Home Health Certification and Plan of Care

Order ID: 1150/18868

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
31628880	05/21/2026	From: 05/21/2026 To: 07/19/2026	26011	217058

6. Patient's Name and Address

Irene Commodore
601 CORNELL ST APT 300,
ABERDEEN, MD 21001
667-201-8288

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 10/04/1953 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
J44.1	Chronic obstructive pulmonary disease w (acute) exacerbation	05/21/26

13. ICD	Other Pertinent Diagnoses	Date
J96.01	Acute respiratory failure with hypoxia	05/21/26
I13.0	Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny	05/21/26
I50.32	Chronic diastolic (congestive) heart failure	05/21/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	05/21/26
N18.30	Chronic kidney disease stage 3 unspecified	05/21/26
D63.1	Anemia in chronic kidney disease	05/21/26
I48.0	Paroxysmal atrial fibrillation	05/21/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	05/21/26
M79.7	Fibromyalgia	05/21/26
E78.5	Hyperlipidemia unspecified	05/21/26
M10.9	Gout unspecified	05/21/26
I25.2	Old myocardial infarction	05/21/26
E03.9	Hypothyroidism unspecified	05/21/26
E53.8	Deficiency of other specified B group vitamins	05/21/26
E04.1	Nontoxic single thyroid nodule	05/21/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	05/21/26
M19.90	Unspecified osteoarthritis unspecified site	05/21/26
Z79.52	Long term (current) use of systemic steroids	05/21/26
Z79.02	Long term (current) use of antithrombotics/antiplatelets	05/21/26
Z99.89	Dependence on other enabling machines and devices	05/21/26
Z99.81	Dependence on supplemental oxygen	05/21/26

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

Breztri Aerosphere 160-9-4.8 MCG/ACT inhalation aerosol 2 puffs by inhalation 2 times daily Generic drug: budeson-glycopyrrol-formoterol
ACETAMINOPHEN 650 mg 650 mg/tablet / Take 1,300 mg by mouth daily Commonly known as: TYLENOL
ALLOPURINOL 100 mg 100 MG tablet by mouth daily Commonly known as: ZYLOPRIM
ATORVASTATIN 40 MG tablet by mouth nightly Commonly known as: LIPITOR
ELIQUIS 5 mg / 1 Tablet by mouth 2 times daily
Flecainide Acetate - Flecainide Acetate 100 mg / 1 Tablet by mouth twice a day Doctor's comments: **Patient requests 90 days supply** Commonly known as: TAMBOCOR
GUAIFENESIN SR 600 mg / 1 Tablet by mouth 2 times daily Commonly known as: MUCINEX
FUROSEMIDE 40 mg 40 mg/tablet / Take 20 mg by mouth once a day Take 1/2 tablet daily. Commonly known as: LASIX
Metoprolol Succinate - Metoprolol Succinate 0 Extended Release 24 Hour 25 MG Tablet by mouth 2 times daily Commonly known as: TOPROL XL
Olmesartan Medoxomil - Olmesartan Medoxomil 40 MG tablet by mouth daily Commonly known as: BENICAR
OMEPRAZOLE 40 mg Delayed Release 40 mg capsule by mouth 1 time daily as needed for Other (GERD). Commonly known as: PrILOSEC
LEVOTHYROXINE 137 mcg tablet by mouth daily Commonly known as: SYNTHROID
ALBUTEROL 2.5 mg/3mL nebulizer solution / USE 1 VIAL VIA NEBULIZER FOUR TIMES DAILY FOR WHEEZING OR SHORTNESS OF BREATH. START ONCE USING BREZTRI

14. DME and Supplies:

diabetic supplies, bath bench, nebulizer, oxygen supplies

15. Safety Measures:

O2 precautions, medication safety, fall precautions, diabetic precautions, , standard precautions, cardiac precautions, bathroom safety, anticoagulant precautions

