Home Health Certification and Plan of Care

Order ID: 1150/20962

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
5NY5NG5RE81	07/29/2026	From: 07/29/2026 To: 09/26/2026	28492	217058

6. Patient's Name and Address

Shahida Sultana
604 Whittier Pkwy,
SEVERNA PARK, MD 21146-
410-570-9252

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 12/01/1940 | **9.Sex** Female

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

ACETAMINOPHEN 325 mg/tablet / Take 2 tablets by mouth 3 times daily
FUROSEMIDE 20 MG / 1 Tablet by mouth daily as needed Shortness of breath, edema or weight gain of > 2 lbs in 24hrs.
GUAIFENESIN 100 MG/5ML oral liquid / Take 10 mL by mouth every 8 hours
Acetaminophen And Codeine Phosphate - Acetaminophen: Codeine Phosphate 300-30 MG / 1 Tablet by mouth every 6 Hours as needed for Pain
FOLIC ACID 1 MG / 1 Tablet by mouth daily
GABAPENTIN 300 MG / 1 Capsule by mouth 2 times daily
ALBUTEROL 108 (90 Base) MCG/ACT inhaler / Inhale 2 puffs into the lungs inhalant every 4 hours as needed for Wheezing
LATANOPROST 0.005 % ophthalmic solution / Place 1 drop into both eyes nightly, at bedtime

11. ICD	Principal Diagnosis	Date
I50.33	Acute on chronic diastolic (congestive) heart failure	07/29/26

13. ICD	Other Pertinent Diagnoses	Date
N18.30	Chronic kidney disease stage 3 unspecified	07/29/26
D63.1	Anemia in chronic kidney disease	07/29/26
I25.5	Ischemic cardiomyopathy	07/29/26
I48.0	Paroxysmal atrial fibrillation	07/29/26
I27.20	Pulmonary hypertension unspecified	07/29/26
D56.3	Thalassemia minor	07/29/26
J44.9	Chronic obstructive pulmonary disease unspecified	07/29/26
F32.A	Depression unspecified	07/29/26
N83.201	Unspecified ovarian cyst right side	07/29/26
E66.9	Obesity unspecified	07/29/26
Z68.30	Body mass index [BMI] 30.0-30.9 adult	07/29/26

14. DME and Supplies:

grab bars, hand held shower, wheelchair, walker, rolling walker, bath bench

15. Safety Measures:

cardiac precautions, transfer with assist, standard precautions, hand rails, ambulates with assistance, emergency phone # clearly displayed, smoke detectors , wheelchair precautions, walker precautions, supervision at all times, remove environmental barriers, non-slip surface in tub, medication safety, infectious material management, fall precautions, bleeding precautions, bathroom safety, avoid temperature extremes, aspiration precautions, anticoagulant precautions, ambulates with device, activity supervision

16. Nutrition:

soft, low sodium,

17. Allergies:

Diltiazem - Rash (Mucositis)

18.A. Functional Limitations

Hearing, Endurance, Bowel/Bladder Incontinence

18.B. Activities Permitted

Wheelchair, 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: 1. Rarely, 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

SN: patient will be responsible for managing treatment
PT: family/caregiver will be responsible for managing treatment
OT: family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Acute on chronic diastolic (congestive) 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:

