Home Health Certification and Plan of Care

Order ID: 1150/20169

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
35139657	07/01/2026	From: 07/01/2026 To: 08/29/2026	27484	217058

6. Patient's Name and Address

Milda Sermuksnis
13 Arkla Court,
Catonsville, MD 21228-
410-788-8771

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 01/15/1934 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
I11.0	Hypertensive heart disease with heart failure	07/01/26

13. ICD	Other Pertinent Diagnoses	Date
I50.30	Unspecified diastolic (congestive) heart failure	07/01/26
I44.2	Atrioventricular block complete	07/01/26
E11.9	Type 2 diabetes mellitus without complications	07/01/26
E78.5	Hyperlipidemia unspecified	07/01/26
J45.909	Unspecified asthma uncomplicated	07/01/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	07/01/26
Z95.0	Presence of cardiac pacemaker	07/01/26
Z95.2	Presence of prosthetic heart valve	07/01/26
Z79.01	Long term (current) use of anticoagulants	07/01/26

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

Latanoprost - Latanoprost Ophthalmic Emulsion 0.005 % / Instill 1 drop both eyes at bedtime for dry eye
BUMETANIDE 1 mg/tablet / Give 2 tablet by mouth once a day for CHF
Therapeutic M - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 0 Give 1 tablet by mouth once a day for Supplement
Metoprolol Succinate - Metoprolol Succinate 0 ER 25 MG / 1 Tablet by mouth once a day for HTN Hold for SBP< 110 and HR< 60
Losartan Potassium - Losartan Potassium 25 mg/tablet / Give 2 tablet by mouth once a day for HTN
Eliquis - Apixaban 5 MG / 1 Tablet by mouth twice a day for A-fib
MELATONIN 3 mg/tablet / Give 2 tablet by mouth at bedtime for Insomnia
TRAZODONE 100 MG / 1 Tablet by mouth at bedtime for Depression
ACETAMINOPHEN 325 mg/tablet / Give 2 tablet by mouth three times a day for Pain
EZETIMIBE 10 MG / 1 Tablet by mouth once a day for HLD
Docusate Sodium - Docusate Sodium 100 MG / 1 Capsule by mouth twice a day for Bowel regimen
Miralax - Polyethylene Glycol 3350 17gm/scoopful by mouth as necessary For constipation
Fluticasone-Salmeterol Inhalation Aerosol Powder Breath Activated 100-50 MCG/ACT / 1 puff inhale orally inhalant twice a day for SOB Rinse mouth with water after use and spit out
Albuterol Sulfate: Ipratropium Bromide - Albuterol Sulfate: Ipratropium Bromide 0.5-2.5 (3) MG/3ML / 3 ml inhale orally every 6 hours as needed for Wheezing/SOB
Exenatide Subcutaneous Solution Pen-injector 10 MCG/0.04ML / Inject 10 mcg subcutaneous twice a day for DM
Aspercreme 0 External Patch 4% / Apply to Abdomen topical once a day for pain and remove per schedule
Lidocaine - Lidocaine 4 % Patch transdermal every 12 hours As needed for right knee pain

14. DME and Supplies:

nebulizer, diabetic supplies, walker

15. Safety Measures:

medical alert/lifeline, bathroom safety, walker precautions, medication safety, fall precautions, diabetic precautions, ambulates with device

16. Nutrition:

diabetic

17. Allergies:

aspirin oxycodone

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: 1. In new or complex situations only, SOCIAL ISOLATION: 3. Often, 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

