Home Health Certification and Plan of Care

Order ID: 1150/19847

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
8AV8N47DN45	06/15/2026	From: 06/15/2026 To: 08/13/2026	26896	217058

6. Patient's Name and Address
Marie Gellert
7628 Gough Street,
BALTIMORE, MD 21224-
410-288-4278

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 05/10/1944 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
L89.313	Pressure ulcer of right buttock stage 3	06/15/26

13. ICD	Other Pertinent Diagnoses	Date
L24.9	Irritant contact dermatitis unspecified cause	06/15/26
I11.0	Hypertensive heart disease with heart failure	06/15/26
I50.32	Chronic diastolic (congestive) heart failure	06/15/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	06/15/26
E78.5	Hyperlipidemia unspecified	06/15/26
D50.9	Iron deficiency anemia unspecified	06/15/26
Z95.810	Presence of automatic (implantable) cardiac defibrillator	06/15/26

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

DICLOFENAC 2 gems apply to both knees topically every 6 hours for Pain management unsupervised self-administration
Tylenol - Acetaminophen 325 mg/tablet / Give 2 tablet by mouth every 6 hours as needed for knee pain and fever of 100 and greater
ROSUVASTATIN CALCIUM 40 mg tablet by mouth at bedtime for HLD
METOPROLOL tablet by mouth every 12 hours for systolic less than 90 or HR less than 60
Fluticasone-Salmeterol Inhalation Aerosol Powder Breath Activated 250-50 MCG/ACT / 1 Inhalation by mouth every 12 hours for Asthma Rinse mouth and expectorate after use
Ferrous Sulfate - Ferrous Sulfate: Folic Acid 325 (65 Fe) MG / 1 Tablet by mouth once a day every other day for iron deficiency give with food
CALCITRIOL 1 capsule by mouth one time a day every Mon, Wed, Fri for AKI
Zinc Oxide - Zinc Oxide External Paste 20 % / Apply to coccyx topical as necessary every shift for IAD prevention

14. DME and Supplies:
rolling walker, bath bench, walker, grab bars, , cane

15. Safety Measures:
walker precautions, medication safety, fall precautions, ambulates with device, standard precautions, knee precautions, bathroom safety

16. Nutrition:
cardiac diet, regular

17. Allergies:
codeine sulfa antibiotics

18.A. Functional Limitations
Ambulation

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: No

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

Homebound status: Due to diagnosis of Pressure ulcer of right buttock stage 3, 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 82-year-old female admitted to home health services with a past medical history significant for hypertension, asthma, atherosclerotic heart disease of the native coronary artery without angina pectoris, hyperlipidemia, and other chronic comorbidities. The patient is alert and oriented to person, place, time, and situation (A&O x4). She reported that she initially developed a fever and contacted her primary care provider, who advised evaluation at an urgent care center. However, while attempting to get up, she lost her balance and was subsequently transported to the emergency department for further evaluation and treatment. During her hospitalization, the patient developed pressure injuries and was later transferred to a rehabilitation facility for wound management and therapy services before returning home. Upon assessment, previously reported pressure sores were found to be fully healed, with skin warm, dry, and intact and no evidence of current skin breakdown. Vital signs were within normal limits, and respirations were even and unlabored. The patient reported bilateral knee pain rated at 4/10, which she manages effectively with prescribed pain medications and topical analgesic creams. Physical assessment revealed +2 bilateral lower extremity edema. Education was provided regarding edema management, including the importance of routine lower extremity elevation to promote venous return and reduce swelling. Medication reconciliation and review were completed with the patient, including reinforcement of medication adherence and monitoring for potential side effects. The patient has an implantable cardioverter-defibrillator (ICD) located in the left upper chest, originally implanted in May 2017. She resides alone in a multi-level home but receives regular assistance and supervision from two cousins, with her cousin Pam serving as the primary caregiver. Due to mobility limitations, the patient utilizes a rollator walker on the main level of the home and a standard walker on the upper level. A stair lift has been installed to allow safe access to her upstairs bedroom. The patient remains at risk for falls due to her recent balance impairment, lower extremity edema, chronic bilateral knee pain, and overall medical complexity. Skilled nursing services remain medically necessary for ongoing assessment, disease process management, medication education, monitoring of cardiovascular and respiratory status, edema management, skin integrity surveillance, fall prevention education, and reinforcement of safety measures to support the patient's continued recovery and ability to remain safely in the home environment.
 Date of Order 06/15/2026 Orders Physician Face-to-Face Date: 06/02/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Pressure ulcer of right buttock stage 3 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
 Physician Collector, Daniel

SN Careplans

SN WK1: 1 (06/15/26-06/20/26)

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,

SN Goals

PATIENT-STATED GOAL: To get back to my baseline and be independent

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

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 06/15/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Daniel Collector
7505 Osler Dr #405
Towson, MD 21204
PHONE: 410-427-5551 FAX: 14106166823 NPI: 1255341475

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 : 06/02/2026

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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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; 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:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, meal preparation, abnormal blood pressure, M1033 - Exhaustion, M1400 - Dyspnea, muscle weakness, balance deficit, Pain Interference with ADLs

PROCEDURES: cough/deep breathing exercises

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, * 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

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
* 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

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/15/2026