HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 115022045

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
AA00006012	09/11/2026	09/11/2026 - 11/09/2026	29884	217058

Patient's Name and Address	Gender	Date of Birth	Phone Number
Jeanette Anderson 3822 Ednor Road Baltimore, MD 21218	Female	03/22/1949	443 326-3561
	Email		Primary Language: English

Clinical Profile

Provider's Name	Address	Phone Number
HomeCentris Healthcare LLC	10 Crossroads Drive, Suite 102 Owings Mills, MD 21117	410-321-8448
NPI: 1487113239		Fax Number: 410-559-3002

Clinical Condition Requiring Homecare:

Home health skilled nursing admission and therapy assessment completed for a 77-year-old female recently discharged from a skilled nursing facility following hospitalization for CABG x3 complicated by a nonhealing midline chest incision requiring wound VAC therapy. Past medical history includes diabetes mellitus, osteoarthritis, coronary artery disease, end-stage renal disease requiring hemodialysis every Tuesday, Thursday, and Saturday, hyperlipidemia, sick sinus syndrome, atrial fibrillation, prior myocardial infarction, and partial amputation of the right first and second toes. Medication reconciliation was completed, and education was provided regarding medication adherence and disease management. The wound VAC dressing was intact but could not be removed for direct wound assessment during the start-of-care visit; VAC changes are ordered twice weekly. Patient was educated on wound VAC management, monitoring for alarms or loss of suction, infection prevention, and signs and symptoms requiring notification of the skilled nurse or provider. Rescue dressing instructions were reviewed, including application of a wet-to-dry dressing by the caregiver/brother as ordered in the event of VAC malfunction or inability to maintain suction. Patient verbalized understanding; however, the brother left before caregiver teaching could be completed, indicating a need for continued caregiver education and reinforcement during subsequent visits. Left upper-arm AV fistula assessed with palpable thrill and audible bruit. Patient resides with her brother in a row house with two steps to the rear exit and seven steps to the front entrance; the bedroom and bathroom are located on the second floor with a stair glide available, and a first-floor setup was recommended. Patient ambulates approximately 30 feet indoors with a rollator at an extremely slow pace due to left shoulder pain and requires close supervision for sit-to-stand transfers and maximal assistance to lift her legs into bed. She tolerated 10 repetitions of supine hip flexion, bridging, straight-leg raises, hip abduction, knee extension, and ankle pumps. Patient is

Physician Statement on Homebound Status:

Due to diagnosis of Disruption of external operation (surgical) wound, not elsewhere classified, subsequent encounter, 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<o:p></o:p>

homebound due to the significant effort required to leave the home and the need for a rollator and human assistance. Continued skilled nursing is necessary for wound assessment, twice-weekly wound VAC changes, infection surveillance, medication and disease-process education, and ongoing patient/caregiver teaching. Home health therapy is recommended to improve strength, functional mobility, and independence. Date of Order 09/11/2026 Physician Face-to-Face Date: 08/21/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's dx: Disruption of external operation (surgical) wound, not elsewhere classified, subsequent encounter 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: PT Eval Notes: Physician: Poon, Thaw	

ICD-10 CM Principal Diagnosis: T81.31XD. Disruption of external operation (surgical) wound NEC subs

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
I12.0	Hyp chr kidney disease w stage 5 chr kidney disease or ESRD	ACETAMINOPHEN Extra Strength 500 MG Tablet / Give 2 tablet by mouth every 8 hours for Pain management ALOGLIPTIN BENZOATE 25 MG / 1 Tablet by mouth once a day for DM ASPIRIN Delayed Release 81 MG / 1 Tablet by mouth one time a day for PPX Atorvastatin Calcium - Atorvastatin Calcium 40 MG / 1 Tablet by mouth at bedtime for HLD. Cyclobenzaprine Hydrochloride - Cyclobenzaprine Hydrochloride 5 MG / 1 Tablet by mouth every 8 hours as needed for Muscle spasm Docusate Sodium - Docusate Sodium 100 MG Capsule / Give 2 cc by mouth every 12 hours as needed for Bowel regimen Lyrica - Pregabalin 75 MG / 1 Capsule by mouth two times a day for Pain management MELATONIN 3 MG Tablet / Give 2 tablet by mouth at bedtime for Insomnia ONDANSETRON Give 4 MG Disintegrating Tablet by mouth every 6 hours as needed for Nausea Pantoprazole Sodium - Pantoprazole Sodium Delayed Release 40 MG / 1 Tablet by mouth one time a day for GERD Sennosides - Senna 8.6 MG / 1 Tablet by mouth every 12 hours as needed for Bowel regimen SEVELAMER CARBONATE 800 MG / 1 Tablet by mouth with meals for Hyperphosphatemia SIMETHICONE Chewable 80 MG / 1 Tablet by mouth every 6 hours as needed for Gas/Flatulence Rena-Vite - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox Give 1 tablet by mouth one time a day for Supplement Midodrine Hydrochloride - Midodrine Hydrochloride 5 MG Tablet / Give 3 tablet by mouth as necessary every 24 hours for Hypotension As needed 30 minutes before dialysis
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	
N18.6	End stage renal disease	
D63.1	Anemia in chronic kidney disease	
L89.152	Pressure ulcer of sacral region stage 2	
I49.5	Sick sinus syndrome	
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	
E78.5	Hyperlipidemia unspecified	

