Home Health Certification and Plan of Care

Order ID: 1150/19787

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
2RX1N11FN17	06/13/2026	From: 06/13/2026 To: 08/11/2026	26839	217058

6. Patient's Name and Address
Margaret Klein
1315 Ridge Road,
Catonsville, MD 21228-
410-747-5073

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 04/19/1942 | **9.Sex** Female

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

BUMETANIDE 1 MG / 1 Tablet by mouth two times a day for EDEMA, for CHF
SPIRONOLACTONE 25 MG / 1 Tablet by mouth one time a day for edma
Monitor for Side Effects Diuretics for signs and symptoms of dehydration, electrolytes, acute kidney injury, monitor for edema, congestion, weight changes.
Rivaroxaban 15 MG / 1 Tablet by mouth once a day for A-fib

11. ICD	Principal Diagnosis	Date
L03.115	Cellulitis of right lower limb	06/13/26

13. ICD	Other Pertinent Diagnoses	Date
I89.0	Lymphedema not elsewhere classified	06/13/26
I87.2	Venous insufficiency (chronic) (peripheral)	06/13/26
I50.33	Acute on chronic diastolic (congestive) heart failure	06/13/26
I82.4Z3	Ac emblsm and thombos unsp deep veins of dist low extrm bi	06/13/26
I48.19	Other persistent atrial fibrillation	06/13/26
I95.9	Hypotension unspecified	06/13/26
D63.8	Anemia in other chronic diseases classified elsewhere	06/13/26
E46.	Unspecified protein-calorie malnutrition	06/13/26
I49.8	Other specified cardiac arrhythmias	06/13/26
F41.1	Generalized anxiety disorder	06/13/26
F33.1	Major depressive disorder recurrent moderate	06/13/26
M19.011	Primary osteoarthritis right shoulder	06/13/26
G47.00	Insomnia unspecified	06/13/26
Z79.01	Long term (current) use of anticoagulants	06/13/26
Z87.891	Personal history of nicotine dependence	06/13/26

14. DME and Supplies:
cane

15. Safety Measures:
bleeding precautions, fall precautions, standard precautions, ambulates with device

16. Nutrition:
cardiac diet

17. Allergies:
bactrim sertraline

18.A. Functional Limitations
Ambulation

18.B. Activities Permitted
Cane

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
patient will be responsible for managing treatment
family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Cellulitis of right lower limb, 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 84-year-old female recently discharged from a subacute rehabilitation facility following hospitalization related to worsening lymphedema of the right lower extremity. Her past medical history is significant for congestive heart failure (CHF), atrial fibrillation, deep vein thrombosis (DVT), lymphedema, and failure to thrive. The patient resides with her husband in a multi-level home, with her bedroom and bathroom located on the second floor. She is considered homebound due to her chronic cardiac conditions, history of DVT, and significant right lower extremity lymphedema, which increase her risk for falls and make leaving the home a taxing effort. The patient ambulates with an assistive device and requires human assistance when leaving the home to ensure safety. Upon skilled nursing assessment, the patient was alert and oriented to person, place, and time and denied any current complaints or acute distress. Vital signs were stable. Respirations were even and unlabored, and lung sounds were clear to auscultation bilaterally. Skin assessment revealed warm, dry, and intact skin overall, with bruising noted to the left forearm and a skin tear present on the right forearm. Persistent lymphedema was observed in the right lower extremity. No additional skin integrity concerns were identified during the visit. A physical therapy evaluation was completed. Prior to hospitalization, the patient was independently ambulatory with a single-point cane, although mobility was intermittently limited by pain and fluctuating edema. At the time of evaluation, the patient demonstrated decreased bilateral lower extremity strength, measured at 3+/5 on manual muscle testing. She was modified independent with transfers but required supervision for short-distance ambulation and stair negotiation using a single-point cane. The patient declined ongoing physical therapy services at this time; however, she was receptive to education and instruction regarding a home exercise program consisting of standing bilateral lower extremity therapeutic exercises. She demonstrated understanding of the exercises and recommendations provided. An occupational therapy evaluation was also completed. The patient demonstrated independence with dressing tasks, toileting, hygiene, clothing management, sit-to-stand transfers, and toilet transfers using appropriate transfer techniques. She requires only setup assistance for showering and is able to perform light meal preparation activities. Bilateral upper extremity strength was within normal limits at 5/5 on manual muscle testing. Based on the evaluation findings, the patient is functioning near her baseline level for activities of daily living and does not require further skilled occupational therapy services at this time. Skilled nursing services remain medically necessary for ongoing assessment and monitoring of cardiopulmonary status, management of CHF, atrial fibrillation, DVT history, and right lower extremity lymphedema, as well as skin integrity surveillance, fall prevention, medication management, and reinforcement of disease process education. The patient was instructed to continue prescribed safety measures, utilize assistive devices as recommended, monitor for worsening edema or cardiopulmonary symptoms, and notify her healthcare provider of any significant changes in condition. The plan of care focuses on maintaining safety, preventing complications and rehospitalization, and supporting the patient's functional independence within the home environment.
 Date of Order 06/13/2026 Orders Physician Face-to-Face Date: 06/08/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Cellulitis of right

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
Ashaben Patel
6501 Baltimore National Pike Ste D
Catonsville, MD 21228
PHONE: 6672342100 FAX: 16672342991 NPI: 1447018999

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 : 06/08/2026

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 limb 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 Patel, Ashaben

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) ,WK5: 1 (07/05/26-07/11/26) ,WK6: 1 (07/12/26-07/18/26) ,WK7: 1 (07/19/26-07/25/26) ,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: 0. No assistance needed - patient is independent or does not have needs in this area

HOSPITALIZATION RISKS: 3. Multiple hospitalizations (2 or more) in the past 6 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

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:Do not resuscitate (DNR) orders

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2020 - Oral Med Management, M1400 - Dyspnea, swelling of affected area, B1000 - Vision Deficit, bruising/discoloration

PROCEDURES: cough/deep breathing exercises, incentive spirometer, apply anti-embolitic stockings, apply compression bandage, physician-ordered wound care, 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, * 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

SN Goals

PATIENT-STATED GOAL: To be independent again

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
* 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

PT Careplans

PT WK1: 1 (06/13/26-06/13/26)

PT Goals

PATIENT-STATED GOAL: Pt reports she is at her baseline

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/13/2026

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PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170D1 - Sit to Stand, GG0170F1 - Toilet Transfer, GG0170M1 - 1 - Step (curb), GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170P1 - Picking Up Object, GG0170I1 - Walk 10 Feet, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170K1 - Walk 150 Feet, GG0170J1 - Walk 50 ft with 2 Turns

PROCEDURES: home exercise program: standing heel/ toe raises, knee flex, hip flex, hip abd at least 1x10 with UE support as needed

OT Careplans	OT Goals
OT WK1: 1 (06/13/26-06/13/26) PROBLEMS IDENTIFIED ON ASSESSMENT: M1400, GG0130B1 - Oral Hygiene, GG0130C1 - Toileting Hygiene, GG0130E1 - Shower/Bathe Self, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130A1 - Eating, GG0130F1 - Upper Body Dressing	PATIENT-STATED GOAL: Eval only

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