Home Health Certification and Plan of Care

Order ID: 1150/20764

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
2R49WG1CP54	07/23/2026	From: 07/23/2026 To: 09/20/2026	28209	217058

6. Patient's Name and Address

Edwina Gwynn Beatty
883 Ellicott Dr,
Bel Air, MD 21015-
410-428-8977

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 08/25/1947 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
J44.1	Chronic obstructive pulmonary disease w (acute) exacerbation	07/23/26

13. ICD	Other Pertinent Diagnoses	Date
I11.0	Hypertensive heart disease with heart failure	07/23/26
I50.32	Chronic diastolic (congestive) heart failure	07/23/26
M17.0	Bilateral primary osteoarthritis of knee	07/23/26
I89.0	Lymphedema not elsewhere classified	07/23/26
F33.1	Major depressive disorder recurrent moderate	07/23/26
K21.9	Gastro-esophageal reflux disease without esophagitis	07/23/26
K59.00	Constipation unspecified	07/23/26
F41.9	Anxiety disorder unspecified	07/23/26
K57.90	Dvrtclos of intest part unsp w/o perf or abscess w/o bleed	07/23/26
E78.5	Hyperlipidemia unspecified	07/23/26
G47.00	Insomnia unspecified	07/23/26
G62.9	Polyneuropathy unspecified	07/23/26
Z79.51	Long term (current) use of inhaled steroids	07/23/26
Z79.891	Long term (current) use of opiate analgesic	07/23/26
Z96.641	Presence of right artificial hip joint	07/23/26
Z91.81	History of falling	07/23/26

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

TRAMADOL 50 mg/tablet / Give 2 tablet by mouth every 12 hours as needed for MODERATE PAIN for 14 Days TAKE 2 TABS TO EQUAL 100mg BID prn
Trelegy Ellipta Aerosol Powder Breath Activated (Fluticasone-Umeclidin-Vilant) 200-62.5-25 MCG/INH / Inhale 1 inhalation by mouth in the morning for COPD RINSE MOUTH AFTER USE HOB ELEVATED AT 45% TO AVOID SHORTNESS OF BREATH FOR COPD.
SENNOSIDES 8.6 mg/tablet / Give 2 tablet by mouth in the evening for BOWEL REGIMEN
Potassium Chloride - Potassium Chloride Extended Release 10 MEQ / 1 Tablet by mouth in the evening for HYPOKALEMIA
OXYCODONE 5 MG / 1 Tablet by mouth every 6 hours as needed for SEVERE PAIN for 14 Days
OMEPRAZOLE Delayed Release 20 MG / 1 Capsule by mouth one time a day for GERD BEFORE BREAKFAST
MIRALAX 0 Powder 17 gram/dose / Give 17 gram by mouth in the morning and at bedtime for BOWEL REGIMEN. SHOULD BE MIXED WITH AT LEAST 8 OUNCES OF FLUID
MELATONIN 3 mg/tablet / Give 2 tablet by mouth at bedtime for INSOMNIA for 14 Days
Lyrica - Pregabalin 100 MG / 1 Capsule by mouth three times a day for NEUROPATHY ADMINISTER WITH FOOD
FUROSEMIDE 40 MG / 1 Tablet by mouth one time a day for EDEMA
DULOXETINE HYDROCHLORIDE Delayed Release 60 MG / 1 Capsule by mouth two times a day for DEPRESSION/ NEUROPATHY
ACETAMINOPHEN 325 mg/tablet / Give 2 tablet by mouth every 4 hours as needed for MILD TO SEVERE PAIN NOT TO EXCEED 3GM ACETAMINOPHEN PER DAY
Acetaminophen - Acetaminophen 650 MG / 1 Tablet by mouth every 8 hours around-the-clock for PAIN
Albuterol Sulfate And Ipratropium Bromide - Albuterol Sulfate: Ipratropium Bromide 0.5 mg-3 mg(2.5 mg base)/3 mL solution for nebulization / 3 ml inhale orally every 6 hours as needed for SHORTNESS OF BREATH VIA NEBULIZER EVERY 6 HOURS
A & D Zinc Oxide Cream (Dimethicone-Zinc Oxide-Vit A-D) - topical as necessary every shift Apply to BUTTOCKS/COOCYX/GROIN for SKIN INTEGRITY APPLY AFTER CLEANSING WITH SOAP/WATER AND OR NSS
betamethasone, augmented cream 0.05% / Apply to AREAS OF PSORIASIS topical twice a day for PSORIASIS SPECIFIC AREAS
NYSTATIN 100,000 unit/gram powder topically every day and evening shift Apply to Under Bil Breast for ANTIFUNGAL RASH for 14 Days AFTER CLEANSING WITH SOAP AND WATER

