Home Health Certification and Plan of Care

Order ID: 1150/18932

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
49205316900	05/07/2026	From: 05/07/2026 To: 07/05/2026	25273	217058

6. Patient's Name and Address

Barbara King
10330 Swift Stream Pl,
Columbia, MD 21044-
240-581-4619

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 08/31/1956 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
E87.1	Hypo-osmolality and hyponatremia	05/07/26

13. ICD	Other Pertinent Diagnoses	Date
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy	05/07/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	05/07/26
N18.4	Chronic kidney disease stage 4 (severe)	05/07/26
D63.1	Anemia in chronic kidney disease	05/07/26
I11.0	Hypertensive heart disease with heart failure	05/07/26
I50.9	Heart failure unspecified	05/07/26
N17.9	Acute kidney failure unspecified	05/07/26
E78.5	Hyperlipidemia unspecified	05/07/26
F03.93	Unsp dementia unspecified severity with mood disturb	05/07/26
F31.9	Bipolar disorder unspecified	05/07/26
F03.94	Unspecified dementia unspecified severity with anxiety	05/07/26
M41.9	Scoliosis unspecified	05/07/26
K21.9	Gastro-esophageal reflux disease without esophagitis	05/07/26
E07.9	Disorder of thyroid unspecified	05/07/26
J45.998	Other asthma	05/07/26
G89.4	Chronic pain syndrome	05/07/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	05/07/26
Z79.02	Long term (current) use of antithrombotics/antiplatelets	05/07/26
Z79.1	Long term (current) use of non-steroidal non-inflam (NSAID)	05/07/26
Z91.81	History of falling	05/07/26

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

Bupropion Hydrochloride - Bupropion Hydrochloride 150 mg Take 1 tab by mouth once a day related to MAJOR DEPRESSIVE DISORDER, RECURRENT SEVERE WITHOUT PSYCHOTIC FEATURES (F33.2)
Atorvastatin - Atorvastatin Calcium 40 mg by mouth once a day
Losartan Potassium - Losartan Potassium 50 MG tablet by mouth once a day for Hypertension Hold dose for systolic blood pressure less than 120. Recheck and administer medication as indicated
Lurasidone Hydrochloride - Lurasidone Hydrochloride 60 mg by mouth once a day At dinner
Pantoprazole Sodium - Pantoprazole Sodium Delayed Release 40 mg / 1 Tablet by mouth in the morning for GERD
OXCARBAZEPINE 300 mg / 1 Tablet by mouth at bedtime for seizure disorder
GABAPENTIN 600 mg / 1 Tablet by mouth every 12 hours for neuropathy
LORATADINE 10 mg / 1 Tablet by mouth one time a day for allergies
Amlodipine Besylate - Amlodipine Besylate 10 mg / 1 Tablet by mouth one time a day for HTN
Trazodone Hydrochloride - Trazodone Hydrochloride 150 mg / 1 Tablet by mouth at bedtime for insomnia related to MAJOR DEPRESSIVE DISORDER, RECURRENT SEVERE WITHOUT PSYCHOTIC FEATURES (F33.2)
Clopidogrel Bisulfate - Clopidogrel Bisulfate 75 mg / 1 Tablet by mouth one time a day for blood clot prevention
Tylenol Es - Acetaminophen 500 mg/tablet / Give 2 tablet by mouth every 8 hours for Pain
Albuterol Sulfate - Albuterol Sulfate HFA Inhalation Aerosol Solution 108(90 Base) MCG/ACT / 2 puff inhale orally by mouth every 6 hours as needed for SOB/Wheezing
Olanzapine - Olanzapine 2.5 mg by mouth as necessary Antipsychotic
Diclofenac Sodium - Diclofenac Sodium 0 External Gel 1 % / Apply to left lateral arm topical every 6 hours as needed for left lateral arm pain

14. DME and Supplies:

walker, cane, bath bench, rolling walker

15. Safety Measures:

walker precautions, medication safety, fall precautions, diabetic precautions, cardiac precautions, bathroom safety, ambulates with device,

16. Nutrition:

cardiac diet, diabetic

17. Allergies:

erythromycin gadobenate hydrocodone hydromorphone ibuprofen naprosyn oxy oranges tomatoes