G62.89	Other specified polyneuropathies	for SBP<110 mg CALCIUM CARBONATE Give 1000 MG Tablet by mouth as necessary every 8 Hours for Heartburn Oxycodone Hydrochloride - Oxycodone Hydrochloride 5 MG / 1 Tablet by mouth as necessary every 4 Hours for Pain Management PAIN MODERATE (4-6) Oxycodone Hydrochloride - Oxycodone Hydrochloride Give 10 MG Tablet by mouth as necessary every 4 Hours for Pain management SEVERE 7-10 Lidocaine Patch - Lidocaine 5 % / Apply to Left Shoulder topical once a day for Pain Management Remove Q pm and remove per schedule TICAGRELOR 90 MG / 1 Tablet by mouth twice a day for CAD Insulin Lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 UNIT/ML / Inject 3 unit subcutaneous after meal for DM Insulin Lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 UNIT/ML subcutaneous before meal and at bedtime for diabetes. Inject as per sliding scale: if 0 - 200 = 0 unit; 201 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units; Call MD/NP for blood sugar less than 70 or greater than 400
I25.2	Old myocardial infarction	
Z99.2	Dependence on renal dialysis	
Z95.1	Presence of aortocoronary bypass graft	
Z79.82	Long term (current) use of aspirin	

Prognosis fair	**Mental and Psychosocial 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: No
Functional Limitations Ambulation, Endurance, Bowel/Bladder Incontinence	**Activities Permitted** Transfer bed/Chair, Wheelchair, Exercises Prescribed, Up As Tolerated
DME & Supplies wheelchair, wound care supplies	**Safety Measures** ambulates with assistance, , activity supervision, anticoagulant precautions, bathroom safety, cardiac precautions, hand rails, no bp left arm, supervision at all times, transfer with assist, bleeding precautions, fall precautions, diabetic precautions, medication safety, standard precautions, wheelchair precautions, smoke detectors , emergency phone # clearly displayed
Nutrition renal diet,	**Allergies** no known allergies

Advance Directives	Caregiver Status
No Advance Directive	2. Non-agency caregiver(s) need training/supportive services to provide assistance; 2. Non-agency caregiver(s) need training/supportive services to provide assistance
Rehabilitation Potential	**DISCHARGE PLAN:**
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.	SN: family/caregiver will be responsible for managing treatment PT: patient will be responsible for managing treatment

Orders for Discipline and Treatment:

1 - SOC - SN

PT Eval

SN CAREPLAN

SN frequency WK1: 2 (09/11/26-09/12/26)

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

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

09/14/2026 Problems : #2 - Observable Surgical Wound - Other - Left bicep - AV fistula
#1 - Non-Observable Surgical Wound - Other - Midline chest -
muscle weakness (MS)
A1250 - Lack of Necessary Transportation
M1610 - Urinary Incontinence
M1400 - Dyspnea
M2020 - Oral Med Management
balance deficit
limited range of motion
limited endurance

SN NARRATIVE

Home health skilled nursing admission completed for a 77-year-old female with a PMH of diabetes mellitus, osteoarthritis, ESRD requiring hemodialysis every Tuesday, Thursday, and Saturday, hyperlipidemia, sick sinus syndrome, and atrial fibrillation. Patient was recently discharged from a skilled nursing facility and is now home. Medication reconciliation was completed, and education was provided regarding medication adherence and disease management. Patient has a wound VAC in place to the midline chest. The wound was unable to be directly assessed during the start-of-care visit due to the nonremovable wound VAC dressing. Dressing appeared intact, and the wound VAC is ordered to be changed twice weekly. Patient was educated on wound VAC management, monitoring for alarms or loss of suction, infection-prevention measures, and signs and symptoms requiring notification of the skilled nurse or provider. Rescue dressing instructions were reviewed, including the need for her caregiver/brother to apply a wet-to-dry dressing as ordered if the wound VAC malfunctions or cannot maintain suction. Patient verbalized understanding. The brother left during the SOC visit before teaching could be completed; therefore, additional caregiver education and reinforcement are required during subsequent visits. Patient has a fistula to the left upper arm, thrill and bruit heard/felt on assessment. Skilled nursing remains necessary for wound assessment, twice-weekly wound VAC changes, infection surveillance, medication and disease-process education, and continued patient/caregiver teaching.

