Home Health Certification and Plan of Care

Order ID: 1150/20121

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
9V33TK0AV98	06/27/2026	From: 06/27/2026 To: 08/25/2026	27031	217058

6. Patient's Name and Address

Beverly Johnson
3927 Carthage Rd,
RANDALLSTOWN, MD 21133-
410-215-9786

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 12/06/1946 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	06/27/26

13. ICD	Other Pertinent Diagnoses	Date
I12.0	Hyp chr kidney disease w stage 5 chr kidney disease or ESRD	06/27/26
N18.6	End stage renal disease	06/27/26
D63.1	Anemia in chronic kidney disease	06/27/26
N25.81	Secondary hyperparathyroidism of renal origin	06/27/26
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy	06/27/26
E46.	Unspecified protein-calorie malnutrition	06/27/26
E11.51	Type 2 diabetes w diabetic peripheral angiopath w/o gangrene	06/27/26
J44.9	Chronic obstructive pulmonary disease unspecified	06/27/26
E78.5	Hyperlipidemia unspecified	06/27/26
F43.21	Adjustment disorder with depressed mood	06/27/26
F17.210	Nicotine dependence cigarettes uncomplicated	06/27/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	06/27/26
Z79.4	Long term (current) use of insulin	06/27/26
Z79.82	Long term (current) use of aspirin	06/27/26
Z99.2	Dependence on renal dialysis	06/27/26
Z91.81	History of falling	06/27/26

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

Brimonidine Tartrate: Timolol Maleate - Brimonidine Tartrate: Timolol Maleate Ophthalmic Solution 0.2-0.5% / Instill 1 drop both eyes one time a day for Optic
Latanoprost - Latanoprost Ophthalmic Solution 0.005% / Instill 1 both eyes at bedtime for eye care
Alogliptin Benzoate 25 MG / 1 Tablet by mouth once a day for Diabetes Mellitus
Amlodipine - Amlodipine Besylate 10 MG / 1 Tablet by mouth once a day for HTN Hold if SBP is less than 110 or HR is less than 60.
ASPIRIN Chewable 81 MG / 1 Tablet by mouth one time a day for anticoagulant
ATORVASTATIN 80 MG / 1 Tablet by mouth at bedtime for hyperlipidemia For high cholesterols.
CARVEDILOL 12.5 MG / 1 Tablet by mouth two times a day for Hypertension. Hold dose for systolic blood pressure less than 120 and heart rate less than 60. Recheck and administer the medication as directed
Ergocalciferol - Ergocalciferol 50 MCG (2000 UT) / 1 Capsule by mouth one time a day for Supplement
Advair Diskus - Fluticasone Propionate: Salmeterol Xinafoate 250-50 MCG/ACT / 1 puff Inhale Orally two times a day for COPD MAINTENANCE
Albuterol Sulfate - Albuterol Sulfate HFA 108 (90 Base) MCG/ACT / 2 puff Inhale Orally every 6 hours as needed for wheezing and shortness of breath
Insulin Glargine-yfgn Subcutaneous Solution Pen-injector 100 UNIT/ML / Inject 10 unit subcutaneous in the evening for hyperglycemia
Insulin Lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 UNIT/ML subcutaneous before meal and at bedtime. Inject as per sliding scale: if 0 - 200 = 0; 201 - 250 = 2; if 251 - 300 = 4; if 301 - 350 = 6; 351 - 400 = 8 Call MD if Blood Sugar is above 400 or less 70. Initiate hypoglycemic precaution., for Diabetes Mellitus
Sarna Calm + Cool External Lotion 1-0.5% / Apply to Affected area topical twice a day for Pruritus

14. DME and Supplies:

cane, bath bench, diabetic supplies, commode, , walker, wheelchair

15. Safety Measures:

medication safety, diabetic precautions, supervision at all times, standard precautions, wheelchair precautions, walker precautions, bathroom safety, fall precautions, cardiac precautions, activity supervision, ambulates with assistance, ambulates with device

