Home Health Certification and Plan of Care

Order ID: 1150/18959

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
68303329	05/26/2026	From: 05/26/2026 To: 07/24/2026	26025	217058

6. Patient's Name and Address

Laverne Harlee
301 McMechen St Apt 602,
BALTIMORE, MD 21217-
240-671-4451

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 09/13/1952 **9.Sex** Female

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

13. ICD	Other Pertinent Diagnoses	Date
I50.22	Chronic systolic (congestive) heart failure	05/26/26
I48.91	Unspecified atrial fibrillation	05/26/26
J44.9	Chronic obstructive pulmonary disease unspecified	05/26/26
E11.9	Type 2 diabetes mellitus without complications	05/26/26
R29.6	Repeated falls	05/26/26
F17.210	Nicotine dependence cigarettes uncomplicated	05/26/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	05/26/26
Z79.01	Long term (current) use of anticoagulants	05/26/26
Z91.81	History of falling	05/26/26

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

CARVEDILOL 12.5 MG tablet by mouth 2 times daily with meals Commonly known as: COREG
FUROSEMIDE 40 MG tablet by mouth daily Commonly known as: LASIX
GABAPENTIN 300 MG capsule by mouth daily Commonly known as: NEURONTIN
GLIPIZIDE 5 MG tablet by mouth 2 times daily Commonly known as: GLUCOTROL
ACETAMINOPHEN 500 mg/tablet / Take 2 tablets by mouth 3 times daily as needed for MILD Pain (or if patient requests it for moderate or severe pain) or Fever (temp in PRN comment) (for fever > 38.0 and notify physician). Commonly known as: TYLENOL
ATORVASTATIN 40 mg / 1 Tablet by mouth nightly Commonly known as: LIPITOR
DABIGATRAN ETEXILATE 150 mg / 1 Capsule by mouth 2 times daily Commonly known as: PRADAXA
SPIRONOLACTONE 25 mg / 1 Tablet by mouth daily Commonly known as: ALDACTONE
BRIMONIDINE TARTRATE 0.2 % ophthalmic solution / Place 1 drop into both eyes 3 times daily Commonly known as: ALPHAGAN
LATANOPROST 0.005 0.005 % ophthalmic solution / Place 1 drop into both eyes nightly Commonly known as: XALATAN
TIMOLOL 0.5 % ophthalmic solution / Place 1 drop into both eyes 2 times daily Commonly known as: TIMOPTIC

14. DME and Supplies:

wheelchair, walker, diabetic supplies, , bath bench

15. Safety Measures:

emergency phone # clearly displayed, bathroom safety, smoke detectors , walker precautions, wheelchair precautions, medication safety, ambulates with device, ambulates with assistance, standard precautions, fall precautions, diabetic precautions

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

no known allergies

18.A. Functional Limitations

Endurance, Ambulation, 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

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:

Home health nursing admission was completed for a 73-year-old female with a significant past medical history of atrial fibrillation, hypertension, chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus, heart failure with congestive heart failure (CHF), obstructive sleep apnea requiring CPAP use at night, recurrent falls, and high fall risk. The patient was recently hospitalized following multiple syncopal episodes with collapse and an additional fall forward from her rollator walker. Following hospitalization, the patient returned home and currently resides alone in an elevator-accessible apartment with intermittent assistance and support from family members. Upon assessment, the patient was alert and oriented to person, place, and time. She ambulates primarily with a rollator walker and utilizes a scooter or wheelchair for longer distances outside the home. Within the apartment, the patient was observed ambulating approximately 25 feet on two occasions without an assistive device, frequently reaching for nearby objects for support and demonstrating increased trunk flexion, indicating impaired balance and safety awareness. Transfers to and from the bed, toilet, and rollator seat were completed with supervision, while bed mobility remained independent. Outdoor mobility, stair negotiation, and car transfer abilities were not assessed during this visit. The patient is considered homebound due to the significant physical effort required to leave the home safely with assistive devices and is further evidenced by a Tinetti Balance and Gait Assessment score of 15/28, indicating an elevated fall risk. Skin assessment revealed no current skin breakdown, wounds, or other integumentary concerns. The home environment was noted to be cluttered, creating potential safety hazards and increasing the patient's risk for falls. Education was provided regarding home safety modifications, including decluttering pathways and keeping the scooter out of the hallway to allow safe use of the rollator throughout the apartment. Additional education was provided on fall prevention strategies, proper use of assistive devices, medication management and compliance, disease process management, energy conservation techniques, and recognition and reporting of changes in condition to the physician or healthcare team. Prior to hospitalization, the patient was independent with self-care activities and functional mobility within the home while utilizing a walker, requiring a wheelchair only for longer community distances. Following hospitalization, the patient demonstrates decreased standing balance, reduced standing tolerance, diminished bilateral upper extremity strength, decreased activity tolerance, and impaired functional mobility. These deficits have negatively impacted her ability to safely perform activities of daily living (ADLs), functional transfers, and mobility tasks independently. Skilled nursing services are medically necessary for ongoing cardiopulmonary assessment and monitoring related to atrial fibrillation, COPD, heart failure, diabetes mellitus, sleep apnea, and recent syncopal episodes. Skilled nursing will monitor for signs and symptoms of disease exacerbation, assess medication compliance and effectiveness, reinforce disease-specific education, evaluate safety risks within the home, implement fall prevention interventions, and monitor overall functional status to reduce the risk of complications, emergency department visits, and rehospitalization. Physical therapy services are warranted to address deficits in strength, balance, gait, endurance, transfer ability, and overall functional mobility with the goal of improving safety, reducing fall risk, and restoring the patient to her prior level of function. Occupational therapy services are also indicated to improve standing balance, standing tolerance, upper extremity strength, activity tolerance, self-care performance, functional transfers, and independence with activities of daily living. The interdisciplinary plan of care is focused on maximizing safety, promoting independence within the home environment, preventing further falls, and supporting the patient's ability to remain safely in the

