Home Health Certification and Plan of Care

Order ID: 1150/20804

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
68303329	05/26/2026	From: 07/25/2026 To: 09/22/2026	26025	217058

6. Patient's Name and Address
Laverne Harlee
301 McMechen St Apt 602,
BALTIMORE, MD 21217-
240-671-4451

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 09/13/1952 **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	05/26/26

13. ICD	Other Pertinent Diagnoses	Date
I50.22	Chronic systolic (congestive) heart failure	05/26/26
I48.91	Unspecified atrial fibrillation	05/26/26
J44.9	Chronic obstructive pulmonary disease unspecified	05/26/26
E11.9	Type 2 diabetes mellitus without complications	05/26/26
R29.6	Repeated falls	05/26/26
F17.210	Nicotine dependence cigarettes uncomplicated	05/26/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	05/26/26
Z79.01	Long term (current) use of anticoagulants	05/26/26
Z91.81	History of falling	05/26/26
I50.23	Acute on chronic systolic (congestive) heart failure	05/26/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	05/26/26
N18.31	Chronic kidney disease stage 3a	05/26/26
D63.1	Anemia in chronic kidney disease	05/26/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	05/26/26
I42.8	Other cardiomyopathies	05/26/26

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

CARVEDILOL 12.5 MG tablet by mouth 2 times daily with meals Commonly known as: COREG
FUROSEMIDE 40 MG tablet by mouth daily Commonly known as: LASIX
GABAPENTIN 300 MG capsule by mouth daily Commonly known as: NEURONTIN
GLIPIZIDE 5 MG tablet by mouth 2 times daily Commonly known as: GLUCOTROL
ACETAMINOPHEN 500 mg/tablet / Take 2 tablets by mouth 3 times daily as needed for MILD Pain (or if patient requests it for moderate or severe pain) or Fever (temp in PRN comment) (for fever > 38.0 and notify physician). Commonly known as: TYLENOL
ATORVASTATIN 40 mg / 1 Tablet by mouth nightly Commonly known as: LIPITOR
DABIGATRAN ETEXILATE 150 mg / 1 Capsule by mouth 2 times daily Commonly known as: PRADAXA
SPIRONOLACTONE 25 mg / 1 Tablet by mouth daily Commonly known as: ALDACTONE
BRIMONIDINE TARTRATE 0.2 % ophthalmic solution / Place 1 drop into both eyes 3 times daily Commonly known as: ALPHAGAN
LATANOPROST 0.005 0.005 % ophthalmic solution / Place 1 drop into both eyes nightly Commonly known as: XALATAN
TIMOLOL 0.5 % ophthalmic solution / Place 1 drop into both eyes 2 times daily Commonly known as: TIMOPTIC

14. DME and Supplies:
wheelchair, walker, diabetic supplies, bath bench

15. Safety Measures:
emergency phone # clearly displayed, bathroom safety, smoke detectors , walker precautions, wheelchair precautions, medication safety, ambulates with device, ambulates with assistance, standard precautions, fall precautions, diabetic precautions

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
no known allergies

18.A. Functional Limitations
Endurance, Ambulation, Bowel/Bladder Incontinence, Dyspnea With Minimal Exertion

18.B. Activities Permitted
Walker, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 1. When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer, ANXIETY: 0. Never, SOCIAL ISOLATION: , BEHAVIORAL ISSUES: , HISTORY OF DEPRESSION:

20. Prognosis: fair

22. A Rehabilitation Potential:
SELF-CARE: , MOBILITY:

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:

