Home Health Certification and Plan of Care

Order ID: 1150/20696

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
72289772	07/20/2026	From: 07/20/2026 To: 09/17/2026	28126	217058

6. Patient's Name and Address

Margaret Early
2501 Violet Avenue Apt 1404 N,
BALTIMORE, MD 21215-
443-979-4943

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 09/01/1954 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
I83.893	Varicose veins of bi low extrem w oth complications	07/20/26

13. ICD	Other Pertinent Diagnoses	Date
R60.0	Localized edema	07/20/26
M84.452D	Pathological fracture left femur subs for fx w routn heal	07/20/26
G89.29	Other chronic pain	07/20/26
I10.	Essential (primary) hypertension	07/20/26
J45.909	Unspecified asthma uncomplicated	07/20/26
E78.5	Hyperlipidemia unspecified	07/20/26
E66.01	Morbid (severe) obesity due to excess calories	07/20/26
Z68.41	Body mass index [BMI] 40.0-44.9 adult	07/20/26
Z79.891	Long term (current) use of opiate analgesic	07/20/26

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

Zofran Odt - Ondansetron Disintegrating 4 MG Tablet / Dissolve 1 tablet on the tongue by mouth every 8 hours as needed for nausea or vomiting. **TEMPORARY USE FOR OPIOID WITHDRAWAL
NEURONTIN 300 MG / 1 Capsule by mouth once a day and 2 capsules at bedtime
Zestril - Lisinopril 40 MG / 1 Tablet by mouth daily
TAGRISSO 80 MG / 1 Tablet by mouth daily
LASIX 20 MG / 1 Tablet by mouth every morning
DULCOLAX Delayed Release 5 mg/tablet / Take 2 tablets by mouth the day before procedure one time with at least 8 ounces of water at 12 noon
SIMETHICONE Chew Tab 80 MG / Chew and swallow 2 tablets by mouth for 3 doses, at 9 PM and 10 PM the night before the procedure, the morning of the procedure before drinking the final one-third of the Gavilyte
NORVASC 10 MG / 1 Tablet by mouth daily
LIPITOR 20 MG / 1 Tablet by mouth daily for cholesterol and heart protection
Centrum Silver - Ascorbic Acid: Biotin: Cyanocobalamin: Ergocalciferol: Folic Acid: Niacinamide: Pantothenic Acid: Phytonadione: Pyridoxine: Ribo 0.4 mg-300 mcg- 250 mcg / 1 Tablet by mouth daily
SINGULAIR 10 MG / 1 Tablet by mouth every evening
Fluticasone Salmeterol (WIXELA INHUB) Inhl Disk w/devi 250-50 mcg/dose / Inhale 1 puff by mouth twice a day (Controller inhaler)
Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 125 mcg (5,000 unit) / 1 Tablet by mouth daily
Iron,Carbonyl Vitamin C (VITRON C) Delayed Release 65 mg iron- 125 mg / 1 Tablet by mouth once a day
Selenium (SELENOMAX) 200 MCG / 1 Tablet by mouth once a day
Zinc (CHELATED ZINC) 50 MG / 1 Tablet by mouth once a day
oxyCODONE IR (DAZIDOX) 10 MG / 1 Tablet by mouth every 4 hours
Albuterol Inhaler - Albuterol 90mcg inhalant as necessary Asthma
NARCAN 4 mg/actuation Nasl Spray / Spray in 1 nostril Nasal as necessary if not breathing/responding. Call 911. If still not breathing/responding, use new spray in 2 to 3 minutes in other nostril. For suspected opioid overdose use only. Watch instructional video at NARCAN.com (Patient not taking: Reported on 5/6/2026)
GINKGO BILOBA Oral 1 tablet Oral daily
Catapres-Tts-1 - Clonidine 0.1 mg/24 hr TD Weekly Patch / Apply 1 Patch to affected area(s) topical every 7 days

14. DME and Supplies:

walker, wheelchair, nebulizer, commode, bath bench

15. Safety Measures:

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

16. Nutrition:

cardiac diet, low cholesterol, low sodium

17. Allergies:

no known allergies

18.A. Functional Limitations

Dyspnea With Minimal Exertion, Ambulation, Endurance, Bowel/Bladder Incontinence, Paralysis

18.B. Activities Permitted

Wheelchair, Walker, 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: Poor

22. A Rehabilitation Potential:

SELF-CARE: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities., MOBILITY: 1. Dependent - A helper completed all the activities for the patient.

22.B.Discharge Plans

patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Varicose veins of bilateral lower extremities with other complications, 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: Informed consent was obtained and signed by the patient prior to the start of care. The patient is a 71-year-old female with a past medical history significant for asthma, chronic edema, varicose veins, hyperlipidemia, hypertension, obesity, chronic lower extremity pain following a left femur fracture, long-term opioid use, and a history of left hip cancer currently managed with oral therapy. The patient's obesity, chronic lower extremity pain, varicose veins, and residual deficits from the left femur fracture significantly impair mobility, resulting in ambulation difficulty requiring the use of an electric scooter, walker, rollator, and supervision for mobility. Due to these functional limitations, leaving the home requires considerable and taxing effort, supporting the patient's homebound status. The patient's husband serves as her primary caregiver and provides assistance as needed. A comprehensive nursing assessment was completed. Medication reconciliation was performed, and all prescribed medications were reviewed with the patient, including indications, dosing, administration, and potential side effects. The <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-5 CE-FMS-medication%20list">medication list</mh> was updated and verified, and the visit calendar was reviewed. The patient denied any abnormal bleeding. She reported being unable to ambulate independently and is only able to stand for short periods due to pain and weakness. No open wounds or skin integrity concerns were identified during the