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 05/26/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Sherell Mason
815 E. Pratt Street
Baltimore, MD 21202
PHONE: 410-637-5700 FAX: 14106375661 NPI: 1750375481

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 : 05/16/2026

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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community.
 Date of Order 05/26/2026 Orders Physician Face-to-Face Date: 05/16/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management, pt-eval & treat, ot-eval & treat, hhadl's due to 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: Created from AI Intake - SOC PT Eval Notes: OT Eval Notes:
 Physician Mason, Sherell

SN Careplans

SN WK1: 1 (05/26/26-05/30/26) ,WK2: 1 (05/31/26-06/06/26) ,WK3: 1 (06/07/26-06/13/26) ,WK4: 1 (06/14/26-06/20/26) ,WK5: 1 (06/21/26-06/27/26) ,WK6: 1 (06/28/26-07/04/26)

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),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:Not Received

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2102d - Caregiver Performs Treatment, M2102c - Med Admin, meal preparation, M2102f - Patient Supervision, M2020 - Oral Med Management, A1250 - Lack of Necessary Transportation, Home Safety, M1400 - Dyspnea, abnormal blood pressure, abnormal BS < 70/140 > mg/dL, M1610 - Urinary Incontinence, limited endurance, limited strength, muscle weakness, B1000 - Vision Deficit, balance deficit, weak hand grips, difficulty sleeping, daytime fatigue, obesity

PROCEDURES: teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange preparation of missing meals, coordinate/arrange for maintenance of clean/uncluttered living area, coordinate/arrange resources for vision-impaired

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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpose, schedule, * urinary incontinence management including bladder training Kegel exercises skin care, related medication(s) purpose, schedule, * how to keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient's transportation needs are met, patient's living environment is clean/uncluttered, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

SN Goals

PATIENT-STATED GOAL: Patient stated she would like to remain free of fall and regain strength

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
* 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
* urinary incontinence management including bladder training
* Kegel exercises
* skin care
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

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

patient's transportation needs are met

patient's living environment is clean/uncluttered

patient is adequately supervised

meal preparation is available to patient for all meals

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

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PT WK1: 1 (05/26/26-05/30/26) ,WK2: 1 (05/31/26-06/06/26) ,WK3: 1 (06/07/26-06/13/26) ,WK4: 1 (06/14/26-06/20/26) ,WK5: 1 (06/21/26-06/27/26) ,WK6: 1 (06/28/26-07/04/26) ,WK7: 1 (07/05/26-07/11/26) ,WK8: 1 (07/12/26-07/18/26)

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, 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: Bed mobility training : Sit to supine and supine to sit., 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: Sit to Stand - 05. Setup or clean-up assistance, Chair to Bed to Chair - 05. Setup or clean-up assistance, Toilet Transfer - 05. Setup or clean-up 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, 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

PATIENT-STATED GOAL: To be able to walk with my rollator to appointments

GOALS
Walk 150 Feet - 04. Supervision or touching assistance

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

4 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

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

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

Toilet Transfer - 05. Setup or clean-up assistance

Walk 10 Feet - 04. Supervision or touching assistance

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

OT Careplans

OT WK1: 5 (05/26/2026 - 05/30/2026), WK2: 1 (05/31/2026 - 06/06/2026), WK3: 1 (06/07/2026 - 06/13/2026), WK4: 1 (06/14/2026 - 06/20/2026), WK5: 1 (06/21/2026 - 06/27/2026), WK6: 1 (06/28/2026 - 07/04/2026)

PROBLEMS IDENTIFIED ON ASSESSMENT: 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: Medication Review : Medication reviewed with patient with all medications in the home, home exercise program: Bilateral UE strengthening of anterior deltoid, biceps, triceps and pectoral muscles, work simplification/energy conservation, strengthening exercises: 1x4wks, transfers training: 1x4wks, assist with bathing: 1x4wks, assist with toilet transferring: 1x4wks, assist with lower body dressing: 1x4wks

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

OT Goals

PATIENT-STATED GOAL: Get in the shower

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Shower/Bathe Self - 05. Setup or clean-up 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

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

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

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Walk 10 Feet - 04. Supervision or touching assistance

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

HHA Careplans

HHA WK1: 5 (05/26/2026 - 05/30/2026), WK2: 2 (05/31/2026 - 06/06/2026), WK3: 2 (06/07/2026 - 06/13/2026), WK4: 2 (06/14/2026 - 06/20/2026), WK5: 2 (06/21/2026 - 06/27/2026)

PROCEDURES: assist with transferring: Min A, assist with grooming: Supervision, assist with lower body dressing: Independent, assist with upper body dressing: Min A

HHA Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:
Electronically Signed by Messick, Charles RN

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