Home Health Certification and Plan of Care

Order ID: 1150/20004

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
77324925	06/23/2026	From: 06/23/2026 To: 08/21/2026	27287	217058

6. Patient's Name and Address

Bernice Jackson
4200 Main Avenue,
GWYNN OAK, MD 21207-
443-841-8193

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 07/19/1941 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
J18.9	Pneumonia unspecified organism	06/23/26

13. ICD	Other Pertinent Diagnoses	Date
I12.0	Hyp chr kidney disease w stage 5 chr kidney disease or ESRD	06/23/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	06/23/26
N18.6	End stage renal disease	06/23/26
I48.91	Unspecified atrial fibrillation	06/23/26
K59.00	Constipation unspecified	06/23/26
N39.498	Other specified urinary incontinence	06/23/26
R15.9	Full incontinence of feces	06/23/26
F43.21	Adjustment disorder with depressed mood	06/23/26
H40.9	Unspecified glaucoma	06/23/26
Z99.2	Dependence on renal dialysis	06/23/26
Z79.01	Long term (current) use of anticoagulants	06/23/26

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

Calcium Acetate - Calcium Acetate 667 mg/capsule / Give 2 capsules by mouth with meals for ESRD
ELIQUIS 2.5 MG / 1 Tablet by mouth two times a day for A-fib
Foltrin (Ferrous Fumarate w/ B12-Vit C-FA-IFC) Give 1 capsule by mouth once a day for ESRD
Metoprolol Tartrate - Metoprolol Tartrate 25 MG / 1 Tablet by mouth two times a day for HTN
LATANOPROST Solution 0.005% / Instill 1 drop in both eyes at bedtime for Glaucoma
Lidocaine Patch - Lidocaine 4% / Apply to Lower back topically in the morning for Pain

14. DME and Supplies:

4 wheeled walker, walker, wheelchair

15. Safety Measures:

ambulates with device, diabetic precautions, fall precautions, medication safety, non-slip surface in tub, walker precautions, ambulates with assistance, wheelchair precautions, standard precautions, bathroom safety, activity supervision

16. Nutrition:

renal diet, fluid restriction

17. Allergies:

Statins: unspecified

18.A. Functional Limitations

Endurance, Bowel/Bladder Incontinence, Dyspnea With Minimal Exertion, Ambulation, Hearing

18.B. Activities Permitted

Wheelchair, Walker

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: good

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: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities.

22.B.Discharge Plans

patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Pneumonia unspecified organism, 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 for pneumonia. Her past medical history is significant for hypertension, atrial fibrillation, diabetes mellitus, chronic kidney disease (CKD), end-stage renal disease (ESRD) requiring hemodialysis three times weekly (Monday, Wednesday, and Friday), and glaucoma. The patient resides alone in a multi-level home with a first-floor living arrangement and has a supportive family network, including a brother and grandson who assist with obtaining food, transportation, and routine wellness checks. She utilizes Mobility transportation services for medical appointments. Advance care planning was reviewed during the visit. The patient is currently designated as Do Not Resuscitate (DNR) and Do Not Intubate (DNI). She stated that she intends to discuss her advance care wishes further with her grandchildren and son. The registered nurse reinforced that the current advance directive will remain in effect unless formally changed, and the patient verbalized understanding. Upon assessment, the patient was alert and oriented to person, place, time, and situation (A&O 4). Vital signs were obtained and were stable with the exception of elevated blood pressure, which the patient attributed to not having taken her prescribed metoprolol prior to the visit. Medication adherence and the importance of taking antihypertensive medications as prescribed were reinforced, and the patient demonstrated understanding. Respiratory assessment revealed rhonchi on auscultation without observed cough. The patient reported persistent generalized weakness, fatigue, and decreased activity tolerance following her recent pneumonia. Cardiovascular assessment demonstrated normal S1 and S2 heart sounds. Gastrointestinal assessment revealed bowel sounds present in all four quadrants. Examination of the left upper extremity arteriovenous dialysis access demonstrated a palpable thrill and audible bruit, indicating a patent vascular access for hemodialysis. The patient exhibits significant functional decline compared to her prior level of function. Before hospitalization, she ambulated independently indoors without an assistive device and utilized a rolling walker outdoors. Currently, she ambulates with a rolling walker and frequently relies on furniture for additional support, demonstrating impaired balance, decreased endurance, and increased fall risk. A wheelchair is available for mobility assistance as needed. Physical therapy evaluation revealed bilateral lower extremity weakness with manual muscle testing (MMT) graded at 3/5, requiring contact guard assistance for transfers and short-distance ambulation using a rolling walker. Occupational therapy assessment identified bilateral upper extremity weakness with MMT of 3+/5. The patient requires setup to standby assistance for upper and lower body dressing, toileting hygiene, clothing management, sit-to-stand transfers, and toilet transfers, with minimal verbal cueing for proper limb placement and transfer techniques. Additionally, the patient is hard of hearing and has visual deficits secondary to glaucoma, further impacting safety, mobility, and independence within the home environment. Skilled nursing services will continue once weekly for eight weeks to provide comprehensive assessment and management of the patient's medical conditions, including medication reconciliation and adherence, monitoring of vital signs, cardiopulmonary status, dialysis access assessment, nutritional status, and overall clinical condition. Ongoing education will focus on disease process management, medication compliance, blood pressure monitoring, fall prevention, energy conservation techniques, home safety, infection prevention, and recognition of signs and symptoms requiring prompt medical attention. Skilled physical therapy will focus on improving lower extremity strength, balance, endurance, gait, transfer ability, and functional mobility to maximize safety and facilitate return to the patient's prior level of function. Occupational therapy will address upper extremity strengthening, activities of daily living (ADL) performance, transfer training, adaptive techniques, and home safety strategies to promote independence and reduce the risk of falls and hospitalization.
 Date of Order 06/23/2026 Orders Physician Face-to-Face Date: 06/18/2024 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management, pt-eval & treat, ot-eval & treat, hha-adl's due to Pneumonia unspecified organism Homebound Status per Certifying Physician: patient requires another person or medical equipment

