Home Health Certification and Plan of Care

Order ID: 1150/18409

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
79293399	05/01/2026	From: 05/01/2026 To: 06/29/2026	25347	217058

6. Patient's Name and Address

Edwina Rusch
212 Aigburth Rd Apt # 308,
TOWSON, MD 21286
443-824-9780

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 12/28/1941 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
I11.0	Hypertensive heart disease with heart failure	05/01/26

13. ICD	Other Pertinent Diagnoses	Date
I50.33	Acute on chronic diastolic (congestive) heart failure	05/01/26
I48.20	Chronic atrial fibrillation unspecified	05/01/26
I27.20	Pulmonary hypertension unspecified	05/01/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	05/01/26
G89.29	Other chronic pain	05/01/26
M54.9	Dorsalgia unspecified	05/01/26
E78.5	Hyperlipidemia unspecified	05/01/26
J47.9	Bronchiectasis uncomplicated	05/01/26
J98.11	Atelectasis	05/01/26
R73.03	Prediabetes	05/01/26
R33.9	Retention of urine unspecified	05/01/26
R91.1	Solitary pulmonary nodule	05/01/26
E66.9	Obesity unspecified	05/01/26
Z68.37	Body mass index [BMI] 37.0-37.9 adult	05/01/26
Z79.01	Long term (current) use of anticoagulants	05/01/26
Z60.2	Problems related to living alone	05/01/26
Z99.89	Dependence on other enabling machines and devices	05/01/26
Z96.1	Presence of intraocular lens	05/01/26
Z96.0	Presence of urogenital implants	05/01/26

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

Gabapentin - Gabapentin 300 mg Take 1 capsule by mouth twice a day Neuropathic pain
Toprol Xl - Metoprolol Tartrate 50mg, take 1 tablet by mouth once a day HTN
Demadex - Torsemide 20 mg Take 2 tablets by mouth in the morning 2 tablets in the morning and 1 tablet in the evening
PRADAXA 150 mg 150 mg by mouth 2 times daily Anticoagulant
VITAMIN 1 capsule Oral 1 time daily
Therapeutic-M (THERAGRAN-M) TABS 1 tablet Oral 1 time daily
SENNA tablets Oral 2 times daily
LIDOCAINE 1 patch transdermal every 24 hours

14. DME and Supplies:

urinary/catheter supplies, grab bars, bath bench, rolling walker

15. Safety Measures:

walker precautions, standard precautions, medication safety, fall precautions, bathroom safety, anticoagulant precautions, ambulates with device

16. Nutrition:

cardiac diet

17. Allergies:

no known allergies

18.A. Functional Limitations

Ambulation

18.B. Activities Permitted

No Restrictions

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 with 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 84-year-old female with a past medical history significant for hypertensive heart disease, pulmonary hypertension, congestive heart failure (CHF), obstructive sleep apnea (OSA), hyperlipidemia, chronic pain, and other comorbidities. Patient is alert and oriented 4 and resides alone in a senior living apartment, with family members providing intermittent support and wellness checks. She remains independent with activities of daily living (ADLs) and ambulates with the assistance of a rollator walker for mobility and safety. Physical assessment was completed during the visit. Bilateral lower extremity edema was observed. Patient is currently prescribed Torsemide, and education was reinforced regarding the importance of lower extremity elevation while seated to assist with edema management and improve circulation. Patient reports occasional lower back pain, which she manages with a prescribed pain patch and oral pain medication regimen, with reported relief. Medication reconciliation and review were completed with the patient, including reinforcement of medication compliance and monitoring for side effects. Patient was discharged from the hospital with a 16 French, 10 mL Foley catheter due to urinary retention. Foley catheter was inserted on 04/21/2026 with instructions for ongoing management by urology. Patient was able to obtain a urology appointment scheduled for July; however, she also has a primary care provider appointment scheduled for 05/05/2026. The current plan is to discuss Foley catheter management with the PCP while awaiting the urology consultation and to determine whether the PCP can assist in obtaining an earlier urology appointment if indicated. Amber-colored urine was noted in the leg drainage bag at the time of assessment. No acute distress or signs of catheter obstruction were observed during the visit. Teaching was provided regarding Foley catheter care and management, including proper hand hygiene, personal hygiene, infection prevention measures, drainage bag positioning, monitoring for signs and symptoms of urinary tract infection, and when to notify the physician. Additional education was provided regarding edema management, fall prevention, and safe ambulation with assistive devices. Patient verbalized understanding of all teaching provided. Skilled nursing services remain indicated for ongoing cardiopulmonary assessment, medication management, Foley catheter monitoring and education, pain assessment, edema management, and continued reinforcement of disease process education and safety measures.
 Date of Order 05/01/2026 Orders Physician Face-to-Face Date: 04/27/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 05/01/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Tamischer Nettles
3400 Box Hill Corporate Center Dr
Abingdon, MD 21009
PHONE: 410-515-5440 FAX: 14105155581 NPI: 1285778225

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 : 04/27/2026

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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Hypertensive heart disease with heart failure 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
 Physician Nettles, Tamischer

SN Careplans

SN WK1: 1 (05/01/26-05/02/26) ,WK2: 1 (05/03/26-05/09/26) ,WK3: 1 (05/10/26-05/16/26) ,WK4: 1 (05/17/26-05/23/26)

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: 0. No assistance needed - patient is independent or does not have needs in this area

HOSPITALIZATION RISKS: 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:Refused

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, Home Safety, abnormal blood pressure, M1033 - Exhaustion, M1400 - Dyspnea, urine retention, M1610 - Urinary Catheter, muscle weakness, balance deficit

PROCEDURES: cough/deep breathing exercises, catheter change, care & irrigation: To be managed by the urologist

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 catheter management including how to flush catheter change and wash drainage bags prevent infection including proper handwashing positioning of catheter, 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's enviroment has adequate stairs railings

SN Goals

PATIENT-STATED GOAL: To be able to urinate freely without a Foley catheter

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 catheter management including how to flush catheter
* change and wash drainage bags
* prevent infection including proper handwashing
* positioning of catheter
* 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 self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

patient's enviroment has adequate stairs railings

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	05/01/2026