Home Health Certification and Plan of Care

Order ID: 1150/21207

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
4E13H47CM79	02/12/2026	From: 08/11/2026 To: 10/09/2026	22295	217058

6. Patient's Name and Address

Martha Smith
718 E 43rd ST,
BALTIMORE, MD 21212-
443-642-0826

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 05/01/1951 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
I87.311	Chronic venous hypertension w ulcer of r low extrem	02/12/26

13. ICD	Other Pertinent Diagnoses	Date
I50.32	Chronic diastolic (congestive) heart failure	02/12/26
E11.40	Type 2 diabetes mellitus with diabetic neuropathy unsp	02/12/26
I87.2	Venous insufficiency (chronic) (peripheral)	02/12/26
L97.811	Non-prs chr ulcer oth prt r low leg limited to brkdwn skin	02/12/26
I26.93	Single subsegmental pulmon emblsm w/o acute cor pulmonale	02/12/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	02/12/26
M17.0	Bilateral primary osteoarthritis of knee	02/12/26
E66.813	Other obesity	02/12/26
Z68.43	Body mass index [BMI] 50.0-59.9 adult	02/12/26
Z85.42	Personal history of malignant neoplasm of oth prt uterus	02/12/26
Z90.710	Acquired absence of both cervix and uterus	02/12/26
Z79.01	Long term (current) use of anticoagulants	02/12/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	02/12/26
Z79.82	Long term (current) use of aspirin	02/12/26
Z79.891	Long term (current) use of opiate analgesic	02/12/26
L97.812	Non-prs chronic ulcer oth prt r low leg w fat layer exposed	02/12/26
L03.115	Cellulitis of right lower limb	02/12/26
I89.0	Lymphedema not elsewhere classified	02/12/26
I13.0	Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny	02/12/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	02/12/26
N18.30	Chronic kidney disease stage 3 unspecified	02/12/26
I48.91	Unspecified atrial fibrillation	02/12/26
J96.11	Chronic respiratory failure with hypoxia	02/12/26
E78.5	Hyperlipidemia unspecified	02/12/26
K21.9	Gastro-esophageal reflux disease without esophagitis	02/12/26
Z99.81	Dependence on supplemental oxygen	02/12/26
Z86.718	Personal history of other venous thrombosis and embolism	02/12/26
Z87.440	Personal history of urinary (tract) infections	02/12/26

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

Gabapentin - Gabapentin 100 mg 100 MG by mouth every 8 hours Commonly known as: NEURONTIN FOR NEUROPATHY PAIN
Farxiga - Dapagliflozin Propanediol 5MG; 1 TAB by mouth once a day DM
Eliquis - Apixaban 5 mg Tab by mouth 2 (two) times daily Commonly known as: ELIQUIS BLOOD THINNER
Constulose - Lactulose 10 gram/15 mL; 30ML by mouth every 12 hours AS NEEDED FOR CONSTIPATION
Cyclobenzaprine - Cyclobenzaprine Hydrochloride 5MG; 1 TAB by mouth every 8 hours AS NEEDED FOR MUSCLE SPASMS
Antivert - Meclizine Hydrochloride 25 mg 25 mg by mouth every 12 hours Take 1 tablet (25 mg total) by mouth 2 times daily as needed for Dizziness
Doxycycline - Doxycycline Hyclate eq 100 mg base 100mg by mouth twice a day 5 days
Lopressor - Metoprolol Tartrate 50 mg 50 mg; 1 TAB by mouth twice a day Take 1 tablet (25 mg total) by mouth for 2 times daily. BLOOD PRESSURE
Roxicodone - Oxycodone Hydrochloride 5 mg 5mg by mouth every 6 hours Prn for pain
Albuterol - Albuterol 0 0.5 mg - 3 mg inhalant every 4 hours 0.5 mg - 3 mg (2.5 mg base) /3 mL nebulizer solution Take 3 mLs by nebulization every 4 hours as needed for Wheezing or shortness of breath
Oxygen - Oxygen 2L inhalant continuous
Fluticasone Propionate - Fluticasone Propionate 0.05 mg/spray 1 SPRAY nasal every 12 hours EACH NOSTRIL FOR ALLERGIES
Polymem Silver Topical topical threee times per week Wound care

14. DME and Supplies:

urinary/catheter supplies, wheelchair, walker, commode, wound care supplies, oxygen supplies, hospital bed

15. Safety Measures:

wheelchair precautions, standard precautions, fall precautions, bleeding precautions, walker precautions, medication safety, infectious material management, transfer with assist, supervision at all times, remove environmental barriers, anticoagulant precautions, activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

banana strawberry

18.A. Functional Limitations

Dyspnea With Minimal Exertion, Bowel/Bladder Incontinence, Ambulation, Endurance

18.B. Activities Permitted

Other, Wheelchair, Walker, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 3. Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently, ANXIETY: 0. Never, SOCIAL ISOLATION: , BEHAVIORAL ISSUES: , HISTORY OF DEPRESSION:

