Home Health Certification and Plan of Care

Order ID: 1150/17977

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
3P16VM6XW87	04/12/2026	From: 04/12/2026 To: 06/10/2026	24666	217058

6. Patient's Name and Address

Stephanie Washington
2938 McElderry St,
BALTIMORE, MD 21205-
410-585-4307

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 01/16/1966 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	04/12/26

13. ICD	Other Pertinent Diagnoses	Date
I13.0	Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny	04/12/26
I50.30	Unspecified diastolic (congestive) heart failure	04/12/26
N18.32	Chronic kidney disease stage 3b	04/12/26
D63.1	Anemia in chronic kidney disease	04/12/26
E11.51	Type 2 diabetes w diabetic peripheral angiopath w/o gangrene	04/12/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	04/12/26
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy	04/12/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	04/12/26
J45.909	Unspecified asthma uncomplicated	04/12/26
I25.2	Old myocardial infarction	04/12/26
F32.A	Depression unspecified	04/12/26
E78.5	Hyperlipidemia unspecified	04/12/26
K21.9	Gastro-esophageal reflux disease without esophagitis	04/12/26
Z89.512	Acquired absence of left leg below knee	04/12/26
Z86.31	Personal history of diabetic foot ulcer	04/12/26
Z79.4	Long term (current) use of insulin	04/12/26
Z79.85	Lng trm (crnt) use injectable non-insulin antidiabetic drugs	04/12/26
Z79.01	Long term (current) use of anticoagulants	04/12/26
Z95.1	Presence of aortocoronary bypass graft	04/12/26
Z87.01	Personal history of pneumonia (recurrent)	04/12/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	04/12/26

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

Ventolin Hfa - Albuterol Sulfate 108 (90 BASE) mcg/act aerosol solution / Give 2 puff by mouth every 6 hours as needed for Wheezing
Atorvastatin Calcium - Atorvastatin Calcium 80 mg by mouth one time a day for HLD
Calcium Carbonate Tablet Chewable 500 mg/tablet / Give 2 tablet by mouth three times a day for GERD
Clopidogrel Bisulfate - Clopidogrel Bisulfate 75 mg mg by mouth one time a day for CAD
Ezetimibe - Ezetimibe 10 mg by mouth one time a day for HLD
Humalog - Insulin Lispro Recombinant 100 unit/mL / Inject 6 Unit subcutaneously before meals for diabetes
Hydralazine Hydrochloride - Hydralazine Hydrochloride 25 mg / 1 Tablet by mouth every 12 hours as needed for Hypertension Give as needed for systolic BP > 160, Double check Manual BP before giving and recheck BP 1-2 hours after administration for effectiveness.
Insulin Glargine Solution 100 UNIT/ML / Inject 18 unit subcutaneous at bedtime for diabetes
Insulin Lispro Injection Solution 100 UNIT/ML subcutaneous before meal and at bedtime for DM. Inject as per sliding scale: if 0 - 150 = 0U; if 151 - 200 = 2U; if 201 - 250 = 4U; 251 - 300 = 6U; 301 - 350 = 8U Call MD/NP for BS Greater than 400 or less than 70; 351 - 400 = 10U, Call MD <70>400
Jardiance - Empagliflozin 10 mg / 1 Tablet by mouth one time a day for DM2
Lyrica - Pregabalin 50 mg / 1 Capsule by mouth every 8 hours for Neuropathy
MELATONIN 3 mg / 1 Tablet by mouth at bedtime for Sleep aide
Mirtazapine - Mirtazapine 7.5 mg by mouth at bedtime for Depression
Mounjaro Subcutaneous Solution Auto-Injector 2.5 MG/0.5ML / Inject 2.5 mg subcutaneous once a day every Mon for DM2
Nifedipine Er - Nifedipine 60 mg / 1 Tablet by mouth one time a day for Hypertension
Oxycodone Hydrochloride - Oxycodone Hydrochloride 5 mg / 1 Tablet by mouth every 6 hours as needed for Pain Hold for sedation, hold for a SBP of less than 110 mmhg, stop med upon DC from facility
Pantoprazole Sodium - Pantoprazole Sodium 40 mg / 1 Tablet by mouth in the morning for GERD
POLYETHYLENE GLYCOL Powder / Give 17 gram orally one time a day for Bowel regimen Dissolve in 4oz water; hold for loose stools
SENNOSIDES 8.6 mg/tablet / Give 2 tablet by mouth at bedtime for CONSTIPATION
TORSEMIDE 10 mg/tablet / Give 2 tablet by mouth one time a day for edema
Venlafaxine Hydrochloride - Venlafaxine Hydrochloride 75 mg by mouth one time a day for DEPRESSION
Spironolactone And Hydrochlorothiazide - Hydrochlorothiazide: Spironolactone 25 mg;25 mg 1 tab by mouth once a day 1/2 tab by mouth daily

