Home Health Certification and Plan of Care

Order ID: 1150/19202

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
6ET4QY5HA63	05/21/2026	From: 05/21/2026 To: 07/19/2026	25702	217058

6. Patient's Name and Address

Jessica Santos
4726 Coralberry Court,
ABERDEEN, MD 21001-
443-377-0877

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 10/11/1955 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy	05/21/26

13. ICD	Other Pertinent Diagnoses	Date
I13.0	Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny	05/21/26
I50.22	Chronic systolic (congestive) heart failure	05/21/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	05/21/26
N18.32	Chronic kidney disease stage 3b	05/21/26
I87.311	Chronic venous hypertension w ulcer of r low extrem	05/21/26
E11.65	Type 2 diabetes mellitus with hyperglycemia	05/21/26
E11.51	Type 2 diabetes w diabetic peripheral angiopath w/o gangrene	05/21/26
E78.2	Mixed hyperlipidemia	05/21/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	05/21/26
E55.9	Vitamin D deficiency unspecified	05/21/26
I95.9	Hypotension unspecified	05/21/26
E03.9	Hypothyroidism unspecified	05/21/26
I08.1	Rheumatic disorders of both mitral and tricuspid valves	05/21/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	05/21/26
K21.9	Gastro-esophageal reflux disease without esophagitis	05/21/26
F41.9	Anxiety disorder unspecified	05/21/26
F32.A	Depression unspecified	05/21/26
K59.01	Slow transit constipation	05/21/26
R91.1	Solitary pulmonary nodule	05/21/26
Z85.038	Personal history of malignant neoplasm of large intestine	05/21/26
Z79.82	Long term (current) use of aspirin	05/21/26
Z79.02	Long term (current) use of antithrombotics/antiplatelets	05/21/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	05/21/26
Z79.4	Long term (current) use of insulin	05/21/26
Z86.711	Personal history of pulmonary embolism	05/21/26
Z87.440	Personal history of urinary (tract) infections	05/21/26
Z86.19	Personal history of other infectious and parasitic diseases	05/21/26

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

ACETAMINOPHEN 325 mg/tablet / Give 2 tablet by mouth every 8 hours as needed for pain Do not exceed 3 grams daily
METFORMIN Extended Release 500 mg / 1 Tablet by mouth one time a day for DM Give with meal
Plavix - Clopidogrel Bisulfate 75 mg / 1 Tablet by mouth once a day for DVT prophylaxis
ASPIRIN 0 Delayed Release 81 mg / 1 Tablet by mouth one time a day for prophylaxis
MULTIPLE VITAMIN 1 tablet by mouth one time a day for supp
Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 25 MCG (1000 UT) / 1 Tablet by mouth once a day for Vit D deficiency
Furosemide - Furosemide 20 mg Take 1 tablet by mouth in the morning Swelling
GLUCAGON 1 mg / Inject 1 mg intramuscularly as necessary for Blood Sugar Less than 70 give glucagon 1mg IM x1 dose and notify MD may repeat glucagon 1mg IM in 5-10 minutes if repeat blood sugar remains below 70
Lantus Solostar - Insulin Glargine Recombinant 100 UNIT/ML / inject 8 unit subcutaneously at bedtime for DM

14. DME and Supplies:

wound care supplies, walker, , , diabetic supplies, bath bench

15. Safety Measures:

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

16. Nutrition:

diabetic

17. Allergies:

losrtan oxycodone latex lovastatin

18.A. Functional Limitations

Ambulation

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: Yes

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

SN:patient will be responsible for managing treatment
PT:family/caregiver will be responsible for managing treatment
OT:patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Type 2 diabetes mellitus with diabetic polyneuropathy, 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.

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

Robert Davidson
4924 Campbell Blvd #200
Nottingham, MD 21236
PHONE: 4434422300 FAX: 14103672035 NPI: 1760537831

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 : 05/06/2026

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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Clinical Condition Requiring Homecare:

