

Home Health Certification and Plan of Care				Order ID: 1150/19626	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
03238861000		02/12/2026		From: 06/12/2026 To: 08/10/2026	
4. Medical Record No.		5. Provider No.			
22295		217058			
6. Patient's Name and Address			7. Provider's Name, Address and Telephone Number		
Martha Smith 718 E 43rd ST, BALTIMORE, MD 21212- 443-642-0826			HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239		
8. DOB			9. Sex		
05/01/1951			Female		
11. ICD		Principal Diagnosis		Date	
I11.0		Hypertensive heart disease with heart failure		02/12/26	
13. ICD		Other Pertinent Diagnoses		Date	
I50.32		Chronic diastolic (congestive) heart failure		02/12/26	
E11.40		Type 2 diabetes mellitus with diabetic neuropathy unsp		02/12/26	
I87.2		Venous insufficiency (chronic) (peripheral)		02/12/26	
L97.811		Non-prs chr ulcer oth prt r low leg limited to brkdwn skin		02/12/26	
I26.93		Single subsegmental pulmon emblsm w/o acute cor pulmonale		02/12/26	
G47.33		Obstructive sleep apnea (adult) (pediatric)		02/12/26	
M17.0		Bilateral primary osteoarthritis of knee		02/12/26	
E66.813		Other obesity		02/12/26	
Z68.43		Body mass index [BMI] 50.0-59.9 adult		02/12/26	
Z85.42		Personal history of malignant neoplasm of oth prt uterus		02/12/26	
Z90.710		Acquired absence of both cervix and uterus		02/12/26	
Z79.01		Long term (current) use of anticoagulants		02/12/26	
Z79.84		Long term (current) use of oral hypoglycemic drugs		02/12/26	
Z79.82		Long term (current) use of aspirin		02/12/26	
Z79.891		Long term (current) use of opiate analgesic		02/12/26	
14. DME and Supplies:			15. Safety Measures:		
wound care supplies, commode, wheelchair, hospital bed, Incontinence supplies			standard precautions, supervision at all times, wheelchair precautions, O2 precautions, fall precautions, activity supervision, ambulates with assistance, ambulates with device		
16. Nutrition:			17. Allergies:		
low cholesterol, low sodium			banana strawberry		
18.A. Functional Limitations			18.B. Activities Permitted		
Bowel/Bladder Incontinence, Ambulation, Endurance			Up As Tolerated, Wheelchair		
19. Mental & Pyschosocial Status: COGNITION: 3. Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently, ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: , BEHAVIORAL ISSUES: , HISTORY OF DEPRESSION:					
20. Prognosis: fair					
22. A Rehabilitation Potential:			22.B.Discharge Plans		
SELF-CARE: , MOBILITY:			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:		<div>The patient is a 74-year-old female recently discharged home following hospitalization and subsequent subacute rehabilitation related to multiple falls. Her past medical history is significant for congestive heart failure (CHF), hypertension, bilateral knee osteoarthritis, type 2 diabetes mellitus, peripheral neuropathy, obesity, obstructive sleep apnea (CPAP not currently available in the home), prior pulmonary embolism managed with Eliquis, chronic right lower extremity (RLE) venous stasis ulcer, and history of uterine cancer. She resides in a two-story home with her two sons; however, her bedroom and bathroom have been relocated to the first floor due to inability to safely negotiate stairs. There are seven steps with a railing at the entrance of the home. Her sons provide assistance with all activities of daily living (ADLs) and instrumental activities of daily living (IADLs), including transportation to medical appointments. At the time of skilled nursing assessment, the patient was alert and oriented to person, place, and time. She denied shortness of breath and was receiving supplemental oxygen at 2 L/min