Home Health Certification and Plan of Care

Order ID: 1150/20429

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
9H57VU4FD36	07/09/2026	From: 07/09/2026 To: 09/06/2026	27619	217058

6. Patient's Name and Address
Catherine Herring
3303 Nova Scotia Rd,
ABERDEEN, MD 21001
352-620-5581

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 09/29/1940 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
E11.65	Type 2 diabetes mellitus with hyperglycemia	07/09/26

13. ICD	Other Pertinent Diagnoses	Date
E11.40	Type 2 diabetes mellitus with diabetic neuropathy unsp	07/09/26
I10.	Essential (primary) hypertension	07/09/26
E78.5	Hyperlipidemia unspecified	07/09/26
Z79.4	Long term (current) use of insulin	07/09/26

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

NIFEDIPINE Extended Release 30 MG / 1 Tablet by mouth in the morning for HTN Hold for SBP < 105
LOSARTAN POTASSIUM 50 MG / 1 Tablet by mouth in the morning for HTN HOLD MEDICATION IF SYSTOLIC BLOOD PRESSURE < 100 mmHg
CRESTOR 5 MG / 1 Tablet by mouth at bedtime for HLD
Meloxicam - Meloxicam 7.5 mg Take 1 tablet by mouth once a day With food for pain
ACETAMINOPHEN 325 mg/tablet / Give 2 tablet by mouth every 4 hours as needed for PAIN to equal 650mg - not to exceed 3 grams in 24 hours
Metformin Er - Metformin Hydrochloride 1 tablet by mouth twice a day 500mg tabl3t
Alendronate Sodium - Alendronate Sodium 10 mg 1 tablet by mouth once a week
Humulin 70/30 Pen - Insulin Recombinant Human: Insulin Susp Isophane Recombinant Human 100 UNIT/ML / Inject 20 unit subcutaneously one time a day for DIABETES TYPE 2
Humalog Kwikpen - Insulin Lispro Recombinant 100 UNIT/ML subcutaneously before meals Inject as per sliding scale: if 150-199 = 1 UNIT; 200 - 249 = 3 UNITS; 250 - 299 = 5 UNITS; 300 - 349 = 7 UNITS; 350 - 350 = 8 UNITS > 350 NOTIFY MD, for DIABETES TYPE 2

14. DME and Supplies:
walker, diabetic supplies,

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

16. Nutrition:
diabetic

17. Allergies:
no known allergies

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: 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
SN: patient will be responsible for managing treatment
PT: family/caregiver will be responsible for managing treatment
OT: family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Type 2 diabetes mellitus with hyperglycemia, 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 85-year-old female admitted to home health services following a recent hospitalization for hyperglycemia with a near-syncopal episode, followed by a stay at a subacute rehabilitation facility. Her past medical history is significant for acute kidney injury (AKI), type 2 diabetes mellitus (T2DM), hypertension, hyperkalemia, head contusion, syncope, and hyperlipidemia. Upon the skilled nursing visit, the patient was found weak and lying on her couch but was alert and oriented to person, place, time, and situation (A&O4). She exhibited no signs of respiratory distress; however, she reported generalized weakness, hunger, thirst, tremors, and sweating. The patient's daughter reported that the patient's blood glucose level had been 219 mg/dL earlier in the day. Following discharge from the rehabilitation facility, the patient had been prescribed a Humalog KwikPen but neither the patient nor her caregiver received education regarding insulin administration or the prescribed sliding scale. Misinterpreting the "100 units/mL" labeling on the insulin package, the patient's daughter administered 100 units of Humalog, after which the patient rapidly developed symptoms consistent with hypoglycemia. Comprehensive education was immediately provided regarding the recognition of hypoglycemia and hyperglycemia, proper use of the Humalog sliding scale, appropriate insulin administration techniques, and interventions to safely increase blood glucose during hypoglycemic episodes. The patient's blood glucose was rechecked during the visit and measured 86 mg/dL after she had recently eaten. The patient is also prescribed Humulin 70/30 insulin, 20 units every morning, and was instructed to hold the dose for the remainder of the day and resume the prescribed regimen the following morning. The patient's daughter verbalized understanding of all education provided through successful teach-back. A message was left with the patient's primary care provider regarding the medication error and current clinical status. By the conclusion of the visit, the patient reported feeling significantly better, denied pain, and her skin was warm, dry, and intact. She resides with her husband and daughter, requires assistance with activities of daily living (ADLs), and ambulates with a walker. A physical therapy evaluation was completed during this visit. The patient resides in a mobile home with two steps to enter equipped with a grab bar and an additional single step leading into a sunken living room, presenting potential mobility and fall risks. Prior to her recent hospitalization, she was independent with community ambulation without an assistive device, independently performed all ADLs, and negotiated stairs without difficulty. The patient's personal goals include improving ease with transfers and returning to outdoor activities such as yard and trim work. Current assessment revealed dizziness, diminished light touch sensation with numbness and tingling in both feet, greater right lower extremity weakness than left, impaired gait, difficulty negotiating steps, and mild difficulty performing transfers. Orthostatic blood pressure assessment was negative for orthostatic hypotension; however, the patient's symptoms are consistent with benign paroxysmal positional vertigo (BPPV). The therapist discussed these findings with the patient and her daughter and plans to perform formal BPPV assessment during the next visit with canalith repositioning treatment if indicated. The patient demonstrates good rehabilitation potential and will continue to receive skilled physical therapy to improve lower extremity strength, balance, gait, transfer safety, stair negotiation, and functional mobility while reducing fall risk. An occupational therapy evaluation was also completed following the patient's hospitalization and subacute rehabilitation stay. Prior to hospitalization, the patient was independent with basic self-care, functional transfers, and household ambulation while residing with her husband and daughter in a single-family home. At the time of evaluation, the patient demonstrated independence with basic self-care activities, functional transfers, and functional ambulation. No deficits requiring ongoing skilled occupational therapy intervention were identified. Skilled occupational therapy services are not recommended at this time, and the patient was discharged following the evaluation only. Continued skilled physical therapy is recommended to address identified gait, balance, strength, and mobility impairments.
 Date of Order 07/09/2026 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