20. Prognosis: fair

22. A Rehabilitation Potential:

SELF-CARE: , MOBILITY:

22.B.Discharge Plans

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

Homebound status: Due to diagnosis of Chronic venous hypertension (idiopathic) with ulcer of right lower extremity, 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 74-year-old female recently discharged home following hospitalization and subsequent subacute rehabilitation related to multiple falls. Her past medical history is significant for congestive heart failure (CHF), hypertension, bilateral knee osteoarthritis, type 2 diabetes mellitus, peripheral neuropathy, obesity, obstructive sleep apnea (CPAP not currently available in the home), prior pulmonary embolism managed with Eliquis, chronic right lower extremity (RLE) venous stasis ulcer, and history of uterine cancer. She resides in a two-story home with her two sons; however, her bedroom and bathroom have been relocated to the first floor due to inability to safely negotiate stairs. There are seven steps with a railing at the entrance of the home. Her sons provide assistance with all activities of daily living (ADLs) and instrumental activities of daily living (IADLs), including transportation to medical appointments. At the time of skilled nursing assessment, the patient was alert and oriented to person, place, and time. She denied shortness of breath and was receiving supplemental oxygen at 2 L/min continuously, with oxygen saturation measured at 95% on oxygen. She reported a good appetite and stated her last bowel movement occurred on the day of assessment. She reported intermittent left leg cramping but denied acute pain. The patient was noted to be incontinent of

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 08/07/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Sharareh Badri
8617 Loch Raven Blvd
Baltimore, MD 21239
PHONE: 443-444-6100 FAX: 14434446110 NPI: 1003278250

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 : 02/01/2026

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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urine and wearing a diaper, with urine odor present in the room, indicating the need for ongoing skin integrity monitoring and hygiene support. Physical assessment revealed bilateral lower extremity hyperpigmentation consistent with chronic venous insufficiency and a venous stasis ulcer located on the lateral aspect of the right lower extremity. Additionally, the patient has a right subclavian Port-a-Cath in place, which she reports is flushed and managed by her physician every three months. Skilled nursing services were initiated with a frequency of 1 visit per week for 12 weeks, followed by 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-6 CE-FMS-visits">visits</mh> per week for 1 week, then 1 visit per week for 6 weeks (1W12, 2W1, 1W6). A substantial amount of time was spent reconciling and organizing medications in the home with the patient's son. A comprehensive medication profile was completed, and missing medications were identified; the son was instructed to obtain refills promptly to ensure compliance. The use of a pillbox was recommended to improve medication adherence and reduce risk of dosing errors. Skilled nursing will continue medication reconciliation and compliance monitoring at the next visit, along with cardiopulmonary assessment, diabetic monitoring, wound assessment and care, anticoagulation monitoring related to Eliquis, and reinforcement of disease management education. From a functional standpoint, the patient is currently spending the majority of the day in bed. Bed mobility from supine to sit is performed with supervision using a bed rail. She is able to roll side to side with supervision and use of the rail. Sit-to-supine transfer requires use of the bed rail and moderate assistance at the left lower extremity. She is able to scoot up in bed with the bed flat using rails with supervision. Sit-to-stand transfers to a walker require moderate assistance of two persons, and she is able to maintain standing for approximately 20 seconds. Due to her current functional limitations, gait, car transfers, and outdoor mobility were not assessed. Her Tinetti balance assessment score is 1/28, indicating extremely high fall risk. She is considered homebound due to the significant physical effort required to leave the home and her severely impaired mobility. Therapeutic exercises performed during evaluation included 10 repetitions each of hip flexion, bridging, hooklying rotation, straight leg raises, hip abduction, knee extension, and ankle pumps, which were tolerated without acute distress. Her sons were present during training and were educated on safe assistance techniques and instructed to avoid over-assisting in order to promote the patient's independence and strength recovery. Occupational therapy evaluation indicates that prior to hospitalization, the patient was independent with basic self-care, functional transfers, and functional ambulation tasks, with assistance from her sons primarily for IADLs. Currently, she demonstrates decreased standing balance, reduced standing tolerance, diminished bilateral upper extremity strength, and limited activity tolerance, all contributing to decreased independence with self-care, functional transfers, and mobility. She utilizes 2 L of oxygen as needed for shortness of breath. The interdisciplinary plan of care includes skilled nursing for cardiopulmonary monitoring, diabetes management, wound care, medication management, and patient/caregiver education; physical therapy to address lower extremity strength, balance, transfer training, fall prevention, and progressive mobility; and occupational therapy to improve upper extremity strength, activity tolerance, self-care performance, and safety with functional tasks. The overall goals are to improve strength and endurance, enhance safety and independence with ADLs and transfers, promote wound healing, ensure medication compliance, reduce fall risk, and prevent rehospitalization.
 Date of Order 08/07/2026 Orders Physician Face-to-Face Date: 02/01/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Chronic venous hypertension (idiopathic) with ulcer of right lower extremity Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home
 4 - Recertification Notes: The patient is recertified due to heart failure with OSA and bedridden obesity requiring supplemental oxygen with static ulcer to lower right leg requiring wound care, making it a taxing effort to leave the home. The patient has limited mobility, is unable to reposition herself without assistance, and requires assistance from family members for wound care, with wound dressing changes 3 times a week and PRN; SN Frequency 1w6.
 Physician Badri, Sharareh