18.A. Functional Limitations

Ambulation

18.B. Activities Permitted

Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 2. Sometimes, BEHAVIORAL ISSUES: 1. Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required!2. Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions, HISTORY OF DEPRESSION: Yes

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

family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Hypo-osmolality and hyponatremia, 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:

Patient is a 69-year-old female admitted to home health services following a schizophrenic breakdown with multiple falls and recent hospitalization. Past medical history is significant for anemia, type 2 diabetes mellitus with polyneuropathy, chronic kidney disease stage III/IV, hypertension, congestive heart failure without current exacerbation, hyperlipidemia, transient ischemic attack, GERD, asthma, paranoid schizophrenia, bipolar disorder, anxiety, dementia, severe scoliosis, dysphagia, gait instability, lack of coordination, right upper extremity wasting/atrophy, retinopathy, chronic pain, history of dehydration, hypovolemia, acute hyponatremia, and recurrent falls. Patient was initially admitted on 03/19/2026 for psychiatric symptoms and later transferred to medical services secondary to fall, acute hyponatremia, hypovolemia, dehydration, weakness, and decline in mobility. Patient remained hospitalized and in rehabilitation for approximately four weeks. She resides with her daughter in an apartment with elevator access and requires assistance with medications and personal care activities. Upon arrival for the home health visit, patient was observed sitting upright in a chair next to her bed. Patient was alert and oriented x4, cooperative, and in no acute distress. Vital signs obtained were temperature 97.5F, pulse 56 bpm, blood pressure 162/90 mmHg in the left arm, oxygen saturation 99% on room air, and pain level 0/10 at time of assessment. Patient reported intermittent low back pain, left shoulder pain, and bilateral knee pain, but denied pain during the visit. She denied chest pain, shortness of breath at rest, nausea, or vomiting, although she reported occasional shortness of breath with exertion. Last bowel movement occurred this morning. Patient also reported intermittent urinary incontinence. Skin assessment revealed warm, dry, intact skin with no wounds noted. Capillary refill was noted to be slow. Medications were reviewed with the patient and her daughter, and nursing assistance with pillbox setup was confirmed. Functional assessment revealed significant limitations related to generalized weakness, impaired balance, neuropathy, chronic pain, decreased endurance, poor posture, reduced activity tolerance, and impaired safety awareness. Patient ambulates with use of a rolling walker/rollator for household and community mobility and requires minimal to moderate assistance with bed mobility, transfers, and ambulation due to high fall risk and unsteady gait. Patient has a documented history of multiple falls within the past year, including a fall during hospitalization. She reports dizziness and nausea with upward reaching and looking up, difficulty standing for prolonged periods, impaired grip strength with difficulty opening containers, hearing impairment bilaterally, impaired vision secondary to retinopathy, cervical nerve impingement, carpal tunnel

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 05/07/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Prema Siva
8871 Gorman Rd
Laurel, MD 20723
PHONE: 3014983150 FAX: 14106018886 NPI: 1699722009

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 : 04/21/2026

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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syndrome, and neuropathy affecting both upper and lower extremities. Patient reports she does not routinely monitor blood glucose levels as recommended. Prior level of function included limited meal preparation using a microwave, bathing every other day using adaptive equipment including a shower chair and long-handled bath brush, and avoidance of stairs due to mobility deficits. Skilled home health nursing, physical therapy, and occupational therapy services are medically necessary at this time to address deficits in strength, balance, gait, endurance, safety awareness, transfer ability, functional mobility, upper extremity function, and activities of daily living performance. Interventions will focus on fall prevention, establishment and progression of a home exercise program, strengthening of upper and lower extremities, gait and transfer training, endurance training, medication management, diabetic education, safety education, and maximizing independence within the home environment. Education was provided regarding fall precautions, safe use of assistive devices, medication compliance, hydration, and monitoring for worsening symptoms. Patient's stated goal is to improve strength and endurance in order to regularly attend the Bain Senior Center and increase independence with daily activities while safely remaining in the home environment.
 Date of Order 05/07/2026 Orders Physician Face-to-Face Date: 04/21/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management, pt-eval & treat, ot-eval & treat due to Hypo-osmolality and hyponatremia 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 Siva, Prema

SN Careplans

SN WK1: 1 (05/07/26-05/09/26) ,WK2: 1 (05/10/26-05/16/26) ,WK3: 1 (05/17/26-05/23/26) ,WK4: 1 (05/24/26-05/30/26)

