Home Health Certification and Plan of Care

Order ID: 1150/20923

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
35197453	06/13/2026	From: 06/13/2026 To: 08/11/2026	26837	217058

6. Patient's Name and Address

Mary Fogle
1412 Providence Road,
Towson, MD 21204-
410-825-1743

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 11/24/1937 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
E11.621	Type 2 diabetes mellitus with foot ulcer	06/13/26

13. ICD	Other Pertinent Diagnoses	Date
L97.529	Non-pressure chronic ulcer oth prt left foot w unsp severity	06/13/26
J45.998	Other asthma	06/13/26
I13.0	Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny	06/13/26
I50.32	Chronic diastolic (congestive) heart failure	06/13/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	06/13/26
N18.4	Chronic kidney disease stage 4 (severe)	06/13/26
D63.1	Anemia in chronic kidney disease	06/13/26
I48.91	Unspecified atrial fibrillation	06/13/26
E78.5	Hyperlipidemia unspecified	06/13/26
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy	06/13/26
F01.50	Vascular dementia unsp severity without beh/psych/mood/anx	06/13/26
R13.12	Dysphagia oropharyngeal phase	06/13/26
D69.6	Thrombocytopenia unspecified	06/13/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	06/13/26
E55.9	Vitamin D deficiency unspecified	06/13/26
N25.81	Secondary hyperparathyroidism of renal origin	06/13/26
I71.40	Abdominal aortic aneurysm without rupture unspecified	06/13/26
K21.9	Gastro-esophageal reflux disease without esophagitis	06/13/26
I25.2	Old myocardial infarction	06/13/26
M19.90	Unspecified osteoarthritis unspecified site	06/13/26
R62.7	Adult failure to thrive	06/13/26
E66.9	Obesity unspecified	06/13/26
Z16.12	Extended spectrum beta lactamase (ESBL) resistance	06/13/26
Z86.718	Personal history of other venous thrombosis and embolism	06/13/26
Z86.711	Personal history of pulmonary embolism	06/13/26
Z87.891	Personal history of nicotine dependence	06/13/26
Z79.82	Long term (current) use of aspirin	06/13/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	06/13/26
Z79.4	Long term (current) use of insulin	06/13/26

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

ACETAMINOPHEN 500 mg/tablet / Give 2 tablet by mouth every 6 hours as needed for Pain
AMLODIPINE 10 mg / 1 Tablet by mouth one time a day for hypertension
ASPIRIN Chewable 81 MG tablet by mouth one time a day for CVA prophylaxis
ATORVASTATIN 40 mg / 1 Tablet by mouth at bedtime for hyperlipidemia
BENZONATATE 100 mg / 1 Capsule by mouth every 8 hours as needed for cough
DOXAZOSIN 4 mg / 1 Tablet by mouth one time a day for HTN
DOXYCYCLINE 100 mg / 1 Capsule by mouth two times a day for PNA for 1 Day
Empagliflozin 10 mg / 1 Tablet by mouth once a day for Diabetes
FUROSEMIDE 40 mg / 1 Tablet by mouth one time a day for CHF
PANTOPRAZOLE Delayed Release 40 mg / 1 Tablet by mouth one time a day for Gerd
HYDRALAZINE 25 mg / 1 Tablet by mouth two times a day for Hypertension
Cefdinir - Cefdinir 300 mg Take 1 capsule by mouth every 12 hours X 14 days for infection
Albuterol Sulfate - Albuterol Sulfate (2.5 MG/3ML) 0.083% / 3 ml inhale orally via nebulizer every 6 hours as needed for asthma/wheezing
Tuberculin PPD Solution 5 UNIT/0.1ML / Inject 0.1 ml intradermally once a day for TB Screening for 1 Day Verify NO BCG or h/o(+); Document Lot# & Exp Date under Immunization tab; Read results in 48-72hrs (Give 7-10 Days After 1st Administration)
Insulin Lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 UNIT/ML / Inject 2 unit subcutaneous after meal for Diabetes
Lantus Solostar - Insulin Glargine Recombinant 100 UNIT/ML / Inject 8 unit subcutaneous at bedtime for DM

14. DME and Supplies:

wound care supplies, walker, , , rolling walker, diabetic supplies

15. Safety Measures:

walker precautions, standard precautions, sharps precautions, medication safety, infectious material management, fall precautions, diabetic precautions, cardiac precautions, bathroom safety, ambulates with device, ambulates with assistance, activity supervision

16. Nutrition:

diabetic

17. Allergies:

Bactrim; Hydralazine; Ibuprofen; ; Sulfa antibiotics; ; Trelegy Ellipta;

18.A. Functional Limitations

Dyspnea With Minimal Exertion, Ambulation, Endurance, Amputation

18.B. Activities Permitted

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: 1. In new or complex situations only, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 1. Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required!2. Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions, HISTORY OF DEPRESSION: No

20. Prognosis: fair

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
family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Type 2 diabetes mellitus with foot ulcer, 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 06/13/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Robert Knight
104 Plumtree Rd
Belair, MD 21015
PHONE: 4105694224 FAX: 14105694368 NPI: 1639258932

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 : 04/22/2026

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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Clinical Condition Requiring Homecare:

Home health skilled nursing admission was completed for an 88-year-old female residing in an assisted living facility following a recent hospitalization and subacute rehabilitation stay related to pneumonia, diabetes mellitus, and a left foot ulcer requiring toe amputation. The patient is alert and oriented and was referred to home health services for ongoing skilled nursing and rehabilitation management. Her past medical history is significant for asthma, heart failure with preserved ejection fraction (HFpEF), chronic kidney disease stage IV, atrial fibrillation (not anticoagulated), hypertension, hyperlipidemia, type 2 diabetes mellitus with polyneuropathy, and diabetic foot ulcers. Assessment revealed a diabetic ulcer involving the left great toe and the medial aspect of the left foot. Ordered wound care consists of cleansing with normal saline solution, painting the wound with betadine, and applying a dry dressing daily. The patient's daughter assists with wound care on non-skilled nursing days. No acute distress was noted during the visit. Prior to her recent hospitalization, the patient resided in the assisted living facility, required assistance with activities of daily living, ambulated with a rolling walker, and was independent with transfers and bed mobility. Following her illness and surgical intervention, the patient demonstrates significant functional decline characterized by bilateral lower extremity weakness, greater on the right than the left, impaired balance, gait dysfunction, difficulty with transfers, and reduced mobility. Gait assessment revealed decreased foot clearance, poor heel strike with frequent forefoot landing, and mild unsteadiness during ambulation. Objective balance testing demonstrated a Tinetti score of 12/28 and a Timed Up and Go (TUG) score of 41 seconds, indicating a high risk for falls. The patient also experiences difficulty with bed mobility and functional transfers, further impacting her safety and independence. The patient remains pleasant, cooperative, and motivated to participate in therapy. Skilled nursing services are required for ongoing wound assessment and management, diabetic education, disease process monitoring, and prevention of infection and further complications. Skilled physical therapy is medically necessary to address lower extremity weakness, impaired balance, transfer deficits, gait abnormalities, decreased functional mobility, and fall risk through strengthening, balance retraining, gait training, transfer training, endurance building, and safety education. Continued interdisciplinary home health services are expected to improve functional mobility, maximize independence, reduce the risk of falls and rehospitalization, and promote optimal wound healing and overall quality of life.
 Date of Order 06/13/2026 Orders Physician Face-to-Face Date: 04/22/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Type 2 diabetes mellitus with foot ulcer 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 Knight, Robert

SN Careplans

SN WK1: 1 (06/13/26-06/13/26) ,WK2: 1 (06/14/26-06/20/26) ,WK3: 1 (06/21/26-06/27/26) ,WK5: 1 (07/05/26-07/11/26) ,WK7: 1 (07/19/26-07/25/26) ,WK9: 1 (08/02/26-08/08/26)

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: 5. Decline in mental, emotional, or behavioral status in the past 3 months, 6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months, 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/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.

NA
Advance Directive:see MOLST

PROBLEMS IDENTIFIED ON ASSESSMENT: M1745 - Behavioral Issues, M2020 - Oral Med Management, swelling in the arms/legs, dependent edema, weak pulses in feet, M1033 - Exhaustion, M1400 - Dyspnea, abnormal BS < 70/140 > mg/dL, M1610 - Urinary Incontinence, poor muscle tone, muscle weakness, swelling of affected area, limited endurance, limited strength, #2 - Diabetic Ulcer - Other - Left lateral foot - Cleanse with nss paint with betadine apply dry dressing daily, #1 - Diabetic Ulcer - Other - Left great toe - Cleanse with nss paint with betadine apply dry dressing daily, open sores/lesions

PROCEDURES: physician-ordered wound care: #1 - Diabetic Ulcer - Other - Left great toe - Cleanse with nss paint with betadine apply dry dressing daily, physician-ordered wound care: #2 - Diabetic Ulcer - Other - Left lateral foot - Cleanse with nss paint with betadine apply dry dressing daily,

SN Goals

PATIENT-STATED GOAL: I want my foot to heal

GOALS
patient/caregiver recalls
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* 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 self-administers medications as prescribed
* 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
* management of mental health condition including joining a peer group
* maintaining regular contact with mental health professional
* avoiding known stressors
* controlling impulses
* recalls related medication(s) purpose, schedule

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/13/2026

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physician-ordered wound care: cleanse tip of left great toe and left lateral foot diabetic ulcer with NS and apply betadine wet to moist with ABD pad and kerlix QD and PRN, bladder training

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, * management of mental health condition including joining a peer group maintaining regular contact with mental health professional avoiding known stressors controlling impulses, 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

PT Careplans

PT WK2: 1 (06/14/26-06/20/26) ,WK4: 1 (06/28/26-07/04/26) ,WK5: 1 (07/05/26-07/11/26) ,WK6: 1 (07/12/26-07/18/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170O1 - 12 Steps, GG0130F1 - Upper Body Dressing, 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, GG0170D1 - Sit to Stand, 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

PROCEDURES: Medication management : Meds reviewed with caregiver, home exercise program: Supine tes as needed slr, aps, QS, seated laq, hip flexion, hip abduction , hamstring curls , DF, heelraises weights as tolerated, standing hip flexion, hip abduction 2-310, equipment training, work simplification/energy conservation, dynamic standing balance exercises: Focus wt shifting, hip ankle step strategies, reaching outside bos, gait training on uneven surfaces, gait training/stair training, transfers training

PT Goals

PATIENT-STATED GOAL: Pt stated to get stronger improve my walking and be steadier

GOALS
Chair to Bed to Chair - 06. Independent

Sit to Stand - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/13/2026