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 06/23/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Raymond Dormevil
7141 Security Blvd
Baltimore, MD 21244
PHONE: 443-663-6000 FAX: 14436636215 NPI: 1245627892

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 : 06/18/2024

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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such as crutches, a walker, or a wheelchair to leave home
 1 - SOC - SN Notes: soc PT Eval Notes: OT Eval Notes:
 Physician Dormevil, Raymond

SN Careplans

SN WK1: 1 (06/23/26-06/27/26) ,WK2: 1 (06/28/26-07/04/26) ,WK3: 1 (07/05/26-07/11/26) ,WK4: 1 (07/12/26-07/18/26) ,WK5: 1 (07/19/26-07/25/26) ,WK6: 1 (07/26/26-08/01/26) ,WK7: 1 (08/02/26-08/08/26) ,WK8: 1 (08/09/26-08/15/26)

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: 2. Non-agency caregiver(s) need training/supportive services to provide assistance

HOSPITALIZATION RISKS: 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, 8. Currently reports exhaustion, 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:DNR/DNI

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2102d - Caregiver Performs Treatment, M2102c - Med Admin, meal preparation, M2102f - Patient Supervision, Financial, M2020 - Oral Med Management, M1033 - Exhaustion, M1400 - Dyspnea, dependent edema, abnormal blood pressure, constipation, diarrhea, M1610 - Urinary Incontinence, limited endurance, muscle weakness, limited strength, B1000 - Vision Deficit, lethargy, balance deficit, loss of appetite

PROCEDURES: Medication Review : Medications reviewed with Patient/caregiver., cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange preparation of missing meals: activating meals on wheels to help while patient gets stronger, coordinate/arrange patient access to necessary nutrition considering patient inability to pay, coordinate/arrange resources for vision-impaired, monitor dialysis schedule: Monday/Wednesday/Friday

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, * 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, * 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, patient has access to necessary nutrition considering patient inability to pay, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver administers and/or packages

SN Goals

PATIENT-STATED GOAL: I want to get back in my kitchen and stand for longer.

GOALS
patient/caregiver recalls
* urinary incontinence management including bladder training
* Kegel exercises
* skin care
* 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/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
* 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 has access to necessary nutrition considering patient inability to pay

patient is adequately supervised

meal preparation is available to patient for all meals

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

Medication Review

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/23/2026

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medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence, Medication Review

PT Careplans

PT WK1: 1 (06/23/26-06/27/26) ,WK3: 1 (07/05/26-07/11/26) ,WK5: 1 (07/19/26-07/25/26) ,WK7: 1 (08/02/26-08/08/26) ,WK9: 1 (08/16/26-08/21/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170D1 - Sit to Stand, GG0170F1 - Toilet 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, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170L1 - Walk 10 ft on Uneven Surface

PROCEDURES: Medication Review: - medications reviewed with patient/caregiver, home exercise program: Review HEP: seated knee ext, hip flex, hip abd, quad sets, gluteal squeezes, ankle pumps at least 1x10. Once tolerated, upgrade to standing heel/ toe raises, knee flex, hip flex, hip abd at least 1x10 with UE support as needed. Upgrade as tolerated, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 05. Setup or clean-up assistance, Chair to Bed to Chair - 05. Setup or clean-up assistance, Toilet Transfer - 05. Setup or clean-up assistance, 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, Car Transfer - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

PT Goals

PATIENT-STATED GOAL: To be able to walk without help

GOALS
Sit to Stand - 05. Setup or clean-up assistance

Chair to Bed to Chair - 05. Setup or clean-up assistance

Toilet Transfer - 05. Setup or clean-up assistance

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

Car Transfer - 05. Setup or clean-up assistance

Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

OT Careplans

OT WK1: 1 (06/23/26-06/27/26) ,WK2: 1 (06/28/26-07/04/26) ,WK3: 1 (07/05/26-07/11/26) ,WK4: 1 (07/12/26-07/18/26) ,WK5: 1 (07/19/26-07/25/26) ,WK6: 1 (07/26/26-08/01/26)

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

PROCEDURES: Functional ambulation : Using rolling walker, Patient/caregiver recalls related purpose and schedule of medications: Medication Review, therapeutic exercises: Using dumbbells or therabands to perform bilateral upper extremity muscle strength exercises, work simplification/energy conservation, transfers training: To address sit to stand and toliet transfers

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, Toilet Transfer - 06. Independent, 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, Patient will demonstrates improved bilateral upper extremity muscle strength from 3+/5 mmt to 4+/5 mmt to improve Adls and transfers safely

OT Goals

PATIENT-STATED GOAL: Patient wants to get stronger

GOALS
Toilet Transfer - 06. Independent

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

Patient will demonstrates improved bilateral upper extremity muscle strength from 3+/5 mmt to 4+/5 mmt to improve Adls and transfers safely

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/23/2026