Home Health Certification and Plan of Care

Order ID: 1150/19825

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
100049536	06/13/2026	From: 06/13/2026 To: 08/11/2026	26818	217058

6. Patient's Name and Address

Carol Peake
930 Bay Forest Court Apt 220,
Annapolis, MD 21403-
410-802-7117

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 06/19/1943 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
C44.42	Squamous cell carcinoma of skin of scalp and neck	06/13/26

13. ICD	Other Pertinent Diagnoses	Date
I87.2	Venous insufficiency (chronic) (peripheral)	06/13/26
L97.822	Non-prs chronic ulcer oth prt l low leg w fat layer exposed	06/13/26
L88.	Pyoderma gangrenosum	06/13/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	06/13/26
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	06/13/26
N18.4	Chronic kidney disease stage 4 (severe)	06/13/26
D63.1	Anemia in chronic kidney disease	06/13/26
J44.9	Chronic obstructive pulmonary disease unspecified	06/13/26
I48.91	Unspecified atrial fibrillation	06/13/26
I65.23	Occlusion and stenosis of bilateral carotid arteries	06/13/26
E11.51	Type 2 diabetes w diabetic peripheral angiopath w/o gangrene	06/13/26
E78.5	Hyperlipidemia unspecified	06/13/26
F41.9	Anxiety disorder unspecified	06/13/26
F32.A	Depression unspecified	06/13/26
K21.9	Gastro-esophageal reflux disease without esophagitis	06/13/26
M10.9	Gout unspecified	06/13/26
G89.29	Other chronic pain	06/13/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	06/13/26
Z79.4	Long term (current) use of insulin	06/13/26
Z79.02	Long term (current) use of antithrombotics/antiplatelets	06/13/26
Z79.82	Long term (current) use of aspirin	06/13/26
Z86.711	Personal history of pulmonary embolism	06/13/26
Z87.891	Personal history of nicotine dependence	06/13/26

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

Metoprolol Tartrate - Metoprolol Tartrate 50 MG / 1 Tablet by mouth two times a day for HTN
ALLOPURINOL 100 MG / 1 Tablet by mouth one time a day for Gout
AMLODIPINE 5 MG / 1 Tablet by mouth one time a day for HTN
OMEPRAZOLE Delayed Release 20 MG / 1 Capsule by mouth one time a day for GERD
Ferrous Sulfate - Ferrous Sulfate: Folic Acid 325 (65 Fe) MG / 1 Tablet by mouth one time a day every other day for Anemia
GABAPENTIN 100 MG / 1 Capsule by mouth two times a day for Neuropathy
CLOPIDOGREL 75 MG / 1 Tablet by mouth one time a day for PE
FOLIC ACID 1 MG / 1 Tablet by mouth one time a day for Supplement
ASPIRIN Chewable 81 MG / 1 Tablet by mouth one time a day for PPX
Sennosides - Senna 8.6-50 MG / 1 Tablet by mouth at bedtime for Bowel Regimen
METHOCARBAMOL 500 MG / 1 Tablet by mouth four times a day for muscle relaxant for 10 Days
ATORVASTATIN 40 MG / 1 Tablet by mouth at bedtime for HLD
ACETAMINOPHEN 500 MG / 1 Tablet by mouth every 6 hours as needed for Pain
Sodium Bicarbonate (Antacid) 650 mg/tablet / Give 2 tablet by mouth twice a day for Supplement
QUETIAPINE FUMARATE 25 MG / 1 Tablet by mouth at bedtime for behavior disturbance
PREDNISONE 20 mg/tablet / Give 2 tablet by mouth one time a day for inflammation for 10 Days give with breakfast daily
Tylenol W/ Codeine No. 3 - Acetaminophen: Codeine Phosphate 300 mg;30 mg 1 tab by mouth every 4 hours Pain
Tylenol W/ Codeine No. 3 - Acetaminophen: Codeine Phosphate 300 mg;30 mg 1 tab by mouth every 4 hours Pain
NYSTATIN External Powder 100000 UNIT/GM / Apply to abdominal folds topical two times a day for fungal infection

14. DME and Supplies:

wound care supplies, wheelchair, rolling walker, bath bench

15. Safety Measures:

walker precautions, standard precautions, medication safety, medical alert/lifeline, emergency phone # clearly displayed, cardiac precautions, bathroom safety, ambulates with device

16. Nutrition:

renal diet

17. Allergies:

procardia

18.A. Functional Limitations

Endurance

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: 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: 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

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

Homebound status: Due to diagnosis of Squamous cell carcinoma of skin of scalp and neck, 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: The patient is an 83-year-old female admitted to home health services with a significant past medical history of squamous cell carcinoma of the scalp status post excision and wound closure, non-healing left lower extremity ulcer with cellulitis, peripheral vascular disease, pyoderma gangrenosum, severe anemia requiring packed red blood cell transfusion, chronic kidney disease stage IV, hypertension, cerebrovascular accident, hypocalcemia, gout, chronic left ankle and foot pain, and a reported history of diabetes mellitus for which she is not currently taking any oral or injectable medications. The patient recently underwent excision of scalp squamous cell carcinoma on 04/16, followed by scalp wound closure by plastic surgery on 05/11. She was hospitalized after presenting with slurred speech, left ankle cellulitis, and severe anemia requiring transfusion, with subsequent fluid overload secondary to blood product administration. Additional recent interventions include an aortogram with lower extremity runoff and angioplasty of the lower extremities performed on 05/18. The patient has a history of two strokes occurring in September and November and underwent a left hip replacement in 2024. The patient resides alone in a senior apartment complex and receives daily assistance from caregiver Jennifer for medication management and activities of daily living. Additional support is provided by her daughter, who serves as the primary caregiver, a home health aide who assists with basic and instrumental activities of daily living for four hours twice weekly, and a neighbor, Diane, who assists with wound care on non-nursing days. Admission paperwork was completed and signed by the patient. During assessment, the patient was alert and oriented to person, place, and time and demonstrated the ability to communicate her needs appropriately. She reported mild left lower extremity wound pain rated 5/10, which she stated is adequately controlled with her current pain management regimen. Medication reconciliation was completed with no missed doses identified and no refill needs reported. Wound care was performed according to physician orders, and additional wound care supplies will be ordered as needed. The patient continues to have a non-healing left