Home health nursing admission was completed for a 73-year-old female with a significant past medical history of atrial fibrillation, hypertension, chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus, heart failure with congestive heart failure (CHF), obstructive sleep apnea requiring CPAP use at night, recurrent falls, and high fall risk. The patient was recently hospitalized following multiple syncopal episodes with collapse and an additional fall forward from her rollator walker. Following hospitalization, the patient returned home and currently resides alone in an elevator-accessible apartment with intermittent assistance and support from family members. Upon assessment, the patient was alert and oriented to person, place, and time. She ambulates primarily with a rollator walker and utilizes a scooter or wheelchair for longer distances outside the home. Within the apartment, the patient was observed ambulating approximately 25 feet on two occasions without an assistive device, frequently reaching for nearby objects for support and demonstrating increased trunk flexion, indicating impaired balance and safety awareness. Transfers to and from the bed, toilet, and rollator seat were completed with supervision, while bed mobility remained independent. Outdoor mobility, stair negotiation, and car transfer abilities were not assessed during this visit. The patient is considered homebound due to the significant physical effort required to leave the home safely with assistive devices and is further evidenced by a Tinetti Balance and Gait Assessment score of 15/28, indicating an elevated fall risk. Skin assessment revealed no current skin breakdown, wounds, or other integumentary concerns. The home environment was noted to be cluttered, creating potential safety hazards and increasing the patient's risk for falls. Education was provided regarding home safety modifications, including decluttering pathways and keeping the scooter out of the hallway to allow safe use of the rollator throughout the apartment. Additional education was provided on fall prevention strategies, proper use of assistive devices, medication management and compliance, disease process management, energy conservation techniques, and recognition and reporting of changes in condition to the physician or healthcare team. Prior to hospitalization, the patient was independent with self-care activities and functional mobility within the home while utilizing a walker, requiring a wheelchair only for longer community distances. Following hospitalization, the patient demonstrates decreased standing balance, reduced standing tolerance, diminished bilateral upper extremity strength, decreased activity tolerance, and impaired functional mobility. These deficits have negatively impacted her ability to safely perform activities of daily living (ADLs), functional transfers, and mobility tasks independently. Skilled nursing services are medically necessary for ongoing cardiopulmonary assessment and monitoring related to atrial fibrillation, COPD, heart failure, diabetes mellitus, sleep apnea, and recent syncopal episodes. Skilled nursing will monitor for signs and symptoms of disease exacerbation, assess medication compliance and effectiveness, reinforce disease-specific education, evaluate safety risks within the home, implement fall prevention interventions, and monitor overall functional status to reduce the risk of complications, emergency department visits, and rehospitalization. Physical therapy services are warranted to address deficits in strength, balance, gait, endurance, transfer ability, and overall functional mobility with the goal of improving safety, reducing fall risk, and restoring the patient to her prior level of function. Occupational therapy services are also indicated to improve standing balance, standing tolerance, upper extremity strength, activity tolerance, self-care performance, functional transfers, and independence with activities of daily living. The interdisciplinary plan of care is focused on maximizing safety, promoting independence within the home environment, preventing further falls, and supporting the patient's ability to remain safely in the community.
 Date of Order 07/20/2026 Orders Physician Face-to-Face Date: 05/16/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management, pt-eval & treat, ot-eval & treat, hhadl's due to Hypertensive heart disease with heart failure Homebound Status per Certifying Physician: patient requires another person or medical equipment

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
Sherell Mason
815 E. Pratt Street
Baltimore, MD 21202
PHONE: 410-637-5700 FAX: 14106375661 NPI: 1750375481

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 : 05/16/2026

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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such as crutches, a walker, or a wheelchair to leave home
 4 - Recertification Notes: The patient is recertified due to the continued need for skilled nursing services for ongoing medication management, reinforcement of medication compliance, fall prevention education, comprehensive health assessments, monitoring for changes in condition, and continued patient/caregiver education to promote safe disease management and prevent hospitalization. The patient remains in stable condition with vital signs within normal limits, with no new concerns, acute changes, or complications noted during today's assessment. Skilled nursing services will continue as ordered to monitor the patient's condition, reinforce education, and support the achievement of established goals.
 Physician Mason, Sherell

SN Careplans

SN WK3: 1 (08/02/26-08/08/26) ,WK4: 1 (08/09/26-08/15/26)

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: 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; 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:Not Received

PROBLEMS IDENTIFIED ON ASSESSMENT: M1700 - Cognition, M2102d - Caregiver Performs Treatment, abnormal blood pressure, abnormal BS < 70/140 > mg/dL, muscle weakness, difficulty sleeping, obesity

PROCEDURES: coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, glucose testing via monitor, monitor intake & output, monitor dialysis schedule

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 keep home safe for patient with dementia coping strategies for the caregiver*, related medication(s) purpose, schedule, * urinary incontinence management including bladder training Kegel exercises skin care, related medication(s) purpose, schedule, * how to keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, patient's transportation needs are met, patient's living environment is clean/uncluttered, 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

SN Goals

PATIENT-STATED GOAL: Patient stated she would like to remain free of fall and regain 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
* urinary incontinence management including bladder training
* Kegel exercises
* skin care
* 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's transportation needs are met

patient's living environment is clean/uncluttered

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

patient/caregiver recalls
* how to keep home safe for patient with dementia
* coping strategies for the caregiver* recalls related medication(s) purpose, schedule

PT Careplans

PT Goals

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/20/2026

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PT WK3: 1 (08/02/26-08/08/26)

PROCEDURES: Bed mobility training : Sit to supine and supine to sit., home exercise program: Supine hip flexion, bridging, hooklying rotation, straight leg raise, hip abduction. Standing, knee flexion, hip abduction, hip extension, plantarflexion, squats. Sitting knee extension, ankle pumps, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Chair to Bed to Chair - 05. Setup or clean-up assistance, Sit to Stand - 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, Walk 150 Feet - 04. Supervision or touching assistance, 1 - Step (curb) - 04. Supervision or touching assistance, 4 Steps - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance, Car Transfer - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

PATIENT-STATED GOAL: To be able to walk with my rollator to appointments

GOALS

1 - Step (curb) - 04. Supervision or touching assistance

4 Steps - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

Car Transfer - 05. Setup or clean-up assistance

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

Walk 150 Feet - 04. Supervision or touching assistance

Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
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