Home Health Certification and Plan of Care

Order ID: 1150/20886

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
2TM9G96MH24	07/25/2026	From: 07/25/2026 To: 09/22/2026	28218	217058

6. Patient's Name and Address

Glenda Oakley
6410 Waterloo Road,
COLUMBIA, MD 21045-
443-979-0613

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 04/05/1960 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
M00.061	Staphylococcal arthritis right knee	07/25/26

13. ICD	Other Pertinent Diagnoses	Date
B95.61	Methicillin suscep staph infct causing dis classd elswhr	07/25/26
I11.0	Hypertensive heart disease with heart failure	07/25/26
I50.32	Chronic diastolic (congestive) heart failure	07/25/26
D64.89	Other specified anemias	07/25/26
G62.9	Polyneuropathy unspecified	07/25/26
I48.0	Paroxysmal atrial fibrillation	07/25/26
M10.071	Idiopathic gout right ankle and foot	07/25/26
J45.998	Other asthma	07/25/26
J96.11	Chronic respiratory failure with hypoxia	07/25/26
F33.8	Other recurrent depressive disorders	07/25/26
F41.8	Other specified anxiety disorders	07/25/26
Z79.82	Long term (current) use of aspirin	07/25/26

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

Albuterol Sulfate - Albuterol Sulfate HFA 108 (90 Base) MCG/ACT Aerosol Solution / Give 1 puff by mouth every 4 hours as needed for SOB
ALLOPURINOL 100 MG / 1 Tablet by mouth one time a day for Gout
ASPIRIN Chewable 81 MG / 1 Tablet by mouth one time a day for CVA ppx
Atorvastatin Calcium - Atorvastatin Calcium 80 MG / 1 Tablet by mouth in the evening for Hyperlipidemia
BACLOFEN 20 MG / 1 Tablet by mouth three times a day for muscular spasms
Budesonide-Formoterol Fumarate Inhalation Aerosol 160-4.5 MCG/ACT / Inhale 2 puff by mouth twice a day for Asthma
BUSPIRONE HCL 15 MG / 1 Tablet by mouth two times a day for Anxiety
CARVEDILOL 3.125 MG / 1 Tablet by mouth two times a day for HTN
COLCHICINE 0.6 MG / 1 Tablet by mouth two times a day for Gout
Ferrous Sulfate - Ferrous Sulfate: Folic Acid 325 (65 Fe) MG / 1 Tablet by mouth once a day for supplementation
Fluoxetine Hydrochloride - Fluoxetine Hydrochloride 40 MG / 1 Capsule by mouth one time a day for Anxiety / depression
IBUPROFEN 400 MG / 1 Tablet by mouth every 8 hours as needed for Pain management
Lasix - Furosemide 20 MG / 1 Tablet by mouth in the morning every Mon, Wed, Fri for Loop diuretic
LISINOPRIL 5 MG / 1 Tablet by mouth one time a day for HTN
MELATONIN 3 MG / 1 Tablet by mouth at bedtime for Insomnia
Oxycodone Hydrochloride - Oxycodone Hydrochloride 5 MG / 1 Tablet by mouth every 6 hours as needed for pain hold for sedation
Trazodone Hydrochloride - Trazodone Hydrochloride 50 MG / 1 Tablet by mouth at bedtime for Insomnia

14. DME and Supplies:

oxygen supplies, cane, wheelchair, rolling walker, hand held shower, bath bench, walker, 4 wheeled walker

15. Safety Measures:

O2 precautions, wheelchair precautions, standard precautions, fall precautions, bleeding precautions, ambulates with device, walker precautions, smoke detectors , medication safety, emergency phone # clearly displayed, ambulates with assistance, transfer with assist, cardiac precautions, bathroom safety, activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

CT-Iodinated Contrast Media(06/11/2026), Ambien(06/11/2026)

18.A. Functional Limitations

Endurance, Bowel/Bladder Incontinence, Ambulation

18.B. Activities Permitted

Exercises Prescribed, 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: Yes

20. Prognosis: good

22. A Rehabilitation Potential:

SELF-CARE: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities., MOBILITY: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities.

