Home Health Certification and Plan of Care

Order ID: 1150/18963

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
72128260	05/18/2026	From: 05/18/2026 To: 07/16/2026	2986	217058

6. Patient's Name and Address

Lydia Sanders
7700 Colonial beach Road,
Pasadena, MD 21122-
443-618-9637

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 05/03/1941 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
M24.571	Contracture right ankle	05/18/26

13. ICD	Other Pertinent Diagnoses	Date
M24.572	Contracture left ankle	05/18/26
M24.561	Contracture right knee	05/18/26
M24.562	Contracture left knee	05/18/26
M17.0	Bilateral primary osteoarthritis of knee	05/18/26
J44.9	Chronic obstructive pulmonary disease unspecified	05/18/26
G30.9	Alzheimer's disease unspecified	05/18/26
F02.83	Dem in other dis classd elswhr unsp sev with mood distrb	05/18/26
F32.A	Depression unspecified	05/18/26
F02.84	Dem in other dis classd elswhr unsp severity with anxiety	05/18/26
N39.0	Urinary tract infection site not specified	05/18/26
J18.8	Other pneumonia unspecified organism	05/18/26
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy	05/18/26
E78.5	Hyperlipidemia unspecified	05/18/26
D64.9	Anemia unspecified	05/18/26
K21.9	Gastro-esophageal reflux disease without esophagitis	05/18/26
K57.30	Dvrtclos of lg int w/o perforation or abscess w/o bleeding	05/18/26
H91.91	Unspecified hearing loss right ear	05/18/26
E02.	Subclinical iodine-deficiency hypothyroidism	05/18/26
E55.9	Vitamin D deficiency unspecified	05/18/26
M10.9	Gout unspecified	05/18/26
Z86.718	Personal history of other venous thrombosis and embolism	05/18/26
Z86.0101	Personal history of adeno	05/18/26
Z86.19	Personal history of other infectious and parasitic diseases	05/18/26
Z90.49	Acquired absence of other specified parts of digestive tract	05/18/26
Z91.81	History of falling	05/18/26

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

Tylenol - Acetaminophen 325mg, 1 tablet by mouth every 6 hours As needed for headache for up to 7 days
Zofran - Ondansetron Hydrochloride 4mg by mouth as necessary Pain
Eliquis - Apixaban 5mg by mouth twice a day Clotting
Pepcid - Famotidine 20 mg by mouth twice a day
Amitiza - Lubiprostone 8mcg cap by mouth twice a day Take 16 mcg for constipation
Mirtazapine - Mirtazapine 30 mg by mouth at bedtime Mood
Trazadone - Trazodone Hydrochloride 10 MG by mouth at bedtime For pain
Boost Breeze Liquid 8oz by mouth three times a day Nutritional supplements
Multivitamin - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 8mg by mouth once a day Supplement
Albuterol - Albuterol 108mcg inhalant as necessary Shortness of breath
Pulmomate/ NEBULUZER MIS DEVI 3ML inhalant as necessary Shortness of breath
Fleet Enema - Fleet Enema 19-7 GM/197ML rectal as necessary Constipation
Nystatin Cream - Nystatin Cream 0.1-20% topical as necessary Radh
Nystatin Cream - Nystatin Cream 0.1-20% topical as necessary Radh
Estradiol - Estradiol 0.1 mg/24hr 0.1 mg/m topical two times per week UTI prevention

14. DME and Supplies:

wheelchair, walker, hospital bed, grab bars, enema supplies, commode, cane, 4 wheeled walker, Sit-to-stand assist

15. Safety Measures:

fall precautions, hand rails, supervision at all times, standard precautions,

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

Sulindac

18.A. Functional Limitations

Endurance, Hearing, Contracture, Bowel/Bladder Incontinence

18.B. Activities Permitted

Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 4. Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium., ANXIETY: 4. Constantly, SOCIAL ISOLATION: 8. Patient unable to respond, 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: No

20. Prognosis: fair

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

family/caregiver will be responsible for managing treatment
family/caregiver will be responsible for managing treatment
add discharge plan
family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Contracture right ankle, 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 an 85-year-old female admitted to home health services with a significant past medical history including advanced Alzheimer's dementia/posterior cortical atrophy (Benson syndrome), recurrent urinary tract infections, pulmonary embolism, recurrent constipation with recent bowel impaction requiring hospitalization approximately two months ago, subclinical hypothyroidism, atherosclerosis of the aorta, postural instability of gait, bilateral lower extremity weakness, ankle edema, right knee arthritis, left shoulder arthritis, Achilles contractures, legal blindness, and overall functional decline. Patient was evaluated at home following referral from Dr. Katz for skilled home care services. Upon SN arrival, patient was resting in bed and awakened to verbal and tactile stimuli. Patient was oriented to self only and unable to reliably provide history secondary to advanced cognitive impairment; therefore, the majority of information was provided by her son, Brian, who is the primary caregiver and remains with the patient nearly full time. Patient currently resides with her son in the home setting and requires total care for all ADLs and mobility needs. Son reviewed and signed all admission paperwork and is in agreement with the established plan of care. Patient is currently enrolled with Gilchrist Palliative Care services with monthly palliative team visits. In addition, a private duty aide assists on an as-needed basis without a fixed schedule. Patient has been bedbound and non-ambulatory for approximately two years and is considered homebound due to severe dementia, impaired safety

