Home Health Certification and Plan of Care

Order ID: 1150/20106

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
9WK4GA3FC90	06/25/2026	From: 06/25/2026 To: 08/23/2026	27187	217058

6. Patient's Name and Address
Deborah Garrett
5071 Silver Oak Drive,
ROSEDALE, MD 21237-
443-622-9338

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 07/22/1953 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
I13.0	Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny	06/25/26

13. ICD	Other Pertinent Diagnoses	Date
I50.9	Heart failure unspecified	06/25/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	06/25/26
N18.9	Chronic kidney disease u	06/25/26
D63.1	Anemia in chronic kidney disease	06/25/26
E11.40	Type 2 diabetes mellitus with diabetic neuropathy unsp	06/25/26
K22.0	Achalasia of cardia	06/25/26
R13.10	Dysphagia unspecified	06/25/26
J44.9	Chronic obstructive pulmonary disease unspecified	06/25/26
I87.2	Venous insufficiency (chronic) (peripheral)	06/25/26
K52.9	Noninfective gastroenteritis and colitis unspecified	06/25/26
E78.00	Pure hypercholesterolemia unspecified	06/25/26
G40.901	Epilepsy unsp not intractable with status epilepticus	06/25/26
E53.8	Deficiency of other specified B group vitamins	06/25/26
E53.1	Pyridoxine deficiency	06/25/26
E55.9	Vitamin D deficiency unspecified	06/25/26
M54.50	Low back pain unspecified	06/25/26
G89.29	Other chronic pain	06/25/26
E66.9	Obesity unspecified	06/25/26
Z68.36	Body mass index [BMI] 36.0-36.9 adult	06/25/26
Z79.4	Long term (current) use of insulin	06/25/26
Z91.81	History of falling	06/25/26
Z87.891	Personal history of nicotine dependence	06/25/26

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

Irbesartan - Irbesartan 300 MG / 1 Tablet by mouth once a day for HTN Hold Med for SBP <110 or HR<50
Carvedilol - Carvedilol 12.5 MG / 1 Tablet by mouth every 12 hours for HTN Hold med for SBP <110
Sennosides-Docusate Sodium 8.6-50 mg/tablet / Give 2 tablet by mouth every 12 hours as needed for Bowel Regimen
Terbinafine Hydrochloride - Terbinafine Hydrochloride 250 MG / 1 Tablet by mouth once a day for Fungal Infection
Duloxetine Hydrochloride - Duloxetine Hydrochloride DR 30 MG / 1 Capsule by mouth once a day for depression
Cholecalciferol 125 MCG (5000 UT) / 1 Tablet by mouth once a day every other day for Vitamin D Deficiency
Rosuvastatin Calcium - Rosuvastatin Calcium 40 MG / 1 Tablet by mouth at bedtime for HLD
Pyridoxine Hydrochloride - Pyridoxine Hydrochloride ER 200 MG / 1 Tablet by mouth once a day for Supplement
Cyanocobalamin - Cyanocobalamin 500 MCG / 1 Tablet by mouth once a day for Supplement
Lasix - Furosemide 40 MG / 1 Tablet by mouth once a day for Edema
Acetaminophen - Acetaminophen 500 mg/tablet / Give 2 tablet by mouth every 8 hours as needed for pain
Cyclobenzaprine Hydrochloride - Cyclobenzaprine Hydrochloride 5 MG / 1 Tablet by mouth every 8 hours as needed for Muscle Spasm
Centrum Silver - Ascorbic Acid: Biotin: Cyanocobalamin: Ergocalciferol: Folic Acid: Niacinamide: Pantothenic Acid: Phytonadione: Pyridoxine: Ribo 0 Give 1 tablet by mouth once a day for vitamin supplement
Insulin Lispro 100 UNIT/ML / Inject 10 unit subcutaneous after meal for monitoring
Insulin Lispro 100 UNIT/ML subcutaneous before meal Inject as per sliding scale: if 0 - 69 = 0 if BS <70, notify doctor; 70 - 200 = 0; 201 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units; 401+ = 8 units if BS >400, give insulin & notify doctor
Insulin Glargine Subcutaneous Solution 100 UNIT/ML / Inject 22 unit subcutaneous at bedtime for DM

