# Home Health Certification and Plan of Care

**Order ID: 1150/21210**

| 1. Patient s HI claim No. | 2. Start Of Care Date | 3. Certification Period | 4. Medical Record No. | 5. Provider No. |
|---|---|---|---|---|
| 1N20PU4MX48 | 08/09/2026 | From: 08/09/2026 To: 10/07/2026 | 28752 | 217058 |

**6. Patient's Name and Address**

Almeta Hardy
3224 Burleith Ave,
BALTIMORE, MD 21215-
443-527-5704

**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** 02/16/1938 | **9.Sex** Female

| 11. ICD | Principal Diagnosis | Date |
|---|---|---|
| I13.2 | Hyp hrt & chr kdny dis w hrt fail and w stg 5 chr kdny/ESRD | 08/09/26 |

| 13. ICD | Other Pertinent Diagnoses | Date |
|---|---|---|
| I50.32 | Chronic diastolic (congestive) heart failure | 08/09/26 |
| E11.22 | Type 2 diabetes mellitus w diabetic chronic kidney disease | 08/09/26 |
| N18.6 | End stage renal disease | 08/09/26 |
| D63.1 | Anemia in chronic kidney disease | 08/09/26 |
| Z99.2 | Dependence on renal dialysis | 08/09/26 |
| E78.5 | Hyperlipidemia unspecified | 08/09/26 |
| C34.92 | Malignant neoplasm of unsp part of left bronchus or lung | 08/09/26 |
| N25.81 | Secondary hyperparathyroidism of renal origin | 08/09/26 |
| J96.11 | Chronic respiratory failure with hypoxia | 08/09/26 |
| J44.9 | Chronic obstructive pulmonary disease unspecified | 08/09/26 |
| L29.9 | Pruritus unspecified | 08/09/26 |
| E44.0 | Moderate protein-calorie malnutrition | 08/09/26 |
| R13.10 | Dysphagia unspecified | 08/09/26 |
| E11.42 | Type 2 diabetes mellitus with diabetic polyneuropathy | 08/09/26 |
| J98.11 | Atelectasis | 08/09/26 |
| J38.6 | Stenosis of larynx | 08/09/26 |
| K86.2 | Cyst of pancreas | 08/09/26 |
| Z99.81 | Dependence on supplemental oxygen | 08/09/26 |
| Z90.2 | Acquired absence of lung [part of] | 08/09/26 |
| Z86.16 | Personal history of COVID-19 | 08/09/26 |
| Z66. | Do not resuscitate | 08/09/26 |

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

Sevelamer Hydrochloride 800 mg/tablet / Give 2 tablet by mouth three times a day with meals
DUONEB 0.5 mg-2.5 mg/3 mL / Inhale 3ml inhalant four times a day
Oxygen - Oxygen 2L inhalant continuous
fluticasone-salmeterol Inhalation Powder 250 mcg-50 mcg / Inhale 1 Inhalation twice a day
AMLODIPINE 10 MG / 1 Tablet PO once a day
LASIX 40 MG / 1 Tablet PO once a day
Metoprolol Tartrate - Metoprolol Tartrate 25 MG / 1 Tablet PO twice a day
RENA-VITE 1 tablet PO once a day
SIMVASTATIN 20 MG / 1 Tablet PO in the evening
FOLIC ACID 1 MG / 1 Tablet PO once a day Take on Tuesday Thursday Saturday and Sunday. Do not take on HD days

**14. DME and Supplies:**

oxygen supplies, hospital bed, walker

**15. Safety Measures:**

bathroom safety, no bp right arm, walker precautions, supervision at all times, standard precautions, fall precautions, medication safety, cardiac precautions, bleeding precautions, activity supervision, ambulates with assistance, ambulates with device

**16. Nutrition:**

low sodium, diabetic, renal diet

**17. Allergies:**

no known allergies

**18.A. Functional Limitations**

Ambulation, Endurance

**18.B. Activities Permitted**

Walker, Up As Tolerated

**19. Mental & Pyschosocial Status:** COGNITION: 1. Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions., 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:** 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**

patient will be responsible for managing treatment

**Homebound status:** Due to diagnosis of Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease, 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:** Skilled nursing start of care (SOC) was completed at 11:25 AM. All required consents were reviewed and signed by the patient. The patient is an 88-year-old female with no known drug allergies and a significant medical history including congestive heart failure (CHF), end-stage renal disease/renal failure newly initiated on hemodialysis every Monday, Wednesday, and Friday at Seton, diabetes mellitus, hyperlipidemia, hyperparathyroidism, chronic obstructive pulmonary disease (COPD) with respiratory failure requiring continuous supplemental oxygen at 2 L/min via nasal cannula, anemia, moderate protein-calorie malnutrition, dysphagia, laryngeal stenosis, polyneuropathy, and absence of a lung. The patient was recently hospitalized related to ESRD and initiation of hemodialysis, with her first scheduled dialysis treatment at Seton planned for the following day. Supplemental oxygen is provided through Nation's Healthcare (410-356-9006) and is used continuously for prevention of shortness of breath. Due to her cardiopulmonary and renal conditions, oxygen dependence, weakness, and need for assistance with mobility, leaving the home requires considerable and taxing effort. The patient recently experienced a fall while using her walker. She is currently staying with her daughter, Natalie, who provides supervision and caregiver support. The patient is designated DNR, and DNR status and related rescue measures were reviewed and discussed with the patient and caregiver; the patient was educated regarding her current code status and verbalized understanding. No abnormal lung sounds were noted during assessment. The patient reports variable oral intake, stating that she "eats when it's something she likes," consistent with her history of dysphagia and moderate protein malnutrition. Hyperparathyroidism is reportedly not being treated with medication at this time per the patient and caregiver. A physical therapy evaluation was completed. Prior to hospitalization, the patient lived alone and was primarily independent with functional mobility, ambulating without an assistive device and using a single-point cane occasionally. Following hospitalization and initiation of hemodialysis, the patient demonstrates a decline from her prior level of function, with bilateral lower-extremity weakness rated at 3-/5 on manual muscle testing. She currently requires minimal assistance for transfers and short-distance ambulation using a rolling walker, with verbal cues required to improve upright trunk posture and safety during mobility. The patient presents with impaired strength, balance, functional mobility, and overall safety, increasing her risk for falls and further functional