SN Careplans

SN WK1: 1 (08/11/26-08/15/26) ,WK2: 1 (08/16/26-08/22/26) ,WK3: 1 (08/23/26-08/29/26) ,WK4: 1 (08/30/26-09/05/26) ,WK5: 1 (09/06/26-09/12/26) ,WK6: 1 (09/13/26-09/19/26)

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; 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:POLST (Physician Orders for Life-Sustaining Treatment)

PROBLEMS IDENTIFIED ON ASSESSMENT: M2102d - Caregiver Performs Treatment, abn cholesterol > 200 mg/dL, abnormal blood pressure, abnormal BS < 70/140 > mg/dL (EN), limited strength, muscle weakness, limited endurance, limited range of motion, balance deficit, obesity, open sores/lesions, rough/scaly/cracked skin, bruising/discoloration

PROCEDURES: physician-ordered wound care: #1 - Observable Stasis Ulcer - Other - RLE LATERAL ASPECT - UNABLE TO MEASURE SCATTERED OPEN AREA: SN/CG TO CLEANSE RLE STASIS ULCER WITH WOUND CLEANSER, VASHE SOAK FOR 5 MINUTES, APPLY FOAM WITH SILVER, ALGINATE, COVER WITH AN ABD PAD, SECURE WITH ROLLED GAUZE AND TAPE. TO BE DONE THREE TIMES A WEEK AND AS NEEEDED IF SOILED, SATURATION OR ACCIDENTAL REMOVAL. SON CAPABLE TO PERFORM WOUND CARE ON DAYS SN NOT AVAILABLE., Doctor ordered wound care: Written order in chart, 08/10/2026 from Personic wound center. Discontinue all previous wound care orders. SN/CG TO CLEANSE RLE STASIS ULCER WITH WOUND CLEANSER, VASHE SOAK FOR 5 MINUTES, APPLY FOAM WITH SILVER, ALGINATE, COVER WITH AN ABD PAD, SECURE WITH ROLLED GAUZE AND TAPE. TO BE DONE THREE TIMES A WEEK AND AS NEEEDED IF SOILED, SATURATION OR ACCIDENTAL REMOVAL. SON CAPABLE TO PERFORM WOUND CARE ON DAYS SN NOT AVAILABLE., cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments, home exercise program: clinician will describe procedure at time of visits, coordinate/arrange for maintenance of clean/uncluttered living area, coordinate/arrange access to adequate trash/sewage disposal

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 medicatio, * 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 relaxatio, * depression-prevention strategies including avoidance of

SN Goals

PATIENT-STATED GOAL: I WANT TO GET STRONGER and resolve upper thigh excursions

GOALS
patient's living environment is clean/uncluttered

patient has access to adequate trash/sewage disposal

insects/rodents not present in the patient's living environment

caregiver performs medical/rehabilitation treatments with adequate competence

patient/caregiver recalls
* bowel incontinence management including dietary changes
* bowel training
* skin care
* 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

meal preparation is available to patient for all meals

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 relaxatio

patient/caregiver recalls
* depression-prevention strategies including avoidance of isolation
* healthy eating
* sleeping habits
* identification of activities that bring pleasure

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	08/07/2026

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isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpos, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification preventing pressure ulcer recurrence record wound measurements, related medication(s) purpose, schedule, * how to manage skin condition including physician-prescribed treatment skin care bathing sun protection diet exercise, related medication(s) purpose, schedule, * bowel incontinence management including dietary changes bowel training skin care, 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 living environment has safe floor coverings, patient's living environment is clean/uncluttered, patient has access to adequate trash/sewage disposal, insects/rodents not present in the patient's living environment, meal preparation is available to patient for all meals, caregiver performs medical/rehabilitation treatments with adequate competence	* preventive care * recalls related medication(s) purpos 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 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 medicatio patient living environment has safe floor coverings patient/caregiver recalls * how to manage skin condition including physician-prescribed treatment * skin care * bathing * sun protection * diet * exercise * 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 * preventing pressure ulcer recurrence * record wound measurements * recalls related medication(s) purpose, schedule

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
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