Home Health Certification and Plan of Care

Order ID: 1150/21031

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
AA00009926	08/01/2026	From: 08/01/2026 To: 09/29/2026	2136	217058

6. Patient's Name and Address
Sabrina Waterstraat
1831 Rutland Avenue,
Baltimore, MD 21213-
443-220-7772

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 09/07/1970 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
E11.621	Type 2 diabetes mellitus with foot ulcer	08/01/26

13. ICD	Other Pertinent Diagnoses	Date
L97.529	Non-pressure chronic ulcer oth prt left foot w unsp severity	08/01/26
I12.0	Hyp chr kidney disease w stage 5 chr kidney disease or ESRD	08/01/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	08/01/26
N18.6	End stage renal disease	08/01/26
D63.1	Anemia in chronic kidney disease	08/01/26
E78.5	Hyperlipidemia unspecified	08/01/26
E11.40	Type 2 diabetes mellitus with diabetic neuropathy unsp	08/01/26
G40.909	Epilepsy unsp not intractable without status epilepticus	08/01/26
D50.9	Iron deficiency anemia unspecified	08/01/26
F41.9	Anxiety disorder unspecified	08/01/26
F32.A	Depression unspecified	08/01/26
M19.90	Unspecified osteoarthritis unspecified site	08/01/26
Z79.85	Lng trm (crnt) use injectable non-insulin antidiabetic drugs	08/01/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	08/01/26
Z79.4	Long term (current) use of insulin	08/01/26
Z79.82	Long term (current) use of aspirin	08/01/26
Z99.2	Dependence on renal dialysis	08/01/26
Z91.81	History of falling	08/01/26

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

pantoprazole(protonix) 40mg, tablet by mouth once a day GERD
Ativan - Lorazepam 2 mg 2mg, 1 tablet by mouth once a day AS NEEDED FOR ANXIETY
Januvia - Sitagliptin Phosphate eq 25 mg base 25MG; 1 TAB by mouth once a day DM
Hydralazine - Hydralazine Hydrochloride 50MG; 1 TAB by mouth three times a day BLOOD PRESSURE
Metoclopramide - Metoclopramide Hydrochloride 5MG; 1 TAB by mouth twice a day STOMACH
divalproex (DEPAKOTE) 500MG, 1 tablet by mouth three times a day SEIZURES
atorvastain (Lipitor) 40MG; 1 TAB by mouth once a day CHOLESTEROL
cholecalciferol, vitamin D3 (D3-50 CHOLECALCIFEROL) 50,000 Units , 1250 mcg (50,000 units) capsule by mouth once a week SAT SUPPLEMENT
Sevelamer Carbonate - Sevelamer Carbonate 800mg; 1 tab by mouth three times a day phosphate binder
oxycodone (oxy-ir) 5mg, 1 capsule by mouth every 4 hours AS NEEDED FOR PAIN
Glipizide - Glipizide 10 mg 10MG; 1 TAB by mouth once a day DM

14. DME and Supplies:
diabetic supplies, walker, wound care supplies, cane

15. Safety Measures:
no bp left arm, supervision at all times, emergency phone # clearly displayed, bathroom safety, smoke detectors , seizure precautions, standard precautions, fall precautions, diabetic precautions, ambulates with device, walker precautions, medication safety, ambulates with assistance, transfer with assist, activity supervision

16. Nutrition:
renal diet, diabetic

17. Allergies:
lisinopril morphine trulicity

18.A. Functional Limitations
Bowel/Bladder Incontinence, Endurance, Ambulation

18.B. Activities Permitted
Up As Tolerated, Cane, Walker, Exercises Prescribed

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: fair

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 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.

Clinical Condition Requiring Homecare: The patient is a 55-year-old female admitted to home health services following an inpatient stay secondary to a mechanical fall with right-sided pain and inability to ambulate safely. Past medical history is significant for end-stage renal disease (ESRD) requiring dialysis Monday, Wednesday, and Friday (MWF), hypertension (HTN), hyperlipidemia (HLD), diabetes mellitus type 2 (DM2) with diabetic neuropathy, chronic left plantar ulcer treated with Hydrofera Blue, seizure disorder/epilepsy, supraventricular tachycardia (SVT) status post ablation, anemia, osteoarthritis including right knee OA, anxiety, and depression. The patient is followed by the wound center for the chronic left foot ulcer and is non-weight-bearing (NWB) on the left lower extremity. She resides in a townhouse with her daughter, with four steps and a railing to enter and 14 steps with a railing leading to the second-floor bedroom and bathroom. A powder room is available on the first floor, and the patient frequently sleeps on the first floor. The patient is homebound due to the significant effort required to leave the home and impaired mobility, as evidenced by a Tinetti score of 12/28. At the skilled nursing visit, the patient was alert and oriented x3 and denied discomfort at the time of assessment as well as shortness of breath. The patient reports a good appetite and last bowel movement today. Most recent blood glucose reading was 112, and the patient reports monitoring blood glucose twice daily. The left arm arteriovenous fistula (AVF) used for dialysis was covered with a dry dressing. The patient uses an assistive device for safe ambulation. Skilled nursing reviewed all medications, including doses, frequencies, and pertinent side effects, and will continue to monitor medication compliance. Education was provided regarding left plantar ulcer wound care, and the patient was receptive to all instructions. Physical therapy evaluation identified impaired functional mobility and endurance. The patient ambulates approximately 40 feet x2 using a left knee scooter with supervision while maintaining no weight on the left foot. Transfers to a chair or steps with supervision. The patient was unable to perform stair training during the evaluation due to fatigue, and the therapist did not assess outside mobility, stairs, or car transfers. The patient would benefit from continued skilled home therapy to increase strength and improve functional mobility while maintaining NWB status and observing wound-care precautions. Occupational therapy evaluation was completed following hospitalization secondary to the fall. Prior to hospitalization, the patient reportedly completed basic self-care, functional transfers, and functional ambulation independently. Currently, she demonstrates decreased standing balance, standing tolerance, bilateral upper extremity strength, and activity tolerance, resulting in

