# Home Health Certification and Plan of Care

**Order ID: 1150/18584**

| 1. Patient s HI claim No. | 2. Start Of Care Date | 3. Certification Period | 4. Medical Record No. | 5. Provider No. |
|---|---|---|---|---|
| 92325537 | 05/08/2026 | From: 05/08/2026 To: 07/06/2026 | 25660 | 217058 |

**6. Patient's Name and Address**
Barbara Pinkney
1111 N Woodyear Street,
BALTIMORE, MD 21217-
443-378-6279

**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** 03/23/1946 | **9.Sex** Female

| 11. ICD | Principal Diagnosis | Date |
|---|---|---|
| I13.0 | Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny | 05/08/26 |

| 13. ICD | Other Pertinent Diagnoses | Date |
|---|---|---|
| I50.23 | Acute on chronic systolic (congestive) heart failure | 05/08/26 |
| E11.22 | Type 2 diabetes mellitus w diabetic chronic kidney disease | 05/08/26 |
| N18.9 | Chronic kidney disease u | 05/08/26 |
| D63.1 | Anemia in chronic kidney disease | 05/08/26 |
| E87.5 | Hyperkalemia | 05/08/26 |
| N17.9 | Acute kidney failure unspecified | 05/08/26 |
| I48.0 | Paroxysmal atrial fibrillation | 05/08/26 |
| E05.80 | Other thyrotoxicosis without thyrotoxic crisis or storm | 05/08/26 |
| I45.2 | Bifascicular block | 05/08/26 |
| I69.391 | Dysphagia following cerebral infarction | 05/08/26 |
| E03.9 | Hypothyroidism unspecified | 05/08/26 |
| E78.2 | Mixed hyperlipidemia | 05/08/26 |
| E55.9 | Vitamin D deficiency unspecified | 05/08/26 |
| M19.90 | Unspecified osteoarthritis unspecified site | 05/08/26 |
| R41.81 | Age-related cognitive decline | 05/08/26 |
| Z79.01 | Long term (current) use of anticoagulants | 05/08/26 |

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

BIDIL 20-37.5 mg / 1 Tablet by mouth two times a day for HTN
CARVEDILOL 6.25 mg / 1 Tablet by mouth two times a day for HTN. *Hold if Systolic Blood Pressure is less than 110. *Hold if Apical Pulse is less than 60.
ELIQUIS 2.5 mg / 1 Tablet by mouth two times a day for Afib Monitor for S/S bleeding
Vitamin D - Ergocalciferol 1.25 MG (50000 UT) / 1 Capsule by mouth in the morning every Thu for Vitamin D Deficiency
METHIMAZOLE 10 mg tablet by mouth 3 times daily with meals for hyperthyroidism
Amilodipine - Amlodipine Besylate 10mg by mouth in the morning Hold for SBP less than 110 and pulse less than 60
Insulin - subcutaneous once a day DM2

**14. DME and Supplies:**
wheelchair, diabetic supplies

**15. Safety Measures:**
medication safety, cardiac precautions, wheelchair precautions, supervision at all times, standard precautions, fall precautions, bleeding precautions, diabetic precautions, avoid temperature extremes, bathroom safety, anticoagulant precautions, ambulates with device, ambulates with assistance, activity supervision

**16. Nutrition:**
cardiac diet, low sodium, diabetic,

**17. Allergies:**
sulfa drugs

**18.A. Functional Limitations**
Ambulation, Bowel/Bladder Incontinence, Endurance

**18.B. Activities Permitted**
Wheelchair, Up As Tolerated

**19. Mental & Pyschosocial Status:** COGNITION: 1. Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No

**20. Prognosis:** good

**22. A Rehabilitation Potential:**
SELF-CARE: 1. Dependent - A helper completed all the activities for the patient., MOBILITY: 1. Dependent - A helper completed all the activities for the patient.

**22.B.Discharge Plans**
SN: patient will be responsible for managing treatment PT and OT: family/careg

**Homebound status:**
Due to diagnosis of Hypertensive heart and chronic kidney disease with heart failure and 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 an 80-year-old female with a recent hospitalization and SNF rehabilitation stay due to CHF exacerbation and decreased right leg function, discharged home without significant improvement in mobility. Her medical history includes systolic heart disease/CHF, chronic kidney disease, hypertension, type 2 diabetes mellitus, atrial fibrillation, hypothyroidism/hyperthyroidism, osteoarthritis of both knees, CVA, hypercalcemia, muscle weakness, cognitive decline related to age, and impaired ambulation with lower extremity weakness. Medications were reviewed in the home, including Eliquis 2.5 mg BID, amlodipine 10 mg daily, carvedilol 6.25 mg BID, vitamin D 50,000 units weekly, isosorbide/hydralazine 29/37.5 mg BID, and methimazole 10 mg TID with meals. The patient requires one-person assistance for bed mobility and transfers and uses a wheelchair for safety due to high fall risk and taxing effort required to leave the home, supported by a Tinetti score of 5/28. She currently requires moderate assistance for sit-to-stand transfers from bed, minimal assistance for bedside commode transfers, and maximal assistance with dressing, sponge bathing, and toileting. The patient is mostly bedbound since discharge four days ago and is incontinent due to decreased mobility. No wounds were noted, bowel movement was reported the previous day, no urinary discomfort was reported, appetite and sleep are adequate, and no issues with eating were identified. Her son, Corey, is the primary caregiver and was instructed on medication management, including proper use of bubble packs, and advised to contact the provider for hospital follow-up and medication reconciliation due to discrepancies between SNF and Kaiser medication lists. OT evaluation noted significant anxiety, an elevated BP of 192/86 with wet cough during the visit, later improving to 140/70, and recommendation for a hospital bed and gait belt. The patient tolerated seated and supine therapeutic exercises with assistance needed for right straight leg raises. Skilled nursing frequency is ordered for 1w1, 1w3, then 1w4, with PT, OT, and HHA services initiated to address ADLs, mobility, strengthening, safety, caregiver training, and the patient's goal of improving mobility to independently access the kitchen and bathroom.<o:p></o:p> <o:p> </o:p> Date of Order<o:p></o:p> 05/08/2026<br> Order<o:p></o:p> Physician Face-to-Face Date: 05/01/2026<br> Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management