14. DME and Supplies:

wheelchair, diabetic supplies, commode

15. Safety Measures:

wheelchair precautions, standard precautions, fall precautions, diabetic precautions, ambulates with device, ambulates with assistance, medication safety, smoke detectors , transfer with assist, supervision at all times, sharps precautions, bathroom safety, activity supervision

16. Nutrition:

diabetic

17. Allergies:

shellfish!gabapentin metformin tylenol tramadol

18.A. Functional Limitations

Ambulation, Amputation, Endurance

18.B. Activities Permitted

Transfer bed/Chair, Wheelchair, Exercises Prescribed, Up As Tolerated

19. Mental & Pyschosocial 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: Yes

20. Prognosis: good

22. A Rehabilitation Potential:

SELF-CARE: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper., 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
patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Type 2 diabetes mellitus with diabetic chronic kidney 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.

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 04/12/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Jane Abernethy
301 Mason F Lord Drive
Baltimore, MD 21224
PHONE: 4105503350 FAX: 14437691237 NPI: 1194285874

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 : 04/06/2026

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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6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number
Stephanie Washington 2938 McElderry St, BALTIMORE, MD 21205- 410-585-4307	HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239

Clinical Condition Requiring Homecare:

The patient is a 59-year-old female recently discharged from a subacute rehabilitation facility and now referred for home health services following significant medical and functional decline. Her past medical history is notable for heart failure with preserved ejection fraction (HFpEF), type 2 diabetes mellitus, hypertension, peripheral arterial disease status post femoropopliteal bypass, coronary artery disease status post percutaneous coronary intervention to the left anterior descending artery in 2006 and coronary artery bypass grafting in 2016, left cerebellar cerebrovascular accident in 2014, chronic kidney disease, obstructive sleep apnea not currently managed with CPAP, diabetic left toe wound resulting in toe amputation in 2024, and a recent left below-knee amputation performed in November 2025. Following hospitalization and rehabilitation, the patient has returned home and requires continued skilled home health services. The patient currently resides with her mother, who assists with caregiving needs, and receives additional support from a large extended family who help with activities of daily living and transportation to medical appointments. The patient's significant other has modified the home environment by establishing a living and sleeping area on the first floor to improve accessibility and safety. The patient currently uses a wheelchair for mobility within the home. She reports independence with transfers between the wheelchair and commode. All prescribed medications are present in the home and are available for ongoing management and education. The patient is designated as full code and has documented allergies to shellfish, gabapentin, metformin, acetaminophen (Tylenol), and tramadol. Prior to her recent medical decline and lower extremity amputation, the patient lived with her husband and was independent with basic self-care, functional transfers, and ambulation. At that time, her bedroom was located on the second floor and she was able to independently navigate approximately 14 steps. Currently, the patient demonstrates decreased activity tolerance, reduced bilateral upper extremity strength, and impaired standing balance. She is awaiting fitting and provision of lower extremity prosthetics, which further limits her functional mobility and independence at this time. Due to these deficits, the patient experiences decreased independence with self-care tasks, functional transfers, and mobility. Skilled nursing services are ordered for medication management, medication education, and disease process teaching related to her multiple chronic conditions. Additionally, skilled physical therapy and occupational therapy services are recommended to address impairments in strength, endurance, balance, and mobility. Therapy will focus on gait training, strengthening, functional transfer training, and activities of daily living in order to maximize safety, improve independence, and support the patient's progression toward her prior level of function as she adapts to mobility changes following her below-knee amputation. Continued interdisciplinary home health care is indicated to support recovery, promote safe mobility within the home, and assist the patient in achieving optimal functional outcomes.
 Date of Order 04/12/2026 Orders Physician Face-to-Face Date: 04/06/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Type 2 diabetes mellitus with diabetic chronic kidney disease 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 Abernethy, Jane