Home health skilled nursing admission completed for a 77-year-old female with a PMH of diabetes mellitus, osteoarthritis, ESRD requiring hemodialysis every Tuesday, Thursday, and Saturday, hyperlipidemia, sick sinus syndrome, and atrial fibrillation. Patient was recently discharged from a skilled nursing facility and is now home. Medication reconciliation was completed, and education was provided regarding medication adherence and disease management. Patient has a wound VAC in place to the midline chest. The wound was unable to be directly assessed during the start-of-care visit due to the nonremovable wound VAC dressing. Dressing appeared intact, and the wound VAC is ordered to be changed twice weekly. Patient was educated on wound VAC management, monitoring for alarms or loss of suction, infection-prevention measures, and signs and symptoms requiring notification of the skilled nurse or provider. Rescue dressing instructions were reviewed, including the need for her caregiver/brother to apply a wet-to-dry dressing as ordered if the wound VAC malfunctions or cannot maintain suction. Patient verbalized understanding. The brother left during the SOC visit before teaching could be completed; therefore, additional caregiver education and reinforcement are required during subsequent visits. Skilled nursing remains necessary for wound assessment, twice-weekly wound VAC changes, infection surveillance, medication and disease-process education, and continued patient/caregiver teaching.

SN GOALS

PATIENT-STATED GOAL: Patient stated she would like to heal wound 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
* 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
* urinary incontinence management including bladder training

limited strength open sores/lesions abnormal BS < 70/140 > mg/dL B1000 - Vision Deficit meal preparation M2102c - Med Admin M2102f - Patient Supervision M2102d - Caregiver Performs Treatment PROCEDURES: physician-ordered wound care: #2 - Observable Surgical Wound - Other - Left bicep - AV fistula: Leave OTA, physician-ordered wound care: #1 - Non-Observable Surgical Wound - Other - Midline chest -: Cleanse wound with normal saline. Apply moistened Silverion contact layer to the base of the wound. Cut black foam to fit wound dimensions with bridging of the trac pad to the upper abdomen. Apply transparent drape and confirm seal, set vac to 125mm twice weekly (Mon/Wednesday/PRN). Rescue Dressing: Cleanse midstemal wound with normal saline, apply wet to moist gauze and cover with dry dressing as needed for Wound Care, glucose testing via monitor, monitor intake & output, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange preparation of missing meals, coordinate/arrange resources for vision-impaired, monitor dialysis schedule: Tuesday, Thursday, Saturday 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 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, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately	* Kegel exercises * skin care * 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 self-administers medications as prescribed * recalls related medication(s) purpose, schedule patient's transportation needs are met meal preparation is available to patient for all meals caregiver administers and/or packages medications appropriately

PT CAREPLAN
PT frequency WK2: 1 (09/13/26-09/19/26)

09/14/2026 Problems : 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: Family training : Curb steps, gait, home program, home exercise program: Supine hip flexion, bridging, hooklying rotation, straight leg raise, hip abduction. Standing knee flexion, hip abduction, hip extension, plantarflexion, squats. Sitting knee extension, ankle pumps, equipment training, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Chair to Bed to Chair - 05. Setup or clean-up assistance, Sit to Stand - 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, 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 - 02. Substantial/maximal assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 03. Partial/moderate assistance, Don/Doff Footwear - 03. Partial/moderate assistance

PT NARRATIVE
Lient is a77 year old with recent hospitalization due to CABG x3 with non healing incision line requiring VAC. History includes CAD, ESRD WITH DIALYSIS, MI, RIGHT 1ST AND SECOND TOE PARTIAL AMPUTATION. Lives with brother in row house with 2 steps to exit rear and 7 front steps. Bed and bath on second with stair glide. Recommended first floor set up. Ambulates on indoor surface 30 feet extremely slowly due to pain in left shoulder. Transfers sit to stand from bed with close supervision. Maximal assistance to lift legs onto bed . Tolerates 10 reps of supine hip flexion, bridging, straight leg raise, hip abduction, knee extension, ankle pumps. Client is homebound due to significant effort to leave home with rollator and human assistance. Client would benefit from home therapy to increase strength and return to independence.

PT GOALS
PATIENT-STATED GOAL: To be able to get out of the house by myself with my walker

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

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 - 02. Substantial/maximal assistance

Upper Body Dressing - 05. Setup or clean-up assistance

Lower Body Dressing - 03. Partial/moderate assistance

Don/Doff Footwear - 03. Partial/moderate assistance

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: Charles Messick RN on 09/11/2026

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. This patient is under my care, and I have authorized the services on this plan of care and I or another physician will periodically review this plan. I attest that a valid face-to-face encounter occurred (or will occur) within timeframe requirements and it is related to the primary reason the patient requires home health services.
F2F date: 08/21/2026

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.

Certifying Physician or Allowed Practitioner Name and Address **Thaw Poon**
7602 Belair Rd
Baltimore, MD 21236
NPI 1912944349

Phone Number 14106638100

Fax Number 14106638119

Physician's Signature and Date Signed

X

Thaw Poon
08/21/2026: Date of physician last face-to-face