Homebound status: Due to diagnosis of Hypertensive heart disease with heart failure, 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 92-year-old female with a significant past medical history including gallstone pancreatitis, hypertension (HTN), hyperlipidemia (HLD), type 2 diabetes mellitus (T2DM), asthma, obstructive sleep apnea (OSA), heart failure, severe aortic stenosis status post pacemaker placement, pulmonary hypertension, acute and chronic kidney disease, and a history of acute respiratory failure. She was recently discharged from the hospital and subacute rehabilitation following treatment for gallstone pancreatitis and was admitted to home health services for continued skilled nursing and rehabilitation. The patient resides alone in a single-level home and receives assistance from a private aide twice weekly with personal care and household needs. She remains homebound due to generalized weakness, impaired functional mobility, decreased endurance, multiple chronic comorbidities, and the need for assistance with activities of daily living, making it a considerable and taxing effort to leave the home safely. Upon skilled nursing assessment, the patient was alert and oriented to person, place, time, and situation and denied pain or discomfort. She was observed ambulating within the home using a rolling walker. Vital signs were obtained, and a comprehensive assessment was completed. Lung sounds were clear to auscultation bilaterally with respirations even and unlabored. Bowel sounds were present in all quadrants, peripheral pulses were palpable, and the skin was warm, dry, and intact without evidence of open areas or breakdown. Skin assessment revealed poor skin turgor with fragile skin that bruises easily. Trace bilateral pedal edema and mildly delayed capillary refill were also noted. Medication reconciliation was completed, and medications were reviewed with the patient to ensure understanding and compliance. The patient reported owning a continuous positive airway pressure (CPAP) machine for management of obstructive sleep apnea; however, the equipment requires replacement, and she is awaiting a prescription from her provider. She also reported that a nebulizer has been ordered but has not yet been received. Skilled nursing will provide education and training regarding proper nebulizer setup, administration techniques, cleaning, maintenance, and prescribed respiratory treatments once the equipment becomes available. Additional education was provided regarding medication adherence, fall prevention strategies, adequate hydration and nutrition, recognition and reporting of worsening respiratory symptoms, edema management, and the importance of following up with her healthcare provider regarding replacement of the CPAP device. The patient demonstrated understanding of the education provided. An occupational therapy evaluation was completed and identified functional deficits

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 07/01/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Kunmi Majekodunmi
1600 South Crain Highway
Glen Burnie, MD 21061
PHONE: 4107600098 FAX: 14107619131 NPI: 1497791917

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 : 06/12/2026

27. Attending Physician's Signature and Date Signed **07/07/2026**: 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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following the recent hospitalization. The patient currently ambulates with a rolling walker and requires contact guard assistance for sit-to-stand transfers with verbal cueing for proper hand and lower extremity placement to ensure safe transfer techniques. She requires assistance with bathing and dressing due to generalized weakness and decreased functional endurance. Assessment revealed bilateral upper extremity weakness with muscle strength measured at 3+/5 on manual muscle testing, contributing to reduced independence with activities of daily living. Skilled occupational therapy services are medically necessary to improve upper extremity strength, balance, transfer safety, activity tolerance, and independence with self-care tasks while providing adaptive techniques and caregiver education as needed. Continued skilled home health services are warranted to monitor the patient's cardiopulmonary and overall medical status, reinforce disease management and medication compliance, improve functional mobility and safety, reduce fall risk, and support the patient's goal of remaining safely and independently in her home.
 Date of Order 07/01/2026 Orders Physician Face-to-Face Date: 06/12/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Hypertensive heart disease with heart failure 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 Majekodunmi, Kunmi

SN Careplans

SN WK1: 1 (07/01/26-07/04/26) ,WK2: 2 (07/05/26-07/11/26) ,WK3: 1 (07/12/26-07/18/26) ,WK4: 1 (07/19/26-07/25/26) ,WK5: 1 (07/26/26-07/31/26)

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

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:Living Will

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, D0700 - Social Isolation, weak pulses in feet, dependent edema, M1400 - Dyspnea, limited range of motion, limited strength, limited endurance, balance deficit, involuntary movement of extremity, Pain Effect on Sleep, Pain Interference with ADLs, B1000 - Vision Deficit, pallor

PROCEDURES: cough/deep breathing exercises, glucose testing via monitor, coordinate/arrange resources for vision-impaired, coordinate/arrange long-term socialization activities

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, * 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, * strategies to increase

SN Goals

PATIENT-STATED GOAL: "I want to get my C-Pap and nebulizer machines up and running."

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
* 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

patient/caregiver recalls
* strategies to increase socialization
* recalls related medication(s) purpose, schedule

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/01/2026

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socialization, related medication(s) purpose, schedule

OT Careplans

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PROBLEMS IDENTIFIED ON ASSESSMENT: M1400, Pain Interference with ADLs, 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, GG0170J1 - Walk 50 ft with 2 Turns, GG0170K1 - Walk 150 Feet, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170I1 - Walk 10 Feet, GG0170P1 - Picking Up Object, GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170M1 - 1 - Step (curb), GG0170G1 - Car Transfer, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand

PROCEDURES: Functional ambulation : Using 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, * 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, Toilet Transfer - 05. Setup or clean-up assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 04. Supervision or touching assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance, 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
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

Toilet Transfer - 05. Setup or clean-up assistance

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 04. Supervision or touching assistance

Lower Body Dressing - 05. Setup or clean-up assistance

Don/Doff Footwear - 05. Setup or clean-up assistance

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	07/01/2026