22.B.Discharge Plans

family/caregiver will be responsible for managing treatment
patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Staphylococcal arthritis right knee, 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 66-year-old female admitted for skilled nursing services following hospitalization for methicillin-susceptible Staphylococcus aureus (MSSA) bacteremia and right knee septic arthritis, status post surgical washout, requiring completion of intravenous antibiotic therapy, rehabilitation, and ongoing management of multiple chronic medical conditions. Her past medical history is significant for chronic diastolic heart failure with preserved ejection fraction (HFpEF)/congestive heart failure, hypertension, paroxysmal atrial fibrillation, chronic respiratory failure with hypoxia requiring supplemental oxygen, asthma, peripheral neuropathy, tremors, chronic gait dysfunction, lumbar spinal stenosis with neurogenic claudication, chronic low back pain, chronic kidney disease stage II, idiopathic gout of the right ankle and foot, hyperlipidemia, cardiomegaly, obstructive sleep apnea, anemia, mild protein-calorie malnutrition, adult failure to thrive, recurrent mild major depressive disorder, generalized anxiety disorder, and orthopedic aftercare following right total knee replacement. The patient completed IV Cefazolin 2 g every 8 hours, with end of therapy on 06/29/2026, for treatment of MSSA bacteremia and septic arthritis. She has a documented allergy to Ambien (zolpidem). Upon assessment, the patient is alert, oriented, awake, cooperative, and in no acute distress. She reports feeling well overall with a good appetite and adequate sleep, although she continues to experience left leg/hip sciatic pain and occasional difficulty falling asleep. She denies chest pain, headache, dizziness, or recent falls. The patient endorses chronic shortness of breath consistent with her underlying cardiopulmonary disease and remains on supplemental oxygen without evidence of acute respiratory distress. Nursing assessment reveals that she is hemodynamically stable, and no acute events have been reported. The right knee surgical incision is clean, dry, and intact without drainage, erythema, swelling, or other signs of infection. Orthopedic follow-up is scheduled for 07/10/2026 for suture removal. Continued monitoring of the surgical site is warranted for any signs of redness, drainage, increased pain, or infection. Functionally, the patient demonstrates significant decline following her recent hospitalization and skilled nursing facility stay. She presents with bilateral lower extremity weakness, impaired balance, altered gait mechanics, decreased endurance, chronic gait dysfunction, peripheral neuropathy with diminished sensation in both heels, and reduced functional activity tolerance. These impairments contribute to difficulty with bed mobility, sit-to-stand transfers, household ambulation, stair negotiation, and completion of activities of daily living. She ambulates with a walker within the home and has required a cane and/or walker since March 2026. The patient currently requires supervision to stand-by assistance for functional mobility and activities of daily living, including basic self-care tasks. She resides with her sister in a single-family home with two steps at the entrance, further increasing her fall risk. Prior to her recent medical decline, she was independent with both basic and instrumental activities of daily living. She expresses the goal of regaining independent ambulation and returning to her

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 07/25/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Elizabeth Miller
6501 Baltimore National Pike
Catonsville, MD 21228
PHONE: 4108012273 FAX: 14103859319 NPI: 1346795309

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 : 07/09/2026

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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prior level of function. The patient remains at increased risk for falls due to generalized weakness, neuromuscular deficits, impaired balance, chronic cardiopulmonary disease, peripheral neuropathy, deconditioning, and reduced activity tolerance. Skilled nursing services remain medically necessary for ongoing assessment of cardiopulmonary status, vital signs, oxygen requirements, medication management, monitoring for recurrence of infection, and evaluation of chronic medical conditions including HFpEF, atrial fibrillation, hypertension, asthma, anemia, and chronic respiratory failure. Skilled physical therapy is indicated to provide therapeutic exercises, gait and transfer training, balance training, neuromuscular re-education, pain management strategies, strengthening, endurance training, and fall prevention interventions to improve mobility, maximize safety, restore functional independence, and reduce the risk of rehospitalization. Skilled occupational therapy is also medically necessary to address upper extremity strengthening, activity tolerance, energy conservation, safety with activities of daily living, adaptive techniques, and prevention of further deconditioning and functional decline. Patient education was reinforced regarding fall prevention strategies, proper use of assistive devices, the importance of maintaining adequate protein intake, nutrition, hydration, and adherence to prescribed medications and oxygen therapy. The patient verbalized understanding of the education provided. The plan of care includes continuation of the current medication regimen as prescribed, close monitoring of vital signs, cardiopulmonary status, oxygen needs, and the right knee surgical incision, maintenance of fall precautions, assistance with activities of daily living as needed, continuation of skilled nursing, physical therapy, and occupational therapy services, encouragement of adequate nutrition and hydration, and follow-up with Orthopedics on 07/10/2026 for suture removal.
 Date of Order 07/25/2026 Orders Physician Face-to-Face Date: 07/09/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Staphylococcal arthritis right knee 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 Miller, Elizabeth

SN Careplans

SN WK1: 1 (07/25/26-07/25/26) ,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: 2. Non-agency caregiver(s) need training/supportive services to provide assistance

HOSPITALIZATION RISKS: 7. Currently taking 5 or more medications

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:PLACEHOLDER

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2020 - Oral Med Management, M2102f - Patient Supervision, M2102c - Med Admin, M2102d - Caregiver Performs Treatment, dependent edema, M1400 - Dyspnea, frequent urination, muscle weakness, limited strength, limited endurance

PROCEDURES: cough/deep breathing exercises, incentive spirometer, teach/coordinate/arrange medication packaging and/or administration

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, * depression-prevention strategies including

SN Goals

PATIENT-STATED GOAL: Caregiver wants patient to regain her independence back and regain her strength to be able to walk safely in her home.

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
* 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 self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

caregiver administers and/or packages medications appropriately

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/25/2026

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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, caregiver administers and/or packages medications appropriately

PT Careplans

PT WK1: 1 (07/23/26-07/25/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170D1 - Sit to Stand, GG0170F1 - Toilet Transfer, GG0170I1 - Walk 10 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170K1 - Walk 150 Feet, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170L1 - Walk 10 ft on Uneven Surface

PROCEDURES: B LE mm strengthening: 1, home exercise program: Ankle pumps, quad sets, glute sets, heel slides, partial squats, and seated/standing knee flexion and extension within tolerance. 10-15 reps ea. 1-2 set per day., 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 - 06. Independent, 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, 12 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

PT Goals

PATIENT-STATED GOAL: To walk much better at home with the walker

GOALS
Toilet Transfer - 06. Independent

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

Chair to Bed to Chair - 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

12 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

OT Careplans

OT 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) ,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: Pain Effect on Sleep, 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: cough/deep breathing exercises, incentive spirometer, home exercise program: exe during the week, equipment training, work simplification/energy conservation

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 - 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: Pt be able to do more in the house

GOALS
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

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
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Optional Name/Signature of Nurse/Therapist:	Date
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