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: 2. Non-agency caregiver(s) need training/supportive services to provide assistance

HOSPITALIZATION RISKS: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 5. Decline in mental, emotional, or behavioral status in the past 3 months, 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:Durable power of attorney for health care/Medical power of attorney

PROBLEMS IDENTIFIED ON ASSESSMENT: M1745 - Behavioral Issues, M1720 - Anxiety, D0160 - Depression, M2102d - Caregiver Performs Treatment, M2102c - Med Admin, M2102f - Patient Supervision, D0700 - Social Isolation, M2020 - Oral Med Management, M1400 - Dyspnea, delayed capillary refill, abnormal blood pressure, heartburn/indigestion, M1610 - Urinary Incontinence, muscle weakness, Pain Interference with ADLs, Pain Effect on Sleep, balance deficit, obesity

PROCEDURES: cough/deep breathing exercises, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, bladder training, teach/coordinate/arrange

SN Goals

PATIENT-STATED GOAL: I don't want to fall anymore

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
* prevention exacerbation of anxiety condition including coping patterns
* improved concentration
* strategies to reduce anxiety
* identification of anxiety precipitants, conflicts, and threats
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* depression-prevention strategies including avoidance of isolation
* healthy eating
* sleeping habits
* identification of activities that bring pleasure
* preventive care
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* management of mental health condition including joining a peer group
* maintaining regular contact with mental health professional
* avoiding known stressors
* controlling impulses
* 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/caregiver recalls
* strategies to increase socialization
* recalls related medication(s) purpose, schedule

patient is adequately supervised

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

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

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
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caregiver physical, emotional and mental exhaustion, bladder training, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange long-term socialization activities

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, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, related medication(s) purpose, schedule, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpose, schedule, * management of mental health condition including joining a peer group maintaining regular contact with mental health professional avoiding known stressors controlling impulses, 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, * strategies to increase socialization, related medication(s) purpose, schedule, patient is adequately supervised, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT WK2: 1 (05/10/26-05/16/26) ,WK3: 1 (05/17/26-05/23/26) ,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: GG0170D1 - Sit to Stand, GG0170F1 - Toilet Transfer, GG0170I1 - Walk 10 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170K1 - Walk 150 Feet, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair

PROCEDURES: B LE strengthening: 1, Standing balance Training: 1, home exercise program: Ankle pumps, quad sets, glute sets, heel slides, partial squats, and seated/standing knee flexion and extension within tolerance. 10-15 reps ea. 1-2 set per day. Emphasis on improving right knee ROM, reducing stiffness, and promoting quadriceps activation., gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 05. Setup or clean-up assistance, Chair to Bed to Chair - 05. Setup or clean-up assistance, Toilet Transfer - 06. Independent, Walk 10 Feet - 05. Setup or clean-up assistance, Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance, Walk 150 Feet - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance, 1 - Step (curb) - 05. Setup or clean-up assistance, 4 Steps - 05. Setup or clean-up assistance, 12 Steps - 05. Setup or clean-up assistance, Picking Up Object - 05. Setup or clean-up assistance, Car Transfer - 05. Setup or clean-up assistance

PT Goals

PATIENT-STATED GOAL: Improve strength and endurance to attend Bain Senior Center regularly.

GOALS
Toilet Transfer - 06. Independent

1 - Step (curb) - 05. Setup or clean-up assistance

Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance

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

Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance

Walk 150 Feet - 05. Setup or clean-up assistance

4 Steps - 05. Setup or clean-up assistance

12 Steps - 05. Setup or clean-up assistance

Picking Up Object - 05. Setup or clean-up assistance

Car Transfer - 05. Setup or clean-up assistance

Sit to Stand - 05. Setup or clean-up assistance

Walk 10 Feet - 05. Setup or clean-up assistance

OT Careplans

OT WK2: 1 (05/10/26-05/16/26) ,WK3: 1 (05/17/26-05/23/26) ,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 Effect on Sleep, 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: Home exercise program: exe for home, Therapeutic exercise : strengthening UE durign the visit, Balance training : in standing and sitting, Medication review : changes in meds, cough/deep breathing exercises, incentive spirometer, 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, * 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 - 06. Independent, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: to be more functional, not fall

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

Shower/Bathe Self - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Signature of Physician:	Date
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Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Toileting Hygiene - 06. Independent

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