Home Health Certification and Plan of Care

Order ID: 1150/20700

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
7AQ5UR3MJ60	07/20/2026	From: 07/20/2026 To: 09/17/2026	27793	217058

6. Patient's Name and Address

Elizabeth Hall
1315 Chesaco Avenue Apt 114,
Rosedale, MD 21237-
4435965974

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 05/26/1947 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
I70.292	Oth athscl native arteries of extremities left leg	07/20/26

13. ICD	Other Pertinent Diagnoses	Date
I69.320	Aphasia following cerebral infarction	07/20/26
I13.0	Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny	07/20/26
I50.30	Unspecified diastolic (congestive) heart failure	07/20/26
N18.30	Chronic kidney disease stage 3 unspecified	07/20/26
I48.20	Chronic atrial fibrillation unspecified	07/20/26
F41.9	Anxiety disorder unspecified	07/20/26
E78.5	Hyperlipidemia unspecified	07/20/26
F51.01	Primary insomnia	07/20/26
Z79.01	Long term (current) use of anticoagulants	07/20/26
Z86.718	Personal history of other venous thrombosis and embolism	07/20/26

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

Tylenol Es - Acetaminophen 500 mg/tablet / Give 2 tablet by mouth every 8 hours as needed for pain
Atorvastatin Calcium - Atorvastatin Calcium 40 MG / 1 Tablet by mouth at bedtime for hyperlipidemia
Dabigatran Etexilate Mesylate 150 MG / 1 Capsule by mouth twice a day for Afib/recurrent LLE DVT's
DIGOXIN 125 MCG / 1 Tablet by mouth one time a day for heart failure. Hold if <60
Diltiazem Hydrochloride - Diltiazem Hydrochloride 90 MG / 1 Tablet by mouth in the morning for HTN HOLD FOR SBP <110 OR HR <60
Hydroxyzine Hydrochloride - Hydroxyzine Hydrochloride 25 MG tablet by mouth in the evening for ANXIETY
MELATONIN 3 MG / 1 Tablet by mouth once a day every 24 hours as needed for insomnia give at hs
Metoprolol Tartrate - Metoprolol Tartrate 50 MG / 1 Tablet by mouth two times a day for HTN hold Sbp less than 110 and heart rate less than 50
MIRALAX Powder 17GM/SCOOP / Give 1 scoop by mouth every 24 hours as needed for Bowel Regimen Dissolve in 4oz of water; hold for loose stools
Tramadol Hcl - Tramadol Hydrochloride 50 MG / 1 Tablet by mouth every 8 hours as needed for pain 7-10
Senna S - Senna 8.6-50 MG / 1 Tablet by mouth twice a day for bowel regimen Hold for loose stools
Naloxone Hcl - Naloxone Hydrochloride Nasal Liquid 4 MG/0.1ML / 1 spray nasal as necessary every 3 minutes for suspected opioid overdose 1 spray in nostril every 3 minutes as needed for overdose may repeat in alternating nostrils every 3 minutes until Coherent. Call 911, continue until paramedics arrive. Notify provider
Dulcolax - Bisacodyl Suppository 10 MG / Insert 1 suppository rectally every 24 hours as needed for promote bm if miralax ineffective

14. DME and Supplies:

wound care supplies, bath bench, hand held shower, grab bars

15. Safety Measures:

smoke detectors , medication safety, fall precautions, bleeding precautions, transfer with assist, medical alert/lifeline, emergency phone # clearly displayed, ambulates with assistance, standard precautions, hand rails, cardiac precautions, bathroom safety, anticoagulant precautions, activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

no known allergies

18.A. Functional Limitations

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

18.B. Activities Permitted

Exercises Prescribed, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 2. Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility, ANXIETY: 1. In new or complex situations only, 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: 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 Other atherosclerosis of native arteries of extremities, left leg, 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 79-year-old female with a past medical history significant for chronic atrial fibrillation, heart failure with preserved ejection fraction (HFpEF), chronic kidney disease stage 3, peripheral arterial disease (PAD), and a prior left middle cerebral artery (MCA) stroke. The patient was assessed during today's skilled nursing visit and was found to be clinically stable with no acute distress observed. Vital signs were obtained and remained within acceptable parameters. The patient denied chest pain, shortness of breath at rest, dizziness, or any other acute complaints. A comprehensive nursing assessment and cardiovascular assessment were completed without complications. A thorough skin assessment revealed that the previously documented left lower extremity ulcer has completely healed with intact skin. No open wounds, drainage, erythema, signs of infection, or new pressure injuries were identified. Preventive skin care measures were reinforced, and continued skin surveillance remains part of the patient's ongoing plan of care. Medication reconciliation was completed, and the patient's medication regimen was reviewed with the patient and caregiver. The patient reported adherence to all prescribed medications without adverse effects. Education was provided regarding medication compliance, recognition of signs and symptoms of worsening heart failure and stroke, <hility is-highlighty="true" role="mark" data-hility="93032137-0230-4c13-a00b-e29ab027a8f4" data-hility-name="bleeding precautions" data-hility-match="highlight-pass-53:1" data-decoration-type="background" style="--decoration-thickness: auto;">bleeding precautions</hility> associated with anticoagulation therapy for atrial fibrillation when applicable, and indications for notifying the physician. Additional teaching included reinforcement of a low-sodium diet, prescribed fluid management, chronic kidney disease-friendly dietary recommendations, daily weight monitoring, edema surveillance, fall prevention, infection prevention, and recognition of emergency symptoms requiring immediate medical attention. The plan is to continue skilled nursing services for ongoing cardiovascular assessment and monitoring, renal status monitoring, medication management and education, continued skin surveillance and preventive skin care, reinforcement of disease process management related to atrial fibrillation, HFpEF, chronic kidney disease, peripheral arterial disease, and prior stroke, as well as coordination of care with the primary care provider and specialists as indicated. The patient remained clinically stable throughout the visit and tolerated the

