: Therapy

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 - 03. Partial/moderate assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 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 to back to being independent

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 - 03. Partial/moderate assistance

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 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	04/25/2026