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 08/01/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Stacy Schwartz
16 S Eutaw St
Baltimore, MD 21201
PHONE: 4103284300 FAX: 14103280648 NPI: 1396157954

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 : 07/16/2026

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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decreased independence with self-care, functional transfers, and functional ambulation. Skilled OT services are recommended to address these deficits and promote return to the patient's prior level of functional independence. Skilled nursing is ordered at a frequency of 1W12, 2W1, and 1W1, with continued monitoring of medication compliance, left plantar ulcer status, diabetes management, dialysis-related needs, and overall clinical condition. PT/OT services will focus on improving strength, balance, activity tolerance, safe functional mobility, and independence while coordinating care with the wound center and maintaining appropriate precautions for the left foot ulcer.
 Date of Order 08/01/2026 Orders Physician Face-to-Face Date: 07/16/2026 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 OT Eval Notes: PT Eval Notes:
 Physician Schwartz, Stacy

SN Careplans

SN WK1: 1 (08/01/26-08/01/26) ,WK3: 2 (08/09/26-08/15/26) ,WK4: 1 (08/16/26-08/22/26) ,WK5: 1 (08/23/26-08/29/26)

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: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 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, 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; 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:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2102d - Caregiver Performs Treatment, M2102c - Med Admin, meal preparation, M2102f - Patient Supervision, M2020 - Oral Med Management, M1400 - Dyspnea, M1033 - Exhaustion, heartburn/indigestion, M1610 - Urinary Incontinence, limited endurance, muscle weakness (MS), limited strength, Pain Interference with ADLs, Pain Interference with Therapy activities, balance deficit, #1 - Diabetic Ulcer - Other - LEFT PLANTAR FOOT ULCER - PT TOLERATED WOUND CARE

PROCEDURES: physician-ordered wound care: #1 - Diabetic Ulcer - Other - LEFT PLANTAR FOOT ULCER - PT TOLERATED WOUND CARE: SN/PT TO CLEAN LEFT PLANTAR FOOT WOUND WITH NSS, HYDROFERA BLUE AND COVER WITH DRY DRESSING. DAILY OR AS NEEDED FOR DRAINAGE., train caregiver(s) to perform medical/rehabilitation treatments, glucose testing via monitor, bladder training, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, monitor dialysis schedule: DIALYSIS M/W/F

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, * 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, 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: I NEED THE WOUND TO HEAL

GOALS
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
* 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
* 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
* 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

meal preparation is available to patient for all meals

patient is adequately supervised

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

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PT 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)

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, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170E1 - Chair to Bed to Chair

PROCEDURES: Family training : Transfers, steps, home program, home exercise program: Supine hip flexion, straight leg raise, hip abduction. Standing left knee flexion, hip abduction and hip extension. Prone knee flexion and hip extension. Sitting knee extension and ankle pumps, gait training/stair training: NWB left leg with knee scooter, transfers training

TEACH PATIENT/CAREGIVER: Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, Car 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, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

PATIENT-STATED GOAL: To be able to get around the house by myself without the knee scooter

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Sit to Stand - 06. Independent

Car 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

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

OT Careplans

OT WK2: 1 (08/02/26-08/08/26)

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 triceps extensions, biceps curls, armchair press-ups 2-3 sets 8-12 reps, equipment training, work simplification/energy conservation, gait training on uneven surfaces, gait training/stair training, transfers training: Skilled OT, transfers training, assist with bathing: Skilled OT, assist with lower body dressing: Skilled OT, assist with upper body dressing: 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 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 - 05. Setup or clean-up assistance, Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance, Walk 150 Feet - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance, 1 - Step (curb) - 05. Setup or clean-up assistance, 4 Steps - 05. Setup or clean-up assistance, 12 Steps - 05. Setup or clean-up assistance, Picking Up Object - 05. Setup or clean-up assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 06. Independent, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: Walk better

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance

1 - Step (curb) - 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

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 05. Setup or clean-up assistance

Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance

Walk 150 Feet - 05. Setup or clean-up assistance

4 Steps - 05. Setup or clean-up assistance

12 Steps - 05. Setup or clean-up assistance

Picking Up Object - 05. Setup or clean-up assistance

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:
Electronically Signed by Messick, Charles RN

Date
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Upper Body Dressing - 06. Independent

Signature of Physician:	Date
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