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 06/13/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

James Clyne
137 Mitchells Chance Rd
Edgewater, MD 21037
PHONE: 4102248220 FAX: 14103672118 NPI: 1952697047

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 : 06/05/2026

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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lower extremity ulcer requiring ongoing skilled nursing assessment and treatment. She also has a healing scalp wound status post surgical closure. The patient ambulates within her apartment using a rollator walker and reports long-term use of the device since 2014 due to hip pain and mobility limitations. Although she denied a recent history of falls, assessment revealed impaired functional mobility, unsteady gait, difficulty with transfers, decreased balance, reduced lower extremity strength, decreased safety awareness, and an increased risk for falls. She requires moderate assistance with basic activities of daily living and is dependent on others for many instrumental activities of daily living, including transportation, grocery shopping, laundry, and mail retrieval. The patient expressed a desire to improve her strength and maintain independence within her home environment. Skilled nursing services remain medically necessary for ongoing wound assessment and management, monitoring for signs and symptoms of infection, medication management, disease process education, and surveillance of chronic conditions including anemia, hypertension, chronic kidney disease, peripheral vascular disease, and diabetes history. Skilled physical therapy is medically necessary to address lower extremity pain, weakness, impaired balance, gait instability, transfer deficits, reduced endurance, and fall risk. Therapy interventions will focus on improving strength, functional mobility, transfer safety, ambulation with assistive devices, balance, and overall safety awareness to maximize independence and prevent further functional decline, falls, and potential rehospitalization. Skilled occupational therapy is also warranted to improve upper extremity strength, functional performance with activities of daily living, energy conservation, safety during self-care tasks, and prevention of further deconditioning. The patient is homebound due to impaired mobility, decreased endurance, dyspnea with exertion, increased fall risk, and the need for a rollator walker and caregiver assistance to safely leave the home. Continued interdisciplinary home health services are indicated to promote wound healing, improve functional status, maintain safety, and support the patient's goal of remaining independent in her home environment.
 Date of Order 06/13/2026 Orders Physician Face-to-Face Date: 06/05/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management, pt-eval & treat, ot-eval & treat due to Squamous cell carcinoma of skin of scalp and neck 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 Clyne, James

SN Careplans

SN WK1: 1 (06/13/26-06/13/26) ,WK2: 1 (06/14/26-06/20/26) ,WK3: 1 (06/21/26-06/27/26) ,WK4: 1 (06/28/26-07/04/26) ,WK6: 1 (07/12/26-07/18/26) ,WK8: 1 (07/26/26-08/01/26)

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, 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
Advance Directive:POLST (Physician Orders for Life-Sustaining Treatment)

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, meal preparation, M2020 - Oral Med Management, M1400 - Dyspnea, M1033 - Exhaustion, abnormal bowel sounds, M1610 - Urinary Incontinence, swelling of affected area, limited endurance, limited range of motion, limited strength, muscle weakness, Pain Effect on Sleep, Pain Interference with ADLs, Pain Interference with Therapy activities, swell/redness surround. skin, rough/scaly/cracked skin, #1 - Diabetic Ulcer - Posterior Left Calf - Site cleaned with NSS,patted dry, Manuka honey applied to woundbed, calcium algenate applied , covered with abd pad, wrapped/ se used with kerlix wrap, #2 - Open Wound - Other - Scalp - Site cleaned with NSS,posted dried, covered with Bordered gauze

PROCEDURES: physician-ordered wound care: #2 - Open Wound - Other - Scalp - Site cleaned with NSS,posted dried, covered with Bordered gauze: - Open Wound - Other - Scalp - Site cleaned with NSS,posted dried, covered with Bordered gauze, physician-ordered wound care: #1 - Diabetic Ulcer - Posterior Left Calf - Site cleaned with NSS,patted dry, Manuka honey applied to woundbed, calcium algenate applied , covered with abd pad, wrapped/ se used with kerlix wrap: Diabetic Ulcer - Posterior Left Calf - Site cleaned with NSS,patted dry, Manuka honey applied to woundbed, calcium algenate applied , covered with abd pad, wrapped/ se used with kerlix wrap, cough/deep breathing exercises, incentive spirometer, monitor intake & output, bladder training, coordinate/arrange preparation of missing meals, monitor dialysis schedule

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, * 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, * 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, meal preparation is available to patient for all meals

SN Goals

PATIENT-STATED GOAL: Maintain my wound and care for them so they wil not get infected

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
* 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

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

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

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

06/13/2026

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PT 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)

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, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170E1 - Chair to Bed to Chair

PROCEDURES: home exercise program: Seated-LAQ hip flex, hip abd, pillow squeeze. Standing-Mini squat, heel/toe raise, hip flex, hip abd, hip ext, leg curls., dynamic standing balance exercises: Dynamic balance activity to be performed on firm surface with no hands on device, weight shifting L-R with wide BOS, and forward backward with separated stance., 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 - 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

PATIENT-STATED GOAL: I want to improve my strength in my legs.

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Sit to Stand - 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

OT Careplans

OT 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) ,WK6: 1 (07/12/26-07/18/26)

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: cough/deep breathing exercises, incentive spirometer, home exercise program, 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 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
* 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

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

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/13/2026