14. DME and Supplies:
bath bench, grab bars, cane

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

16. Nutrition:
diabetic

17. Allergies:
nortriptyline penicillin pregabalin crestor metformin

18.A. Functional Limitations
Ambulation

18.B. Activities Permitted
Cane

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: 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 Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified 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 72-year-old female admitted to home health services following hospitalization and subsequent subacute rehabilitation after multiple syncopal episodes resulting in an unwitnessed fall with head injury. The patient reported that she was living alone at the time of the fall and struck the posterior aspect of her head, sustaining a hematoma. Following acute hospitalization, she completed a course of inpatient rehabilitation and was discharged to her granddaughter's home, where she currently resides. Her granddaughter serves as her primary caregiver and provides assistance as needed. The patient's past medical history is significant for type 2 diabetes mellitus (T2DM), hypertension (HTN), congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), hyperlipidemia (HLD), chronic kidney disease (CKD), polyneuropathy, achalasia, chronic diarrhea, dysphagia, and a history of left rotator cuff surgery. Upon skilled nursing assessment, the patient was alert and oriented to person, place, time, and situation (A&O 4). She denied pain, nausea, vomiting, dizziness, lightheadedness, and reported no additional syncopal episodes or falls since her hospitalization. Skin assessment revealed warm, intact skin without evidence of breakdown. Vital signs were obtained and remained within acceptable parameters. The patient ambulates with a cane and wears compression stockings as prescribed. A comprehensive medication reconciliation was completed, including review of her sliding-scale Novolog insulin regimen. Education was provided regarding proper insulin administration, blood glucose monitoring, medication adherence, recognition and management of signs and symptoms of hypo- and hyperglycemia, fall prevention strategies, safe use of her cane, energy conservation techniques, and the importance of attending scheduled follow-up appointments, including her ophthalmology appointment on 07/12/2026. The patient verbalized understanding of all teaching provided and expressed that her

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
Eyrusalam Gebremedhine
630 S Exeter St
Baltimore, MD 21202
PHONE: 4103327460 FAX: 14103329669 NPI: 1144042896

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 : 06/09/2026

27. Attending Physician's Signature and Date Signed **07/02/2026**: 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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primary goal is to regain the ability to ambulate safely without experiencing additional falls. Prior to hospitalization, the patient resided independently in a two-story home with 13 stairs leading to the bedroom and was independent with basic activities of daily living, functional transfers, and household ambulation. Occupational therapy evaluation initially identified decreased standing balance, reduced standing tolerance, decreased bilateral upper extremity strength, and diminished activity tolerance, resulting in deficits with self-care, functional transfers, and functional mobility. Although skilled occupational therapy was initially recommended to address these impairments and facilitate return to her prior level of function, a subsequent reassessment demonstrated that the patient had regained independence with basic self-care, functional transfers, and household ambulation within the home environment. As no additional skilled occupational therapy needs were identified, occupational therapy services were concluded following the evaluation only. The patient remains appropriate for continued home health services, including skilled nursing for ongoing assessment, medication management, diabetes education, chronic disease monitoring, and reinforcement of fall prevention strategies. Continued skilled physical therapy is medically necessary to improve strength, balance, gait, endurance, and overall functional mobility, with the goal of maximizing safety, reducing fall risk, preventing rehospitalization, and restoring the patient to her highest attainable level of independence within the home environment.
 Date of Order 06/25/2026 Orders Physician Face-to-Face Date: 06/09/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified 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: PT Eval Notes:
 Physician Gebremedhine, Eyrusalam

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) ,WK4: 1 (07/12/26-07/18/26) ,WK5: 1 (07/19/26-07/25/26)

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, 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:POLST (Physician Orders for Life-Sustaining Treatment)

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2020 - Oral Med Management, abnormal blood pressure, M1400 - Dyspnea, abnormal BS < 70/140 > mg/dL, muscle weakness, limited strength, balance deficit, Pain Interference with ADLs

PROCEDURES: 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, * 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

SN Goals

PATIENT-STATED GOAL: To walk without falling

GOALS
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
* 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
* 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 self-administers medications as prescribed
* 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	06/25/2026

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avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule

OT Careplans

OT WK1: 1 (06/26/26-06/27/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with Therapy activities, Pain Interference with ADLs, M1400 - Dyspnea, Pain Effect on Sleep, 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, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170L1 - Walk 10 ft on Uneven Surface, 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

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, Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, Car 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, 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

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

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

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

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

Sit to Stand - 06. Independent

Car 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

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

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

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

Date
06/25/2026