continuously, with oxygen saturation measured at 95% on oxygen. She reported a good appetite and stated her last bowel movement occurred on the day of assessment. She reported intermittent left leg cramping but denied acute pain. The patient was noted to be incontinent of urine and wearing a diaper, with urine odor present in the room, indicating the need for ongoing skin integrity monitoring and hygiene support. Physical assessment revealed bilateral lower extremity hyperpigmentation consistent with chronic venous insufficiency and a venous stasis ulcer located on the lateral aspect of the right lower extremity. Additionally, the patient has a right subclavian Port-a-Cath in place, which she reports is flushed and managed by her physician every three months. Skilled nursing services were initiated with a frequency of 1 visit per week for 12 weeks, followed by 2 visits per week for 1 week, then 1 visit per week for 6 weeks (1W12, 2W1, 1W6). A substantial amount of time was spent reconciling and organizing medications in the home with the patient's son. A comprehensive medication profile was completed, and missing medications were identified; the son was instructed to obtain refills promptly to ensure compliance. The use of a pillbox was recommended to improve medication adherence and reduce risk of dosing errors. Skilled nursing will continue medication reconciliation and compliance monitoring at the next visit, along with cardiopulmonary assessment, diabetic monitoring, wound assessment and care, anticoagulation monitoring related to Eliquis, and reinforcement of disease management education. From a functional standpoint, the patient is currently spending the majority of the day in bed. Bed mobility from supine to sit is performed with supervision using a bed rail. She is able to roll side to side with supervision and use of the rail. Sit-to-supine transfer requires use of the bed rail and moderate assistance at the left lower extremity. She is able to scoot up in bed with the bed flat using rails with supervision. Sit-to-stand transfers to a walker require moderate assistance of two persons, and she is able to maintain standing for approximately 20 seconds. Due to her current functional limitations, gait, car transfers, and outdoor mobility were not assessed. Her Tinetti balance assessment score is 1/28, indicating extremely high fall risk. She is considered homebound due to the significant physical effort required to leave the home and her severely impaired mobility. Therapeutic exercises performed during evaluation included 10 repetitions each of hip flexion, bridging, hooklying rotation, straight leg raises, hip abduction, knee extension, and ankle pumps, which were tolerated without acute distress. Her sons were present during training and were educated on safe assistance techniques and instructed to avoid over-assisting in order to promote the patient's independence and strength recovery. Occupational therapy evaluation indicates that prior to hospitalization, the patient was independent with basic self-care,			
23. Signature and Date of Verbal SOC Where Applicable:				25. Date HHA Received Signed POT	
Electronically Signed by Messick, Charles RN on 06/09/2026					
24. Physician's Name and Address			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.		
Sharareh Badri 8617 Loch Raven Blvd Baltimore, MD 21239 PHONE: 443-444-6100 FAX: 14434446110 NPI: 1003278250			F2F date : 02/01/2026		
27. Attending Physician's Signature and Date Signed			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.		
: Date of physician last face-to-face			PAGE 1 of 3		