SN Careplans

SN WK1: 1 (04/12/26-04/18/26) ,WK2: 1 (04/19/26-04/25/26) ,WK3: 1 (04/26/26-05/02/26) ,WK4: 1 (05/03/26-05/09/26) ,WK5: 1 (05/10/26-05/16/26) ,WK6: 1 (05/17/26-05/23/26)

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, 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:SEE MOLST***

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2020 - Oral Med Management,

SN Goals

PATIENT-STATED GOAL: Patient states she wants to learn how to walk with her prosthetic leg.

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 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
* 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

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	04/12/2026

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M2102c - Med Admin, M2102f - Patient Supervision, M2102d - Caregiver Performs Treatment, M1033 - Exhaustion, M1400 - Dyspnea, dependent edema, limited endurance, limited strength, muscle weakness, Pain Effect on Sleep, Pain Interference with ADLs, balance deficit, daytime fatigue, weak hand grips

PROCEDURES: Teach how to perform daily dry weights.: Weigh themselves every morning After urinating Before eating or drinking Wearing similar clothing each time Use the same scale and place it on a hard surface Record weight in a log or app Notify the provider if gain of 2-3 pounds in 1 day, OR Gain of 5 pounds in 1 week, cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, glucose testing via monitor: Ensure patient is checking BS and keeping track of glucose results, 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 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, caregiver administers and/or packages medications appropriately

OT Careplans

OT WK1: 1 (04/12/26-04/18/26) ,WK3: 1 (04/26/26-05/02/26) ,WK4: 1 (05/03/26-05/09/26) ,WK5: 1 (05/10/26-05/16/26) ,WK6: 1 (05/17/26-05/23/26) ,WK7: 1 (05/24/26-05/30/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, GG0170J1 - Walk 50 ft with 2 Turns, GG0130A1 - Eating, GG0170S1 - Wheel 150 feet, GG0170R1 - Wheel 50 ft w 2 Turns, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170L1 - Walk 10 ft on Uneven Surface, GG0170K1 - Walk 150 Feet, GG0130B1 - Oral Hygiene, GG0170I1 - Walk 10 Feet, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170D1 - Sit to Stand, GG0130C1 - Toileting Hygiene, GG0170F1 - Toilet Transfer, GG0130E1 - Shower/Bathe Self, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing

PROCEDURES: Medication Review : Medication reviewed with patient with all medications in the home, cough/deep breathing exercises, incentive spirometer, wheelchair training, equipment training, work simplification/energy conservation, strengthening exercises: Skilled OT 1x6wks, gait training/stair training, transfers training: Skilled OT 1x6wks, transfers training, assist with bathing: Skilled OT 1x6wks, assist with transferring: Skilled OT 1x6wks, assist with lower body dressing: Skilled OT 1x6wks, assist with upper body dressing: Skilled OT 1x6wks

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, Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, 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, Wheel 50 ft w 2 Turns - 06. Independent, Wheel 150 feet - 06. Independent, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance, 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: Get in the shower

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 - 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

Wheel 50 ft w 2 Turns - 06. Independent

Wheel 150 feet - 06. Independent

Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

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
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	04/12/2026