The patient is an 86-year-old female referred for home health services following hospitalization from 07/12/2026 to 07/21/2026 for acute congestive heart failure (CHF) with associated chest pain. During hospitalization, the patient also underwent evaluation for abdominal pain, which revealed a urinary tract infection (UTI) and pleural effusions consistent with volume overload. Her past medical history is significant for chronic kidney disease stage III, acute-on-chronic diastolic congestive heart failure, paroxysmal atrial fibrillation (previously managed with apixaban, discontinued secondary to gastrointestinal bleeding), thalassemia minor, mild intermittent asthma, class I obesity, dysphagia, dysuria, hyponatremia, gout, right eye glaucoma, and a history of bilateral total knee replacements (2000 and 2016). Upon assessment, the patient is alert and oriented to person and place (A&O 2), with occasional periods of drowsiness but able to follow simple commands. She denies current chest pain, fever, nausea, or vomiting. Lung sounds are clear to diminished bilaterally. She reports intermittent shortness of breath and has a history of pleural effusions and pulmonary edema related to CHF. No peripheral edema is noted during today's assessment, although the caregiver reports intermittent bilateral lower extremity swelling when the patient sits with her legs in a dependent position. The abdomen is soft with normoactive bowel sounds, and the patient reports her last bowel movement occurred this morning. She is incontinent of both bowel and bladder and wears absorbent briefs. Skin assessment reveals no wounds or pressure injuries. The patient demonstrates generalized weakness, including weak bilateral handgrip strength and decreased strength throughout both lower extremities. She also reports numbness in both feet. Functional assessment reveals impaired bed mobility, difficulty with transfers, decreased balance, unsteady gait, reduced endurance, impaired safety awareness, and difficulty negotiating stairs. She ambulates with a front-wheeled walker and requires contact guard assistance for ambulation, moderate assistance with basic activities of daily living, and significant caregiver assistance for meal preparation and feeding due to functional decline since her recent illness. She has experienced no falls within the past two months; however, she has a significant fall history, including approximately five to six falls over the past year, as well as previous falls in 2023 and 2025 resulting in neck and elbow injuries. She resides with her daughter and family in a single-family home, with her son living nearby and available to assist as needed. The patient remains on the main level of the home, where both her bedroom and bathroom are located. The home has two to five entrance steps, and she requires assistance to safely enter and exit the residence. The patient's current impairments include generalized deconditioning, bilateral lower extremity weakness, impaired balance, decreased functional mobility, difficulty with transfers and stair negotiation, gait instability, gout-related pain, limited endurance, and increased risk for falls, all of which significantly limit her ability to safely perform activities of daily living and functional mobility. Skilled physical therapy is medically necessary to improve lower extremity strength, balance, gait mechanics, transfer ability, endurance, stair negotiation, and overall safety awareness in order to restore the highest possible level of functional independence and reduce the risk of falls, hospitalization, and further functional decline. The physical therapy plan of care includes visits beginning 07/30/2026 with a frequency of 1 visit for 1 week, followed by 2 visits per week for 2 weeks (Tuesday/Thursday), then 1 visit per week for 6 weeks (Tuesday). The patient and family are in agreement with the established plan of care. The patient is considered homebound due to cardiovascular and respiratory disease, generalized weakness, impaired endurance, gait instability, and a significant history of falls. Leaving the home requires the use of a front-wheeled walker and the physical assistance of another person, and community mobility results in excessive fatigue, increased fall risk, and prolonged recovery time, making routine absences from the home medically contraindicated.

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 07/29/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Sukhpal Jassi
1600 Crain Highway
Glen Burnie, MD 21061
PHONE: 4434103161 FAX: 14434103199 NPI: 1649205238

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 : 07/18/2026

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.

Home Health Certification and Plan of Care

Order ID: 1150/20962

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
5NY5NG5RE81	07/29/2026	From: 07/29/2026 To: 09/26/2026	28492	217058

6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number
Shahida Sultana 604 Whittier Pkwy, SEVERNA PARK, MD 21146- 410-570-9252	HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239

Occupational therapy evaluation further indicates deficits in bed mobility, self-care performance, activity tolerance, and functional independence. Skilled occupational therapy is warranted to improve performance with basic activities of daily living, increase activity tolerance, maximize independence, and prevent further deconditioning while reducing caregiver burden.
 Date of Order 07/29/2026 Orders Physician Face-to-Face Date: 07/18/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management, pt-eval & treat, ot-eval & treat due to Acute on chronic diastolic (congestive) heart failure 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: OT Eval Notes:
 Physician Jassi, Sukhpal

SN Careplans

SN WK1: 1 (07/29/26-08/01/26) ,WK2: 1 (08/02/26-08/08/26) ,WK3: 1 (08/09/26-08/15/26) ,WK4: 1 (08/16/26-08/22/26) ,WK5: 1 (08/23/26-08/29/26)