Home Health Certification and Plan of Care				Order ID: 1150/19626
1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
03238861000	02/12/2026	From: 06/12/2026 To: 08/10/2026	22295	217058
6. Patient's Name and Address Martha Smith 718 E 43rd ST, BALTIMORE, MD 21212- 443-642-0826		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		

functional transfers, and functional ambulation tasks, with assistance from her sons primarily for IADLs. Currently, she demonstrates decreased standing balance, reduced standing tolerance, diminished bilateral upper extremity strength, and limited activity tolerance, all contributing to decreased independence with self-care, functional transfers, and mobility. She utilizes 2 L of oxygen as needed for shortness of breath. The interdisciplinary plan of care includes skilled nursing for cardiopulmonary monitoring, diabetes management, wound care, medication management, and patient/caregiver education; physical therapy to address lower extremity strength, balance, transfer training, fall prevention, and progressive mobility; and occupational therapy to improve upper extremity strength, activity tolerance, self-care performance, and safety with functional tasks. The overall goals are to improve strength and endurance, enhance safety and independence with ADLs and transfers, promote wound healing, ensure medication compliance, reduce fall risk, and prevent rehospitalization. Order</div><div>06/09/2026</div><div>Orders</div><div>Physician Face-to-Face Date: 02/01/2026</div><div>Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Hypertensive Heart Disease With Heart Failure</div><div>Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home</div><div>
</div><div>4 - Recertification Notes: Patient is being recertified due to Heart failure with OSA and bedridden obesity requiring supplemental oxygen with static ulcer to lower right leg requiring wound care makes it a taxing effort to leave the home.</div><div>
</div><div>Physician</div><div>Badri, Sharareh</div>	SN Careplans SN WK2: 1 (06/14/26-06/20/26) ,WK3: 1 (06/21/26-06/27/26) ,WK4: 1 (06/28/26-07/04/26) ,WK5: 1 (07/05/26-07/11/26) 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: 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; 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 ; 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. SN/CG TO CLEANSE RLE STASIS ULCER WITH WOUND CLEANSER, APPLY MEDIHONEY, CALCIUM ALGINATE, 4X4 GAUZE AND WRAP WITH KERLIX, SECURE WITH TAPE DAILY. SON CAPABLE TO PERFORM WOUND CARE ON DAYS SN NOT AVAILABLE. Advance Directive:POLST (Physician Orders for Life-Sustaining Treatment) PROBLEMS IDENTIFIED ON ASSESSMENT: swelling in legs/around eyes, abnormal blood pressure, abn cholesterol > 200 mg/dL, abnormal BS < 70/140 > mg/dL (EN), heartburn/indigestion, #1 - Observable Stasis Ulcer - Other - RLE LATERAL ASPECT - UNABLE TO MEASURE SCATTERED OPEN AREA PROCEDURES: physician-ordered wound care: #1 - Observable Stasis Ulcer - Other - RLE LATERAL ASPECT - UNABLE TO MEASURE SCATTERED OPEN AREA: SN/CG TO CLEANSE RLE STASIS ULCER WITH WOUND CLEANSER, APPLY MEDIHONEY, CALCIUM ALGINATE, 4X4 GAUZE AND WRAP WITH KERLIX, SECURE WITH TAPE DAILY. SON CAPABLE TO PERFORM WOUND CARE ON DAYS SN NOT AVAILABLE., cough/deep breathing exercises, home exercise program: clinician will describe procedure at time of visits 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 medicatio, * 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	SN Goals PATIENT-STATED GOAL: I WANT TO GET STRONGER and resolve upper thigh excursions GOALS patient's living environment is clean/uncluttered patient/caregiver recalls * how to achieve wound healing including cleaning and dressing wound * position changes * skin care * diet modification * preventing pressure ulcer recurrence * record wound measurements * recalls related medication(s) purpose, schedule patient/caregiver recalls * how to manage skin condition including physician-prescribed treatment * skin care * bathing * sun protection * diet * exercise * recalls related medication(s) purpose, schedule patient/caregiver recalls * bowel incontinence management including dietary changes * bowel training * skin 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 * strategies to minimize fatigue and exhaustion including work simplification * energy conservation * lifestyle changes * diet * recalls related medication(s) purpose, schedule meal preparation is available to patient for all meals 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 relaxatio 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) purpos 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
--	---	---

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Mgd by Messick, Charles RN	06/09/2026

Home Health Certification and Plan of Care				Order ID: 1150/19626
1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
03238861000	02/12/2026	From: 06/12/2026 To: 08/10/2026	22295	217058
6. Patient's Name and Address Martha Smith 718 E 43rd ST, BALTIMORE, MD 21212- 443-642-0826		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		
works best to relieve pain teach relaxatio, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpos, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification preventing pressure ulcer recurrence record wound measurements, 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, * how to manage skin condition including physician-prescribed treatment skin care bathing sun protection diet exercise, related medication(s) purpose, schedule, * bowel incontinence management including dietary changes bowel training skin care, related medication(s) purpose, schedule, * urinary incontinence management including bladder training Kegel exercises skin care, 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 living environment has safe floor coverings, patient's living environment is clean/uncluttered, meal preparation is available to patient for all meals		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 medicatio patient living environment has safe floor coverings		

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/09/2026