The patient is a 70-year-old female referred to home health services following a recent hospitalization and subsequent subacute rehabilitation stay related to shortness of breath, bilateral lower extremity edema, and a recent fall. Her past medical history is significant for type 2 diabetes mellitus with neuropathy, coronary artery disease, hypertensive heart disease, essential hypertension, chronic kidney disease, heart failure with reduced ejection fraction (EF 35%), hyperlipidemia, vitamin D deficiency, history of pleural effusion, and bilateral lower extremity ischemia. The patient also has right lower extremity wounds associated with chronic edema and vascular compromise. The patient resides in the basement of her son's two-story townhome with her husband, who receives dialysis treatments twice weekly. Prior to her recent hospitalization, the patient was modified independent with mobility and activities of daily living, did not use an assistive device regularly, and was independent with self-care tasks. She does not drive. The patient reports sliding out of bed on three occasions during her stay at the rehabilitation facility. She currently sleeps in a standard bed in the basement and is able to negotiate stairs by utilizing the handrails for support. Assessment revealed the patient to be alert and oriented to person, place, time, and situation (A&O x4). Respirations were even and unlabored with no signs of acute respiratory distress. Daily blood glucose monitoring is performed by her son, with a fasting blood glucose level of 149 mg/dL reported today. The patient ambulates with a walker as needed; however, she reports inconsistent use of the device. Physical therapy evaluation demonstrated impaired balance and increased fall risk, evidenced by a Tinetti Balance Assessment score of 14/28 and a Timed Up and Go (TUG) score of 29.1 seconds. The patient exhibits bilateral lower extremity weakness, minor difficulty with transfers, contact guard assistance required for ambulation, intermittent unsteadiness with a wide base of support, one observed loss of balance requiring minimal assistance to recover, and minimal assistance required for stair negotiation. These deficits place the patient at elevated risk for falls and reduced functional mobility. The patient has chronic bilateral lower extremity swelling and ischemia with wounds present on the right lower extremity. The wounds were recently dressed and therefore were not visualized during the visit. No wound care orders were available at the time of assessment. Per patient report, wound care management at the rehabilitation facility initially consisted of wet-to-dry dressings and was later changed to cleansing with sterile water, patting dry, applying Remedy antifungal ointment to the wound bed, applying ammonium lactate lotion to the dry surrounding skin, covering with gauze, and securing with Kerlix. The patient received wound care education and supplies prior to discharge and has independently continued wound care management at home. She reports the wound is healing well without current complications. Ongoing education was reinforced regarding proper wound care techniques, skin inspection, infection prevention, edema management, and the importance of monitoring for signs and symptoms of infection. Occupational therapy assessment revealed decreased standing balance, reduced standing tolerance, diminished bilateral upper extremity strength, and decreased overall activity tolerance. These impairments are negatively impacting the patient's independence with self-care activities, functional transfers, and household mobility. The patient demonstrates a decline from her prior level of function and requires skilled intervention to maximize safety and independence within the home environment. Skilled physical therapy services were initiated, including lower extremity therapeutic exercises to address strength deficits, balance impairments, gait abnormalities, transfer limitations, and fall risk. The patient demonstrates good rehabilitation potential and is expected to benefit from continued skilled physical therapy focused on strengthening, balance training, gait training, stair negotiation, transfer training, endurance building, and fall prevention strategies. Skilled occupational therapy services are also recommended to address deficits in upper extremity strength, standing tolerance, activity tolerance, functional mobility, and performance of activities of daily living. The overall plan of care is aimed at improving functional independence, enhancing safety within the home, promoting wound healing, reducing fall risk, and facilitating a return to the patient's prior level of function.
 Date of Order 05/21/2026 Orders Physician Face-to-Face Date: 05/06/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Type 2 diabetes mellitus with diabetic polyneuropathy 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 Davidson, Robert

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 (06/14/26-06/20/26) ,WK6: 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: 3. Multiple hospitalizations (2 or more) in the past 6 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, 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,

SN Goals

PATIENT-STATED GOAL: To walk without an assistive device

GOALS
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
* 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/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 achieve wound healing including cleaning and dressing wound
* position changes
* skin care
* diet modification
* record wound measurements
* recalls related medication(s) purpose, schedule

meal preparation is available to patient for all meals

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	05/21/2026

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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: D0160 - Depression, M2020 - Oral Med Management, meal preparation, abnormal blood pressure, M1033 - Exhaustion, M1400 - Dyspnea, abnormal BS < 70/140 > mg/dL, limited strength, muscle weakness, balance deficit, open sores/lesions, #1 - Diabetic Ulcer - Anterior Right Foot - Anterior right foot upper, #2 - Diabetic Ulcer - Anterior Right Foot - Anterior right foot middle, #3 - Diabetic Ulcer - Anterior Right Foot - Anterior right foot lower

PROCEDURES: physician-ordered wound care: #3 - Diabetic Ulcer - Anterior Right Foot - Anterior right foot lower, physician-ordered wound care: #2 - Diabetic Ulcer - Anterior Right Foot - Anterior right foot middle, physician-ordered wound care: #1 - Diabetic Ulcer - Anterior Right Foot - Anterior right foot upper, 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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpose, schedule, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, 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, meal preparation is available to patient for all meals

PT Careplans

PT WK2: 2 (05/24/26-05/30/26) ,WK3: 1 (05/31/26-06/06/26) ,WK4: 1 (06/07/26-06/13/26) ,WK5: 1 (06/14/26-06/20/26) ,WK6: 1 (06/21/26-06/27/26) ,WK7: 1 (06/28/26-07/04/26) ,WK8: 1 (07/05/26-07/11/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170D1 - Sit to Stand, GG0170F1 - Toilet Transfer, GG0170G1 - Car 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, GG0170E1 - Chair to Bed to Chair

PROCEDURES: Medication management : Reviewed medication with pr, home exercise program: Standing hip flexion, hip abduction, hamstring curls , hip extension. Seated heelraises, laq, gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car 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

PT Goals

PATIENT-STATED GOAL: To be independent and not need therapy, be steadier

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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

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

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

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

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

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

OT Careplans

OT 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)

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, equipment training, work simplification/energy conservation, transfers training: Skilled 1x5wks, assist with transferring: Skilled 1x5wks, assist with lower body dressing: Skilled 1x5wks, assist with upper body dressing: Skilled 1x5wks

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 - 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
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

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

Signature of Physician:

Date

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

Date
05/21/2026