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: 3. Multiple hospitalizations (2 or more) in the past 6 months, 4. Multiple emergency department visits (2 or more) in the past 6 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; 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:MOLST

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2102d - Caregiver Performs Treatment, M2102c - Med Admin, M2102f - Patient Supervision, M2020 - Oral Med Management, M1400 - Dyspnea, dependent edema (CR), M1033 - Exhaustion, chest pain, constipation, frequent urination (GU), M1610 - Urinary Incontinence, M1600 - UTI, urine retention (GU), limited strength, limited endurance, muscle weakness, B0200 - Hearing Deficit, B1000 - Vision Deficit, balance deficit, weak hand grips, difficulty sleeping, daytime fatigue, obesity (NU), loss of appetite

PROCEDURES: cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, monitor intake & output, bladder training, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange resources for vision-impaired, coordinate/arrange home modifications for hearing impaired, i.e. alarms

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 avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpose, schedule, * prevention including increase fluid intake increase Vitamin C intake to promote acidic bladder environment (cranberry juice) perineal hygiene, 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,

SN Goals

PATIENT-STATED GOAL: I want to regain my strength

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/caregiver recalls
* prevention including increase fluid intake
* increase Vitamin C intake to promote acidic bladder environment (cranberry juice)
* perineal hygiene
* 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/caregiver recalls
* how to keep home safe for hearing-impaired including installing special fire-detector/CO2 alarms
* 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 self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

patient is adequately supervised

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/29/2026

Home Health Certification and Plan of Care

Order ID: 1150/20962

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
5NY5NG5RE81	07/29/2026	From: 07/29/2026 To: 09/26/2026	28492	217058

6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number
Shahida Sultana 604 Whittier Pkwy, SEVERNA PARK, MD 21146- 410-570-9252	HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239

related medication(s) purpose, schedule, * how to keep home safe for hearing-impaired including installing special fire-detector/CO2 alarms, related medication(s) purpose, schedule, * how to keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient is adequately supervised, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT WK1: 1 (07/29/26-08/01/26) ,WK2: 2 (08/02/26-08/08/26) ,WK3: 2 (08/09/26-08/15/26) ,WK4: 1 (08/16/26-08/22/26) ,WK5: 1 (08/23/26-08/29/26) ,WK6: 1 (08/30/26-09/05/26) ,WK7: 1 (09/06/26-09/12/26) ,WK8: 1 (09/13/26-09/19/26) ,WK9: 1 (09/20/26-09/26/26)

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: home exercise program: Supine- ankle pump, quad set, gluteal set, heel slide, SLR, bridging. Seated-LAQ hip flex, hip abd, pillow squeeze. Standing-Mini squat, heel/toe raise, hip flex, hip abd, hip ext, leg curls., gait training/stair training, transfers training, assist with home exercise program: teach PCGs how to administer HEP

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 - 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, 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 improve mobility

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

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 (08/02/26-08/08/26) ,WK4: 1 (08/16/26-08/22/26) ,WK6: 1 (08/30/26-09/05/26) ,WK8: 1 (09/13/26-09/19/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with ADLs, M1400 - Dyspnea, GG0130B1 - Oral Hygiene, GG0130C1 - Toileting Hygiene, GG0130E1 - Shower/Bathe Self, GG0130F1 - Upper Body Dressing, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130A1 - Eating

PROCEDURES: cough/deep breathing exercises, incentive spirometer, home exercise program, 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 - 05. Setup or clean-up assistance, Toileting Hygiene - 05. Setup or clean-up assistance, Shower/Bathe Self - 02. Substantial/maximal assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance, Eating - 06. Independent

OT Goals

PATIENT-STATED GOAL: Family stayed the pt should be able to go to the bathroom by herself

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
* 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 - 05. Setup or clean-up assistance

Toileting Hygiene - 05. Setup or clean-up assistance

Shower/Bathe Self - 02. Substantial/maximal assistance

Upper Body Dressing - 05. Setup or clean-up assistance

Lower Body Dressing - 05. Setup or clean-up assistance

Don/Doff Footwear - 05. Setup or clean-up assistance

Eating - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/29/2026