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 07/20/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Anita Tammara
9000 Franklin Square Dr
Baltimore, MD 21237
PHONE: 4437778300 FAX: 18665095858 NPI: 1578851986

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 : 07/06/2026

27. Attending Physician's Signature and Date Signed **07/28/2026**: 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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assessment without complications. A skilled occupational therapy evaluation was also completed following hospitalization and subsequent subacute rehabilitation for atrial fibrillation. Prior to hospitalization, the patient resided alone in a senior apartment and was independent with basic self-care, functional transfers, and household ambulation, while receiving assistance from her daughter for instrumental activities of daily living. At the time of evaluation, the patient demonstrated independence with basic self-care, functional transfers, and functional ambulation within the home without the use of an assistive device. No deficits requiring ongoing occupational therapy intervention were identified. Skilled occupational therapy evaluation was completed, and no additional OT services are warranted at this time.
 Date of Order 07/20/2026 Orders Physician Face-to-Face Date: 07/06/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Other atherosclerosis of native arteries of extremities, left leg 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:
 Physician Tammara, Anita

SN Careplans

SN WK1: 1 (07/20/26-07/25/26) ,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)

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:Yes

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M1700 - Cognition, M2102d - Caregiver Performs Treatment, M2102c - Med Admin, M2102f - Patient Supervision, M2020 - Oral Med Management, dependent edema, M1400 - Dyspnea, M1033 - Exhaustion, M1610 - Urinary Incontinence, M1600 - UTI, limited endurance, limited strength, muscle weakness, balance deficit, weak hand grips, bruising/discoloration, bleeding/discharge at site, open sores/lesions, discolored patches of skin, rough/scaly/cracked skin, #1 - Abrasion - Other - Left shin - Patient scrapped her left shin while in the hospial.

PROCEDURES: physician-ordered wound care: #1 - Abrasion - Other - Left shin - Patient scrapped her left shin while in the hospial.: Wound Care: Left lower leg wound. Cleanse wound gently with normal saline and pat dry with sterile gauze. Apply Vaseline (petrolatum)-infused gauze directly to the wound bed. Cover with ABD pads. Secure dressing with Kerlix gauze and tape, ensuring the wrap is snug but not constrictive. Change dressing daily and additionally as needed if the dressing becomes wet, soiled, loose, or saturated. Skilled Nursing to: Assess wound at each visit for size, depth, drainage, odor, tissue type, and signs/symptoms of infection. Monitor surrounding skin for maceration, erythema, edema, or breakdown. Reinforce wound care instructions with the

SN Goals

PATIENT-STATED GOAL: CG states she wants to be able to get her mother out of bed safely to get her to the bathroom for a shower and to use the toilet.

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 keep home safe for patient with dementia
* coping strategies for the caregiver* 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
* 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
* 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 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	07/20/2026

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patient/caregiver. Notify the physician of increased drainage, foul odor, increased redness, warmth, swelling, worsening pain, fever, wound deterioration, or lack of healing. Encourage adequate nutrition, hydration, and pressure/offloading measures as appropriate to promote wound healing., cough/deep breathing exercises, incentive spirometer, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, monitor intake & output, 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, * how to keep home safe for patient with dementia coping strategies for the caregiver*, 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, * 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, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, caregiver administers and/or packages medications appropriately

OT Careplans

OT WK1: 1 (07/17/26-07/18/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, GG0170O1 - 12 Steps, GG0130F1 - Upper Body Dressing, GG0130A1 - Eating, 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, 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, GG0170D1 - Sit to Stand

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, Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven Surface - 06. Independent, 1 - Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent, 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: Evaluation only

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Walk 10 ft on Uneven Surface - 06. Independent

1 - Step (curb) - 06. Independent

4 Steps - 06. Independent

12 Steps - 06. Independent

Picking Up Object - 06. Independent

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

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

Date
07/20/2026