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 05/18/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Jeffrey Katz
1701 Twin Springs Rd
Halethorpe, MD 21227
PHONE: 800-777-7904 FAX: 14107975401 NPI: 1013954213

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 : 05/05/2026

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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awareness, profound mobility limitations, and inability to leave the home without total human assistance. Patient requires maximal to total assistance for transfers and all basic activities of daily living. Son reports he transfers the patient out of bed for approximately two hours daily as tolerated. Patient utilizes a hospital bed and wheelchair within the home. Multiple bed rails are in place for fall prevention. No recent falls were reported. Skin assessment revealed no current pressure injuries or open areas. Patient demonstrates sundowning behaviors beginning around 4 PM or later and intermittently fails to recognize her son. Sensory deficits include severe visual impairment/legal blindness and selective hearing impairment. Patient has difficulty focusing on activities for extended periods. Nutritional intake remains generally adequate per caregiver report. Patient requires hand feeding but is occasionally able to manage finger foods. She experiences difficulty locating her mouth during feeding and is unable to independently hold a drink. Son reports patient maintains a good appetite and consumes protein-rich foods, Boost supplements, water flavored with Mio, ginger ale, and Coca-Cola. Bowel movements remain irregular, and patient continues management for chronic constipation with MiraLAX, magnesium citrate, and bowel regimen support. Family expressed concerns regarding prevention of muscle wasting and maintaining patient comfort and quality of life. Physical and occupational therapy evaluations identified significant deficits including generalized weakness, decreased bilateral lower extremity strength, impaired sitting balance, severe functional mobility limitations, pain with seated positioning, total dependence for transfers, and high fall risk. Prior therapy services completed in February/March 2026 reportedly focused on supine exercises and edge-of-bed sitting tolerance. Skilled PT and OT services are medically necessary to address strength maintenance, caregiver training, transfer safety, positioning, fall prevention, contracture prevention, activity tolerance, endurance, and preservation of functional abilities and quality of life to the greatest extent possible. Without continued skilled intervention, patient remains at high risk for further functional decline, falls, skin breakdown, muscle wasting, and caregiver burden. Skilled nursing services initiated for medication management, ongoing assessment, and caregiver education related to recurrent UTIs, chronic constipation management, dementia care, skin integrity monitoring, fall prevention, and disease process education. SN frequency established at 1W4. PT ordered at frequency of 1W9 beginning 05/21/2026, with future visits assigned to PTA Jenn Foster. OT evaluation completed with recommendations for continued skilled intervention. Home health aide services ordered at 2W4 to assist with personal care needs. Patient will continue to be closely monitored for changes in condition, safety concerns, skin integrity, bowel status, hydration, pain, and overall functional decline.
 Date of Order 05/18/2026 Orders Physician Face-to-Face Date: 05/05/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management, pt-eval & treat,ot-eval & treat, hha-adl's due to Contracture right ankle 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 1 - SOC - PT Notes: OT Eval Notes:
 Physician Katz, Jeffrey

SN Careplans

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

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: 2. Unintentional weight loss of a total of 10 pounds or more 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, 9. Other risk(s) not listed in 1- 8

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
Advance Directive:Living Will

PROBLEMS IDENTIFIED ON ASSESSMENT: M1720 - Anxiety, M1700 - Cognition, M1745 - Behavioral Issues, M2020 - Oral Med Management, meal preparation, M1033 - Unintentional Weight Loss, M1400 - Dyspnea, constipation, poor muscle tone, muscle weakness, limited endurance, limited strength, limited range of motion, B0200 - Hearing Deficit, B1000 - Vision Deficit

PROCEDURES: Labs: CBC, Chem 7, hepatic profile, UAC&S monthly drop at KP lab North Arundel Medical Center in GlenBurnie, cough/deep breathing exercises, incentive spirometer, coordinate/arrange resources for vision-impaired, coordinate/arrange home modifications for hearing impaired, i.e. alarms

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, * 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, * how to keep home safe for patient with dementia coping strategies for the caregiver*, 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, * strategies to increase caloric intake, related medication(s) purpose, schedule, * how to keep home safe for hearing-impaired including installing special fire-detector/CO2 alarms, 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, meal preparation is available to patient for all meals