14. DME and Supplies:

bath bench, rolling walker, cane

15. Safety Measures:

standard precautions, fall precautions, ambulates with device, medication safety, bathroom safety

16. Nutrition:

regular

17. Allergies:

atorvastatin penicillin g ace inhibitors latex

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: 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 Chronic obstructive pulmonary disease with (acute) exacerbation, 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.

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 07/23/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Luisa Massari
3346 Paper Mill Rd
Phoenix, MD 21131
PHONE: 4104272020 FAX: 14104272013 NPI: 1225075567

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 : 07/07/2026

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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Edwina Gwynn Beatty 883 Ellicott Dr, Bel Air, MD 21015- 410-428-8977	HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239

Clinical Condition Requiring Homecare:

The patient is a 78-year-old female with a significant past medical history of congestive heart failure, congestive heart failure with preserved ejection fraction (HFpEF), acute respiratory failure with hypoxia, COPD, essential hypertension, hyperlipidemia, GERD without esophagitis, hydronephrosis, diverticulosis without perforation or bleeding, bilateral primary osteoarthritis of the knees, anxiety disorder, depression, insomnia, lymphedema, polyneuropathy, hypoxemia, pain in the left leg, pain in the right knee, difficulty walking, and presence of a right artificial hip joint. The patient was recently hospitalized following a fall at home and subsequently completed a stay in subacute rehabilitation before being referred for home health services. The patient reported that she was found by her granddaughter after the fall and transported to the emergency department for evaluation. During the current assessment, the patient also reported another recent fall while wearing grip socks, stating that the socks caught on the floor. She was able to get herself up with significant effort and denied sustaining any new injuries, although she reported generalized soreness. The patient remains alert and oriented to person, place, time, and situation (A&O4) and denies nausea, vomiting, shortness of breath, headache, lightheadedness, or other acute complaints. She reports chronic bilateral knee and hip pain, which is currently managed under a pain management protocol. Physical assessment revealed a laceration to the posterior left thigh that is open to air without indication for dressing. Vital signs were within normal limits, and respirations were even and unlabored. The patient resides with her daughter and grandson in a multilevel townhouse. The bedroom is located in the basement, with a half bathroom on the basement level and a full bathroom on the upper floor. Her daughter works during the day, limiting caregiver availability. Prior to hospitalization, the patient was independent with community ambulation, basic and instrumental activities of daily living, and driving. She ambulated independently without an assistive device inside the home and used a single-point cane for outdoor mobility. At the time of evaluation, the patient ambulates slowly without an assistive device within the home but utilizes a walker or rollator for improved safety during ambulation. Physical therapy assessment identified impaired balance, lower extremity weakness, difficulty with gait, and impaired stair negotiation. Objective measures demonstrated a Tinetti Balance Assessment score of 17/28, indicating an increased risk for falls, and a Timed Up and Go (TUG) score of 14.2 seconds, reflecting impaired functional mobility. These deficits contribute to decreased safety and independence with functional mobility and increase the patient's fall risk. Occupational therapy evaluation further revealed decreased standing balance, reduced standing tolerance, diminished bilateral upper extremity strength, and decreased activity tolerance, resulting in reduced independence with self-care activities, functional transfers, and functional ambulation. Compared to her prior level of function, the patient now requires skilled intervention to address deficits limiting her ability to safely perform daily activities and return to her previous level of independence. Skilled physical therapy is medically necessary to improve lower extremity strength, balance, gait mechanics, stair negotiation, endurance, and overall mobility while reducing fall risk. Skilled occupational therapy is indicated to improve upper extremity strength, standing tolerance, activity tolerance, functional transfers, self-care performance, and overall safety with activities of daily living. Patient education was provided regarding fall prevention strategies, safe mobility techniques, appropriate use of assistive devices, home safety, and adherence to the prescribed plan of care. The patient demonstrates good rehabilitation potential and is expected to benefit from continued skilled therapy services to maximize functional independence and safely return to her prior level of function.
 Date of Order 07/23/2026 Orders Physician Face-to-Face Date: 07/07/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Chronic obstructive pulmonary disease with (acute) exacerbation 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 Massari, Luisa

