Home Health Certification and Plan of Care

Order ID: 1150/20441

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
36368785	07/10/2026	From: 07/10/2026 To: 09/07/2026	25402	217058

6. Patient's Name and Address

Mable McCullough
2211 Walshire Avenue,
BALTIMORE, MD 21214-
443-522-1094

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 08/29/1942 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
T87.89	Other complications of amputation stump	07/10/26

13. ICD	Other Pertinent Diagnoses	Date
E11.69	Type 2 diabetes mellitus with other specified complication	07/10/26
M86.9	Osteomyelitis unspecified	07/10/26
Z48.812	Encntr for surgical aftcr following surgery on the circ sys	07/10/26
E11.52	Type 2 diabetes w diabetic peripheral angiopathy w gangrene	07/10/26
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	07/10/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	07/10/26
N18.31	Chronic kidney disease stage 3a	07/10/26
I48.0	Paroxysmal atrial fibrillation	07/10/26
E11.49	Type 2 diabetes w oth diabetic neurological complication	07/10/26
E03.9	Hypothyroidism unspecified	07/10/26
H40.9	Unspecified glaucoma	07/10/26
E78.5	Hyperlipidemia unspecified	07/10/26
Z79.01	Long term (current) use of anticoagulants	07/10/26
Z89.421	Acquired absence of other right toe(s)	07/10/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	07/10/26

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

ACETAMINOPHEN 500 mg/tablet / Give 2 tablet by mouth every 8 hours for pain DO NOT EXCEED 3 GRAMS PER DAY
ELIQUIS 5 mg / 1 Tablet by mouth twice a day for AFIB
Atorvastatin Calcium - Atorvastatin Calcium 80 mg / 1 Tablet by mouth at bedtime for HLD
CARVEDILOL 3.125 mg / 1 Tablet by mouth twice a day for HTN HOLD FOR SBP LESS THAN 110 OR HR LESS THAN 60
GABAPENTIN 300 mg / 1 Capsule by mouth once a day for NEUROPATHY
Gabapentin - Gabapentin 600 mg / 1 Capsule by mouth at bedtime for NEUROPATHY
Oxycodone Hydrochloride - Oxycodone Hydrochloride 5 mg/tablet / Give 0.5 tablet by mouth every 6 hours as needed for PAIN MANAGEMENT
Synthroid - Levothyroxine Sodium 25 mcg / 1 Tablet by mouth once a day for thyroid hormone replacement
Omega 3 - Cod Liver Oil Give 2 capsule by mouth once a day for Supplement
Ferrous Gluconate - Ferrous Sulfate: Folic Acid 324mg=1tablet by mouth once a day

14. DME and Supplies:

wound care supplies, walker, , hand held shower, diabetic supplies

15. Safety Measures:

diabetic precautions, fall precautions, standard precautions, medication safety, walker precautions, smoke detectors , emergency phone # clearly displayed, , anticoagulant precautions, ambulates with device

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

capsicum penicillin nsaids basaglar

18.A. Functional Limitations

Endurance, Ambulation, Bowel/Bladder Incontinence

18.B. Activities Permitted

Transfer bed/Chair, Exercises Prescribed, Walker, Partial Weight Bearing

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: 2. Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions, HISTORY OF DEPRESSION: No

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: 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

family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Other complications of amputation stump, 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 admission was completed for an 83-year-old female recently discharged from the hospital following treatment for an infected right toe amputation site. Her past medical history is significant for atrial fibrillation, chronic kidney disease, diabetes mellitus, glaucoma, hypertension, and cerebrovascular accident (stroke). The patient returned home with physician-ordered home health services for skilled nursing assessment, wound care, and disease management. Upon assessment, the patient was alert and oriented to person and place with intermittent orientation to time (A&O x2-3). Vital signs were obtained and remained stable. The patient ambulates with a walker and requires assistance with mobility due to generalized weakness, impaired balance, and an increased risk for falls. Assessment of the right foot wound revealed no signs or symptoms of infection, including no increased erythema, warmth, swelling, or purulent drainage. Wound care was performed in accordance with physician orders, and the patient tolerated the procedure without difficulty. A comprehensive medication review was completed, and medication management was reinforced, emphasizing adherence to prescribed medications and the importance of reporting any adverse effects or concerns to the physician. Skilled education was provided regarding infection prevention, including proper hand hygiene, recognition of signs and symptoms of wound infection, and when to notify the physician of any changes in the wound. Fall prevention education included the consistent use of the walker, maintaining clutter-free walkways, wearing non-slip footwear, and changing positions slowly to reduce the risk of falls. Diabetes management education focused on routine blood glucose monitoring, medication compliance, adherence to a diabetic diet, daily foot inspections, and maintaining optimal glycemic control to promote wound healing. Due to cognitive deficits, reinforcement of education remains necessary, although the patient demonstrated understanding of the teaching provided. Skilled nursing services remain medically necessary for ongoing comprehensive assessment, wound care, medication management, disease process education, and continued monitoring to promote wound healing, prevent infection, reduce fall risk, and avoid hospitalization. A scheduled therapy evaluation was not completed because the patient declined the evaluation, reporting a planned admission to Mercy Hospital the following day for a leg amputation. Therapy services will remain on hold pending hospitalization, and new physician orders will be obtained following hospital discharge before resuming home health therapy services, as appropriate.
 Date of Order 07/10/2026 Orders Physician Face-to-Face Date: 06/22/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Other complications of amputation stump 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 <span style="font-size:

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 07/10/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Naisha Williams
301 Saint Paul St
Baltimore, MD 21202
PHONE: 410-500-5500 FAX: 14106595691 NPI: 1649779851

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 : 06/22/2026

27. Attending Physician's Signature and Date Signed **08/18/2026**: 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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14px;">
 Physician Williams, Naisha

SN Careplans

SN WK1: 1 (07/10/26-07/11/26) ,WK3: 1 (07/19/26-07/25/26) ,WK4: 1 (07/26/26-08/01/26)

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; 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:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M1745 - Behavioral Issues, M2102d - Caregiver Performs Treatment, M2102c - Med Admin, meal preparation, M2102f - Patient Supervision, M2020 - Oral Med Management, A1250 - Lack of Necessary Transportation, M1400 - Dyspnea, abnormal BS < 70/140 > mg/dL, M1610 - Urinary Incontinence, limited range of motion, limited strength, limited endurance, B1000 - Vision Deficit, Pain Effect on Sleep, balance deficit, #1 - Observable Surgical Wound - Other - Right foot/toe - , open sores/lesions

PROCEDURES: physician-ordered wound care: #1 - Observable Surgical Wound - Other - Right foot/toe -, physician-ordered wound care: Cleanse wound with wound cleaner and pat dry apply betadine soaked gauze to open second toe,cover with dry gauze then wrap with Kerlix wrap daily and PRN for soiled dressing., bladder training, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange preparation of missing meals, coordinate/arrange resources for vision-impaired

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, * management of mental health condition including joining a peer group maintaining regular contact with mental health professional avoiding known stressors controlling impulses, 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, * 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's transportation needs are met, 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: Patient stated she would like to heal properly without difficulty

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
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

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
* management of mental health condition including joining a peer group
* maintaining regular contact with mental health professional
* avoiding known stressors
* controlling impulses
* 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

patient's transportation needs are met

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

Signature of Physician:

Date

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

Date
07/10/2026