**23. Signature and Date of Verbal SOC Where Applicable:**
Electronically Signed by Messick, Charles RN on 05/08/2026

**25. Date HHA Received Signed POT**

**24. Physician's Name and Address**
Kenetra Hix
3510 Brenbrook Dr
Randallstown, 0 21133
PHONE: 4107375000 FAX: 899290091 NPI: 1972917979

**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 : 05/01/2026

**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-eval & treat ot-eval & treat hha-adl's dx: Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease<br> Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home<o:p></o:p> <br> 1 - SOC - SN Notes:<o:p></o:p> PT Eval Notes:<o:p></o:p> OT Eval Notes:<o:p></o:p> Physician: Hix, Kenetra

## SN Careplans

SN WK1: 1 (05/08/26-05/09/26) ,WK2: 1 (05/10/26-05/16/26) ,WK3: 1 (05/17/26-05/23/26) ,WK4: 1 (05/24/26-05/30/26) ,WK5: 1 (05/31/26-06/06/26) ,WK6: 1 (06/07/26-06/13/26) ,WK7: 1 (06/14/26-06/20/26) ,WK8: 1 (06/21/26-06/27/26)

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.

No open wounds noted
Advance Directive:Na

PROBLEMS IDENTIFIED ON ASSESSMENT: M2102d - Caregiver Performs Treatment, meal preparation, M2102f - Patient Supervision, Financial, M2020 - Oral Med Management, M1400 - Dyspnea, abnormal blood pressure, abnormal BS < 70/140 > mg/dL, abnormal thyroid <> 0.40 - 4.50 mIU/mL, frequent urination, limited strength, limited endurance, limited range of motion, poor muscle tone, muscle weakness, Pain Interference with Therapy activities, Pain Interference with ADLs, balance deficit, pain radiating to arms/legs, weak hand grips

PROCEDURES: cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments, glucose testing via monitor, monitor intake & output, coordinate/arrange for adequate patient supervision, coordinate/arrange preparation of missing meals, coordinate/arrange access to medicine/medical supplies considering patient inability to pay

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, 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 performs medical/rehabilitation treatments with adequate competence

## SN Goals

PATIENT-STATED GOAL: Patient goal is improve her mobility and be able to go to the kitchen and bathroom without assistance.

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

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

meal preparation is available to patient for all meals

caregiver performs medical/rehabilitation treatments with adequate competence

patient is adequately supervised

## PT Careplans

## PT Goals

Signature of Physician:

Date



Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

05/08/2026

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PT WK2: 2 (05/10/26-05/16/26) ,WK3: 2 (05/17/26-05/23/26) ,WK4: 2 (05/24/26-05/30/26) ,WK5: 1 (05/31/26-06/06/26) ,WK6: 1 (06/07/26-06/13/26) ,WK7: 1 (06/14/26-06/20/26) ,WK8: 1 (06/21/26-06/27/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, M1400 - Dyspnea, GG0170D1 - Sit to Stand, GG0170F1 - Toilet 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, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170L1 - Walk 10 ft on Uneven Surface

PROCEDURES: Family training: Transfers, gait, bed mobility, cough/deep breathing exercises, 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, 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, * 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, Chair to Bed to Chair - 05. Setup or clean-up assistance, Sit to Stand - 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, 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, Car Transfer - 05. Setup or clean-up assistance

PATIENT-STATED GOAL: To return to sleeping upstairs

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

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

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

Car Transfer - 05. Setup or clean-up assistance

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

## OT Careplans

OT WK2: 1 (05/10/26-05/16/26) ,WK4: 1 (05/24/26-05/30/26) ,WK6: 1 (06/07/26-06/13/26) ,WK8: 1 (06/21/26-06/27/26) ,WK10: 1 (07/05/26-07/06/26)

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

PROCEDURES: cough/deep breathing exercises, incentive spirometer, home exercise program: Cane exrercises: lateral shoulder flex chest presses horizontal abd add forward backwards circles, equipment training, work simplification/energy conservation

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, Oral Hygiene - 05. Setup or clean-up assistance, Toileting Hygiene - 05. Setup or clean-up assistance, Shower/Bathe Self - 02. Substantial/maximal assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance, Eating - 06. Independent

## OT Goals

PATIENT-STATED GOAL: To get around like I used to

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

Oral Hygiene - 05. Setup or clean-up assistance

Toileting Hygiene - 05. Setup or clean-up assistance

Shower/Bathe Self - 02. Substantial/maximal assistance

Upper Body Dressing - 05. Setup or clean-up assistance

Lower Body Dressing - 05. Setup or clean-up assistance

Don/Doff Footwear - 05. Setup or clean-up assistance

Eating - 06. Independent

| Signature of Physician: | Date |
|---|---|
| | PAGE 3 of 3 |
| Optional Name/Signature of Nurse/Therapist: | Date |
| Electronically Signed by Messick, Charles RN | 05/08/2026 |