SN Careplans

SN WK1: 1 (07/23/26-07/25/26) ,WK2: 1 (07/26/26-08/01/26) ,WK3: 1 (08/02/26-08/08/26) ,WK4: 1 (08/09/26-08/15/26) ,WK5: 1 (08/16/26-08/22/26)

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: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 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

SN Goals

PATIENT-STATED GOAL: For pain to subside.

GOALS
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/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
* how to achieve wound healing including cleaning and dressing wound
* position changes
* skin care
* diet modification
* record wound measurements
* 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

Signature of Physician:	Date
	PAGE 2 of 4
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/23/2026

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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:Patient is on Full code as indicated on POST/MOST form. Discussed and reviewed ongoing goals of care as well as potential decisions associated with unexpected medical events.

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2020 - Oral Med Management, abnormal blood pressure, M1033 - Exhaustion, M1400 - Dyspnea, limited strength, muscle weakness, balance deficit, Pain Interference with ADLs, open sores/lesions, #1 - Laceration - Posterior Left Thigh - Laceration sustained from a fall.

PROCEDURES: physician-ordered wound care: #1 - Laceration - Posterior Left Thigh - Laceration sustained from a fall.: Nurse please check wound, if healed , no problem, if not please call MD for wound other., cough/deep breathing exercises, incentive spirometer

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 avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpose, schedule, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, 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

PT Careplans

PT WK2: 2 (07/26/26-08/01/26) ,WK3: 1 (08/02/26-08/08/26) ,WK4: 1 (08/09/26-08/15/26) ,WK5: 1 (08/16/26-08/22/26) ,WK6: 1 (08/23/26-08/29/26) ,WK7: 1 (08/30/26-09/05/26) ,WK8: 1 (09/06/26-09/12/26)

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 pt, home exercise program: Seated laq, hip abduction, standing heelraises, hamstring curls, toe raises, hip flexion, abduction 2-310, dynamic standing balance exercises: Dynamic balance training exercises to focus on improving reaction time balance recovery use of hip ankle step strategies., 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, 12 Steps - 06. Independent, Picking Up Object - 06. Independent

PT Goals

PATIENT-STATED GOAL: To improve my balance and walking be Independent and get back to driving 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

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

12 Steps - 06. Independent

Picking Up Object - 06. Independent

OT Careplans

OT WK1: 1 (07/23/26-07/25/26) ,WK3: 1 (08/02/26-08/08/26) ,WK5: 1 (08/16/26-08/22/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, 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

PROCEDURES: Medication Review : Medication reviewed with patient with all medications in the home, home exercise program: Bilateral UE strengthening including biceps curls, armchair press-ups, triceps extensions 2-3sets 8-10 reps, equipment training, work simplification/energy conservation, transfers training, transfers training: Skilled OT, assist with bathing: Skilled OT

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

OT Goals

PATIENT-STATED GOAL: Walk better

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
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to relieve pain teach relaxation skills and diversional activities, related medication(s) purpose, schedule, 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, 12 Steps - 06. Independent, Picking Up Object - 06. Independent, 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	* teach relaxation skills and diversional activities * recalls related medication(s) purpose, schedule Sit to Stand - 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 12 Steps - 06. Independent Picking Up Object - 06. Independent 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

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