16. Nutrition:

regular

17. Allergies:

montelukast sodium penicillins amlodipine gabapentin spironolactone

18.A. Functional Limitations

Dyspnea With Minimal Exertion

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 Chronic obstructive pulmonary disease with (acute) exacerbation, 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 73-year-old female admitted to home health services following recent discharge from a skilled nursing facility to home after hospitalization related to an unresponsive episode with seizure activity. Her past medical history is significant for Parkinson's disease, progressive supranuclear ophthalmoplegia, dementia, left carotid artery stenosis, dysarthria, hypotension, atrial fibrillation, depression, arthritis, hypertension, hyperlipidemia, type 2 diabetes mellitus, and recurrent falls. The patient resides with her son in a first-floor apartment with one step required for entry. Her son serves as the primary caregiver and assists with daily care and supervision. The patient also receives home health aide assistance five days per week for approximately two hours daily to assist with personal care activities. At the time of assessment, the patient was alert and oriented x2 with low-pitched slurred speech noted, consistent with her neurological diagnoses. The patient is primarily wheelchair-bound for mobility but is able to ambulate short household distances with a rolling walker and assistance. No skin breakdown, open wounds, or pressure injuries were observed during the visit. Diabetes mellitus is currently managed through diet control, and the patient does not routinely monitor blood glucose levels at home. The patient requires extensive assistance with activities of daily living and mobility-related tasks due to weakness, impaired balance, decreased endurance, and neurological impairment. Physical therapy evaluation revealed significant deficits in functional mobility, strength, endurance, gait stability, transfers, and balance. The patient ambulated approximately 25 feet twice on indoor surfaces using a rolling walker with minimal assistance. Bed mobility, specifically supine-to-sit transfers, required minimal assistance, and sit-to-stand transfers from bed and wheelchair also required minimal assistance for safety. The patient demonstrated impaired balance with a Tinetti balance assessment score of 8/28, indicating very high fall risk. The patient tolerated therapeutic exercises including 10 repetitions each of supine hip flexion, bridging, hooklying rotation, straight leg raises, and hip abduction exercises. Skilled physical therapy services are medically necessary to address lower extremity strengthening, transfer training, gait training, balance retraining, endurance improvement, and fall prevention in order to maximize safety and functional mobility within the home environment. Occupational therapy evaluation

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 05/21/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Karen Johnson
998 Hospitality Way Ste 102
Aberdeen, MD 21001
PHONE: 4102979500 FAX: 14102979016 NPI: 1730321241

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 : 05/15/2026

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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identified decreased standing balance, reduced standing tolerance, decreased bilateral upper extremity strength, impaired activity tolerance, and deficits affecting self-care, functional transfers, and functional ambulation tasks. Prior to the recent hospitalization, the patient already required extensive assistance with activities of daily living and primarily utilized a wheelchair for mobility while ambulating short distances with assistance and a walker. Skilled occupational therapy services are recommended to address deficits limiting the patient's ability to safely perform activities of daily living, improve upper extremity strength and endurance, increase safety with functional mobility and transfers, and support maintenance of the highest possible level of independence. The patient remains homebound due to impaired mobility related to Parkinson's disease, progressive neurological decline, weakness, arthritis, recurrent falls, poor balance, and need for wheelchair mobility with assistance required for short-distance ambulation. Leaving the home requires significant effort and caregiver assistance. Skilled nursing and therapy services remain medically necessary for disease management, medication education, cardiopulmonary monitoring, safety assessment, strengthening, balance training, transfer training, functional mobility retraining, fall prevention, and caregiver education to reduce risk of injury, further decline, and rehospitalization while promoting optimal quality of life within the home setting.
 Date of Order 05/21/2026 Orders Physician Face-to-Face Date: 05/15/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management due to Chronic obstructive pulmonary disease with (acute) exacerbation 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 Johnson, Karen

SN Careplans

SN WK1: 1 (05/21/26-05/23/26) ,WK2: 1 (05/24/26-05/30/26) ,WK3: 1 (05/31/26-06/06/26) ,WK4: 1 (06/07/26-06/13/26) ,WK5: 1 (06/14/26-06/18/26)

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:Not Received

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, A1250 - Lack of Necessary Transportation, wheezing, coughing, abnormal blood pressure, M1033 - Exhaustion, M1400 - Dyspnea, abnormal BS < 70/140 > mg/dL, limited strength, daytime fatigue

PROCEDURES: cough/deep breathing exercises, incentive spirometer, glucose testing via monitor

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, * 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 transportation needs are met

SN Goals

PATIENT-STATED GOAL: To get better and manage her COPD

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

patient's transportation needs are met

Signature of Physician:	Date
	PAGE 2 of 2
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	05/21/2026