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 07/09/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Karen Johnson
998 Hospitality Way Ste 102
Aberdeen, MD 21001
PHONE: 4102979500 FAX: 14102979016 NPI: 1730321241

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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due to Type 2 diabetes mellitus with hyperglycemia 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: sic PT Eval Notes: OT Eval Notes:
 Physician Johnson, Karen

SN Careplans

SN WK1: 1 (07/09/26-07/11/26) ,WK2: 1 (07/12/26-07/18/26) ,WK3: 1 (07/19/26-07/25/26) ,WK4: 1 (07/26/26-08/01/26) ,WK5: 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

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

HOSPITALIZATION RISKS: 3. Multiple hospitalizations (2 or more) in the past 6 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:NO CPR OPTION A-2, DO NOT INTUBATE (DNI)

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, abnormal blood pressure, M1033 - Exhaustion, M1400 - Dyspnea, abnormal BS < 70/140 > mg/dL, frequent urination, limited strength, muscle weakness, balance deficit

PROCEDURES: Diabetic teaching : Please provide teaching on signs and symptoms of hypoglycemia, hyperglycemia and insulin management, glucose testing via monitor

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, * 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: To get my blood glucose levels under control.

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
* 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 WK2: 2 (07/12/26-07/18/26) ,WK3: 1 (07/19/26-07/25/26) ,WK4: 1 (07/26/26-08/01/26) ,WK5: 1 (08/02/26-08/08/26) ,WK6: 1 (08/09/26-08/15/26) ,WK7: 1 (08/16/26-08/22/26) ,WK8: 1 (08/23/26-08/29/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170D1 - Sit to Stand, GG0170F1 - Toilet Transfer, GG0170G1 - Car 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, GG0170E1 - Chair to Bed to Chair

PROCEDURES: Medication management : Review medication with patient and daughter, Medication management : Review medication with patient and daughter, Assess for vertigo: Assess pt for potential BPPV, if she is positive will treat the condition., home

PT Goals

PATIENT-STATED GOAL: Patient goal is to improve strength and balance.Get rid of vertigo , be able to get out and work in the yard again

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 06. Independent

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/09/2026

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exercise program: Hip flexion, knee extension hip abduction heel raises toeraises standing exercises as tolerated, including heel, raises, toe, raises hamstring curls, hip abduction and hip flexion. 2-310, dynamic standing balance exercises: Work on dynamic balance to improve hip ankle and step strategy improve reaction time to reduce risk for falls, gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 06. Independent, Chair to Bed to Chair - 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, Picking Up Object - 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

Picking Up Object - 06. Independent

OT Careplans

OT WK1: 1 (07/09/26-07/11/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, 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, * 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, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 06. Independent, 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
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

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 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	07/09/2026