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 07/20/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Faryal Nadeem
7141 Security Blvd
Windsor Mill, MD 21244
PHONE: 800-777-7904 FAX: NPI: 1699138537

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 : 07/16/2026

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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assessment. The patient reported her last bowel movement occurred the previous day and denied constipation or gastrointestinal concerns. She is scheduled for a colonoscopy in August and confirmed that the bowel preparation medications have already been obtained. The patient denied dysuria or other urinary discomfort but reported occasional urinary incontinence requiring the use of incontinence briefs. She has a nebulizer with albuterol solution available for use as needed to manage asthma symptoms. The patient reported sleeping approximately 6 to 7 hours nightly, maintaining a good appetite and adequate hydration, and denied any recent falls. She reported chronic left hip pain rated at 4/10, managed with a transdermal pain patch changed every three days and prescribed oxycodone as needed for pain control. She also wears a clonidine transdermal patch for hypertension management, which is changed every seven days. The patient has been admitted for skilled home health services, including skilled nursing, physical therapy, and occupational therapy. Skilled nursing services are ordered at a frequency of 1 visit per week for 2 weeks, followed by every other week until the end of the episode or until all goals are met, with a focus on ongoing disease process management, medication management, pain assessment, safety monitoring, patient and caregiver education, and coordination of care. A physical therapy evaluation was completed following the patient's recent hospitalization for worsening left hip pain. Prior to hospitalization, the patient was able to ambulate short distances within her apartment using a rollator with supervision and otherwise relied on an electric scooter for mobility. On evaluation, the patient demonstrated significant bilateral lower extremity weakness with manual muscle testing of 2-/5, impaired balance, decreased functional mobility, and reduced endurance. She required minimal assistance for transfers and short-distance ambulation with a rollator, along with verbal cues to improve trunk extension and posture during gait. These impairments have resulted in decreased safety and independence with functional mobility and an increased risk for falls. Skilled physical therapy is medically necessary to provide therapeutic exercises, gait training, transfer training, balance activities, strengthening, safety instruction, and functional mobility training to improve strength, maximize independence, reduce fall risk, and facilitate a return to the patient's prior level of function.
 Date of Order 07/20/2026 Orders Physician Face-to-Face Date: 07/16/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Varicose veins of bilateral lower extremities with other complications 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 PT Eval Notes:
 Physician Nadeem, Faryal

SN Careplans

SN WK1: 1 (07/20/26-07/25/26) ,WK2: 1 (07/26/26-08/01/26) ,WK4: 1 (08/09/26-08/15/26) ,WK6: 1 (08/23/26-08/29/26) ,WK8: 1 (09/06/26-09/12/26) ,WK9: 1 (09/13/26-09/17/26)

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: 2. Non-agency caregiver(s) need training/supportive services to provide assistance

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; 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:Na

PROBLEMS IDENTIFIED ON ASSESSMENT: M2102d - Caregiver Performs Treatment, M2102c - Med Admin, meal preparation, M2102f - Patient Supervision, M2020 - Oral Med Management, M1033 - Exhaustion, M1400 - Dyspnea, abnormal blood pressure, abn cholesterol > 200 mg/dL, frequent urination, M1610 - Urinary Incontinence, limited strength, limited endurance, muscle weakness, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, balance deficit, pain radiating to arms/legs, obesity, red/tender pressure points

SN Goals

PATIENT-STATED GOAL: To decrease left hip pain and increase mobility

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
* 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

patient is adequately supervised

meal preparation is available to patient for all meals

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/20/2026

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PROCEDURES: cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments, bladder training, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange preparation of missing meals

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, * 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, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT WK1: 1 (07/20/26-07/25/26) ,WK3: 1 (08/02/26-08/08/26) ,WK5: 1 (08/16/26-08/22/26) ,WK7: 1 (08/30/26-09/05/26) ,WK9: 1 (09/13/26-09/17/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170G1 - Car Transfer, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130B1 - Oral Hygiene, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170E1 - Chair to Bed to Chair, GG0170D1 - Sit to Stand, GG0170P1 - Picking Up Object, 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, GG0170F1 - Toilet Transfer

PROCEDURES: Medication Review: - medications reviewed with patient/caregiver, home exercise program: Review HEP: seated knee ext, hip flex, hip abd, quad sets, gluteal squeezes, ankle pumps at least 1x10. Once tolerated, upgrade to standing heel/ toe raises, knee flex, hip flex, hip abd at least 1x10 with UE support as needed. Upgrade as tolerated, equipment training, work simplification/energy conservation, 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 - 05. Setup or clean-up assistance, Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance, Car Transfer - 05. Setup or clean-up assistance, Oral Hygiene - 03. Partial/moderate assistance, Toileting Hygiene - 03. Partial/moderate assistance, Shower/Bathe Self - 03. Partial/moderate assistance, Upper Body Dressing - 03. Partial/moderate assistance, Lower Body Dressing - 03. Partial/moderate assistance, Don/Doff Footwear - 03. Partial/moderate assistance

PT Goals

PATIENT-STATED GOAL: To be able to walk without pain

GOALS

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

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

Toilet Transfer - 05. Setup or clean-up assistance

Walk 10 Feet - 04. Supervision or touching assistance

Walk 50 ft with 2 Turns - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

Car Transfer - 05. Setup or clean-up assistance

Oral Hygiene - 03. Partial/moderate assistance

Toileting Hygiene - 03. Partial/moderate assistance

Shower/Bathe Self - 03. Partial/moderate assistance

Upper Body Dressing - 03. Partial/moderate assistance

Lower Body Dressing - 03. Partial/moderate assistance

Don/Doff Footwear - 03. Partial/moderate assistance

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/20/2026