**23. Signature and Date of Verbal SOC Where Applicable:**

Electronically Signed by Messick, Charles RN on 08/09/2026

**25. Date HHA Received Signed POT**

**24. Physician's Name and Address**

Tanya Johnson
2435 W Belvedere Ave
Baltimore, MD 21215
PHONE: 4434710472 FAX: 14105841877 NPI: 1306513031

**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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decline. Skilled physical therapy services are recommended to address these deficits through therapeutic exercise, transfer and gait training, balance activities, safety education, and progressive functional mobility training to improve strength, endurance, balance, independence, and safety and facilitate return toward her prior level of function. Skilled nursing and therapy will continue to monitor the patient's cardiopulmonary status, oxygen needs, renal disease and dialysis-related needs, nutritional status, fall risk, medication and disease management, and overall response to the plan of care. <br> Date of Order 08/09/2026 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 hha-adl's due to Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home <br> 1 - SOC - SN Notes: soc PT Eval Notes: <br> Physician Johnson, Tanya

## SN Careplans

SN WK1: 2 (08/09/26-08/15/26) ,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)

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, 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:DNR/DNI

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2102d - Caregiver Performs Treatment, M2102c - Med Admin, meal preparation, M2102f - Patient Supervision, M2020 - Oral Med Management, swelling in the arms/legs, M1400 - Dyspnea, M1033 - Exhaustion, abnormal blood pressure, abn cholesterol > 200 mg/dL, coughing, abnormal BS < 70/140 > mg/dL, muscle weakness, limited strength, limited endurance, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, balance deficit, daytime fatigue, loss of appetite, discolored patches of skin

PROCEDURES: cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments, monitor intake & output, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange preparation of missing meals, monitor dialysis schedule

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, * 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: To be able to walk up and down the steps safely

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
* 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
* 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

caregiver performs medical/rehabilitation treatments with adequate competence

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 is adequately supervised

meal preparation is available to patient for all meals

## PT Careplans

PT WK1: 1 (08/09/26-08/15/26) ,WK3: 1 (08/23/26-08/29/26) ,WK5: 1 (09/06/26-09/12/26) ,WK7: 1 (09/20/26-09/26/26) ,WK9: 1 (10/04/26-10/07/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170G1 - Car Transfer, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130B1 - Oral Hygiene, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170E1 - Chair to Bed to Chair, GG0170D1 - Sit to Stand, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170K1 - Walk 150 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170I1 - Walk 10 Feet, GG0170F1 - Toilet Transfer

PROCEDURES: Medication Review: - medications reviewed with patient/caregiver, home exercise program: Review HEP: seated knee ext, hip flex, hip abd, quad sets, gluteal squeezes, ankle pumps at least 1x10. Once tolerated, upgrade to standing heel/ toe raises, knee flex, hip flex, hip abd at least 1x10 with UE support as needed. Upgrade as tolerated, work simplification/energy conservation, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 05. Setup or clean-up assistance, Chair to Bed

## PT Goals

PATIENT-STATED GOAL: To be able to go up and down the steps with no help

GOALS
Sit to Stand - 05. Setup or clean-up assistance

Chair to Bed to Chair - 05. Setup or clean-up assistance

Toilet Transfer - 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

| Signature of Physician: | Date |
|---|---|
| | |



| Optional Name/Signature of Nurse/Therapist: | Date |
|---|---|
| Electronically Signed by Messick, Charles RN | 08/09/2026 |

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to Chair - 05. Setup or clean-up assistance, Toilet Transfer - 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, 12 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, Oral Hygiene - 05. Setup or clean-up assistance, Toileting Hygiene - 05. Setup or clean-up assistance, Shower/Bathe Self - 04. Supervision or touching 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

12 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

Oral Hygiene - 05. Setup or clean-up assistance

Toileting Hygiene - 05. Setup or clean-up assistance

Shower/Bathe Self - 04. Supervision or touching 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

| Signature of Physician: | Date |
|---|---|
| | PAGE 3 of 3 |
| Optional Name/Signature of Nurse/Therapist: | Date |
| Electronically Signed by Messick, Charles RN | 08/09/2026 |