Home Health Certification and Plan of Care

Order ID: 1150/20086

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
AA00003888	06/25/2026	From: 06/25/2026 To: 08/23/2026	27380	217058

6. Patient's Name and Address
Joann Tufts
3602 Monterey Road Apt C,
Baltimore, MD 21218
443-844-0597

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 12/12/1944 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
N39.0	Urinary tract infection site not specified	06/25/26

13. ICD	Other Pertinent Diagnoses	Date
B96.1	Klebsiella pneumoniae as the cause of diseases classd elswhr	06/25/26
N28.1	Cyst of kidney acquired	06/25/26
I10.	Essential (primary) hypertension	06/25/26
E11.9	Type 2 diabetes mellitus without complications	06/25/26
E78.5	Hyperlipidemia unspecified	06/25/26
D86.9	Sarcoidosis unspecified	06/25/26
M17.0	Bilateral primary osteoarthritis of knee	06/25/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	06/25/26
Z79.4	Long term (current) use of insulin	06/25/26
Z79.82	Long term (current) use of aspirin	06/25/26
Z90.710	Acquired absence of both cervix and uterus	06/25/26

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

Metoprolol Succinate - Metoprolol Succinate 200 mg = 1 tab PO qPM
METFORMIN 1,000 mg PO once a day Diabetes management
HYDROCHLOROTHIAZIDE 25 mg = 1 tab PO Daily
LOSARTAN POTASSIUM 100 mg = 1 tab PO Daily HTN
AMLODIPINE 10 mg = 1 tab PO qPM
ASPIRIN 81 mg = 1 tab PO Daily
ACETAMINOPHEN 500 mg = 1 tab PO q6h PRN as needed for pain
ATORVASTATIN 40 mg = 1 tab PO at bedtime
LANTUS 100 units/mL / 45 units subcutaneous Daily

14. DME and Supplies:
walker, diabetic supplies, commode, cane, bath bench

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

16. Nutrition:
diabetic

17. Allergies:
No Known Allergies

18.A. Functional Limitations
None of the above

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: 1. In new or complex situations only, SOCIAL ISOLATION: 1. Rarely, 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: 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 Urinary tract infection site not specified, 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 81-year-old African American female admitted to home health services following a recent short-term hospitalization for severe right lower quadrant abdominal pain and a urinary tract infection (UTI). Her past medical history is significant for hypertension (HTN), type 2 diabetes mellitus (T2DM), sarcoidosis, renal cysts, bilateral knee osteoarthritis, recurrent UTIs, and a prior hysterectomy. Prior to hospitalization, the patient lived independently in an apartment with eight steps required for entry and was independent with basic activities of daily living, functional transfers, and household ambulation. Upon the Start of Care visit, the patient was alert and oriented to person, place, time, and situation (A&O 4) and denied pain at the time of assessment. She also denied shortness of breath, chest pain, dizziness, lightheadedness, nausea, and vomiting. Pulmonary assessment revealed lungs clear to auscultation bilaterally. Bowel sounds were present and active in all quadrants, with the patient reporting her last bowel movement occurred earlier that morning. Skin was warm, dry, and intact, with palpable peripheral pulses and no edema noted. The patient reported stress urinary incontinence, which she manages with absorbent pads. Vital signs were obtained and remained within acceptable parameters. A comprehensive physical assessment was completed, medications were reviewed and reconciled, and the patient was admitted to home health services. Education was provided regarding medication compliance, management of chronic conditions including hypertension and diabetes, fall prevention strategies, infection prevention, recognition of signs and symptoms requiring physician notification, and when to seek emergency medical care. The patient demonstrated understanding of the education provided. The patient resides alone but has a supportive family, with one son present during the visit and another son living nearby. Physical therapy evaluation revealed the patient is independent with bed mobility but requires supervision for transfers to and from the toilet, chair, and bedside. She ambulates approximately 30 feet within the home using a cane under supervision and is able to negotiate the eight entrance steps with the use of a handrail and cane while requiring supervision and verbal cueing for proper technique. Outdoor ambulation and car transfer abilities were not assessed during this evaluation. The patient is considered homebound due to the considerable and taxing effort required to leave the home, reliance on an assistive device, and need for supervision with functional mobility. Her Tinetti Balance and Gait Assessment score of 16/28 indicates impaired balance and gait with an increased risk for falls. The patient tolerated therapeutic exercises consisting of 10 repetitions each of supine hip flexion, bridging, straight leg raises, hip abduction, knee extension, and ankle pumps without adverse response. Skilled physical therapy is medically necessary to improve lower extremity strength, balance, gait, endurance, stair negotiation, and overall functional mobility with the goal of returning the patient to her prior level of independence while minimizing fall risk. An occupational therapy evaluation was also completed following hospitalization. The patient demonstrated independence with basic self-care activities, functional transfers, and functional ambulation within the home and was found to have returned to her prior level of function for activities of daily living. No skilled occupational therapy deficits were identified; therefore, no further occupational therapy services are warranted, and evaluation only was completed. The plan of care includes continued skilled nursing for ongoing assessment, medication management, chronic disease monitoring, patient education, and surveillance for signs and symptoms of infection or disease exacerbation. Skilled physical therapy will continue to focus on strengthening, balance training, gait and transfer training, endurance enhancement, fall prevention, and improving functional mobility to maximize safety and independence within the home environment.
 Date of Order 06/25/2026 Orders Physician Face-to-Face Date: 06/22/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Urinary tract infection site not specified 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:

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 06/25/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Emily Sippel
3700 Fleet St
Baltimore, MD 21212
PHONE: 4105584900 FAX: 14105221475 NPI: 1306983192

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 : 06/22/2026

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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soc PT Eval Notes: OT Eval Notes:
 Physician Sippel, Emily

SN Careplans

SN WK1: 1 (06/25/26-06/27/26) ,WK2: 1 (06/28/26-07/04/26) ,WK3: 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: 0. No assistance needed - patient is independent or does not have needs in this area

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; 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:MO(L)ST

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2020 - Oral Med Management, M1033 - Exhaustion, M1400 - Dyspnea, abnormal BS < 70/140 > mg/dL, abdominal pain, M1600 - UTI, M1610 - Urinary Incontinence, muscle weakness, limited strength, Pain Interference with ADLs

PROCEDURES: cough/deep breathing exercises, glucose testing via monitor, bladder training

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, * prevention including increase fluid intake increase Vitamin C intake to promote acidic bladder environment (cranberry juice) perineal hygiene, 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

SN Goals

PATIENT-STATED GOAL: I want to feel better and move around more.

GOALS
patient/caregiver recalls
* prevention including increase fluid intake
* increase Vitamin C intake to promote acidic bladder environment (cranberry juice)
* perineal hygiene
* 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 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
* 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
* 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

PT Careplans

PT Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

06/25/2026

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PT 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)

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, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair

PROCEDURES: home exercise program: Supine quad sets, short arc quads, hip flexion, straight leg raise, hip abduction. Standing knee flexion, hip abduction, hip extension, plantarflexion, squats. Sitting knee extension, ankle pumps, gait training on uneven surfaces, 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 - 06. Independent, Walk 10 Feet - 05. Setup or clean-up assistance, Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance, Walk 150 Feet - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance, 1 - Step (curb) - 05. Setup or clean-up assistance, 4 Steps - 05. Setup or clean-up assistance, 12 Steps - 05. Setup or clean-up assistance, Picking Up Object - 05. Setup or clean-up assistance, Car Transfer - 05. Setup or clean-up assistance

PATIENT-STATED GOAL: To be able to get around with my cane and have less pain

GOALS
Toilet Transfer - 06. Independent

Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance

1 - Step (curb) - 05. Setup or clean-up assistance

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

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

Walk 10 Feet - 05. Setup or clean-up assistance

Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance

Walk 150 Feet - 05. Setup or clean-up assistance

4 Steps - 05. Setup or clean-up assistance

12 Steps - 05. Setup or clean-up assistance

Picking Up Object - 05. Setup or clean-up assistance

Car Transfer - 05. Setup or clean-up assistance

OT Careplans

OT WK2: 1 (06/28/26-07/04/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: 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

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, Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven Surface - 06. Independent, 1 - Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 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

OT Goals

PATIENT-STATED GOAL: Evaluation only

GOALS
Chair to Bed to Chair - 06. Independent

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

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Walk 10 ft on Uneven Surface - 06. Independent

1 - Step (curb) - 06. Independent

4 Steps - 06. Independent

12 Steps - 06. Independent

Picking Up Object - 06. Independent

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

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/25/2026