SN Goals

PATIENT-STATED GOAL: to get better

GOALS
patient/caregiver recalls
* how to keep home safe for patient with dementia
* coping strategies for the caregiver* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to keep home safe for hearing-impaired including installing special fire-detector/CO2 alarms
* recalls related medication(s) purpose, schedule

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
* 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
* strategies to increase caloric intake
* 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

meal preparation is available to patient for all meals

PT Careplans

PT Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

05/18/2026

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PT WK1: 1 (05/18/26-05/23/26) ,WK3: 1 (05/31/26-06/06/26) ,WK4: 1 (06/07/26-06/13/26) ,WK5: 1 (06/14/26-06/20/26) ,WK7: 1 (06/28/26-07/04/26) ,WK9: 1 (07/12/26-07/16/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170A1 - Roll left & Right, GG0170B1 - Sit to Lying, GG0170C1 - Lying to sitting/bed, GG0170D1 - Sit to Stand, GG0170F1 - Toilet Transfer, GG0170G1 - Car Transfer, GG0170R1 - Wheel 50 ft w 2 Turns, GG0170S1 - Wheel 150 feet, GG0170E1 - Chair to Bed to Chair

PROCEDURES: Assist PCG with positional strategies to prevent pressure ulcers.: Instruct on positional strategies to decrease the risk for developing pressure ulcers, and or to prevent the advancement of pressure ulcers. Instruct where pressure ulcers are most likely to develop, and signs of a pressure ulcer. Recomend positional changes hourly, sidelying when in bed, to lie flat instead of with head and feet elevated in a hospital bed, and to get out of bed, into a w/c when possible. Considerations for different types of mattresses and cushions for wheelchairs., train caregiver(s) to perform medical/rehabilitation treatments: na, home exercise program: Supine- ankle pump, quad set, gluteal set, heel slide, SLR, bridging. Seated-LAQ hip flex, hip abd, pillow squeeze., transfers training, assist with home exercise program: Instruct caregiver in how to administer HEP and ROM program

TEACH PATIENT/CAREGIVER: Roll left & Right - 01. Dependent, Sit to Lying - 01. Dependent, Lying to sitting/bed - 01. Dependent, Sit to Stand - 01. Dependent, Chair to Bed to Chair - 01. Dependent

PATIENT-STATED GOAL: Pts son would like to prevent atrophy

GOALS
Roll left & Right - 01. Dependent

Sit to Lying - 01. Dependent

Lying to sitting/bed - 01. Dependent

Sit to Stand - 01. Dependent

Chair to Bed to Chair - 01. Dependent

Toilet Transfer - 03. Partial/moderate assistance

Car Transfer - 01. Dependent

OT Careplans

OT WK1: 1 (05/18/26-05/23/26) ,WK2: 1 (05/24/26-05/30/26) ,WK4: 1 (06/07/26-06/13/26) ,WK5: 1 (06/14/26-06/20/26) ,WK6: 1 (06/21/26-06/27/26) ,WK8: 1 (07/05/26-07/11/26)

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

PROCEDURES: Bed mobility training : bed transfers, activity tolerance : to encourage activity level, Medication review : change in med, cough/deep breathing exercises, home exercise program, home exercise program, home exercise program: exe for home, 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 - 03. Partial/moderate assistance, Toileting Hygiene - 03. Partial/moderate assistance, Shower/Bathe Self - 02. Substantial/maximal assistance, Upper Body Dressing - 03. Partial/moderate assistance, Don/Doff Footwear - 03. Partial/moderate assistance, Eating - 05. Setup or clean-up assistance

OT Goals

PATIENT-STATED GOAL: to use trapez bar, prevent ms wasting

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 - 03. Partial/moderate assistance

Toileting Hygiene - 03. Partial/moderate assistance

Don/Doff Footwear - 03. Partial/moderate assistance

Eating - 05. Setup or clean-up assistance

Shower/Bathe Self - 02. Substantial/maximal assistance

Upper Body Dressing - 03. Partial/moderate assistance

HHA Careplans

HHA WK2: 2 (05/24/26-05/30/26) ,WK3: 2 (05/31/26-06/06/26) ,WK4: 2 (06/07/26-06/13/26) ,WK5: 2 (06/14/26-06/20/26)

PROCEDURES: assist with bathing, bed bath: Bathing and toileting are the main activity that the family needs support for, assist with toilet transferring, assist with toileting hygiene, assist with transferring: for bed to chair if needed., assist with feeding/eating: Pt is spoon fed, assist with infection control: STandrad precautions, assist with fall prevention: pt is not bearing her weight, assist with grooming, assist with lower body dressing, assist with upper body dressing, assist with home exercise program Passive range of motion upper and lower extremities

HHA Goals

PATIENT-STATED GOAL: add patient-stated goal

GOALS

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

05/18/2026