16. Nutrition:

low cholesterol, diabetic, low sodium, renal diet

17. Allergies:

no known allergies

18.A. Functional Limitations

Endurance

18.B. Activities Permitted

Wheelchair, Walker, Cane, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 1. Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions., ANXIETY: 1. In new or complex situations only, 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: 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

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

Homebound status: Due to diagnosis of Type 2 diabetes mellitus with diabetic chronic kidney disease, 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 a 79-year-old female admitted to home health services following discharge from subacute rehabilitation after hospitalization for stroke-like symptoms. A Start of Care (SOC) assessment was completed, and all required consents were signed by the patient. The patient was referred for skilled nursing services due to poorly controlled diabetes mellitus with hyperglycemia, end-stage renal disease (ESRD) requiring hemodialysis, chronic kidney disease (CKD), anemia, insulin dependence, protein-calorie malnutrition, and generalized weakness. Her past medical history is significant for type 2 diabetes mellitus requiring insulin therapy, ESRD on hemodialysis every Monday, Wednesday, and Friday, chronic kidney disease, anemia, chronic obstructive pulmonary disease (COPD), hyperlipidemia (HLD), peripheral vascular disease (PVD), peripheral angioplasty, history of transient ischemic attack (TIA), history of falls, long-term aspirin therapy, and protein-calorie malnutrition. The patient resides with her family in a multi-level home with a first-floor living arrangement to accommodate her mobility limitations. Her son, Dwayne, was present during the visit and actively participated in education and care planning. The patient was alert and oriented to person and place with intermittent orientation to time (A&O 2-3). She denied pain, urinary discomfort, recent falls, and abnormal bleeding. She reported sleeping well, although her appetite remains poor. Her last bowel movement occurred the previous day, and bowel sounds were present and active in all quadrants. Pulmonary assessment revealed clear breath sounds without adventitious lung sounds; however, the patient demonstrated a newly developed dry cough beginning on the day of assessment. She was instructed to maintain hydration within her prescribed 64-ounce daily fluid restriction and to notify her healthcare provider if the cough worsens or is accompanied by fever, shortness of breath, or other concerning symptoms. No open wounds or skin breakdown were identified during the assessment. Vital signs were obtained and remained within acceptable parameters. The patient utilizes a Dexcom continuous glucose monitor located on the left upper arm. Blood glucose at the time of assessment was 250 mg/dL, and the patient appropriately self-administered 2 units of insulin according to her prescribed sliding-scale regimen. A comprehensive medication reconciliation was completed. All prescribed medications, including insulin therapies and inhalers, were reviewed with both the patient and caregiver, emphasizing indications, dosing schedules, administration techniques, potential side effects, and the importance

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 06/27/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Chukwuemeka Ufomadu
2300 Garrison Blvd Ste 210
Baltimore, MD 21216
PHONE: 4434539947 FAX: 16673122998 NPI: 1164424545

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 : 06/11/2026

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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of medication adherence. The patient's Nephro-Vite prescription was unavailable during the visit, and the caregiver plans to clarify its administration with the dialysis center. Education was also provided regarding consuming small, frequent, nutrient-dense meals to improve caloric intake, support nutritional status, and maintain more consistent blood glucose control while receiving insulin therapy. Written educational materials were provided for reinforcement, and the home health visit calendar was reviewed and marked with upcoming appointments. The patient's cardiology follow-up is scheduled for 07/09/2026, and the caregiver will reschedule the patient's ophthalmology appointment. The patient's son plans to obtain all prescribed medications from the pharmacy following the visit. The patient ambulates with a rolling walker and requires one-person assistance for safe mobility due to generalized weakness, impaired balance, and increased fall risk. She requires assistance with lower body dressing and currently performs bathing at the sink. Functional assessment demonstrated standby assistance is required for toilet transfers and sit-to-stand transfers with verbal cueing for proper hand and lower extremity placement. Bilateral upper extremity strength is reduced, measuring approximately 4-/5 on manual muscle testing. These impairments significantly limit the patient's functional mobility and activities of daily living and place her at increased risk for falls. The patient is considered homebound due to weakness associated with ESRD, anemia, malnutrition, insulin-dependent diabetes, and multiple chronic comorbidities, requiring the use of a rolling walker and one-person assistance, making it a considerable and taxing effort to leave the home safely. Continued skilled nursing services are medically necessary for comprehensive assessment, diabetes management, medication reconciliation, monitoring of blood glucose trends, education regarding insulin administration, chronic disease management, nutritional counseling, monitoring for complications related to ESRD and hemodialysis, and reinforcement of fall prevention strategies. Skilled physical and occupational therapy have been ordered to address deficits in strength, balance, transfers, mobility, endurance, and activities of daily living with the goal of improving safety, maximizing functional independence, reducing fall risk, and preventing rehospitalization. Skilled nursing services are planned at a frequency of one visit per week for six weeks.
 Date of Order 06/27/2026 Orders Physician Face-to-Face Date: 06/11/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hhadl's due to Type 2 diabetes mellitus with diabetic chronic kidney disease 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 OT Eval Notes:
 Physician Ufomadu, Chukwuemeka

SN Careplans

SN WK1: 1 (06/27/26-06/27/26) ,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)

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, blood sugar < 60 > 300

CAREGIVER: 1. Non-agency caregiver(s) currently provide assistance

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

No open wounds noted
Advance Directive:See MOLST

PROBLEMS IDENTIFIED ON ASSESSMENT: M2102d - Caregiver Performs Treatment, meal preparation, M2102f - Patient Supervision, M2020 - Oral Med Management, abnormal blood pressure, M1400 - Dyspnea, M1033 - Exhaustion, abn cholesterol > 200 mg/dL, abnormal BS < 70/140 > mg/dL, muscle weakness, limited endurance, poor muscle tone, limited strength, Pain Effect on Sleep, Pain

SN Goals

PATIENT-STATED GOAL: Increase appetite and 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

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 is adequately supervised

meal preparation is available to patient for all meals

caregiver performs medical/rehabilitation treatments with adequate competence

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/27/2026

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Interference with Therapy activities, Pain Interference with ADLs, balance deficit, daytime fatigue, loss of appetite

PROCEDURES: cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments, glucose testing via monitor, monitor intake & output, coordinate/arrange for adequate patient supervision, coordinate/arrange preparation of missing meals, monitor dialysis schedule: Monday Wednesday and Fridays

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, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver performs medical/rehabilitation treatments with adequate competence

OT Careplans

OT WK2: 1 (06/28/26-07/04/26) ,WK3: 1 (07/05/26-07/11/26) ,WK4: 1 (07/12/26-07/18/26) ,WK6: 1 (07/26/26-08/01/26) ,WK8: 1 (08/09/26-08/15/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, GG0170P1 - Picking Up Object, GG0130F1 - Upper Body Dressing, GG0130A1 - Eating, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130B1 - Oral Hygiene, GG0170E1 - Chair to Bed to Chair, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170K1 - Walk 150 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170I1 - Walk 10 Feet, GG0170G1 - Car Transfer, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand

PROCEDURES: Functional ambulation : Rolling walker, Patient/caregiver recalls related purpose and schedule of medications: Medication Review, cough/deep breathing exercises, therapeutic exercises: Using dumbbells or therabands to perform bilateral upper extremity muscle strength exercises, transfers 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, 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, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 04. Supervision or touching assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent, Patient will demonstrates improved left upper extremity muscle strength from 4-/5 mmt to 4+/5 mmt to improve Adls and transfers safely

OT Goals

PATIENT-STATED GOAL: Patient wants to get stronger and use the shower for bathing

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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 - 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

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 04. Supervision or touching assistance

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

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

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:
Electronically Signed by Messick, Charles RN

Date
06/27/2026